UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 6-K

REPORT OF FOREIGN PRIVATE ISSUER PURSUANT TO RULE 13a-16 OR 15d-16 UNDER THE SECURITIES EXCHANGE ACT OF 1934

For the month of November, 2016

Commission File Number: 001-36582

Auris Medical Holding AG

(Exact name of registrant as specified in its charter)

Bahnhofstrasse 21
6300 Zug, Switzerland
(Address of principal executive office)

Indicate by check mark whether the registrant files or will file annual reports under cover of Form 20-F or Form 40-F:

Form 20-F X Form 40-F _____

Indicate by check mark if the registrant is submitting the Form 6-K in paper as permitted by Regulation S-T Rule 101(b)(1):

Yes _____ No X

Indicate by check mark if the registrant is submitting the Form 6-K in paper as permitted by Regulation S-T Rule 101(b)(7):

Yes _____ No X

INCORPORATION BY REFERENCE

Exhibits 99.1, 99.2 and 99.3 to this Report on Form 6-K shall be deemed to be incorporated by reference into the registration statements on Form F-3 (Registration Number 333-206710) and Form S-8 (Registration Numbers 333-198037 and 333-200805) of Auris Medical Holding AG and to be a part thereof from the date on which this report is filed, to the extent not superseded by documents or reports subsequently filed or furnished.

Exhibit 99.4 to this Report on Form 6-K shall not be deemed "filed" for purposes of Section 18 of the Securities Exchange Act of 1934 (the "Exchange Act") or otherwise subject to the liabilities of that section, nor shall it be deemed incorporated by reference in any filing under the Securities Act of 1933 or the Exchange Act.

RISK FACTORS

The risk factors set forth in Exhibit 99.3 filed herewith supplement and update certain risk factors in the discussion of material risks in Item 3.D of our Annual Report on Form 20-F for the fiscal year ended December 31, 2015. Additional risks and uncertainties not currently known to us, or that we currently deem to be immaterial, also may affect our business, financial condition and/or future operating results.

SIGNATURE

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

Auris Medical Holding AG

By: /s/ Thomas Meyer
Name: Thomas Meyer
Title: Chief Executive Officer

Date: November 10, 2016

EXHIBIT INDEX

Exhibit Number	Description
99.1	Unaudited Condensed Consolidated Interim Financial Statements
99.2	Management's Discussion and Analysis of Financial Condition and Results of Operations
99.3	Updated Risks Related to the Development and Clinical Testing of our Product Candidates and Risks Related to Regulatory Approval of our Product Candidates.
99.4	Press Release dated November 10, 2016

Exhibit 99.1

Unaudited Condensed Consolidated Interim Financial Statements as of September 30, 2016 and December 31, 2015 and for the Three and Nine Months Ended September 30, 2016 and 2015

Condensed Consolidated Interim Statement of Profit or Loss and Other Comprehensive Loss
Condensed Consolidated Interim Statement of Financial Position
Condensed Consolidated Interim Statement of Changes in Equity
Condensed Consolidated Interim Statement of Cash Flows
Notes to the Condensed Consolidated Interim Financial Statements

Condensed Consolidated Interim Statement of Profit or Loss and Other Comprehensive Loss (unaudited)
For the Three and Nine Months Ended September 30, 2016 and 2015 (in CHF)

	Note	THREE MONTHS ENDED SEP. 30		NINE MONTHS ENDED SEP. 30	
		2016	**2015**	**2016**	**2015**
Research and development		-6,344,600	-5,884,313	-19,763,338	-20,865,100
General and administrative		-1,197,541	-1,326,750	-4,144,687	-3,236,856
Operating loss		**-7,542,141**	**-7,211,063**	**-23,908,025**	**-24,101,956**
Interest income		18,118	12,873	44,284	23,141
Interest expense		-404,453	-1,608	-409,712	-6,212
Foreign currency exchange gain/(loss), net		-191,687	1,988,870	-1,177,624	-136,438
Revaluation gain/(loss) from derivative financial instrument		228,190	-	228,190	-
Loss before tax		**-7,891,973**	**-5,210,928**	**-25,222,887**	**-24,221,465**
Income tax expense	3	-	-	-	-
Net loss attributable to owners of the Company		**-7,891,973**	**-5,210,928**	**-25,222,887**	**-24,221,465**
Other comprehensive loss:					
Items that will never be reclassified to profit or loss					
Remeasurement of defined benefit liability, net of taxes of CHF 0		23,412	-3,792	-584,455	-232,962
Items that are or may be reclassified to profit or loss					
Foreign currency translation differences, net of taxes of CHF 0		5,968	-40,524	31,932	16,339
Other comprehensive income/(loss), net of taxes of CHF 0		**29,380**	**-44,316**	**-552,523**	**-216,623**
Total comprehensive loss attributable to owners of the Company		**-7,862,593**	**-5,255,244**	**-25,775,410**	**-24,438,088**
Basic and diluted loss per share	8	-0.23	-0.15	-0.73	-0.76

The accompanying notes form an integral part of these condensed consolidated interim financial statements

Condensed Consolidated Interim Statement of Financial Position (unaudited)
As of September 30, 2016 and December 31, 2015 (in CHF)

	Note	SEPTEMBER 30, 2016	DECEMBER 31, 2015
ASSETS			
Non-current assets			
Property and equipment		161,960	222,570
Intangible assets		1,482,520	1,482,520
Other non-current receivables		114,766	38,066
Total non-current assets		**1,759,246**	**1,743,156**
Current assets			
Other receivables		1,449,480	650,716
Prepayments		261,669	181,044
Cash and cash equivalents		37,526,723	50,237,300
Total current assets		**39,237,872**	**51,069,060**
Total assets		**40,997,118**	**52,812,216**
EQUITY AND LIABILITIES			
Equity			
Share capital	5	13,731,881	13,721,556
Share premium		112,838,815	112,662,910
Foreign currency translation reserve		-31,889	-63,821
Accumulated deficit		-107,201,111	-81,578,733
Total shareholders' equity attributable to owners of the Company		**19,337,696**	**44,741,912**
Non-current liabilities			
Loan	4	10,630,681	-
Derivative financial instrument	4	177,650	-
Employee benefits		2,250,936	1,575,833
Deferred tax liabilities	3	327,637	327,637
Total non-current liabilities		**13,386,904**	**1,903,470**
Current liabilities			
Loan	4	1,042,736	-
Trade and other payables		1,613,602	1,205,522
Accrued expenses		5,616,180	4,961,312
Total current liabilities		**8,272,518**	**6,166,834**
Total liabilities		**21,659,422**	**8,070,304**
Total equity and liabilities		**40,997,118**	**52,812,216**

The accompanying notes form an integral part of these condensed consolidated interim financial statements

Condensed Consolidated Interim Statement of Changes in Equity (unaudited)
As of September 30, 2016 and 2015 (in CHF)

		Attributable to Owners of the Company				
	Note	**Share Capital**	**Share Premium**	**Foreign Currency Translation Reserve**	**Accumulated Deficit**	**Total Equity**
Balance as of January 1, 2015		**11,604,156**	**93,861,171**	**-51,109**	**-52,131,426**	**53,282,792**
Total comprehensive loss						
Net loss		-	-	-	-24,221,465	**-24,221,465**
Other comprehensive income/(loss)		-	-	16,339	-232,962	**-216,623**
Total comprehensive income/(loss)		-	-	**16,339**	**-24,454,427**	**-24,438,088**
Transactions with owners of the Company						
Capital increase from follow-on offering	5	2,110,000	19,604,877	-	-	**21,714,877**
Share issuance costs		-	-210,826	-	-	**-210,826**
Transaction costs		-	-643,796	-	-	**-643,796**
Share based payments	7	-	-	-	207,313	**207,313**
Share options exercised	5	3,400	33,593	-	-	**36,993**
Balance as of September 30, 2015		**13,717,556**	**112,645,019**	**-34,770**	**-76,378,540**	**49,949,265**
Balance as of January 1, 2016		**13,721,556**	**112,662,910**	**-63,821**	**-81,578,733**	**44,741,912**
Total comprehensive loss						
Net loss					-25,222,887	**-25,222,887**
Other comprehensive income/(loss)				31,932	-584,455	**-552,523**
Total comprehensive income/(loss)		-	-	**31,932**	**-25,807,342**	**-25,775,410**
Transactions with owners of the Company						
Share issuance costs		-	-1,862	-	-	**-1,862**
Share based payments	7	-	-	-	184,964	**184,964**
Issue of bonus shares	5	10,325	177,767	-	-	**188,092**
Balance as of September 30, 2016		**13,731,881**	**112,838,815**	**-31,889**	**-107,201,111**	**19,337,696**

The accompanying notes form an integral part of these condensed consolidated interim financial statements

Condensed Consolidated Interim Statement of Cash Flows (unaudited)
For the Nine Months Ended September 30, 2016 and 2015 (in CHF)

	Note	NINE MONTHS ENDED SEPTEMBER 30, 2016	NINE MONTHS ENDED SEPTEMBER 30, 2015
Cash flows from operating activities			
Net loss		**-25,222,887**	**-24,221,465**
Adjustments for:			
Depreciation		72,084	68,217
Unrealized net foreign currency exchange loss, net		1,214,572	168,232
Net interest expense/(income)		355,429	-22,969
Share option costs	7	184,964	207,313
Employee benefits		90,648	115,211
Fair value derivative financial instrument	4	-228,190	-
Changes in:			
Other receivables		-875,464	-33,428
Prepayments		-80,625	-29,296
Trade and other payables		408,079	-411,937
Accrued expenses		842,960	1,938,089
Net cash used in operating activities		**-23,238,430**	**-22,222,033**
Cash flows from investing activities			
Purchase of property and equipment		-11,474	-79,917
Interest received		44,284	22,969
Net cash from/(used in) investing activities		**32,810**	**-56,948**
Cash flows from financing activities			
Proceeds from share capital increase	5	-	36,993
Share issuance costs		-1,862	-210,826
Proceeds from loan issuance	4	11,986,671	-
Interest paid		-238,415	-
Proceeds from follow-on offering	5	-	21,071,081
Net cash from financing activities		**11,746,394**	**20,897,248**
Net decrease in cash and cash equivalents		**-11,459,226**	**-1,381,733**
Cash and cash equivalents at beginning of the period		50,237,300	56,934,325
Net effect of currency translation on cash		-1,251,351	-151,885
Cash and cash equivalents at end of the period		**37,526,723**	**55,400,707**

The accompanying notes form an integral part of these condensed consolidated interim financial statements

AURIS MEDICAL HOLDING AG

Notes to the Condensed Consolidated Interim Financial Statements
as of September 30, 2016 and December 31, 2015 and for the Three and Nine Months Ended September 30, 2016 and 2015 (in CHF)

1. Reporting entity

Auris Medical Holding AG (the "Company") is domiciled in Switzerland. The Company's registered address is at Bahnhofstrasse 21, 6300 Zug. These condensed consolidated interim financial statements comprise the Company and its subsidiaries (together referred to as the "Group" and individually as "Group entities"). The Company is the ultimate parent of the following Group entities:

- Auris Medical AG, Basel, Switzerland (100%)
- Otolanum AG, Zug, Switzerland (100%)
- Auris Medical Inc., Chicago, United States (100%)
- Auris Medical Ltd., Dublin, Ireland (100%)

The Group is primarily involved in the development of pharmaceutical products for the treatment of inner ear disorders, in particular tinnitus and hearing loss. Its most advanced projects are in the late stage of clinical development.

2. Basis of preparation

Statement of compliance

These condensed consolidated interim financial statements as of September 30, 2016 and December 31, 2015 and for the three and nine months ended September 30, 2016 have been prepared in accordance with International Accounting Standard *Interim Financial Reporting* ("IAS 34") and should be read in conjunction with the audited consolidated financial statements as of and for the year ended December 31, 2015.

These condensed consolidated interim financial statements include all adjustments that are necessary to fairly state the results of the interim period, and the Group believes that the disclosures are adequate to make the information presented not misleading. Interim results are not necessarily indicative of results to be expected for the full year. Management does not consider the business to be seasonal or cyclical.

Certain information and footnote disclosures normally included in consolidated financial statements prepared in accordance with International Financial Reporting Standards ("IFRS"), as issued by the International Accounting Standards Board, have been condensed or omitted as permitted by IAS 34. The condensed consolidated statement of financial position as of December 31, 2015 was derived from the audited consolidated financial statements.

The interim condensed consolidated financial statements were authorized for issuance by the Company's Audit Committee on November 7, 2016.

Functional and reporting currency

These interim condensed consolidated financial statements are presented in Swiss Francs ("CHF"), which is the Company's functional currency ("functional currency") and the Group's reporting currency.

Significant accounting policies

The accounting policies applied by the Group in these condensed consolidated interim financial statements are the same as those applied by the Group in its audited consolidated financial statements as of and for the year ended December 31, 2015 and have been applied consistently to all periods presented in these condensed consolidated interim financial statements, unless otherwise indicated.

New standards, amendments and interpretations adopted by the Group

The Group has not early adopted any standard, interpretation or amendment that was issued, but is not yet effective.

A number of new standards, amendments to standards and interpretations are effective for the Group's 2016 reporting year and have not been applied in preparing these condensed consolidated interim financial statements. Management does not believe that the adoption of these standards, amendments or interpretations will have a material impact on the financial statements of the Group.

3. Taxation

The Group's income tax expense recognized in the consolidated statement of profit or loss is presented as follows:

	NINE MONTHS ENDED SEPTEMBER 30,	
	2016	**2015**
Deferred income tax expense	-80,124	-
Deferred income tax	80,124	-
Total income tax expense	-	-

The tax effect of taxable temporary differences that give rise to deferred income tax liabilities or to deferred income tax assets as of September 30, 2016 and 2015 are as follows:

	SEPTEMBER 30, 2016	SEPTEMBER 30, 2015
Deferred Tax liabilities		
Intangible assets	-327,637	-327,637
Hercules Loan Facility and Warrant	-80,124	-
Total	**-407,761**	**-327,637**
Deferred Tax assets		
Net operating loss (NOL)	80,124	-
Total	**80,124**	**-**
Deferred Tax, net	**-327,637**	**-327,637**

4. Loan and Warrant

On July 19, 2016, the Company entered into a Loan and Security Agreement for a secured term loan facility of up to US$20.0 million with Hercules Capital, Inc. as administrative agent ("Hercules") and the lenders party thereto. An initial tranche of US$12.5 million was drawn on July 19, 2016, concurrently with the execution of the loan agreement. The loan matures on January 2, 2020 and bears interest at a minimum rate of 9.55% per annum, and is subject to the variability of the prime interest rate. The loan is secured by a pledge of the shares of Auris Medical AG owned by the Company, all intercompany receivables owed to the Company by its Swiss subsidiaries and a security assignment of the Company's bank accounts.

The loan was initially recognized at transaction value less the fair value of the warrant as of the transaction date and less directly attributable transactions costs. Following the initial recognition, the loan is measured at amortized cost using the effective interest method. As of September 30, 2016, the loan is valued at CHF 11,673,417. Of the CHF 11,673,417 an amount of CHF 1,042,736, reflecting amortization payments due within the next 12 months, is classified as current liability and the remainder as non-current liability.

In connection with the loan facility, the Company issued Hercules a warrant to purchase up to 241,117 of its common shares at an exercise price of US$3.94 per share. As of July 19, 2016, the warrant is exercisable for 156,726 common shares. Upon Hercules making the second advance under the loan facility, the warrant shall become exercisable for the additional 84,391 common shares. The warrant expires on July 19, 2023. The fair value calculation of the warrant is based on the Black-Sholes option pricing model. Assumptions are made regarding inputs such as volatility and the risk free rate in order to determine the fair value of the warrant. As the warrant is part of the loan transaction, its initial fair value was deducted from the loan proceeds and accounted for as non-current financial liability. Following the initial recognition, the warrant is measured at fair value and changes in fair value are shown as profit or loss.

As of September 30, 2016 and after deduction of a currency revaluation gain of CHF 2,340, the fair value of the warrant amounts to CHF 177,650. Since its initial recognition, the fair value decreased by CHF 228,190 resulting in a gain in the corresponding amount (fair value as of July 19, 2016: CHF 408,180).

5. Capital and reserves

Share capital

The issued share capital of the Company consisted of:

	COMMON SHARES (Number)	
	2016	2015
As of January 1	34,303,891	29,010,391
Common shares issued for stock option exercises with a nominal value of CHF 0.40 each	—	8,500
Common shares issued for the follow-on offering with a nominal value of CHF 0.40 each	—	5,275,000
Common shares issued for restricted share awards with a nominal value of CHF 0.40 each	25,813	—
Total, as of September 30, 2016 and September 30, 2015	**34,329,704**	**34,293,891**

All shares have a nominal value of CHF 0.40 and are fully paid in. As of September 30, 2016, the nominal value of the 34,329,704 issued shares amounted to CHF 13,731,881.60 (as of December 31, 2015, the nominal value of 34,303,891 issued shares amounted to CHF 13,721,556.40).

Issue of common shares upon exercise of options

During the nine months ended September 30, 2015, beneficiaries of the Option Plan A exercised their right to acquire common shares of the Company at CHF 3.20 per share. This resulted in an increase in the number of outstanding common shares of 8,500 and an increase in the nominal value of the share capital of CHF 3,400. Total proceeds from the exercise to the Company were CHF 27,200.

During the nine months ended September 30, 2016, no options were exercised.

On January 7, 2016, the Company granted 25,813 restricted shares to employees under the Equity Incentive Plan as a compensation bonus for 2015. These shares vested upon grant and have a sales restriction of 3 years. The Company recorded a corresponding payroll charge of CHF 188,092 in 2015. As a result of the grant, the nominal share capital increased by CHF 10,325.

Follow-On Offering on NASDAQ Global Market

On May 20, 2015, the Company completed a public offering of 5,275,000 shares, yielding net proceeds after underwriting discounts of US$23.6 million (CHF 21.7 million). As of September 30, 2015, following the offering (and settlement of the aforementioned employee options) there were 34,293,891 common shares of the Company outstanding.

Controlled Equity Offering

On June 1, 2016, the Company entered into a Controlled Equity Offering^{SM} Sales Agreement (the “Sales Agreement”) with Cantor Fitzgerald & Co. (“Cantor”), pursuant to which the Company may offer and sell, from time to time common shares, with a nominal value of CHF 0.40 per share, having an aggregate offering price of up to US$35 million through Cantor. Any common shares offered and sold will be issued pursuant to the Company’s shelf registration statement on Form F-3 (Registration No. 333-206710) as supplemented by a prospectus supplement, dated June 1, 2016. In the third quarter of 2016, the Company did not offer or sell any common shares under the Sales Agreement.

6. Employee benefits

	NINE MONTHS ENDED SEPTEMBER 30,	
	2016	**2015**
Salaries	2,820,562	1,920,616
Pension costs	254,757	239,247
Share based compensation expense	184,964	207,313
Other employee costs and social benefits	627,271	164,437
Total employee benefits	**3,887,554**	**2,531,613**

7. Share based compensation expense

Share based compensation expense of CHF 184,964 was recognized for the nine months ended September 30, 2016 (for the nine months ended September, 2015: CHF 207,313).

A total of 148,150 options were granted in the nine months ended September 30, 2016. The exercise price of the granted options is US$3.92 (CHF 3.76). The methodology for computation of share based compensation expense for the period is consistent with the methodology used in 2015.

8. Loss per share

	THREE MONTHS ENDED SEPTEMBER 30,		NINE MONTHS ENDED SEPTEMBER 30,	
	2016	**2015**	**2016**	**2015**
Loss attributable to owners of the Company	(7,891,973)	(5,210,928)	(25,222,887)	(24,221,465)
Weighted average number of shares outstanding	34,329,704	34,290,141	34,329,045	31,828,984
Basic and diluted loss per share	(0.23)	(0.15)	(0.73)	(0.76)

For the nine months ended September 30, 2016 and September 30, 2015 basic and diluted loss per share are calculated based on the weighted average number of shares issued and outstanding and excludes shares to be issued under the stock option plans, as they would be anti-dilutive. As of September 30, 2016, the Company had 652,650 options outstanding under its stock option plans, of which 4,520 are considered forfeited due to the termination of the beneficiaries' employment relationships. The average number of options outstanding between January 1, 2016 and September 30, 2016 was 640,830 (527,885 for the period between January 1, 2015 and September 30, 2015).

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

This management's discussion and analysis is designed to provide you with a narrative explanation of our financial condition and results of operations. We recommend that you read this in conjunction with our unaudited condensed consolidated interim financial statements as of and for the three and nine months ended September 30, 2016 and 2015 included as Exhibit 99.1 to this Report on Form 6-K, which have been prepared in accordance with International Accounting Standard ("IAS") 34, *Interim Financial Reporting*. We also recommend that you read our management's discussion and analysis and our audited consolidated financial statements and the notes thereto, which appear in our Annual Report on Form 20-F for the year ended December 31, 2015 (the "Annual Report") filed with the U.S. Securities and Exchange Commission (the "SEC") pursuant to the U.S. Securities and Exchange Act of 1934, as amended.

Unless otherwise indicated or the context otherwise requires, all references to "Auris Medical" or the "company," "we," "our," "ours," "us" or similar terms refer to Auris Medical Holding AG and its subsidiaries.

We prepare and report our consolidated financial statements and financial information in accordance with International Financial Reporting Standards ("IFRS") as issued by the International Accounting Standards Board (the "IASB"). None of our financial statements were prepared in accordance with generally accepted accounting principles in the United States. We maintain our books and records in Swiss Francs. We have made rounding adjustments to some of the figures included in this management's discussion and analysis. Accordingly, numerical figures shown as totals in some tables may not be an arithmetic aggregation of the figures that precede them. Unless otherwise indicated, all references to currency amounts in this discussions and analysis are in Swiss Francs.

This discussion and analysis is dated as of November 7, 2016.

Overview

We are a clinical-stage biopharmaceutical company focused on the development of novel products for the treatment of inner ear disorders. Our most advanced product candidates are in Phase 3 clinical development. Keyzilen™ (AM-101) is being developed for the treatment of acute inner ear tinnitus and has received fast track designation from the FDA. In two Phase 2 clinical trials, Keyzilen™ demonstrated a favorable safety profile and statistically significant improvement in tinnitus loudness and other patient reported outcomes. In August 2016, we announced that the trial Efficacy and Safety of AM-101 in the Treatment of Acute Peripheral Tinnitus 2 (TACTT2), the first of two pivotal Phase 3 clinical trials with Keyzilen™, did not meet the two co-primary endpoints of statistically significant changes in tinnitus loudness and tinnitus burden as measured by the Tinnitus Functional Index (TFI), compared to placebo. The TACTT2 trial data showed treatment effects on TFI in favor of Keyzilen™ for certain subgroups. Data from the TACTT2 trial support the positive safety profile established in the Phase 2 trials. See "Recent Developments—TACTT2 Results and Protocol Amendment for TACTT3.

We have submitted a protocol amendment to regulatory agencies in Europe for TACTT3, the second Phase 3 clinical trial with Keyzilen™. Under the amended protocol, the trial size will be increased, certain patient subgroups will be included in confirmatory testing and the TFI will be elevated from a key secondary endpoint to an alternate primary efficacy endpoint. We expect to have top-line results from the expanded TACTT3 trial in early 2018. We plan to review the outcomes from TACTT2, the planned changes to the TACTT3 protocol and the regulatory path with the U.S. Food and Drug Administration in early December 2016. See "Recent Developments—TACTT2 Results and Protocol Amendment for TACTT3."

We are also developing AM-111 for acute inner ear hearing loss. We are conducting two pivotal Phase 3 trials in the treatment of idiopathic sudden sensorineural hearing loss, titled HEALOS and ASSENT. HEALOS is enrolling 255 patients in Europe and Asia, and ASSENT is enrolling 300 patients in the United States, Canada and South Korea. HEALOS achieved the mid-point of recruitment in September 2016, and we expect to have top-line data from HEALOS in the third quarter of 2017. ASSENT started enrollment in June 2016, and we expect to have top-line data from the trial in the first half of 2018.

To date, we have financed our operations through public offerings of our common shares, private placements of equity securities and loans. On July 19, 2016, we entered into a Loan and Security Agreement (the "Hercules Loan and Security Agreement") for a secured term loan facility of up to US$20.0 million with Hercules Capital, Inc. as administrative agent ("Hercules") and the lenders party thereto. We have no products approved for commercialization and have never generated any revenues from royalties or product sales. As of September 30, 2016, we had cash and cash equivalents of CHF 37.5 million. Based on our current plans, we do not expect to generate royalty or product revenues unless and until we obtain marketing approval for, and commercialize, Keyzilen™, AM-111 or any of our other product candidates.

As of September 30, 2016, we had an accumulated deficit of CHF 107.2 million. We expect to continue incurring losses as we continue our clinical and pre-clinical development programs, apply for marketing approval for our product candidates and, subject to obtaining regulatory approval of our product candidates, build a sales and marketing force in preparation for the potential commercialization of our product candidates.

Recent Developments

Thomas Jung, MD, PhD, joined the Company on September 1, 2016 as Chief Development Officer. Dr. Jung previously served as the Chief Medical Officer of Delenex Therapeutics AG and spent 13 years at Novartis, most recently as Head Translational Medicine for the European Union.

Hernan Santiago Levett has been appointed Chief Financial Officer of the Company, effective January 2017. Mr. Levett trained as an accountant and currently serves as Head Group Controlling at Acino Pharma AG. Before joining Acino Pharma, Mr. Levett served as VP Finance & Administration Europe at Intermune International AG. In the interim, the functions of the Chief Financial Officer are assigned to Thomas Meyer, Chief Executive Officer of the Company.

There have been no developments in the previously disclosed patent interference involving our issued patent No. 9,066,865 and Otonomy Inc.'s patent application No. 13/848,636.

TACTT2 Results and Protocol Amendment for TACTT3

On August 18, 2016, we announced that the Phase 3 TACTT2 clinical trial with our lead product candidate, Keyzilen™ (AM-101), did not meet the two co-primary efficacy endpoints of statistically significant changes in tinnitus loudness and tinnitus burden compared to placebo. TACTT2 was designed as a randomized, double-blind, placebo-controlled trial in acute inner ear tinnitus following traumatic cochlear injury or otitis media. The trial was conducted primarily in North America and randomized 343 patients to receive either Keyzilen™ 0.87 mg/mL or placebo in a 3:2 ratio. The co-primary endpoints were the change in subjective tinnitus loudness, measured by the tinnitus loudness question, or TLQ, and the change in tinnitus burden from baseline to Day 84, measured by the TFI.

Treatment with Keyzilen™ did not demonstrate a statistically significant difference in tinnitus improvement as compared to placebo for either co-primary efficacy endpoint. In TACTT2, baseline values for TLQ and TFI were 6.44 and 52.4 points in the Keyzilen™ group, and 6.47 and 50.2 points in the placebo group. Treatment with Keyzilen™ resulted in a reduction in tinnitus loudness of 0.63 points, compared to a reduction of 0.80 points for placebo (p-value of 0.321). With respect to tinnitus burden, treatment with Keyzilen™ resulted in a 9.67 point reduction, as measured by the TFI, compared to a reduction of 10.63 points for placebo (p-value of 0.565). A reduction of 13 points as measured by the TFI was defined as clinically meaningful by the developers of the TFI. By convention, a p-value that is less than 0.05 is considered statistically significant.

While we are continuing to analyze the TACTT2 results, we believe we have identified two principal sources for the outcome: (i) the high frequency of tinnitus loudness ratings over an extended period of time and (ii) an unexpectedly high level of variability in outcomes among study sites. We believe the daily capture of TLQ data may have caused a number of patients to excessively focus on their tinnitus symptoms. With respect to variability, our analysis subsequent to the unblinding of the trial data has shown positive outcomes at numerous sites, including many of the high enrolling study centers, but inconclusive or contradictory outcomes at other sites.

However, the TACTT2 trial data show treatment effects on TFI in favor of Keyzilen™ for specific subgroups. In the pre-specified subgroup of patients suffering from tinnitus following otitis media, treatment with Keyzilen™ resulted in a reduction of 14.76 points in the TFI from baseline, as compared to 6.19 points for placebo (p-value of 0.048).

Another clinically meaningful effect was observed in active-treated patients who suffered from severe or extreme tinnitus (a subgroup that was not pre-specified), as determined by the Patient Global Impression of Severity, independent of tinnitus etiology, at baseline: a 15.53 point reduction as measured by the TFI from baseline, as compared to 11.48 points for placebo (p-value of 0.238). Keyzilen™ was well tolerated with no drug-related serious adverse events. The trial's primary safety endpoint, incidence of clinically meaningful hearing deterioration, was low with no statistically significant difference from the placebo group (p-value of 0.82), supporting the safety profile of Keyzilen™.

Based on insights from our continuing analysis of the TACTT2 trial, we submitted a protocol amendment to regulatory agencies in Europe for TACTT3, the ongoing second Phase 3 clinical trial with Keyzilen™. In the amended trial protocol, the change in TFI score will be elevated from a key secondary endpoint to an alternate primary efficacy endpoint such that both the TLQ and the TFI will be alternate primary efficacy endpoints. In order to corroborate the TACTT2 results showing clinically meaningful treatment effect under the TFI over placebo for patients with otitis media-related tinnitus and greater tinnitus severity, the severity subgroup will be included in confirmatory statistical testing in TACTT3 along with the overall study population and the already pre-specified subgroup of patients with otitis media-related tinnitus. Type I error (false positive) control will be provided across the three populations (overall study population, otitis media-related tinnitus and severe tinnitus) by application of the Hochberg procedure. The Hochberg procedure, a method applied to statistical testing to control for multiplicity, avoids the need for pre-specification of a hierarchy among the three populations for analysis, providing more flexibility than with other methods and allowing the possibility of achieving success in a subpopulation. Additionally, the trial size will be increased by 60 patients in each of Stratum A (acute tinnitus stage) and Stratum B (post-acute tinnitus stage) to enhance statistical sensitivity to the effects of treatment.

As of the date hereof, TACTT3 has enrolled more than 300 patients in Stratum A and approximately 330 patients in Stratum B. As in TACTT2, TLQ is determined based on averaged daily ratings around study visits; however, fewer additional data will be captured from the newly enrolled patients in between study visits in order to lighten their burden. . We expect enrollment to resume in early 2017. Top-line results from the expanded TACTT3 trial are expected in early 2018. We intend to review the outcomes from TACTT2, the planned changes to the TACTT3 protocol and the regulatory path forward with the U.S. Food and Drug Administration in early December 2016.

Even if the protocol amendment for TACTT3 is approved by the applicable regulatory agencies, we cannot assure you that the TACTT3 clinical trial will be successful. Additionally, we cannot be certain that Keyzilen™ will be approved even if it the TACTT3 clinical trial is considered successful.

Collaboration and License Agreements

There have been no material changes to our collaboration and license agreements from those reported in "Item 5—Operating and Financial Review and Prospects–Operating results—Collaboration and License Agreements" in the Annual Report.

Research and Development Expense

Our research and development expense is highly dependent on the development phases of our research projects and therefore may fluctuate substantially from period to period. Our research and development expense mainly relates to the following key programs:

- *Keyzilen™ (AM-101)*. We are conducting a Phase 3 clinical development program with Keyzilen™ comprising two Phase 3 studies (TACTT2 and TACTT3) and two open label follow-on studies (AMPACT1 and AMPACT2). TACTT2 has been completed, and top-line results were announced on August 18, 2016. AMPACT1 is expected to complete enrollment in late 2016. TACTT3 is expected to resume enrollment under an amended protocol in early 2017, and we expect top-line results of the TACTT3 trial in early 2018. AMPACT2 completed enrollment in June 2016. We anticipate that our research and development expenses in connection with these clinical trials will be lower in 2016 than in the preceding year but will remain at a substantial level.

- *AM-111*. We are conducting two pivotal Phase 3 trials in the treatment of ISSNHL, titled HEALOS and ASSENT. HEALOS initiated enrollment in Europe and Asia in the fourth quarter of 2015 and ASSENT started enrollment in the United States in the second quarter of 2016 and is expected to also include Canadian and South Korean sites. Our research and development expenses have increased substantially in 2016 compared to the previous year as a result of the two AM-111 trials.

Other research and development expenses mainly relate to our pre-clinical studies of AM-102 (second generation tinnitus treatment). The expenses mainly consist of costs for production of the pre-clinical compounds and costs paid to academic and other research institutions in conjunction with pre-clinical testing.

For a discussion of our other key financial statement line items, please see “Item 5—Operating and Financial Review and Prospects–Operating results—Financial Operations Overview” in the Annual Report.

Results of Operations

The numbers below have been derived from our unaudited condensed consolidated interim financial statements as of and for the three and nine months ended September 30, 2016 and 2015. The discussion below should be read along with this financial information, and it is qualified in its entirety by reference to them.

Comparison of the three months ended September 30, 2016 and 2015

	THREE MONTHS ENDED SEPTEMBER 30,		
	2016	**2015**	**Change**
	(in thousands of CHF)		**%**
Research and development	(6,344)	(5,884)	8%
General and administrative	(1,198)	(1,327)	(10%)
Operating loss	**(7,542)**	**(7,211)**	**5%**
Interest income	18	13	38%
Interest expense	(404)	(2)	20,100%
Revaluation gain/(loss) from derivative financial instrument	228	-	n/a
Foreign currency exchange gain/(loss), net	(192)	1,989	(110%)
Loss before tax	**(7,892)**	**(5,211)**	**51%**
Income tax expense	**—**	**—**	
Net loss attributable to owners of the Company	**(7,892)**	**(5,211)**	**51%**
Other comprehensive loss:			
Items that will never be reclassified to profit or loss			
Remeasurements of defined benefits liability	23	(4)	(675%)
Items that are or may be reclassified to profit or loss			
Foreign currency translation differences	6	(40)	(115%)
Other comprehensive gain/(loss)	**29**	**(44)**	**(166%)**
Total comprehensive loss attributable to owners of the Company	**(7,863)**	**(5,255)**	**50%**

Research and development expense

	THREE MONTHS ENDED SEPTEMBER 30,		
Research and development expense	**2016**	**2015**	**Change**
	(in thousands of CHF)		**%**
Clinical projects	(3,905)	(4,292)	(9%)
Pre-clinical projects	(363)	(84)	332%
Drug manufacture and substance	(736)	(570)	29%
Employee benefits	(805)	(538)	50%
Other research and development expenses	(535)	(401)	33%
Total	**(6,344)**	**(5,884)**	**8%**

Research and development expenses amounted to CHF 6.3 million in the three months ended September 30, 2016. This represents an increase of about CHF 0.4 million over the CHF 5.9 million research and development expenses for the three months ended September 30, 2015. The increase is mainly due to the following:

- *Clinical projects.* In the three months ended September 30, 2016 we incurred lower clinical expenses than in the three months ended September 30, 2015, due to lower service and milestone costs charged by contracted service providers in connection with the Phase 3 Keyzilen™ trials (TACTT2, TACTT3, AMPACT1 and AMPACT2) mainly reflecting the completion of enrollment in TACTT2 and AMPACT1 (related costs were CHF 2.5 million in the third quarter of 2016 and CHF 3.1 million in the third quarter of 2015). The decrease in Keyzilen™ related costs was partially offset by higher AM-111 related expenses due to the initiation of the ASSENT trial.

- *Pre-clinical projects*. In the three months ended September 30, 2016, pre-clinical expenses increased primarily due to AM-102 and AM-111 related pre-clinical projects.

- *Drug manufacture and substance.* In the three months ended September 30, 2016, drug manufacture and substance related costs slightly increased by CHF 0.17 million compared to the three months ended September 30, 2015. This increase is due to higher costs related to raw material purchases and expenses for process validation.

- *Employee benefits*. Employee expenses were higher in the three months ended September 30, 2016 than in the same period in 2015 (CHF 0.8 million vs CHF 0.5 million) due to an increased headcount and higher compensation expenses.

Other research and development expenses.

- Other research and development expenses increased by CHF 0.1 million in the three months ended September 30, 2016 compared with the corresponding period in 2015 due to higher regulatory and quality assurance related expenses partially offset by lower intellectual property related expenses.

General and administrative expense

General and administrative expense was CHF 1.2 million in the three months ended September 30, 2016 compared to CHF 1.3 million in the same period in the previous year, as a result of lower administration costs (CHF 0.6 million vs CHF 0.9 million) offset by higher employee benefits due to higher headcount and increased compensation expenses (CHF 0.6 million vs CHF 0.4 million).

We expect that general and administrative expense will increase in the future as our business expands and we continue to incur costs associated with operating as a public company and protecting our intellectual property portfolio.

Interest income

Interest income increased in the three months ended September 30, 2016 compared to the three months ended September 30, 2016, due to higher return on short-term deposits.

Interest expense

Interest expense increased by CHF 0.4 million in the three months ended September 30, 2016 compared to the previous period. The increase mainly relates to interest expense related to the Hercules Loan and Security Agreement.

Revaluation gain/(loss) from derivative financial instrument

In connection with the Hercules Loan and Security Agreement, the Company issued Hercules a warrant to purchase up to 241,117 of its common shares at an exercise price of US$3.94 per share. As of July 19, 2016, the warrant was exercisable for 156,726 common shares. As of September 30, 2016, and after deduction of a currency revaluation gain of CHF 2,340, the fair value of the warrant amounts to CHF 177,650. Since its initial recognition, the fair value decreased by CHF 228,190 resulting in a gain in the corresponding amount (fair value as of July 19, 2016: CHF 408,180).

Foreign currency exchange losses, net

For the three months ended September 30, 2016 the depreciation of the U.S. dollar against the Swiss Franc triggered a net foreign unrealized currency loss on the U.S. dollar denominated cash and cash equivalents compared to the unrealized gains due the appreciation of the U.S. dollar against the Swiss Franc in the three months' period ended September 30, 2015.

Comparison of the nine months ended September 30, 2016 and 2015

	NINE MONTHS ENDED SEPTEMBER 30,		
	2016	**2015**	**Change**
	(in thousands of CHF)		**%**
Research and development	(19,763)	(20,865)	(5%)
General and administrative	(4,145)	(3,237)	28%
Operating loss	**(23,908)**	**(24,102)**	**(1%)**
Interest income	44	23	91%
Interest expense	(410)	(6)	6,733%
Revaluation gain/(loss) from derivative financial instrument	228	-	n/a
Foreign currency exchange losses, net	(1,177)	(136)	765%
Loss before tax	**(25,223)**	**(24,221)**	**4%**
Income tax expense	**—**	**—**	
Net loss attributable to owners of the Company	**(25,223)**	**(24,221)**	**4%**
Other comprehensive loss:			
Items that will never be reclassified to profit or loss			
Remeasurements of defined benefits liability	(584)	(233)	151%
Items that are or may be reclassified to profit or loss			
Foreign currency translation differences	32	16	100%
Other comprehensive loss	**(552)**	**(217)**	**154%**
Total comprehensive loss attributable to owners of the Company	**(25,775)**	**(24,438)**	**5%**

Research and development expense

	NINE MONTHS ENDED SEPTEMBER 30,		
Research and development expense	**2016**	**2015**	**Change**
	(in thousands of CHF)		**%**
Clinical projects	(13,297)	(17,232)	(23%)
Pre-clinical projects	(562)	(333)	69%
Drug manufacture and substance	(1,838)	(1,058)	74%
Employee benefits	(2,235)	(1,434)	56%
Other research and development expenses	(1,831)	(808)	127%
Total	**(19,763)**	**(20,865)**	**(5%)**

Research and development expenses amounted to CHF 19.8 million in the nine months ended September 30, 2016. This represents a decrease of about CHF 1.1 million over the CHF 20.9 million for the nine months ended September 30, 2015. The decrease is mainly due to the following:

- *Clinical projects.* In the nine months ended September 30, 2016, we incurred lower clinical expenses than in the nine months ended September 30, 2015, due to lower service and milestone costs charged by contracted service providers in connection with the Phase 3 Keyzilen™ clinical trials (TACTT2, TACTT3, AMPACT1 and AMPACT2) reflecting the completion of enrollment in TACTT2 and AMPACT2 (related costs were CHF 8.0 million in the first nine months of 2016 and CHF 13.8 million in the first nine months of 2015). The decrease in Keyzilen™ related costs was partially offset by higher AM-111 related expenses due to the initiation of ASSENT.

- *Pre-clinical projects*. In the nine months ended September 30, 2016, pre-clinical expenses increased primarily due to AM-111 and AM-102 related pre-clinical projects partially offset by lower expenses for Keyzilen™.

- *Drug manufacture and substance.* In the nine months ended September 30, 2016, drug manufacture and substance related costs increased by CHF 0.7 million compared to the nine months ended September 30, 2015. This increase is due to higher costs related to raw material purchases and expenses for process validation.

- *Employee benefits*. Employee expenses were higher in the nine months ended September 30, 2016 than in the same period in 2015 (CHF 2.2 million vs CHF 1.4 million) due to an increased headcount and higher compensation expenses.

- *Other research and development expenses.* Other research and development expenses increased by CHF 1.0 million in the nine months ended September 30, 2016 compared with the corresponding period in 2015 due to higher regulatory, quality and intellectual property related expenses.

General and administrative expense

General and administrative expense was CHF 4.1 million in the nine months ended September 30, 2016, compared to CHF 3.2 million in the nine months ended September 30, 2015, as a result of higher administration costs (CHF 2.5 million vs CHF 2.1 million) as well as higher employee benefits due to higher headcount and increased compensation expenses (CHF 1.6 million vs CHF 1.1 million).

We expect that general and administrative expense will increase in the future as our business expands and we continue to incur costs associated with operating as a public company and protecting our intellectual property portfolio.

Interest income

Interest income increased in the nine months ended September 30, 2016 compared to the nine months ended September 30, 2015, due to a higher return on short-term deposits.

Interest expense

Interest expense increased by the amount of CHF 0.4 million in the nine months ended September 30, 2016 compared to the previous period. The increase mainly relates to the interest expenses related to the Hercules Loan and Security Agreement.

Revaluation gain/(loss) from derivative financial instrument

In connection with the Hercules Loan and Security Agreement, the Company issued Hercules a warrant to purchase up to 241,117 of its common shares at an exercise price of US$3.94 per share. As of July 19, 2016, the warrant was exercisable for 156,726 common shares. As of September 30, 2016, and after deduction of a currency revaluation gain of CHF 2,340, the fair value of the warrant amounts to CHF 177,650. Since its initial recognition, the fair value decreased by CHF 228,190 resulting in a gain in the corresponding amount (fair value as of July 19, 2016: CHF 408,180).

Foreign currency exchange losses, net

For the nine months ended September 30, 2016 the higher depreciation of the U.S. dollar against the Swiss Franc triggered an increase of the net foreign unrealized currency loss on the U.S. dollar denominated cash and cash equivalents compared to the nine months' period ended September 30, 2015.

Cash flows

Comparison of the nine months ended September 30, 2016 and 2015

The table below summarizes our cash flows for the nine months ended September 30, 2016 and 2015:

	NINE MONTHS ENDED SEPTEMBER, 30	
	2016	**2015**
	(in thousands of CHF)	
Net cash used in operating activities .	(23,238)	(22,222)
Net cash from investing activities	33	(57)
Net cash from financing activities .	11,746	20,897
Net effect of currency translation on cash .	(1,251)	(151)
Cash and cash equivalents at the beginning of the period .	50,237	56,934
Cash and cash equivalents at the end of the period	**37,527**	**55,401**

The increase in net cash used in operating activities from CHF 22.2 million in the nine months ended September 30, 2015, to CHF 23.2 million in the nine months ended September 30, 2016, was mainly due to higher general and administrative expenses partially offset by lower research and development expenses as well as a lower increase in accrued liabilities from January 1, 2016 to September 30, 2016, compared to the period from January 1, 2015 to September 30, 2015.

Net cash from investing activities increased in the nine months ended September 30, 2016, compared to the nine months ended September 30, 2015 and was comprised of interest received (higher in the period ended September 30, 2016, than in the prior year period) and purchases of equipment (lower in the period ended September 30, 2016, than in the prior year period).

Cash from financing activities in the nine months ended September 30, 2015, includes the net proceeds of the public offering of 5,275,000 of our common shares at a price of US$ 4.75 per share, yielding net proceeds of US$23.6 million (CHF 21.7 million). Cash from financing activities in the nine months ended September 30, 2016, includes the net proceeds from the loan issuance under the Hercules Loan and Security Agreement, the related interest payments and the share issuance costs from the grant of 25,813 restricted shares to employees under the Equity Incentive Plan as a compensation bonus for 2015 on January 7, 2016.

Cash and funding sources

On June 1, 2016, we entered into a Controlled Equity Offering^{SM} Sales Agreement (the “Sales Agreement”) with Cantor Fitzgerald & Co. (“Cantor”), pursuant to which we may offer and sell, from time to time common shares, with a nominal value of CHF 0.40 per share, having an aggregate offering price of up to US$35 million through Cantor. Any common shares offered and sold will be issued pursuant to our shelf registration statement on Form F-3 (Registration No. 333-206710) as supplemented by a prospectus supplement, dated June 1, 2016. In the third quarter of 2016, we did not offer or sell any common shares under the Sales Agreement.

On July 19, 2016, we entered into the Hercules Loan and Security Agreement for a secured term loan facility of up to US$20.0 million. An initial tranche of US$12.5 million was drawn on July 19, 2016, concurrently with the execution of the loan agreement. The loan matures on January 2, 2020 and bears interest at a minimum rate of 9.55% per annum, and is subject to the variability of the prime interest rate. In connection with the loan facility, we issued Hercules a warrant to purchase up to 241,117 of our common shares at an exercise price of US$3.94 per share. As of July 19, 2016, the warrant is exercisable for 156,726 common shares. Upon Hercules making the second advance under the loan facility, the warrant shall become exercisable for the additional 84,391 common shares. The warrant expires on July 19, 2023. The loan is secured by a pledge of the shares of Auris Medical AG, our principal operating subsidiary, owned by us, all intercompany receivables owed to us by our Swiss subsidiaries and a security assignment of our bank accounts.

Funding requirements

We expect that our existing cash and cash equivalents will enable us to fund our operating expenses and capital expenditure requirements until fall 2017. We have based this estimate on assumptions that may prove to be wrong, and we could use our capital resources sooner than we currently expect. Our future funding requirements will depend on many factors, including but not limited to:

- the scope, rate of progress, results and cost of our clinical trials, nonclinical testing, and other related activities;
- the cost of manufacturing clinical supplies, and establishing commercial supplies, of our product candidates and any products that we may develop;
- the number and characteristics of product candidates that we pursue;
- the cost, timing, and outcomes of regulatory approvals;
- the cost and timing of establishing sales, marketing, and distribution capabilities; and
- the terms and timing of any collaborative, licensing, and other arrangements that we may establish, including any required milestone and royalty payments thereunder.

We expect that we will require additional capital to commercialize our product candidates Keyzilen™ and AM-111. If we receive regulatory approval for Keyzilen™ or AM-111, and if we choose not to grant any licenses to partners, we expect to incur significant commercialization expenses related to product manufacturing, sales, marketing and distribution, depending on where we choose to commercialize. Additional funds may not be available on a timely basis, on favorable terms, or at all, and such funds, if raised, may not be sufficient to enable us to continue to implement our long-term business strategy. If we are not able to raise capital when needed, we could be forced to delay, reduce or eliminate our product development programs or commercialization efforts. Likewise, if we are unable to refinance amounts outstanding under our existing term loan facility before such amounts are due we may be unable to repay such amounts, which could result in foreclosure of the collateral pledged to secure such loan.

We may raise additional capital through the sale of equity or convertible debt securities. In such an event, your ownership interest will be diluted, and the terms of these new securities may include liquidation or other preferences that adversely affect your rights as a holder of our common shares.

For more information as to the risks associated with our future funding needs, see “Item 3—Key Information—Risk factors” in the Annual Report.

Contractual Obligations and Commitments

The following table presents information relating to our contractual obligations as of September 30, 2016:

	PAYMENTS DUE BY PERIOD		
	Less Than 1 Year	Between 1 and 5 Years	Total
	(in thousands of CHF)		
Operating lease obligations (1)	234	586	820
Long-term debt obligations (2)	693	12,146	12,839
Total	927	12,732	13,659

(1) Operating lease obligations consist of payments pursuant to non-cancellable operating lease agreements relating to our leases of office space and are not accounted for on the balance sheet. The lease term of both leases is 5 years. The leases expire on March 31, 2018 and September 30, 2021, respectively, with an option to extend for another five years.

(2) Long-term debt obligations consist of amortization payments due under the Hercules Loan and Security Agreement converted to CHF at an exchange rate of CHF 0.9713 to US$1.00.

Under the terms of our collaboration and license agreement with Xigen, we are obliged to make development milestone payments on an indication-by-indication basis of up to CHF 1.5 million upon the successful completion of a Phase 2 clinical trial and regulatory milestone payments on a product-by-product basis of up to CHF 2.5 million, subject to a mid-twenties percentage reduction for smaller indications, e.g., those qualifying for orphan drug status, upon receiving marketing approval for a product. The milestones are not included in the table above as they have not met the recognition criteria for provisions and the timing of these is not yet determinable as it is dependent upon the achievement of earlier mentioned milestones.

Off-Balance Sheet Arrangements

As of the date of this discussion and analysis, we do not have any, and during the periods presented we did not have any, off-balance sheet arrangements except for the Operating Lease mentioned in "Item 5—Operating and Financial Review and Prospects—Tabular disclosure of contractual obligations" in the Annual Report.

Significant Accounting Policies and Use of Estimates and Judgment

There have been no material changes to the significant accounting policies and estimates described in "Item 5—Operating and Financial Review and Prospects–Operating results—Significant accounting policies and use of estimates and judgment" in the Annual Report.

Recent Accounting Pronouncements

There are no IFRS standards as issued by the IASB or interpretations issued by the IFRS interpretations committee that are effective for the first time for the financial year beginning on or after January 1, 2016 that would be expected to have a material impact on our financial position.

JOBS Act Exemption

On April 5, 2012, the JOBS Act was signed into law. The JOBS Act contains provisions that, among other things, reduce certain reporting requirements for an "emerging growth company". As an emerging growth company, we are not required to provide an auditor attestation report on our system of internal controls over financial reporting. This exemption will apply for a period of five years following the completion of our initial public offering (2019) or until we no longer meet the requirements of being an "emerging growth company," whichever is earlier. We would cease to be an emerging growth company if we have more than US$1.0 billion in annual revenue, have more than US$700 million in market value of our common shares held by non-affiliates or issue more than US$1.0 billion of non-convertible debt over a three-year period.

Cautionary Statement Regarding Forward Looking Statements

Forward-looking statements appear in a number of places in this discussion and analysis and include, but are not limited to, statements regarding our intent, belief or current expectations. Many of the forward-looking statements contained in this discussion and analysis can be identified by the use of forward-looking words such as "anticipate," "believe," "could," "expect," "should," "plan," "intend," "estimate" and "potential," among others. Forward-looking statements are based on our management's beliefs and assumptions and on information currently available to our management. Such statements are subject to risks and uncertainties, and actual results may differ materially from those expressed or implied in the forward-looking statements due to various factors, including, but not limited to, those identified under the section entitled "Item 3—Key Information—Risk factors" in the Annual Report. These risks and uncertainties include factors relating to:

- our operation as a development stage company with limited operating history and a history of operating losses;
- our need for substantial additional funding before we can expect to become profitable from sales of our products;

- our dependence on the success of Keyzilen™ (AM-101) and AM-111, which are still in clinical development and may eventually prove to be unsuccessful, including the likelihood that the TACTT3 clinical trial with Keyzilen™ will not meet its endpoints;
- the chance that we may become exposed to costly and damaging liability claims resulting from the testing of our product candidates in the clinic or in the commercial stage;
- the chance our clinical trials may not be completed on schedule, or at all, as a result of factors such as delayed enrollment or the identification of adverse effects;
- uncertainty surrounding whether and when any of our product candidates will receive regulatory approval, which is necessary before they can be commercialized;
- if our product candidates obtain regulatory approval, our being subject to expensive ongoing obligations and continued regulatory overview;
- enacted and future legislation may increase the difficulty and cost for us to obtain marketing approval and commercialization;
- the chance that we do not obtain orphan drug exclusivity for AM-111, which would allow our competitors to sell products that treat the same conditions;
- dependence on governmental authorities and health insurers establishing adequate reimbursement levels and pricing policies;
- our products may not gain market acceptance, in which case we may not be able to generate product revenues;
- our reliance on our current strategic relationships with INSERM or Xigen and the potential failure to enter into new strategic relationships;
- our reliance on third parties to conduct our nonclinical and clinical trials and on third-party single-source suppliers to supply or produce our product candidates;
- our ability to draw on the second tranche of financing under our term loan facility with Hercules and our ability to comply with the requirements of the term loan facility, including repayment of amounts outstanding when due; and
- other risk factors discussed under “Item 3—Key Information—Risk factors” included in the Annual Report.

Forward-looking statements speak only as of the date they are made, and we do not undertake any obligation to update them in light of new information or future developments or to release publicly any revisions to these statements in order to reflect later events or circumstances or to reflect the occurrence of unanticipated events.

Risks Related to the Development and Clinical Testing of our Product Candidates

We depend entirely on the success of Keyzilen™ and AM-111, which are still in clinical development. If our clinical trials are unsuccessful, we do not obtain regulatory approval or we are unable to commercialize Keyzilen™ and AM-111, or we experience significant delays in doing so, our business, financial condition and results of operations will be materially adversely affected.

We currently have no products approved for sale and have invested a significant portion of our efforts and financial resources in the development of Keyzilen™ and AM-111, which are still in clinical development. Our ability to generate product revenues, which we do not expect will occur for at least the next couple years, if ever, will depend heavily on successful clinical development, obtaining regulatory approval and eventual commercialization of these product candidates. We currently generate no revenues from sales of any drugs, and we may never be able to develop or commercialize a marketable drug. The success of Keyzilen™ and AM-111 will depend on several factors, including the following:

- completing clinical trials that demonstrate the efficacy and safety of our product candidates;
- receiving marketing approvals from competent regulatory authorities;
- establishing commercial manufacturing capabilities;
- launching commercial sales, marketing and distribution operations;
- acceptance of our product candidates by patients, the medical community and third-party payors,
- a continued acceptable safety profile following approval;
- competing effectively with other therapies; and
- qualifying for, maintaining, enforcing and defending our intellectual property rights and claims.

If we do not achieve one or more of these factors in a timely manner or at all, we could experience significant delays or an inability to successfully commercialize Keyzilen™ or AM-111, which would materially adversely affect our business, financial condition and results of operations.

Clinical drug development involves a lengthy and expensive process with uncertain timelines and uncertain outcomes, and results of earlier studies and trials may not be predictive of future trial results. If clinical trials of our product candidates are prolonged or delayed, we may be unable to obtain required regulatory approvals, and therefore be unable to commercialize our product candidates on a timely basis or at all.

To obtain the requisite regulatory approvals to market and sell any of our product candidates, we must demonstrate through extensive pre-clinical studies and clinical trials that our products are safe and effective in humans. Clinical testing is expensive and can take many years to complete, and its outcome is inherently uncertain. Failure can occur at any time during the clinical trial process. The results of pre-clinical studies and early clinical trials of our product candidates may not be predictive of the results of later-stage clinical trials. For example, the positive results generated to date in clinical trials for our product candidates do not ensure that later clinical trials will demonstrate similar results. Product candidates in later stages of clinical trials may fail to show the desired safety and efficacy traits despite having progressed through pre-clinical studies and initial clinical trials. A number of companies in the biopharmaceutical industry have suffered significant setbacks in advanced clinical trials due to lack of efficacy or adverse safety profiles, notwithstanding promising results in earlier trials. Our future clinical trial results may not be successful.

Clinical trials must be conducted in accordance with FDA, EMA and comparable foreign regulatory authorities' legal requirements, regulations or guidelines, and are subject to oversight by these governmental agencies and Institutional Review Boards, or IRBs, at the medical institutions where the clinical trials are conducted. In addition, clinical trials must be conducted with supplies of our product candidates produced under current good manufacturing practices, or cGMP, and other requirements. We depend on medical institutions and clinical research organizations, or CROs, to conduct our clinical trials in compliance with current good clinical practice, or cGCP, standards. To the extent the CROs fail to enroll participants for our clinical trials, fail to conduct the trial to cGCP standards or are delayed for a significant time in the execution of trials, including achieving full enrollment, we may be affected by increased costs, program delays or both, which may harm our business.

To date, we have not completed all clinical trials required for the approval of any of our product candidates. Keyzilen™ and AM-111 are in Phase 3 clinical development. Keyzilen™ is being developed for acute inner ear tinnitus under a special protocol assessment, or SPA, with the FDA. AM-111 is being developed for acute sensorineural hearing loss. A first Phase 3 clinical trial, entitled Efficacy and Safety of AM-111 in the Treatment of Acute Inner Ear Hearing Loss, or HEALOS, is enrolling 255 patients in Europe and Asia, and a second Phase 3 trial, entitled Efficacy and Safety of AM-111 as Acute Sudden Sensorineural Hearing Loss Treatment, or ASSENT, is enrolling 300 patients in the U.S., Canada, and South Korea. In addition, we are planning a Phase 2 trial, entitled Efficacy and Safety of AM-111 in the Treatment of Surgery-Induced Hearing Loss, or REACH, in the U.S. Provided that we obtain grant or other funding, REACH could be initiated in the first half 2017 at the earliest. The development of our other product candidates is less advanced and trials have not yet started.

The completion of clinical trials for our clinical product candidates may be delayed, suspended or terminated as a result of many factors, including but not limited to:

- the delay or refusal of regulators or IRBs to authorize us to commence a clinical trial at a prospective trial site and changes in regulatory requirements, policies and guidelines;
- delays or failure to reach agreement on acceptable terms with prospective CROs and clinical trial sites, the terms of which can be subject to extensive negotiation and may vary significantly among different CROs and trial sites;
- delays in patient enrollment and variability in the number and types of patients available for clinical trials;
- the inability to enroll a sufficient number of patients in trials to ensure adequate statistical power to detect statistically significant treatment effects;
- negative or inconclusive results, which may require us to conduct additional pre-clinical or clinical trials or to abandon projects that we expect to be promising;
- safety or tolerability concerns could cause us to suspend or terminate a trial if we find that the participants are being exposed to unacceptable health risks;
- regulators or IRBs requiring that we or our investigators suspend or terminate clinical research for various reasons, including noncompliance with regulatory requirements or safety concerns, among others;
- lower than anticipated retention rates of patients and volunteers in clinical trials;
- our CROs or clinical trial sites failing to comply with regulatory requirements or meet their contractual obligations to us in a timely manner, or at all, deviating from the protocol or dropping out of a trial;
- delays relating to adding new clinical trial sites;
- difficulty in maintaining contact with patients after treatment, resulting in incomplete data;
- errors in survey design and translation;
- delays in establishing the appropriate dosage levels;
- the quality or stability of the product candidate falling below acceptable standards;
- the inability to produce or obtain sufficient quantities of the product candidate to complete clinical trials; and
- exceeding budgeted costs due to difficulty in accurately predicting costs associated with clinical trials.

Any delays in completing our clinical trials will increase our costs, slow down our product candidate development and approval process and jeopardize our ability to commence product sales and generate revenues. Any of these occurrences may harm our business, financial condition and prospects significantly. In addition, many of the factors that cause, or lead to, a delay in the commencement or completion of clinical trials may also ultimately lead to the denial of regulatory approval of our product candidates.

Positive or timely results from pre-clinical or early stage trials do not ensure positive or timely results in late stage clinical trials or product approval by the FDA, the EMA or comparable foreign regulatory authorities. Products that show positive pre-clinical or early clinical results may not show sufficient safety or efficacy in later stage clinical trials and therefore may fail to obtain regulatory approvals. For example, although Keyzilen™ achieved favorable results in our Phase 2 efficacy trial, in August 2016, we announced that the Phase 3 TACTT2 clinical trial of Keyzilen™ did not meet its two co-primary efficacy endpoints of statistically significant changes in tinnitus loudness and tinnitus burden compared to placebo. There can be no assurances that TACTT3, our ongoing Phase 3 clinical trial with Keyzilen™ will meet its primary efficacy endpoints. In addition, pre-clinical and clinical data are often susceptible to varying interpretations and analyses. Many companies that believed their product candidates performed satisfactorily in pre-clinical studies and clinical trials have nonetheless failed to obtain marketing approval for the product candidates. The FDA, the EMA and comparable foreign regulatory authorities have substantial discretion in the approval process and in determining when or whether regulatory approval will be obtained for any of our product candidates. Even if we believe the data collected from clinical trials of our product candidates are promising, such data may not be sufficient to support approval by the FDA, the EMA or any other regulatory authority.

In some instances, there can be significant variability in safety and/or efficacy results between different trials of the same product candidate due to numerous factors, including changes in trial procedures set forth in protocols, differences in the size and type of the patient populations, adherence to the dosing regimen and other trial protocols and the rate of dropout among clinical trial participants. In the case of our late stage clinical product candidates, results may differ in general on the basis of the larger number of clinical trial sites and additional countries and languages involved in Phase 3 clinical trials.

In the case of Keyzilen™ our endpoints in Phase 3 clinical trials are based on patient reported outcomes, some of which are captured daily from trial participants with electronic diaries. Based on insights from our continuing analysis of the TACTT2 trial, we believe the high frequency of tinnitus loudness ratings over an extended period of time may have caused a number of patients to excessively focus on their tinnitus symptoms, thereby influencing the measured outcome. In addition, low compliance with daily reporting requirements may impact the trials' validity or statistical power.

Under the SPA with the FDA we agreed to use the Tinnitus Functional Index, or TFI, as a co-primary efficacy endpoint in the TACTT2 trial and a secondary efficacy endpoint in the TACTT3 trial. Based on our ongoing analysis of the TACTT2 clinical trial results, we are amending our protocol for the TACTT3 Phase 3 clinical trial of Keyzilen™ to elevate the change in the TFI score from a key secondary endpoint to an alternate primary efficacy endpoint. We used a different tinnitus questionnaire in the previous clinical trials with Keyzilen™ (Tinnitus Handicap Inventory 12, THI-12, a 12-item short version of the 25-item Tinnitus Handicap Inventory, or THI). Unlike the THI-12, the TFI was developed and validated broadly in accordance with the FDA's guidance for patient-reported outcome measures and with the explicit aim of measuring treatment-related changes in tinnitus. In addition, the TFI covers all important domains of negative tinnitus impact including sleep difficulties, whereas the THI-12 does not include any sleep-related item. In spite of the methodological superiority of the TFI and a 2011 study by Meikle et al. showing a high correlation between THI and TFI scores with higher responsiveness to change of the latter, there is no assurance that outcomes with the TFI will be qualitatively and quantitatively similar or the same as those that would result with the THI-12. In the TACTT2 trial, treatment with Keyzilen™ did not result in a clinically meaningful change in TFI in the overall study population.

In the case of AM-111 we are evaluating the safety and efficacy in an idiopathic condition which implies a considerable heterogeneity in the etiology and natural history of the condition. This may have an impact on the safety and efficacy outcomes of our Phase 3 clinical trials. In addition, in HEALOS and ASSENT, we extended the time window for enrollment into the study, from up to 48 hours to up to 72 hours, in response to results from the Phase 2 trial showing an increasing treatment effect the later the treatment was given. This was due to declining spontaneous recovery rates while the effects with active treatment held steady. Although spontaneous recovery is expected to decline further between 48 and 72 hours, we have no assurance that improvement achieved with the active treatment will remain stable. Based on discussions with the FDA and EMA, we moved the primary endpoint from Day 7 in the Phase 2 trial to later time points in the Phase 3 trials: to Day 28 in HEALOS and to Day 91 in ASSENT. In the Phase 2 trial, a therapeutic effect of AM-111 was observed in a clinically meaningful and statistically significant way in the relevant patient population on Day 3, and the majority of the effect was achieved by Day 7; however, superior results were also observed at later time points. Therefore, we expect to be able to demonstrate a therapeutic effect at the later time points in the Phase 3 trials. However, this expectation is based on the assumption that hearing recovery patterns will be similar as in the Phase 2 trial, and there is no assurance that this will be the case.

Whereas in our Phase 2 trial we had full placebo control for the primary endpoint at Day 7 and an oral corticosteroid could only be administered as a reserve therapy in case of insufficient hearing recovery to that point, such trial design is not feasible in certain countries due to the use of oral corticosteroids as standard of care. Hence, in the planned ASSENT trial oral corticosteroids will be offered as background therapy to all study participants. Although there is no clear evidence for the efficacy of oral corticosteroids in the treatment of idiopathic sudden sensorineural hearing loss, or ISSNHL, we have assumed a small impact of background therapy on hearing recovery when calculating the number of patients that are required to demonstrate AM-111's efficacy in a statistically significant and clinically meaningful way. We cannot rule out the possibility that the background therapy will enhance hearing recovery more substantially, and that in consequence the trial may not demonstrate the therapeutic benefit of AM-111. We will conduct an interim analysis at the midpoint of enrollment, and the study protocol allows for adjusting the size of the trial if suggested by the interim analysis; however, the required adjustment may be too large to be considered feasible and we may have to change the trial design significantly or stop the trial altogether.

Orphan drug designation for AM-111 was granted by the FDA and EMA for the treatment of acute sensorineural hearing loss, or ASNHL, an umbrella term that comprises hearing loss from acute acoustic trauma, or AAT, surgery-induced trauma or ISSNHL. We estimate ISSNHL to be the largest of the three subgroups. The broader, more general designation of ASNHL is based on the common pathophysiologic pathway shared by the three subgroups. Although we expect to obtain regulatory approval for the entire indication of ASNHL based on confirmatory efficacy and safety data that covers only one or two rather than all of the three subgroups, there can be no assurance that regulatory agencies will concur with this assumption at the time of the marketing approval procedure. In that case, it may not be sufficient to conduct HEALOS and ASSENT in the subgroup of ISSNHL and REACH in the subgroup of surgery-related trauma, as is currently planned.

Based on our ongoing analysis of the TACTT2 clinical trial results, we are amending our protocol for the ongoing TACTT3 Phase 3 clinical trial of Keyzilen™, which will cause our product development costs to increase. If we are required to make further changes the trial design of, or conduct additional clinical trials or other testing of Keyzilen™, AM-111, or any other product candidate that we develop beyond the trials and testing that we contemplate, if we are unable to successfully complete clinical trials of our product candidates or other testing, if the results of these trials or tests are unfavorable or are only modestly favorable or if there are safety concerns associated with Keyzilen™, AM-111 or our other product candidates, we may:

- be delayed in obtaining marketing approval for our product candidates;
- not obtain marketing approval at all;
- obtain approval for indications or patient populations that are not as broad as intended or desired;
- obtain approval with labeling that includes significant use or distribution restrictions or significant safety warnings, including boxed warnings;
- be subject to additional post-marketing testing or other requirements; or
- remove the product from the market after obtaining marketing approval.

Our product development costs will also increase if we experience delays in testing or marketing approvals or if we are required to conduct additional clinical trials or other testing of Keyzilen™ and we may be required to obtain additional funds to complete clinical trials. We cannot assure you that our clinical trials will begin as planned or be completed on schedule, if at all, or that we will not need to restructure our trials after they have begun. Significant clinical trial delays also could shorten any periods during which we may have the exclusive right to commercialize our product candidates or allow our competitors to bring products to market before we do or shorten any periods during which we have the exclusive right to commercialize our product candidates, which may harm our business and results of operations. In addition, some of the factors that cause, or lead to, clinical trial delays may ultimately lead to the denial of regulatory approval of Keyzilen™, AM-111 or any other product candidate.

If serious adverse, undesirable or unacceptable side effects are identified during the development of our product candidates or following approval, if any, we may need to abandon our development of such product candidates, the commercial profile of any approved label may be limited, or we may be subject to other significant negative consequences following marketing approval, if any.

If our product candidates are associated with serious adverse, undesirable or unacceptable side effects, we may need to abandon their development or limit development to certain uses or sub-populations in which such side effects are less prevalent, less severe or more acceptable from a risk-benefit perspective. Many compounds that initially showed promise in pre-clinical or early stage testing have later been found to cause side effects that restricted their use and prevented further development of the compound for larger indications.

In our clinical trials of Keyzilen™ and AM-111 to date, adverse events have included procedure-related transient changes in tinnitus loudness, muffled hearing, ear discomfort or pain, incision site complications and middle ear infections. A limited number of serious adverse events were observed (in 2.4% of patients enrolled in the Keyzilen™ Phase 2 program, in 2.5% in the TACTT2 clinical trial with Keyzilen™ and in 4.5% of patients in the AM-111 Phase 2 study); all (Keyzilen™) or most (AM-111) were considered unrelated or unlikely related to the treatment. Occurrence of serious procedure-or treatment-related side effects could impede clinical trial enrollment and receipt of marketing approval from the FDA, the EMA and comparable foreign regulatory authorities. They could also adversely affect physician or patient acceptance of our product candidates.

Additionally if one or more of our product candidates receives marketing approval, and we or others later identify undesirable side effects caused by such products, a number of potentially significant negative consequences could result, including:

- regulatory authorities may withdraw approvals of such product;
- regulatory authorities may require additional warnings on the label;
- we may be required to create a medication guide outlining the risks of such side effects for distribution to patients;
- we could be sued and held liable for harm caused to patients; and
- our reputation and physician or patient acceptance of our products may suffer.

Any of these events could prevent us from achieving or maintaining market acceptance of the particular product candidate, if approved, and could significantly harm our business, results of operations and prospects.

We depend on enrollment of patients in our clinical trials for our product candidates. If we are unable to enroll patients in our clinical trials, our research and development efforts could be materially adversely affected.

Successful and timely completion of clinical trials will require that we enroll a sufficient number of patient candidates. Trials may be subject to delays as a result of patient enrollment taking longer than anticipated or patient withdrawal. Patient enrollment depends on many factors, including the size and nature of the patient population, eligibility criteria for the trial, the proximity of patients to clinical sites, the design of the clinical protocol, the availability of competing clinical trials, the availability of new drugs approved for the indication the clinical trial is investigating, and clinicians' and patients' perceptions as to the potential advantages of the drug being studied in relation to other available therapies. In our Phase 3 clinical trials of Keyzilen™, we enroll patients with acute inner ear tinnitus, meaning patients with symptom duration of three months or less, due to traumatic injury to their cochlea or otitis media. Thus, we must identify, recruit, enroll and dose patients with tinnitus caused by a pre-determined universe of factors in a limited time frame. Our product candidate AM-111, which is intended for patients with acute inner ear hearing loss, which is also known as acute sensorineural hearing loss or ASNHL, has orphan drug designation for the treatment of ASNHL, which means that the potential patient population is more limited. In our late stage clinical program with AM-111 the enrollment window is 72 hours from onset, meaning that we must enroll patients in a short time frame. This short enrollment window may negatively impact our enrollment rate.

The specific target population of patients and therapeutic time windows may make it difficult for us to enroll enough patients to complete our clinical trials in a timely and cost-effective manner. Delays in the completion of any clinical trial of our product candidates will increase our costs, slow down our product candidate development and approval process and delay or potentially jeopardize our ability to commence product sales and generate revenue. In addition, many of the factors that cause, or lead to, a delay in the commencement or completion of clinical trials may also ultimately lead to the denial of regulatory approval of our product candidates.

We may become exposed to costly and damaging liability claims, either when testing our product candidates in the clinic or at the commercial stage; and our product liability insurance may not cover all damages from such claims.

We are exposed to potential product liability and professional indemnity risks that are inherent in the research, development, manufacturing, marketing and use of pharmaceutical products. Currently we have no products that have been approved for commercial sale; however, the current and future use of product candidates by us in clinical trials, and the sale of any approved products in the future, may expose us to liability claims. These claims might be made by patients that use the product, healthcare providers, pharmaceutical companies or others selling such products. Any claims against us, regardless of their merit, could be difficult and costly to defend and could materially adversely affect the market for our product candidates or any prospects for commercialization of our product candidates.

Although the clinical trial process is designed to identify and assess potential side effects, it is always possible that a drug, even after regulatory approval, may exhibit unforeseen side effects. If any of our product candidates were to cause adverse side effects during clinical trials or after approval of the product candidate, we may be exposed to substantial liabilities. Physicians and patients may not comply with any warnings that identify known potential adverse effects and patients who should not use our product candidates.

We purchase liability insurance in connection with each of our clinical trials. It is possible that our liabilities could exceed our insurance coverage. We intend to expand our insurance coverage to include the sale of commercial products if we obtain marketing approval for any of our product candidates. However, we may not be able to maintain insurance coverage at a reasonable cost or obtain insurance coverage that will be adequate to satisfy any liability that may arise. If a successful product liability claim or series of claims is brought against us for uninsured liabilities or in excess of insured liabilities, our assets may not be sufficient to cover such claims and our business operations could be impaired.

Should any of the events described above occur, this could have a material adverse effect on our business, financial condition and results of operations.

We have obtained orphan drug designation for AM-111 for the treatment of ASNHL from the FDA and the EMA, and we may rely on obtaining and maintaining orphan drug exclusivity for AM-111, if approved. Orphan drug designation may not ensure that we will enjoy market exclusivity in a particular market, and if we fail to obtain or maintain orphan drug exclusivity for AM-111, we may be subject to earlier competition and our potential revenue will be reduced.

AM-111 has been granted orphan drug designation for the treatment of ASNHL by the FDA and EMA. Under the Orphan Drug Act, the FDA may designate a product as an orphan drug if it is intended to treat a rare disease or condition, defined as a patient population of fewer than 200,000 in the United States, or a patient population greater than 200,000 in the United States where there is no reasonable expectation that the cost of developing the drug will be recovered from sales in the United States. In the European Union, the EMA's Committee for Orphan Medicinal Products, or COMP, grants orphan drug designation to promote the development of products that are intended for the diagnosis, prevention, or treatment of a life-threatening or chronically debilitating condition affecting not more than five in 10,000 persons in the European Union. Additionally, designation is granted for products intended for the diagnosis, prevention, or treatment of a life-threatening, seriously debilitating or serious and chronic condition when, without incentives, it is unlikely that sales of the drug in the European Union would be sufficient to justify the necessary investment in developing the drug or biological product or where there is no satisfactory method of diagnosis, prevention, or treatment, or, if such a method exists, the medicine must be of significant benefit to those affected by the condition.

In the United States, orphan drug designation entitles a party to financial incentives such as opportunities for grant funding towards clinical trial costs, tax advantages and user-fee waivers. In addition, if a product receives the first FDA approval for the indication for which it has orphan designation, the product is entitled to orphan drug exclusivity, which means the FDA may not approve any other application to market the same drug for the same indication for a period of seven years, except in limited circumstances, such as a showing of clinical superiority over the product with orphan exclusivity or where the manufacturer is unable to assure sufficient product quantity. In the European Union, orphan drug designation entitles a party to financial incentives such as reduction of fees or fee waivers and ten years of market exclusivity following drug or biological product approval. This period may be reduced to six years if the orphan drug designation criteria are no longer met, including where it is shown that the product is sufficiently profitable not to justify maintenance of market exclusivity.

Even though we have obtained orphan drug designation for AM-111 for the treatment of ASNHL in the United States and Europe, we may not be the first to obtain marketing approval for any particular orphan indication due to the uncertainties associated with developing pharmaceutical products. Further, even if we obtain orphan drug designation for a product, that exclusivity may not effectively protect the product from competition because different drugs with different active moieties can be approved for the same condition. Orphan drug designation neither shortens the development time or regulatory review time of a drug nor gives the drug any advantage in the regulatory review or approval process.

The orphan drug designation for AM-111 relates to ASNHL, an umbrella term comprising acute acoustic trauma, ISSNHL and surgery-induced trauma based on a common pathophysiologic pathway. Our Phase 3 late-stage program is only enrolling patients suffering from ISSNHL, which represent the largest of the three ASNHL subgroups. Based on its outcomes, we may obtain marketing authorization only for the ISSNHL subgroup, and additional studies may be required to obtain marketing authorization for the entire ASNHL indication.

Due to our limited resources and access to capital, we must and have in the past decided to prioritize development of certain product candidates; these decisions may prove to have been wrong and may adversely affect our revenues.

Because we have limited resources and access to capital to fund our operations, we must decide which product candidates to pursue and the amount of resources to allocate to each. As such, we are currently primarily focused on the development of Keyzilen^{TM} and AM-111 for the treatment of acute inner ear tinnitus and acute inner ear hearing loss, respectively. Our decisions concerning the allocation of research, collaboration, management and financial resources toward particular compounds, product candidates or therapeutic areas may not lead to the development of viable commercial products and may divert resources away from better opportunities. Similarly, our potential decisions to delay, terminate or collaborate with third parties in respect of certain product development programs may also prove not to be optimal and could cause us to miss valuable opportunities. If we make incorrect determinations regarding the market potential of our product candidates or misread trends in the biopharmaceutical industry, in particular for inner ear disorders, our business, financial condition and results of operations could be materially adversely affected.

Our research and development activities could be affected or delayed as a result of possible restrictions on animal testing.

Certain laws and regulations require us to test our product candidates on animals before initiating clinical trials involving humans. Animal testing activities have been the subject of controversy and adverse publicity. Animal rights groups and other organizations and individuals have attempted to stop animal testing activities by pressing for legislation and regulation in these areas and by disrupting these activities through protests and other means. To the extent the activities of these groups are successful, our research and development activities may be interrupted, delayed or become more expensive.

Risks Related to Regulatory Approval of our Product Candidates

We cannot give any assurance that any of our product candidates will receive regulatory approval, which is necessary before they can be commercialized.

Our future success is dependent on our ability to successfully develop, obtain regulatory approval for, and then successfully commercialize one or more product candidates. We currently have two product candidates in late-stage clinical development. Keyzilen^{TM} is in Phase 3 clinical development for the treatment of acute inner ear tinnitus under a SPA from the FDA and based on scientific advice from the EMA. AM-111 is in Phase 3 clinical development for the treatment of acute sensorineural hearing loss for which we received feedback from the FDA and EMA on multiple occasions. We are not permitted to market or promote any of our product candidates before we receive regulatory approval from the FDA, EMA or comparable foreign regulatory authorities, and we may never receive such regulatory approval for any of our product candidates.

Although certain of our employees have prior experience with submitting marketing applications to the FDA, EMA or comparable foreign regulatory authorities, we as a company have not submitted such applications for our product candidates. We cannot be certain that any of our product candidates will be successful in clinical trials or receive regulatory approval. Applications for our product candidates could fail to receive regulatory approval for many reasons, including but not limited to the following:

- the FDA, EMA or comparable foreign regulatory authorities may disagree with the design or implementation of our clinical trials;
- the population studied in the clinical program may not be sufficiently broad or representative to assure safety in the full population for which we seek approval;
- the FDA, EMA or comparable foreign regulatory authorities may disagree with our interpretation of data from nonclinical trials or clinical trials;
- the data collected from clinical trials of our product candidates may not be sufficient to support the submission of a new drug application, or NDA, or other submission or to obtain regulatory approval in the United States or elsewhere;
- we may be unable to demonstrate to the FDA, EMA or comparable foreign regulatory authorities that a product candidate's risk-benefit ratio for its proposed indication is acceptable;
- the FDA, EMA or other regulatory authorities may fail to approve the manufacturing processes, test procedures and specifications, or facilities of third-party manufacturers with which we contract for clinical and commercial supplies; and
- the approval policies or regulations of the FDA, EMA or comparable foreign regulatory authorities may significantly change in a manner rendering our clinical data insufficient for approval.

In addition, no product for the treatment of acute inner ear tinnitus or acute inner ear hearing loss has been approved by the FDA or the EMA. Accordingly, our current product candidates or any of our other future product candidates could take a significantly longer time to gain regulatory approval than expected or may never gain regulatory approval. This could delay or eliminate any potential product revenue by delaying or terminating the potential commercialization of our product candidates.

We generally plan to seek regulatory approval to commercialize our product candidates in the United States, the European Union and in additional foreign countries where we have commercial rights. To obtain regulatory approval in other countries, we must comply with numerous and varying regulatory requirements of such other countries regarding safety, efficacy, chemistry, manufacturing and controls, clinical trials, commercial sales, pricing, and distribution of our product candidates. Even if we are successful in obtaining approval in one jurisdiction, we cannot ensure that we will obtain approval in any other jurisdictions. Failure to obtain marketing authorization for our product candidates will result in our being unable to market and sell such products, which would materially adversely affect our business, financial conditional and results of operations. If we fail to obtain approval in any jurisdiction, the geographic market for our product candidates could be limited. Similarly, regulatory agencies may not approve the labeling claims that are necessary or desirable for the successful commercialization of our product candidates.

Because we are developing therapies for which there is little clinical experience and, in some cases, using new endpoints, there is more risk that the outcome of our clinical trials will not be favorable. Even if the results of our trials are favorable, there is risk that they will not be acceptable to regulators or physicians.

There are currently no drugs with proven efficacy for acute inner ear tinnitus or acute inner ear hearing loss. In addition, there has been limited historical clinical trial experience generally for the development of drugs to treat these conditions. Regulatory authorities in the United States and European Union have not issued definitive guidance as to how to measure the efficacy of treatments for acute inner ear tinnitus or acute inner ear hearing loss, and regulators have not yet established what is required to be demonstrated in a clinical trial in order to signify a clinically meaningful result and/or obtain marketing approval. We have designed our Phase 3 trials for Keyzilen™ and AM-111 to include endpoints that we believe are clinically justified and meaningful. Specifically with regard to Keyzilen™, the EMA indicated that a statistically significant improvement in tinnitus loudness that is supported by several secondary variables would demonstrate a clinically meaningful result. The FDA indicated that an improvement in tinnitus loudness supported by a co-primary efficacy point, such as the TFI questionnaire, would be clinically meaningful. The TACTT2 clinical trial with Keyzilen™ did not meet the two co-primary efficacy endpoints of statistically significant changes in tinnitus loudness and tinnitus burden compared to placebo. Additionally, no product has been approved for marketing based upon such guidance and we cannot be certain that Keyzilen™ will be approved even if it were to demonstrate such results in TACTT3, its second Phase 3 trial, in particular because of the results of TACTT2.

With regard to AM-111, the FDA and EMA have indicated that a 10 dB improvement in hearing thresholds is clinically significant, in line with clinical practice. However, no product has been approved for marketing based upon such guidance and we cannot be certain that AM-111 will be approved even if it were to demonstrate such results in its Phase 3 trial.

Some of our conclusions regarding the potential efficacy of Keyzilen™ in our completed TACTT2 clinical trial of Keyzilen™ for the treatment of acute inner ear tinnitus in certain subgroups are based on retrospective analyses of the results of these trials, which are generally considered less reliable indicators of efficacy than pre-specified analyses.

After determining that we did not achieve the co-primary efficacy endpoints in our completed TACTT2 clinical trial of Keyzilen™ for the treatment of acute inner ear tinnitus, we performed retrospective analyses that we believe show treatment effects on TFI in favor of Keyzilen™ in case of greater tinnitus severity at baseline. Although we believe that these additional analyses were warranted, a retrospective analysis performed after unblinding trial results can result in the introduction of bias if the analysis is inappropriately tailored or influenced by knowledge of the data and actual results. In particular, the analysis that resulted in a clinically meaningful effect being observed in active-treated patients who suffered from severe or extreme tinnitus poses greater risk of bias as such subgroup was not pre-specified in the trial design.

Because of these limitations, regulatory authorities typically give greatest weight to results from pre-specified analyses and less weight to results from post-hoc, retrospective analyses. As a result, even if TACTT3 provides confirmatory results for the subgroup of severe to extreme tinnitus, the TACTT2 results and the retrospective analysis could negatively impact the evaluation by the EMA or the FDA of our anticipated applications for marketing approval for Keyzilen™.

If Keyzilen™ is only shown to be efficacious in certain subgroups, such as patients with otitis media-related tinnitus or greater tinnitus severity, we may only be able to obtain approval for these limited patient populations, which would reduce the market potential for Keyzilen™ and could materially adversely affect our business, financial condition and results of operations.

While our TACTT2 clinical trial with Keyzilen™ did not meet the two co-primary efficacy endpoints of statistically significant changes in tinnitus loudness and tinnitus burden compared to placebo, we believe that the trial data show treatment effects on TFI in favor of Keyzilen™ for the subgroups of patients with otitis media-related tinnitus or greater tinnitus severity. As a result, our amended trial protocol for TACTT3 includes these two subgroups in confirmatory statistical testing along with the overall study population.

If the TACTT3 results were to show clinically meaningful treatment effects in these subgroups but fail to show efficacy in the overall study population, we may not be able to receive regulatory approval for a patient population that is as broad as originally intended. If Keyzilen™ were to receive marketing approval for these more limited patient populations, its market potential would be diminished. We currently have no products approved for sale and have invested a significant portion of our efforts and financial resources in the development of Keyzilen™, our lead product candidate. As a result, approval for a more limited patient population could materially adversely affect our business, financial condition and results of operations.

Safety issues with isomers of our product candidates or with approved products of third parties that are similar to our product candidates, could delay or prevent the regulatory approval process or result in restrictions on labeling.

Discovery of previously unknown problems, or increased focus on a known problem, with an approved product may result in restrictions on its permissible uses, including withdrawal of the medicine from the market. Esketamine, the active pharmaceutical ingredient of Keyzilen™, is an isomer of Ketamine, and may be affected by the safety of the drugs related to them. Although Ketamine has been used successfully in patients for many years, newly observed toxicities or worsening of known toxicities, in pre-clinical studies of, or in patients receiving, Ketamine, or reconsideration of known toxicities of Ketamine in the setting of new indications, could result in increased regulatory scrutiny of Keyzilen™. For example, Ketamine is regulated by the Drug Enforcement Administration, or DEA, under the Controlled Substances Act as a Schedule III drug. DEA scheduling is a separate process that can delay when a drug may become available to patients beyond a New Drug Application, or NDA approval date, and the timing and outcome of such DEA process is uncertain. Although we have observed no abuse liability associated with Keyzilen™ to date, if Keyzilen™ were to be scheduled under the Controlled Substances Act, such scheduling could negatively impact the ability or willingness of physicians to prescribe Keyzilen™ and our ability to commercialize it.

Our special protocol assessment agreement with the FDA for our Phase 3 study of Keyzilen™ does not guarantee any particular outcome from regulatory review, including ultimate approval and may not lead to a faster development or regulatory review or approval process.

We obtained agreement from the FDA on an SPA for the design of our U.S. Phase 3 trial of Keyzilen™. We also designed our Phase 3 clinical trials for Keyzilen™ based on scientific advice that we received from the EMA. The FDA's SPA process is designed to facilitate the FDA's review and approval of drugs by allowing the FDA to evaluate the proposed design and size of Phase 3 clinical trials that are intended to form the primary basis for determining a drug product's efficacy. Upon specific request by a clinical trial sponsor, the FDA will evaluate the protocol and respond to a sponsor's questions regarding, among other things, primary efficacy endpoints, trial conduct and data analysis, within 45 days of receipt of the request. The FDA ultimately assesses whether the protocol design and planned analysis of the trial are acceptable to support regulatory approval of the product candidate with respect to the effectiveness of the indication studied. All agreements and disagreements between the FDA and the sponsor regarding an SPA must be clearly documented in an SPA letter or the minutes of a meeting between the sponsor and the FDA. However, a SPA agreement does not guarantee approval of a product candidate, and even if the FDA agrees to the design, execution, and analysis proposed in protocols reviewed under the SPA process, the FDA may revoke or alter its agreement in certain circumstances. In particular, an SPA agreement is not binding on the FDA if public health concerns emerge that were unrecognized at the time of the SPA agreement, other new scientific concerns regarding product safety or efficacy arise, the sponsor company fails to comply with the agreed upon trial protocols, or the relevant data, assumptions or information provided by the sponsor in a request for the SPA change or are found to be false or omit relevant facts. In addition, even after an SPA agreement is finalized, the SPA agreement may be modified, and such modification will be deemed binding on the FDA review division, except under the circumstances described above, if the FDA and the sponsor agree in writing to modify the protocol and such modification is intended to improve the study. The FDA retains significant latitude and discretion in interpreting the terms of the SPA agreement and the data and results from any study that is the subject of the SPA agreement.

On August 18, 2016, we announced that the TACTT2 clinical trial with Keyzilen™ did not meet the two co-primary efficacy endpoints of statistically significant changes in tinnitus loudness and tinnitus burden compared to placebo. TACTT2 was designed as a randomized, double-blind, placebo-controlled trial in acute inner ear tinnitus following traumatic cochlear injury or otitis media. The trial was conducted primarily in North America and randomized 343 patients to receive either Keyzilen™ 0.87 mg/mL or placebo in a 3:2 ratio. Based on insights from our continuing analysis of the TACTT2 trial, we are submitting a protocol amendment to regulatory agencies in Europe for TACTT3, the ongoing second Phase 3 clinical trial with Keyzilen™. TACTT3 was originally designed as congruent with the design of TACTT2 regarding outcome measures and the patient population to be enrolled but it differed in that the improvement in the TFI score was not a co-primary efficacy endpoint, that it had a slightly smaller size (300 instead of 330 patients) and it also includes a separate stratum of patients suffering from post-acute inner ear tinnitus. In the amended trial protocol, the change in TFI score will be elevated from a key secondary endpoint to an alternate primary efficacy endpoint and the trial size will be increased by 60 patients in each of Stratum A (acute tinnitus stage) and Stratum B (post-acute tinnitus stage) to enhance statistical sensitivity to the effects of treatment. Additionally, in order to corroborate the TACTT2 results showing clinically meaningful treatment effect under the TFI over placebo for patients with otitis media-related tinnitus and greater tinnitus severity, the severity subgroup will be included in confirmatory statistical testing in TACTT3 along with the overall study population and the already pre-specified subgroup of patients with otitis media-related tinnitus.

We cannot be sure of how the FDA, EMA or other regulatory authorities will view the TACTT2 results, including the results that we believe show treatment effects on TFI in favor of Keyzilen™ for specific subgroups. Additionally, we cannot assure you that the protocol amendments to TACTT3 will be viewed favorably by the FDA, EMA or other regulatory authorities or that the TACTT3 clinical trial will succeed. We hope to apply for regulatory approval with the data from both the TACTT2 and TACTT3 clinical trials, but we have not spoken to the FDA, EMA or other regulatory authorities since obtaining the TACTT2 clinical trial results. These uncertainties could significantly delay or prevent any potential approval for Keyzilen™.

In addition, TACTT3 was not assessed by the FDA as part of the SPA process, and in spite of the congruence between the trials, we cannot exclude that even if TACTT3 is successful, the differences in outcomes between the two pivotal trials may affect the FDA's assessment (for example, from cultural differences in patient attitudes or perceptions as TACTT3 is being conducted outside North America). If the FDA revokes or alters its agreement under the SPA, or interprets the data collected from the clinical trials differently than we do, the FDA may not deem the data sufficient to support an application for regulatory approval. A revocation or alteration in our existing SPA could significantly delay or prevent approval of our application. Our SPA with the FDA and the scientific advice from the EMA does not ensure that Keyzilen™ will receive marketing approval or that the approval process will be faster than conventional regulatory procedures.

As a result, if TACTT3 is not successful, we may not be able to obtain marketing approval, and even if TACTT3 is successful, we may not be able to obtain marketing approval without any further data, which could materially adversely affect our business, financial condition and results of operations.

We do not have control over the actual number of study participants that are willing and eligible for enrollment in the open label follow-on safety studies, AMPACT1 and AMPACT2. Hence, the number of patients with safety data may fail to reach the levels specified and requested by the FDA.

The FDA has requested safety data from chronic intermittent use of Keyzilen™ by a minimum of 300 patients treated for six months and a minimum of 100 patients treated for one year, to support a new drug application filing for Keyzilen™ in the treatment of acute peripheral tinnitus. We are seeking to address this request by offering all participants completing the TACTT2 and TACTT3 studies and continuing to meet certain criteria the option to roll over into an open label follow-on safety study (AMPACT1 and AMPACT2, respectively) and receive up to three treatment cycles with Keyzilen™ over a period of up to nine months. Together with the three month TACTT study duration, this would cover up to 12 months of exposure. Since a higher than expected number of TACTT study participants has been willing and eligible for enrollment into the AMPACT studies so far, we reduced the number of available treatment cycles in AMPACT2 from three to one by way of a protocol amendment in the first quarter 2016 and are still confident of meeting the requested number of patients with chronic intermittent use data. However, we have no control over the actual number and over the number of treatment cycles that the AMPACT participants will choose. Hence the number of patients with safety data over six months and over 12 months may or may not reach the levels specified and requested by the FDA. In case of insufficient numbers, this will become a review issue at the time of the NDA submission. Although we plan to apply for an indication of acute inner ear tinnitus, rather than chronic inner ear tinnitus, we cannot ensure that the FDA will be satisfied with the data supporting our NDA if we are not able to enroll sufficient numbers of patients in AMPACT1 and AMPACT2.

Even if our product candidates obtain regulatory approval, we will be subject to ongoing obligations and continued regulatory review, which may result in significant additional expense. Additionally, our product candidates, if approved, could be subject to labeling and other restrictions and market withdrawal and we may be subject to penalties if we fail to comply with regulatory requirements or experience unanticipated problems with our products.

If marketing authorization is obtained for any of our product candidates, the product will remain subject to continual regulatory review and therefore authorization could be subsequently withdrawn or restricted. Any regulatory approvals that we receive for our product candidates may also be subject to limitations on the approved indicated uses for which the product may be marketed or to the conditions of approval, or contain requirements for potentially costly post-marketing testing, including Phase 4 clinical trials and surveillance to monitor the safety and efficacy of the product candidate. In addition, if the FDA or a comparable foreign regulatory authority approves any of our product candidates, we will be subject to ongoing regulatory obligations and oversight by regulatory authorities, including with respect to the manufacturing processes, labeling, packing, distribution, adverse event reporting, storage, advertising and marketing restrictions, and recordkeeping and, potentially, other post-marketing obligations, all of which may result in significant expense and limit our ability to commercialize such products. These requirements include submissions of safety and other post-marketing information and reports, registration, as well as continued compliance with cGMPs, cGDPs and cGCPs for any clinical trials that we conduct post-approval. Later discovery of previously unknown problems with a product, including adverse events of unanticipated severity or frequency, or with our third-party manufacturers or manufacturing processes, or failure to comply with regulatory requirements, may result in, among other things:

- restrictions on the marketing or manufacturing of the product, withdrawal of the product from the market, or voluntary or mandatory product recalls;
- fines, warning letters or holds on clinical trials;
- refusal by the FDA to approve pending applications or supplements to approved applications filed by us, or suspension or revocation of product license approvals;
- product seizure or detention, or refusal to permit the import or export of products; and
- injunctions or the imposition of civil or criminal penalties.

If any of these events occurs, our ability to sell such product may be impaired, and we may incur substantial additional expense to comply with regulatory requirements, which could materially adversely affect our business, financial condition and results of operations. The FDA's or any other regulatory authority's policies may change and additional government regulations may be enacted that could prevent, limit or delay regulatory approval of our product candidates. If we are slow or unable to adapt to changes in existing requirements or the adoption of new requirements or policies, or if we are not able to maintain regulatory compliance, we may lose any marketing approval that we may have obtained, which would adversely affect our business, prospects and ability to achieve or sustain profitability.

Enacted and future legislation may increase the difficulty and cost for us to obtain marketing approval of and commercialize our product candidates and may affect the prices we may set.

In the United States and the European Union, there have been a number of legislative and regulatory changes and proposed changes regarding the healthcare system. These changes could prevent or delay marketing approval of our product candidates, restrict or regulate post-approval activities and affect our ability to profitably sell any products for which we obtain marketing approval.

For example, in March 2010, President Obama signed into law the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act, or collectively, the Health Care Reform Law, a sweeping law intended to broaden access to health insurance, reduce or constrain the growth of healthcare spending, enhance remedies against fraud and abuse, add new transparency requirements for health care and health insurance industries, impose new taxes and fees on the health industry and impose additional health policy reforms. The Health Care Reform Law, among other things, increased rebates a manufacturer must pay to the Medicaid program, addressed a new methodology by which rebates owed by manufacturers under the Medicaid Drug Rebate Program are calculated for drugs that are inhaled, infused, instilled, implanted or injected, established a new Medicare Part D coverage gap discount program, in which manufacturers must provide 50% point-of-sale discounts on products covered under Part D and implemented payment system reforms including a national pilot program on payment bundling to encourage hospitals, physicians and other providers to improve the coordination, quality and efficiency of certain healthcare services through bundled payment models. Further, the new law imposed a significant annual fee on companies that manufacture or import branded prescription drug products, expanded eligibility criteria for Medicaid programs, and created a new Patient-Centered Outcomes Research Institute to oversee, identify priorities in, and conduct comparative clinical effectiveness research, along with funding for such research. Substantial new provisions affecting compliance were enacted, which may affect our business practices with health care practitioners. Although we will not know the full effects of the Health Care Reform Law until applicable federal and state agencies issue regulations or guidance under the law, the Health Care Reform Law appears likely to continue the pressure on pharmaceutical pricing and may also increase our regulatory burdens and operating costs. There have been judicial and Congressional challenges to certain aspects of the Health Care Reform Law, and we expect there will be additional challenges and amendments to the Health Care Reform Law in the future.

Moreover, other legislative changes have also been proposed and adopted in the United States since the Health Care Reform Law was enacted. On August 2, 2011, the Budget Control Act of 2011, among other things, created measures for spending reductions by Congress. A Joint Select Committee on Deficit Reduction, tasked with recommending a targeted deficit reduction of at least $1.2 trillion for the years 2013 through 2021, was unable to reach required goals, thereby triggering the legislation's automatic reduction to several government programs. This includes aggregate reductions to Medicare payments to providers of 2% per fiscal year, which went into effect on April 1, 2013 and, due to subsequent legislative amendments to the statute, will remain in effect through 2025 unless additional Congressional action is taken. On January 2, 2013, President Obama signed into law the American Taxpayer Relief Act of 2012, or the ATRA, which, among other things, further reduced Medicare payments to several providers, including hospitals, imaging centers and cancer treatment centers, and increased the statute of limitations period for the government to recover overpayments to providers from three to five years. These laws may result in additional reductions in Medicare and other health care funding, which could have a material adverse effect on our customers and accordingly, our financial operations. Additionally, there has been increasing legislative and enforcement interest in the United States with respect to specialty drug pricing practices. Specifically, there have been several recent U.S. Congressional inquiries and proposed bills designed to, among other things, bring more transparency to drug pricing, review the relationship between pricing and manufacturer patient programs, and reform government program reimbursement methodologies for drugs.

In the European Union, proposed new clinical trial regulations will centralize clinical trial approval, which eliminates redundancy, but in some cases this may extend timelines for clinical trial approvals due to potentially longer wait times. Proposals to require specific consents for use of data in research, among other measures, may increase the costs and timelines for our product development efforts. Austerity measures in certain European nations may also affect the prices we are able to seek if our products are approved, as discussed below.

Both in the United States and in the European Union, legislative and regulatory proposals have been made to expand post-approval requirements and restrict sales and promotional activities for pharmaceutical products. We do not know whether additional legislative changes will be enacted, or whether the regulations, guidance or interpretations will be changed, or what the impact of such changes on the marketing approvals of our product candidates, if any, may be.

Our relationships with customers and payors may be subject to applicable anti-kickback, fraud and abuse and other healthcare laws and regulations, which, if violated, could expose us to criminal sanctions, civil penalties, exclusion from government healthcare programs, contractual damages, reputational harm and diminished profits and future earnings, among other penalties.

Healthcare providers, payors and others play a primary role in the recommendation and prescription of any products for which we obtain marketing approval. Our future arrangements with third-party payors and customers may expose us to broadly applicable fraud and abuse and other healthcare laws and regulations, primarily in the United States, that may constrain the business or financial arrangements and relationships through which we market, sell and distribute our products for which we obtain marketing approval. Restrictions under applicable U.S. healthcare laws and regulations, include the following:

- the U.S. healthcare anti-kickback statute prohibits, among other things, persons from knowingly and willfully soliciting, offering, receiving or providing remuneration, directly or indirectly, in cash or in kind, to induce or reward either the referral of an individual for, or the purchase, order or recommendation of, any good or service, for which payment may be made under U.S. government healthcare programs such as Medicare and Medicaid;

- the U.S. False Claims Act imposes criminal and civil penalties, including civil whistleblower or qui tam actions, against individuals or entities for knowingly presenting, or causing to be presented, to the U.S. government, claims for payment that are false or fraudulent or making a false statement to avoid, decrease or conceal an obligation to pay money to the federal government;

- the U.S. Health Insurance Portability and Accountability Act of 1996, or HIPAA, imposes criminal and civil liability for executing a scheme to defraud any healthcare benefit program or making false statements relating to healthcare matters;

- HIPAA, as amended by the Health Information Technology for Economic and Clinical Health Act, imposes obligations, including mandatory contractual terms, with respect to safeguarding the privacy, security and transmission of individually identifiable health information;

- the transparency requirements under the Health Care Reform Law require manufacturers of drugs, devices, biologics and medical supplies to report to the U.S. Department of Health and Human Services information related to payments and other transfers of value made by such manufacturers to physicians and teaching hospitals, and ownership and investment interests held by physicians or their immediate family members; and

- analogous laws and regulations, such as state anti-kickback and false claims laws, may apply to sales or marketing arrangements and claims involving healthcare items or services reimbursed by non-governmental third-party payors, including private insurers, and some state laws require pharmaceutical companies to comply with the pharmaceutical industry's voluntary compliance guidelines and the relevant compliance guidance promulgated by the federal government in addition to requiring manufacturers to report information related to payments to physicians and other health care providers or marketing expenditures.

Similar laws exist in other jurisdictions.

Because of the breadth of these laws and the narrowness of the statutory exceptions and safe harbors available under the U.S. federal Anti-Kickback Statute, it is possible that some of our future business activities could be subject to challenge under one or more of such laws. In addition, recent health care reform legislation has strengthened these laws. For example, the Health Care Reform Law, among other things, amends the intent requirement of the federal anti-kickback and criminal healthcare fraud statutes. A person or entity no longer needs to have actual knowledge of this statute or specific intent to violate it. Moreover, the Health Care Reform Law provides that the government may assert that a claim including items or services resulting from a violation of the federal anti-kickback statute constitutes a false or fraudulent claim for purposes of the False Claims Act.

Efforts to ensure that our business arrangements with third parties will comply with applicable healthcare laws and regulations will involve substantial costs. It is possible that governmental authorities will conclude that our business practices may not comply with current or future statutes, regulations or case law involving applicable fraud and abuse or other healthcare laws and regulations. If our operations are found to be in violation of any of these laws or any other governmental regulations that may apply to us, we may be subject to significant civil, criminal and administrative penalties, damages, fines, exclusion from U.S. government funded healthcare programs, such as Medicare and Medicaid, and the curtailment or restructuring of our operations. If any of the physicians or other providers or entities with whom we expect to do business with are found to be not in compliance with applicable laws, they may be subject to criminal, civil or administrative sanctions, including exclusions from government funded healthcare programs.

Auris Medical News Release

Auris Medical Provides Business Update and Reports Third Quarter 2016 Financial Results

- *AM-111 Phase 3 program for acute inner ear hearing loss is ongoing*
- *Amended TACTT3 trial of Keyzilen™ provides clear path forward for acute inner ear tinnitus program*
- *Conference call today at 8 am Eastern Time*

Zug, Switzerland, Nov. 10, 2016 – Auris Medical Holding AG (NASDAQ: EARS), a clinical-stage company dedicated to developing therapeutics that address important unmet medical needs in otolaryngology, today provided a business update and announced financial results for the third quarter ended Sept. 30, 2016.

"We are focused on the efficient execution of our two Phase 3 programs for acute inner ear hearing loss and tinnitus," commented Thomas Meyer, Auris Medical's founder, Chairman and Chief Executive Officer. "With AM-111 for acute inner ear hearing loss, we continue to progress with enrollment for the HEALOS trial and expect top-line results in the second half of next year. As we communicated recently for the Keyzilen™ program for acute inner ear tinnitus, we are implementing changes to the TACTT3 protocol based on findings from TACTT2 and working toward continuation of patient enrollment. We very much appreciate the continued strong interest and encouragement from the tinnitus community and remain fully committed to bringing Keyzilen™ to patients."

Development Program Updates

AM-111 for Acute Inner Ear Hearing Loss

- Surpassed the enrollment midpoint in the Phase 3 HEALOS trial, which is being conducted in several European and Asian countries. The trial aims to enroll approximately 255 patients with severe to profound idiopathic sudden sensorineural hearing loss. Top-line results from this trial are expected in the second half of 2017 as per previous guidance.
- Continued ramp-up of the Phase 3 ASSENT trial, which is being conducted in the U.S., Canada and South Korea. The trial aims to enroll approximately 300 patients with severe to profound idiopathic sudden sensorineural hearing loss. Top-line results from this trial are expected in the first half of 2018.

Keyzilen™ (AM-101) for Acute Inner Ear Tinnitus

- Announced additional results from the Phase 3 TACTT2 trial. Although the trial did not meet its co-primary efficacy endpoints, the data show greater improvements as compared to placebo in the Tinnitus Functional Index (TFI) for active-treated patients who suffered from tinnitus following otitis media and who suffered from severe or extreme tinnitus.

- Submitted a protocol amendment to regulatory agencies in Europe for the TACTT3 trial. Under the amendment, the TFI will be elevated from a key secondary endpoint to an alternate primary endpoint, patient subgroups (for patients with tinnitus following otitis media and patients with severe or extreme tinnitus), will be included in confirmatory testing and 60 additional patients will be recruited in each of Stratum A and Stratum B. Auris Medical expects to resume enrollment in the TACTT3 trial in early 2017 and announce top-line results from the expanded trial in early 2018.

- Prepared for a Type C Meeting with the U.S. Food and Drug Administration scheduled for early December 2016. Auris Medical seeks feedback from the FDA on the outcomes from the TACTT2 trial, the changes to the TACTT3 protocol and the regulatory path forward.

- Participated in the 2016 Annual Meeting & OTO EXPO^{SM} of the American Academy of Otolaryngology-Head and Neck Surgery Foundation (AAO-HNSF) in San Diego. During the meeting, Hinrich Staecker, MD, PhD, presented the favorable safety outcomes from the TACTT2 trial, and Auris Medical hosted a corporate symposium featuring several experts in the field of tinnitus research.

Management Team Update

- Appointed Hernan Levett as Chief Financial Officer. Mr. Levett will join Auris Medical in January 2017. He is currently Head of Group Controlling at Acino Pharma AG and previously served as Vice President of Finance and Administration Europe at InterMune International AG. In addition, he spent 10 years at Novartis, most recently as Chief Financial Officer of Novartis Chile SA.

Third Quarter 2016 Financial Results

- Cash and cash equivalents at Sept. 30, 2016, totaled CHF 37.5 million.

- Total operating expenses for the third quarter of 2016 were CHF 7.5 million compared to CHF 7.2 million for the third quarter of 2015.

- Research and development expenses for the third quarter of 2016 were CHF 6.3 million compared to CHF 5.9 million for the third quarter of 2015.

- General and administrative expenses for the third quarter of 2016 were CHF 1.2 million compared to CHF 1.3 million for the third quarter of 2015.

- Net loss for the third quarter of 2016 was CHF 7.9 million, or CHF 0.23 per share, compared to CHF 5.2 million, or CHF 0.15 per share, for the third quarter of 2015. Net loss for the third quarter of 2016 includes interest expense of 0.4 million payable under the loan agreement with Hercules Capital, Inc., and a net unrealized foreign currency exchange loss of CHF 0.2 million, which compares to a foreign currency exchange gain of CHF 2.0 million in the third quarter of 2015.

The Company continues to expect that its operating expenses in 2016 will be in the range of CHF 33.0 to 38.0 million. Existing cash and cash equivalents are expected to enable the funding of operations until fall 2017.

Today's Conference Call & Webcast Information

Auris Medical will host a conference call and webcast to discuss the third quarter 2016 financial results and to provide a general business update today, Nov. 10, 2016, at 8:00 am Eastern Time (2:00 pm Central European Time). To participate in this conference call, dial 1-877-280-3459 (USA) or +1-646-254-3373 (International), and enter passcode 6069780. A live webcast of the conference call will be available in the Investor Relations section of the Auris Medical website at www.aurismedical.com and a replay of the conference call will be available following the live call.

About Auris Medical

Auris Medical is a Swiss biopharmaceutical company dedicated to developing therapeutics that address important unmet medical needs in otolaryngology. The Company is currently focusing on the Phase 3 development of treatments for acute inner ear tinnitus (Keyzilen™; AM-101) and for acute inner ear hearing loss (AM-111) by way of intratympanic administration with biocompatible gel formulations. In addition, Auris Medical is pursuing early-stage research and development projects. The Company was founded in 2003 and is headquartered in Zug, Switzerland. The shares of the parent company Auris Medical Holding AG trade on the NASDAQ Global Market under the symbol "EARS."

Forward-looking Statements

This press release may contain statements that constitute "forward-looking statements" within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934. Forward-looking statements are statements other than historical fact and may include statements that address future operating, financial or business performance or Auris Medical's strategies or expectations. In some cases, you can identify these statements by forward-looking words such as "may," "might," "will," "should," "expects," "plans," "anticipates," "believes," "estimates," "predicts," "projects," "potential," "outlook" or "continue," and other comparable terminology. Forward-looking statements are based on management's current expectations and beliefs and involve significant risks and uncertainties that could cause actual results, developments and business decisions to differ materially from those contemplated by these statements. These risks and uncertainties include, but are not limited to, the timing and conduct of clinical trials of Auris Medical's product candidates, including the likelihood that the TACTT3 clinical trial with Keyzilen™ will not meet its endpoints, the clinical utility of Auris Medical's product candidates, the timing or likelihood of regulatory filings and approvals, Auris Medical's intellectual property position and Auris Medical's financial position, including the impact of any future acquisitions, dispositions, partnerships, license transactions or changes to Auris Medical's capital structure, including future securities offerings. These risks and uncertainties also include, but are not limited to, those described under the caption "Risk Factors" in Auris Medical's Annual Report on Form 20-F and future filings with the Securities and Exchange Commission. Forward-looking statements speak only as of the date they are made, and Auris Medical does not undertake any obligation to update them in light of new information, future developments or otherwise, except as may be required under applicable law. All forward-looking statements are qualified in their entirety by this cautionary statement.

Company contact: Cindy McGee, Head of Investor Relations and Corporate Communications, +41 61 201 13 50, investors@aurismedical.com

Media contact: David Schull, Russo Partners, 1-858-717-2310, david.schull@russopartnersllc.com

Auris Medical Holding AG

Condensed Consolidated Interim Statement of Loss and Other Comprehensive Loss (unaudited)
(in CHF)

	THREE MONTHS ENDED SEPTEMBER 30,		NINE MONTHS ENDED SEPTEMBER 30,	
	2016	**2015**	**2016**	**2015**
Research and development	-6,344,600	-5,884,313	-19,763,338	-20,865,100
General and administrative	-1,197,541	-1,326,750	-4,144,687	-3,236,856
Operating loss	**-7,542,141**	**-7,211,063**	**-23,908,025**	**-24,101,956**
Interest income	18,118	12,873	44,284	23,141
Interest expense	-404,453	-1,608	-409,712	-6,212
Foreign currency exchange gain/(loss), net	-191,687	1,988,870	-1,177,624	-136,438
Revaluation gain/(loss) from derivative financial instrument	228,190	-	228,190	-
Loss before tax	**-7,891,973**	**-5,210,928**	**-25,222,887**	**-24,221,465**
Income tax expense	-	-	-	-
Net loss attributable to owners of the Company	**-7,891,973**	**-5,210,928**	**-25,222,887**	**-24,221,465**
Other comprehensive loss:				
Items that will never be reclassified to profit or loss				
Remeasurement of defined benefit liability, net of taxes of CHF 0	23,412	-3,792	-584,455	-232,962
Items that are or may be reclassified to profit or loss				
Foreign currency translation differences, net of taxes of CHF 0	5,968	-40,524	31,932	16,339
Other comprehensive income/(loss), net of taxes of CHF 0	**29,380**	**-44,316**	**-552,523**	**-216,623**
Total comprehensive loss attributable to owners of the Company	**-7,862,593**	**-5,255,244**	**-25,775,410**	**-24,438,088**
Basic and diluted loss per share	-0.23	-0.15	-0.73	-0.76

Auris Medical Holding AG

Condensed Consolidated Interim Statement of Financial Position (unaudited)
(in CHF)

	SEPTEMBER 30, 2016	DECEMBER 31, 2015
ASSETS		
Non-current assets		
Property and equipment	161,960	222,570
Intangible assets	1,482,520	1,482,520
Other non-current receivables	114,766	38,066
Total non-current assets	**1,759,246**	**1,743,156**
Current assets		
Other receivables	1,449,480	650,716
Prepayments	261,669	181,044
Cash and cash equivalents	37,526,723	50,237,300
Total current assets	**39,237,872**	**51,069,060**
Total assets	**40,997,118**	**52,812,216**
EQUITY AND LIABILITIES		
Equity		
Share capital	13,731,881	13,721,556
Share premium	112,838,815	112,662,910
Foreign currency translation reserve	-31,889	-63,821
Accumulated deficit	-107,201,111	-81,578,733
Total shareholders' equity attributable to owners of the Company	**19,337,696**	**44,741,912**
Non-current liabilities		
Loan	10,630,681	-
Derivative financial instrument	177,650	-
Employee benefits	2,250,936	1,575,833
Deferred tax liabilities	327,637	327,637
Total non-current liabilities	**13,386,904**	**1,903,470**
Current liabilities		
Loan	1,042,736	-
Trade and other payables	1,613,602	1,205,522
Accrued expenses	5,616,180	4,961,312
Total current liabilities	**8,272,518**	**6,166,834**
Total liabilities	**21,659,422**	**8,070,304**
Total equity and liabilities	**40,997,118**	**52,812,216**