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INITIATION REPORT

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Can-Fite BioPharma Ltd. (NYSE/CANF)

December 13, 2018

BUY A Late Stage Company in Multiple Indications

One of Can-Fite's most exciting trials in Liver Cancer, where the expected survival is short (six months), and the trial, which is event-driven, and was fully enrolled since August of 2017 has not yet reached its pre-requisite events, suggesting efficacy.

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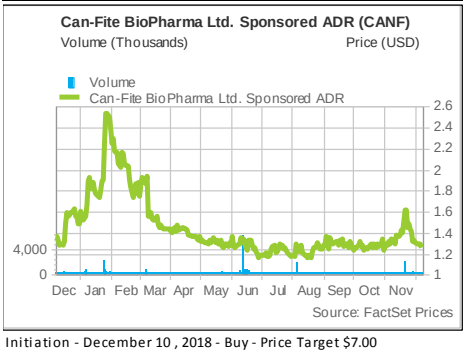
Investment Highlights

Can-Fite is a pivotal company. Two Phase 3 trials, "Acrobat" in Rheumatoid Arthritis and "Comfort" in Psoriasis both hold great promise as alternative therapies with in our opinion, a more favorable side-effects profile versus the standard of care. In addition, we are focused on the company's Phase 2, potentially registrational quality, event-driven trial in Child-Pugh Class B, liver cancer. Typical survival in this indication is just three to six months. The study enrolled 78 patients in August 2018. The study has not reached the requisite number of events, which suggests to us, that the drug is affecting patients. We expect to see results in the first quarter, next year.

It's all about A_3AR. We see the Adenosine Receptor as an ideal target for drug development. It is overexpressed on both inflammatory cells and cancer cells but has a low expression on normal cells. The differential expression levels make it an ideal target for drug development in these conditions. Can-Fite's A_3AR lead drugs, Piclidenoson (CF-101) and Namodenoson (CF-102) modulate key signaling proteins that subsequently induce cell death and a reduction of inflammatory cytokines. Importantly, the A3AR protein serves as a biomarker. Patients can be screened for A3AR expression to determine which patients are likely to respond to treatment with Piclidenoson or Namodenoson. Can-Fite is developing drugs targeting A_3AR for several indications including rheumatoid arthritis (RA, CF101), plaque psoriasis (CF101), liver cancer (CF102), NAFLD/NASH (non-alcohol steatohepatitis, CF102) and erectile dysfunction (CF602).

Current Price	**$1.28**
Price Target	**$7.00**

Estimates	F2017A	F2018E	F2019E
Revenues ($000s)	847	3531	0
1Q March	73	632	0
2Q June	79	270	0
3Q September	588	2629	0
4Q December	107	0	0
	F2017A	F2018E	F2019E
EPS (diluted)	(0.14)	(0.08)	(0.17)
1Q March	(0.04)	(0.04)	(0.05)
2Q June	(0.06)	(0.03)	(0.04)
3Q September	(0.05)	0.02	(0.04)
4Q December	0.01	(0.03)	(0.04)
EBITDA/Share	($0.15)	($0.10)	($0.17)
EV/EBITDA (x)	0.0	0.0	0.0
Stock Data			
52-Week Range	$1.12	-	$2.75
Shares Outstanding (mil.)			40
Market Capitalization (mil.)			$52
Enterprise Value (mil.)			$46
Debt to Capital			0.0%
Book Value/Share			$0.18
Price/Book			8.1
Average Three Months Trading Volume (M)			0.0
Insider Ownership			1.1%
Institutional Ownership			9.4%
Short interest (mil.)			1.6%
Dividend / Yield			$0.00/0.0%



Initiation - December 10 , 2018 - Buy - Price Target $7.00

Psoriasis remains a blockbuster indication, and *ACRobat* could represent a new treatment paradigm. Piclidenoson is now in a Phase 3, 24-week, 525-person four arm (high and low dose versus MTX and placebo) study designed to establish the drug as non-inferior to Methotrexate (MTX) in newly diagnosed patients with moderate-to-severe RA. The primary endpoint of ACRobat is a disease activity score (DAS) after 12 weeks of treatment in patients dosed with Piclidenoson compared to those dosed with MTX. In a Phase 2b study (N=79) with Piclidenoson given twice daily, 49% of patients achieved ACR20, 19% ACR50 and 11% ACR70. The scores are comparable to MTX but with a benign AE profile. Patients have been selected for the study based on over expression of the A3AR biomarker. The study should complete enrollment this year with data to follow in nine months. RA alone is estimated to be a $25B market.

The *COMFORT* pivotal trial is now underway. The Phase 3 Psoriasis study is designed to evaluate the efficacy and safety of daily Piclidenoson, administered orally compared to Apremilast (Otezla) and placebo in 400 patients with moderate-to-severe plaque psoriasis. The study is being conducted in five countries in Europe, Israel, and Canada. The primary endpoint is to be based on the percent of patients which achieve a PASI 75 score at week 16 vs. placebo. The secondary endpoints are to include non-inferiority vs. Otezla at week 32. We assume once all sites are enrolling it may take eight months to completely enroll the trial and that should set the stage for data a year later. Psoriasis alone is estimated to be a $9B market.

Namodenoson in Nexavar failures in liver cancer. The global Phase 2 advanced liver cancer (Child-Pugh Class B) study enrolled as of August 2017, with 78 patients. The trial is event-driven and expected survival in this group is typically 3-6 months, so we should see data later this year. The study is being conducted in the U.S., Europe, and Israel. Patients with advanced Hepatocellular Carcinoma (HCC), who failed Nexavar as a first-line treatment are treated twice daily with 25 mg of oral Namodenoson or placebo using a 2:1 randomization. Secondary endpoints include progression-free survival (PFS), safety, and the relationship between outcomes and A3 adenosine receptor expression.

Namodenoson in fatty liver disease (NAFLD). This is a small Phase 2 exploratory study in NAFLD, which is considered to be a pre-cursor to NASH. The study is a multicenter, randomized, double-blinded, placebo-controlled, dose-finding efficacy and safety study in 60 patients with NAFLD with or without NASH. The primary end point is to be the mean percent change from baseline in serum alanine aminotransferase (ALT) levels and safety. The secondary end point is to be a percent change from baseline in hepatic steatosis measured by magnetic resonance imaging-determined proton-density fat fraction (MRI-PDFF). The study is expected to complete enrollment soon. If so, we could see top-line data by the middle of next year. Namodenoson has both Orphan and Fast Track status in HCC indication.

Valuation. We model the respective indications, Piclidenoson in RA and psoriasis, Namodenoson in HCC and NAFLD. We apply a probability of success in these patient-based models. For Piclidenoson, we use 50% as the product is now in pivotal trials (RA and psoriasis). We assume a 50% probability for Namodenoson in HCC, but in NAFLD we use a lower probability of just 10% as we view this study as exploratory. These metrics then flow into our valuation models. For Can-Fite we apply a 30% discount rate, which is in addition to our therapeutic probability of success rate. We select 30% as the company is not yet profitable and most of the products are still dependent on the outcome of the clinical trial. Our valuation conclusion is an equally weighted average of our FCFF, EPS, and sum-of-the-parts analysis. We use a fully diluted end-year share count and assume multiple raises. The conclusion of this method is a $7.00 price target.

Risk to our thesis, include the following: (1) commercial; (2) regulatory; (3) clinical; (4) manufacturing; (5) financial; (6) liability; and (7) intellectual property. We review these and other risks in the risk section of this report.

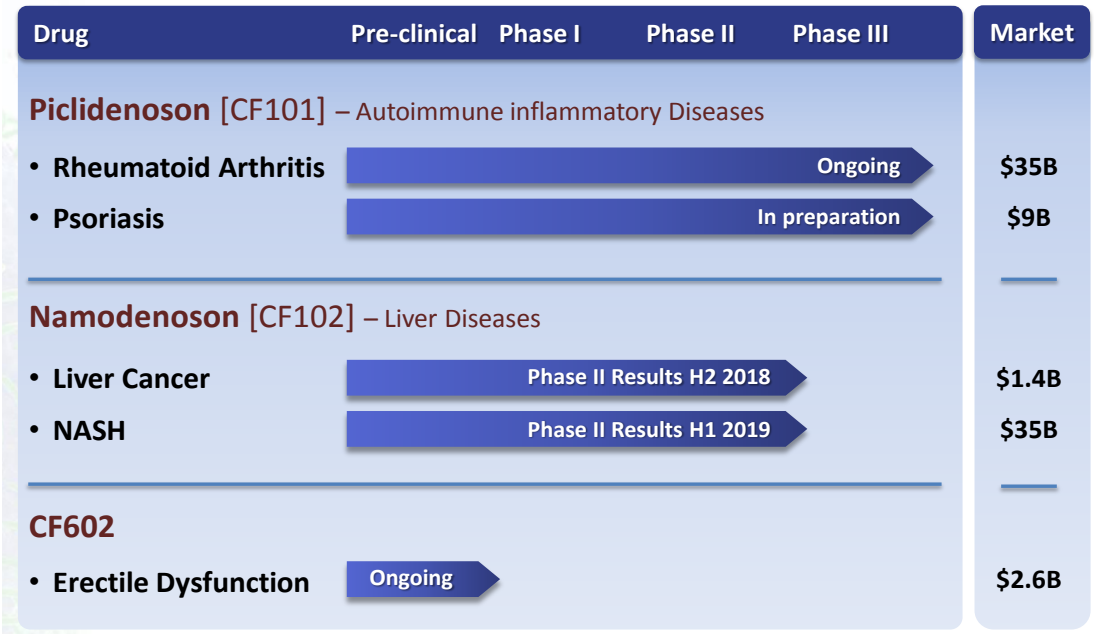
Company Business/History

Can-Fite Biopharma is an Israeli biopharmaceutical company with integrated pharmaceutical discovery and clinical development capabilities. The company has a pipeline of proprietary compounds in Phase 2 and Phase 3 clinical development, which address auto-immune inflammatory disease and cancer. The company's platform technology utilizes the G protein associated A3 adenosine receptor (A3AR) as a therapeutic target. A3AR is highly expressed in inflammatory and cancer cells where low expression is found in normal cells, suggesting that the receptor could be a unique target for pharmacological intervention. The company compounds appear to bind with nanomolar (nm) affinity to A3AR and initiate de-regulation of the NF-kB and Wnt signal transduction pathways resulting in anti-inflammatory and anti-cancer effects.

Can-Fite's pipeline drugs are synthetic, highly specific agonists and allosteric modulators targeting the A3A receptor. Each is orally bioavailable with a strong safety profile in trials to date. Piclidenoson (CF101), Can-Fite's lead drug candidate, is in advanced clinical development for the treatment of autoimmune-inflammatory diseases, including rheumatoid arthritis (RA) and psoriasis. Namodenoson (CF102), Can-Fite's second drug candidate, is being developed for the treatment of Child-Pugh B - hepatocellular carcinoma (primary liver cancer) and is being evaluated in NAFLD/NASH. The drug has received orphan drug designation (Orphan Status). CF602 is Can-Fite's second-generation allosteric drug candidate for the treatment of inflammatory diseases and may have utility in erectile dysfunction (ED). Can-Fite has clinical experience which includes over 1,200 patients who have participated in clinical trials with the molecules evaluating the A3AR, as conducted by the company.

We see an opportunity in Can-Fite as a wealth of clinical data suggests the A3AR is a valid target. We view the historical clinical data not as failures but as enabling the company's current clinical programs which now use a biomarker for A3AR expression, but the development path which has taken years and the ability to raise capital appear to have combined to depress the current valuation. The recent partnership (Feb.2018) with Gebro Holdings uplifted the stock, and the company took advantage of the rise to raise incremental capital. Going forward we see the potential for data across multiple indications with both lead drugs could set the stage for additional partnerships and a sustainable rise in the company's valuation.

Exhibit 1. Pipeline



Source: Can-Fite Biopharma Ltd.

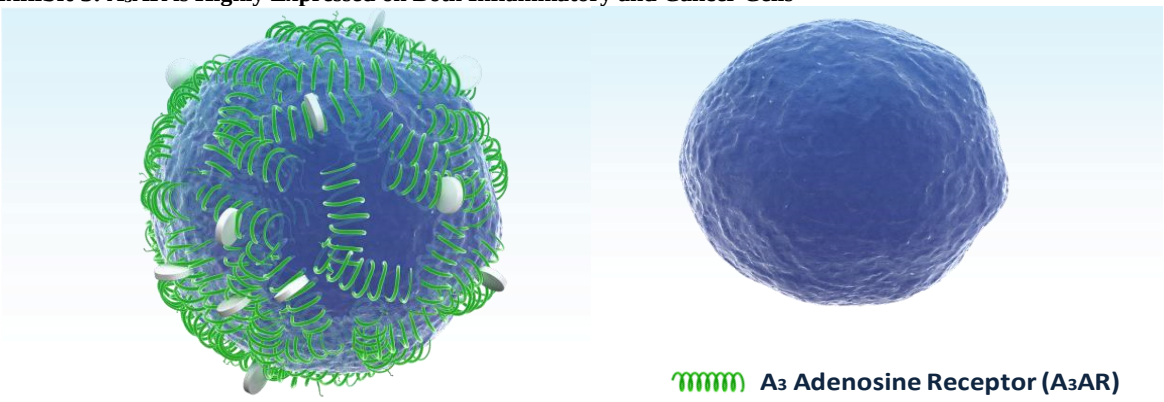
Exhibit 2. Catalysts Table

Product	Geography	Indication	Event	Timeline	Impact
Namodenoson (CF102)	U.S.	Liver Cancer	Complete Phase 2 enrollment	Complete	
Namodenoson (CF102)	U.S.	Liver Cancer	Phase 2 top-line data	1Q19	++
Namodenoson (CF102)	U.S.	Liver Cancer	Initiate A Phase 3 trial	1H19	+
Namodenoson (CF102)	U.S.	Liver Cancer	Phase 3 top-line data	1H21	+++
Namodenoson (CF102)	U.S.	Liver Cancer	Approval and commercialization	2022	+++
Piclidenoson (CF101)	U.S.	Rheumatoid Arthritis	Initiate Phase ACRobat 3 trial	completed	
Piclidenoson (CF101)	U.S.	Rheumatoid Arthritis	Complete Enrollment ACRobat	YE18	+
Piclidenoson (CF101)	U.S.	Rheumatoid Arthritis	Phase 3 top-line data ACRobat	YE19	++
Namodenoson (CF102)	U.S.	NAFLD/NASH	Initiate Phase 2 trial	completed	
Namodenoson (CF102)	U.S.	NAFLD/NASH	Phase 2 top-line data	1H19	+
Piclidenoson (CF101)	U.S.	Psoriasis	Launch Phase 3 Comfort Trial	completed	+
Piclidenoson (CF101)	U.S.	Psoriasis	Phase 3 top-line data Comfort	2H20	+++
Piclidenoson (CF101)	U.S.	Psoriasis	Approval and commercialization	2023	+

Stock Significance Scale: + of moderate importance; ++ higher level; +++ highest Importance.
Source: Dawson James Securities

Can-Fite Biopharma's platform technology is based on the A3 adenosine receptor (A_3AR). Adenosine receptors are part of the superfamily of G-protein-coupled receptors (GPCRs). Recent research has demonstrated that the A_3AR holds promise as both a therapeutic target and as a biological predictive marker[1]. It has been shown to be highly expressed in both inflammatory and cancer cells. Over expression of the A_3AR is also found in peripheral blood mononuclear cells (PBMCs) of patients with autoimmune inflammatory diseases, suggesting that A_3AR can serve as a biomarker for disease. The company's proprietary compounds, Piclidenoson (CF101) and Namodenoson (CF102), are highly selective A_3AR agonists that induce specific cell death of cancer and inflammatory cells. The molecules can produce a differential effect by exhibiting anti-cancer and anti-inflammatory effects on targeted cells that overexpress A_3AR, while normal cells that have low expression of A_3AR are unaffected. As such, this differential binding pattern contributes to a positive safety profile for A_3AR agonists. A_3AR also serves as a biological predictive marker to determine which patients are more likely to respond to treatment with an A_3AR agonist. A_3AR has been shown to be directly correlated to key inflammatory regulators, including Nuclear Factor Kappa B (NF- κB) and Wnt[2]. Can-Fite focuses on treating several diseases associated with both inflammation disease and tumors including rheumatoid arthritis, psoriasis, and hepatocellular carcinoma, as well as NAFLD/NASH (nonalcoholic steatohepatitis). Can-Fite's Piclidenoson (CF101) and Namodenoson (CF102) are being developed as selective A_3AR agonists to induce apoptosis of pathogenic cells. As shown below, A_3AR is overexpressed on inflammatory and tumor cells but not on normal healthy cells. As such, normal cells are refractory to the apoptotic effects of A_3AR agonists. The safety profile can likely be attributed to this differential.

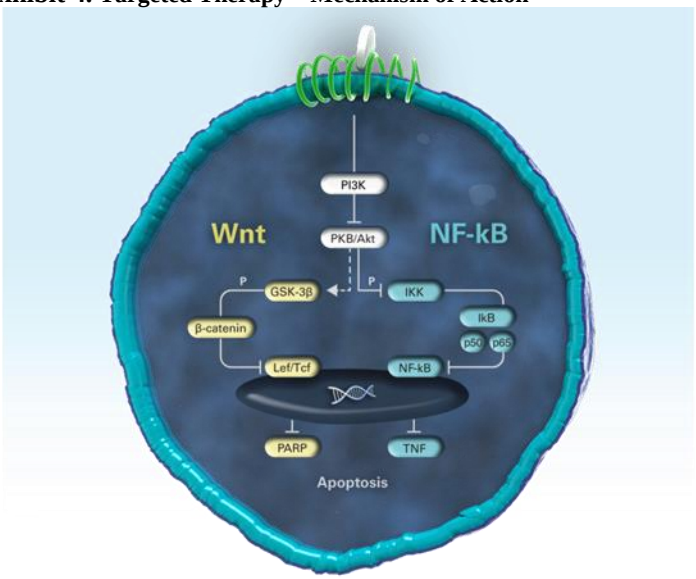
Exhibit 3. A_3AR is Highly Expressed on Both Inflammatory and Cancer Cells



Source: Can-Fite Biopharma Ltd.

[1] http://www.drug-dev.com/THERAPEUTIC-FOCUS-Adenosine-Receptors-The-Promise-918.aspx
[2] https://www.ncbi.nlm.nih.gov/pubmed/17216675

Exhibit 4. Targeted Therapy – Mechanism of Action



Source: Can-Fite Biopharma Ltd.

A_3AR appears to mediate the modulation of key signaling proteins such as PI2K, GSK-3β, PKA, PKB/Akt, IKK, and NF-κB, resulting in the de-regulation of Wnt and NF-κB pathways.

Investment Overview

Targeting A_3AR is emerging as a new class of drugs that could expand the therapeutic armamentarium for both autoimmune disease and cancer. Can-Fite has two lead A_3AR drugs, Piclidenoson and Namodenoson. In rheumatoid arthritis (RA), Piclidenoson is now in a 525-person Phase 3 trial (ACRobat) in RA and in a 400-person study in psoriasis. Piclidenoson may represent an alternative option to frontline methotrexate. In psoriasis, Piclidenoson appears better when compared to Otezala. These markets are tens of billions of dollars. Namodenoson has demonstrated positive data in second-line liver cancer (HCC), where the only approved drug, Nexavar, has failed. More data from the Phase 2 study with Namodenoson (the trial is now fully enrolled, N=76) should provide the basis to initiate a pivotal study. In addition, Namodenoson is now in a 60-person, Phase 2 exploratory study in NAFLD.

We can simplify our investment thesis to the following points:

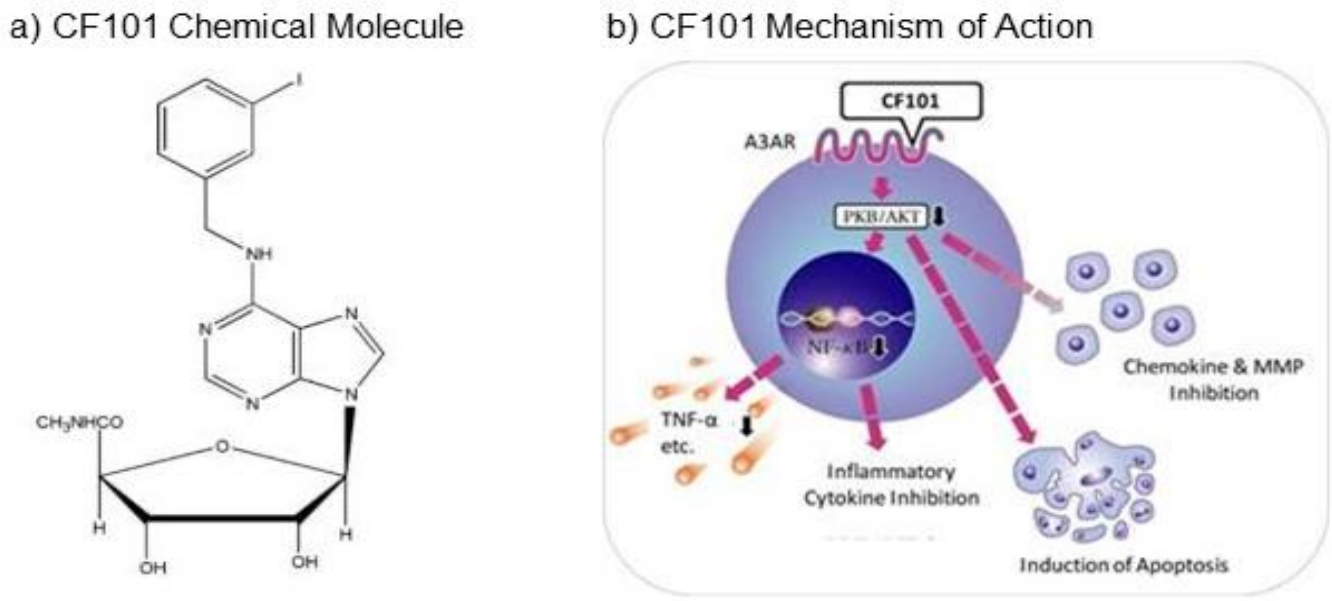
1. Can-Fite is now a pivotal company with two drugs being developed for large markets: Piclidenoson in RA and Psoriasis and Namodenoson in HCC and NAFLD/NASH. Our valuation of the company is based on the prospects of both drugs being developed for their respective indications. We evaluate the science, the historical trial data and the current trial plans and provide our models with assumptions to drive a valuation conclusion.

2. Can-Fite has put together several small partnership deals. We assume the company, on good pivotal data, may partner the lead products versus commercialize it alone. We provide our therapeutic models and list our assumptions in this report.

3. Valuation. We provide our valuation assessment and the basis of our assumptions. We conclude that the risk-reward ratio appears favorable. We base this on the Phase 2 data sets across several significant indications for both lead drugs. Critical to the company's success is their ability to continue to raise capital at favorable terms. This may be through a combination of partnerships or accessing capital markets. Concurrently the company must continue to manage expenses while working to complete the current and planned pivotal trials.

1. Rheumatoid Arthritis. CF101, Piclidenoson is an Oral, A_3AR Agonist being developed as a treatment of rheumatoid arthritis and psoriasis. Piclidenoson has also shown potential for the treatment of Crohn's disease. The orally bioavailable A_3AR agonist has a half-life of approximately eight to nine hours in circulation. Piclidenoson is a highly selective A_3AR agonist and is a nucleoside derivative with a molecular weight of 510.29 daltons. Piclidenoson is not metabolized in the body and is secreted unchanged. Binding of Piclidenoson to A_3AR inhibits the production of inflammatory cytokines including Tumor Necrosis Factor Alpha (TNF-α), Interleukin (IL) -6, IL-1, and chemokines, or small cytokines, such as MMP, by signaling through the NF-κB pathway and the PKB/AKT pathway. The net result is believed to be deregulation of the Wnt and the NF-κB pathways. NF-κB is a transcription factor responsible for the expression of pro-inflammatory cytokines, and it is activated by intra and extra cellular stimuli such as TNF-α and IL-1 (and other cytokines and chemokines).[3] Dysregulation of Wnt and NF-κB signaling induces inflammatory conditions/diseases.

Exhibit 5. CF101 (Piclidenoson), Structure and Activity



Source: Can-Fite Biopharma presentation.

a) Piclidenoson is an oral, small molecular drug formulated as a tablet. CF101 has a molecular weight of 510 Daltons and is manufactured via a four-step chemical synthesis (up-scaled to a semi-commercial level). The highly selective A_3AR agonist is a nucleoside derivative and is water soluble with a half-life time of eight to nine hours.

b) Mechanism of Action – Piclidenoson's mechanism of action binds the A_3AR which disrupts Wnt and NF-κB signaling. The net result is induction of apoptosis of inflammatory cells. Currently, Piclidenoson is being developed for both rheumatoid arthritis and psoriasis.

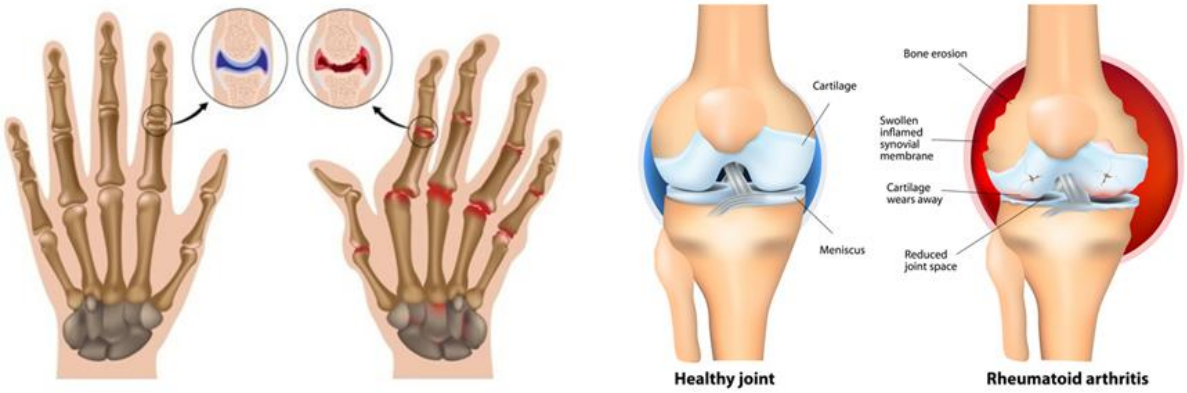
Rheumatoid arthritis (RA) is a chronic, systemic, autoimmune-inflammatory disease in which the body's immune system mistakenly attacks the joints, resulting in inflammation and loss of function. RA affects more than 1.5 million patients in the U.S. and as much as 1% of the worldwide population, with three times as many women developing the disease than men.[4] The effects of the disease include synovial inflammation and hyperplasia, which can lead to pain in and around the joints, cartilage and bone destruction, and systemic features, including cardiovascular, pulmonary, psychological, and skeletal disorders.[5] Patients with RA tend to experience degeneration primarily in the fingers, hands, and feet. Symptom effects are usually symmetrical; therefore, patients are likely to experience symptoms on joints of both sides of the body. Pathogenesis of RA is characterized by increased secretion of key pro-inflammatory cytokines, such as tumor necrosis factor-alpha (TNF-α), and interleukins (IL) (IL-1β, IL-6, IL-10, and IL-17).[6] Produced in the joints of RA patients, cytokines signal the release of inflammatory cells. Symptoms experienced by RA patients include irritation, wearing down of cartilage,

[3] http://www.pathwaycommons.org/pc/record2.do?id=543635
[4] https://www.rheumatoidarthritis.org/ra/facts-and-statistics/
[5] http://www.nejm.org/doi/full/10.1056/NEJMra1004965
[6]http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0178879

swelling, and inflammation of the joint lining caused by excess synovial fluid, and the development of fibrous tissue. If conditions worsen, severe bone damage may occur due to excessive fluid from inflammation, which expands the joint lining and causes adjacent bones to erode.

RA causes joint damage in 80% to 85% of patients due to cartilages and bones within joints wearing down over time.[7] RA patients are characterized as having their joint linings affected, which causes painful swelling; patients with late-stage RA develop deformity of their fingers as shown in the figure below.

Exhibit 6. Healthy Joint Versus Rheumatoid Arthritis



Source: Genetics Home Reference.

The current standard treatment for RA is lacking. Although the disease is currently incurable, several standard treatments exist for managing RA. The physician's recommendation of medication relies upon the patient's symptoms and the duration of his or her disease. Early-stage RA is commonly managed with non-steroidal anti-inflammatory drugs (NSAIDs) and corticosteroid medications. Both treatments are aimed to reduce inflammation and relieve pain. Disease-modifying anti-rheumatic drugs (DMARDs) are provided for patients whose RA is shown to progress. DMARDs are used in order to slow the progression of RA and to save the joints and other tissues from permanent damage. Common DMARDs include methotrexate, hydroxychloroquine, and sulfasalazine. As the disease progresses further, patients are treated with biologic response modifiers. These types of medications include abatacept (Orencia), adalimumab (Humira), anakinra (Kineret), certolizumab (Cimzia), etanercept (Enbrel), golimumab (Simponi), infliximab (Remicade), rituximab (Rituxan), tocilizumab (Actemra) and tofacitinib (Xeljanz).[8] In order to increase effectiveness, these immunosuppressive drugs are often paired with a non-biologic DMARD, such as methotrexate. However, these patients are faced with high risk of developing serious infections as a result of immune-suppression, which can ultimately lead to death. Furthermore, these drugs are administered through injections, which is invasive and inconvenient for the patient. Can-Fite is developing orally bioavailable, CF101 which, if approved, could become a safer and more patient-convenient alternative for treating RA.

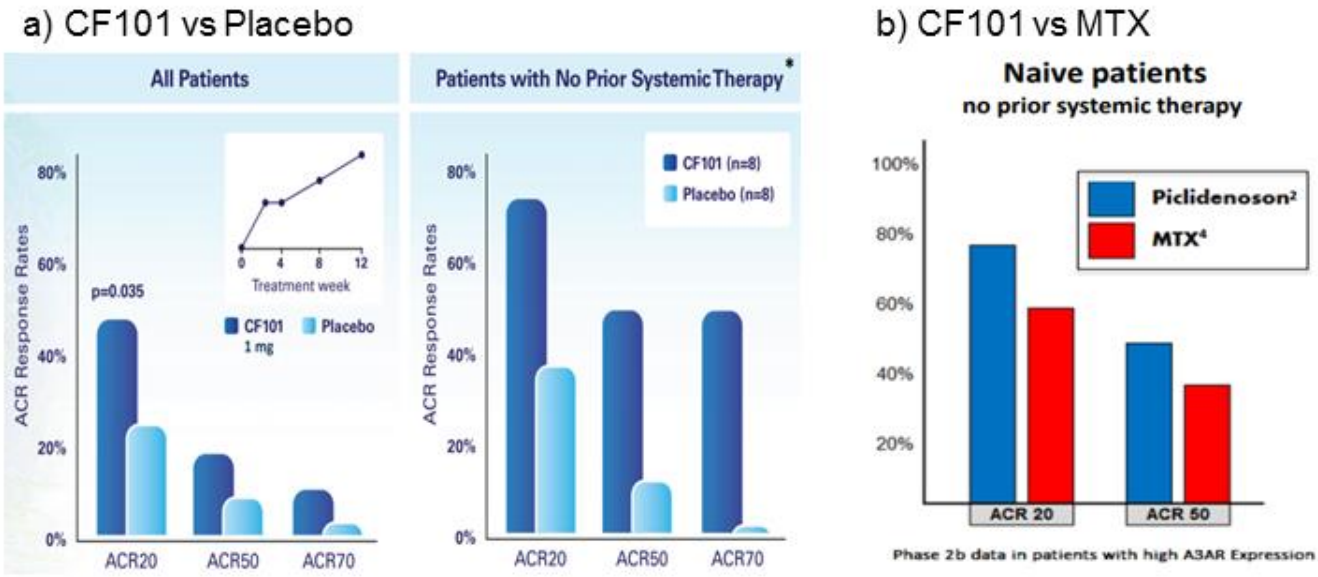
Can-Fite conducted a Phase 2a blinded study in 74 patients with RA, randomized to receive Piclidenoson as monotherapy in one of three doses: 0.1 mg, 1.0 mg, and 4.0 mg. The primary efficacy endpoint was an ACR20 response at week 12, a criterion determined by the American College of Rheumatology that reflects 20% improvement in inflammation parameters. The study data revealed maximal response at the 1.0 mg group, showing 55.6% with ACR20, 33.3% with 50% improvement, or ACR50, and 11.5% with 70% improvement, or ACR70. Piclidenoson administered BID for 12 weeks resulted in improvement in signs and symptoms of RA and was safe and well-tolerated. Studies in the United States were conducted pursuant to an open IND, which was received by the FDA in 2005. Following the Phase 2a study, two Phase 2b studies were conducted. The first study combined Piclidenoson with methotrexate but showed no significant change in ACR20 vs. methotrexate alone. The treatment though was safe and well tolerated, and the 1.0 mg dose appears to be ideal. This dose yielded the highest ACR50 score. The second Phase 2b study initiated in 2009 (N=230) and evaluated Piclidenoson + methotrexate vs. methotrexate alone for 12 weeks; though there was no significant difference vs. methotrexate in ACR scores, again, safety and tolerability were positive. However, in the Phase 2a study, in patients that received Piclidenoson as a stand-alone therapy and which demonstrated a clinical benefit, those patients were high A_3AR expressers. Conversely, in the two Phase 2b studies, patients were not high A_3AR expressers. As such, it was determined that the Piclidenoson should be administered as a stand-alone therapy without methotrexate, and patients should be screened prior to treatment for A_3AR expression levels.

[7] https://www.hopkinsarthritis.org/arthritis-info/rheumatoid-arthritis/
[8] http://www.mayoclinic.org/diseases-conditions/rheumatoid-arthritis/diagnosis-treatment/treatment/txc-20197400

Based on these results, an additional Phase 2b study with Piclidenoson as a stand-alone, monotherapy treatment and not in combination with MTX was conducted. The trial was a 12-week multicenter, randomized, double-blind, placebo-controlled, parallel-group study involving 79 patients to determine the safety and efficacy of Piclidenoson administered orally daily in patients with active RA and elevated baseline expression levels of the A_3AR in PBMCs. Enrolled patients had high baseline A_3AR biomarker expression (determined at 1.5-fold over a predetermined age-matched standard). Results of the study demonstrated that in the Piclidenoson group, all primary efficacy endpoints were met, showing statistically significant superiority over placebo in reducing signs and symptoms of RA. The ACR20 response rate was 49% for Piclidenoson compared to 25% for placebo (p=0.035), an ACR50 response rate of 19% for Piclidenoson compared to 9% for placebo, and an ACR70 response rate of 11% for Piclidenoson arm compared to 3% for placebo. Similar to observations in the previously reported Piclidenoson psoriasis trials, the response of patients with RA was cumulative over time, suggesting a consistent anti-inflammatory effect of Piclidenoson. Moreover, half of the RA patients treated with Piclidenoson showed clinically meaningful improvement. Piclidenoson was very well tolerated and showed no evidence of immunosuppression, and there were no severe treatment-emergent adverse events during the study. A subgroup analysis of 16 patients with no prior systemic therapy showed a dramatic increase in the response with an ACR20 of 75%, ACR50 of 50%, and ACR70 of 50%. The company believes this may be related to the fact that in this patient population there is a full receptor expression since they had not been treated earlier with any systemic drugs.

Data from the Phase 2b study (shown below) with a total of 79 RA patients with either of three ACR levels (20, 50, and 70) yielding significantly higher response rates when treated with Piclidenoson in comparison to the placebo. Response rates were higher regardless of whether or not patients were treated prior with methotrexate (MTX). In the diagrams below data on from the Phase 2b study with naïve patients in either of the two ACR levels (20 and 50), treated with either CF101 or with MTX is shown. Although MTX is the recommended first-line therapy for treating patients with RA, the drug holds a 34% discontinuation rate due to adverse events. Data from the Phase 2 study supports the opportunity for Piclidenoson as an alternative to MTX as first-line oral DMARD therapy.

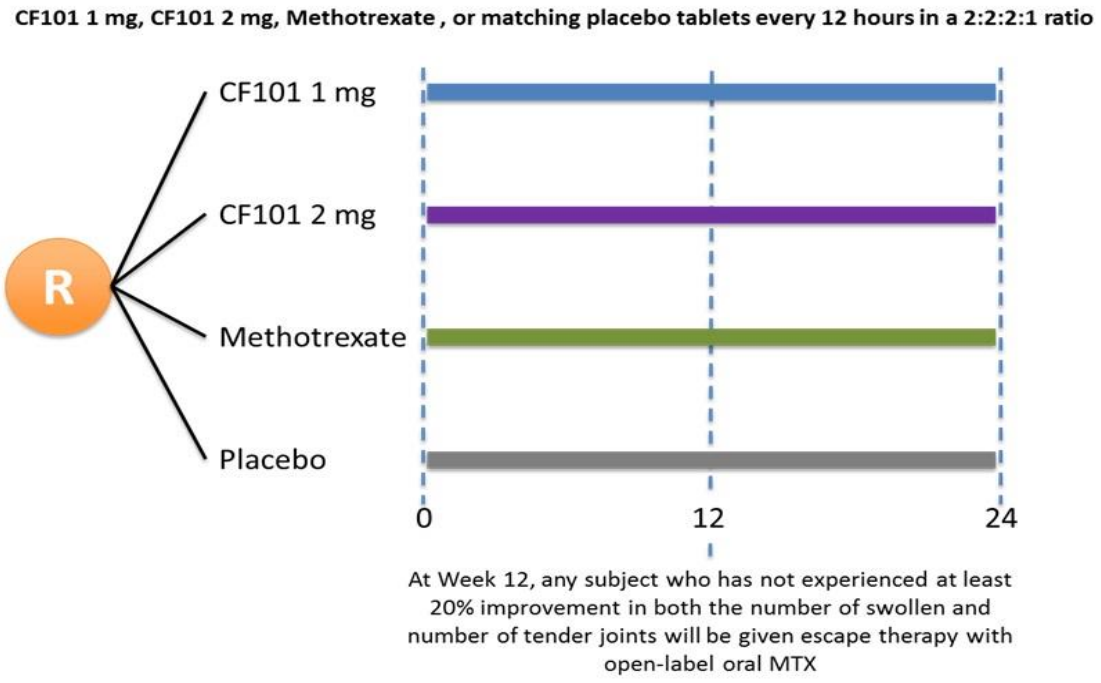
Exhibit 7. CF101 (Piclidenoson), RA Phase 2b Study Versus Placebo and Methotrexate (MTX)



Source: Can-Fite Biopharma presentation.

Can-Fite has now commenced ACRobat, a Phase 3 trial of Piclidenoson for RA. Piclidenoson is being developed as a first-line therapy and replacement for the current standard of care, MTX, the most widely used drug for RA. The trial is a randomized, double-blind, active and placebo-controlled study to establish non-inferiority of Piclidenoson versus MTX, conducted in 525 patients worldwide. We anticipate complete enrollment could occur by the end of 2018 with data six to nine months after the last patient is treated. The primary endpoint of ACRobat is disease activity score after 12 weeks of treatment in patients dosed with Piclidenoson compared to those dosed with MTX. Piclidenoson at 1mg and 2mg, or placebo, is to be administered twice daily, and MTX or placebo is to be administered once weekly. The total study duration is planned for 24 weeks in order to provide more data on long-term efficacy and safety.

Exhibit 8. ACRobat – Phase 3 Clinical Trial for Patients with Moderate-to-Severe RA



Source: Can-Fite Biopharma presentation.

The RA market opportunity. With an incidence rate of 41 out of 100,000 and growing, the economic burden on healthcare systems for RA is significantly large. According to Research and Markets, the RA market has already surpassed more than $25 billion in 2016 and should continue to grow.[9,10] Drug development for RA has shifted towards novel biologic therapies, making these second-class DMARDs, such as Humira (adalimumab), Enbrel (etanercept), and Remicade (infliximab), among the best-selling therapeutics in the world with combined sales of $33 billion in 2016.[11] Alternatives to costly biologics and earlier lines of treatment before progressing to need a biologic are highly desired. Can-Fite's Piclidenoson could be an ideal therapy for RA (and other autoimmune diseases) and an alternative to methotrexate, first-line therapy and prior to biologics.

The U.S. market opportunity. According to the GBI Research, the U.S. RA medication market is estimated to increase from $6.4 billion in 2013 to $9.3 billion by 2020. [12] Currently, approved drugs for RA include non-steroidal anti-inflammatory agents (NSAIDs), corticosteroids, conventional disease modifying anti-rheumatic drugs (DMARDs), targeted oral treatments, and biologic DMARDs. Although prices for conventional DMARDs are decreasing; novel biologic DMARDs are high in price, and can cost up to $30,000 per patient annually. Piclidenoson is intended to treat those patients who have failed first class DMARDs; and due to high rates of RA patients who express elevated levels of A_3AR, this segment of the market represents a significant commercial opportunity.

The psoriasis indication. Psoriasis is a common, chronic, immune-mediated disorder that causes epithelial cells to build up and form scales and itchy, dry patches. The disease typically affects patients outside of their elbows, lower back, knees or scalp. Psoriasis can be associated with further serious health conditions, such as diabetes, heart disease, and depression. According to the World Psoriasis Day consortium, 125 million people worldwide suffer from the disease. Several forms of the disease exist, but plaque psoriasis is the most common type, accounting for about 85% of all cases.[13]

Affecting approximately 6 million individuals in the U.S., plaque psoriasis is one of the most common skin diseases. Patients with plaque psoriasis are characterized as having swollen red skin lesions with a silvery white scale. Pathogenesis of psoriasis involves the activation of T-cells, which results in the abnormal hyper-proliferation and differentiation of keratinocytes, and infiltration of inflammatory elements.[14] As immune cells shift from the dermis to the epidermis, keratinocytes are stimulated. High proliferation of keratinocytes stimulates an inflammatory response, in which cytokines such as IL-1, IL-6, IL-8, TNF-α, and antimicrobial peptides are then activated. Due to this event, faulty signals are sent out to accelerate the growth cycle of skin cells. Normally, new skin cells would take weeks to move to the skin's surface. However, with psoriasis, the process only takes a few days, resulting in accrued formation of thick patches called plaques.

Although there is currently no cure for psoriasis, several treatment options are available for patients to reduce inflammation and clear some symptoms. Mild forms of the disease are treated with topical agents, moderate forms with phototherapies, and severe forms with systemic agents. Biologic therapies, such as the TNF-α and IL-12/23 inhibitors are also used to treat moderate-to-severe plaque psoriasis. Leading biologic treatments approved for psoriasis include Adalimumab (Humira), Etanercept (Enbrel), and Infliximab (Remicade). Although biologics produce mild side-effects compared to the other types of treatments, these drugs increase the risk of serious infection such as lymphoma, tuberculosis and neurological diseases due to immune-suppression. Can-Fite is developing Piclidenoson as a potentially safer, more convenient therapy for patients with moderate-to-severe psoriasis.

[9] https://www.researchandmarkets.com/research/dbrsks/global_rheumatoid

[10] https://www.visiongain.com/Press_Release/403/Rheumatoid-arthritis-drug-market-will-reach-38-5bn-in-2017-predicts-visiongain-in-new-report

[11] http://www.genengnews.com/the-lists/the-top-15-best-selling-drugs-of-2016/77900868

[12] https://www.rheumatoidarthritis.org/treatment/costs/

[13] http://www.healthline.com/health/photos-types-psoriasis#plaque4

[14] http://legacy.jyi.org/volumes/volume4/issue1/articles/grove.html

The psoriasis market opportunity. Psoriasis is the most common autoimmune disease, affecting 125 million individuals. The U.S. prevalence of psoriasis among adults ages 20 years and older is 3.2%, which translates to approximately 6.9 million individuals.[15] The overall world market for psoriasis medicine is estimated to reach $11.4 billion in 2020.[16] Biologics are being developed as some of the best-selling therapeutics, greatly increasing the market price for autoimmune indications.

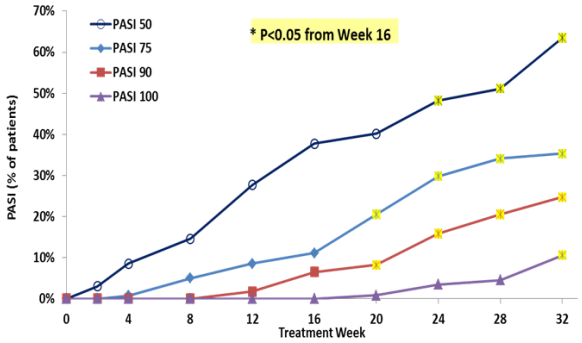
The rationale for utilizing Piclidenoson to treat psoriasis stems from Can-Fite's pre-clinical pharmacology studies showing that Piclidenoson acts as an anti-inflammatory agent via the inhibition of inflammatory cytokines, including TNF-α, which plays a major role in the pathogenesis of psoriasis. In addition, overexpression of A_3AR is found in tissues and PBMCs of patients with psoriasis.

Can-Fite completed an exploratory Phase 2 trial in ten European and Israeli medical centers involving 76 patients. This study was randomized, double-blind, and placebo-controlled and included four cohorts of 1.0, 2.0, and 4.0mg of Piclidenoson and a placebo for a 12-week period. Piclidenoson met efficacy endpoints and was safe, well tolerated and effective in ameliorating disease manifestations in these patients. The patient group receiving 2.0 mg of Piclidenoson BID showed progressive improvement over the course of the 12-week study in PGA (Physician Global Assessment) and PASI (Psoriasis Area Severity Index) scores. Analysis of the mean change from baseline in the PASI score at week 12 revealed a statistically significant difference between the 2.0 mg Piclidenoson BID treated group and the placebo group ($P < 0.001$ versus baseline and $P = 0.031$ versus placebo). Analysis of the PGA score revealed that 23.5% of the patients treated with the 2.0 mg Piclidenoson BID achieved a score of 0 or 1, in comparison to 0% in the placebo group ($P < 0.05$). The study also demonstrated linear improvement in patients in both PASI and PGA. No drug-related serious adverse events were evident during the study.

In March 2015, Can-Fite announced that a Phase 2/3 study did not meet its primary endpoint of a statistically significant improvement in the PASI 75 score relative to placebo after 12 weeks of treatment. Further analysis of the entire study period revealed that by 32 weeks of treatment with Piclidenoson, 33% of the patients achieved PASI 75 while the mean percent of improvement in PASI score was 57% ($p<0.001$). This was a statistically significant cumulative and linear improvement during weeks 16 to 32. Most significantly, by week 32 of the study, 20% of the study patients reached PASI 90, a result demonstrating a response rate of 90% clearing of skin lesions. PASI 90 is one of the most stringent and difficult to meet clinical endpoints for measuring responses to psoriasis treatments. Moreover, the PASI 90 subset analysis further suggests a higher and significant ($p=0.026$) Piclidenoson response rate of 27% among patients previously untreated with systemic psoriasis therapy compared to patients pre-treated with systemic drugs. Can-Fite believes this presents the opportunity for Piclidenoson to be developed as first-line systemic therapy for patients with moderate-severe psoriasis and for patients who do not want to be treated with the current systemic drugs due to safety issues.

Can-Fite is commencing a global pivotal Phase 3 trial. The trial is a randomized, double-blind, placebo- and active-controlled study that is to investigate the efficacy and safety of daily Piclidenoson administered orally as compared to placebo. We expect the study may enroll up to 400 patients with moderate-to-severe plaque psoriasis and enrollment should take eight months once all sites are open. Medication is to be taken orally twice daily for 32 weeks in a double-blinded fashion. The primary end point is to be the proportion of subjects who achieve a PASI score response of ≥75% (PASI 75) vs. placebo at week 16. The secondary endpoints are planned to include non-inferiority to Otezla on week 32 and efficacy and safety data for CF101 through the extension period of up to 48 weeks of treatment. Patients are to be selected to the study based on over expression of the A_3AR biomarker. We expect data approximately a year after the last patient is treated, suggesting data by YE2020.

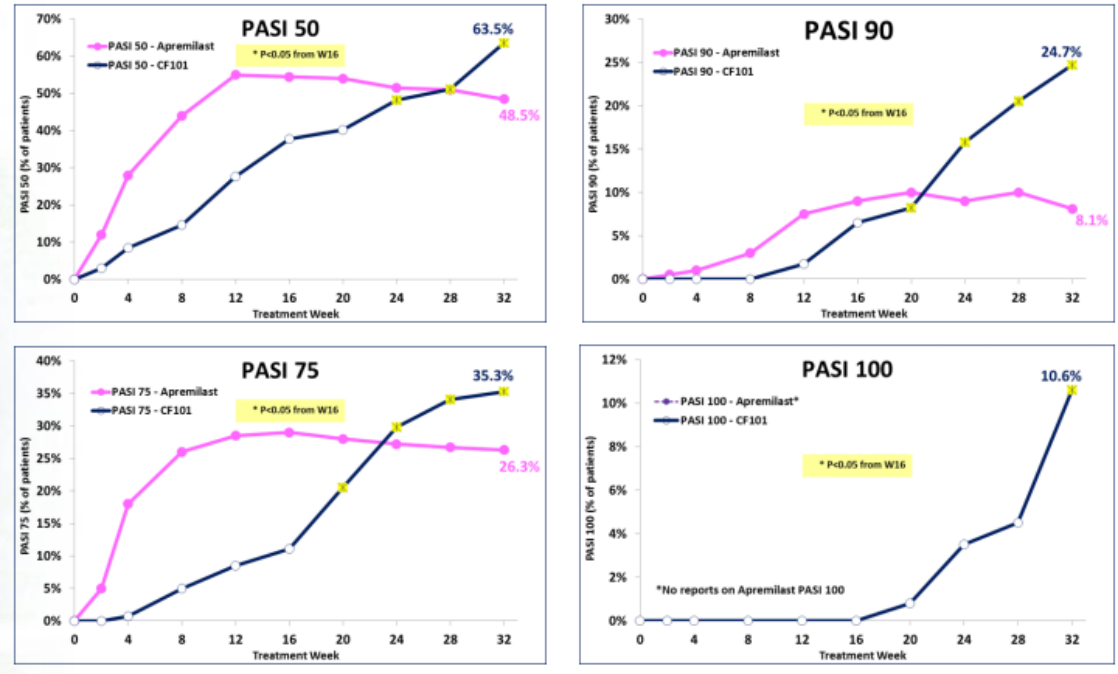
Exhibit 9. ACRobat – Phase 2/3 study did not achieve the primary endpoint of PASI 75 at 12 weeks but did show an excellent safety profile for long-term use. The Phase 2/3study showed patient response improved over time with positive linear data on weeks 12 to 32



Source: Can-Fite Biopharma presentation.

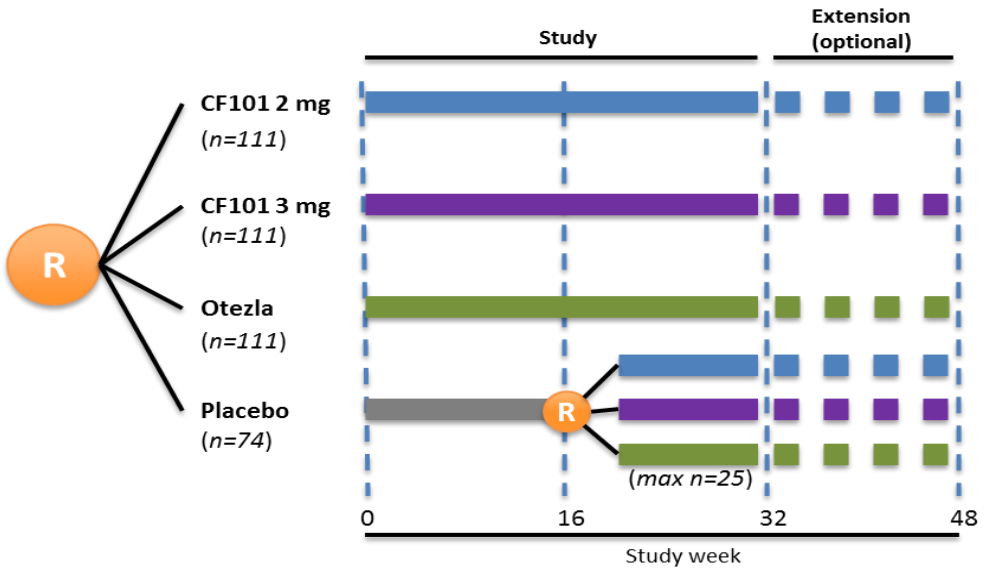
[15] https://www.ncbi.nlm.nih.gov/pubmed/24388724
[16] http://www.prnewswire.com/news-releases/psoriasis-drugs-market-forecasts-2016-2026-584674561.html

Exhibit 10. Piclidenoson Psoriasis 325 Person Phase 2/3 study, Placebo Controlled Versus Otezla



Source: Can-Fite Biopharma presentation.

Exhibit 11. Comfort – Phase 3 Clinical Trial for Patients with Moderate-to-Severe Plaque Psoriasis



Source: Can-Fite Biopharma presentation.

The comfort trial is planned to be a randomized, double-blind, active and placebo-controlled Phase 3 trial. Approximately 407 patients are to be selected to enroll in Europe, Canada, and Israel based on over expression of the A_3AR biomarker. Comfort was designed to establish Piclidenoson superiority vs. placebo and non-inferiority vs. Otezla. The trial is planned to have a total duration of 32 weeks with an optional extension to 48 weeks. We assume eight months to enroll the study with data a year after the last patient is treated.

2. CF102, Namodenoson. This is an oral, A_3AR agonist for the treatment of liver cancer. Can-Fite's Namodenoson is being developed for several indications including hepatocellular carcinoma (HCC, Child-Pugh Class B). The Child-Pugh score (or the Child–Turcotte–Pugh score or Child Criteria) is used to assess the prognosis of chronic liver disease, mainly cirrhosis. Although it was originally used to predict mortality during surgery, it is now used to determine the prognosis, as well as the required strength of treatment and the necessity of liver transplantation. Namodenoson has been granted Orphan Drug Designation in the U.S. and Europe, and Fast Track designation by the FDA as a second-line treatment for HCC, for patients that have progressed on standard of care Nexavar. Namodenoson is being developed as a second highly selective A_3AR agonist, with a similar mechanism as Piclidenoson; inhibiting inflammation and inducing apoptosis of target cells (inflammatory or cancer). As such, Namodenoson is also being developed for non-alcohol steatohepatitis (NASH) and non-alcohol fatty liver disease (NAFLD). Due to the high presence of A_3AR on liver cancer cells and peripheral blood mononuclear cells (PBMCs), Can-Fite can use high A_3AR presence as a predictive biomarker for patient's response to the drug. Preclinical studies have shown Namodenoson's ability to not only inhibit the growth of HCC but growth of hepatitis C virus (HCV).

Hepatocellular Carcinoma. The most common form of human liver cancer, hepatocellular carcinoma (HCC), accounts for 75% of all liver cancers. HCC is primarily caused by infection with hepatitis B or C (HBV, HCV), or cirrhosis of the liver caused by alcoholism.[17] Approximately 30,000 new incidences of HCC occur each year in the U.S., with diagnosis for men occurring three times more often than women. Although HCC is relatively uncommon in the U.S., the worldwide incidence is rising due to the spread of HCV/HBV infection. HCC is the sixth most common form of cancer worldwide. The five-year survival rate of patients after curative resection has been reported to be 30 to 50%.[18] HCC patients typically do not experience symptoms until later stages of the disease. Symptoms include weight loss, upper abdominal pain, or yellowing of the skin (jaundice). HCC patients demonstrate high expression of the A_3AR in their tumor tissues and their peripheral blood mononuclear cells (PBMCs). The high expression level of the receptor was directly correlated to overexpression of NF-kB, known as a transcription factor of A_3AR.[19] Available treatments for HCC include curative resection, liver transplant, radiofrequency ablation, trans-arterial chemoembolization, and radio-embolization. The treatment of HCC depends on the tumor stage, patient performance status and liver function reserve, and requires a multidisciplinary approach.[20] However, Nexavar (Sorafenib) is the only FDA approved chemotherapy for advanced disease.

In a study conducted by Lee Cheng, *Determinants of Survival After Sorafenib Failure in Patients with BCLC-Hepatocellular Carcinoma in Real-World Practice*, during a 7.5-month period, 96/149 (64.4%) patients died while receiving Sorafenib, while 120/149 (80.5%) of patients developed Progressive Disease (PD). Can-Fite is developing Namodenoson as a second-line treatment for patients whose disease did not demonstrate a positive outcome after using Sorafenib.

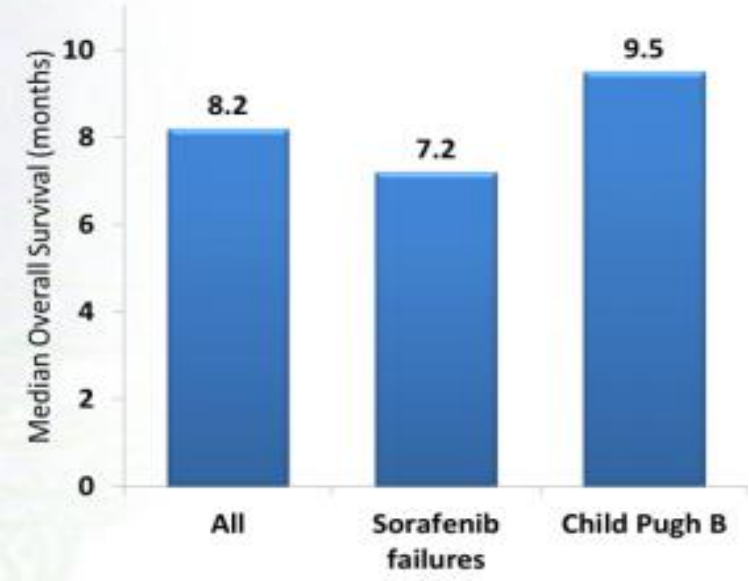
Clinical background. Namodenoson completed two Phase 1/2 studies in Israel, one in patients with HCC and another in patients with HCV. The HCC Phase 1/2 study was an open-label, dose-escalation study evaluating the safety, tolerability, pharmacokinetics, and pharmacodynamics of orally administered Namodenoson in patients with advanced HCC. The study included 18 patients, nine of which were also carriers of HCV. The initial dose of Namodenoson was 1.0 mg BID, with planned dose escalations in subsequent cohorts to 5.0 and 25.0 mg BID. This Phase 1/2 study demonstrated a positive safety profile and linear pharmacokinetics with no dose-limiting toxicities. The median overall survival in Namodenoson treated patients was 7.8 months. Importantly, 67% of the patients had previously progressed on Nexavar, and 28% of patients were classified as Child-Pugh Class B (chronic liver disease, severe impairment). The OS in this population is only 3.5 to 5.5 months, historically. Namodenoson did not impact liver function over a six-month period in 12 of the patients. As was the case for Piclidenoson, the Namodenoson response was greater in patients with HCC that had high expression of A_3AR.

[17] http://www.cancercenter.com/liver-cancer/types/
[18] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2687566/
[19] https://www.ncbi.nlm.nih.gov/pubmed/18636149
[20] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3989948/

In the second Phase 1/2 study (N=32), orally administered Namodenoson was evaluated in patients with chronic HCV genotype 1 infection. Patients received QD or BID treatment of 1.0, 5.0 or 25.0 mg of Namodenoson for 15 days or placebo. The primary endpoint was to assess the HCV viral load during 15 days of treatment with Namodenoson. The secondary endpoint explored the relationship between A_3AR expression in PBMCs at baseline and clinical outcome. Following the decrease in HCV load that had been observed in HCV patients treated with Namodenoson (in the parallel HCC study) and the established safety profile of Namodenoson, Can-Fite received Israeli IRB, approval to extend the treatment period in the Phase 1/2 HCV study to four months with the 1.0 mg dose. Results demonstrated no significant decrease in the viral load. Notwithstanding, it was observed in the study that seven out of the nine patients with both HCC and HCV experienced a decrease in viral load and that these seven patients were treated with higher Namodenoson dosages than what was administered to the patients with chronic HCV genotype 1 only, and not HCC, possibly explaining the difference in results. The HCV element of this study helped to re-enforce the notion that Namodenoson may be hepato-protective agent.

Can-Fite is currently conducting a Phase 2 global study of Namodenoson as a second-line treatment in Child-Pugh B HCC. The study has completed enrollment of the target 78 patients as of August 9, 2017. Patients enrolled in the study have advanced HCC; Child-Pugh Class B. The primary endpoint of the study is event-driven, (75 events), overall survival. The literature on expected survival in this group of patients is based on limited data from multiple sources and time periods, so its value and applicability in predicting OS for a small Phase 2 study are limited. As a rough tool, it suggests an expected survival for the control group of just 3.5 months. As such we should see data by year-end. Both the FDA and EMA have granted orphan status for Namodenoson, and the FDA has also granted Fast Track designation. Pending the outcome of the study, a single pivotal Phase 3 study would likely follow and should be sufficient for approval.

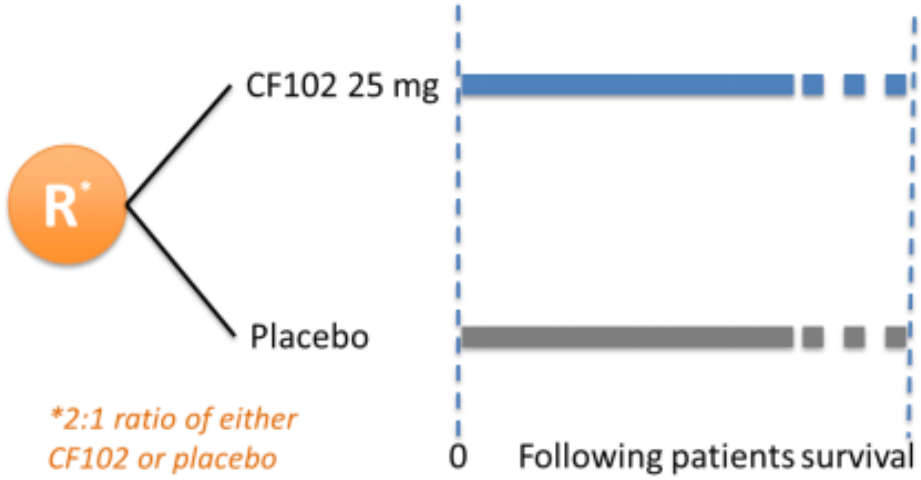
Exhibit 12. Namodenoson Phase 1/2 Study Results



Source: Stemmer et al. The Oncologist, 2012

In the Phase 1/2 study, Namodenoson-treated patients experienced median overall survival of 7.8 months. In patients that failed Nexavar, the OS was 7.2 months and was even higher at 9.5 months in patients that were Child-Pugh Class B. Again, the expected overall survival in these groups historically is only 3.5 to 5.5 months.

Exhibit 13. Namodenoson Phase 2 Study Design HCC



Source: Can-Fite Biopharma presentation.

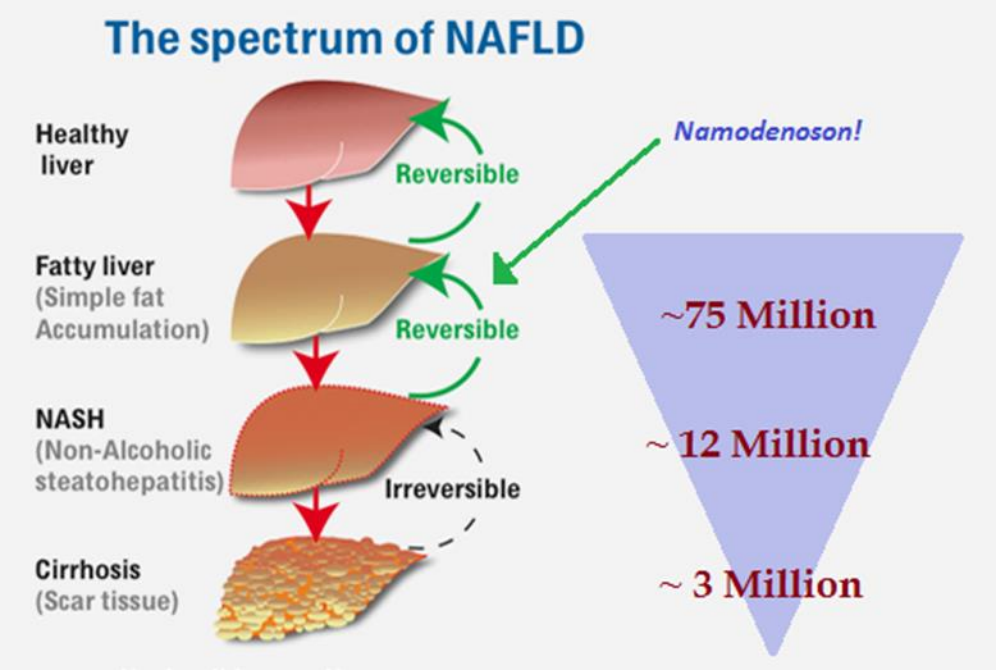
The Phase 2 study is a randomized, double-blind, placebo-controlled trial conducted in the U.S., Europe, and Israel. Target enrollment is N=78, which completed in 2Q17. Namodenoson is being evaluated for efficacy and safety as a second-line treatment for advanced HCC in subjects with Child-Pugh B who failed Nexavar as a first-line treatment.

HCC Market Information. According to the American Cancer Society (ACS), liver cancer affects more than 700,000 people worldwide each year, with an estimated 600,000 deaths occurring every year. The ACS also estimates that 30,532 new cases were diagnosed in the U.S. in 2017. The growth market for liver cancer should rise from $420 million in 2014 to $550 by 2024.[21] Sales in Nexavar, the only approved drug for the treatment of advanced or metastatic HCC, is predicted to exceed $1 billion in sales in 2018.[22] With the high market penetration, Can-Fite has a significant opportunity to commercialize CF102 as a second-line treatment for HCC.

Namodenoson in NASH/NAFLD. Non-alcoholic fatty liver disease (NAFLD) is characterized by the accumulation of fats in the liver in the form of triglycerides (steatosis). NAFLD includes a range of liver diseases, with NASH being the more advanced form. NASH is a severe form of NAFLD, which is characterized by inflammation in the liver in addition to the presence of excess liver fat. NASH is often discovered incidentally, often times by elevated liver enzyme levels in blood tests. NASH patients may be asymptomatic or suffer from fatigue, with other symptoms occurring as the liver disease advances. As the disease progresses, persistent fatty infiltration and inflammation cause liver damage marked by fibrosis and the gradual loss of normal liver cells, which dramatically increases the risk of late-stage severe liver diseases, such as cirrhosis, carcinoma, and end-stage liver disease, each potentially requiring liver transplantation. In addition to its serious hepatic complications, NASH is also associated with an increased risk of cardiovascular complications associated with metabolic syndrome. Metabolic syndrome is a serious health condition caused by obesity, physical inactivity, and genetic factors that result in a higher risk of cardiovascular disease, diabetes, stroke, and diseases related to fatty buildups in artery walls. Patients with NASH have an increased overall mortality rate, as compared to control populations, and independent third-party epidemiological studies have shown that this increased mortality is a result of liver-related mortality and a higher risk of cardiovascular disease associated with NASH.

[21] https://www.thepharmaletter.com/article/hepatocellular-carcinoma-treatment-market-will-see-marginal-growth-over-next-10-years-globaldata
[22] http://www.fiercepharma.com/special-report/nexavar

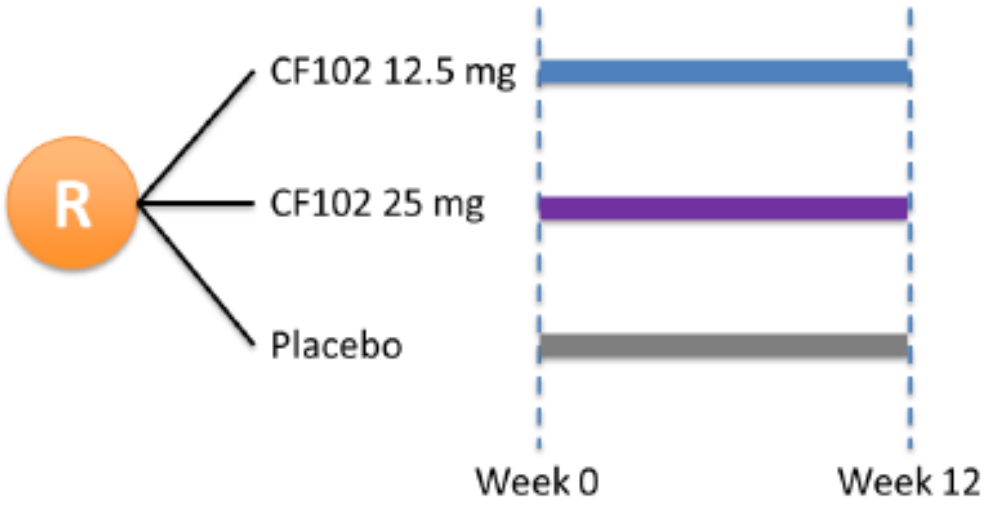
Exhibit 14. Progression of a Normal Liver to NASH and Cirrhosis



Source: VitaminDWiki, Can-Fite

Clinical Development in NAFLD/NASH. This is a Phase 2 study in NAFLD (a disease considered to be a pre-cursor to NASH). The study is a multicenter, randomized, double-blinded, placebo-controlled, dose-finding efficacy and safety study in 60 patients with NAFLD with or without NASH. Patients are planned to be enrolled in three arms, two receiving Namodenoson at different doses and a placebo arm. Dosing is planned to be BID. The primary endpoint of the study is planned to be the mean percent change from baseline in serum alanine aminotransferase (ALT) levels and safety. Secondary endpoints are planned to be hepatic steatosis, specifically the percentage change from baselines in liver triglyceride (fat) concentration measured by magnetic resonance imaging-determined proton-density fat-fraction (MRI-PDFF). We expect enrollment to complete by the end of this year, which suggests we could see data by 1H19.

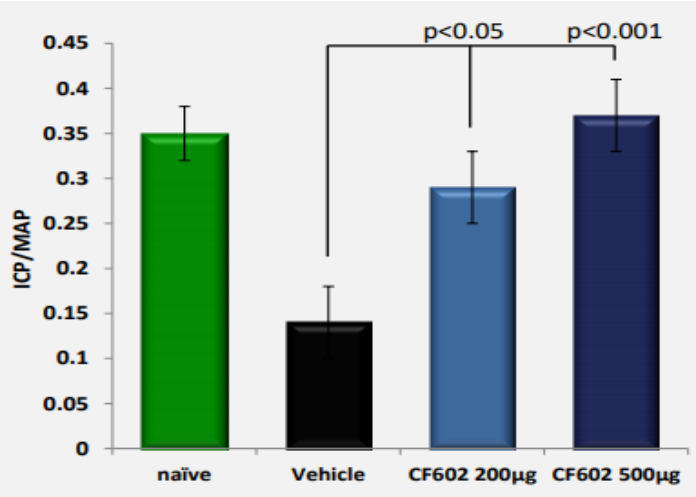
Exhibit 15. Namodenoson Phase 2 NAFLD/NASH Design



Source: Can-Fite Biopharma presentation.

CF 602 for Erectile Dysfunction. In addition to CF101 and CF102, Can-Fite is also developing CF602. It appears to be a novel A_3AR allosteric modulator which is highly selective of the A_3A receptor. According to data from preclinical studies, CF602 has potential to treat several inflammatory diseases, and the company is first targeting erectile dysfunction (ED). ED has been found to be associated with multiple inflammatory markers. ED affects approximately 30 million men in the United States and is a condition in which a man cannot achieve or sustain an erection during sexual intercourse.[23] Can-Fite has tested Namodenoson for the treatment of ED in animal (rat) models, (which are considered to be predictable in man) with diabetic mellitus. The American Diabetes Association estimates that 35-75% of men with diabetes mellitus suffer from erectile dysfunction. A standard method of treatment includes sildenafil citrate (Viagra), which today is a blockbuster drug with annual sales between of approximately $1.5 billion.

Exhibit 16. CF602 in a Rat ED Model



Source: Can-Fite Biopharma presentation.

The study demonstrated significant full recovery from erectile dysfunction in a diabetic rat model. CF602 induced a response after only a single dose. Namodenoson's novel mechanism of action involves up-regulation of eNOS and VEGF and improves vasodilation and smooth muscle relaxation. We expect the company to advance this program only in collaboration with a partner, based on the current capital constraints.

3. Multiple Regional Partnerships. Can-Fite has received approximately $14 million in upfront and milestone payments from multiple partners including Kwang Dong (Korea: A009290; not rated) to develop and commercialize Piclidonoson for RA in the home country, Chong Kun Dang (Korea: 185750; not rated) for Namodenoson for HCC in Korea. Lastly, Gebro Pharma (private) for Piclodenoson in RA and psoriasis in Spain and Austria.

Exhibit 17. Regional out-licensing Deals as a source of non-dilutive capital

KWANG DONG [Trades on South Korean Stock Exchange (Ticker: A009290)]
- Exclusive regional license to develop and commercialize Piclidenoson for the treatment of rheumatoid arthritis in Korea

cipher [Trades on TSX: (Ticker: CPH)]
- Exclusive regional license to distribute Piclidenoson for the treatment of rheumatoid arthritis and moderate to severe psoriasis in Canada

Chong Kun Dang Pharm. [Traded on South Korean Stock Exchange (Ticker: 185750)]
- Exclusive distribution agreement in South Korea for distribution of Namodenoson for treatment of liver cancer

Gebro Pharma [privately-own company]
- Exclusive regional license to distribute Piclidenoson for the treatment of rheumatoid arthritis and moderate to severe psoriasis in Spain, Switzerland and Austria

CMS 康哲药业 [Trades on Hong Kong Stock Exchange (Ticker: 867)]
- Exclusive regional license to develop, register & market Piclidenoson & Namodenoson in China, Hong Kong, Macao and Taiwan.

Source: Can-Fite Biopharma presentation

[23] http://www.healthline.com/health/erectile-dysfunction/ed-natural-treatments#overview1

Product Modeling Assumptions

1. We assume a second study is likely to follow the current pivotal programs for Piclidenoson in RA and psoriasis. If we assume a similar size, cost and time for the studies it suggests we could see a U.S. and EU approval in rheumatoid arthritis in 2022, followed by for approval in psoriasis in 2023.
2. We assume Can-Fite may partner Piclidenoson (and Namodenoson). For the purpose of our model we assume a sliding scale royalty at a base of 25% but rising to 30% based on sales levels. In accordance with this assumption, we only moderately increase G&A expenses as the company is not likely to build a salesforce in this scenario.
3. We assume pricing of $5,000 in the U.S. and $3,000 in Europe with a 2% year on year increases for Piclidenoson in RA and Psoriasis and the target population is assumed to be high A_3AR expressers.
4. A probability success factor of 50% to our models for RA and Psoriasis as this is still a Phase 2 product.
5. We assume Namodenoson is approved and launches (U.S. and Europe), for late-stage liver cancer in 2022.
6. We assume Namodenoson pricing of $50,000 in the U.S. and $35,000 in Europe with a 2% y/y increase.
7. A probability success factor of 50% is applied to our HCC model based which is based on Phase 2 data.
8. A probability success factor of 10% to our U.S. and EU models for NAFLD/NASH as the current Phase 2 study is exploratory and the clinical development pathway for this indication is long and expensive and may require a partner to pay development costs. As such we believe it's prudent to heavily discount the indication.
9. We do not include CF 602 for the ED indication in our model as the product is still in early stages of testing. We assume a partner is needed to move the project into the clinic.

Exhibit 18. U.S. Market Model for RA

Piclidenoson - CF101 (US)	2018E	2019E	2020E	2021E	2022E	2023E	2024E	2025E	2026E	2027E
Rheumatoid arthritis incidence	1,560,600	1,591,812	1,623,648	1,656,121	1,689,244	1,723,029	1,757,489	1,792,639	1,828,492	1,865,061
Increase in incidence	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Patients with RA and high levels of A3AR biomarker expression (70%)	1,092,420	1,114,268	1,136,554	1,159,285	1,182,471	1,206,120	1,230,242	1,254,847	1,279,944	1,305,543
Patients that only received non-biologics DMARDS (70%)	764,694	779,988	795,588	811,499	827,729	844,284	861,170	878,393	895,961	913,880
Market Penetration					1.0%	2.0%	6.2%	11.9%	18.1%	22.1%
Patients receiving CF101					8,277	16,886	53,393	104,529	162,169	201,968
Annual cost of treatment					$ 5,000	$ 5,100	$ 5,202	$ 5,306	$ 5,412	$ 5,520
Increase in Price					2%	2%	2%	2%	2%	2%
Revenue ('000)					$ 41,386	$ 86,117	$ 277,748	$ 554,634	$ 877,684	$ 1,114,942
Probability of Success					50%	50%	50%	50%	50%	50%
Total Revenue ('000)					**$ 20,693**	**$ 43,058**	**$ 138,874**	**$ 277,317**	**$ 438,842**	**$ 557,471**

Source: Dawson James

Exhibit 19. EU Market Model for RA

Piclidenoson - CF101 (EU)	2018E	2019E	2020E	2021E	2022E	2023E	2024E	2025E	2026E	2027E
Rheumatoid arthritis incidence	3,017,160	3,077,503	3,139,053	3,201,834	3,265,871	3,331,188	3,397,812	3,465,768	3,535,084	3,605,785
Increase in incidence	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Patients with RA and high levels of A3AR biomarker expression (70%)	2,112,012	2,154,252	2,197,337	2,241,284	2,286,110	2,331,832	2,378,469	2,426,038	2,474,559	2,524,050
Patients that only received non-biologics DMARDS (70%)	1,478,408	1,507,977	1,538,136	1,568,899	1,600,277	1,632,282	1,664,928	1,698,227	1,732,191	1,766,835
Market Penetration					1.0%	2.0%	5.0%	11.0%	13.5%	18.2%
Patients receiving CF101					16,003	32,646	83,246	186,805	233,846	321,564
Annual cost of treatment					$ 3,000	$ 6,600	$ 6,732	$ 6,867	$ 7,004	$ 7,144
Increase in Price					2%	2%	2%	2%	2%	2%
Revenue ('000)					$ 48,008	$ 215,461	$ 560,415	$ 1,282,722	$ 1,637,850	$ 2,297,270
Probability of Success					50%	50%	50%	50%	50%	50%
Total Revenue ('000)					**$ 24,004**	**$ 107,731**	**$ 280,207**	**$ 641,361**	**$ 818,925**	**$ 1,148,635**

Source: Dawson James

Exhibit 20. U.S. Market Model for Psoriasis

Piclidenoson - CF101 (US)	2018E	2019E	2020E	2021E	2022E	2023E	2024E	2025E	2026E	2027E
Psoriasis incidence	7,178,760	7,322,335	7,468,782	7,618,158	7,770,521	7,925,931	8,084,450	8,246,139	8,411,061	8,579,283
Increase in incidence	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Plaque psoriasis (80%)	5,743,008	5,857,868	5,975,026	6,094,526	6,216,417	6,340,745	6,467,560	6,596,911	6,728,849	6,863,426
Moderate to severe plaque psoriasis (17%)	976,311	995,838	1,015,754	1,036,069	1,056,791	1,077,927	1,099,485	1,121,475	1,143,904	1,166,782
Patients seeking treatment (84%)	820,102	836,504	853,234	870,298	887,704	905,458	923,568	942,039	960,880	980,097
Market Penetration						1.0%	3.0%	6.0%	9.0%	15.0%
Patients receiving CF101						9,055	27,707	56,522	86,479	147,015
Annual cost of treatment						$ 5,000	$ 5,100	$ 5,202	$ 5,306	$ 5,412
Increase in Price						2%	2%	2%	2%	2%
Revenue ('000)						$ 45,273	$ 141,306	$ 294,029	$ 458,862	$ 795,667
Probability of Success					50%	50%	50%	50%	50%	50%
Total Revenue ('000)					**$ -**	**$ 22,636.46**	**$ 70,653**	**$ 147,015**	**$ 229,431**	**$ 397,833**

Source: Dawson James

Exhibit 21. EU Market Model for Psoriasis

Piclidenoson - CF101 (EU)	2018E	2019E	2020E	2021E	2022E	2023E	2024E	2025E	2026E	2027E
Psoriasis incidence	11,548,440	11,779,409	12,014,997	12,255,297	12,500,403	12,750,411	13,005,419	13,265,528	13,530,838	13,801,455
Increase in incidence	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Plaque psoriasis (80%)	9,238,752	9,423,527	9,611,998	9,804,238	10,000,322	10,200,329	10,404,335	10,612,422	10,824,670	11,041,164
Moderate to severe plaque psoriasis (17%)	1,570,588	1,602,000	1,634,040	1,666,720	1,700,055	1,734,056	1,768,737	1,804,112	1,840,194	1,876,998
Patients seeking treatment (84%)	1,319,294	1,345,680	1,372,593	1,400,045	1,428,046	1,456,607	1,485,739	1,515,454	1,545,763	1,576,678
Market Penetration						1.0%	2.0%	9.0%	12.0%	14.0%
Patients receiving CF101						14,566	29,715	136,391	185,492	220,735
Price of treatment						$ 3,000	$ 3,060	$ 3,121	$ 3,184	$ 3,247
Increase in Price						2%	2%	2%	2%	2%
Revenue ('000)						$ 43,698	$ 90,927	$ 425,703	$ 590,535	$ 716,792
Probability of Success					50%	50%	50%	50%	50%	50%
Total Revenue ('000)					**$ -**	**$ 21,849**	**$ 45,464**	**$ 212,852**	**$ 295,268**	**$ 358,396**

Source: Dawson James

Exhibit 22. U.S. Market Model for HCC

Namodenoson - CF102 (US)	2018E	2019E	2020E	2021E	2022E	2023E	2024E	2025E	2026E	2027E
Hepatocellular Carcinoma incidence	42,355	43,202	44,066	44,947	45,846	46,763	47,698	48,652	49,625	50,618
Increase in incidence	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
% of deaths due to Sorafenib in patients with Barcelona Clinic Liver Cancer stage C HCC (64%)	27,107	27,649	28,202	28,766	29,341	29,928	30,527	31,137	31,760	32,395
Market Penetration					1.0%	5.0%	10.0%	20.0%	30.0%	40.0%
Patients receiving CF101					293	1,496	3,053	6,227	9,528	12,958
Price of treatment					$ 50,000	$ 51,000	$ 52,020	$ 53,060	$ 54,122	$ 55,204
Increase in Price					2%	2%	2%	2%	2%	2%
Revenue ('000)					$ 14,671	$ 76,317	$ 158,801	$ 330,433	$ 515,673	$ 715,342
Probability of Success					50%	50%	50%	50%	50%	50%
Total Revenue ('000)					**$ 7,335**	**$ 38,159**	**$ 79,400**	**$ 165,216**	**$ 257,837**	**$ 357,671**

Source: Dawson James

Exhibit 23. EU Market Model for HCC

Namodenoson - CF102 (EU)	2018E	2019E	2020E	2021E	2022E	2023E	2024E	2025E	2026E	2027E
Hepatocellular Carcinoma incidence	54,111	55,193	56,297	57,423	58,572	59,743	60,938	62,157	63,400	64,668
Increase in incidence	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
% of death occurrence due to Sorafenib in patients with Barcelona Clinic Liver Cancer stage C HCC (64%)	34,631	35,324	36,030	36,751	37,486	38,236	39,000	39,780	40,576	41,387
Market Penetration					1.0%	5.0%	10.0%	20.0%	30.0%	50.0%
Patients receiving CF101					586	2,987	6,094	12,431	19,020	32,334
Price of treatment					$ 35,000	$ 35,700	$ 36,414	$ 37,142	$ 37,885	$ 38,643
Increase in Price					2%	2%	2%	2%	2%	2%
Revenue ('000)					$ 20,500	$ 106,642	$ 221,900	$ 461,729	$ 720,574	$ 1,249,475
Probability of Success					50%	50%	50%	50%	50%	50%
Total Revenue ('000)					**$ 10,250**	**$ 53,321**	**$ 110,950**	**$ 230,864**	**$ 360,287**	**$ 624,738**

Source: Dawson James

Exhibit 24. U.S. Market Model for NASH/NAFLD

Namodenoson - CF102 (US)	2018E	2019E	2020E	2021E	2022E	2023E	2024E	2025E	2026E	2027E
NAFLD/NASH	11,548,440	11,779,409	12,014,997	12,255,297	12,500,403	12,750,411	13,005,419	13,265,528	13,530,838	13,801,455
Increase in incidence	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Market Penetration							0.25%	0.50%	0.75%	1.00%
Patients receiving CF101							32,514	66,328	101,481	138,015
Price of treatment							$ 25,000	$ 25,500	$ 26,010	$ 26,530
Increase in Price							2%	2%	2%	2%
Revenue ('000)						$ -	$ 812,839	$ 1,691,355	$ 2,639,528	$ 3,661,554
Probability of Success					10%	10%	10%	10%	10%	10%
Total Revenue ('000)					**$ -**	**$ -**	**$ 81,284**	**$ 169,135**	**$ 263,953**	**$ 366,155**

Source: Dawson James

Exhibit 25. EU Market Model for NASH/NAFLD

Namodenoson - CF102 (EU-5)	2018E	2019E	2020E	2021E	2022E	2023E	2024E	2025E	2026E	2027E
NAFLD/NASH	11,548,440	11,779,409	12,014,997	12,255,297	12,500,403	12,750,411	13,005,419	13,265,528	13,530,838	13,801,455
Increase in incidence	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Market Penetration							0.00%	0.25%	0.50%	0.75%
Patients receiving CF101							-	33,164	67,654	103,511
Price of treatment							$ 20,000	$ 20,400	$ 20,808	$ 21,224
Increase in Price							2%	2%	2%	2%
Revenue ('000)							$ -	$ 676,542	$ 1,407,748	$ 2,196,932
Probability of Success					10%	10%	10%	10%	10%	10%
Total Revenue ('000)					**$ -**	**$ -**	**$ -**	**$ 67,654**	**$ 140,775**	**$ 219,693**

Source: Dawson James

Valuation. Our valuation is based on our therapeutic models which include probability of success factors for each product and each model. For Picledenoson we use a probability of success of just 50% in RA and psoriasis. The same is true for Namodenoson in HCC. Here the mechanism of action is new, and the data is based on Phase 2 trials, and the disease conditions can be heterogeneous. For example, in HCC there are often multiple mechanisms of action behind cancer's growth. Blocking one path often results in the cancer adapting to leverage a different pathway. In NASH we assume just a 10% probability as the current study is exploratory. The result of these models then drives the company's income statement. The valuation conclusion is an equally weighted average of our FCFF, EPS, and sum-of-the-parts analysis, discounted at a rate of 30% to account for the risks of development and rounded to the nearest whole number. For companies that are well established with mature products and revenues, we typically use a 10% risk rate. For companies in the early stages of product commercialization, we typically choose a higher risk rate of 15%. For Can-Fite we use our maximum discount rate of 30% as the company does not yet have an approved therapeutic product.

Can-Fite has received approximately $14 million in upfront and milestone payments from multiple partners including Kwang Dong (Korea: A009290; not rated) to develop and commercialize Picledenoson for RA in Korea, Cipher (TSX: CPH; not rated), Chong Kun Dang (Korea: 185750; not rated) for Namodenoson for HCC and most recently Gebro Pharma (private) for Piclidenoson in RA and psoriasis in Spain and Austria. We expect to see additional and larger partnership deals which represent a source of non-dilutive capital to the company.

In our model, we assume multiple raises. The current diluted share count is approximately 55M, for purposes of our model we assume 83M shares are outstanding by 2027. At the end of September 2018, Can-Fite reported $5.7M in cash and spent $1.9M in the quarter. As such the company is funded through the next set of trial read-outs which should act as catalysts for a higher valuation.

Exhibit 26. Discounted Free-Cash-Flow Model

Average	7

Price Target	8
Year	2019

DCF Valuation Using FCF (mln):

units ('000)	2018E	2019E	2020E	2021E	2022E	2023E	2024E	2025E	2026E	2027E
EBIT	(4,642)	(13,000)	(13,160)	(13,573)	1,280	39,554	155,843	412,901	622,662	952,032
Tax Rate	0%	0%	0%	0%	0%	0%	5%	8%	12%	15%
EBIT (1-t)	(4,642)	(13,000)	(13,160)	(13,573)	1,280	39,554	148,051	379,869	547,943	809,227
CapEx	-	-	-	-	-	-	-	-	-	-
Depreciation	431	-	-	-	-	-	-	-	-	-
Change in NWC										
FCF	(4,211)	(13,000)	(13,160)	(13,573)	1,280	39,554	148,051	379,869	547,943	809,227
PV of FCF	(5,474)	(13,000)	(10,123)	(8,031)	583	13,849	39,874	78,700	87,324	99,203
Discount Rate	30%									
Long Term Growth Rate	1%									
Cash Flow	2,818,343									
Terminal Value YE2025	345,499									
NPV	633,877									
NPV-Debt										
Shares out ('000)	83,345	2027E								
NPV Per Share	7.6									

Source: Dawson James

Exhibit 27. EPS Model

Current Year	2019
Year of EPS	2027
Earnings Multiple	5
Discount Factor	30%
Selected Year EPS	11.42
NPV	7.00

	Discount Rate and Earnings Multiple Varies, Year is Constant					
	5%	10%	15%	20%	25%	30%
Earnings Multiple 2	15	11	7	5	4	3
5	39	27	19	13	10	7
10	77	53	37	27	19	14
15	116	80	56	40	29	21
20	155	107	75	53	38	28
25	193	133	93	66	48	35
30	232	160	112	80	57	42
35	271	187	131	93	67	49

Source: Dawson James

Exhibit 28. Sum-of-the-Parts Model

	LT Gr	Discount Rate	Yrs to Mkt	% Success	Peak Sales (M)	NPV
Piclidenoson (RA) U.S.	1%	30%	4	50%	$557	$1,922
NPV						$2.8
Piclidenoson (RA) EU	1%	30%	5	50%	$1,149	$3,961
NPV						$4.5
Piclidenoson (Psoriasis) U.S.	1%	30%	4	50%	$398	$1,372
NPV						$2.0
Piclidenoson (Psoriasis) EU	1%	30%	5	50%	$358	$1,236
NPV						$1.4
Namodenoson (Liver Cancer) U.S.	1%	30%	4	50%	$358	$1,233
NPV						$1.8
Namodenoson (Liver Cancer) EU	1%	30%	5	50%	$625	$2,154
NPV						$2.4
Namodenoson (NAFLD/NASAH) U.S.	1%	30%	6	10%	$366	$1,263
NPV						$0.2
Namodenoson (NAFLD/NASAH) EU	1%	30%	7	10%	$220	$758
NPV						$0.1
Pipeline	1%	30%	7	0%	$50	$172
NPV						$0.0
Net Margin						70%
MM Shrs OS (2024E)						83
Total						$6.7

Source: Dawson James

Exhibit 29. Income Statement

Can-Fite Biopharma.: Income Statement ($000)																				
.: YE December 31	2015A	2016A	2017A	1Q18A	2Q18A	3Q18A	4Q18E	2018E	1Q19E	2Q19E	3Q19E	4Q19E	2019E	2020E	2021E	2022E	2023E	2024E	2025E	2026E	2027E
Revenue:	165	170	847																		
Piclidenoson (CF-101), Rheumatoid Arthritis U.S.																44,697	43,058	138,874	277,317	438,842	557,471
Piclidenoson (CF-101), Rheumatoid Arthritis EU																24,004	107,731	280,207	641,361	818,925	1,148,635
Piclidenoson (CF-101), Psoriasis U.S.																-	22,636	70,653	147,015	229,431	397,833
Piclidenoson (CF-101), Psoriasis EU																-	21,849	45,464	212,852	295,268	358,396
Namodenoson HCC U.S.																7,335	38,159	79,400	165,216	257,837	357,671
Namodenoson HCC EU																10,250	53,321	110,950	230,864	360,287	624,738
Namodenoson NASH/NAFLD U.S.																-	-	81,284	169,135	263,953	366,155
Namodenoson NASH/NAFLD EU																-	-	-	67,654	140,775	219,693
Total Product Sales	165	170	847	-	-	-	-	-	-	-	-	-	-	-	-	76,037	233,433	614,598	1,443,761	2,040,302	2,820,006
Milestone From Gebro Holdings					270	2,629		2,899													
Piclidenoson (CF-101), Rheumatoid Arthritis U.S.																11,174	10,765	34,718	83,195	131,653	167,241
Royalty Rate from Global Partnership																25%	25%	25%	30%	30%	30%
Piclidenoson (CF-101), Rheumatoid Arthritis EU																6,001	26,933	70,052	192,408	245,677	344,590
Royalty Rate from Global Partnership																25%	25%	25%	30%	30%	30%
Piclidenoson (CF-101), Psoriasis U.S.																-	5,659	17,663	36,754	57,358	99,458
Royalty Rate from Global Partnership																	26%	39%	17%	19%	28%
Piclidenoson (CF-101), Psoriasis EU																-	5,659	17,663	36,754	57,358	99,458
Royalty Rate from Global Partnership																	26%	39%	17%	19%	28%
Namodenoson HCC U.S.																1,834	9,540	19,850	41,304	64,459	89,418
Royalty Rate from Global Partnership																25%	25%	25%	25%	25%	25%
Namodenoson HCC EU																2,563	13,330	27,737	57,716	90,072	168,679
Royalty Rate from Global Partnership																25%	25%	25%	25%	25%	27%
Namodenoson NASH/NAFLD U.S.																-	-	20,321	42,284	65,988	93,223
Royalty Rate from Global Partnership																		25%	25%	25%	25%
Namodenoson NASH/NAFLD EU																-	-	-	16,914	35,194	54,923
Royalty Rate from Global Partnership																			25%	25%	25%
Total royalties, collaborative revenue	-	-	-	632	270	2,629	-	3,531													
Total Revenue	-	170	847	632	270	2,629	-	3,531	-	-	-	-	-	-	-	21,572	71,885	208,005	507,328	747,758	1,116,992
Expenses:																					
Partnership Costs including COGS			-	-	-	-		-	-	-	-	-	-	-	-	3,802	11,672	30,730	72,188	102,015	141,000
%COGS																5%	5%	5%	5%	5%	5%
Research and Development	3,858	6,081	5,285	1,313	1,325	1,418	1,000	5,056	1,840	1,920	2,080	2,160	8,000	8,160	8,323	8,490	8,659	8,833	9,009	9,189	9,373
%R&D																					
General and Administrative	2,725	2,726	2,956	907	912	567	500	2,886	1,150	1,200	1,300	1,350	5,000	5,000	5,250	8,000	12,000	12,600	13,230	13,892	14,586
%SG&A																					
Total Expenses	6,583	8,807	8,241	2,220	2,237	1,985	1,500	7,942	2,990	3,120	3,380	3,510	13,000	13,160	13,573	20,292	32,331	52,163	94,427	125,096	164,960
Operating Income (Loss)	(6,418)	(8,637)	(7,394)	(1,588)	(1,967)	644	(1,500)	(4,411)	(2,990)	(3,120)	(3,380)	(3,510)	(13,000)	(13,160)	(13,573)	1,280	39,554	155,843	412,901	622,662	952,032
Finance expenses	564	178	1,102	(139)	(207)	774		428													
Finance income	(1,920)	(1,820)	(2,999)	6	930	(1,133)		(197)													
Total Other Income	**(1,356)**	**(1,642)**	**(1,897)**	**(133)**	**723**	**(359)**	-	**231**	-	-	-	-	-	-	-	-	-	-	-	-	-
Pretax Income	5,062	(6,995)	(4,963)	(1,721)	(1,244)	1,003	(1,500)	(4,642)	(2,990)	(3,120)	(3,380)	(3,510)	(13,000)	(13,160)	(13,573)	1,280	39,554	155,843	412,901	622,662	952,032
Taxes on income	4	29																			
Adjustments arising from translating financial statements of foreign operations		9	30															7,792	33,032	74,719	142,805
Remeasurement loss from defined benefit plans	99		-																		
Tax Rate																		5%	8%	12%	15%
GAAP Net Income (Loss)	5,066	(6,966)	(4,993)	(1,721)	(1,244)	1,003	(1,500)	(4,642)	(2,990)	(3,120)	(3,380)	(3,510)	(13,000)	(13,160)	(13,573)	1,280	39,554	155,843	412,901	622,662	952,032
Total comprehensive loss	5,066	(6,957)	(4,993)	(1,721)	(1,244)	1,003	(1,500)	(4,642)	(2,990)	(3,120)	(3,380)	(3,510)	(13,000)	(13,160)	(13,573)	1,280	39,554	163,635	379,869	547,943	809,227
GAAP-EPS	#DIV/0!	(0.25)	(0.14)	(0.05)	(0.03)	0.02	(0.04)	(0.09)	(0.06)	(0.05)	(0.06)	(0.06)	(0.22)	(0.22)	(0.22)	0.02	0.64	2.52	6.66	10.00	15.23
GAAP-EPS (Dil)			(0.14)	(0.04)	(0.03)	0.02	(0.03)	(0.08)	(0.05)	(0.04)	(0.04)	(0.04)	(0.17)	(0.16)	(0.17)	0.02	0.48	1.89	4.99	7.50	11.42
Wgtd Avg Shrs (Bas) - '000s	-	28,096	32,994	37,184	37,222	40,362	40,403	38,793	50,443	60,493	60,554	60,615	58,026	60,766	61,010	61,254	61,499	61,746	61,993	62,242	62,491
Wgtd Avg Shrs (Dil) - '000s	-	28,096	32,994	39,684	39,724	55,000	55,550	47,489	65,606	80,671	80,752	80,833	76,965	81,035	81,359	81,685	82,013	82,341	82,671	83,002	83,335

Source: Dawson James Securities

Risk Analysis
In addition to the typical risks associated with development stage specialty pharmaceutical companies, potential risks specific to Can-Fite are as follows:

Financial risk. The company may need to raise capital in the marketplace, and there can be no assurances that the company will be able to successfully raise capital and or do so, on favorable terms.

Clinical and regulatory risk. Lead products must start and complete clinical trials. Trials may not produce results sufficient for regulatory approval.

Partnership risk. Can-Fite may seek partnerships for clinical development support and commercialization. We have no specific knowledge of any discussions with possible partners today, and there can be no assurances that the company will be able to secure a favorable partnership.

Commercial risk. There are no assurances that the company will be able to secure favorable pricing, commercially launch products and achieve significant market share to become profitable.

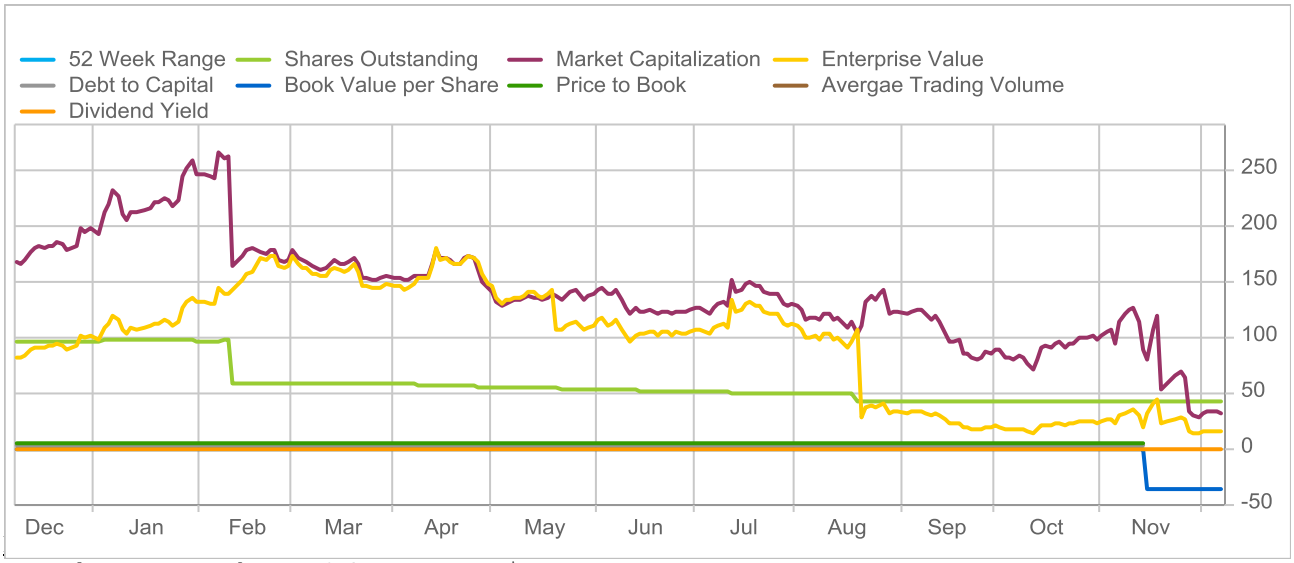
Legal and intellectual property risk. The company may have to defend its patents and technical know-how, and there can be no assurances that the patents will not be infringed or will be held as valid if challenged, and or that the company may infringe on third party's patents.

Companies mentioned in this report:

Kwang Dong (Korea: A009290; not rated)
Cipher (TSX: CPH; not rated)
Chong Kun Dang (Korea: 185750; not rated)
Gebro Pharma (private)

Important Disclosures:

Price Chart:



Initiated – Buy – December 12, 2018 – Price Target $7

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1) **Buy**: the analyst believes the price of the stock will appreciate and produce a total return of at least 20% over the next 12-18 months;
2) **Neutra**l: the analyst believes the price of the stock is fairly valued for the next 12-18 months;
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The following chart reflects the range of current research report ratings for all companies followed by the analysts of the Firm. The chart also reflects the research report ratings relating to those companies for which the Firm has performed investment banking services.

	Company Coverage		Investment Banking	
Ratings Distribution	# of Companies	% of Total	# of Companies	% of Totals
Market Outperform (Buy)	37	88%	10	27%
Market Perform (Neutral)	5	12%	0	0%
Market Underperform (Sell)	0	0%	0	0%
Total	42	100%	10	24%

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