

## COMPANY NOTE

Estimate Change

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# Jefferies

EQUITY RESEARCH AMERICAS

## Presbia (LENS) Call with Dr. Kerry Assil on Presbia's Microlens; Takeaways and Transcript

### Key Takeaway

**We hosted a call on May 10 with California-based ophthalmologist, Dr. Kerry Assil to discuss presbyopia and new technologies to treat it. Dr. Assil offered a strong endorsement for Presbia's (LENS) Microlens technology, which is currently being launched in select international markets and is on track for 2018 FDA approval. We have included a few key takeaways from the call below and a full transcript is attached.**

**A big, big market.** Nearly everyone over 40 develops presbyopia and while not everyone will seek a surgical treatment, there are many that are looking for a solution other than reading glasses. In Dr. Assil's opinion, the Microlens from Presbia offers the best balance of good outcomes, minimal invasiveness, and upgradability of available treatments for the condition. Dr. Assil also noted that individuals who have already had LASIK to correct distance vision may be the most interested and positively-impacted: "we consider those to be some of the best candidates for the procedure because they've already identified themselves as people [who] don't [want] to wear glasses." More than 50mn people have had LASIK globally, making the market for Presbia significant by any measure.

**The procedure is relatively easy.** On a scale from 1 to 10, Dr. Assil ascribed a "two or three" to the Presbia Microlens procedure, vs. a 7 for cataracts. Beyond being easy, the Microlens is also attractive as it requires the same device, a femtosecond laser, as LASIK surgery. The lens can also be easily replaced so that as patients accommodative power continues to change, the lens can be upgraded; a cycle that could give patients 5-10 years or more before lens changes are needed.

**The Microlens is unique.** Issues seen with competing technologies, such as glares and halos, are not seen to the same degree with the Microlens. The fundamental technology, an implanted refractive lens, is wholly different and as the lens only covers a small portion of one pupil, the Microlens does not create the same visual aberrations as other devices. Patients readily adapt to the lens and in nearly all cases to date, near vision is fully restored with minimal or no loss in distance vision or adverse events.

A replay of the call will be available until May 24, 2016. REPLAY: (855) 859-2056 or (404) 537-3406 for international callers. Conference ID: 7174477.

### Valuation/Risks

Our \$11 target is 5.0x 2020E sales risk adjusted 50%, & discounted 2 years. Risks include slower adoption, clinical data, and competition.

USD	Prev.	2015A	Prev.	2016E	Prev.	2017E	Prev.	2018E
Rev. (MM)	--	0.2	1.0	0.8	4.4	3.8	12.6	11.6
EV/Rev		NM		51.2x		10.8x		3.5x
<b>EPS</b>								
Mar	--	(0.39)	--	(0.28)A	--	--	--	--
Jun	--	(0.40)	(0.29)	(0.27)	--	--	--	--
Sep	--	(0.37)	(0.28)	(0.26)	--	--	--	--
Dec	--	(0.26)	(0.28)	(0.26)	--	--	--	--
FY Dec	--	(1.41)	(1.13)	(1.08)	(0.72)	(0.70)	(0.37)	(0.38)
FY P/E		NM		NM		NM		NM

**BUY**

Price target \$11.00

Price \$4.48

### Financial Summary

Book Value (MM):	\$20.8
Book Value/Share:	\$1.56
Net Debt (MM):	(\$18.6)
Long-Term Debt (MM):	\$0.0
Cash & ST Invest. (MM):	\$18.6

### Market Data

52 Week Range:	\$9.38 - \$2.94
Total Entprs. Value (MM):	\$41.0
Market Cap. (MM):	\$59.6
Insider Ownership:	73.0%
Institutional Ownership:	27.0%
Shares Out. (MM):	13.3
Float (MM):	3.7
Avg. Daily Vol.:	9,130

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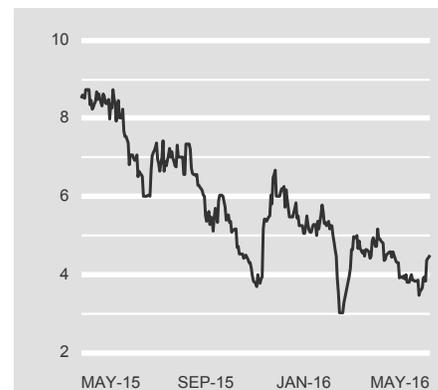
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### Price Performance



**JEFFERIES LLC****Moderator: Raj Denhoy**  
**May 10, 2106**  
**4:15 p.m. ET**

Operator: Good afternoon my name is (Amanda) and I'll be your conference operator today. At this time I'd like to welcome everyone to the physician's conference call.

All lines have been placed on mute to prevent any background noise. After the speaker's remarks there will be a question-and-answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you like to withdraw your question press the pound key.

Thank you. Mr. Raj Denhoy, please go ahead.

Raj Denhoy: Thanks, Amanda. Again, it's Raj Denhoy with Jeffries. We will have a couple of minutes for Q&A at the end but if anybody has any questions, you can e-mail me and I can ask them. We're hoping to keep the call to about 30 or so minutes.

The broad topic of the conversation is about presbyopia treating technologies and in particular corneal inlay technologies. We do have Dr. Kerry Assil, who's an ophthalmologist and refractive surgeon from Southern California with a lot of experience with these technologies. We are hoping to have really a broad discussion for about 30 minutes or so about the different offerings and progress of these.

And so with that as a very brief introduction, Dr. Assil, maybe you could spend a minute about your practice, what you spend your time on and then we can get a bit into the different technologies.

Dr. Kerry Assil: Certainly, thank you Raj. My name is Kerry Assil. I've been practicing refractive surgery for about 25 years now a little bit longer and that, I hate to admit. My – core of my practice nowadays is a private practice in Beverly Hills, California, in Santa Monica, California and I've treated – performed more than 50,000 procedures of various types of refractive surgery, ranging from corneal inlays to LASIK to intra ocular procedures known as Phakic IOLs and cataract and the refractive lens exchange.

And I have been involved with the corneal inlay space for almost now I guess since 1991 when I started working with this product that was eventually referred to as Intacs. And with the Presbia and Kamra technologies each for a well over 10 years.

Raj Denhoy: OK. That's helpful. And just for full disclosure as well, perhaps you could tell us about your relationship with Presbia, which is the company we want to speak about mostly on this call but my understanding is you are on their medical advisory board and have some experience there so just – if you could tell us that'd be helpful.

Dr. Kerry Assil: Yes. I do serve on their medical advisory board. And as such I have an equity position in the company.

Raj Denhoy: OK. Helpful. So maybe just starting at the beginning, could you describe for us the need for these types of technologies the need amongst patients for surgical or implantable technologies for treating presbyopia. You know how big the market is for patient asking for this kind of technologies -- to get us grounded.

Dr. Kerry Assil: Well, recognizing that presbyopia which is a stiffening of the zooming mechanism of the eye affects everybody starting in their late 30s or early 40s and takes its full course in most people by our late 40s or early 50s. It's clear that if this were considered a medical indication, it would be the largest medical space in the world with billions of people on the planet that would be

candidates for treatment. Not every person who is bothered with the difficulty in reading is bothered by it to the same degree and not at one who's bothered by it – who's bothered to the point of wanting to have something done surgical about it, not wanting to wear reading glasses.

But certainly we find it's one the most common conversations even outside of my medical practice. It's the most common thing that I get cornered about at cocktail parties and so forth by folks who want to pull me aside and tell me that all their life they've seen wonderfully and all of a sudden now their vision is terrible.

And I say to them why and my – “I guess you're vision is probably not terrible. What you mean is you're really having a hard time seeing up close and reading.” And they say, “Yes, yes. Exactly.” And so it is something that bothers people.

Historically, everybody grew up thinking that there was no other alternative so they expected it and their mother and their grandparents told them that something they would need reading glasses and that's what they expected. And now as – you know ever since the age of LASIK and alternative surgical procedures starting to come available before – becoming more curious and questioning more what their options might look like.

**Raj Denhoy:** So within that context what are the options for patients right now? So you mentioned reading glasses but what else do patients do to treat this?

**Dr. Kerry Assil:** Certainly. So reading glasses go back to over a thousand years. Actually, a guy named (Itnel Hassen) in the Eastern world came up with the first magnifiers. So that's over thousand-year-old technology that we're all familiar with.

Other than that, if people wish not to wear reading glasses one option is to wear contact lens and only one eye that's referred to as monovision. Another option is to have LASIKs in only one eye that's known as monovision LASIK. Yet other options are to wear what are known as multifocal contact lenses in both eyes so that the vision is split between near and distance.

And even more aggressive options would be to do procedure similar to cataract surgery which we do on occasion but typically for people who have significant other things going on with their eyes, either frankly a cataract or early – or pre-cataract in other words, the loss of transparency of their natural lens or their prescriptions are quite high and we don't feel that LASIK is really a appropriate choice for them and so we'll place the internal lens for 90 plus percent of people who walk around complaining about their reading vision.

Those are folks who see well at distance and their only problem is up close, and that's where the inlays become quite attractive and the competition for the inlays being a contact lens in just one eye called monovision contacts.

Some people do well with monovision contacts. A lot of people can do quite well with monovision contacts. A lot of folks don't like to mess with the contact lens. Others become intolerant of the contact lenses over time because we blink 3 million times a year and every time we blink the eyelid rubs against that contact and especially people who aren't used to wearing contacts most of their life to start to gain comfort with wearing contacts at later in life can be a little more problematic. But even those who wore them all their life find that there's only a certain number of years that you can wear contact lens before your eyes start to become resistant because of this chasing mechanism of the eyelids rubbing on the contacts (calling) overtime.

So eventually, lots and lots of folks become candidates for this particular procedure or the corneal inlay procedures where we have the option of implanting a material, if you will, in their cornea. In the case of Presbia, you can think of it as literally implanting the contact lens inside the cornea and that contact lens is only by volume about 1 percent the size of a traditional contact lens, except that we're able to place at precisely in the location that we want at the time of surgery so it does the job nicely.

Yes. Doing the job nicely meaning that when the patient is reading and their pupil constricts, which is what happens when we read or when we see things up close. The pupil, which is the aperture – the f-stop of our eye – gets

smaller. Then the light that they see goes through this inlay and they have excellent near vision.

And for them to become seamless because they're not aware it's there. You can't see it. You can't touch it. You can't really alter in any way. You don't have to use any eye drops after the initial healing phases done with so you're not chronically wetting your eyes like you would if you're wearing contact lenses, your wetting solutions or all those things. And so patients find this to be an extremely attractive option.

**Raj Denhoy:** So a couple questions, do patients have to have their distance vision preserved in order to get this? Or can a patient continue to wear contacts or glasses for distance vision and still get a – the Presbia implant?

**Dr. Kerry Assil:** Good question. They could. You know the kind of person who wants to be free of glasses wants to be free of glasses. But what's unique about the Presbia inlay is that it uses the traditional principles of optics that we're already familiar with. And it's no different than putting an eyeglass or contact lens over the eye but the only exception is it's putting in such a manner that it preferentially works when you're trying to read.

And so you could if – let's say you wear coke bottle glasses and you're extraordinarily nearsighted and you're phobic about wearing contact lenses so you stuck with these coke bottle glasses but you have not gotten to the age where the zooming mechanism in your eye has started to give out and you're frustrated because bifocals in these coke bottle glasses don't work so well. They cause an even greater distortions. You could in that scenario continue where your same glasses but have the Presbia inlay so that with your glasses on, you see just fine at distance. When you go to read the inlay takes effect and you see just fine up close.

**Raj Denhoy:** Right. So what...

(Multiple Speakers)

**Dr. Kerry Assil:** ...with contacts.

Raj Denhoy: Right. So what about patients who have had LASIK for distance vision. Is that a...

(Multiple Speakers)

Dr. Kerry Assil: We consider those to be – we consider those to be some of the best candidates for the procedure because they've already identified themselves as people don't have to wear glasses. And when they got their LASIK, they went through their liberation period. And now they're extremely frustrated that they've hit it – hit the wall and the inlay could be put into just one eye in their case into what we call their non dominant eye which means that the eye of the brain doesn't pay as much attention to when you look at things far away ironically it tends to pay more attention to that eye in most people when they're looking up close.

And so therefore, the inlay could be put into that post-LASIK eye. And now they get that liberation that they had experienced previously all over again. Now they don't need glasses still for distance and can see well up close. And in fact, we believe that that will be one of the largest target populations for the product when it's well post-FDA approval on and all those other things.

Raj Denhoy: OK. I realized we sort of jumped into this without really talking much about the procedure itself. But as you mentioned, it is only implanted in one eye and so patients have to undergo this neural adaptation. You know they have to get adjusted to having this sort of monovision effect. How tolerant are patients of that? And do you find that there are patients that cannot tolerate it?

Dr. Kerry Assil: So, there will be some patients who can't tolerate it. But what's interesting about it the amount of neural adaptation. And neural adaptation – it sounds like it's something you're quite familiar with. I'm not sure the listeners might be.

But it has to do with the adaptation of the eye brain coordination goes through any time a new optical system is created. Neural adaptation occurs in someone who's never worn eyeglasses and has given glasses for the first time, it's fairly (seamless) because things are done symmetrically in both eyes and so they adjust very quickly.

It occurs every time we do cataract surgery on somebody. Anytime you put contact lenses on just one eye, et cetera. So there's different degrees of demand for neural adaptation, depending on what it is that you do.

Again, the amount of neural adaptation required for the Presbia inlay interestingly is significantly less than it is with monovision LASIK or with monovision contact lenses. And the reason for that is not initially intuitive but easy to explain.

When we do monovision contact lenses, we pop a contact lens on one eye for near. The other eye is for distance. Well, that means that the near eye that now has the contact lens is significantly blurred out at distance and so you've disrupted the binocular viewing mechanism of the patient, and they have to adapt to that and that's what neural adaptation is. Their brain used to suppress that blurry image from the contact lens in the one eye and continue to stay locked on their dominant eye with the image from the other eye.

Now, when we do – and they adapt to that over time. And the proof in the pudding is that there's millions and millions of people that walk around with monovision contact lenses. They're not very happy with this.

When we do monovision LASIK, more or less to the same degree slightly less disruptive than with contacts but essentially the same story where we make one eye for near and the other eye for distance and then they adjust in the same way as with contacts so that has – that's neural adaptation.

With the Presbia inlay, it's uniquely different. The inlay sits within the diameter of the average person's entrance pupil when they're reading. Meaning that when we go to read, our pupils automatically constrict. Lots of things happen to the eye when you go to read or to see up close.

But one of the most obvious and striking that can demonstrate for themselves by looking at a friend and holding out their finger in front of their friends. I bring you closer and closer asking a friend to look at it. They'll notice that that person's pupil keeps getting smaller the closer that finger comes to the face, hopefully not poking them in the eye, of course.

So when the inlay is placed in the cornea, it sits in a zone that when you go to reading your pupil constricts, the inlay dominates and therefore you have wonderful reading vision. However when that same person looks up and looks far away, their pupil expands tremendously, especially at night time. And therefore the distance vision is not so hampered in that eye because there's lots of surface area of cornea that's recruiting vision for distance in that eye. So when they look far away, they're essentially seeing close to binocular untethered at distance so they're getting the benefit of monovision at near but not the penalty of monovision at distance. And therefore the neural adaptation tends to be easier.

Now what we do tend to do to make sure that we don't have that rare finicky patient is that – finicky meaning finicky in an inability to have much plasticity with neural adaptation whatsoever is we will do a monovision contact lens trial on patients.

Typically, we're considering this. We showed them the worst-case scenario. We popped a contact lens on one eye and we blurred their distance therefore in that eye but give them good near vision. And if they are not overly bothered by that, we know we have an excellent candidate for the Presbia, even though the Presbia inlay would likely satisfy even a lot of those patients who fail the monovision contact lens trial. We use that as a screening methodology, nonetheless.

**Raj Denhoy:** And what percentage of patients find that they can't tolerate or do screen out using that test, the monovision test?

**Dr. Kerry Assil:** In the real world far less than the FDA studies, in the FDA studies you have to remember we're not allowed to treat astigmatism or other refractive errors and we're not allowed to treat the other eye in any way whatsoever.

So in FDA studies you're dependent on a guy who walks in, who has superb distance vision in both eyes and lousy near vision in both eyes, whereas in the real world you are able to – let's say my friend wanted to have the procedure done and he was wearing glasses at the moment, then I can do

LASIK on one eye and make that eye crisp for distance and do the Presbia inlay on their eye that's having difficulty at near in their contra lateral eye.

And so in the real world, the population that would fit into the inclusion would be much larger than the ones that we exclude during the FDA studies. But even during the FDA studies the super majority of people that we attempted to contact lens trial on did well and qualified for the study. Meaning, that even though we didn't do anything to help them in their other eye if their other eye wasn't seeing perfect at distance, they still felt that their distance vision overall with their two eyes are sufficiently good enough that they were enrolled into the study and they've done well with the inlays.

**Raj Denhoy:** OK. Yes, one question that I've gotten from folks or from one person in particular, you know they – when you have presbyopia, you lose that accommodative power in your eye, right? Your focal distance continues to get further and further away. And with these lenses, you correct for that by restoring a level of refractive power to the eye. But over time your focal distance will continue to deteriorate, right? Your – the accommodating power will continue to go down, which suggests that again that focal distance will continue to move out again.

So the question is how long will this last in the sense assuming that patient continue to have a deterioration of that accommodative power, how long would putting the Presbia inlay in restorative vision before they would have to do something else?

**Dr. Kerry Assil:** Excellent question. I started performing these inlays overseas more than 10 years ago and I've been amused or impressed with how forgiving the depth of focus is with the lens and how infrequently they do need to be changed.

However, two years ago I was in Columbia patient would had the inlay eight years prior, was loving life except the near had started to give out. And the exchange procedure is much simpler even than the primary procedure because all of the – 90 percent of surgery doesn't need to be repeated. All you do is find the tunnel for the initial inlay. It is a tiny (loaf in) tunnel. You go in and you are able to easily remove the previous inlay and put another one in its

place that has higher power. And the next day that patient was tickled pink and was seeing superbly again.

So we do believe that the exchanges will actually offer an opportunity because we won't be doing these exchanges every six months or every year or two but maybe every five to 10 years and only a couple of times.

Because once – you know once the zooming mechanism starts to go – goes fairly, fairly quickly so most people will probably only need – if ever a single exchange. If it's somebody who shows up in their mid-50s, they're not likely ever going to need an exchange. If it's somebody who shows up at the age of 42, you might be exchanging them again 10 years later and that would probably be the final exchange as the lens you put in at that time will be sufficiently powerful. It gives him the near they need no matter how much weaker the zoom lens in their eye gets. Because at that point, their zoom lens has very little to offer them to begin with.

Raj Denhoy: So, the idea of being that the lens will last about 10 years, is that sort of what you're telling folks that 10 years is...

(Multiple Speakers)

Dr. Kerry Assil: I think in some – I think in some people that will last forever. In others, it could last 10 years or less. And the lens itself will last forever. The clarity of their vision up close will have a time window that could be anywhere, say, from five years to permanent.

Raj Denhoy: OK.

Dr. Kerry Assil: An therefore some people will find that sometime during the course of their lifetime an exchange of the lens for higher power lens might be fortuitous and if it is it's a quite a simple procedure.

Raj Denhoy: Is the idea though that if you put in a patient let's say, 45 and then maybe you need to change at 55 because the focal distance again is – has receded because of loss (accommodation). But then at 65 if they're seeing that same effect at

that point are they getting their permanent lens replaced or getting an intraocular lens at the point?

Dr. Kerry Assil: Very good question. If they get it exchanged at 45 and again at 55, at 55 you'll be able to build sufficient power to the lens so that it will last and even when they're 65.

When – it is going to give out for them is therefore not so much when they get too much stiffening of their natural lens but when they start to lose the transparency of their natural lens, in other words, they start to develop cataracts

Raj Denhoy: Right.

Dr. Kerry Assil: And when you develop a cataract, if they loved their vision all their life – so what the cataract now is the natural lens in the eye has start to lose its transparency. It's a dirty windshield so it has no longer to do with the focusing of the eye that the camera could be great focus but it's kind of dirty lens so you have to exchange that lens. You have to remove that lens and put in a clear lens in its place.

If they love their vision all their life with their camera other than the fact that they've now lost transparency of their lens, you could do simple cataract surgery and just put in this simple monofocal lens they'll go right back to the way their eye was when they had the camera without the cataract and they'll be tickled pink.

If technologies have come along 10, 15, 20 years from now that can create superhuman vision, it's nice to know that the camera could always be removed. So I view it as a potentially permanent solution but upgradable, and I think that's a nice feature about it as well.

Raj Denhoy: So two things I want to hit on before and ask you about competing technologies. Perhaps you could describe a bit about the implant procedure itself. How difficult it is – how difficult it is to get the lens perfectly centered in the eye? How much learning there is? If you could help us with that, it'd be helpful.

Dr. Kerry Assil: Sure. You know everybody always hopes to discover the surgery that doesn't require a surgeon and we haven't solved that equation yet, whether it's LASIK or cataract surgery or inlays surgeon skill always is significant.

The surgery, if I had to rate it however on a level of complexity compared to say cataract surgery which I do for some of the other more demanding surgery such as Phakic IOLs with corneal transplantation, et cetera, if I waited, say, a cataract is being a seven out of 10 in the complexity of surgeries I do in other surgeries that are aged nines and 10s that I do, I would weigh the complexity of this as maybe a two or three.

It's fairly standardized. We use the same femtosecond laser that we normally use in LASIK surgery, except (that's) creating a large flap that has such a large circumference to that you can lift it. It's great just to make a tiny tunnel. And within that tunnel, we slip in the lens with a special carrier that delivers a lens for us and then we release it. When we initially release in the eye, it's rare for it to be already sitting in perfect position.

But because the lens itself is semi – somewhat transparent it's essentially nearly transparent. If it was completely transparent, the surgery will be tough because (we won't be able) to see the lens in the cornea. But it's essentially transparent so the same way to that contact lenses is transparent except under microscope we can see it.

We're able to continue to visualize the optics of the eye and we're able to tell to what degree it's not perfectly centered. And moving it within that little tunnel to get it perfectly centered is pretty straightforward. So we leave it perfectly centered at the end of the case and then we're done.

Raj Denhoy: And the tunnel that it's put in that just seals over time? Or you mentioned you can go back in later but is that not as...

(Multiple Speakers)

Dr. Kerry Assil: Yes. You know what? When you think about the fact that a LASIK flap seals naturally just overnight and that's an entire flap that has margin that is been cut with a laser for about 305 degrees and here you're just cutting a margin that's going to be about 40 degrees, you can quickly appreciate how healing has very little to do here has a very little influence in this circumstance.

Raj Denhoy: OK.

Dr. Kerry Assil: You're creating a surface of exposure that's – may be altogether one-tenth of what it is in LASIK.

Raj Denhoy: Got it...

(Multiple Speakers)

Dr. Kerry Assil: And of course now with worldwide more than 50 million people having had LASIK will recognize that when that procedure is done properly by a surgeon that people do beautifully well.

Raj Denhoy: OK. So speaking of sort of outcomes, right? I realized that during the clinical trials that there isn't – the (tremendous amount) you can say about that experience so far but what has been the experience you've see in patients in Europe, in Latin America, other places in terms of both patients' expectations and realization of expectation but then also any particular visual side effects of patients are having whether it's halos and glare other types of...

(Multiple Speakers)

Dr. Kerry Assil: Very good question. Very good question. So first of all that I think the six-month FDA trials have been released. I'm not sure whether it's OK or not OK that – to include those in our conversation.

(Multiple Speakers)

Raj Denhoy: Yes. Those were...

(Multiple Speakers)

Raj Denhoy: ...a couple weeks ago. So...

(Multiple Speakers)

Dr. Kerry Assil: Right.

(Multiple Speakers)

Dr. Kerry Assil: So I'll include that because what's interesting about those trials – that's the beauty of this product, its reproducibility and dependability. That data is no different than the data that we were getting and when I was doing the surgeries at Mexico. You know 12 years ago it's no different than the data that we're getting – that we got in Greece, the data that we got in other countries et cetera.

And that the reason for that is very simple. You're custom seizing the power of the lens for the individuals' needs. And so it's not surprising that we're seeing this large improvement in people's vision at near.

At six months, we were seeing about five lines of improvement which meant going from around 20/80 to close to 20/20. And what we find with the adaptation to the visual system is that we continue to get improvements. So (if the) trials continue like they did with our experience elsewhere at one year and two years, we should expect to notice even further improvement in the vision in these patients. It's not like it plateaus and then it starts to regress. They keep getting better.

Raj Denhoy: Right.

Dr. Kerry Assil: And I had refractive surgery on my own eyes 22 years ago. I can tell you as a very keen observer, I noticed subtle improvements in my vision for two entire years. Of course, 90 percent improvement had already occurred by week one. But I did notice subtle improvements and these patients will be no different.

The degree of halos and glare that they get is significantly less than some of the other inlays that we've worked with and I'm happy to get into reasons for that if you wish to but...

Raj Denhoy: You know...

(Multiple Speakers)

Dr. Kerry Assil: It's also far less – it's also far less than we see with the multifocal IOLs even the newest generation multi focal IOLs which have cut down on the halo and glare tremendously, compared to the ones that were exclusively available to us, say, as recently as two to three years ago the ones that are – happened (to be able) in the last couple years cut down on those tremendously, this has even less a halo and glare than that.

The reasons for this having such little halo and glare is again the fact that one of the settings in which you're going to notice halo and glare. So (which) you're going to notice halo and glare is at night time – when your pupil is big.

Well, this covers such a small portion of your visual system and it's transparent so it's not causing halo and glare due to diffraction of light, due to obscuration of the light rays passing through. It's always causing a little bit of halo and glare because you're getting a subset of the light rays that are defocused. They're blurred out of it. And with spatial adaptation discussion that we had at length earlier that halo and glare gets filtered out quickly just in the same way that the patient notices less issues with monovision than they do with the contact lens or with LASIK.

Raj Denhoy: Right. So the pupil is large and the lens is small so you're still going to get a lot of light coming around the outside but that part that goes through the center that goes through the Microlens is still going to be distorted but this question whether that's...

(Multiple Speakers)

Dr. Kerry Assil: It's going to be blurred more than it's going to be distorted.

(Multiple Speakers)

Dr. Kerry Assil: It's not – those light rays are not getting scattered all over the place like it can be with other types of inlays. They're just out of focus and that's a much more forgiving distortion than scatter of light.

Raj Denhoy: Right. So scatter would be more of a halo, I guess, is how that would manifest or...

Dr. Kerry Assil: Scattered? Well, it depends. It can be glare, it can be halo. Scatter for multi-focal lenses that have the concentric diffractive optics is multi-circumferential halos.

But again just to put in perspective for you, for example, AMO released its 275 Ab lens in the United States about a year and a half ago and the amount of complaints that we got from patients with halo and glare dropped by about 90 percent. And even the (40) lens that was his predecessor was tolerated by most patients but now it is one-tenth as much halo and glare complaints by the patients.

In fact, I don't have a single patient that have implanted with that lens in a cohort of probably well over 500 implants that a year, year and a half later is complaining to me about halo and glare. And the halo glare with the Presbia is even less than that.

So I don't foresee halo and glare being a – as something for us to content with. And if the study – we haven't seen halo and glare.

The issue for the patients, you know we do the study in a large number of centers. And I, I can't recall whether the halo and glare data was part of the six-month data so I don't want to – I don't want to...

(Multiple Speakers)

Raj Denhoy: No, it was not. It wasn't.

(Multiple Speakers)

Dr. Kerry Assil: Yes. So, retract my last comment.

Mr. Raj Denhoy: Well, right. But (we know to the data) but I guess – well, we concluded the fact that...

Dr. Kerry Assil: But outside the U.S...

(Multiple Speakers)

Dr. Kerry Assil: ...outside the U.S. we're not seeing much issue with that.

(Multiple Speakers)

Raj Denhoy: And what about dryness just quickly on that. Are you seeing anything with dry eye?

Dr. Kerry Assil: No. Unlike – there's not a lot of – so some of the dry eye that people get with LASIK and with contact lenses and with the Kamra inlay each of those is for slightly different reasons – the dry eye symptoms. They all translated to dry eyes symptoms but some of them have to do with specific decreased tear film over the eye but more often have to do with the disruption of corneal nerves and nutritional flow across the cornea.

This polymer doesn't lock nutritional flow and also with the procedure itself we don't tend to disrupt very much in the degree of corneal nerves so we haven't found dry eyes to be an issue.

Raj Denhoy: OK. So, (Amanda), I just want to see if there's any questions before you ask about the Kamra inlay. Did anybody – does anybody have any questions that they want to ask Dr. Assil?

Operator: As reminder, if you'd like to ask a question please press star then the number one on your telephone keypad. That's star one. And there are no audio questions.

Raj Denhoy: OK. So, Dr Assil, just in the last five minutes or so, maybe we could talk about the Kamra inlay, might – my understanding is that you had some experience with that. The product was approved last year by the FDA.

Maybe you could describe a bit about that technology, your experience with it, outcomes?

Dr. Kerry Assil: Sure. It sounds like you're going to ask one more thing. So the Kamra inlay works on a completely different optical principle than the Presbia inlay. Presbia inlay works off of the concept of traditional optics, whereas I described earlier no different than eyeglasses or contact lenses that you place over the eye. Therefore you can (decide) the power of the lens for which an individual whatever degree that individual is seeking. Somebody may be only mostly interested in computer distance and doesn't really care much (for our close) while another person really, really wants to work up close and (then) works on (our) computers. You're going to get that same individual, same age, same eye, different power the Presbia inlays.

The Kamra works on the principle of pinhole optics, by filtering out the para axial non parallel rays so that only the central most (bundle) of rays make their way through that don't depend as much on the focusing power or assuming capability of the eye. So it worked on two entirely different principles.

Furthermore, the Kamra inlay we've come to learn does best when the patients' natural refractive error or their natural prescriptions to begin with is a tiny bit nearsighted to begin with. So the difference between the two, if you found two patients or if you start looking at patient populations, the Presbia inlay patients population candidates, the potential candidates, are going to be a much larger cohorts of folks because the average person walking into office complaining of the inability to read is someone who feels they have wonderful distance vision all their life but it turns out to be not only have stiffening of the lens but also have a tiny bit of farsightedness also when you measure their eye and the Presbia does beautifully in those eyes.

Whereas with the Kamra, it's the subset of patients who have a tiny bit of nearsightedness to begin with and those are far fewer population size.

Raj Denhoy: OK.

Dr. Kerry Assil: And so just based on population dynamics alone the Presbia would have a larger audience, so to speak.

Raj Denhoy: So the Kamra device in the way it works is fundamentally different, right, in the sense it restores focal power in all distances, right? You sort of lose focus – you lose focusing ability any distance but you're gaining at all distance, right, is my understanding of how that works much like with the Kamra if you make the aperture very small.

But it has – and so it did restore vision in a lot of people in the clinical trial but there was a fair amount of side effects with it – you know, dry eye, glare, halos and large percentage of patients has...

(Multiple Speakers)

Dr. Kerry Assil: So the Presbia device is different in many ways.

One is that from the outset we've implanted a deeper in the cornea where there's less propensity for inflammation. It covers a smaller surface area. It is more accessible for nutritional flow across the cornea, et cetera and so we don't find the propensity for not only dry eyes symptoms but the need for a super tear film in order for patients to do well with the Presbia.

Raj Denhoy: OK.

Dr. Kerry Assil: We in fact, in our screening process, don't go out of our way to try and may ensure that patients have a perfect tear film or a near perfect tear film before we consider them for the procedure.

Raj Denhoy: Are there patients for whom the Kamra device would be preferred over the Presbia device – the Microlens...

(Multiple Speakers)

Dr. Kerry Assil: Great. It's a great question. I hadn't thought of that question.

I suppose if the patient was a minus 75 – minus 0.75 in the prescription which would be less than 1 out of 1,000 people just walking down the street

you know and they didn't want any other procedure done on their eye just an inlay and nothing else. One might argue that the Kamra would be a better product for that one person.

In all other settings, I see them as either both be good choices, especially if you can do LASIK or the Presbia being an even better option.

Raj Denhoy: OK.

Dr. Kerry Assil: And the better option – the better option ensues from the fact that we notice that there's less dependency on spatial adaptation – something we talked about quite a bit earlier, faster vision recovery, less halos and glare and those sort of symptoms so more seamless.

Raj Denhoy: Well, you mentioned a question about that because one of the things we've heard from other clinicians and from Presbia is that the experience with the Kamra device has not been good. And if you look at the use of that device now globally, it's lower than it was at its peak in the sense that it already started to lose favor. And in some markets like South Korea were Presbia is now launching the Microlens.

They've talked about some mudding of the water in the sense by that device -- that clinicians are little less reticent to adopt the Microlens because of their experience with the Kamra device. Is that true? I mean if you heard that people in the sense turned off in this category by their experience with the Kamra device?

Dr. Kerry Assil: Well, I wouldn't just focus on Kamra as an individual. There's also a procedure called Intacs. There've been attempts on cornea inlays over and over. The Raindrop is in the inlay that people are looking at it internationally.

The thing to remember is that this inlay is very unique and uniquely different than all other inlays and so it can be very difficult to try to judge its performance or its adaptation curve versus others. If you're asking whether or not the fact that other inlays that have come into the marketplace have not been successful, if that'll make some consumers or some surgeons a little bit reticent, the answer is yes.

If you're asking whether it will ultimately impede the ability of this inlay to gain traction when we already know that patients have a very high satisfaction experience with its similar types of satisfaction has received cataract surgery in LASIK, no I don't think that that'll holdup overtime. I think that as long as any new procedures rolled out in an intelligent fashion and in the hands of surgeons and the surgical techniques are standardized, et cetera, then you're going to gain traction.

It's a far, far less invasive procedure than LASIK and yet we see from our international experience that no amount of pushback was able to push LASIK off the table. It's – you know it's a household term now and it's almost a rite of passage. I see a second peak in my LASIK experience where numbers are picking up. And ironically what we were doing LASIK after initial pool of 20-plus years ago, our average patient was around 40-ish years old. And their late 30s, the program the nearsighted patients with their late 30s the farsighted patients were in their late 40s.

Now we're seeing a lot of patients in their early 20s asking for LASIK. You know how much higher percentage that used to be 20 years ago skewing the data. And what's interesting is a lot of the modern children of people who previously had LASIK.

So the parents when they're in their 30s 40s have LASIK. Now they got kids that are 18, 20, 22 years old and they're showing up for LASIK.

So LASIK has become – you know it become a rite of passage eventually just like – someday as LASIK continues to become more accepted around the world just as in the United States it's not OK to have crooked teeth. At a certain age, a kid goes and see an orthodontist and they get the braces. In other parts of the world, you see people they smile and their teeth are pointing in every direction but in the States, it's not acceptable.

And LASIK has – will eventually gain that position and I think (correction of presbyopia) will eventually gain that position. And right now of the technologies that are available on the planet, either on the drawing table or clinically available, the presbyopia procedure is safe to say is the least

invasive and have – any of them and as reliable as any of them for actually correcting the difficulty with near vision.

Raj Denhoy: Great. Well, that's just about as good point to end on as (any) so thank you again, Dr. Assil, for your time and for folks for listening and leave it there. Thanks again.

Dr. Kerry Assil: Sure thing. The fact that there were no questions, I'd like to think it means that I was very clear in my responses.

Raj Denhoy: No, you were. Absolutely. So I think it was great.

Dr. Kerry Assil: Thank you, Raj.

END

# LENS

Estimate

May 17, 2016

## Chart 1: LENS Income Statement

### Presbia Plc

Income Statement

In Millions, Except Per Share Data

FYE Dec 31

Jefferies

	2013 A Dec	2014 A Dec	2015 A Dec	1Q16 A Mar	2Q16 E Jun	3Q16 E Sept	4Q16 E Dec	2016 E Dec	2017 E Dec	2018 E Dec	2019 E Dec	2020 E Dec	2021 E Dec	2022 E Dec	2023 E Dec	2024 E Dec
<b>Total Revenue</b>	<b>\$0.1</b>	<b>\$0.2</b>	<b>\$0.2</b>	<b>\$0.003</b>	<b>\$0.055</b>	<b>\$0.293</b>	<b>\$0.440</b>	<b>\$0.8</b>	<b>\$3.8</b>	<b>\$11.6</b>	<b>\$29.7</b>	<b>\$67.3</b>	<b>\$127.0</b>	<b>\$219.6</b>	<b>\$334.3</b>	<b>\$457.4</b>
Year-to-Year Growth	nm	203.4%	156.3%	126.7%	88.7%	72.9%	52.2%	36.8%								
Cost of revenues	0.1	0.0	0.2	0.0	0.1	0.1	0.1	0.3	0.8	2.2	5.3	11.4	19.0	26.4	40.1	54.9
<b>Gross Profit</b>	<b>(0.0)</b>	<b>0.1</b>	<b>(0.0)</b>	<b>(0.0)</b>	<b>0.0</b>	<b>0.2</b>	<b>0.3</b>	<b>0.5</b>	<b>3.1</b>	<b>9.4</b>	<b>24.3</b>	<b>55.9</b>	<b>107.9</b>	<b>193.2</b>	<b>294.1</b>	<b>402.5</b>
Gross Margin %	nm	72.3%	nm	nm	nm	65.8%	77.3%	nm	80.0%	81.0%	82.0%	83.0%	85.0%	88.0%	88.0%	88.0%
<b>Operating Expenses</b>																
R&D	2.1	12.1	7.9	1.3	1.5	1.6	1.6	5.9	9.0	10.0	6.8	5.4	8.9	12.1	17.4	22.9
% of Sales	nm	23.0%	8.0%	7.0%	5.5%	5.2%	5.0%									
Selling & marketing	1.0	1.6	2.7	0.7	0.8	0.9	0.9	3.2	1.5	3.5	9.5	18.8	38.1	65.9	100.3	128.1
% of Sales	nm	38.0%	30.0%	32.0%	28.0%	30.0%	30.0%	30.0%	28.0%							
G&A	4.1	8.4	7.5	1.8	1.6	1.7	1.7	6.7	2.2	2.9	5.3	12.8	22.9	37.3	53.5	68.6
% of Sales	nm	58.8%	25.0%	18.0%	19.0%	18.0%	17.0%	16.0%	15.0%							
Total SG&A	5.1	10.03	10.2	2.5	2.4	2.5	2.6	10.0	3.7	6.4	14.8	31.6	61.0	103.2	153.8	196.7
% of Sales	nm	55.0%	50.0%	47.0%	48.0%	47.0%	46.0%	43.0%								
<b>Total Operating Expenses</b>	<b>7.3</b>	<b>22.1</b>	<b>18.1</b>	<b>3.8</b>	<b>3.9</b>	<b>4.1</b>	<b>4.2</b>	<b>15.9</b>	<b>12.7</b>	<b>16.4</b>	<b>21.7</b>	<b>37.0</b>	<b>69.8</b>	<b>115.3</b>	<b>171.1</b>	<b>219.5</b>
<b>Operating Income</b>	<b>(7.3)</b>	<b>(22.0)</b>	<b>(18.1)</b>	<b>(3.8)</b>	<b>(3.9)</b>	<b>(3.9)</b>	<b>(3.9)</b>	<b>(15.4)</b>	<b>(9.6)</b>	<b>(7.0)</b>	<b>2.7</b>	<b>18.8</b>	<b>38.1</b>	<b>78.0</b>	<b>123.0</b>	<b>183.0</b>
Operating Margin	nm	9.0%	28.0%	30.0%	35.5%	36.8%	40.0%									
Adjusted EBITDA	(5.3)	(21.7)	(18.0)	(3.7)	(3.7)	(3.5)	(3.4)	(14.3)	(6.6)	(4.0)	6.7	21.8	41.1	81.0	126.0	186.0
EBITDA % of Sales	nm	22.5%	32.5%	32.4%	36.9%	37.7%	40.7%									
Net interest income (loss)	(2.2)	(2.3)	0.0	0.0	0.2	0.2	0.2	0.7	0.0	0.0	0.1	1.0	1.7	2.7	3.9	3.9
Other Income (expense)	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)	(0.0)	(0.0)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Earnings (Loss) Before Taxes	(9.4)	(24.3)	(18.1)	(3.8)	(3.7)	(3.6)	(3.6)	(14.7)	(9.6)	(7.0)	2.7	19.8	39.8	80.7	126.9	186.9
Pre-Tax Margin	nm	9.2%	29.5%	31.3%	36.7%	38.0%	40.9%									
Income Tax Expense	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(1.7)	0.7	4.8	8.8	16.1	25.4	37.4
Tax Rate	nm	0.0%	25.0%	25.0%	24.0%	22.0%	20.0%	20.0%	20.0%							
<b>Net Income</b>	<b>(\$9.5)</b>	<b>(\$24.3)</b>	<b>(\$18.2)</b>	<b>(\$3.8)</b>	<b>(\$3.7)</b>	<b>(\$3.6)</b>	<b>(\$3.6)</b>	<b>(\$14.7)</b>	<b>(\$9.6)</b>	<b>(\$5.2)</b>	<b>\$2.0</b>	<b>\$15.1</b>	<b>\$31.0</b>	<b>\$64.5</b>	<b>\$101.5</b>	<b>\$149.5</b>
Net Margin	nm	6.9%	22.4%	24.4%	29.4%	30.4%	32.7%									
<b>Adjusted EPS</b>	<b>(\$0.25)</b>	<b>(\$2.65)</b>	<b>(\$1.41)</b>	<b>(\$0.28)</b>	<b>(\$0.27)</b>	<b>(\$0.26)</b>	<b>(\$0.26)</b>	<b>(\$1.08)</b>	<b>(\$0.70)</b>	<b>(\$0.38)</b>	<b>\$0.14</b>	<b>\$1.06</b>	<b>\$2.16</b>	<b>\$4.44</b>	<b>\$6.91</b>	<b>\$10.08</b>
Year-to-Year Growth		nm	nm					nm	nm	-46.2%	-138.5%	631.0%	103.7%	105.7%	55.7%	45.7%
Basic Shares Outstanding	9.2	9.2	12.8	13.3	13.5	13.7	13.9	13.6	13.8	13.9	14.1	14.2	14.4	14.5	14.7	14.8
Diluted Shares Outstanding	9.2	9.2	12.8	13.3	13.5	13.7	13.9	13.6	13.8	13.9	14.1	14.2	14.4	14.5	14.7	14.8

Source: Jefferies estimates, company data

**LENS**

Estimate

May 17, 2016

**Chart 2: LENS Revenue Model****Presbia Plc**

Revenue Model

	2013 A Dec	2014 A Dec	2015 Dec	2016 E Dec	2017 E Dec	2018 E Dec	2019 E Dec	2020 E Dec	2021 E Dec	2022 E Dec	2023 E Dec	2024 E Dec
<b>High-volume physicians</b>												
<b>New physicians</b>	0	0	4	6	40	45	125	200	225	225	250	250
Procedures per surgeon			22.5	40	45	45	45	45	45	45	45	45
<b>New physician total lenses</b>	0	0	90	270	1,800	2,025	5,625	9,000	10,125	10,125	11,250	11,250
Existing physicians	0	0	0	4	10	50	95	220	420	645	870	1,120
Procedures per surgeon				144	216	200	265	279	295	347	399	429
<b>Existing physician total lenses</b>	0	0	0	576	2,160	10,008	25,200	61,380	124,020	223,920	347,220	480,420
Total high-volume physicians	0	0	4	10	50	95	220	420	645	870	1,120	1,370
<b>Total high-volume lenses</b>	0	0	90	846	3,960	12,033	30,825	70,380	134,145	234,045	358,470	491,670
<b>Low-volume physicians</b>												
<b>New physicians</b>	0	0	0	5	15	25	75	100	125	150	150	150
Procedures per surgeon				22.5	22.5	22.5	22.5	22.5	22.5	22.5	22.5	22.5
<b>New physician total lenses</b>	0	0	0	113	338	563	1,688	2,250	2,813	3,375	3,375	3,375
Existing physicians	0	0	0	0	5	20	45	120	220	345	495	645
Procedures per surgeon					72	81	92	92	99	107	113	119
<b>Existing physician total lenses</b>	0	0	0	0	360	1,620	4,140	10,980	21,780	37,080	55,980	76,680
Total mid-volume physicians	0	0	0	5	20	45	120	220	345	495	645	795
<b>Total mid-volume lenses</b>	0	0	0	113	698	2,183	5,828	13,230	24,593	40,455	59,355	80,055
New physicians	0	0	4	11	55	70	200	300	350	375	400	400
<b>Total physicians</b>	0	0	4	15	70	140	340	640	990	1,365	1,765	2,165
<b>Total lens volume ('000)</b>	0.0	0.0	0.1	1.0	4.7	14.2	36.7	83.6	158.7	274.5	417.8	571.7
<b>Lens ASP (\$USD)</b>	\$800	\$800	\$850	\$825	\$820	\$815	\$810	\$805	\$800	\$800	\$800	\$800
<b>Total lens revenues (\$m)</b>	\$0.0	\$0.0	\$0.1	\$0.8	\$3.8	\$11.6	\$29.7	\$67.3	\$127.0	\$219.6	\$334.3	\$457.4

Source: Jefferies estimates, company data

## Company Description

Presbia Plc is an ophthalmic device company that has developed a proprietary optical lens implant for treating presbyopia, the age-related loss of the ability to focus on near objects. The Flexivue Microlens is currently available in select OUS markets including the EU and Australia with plans to enter the US market by 2018.

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**Notes:** Each box in the Rating and Price Target History chart above represents actions over the past three years in which an analyst initiated on a company, made a change to a rating or price target of a company or discontinued coverage of a company.

### Legend:

I: Initiating Coverage

D: Dropped Coverage

B: Buy

H: Hold

UP: Underperform

## Distribution of Ratings

Rating	Count	Percent	IB Serv./Past 12 Mos.	
			Count	Percent
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HOLD	843	38.85%	161	19.10%
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