XOMA Corporation
Fourth Quarter and Full Year 2015 Earnings Call
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CORPORATE PARTICIPANTS

Ashleigh Barreto *XOMA Corporation – Investor Relations*
John Varian *XOMA Corporation – Chief Executive Officer*
Paul Rubin *XOMA Corporation - SVP of Research & Development & Chief Medical Officer*
Tom Burns *XOMA Corporation – Chief Financial Officer*

CONFERENCE CALL PARTICIPANTS

Ted Tenthoff *Piper Jaffray - Analyst*
Biren Amin *Jefferies LLC - Analyst*
Arsher Hydra *RBC Capital Markets - Analyst*
Matt Kaplan *Ladenburg Thalmann & Company Inc. - Analyst*

Operator

Good afternoon, ladies and gentlemen, and welcome to the XOMA Corporation's fourth quarter and full year 2015 financial results and corporate update conference call.

(Operator Instructions)

I would now like to turn the conference over to your host for today, Ashleigh Barreto, Investor Relations at XOMA. You may begin.

Ashleigh Barreto - *XOMA Corporation - IR*

Thank you, operator, and good afternoon, everyone. Joining us on the call today are John Varian, Chief Executive Officer, Paul Rubin, Senior Vice President Research and Development and Chief Medical Officer, and Tom Burns, Chief Financial Officer.

Before we begin, I'd like to remind everyone that this conference call will contain forward-looking statements about the Company. These statements are subject to risks and uncertainties that could cause actual results to differ. Please note that these forward-looking statements reflect our opinions only as of the date of this call. We will undertake no obligation to revise or publicly release the results of any revisions to these forward-looking statements in light of new information or future events. Factors that could cause actual results or outcomes to differ materially from those expressed in or implied by such forward-looking statements are discussed in greater detail in our most recent filings of Form 10-K and other SEC filings.

I would now like to turn the call over to John.

John Varian - *XOMA Corporation - CEO*

Thanks, Ashleigh, and welcome, everyone.

When we end our call today, 2015 is fully behind us. In fact, today, we're announcing the final decision that enables a laser-like focus on advancing our endocrine portfolio. Our focus is in one direction and that's forward.

It's important to recognize that our aggressive actions in the fall of 2015 have enabled that transition. Most of what we accomplished last year was unexpected. Drug development has inherent risk. As is often said, it's not for the faint of heart. It's those challenges that demonstrate whether management has created a business model that can weather the storm and move the Company forward in its mission. Our mission is to improve human health, to break through therapeutic monoclonal antibodies. It's those challenges that allow true leadership throughout all levels of an organization to shine.

The scale and complexity of the transformation our team initiated and completed in less than six months should not be underestimated. We were forced to make difficult decisions, but they were the necessary and right decisions. These required leadership, teamwork and a commitment to see XOMA succeed. It also required an innovative discovery effort that has been the hallmark of XOMA throughout its history.

XOMA scientists created novel programs against a variety of targets, including TGF-beta in the insulin receptor. Novartis, Novo Nordisk, Agenus and Nanotherapeutics saw the value in the programs and breakthroughs made by our scientists. I am confident these assets are moving forward in very capable hands. In all cases, except for the sale of our manufacturing plant, we expect to share in any potential future successes that come from XOMA's discoveries. Today, we won't dwell on our team's significant wins in getting these crucial deals done in an incredibly compressed time period. The details are included in our 10-K and other filings, but their completion has positioned us for success.

Future successes will come from our efforts on our endocrine portfolio. In spite of our expressed historical focus on gevokizumab, Paul and our discovery team committed to building a pipeline to answer the "what's next" or "what now" questions that we knew we'd face. These efforts led us to the endocrine assets were now taking forward.

2016 is focused on XOMA 358, XOMA 129 and XOMA 213. These three molecules have the potential to address serious unmet medical needs in endocrinology. Our XOMA 358 proof of concept study in patients with hypoglycemia due to congenital hyperinsulinism is progressing as we anticipated. At Children's Hospital of Philadelphia, or CHOP here in the US, and Great Ormond Street Hospital, or GOSH in the UK. Several patients have been treated, and more are in the near-term queues. The way this study is designed allows us to learn and adapt as we go; each patient is a treasure trove of data.

Now before it comes up in our Q&A session, I want to reiterate something we've said consistently. We will not disclose any data from the 358 studies until we have enough for it to be useful information. Patient by patient updates can be confusing, and even dangerous. Once we know enough to describe the path forward, we will communicate it, and not before then.

Paul's team has been working with the investigators and study centers to begin our XOMA 358 proof of concept study in patients who develop hyperinsulinism subsequent to having bariatric bypass surgery. This study in PBS patients will occur at multiple centers of excellence here in the US and in Europe. We expect to start dosing patients in the coming weeks.

We have made good progress in our XMetD fab program for the treatment of severe acute hypoglycemia. We have developed and evaluated XMetD fragments and the potential to reverse severe hypoglycemia. This requires a rapid onset of action and rapid clearing from the body. We have generated the data on XOMA 129 to be confident that this is the right antibody fragment to move into IND enabling studies. Paul will talk more about where we are in our plans for XOMA 129.

We are finalizing design of our proof of concept study for XOMA 213. Which may offer a new therapeutic option for patients who experience hyperprolactinemia, and expect to launch the study midyear. Paul will describe our near and longer-term plans for this Phase 2 asset.

We know data is the most important inflection point for driving value. We will have data from XOMA 358 in 2016, and XOMA 213 will be progressing in a Phase 2 study.

As I mentioned in my opening remarks, we've made an important decision for our remaining non-endocrine late-stage asset. Gevokizumab clearly does not fit within our forward focus. We have been approached recently by several companies interested in acquiring the asset. These factors led to our decision to launch a formal sales process. We knew that potential buyers of gevokizumab would likely require the data from the ongoing pyoderma gangrenosum studies in order to fully evaluate the product. Because of this, earlier this week, we stopped these studies.

Based on our preliminary view of the data generated to date in approximately 25 patients in the study, we don't see a clear signal of activity. It appears unlikely that the studies would have achieved their primary endpoint if we had continued to let them go to their completion. These data also add to a safety database that potentially could translate into a favorable safety and adverse event profile.

Well over 1,000 people have been treated with gevokizumab. We will assess which companies are best suited to bring gevokizumab to the patients for which it may be useful.

Making this decision does several positive things for us. First, we were spending approximately $400,000 a month on these studies, which we are curtailing by taking this step. Second, it may bring in additional financial resources which we can use to advance our endocrine portfolio. And lastly, it allows the team to exclusively focus on what matters to us most.

Letting gevokizumab go is one of those tough but necessary decisions. Over my four years as XOMA's CEO, gevokizumab has been central to our efforts. Paul and the teams here and that Servier knew we were trying to solve a puzzle. We know we have an active molecule, but we needed to figure out in which diseases modulating IL-1 beta would matter enough to demonstrate a clinical benefit.

Based on the data separately generated by both us and Servier, we thought uveitis was one of those diseases. We also executed a proof of concept programs at both companies to try to identify additional indications. The data generated in the partially completed EYEGUARD A and C studies were consistent with what we saw in EYEGUARD B. This validated August decision to stop spending on those studies quickly. While Schnitzler Syndrome and certain other indications remain promising, it is time for us to let someone else solve the rest of this puzzle. We believe we are now focused on solving a simpler puzzle.

What makes XOMA 358, 129 and 213 different from our previous endeavor is that each has a clinically validated biomarker that is known to directly impact a disease condition. These antibodies are not targeting one point within a complex inflammatory response cascade that indirectly results in symptoms. We know the body responds to insulin or prolactin production very predictably. We should have yes and no answers not maybes from the results of these studies, and we should have them quickly.

Now I'm going to turn the call over to Paul to provide you with the detail and our plans for these assets. Paul?

Paul Rubin - ***XOMA Corporation - SVP of Research & Development & Chief Medical Officer***

Good afternoon, everyone.

Before I start, as John said, we won't be discussing the ongoing XOMA 358 studies today. Although, I must say these studies are our top priority and my dedicated team clearly demonstrates the conviction that information from those studies is first and foremost to XOMA. We hope to have an informative update as to what we're seeing by mid-summer. But it may be later or even sooner depending on the dose necessary to achieve a consistent response, which will drive the number of patients we need to enroll and thus the time to completion.

Hypoglycemia is a serious medical condition that in addition to occurring from congenital or acquired forms of hyperinsulinism, can also manifest as a result of prescribed insulin therapy, accidental insulin overdose or treatment with sulfonylureas. Data suggests that there are over 300,000 visits to the emergency rooms each year for insulin related hypoglycemia. Recurrent hypoglycemia leads to diminished recognition of the symptoms, and can lead to unrecognized acute severe hypoglycemia resulting in confusion, loss of consciousness, and seizure.

One particularly troublesome version of this can present during the nocturnal hours in patients are treated aggressively with insulin. Treatment of this condition is especially complex, as patients do not wake up when their blood sugar drops. The medical community has long been challenged with how to prevent patients from experiencing nocturnal acute severe hypoglycemia, yet there is still a need for additional measures to prevent this condition.

Our experiments to interrogate the insulin receptor have been extensive. We have also made some major technological advances in the discovery and selection of antibodies and their fragments. Coupled, these had led us to molecules with the appropriate properties to significantly modify insulin's ability to control glucose uptake into cells.

XOMA 358 was designed to prevent low blood sugars from occurring in patients with abnormally high insulin levels. We then worked on modifying the characteristics of this molecule to discover an additional compound with enhanced potency, rapid onset of action and shorter duration to be used for a complementary set of indications. Specifically, the reversal of acute severe hypoglycemia.

As a result of this work, we have discovered a series of molecules that are fragments or fabs derived from our lead antibody XOMA 358. In vivo and in vitro testing has shown that these fabs have the characteristics that might make them useful for treatment of acute hypoglycemic disorders. XOMA 129 has emerged as our lead fab. It has been shown to be more potent, rapidly effective and rapidly

cleared in animals where insulin was causing an acute overdose. We are presently moving this asset forward toward clinical development.

Our strategy is to allow data from the initial human study to ultimately determine if XOMA 129 is the right asset to advance into multiple dose studies, or if we are better served advancing one of our backup candidates which we continue to bring forward. The in vivo data which led us to select XOMA 129 for clinical development has been accepted for a poster presentation at this April's annual Endocrine Society Meeting or ENDO.

In addition to our insulin receptor work, we are about to initiate a proof of concept trial for our antibody XOMA 213, a potent inhibitor of prolactin signaling. Prolactin is a hormone secreted by the pituitary gland that is responsible for milk production in females directly after giving birth. Apart from this normal occurrence, certain individuals develop benign tumors of the pituitary gland or prolactinomas resulting in abnormally high levels of prolactin secreted into the bloodstream causing infertility in women, as well as sexual dysfunction, abnormal milk production, breast enlargement and osteoporosis in both genders.

Now many patients can be treated successfully with drugs such as bromocriptine and cabergoline, which are dopamine agonists. But, approximately 20% of these patients do not respond or cannot tolerate these therapies and require alternatives. Our proof of concept study for XOMA 213 will study the ability to decrease milk production in women immediately postpartum who have decided that breast feeding is either undesirable or medically contraindicated and will occur solely in Spain.

Although not truly a pathologic state, these women have prolactin levels that are comparable to those seen in patients with pituitary tumors. And studies using dopamine agonists have confirmed that the drug levels required to accelerate the cessation of lactation after birth correlate well with the drug levels necessary to normalize prolactin signaling in patients with prolactin illness. Thus, this study can provide a relatively rapid model to confer magnitude, duration and potency of XOMA 213 as an agent to reduce abnormal prolactin activity. Which can then accurately inform dose selection for later trials in patients with prolactinomas.

Now as you can see, my team has made great strides to push our endocrine portfolio forward quickly. With that, I turn the call to Tom Burns to review our financials.

Tom Burns - ***XOMA Corporation - CFO***

Thanks, Paul. Hello, everyone. My comments today are going to focus on elements of the fourth-quarter results that may require color and further discussion.

In the fourth quarter of 2015, we reported $48.2 million in revenue, including $45.8 million in up-front license fees. These include a $37 million up-front payment from Novartis, a $5 million up-front payment from Novo Nordisk and a $3.8 million payment from Pfizer. In 2016, will have minimal reimbursements related to bio defense, and after the first quarter there will be no revenue associated with reimbursements from Servier.

R&D expenses were $13.6 million and $19.4 million for the 2015 and 2014 fourth quarters, respectively. Reflecting reduced headcount in the clinical trial costs, which are the bulk of our R&D expenses. All of the clinical trials we are funding in 2016 our Phase 2 clinical studies, which are less expensive than Phase 3 programs.

SG&A expenses were $4.7 million in the fourth quarter of 2015, as compared to $4.1 million in the corresponding quarter of 2014. While headcount was reduced significantly in the second half of 2015, we had increased legal fees associated with our licensing and divestiture activities. We expect these expenses to modulate going forward.

Implementing our restructuring plan during the second half of 2015 resulted in the elimination of approximately 90 positions throughout all areas of the Company. We recorded charges of $2.9 million related to severance, other termination benefits, and out placement services. We also recognized a restructuring charge of $800,000 in contract termination costs, which primarily included costs related to the discontinuation of the EYEGUARD studies.

For the three months ended December 31, 2015, we reported net income of $25.4 million which included a non-cash expense of $6.4 million directly related to the revaluation of contingent warrant liabilities. Excluding a $12.1 million non-cash revaluation of the contingent warrant liabilities, the net loss for the 2014 fourth quarter was $19.4 million. We closed 2015 with $65.8 million in cash, compared with cash of $78.4 million on December 31, 2014.

So the question I'm asked most often is how long will your cash last. In the middle of 2015, we anticipated net cash used to fund operations would be $60 million to $65 million, and that included the assumption of up-front payments associated with licensing activities. With all of our restructuring activities in the last four months of 2015, we anticipate we have the financial resources to fund our operations through the first quarter of 2017. Our decision to stop spending on gevokizumab now adds approximately $5 million to our runway, and our attempt to generate cash from the asset may extend that further. Most importantly in 2016, we expect to have value inflection points as we receive data from XOMA 358.

With that, I'll turn the call back to John for closing remarks.

John Varian - ***XOMA Corporation - CEO***

Thanks, Tom.

After careful review and discussion, including with some of you, we are electing to no longer hold preset quarterly conference calls. Rather, we will hold calls when we have important clinical updates to give you. Drug development milestones cannot be timed for inclusion in quarterly calls. We think this approach will be more useful and efficient for you and us.

We continue to speak at conferences and with the media. We will publish transcripts from our presentations at investment banking sponsored conferences. We will continue to provide detailed updates in our quarterly press releases, investor presentations and SEC filings. When we have clinical updates, we will notify you that we will be hosting a call in order to make our calls more valuable. We believe we will have lots talk about.

Before I conclude today, I want you to know that we will continue to be prudent in our actions, weighing the benefit on XOMA today and into the future, while seeking additional ways to mitigate the risk inherent in drug development. This approach is being applied and adopted throughout the organization. Today, all of our antibodies target proteins that are directly related to the disease, and each is paired with a clinically validated biomarker. This approach allows us to determine very early in the development process if the antibodies are blocking the secretion or activity of their targeted proteins. We won't have to wait long periods of time to know if each of our antibodies is achieving the result they were designed to have.

We are excited about XOMA 358, XOMA 129 and XOMA 213, as they could have a dramatic impact on the diseases they are designed to treat. In 2016, we will have data from XOMA 358 and a Phase 2 study of XOMA 213 in progress. They will set the stage for XOMA in 2017 and beyond.

With that, operator, please open the call for questions.

QUESTION AND ANSWER

Operator

Thank you.

(Operator Instructions)

And our first question comes from the line of Ted Tenthoff of Piper Jaffray. Your line is now open.

Ted Tenthoff - ***Piper Jaffray - Analyst***

Great. Thank you. Can you hear me okay?

John Varian - ***XOMA Corporation - CEO***

Yes. Hello, Ted.

Ted Tenthoff - ***Piper Jaffray - Analyst***

Hello, how are you? So thanks very much for the update, and appreciate the guidance with respect to gevokizumab. My first question had to do just to pick up on some of Tom's comments with respect to revenues starting to decline. Would this be -- what would be the sources of revenue going forward into 2016 and 2017 as currently exists?

Tom Burns - ***XOMA Corporation - CFO***

Yes, so it's important -- so there's two compartments that I talked about there, one of which is the biodefense and the other is Servier. Biodefense is, just to recall, relates directly to the expenses that we had been incurring, and being reimbursed associated with those expenses. Now that we don't have those expenses anymore, we actually net-net come out ahead, believe it or not.

Servier, is very similar in nature, and though the collaboration itself was a combination of expenses, if one party was being paid more than the other or was spending more, then they would be able to recognize revenue on it. So those are the two components that I mentioned that would be going down from here on out.

John Varian - ***XOMA Corporation - CEO***

A dollar spent, a dollar received. The kind of revenues that we would seek to have in the future are the kind of revenues that we had in the third and fourth quarter of 2015, where we take assets that exist at XOMA, and try to turn those into licensing fees on the new things.

Ted Tenthoff - ***Piper Jaffray - Analyst***

Yes, understood. And then, so I guess with respect to the other question is with the guidance through 1Q of 2017, does that also factor in the debt repayments to Servier? And I guess maybe going back to the first question, so does this mean that this Servier alliance is terminated, or does it mean that it would be transferred to someone who would buy gevo?

John Varian - ***XOMA Corporation - CEO***

Yes, so let me talk about Servier first. So the first answer is on the debt. All of our cash projections include all of the scheduled debt payments booked for Hercules, as well. Okay. On Servier, the deal itself is being terminated at the end of March. Then we 100% own the asset, and so anything that we would get for selling the asset would be XOMA's.

Ted Tenthoff - ***Piper Jaffray - Analyst***

Great. Excellent, that's really helpful, and I look forward to more data on the endocrine pipeline to understand those assets better as we go forward.

John Varian - ***XOMA Corporation - CEO***

Great, we look forward to telling you about it.

Operator

Thank you. And our next question comes from the line of Biren Amin of Jefferies. Your line is now open.

Biren Amin - ***Jefferies LLC - Analyst***

Yes, hello, guys, thanks for taking my questions. On XOMA 358, you're running this trial in congenital hyperinsulinism in about 12 patients. What can we expect from the data?

Paul Rubin - *XOMA Corporation - SVP of Research & Development & Chief Medical Officer*

Sure. I think that the way the study is designed, we're taking patients that have predictable drops in blood sugar during a provocation. So they have the diagnosis of congenital hyperinsulinism, they're brought in, they're documented to drop their blood sugars after we taper off their existing medication. We challenge them on multiple occasions to prove that they have a consistent hypoglycemic response, then we give the drug and do the same provocations.

So as each patient serves as their own control and we've validated their consistent hypoglycemic response, it's essentially almost like a crossover trial, no drug, then with drug. And we'll be able to demonstrate that, A, that XOMA 358 does prevent the hypoglycemic episodes from occurring, we'll know the dose where this optimal effect occurs, and we'll know the duration of activity of the drug. Will that allow us to better design our multiple-dose trials?

Biren Amin - *Jefferies LLC - Analyst*

And do you anticipating moving forward with an intravenous infusion, like what you're testing currently?

Paul Rubin - *XOMA Corporation - SVP of Research & Development & Chief Medical Officer*

I think that it's -- we're -- our first choice is to be able to then change this to either an intramuscular or subcutaneous injection, and the kinetics make it very amenable to doing that. The key to being able to do that is determining what the effective dose is.

And obviously to move to a non-intravenous formulation is a function of the volume that you can administer. Now for congenital hyperinsulinism, the existing therapies are so difficult to administer now, that even in intravenous dose, that would be once or twice a month, would be far preferable to what the way they are being treated now.

Biren Amin - *Jefferies LLC - Analyst*

Great, thanks.

John Varian - *XOMA Corporation - CEO*

But it's preferred but not necessary is what we think at this point in time.

Biren Amin - *Jefferies LLC - Analyst*

Thank you.

Paul Rubin - *XOMA Corporation - SVP of Research & Development & Chief Medical Officer*

Great.

Operator

Thank you. And our next question comes from the line of Adnan Butt of RBC Capital Markets. Your line is now open.

Arsher Hydra - *RBC Capital Markets - Analyst*

Yes, hello, guys, this is Arsher Hydra on for Adnan. Thanks for taking the question. Could you maybe talk about your R&D expenditures for 2016? Will it look similar to 2015?

Tom Burns - ***XOMA Corporation - CFO***

Yes, so if you were to look at 2015, which, once again, is actually reduced spend from 2014, because of the mid-year reductions that we did, fused our all-in basis for as total expenses. R&D and actually all expenses would be around 30% less than the previous year in 2015. And I would say from a mix perspective, 75% R&D, 25% SG&A is how I am looking at the expenses right now.

Arsher Hydra - ***RBC Capital Markets - Analyst***

Okay. Thank you. And then can you maybe talk about how many -- I think you alluded to having to two centers for the congenital hyperinsulinism trial. Is that right? How many --?

Paul Rubin - ***XOMA Corporation - SVP of Research & Development & Chief Medical Officer***

We have two open centers, but we continue to speak with all of the centers worldwide. So obviously, what we want to do is advance -- once we determine what hopefully will be the active dose, then we want to advance this into multiple-dosing trials. And we are already in discussions with virtually all of the major centers in the world to get access to even more patients for that.

John Varian - ***XOMA Corporation - CEO***

Which importantly to say is, still only about handful of ones that actually have significant patients. So it's pretty easy for us to really get access to a substantial percentage of the patients through just a small number of the centers.

Paul Rubin - ***XOMA Corporation - SVP of Research & Development & Chief Medical Officer***

There's probably 10 or 12 major centers worldwide, and we'd be working with all of them.

Arsher Hydra - ***RBC Capital Markets - Analyst***

Okay, got you. Thank you. And I'll get back in line. Thank you.

Operator

Thank you. Our next question comes from the line of Matt Kaplan of Ladenburg Thalmann. Your line is now open.

Matt Kaplan - ***Ladenburg Thalmann & Company Inc. - Analyst***

Hey, guys. Good afternoon.

John Varian - ***XOMA Corporation - CEO***

Good afternoon.

Matt Kaplan - ***Ladenburg Thalmann & Company Inc. - Analyst***

Just a couple of follow-up questions. In terms of 358, could you talk a little bit about what the market opportunity is there? And then also talk about how much it's going to potentially cost you to get through Phase 3 development?

Paul Rubin - ***XOMA Corporation - SVP of Research & Development & Chief Medical Officer***

Okay. I can certainly talk about the market opportunity. And although I wouldn't give you a direct estimate of cost, if Tom or John want to comment, I could tell you the magnitude of the trials that we think we would need going forward, based on precedent for similar diseases.

So the market itself, for congenital hyperinsulinism, where if you strictly look at epidemiologic data, which is probably inaccurate because there hasn't really been a lot of attention paid to it. It's between 1 in 20,000 to 1 in 50,000 live births are diagnosed with the disease in the United States, of which there are about 4 to 5 million births per year, and that number is going up.

In ex-US, the number is actually higher. The prevalence is higher, as a function of number births, and it's mostly related in countries where there's more intermarriage among closer family members, as you can imagine that, that would occur. So in counties like Ireland, in Scandinavia, in the Middle East, the numbers are even higher. So the market opportunity from that perspective, you can estimate on that basis.

But we've also done some preliminary looks at claims data. And from that database, which we think is a very good one, we probably view there's somewhere between 3,000 and 6,000 accessible patients in the United States, and probably a little bit more than double that if you include mostly Europe. And we haven't done a lot of work for the non-European countries, such as Asia and South America. So somewhere for congenital hyperinsulinism in around maybe the 12,000 to 15,000 range worldwide.

Now for post-bariatric surgery, this is mostly involved with patients that have had a procedure known as Roux-en-Y, which is a true gastric bypass. In the United States, if you look in the literature, there's approximately 60,000 new cases done per year. Now the prevalence of this disease is about anywhere, depending on what you read, from 1% to 11% of the patients that have undergone this particular procedure, and it occurs anywhere from one to three years after they have the procedure.

We, again, estimate through these claims analyses that there's approximately 20,000 patients in the United States. That would be an embedded population that could immediately theoretically be treated with this drug. The hypoglycemia is probably more common, but we're looking at those patients that are severe enough that require a therapy for that particular indication.

John Varian - ***XOMA Corporation - CEO***

And the people -- the parents who have children who have CHI, they spend, we've heard $1.5 million --

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Paul Rubin - ***XOMA Corporation - SVP of Research & Development & Chief Medical Officer***

Especially in the first few years of life, it's almost $1 million per year in taking care of these patients. Because in addition to the medication, there's intensive monitoring. Many of these require various pumps and intravenous infusions on a regular basis, so the cost of care is quite high, not to mention the quality of life aspects.

What we would be aiming for with this drug is, approximately half these patients, the only therapy is removal of the pancreas. Which you could imagine morbidity associated with that, and the majority of these patients become type 1 diabetics. So an aim for this would be can we prevent or delay the need for pancreatectomy, which as can you imagine, would provide incredible value to the treatment of these patients.

Matt Kaplan - ***Ladenburg Thalmann & Company Inc. - Analyst***

Is that a similar procedure in the post-bariatric patients as well?

Paul Rubin - ***XOMA Corporation - SVP of Research & Development & Chief Medical Officer***

No, in the post-bariatric patients, in those patients that we would be aiming, their quality of life is very, very bad. They have profound low blood sugars, and most of the therapies don't provide adequate treatment for them. So where some of them require, they do, do pancreatic surgery in some of them, although the number is a lot smaller.

They really try to manage it with continuous infusion of glucose or continuous oral supplementation with things like corn syrup, but some of these patients end up having to have their gastric bypass reversed. Which you can imagine, they were morbidly obese in the first place, and the prospect of the thing that allowed them to lose weight to be reversed is also daunting for many of these patients.

John Varian - ***XOMA Corporation - CEO***

And then the studies themselves.

Paul Rubin - ***XOMA Corporation - SVP of Research & Development & Chief Medical Officer***

So the studies themselves, if you look at, certainly of congenital hyperinsulinism for the prevalence that we mentioned and the severity of the disease, there are many examples where pivotal trials encompass somewhere around 30 to 40 patients. So although, obviously we'll have to discuss this with both FDA and with the EMA, there certainly is precedent for trials in that range to allow for marketing authorization for these products.

Matt Kaplan - ***Ladenburg Thalmann & Company Inc. - Analyst***

Great. Okay, that's helpful. And then a question just a follow up in terms of your debt and your repayment schedule. What's the current debt level and the schedule for repayment?

Tom Burns - ***XOMA Corporation - CFO***

Sure. Yes, so as of today, we have EUR12 million that is due to Servier with a 2.5% interest rate associated with it. EUR5 million of that is due in January of 2017, and EUR7 million is due in 2018.

The Novartis debt, which is $13.5 million, has been pushed off to September of 2020, and that also has what I would characterize as a sweetheart rate associated with it around 2.5% as well. The last component is Hercules Capital, which is more of the traditional debt. And that is a $20 million facility that we have drawn on, and we will start to make principal payments the middle of this year and the end of which will be in September of 2018.

Matt Kaplan - ***Ladenburg Thalmann & Company Inc. - Analyst***

Great. And then a follow up in terms of your comment on the expenses. You said a 30% reduction in terms of R&D and SG&A from 2015?

Tom Burns - ***XOMA Corporation - CFO***

Yes. It was around $95 million in reported expense for 2015, but once again, that takes into account our already reduced expenses in Q3 and Q4. So if you use that as your basis, and then do approximately a 30% reduction off of that, and then, as I mentioned, there's about a 75%/25% split ratio there for R&D versus SG&A.

John Varian - ***XOMA Corporation - CEO***

And then, also, as Tom has projected forward, as to cash and how long it lasts and that sort of thing. The only revenues assumed in his projections are things that we pretty much know are going to happen. And so anything that would be a new deal around a molecule that you guys are unaware of, or additional things that we do that would come outside of the existing deals that are in place, is not included in Tom's forward projections of cash.

Tom Burns - ***XOMA Corporation - CFO***

That make sense?

Matt Kaplan - ***Ladenburg Thalmann & Company Inc. - Analyst***

Yes. Thank you.

Tom Burns - ***XOMA Corporation - CFO***

Thanks.

Operator

Thank you. And our final question is a follow up from the line of Ted Tenthoff of Piper Jaffray. Your line is now open.

Ted Tenthoff - ***Piper Jaffray - Analyst***

Great, thank you very much. And just to pick up a question with respect to data this year. Would the plan be to seek partnership for the wholly owned pipeline, or would it be to find alternative financing in order to continue to advance those on your own?

John Varian - ***XOMA Corporation - CEO***

It's a great question, Ted, and we consider all alternatives. It is unlikely, I will say this, it is unlikely that I and the rest of the executive team and Board would be convinced that we should be licensing away our lead Phase 2 assets at this point in time. The markets are accessible enough, the physicians are accessible enough, the patients are accessible enough that we think we really want to own these further forward.

So you never say never, but at the same time, we think we can do a lot of good in building, we hope, value with those assets on our own in the near-term future. There are other things that we have at XOMA, just like you saw we did last fall that could be good sources of capital that lets us do that. So as we think further forward, we think there's other things that we can do to allow us to finance our way forward without equity raises to advance those assets that we really want to hold onto and keep rights to for the foreseeable future.

Ted Tenthoff - ***Piper Jaffray - Analyst***

Okay. Great. Thank you very much.

John Varian - ***XOMA Corporation - CEO***

Sure.

Operator

Thank you. I would now like to turn the conference over to John Varian for closing remarks.

John Varian - ***XOMA Corporation - CEO***

Thanks, everyone, for being on the call today. But before we close, I just want to reiterate a couple of things.

One is, we are 100% focused on advancing these endocrine therapies to treat these rare diseases. All of these choices that we've made around ones to go after are ones where there are these validated biomarkers. So we should know sooner, rather than later, whether we're having an impact, and we will have a lot to communicate with you in 2016.

We've been careful to not over promise what we will be able to say, but we have a lot of work going on that I think we're going to be able to share with you over this next year. And I think around 358, we are extremely excited about the potential for that product and our ability to share some good data with you as we hope it evolves going forward. So, everyone, have a great evening, and thank you for joining us.

Operator

Ladies and gentlemen, thank you participating in today's conference. This does conclude the program. You may all disconnect. Everyone, have a great day.