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OPERATOR: Good afternoon, ladies and gentlemen. Welcome to the Allon Therapeutics Inc. Conference Call. At this time, all participants are in a listen-only mode. Later, we will conduct a question and answer session with instructions provided. If anyone has any difficulties hearing the conference, please press star, zero for Operator assistance at any time. I would like to remind everyone that this conference call is being recorded today, Thursday, July 9th, 2009, at 4:30 p.m. Eastern Time.

And I would now like to turn the conference over to Mr. Matthew Carlyle, Chief Financial Officer. Please go ahead, sir.

MATTHEW CARLYLE (Chief Financial Officer, Allon Therapeutics Inc.). Thank you. Good afternoon. As the Operator said, my name is Matthew Carlyle, and I'm the Chief Financial Officer at Allon. Thank you for joining us today for Allon Therapeutics' teleconference and webcast reviewing the positive top-line Phase IIa clinical trial results we released earlier today. Our trial evaluated the Company's lead neuroprotective drug candidate, davunetide intranasal, as a potential treatment for schizophrenia-related cognitive impairment.

With me today are Gordon McCauley, President and CEO; Dr. Bruce Morimoto, Vice President of Drug Development; and Dr. Steve Whitaker, Vice President, Clinical Development and Chief Medical Officer. On the

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call today, Gordon will review the highlights of the results and our next steps. Bruce will run through the trial design and top-line results. Steve will discuss our clinical development plans in the schizophrenia-related cognitive impairment indication, and then we will open up the call for your questions.

The TURNS consortium fully intends to present and publish this data at an appropriate forum. As is often customary, they are not participating in Allon's public disclosure. If you have not yet received a copy of our news release, you can find it by visiting our website at *allontherapeutics.com*. This conference call is being webcast live, and will be recorded and available on our website.

Before starting today, we do want to remind listeners that our presentation and, more than likely, some of our responses to your questions will take us beyond what are strictly historical fact statements. Therefore, we want to open today with a short, general forward-looking commentary disclaimer. When listening today, you must take into account the risks inherent in the drug development business, which, we believe, our written disclosures and filings articulate reasonably well. They can be found at *sedar.com*, our regulatory website which is linked from our website.

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With this caveat in mind, I'd like to begin. So, now, over to Gordon.

GORDON McCAULEY (President and Chief Executive Officer, Allon Therapeutics Inc.): Thanks, Matt. And good afternoon, everyone, and thank you for joining us today. Today is another important day for Allon and our shareholders, and we think also for schizophrenia patients, their families, physicians, and caregivers. Today we're announcing top-line results from an exploratory Phase IIa clinical trial, showing the Company's lead neuroprotective drug candidate, davunetide, which was previously called AL-108, has a positive impact on the functional capacity of schizophrenia patients, statistically significant efficacy, with a P value of 0.015 was achieved on the University of California at San Diego Performance-based Skills Assessment, known as the UPSA scale.

The UPSA scale assesses a functional capacity of skills for daily living, such as managing medication, money, transportation, and household chores as well as communication and overall comprehension and planning. The UPSA scale has been recognized by regulators as a co-primary endpoint in pivotal trials for any drug seeking approval in schizophrenia-related cognitive impairment. More importantly, the UPSA scale correlates to a schizophrenia patient's capacity to live independently.

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The trial results reconfirmed the potential of davunetide to treat patients suffering cognitive impairment. I say “reconfirm” because in 2008, we reported Phase IIa data showing that davunetide had a statistically significant dose-dependent and durable impact on memory function in patients with amnesic mild cognitive impairment, a precursor to Alzheimer’s disease.

The trial we’re reporting today was managed by some of the leading academic clinicians in psychiatric practice and schizophrenia research. Of course, I’m referring to the organization known as TURNS, which stands for Treatment Units for Research on Neurocognition and Schizophrenia, and its member medical centres and clinicians. TURNS reviewed our large body of preclinical research and the mechanism by which we believe this drug is working, and saw real potential for schizophrenia patients. Given that potential, TURNS offered to conduct and substantively fund the trial with significant support from the United States National Institute of Mental Health.

As Matt said, the TURNS group intends to present and publish the full results for this study. And we expect that it will justify attention at a major forum. Until then, these top-line results and the forthcoming top-line results from the small imaging companion study are the only data

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available. Of course, we're sharing them today to meet our public disclosure obligations. As I just mentioned, in addition to this trial, TURNS and Allon collaborated on a companion study looking at changes in brain imaging in a small subset of the patients. Analysis of the imaging—images from this study has neither been completed nor shared with the Company. Of course, we anticipate public disclosure of these findings in due course when they're received.

At this point, I'd like to ask Bruce Morimoto, our V.P. of Drug Development, to review the trial design and top-line results.

DR. BRUCE MORIMOTO, Ph.D (Vice President of Drug Development, Allon Therapeutics Inc.): Thank you, Gordon. Let me begin by providing a brief description of the trial design. This Phase IIa clinical trial was a randomized double-blind placebo-controlled study to assess the effect of davunetide in patients with schizophrenia-related cognitive impairment. All patients were on a stable dose of an improved antipsychotic. Two doses of davunetide intranasal, 5 milligrams once a day or 15 milligrams twice a day, were compared to placebo. Patients were treated for 12 weeks with cognitive assessment at baseline, six and 12 weeks. The primary endpoint was the matrix composite cognitive battery. Secondary endpoints included functional assessments as well as

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general safety assessments. A total of 54 patients completed the trial at seven medical institutions in the United States. A list of those sites is published in our news release.

And now, on to the top-line results. A potential treatment effect on matrix was observed, but statistical significance was not achieved. On UPISA, a scale FDA recognizes as an important co-primary endpoint, davunetide had a positive and statistically significant impact on functional capacity. The UPISA scale was developed specifically to assess the functional capacity of schizophrenia patients in which daily living skills are assessed in a standardized role play situation. This functional test requires integration of multiple cognitive domains to complete the task. This functional impairment significantly affects a schizophrenic's quality of life, and improvement on the UPISA scale reflects the potential for independent living.

From a safety perspective, this Phase IIa clinical trial demonstrated that davunetide continues to be safe and well tolerated, with adverse events typical of this patient population. In this context, the trial also examined the impact of davunetide on psychosis and, as expected, no treatment effect was observed. We are encouraged by the results of this highly (phon) clinical trial on schizophrenia patients. Just as we observed

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last year in our proof of concept trial of amnestic mild cognitive impairment patients, davunetide has the potential to affect neurocognition and now function in a relatively short treatment period.

With that, let me hand things over to Steve Whitaker, Allon's Chief Medical Officer, for some comments about the schizophrenia-related cognitive impairment indication and our future clinical plans. Steve?

DR. J. STEVEN WHITAKER, M.D., J.D. (Vice President, Clinical Development and Chief Medical Officer): Thanks, Bruce. Schizophrenia is a devastating medical condition. More than 2 million people in North America suffer from schizophrenia, a disease that includes psychotic episodes and cognitive impairment. Most people are familiar with the symptoms of the psychosis of schizophrenia, such as hallucinations and delusions. Currently available antipsychotic drugs target these symptoms, and cognitive impairment is more constant and persistent in periods of psychosis. Cognitive impairment causes the greatest disability for many patients. It impacts the functional capacity for daily living, affecting simple tasks that most of us take for granted. Obviously, these impairments affect social functioning, employability, and success in rehabilitation programs. The cognitive impairment underlies many of the barriers faced daily by schizophrenia patients and is the source of tremendous societal cost.

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Cognitive impairments are common at the onset of schizophrenia and can frequently be identified before psychotic symptoms emerge. In contrast to psychotic symptoms which are typically at the site (phon), impairments in cognition appear to be a chronic feature of the illness. We believe that davunetide works by restoring the function of structures known as microtubules which are damaged in the brains of patients with Alzheimer's disease and schizophrenia. It's significant that while there are sales of \$4 billion to treat the psychosis associated with schizophrenia, there are no approved drugs treating schizophrenia-related cognitive impairment. We believe these trial results demonstrate the potential of davunetide to be that first drug. We'll be working with experts in the field to help us determine what our next step should be.

Obviously, similar to the situation of an Alzheimer's program, a larger Phase IIb trial in this patient population needs to be done to fully define the potential of the drug. As we reported last month, we also believe that there are sufficient data and rationale to conduct a Phase II trial to evaluate whether davunetide has the potential to become the first effective treatment for a number of brain disorders broadly characterized as frontotemporal dementia. We expect to begin this study in the second half of 2009. This is an exciting position in drug development with great

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potential to treat three disease, Alzheimer's disease, schizophrenia-related cognitive impairment, and frontotemporal dementia, with a mechanism with the potential for disease modification.

With that, I'll hand it back to Gordon.

GORDON McCAULEY: Thanks, Steve. Before moving on to questions, let me wrap up with a few thoughts. First, our collaboration with TURNS is a wonderful example of an effective public policy investment in drug development. Without the encouragement and expertise of the TURNS consortium and the substantial financial support from the U.S. National Institute of Mental Health, we would never have embarked on this study. We did embark on this trial because of our corporate strategy to add value to our clinical assets by testing for, and as it turns out, showing human efficacy in multiple large neurodegenerative diseases for which treatments are not currently available or for which treatments only modify symptoms, not the disease itself. With the support of TURNS and the NIMH, this clinical trial was an efficient way for us to explore further potential for davunetide and reconfirm its impact in humans.

Even so, given the challenges of this patient population, the small groups of about 20 subjects, a short treatment duration of 12 weeks, and the numerous studies that have failed in schizophrenia cognition, we had

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very, very low expectations for this trial. And yet, here we are, with statistically significant data and a recognized endpoint, that these trials ought to give hope to patients with Alzheimer's or schizophrenia because they suggest that this could be the first therapy, in either indication, to impact the disease course itself and not just the symptoms. However, we need to be careful about raising hopes for a development stage product. We still have lots of confirmatory development work to do. Furthermore, in this economic climate, we need to continue to manage our financial resources effectively and make our resource allocation decisions carefully.

Third, as you know, we're in partnership discussions with several companies. We believe that prospective partners will look at this new dataset with great interest as they evaluate the potential of davunetide in Alzheimer's and now schizophrenia as well. We do expect the Phase IIb trials in Alzheimer's and schizophrenia will be defined in collaboration with a partner. While those discussions advance, we will prepare to commence the Phase II trial in FTD later on this year. Obviously, we have some important decisions to make.

Finally, the trial results announced today put us in an enviable position for an emerging drug development company. When patients with a cognitive deficit use our drug, we see statistically significant results.

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These results have been generated and trialed into two major unmet medical needs, Alzheimer's and schizophrenia cognition, and these results suggest significant promise in a third unmet medical need, frontotemporal dementia. We look forward to using this enviable position to create more value for our shareholders and hope for patients and their families.

So, with those comments, we'll ask the moderator to take us into Q&A session. Operator?

OPERATOR: Thank you very much. Ladies and gentlemen, we will now conduct the question and answer session. If you do have a question, please press the star followed by the one on your touchtone phone. You will hear a tone acknowledging your request. Your questions will be polled in the order they are received. Please ensure you lift the handset, if you are using a speaker phone, before pressing any keys.

Your first question today comes from Cosme Ordonez of GMP Securities. Please go ahead.

COSME ORDONEZ: Thank you. Gordon, could you try to explain to us why the drug shows significant effect? We see UPSA methodology and no metrics, and specifically, what are the differences between the two methodologies, and which one of the two, in the opinion of your team, carries the most weight with the FDA as an endpoint?

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GORDON McCAULEY: Thanks, Cosme. It's a great question, and I'll obviously ask Bruce to comment in more specific on the question. From our perspective, I think if you step back and say, what do we want to achieve with this study, this was an exploratory study to see if the drug has a statistically significant impact in this population, or a biological effect in this population. And the answer is clearly, yes. When you look at the UPSA, it is an important measure of functional capacity for patients and it is an endpoint that the FDA has identified as a potential or pivotal—co-primary endpoint in pivotal studies. The matrix has very important learning in it as well. But maybe what I'll do is ask Bruce to comment on the distinction between the two and how they—how we see them interrelating.

DR. BRUCE MORIMOTO, Ph.D: Sure. So, as you know, the FDA's perspective on approval of drugs in this indication as well as Alzheimer's is that they want to see changes both on cognitive domains, but that the changes also relate to a functional or clinical improvement in that patient. What has us very excited about the results that we're seeing today is that our drug, davunetide, is having an effect on this functional assessment, the UPSA. Now, as you can imagine, in order to perform the type of tasks that are being challenged in the UPSA, a person needs to integrate a number of different cognitive domains, and they have to process that information in

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order to perform the tasks that they're being asked to, so that's really quite interesting in that there's a benefit on more of a global central effect in order to give rise to this statistically significant effect we're seeing on the UPSA.

COSME ORDONEZ: With regard to metrics, this one, you mentioned it's about your tests and not fully aware of what these tests are and how do they work, what are the logistics and all these things are measured, but I would have guessed that functionality is something that is measured in some of these tests, but that's not the case?

DR. BRUCE MORIMOTO, Ph.D: I think that the UPSA test kind of steps back and looks at the global function of the individual and how the drug might have—be having an effect on, really, a lot of different domains, some that are covered by the matrix test battery but others that are not necessarily captured by that battery.

GORDON McCAULEY: The other thing that you might take from these results today is, it may be the case that the UPSA is more sensitive to davunetide, and that in order to show significance on a scale-like matrix, we need a longer treatment duration.

COSME ORDONEZ: That's another question that I had. I mean, the cutoff, periods of treatment here, the measurements, was on six and

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12 weeks, which seems like a rather short period of time. Why is the parameters (phon)—what is the hypothesis for mechanism of action of the drug where you can achieve a therapeutic effect in such a short period of time?

GORDON McCAULEY: So, the—again, the objective of the study was to show a biological effect in humans to help us learn more about how the drug would be working in this population in order to design further studies. Maybe I'll ask Bruce to go through the hypothesis that TURNS used to choose this program in the first place.

DR. BRUCE MORIMOTO, Ph.D: Right. I guess what the results from this study as well as the ones that we presented last year on the amnesic MCI patient, really is telling us to rethink how we view disease-modifying therapeutics. There's a common thought that disease-modifying therapeutics require long treatment periods in order to see some type of clinical benefit. I think what this trial as well as our amnesic MCI trial is telling us is that that's not necessarily the way that we think about it, and that if we look at both Alzheimer's disease as well as schizophrenia, the underlying pathology, which is the collapse of cellular structure microtubules that leads to both the functional and structural impairment that's associated with that, that our compound has an effect on that sort of

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central mechanism, hence, it's having a benefit in both the amnestic MCI population and now what we're seeing in the schizophrenic population.

COSME ORDONEZ: My last question is with regard to TURNS. Are you expecting them to continue to participate in the future clinical development, or is Allon going to take over the program?

GORDON McCAULEY: I think the intent behind TURNS and the NIMH support is to act as a catalyst to move compounds into this disease indication that otherwise wouldn't have. And, as I said in my comments, this is a perfect example of one where we would not have run the study if they hadn't operated (phon) for us and substantively paid for it. So, our expectation is that now they will step back and they would—they would expect more direct participation by the—by the Company. But, again, that's their basic role, so it's worked quite perfectly for them and for us.

COSME ORDONEZ: Would any of you guys take the helm of these programs, will TURNS still participate, or they are essentially out?

GORDON McCAULEY: I think, as we understand it, their role is done in this kind of study. They wanted to see if there was an effect, and understand the fact they've done that part, now they're kind of handing it back to us and saying, "Okay, you folks carry forward."

COSME ORDONEZ: Okay. Thank you very much.

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GORDON McCAULEY: Thank you.

OPERATOR: Your next question comes from Neil Maruoka of Canaccord Adams. Please go ahead.

NEIL MARUOKA: Good afternoon. Thanks for taking the question. Just a little bit more on the—on the endpoints. You talked a little bit about UPSA and its relationship with cognitive function, is there any more firm relationships—can you—can you look at UPSA and make any more conclusions on its impact on cognitive improvement as opposed to—as opposed to just the functional measurements?

GORDON McCAULEY: I think—I think we have to be careful in asking a small exploratory two-way study to tell us too much. But, again, the original objective was, is there a biological effect here, and the answer is, clearly, yes. And as we look at the UPSA, and as Bruce described, in the different cognitive, (unintelligible) of different cognitive functions is necessary there, we think is quite interesting. But I think we have to be careful in relatively small group sizes in trying to take too much specific learning from it.

NEIL MARUOKA: Okay. And on matrix, it is a battery of tests, similar to your analysis of your MCI study. Would—did you see any trends in the individual tests that you can comment on?

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GORDON McCAULEY: We're not in a position to talk about the specific details other than what we've disclosed today. Obviously, TURNS wants to preserve the opportunity to present and publish this data, and we want to make sure that they have the opportunity to do that. So, we've just released the top-line data, and that's all we can talk about today.

NEIL MARUOKA: Okay. All right, I understand. Thanks a lot.

OPERATOR: Ladies and gentlemen, if there are any additional questions at this time, please press the star followed by the one.

UNIDENTIFIED SPEAKER: Oh, another line.

OPERATOR: Your next question is a follow-up from Cosme Ordonez of GMP Securities. Please go ahead.

COSME ORDONEZ: Thank you. Gordon, you mentioned that this is also an interesting concept of principle to discuss with your potential partners. Is this something that you are planning to initiate now, or are your current partner discussions taking into consideration this program as well?

GORDON McCAULEY: Realize, Cosme, it took you four questions to get to partners. The—look, we think this is very interesting data. When you look at the universe of prospective partners, the ones we're most advanced with are, obviously, those that are more focused on neurology,

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and I think that the immediate impact of this kind of data would be in those folks that have a pure neurology focus. You know, would we reach out to folks with a more pure psychiatry focus? Of course, and we look forward to telling you more about that when we have more to say.

COSME ORDONEZ: But, initially, this has not been part of the discussion, of the presentations, of course, that data is new.

GORDON McCAULEY: I mean, look, everybody knew we were running the study, obviously, but given that it was an exploratory study until we actually had hard data, it was pretty hard to talk about it substantively.

COSME ORDONEZ: Understand, understand. And, any comments, now that I have you on the topic, on the potential partnership for the Alzheimer's program?

GORDON McCAULEY: I think that we will continue the discussions we've been having, and look forward to telling you more about it when we can tell you more about it.

COSME ORDONEZ: All right. Thank you very much.

GORDON McCAULEY: Thank you.

OPERATOR: And your next question comes from Mr. Doug Loe of Versant Partners. Please go ahead.

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DOUG LOE: Yes, thanks very much. And good afternoon, gentlemen. Just a housekeeping question, you indicated that the drug performed to a statistically significant measure on the UPSA score, but you didn't indicate whether that was—that's a blended analysis of all doses or just at the high dose?

GORDON McCAULEY: What we are in a position to talk about is the data that's been disclosed here, again, to give TURNS the opportunity to present it and have it published on a peer review basis. So, we're not in a spot to go into more detail than we have.

DOUG LOE: Fair enough. Okay, thanks.

GORDON McCAULEY: Thank you.

OPERATOR: Mr. Carlyle, there are no further questions at this time. Please continue.

MATTHEW CARLYLE: Thank you, everyone, for joining us today on the call. If there are any additional questions or follow-up later in the day, Gordon, Bruce, Steve, and I will be available in the office, so feel free to get in touch with us. Thank you again.

GORDON McCAULEY: Thanks very much.

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OPERATOR: Ladies and gentlemen, this concludes the conference call for today. Thank you for your participation. You may now disconnect your lines.

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