# Exelixis and Ipsen Announce Results from Phase 2 CABOSUN Trial of Cabozantinib versus Sunitinib in Previously Untreated Advanced Renal Cell Carcinoma at ESMO 2017

September 9, 2017

*– Independent Radiology Review Committee confirms primary endpoint analysis per investigator: cabozantinib provided statistically significant improvement of progression-free survival, with a 52 percent reduction in the rate of progression or death compared to sunitinib –*

*– Exelixis and Ipsen to host investor and media webcast from Madrid to discuss the data on Sunday, September 10 starting at 6:45 p.m. CEST –*

SOUTH SAN FRANCISCO, Calif. & PARIS--(BUSINESS WIRE)--Sep. 9, 2017-- Exelixis, Inc. (NASDAQ:EXEL) and Ipsen (Euronext:IPN; ADR:IPSEY) today announced updated results from the CABOSUN randomized phase 2 trial of cabozantinib in patients with previously untreated advanced renal cell carcinoma (RCC) with intermediate- or poor-risk disease per the International Metastatic Renal Cell Carcinoma Database Consortium (IMDC). Principal investigator Toni K. Choueiri, M.D., will present detailed data from late-breaking CABOSUN abstract [#LBA38_PD] today in the Genitourinary Tumors, Non-Prostate poster discussion session, starting at 2:45 p.m. CEST (local Madrid time) / 8:45 a.m. EDT / 5:45 a.m. PDT at the European Society for Medical Oncology (ESMO) 2017 Congress, which is being held September 8-12, 2017 in Madrid, Spain.

CABOSUN is being conducted by The Alliance for Clinical Trials in Oncology as part of Exelixis' collaboration with the National Cancer Institute's Cancer Therapy Evaluation Program (NCI-CTEP). The data presented at ESMO 2017 included the analysis from a blinded independent radiology review committee (IRC), which confirmed the primary efficacy endpoint results of investigator-assessed progression-free survival (PFS), as well as an updated investigator-assessed analysis. Per the IRC analysis, cabozantinib demonstrated a clinically meaningful and statistically significant 52 percent reduction in the rate of disease progression or death (HR 0.48, 95% CI 0.31-0.74, two-sided P=0.0008). The median PFS for cabozantinib was 8.6 months versus 5.3 months for sunitinib, corresponding to a 3.3 month (62 percent) improvement favoring cabozantinib over sunitinib.

"These updated analyses from CABOSUN consistently show that cabozantinib provided a statistically significant decrease in the rate of disease progression or death compared to sunitinib, a current standard of care – potentially offering a new treatment option for physicians to treat patients in the first-line advanced renal cell carcinoma setting," said Toni K. Choueiri, M.D., Director, Lank Center for Genitourinary Oncology, Dana-Farber Cancer Institute. "The CABOSUN trial included patients with intermediate or poor prognostic factors per the IMDC criteria; in addition, patients had a notable number of other independent adverse prognostic risk factors. These included a high rate of bone metastases, two or more sites of metastatic disease, ECOG 2 performance status, and lack of prior nephrectomy. This patient population fares poorly and is in need of new therapies to better control their disease."

The following chart outlines data from the CABOSUN trial presented today at ESMO 2017, as compared to the data previously published in the *Journal of Clinical Oncology* (JCO) in October 2016:

| | ***JCO*** **Investigator-assessed** *(April 11, 2016 Cut-off)* | | **ESMO 2017 Investigator-assessed** *(Sept 15, 2016 Cut-off)* | | **ESMO 2017 IRC Review** *(Sept 15, 2016 Cut-off)* | |
|---|---|---|---|---|---|---|
| | **Cabozantinib N = 79** | **Sunitinib N = 78** | **Cabozantinib N = 79** | **Sunitinib N = 78** | **Cabozantinib N = 79** | **Sunitinib N = 78** |
| **Progression-free survival** | | | | | | |
| **Median PFS, months** | 8.2 | 5.6 | 8.3 | 5.4 | 8.6 | 5.3 |
| **Stratified HR (95% CI)** | 0.66 (0.46-0.95) | | 0.56 (0.37-0.83) | | 0.48 (0.31-0.74) | |
| ***P* value** | 0.012 (1-sided) | | 0.0042 (2-sided) | | 0.0008 (2-sided) | |
| **Tumor Response** | | | | | | |
| **Objective response rate (95% CI),[a] %** | 46 (34-57) | 18 (10-28) | 33 (23-44) | 12 (5-21) | 20 (12-31) | 9 (4-18) |
| **Disease control rate,[b] %** | 78 | 54 | 76 | 49 | 75 | 47 |
| **Progressive disease,[c] %** | 18 | 26 | 18 | 24 | 18 | 29 |
| **Not evaluable or missing, %** | 4 | 21 | 6 | 27 | 8 | 23 |
| **Any reduction in target lesions, %** | 87 | 44 | 85 | 38 | 80 | 50 |

[a] One complete response was observed with cabozantinib for both investigator assessments, and one complete response was observed with sunitinib for the original investigator assessment, all other responses were partial responses; [b] Complete response + partial response + stable disease; [c] Progressive disease as best overall response.

The updated 2017 data sets and methods differ from the initial investigator analyses presented in 2016. The comprehensive image collection for IRC review used a later cut-off point (5 months) than the initial investigator analysis and followed a rigorous IRC review process. The analysis of IRC data applied U.S. Food and Drug Administration (FDA) guidance for PFS analyses in oncology studies, including recommended censoring rules (i.e., censoring at the last adequate tumor assessment prior to initiation of subsequent anti-cancer therapy, and censoring for events that occur after two or more missing adequate tumor assessments).[1] Both the updated investigator assessment and IRC analysis demonstrated consistent and statistically

significant improvement of PFS with cabozantinib as compared to sunitinib.

The updated overall survival (OS) analysis had a data cut-off of July 1, 2017, and showed a favorable trend for patients randomized to cabozantinib compared to sunitinib that was not statistically significant. Median overall survival was 26.6 months for patients receiving cabozantinib versus 21.2 months for those receiving sunitinib (HR= 0.80, 95% CI 0.53-1.21, two-sided P=0.29).

"We are very encouraged by the clinically meaningful and statistically significant efficacy results on the primary endpoint of progression-free survival, which formed the basis of the recent supplemental New Drug Application submitted to the U.S. Food and Drug Administration for cabozantinib in first-line advanced renal cell carcinoma," said Michael M. Morrissey, Ph.D., President and Chief Executive Officer of Exelixis. "The latest CABOSUN data continue to underscore the value that cabozantinib may offer patients with previously untreated renal cell carcinoma, and we are working tirelessly in our efforts to bring this option to patients and their physicians as quickly as possible."

David Meek, Chief Executive Officer of Ipsen stated, "Following the recent European approval of cabozantinib for second-line treatment of patients with advanced renal cell carcinoma following prior VEGF-targeted therapy, the latest data from the CABOSUN study being presented this year at ESMO extends the clinical benefit of cabozantinib in first-line therapy setting for patients with advanced RCC. With our partner Exelixis, we are committed to strengthening the medical value of cabozantinib and to continuing to bring innovative therapeutic solutions for the treatment of patients with RCC."

The most common all-causality grade 3 or 4 adverse events in more than 5 percent of patients for cabozantinib (N=78) and sunitinib (N=72), respectively, were diarrhea (10 vs. 11 percent), hypertension (28 vs. 21 percent), fatigue (6 vs. 17 percent), increased alanine aminotransferase (ALT; 5 vs. 0 percent), decreased appetite (5 vs. 1 percent), palmar-plantar erythrodysesthesia syndrome (PPES; 8 vs. 4 percent), decreased platelet count (1 vs. 11 percent) and stomatitis (5 vs. 6 percent). Twenty-one percent of patients in the cabozantinib arm and 22 percent of patients in the sunitinib arm discontinued treatment due to adverse events.

Exelixis filed a supplemental New Drug Application based on the CABOSUN data with the FDA for cabozantinib as a treatment for previously untreated advanced RCC on August 16, 2017. Ipsen also submitted to EMA the regulatory dossier for cabozantinib as a treatment for first-line advanced RCC in the European Union on August 28, 2017; on September 8, 2017, Ipsen announced that the EMA validated the application.

**About the CABOSUN Study**

On May 23, 2016, Exelixis announced that CABOSUN met its primary endpoint, demonstrating a statistically significant and clinically meaningful improvement in PFS compared with sunitinib in patients with advanced intermediate- or poor-risk RCC as determined by investigator assessment. The CABOSUN trial is being conducted by The Alliance for Clinical Trials in Oncology as part of Exelixis' collaboration with the NCI-CTEP. These results were first presented in a plenary session by Dr. Toni Choueiri at the ESMO 2016 Congress, and published in the *JCO*.[2] In June 2017, a blinded IRC confirmed that cabozantinib provided a clinically meaningful and statistically significant improvement in the primary efficacy endpoint of investigator-assessed PFS.

CABOSUN is a randomized, open-label, active-controlled phase 2 trial that enrolled 157 patients with advanced RCC determined to be intermediate- or poor-risk by the IMDC criteria. Patients were randomized 1:1 to receive cabozantinib (60 mg once daily) or sunitinib (50 mg once daily, 4 weeks on followed by 2 weeks off). The primary endpoint was PFS. Secondary endpoints included OS and objective response rate.

Eligible patients were required to have locally advanced or metastatic clear-cell RCC, ECOG performance status 0-2 and had to be intermediate or poor risk per the IMDC criteria (Heng, *JCO*, 2009).[3] Prior systemic treatment for RCC was not permitted. Baseline characteristics included:

| Characteristic | Cabozantinib (N=79) | Sunitinib (N=78) |
|---|---|---|
| **ECOG performance status, %** | | |
| 0 | 46 | 46 |
| 1 | 42 | 41 |
| 2 | 13 | 13 |
| **IMDC risk group, %** | | |
| Intermediate | 81 | 81 |
| Poor | 19 | 19 |
| **Bone metastasis per IxRS,[a] %** | | |
| Yes | 37 | 36 |
| No | 63 | 64 |
| **Prior nephrectomy, %** | | |
| Yes | 72 | 77 |
| No | 28 | 23 |
| **Number of metastatic sites per investigator, %** | | |
| 1 | 22 | 33 |
| 2 | 47 | 26 |
| ≥3 | 32 | 41 |

[a] interactive voice/web response system

Please see Important Safety Information below and full U.S. prescribing information at https://cabometyx.com/downloads/cabometyxuspi.pdf.

**Webcast for the Financial Community and Media**

Exelixis and its partner Ipsen will jointly host a live webcast on Sunday, September 10. The webcast will begin at 6:45 p.m. CEST (local Madrid time) / 12:45 p.m. EDT / 9:45 a.m. PDT. During the webcast, Exelixis and Ipsen management and invited guest speakers will review results from the CABOSUN trial, along with the other relevant data sets presented at the conference.

To access the webcast link, log onto www.exelixis.com and proceed to the News & Events / Event Calendar page under the Investors & Media heading. Please connect to the company's website at least 15 minutes prior to the webcast to ensure adequate time for any software download that may be required to view the program. To listen to an audio-only version of the program by phone, please dial (855) 793-2457 (domestic) or (631) 485-4921 (international/toll dial) and use passcode 68961937. A telephone replay will be available until 11:59 p.m. EDT on September 17, 2017. Access numbers for the telephone replay are: 855-859-2056 (domestic) and 404-537-3406 (international); the passcode is 68961937. A webcast replay will also be available archived on www.exelixis.com for one year.

**About Advanced Renal Cell Carcinoma**

The American Cancer Society's 2017 statistics cite kidney cancer as among the top ten most commonly diagnosed forms of cancer among both men and women in the U.S.[4] Clear cell RCC is the most common type of kidney cancer in adults.[5] If detected in its early stages, the five-year survival rate for RCC is high; for patients with advanced or late-stage metastatic RCC, however, the five-year survival rate is only 12 percent, with no identified cure for the disease.[6] Approximately 30,000 patients in the U.S. and 68,000 globally require treatment, and an estimated 14,000 patients in the U.S. each year are in need of a first-line treatment for advanced kidney cancer.[7]

The majority of clear cell RCC tumors have lower than normal levels of a protein called von Hippel-Lindau, which leads to higher levels of MET, AXL and VEGF.[8,9] These proteins promote tumor angiogenesis (blood vessel growth), growth, invasiveness and metastasis.[10-13] MET and AXL may provide escape pathways that drive resistance to VEGF receptor inhibitors.[8,9]

**About CABOMETYX® (cabozantinib)**

CABOMETYX is the tablet formulation of cabozantinib. Its targets include MET, AXL and VEGFR-1, -2 and -3. In preclinical models, cabozantinib has been shown to inhibit the activity of these receptors, which are involved in normal cellular function and pathologic processes such as tumor angiogenesis, invasiveness, metastasis and drug resistance. CABOMETYX is available in 20 mg, 40 mg or 60 mg doses. The recommended dose is 60 mg orally, once daily.

On April 25, 2016, the FDA approved CABOMETYX tablets for the treatment of patients with advanced RCC who have received prior anti-angiogenic therapy. In February of 2016, Exelixis and Ipsen jointly announced an exclusive licensing agreement for the commercialization and further development of cabozantinib indications outside of the United States, Canada and Japan. This agreement was amended in December of 2016 to include commercialization rights for Ipsen in Canada. On September 9, 2016, the European Commission approved CABOMETYX tablets for the treatment of advanced RCC in adults who have received prior vascular endothelial growth factor (VEGF)-targeted therapy in the European Union, Norway and Iceland.

On January 30, 2017, Exelixis and Takeda Pharmaceutical Company Limited announced an exclusive licensing agreement for the commercialization and further clinical development of cabozantinib for all future indications in Japan, including RCC.

CABOMETYX is not indicated for the treatment of previously untreated advanced RCC.

**U.S. Important Safety Information**

**Hemorrhage:** Severe hemorrhage occurred with CABOMETYX. The incidence of Grade ≥3 hemorrhagic events was 2.1% in CABOMETYX-treated patients and 1.6% in everolimus-treated patients. Fatal hemorrhages also occurred in the cabozantinib clinical program. Do not administer CABOMETYX to patients that have or are at risk for severe hemorrhage.

**Gastrointestinal (GI) Perforations and Fistulas:** Fistulas were reported in 1.2% (including 0.6% anal fistula) of CABOMETYX-treated patients and 0% of everolimus-treated patients. GI perforations were reported in 0.9% of CABOMETYX-treated patients and 0.6% of everolimus-treated patients. Fatal perforations occurred in the cabozantinib clinical program. Monitor patients for symptoms of fistulas and perforations. Discontinue CABOMETYX in patients who experience a fistula that cannot be appropriately managed or a GI perforation.

**Thrombotic Events:** CABOMETYX treatment results in an increased incidence of thrombotic events. Venous thromboembolism was reported in 7.3% of CABOMETYX-treated patients and 2.5% of everolimus-treated patients. Pulmonary embolism occurred in 3.9% of CABOMETYX-treated patients and 0.3% of everolimus-treated patients. Events of arterial thromboembolism were reported in 0.9% of CABOMETYX-treated patients and 0.3% of everolimus-treated patients. Fatal thrombotic events occurred in the cabozantinib clinical program. Discontinue CABOMETYX in patients who develop an acute myocardial infarction or any other arterial thromboembolic complication.

**Hypertension and Hypertensive Crisis:** CABOMETYX treatment results in an increased incidence of treatment-emergent hypertension. Hypertension was reported in 37% (15% Grade ≥3) of CABOMETYX-treated patients and 7.1% (3.1% Grade ≥3) of everolimus-treated patients. Monitor blood pressure prior to initiation and regularly during CABOMETYX treatment. Withhold CABOMETYX for hypertension that is not adequately controlled with medical management; when controlled, resume CABOMETYX at a reduced dose. Discontinue CABOMETYX for severe hypertension that cannot be controlled with anti-hypertensive therapy. Discontinue CABOMETYX if there is evidence of hypertensive crisis or severe hypertension despite optimal medical management.

**Diarrhea:** Diarrhea occurred in 74% of patients treated with CABOMETYX and in 28% of patients treated with everolimus. Grade 3 diarrhea occurred in 11% of CABOMETYX-treated patients and in 2% of everolimus-treated patients. Withhold CABOMETYX in patients who develop intolerable Grade 2 diarrhea or Grade 3-4 diarrhea that cannot be managed with standard antidiarrheal treatments until improvement to Grade 1; resume CABOMETYX at a reduced dose. Dose modification due to diarrhea occurred in 26% of patients.

**Palmar-Plantar Erythrodysesthesia Syndrome (PPES):** Palmar-plantar erythrodysesthesia syndrome (PPES) occurred in 42% of patients treated with CABOMETYX and in 6% of patients treated with everolimus. Grade 3 PPES occurred in 8.2% of CABOMETYX-treated patients and in <1% of

everolimus-treated patients. Withhold CABOMETYX in patients who develop intolerable Grade 2 PPES or Grade 3 PPES until improvement to Grade 1; resume CABOMETYX at a reduced dose. Dose modification due to PPES occurred in 16% of patients.

**Reversible Posterior Leukoencephalopathy Syndrome (RPLS):** RPLS, a syndrome of subcortical vasogenic edema diagnosed by characteristic finding on MRI, occurred in the cabozantinib clinical program. Perform an evaluation for RPLS in any patient presenting with seizures, headache, visual disturbances, confusion, or altered mental function. Discontinue CABOMETYX in patients who develop RPLS.

**Embryo-fetal Toxicity:** CABOMETYX can cause fetal harm when administered to a pregnant woman. Advise pregnant women of the potential risk to a fetus. Advise females of reproductive potential to use effective contraception during treatment with CABOMETYX and for 4 months after the last dose.

**Adverse Reactions:** The most commonly reported (≥25%) adverse reactions are: diarrhea, fatigue, nausea, decreased appetite, PPES, hypertension, vomiting, weight decreased, and constipation.

**Drug Interactions: Strong CYP3A4 inhibitors and inducers:** Reduce the dosage of CABOMETYX if concomitant use with strong CYP3A4 inhibitors cannot be avoided. Increase the dosage of CABOMETYX if concomitant use with strong CYP3A4 inducers cannot be avoided.

**Lactation:** Advise a lactating woman not to breastfeed during treatment with CABOMETYX and for 4 months after the final dose.

**Reproductive Potential: Contraception—**Advise females of reproductive potential to use effective contraception during treatment with CABOMETYX and for 4 months after the final dose. **Infertility —**CABOMETYX may impair fertility in females and males of reproductive potential.

**Hepatic Impairment:** Reduce the CABOMETYX dose in patients with mild (Child-Pugh score [C-P] A) or moderate (C-P B) hepatic impairment. CABOMETYX is not recommended for use in patients with severe hepatic impairment.

**Please see full Prescribing Information at https://cabometyx.com/downloads/cabometyxuspi.pdf.**

**About Exelixis**

Founded in 1994, Exelixis, Inc. (Nasdaq: EXEL) is a commercially successful, oncology-focused biotechnology company that strives to accelerate the discovery, development and commercialization of new medicines for difficult-to-treat cancers. Following early work in model genetic systems, we established a broad drug discovery and development platform that has served as the foundation for our continued efforts to bring new cancer therapies to patients in need. We discovered our lead compounds, cabozantinib and cobimetinib, and advanced them into clinical development before entering into partnerships with leading biopharmaceutical companies in our efforts to bring them to patients globally. With growing revenues from the three resulting commercialized products – CABOMETYX®, COMETRIQ®, and COTELLIC® – we are reinvesting in our business to maximize the potential of our pipeline, which we intend to supplement with targeted business development activities and internal drug discovery, all to deliver the next generation of Exelixis medicines and help patients recover stronger and live longer. For more information about Exelixis, please visit www.exelixis.com or follow @ExelixisInc on Twitter.

**About Ipsen**

Ipsen is a global specialty-driven pharmaceutical group with total sales exceeding €1.4 billion in 2015. Ipsen sells more than 20 drugs in more than 115 countries, with a direct commercial presence in more than 30 countries. Ipsen's ambition is to become a leader in specialty healthcare solutions for targeted debilitating diseases. Its fields of expertise cover oncology, neurosciences and endocrinology (adult & pediatric). Ipsen's commitment to oncology is exemplified through its growing portfolio of key therapies improving the care of patients suffering from prostate cancer, bladder cancer and neuro-endocrine tumors. Ipsen also has a significant presence in primary care. Moreover, the Group has an active policy of partnerships. Ipsen's R&D is focused on its innovative and differentiated technological platforms, peptides and toxins, located in the heart of the leading biotechnological and life sciences hubs (Les Ulis/Paris-Saclay, France; Slough/Oxford, UK; Cambridge, US). In 2015, R&D expenditure totaled close to €193 million. The Group has more than 4,600 employees worldwide. Ipsen's shares are traded on segment A of Euronext Paris (stock code: IPN, ISIN code: FR0010259150) and eligible to the "Service de Règlement Différé" ("SRD"). The Group is part of the SBF 120 index. Ipsen has implemented a Sponsored Level I American Depositary Receipt (ADR) program, which trade on the over-the-counter market in the United States under the symbol IPSEY. For more information on Ipsen, visit www.ipsen.com.

**Exelixis Forward-Looking Statement Disclaimer**

This press release contains forward-looking statements, including, without limitation, statements related to: the presentation of detailed data from CABOSUN at ESMO; the therapeutic potential of cabozantinib as a treatment for patients with previously untreated RCC; the commitment of Exelixis its partner Ipsen to strengthening the medical value of cabozantinib and to continuing to bring innovative therapeutic solutions for the treatment of patients with RCC; and the continued development of cobimetinib and its potential in a variety of forms of cancer. Words such as "will," "potentially," "may," "committed," "continue," or other similar expressions identify forward-looking statements, but the absence of these words does not necessarily mean that a statement is not forward-looking. In addition, any statements that refer to expectations, projections or other characterizations of future events or circumstances are forward-looking statements. These forward-looking statements are based upon Exelixis' current plans, assumptions, beliefs, expectations, estimates and projections. Forward-looking statements involve risks and uncertainties. Actual results and the timing of events could differ materially from those anticipated in the forward-looking statements as a result of these risks and uncertainties, which include, without limitation: the availability of data at the referenced times; risks related to the potential failure of cabozantinib to demonstrate safety and efficacy in clinical testing; risks and uncertainties related to regulatory review and approval processes and Exelixis' compliance with applicable legal and regulatory requirements; Exelixis' dependence on its relationship with Genentech/ Roche with respect to cobimetinib and Exelixis' ability to maintain its rights under the collaboration; Exelixis' ability to protect the company's intellectual property rights; market competition; changes in economic and business conditions, and other factors discussed under the caption "Risk Factors" in Exelixis' quarterly report on Form 10-Q filed with the Securities and Exchange Commission (SEC) on August 2, 2017, and in Exelixis' future filings with the SEC. The forward-looking statements made in this press release speak only as of the date of this press release. Exelixis expressly disclaims any duty, obligation or undertaking to release publicly any updates or revisions to any forward-looking statements contained herein to reflect any change in Exelixis' expectations with regard thereto or any change in events, conditions or circumstances on which any such statements are based.

**References**


1. Guidance for Industry: Clinical Trial Endpoints for the Approval of Cancer Drugs and Biologics. U.S. Department of Health and Human Services Food and Drug Administration; May 2007.

2. Choueiri, T.K., et al. Cabozantinib versus Sunitinib as Initial Targeted Therapy for Patients with Metastatic Renal Cell Carcinoma of Poor or Intermediate Risk: The Alliance A031203 CABOSUN Trial. *Am J Clin Oncol*. 2016; 35:591-597.

3. Heng D.Y., Xie W., Regan M.M., et al. Prognostic factors for overall survival in patients with metastatic renal cell carcinoma treated with vascular endothelial growth factor-targeted agents: Results from a large, multicenter study. *Am J Clin Oncol*. 2009; 27:5794-5799.

4. American Cancer Society. Cancer Facts & Figures 2017. Atlanta: American Cancer Society; 2017.

5. Jonasch, E., Gao, J., Rathmell, W. Renal cell carcinoma. *BMJ*. 2014; 349:g4797.

6. Ko, J., Choueiri, T., et al. First-, second- third-line therapy for mRCC: benchmarks for trial design from the IMDC. *Br J Cancer*. 2014; 110:1917-1922.

7. Decision Resources Report: Renal Cell Carcinoma. October 2014 (internal data on file).

8. Harshman, L., and Choueiri, T. Targeting the hepatocyte growth factor/c-Met signaling pathway in renal cell carcinoma. *Cancer J*. 2013; 19:316-323.

9. Rankin, et al. Direct regulation of GAS6/AXL signaling by HIF promotes renal metastasis through SRC and MET. *Proc Natl Acad Sci U S A.* 2014; 111:13373-13378.

10. Zhou, L., Liu, X-D., Sun, M., et al. Targeting MET and AXL overcomes resistance to sunitinib therapy in renal cell carcinoma. *Oncogene*. 2016; 35:2687-2697.

11. Koochekpour, et al. The von Hippel-Lindau tumor suppressor gene inhibits hepatocyte growth factor/scatter factor-induced invasion and branching morphogenesis in renal carcinoma cells. *Mol Cell Biol.* 1999; 19:5902–5912.

12. Takahashi, A., Sasaki, H., Kim, S., et al. Markedly increased amounts of messenger RNAs for vascular endothelial growth factor and placenta growth factor in renal cell carcinoma associated with angiogenesis. *Cancer Res*. 1994; 54:4233-4237.

13. Nakagawa, M., Emoto, A., Hanada, T., Nasu, N., Nomura, Y. Tubulogenesis by microvascular endothelial cells is mediated by vascular endothelial growth factor (VEGF) in renal cell carcinoma. *Br J Urol*. 1997; 79:681-687.


View source version on businesswire.com: http://www.businesswire.com/news/home/20170909005044/en/

Source: Exelixis, Inc.


*Exelixis, Inc.*
**Investors**
*Susan Hubbard, 650-837-8194*
*EVP, Public Affairs and Investor Relations*
*shubbard@exelixis.com*
*or*
**Media**
*Lindsay Treadway, 650-837-7522*
*Director, Public Affairs and Advocacy Relations*
*ltreadway@exelixis.com*