iCo THERAPEUTICS INC.

ANNUAL INFORMATION FORM

For the year ended December 31, 2014

Dated April 27, 2015

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INTRODUCTION

In this annual information form ("Annual Information Form"), unless the context requires otherwise, references to the "Company", "iCo", "we", "us", "our" and similar words refer to iCo Therapeutics Inc. or any predecessor thereto, as the context requires. The information in this Annual Information Form is presented as of December 31, 2014, unless otherwise indicated. All dollar amounts in this Annual Information Form are in Canadian dollars, except where otherwise indicated.

FORWARD LOOKING STATEMENTS

This Annual Information Form contains certain statements, other than statements of historical fact, that are forward-looking statements which reflect the current view of the Company with respect to future events including corporate developments, financial performance and general economic conditions which may affect the Company. The forward-looking statements in this Annual Information Form include, but are not limited to, statements regarding: the status of our research and development programs; iCo-008 and the Oral AmpB Delivery System; our expectations regarding future research and development expenses; the sufficiency of the Company's financial resources to fund operations for 2015 and future funding requirements for the Company. Forward-looking statements include, but are not limited to, those statements set out in this Annual Information Form under General Development of the Business, The Business, and Risk Factors.

We have based these forward-looking statements largely on our current expectations, projections and assumptions made based on our experience, perception of historical trends, the current business and financial environment. Key assumptions upon which the forward-looking statements are based include the following:

a) The Company's research and development programs, in particular the Oral AmpB Delivery System will not be unreasonably delayed and expenses will not increase substantially;
b) The Company will be able to secure additional financial resources to continue our research and development activities;
c) Key personnel will continue their employment with the Company;
d) The Company will successfully maintain all necessary commitments to product licenses and other agreements and maintain regulatory approvals in good standing;
e) The Company will be able to maintain and enforce its intellectual property rights and otherwise protect its proprietary technologies.

Forward-looking statements should not be read as a guarantee of future performance or results, and will not necessarily be accurate indications of the times at, or by, which such performance or results will be achieved. Forward-looking statements are based on information available at the time those statements are made and/or management's good faith belief as of that time with respect to future events, and are subject to risks and uncertainties that could cause actual performance or results to differ materially from those expressed in or suggested by the forward-looking statements. Risks that could cause actual results to differ from current expectations include: reliance on collaborative partners; changes in government and government agency policies and regulations; general economic and financial market conditions; failure to retain key employees; performance failure of third parties and/or sub-contractors; potential for clinical trial delays and/or adverse events leading to clinical trial liability; inadequate protection of intellectual property rights; the impact of US/Canadian exchange rates; inability to raise sufficient capital to fund research and development activities, in particular the Oral AmpB Delivery System; the development and adoption of competitive technologies; and general risks inherent to the biotechnology industry.

Except as may be required by applicable law or stock exchange regulation, we undertake no obligation to update publicly or release any revisions to these forward looking statements to reflect events or circumstances after the date of this document or to reflect the occurrence of unanticipated events. Accordingly, readers should not place undue reliance on forward-looking statements. If we do update one or more forward-looking statements, no inference should be drawn that additional updates will be made with respect to those or other forward-looking statements. Additional information relating to our Company, including our annual information form, is available by accessing the SEDAR website at www.sedar.com

CORPORATE STRUCTURE

General

The Company was incorporated under the *Business Corporations Act* (British Columbia) on April 20, 2006 under the name Beanstalk Capital Corporation. The Company changed its name to Beanstalk Capital Ltd. ("Beanstalk"). Prior to completing its qualifying transaction on December 31, 2007, the Company was a "capital pool company" under Policy 2.4 of the TSX Venture Exchange Corporate Finance Manual. As a capital pool company, the Company had no assets other than cash and did not carry on any operations.

The Company's qualifying transaction under Policy 2.4 involved a reverse take-over transaction by way of statutory arrangement (the "Arrangement") involving a wholly-owned subsidiary of the Company known as 4448073 Canada Inc. and a company formerly known as iCo Therapeutics Inc. ("Privateco"). Under the Arrangement:

- Privateco amalgamated with 4448073 Canada Inc. to form a new company known as iCology Corporation ("iCology");
- all of the issued and outstanding securities of Privateco, including warrants and options, were exchanged for equivalent securities of the Company on a one-for-one basis; and
- the Company changed its name from Beanstalk Capital Ltd. to iCo Therapeutics Inc.

As a consequence of the Arrangement, iCology became a wholly-owned subsidiary of the Company and the shareholders of Privateco acquired a majority of the Company's shares. On January 8, 2008, the Company's common shares began trading on the TSX Venture Exchange ("TSXV") under the symbol ICO.

Following completion of the Arrangement, iCology continued to conduct the biotechnology business previously conducted by Privateco until January 1, 2009, when iCology and the Company were amalgamated with the Company being the successor entity. The Company currently has no subsidiaries. The Company's head office is located at 760-777 Hornby Street, Vancouver, British Columbia, V6Z 1S4, and the Company's registered and records office is located at 595 Burrard Street, Suite 2600, Vancouver, British Columbia, V7X 1L3.

GENERAL DEVELOPMENT OF THE BUSINESS

History

We are a Canadian biotechnology company principally focused on the identification, development and commercialization of drug candidates to treat sight- and life-threatening diseases.

We principally focus on in-licensing drug candidates with a clinical history and re-dose, reformulate and develop drug candidates for the treatment of sight- and life-threatening diseases. We assume the clinical, regulatory and commercial development activities for our product candidates and advance them along the regulatory and clinical pathway toward commercial approval. We believe that our approach may reduce the risk, time and cost of developing therapeutics by avoiding the uncertainty associated with certain research and pre-clinical stages of drug development. We use our expertise to manage and perform what we believe are the critical aspects of the drug development process, including the design and conduct of clinical trials, the development and execution of strategies for the protection and maintenance of intellectual property rights and interaction with drug regulatory authorities.

We have in-licensed three product candidates: iCo-007, iCo-008 (also known as Bertilimumab), and an oral Amphotericin B delivery system, ("Oral AmpB Delivery System") (formerly known as iCo-009) that we believe have the potential to treat sight threatening and life threatening conditions.

iCo-007

In August 2005, we entered into a license agreement with Isis Pharmaceuticals, Inc. ("Isis") for the exclusive world-wide rights to develop and, upon regulatory approval, market iCo-007 for all use indications. iCo-007 is a second generation antisense compound that we believe reduces levels of a key protein associated with diabetic retinopathy. Diabetic retinopathy is an ocular complication of diabetes and is the leading cause of vision loss and blindness in working age adults. Diabetic macular edema ("DME") is the most serious form of diabetic retinopathy and afflicts up to 1.6 million patients in the United States. In May, 2010 we completed a Phase I, open label, dose-escalating clinical trial at four trial sites in the United States using a single injection of iCo-007 in patients with DME. The primary endpoint for the trial was to assess the safety of iCo-007 at four different dosage levels in four groups ("cohorts") of patients – fifteen patients in total. Because the trial was conducted in patients with disease as opposed to healthy volunteers, as secondary endpoints we were also able to collect limited data on what effect the drug may be having on the disease itself.

The Phase I trial for iCo-007 met its primary end point, which was to evaluate the ocular safety and tolerability of iCo-007 following a single intravitreal administration. Secondary objectives included assessment of systemic pharmacokinetics, retinal thickness using optical coherence tomography (OCT) measurements, and visual acuity. Intravitreal injections of iCo-007 were well tolerated with a good safety profile; ultimately progressing to the highest dose of 1000 ug based on positive safety evaluation committee meetings two months post each dosing level. Analysis of blood plasma in patients demonstrated that iCo-007 was not detectable in the blood plasma with any of the doses used in the Phase I trial. There were signs of biological activity in responsive patients at 24 weeks with a reduction of retinal thickness ranging between 149 and 743 microns (and 115 to 743 microns if one additional patient followed only to week 18 is included). The mean change in retinal thickness for all patients completing the 24 week follow-up (12 of 15 patients) was minus 169 microns (or 40% reduction of excess retinal thickness). In several subjects there was a transient increase in retinal edema preceding biological effect. Approximately 69% of patients completing a 24 week follow up (13 of 15 patients) had stable or improved vision, defined as between zero and under 5 letters or better compared to baseline and 23% of patients experienced greater than or equal to 5 letters of visual improvement. The highest dose seemed to show a smaller biological effect than lower doses. The first three doses appeared to display some dose-related biological effect, warranting further exploration of dosing and treatment regimen in a Phase II clinical trial.

Strategic and preliminary planning for the Phase II clinical trial was initiated in 2009 and formal Phase II clinical trial planning started on conclusion of our Phase I trial in May 2010. Regulatory documents were filed with Health Canada, and we successfully received a "No Objection" letter from Health Canada in response to an application to initiate a Canadian Phase II clinical trial in July 2010. In May 2010, we entered into a technology transfer agreement with Isis pursuant to which Isis transferred certain technology (including certain analytical methods, chemistry reports and assays) related to the manufacturing of iCo-007 to iCo. In consideration of the technology transfer, we issued to Isis a warrant to purchase 235,000 shares of iCo's common stock at an exercise price of $0.61 per share. The warrant expired on May 16, 2012.

In February 2011, iCo announced the completion of drug product manufacturing activities as part of its Phase II clinical program. In August 2011 we initiated the iDEAL study, a US physician-sponsored Phase II clinical trial involving iCo-007, that has been conducted in 28 sites throughout the United States. The iDEAL Study was led by the clinician scientists who were investigators in the trial and was coordinated at the Wilmer Eye Institute of John Hopkins University and later at the Stanley M. Truhlsen Eye Institute of University of Nebraska Medical Center. The iDEAL study was entitled: "Randomized, Multi-center, Phase II Study of the Safety, Tolerability and Bioactivity of Repeated Intravitreal Injections of iCo-007 as Monotherapy or in Combination with Ranibizumab or Laser Photocoagulation in the Treatment of Diabetic Macular Edema With Involvement of the Foveal Center ."

On September 26, 2011, we announced a research collaboration agreement with the Juvenile Diabetes Research Foundation (JDRF), the worldwide leader for research to cure, treat, and prevent T1D, to support the previously announced Phase 2 investigator sponsored clinical trial investigating iCo-007 in DME and in March 2012, we outlined the clinical trial plan for the iDEAL study and began the process of recruiting patients. Further to this, on January 3, 2013, we announced that, having reached the midpoint of the iDEAL study, there were no drug related serious adverse events among patients receiving repeat doses of iCo-007. On June 18, 2013 we announced that we had completed enrollment for the iDEAL study and subsequently on March 5, 2014, we announced the final month eight patient visit in the iDEAL Study.

On June, 9, 2014, we announced top-line results related to the eight month visual acuity (VA) primary endpoint for subjects enrolled in the iDEAL Study.

Statistical methods employed included both Last Observation Carry Forward ("LOCF") and Multiple Imputation ("MI") analyses given the departure of patients from the study prior to their eight month visit. Using both statistical methods, mean changes in visual acuity measures in all four groups at both month four and month eight were negative. Using the LOCF method, mean change in VA at eight months was approximately minus 11 letters (350 µg monotherapy), minus 21 letters (700 µg monotherapy), minus 14 letters (350 µg + laser arm) and minus 14 letters (350 µg + Lucentis). Some patients in each cohort did show improvements in mean change in VA. At eight months using the LOCF analysis, roughly 20% of patients in the 350 µg monotherapy arm gained five letters or greater of vision versus 13% in the 700 µg monotherapy arm, 12% in the 350 µg + laser arm and 11% in the 350 µg + Lucentis arm. At four months, patients gaining five letters or more for the 350 µg, 700 µg, 350 µg + laser and 350 µg + Lucentis arms were approximately 24%, 18%, 21% and 30%, respectively.

Using the LOCF method, it was observed that at month eight there was an inverse statistically significant difference in mean VA change from baseline between 350 µg monotherapy and 700 µg monotherapy arms, meaning there was greater loss of VA in the 700 µg monotherapy cohort. There was no statistically significant difference in mean VA between the 350 µg monotherapy and either 350 µg + laser or 350 µg + Lucentis arms. When using MI analysis there was no statistically significant difference observed between 350 µg monotherapy and each of the 700 µg monotherapy, 350 µg + laser and 350 µg + Lucentis arms.

At eight months, in the 700 µg monotherapy arm, 64% of patients experienced a 15 letter or greater loss of vision, compared to 33% in the 350 µg monotherapy arm, 33% in the 350 µg + laser arm, and 41% in the 350 µg + Lucentis arm. At four months the corresponding numbers were 29%, 9%, 9%, and 14%, respectively.

Management has determined that the Phase 2 iCo-007 diabetic macular edema (DME) data that has been presented, along with our internal analysis, did not demonstrate any subgroup response rates that warrant further financial investment by iCo in DME at this time. Management will, however, continue to investigate other potential use indications for its licensed technology which targets the C-Raf kinase pathway. Use indications may include certain oncology applications as a number of approved drugs currently target Raf kinase isoforms.

iCo-008 (Bertilimumab)

In December 2006, we entered into a license agreement with Cambridge Antibody Technology Limited ("CAT"), now known as MedImmune Limited ("MedImmune") for the exclusive world-wide rights to develop and, upon regulatory approval, market iCo-008 for all use indications. iCo-008 is a human monoclonal antibody that we believe has the potential to inhibit the development of severe allergic conjunctivitis, severe asthma, inflammatory bowel diseases and other indications. MedImmune is a wholly owned subsidiary of the AstraZeneca group of companies. Before we licensed iCo-008 from MedImmune, MedImmune conducted a number of clinical studies in 126 individuals to establish safety and signs of efficacy, including a Phase I clinical trial of iCo-008 in healthy human volunteers and Phase II clinical trials of iCo-008 for allergic rhinitis and allergic conjunctivitis. No safety concerns were reported in any of these trials.

We have developed a Phase II clinical plan to test the efficacy and safety of iCo-008 in individuals with a serious sight threatening form of allergic conjunctivitis known as vernal keratoconjunctivitis ("VKC"), however this work is preliminary and no formal decision or plans have been made to begin formal clinical development.

In December 2010, we granted Immune Pharmaceuticals Corp. ("IMMUNE"), an option to an exclusive sub-license for the development and commercialization rights to the systemic uses of iCo-008, including inflammatory bowel disease and severe asthma. iCo retained worldwide exclusive rights to all uses and applications in the ocular field. Under the terms of the option, IMMUNE paid iCo a non-refundable option fee creditable upon exercise of the option against an upfront license fee payment of U.S. $1 million. In June, 2011, IMMUNE exercised the option and entered into an exclusive sub-licence agreement (the "IMMUNE Licence Agreement") with iCo. If IMMUNE successfully develops and commercializes iCo-008 for systemic uses, iCo may receive up to an additional US$32 million in milestone payments as well as royalties on net sales of licensed products. IMMUNE will also share in funding 50% of the patent prosecution and maintenance costs of the iCo-008 patent family. Including the initial option fee, option extension fees and the fee for exercising the option to an exclusive sub-licence, we received a total of US$500,000 in cash as well as a 6.4% equity stake in IMMUNE. Please refer to the Company's financial statements for the year ended December 31, 2013 for specific details of the transaction.

IMMUNE has initiated a Phase 2 double-blind, placebo controlled study with its lead drug, Bertilimumab (iCo-008), in patients with moderate-to-severe ulcerative colitis. The clinical trial is a randomized, double-blind, placebo-controlled parallel group study that will evaluate the safety, clinical efficacy, and pharmacokinetic profile of Bertilimumab in subjects with active moderate-to-severe ulcerative colitis. Ninety patients are expected to be enrolled into the study, sixty of whom will be treated with Bertilimumab 7mg/kg and thirty of whom will be treated with placebo every two weeks, at days 0, 14, and 28. These patients are being evaluated for clinical response after 6 weeks to determine the decrease if any in the full Mayo Clinic Ulcerative Colitis Score. Secondary and exploratory end points will include clinical remission defined as symptom free, fecal calprotectin, a recognized marker of gastro-intestinal inflammation, histopathology improvement and degree of mucosal injury. Patient follow-up will continue up to day 90. IMMUNE will also be enrolling and studying patients with Bullous Pemphigoid, a rare auto-immune condition that affects the skin and causes the formation of blisters.

On April 15, 2015, IMMUNE announced that patient enrollment in the Bullous Pemphigoid and moderate-to-severe Ulcerative Colitis Phase II trials with Bertilimumab (iCo-008) is scheduled to start in the second quarter of 2015. Initial clinical data form the Bullous Pemphigoid trial may be available by the end of 2015.

Oral AmpB Delivery System

In July 27, 2007, we entered into an option agreement with the University of British Columbia ("UBC") which granted us an option to negotiate a licence for the exclusive rights to a novel formulation for Amphotericin B ("Oral AmpB Delivery System") to be used for potential systemic fungal infections. The Company exercised the option on February 26, 2008 and on May 6, 2008 signed an agreement with UBC for the exclusive worldwide licence to the Oral Amp B Delivery System (the "UBC Licence"). The Oral AmpB Delivery System has been developed in the laboratory of Dr. Kishor Wasan at the University of British Columbia and subsequently the University of Saskatchewan. Intravenous AmpB has been historically a potent but toxic option for treatment of serious life and sight threatening fungal infections in immune-compromised patients (e.g. in HIV/AIDS, cancer, transplant recipients, diabetics, etc.). In addition, in developing nations, oral therapy is needed for a disease called visceral leishmaniasis ("VL"), known for its high mortality rates. Current AmpB therapy requires repeated infusions in the

hospital setting and is often associated with infusion-related adverse events, including renal toxicity. Successful oral formulation could resolve the safety issues associated with parenteral application and enable a much broader patient access to this treatment option. Oral dosing of AmpB has not been successful in the past due to inactivation of the drug in the gastro-intestinal tract before it could get into the systemic circulation.

We have completed a number of pre-clinical studies with iCo's Oral AmpB Delivery System which have shown promising pharmacokinetic and tissue distribution results in two anti-fungal animal models. We are currently initiating formal good laboratory practice ("GLP") toxicology studies and manufacturing of drug product under good manufacturing practice ("GMP") standards that are required to support an investigational new drug application ("IND") to the U.S. Food and Drug Administration ("FDA") and a Phase I clinical trial. iCo's oral AmpB formulations have also demonstrated promising results in animal models for VL conducted at independent laboratories in the United States. All these development programs will only be undertaken subject to obtaining appropriate financing. To this end we have been working in cooperation with UBC to obtain third party financing, primarily through government and private granting agencies such as the Canadian Institute of Health Research ("CIHR") to fund certain pre-clinical studies. UBC, with assistance and sponsorship from iCo, has been awarded two CIHR grants to fund the development of the Oral AmpB Delivery System: a CIHR Chair and a CIHR Proof of Principal II grant for an aggregate of up to $1,200,000 of research funding.

On May 31, 2012 we announced that the company had been awarded a $1.1 Million non-repayable financial contribution from the National Research Council of Canada to support iCo's Oral Amphotericin B (AmpB) delivery system as novel treatment for patients with Human Immunodeficiency Virus (HIV). The funding supports feasibility testing and pre-clinical toxicology studies, as well as human safety and efficacy clinical trials to examine the role of the AmpB delivery system in potentially treating patients with latent HIV reservoirs. The funding for the 3-year project comes from the NRC Industrial Research Assistance Program (NRC-IRAP) under the CHTD Program, which aims to encourage and support the participation of small and medium-sized enterprises in the development of an HIV vaccine and other technologies related to the prevention, treatment, and diagnosis of HIV. The program is part of the Canadian HIV Vaccine Initiative (CHVI), collaboration between the Government of Canada and the Bill & Melinda Gates Foundation. On December 12, 2013**,** we announced that the Oral AmpB technology had moved into *in vitro* testing with study partners in Montreal to examine the role of this formulation in targeting latent HIV reservoirs which remain in individuals despite enormous therapeutic advances in the treatment of HIV/AIDS. In this project, memory cells, or white blood cells, from eight HIV-infected subjects with a durable viral suppression using antiretroviral therapy (HAART) were obtained and exposed *in vitro* to various concentrations of Oral AmpB. Samples from one patient were determined not to be susceptible to reactivation. In the remaining subjects oral AmpB demonstrated a reactivation response of HIV viral production in six out of seven *in vitro* cultures with detectable HIV reservoir. Some HIV reservoirs are not possible to reactivate and this may explain why one culture did not show reactivation response.

On October 22, 2014, we announced next steps for our Oral AmpB Delivery System, having previously announced positive findings from its *in vitro* work involving samples from HIV/AIDS patients exposed to HAART therapy. iCo now plans to complete pre clinical studies and regulatory filings to move forward with an initial Phase 1A clinical trial, utilizing approximately $700,000 remaining of the aggregate $1.1m funding and technological advice from NRC-IRAP under CHTD Program. The preparation and regulatory filings are expected to be underway in the second half of 2015, with initiation of a Phase 1A study in the first quarter of 2016.

UBC and iCo are currently collaborating on obtaining additional non-dilutive sources of capital which would fund the necessary GLP/GMP pre-clinical work to permit iCo's oral AmpB formulations to enter into human Phase I clinical trials.

THE BUSINESS

Overview

We currently have three in-licensed product candidates in our pipeline: iCo-007, iCo-008 and the oral AmpB Delivery System. iCo-007 is a second generation anti-sense compound that we believe may inhibit the over-production of proteins associated with diabetic retinopathy, including DME. iCo-008 is a human monoclonal antibody against eotaxin-1 that we believe may treat sight threatening ocular allergies and various systemic indications. The oral AmpB Delivery System is for treatment of systemic fungal infections in immune-compromised patients (e.g. in HIV/AIDS, cancer, transplant recipients, diabetics, etc.) and certain parasitical infections in the developing world such as VL.

Strategy

We are a Canadian biotechnology company principally focused on the identification, development and commercialization of drug candidates to treat sight- and life-threatening diseases.

We principally focus on in-licensing drug candidates with a clinical history and re-dose, reformulate and develop drug candidates for the treatment of sight- and life-threatening diseases. We assume the clinical, regulatory and commercial development activities for our product candidates and advance them along the regulatory and clinical pathway toward commercial approval. We believe that our approach may reduce the risk, time and cost of developing therapeutics by avoiding the uncertainty associated with certain research and pre-clinical stages of drug development. We use our expertise to manage and perform what we believe are the critical aspects of the drug development process, including the design and conduct of clinical trials, the development and execution of strategies for the protection and maintenance of intellectual property rights and interaction with drug regulatory authorities. The main elements of our strategy are as follows:

Identification of Product Candidates

We directly perform scientific evaluation and market assessment of pharmaceutical products and research developed by other biopharmaceutical companies. As part of this process, we evaluate the related scientific research and pre-clinical and clinical research, if any, and the intellectual property rights in such products and research, with a view to determining the therapeutic and commercial potential of the applicable product candidates. We intend to mitigate the risks associated with our development and commercialization efforts by targeting drug candidates that:

- have an established clinical history or are in late-stage pre-clinical trials;
- have well-established safety profiles;
- may be well-suited to reformulation as a means of expanding use indications or altering the route of administration;
- have been successfully manufactured on a clinical grade basis in quantities sufficient for clinical trials; and
- has data suggestive of potential efficacy as treatments for sight- or life-threatening diseases.

Our initial focus was on sight threatening diseases because we believe that there is an unmet need for new and effective therapeutics in this field. In addition, several members of our management team and key advisors have considerable expertise in ophthalmology. Subsequently, we have also focused on certain life-threatening diseases, through the advancement of our Oral AmpB Delivery System and the expertise that has been gained through its development.

In addition to continued efforts involving other potential indications for our current assets, Management is also actively engaging in a review of certain complimentary assets that the company may consider in-licensing or acquiring.

Licensing

Upon identifying a promising biopharmaceutical product, we seek to negotiate a license to the rights for the product from the holder of those rights. The terms of such licenses vary, but generally our goal is to secure licenses that permit us to engage in further development, reformulation, clinical trials, intellectual property protection (on behalf of the licensor or otherwise) and further licensing of manufacturing and marketing rights to any resulting products. This process of securing license rights to products is commonly known as "in-licensing". In certain instances, we have taken the "option" approach, whereby we gain an exclusive right to in-license a drug candidate for a defined period of time before we have to actually make a commitment to do so. This approach allows us to review additional data before making a decision to in-license a particular drug candidate.

Product Advancement

Upon in-licensing a product candidate, our strategy is to apply our skills and expertise to advance the product toward regulatory approval and commercial production and sale in major markets. These activities include implementing intellectual property protection and registration strategies, formulating or reformulating existing drug products, making regulatory submissions, performing or managing clinical trials in target jurisdictions, and undertaking or managing the collection, collation and interpretation of clinical and field data and the submission of such data to the relevant regulatory authorities in compliance with applicable protocols and standards.

Developing Partnerships with Biopharmaceutical Companies

In order to augment our ability to develop our product candidates and effectively market any products in respect of which we obtain regulatory approval, we may enter into an agreement or partnership with a biopharmaceutical company that has drug development or sales and marketing capabilities, or both. Entering into an agreement or partnership with a pharmaceutical or biotechnology company that has these capabilities may enable us to increase our returns from our product candidates by utilizing that company's development or sales and marketing capabilities, or both, to further accelerate development of our product candidates or enable us to develop the candidate in more than one indication simultaneously.

Outsourcing

In order to optimize the development of our product candidates, we outsource certain of our product development activities. Factors that we consider in determining which activities to outsource include cost, relative expertise, capacity and quality assurance. The product development functions that we have chosen to outsource include pre-clinical activities in support of regulatory filings, clinical trials and manufacturing. We believe that our relationships with external laboratories enable us to complete pre-clinical testing faster and more efficiently than if we performed these activities ourselves. Additionally, there are many independent contract research organizations that are specifically equipped and set up to manage clinical trial projects, thus alleviating the need for iCo to commit internal resources to do so. Because our manufacturing needs are currently sporadic, we believe that it is more efficient to outsource manufacturing.

iCo-007

Diabetic retinopathy is an ocular complication of diabetes and is the leading cause of vision loss and blindness in working age adults. It is characterized by new blood vessel growth and increased vascular permeability in the back of the eye. Diabetic retinopathy can have many symptoms, including fluid leak into the macula, the part of the eye where the sharpest vision occurs, causing it to swell, known as DME. DME is the most serious form of diabetic retinopathy and afflicts up to 1.6 million patients in the United States alone. Lucentis and Eylea are currently the

only approved drug available for this disease in Canada and the United States, in addition to laser photocoagulation of leaking blood vessels. Steroids and off label drugs such as Avastin s are also used in certain situations. iCo-007 (previously known as ISIS 13650), is a second generation antisense compound which has been shown in a variety of studies to reduce levels of C-Raf kinase, a key protein associated with diabetic retinopathy (including DME). However, based on negative results of the Phase II iDEAL study in DME, we ceased development for this particular indication. Nevertheless, we believe that reducing C-Raf kinase levels may provide a clinical benefit for patients in other indications, such as oncology, and are currently studying the merits of pursuing such opportunities.

Therapeutic Approach

The Role of C-Raf kinase in Blood Vessel Growth

The Raf kinase family of enzymes is critical in delivering signals in cells through the mitogen activated protein kinase pathway ("MAP kinase pathway"). In particular, in vitro experiments have demonstrated that C-Raf kinase plays an important role in delivering signals that promote cell proliferation and interfere with natural cell death, or apoptosis. We believe that drug products which reduce C-r\Raf kinase expression may have the potential to prevent the growth of new blood vessels and increased vascular permeability.

The raf kinase family of enzymes is composed of 3 isotypes: A-Raf, B-Raf and C-Raf (also known as Raf-1 or C-Raf-1). The tissue expression profile of each member of the raf kinase family varies significantly, with C-Raf kinase having the broadest tissue distribution. Compared to C-Raf kinase, the expression profile of A-Raf kinase and B-Raf kinase is much more restricted. A-Raf kinase has higher expression levels in urogenital tissues, while B-Raf kinase has expression in only the testis, cerebellum, and spinal cord. While reducing expression of each member of the raf kinase family is a potential treatment for diseases involving growth of new blood vessels, we believe that C-Raf kinase is a better therapeutic target than A-Raf kinase or B-Raf kinase because of its broader expression profile.

We believe that the activity of C-Raf kinase in the MAP kinase pathway can be triggered both by growth factors and by integrins. Growth factors and integrins are naturally occurring proteins that send messages to cells by binding to receptors on the cell surface. Clinical studies have indicated that a number of growth factors are linked to the growth of new blood vessels. We believe that growth factors cause blood vessel proliferation by binding to cells and sending signals in cells to activate C-Raf kinase. We believe that integrin mediated signalling also results in the growth of new blood vessels. Studies have indicated that integrin binding in endothelial cells causes activation of raf kinase and activation of the MAP kinase pathway, thereby providing a signal for blood vessel growth.

Inhibiting Protein Production: Second Generation Antisense Technology

Proteins are complex molecules assembled from simpler building blocks called amino acids. Each distinct protein consists of a series of amino acids linked together in a single chain. The identity of each protein is determined by the sequence of amino acids. The order of amino acids is, in turn, dictated by a corresponding gene. Each gene contains information regarding the amino acid sequence that its corresponding protein will have, as well as when, in what cell type, and in what quantity its corresponding protein will be produced.

Genes sit at the top of a unidirectional flow of information in a cell, summarized as follows:

- the DNA of a gene is transcribed into messenger ribonucleic acid ("mRNA");
- mRNA carries information regarding protein sequence to the ribosomes (the structure within cells that manufactures proteins); and
- the ribosome translates the information carried by mRNA into proteins.

Each molecule of mRNA is composed of a series of four distinct ribonucleotides linked together in a single chain to which ribosomes bind for protein assembly. The structure of an mRNA molecule is referred to as "sense" RNA. Therapeutic oligonucleotide candidates that are designed to bind to particular mRNA molecules, or "sense"

molecules, are referred to as "antisense" therapeutics. Each antisense molecule is composed of a sequence of nucleotides that is complementary to the sequence of ribonucleotides of the target sense molecule. The antisense molecule inhibits protein production by binding to the sense molecule and either leading to the degradation of the target RNA or physically preventing it from being translated into a protein by the ribosome.

First generation therapeutics have been studied extensively in safety and efficacy clinical trials but are susceptible to rapid degradation and loss of functionality when introduced to the human body. As a consequence, every two to three day dosing or every two to four week injection to the eye is generally required in order to maintain first generation antisense in concentrations that are sufficient to be effective. The FDA approved Vitravene®, a first generation antisense therapeutic developed by Isis for the treatment of cytomegalovirus retinitis in people with AIDS, in 1998.

Antisense therapeutics based on second generation antisense chemistry have increased target binding affinity, improved resistance to degradation and decreased toxicities. Because of these improvements, second generation antisense therapeutics degrade more slowly when introduced to the human body. The primary advantage of slower degradation is less frequent dosing, which means that therapeutics based on second generation antisense technology are less intrusive and more cost efficient than therapeutics based on first generation antisense technology.

Development Status

Pre-Clinical Studies

In 2001, Isis conducted a study on the effect of a pig-specific oligonucleotide (ISIS 107189) using second generation antisense technology to inhibit C-Raf kinase production in pig eye tissue. In this study, C-Raf kinase levels in animals that received ISIS 107189 was compared to C-Raf kinase levels in animals that received a saline vehicle. C-raf kinase levels in animals that received ISIS 107189 was reduced by 60% seven days after treatment. In addition to measuring C-Raf kinase mRNA levels, the study also monitored the growth of new blood vessels subsequent to branched vein occlusion during the three months following treatment. The study indicated that there was a reduction in new blood vessel growth in eyes treated with ISIS 107189.

In 2002, Isis conducted a study on the effect of a mouse specific second generation oligonucleotide (ISIS 15770) targeting C-Raf kinase. In this study, mice experiencing new blood vessel growth were administered a dose of ISIS 15770 in one eye and a saline vehicle in the other eye. The treatment was delivered seven days prior to the onset of new blood vessel growth and again at the onset. Three days after the onset of new blood vessel growth, or neovascularisation, there was a 40% reduction in C-Raf kinase mRNA levels activity in eyes that received injections of ISIS 15770, and seven days after onset there was a 30% reduction in C-raf kinase mRNA levels in eyes that received injections of ISIS 15770. Fourteen days after the onset of neovascularisation there were significantly fewer rupture sites on the retina in eyes that received ISIS 15770 treatment.

Isis has also conducted pre-clinical studies regarding the pharmacokinetics of iCo-007 following intravitreal injection. In these studies, Isis studied the half-life of iCo-007 in rabbits and monkeys. We believe that the data from these studies indicates that a dosing regimen of once every three to six months may be appropriate. We also believe that these studies indicate that iCo-007 has the potential to be administered in quantities that are not of toxicological concern and that can be safely tolerated by the human body.

Phase I Clinical Trials

In May 2010, we completed a Phase I, open label, dose-escalating clinical trial at four trial sites in the United States using a single injection of iCo-007 in patients with DME. The primary endpoint for the trial was to assess the safety of iCo-007 at four different dosage levels in four groups ("cohorts") of patients – fifteen patients in total. Because the trial was conducted in patients with disease as opposed to healthy volunteers, we were also able to collect limited data on what effect the drug may be having on the disease itself. All patients have been treated and have completed their subsequent clinic visits.

The Phase I clinical trial for iCo-007 met its primary end point, which was to evaluate the ocular safety and tolerability of iCo-007 in 15 patients following a single intravitreal administration. Secondary objectives included assessment of systemic pharmacokinetics, retinal thickness using optical coherence tomography ("OCT") measurements, and visual acuity. Intravitreal injections of iCo-007 were well tolerated with a good safety profile; ultimately progressing to the highest dose of 1000 ug based on positive safety evaluation committee meetings two months post each dosing level. Analysis of blood plasma in patients demonstrated that iCo-007 was not detectable in the blood plasma with any of the doses used in the Phase I trial. There were signs of biological activity in responsive patients at 24 weeks with a reduction of retinal thickness ranging between 149 and 743 microns (and 115 to 743 microns if one additional patient followed only to week 18 is included). For the 12 patients completing the 24 week follow-up, the mean change in retinal thickness was minus 169 microns (or 40% reduction of excess retinal thickness). In a number of subjects there was a transient increase in retinal edema preceding biological effect. Approximately 69% of the patients completing the 24 week follow up had stable or improved vision, defined as between zero and less than 5 letters or better compared to baseline. 23% of patients experienced greater than or equal to 5 letters of visual improvement. The highest dose seemed to show a smaller biological effect than lower doses. The first three doses appeared to display some dose-related biological effect, warranting further exploration of dosing and treatment regimen in a Phase II clinical trial.

Strategic and preliminary planning for the Phase II clinical trial was initiated in 2009 and formal Phase II clinical trial planning started on conclusion of our Phase I trial in May, 2010. Regulatory documents were filed with Health Canada, and we successfully received a "No Objection" letter from Health Canada in response to an application to initiate a Canadian Phase II clinical trial in July 2010. In mid 2010, we entered into a technology transfer agreement with Isis pursuant to which Isis transferred certain technology (including certain analytical methods, chemistry reports and assays) related to the manufacturing of iCo-007 to iCo. In consideration of the technology transfer, we issued to Isis a warrant to purchase 235,000 shares of iCo's common stock at an exercise price of $0.61 per share. The warrant expired on May 16, 2012.

In February 2011, iCo announced the completion of drug product manufacturing activities as part of its Phase II clinical program. In August 2011 we initiated the iDEAL study, a US physician-sponsored Phase II clinical trial involving iCo-007, that has been conducted in 28 sites throughout the United States. The iDEAL Study is led by the clinician scientists who are investigators in the trial and has been coordinated at the Wilmer Eye Institute of John Hopkins University and later at the Stanley M. Truhlsen Eye Institute of University of Nebraska Medical Center (after the move of our study chair Dr. Quan Nguyen). The iDEAL study is entitled: "Randomized, Multi-center, Phase II Study of the Safety, Tolerability and Bioactivity of Repeated Intravitreal Injections of iCo-007 as Monotherapy or in Combination with Ranibizumab or Laser Photocoagulation in the Treatment of Diabetic Macular Edema With Involvement of the FoveAL Center ."

On September 26, 2011, iCo announced a research collaboration agreement with JDRF, the worldwide leader for research to cure, treat, and prevent T1D, to support the previously announced Phase II investigator sponsored clinical trial investigating iCo-007 in DME. On March 28, 2012, we officially announced the trial design of the iDEAL study. During the trial, patients were randomized into one of the following four groups: either one of two mono-therapy arms using repeated intravitreal dosing of two different concentrations of iCo-007; or one of two combination arms using iCo-007 with laser photocoagulation or iCo-007 and ranibizumab. Patients were followed for 12 months after their intial treatment. To be eligible for the trial, participants must have T1D or T2D, baseline visual acuity between 20/32 and 20/320 on the Early Treatment Diabetic Retinopathy Study (ETDRS) chart, and DME with central subfoveal thickness greater than 250 microns as measured by optical coherence tomography (OCT). On June18, 2013, we announced completion of enrollment for the iDEAL study. 187 patinents were randomized into the study with 185 subjects treated with iCo-007.

Subsequently on June, 9, 2014, we announced top-line results related to the eight month visual acuity (VA) primary endpoint for subjects enrolled in the iDEAL Study. Statistical methods employed included both Last Observation Carry Forward ("LOCF") and Multiple Imputation ("MI") analyses given the departure of patients from the study prior to their eight month visit. Using both statistical methods, mean changes in visual acuity measures in all four groups at both month four and month eight were negative. Using the LOCF method, mean change in VA at eight months was approximately minus 11 letters (350 µg monotherapy), minus 21 letters (700 µg monotherapy), minus 14 letters (350 µg + laser arm) and minus 14 letters (350 µg + Lucentis). Some patients in each cohort did show improvements in mean change in VA. At eight months using the LOCF analysis, roughly 20% of patients in the 350

µg monotherapy arm gained five letters or greater of vision versus 13% in the 700 µg monotherapy arm, 12% in the 350 µg + laser arm and 11% in the 350 µg + Lucentis arm. At four months, patients gaining five letters or more for the 350 µg, 700 µg, 350 µg + laser and 350 µg + Lucentis arms were approximately 24%, 18%, 21% and 30%, respectively.

Using the LOCF method, it was observed that at month eight there was an inverse statistically significant difference in mean VA change from baseline between 350 µg monotherapy and 700 µg monotherapy arms, meaning there was greater loss of VA in the 700 µg monotherapy cohort. There was no statistically significant difference in mean VA between the 350 µg monotherapy and either 350 µg + laser or 350 µg + Lucentis arms. When using MI analysis there was no statistically significant difference observed between 350 µg monotherapy and each of the 700 µg monotherapy, 350 µg + laser and 350 µg + Lucentis arms.

At eight months, in the 700 µg monotherapy arm, 64% of patients experienced a 15 letter or greater loss of vision, compared to 33% in the 350 µg monotherapy arm, 33% in the 350 µg + laser arm, and 41% in the 350 µg + Lucentis arm. At four months the corresponding numbers were 29%, 9%, 9%, and 14%, respectively.

Management has determined that the Phase 2 iCo-007 diabetic macular edema (DME) data that has been presented, along with our internal analysis, did not demonstrate any subgroup response rates that warrant further financial investment by iCo in the DME program at this time. Management will, however, continue to investigate other potential use indications for its licensed technology which targets the C-Raf kinase pathway. Use indications may include certain oncology applications as a number of approved drugs currently target Raf kinase isoforms.

Secondary Target Indications

We believe that iCo-007 may have potential as a treatment for select oncology indications, including ovarian cancer. In vitro studies have indicated that signalling through the extracellular signal related kinase pathway is associated with increased ovarian cancer cell growth and that C-Raf kinase is the predominant raf isoform responsible for regulating cellular growth in ovarian cancer. These studies suggest that C-Raf kinase inhibitors may have the potential to inhibit ovarian cancer cell growth. As we will no longer be pursuing clinical development of iCo-007 for DME, we may pursue clinical development opportunities for oncology or other indications through partnerships or out-licensing arrangements with third parties who have competencies in these areas.

iCo-008 (Bertilumumab)

Allergic conjunctivitis is the most common form of ocular allergy. iCo-008 is a human monoclonal antibody that we believe has the potential to inhibit the development of allergic conjunctivitis as well as a number of other diseases such as inflammatory bowel disease.

Therapeutic Approach

The Role of Eotaxin-1 in Allergic Conjunctivitis

Our approach to treating severe allergic conjunctivitis involves neutralizing eotaxin-1, a chemokine that we believe plays an important role in mast cell degranulation and attracting eosinophils to inflammation sites. Pre-clinical studies have indicated that mast cell degranulation and recruitment of eosinophils to the conjunctiva is critical in the pathophysiology of severe ocular conjunctivitis. We believe that drug products which neutralize eotaxin-1 and inhibit mast cell degranulation and eosinophilia have potential as a treatment for severe ocular allergies such as severe allergic conjunctivitis.

Chemokines are a class of chemotactic cytokines, which are soluble proteins that transmit intracellular messages by binding to specific receptors on target cells. The chemokine receptor associated with eotaxin-1 is CC chemokine receptor three ("CCR3"). Studies have indicated that signalling by eotaxin-1 plays an important role both in mast cell degranulation and in mediating eosinophil recruitment to the site of allergic reactions. Studies have also

indicated higher than normal concentrations of eotaxin-1 in patients suffering from vernal keratoconjunctivitis ("VKC") and atopic keratoconjunctivitis ("AKC").

Treatment of Allergic Conjunctivitis with iCo-008

An antibody or immunoglobulin is a large Y-shaped protein used by the immune system to identify and neutralize antigens. Each antibody recognizes a specific antigen. The two tips of the "Y" each contain a paratope, a structure analogous to a lock, that is specific to the epitope, a structure analogous to a key, on a particular antigen. The shape of the antibody and the antigen allows each antibody to bind to the corresponding antigen. This binding mechanism allows the antibody to "tag" an antigen for attack by other parts of the immune system or to neutralize an antigen by interfering with its functionality. A monoclonal antibody is a laboratory produced antibody that has been specifically tailored to bind to a particular antigen.

iCo-008 is a human monoclonal antibody that has been developed to neutralize eotaxin-1. iCo-008 neutralizes eotaxin-1 by binding to it and, as a consequence, preventing it from binding to CCR3. By preventing eotaxin-1 from binding to CCR3, we believe that iCo-008 has the potential to inhibit intracellular signalling associated with mast cell degranulation and the recruitment of eosinophilic leukocytes to the site of allergic reactions and, as a result, potentially inhibit both early stage and late stage development of severe allergic conjunctivitis.

Development Status

Pre-Clinical Studies

Cambridge Antibody Technology Limited ("CAT", now known as Medimmune) conducted pre-clinical studies of iCo-008 from 1999 to 2001. We believe that these studies indicated that iCo-008 has the potential to neutralize human eotaxin-1.

Clinical Studies

In December 2006, we entered into a licence agreement with Medimmune for the exclusive world-wide rights to develop and, upon regulatory approval, market iCo-008 for all disease indications. Before we licensed iCo-008 from MedImmune, MedImmune conducted Phase I clinical trials testing the safety, tolerability and pharmacokinetics of iCo-008 and Phase II clinical trials testing the efficacy of iCo-008 as a treatment for allergic rhinitis and allergic conjunctivitis.

A Phase I clinical trial conducted by CAT indicated that iCo-008 was well-tolerated when administered as a single intravenous infusion, with no adverse safety findings. The half-life of iCo-008 was estimated to be nine days.

A Phase II clinical trial conducted by CAT testing the efficacy of iCo-008 as a potential treatment for allergic conjunctivitis involved a 49 person trial. The trial tested the efficacy of administering a single topical dose of iCo-008. The primary aim of this study was to determine the concentration of iCo-008 needed to suppress early phase ocular itch in subjects with mild cases of non-active seasonal allergic conjunctivitis. As a secondary objective, the study also aimed to assess the safety and tolerability of topical ophthalmic doses of iCo-008. Preliminary data from the trial indicated that a single dose of topically applied iCo-008 is safe and well-tolerated, but did not provide evidence of statistically significant pharmacological activity. These results are consistent with the low level of eosinophil involvement in early phase seasonal allergic conjunctivitis. We believe that iCo-008 has potential as a treatment for more severe types of allergic conjunctivitis, such as VKC, because of the increased involvement of eosinophils in such subtypes of allergic conjunctivitis. In addition, more severe subtypes of allergic conjunctivitis, including VKC, are characterized by larger amounts of inflammation. Because increased inflammation results in the opening of the tight epithelial junctions of the conjunctiva, we believe that it may be easier to deliver higher concentrations of iCo-008 to the target tissue.

A Phase II clinical trial conducted by CAT testing the efficacy and safety of iCo-008 as a treatment for allergic rhinitis or hay fever involved 52 participants. The trial tested the efficacy of administering a single dose of iCo-008 both intravenously and intranasally. This trial did not show statistically significant treatment differences between

the placebo group and the group that was administered iCo-008 intravenously. However, there was statistical evidence of significant treatment differences between the placebo group and the group that received 10mg of iCo-008 by intranasal spray. Although we believe that the results of this study support the continued investigation of intranasal administration of iCo-008 as a treatment for allergic diseases such as hay fever, we are not planning on conducting in-house studies for the development of iCo-008 as a treatment for hay fever. We may consider out-licensing iCo-008 for development as a treatment of hay fever or entering into an agreement with a partner who will take responsibility for developing iCo-008 as a treatment for hay fever.

We have developed a Phase II clinical plan to test the efficacy and safety of iCo-008 in individuals with a serious sight threatening form of allergic conjunctivitis known as vernal keratoconjunctivitis ("VKC"), however, the global credit crisis which began in 2008 severely restricted our ability to raise equity capital and the strategic decision was made to preserve our cash resources for developing iCo-007 and explore strategic initiatives to fund further development of iCo-008, which resulted in the outlicencing of systemic rights to iCo-008 to Immune Pharmaceuticals Inc. ("IMMUNE"). Subsequently, given the recent positive developments for raising capital in the life sciences industry, we have since begun to re-evaluate a possible Phase II trial for iCo-008 in VKC or or a similar eye disease indication. However this work is preliminary and no formal decision or plans have been made to begin formal clinical development.

Secondary Target Indications

Although the focus of our initial development programs for iCo-008 are in the area of allergic conjunctivitis, we believe that iCo-008 has potential as a treatment for other conditions involving mast cell degranulation or eosinophilia, such as food allergies, severe asthma and inflammatory bowel disease. In December 2010, we granted IMMUNE an option to an exclusive sub-license for the development and commercialization rights to the systemic uses of iCo-008, including inflammatory bowel disease and severe asthma. iCo retained worldwide exclusive rights to all uses and applications in the ocular field. Under the terms of the option, IMMUNE paid iCo a non-refundable option fee creditable upon exercise of the option against an upfront license fee payment of U.S. $1 million. In June, 2011, IMMUNE exercised the option and entered into an exclusive sub-licence agreement (the "IMMUNE Licence Agreement") with iCo. If IMMUNE successfully develops and commercializes iCo-008 for systemic uses, iCo may receive up to an additional US$32 million in milestone payments as well as royalties on net sales of licensed products. IMMUNE will also share in funding 50% of the patent prosecution and maintenance costs of the iCo-008 patent family. Including the initial option fee, option extension fees and the fee for exercising the option to an exclusive sub-licence, we received a total of US$500,000 in cash as well as a 6.4% equity stake in IMMUNE. Please refer to the Company's financial statements for the year ended December 31, 2014 for specific details of the transaction.

IMMUNE has initiated a Phase 2 double-blind, placebo controlled study with its lead drug, Bertilimumab (iCo-008), in patients with moderate-to-severe ulcerative colitis. The ulcerative colitis clinical trial is a randomized, double-blind, placebo-controlled parallel group study that will evaluate the safety, clinical efficacy, and pharmacokinetic profile of Bertilimumab in subjects with active moderate-to-severe ulcerative colitis. Ninety patients are expected to be enrolled into the study, sixty of whom will be treated with Bertilimumab 7mg/kg and thirty of whom will be treated with placebo every two weeks, at days 0, 14, and 28. These patients will be evaluated for clinical response after 6 weeks to determine the decrease if any in the full Mayo Clinic Ulcerative Colitis Score. Secondary and exploratory end points will include clinical remission defined as symptom free, fecal calprotectin, a recognized marker of gastro-intestinal inflammation, histopathology improvement and degree of mucosal injury. Patient follow-up will continue up to day 90. IMMUNE will also be enrolling and studying patients with Bullous Pemphigoid a rare auto-immune condition that affects the skin and causes the formation of blisters.

On April 15, 2015, IMMUNE announced that patient enrollment in the Bullous Pemphigoid and moderate-to-severe Ulcerative Colitis Phase II trials with Bertilimumab (iCo-008) is scheduled to start in the second quarter of 2015. Initial clinical data form the Bullous Pemphigoid trial may be available by the end of 2015.

Scientific literature (e.g. Nature: Takeda et al, 2009: CCR3 is a Target for Age-related Macular Degeneration Diagnosis and Therapy) has also indicated that iCo-008 may have utility to potentially treat AMD (described above). In light of this new information, we continue to explore AMD as a possible therapeutics indication for iCo-008.

Oral Amphotericin B Delivery System ("Oral AmpB Delivery System"), formerly known as iCo-009 (and related derivatives)

In July 27, 2007, we entered into an option agreement with UBC which granted us an option to negotiate a licence for the exclusive rights to the Oral AmpB Delivery System to be used for potential systemic fungal infections. The Company exercised the option on February 26, 2008 and on May 6, 2008 signed an agreement with UBC for the exclusive worldwide licence to the oral Amphotericin B delivery system .

iCo's Oral AmpB Delivery System has been developed in the laboratory of Dr. Kishor Wasan at the University of British Columbia and the University of Saskatchewan. Intravenous AmpB has historically been a potent but toxic option for the treatment of serious systemic fungal infections. Systemic fungal infections are fungal infections that affect the entire body and are particularly prevalent among people whose immune systems have been weakened by certain treatments, such as organ transplant recipients, or certain conditions, such as cancer, diabetes or AIDS. Although drugs have been developed for the treatment of systemic fungal infections, systemic fungal infection remains a leading cause of death for organ transplant recipients and people suffering from such conditions. In addition, in developing nations, oral therapy is needed for VL, known for its high mortality rates. Current AmpB therapy requires repeated infusions in the hospital setting and is often associated with infusion-related adverse events, including renal toxicity. Successful oral formulation could resolve the safety issues associated with parenteral application and enable a much broader patient access to this highly effective treatment option. Oral dosing of AmpB has not been successful in the past due to inactivation of the drug in the gut before it could get into the systemic circulation. Although the experimental oral formulation that has been studied by Dr. Wasan shows encouraging results so far, additional pre-clinical data will need to be generated to further demonstrate oral bioavailability, safety and efficacy prior to commencing a clinical program.

Therapeutic Approach

Despite the development of a number of new antifungal agents, intravenous AmpB remains one of the most effective agents for the treatment of systemic fungal infections. However, intravenous AmpB is often associated with severe side effects, such as fever, shaking, chills, hypotension, anorexia, nausea, vomiting, headache and kidney toxicity. In addition, intravenous formulations of drug products are generally more expensive and less convenient to administer than oral formulations. Because of the limitations of intravenous AmpB, we believe that Oral AmpB has potential as a treatment for systemic fungal infections. If an effective formulation of Oral AmpB can be developed, we believe that it would have the potential to provide a safer, cheaper and more effective alternative than intravenous AmpB.

Development Status

Both prior and subsequent to the in-licencing of the Oral AmpB Delivery System in May, 2008, we have completed a number of studies with the Oral AmpB Delivery System showing promising pharmacokinetic and tissue distribution results in two anti-fungal models that are known to be predictive of activity in humans. In these studies, it showed activity against both *Candida albicans* and *Aspergillus fumigatus*. The results of these studies have demonstrated significant antifungal knock-down at oral dosage levels where no kidney toxicity was observed, a key differentiator of the Oral AmpB Delivery System. On May 2, 2008, we held a Pre-IND meeting with the FDA to provide further guidance as to the regulatory path moving forward, including a clinical plan review for a single dose escalation safety and tolerability clinical trial. We are currently initiating formal good laboratory practice

("GLP") toxicology studies and manufacturing of drug product under good manufacturing practice ("GMP") standards that are required to support an investigational new drug application ("IND") to the U.S. Food and Drug Administration ("FDA") and a Phase I clinical trial. These development programs will only be undertaken subject to obtaining appropriate financing. To this end, we have been working in cooperation with UBC to obtain third party financing, primarily through government and private granting agencies such as the CIHR to fund certain pre-clinical studies. UBC, with assistance and sponsorship from iCo, was awarded two CIHR grants to fund development of the Oral AmpB Delivery System: a CIHR Research Chair and a CIHR Proof of Principal II ("POP II") grant for an aggregate of up to $1,200,000 of research funding. This amount included matching funding requirements from the Company of 50% for the CIHR Research Chair and 66% for the POP II**.**

The Oral AmpB Delivery System has also demonstrated promising results in an animal model of the parasitic infection that causes VL at a leading independent U.S. research laboratory. The studies showed a greater than 99% eradication of the parasitic infection. The Oral AmpB Delivery System's preclinical results to date have generated preliminary interest from various global philanthropy organizations and pharmaceutical companies. In September 2009 we entered into a collaboration development agreement with the Consortium for Parasitic Drug Development ("CPDD") for up to U.S. $182,930 for the research and development of our Oral AmpB Delivery System oral drug delivery technology for the treatment of neglected diseases such as leishmaniasis and trypanosomiasis. This program was completed in the third quarter of 2010.

On May 31, 2012 we announced that the company had been awarded a $1.1Million non-repayable financial contribution from the National Research Council of Canada to support iCo's Oral Amphotericin B (Amp B) delivery system as novel treatment for patients with Human Immunodeficiency Virus (HIV). The funding will support feasibility testing and pre-clinical toxicology studies, as well as human safety and efficacy clinical trials to examine the role of the Amp B delivery system in potentially treating patients with latent HIV reservoirs. The funding for the 3-year project comes from the NRC Industrial Research Assistance Program (NRC-IRAP) under the CHTD Program, which aims to encourage and support the participation of small and medium-sized enterprises in the development of an HIV vaccine and other technologies related to the prevention, treatment, and diagnosis of HIV. The program is part of the Canadian HIV Vaccine Initiative (CHVI), collaboration between the Government of Canada and the Bill & Melinda Gates Foundation. On December 12, 2013**,** we announced that the Oral AmpB technology had moved into in vitro testing with study partners in Montreal to examine the role of this formulation in targeting latent HIV reservoirs which remain in individuals despite enormous therapeutic advances in the treatment of HIV/AIDS and subsequently released the results on August 29, 2014. Memory cells, or white blood cells, from eight HIV-infected subjects with a durable viral suppression using antiretroviral therapy (HAART) were obtained and exposed *in vitro* to various concentrations of Oral AmpB. Samples from one patient were determined not to be susceptible to reactivation. In the remaining subjects, Oral Amp B demonstrated a reactivation response of HIV viral production in six out of seven *in vitro* cultures with detectable HIV reservoir. Some HIV reservoirs are not possible to reactivate and this may explain why one culture did not show reactivation response.

On October 22, 2014, we announced next steps for our Oral AmpB Delivery System, having previously announced positive findings from its *in vitro* work involving samples from HIV/AIDS patients exposed to HAART therapy. iCo now plans to complete pre clinical studies and regulatory filings to move forward with an initial Phase 1A clinical trial, utilizing approximately $700,000 remaining of the aggregate $1.1 million funding and technological advice from NRC-IRAP under CHTD Program. The preparation and regulatory filings are expected to be underway in the second half of 2015, with initiation of a Phase 1A study in the first quarter of 2016.

UBC and iCo are currently collaborating on obtaining additional non-dilutive sources of capital which would fund the necessary GLP/GMP pre-clinical work to permit iCo's oral AmpB formulations to enter into human Phase I clinical trials.

Intellectual Property

Our intellectual property rights for iCo-007 (formerly Isis 13650) arise from a licensing agreement with Isis. Under this agreement, we have exclusive worldwide rights to develop, manufacture and commercialize iCo-007 under all C-Raf antisense oligonucleotide patents granted to Isis in various countries in North America, Europe and around

the world, including the United States, Canada and Japan with expiration dates between 2014 and 2016. Under this agreement, we were also granted rights with respect to any intellectual property owned, licensed or otherwise controlled by Isis as at the date of the agreement that relates to second generation antisense chemistry and is required for development and commercialization of iCo-007. These enabling technologies, which are necessary for the manufacture of iCo-007 in its current form, are protected by a United States patents that expires in 2023. In addition, we filed patent applications related to dosing regimens of iCo-007. Our intellectual property rights for iCo-007 are further protected in that Isis will not develop or commercialize or grant any licence or other rights to a third party to develop or commercialize any antisense RNA or analog thereof that directly inhibits C-Raf kinase (the target for iCo-007) expression or translation. Based on the results obtained in the iDEAL trial, and that the core iCo-007 C-Raf antisense oligonucleotide patents were expiring, we have abandoned the remaining C-Raf antisense oligonucleotide patents and applications, as well as the patent applications related to dosing regimens of iCo-007 and will not prosecute any further patents related to this product.

Our intellectual property rights for iCo-008 (formerly CAT-213) arise from our licensing agreement with MedImmune. Under this agreement, we have exclusive rights to develop, manufacture and commercialize iCo-008 under all CAT-213 patents held by MedImmune in a number of key jurisdictions in North America, Europe and around the world, including the United States, Canada and Japan. The issued patents will expire in 2021-2022, absent any extensions thereto.

Our intellectual property rights for the Oral AmpB Delivery System arise from our licensing agreement with the University of British Columbia (UBC). Under this agreement, we have exclusive rights to develop, manufacture and commercialize iCo-010 under the relevant UBC patents related to stabilized formulations of therapeutic agents, which include granted patents in the United States and pending patent applications in key jurisdictions in North America, Europe and around the world. We have also filed additional patent applications related to new uses for the Oral Delivery System technology for other stabalized drug formulations.

Under our license agreements with Isis and MedImmune, we direct patent prosecution and are responsible for all fees and costs related to the prosecution and maintenance of the patent rights underlying the agreements. We file patent applications for the relevant intellectual property underlying these agreements in the United States, Canada, Europe, Japan, and numerous other jurisdictions. Where necessary or preferable, we also rely on trade secrets and know-how to protect certain intellectual property. We pursue proprietary protection that we consider important to our business by filing patent applications on compositions of matter and their methods of use. Under our licence agreement with UBC, we and UBC jointly coordinate patent prosecution activities.

The actual protection afforded by a patent varies from country to country and depends upon many factors, including the country for which the patent has been granted, the type of patent, the scope of its coverage, the availability of regulatory related extensions, the availability of legal remedies in a particular country and the validity and enforceability of the patent. For patent applications filed in the United States on or after June 8, 1995, patents are generally effective for 20 years from the earliest non-provisional filing date, (otherwise the term is the longer of 17 years from the issue date or 20 years from the earliest non-provisional filing date). The duration of patent terms for non-U.S. patents is typically 20 years from the earliest corresponding national or international filing date.

Licensing Agreements

Isis

We acquired exclusive, world-wide rights from Isis to develop and commercialize iCo-007 for all indications pursuant to a license agreement dated August 24, 2005. Under the agreement, we are solely responsible for the clinical development, commercialization and marketing of iCo-007. In consideration for entering into the agreement, we paid Isis an upfront fee of US$500,000, comprising US$250,000 in cash and a US$250,000 convertible note. On April 26, 2006, Isis converted the note into 362,094 common shares of Privateco at an exercise price of $0.80 per share. In addition, we are required to make further payments of up to US$22 million upon the attainment of certain milestones relating to the commercial development of the product candidates. On September

17, 2007, we made our first such payment to Isis by issuing securities to Isis having an aggregate subscription price of $1,311,625. We will also pay a royalty to Isis based on future sales.

MedImmune

We acquired exclusive, world-wide rights from MedImmune to develop and commercialize iCo-008 for all indications pursuant to a license agreement dated December 20, 2006. Under the agreement, we are solely responsible for the clinical development, commercialization and marketing of iCo-008. In consideration for entering the agreement, we will pay MedImmune up to US$7.4 million, of which US$0.4 million has been paid and the rest on achieving certain development milestones. A royalty will also be paid to MedImmune based on future sales. The agreement additionally provides that we will pay up to US$7 million in milestone payments, plus royalties, for each non-ocular disease indication for which the compound is developed.

UBC

On July 27, 2007, we entered into an option agreement with UBC which granted us an option to negotiate a licence for the exclusive rights to the Oral AmpB Delivery System to be used for potential systemic fungal infections. We exercised the option on February 26, 2008 and on May 6, 2008 signed an agreement with UBC for the exclusive worldwide license to the Oral AmpB Delivery System (the "UBC License"). In consideration for the UBC License, we paid UBC an initial license fee of $20,000 and are required to pay annual fees to UBC for maintaining the license until such time as a New Drug Application ("NDA") for the Oral AmpB Delivery System is approved by the FDA or other regulatory body. We are required to make additional contingent payments of up to $1,900,000 in aggregate upon the achievement of certain development and commercialization milestones and are also required to pay royalties on future revenues.

As part of the UBC Licence, we also made a separate commitment to secure additional research funding for the Oral AmpB Delivery System. The research funding commitment may take the form of indirect financial contributions, such as government or privately sponsored research grants, direct contributions from us, or a combination of the two. We were successful in securing additional research funding for the Oral AmpB Delivery System through the award of a CIHR Research Chair to fund further research over a four year period. In consideration of securing the CIHR Research Chair, on February 23, 2009 UBC provided notification to us that our obligation to UBC under the UBC Licence to secure the research funding for the Oral AmpB Delivery System will be satisfied in its entirety as long as we meet our funding obligations under the CIHR Research Chair and fulfill our obligations to pay UBC the remaining outstanding balance in direct research funding committed to by the Company for 2009. As of the date hereof, we have met all of our direct financial obligations to UBC and the CIHR Research Chair.

Immune Pharmacaeutials Corp.

In December 2010, we granted IMMUNE an option to an exclusive license for the development and commercialization rights to the systemic uses of iCo-008, including inflammatory bowel disease and severe asthma. We retained worldwide exclusive rights to all uses and applications in the ocular field. Under the terms of the agreement, IMMUNE paid iCo a non-refundable option fee creditable upon conversion against an upfront license fee payment of US $1 million. iCo may receive up to an additional US$32 million in milestone payments as well as royalties on net sales of licensed products. Subsequently, upon exercise of the option on June 24, 2011, iCo and IMMUNE entered into the IMMUNE Licence Agreement. In connection with the exercise of the option iCo received a further payment of US$200,000 plus 600,000 IMMUNE ordinary shares (valued at US$2.00 per share) and 200,000 IMMUNE warrants. The warrants are exercisable at a discount to the initial public offering price if as and when IMMUNE undertakes a going public transaction. IMMUNE will also share in funding 50% of the patent prosecution and maintenance costs of the iCo-008 patent family. Including the initial option fee, the option extension fees and the fee for converting the option to an exclusive sub-licence, the Company received a total of US$500,000 in cash from IMMUNE.

On August 26, 2013, IMMUNE completed a merger with Epicept Corporation, a company publicly traded on the NASDAQ OTCQX. The combined company changed its name to Immune Pharmaceuticals Inc. ("Immune Pharmaceuticals") and currently trades on the OTCQX under the symbol IMNP and Stockholm Exchange under the symbol IMNP. The impact of the merger on iCo's investment in Immune is explained in more detail below under the heading: "Investment in Immune Pharmaceuticals".

Investment in Immune Pharmaceuticals

As mentioned above, in consideration for the exclusive licence agreement entered into on June 24, 2011, with IMMUNE, we received 600,000 IMMUNE common shares ("IMMUNE shares") and 200,000 IMMUNE Warrants in addition to certain other cash consideration. The IMMUNE shares contained certain anti-dilution features such that our equity position in IMMUNE would be maintained at 6.14%, subject to certain conditions. Subsequently, we were issued an additional 458,621 IMMUNE shares pursuant to the anti-dilution rights for a total holding of 1,058,621 IMMUNE shares. As part of the merger between Epicept and IMMUNE completed on August 26, 2013, there was a share consolidation such that our holdings in the new company, Immune Pharmaceuticals, was reduced to 654,486 common shares and 123,649 warrants. As at December 31, 2014, the fair market value of Immune Pharmaceuticals shares was determined to be US$1.89. As at December 31, 2014**,** 117,817 IMMUNE shares had been sold. Refer to our financial statements for the year ended December 31, 2014 for further details.

Other Collaborations

In keeping with our strategy to outsource certain activities, we have entered into agreements with third parties for pre-clinical, regulatory, clinical, manufacturing, data and information technology management services. We choose each third party based on their expertise, capacity, industry reputation and the cost of the service. Specific agreements we have entered into during 2014 or which were in effect through 2014 include the following:

In February 2010 we engaged Ashuren Cantox Health Sciences International now Intertek Scientific & Regulatory Consultancy ("Intertek") to assist us with the preparation of our clinical trial application ("CTA") for iCo-007 in Canada. Intertek prepared summaries of the formatted toxicology, pharmacology and pharmacokinetic data from the IND into appropriate Canadian format. Intertek also summarized the phase I clinical trial data and drafted the Protocol Safety and Efficacy Assessment Template ("PSEAT") section of the CTA. Although regulatory activities for iCo-007 have ended, Intertek continues to support iCo's regulatory efforts for our Oral AmpB program in the capacity of Canadian and U.S. agent.

On July 7, 2011 we signed an agreement with Almac Group for the production and storage of clinical supply kits to support the iDEAL Phase II study. The production of the clinical supply kits has been completed, however storage of remaining iCo-007 API and drug product continues.

Also on July 7, 2011 we entered into an agreement with Charles River Laboratories to produce pharmacokinetic collection kits, return shippers for samples, and run pharmacokinetic hybridization assay analyses in support of the Phase II iDEAL study. This arrangement is ongoing.

On September 26, 2011, iCo announced a research collaboration agreement with the JDRF, the worldwide leader for research to cure, treat, and prevent T1D, to support the Phase II iDEAL study. This collaboration concluded April 7, 2015.

On May 31, 2012 we announced that the company had been awarded a $1.1Million non-repayable financial contribution from the National Research Council of Canada to support iCo's Oral AmpB delivery system as novel treatment for patients with Human Immunodeficiency Virus (HIV). This collaboration is ongoing.

Manufacturing

We do not manufacture our own products. We rely on contracts with third parties for the manufacture of product candidates for use in clinical trials. If and when any of our products are approved for commercial sale, we expect to continue to enter into manufacturing contracts with third parties to manufacture our drug product for commercial sale. We require all of our third party manufacturers to manufacture our product in accordance with current good manufacturing practices ("cGMP").

We acquired the active pharmaceutical ingredient ("API") for iCo-007 from Isis pursuant to a manufacturing agreement dated December 16, 2005 at a cost of approximately $900,000. Isis was responsible for manufacturing the active pharmaceutical ingredient for iCo-007 and subcontracted the manufacture of the drug product for iCo-007 to Althea Technologies, Inc. iCo will not be manufacturing any further iCo-007 API or drug product, and the majority of the remaining API and drug product is currently being destroyed. A select amount will be maintained in storage for regulatory purposes.

As part of our agreement with Immune Pharmaceuticals, we have access to limited quantities of iCo-008 antibody on a "cost plus" basis, however this access is subject to sufficient quantitities of iCo-008 being available and that it is in a format suitable for our requirements.

Facilities

As we outsource the majority of our research and development, we do not have any laboratories. We lease approximately 1,200 square feet of office space in downtown Vancouver, which is sufficient space for the size of our operations**.** On April 29, 2014, the Company extended its operating lease agreement for office space (expiring May 31, 2015) for an additional extension, extending the expiration date to December 31, 2015. Beyond this date we will need to either negotiate an additional extension or re-locate to new office space.

Employees

We have a total of six employees, five of whom are employed on a full-time basis and one of whom is employed on a part-time basis. Two of our employees are responsible for oversight of clinical trials, regulatory affairs and business development and four are responsible for administration, investor relations, accounting and finance. In addition to our permanent workforce, we regularly use outside consultants to provide advice on our clinical development plans, research programs and potential acquisitions of new technologies on a project-by-project basis.

All of our employees and consultants have entered into non-disclosure agreements with us regarding our intellectual property, trade secrets and other confidential information. In addition, we have entered into non-competition agreements with each of our key employees and consultants. None of our employees are represented by a labour union or covered by a collective bargaining agreement, nor have we experienced any work stoppages. We believe that we maintain satisfactory relations with our employees.

Insurance

We maintain director and officer insurance, clinical trial insurance, general liability insurance for our facilities and shipping and storage insurance for product candidates. We do not have key person insurance. If and when marketing approval is obtained for any of our product candidates, we will expand our insurance coverage to include the commercial sale of approved drug products.

RISK FACTORS

Investing in our securities involves a high degree of risk. Before deciding to invest in our securities, you should carefully consider the risks described below, together with other information included in or incorporated by reference into this Annual Information Form and filed on SEDAR at www.sedar.com. If any of the following risks materialize, the business, financial condition, results of operation and future prospects of the Company will likely be materially and adversely affected. This could cause actual future events to differ materially from those described in

forward-looking statements and may cause the trading price of our securities to decline. The following discussion highlights some of the risks and uncertainties facing the Company.

Risks Related to Our Business

We have a limited operating history, have incurred losses since inception and anticipate that we will continue to incur losses for the foreseeable future. We have never had any products available for commercial sale and may never achieve or sustain profitability.

We are a clinical stage biopharmaceutical company with a limited operating history. We are not profitable and have incurred losses in each year since our inception in 2005. We have never had any products available for commercial sale and have not generated any revenue from product sales. We do not anticipate that we will generate revenue from the sale of products for the foreseeable future. We have not yet submitted any products for approval by regulatory authorities. We continue to incur research and development and general and administrative expenses related to our operations. Our total comprehensive loss for the years ended December 31, 2014 and 2013 was $2,079,657 and $5,918,965, respectively. As of December 31, 2014, we had incurred cumulative losses of $28,819,566 To date, we have funded our operations primarily from the sale of our securities, and the monetization of investments. We expect to continue to incur losses for the foreseeable future, and expect these losses to increase as we continue our research activities and to conduct development of, and seek regulatory approvals for, our product candidates, and prepare for and begin to commercialize any approved products and acquire rights to additional products for our development pipeline. Because of the numerous risks and uncertainties associated with developing and commercializing drug candidates, we are unable to predict if or when we will be able to generate revenues to support our operations or the extent of any future losses. We may never successfully commercialize any of our product candidates and thus may never have any significant future revenues or achieve and sustain profitability. Even if we achieve profitability in the future, we may not be able to sustain profitability in subsequent periods.

We are largely dependent on the success of two product candidates, iCo008 and the Oral AmpB Delivery System, and we cannot be certain that any of our product candidates will receive regulatory approval or be successfully commercialized.

We currently have no drug products for sale and we cannot guarantee that we will ever have marketable drug products. The research, testing, manufacturing, labeling, approval, selling, marketing and distribution of drug products are subject to extensive regulation by the FDA, the Canadian Therapeutic Products Directorate, ("**TPD**"), and other regulatory authorities in the United States, Canada and other countries, which regulations differ from country to country. We are not permitted to market our product candidates in the United States until we receive approval of a new drug application ("**NDA**"), from the FDA. We have not submitted an NDA or received marketing approval for any of our product candidates. Obtaining approval of an NDA is a lengthy, expensive and uncertain process. We currently have three product candidates. However with the lack of efficacy shown by iCo-007 in the iDEAL trial, our business success currently depends on the successful development and commercialization of the Oral AmpB Delivery System and, to a lesser degree, iCo-008.

The Oral AmpB Delivery System is at a pre-clinical stage. The Oral AmpB Delivery System will require IND enabling GLP toxicology in two animal species, Phase I, II and III trials to support safety, efficacy and registration.

We are currently evaluating plans to re-initiate the clinical development of iCo-008, however no formal decision has been made to move forward at this time . We will have to complete one or more Phase II clinical trials as well as Phase III clinical trials to demonstrate safety and efficacy.

The clinical trials of our product candidates are, and the manufacturing and marketing of our products will be, subject to extensive and rigorous review and regulation by numerous government authorities in the United States, Canada and in other countries where we intend to test and market our product candidates. Before obtaining regulatory approvals for the commercial sale of any product candidate, we must demonstrate through preclinical testing and clinical trials that the product candidate is safe and effective for use in each target indication. This process can take many years and require the expenditure of substantial resources and may include post-marketing studies and surveillance. To date, we have not successfully completed any Phase II or Phase III clinical trials. If our proposed Phase I and II clinical trials for the Oral AmpB Delivery System and potentially, iCo-008 generate safety concerns or lack of efficacy, or competitive products developed by third parties show significant benefit in the

indications in which we are developing our product candidates, any planned Phase III clinical trial may be delayed, altered or not initiated.

If a significant portion of these development efforts are not successfully completed, required regulatory approvals are not obtained, or any approved products are not commercially successful, our business, financial condition, and results of operations may be materially harmed.

Our product candidates may never achieve market acceptance even if we obtain regulatory approvals.

Even if we receive regulatory approvals to market our product candidates, the commercial success of these products will depend, among other things, on their acceptance by physicians, patients, third-party payors and other members of the medical community as a therapeutic and cost-effective alternative to competing products and treatments. The degree of market acceptance will depend on a number of factors, including:

- demonstration of the clinical efficacy and safety of the products;
- cost-effectiveness;
- potential advantage over alternative treatment methods;
- the effectiveness of marketing and distribution support for the products; and
- reimbursement policies of government and third party payers.

If our product candidates fail to gain market acceptance, we may be unable to earn sufficient revenue to continue our business. If our product candidates do not become widely accepted by physicians, patients, third party payors and other members of the medical community, it is unlikely that we will ever become profitable.

We are subject to extensive and costly government regulation.

Our product candidates are subject to extensive and rigorous government regulation by the FDA, the Centers for Medicare and Medicaid Services, other divisions of the U.S. Department of Health and Human Services, the U.S. Department of Justice, state and local governments, and their respective foreign equivalents. The FDA regulates the research, development, preclinical and clinical testing, chemistry, manufacturing and controls (CMC), safety, effectiveness, record keeping, reporting, labeling, storage, approval, advertising, promotion, sale, distribution, import, and export of pharmaceutical products. Our product candidates are also subject to extensive regulation by foreign governments, whether or not we have obtained FDA approval for a given product and its uses. Such foreign regulation may be equally or more demanding than corresponding U.S. regulation. Government regulation significantly increases the cost and risk of researching, developing, manufacturing, and selling our drug candidates. The regulatory review and approval process, which includes preclinical testing and clinical trials of each product candidate, is lengthy, expensive, and uncertain. We or our partners must obtain and maintain regulatory authorization to conduct clinical trials and must obtain regulatory approval for each product we intend to market, and the manufacturing facilities used for the products must be inspected and meet legal and regulatory requirements. Securing regulatory approval requires the submission of extensive preclinical and clinical data and other supporting information for each proposed therapeutic indication in order to establish the product candidate's safety and efficacy for each intended use. The development and approval process takes many years, requires substantial resources, and may never lead to the approval of a product. Failure to obtain regulatory approvals or delays in obtaining regulatory approvals may:

- adversely affect the successful commercialization of any drugs that we or our partners develop;
- impose additional costs on us or our partners;
- diminish any competitive advantages that we or our partners may attain; and
- adversely affect our receipt of revenues or royalties.

Even if we are able to obtain regulatory approval for a particular product candidate, the approval may limit the indicated medical uses for the product, may otherwise limit our ability to promote, sell, and distribute the product, may require that we conduct costly post-marketing surveillance, and/or may require that we conduct ongoing post-marketing studies. Material changes to an approved product, such as, for example, manufacturing changes or

revised labeling, may require further regulatory review and approval. Once obtained, any approvals may be withdrawn, including, for example, if there is a later discovery of previously unknown problems with the product, such as a previously unknown safety issue. If we, our partners, or our contract manufacturers fail to comply with applicable regulatory requirements at any stage during the regulatory process, such noncompliance could result in, among other things:

- delays in the approval of applications or supplements to approved applications;
- refusal of a regulatory authority, including the FDA, to review pending market approval applications or supplements to approved applications;
- warning letters;
- fines;
- import and/or export restrictions;
- product withdrawal, recalls or seizures;
- injunctions;
- suspension of regulatory approvals;
- restrictions on the products or manufacturing processes;
- total or partial suspension of production;
- civil penalties;
- withdrawals of previously approved marketing applications or licenses;
- recommendations by the FDA or other regulatory authorities against governmental contracts; and
- criminal prosecutions.

Clinical trials may not demonstrate a clinical benefit of our product candidates.

Positive results from pre-clinical studies and early clinical trials should not be relied upon as evidence that later stage or large scale clinical trials will succeed. We will be required to demonstrate with substantial evidence through well-controlled clinical trials that our product candidates are safe and effective for use in a diverse population before we can seek regulatory approvals for their commercial sale. Success in early clinical trials does not mean that future clinical trials will be successful because product candidates in later stage clinical trials may fail to demonstrate sufficient safety and efficacy to the satisfaction of the FDA and other non-U.S. regulatory authorities despite having progressed through initial clinical trials. For example, our iDEAL trial results for iCo-007 announced on June 9, 2014, failed to show a clinical benefit to patients.

Even after the completion of Phase III clinical trials, the FDA or other non-U.S. regulatory authorities may disagree with our clinical trial design and our interpretation of data, and may require us to conduct additional clinical trials to demonstrate the efficacy of our product candidates.

Failure to recruit and enrol patients for clinical trials may cause the development of our product candidates to be delayed. We may be unable to recruit a sufficient number of patients to carry out clinical trials for our product candidates.

The rate at which we complete any clinical trial depends on many factors, including our ability to recruit and enroll sufficient numbers of patients to carry out clinical trials for our product candidates. Many factors affect patient enrollment, including the size and nature of the patient population, the proximity of patients to clinical sites, slower than expected approvals by ethics review boards, the eligibility criteria for the trial, the design of the clinical trial, clinicians' and patients' perceptions as to the potential advantages of the drug being studied in relation to other available therapies, including any new drugs that may be approved for the indications we are investigating and whether the clinical trial design involves comparison to placebo. Further, clinical trials utilizing third party drug candidates in target indications which may either be underway or soon to be initiated may compete with the Oral

AmpB Delivery System or iCo-008 clinical trials for potential patients, resulting in delays enrolling patients in the event we undertake a future clinical trial. Any delays in planned patient enrolment may result in delays to our product development and increased development costs, which could harm our ability to develop products.

Any failure or delay in commencing or completing clinical trials for product candidates could severely harm our business.

We do not know whether any of our planned clinical trials for iCo-008 and the Oral AmpB Delivery System will proceed or be completed on schedule, or at all. The commencement of any clinical trial could be substantially delayed or prevented by several factors, including:

- limited number of, and competition for, suitable patients with the indications required for enrolment in our clinical trials;
- limited number of, and competition for, suitable sites to conduct our clinical trials;
- delay or failure to obtain FDA or non-U.S. regulatory agencies' approval or agreement to commence a clinical trial;
- delay or failure to obtain sufficient supplies of the product candidate for our clinical trials;
- delay or failure to reach agreement on acceptable clinical trial agreement terms or clinical trial protocols with prospective sites or investigators; and
- delay or failure to obtain Institutional Review Board ("IRB") approval to conduct a clinical trial at a prospective site.

The completion of any future clinical trials could also be substantially delayed or prevented by several factors, including:

- slower than expected rates of patient recruitment and enrolment;
- failure of patients to complete the clinical trial;
- unforeseen safety issues;
- lack of efficacy evidenced during clinical trials;
- termination of our clinical trials by one or more clinical trial sites;
- inability or unwillingness of patients or medical investigators to follow our clinical trial protocols;
- inability to monitor patients adequately during or after treatment; and
- introduction of competitive products that may impede our ability to retain patients in our clinical trials.

Also, recent events have raised questions about the safety of marketed drugs and may result in increased cautiousness by the FDA in reviewing new drugs based on safety, efficacy or other regulatory considerations and may result in significant delays in obtaining regulatory approvals, additional clinical trials being required, or more stringent product labelling requirements. Any delay in obtaining, or inability to obtain, applicable regulatory approvals would prevent us from commercializing our product candidates.

Future clinical trials we undertake may be suspended or terminated at any time by the FDA, other regulatory authorities, the IRB overseeing the clinical trial at issue, any of our clinical trial sites with respect to that site, or us. It is possible that none of our product candidates will complete clinical trials in any of the markets in which we or our collaborators intend to sell those product candidates. Accordingly, we may not receive the regulatory approvals necessary to market our product candidates. Any failure or delay in commencing or completing clinical trials or obtaining regulatory approvals for product candidates would prevent or delay their commercialization and severely harm our business and financial condition.

Our product candidates may cause undesirable and potentially serious side effects during clinical trials that could delay or prevent their regulatory approval or commercialization.

Amongst the four patient cohorts (185 patients) treated with iCo-007 in the iDEAL trial, there was one ocular serious adverse event that was rated as "drug-related". The iDEAL trial has now been completed and based on the efficacy results, development of iCo-007 for DME has been discontinued.
iCo-008 already has a clinical history and has been tested in Phase I and Phase II clinical trials in humans. Some of the patients in the iCo-008 clinical trials experienced various adverse effects. The majority of adverse effects were mild and for the most part iCo-008 was considered safe at the doses and routes tested. While intravenous AmpB is a well known and understood drug that is associated with severe effects and we believe that an oral formulation of AmpB has the potential to decrease the adverse effect profile of AmpB, there can be no assurance that the Oral AmpB Delivery System will not result in adverse side effects.

Undesirable side effects caused by any of our product candidates could cause us or regulatory authorities to interrupt, delay or halt clinical trials and could result in the denial of regulatory approval by the FDA or non-U.S. regulatory authorities for any or all targeted indications. This, in turn, could prevent us from commercializing our product candidates and generating revenues from their sale. In addition, if our product candidates receive marketing approval and we or others later identify undesirable side effects caused by the product:

- regulatory authorities may withdraw their approval of the product;
- we may be required to recall the product, change the way the product is administered, conduct additional clinical trials or change the labelling of the product;
- a product may become less competitive and product sales may decrease; or
- our reputation may suffer.

Any one or a combination of these events could prevent us from achieving or maintaining market acceptance of the affected product or could substantially increase the costs and expenses of commercializing the product, which in turn could delay or prevent us from generating significant revenues from the sale of the product.

The success of our product candidates is influenced by our collaborations with our partners. Any adverse developments in our relationship with our partners could materially harm our business.

iCo-007 was in-licenced pursuant to a license agreement with Isis, iCo-008 pursuant to a license agreement with MedImmune and the Oral AmpB Delivery System pursuant to an agreement with UBC. We also have an exclusive sub-license arrangement with IMMUNE for iCo-008, which has the initiationed a Phase II double-blind placebo controlled study with its lead drug, Bertilimumab (iCo-008), in patients with moderate-to-severe ulcerative colitis and bullous pemphigoid. We are subject to a number of risks associated with our collaboration with each of our partners, including the risk that Isis, MedImmune, UBC or IMMUNE, as applicable, may terminate the license agreement upon the occurrence of certain specified events. Our license agreements require, among other things, that we make certain payments and use reasonable commercial efforts to meet certain clinical and regulatory milestones. If we breach any of the provisions of these license agreements, we may lose substantial intellectual property rights and our future prospects may be materially adversely affected.

Our ability to develop and commercialize our product candidates is dependent on our ability to obtain adequate financing. If we fail to obtain additional financing, we may be unable to develop and commercialize our product candidates.

If we fail to obtain additional financing, we may be unable to complete the development and commercialization of, iCo-008, the Oral AmpB Delivery System or continue activities for other research and development programs that we may pursue.

Our business development and clinical regulatory operations have consumed considerable amounts of cash since inception. Going forward, we expect to continue to spend funds to:

- further develop the Oral AmpB Delivery System and potentially iCo-008;
- license or acquire and develop additional product candidates;
- launch and commercialize any product candidates for which we receive regulatory approval; and
- continue our search and development programs.

It will be necessary for us to raise additional capital, through private placements or public offerings of our equity or debt securities to complete the development and commercialization of our current product candidates.

Prior to being successfully commercialized, we will also be required, at a minimum, to complete Phase II and III clinical trials for iCo-008 and a Phase I, II and Phase III clinical trial for the Oral AmpB delivery system. The costs for these additional trials cannot be determined at this time. The actual cost of such Phase I, II and III clinical trials will vary depending on a number of factors, including the ocular indication and stage of disease for which the clinical trial is undertaken, the number of patients included in the clinical trial, and the number and geographic distribution of clinical trial sites. Clinical costs for the Oral AmpB Delivery System are unknown at this time as we are still in the early stages of developing a clinical development protocol.

We may be subject to unanticipated costs or delays that would accelerate our need for additional capital or increase the costs of individual clinical trials. If we are unable to raise additional capital when required or on acceptable terms, we may have to significantly delay, scale back or discontinue the development and/or commercialization of one or more of our product candidates. We also may be required to:

- seek collaborators for our product candidates at an earlier stage than otherwise would be desirable and on terms that are less favourable than might otherwise be available;
- relinquish or license on unfavourable terms our rights to technologies or product candidates that we otherwise would seek to develop or commercialize ourselves; or
- license the non-ocular rights to the product candidates on terms that are less favourable than might otherwise be available.

If we raise additional financing, the terms of such transactions may cause dilution to existing shareholders or contain terms that are not favourable to us.

In the future, we may seek to raise additional financing through private placements or public offerings of our equity or debt securities. We cannot be certain that additional funding will be available on acceptable terms, or at all. To the extent that we raise additional funds by issuing equity securities, shareholders may experience significant dilution. Given that we have do not expect to have any significant revenues in the foreseeable future, it is unlikely that we will be able to raise a significant amount of debt financing or such financing may have an equity component. Also, any debt financing, if available, may require us to pledge our assets as collateral or involve restrictive covenants, such as limitations on our ability to incur additional indebtedness, limitations on our ability to acquire or license intellectual property rights and other operating restrictions that could negatively impact our ability to conduct our business. General conditions in the capital markets as well as conditions that particularly effect biotechnology companies could also impact our ability to raise additional funds. In addition, we cannot guarantee that future financing will be available in sufficient amounts or on terms acceptable to us, if at all. If we are unable to raise additional capital in sufficient amounts or on terms acceptable to us, we will be prevented from pursuing our research and development efforts. This could harm our business, prospects and financial condition and cause the price of our securities to fall, or to cause us to cease operations.

If our competitors develop and market products that are more effective, safer or less expensive than our product candidates, our clinical trials and commercial opportunities will be negatively impacted.

The life sciences industry is highly competitive, and we face significant competition from many pharmaceutical, biopharmaceutical and biotechnology companies that are researching and marketing products designed to address ocular indications for which we are currently developing products or for which we may develop products in the future. We are aware of several companies who have developed or are developing drug products for the treatment of allergic conjunctivitis, including Alcon, Inc., Novartis Opthalmics (a branch of Novartis Pharmaceuticals Corporation), MedPointe Inc. and Novagali Pharma SA., all of which would potentially compete with iCo-008. With respect to the Oral AmpB Delivery System, we are aware of several companies, including Gilead Sciences,

Inc., Astellas Pharma US, Three Rivers Pharmaceuticals, Enzon Pharmaceuticals, Inc. and Bristol-Myers Squibb that have developed injectable amphotericin formulations for the treatment of fungal infections. and we are aware of one company, BioDelivery Sciences International, Inc. that had a systemic oral amphotericin formulation which has completed Phase I clinical trials although to our knowledge, further development of this program has not been initiated. Additionally, other technologies may be under development which would compete with our Oral AmpB Delivery System.

Any products we may develop in the future are also likely to face competition from other drugs and therapies. Many of our competitors have significantly greater financial, manufacturing, marketing and drug development resources than we do. Large pharmaceutical companies, in particular, have extensive experience in clinical testing and in obtaining regulatory approvals for drugs. These companies also have significantly greater research and marketing capabilities than we do. In addition, many universities and private and public research institutes are, or may become, active in ocular research, the products of which may be in direct competition with us. If our competitors market products that are more effective, safer or less expensive than our future product candidates, if any, or that reach the market sooner than our future product candidates, if any, we may not achieve commercial success.

If new therapies become broadly used, we may need to conduct clinical trials of our product candidates in combination with these new therapies to demonstrate safety and efficacy of the combination. Additional trials will delay the development of our product candidates and increase our costs. The failure of our product candidates to work in combination with these new therapies would have an adverse effect on our business.

While our intention is to test our product candidates as stand alone therapies for the primary indications we will be investigating, there is also a possibility that our product candidates could be used in combination with other products that are used by clinicians and considered effective. As new therapies are developed, we will need to assess these therapies to determine whether to conduct clinical trials of our product candidates in combination with them to demonstrate safety and efficacy of the combination. If we determine to conduct additional clinical trials of our product candidates in combination with these new therapies, the development of our product candidates will be delayed and our costs increased. If these clinical trials generate safety concerns or lack of efficacy, our business would be adversely affected.

If our product candidates become approved in combination with a specific therapy that is broadly used and that therapy becomes displaced by another product, the market for our product candidate may decrease.

If product liability lawsuits are successfully brought against us, we may incur substantial liabilities and may be required to limit commercialization of our product candidates.

We face an inherent risk of product liability lawsuits related to the testing of our product candidates, and will face an even greater risk if product candidates are introduced commercially. An individual may bring a liability claim against us if one of our product candidates causes, or merely appears to have caused, an injury. Because we conduct clinical trials in humans, we face the risk that the use of our product candidates will result in adverse side effects. We cannot predict the possible harms or side effects that may result from our clinical trials. Although we currently have clinical trial insurance in place, we do not know whether the limits of the insurance will be sufficient to satisfy any claims, should they arise. We may not have sufficient resources to pay for any liabilities resulting from a claim excluded from, or beyond the limit of, our insurance coverage. Additionally, as our clinical trial insurance is renewed annually, we cannot predict whether this insurance can be renewed on acceptable terms, if at all. There is also a risk that third parties that we have agreed to indemnify could incur liability. If we cannot successfully defend ourselves against a product liability claim, we may incur substantial liabilities. Regardless of merit or eventual outcome, liability claims either during clinical trials or following commercial introduction may result in:

- decreased demand for our product candidates;
- injury to our reputation;
- withdrawal of clinical trial participants;
- significant litigation costs;
- substantial monetary awards to or costly settlement with patients;
- product recalls;
- loss of revenue; or
- the inability to commercialize our product candidates.

We could also be adversely affected if any of our product candidates or any similar products distributed by other companies prove to be, or are asserted to be, harmful to consumers.

If we fail to acquire and develop products or product candidates at all or on commercially reasonable terms, we may be unable to grow our business.

We currently neither have nor intend to establish internal discovery capabilities and are dependent upon pharmaceutical and biotechnology companies and other research institutions to sell or license products or product candidates to us. To date, our product candidates have been derived from technologies discovered by, and licensed to us by Isis (iCo-007), MedImmune (iCo-008) and UBC (the Oral AmpB Delivery System). We intend to continue to search for available molecules from external pharmaceutical or biotechnology partners for a source of new product candidates to develop. We cannot guarantee that we will continue to have access to such opportunities or that we will be able to purchase or license these product candidates on commercially reasonable terms, or at all.

The success of our product pipeline strategy depends upon our ability to identify, select and acquire pharmaceutical product candidates. Proposing, negotiating and implementing an economically viable product acquisition or license is a lengthy and complex process. We compete for partnering arrangements and license agreements with pharmaceutical and biotechnology companies and academic research institutions. These competitors may have stronger relationships with third parties with whom we are interested in collaborating and/or may have more established histories of developing and commercializing products. As a result, these competitors may have a competitive advantage in entering into partnering arrangements with such third parties. In addition, even if we find promising product candidates, and generate interest in a partnering or strategic arrangement to acquire such product candidates, we may not be able to acquire rights to additional product candidates or approved products on terms that we find acceptable, or at all. If we fail to acquire and develop product candidates, we may be unable to grow our business.

We expect that any product candidates to which we acquire rights will require additional development efforts prior to commercial sale, including extensive clinical testing and approval by the FDA and non-U.S. regulatory authorities. All product candidates are subject to the risks of failure inherent in pharmaceutical product development, including the possibility that the product candidate will not be shown to be sufficiently safe and effective for approval by regulatory authorities. Even if the product candidates are approved, we cannot be sure that they would be capable of economically feasible production or commercial success.

If we fail to attract and retain key management and scientific personnel, we may be unable to successfully develop or commercialize our product candidates.

We will need to expand and effectively manage our managerial, operational, financial, development and other resources in order to successfully pursue our research, development and commercialization efforts for our existing and future product candidates. Our success depends on our continued ability to attract, retain and motivate highly qualified management, pre-clinical and clinical personnel, including our key management personnel, Andrew Rae, John Meekison and Peter Hnik. The loss of the services of any of our senior management could delay or prevent the commercialization of our product candidates. Although we have entered into employment agreements with each of Andrew Rae, Peter Hnik, and John Meekison for an indefinite term, such agreements permit the executive to terminate his employment with us at any time, subject to providing us with advance written notice. At this time, we do not have "key man" insurance policies on the lives of any of our employees or consultants.

We have scientific and clinical advisors who assist us in formulating our development and clinical strategies. These advisors are not our employees and may have commitments to, or consulting or advisory contracts with, other entities that may limit their availability to us. In addition, our advisors may have arrangements with other companies to assist those companies in developing products or technologies that potentially may compete with our products or technologies. All of our advisors and consultants sign agreements with us which include provisions for: confidentiality; non-disclosure; intellectual property rights; and non-competes covering our intellectual property and other proprietary information.

We will need to hire additional personnel as we continue to expand our development activities. We may not be able to attract or retain qualified management and scientific personnel in the future due to the intense competition for qualified personnel among biotechnology, pharmaceutical and other businesses. If we are not able to attract and retain the necessary personnel to accomplish our business objectives, we may experience constraints that will impede significantly the achievement of our development objectives, our ability to raise additional capital and our ability to implement our business strategy. In particular, if we lose any members of our senior management team, we may not be able to find suitable replacements in a timely fashion or at all and our business may be harmed as a result.

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

As we advance our product candidates through development and clinical trials, we will need to develop or expand our development, regulatory, manufacturing, marketing and sales capabilities or contract with third parties to provide these capabilities for us. Maintaining additional relationships and managing future growth will impose significant added responsibilities on members of our management. We must be able to: manage our development efforts effectively; manage our clinical trials effectively; hire, train and integrate additional management, development, administrative and sales and marketing personnel; improve our managerial, development, operational and finance systems; and expand our facilities, all of which may impose a strain on our administrative and operational infrastructure.

Furthermore, we may acquire additional businesses, products or product candidates that complement or augment our existing business. To date, we have no experience in acquiring and integrating other businesses. Integrating any newly acquired business, product or product candidate could be expensive and time-consuming. We may not be able to integrate any acquired business, product or product candidate successfully or operate any acquired business profitably. Our future financial performance will depend, in part, on our ability to manage any future growth effectively and our ability to integrate any acquired businesses. We may not be able to accomplish these tasks, and our failure to accomplish any of them could prevent us from successfully growing.

We rely, in part, on third parties to conduct clinical trials for our product candidates and plan to rely on third parties to conduct future clinical trials. If these third parties do not successfully carry out their contractual duties or meet expected deadlines, we may be unable to obtain regulatory approval for or commercialize our current and future product candidates.

To implement our product development strategies, we rely on third parties, such as contract research organizations, medical institutions, clinical investigators and contract laboratories, to conduct clinical trials of our product candidates. Although we rely on these third parties to conduct our clinical trials, we are responsible for ensuring that each of our clinical trials is conducted in accordance with our investigational plan and protocol. Moreover, the FDA and non-U.S. regulatory authorities require us to comply with regulations and standards, commonly referred to as current Good Clinical Practices ("c**GCPs**") for conducting, monitoring, recording and reporting the results of clinical trials to ensure that the data and results are scientifically credible and accurate and that the clinical trial subjects are adequately informed of the potential risks of participating in clinical trials. Our reliance on third parties does not relieve us of these responsibilities and requirements. If the third parties conducting such clinical trials do not perform their contractual duties or obligations, do not meet expected deadlines or need to be replaced, or if the quality or accuracy of the clinical data they obtain is compromised due to the failure to adhere to GCPs or for any other reason, we may need to enter into new arrangements with alternative third parties and our clinical trials may be extended, delayed or terminated. In addition, a failure by such third parties to perform their obligations in compliance with GCPs may cause our clinical trials to fail to meet regulatory requirements, which may require us to repeat clinical trials.

We rely on third parties to manufacture and supply our product candidates.

We do not own or operate manufacturing facilities, and depend on third party contract manufacturers for production of our product candidates. We have no experience in drug formulation or manufacturing, and lack the resources and the capability to manufacture any of our product candidates. To date, our product candidates have been manufactured in limited quantities for pre-clinical studies and clinical trials. All active pharmaceutical ingredients for iCo-007 have been manufactured by Isis. Drug product for our Phase I trial was manufactured by Althea Technologies, in each case pursuant to a purchase order or short-term contract that has been fulfilled. Pyramid Laboratories manufactured our drug product for the Phase II iDEAL study.

To date, experimental batches of the Oral AmpB Delivery System have been manufactured by UBC. We are currently looking to source a manufacturer to produce a clinical supply. AmpB is a widely available generic, however the formulation contains certain excipients which may be more difficult to source.

iCo-008, a monoclonal antibody, is somewhat complex and costly to manufacture, however we believe there are a number of potential third party manufacturers which we could source for clinical and/or commercial quantities. Additionally, we may also be able to purchase iCo-008 in limited quantities from IMMUNE.

If, in the future, one of our product candidates is approved for commercial sale, we will need to manufacture that product candidate in commercial quantities. We cannot guarantee that the third party manufacturers with which we have contracted in the past will have sufficient capacity to satisfy our future manufacturing needs, or that we will be able to negotiate additional purchases of active pharmaceutical ingredients or drug products from these or alternative manufacturers on terms favourable to us, or at all.

Third party manufacturers may fail to perform under their contractual obligations, or may fail to deliver the required clinical or commercial quantities of bulk drug substance or finished product on a timely basis and at commercially reasonable prices. Any performance failure on the part of contract manufacturers could delay clinical development or regulatory approval of our product candidates or commercialization of our future product candidates, depriving us of potential product revenue and resulting in additional losses. If we are required to identify and qualify an alternate manufacturer, we may be forced to delay or suspend our clinical trials, regulatory submissions, required approvals or commercialization of our product candidates, which may cause us to incur higher costs and could prevent us from commercializing our product candidates successfully. If we are unable to find one or more replacement manufacturers capable of production at a reasonably favourable cost, in adequate volumes, of adequate quality, and on a timely basis, we would likely be unable to meet demand for our product candidates and our clinical trials could be delayed or we could lose potential revenue. Our ability to replace an existing active pharmaceutical ingredient manufacturer may be difficult because the number of potential manufacturers may be limited and the FDA must approve any replacement manufacturer before we can begin manufacturing product candidates. Such approval would require new testing and compliance inspections. It may be difficult or impossible for us to identify and engage a replacement manufacturer on acceptable terms in a timely manner, or at all. We expect to continue to depend on third party contract manufacturers for the foreseeable future.

Our product candidates require precise, high quality manufacturing. Any of our contract manufacturers will be subject to ongoing periodic unannounced inspection by the FDA and non-U.S. regulatory authorities to ensure strict compliance with cGMP and other applicable government regulations and corresponding standards. If our contract manufacturers fail to achieve and maintain high manufacturing standards in compliance with cGMP regulations, we may experience manufacturing errors resulting in patient injury or death, product recalls or withdrawals, delays or interruptions of production or failures in product testing or delivery, delay or prevention of filing or approval of marketing applications for our product candidates, cost overruns or other problems that could seriously harm our business. Significant scale-up of manufacturing may require additional validation studies, which the FDA must review and approve. Additionally, any third party manufacturers we retain to manufacture our product candidates on a commercial scale must pass an FDA pre-approval inspection for conformance to the cGMPs before we can obtain approval of our product candidates. If we are unable to successfully increase the manufacturing capacity for a product candidate in conformance with cGMPs, the regulatory approval or commercial launch of any related products may be delayed or there may be a shortage in supply.

We have entered into and intend in the future to enter into various arrangements with various third parties, including corporate and academic collaborators, licensors, licensees and others for the research, development, clinical testing, manufacturing, regulatory applications, marketing and commercialization of our products and data and information technology management services, and we will not have control over how they perform their contractual obligations. Accordingly, we will suffer if they do not fulfill their contractual obligations.

We intend to enter into additional corporate agreements to develop and commercialize product candidates. We might not be able to establish such additional agreements on favourable terms, if at all, or guarantee that our current or future collaborative arrangements will be successful. In addition, third party arrangements may require us to grant certain rights to third parties, including exclusive marketing rights to one or more products, or may have other terms that are burdensome to us. These arrangements may place responsibility on third parties for Phase III clinical trials, human clinical trials, the preparation and submission of applications for regulatory approval, or for marketing, sales and distribution support for product commercialization. If we enter into such arrangements, the timing for approval of a drug candidate may be largely out of our control. These third parties might not fulfill their obligations in a manner which maximizes our revenues. These arrangements may also require us to transfer certain material rights or issue equity securities to corporate investors, licensees and others. If we license or sublicense our commercial rights to others, as we intend to do, we might realize reduced product revenue compared to what we could expect to realize through direct commercial exploitation. Moreover, we might not derive any revenue or profit from these arrangements. Third parties might also pursue alternative technologies or drug candidates, either on their own or in collaboration with others, and compete directly with us.

We could suffer the consequences of non-compliance or breaches by third parties of our agreements. Such non-compliance or breaches by such third parties could in turn result in our breaches or defaults under our agreements with our other collaboration partners, including those who license products to us, and we could be found liable for damages or lose certain rights, including rights to develop and/or commercialize a product or product candidate.

If we are unable to develop our sales and marketing and distribution capability on our own or through collaborations with marketing partners, we will not be successful in commercializing our product candidates. We currently do not have a marketing staff or a sales or distribution organization.

We currently do not have marketing, sales or distribution capabilities. If our product candidates are approved, we may establish a sales and marketing organization with technical expertise and supporting distribution capabilities to commercialize our product candidates, which will be expensive and time consuming. Any failure or delay in the development of internal sales, marketing and distribution capabilities would adversely impact the commercialization of these product candidates. We may choose to collaborate with third parties that have direct sales forces and established distribution systems, either to augment our own sales force and distribution systems or in lieu of our own sales force and distribution systems. To the extent that we enter into co-promotion or other licensing arrangements, our product revenue is likely to be lower than if we directly marketed or sold our products, when and if we have any. In addition, any revenue we receive will depend in whole or in part upon the efforts of such third parties, which may not be successful and will generally not be within our control. If we are unable to enter into such arrangements on acceptable terms or at all, we may not be able to successfully commercialize our existing and future product candidates. If we are not successful in commercializing our existing and future product candidates, either on our own or through collaborations with one or more third parties, our future product revenue will suffer and we may incur significant additional losses.

If government and third party payors fail to provide coverage and adequate reimbursement rates for our product candidates, our revenues and potential for profitability will be reduced.

In the United States and elsewhere, our product revenues will depend principally upon the reimbursement rates established by third party payors, including government health administration authorities, managed-care providers, public health insurers, private health insurers and other organizations. These third party payors are increasingly challenging the price, and examining the cost effectiveness, of medical products and services. In addition, significant uncertainty exists as to the reimbursement status, if any, of newly approved drugs, pharmaceutical products or product indications. We may need to conduct post-marketing clinical trials in order to demonstrate the cost-effectiveness of products. Such clinical trials may require us to commit a significant amount of management time and financial and other resources. If reimbursement of such product is unavailable or limited in scope or amount or if pricing is set at unsatisfactory levels, our revenues could be reduced.

In some countries other than the United States, particularly the countries of the European Union and Canada, the pricing of prescription pharmaceuticals is subject to governmental control. In these countries, obtaining pricing approval from governmental authorities can take six to twelve months or longer after the receipt of regulatory marketing approval of a product for an indication. To obtain reimbursement or pricing approval in some countries, we may be required to conduct a clinical trial that compares the cost-effectiveness of one of our product candidates

to other available therapies. If reimbursement of such product candidate is unavailable or limited in scope or amount or if pricing is set at unsatisfactory levels, our revenues could be reduced.

Domestic and foreign governments continue to propose and pass legislation designed to reduce the cost of healthcare, including drugs. In the United States, there have been, and we expect that there will continue to be, federal and state proposals to implement similar governmental control. In addition, increasing emphasis on managed care in the United States will continue to put pressure on the pricing of pharmaceutical products. For example, the Patient Protection and Affordable Care Act (known as the "**Senate bill**") became law on March 23, 2010 and was shortly thereafter amended by the Health Care and Education Reconciliation Act of 2010. The law and the amendments thereto include a large number of health-related provisions, including such items as expanding Medicaid eligibility, subsidizing insurance premiums, providing incentives for businesses to provide health care benefits, prohibiting denial of coverage/claims based on pre-existing conditions, establishing health insurance exchanges, and support for medical research. Also, the Medicare Prescription Drug Improvement and Modernization Act of 2003 reformed the way Medicare will cover and reimburse for pharmaceutical products. The legislation expands Medicare coverage for drug purchases by the elderly and eventually will introduce a new reimbursement methodology based on average sales prices for certain drugs. In addition, the legislation provides authority for limiting the number of outpatient drugs that will be covered in any therapeutic class. As a result of the new legislation and the expansion of federal coverage of drug products, we expect that there will be additional pressure to contain and reduce costs. The Medicaid program and state healthcare laws and regulations may also be modified to change the scope of covered products and/or reimbursement methodology. Cost control initiatives could decrease the established reimbursement rates that we receive for any products in the future, which would limit our revenues and profitability. Legislation and regulations affecting the pricing of pharmaceutical products may change at any time, which could further limit or eliminate reimbursement rates for our product candidates.

Failure to obtain regulatory approvals in jurisdictions outside the United States would prevent us from marketing our product candidates abroad.

We intend to market certain of our existing and future product candidates in non-American markets. In order to market our existing and future product candidates in the European Union and many other non-North American jurisdictions, we must obtain separate regulatory approvals. We have had no interaction with non-North American regulatory authorities, and the approval procedures vary among countries and can involve additional testing, and the time required to obtain approval may differ from that required to obtain FDA approval. Approval by the FDA or other regulatory authorities does not ensure approval by regulatory authorities in other countries, and approval by one or more non-North American regulatory authorities does not ensure approval by regulatory authorities in other countries or by the FDA. The non-North American regulatory approval process may include all of the risks associated with obtaining FDA approval. We may not obtain non-North American regulatory approvals on a timely basis, if at all. We may not be able to file for non-North American regulatory approvals and may not receive necessary approvals to commercialize our existing and future product candidates in any market.

If we use biological and hazardous materials in a manner that causes contamination or injury or violates laws, we may be liable for damages.

Our research and development activities involve the use of potentially harmful biological materials as well as hazardous materials, chemicals and various radioactive compounds. We cannot completely eliminate the risk of accidental contamination or injury from the use, storage, handling or disposal of these materials. In the event of contamination or injury, we could be held liable for damages that result, and any liability could exceed our resources. We do not maintain liability insurance coverage for our handling of biological or hazardous materials. We, the third parties that conduct clinical trials on our behalf and the third parties that manufacture our product candidates are subject to federal, state and local laws and regulations governing the use, storage, handling and disposal of these materials and waste products. The cost of compliance with these laws and regulations could be significant. The failure to comply with these laws and regulations could result in significant fines and work stoppages, which could damage our reputation and harm our business.

Risks Related to Our Intellectual Property

Our proprietary rights may not adequately protect our technologies and product candidates.

Our commercial success will depend on our ability to obtain patents and/or regulatory exclusivity and maintain adequate protection for our technologies and product candidates in Canada, the United States and other

countries. As of December 31, 2014 we owned or had exclusive rights to approximately 19 issued U.S. and foreign patents and approximately 19 pending U.S. and foreign patent applications. We will be able to protect our proprietary rights from unauthorized use by third parties only to the extent that our proprietary technologies and future product candidates are covered by valid and enforceable patents or are effectively maintained as trade secrets. We apply for patents covering both our technologies and product candidates, as we deem appropriate. However, we may fail to apply for patents on important technologies or product candidates in a timely fashion, or at all. Our existing patents and any future patents we obtain may not be sufficiently broad to prevent others from utilizing our technologies or from developing competing products and technologies. Moreover, the patent positions of biopharmaceutical companies are highly uncertain and involve complex legal and factual questions for which important legal principles remain unresolved. As a result, the validity and enforceability of our patents cannot be predicted with certainty. In addition, we cannot guarantee that:

- we or our licensors were the first to make the inventions covered by each of our issued patents and pending patent applications;
- we or our licensors were the first to file patent applications for these inventions;
- others will not independently develop similar or alternative technologies or duplicate any of our or our licensors' technologies;
- any of our or our licensors' pending patent applications will result in issued patents;
- any of our or our licensors' patents will be valid or enforceable;
- any patents issued to us or our licensors and collaboration partners will provide us with any competitive advantages, or will not be challenged by third parties;
- we will develop or in-license additional proprietary technologies that are patentable; or
- the patents of others will not have an adverse effect on our business.

The actual protection afforded by a patent varies on a product-by-product basis, from country to country and depends upon many factors, including the type of patent, the scope of our coverage, the availability of regulatory related extensions, the availability of legal remedies in a particular country and the validity and enforceability of the patents. Our ability to maintain and solidify our proprietary position for our product candidates will depend on our success in obtaining effective claims and enforcing those claims once granted. Our issued patents and those that may issue in the future, or those licensed to us, may be challenged, invalidated or circumvented, and the rights granted under any issued patents may not provide us with proprietary protection or competitive advantages against competitors with similar products. Due to the extensive amount of time required for the development, testing and regulatory review of a potential product, it is possible that, before any of our product candidates can be commercialized, any related patent may expire or remain in force for only a short period following commercialization, thereby reducing any advantage of the patent.

Protection afforded by U.S. patents may be adversely affected by recent or future changes to patent related U.S. statutes and to U.S. Patent and Trademark Office ("U.S. PTO") rules. Recent patent reform legislation could increase the uncertainties and costs surrounding the prosecution of our patent applications and the enforcement or defense of our issued patents. On September 16, 2011, the Leahy-Smith America Invents Act, or the Leahy-Smith Act, was signed into law. The Leahy-Smith Act includes a number of significant changes to United States patent law. These include provisions that affect the way patent applications are prosecuted and may also affect patent litigation. The United States Patent Office recently developed new regulations and procedures to govern administration of the Leahy-Smith Act, and many of the substantive changes to patent law associated with the Leahy-Smith Act, and in particular, the first to file provisions, only became effective on March 16, 2013. Accordingly, it is not clear what, if any, impact the Leahy-Smith Act will have on the operation of our business. However, the Leahy-Smith Act and its implementation could increase the uncertainties and costs surrounding the prosecution of our patent applications and the enforcement or defense of our issued patents, all of which could have a material adverse effect on our business and financial condition.

Moreover, we may be subject to a third party preissuance submission of prior art to the U.S. Patent and Trademark Office, or become involved in opposition, derivation, reexamination, *inter partes* review or interference proceedings, or other preissuance or post-grant proceedings in the United States or other jurisdictions, challenging our patent rights or the patent rights of others. An adverse determination in any such submission, proceeding or litigation could reduce the scope of, or invalidate, our patent rights, allow third parties to commercialize our technology or products and compete directly with us, without payment to us, or result in our inability to manufacture or commercialize products without infringing third party patent rights. In addition, if the breadth or strength of protection provided by our patents and patent applications is threatened, it could dissuade companies from collaborating with us to license, develop or commercialize current or future product candidates. Other changes to the patent statutes may adversely affect the protection afforded by U.S. patents and/or open U.S. patents up to third party attack in non-litigation settings.

We also rely on trade secrets to protect some of our technology, especially where we do not believe patent protection is appropriate or obtainable. However, trade secrets are difficult to maintain. While we use reasonable efforts to protect our trade secrets, we or our collaboration partners' employees, consultants, contractors or scientific and other advisors may unintentionally or wilfully disclose our proprietary information to competitors. Enforcement of claims that a third party has illegally obtained and is using trade secrets is expensive, time consuming and uncertain. In addition, non-U.S. courts are sometimes less willing than U.S. courts to protect trade secrets. If our competitors independently develop equivalent knowledge, methods and know-how, we would not be able to assert our trade secrets against them and our business could be harmed.

The intellectual property protection for some of our product candidates is dependent on third parties.

With respect to iCo-007 and iCo-008, we have exclusively licensed from Isis and MedImmune, respectively, certain issued patents and pending patent applications covering the respective antisense sequences and antibody binding domains underlying these product candidates and their commercialization and use. These patents and pending patent applications do not cover all potential antisense sequences for the corresponding molecular targets of these product candidates nor all potential uses. We direct patent prosecution and are responsible for all fees and costs related to the preparation, filing, prosecution, enforcement and maintenance of these patent rights that we have licensed from our partners.

Similarly, we have licensed from Isis certain issued patents and pending patent applications directed to chemical modification of our product candidates for commercialization, use and the manufacturing thereof. We have also received a sublicense from Isis under certain third party patent portfolios directed to such modifications. These patents and pending patent applications do not cover all potential modifications of our product candidates.

With respect to the Oral AmpB Delivery System, under our licence agreement with UBC, UBC has filed patents relating to the Oral AmpB Delivery System, which are now issued or pending in a number of jurisdictions worldwide. UBC maintains the responsibility of prosecuting and maintaining all patents related to the Oral AmpB Delivery System in consultation with us.

We do not have and have not had any control over the filing, prosecution or enforcement of certain patents or patent applications previously filed by Isis, Medimmune or UBC, including those filed or prosecuted prior to our obtaining a license and those sub-licensed to us from Isis. We cannot be certain that such prosecution efforts have been or will be conducted in compliance with applicable laws and regulations or will result in valid and enforceable patents. We also cannot be assured that Isis or our licensors will agree to enforce any such patent rights at our request or devote sufficient efforts to attain a desirable result. Any failure by Isis, or any of our licensing partners, to properly protect the intellectual property rights relating to our product candidates could have a material adverse effect on our financial condition and results of operation.

We may not be able to protect our intellectual property rights throughout the world.

Filing, prosecuting and defending patents on all of our product candidates and products, when and if we have any, in every jurisdiction would be prohibitively expensive. Competitors may use our technologies in jurisdictions where we or our licensors have not obtained patent protection to develop our own products. These products may compete with our products, when and if we have any, and may not be covered by any of our or our licensors' patent claims or other intellectual property rights.

The laws of some non-U.S. countries do not protect intellectual property rights to the same extent as the laws of the United States, and many companies have encountered significant problems in protecting and defending such rights

in foreign jurisdictions. The legal systems of certain countries, particularly certain developing countries, do not favour the enforcement of patents and other intellectual property protection, particularly those relating to biotechnology and/or pharmaceuticals, which could make it difficult for us to stop the infringement of our patents. Proceedings to enforce our patent rights in foreign jurisdictions could result in substantial cost and divert our efforts and attention from other aspects of our business.

The patent protection for our product candidates or products may expire before we are able to maximize their commercial value which may subject us to increased competition and reduce or eliminate our opportunity to generate product revenue.

The patents for our product candidates have varying expiration dates and, when these patents expire, we may be subject to increased competition and may not be able to recover our development costs. For example, the first granted U.S. patent directed to iCo-007 and licensed from Isis expired in 2014, with the remaining patents expiring in 2015 and 2016. A U.S. patent issuing from one of the pending patent families directed to iCo-008 and licensed from MedImmune would expire as early as 2021. In some of the larger economic territories, such as the United States and Europe, patent term extension/restoration may be available to compensate for time taken during aspects of the product candidate's regulatory review. However, we cannot be certain that an extension will be granted, or if granted, what the applicable time period or the scope of patent protection afforded during any extended period will be. In addition, even though some regulatory agencies may provide some other exclusivity for a product candidate under our own laws and regulations, we may not be able to qualify the product candidate or obtain the exclusive time period.

If we are unable to obtain patent term extension/restoration or some other exclusivity, we could be subject to increased competition and our opportunity to establish or maintain product revenue could be substantially reduced or eliminated. Furthermore, we may not have sufficient time to recover our development costs prior to the expiration of our U.S. and non-U.S. patents.

We may incur substantial costs as a result of litigation or other proceedings relating to enforcement of our patent and other intellectual property rights and we may be unable to protect our rights to, or use of, our technology.

If we choose to go to court to prevent a third party from using the inventions claimed in our patents or licensed patents, that third party has the right to ask the court to rule that these patents are invalid and/or should not be enforced against that third party. These lawsuits are expensive and would consume time and other resources even if we were successful in stopping the infringement of these patents. In addition, there is a risk that the court will decide that these patents are invalid or unenforceable and that we do not have the right to prevent the other party from using the inventions. There is also the risk that, even if the validity of these patents is upheld, the court will refuse to prevent the other party on the ground that such other party's activities do not infringe our rights.

In 2007, we filed an Opposition against European Patent No. 0719331 held by Imperial Innovations Limited. In 2009, the Opposition Division ruled favourably to iCo and substantially limited the scope of this European Patent. Imperial Innovations Limited appealed this decision, but the appeal was dismissed by the European Board of Appeal in September 2013.

We may be subject to lawsuits from, liable for damages to, or be required to enter into license agreements with, a third party which claims we infringed its patents or otherwise misused its proprietary information.

If we wish to use the technology or compound claimed in issued and unexpired patents owned by others, we will need to obtain a license from the owner, enter into litigation to challenge the validity or enforceability of the patents or incur the risk of litigation in the event that the owner asserts that we infringed our patents. The failure to obtain a license to technology or the failure to challenge an issued patent that we may require to develop or commercialize our product candidates may have a material adverse impact on us.

In addition, if a third party asserts that we infringed its patents or other proprietary rights, we could face a number of risks that could seriously harm our results of operations, financial condition and competitive position, including:

- patent infringement and other intellectual property claims, which would be costly and time consuming to defend, whether or not the claims have merit, and which could delay the regulatory approval process and divert management's attention from our business;

- substantial damages for past infringement, including possible treble damages, which we may have to pay if a court determines that our product candidates or technologies infringe a competitor's patent or other proprietary rights;

- a court prohibiting us from selling or licensing our technologies or future drugs unless the third party licenses our patents or other proprietary rights to us on commercially reasonable terms, which it is not required to do; and

- if a license is available from a third party, we may have to pay substantial royalties or lump sum payments or grant cross licenses to our patents or other proprietary rights to obtain that license.

The biotechnology industry has produced a proliferation of patents, and it is not always clear to industry participants, including us, which patents cover various types of products or methods of use. The coverage of patents is subject to interpretation by the courts, and the interpretation is not always uniform. If we are sued for patent infringement, we would need to demonstrate that our product candidates or methods of use either do not infringe the patent claims of the relevant patent and/or that the patent claims are invalid, and we may not be able to do this. Proving invalidity, in particular, is difficult since it requires a showing of clear and convincing evidence to overcome the presumption of validity enjoyed by issued patents.

U.S. patent laws as well as the laws of some foreign jurisdictions provide for provisional rights in published patent applications beginning on the date of publication, including the right to obtain reasonable royalties, if a patent is subsequently issued and certain other conditions are met. While we believe that there may be multiple grounds on which to challenge the validity of the U.S. patent and the foreign counterparts, we cannot predict the outcome of any invalidity challenge. Alternatively, it is possible that we may determine it prudent to seek a license from the patent holder to avoid potential litigation and other potential disputes. We cannot be sure that a license would be available to us on acceptable terms, or at all.

Because some patent applications in the United States may be maintained in secrecy until the patents are issued, because patent applications in the United States and many foreign jurisdictions are typically not published until 18 months after filing, and because publications in the scientific literature often lag behind actual discoveries, we cannot be certain that others have not filed patent applications for technology covered by our licensors' issued patents or our pending applications or our licensors' pending applications, or that we or our licensors were the first to invent the technology.

Patent applications filed by third parties that cover technology similar to our may have priority over our or our licensors' patent applications and could further require us to obtain rights to issued patents covering such technologies. If another party files a United States patent application on an invention similar to ours, we may elect to participate in or be drawn into an interference proceeding declared by the U.S. PTO to determine priority of invention in the United States. The costs of these proceedings could be substantial, and it is possible that such efforts would be unsuccessful, resulting in a loss of our United States patent position with respect to such inventions.

We may also be subject to damages resulting from claims that we, or our employees or consultants, have wrongfully used or disclosed alleged trade secrets of third parties. Many of our employees were previously employed, and certain of our consultants are currently employed, at universities or biotechnology or pharmaceutical companies, including our competitors or potential competitors. Although we have not received any claim to date, we may be subject to claims that we, or these employees or consultants, have inadvertently or otherwise used or disclosed trade secrets or other proprietary information of these current or former employers. Litigation may be necessary to defend against these claims. If we fail in defending such claims, in addition to paying monetary damages, we may lose valuable intellectual property rights or personnel. We may be subject to claims that employees of our partners or licensors of technology licensed by us have inadvertently or otherwise used or disclosed trade secrets or other proprietary information of their former employers. We may become involved in litigation to defend against these claims. If we fail in defending such claims, in addition to paying monetary damages, we may lose valuable intellectual property rights or personnel.

Some of our competitors may be able to sustain the costs of complex patent litigation more effectively than we can because they have substantially greater resources. In addition, any uncertainties resulting from the initiation and continuation of any litigation could have a material adverse effect on our ability to raise the funds necessary to continue our operations. We cannot predict whether third parties will assert these claims against us or against our

licensors, or whether those claims will harm our business. If we are forced to defend against these claims, whether they are with or without any merit, whether they are resolved in favour of or against us or our licensors, we may face costly litigation and diversion of management's attention and resources. As a result of these disputes, we may have to develop costly non-infringing technology, or enter into licensing agreements. These agreements, if necessary, may be unavailable on terms acceptable to us, if at all, which could seriously harm our business or financial condition.

If we breach any of the agreements under which we license rights to our product candidates or technology from third parties, we could lose license rights that are important to our business. Certain of our license agreements may not provide an adequate remedy for their breach by the licensor.

We license the development and commercialization rights for each of our product candidates, and we expect to enter into similar licenses in the future. For instance, we licensed exclusive worldwide rights from Isis that enable us to use, manufacture, distribute and sell the antisense sequences corresponding to iCo-007. Under these licenses we are subject to various obligations, including royalty and milestone payments, annual maintenance fees, limits on sublicensing, insurance obligations and the obligation to use commercially reasonable best efforts to develop and exploit the licensed technology. If we fail to comply with any of these obligations or otherwise breaches these agreements, our licensors may have the right to terminate the license in whole or in part or to terminate the exclusive nature of the license. Loss of any of these licenses or the exclusivity rights provided therein could harm our financial condition and operating results.

Risks Related to our Securities

The price of our common stock has experienced volatility and may be subject to fluctuation in the future based on market conditions.

The market prices for the securities of biotechnology companies, including our own, have historically been highly volatile. The market has from time to time experienced significant price and volume fluctuations that are unrelated to the operating performance of any particular company. In addition, because of the nature of our business, certain factors such as our announcements, competition from new therapeutic products or technological innovations, government regulations, fluctuations in our operating results, results of clinical trials, public concern regarding the safety of drugs generally, general market conditions and developments in patent and proprietary rights can have an adverse impact on the market price of our common stock. For example, from January 1, 2014 through December 31, 2014, the closing price of the shares of our common stock on the TSXV has ranged from a low of C$0.025 to a high of C$0.59. Any negative change in the public's perception of our prospects could cause the price of our common stock to decrease dramatically. Furthermore, any negative change in the public's perception of the prospects of biotechnology companies in general or the market in general could depress our share price regardless of our results. Volatility or depression in the capital markets, particularly with respect to biotechnology stocks, could also affect our ability to raise additional capital.

Our stockholders may experience significant dilution from future sales of our securities.

We anticipate that we will need to raise additional capital in the future. The sale of additional equity, including warrants or debt securities, if convertible into equity, will result in dilution to our existing stockholders. As a result, our net income per share could decrease in future periods and the market price of our common stock could decline. The perceived risk of dilution may negatively impact the price of our stock and may cause our stockholders to sell their shares, which would contribute to a decline in the price of our common stock. Moreover, the perceived risk of dilution and the resulting downward pressure on our stock price could encourage investors to engage in short sales of our common stock, which could further contribute to progressive price declines in our common stock.

DIVIDENDS

No dividends have been paid by us on any common shares since the date of our incorporation. The Company may declare dividends in the future, depending on the financial requirements of the Company to finance future growth, our financial condition and other factors which our board of directors may consider appropriate in the circumstances. See "Risk Factors".

CAPITAL STRUCTURE

Common Shares

The authorized share capital of the Company is an unlimited number of common shares without par value. As at December 31, 2014, we had 84,457,713 common shares issued and outstanding as fully paid and non-assessable. All of the common shares of the Company are of the same class and, once issued, rank equally. The holders of common shares are entitled to dividends, if, as and when declared by the board of directors, to one vote per common share at meetings of the shareholders of the Company and, upon liquidation, to share equally in such assets of the Company as are distributable to the holders of common shares. There are no pre-emptive or conversion rights.

Stock Options

The Company has a share option plan which authorizes the Company to grant up to 4,000,000 options to acquire common shares to directors, officers, employees and consultants of the Company or any of its subsidiaries. The exercise of options granted under the plan must be greater than or equal to the fair market value of the common shares on the date the option is granted. The options are generally exercisable for up to five years from the date of grant. As at December 31, 2014, there were 2,165,000 options outstanding.

Share Purchase Warrants

As at December 31, 2014, the Company had 22,407,448 common share purchase warrants ("Warrants") outstanding. During the year ended December 31, 2014 we issued an additional 12,154,862 warrants while 5,669,558 expired. During the year ended December 31, 2014, 340,000 warrants were exercised for total proceeds of $136,000.

MARKET FOR SECURITIES

Trading Price and Volume

The Common Shares are listed on the TSX-V under the trading symbol "ICO" and on the OTCQX, under the symbol "ICOTF". The following table sets forth, for the periods during the year ended 2014, the reported high and low prices (in Canadian dollars) and the aggregate monthly volume of trading on the TSX-V:

	High	Low	Close	Volume
December 2014	0.045	0.025	0.035	12,657,297
November 2014	0.05	0.035	0.04	4,762,755
October 2014	0.055	0.035	0.045	4,644,698
September 2014	0.07	0.045	0.05	7,177,6504
August 2014	0.085	0.05	0.07	29,418,387
July 2014	0.075	0.05	0.055	23,898,346
June 2014	0.37	0.055	0.06	72,063,171
May 2014	0.365	0.245	0.335	3,974,894
April 2014	0.475	0.31	0.335	8,225,218
March 2014	0.59	0.41	0.43	17,429,775
February 2014	0.56	0.39	0.54	17,678,761
January 2014	0.58	0.38	0.44	11,095870

DIRECTORS AND OFFICERS

The names of the directors and executive officers of the Company as of the date hereof, their province or state and country of residence, their respective positions with our Company and the date upon which they were first elected as a director or officer of Privateco or the Company are set out in the table below. Upon completion of the Arrangement, the directors and officers of Privateco became the directors and officers of the Company. The term of each director expires on the date of our next annual meeting.

Name and Place of Residence	Current Position(s) with the Company	Principal Occupation For the Past Five Years[1]	Director and/or Officer Since[1]
Andrew J. Rae[1][2][3][4] West Vancouver, BC	Chief Executive Officer, President and Director	Chief Executive Officer and President, iCo Therapeutics Inc. (February 2005 to Present); Chief Financial Officer, Ability Biomedical Corporation (acquired by Medarex, Inc.) (February 2002 to August 2004)	February 15, 2005
William Jarosz[1][2][3][4] Sleepy Hollow, New York	Director	Partner, Cartesian Capital Group, LLC (May 2005 to present); Managing Director, AIG Capital Partners Inc. (February 1997 to May 2005)	June 1, 2006
Noel Hall [3][4] Victoria, BC	Director	Consultant (February 2008 to present); President, Aspreva Pharmaceuticals Corporation (December 2001 to January 2008).	June 27, 2008
Richard Barker [2] London, England	Director	Consultant, (June 2011 to present), Director General of the Association of the British Pharmaceutical Industry (August 2004 to May 2011); President, New Medicine Partners (May 2001 to August 2004)	June 1, 2006
W. John Meekison [1] West Vancouver, BC	Chief Financial Officer and Corporate Secretary	Chief Financial Officer, iCo Therapeutics Inc. (April 2005 to Present); Institutional Sales, Pacific International Securities Inc. (March 2004 to March 2005); Chief Financial Officer, Response Biomedical Corp. (February 2003 to February 2004); Private Consulting (January 2003); Vice President, Corporate Finance, Dlouhy Merchant Group Inc. (January 2001 to December 2002)	February 15, 2005
Douglas Janzen Vancouver, British Columbia	Director	Founder, Northview Ventures (November 2012 to present); President & Chief Executive Officer, Cardiome Pharma Corp. (August 2009 to July, 2012), President & Chief Business Officer, Cardiome Pharma Corp.. (March 2006 to July 2009)	March 2, 2012
Peter Hnik Vancouver, BC	Chief Medical Officer	Chief Medical Officer, iCo Therapeutics Inc. (July 2006 to Present); Associate Director, Clinical Development, QLT Inc. (September 1999 to June 2006)	June 16, 2006

(1) References to iCo Therapeutics Inc. during the period up to December 31, 2007 are references to Privateco.

(2) Member of Audit Committee

(3) Member of Compensation Committee

(4) Member of Governance and Nomination Committee

As of April 27, 2015, the directors and executive officers of the Company owned, directly or indirectly, or exercised control or direction over 5,472,599 (6.48%) of the issued and outstanding common shares of the Company.

Directors and Executive Officers Biographies

The following are short biographies of our directors and executive officers:

Andrew J. Rae, MBA — Director, President and Chief Executive Officer

Andrew Rae is the Chief Executive Officer and President of the Company on a full-time basis. Mr. Rae has spent almost two decades in the biotechnology industry, formerly as CFO with Ability Biomedical Corporation (Irvine CA, Vancouver BC), acquired by Medarex, Inc. in 2004. Mr. Rae has also served as Vice President, Finance & Corporate Affairs at Active Pass Pharmaceuticals (Vancouver BC). In his various roles, Mr. Rae has raised over $50M in venture, strategic and capital markets financings, engaged in a successful cross-border M&A transaction, and played a significant role in shaping multiple business development deals (Cambridge Antibody, Isis Pharmaceuticals, Medarex, Immune Pharmaceuticals, JDRF). Prior to his operational experiences, Mr. Rae served as Biotechnology Equities Analyst, Goepel Shields & Partners (now Raymond James Canada), covering Canadian biotechnology stocks including Angiotech Pharmaceuticals, QLT Inc. and ID Biomedical. Mr. Rae currently sits on the Dean's External Advisory Board for the Faculty of Business Administration at Simon Fraser University, Honours Program Advisory Committee, and the Board of Directors of Covenant House Vancouver, a charity operating shelters and counsel to homeless youth in Vancouver, BC. In 2009 Andrew was Pacific Finalist, Ernst & Young Entrepreneur of the Year (Canada). Mr. Rae's degrees include a B.Sc. from the University of Western Ontario and an MBA from Simon Fraser University.

William Jarosz, J.D. — Chairman and Director

William Jarosz is currently a Partner at Cartesian Capital Group, LLC, a global investment management firm. From 1997 until 2005, Mr. Jarosz served as Managing Director and General Counsel of AIG Capital Partners, a subsidiary of American International Group, Inc., and as Managing Director of the AIG-Brunswick Millennium Fund. While at AIG Capital Partners, Mr. Jarosz oversaw global private equity transactions for the firm's various private equity funds. Prior to joining AIG in 1997, Mr. Jarosz practiced law at Debevoise & Plimpton, specializing in international private equity investment and Russian corporate and securities laws. Mr. Jarosz also served as a consultant to the World Bank on the regulation of Foreign Direct Investment in emerging markets. Mr. Jarosz is a graduate of the University of Montana, and received an MA in Law and Diplomacy from the Fletcher School at Tufts University and a JD from Harvard Law School.

Noel Hall – Director

Noel Hall is currently a consultant to the life sciences industry and has approximately 25 years experience in the biotechnology industry, including as president of Aspreva Pharmaceuticals Corporation, which was acquired by the Galenica Group in January 2008. Prior to co-founding Aspreva in December 2001, Mr. Hall co-founded the life sciences practice of consulting firm Hill and Knowlton in 1995 and served as head of global strategic planning for the firm's worldwide pharmaceutical consulting practice. From 1992 to 1995, Mr. Hall was the director of corporate affairs for the United Kingdom and Northern Europe for The Wellcome Foundation Ltd., which is now part of GlaxoSmithKline PLC. From 1985 to 1990, Mr. Hall worked in market development with Abbott Laboratories Ltd. and from 1983 to 1985 Mr. Hall was a regional sales manager with Leo Laboratories Ltd. Mr. Hall holds a BSc in Medical Laboratory Science from London University. He has als been a director of Zymeworks Inc. since October 2008.

Richard Barker, D.Phil, MA — Director

Richard Barker is a strategic advisor, speaker and author on healthcare and life sciences. Mr. Barker is Director of the Centre for the Advancement of Sustainable Medical Innovation, a major European initiative aimed at

transforming the R&D and regulatory processes in life sciences to bring advances more rapidly and affordably to patients. His 25-year business career in healthcare has spanned biopharmaceuticals, diagnostics and medical informatics – both in the USA and Europe. Most recently he was Director General of the Association of the British Pharmaceutical Industry, member of the Executive Committee of EFPIA (the European industry association) and Council member of IFPMA (the international equivalent). As a co-founder of Life Sciences UK, member of the NHS Stakeholder Forum, vice-chair of the UK Clinical Trials Collaboration and in many other roles, he has advised successive UK governments on healthcare issues, especially those relating to developing, valuing and using new healthcare technologies. He is also chairman of the South London Academic Health Science Network**,** accelerating innovation in this region of the NHS, and also chairman of the Precision Medicine Catapult, a UK initiative to accelerate the creation and adoption of personalised medicine solutions in the UK. He is a board member of Celgene, a major US-based bio-therapeutics company. His past leadership roles include head of McKinsey's European healthcare practice, General Manager of Healthcare Solutions for IBM and Chief Executive of Chiron Diagnostics. He was also Chairman and Chief Executive of Molecular Staging, a US bioscience company, now part of Qiagen. He therefore has experience in leading and advising a wide range of high-technology companies. He holds an honorary professorship at UCL (University College London) and an associate professorship at Oxford University, and holds a D.Phil in biophysics and a B.A. in chemistry, both from Oxford University.

Douglas Janzen, — Director

Mr. Janzen has been involved in the Life Sciences industry for the past 19 years. Most recently he was President and CEO of Cardiome Pharma, a NASDAQ listed drug development company that completed an $800M licensing deal with Merck and saw its lead product Brinavess approved in Europe in 2010. Prior to that, Mr. Janzen was an investment banker with Cormark Securities, acting as Managing Director of Life Sciences. Mr. Janzen is the past Chairman of Life Sciences British Columbia, has served as a Director of Biotech Canada, and sits as a Director on a number of public and private boards. Mr. Janzen is a past winner of Vancouver's Top 40 under 40 award, and is currently the Founder of NorthView Ventures, an entity which invests in and provides strategic advisory services to a number of technology companies.

W. John Meekison, BA, CIM, P. Log — Chief Financial Officer and Corporate Secretary

Mr. Meekison has been the CFO for iCo since February 2005. He is a former investment banker where he specialized in life sciences while employed at a number of investment banking firms including: Loewen Ondaatje McCutcheon; Haywood Securities; Dlouhy Merchant Group; and PI Securities. As a financier, Mr. Meekison has raised equity capital for biotechnology companies both in Canada and the United States. Subsequently, as CFO for a TSE listed company developing a novel clinical diagnostic platform, Mr. Meekison supervised all public reporting functions, human resources, accounting and budgeting, raising equity capital, renegotiating the Company's existing line of credit, reviewing corporate strategy, and led M&A discussions. Mr. Meekison sits on the Board of Directors of Pacific Cascade Minerals Inc., Sojourn Ventures Inc. and Natcore Technology Inc. Mr. Meekison received his BA from the University of British Columbia and is a Certified Investment Manager and Professional Logistician.

Dr. Peter Hnik, MD, MHSc — Chief Medical Officer

Dr. Hnik received his medical degree from the Medical Faculty of Charles University of Prague in 1981. After practicing t the Eye Clinic of the Charles University Hospital where he performed surgery and consultation in glaucoma and neuro-ophthalmology, Dr. Hnik later joined the Eye Clinic of the University of British Columbia as part of the glaucoma research group. He received his Master of Health Sciences degree from the University of British Columbia in 1999. Prior to joining iCo Therapeutics, Dr. Hnik served as Associate Director of Clinical Research with QLT Inc., playing a critical role in designing and directing Visudyne clinical trials in AMD and diabetic retinopathy. He was also heavily involved in the publication, in-licensing and pharmacovigilance activities for Visudyne. He has authored numerous ocular publications and presentations at international forums. Dr. Hnik is a member of the Association for Research in Vision and Ophthalmology (ARVO), the American Academy of Ophthalmology (AAO), the European Society of Retina Specialists (EURETINA), the Drug Information Association (DIA), and the New York Academy of Sciences (NYAS).

Cease Trade Orders

To the best of our knowledge, no director or executive officer of the Company, is, or within the ten years prior to the date hereof, has been, a director, chief executive officer or chief financial officer that: (i) while that person was acting in that capacity was the subject of a cease trade order or similar order, or an order that denied the other issuer access to any exemptions under Canadian securities legislation, that was in effect for a period of more than thirty consecutive days or, (ii) after that person ceased to act in that capacity, was the subject of a cease trade order or similar order, or an order that denied the other issuer access to any exemptions under Canadian securities legislation, that was in effect for a period of more than thirty consecutive days and which resulted from an event that occurred while that person was acting in that capacity.

Penalties or Sanctions

To the best of our knowledge, no director or executive officer of the Company, or a shareholder holding a sufficient number of shares of the Company to affect materially the control of the Company, has been subject to any penalties or sanctions imposed by a court relating to Canadian securities legislation or by a Canadian securities regulatory authority or has entered into a settlement agreement with a Canadian securities authority, or any other penalties or sanctions imposed by a court or regulatory body that would likely be considered important to a reasonable investor in making an investment decision.

Personal Bankruptcies

To the best of our knowledge, no director or executive officer of the Company, or a shareholder holding a sufficient number of shares of the Company to affect materially the control of the Company, (i) has, during the ten years prior to the date hereof, been a director or executive officer of any company that, while that person was acting in that capacity, become bankrupt, made a proposal under any legislation relating to bankruptcy or insolvency, or been subject to or instituted any proceedings, arrangement or compromise with creditors, or had a receiver, receiver manager or trustee appointed to hold his, her or its assets or (ii) has, during the ten years prior to the date hereof, become bankrupt, made a proposal under any legislation relating to bankruptcy or insolvency, or been subject to or instituted any proceedings, arrangement or compromise with creditors, or had a receiver, receiver manager or trustee appointed to hold his, her or its assets.

Conflicts of Interest

Certain of our directors and officers may serve as directors or officers of other companies or have shareholdings in other companies and, to the extent that such other companies may participate in ventures in which we may participate, conflicts of interest may arise which may be harmful to our interests. In the event that such a conflict of interest arises at a meeting of the directors of our company, a director who has such a conflict is required to advise our board of directors his or her conflict, and abstain from voting for or against the approval of the matter before the meeting. In accordance with the corporate laws affecting us, our directors are required to act honestly, in good faith and in the best interests of the Company. See also "Interest of Management and Others in Material Transactions".

AUDIT COMMITTEE INFORMATION

Audit Committee Charter

The primary function of the Audit Committee is to assist the board of directors of the Company in fulfilling its oversight responsibilities with respect to the quality and integrity of the consolidated financial statements of the Company; appointing and overseeing the external auditors and reviewing the qualifications and independence of the external auditors; reviewing the performance of the external auditors; ensuring compliance by the Company with all legal and regulatory requirements for audit and related financial functions of the Company; reviewing financial information contained in public filings of the Company; reviewing earnings announcements of the Company prior to release to the public; monitoring the Company's systems of and compliance with internal financial controls; reviewing the Company's auditing, accounting and financial reporting processes; and dealing with all complaints

regarding accounting, internal accounting controls and auditing matters. The Audit Committee Mandate is attached as Appendix "A".

Composition of Audit Committee

The Audit Committee consists of Mr. Richard Barker, Mr. Andrew Rae and Mr. William Jarosz. Mr. Jarosz, who chairs the Audit Committee, and Mr. Barker are each non-employee members of our board of directors. Our board of directors has determined that Mr. Barker and Mr. Jarosz are "independent" as such term is defined in Multilateral Instrument 52-110 – *Audit Committees* ("MI 52-110"). In addition, our board of directors has determined that each member of the Audit Committee is "financially literate" under MI 52-110.

Relevant Education and Experience

The education and experience of each member of the Audit Committee that is relevant to the performance of his responsibilities as a member of the Audit Committee member is described below:

Richard Barker

Richard Barker is a strategic advisor, speaker and author on healthcare and life sciences. Mr. Barker is Director of the Centre for the Advancement of Sustainable Medical Innovation, a major European initiative aimed at transforming the R&D and regulatory processes in life sciences to bring advances more rapidly and affordably to patients. His 25-year business career in healthcare has spanned biopharmaceuticals, diagnostics and medical informatics – both in the USA and Europe. Most recently he was Director General of the Association of the British Pharmaceutical Industry, member of the Executive Committee of EFPIA (the European industry association) and Council member of IFPMA (the international equivalent). As a co-founder of Life Sciences UK, member of the NHS Stakeholder Forum, vice-chair of the UK Clinical Trials Collaboration and in many other roles, he has advised successive UK governments on healthcare issues, especially those relating to developing, valuing and using new healthcare technologies. He is also chairman of the South London Academic Health Science Network**,** accelerating innovation in this region of the NHS, and also chairman of the Precision Medicine Catapult, a UK initiative to accelerate the creation and adoption of personalised medicine solutions in the UK. He is a board member of Celgene, a major US-based bio-therapeutics company. His past leadership roles include head of McKinsey's European healthcare practice, General Manager of Healthcare Solutions for IBM and Chief Executive of Chiron Diagnostics. He was also Chairman and Chief Executive of Molecular Staging, a US bioscience company, now part of Qiagen. He therefore has experience in leading and advising a wide range of high-technology companies. He holds an honorary professorship at UCL (University College London) and an associate professorship at Oxford University, and holds a D.Phil in biophysics and a B.A. in chemistry, both from Oxford University.

William Jarosz

William Jarosz is currently a Partner at Cartesian Capital Group, LLC, a global investment management firm. From 1997 until 2005, Mr. Jarosz served as Managing Director and General Counsel of AIG Capital Partners, a subsidiary of American International Group, Inc., and as Managing Director of the AIG-Brunswick Millennium Fund. While at AIG Capital Partners, Mr. Jarosz oversaw global private equity transactions for the firm's various private equity funds. Prior to joining AIG in 1997, Mr. Jarosz practiced law at Debevoise & Plimpton, specializing in international private equity investment and Russian corporate and securities laws. Mr. Jarosz also served as a consultant to the World Bank on the regulation of Foreign Direct Investment in emerging markets. Mr. Jarosz is a graduate of the University of Montana, and received an MA in Law and Diplomacy from the Fletcher School at Tufts University and a JD from Harvard Law School.

Andrew Rae

Andrew Rae is the Chief Executive Officer and President of the Company on a full-time basis. Mr. Rae has spent almost two decades in the biotechnology industry, formerly as CFO with Ability Biomedical Corporation (Irvine CA, Vancouver BC), acquired by Medarex, Inc. in 2004. Mr. Rae has also served as Vice President, Finance & Corporate Affairs at Active Pass Pharmaceuticals (Vancouver BC). In his various roles, Mr. Rae has raised over

$50M in venture, strategic and capital markets financings, engaged in a successful cross-border M&A transaction, and played a significant role in shaping multiple business development deals (Cambridge Antibody, Isis Pharmaceuticals, Medarex, Immune Pharmaceuticals, JDRF). Prior to his operational experiences, Mr. Rae served as Biotechnology Equities Analyst, Goepel Shields & Partners (now Raymond James Canada), covering Canadian biotechnology stocks including Angiotech Pharmaceuticals, QLT Inc. and ID Biomedical. Mr. Rae currently sits on the Dean's External Advisory Board for the Faculty of Business Administration at Simon Fraser University, Honours Program Advisory Committee, and the Board of Directors of Covenant House Vancouver, a charity operating shelters and counsel to homeless youth in Vancouver, BC. In 2009 Andrew was Pacific Finalist, Ernst & Young Entrepreneur of the Year (Canada). Mr. Rae's degrees include a B.Sc. from the University of Western Ontario and an MBA from Simon Fraser University.

Pre-Approval of Audit Services and Permitted Non-Audit Services

As set forth in the Audit Committee Mandate, the Audit Committee is required to pre-approve all audit services and permitted non-audit services performed by our external auditors.

External Auditor Service Fees

The following table sets forth, by category, the fees billed by PricewaterhouseCooper LLP to the Company for the year ended December 31, 2014 (including estimates) and for the year ended December 31, 2013 (actuals). During these years, PricewaterhouseCooper LLP was the Company's only external auditor.

Financial Year Ending	Audit Fees	Audit Related Fees	Tax Fees	All Other Fees	Total
December 31, 2014	$52,000[(1)]	$22,855	$14,700 [(1)]	$73,317	$162,872
December 31, 2013	$54,678	$61,730	$7,402	38,850	$162,300

(1) Estimated

LEGAL PROCEEDINGS AND REGULATORY ACTIONS

We are not aware of any legal proceedings to which we are a party, or by which any of our property is subject, which would be material to us and are not aware of any such proceedings being contemplated.

INTEREST OF MANAGEMENT AND OTHERS IN MATERIAL TRANSACTIONS

Except as described below, no director, officer or principal shareholder of the Company, or any associate or affiliate of any of the foregoing persons or entities, has any direct or indirect material interest in any transaction within three years of the date of this Annual Information Form or in any proposed transaction of the Company that has materially affected or will materially affect the Company or any of our subsidiaries.

REGISTRAR AND TRANSFER AGENT

The registrar and transfer agent for the Company is Computershare Investor Services Inc., 510 Burrard Street., 2nd Floor, Vancouver, BC, V6C 3B9.

MATERIAL CONTRACTS

The licensing agreements in respect of each of iCo-007, iCo-008 and the Oral AmpB Delivery System are material contracts of the Company. For a full discussion of each of these agreements, see "The Business – Licensing Agreements".

INTERESTS OF EXPERTS

Our auditor is PricewaterhouseCoopers LLP, Chartered Accountants, of Vancouver, British Columbia. PricewaterhouseCoopers LLP has advised the Corporation that it is independent in accordance with the rules of professional conduct of the Institute of Chartered Accountants of British Columbia.

ADDITIONAL INFORMATION

Additional information relating to the Company, including information relating to directors' and officers' remuneration and indebtedness, principal holders of our securities and securities authorized for issue under equity compensation plans is contained in our Notice of Annual General Meeting and Management Information Circular dated April 22, 2013 and filed at www.sedar.com. Additional financial information is provided in our audited consolidated financial statements and management's discussion and analysis for our most recently completed financial year, each of which and is available under the Company's profile at www.sedar.com.

APPENDIX A
Audit Committee Mandate

Purpose

The audit committee (the "Committee") of iCo Therapeutics Inc. (the "Corporation") is responsible for ensuring accounting integrity and solvency. The Committee is also responsible for ensuring the appropriateness of insurance, investment of liquid funds, information security policies, material contracts and events that could lead to material liabilities. The Committee will assist the board of directors of the Corporation (the "Board") in fulfilling its oversight responsibilities by:

- reviewing the integrity of the consolidated financial statements of the Corporation;
- appointing and removing (subject to shareholder ratification if required), determine funding for, and oversee the external auditors and reviewing the external auditors' qualifications and independence;
- reviewing the performance of the Corporation's external auditors;
- in conjunction with the Chief Financial Officer, reviewing the timely compliance by the Corporation with all legal and regulatory requirements for audit and related financial functions of the Corporation;
- in conjunction with the Chief Financial Officer, reviewing financial information contained in public filings of the Corporation prior to filing;
- in conjunction with the Chief Financial Officer, reviewing earnings announcements of the Corporation prior to release to the public;
- in conjunction with the Chief Financial Officer, reviewing the Corporation's systems of and compliance with internal financial controls;
- in conjunction with the Chief Financial Officer, reviewing the Corporation's auditing, accounting and financial reporting processes;
- dealing with all complaints brought to the attention of the audit committee regarding accounting, internal accounting controls and auditing matters; and
- dealing with any issues that result from the reviews set forth above.

Membership and Reporting

The Committee will be comprised of independent directors and will have a minimum of three members. All members of the Committee must have a working familiarity with basic finance and accounting practices and be able to read and understand financial statements.

Appointments and replacements to the Committee will be made by the Board and will be reviewed on an annual basis. The Board will provide for continuity of membership, while at the same time allowing fresh

perspectives to be added. Each member of the Committee will automatically cease to be a member if he or she ceases to be an independent director.

The chairman of the Committee (the "Chairman") will be appointed by a majority vote of the Board on an annual basis.

The Committee will report to the Board, at the next scheduled meeting of the Board, the proceedings of the Committee and any recommendations made by the Committee.

Each member of the Committee will be "financially literate", as such term is defined in Multilateral Instrument 52-110".

The external auditors will report directly to the Committee.

Terms of Reference

1. The Committee is responsible for overseeing the work of the external auditors and will communicate directly with the external auditors as required.

2. The Committee will meet as required, but at least once quarterly (to review the quarterly financial statements, management accounting, management discussion and analysis ("MD&A") and any related press release before such documents are presented to the Board or filed with regulatory authorities, as the case may be). Special meetings of the Committee will be authorized at the request of any member of the Committee or at the request of the Corporation's external auditors. The external auditors will be informed about, and can attend, meetings of the Committee as deemed appropriate by the Chairman of the Committee. Provision will be made to meet privately with external auditors on a quarterly basis and to meet privately with management at least once per annum.

3. The Committee will review, with the external auditors, the results of the external audit and any changes in accounting practices or policies and the financial statements impact thereof. In addition, the Committee will review any accruals, provisions, or estimates that have a significant effect upon the financial statements as well as other sensitive matters such as disclosure of related party transactions.

4. The Committee will review and approve interim financial statements, MD&A and any related press release on behalf of the Board and sign a resolution to that effect.

5. In addition, the Committee will review other financial statements, information and documents that require the approval of the Board. These will include year-end audited statements, year-end MD&A, statements in prospectuses and other offering memoranda and statements required by regulatory authorities. The Committee will sign a resolution to the effect that such financial statements, information or documents that are being presented to the Board are satisfactory, and recommend their approval.

6. The Committee will review and discuss with management and the external auditors any major issue as to the adequacy and effectiveness of internal controls over the accounting and financial reporting systems of the Corporation, either directly, or through the external auditors or other advisors and obtain and review a

report from the external auditors, at least annually, regarding same; and the Committee will review and discuss with management and the external auditors any special steps adopted in light of material internal control deficiencies and the adequacy of disclosures about changes in internal controls over financial reporting.

7. The Committee will review any policies and practices developed by the Corporation regarding the regular examination of officers' expenses and perquisites, including the use of the assets of the Corporation.

8. The Committee will review the basis and amount of the external auditors' fees and pre-approve all auditing services and permitted non-audit services.

9. The Committee will consider whether the external auditors should be re-appointed and make recommendations to the Board. At least on an annual basis, the Committee will evaluate the qualifications, performance and independence of the external auditors and the senior audit partners having primary responsibility for the audit, including considering whether the auditors' quality controls are adequate.

10. The Committee will pre-approve the appointment of the external auditors for all accounting services, internal control related services and permitted non-audit services to be provided to the Corporation. The Committee may establish policies and procedures, from time to time, pre-approving the appointment of the external auditors for certain non-audit services. In addition, the Committee may delegate to one or more members the authority to pre-approve the appointment of the external auditors for any non-audit service to the extent permitted by applicable law, provided that any pre-approvals granted pursuant to such delegation will be reported to the full Committee at its next scheduled meeting.

11. The Committee will review and approve the Corporation's hiring of partners and employees of the external auditors of the Corporation.

12. The Committee will establish procedures for the receipt, retention and treatment of complaints received by the Corporation regarding accounting, internal accounting controls or auditing matters and for the confidential, anonymous submission by employees of the Corporation of concerns regarding questionable accounting or auditing matters.

13. The Committee will review and reassess the adequacy of this mandate annually.

14. The Committee has the authority, to the extent it deems necessary or appropriate, to retain independent legal, accounting or other advisors ("Advisors"). The Corporation will provide appropriate funding, as determined by the Committee, for payment of compensation to the external auditors for the purpose of rendering or issuing an audit report and to any Advisors employed by the Committee.

15. The Committee will issue any necessary reports required of the Committee to be included in the Corporation's annual proxy statement. The Committee will review and recommend to the Board the approval of all documents filed with securities regulatory authorities.

16. The Committee will approve all related party transactions brought to the attention of the Committee.

17. The Committee will discuss with management and the external auditors any correspondence with regulators or governmental agencies and any published reports that raise material issues regarding the Corporation's financial statements or accounting policies.

18. The Committee will receive from the external auditors a formal written statement delineating all relationships between the external auditors and the Corporation and will actively engaging in a dialogue with the external auditors with respect to any disclosed relationships or services that may impact the objectivity and independence of the external auditors.

Approved: January 1, 2008