Diurnal Group

11 November 2020

Share Price	**53.5p**
CP Fair Value	**99p**

Market Cap (£m)	74
Net Cash (£m)	15
Enterprise Value (£m)	59

Country	UK
Code	DNL
Index	FTSE AIM

Source: Calvine Partners Research

Shifting gear

With Diurnal's focus on endocrine disorders, the initial target has been addressing conditions characterised by low levels of cortisol. Alkindi is already approved for paediatric adrenal insufficiency, while Chronocort has been filed in Europe for the orphan indication of congenital adrenal hyperplasia. With the recent fundraising and the confirmation of a truncated development pathway, Diurnal's native testosterone preparation, DITEST, has come to the fore. Although testosterone replacement therapy (TRT) has been used successfully for many decades, recent product developments have been fraught with disappointment. As a result, we believe little value is being attributed to Diurnal's programme despite the substantial market opportunity and DITEST's encouraging proof of concept data.

Pipeline potential

Diurnal has ambitions to become a leading (non-diabetes) endocrinology specialty pharma business. First up has been the development and approval of Alkindi in Europe and the US. Meanwhile, Chronocort is moving towards a regulatory conclusion at the EMA in Q1 2021. Successful execution of the adrenal franchise will be critical for Diurnal to achieve sustainable profitability; however, it is important not to overlook the advancing pipeline at Diurnal. In particular, we would highlight the potential for DITEST in the large TRT market for the treatment of hypogonadal men with low testosterone levels. This looks like a straightforward proposition, administering testosterone and returning to normal physiological levels. However, testosterone suffers from poor bioavailability, and non-oral therapies have dominated the market. Unsurprisingly, given the potential to transform TRT market dynamics, there have been various efforts to develop oral treatments. However, efforts have been more protracted than anticipated, and approval has been significantly delayed (Jatenzo) or as yet unattainable (Tlando). We believe that there are reasons to be more optimistic regarding DITEST and the hypogonadism segment generally.

DITEST could be best-in-class

Recent TRT development efforts have been undone by the desire to gain approval for the broader low testosterone segment including those with idiopathic origin. Due to the safety profile, the FDA has narrowed TRT's applicability only to those with a specific medical condition, resulting in the off-label treatment of ageing males with low testosterone levels. This highlights a large unmet need, with requirement for safer, more convenient alternatives - we believe DITEST shows potential to provide a best-in-class addition. With a streamlined branded generic regulatory pathway, we look forward to the attraction of a suitable partner to progress DITEST for classical male hypogonadism. (For Risks see Page 10).

Dr Brian White
Partner
bw@calvinepartners.com

Andrew Keith
Partner
ak@calvinepartners.com

Beyond Alkindi and Chronocort

Attention should start to focus on Diurnal's pipeline prospects

Undoubtedly, the near-term investment case at Diurnal is dominated by the adrenal franchise and in particular the potential for Chronocort to successfully navigate the European regulatory process, with a decision due in Q1 2021. Alkindi is now approved in both Europe and the US for the treatment of paediatric adrenal insufficiency. Chronocort in the US awaits the attraction of a development partner to take it through Phase 3. The rest of the pipeline is now coming into view, and with the proceeds of the recent fundraising, Diurnal is better resourced to progress its drug candidates.

DITEST – unlocking the $4.8bn testosterone replacement market opportunity

DITEST is Diurnal's treatment for testosterone deficiency

With Diurnal's objective of becoming a specialty pharma company focusing on endocrinology, DITEST is targeting the treatment of testosterone deficiency as it relates to male hypogonadism. Testosterone is responsible for many facets of male development and behaviour, including increased muscle strength, bone mass and red blood cell production, as well as sexual prowess and aggressiveness. Normal physiological levels vary significantly between different males, and levels decrease markedly after the age of 40 in most (but not all) men.

Testosterone levels decrease substantially in most men after the age of 40

Hypogonadism is caused by testosterone deficiency and can be of central (hypothalamic or pituitary) or testicular origin, or both. Hypogonadism with testicular failure as a result of genetic disorders such as Klinefelter syndrome, trauma, radiation, chemotherapy, or undescended testes, is classified as hypergonadotropic hypogonadism (primary hypogonadism). Hypogonadism with gonadotropin deficiency as a result of disease or damage to the hypothalamic-pituitary axis is known as hypogonadotropic hypogonadism (secondary hypogonadism). This may be caused by Kallmann's syndrome, cancer, trauma, radiation or sarcoidosis. In addition, older males may suffer from low testosterone levels with functional abnormalities at several levels of the hypothalamic-pituitary-testicular axis. The most common symptoms of hypogonadism are reduced sexual desire and sexual activity, erectile dysfunction, and hot flushes. Other clinical factors associated with low testosterone include obesity, metabolic syndrome and a generally negative impact on overall health status. Other less-specific symptoms can include loss of physical strength and muscle mass, fatigue, mood changes, anger, sleep disturbance and cognitive impairment. Characteristic signs include gynaecomastia, smaller testes and reduced body hair. Diagnosis of hypogonadism usually involves confirmation of low testosterone concentrations on at least two occasions with symptoms checked using a questionnaire. Commonly used assessments for diagnosis of clinical hypogonadism include the Androgen Deficiency in the Aging Male questionnaire and the Aging Males' Symptoms scale.

Confirmatory diagnosis is made via total testosterone, luteinising hormone, and follicle-stimulating hormone concentrations.

US testosterone replacement therapy prescriptions increased by over 300% between 2001 and 2013

One of the more contentious areas in testosterone deficiency has been the recognition that in addition to structural reasons, testosterone production decreases naturally with age. Studies such as the Baltimore Longitudinal study of Aging suggested that circa 20% of men over the age of 60 are hypogonadal, and this rises to 50% of men over the age of 80. TRT prescriptions apparently increased in the US by more than 300% from 2001 to 2013. Many of these prescriptions were written for men under the age of 45, and indeed much of the increase came from that age category. Concerningly, the increase was purported to have been driven not by a formal diagnosis of hypogonadism but by other symptoms, including low libido and fat redistribution which are a normal consequence of aging, as well as obesity. In 2015, the FDA took action to limit TRT and has been successful to the extent that prescribing has decreased significantly, better reflecting the product labelling. Nevertheless, we suspect that TRT is still being prescribed to men without a formal diagnosis of hypogonadism.

In 2015 the FDA took action to limit TRT prescriptions

Testosterone replacement therapy has been a mainstay of both primary and secondary hypogonadism for several decades and has generally been associated with good outcomes (increased sexual function, reduced body fat, increased lean muscle and better lipid profile). Notably, many of these apparent benefits reversed on TRT withdrawal, confirming the requirement for chronic therapy. While the weight of available evidence appears to suggest that TRT has not been associated with significant adverse events, we note that TRT comes with a black box label in the US. The labelling warns of cardiovascular risk and its promotion in the US is limited to patients with hypogonadism linked to specific (structural or genetic) medical disorders. TRT is not indicated for the treatment of age-related hypogonadism where significant (now off-label) use has been experienced. The FDA's action in 2015, followed a 2014 Advisory Committee meeting to review TRT. The committee voted 20-1 to recommend restricting the indicated population for TRT and to require the companies concerned to conduct a cardiovascular safety study. Following the FDA action, the EMA and Health Canada also warned of heightened cardiovascular risk. As a result, males with adult-onset hypogonadism, who represented the majority of the treated patient population, were deemed off-label. One of the consequences of the FDA action has been a reduction in TRT coverage from health insurers in the US.

Adult-onset hypogonadism deemed off-label for TRT and health insurers reduced coverage

The apparent wariness of regulators hasn't been helped by concerns regarding supraphysiologal levels of testosterone. Indeed, athletes who abuse testosterone and other androgenic steroids have a sharply increased risk of high blood pressure, heart attack, and stroke. However, the development and subsequent regulatory review of testosterone-based therapies Jatenzo and Tlando has brought safety concerns to the fore. Indeed, the FDA Briefing Documents for both products scrutinised the apparent increase in cardiovascular risk. For Jatenzo the commentary suggested that

Concerns raised with new TRT therapies

when compared to a topical testosterone formulation, Jatenzo was associated with increased blood pressure, increased haematocrit as well as reduced HDL and increased LDL cholesterol. Furthermore, these changes apparently increased with longer duration of Jatenzo treatment. Additionally, for Tlando, clinical evaluation showed that both Tlando and Androgel raised heart rate.

Potential for abuse

It is also worth highlighting that there are long-held concerns regarding the potential abuse of testosterone products, with oral formulations, particularly at risk given the heightened convenience. Nevertheless, TRT remains an effective mainstay of treatment for hypogonadism returning patients to normal levels of testosterone and indeed there are conflicting studies, which highlight the cardioprotective potential of returning patients to normal testosterone levels, particularly elderly men with low testosterone levels and pre-existing coronary artery disease with TRT apparently reducing the risks of MACE including strokes, heart attacks, and death.

A significant market opportunity

Given the aforementioned attributes associated with testosterone, it is perhaps unsurprising that testosterone replacement therapy has become a very attractive proposition for many males including, more contentiously, those with apparently normal levels of testosterone. Testosterone also has a complex relationship with many organs resulting in concerns regarding increased risk of prostate cancer, increased cardiovascular risk and an impact on blood lipids (to name a few). Consequently, regulators particularly in the US, are cognisant of the risk of off-label use and promotion given the size of the market opportunity. The Endocrine Society has sought to provide guidance which balances the risk/reward of TRT.

New practise guidelines for TRT

The 2018 guideline, Testosterone Therapy in Men with Hypogonadism – An Endocrine Society Clinical Practise Guideline, recommends against routine screening of men in the general population for hypogonadism (due to unclear mortality risk) but does recommend diagnosing hypogonadism in those patients with clinical manifestations and consistently low levels of testosterone. Helpfully, in the more controversial age-related (>65 years) patient population, the guidelines suggest against routine TRT use but do advocate that "…clinicians offer testosterone therapy on an individualised basis after explicit discussion of the potential risks and benefits" for those suffering from symptoms (e.g. low libido and anaemia as well as low testosterone levels).

Compliance rates are low with injectable and gel TRT formulations

While TRT has been used since the 1950s, due to the poor bioavailability of oral testosterone, the market has been dominated by topical formulations (such as Androgel) and injectable products. It should be noted that compliance rates with injectable and gel formulations have generally been poor. Administration of injectable products can be painful while topical formulation are associated with skin reactions and transference to women and children (hence the Black Box warning of virilisation). While oral formulations of testosterone have been available for some time outside the US, until

the approval of Jatenzo, the only US approved oral product was a 17-alpha-alkyl preparation methyltestosterone (Android) which has been associated with significant liver toxicity and as a result has not been widely used.

Oral treatment development has been difficult

The development of the first non-17-alpha-alkyl based oral testosterone treatments in the US (Jatenzo & Tlando) was protracted and problematic. While Tlando has received three FDA rejections so far, Jatenzo was ultimately approved (after two negative AdCom votes). Initially submitted by Clarus in 2014, it wasn't until 2019 that the product was finally approved. After Jatenzo's initial rejection by FDA, to deal with concerns, a second Phase 3 study was needed which included food effect data, a revised starting dose and titration regimen, plus ambulatory blood pressure monitoring.

Tlando has received three FDA rejections

Limitations of different TRT formulations

Delivery method	
Intramuscular	Injection site pain, coughing fit post administration
Gels	Skin irritation, risk of unintended transfer (e.g. female virilisation), nasal gel causes discomfort, sinusitis, congestion and discharge
Patches	Skin irritation, risk of female virilisation
Buccal	Gum irritation, bitter taste
Implant	Infection, expulsion
Oral	Hepatotoxicity (methyltestosterone), need to take with food

Source: Calvine Partners Research

Jatenzo (testosterone undecanoate) is a prodrug, and it uses the intestinal lymphatic pathway, bypassing the liver and reducing the risk of hepatotoxicity. Hepatotoxicity had blighted acceptance of previous oral formulations such as methyltestosterone, and this reduced risk resulted in Jatenzo's exalted status as the first oral soft gel TRT. Although Jatenzo represents a significant improvement in convenience, it does have some limitations. Looking at the prescribing label, Jatenzo needs to be taken at the same time as meals (fasted administration not being a viable option), and we note that it can result in supraphysiological levels of dihydrotestosterone (DHT) while testosterone levels can be variable. Given the potential cardiovascular issues associated with treatment of hypogonadal patients, the need for a high-fat diet is clearly less than optimal. Also, there may be a link between supraphysiological levels of DHT and heightened cardiovascular risk (left ventricular hypertrophy).

Jatenzo needs to be taken with high-fat meals

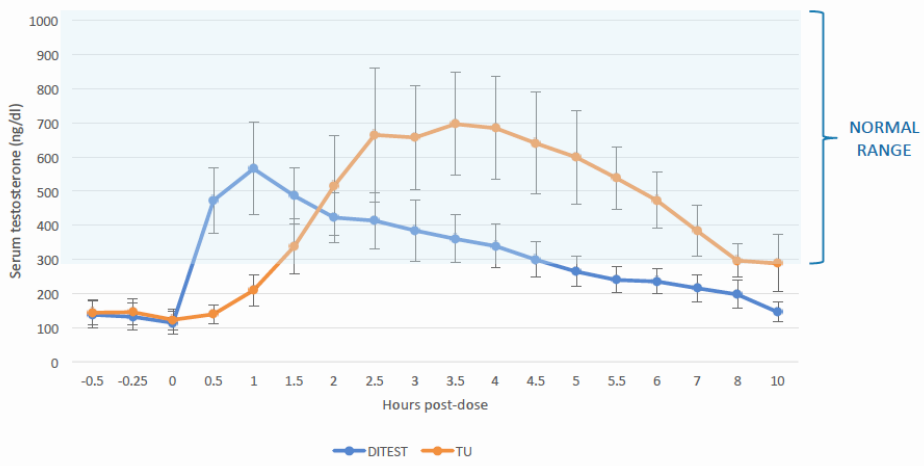
DITEST profile confirmed in proof of concept study

DITEST is a native testosterone which has been formulated for oral administration, but designed to provide normal physiological levels of testosterone irrespective of the need for food. Potentially, DITEST should overcome some of the limitations associated with the current TRT profile of testosterone undecanoate. In a Phase 1 study, Diurnal confirmed the differentiated nature of DITEST compared to testosterone undecanoate.

DITEST has been designed to produce normal levels of testosterone irrespective of the need for food

DITEST achieved normal physiological testosterone levels with less variability compared to the comparator.

The primary endpoint of the small proof of concept study compared the rate and extent of absorption of testosterone from 120mg DITEST administration with a single dose of testosterone undecanoate 80mg in hypogonadal men after eating. Encouragingly, DITEST administration was associated with achievement of testosterone levels within the normal physiological range for young adults, and with less variability compared to the comparator.

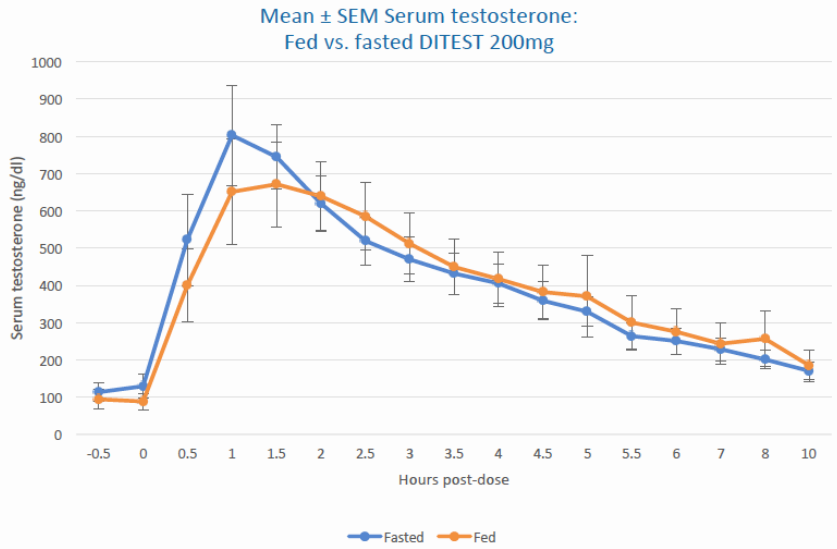


Testosterone	DITEST 120mg	TU 80mg	Geometric LS Mean Ratio (90% CI)
Cmax nmol/L	19.1 (16.6)	31.4 (23.1)	55.58 (44.99 - 68.65)
AUC0-10 h*nmol/L	59.5 (54.4)	102 (85.5)	51.26 (34.70 - 75.71)

Source: Company Reports

There were no SAEs from DITEST administration, and androgen levels were lower than the control

Secondary endpoints showed no impact on absorption of testosterone with DITEST irrespective of whether it was taken with food. The result confirmed the higher convenience associated with the DITEST formulation. From a safety perspective, there were no serious adverse events from DITEST administration. Encouragingly, levels of dihydrotestosterone (DHT), the potent testosterone derived androgen, were lower when compared to the comparator.



Testosterone	fed	fasted	Geometric LS Mean Ratio (90% CI)
Cmax nmol/L	26.5 (14.5)	30.4 (15.8)	85.14 (57.54 - 125.97)
AUC0-10 h*nmol/L	87.0 (55.7)	88.6 (51.6)	94.20 (66.14 - 134.17)

Source: Company Reports

Metabolites of testosterone were returned to normal physiological levels, and DITEST was observed to return dihydrotestosterone levels to normal, irrespective of whether patients were fed or fasted.

The FDA confirmed that DITEST can use the 505(b)(2) branded generic pathway which should expedite development

While the data were generated in a relatively small number of patients, it is important to bear in mind that the market for testosterone replacement is well understood and native testosterone is a well-characterised molecule. Importantly, discussions with the FDA have confirmed that DITEST can be developed using the branded generic pathway (505(b)(2)). This means that clinical development can be streamlined. The 505(b)(2) pathway is associated with significantly lower costs and risks than traditional drug development. Effectively, Diurnal (and a potential partner) can take advantage of data previously provided by other testosterone-based products as it seeks to provide a regulatory package that fulfils the Agency's requirement that DITEST is safe and efficacious.

In the US roughly 6% of males suffer from low levels of testosterone

TRT is a large market opportunity, with approximately 6% of US males affected by low levels of testosterone (approx. 4-5 million men). However, diagnosis of testosterone deficiency is subjective with variable testosterone thresholds used globally (200-400ng/dl with FDA 300ng/dl) while others are more focussed on the presenting clinical symptoms. There is a very clear need for oral products with fewer limitations, that are more convenient than topical or injectable products.

Given the market size, Diurnal should be able to attract a development partner with relevant experience to ensure best positioning

This is a fragmented market with no clear leadership, and we sense that this is a highly promotionally sensitive therapeutic area. Given the challenges faced in diagnosis, concerns over abuse and the significantly higher prescribing of TRT in the US over Europe, we believe that a development partner with relevant experience will be required to ensure optimal positioning and drive uptake in the relevant patient populations. This is a significant market opportunity and we believe that Diurnal should be able to deliver a suitable commercial development partner particularly given the well-defined low-risk pathway agreed with FDA, as well as the positive Phase I data. Diurnal's timing could be helped by the regulatory actions which have effectively limited the target population to patients with hypogonadism, and specifically those with structural issues.

Even a very modest market share would see US market sales of $1.5bn

Currently, DITEST has not been included in our Diurnal financial model or valuation given its relatively early stage of development. However, our analysis suggests that even a modest penetration of 3% of the US TRT market highlights in-market sales in the region of $1.5bn. DITEST, if successful, should be positioned as the most convenient treatment - an oral therapy which can be taken irrespective of fed or fasted state. With the right partner, DITEST demand could be driven beyond our estimates, by a best-in-class appreciation.

Native Oral Testosterone	2025E	2026E	2027E	2028E	2029E	2030E
US						
Patient number (m)	4.85	4.95	5.05	5.15	5.25	5.36
growth	2%	2%	2%	2%	2%	2%
Penetration	1%	2%	3%	3%	3%	3%
Price GBP	8671	8845	9022	9202	9386	9574
growth	2%	2%	2%	2%	2%	2%
Revenue	421	875	1,138	1,421	1,479	1,538
growth		108.1%	30.1%	24.8%	4.0%	4.0%
Royalty rate	10.0%	12.0%	13.0%	14.0%	15.0%	16.0%
Royalty	42.07	105.05	148.00	198.98	221.81	246.16
EU						
Patient number	4.22	4.31	4.39	4.48	4.57	4.66
growth	2%	2%	2%	2%	2%	2%
Penetration	1.0%	1.2%	2.0%	2.2%	2.5%	2.5%
Price GBP	4590	4682	4775	4871	4968	5068
growth	2%	2%	2%	2%	2%	2%
Revenue	91.80	93.64	95.51	97.42	99.37	101.35
growth		2.0%	2.0%	2.0%	2.0%	2.0%
Royalty rate	10.0%	12.0%	13.0%	14.0%	15.0%	16.0%
Royalty	9.18	11.24	12.42	13.64	14.91	16.22
Total unrisked sales (£m)	**512**	**969**	**1234**	**1519**	**1578**	**1640**
Total royalty to Diurnal (£m)	**51.25**	**116.28**	**160.41**	**212.62**	**236.72**	**262.37**

Source: Calvine Partners Research

Risks

The principal risks associated with Diurnal are largely clinical and commercial in nature. The failure of the European Phase 3 study for Chronocort was an unexpected disappointment although a review of the data has suggested significant support for Diurnal's approach. While we hope that the EMA will be pragmatic in its approach to reviewing the data there are lingering risks in this approach.

Diurnal has retained European rights to its adrenal disorder franchise, which brings commercialisation risks. We note that Diurnal has engaged the services of Ashfield, which has a successful track record in helping life science companies launch new products. Nevertheless, the pace of uptake is difficult to predict which could affect out forecasts although we recognise that market expectations for Alkindi are modest.

If successful, and Chronocort ultimately achieves a market introduction, Diurnal is seeking to launch its products into what is largely a generic market environment. We have assumed a price for Chronocort that is consistent with the European price of Plenadren – a once daily formulation of hydrocortisone which looks to be a reasonable proxy. We note that in this regard there is no equivalent product in the US. With Diurnal looking to partner its products in the US, including DITEST, there is an associated partnering risk.

As a development stage company, Diurnal is currently a loss making enterprise. Diurnal has successfully raised funds to continue with its development plans and to aid the launch of Alkindi in Europe. Even with this near-term funding, our forecasts suggest that in order to progress its pipeline assets expeditiously, Diurnal may require additional funding.

Financial Model and Summary

Our financial model for Diurnal is limited to the prospects for the adrenal franchise - the cortisol replacement-based treatments Alkindi and Chronocort. With the recent successful fundraising, Diurnal has highlighted the potential of the pipeline to deliver future value for shareholders and improve the treatment of patients with other endocrine disorders such as hypogonadism.

The streamlined regulatory pathway for DITEST is extremely helpful

Despite the longevity of TRT, there has been significant conjecture with respect to the safety profile, particularly in patients without a formal diagnosis of hypogonadism as well as those with apparently normal levels of testosterone. Fortunately for Diurnal, the regulatory pathway appears to have cleared helped by the identification of the suitable target patient population and the implementation of appropriate guidelines. The confirmation of a streamlined development pathway is enormously helpful in this regard we believe.

Recent regulatory actions have helped to increase awareness of hypogonadism diagnosis and treatment

We believe that recent regulatory actions have served to increase the awareness of properly diagnosing and treating patients with hypogonadism. The more limited prescribing label in the US may have served to blunt demand and to have effectively alienated those with age-related reduced testosterone levels. However, the guidelines do provide a means by which physicians can still diagnose and treat those with a formal diagnosis of hypogonadism (albeit off-label).

The market lacks a convenient, safe and efficacious oral treatment - DITEST could be the answer

With all of the various preparations of testosterone available, this is a fragmented market and one that still lacks a truly convenient oral preparation. The data generated to date suggests that DITEST could satisfy that need as the first orally available native testosterone treatment.

Taking DITEST's development further forward will result in a more lucrative partner for Diurnal

With a clear outline of a registrational programme ahead, it makes sense for Diurnal to take this relatively low-risk programme forward before selecting an appropriate development partner. This should result in a more lucrative partnership both with respect to the up-front payment and potential royalty rates. We have currently assumed a double-digit to mid-teens royalty rate but have made no allowance for any upfront payment, instead waiting to see what a collaboration may look like. These are still relatively early days and, despite our belief that this is likely a relatively low-risk endeavour, we have not yet included DITEST sales in our financial model or valuation of Diurnal; we await further clinical data.

We have updated our forecasts to include the cash proceeds from the fundraising. Our projections suggest Diurnal is in a strong position to continue clinical evaluation of DITEST before securing a partner and to progress the earlier stage pipeline generally. We forecast Diurnal should remain in a cash positive position based on the expected spend associated with these activities.

Diurnal Group Cash Flow Statement

Diurnal Cash Flow (£m)							
Year to June	**2019A**	**2020A**	**2021E**	**2022E**	**2023E**	**2024E**	**2025E**
Net income	(12.29)	(4.07)	(14.64)	(9.04)	2.91	23.32	35.22
Licensing income received as non-cash		(1.04)					
Fair value adjustment to investments		(0.63)					
Dep/Amort/Impair	0.02	0.03	0.01	0.01	0.01	0.02	0.04
Share- based payment	0.83	0.84	0.84	0.84	0.84	0.84	0.84
Net Fx gain	(0.01)	(0.36)					
Financial income	(0.13)	(0.11)	(0.15)	(0.11)	(0.02)	(0.05)	(0.28)
Financial expense	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Tax	(2.11)	(1.21)	0.00	0.00	0.97	7.77	11.74
(Increase) in receivables	1.36	0.12	0.01	(0.11)	(0.22)	(0.50)	(0.45)
Increase in payables	(3.14)	0.07	0.10	0.10	0.14	0.40	0.36
(Increase) in inventories	(0.55)	(0.57)	(0.14)	(0.49)	(0.71)	(0.23)	0.44
Interest paid	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Tax paid/ received	2.28	2.12	0.00	0.00	(0.97)	(7.77)	(11.74)
CFO	(13.74)	(4.81)	(13.97)	(8.80)	2.95	23.81	36.17
PP&E	(0.03)	(0.01)	(0.01)	(0.01)	(0.08)	(0.10)	(0.17)
R&D capitalised	(0.04)	(0.04)					
Investments	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Interest received	0.13	0.11	0.15	0.11	0.02	0.05	0.28
CFI	0.07	0.07	0.15	0.10	(0.06)	(0.05)	0.11
Net proceeds from issuance of share capital	5.53	10.67	9.30	0.00	0.00	0.00	0.00
Repayment of borrowings	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Net proceeds from new borrowings	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
CFF	5.53	10.67	9.30	0.00	0.00	0.00	0.00
Increase in cash	(8.15)	5.93	(4.53)	(8.70)	2.89	23.76	36.28
Cash brought forward	**17.28**	**9.14**	**15.07**	**10.54**	**1.84**	**4.73**	**28.49**
Fx		0.36					
Cash EOP	**9.14**	**15.07**	**10.54**	**1.84**	**4.73**	**28.49**	**64.77**

Source: Calvine Partners Research

Diurnal Group Income Statement

Year to June	2019A	2020A	2021E	2022E	2023E	2024E	2025E	2026E	2027E	2028E	2029E	2030E
Sales	**1.04**	**6.31**	**5.72**	**16.63**	**38.60**	**88.71**	**133.36**	**235.55**	**274.22**	**290.58**	**346.06**	**372.54**
COGS	(0.22)	(0.67)	(1.72)	(4.16)	(7.72)	(17.74)	(26.67)	(47.11)	(54.84)	(58.12)	(69.21)	(74.51)
Gross profit	**0.82**	**5.65**	**4.01**	**12.47**	**30.88**	**70.97**	**106.69**	**188.44**	**219.38**	**232.46**	**276.85**	**298.03**
Gross margin	78.5%	89.4%	70.0%	75.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
SG&A	(6.66)	(7.04)	(8.59)	(9.98)	(11.58)	(17.74)	(33.34)	(58.89)	(68.56)	(72.64)	(86.52)	(93.13)
R&D	(8.69)	(4.63)	(10.21)	(11.64)	(15.44)	(22.18)	(26.67)	(35.33)	(41.13)	(43.59)	(51.91)	(55.88)
Other operating income	0.00	0.63	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Operating profit	**(14.53)**	**(5.39)**	**(14.79)**	**(9.15)**	**3.86**	**31.05**	**46.68**	**94.22**	**109.69**	**116.23**	**138.43**	**149.02**
Finance income	0.13	0.11	0.15	0.11	0.02	0.05	0.28	0.65	1.36	2.20	3.09	4.14
Finance expense	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PBT	**(14.40)**	**(5.28)**	**(14.64)**	**(9.04)**	**3.88**	**31.10**	**46.96**	**94.87**	**111.05**	**118.43**	**141.51**	**153.16**
Tax	2.11	1.21	0.00	0.00	(0.97)	(7.77)	(11.74)	(23.72)	(27.76)	(29.61)	(35.38)	(38.29)
Net income	**(12.29)**	**(4.07)**	**(14.64)**	**(9.04)**	**2.91**	**23.32**	**35.22**	**71.15**	**83.28**	**88.82**	**106.14**	**114.87**
EPS Basic (p)	-19.70	-4.30	-11.26	-6.54	2.10	16.86	25.46	51.44	60.21	64.21	76.73	83.04
EPS Diluted (p)	**-19.70**	**-4.30**	**-11.26**	**-6.54**	**2.10**	**16.86**	**25.46**	**51.44**	**60.21**	**64.21**	**76.73**	**83.04**

Source: Calvine Partners Research

CALVINE

Diurnal Group Balance Sheet

Diurnal Balance Sheet (£m)							
Year to June	**2019A**	**2020A**	**2021E**	**2022E**	**2023E**	**2024E**	**2025E**
Intangible assets	0.05	0.08	0.01	0.01	0.01	0.01	0.01
PP&E	0.03	0.02	0.02	0.02	0.10	0.17	0.31
Inv held at fair value through P&L		1.67	1.67	1.67			
Non-current assets	0.08	1.77	1.69	1.69	0.10	0.18	0.32
Trade and other receivables	3.56	2.53	0.06	0.17	0.39	0.89	1.33
Inventory	0.67	1.24	0.34	0.83	1.54	1.77	1.33
Financial assets	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Cash & Cash equivalents	9.15	15.43	10.54	1.84	4.73	28.49	64.77
Current assets	13.38	19.21	10.94	2.84	6.66	31.15	67.43
Total Assets	**13.46**	**20.98**	**12.64**	**4.54**	**6.76**	**31.33**	**67.75**
Loans and borrowings	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Trade and other payables	(2.50)	(2.56)	0.07	0.17	0.31	0.71	1.07
Current liabilities	(2.50)	(2.56)	0.07	0.17	0.31	0.71	1.07
Loans and borrowings	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Trade and other payables	(0.02)	(0.04)	(0.05)				
Non-current liabilities	(0.02)	(0.04)	(0.05)	0.00	0.00	0.00	0.00
Total Liabilities	**(2.52)**	**(2.59)**	**0.02**	**0.17**	**0.31**	**0.71**	**1.07**
Share capital	4.23	6.08	6.08	6.08	6.08	6.08	6.08
Share premium	42.15	50.97	59.47	59.47	59.47	59.47	59.47
Consolidation reserve	(2.94)	(2.94)	(2.94)	(2.94)	(2.94)	(2.94)	(2.94)
Other reserve	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Retained earnings	(32.49)	(35.72)	(49.86)	(58.40)	(54.99)	(31.17)	4.55
Total equity	**10.94**	**18.39**	**12.75**	**4.20**	**7.61**	**31.44**	**67.16**

Source: Calvine Partners Research

Disclaimers and disclosures

Calvine Partners LLP is an appointed representative of Midmar Capital LLP, which is authorised and regulated by the Financial Conduct Authority.

This publication has been commissioned and paid for by Diurnal Group and as defined by the FCA is non-independent research. This report is considered to be a marketing communication under FCA Rules, and it has not been prepared under the laws and requirements established to promote the independence of investment research and it is not subject to any prohibition on dealing ahead of the dissemination of investment research. This information is widely available to the public.

This report in the United Kingdom is directed at investment professionals, certified high net worth individuals, high net worth entities, self-certified sophisticated investors, eligible counterparties as defined by Financial Services and Markets Act 2000 (Financial Promotion) Order 2000. The report may also be distributed and made available to persons to whom Calvine Partners is lawfully permitted. This publication is not intended for use by any individual or entity in any jurisdiction or country where that use would breach law or regulations, or which would subject Calvine Partners or its affiliates to any registration requirement within such jurisdiction or country.

Calvine Partners may provide, or seek to provide, services to other companies mentioned in this report. Partners, employees, or related parties thereof may hold positions in the companies mentioned in the report subject to Calvine Partners' personal account dealing rules.

Calvine Partners has only used publicly available information believed to be reliable at the time of this publication and made best efforts to ensure that the facts and opinions stated are fair, accurate, timely and complete as at 11/11/2020. However, Calvine Partners provides no guarantee concerning the accuracy or completeness of the report or the information or opinions within. This publication is not intended to be an investment recommendation, personal or otherwise, and it is not intended to be advice and should not be treated in any way as such. Any valuation estimate, such as a those derived from a discounted cash flow, price multiple, or peer group comparison, do not represent an estimate or forecast of a future company share price. In no circumstances should the report be relied on or acted upon by non-qualified individuals. Personal or otherwise, it is not intended to be advice and should not be relied on in any way as such.

Forward-looking statements, information, estimates and assumptions contained in this report are not yet known, and uncertainties may cause the actual results, performance or achievements to be significantly different from expectations.

This report does not constitute an offer, invitation or inducement to engage in a purchase or sale of any securities in the companies mentioned. The information provided is for educational purposes only. This publication should not be relied upon when making any investment decision or entering any commercial contract. Readers should seek appropriate, independent advice before acting on any of the information contained herein. This report should not be considered as investment advice, and Calvine Partners will not be liable for any losses, costs or damages arising from the use of this report. The information provided in this report should not be considered in any circumstances as personalised advice.

Calvine Partners LLP, its affiliates, officers or employees, do not accept any liability or responsibility with regard to the information in this publication. None of the information or opinions in this publication has been independently verified. Information and opinions are subject to change after the publication of this report, possibly rendering them inaccurate and/or incomplete.