Forward Looking Statements

This presentation contains forward-looking statements that involve substantial risks and uncertainties. All statements, other than statements of historical facts, contained in this presentation, including statements regarding our strategy, future operations, future financial position, future revenues, projected costs, prospects, plans and objectives of management, are forward-looking statements within the meaning of The Private Securities Litigation Reform Act of 1995. The words “anticipate,” “believe,” “estimate,” “expect,” “intend,” “may,” “plan,” “predict,” “project,” “target,” “potential,” “will,” “would,” “could,” “should,” “continue,” and similar expressions are intended to identify forward-looking statements, although not all forward-looking statements contain these identifying words. We may not actually achieve the plans, intentions or expectations disclosed in our forward-looking statements, and you should not place undue reliance on our forward-looking statements. Actual results or events could differ materially from the plans, intentions and expectations disclosed in the forward-looking statements we make. The forward-looking statements contained in this presentation reflect Durata’s current views with respect to future events, and Durata assumes no obligation to update any forward-looking statements except as required by applicable law.
A pharmaceutical company focused on the development and commercialization of novel therapeutics for patients with infectious diseases and acute illnesses. Its lead product candidate, dalbavancin, is in development for the treatment of patients with acute bacterial skin and skin structure infections, or ABSSSI.
Primary Asset Highlights

- Dalbavancin is a highly differentiated, late stage, product candidate
- New Phase 3 program met primary endpoints; second study to report results in Q1
- Prior phase 3 program documented efficacy, safety and tolerability
- FDA designated dalbavancin a QIDP
- Clearly defined clinical and regulatory path with FDA and EMA
- Large and growing category
- Opportunities exist for expansion beyond the primary indication
- Value added health-economics
- Worldwide development and commercial rights
- Patent coverage / exclusivity through 2023
Dalbavancin: Differentiation and Existing data
Dalbavancin: Mechanism of Action

Dalbavancin is a semisynthetic glycopeptide (lipoglycopeptide) which interferes with peptidoglycan cross-linking in the cell wall by binding to the D-ala-D-ala terminus of stem peptides.

Peptidoglycan of S. aureus

Comparative MIC90 (µg/ml) of selected agents and dalbavancin tested against Worldwide clinical isolates (2002)*

<table>
<thead>
<tr>
<th></th>
<th>S. aureus (1,815)</th>
<th>S. aureus (1,177)</th>
<th>β-hemolytic streptococci (234)</th>
<th>viridans group streptococci (30)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dalbavancin</td>
<td>0.06</td>
<td>0.06</td>
<td>0.06</td>
<td>0.03</td>
</tr>
<tr>
<td>Teicoplanin</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vancomycin</td>
<td>1</td>
<td>2</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>Oxacillin</td>
<td>S</td>
<td>R</td>
<td>PCN = 0.06</td>
<td>R</td>
</tr>
<tr>
<td>Linezolid</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

*Streit, et al. DMID 2004, p137
Dalbavancin’s pharmacokinetic profile enables:
- Broad tissue distribution
- Continuous cidality
- Once weekly dosing
- Maintenance of high plasma concentration

Dalbavancin dosed with 1000 mg IV on Day 1 and 500 mg IV on Day 8

Dorr, JAC 2005;55 Supp S2:ii25; data on file
The DISCOVER 1 protocol design is consistent with the U.S. Food and Drug Administration (FDA) Draft Guidance for Developing Drugs for Treatment of ABSSSI.

The study was conducted pursuant to a special protocol agreement (SPA) with the FDA, as well as scientific advice provided by the European Medicines Agency (EMA).

DISCOVER 1 is a randomized, double-blind, double-dummy trial conducted in 92 sites in the United States, Canada, and Eastern Europe comparing dalbavancin to a regimen of vancomycin and an option for oral linezolid for the treatment of ABSSSI.
DISCOVER 1 Endpoints

Primary Endpoint
- Early response at 48-72 post initiation of therapy
  - Cessation of spread of the erythema of the lesion, and
  - Resolution of fever
- Non-inferiority if lower limit of the 95% Confidence Interval on the Difference exceeds -10%

Secondary Endpoints
- Clinical Status at End of Therapy (Day 14-15) in CE* and ITT population
- Clinical Status at Short Term Follow-up (SFU) (Day 28), CE and ITT population
- Investigator Assessments at EOT and SFU
- Microbiologic Outcome

*Primary endpoint for EMA; CE=Clinically Evaluable; ITT =Intent to Treat;
## DISCOVER 1
### Efficacy Analysis: Primary Endpoint

<table>
<thead>
<tr>
<th>Endpoint</th>
<th>Dalbavancin</th>
<th>Vancomycin/linezolid</th>
<th>Difference (95% Confidence Interval)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary (Early Response)</td>
<td>240/288 (83.3%)</td>
<td>233/285 (81.8%)</td>
<td>1.5% (-4.6, 7.9)</td>
</tr>
<tr>
<td>Patients with MRSA</td>
<td>37/44 (84.1%)</td>
<td>32/39 (82.1%)</td>
<td></td>
</tr>
<tr>
<td>Sensitivity analysis (&gt;20% reduction in lesion area at 48-72 hours)</td>
<td>258/288 (89.6%)</td>
<td>259/285 (90.9%)</td>
<td>-1.3% (-6.1, 3.7)</td>
</tr>
</tbody>
</table>
### DISCOVER 1
Efficacy Analysis: Secondary Endpoints

<table>
<thead>
<tr>
<th>Secondary Endpoint</th>
<th>Dalbavancin</th>
<th>Vancomycin/ linezolid</th>
<th>Difference (95% Confidence Interval)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Status at EOT*</td>
<td>214/246 (87.0%)</td>
<td>222/243 (91.4%)</td>
<td>-4.4 (-9.6, 1.6)</td>
</tr>
<tr>
<td>Patients with MRSA</td>
<td>30/35 (85.7%)</td>
<td>30/31 (96.8%)</td>
<td></td>
</tr>
<tr>
<td>Investigator assessment at EOT</td>
<td>233/246 (94.7%)</td>
<td>237/243 (97.5%)</td>
<td>-2.8% (-6.7, 0.7 )</td>
</tr>
</tbody>
</table>

*EMA primary endpoint
### DISCOVER 1
**Efficacy Analysis: Secondary Endpoints**

<table>
<thead>
<tr>
<th>Secondary Endpoint</th>
<th>Patient Population</th>
<th>Dalbavancin</th>
<th>Vancomycin/ linezolid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Status at SFU</td>
<td>CE</td>
<td>212/226 (93.8%)</td>
<td>220/229 (96.1%)</td>
</tr>
<tr>
<td></td>
<td>ITT</td>
<td>241/288 (83.7%)</td>
<td>251/285 (88.1%)</td>
</tr>
<tr>
<td>Investigator assessment SFU</td>
<td>CE</td>
<td>213/226 (94.2%)</td>
<td>223/229 (97.4%)</td>
</tr>
<tr>
<td></td>
<td>ITT</td>
<td>248/288 (86.1%)</td>
<td>255/285 (89.5%)</td>
</tr>
</tbody>
</table>
DISCOVER 1
Safety Assessment

<table>
<thead>
<tr>
<th>Patients who experienced at least one of:</th>
<th>Dalbavancin (N=284)</th>
<th>Vancomycin/linezolid (N=284)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse event</td>
<td>113 (39.8%)</td>
<td>117 (41.2%)</td>
</tr>
<tr>
<td>Treatment emergent adverse event (TEAE)</td>
<td>99 (34.9%)</td>
<td>112 (39.4%)</td>
</tr>
<tr>
<td>TEAE with onset through the SFU (D28) visit</td>
<td>96 (33.8%)</td>
<td>108 (38.0%)</td>
</tr>
<tr>
<td>TEAE with onset after the SFU (D28) visit</td>
<td>12 (4.2%)</td>
<td>24 (8.5%)</td>
</tr>
<tr>
<td>Drug Related TEAE</td>
<td>35 (12.3%)</td>
<td>52 (18.3%)</td>
</tr>
<tr>
<td>Treatment emergent serious adverse events (SAE)</td>
<td>5 (1.8%)</td>
<td>12 (4.2%)</td>
</tr>
<tr>
<td>Drug related treatment emergent SAE</td>
<td>0</td>
<td>2 (0.7%)</td>
</tr>
<tr>
<td>Treatment emergent SAE leading to death</td>
<td>0</td>
<td>5 (1.8%)</td>
</tr>
<tr>
<td>TEAE leading to premature discontinuation (d/c) from drug</td>
<td>5 (1.8%)</td>
<td>6 (2.1%)</td>
</tr>
</tbody>
</table>
# DISCOVER 1

## Adverse Events

<table>
<thead>
<tr>
<th></th>
<th>Dalbavancin (N=284)</th>
<th>Vancomycin/linezolid (N=284)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unrelated</td>
<td>Related</td>
</tr>
<tr>
<td>Patients with at least one TEAE through SFU (D 28)</td>
<td>61 (21.5%)</td>
<td>56 (19.7%)</td>
</tr>
<tr>
<td></td>
<td>35 (12.3%)</td>
<td>52 (18.3%)</td>
</tr>
</tbody>
</table>

**TEAE at ≥2% in any arm**

<table>
<thead>
<tr>
<th></th>
<th>Dalbavancin</th>
<th>Vancomycin/linezolid</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unrelated</td>
<td>Related</td>
</tr>
<tr>
<td>Nausea</td>
<td>5 (1.8%)</td>
<td>7 (2.5%)</td>
</tr>
<tr>
<td></td>
<td>1 (0.4%)</td>
<td>12 (4.2%)</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>2 (0.7%)</td>
<td>2 (0.7%)</td>
</tr>
<tr>
<td></td>
<td>2 (0.7%)</td>
<td>9 (3.2%)</td>
</tr>
<tr>
<td>Headache</td>
<td>5 (1.8%)</td>
<td>9 (3.2%)</td>
</tr>
<tr>
<td></td>
<td>7 (2.5%)</td>
<td>7 (2.5%)</td>
</tr>
<tr>
<td>Pruritus</td>
<td>0</td>
<td>1 (0.4%)</td>
</tr>
<tr>
<td></td>
<td>2 (0.7%)</td>
<td>9 (3.2%)</td>
</tr>
<tr>
<td>Hypertension</td>
<td>7 (2.5%)</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>7 (2.5%)</td>
<td>0</td>
</tr>
<tr>
<td>Rash</td>
<td>2 (0.7%)</td>
<td>3 (1.1%)</td>
</tr>
<tr>
<td></td>
<td>1 (0.4%)</td>
<td>5 (1.8%)</td>
</tr>
<tr>
<td>Asthenia</td>
<td>1 (0.4%)</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>5 (1.8%)</td>
<td>1 (0.4%)</td>
</tr>
</tbody>
</table>
**Dalbavancin: Potential Opportunities Beyond the ABSSSI Indication**

<table>
<thead>
<tr>
<th><strong>Dalbavancin in ABSSSI</strong></th>
<th>Preclinical</th>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
<th>NDA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program to complete re-activated NDA will conclude in 4Q 2012 /1Q 2013</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data in Bacteremia will be available as a sub-analysis and for publication at time of launch</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Dalbavancin in Osteomyelitis**

- Program to pursue a near term publication is underway

**Dalbavancin in Diabetic Foot Ulcer**

- Program to pursue a near term publication, probably with Phase 2 data, could result in publications available during year 1 of commercial sale

**Dalbavancin in Hospitalized Community Acquired Pneumonia**

- Phase 1 to be initiated in 2013
Regulatory and Clinical Activities
Recent Regulatory Interactions: US & EU

- An NDA re-activation is possible using the old number
- The non-clinical package is complete and no new studies are required
- One new clinical trial & re-analysis of VER001-9 needed to complete the filing
- Safety database believed to be sufficient for approval
- DUR000-201 non-interventional, observational, Phase 2 clinical trial part of filing
- Received QIDP designation
- Anticipate filing NDA mid-2013

Durata’s decision to conduct two new Phase 3 studies to strengthen regulatory filing

- Special Protocol Agreement for DUR001-301 (September 2010)
- Special Protocol Agreement for DUR001-302 (June 2011)

- Previously submitted preclinical package supports the claim
- DISCOVER program with separate EU statistical analysis plan will be adequate
- Anticipate filing MAA late 2013
Dalbavancin’s patent strength emanates from covering a wide range of dosing intervals, dosages, and the amount of dalbavancin in each dose:

- Administering initial and subsequent therapeutically effective doses wherein:
  - Each dose is separated by 5 -10 days
  - Amount of each dose is about 100 mg to 5000 mg
  - Amount of initial dose is at least about two times the amount of the subsequent dose
- QIDP designation provides incremental 5-yr exclusivity
Market Opportunity
Dalbavancin Commercial Thesis

- Large US abSSSI (at risk for MRSA) market; 35mm Days of Therapy (DOT), dominated by generic vancomycin
- High and growing prevalence of MRSA leads to empiric selection of therapies
- Providers respond favorably to the dalbavancin product profile
- Dalbavancin profile is very attractive in indications beyond abSSSI
- Dalbavancin is uniquely positioned to address the overall need to deliver therapeutic value and drive patients to more ambulatory care.
- The health economics and reimbursement dynamics are favorable
- Reimbursement metrics driving care to hospital ambulatory or out-patient clinics
- Customer universe is highly targeted

Source: LEK analysis and interviews
We believe there are ~35 million days of treatment (DOT) annually, in the US, for abSSSI patients at risk for MRSA utilizing intravenous antibiotics; this represents a market potential of approximately $10 billion at branded pricing.

**abSSSI Annual Days of Treatment – IV Antibiotics**

- **Outpatient**: 25%
- **Hospital**: 75%

**Leading Products**

<table>
<thead>
<tr>
<th>Product</th>
<th>DOT (Millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vancomycin</td>
<td>7.2</td>
</tr>
<tr>
<td>Cefazolin</td>
<td>3.4</td>
</tr>
<tr>
<td>Piperacillin</td>
<td>3.4</td>
</tr>
<tr>
<td>Clindamycin</td>
<td>2.5</td>
</tr>
<tr>
<td>Ampicillin</td>
<td>1.6</td>
</tr>
<tr>
<td>Ceftriaxone</td>
<td>1.3</td>
</tr>
<tr>
<td>Levofloxacin</td>
<td>1.1</td>
</tr>
<tr>
<td>Gentamicin</td>
<td>0.7</td>
</tr>
<tr>
<td>Daptomycin</td>
<td>0.6</td>
</tr>
<tr>
<td>Tigercycline</td>
<td>0.4</td>
</tr>
</tbody>
</table>

Market is larger when expanded to include MSSA and oral step-down therapies.

Source: Stanford Group June 2007, AMR 2010

* If generic units were converted to branded daptomycin pricing
Clinician Response to Dalbavancin Product Profile by Feature

1 = Not favorable at all; 10 = Extremely favorable

- Ensured compliance for 7 days: 8.9
- Potential to reduce in-patient stay: 8.7
- Dose regime (day 1 & 8): 8.7
- No need for PICC line: 8.7
- No blood monitoring: 8.5
- Bactericidal activity: 8.3
- Safety / tolerability profile: 8.1
- Glycopeptide class: 6.2

ePocrates market research, May 2009, 150 physicians
Clinicians Response to Treatment Setting Using Dalbavancin

- 86% of respondents believe that >10% of SSSI patients, currently admitted to the hospital, could be treated as an outpatient with dalbavancin.

Q: What percent of SSSI patients currently admitted to the hospital could now be treated on an out-patient basis over the entire course of treatment due to this product’s profile?

- >50%: 15%
- 31-50%: 24%
- 21-30%: 22%
- 11-20%: 25%
- 6-10%: 11%
- 1-5%: 2%
- 0: 1%

Institutional burden is a factor for assessing benefit.

Q: Will your hospital/institution factor in the savings from administrative benefits, such as lower burden on nursing time, in assessing the cost/benefit of this drug?

- No: 18%
- Yes: 82%

ePocrates market research, May 2009, 150 physicians
Reduction in Total Treatment Costs Are Expected to Drive Adoption

- Decreased length of stay
- Potential admission avoidance
- Less indwelling catheters
- No therapeutic drug monitoring
- Less ancillary supply utilization
- Shorter nursing time
- Lower drug preparation frequency
- Less drug wastage

- Improved patient convenience, compliance, and satisfaction
Hypothetical Scenario with Dalbavancin and Potential Cost Implications

Scenario 1:
Assumes first line treatment only, equal efficacy 88.9%¹

Comparators and Selected Assumptions:

1) Dalbavancin:
3 days in-patient
11 days out-patient

2) Vancomycin:
3 days in-patient
11 days out-patient

3) Daptomycin:
3 days in-patient
11 days out-patient

Hypothetical Early Intervention Scenario with Dalbavancin and Potential Cost Implications

Scenario:
Assumes 1st line treatment only, equal efficacy 88.9%\(^1\)

Comparators and Selected Assumptions:

1) Dalbavancin:
- 14 days out-patient (no in-patient admission)

2) Vancomycin:
- 3 days in-patient
+ Linezolid (oral):
- 11 days out-patient

3) Daptomycin:
- 3 days in-patient, 11 days out-patient

Potential Patient Flow Scenarios

<table>
<thead>
<tr>
<th>1st Infusion</th>
<th>2nd Infusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Emergency Department (ED)</td>
<td>Hospital Outpatient Department (HOPD)</td>
</tr>
<tr>
<td>2 Inpatient</td>
<td>HOPD / Infusion center</td>
</tr>
<tr>
<td>3 Physician office</td>
<td>Physician office</td>
</tr>
</tbody>
</table>

**Scenario 1**
- Patients who are released from the ER without being admitted to the hospital inpatient setting are an optimal target population for the drug
  - **Infusion 1** – performed in ED, separate payment for the drug
  - **Infusion 2** – performed in HOPD, separate payment for the drug

**Scenario 2**
- While the inpatient setting is important for the drug, drug costs are bundled into a single payment
  - **Infusion 1** – in inpatient setting, no separate payment for the drug (bundled into DRG)
  - **Infusion 2** – performed in HOPD, separate payment for the drug

**Scenario 3**
- Patients who receive infusions in physician offices are an optimal target population
  - **Infusion 1** – in the physician office, separate payment for the drug
  - **Infusion 2** – in the physician office, separate payment for the drug
In the US, approximately 2,000 hospitals/ambulatory centers account for a large percentage of the market opportunity.

Pre-launch efforts will focus on key stakeholders:
- Mapping formulary submission processes and evidence requirements
- Development and validation of value dossier, formulary submissions
- Infectious disease and pharmacy — key thought leader development
- Develop key account plans and value proposition with payers and hospital administration
- Develop reimbursement support services and resources

Target audiences:
- 1,600-2,000 hospitals
- 7,000 IDs
- 6,000 high volume (gram + utilization) IMs and surgeons

Anticipate a commercial organization of ~140, including hospital specialists, key accounts, formulary, marketing and reimbursement support.

Similar characteristics typify the EU5 marketplace.
Primary Asset Highlights

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