CONCERT PHARMACEUTICALS, INC.
Form 10-K
March 06, 2017
UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

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FORM 10-K

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(Mark One)
ýANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the fiscal year ended: December 31, 2016
or
¨TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the transition period from to
Commission file number: 001-36310

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CONCERT PHARMACEUTICALS, INC.
(Exact name of registrant as specified in its charter)

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Delaware	20-4839882
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)

99 Hayden Avenue, Suite 500
Lexington, Massachusetts 02421
(Address of principal executive offices) (Zip Code)
Registrant's telephone number, including area code: (781) 860-0045
Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Name of each exchange on which registered
Common Stock, par value $0.001 per share	The NASDAQ Global Market

Securities registered pursuant to Section 12(g) of the Act:
None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ¨ No ý
Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ¨ No ý
Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ý No ¨
Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ý No ¨

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ¨

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See definitions of "large accelerated filer," "accelerated filer," and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ¨	Accelerated filer x
Non-accelerated filer ¨ (Do not check if a smaller reporting company)	Smaller reporting company ¨

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ¨ No ý

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant as of June 30, 2016 was approximately $135,211,000, based on the closing price of the registrant's common stock on the NASDAQ Global Market on that date.

The number of shares outstanding of the registrant's Common Stock as of February 27, 2017: 22,328,982

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References to Concert

Throughout this Annual Report on Form 10-K, the "Company," "Concert," "we," "us," and "our," except where the context requires otherwise, refer to Concert Pharmaceuticals, Inc. and its consolidated subsidiary, and "our board of directors" refers to the board of directors of Concert Pharmaceuticals, Inc.

Forward-Looking Information

This Annual Report on Form 10-K contains forward-looking statements regarding, among other things, our future discovery and development efforts, our future operating results and financial position, our business strategy, and other objectives for our operations. The words "anticipate," "believe," "estimate," "expect," "intend," "may," "plan," "predict," "pro "would" and similar expressions are intended to identify forward-looking statements, although not all forward-looking statements contain these identifying words. You also can identify forward-looking statements by the fact that they do not relate strictly to historical or current facts. There are a number of important risks and uncertainties that could cause our actual results to differ materially from those indicated by forward-looking statements. These risks and uncertainties include those inherent in pharmaceutical research and development, such as adverse results in our drug discovery and clinical development activities, decisions made by the U.S. Food and Drug Administration and other regulatory authorities with respect to the development and commercialization of our drug candidates, our ability to obtain, maintain and enforce intellectual property rights for our drug candidates, our ability to obtain any necessary financing to conduct our planned activities and other risk factors. We may not actually achieve the plans, intentions or expectations disclosed in our forward-looking statements, and you should not place undue reliance on our forward-looking statements. Actual results or events could differ materially from the plans, intentions and expectations disclosed in the forward-looking statements we make. We have included important factors in the cautionary statements included in this Annual Report on Form 10-K, particularly in the section entitled "Risk Factors" in Part I that could cause actual results or events to differ materially from the forward-looking statements that we make. Our forward-looking statements do not reflect the potential impact of any future acquisitions, mergers, dispositions, joint ventures or investments that we may make. Unless required by law, we do not undertake any obligation to publicly update any forward-looking statements.

Part I
Item 1. Business
OVERVIEW

We are a clinical stage biopharmaceutical company applying our extensive knowledge of deuterium chemistry to discover and develop novel small molecule drugs. Selective incorporation of deuterium into known molecules has the potential, on a case-by-case basis, to provide better pharmacokinetic or metabolic properties, thereby enhancing their clinical safety, tolerability or efficacy. Our approach typically starts with approved drugs that may be improved with deuterium substitution. Our technology provides the opportunity to develop products that may compete with the non-deuterated drug in existing markets or to leverage the known activity of approved drugs to expand into new indications. Our deuterated chemical entity platform, or DCE Platform®, has broad potential across numerous therapeutic areas. The following table summarizes our clinical pipeline of product candidates. All of these candidates are small molecules being developed for oral administration.

OUR STRATEGY

Our strategy is to apply our deuterium technology to well characterized molecules in order to leverage their known safety and efficacy profiles. We select pipeline candidates based on the medical needs of patients, commercial opportunity, regulatory considerations, and competitive landscape.

Our approach aims to enable drug discovery and clinical development that is more efficient and less expensive than conventional small molecule drug research and development. Key elements of our strategy include:

- using deuterium technology to develop deuterated product candidates with substantially improved safety, tolerability or efficacy profiles to compete directly with the non-deuterated compound in its approved indication and develop deuterated product candidates that are based on approved drugs but for new indications that we believe are promising in view of the known biology of the approved drug;

- developing our deuterated product candidates quickly through proof-of-concept clinical trials, which could be as early as Phase 1, and then determining whether to advance it independently or with a partner; and

- commercializing product candidates on our own, or with a strategic partner.

DEUTERIUM

Due to its natural abundance, the average adult human body contains approximately two grams of deuterium. While essentially identical to hydrogen in size and shape, deuterium differs from hydrogen in that it contains an additional neutron. As a result, deuterium forms a more stable chemical bond with carbon than does hydrogen. The deuterium-carbon bond is typically six to nine times more stable than the hydrogen-carbon bond. This has important implications for drug development because drug metabolism often involves the breaking of hydrogen-carbon bonds. Because deuterium forms more stable bonds with carbon, deuterium substitution can in some cases alter drug metabolism, including through improved metabolic stability, reduced formation of toxic metabolites, increased formation of desired active metabolites, or a combination of these effects. At the same time, because deuterium closely resembles hydrogen, the substitution of deuterium for hydrogen has generally been found not to materially alter the intrinsic biological activity of a compound. Deuterated compounds can generally be expected to retain biochemical potency and selectivity similar to their hydrogen analogs. The effects, if any, of deuterium substitution on metabolic properties are highly dependent on the specific molecular positions at which deuterium is substituted for hydrogen. In addition, the metabolic effects of deuterium substitution, if any, are unpredictable, even in compounds that have similar chemical structures.

Potential advantages of product candidates based on our DCE Platform

Using our DCE Platform, we create novel drugs designed to have superior properties - including enhanced clinical safety, tolerability or efficacy - based on compounds that have established pharmacological activity. In many instances, Phase 1 clinical evaluation has the potential to demonstrate whether there will be product differentiation. Potential advantages of our DCE Platform include the following:

- Improved metabolic profile. An improved metabolic profile may potentially reduce or eliminate unwanted side effects or undesirable drug interactions or increase efficacy. Metabolic profile refers to the relative amounts and exposure profile of the parent drug and its metabolites in the body.

- Increased half-life. A longer half-life may decrease the number of doses that a patient is required to take per day or provide more consistent exposure of the compound in comparison to the corresponding non-deuterated compound, potentially improving the drug's therapeutic profile. Half-life is usually defined as the time it takes for the body to clear half of a given concentration of the drug from the plasma.

- Avoidance of undesirable metabolism: By avoiding first pass metabolism, we may be able to improve oral bioavailability, which could potentially lead to better efficacy at a lower dose of drug. First pass metabolism is metabolism that occurs before the drug reaches the circulatory system.

OUR PRODUCT CANDIDATES

Our pipeline is focused on leveraging our deuterium expertise and proprietary product platform to develop novel medications designed to enhance patient outcomes in diverse therapeutic areas including pulmonary diseases, including cystic fibrosis, autoimmune and inflammatory diseases, and central nervous systems (CNS) disorders. The discussion below highlights our current clinical programs including those being developed by our collaborators.

CTP-656

Background on Cystic Fibrosis

Cystic fibrosis is a rare, life-threatening genetic disease affecting approximately 70,000 people worldwide. There is no known cure for cystic fibrosis. The median predicted survival age is close to 40 years and nearly half of the cystic fibrosis population is 18 or older. Cystic fibrosis is caused by mutations in the gene that encodes the cystic fibrosis transmembrane conductance regulator protein, or CFTR, a chloride channel that regulates the movement of salt and

water into and out of cells. Children who develop cystic fibrosis inherit two defective CFTR genes, one from each parent, which are referred to as alleles. There are more than 1,900 known mutations in the CFTR gene, some of which result in cystic fibrosis, including the most prevalent F508del mutation and the less prevalent G551D gating mutation. In the United States, it is estimated that approximately 85% of individuals with cystic fibrosis have at least one F508del mutation and approximately 4.4% of people with cystic fibrosis have

a G551D gating mutation. Each mutation causes a different defect in the CFTR protein. When there is a defect caused by the G551D gating mutation, the defective CFTR protein reaches the surface of a cell but does not efficiently transport chloride ions across the cell membrane. The F508del mutation results in a different defect that largely prevents the CFTR protein from reaching the cell surface and also impairs its ability to transport chloride ions.

Defective CFTR results in decreased chloride secretion and reduced hydration of the mucus layer leading to the buildup of thick mucus in the lungs and other vital organs. Lung disease, the most critical manifestation of cystic fibrosis, is characterized by airway obstruction, infection and inflammation, such that more than 90% of all cystic fibrosis patients die of lung disease. Cystic fibrosis patients typically require lifelong treatment, with multiple daily medications, in many cases hospitalization due to lung infections, and potentially lung transplantation.

Ivacaftor (Kalydeco®) is a drug marketed by Vertex Pharmaceuticals, Inc., or Vertex, and initially approved for patients with the G551D gating mutation. The label has been expanded to include patients with certain other mutations. Ivacaftor is a CFTR potentiator, which keeps the CFTR protein channels on the cell surface open more often, to increase the flow of salt and water into and out of the cell. Vertex has also incorporated ivacaftor into the fixed dose combination drug, Orkambi®, which is marketed for patients homozygous for the F508del mutation.

CTP-656 Opportunity

CTP-656 is a novel, next generation potentiator that we are initially developing for the treatment of cystic fibrosis in patients who have gating mutations, including the G551D mutation. CTP-656 was discovered by applying our deuterium chemistry technology to modify ivacaftor, which is the current standard of care for this population. Due to its differentiated pharmacokinetic profile, CTP-656 has the potential to offer a greater therapeutic benefit relative to ivacaftor for this patient population. The potential benefits of CTP-656 include improved efficacy due to better treatment adherence, as a result of once-daily dosing and increased exposure to the parent drug, which is more active than the metabolites; and fewer drug-drug interactions.

CTP-656 also has the potential to be a key component of combination therapies that enable the treatment of patients having many other CFTR mutations. To advance combination therapies of CTP-656, we intend to collaborate with companies who are focused on developing drugs that target other mechanisms of action and that we believe may be suitable to combine with CTP-656.

On March 3, 2017, we entered into an Asset Purchase Agreement with Vertex, through Vertex Pharmaceuticals (Europe) Limited, pursuant to which we agreed to sell and assign, subject to the satisfaction or waiver of certain conditions, the cystic fibrosis assets of the Company, including CTP-656, for up to $250 million. Additional information concerning the sale of CTP-656 is discussed further in Note 18 in the consolidated financial statements, Item 1A. and Item 9B., each appearing elsewhere in this Annual Report on Form 10-K.

Clinical Development of CTP-656

In December 2016, we announced the initiation of a U.S.-based Phase 2 clinical trial evaluating CTP-656 in patients who have gating mutations, including the G551D mutation. The Phase 2 clinical trial is a randomized, parallel-group, double-blind, placebo-controlled, clinical trial to evaluate the safety and efficacy of CTP-656 in cystic fibrosis patients with gating mutations who are receiving stable treatment with Kalydeco. Patients enrolled in the 28-day study will receive either 20 mg, 100 mg, or 150 mg of CTP-656 once-daily or placebo. There will also be an open-label Kalydeco comparator arm in the trial. Approximately 30-40 patients will be enrolled in the Phase 2 trial. The primary endpoint of the Phase 2 trial is a change from baseline in sweat chloride at Day 28. Secondary endpoints include change in percent predicted forced expiratory volume (FEV1) and change from baseline in CFQ-R Respiratory Domain. The U.S. Phase 2 trial is being conducted at multiple study sites within the Cystic Fibrosis Foundation’s Therapeutic Development Network. Top-line data are expected by year-end 2017.

In January 2017, subsequent to the initiation of the study, the U.S. Food and Drug Administration, or FDA, informed Concert that, in order to support dose selection for Phase 3, an adequate washout period, in which Kalydeco treatment is withheld, would be required in addition to a placebo-control.

Following the Asset Purchase Agreement with Vertex, we do not intend to initiate any new clinical trials with CTP-656 at this time.

In January 2017, we also announced that the FDA granted orphan drug designation for CTP-656, which provides various incentives for companies to develop products for rare diseases affecting fewer than 200,000 people in the United States.

During 2015 and 2016, we completed multiple Phase 1 clinical trials evaluating CTP-656. In Phase 1, CTP-656 demonstrated an increase in half-life, decreased clearance, and an overall increase in exposure compared to Kalydeco. We also showed that CTP-656 plasma exposure was less dependent on dietary conditions than has been reported for Kalydeco, allowing CTP-656 to be dosed without regard to fat content of food. CTP-656 was well-tolerated and its safety profile was comparable to that of Kalydeco. No serious adverse events were reported in Phase 1 studies.

CTP-543

Background on Alopecia Areata

Alopecia areata is an autoimmune disease affecting up to 650,000 Americans at any given time and that results in partial or complete loss of hair on the scalp or body. The scalp is the most commonly affected area. Onset of the disease can occur throughout life, however, disease onset typically occurs in patients 30 years of age or younger and affects both men and women. Alopecia areata can be associated with serious psychological consequences, including anxiety and depression. There are currently no drugs approved by the U.S. Food and Drug Administration (FDA) for the treatment of alopecia areata. Alopecia areata is one of the disease areas that the FDA will focus on under its Patient-Focused Drug Development Initiative (PFDDI) in 2017. The goal of the PFDDI is to bring patient perspectives into an earlier stage of product development.

CTP-543 Opportunity

CTP-543 was discovered by applying Concert's deuterium chemistry technology to modify ruxolitinib, which is commercially available under the name Jakafi® in the United States for the treatment of certain blood disorders. Ruxolitinib has been used to treat alopecia areata in academic settings, including an investigator-sponsored clinical trial, and has been shown to promote hair growth in individuals with moderate-to-severe disease. Published findings from an open-label clinical trial of 12 patients with moderate to severe alopecia areata conducted by investigators at Columbia University demonstrated that 20 mg of ruxolitinib administered orally twice daily resulted in substantial efficacy, including nearly complete reversal of the disease in most cases, in 75% of patients.

Clinical Development of CTP-543

In 2016, we completed single and multiple ascending dose Phase 1 trials. The single and multiple ascending dose trials enrolled a total of 77 healthy volunteers. The pharmacokinetic measurements showed increased exposure with increasing doses. CTP-543 was well-tolerated across all dose groups and there were no serious adverse events reported in subjects who received CTP-543. The safety and exposure observed with 16 mg of CTP-543 twice daily appeared comparable to the reported exposure of 20 mg ruxolitinib twice daily. In the multiple ascending dose Phase 1 trial of CTP-543, pharmacodynamic analyses were performed to assess the inhibition of IL-6- and IFN-gamma-mediated JAK/STAT signaling. Consistent with the established pharmacological activity of CTP-543, a dose-related reduction in IL-6-stimulated phosphorylated STAT3 was observed. Also, IFN-gamma-mediated STAT1 signaling, which is believed to play a key role in the pathogenesis of alopecia areata, was significantly inhibited in disease-relevant immune cell types at all doses evaluated.

We also conducted a Phase 1 crossover study evaluating the metabolite profiles of CTP-543 and ruxolitinib. In this study, except for the presence of deuterium, no new metabolites were observed with CTP-543.

The Company's planned Phase 2a trial will enroll approximately 100 patients with moderate-to-severe alopecia areata. The dose-ranging trial will evaluate four active arms of CTP-543 (4, 8, 12 and 16 mg BID) and a placebo control. The primary outcome measure of the Phase 2a trial will be the effect on treating hair loss as measured by the severity of alopecia tool (SALT) after 24 weeks of dosing. The trial will include an additional 28 weeks of dosing where all patients enrolled in the study will receive CTP-543. The trial is expected to commence in the first quarter of 2017 and top-line primary outcome data are expected by the end of 2017.

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Collaboration Product Candidates

We have entered into several collaborative arrangements with companies to develop deuterium-modified versions of their marketed products. The deuterium product candidates may be developed for an existing indication or in new indications.

AVP-786

In February 2012, we granted Avanir Pharmaceuticals, Inc., or Avanir, an exclusive worldwide license to develop and commercialize deuterated dextromethorphan analogs, including the d_6-dextromethorphan compound, deudextromethorphan . Subsequent to our agreement, Avanir was acquired by Otsuka Pharmaceutical Co., Ltd. and is now a wholly owned subsidiary of Otsuka America, Inc.

Avanir is developing AVP-786, which is a combination of deudextromethorphan and an ultra-low dose of quinidine. In November 2015, Avanir announced the initiation of the Phase 3 clinical program to evaluate the safety and efficacy of AVP-786 for the treatment of agitation associated with Alzheimer's disease. It expects to enroll approximately 700 patients in two Phase 3 trials. The Phase 3 trials are expected to be completed in the third quarter of 2018.

In addition, Avanir is conducting multiple Phase 2 trials exploring additional neurological indications.

CTP-730

In April 2013, we entered into a strategic worldwide collaboration with Celgene Pharmaceuticals, Inc., Celgene International Sarl and Celgene Corporation, together referred to as Celgene, related to certain deuterium-substituted compounds for the treatment of inflammation or cancer. While the collaboration has the potential to encompass multiple programs, it is initially focused on one program, CTP-730.

CTP-730 is a deuterated analog of apremilast. Apremilast is a selective phosphodiesterase 4 (PDE4) inhibitor approved for the treatment of psoriasis and psoriatic arthritis. We have completed the Phase 1 clinical evaluation of CTP-730. Once daily dosing of 50 mg of CTP-730 administered for seven days in the Phase 1 clinical trial demonstrated similar steady state exposure to historical data for 30 mg of apremilast twice daily. Treatment with CTP-730 was generally well-tolerated and no serious adverse events were observed. Celgene is responsible for any development of CTP-730 beyond the completed Phase 1 clinical trials. Celgene is assessing the path forward for CTP-730. However, CTP-730 has not advanced into new trials at this time.

JZP-386

In February 2013, we licensed the commercial rights to deuterated analogs of sodium oxybate, including JZP-386, to Jazz Pharmaceuticals under an exclusive worldwide license agreement. Sodium oxybate is the active ingredient in Xyrem®, marketed in the United States by Jazz Pharmaceuticals to treat two of the key symptoms of narcolepsy, excessive daytime sleepiness and cataplexy. JZP-386 is being developed for the potential treatment of patients with narcolepsy.

In May 2015, we and Jazz Pharmaceuticals announced the completion of a Phase 1 clinical study. Clinical data from this Phase 1 study demonstrated that JZP-386 provided favorable deuterium-related effects, including higher serum concentrations and correspondingly increased PD effects at clinically relevant time points compared to Xyrem® (sodium oxybate) oral solution. The safety profile of JZP-386 was similar to that observed with Xyrem. Jazz Pharmaceuticals is responsible for any further development of JZP-386 and is continuing to evaluate once-nightly dosing.

INTELLECTUAL PROPERTY

We protect our product candidates through the use of patents, trade secrets and careful monitoring of our proprietary know-how. Our patents and patent applications, if they issue as patents, for our lead programs expire between 2028 and 2034. The expected expiration dates are before any patent term extension to which we may be entitled under the Drug Price Competition and Patent Term Restoration Act of 1984 (commonly referred to as the Hatch-Waxman Amendments) or equivalent laws in other jurisdictions where we have issued patents.

AVP-786

We hold U.S. patents and pending applications covering the composition of matter and methods of use of deudextromethorphan and other deuterated dextromethorphan analogs, as well as a U.S. patent application covering methods of use of certain other dextromethorphan compounds. These patents and patent applications are expected to expire between 2028 and 2030. We have

corresponding patents and patent applications in Europe and Japan that are expected to expire in 2028. We have granted exclusive licenses under these patent rights to Avanir.

CTP-656

We hold U.S. patents covering the composition of matter of deuterated analogs of ivacaftor and methods of treating cystic fibrosis, and a corresponding U.S. patent application. The patents and the patent application are expected to expire in 2032. We have corresponding patent applications in Europe and Japan that are expected to expire in 2032. We have retained all of the CTP-656 patent rights.

CTP-543

We hold a U.S. patent covering the composition of matter of deuterated analogs of ruxolitinib and a corresponding U.S. patent application. The patent and the patent application are expected to expire in 2033. We have corresponding patent applications in Europe and Japan that are expected to expire in 2033. We have retained all of the CTP-543 patent rights.

JZP-386

We hold a U.S. patent, as well as a corresponding U.S. patent application, covering the composition of matter of deuterated analogs of sodium oxybate, including JZP-386, and methods of using them for treating certain diseases and disorders, including narcolepsy. This patent and patent application are expected to expire in 2030. We hold a corresponding European patent that is expected to expire in 2030. We also have U.S. patents covering pharmaceutical compositions of JZP-386 and methods of use of JZP-386 for treating certain diseases and disorders, including narcolepsy, as well as patent applications in the United States, Europe and Japan, covering the composition of matter and methods of use of JZP-386, that are expected to expire in 2032. We have granted exclusive licenses under these patent rights to Jazz Pharmaceuticals.

CTP-730

We hold U.S. patents and a U.S. patent application covering the composition of matter of CTP-730. The patents and the patent application are expected to expire in 2030. We also hold corresponding patents in Europe and Japan that are expected to expire in 2030. We have granted exclusive licenses under these patent rights to Celgene.

Other Product Candidates

We also have patent portfolios that are related to a number of other programs. These patent portfolios are wholly owned by us. These include issued patents or patent applications that claim deuterated analogs of more than 90 non-deuterated drugs and drug candidates.

The term of individual patents depends upon the legal term of the patents in the countries in which they are obtained. In the United States and other countries in which we file, the patent term is 20 years from the earliest date of filing a non-provisional patent application.

Under U.S. patent law, the patent term may be extended by patent term adjustment due to certain failures of the U.S. Patent and Trademark Office to act in a timely manner. The patent term of a patent that covers an FDA-approved drug may also be eligible for patent term extension, which permits patent term restoration as compensation for the patent term lost during the FDA regulatory review process. The Hatch-Waxman Amendments permit a patent term extension of up to five years beyond the expiration of the patent. The length of the patent term extension is related to the length of time the drug is under regulatory review. Patent extension cannot extend the remaining term of a patent beyond a total of 14 years from the date of product approval and only one patent applicable to an approved drug may be extended. Similar provisions are available in Europe and other non-U.S. jurisdictions to extend the term of a patent that covers an approved drug. In the future, if and when our pharmaceutical products receive FDA approval, we expect to apply for patent term extensions on patents that we believe are eligible for such extension. We also intend to seek patent term extensions in other jurisdictions where these are available. However, there is no guarantee that the applicable authorities, including the FDA, will agree with our assessment of whether such extensions should be granted, and even if granted, the length of such extensions.

We also rely on trade secrets and careful monitoring of our proprietary know-how to protect aspects of our business that are not amenable to, or that we do not consider appropriate for, patent protection, including our DCE Platform, such as:

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- our methods of evaluating candidate compounds for deuteration;
- our bioanalytical methods for identifying and measuring metabolites formed by the in vitro and in vivo metabolism of deuterated compounds;
- our analytical methods for evaluating how selective deuterium substitution affects different pharmacokinetic and metabolic parameters in vitro and in vivo systems; and
- our methods to determine the degree of deuterium substitution in compounds we manufacture.

MANUFACTURING AND SUPPLY

We currently rely, and expect to continue to rely, on third parties for the manufacture of product candidates for our clinical trials. We obtain these manufacturing services, including both the manufacture of the active pharmaceutical ingredients and finished drug product, on a purchase order basis and have not entered into long-term contracts with any of these third party manufacturers. We expect to rely on third parties for commercial manufacturing for any of our product candidates that receive marketing approval.

We have successfully transferred the methods we use in our internal manufacturing to our third party manufacturers, allowing them to produce multi-kilogram quantities of clinical trial materials with similar or greater efficiency than we achieved internally. If any of our third party manufacturers should become unavailable to us for any reason, we believe that there are a number of potential replacements, although we might incur some delay in identifying and qualifying such replacements.

We believe that all of the deuterium that we use in manufacturing our product candidates is currently derived, directly or indirectly, from deuterium oxide. For most of our deuterium supply we rely on bulk supplies of deuterium oxide, which we currently source from multiple suppliers, including two located in North America, one of which is in the United States. In order to internationally transport any deuterium oxide that we purchase from foreign suppliers, we, or our U.S. supplier, may be required to obtain an export license from the country of origin and we may be required to obtain an International Import Certificate from the country of destination. We are also generally required to obtain an export license from the Nuclear Regulatory Commission before shipping deuterium oxide from the United States to any contract manufacturer in another country. Each of these documents specifies the maximum amount of deuterium oxide that we, or our suppliers, are permitted to either import or export. In particular, in order to obtain additional supplies of deuterium oxide from one of the foreign suppliers from which we have previously purchased deuterium oxide, the supplier will be required to obtain an additional export license from the country of origin and, as part of the export license application process, we may be required to obtain a U.S. import certificate. While we and our suppliers have obtained similar licenses and certificates in the past, we or our suppliers may not be able to obtain them in the future in a timely manner or at all.

Certain of our manufacturing processes for our product candidates incorporate deuterium by using deuterated chemical intermediates or reagents that are derived from deuterium oxide. For the deuterated chemical intermediates and reagents, we may be subject to the license requirements applicable to deuterium oxide. In addition, the manufacturer of the deuterated chemical intermediate or reagent may themselves be required to obtain deuterium oxide under applicable licensing requirements. Most of the manufacturers of these deuterated chemical intermediates and reagents are not located in countries that produce bulk quantities of deuterium oxide. Therefore, our ability to source these deuterated chemical intermediates or reagents will depend on the ability of these manufacturers to obtain deuterium oxide from other countries.

We purchase our raw materials on a purchase order basis and have not entered into long-term contracts with any of these third party suppliers. We believe that the raw materials for our product candidates are readily available and that the cost of manufacturing for our product candidates will not preclude us from selling them profitably, if approved for sale.

COMMERCIALIZATION

We have not yet established a sales, marketing or product distribution infrastructure. We plan to use a combination of third party collaboration, licensing and distribution arrangements and a focused in-house commercialization capability

to sell any of our products that receive marketing approval. With respect to the United States, we plan to seek to retain full commercialization rights for products that we can commercialize with a specialized sales force and to retain co-promotion or similar rights when feasible in indications requiring a larger commercial infrastructure. We plan to collaborate with third parties for commercialization in the United States of any products that require a large sales, marketing and product distribution infrastructure. We also plan to collaborate with third parties for commercialization outside the United States.

We plan to build a marketing and sales management organization to create and implement marketing strategies for any products that we market through our own sales organization and to oversee and support our sales force. We expect the responsibilities of the marketing organization would include developing educational initiatives with respect to approved products and establishing relationships with thought leaders in relevant fields of medicine.

COMPETITION

The development and commercialization of new drug products is highly competitive. We expect that we, and our collaborators, will face significant competition from major pharmaceutical companies, specialty pharmaceutical companies and biotechnology companies worldwide with respect to our product candidates that we, or they, may seek to develop or commercialize in the future. Specifically, there are a number of large pharmaceutical and biotechnology companies that currently market and sell products or are pursuing the development of product candidates for the treatment of neurologic disorders, inflammation, and cystic fibrosis, the key indications for our current research and development programs. Our competitors may succeed in developing, acquiring or licensing technologies and drug products that are more effective, have fewer or more tolerable side effects or are less costly than any product candidates that we are currently developing or that we may develop, which could render our product candidates obsolete and noncompetitive.

Our commercial opportunity could be reduced or eliminated if our competitors develop and commercialize products that are safer, more effective, have fewer or less severe side effects, are more convenient or are less expensive than any products that we, or our collaborators, may develop. Our competitors also may obtain FDA or other marketing approval for their products before we, or our collaborators, are able to obtain approval for ours, which could result in our competitors establishing a strong market position before we, or our collaborators, are able to enter the market.

Many of our existing and potential future competitors have significantly greater financial resources and expertise in research and development, manufacturing, nonclinical testing, conducting clinical trials, obtaining marketing approvals and marketing approved products than we do. Mergers and acquisitions in the pharmaceutical and biotechnology industries may result in even more resources being concentrated among a smaller number of our competitors. Smaller or early stage companies may also prove to be significant competitors, particularly through collaborative arrangements with large and established companies. These competitors also compete with us in recruiting and retaining qualified scientific and management personnel and establishing clinical trial sites and patient registration for clinical trials, as well as in acquiring technologies complementary to, or necessary for, our programs.

Many pharmaceutical and biotechnology companies have begun to cover deuterated analogs of their product candidates in patent applications and may choose to develop these deuterated compounds. Some of these pharmaceutical and biotechnology companies may have significantly greater financial resources and expertise in research and development, manufacturing, nonclinical testing, conducting clinical trials, obtaining marketing approvals and marketing approved products than we do. In addition, we know of other companies that are broadly utilizing deuterium substitution for drug development, including Auspex Pharmaceuticals, Inc., a wholly owned subsidiary of Teva Pharmaceutical Industries Ltd., and DeuteRx LLC. In some cases, these competitors may be interested in developing deuterated compounds that we may be interested in developing for ourselves. In addition, these competitors may enter into collaborative arrangements or business combinations that result in their ability to research and develop deuterated compounds more effectively than us. Our potential competitors also include academic institutions, government agencies and other public and private research organizations.

CTP-656

We are initially developing CTP-656, a deuterated analog of ivacaftor, as a treatment for cystic fibrosis in individuals with gating mutations of the CFTR gene, such as G551D. The current standard of care for this population is ivacaftor, which is marketed by Vertex Pharmaceuticals, Inc. under the name Kalydeco®. If CTP-656 receives marketing

approval, it would compete with this product and may face competition from a number of other product candidates that are currently in clinical development by AbbVie and Galapagos Pharmaceuticals, Flatley Labs, Novartis and Proteostasis, including additional candidates being developed by Vertex, among others.

CTP-543

CTP-543 is a deuterated analog of ruxolitinib, which is being developed for the treatment of moderate-to-severe alopecia areata, an autoimmune disease that results in partial or complete loss of hair on the scalp and body. If CTP-543 receives marketing approval for this indication, it may face competition from a number of other product candidates that are being studied for alopecia areata. The non-deuterated analog of CTP-543, ruxolitinib, is being developed as a topical treatment for

alopecia areata by Incyte, who markets ruxolitinib (Jakafi®) in the U.S. for myelofibrosis and polycythemia vera. Aclaris Therapeutics and Pfizer are pursuing the development of other Janus, kinase inhibitors, or JAK inhibitors, with differing subtype selectivity for alopecia areata. In addition, various academic investigators, are conducting or have conducted efficacy trials in alopecia areata, including with currently approved JAK inhibitors such as ruxolitinib and tofacitinib (Xeljanz®).

AVP-786

Avanir is developing AVP-786 for the treatment of agitation associated with Alzheimer's disease and other neurological indications. There are marketed drugs and product candidates in clinical development for each indication. Intra-Cellular Therapies is developing a treatment for agitation in patients with dementia, including Alzheimer's Disease.

JZP-386

JZP-386 is a deuterated analog of sodium oxybate, which is being developed for the treatment of excessive daytime sleepiness and cataplexy in patients with narcolepsy. The current standard of care is treatment with sodium oxybate, which is marketed by Jazz Pharmaceuticals, Inc., under the name Xyrem®. Avadel Pharmaceuticals is developing an extended release formulation of sodium oxybate for the treatment of narcolepsy. Roxane Laboratories, Inc. developed a generic version of Xyrem® for the treatment of narcolepsy, which was approved by the FDA in January 2017 but is not yet marketed pending ongoing litigation.

CTP-730

CTP-730 is a phosphodiesterase 4, or PDE4, inhibitor that has potential for the treatment of various inflammatory diseases. The non-deuterated drug apremilast is marketed for certain types of psoriasis and psoriatic arthritis. It is also being evaluated for efficacy in other chronic inflammatory diseases. If CTP-730 receives marketing approval, the competition it may face will depend on the particular inflammatory disease for which it receives approval.

GOVERNMENT REGULATIONS

Government authorities in the United States, at the federal, state and local level, and in other countries and jurisdictions, including the European Union, extensively regulate, among other things, the research, development, testing, manufacture, manufacturing changes, packaging, storage, recordkeeping, labeling, advertising, promotion, sales, distribution, marketing, and import and export of pharmaceutical products. The processes for obtaining regulatory approvals in the United States and in foreign countries and jurisdictions, along with subsequent compliance with applicable statutes and regulations and other regulatory authorities, require the expenditure of substantial time and financial resources.

Review and Approval of Drugs in the United States

In the United States, the FDA regulates drugs under The Federal Food, Drug, and Cosmetic Act, or FDCA, and implementing regulations. The process of obtaining regulatory approvals and the subsequent compliance with appropriate federal, state, local and foreign statutes and regulations requires the expenditure of substantial time and financial resources. Failure to comply with the applicable U.S. requirements at any time during the product development process, approval process or after approval, may subject an applicant and/or sponsor to a variety of administrative or judicial sanctions, including refusal by the FDA to approve pending applications, withdrawal of an approval, imposition of a clinical hold, issuance of warning letters and other types of letters, product recalls, product seizures, total or partial suspension of production or distribution, injunctions, fines, refusals of government contracts, restitution, disgorgement of profits, or civil or criminal investigations and penalties brought by the FDA and the Department of Justice or other governmental entities.

An applicant seeking approval to market and distribute a new drug product in the United States must typically undertake the following:

- completion of nonclinical laboratory tests, animal studies and formulation studies in compliance with the FDA's good laboratory practice, or GLP, regulations;

- production of well-characterized drug substance and drug product, and potentially matching placebos;

- submission to the FDA of an investigational new drug application, or IND application, which allows human clinical trials to begin unless the FDA otherwise informs the drug's sponsor within 30 days;

- agreement by clinical investigators and their clinical trial sites, followed by approval by an independent institutional review board, or IRB, representing each clinical site, before the clinical trial may be initiated at that site;

- performance of adequate and well-controlled human clinical trials in accordance with the FDA's current Good Clinical Practices, or GCPs, to establish the safety and efficacy of the proposed drug product for each indication;

- preparation and submission to the FDA of a New Drug Application, or NDA;

- review of the NDA by an FDA advisory committee, where appropriate or if applicable;

- satisfactory completion of one or more FDA inspections of the manufacturing facility or facilities at which the drug product, and the active pharmaceutical ingredient or active ingredients thereof, are produced to assess compliance with current good manufacturing practices and to assure that the facilities, methods and controls are adequate to ensure the product's identity, strength, quality and purity;

- payment of user fees and securing FDA approval of the NDA; and

- compliance with any post-approval requirements, including REMS and post-approval studies required by the FDA.

Nonclinical Studies and an IND

Nonclinical studies can include in vitro and animal studies to assess the potential for efficacy and adverse events and, in some cases, to establish a rationale for human therapeutic use. The conduct of nonclinical studies is subject to federal regulations and requirements, including GLP regulations. Other studies include laboratory evaluation of the purity, stability and physical form of the manufactured drug substance or active pharmaceutical ingredient and the physical properties, stability and reproducibility of the formulated drug or drug product. An IND sponsor must submit the results of the relevant nonclinical tests, including all tests conducted under GLP conditions, together with manufacturing information, analytical data, any available clinical data or literature and plans for clinical studies, among other things, to the FDA as part of an IND. Some nonclinical testing, such as longer-term toxicity testing, animal tests of reproductive adverse events and carcinogenicity, may continue after the IND is submitted. An IND automatically becomes effective 30 days after receipt by the FDA, unless before that time the FDA raises concerns or questions related to a proposed clinical trial and places the trial on clinical hold or partial clinical hold. In such a case, the IND sponsor and the FDA must resolve any outstanding concerns before the clinical trial can begin. As a result, submission of an IND may not result in the FDA allowing clinical trials to commence.

Following commencement of a clinical trial under an IND, the FDA may place a clinical hold on that trial. A clinical hold is an order issued by the FDA to the sponsor to delay a proposed clinical investigation or to suspend an ongoing investigation. A partial clinical hold is a delay or suspension of only part of the clinical work requested under the IND. For example, a specific protocol or part of a protocol is not allowed to proceed, while other protocols may do so. No more than 30 days after imposition of a clinical hold or partial clinical hold, the FDA will provide the sponsor a written explanation of the basis for the hold. Following issuance of a clinical hold or partial clinical hold, an investigation may only resume after the FDA has notified the sponsor that the investigation may proceed. The FDA will base that determination on information provided by the sponsor correcting the deficiencies previously cited or otherwise satisfying the FDA that the investigation can proceed.

Human Clinical Studies in Support of an NDA

Clinical trials involve the administration of the investigational product to human subjects under the supervision of qualified investigators in accordance with GCP requirements, which include, among other things, the requirement that all research subjects provide their informed consent in writing before their participation in any clinical trial. Clinical trials are conducted under written study protocols detailing, among other things, the objectives of the study, the parameters to be used in monitoring safety and the effectiveness criteria to be evaluated. A protocol for each clinical trial and any subsequent protocol amendments must be submitted to the FDA as part of the IND. In addition, an IRB representing each institution participating in the clinical trial must review and approve the plan for any clinical trial

before it commences at that institution, and the IRB must conduct continuing review and reapprove the study at least annually. The IRB must review and approve, among other things, the study protocol and informed consent information to be provided to study subjects. An IRB must operate in compliance with FDA regulations. Information about certain clinical trials must be submitted within specific timeframes to the NIH for public dissemination on their ClinicalTrials.gov website. Human clinical trials are typically conducted in three sequential phases, which may overlap or be combined:

Phase 1: The product candidate is initially introduced into healthy human subjects or patients with the target disease or condition and tested for safety, dosage tolerance, absorption, metabolism, distribution, excretion and, if possible, to gain an early indication of its effectiveness.

Phase 2: The product candidate is administered to a limited patient population to identify possible adverse effects and safety risks, to preliminarily evaluate the efficacy of the product for specific targeted diseases and to determine dosage tolerance and dosage for Phase 3 studies.

Phase 3: The product candidate is administered to an expanded patient population, generally at geographically dispersed clinical trial sites, in well-controlled clinical trials to generate enough data to statistically evaluate the efficacy and safety of the product for approval, to establish the overall risk-benefit profile of the product, and to provide adequate information for the labeling of the product.

Progress reports detailing the results of the clinical trials must be submitted at least annually to the FDA and more frequently if serious adverse events occur. Phase 1, Phase 2 and Phase 3 clinical trials may not be completed successfully within any specified period, or at all. Furthermore, the FDA or the sponsor may suspend or terminate a clinical trial at any time on various grounds, including a finding that the research subjects are being exposed to an unacceptable health risk. Similarly, an IRB can suspend or terminate approval of a clinical trial at its institution, or an institution it represents, if the clinical trial is not being conducted in accordance with the IRB's requirements or if the drug has been associated with unexpected serious harm to patients. The FDA will often inspect one or more clinical sites in late-stage clinical trials to assure compliance with GCP and the integrity of the clinical data submitted.

Section 505(b)(2) NDAs

NDAs for most new drug products are based on two adequate and well-controlled clinical trials which must contain substantial evidence of the safety and efficacy of the proposed new product. These applications are generally submitted under Section 505(b)(1) of the FDCA. The FDA is, however, authorized to approve an alternative type of NDA under Section 505(b)(2) of the FDCA. This latter type of application allows the applicant to rely, in part, on the FDA's previous findings of safety and efficacy for a similar reference product, or may rely on published literature. Specifically, Section 505(b)(2) applies to NDAs for a drug for which the applicant relies, as part of its application, on investigations made to show whether or not the drug is safe and effective for use "that were not conducted by or for the applicant and for which the applicant has not obtained a right of reference or use from the person by or for whom the investigations were conducted."

Thus, Section 505(b)(2) authorizes the FDA to approve an NDA based on safety and effectiveness data that were not developed by the applicant. NDAs filed under Section 505(b)(2) may provide an alternate and potentially more expeditious pathway to FDA approval for new or improved formulations or new uses of previously approved products. If the 505(b)(2) applicant can establish that reliance on the FDA's previous approval is scientifically appropriate, the applicant may eliminate the need to conduct certain nonclinical or clinical studies of the new product. The FDA may also require companies to perform additional studies or measurements to support the change from the approved product. The FDA may then approve the new drug candidate for all or some of the label indications for which the referenced product has been approved, as well as for any new indication sought by the Section 505(b)(2) applicant.

If our partners submit NDAs for approval of deuterated analogs of marketed compounds for which they are the NDA holder, we believe that in certain cases the FDA may allow referencing of data from the non-deuterated compound in support of the application for approval of the deuterated product. Since this referencing by our partners would involve use of their own data and not require the use of another party's data, it would constitute a Section 505(b)(1) application.

Submission of an NDA to the FDA

Assuming successful completion of required clinical testing and other requirements, the results of the nonclinical and clinical studies, together with detailed information relating to the product's chemistry, manufacture, controls and

proposed labeling, among other things, are submitted to the FDA as part of an NDA requesting approval to market the drug product for one or more indications. Under federal law, the submission of most NDAs is additionally subject to a number of application and user fees.

Under certain circumstances, the FDA will waive the application fee for the first human drug application that a small business, defined as a company with less than 500 employees, or its affiliate submits for review. An affiliate is defined as a business entity that has a relationship with a second business entity if one business entity controls, or has the power to control, the other business entity, or a third party controls, or has the power to control, both entities.

The FDA conducts a preliminary review of an NDA within 60 days of its receipt and informs the sponsor by the 74th day after the FDA's receipt of the submission to determine whether the application is sufficiently complete to permit substantive review. The FDA may request additional information rather than accept an NDA for filing. In this event, the application must be resubmitted with the additional information. The resubmitted application is also subject to review before the FDA accepts it for filing. Once the submission is accepted for filing, the FDA begins an in-depth substantive review. The FDA has agreed to specified performance goals in the review process of NDAs. Most such applications are meant to be reviewed within ten months from the date of filing, and most applications for "priority review" products are meant to be reviewed within six months of filing. The review process may be extended by the FDA for three additional months to consider new information or clarification provided by the applicant to address an outstanding deficiency identified by the FDA following the original submission.

Before approving an NDA, the FDA typically will inspect the facility or facilities where the product is manufactured. The FDA will not approve an application unless it determines that the manufacturing processes and facilities are in compliance with cGMP requirements and adequate to assure consistent production of the product within required specifications. Additionally, before approving an NDA, the FDA will typically inspect one or more clinical sites to assure compliance with GCP.

The FDA also may require submission of a risk evaluation and mitigation strategy, or REMS, plan to mitigate any identified or suspected serious risks. The REMS plan could include medication guides, physician communication plans, assessment plans, and elements to assure safe use, such as restricted distribution methods, patient registries, or other risk minimization tools.

The FDA is required to refer an application for a novel drug to an advisory committee or explain why such referral was not made. Typically, an advisory committee is a panel of independent experts, including clinicians and other scientific experts, that reviews, evaluates and provides a recommendation as to whether the application should be approved and under what conditions. The FDA is not bound by the recommendations of an advisory committee, but it considers such recommendations carefully when making decisions.

The FDA's Decision on an NDA

On the basis of the FDA's evaluation of the NDA and accompanying information, including the results of the inspection of the manufacturing facilities, the FDA may issue an approval letter or a complete response letter. An approval letter authorizes commercial marketing of the product with specific prescribing information for specific indications. A complete response letter generally outlines the deficiencies in the submission and may require substantial additional testing or information in order for the FDA to reconsider the application. If and when those deficiencies have been addressed to the FDA's satisfaction in a resubmission of the NDA, the FDA will issue an approval letter. The FDA has committed to reviewing such resubmissions in two or six months depending on the type of information included. Even with submission of this additional information, the FDA ultimately may decide that the application does not satisfy the regulatory criteria for approval.

If the FDA approves a product, it may limit the approved indications for use for the product, require that contraindications, warnings or precautions be included in the product labeling, require that post-approval studies, including Phase 4 clinical trials, be conducted to further assess the drug's safety after approval, require testing and surveillance programs to monitor the product after commercialization, or impose other conditions, including distribution restrictions or other risk management mechanisms, including REMS, which can materially affect the potential market and profitability of the product. The FDA may prevent or limit further marketing of a product based on the results of post-market studies or surveillance programs. After approval, some types of changes to the approved product, such as adding new indications, manufacturing changes and additional labeling claims, are subject to further testing requirements and FDA review and approval.

The product may also be subject to official lot release, meaning that the manufacturer is required to perform certain tests on each lot of the product before it is released for distribution. If the product is subject to official release, the manufacturer must submit samples of each lot, together with a release protocol showing a summary of the history of manufacture of the lot and the results of all of the manufacturer's tests performed on the lot, to the FDA. The FDA may in addition perform certain confirmatory tests on lots of some products before releasing the lots for distribution. Finally, the FDA will conduct laboratory research related to the safety and effectiveness of drug products.

Post-Approval Requirements

Drugs manufactured or distributed pursuant to FDA approvals are subject to pervasive and continuing regulation by the FDA, including, among other things, requirements relating to recordkeeping, periodic reporting, product sampling and distribution, advertising and promotion and reporting of adverse experiences with the product. After approval, most changes to the approved product, such as adding new indications or other labeling claims, are subject to prior FDA review and approval. There also are

continuing, annual user fee requirements for any marketed products and the establishments at which such products are manufactured, as well as new application fees for supplemental applications with clinical data.

In addition, drug manufacturers and other entities involved in the manufacture and distribution of approved drugs are required to register their establishments with the FDA and state agencies, and are subject to periodic unannounced inspections by the FDA and these state agencies for compliance with cGMP requirements. Changes to the manufacturing process are strictly regulated and often require prior FDA approval before being implemented. FDA regulations also require investigation and correction of any deviations from cGMP and impose reporting and documentation requirements upon the sponsor and any third-party manufacturers that the sponsor may decide to use. Accordingly, manufacturers must continue to expend time, money, and effort in the area of production and quality control to maintain cGMP compliance.

Once an approval is granted, the FDA may withdraw the approval if compliance with regulatory requirements and standards is not maintained or if problems occur after the product reaches the market. Later discovery of previously unknown problems with a product, including adverse events or problems with manufacturing processes of unanticipated severity or frequency, or failure to comply with regulatory requirements, may result in revisions to the approved labeling to add new safety information; imposition of post-market studies or clinical trials to assess new safety risks; or imposition of distribution or other restrictions under a REMS program. Other potential consequences include, among other things:

- restrictions on the marketing or manufacturing of the product, complete withdrawal of the product from the market or product recalls;
- fines, warning letters or holds on post-approval clinical trials;
- refusal of the FDA to approve pending NDAs or supplements to approved NDAs, or suspension or revocation of product license approvals;
- product seizure or detention, or refusal to permit the import or export of products; or
- injunctions or the imposition of civil or criminal penalties.

The FDA strictly regulates marketing, labeling, advertising and promotion of products that are placed on the market. Drugs may be promoted only for the approved indications and in accordance with the provisions of the approved label. The FDA and other agencies actively enforce the laws and regulations prohibiting the promotion of off-label uses, and a company that is found to have improperly promoted off-label uses may be subject to significant liability.

In addition, the distribution of prescription pharmaceutical products is subject to the Prescription Drug Marketing Act, or PDMA, which regulates the distribution of drugs and drug samples at the federal level, and sets minimum standards for the registration and regulation of drug distributors by the states. Both the PDMA and state laws limit the distribution of prescription pharmaceutical product samples and impose requirements to ensure accountability in distribution.

Abbreviated New Drug Applications for Generic Drugs

In 1984, with passage of the Hatch-Waxman Amendments to the FDCA, Congress authorized the FDA to approve generic drugs that are the same as drugs previously approved by the FDA under the NDA provisions of the statute. To obtain approval of a generic drug, an applicant must submit an abbreviated new drug application, or ANDA, to the agency. In support of such applications, a generic manufacturer may rely on the nonclinical and clinical testing previously conducted for a drug product previously approved under an NDA, known as the reference listed drug, or RLD. To reference that information, however, the ANDA applicant must demonstrate, and the FDA must conclude, that the generic drug does, in fact, perform in the same way as the RLD it purports to copy.

Specifically, in order for an ANDA to be approved, the FDA must find that the generic version is identical to the RLD with respect to the active ingredients, the route of administration, the dosage form, and the strength of the drug. At the same time, the FDA must also determine that the generic drug is “bioequivalent” to the innovator drug. Under the statute, a generic drug is bioequivalent to a RLD if “the rate and extent of absorption of the generic drug do not show a significant difference from the rate and extent of absorption of the reference listed drug. . . .”

Upon approval of an ANDA, the FDA indicates that the generic product is “therapeutically equivalent” to the RLD and it assigns a therapeutic equivalence rating to the approved generic drug in its publication “Approved Drug Products with Therapeutic Equivalence Evaluations,” also referred to as the “Orange Book.” Physicians and pharmacists consider the therapeutic equivalence rating to mean that a generic drug is fully substitutable for the RLD. In addition, by operation of certain state laws and numerous health insurance programs, the FDA’s designation of a therapeutic equivalence rating often results in substitution of the generic drug without the knowledge or consent of either the prescribing physician or patient.

Under the Hatch-Waxman Amendments, the FDA may not approve an ANDA until any applicable period of non-patent exclusivity for the RLD has expired. The FDCA provides a period of five years of data exclusivity for new drug containing a new chemical entity. For the purposes of this provision, a new chemical entity is a drug that contains no active moiety that has been previously approved by FDA in any other NDA. An active moiety is the molecule or ion responsible for the physiological or pharmacological action of the drug substance. In cases where such new chemical entity exclusivity has been granted, an ANDA may not be filed with the FDA until the expiration of five years unless the submission is accompanied by a Paragraph IV certification, in which case the applicant may submit its application four years following the original product approval.

The FDCA also provides for a period of three years of exclusivity if the NDA includes reports of one or more new clinical investigations, other than bioavailability or bioequivalence studies, that were conducted by or for the applicant and are essential to the approval of the application. This three-year exclusivity period often protects changes to a previously approved drug product, such as a new dosage form, route of administration, combination or indication. Three year exclusivity would be available for a drug product that contains a previously approved active moiety, provided the statutory requirement for a new clinical investigation is satisfied. Unlike five year new chemical entity exclusivity, an award of three year exclusivity does not block the FDA from accepting ANDAs seeking approval for generic versions of the drug as of the date of approval of the original drug product.

Hatch-Waxman Patent Certification and the 30 Month Stay

NDA sponsors are required to list with the FDA each patent with claims that cover the applicant's product or a method of using the product. Each of the patents listed by the NDA sponsor is published in the Orange Book. When an ANDA applicant files its application with the FDA, the applicant is required to certify to the FDA concerning any patents listed for the reference product in the Orange Book, except for patents covering methods of use for which the ANDA applicant is not seeking approval.

Specifically, the applicant must certify with respect to each patent that:

- the required patent information has not been filed;
- the listed patent has expired;
- the listed patent has not expired, but will expire on a particular date and approval is sought after patent expiration; or
- the listed patent is invalid, unenforceable or will not be infringed by the new product.

A certification that the new product will not infringe the already approved product's listed patents or that such patents are invalid or unenforceable is called a Paragraph IV certification. If the applicant does not challenge the listed patents or indicate that it is not seeking approval of a patented method of use, the ANDA application will not be approved until all the listed patents claiming the referenced product have expired.

If the ANDA applicant has provided a Paragraph IV certification to the FDA, the applicant must also send notice of the Paragraph IV certification to the NDA and patent holders once the ANDA has been accepted for filing by the FDA. The NDA and patent holders may then initiate a patent infringement lawsuit in response to the notice of the Paragraph IV certification. The filing of a patent infringement lawsuit within 45 days after the receipt of a Paragraph IV certification automatically prevents the FDA from approving the ANDA until the earlier of 30 months, expiration of the patent, settlement of the lawsuit or a decision in the infringement case that is favorable to the ANDA applicant.

To the extent that the Section 505(b)(2) applicant is relying on studies conducted for an already approved product, the applicant is required to certify to the FDA concerning any patents listed for the approved product in the Orange Book to the same extent that an ANDA applicant would. As a result, approval of a 505(b)(2) NDA can be stalled until all the listed patents claiming the referenced product have expired, until any non-patent exclusivity, such as exclusivity for obtaining approval of a new chemical entity, listed in the Orange Book for the referenced product has expired, and, in the case of a Paragraph IV certification and subsequent patent infringement suit, until the earlier of 30 months, settlement of the lawsuit or a decision in the infringement case that is favorable to the Section 505(b)(2) applicant.

Pediatric Studies and Exclusivity

Under the Pediatric Research Equity Act of 2003, a NDA or supplement thereto must contain data that are adequate to assess the safety and effectiveness of the drug product for the claimed indications in all relevant pediatric subpopulations, and to support dosing and administration for each pediatric subpopulation for which the product is

safe and effective. With enactment of the Food and Drug Administration Safety and Innovation Act, or FDASIA, in 2012, sponsors must also submit pediatric study plans prior to the assessment data. Those plans must contain an outline of the proposed pediatric study or studies the applicant plans to conduct, including study objectives and design, any deferral or waiver requests, and other information required by regulation. The applicant, the FDA, and the FDA's internal review committee must then review the information

submitted, consult with each other, and agree upon a final plan. The FDA or the applicant may request an amendment to the plan at any time.

The FDA may, on its own initiative or at the request of the applicant, grant deferrals for submission of some or all pediatric data until after approval of the product for use in adults, or full or partial waivers from the pediatric data requirements. Additional requirements and procedures relating to deferral requests and requests for extension of deferrals are contained in FDASIA. Unless otherwise required by regulation, the pediatric data requirements do not apply to products with orphan designation.

Pediatric exclusivity is another type of non-patent marketing exclusivity in the United States and, if granted, provides for the attachment of an additional six months of marketing protection to the term of any existing regulatory exclusivity, including the non-patent and orphan exclusivity. This six-month exclusivity may be granted if an NDA sponsor submits pediatric data that fairly respond to a written request from the FDA for such data. The data do not need to show the product to be effective in the pediatric population studied; rather, if the clinical trial is deemed to fairly respond to the FDA's request, the additional protection is granted. If reports of requested pediatric studies are submitted to and accepted by the FDA within the statutory time limits, whatever statutory or regulatory periods of exclusivity or patent protection cover the product are extended by six months. This is not a patent term extension, but it effectively extends the regulatory period during which the FDA cannot accept or approve another application.

Patent Term Restoration and Extension

A patent claiming a new drug product may be eligible for a limited patent term extension under the Hatch-Waxman Amendments. Those Amendments permit a patent restoration of up to five years for patent term lost during product development and the FDA regulatory review. The restoration period granted is typically one-half the time between the effective date of an IND and the submission date of a NDA, plus the time between the submission date of a NDA and ultimate approval. Patent term restoration cannot be used to extend the remaining term of a patent past a total of 14 years from the product's approval date. Only one patent applicable to an approved drug product is eligible for the extension, and the application for the extension must be submitted prior to the expiration of the patent in question. The U.S. Patent and Trademark Office reviews and approves the application for any patent term extension or restoration in consultation with the FDA.

Review and Approval of Drug Products in the European Union

In order to market any product outside of the United States, a company must also comply with numerous and varying regulatory requirements of other countries and jurisdictions regarding quality, safety and efficacy and governing, among other things, clinical trials, marketing authorization, commercial sales and distribution of our products. Whether or not it obtains FDA approval for a product, the company would need to obtain the necessary approvals by the comparable foreign regulatory authorities before it can commence clinical trials or marketing of the product in those countries or jurisdictions. The approval process ultimately varies between countries and jurisdictions and can involve additional product testing and additional administrative review periods. The time required to obtain approval in other countries and jurisdictions might differ from and be longer than that required to obtain FDA approval. Regulatory approval in one country or jurisdiction does not ensure regulatory approval in another, but a failure or delay in obtaining regulatory approval in one country or jurisdiction may negatively impact the regulatory process in others.

Pursuant to the European Clinical Trials Directive, a system for the approval of clinical trials in the European Union has been implemented through national legislation of the member states. Under this system, an applicant must obtain approval from the competent national authority of a European Union member state in which the clinical trial is to be conducted. Furthermore, the applicant may only start a clinical trial after a competent ethics committee has issued a favorable opinion. Clinical trial applications must be accompanied by an investigational medicinal product dossier with supporting information prescribed by the European Clinical Trials Directive and corresponding national laws of the member states and further detailed in applicable guidance documents.

To obtain marketing approval of a drug under European Union regulatory systems, an applicant must submit a marketing authorization application, or MAA, either under a centralized or decentralized procedure.

The centralized procedure provides for the grant of a single marketing authorization by the European Commission that is valid for all European Union member states. The centralized procedure is compulsory for specific products,

including for medicines produced by certain biotechnological processes, products designated as orphan medicinal products, advanced therapy products and products with a new active substance indicated for the treatment of certain diseases. For products with a new active substance indicated for the treatment of other diseases and products that are highly innovative or for which a centralized process is in the interest of patients, the centralized procedure may be optional.

Under the centralized procedure, the Committee for Medicinal Products for Human Use, or the CHMP, established at the European Medicines Agency, or EMA, is responsible for issuing an Opinion following the initial assessment of an MAA. Under the centralized procedure, the maximum timeframe for the evaluation of an MAA is 210 days, excluding clock stops, when additional information or written or oral explanation is to be provided by the applicant in response to questions of the CHMP. Accelerated evaluation might be granted by the CHMP in exceptional cases, when a medicinal product is of major interest from the point of view of public health and in particular from the viewpoint of therapeutic innovation. In this circumstance, the EMA ensures that the opinion of the CHMP is given within 150 days. Following a positive Opinion by the CHMP the final authorization is issued by the European Commission.

The decentralized procedure is available to applicants who wish to market a product in various European Union member states where such product has not received marketing approval in any European Union member states before. The decentralized procedure provides for approval by one or more other, or concerned, member states of an assessment of an application performed by one member state designated by the applicant, known as the reference member state. Under this procedure, an applicant submits an application based on identical dossiers and related materials to the reference member state and concerned member states. The reference member state prepares a draft assessment report and drafts of the related materials within 120 days after receipt of a valid application. Within 90 days of receiving the reference member state's assessment report and related materials, each concerned member state must decide whether to approve the assessment report and related materials.

If a member state cannot approve the assessment report and related materials on the grounds of potential serious risk to public health, the disputed points are subject to a dispute resolution mechanism and may eventually be referred to the European Commission, whose decision is binding on all member states.

Data and Market Exclusivity in the European Union

In the European Union, new chemical entities qualify for eight years of data exclusivity upon marketing authorization and an additional two years of market exclusivity. This data exclusivity, if granted, prevents regulatory authorities in the European Union from referencing the innovator's data to assess a generic (abbreviated) application for eight years, after which generic marketing authorization can be submitted, and the innovator's data may be referenced, but not approved for two years. The overall ten-year period will be extended to a maximum of eleven years if, during the first eight years of those ten years, the marketing authorization holder obtains an authorization for one or more new therapeutic indications which, during the scientific evaluation prior to their authorization, are held to bring a significant clinical benefit in comparison with existing therapies. Even if a compound is considered to be a new chemical entity and the sponsor is able to gain the prescribed period of data exclusivity, another company nevertheless could also market another version of the drug if such company can complete a full MAA with a complete database of pharmaceutical test, nonclinical tests and clinical trials and obtain marketing approval of its product.

Pharmaceutical Coverage, Pricing and Reimbursement

Significant uncertainty exists as to the coverage and reimbursement status of products approved by the FDA and other government authorities. Sales of products will depend, in part, on the extent to which third-party payors, including government health programs in the United States such as Medicare and Medicaid, commercial health insurers and managed care organizations, provide coverage, and establish adequate reimbursement levels, for such products. The process for determining whether a payor will provide coverage for a product may be separate from the process for setting the price or reimbursement rate that the payor will pay for the product once coverage is approved. Third-party payors are increasingly challenging the prices charged for medical products and services and imposing controls to manage costs. Third-party payors may limit coverage to specific products on an approved list, or formulary, which might not include all of the approved products for a particular indication. In order to secure coverage and reimbursement for any product that might be approved for sale, a company may need to conduct expensive pharmacoeconomic studies in order to demonstrate the medical necessity and cost-effectiveness of the product, in addition to the costs required to obtain FDA or other comparable regulatory approvals. A payor's decision to provide coverage for a drug product does not imply that an adequate reimbursement rate will be approved. Third-party reimbursement may not be sufficient to maintain price levels high enough to realize an appropriate return on our investment in product development.

The containment of healthcare costs has also become a priority of federal, state and foreign governments, and the prices of drugs have been a focus in this effort. Governments have shown significant interest in implementing cost-containment programs, including price controls, restrictions on reimbursement and requirements for substitution of generic products. Adoption of price controls and cost-containment measures, and adoption of more restrictive policies in jurisdictions with existing controls and measures, could adversely affect our net revenue and results.

Outside of the United States, ensuring adequate coverage and payment for products remains challenging. Pricing of prescription pharmaceuticals is subject to governmental control in many countries. Pricing negotiations with governmental authorities can extend well beyond the receipt of regulatory marketing approval for a product and may require us to conduct a clinical trial that compares the cost effectiveness of our product candidates or products to other available therapies. The conduct of such a clinical trial could be expensive and result in delays in our commercialization efforts.

As a result, the marketability of any product which receives regulatory approval for commercial sale may suffer if the government and third-party payors fail to provide adequate coverage and reimbursement. In addition, an increasing emphasis on managed care in the United States has increased and will continue to increase the pressure on drug pricing. Coverage policies, third-party reimbursement rates and drug pricing regulation may change at any time. In particular, the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Affordability Reconciliation Act, contains provisions that may reduce the profitability of drug products, including, for example, increased rebates for drugs sold to Medicaid programs, extension of Medicaid rebates to Medicaid managed care plans, mandatory discounts for certain Medicare Part D beneficiaries and annual fees based on pharmaceutical companies' share of sales to federal health care programs. Even if favorable coverage and reimbursement status is attained for one or more products that receive regulatory approval, less favorable coverage policies and reimbursement rates may be implemented in the future.

In the European Union, pricing and reimbursement schemes vary widely from country to country. Some countries provide that drug products may be marketed only after a reimbursement price has been agreed. Some countries may require the completion of additional studies that compare the cost-effectiveness of a particular product candidate to currently available therapies. For example, the European Union provides options for its member states to restrict the range of drug products for which their national health insurance systems provide reimbursement and to control the prices of medicinal products for human use. European Union member states may approve a specific price for a drug product or it may instead adopt a system of direct or indirect controls on the profitability of the company placing the drug product on the market. Other member states allow companies to fix their own prices for drug products, but monitor and control company profits. The downward pressure on health care costs in general, particularly prescription drugs, has become intense. As a result, increasingly high barriers are being erected to the entry of new products. In addition, in some countries, cross-border imports from low-priced markets exert competitive pressure that may reduce pricing within a country. Any country that has price controls or reimbursement limitations for drug products may not allow favorable reimbursement and pricing arrangements for any of our products.

Healthcare Law and Regulation

Healthcare providers, physicians and third-party payors will play a primary role in the recommendation and prescription of drug products that are granted marketing approval. Arrangements with third-party payors and customers are subject to broadly applicable fraud and abuse and other healthcare laws and regulations that may constrain the business or financial arrangements and relationships through which we market, sell and distribute our products for which we obtain marketing approval. Restrictions under applicable federal and state healthcare laws and regulations, include the following:

- the federal healthcare Anti-Kickback Statute prohibits, among other things, persons and entities from knowingly and willfully soliciting, offering, receiving or providing remuneration, directly or indirectly, in cash or in kind, to induce or reward either the referral of an individual for, or the purchase, order or recommendation of, any good or service, for which payment may be made, in whole or in part, under a federal healthcare program such as Medicare and Medicaid;

- the federal civil and criminal false claims laws, including the False Claims Act, which imposes civil monetary penalties, and provides for civil whistleblower or qui tam actions, against individuals or entities for, among other things, knowingly presenting, or causing to be presented, to the federal government, claims for payment that are false or fraudulent or making a false statement to avoid, decrease or conceal an obligation to pay money to the federal government;

- the federal Health Insurance Portability and Accountability Act of 1996, or HIPAA, which imposes federal criminal and civil liability for, among other things, knowingly and willingly executing, or attempting to execute, a scheme to defraud any healthcare benefit program or making false statements relating to healthcare matters;

- HIPAA, as amended by the Health Information Technology for Economic and Clinical Health Act and its implementing regulations, also imposes obligations, including mandatory contractual terms, with respect to safeguarding the privacy, security and transmission of individually identifiable health information;

- the federal false statements statute prohibits knowingly and willfully falsifying, concealing or covering up a material fact or making any materially false statement in connection with the delivery of or payment for healthcare benefits, items or services;

- the federal transparency requirements under the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act, or the Affordable Care Act, which requires certain manufacturers of drugs, devices, biologics and medical supplies to report to the Department of Health and Human Services information related to payments and other transfers of value to physicians and teaching hospitals and physician ownership and investment interests; and

- analogous state and foreign laws and regulations, such as state anti-kickback and false claims laws, which may apply to healthcare items or services that are reimbursed by non-governmental third-party payors, including private insurers. Some state laws require pharmaceutical companies to comply with the pharmaceutical industry's voluntary compliance guidelines and the relevant compliance guidance promulgated by the federal government in addition to requiring drug manufacturers to report information related to payments to physicians and other health care providers or marketing expenditures. State and foreign laws also govern the privacy and security of health information in some circumstances, many of which differ from each other in significant ways and often are not preempted by HIPAA, thus complicating compliance efforts.

Regulation of Deuterium Oxide

We believe that all of the deuterium that we use in manufacturing our product candidates is currently derived, directly or indirectly, from deuterium oxide. For most of our deuterium supply we rely on bulk supplies of deuterium oxide, which we currently source from multiple suppliers, including two located in North America, one of which is located in the United States. In order to internationally transport any deuterium oxide that we purchase from foreign suppliers, we, or our U.S. supplier, may be required to obtain an export license from the country of origin and we may be required to obtain an International Import Certificate from the country of destination. We are also generally required to obtain an export license from the Nuclear Regulatory Commission before shipping deuterium oxide from the United States to any contract manufacturer in another country. Each of these documents specifies the maximum amount of deuterium oxide that we, or our suppliers, are permitted to either import or export. We have obtained a license from the Nuclear Regulatory Commission, or NRC, for the export of 20,000 kilograms of heavy water over the life of the license, which is valid until January 2019. We have obtained an additional export license from the NRC for the export of 20,000 kilograms of heavy water over the life of the license, which is valid until March 2020. In addition, in order to obtain additional supplies of deuterium oxide from one of the foreign suppliers from which we have previously purchased deuterium oxide, the supplier will be required to obtain an additional export license from the country of origin and, as part of the export license application process, we may be required to obtain a U.S. import certificate. While we and our suppliers have obtained similar licenses and certificates in the past, we or our suppliers may not be able to obtain them in the future in a timely manner or at all. We have not obtained an export license from the country in which our potential future foreign supplier is located. In addition, if any of our product candidates is approved by the FDA, then the FDA will also have regulatory jurisdiction over the manufacture and use of deuterium oxide in such product.

EMPLOYEES

As of December 31, 2016, we had 69 employees, 47 of whom were primarily engaged in research and product development activities. A total of 24 employees have Ph.D. degrees. None of our employees are represented by a labor union and we believe our relations with our employees are good.

FACILITIES

Our offices are located in Lexington, Massachusetts, consisting of approximately 50,000 square feet of leased office and laboratory space. The term of the lease expires in September 2018.

RESEARCH AND DEVELOPMENT

We have dedicated a significant portion of our resources to our efforts to develop our pipeline and product candidates. We incurred research and development expenses of $37.0 million, $28.9 million and $27.5 million during the years ended December 31, 2016, 2015 and 2014, respectively. We anticipate that a significant portion of our

operating expenses in future periods will continue to be related to research and development as we continue to advance our product candidates through clinical development.

LEGAL PROCEEDINGS

We are not currently a party to any material legal proceedings.

AVAILABLE INFORMATION

We file reports and other information with the Securities and Exchange Commission, or SEC, as required by the Securities Exchange Act of 1934, as amended, which we refer to as the Exchange Act. You can find, copy and inspect information we file at the SEC's public reference room, which is located at 100 F Street, N.E., Room 1580, Washington, DC 20549. Please call the SEC at 1-800-SEC-0330 for more information about the operation of the SEC's public reference room. You can review our electronically filed reports and other information that we file with the SEC on the SEC's web site at http://www.sec.gov.

We were incorporated under the laws of the State of Delaware on April 12, 2006 as Concert Pharmaceuticals, Inc. Our principal executive offices are located at 99 Hayden Avenue, Suite 500, Lexington, Massachusetts, 02421, and our telephone number is (781) 860-0045. Our Internet website is http://www.concertpharma.com. We make available free of charge through our website our Annual Report on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K and amendments to those reports filed or furnished pursuant to Sections 13(a) and 15(d) of the Exchange Act. We make these reports available through our website as soon as reasonably practicable after we electronically file such reports with, or furnish such reports to, the SEC. In addition, we regularly use our website to post information regarding our business, product development programs and governance, and we encourage investors to use our website, particularly the information in the section entitled "Investors," as a source of information about us.

The foregoing references to our website are not intended to, nor shall they be deemed to, incorporate information on our website into this Annual Report on Form 10-K by reference.

Item 1A. Risk Factors.

Our business is subject to numerous risks. The following important factors, among others, could cause our actual results to differ materially from those expressed in forward-looking statements made by us or on our behalf in this Annual Report on Form 10-K and other filings with the Securities and Exchange Commission, or the SEC, press releases, communications with investors and oral statements. Actual future results may differ materially from those anticipated in our forward-looking statements. We undertake no obligation to update any forward-looking statements, whether as a result of new information, future events or otherwise.

RISKS RELATED TO OUR FINANCIAL POSITION AND NEED FOR ADDITIONAL CAPITAL

We have incurred significant losses since inception, expect to incur losses for at least the next several years and may never sustain profitability.

We have incurred significant annual net operating losses in every year since our inception, except for fiscal year 2015. Although we were profitable for fiscal year 2015 as a result of a one-time payment of $50.2 million that we received in June 2015, as a result of our patent assignment agreement with Auspex, we expect to incur significant annual net operating losses in future periods. As of December 31, 2016, we had an accumulated deficit of $171.9 million. We have not generated any revenues from product sales and have financed our operations to date primarily through the public offering of our common stock, private placements of our preferred stock, debt financings and funding from collaborations and a patent assignment agreement. We have not completed development of any product candidate and have devoted substantially all of our financial resources and efforts to research and development, including nonclinical studies and our clinical development programs. We expect to continue to incur significant expenses and increasing operating losses for at least the next several years. Our net losses may fluctuate significantly from quarter to quarter and year to year. Net losses and negative cash flows have had, and will continue to have, an adverse effect on our stockholders' equity and working capital.

We anticipate that our expenses will increase substantially if and as we:

- continue to develop and conduct nonclinical studies and clinical trials with respect to our product candidates;
- seek to identify additional product candidates;
- in-license or acquire additional product candidates;
- seek marketing approvals for our product candidates that successfully complete clinical trials;
- establish sales, marketing, distribution and other commercial infrastructure in the future to commercialize various products for which we may obtain marketing approval;
- require the manufacture of larger quantities of product candidates for clinical development and potentially commercialization;
- maintain, expand and protect our intellectual property portfolio;
- hire additional personnel;
- add equipment and physical infrastructure to support our research and development; and
- continue to implement the infrastructure necessary to support our product development and help us comply with our obligations as a public company.

Our ability to become and remain profitable depends on our ability to generate revenue. We do not expect to generate significant revenue unless and until we are, or one of our collaborators is, able to successfully commercialize one or more of our product candidates. This will require success in a range of challenging activities, including completing clinical trials of our product candidates, obtaining marketing approval for these product candidates, manufacturing, marketing and selling those products for which we, or our collaborators, may obtain marketing approval, satisfying any post-marketing requirements and obtaining reimbursement for our products from private insurance or government payors. We, and our collaborators, may never succeed in these activities and, even if we do, or one of our collaborators does, we may never generate revenues that are large enough for us to achieve profitability. Even if we do achieve profitability, we may not be able to sustain or increase profitability on a quarterly or annual basis. Our failure to become and remain profitable would decrease the value of our Company and could impair our ability to raise

capital, expand our business, maintain our research and development efforts, diversify our pipeline of product candidates or continue our operations. A decline in the value of our Company could cause our stockholders to lose all or part of their investments in us.

We have a limited operating history and no history of commercializing pharmaceutical products, which may make it difficult to evaluate the prospects for our future viability.

We began operations in April 2006. Our operations to date have been limited to financing and staffing our Company, developing our technology and product candidates and establishing collaborations. We have not yet demonstrated an ability to successfully conduct an international multi-center clinical trial, conduct a large-scale pivotal clinical trial, obtain marketing approvals, manufacture product on a commercial scale or arrange for a third party to do so on our behalf, or conduct sales and marketing activities necessary for successful product commercialization. Consequently, predictions about our future success or viability may not be as accurate as they could be if we had a longer operating history or a history of successfully developing and commercializing pharmaceutical products.

We will need substantial additional funding. If we are unable to raise capital when needed, we could be forced to delay, reduce or eliminate our product development programs or commercialization efforts.

Developing pharmaceutical products, including conducting nonclinical studies and clinical trials, is a very time-consuming, expensive and uncertain process that takes years to complete. We expect our expenses to increase in connection with our ongoing activities, particularly as we initiate new clinical trials of, initiate new research and nonclinical development efforts for and seek marketing approval for, our product candidates, or if we in-license or acquire product candidates. In addition, if we obtain marketing approval for any of our product candidates, we may incur significant commercialization expenses related to product sales, marketing, manufacturing and distribution to the extent that such sales, marketing and distribution are not the responsibility of one of our collaborators. In particular, the costs that we may be required to incur for the manufacture of any product candidate that receives marketing approval may be substantial. To our knowledge, no deuterated drug has ever been successfully commercialized. Manufacturing a deuterated drug at commercial scale may require specialized facilities, processes and materials. Furthermore, we will continue to incur costs associated with operating as a public company. Accordingly, we will need to obtain substantial additional funding in connection with our continuing operations. If we are unable to raise capital when needed or on attractive terms, we may be forced to delay, reduce or eliminate our research and development programs or any future commercialization efforts.

In any event, our existing cash and cash equivalents and investments will not be sufficient to fund all of the efforts that we plan to undertake or to fund the completion of development of any of our product candidates. Accordingly, we will be required to obtain further funding through public or private equity offerings, debt financings, collaborations and licensing arrangements or other sources. Adequate additional financing may not be available to us on acceptable terms, or at all. Our failure to raise capital when needed would have a negative impact on our financial condition and our ability to pursue our business strategy.

Based on our current expectations, including with respect to our development plans, we believe our existing cash and cash equivalents and investments as of December 31, 2016 will enable us to fund our operating expenses and capital expenditure requirements through the second quarter of 2018. Upon closing of the CTP-656 asset purchase agreement, we expect our cash will be sufficient to fund the Company into 2021 under our current operating plan. Our estimate as to how long we expect our cash and cash equivalents and investments to be able to continue to fund our operations is based on assumptions that may prove to be wrong, and we could use our available capital resources sooner than we currently expect. Changing circumstances could cause us to consume capital significantly faster than we currently anticipate, and we may need to spend more money than currently expected because of circumstances beyond our control. Our future funding requirements, both short-term and long-term, will depend on many factors, including:

- the successful closing of our asset sale with Vertex;
- the progress, timing, costs and results of clinical trials of, and research and nonclinical development efforts for, our product candidates and potential product candidates, including current and future clinical trials;
- our current collaboration agreements and achievement of milestones under these agreements;
- our ability to enter into and the terms and timing of any additional collaborations, licensing, product acquisition or other arrangements that we may establish;
- the number of product candidates that we pursue and their development requirements;
- the outcome, timing and costs of seeking regulatory approvals;

- our headcount growth and associated costs as we expand our research and development and establish a commercial infrastructure;
- the costs of preparing, filing and prosecuting patent applications, maintaining and protecting our intellectual property rights and defending against intellectual property related claims; and
- the costs of operating as a public company.

Raising additional capital may cause dilution to our stockholders or require us to relinquish rights to our technologies or product candidates.

Until such time, if ever, as we can generate substantial product revenues, we expect to finance our cash needs through a combination of public or private equity offerings, debt financings, additional collaborations and licensing arrangements and other sources. We do not have any committed external source of funds, other than potential milestone payments and royalties under our collaborations with Celgene, Avanir and Jazz Pharmaceuticals, each of which is subject to the achievement of development, regulatory and/or sales-based milestones with respect to our product candidates. To the extent that we raise additional capital through the sale of common stock, convertible securities or other equity securities, the ownership interests of our stockholders may be materially diluted, and the terms of these securities could include liquidation or other preferences and anti-dilution protections that could adversely affect the rights of our stockholders. In addition, debt financing, if available, would result in increased fixed payment obligations and may involve agreements that include restrictive covenants that limit our ability to take specific actions, such as incurring additional debt, making capital expenditures or declaring dividends, that could adversely impact our ability to conduct our business.

If we raise additional funds through collaborations or marketing, distribution or licensing arrangements with third parties, we may have to relinquish valuable rights to our technologies, future revenue streams or product candidates or grant licenses on terms that may not be favorable to us. If we are unable to raise additional funds when needed, we may be required to delay, limit, reduce or terminate our product development or future commercialization efforts or grant rights to develop and market product candidates that we would otherwise prefer to develop and market ourselves.

Any future indebtedness could adversely affect our ability to operate our business.

We could in the future incur indebtedness containing financial obligations and restrictive covenants, which could have significant adverse consequences, including:

MICROS Systems, Inc. *	
$	412,754
	12,000
Netgear, Inc. *	
	310,680
	24,000
Open Text Corp. *	
	1,250,880
	58,000
Oracle Corp.	
	1,666,920
	9,000
Rackspace Hosting, Inc. *	

	307,260
	7,000
Rovi Corp. *	
	300,860
	7,000
Salesforce.com, Inc. *	
	799,960
	15,300
Solera Holdings, Inc.	
	772,650
	12,000
SuccessFactors, Inc. *	
	275,880
	3,000
Teradata Corp. *	
	160,590
	20,000
TIBCO Software, Inc. *	
	447,800
	6,000
VMware, Inc. Class A *	
	482,280
	8,100
Wright Express Corp. *	
	308,124

18,969,721

MATERIALS (8.4%)

15,800

Albemarle Corp.

638,320

23,000

Ball Corp.

713,460

8,200

CF Industries Holdings, Inc.

1,011,798

38,000

Crown Holdings, Inc. *

1,163,180

10,000

Cytec Industries, Inc.

351,400

19,000

FMC Corp.

1,314,040

8,100

NewMarket Corp.

1,230,147

10,000

Packaging Corp. of America

233,000

	11,300
Praxair, Inc.	
	1,056,324
	8,000
Rock-Tenn Co. Class A	
	389,440
	14,000
Scotts Miracle-Gro Co. (The) Class A	
	624,400
	12,400
Sigma-Aldrich Corp.	
	766,196
	25,900
Silgan Holdings, Inc.	
	951,566
	10,100
Solutia, Inc. *	
	129,785
	11,400
Valspar Corp. (The)	
	355,794
	10,928,850
TELECOMMUNICATION SERVICES (0.8%)	
	10,000

American Tower Corp. Class A *	
	538,000
	13,000
Crown Castle International Corp. *	
	528,710
	1,066,710
UTILITIES (2.4%)	
	14,000
ITC Holdings Corp.	
	1,084,020
	10,600
NSTAR	
	474,986
	9,600
Oneok, Inc.	
	633,984
	23,000
Questar Corp.	
	407,330
	15,300
Wisconsin Energy Corp.	
	478,737
3,079,057	
TOTAL COMMON STOCKS AND TOTAL INVESTMENT SECURITIES (99.9%) (Cost $106,715,353)	
	130,405,049

CASH AND OTHER ASSETS IN EXCESS OF LIABILITIES (0.1%)		119,143
NET ASSETS (1) (100%)	$	130,524,192
NET ASSET VALUE OFFERING AND REDEMPTION PRICE, PER OUTSTANDING SHARE ($130,524,192 ÷ 15,560,234 shares outstanding)	$	8.39

* Non-income producing.

Schedule of Investments (unaudited)

(1) For federal income tax purposes, the aggregate cost was $106,715,353, aggregate gross unrealized appreciation was $30,731,878, aggregate gross unrealized depreciation was $7,042,182 and the net unrealized appreciation was $23,689,696.

ADR American Depositary Receipt.

The Fund follows fair valuation accounting standards (FASB ASC 820-10) which establish a definition of fair value and set out a hierarchy for measuring fair value. These standards require additional disclosures about the various inputs and valuation techniques used to develop the measurements of fair value and a discussion in changes in valuation techniques and related inputs during the period. These inputs are summarized in the three broad levels listed below:

Level 1 – Inputs that reflect unadjusted quoted prices in active markets for identical assets or liabilities that the Fund has the ability to access at the measurement date;
Level 2 – Inputs other than quoted prices that are observable for the asset or liability either directly or indirectly, including inputs in markets that are not considered to be active;
Level 3 – Inputs that are unobservable.

Transfers between investment levels may occur as the markets fluctuate and/or the availability of data used in an investment's valuation changes. The inputs or methodologies used for valuing securities are not necessarily an indication of the risk associated with investing in those securities.

The following table summarizes the inputs used to value the Fund's net assets as of September 30, 2011:

Investments in Securities:	Level 1	Level 2	Level 3	Total
Assets				
Common Stocks	$130,405,049	$0	$0	$130,405,049
Total Investments in Securities	$130,405,049	$0	$0	$130,405,049

The Fund follows the updated provisions surrounding fair value measurements and disclosures on transfers in and out of all levels of the fair value hierarchy on a gross basis and the reasons for the transfers as well as to disclosures about the valuation techniques and inputs used to measure fair value for investments that fall in either Level 2 or Level 3 fair value hierarchy.

For the period ended September 30, 2011, there was no significant transfer activity between Level 1 and Level 2.

For the period ended September 30, 2011, there were no Level 3 investments. The Schedule of Investments includes a breakdown of the Schedule's investments by category.

Item 2. Controls and Procedures.

(a) The registrant's principal executive officer and principal financial officer have concluded that the registrant's disclosure controls and procedures (as defined in rule 30a-2(c) under the Act (17 CFR 270.30a-2(c)) based on their evaluation of these controls and procedures as of the date within 90 days of filing date of this report, are approximately designed to ensure that material information relating to the registrant is made known to such officers and are operating effectively.

(b) The registrant's principal executive officer and principal financial officer have determined that there have been no significant changes in the registrant's internal controls or in other factors that could significantly affect these controls subsequent to the date of their evaluation, including corrective actions with regard to significant deficiencies and material weaknesses.

Item 3. Exhibits:

(a) Certifications of principal executive officer and principal financial officer of the registrant.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934 and the Investment Company Act of 1940, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

By	/s/ Mitchell E. Appel Mitchell E. Appel, President
Date:	November 18, 2011

Pursuant to the requirements of the Securities Exchange Act of 1934 and the Investment Company Act of 1940, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

By:	/s/ Mitchell E. Appel Mitchell E. Appel, President, Principal Executive Officer
By:	/s/ Emily D. Washington Emily D. Washington, Treasurer, Principal Financial Officer
Date:	November 18, 2011