AmpliPhi Biosciences Corp
Form 10-12G/A
May 22, 2014

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

AMENDMENT NO. 3 TO FORM 10

GENERAL FORM FOR REGISTRATION OF SECURITIES

Pursuant to Section 12(b) or (g) of the Securities Exchange Act of 1934

AMPLIPHI BIOSCIENCES CORPORATION

(Exact name of registrant as specified in its charter)

Washington (prior to reincorporation)
Delaware (after reincorporation)

(State or other jurisdiction of incorporation or organization)

91-1549568

(I.R.S. Employer Identification No.)

4870 Sadler Road, Suite 300
Glen Allen, Virginia 23060

(Address of principal executive offices) (Zip Code)

(804) 205-5069

(Registrant s telephone number, including area code)

Securities to be registered pursuant to Section 12(b) of the Act:

Title of each class to be so registered	Name of each exchange on which each class is to be registered
None	Not applicable

Securities to be registered pursuant to Section 12(g) of the Act:

Common Stock, par value $0.01 per share

(Title of class)

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 the definitions of large accelerated filer, accelerated filer and smaller reporting company in Rule 12b-2 of the Exchange Act.

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

TABLE OF CONTENTS

TABLE OF CONTENTS

i

TABLE OF CONTENTS

EXPLANATORY NOTE REGARDING RESTATEMENT

Unless the context otherwise requires, we use the terms AmpliPhi Biosciences, AmpliPhi, we, us, the Company and our in this report to refer to AmpliPhi Biosciences Corporation and its subsidiaries.

This Registration Statement on Form 10 includes restatement of the following previously filed consolidated financial statements and data (and related disclosures): (1) our consolidated balance sheets as of December 31, 2013, December 31, 2012, and December 31, 2011 and our consolidated statements of operations and comprehensive loss, consolidated statement of stockholders equity (deficit), and consolidated statement of cash flows for the fiscal years ended December 31, 2013, December 31, 2012 and December 31, 2011; (2) our consolidated balance sheet as of September 30, 2013, and our consolidated statements of operations and comprehensive loss, consolidated statement of stockholders equity (deficit), and consolidated statement of cash flows for the nine months ended September 30, 2013, (3) our management s discussion and analysis of financial condition and results of operations as of and for our fiscal years ended December 31, 2013, 2012 and 2011, contained in Item 2 of this Registration Statement on Form 10 and (4) our management s discussion and analysis of financial condition and results of operations as of and for the nine months ended September 30, 2013 and 2012. All the aforementioned periods are collectively referenced as Affected Periods .

The Company s previously issued December 31, 2013 financial statements have been restated to net investment fees paid as part of the December financing against the proceeds received. As a result of this correction, we reduced general and administrative expenses and additional paid in capital by $2,550,000. The Company s net loss decreased $2,550,000 to $55,861,000. The net loss per share decreased by $0.02 per share to $(0.64) per share.

The Company s previously issued 2012 financial statements have been restated to reclassify the revenue from the sale of assets that was previously reported as part of revenue to a gain on sale of assets from discontinued operations. As a result of this correction, revenue for 2012 was reduced $3,150,000 and a gain on sale of assets from discontinued operations was recorded for $3,150,000. The net loss per share remained the same, but additional disclosures were added to the Consolidated Statements of Operations and Comprehensive Loss for net loss per share from continuing operations and gain from discontinued operations per share.

The Company also contracted a valuation team to review the purchase price allocation of our acquisitions of Biocontrol and Special Phage Services. As a result, overall goodwill was restated and a new intangible asset, in process research and development (IPR&D), was recognized. For the Biocontrol acquisition, $7,778,000 of goodwill was reclassified to IPR&D. For the Special Phage Services, $5,161,000 of goodwill was reclassified to IPR&D. The overall purchase price of Special Phage Services was reduced by $299,000 due to a decrease in the valuation of contingent shares reserved for the milestone agreement. This further reduced goodwill by $299,000 and paid-in-capital contingent shares by $299,000.

The Company s previously issued financial statements for the period ended September 30, 2013, have been restated to reflect the full non-cash impact of the treatment of the Company s Series B Preferred Stock, certain promissory notes and certain warrants issued in June 2013 and July 2013 (the Securities) as derivative instruments. Under Accounting Standards Codification 815, Derivatives and Hedging, the Securities should be classified as derivative instruments because they contain certain anti-dilution protections, and in periods subsequent to issuance, changes in the estimated fair value of the derivative instruments should be recorded as non-cash income or expense in the statement of operations.

For more information regarding these restatements, please refer to Item 2, Management s Discussion and Analysis of Financial Condition and Results of Operations ; Note 8 (Correction of Errors) to Notes to Consolidated Financial Statements Nine Months Ended September 30, 2013 (Unaudited); Note 14 (Correction of Errors) in Notes to Consolidated Financial Statements Year Ended December 31, 2013; and Note 12 (Correction of Errors) in Notes to Consolidated Financial Statements Year Ended December 31, 2012.

1

TABLE OF CONTENTS

SPECIAL NOTE REGARDING FORWARD-LOOKING STATEMENTS

This registration statement contains forward-looking statements. The forward-looking statements are contained principally in the sections entitled Risk Factors, Management s Discussion and Analysis of Financial Condition and Results of Operations and Business. These statements relate to future events or to our future financial performance and involve known and unknown risks, uncertainties and other factors which may cause our actual results, performance or achievements to be materially different from any future results, performance or achievements expressed or implied by the forward-looking statements. Forward-looking statements include, but are not limited to, statements about:

our ability to manufacture, or otherwise secure the manufacture of, sufficient amounts of our product candidates for our preclinical studies and clinical trials;

our clinical development plans, including planned clinical trials;

our research and development plans, including our plans to initiate at least one new clinical study in 2014;

the safety and efficacy of our products and product candidates;

the anticipated regulatory pathways for our product candidates;

our ability to successfully complete preclinical and clinical development of, and obtain regulatory approval of our product candidates and commercialize any approved products on our expected timeframes or at all;

the content and timing of submissions to and decisions made by the FDA and other regulatory agencies;

our ability to leverage the experience of our management team;

our ability to attract and keep management and other key personnel;

the capacities and performance of our suppliers, manufacturers, contract research organizations, or CROs, and other third parties over whom we have limited control;

the actions of our competitors and success of competing drugs that are or may become available;

our expectations with respect to future growth and investments in our infrastructure, and our ability to effectively manage any such growth;

the size and potential growth of the markets for any of our product candidates, and our ability to capture share in or impact the size of those markets;

the benefits of our products and product candidates;

market and industry trends;

the effects of government regulation and regulatory developments, and our ability and the ability of the third parties with whom we engage to comply with applicable regulatory requirements;

our financial performance, including our net revenue, return rates and related estimates, cost of revenue, gross profit and gross margin, operating expenses, utilization of net operating losses, or NOLs, stock-based compensation expense, cash flows, expected uses of anticipated cash flow, funding requirements and market risk;

our expectations regarding future planned expenditures;

our expectations with respect to product pricing;

our ability to effectively remediate any significant deficiencies or material weaknesses in our internal control over financial reporting;

our ability to achieve and maintain effective internal control over financial reporting in accordance with Section 404 of the Sarbanes-Oxley Act;

TABLE OF CONTENTS

our ability to obtain, maintain and successfully enforce adequate patent and other intellectual property protection of any of our products and product candidates;

our ability to operate our business without infringing the intellectual property rights of others; and

our plans to potentially transact business outside the United States.

In some cases, you can identify these statements by terms such as anticipates, believes, could, estimates, expec intends, may, plans, potential, predicts, projects, should, will, would or the negative of those ter expressions. These forward-looking statements reflect our management s beliefs and views with respect to future events and are based on estimates and assumptions as of the date of this registration statement and are subject to risks and uncertainties. We discuss many of these risks in greater detail in the section entitled Risk Factors. Moreover, we operate in a very competitive and rapidly changing environment. New risks emerge from time to time. It is not possible for our management to predict all risks, nor can we assess the impact of all factors on our business or the extent to which any factor, or combination of factors, may cause actual results to differ materially from those contained in any forward-looking statements we may make. Given these uncertainties, you should not place undue reliance on these forward-looking statements.

You should read this registration statement and the documents that we reference in this registration statement, and have filed as exhibits to this registration statement, completely and with the understanding that our actual future results may be materially different from what we expect. We qualify all of the forward-looking statements in this registration statement by these cautionary statements.

Except as required by law, we assume no obligation to update these forward-looking statements publicly, or to update the reasons actual results could differ materially from those anticipated in these forward-looking statements, even if new information becomes available in the future.

Item 1. Business.

History

We were incorporated under the laws of the State of Washington in March 1989 as a wholly owned subsidiary of Immunex Corporation and began operations as an independent company in 1992 as Targeted Genetics Corporation (TGEN). This predecessor company was effectively closed and any remaining technology was licensed or otherwise sold.

In January 2011, we completed the acquisition of Biocontrol Ltd, which we refer to as Biocontrol, an antimicrobial biotechnology company based in the United Kingdom, with the goal of developing their phage therapy programs using funding from the sale of our legacy gene therapy assets. On February 22, 2011, we changed our name to AmpliPhi Biosciences Corporation.

In November 2012, we completed the acquisition of Special Phage Holdings Pty Ltd, a company based in Australia, which we refer to as SPH, pursuant to our offer to acquire all outstanding shares of SPH from its shareholders under the terms of a Shareholder Sale Agreement and a Managers Warranty Deed. SPH was formed in 2004 to address the rapidly escalating problem of antibiotic resistance through the development of a series of bacteriophage-based treatments.

We intend to reincorporate as AmpliPhi Biosciences Corporation in the State of Delaware.

Our principal executive offices are located at 4870 Sadler Road, Suite 300, Glen Allen, VA 23060. The telephone number at our principal executive office is (804) 205-5069. Our website address is *http://www.ampliphibio.com*. Our

website and the information contained on, or that can be accessed through, our website will not be deemed to be incorporated by reference in, and are not considered part of, this registration statement. You should not rely on our website or any such information in making your decision whether to purchase our common stock.

Implications of Being an Emerging Growth Company

We are an emerging growth company, as defined in the Jumpstart Our Business Startups Act of 2012. We will remain an emerging growth company until the earliest of (1) the last day of the first fiscal year

TABLE OF CONTENTS

(a) following the fifth anniversary of the completion of an initial public offering, (b) in which we have total annual gross revenue of at least $1.0 billion or (c) in which we are deemed to be a large accelerated filer, which means the market value of our common stock that is held by non-affiliates exceeded $700.0 million as of the prior June 30th; or (2) the date on which we have issued more than $1.0 billion in non-convertible debt during the prior three-year period. We refer to the Jumpstart Our Business Startups Act of 2012 herein as the JOBS Act and references herein to emerging growth company shall have the meaning associated with it in the JOBS Act.

As an emerging growth company, we intend to take advantage of specified reduced disclosure and other requirements that are otherwise applicable generally to public companies. These provisions include:

only two years of audited consolidated financial statements in addition to any required unaudited interim financial statements with correspondingly reduced Management s Discussion and Analysis of Financial Conditions and Results of Operations disclosure;

reduced disclosure about our executive compensation arrangements;

no requirement that we hold non-binding advisory votes on executive compensation or golden parachute arrangements; and

exemption from the auditor attestation requirement in the assessment of our internal control over financial reporting.

Under the JOBS Act, emerging growth companies can delay adopting new or revised accounting standards issued subsequent to the enactment of the JOBS Act until such time as those standards apply to private companies. We have irrevocably elected not to avail ourselves of this exemption from new or revised accounting standards, and, therefore, will be subject to the same new or revised accounting standards as other public companies that are not emerging growth companies.

We also qualify as a smaller reporting company, as defined by Regulation S-K under the Securities Act of 1933, as amended, which we refer to as the Securities Act. As such, we also are exempt from the auditor attestation requirements of Section 404 of the Sarbanes-Oxley Act and also are subject to less extensive disclosure requirements regarding executive compensation in our periodic reports and proxy statements, and to exemptions from the requirements to hold a nonbinding advisory vote on executive compensation and shareholder approval of any golden parachute payments not previously approved. We will continue to be deemed a smaller reporting company until our public float exceeds $75 million on the last day of our second fiscal quarter in any fiscal year.

As used in this registration statement, unless the context requires otherwise, the Company, we, us and our refer t AmpliPhi Biosciences Corporation, a Washington corporation, or, where appropriate, Targeted Genetics Corporation or AmpliPhi Biosciences Corporation, a Delaware corporation to be formed in connection with the Company s planned reincorporation.

Background

AmpliPhi Biosciences is a biotechnology company focused on the discovery, development and commercialization of novel phage therapeutics. Our proprietary pipeline is based on the use of bacteriophages, a family of viruses that infect only bacteria. Phages have powerful and highly selective mechanisms of action that permit them to target and kill specific bacterial pathogens, including the so-called multi-drug-resistant (MDR) or Superbug strains.

We believe that we are a leading developer of phage-based therapeutics. We are combining our proprietary approach and expertise in identifying, characterizing and developing naturally occurring bacteriophages with that of our collaboration partners in bacteriophage biology, drug engineering, development and manufacturing, to develop second-generation bacteriophage products. We believe that phages represent a promising means to treat bacterial

infections, especially those that have developed resistance to current medicines.

The extensive use of antibiotics, since their discovery in the 1940s, has resulted in drug resistance among many disease-causing bacteria. Resistance to antibiotics, according to the Centers for Disease Control (CDC),

TABLE OF CONTENTS

threatens to reverse the medical advances of the last half-century. Examples of clinically important microbes that are rapidly developing resistance to available antimicrobials include bacteria that cause skin, bone, lung and bloodstream infections (e.g., *S. aureus* and MRSA), pneumonia and lung infections in the community, hospital and cystic fibrosis (e.g., *A. baumanii*, *P. aeruginosa*, and *K. pneumoniae*), meningitis (e.g., *S. pneumonia*), urinary tract and gastrointestinal infections (e.g., *E. coli* and *C. difficile*). As a phage kills bacteria in ways entirely unlike the mechanisms used by antibiotics, MDR bacteria are not resistant to a phage in the same manner. Furthermore, as new resistant bacteria emerge, it should be possible to identify new phages that will still have efficacy.

Our lead programs consist of three product candidates: AmpliPhage-001 for the treatment of *P. aeruginosa* lung infections in CF patients; AmpliPhage-002, for the treatment of *S. aureus* infections (including methicillin-resistant MRSA); and AmpliPhage-004 for the treatment of *C. difficile* infections.

We currently plan to develop these phage product candidates using our proprietary discovery and development platform, which is designed for rapid identification, characterization and manufacturing of multiple phage therapies. Each product candidate combines several carefully chosen phages which target a specific disease-causing bacterial pathogen such as MRSA, *P. aeruginosa* and *C. difficile*. We believe that our understanding of unique regulatory and development requirements of bacteriophage biology combined with the clinical and scientific expertise of our collaboration partners will enable the rapid advancement of phage treatments through the clinic and eventually to the market.

In March 2013, we entered into an Exclusive Channel Collaboration (ECC) with Intrexon directed towards the research, development and commercialization of new bacteriophage-based therapies to target specific antibiotic-resistant infections, including for use in the treatment of bacterial infections associated with acute and chronic wounds, the treatment of acute and chronic *P. aeruginosa* lung infections, and the treatment of infections of *C. difficile*.

In April 2013, we entered into a collaboration agreement, which we refer to as the April Collaboration Agreement, and on September 5, 2013, we entered into a license agreement, which we refer to as the Leicester License Agreement, with the University of Leicester to develop a phage therapy that targets and kills all toxin types of *C. difficile*. Pursuant to the Leicester License Agreement, we may be obligated to pay the University of Leicester a royalty in the single digits and an aggregate of up to £575,000 million in milestone payments. We also entered into a collaboration agreement on August 1, 2013, which we refer to as the August Collaboration Agreement, with the University of Leicester and the University of Glasgow, whereby the University of Glasgow will carry out certain animal model development work. Pursuant to the August Collaboration Agreement, we may be obligated to pay up to a total of approximately £205,000 in milestone payments.

In June 2013, we entered a Cooperative Research and Development Agreement (CRADA) with the United States Army Medical Research and Material Command (USAMRMC) and the Walter Reed Army Institute of Research (WRAIR) focusing on developing bacteriophage therapeutics to treat *S. aureus*, *E. coli* and *P. aeruginosa* infections.

We plan to initiate at least one new clinical study in 2014.

The Need for New Anti-Infective Therapies

The rapid and continuous emergence of antibiotic-resistant bacteria has become a global crisis. While the numbers of novel anti-infective therapies in development are at historically low levels, antibiotic-resistant infections have dramatically increased. The CDC estimates that more than two million people in the United States acquire an

antibiotic-resistant infection each year and more than 23,000 of these prove fatal. It is estimated that 50 70% of hospital-acquired infections are resistant to first-line anti-infective therapies. The cumulative annual cost for treating resistant bacterial infections in the United States alone is estimated to be $20 billion, while the global antibiotics market opportunity is estimated to be $40.3 billion by 2015.

The CDC s latest report on the matter, *Antibiotic Resistance Threats in the United States, 2013*, notes that there are potentially catastrophic consequences of inaction and ranks *C. difficile* as belonging to the highest tier of threat, Urgent Threats. Despite the potential market opportunity, only two new antibacterial drug applications were approved between 2010 and 2012 compared to eighteen in the period between 1980 and 1984. One of the primary CDC recommendations is the development of new antibiotics to diversify treatment options.

TABLE OF CONTENTS

Product Candidates

AmpliPhage-001: Lung Infections in Cystic Fibrosis (CF) Patients Caused by *P. aeruginosa*

According to Global Data in April 2013, the market for CF therapeutics was $1.2 billion in 2012 and forecasted to grow to $4.6 billion in 2017, with 65% of this market in the United States. One of our lead programs targets *P. aeruginosa*, the most prevalent bacterial infection that leads to the highest mortality in patients with CF with approximately 440 deaths per year in the United States. To develop our products, we have created a global diversity panel of relevant *P. aeruginosa* clinical isolates from CF clinics around the globe. Clinical isolates are bacteria isolated from patients. This diversity panel has been screened against our phage library that was isolated and characterized according to our proprietary discovery and development platform. We have demonstrated *in vitro* that we are able to effectively kill the targeted bacteria with a mixture of a few phages propagated in carefully selected bacterial hosts. Furthermore, our phage mix is designed to exhibit a high degree of complementation, defined as the number of bacteria targeted by more than one phage in the product. We believe that high complementation is an important factor in preventing bacteria from developing resistance to our phage products.

TABLE OF CONTENTS

In collaboration with Institut Pasteur (Paris, France) and Brompton Clinic, Imperial College (London, United Kingdom), we have demonstrated in the preclinical studies described below that phages can effectively treat infections in animal models of acute *P. aeruginosa* lung infections. The graphic below shows the three groups from a study conducted at the Institute Pasteur. Each group consisted of eight mice. Group 1 was treated with Placebo, or PBS, Group 2 was treated with an antibiotic (note the model was optimized for this antibiotic) and Group 3 was treated with an AmpliPhi phage mix. The colored regions, measured by light intensity, or luminescence, demonstrate where the *P. aeruginosa* infection is active and the bacteria are actively replicating. By the 24th hour, the surviving untreated animals (Group 1) are sacrificed as the infection has spread and in some cases has already proved lethal whereas the two treatment groups (Group 2, antibiotic and Group 3, phage) demonstrate effective reduction of the active infection.

TABLE OF CONTENTS

Average luminescence for each group is shown below:

Bacterial counts and the number of bacteriophage infection units detected by assay, or phage titers, were measured in these animals after 24 hours, and the results demonstrated that our phage mix effectively lowered the bacterial counts, or CFU, in the mouse lung to levels comparable to antibiotic treatment (PBS vs. antibiotic, p=0.0003; PBS vs. bacteriophage, p=0.0003). Furthermore, it was evident that phage replicated to high levels in the infected lung. These results are shown in the graphics below.

TABLE OF CONTENTS

In a separate *in vivo* study of acute *P. aeruginosa* infection of the mouse lung conducted at the Brompton Clinic, results demonstrated that our phage mix reduced CFU levels upon simultaneous intranasal administration (six mice in each of the treatment and control groups) and also when administered 24 hours post-bacterial infection (seven mice in the treatment group and eight mice in the control group) using Pa01, a standard strain of *P. aeruginosa*. These results are depicted in the graphics below.

Importantly, a preclinical study conducted at the Institut Pasteur in mice (12 mice in each of the treatment and control groups) demonstrated the ability of our phage mix to reach the lung within two hours of being delivered by oral administration. The phage levels increased between two and six hours post-treatment, and the results were statistically significant (p-value <0.001). A p-value is a statistical measure of the probability that the difference in two values could have occurred by chance. The smaller the p-value, the greater the confidence that the results are significant. These results demonstrate that when orally administered in mice, phages not only reached the lungs but were also able to infect and multiply in target bacteria.

We were granted a meeting with the United Kingdom Medicines and Healthcare Products Regulatory Agency (MHRA) in the first quarter of 2014 to discuss our plans and intent to move the CF program into additional preclinical testing in preparation for a Phase 1/2 study in CF patients. We also sought advice and comment that our planned Chemistry Manufacturing Controls (CMC) plans were acceptable to the MRHA. The MRHA concurred with our approach and plans as presented, including a first in man dose ranging clinical study in CF patients. We plan to manufacture the AmpliPhage-001 product as further described below.

We believe that successful proof of concept in this lung indication could lead to other acute and chronic lung infection markets, such as Ventilator Associated Bacterial Pneumonia (VABP) and Chronic Obstructive Pulmonary Disease (COPD). The bacteria we are currently targeting are predominant pathogens in both of these indications.

AmpliPhage-002: Wound and Skin Infections Caused by *S. aureus*

In conjunction with our CRADA with the USAMRMC, we are developing a phage product that is intended to effectively treat acute and chronic wound and skin infections caused by *S. aureus*, including infections caused by methicillin-resistant (MRSA) strains of the same bacterium. MRSA infections are one of the most common causes of hospital-acquired (nosocomial) infections and Global Data estimates the MRSA market for infections alone was more than $2.7 billion in 2007. This market is forecast to grow to more than $3.5 billion by 2019.

Using the same strategy outlined above for product development of AmpliPhage-001, we have selected a phage product mix that has greater than 85% efficacy with high complementation against a global diversity panel that includes some of the most virulent isolates of *S. aureus*, including MRSA, identified by the U.S. Army.

TABLE OF CONTENTS

We plan to initiate a Phase 1 study of AmpliPhage-002 in 2014 to demonstrate the safety of AmpliPhage-002 when administered to healthy volunteers colonized by *S. aureus*. The study population will be enriched to contain subjects with MRSA colonization. If that study is successful, we then intend to conduct a Phase 2 study in *S. aureus* for wound and skin infections.

After extensive financial and capability evaluation and a global search, we have elected to proceed with cGMP manufacturing at a wholly owned facility that is under final construction in Ljublyana, Slovenia. We have been able to access and hire highly skilled process development and phage manufacturing expertise and believe that we now have control of our proprietary platform from phage identification through final product fill and finish. Our facility, inclusive of laboratory and office space, will be approximately 4,000 sq. ft. and is planned to come on line in Q3 and produce cGMP product for our currently planned and future studies. We believe that this facility should be sufficient to meet our product needs through Phase 3 and initial commercialization. Our current formulation for AmpliPhage-002 is intended for nasal delivery via a small spray device. We plan to further formulate our product for delivery to patients with wound and skin infections.

AmpliPhage-004: Gastrointestinal (GI) Infection Caused by *C. difficile Infection (CDI)*

From 2000 through 2007, deaths in the United States from *C. difficile* infection increased over 400%. Over 90% of such deaths occur in hospitalized or confined patients over the age of 65. Global Data estimates that the major European Union and United States markets for CDI therapies grew to more than $314 million in 2011 and they are expected to grow to more than $500 million by 2019.

According to the CDC, almost 250,000 people each year require hospitalization for *C.difficile* infections, and at least 14,000 people die each year in the United States from *C. difficile* infections. From 2000 through 2007, deaths in the United States from *C. difficile* infections increased over 400%. We are actively working with researchers at the University of Leicester and the University of Glasgow to develop a phage therapy that targets and kills all toxin types of *C. difficile*. We believe that orally delivered phages are well suited to treat CDI. Within this collaboration, researchers at the University of Leicester have discovered phages that have been shown to be effective against clinically-relevant strains of *C. difficile* isolated from around the world. Since current therapies against *C. difficile* are considered less than optimal, we believe that there is a significant market opportunity for our product in treating this disease.

Prior Clinical Development

In 2010, the Company s wholly owned subsidiary, Biocontrol, reported a double-blind placebo-controlled, randomized Phase 1/2 clinical trial targeting chronic ear infections (otitis) caused by antibiotic-resistant *P. aeruginosa*. This was the first, and to date, we believe the only, regulated efficacy trial of bacteriophage therapy in humans that has been reported. Positive results were reported demonstrating decreasing levels of *P. aeruginosa* in the ear and improvement of clinical condition with a single input dose of 2.4 nanograms of bacteriophage preparation. While this was a small trial (n=24), changes from baseline at the end of the trial in the test group (n=12) were statistically significant for both clinical condition (p=0.001) and bacterial load (p=0.016). No significant changes were seen in the control group (n=12) compared to baseline at the end of the trial. Difference between test and control groups was statistically significant by analysis by covariance (ANCOVA) on day 21 for bacterial count (p=0.0365). These results will need to be validated in larger well-controlled trials.

Anti-Infective Therapeutics Market

The market opportunity for antibiotics is extremely large, with the market estimated to reach $40.3 billion in annual sales globally in 2015.

Almost one in every five deaths worldwide occurs as a result of infection and, according to the World Health Organization, or WHO, many bacterial infections will become difficult or impossible to cure as the efficacy of current antibiotic drugs wanes. Despite the advances in antimicrobial and vaccine development, infectious diseases still remain as the third-leading cause of death in the United States and the second-leading cause of death worldwide.

TABLE OF CONTENTS

The number of new antibiotics approved by the FDA and other global regulatory authorities has declined consistently over the last two decades. According to the Infectious Diseases Society of America, as of early 2013, only two new antibiotics have been approved by the FDA since 2009 and only seven new antibiotics targeting multi-drug-resistant Gram-negative bacilli were in either Phase 2 or Phase 3 trials. This dramatic decrease in productivity is evidenced by only two classes of antibiotics oxazolidinones and cyclic lipopeptides having been developed and launched in the last 30 years. At the same time, the evolution of antibiotic-resistant bacteria has led to an increasing number of infections for which there are no current treatments available.

Hospital-acquired (nosocomial) infections are a major healthcare problem throughout the world, affecting developed countries as well as resource-poor countries. The WHO reports that hospital-acquired infections are among the major causes of death and increased morbidity among hospitalized patients and estimates that more than 1.4 million people per year worldwide suffer from infectious complications from a hospital stay.

A recent CDC report also cites that in the United States, between 5 and 10% of all patients admitted to a hospital will be affected by a hospital-aquired infection during their stay, typically requiring extended stays and additional care. There is also a significant risk of death from such infections. In the United States, the CDC estimates that approximately 99,000 people die from hospital-acquired infections each year. The Cystic Fibrosis Foundation estimates that *P. aeruginosa* accounts for 10% of all hospital-acquired infections.

Infections also occur in connection with Cystic Fibrosis (CF), which is a genetic disease affecting primarily Caucasians of northern European descent. According to the Cystic Fibrosis Foundation, there are approximately 50,000 cases of CF in North America and Europe. *P. aeruginosa* opportunistically infects the mucous membranes, primarily the lungs, of CF patients and quickly grows out of control, resulting in pneumonia. *P. aeruginosa* infections are notoriously resistant to known antibiotics, and treatment may be further complicated by the formation of biofilms. Biofilms are organized structures of microorganisms growing on solid surfaces (such as lung tissue) and often limit access of antibiotics to the covered tissues. Since phages attack bacteria in a manner independent of chemical antibiotic resistance mechanisms and can infect bacteria growing in biofilms, we believe that *P. aeruginosa* infection among CF patients represents a compelling indication to pursue. The availability of *Pseudomonas*-specific phages along with validated animal models of *P. aeruginosa* lung infections has contributed to the development of our bacteriophage program in CF.

Compounding the above situations is the alarming and continuing rise in the prevalence of antibiotic-resistant bacterial infections. This, coupled with the lack of new antibiotics in current discovery and development pipelines, has generated a significant clinical management problem worldwide, leading to increases in morbidity and mortality due to these antibiotic-resistant bacteria as well as increases in healthcare costs.

The first of these antibiotic-resistant infections to reach epidemic proportions was caused by the Gram-positive bacterium *S. aureus*. *S. aureus* resistance to a broad range of antibiotics has necessitated the use of expensive and potentially toxic drugs of last resort , most notably vancomycin. Antibiotic-resistant forms of *S. aureus*, usually termed MRSA (methicillin-resistant *S. aureus*), VISA (vancomycin-intermediate *S. aureus*), or VRSA (vancomycin-resistant *S. aureus*), can be extremely challenging to treat. Although several antibiotics targeting *S. aureus* have been developed, rapidly developing bacterial resistance has been noted for all of these including linezolid, daptomycin and tigecycline. On the basis of historical evidence, resistance to these existing products is likely to increase over time, and this picture is further complicated by the reduced efficacy of conventional antibiotics against *Staphylococcus* biofilms.

Typically *S. aureus* infection causes a variety of suppurative (pus-forming) infections and toxinoses in humans. It causes superficial skin lesions such as boils, styes and furuncles; more serious infections such as pneumonia, mastitis,

phlebitis, meningitis and urinary tract infections; and deep-seated infections, such as osteomyelitis and endocarditis. *S. aureus* is the leading cause of wound infections, in particular, hospital-acquired (nosocomial) infection of surgical wounds and infections associated with indwelling medical devices. *S. aureus* is the leading pathogen in healthcare-associated infections in the United States as a whole, accounting for 30.4% of surgical site infections (SSI), and 15.6% of such infections overall.

TABLE OF CONTENTS

Anti-Infective Treatments with Bacteriophages

Background

The dramatic rise in antibiotic resistance, the appearance of an increasing number of new superbugs and the lack of new antibiotics in the pipeline has prompted calls to action from many of the world s major health bodies such as the CDC and the WHO, who warn of an antibiotic cliff and a post-antibiotic era. In 2009, the European Antimicrobial Resistance Surveillance System, or EARSS, concluded that the loss of effective antimicrobial therapy increasingly threaten[s] the delivery of crucial health services in hospitals and in the community. This conclusion was reinforced by The Antimicrobial Availability Task Force, or AATF, of the Infectious Diseases Society of America, or IDSA, and the European Centre for Disease Prevention and Control, or ECDC, in conjunction with the European Medicine Agency, or EMA. Clearly, there is a pressing need to find alternative antibacterial therapies.

Bacteriophage therapy has the potential to be an alternative method of treating bacterial infection. Phages are ubiquitous environmental viruses that grow only within bacteria. The name bacteriophage translates as eaters of bacteria and reflects the fact that as they grow, phages kill the bacterial host by multiplying inside and then bursting through the cell membrane in order to release the next generation of phages. Phages can differ substantially in morphology and each phage is active against a specific range of a given bacterial species. Phages were first discovered in 1915 at the Institut Pasteur and were shown to kill bacteria taken from patients suffering from dysentery. Furthermore, it was noted that phage numbers rose as patients recovered from infection, suggesting a direct association.

Life Cycle of a Bacteriophage

Until the discovery of effective antibiotics, phages were used as an effective means of combating bacterial infection. When broad-spectrum antibiotics came into common use in the early 1940s, phages were considered unnecessary, with antibiotics being seen for many years as the answer to bacterial disease. This attitude persisted until the development of the wide-ranging, and in some cases total, resistance to antibiotics seen within the last 10 years.

It is now clear that bacteria can adapt to resist chemical antibiotics. In addition, there is now strong pressure to limit the use of antibiotics for human and veterinary use. There is a real need for different approaches to the control of antibiotic-resistant bacterial infections. In the light of current knowledge, it is apparent that early work with phages was hindered by poor understanding of the biology of phages, leading to exaggerated claims that damaged the reputation of phage therapy. Several companies in the 1920s and 1930s began to produce and market bacteriophage preparations. Unfortunately, these were often marketed with promises of efficacy against diseases that are now known to have nothing to do with bacteria, and many preparations themselves failed to actually contain bacteriophages. These conditions made bacteriophage subject to understandable skepticism. Now, with the far greater understanding of phages and their function that is now available, it is possible to identify the bacteria that are causing disease and then target them with highly specific phages that will kill only those bacteria.

Phages have the potential to provide both an alternative to, and a synergistic approach with, antibiotic therapy. Since they use entirely different mechanisms of action, phages are unaffected by resistance to conventional antibiotics. Phage containing certain enzymes also have the ability to disrupt bacterial biofilms, thus potentiating the effect of chemical antibiotics when used in combination with them.

TABLE OF CONTENTS

In fact, the ability to isolate and develop phages for any of a broad range of bacterial targets, combined with their ability to disrupt bacterial biofilms, suggests strong potential for this approach in the control of bacterial infections. Published literature indicates that phages have the potential to be used as topical agents for the control of bacterial infection, and that such use is compatible with the approaches that have been shown to be effective in the treatment of wound injuries.

Bacteriophage therapy for the treatment of bacterial infections has been in constant use since 1917. Most of the research on phage-based therapy was conducted in the former Soviet Union prior to and immediately after World War II. While the West primarily focused resources into the development of chemical antibiotics, physicians and researchers in the Soviet Union were mass-producing phages and demonstrating their efficacy against a wide range of bacterial infections affecting the GI tract (dysentery), wounds (surgical and combat), skin (boils) and bone (osteomyelitis). While these studies are compelling, most lacked appropriate control group design or lacked control groups completely. Furthermore, the standard of care has changed substantially during the ensuing decades since those studies were performed, making claims of improved cure rates open for debate.

Despite numerous encouraging case studies, bacteriophage treatment was never adopted by Western medicine due to a lack of robust scientific evidence generated through systematically planned, controlled and regulated clinical trials. Recently, however, an increasing number of papers, reviews and books appearing on bacteriophage therapy indicate an increasing appetite among the scientific community and healthcare industry for developing bacteriophage therapy as part of mainstream medicine. Current biomedical technology is vastly superior to that available during the early days of bacteriophage therapy and our understanding of phage biology and the mechanisms of phage-bacterial host interaction have improved, along with advances in knowledge concerning bacterial infection. Although our knowledge of the biology, genetics and bactericidal efficacy of bacteriophages *in vitro* is impressive, less is known about their pharmacokinetic behavior *in vivo*, in particular in human subjects. To date very few human clinical trials have been conducted to modern standards in either the United States or Europe. In 2009, a U.S. Phase 1 clinical trial carried out at the Southwestern Regional Wound Care Center in venous ulcers using a mixture or cocktail of phages which individually attack different species of bacteria (*S. aureus*, *P. aeruginosa* and *E. coli*) was reported. The results of this trial showed this multi-bacteriophage preparation to be safe in trial subjects.

These trials, alongside published reports of less well-conducted studies, suggest that phage therapy shows promise for treating infectious diseases caused by antibiotic-resistant bacteria. One, conducted by the Polish Academy of Sciences, started in 2005 and is treating a broad range of infections and clinical conditions associated with antibiotic-refractory infections. This work derives from a phage therapy clinic that has operated at this location. A second is the European Union-sponsored Phagoburn Phase 1/2 clinical trial, which is being conducted at multiple centers in France, Belgium and Switzerland. The project has been under way since June 2013, using a large phage mix for treatment of burn wounds infected with *E. coli* and *P. aeruginosa*.

Our Strategy

Our strategy is to use techniques of modern biotechnology and current state-of-the-art practices for drug development in concert with existing regulatory guidance to develop a pipeline of bacteriophage products that will destroy bacterial pathogens such as MRSA, which are resistant to chemical antibiotics. Our business strategy will apply state-of-the-art techniques in molecular biology and in clinical trial design to build upon the long successful history of using phages therapeutically to treat and cure infections.

We plan to initiate a Phase 1 study in 2014 and commence subsequent Phase 2 studies if the Phase 1 study is successful. Initially, in collaboration with the U.S. Army, we plan to study the safety and tolerability of our phage

product (AmpliPhage-002) developed for treating *S. aureus* (MRSA) infections in a Phase 1 study and then in a Phase 2 study of wounds and skin infections. Additionally, in conjunction with leading Centers of Excellence in the UK, we plan to conduct a Phase 1/2 study using AmpliPhage-001 to treat CF patients with *P. aeruginosa* lung infections. Longer term, we plan to build upon our preclinical data and conduct studies in patients suffering from serious gastrointestinal infections caused by *C. difficile*.

TABLE OF CONTENTS

Recent Acquisitions

In January 2011, we completed the acquisition of Biocontrol, with the goal of developing their phage therapy programs using funding from the sale of our legacy gene therapy assets. Under the terms of our acquisition of Biocontrol, we issued 22,817,198 shares of our common stock to the shareholders of Biocontrol with a total fair value of approximately $8.6 million as of January 6, 2011, resulting in Biocontrol s former shareholders owning approximately 50% of our outstanding equity securities at the time. As a condition to closing the acquisition, Biocontrol raised approximately £200,000 (US$310,000) in working capital for use by us.

In November 2012, we acquired SPH, pursuant to our offer to acquire all outstanding shares of SPH from its shareholders under the terms of a Shareholder Sale Agreement and a Managers Warranty Deed, collectively referred to as the SPH Agreements, in exchange for up to 40,000,000 shares of our common stock. 20,000,000 of those shares were issued directly to the selling stockholders of SPH upon the closing of the acquisition, and the remaining 20,000,000 shares were issued and held in escrow. Of the escrow shares, 8,000,000 shares, referred to as Claims Shares, were subject to claims by us for breaches of representations by the selling stockholders of certain individual representations and certain additional representations made with respect to SPH itself and its operations by Dr. Anthony Smithyman and Mrs. Margaret Smithyman, the two largest shareholders of SPH, referred to as the Managers. The Claims Shares were released from escrow in November 2013, 12 months following the closing of the acquisition. The remaining 12,000,000 shares held in escrow, referred to as Contingent Shares, are to be released to the Managers upon the meeting (within 24 months of the closing) of three clinical and developmental milestones relating to SPH s phage therapy projects. At the satisfaction of each of those milestones, one third of the Contingent Shares will be released to the Managers. If, within 24 months of the closing, any of those milestones has not been met, as a result of our failure to use best endeavors to cause such milestones to occur or as a result of a natural and unavoidable catastrophe that prevents the milestone from occurring, the unsatisfied milestone will be deemed satisfied and we will be required to release the applicable number of Contingent Shares to the Managers. Contingent Shares relating to milestones that have not been released to the Managers as of the 24th month following the acquisition, and that are not subject to claim by the Managers that such milestone was met or is otherwise due, will be returned to us. The Contingent Shares are also subject to claims for breaches of the representations being made by the Managers to the extent that the Claims Shares are insufficient to satisfy our claims under the terms of the SPH Agreements. Further, the Managers are not eligible to retain any dividends or other distributions by us that are allocable to unreleased Contingent Shares and have designated our President and Chairman of the Board, and each of them, as proxies to vote unreleased Contingent Shares.

In connection with our acquisition of SPH, we entered into certain other arrangements, including the repayment under a Loan Repayment Deed (as amended) of a $770,000 loan originally made by Cellabs Pty Ltd, or Cellabs, an Australian company affiliated with Dr. Smithyman, to SPH, a consulting agreement with Dr. Smithyman and the payment of $3,017 per month to Cellabs for our laboratory space in Australia. Under the terms of the Loan Repayment Deed, the loan from Cellabs to SPH was to be repaid and fully satisfied partly in cash and partly by issuing 2,000,000 shares of our common stock to Cellabs. As of December 31, 2013, $350,000 has been paid by us to Cellabs and all 2,000,000 shares have been issued. Under the terms of the Loan Repayment Deed, we are obligated to pay an additional $200,000. The SPH acquisition also included several phage therapy projects which had reached the pre-clinical or animal study stage, including the Brompton Hospital CF study, the Adelaide University MRSA chronic rhinosinusitis study and the University of Leicester *C. difficile* project. We believe that acquisition of SPH brings substantial phage scientific expertise and know-how to the Company sufficient to develop, manufacture and commercialize phage-based therapeutics. Under the terms of the consulting agreement with Dr. Smithyman, we were obligated to pay a fee of $10,000 per month to Dr. Smithyman, who provided management consulting services as an independent contractor for an initial term of 12 months ending October 2013. Between the acquisitions of Biocontrol

and SPH, we believe that we are the leading therapeutically focused phage company in the world.

Strategic Alliances and Research Agreements

As discussed below, we have established collaborations with Intrexon, the U.S. Army and the University of Leicester, which provide us with access to the considerable scientific, developmental, and regulatory

TABLE OF CONTENTS

capabilities of our collaborators. We believe that our collaborations contribute to our ability to rapidly advance our product candidates, build our product platform and concurrently progress a wide range of discovery and development programs.

Exclusive Channel Collaboration with Intrexon

On March 29, 2013, we entered into the ECC with Intrexon that governs a collaboration arrangement in which AmpliPhi uses Intrexon s technologies directed towards the research, development and commercialization of new bacteriophage-based therapies to target specific antibiotic-resistant infections. We believe that combining the broadest and most advanced synthetic biology platform with our world-leading phage capabilities will lead to the development of innovative second-generation phage products. The ECC establishes committees comprised of representatives of the Company and Intrexon that govern activities related to the bacteriophage programs in the areas of project establishment and prioritization, as well as budgets and their approval, chemistry, manufacturing and controls, clinical and regulatory matters, commercialization efforts and intellectual property.

Intrexon is a publicly held biotechnology company focused on the industrial engineering of synthetic biology. According to Intrexon, their advanced bioindustrial engineering platform enables Better DNA™ technology by combining DNA control systems with corresponding advancements in modular transgene design, assembly and optimization to enable unprecedented control over the function and output of living cells.

Under the terms of the ECC, the Company will receive an exclusive, worldwide license to utilize Intrexon s proprietary technology and expertise for the standardized design and production of genetically modified bacteriophages, which we refer to collectively as the Bacteriophage Program. The ECC seeks to develop bacteriophage-containing human therapeutics for use in the treatment of bacterial infections associated with acute and chronic wounds, the treatment of acute and chronic *P. aeruginosa* lung infections and the treatment of infections of *C. difficile*, which we collectively refer to as AmpliPhi Products. The ECC grants the Company a worldwide license to use patents and other intellectual property of Intrexon in connection with the research, development, use, importing, manufacture, sale and offer for sale of AmpliPhi Products. Such license is exclusive with respect to any clinical development, selling, offering for sale or other commercialization of AmpliPhi Products, and otherwise is non-exclusive. Subject to limited exceptions, we may not sublicense the rights to Intrexon s technology without Intrexon s written consent.

Under the ECC, and subject to certain exceptions, we are responsible for, among other things, the performance of the Bacteriophage Program, including development, commercialization and certain aspects of manufacturing AmpliPhi Products. Intrexon is responsible for the costs of establishing manufacturing capabilities and facilities, subject to certain exceptions, for the bulk manufacture of products developed under the Bacteriophage Program, certain other aspects of manufacturing and costs of basic-stage research with respect to Intrexon Channel Technology and Intrexon materials, i.e., platform improvements and costs of filing, prosecution and maintenance of Intrexon s patents.

Subject to certain expense allocations and other offsets provided in the ECC, AmpliPhi has agreed to pay Intrexon on a quarterly basis tiered royalties on net sales derived in that quarter from the sale of AmpliPhi Products, which are based on or incorporate Intrexon s technology, calculated on a product-by-product basis. If AmpliPhi sublicenses a product developed under the collaboration with Intrexon, AmpliPhi has likewise agreed to pay Intrexon on a quarterly basis a certain percentage of revenues received from the sublicensee. Pursuant to the ECC, Intrexon received 24,000,000 shares of our common stock as an upfront technology access fee. We may also pay Intrexon up to $7.5 million in aggregate milestone payments for each product, payable either in cash or equity upon the achievement of certain events. Intrexon is also entitled to tiered royalties as a percentage in the upper-single digits of the net product sales of a product developed under the ECC.

The ECC is effective until terminated by either Intrexon or AmpliPhi. Intrexon may terminate the ECC if AmpliPhi fails to use diligent efforts to develop and commercialize AmpliPhi Products or if AmpliPhi elects not to pursue the development of an AmpliPhi Program identified by Intrexon that is a Superior Therapy as defined in the ECC. AmpliPhi has the right to terminate the ECC upon 90 days written notice to Intrexon at any time.

TABLE OF CONTENTS

Upon termination of the ECC, AmpliPhi may continue to develop and commercialize any AmpliPhi Product that, at the time of termination:

is being commercialized by the Company;
has received regulatory approval;
is a subject of an application for regulatory approval that is pending before the applicable regulatory authority; or
is the subject of an ongoing Phase 2 or completed Phase 3 clinical trial in the field.

AmpliPhi s obligation to pay royalties described above with respect to these retained products will survive termination of the ECC.

Global R&D Agreement with U.S. Army

In June 2013, we entered a CRADA with the USAMRMC and the WRAIR. The CRADA will focus on developing bacteriophage therapeutics to treat at least three types of infections: *S. aureus*, *E. coli* and *P. aeruginosa*. The increasing prevalence of antibiotic-resistant bacteria poses a serious threat to public health and military personnel and is a major problem in hospitals and clinics around the world. The initial indication will be wounds and skin infections from *S. aureus*, which is the leading pathogen in healthcare-associated infections in the United States as a whole, accounting for 30.4% of surgical site infections.

In connection with our CRADA with the U.S. Army, we submitted a Pre-IND briefing package to the FDA to obtain their feedback on our Chemistry, Manufacturing and Controls (CMC) program and plans for our first human study with our lead product, AmpliPhage-002 (*S. aureus*). The FDA endorsed our plan for progressing bacteriophage therapy to the clinic, specifically agreeing to our platform s manufacturing process, product specifications and the absence of any need of non-clinical toxicology to initiate our first Phase 1 study.

We plan to conduct our Phase 1 study at the WRAIR and to conduct further clinical trials at various sites throughout the world. We plan to initiate a Phase 1 feasibility and safety study in phage treatment of *S. aureus* infections in 2014 followed by a Phase 2 study of *S. aureus* infections.

We will retain global regulatory ownership and commercial rights to all products developed by us under the agreement. USAMRMC will gain access rights to any products developed. We also have the rights to exclusively license any intellectual property developed by USAMRMC under the collaboration on terms to be agreed upon.

The CRADA expires in June 2018 and can be terminated by either USAMRMC or AmpliPhi upon 60 days written notice to the other party at any time.

University of Leicester Development Agreements

On April 24, 2013, we entered into the April Collaboration Agreement and on September 5, 2013, we entered into the Leicester License Agreement with the University of Leicester to develop a phage therapy that targets and kills all toxin types of *C. difficile*. We also entered into the August Collaboration Agreement with the University of Leicester and the University of Glasgow, whereby the University of Glasgow will carry out certain animal model development work.

Under these agreements, which we refer to collectively as the Leicester Development Agreements, we are funding the University of Leicester to carry out *in vitro* and the University of Glasgow to carry out animal model development work on the University of Leicester s development of a bacteriophage therapeutic to resolve *C. difficile* infections and

we are licensing related patents, materials and know-how from the University of Leicester. Under the Leicester Development Agreements, the University of Leicester will provide the bacteriophage and act as overall project coordinator for the development work. All rights, title and interest to any intellectual property developed under the Leicester Development Agreements belong to us. Under the Leicester License Agreement, we have exclusive rights to certain background intellectual property of the University of Leicester, for which we will pay the University of Leicester royalties based on product sales and make certain milestone payments based on product development.

TABLE OF CONTENTS

The April Collaboration Agreement expires on November 12, 2014 and is terminable by either party upon (a) material breach by the other party, subject to a 90-day cure period, (b) the inability of the principal investigator to continue the collaboration or (c) our bankruptcy or winding up of our operations.

The August Collaboration Agreement expires on October 22, 2014 and is terminable under the same conditions as the April Collaboration Agreement.

The license agreement expires on the later of the expiration of the licensed patents or September 5, 2028, and is terminable by us at any time upon 60 days notice, by the University of Leicester (a) if we legally challenge the validity or ownership of any of the licensed patents, (b) if we fail to pay the fees, milestones or royalties due under the license agreement or (c) if we fail to make substantial commercial process and agree with Leicester that we will be unable to do so. The license agreement is also terminable by either party upon the material breach by the other party (subject to a 30-day cure period) or upon the other party s bankruptcy or insolvency.

Grants

Engineering and Physical Sciences Research Council (EPSRC) Grant: Encapsulated Phage for Treatment of Burns and Wound Site Infections

Through its wholly owned subsidiary, Biocontrol, the Company benefits from a United Kingdom grant awarded jointly to the University of Bath, the Frenchay Hospital, and Biocontrol. The grant runs for four years from June 2011. The awarding body is the Engineering and Physical Sciences Research Council. The total amount awarded is £0.6 million (US$0.9 million), of which £63,000 (US$0.1 million) is allocated to fund work at Biocontrol, along with staff paid from the grant, which is administered by the University of Bath. At present all staff are based at the University of Bath.

Technology Strategy Board Grant: Development of Instrumental and Bioinformatic Pipelines to Accelerate Commercial Applications of Metagenomics Approaches

Through its wholly owned subsidiary, Biocontrol, the Company benefits from a United Kingdom grant awarded jointly to Unilever PLC, the University of Glasgow, the University of Liverpool, Skalene Limited, and Biocontrol. The grant runs for three years from September 2011. The grant-awarding body is the Technology Strategy Board. The total amount awarded is £2.3 million (US$3.5 million as of June 30, 2013), of which up to £0.3 million (US$0.4 million as of June 30, 2013) is to be used at Biocontrol.

European Union Consortium Grant

The Company is also in the process of closing down a European Union consortium grant and returning £45,481 (US$70,496) of a £69,353 (US$0.1 million) advance, the remainder of which has been spent on work carried out prior to closure.

Legacy Programs

Sale of Assets to Celladon Corporation

On June 27, 2012, we entered into an asset purchase agreement and amended and restated license agreement, or license agreement, with Celladon Corporation, or Celladon, where we sold and transferred all of our rights and interest in our gene therapy business, subject to certain limitations relating to rights contained in our license agreements with the University of Pennsylvania and Genzyme Corporation. Pursuant to our license agreement with the University of Pennsylvania, or UPenn, we may be obligated to make certain royalty and license payments to UPenn as a result of Celladon s (or its affiliate s or licensee s) use of certain technology licensed under our license agreement with Celladon. Pursuant to the license agreement with Celladon, Celladon has agreed to comply with certain terms of the UPenn license agreement and to reimburse us for any payments that come due under the UPenn license agreement. Pursuant to the license agreement, we may receive a long-term royalty of 1.75% on certain product sales. This royalty may be completely canceled at any time by making a one-time payment to us in the amount of $1.75 million. In May 2013, we received a royalty payment from Celladon in the amount of $0.3 million. Celladon s obligation to pay us these royalties continues until the earlier of Celladon s termination of the agreement (which it may elect to do at any time upon thirty days notice to us) or expiration of the patents related to the licensed technology.

TABLE OF CONTENTS

Under the terms of the Celladon asset sale and license agreement, we retained certain liabilities, including obligations to indemnify against charges of infringement of certain intellectual property pursuant to our asset purchase agreement with Genzyme Corporation, our license agreement with Amsterdam Molecular Therapeutics B.V. and our collaboration and license agreement dated January 1, 2005 with the International AIDS Vaccine Initiative, the Children s Research Institute and the Children s Hospital of Philadelphia.

Intellectual Property

General

Our goal is to obtain, maintain and enforce patent protection for our product candidates, formulations, processes, methods and any other proprietary technologies, preserve our trade secrets and operate without infringing on the proprietary rights of other parties, both in the United States and in other countries. Our policy is to actively seek to obtain, where appropriate, the broadest intellectual property protection possible for our current product candidates and any future product candidates, proprietary information and proprietary technology through a combination of contractual arrangements and patents, both in the United States and abroad. However, patent protection may not afford us with complete protection against competitors who seek to circumvent our patents.

We also depend upon the skills, knowledge, experience and know-how of our management and research and development personnel, as well as that of our advisors, consultants and other contractors. To help protect our proprietary know-how, which is not patentable, and for inventions for which patents may be difficult to enforce, we currently and will in the future rely on trade secret protection and confidentiality agreements to protect our interests. To this end, we require all of our employees, consultants, advisors and other contractors to enter into confidentiality agreements that prohibit the disclosure of confidential information and, where applicable, require disclosure and assignment to us of the ideas, developments, discoveries and inventions important to our business.

We hold or have exclusive license rights to five U.S. and foreign patents, expiring on various dates between 2024 and 2029. These patents relate to the therapeutic uses of bacteriophages, bacteriophage compositions, the sequential use of bacteriophages in combination with conventional antibiotics, genetic sequence variations, biofilm disrupting agents and methods to reduce antibiotic resistance.

US 7758856 and national patents within the EU deriving from PCT WO2004062677; Bacteriophage for the treatment of bacterial biofilms

Under an existing license from the United Kingdom Health Protection Agency, we have exclusive rights to develop and exploit technologies relating to the use of bacteriophages combined with biofilm-disrupting agents in treating biofilm infections. The patent specifies agents able to facilitate the penetration of biofilms, and their combination with therapeutic bacteriophage preparations. The priority date for these patents is January 10, 2003 and the date of U.S. grant is July 20, 2010. The date of expiration is December 5, 2026 in the United States (extended by the United States Patent and Trademark Office, or USPTO). The patent is also granted in the European Union (France, Germany, Netherlands, Switzerland/Liechtenstein and the United Kingdom). The date of expiration is January 12, 2024 in the European Union. Pursuant to this license agreement, we may be required to pay the United Kingdom Health Protection Agency aggregate milestone payments of up to £10,000 per product and single-digit royalties. The agreement, which may be terminated by the Health Protection Agency upon our default, continues until the earlier of such termination or the expiration of the Health Protection Agency s rights in the licensed intellectual property.

US 7807149, US 8105579, US 8388946, continuation application and national filings deriving from PCT WO2005009451; Bacteriophage containing therapeutic agents

Through our wholly owned subsidiary, Biocontrol, we have three granted U.S. patents and a further continuation application filed. The granted patents relate to therapeutic, sequential use of bacteriophages in combination with conventional antibiotics, to bacteriophage compositions, and to the uses of bacteriophages. The filed continuation application relates to genetic sequence variation around the protected agents. The priority dates for these patents are July 23, 2003 and May 14, 2004. Dates of U.S. grant are October 5, 2010, January 31, 2012 and March 5, 2013. The dates of expiry for the granted patents are March 18, 2027 (extended by the USPTO), July 23, 2024 and July 23, 2024 in the United States. The national application in

TABLE OF CONTENTS

Australia was granted as AU 2004258731 on February 9, 2010, with July 23, 2024 as the date of expiry. Examination in other jurisdictions is proceeding: for example, in the EU, claims for bacteriophage compositions are approaching allowance; and a divisional application has been submitted for therapy claims although there is no assurance that claims or applications will ultimately be granted.

US 8475787, continuation application and national filings deriving from PCT WO2008110840; Beneficial effects of bacteriophage treatment

Through our wholly owned subsidiary, Biocontrol, we have one granted U.S. patent, with a continuation application filed. The granted patent relates to bacteriophage-induced induction of antibiotic sensitivity for *P. aeruginosa*. The priority date for these patents is March 9, 2007. The date of U.S. grant is July 2, 2013 and the date of expiry for the granted patent is March 21, 2029 (extended by the USPTO). The continuation application has been filed relating to other bacterial species. The national application in Australia was granted as AU 2008224651 on August 7, 2013, with March 7, 2028 as the date of expiry. National applications are under examination in other jurisdictions.

United Kingdom filing 1207910.9; Therapeutic bacteriophage compositions

Through our wholly owned subsidiary, Biocontrol, we have a United Kingdom patent application relating to the design of effective combinations of bacteriophages. The priority date for this application is May 4, 2012. The application has now progressed to the PCT stage (as yet unpublished).

Our success in preserving market exclusivity for our product candidates relies on patent protection, including extensions to this where appropriate, and on data exclusivity relating to an approved biologic. This may be extended by orphan drug and/or pediatric use protection where appropriate. Once any regulatory period of data exclusivity expires, depending on the status of our patent coverage, we may not be able to prevent others from marketing and selling biosimilar versions of our product candidates. We are also dependent upon the diligence of our appointed agents in national jurisdictions, acting for and on behalf of the Company, which manage the prosecution of pending domestic and foreign patent applications and maintain granted domestic and foreign patents.

Competition

We operate in highly competitive segments of the biotechnology and biopharmaceutical markets. We face competition from many different sources, including commercial pharmaceutical and biotechnology enterprises, academic institutions, government agencies and private and public research institutions all seeking to develop novel treatment modalities for bacterial disease. Many of our competitors have significantly greater financial, product development, manufacturing and marketing resources than we do. Large pharmaceutical companies have extensive experience in clinical testing and obtaining regulatory approval for drugs. In addition, many universities and private and public research institutes are active in cancer research, some in direct competition with us. We also may compete with these organizations to recruit scientists and clinical development personnel. Smaller or early-stage companies may also prove to be significant competitors, particularly through collaborative arrangements with large and established companies.

Manufacturing and Supply

The manufacturing process for our bacteriophage product is currently under development. We are optimizing a manufacturing platform that will allow us to prepare therapeutic phages to cGMP regulations, in a cost-effective

manner. We currently depend on third-party contract manufacturers for all of our required raw materials, active pharmaceutical ingredients, or API, and finished products for our preclinical and clinical trials and we are developing our own manufacturing capabilities at a wholly owned facility under construction in Ljublyana, Slovenia. Manufacturers of our products are required to comply with applicable cGMP regulations, which require, among other things, quality control and quality assurance as well as the corresponding maintenance of records and documentation. Pharmaceutical product manufacturers and other entities involved in the manufacture and distribution of approved pharmaceutical products are required to register their establishments with the FDA and certain state agencies, and are subject to periodic unannounced inspections by the FDA and certain state agencies for compliance with cGMP and other laws. Accordingly, manufacturers must continue to expend time, money and effort in the areas of production and quality control to maintain cGMP compliance. Discovery of problems with a product after approval may result in restrictions on a

TABLE OF CONTENTS

product, manufacturer or holder of an approved NDA/Biologics License Application, or BLA, including withdrawal of the product from the market. In addition, changes to the manufacturing process generally require prior FDA approval before being implemented and other types of changes to the approved product, such as adding new indications and additional labeling claims, are also subject to further FDA review and approval.

Commercialization and Marketing

We have full worldwide commercial rights to all of our phage-based products to treat drug-resistant bacterial infections, including our lead programs: AmpliPhage-001 for the treatment of CF patients with *P. aeruginosa* lung infections; AmpliPhage-002, for the treatment of antibiotic-resistant *S. aureus* (MRSA) infections; and AmpliPhage-004 for the treatment of *C. difficile* infections. We believe we can maximize the value of our company by retaining substantial global commercialization rights to these product candidates and, where appropriate, entering into partnerships to develop and commercialize our other product candidates. We plan to build a successful commercial enterprise using a sales team in the United States and possibly other major markets and with partners in other territories.

We have not yet established a sales, marketing or product distribution infrastructure because our lead candidates are still in early clinical development. We generally expect to retain commercialization and co-commercialization rights in the United States for all of our product candidates for which we receive marketing approvals. Subject to receiving marketing approvals, we intend to explore building the necessary marketing and sales infrastructure to market and sell our current product candidates. We also intend to explore the use of a variety of distribution agreements and commercial partnerships in those territories where we do not establish a sales force for any of our product candidates that obtain marketing approval.

Government Regulation and Product Approval

Government authorities in the United States, at the federal, state and local level, and other countries extensively regulate, among other things, the research, development, testing, manufacture, quality control, approval, labeling, packaging, storage, record-keeping, promotion, advertising, distribution, post-approval monitoring and reporting, marketing and export and import of products such as those we are developing.

United States Product Development Process

In the United States, the FDA regulates biological products under the Federal Food, Drug and Cosmetic Act, or FDCA, and the Public Health Service Act, or the PHS Act, and related regulations. Biological products are also subject to other federal, state and local statutes and regulations. The process of obtaining regulatory approvals and the subsequent compliance with appropriate federal, state, local and foreign statutes and regulations require the expenditure of substantial time and financial resources. Failure to comply with the applicable United States requirements at any time during the product development process or approval process, or after approval, may subject an applicant to administrative or judicial sanctions. FDA sanctions could include refusal to approve pending applications, withdrawal of an approval, a clinical hold, warning letters, product recalls, product seizures, total or partial suspension of production or distribution injunctions, fines, refusals of government contracts, restitution, disgorgement or civil or criminal penalties. Any agency or judicial enforcement action could have a material adverse effect on us. The process required by the FDA before a biological product may be marketed in the United States generally includes the following:

completion of preclinical laboratory tests, animal studies and formulation studies according to good laboratory practice requirements, or GLP, or other applicable regulations;

submission to the FDA of an IND, which must become effective before human clinical trials may begin in the United States;

performance of adequate and well-controlled human clinical trials according to the FDA s regulations commonly referred to as good clinical practices, or GCPs, and any additional requirements for the protection of human research subjects and their health information, to establish the safety and efficacy of the proposed biological product for its intended use or uses;

submission to the FDA of a Biologics License Application (BLA) for a new biological product;

TABLE OF CONTENTS

satisfactory completion of an FDA inspection of the manufacturing facility or facilities where the biological product is produced to assess compliance with the FDA s cGMP regulations, to assure that the facilities, methods and controls are adequate to preserve the biological product s identity, strength, quality and purity;
potential FDA audit of the nonclinical study sites and clinical trial sites that generated the data in support of the BLA; and
FDA review and approval, or licensure, of the BLA which must occur before a biological product can be marketed or sold.

The lengthy process of seeking required approvals and the continuing need for compliance with applicable statutes and regulations require the expenditure of substantial resources even when approvals are inherently uncertain.

The strategies, nature, and technologies of bacteriophage products are different from the conventional antibiotic therapy products. From the regulatory requirements established to ensure the safety, efficacy and quality of bacteriophage preparations, there are several major points to consider during the development, manufacturing, characterization, preclinical study and clinical study of bacteriophage. The major issues include:

bacteriophage preparation design (single agent versus phage mixes and wild-type phage versus genetically engineered phage);
proof of concept in development of bacteriophage products;
selectivity of bacteriophage replication and targeting to specific species of bacteria;
relevant animal models in preclinical studies; and
clinical safety.

Before testing any compounds with potential therapeutic value in humans, the biological product candidate enters the preclinical testing stage. Preclinical tests include laboratory evaluations of product biology, toxicity and formulation, as well as animal studies to assess the potential safety and activity of the biological product candidate. The conduct of the preclinical tests must comply with federal regulations and requirements including GLP. The sponsor must submit the results of the preclinical tests, together with manufacturing information, analytical data, any available clinical data or literature and a proposed clinical protocol, to the FDA as part of the IND application. The IND automatically becomes effective 30 days after receipt by the FDA, unless the FDA places the IND on a clinical hold within that 30-day time period. In such a case, the IND sponsor and the FDA must resolve any outstanding concerns before the clinical trial can begin. The FDA may also impose clinical holds on a biological product candidate at any time before or during clinical trials due to safety concerns or non-compliance. Accordingly, we cannot be certain that submission of an IND will result in the FDA allowing clinical trials to begin, or that, once begun, issues will not arise that suspend or terminate such clinical trial.

Clinical trials involve the administration of the biological product candidate to healthy volunteers or patients under the supervision of qualified investigators, generally physicians not employed by the sponsor. Clinical trials are conducted under protocols detailing, among other things, the objectives of the clinical trial, dosing procedures, subject inclusion and exclusion criteria and the parameters to be used to monitor subject safety. Each protocol must be submitted to the FDA if conducted under an IND. Clinical trials must be conducted in accordance with GCP requirements. Further, each clinical trial must be reviewed and approved by an independent institutional review board, or IRB, or ethics committee if conducted outside of the U.S., at or servicing each institution at which the clinical trial will be conducted. An IRB or ethics committee is charged with protecting the welfare and rights of trial participants and considers such items as whether the risks to individuals participating in the clinical trials are minimized and are reasonable in relation to anticipated benefits. The IRB or ethics committee also approves the informed consent form that must be provided to each clinical trial subject or his or her legal representative and must monitor the clinical trial until completed. We intend to use third-party CROs to administer and conduct our planned clinical trials and will

TABLE OF CONTENTS

rely upon such CROs, as well as medical institutions, clinical investigators and consultants, to conduct our trials in accordance with our clinical protocols and to play a significant role in the subsequent collection and analysis of data from these trials. The failure by any of such third parties to meet expected timelines, adhere to our protocols or meet regulatory standards could adversely impact the subject product development program and we remain legally responsible for compliance with applicable laws and regulations governing the conduct of these clinical trials.

Human clinical trials are typically conducted in three sequential phases that may overlap or be combined:

Phase 1: The biological product is initially introduced into healthy human subjects and tested primarily for safety and dosage tolerance. Absorption, metabolism, distribution and excretion may also be tested.

Phase 2: The biological product is evaluated in 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, optimal dosage and dosing schedule.

Phase 3: Clinical trials are undertaken to further evaluate dosage, clinical efficacy and safety in an expanded patient population at geographically dispersed clinical trial sites. These clinical trials are intended to establish the overall risk/benefit ratio of the product and provide an adequate basis for product labeling. Generally, two adequate and well-controlled Phase 3 clinical trials are required by the FDA and other regulatory authorities for approval of a marketing application.

Post-approval studies, or Phase 4 clinical trials, may be requested by the FDA as a condition of approval and are conducted after initial marketing approval. These studies are used to gain additional experience from the treatment of patients in the intended therapeutic indication.

Progress reports detailing the results of the clinical trials must be submitted at least annually to the FDA and written IND safety reports must be submitted to the FDA and the investigators for serious and unexpected adverse events or any finding from tests in laboratory animals that suggests that there may be a significant risk for human subjects. The FDA or the sponsor or, if used, its data safety monitoring board may suspend a clinical trial at any time on various grounds, including a finding that the research subjects or patients are being exposed to an unacceptable health risk. Similarly, an IRB or ethics committee can suspend or terminate approval of a clinical trial at its institution if the clinical trial is not being conducted in accordance with the IRB s or ethics committee s requirements or if the pharmaceutical product has been associated with unexpected serious harm to patients. Suspension of a clinical study due to safety risks attributed to the investigational product will result in termination of the study and possibly others that are underway.

Concurrent with clinical trials, companies usually complete additional animal studies and must also develop additional information about the physical characteristics of the biological product as well as finalize a process for manufacturing the product in commercial quantities in accordance with cGMP requirements. To help reduce the risk of the introduction of adventitious agents or other impurities with the use of biological products, the PHS Act emphasizes the importance of manufacturing control for products whose attributes cannot be precisely defined. The manufacturing process must be capable of consistently producing quality batches of the product candidate and, among other things, the sponsor must develop methods for testing the identity, strength, quality, potency, and purity of the final biological product. Additionally, appropriate packaging must be selected and tested and stability studies must be conducted to demonstrate that the biological product candidate does not undergo unacceptable deterioration over its shelf life.

United States Review and Approval Processes

In order to obtain approval to market a biological product in the United States, a BLA must be submitted to the FDA that provides data establishing to the FDA s satisfaction the safety and effectiveness of the investigational biological product for the proposed indication. The application includes all data available from nonclinical studies and clinical trials, including negative or ambiguous results as well as positive findings, together with detailed information relating to the product s manufacture and composition, and proposed labeling, among other things. The testing and approval processes require substantial time and effort and there can be no assurance that the FDA will accept the BLA for filing and, even if filed, that any approval will be granted on a timely basis, if at all.

TABLE OF CONTENTS

Under the Prescription Drug User Fee Act, or PDUFA, as amended, each BLA must be accompanied by a user fee. The FDA adjusts the PDUFA user fees on an annual basis. According to the FDA s fee schedule, effective through September 30, 2014, the user fee for an application requiring clinical data, such that the biological product candidate does not undergo unacceptable deterioration over its shelf life as a BLA, is $2,169,100. PDUFA also imposes an annual product fee for biologics ($104,060), and an annual establishment fee ($554,600) on facilities used to manufacture prescription biologics. Fee waivers or reductions are available in certain circumstances, including a waiver of the application fee for the first application filed by a small business. Additionally, no user fees are assessed on BLAs for products designated as orphan drugs, unless the product also includes a non-orphan indication.

The FDA has 60 days from its receipt of a BLA to determine whether the application will be accepted for filing based on the agency s threshold determination that the application is sufficiently complete to permit substantive review. The FDA may refuse to file any BLA that it deems incomplete or not properly reviewable at the time of submission and may request additional information. In this event, the BLA must be resubmitted with the additional information. The resubmitted application also is subject to review before the FDA accepts it for filing. After the BLA submission is accepted for filing, the FDA reviews the BLA to determine, among other things, whether the proposed product is safe and effective for its intended use, has an acceptable purity profile, and whether the product is being manufactured in accordance with GMP regulations to assure and preserve the product s identity, safety, strength, quality, potency, and purity. The FDA may refer applications for novel biological products or biological products that present difficult questions of safety or efficacy to an advisory committee, typically a panel that includes clinicians and other experts, for review, evaluation and a recommendation as to whether the application should be approved and, if so, 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 may ultimately decide that the NDA/BLA does not satisfy the criteria for approval. If a product receives regulatory approval, the approval may be significantly limited to specific diseases and dosages or the indications for use may otherwise be limited, which could restrict the commercial value of the product. Further, the FDA may require that certain contraindications, warnings or precautions be included in the product labeling.

Special FDA Expedited Review and Approval Programs

The FDA has various programs, including fast track designation, accelerated approval and priority review, that are intended to expedite the process for the development and FDA review of drugs that are intended for the treatment of serious or life threatening diseases or conditions and demonstrate the potential to address unmet medical needs. The purpose of these programs is to provide important new drugs and biological products to patients earlier than under standard FDA review procedures.

To be eligible for a fast track designation, the FDA must determine, based on the request of a sponsor, that a product is intended to treat a serious or life threatening disease or condition and demonstrates the potential to address an unmet medical need, or if the drug or biological product qualifies as a qualified infectious disease product under the recently enacted Generating Antibiotic Incentives Now, or GAIN Act. The FDA will determine that a product will fill an unmet medical need if it will provide a therapy where none exists or provide a therapy that may be potentially superior to existing therapy based on efficacy or safety factors. We intend to request fast track designation for our product candidates if applicable.

Specifically, new drugs and biological products are eligible for Fast Track designation if they are intended to treat a serious or life-threatening condition and demonstrate the potential to address unmet medical needs for the condition. Fast Track designation applies to the combination of the product and the specific indication for which it is being studied. The sponsor of a new drug or biological may request the FDA to designate the drug or biologic as a Fast

Track product at any time during the clinical development of the product. Unique to a Fast Track product, the FDA may consider for review sections of the marketing application on a rolling basis before the complete application is submitted, if the sponsor provides a schedule for the submission of the sections of the application, the FDA agrees to accept sections of the application and determines that the schedule is acceptable, and the sponsor pays any required user fees upon submission of the first section of the application.

TABLE OF CONTENTS

Any product submitted to the FDA for marketing, including under a Fast Track program, may be eligible for other types of FDA programs intended to expedite development and review, such as priority review and accelerated approval. Any product is eligible for priority review if it has the potential to provide safe and effective therapy where no satisfactory alternative therapy exists or a significant improvement in the treatment, diagnosis or prevention of a disease compared to marketed products. The FDA will attempt to direct additional resources to the evaluation of an application for a new drug or biological product designated for priority review in an effort to facilitate the review. Additionally, a product may be eligible for accelerated approval. Drug or biological products studied for their safety and effectiveness in treating serious or life-threatening illnesses and that provide meaningful therapeutic benefit over existing treatments may receive accelerated approval, which means that they may be approved on the basis of adequate and well-controlled clinical studies establishing that the product has an effect on a surrogate endpoint that is reasonably likely to predict a clinical benefit, or on the basis of an effect on a clinical endpoint other than survival or irreversible morbidity or mortality, that is reasonably likely to predict an effect on irreversible morbidity or mortality or other clinical benefit, taking into account the severity, rarity or prevalence of the condition and the availability or lack of alternative treatments.

As a condition of approval, the FDA may require a sponsor of a drug or biological product receiving accelerated approval perform post-marketing studies to verify and describe the predicted effect on irreversible morbidity or mortality or other clinical endpoint, and the drug or biological product may be subject to accelerated withdrawal procedures. In addition, the FDA currently requires as a condition for accelerated approval pre-approval of promotional materials, which could adversely impact the timing of the commercial launch of the product. Fast Track designation, priority review and accelerated approval do not change the standards for approval but may expedite the development or approval process.

Moreover, under the provisions of the new Food and Drug Administration Safety and Innovation Act, or FDASIA, enacted in 2012, a sponsor can request designation of a product candidate as a breakthrough therapy. A breakthrough therapy is defined as a drug or biological product that is intended, alone or in combination with one or more other drugs or biological products, to treat a serious or life-threatening disease or condition, and preliminary clinical evidence indicates that the biological product or drug may demonstrate substantial improvement over existing therapies on one or more clinically significant endpoints, such as substantial treatment effects observed early in clinical development. Drugs or biological products designated as breakthrough therapies are also eligible for accelerated approval. The FDA must take certain actions, such as holding timely meetings and providing advice, intended to expedite the development and review of an application for approval of a breakthrough therapy. We intend to request breakthrough therapy designation for our product candidates if applicable.

Even if a product qualifies for one or more of these programs, the FDA may later decide that the product no longer meets the conditions for qualification or decide that the time period for FDA review or approval will not be shortened.

Drug Price Competition and Patent Term Restoration Act of 1984

Under the Drug Price Competition and Patent Term Restoration Act of 1984, known as the Hatch-Waxman Amendments, a portion of a product s patent term that was lost during clinical development and application review by the FDA may be restored. The Hatch-Waxman Amendments also provide for a statutory protection, known as non-patent market exclusivity, against the FDA s acceptance or approval of certain competitor applications.

Patent term restoration can compensate for time lost during product development and the regulatory review process by returning up to five years of patent life for a patent that covers a new product or its use. This period is generally one-half the time between the effective date of an IND (falling after issuance of the patent) and the submission date of

an NDA, plus the time between the submission date of a BLA and the approval of that application. Patent term restorations, however, cannot extend the remaining term of a patent beyond a total of 14 years. The application for patent term extension is subject to approval by the United States Patent and Trademark Office in conjunction with the FDA. It takes at least six months to obtain approval of the application for patent term extension. Up to five years of interim one-year extensions are available if a product is still undergoing development or FDA review at the time of the expiration.

TABLE OF CONTENTS

A patent term extension is only available when the FDA approves a biological product for the first time. However, we cannot be certain that the PTO and the FDA will agree with our analysis or will grant a patent term extension.

A biological product can obtain pediatric market exclusivity in the United States. Pediatric exclusivity, if granted, adds six months to existing exclusivity periods and patent terms. This six-month exclusivity, which runs from the end of other exclusivity protection or patent term, may be granted based on the voluntary completion of a pediatric study in accordance with an FDA-issued Written Request for such a study.

An abbreviated approval pathway for biological products shown to be similar to, or interchangeable with, an FDA-licensed reference biological product was created by the Biologics Price Competition and Innovation Act of 2009, which was part of the Patient Protection and Affordable Care Act, or PPACA, signed into law on March 23, 2010. This amendment to the PHS Act attempts to minimize duplicative testing. Biosimilarity, which requires that there be no clinically meaningful differences between the biological product and the reference product in terms of safety, purity, and potency, can be shown through analytical studies, animal studies, and a clinical study or studies. Interchangeability requires that a biological product is biosimilar to the reference biological product and the product must demonstrate that it can be expected to produce the same clinical results as the reference product and, for products administered multiple times, the product and the reference product may be switched after one has been previously administered without increasing safety risks or risks of diminished efficacy relative to exclusive use of the reference biological product. However, complexities associated with the larger, and often more complex, structure of biological products, as well as the process by which such products are manufactured, pose significant hurdles to implementation that are still being worked out by the FDA.

A reference biological product is granted twelve years of exclusivity from the time of first licensure of the reference product. On April 10, 2013, President Obama released his proposed budget for fiscal year 2014 and proposed to cut this twelve year period of exclusivity down to seven years. He also proposed to prohibit additional periods of exclusivity for brand biological products due to minor changes in product formulation, a practice often referred to as evergreening. The first biological product submitted under the abbreviated approval pathway that is determined to be interchangeable with the reference product has exclusivity against other biologics submitting under the abbreviated approval pathway for the lesser of (i) one year after the first commercial marketing, (ii) 18 months after approval if there is no legal challenge, (iii) 18 months after the resolution in the applicant s favor of a lawsuit challenging the biologic s patents if an application has been submitted, or (iv) 42 months after the application has been approved if a lawsuit is ongoing within the 42-month period.

FDA Post-Approval Requirements

Maintaining substantial compliance with applicable federal, state, local, and foreign statutes and regulations requires the expenditure of substantial time and financial resources. Rigorous and extensive FDA regulation of biological products continues after approval, particularly with respect to GMP. We will rely, and expect to continue to rely, on third parties for the production of clinical and commercial quantities of any products that we may commercialize. Manufacturers of our products are required to comply with applicable requirements in the GMP regulations, including quality control and quality assurance and maintenance of records and documentation. We cannot be certain that we or our present or future suppliers will be able to comply with the GMP and other FDA regulatory requirements. Other post-approval requirements applicable to biological products include reporting of GMP deviations that may affect the identity, potency, purity and overall safety of a distributed product, record-keeping requirements, reporting of adverse effects, reporting updated safety and efficacy information, and complying with electronic record and signature requirements. After a BLA is approved, the product also may be subject to official lot release. As part of the manufacturing process, 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 by the FDA, the manufacturer submits samples of each lot of product to the FDA 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. The FDA also may perform certain confirmatory tests on lots of some products, such as viral vaccines, before releasing the lots for distribution by the manufacturer. In addition, the FDA conducts laboratory research related to the regulatory standards on the safety, purity, potency, and effectiveness of biological products.

TABLE OF CONTENTS

Discovery of previously unknown problems or the failure to comply with the applicable regulatory requirements, by us or our suppliers, may result in restrictions on the marketing of a product or withdrawal of the product from the market as well as possible civil or criminal sanctions and adverse publicity. FDA sanctions could include refusal to approve pending applications, withdrawal of an approval, clinical hold, warning or untitled letters, product recalls, product seizures, total or partial suspension of production or distribution, injunctions, fines, refusals of government contracts, mandated corrective advertising or communications with doctors, debarment, restitution, disgorgement of profits, or civil or criminal penalties. Any agency or judicial enforcement action could have a material adverse effect on us.

Biological product manufacturers and other entities involved in the manufacture and distribution of approved biological products are required to register their facilities with the FDA and certain state agencies, and are subject to periodic unannounced inspections by the FDA and certain state agencies for compliance with GMPs and other laws. In addition, changes to the manufacturing process or facility generally require prior FDA approval before being implemented and other types of changes to the approved product, such as adding new indications and additional labeling claims, are also subject to further FDA review and approval.

Labeling, Marketing and Promotion

The FDA closely regulates the labeling, marketing and promotion of biological products, including direct-to-consumer advertising, promotional activities involving the internet, and industry-sponsored scientific and educational activities. While doctors are free to prescribe any product approved by the FDA for any use, a company can only make claims relating to safety and efficacy of a biological product that are consistent with FDA approval, and the company is allowed to actively market a biological product only for the particular use and treatment approved by the FDA. In addition, any claims we make for our products in advertising or promotion must be appropriately balanced with important safety information and otherwise be adequately substantiated. Failure to comply with these requirements can result in adverse publicity, warning letters, corrective advertising, injunctions and potential civil and criminal penalties.

Other Healthcare Laws and Compliance Requirements

In the United States, our activities are potentially subject to regulation by various federal, state and local authorities in addition to the FDA, including the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration), other divisions of the United States Department of Health and Human Services (e.g., the Office of Inspector General), the United States Department of Justice and individual United States Attorney offices within the Department of Justice and state and local governments.

International Regulation

In addition to regulations in the United States, we will be subject to a variety of foreign regulations governing clinical trials and commercial sales and distribution of our future products. Whether or not we obtain FDA approval for a product, we must obtain approval of a product by the comparable regulatory authorities of foreign countries before we can commence clinical trials or marketing of the product in those countries. The approval process varies from country to country, and the time may be longer or shorter than that required for FDA approval. The requirements governing the conduct of clinical trials, product licensing, pricing and reimbursement vary greatly from country to country.

Under European Union regulatory systems, marketing authorizations may be submitted either under a centralized or a mutual recognition procedure. The centralized procedure provides for the grant of a single marketing authorization

that is valid for all European Union member states. The mutual recognition procedure provides for mutual recognition of national approval decisions. Under this procedure, the holder of a national marketing authorization may submit an application to the remaining member states. Within 90 days of receiving the applications and assessment report, each member state must decide whether to recognize approval.

Pricing and Reimbursement

Although none of our product candidates has been commercialized for any indication, if they are approved for marketing, commercial success of our product candidates will depend, in part, upon the availability of coverage and reimbursement from third-party payors at the federal, state and private levels.

TABLE OF CONTENTS

Government payor programs, including Medicare and Medicaid, private healthcare insurance companies and managed-care plans have attempted to control costs by limiting coverage and the amount of reimbursement for particular drug treatments. The U.S. Congress and state legislatures from time to time propose and adopt initiatives aimed at cost-containment. Ongoing federal and state government initiatives directed at lowering the total cost of healthcare will likely continue to focus on healthcare reform, the cost of prescription drugs and biological products and on the reform of the Medicare and Medicaid payment systems. Examples of how limits on drug coverage and reimbursement in the United States may cause reduced payments for drugs in the future include:

changing Medicare reimbursement methodologies;
fluctuating decisions on which drugs to include in formularies;
revising drug rebate calculations under the Medicaid program; and
reforming drug importation laws.

Indeed, the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, or collectively, the Healthcare Reform Act, which was signed into law in March of 2010, substantially changes the way healthcare is financed by both governmental and private insurers, and significantly impacts drugs and biological products manufacturers. The Healthcare Reform Act includes, among other things, the following measures:

annual, non-deductible fees on any entity that manufactures or imports certain prescription drugs;
increases in Medicaid rebates owed by manufacturers under the Medicaid Drug Rebate Program for both branded and generic drugs;
a new Patient-Centered Outcomes Research Institute to oversee, identify priorities in and conduct comparative clinical effectiveness research;
new requirements for manufacturers to discount drug prices to eligible patients by 50 percent at the pharmacy level and for mail order services in order for their outpatient drugs to be covered under Medicare Part D; and
an increase in the number of entities eligible for discounts under the Public Health Service pharmaceutical pricing program.

Additionally, some third-party payors also require pre-approval of coverage for new or innovative drug therapies before they will reimburse healthcare providers who use such therapies. While we cannot predict whether any proposed cost-containment measures will be adopted or otherwise implemented in the future, the announcement or adoption of these proposals could have a material adverse effect on our ability to obtain adequate prices for our product candidates and operate profitably.

In the United States and markets in other countries, sales of any products for which we receive regulatory approval for commercial sale will depend in part on the availability of reimbursement from third-party payors, including government health administrative authorities, managed care providers, private health insurers and other organizations. Third-party payors are increasingly examining the medical necessity and cost-effectiveness of medical products and services, in addition to their safety and efficacy, and, accordingly, significant uncertainty exists as to the reimbursement status of newly approved therapeutics. Adequate third-party reimbursement may not be available for our products to enable us realize an appropriate return on our investment in research and product development.

Employees

As of May 15, 2014, we had nineteen full-time employees and three part-time employees.

TABLE OF CONTENTS

Item 1A. Risk Factors.

An investment in our common stock involves a high degree of risk. We operate in an industry that involves numerous risks and uncertainties. The risks and uncertainties described below are not the only ones we face. Other risks and uncertainties, including those that we do not currently consider material, may impair our business. If any of the risks discussed below actually occur, our business, financial condition, operating results or cash flows could be materially adversely affected. This could cause the trading price of our common stock to decline, and you may lose all or part of your investment.

Risks Related to Our Business

We are seeking to develop antibacterial agents using bacteriophage technology, which has not resulted in any approved product on the market to date.

We are developing our product candidates with bacteriophage technology. We have not, nor to our knowledge has any other company, received regulatory approval from the U.S. Food and Drug Administration, or FDA or equivalent foreign agencies for a pharmaceutical drug based on this approach. While *in vitro* studies have characterized the behavior of bacteriophages in cell cultures and there exists a body of literature regarding the use of phage therapy in humans, the safety and efficacy of phage therapy in humans has not been extensively studied in well-controlled modern clinical trials. Most of the prior research on phage-based therapy was conducted in the former Soviet Union prior to and immediately after World War II and lacked appropriate control group design or lacked control groups at all. Furthermore, the standard of care has changed substantially during the ensuing decades since those studies were performed, making claims of improved cure rates open for debate. We cannot be certain that our approach will lead to the development of approvable or marketable drugs.

Developing phage-based therapies on a commercial scale will also require developing new manufacturing processes and techniques. We and our third-party collaborators may experience delays in developing manufacturing capabilities for our product candidates, and may not be able to do so at the scale required to conduct efficiently the clinical trials required to obtain regulatory approval of our products, or to manufacture commercial quantities of our products, if approved.

In addition, the FDA or other regulatory agencies may lack experience in evaluating the safety and efficacy of drugs based on these targeting approaches, which could lengthen the regulatory review process, increase our development costs and delay or prevent commercialization of our product candidates.

Delays in our clinical trials could result in us not achieving anticipated developmental milestones when expected, increased costs and delay our ability to obtain regulatory approval and commercialize our product candidates.

Delays in our ability to commence or enroll patients for our clinical trials could result in us not meeting anticipated clinical milestones and could materially impact our product development costs and delay regulatory approval of our product candidates. We do not know whether planned clinical trials will be commenced or completed on schedule, if at all. Clinical trials can be delayed for a variety of reasons, including:

delays in the development of manufacturing capabilities for our product candidates to enable their consistent production at clinical trial scale;

delays in the commencement of clinical trials as a result of clinical trial holds or the need to obtain additional information to complete an Investigational New Drug Application (IND);

delays in obtaining regulatory approval to commence new trials;

adverse safety events experienced during our clinical trials;

delays in obtaining clinical materials;

slower than expected patient recruitment for participation in clinical trials; and

delays in reaching agreement on acceptable clinical trial agreement terms with prospective sites or obtaining institutional review board approval.

Delays in our clinical trials could result in us not achieving anticipateddevelopmental milestones when expected, inc

TABLE OF CONTENTS

If we do not successfully commence or complete our clinical trials on schedule, the price of our common stock may decline.

Preclinical studies and Phase 1 or 2 clinical trials of our product candidates may not predict the results of subsequent human clinical trials.

Preclinical studies, including studies of our product candidates in animal models of disease, may not accurately predict the result of human clinical trials of those product candidates. In particular, promising animal studies suggesting the efficacy of prototype phage products in the treatment of bacterial infections, such as *P. aeruginosa* may not predict the ability of these products to treat similar infections in humans. Our phage technology may be found not to be efficacious in treating bacterial infections alone or in combination with other agents, when studied in human clinical trials.

To satisfy FDA or foreign regulatory approval standards for the commercial sale of our product candidates, we must demonstrate in adequate and controlled clinical trials that our product candidates are safe and effective. Success in early clinical trials, including Phase 2 trials, does not ensure that later clinical trials will be successful. Our initial results from Phase 1/2 clinical trials also may not be confirmed by later analysis or subsequent larger clinical trials. A number of companies in the pharmaceutical industry have suffered significant setbacks in advanced clinical trials, even after obtaining promising results in earlier clinical trials.

Our product candidates must undergo rigorous clinical testing, the results of which are uncertain and could substantially delay or prevent us from bringing them to market.

Before we can obtain regulatory approval for a product candidate, we must undertake extensive clinical testing in humans to demonstrate safety and efficacy to the satisfaction of the FDA or other regulatory agencies. Clinical trials of new drug candidates sufficient to obtain regulatory marketing approval are expensive and take years to complete.

We cannot be certain of successfully completing clinical testing within the time frame we have planned, or at all. We may experience numerous unforeseen events during, or as a result of, the clinical trial process that could delay or prevent us from receiving regulatory approval or commercializing our product candidates, including the following:

our clinical trials may produce negative or inconclusive results, and we may decide, or regulators may require us, to conduct additional clinical and/or preclinical testing or to abandon programs;

the results obtained in earlier stage clinical testing may not be indicative of results in future clinical trials;

clinical trial results may not meet the level of statistical significance required by the FDA or other regulatory agencies;

enrollment in our clinical trials for our product candidates may be slower than we anticipate, resulting in significant delays and additional expense;

we, or regulators, may suspend or terminate our clinical trials if the participating patients are being exposed to unacceptable health risks; and

the effects of our product candidates on patients may not be the desired effects or may include undesirable side effects or other characteristics that may delay or preclude regulatory approval or limit their commercial use, if approved.

Completion of clinical trials depends, among other things, on our ability to enroll a sufficient number of patients, which is a function of many factors, including:

the therapeutic endpoints chosen for evaluation;
the eligibility criteria defined in the protocol;
the perceived benefit of the investigational drug under study;
the size of the patient population required for analysis of the clinical trial s therapeutic endpoints;

Our product candidates must undergo rigorous clinical testing, the results ofwhich are uncertain and could substant

TABLE OF CONTENTS

our ability to recruit clinical trial investigators and sites with the appropriate competencies and experience;
our ability to obtain and maintain patient consents; and
competition for patients by clinical trial programs for other treatments.

We may experience difficulties in enrolling patients in our clinical trials, which could increase the costs or affect the timing or outcome of these clinical trials. This is particularly true with respect to diseases with relatively small patient populations.

We must develop manufacturing processes for our lead product candidates and any delay in or our inability to do so would result in delays in our clinical trials and materially and negatively affect our business and results.

We are developing novel manufacturing processes for the production of AmpliPhage-002 for treatment of *S. aureus* (MRSA) infections, AmpliPhage-001for the treatment of *P. aeruginosa* infections and AmpliPhage-004 for the treatment of *C. difficile* infections at facilities under construction in Ljublyana, Slovenia. The manufacturing processes for our product candidates, and the scale up of such processes for clinical trials, is novel, and there can be no assurance that we will be able to complete this work in a timely manner, if at all. Any delay in the development or scale up of these manufacturing processes could delay the start of clinical trials and harm our business. Our facilities in Slovenia must also undergo inspections by the European regulatory authorities for compliance with their and the FDA s current good manufacturing practice regulations, or cGMP regulations, before the respective product candidates can be approved for use in clinical trials or commercialization. In the event these facilities do not receive a satisfactory cGMP inspection for the manufacture of our product candidates, we may need to fund additional modifications to our manufacturing process, conduct additional validation studies, or find alternative manufacturing facilities, any of which would result in significant cost to us as well as a delay of up to several years in obtaining approval for such product candidates.

Our manufacturing facilities will be subject to ongoing periodic inspection by the European regulatory authorities and the FDA for compliance with European and FDA cGMP regulations. Compliance with these regulations and standards is complex and costly, and there can be no assurance that we will be able to comply. Any failure to comply with applicable regulations could result in sanctions being imposed (including fines, injunctions and civil penalties), failure of regulatory authorities to grant marketing approval of our product candidates, delays, suspension or withdrawal of approvals, license revocation, seizures or recalls of product candidates or products, operating restrictions and criminal prosecution.

We have conducted and may in the future conduct clinical trials for our products or product candidates outside the United States and the FDA may not accept data from such trials.

We have conducted and may in the future choose to conduct one or more of our clinical trials outside the United States. Although the FDA may accept data from clinical trials conducted outside the United States, acceptance of such study data by the FDA is subject to certain conditions. For example, the study must be well designed and conducted and performed by qualified investigators in accordance with ethical principles. The study population must also adequately represent the U.S. population, and the data must be applicable to the U.S. population and U.S. medical practice in ways that the FDA deems clinically meaningful. Generally, the patient population for any clinical studies conducted outside of the United States must be representative of the population for whom we intend to label the product in the United States. In addition, such studies would be subject to the applicable local laws and FDA acceptance of the data would be dependent upon its determination that the studies also complied with all applicable

U.S. laws and regulations. There can be no assurance the FDA will accept data from trials conducted outside of the United States. If the FDA does not accept any such data, it would likely result in the need for additional trials, which would be costly and time consuming and delay aspects of our business plan.

We may need to license additional intellectual property rights.

The development and commercialization of phage-based antibacterial agents may require us to obtain rights to intellectual property from third parties. For example, pursuant to our Collaborative Research and

TABLE OF CONTENTS

Development Agreement, or CRADA, with the United States Army Medical Research and Materiel Command, or USAMRMC and the Walter Reed Army Institute of Research, or WRAIR, we are focusing on developing bacteriophage therapeutics to treat *S. aureus, E. coli* and *P. aeruginosa* infections. To the extent the intellectual property is generated from the USAMRMC or WRAIR that is used in a commercial product, we may be obligated to make payments such as royalties, licensing fees and milestone payments. We may also determine that it is necessary or advisable to license other intellectual property from third parties. There can be no assurance that such intellectual property rights would be available on commercially reasonable terms, if at all.

We are subject to significant regulatory approval requirements, which could delay, prevent or limit our ability to market our product candidates.

Our research and development activities, preclinical studies, clinical trials and the anticipated manufacturing and marketing of our product candidates are subject to extensive regulation by the FDA and other regulatory agencies in the United States and by comparable authorities in Europe and elsewhere. For example, our research facilities in Colworth, United Kingdom, recently failed an audit by the Health and Safety Executive, Britain s national regulatory for workplace health and safety; as a result of this failure we have elected to reconfigure our research operations. There can be no assurance that our planned manufacturing facilities will satisfy the requirements of the FDA or comparable foreign authorities. We require the approval of the relevant regulatory authorities before we may commence commercial sales of our product candidates in a given market. The regulatory approval process is expensive and time-consuming, and the timing of receipt of regulatory approval is difficult to predict. Our product candidates could require a significantly longer time to gain regulatory approval than expected, or may never gain approval. We cannot be certain that, even after expending substantial time and financial resources, we will obtain regulatory approval for any of our product candidates. A delay or denial of regulatory approval could delay or prevent our ability to generate product revenues and to achieve profitability.

Changes in regulatory approval policies during the development period of any of our product candidates, changes in, or the enactment of, additional regulations or statutes, or changes in regulatory review practices for a submitted product application may cause a delay in obtaining approval or result in the rejection of an application for regulatory approval.

Regulatory approval, if obtained, may be made subject to limitations on the indicated uses for which we may market a product. These limitations could adversely affect our potential product revenues. Regulatory approval may also require costly post-marketing follow-up studies. In addition, the labeling, packaging, adverse event reporting, storage, advertising, promotion and record-keeping related to the product will be subject to extensive ongoing regulatory requirements. Furthermore, for any marketed product, its manufacturer and its manufacturing facilities will be subject to continual review and periodic inspections by the FDA or other regulatory authorities. Failure to comply with applicable regulatory requirements may, among other things, result in fines, suspensions of regulatory approvals, product recalls, product seizures, operating restrictions and criminal prosecution.

The FDA and foreign regulatory authorities may impose significant restrictions on the indicated uses and marketing of pharmaceutical products.

FDA rules for pharmaceutical promotion require that a company not promote an unapproved drug or an approved drug for an unapproved use. In addition to FDA requirements, regulatory and law enforcement agencies, such as the United States Department of Health and Human Services Office of Inspector General and the United States Department of Justice, monitor and investigate pharmaceutical sales, marketing and other practices. For example, sales, marketing and scientific/educational grant programs must comply with the Medicare-Medicaid Anti-Fraud and Abuse Act, as

amended, the False Claims Act, as amended, and similar state laws. In recent years, actions by companies sales forces and marketing departments have been scrutinized intensely to ensure, among other things, that actions by such groups do not qualify as kickbacks to healthcare professionals. A kickback refers to the provision of any item of value to a healthcare professional or other person in exchange for purchasing, recommending, or referring an individual for an item or service reimbursable by a federal healthcare program. These kickbacks increase the expenses of the federal healthcare program and may result in civil penalties, criminal prosecutions, and exclusion from participation in government programs, any of which would adversely affect our financial condition and business operations. In

The FDA and foreign regulatory authorities may impose significantrestrictions on the indicated uses and marketing

TABLE OF CONTENTS

addition, even if we are not determined to have violated these laws, government investigations into these issues typically require the expenditure of significant resources and generate negative publicity, which would also harm our financial condition. Comparable laws also exist at the state level.

Our relationships with customers and third-party payors will be subject to applicable anti-kickback, fraud and abuse and other healthcare laws and regulations, which could expose us to criminal sanctions, civil penalties, contractual damages, reputational harm and diminished profits and future earnings.

Healthcare providers, physicians and third-party payors will play a primary role in the recommendation and prescription of any product candidates for which we obtain marketing approval. Our future arrangements with third-party payors and customers may expose us 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 would market, sell and distribute our products. As a biotechnology company, even though we do not and will not control referrals of healthcare services or bill directly to Medicare, Medicaid or other third-party payors, federal and state healthcare laws and regulations pertaining to fraud and abuse and patients rights are and will be applicable to our business. Federal healthcare Anti-Kickback Statute will constrain our marketing practices, educational programs, pricing policies, and relationships with healthcare providers or other entities, by prohibiting, among other things, persons from knowingly and willfully soliciting, offering, receiving or providing remuneration, directly or indirectly, in cash or in kind, to induce or reward, or in return for, either the referral of an individual for, or the purchase, order or recommendation of, any good or service, for which payment may be made under a federal healthcare program such as Medicare and Medicaid. Federal civil and criminal false claims laws and civil monetary penalty laws impose criminal and civil penalties, including through civil whistleblower or qui tam actions, against individuals or entities for knowingly presenting, or causing to be presented, to the federal government, including the Medicare and Medicaid programs, 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, imposes criminal and civil liability for executing a scheme to defraud any healthcare benefit program and also created federal criminal laws that prohibit knowingly and willfully falsifying, concealing or covering up a material fact or making any materially false statements in connection with the delivery of or payment for healthcare benefits, items or services. HIPAA, as amended by the Health Information Technology for Economic and Clinical Health Act, or HITECH, also imposes obligations, including mandatory contractual terms, with respect to safeguarding the privacy, security and transmission of individually identifiable health information.

The federal physician sunshine requirements under the Affordable Care Act requires manufacturers of drugs, devices, biologics and medical supplies to report annually to HHS information related to payments and other transfers of value to physicians, other healthcare providers, and teaching hospitals, and ownership and investment interests held by physicians and other healthcare providers and their immediate family members and applicable group purchasing organizations. Analogous state and foreign laws and regulations, such as state anti-kickback and false claims laws, may apply to sales or marketing arrangements and claims involving healthcare items or services 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 and may require drug manufacturers to report information related to payments and other transfers of value to physicians and other healthcare providers or marketing expenditures. State and foreign laws also govern the privacy and security of health information in specified circumstances, many of which differ from each other in significant ways and often are not preempted by HIPAA, thus complicating compliance efforts. Efforts

to ensure that our business arrangements with third parties will comply with applicable healthcare laws and regulations will involve substantial costs. It is possible that governmental authorities will conclude that our business practices may not comply with current or future statutes, regulations or case law involving applicable fraud and abuse or other healthcare laws and regulations. If our operations are found to be in violation of any of these laws or any other governmental regulations that may apply to us, we may be subject to significant civil, criminal and administrative penalties, damages, fines, imprisonment, exclusion from government funded healthcare programs, such as Medicare and Medicaid, and the curtailment or restructuring of our operations. If any physicians or other healthcare providers or entities with whom we expect to do business are found to not be in

Our relationships with customers and third-party payors will be subject to applicable anti-kickback, fraud and abuse

TABLE OF CONTENTS

compliance with applicable laws, they may be subject to criminal, civil or administrative sanctions, including exclusions from government funded healthcare programs.

We are, and in the future may be, subject to new federal and state requirements to submit information on our open and completed clinical trials to public registries and databases.

In 1997, a public registry of open clinical trials involving drugs intended to treat serious or life-threatening diseases or conditions was established under the Food and Drug Administration Modernization Act, or FDMA, in order to promote public awareness of and access to these clinical trials. Under FDMA, pharmaceutical manufacturers and other clinical trial sponsors are required to post the general purpose of these clinical trials, as well as the eligibility criteria, location and contact information of the clinical trials. Since the establishment of this registry, there has been significant public debate focused on broadening the types of clinical trials included in this or other registries, as well as providing for public access to clinical trial results. A voluntary coalition of medical journal editors has adopted a resolution to publish results only from those clinical trials that have been registered with a no-cost, publicly accessible database, such as *www.clinicaltrials.gov*. The Pharmaceuticals and Research Manufacturers of America has also issued voluntary principles for its members to make results from certain clinical trials publicly available and has established a website for this purpose. Other groups have adopted or are considering similar proposals for clinical trial registration and the posting of clinical trial results. The state of Maine has enacted legislation, with penalty provisions, requiring the disclosure of results from clinical trials involving drugs marketed in the state, and similar legislation has been introduced in other states. Federal legislation was introduced in the fall of 2004 to expand *www.clinicaltrials.gov* and to require the inclusion of clinical trial results in this registry. In some states, such as New York, prosecutors have alleged that a lack of disclosure of clinical trial information constitutes fraud, and these allegations have resulted in settlements with pharmaceutical companies that include agreements to post clinical trial results. Our failure to comply with any clinical trial posting requirements could expose us to negative publicity, fines, and other penalties, all of which could materially harm our business.

We do not have a sales force and do not currently have plans to develop one.

The commercial success of any of our product candidates will depend upon the strength of sales and marketing efforts for them. We do not have a sales force and have no experience in sales, marketing or distribution. To successfully commercialize our product candidates, we will need to develop such a capability ourselves or seek assistance from a third party with a large distribution system and a large direct sales force. We may be unable to put such a plan in place. In addition, if we arrange for others to market and sell our products, our revenues will depend upon the efforts of those parties. Such arrangements may not succeed. Even if one or more of our product candidates is approved for marketing, if we fail to establish adequate sales, marketing and distribution capabilities, independently or with others, our business will be materially harmed.

Our auditors have expressed substantial doubt about our ability to continue as a going concern and we must raise additional capital to continue operations.

Our consolidated financial statements were prepared under the assumption that we would continue our operations as a going concern. However, as discussed in Note 2 to our consolidated financial statements, we have had recurring losses from operations, negative operating cash flow and an accumulated deficit that raise substantial doubt about our ability to continue as a going concern. Uncertainty concerning our ability to continue as a going concern may hinder our

ability to obtain future financing.

In December 2013, we completed a private placement of shares of our common stock, which raised approximately $18 million, prior to commissions. We do not generate any cash from operations and must raise additional funds in order to continue operating our business. We expect to continue to fund our operations primarily through equity and debt financings in the future. If additional capital is not available, we may not be able to continue to operate our business pursuant to our business plan or we may have to discontinue our operations entirely.

Our auditors have expressed substantial doubt about our ability to continueas a going concern and we must raise a

TABLE OF CONTENTS

Developing drugs and conducting clinical trials is expensive. Our future funding requirements will depend on many factors, including:

the costs and timing of our research and development activities;
the progress and cost of our clinical trials and other research and development activities;
the cost and timing of securing manufacturing capabilities for our clinical product candidates and commercial products, if any;
the terms and timing of any collaborative, licensing, acquisition or other arrangements that we may establish;
the costs and timing of obtaining regulatory approvals;
the costs of filing, prosecuting, defending and enforcing any patent applications, claims, patents and other intellectual property rights; and
the costs of lawsuits involving us or our product candidates.

We will seek additional capital to support our product development activities. We may seek funds through arrangements with collaborators or others that may require us to relinquish rights to the products candidates that we might otherwise seek to develop or commercialize independently. We cannot be certain that we will be able to enter into any such arrangements on reasonable terms, if at all.

We may seek to raise capital through a variety of sources, including:

the public equity market;
private equity financing;
collaborative arrangements;
licensing arrangements; and/or
public or private debt.

Our ability to raise additional funds will depend, in part, on the status of our product development activities and other business operations, as well as factors related to financial, economic, and market conditions, collaboration or license agreement with others and factors related to financial, economic and market conditions, many of which are beyond our control. We cannot be certain that sufficient funds will be available to us when required or on satisfactory terms, if at all. Raising additional capital through the sale of securities could cause significant dilution to our stockholders. If adequate funds are not available, we may be required to significantly reduce or refocus our operations or to obtain funds through additional arrangements that may require us to relinquish rights to certain of our products, technologies or potential markets, any of which could delay or require that we curtail or eliminate some or all of our development programs or otherwise have a material adverse effect on our business, financial condition and results of operations. In addition, we may have to delay, reduce the scope of or eliminate some of our research and development, which could delay the time to market for any of our product candidates, if adequate funds are not available.

If we are unable to secure additional financing on a timely basis or on terms favorable to us, we may be required to cease or reduce certain research and development projects, to sell some or all of our technology or assets or to merge all or a portion of our business with another entity. Insufficient funds may require us to delay, scale back, or eliminate some or all of our activities, and if we are unable to obtain additional funding, there is uncertainty regarding our continued existence.

Risks Related to Our Financial Performance and Operations

We have incurred losses since our inception and anticipate that we will continue to incur significant losses for the foreseeable future, and our future profitability is uncertain.

We have incurred losses in each year since our inception in 1992. Prior to the merger of Targeted Genetics Corporation with Biocontrol in January 2011, our accumulated deficit was $315.5 million, and Biocontrol had an accumulated deficit of $6.9 million. Since January 2011, we have incurred a cumulative

TABLE OF CONTENTS

deficit of $14.6 million, and we expect to incur losses for the foreseeable future. We have devoted, and will continue to devote for the foreseeable future, substantially all of our resources to research and development of our product candidates. For the year ended December 31, 2012, we had an operating loss of $4.2 million and a net loss of $1.1 million. For the year ended December 31, 2013, we had an operating loss of $15.0 million and a net loss of $58.4 million. Clinical trials and activities associated with discovery research are costly. We do not expect to generate any revenue from the commercial sales of our product candidates in the near term, and we expect to continue to have significant losses for the foreseeable future.

To attain ongoing profitability, we will need to develop products successfully and market and sell them effectively, or rely on other parties to do so. We cannot predict when we will achieve ongoing profitability, if at all. We have never generated revenue from the commercial sales of our product candidates, and there is no guarantee that we will be able to do so in the future. If we fail to become profitable, or if we are unable to fund our continuing losses, we would be unable to continue our research and development programs.

Our success depends in part on retaining and motivating key personnel and, if we fail to do so, it may be more difficult for us to execute our business strategy. As a small organization we are dependent on key employees and may need to hire additional personnel to execute our business strategy successfully.

Our success depends on our continued ability to attract, retain and motivate highly qualified management, clinical and scientific personnel and on our ability to develop and maintain important relationships with leading academic institutions, clinicians and scientists. We are highly dependent upon our senior management, particularly our Chief Executive Officer, Philip J. Young. The loss of the services of Mr. Young or one or more of our other key employees could delay or have an impact on the successful completion of our clinical trials or the development of additional product candidates.

As of May 15, 2014, we had twenty-two employees. Our success will depend on our ability to retain and motivate remaining personnel and hire additional qualified personnel when required. Competition for qualified personnel in the biotechnology field is intense. We face competition for personnel from other biotechnology and pharmaceutical companies, universities, public and private research institutions and other organizations. We may not be able to attract and retain qualified personnel on acceptable terms given the competition for such personnel. If we are unsuccessful in our retention, motivation and recruitment efforts, we may be unable to execute our business strategy.

We have determined that a material weakness existed in our system of internal control over financial reporting, which could have had a material impact on our business.

We are required to maintain internal control over financial reporting adequate to provide reasonable assurance regarding the reliability of financial reporting and the preparation of our consolidated financial statements in accordance with generally accepted accounting principles. In connection with the restatement of our consolidated financial statements for the years ended December 31, 2012 and 2011 and the quarter ended September 30, 2013, we determined that we had a material weakness as of December 31, 2013, namely that our controls over the evaluation and review of complex and non-routine transactions were not effective.

Due to this material weakness, we have concluded that as of December 31, 2013, our internal control over financial reporting was not effective. Subsequent to December 31, 2013, we have restated our consolidated financial statements as of December 31, 2013 to correct for errors caused by this weakness.

We do not expect that our internal control over financial reporting will prevent all errors and all fraud. A control system, no matter how well designed and operated, can provide only reasonable, not absolute, assurance that the control system s objectives will be met. Further, the design of a control system must reflect the fact that there are resource constraints, and the benefits of controls must be considered relative to their costs. Controls can be circumvented by the individual acts of some persons, by collusion of two or more people, or by management override of the controls. Over time, controls may become inadequate because changes in conditions or deterioration in the degree of compliance with policies or procedures may occur. Because of the inherent limitations in a cost-effective control system, misstatements due to error or fraud may occur and not be detected. As a result, we cannot assure you that significant deficiencies or material weaknesses in our internal control over financial reporting will not be identified in the future. A material weakness means a deficiency, or combination of deficiencies, in internal control over financial reporting such

We have determined that a material weakness existed in our system ofinternal control over financial reporting, whic

TABLE OF CONTENTS

that there is a reasonable possibility that a material misstatement of the registrant s annual or interim financial statements will not be prevented or detected on a timely basis.

Risks Related to Our Dependence on Third Parties

We rely on third parties for aspects of product development.

We rely on third parties such as the University of Leicester for certain aspects of product development. We are working with the University of Leicester for research and development of product candidates to treat *C. difficile* infections and we are working with Intrexon to develop new strains of manufacturing hosts for our phage therapies. Because we rely on third parties to conduct these activities, we have less control over the success of these programs than we would if we were conducting them on our own. Factors beyond our control that could impact the success of these programs include the amount of resources devoted to the programs by the applicable third party, the staffing of those projects by third-party personnel, and the amount of time such personnel devote to our programs compared to other programs. Failure of our third-party collaborators to successfully complete the projects that we are working on with them could result in delays in product development and the need to expend additional resources, increasing our expenses beyond current expectations.

We will rely on third parties to conduct some of our clinical trials, and their failure to perform their obligations in a timely or competent manner may delay development and commercialization of our product candidates.

We expect to use clinical research organizations to assist in conduct of our clinical trials. There are numerous alternative sources to provide these services. However, we may face delays outside of our control if these parties do not perform their obligations in a timely or competent fashion or if we are forced to change service providers. This risk is heightened for clinical trials conducted outside of the United States, where it may be more difficult to ensure that clinical trials are conducted in compliance with FDA requirements. Any third-party that we hire to conduct clinical trials may also provide services to our competitors, which could compromise the performance of their obligations to us. If we experience significant delays in the progress of our clinical trials and in our plans to file New Drug Applications (NDAs), the commercial prospects for product candidates could be harmed and our ability to generate product revenue would be delayed or prevented.

We must manage a geographically dispersed organization.

While we are a small company, we currently have operations in the United States, Australia, the United Kingdom and Slovenia. In the future, we may also locate facilities in other locations based on proximity to personnel with the expertise needed to research, develop and manufacture phage-based therapeutics, costs of operations or other factors. Managing our organization across multiple locations and multiple time zones may reduce our efficiency, increase our expenses and increase the risk of operational difficulties in the execution of our plans.

Risks Related to Our Intellectual Property

We are dependent on patents and proprietary technology. If we fail to adequately protect this intellectual property or if we otherwise do not have exclusivity for the marketing of our products, our ability to commercialize products could suffer.

Our commercial success will depend in part on our ability to obtain and maintain patent protection sufficient to prevent others from marketing our product candidates, as well as to defend and enforce these patents against infringement and to operate without infringing the proprietary rights of others. Protection of our product candidates from unauthorized use by third parties will depend on having valid and enforceable patents cover our product candidates or their manufacture or use, or having effective trade secret protection. If our patent applications do not result in issued patents, or if our patents are found to be invalid, we will lose the ability to exclude others from making, using or selling the inventions claimed therein. We have a limited number of patents and pending patent applications.

The patent positions of biotechnology companies can be uncertain and involve complex legal and factual questions. This is due to inconsistent application of policy and changes in policy relating to examination and

TABLE OF CONTENTS

enforcement of biotechnology patents to date on a global scale. The laws of some countries may not protect intellectual property rights to the same extent as the laws of countries having well-established patent systems, and those countries may lack adequate rules and procedures for defending our intellectual property rights. Also, changes in either patent laws or in interpretations of patent laws may diminish the value of our intellectual property. We are not able to guarantee that all of our patent applications will result in the issuance of patents and we cannot predict the breadth of claims that may be allowed in our patent applications or in the patent applications we may license from others.

The degree of future protection for our proprietary rights is uncertain because legal means afford only limited protection and may not adequately protect our rights or permit us to gain or keep our competitive advantage. For example:

we might not have been the first to make the inventions covered by each of our pending patent applications and issued patents, and we may have to participate in expensive and protracted interference proceedings to determine priority of invention;

we might not have been the first to file patent applications for these inventions;