Evoke Pharma Inc
Form 10-K
March 10, 2016

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, DC 20549

Form 10-K

(Mark One)

x ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the fiscal year ended December 31, 2015

or

¨TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the transition period from to

Commission file number: 001-36075

Evoke Pharma, Inc.

(Exact Name of Registrant as Specified in its Charter)

Delaware	20-8447886
(State or Other Jurisdiction of	(I.R.S. Employer
Incorporation or Organization)	Identification No.)
505 Lomas Santa Fe Drive, Suite 270	
Solana Beach, California	92075
(Address of Principal Executive Offices)	(Zip Code)

858-345-1494

(Registrant's Telephone Number, Including Area Code)

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

Title of Each Class	Name of Each Exchange on Which Registered
Common Stock, par value $0.0001 per share	The NASDAQ Capital Market

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

None

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

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

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). x Yes ¨ No

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company. See definitions of "large accelerated filer", "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer	¨	Accelerated filer	¨
Non-accelerated filer	¨	Smaller reporting company	x

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Securities Exchange Act of 1934). Yes ¨ No x

As of February 29, 2016, the aggregate market value of the registrant's common stock held by non-affiliates of the registrant was approximately $14.0 million, based on the closing price of the registrant's common stock on the NASDAQ Capital Market of $3.43 per share.

The number of outstanding shares of the registrant's common stock, par value $0.0001 per share, as of February 29, 2016 was 7,201,774.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's definitive proxy statement to be filed with the Securities and Exchange Commission pursuant to Regulation 14A in connection with the registrant's 2015 Annual Meeting of Stockholders, which will be filed subsequent to the date hereof, are incorporated by reference into Part III of this Form 10-K. Such proxy statement will be filed with the Securities and Exchange Commission not later than 120 days following the end of the registrant's fiscal year ended December 31, 2015.

EVOKE PHARMA, INC.

FORM 10-K — ANNUAL REPORT

For the Fiscal Year Ended December 31, 2015

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PART I

Forward-Looking Statements and Market Data

This Annual Report on Form 10-K contains "forward-looking statements" within the meaning of Section 27A of the Securities Act of 1933, as amended, or the Securities Act, and Section 21E of the Securities Exchange Act of 1934, as amended, or the Exchange Act. All statements other than statements of historical facts contained in this Annual Report on Form 10-K, including statements regarding our future results of operations and financial position, business strategy, prospective products, product approvals, research and development costs, timing and likelihood of success, plans and objectives of management for future operations, and future results of current and anticipated products are forward-looking statements. These statements involve known and unknown risks, uncertainties and other important factors that may cause our actual results, performance or achievements to be materially different from any future results, performance or achievements expressed or implied by the forward-looking statement. The forward-looking statements are contained principally in the sections entitled "Risk Factors," "Management's Discussion and Analysis of Financial Condition and Results of Operations" and "Business." In some cases, you can identify forward-looking statements by terms such as "may," "will," "should," "expect," "plan," "anticipate," "could," "intend," "target," "project," "cor "believes," "estimates," "predicts," "potential" or "continue" or the negative of these terms or other similar expressions. Although we believe the expectations reflected in these forward-looking statements are reasonable, such statements are inherently subject to risk and we can give no assurances that our expectations will prove to be correct. Given these risks, uncertainties and other factors, you should not place undue reliance on these forward-looking statements, which speak only as of the date of this Annual Report on Form 10-K. You should read this Annual Report on Form 10-K completely. As a result of many factors, including without limitation those set forth under "Risk Factors" under Item 1A of this Part I below, and elsewhere in this Annual Report on Form 10-K, our actual results may differ materially from those anticipated in these forward-looking statements. Except as required by applicable law, we undertake no obligation to update these forward-looking statements to reflect events or circumstances after the date of this report or to reflect actual outcomes. For all forward-looking statements, we claim the protection of the safe harbor for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995.

This Annual Report on Form 10-K also contains estimates, projections and other information concerning our industry, our business, and the markets for EVK-001, including data regarding the estimated size of those markets, their projected growth rates, the incidence of certain medical conditions, statements that certain drugs or classes of drugs are the most widely prescribed in the United States or other markets, the perceptions and preferences of patients and physicians regarding certain therapies and other prescription, prescriber and patient data, as well as data regarding market research, estimates and forecasts prepared by our management. Information that is based on estimates, forecasts, projections, market research or similar methodologies is inherently subject to uncertainties and actual events or circumstances may differ materially from events and circumstances reflected in this information. Unless otherwise expressly stated, we obtained this industry, business, market and other data from reports, research surveys, studies and similar data prepared by market research firms and other third parties, industry, medical and general publications, government data and similar sources

We use our registered trademark, EVOKE PHARMA, in this Annual Report on Form 10-K. This Annual Report on Form 10-K also includes trademarks, tradenames and service marks that are the property of other organizations. Solely for convenience, trademarks and tradenames referred to in this Annual Report on Form 10-K appear without the ® and ™ symbols, but those references are not intended to indicate, in any way, that we will not assert, to the fullest extent under applicable law, our rights or that the applicable owner will not assert its rights, to these trademarks and tradenames.

Unless the context requires otherwise, references in this Annual Report on Form 10-K to "Evoke," "we," "us" and "our" refer to Evoke Pharma, Inc.

Item 1. Business

Overview

We are a specialty pharmaceutical company focused primarily on the development of drugs to treat gastrointestinal, or GI, disorders and diseases. We are developing EVK-001, a metoclopramide nasal spray for the relief of symptoms associated with acute and recurrent diabetic gastroparesis in women. Diabetic gastroparesis is a GI disorder afflicting millions of sufferers worldwide in which the stomach takes too long to empty its contents resulting in serious digestive system symptoms. Metoclopramide is the only product currently approved in the United States to treat the symptoms associated with gastroparesis, and is currently available only in oral and intravenous forms. EVK-001 is a novel formulation of this drug, designed to provide systemic delivery of metoclopramide through nasal administration.

Gastroparesis is a condition of delayed gastric emptying in the absence of mechanical obstruction. Gastroparesis results in food remaining in the stomach for a longer time than normal, yielding a variety of symptoms and systemic metabolic complications. Gastroparesis is a common problem in individuals with diabetes, but also is observed in patients with prior gastric surgery, a preceding infectious illness, pseudo-obstruction, collagen vascular disorders and anorexia nervosa. According to the American Motility Society Task Force on Gastroparesis, the prevalence of gastroparesis is estimated to be up to 4% of the United States population. Signs and

symptoms of gastroparesis include nausea, early satiety, prolonged fullness, bloating, upper abdominal pain, vomiting and retching. The disorder can lead to considerable pain and discomfort, poor nutrition, impaired glycemic control and diminished quality of life. According to a 2008 study published in the American Journal of Gastroenterology, it is estimated that hospitalization costs associated with gastroparesis exceed $3.5 billion annually.

We believe nasal administration has the potential to provide our target population of gastroparesis patients with a preferred treatment option for several important reasons: (1) unlike metoclopramide tablets which may have erratic absorption due to gastroparesis itself, EVK-001 is designed to bypass the digestive system to allow for more predictable drug absorption, even when patients are vomiting; (2) the absorption of EVK-001 occurs across the thin mucosa in the nasal cavity to allow for rapid and predictable drug administration through the nasal route; and (3) for gastroparesis patients experiencing nausea, a nasal spray may be better tolerated than an oral medication.

We have evaluated EVK-001 in a multicenter, randomized, double-blind, placebo-controlled parallel group, dose-ranging Phase 2b clinical trial in 287 subjects with diabetic gastroparesis where EVK-001 was observed to be effective in improving the most prevalent and clinically relevant symptoms associated with gastroparesis in women while exhibiting a favorable safety profile. In April 2014, we commenced enrollment in a Phase 3 clinical trial of EVK-001 in female subjects with symptoms associated with acute and recurrent diabetic gastroparesis. This Phase 3 clinical trial is a multicenter, randomized, double-blind, placebo-controlled, parallel-group study evaluating the efficacy, safety and population pharmacokinetics of EVK-001 in adult female subjects with diabetic gastroparesis when dosed four times a day for 28 days.

The Phase 3 trial is expected to enroll approximately 200 female subjects at sites across the United States. As of February 29, 2016, we had randomized 186 subjects. Overall enrollment in the trial has been slower than previously anticipated. Although the trial sites have been screening significant numbers of subjects, those with diabetic gastroparesis typically have symptoms that vary in timing and severity, unpredictable gastric emptying delays, and complex medical histories. We are also facing competition for subjects from other ongoing competing clinical trials that were not active when we started our Phase 3 trial. This combination of factors creates a challenge for enrollment in diabetic gastroparesis trials. We anticipate fully enrolling this clinical trial during the second quarter of 2016. We will need to successfully complete this trial before we are able to submit a new drug application, or NDA, to the U.S. Food and Drug Administration, or FDA, for EVK-001. FDA approval of the NDA is required in order for us to commercially market EVK-001 in the United States.

In addition, we are conducting a companion clinical trial with EVK-001 in male subjects with symptoms associated with acute and recurrent diabetic gastroparesis to assess the safety and efficacy of EVK-001 in men. The male companion trial was initiated in May 2014 and is designed similarly to the Phase 3 trial in women. This trial was requested by the FDA, but is not required for submission of the EVK-001 NDA for women; however, we expect to include safety data from this trial in the NDA.

We successfully completed a thorough ECG (QT/QTc) study and reported positive results in December 2014. A QT/QTc study is a specialized clinical trial designed to assess whether a drug has the potential to prolong the QT interval. The QT interval represents the amount of time the heart’s electrical system takes to repolarize, or recharge, after each beat, and the QTc interval represents the QT interval corrected for differences in heart rate. Prolongation of the QT interval may increase the risk for cardiac arrhythmias. Data from the thorough ECG (QT/QTc) study met the pre-specified primary endpoint, demonstrating that EVK-001, at therapeutic and supratherapeutic doses, did not prolong the QT/QTc interval in healthy subjects.

In April 2015, we announced the completion of production of a commercial scale lot of EVK-001 as required by the FDA. With the completion of this large scale production of EVK-001, we believe we have demonstrated our ability to manufacture EVK-001 at commercial scale quantities in accordance with the FDA standards for chemistry, manufacturing and controls, or CMC. In addition to data from this recent program, we have a three-year registration stability data package from previous studies which have all met proposed specifications. We expect that these CMC

datasets will be submitted as part of our NDA submission following completion of our ongoing Phase 3 clinical trial.

In July 2015, the FDA published draft guidance intended to assist sponsors in the clinical development of drugs for the treatment of diabetic and idiopathic gastroparesis, Gastroparesis: Clinical Evaluation of Drugs for Treatment – Guidance for Industry, or the FDA Guidance. We believe that the FDA Guidance is consistent with the advice the FDA has provided to us regarding trial design and study endpoints for our ongoing Phase 3 trials. As a result, our Phase 3 protocol is consistent with the specific recommendations in the FDA Guidance. In addition, the FDA Guidance explicitly states that there is an urgent medical need for development of drugs with a favorable risk-benefit profile to treat patients with gastroparesis and acknowledges that "patients with diabetic gastroparesis may experience further derangement of glucose control because of unpredictable gastric emptying and altered absorption of orally administered hypoglycemic drugs." We believe these statements from the FDA Guidance support the need for the development of non-oral drugs like EVK-001 to treat the symptoms of this debilitating disease.

In August 2015, we received a letter from the FDA indicating the agency's concurrence with our proposed pediatric study plan for EVK-001. Pursuant to the terms of the letter, the FDA has accepted our EVK-001 pediatric study plan, which included a request for a

full waiver of the requirement to conduct pediatric studies on the basis that diabetic gastroparesis is an adult disease. We expect that the pediatric study plan will be included in our NDA submission.

Business Strategy

Our objective is to develop and bring to market products to treat acute and chronic GI motility disorders that are not satisfactorily treated with current therapies and that represent significant market opportunities. Our business strategy is to:

- Continue development and pursue regulatory approval for EVK-001. We are currently conducting a Phase 3 trial of EVK-001 in female subjects suffering from diabetic gastroparesis, which if successful, will allow us to file an NDA with the FDA.
- Seek partnerships to accelerate and maximize the potential for EVK-001. As we continue to generate data on EVK-001, we are seeking partnering opportunities with pharmaceutical companies that have established development and sales and marketing capabilities to potentially enhance and accelerate the development and commercialization of EVK-001.
- Explore building in-house capabilities to potentially commercialize EVK-001 in the United States. As EVK-001 progresses through its Phase 3 clinical program, in addition to partnering opportunities, we are evaluating the development of a specialty sales force and marketing capabilities, either internally or externally, to allow us to directly market EVK-001 in the United States, if approved by the FDA.
- Explore regulatory approval of EVK-001 outside the United States. We will initially seek approval of EVK-001 in the United States and then will evaluate the market opportunity in other countries.
- Evaluate the development and/or commercialization of other therapies for GI motility disorders. Similar to our initial focus on gastroparesis, we will evaluate opportunities to in-license or acquire other product candidates, as well as commercial products, to treat patients suffering from predominantly GI disorders, seeking to identify areas of high unmet medical needs with limited treatment options.

The Gastrointestinal Market

The health of the GI system has a major effect on an individual's daily activities and quality of life. A retrospective review published by the National Institute of Diabetes and Digestive and Kidney Diseases estimated that in 2004 there were more than 72 million ambulatory care visits with a diagnosis of a GI disorder in the United States alone. The annual cost of these GI disorders in 2004, not including digestive cancers and viral diseases, was estimated to be greater than $114 billion in direct and indirect expenditures, including hospital, physician and nursing services as well as over-the-counter and prescription drugs.

In 2004, the total cost of GI prescription drugs in the United States was $12.3 billion, and over half of this cost ($7.7 billion) was associated with drugs prescribed for Gastroesophageal Reflux Disease, or GERD. Peptic Ulcer disease, hepatitis C, irritable bowel syndrome, or IBS, and inflammatory bowel disease, or IBD, were major contributors to the remaining drug cost. Historically GI product development efforts have focused on indications with the largest patient populations such as GERD, constipation, peptic ulcers and IBS. As a result, limited innovation has occurred in other segments of the GI market, such as upper GI motility disorders, even though these disorders affect several million patients worldwide. Consequently, due to the limited treatment options available for upper GI motility disorders, we believe there is a substantial market opportunity for us to address significant unmet medical needs, initially for diabetic gastroparesis.

GI Motility Disorders

Motility disorders are one of the most common GI disorders. Motility disorders affect the orderly contractions or relaxation of the GI tract which move contents forward and prevent backwards egress. This is important in the normal movement of food through the GI tract. Motility disorders are sometimes referred to as functional GI disorders to highlight that many abnormalities in stomach function can occur even when anatomic structures appear normal.

Functional GI disorders affect the upper and lower GI tract and include gastroparesis, GERD, functional dyspepsia, constipation and IBS. It has been estimated by the International Foundation for Functional Gastrointestinal Disorders that one in four people in the United States suffer from functional GI disorders, having signs and symptoms such as abdominal pain, nausea, constipation, diarrhea, bloating, decreased appetite, early satiety, swallowing difficulties, heartburn, vomiting and/or incontinence.

Gastroparesis

Gastroparesis is a debilitating, chronic condition that has a significant impact on patients' lives. It is characterized by slow or delayed gastric emptying and evidence of gastric retention in the absence of mechanical obstruction. Muscular contractions in the stomach, which move food into the intestine, may be too slow, out of rhythm or erratic. The following graph depicts the timing associated with the emptying of solids in patients with diabetic gastroparesis compared to normal individuals:

The stomach is a muscular sac between the esophagus and the small intestine where the digestion of food begins. The stomach makes acids and enzymes referred to as gastric juices which are mixed with food by the churning action of the stomach muscles. Peristalsis is the contraction and relaxation of the stomach muscles to physically breakdown food and propel it forward. The crushed and mixed food is liquefied to form chyme and is pushed through the pyloric canal into the small intestine in a controlled and regulated manner.

In gastroparesis, the stomach does not perform these functions normally, causing characteristic flares of signs and symptoms that include nausea, early satiety, prolonged fullness, bloating, upper abdominal pain, vomiting and retching. As a result of these signs and symptoms, patients may limit their food and liquid intake leading to poor nutrition, experience dehydration and electrolyte disturbances due to vomiting, and have poor blood glucose control, ultimately requiring hospitalization. If left untreated or not adequately treated, gastroparesis causes significant acute and chronic medical problems, including additional diabetic complications resulting from poor glucose control.

Gastroparesis in the Hospital Setting

When patients experience a flare of their gastroparesis symptoms that cannot be adequately managed by oral medications, they may be hospitalized for hydration, parenteral nutrition, and correction of abnormal blood glucose or electrolyte levels. In this setting, intravenous metoclopramide is the first line of treatment. Typically, these diabetic patients with severe gastroparesis symptoms remain in the hospital until they are stabilized and able to be effectively treated with oral metoclopramide. These hospitalizations are costly and expose patients to increased risks, including hospital-acquired infections. The number of patients with gastroparesis that require hospitalization due to their disease is growing, according to a study published in the American Journal of Gastroenterology in 2008. Additionally, the study reported, from 1995 to 2004, total hospitalizations with a primary diagnosis of gastroparesis increased 158%. Hospital admissions for patients with gastroparesis as the secondary diagnosis increased 136%. The average length of stay for a patient is approximately six days at an estimated cost of approximately $22,000. Compared to the other four most common upper GI admission diagnoses (GERD, gastric ulcer, gastritis or nonspecific nausea/vomiting), gastroparesis had the longest length of stay and one of the highest total charges per stay. Additionally, the study estimates that costs associated with gastroparesis as the primary or secondary diagnosis for admission exceeded $3.5 billion in 2004.

A study of patients in clinics at the University of Pittsburgh Medical Center between January 2004 and December 2008, published in the Journal of Gastroenterology and Hepatology, showed that patients with diabetic or post-surgical gastroparesis had significantly more emergency room visits than other gastroparesis groups. The study reinforced the view that gastroparesis constitutes a significant burden for patients and the healthcare system, with more than one-third of patients requiring hospitalization. The number of emergency room visits and annual days of inpatient treatment were comparable to patients with Crohn's disease. The study indicated that patients received an average of 6.7 prescriptions on admission. Eighty percent of the patients identified in the University of Pittsburgh study were women.

Etiology

Gastroparesis can be a manifestation of many systemic illnesses, arise as a complication of select surgical procedures, or develop due to unknown causes. Any disease inducing neuromuscular dysfunction of the GI tract can result in gastroparesis, with diabetes being one of the leading known causes. In a 2007 study published in Current Gastroenterology Reports, 29% of gastroparesis cases were found in association with diabetes, 13% developed as a complication of surgery and 36% were due to unknown causes. According to the American Motility Society Task Force on Gastroparesis, up to 4% of the U.S. population experiences symptomatic manifestations of gastroparesis. As the incidence of diabetes rises worldwide, the prevalence of gastroparesis is expected to rise correspondingly.

The most common identified cause of gastroparesis is diabetes mellitus. The underlying mechanism of diabetic gastroparesis is unknown, though it is thought to be related in part to neuropathic changes in the vagus nerve and/or the myenteric plexus. Prolonged elevated serum glucose levels are also associated with vagus nerve damage. The vagus nerve controls the movement of food through the digestive tract and when it is damaged, movement of food through the GI tract may be abnormal. The prevalence of diabetes in the United States is rapidly rising, with the Centers for Disease Control estimating that one in ten adults currently suffer from the disease. Sedentary lifestyles, poor dietary habits and a consequent rising prevalence of obesity are expected to cause this number to grow substantially.

According to a study published in the Journal of Gastrointestinal and Liver Diseases in July 2010, between 25% and 55% of Type 1 and 15% and 30% of Type 2 diabetics suffer from symptoms associated with the condition and diabetics are 29% of the total gastroparesis population. A 2007 study published in Current Gastroenterology Reports states that approximately 36% of gastroparesis patients suffer from idiopathic gastroparesis. The development of idiopathic gastroparesis is thought to be related to loss of myenteric ganglion cells in the distal large bowel (myenteric hypoganglionosis) and reduction in the interstitial cells of Cajal, which help control contraction of the smooth muscle in the GI tract. Post-surgical gastroparesis is a smaller subset of the total patient pool and accounts for approximately 13% of all cases of the disease, according to a 2007 study published in Current Gastroenterology Reports. Post-surgical gastroparesis is often associated with peptic ulcer surgery, bariatric procedures or esophageal procedures and is thought to result from damage/desensitization of the vagus nerve.

Prevalence

In 2012, the American Diabetes Association estimated that diabetes affects approximately 29.1 million people of all ages in the United States, equating to about 9.3% of the U.S. population. Based on prevalence data, the potential gastroparesis patient pool in the United States is approximately 12 to 16 million adults with women making up 82% of this population, according to a 2007 study published in Current Gastroenterology Reports. There are 2.3 million diabetic patients with moderate or severe gastroparesis symptoms who are seeking treatment in the United States by a health care professional, according to a study presented at the Digestive Disease Week 2013 conference in Orlando, Florida. When patients do receive treatment for gastroparesis, multiple medications are frequently used to address the individual signs and symptoms of gastroparesis. For example, patients may receive anti-emetics for nausea and vomiting and opioids for abdominal pain, which can exacerbate delayed gastric emptying in patients with gastroparesis.

Unmet Needs in Gastroparesis Treatment

Market research and physician interviews demonstrate that existing treatment options for diabetic gastroparesis are inadequate and there is a high level of interest in effective outpatient options for managing patients with gastroparesis symptoms. The market is currently served by oral metoclopramide, intravenous metoclopramide, and the oral disintegrating tablet, or ODT, formulation of metoclopramide (Metozolv® ODT), with approximately 4.5 million prescriptions in the United States per year, according to IMS Health. Due to the limited availability of FDA-approved treatments for gastroparesis, physicians may resort to using medications “off-label” in an attempt to address individual

symptoms experienced by patients. Off-label therapies are pharmaceuticals prescribed by physicians for an unapproved indication or in an unapproved age group, unapproved dose or unapproved form of administration. Examples of drugs used without FDA approval in gastroparesis include erythromycin and Botox® injected via endoscopic procedure directly into the lower gastric sphincter. Previously-approved drugs, such as cisapride and tegaserod, are no longer commercially available in the United States because of safety concerns. Domperidone has never been approved by the FDA but is obtained through certain compounding pharmacies for individual patients under special FDA usage rules.

EVK-001 is a non-oral, promotility and anti-emetic treatment that we believe has the potential to significantly improve the standard of care for female gastroparesis patients. If metoclopramide nasal spray is approved for the treatment of diabetic gastroparesis in women, patients and physicians will have access to an outpatient therapy that could be administered and absorbed even when patients are experiencing delayed gastric emptying or nausea and vomiting.

Our Solution: EVK-001 (Metoclopramide Nasal Spray)

We are developing EVK-001, a dopamine antagonist / mixed 5-HT3 antagonist / 5-HT4 agonist with promotility and anti-emetic effects, for the relief of symptoms associated with acute and recurrent diabetic gastroparesis in women. Since oral metoclopramide

was approved by the FDA in 1980, oral and intravenous metoclopramide have been the only products approved in the United States to treat gastroparesis. EVK-001 is a novel formulation of metoclopramide offering systemic delivery by nasal administration.

We are developing the nasal formulation of metoclopramide to provide our targeted patient population with acute or recurrent symptoms of diabetic gastroparesis with a product that can be systemically delivered as an alternative to the oral or intravenous routes of administration. Nasal delivery is possible because the mucosa of the nasal cavity is a single epithelial cell layer which is well vascularized and allows metoclopramide molecules to be transferred directly to the systemic circulation. There is no first pass liver metabolism required prior to onset of action. Since gastroparesis is a disease that halts or slows the movement of the contents of the stomach to the small intestine, oral drug administration is often compromised. Unlike the oral tablet formulation of metoclopramide, we believe that EVK-001 may be tolerated even when patients are experiencing nausea and vomiting. The nasal formulation may also provide a predictable and consistent means of delivering metoclopramide in patients with delayed gastric emptying and/or frequent vomiting.

A nasal spray formulation of metoclopramide could offer an alternative route of administration for female patients with severe symptoms of diabetic gastroparesis receiving the parenteral formulation of metoclopramide. Following hospitalization for intravenous metoclopramide, a nasal spray formulation would also provide a non-oral option for the transition to an outpatient treatment.

Phase 2b Clinical Trial

We have evaluated EVK-001 in a multicenter, randomized, double-blind, placebo-controlled parallel group, dose-ranging Phase 2b clinical trial in 287 subjects (71% female) with diabetic gastroparesis. Subjects in the trial were between the ages of 18 and 75, with a history of diabetes (Type 1 and Type 2) and diabetic gastroparesis, who had a baseline modified Gastroparesis Cardinal Symptom Index Daily Diary, or mGCSI-DD, of > 2 and < 4 for the seven days prior to randomization to blinded study drug (EVK-001 or placebo).

In the pre-specified analysis of the primary endpoint, mean mGCSI-DD total score change from Baseline to Week 4, by gender, there was a benefit demonstrated in female subjects that was clinically and statistically significant ($p < 0.025$) while male subjects demonstrated a high placebo response rate. This improvement in mGCSI-DD was supported by secondary and exploratory measures of efficacy in females across the majority of parameters evaluated. Due to the results in men, the primary objective of statistical significance in the overall population was not achieved ($p = 0.15$).

We believe this Phase 2b trial is the largest ever conducted in a diabetic gastroparesis population for any approved metoclopramide dosage forms (oral tablet, orally disintegrating tablet and intravenous). Previous metoclopramide studies enrolled small numbers of subjects and did not evaluate treatment effects by gender. For example, fewer than 130 gastroparesis subjects were enrolled across all studies included in the NDA for Reglan Tablets, a branded form of metoclopramide currently marketed in the United States by Ani Pharmaceuticals.

The results of our Phase 2b trial are consistent with what is known about the gender effects in other GI motility disorders. GI motility and functional GI disorders, including gastroparesis, are more common in females than in males. Also, healthy females generally have slower gastric emptying rates. In a study conducted at Temple University (Parkman, et al), gastric emptying of solid food in normal young women was shown to be slower than in age-matched men, even in the first 10 days of the menstrual cycle when estrogen and progesterone levels are low, and the delay in gastric emptying of solids in women appears to be primarily due to altered distal gastric motor function. One explanation may be that less vigorous antral contractions may contribute to slower breakdown of food particles and thus delay the rate of emptying.

Gastrointestinal disorders present differently in males and females and responses to therapy vary by gender. There is general consensus among thought leaders in GI motility that women have a higher prevalence of symptoms, their neural and sensory pathways differ, and hormones, such as estrogen and progesterone, play a role. While the EVK-001 Phase 2b trial is the first report of a gender- based difference in response to metoclopramide among subjects with diabetic gastroparesis, gender effects have been reported in drug studies for other GI disorders, such as IBS. For example, products such as Lotronex® (alosetron), Zelnorm® (tegaserod) and Amitiza® (lubiprostone) were approved by FDA based on effectiveness in women, but not in men.

Phase 2b Trial Design

The Phase 2b clinical trial consisted of up to a 23-day screening period and a seven-day washout period, followed by 28 days of treatment with study drug. We evaluated two dosage strengths of EVK-001: 10 mg and 14 mg; as well as placebo. The study drug was administered for the 28-day treatment period as a single nasal spray four times daily, 30 minutes before meals and at bedtime. Subjects recorded the severity of their gastroparesis symptoms in a telephonic diary using an interactive voice response system once each day. The symptoms were analyzed using a patient reported outcomes instrument, the Gastroparesis Cardinal Symptom Index Daily Diary, or GCSI-DD, developed for collecting and analyzing data to evaluate the effectiveness of treatments for gastroparesis.

The GCSI-DD contains nine signs and symptoms (nausea, retching, vomiting, stomach fullness, not able to finish a normal sized meal, feeling excessively full after meal, loss of appetite, bloating, and stomach or belly visibly larger) grouped in three subscales. The daily score is calculated as a mean of three subscale means. Additional signs and symptoms collected in the daily diary included abdominal pain, abdominal discomfort, number of hours of nausea, number of episodes of vomiting, and overall severity of gastroparesis symptoms. In close collaboration with the staff of the FDA's Division of Gastroenterology and Inborn Errors Products and the Clinical Outcome Assessments, or COA, these additional symptom data were used to further refine the patient reported outcome instrument.

The result is the mGCSI-DD comprised of four symptoms (nausea, early satiety, bloating, and upper abdominal pain) rated from zero (none) to five (very severe). The instrument has been optimized to detect symptom variability on a severity continuum from nausea to vomiting.

Phase 2b Efficacy Results

Two patient reported outcome endpoints (mGCSI-DD and GCSI-DD) were examined in the intention-to-treat, or ITT, population based the protocol design and FDA communications:

- The primary efficacy endpoint was the change from seven-day baseline to Week 4 of the treatment period in the mGCSI-DD total score (mean of four symptoms).
- The second efficacy endpoint analyzed was the change from seven-day baseline to Week 4 of the treatment period in the GCSI-DD total score (mean of three subset means with a total of nine symptoms).

Although an overall improvement in symptoms was observed in EVK-001-treated subjects with diabetic gastroparesis compared to placebo, the difference was not statistically significant due to a high placebo response among male subjects. However, statistically significant improvement in gastroparesis symptoms was observed in female subjects with diabetic gastroparesis as measured by the mGCSI-DD and GCSI-DD total scores for both doses of EVK-001 compared to the placebo. The beneficial effect of treatment in females appears to be uniform. The results are consistent across the overall endpoints, the individual components, and the two dose groups.

The observed differences in efficacy were based on gender and were not due to severity of baseline disease or other demographic characteristics. No statistically significant differences were observed in efficacy between the 10 mg and 14 mg EVK-001 doses; thus the 10 mg dose was considered the lowest effective dose in this study. The table below summarizes the p -values observed for both doses of EVK-001 compared to placebo in the Phase 2b clinical trial across all subjects and for male and female subjects separately.

EVK-001 Phase 2b Clinical Trial

Gastroparesis Study Endpoint Points P -Value Summary

(EVK-001 vs. Placebo: Change from Baseline to Week 4)

	EVK-001 10 mg p -values	EVK-001 14 mg p -values
mGCSI-DD Total Score (per FDA guidance) (1)		
All Subjects	0.1504	0.3005
Females	0.0247	0.0215
Males	0.4497	0.2174
GCSI-DD Total Score (per trial protocol) (2)		
All Subjects	0.2277	0.5266

Females	0.0485	0.0437
Males	0.4054	0.0972

P -values for pairwise comparisons are obtained from an analysis of covariance, or ANCOVA, model with effects for treatment group and Baseline value as a covariate.

(1) The mGCSI-DD was comprised of four symptoms collected on a severity rating scale of 0 to 5. Baseline was seven days prior to treatment or qualifying days during washout and Week 4 was days 21 to 27 of treatment.
(2) The GCSI-DD was comprised of nine symptoms collected on a severity rating scale of 0 to 5. Baseline was seven days prior to treatment or qualifying days during washout and Week 4 was days 21 to 27 of treatment.

The table below summarizes the key data from the trial across all subjects and for female and male patients separately:

EVK-001 Phase 2b Clinical Trial

Primary Endpoint: Mean mGCSI-DD Total Score Change

from Baseline to Week 4 by All Subjects and Gender

(intent-to-treat, last observation carried forward on treatment)

Time Point	Placebo (N=95)	Metoclopramide 10 mg IN (N=96)	Metoclopramide 14 mg IN (N=96)
ALL SUBJECTS			
Baseline (1)			
N	95	96	96
Mean (SD)	2.8 (0.57)	2.9 (0.60)	2.8 (0.62)
Week 4			
N	95	96	96
Mean (SD)	1.8 (1.00)	1.6 (1.06)	1.7 (0.90)
Change from Baseline to Week 4			
N	95	96	96
Mean (SD)	- 1.0 (0.89)	-1.2 (1.18)	-1.2 (0.94)
Difference of Least Square Means (95% CI)		-0.20 (-0.47, 0.07)	-0.14 (-0.42, 0.13)
Pairwise p -value vs. Placebo (2)		0.1504	0.3005
Difference of Least Square Means (95% CI)			0.06(-0.22, 0.33)
Pairwise p -value vs. Metoclopramide 10 mg (2)			0.6830
FEMALES			
Baseline (1)			
N	68	65	70
Mean (SD)	2.7 (0.54)	2.9 (0.62)	2.9 (0.62)
Week 4			
N	68	65	70
Mean (SD)	1.9 (1.02)	1.6 (1.08)	1.7(0.94)
Change from Baseline to Week 4			
N	68	65	70
Mean (SD)	- 0.8 (0.79)	-1.2 (1.18)	-1.3(0.98)
Difference of Least Square Means (95% CI)		-0.38 (-0.71, -0.05)	-0.38 (-0.71, -0.06)
Pairwise p -value vs. Placebo (2)		0.0247	0.0215
Difference of Least Square Means (95% CI)			-0.00 (-0.33, 0.32)
Pairwise p -value vs. Metoclopramide 10 mg (2)			0.9864
MALES			
Baseline (1)			
N	27	31	26
Mean (SD)	2.9 (0.63)	2.8(0.54)	2.5 (0.56)
Week 4			
N	27	31	26
Mean (SD)	1.4 (0.84)	1.6(1.05)	1.7 (0.79)
Change from Baseline to Week 4			

N	27	31	26
Mean (SD)	- 1.4 (0.98)	-1.2 (1.21)	-0.9 (0.78)
Difference of Least Square Means (95% CI)		0.18 (-0.30, 0.66)	0.32 (-0.19, 0.83)
Pairwise p -value vs. Placebo (2)		0.4497	0.2174
Difference of Least Square Means (95% CI)			0.14 (-0.35, 0.63)
Pairwise p -value vs. Metoclopramide 10 mg (2)			0.5805

(1) Baseline is defined as the mean mGCSI-DD total score during the washout period
(2) p -values for pairwise comparisons are obtained from an ANCOVA model with effects for treatment group and baseline value as a covariate

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Phase 2b Safety Observations

In the Phase 2b clinical trial, EVK-001 10 mg and 14 mg doses were well-tolerated and no differences in the safety profiles were observed between the two doses administered. No serious adverse events occurred related to study treatment. In addition, there were no clinically-meaningful differences observed in clinical laboratory parameters, physical examination findings, or electrocardiogram recordings.

Adverse events that occurred more commonly in both EVK-001 10 mg and 14 mg doses compared to placebo (≥ 2% difference between treated compared to placebo groups) were dysgeusia, headache, nasal discomfort, rhinorrhea, throat irritation, fatigue, hypoglycemia and hyperglycemia. The majority of adverse events were mild to moderate and transient in nature.

Treatment-Emergent Adverse Events Reported by More than Two Subjects in Any Treatment Group

	All Subjects		
System Organ Class Preferred Term	Placebo (N = 95)	EVK-001 10 mg (N = 95)	EVK-001 14 mg (N = 95)
Nervous System Disorders			
Dysgeusia	4 (4.2%)	12 (12.6%)	13 (13.7%)
Headache	4 (4.2%)	7 (7.4%)	8 (8.4%)
Dizziness	2 (2.1%)	3 (3.2%)	3 (3.2%)
Gastrointestinal Disorders			
Diarrhea	9 (9.5%)	3 (3.2%)	2 (2.1%)
Nausea	4 (4.2%)	1 (1.1%)	4 (4.2%)
Gastroesophageal reflux disease	1 (1.1%)	4 (4.2%)	0 (0.0%)
Respiratory, Thoracic, and Mediastinal Disorders			
Epistaxis	2 (2.1%)	2 (2.1%)	3 (3.2%)
Cough	2 (2.1%)	0 (0.0%)	3 (3.2%)
Nasal discomfort	0 (0.0%)	3 (3.2%)	2 (2.1%)
Rhinorrhea	1 (1.1%)	1 (1.1%)	3 (3.2%)
Throat irritation	1 (1.1%)	0 (0.0%)	3 (3.2%)
Infections and Infestations			
Upper respiratory tract infection	4 (4.2%)	0 (0.0%)	2 (2.1%)
Nasopharyngitis	1 (1.1%)	3 (3.2%)	1 (1.1%)
General Disorders and Admin Site Conditions			
Fatigue	1 (1.1%)	5 (5.3%)	6 (6.3%)
Metabolism & Nutrition Disorders			
Hyperglycemia	1 (1.1%)	1 (1.1%)	3 (3.2%)
Hypoglycemia	1 (1.1%)	1 (1.1%)	3 (3.2%)
Psychiatric Disorders			
Depression	3 (3.2%)	0 (0.0%)	0 (0.0%)

Phase 1 Comparative Bioavailability Bridging Study

Our Phase 1 clinical trial of EVK-001 was an open-label, four-treatment, four-period, four-sequence crossover study conducted at a single study center. Forty healthy volunteers were enrolled and randomly assigned to one of four treatment sequences. After an overnight fast, subjects received a single dose of each of the metoclopramide treatments (10 mg EVK-001, 20 mg EVK-001, 10 mg oral tablet, and 5 mg/mL injection) in random sequence with a seven-day washout period between doses. Thirty nine subjects received at least one dose of metoclopramide. The pharmacokinetic analysis population consisted of 37 subjects who received all four treatments and two subjects who

received three of the four treatments.

After nasal administration of the 10 mg and 20 mg doses of EVK-001, mean plasma metoclopramide concentrations increased in a dose-related manner, as did mean values for C max and AUC (inf). The absolute bioavailability of EVK-001 after nasal administration was comparable for the 10 mg (47.4%) and 20 mg (52.5%) doses as were the bioavailabilities relative to the oral tablet (60.1% and

66.5%, respectively). The graphs below illustrate the mean plasma concentrations of the active ingredient in the two doses of EVK-001 as well as the oral and injection forms.

Thorough ECG (QT/QTc) Study

We conducted a randomized, double-blind, double-dummy, four-way crossover thorough ECG (QT/QTc) study of EVK-001 in 2014. The study was designed in accordance with the FDA's published guidance on clinical evaluation of QT/QTc interval, and compared the effects of EVK-001 on the QT/QTc interval when administered at therapeutic and supratherapeutic doses in 48 healthy female and male volunteers. Moxifloxacin, an antibiotic known to prolong the QT/QTc interval, was used as the positive control. In December 2014 we reported that data from the study met the pre-specified primary endpoint, demonstrating that EVK-001, at therapeutic and supratherapeutic doses, did not prolong the QT/QTc interval in healthy subjects. The study was conducted to satisfy a safety requirement by the FDA in support of our submission of an NDA for EVK 001.

Prior Development

From 1985 to present, we, or our predecessors, have conducted 25 clinical studies to evaluate the safety and pharmacokinetic profile of nasal spray formulations of metoclopramide in healthy volunteers and the safety, efficacy, pharmacokinetic and pharmacodynamic profile of metoclopramide nasal spray in subjects. More than 1,100 subjects have been dosed in these studies with nasal formulations of metoclopramide at doses ranging from 10 mg to 80 mg.

In one study, a Phase 2A, multicenter, randomized, open-label, parallel design study, Questcor Pharmaceuticals, Inc., or Questcor (now part of Mallinckrodt plc), compared the efficacy and safety of two doses of metoclopramide nasal spray, 10 mg and 20 mg, with the FDA-approved 10 mg metoclopramide tablet. For the primary efficacy endpoint in the per protocol population analysis, a statistically significant difference in the total symptom score between baseline and week 6 for both the nasal 10 mg ($p = 0.026$) and nasal 20 mg ($p = 0.008$) cohorts compared to the oral 10 mg group was observed. Metoclopramide nasal spray was initially developed by Nastech Pharmaceutical Company, Inc. in precursor formulations to EVK-001 and subsequently acquired and developed by Questcor.

We acquired rights to this product candidate from Questcor in 2007. We then optimized the acquired formulation of metoclopramide nasal spray to improve stability and remove inactive ingredients to improve the palatability and tolerability of EVK-001 for subjects. We also developed the current formulation with excipients that are at or below the levels listed in the FDA's Inactive Ingredient Database for nasal products. We evaluated the current formulation of EVK-001 in 378 subjects in our completed clinical trials (Phase 1 (39), Phase 2 (190), and QT/QTc (54)) and are evaluating the same formulation in our ongoing Phase 3 clinical trial. Similarly, the nasal spray pump used in our completed clinical trials was identical and is also being used in our ongoing Phase 3 clinical trial.

The primary container closure system for EVK-001 is comprised of an amber glass vial directly attached to a pre-assembled spray pump unit with a protection cap. Each multi dose sprayer system comes preassembled and capable of delivering a 30 day supply (120 doses at 4 doses per day.) The sprayer is a standardized metered sprayer technology utilized in other nasal spray products as well as the amber vial.

Our Ongoing Four-Week Phase 3 Clinical Trial in Female Subjects with Diabetic Gastroparesis

Based on discussions with the FDA, we are conducting one Phase 3 trial in women, which we believe, if successful, will be sufficient for NDA submission. In April 2014, we began enrolling the four-week, multicenter, randomized, double-blind, placebo-controlled, parallel Phase 3 clinical trial to evaluate the efficacy, safety and population pharmacokinetics of EVK-001 in adult female subjects with diabetic gastroparesis. We plan to enroll approximately 200 subjects at sites across the United States. The trial population will consist of female diabetic subjects with gastroparesis, identified by the presence of relevant symptoms and delayed gastric emptying. Female subjects with diabetic gastroparesis meeting the protocol-specified entry criteria are being studied in a parallel-group design with randomization in a 1:1 ratio to EVK-001 10 mg or placebo administered as a single nasal spray four times daily, 30 minutes before meals and at bedtime.

As of February 29, 2016, we had randomized 186 subjects in the Phase 3 clinical trial in women. Overall enrollment of the trial has been slower than previously anticipated. Although the trial sites have been screening significant numbers of potential subjects, patients with diabetic gastroparesis typically have symptoms that vary in timing and severity, their gastric emptying delays are unpredictable, and their medical histories and ongoing medical problems are complex. We are also facing competition for subjects from other ongoing competing clinical trials that were not active when we started our Phase 3 trial. This combination of factors creates a challenge for enrollment into diabetic gastroparesis trials. We anticipate fully enrolling this clinical trial during the second quarter of 2016. We will need to successfully complete this trial before we are able to submit an NDA to the FDA for EVK-001. FDA approval of the NDA is required in order for us to commercially market EVK-001 in the United States.

Based on our discussions with the FDA, we plan to use specific symptoms from a composite score, the Gastroparesis Symptom Assessment, or GSA, as a patient-reported outcome, or PRO, instrument to assess efficacy in this patient population. The primary efficacy endpoint for this Phase 3 clinical trial will be based upon a change from baseline in total composite score of the specific symptoms included in the GSA.

Also based on discussions with FDA, and to assess safety in men, we are conducting a similar and concurrent companion study for safety and efficacy in diabetic men with gastroparesis. The trial design includes an early stop for futility. The FDA has indicated that completion of the male companion study is not required for submission of the NDA seeking approval of EVK-001 for use in women. Whether the male study stops early for futility or continues to enroll, we plan to include safety data from the male companion study in the NDA seeking approval for the drug for use in women.

Intellectual Property and Proprietary Rights

Overview

We are building an intellectual property portfolio for EVK-001 in the United States and abroad. We seek patent protection in the United States and internationally for our product candidate, its methods of use and processes for its manufacture, and for other technologies, where appropriate. Our policy is to actively seek to protect our proprietary position by, among other things, filing patent applications in the United States and abroad relating to proprietary technologies that are important to the development of our business. We also rely on trade secrets, know-how, continuing technological innovation and in-licensing opportunities to develop and maintain our proprietary position. We cannot be sure that patents will be granted with respect to any of our pending patent applications or with respect to any patent applications filed by us in the future, nor can we be sure that any of our existing patents or any patents that may be granted to us in the future will be commercially useful in protecting our technology.

Our success will depend significantly on our ability to obtain and maintain patent and other proprietary protection for the technologies we consider important to our business, defend our patents, preserve the confidentiality of our trade secrets and operate our business without infringing the patents and proprietary rights of third parties.

Patent Portfolio

Our patent portfolio currently includes the following patents and applications:

- U.S. Patent 6,770,262—Nasal Administration of Agents for the Treatment of Gastroparesis. This patent expires in 2021.
- U.S. Patent 8,334,281—Nasal Formulations of Metoclopramide. This patent expires in 2030.
- Non-Provisional Patent Application No. PCT/US2012/052096—Treatment of Symptoms Associated with Female Gastroparesis. If granted, this patent would expire in 2032.

We have also been granted patents in the European Union for the method of use of metoclopramide via nasal delivery for gastroparesis. These patents provide protection through 2021. We have also received patents in the European Union covering the nasal use of metoclopramide for delayed onset emesis. These patents offer protection through 2017.

The United States patent system permits the filing of provisional and non-provisional patent applications. A non-provisional patent application is examined by the U.S. Patent and Trademark Office, or USPTO, and can mature into a patent once the USPTO determines that the claimed invention meets the standards for patentability. A provisional patent application is not examined for patentability, and automatically expires 12 months after its filing date. As a result, a provisional patent application cannot mature into a patent. The requirements for filing a provisional patent application are not as strict as those for filing a non-provisional patent application. Provisional applications are often used, among other things, to establish an earlier filing date for a subsequent non-provisional patent application. The term of individual patents depends upon the legal term of the patents in the countries in which they are obtained. In most countries in which we file, the patent term is 20 years from the earliest date of filing a non-provisional patent application. In the United States, a patent's term may be lengthened by patent term adjustment, or PTA, which compensates a patentee for administrative delays by the USPTO in granting a patent. In view of a recent court decision, the USPTO is under greater scrutiny regarding its calculations where the USPTO erred in calculating the patent term adjustment for the patents in question denying the patentee a portion of the patent term to which it was entitled. Alternatively, a patent's term may be shortened if a patent is terminally disclaimed over another patent.

The effective filing date of a non-provisional patent application is used by the USPTO to determine what information is prior art when it considers the patentability of a claimed invention. If certain requirements are satisfied, a non-provisional patent application can claim the benefit of the filing date of an earlier filed provisional patent application. As a result, the filing date accorded by the provisional patent application may supersede information that otherwise could preclude the patentability of an invention.

Other Intellectual Property Rights

We currently have a registered trademark for EVOKE PHARMA in the United States.

Confidential Information and Inventions Assignment Agreements

We require our employees and consultants to execute confidentiality agreements upon the commencement of employment, consulting or collaborative relationships with us. These agreements provide that all confidential information developed or made known during the course of the relationship with us be kept confidential and not disclosed to third parties except in specific circumstances.

In the case of employees, the agreements provide that all inventions resulting from work performed for us, utilizing our property or relating to our business and conceived or completed by the individual during employment shall be our exclusive property to the extent permitted by applicable law. Our consulting agreements also provide for assignment to us of any intellectual property resulting from services performed for us.

Sales and Marketing

We plan to commercialize EVK-001 in the United States alone, or in partnership with pharmaceutical companies that have established development and sales and marketing capabilities. Our strategy for EVK-001, if approved, will be to establish EVK-001 as the prescription product of choice for diabetic gastroparesis in women. If the product candidate is approved, our expectation is that EVK-001 would initially be sold to gastrointestinal and internal medicine specialists, primary care physicians and select health care providers. We may also utilize contract sales forces to assist in the marketing of EVK-001 to approved patient populations.

Manufacturing

We do not own or operate manufacturing facilities for the production of EVK-001, nor do we have plans to develop our own manufacturing operations in the foreseeable future. We currently depend on third-party contract manufacturers for all of our required raw materials, drug substance and finished product for our clinical trials.

In April 2015, we announced the completion of production of a commercial scale lot of EVK-001 as required by the FDA. With the completion of this large scale production of EVK-001, we believe we have demonstrated our ability to manufacture EVK-001 at commercial scale quantities in accordance with CMC. In addition to data from this recent program, we have a three-year registration stability data package from previous studies which have all met proposed specifications. These CMC datasets will be submitted as part of our NDA submission following completion of our ongoing Phase 3 clinical trial and male companion trial.

We do not have any current contractual relationships for the manufacture of commercial supplies of EVK-001. We intend to enter into agreements with third-party contract manufacturers for the commercial production of EVK-001 prior to regulatory approval. We currently utilize a third-party consultant, which we engage on an as-needed, hourly basis, to manage our manufacturing contractors.

Competition

The pharmaceutical industry is characterized by intense competition and rapid innovation. Our potential competitors include large pharmaceutical and biotechnology companies, specialty pharmaceutical and generic drug companies, academic institutions, government agencies and research institutions. We believe the key competitive factors that will affect the development and commercial success of our product candidates are efficacy, safety and tolerability profile, reliability, convenience of dosing, coverage pricing and reimbursement.

Many of our potential competitors have substantially greater financial, technical and human resources than we do and significantly greater experience in the discovery and development of product candidates, obtaining FDA and other regulatory approvals of products and the commercialization of those products. Accordingly, our competitors may be more successful than we may be in obtaining FDA approval for drugs and achieving widespread market acceptance. Our competitors' drugs may be more effective, or more effectively marketed and sold, than any drug we may commercialize and may render our product candidates obsolete or non-competitive before we can recover the expenses of developing and commercializing any of our product candidates. We anticipate that we will face intense and increasing competition as new drugs enter the market and advanced technologies become available. Finally, the development of new treatment methods for the diseases we are targeting could render our drugs non-competitive or obsolete.

We expect that, if approved, EVK-001 will compete directly with metoclopramide oral, erythromycin and domperidone as a treatment for gastroparesis. Metoclopramide is the only product currently approved in the United States to treat gastroparesis. Metoclopramide is available from a number of generic pharmaceutical manufacturers as well in branded form in the United States under the tradename Reglan® Tablets from Ani Pharmaceuticals.

Previously, Propulsid® (cisapride) and Zelnorm® (tegaserod) were prescribed off-label by physicians to treat gastroparesis. Propulsid® (cisapride) was approved for use in the treatment of dyspepsia and GERD. Zelnorm® (tegaserod) was approved for use in IBS and idiopathic chronic constipation. Both of these products have been withdrawn from the market because of cardiac safety issues.

Salix Pharmaceuticals launched an orally dissolving tablet formulation of metoclopramide in 2009. Other programs in the gastroparesis pipeline include new chemical entities in earlier-stage clinical trials. In addition to our EVK-001 product candidate, we are aware of the following development candidates; all of which are in Phase 2 clinical development.

Gastroparesis Treatment Development Pipeline

Product	Class	Route	Company	Status
EVK-001	dopamine antagonist /mixed	nasal	Evoke Pharma	Phase 3
RM-131	5-HT3 antagonist 5-HT4 agonist ghrelin agonist	sub-cutaneous	Rhythm/Allergan	Phase 2b
GSK962040	motilin agonist	oral	GlaxoSmithKline	Phase 2
TD-5108	5-HT4 receptor agonist	oral	Theravance	Phase 2
IW-9179	GC-C agonist	oral	Ironwood	Phase 2a

RM-131 is a small-peptide analog of ghrelin, a hormone produced in the stomach that stimulates gastrointestinal activity. The compound is being developed for GI motility disorders and has shown efficacy in surgical and opiate-induced ileus in animal models due to a direct prokinetic effect. RM-131 reverses body weight loss in cachexia models.

Two other ghrelin analogs were previously being developed by Tranzyme Pharma: an intravenous ghrelin agonist, ulimorelin, in post-operative ileus and a different oral ghrelin agent, TZP-102, in diabetic gastroparesis. Development of both product candidates has been discontinued after ulimorelin was unsuccessful in two Phase 3 studies and TZP-102 was unsuccessful in two Phase 2b trials.

GSK962040 is a selective non-peptide motilin receptor agonist under development for the treatment of conditions associated with slow rates of gastric emptying. Motilin is an endogenous peptide, produced mainly in the duodenum, whose physiological action is mediated by motilin receptors located on enteric neurons, peripheral terminals of the vagus, and on the smooth muscle of the stomach. Motilin and non-peptide agonists of motilin receptors increase gastric emptying and may offer a new approach to the treatment of delayed gastric emptying conditions.

TD-5108, also called Velusetrag, is a 5-HT4 receptor agonist compound under development for the treatment of gastroparesis by Theravance in collaboration with Alfa Wassermann S.p.A. Previously, TD-5108 was under development for chronic constipation.

IW-9179 is an investigational guanylate cyclase-C, or GC-C, agonist and is under development for the treatment of functional dyspepsia and diabetic gastroparesis by Ironwood Pharmaceuticals.

Erythromycin is a motilin receptor agonist and is frequently used off-label in the treatment of gastroparesis. Erythromycin is well known to induce nausea and vomiting across all indications and is particularly associated with exacerbated nausea when used in gastroparesis. Repeated administration of macrolides is also linked to desensitization of the motilin receptor and tachyphylaxis. Extended dosing with antibiotics can lead to the development of resistant organisms as well as pathologic changes in intestinal flora.

Tegaserod, another 5-HT4 agonist, was approved in the United States and other countries for treatment of chronic idiopathic constipation and IBS-C. In 2007, Tegaserod was removed from the market in the United States by the FDA for cardiac safety concerns.

One additional medication, Motilium (domperidone), a dopamine receptor modulator, is not FDA-approved, but is available in the United States through various compounding pharmacies under a specific FDA restricted-access program. The safety and efficacy of Motilium as a promotility agent is not fully established.

Technology Acquisition Agreement

In June 2007, we acquired all worldwide rights, data, patents and other related assets associated with EVK-001 from Questcor pursuant to an asset purchase agreement. We paid Questcor $650,000 in the form of an upfront payment and $500,000 in May 2014 as a milestone payment based upon the initiation of the first patient dosing in our Phase 3 clinical trial for EVK-001. In August 2014, Mallinckrodt plc, or Mallinckrodt, acquired Questcor. As a result of that acquisition, Questcor transferred its rights included in the asset purchase agreement with us to Mallinckrodt. In addition to the payments we made to Questcor, we may also be required to make additional milestone payments to Mallinckrodt totaling up to $51.5 million. These milestones include up to $4.5 million in payments if EVK-001 achieves the following development targets:

- $1.5 million upon the FDA's acceptance for review of an NDA for EVK-001; and
- $3 million upon the FDA's approval of EVK-001.

The remaining $47 million in milestone payments depend on EVK-001's commercial success and will only apply if EVK-001 receives regulatory approval. In addition, we will be required to pay to Mallinckrodt a low single digit royalty on net sales of EVK-001. Our obligation to pay such royalties will terminate upon the expiration of the last patent right covering EVK-001, which is expected to occur in 2030.

Government Regulation

FDA Approval Process

In the United States, pharmaceutical products are subject to extensive regulation by the FDA. The Federal Food, Drug, and Cosmetic Act, or FFDCA, and other federal and state statutes and regulations, govern, among other things, the research, development, testing, manufacture, storage, recordkeeping, approval, labeling, promotion and marketing, distribution, post-approval monitoring and reporting, sampling, and import and export of pharmaceutical products. Failure to comply with applicable FDA or other requirements may subject a company to a variety of administrative or judicial sanctions, such as the FDA's refusal to approve pending applications, a clinical hold, warning letters, recall or seizure of products, partial or total suspension of production, withdrawal of the product from the market, injunctions, fines, civil penalties or criminal prosecution.

FDA approval is required before any new unapproved drug or dosage form, including a new use of a previously approved drug, can be marketed in the United States. The process required by the FDA before a drug may be marketed in the United States generally involves:

- completion of pre-clinical laboratory and animal testing and formulation studies in compliance with the FDA's good laboratory practice regulations;

submission to the FDA of an Investigational New Drug Application, or IND, for human clinical testing which must become effective before human clinical trials may begin in the United States;

approval by an independent institutional review board, or IRB, at each clinical trial site before each trial may be initiated;

performance of adequate and well-controlled human clinical trials in accordance with good clinical practice, or GCP, regulations to establish the safety and efficacy of the proposed drug product for each intended use;

satisfactory completion of an FDA pre-approval inspection of the facility or facilities at which the product is manufactured to assess compliance with the FDA's current good manufacturing practices, or cGMP, regulations, including, for devices and device components, the Quality System Regulation, or QSR, and to assure that the facilities, methods and controls are adequate to preserve the product's identity, strength, quality and purity;

submission to the FDA of an NDA;

satisfactory completion of an FDA advisory committee review, if applicable; and
FDA review and approval of the NDA.

The pre-clinical and clinical testing and approval process requires substantial time, effort and financial resources, and we cannot be certain that any approvals for our product candidates will be granted on a timely basis, if at all. Pre-clinical tests include laboratory evaluation of product chemistry, formulation, stability and toxicity, as well as animal studies to assess the characteristics and potential safety and efficacy of the product. The results of pre-clinical tests, together with manufacturing information, analytical data and a proposed clinical trial protocol and other information, are submitted as part of an IND to the FDA. Some pre-clinical testing may continue even after the IND is submitted. The IND automatically becomes effective 30 days after receipt by the FDA, unless the FDA, within the 30-day time period, raises concerns or questions relating to one or more proposed clinical trials and places the clinical trial on a clinical hold, including concerns that human research subjects will be exposed to unreasonable health risks. In such a case, the IND sponsor and the FDA must resolve any outstanding concerns before the clinical trial can begin. As a result, our submission of an IND may not result in FDA authorization to commence a clinical trial. A separate submission to an existing IND must also be made for each successive clinical trial conducted during product development.

Further, an IRB covering each site proposing to conduct the clinical trial must review and approve the plan for any clinical trial and informed consent information for subjects before the trial commences at that site, and it must monitor the study until completed. The FDA, the IRB or the sponsor may suspend a clinical trial at any time on various grounds, including a finding that the subjects or patients are being exposed to an unacceptable health risk or for failure to comply with the IRB's or regulatory requirements, or for other reasons, or the FDA or IRB may impose other conditions.

Clinical trials involve the administration of the investigational new drug to human subjects under the supervision of qualified investigators in accordance with GCP requirements, which include the requirement that all research subjects provide their informed consent in writing for their participation in any clinical trial. Sponsors of clinical trials generally must register and report, at the National Institutes of Health-maintained website ClinicalTrials.gov, key parameters of certain clinical trials. For purposes of an NDA submission and approval, human clinical trials are typically conducted in the following sequential phases, which may overlap or be combined:

Phase 1: The drug is initially introduced into healthy human subjects or patients and tested for safety, dose tolerance, absorption, metabolism, distribution and excretion and, if possible, to gain an early indication of its effectiveness.
Phase 2: The drug is administered to a limited patient population to identify possible adverse effects and safety risks, to preliminarily evaluate the efficacy of the product for specific targeted indications and to determine dose tolerance and optimal dosage. Multiple Phase 2 clinical trials may be conducted by the sponsor to obtain information prior to beginning larger and more extensive Phase 3 clinical trials.
Phase 3: These are commonly referred to as pivotal studies. When Phase 2 evaluations demonstrate that a dose range of the product appears to be effective and has an acceptable safety profile, Phase 3 trials are undertaken in large patient populations to further evaluate dosage, to obtain additional evidence of clinical efficacy and safety in an expanded patient population at multiple, geographically-dispersed clinical trial sites, to establish the overall risk-benefit relationship of the drug and to provide adequate information for the labeling of the drug.
Phase 4: In some cases, the FDA may condition approval of an NDA for a product candidate on the sponsor's agreement to conduct additional clinical trials to further assess the drug's safety and effectiveness after NDA approval. Such post-approval trials are typically referred to as Phase 4 studies.

The results of product development, pre-clinical studies and clinical trials are submitted to the FDA as part of an NDA. NDAs must also contain extensive information relating to the product's pharmacology, chemistry, manufacturing and controls, or CMC, and proposed labeling, among other things.

Under federal law, the submission of most NDAs is subject to a substantial application user fee, and the manufacturer and/or sponsor under an approved NDA are also subject to annual product and establishment user fees. The FDA has 60 days from its receipt of an NDA to determine whether the application will be accepted for filing based on the

agency’s threshold determination that it is sufficiently complete to permit substantive review. The FDA may request additional information rather than accept an NDA for filing. In this event, the NDA must be resubmitted with the additional information and is subject to payment of additional user fees. The resubmitted application is also subject to review before the FDA accepts it for filing.

Once the submission has been accepted for filing, the FDA begins an in-depth substantive review. Under the Prescription Drug User Fee Act, or PDUFA, the FDA agrees to specific performance goals for NDA review time through a two-tiered classification system, Standard Review and Priority Review. Standard Review NDAs have a goal of being completed within ten months of the date of receipt by FDA (for drugs that do not contain new molecular entities) and ten months of the 60-day filing date (for drugs that contain new molecular entities). A Priority Review designation is given to drugs that treat a serious condition and, if approved, would provide a significant

improvement in safety or effectiveness. The goal for completing a Priority Review is six months from the date of receipt by FDA (for drugs that do not contain new molecular entities) and six months of the 60-day filing date (for drugs that contain new molecular entities). However, the FDA does not always complete its review within these timelines and the Agency's review can take substantially longer.

It is likely that our product candidate will be granted a Standard Review for a product that does not contain a new chemical entity. The review process may be extended to allow the FDA to request and review additional information or obtain clarification regarding information provided in the original submission. The FDA may refer applications for novel drug products or drug products which present difficult questions of safety or efficacy to an advisory committee for review, evaluation and recommendation as to whether the application should be approved and under what conditions. The FDA is not bound by the recommendation of an advisory committee, but it considers such recommendations carefully when making decisions.

Before approving an NDA, the FDA may inspect the facility or facilities where the product is manufactured. The FDA will not approve an application unless it determines that the manufacturing processes and facilities are in compliance with cGMP requirements, including QSR requirements for the device component of the product, and are adequate to assure consistent production of the product within required specifications. Additionally, the FDA will typically inspect one or more clinical sites to assure compliance with GCP requirements before approving an NDA.

After the FDA evaluates the NDA and, in some cases, the related manufacturing facilities, it may issue an approval letter or a Complete Response Letter, or CRL, to indicate that the review cycle for an application is complete or that the application is not ready for approval. CRLs generally outline the deficiencies in the submission and may require substantial additional testing or information in order for the FDA to reconsider the application. Even with submission of this additional information, the FDA ultimately may decide that the application does not satisfy the regulatory criteria for approval. If and when the deficiencies have been addressed to the FDA's satisfaction, the FDA will typically issue an approval letter. An approval letter authorizes commercial marketing of the drug with specific prescribing information for specific indications.

Once issued, the FDA may withdraw product approval if ongoing regulatory requirements are not met or if safety problems are identified after the product reaches the market. In addition, the FDA may require post-approval testing, including Phase 4 studies, and surveillance programs to monitor the effect of approved products which have been commercialized, and the FDA has the power to prevent or limit further marketing of a product based on the results of these post-marketing programs. Drugs may be marketed only for the approved indications and in accordance with the provisions of the approved label, and, even if the FDA approves a product, it may limit the approved indications for use for the product or impose other conditions, including labeling or distribution restrictions or other risk-management mechanisms. Further, if there are any modifications to the drug, including changes in indications, labeling, or manufacturing processes or facilities, we may be required to submit and obtain FDA approval of a new or supplemental NDA, which may require us to develop additional data or conduct additional pre-clinical studies and clinical trials.

Post-Approval Requirements

Once an NDA is approved, a product will be subject to pervasive and continuing regulation by the FDA, including, among other things, requirements relating to drug/device listing, recordkeeping, periodic reporting, product sampling and distribution, advertising and promotion and reporting of adverse experiences with the product.

In addition, drug manufacturers and other entities involved in the manufacture and distribution of approved products are required to register their establishments with the FDA and state agencies, and are subject to periodic unannounced inspections by the FDA and these state agencies for compliance with cGMP requirements. Changes to the manufacturing process are strictly regulated and generally require prior FDA approval before being implemented. FDA regulations also require investigation and correction of any deviations from cGMP and impose reporting and

documentation requirements upon us and any third-party manufacturers that we may decide to use. Accordingly, manufacturers must continue to expend time, money, and effort in the area of production and quality control to maintain cGMP compliance.

Once an approval is granted, the FDA may suspend, restrict or withdraw the approval, require a product recall, or impose additional restrictions or limitations if compliance with regulatory requirements and standards is not maintained or if problems occur after the product reaches the market. Later discovery of previously unknown problems with a product, including adverse events of unanticipated severity or frequency, or with manufacturing processes, or failure to comply with regulatory requirements, may result in, among other things:

- restrictions on the marketing or manufacturing of the product, complete withdrawal of the product from the market or product recalls;
- fines, warning letters or holds on post-approval clinical trials;
- refusal of the FDA to approve pending applications or supplements to approved applications, or suspension or revocation of product license approvals;

product seizure or detention, or refusal to permit the import or export of products; or

injunctions or the imposition of civil or criminal penalties.

The FDA may require post-approval studies and clinical trials if the FDA finds that scientific data, including information regarding related drugs, deem it appropriate. The purpose of such studies would be to assess a known serious risk or signals of serious risk related to the drug or to identify an unexpected serious risk when available data indicate the potential for a serious risk. The FDA may also require a labeling change if it becomes aware of new safety information that it believes should be included in the labeling of a drug.

The Food and Drug Administration Amendments Act of 2007 gave the FDA the authority to require a Risk Evaluation and Mitigation Strategy, or REMS, from manufacturers to ensure that the benefits of a drug outweigh its risks. In determining whether a REMS is necessary, the FDA must consider the size of the population likely to use the drug, the seriousness of the disease or condition to be treated, the expected benefit of the drug, the duration of treatment, the seriousness of known or potential adverse events, and whether the drug is a new molecular entity. If the FDA determines a REMS is necessary, the drug sponsor must agree to the REMS plan at the time of approval. A REMS may be required to include various elements, such as a medication guide or patient package insert, a communication plan to educate health care providers of the drug's risks, limitations on who may prescribe or dispense the drug, or other measures that the FDA deems necessary to assure the safe use of the drug. In addition, the REMS must include a timetable to assess the strategy at 18 months, three years, and seven years after the strategy's approval. The FDA may also impose a REMS requirement on a drug already on the market if the FDA determines, based on new safety information, that a REMS is necessary to ensure that the drug's benefits continue to outweigh its risks.

In March 2009, the FDA informed drug manufacturers that it will require a REMS for metoclopramide drug products. The FDA's authority to take this action is based on risk management and post market safety provisions within the Food and Drug Administration Amendments Act. The REMS consists of a Medication Guide, elements to assure safe use (including an education program for prescribers and materials for prescribers to educate patients), and a timetable for submission of assessments of at least six months, 12 months, and annually after the REMS is approved. In 2011, the FDA determined that maintaining the Medication Guide as a part of the approved labeling is adequate to address the public health concern and meets the regulatory standards. As a result, the FDA determined that a REMS for metoclopramide is no longer required. We intend to follow current labeling procedures to include a medication guide at the time of the NDA submission for EVK-001.

The FDA strictly regulates marketing, labeling, advertising and promotion of products that are placed on the market, and the FDA imposes a number of complex regulations on entities that advertise and promote pharmaceuticals, which include, among others, standards for direct-to-consumer advertising, off-label promotion, industry-sponsored scientific and educational activities, and promotional activities involving the internet. While physicians may prescribe for off-label uses, manufacturers may only promote for the approved indications and in accordance with the provisions of the approved label. The FDA and other agencies actively enforce the laws and regulations prohibiting the promotion of off-label uses, and a company that is found to have improperly promoted off-label uses may be subject to significant liability. Indeed, the FDA has very broad enforcement authority under the FFDCA, and failure to abide by these regulations can result in penalties, including the issuance of a warning letter directing entities to correct deviations from FDA standards, a requirement that future advertising and promotional materials are pre-cleared by the FDA, and state and federal civil and criminal investigations and prosecutions.

The distribution of prescription pharmaceutical products is also subject to the Prescription Drug Marketing Act, or PDMA, which regulates the distribution of drugs and drug samples at the federal level and sets minimum standards for the registration and regulation of drug distributors by the states. Both the PDMA and state laws limit the distribution of prescription pharmaceutical product samples and impose requirements to ensure accountability in distribution, including a drug pedigree which tracks the distribution of prescription drugs.

Section 505(b)(2) New Drug Applications

As an alternate path to FDA approval for modifications to formulations or uses of products previously approved by the FDA, an applicant may submit an NDA under Section 505(b)(2) of the FFDCA. Section 505(b)(2) was enacted as part of the Drug Price Competition and Patent Term Restoration Act of 1984, also known as the Hatch-Waxman Amendments, and permits the filing of an NDA where at least some of the information required for approval comes from studies not conducted by or for the applicant and for which the applicant has not obtained a right of reference. The applicant may rely upon published literature and the FDA's findings of safety and effectiveness based on certain pre-clinical or clinical studies conducted for an approved product. The FDA may also require companies to perform additional studies or measurements to support the change from the approved product. The FDA may then approve the new product candidate for all or some of the label indications for which the referenced product has been approved, as well as for any new indication sought by the Section 505(b)(2) applicant.

To the extent that a Section 505(b)(2) NDA relies on studies conducted for a previously approved drug product, the applicant is required to certify to the FDA concerning any patents listed for the approved product in the FDA Orange Book. The FDA Orange Book is where patents associated with a FDA-approved product are listed. Specifically, the applicant must certify for each listed patent that (1) the required patent information has not been filed; (2) the listed patent has expired; (3) the listed patent has not expired, but will expire on a particular date and approval is sought after patent expiration; or (4) the listed patent is invalid, unenforceable or will not be infringed by the new product. A certification that the new product will not infringe the already approved product's listed patent or that such patent is invalid is known as a Paragraph IV certification. If the applicant does not challenge the listed patents through a Paragraph IV certification, the Section 505(b)(2) NDA application will not be approved until all the listed patents claiming the referenced product have expired. The Section 505(b)(2) NDA application also will not be accepted or approved until any non-patent exclusivity, such as exclusivity for obtaining approval of a New Chemical Entity, listed in the Orange Book for the referenced product has expired.

If the 505(b)(2) NDA applicant has provided a Paragraph IV certification to the FDA, the applicant must also send notice of the Paragraph IV certification to the referenced NDA and patent holders once the 505(b)(2) NDA has been accepted for filing by the FDA. The NDA and patent holders may then initiate a legal challenge to the Paragraph IV certification. Under the FFDCA, the filing of a patent infringement lawsuit within 45 days of the NDA and patent holders' receipt of a Paragraph IV certification in most cases automatically prevents the FDA from approving the Section 505(b)(2) NDA for 30 months, or until a court decision or settlement finding that the patent is invalid, unenforceable or not infringed, whichever is earlier. The court also has the ability to shorten or lengthen the 30-month stay if either party is found not to be reasonably cooperating in expediting the litigation. Thus, the Section 505(b)(2) applicant may invest a significant amount of time and expense in the development of its product only to be subject to significant delay and patent litigation before its product may be commercialized.

The 505(b)(2) NDA applicant also may be eligible for its own regulatory exclusivity period, such as three-year exclusivity. Specifically, a product may be granted three-year Hatch-Waxman exclusivity if one or more clinical studies, other than bioavailability or bioequivalence studies, was essential to the approval of the application and was conducted/sponsored by the applicant. Should this occur, the FDA would be precluded from making effective any other application for the same condition of use or for a change to the drug product that was granted exclusivity until after that three-year exclusivity period has expired. Additional exclusivities may also apply.

Additionally, the 505(b)(2) NDA applicant may have relevant patents in the Orange Book, and if so, it can initiate patent infringement litigation against those applicants that challenge such patents, which could result in a 30-month stay delaying those applicants.

Manufacturing Requirements

We and our third-party manufacturers must comply with applicable FDA regulations relating to the FDA's cGMP regulations including applicable QSR requirements. The cGMP regulations include requirements relating to, among other things, organization of personnel, buildings and facilities, equipment, control of components and drug product containers and closures, production and process controls, packaging and labeling controls, holding and distribution, laboratory controls, records and reports, and returned or salvaged products. The manufacturing facilities for our products must meet cGMP requirements to the satisfaction of the FDA pursuant to a pre-approval inspection before we can use them to manufacture our products. We and our third-party manufacturers are also subject to periodic unannounced inspections of facilities by the FDA and other authorities, including procedures and operations used in the testing and manufacture of our products to assess our compliance with applicable regulations. Failure to comply with statutory and regulatory requirements subjects a manufacturer to possible legal or regulatory action, including, among other things, warning letters, the seizure or recall of products, injunctions, consent decrees placing significant restrictions on or suspending manufacturing operations and civil and criminal penalties.

Other Regulatory Requirements

We are also subject to various laws and regulations regarding laboratory practices, the experimental use of animals, and the use and disposal of hazardous or potentially hazardous substances in connection with our research. In each of these areas, as above, the FDA has broad regulatory and enforcement powers, including, among other things, the ability to levy fines and civil penalties, suspend or delay issuance of approvals, seize or recall products, and withdraw approvals, any one or more of which could have a material adverse effect on us.

Coverage and Reimbursement

Sales of our products, if approved, will depend, in part, on the extent to which our products will be covered by third-party payors, such as government health care programs, commercial insurance and managed healthcare organizations. These third-party payors are increasingly limiting coverage and reducing reimbursements for medical products and services. In addition, the U.S. government, state legislatures and foreign governments have continued implementing cost-containment programs, including price controls, restrictions on coverage and reimbursement and requirements for substitution of generic products. Adoption of price controls and cost-

containment measures, and adoption of more restrictive policies in jurisdictions with existing controls and measures, could further limit our net revenue and results. Decreases in third-party reimbursement for our drug candidates or a decision by a third-party payor to not cover our drug candidates could reduce physician utilization of our products and have a material adverse effect on our sales, results of operations and financial condition.

Other Healthcare Laws

Although we currently do not have any products on the market, if our drug candidates are approved and we begin commercialization, we will be subject to healthcare regulation and enforcement by the federal government and the states and foreign governments in which we conduct our business. These laws include, without limitation, state and federal anti-kickback, fraud and abuse, false claims and physician sunshine laws and regulations.

The federal Anti-Kickback Statute prohibits, among other things, any person from knowingly and willfully offering, soliciting, receiving or providing remuneration, directly or indirectly, to induce either the referral of an individual, for an item or service or the purchasing or ordering of a good or service, for which payment may be made under federal healthcare programs such as the Medicare and Medicaid programs. The Anti-Kickback Statute is subject to evolving interpretations. In the past, the government has enforced the Anti-Kickback Statute to reach large settlements with healthcare companies based on sham consulting and other financial arrangements with physicians. Further, a person or entity does not need to have actual knowledge of the statute or specific intent to violate it in order to have committed a violation. In addition, the government may assert that a claim including items or services resulting from a violation of the federal Anti-Kickback Statute constitutes a false or fraudulent claim for purposes of the federal False Claims Act. The majority of states also have anti-kickback laws which establish similar prohibitions and in some cases may apply to items or services reimbursed by any third-party payor, including commercial insurers.

Additionally, the False Claims Act prohibits knowingly presenting or causing the presentation of a false, fictitious or fraudulent claim for payment to the U.S. government. Actions under the False Claims Act may be brought by the Attorney General or as a qui tam action by a private individual in the name of the government. Violations of the False Claims Act can result in very significant monetary penalties and treble damages. The federal government is using the False Claims Act, and the accompanying threat of significant liability, in its investigation and prosecution of pharmaceutical and biotechnology companies throughout the country, for example, in connection with the promotion of products for unapproved uses and other sales and marketing practices. The government has obtained multi-million and multi-billion dollar settlements under the False Claims Act in addition to individual criminal convictions under applicable criminal statutes. Given the significant size of actual and potential settlements, it is expected that the government will continue to devote substantial resources to investigating healthcare providers' and manufacturers' compliance with applicable fraud and abuse laws.

The federal Health Insurance Portability and Accountability Act of 1996, or HIPAA, also created new federal criminal statutes that prohibit among other actions, knowingly and willfully executing, or attempting to execute, a scheme to defraud any healthcare benefit program, including private third-party payors, knowingly and willfully embezzling or stealing from a healthcare benefit program, willfully obstructing a criminal investigation of a healthcare offense, and knowingly and willfully falsifying, concealing or covering up a material fact or making any materially false, fictitious or fraudulent statement in connection with the delivery of or payment for healthcare benefits, items or services. Similar to the federal Anti-Kickback Statute, a person or entity does not need to have actual knowledge of the statute or specific intent to violate it in order to have committed a violation.

In addition, there has been a recent trend of increased federal and state regulation of payments made to physicians and other healthcare providers. The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act, or collectively, the Affordable Care Act, among other things, imposes new reporting requirements on certain drug manufacturers for payments made by them to physicians and teaching hospitals, as well as ownership and investment interests held by physicians and their immediate family members. Failure to submit required information may result in civil monetary penalties of up to an aggregate of $150,000 per year (or up to an

aggregate of $1 million per year for “knowing failures”), for all payments, transfers of value or ownership or investment interests that are not timely, accurately and completely reported in an annual submission. Drug manufacturers are required to submit reports to the government by the 90th day of each calendar year. Certain states also mandate implementation of commercial compliance programs, impose restrictions on drug manufacturer marketing practices and/or require the tracking and reporting of gifts, compensation and other remuneration to physicians.

The shifting commercial compliance environment and the need to build and maintain robust and expandable systems to comply with different compliance and/or reporting requirements in multiple jurisdictions increase the possibility that a healthcare company may violate one or more of the requirements. If our operations are found to be in violation of any of such laws or any other governmental regulations that apply to us, we may be subject to penalties, including, without limitation, civil and criminal penalties, damages, fines, the curtailment or restructuring of our operations, exclusion from participation in federal and state healthcare programs and imprisonment, any of which could adversely affect our ability to operate our business and our financial results.

Employees

We currently have seven employees and several consultants in the regulatory, clinical, manufacturing and finance areas. None of our employees are represented by a collective bargaining arrangement, and we believe our relationship with our employees is good.

Research and Development

We incurred $8.2 million and $10.0 million in research and development expenses for the years ended December 31, 2015 and 2014, respectively.

About Evoke

We were formed as a Delaware corporation on January 29, 2007. Our principal executive offices are located at 505 Lomas Santa Fe Drive, Suite 270, Solana Beach, California 92075, and our telephone number is (858) 345-1494.

Financial Information about Segments

We have one operating segment, which is the development of pharmaceutical products. See Note 2 to our financial statements included in this Annual Report on Form 10-K. For financial information regarding our business, see “Management’s Discussion and Analysis of Financial Condition and Results of Operations” and those financial statements and related notes.

Available Information

We file electronically with the Securities and Exchange Commission, or SEC, our annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K pursuant to Sections 13(a) and 15(d) of the Securities Exchange Act of 1934, as amended. We make available copies of these reports, free of charge, on our website at www.evokepharma.com, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the SEC. The public may read or copy any materials we file with the SEC at the SEC’s Public Reference Room at 100 F Street NE, Washington, D.C. 20549. The public may obtain information on the operation of the Public Reference Room by calling the SEC at 1-800-SEC-0330. The SEC maintains a website that contains reports, proxy and information statements, and other information regarding issuers that file electronically with the SEC. The address of that website is www.sec.gov. The information in or accessible through the SEC and our website are not incorporated into, and are not considered part of, this report. Further, our references to the URLs for these websites are intended to be inactive textual references only.

Item 1A. Risk Factors

We operate in a dynamic and rapidly changing environment that involves numerous risks and uncertainties. Certain factors may have a material adverse effect on our business prospects, financial condition and results of operations, and you should carefully consider them. Accordingly, in evaluating our business, we encourage you to consider the following discussion of risk factors, in its entirety, in addition to other information contained in this Annual Report on Form 10-K and our other public filings with the Securities and Exchange Commission, or SEC. Other events that we do not currently anticipate or that we currently deem immaterial may also affect our business, prospects, financial condition and results of operations.

Risks Related to our Business, including the Development, Regulatory Approval and Potential Commercialization of our Product Candidate, EVK-001

Our business is entirely dependent on the success of a single product candidate, EVK-001, for which we are conducting a Phase 3 clinical trial. We cannot be certain that we will be able to obtain regulatory approval for, or successfully commercialize, EVK-001.

We have only one product candidate: EVK-001, a metoclopramide nasal spray to treat female patients with symptoms associated with acute and recurrent diabetic gastroparesis. We are entirely dependent on successful continued development and regulatory approval of this product candidate for our future business success. We have invested, and will continue to invest, a significant portion of our time and financial resources in the development of EVK-001. We will need to successfully enroll and complete our ongoing Phase 3 clinical trial of EVK-001, which we commenced in April 2014, and, if required, raise sufficient funds for the completion of this trial. The future regulatory and commercial success of this product candidate is subject to a number of risks, including the following:

- we may not have sufficient financial and other resources to complete the Phase 3 clinical trial;
- we may not be able to provide acceptable evidence of safety and efficacy for EVK-001;
- the results of our planned and ongoing clinical trials may not confirm the positive results of earlier clinical trials, particularly because we are utilizing a modified patient report outcomes, or PRO, instrument for our current Phase 3 clinical trial compared to our Phase 2b clinical trial;
- the FDA may disagree with the design of current and future clinical trials;
- variability in subjects, adjustments to clinical trial procedures and inclusion of additional clinical trial sites;
- the results of our clinical trial may not meet the level of statistical or clinical significance required by the FDA for marketing approval;
- we may be required to undertake additional clinical trials and other studies of EVK-001 before we can submit an NDA, to the FDA or receive approval of the NDA;
- subjects in our clinical trials may die or suffer other adverse effects for reasons that may or may not be related to EVK-001, such as dysgeusia, headache, diarrhea, nasal discomfort, tremor, myoclonus, somnolence, rhinorrhea, throat irritation, and fatigue;
- if approved, EVK-001 will compete with well-established products already approved for marketing by the FDA, including oral and intravenous forms of metoclopramide, the same active ingredient in the nasal spray for EVK-001;
- we may not be able to obtain, maintain and enforce our patents and other intellectual property rights; and
- we may not be able to obtain and maintain commercial manufacturing arrangements with third-party manufacturers or establish commercial-scale manufacturing capabilities.

Of the large number of drugs in development in this industry, only a small percentage result in the submission of an NDA to the FDA and even fewer are approved for commercialization. Furthermore, even if we do receive regulatory approval to market EVK-001, any such approval may be subject to limitations on the indicated uses for which we may market the product.

We will require substantial additional funding and may be unable to raise capital when needed, which would force us to suspend our Phase 3 clinical trial and otherwise delay, reduce or eliminate our development program for EVK-001.

Our operations have consumed substantial amounts of cash since inception. To date, our operations have been primarily financed through the proceeds from the sale of our common and preferred stock, and borrowings under our loan and financing agreements. We believe, based on our current operating plan, that our existing cash and cash equivalents, together with interest thereon, will be sufficient to fund our operations through October 2016, which includes the reporting of Phase 3 trial date, although there can be no assurance in that regard. As of February 29, 2016, we had randomized 186 subjects in our ongoing Phase 3 clinical trial with female subjects. We anticipate fully enrolling this trial during the second quarter of 2016. If the Phase 3 trial is not enrolled on our expected timeframe, we may need to raise additional funds to complete this trial. We may also need to raise additional funds to finance any

additional development requirements requested by the FDA, as well as for NDA preparation and pre-commercial activities, including marketing and manufacturing of EVK-001.

Our estimates of the amount of cash necessary to fund our activities may prove to be wrong, and we could spend our available financial resources much faster than we currently expect. Our future funding requirements will depend on many factors, including, but not limited to:

- the rate of progress and cost of our Phase 3 clinical trial and any other clinical requirements for EVK-001;
- the timing of regulatory approval, if granted, of EVK-001 or any other product candidates;
- the costs of filing, prosecuting, defending and enforcing any patent claims and other intellectual property rights associated with EVK-001;
- the costs and timing of completion of outsourced commercial manufacturing supply arrangements for EVK-001;
- costs associated with any other product candidates that we may develop, in-license or acquire;
- the effect of competing technological and market developments; and
- the terms and timing of any collaborative, licensing, co-promotion or other arrangements that we may establish.

The results observed in female subjects with symptoms associated with acute and recurrent diabetic gastroparesis in our Phase 2b clinical trial of EVK-001 may not be predictive of the safety and efficacy results in our ongoing Phase 3 clinical trial.

A number of companies in the pharmaceutical and biotechnology industries have suffered significant setbacks in late-stage clinical trials even after achieving promising results in earlier-stage development. We commenced our Phase 3 clinical trial in female subjects with symptoms associated with acute and recurrent diabetic gastroparesis in April 2014. Our Phase 2b clinical trial of EVK-001 for the treatment of diabetic gastroparesis showed statistically significant improvement in clinically meaningful endpoints in female subjects. This was a pre-specified analysis of the primary efficacy endpoint performed on a gender subgroup of the intent to treat, or ITT, population. Due to a large placebo response in male subjects, EVK-001 did not achieve the primary endpoint in the ITT population for all subjects in this Phase 2b clinical trial.

This risk may be particularly significant for us because the primary endpoint in our ongoing Phase 3 clinical trial is not identical to the primary endpoint used in our Phase 2b trial. In our Phase 2b clinical trial, the primary endpoint was the GCSI-DD, a PRO instrument. The GCSI-DD is a composite of clinically relevant diabetic gastroparesis symptoms which patients rate according to severity. Based on our discussions with the FDA, the primary endpoint for our Phase 3 trial will be the GSA, which is a PRO instrument derived from the GCSI-DD. We have analyzed our Phase 2b data utilizing the GSA's methodology. Although we observed statistically significant and nearly identical statistical improvement in the GSA compared to the GCSI-DD in females in our Phase 2b trial, we cannot assure you that our Phase 3 trials will achieve positive results.

A number of factors could contribute to a lack of favorable safety and efficacy results in our ongoing Phase 3 trial. For example:

- a multicenter trial could result in increased variability due to varying site characteristics, such as local standards of care;
- a multicenter trial could result in increased variability due to varying patient characteristics including demographic factors, health status, underlying reason for disease state and concomitant medications; and
- diagnosis of diabetic gastroparesis by physicians, including use of gastric emptying tests, could select for a patient population that differs from those patients included within previous clinical trials.

If we are not able to obtain regulatory approval for EVK-001, we will not be able to commercialize this product candidate and our ability to generate revenue will be limited.

We have not submitted an NDA or received regulatory approval to market any product candidates in any jurisdiction. We are not permitted to market EVK-001 in the United States until we receive approval of an NDA for the product

candidate in a particular indication from the FDA. To date, we have completed one Phase 2b clinical trial for EVK-001 in diabetic subjects with gastroparesis and acquired the results from a separate Phase 2 clinical trial in diabetic subjects with gastroparesis. In the Phase 2b clinical trial that we performed ourselves, which concluded in 2011, EVK-001 failed to meet the primary endpoint for the trial. Although an overall improvement in symptoms was observed in EVK-001-treated subjects with diabetic gastroparesis compared to placebo in this Phase 2b clinical trial, the difference was not statistically significant due to a high placebo response among male subjects. The earlier Phase 2 clinical trial performed by Questcor was a multicenter, randomized, open-label, parallel design study. This head-to-head study compared the efficacy and safety of two doses of metoclopramide nasal spray, 10 mg and 20 mg, with the FDA-approved 10 mg metoclopramide tablet. Although data from the earlier Phase 2 clinical trial will be referenced in the EVK-001 NDA, the open-label study design limits the importance of the efficacy results in the NDA.

We commenced our Phase 3 clinical trial in female subjects with symptoms associated with acute and recurrent diabetic gastroparesis in April 2014. There is no guarantee that this Phase 3 clinical trial or any other future trials will be successful or that regulators will agree with our assessment of the clinical trials for EVK-001 conducted to date. In addition, we have only limited experience in filing the applications necessary to gain regulatory approvals and expect to rely on consultants and third party contract research organizations to assist us in this process. The FDA and other regulators have substantial discretion in the approval process and may refuse to accept any application or may decide that our data are insufficient for approval and require additional clinical trials, or preclinical or other studies.

Varying interpretation of the data obtained from preclinical and clinical testing could delay, limit or prevent regulatory approval of a product candidate. Furthermore, we have acquired our rights to EVK-001 from Questcor, who acquired its rights from a predecessor. Thus, much of the preclinical and a portion of the clinical data relating to EVK-001 that we would expect to submit in an NDA for EVK-001 was obtained from studies conducted before we owned the rights to the product candidate and, accordingly, was prepared and managed by others. These predecessors may not have applied the same resources and given the same attention to this development program as we would have if we had been in control from inception.

EVK-001 and the activities associated with its development and potential commercialization, including its testing, manufacture, safety, efficacy, recordkeeping, labeling, storage, approval, advertising, promotion, sale and distribution, are subject to comprehensive regulation by the FDA and other regulatory agencies in the United States and by comparable authorities in other countries. Failure to obtain regulatory marketing approval for EVK-001 will prevent us from commercializing the product candidate, and our ability to generate revenue will be materially impaired.

The FDA may impose requirements on our clinical trials that are difficult to comply with, which could harm our business.

The requirements that the FDA may impose on clinical trials for EVK-001 are uncertain. However, in July 2015 the FDA published draft guidance intended to assist sponsors in the clinical development of drugs for the treatment of diabetic and idiopathic gastroparesis clinical trials, Gastroparesis: Clinical Evaluation of Drugs for Treatment – Guidance for Industry. We believe that the FDA Guidance is consistent with the advice the FDA provided to us regarding trial design and study endpoints for our ongoing Phase 3 trials. As a result, our Phase 3 protocol is consistent with the specific recommendations in the FDA Guidance. In addition, the FDA Guidance explicitly states that there is an urgent medical need for development of drugs with a favorable risk-benefit profile to treat patients with gastroparesis and acknowledges that “patients with diabetic gastroparesis may experience further derangement of glucose control because of unpredictable gastric emptying and altered absorption of orally administered hypoglycemic drugs.”

We are conducting one Phase 3 trial in adult female subjects with diabetic gastroparesis, which, along with the completed thorough ECG (QT) trial, we believe will be sufficient for NDA submission seeking an indication of treatment of symptoms associated with diabetic gastroparesis in women. In April 2014, we commenced a multicenter, randomized, double-blind, placebo-controlled, parallel-group Phase 3 clinical trial to evaluate the efficacy, safety and population pharmacokinetics of EVK-001 in adult female subjects with diabetic gastroparesis when dosed four times a day for 28 days. Although we believe successful results from this single Phase 3 clinical trial, along with the thorough ECG (QT) trial, will be sufficient to allow us to submit an NDA for EVK-001, it is possible the FDA will require additional clinical testing before submission or approval of the NDA. In addition, based on discussions with the FDA, we also are conducting a similar study for safety and efficacy in adult male subjects with diabetic gastroparesis which is not required for an NDA submission. If we are unable to comply with the FDA’s requirements, we will not be able to obtain approval for EVK-001 and our ability to generate revenue will be materially impaired.

Any termination or suspension of, or delays in the enrollment or completion of, our ongoing Phase 3 clinical trial could result in increased costs to us, delay or limit our ability to generate revenue and adversely affect our commercial prospects.

Delays in the enrollment or completion of our ongoing Phase 3 clinical trial for EVK-001 could significantly affect our product development costs. We do not know whether this trial will complete enrollment or produce data on schedule, if at all. The commencement and completion of clinical trials can be delayed for a number of reasons, including delays related to:

- the FDA placing the clinical trial on hold;
- subjects failing to enroll or remain in our trial at the rate we expect (for example, due to variable patient frequency and severity of disease and variability in gastric emptying testing);
- subjects choosing an alternative treatment for the indication for which we are developing EVK-001, or participating in competing clinical trials;
- subjects experiencing severe or unexpected drug-related adverse effects;
- a facility manufacturing EVK-001 or any of its components being ordered by the FDA or other government or regulatory authorities to temporarily or permanently shut down due to violations of cGMP or other applicable requirements, or infections or cross-contaminations of product candidate in the manufacturing process;

- any changes to our manufacturing process that may be necessary or desired;
- third-party clinical investigators losing their license or permits necessary to perform our clinical trials, not performing our clinical trials on our anticipated schedule or consistent with the clinical trial protocol, GCP and regulatory requirements, or other third parties not performing data collection and analysis in a timely or accurate manner;
- inspections of clinical trial sites by the FDA or the finding of regulatory violations by the FDA or an IRB that require us to undertake corrective action, result in suspension or termination of one or more sites or the imposition of a clinical hold on the entire trial, or that prohibit us from using some or all of the data in support of our marketing applications;
- third-party contractors becoming debarred or suspended or otherwise penalized by the FDA or other government or regulatory authorities for violations of regulatory requirements, in which case we may need to find a substitute contractor, and we may not be able to use some or any of the data produced by such contractors in support of our marketing applications; or
- one or more IRBs refusing to approve, suspending or terminating the trial at an investigational site, precluding enrollment of additional subjects, or withdrawing its approval of the trial.

Product development costs will increase if we have delays in testing or approval of EVK-001, or if we need to perform more or larger clinical trials than planned. Additionally, changes in regulatory requirements and policies may occur and we may need to amend clinical trial protocols to reflect these changes. Amendments may require us to resubmit our clinical trial protocols to IRBs for reexamination, which may impact the costs, timing or successful completion of a clinical trial. If we experience delays in completion of or if we, the FDA or other regulatory authorities, the IRB, or other reviewing entities, or any of our clinical trial sites suspend or terminate any of our clinical trials, the commercial prospects for our product candidate may be harmed and our ability to generate product revenues will be delayed. In addition, many of the factors that cause, or lead to, termination or suspension of, or a delay in the commencement or completion of, clinical trials may also ultimately lead to the denial of regulatory approval of a product candidate. Also, if one or more clinical trials are delayed, our competitors may be able to bring products to market before we do, and the commercial viability of EVK-001 could be significantly reduced.

The Phase 3 trial is expected to enroll approximately 200 female subjects at sites across the United States. Many of the clinical trial sites with previous gastroparesis study experience have experienced slower than previously anticipated enrollment. Although the trial sites have been screening significant numbers of subjects with diabetic gastroparesis, these subjects typically have symptoms that vary in timing and severity, unpredictable gastric emptying delays, and complex medical histories, making study enrollment challenging. We are also facing competition for subjects from other ongoing competing clinical trials that were not active when we started our Phase 3 trial. This combination of factors creates a challenge for enrollment into diabetic gastroparesis trials, though we continue to anticipate fully enrolling this trial during the second quarter of 2016. Continued delays in the enrollment and completion of the Phase 3 trial, as well as potential delays in any other clinical trials and studies, could be harmful to our business and cause us to require additional funding sooner than anticipated.

Final marketing approval for EVK-001 by the FDA or other regulatory authorities for commercial use may be delayed, limited, or denied, any of which would adversely affect our ability to generate operating revenues.

After the completion of our Phase 3 clinical trial and, assuming the results of the trial are successful, the submission of an NDA, we cannot predict whether or when we will obtain regulatory approval to commercialize EVK-001 and we cannot, therefore, predict the timing of any future revenue. Because EVK-001 is our only product candidate this risk is particularly significant for us. We cannot commercialize EVK-001 until the appropriate regulatory authorities have reviewed and approved marketing applications for this product candidate. We cannot assure you that the regulatory agencies will complete their review processes in a timely manner or that we will obtain regulatory approval for EVK-001. In addition, we may experience delays or the application may be rejected based upon additional government regulation from future legislation or administrative action or changes in FDA policy during the period of product development, clinical trials and FDA regulatory review. For example, in 2009 following an FDA review of metoclopramide spontaneous safety reports, the FDA required a boxed warning be added to the metoclopramide

product label concerning the chance of tardive dyskinesia, or TD, for patients taking these products. The FDA requires a boxed warning (sometimes referred to as a “Black Box” Warning) for products that have shown a significant risk of severe or life-threatening adverse events. Recently, the European Medicines Agency’s Committee on Medicinal Products for Human Use, or CHMP, has reviewed and has proposed labeling changes for marketed metoclopramide products in the European Union based on age, dosing guidelines or indications. Based on their assessment of the limited efficacy and safety data currently available to the CHMP, the CHMP recommended to the European Medicines Agency that indications with limited or inconclusive efficacy data, including GERD, dyspepsia and gastroparesis, be removed from the approved product label in the European Union. There can be no assurance as to whether the FDA will re-review approved metoclopramide product labels as a result of any such regulatory actions in the European Union or otherwise. If marketing approval for EVK-001 is delayed, limited or denied, our ability to market the product candidate, and our ability to generate product sales, would be adversely affected.

If the FDA does not conclude that EVK-001 satisfies the requirements for the Section 505(b)(2) regulatory approval pathway, or if the requirements under Section 505(b)(2) are not as we expect, the approval pathway for our primary product candidate will likely take significantly longer, cost significantly more and entail significantly greater complications and risks than anticipated, and in either case may not be successful.

We intend to seek FDA approval through the Section 505(b)(2) regulatory pathway for our primary product candidate, EVK-001. EVK-001 is a drug/device combination product that will be regulated under the drug provisions of the FFDCA, enabling us to submit an NDA for its approval. The Drug Price Competition and Patent Term Restoration Act of 1984, also known as the Hatch-Waxman Amendments, added Section 505(b)(2) to the FDCA. Section 505(b)(2) permits the filing of an NDA where at least some of the information required for approval comes from studies not conducted by or for the applicant and for which the applicant has not obtained a right of reference.

If the FDA does not allow us to pursue the Section 505(b)(2) regulatory pathway as anticipated, we may need to conduct additional clinical trials, provide additional data and information and meet additional standards for regulatory approval. If this were to occur, the time and financial resources required to obtain FDA approval for EVK-001, and the complications and risks associated with our lead product candidate, would likely substantially increase. We may need to obtain additional funding, which could result in significant dilution to the ownership interests of our then existing stockholders to the extent we issue equity securities or convertible debt. We cannot assure you that we would be able to obtain such additional financing on terms acceptable to us, if at all. Moreover, inability to pursue the Section 505(b)(2) regulatory pathway could result in competitive products reaching the market before EVK-001, which could impact our competitive position and prospects. Even if we are allowed to pursue the Section 505(b)(2) regulatory pathway, we cannot assure you that EVK-001 or any future product candidates will receive the requisite approvals for commercialization.

Even if we obtain marketing approval for EVK-001, it could be subject to restrictions or withdrawal from the market and we may be subject to penalties if we fail to comply with regulatory requirements or if we experience unanticipated problems with our product candidate, when and if EVK-001 is approved.

Even if U.S. regulatory approval is obtained, the FDA may still impose significant restrictions on EVK-001's indicated uses or marketing or impose ongoing requirements for potentially costly and time consuming post-approval studies, post-market surveillance or clinical trials. EVK-001 will also be subject to ongoing FDA requirements governing the labeling, packaging, storage, distribution, safety surveillance, advertising, promotion, recordkeeping and reporting of safety and other post-market information. In addition, manufacturers of drug products and their facilities are subject to continual review and periodic inspections by the FDA and other regulatory authorities for compliance with cGMP requirements relating to quality control, quality assurance and corresponding maintenance of records and documents. If we or a regulatory agency discovers previously unknown problems with a product, such as adverse events of unanticipated severity or frequency, or problems with the facility where the product is manufactured, a regulatory agency may impose restrictions on that product, the manufacturing facility or us, including requesting recall or withdrawal of the product from the market or suspension of manufacturing.

If we or the manufacturing facilities for EVK-001 fail to comply with applicable regulatory requirements, a regulatory agency may:

- issue warning letters or untitled letters;
- seek an injunction or impose civil or criminal penalties or monetary fines;
- suspend or withdraw regulatory approval;
- suspend any ongoing clinical trials;
- refuse to approve pending applications or supplements or applications filed by us;
- suspend or impose restrictions on operations, including costly new manufacturing requirements; or
- seize or detain products, refuse to permit the import or export of product, or request us to initiate a product recall.

The occurrence of any event or penalty described above may inhibit our ability to commercialize our products and generate revenue.

The FDA has the authority to require a REMS as a condition of approval of an NDA or following approval, which may impose further requirements or restrictions on the distribution or use of an approved drug, such as limiting prescribing to certain physicians or medical centers that have undergone specialized training, limiting treatment to patients who meet certain safe-use criteria and requiring treated patients to enroll in a registry. In March 2009, the FDA informed drug manufacturers that it will require a REMS for metoclopramide drug products, including a Medication Guide, elements to assure safe use (including an education program for prescribers and materials for prescribers to educate patients), and a timetable for submission of assessments of at least six months, 12 months, and annually after the REMS is approved. We intend to submit a proposed REMS at the time of the NDA submission for EVK-001.

In addition, if EVK-001 is approved, our product labeling, advertising and promotion would be subject to regulatory requirements and continuing regulatory review. The FDA strictly regulates the promotional claims that may be made about prescription products. In particular, a product may not be promoted for uses that are not approved by the FDA as reflected in the product's approved labeling. If we receive marketing approval for EVK-001, physicians may nevertheless prescribe it to their patients in a manner that is inconsistent with the approved label. If we are found to have promoted such off-label uses, we may become subject to significant liability. The FDA and other agencies actively enforce the laws and regulations prohibiting the promotion of off-label uses, and a company that is found to have improperly promoted off-label uses may be subject to significant sanctions. The federal government has levied large civil and criminal fines against companies for alleged improper promotion and has enjoined several companies from engaging in off-label promotion. The FDA has also requested that companies enter into consent decrees or permanent injunctions under which specified promotional conduct is changed or curtailed.

Even if we receive regulatory approval for EVK-001, we still may not be able to successfully commercialize it and the revenue that we generate from its sales, if any, will be limited.

EVK-001's commercial success will depend upon the acceptance of the product candidate by the medical community, including physicians, patients and health care payors. The degree of market acceptance of our product candidate will depend on a number of factors, including:

- demonstration of clinical efficacy and safety compared to other more-established products;
- the limitation of our targeted patient population to women-only;
- limitations or warnings contained in any FDA-approved labeling, including the potential boxed warning on all metoclopramide product labels concerning the chance of TD for patients taking these products, or any limitations with respect to metoclopramide product labels in the European Union;
- acceptance of a new formulation by health care providers and their patients;
- the prevalence and severity of any adverse effects;
- new procedures or methods of treatment that may be more effective in treating or may reduce the incidences of diabetic gastroparesis;
- pricing and cost-effectiveness;
- the effectiveness of our or any future collaborators' sales and marketing strategies;
- our ability to obtain and maintain sufficient third-party coverage and reimbursement from government health care programs, including Medicare and Medicaid, private health insurers and other third-party payors; and
- the willingness of patients to pay out-of-pocket in the absence of third-party coverage.

If EVK-001 is approved, but does not achieve an adequate level of acceptance by physicians, health care payors and patients, we may not generate sufficient revenue, and we may not be able to achieve or sustain profitability. Our efforts to educate the medical community and third-party payors on the benefits of EVK-001 may require significant resources and may never be successful. In addition, our ability to successfully commercialize our product candidate will depend on our ability to manufacture our products, differentiate our products from competing products and defend the intellectual property of our products.

It will be difficult for us to profitably sell EVK-001 if coverage and reimbursement are limited.

Market acceptance and sales of our product candidate will depend on coverage and reimbursement policies and may be affected by healthcare reform measures. Government authorities and third-party payors, such as private health insurers and health maintenance organizations, decide which medications they will pay for and establish reimbursement levels. A primary trend in the U.S. healthcare industry and elsewhere is cost containment. Government authorities and these third-party payors have attempted to control costs by limiting coverage and the amount of reimbursement for particular medications. Increasingly, third-party payors have been challenging the prices charged for products. They may also refuse to provide any coverage of uses of approved products for medical indications other than those for which the FDA has granted marketing approval. This trend may impact the reimbursement for treatments for GI disorders especially, including EVK-001, as physicians typically focus on symptoms rather than

underlying conditions when treating patients with these disorders and drugs are often prescribed for uses outside of their approved indications. In instances where alternative products are available, it may be required that those alternative treatment options are tried before coverage and reimbursement are available for EVK-001. Although EVK-001 is a novel nasal spray formulation of metoclopramide, this is the same active ingredient that is already available in other formulations approved for the treatment of gastroparesis that are already widely available at generic prices. We cannot be sure that coverage will be available for EVK-001 and, if coverage is available, the level of reimbursement. Reimbursement may impact the demand for, or the price of, this product candidate. In addition, in certain foreign countries, particularly the countries of the European Union, the pricing of prescription pharmaceuticals is subject to governmental

control. If reimbursement is not available or is available only to limited levels, we may not be able to successfully commercialize our product candidate.

We rely and will continue to rely on outsourcing arrangements for many of our activities, including clinical development and supply of EVK-001.

We have only seven full-time employees and, as a result, we rely on outsourcing arrangements for a significant portion of our activities, including clinical research, data collection and analysis and manufacturing, as well as functioning as a public company. We may have limited control over these third parties and we cannot guarantee that they will perform their obligations in an effective and timely manner.

We have retained SynteractHCR, a contract research organization, or CRO, to conduct our ongoing Phase 3 clinical trial of EVK-001. We rely on our CRO to recruit suitable subjects to participate in the trial at each trial site. Enrollment in our Phase 3 clinical trial of EVK-001 has progressed more slowly than anticipated, and although we have undertaken additional initiatives to increase enrollment and to further assist clinical trial sites in the identification of eligible study subjects, our CRO is ultimately responsible for recruitment efforts.

The manufacture of pharmaceutical products requires significant expertise and capital investment, including the development of advanced manufacturing techniques and process controls. We do not own or operate manufacturing facilities for the production of any component of EVK-001, including metoclopramide, the nasal spray device or associated bottle, nor do we have plans to develop our own manufacturing operations in the foreseeable future. We currently depend on third-party contract manufacturers for all of our required raw materials, drug substance and drug product for our clinical trials. For EVK-001, we are currently using, and relying on, single suppliers and single manufacturers for starting materials, the final drug substance and nasal spray delivery device. Although potential alternative suppliers and manufacturers for some components have been identified, we have not qualified these vendors to date. If we were required to change vendors, it could result in a failure to meet regulatory requirements or projected timelines and necessary quality standards for successful manufacturing of the various required lots of material for our development and commercialization efforts.

We do not have any current contractual relationships for the manufacture of commercial supplies of EVK-001. If EVK-001 is approved for sale by any regulatory agency, we intend to enter into agreements with third-party contract manufacturers for commercial production. The number of third-party manufacturers with the expertise, required regulatory approvals and facilities to manufacture bulk drug substance on a commercial scale is limited. We have identified one manufacturer for potentially providing commercial supplies of EVK-001; however, no alternative providers have been identified to date. If we are unable to come to terms on becoming our commercial supplier with this manufacturer, we would have to find replacements, which could delay the commercialization of our product candidate.

In addition, our reliance on third party CROs and contract manufacturing organizations, or CMOs, entails further risks including:

- non-compliance by third parties with regulatory and quality control standards;
- breach by third parties of our agreements with them;
- termination or non-renewal of an agreement with third parties; and
- sanctions imposed by regulatory authorities if compounds supplied or manufactured by a third party supplier or manufacturer fail to comply with applicable regulatory standards.

We face substantial competition, which may result in others selling their products more effectively than we do, and in others discovering, developing or commercializing product candidates before, or more successfully, than we do.

Our future success depends on our ability to demonstrate and maintain a competitive advantage with respect to the design, development and commercialization of EVK-001. We anticipate that EVK-001, if approved, would compete

directly with metoclopramide, erythromycin and domperidone, each of which is available under various trade names sold by several major pharmaceutical companies, including generic manufacturers. Metoclopramide is the only molecule currently approved in the United States to treat gastroparesis. Metoclopramide is generically-available and indicated for the relief of symptoms associated with acute and recurrent diabetic gastroparesis, without the limitation of use in women only.

Many of our potential competitors have substantially greater financial, technical and personnel resources than we have. In addition, many of these competitors have significantly greater commercial infrastructures than we have. We will not be able to compete successfully unless we successfully:

- assure health care providers, patients and health care payors that EVK-001 is beneficial compared to other products in the market;
- obtain patent and/or other proprietary protection for EVK-001;
- obtain and maintain required regulatory approvals for EVK-001; and
- collaborate with others to effectively market, sell and distribute EVK-001.

Established competitors may invest heavily to quickly discover and develop novel compounds that could make our product candidate obsolete. In addition to our EVK-001 product candidate, we are aware of other development candidates in clinical development. Any of these product candidates could advance through clinical development faster than EVK-001 and, if approved, could attain faster and greater market acceptance than our product candidate. If we are not able to compete effectively against our current and future competitors, our business will not grow and our financial condition and operations will suffer.

We have no sales, marketing or distribution capabilities currently and we will have to invest significant resources to develop these capabilities.

Currently, we have no internal sales, marketing or distribution capabilities. If EVK-001 ultimately receives regulatory approval, we may not be able to effectively market and distribute the product candidate. We will have to invest significant amounts of financial and management resources to develop internal sales, distribution and marketing capabilities, some of which will be committed prior to any confirmation that EVK-001 will be approved. We may not be able to hire consultants or external service providers to assist us in sales, marketing and distribution functions on acceptable financial terms or at all. Even if we determine to perform sales, marketing and distribution functions ourselves, we could face a number of additional related risks, including:

- inability to attract and build an effective marketing department or sales force;
- the cost of establishing a marketing department or sales force may exceed our available financial resources and the revenues generated by EVK-001 or any other product candidates that we may develop, in-license or acquire; and
- our direct sales and marketing efforts may not be successful.

If we fail to attract and retain senior management and key commercial personnel, we may be unable to successfully complete the development of EVK-001 and commercialize this product candidate.

Our success depends in part on our continued ability to attract, retain and motivate highly qualified management, clinical and commercial personnel. We are highly dependent upon our senior management team composed of three individuals: David A. Gonyer, R.Ph., our President and Chief Executive Officer, Matthew J. D'Onofrio, our Executive Vice President and Chief Business Officer, and Marilyn Carlson, D.M.D., M.D., our Chief Medical Officer. The loss of services of any of these individuals could delay or prevent the successful development of EVK-001 or the commercialization of this product candidate, if approved.

We will need to hire and retain qualified personnel. We could experience problems in the future attracting and retaining qualified employees. For example, competition for qualified personnel in the biotechnology and pharmaceuticals field is intense, particularly in the San Diego, California area where we are headquartered. We may not be able to attract and retain quality personnel on acceptable terms who have the expertise we need to sustain and grow our business.

We may encounter difficulties in managing our growth and expanding our operations successfully.

Because we currently have only seven full-time employees, we will need to grow our organization substantially to pursue the potential commercialization of EVK-001 and to potentially conduct additional development activities. As

we seek to advance EVK-001, we will need to expand our regulatory, manufacturing, marketing and sales capabilities or contract with third parties to provide these capabilities for us. As our operations expand, we expect that we will need to manage additional relationships with various strategic partners, suppliers and other third parties. Future growth will impose significant added responsibilities on members of management and require us to retain additional internal capabilities. Our future financial performance and our ability to commercialize EVK-001 and to compete effectively will depend, in part, on our ability to manage any future growth effectively. To that end, we must be able to manage our development efforts and clinical trials effectively and hire, train and integrate additional management, clinical and regulatory, financial, administrative and sales and marketing personnel. We may not be able to accomplish these tasks, and our failure to accomplish any of them could prevent us from successfully growing our company.

Recently enacted and future legislation may increase the difficulty and cost for us to obtain marketing approval of and commercialize EVK-001 and affect the prices we may obtain.

In the United States and some foreign jurisdictions, there have been a number of legislative and regulatory changes and proposed changes regarding the healthcare system that could prevent or delay marketing approval for EVK-001, restrict or regulate post-approval activities and affect our ability to profitably sell our product candidate, assuming we obtain marketing approval.

Legislative and regulatory proposals have been made to expand post-approval requirements and restrict sales and promotional activities for pharmaceutical products. We are not sure whether additional legislative changes will be enacted, or whether the FDA regulations, guidance or interpretations will be changed, or what the impact of such changes on the marketing approvals of EVK-001, if any, may be. In addition, increased scrutiny by the U.S. Congress of the FDA's approval process may significantly delay or prevent marketing approval, as well as subject us to more stringent product labeling and post-marketing testing and other requirements.

In the United States, the Medicare Modernization Act, or MMA, changed the way Medicare covers and pays for pharmaceutical products. The legislation expanded Medicare coverage for outpatient drug purchases by Medicare beneficiaries under a new Part D and introduced a new reimbursement methodology based on average sales prices for Medicare Part B physician-administered drugs. In addition, this legislation authorized Medicare Part D prescription drug plans to use formularies where they can limit the number of drugs that will be covered in any therapeutic class. As a result of this legislation and the expansion of federal coverage of drug products, we expect that there will be additional pressure to contain and reduce costs. These cost reduction initiatives and other provisions of this legislation could decrease the coverage and price that we receive for any approved products and could seriously harm our business. While the MMA applies only to drug benefits for Medicare beneficiaries, private payors often follow Medicare coverage policy and payment limitations in setting their own reimbursement rates, and any reduction in Medicare reimbursement may result in a similar reduction in payments from private payors.

In early 2010, President Obama signed into law the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act, or collectively, the Affordable Care Act, a sweeping law intended to broaden access to health insurance, reduce or constrain the growth of healthcare spending, enhance remedies against fraud and abuse, add new transparency requirements for healthcare and health insurance industries, impose new taxes and fees on the health industry and impose additional health policy reforms. The Affordable Care Act, among other things, increased the Medicaid rebates owed by manufacturers under the Medicaid Drug Rebate Program for both branded and generic drugs and revised the definition of "average manufacturer price" for reporting purposes, which could further increase the amount of Medicaid drug rebates to states. Further, the new law imposes a significant annual fee on companies that manufacture or import branded prescription drug products, increased the number of entities eligible for discounts under the 340B program and included a 50% discount on brand name drugs for Medicare Part D beneficiaries in the coverage gap, or "donut hole." Substantial new provisions affecting compliance have also been enacted, which may require us to modify our business practices with healthcare practitioners. Although it is too early to determine the full effect of the Affordable Care Act, the new law appears likely to continue the pressure on pharmaceutical pricing, especially under the Medicare program, and may also increase our regulatory burdens and operating costs.

In addition, other legislative changes have been proposed and adopted in the United States since the Affordable Care Act was enacted. In August 2011, the Budget Control Act of 2011 among other things, created the Joint Select Committee on Deficit Reduction to recommend proposals in spending reductions to Congress. The Joint Select Committee did not achieve its targeted deficit reduction of at least $1.2 trillion for the years 2013 through 2021, triggering the legislation's automatic reduction to several government programs. This includes aggregate reductions to Medicare payments to providers of two percent per fiscal year, which went into effect on April 1, 2013, and due to subsequent legislative amendments, will remain in effect through 2025, unless additional Congressional action is taken. On January 2, 2013, President Obama signed into law the American Taxpayer Relief Act of 2012, which,

among other things, further reduced Medicare payments to several providers, including hospitals, imaging centers and cancer treatment centers. These new laws and the regulations and policies implementing them, as well as other healthcare reform measures that may be adopted in the future, may have a material adverse effect on our industry generally and on our ability to successfully develop and commercialize our products, if approved.

If we market products in a manner that violates healthcare fraud and abuse laws, or if we violate government price reporting laws, we may be subject to civil or criminal penalties.

In addition to FDA restrictions on marketing of pharmaceutical products, several other types of state and federal healthcare fraud and abuse laws have been applied in recent years to restrict certain marketing practices in the pharmaceutical industry. These laws include false claims, anti-kickback and physician payment transparency laws and regulations. Because of the breadth of these laws and the narrowness of the safe harbors, it is possible that some of our business activities could be subject to challenge under one or more of these laws.

The federal Anti-Kickback Statute prohibits, among other things, knowingly and willfully offering, paying, soliciting or receiving remuneration to induce, or in return for, purchasing, leasing, ordering or arranging for the purchase, lease or order of any healthcare

item or service reimbursable under Medicare, Medicaid or other federally financed healthcare programs. This statute has been interpreted to apply to arrangements between pharmaceutical manufacturers on the one hand and prescribers, purchasers and formulary managers on the other. Although there are several statutory exceptions and regulatory safe harbors protecting certain common activities from prosecution, the exceptions and safe harbors are drawn narrowly, and practices that involve remuneration intended to induce prescribing, purchasing or recommending may be subject to scrutiny if they do not qualify for an exception or safe harbor. Our practices may not in all cases meet all of the criteria for safe harbor protection from anti-kickback liability. Further, the Affordable Care Act, among other things, amends the intent requirement of the federal Anti-Kickback Statute and the criminal healthcare fraud statutes that prohibit executing a scheme to defraud any federal healthcare benefit program or making false statements relating to healthcare matters. A person or entity no longer needs to have actual knowledge of these statutes or specific intent to violate them in order to have committed a violation. In addition, the Affordable Care Act provides that the government may assert that a claim including items or services resulting from a violation of the federal Anti-Kickback Statute constitutes a false or fraudulent claim for purposes of the federal False Claims Act.

Federal false claims laws prohibit any person from knowingly presenting, or causing to be presented, a false claim for payment to the federal government or knowingly making, or causing to be made, a false statement to get a false claim paid. Violations of the False Claims Act can result in very significant monetary penalties and treble damages. Over the past few years, several pharmaceutical and other healthcare companies have been prosecuted under these laws for a variety of alleged promotional and marketing activities, such as: allegedly providing free trips, free goods, sham consulting fees and grants and other monetary benefits to prescribers; reporting to pricing services inflated average wholesale prices that were then used by federal programs to set reimbursement rates; engaging in off-label promotion that caused claims to be submitted to Medicaid for non-covered, off-label uses; and submitting inflated best price information to the Medicaid Rebate Program to reduce liability for Medicaid rebates. Most states also have statutes or regulations similar to the federal anti-kickback law and false claims laws, which apply to items and services reimbursed under Medicaid and other state programs, or, in several states, apply regardless of the payor.

In addition, the Affordable Care Act included the federal Physician Payment Sunshine Act, which requires manufacturers of drugs, devices, biologics and medical supplies for which payment is available under Medicare, Medicaid or the Children's Health Insurance Program (with certain exceptions) to report annually to the government information related to payments or other "transfers of value" made to physicians (defined to include doctors, dentists, optometrists, podiatrists and chiropractors) and teaching hospitals, and applicable manufacturers and group purchasing organizations to report annually to the government ownership and investment interests held by physicians (as defined above) and their immediate family members. Manufacturers are required to report such data to the government by the 90th calendar day of each year. There are also several states with similar laws that require drug manufacturers to report information related to payments and other transfers of value to physicians and other healthcare providers or marketing expenditures, and/or require pharmaceutical companies to comply with the pharmaceutical industry's voluntary compliance guidelines and the relevant compliance guidance promulgated by the federal government or otherwise restrict payments that may be made to healthcare providers.

The risk of our being found in violation of these laws and regulations is increased by the fact that many of them have not been fully interpreted by the regulatory authorities or the courts, and their provisions are open to a variety of interpretations. If our operations are found to be in violation of any of the laws described above or any other governmental regulations that apply to us, we may be subject to penalties, including civil and criminal penalties, damages, fines, exclusion from governmental health care programs, and the curtailment or restructuring of our operations, any of which could adversely affect our ability to operate our business and our financial results.

Federal legislation and actions by state and local governments may permit re-importation of drugs from foreign countries into the United States, including foreign countries where the drugs are sold at lower prices than in the United States, which could materially adversely affect our operating results and our overall financial condition.

We may face competition in the United States for EVK-001, if approved, from lower priced products from foreign countries that have placed price controls on pharmaceutical products. This risk may be particularly applicable to drugs such as EVK-001. The MMA contains provisions that may change U.S. importation laws and expand pharmacists' and wholesalers' ability to import lower priced versions of an approved drug and competing products from Canada, where there are government price controls. These changes to U.S. importation laws will not take effect unless and until the Secretary of Health and Human Services certifies that the changes will pose no additional risk to the public's health and safety and will result in a significant reduction in the cost of products to consumers. The Secretary of Health and Human Services has not yet announced any plans to make this required certification.

A number of federal legislative proposals have been made to implement the changes to the U.S. importation laws without any certification and to broaden permissible imports in other ways. Even if the changes do not take effect, and other changes are not enacted, imports from Canada and elsewhere may continue to increase due to market and political forces, and the limited enforcement resources of the FDA, U.S. Customs and Border Protection and other government agencies. For example, Pub. L. No. 111-83, which was signed into law in October 2009 and provides appropriations for the Department of Homeland Security for the 2010 fiscal year, expressly prohibits U.S. Customs and Border Protection from using funds to prevent individuals from importing from Canada less

than a 90-day supply of a prescription drug for personal use, when the drug otherwise complies with the Federal Food, Drug, and Cosmetic Act, or FDCA. Further, several states and local governments have implemented importation schemes for their citizens and, in the absence of federal action to curtail such activities, we expect other states and local governments to launch importation efforts.

The importation of foreign products that compete with EVK-001 could negatively impact our revenue and profitability, possibly materially.

If product liability lawsuits are brought against us, we may incur substantial liabilities and may be required to limit commercialization of EVK-001.

We face an inherent risk of product liability as a result of the clinical testing of EVK-001 and will face an even greater risk if we commercialize the product candidate. For example, we may be sued if EVK-001 allegedly causes injury or is found to be otherwise unsuitable during product testing, manufacturing, marketing or sale. Any such product liability claims may include allegations of defects in manufacturing, defects in design, a failure to warn of dangers inherent in the product candidate, negligence, strict liability and a breach of warranties. Claims could also be asserted under state consumer protection acts.

In particular, products containing metoclopramide have been reported to cause side effects, including TD. It is possible that a patient taking EVK-001 will be found to experience a variety of side effects. In 2009, the FDA required a boxed warning on all metoclopramide product labels concerning the chance of TD for patients taking these products. We expect that the label for EVK-001, if approved, will likely contain a similar warning regarding TD. Several manufactures of metoclopramide products have been sued by patients regarding TD.

If we cannot successfully defend ourselves against product liability claims, we may incur substantial liabilities or be required to limit commercialization of our product candidate. Even successful defense would require significant financial and management resources. Regardless of the merits or eventual outcome, liability claims may result in:

- decreased demand for EVK-001;
- injury to our reputation;
- withdrawal of clinical trial participants;
- costs to defend the related litigation;
- a diversion of management's time and our resources;
- substantial monetary awards to trial participants or patients;
- product recalls, withdrawals or labeling, marketing or promotional restrictions;
- loss of revenue;
- the inability to commercialize EVK-001; and
- a decline in our stock price.

We may form strategic alliances in the future, and we may not realize the benefits of such alliances.

We may form strategic alliances, create joint ventures or collaborations or enter into licensing arrangements with third parties that we believe will complement or augment our existing business, including for the continued development or commercialization of EVK-001. These relationships or those like them may require us to incur non-recurring and other charges, increase our near- and long-term expenditures, issue securities that dilute our existing stockholders or disrupt our management and business. In addition, we face significant competition in seeking appropriate strategic partners and the negotiation process is time-consuming and complex. Moreover, we may not be successful in our efforts to establish a strategic partnership or other alternative arrangements for EVK-001 because third parties may view the risk of success in our ongoing Phase 3 clinical trial as too significant or the commercial opportunity for our product candidate as too limited. We cannot be certain that, following a strategic transaction or license, we will achieve the revenues or specific net income that justifies such transaction.

Our business and operations would suffer in the event of system failures.

Despite the implementation of security measures, our internal computer systems and those of our current and any future CROs and other contractors and consultants and collaborators are vulnerable to damage from computer viruses, unauthorized access, natural disasters, terrorism, war and telecommunication and electrical failures. While we have not experienced any such material system failure, accident or security breach to date, if such an event were to occur and cause interruptions in our operations, it could result in a material disruption of our development program for EVK-001 and our business operations. For example, the loss of clinical trial data from completed or future clinical trials could result in delays in our regulatory approval efforts and significantly increase our costs to

recover or reproduce the data. Likewise, we rely on third parties to manufacture EVK-001 and conduct clinical trials, and similar events relating to their computer systems could also have a material adverse effect on our business. To the extent that any disruption or security breach were to result in a loss of, or damage to, our data or applications, or inappropriate disclosure of confidential or proprietary information, we could incur liability and the further development and commercialization of our product candidate could be delayed.

Business disruptions could seriously harm our future revenues and financial condition and increase our costs and expenses.

Our operations could be subject to earthquakes, power shortages, telecommunications failures, water shortages, floods, hurricanes, typhoons, fires, extreme weather conditions, medical epidemics and other natural or manmade disasters or business interruptions, for which we are predominantly self-insured. The occurrence of any of these business disruptions could seriously harm our operations and financial condition and increase our costs and expenses. We rely on third-party manufacturers to produce our EVK-001. Our ability to obtain clinical supplies of EVK-001 could be disrupted, if the operations of these suppliers are affected by a man-made or natural disaster or other business interruption. Our operations are located in Solana Beach, California near major earthquake faults and fire zones. The ultimate impact on us, our significant suppliers and our general infrastructure of being located near major earthquake faults and fire zones and being consolidated in certain geographical areas is unknown, but our operations and financial condition could suffer in the event of a major earthquake, fire or other natural disaster.

If we fail to develop and commercialize other product candidates, we may be unable to grow our business.

As part of our growth strategy, we plan to evaluate the development and/or commercialization of other therapies for GI motility disorders. Similar to our initial focus on gastroparesis, we will evaluate opportunities to in-license or acquire other product candidates as well as commercial products to treat patients suffering from predominantly GI disorders, seeking to identify areas of high unmet medical needs with limited treatment options. These other product candidates will require additional, time-consuming development efforts prior to commercial sale, including preclinical studies, extensive clinical trials and approval by the FDA and applicable foreign regulatory authorities. All product candidates are prone to the risks of failure that are inherent in pharmaceutical product development, including the possibility that the drug candidate will not be shown to be sufficiently safe and/or effective for approval by regulatory authorities. In addition, we cannot assure you that any such products that are approved will be manufactured or produced economically, successfully commercialized or widely accepted in the marketplace or be more effective than other commercially available alternatives.

If we engage in an acquisition, reorganization or business combination, we will incur a variety of risks that could adversely affect our business operations or our stockholders.

From time to time we have considered, and we will continue to consider in the future, strategic business initiatives intended to further the development of our business. These initiatives may include acquiring businesses, technologies or products or entering into a business combination with another company. If we do pursue such a strategy, we could, among other things:

- issue equity securities that would dilute our current stockholders' percentage ownership;
- incur substantial debt that may place strains on our operations;
- spend substantial operational, financial and management resources in integrating new businesses, technologies and products; and
- assume substantial actual or contingent liabilities.

We may be unable to maintain sufficient product liability insurance.

Our inability to obtain and retain sufficient product liability insurance at an acceptable cost to protect against potential product liability claims could prevent or inhibit the commercialization of products we develop. We currently carry

product liability insurance covering our clinical studies. Although we maintain such insurance, any claim that may be brought against us could result in a court judgment or settlement in an amount that is not covered, in whole or in part, by our insurance or that is in excess of the limits of our insurance coverage. If we determine that it is prudent to increase our product liability coverage due to the commercial launch of any product, we may be unable to obtain such increased coverage on acceptable terms or at all. Our insurance policies also have various exclusions, and we may be subject to a product liability claim for which we have no coverage. We will have to pay any amounts awarded by a court or negotiated in a settlement that exceed our coverage limitations or that are not covered by our insurance, and we may not have, or be able to obtain, sufficient capital to pay such amounts.

Risks Relating to Our Intellectual Property

It is difficult and costly to protect our intellectual property rights, and we cannot ensure the protection of these rights. Any impairment of our intellectual property rights would materially affect our business.

We place considerable importance on obtaining patent protection for new technologies, products and processes because our commercial success will depend, in large part, on obtaining patent protection for new technologies, products and processes, successfully defending these patents against third-party challenges and successfully enforcing our patents against third party competitors. To that end, we have acquired and will file applications for patents covering formulations containing or uses of EVK-001 or our proprietary processes as well as other intellectual property important to our business. One of our patents related to EVK-001 was acquired from Questcor. This method of use patent was not written by us or our attorneys, and we did not have control over the drafting and prosecution of these patents. Further, Questcor and other predecessors might not have given the same attention to the drafting and prosecution of these patents and applications as we would have if we had been the owners of the patent and application and had control over the drafting and prosecution.

The patent position of biotechnology and pharmaceutical companies generally is highly uncertain and involves complex legal and factual questions for which legal principles remain unresolved. In recent years patent rights have been the subject of significant litigation, in particular due to inter partes review, introduced by the America Invents Act of 2012, which allows for quicker patent challenges decided by the U.S. Patent and Trademark Office's Patent Trial and Appeal Board rather than a lay jury. As a result, the issuance, scope, validity, enforceability and commercial value of our patent rights are highly uncertain. Our pending and future patent applications may not result in patents being issued which protect our technology or products or which effectively prevent others from commercializing competitive technologies and products. Changes in either the patent laws or interpretation of the patent laws in the United States and other countries may diminish the value of our patents or narrow the scope of our patent protection. The laws of foreign countries may not protect our rights to the same extent as the laws of the United States. Publications of discoveries in the scientific literature often lag behind the actual discoveries, and patent applications in the United States and other jurisdictions are typically not published until 18 months after filing, or in some cases not at all. Therefore, we cannot be certain that we or our predecessors were the first to make the inventions claimed in our owned and licensed patents or pending patent applications, or that we or our predecessors were the first to file for patent protection of such inventions One or more of these factors could possibly result in findings of invalidity or unenforceability of one or more of the patents we own.

The patent rights we own covering EVK-001 are limited to specific methods of use and formulations of metoclopramide. As a result, our ability to market EVK-001 may be limited by the lack of patent protection for the active ingredient itself and other metoclopramide formulations may be developed by competitors. The active ingredient in EVK-001 is metoclopramide. No patent protection is available for metoclopramide itself. As a result, competitors who develop and receive required regulatory approval for competing products using the same active ingredient as EVK-001 may market their competing products so long as they do not infringe any of the method or formulation patents owned by us.

Others have filed, and in the future are likely to file, patent applications covering products and technologies that are similar, identical or competitive to ours, or important to our business. We cannot be certain that any patent application owned by a third party will not have priority over patent applications filed or in-licensed by us, or that we will not be involved in interference, opposition or invalidity proceedings before U.S. or foreign patent offices.

We have focused our intellectual property efforts on the United States. To the extent that our patent portfolio differs from country to country outside the United States, this may make protecting EVK-001 as a product outside the United States even more difficult and unpredictable. Various countries maintain their own standards and interpretation of intellectual property law, potentially creating additional patent risk beyond even that experienced within the United States.

We also rely on trade secrets to protect technology in cases when we believe patent protection is not appropriate or obtainable. However, trade secrets are difficult to protect. While we require employees, consultants and other contractors to enter into confidentiality agreements, we may not be able to adequately protect our trade secrets or other proprietary information. Our research collaborators and scientific advisors may have rights to publish data and information in which we have rights. If we cannot maintain the confidentiality of our technology and other confidential information in connection with our collaborators and advisors, our ability to receive patent protection or protect our proprietary information may be imperiled.

Claims by third parties that we infringe their proprietary rights may result in liability for damages or prevent or delay our developmental and commercialization efforts.

The biotechnology industry has been characterized by frequent litigation regarding patent and other intellectual property rights. Because patent applications are maintained in secrecy until the application is published, we may be unaware of third party patents that may be infringed by commercialization of EVK-001. In addition, identification of third party patent rights that may be relevant to our technology is difficult because patent searching is imperfect due to differences in terminology among patents, incomplete databases and the difficulty in assessing the meaning of patent claims. Any claims of patent infringement asserted by third parties would be time

consuming and could likely:

- result in costly litigation;
- divert the time and attention of our technical personnel and management;
- cause development delays;
- prevent us from commercializing EVK-001 until the asserted patent expires or is held finally invalid or not infringed in a court of law;
- require us to develop non-infringing technology; or
- require us to enter into royalty or licensing agreements.

Although no third party has asserted a claim of infringement against us, others may hold proprietary rights that could prevent EVK-001 from being marketed. Any patent-related legal action against us claiming damages or seeking to enjoin commercial activities relating to our product candidate or processes could subject us to potential liability for damages and could require us to obtain a license to continue to manufacture or market EVK-001, or, if no such license were available on commercially viable terms, could require us to cease manufacturing and marketing of EVK-001. We cannot predict whether we would prevail in any such actions or that any license required under any of these patents would be made available on commercially acceptable terms, if at all. In addition, we cannot be sure that we could redesign our product candidate or processes to avoid infringement, if necessary. Accordingly, an adverse determination in a judicial or administrative proceeding, or the failure to obtain necessary licenses, could prevent us from developing and commercializing EVK-001, which could harm our business, financial condition and operating results. Whatever the outcome, any patent litigation would be costly and time consuming, could be distracting to our management, and could have a material adverse effect on our business.

We may be subject to claims that we have wrongfully hired an employee from a competitor or that we or our employees have wrongfully used or disclosed alleged confidential information or trade secrets of their former employers.

As is commonplace in our industry, we employ and consult with individuals who were previously employed at other biotechnology or pharmaceutical companies, including our competitors or potential competitors. Although no claims against us are currently pending, we may be subject in the future to claims that our employees or consultants are subject to a continuing obligation to their former employers or clients (such as non-competition or non-solicitation obligations) or claims that our employees, our consultants or we have inadvertently or otherwise used or disclosed trade secrets or other proprietary information of their former employers or clients. Litigation may be necessary to defend against these claims. Even if we are successful in defending against these claims, litigation could result in substantial costs and be a distraction to management.

Risks Related to Our Financial Position and Need for Capital

Our recurring losses from operations have raised substantial doubt regarding our ability to continue as a going concern.

Our recurring losses from operations raise substantial doubt about our ability to continue as a going concern, and as a result, our independent registered public accounting firm included an explanatory paragraph in its report on our financial statements as of and for the year ended December 31, 2015 with respect to this uncertainty. This going concern opinion could materially limit our ability to raise additional funds through the issuance of new debt or equity securities or otherwise. Future reports on our financial statements may also include an explanatory paragraph with respect to our ability to continue as a going concern. We have incurred significant losses since our inception and have never been profitable, and it is possible we will never achieve profitability. We have devoted our resources to developing our product candidate, but it cannot be marketed until regulatory approvals have been obtained. Based upon our currently expected level of operating expenditures, we expect to be able to fund our operations through October 2016. This period could be shortened if there are any significant increases in planned spending on our EVK-001 development program or more rapid progress of our ongoing Phase 3 clinical trial than anticipated. There is

no assurance that other financing will be available when needed to allow us to continue as a going concern. The perception that we may not be able to continue as a going concern may cause others to choose not to deal with us due to concerns about our ability to meet our contractual obligations.

We have incurred significant operating losses since inception, and we expect to incur losses for the foreseeable future. We may never become profitable or, if achieved, be able to sustain profitability.

We have incurred significant operating losses since we were founded in 2007 and expect to incur significant losses for the next several years related to completing our Phase 3 clinical trial for EVK-001, and seeking regulatory approval from the FDA to manufacture and commercialize EVK-001. Our net loss for the year ended December 31, 2015, was approximately $12.1 million. As of December 31, 2015, we had an accumulated deficit of approximately $48.1 million. Losses have resulted principally from costs incurred in our clinical trials, research and development programs and from our general and administrative expenses, especially since we became a public company in September 2013. In the future, we intend to continue to conduct research and development, clinical testing,

regulatory compliance activities and, if EVK-001 is approved, sales and marketing activities that, together with anticipated general and administrative expenses, will likely result in our incurring further significant losses for the next several years.

We currently generate no revenue from sales, and we may never be able to commercialize EVK-001 or other marketable drugs. As a result, there can be no assurance that we will ever generate revenues or achieve profitability, which could impair our ability to sustain operations or obtain any required additional funding. If we achieve profitability in the future, we may not be able to sustain profitability in subsequent periods.

If we fail to obtain the capital necessary to fund our operations, we will be unable to successfully develop and commercialize EVK-001.

We will require substantial additional future capital in order to finance additional development requirements requested by the FDA, as well as for NDA preparation and pre-commercial activities, including marketing and manufacturing of EVK-001. The amount and timing of any expenditure needed to implement our development and commercialization programs will depend on numerous factors, including:

- the progress, costs, results of and timing of our clinical development program for EVK-001, including our ongoing Phase 3 clinical trial;
- the need for, and the progress, costs and results of, any additional clinical trials of EVK-001 we may initiate based on the results of our planned and ongoing clinical trials or discussions with the FDA, including any additional trials the FDA or other regulatory agencies may require evaluating the safety of EVK-001;
- the outcome, costs and timing of seeking and obtaining regulatory approvals from the FDA, and any similar regulatory agencies;
- the timing and costs associated with manufacturing EVK-001 for clinical trials and other studies and, if approved, for commercial sale;
- our need and ability to hire additional management, development and scientific personnel;
- the cost to maintain, expand and defend the scope of our intellectual property portfolio, including the amount and timing of any payments we may be required to make, or that we may receive, in connection with licensing, filing, prosecution, defense and enforcement of any patents or other intellectual property rights;
- the timing and costs associated with establishing sales and marketing capabilities;
- market acceptance of EVK-001;
- the extent to which we are required to pay milestone or other payments under our Mallinckrodt asset purchase agreement and the timing of such payments;
- the costs of acquiring, licensing or investing in additional businesses, products, product candidates and technologies; and
- our need to implement additional internal systems and infrastructure, including financial and reporting systems.

Some of these factors are outside of our control. We cannot provide any assurance that our existing capital resources will be sufficient to enable us to fund the completion of our Phase 3 clinical trial and remaining development program, and, in any event, we will need to raise additional capital to submit marketing applications for and prepare for commercialization of EVK-001 should we receive product approval. We may need to raise additional funds in the near future to complete development activities for EVK-001.

We may seek additional funding through collaboration agreements and public or private financings. For example, in November 2014 we entered into a sales agreement, or the Sales Agreement, with MLV & Co. LLC, or MLV, pursuant to which we may sell from time to time, at our option, up to an aggregate of $6.6 million of shares of our common stock through MLV, as sales agent. During September 2015, FBR & Co., or FBR, acquired MLV and assumed its rights and obligations under the Sales Agreement. Sales of our common stock made pursuant to the Sales Agreement are made on The NASDAQ Capital Market under our shelf registration statement on Form S-3 filed on November 13, 2014, which was declared effective by the SEC on November 25, 2014, by means of ordinary brokers' transactions at

market prices. Although sales of our common stock have taken place pursuant to the Sales Agreement, there can be no assurance that FBR will be successful in consummating future sales based on prevailing market conditions or in the quantities or at the prices that we deem appropriate. Under current SEC regulations, at any time during which the aggregate market value of our common stock held by non-affiliates, or public float, is less than $75.0 million, the amount we can raise through primary public offerings of securities in any twelve-month period using shelf registration statements, including sales under the Sales Agreement, is limited to an aggregate of one-third of our public float. As of February 29, 2016, our public float was 4.1 million shares, the value of which was $14.6 million based upon the closing price of our common stock of $3.57 on February 22, 2016. The value of one-third of our public float calculated on the same basis was $4.8 million. We are unable to sell any further shares of common stock pursuant to the Sales Agreement due to current capacity restrictions. Furthermore, FBR is permitted to terminate the Sales Agreement

in its sole discretion upon ten days' notice, or at any time in certain circumstances, including the occurrence of an event that would be reasonably likely to have a material adverse effect on our assets, business, operations, earnings, properties, condition (financial or otherwise), prospects, stockholders' equity or results of operations.

Additional funding may not be available to us on acceptable terms or at all. In addition, the terms of any financing may adversely affect the holdings or the rights of our stockholders. In addition, the issuance of additional shares by us, or the possibility of such issuance, may cause the market price of our shares to decline and dilute the holdings of our existing stockholders.

If we are unable to obtain funding on a timely basis, if required, we will be unable to complete the ongoing Phase 3 clinical trial for EVK-001 and may be required to significantly curtail all of our activities. We also could be required to seek funds through arrangements with collaborative partners or otherwise that may require us to relinquish rights to our product candidate or some of our technologies or otherwise agree to terms unfavorable to us.

The terms of our secured debt facility require us to meet certain operating and financial covenants and place restrictions on our operating and financial flexibility. If we raise additional capital through debt financing, the terms of any new debt could further restrict our ability to operate our business.

We have a $4.5 million loan and security agreement with Square 1 Bank, a division of Pacific Western Bank, or Square 1, that is secured by a lien covering substantially all of our personal property, excluding intellectual property. On December 31, 2014, we drew the entire $4.5 million line. The credit facility contains affirmative and negative covenants applicable to us and any subsidiaries we create in the future. The affirmative covenants include, among others, covenants requiring us to maintain our legal existence and governmental approvals, deliver certain financial reports, maintain insurance coverage and meet certain covenants with respect to enrollment and results of our Phase 3 trial for EVK-001. The negative covenants include, among others, restrictions on transferring collateral, incurring additional indebtedness, engaging in mergers or acquisitions, paying dividends or making other distributions, making investments, creating liens and selling assets, in each case subject to certain exceptions. The credit facility also includes events of default, the occurrence and continuation of which provide Square 1 with the right to exercise remedies against us and the collateral securing the term loans under the credit facility, including foreclosure against our properties securing the credit facilities, including our cash. These events of default include, among other things, our failure to pay any amounts due under the credit facility, a breach of covenants under the credit facility, our insolvency, a material adverse change, the occurrence of any default under certain other indebtedness in an amount greater than $400,000 and a final judgment against us in an amount greater than $400,000. Square 1 could declare a default upon the occurrence of any event that they interpret as a material adverse change as defined under the loan agreement, thereby requiring us to repay the loan immediately or to attempt to reverse the declaration of default through negotiation or litigation. Any declaration by the lender of an event of default could significantly harm our business and prospects and could cause the price of our common stock to decline. If we raise any additional debt financing, the terms of such additional debt could further restrict our operating and financial flexibility.

Our ability to use net operating loss and tax credit carryforwards and certain built-in losses to reduce future tax payments is limited by provisions of the Internal Revenue Code, and may be subject to further limitation as a result of the transactions completed in connection with our initial public offering.

Under Section 382 of the Internal Revenue Code of 1986, as amended, if a corporation undergoes an "ownership change" (generally defined as a greater than 50% change (by value) in its equity ownership over a three year period), the corporation's ability to use its pre-change net operating loss carryforwards and other pre-change tax attributes to offset its post-change income may be limited. As a result of our initial public offering, our most recent private placement and other transactions that have occurred over the past three years, we may have experienced an "ownership change." We may also experience ownership changes in the future as a result of subsequent shifts in our stock ownership. As of December 31, 2015, we had federal and state net operating loss carryforwards of approximately $43.9 million and $42.9 million, respectively, and federal research and development credits of approximately $1.5

million which could be limited if we experience an “ownership change.”

Risks Related to Ownership of Our Common Stock

An active trading market for our common stock may not develop or be sustained.

Prior to our initial public offering in September 2013, there was no public market for our common stock. An active trading market may never develop or be sustained. If an active trading market does not develop or is not sustained, it may be difficult to sell shares of our common stock at a price that is desirable or at all. In addition, an inactive market may impair our ability to raise capital by selling shares and may impair our ability to acquire other companies or technologies by using our shares as consideration, which, in turn, could materially adversely affect our business. Since the commencement of trading in connection with our initial public offering in September 2013 through February 29, 2016, the sale price per share of our common stock on The NASDAQ Capital Market has ranged from a low of $2.37 to a high of $14.25.

The price of the shares of our common stock could be highly volatile, and purchasers of our common stock could incur substantial losses.

Our stock price is likely to be volatile and could be subject to wide fluctuations in response to various factors, some of which are beyond our control. The stock market in general and the market for biotechnology companies in particular have experienced extreme volatility that has often been unrelated to the operating performance of particular companies. As a result of this volatility, investors may not be able to sell their common stock at or above the price at which they purchased the shares. The market price for our common stock may be influenced by many factors, including:

- our ability to enroll patients in our ongoing Phase 3 clinical trial;
- results of the clinical trial, and the results of trials of our competitors or those of other companies in our market sector;
- regulatory developments in the United States and foreign countries;
- variations in our financial results or those of companies that are perceived to be similar to us;
- changes in the structure of healthcare payment systems, especially in light of current reforms to the U.S. healthcare system;
- announcements by us or our competitors of significant acquisitions, strategic partnerships, joint ventures or capital commitments;
- market conditions in the pharmaceutical and biotechnology sectors and issuance of securities analysts' reports or recommendations;
- sales of our stock by insiders and 5% stockholders;
- trading volume of our common stock;
- general economic, industry and market conditions other events or factors, many of which are beyond our control;
- additions or departures of key personnel; and
- intellectual property, product liability or other litigation against us.

In addition, in the past, stockholders have initiated class action lawsuits against biotechnology and pharmaceutical companies following periods of volatility in the market prices of these companies' stock. Such litigation, if instituted against us, could cause us to incur substantial costs and divert management's attention and resources, which could have a material adverse effect on our business, financial condition and results of operations.

Our quarterly operating results may fluctuate significantly.

We expect our operating results to be subject to quarterly fluctuations. Our net loss and other operating results will be affected by numerous factors, including:

- variations in the level of expenses related to our EVK-001 development program;
- addition or termination of clinical trials;
- any intellectual property infringement lawsuit in which we may become involved;
- regulatory developments affecting EVK-001; and
- our execution of any collaborative, licensing or similar arrangements, and the timing of payments we may make or receive under these arrangements.

If our quarterly operating results fall below the expectations of investors or securities analysts, the price of our common stock could decline substantially. Furthermore, any quarterly fluctuations in our operating results may, in turn, cause the price of our stock to fluctuate substantially.

Our principal stockholders and management own a significant percentage of our stock and will be able to exert significant control over matters subject to stockholder approval.

As of February 29, 2016, our executive officers, directors and greater than 5% stockholders, in the aggregate, owned 43.2% of our outstanding common stock. As a result, such persons, acting together, will have the ability to control our management and affairs and substantially all matters submitted to our stockholders for approval, including the election and removal of directors and approval of any significant transaction. These persons will also have the ability to control our management and business affairs. This concentration of ownership may have the effect of delaying, deferring or preventing a change in control, impeding a merger, consolidation, takeover

or other business combination involving us, or discouraging a potential acquirer from making a tender offer or otherwise attempting to obtain control of our business, even if such a transaction would benefit other stockholders.

Anti-takeover provisions in our charter documents and under Delaware law could make an acquisition of us, which may be beneficial to our stockholders, more difficult and may prevent attempts by our stockholders to replace or remove our current management.

Provisions in our amended and restated certificate of incorporation and amended and restated bylaws may delay or prevent an acquisition of us or a change in our management. These provisions include:

- authorizing the issuance of "blank check" preferred stock, the terms of which may be established and shares of which may be issued without stockholder approval;
- limiting the removal of directors by the stockholders;
- creating a staggered board of directors;
- prohibiting stockholder action by written consent, thereby requiring all stockholder actions to be taken at a meeting of our stockholders;
- eliminating the ability of stockholders to call a special meeting of stockholders;
- permitting our board of directors to accelerate the vesting of outstanding option grants upon certain transactions that result in a change of control; and
- establishing advance notice requirements for nominations for election to the board of directors or for proposing matters that can be acted upon at stockholder meetings.

In addition, because we are incorporated in Delaware, we are governed by the provisions of Section 203 of the Delaware General Corporation Law, which limits the ability of stockholders owning in excess of 15% of our outstanding voting stock to merge or combine with us. Although we believe these provisions collectively provide for an opportunity to obtain greater value for stockholders by requiring potential acquirors to negotiate with our board of directors, they would apply even if an offer rejected by our board were considered beneficial by some stockholders. In addition, these provisions may frustrate or prevent any attempts by our stockholders to replace or remove our current management by making it more difficult for stockholders to replace members of our board of directors, which is responsible for appointing the members of our management.

We do not intend to pay dividends on our common stock and, consequently, the ability of our stockholders to achieve a return on their investment will depend on appreciation in the price of our common stock.

We have never declared or paid any cash dividend on our common stock and do not currently intend to do so for the foreseeable future. We currently anticipate that we will retain future earnings for the development, operation and expansion of our business. In addition, our loan and security agreement with Square 1 currently prohibits us from paying dividends on our equity securities, and any future debt financing arrangement may contain terms prohibiting or limiting the amount of dividends that may be declared or paid on our common stock. Any return to stockholders will therefore be limited to the appreciation of their stock. Therefore, the success of an investment in shares of our common stock will depend upon any future appreciation in their value. There is no guarantee that shares of our common stock will appreciate in value or even maintain the price at which our stockholders have purchased their shares.

Sales of a substantial number of shares of our common stock by our existing stockholders in the public market could cause our stock price to fall.

Persons who were our stockholders prior to the sale of shares in our initial public offering in September 2013 continue to hold a substantial number of shares of our common stock that they are able to sell in the public market, subject in some cases to certain legal restrictions. Significant portions of these shares are held by a small number of stockholders. Sales of a substantial number of shares of our common stock in the public market, or the perception that these sales might occur, could significantly reduce the market price of our common stock and impair our ability to

raise adequate capital through the sale of additional equity securities.

As of February 29, 2016, we had 7,201,774 shares of common stock outstanding. All of these shares are freely tradable without restriction in the public market, except for 3,112,527 shares that are held by directors, executive officers and other affiliates that are subject to volume limitations under Rule 144 under the Securities Act. In addition, shares of common stock that are either subject to outstanding options or reserved for future issuance under our employee benefit plans will become eligible for sale in the public market to the extent permitted by the provisions of various vesting schedules and Rule 144 and Rule 701 under the Securities Act. If these additional shares of common stock are sold, or if it is perceived that they will be sold, in the public market, the trading price of our common stock could decline.

As of February 29, 2016, the holders of 2,590,564 shares of our common stock are entitled to reasonable best efforts registration rights with respect to the registration of their shares under the Securities Act. In addition, holders of 84,000 shares of common stock issuable upon the exercise of warrants are also entitled to reasonable best efforts registration rights with respect to the registration of their shares under the Securities Act. Registration of these shares under the Securities Act would result in the shares becoming freely tradable without restriction under the Securities Act, except for shares held by affiliates, as defined in Rule 144 under the Securities Act. Any sales of securities by these stockholders could have a material adverse effect on the trading price of our common stock.

We are an emerging growth company, and we cannot be certain if the reduced reporting requirements applicable to emerging growth companies will make our common stock less attractive to investors.

We are an emerging growth company, as defined in the Jumpstart Our Business Startups Act of 2012, or the JOBS Act. For as long as we continue to be an emerging growth company, we may take advantage of exemptions from various reporting requirements that are applicable to other public companies that are not emerging growth companies, including not being required to comply with the auditor attestation requirements of Section 404 of the Sarbanes-Oxley Act of 2002, or the Sarbanes-Oxley Act, reduced disclosure obligations regarding executive compensation in our periodic reports and proxy statements and exemptions from the requirements of holding nonbinding advisory votes on executive compensation and stockholder approval of any golden parachute payments not previously approved. We could be an emerging growth company for up to five years following 2013, the year in which we completed our initial public offering, although circumstances could cause us to lose that status earlier, including if the market value of our common stock held by non-affiliates exceeds $700.0 million as of any June 30 before that time or if we have total annual gross revenue of $1.0 billion or more during any fiscal year before that time, in which cases we would no longer be an emerging growth company as of the following December 31 or, if we issue more than $1.0 billion in non-convertible debt during any three year period before that time, we would cease to be an emerging growth company immediately. Even after we no longer qualify as an emerging growth company, we may still qualify as a “smaller reporting company” which would allow us to take advantage of many of the same exemptions from disclosure requirements including not being required to comply with the auditor attestation requirements of Section 404 of the Sarbanes-Oxley Act and reduced disclosure obligations regarding executive compensation in our periodic reports and proxy statements. We cannot predict if investors will find our common stock less attractive because we may rely on these exemptions. If some investors find our common stock less attractive as a result, there may be a less active trading market for our common stock and our stock price may be more volatile.

Under the JOBS Act, emerging growth companies can also delay adopting new or revised accounting standards until such time as those standards apply to private companies. We have irrevocably elected not to avail ourselves of this exemption from new or revised accounting standards and, therefore, will be subject to the same new or revised accounting standards as other public companies that are not emerging growth companies. As a result, changes in rules of U.S. generally accepted accounting principles or their interpretation, the adoption of new guidance or the application of existing guidance to changes in our business could significantly affect our financial position and results of operations.

We will continue to incur significant increased costs as a result of operating as a public company, and our management will be required to devote substantial time to new compliance initiatives.

As a public company, we have incurred and will continue to incur significant legal, accounting and other expenses under the Sarbanes-Oxley Act and the Dodd-Frank Wall Street Reform and Consumer Protection Act, as well as rules adopted by the SEC and The NASDAQ Stock Market. These rules impose significant requirements on public companies, including requiring establishment and maintenance of effective disclosure and financial controls, changes in corporate governance practices, proxy access and “say on pay” votes. As an “emerging growth company,” we are permitted to implement many of these requirements over a longer period of time. While we are taking advantage of this option to delay implementation, we cannot guarantee that we will not be required to implement these requirements sooner than budgeted or planned and thereby incur unexpected expenses. Stockholder activism, the

current political environment and the current high level of government intervention and regulatory reform may lead to substantial new regulations and disclosure obligations, which may lead to additional compliance costs and impact the manner in which we operate our business in ways we cannot currently anticipate.

We expect the rules and regulations applicable to public companies to substantially increase our legal and financial compliance costs and to make some activities more time-consuming and costly. If these requirements divert the attention of our management and personnel from other business concerns, they could have a material adverse effect on our business, financial condition and results of operations. The increased costs will decrease our net income or increase our net loss, and may require us to reduce costs in other areas of our business or increase the prices of our products or services. For example, we expect these rules and regulations to make it more difficult and more expensive for us to obtain director and officer liability insurance and we may be required to incur substantial costs to maintain the same or similar coverage. We cannot predict or estimate the amount or timing of additional costs we may incur to respond to these requirements. The impact of these requirements could also make it more difficult for us to attract and retain qualified persons to serve on our board of directors, our board committees or as executive officers.

If securities or industry analysts publish unfavorable research or reports about our business, our stock price and trading volume could decline.

The trading market for our common stock depends in part on the research and reports that securities or industry analysts publish about us, our business, our market or our competitors. We currently have limited research coverage by securities and industry analysts. If one or more of the analysts who covers us downgrades our stock, our stock price would likely decline. If one or more of these analysts ceases to cover us or fails to regularly publish reports on us, interest in our stock could decrease, which could cause our stock price or trading volume to decline.

We could be subject to securities class action litigation.

In the past, securities class action litigation has often been brought against a company following a decline in the market price of its securities. This risk is especially relevant for us because pharmaceutical companies have experienced significant stock price volatility in recent years. If we face such litigation, it could result in substantial costs and a diversion of management's attention and resources, which could harm our business.

Item 1B. Unresolved Staff Comments

Not applicable.

Item 2. Properties

We occupy approximately 2,741 square feet of office space in Solana Beach, California under a lease that we entered into in November 2013. This facility lease expires in December 2016. We believe that our facility is adequate to meet our needs and that, if necessary, additional space can be leased to accommodate any future growth on commercially reasonable terms.

Item 3. Legal Proceedings

We are not currently a party to any material legal proceedings.

Item 4. Mine Safety Disclosures

Not Applicable.

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PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

Market Information

Our common stock has been traded on the NASDAQ Capital Market since September 25, 2013 under the symbol "EVOK." Prior to such time, there was no public market for our common stock. The following table sets forth the high and low sales price of our common stock, as reported by the NASDAQ Capital Market for the period indicated:

	High	Low
Year Ended December 31, 2015		
Fourth Quarter	$4.57	$2.88
Third Quarter	$7.17	$