THOMSON REUTERS STREETEVENTS

EDITED TRANSCRIPT

INCY - Q4 2019 Incyte Corp Earnings Call

EVENT DATE/TIME: FEBRUARY 13, 2020 / 1:00PM GMT

OVERVIEW:

Co. reported 4Q19 results.

CORPORATE PARTICIPANTS

Barry P. Flannelly *Incyte Corporation - Executive VP & General Manager of U.S.*

Christiana Stamoulis *Incyte Corporation - Executive VP & CFO*

Hervé Hoppenot *Incyte Corporation - Chairman, President & CEO*

Michael Booth *Incyte Corporation - Divisional VP of IR & Corporate Social Responsibility*

Steven H. Stein *Incyte Corporation - Executive VP & Chief Medical Officer*

CONFERENCE CALL PARTICIPANTS

Alethia Rene Young *Cantor Fitzgerald & Co., Research Division - Head of Healthcare Research*

Andrea R. Tan *Goldman Sachs Group Inc., Research Division - Research Analyst*

Brian Corey Abrahams *RBC Capital Markets, Research Division - Senior Biotechnology Analyst*

Christopher N. Marai *Nomura Securities Co. Ltd., Research Division - MD & Senior Analyst of Biotechnology*

Cory William Kasimov *JP Morgan Chase & Co, Research Division - Senior Biotechnology Analyst*

Evan David Seigerman *Crédit Suisse AG, Research Division - VP & Senior Equity Research Analyst*

Jay Olson *Oppenheimer & Co. Inc., Research Division - Executive Director & Senior Analyst*

Mara Goldstein *Mizuho Securities USA LLC, Research Division - MD of Equity Research Department*

Marc Alan Frahm *Cowen and Company, LLC, Research Division - VP*

Tyler Martin Van Buren *Piper Sandler & Co., Research Division - Principal & Senior Biotech Analyst*

Vikram Purohit *Morgan Stanley, Research Division - Equity Analyst*

PRESENTATION

Operator

Greetings, and welcome to the Incyte's Fourth Quarter and Year-End 2019 Earnings Conference Call. (Operator Instructions) As a reminder, this conference is being recorded.

It is now my pleasure to introduce your host, Mike Booth, Head of Investor Relations for Incyte. Please go ahead, sir.

Michael Booth - *Incyte Corporation - Divisional VP of IR & Corporate Social Responsibility*

Thank you, Kevin. Good morning, and welcome to Incyte's Fourth Quarter and Full Year 2019 Earnings Conference Call and Webcast. The slides used today are available for download on the Investors Section of incyte.com.

I'm joined on the call today by Hervé, Barry, Steven and Christiana, who will deliver our prepared remarks, and by Dash, who will join us for the Q&A session. (Operator Instructions)

Before we begin, I'd like to remind you that some of the statements made during the call today are forward-looking statements. Including statements regarding our expectations for 2020 guidance, the commercialization of our products and our development plans for the compounds in our pipeline as well as the development plans of our collaboration partners. These forward-looking statements are subject to a number of risks and uncertainties that may cause our actual results to differ materially, including those described in our 10-Q for the quarter ended September 30, 2019, and from time to time in our other SEC documents.

It is also important to note that our recently announced collaboration with MorphoSys for the global development and commercialization of tafasitamab is subject to clearance by antitrust authorities, and therefore, any statements we may make about the collaboration and tafasitamab are conditioned on such clearance.

We'll now begin the call with Hervé.

Hervé Hoppenot - *Incyte Corporation - Chairman, President & CEO*

Thank you, Mike, and good morning, everyone. So 2019 was another year marked by strong commercial performance, including surpassing $2 billion in annual revenue for the first time. In addition, we continue to advance our R&D portfolio and make progress towards our strategic goal of diversification and growth.

During the year, we achieved 13 of the 15 key goals we laid out this time last year, including the approval and successful launch of Jakafi in steroid-refractory acute GVHD. While the results of the GRAVITAS-301 trial of itacitinib was disappointing, we announced positive results of the Phase III REACH2 trial, we submitted the NDA for pemigatinib based on strong updated data, and we are very pleased to recently report positive top line Phase III results from rux cream in atopic dermatitis.

In addition to our internal portfolio, we continue to seek external assets that could complement our business. Our recent collaboration with MorphoSys for tafasitamab represents a strong fit with our portfolio and we expect to be able to capitalize on our commercial expertise in the U.S. and Europe.

Turning now to our commercial performance in 2019. We had another year of robust top line growth. Product and royalty revenues grew 22% year-over-year, with growth coming from all 4 sources. Jakafi was up 21%, Jakavi royalties up 16%, Iclusig up 13% and Olumiant royalties doubled to $80 million.

Slide 5 shows the revenue momentum over the last several years. Product and royalty revenues have more than tripled since 2015. Jakafi with a 4-year CAGR of 29% remains a significant revenue driver and non-Jakafi revenues have shown over 50% compounded growth over the same period.

Two new molecules, both of which were discovered at Incyte are currently under priority review at the FDA and these are highlighted on Slide 6. Both have breakthrough therapy designation from the FDA. The PDUFA date for pemigatinib is May 30, and we expect the FDA decision on Novartis' application for the approval of capmatinib in around 6 months' time. The capmatinib economics to Incyte include royalties in the range of 12% to 14% on global net sales by Novartis and over $500 million in potential milestones.

Tafasitamab, from our recently announced collaboration with MorphoSys is the third molecule currently under FDA review. We see CD19 inhibition with an Fc-engineered antibody as a unique mechanism of action that is fundamental to the treatment of B-cell malignancies. We believe that tafasitamab can become a very important part of our oncology portfolio, and provides both a near-term opportunity through the potential launch in DLBCL, where the BLA was submitted late last year, and the MAA is expected to be submitted mid this year, as well as significant potential upside in the medium to longer term. Tafasitamab fits very well with our current commercial hematology footprint and, therefore, enables us to capitalize on our significant commercial capabilities in U.S. and Europe.

Turning now to the key development and commercial priorities for 2020. We have the 3 potential new product approvals this year that I have already mentioned. And we also expect to submit the NDA for rux cream in atopic dermatitis before the end of the year. We also expect to continue the momentum within our LIMBER program with the initiation of the first pivotal combination development trial as well as important data from the once-a-day formulation of ruxolitinib.

On the commercial side, we will work to drive continued Jakafi growth in all 3 indications, while also ensuring that we are ready to pursue successful launches of pemigatinib and tafasitamab.

I will now pass to Barry for more detail on both 2019 Jakafi performance as well as our commercial preparations for pemi and tafa.

Barry P. Flannelly - *Incyte Corporation - Executive VP & General Manager of U.S.*

Thank you, Hervé, and good morning, everyone. In the fourth quarter of 2019, Jakafi grew 23% year-over-year to $466 million. Patient demand continued to drive the uptake of Jakafi, and growth was strong across all 3 indications. Jakafi has grown consistently in total patients treated and net sales for each of the past several years, fueled by growth across all indications.

The 2020 net product revenue guidance we provided for Jakafi today reflects a continuation of this growth in patients and in top line sales to a range of $1.88 billion to $1.95 billion.

Slide 11 also highlights the key priorities for our U.S. team this year. These priorities include continuing the growth of total patients treated in myelofibrosis, increasing the number of patients on therapy in polycythemia vera, where we recently launched a nationwide disease awareness campaign and continuing the momentum in GVHD where we have seen strong traction since the launch in the steroid-refractory acute setting.

We look forward to the presentation of data from REACH2 in the Presidential Symposium at the EBMT meeting next month, and to the results of REACH3 in the second half of this year. REACH3 is the randomized Phase 3 trial of Jakafi versus best available therapy in steroid-refractory chronic GVHD.

In addition, we are also planning for the potential launches of both tafasitamab and pemigatinib. We expect to be able to leverage our commercial expertise for both compounds and we will be ready to launch immediately, if approved by the FDA.

I'll turn the call over to Steven for our clinical updates.

Steven H. Stein - *Incyte Corporation - Executive VP & Chief Medical Officer*

Thanks, Barry, and good morning, everyone. At the beginning of 2019, we had laid out a list of key R&D goals for the year, and I'm pleased to say that we achieved most of which we set out to do. While the recent results of GRAVITAS-301 was disappointing, we were able to report multiple successes last year. Some highlights include the positive top line result reported for the randomized REACH2 trial of ruxolitinib in steroid-refractory acute graft-versus-host disease, the submission of an NDA for pemigatinib in cholangiocarcinoma and the initiation of pivotal trials for ruxolitinib cream in both atopic dermatitis and vitiligo.

We recently announced that the first of 2 Phase 3 trials evaluating ruxolitinib cream in atopic dermatitis, met its primary endpoint, and I'll cover this on the next slide.

We were pleased to announce that our pivotal Phase 3 TRuE-AD2 study achieved its primary endpoint of proportion of patients with an IGA treatment success following 8 weeks of therapy. This is the first of 2 identical pivotal trials, and we expect the results of TRuE-AD1 later in the first quarter. In terms of study design, TRuE-AD2 recruited approximately 600 patients with mild-to-moderate atopic dermatitis. Inclusion criteria included an age range of 12 to 75 years of age, an IGA score of 2 to 3 and a percentage body surface area affected of 3% to 20%. Patients were randomized 2:2:1 to 0.75% rux cream BID, 1.5% rux cream BID and a vehicle cream, respectively, and were on therapy for 8 weeks, at which point all eligible patients could either switch to or continue on 0.75% or 1.5% rux cream BID for the long-term safety extension period.

In the Phase 3 TRuE-AD2 study and for both doses, the efficacy data as measured in the primary and secondary endpoints, as well as the safety profile, are consistent with previous data from our Phase 2 program, which, as a reminder, were presented at EADV in 2018 and have since been published in manuscript form in JACI.

As required by the FDA for dermatologic studies, long-term safety data are being collected, and we continue to expect to submit the NDA for ruxolitinib cream in Q4 of this calendar year.

I wanted to take this opportunity to briefly walk through the summary clinical development program for tafasitamab. With MorphoSys, we intend to pursue development in both relapsed/refractory and front-line diffuse large B-cell lymphoma as well as in relapse/refractory CLL and other non-Hodgkin's lymphomas. For relapse/refractory diffuse large B-cell lymphoma, L-MIND was the basis for the BLA submission seeking approval of the combination of tafasitamab plus lenalidomide. The B-MIND Phase 3 study is also underway, assessing tafa versus rituximab, both on top of bendamustine. The futility analysis for B-MIND was passed in late 2019 and primary completion is estimated for 2022. Tafa is also being evaluated in front-line diffuse large B-cell lymphoma.

The safety portion of the first-line study is expected to be completed later this year, where upon, we expect to start the pivotal portion of the program.

As it relates to relapse/refractory CLL and other non-Hodgkin's lymphomas, based on some promising data of tafa in combination with the PI3-kinase delta inhibitor in the COSMOS trial, we expect to initiate a trial of tafa plus our own PI3-kinase delta inhibitor parsaclisib in 2020.

Moving on to our LIMBER project on Slide 16, which is our initiative focused on expanding our leadership within MPNs beyond ruxolitinib. Later this year, we expect initial bioavailability and bioequivalence data for once-a-day ruxolitinib, which is an important step towards a potential launch in 2022. We expect to begin proof-of-concept combination trials of ruxolitinib for both our BET and ALK2 inhibitors during this year, and we also plan to initiate a pivotal trial combining ruxolitinib with parsaclisib in myelofibrosis patients with a suboptimal response to ruxolitinib monotherapy based on encouraging proof-of-concept data. This initiation would mark the first pivotal trial within the LIMBER program.

With that, I would like to turn the call over to Christiana for the financial update.

Christiana Stamoulis - *Incyte Corporation - Executive VP & CFO*

Thank you, Steven, and good morning, everyone. The financial update this morning will include GAAP and non-GAAP numbers. For a full reconciliation of GAAP to non-GAAP, please refer to Slides 25 and 26 in the backup section of the deck and to the press release we issued this morning.

Our fourth quarter results reflect continued strong revenue growth across all products, with total product and royalty revenues of $579 million, representing an increase of 24% over the fourth quarter of 2018. This is comprised of $466 million in Jakafi and $24 million in Iclusig net product revenues, $65 million in Jakavi royalties from Novartis and $24 million in Olumiant royalties from Lilly.

Our total costs and expenses for the quarter on a non-GAAP basis of $434 million increased by 10% from the prior year quarter. As you can see, the growth rate in total costs and expenses was well below the growth rate in product and royalty revenues.

Ongoing R&D expense for the quarter was $282 million on a non-GAAP basis, representing a 3% increase from the prior year quarter. This was primarily due to our existing pipeline programs progressing to later stages of development and was partially offset by our election to end additional co-funding of development of baricitinib with Lilly.

SG&A expense for the quarter was $123 million on a non-GAAP basis, representing a 27% increase over the prior year quarter. This was primarily due to an increase in the commercialization efforts related to Jakafi.

Looking at full year 2019 results, total product and royalty revenues of $2.08 billion, grew 22%, while total costs and expenses stayed relatively flat at $1.55 billion on a non-GAAP basis. As a result, non-GAAP operating income increased by 88% from $325 million in 2018 to $610 million in 2019.

Looking at the trend from 2015 through 2019, the growth in our product and royalty revenues has exceeded the growth in both our ongoing R&D expense and SG&A expense on a non-GAAP basis, leading to higher operating leverage and reflecting our commitment to disciplined management of our financial resources.

Moving on to 2020. I will now discuss the key components of our 2020 guidance. Please note that the guidance we provide today does not include the financial impact of our recently announced collaboration with MorphoSys, which has not yet closed and also excludes the impact of any additional potential future strategic transactions.

For the full year 2020 on both a GAAP and non-GAAP basis, we expect net product revenue for Jakafi to be in the range of $1.88 billion to $1.95 billion, driven by continued growth across all indications. For Iclusig, we expect net product revenue to be in the range of $100 million to $105 million. As in previous years, we will not be providing guidance for milestones or royalty revenues.

We expect our gross to net adjustment for 2020 to be approximately 16% for Jakafi, with the adjustment in the first quarter of the year being higher relative to both the previous quarter and subsequent quarters.

We expect the GAAP R&D expense to be in the range of $1.21 billion to $1.28 billion and non-GAAP R&D expense to range from $1.08 billion to $1.15 billion. The increase compared to 2019 is primarily driven by our existing pipeline programs progressing to later stages of development.

We expect GAAP SG&A expense to be in the range of $505 million to $535 million and non-GAAP SG&A expense to range from $447 million to $477 million. The increase compared to 2019 is primarily driven by efforts to support the expansion of our commercial portfolio and investment in infrastructure to support the continued growth of the business.

Both in the case of R&D and SG&A, the non-GAAP expense guidance excludes estimated stock-based compensation expense.

I will now turn the call back to Hervé for further discussion of the year ahead.

Hervé Hoppenot - *Incyte Corporation - Chairman, President & CEO*

Thank you, Christiana. So 2019 was a strong year in terms of business performance and pipeline progression. and as you can see on Slide 23, 2020 is shaping up to be another busy and important year for Incyte. In my opening remarks, I laid out our key priorities for the year, and here, we have highlighted the 5 key regulatory updates that we expect, which are the FDA decision on pemigatinib, tafasitamab and capmatinib, the MAA submission of tafa and the NDA submission of rux cream. We also look forward to providing numerous other data announcements as the year progresses.

Operator, that concludes our prepared remarks and please give your instructions and open the call for Q&A.

QUESTIONS AND ANSWERS

Operator

(Operator Instructions) Our first question today is coming from Brian Abrahams from RBC.

Brian Corey Abrahams - *RBC Capital Markets, Research Division - Senior Biotechnology Analyst*

Congrats on the continued commercial performance and on the TRuE-AD2 results. On topical rux, I was wondering if you could talk about your expectations for whether there might be ultimately a boxed warning on the label with respect to class safety. What, if any, impact you think that might have on dermatologist views and uptake of the agent, ultimately? And I guess, along those lines, any type of work that you have done or expect to do over the course of the program to fully characterize systemic exposure and maybe the relative importance of that as you think about a future label there and adoption?

Steven H. Stein - *Incyte Corporation - Executive VP & Chief Medical Officer*

Brian, it's Steven. Thank you for your question. The data that we've already presented both at EADV and then published in a paper in JACI shows the safety profile to date for our topical rux cream. Obviously, what you referenced in terms of box warning has to date largely applied to compounds that give you substantial systemic exposure. And what we've already published, we have little to no systemic exposure. We have a very clean safety profile. So given all of the above, we don't think that we're going to be in that territory of having a box warning. Obviously, ultimately, it's up to the FDA and not to us. But again, given the little to no systemic exposure seen to date, the very clean safety profile, we don't expect that. And then we'll update the safety as this year goes along, with more long-term data, but that's our expectation currently.

Operator

Our next question is coming from Marc Frahm from Cowen & Company.

Marc Alan Frahm - *Cowen and Company, LLC, Research Division - VP*

For Hervé and Christiana, with the MorphoSys deal, assuming this closes, you'll have about 3 products hopefully launching in the next 1.5 years or so. So I'm just wondering kind of the appetite for continued M&A? And should we expect that you might do more larger deals like the MorphoSys deal for late stage assets? Or do you think you're kind of done on that end of the pipeline, and we should really be more focused on kind of smaller or later stage deals going forward?

Christiana Stamoulis - *Incyte Corporation - Executive VP & CFO*

Marc, thank you for the question. So in terms of the BD strategy, it hasn't really changed from what it was before the MorphoSys deal. We are continuing to look at external assets to complement or supplement our internal activities. And the focus is similar to what it was before, looking at programs that could help diversify and continue to grow revenue, programs that allow us to capitalize on our existing capabilities in oncology, heme, MPNs of course, and more on the bolt-on type of transactions versus larger deals. And when you look from a capacity point of view, we ended the year with $2.1 billion of cash on the balance sheet. The pro forma for the MorphoSys transaction is $1.2 billion. So we still have capacity to continue to look for those bolt-on type of transactions.

Operator

Our next question is coming from Tyler Van Buren from Piper Sandler.

Tyler Martin Van Buren - *Piper Sandler & Co., Research Division - Principal & Senior Biotech Analyst*

With respect to the TRuE-AD results in the press release, there's 1 line which appears pretty deliberate and was repeated in the press release this morning where you guys state that the overall efficacy and safety profile of ruxolitinib cream is consistent with previous data. So -- and I know you guys can't speak about the data. But I guess, just with respect to that statement, could you say that it's consistent with the effect size compared to vehicle as we think about it relative to prior data? And then just as a quick follow-up, just can you talk about the potential conferences that you guys might present data at? And I'm assuming that you would wait for the results from TRuE-AD1 as well.

Steven H. Stein - *Incyte Corporation - Executive VP & Chief Medical Officer*

Got it. Yes, it's Steven. Thanks for your question. So the -- just the back part of your question first. The TRuE-AD1 results will come sometime this quarter. And obviously, we are awaiting them, and we expect them to be in line with TRuE-AD2, and then again, with the proof-of-concept data. What we're trying to communicate as much as we can without actually giving the actual results because we have to protect future meetings where we want to present the data as soon as possible, is that directionally and quantitatively the active arms, the 0.75% and 1.5%, were in line with the

primary and secondary efficacy endpoints seen in the Phase 2 data, and the vehicle was as well, which is very encouraging. So when we went from 150 patient proof-of-concept study to a 600 patient Phase 3 in TRuE-AD2, we are seeing the same quantitative results in terms of the primary and secondary efficacy as well as the safety. And that's as much as we can say to try and protect both the presentation and a future manuscript, which we hope to be able to do soon.

Operator

Our next question is coming from Cory Kasimov from JPMorgan.

Cory William Kasimov - *JP Morgan Chase & Co, Research Division - Senior Biotechnology Analyst*

I wanted to ask on Jakafi. Just with regard to your 2020 guidance, it looks like it implies growth of, I think, it's 12% to 16%. Can you just qualitatively discuss how much of this is coming from GVHD versus the longer-term indications of MF and PV? And then also, can you just comment on what happened with the Jakafi RESET study in ET, saw in the press release that recruitment was discontinued. So curious what happened on that front?

Barry P. Flannelly - *Incyte Corporation - Executive VP & General Manager of U.S.*

Cory, this is Barry. I'll let Steven handle the RESET study. But as far as the growth goes, we're very encouraged by the approval and launch in acute steroid-refractory GVHD for Jakafi that continues to now add a significant portion to the overall net sales, but myelofibrosis continues to be the largest portion of our net sales, while PV, total percentage of patients, continues to increase at a faster rate than MF. But those 2 indications, MF and PV will drive the indications. Obviously, we talked before, whether it's acute GVHD or chronic GVHD, the total population in the United States in the steroid-refractory setting is about 3,000 patients. And obviously, you know that it's a much larger patient population. So MF and PV will continue to drive the growth towards $3 billion, ultimately, but GVHD is now a significant contributor to that. Steven?

Steven H. Stein - *Incyte Corporation - Executive VP & Chief Medical Officer*

Cory, in terms of the RESET study, so that's looking at ruxolitinib in essential thrombocythemia. The study design was a little bit complicated because of the composite endpoint. So the endpoint that was required in negotiation with the regulatory agencies was to obtain control of blood counts in terms of both the white blood cell count and the platelet count together and not an event endpoint like thrombosis. So what was required in terms of eligibility was patients coming on who had either intolerance or progressed on hydroxyurea, had a white blood cell count above 11,000 and had no prior exposure to anagrelide because the study was randomized against anagrelide. And trying that for more than a year, in fact, longer, we were unable to enroll a sufficient number of patients in a timely manner. We looked at various amendments to try and get around this, but ultimately, because of that composite endpoint, we couldn't do that in terms of either the white count or prior anagrelide. So the current thinking is to change it to a publication strategy, finish up the study and publish it, but it will not be of registration quality in terms of its size.

Operator

Our next question is coming from Vikram Purohit from Morgan Stanley.

Vikram Purohit - *Morgan Stanley, Research Division - Equity Analyst*

I had a question on your commercialization plans for rux cream. So you previously noted that you're still thinking through your options when it comes to whether you'd like to pursue commercialization independently or to find a partner for Europe. And I just wanted to see if your thinking here has evolved or changed at all based on the first set of Phase 3 data you saw based on the recent readout?

Hervé Hoppenot - *Incyte Corporation - Chairman, President & CEO*

So the recent -- Hervé here. So the recent readout is obviously improving our optimism regarding the chance of getting regulatory approval in the U.S., where, as you know, we have decided to go by ourselves. Regarding the rest of the world, as I said previously, things have not really changed. I mean, we will be -- there's a high probability we'll have a partnership regarding Asia. And in Europe, we are still in the process of looking at what options we have, either going alone, licensing out completely or some form of a partnership, and each of the 3 options is still open regarding Europe.

Operator

Our next question is coming from Evan Seigerman from Crédit Suisse.

Evan David Seigerman - *Crédit Suisse AG, Research Division - VP & Senior Equity Research Analyst*

Congrats on the progress. So I noticed in the press release, there were some updates on the low dose itacitinib trial in ulcerative colitis and also parsaclisib in Sjogren's disease. Can you help me understand why the UC trial was discontinued and what you saw in the data from the Sjogren's trial not to warrant continuation?

Steven H. Stein - *Incyte Corporation - Executive VP & Chief Medical Officer*

Sure, Evan, it's Steven. Thanks for your question. In terms of the low dose itacitinib in inflammatory bowel diseases, particularly ulcerative colitis, again, it was around operational dynamics in the competitive space. So we were unable to enroll sufficient numbers of patients to keep progressing the study as well as given the competitive space with other compounds with similar mechanisms being way ahead. We elected at the end of last year to no longer pursue that program. In terms of Sjogren's, again, a difficult medical condition in terms of measuring end points and getting sufficient spread versus standard of care or even placebo. We're not seeing enough of the activity to warrant going forward into a full registration program. It was a proof-of-concept study. And in our opinion, we know we didn't get to the proof-of-concept we wanted to pursue registration further there. Across inflammation and autoimmunity, one of the beauties of the program is we have this pipeline of targeted therapy agents, immunooncology agents, all of which were primarily in the beginning developed for either hematology or oncology indications, but because of their mechanism of action, either in terms of JAK inhibition or B-cell inhibition with delta inhibitors, they lend themselves to conditions in the inflam autoimmune setting where those mechanisms are important. So we have the ability to conduct multiple proof-of-concept studies very efficiently and then make decisions to go forward or not. And in those 2 instances, it didn't meet our own internal expectations to pursue registration programs.

Operator

Our next question is coming from Jay Olson from Oppenheimer.

Jay Olson - *Oppenheimer & Co. Inc., Research Division - Executive Director & Senior Analyst*

Congratulations on the financial performance in 2019. You delivered impressive non-GAAP operating margin growth last year. And since you're now investing in multiple new product launches over the next year or 2, do you expect to continue growing operating margins at the same rate? And where do you see them going longer term? And then maybe if I could just ask a follow-up question on QD Jakafi, do you expect any clinical benefits versus BID Jakafi? And if so, would those benefits appear in the label?

Christiana Stamoulis - *Incyte Corporation - Executive VP & CFO*

Jay, Christiana here, let me take the part on the margins. As you can see, both in the case of 2019, and with the guidance that we provided for 2020, we are looking to continue to invest in supporting our portfolio, both on the R&D and commercial side, but the growth on the expense front is

slower than that of the top line, which is what we had indicated in the past. And as you can see, we are in line with what we have said. We will continue to invest in our activities and in the company on the R&D front, as we have discussed in the past, we will be looking to invest based on the quality of the programs. And if data supports moving programs into development and late year stages of development we'll continue to do that, but the trend that we see is continuing to have growth on the expense side being below that of the top line.

Steven H. Stein - *Incyte Corporation - Executive VP & Chief Medical Officer*

Jay, in terms of your question for the once-a-day formulation, so the work with that is progressing very well. The intent is to follow a 505(b) route in terms of first, obtaining sufficient bioavailability in terms of PK of the different strengths, and then moving on to prove those individual different once-a-day strengths meet the bioequivalence in terms of the ratios on the FDA guidance for each of the strengths you're matching it up with. So there's no -- in the beginning, it's not built around clinical differentiation, if you will. It's built around BA/BE route to obtain approval in that 2022 time frame. We do know from a publication in 2011 with a single once-daily strength, the 25 milligram XR strength, not surprisingly, the PK profile was flatter. So there was less of a Cmax, which we think is related to the anemia seen in myelofibrosis. And there may be ultimately less anemia with these products. That will need to be proven down the pike once we've finished the once-a-day formulation work. Once you've taken it through the BA/BE route and gotten approved, then we could potentially do clinically differentiating work to see if there is a flatter profile with all the strengths and ultimately less anemia and then make that claim and get it in the label. So it's a very stepwise approach.

Hervé Hoppenot - *Incyte Corporation - Chairman, President & CEO*

If I may add on the QD -- the strategy around the QD that there is obviously this practical aspect of QD. There is this potential clinical benefit, maybe on anemia, we just discussed. And there is the ability to combine with other mechanisms that have a once-a-day regimen. So this project by itself has a lot of potential positive consequences under the management of the life cycle of Jakafi.

Operator

The next question is coming from Salveen Richter from Goldman Sachs.

Andrea R. Tan - *Goldman Sachs Group Inc., Research Division - Research Analyst*

This is Andrea on for Salveen. The first one, as you look to the upcoming launch for pemigatinib in cholangiocarcinoma, can you talk a little bit more about how you've approached building out a solid tumor sales force and the efforts that might be needed for patient or physician education to improve the disease awareness as well as the need for diagnostic screening? And then I have a follow-up.

Barry P. Flannelly - *Incyte Corporation - Executive VP & General Manager of U.S.*

Sure, Andrea. This is Barry. First, we're actually launching in cholangiocarcinoma in this patient population that has FGFR2 fusions or rearrangements, we're already educating, providing health care professionals, getting them ready to, in fact, always test cholangiocarcinoma patients for various mutations, alterations and so forth. So those educational efforts are ongoing now. In terms of FTEs that we put in the field, we do have a few more FTEs in the field. But the way that works in the United States, we have now 147 representatives across the United States, and they call on community oncologists and academic centers across the nation, even though there is people who are specific to heme and solid tumor, most of the community oncologist offices throughout the United States treat both. And certainly, geographically, we hit all of the centers. So we will have a dedicated team that's specifically trained on solid tumors and particularly pemigatinib and cholangiocarcinoma and, of course, the need for NGS testing or diagnostic testing to remind all these health care professionals that are treating these patients, but in fact, we have oncology clinical nurse educators, who are providing educational services. We have medical science liaisons that are all trained.

So each of the teams have already been trained, and we have ongoing training for the sales force. So we think we're in solid shape. And we're going to continue to educate all health care professionals about the need for diagnostic testing to best help these patients.

Andrea R. Tan - *Goldman Sachs Group Inc., Research Division - Research Analyst*

Maybe just another one for you then on the MorphoSys potential launch. Just what additional add to the infrastructure is needed there? And where do you see points of synergies or components that can be leveraged from your existing network?

Barry P. Flannelly - *Incyte Corporation - Executive VP & General Manager of U.S.*

Well, Andrea, as you know, until we close, we can't really plan together with our future partners at MorphoSys. So we've been thinking about this a lot. And independently, we've been planning about what we actually need, but the ability to guide. Now on the other hand, we certainly have a great deal of experience in heme malignancies, certainly here in Wilmington, Delaware and throughout the United States. So we're very confident that we know the space, the lymphoma space very well. We just have to take time, wait a couple of more weeks to actually get together and sit down with our partner MorphoSys about the real details that we have that we can do.

Operator

Next question is coming from Alethia Young from Cantor Fitzgerald.

Alethia Rene Young - *Cantor Fitzgerald & Co., Research Division - Head of Healthcare Research*

Congrats on all the progress. One, can you just talk a little bit about the status of the CITADEL program and when we could expect data there? And then basically, kind of your thoughts and your increased conviction. And I saw some data, obviously, from parsaclisib and ruxolitinib, but just maybe talk a little bit about your increased conviction in that combo and then also the other kind of the combos in the LIMBER program as well?

Steven H. Stein - *Incyte Corporation - Executive VP & Chief Medical Officer*

Alethia, it's Steven. Thanks for the question. So the CITADEL program has 3 components in terms of B-cell malignancies. There's a follicular lymphoma study 203-CITADEL; a marginal zone lymphoma study 204; and then a mantle cell lymphoma study 205. Essentially, we've completed recruitment across all those studies. There may be just a few patients left on one to be done. And now we're in the follow-up phase. As we've presented this data multiple times because they are open-label single-arm studies, we're very encouraged by the high activity of parsaclisib across these B-cell malignancies, and now it's really a wait for the duration of response data. And then they all could be potentially accelerated approval routes in the United States, given the designs of the study, and we may have to then go on and do confirmatory studies as well. So we'll get the bulk of all of their data with the long follow-up through this calendar year and then look at potential submissions across the board. But we're very encouraged by that program and what we've done with it.

In terms of the myelofibrosis combinations, as we announced in our prepared remarks, the most advanced is the rux plus PI3 delta combination. We also presented that data a number of times. We now have the updated data set, looking at the experiments we did in terms of weekly versus daily dosing, and we're most encouraged by the daily dosing arm of the proof-of-concept study. And that's why we'll be going forward this year in a pivotal registration route with that combination. We still have to work out the details with regulatory agencies, but the likely population, as we said in our prepared remarks, are patients who have been on rux probably for approximately 3 months, but don't have a sufficient response and are then randomized to rux plus PI3 delta versus rux alone in some sort of registration fashion with sufficient numbers. And given the effect we've seen from the addition of delta in that population to date, where we saw further spleen volume response, particularly with the daily arm as well as symptom response obviously, we're encouraged by going forward to a pivotal program there.

In terms of the rest of the LIMBER program, it's also a big year, as we announced at JP Morgan, we are beginning and we've resurrected our BET program based on the external environment and what's happening with BET inhibitors in myelofibrosis. So we are a go with our own BET inhibitor this year, we'll do, the monotherapy safety work and go as quickly as we can to combination with rux there. And then our ALK2 program as well, which is targeted around alleviating the anemia through a hepcidin mechanism in combination with rux, and that will also go to combination this

year. And then we'll get further proof-of-concept data for rux plus PIM inhibition. So obviously, an extremely important development program to us, given the importance of rux in myeloproliferative neoplasms in general and an active year in terms of initiating a pivotal study, getting further proof-of-concept study and starting 2 new mechanisms.

Operator

(Operator Instructions) Our next question is coming from Mara Goldstein from Mizuho.

Mara Goldstein - *Mizuho Securities USA LLC, Research Division - MD of Equity Research Department*

Just to circle back on the previous question and the rux plus parsaclisib in myelofibrosis, can you characterize what that proof-of-concept was? And also, what is considered an insufficient response to rux in the clinical trial, but also in clinical practice today?

Steven H. Stein - *Incyte Corporation - Executive VP & Chief Medical Officer*

Mara, thanks for your question. It's a good question. Because as you look across, not only us, but everybody else doing studies in this arena, you have to be very careful of doing cross-study comparisons and make sure that you're actually doing apple-to-apple comparisons, particularly in terms of how people define the population they study in terms of the amount of prior rux exposure, what constitutes either refractory or disease that's progressing and how much was allowed. And then was rux actually discontinued versus was it continued. And the reason I mentioned the latter is just to be clear, is that if you discontinue rux and then allow patients to rebound, if you will, in terms of their spleen and symptoms, just reintroducing rux again, you'll see quite a substantial effect. And we've documented that before and published that. So you have to be very, very careful of the populations you're looking at.

Our proof-of-concept work from a definition point of view with rux plus PI3 delta was defined as patients who have been on at least 6 months of ruxolitinib, for at least 2 months of stable dosing, and then were showing insufficient response in terms of spleen or symptoms and then allowed to come on to the combination without discontinuing rux. With that, we showed a further detriment in terms of spleen volume reduction. That was better with daily dosing rather than weekly dosing. If you ask in the exact quantitative excursion in terms of spleen volume response, that's a good question. In the front-line setting, obviously, given our own approval in the setting, we have now established the endpoint of spleen volume reduction of 35% or greater done through a measurement like MRI, for example, which is not subjective as the probable endpoint that regulators will use going forward as well as validated symptom scores.

In the latter line settings, one could argue that, that may be too high a bar to get to and maybe 20% or more improvement in spleen volume reduction with concurrent symptom improvement may get you across the finish line or other endpoints like transfusion independence. But that's sort of where the field is right now. I think for the moment, first-line studies will still require spleen volume response as a primary endpoint with symptoms as secondary endpoint, and we've established with our own label, what that bar is with the COMFORT studies, and that's what people have to use going forward.

In the other settings, there may be somewhat more creative endpoints that you could do as long as you prove to regulators and patients that you're actually getting clinical benefit.

Operator

Our next question is coming from Christopher Marai from Nomura Instinet.

Christopher N. Marai - *Nomura Securities Co. Ltd., Research Division - MD & Senior Analyst of Biotechnology*

I'm wondering if you could elaborate a little bit on the vehicle performance in TRuE-AD that you saw. Just being cognizant that the Eucrisa Phase 3 saw some variability in that vehicle performance, how do you feel, I guess, given that type of variability about the chance for success of TRuE-AD1? And maybe if you could just remind us of some of your powering assumptions around that?

Steven H. Stein - *Incyte Corporation - Executive VP & Chief Medical Officer*

Chris, it's Steven. So if you look at the atopic dermatitis arena in general, there are some vehicles that on their own without "active" ingredient will have a response rate because of the emollient effect of different vehicles that will then result in improvement in the underlying condition. Our vehicle is cream-based, just like our actual active product. And you saw in the proof-of-concept 150 patient study, our vehicle response rate was 10% or less percentage points. Just to give you by way of comparison, a number, but not to make a direct comparison, Eucrisa in their registration studies had to use an ointment-based vehicle because of their constitution of their active product and their ointment-based vehicle response rate was north of 20%.

So we don't expect, and that's why earlier when we spoke, we said our results are consistent with our proof-of-concept data to date, directionally and quantitatively. We expect the same vehicle cream response rate in our TRuE-AD1 and TRuE-AD2 studies that we saw in our proof-of-concept work. And that's where we stand right now. Obviously, we want to share this with you as soon as we can in an appropriate meeting.

Christopher N. Marai - *Nomura Securities Co. Ltd., Research Division - MD & Senior Analyst of Biotechnology*

I appreciate that. And just one last one on the rux guidance. How much GVHD acute or chronic is sort of in those numbers?

Barry P. Flannelly - *Incyte Corporation - Executive VP & General Manager of U.S.*

I'm sorry, could you repeat the question? I didn't hear the question.

Christopher N. Marai - *Nomura Securities Co. Ltd., Research Division - MD & Senior Analyst of Biotechnology*

In terms of your rux guidance for the year, how much of that, if any, accounts for use in GVHD?

Barry P. Flannelly - *Incyte Corporation - Executive VP & General Manager of U.S.*

Well, we were hoping for a particular number of patients. I think I said before that there is 3,000 patients in total for steroid refractory GVHD, acute GVHD is about 1,500 patients. We think we're approaching about 1,000 patients. It's hard to actually for GVHD because the drug oftentimes is given in the hospital, and we don't get as much detail as you do when you get a prescription on the outside. So GVHD is an important part of the guidance for this year. But overwhelmingly, it's the continued growth in myelofibrosis, which is really going very well and the continued growth in -- for patients with polycythemia vera, again, which is continuing, going very well but Jakafi in acute steroid-refractory GVHD is becoming one of the most used, if not the most used drug other than steroids in treatment of these patients.

Operator

We reached end of our question-and-answer session. I'd like to turn the floor back over for any further or closing comments.

Hervé Hoppenot - *Incyte Corporation - Chairman, President & CEO*

Thank you, and thank you all for your time today and for your questions. So we look forward to seeing you at upcoming investor and medical conferences. But for now, we thank you again for your participation to the call today. Thank you, and goodbye.

Operator

Thank you. That does conclude today's teleconference and webcast. You may disconnect your lines at this time, and have a wonderful day. We thank you for your participation today.
