ARROWHEAD PHARMACEUTICALS

Fiscal 2023 Second Quarter Conference Call – Prepared Remarks

May 2, 2023

1:30 PM Pacific time

Operator

Ladies and gentlemen welcome to the Arrowhead Pharmaceuticals conference call. Throughout today's recorded presentation all participants will be in a listen-only mode. After the presentation, there will be an opportunity to ask questions. I will now hand the conference call over to Vincent Anzalone, Vice President of Investor Relations for Arrowhead. Please go-ahead Vince.

Vince Anzalone

Good afternoon and thank you for joining us today to discuss Arrowhead's results for its fiscal 2023 second quarter ended March 31, 2023.

With us today from management are president and CEO Dr. Christopher Anzalone, who will provide an overview of the quarter; Dr. Javier San Martin, our chief medical officer, who will provide an update on our mid and later stage clinical pipeline; Dr. James Hamilton, our Chief of Discovery & Translational Medicine, who will provide an update on our earlier stage programs; and Ken Myszkowski, our chief financial officer, who will give a review of the financials. In addition, Tracie Oliver, our chief commercial officer, and Patrick O'Brien, our chief operating officer and general counsel, will be available during the Q&A portion of the call.

Before we begin, I would like to remind you that comments made during today's call contain certain forward-looking statements within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934. All statements other than statements of historical fact are forward-looking statements and are subject to numerous risks and uncertainties that could cause actual results to differ materially from those expressed in any forward-looking statements. For further details concerning these risks and uncertainties, please refer to our SEC filings, including our most recent annual report on Form 10-K and our quarterly reports on Form 10-Q.

I'd now like to turn the call over to Christopher Anzalone, President and CEO of the Company. Chris?

Chris Anzalone

Thanks Vince. Good afternoon everyone and thank you for joining us today.

In 2017, we introduced our proprietary TRiM platform. We believed then that it could become an industry-leading RNAi platform for hepatocyte-focused therapies and, importantly, one that could bring RNAi outside the liver. This was based entirely on our confidence in the potential of the science: at the time we had no clinical programs, a single partner, and our stock was trading for less than 2 dollars.

Six years later, we have:

- 12 individual drug candidates in clinical studies targeting 2 different organ systems,
- three ongoing Phase 3 studies,
- 5 strong partners,
- a healthy balance sheet,
- and reason to believe that the next 6 years will be characterized by even more rapid growth.

We expect to have at least 14 drug candidates in clinical studies by the end of this year, targeting 3 different organ systems: liver, lung, and CNS. Skeletal muscle-targeting programs could grow this to 16 individual drug candidates across 4 different organ systems in 2023, but partnering opportunities make that a bit more difficult to predict and I will touch on that later in the call. We are well on our way to reaching our "20 in 25" goal to grow our pipeline of RNAi therapeutics to a total of 20 clinical stage or marketed products in the year 2025. I do not believe there is a company on the planet that will match this.

We've made substantial progress over the past quarter and since our last call. Let's start with pulmonary.

We recently disclosed early topline data for ARO-RAGE in normal healthy volunteers. The data were very encouraging and indicated a high level of target gene knockdown with a long duration of effect, in a well-tolerated manner. James will talk about these data in a moment, but I want to put this into context. I believe that Arrowhead is the first company to ever show RNAi mediated target gene knockdown in the lung. Even more impressive was the magnitude of response. We didn't just get on the board, we saw up to 90% knockdown in serum after just two

inhaled doses at the 4th of 5 planned dose levels. We do not yet have data from the highest single or multiple dose cohorts. It appears that the pulmonary platform is doing what it was designed to do and ARO-RAGE appears to be highly potent. I expect the durability to enable monthly or less frequent dosing.

We've often said that clinical validation of the lung platform could mark the beginning of a second rapid wave of growth for our company. Cells don't care what the sequence of an RNAi drug is. Once we find that reducing expression of a specific target gene can be done in a well-tolerated manner, we have a high degree of confidence we can replicate it with any number of new gene targets, much as we have done in the liver. That is where we may be with the pulmonary franchise. I think the data we reported and the additional data we expect to present at the R&D Day on June 1st represent the initial clinical validation we were hoping for. This is a big deal. I fully expect that in the near- to mid-term we will have several potentially important new drug candidates targeting the lung that could address grinding, unmet medical needs.

ARO-MUC5AC will be our next pulmonary data set, and I expect that we will have some normal healthy volunteer data by the R&D Day. These two programs continue to move forward and both have progressed into Part 2 of the Phase 1/2 studies where asthma patients are treated. We hope to have some data from the patient portion of the studies by the end of the year.

Rounding out our current pulmonary pipeline is ARO-MMP7. During the last quarter, we initiated a Phase 1/2 study for the treatment of idiopathic pulmonary fibrosis, and we are currently dosing normal healthy volunteers.

So, where do we go next? The central nervous system. There are a number of untreatable and poorly treated CNS conditions and many genes that could serve as powerful targets for RNAi therapeutics. We have spent a substantial amount of time developing a CNS-focused TRiM platform and are just about ready to bring our first drug candidate to the clinic. As we announced a couple weeks back, ARO-SOD1 is our first CNS-targeted drug candidate to be nominated. It will be investigated as a potential treatment for patients with ALS caused by SOD1 mutations. We have already completed disease model work and CTA enabling toxicology studies and are now on track to file a CTA next quarter. You will hear more about the platform and candidate at the June 1st Analyst Day, and we see these as powerful tools for a new set of patients we seek to serve. Importantly, as with liver, pulmonary, and skeletal muscle delivery, we expect to follow ARO-SOD1 with several additional drug candidates. In addition, we have made impressive progress on different modes of administration and while we are not quite there yet, we believe we are approaching the day where we may administer RNAi CNS drug candidates systemically that cross the blood brain barrier. This would be a truly disruptive leap forward and our data suggest that we are close. We look forward to discussing this as well at the Analyst Day.

We have said in the past that we are committed to bringing RNAi to where unmet medical need is, and that means constantly expanding TRiM. We believe we can address a new cell type every 18-24 months, and while our new CNS franchise meets this, it is not the only new organ system we are exploring. I believe we can now also deliver to adipose tissue and have demonstrated in non-human primates target gene silencing of greater than 90% with over six months of duration after a single subcutaneous injection, using what we believe are clinically relevant dose levels. Adipose tissue is the largest endocrine organ in the body, and we believe

there are many targets to address and many potential patients to help. You will hear more about this new platform next month at the Analyst Day.

Let's now turn to our more established clinical programs.

We've shared some early data from the Phase 1/2 study of ARO-C3 for complement mediated diseases, and they are compelling. We are seeing deep and durable knockdown in healthy volunteers and have progressed to the patient portion of the study. We also shared liver fat data that Janssen generated in a P1/2 study of ARO-PNPLA3 for NASH in patients with PNPLA3 mutations. Those too were quite encouraging and demonstrated deep reductions in liver fat after only a single dose of ARO-PNPLA3. We plan to move that into a multidose P2 study in NASH patients late this year.

Moving on to our later stage pipeline, we continued to enroll patients in the Phase 3 PALISADE study of ARO-APOC3 in patients with familial chylomicronemia syndrome, or FCS, and expect to meet our enrollment goal of 72 patients tomorrow. There are also some additional patients that have passed screening and who will likely be randomized over the next 2 weeks. At that point enrollment will be complete and I suspect that we will have closer to 80 patients in the study. We also received Fast Track designation from the FDA for ARO-APOC3 for reducing triglycerides in adult patients with FCS, which will be helpful as we advance the program rapidly. Javier will talk about this in a moment, but I expect this to be our first drug to complete a Phase 3 study and, if efficacy and safety are established, could be the first NDA that we file. This could be next year, and it would represent an important step for us. Of course that is not the only population of patients we intend to treat with ARO-APOC3. Rather, I expect us to take steps toward pivotal

studies in patients with severe hypertriglyceridemia and those with mixed dyslipidemia later this year.

The ARO-ANG3 P2 study in mixed dyslipidemia patients is complete as is the P2 study in patients with homozygous familial hypercholesterolemia, or HoFH. I expect that both of these will move toward P3 studies later this year.

Both ARO-ANG3 and ARO-APOC3 appear to be potentially powerful drug candidates. We have included nearly 900 patients in the basket of P2 and P3 studies of ARO-ANG3 and ARO-APOC3 over the past couple of years and continue to be encouraged by the drug candidates' activity and safety profiles. I believe that both of these will ultimately be important drugs for many patients.

Also, during the quarter, we announced that our partner Takeda had treated the first patient in the Phase 3 REDWOOD study of fazirsiran being investigated as a potential treatment for alpha-1 antitrypsin deficiency liver disease. This is the third TRiM enabled candidate to reach a Phase 3 study, which earned Arrowhead a $40 million milestone payment.

We also received a $30 million milestone payment from GSK after the start of GSK's Phase 2b trial of GSK4532990, formerly called ARO-HSD, an investigational RNAi therapeutic for the treatment of patients with NASH.

These milestone payments are helpful for our balance sheet but also represent two more important things. First, they are a confirmation that our strategy to have a healthy mix of both wholly owned and partnered programs is playing out as intended. Second, they indicate that important new medicines that Arrowhead discovered are getting closer to the patients that need them.

Before I hand off to Javier, let me say a few words about the skeletal muscle franchise and ARO-DUX4 specifically. We completed everything required for the CTA including regulatory filing preparation, acute and even chronic GLP toxicology studies. We are prepared to file the CTA and begin a P1/2 study but several companies have expressed interest in potentially partnering on the development of ARO-DUX4 and, potentially, our next skeletal muscle-targeted drug candidate, that will be CTA-ready in Q4. As such, we paused filing while we explore these options. Of course, I do not know if any of these will translate into license agreements and partnerships, but I expect we will either complete a deal or move forward with the ARO-DUX4 clinical program over the next couple months.

Arrowhead is executing at a very high level: our platform is expanding into new areas; our early pipeline is generating impressive results; our mid and later stage pipeline are giving us line of sight to when we may be able to make the transition into a commercial stage company; and our business development activities continue to bear fruit.

With that overview, I'd now like to turn the call over to Dr. Javier San Martin. Javier?

Javier San Martin

Thank you, Chris, and good afternoon everyone.

Before I go into the mid and late stage cardiometabolic studies, I want to quickly review the status of the fazirsiran, our investigational RNAi therapeutic being

developed in partnership with Takeda for the treatment of liver disease associated with alpha-1 antitrypsin deficiency.

During the last quarter we reported data demonstrating that patients receiving 25, 100, or 200 mg of fazirsiran who had baseline fibrosis achieved a dose dependent mean reduction in serum Z-AAT concentration at week 48 of 74%, 89%, and 94%, respectively, leading to dramatic reductions in total liver Z-AAT and PAS-D globule burden, a histological measure of Z-AAT accumulation. In addition 42% of patients showed an improvement in portal inflammation and 50% of patients achieved an improvement in fibrosis of at least one point by METAVIR stage. These data were very consistent with the prior data generated from the 2002 open-label study.

Subsequently, Takeda initiated and began dosing in the REDWOOD clinical study. It is a randomized, double-blind, placebo-controlled, Phase 3 trial to evaluate the efficacy and safety of fazirsiran in the treatment of AATD liver disease. Approximately 160 adult patients with METAVIR stage F2 to F4 fibrosis will be randomized 1:1 to receive fazirsiran or placebo. The primary endpoint of the study is a decrease from baseline of at least 1 stage of histologic fibrosis METAVIR staging in the centrally read liver biopsy done at Week 106 in patients with METAVIR stage F2 and F3 fibrosis. Additional information on the REDWOOD study can be found at www.theredwoodliverstudy.com.

I also want to give a brief update on where we are with our cardiometabolic candidates, ARO-APOC3 and ARO-ANG3.

I will start with ARO-APOC3, our investigational RNAi therapeutic being developed as a treatment for patients with mixed dyslipidemia, severe hypertriglyceridemia, and FCS.

The SHASTA-2 Phase 2 study in 229 patients with severe hypertriglyceridemia and the MUIR Phase 2 study in 353 patients with mixed dyslipidemia are both on schedule for data readouts later this year. These data will enable us to request end of Phase 2 meetings with regulators to discuss and get feedback on our plans for Phase 3 studies.

The PALISADE Phase 3 study in 72 patients with FCS is ongoing. We have enrolled 70 of the planned 72 patients and we believe we will reach planned enrollment tomorrow. This is a 48 week study with a primary endpoint of percent change from baseline in fasting triglycerides. This puts us on schedule for study completion in Q2 of 2024, a data readout shortly after that, and then NDA preparation. I am also pleased to announce that during last quarter ARO-APOC3 was granted Fast Track designation by the US FDA for reducing triglycerides in adult patients with FCS. ARO-APOC3 was previously granted Orphan Drug designation by the FDA and the European Union for the same use.

Fast Track is a process designed to expedite the development and review of drugs to treat serious or life-threatening conditions and fulfill an unmet medical need. The purpose is to get important new drugs to patients earlier. This designation makes Arrowhead eligible for multiple potential benefits including more frequent interactions with FDA, eligibility for priority review, and eligibility for rolling review of the NDA. Once we have complete data from the Phase 3 PALISADE study in 2024, we intend to utilize all available mechanisms to get this potentially important drug to patients as quickly as possible.

This would be the first Phase 3 readout for Arrowhead and our pipeline of RNAi therapeutics that utilize our proprietary TRiM platform. That represents a significant milestone for the company.

Moving on to the second wholly-owned cardiometabolic candidate ARO-ANG3, which is our investigational RNAi therapeutic being developed as a treatment for homozygous familial hypercholesterolemia, or HoFH, and heterozygous familial hypercholesterolemia, or HeFH.

We have completed the ARCHES-2 Phase 2 study in 204 patients with mixed dyslipidemia and we are currently in the process of generating and analyzing study data, which we intend to report on later this year.

The second Phase 2 study of ARO-ANG3 is the GATEWAY study in 18 patients with HoFH. This study is open label and was fully enrolled previously. I'm happy to report that the LDL-C reduction in this difficult to treat population with limited treatment options appears to be competitive with evinacumab, a monoclonal antibody that targets the same ANGPTL3 protein which is currently approved for HoFH patients. We will present interim data for the GATEWAY study at the 91st European Atherosclerosis Society Congress on May 23. These were welcome results, and thus we are currently working on a Phase 3 study design and plan for ARO-ANG3 in HofH.

We will also talk in more detail about the unmet need in cardiovascular disease, the results from our cardiometabolic programs, our clinical development plans, and our commercial strategy at the upcoming R&D Day in June.

I will now turn the call over to Dr. James Hamilton. James?

James Hamilton

Thank you, Javier.

We have demonstrated significant progress across discovery and early development. We continue to extend the reach of our TRiM platform to new tissue types and expand our pipeline into new disease areas in which patients have inadequate treatment options. We have also rapidly and efficiently advanced multiple early clinical stage programs and continue to generate highly encouraging data using various versions of the TRiM platform, each optimized for a different cell type.

I want to focus today on a few different areas: The pulmonary platform, with recent topline data announced for ARO-RAGE; ARO-C3, our candidate for complement mediated diseases; and, our emerging CNS platform, with the first candidate being ARO-SOD1.

Let's start with pulmonary. We have three candidates in the clinic now: ARO-RAGE, ARO-MUC5AC, and ARO-MMP7, which all use the same TRiM conjugate that targets the αvβ6 integrin for delivery to pulmonary epithelial cells. I will talk about each individually, but we think one of the benefits of gaining a RNAi therapeutic delivery platform with increasing validation is that learnings from each program can directly inform advancements in others. So, we view de-risking events for one program, such as the data we saw with ARO-RAGE, as potentially de-risking to some extent to the others.

ARO-RAGE is our investigational RNAi therapeutic designed to reduce expression of the receptor for advanced glycation end products, or RAGE, as a potential treatment for inflammatory pulmonary diseases, such as asthma. We are currently conducting a Phase 1/2a, randomized, double-blinded, placebo-controlled study in normal healthy volunteers, which is Part 1, and in patients with mild-to-moderate asthma, which is Part 2. The single ascending dose portion of the study includes 5 sequentially enrolled NHV cohorts with escalating single-dose levels. The multiple ascending dose portion of the study includes 5 NHV cohorts and 3 asthma patient cohorts.

We have fully enrolled and dosed all SAD cohorts and the final MAD cohort is anticipated to be fully enrolled in the coming weeks. We have also opened the patient cohorts with enrollment of the first cohort nearly complete.

We reported very encouraging topline results from 4 of the 5 SAD and MAD cohorts in NHVs. We do not yet have data from the 5th and highest dose level, but we plan to report on those results when they are available later this year.

First, safety and tolerability assessments have been encouraging. Overall, there were no patterns of adverse changes in any clinical safety parameters, no reported serious or severe adverse events, and no dropouts related to drug or related to adverse events.

In addition to safety and tolerability, ARO-RAGE demonstrated a strong pharmacodynamic effect. The mean maximum reduction in soluble RAGE, or sRAGE, at the 92 mg dose as measured in serum after two doses on Day 1 and Day 29 was 80% with a maximum reduction of 90%. The lower doses of 10, 20, and 44 mg also showed a dose response ranging from 31% to 59%. Serum sRAGE was

also reduced after a single dose, with a mean maximum reduction at the 92 mg dose of 56% and a maximum reduction of 68%. Reductions in sRAGE as measured in bronchoalveolar lavage fluid on Day 31 after a single dose were also observed, with a mean reduction at 92 mg of 75% and a maximum reduction of 92%. We have additional planned cohorts in which BALF will be collected at later timepoints to quantify the additional lung level knockdown after two doses.

Lastly, the duration of pharmacologic effect persisted for at least 6 weeks after the second administration of the 92 mg dose. This is the last timepoint currently available and additional follow up is ongoing. This suggests that monthly, bi-monthly, or less frequent dosing may be possible with ARO-RAGE. All in all, we believe these data show good translation of preclinical results to humans.

Moving on to ARO-MUC5AC, our investigational RNAi therapeutic designed to reduce production of mucin 5AC, or MUC5AC, as a potential treatment for various muco-obstructive pulmonary diseases. We are currently conducting a Phase 1/2a study, similar in design to the ARO-RAGE study and we have begun enrollment of the asthma patient cohorts.

Sample processing and analysis for the NHV cohorts is ongoing and we intend to report on initial data when available.

The third pulmonary program in the clinic is ARO-MMP7, which is designed to reduce expression of matrix metalloproteinase 7, or MMP7, as a potential treatment for idiopathic pulmonary fibrosis, or IPF. During the last quarter we initiated a Phase 1/2a single ascending dose and multiple ascending dose study to evaluate the safety, tolerability, pharmacokinetics, and pharmacodynamics of

ARO-MMP7 in healthy volunteers and patients with IPF. Dose escalation in this study is ongoing.

Now let's discuss initial results with ARO-C3, our investigational RNAi therapeutic targeting hepatic C3 expression as a potential treatment for complement mediated hematologic and renal diseases. Substantial unmet medical need remains in the treatment of multiple complement mediated diseases, including IgA nephropathy, C3 glomerulopathy, and additional renal and hematologic indications.

We are conducting a Phase 1/2, placebo controlled, dose-escalating study to evaluate the safety, tolerability, pharmacokinetics, and pharmacodynamics of ARO-C3 in adult healthy volunteers and patients with complement-mediated renal disease. We originally planned to also include patients with PNH in this study, but we have since decided to eliminate these cohorts. We may decide to study PNH patients in the future, but we believe we can generate the data we need in the other populations.

During the quarter we reported topline interim data and presented additional data at the 7th Complement UK Training Course and Symposium in April. In Part 1 of the study in NHVs, ARO-C3 demonstrated a dose-dependent reduction in serum C3, with 88% mean reduction after two doses at highest dose tested. A dose-dependent reduction in AH50, a marker of alternative complement pathway hemolytic activity, was also observed with a 91% mean reduction at highest dose tested. ARO-C3 had a long duration of pharmacologic effect, and we think this suggests quarterly or less frequent subcutaneous dose administration is possible.

Lastly, I want to briefly mention our announcement that CNS is the next area of focus for the TRiM platform. We have been working on CNS delivery for some time but have not discussed these efforts publicly until now. Our TRiM platform now includes a construct optimized for intrathecal administration to the central nervous system with good distribution throughout the brain and in all relevant brain cell types.

ARO-SOD1, the first program to use this new delivery platform, is designed to reduce expression of superoxide dismutase 1, or SOD1, in the CNS as a potential treatment for patients with amyotrophic lateral sclerosis, or ALS, caused by SOD1 mutations. ARO-SOD1 was highly active against its target with a long duration of effect in multiple preclinical models that we believe suggests it may be administered quarterly or less frequently. In preclinical studies, ARO-SOD1 achieved 95% spinal cord tissue mRNA knockdown after a single intrathecal dose in SOD1 transgenic rats and maintained greater than 80% spinal cord tissue mRNA knockdown three months after a single intrathecal dose in non-human primates.

ARO-SOD1, is on track for a CTA filing in the third quarter of 2023. We will talk more about our CNS platform and about ARO-SOD1 at the R&D Day in June, but I wanted to introduce the program because we are very excited about the potential for siRNA in the CNS.

I will now turn the call over to Ken Myszkowski. Ken?

Ken Myszkowski

Thank you, James, and good afternoon, everyone.

As we reported today, our net income for the quarter ended March 31, 2023 was $48.7 million or $0.45 per share based on 108.1 million fully-diluted weighted average shares outstanding. This compares with net income of $44.4 million or $0.41 per share based on 107.9 million fully-diluted weighted average shares outstanding, for the quarter ended March 31, 2022.

Revenue for the quarter ended March 31, 2023 was 146.3 million, compared to 151.8 million for the quarter ended March 31, 2022. Revenue in the current period primarily relates to our collaboration agreements with Takeda and GSK.

Revenue is recognized as we complete our performance obligations, which include managing the ongoing AAT Phase 2 clinical trials for Takeda. There remains $31 million of revenue to be recognized associated with the Takeda collaboration which we anticipate will be recognized over the next year.

Additionally in the quarter ended March 31, 2023, Takeda dosed the first patient in its Phase 3 REDWOOD clinical study of fazirsiran, triggering a $40.0 million milestone payment, and GSK dosed the first patient in its Phase 2b trial of GSK4532990, formerly known as ARO-HSD, in March, triggering a $30.0 million milestone payment. Both milestone payments are expected to be paid in the third quarter of fiscal 2023. Revenue in the prior period primarily related to the recognition of the $120.0 million associated with the upfront payment received from GSK in addition to a portion of the payments received from our license and collaboration agreements with Takeda and Horizon.

Total operating expenses for the quarter ended March 31, 2023 were $98.1 million, compared to $110.3 million for the quarter ended March 31, 2022. The key driver of this change was decreased candidate costs and lower stock compensation

expense. The decreased candidate costs were primarily due to the reduction in outsourced manufacturing and toxicity study costs related to our cardiometabolic studies as the Company's pipeline of candidates progressed through clinical trials in 2022.

Net cash used by operating activities during the quarter ended March 31, 2023 was $107.2 million, compared with net cash provided by operating activities of $1.4 million for the quarter ended March 31, 2022. The prior period includes $120 million cash inflow from the GSK licensing and collaboration agreement. We expect our operating cash burn to be at the lower range of $70 to $90 million per quarter in fiscal 2023. We expect capital expenditures of approximately $90 million in the second half of fiscal 2023 as we near completion on our footprint expansion projects, including GMP manufacturing.

Turning to our balance sheet, our cash and investments totaled 559.8 million at March 31, 2023, compared to $482.3 million at September 30, 2022. The increase in our cash and investments was primarily related to the $250.0 million payment from Royalty Pharma, offset by our operating cash burn along with continuing capital projects.

Our common shares outstanding at March 31, 2023, were 106.9 million.

With that brief overview, I will now turn the call back to Chris.

Chris Anzalone

Thanks Ken.

We have already had a busy 2023 and have made a great deal of progress on many fronts. However, we anticipate that the middle and into the second half of the year will be even busier and offer even more opportunities to demonstrate what our pipeline can bring to patients.

We have always been clear that we believe for RNAi to reach its full potential as a revolutionary therapeutic modality, it needs to be able to address gene targets *wherever they are*. That no longer feels like a long-term goal. Between the liver franchise, the pulmonary franchise, the skeletal muscle franchise, the CNS franchise, and the adipose franchise, we have the opportunity to help a lot of people and create a substantial amount of value. But this is just the start. I expect us to blow through 20 in ’25 and build a uniquely large and diverse pipeline of important medicines across multiple therapeutic areas. I have never been more excited about our near-term prospects or more proud of this amazing team. When you combine a technology that works with talented innovators who are aligned as to mission and empowered to make decisions and push science, incredible things can follow.

We hope you can all join us on June 1 at our R&D Day to hear more.

Thank you for joining us today and I would now like to open the call to your questions. Operator?

Operator