BERNSTEIN

27 November 2018
Estimate Change

Wimal Kapadia
+44-207-170-5153
wimal.kapadia@bernstein.com

Rushee Jolly
+44-207-170-0516
rushee.jolly@bernstein.com

Emma-Kate Ryan
+44-207-170-0602
emma-kate.ryan@bernstein.com

European Specialty Pharma & Biotech

Galapagos NV

Rating

Outperform

Target Price

GLPG.NA **122.00 EUR**

Galapagos: Thoughts from the GLPG symposium on IPF - GLPG's game changer waiting in the wings

We attended the GLPG idiopathic pulmonary fibrosis (IPF) scientific symposium in Basel yesterday aimed at drawing attention to the Company's IPF portfolio. We provide our takeaways here (and update our GLPG model post the ABBV CF deal).

IPF is the game changer for GLPG. IPF is a severe, progressive lung disease marked by a highly variable clinical course which makes a confident diagnosis challenging to achieve. Under-analysed and under-appreciated, GLPG have a broad IPF portfolio of assets with GLPG1690 moving into p3 (1st patient recently screened). The unmet need is high with current treatments plagued by tolerability issues that limit use. Initial p2 data suggests the product should do well although this is a very high-risk program and trial certainty is limited (patient outcomes highly variable) - see our recent initiation for our detailed analysis (link). With full ownership, our sales estimates of €1.3B in 2030 (at 30% prob.) suggest IPF is as important as filgotinib. The way we see it, get an approval and the drugs will sell.

GLPG can benefit from advances in IPF and opportunities beyond. (i) Biomarker approaches may not be far off (efficacy metrics beyond FVC, may allow for earlier diagnosis). (ii) Combinations of current SoC may be additive, but are limited by tolerability. With a low bar, GLPG1690 combinations are likely to be better. (iii) IPF may be the tip of the iceberg and only accounts for ~1/3 of fibrotic lung diseases, indicating opportunities beyond IPF if successful, although some way off (no FDA approved endpoints, patient population poorly characterised for clinical trials). PoC of GLPG1690 in SSc to read out before end of 2018.

Investment Implications

We like Galapagos for filgotinib near-term and IPF longer-term. The risk-reward for our filgotinib estimates remain to the upside (given our conservative approach), IPF is under-appreciated and Galapagos is catalyst rich. We rate GLPG O/P - PT €122.

Close Date	26-Nov-2018
GLPG.NA Close Price (EUR)	88.04
Target Price (EUR)	122.00
Upside/(Downside)	39%
52-Week Low	70.64
52-Week High	105.35
MSDLE15	1,487.17
FYE	Dec
Indicated Div Yield	NA
Market Cap (EUR) (M)	4,792
EV (EUR) (M)	3,449

Performance	YTD	1M	6M	12M
Absolute (%)	11.5	2.9	1.9	14.3
MSDLE15 (%)	(8.0)	1.7	(7.9)	(7.5)
Relative (%)	19.5	1.2	9.8	21.8

Analyst Page
Bernstein Events
Company Page

EPS Adjusted	F17A	F18E	F19E
GLPG.NA (EUR)	(2.34)	**(2.05)**	**(3.29)**
OLD		(2.99)	(3.62)
MSDLE15	101.50	108.92	118.99

Financials	F17A	F18E	F19E	CAGR
Revenues (M)	156	268	203	14.2%
EBIT (M)	(90)	(117)	(184)	NA
Net Earnings (M)	(116)	(107)	(180)	NA

Valuation Metrics	F17A	F18E	F19E
P/E Adjusted (x)	(37.62)	(42.88)	(26.74)

DETAILS

IPF is surprisingly an area of limited focus for investors but one that we view as potentially game changing (we dug deep into IPF in our initiation - Galapagos: Buy now for filgotinib but own long-term for IPF - Initiate Outperform). Galapagos have a broad IPF portfolio of assets with differing mechanisms but only one asset (GLPG1690) has demonstrated proof of concept – yesterday's scientific symposium was aimed at drawing investor focus to what lies beyond Filgotinib. We provide our key takeaways below.

The first session served as an introduction to IPF. Briefly, IPF is a serious, progressive disease involving fibrosis (scarring) of the lungs that eventually leads to respiratory failure and death. Some tidbits from the presentation that provided additional colour on the background to IPF: (i) Prognosis for the disease is poor with median survival post diagnosis typically ~3-3.5yrs and 5 year survival rates at ~20%, on par with some of the more nefarious cancers. Furthermore, incidence of IPF is increasing (~2.5k new cases in the UK in 1990 vs ~6k in 2010). To give some context, there are ~5k IPF related fatalities per year in the UK, which represents close to 1% of all deaths in the UK. Quite some stat. (ii) SoC is insufficient and the only approved products (Ofev, Esbriet) are plagued by GI side effects. Lung transplant, the only curative treatment, is only suitable for very few patients (~350 transplants in the UK per year out of ~6k new cases). (iii) Disease understanding is starting to grow and whilst genetic, environmental and immune factors are implicated, IPF ultimately is likely to start with lung injury (epithelial damage) and may represent premature ageing of the lungs. (iv) The disease is heterogenous and there are broadly three categories of patients - rapidly progressive, indolent and "average" patients who typically lose ~10% FVC p.a. About 5% of patients have an acute exacerbation (sudden, rapid step down in FVC), of which about ~50% will die in a matter of weeks. (v) FVC is a validated FDA endpoint for clinical trials and whilst studies have shown that improvements in FVC correlate with an overall survival benefit, this is still some way away from normal life expectancy. As an aside, the primary endpoint of the ISABELA p3 trials is FVC and the trial design was approved by both FDA/EMA.

The more interesting points to us were:

+ *Biomarker approaches may not be that far off in IPF.* The PROFILE study (started prior to Ofev and Esbriet were on the market) correlated certain protein markers (e.g. collagen) with IPF patient outcomes. A newer biomarker trial (INMARK), which will include biomarker changes to subsequently approved anti-fibrotics is currently ongoing. This raises the possibility of being able to adopt a biomarker approach to IPF treatment (i.e. who responds to what) and GLPG will aim to include assessments for any relevant biomarkers identified from the INMARK trial into their p3 for GLPG1690, and may mean metrics beyond FVC could be used in any potential submission. As an aside, we think that any biomarkers in IPF can only be a good thing. The disease is typically diagnosed late, and often by a process of elimination - a reliable biomarker would allow for easier diagnosis which means that patients can potentially start on disease modifying drugs earlier on.

+ *Combinations unlikely for current treatments, but almost a certainty for GLPG1690.* Based on two small, 12-week combination trials with Ofev on top of Esbriet (and vice-versa), the drugs were shown to be additive in terms of efficacy. However, tolerability was unsurprisingly an issue and less than 50% of patients completed the 12-week trial on both drugs. With the p3 ISABELA trials for GLPG1690 on top of SoC (mono p3 trial design was rejected by FDA), the drug will almost certainly be used in combination. Given the seemingly superior tolerability for GLPG1690, combination usage is much less likely to cause the same degree of issues and with another differing mechanism (ATX), we could well expect to see incremental efficacy. Furthermore, Esbriet will go generic in 2026 and Ofev most likely in 2024, and so we will have a cheaper generic backbone on the market not long after GLPG1690 could potentially launch.

+ *There remains potential for wider use of anti-fibrotics, but it's some way off.* As we have previously highlighted, anti-fibrotic agents could be used in other scarring diseases of the lung that result in respiratory failure (eg. RA-associated fibrosis, farmers lung, asbestos lung injury etc). IPF is potentially the tip of the iceberg here as it only represents ~1/3 of fibrotic lung diseases, the rest of which are treated with immunosuppressants despite a lack of supportive clinical evidence. The p3 PF-ILD trial (NCT02999178, readout late 2019) aims to assess the potential of Ofev across various ILDs and could be hugely significant in widening anti-fibrotic usage. However, we note that this is very much one for the future as (i) There is no FDA-approved clinical endpoint for other lung scarring diseases (unlike FVC in IPF), and (ii) Very little is known about the clinical course / characteristics of these patients and understanding is akin to IPF 15 years ago (this doesn't mean anti-fibrotic drugs won't work, the trial design to accommodate patient heterogeneity is just some time away).

Very little on GLPG1690 (we need to wait!). (i) Several mechanistic advantages of the drug vs competition. Firstly, by acting on ATX, GLPG1690 reduces LPA which acts on 6+ GPCRs (you need this broad activity as single target agents have failed in fibrosis). Secondly, GLPG1690 has dual action (LPA and indirectly on connective tissue growth factor [CTGF]), which GLPG believe that it explains why it works well in IPF. (ii) We have a long time to wait - the first patient has been screened in the