AERIE PHARMACEUTICALS INC
Form 10-K
March 26, 2014
Table of Contents

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, DC 20549

FORM 10-K

(Mark One)

x **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2013

or

¨ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

Commission File Number: 001-36152

Aerie Pharmaceuticals, Inc.

(Exact name of registrant as specified in its charter)

Delaware	**20-3109565**
(State or other jurisdiction of incorporation or organization)	**(IRS Employer Identification No.)**

135 US Highway 206, Suite 15

Bedminster, New Jersey 07921

(908) 470-4320

(Address, including zip code, and telephone number, including area code, of registrant s principal executive offices)

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

Title of Each Class	**Name of Each Exchange on Which Registered**
Common Stock, $0.001 par value per share	**NASDAQ Global Market**

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

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ¨ No x

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or 15(d) of the Act. Yes ¨ No x

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes x No ¨

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files): Yes x No ¨

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

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. (Check one):

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

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

The aggregate market value of the voting stock held by non-affiliates of the registrant on October 25, 2013, based upon the closing price of $10.61 of the registrant s common stock as reported on the NASDAQ Global Market, was $79,913,000. The registrant has elected to use October 25, 2013, as the calculation date, which was the initial trading date of the registrant s common stock on the NASDAQ Global Market, because on June 28, 2013 (the last business day of the registrant s most recently completed second fiscal quarter), the registrant was a privately held company.

As of March 19, 2014, the registrant had 23,316,653 shares of common stock, $0.001 par value, issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant s definitive proxy statement (the Proxy Statement) for the 2014 Annual Meeting of Stockholders are incorporated by reference into Part III of this Annual Report on Form 10-K. The Proxy Statement will be filed with the Securities and Exchange Commission (the SEC) within 120 days of the registrant s fiscal year ended December 31, 2013.

Table of Contents

TABLE OF CONTENTS

Table of Contents

SPECIAL NOTE REGARDING FORWARD-LOOKING STATEMENTS

This report contains forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended (the Securities Act), and Section 21E of the Securities Exchange Act of 1934, as amended (the Exchange Act). We may, in some cases, use terms such as predicts, believes, potential, proposed, continue, estimates, anticipates, expects, plans, intends, may, could, might, will, should or other words that convey uncer events or outcomes to identify these forward-looking statements.

Forward-looking statements appear in a number of places throughout this report and include statements regarding our intentions, beliefs, projections, outlook, analyses or current expectations concerning, among other things:

- the success, timing and cost of our ongoing and anticipated Phase 3 and Phase 2b clinical trials for our current product candidates, including statements regarding the timing of initiation and completion of the trials;
- our expectations regarding the clinical effectiveness of our product candidates and results of our clinical trials;
- the timing of and our ability to obtain and maintain U.S. Food and Drug Administration (FDA) or other regulatory authority approval of, or other action with respect, to our product candidates;
- our expectations related to the use of proceeds from our initial public offering (IPO);
- our estimates regarding anticipated capital requirements and our needs for additional financing;
- the commercial launch and potential future sales of our current or any other future product candidates;
- our commercialization, marketing and manufacturing capabilities and strategy;
- third-party payor reimbursement for our product candidates;
- the glaucoma patient market size and the rate and degree of market adoption of our product candidates by eye-care professionals and patients;
- the timing, cost or other aspects of the commercial launch of our product candidates;

our plans to pursue development of our product candidates for additional indications and other therapeutic opportunities;

the potential advantages of our product candidates;

our ability to protect our proprietary technology and enforce our intellectual property rights; and

our expectations regarding licensing, acquisitions and strategic operations.

By their nature, forward-looking statements involve risks and uncertainties because they relate to events, competitive dynamics and industry change, and depend on regulatory approvals and economic and other environmental circumstances that may or may not occur in the future or may occur on longer or shorter timelines than anticipated. We discuss many of these risks in greater detail under the heading Risk Factors in Part I, Item 1A of this report and elsewhere in this report. You should not rely upon forward-looking statements as predictions of future events.

Although we believe that we have a reasonable basis for each forward-looking statement contained in this report, we caution you that forward-looking statements are not guarantees of future performance and that our actual results of operations, financial condition and liquidity, and the development of the industry in which we operate may differ materially from the forward-looking statements contained in this report. In addition, even if our results of operations, financial condition and liquidity, and events in the industry in which we operate are consistent with the forward-looking statements contained in this report, they may not be predictive of results or developments in future periods.

Any forward-looking statements that we make in this report speak only as of the date of this report. Except as required by law, we are under no duty to update or revise any of the forward-looking statements, whether as a result of new information, future events or otherwise, after the date of this report.

Table of Contents

PART I

ITEM 1. BUSINESS

Overview

We are a clinical-stage pharmaceutical company focused on the discovery, development and commercialization of first-in-class therapies for the treatment of patients with glaucoma and other diseases of the eye. Our strategy is to advance our product candidates, including triple-action Rhopressa (which we previously referred to as dual-action AR-13324) and quadruple-action Roclatan (which we previously referred to as triple-action PG324), to regulatory approval, and commercialize these products ourselves in the United States. We plan to build a commercial team of approximately 100 sales representatives to target approximately 10,000 high prescribing eye-care professionals throughout the United States. For certain key markets outside the United States, including Europe, Japan and emerging markets, we intend to explore partnership opportunities through collaboration and licensing arrangements. We plan to further maximize our commercial potential by identifying and advancing additional product candidates, both through our internal discovery efforts and through possible in-licensing or acquisitions of additional ophthalmic products or product candidates that would complement our current product portfolio. Our senior leadership team has extensive experience in the ophthalmology market and has overseen the development and commercialization at major pharmaceutical companies of several successful ophthalmic products, including *Acular*, *Alphagan P*, *Bepreve*, *Besivance*, *Bromday*, *Istalol*, *Ocuflox*, *Retisert*, *Vitrase*, *Xibrom* and *Zylet*. If our products are approved and we are commercially successful, we believe Aerie could become a market-leading ophthalmic company.

Our lead product candidate, once-daily, triple-action Rhopressa , completed a Phase 2b clinical trial in patients with open-angle glaucoma and ocular hypertension in May 2013. We are developing Rhopressa as the first of a new class of compounds that is designed to lower intraocular pressure, or IOP, in patients through novel mechanisms of action, or MOAs. We believe that, if approved, Rhopressa will represent the first new MOAs for lowering IOP in patients with glaucoma in over 20 years. Based on clinical data to date, we expect Rhopressa to compete within the prostaglandin analogue, or PGA, market segment due to its equivalent or potentially better efficacy for patients with IOP of 26 millimeters of mercury, or mmHg, or below at the time of diagnosis, which we refer to as low to moderately elevated IOP, while also targeting the diseased tissue responsible for elevated IOP. Approximately 80% of glaucoma patients have low to moderately elevated IOP at the time of diagnosis. Furthermore, we expect Rhopressa to compete against non-PGA products as a preferred add-on therapy to PGAs, due to its strong and consistent IOP-lowering effect with once-daily dosing relative to currently marketed non-PGA products. In addition, we expect Rhopressa to become a preferred therapy where PGAs are contraindicated, for patients who do not respond to PGAs, for patients who have IOPs below 21 mmHg but nevertheless present with glaucomatous damage to the optic nerve, which is commonly referred to as low-tension glaucoma, as well as for patients who choose to avoid the cosmetic issues associated with PGAs. We are currently planning two Phase 3 registration trials for Rhopressa , which we expect to commence in early third quarter 2014 upon completion of Phase 3-enabling toxicology studies.

We are also developing a second product candidate, once-daily, quadruple-action Roclatan , which is a single drop fixed-dose combination of Rhopressa and latanoprost, the most commonly prescribed drug for the treatment of patients with glaucoma. Based on our preclinical data to date, we believe Roclatan has the potential to provide a greater IOP-lowering effect than any currently approved glaucoma product. Therefore, we believe Roclatan could compete with both PGA and non-PGA therapies and become the product of choice for patients requiring maximal IOP lowering. In January 2014, we commenced a 28-day Phase 2b clinical trial for Roclatan , for which we expect results in early third quarter 2014.

1

Table of Contents

Glaucoma is one of the largest segments in the global ophthalmic market. In 2013, branded and generic glaucoma product sales exceeded $4.5 billion in the United States, Europe and Japan in aggregate, according to IMS. Prescription volume for glaucoma products in the United States alone exceeded 31 million in 2013 and is expected to grow, driven in large part by the aging population. The PGA and non-PGA market segments each represent approximately half of the prescription volume in the glaucoma market, as shown in the following pie chart, which is based on IMS data.

According to the National Eye Institute, it is estimated that over 2.7 million people in the United States suffer from glaucoma, a number that is expected to reach 4.3 million by 2030. Furthermore, The Eye Diseases Prevalence Research Group has estimated that only half of the nation s glaucoma sufferers know that they have the disease. Glaucoma is a progressive and highly individualized disease, in which elevated levels of IOP are associated with damage to the optic nerve, which results in irreversible vision loss and potentially blindness. Patients may suffer the adverse effects of glaucoma across a wide range of IOP levels, including at normotensive levels between 10 and 21 mmHg, generally accepted as the range of IOP levels in healthy individuals. There are multiple factors that can contribute to an individual getting glaucoma, including age, family history and ethnicity. For example, there generally is a higher incidence and severity of the disease in African-American and Hispanic populations. Based on data from the Baltimore Eye Survey, approximately 80% of glaucoma patients have low to moderately elevated IOP at the time of diagnosis and approximately 60% of glaucoma patients have IOP of 21 mmHg or below at the time of diagnosis. Additionally, in Japan, the Tajimi Study found that approximately 90% of glaucoma patients had IOP of 21 mmHg or below at the time of diagnosis.

Glaucoma is treated by the reduction of IOP, which has been shown to slow the progression of vision loss. In a healthy eye, fluid is continuously produced and drained in order to maintain pressure equilibrium and provide nutrients to the eye tissue. The FDA recognizes sustained lowering of IOP as the primary clinical endpoint for the approval of drugs to treat patients with glaucoma and ocular hypertension. The primary drainage mechanism of the eye is the trabecular meshwork, or TM, which accounts for approximately 80% of fluid drainage, while the secondary drainage mechanism, the uveoscleral pathway, is responsible for the remaining drainage. In glaucoma

Table of Contents

patients, damage to the TM results in insufficient drainage of fluid from the eye, which causes increased IOP and damage to the optic nerve. In addition to eye fluid production and drainage through the TM and uveoscleral pathway, episcleral venous pressure, or EVP, makes a significant contribution to IOP. EVP represents the pressure of the blood in the episcleral veins of the eye where the eye fluid drains into the bloodstream. Historical studies have shown that EVP accounts for approximately half of IOP in normotensive subjects and approximately one-third of IOP in patients with pressures of 24 to 30 mmHg. When EVP is lowered, fluid is able to flow more freely from the eye. Drugs that lower IOP without lowering EVP are most effective at high IOPs, where EVP is believed to contribute less to IOP, and are less effective at lower IOPs, where EVP is seen to account for a larger portion of IOP.

Once glaucoma develops, it is a chronic condition that requires life-long treatment. The initial treatment for glaucoma patients is typically the use of prescription eye drops. PGAs have become the most widely prescribed glaucoma drug class. The most frequently prescribed PGA is once-daily latanoprost. The most commonly prescribed non-PGA drugs belong to the beta blocker class. The most frequently prescribed beta blocker is twice-daily timolol. Other non-PGA drug classes include the alpha agonists and carbonic anhydrase inhibitors. When PGA monotherapy is insufficient to control IOP or contraindicated due to concerns about side effects, non-PGA products are used either as add-on therapy to the PGA or as an alternative monotherapy. It is estimated that up to 50% of glaucoma patients receiving PGA monotherapy require add-on therapy within two years of initial prescription of the drug, in order to maintain adequate control of IOP.

Our product candidates represent a new class of drugs utilizing novel MOAs that are applied topically as once-daily eye drops. Currently approved drugs mainly reduce IOP by increasing fluid outflow through the eye s secondary drain with once-daily dosing or reducing fluid inflow by decreasing fluid production with multiple doses per day. Rhopressa lowers IOP through a triple MOA that (i) relaxes the contracted tissue of the TM to improve fluid outflow through the eye s primary drain, (ii) decreases fluid production in the eye and (iii) also lowers EVP, an MOA that we believe further differentiates Rhopressa from currently marketed glaucoma products. Roclatan , our quadruple-action fixed-combination product candidate, combines the triple MOA of Rhopressa with latanoprost, a PGA that increases fluid drainage through the uveoscleral pathway. In addition to our primary product candidates, we are in preclinical development with AR-13533, our second-generation ROCK/NET inhibitor.

We believe there are significant unmet needs in the glaucoma market and that eye-care professionals are eager for new therapy choices. None of the commonly prescribed PGAs or non-PGAs target the TM, the diseased tissue responsible for elevated IOP in glaucoma and the eye s primary drain. Moreover, PGAs have side effects, contraindications and reduced efficacy in patients with low to moderately elevated IOPs relative to patients with higher IOPs. Non-PGAs are less efficacious than PGAs, have more serious and a greater number of side effects and contraindications, and require multiple daily dosings. As a result, we believe there is a significant unmet need in both the PGA and non-PGA market segments, each of which represents approximately half of the U.S. and European glaucoma market based on prescription volumes. Despite the limitations of existing glaucoma drugs, Xalatan (latanoprost), the best-selling PGA, together with Xalacom, its fixed-combination with a beta blocker, which is not available in the United States, generated peak annual global revenues of approximately $1.7 billion prior to the introduction of its generic equivalents, and the most commonly prescribed non-PGA drugs each generated peak annual global revenues of over $400 million prior to the introduction of their generic equivalents.

We believe Rhopressa may be prescribed by eye-care professionals as an initial therapy for patients with low to moderately elevated baseline IOPs of 26 mmHg or below at the time of diagnosis, representing approximately 80% of glaucoma patients. At these IOP levels, we believe the amount of IOP reduction achieved by Rhopressa would be equal to or exceed that of all currently marketed PGA and non-PGA products. In addition, Rhopressa targets the TM, the diseased tissue responsible for elevated IOP in glaucoma and the eye s primary drain, whereas commonly prescribed PGAs and non-PGAs target the secondary drain and the fluid production in the eye, respectively.

Table of Contents

In addition to the expected primary use of Rhopressa as an initial therapy for patients with low to moderately elevated baseline IOPs described above, we also believe Rhopressa may be prescribed by eye-care professionals in the following circumstances:

- As an add-on drug of choice for patients taking PGAs, due to the MOAs of Rhopressa being complementary to the MOA of PGAs, and due to the strong efficacy, more convenient dosing and better tolerability profile of Rhopressa compared to currently marketed non-PGA add-on products. It is estimated that up to 50% of glaucoma patients receiving PGA monotherapy require add-on therapy within two years of initial prescription of the PGA in order to maintain control of IOP.

- As a preferred alternative therapy for patients who do not respond to PGAs.

- As a preferred initial therapy for patients with low-tension glaucoma.

- As a preferred initial therapy where PGAs are contraindicated and for patients who choose to avoid the cosmetic issues associated with PGAs, including iris color change in light-eyed patients, discoloration of tissue surrounding the eyes and eyelid droopiness and sunken eyes caused by loss of orbital fat.

In addition, based on our preclinical data to date, we believe that quadruple-action Roclatan would be the only glaucoma product that covers the full spectrum of currently known IOP-lowering MOAs, giving it the potential to provide a greater IOP-lowering effect than any currently approved glaucoma product. Therefore, we believe Roclatan could compete with both PGA and non-PGA therapies for patients requiring maximal IOP lowering, including those with IOPs above 26 mmHg and those who present with significant disease progression despite currently available therapies.

We own the worldwide rights to all indications for our current product candidates. We currently plan to commercialize our products ourselves in the United States and to explore partnership opportunities through collaboration and licensing arrangements in certain key markets outside of the United States, including Europe, Japan and emerging markets. In Japan specifically, the Tajimi study found that 90% of glaucoma patients had IOP of 21 mmHg or below at the time of diagnosis, which we believe creates a significant market opportunity in Japan for Rhopressa due to its differentiated ability to reduce IOP at consistent levels across all tested baseline IOPs, as demonstrated in our Phase 2b clinical trial.

Our intellectual property portfolio contains patents and pending patent applications related to composition of matter, pharmaceutical compositions and methods of use for our product candidates. We have patent protection for our primary product candidates, Rhopressa and Roclatan , in the United States through at least 2030.

Our Product Pipeline

Our primary product candidates, triple-action Rhopressa and quadruple-action Roclatan , are once-daily eye drops. Rhopressa inhibits Rho Kinase, or ROCK, and the norepinephrine transporter, or NET, which are both novel biochemical targets for lowering IOP. By inhibiting these targets, we believe Rhopressa reduces IOP via three separate MOAs: (i) through ROCK inhibition, it increases fluid outflow through the TM, which accounts for approximately 80% of fluid drainage from the eye; (ii) also through ROCK inhibition, as demonstrated in a recent

preclinical study, it reduces EVP, which represents the pressure of the blood in the episcleral veins of the eye where eye fluid drains into the bloodstream; and (iii) through NET inhibition, it reduces the production of eye fluid. Roclatan , a single-drop fixed-dose combination of Rhopressa and latanoprost, lowers IOP through the same three MOAs as Rhopressa and, as a fourth MOA, through the ability of latanoprost to increase fluid outflow through the uveoscleral pathway, the eye s secondary drain.

We discovered and developed our product candidates internally through a rational drug design approach that coupled medicinal chemistry with high content screening of compounds in proprietary cell-based assays. We selected and formulated our product candidates for preclinical *in vivo* testing following a detailed characterization of over 1,500 synthesized ROCK-selective and ROCK/NET inhibitors. We continue to seek to

Table of Contents

discover and develop new compounds in our research laboratories and employ a scientific staff with expertise in medicinal chemistry, analytical chemistry, biochemistry, cell biology, pharmacology and pharmaceutical science.

The following table summarizes each of our existing product candidates, their MOAs and their development status, as well as our intellectual property rights for these product candidates.

Product Candidate and Mechanism		Phase of Development	Intellectual Property Rights
Rhopressa	Triple-action ROCK/NET inhibition	Phase 3 registration trials expected to begin early third quarter 2014	Wholly-Owned
Roclatan	Quadruple-action Combination of triple-action Rhopressa and latanoprost, a PGA	Phase 2b clinical trial initiated January 2014	Wholly-Owned
AR-13533	Second-generation ROCK/NET inhibitor	Preclinical	Wholly-Owned

Triple-Action Rhopressa™

Rhopressa is the first of a new class of glaucoma drug products that was discovered by our scientists. It is a once-daily eye drop designed to reduce IOP in patients with glaucoma or ocular hypertension. It increases fluid outflow through the primary drain of the eye while also reducing eye fluid production. In addition, a recent preclinical study demonstrated reduction of EVP as an additional MOA of Rhopressa , as further described below. The active ingredient in Rhopressa , AR-13324, acts through the inhibition of both ROCK and NET.

ROCK is a protein kinase, which is an enzyme that modifies other proteins by chemically adding phosphate groups to them. Specifically, ROCK regulates actin and myosin, which are proteins that are responsible for cellular contraction. ROCK activity also promotes the production of extracellular matrix proteins. ROCK inhibitors block TM cell contraction and reduce the production of extracellular matrix, thereby improving fluid outflow and consequently decreasing IOP. In addition, we believe ROCK inhibition may also be responsible for reduction of EVP. EVP represents the pressure of the blood in the episcleral veins of the eye, where eye fluid drains into the bloodstream. When EVP is lowered, the fluid is able to flow more freely from the eye.

NET is a protein that transports norepinephrine across neuronal cell membranes. Norepinephrine is a chemical released by neurons to communicate with targeted cells. NET returns excess norepinephrine back into the neuron, which helps end the signaling between the neuron and the neuron s target cells. We believe the inhibition of NET prolongs the activation of target cells in the ciliary body of the eye, which reduces the production of eye fluid and thereby lowers IOP.

In addition to its triple MOA, Rhopressa has a number of characteristics that distinguish it from our previously developed product candidates, including ROCK-selective drug AR-12286 and its fixed-dose combination product PG286, and other clinical-stage ROCK inhibitors, which together we refer to as comparator ROCK inhibitors. The active ingredient in Rhopressa , AR-13324, has a unique chemical composition that was specifically designed to allow maximal efficacy of the drug in the eye. Enzymatic conversion of AR-13324 produces two separate molecules, one of which is approximately ten to 160 times more potent at inhibiting ROCK than comparator ROCK inhibitors. This

contributes to greater efficacy and longer duration of effect of AR-13324 relative to comparator ROCK inhibitors that we observed in preclinical models. In addition, AR-13324 has inhibitory activity against a secondary kinase target, Protein Kinase C, or PKC, which is known to act in parallel with ROCK to promote cell contraction. Compounds that inhibit ROCK without inhibiting PKC may allow PKC activity to increase in TM cells over time, resulting in a loss of IOP-lowering efficacy. We believe the ability of

Table of Contents

AR-13324 to inhibit both the primary, ROCK, and secondary, PKC, signaling pathways that lead to TM cell contraction contributes to the ability of Rhopressa to maintain its efficacy over time.

Rhopressa is expected to compete against all products in the glaucoma market, the significant majority of which have been in the market for over 20 years. The PGA and non-PGA market segments each represents approximately half of the U.S. and European glaucoma market based on prescription volumes. Despite the limitations of existing glaucoma drugs, Xalatan (latanoprost), the best-selling PGA, together with Xalacom, its fixed-combination with a beta blocker, which is not available in the United States, generated peak annual global revenues of approximately $1.7 billion prior to the introduction of its generic equivalents, and the most commonly prescribed non-PGA drugs each generated peak annual global revenues of over $400 million prior to the introduction of their generic equivalents. We believe there is a significant unmet need across the glaucoma market due to many drugs requiring multiple daily dosings, side effects and contraindications of other products, and the fact that none of the commonly prescribed drugs target the diseased TM tissue. We believe that triple-action Rhopressa has several significant differentiating characteristics that would make it a strong competitor in both the PGA and non-PGA market segments, if approved, including:

Strong IOP-Lowering Effect In our Phase 2b clinical trial, once-daily Rhopressa demonstrated mean IOP reductions of 5.7 and 6.2 mmHg on days 28 and 14, respectively. Studies have shown that a sustained 5 mmHg reduction in IOP reduces risk of disease progression by approximately 50%. If the results from our Phase 2b trial are confirmed in our planned Phase 3 registration trials, we believe the level of IOP reduction achieved by Rhopressa would be equal to or exceed that of all currently marketed non-PGA products and, in addition, for patients with low to moderately elevated IOPs at the time of diagnosis, representing approximately 80% of glaucoma patients, would be equal to or potentially exceed that of all currently marketed PGA products.

Consistent IOP-Lowering Effect Across Various Baseline IOPs Published studies have indicated that currently marketed PGA and non-PGA products do not lower IOP as effectively in patients with low to moderately elevated baseline IOPs relative to patients with higher IOPs. In our Phase 2b clinical trial, Rhopressa demonstrated a differentiated ability to reduce IOP at consistent levels across all baseline IOPs tested in the trial. The results of a preclinical *in vivo* study sponsored by Aerie and reported in February 2014 suggest that this differentiated effect may be attributable to the ability of Rhopressa to lower EVP.

Novel Triple-Action MOA We believe Rhopressa works through three MOAs: increasing outflow through the TM, decreasing fluid production in the eye and reducing EVP. If approved, we believe Rhopressa would be the only once-daily drug available that works through these three MOAs. In addition, we believe the three MOAs of Rhopressa are highly complementary to the MOA of market-leading PGAs, which increase fluid outflow through the uveoscleral pathway.

Once-Daily Dosing Advantage The most commonly prescribed non-PGA drugs are dosed two to three times daily, which places a considerable daily burden on patients, who are generally required to use these drugs for the remainder of their lives. Rhopressa is being developed as a once-daily dosed glaucoma therapy. This more convenient dosing regimen is expected to result in higher patient compliance, which may lead to improved outcomes.

Favorable Tolerability Profile Currently marketed glaucoma drugs have several tolerability issues indicated on their product labels, including ocular allergic reaction, itching of the eye, iris color change, orbital tissue discoloration, unusual taste and hyperemia. In our Phase 2a and Phase 2b clinical trials for Rhopressa , a total of 209 patients were exposed to Rhopressa . The main tolerability finding for Rhopressa was transient, or temporary, hyperemia, which is a cosmetic asymptomatic redness of the eye. Most of the hyperemia was scored as mild as evaluated by the eye-care professionals in the morning following instillation of the drop the previous night. Hyperemia is a common tolerability finding also associated with PGAs.

Table of Contents

Lack of Systemic Side Effects Rhopressa has demonstrated a lack of systemic side effects in clinical trials to date, including our Phase 1 pharmacokinetic, or PK, study, the results of which were reported in January 2014. Currently marketed non-PGA drugs have systemic side effect issues indicated on their product labels, including among others, lethargy, reduced heart rate, Stevens Johnson syndrome and blood dyscrasias. Furthermore, the most widely prescribed non-PGA drug, timolol, has contraindications that include bronchospasm, arrhythmia and heart failure.

Based on the Phase 2b clinical trial results, and the several positive differentiating attributes of Rhopressa , we believe Rhopressa has the potential to be a strong competitor across the glaucoma market. Our Phase 3 registration trials are designed to use timolol as the comparator, as timolol represents the most widely used comparator in registration trials in glaucoma, and is also the most widely prescribed non-PGA drug.

Rhopressa™ Phase 2 Efficacy Results

In May 2013, we completed a 28-day Rhopressa Phase 2b clinical trial. This trial included 224 patients who were treated once daily with Rhopressa 0.01%, Rhopressa 0.02% or latanoprost. Latanoprost was used as the comparator because it is the most widely prescribed drug of all currently marketed glaucoma products. The primary efficacy endpoint for this Phase 2b clinical trial was mean diurnal IOP across subjects within each treatment group on day 28. We observed statistically significant decreases in mean diurnal IOP in all treatment groups on day 28 as compared to unmedicated baseline.

Baseline IOP was measured prior to treatment. Following treatment, IOP was measured on day seven at 8 a.m. and on days 14 and 28 at 8 a.m., 10 a.m. and 4 p.m. On day 14, mean diurnal IOP (which refers to the average of mean IOPs measured at 8 a.m., 10 a.m. and 4 p.m.) decreased to 19.8, 19.5 and 18.4 mmHg in the Rhopressa 0.01%, Rhopressa 0.02% and latanoprost groups, respectively, representing a decrease from unmedicated baseline of 5.9, 6.2 and 7.1 mmHg. On day 28, mean diurnal IOP was 20.1, 20.0 and 18.7 mmHg, respectively, representing a decrease from unmedicated baseline of 5.5, 5.7 and 6.8 mmHg. These decreases from unmedicated baseline were statistically significant with p-values < 0.001. P-value, or probability value, is a statistical measure that helps scientists determine if their hypotheses are correct. It is directly related to the statistical significance level of the results, which is an important component in determining whether the data obtained from scientific research support the hypothesis being tested.

The statistical significance level is determined by the researcher and is customarily set at 0.05, or 5%. Essentially, this means that 5% of the time, the results in the study would be derived by complete chance, but 95% of the time, the variable in the study would be directly related to the results of the study. Efficacy results from the Phase 2b trial are further described below.

Table of Contents

Efficacy Results of the 28-day Phase 2b Clinical Trial Comparing Rhopressa™ to Latanoprost

Showing Mean Diurnal IOP for Days 14 and 28 Compared to Baseline

Rhopressa maintained consistent efficacy from day seven to day 28. For Rhopressa 0.02%, which is the concentration we intend to use in our planned Phase 3 trials, at the 8 a.m. time point, the time of highest baseline IOP, the IOP reductions achieved on day seven and day 28 were 6.0 and 5.9 mmHg, respectively. The level of IOP reduction achieved by Rhopressa 0.02% in our Phase 2b study was clinically significant, since previously published long-term studies have demonstrated that a sustained 5 mmHg reduction in IOP reduces the risk of disease progression by approximately 50%.

Clinical significance means that the effect is large enough to be important to patients and physicians. An effect that is statistically significant may or may not also be clinically significant. In glaucoma, the Early Manifest Glaucoma Trial, a large long-term study evaluating the effect of IOP lowering in patients with glaucoma, concluded that each 1 mmHg reduction in IOP lowered the risk of progression of optic nerve damage by 10%, indicating that each 1 mmHg reduction in IOP provides a meaningful level of protection to the patient.

IOP-Lowering Effect of Rhopressa™ 0.02% at 8 a.m. on Days 7, 14 and 28

In the full Phase 2b trial population, which consisted of patients with unmedicated baseline IOPs ranging from 22 to 36 mmHg, the IOP-lowering effect of our once-daily Rhopressa 0.02% was 1.2 mmHg less than that of latanoprost on day 28 and did not show non-inferiority. However, Rhopressa 0.02% efficacy relative to

Table of Contents

latanoprost was in line with published historical data for twice-daily timolol relative to latanoprost. Timolol is the most commonly prescribed non-PGA drug and the comparator for our planned Phase 3 non-inferiority registration trials.

A study by Hedman and Alm, which reports on the pooled data from three registration trials of latanoprost versus timolol, showed the IOP-lowering effect of timolol to be 1.2 mmHg less than that of latanoprost, as reflected in the graph on the following page under the heading Comparison of Latanoprost and Timolol from Pooled Data of Three Registration Trials. Our Rhopressa Phase 2b clinical trials similarly showed Rhopressa to have an IOP-lowering effect of 1.2 mmHg less than that of latanoprost.

An additional protocol-specified analysis that compared the results for the patients who entered the trial with moderately elevated baseline IOPs (22 to 26 mmHg) to patients with highly elevated baseline IOPs (greater than 26 mmHg) revealed a differentiated efficacy profile of Rhopressa compared to latanoprost. Consistent with previous scientific literature, latanoprost produced smaller IOP reductions in patients with moderately elevated IOPs than in patients with highly elevated IOPs. In contrast, Rhopressa maintained essentially the same IOP-lowering effect in patients with moderately elevated IOPs as in patients with highly elevated IOPs ($p>0.30$). As a result, the IOP-lowering effect of Rhopressa was equivalent to latanoprost in patients with moderately elevated baseline IOPs and Rhopressa thereby demonstrated statistical non-inferiority to latanoprost in this sub-group. A non-inferiority trial is a type of clinical trial performed to see if a new drug or treatment is *not inferior* to a current active treatment or to determine if a new treatment is *at least as good as,* or *not unacceptably worse than*, the active comparator treatment. A non-inferiority trial aims at demonstrating that the test product is not worse than the comparator by more than a small pre-specified amount. This amount is known as the non-inferiority margin, which for the Rhopressa Phase 2b trial was 1.5 mmHg.

IOP-Lowering Effect of Rhopressa™ 0.02% and Latanoprost in the Full Patient Population

Compared to the Subgroup with Moderately Elevated IOP*

* Based on diurnal measurements.

A study published in 2000, which pooled data from three latanoprost registration trials, demonstrated that both latanoprost and timolol lose approximately 0.5 mmHg in efficacy for every 1 mmHg lower baseline IOP, as illustrated in the chart below. Additional publications have indicated similar declining efficacy results for other currently marketed non-PGA glaucoma drugs, including the alpha agonist brimonidine and the carbonic anhydrase inhibitor dorzolamide.

Table of Contents

Comparison of Latanoprost and Timolol from Pooled Data of Three Registration Trials

Source: Hedman and Alm (Eur J Ophthalmol 2000; 10:95-104)

We believe the ability of Rhopressa to maintain a consistent IOP-lowering effect on baseline IOP will place Rhopressa in a favorable competitive position relative to current PGA and non-PGA products because a significant majority of glaucoma patients have baseline IOPs of 26 mmHg or below at the time of diagnosis. Results from a large epidemiological survey published in 1991, the Baltimore Eye Survey, demonstrated that greater than 78% of patients have unmedicated baseline IOPs of 26 mmHg or below when first diagnosed with glaucoma.

Prevalence of Glaucoma by Baseline IOP at the Time of Diagnosis

Adapted from Baltimore Eye Survey in which 10,444 subjects were screened for the prevalence of Open-Angle Glaucoma (OAG)

Table of Contents

Furthermore, in the Tajimi Study carried out in Japan in 2000 and 2001, 92% of patients with primary open-angle glaucoma were found to have IOPs of 21 mmHg or less at the time of diagnosis. In this study, 3,870 randomly selected residents of the city of Tajimi were screened for primary open-angle glaucoma.

Rhopressa™ Phase 2a Efficacy Results

In August 2012, we completed a 7-day Rhopressa Phase 2a clinical trial. This trial included 85 patients who were treated once-daily with Rhopressa 0.01%, Rhopressa 0.02%, Rhopressa 0.04% or the vehicle of Rhopressa . Vehicle refers to the formulation without the active ingredient. Baseline IOP was measured prior to treatment. IOP was measured following seven days of dosing at 8 a.m., 10 a.m., 12 p.m. and 4 p.m. The primary efficacy endpoint for this Phase 2a clinical trial was the mean diurnal IOP (which refers to the average of mean IOPs measured at 8 a.m., 10 a.m., 12 p.m. and 4 p.m.) across subjects within each treatment group on day eight. We observed statistically significant decreases in mean diurnal IOP in all Rhopressa treatment groups following seven days of dosing compared to unmedicated baseline. Additionally, each concentration of Rhopressa was shown to be statistically superior to the vehicle following seven days of dosing with p-values ranging from 0.018 to <0.001.

Rhopressa™ Phase 2 Safety Data

In our 7-day Phase 2a and 28-day Phase 2b clinical trials for Rhopressa a total of 209 patients were exposed to Rhopressa . In these trials, Rhopressa was well tolerated. The main adverse event was transient hyperemia, or asymptomatic redness of the eye, with all hyperemia scored as mild or moderate. This cosmetic tolerability finding is based on the MOA of the drug, which induces a transient dilation of small blood vessels located over the sclera, or white part of the eye.

The biomicroscopy findings in the Phase 2b trial for the vast majority of patients who experienced ocular hyperemia were mild and transient, and there were no observations of severe ocular hyperemia. Biomicroscopy refers to the observation by a masked examiner of the anterior part of the eye. On day 28 at 8 a.m., mild and moderate conjunctival hyperemia was observed in 18% and 24% of patients in the Rhopressa 0.01% and 0.02% treatment groups, respectively, and in 11% of patients in the latanoprost group. The incidence of conjunctival hyperemia decreased throughout the study for Rhopressa and increased for latanoprost.

Published data indicate that latanoprost generates the lowest rate of hyperemia among the commonly prescribed PGAs. In a study that compared the relative frequency of hyperemia for bimatoprost, travaprost and latanoprost after 12 weeks of treatment, the largest proportion of patients reporting redness was found in the bimatoprost group with 35%, followed by the travoprost and latanoprost groups with 27% and 16%, respectively.

Table of Contents

Rhopressa™ Comparison to AR-12286

We have analyzed our clinical and preclinical data for Rhopressa , the lead candidate from our ROCK/NET inhibitor class, relative to our clinical and preclinical data for AR-12286, our ROCK-selective compound that we were previously evaluating for further clinical development in addition to Rhopressa . We conducted similarly designed 28-day Phase 2 clinical trials for each of Rhopressa and AR-12286, the comparative results of which are presented in the chart below. Rhopressa 0.02% maintained stable efficacy on day 28 relative to day seven in its 28-day Phase 2 clinical trial. In contrast, AR-12286 0.5% lost 1.4 mmHg of IOP-lowering efficacy from day seven to day 28 in its 28-day Phase 2 clinical trial.

IOP-Lowering Effect of Rhopressa™ and AR-12286

at 8 a.m. on Days 7, 14 and 28

We subsequently completed a three-month Phase 2 clinical trial for AR-12286, for which data were available in June 2013. This trial confirmed the trend observed in the 28-day trial discussed above. In the three-month trial, the efficacy of AR-12286 continued to decline over the trial period such that it failed to meet its primary efficacy endpoint, non-inferiority to timolol.

Our lead product candidate, Rhopressa , has a number of characteristics that distinguish it from AR-12286. Rhopressa lowers IOP by inhibiting both ROCK and NET, whereas AR-12286 inhibits only ROCK. In addition, the active ingredient in Rhopressa , AR-13324, has a unique chemical composition that was specifically designed to allow maximal efficacy of the drug in the eye. Enzymatic conversion of AR-13324 produces two separate molecules, one of which is approximately ten times more potent at inhibiting ROCK than AR-12286. The more potent ROCK inhibition provided by Rhopressa , as well as its ability to inhibit NET, contributes to its greater efficacy and longer duration of effect relative to AR-12286.

In addition, the analyses of our data suggest that there is a secondary signaling pathway that is activated by a protein called PKC that also leads to contraction of the TM. Our preclinical analyses show that AR-13324 is a potent inhibitor of both ROCK and PKC, whereas AR-12286 is a potent inhibitor of ROCK but not of PKC. We believe that the ability of AR-13324 to inhibit both the primary, ROCK, and the secondary, PKC, signaling pathways that lead to TM cell contraction contributes to the ability of Rhopressa to maintain its efficacy over time.

Furthermore, in a six-month toxicology study with exaggerated dosing of AR-12286, lens opacities, otherwise known as cataracts, were observed in rabbit eyes beginning at three months. In a similar six-month toxicology study with exaggerated dosing of Rhopressa , no adverse lens effects were observed.

Table of Contents

As a result of these observations, in June 2013, we selected Rhopressa for advancement to Phase 3 clinical development and discontinued development of AR-12286 and its related fixed-dose combination product PG286.

Rhopressa™ Phase 1 Pharmacokinetic Study Results

In January 2014, we reported top-line results from our recently completed Phase 1 PK study, in which Rhopressa eye drops were administered once daily to 18 healthy individuals over an eight-day period to assess systemic exposure to the drug. In addition, the drug s effect on IOP was measured. All study subjects had normotensive IOPs in the range of 12 to 21 mmHg, with an average diurnal IOP for the group of approximately 16 mmHg prior to dosing. The PK study demonstrated very low systemic exposure to Rhopressa , with blood levels at or below the limit of detection of 0.1 ng/mL at all time points, and no drug-related effects on systemic safety parameters such as blood pressure and heart rate. Of particular importance to the product s efficacy profile, the subjects average diurnal IOP decreased by approximately 5 mmHg, or more than 30%, to approximately 11 mmHg after the eight days of dosing. The completion of the PK study is an important step in preparing for our two planned Phase 3 registration trials of Rhopressa , which are expected to begin in early third quarter 2014.

Rhopressa™ Preclinical in Vivo Study Results

We believe that the strong IOP-lowering effect of Rhopressa at lower baseline IOPs, and its consistent IOP-lowering effect across all tested baseline IOPs, are due in part to the ability of Rhopressa to lower EVP, which accounts for approximately half of IOP in normotensive individuals. This is an MOA that we believe further differentiates Rhopressa from currently marketed PGA and non-PGA products. The EVP-lowering effect of Rhopressa was demonstrated in a preclinical *in vivo* rabbit study sponsored by Aerie, the results of which we reported in February 2014. In this study, Rhopressa demonstrated statistically significant reductions in EVP and IOP following the third daily dose. EVP decreased by 35% relative to baseline, and IOP was reduced by 39%. Based on these study results, it was estimated that up to 42% of the reduction in IOP caused by Rhopressa was due to the reduction in EVP.

Rhopressa™ Development Strategy

Registration trials for Rhopressa are expected to begin in early third quarter 2014 upon completion of three-month interim study reports from our six-month and nine-month Phase 3-enabling ocular toxicology studies. The Rhopressa doses and dosing frequencies being tested in these studies have previously been shown to be well tolerated in 28-day and six-month ocular toxicology studies. We plan to run two pivotal trials that will include at least 1,200 patients in total. The entry criteria for our Phase 3 trials are planned to include a minimum IOP of 21 mmHg and a maximum of 26 mmHg. Based on discussions with the FDA, we believe that the planned entry criteria for our Phase 3 trials are acceptable to the FDA and will not impact the product label. The entry criteria for our Phase 2 trials were 22 to 36 mmHg. Lowering the IOP entry criteria for our Phase 3 trials will increase the representation of patients with moderately elevated IOPs in the trials and thereby provide a more representative cross-section of the glaucoma patient population. The registration trials will be non-inferiority trials comparing Rhopressa 0.02% taken once daily in the evening to twice-daily timolol, the standard comparator for glaucoma registration trials and also the most widely prescribed non-PGA glaucoma drug. Phase 3 efficacy results will be determined after three months of treatment and safety results will be analyzed and submitted following 12 months of treatment. Assuming we commence the Phase 3 trials in early third quarter 2014 and fully enroll the trials within our anticipated timeframe, we would expect efficacy data from the two trials in mid-2015 and, if the results of the Phase 3 trials are positive, that we would make a new drug application, or an NDA, filing by mid-2016. We intend to explore the potential for priority review with the FDA, although there can be no assurance that such priority review will be granted by the FDA.

13

Table of Contents

Quadruple-Action Roclatan™

Our once-daily, quadruple-action product candidate Roclatan is a combination of our triple-action compound AR-13324, the active ingredient in Rhopressa, formulated with latanoprost in a single eye drop. If approved, we believe that Roclatan would be the first glaucoma product to lower IOP through all currently known MOAs:

- increasing fluid outflow through the TM, the eye s primary drain,
- reducing fluid production in the eye,
- reducing EVP, and
- through the MOA of latanoprost, increasing fluid outflow through the uveoscleral pathway, the eye s secondary drain.

Quadruple-action Roclatan has been tested in a preclinical primate model to assess its effectiveness at lowering IOP. The graph below presents the data from dosing Roclatan and latanoprost once daily for three days (at hours 0, 24 and 48). The results of the study show that at all time points measured, Roclatan reduced IOP substantially more than latanoprost alone. No IOP measurements were taken on day two of the study between hours 24 and 48.

* SEM refers to Standard Error of the Mean.

In addition, we have established human proof of concept in prior ROCK inhibitor/PGA combination trials with our discontinued PG286 product, which demonstrated significant IOP lowering beyond the PGA alone at 28 days.

We believe Roclatan, if approved, would be the only glaucoma product that covers the full spectrum of currently known IOP-lowering MOAs, giving it the potential to provide a greater IOP-lowering effect than any currently marketed glaucoma product. Therefore, we believe Roclatan could compete with both PGA and non-PGA therapies for patients requiring maximal IOP lowering, including those with IOPs above 26 mmHg and those who present with significant disease progression despite currently available therapies.

Table of Contents

Roclatan™ Development Strategy

In light of the clinical experience with Rhopressa to date and the extensive clinical experience with latanoprost, which has been used in patients for approximately 20 years, we advanced Roclatan directly into a Phase 2b clinical trial in January 2014. Roclatan is covered by the investigational new drug application, or IND, for Rhopressa . We have 28-day toxicology data to support a 28-day clinical trial. The process followed for the Phase 2b clinical trial is consistent with normal FDA guidelines, including the submission of the protocol to the FDA. The trial is a randomized, controlled 28-day trial in approximately 300 patients. The trial is designed to measure the efficacy of two concentrations of Roclatan (with AR-13324 0.01% or 0.02% concentrations) compared to latanoprost and Rhopressa 0.02%, all dosed once daily. The efficacy endpoint is superiority of Roclatan to each of its components. We expect the results of this Phase 2b trial in early third quarter 2014. The Phase 3 registration trial for Roclatan is expected to mirror the Phase 2b trial but with three-month efficacy and a 12-month safety trial, and will only test one concentration of Roclatan .

Second-Generation AR-13533

In addition to our primary product candidates, Rhopressa and Roclatan , we are in the preclinical development stage with AR-13533, our second-generation ROCK/NET inhibitor. AR-13533 does not require enzymatic conversion in the eye to deliver maximal ROCK inhibitor activity, and therefore AR-13533 may provide additional IOP-lowering effect in patients beyond that obtained with Rhopressa . We have not submitted an IND for AR-13533 to the FDA and there can be no assurance that an IND will be submitted.

Our Strategy

Our goal is to be a leader in the discovery, development and commercialization of innovative pharmaceutical products for the treatment of patients with glaucoma and other diseases of the eye. We believe our product candidates have the potential to address many of the unmet medical needs in the glaucoma market. Key elements of our strategy are to:

Advance the development of our product candidates to approval. Based on the results from our Phase 2b clinical trial for triple-action Rhopressa , we plan to proceed into Phase 3 registration trials for this drug in early third quarter 2014. In January 2014, we initiated a Phase 2b clinical trial for Roclatan , our quadruple-action combination of Rhopressa and latanoprost and, over the longer term, we plan to evaluate opportunities associated with preclinical-stage AR-13533, our second-generation ROCK/NET inhibitor.

Establish internal sales capabilities to commercialize our product candidates in the United States. We own worldwide rights to all indications for our product candidates and we plan to retain U.S. commercialization rights. Ultimately, if our product candidates are approved, we plan to build a commercial team of approximately 100 sales representatives. We expect our sales organization to target approximately 10,000 high prescribing eye-care professionals throughout the United States.

Explore partnerships with leading pharmaceutical and biotechnology companies to maximize the value of our product candidates outside the United States. We currently plan to explore the licensing of commercialization rights or other forms of collaboration with qualified potential partners for the commercialization of our product candidates in certain key markets outside of the United States, including Europe, Japan and emerging markets.

Continue to leverage and strengthen our intellectual property portfolio. We believe we have a strong intellectual property position relating to our product candidates. Our intellectual property portfolio contains U.S. patents and pending U.S. and foreign patent applications related to composition of matter, pharmaceutical compositions and

methods of use for our product candidates. We have patent protection for our primary product candidates in the United States through at least 2030.

Table of Contents

Expand our product portfolio through internal discovery efforts and possible in-licensing or acquisitions of additional ophthalmic product candidates or products. We continue to seek to discover and develop new compounds in our research laboratories and employ a scientific staff with expertise in medicinal chemistry, analytical chemistry, biochemistry, cell biology, pharmacology and pharmaceutical science. In addition, we also plan to evaluate the expansion of our product portfolio through in-licensing or acquisitions of additional ophthalmic product candidates or products.

Glaucoma Overview

Glaucoma is generally characterized by relatively high IOP as a result of impaired drainage of fluid, known as aqueous humor, from the eye. The FDA recognizes sustained lowering of IOP, measured in terms of mmHg, as the primary clinical endpoint for regulatory approval, making clinical trials for this indication relatively straight-forward due to easily measured objective parameters.

In a healthy eye, aqueous humor is continuously produced and drained from the eye in order to maintain pressure equilibrium and provide micronutrients to various tissues in the eye. The normal range of IOP is generally between 10 and 21 mmHg. Several studies have demonstrated that the significant majority of glaucoma patients have IOPs below 26 mmHg at the time of diagnosis. An insufficient drainage of fluid can increase IOP above normal levels, which can eventually cause damage to the optic nerve. Once damaged, the optic nerve cannot regenerate and thus, damage to vision is permanent.

The most common form of glaucoma is open-angle glaucoma, which is characterized by abnormally high IOP as a result of impaired drainage of fluid from the eye s primary drain, the TM. Open-angle glaucoma is a progressive disease leading to vision loss and blindness for some patients as a result of irreversible damage to the optic nerve.

Studies of the disease have demonstrated that reducing IOP in patients with glaucoma can help slow or halt further damage to the optic nerve and help preserve vision. Once diagnosed, glaucoma requires life-long treatment to maintain IOP at lower levels based on the individual patient s risk of disease progression. Ophthalmologists will routinely determine a target IOP, which represents the desired IOP level to achieve with glaucoma therapy for an individual patient. Should the disease progress even once the initial target IOP is reached, further lowering of the IOP has been shown to help in preventing additional damage to the optic nerve and further vision loss. This may require lowering IOP until it is in the so-called low normal range of 12 to 14 mmHg to protect the optic nerve from further damage.

There are multiple factors that can contribute to an individual getting open-angle glaucoma, including age, family history and ethnicity. For example, there generally is a higher incidence and severity of the disease in African-American and Hispanic populations.

Some patients with high IOP are diagnosed with a condition known as ocular hypertension. Patients with ocular hypertension have high IOP without the loss of visual fields or observable damage to the optic nerve, and are at an increased risk of developing glaucoma. These patients are commonly treated in the same manner as glaucoma patients.

Table of Contents

The following diagram illustrates how increased IOP eventually leads to increased pressure on the optic nerve, resulting in gradual loss of vision and ultimately visual disability and blindness.

The ciliary body in the eye is the tissue that produces aqueous humor, the production of which is commonly referred to as fluid inflow. The fluid leaves the eye primarily through the TM, the process of which is commonly referred to as fluid outflow. The healthy eye maintains a state of IOP homeostasis through a constant physiological process of aqueous humor production and drainage. The deteriorating function of the TM in glaucoma leads to increased resistance to fluid outflow and higher IOP. There is also a secondary drain for the fluid in the eye known as the uveoscleral pathway, which is typically responsible for approximately 20% of fluid drainage.

In addition to aqueous humor production and drainage through the TM and uveoscleral pathway, EVP plays a significant role in the regulation of IOP. EVP represents the pressure of the blood in the episcleral veins of the eye which are the site of drainage of eye fluid into the bloodstream. Historical studies have shown that EVP accounts for approximately half of IOP in normotensive subjects and approximately one-third of IOP in patients with pressures of 24 to 30 mmHg. When EVP is lowered, aqueous humor is able to flow more freely from the eye.

Patients are diagnosed through measurements of IOP using Goldmann applanation tonometry, the standard device used by clinicians to measure IOP, along with an evaluation of visual fields and observing the appearance of the optic nerve. These tests are routinely carried out by eye-care professionals. The initial treatment for patients diagnosed with open-angle glaucoma or ocular hypertension is typically a PGA eye drop. PGAs are designed to lower IOP by increasing outflow through the eye s secondary fluid drain. An eye-care professional will then measure a patient s response to the drug over the first few months. It has been shown that up to 50% of glaucoma patients require more than one drug to treat their IOP. This may occur as early as three to six months after initiating treatment with a PGA. The eye-care professionals may then add a second drug from one of the non-PGA classes, to be used together with the initial drug, or switch to a fixed-combination of two drugs in a single eye drop, or select an alternative single treatment. The reason so many patients eventually need more than one drug is generally considered to be a reflection of the progressive nature of the disease at the TM.

In severe glaucoma cases, patients may need to undergo an invasive surgical procedure. Trabeculectomy is the most common glaucoma-related surgical procedure, also referred to as filtration surgery, in which a piece of tissue in the drainage angle of the eye is removed, creating an opening to the outside of the eye. The opening is partially covered with a scleral flap, the white part of the eye, and the conjunctiva, the thin membrane covering the sclera. This new opening allows fluid to drain out of the eye, bypassing the clogged drainage channels of the TM to maintain a lowered IOP. Devices called shunts are used in glaucoma surgery to divert fluid in a controlled manner from the inside of the eye to the subconjunctival space bypassing the blocked TM. Generally, the shunts reduce IOP to the extent that the use of drops can be reduced, but often not completely eliminated. Many patients continue to require eye drops even following surgery.

Table of Contents

Competition

The pharmaceutical industry is characterized by rapidly advancing technologies, intense competition and a strong emphasis on proprietary products. While we believe that our experience and scientific knowledge provide us with competitive advantages, we face competition from established branded and generic pharmaceutical companies, such as Bausch + Lomb, Inc. (acquired in 2013 by Valeant Pharmaceuticals International, Inc.), Merck & Co., Inc., Novartis International AG, Allergan, Inc., Santen Inc. and smaller biotechnology and pharmaceutical companies as well as from academic institutions, government agencies and private and public research institutions, which may in the future develop products to treat glaucoma. Any product candidates that we successfully develop and commercialize will compete with existing therapies and new therapies that may become available in the future. We believe that the key competitive factors affecting the success of our product candidates, if approved, are likely to be efficacy, safety, convenience, price, tolerability and the availability of reimbursement from government and other third-party payors.

We expect to compete directly against companies producing existing and future glaucoma treatment products. The most commonly approved classes of eye drops to lower IOP in glaucoma are discussed below:

PGA Drug Class

Prostaglandin Analogues (PGAs). Most PGAs are once-daily dosed eye drops generally prescribed as the initial drug to reduce IOP by increasing fluid outflow through the eye s secondary drain. They do not target the diseased tissue, or TM. PGAs represent approximately half of the U.S. and European prescription volume for the treatment of glaucoma.

Xalatan (latanoprost), the best-selling PGA, together with Xalacom, its fixed-combination with a beta blocker, which is not available in the United States, had worldwide peak sales of approximately $1.7 billion before its patent expired in 2012, according to publicly reported sales. The adverse effects of PGAs include hyperemia or eye redness, irreversible change in iris color, discoloration of the skin around the eyes, and droopiness of eyelids caused by the loss of orbital fat. PGAs should be used with caution in patients with a history of intraocular inflammation.

Non-PGA Drug Class

Beta Blockers. Beta blockers, with their MOA designed to inhibit aqueous production, are one of the oldest approved drugs for the lowering of IOP. The most commonly used drug in this class is timolol. Beta blockers are less effective than PGAs in terms of IOP lowering and are typically used twice daily. Beta blockers are the most commonly used non-PGA drug. They are used as an initially prescribed monotherapy and as an adjunct therapy to PGAs when the efficacy of PGAs is insufficient. Beta blocker eye drops have contraindications in their label as a result of systemic exposure from topical application of the eye drops, potentially leading to cardio-pulmonary events such as bronchospasm, arrhythmia and heart failure.

Carbonic Anhydrase Inhibitors. Carbonic anhydrase inhibitors, with their MOA designed to inhibit aqueous production, are less effective than PGAs and are required to be dosed three times daily in order to obtain the desired IOP lowering. In published clinical studies of carbonic anhydrase inhibitors, the most frequently reported adverse events reported were blurred vision and bitter, sour or unusual taste. Carbonic

anhydrase inhibitors are sulfonamides and, as such, systemic exposure increases risk of adverse responses such as Stevens Johnson syndrome and blood dyscrasias.

Alpha Agonists. Alpha agonists, with their MOA designed to inhibit aqueous production plus have an effect on uveoscleral outflow, are less effective than PGAs and need to be dosed three times daily in order to obtain the desired IOP lowering. In clinical studies, the most frequently reported adverse reactions that occurred in individuals receiving brimonidine ophthalmic solution, a commonly

Table of Contents

prescribed alpha agonist, included allergic conjunctivitis, conjunctival hyperemia, eye pruritus, burning sensation, conjunctival folliculosis, hypertension, ocular allergic reaction, oral dryness and visual disturbance.

Despite their modest efficacy, safety and tolerability profiles, the requirement for two to three doses per day, and the fact that they do not target the diseased tissue in glaucoma, the beta blocker, carbonic anhydrase inhibitor and alpha agonist products account for up to half of the total prescription volume for the treatment of glaucoma based on historical prescription patterns, with beta blocker timolol being the most widely prescribed non-PGA drug. This is driven by the PGA products not being sufficiently effective as monotherapy for up to half of all glaucoma patients. Among the non-PGA drug classes, brands such as Allergan s Alphagan / Combigan franchise generated combined global revenues in 2012 of over $420 million, and prior to the introduction of generics, the branded beta blockers and carbonic anhydrase inhibitors generated peak annual product revenues of over $400 million. Despite targeting the secondary drain and not the diseased TM, and despite cosmetic side effects, Xalatan (latanoprost), the best-selling PGA, and Xalacom, its fixed-combination with a beta blocker, which is not available in the United States, generated peak annual global revenues of approximately $1.7 billion prior to the introduction of its generic equivalents. Fixed-combination glaucoma products are currently marketed in the United States, including Cosopt, the combination of a beta blocker with a carbonic anhydrase inhibitor, and Combigan, the combination of a beta blocker with an alpha agonist. In April 2013, Alcon announced FDA approval of Simbrinza, a fixed-dose combination of brinzolamide, a carbonic anhydrase inhibitor, and brimonidine tartrate, an alpha agonist, which requires dosing three times per day. There are no fixed-combinations of PGAs with other glaucoma drugs currently available in the United States.

In addition to demonstrating suboptimal efficacy and safety profiles, many of the older glaucoma drugs are associated with compliance issues. For example, non-compliance can result from the difficulty of administering multiple eye drops in a single day. Challenges such as this are magnified for elderly patients, who constitute a large and growing proportion of the glaucoma population.

Administering multiple eye drops two or three times daily also increases exposure of patients to the preservatives in eye drops. Over time, this increased exposure may lead to damage to the surface of the cornea resulting in discomfort and symptoms of dry eye disease.

New eye drops for the treatment of glaucoma continue to be developed by our competitors. The following table outlines publicly disclosed development programs for the treatment of glaucoma of which we are aware.

Brand	**New PGA***	**Trial Stage**
BOL-303259 (Bausch + Lomb)	NO-donating latanoprost (qd)	Phase 3
DE-117 (Santen)	EP2 agonist (qd)	Phase 2a
ONO-9054 (Ono)	FP/EP3 agonist (qd)	Phase 1
Brand	**New non-PGA***	**Trial Stage**
Rhopressa (Aerie)	ROCK/NET inhibitor (qd)	Phase 2b
K-115 (Kowa)	ROCK inhibitor (bid)	Phase 3 (Japan)
AMA0076 (Amakem)	ROCK inhibitor (bid)	Phase 2a
INO-8875 (Inotek)	Adenosine-A1 agonist (bid)	Phase 2
OPA-6566 (Acucela)	Adenosine-A2a receptor (bid)	Phase 1/2
SYL040012 (Sylentis)	RNAi beta blocker (bid)	Phase 2

* References to qd are to once daily-dosed products, and bid are to twice-daily products.

Many of our competitors have significantly greater financial resources and expertise in research and development, manufacturing, preclinical testing, conducting clinical trials, obtaining regulatory approvals and marketing approved products than we do. In early 2013, Sucampo Pharmaceuticals, Inc. commercially relaunched Rescula, a twice-daily dosed PGA, with the claim that it reduces elevated IOP by increasing the

Table of Contents

outflow of aqueous humor through the TM. In addition, early-stage companies that are also developing glaucoma treatments, such as Inotek Pharmaceuticals, which is developing an adenosine receptor agonist, may prove to be significant competitors. We expect that our competitors will continue to develop new glaucoma treatments, which may include eye drops, oral treatments, surgical procedures, implantable devices or laser treatments. Alternative treatments beyond eye drops continue to develop.

Other early-stage companies may also compete through collaborative arrangements with large and established companies. Mergers and acquisitions in the pharmaceutical and biotechnology industries may result in even more resources being concentrated among a smaller number of our competitors. These competitors also compete with us in recruiting and retaining qualified scientific and management personnel and establishing clinical trial sites and patient registration for clinical trials, as well as in acquiring technologies complementary to, or necessary for, our programs.

Our commercial opportunity could be reduced or eliminated if our competitors develop and commercialize products that are safer, more effective, have fewer adverse effects, are more convenient or are less expensive than any products that we may develop. Our competitors also may obtain FDA or other regulatory approval for their products more rapidly than we may obtain approval for ours. In addition, our ability to compete may be affected because in many cases insurers or other third-party payors encourage the use of generic products. Our industry is highly competitive and is currently dominated by generic drugs, such as latanoprost and timolol, and additional products are expected to become available on a generic basis over the coming years. If any of our product candidates are approved, we expect that they will be priced at a premium over competitive generic products and consistent with other branded glaucoma drugs.

Manufacturing

AR-13324, the active ingredient in Rhopressa , is a small molecule and capable of being manufactured in reliable and reproducible synthetic processes from readily available starting materials. We believe the chemistry used to manufacture AR-13324 and Rhopressa is amenable to scale up and does not require unusual equipment in the manufacturing process. We do not currently operate manufacturing facilities for clinical or commercial production of our product candidates. We currently rely on third-party manufacturers to produce the active pharmaceutical ingredient and final drug product for our clinical trials. We manage such production with all our vendors on a purchase order basis in accordance with applicable master service and supply agreements. We do not have long-term agreements with any of these or any other third-party suppliers. Latanoprost, used in the manufacture of Roclatan , is available in commercial quantities from multiple reputable third-party manufacturers. We intend to procure quantities on a purchase order basis for our clinical and commercial production. If any of our existing third-party suppliers should become unavailable to us for any reason, we believe that there are a number of potential replacements, although we might experience a delay in our ability to obtain alternative suppliers. We also do not have any current contractual relationships for the manufacture of commercial supplies of our product candidates if they are approved. With respect to commercial production of our potential products in the future, we plan on outsourcing production of the active pharmaceutical ingredients and final drug product manufacturing if they are approved for marketing by the applicable regulatory authorities.

We expect to continue to develop drug candidates that can be produced cost-effectively at contract manufacturing facilities. However, should a supplier or manufacturer on which we have relied to produce a product candidate provide us with a faulty product or such product is later recalled, we would likely experience delays and additional costs, each of which could be significant.

Intellectual Property

We have obtained patent protection for our primary product candidates, Rhopressa and Roclatan (patent protection for Roclatan arises from the patent protection we have secured for Rhopressa), in the United States and are seeking patent protection in a number of foreign jurisdictions for these product candidates. We intend to maintain and defend our patent rights to protect our technology, inventions, processes and

Table of Contents

improvements that are commercially important to the development of our business. We cannot be sure that any of our existing patents or patents we obtain in the future will be commercially useful in protecting our technology. We cannot be sure that our patents will issue on any of our pending patent applications or patent applications we file in the future. Our commercial success also depends in part on our non-infringement of the patents or proprietary rights of third parties. For a more comprehensive discussion of the risks related to our intellectual property, see Risk Factors Risks Related to Intellectual Property.

Our intellectual property consists of issued patents, and pending patent applications for compositions of matter and methods of use, for our product candidates and other proprietary technology. For our primary product candidates Rhopressa and Roclatan , we hold U.S. Patent 8,450,344, which is scheduled to expire in 2026, and U.S. Patent 8,394,826, which is scheduled to expire in 2030, each of which has composition of matter and method use of claims for composition of matter. We hold additional patents for other ROCK Inhibitor molecules.

We have established and continue to build proprietary positions for our product candidates and related technology in the United States and other jurisdictions. As of December 31, 2013, we had nine United States or foreign issued patents that cover previously discontinued product candidates and 33 U.S. patent applications or foreign national patent applications that, if patents were to issue based on the existing claims, would cover various aspects of our current and previously discontinued product candidates.

Aerie® is a registered trademark of ours and we have applications pending from the U.S. Patent and Trademark Office, or USPTO, for the registration of our trademarks Rhopressa and Roclatan .

In October 2012, our board of directors authorized the divestiture of certain non-core intellectual property relating to implantable ophthalmic devices for future development by Novaer Holding, Inc., or Novaer, an independent company. In addition, as part of this transaction, we also licensed the non-ophthalmic rights to our intellectual property portfolio to Novaer. See Note 13 to our audited financial statements appearing elsewhere in this report.

On September 6, 2013, we terminated our agreement to exclusively license to Novaer our intellectual property for non-ophthalmic indications. No consideration, or future obligation thereof, was exchanged in connection with this termination. Since September 6, 2013, we own all of the worldwide rights to our current product candidates for all indications, both ophthalmic and non-ophthalmic.

Regulatory Matters

FDA Regulation and Marketing Approval

In the United States, the FDA regulates drugs under the Federal Food, Drug, and Cosmetic Act, or FDCA, and related regulations. Drugs are also subject to other federal, state and local statutes and regulations. Failure to comply with the applicable United States regulatory requirements at any time during the product development process, approval process or after approval may subject an applicant to administrative or judicial sanctions and non-approval of product candidates. These sanctions could include the imposition by the FDA or an Institutional Review Board, or IRB, of a clinical hold on trials, the FDA s refusal to approve pending applications or related supplements, withdrawal of an approval, untitled or warning letters, product recalls, product seizures, total or partial suspension of production or distribution, injunctions, fines, restitution, disgorgement, civil penalties or criminal prosecution. Such actions by government agencies could also require us to expend a large amount of resources to respond to the actions. Any agency or judicial enforcement action could have a material adverse effect on us.

The FDA and comparable regulatory agencies in state and local jurisdictions and in foreign countries impose substantial requirements upon the clinical development, manufacture and marketing of pharmaceutical products.

These agencies and other federal, state and local entities regulate research and development activities and the testing, manufacture, quality control, safety, effectiveness, labeling, packaging, storage, distribution, record

Table of Contents

keeping, approval, post-approval monitoring, advertising, promotion, sampling and import and export of our products. Our drugs must be approved by the FDA through the NDA process before they may be legally marketed in the United States. See The NDA Approval Process below.

The process required by the FDA before drugs may be marketed in the United States generally involves the following:

- completion of non-clinical laboratory tests, animal studies and formulation studies conducted according to Good Laboratory Practices or other applicable regulations;
- submission of an IND, which allows clinical trials to begin unless FDA objects within 30 days;
- adequate and well-controlled human clinical trials to establish the safety and efficacy of the proposed drug for its intended use or uses conducted in accordance with FDA regulations, Good Clinical Practices, or GCP, which are international ethical and scientific quality standards meant to assure the rights, safety and well-being of trial participants are protected and to define the roles of clinical trial sponsors, administrators, and monitors;
- pre-approval inspection of manufacturing facilities and clinical trial sites; and
- FDA approval of an NDA, which must occur before a drug can be marketed or sold.

IND and Clinical Trials

Prior to commencing the first clinical trial, an initial IND, which contains the results of preclinical tests along with other information, such as information about product chemistry, manufacturing and controls and a proposed protocol, must be submitted to the FDA. The IND automatically becomes effective 30 days after receipt by the FDA unless the FDA within the 30-day time period raises concerns or questions about the conduct of the clinical trial. In such a case, the IND sponsor must resolve any outstanding concerns with the FDA before the clinical trial may begin. A separate submission to the existing IND must be made for each successive clinical trial to be conducted during product development. Further, an independent IRB for each site proposing to conduct the clinical trial must review and approve the plan for any clinical trial before it commences at that site. Informed written consent must also be obtained from each trial subject. Regulatory authorities, including the FDA, an IRB, a data safety monitoring board or the sponsor, may suspend or terminate a clinical trial at any time on various grounds, including a finding that the participants are being exposed to an unacceptable health risk or that the clinical trial is not being conducted in accordance with FDA requirements.

For purposes of NDA approval, human clinical trials are typically conducted in sequential phases that may overlap:

- Phase 1 the drug is initially given to healthy human subjects or patients and tested for safety, dosage tolerance, absorption, metabolism, distribution and excretion. These trials may also provide early evidence on effectiveness. During Phase 1 clinical trials, sufficient information about the investigational drug s

pharmacokinetics and pharmacologic effects may be obtained to permit the design of well- controlled and scientifically valid Phase 2 clinical trials.

Phase 2 trials are conducted in a limited number of patients in the target population to identify possible adverse effects and safety risks, to determine the efficacy of the product for specific targeted diseases and to determine dosage tolerance and optimal dosage. Multiple Phase 2 clinical trials may be conducted by the sponsor to obtain information prior to beginning larger and more expensive Phase 3 clinical trials. Throughout this report, we refer to our initial Phase 2 clinical trials as Phase 2a clinical trials and our subsequent Phase 2 clinical trials as Phase 2b clinical trials.

Phase 3 when Phase 2 evaluations demonstrate that a dosage range of the product appears effective and has an acceptable safety profile, and provide sufficient information for the design of Phase 3 registration trials, Phase 3 registration trials are undertaken to provide statistically significant evidence of clinical efficacy and to further test for safety in an expanded patient population at multiple clinical

Table of Contents

trial sites. They are performed after preliminary evidence suggesting effectiveness of the drug has been obtained, and are intended to further evaluate dosage, effectiveness and safety, to establish the overall benefit-risk relationship of the investigational drug and to provide an adequate basis for product labeling and approval by the FDA. In most cases, the FDA requires two adequate and well-controlled Phase 3 clinical trials to demonstrate the efficacy of the drug.

All clinical trials must be conducted in accordance with FDA regulations, GCP requirements and their protocols in order for the data to be considered reliable for regulatory purposes.

An investigational drug product that is a combination of two different drugs in the same dosage form must comply with an additional rule that requires that each component make a contribution to the claimed effects of the drug product. This typically requires larger studies that test the drug against each of its components. In addition, typically, if a drug product is intended to treat a chronic disease, as is the case with our products, safety and efficacy data must be gathered over an extended period of time, which can range from six months to three years or more. Government regulation may delay or prevent marketing of product candidates or new drugs for a considerable period of time and impose costly procedures upon our activities.

Disclosure of Clinical Trial Information

Sponsors of clinical trials of FDA-regulated products, including drugs, are required to register and disclose certain clinical trial information. Information related to the product, patient population, phase of investigation, study sites and investigators, and other aspects of the clinical trial is then made public as part of the registration. Sponsors are also obligated to discuss the results of their clinical trials after completion. Disclosure of the results of these trials can be delayed until the new product or new indication being studied has been approved. Competitors may use this publicly available information to gain knowledge regarding the progress of development programs.

The NDA Approval Process

In order to obtain approval to market a drug in the United States, a marketing application must be submitted to the FDA that provides data establishing to the FDA s satisfaction the safety and effectiveness of the investigational drug for the proposed indication. Each NDA submission requires a substantial user fee payment (currently exceeding $2,100,000 for fiscal year 2014) unless a waiver or exemption applies. The application includes all relevant data available from pertinent non-clinical, preclinical and clinical trials, including negative or ambiguous results as well as positive findings, together with detailed information relating to the product s chemistry, manufacturing, controls and proposed labeling, among other things. Data can come from company-sponsored clinical trials intended to test the safety and effectiveness of a use of a product, or from a number of alternative sources, including studies initiated by investigators that meet GCP requirements.

During the development of a new drug, sponsors are given opportunities to meet with the FDA at certain points. These points may be prior to submission of an IND, at the end of Phase 2, and before an NDA is submitted. Meetings at other times may be requested. These meetings can provide an opportunity for the sponsor to share information about the data gathered to date, for the FDA to provide advice and for the sponsor and the FDA to reach agreement on the next phase of development. Sponsors typically use the end of Phase 2 meetings to discuss their Phase 2 clinical results and present their plans for the pivotal Phase 3 registration trial that they believe will support approval of the new drug.

Concurrent with clinical trials, companies usually complete additional animal safety studies and must also develop additional information about the chemistry and physical characteristics of the drug and finalize a process for manufacturing the product in accordance with current Good Manufacturing Practice, or cGMP, requirements. The manufacturing process must be capable of consistently producing quality batches of the drug candidate and the

manufacturer must develop methods for testing the identity, strength, quality and purity of the final drugs. Additionally, appropriate packaging must be selected and tested and stability studies must be conducted to demonstrate that the drug candidate does not undergo unacceptable deterioration over its shelf-life.

Table of Contents

The results of product development, non-clinical studies and clinical trials, along with descriptions of the manufacturing process, analytical tests conducted on the chemistry of the drug, proposed labeling and other relevant information are submitted to the FDA as part of an NDA requesting approval to market the product. The FDA reviews all NDAs submitted to ensure that they are sufficiently complete for substantive review before it accepts them for filing. It may request additional information rather than accept a NDA for filing. In this event, the NDA must be resubmitted with the additional information. The resubmitted application also is subject to review before the FDA accepts it for filing. The FDA has 60 days from its receipt of an NDA to conduct an initial review 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. If the NDA submission is accepted for filing, the FDA reviews the NDA to determine, among other things, whether the proposed product is safe and effective for its intended use, and whether the product is being manufactured in accordance with cGMP to assure and preserve the product s identity, strength, quality and purity. The FDA has agreed to specific performance goals on the review of NDAs and seeks to review standard NDAs in 12 months from submission of the NDA. The review process may be extended by the FDA for three additional months to consider certain late submitted information or information intended to clarify information already provided in the submission. After the FDA completes its initial review of an NDA, it will communicate to the sponsor that the drug will either be approved, or it will issue a complete response letter to communicate that the NDA will not be approved in its current form and inform the sponsor of changes that must be made or additional clinical, non-clinical or manufacturing data that must be received before the application can be approved, with no implication regarding the ultimate approvability of the application or the timing of any such approval, if ever. If, or when, those deficiencies have been addressed to the FDA s satisfaction in a resubmission of the NDA, the FDA will issue an approval letter. FDA has committed to reviewing such resubmissions in two to six months depending on the type of information included. The FDA may refer applications for novel drug products or drug 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.

Before approving an NDA, the FDA typically will inspect the facilities at which the product is manufactured. The FDA will not approve the product unless it determines that the manufacturing processes and facilities are in compliance with cGMP requirements and adequate to assure consistent production of the product within required specifications. Additionally, before approving an NDA, the FDA may inspect one or more clinical sites to assure compliance with GCP. If the FDA determines the application, manufacturing process or manufacturing facilities are not acceptable, it typically will outline the deficiencies and often will request additional testing or information. This may significantly delay further review of the application. If the FDA finds that a clinical site did not conduct the clinical trial in accordance with GCP, the FDA may determine the data generated by the clinical site should be excluded from the primary efficacy analyses provided in the NDA. Additionally, notwithstanding the submission of any requested additional information, the FDA ultimately may decide that the application does not satisfy the regulatory criteria for approval.

The FDA may require, or companies may pursue, additional clinical trials after a product is approved. These so-called Phase 4 trials may be made a condition to be satisfied for continuing drug approval. The results of Phase 4 trials can confirm the effectiveness of a product candidate and can provide important safety information. In addition, the FDA now has express statutory authority to require sponsors to conduct post-marketing trials to specifically address safety issues identified by the agency. See Post-Marketing Requirements below.

The FDA also has authority to require a Risk Evaluation and Mitigation Strategy, or a REMS, from manufacturers to ensure that the benefits of a drug outweigh its risks. A sponsor may also voluntarily propose a REMS as part of the NDA submission. The need for a REMS is determined as part of the review of the NDA. Based on statutory standards,

elements of a REMS may include dear doctor letters, a medication guide, more elaborate targeted educational programs, and in some cases elements to assure safe use, or ETASU. ETASU can include, but are not limited to, special training or certification for prescribing or dispensing, dispensing only

Table of Contents

under certain circumstances, special monitoring and the use of patient registries. These elements are negotiated as part of the NDA approval, and in some cases if consensus is not obtained until after the PDUFA review cycle, the approval date may be delayed. Once adopted, REMS are subject to periodic assessment and modification.

Changes to some of the conditions established in an approved application, including changes in indications, labeling, manufacturing processes or facilities, require submission and FDA approval of a new NDA or NDA supplement before the change can be implemented. An NDA supplement for a new indication typically requires clinical data similar to that in the original application, and the FDA uses the same procedures and actions in reviewing NDA supplements as it does in reviewing NDAs.

Even if a product candidate receives regulatory approval, the approval may be limited to specific disease states, patient populations and dosages, or might contain significant limitations on use in the form of warnings, precautions or contraindications, or in the form of onerous risk management plans, restrictions on distribution, or post-marketing trial requirements. Further, even after regulatory approval is obtained, later discovery of previously unknown problems with a product may result in restrictions on the product or even complete withdrawal of the product from the market. Delay in obtaining, or failure to obtain, regulatory approval for our products, or obtaining approval but for significantly limited use, would harm our business. In addition, we cannot predict what adverse governmental regulations may arise from future U.S. or foreign governmental action.

The Hatch-Waxman Amendments

Under the Drug Price Competition and Patent Term Restoration Act of 1984, referred to as the Hatch-Waxman Amendments, a portion of a product s U.S. patent term that was lost during clinical development and regulatory review by the FDA may be restored. The Hatch-Waxman Amendments also provide a process for listing patents pertaining to approved products in the FDA s Approved Drug Products with Therapeutic Equivalence Evaluations (commonly known as the Orange Book) and for a competitor seeking approval of an application that references a product with listed patents to make certifications pertaining to such patents. In addition, the Hatch-Waxman Amendments provide for a statutory protection, known as non-patent exclusivity, against the FDA s acceptance or approval of certain competitor applications.

Patent Term Restoration

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 an NDA and the approval of that application, provided the sponsor acted with diligence. Patent term restorations, however, cannot extend the remaining term of a patent beyond a total of 14 years from the date of product approval and only one patent applicable to an approved drug may be extended and the extension must be applied for prior to expiration of the patent. The USPTO, in consultation with the FDA, reviews and approves the application for any patent term extension or restoration.

Orange Book Listing

In seeking approval for a drug through an NDA, applicants are required to list with the FDA each patent whose claims cover the applicant s product. Upon approval of a drug, each of the patents listed in the application for the drug are then published in the FDA s Orange Book. Drugs listed in the Orange Book can, in turn, be cited by potential generic competitors in support of approval of an abbreviated new drug application, or ANDA. An ANDA provides for marketing of a drug product that has the same active ingredients in the same strengths and dosage form as the listed

drug and has been shown through bioequivalence testing to be therapeutically equivalent to the listed drug. Other than the requirement for bioequivalence testing, ANDA applicants are not required to conduct, or submit results of, preclinical or clinical tests to prove the safety or effectiveness of their

Table of Contents

drug product. Drugs approved in this way are commonly referred to as generic equivalents to the listed drug, and can often be substituted by pharmacists under prescriptions written for the original listed drug.

The ANDA applicant is required to certify to the FDA concerning any patents listed for the approved product in the FDA s Orange Book. Specifically, the applicant must certify that: (i) the required patent information has not been filed; (ii) the listed patent has expired; (iii) the listed patent has not expired, but will expire on a particular date and approval is sought after patent expiration; or (iv) the listed patent is invalid or will not be infringed by the new product. The ANDA applicant may also elect to submit a Section VIII statement certifying that its proposed ANDA label does not contain (or carves out) any language regarding the patented method-of-use rather than certify to a listed method-of-use patent. If the applicant does not challenge the listed patents, the ANDA application will not be approved until all the listed patents claiming the referenced product have expired.

A certification that the new product will not infringe the already approved product s listed patents, or that such patents are invalid, is called a Paragraph IV certification. If the ANDA applicant has provided a Paragraph IV certification to the FDA, the applicant must also send notice of the Paragraph IV certification to the NDA and patent holders once the ANDA has been accepted for filing by the FDA. The NDA and patent holders may then initiate a patent infringement lawsuit in response to the notice of the Paragraph IV certification. The filing of a patent infringement lawsuit within 45 days of the receipt of a Paragraph IV certification automatically prevents the FDA from approving the ANDA until the earlier of 30 months, expiration of the patent, settlement of the lawsuit or a decision in the infringement case that is favorable to the ANDA applicant.

An applicant submitting an NDA under Section 505(b)(2) of the FDCA, which permits the filing of an NDA where at least some of the information required for approval comes from studies not conducted by, or for, the applicant and for which the applicant has not obtained a right of reference, is required to certify to the FDA regarding any patents listed in the Orange Book for the approved product it references to the same extent that an ANDA applicant would.

Market Exclusivity

Market exclusivity provisions under the FDCA also can delay the submission or the approval of certain applications. The FDCA provides a five-year period of non-patent marketing exclusivity within the United States to the first applicant to gain approval of an NDA for a new chemical entity. A drug is a new chemical entity if the FDA has not previously approved any other new drug containing the same active moiety, which is the molecule or ion responsible for the action of the drug substance. During the exclusivity period, the FDA may not accept for review an ANDA or a 505(b)(2) NDA submitted by another company for another version of such drug where the applicant does not own or have a legal right of reference to all the data required for approval. However, an application may be submitted after four years if it contains a Paragraph IV certification. The FDCA also provides three years of marketing exclusivity for an NDA, 505(b)(2) NDA or supplement to an existing NDA if new clinical investigations, other than bioavailability studies, that were conducted or sponsored by the applicant are deemed by the FDA to be essential to the approval of the application, for example, for new indications, dosages or strengths of an existing drug. This three-year exclusivity covers only the conditions associated with the new clinical investigations and does not prohibit the FDA from approving ANDAs for drugs containing the original active agent. Five-year and three-year exclusivity will not delay the submission or approval of a full NDA; however, an applicant submitting a full NDA would be required to conduct or obtain a right of reference to all of the non-clinical studies and adequate and well-controlled clinical trials necessary to demonstrate safety and effectiveness.

Post-Marketing Requirements

Following approval of a new product, a pharmaceutical company and the approved product are subject to continuing regulation by the FDA, including, among other things, monitoring and recordkeeping activities, reporting to the applicable regulatory authorities of adverse experiences with the product, providing the

Table of Contents

regulatory authorities with updated safety and efficacy information, product sampling and distribution requirements, and complying with promotion and advertising requirements, which include, among others, standards for direct-to-consumer advertising, restrictions on promoting drugs for uses or in patient populations that are not described in the drug s approved labeling (known as off-label use), limitations on industry-sponsored scientific and educational activities and requirements for promotional activities involving the internet. Although physicians may prescribe legally available drugs for off-label uses, manufacturers may not market or promote such off-label uses. Modifications or enhancements to the product or its labeling or changes of the site of manufacture are often subject to the approval of the FDA and other regulators, who may or may not grant approval or may include in a lengthy review process.

Prescription drug advertising is subject to federal, state and foreign regulations. In the United States, the FDA regulates prescription drug promotion, including direct-to-consumer advertising. Prescription drug promotional materials must be submitted to the FDA in conjunction with their first use. Any distribution of prescription drug products and pharmaceutical samples must comply with the U.S. Prescription Drug Marketing Act, or the PDMA, a part of the FDCA.

In the United States, once a product is approved, its manufacture is subject to comprehensive and continuing regulation by the FDA. The FDA regulations require that products be manufactured in specific approved facilities and in accordance with cGMP. We rely, and expect to continue to rely, on third parties for the production of clinical and commercial quantities of our products in accordance with cGMP regulations. cGMP regulations require among other things, quality control and quality assurance as well as the corresponding maintenance of records and documentation and the obligation to investigate and correct any deviations from cGMP. Drug manufacturers and other entities involved in the manufacture and distribution of approved drugs 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 area of production and quality control to maintain cGMP compliance. These regulations also impose certain organizational, procedural and documentation requirements with respect to manufacturing and quality assurance activities. NDA holders using contract manufacturers, laboratories or packagers are responsible for the selection and monitoring of qualified firms, and, in certain circumstances, qualified suppliers to these firms. These firms and, where applicable, their suppliers are subject to inspections by the FDA at any time, and the discovery of violative conditions, including failure to conform to cGMP, could result in enforcement actions that interrupt the operation of any such product or may result in restrictions on a product, manufacturer, or holder of an approved NDA, including, among other things, recall or withdrawal of the product from the market.

In addition, the manufacturer and/or sponsor under an approved NDA are subject to annual product and establishment fees, currently exceeding $104,000 per product and $554,000 per establishment for fiscal year 2014. These fees are typically increased annually.

The FDA also may require post-marketing testing, also known as Phase 4 testing, REMS to monitor the effects of an approved product or place conditions on an approval that could restrict the distribution or use of the product. Discovery of previously unknown problems with a product or the failure to comply with applicable FDA requirements can have negative consequences, including adverse publicity, judicial or administrative enforcement, untitled or warning letters from the FDA, mandated corrective advertising or communications with doctors, withdrawal of approval, and civil or criminal penalties, among others. Newly discovered or developed safety or effectiveness data may require changes to a product s approved labeling, including the addition of new warnings and contraindications, and also may require the implementation of other risk management measures. Also, new government requirements, including those resulting from new legislation, may be established, or the FDA s policies may change, which could delay or prevent regulatory approval of our products under development.

27

Table of Contents

Reimbursement, Anti-Kickback and False Claims Laws and Other Regulatory Matters

In the United States, the research, manufacturing, distribution, sale and promotion of drug products and medical devices are potentially subject to regulation by various federal, state and local authorities in addition to the FDA, including the Centers for Medicare & Medicaid Services, other divisions of the U.S. Department of Health and Human Services (e.g., the Office of Inspector General), the Drug Enforcement Administration, the Consumer Product Safety Commission, the Federal Trade Commission, the Occupational Safety & Health Administration, the Environmental Protection Agency, state Attorneys General and other state and local government agencies. For example, sales, marketing and scientific/educational grant programs must comply with the Federal Anti-Kickback Statute, the False Claims Act, as amended, the privacy regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA), as amended, and similar state laws. Pricing and rebate programs must comply with the Medicaid Drug Rebate Program requirements of the Omnibus Budget Reconciliation Act of 1990, as amended, and the Veterans Health Care Act of 1992, as amended. If products are made available to authorized users of the Federal Supply Schedule of the General Services Administration, additional laws and requirements apply. The handling of any controlled substances must comply with the U.S. Controlled Substances Act and Controlled Substances Import and Export Act. Products must meet applicable child-resistant packaging requirements under the U.S. Poison Prevention Packaging Act. All of these activities are also potentially subject to federal and state consumer protection and unfair competition laws.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, or the MMA, established the Medicare Part D program to provide a voluntary prescription drug benefit to Medicare beneficiaries. Under Part D, Medicare beneficiaries may enroll in prescription drug plans offered by private entities which will provide coverage of outpatient prescription drugs. Unlike Medicare Part A and B, part D coverage is not standardized. Part D prescription drug plan sponsors are not required to pay for all covered Part D drugs, and each drug plan can develop its own drug formulary that identifies which drugs it will cover and at what tier or level. However, Part D prescription drug formularies must include drugs within each therapeutic category and class of covered Part D drugs, though not necessarily all the drugs in each category or class. Any formulary used by a part D prescription drug plan must be developed and reviewed by a pharmacy and therapeutic committee. Government payment for some of the costs of prescription drugs may increase demand for products for which we receive regulatory approval. However, any negotiated prices for our products covered by a Part D prescription drug plan will likely be lower than the prices we might otherwise obtain. Moreover, while the MMA applies only to drug benefits for Medicare beneficiaries, private payors often follow Medicare coverage policy and payment limitations in setting their own payment rates. Any reduction in payment that results from the MMA may result in a similar reduction in payments from non-government payors.

The distribution of pharmaceutical products is subject to additional requirements and regulations, including extensive record-keeping, licensing, storage and security requirements intended to prevent the unauthorized sale of pharmaceutical products.

The American Recovery and Reinvestment Act of 2009 provides funding for the federal government to compare the effectiveness of different treatments for the same illness. A plan for the research will be developed by the Department of Health and Human Services, the Agency for Healthcare Research and Quality and the National Institutes for Health, and periodic reports on the status of the research and related expenditures will be made to Congress. Although the results of the comparative effectiveness studies are not intended to mandate coverage policies for public or private payors, it is not clear what effect, if any, the research will have on the sales of our product candidate, if any such product or the condition that it is intended to treat is the subject of a trial. It is also possible that comparative effectiveness research demonstrating benefits in a competitor s product could adversely affect the sales of our product candidate. If third-party payors do not consider our products to be cost-effective compared to other available therapies,

they may not cover our products after approval as a benefit under their plans or, if they do, the level of payment may not be sufficient to allow us to sell our products on a profitable basis.

Table of Contents

In addition, in some foreign countries, the proposed pricing for a drug must be approved before it may be lawfully marketed. The requirements governing drug pricing vary widely from country to country. For example, the European Union provides options for its member states to restrict the range of medicinal products for which their national health insurance systems provide reimbursement and to control the prices of medicinal products for human use. A member state may approve a specific price for the medicinal product or it may instead adopt a system of direct or indirect controls on the profitability of the company placing the medicinal product on the market. There can be no assurance that any country that has price controls or reimbursement limitations for pharmaceutical products will allow favorable reimbursement and pricing arrangements for any of our products. Historically, products launched in the European Union do not follow price structures of the United States and generally tend to be significantly lower.

As noted above, in the United States, we are subject to complex laws and regulations pertaining to healthcare fraud and abuse, including, but not limited to, the Federal Anti-Kickback Statute, the Federal False Claims Act, and other state and federal laws and regulations. The Federal Anti-Kickback Statute makes it illegal for any person, including a prescription drug manufacturer (or a party acting on its behalf) to knowingly and willfully solicit, receive, offer, or pay any remuneration that is intended to induce the referral of business, including the purchase, order, or prescription of a particular drug, for which payment may be made under a federal healthcare program, such as Medicare or Medicaid. Violations of this law are punishable by up to five years in prison, criminal fines, administrative civil money penalties, and exclusion from participation in federal healthcare programs. In addition, many states have adopted laws similar to the Federal Anti-Kickback Statute. Some of these state prohibitions apply to the referral of patients for healthcare services reimbursed by any insurer, not just federal healthcare programs such as Medicare and Medicaid. Due to the breadth of these federal and state anti-kickback laws, the absence of guidance in the form of regulations or court decisions, and the potential for additional legal or regulatory change in this area, it is possible that our future sales and marketing practices and/or our future relationships with eye-care professionals might be challenged under anti-kickback laws, which could harm us. Because we intend to commercialize products that could be reimbursed under a federal healthcare program and other governmental healthcare programs, we plan to develop a comprehensive compliance program that establishes internal controls to facilitate adherence to the rules and program requirements to which we will or may become subject.

The Federal False Claims Act prohibits anyone from knowingly presenting, or causing to be presented, for payment to federal programs (including Medicare and Medicaid) claims for items or services, including drugs, that are false or fraudulent, claims for items or services not provided as claimed, or claims for medically unnecessary items or services. Although we would not submit claims directly to payors, manufacturers can be held liable under these laws if they are deemed to cause the submission of false or fraudulent claims by, for example, providing inaccurate billing or coding information to customers or promoting a product off-label. In addition, our future activities relating to the reporting of wholesaler or estimated retail prices for our products, the reporting of prices used to calculate Medicaid rebate information and other information affecting federal, state and third-party reimbursement for our products, and the sale and marketing of our products, are subject to scrutiny under this law. For example, pharmaceutical companies have been found liable under the Federal False Claims Act in connection with their off-label promotion of drugs. Penalties for a False Claims Act violation include three times the actual damages sustained by the government, plus mandatory civil penalties of between $5,500 and $11,000 for each separate false claim, the potential for exclusion from participation in federal healthcare programs, and, although the Federal False Claims Act is a civil statute, conduct that results in a False Claims Act violation may also implicate various federal criminal statutes. If the government were to allege that we were, or convict us of, violating these false claims laws, we could be subject to a substantial fine and may suffer a decline in our stock price. In addition, private individuals have the ability to bring actions under the Federal False Claims Act and certain states have enacted laws modeled after the Federal False Claims Act.

There are also an increasing number of state laws that require manufacturers to make reports to states on pricing and marketing information. Many of these laws contain ambiguities as to what is required to comply with the

Table of Contents

laws. In addition, as discussed below, beginning in 2013, a similar federal requirement will require manufacturers to track and report to the federal government certain payments made to physicians and teaching hospitals made in the previous calendar year. These laws may affect our sales, marketing and other promotional activities by imposing administrative and compliance burdens on us. In addition, given the lack of clarity with respect to these laws and their implementation, our reporting actions could be subject to the penalty provisions of the pertinent state, and soon federal, authorities.

The failure to comply with regulatory requirements subjects firms to possible legal or regulatory action. Depending on the circumstances, failure to meet applicable regulatory requirements can result in criminal prosecution, fines or other penalties, injunctions, recall or seizure of products, total or partial suspension of production, denial or withdrawal of product approvals, or refusal to allow a firm to enter into supply contracts, including government contracts.

Changes in regulations, statutes or the interpretation of existing regulations could impact our business in the future by required, for example: (i) changes to our manufacturing arrangements; (ii) additions or modifications to product labeling; (iii) the recall or discontinuation of our products; or (iv) additional record-keeping requirements. If any such changes were to be imposed, they could adversely affect the operation of our business.

Patient Protection and Affordable Care Act

In March 2010, the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, PPACA) was enacted, which includes measures that have or will significantly change the way healthcare is financed by both governmental and private insurers. Among the provisions of PPACA of greatest importance to the pharmaceutical industry are the following:

The Medicaid Drug Rebate Program requires pharmaceutical manufacturers to enter into and have in effect a national rebate agreement with the Secretary of the Department of Health and Human Services a condition for states to receive federal matching funds for the manufacturer s covered outpatient drugs furnished to Medicaid patients. Effective in 2010, PPACA made several changes to the Medicaid Drug Rebate Program, including increasing pharmaceutical manufacturers rebate liability by raising the minimum basic Medicaid rebate on most branded prescription drugs and biologic agents to 23.1% of AMP and adding a new rebate calculation for line extensions (i.e., new formulations, such as extended release formulations) of solid oral dosage forms of branded products, as well as potentially impacting their rebate liability by modifying the statutory definition of AMP. PPACA also expanded the universe of Medicaid utilization subject to drug rebates by requiring pharmaceutical manufacturers to pay rebates on Medicaid managed care utilization as of 2010 and by expanding the population potentially eligible for Medicaid drug benefits, to be phased-in by 2014. The Centers for Medicare & Medicaid Services, or CMS, have proposed to expand Medicaid rebate liability to the territories of the United States as well. In addition, PPACA provides for the public availability of retail survey prices and certain weighted average AMPs under the Medicaid program. The implementation of this requirement by the CMS may also provide for the public availability of pharmacy acquisition of cost data, which could negatively impact our sales.

In order for a pharmaceutical product to receive federal reimbursement under the Medicare Part B and Medicaid programs or to be sold directly to U.S. government agencies, the manufacturer must extend discounts to entities eligible to participate in the 340B drug pricing program. The required 340B discount on a given product is calculated based on the AMP and Medicaid rebate amounts reported by the manufacturer.

Effective in 2010, PPACA expanded the types of entities eligible to receive discounted 340B pricing, although, under the current state of the law, with the exception of children s hospitals, these newly eligible entities will not be eligible to receive discounted 340B pricing on orphan drugs when used for the orphan indication. In addition, as 340B drug pricing is determined based on AMP and Medicaid rebate data, the revisions to the Medicaid rebate formula and AMP definition described above could cause the required 340B discount to increase.

Table of Contents

Effective in 2011, PPACA imposed a requirement on manufacturers of branded drugs and biologic agents to provide a 50% discount off the negotiated price of branded drugs dispensed to Medicare Part D patients in the coverage gap (i.e., donut hole).

Effective in 2011, PPACA imposed an annual, nondeductible fee on any entity that manufactures or imports certain branded prescription drugs and biologic agents, apportioned among these entities according to their market share in certain government healthcare programs, although this fee would not apply to sales of certain products approved exclusively for orphan indications.

Effective in 2012, PPACA required pharmaceutical manufacturers to track certain financial arrangements with physicians and teaching hospitals, including any transfer of value made or distributed to such entities, as well as any investment interests held by physicians and their immediate family members. Manufacturers are required to track this information beginning in 2013 and make their first reports in the first half of 2014. The information reported will be publicly available on a searchable website in September 2014.

As of 2010, a new Patient-Centered Outcomes Research Institute was established pursuant to PPACA to oversee, identify priorities in and conduct comparative clinical effectiveness research, along with funding for such research. The research conducted by the Patient-Centered Outcomes Research Institute may affect the market for certain pharmaceutical products.

PPACA created the Independent Payment Advisory Board, which, beginning in 2014, will have authority to recommend certain changes to the Medicare program to reduce expenditures by the program that could result in reduced payments for prescription drugs. Under certain circumstances, these recommendations will become law unless Congress enacts legislation that will achieve the same or greater Medicare cost savings.

PPACA established the Center for Medicare and Medicaid Innovation within CMS to test innovative payment and service delivery models to lower Medicare and Medicaid spending, potentially including prescription drug spending. Funding has been allocated to support the mission of the Center for Medicare and Medicaid Innovation from 2011 to 2019.

Many of the details regarding the implementation of PPACA are yet to be determined, and at this time, it remains unclear the full effect that PPACA would have on our business.

European Union Drug Development

In the European Union, our products will also be subject to extensive regulatory requirements. As in the United States, medicinal products can only be marketed if a marketing authorization from the competent regulatory agencies has been obtained, and the various phases of preclinical and clinical research in the European Union are subject to significant regulatory controls. Although the EU Clinical Trials Directive 2001/20/EC has sought to harmonize the EU clinical trial regulatory framework, setting out common rules for the control and authorization of clinical trials in the European Union, the EU Member States have transposed and applied the provisions of the Directive differently. This has led to significant variations in the member state regimes. Under the current regime, before a clinical trial can be initiated it must be approved in each of the EU countries where the trial is to be conducted by two distinct bodies: the National Competent Authority, or NCA, and one or more Ethics Committees, or ECs. In addition, all suspected

unexpected serious adverse reactions to the investigated drug that occur during the clinical trial must be reported to the NCA and ECs of the Member State where they occurred.

The EU clinical trials legislation is currently undergoing a revision process mainly aimed at making more uniform and streamlining the clinical trials authorization process, simplifying adverse event reporting procedures, improving the supervision of clinical trials and increasing the transparency of clinical trials.

Table of Contents

European Union Drug Review Approval

In the European Economic Area, or EEA, which is comprised of the 27 Member States of the European Union plus Norway, Iceland and Liechtenstein, medicinal products can only be commercialized after obtaining a Marketing Authorization, or MA. There are two types of marketing authorizations: the Community MA, which is issued by the European Commission through the Centralized Procedure based on the opinion of the Committee for Medicinal Products for Human Use, or CHMP, a body of the European Medicines Agency, or the EMA, and which is valid throughout the entire territory of the EEA; and the National MA, which is issued by the competent authorities of the Member States of the EEA and only authorized marketing in that Member State s national territory and not the EEA as a whole.

The Centralized Procedure is mandatory for certain types of products, such as biotechnology medicinal products, orphan medicinal products and medicinal products containing a new active substance indicated for the treatment of AIDS, cancer, neurodegenerative disorders, diabetes, auto-immune and viral diseases. The Centralized Procedure is optional for products containing a new active substance not yet authorized in the EEA, or for products that constitute a significant therapeutic, scientific or technical innovation or which are in the interest of public health in the European Union. The National MA is for products not falling within the mandatory scope of the Centralized Procedure. Where a product has already been authorized for marketing in a Member State of the EEA, this National MA can be recognized in another Member States through the Mutual Recognition Procedure. If the product has not received a National MA in any Member State at the time of application, it can be approved simultaneously in various Member States through the Decentralized Procedure. Under the Decentralized Procedure an identical dossier is submitted to the competent authorities of each of the Member States in which the MA is sought, one of which is selected by the applicant as the Reference Member state, or RMS. If the RMS proposes to authorize the product, and the other Member States do not raise objections, the product is granted a national MA in all the Member States where the authorization was sought. Before granting the MA, the EMA or the competent authorities of the Member States of the EEA make an assessment of the risk-benefit balance of the product on the basis of scientific criteria concerning its quality, safety and efficacy.

Other Regulations

We are also subject to numerous federal, state and local laws relating to such matters as safe working conditions, manufacturing practices, environmental protection, fire hazard control and disposal of hazardous or potentially hazardous substances. We may incur significant costs to comply with such laws and regulations now or in the future.

Employees

We had 23 full-time employees as of December 31, 2013. None of our employees are represented by any collective bargaining unit. We believe that we maintain good relations with our employees.

Corporate and Available Information

Our principal executive offices are located at 135 US Highway 206, Suite 15, Bedminster, New Jersey 07921 and our telephone number is (908) 470-4320. We were incorporated in Delaware in June 2005. Our internet address is www.aeriepharma.com. We make available on our website, free of charge, our Annual Report on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K and any amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Exchange Act as soon as reasonably practicable after we electronically file such material with, or furnish it to, the SEC. Our SEC reports can be accessed through the Investors section of our website. Further, a copy of this Annual Report on Form 10-K is located at the SEC s Public Reference Room at 100 F Street, N.E., Washington, D. C. 20549. Information on the operation of the Public Reference Room

can be obtained by calling the SEC at 1-800-SEC-0330. The SEC maintains a website that contains reports, proxy and information statements and other information regarding our filings at www.sec.gov. The information found on our website is not incorporated by reference into this report or any other report we file with or furnish to the SEC.

Table of Contents

ITEM 1A. RISK FACTORS

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.

Risks Related to Development, Regulatory Approval and Commercialization

We depend substantially on the success of our product candidates, particularly Rhopressa™ and Roclatan™, which are still in development. If we are unable to successfully commercialize our product candidates, or experience significant delays in doing so, our business will be materially harmed.

Our business and the ability to generate revenue related to product sales, if ever, will depend on the successful development, regulatory approval and commercialization of our product candidates for the treatment of patients with glaucoma, particularly Rhopressa™ and Roclatan™, which are still in development, and other potential products we may develop or license. We have invested a significant portion of our efforts and financial resources in the development of our existing product candidates. The success of our product candidates will depend on several factors, including:

- successful completion of clinical trials;
- receipt of regulatory approvals from applicable regulatory authorities;
- establishment of arrangements with third-party manufacturers;
- obtaining and maintaining patent and trade secret protection and regulatory exclusivity;
- protecting our rights in our intellectual property;
- launching commercial sales of our product candidates, if and when approved;
- obtaining reimbursement from third-party payors for product candidates, if and when approved;
- competition with other products; and
- continued acceptable safety profile for our product candidates following regulatory approval, if and when received.

If we do not achieve one or more of these factors in a timely manner or at all, we could experience significant delays or an inability to successfully commercialize our product candidates, which would materially harm our business and we may not be able to earn sufficient revenues and cash flows to continue our operations.

We have not obtained regulatory approval for any of our product candidates in the United States or any other country.

We currently do not have any product candidates that have gained regulatory approval for sale in the United States or any other country, and we cannot guarantee that we will ever have marketable products. Our business is substantially dependent on our ability to complete the development of, obtain regulatory approval for and successfully commercialize product candidates in a timely manner. We cannot commercialize product candidates in the United States without first obtaining regulatory approval to market each product from the FDA; similarly, we cannot commercialize product candidates outside of the United States without obtaining regulatory approval from comparable foreign regulatory authorities. Rhopressa™ is planned to be advanced into Phase 3 clinical trials and Roclatan™ recently advanced into Phase 2b clinical trials. We cannot predict whether these trials and future trials will be successful or whether regulators will agree with our conclusions regarding the preclinical studies and clinical trials we have conducted to date.

Table of Contents

Before obtaining regulatory approvals for the commercial sale of any product candidate for a target indication, we must demonstrate in preclinical studies and well-controlled clinical trials, and, with respect to approval in the United States, to the satisfaction of the FDA, that the product candidate is safe and effective for use for that target indication and that the manufacturing facilities, processes and controls are adequate. In the United States, we have not submitted an NDA for any of our product candidates. An NDA must include extensive preclinical and clinical data and supporting information to establish the product candidate s safety and effectiveness for each desired indication. The NDA must also include significant information regarding the chemistry, manufacturing and controls for the product. Obtaining approval of an NDA is a lengthy, expensive and uncertain process, and approval may not be obtained. If we submit an NDA to the FDA, the FDA must decide whether to accept or reject the submission for filing. We cannot be certain that any submissions will be accepted for filing and review by the FDA.

Regulatory authorities outside of the United States, such as in Europe and Japan and in emerging markets, also have requirements for approval of drugs for commercial sale with which we must comply prior to marketing in those areas. Regulatory requirements can vary widely from country to country and could delay or prevent the introduction of our product candidates. Clinical trials conducted in one country may not be accepted by regulatory authorities in other countries, and obtaining regulatory approval in one country does not mean that regulatory approval will be obtained in any other country. Approval processes vary among countries and can involve additional product testing and validation and additional administrative review periods. Seeking foreign regulatory approval could require additional non-clinical studies or clinical trials, which could be costly and time consuming. The foreign regulatory approval process may include all of the risks associated with obtaining FDA approval. For all of these reasons, we may not obtain foreign regulatory approvals on a timely basis, if at all.

The process to develop, obtain regulatory approval for and commercialize product candidates is long, complex and costly both inside and outside of the United States, and approval is never guaranteed. Even if our product candidates were to successfully obtain approval from the regulatory authorities, any approval might significantly limit the approved indications for use, or require that precautions, contraindications, or warnings be included on the product labeling, or require expensive and time-consuming post-approval clinical studies or surveillance as conditions of approval. Following any approval for commercial sale of our product candidates, certain changes to the product, such as changes in manufacturing processes and additional labeling claims, will be subject to additional FDA review and approval. Also, regulatory approval for any of our product candidates may be withdrawn. If we are unable to obtain regulatory approval for our product candidates in one or more jurisdictions, or any approval contains significant limitations, our target market will be reduced and our ability to realize the full market potential of our product candidates will be harmed. Furthermore, we may not be able to obtain sufficient funding or generate sufficient revenue and cash flows to continue the development of any other product candidate in the future.

Regulatory approval may be substantially delayed or may not be obtained for one or all of our product candidates if regulatory authorities require additional time or studies to assess the safety and efficacy of our product candidates.

We may be unable to initiate or complete development of our product candidates on schedule, if at all. The timing for the completion of the studies for our product candidates will require funding beyond the amounts currently on our balance sheet. In addition, if regulatory authorities require additional time or studies to assess the safety or efficacy of our product candidates, we may not have or be able to obtain adequate funding to complete the necessary steps for approval for any or all of our product candidates. Preclinical studies and clinical trials required to demonstrate the safety and efficacy of our product candidates are time consuming and expensive and together take several years or more to complete. Delays in regulatory approvals or rejections of applications for regulatory approval in the United States, Europe, Japan or other markets may result from many factors, including:

our inability to obtain sufficient funds required for a clinical trial;

regulatory requests for additional analyses, reports, data, non-clinical and preclinical studies and clinical trials;

Table of Contents

regulatory questions regarding interpretations of data and results and the emergence of new information regarding our product candidates or other products;

clinical holds, other regulatory objections to commencing or continuing a clinical trial or the inability to obtain regulatory approval to commence a clinical trial in countries that require such approvals;

failure to reach agreement with the FDA or non-U.S. regulators regarding the scope or design of our clinical trials;

our inability to enroll a sufficient number of patients who meet the inclusion and exclusion criteria in our clinical trials;

our inability to conduct the clinical trial in accordance with regulatory requirements or our clinical protocols;

unfavorable or inconclusive results of clinical trials and supportive non-clinical studies, including unfavorable results regarding effectiveness of product candidates during clinical trials;

any determination that a clinical trial presents unacceptable health risks;

lack of adequate funding to continue the clinical trial due to unforeseen costs or other business decisions;

our inability to reach agreements on acceptable terms with prospective contract research organizations, or CROs, and trial sites, the terms of which can be subject to extensive negotiation and may vary significantly among different CROs and trial sites;

our inability to identify and maintain a sufficient number of sites, many of which may already be engaged in other clinical trial programs, including some that may be for the same indications targeted by our product candidates;

our inability to obtain approval from institutional review boards to conduct clinical trials at their respective sites;

our inability to timely manufacture or obtain from third parties sufficient quantities or quality of the product candidate or other materials required for a clinical trial; and

difficulty in maintaining contact with patients after treatment, resulting in incomplete data.

Changes in regulatory requirements and guidance may also occur and we may need to amend clinical trial protocols submitted to applicable regulatory authorities to reflect these changes. Amendments may require us to resubmit clinical trial protocols to institutional review boards for re-examination, which may impact the costs, timing or successful completion of a clinical trial.

If we are required to conduct additional clinical trials or other studies with respect to any of our product candidates beyond those that we initially contemplated, if we are unable to successfully complete our clinical trials or other studies or if the results of these studies are not positive or are only modestly positive, we may be delayed in obtaining regulatory approval for that product candidate, we may not be able to obtain regulatory approval at all or we may obtain approval for indications that are not as broad as intended. Our product development costs will also increase if we experience delays in testing or approvals and we may not have sufficient funding to complete the testing and approval process. Significant clinical trial delays could allow our competitors to bring products to market before we do and impair our ability to commercialize our products if and when approved. If any of this occurs, our business will be materially harmed.

If we are unable to establish a direct sales force in the United States, our business may be harmed.

We currently do not have an established sales organization and do not have a marketing or distribution infrastructure. To achieve commercial success for any approved product, we must either develop a sales and marketing organization or outsource these functions to third parties. If our product candidates are approved by

Table of Contents

the FDA for commercial sale, we intend to market directly to eye-care professionals in the United States through our own sales force, targeting approximately 10,000 high-prescribing eye-care professionals in the United States. We will need to incur significant additional expenses and commit significant additional time and management resources to establish and train a sales force to market and sell our products. We may not be able to successfully establish these capabilities despite these additional expenditures.

Factors that may inhibit our efforts to successfully establish a sales force include:

- our inability to compete with other pharmaceutical companies to recruit, hire, train and retain adequate numbers of effective sales and marketing personnel with requisite knowledge of our target market;
- the inability of sales personnel to obtain access to adequate numbers of eye-care professionals to prescribe any future approved products;
- unforeseen costs and expenses associated with creating an independent sales and marketing organization; and
- a delay in bringing products to market after efforts to hire and train our sales force have already commenced.

In the event we are unable to successfully market and promote our products, our business may be harmed.

We currently intend to explore the licensing of commercialization rights or other forms of collaboration outside of the United States, which will expose us to additional risks of conducting business in international markets.

The non-U.S. markets are an important component of our growth strategy. If we fail to obtain licenses or enter into collaboration arrangements with selling parties, or if these parties are not successful, our revenue-generating growth potential will be adversely affected. Moreover, international business relationships subject us to additional risks that may materially adversely affect our ability to attain or sustain profitable operations, including:

- efforts to enter into collaboration or licensing arrangements with third parties in connection with our international sales, marketing and distribution efforts may increase our expenses or divert our management s attention from the acquisition or development of product candidates;
- changes in a specific country s or region s political and cultural climate or economic condition;
- differing regulatory requirements for drug approvals and marketing internationally;
- difficulty of effective enforcement of contractual provisions in local jurisdictions;

potentially reduced protection for intellectual property rights;

potential third-party patent rights in countries outside of the United States;

unexpected changes in tariffs, trade barriers and regulatory requirements;

economic weakness, including inflation, or political instability, particularly in non-U.S. economies and markets, including several countries in Europe;

compliance with tax, employment, immigration and labor laws for employees traveling abroad;

the effects of applicable foreign tax structures and potentially adverse tax consequences;

foreign currency fluctuations, which could result in increased operating expenses and reduced revenue, and other obligations incidental to doing business in another country;

workforce uncertainty in countries where labor unrest is more common than in the United States;

Table of Contents

- the potential for so-called parallel importing, which is what happens when a local seller, faced with high or higher local prices, opts to import goods from a foreign market (with low or lower prices) rather than buying them locally;

- failure of our employees and contracted third parties to comply with Office of Foreign Asset Control rules and regulations and the Foreign Corrupt Practices Act;

- production shortages resulting from any events affecting raw material supply or manufacturing capabilities abroad; and

- business interruptions resulting from geo-political actions, including war and terrorism, or natural disasters, including earthquakes, volcanoes, typhoons, floods, hurricanes and fires.

These and other risks may materially adversely affect our ability to attain or sustain revenue from international markets.

Failure can occur at any stage of clinical development. If the clinical trials for our product candidates are unsuccessful, we could be required to abandon development.

A failure of one or more clinical trials can occur at any stage of testing for a variety of reasons. The outcome of preclinical testing and early clinical trials may not be predictive of the outcome of later clinical trials, and interim results of a clinical trial do not necessarily predict final results. In addition, adverse events may occur or other risks may be discovered in Phase 2 or Phase 3 clinical trials that will cause us to suspend or terminate our clinical trials. In some instances, there can be significant variability in safety and/or efficacy results between different trials of the same product candidate due to numerous factors, including changes in or adherence to trial protocols, differences in size and type of the patient populations and the rates of dropout among clinical trial participants. Our future clinical trial results therefore may not demonstrate safety and efficacy sufficient to obtain regulatory approval for our product candidates.

Flaws in the design of a clinical trial may not become apparent until the clinical trial is well-advanced. We have limited experience in designing clinical trials and may be unable to design and execute a clinical trial to support regulatory approval. In addition, clinical trials often reveal that it is not practical or feasible to continue development efforts. Further, we have never submitted an NDA for any potential products.

We may voluntarily suspend or terminate our clinical trials if at any time we believe that they present an unacceptable risk to participants. Further, regulatory agencies, institutional review boards or data safety monitoring boards may at any time order the temporary or permanent discontinuation of our clinical trials or request that we cease using investigators in the clinical trials if they believe that the clinical trials are not being conducted in accordance with applicable regulatory requirements, or that they present an unacceptable safety risk to participants. Since our inception, we have not voluntarily or involuntarily suspended or terminated a clinical trial due to unacceptable safety risks to participants.

If the results of our clinical trials for our current product candidates or clinical trials for any future product candidates do not achieve the primary efficacy endpoints or demonstrate unexpected safety issues, the prospects for approval of our product candidates will be materially adversely affected. Moreover, preclinical and clinical data are often susceptible to varying interpretations and analyses, and many companies that believed their product candidates performed satisfactorily in preclinical studies and clinical trials have failed to achieve similar results in later clinical

trials, including longer term trials, or have failed to obtain regulatory approval of their product candidates. Many compounds that initially showed promise in clinical trials or earlier stage testing have later been found to cause undesirable or unexpected adverse effects that have prevented further development of the compound. Our trials for our primary product candidates, Rhopressa™ and Roclatan™, may not produce the results that we expect. In addition, if based on clinical results of Rhopressa™ we discontinue the advancement of this product candidate, in certain circumstances we may similarly determine not to advance Roclatan™, which

Table of Contents

combines Rhopressa™ with latanoprost. Our clinical trials are also designed to test right;font-size:10pt;">87.65

100,100

$
86,233,902

November 29, 2015 through January 2, 2016

127,900

$
89.03

127,900

$
74,847,185

Total

360,135

359,263

Includes shares of our common stock surrendered by our employees to satisfy required tax withholding upon the (1) vesting of restricted stock awards. There were 872 shares surrendered between October 4, 2015 and January 2, 2016.

Amounts purchased during the fiscal year were made in accordance with the share repurchase authorizations (2) described in Note 8 to the accompanying audited consolidated financial statements contained in this Annual Report on Form 10-K.

Repurchase Program

In the second quarter of fiscal 2013, our Board of Directors authorized the repurchase of shares in an amount up to $300 million, inclusive of amounts remaining under previous authorizations. The total remaining capacity under the repurchase authorizations as of January 2, 2016 was approximately $74.8 million.

On February 24, 2016, our Board of Directors authorized a new $500 million share repurchase program. The new share repurchase authorization permits us to repurchase shares of our common stock up to $500 million, in addition to the approximate $74.8 million remaining at January 2, 2016 under previous authorizations described above.

Repurchases under the authorizations may be made in the open market or in privately-negotiated transactions, with the level and timing of such activity at the discretion of our management depending on market conditions, stock price, other investment priorities, and other factors. The share repurchase authorizations have no expiration dates.

Open Market Purchases

During the fiscal year ended January 2, 2016, we repurchased and retired 1,154,288 shares with an average share price of $95.55 for an aggregate cost of approximately $110.3 million, in open market transactions.

DIVIDENDS

On February 24, 2016, our Board of Directors authorized a quarterly cash dividend payment of $0.33 per common share, payable on March 25, 2016 to shareholders of record at the close of business on March 11, 2016.

In fiscal 2015, we paid quarterly cash dividends of $0.22 per share each quarter. In fiscal 2014, we paid quarterly cash dividends of $0.19 per share each quarter. Future declarations of quarterly dividends and the establishment of future record and payment dates are at the discretion of our Board of Directors based on a number of factors, including our future financial performance and other investment priorities.

Provisions in our secured revolving credit facility and indenture governing our senior notes could have the effect of restricting our ability to pay future cash dividends on or make future repurchases of our common stock. For more information concerning these dividend restrictions, refer to the "Financial Condition, Capital Resources, and Liquidity" section of Item 7 in this Annual Report on Form 10-K.

RECENT SALES OF UNREGISTERED SECURITIES

Not applicable.

ITEM 6. SELECTED FINANCIAL DATA

The following selected financial and other data has been derived from our consolidated financial statements for each of the five years presented. The following information should be read in conjunction with Item 7 - "Management's Discussion and Analysis of Financial Condition and Results of Operations" and Item 8-"Financial Statements and Supplementary Data" which includes the consolidated financial statements and related notes appearing elsewhere in this Annual Report on Form 10-K, or the respective prior fiscal years' Form 10-K.

The Company's fiscal year ends on the Saturday, in December or January, nearest the last day of December, resulting in an additional week of results every five or six years. All fiscal years for which financial information is set forth below contained 52 weeks, except for the fiscal year ended January 3, 2015, which contained 53 weeks.

	For the fiscal years ended				
(dollars in thousands, except per share data)	January 2, 2016	January 3, 2015	December 28, 2013	December 29, 2012	December 31, 2011
Operating Data:					
Retail sales - Carter's	$1,151,268	$1,087,165	$954,160	$818,909	$671,590
Wholesale sales - Carter's	1,107,706	1,081,888	1,035,420	981,445	939,115
Retail sales - OshKosh	363,087	335,140	289,311	283,343	280,900
Wholesale sales - OshKosh	65,607	73,201	74,564	79,752	81,888
International	326,211	316,474	285,256	218,285	136,241
Total net sales	$3,013,879	$2,893,868	$2,638,711	$2,381,734	$2,109,734
Cost of goods sold	$1,755,855	$1,709,428	$1,543,332	$1,443,786	$1,417,456
Gross profit (a)	$1,258,024	$1,184,440	$1,095,379	$937,948	$692,278
Operating income (b)	$392,857	$333,345	$264,151	$261,986	$187,466
Income before income taxes	$368,188	$302,906	$249,465	$255,391	$180,888
Net income	$237,822	$194,670	$160,407	$161,150	$114,016
Per Common Share Data:					
Basic net income	$4.55	$3.65	$2.78	$2.73	$1.96
Diluted net income	$4.50	$3.62	$2.75	$2.69	$1.94
Balance Sheet Data:					
Working capital (c)	$868,747	$793,487	$701,242	$713,468	$629,394
Total assets	$2,009,113	$1,893,096	$1,812,484	$1,630,109	$1,402,709
Total debt	$584,431	$586,000	$586,000	$186,000	$236,000
Stockholders' equity	$875,051	$786,684	$700,731	$985,479	$805,709
Cash Flow Data:					
Net cash provided by operating activities	$307,987	$282,397	$209,696	$278,619	$81,074
Net cash (used in) investing activities	$(103,425)	$(104,732)	$(220,532)	$(83,392)	$(106,692)
Net cash (used in) provided by financing activities	$(162,005)	$(122,438)	$(84,658)	$(46,317)	$11,505
Other Data:					
Capital expenditures	$103,497	$103,453	$182,525	$83,398	$45,495
Dividend declared and paid per common share	$0.88	$0.76	$0.48	$—	$—

NOTES TO SELECTED FINANCIAL DATA

(a) Gross profit in fiscal 2011 includes $6.7 million in additional expenses related to the amortization of the fair value step-up of inventory acquired as a result of the acquisition of our former licensee, Bonnie Togs, in 2011.

(b) The following selling, general, & administrative expenses were included in the calculation of operating income:

	For the fiscal years ended				
(dollars in thousands)	January 2, 2016	January 3, 2015	December 28, 2013	December 29, 2012	December 31, 2011
Amortization of H.W. Carter and Sons tradenames	$6,239	$16,437	$13,588	$—	$—
Workforce reduction, facility write-down, and closure costs	$—	$9,126	$38,214	$9,490	—
Accretion and adjustment of contingent consideration	$1,886	$1,348	$2,825	$3,589	2,484
Acquisition-related charges	$—	$—	$—	$—	3,050

(c) Represents total current assets less total current liabilities.

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following is a discussion of our results of operations and current financial condition. You should read this discussion in conjunction with our consolidated historical financial statements and notes included elsewhere in this Annual Report on Form 10-K. Our discussion of our results of operations and financial condition includes various forward-looking statements about our markets, the demand for our products and services, and our future results. We based these statements on assumptions that we consider reasonable. Actual results may differ materially from those suggested by our forward-looking statements for various reasons including those discussed in the "Risk Factors" in Item 1A of this Annual Report on Form 10-K. Those risk factors expressly qualify all subsequent oral and written forward-looking statements attributable to us or persons acting on our behalf. Except for any ongoing obligations to disclose material information as required by the federal securities laws, we do not have any intention or obligation to update forward-looking statements after we file this Annual Report on Form 10-K.

Fiscal Year

Our fiscal year ends on the Saturday, in December or January nearest the last day of December, resulting in an additional week of results every five or six years. Fiscal 2015, which ended on January 2, 2016, contained 52 weeks. Fiscal 2014, which ended on January 3, 2015, contained 53 weeks. Fiscal 2013, which ended on December 28, 2013, contained 52 weeks.

The 53rd week in fiscal 2014 contributed approximately $44.1 million of incremental consolidated revenue. Certain expenses increased in relationship to the additional revenue from the 53rd week, while other expenses, such as fixed costs and expenses incurred on a calendar-month basis, did not increase. The consolidated gross margin for the incremental revenue was comparable to our consolidated gross margin for all of fiscal 2014.

Our Business

We are the largest branded marketer in the U.S. and Canada of apparel exclusively for babies and young children. We own two of the most highly recognized and most trusted brand names in the children's apparel industry, Carter's and OshKosh B'gosh ("OshKosh"). Established in 1865, our Carter's brand is recognized and trusted by consumers for high-quality apparel for children sizes newborn to eight. Established in 1895, OshKosh is a well-known brand, trusted by consumers for apparel for children sizes newborn to 12, with a focus on playclothes for toddlers and young children. Given each brand's product category emphasis and brand aesthetic, we believe the brands provide a complementary product offering. We have extensive experience in the young children's apparel market and focus on delivering products that satisfy our consumers' needs. Our strategy is to market high-quality, essential core products at prices that deliver an attractive value proposition for consumers.

In the U.S., our brands compete in the $20.5 billion children's apparel market, for children ages zero to seven. In 2015, our Carter's brand was the largest brand with a 14.6% market share and our OshKosh brand had a 2.3% market share. We offer multiple product categories, including baby, sleepwear, playclothes, and related accessories. Our distribution strategy enables us to reach a broad range of consumers across various channels, socio-economic groups, and geographic regions.

We distribute our products through multiple channels of distribution in the U.S. children's apparel market, which, as of January 2, 2016, includes approximately 17,400 wholesale locations (including department stores, national chain stores, specialty stores, and discount retailers), 982 Company-operated stores, and our websites. As of January 2, 2016, we operated 594 Carter's and 241 OshKosh stores in the U.S. As of January 2, 2016, our products were sold through 147 Company-operated stores in Canada in addition to our international wholesale, licensing, and online channels.

We operate "side-by-side" locations wherein adjacent retail stores for our Carter's and OshKosh brands are connected, allowing customers to shop for both brands in a single location. Each "side-by-side" location is counted as one Carter's retail store and one OshKosh retail store. As of January 2, 2016, the U.S. store count data presented in the preceding paragraph includes 97 such "side-by-side" locations for both Carter's and OshKosh.

Segments

The five segments we use to manage and evaluate our performance are: Carter's Retail, Carter's Wholesale, OshKosh Retail, OshKosh Wholesale, and International. These segments are our operating and reportable segments.

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (Continued)

RESULTS OF OPERATIONS

The following table sets forth, for the periods indicated, (i) selected statement of operations data expressed as a percentage of consolidated net sales and (ii) the number of retail stores open at the end of fiscal year:

	For the fiscal years ended		
	January 2, 2016 (52 weeks)	January 3, 2015 (53 weeks)	December 28, 2013 (52 weeks)
Net sales			
Carter’s Retail	38.2%	37.6%	36.2%
Carter’s Wholesale	36.8%	37.4%	39.2%
Total Carter’s (U.S.)	75.0%	75.0%	75.4%
OshKosh Retail	12.0%	11.6%	11.0%
OshKosh Wholesale	2.2%	2.5%	2.8%
Total OshKosh (U.S.)	14.2%	14.1%	13.8%
International	10.8%	10.9%	10.8%
Consolidated net sales	100.0%	100.0%	100.0%
Cost of goods sold	58.3%	59.1%	58.5%
Gross profit	41.7%	40.9%	41.5%
Selling, general, and administrative expenses	30.2%	30.8%	32.9%
Royalty income	(1.5)%	(1.4)%	(1.4)%
Operating income	13.0%	11.5%	10.0%
Interest expense	0.9%	1.0%	0.5%
Interest income	n/m	n/m	n/m
Other (income) expense, net	(0.1)%	0.1%	n/m
Income before income taxes	12.2%	10.4%	9.5%
Provision for income taxes	4.3%	3.7%	3.4%
Net income	7.9%	6.7%	6.1%
Number of retail stores at end of fiscal year:			
Carter’s - U.S.	594	531	476
OshKosh - U.S.	241	200	181
International	147	124	117
Total	982	855	774

n/m - rounds to less than 0.1%, therefore not material.

Note: Results may not be additive due to rounding.

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (Continued)

STORE COUNT DATA

		Carter's Retail	OshKosh Retail	Canada	Total
Fiscal 2014:	Openings	61	27	23	111
	Closings	6	8	1	15
Fiscal 2015:	Openings	67	47	23	137
	Closings	4	6	—	10
Projections for fiscal 2016:	Openings	60	52	19	131
	Closings	4	5	1	10

Most all of the OshKosh retail store openings included in the above table are in a "side-by-side" format with a Carter's retail store.

COMPARABLE SALES METRICS

Our comparable store sales metrics include sales for all stores and eCommerce websites that were open during the comparable fiscal period, including remodeled stores and certain relocated stores. A store becomes comparable following 13 consecutive full fiscal months of operations. If a store relocates within the same center with no business interruption or material change in square footage, the sales of such store will continue to be included in the comparable store metrics. If a store relocates to another center, or there is a material change in square footage, such store is treated as a new store. Stores that are closed during the relevant fiscal period are included in the comparable store sales metrics up to the last full fiscal month of operations.

Our fiscal years 2015 and 2013 each contained 52 weeks, while our fiscal year 2014 contained 53 weeks. When presenting U.S. and Canada comparable retail sales, the following adjustments to sales metrics were used to align periods for comparability:

- When comparing 2015 to 2014, comparable 52-week periods were used; and
- When comparing 2014 to 2013, comparable 53-week periods were used.

However, in all other discussion and analysis related to fiscal years 2015, 2014, and 2013, the net sales amounts are based on the same fiscal-year periods used to prepare the consolidated financial statements.

The method of calculating sales metrics varies across the retail industry. As a result, our method of calculating comparable sales may not be the same as that of other retailers.

FISCAL YEAR ENDED JANUARY 2, 2016 (52 WEEKS) COMPARED TO FISCAL YEAR ENDED JANUARY 3, 2015 (53 WEEKS)

U.S. COMPARABLE RETAIL SALES

The following table presents the percentage changes for our U.S. direct-to-consumer ("DTC") comparable sales:

25

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (Continued)

Increase (Decrease)	U.S. Direct-to-Consumer Comparable Sales Change from 2014 to 2015	
	Carter's Retail	OshKosh Retail
Stores	(3.1)%	(2.5)%
eCommerce	+18.9%	+24.0%
Total DTC	+1.2%	+2.4%

The decreases in Carter's Retail and OshKosh Retail comparable store sales during the 2015 period were primarily due to decreases in the number of transactions and the average price per unit.

During the 2015 period, we believe that total DTC comparable sales were negatively impacted by lower demand from international tourists shopping in our U.S. stores and eCommerce websites, likely resulting from the strength of the U.S. dollar relative to other global currencies.

The increases in eCommerce comparable sales during the 2015 period were primarily due to an increase in the number of transactions.

CONSOLIDATED NET SALES

Compared to fiscal 2014, consolidated net sales in fiscal 2015 increased $120.0 million, or 4.1%, to $3.0 billion. This improvement was primarily due to sales growth in all of our segments except OshKosh Wholesale. The 53rd week in fiscal 2014 contributed approximately $44.1 million in additional consolidated net sales in fiscal 2014. Fiscal 2015 contained 52 weeks. Changes in foreign currency exchange rates in fiscal 2015 as compared to fiscal 2014 negatively impacted consolidated net sales by approximately $35.1 million, or 1.2%.

(dollars in thousands)	For the fiscal years ended January 2, 2016 (52 weeks)	% of Total Net Sales		January 3, 2015 (53 weeks)	% of Total Net Sales	
Net sales:						
Carter’s Retail	$1,151,268	38.2	%	$1,087,165	37.6	%
Carter’s Wholesale	1,107,706	36.8	%	1,081,888	37.4	%
Total Carter’s (U.S.)	2,258,974	75.0	%	2,169,053	75.0	%
OshKosh Retail	363,087	12.0	%	335,140	11.6	%
OshKosh Wholesale	65,607	2.2	%	73,201	2.5	%
Total OshKosh (U.S.)	428,694	14.2	%	408,341	14.1	%
International	326,211	10.8	%	316,474	10.9	%
Total net sales	$3,013,879	100.0	%	$2,893,868	100.0	%

CARTER’S RETAIL SALES (U.S.)

Carter’s Retail net sales increased $64.1 million, or 5.9%, in fiscal 2015 to $1.2 billion. The change in fiscal 2015 was primarily driven by an/a:

- Increase of $68.9 million from new store openings;
- Increase of $38.5 million in eCommerce sales;
- Decrease of $25.9 million in comparable store sales; and
- Decrease of $4.0 million due to the impact of store closings.

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (Continued)

The 53rd week of fiscal 2014 contributed additional net sales of approximately $13.7 million to fiscal 2014.

CARTER’S WHOLESALE SALES (U.S.)

Carter’s Wholesale net sales increased $25.8 million, or 2.4%, in fiscal 2015 to $1.1 billion. Compared to fiscal 2014, the 2015 growth reflected a 1.5% increase in average price per unit and a 0.9% increase in units shipped, primarily driven by increased seasonal product demand, a new playwear initiative, and favorable replenishment trends. The 53rd week of fiscal 2014 contributed approximately $19.4 million in additional net sales to fiscal 2014.

OSHKOSH RETAIL SALES (U.S.)

OshKosh Retail net sales increased $27.9 million, or 8.3%, in fiscal 2015 to $363.1 million. The growth in net sales in fiscal 2015 was primarily driven by an/a:

- Increase of $30.9 million from new store openings;
- Increase of $14.2 million in eCommerce sales;
- Decrease of $6.5 million in comparable store sales; and
- Decrease of $6.0 million due to the impact of store closings.

The 53rd week of fiscal 2014 contributed additional net sales of approximately $4.8 million to fiscal 2014.

OSHKOSH WHOLESALE SALES (U.S.)

OshKosh Wholesale net sales decreased $7.6 million, or 10.4%, in fiscal 2015 to $65.6 million. Compared to fiscal 2014, this decrease reflected a 15.8% decline in units shipped, partially offset by a 5.4% increase in the average price per unit, primarily driven by lower seasonal bookings and a decline in sales to the off-price channel. The 53rd week of fiscal 2014 contributed additional net sales of approximately $1.9 million to fiscal 2014.

INTERNATIONAL SALES

Net sales in our International segment include our Canada operations, wholesale sales to our international licensees, China eCommerce and other international eCommerce sales.

International net sales increased $9.7 million, or 3.1%, in fiscal 2015 to $326.2 million. Changes in foreign currency exchange rates in fiscal 2015 as compared to fiscal 2014, primarily between the U.S. dollar and the Canadian dollar, negatively impacted the International segment net sales by approximately $35.1 million, or 11.1%.

This overall increase in sales for fiscal 2015 primarily reflected an/a:

- Increase of $9.6 million from international wholesale locations, excluding Canada;
- Increase of $7.2 million from eCommerce driven primarily by our Canadian website;
- Increase of $6.9 million from our Canadian retail stores;
- Increase of $5.9 million from eCommerce primarily due to the 2015 launch of our website in China;
- Decrease of $15.0 million in our wholesale business primarily due to the Target Canada bankruptcy that occurred in early 2015; and
- Decrease of $4.4 million related to the exit of retail operations in Japan during the first quarter of fiscal 2014.

The changes noted above include approximately $4.3 million of additional net sales that occurred in the 53rd week of fiscal 2014.

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (Continued)

Comparable store sales, which were measured based on aligned years as previously discussed, in Canada increased 6.4% during the 2015 compared to 2014. Because 2014 did not contain a full year of sales from our Canadian eCommerce website, comparable eCommerce metrics are not presented for 2015.

GROSS PROFIT AND GROSS MARGIN

Our consolidated gross profit increased $73.6 million, or 6.2%, to $1.3 billion in fiscal 2015, primarily due to increased sales. Consolidated gross margin increased from 40.9% in fiscal 2014 to 41.7% in fiscal 2015. The increase was primarily attributable to margin improvements in our domestic wholesale and international segments.

We include distribution costs in selling, general, and administrative ("SG&A") expenses. Accordingly, our gross profit and gross margin may not be comparable to other entities that include such distribution costs in their cost of goods sold.

SELLING, GENERAL, AND ADMINISTRATIVE ("SG&A") EXPENSES

Consolidated SG&A expenses in fiscal 2015 increased $19.0 million, or 2.1%, to $909.2 million. As a percentage of consolidated net sales, consolidated SG&A expenses decreased from 30.8% in fiscal 2014 to 30.2% in fiscal 2015.

The decrease in SG&A expenses, as a percentage of net sales, in fiscal 2015 primarily reflected a:
- $10.2 million decrease in amortization expense for the H.W. Carter & Sons trademarks;
- $6.7 million decrease in provisions for doubtful receivables;
- $6.6 million decrease in expenses associated with office consolidations occurring in prior periods;
- $6.5 million decrease in expenses for legal and consulting services;
- $6.3 million decrease in fulfillment and distribution expenses;
- $4.0 million decrease in expenses related to our exit from Japan retail operations in the first quarter of fiscal 2014; and
- $2.0 million decrease in incentive compensation expenses;

which were partially offset by a:
- $29.8 million increase in expenses related to retail store operations, primarily due to new stores;
- $10.5 million increase in expenses related to marketing and brand management;
- $6.3 million increase in insurance and other benefits primarily due to higher health insurance costs; and
- $1.8 million increase in the Company's match of 401(k) contributions due to higher employee participation.

ROYALTY INCOME

We license the use of our Carter’s, Just One You, Child of Mine, OshKosh B’gosh, OshKosh, Genuine Kids from OshKosh, and Precious Firsts brand names. Royalty income from these brands increased $4.9 million, or 12.5%, to $44.1 million in fiscal 2015. The increase in fiscal 2015 primarily reflected growth in both our domestic Carter's and OshKosh licensing revenues, along with the timing of favorable settlements with our licensees in the first half of fiscal 2015.

OPERATING INCOME

Compared to fiscal 2014, consolidated operating income for fiscal 2015 increased $59.5 million, or 17.9%, to $392.9 million. Consolidated operating margin increased from 11.5% in fiscal 2014 to 13.0% in fiscal 2015. The table below summarizes the changes in each of our segments' operating results and unallocated corporate expenses during fiscal 2015:

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (Continued)

(dollars in thousands)	Carter's Wholesale	Carter's Retail	OshKosh Wholesale	OshKosh Retail	International	Unallocated Corporate Expenses	Total
Operating income (loss) for fiscal 2014	$185,463	$211,297	$8,842	$8,210	$39,470	$(119,937)	$333,345
Increase (decrease) in:							
Gross profit	32,872	20,214	2,114	12,073	7,974	(1,663)	73,584
Royalty income	1,832	1,627	1,438	969	(956)	—	4,910
SG&A expenses	(12,330)	34,098	(876)	9,321	(516)	(10,715)	18,982
Operating income (loss) for fiscal 2015	$232,497	$199,040	$13,270	$11,931	$47,004	$(110,885)	$392,857

The following table summarizes the operating margin for each of our five operating segments in fiscal 2014 and fiscal 2015, as well as the primary drivers of the change in operating margin between those two periods. Each driver is presented in terms of the difference in that driver's margin (based on net sales) between fiscal 2014 and fiscal 2015, in each case expressed in basis points ("bps").

	Carter's Retail	Carter's Wholesale	OshKosh Retail	OshKosh Wholesale	International
Operating margin for fiscal 2014	19.4 %	17.1 %	2.4 %	12.1 %	12.5 %
Favorable (unfavorable) bps changes in fiscal 2015:					
Gross profit	(130) bps	240 bps	(40) bps	540 bps	110 bps
Royalty income	10 bps	10 bps	20 bps	350 bps	(40) bps
SG&A expenses	(90) bps	140 bps	110 bps	(80) bps	120 bps
Operating margin for fiscal 2015	17.3 %	21.0 %	3.3 %	20.2 %	14.4 %
	(a)	(b)	(c)	(d)	(e)

(a) Carter's Retail operating income in fiscal 2015 decreased $12.3 million, or 5.8%, from fiscal 2014 to $199.0 million. The segment's operating margin decreased 210 bps from 19.4% in fiscal 2014 to 17.3% in fiscal 2015. The primary drivers of the change in the operating margin were a:

- 130 bps decrease in gross profit primarily due to lower average price per unit; and
- 90 bps increase in SG&A expenses mainly due to a:
  - 60 bps increase in marketing expenses; and
  - 50 bps increase in expenses associated with new stores.

(b) Carter's Wholesale operating income in fiscal 2015 increased $47.0 million, or 25.4%, from fiscal 2014 to $232.5 million. The segment's operating margin increased 390 bps from 17.1% in fiscal 2014 to 21.0% in fiscal 2015. The primary drivers of the change in the operating margin were a:

- 240 bps increase in gross profit primarily due to strong demand and product performance, supply chain efficiencies, favorable product costs, and higher average price per unit as a result of product mix; and
- 140 bps decrease in SG&A expenses consisting primarily of a:

- 100 bps decrease in distribution and other expenses driven by efficiencies at our Braselton, Georgia distribution center; and
- 20 bps decrease related to provisions for accounts receivable.

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (Continued)

(c) OshKosh Retail operating income in fiscal 2015 increased $3.7 million, or 45.3%, from fiscal 2014 to $11.9 million. The segment's operating margin increased 90 bps from 2.4% in fiscal 2014 to 3.3% in fiscal 2015. The primary drivers of the change in the operating margin were a:

- 110 bps decrease in SG&A expenses primarily due to a:
  - 70 bps decrease in retail administration expenses;
- 60 bps decrease in fulfillment and distribution expenses; and
- 40 bps increase in marketing expenses;
- 20 bps increase in royalty income from our licensees; and
- 40 bps decrease in gross profit due to lower average price per unit.

(d) OshKosh Wholesale operating income in fiscal 2015 increased $4.4 million, or 50.1%, from fiscal 2014 to $13.3 million. The segment's operating margin increased 810 bps from 12.1% in fiscal 2014 to 20.2% in fiscal 2015. The primary drivers of the change in the operating margin were a:

- 540 bps increase in gross profit primarily due to favorable product costs and a higher average price per unit as a result of product mix;
- 350 bps increase in royalty income primarily due to sales growth from our licensees; and
- 80 bps increase in SG&A expenses primarily due to a:
- 190 bps increase in customer service expenses; and
- 80 bps decrease in distribution and freight expenses.

(e) International operating income in fiscal 2015 increased $7.5 million, or 19.1%, from fiscal 2014 to $47.0 million. This segment's operating margin increased 190 bps from 12.5% in fiscal 2014 to 14.4% in fiscal 2015. The primary drivers of the change in the operating margin were a:

- 110 bps increase in gross profit driven primarily by growth in our eCommerce channel;
- 40 bps decrease in royalty income; and
- 120 bps decrease in SG&A expenses consisting mainly of a:

210 bps decrease due to the exit of retail operations in Japan in the first quarter of fiscal 2014;
60 bps decrease in customer service expenses;
40 bps decrease related to provisions for accounts receivable;
90 bps increase in retail expenses associated with new stores in Canada;
60 bps increase in marketing expenses; and
60 bps increase in distribution and freight expenses.

Unallocated corporate expenses decreased by $9.1 million, from $119.9 million in fiscal 2014 to $110.9 million in fiscal 2015. Unallocated corporate expenses as a percentage of consolidated net sales decreased from 4.1% in fiscal 2014 to 3.7% in fiscal 2015. The decrease primarily reflected a/an:

- Decrease of $10.2 million in amortization expense for the H.W. Carter & Sons tradenames;
- Decrease of $6.6 million in expenses related to office consolidations that occurred in prior periods;
- Decrease of $4.0 million in administrative and legal expenses;

30

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (Continued)

- Increase of $8.0 million in insurance and other benefits, primarily driven by higher employee health insurance costs and higher 401-K match expense due to higher employee participation; and
- Increase of $4.2 million in expenses related to information technology.

INTEREST EXPENSE

Interest expense and effective interest rate calculations include the amortization of debt issuance costs.

Interest expense in fiscal 2015 decreased $0.6 million from fiscal 2014 to $27.0 million. Weighted-average borrowings for fiscal 2015 were $585.9 million at an effective interest rate of 4.59%, compared to weighted-average borrowings for fiscal 2014 of $586.0 million at an effective interest rate of 4.68%. The decrease in the effective interest rate for fiscal 2015 compared to fiscal 2014 was due primarily to a lower interest rate on the U.S. borrowings outstanding under our amended revolving credit agreement, partially offset by a higher interest rate on the new Canadian portion of the outstanding borrowings on our amended revolving credit agreement and higher debt issuance costs.

During fiscal 2015, we amended our revolving credit agreement to, among other things, achieve better pricing terms. The change in weighted-average borrowings between fiscal 2015 and fiscal 2014 was due solely to changes in foreign currency exchange rates between the U.S. and Canadian dollars.

OTHER EXPENSE, NET

Other expense (income), net is comprised primarily of net gains and losses on foreign currency transactions and foreign currency contracts. The amounts related to foreign currency represented a gain of $1.8 million for fiscal 2015 and a loss of $3.2 million for fiscal 2014.

As part of our overall strategy to manage the level of exposure to the risk of foreign currency exchange rate fluctuations, primarily between the U.S. dollar and Canadian dollar, in fiscal 2015 our Canadian subsidiary began using foreign currency forward contracts to hedge currency exposure on purchases that are made in U.S. dollars, primarily for inventory.

INCOME TAXES

Our consolidated effective tax rates for fiscal 2015 and 2014 were 35.4% and 35.7%, respectively.

NET INCOME

Our consolidated net income for fiscal 2015 increased $43.2 million, or 22.2%, to $237.8 million as compared to $194.7 million in fiscal 2014, due to the factors previously discussed.

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (Continued)

FISCAL YEAR ENDED JANUARY 3, 2015 (53 WEEKS) COMPARED TO FISCAL YEAR ENDED DECEMBER 28, 2013 (52 WEEKS)

U.S. COMPARABLE RETAIL SALES

The following table presents the percentage changes for our U.S. DTC comparable sales which were measured based on aligned years as previously discussed:

Increase (Decrease)	U.S. Direct-to-Consumer Comparable Sales Change from 2013 to 2014	
	Carter's Retail	OshKosh Retail
Stores	(1.0)%	+3.3%
eCommerce	+26.1%	+27.4%
Total DTC	+3.7%	+7.3%

The increases in eCommerce comparable sales during the 2014 period were primarily due to an increase in the number of transactions.

CONSOLIDATED NET SALES

Compared to fiscal 2013, consolidated net sales in fiscal 2014 increased $255.2 million, or 9.7%, to 2.9 billion. The growth primarily reflected strength in both our Carter's segments and in our OshKosh Retail segment. The 53rd week in fiscal 2014 contributed approximately $44.1 million in additional consolidated net sales. Changes in foreign currency exchange rates in fiscal 2014 as compared to fiscal 2013 negatively impacted consolidated net sales by approximately $16.0 million, or 0.6%.

(dollars in thousands)	For the fiscal years ended January 3, 2015 (53 weeks)	% of Total Net Sales		December 28, 2013 (52 weeks)	% of Total Net Sales	
Net sales:						
Carter’s Retail	$1,087,165	37.6	%	$954,160	36.2	%
Carter’s Wholesale	1,081,888	37.4	%	1,035,420	39.2	%
Total Carter’s	2,169,053	75.0	%	1,989,580	75.4	%
OshKosh Retail	335,140	11.6	%	289,311	11.0	%
OshKosh Wholesale	73,201	2.5	%	74,564	2.8	%
Total OshKosh	408,341	14.1	%	363,875	13.8	%
International	316,474	10.9	%	285,256	10.8	%
Total net sales	$2,893,868	100.0	%	$2,638,711	100.0	%

CARTER’S RETAIL SALES

Carter’s Retail net sales increased $133.0 million, or 13.9%, in fiscal 2014 to $1.1 billion. The increase in fiscal 2014 was primarily driven by an/a:

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (Continued)

- Increase of $87.7 million from new store openings;
- Increase of $43.2 million in eCommerce sales;
- Decrease of $9.0 million in comparable store s