

DELCATH SYSTEMS, INC.
Form 424B3
March 21, 2016
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Filed Pursuant to Rule 424(b)(3)

Registration Statement No. 333-204979

Prospectus Supplement No. 9

(to Prospectus dated July 16, 2015)

DELCATH SYSTEMS, INC.

9,350,000 Units

Consisting of 9,350,000 Shares of Common Stock

and

7,012,500 Series A Warrants to Purchase 7,012,500 Shares

of Common Stock

and

9,350,000 Series B Warrants to Purchase 9,350,000 Shares of

Common Stock and 7,012,500 Series A Warrants

This prospectus amends and supplements the prospectus dated July 16, 2015 (the "Prospectus"), which forms a part of our Registration Statement on Form S-1 (Registration Statement No. 333-204979). This prospectus supplement is being filed to update and supplement the information included or incorporated by reference in the prospectus with the information contained in our Current Report on Form 10-K, filed with the Securities and Exchange Commission on March 18, 2016 (the "Form 10-K"). Accordingly, we have attached the Form 10-K to this prospectus supplement.

The prospectus and this prospectus supplement relate to the issuance of shares of our common stock and Series A Warrants upon the exercise of Series A Warrants and Series B Warrants issued in connection with our offering of units consisting of common stock, Series A Warrants and Series B Warrants on July 16, 2015.

Our common stock is traded on The Nasdaq Capital Market under the symbol "DCTH". Neither series of warrants will trade on The Nasdaq Capital Market or any other securities exchange or trading market. On March 17, 2016, the closing price for a share of our common stock on The Nasdaq Capital Market was \$0.33 per share.

Investing in our Common Stock involves risks. See "Risk Factors" beginning on page 9 of the Prospectus to read about factors you should consider before you make your investment decision.

Neither the Securities and Exchange Commission nor any state securities commission has approved or disapproved of these securities or passed upon the accuracy or adequacy of this prospectus. Any representation to the contrary is a criminal offense.

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The date of this Prospectus Supplement No. 9 is March 18, 2016

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**UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549**

FORM 10-K

x **Annual report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934
for the fiscal year ended December 31, 2015**

.. **Transition report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934
for the transition period from _____ to _____**

Commission file number: 001-16133

DELCATH SYSTEMS, INC.

**Delaware
(State or other jurisdiction of
incorporation or organization)**

**06-1245881
(I.R.S. Employer
Identification No.)**

**1301 Avenue of the Americas, 43rd Floor New York,
NY**

(Address of principal executive offices)

10019

(Zip Code)

212-489-2100

(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of Each Class	Name of Each Exchange on Which Registered
Common Stock, par value \$0.01 per share	The NASDAQ Stock Market LLC
Securities registered pursuant to Section 12(g) of the Act: None.	

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or 15(d) of the Act. Yes No

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes No

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405) is not contained herein, and will not be contained, to the best of the registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K.

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company. See the definitions of large accelerated filer, accelerated filer and smaller reporting company in Rule 12b-2 of the Exchange Act.

Large accelerated filer

Accelerated filer

Non-accelerated filer (Do not check if smaller reporting company)

Smaller reporting company

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes No

The aggregate market value of the voting common stock held by non-affiliates of the registrant, based on the closing sale price on The NASDAQ Capital Market of \$0.96 per share, was \$11,848,790 as of June 30, 2015.

At March 18, 2016 the registrant had outstanding 24,043,491 shares of par value \$0.01 Common Stock.

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Disclosure Regarding Forward-Looking Statements

This Annual Report on Form 10-K for the period ended December 31, 2015 contains certain forward-looking statements within the meaning of the safe harbor provisions of the Private Securities Litigation Reform Act of 1995 with respect to our business, financial condition, liquidity and results of operations. Words such as anticipates, expects, intends, plans, predicts, believes, seeks, estimates, could, would, will, may, can, and the negative of these terms or other comparable terminology often identify forward-looking statements. Statements in this Annual Report on Form 10-K for the period ending December 31, 2015 that are not historical facts are hereby identified as forward-looking statements for the purpose of the safe harbor provided by Section 21E of the Exchange Act and Section 27A of the Securities Act. These forward-looking statements are not guarantees of future performance and are subject to risks and uncertainties that could cause actual results to differ materially from the results contemplated by the forward-looking statements, including the risks discussed in this Annual Report on Form 10-K for the fiscal year ended December 31, 2015 in Item 1A under Risk Factors as well as in Item 7A Quantitative and Qualitative Disclosures About Market Risk, our Quarterly Report on Form 10-Q for the period ended September 30, 2015 in Part II, Item 1A under Risk Factors as well as in Part I, Item 3 Quantitative and Qualitative Disclosures About Market Risk and the risks detailed from time to time in our future SEC reports. These forward-looking statements include, but are not limited to, statements about:

our estimates regarding sufficiency of our cash resources, anticipated capital requirements and our need for additional financing;

the commencement of future clinical trials and the results and timing of those clinical trials;

our ability to successfully commercialize CHEMOSAT/Melphalan/HDS, generate revenue and successfully obtain reimbursement for the procedure and System;

the progress and results of our research and development programs;

submission and timing of applications for regulatory approval and approval thereof;

our ability to successfully source certain components of the system and enter into supplier contracts;

our ability to successfully manufacture CHEMOSAT/Melphalan/HDS;

our ability to successfully negotiate and enter into agreements with distribution, strategic and corporate partners;
and

our estimates of potential market opportunities and our ability to successfully realize these opportunities.

Many of the important factors that will determine these results are beyond our ability to control or predict. You are cautioned not to put undue reliance on any forward-looking statements, which speak only as of the date of this Annual Report on Form 10-K. Except as otherwise required by law, we do not assume any obligation to publicly update or release any revisions to these forward-looking statements to reflect events or circumstances after the date of this Annual Report on Form 10-K or to reflect the occurrence of unanticipated events.

Item 1. Business.

Unless the context otherwise requires, all references in this Annual Report on Form 10-K to the Company, Delcath, Delcath Systems, we, our, and us refers to Delcath Systems, Inc., a Delaware corporation, incorporated in August 1988, and all entities included in our consolidated financial statements. Our corporate offices are located at 1301 Avenue of the Americas, 43rd Floor, New York, New York 10019. Our telephone number is (212) 489-2100.

Company Overview

Delcath Systems, Inc. is a late-stage clinical development company with early commercial activity in Europe focused on cancers of the liver. We are a specialty pharmaceutical and medical device company developing our proprietary product Melphalan Hydrochloride for Injection for use with the Delcath Hepatic Delivery System (Melphalan/HDS). In Europe, our proprietary system to deliver and filter melphalan hydrochloride is marketed as a device under the trade name Delcath Hepatic CHEMOSAT[®] Delivery System for Melphalan (CHEMOSAT).

Our primary focus is on the execution of our clinical development program (CDP) in ocular melanoma liver metastases (mOM), intrahepatic cholangiocarcinoma (ICC), hepatocellular carcinoma (HCC or primary liver), and certain other cancers that are metastatic to the liver. We believe the disease states we are investigating represent a multi-billion dollar global market opportunity and a clear unmet medical need.

Our clinical development program for CHEMOSAT/Melphalan/HDS is comprised of: The FOCUS Clinical Trial for Patients with Hepatic Dominant Ocular Melanoma, a Global Phase 3 clinical trial that is investigating overall survival in mOM, and a Global Phase 2

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clinical trial program investigating Melphalan/HDS with and without sorafenib in HCC and Melphalan/HDS in ICC. Our CDP also includes a commercial registry for CHEMOSAT non-clinical commercial cases performed in Europe and sponsorship of select investigator initiated trials (IITs) in HCC and colorectal cancer liver metastases (mCRC).

The direction and focus of our CDP for CHEMOSAT/Melphalan/HDS is informed by prior clinical development conducted between 2004 and 2010, non-clinical, commercial CHEMOSAT cases performed on approximately 150 patients in Europe, and prior regulatory experience with the FDA. Experience gained from this research, development, early European commercial and U.S. regulatory activity has led to the implementation of several safety improvements to our product and the associated medical procedure.

In the United States, Melphalan/HDS is considered a combination drug and device product, and is regulated as a drug by the FDA. The FDA has granted us six orphan drug designations, including three orphan designations for the use of the drug melphalan for the treatment of patients with mOM, HCC and ICC. Melphalan/HDS has not been approved for sale in the United States.

In Europe, the current version of our CHEMOSAT product is regulated as a Class IIb medical device and received its CE Mark in 2012. We are in an early phase of commercializing the CHEMOSAT system in select markets in the European Union where the prospect of securing adequate reimbursement for the procedure is strongest. In 2015 national reimbursement coverage for CHEMOSAT procedures was awarded in Germany, with coverage levels to be determined by German authorities in mid to late 2016.

Currently there are few effective treatment options for certain cancers in the liver. Traditional treatment options include surgery, chemotherapy, liver transplant, radiation therapy, interventional radiology techniques, and isolated hepatic perfusion. We believe that CHEMOSAT/Melphalan/HDS represents a potentially important advancement in regional therapy for primary liver cancer and certain other cancers metastatic to the liver. We believe that CHEMOSAT/Melphalan/HDS is uniquely positioned to treat the entire liver either as a standalone therapy or as a complement to other therapies.

Cancers in the Liver – A Significant Unmet Need

Cancers of the liver remain a major unmet medical need globally. According to GLOBOCAN and American Cancer Society (ACS) Facts & Figures 2008, approximately 1.2 million patients globally are diagnosed each year with primary liver cancer or cancer that has metastasized to the liver. According to the American Cancer Society's (ACS) *Cancer Facts & Figures 2013* report, cancer is the second leading cause of death in the United States, with an estimated 580,350 deaths and 1,660,290 new cases expected to be diagnosed in 2013. Cancer is one of the leading causes of death worldwide, accounting for approximately 8.2 million deaths and 14.1 million new cases in 2012 according to GLOBOCAN. The financial burden of cancer is enormous for patients, their families and society. The National Institutes of Health (NIH) estimates that the overall costs of cancer in 2008 were \$201 billion: \$77 billion for direct medical costs (total of all health expenditures) and \$124 billion for indirect mortality costs (cost of lost productivity due to premature death). The liver is often the life-limiting organ for cancer patients and one of the leading causes of cancer death. Patient prognosis is generally poor once cancer has spread to the liver.

Liver Cancers – Incidence and Mortality

There are two types of liver cancers: primary liver cancer and metastatic liver disease. Primary liver cancer (hepatocellular carcinoma or HCC, including intrahepatic bile duct cancers or ICC) originates in the liver or biliary tissue and is particularly prevalent in populations where the primary risk factors for the disease, such as hepatitis-B, hepatitis-C, high levels of alcohol consumption, aflatoxin, cigarette smoking and exposure to industrial pollutants, are

present. Metastatic liver disease, also called liver metastasis, or secondary liver cancer, is characterized by microscopic cancer cell clusters that detach from the primary site of disease and travel via the blood stream and lymphatic system into the liver, where they grow into new tumors. These metastases often continue to grow even after the primary cancer in another part of the body has been removed. Given the vital biological functions of the liver, including processing nutrients from food and filtering toxins from the blood, it is not uncommon for metastases to settle in the liver. In many cases patients die not as a result of their primary cancer, but from the tumors that metastasize to their liver. In the United States, metastatic liver disease is more prevalent than primary liver cancer.

Ocular Melanoma

Ocular melanoma is one of the cancer histologies with a high likelihood of metastasizing to the liver. We estimate that up to 8,600 cases of ocular melanoma are diagnosed in the U.S. and Europe annually, and that approximately 55% of these patients will develop metastatic disease. Of metastatic cases of ocular melanoma, we estimate that approximately 90% of patients will development liver involvement. Once ocular melanoma has spread to the liver, current evidence suggests median overall survival for these patients is generally six to eight months. Currently there is no standard of care for patients with ocular melanoma liver metastases. As a result, we estimate that up to 4,300 patients with ocular melanoma liver metastases in the U.S. and Europe may be eligible for treatment with the Melphalan/HDS.

Table of Contents**Hepatocellular Carcinoma (HCC) and Intrahepatic Cholangiocarcinoma (ICC)**

Hepatobiliary cancers including HCC and ICC are among the most prevalent and lethal forms of cancer. According to GLOBOCAN, an estimated 76,000 new cases of primary liver cancers are diagnosed in the U.S. and Europe annually. Approximately 90% of these patients are diagnosed with HCC. Excluding patients who are eligible for surgical resection or certain focal treatments, we estimate that approximately 15,000 patients with HCC in the U.S. and Europe may be eligible for treatment with Melphalan/HDS. We estimate that an additional 6,500 patients diagnosed with ICC may also be eligible for treatment with Melphalan/HDS. According to the ACS, the overall five-year survival rate for liver cancer patients in the U.S is approximately 15% compared to 68% for all cancer combined. Globally, with 782,000 new cases in 2012, HCC was the fifth most common cancer in men and the ninth in women according to GLOBOCAN. GLOBOCAN estimates indicate that HCC was responsible for 746,000 deaths in 2012 (9.1% of the total cancer deaths), making it the second most common cause of death from cancer worldwide.

The prognosis for primary liver cancer is very poor, as indicated by an overall ratio of mortality to incidence of 0.95. The American Cancer Society's *Cancer Facts & Figures 2013* outlines the treatment options for HCC as follows:

Early stage HCC can sometimes be successfully treated with surgery in patients with sufficient healthy liver tissue; liver transplantation may also be an option. Surgical treatment of early stage HCC is often limited by pre-existing liver disease that has damaged the portion of the liver not affected by cancer. Patients whose tumors cannot be surgically removed may choose ablation (tumor destruction) or embolization, a procedure that cuts off blood flow to the tumor. Fewer treatment options exist for patients diagnosed at an advanced stage of the disease. Sorafenib (Nexavar) is a targeted drug approved for the treatment of HCC in patients who are not candidates for surgery.

In HCC, the impact of systemic chemotherapy has been very limited, primarily due to the poor liver function of presenting patients. Modest results have been reported in Phase II trials with various agents such as doxorubicin, gemcitabine, and capecitabine. A Phase III open label study compared advanced HCC patients who received doxorubicin or FOLFOX4 (5-fluorouracil and leucovorin plus oxaliplatin), and found no statistical difference in median overall survival. For HCC patients who are not eligible surgery or TACE, the only current FDA-approved chemotherapy option is sorafenib. Sorafenib, taken orally, is a small molecule, multikinase inhibitor with activity against Raf-1, B-raf, VEGFR2 and PDGFR- proteins and signaling pathways shown to be involved in the pathogenesis of HCC. Data from two randomized Phase III clinical trials (the SHARP trial and the Asian trial) in patients with unresectable advanced HCC with Child-Pugh A score reported very modest response rates (2%), but demonstrated statistically significant survival advantages favoring sorafenib. Phase III trials evaluating the efficacy of sorafenib alone versus a combination of sorafenib plus doxorubicin, or sorafenib plus capecitabine and oxaliplatin (SECOX) are currently ongoing.

Despite its approval and widespread use as the first line treatment for unresectable HCC, there are challenges and limitations associated with sorafenib. High rates of dermatologic side effects, such as hand-foot skin reaction (HSFR) were reported in the SHARP and Asian Phase III trials. Acute diarrhea has also been described as an early and common side effect of sorafenib treatment. More recently, there have been reports of pancreatic atrophy associated with long-term sorafenib therapy, possibly due to its overall anti-angiogenic activity. Resistance to sorafenib despite initial responses has also been reported. This has spurred efforts to develop other chemotherapeutics, most of which target the multiple signaling pathways and molecules involved in HCC. Notable among these are small molecule agents such as brivanib (targeting VEGFR, FGFR), ARQ 197 or tivantinib (targeting c-MET), XL184 or cabozantinib (targeting c-MET and VEGFR), and ABT-869 or linifanib (targeting VEGFR, PDGFR, c-KIT, FLT-3), and monoclonal antibody/biologics such as ramucirumab (anti-VEGFR2), all of which are currently in Phase III trials. Other agents currently in HCC or metastatic liver cancer Phase II trials include axitinib, cediranib, and orantinib (all targeting VEGFR), lapatinib, and gefitinib (both targeting EGFR), selumetinib (targeting MEK), and belinostat (targeting histone deacetylase). In addition to these agents, MDX-1106 (also known as BMS-936558 or nivolumab),

an antibody that targets the PD-1 immuno-inhibitory receptor, is in a Phase I trial for advanced HCC.

Based on third party research, we estimate that approximately 15,000 of the 76,000 patients diagnosed annually in the U.S. and Europe could be eligible candidates for treatment with the Melphalan/HDS. The FDA has granted orphan drug status to the Melphalan/HDS for treatment of patients with unresectable HCC. We believe that there is a large unmet medical need in first line therapy for patients with HCC, with Sorafenib the only currently approved systemic therapy in the U.S., Europe and certain Asian markets.

ICC is the second most common primary liver tumor and accounts for 3% of all gastrointestinal cancers and 15% of HCC cases diagnosed in the U.S. and Europe annually. Outside of resection, which is the only cure for ICC, there is currently no standard of care (SOC). Base on third party research we believe that 90% of ICC patients are not candidates for surgical resection, and that approximately 20-30% of these may be candidates for certain focal interventions. We estimate that approximately 6,500 ICC patients in the U.S. and Europe annually could be candidates for treatment with Melphalan/HDS, which we believe represents a significant market opportunity. We intend to pursue an orphan drug designation from the FDA for Melphalan/HDS for the treatment of patients with ICC.

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About CHEMOSAT/Melphalan/HDS

CHEMOSAT/Melphalan/HDS administers concentrated regional chemotherapy to the liver. This whole organ therapy is performed by isolating the circulatory system of the liver, infusing the liver with chemotherapeutic agent, and then filtering the blood prior to returning it to the patient. During the procedure, known as percutaneous hepatic perfusion (PHP), three catheters are placed percutaneously through standard interventional radiology techniques. The catheters temporarily isolate the liver from the body's circulatory system, allow administration of the chemotherapeutic agent melphalan hydrochloride directly to the liver, and collect blood exiting the liver for filtration by our proprietary filters. The filters absorb chemotherapeutic agent in the blood, thereby reducing systemic exposure to the drug and related toxic side effects, before the filtered blood is returned to the patient's circulatory system.

The PHP procedure is performed in an interventional radiology suite in approximately two to three hours. Patients remain in an intensive care or step-down unit overnight for observation following the procedure. Treatment with CHEMOSAT/Melphalan/HDS is repeatable, and a new disposable CHEMOSAT/Melphalan/HDS is used for each treatment. Patients treated in both clinical and non-clinical settings have received up to 6 treatments. In the United States, melphalan hydrochloride for injection will be included with the system. In Europe, the system is sold separately and used in conjunction with melphalan hydrochloride commercially available from a third party. In our clinical trials, melphalan hydrochloride for injection is provided to both European and U.S. clinical trial sites.

Risks associated with the CHEMOSAT/Melphalan/HDS Procedure

As with many cancer therapies, treatment with CHEMOSAT/Melphalan/HDS is associated with toxic side effects and certain risks, some of which are potentially life threatening. An integrated safety population comprised of patients treated during our prior clinical development using early versions of the Melphalan/HDS showed these risks to include grade 3 or 4 bone marrow suppression and febrile neutropenia, as well as risks of hepatic injury, severe hemorrhage, gastrointestinal perforation, stroke, and myocardial infarction in the setting of an incomplete cardiac risk assessment. In this integrated safety population, deaths due to certain adverse reactions did not occur again during the clinical trials following the adoption of related protocol amendments.

Procedure and Product Refinements

The trials that comprised this integrated safety population used early versions of the device and procedure. As a consequence of these identified risks and experience gained in non-clinical, commercial usage in Europe, we have continued to develop and refine both the CHEMOSAT/Melphalan/HDS and the PHP procedure. The procedure refinements have included modifications to the pre, peri and post procedure patient management and monitoring, as well as the use of the following: prophylactic administration of proton pump inhibitors, prophylactic platelet transfusions, prophylactic hydration at key pre-treatment intervals, use of vasopressor agents coupled with continuous monitoring for maintenance of blood pressure and prophylactic administration of growth factors to reduce risk of serious myelosuppression. In addition, in 2012 we introduced the Generation Two version of the CHEMOSAT system, which offered improved hemofiltration and other product enhancements.

Reports from treating physicians in both Europe and the U.S. using the Generation Two CHEMOSAT/Melphalan/HDS in a non-clinical, commercial setting have suggested that these product improvements and procedure refinements have improved the safety profile. In 2015, physicians in Europe and the U.S. also presented the results of research that signaled an improved safety profile as well as efficacy in multiple tumor types at several major medical conferences.

Prior Clinical Development

Our Phase 3 clinical trial and multi-arm Phase 2 clinical trial of the Melphalan/HDS with melphalan in patients with liver cancers are summarized below. The Phase 3 and Phase 2 clinical trials were subject to the terms and conditions of the Cooperative Research and Development Agreement (CRADA), between the Company and the National Cancer Institute (NCI). The Phase 3 trial was conducted under an FDA Special Protocol Assessment (SPA) and was conducted at centers throughout the United States.

Phase 3 Melanoma Metastases Trial

In February 2010, we concluded a randomized Phase 3 multi-center study for patients with unresectable metastatic ocular or cutaneous melanoma exclusively or predominantly in the liver. In the trial, patients were randomly assigned to receive PHP treatments with melphalan using the Melphalan/HDS, or to a control group providing best alternative care (BAC). Patients assigned to the PHP arm were eligible to receive up to six cycles of treatment at approximately four to eight week intervals. Patients randomized to the BAC arm were permitted to cross-over into the PHP arm at radiographic documentation of hepatic disease progression. A majority of the BAC patients did in fact cross over to the PHP arm. Secondary objectives of the study were to determine the response rate, safety, tolerability and overall survival.

On April 21, 2010, we announced that our randomized Phase 3 clinical trial of PHP with melphalan using Melphalan/HDS for patients with unresectable metastatic ocular and cutaneous melanoma in the liver had successfully achieved the study's primary endpoint of

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extended hepatic progression-free survival, or hPFS. An updated summary of the results was presented at the European Multidisciplinary Cancer Congress organized by the European Cancer Organization (ECCO) and the European Society of Medical Oncology (ESMO) in September 2011. Data submitted in October 2012 to the FDA in Delcath's New Drug Application (NDA) comparing treatment with the PHP with melphalan (the treatment group) to BAC (the control group), showed that patients in the PHP arm had a statistically significant longer median hPFS of 7.0 months compared to 1.7 months in the BAC control group, according to the Independent Review Committee (IRC) assessment. This reflects a 4-fold increase of hPFS over that of the BAC arm, with 50% reduction in the risk of progression and/or death in the PHP treatment arm compared to the BAC control arm. Results of this study were published in *Annals of Surgical Oncology*, a prestigious medical journal in December 2015.

Phase 2 Multi-Histology, Unresectable Hepatic Tumor Trial

Also in 2010, we concluded a separate multi-arm Phase 2 clinical trial of PHP with melphalan using an early version of the Melphalan/HDS in patients with primary and metastatic liver cancers, stratified into four arms: neuroendocrine tumors (carcinoid and pancreatic islet cell tumors), ocular or cutaneous melanoma, metastatic colorectal adenocarcinoma (mCRC), and HCC. In the metastatic neuroendocrine (mNET) cohort (n=24), the objective tumor response rate was 42%, with 66% of patients achieving hepatic tumor shrinkage and durable disease stabilization. In the mCRC cohort, there was inconclusive efficacy possibly due to advanced disease status of the patients. Similar safety profiles were seen across all tumor types studied in the trial.

Phase 2 Multi-Histology Clinical Trial - HCC Cohort

In the HCC cohort (n=8) of our Phase 2 Multi-Histology trial, a positive signal in hepatic malignancies was observed in 5 patients. Among these patients, one patient received four treatments, achieved a partial response lasting 12.22 months, and survived 20.47 months. Three other patients with stable disease received 3-4 treatments, with hepatic progression free survival (hPFS) ranging 3.45 to 8.15 months, and overall survival (OS) ranging 5.26 to 19.88 months. There was no evidence of extrahepatic disease progression. The observed duration of hPFS and OS in this limited number of patients exceeded that generally associated with this patient population. We believe these results constitute a promising signal that warrants further clinical investigation.

Prior U.S. Regulatory Experience

Based on the results from our prior clinical development in August 2012 we submitted a New Drug Application (NDA) under Section 505(b)(2) of the Federal Food Drug Cosmetic Act (FDCA) seeking an indication for the percutaneous intra-arterial administration of melphalan for use in the treatment of patients with metastatic melanoma in the liver, and subsequently amended the indication to ocular melanoma metastatic to the liver. Data submitted to the FDA used the early clinical trial versions of the system along with early clinical procedure techniques. Our NDA was accepted for filing by the Food and Drug Administration (FDA) on October 15, 2012, and was designated for standard review with an initial Prescription Drug User Fee Act (PDUFA) goal date of June 15, 2013. On April 3, 2013, the FDA extended its PDUFA goal date to September 13, 2013.

On May 2, 2013 we announced that an *Oncologic Drug Advisory Committee* (ODAC) panel convened by the FDA voted 16 to 0, with no abstentions, that the benefits of treatment with the early version of Melphalan/HDS did not outweigh the risks associated with the procedure. A significant portion of FDA's presentation to the ODAC panel was focused on the FDA's assessment of treatment related risks, including the analysis of treatment-related deaths that occurred during clinical trials. The FDA also expressed concerns about hypotension (low blood pressure) during the procedure, length of hospital stay, as well as risks of stroke, heart attack, renal failure, and bone marrow suppression. We believe that the protocol amendments and other procedure refinements instituted during clinical trials and

subsequently in commercial, non-clinical usage in Europe, including changes to the way blood pressure is managed and monitored, may help address these procedure related risks. Collection of adequate safety data on all aspects of the procedure is a major focus of the clinical trials in our current CDP.

Briefing materials presented to the 2013 ODAC panel by both the FDA and Delcath are available on our website at <http://delcath.com/clinical-research/clinical-bibliography>.

2013 Complete Response Letter

In September 2013 the FDA issued a complete response letter (CRL) in response to our NDA. The FDA issues a CRL after the review of a file has been completed and questions remain that preclude approval of the NDA in its current form. The FDA comments included, but were not limited to, a statement that Delcath must perform another well-controlled randomized trial(s) to establish the safety and efficacy of Melphalan/HDS using overall survival as the primary efficacy outcome measure, and which demonstrates that the clinical benefits of Melphalan/HDS outweigh its risks. The FDA also required that the additional clinical trial(s) be conducted using the product the Company intends to market, and that certain clinical, clinical pharmacology, human factors and product quality elements of the CRL be addressed.

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In January 2016, we announced the conclusion of a Special Protocol Assessment Agreement with the FDA on the design of a new Phase 3 clinical trial of Melphalan/HDS to treat patients with hepatic dominant ocular melanoma. This SPA provides agreement that our new Phase 3 trial design adequately addresses objectives that, if met, would support the submission for regulatory approval of Melphalan/HDS. The SPA agreement also represents the satisfactory resolution of a substantial number of the FDA's CRL non-clinical trial related requirements.

Current Clinical Development Program

The focus of our current CDP is to generate clinical data for the CHEMOSAT/Melphalan/HDS in various disease states and validate the safety profile of the current version of the product and treatment procedure. We believe that the improvements we have made to CHEMOSAT/Melphalan/HDS and to the PHP procedure have addressed the severe toxicity and procedure-related risks observed during the previous Phase 2 and 3 clinical trials. The CDP is also designed to support clinical adoption of and reimbursement for CHEMOSAT in Europe, and to support regulatory approvals in various jurisdictions, including the U.S.

FOCUS Clinical Trial for Patients with Hepatic Dominant Ocular Melanoma (the FOCUS Trial)

In January 2016, we initiated a new pivotal Phase 3 overall survival (OS) clinical trial in hepatic dominant ocular melanoma with the first patient enrolled in February 2016. Called the FOCUS Trial, this new global Phase 3 trial will evaluate the safety, efficacy and pharmacokinetic profile of Melphalan/HDS versus best alternative care in 240 patients with hepatic dominant OM. The primary endpoint is a comparison of overall survival between the two study arms. Secondary and exploratory endpoints include progression-free survival, overall response rate and Quality of Life (QoL) measures. In the FOCUS trial's treatment phase, patients randomized to the Melphalan/HDS arm will receive up to six treatments at intervals of six to eight weeks for up to 12 months. Tumor response will be assessed in both study arms every 12 weeks until evidence of hepatic disease progression. For patients progressing to the follow-up phase, disease assessment scans will continue every 12 weeks for up to two years.

The FOCUS Trial will be conducted at leading cancer centers in the United States and Europe. The Moffitt Cancer Center in Tampa, Fla. has been activated as a participating center and Jonathan Zager, M.D., FACS, Professor of Surgery in the Cutaneous Oncology and Sarcoma Departments and a Senior Member at Moffitt Cancer Center, is serving as the trial's principal investigator.

The FOCUS Trial is being conducted under a Special Protocol Assessment (SPA) we concluded with the U.S. Food and Drug Administration (FDA) in January 2016. Under the terms of the SPA, the FOCUS Trial is the only Phase 3 trial required for submission of a New Drug Application.

There currently is no standard of care for the treatment of hepatic dominant ocular melanoma. The Melphalan/HDS has been granted orphan drug status by FDA for treatment of patients with ocular melanoma. Based on the strength of the efficacy data in this disease observed in our prior Phase 3 clinical trial and the reports of an improved safety profile from approximately 150 patients treated in a non-clinical trial setting in Europe, we are confident that this program can address the concerns raised by the FDA in its CRL. We believe that ocular melanoma liver metastases represent a high unmet medical need, and that pursuit of an indication in this disease state represents the fastest path to potential approval of the Melphalan/HDS in the U.S.

Phase 2 Hepatocellular Carcinoma (HCC) & Intrahepatic Cholangiocarcinoma (ICC) Program

In 2014 we initiated a new Phase 2 clinical trial program in Europe and the U.S., with the goal of obtaining an efficacy and safety signal for Melphalan/HDS in the treatment of HCC and ICC. Due to differences in treatment practice

patterns between Europe and the U.S., we established separate European and U.S. trial protocols for the HCC Phase 2 program with different inclusion and exclusion patient selection criteria:

Protocol 201 Conducted in the U.S., this trial will assess the safety and efficacy of Melphalan/HDS followed by sorafenib. The trial will evaluate overall response rate via modified Response Evaluation Criteria in Solid Tumors (mRECIST), progression free survival, characterize the systemic exposure of melphalan and assess patient quality of life. The Moffitt Cancer Center opened for enrollment in this trial October 2014, and we expect to add additional centers in the U.S. in 2015.

Protocol 202 conducted in Europe, this trial will assess the safety and efficacy of Melphalan/HDS without sorafenib. The trial will also evaluate overall response rate via (mRECIST) criteria, progression free survival, characterize the systemic exposure of melphalan and assess patient quality of life. Three hospitals in Germany have opened for enrollment – Goethe University Hospital, Hannover Medical School Hospital and Jena University Hospital. The Company intends to open additional centers in Germany and the U.K., subject to the applicable authorizations and approvals including ethics committee approval at participating hospitals.

ICC Cohort In 2015 we expanded *Protocol 202* to include a cohort of patients with ICC. The trial for this cohort is being conducted at the same centers participating in the Phase 2 HCC trial.

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Clinical trials are long, expensive and highly uncertain processes and failure can unexpectedly occur at any stage of clinical development. These trials are actively enrolling, but the start or end of a clinical trial is often delayed or halted due to changing regulatory requirements, manufacturing challenges, required clinical trial administrative actions, slower than anticipated patient enrollment, changing standards of care, availability or prevalence of use of a comparator treatment or required prior therapy.

European Investigator Initiated Trials

In addition to the clinical trials in our CDP, we are supporting data generation in other areas. We are currently two Investigator Initiated Trials (IITs) in Europe – one in colorectal carcinoma metastatic to the liver (mCRC) at Leiden University Medical Center in The Netherlands, and another in HCC at Goethe University Hospital in Frankfurt Germany. Both of these trials have opened for enrollment. We continue to evaluate other IITs as suitable opportunities present in Europe. We believe IITs will serve to build clinical experience at key cancer centers, and will help support efforts to obtain full reimbursement in Europe.

European Clinical Data Generation

On April 2, 2015 we announced the activation of our prospective patient registry in Europe to collect uniform essential patient safety, efficacy, and QoL information using observational study methods. This registry will gather data in multiple tumor types from commercial cases performed by participating cancer centers in Europe. A prospective registry is an organized system that uses observational study methods to collect defined clinical data under normal conditions of use to evaluate specified outcomes for a population defined by a particular disease, condition, or exposure. Registry data is non-randomized, and as such cannot be used for either registration approval, promotional or competitive claims. However, we believe the Patient Registry will provide a valuable data repository from a commercial setting that can be used to identify further clinical development opportunities, support clinical adoption and reimbursement in Europe. Cancer centers in Germany, the United Kingdom, and the Netherlands are participating in the registry and patient enrollment has begun.

Recent Data Presentations

In September 2015, results from a study conducted by two EU treatment centers on the treatment of patients with liver metastases from ocular melanoma with CHEMOSAT was presented as a poster at the European Cancer Congress (ECCO) annual meeting. The study entitled, *Treating Unresectable Liver Metastases of Uveal Melanoma with (Percutaneous) Isolated Hepatic Perfusion with Melphalan: Results from Two Experienced Centers*, by E.M. De Leede, M.C. Burgmans, et al., was a retrospective study conducted by investigators at Leiden University Medical Center (LUMC) and Erasmus Medical Center (EMC) in the Netherlands. Investigators compared patients with uveal (ocular) melanoma liver metastases treated with isolated hepatic perfusion (IHP), an open surgical procedure that can be performed only once, with patients treated with repeatable percutaneous hepatic perfusion (PHP) using the CHEMOSAT system with an aim to treat patients twice with a six week interval. Treatment characteristics, complications, toxicity, progression free and overall survival of both therapeutic approaches were analyzed. Both IHP and PHP treatments were performed with melphalan.

In the IHP cohort (30 patients treated between March 1999 and April 2009) progression free survival was 6 months and recurrence was mainly in the liver, and overall survival was 10 months. In the PHP cohort (9 patients who received 15 PHP treatments since February 2014), the maximum follow-up period was 14 months. Eight patients are still alive, seven without progression of disease. A decrease in red and white blood cell count and thrombocytes after the procedure was observed, and 3 patients needed blood transfusions or platelet infusion. Treatment was overall well tolerated. Investigators concluded that percutaneous hepatic perfusion appears to be an effective and safe procedure in

selected patients with unresectable liver metastases of colorectal cancer or uveal melanoma and can be repeated.

Also in September 2015, results of two European investigator-sponsored studies with CHEMOSAT for the treatment of liver metastases were presented as posters at the Cardiovascular and Interventional Radiology Society (CIRSE) annual meeting. An investigator-sponsored study entitled *Safety and Efficiency of The Delcath^{2nd} Generation Filter in Percutaneous Hepatic Perfusion (PHP) with Melphalan for Unresectable Hepatic Metastases of Colorectal Cancer and Uveal Melanoma* conducted at the Leiden University Medical Center (LUMC) by M.C. Burgmans, N. de Leede, et al. analyzed safety and pharmacokinetics of CHEMOSAT. Investigators examined pharmacokinetic blood samples taken at baseline and set intervals during 15 PHP procedures performed with CHEMOSAT on 10 patients. The PHP procedures were performed with a melphalan dose of 3.0 mg/kg. Results showed grade 3 complications (mostly asymptomatic leukocytopenia and thrombocytopenia) in seven patients, and febrile neutropenia with bacterial pharyngitis in one patient. Febrile neutropenia was not seen again in the study after growth factors were instituted in a study protocol amendment. Analysis of the first blood samples showed filter efficiency of 93%. Investigators concluded that the efficiency of the Delcath 2nd Generation Filter was very high, and that PHP with the filter was associated with no mortality and acceptable morbidity consistent with commercial use in Europe.

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Another study, entitled *Lessons and Early Results from the Largest Single Centre Experience in Europe of Treating Ocular Melanoma Liver Metastases with Chemosaturation via Percutaneous Hepatic Perfusion* and conducted at Southampton University in the United Kingdom by G. Hickson, I. Wilson, B. Steadman, et al., reported results from a retrospective analysis of mortality, morbidity, intra-procedural imaging and complication data on 22 consecutive patients who were planned for PHP treatment over a 30-month period. Of the 20 patients who were able to receive treatment, 11 patients remained alive after a median of 280 days, with one complete response ongoing at more than one year post-treatment. Nine deaths from disease progression occurred after a median of 264 days from the first procedure. A complete imaging response in the liver was observed in two patients (10%), 13 patients (65%) had a partial liver response and two patients (10%) had stable disease for more than three months. Investigators concluded that PHP is an effective palliative treatment in a bleak disease with an acceptable side-effect profile.

In November 2015 we announced that data from three studies supporting treatment for liver metastases with CHEMOSAT were presented at the European Association of Dermato Oncology (EADO) annual congress, which was held in Marseille, France, October 28-31, 2015.

Details of the presentations are as follows:

Liver Directed Treatment Of Metastatic Uveal Melanoma By Chemosaturation Via Percutaneous Hepatic Perfusion A Single Centre Experience, Southampton University (United Kingdom), presented by lead author Dr. Ioannis Karydis. Researchers conducted a retrospective evaluation of 20 patients treated with CHEMOSAT over 3 years, analyzing survival, tumor response, time to progression and treatment related adverse events. Eighteen patients were able to receive treatment, and 17 of these were evaluable for study purposes. Results showed that ten patients remained alive after median 256 days, with one complete response (6%), four partial responses (24%), and eleven (65%) patients with stable disease for greater than 90 days. Progression free survival for patients who had progressed was 181 days at the time of data cut off, and six patients were alive for greater than one year following their first treatment. Eight deaths from disease progression occurred at a median of 241 days following first treatment, and there were no treatment related deaths. Treatment overall was well tolerated, and non-hematological adverse events were rare (3). Most common adverse events were transient, mild \leq grade 2 and included transaminitis (56%) and thrombocytopenia (89%); grade 3 anemia was seen in 4 patients and grade 2-4 neutropenia was seen in 4 patients. Researchers concluded that PHP can be used safely by an experienced team to deliver liver-directed therapy in selected uveal melanoma patients with high progression free and excellent overall survival.

Treating Unresectable Liver Metastases Of Uveal Melanoma With Percutaneous Hepatic Perfusion With Melphalan, Leiden University Medical Center, Erasmus Cancer Institute (the Netherlands) presented by Dr. Mark Burgmans (Leiden). This is an active two-center Investigator Initiated Phase 2 study that aims to evaluate 20 patients with uveal, or ocular melanoma treated with PHP (CHEMOSAT). Data from the first 11 patients with a maximum follow up period of 16 months were presented. Primary endpoints for the study are response rate (as measured by RECIST criteria) following two treatments at 6-week intervals and the percentage of patients with stable disease. Secondary endpoints are safety, overall survival, hepatic progression free survival, and quality of life. Eighteen treatments have been performed on eleven patients and the maximum follow up is currently sixteen months. Current results are that ten patients remain in follow up, and four are without progression of disease. Four patients experienced grade 3 or 4 toxicities that were managed with blood or platelet transfusions. The researchers concluded that PHP with CHEMOSAT appears to be an effective and safe procedure in selected patients with unresectable liver metastases of uveal melanoma and can be repeated.

Chemosaturation with Percutaneous Hepatic Perfusion of Melphalan for Hepatic Metastases from Uveal Melanoma: Multiinstitutional Evaluation. This study was presented as a poster by lead author Prof. Thomas Vogl, Frankfurt University Hospital and was a retrospective evaluation of non-resectable hepatic metastases from uveal melanoma in

14 patients treated with CHEMOSAT between 2012 and 2014. Eleven patients who received one to three treatments were evaluated by RECIST criteria; survival time analysis was conducted and complications were recorded. Results showed 4 patients (36%) with a partial response, five (46%) with stable disease, and two (18%) with progressive disease. Survival time ranged between 1.5 months to 23 months, with median overall survival of 6.5 months. Time to progression for the two patients who had progressed was 6.2 months for one patient and 1.6 months for a patient who died after evaluation. Treatment was well tolerated by all 14 patients, with seven experiencing leukopenia, six had thrombocytopenia, and two had neutropenia. Researchers concluded that PHP with CHEMOSAT has been manifested as a potential treatment for patients with non-resectable hepatic metastases of uveal melanoma. This study was subsequently accepted for presentation at the 2015 Radiology Society of North America (RSNA) annual meeting, held in Chicago, IL from November 29 - December 4, 2015.

Market Access & Commercial Clinical Adoption

European Union

Our immediate market access and clinical adoptions efforts continue to be focused on the key target markets of Germany and the United Kingdom, which represent a majority of the total potential liver cancer market (primary and metastatic) in the EU and where progress in securing reimbursement for CHEMOSAT treatments offers the best near-term opportunities. We also continue to support clinical adoption of CHEMOSAT in the Netherlands, Spain, France and Italy. We employ a combination of direct and indirect sales channels to market and sell CHEMOSAT in these markets. Our European Headquarters is in Galway, Ireland.

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Since launching CHEMOSAT in Europe, treatments have been performed at over 20 leading European cancer centers. Physicians in Europe have used CHEMOSAT to treat patients with a variety of cancers in the liver primarily ocular melanoma liver metastases, and other tumor types, including hepatocellular carcinoma, cholangiocarcinoma, and liver metastases from colorectal cancer, breast, and cutaneous melanoma.

European Reimbursement

A critical driver of utilization growth for CHEMOSAT in Europe is the expansion of reimbursement mechanisms for the procedure in our priority markets. In Europe, there is no centralized pan-European medical device reimbursement body. Reimbursement is administered on a regional and national basis. Medical devices are typically reimbursed under Diagnosis Related Groups (DRG) as part of a procedure. Prior to obtaining permanent DRG reimbursement codes, in certain jurisdictions, the Company is actively seeking interim reimbursement from existing mechanisms that include specific interim reimbursement schemes, new technology payment programs as well as existing DRG codes. In most EU countries, the government provides healthcare and controls reimbursement levels. Since the EU has no jurisdiction over patient reimbursement or pricing matters in its member states, the methodologies for determining reimbursement rates and the actual rates may vary by country.

Germany

In October 2015, we announced that the Institut für das Entgeltsystem im Krankenhaus (InEk), the German federal reimbursement agency, established a national Zusatzentgelt (ZE) reimbursement code for procedures performed with CHEMOSAT in Germany. The ZE diagnostic-related group (DRG) code is a national reimbursement code that augments existing DRG codes until a specific new DRG code can be created. With ZE reimbursement established, hospitals in Germany can begin to negotiate with insurers to obtain reimbursement rates for CHEMOSAT procedures beginning in February 2016. With the establishment of a ZE code for CHEMOSAT, the procedure is now permanently represented in the DRG catalog in Germany. This decision represents the first national reimbursement mechanism for CHEMOSAT procedures in Europe.

ZE reimbursement will replace the previous Neue Untersuchungs und Behandlungsmethoden (NUB) procedure that required patients in Germany to apply individually for reimbursement of their CHEMOSAT treatment. Until ZE reimbursement rates are negotiated, we expect that Individual Funding Requests (IFRs) will continue to be the primary reimbursement vehicle in the German market. IFRs are case-by-case appeals for reimbursement made to the patient's insurance carrier (sickness funds). While each IFR is evaluated independently, the majority of these applications are being approved.

The establishment of ZE coverage by InEK was made in response to an application made by the German Radiology Society for CHEMOSAT in March 2015 with wide support among medical cancer centers in Germany.

United Kingdom

In the United Kingdom, though Delcath and our participating cancer centers identified existing Healthcare Resource Groups (HRG) code(s), we have been advised that hospitals have not used it for coverage of CHEMOSAT related costs. We continue to work with the HRG organization that decides on new HRG codes toward receipt of a dedicated and permanent reimbursement code in the future.

We are supporting efforts to seek a block fund grant through the *Commissioning Through Evaluation* (CTE) process, which may ultimately provide funding for up to 50-75 ocular melanoma patients to be treated utilizing CHEMOSAT at two or three centers in the U.K. This process has been driven by our partner centers and their clinical community,

with the centers applying for funding for a limited number of patients with ocular melanoma. In the fourth quarter of 2014, Aintree University Hospital in Liverpool was activated with the intention of it becoming one of these CTE centers. The British healthcare system continues to evolve however, and ongoing changes to the CTE process and funding streams have resulted in delays that made the award and timing of any block grant funding difficult to predict. The entire CTE funding mechanism is a new process and the ongoing policy changes in the National Health Service (NHS) make it difficult to predict the likelihood of success in the near term.

In May 2014, the National Institute for Clinical Excellence (NICE), a non-departmental public body that provides guidance and advice to improve health and social care in the UK, completed a clinical review of CHEMOSAT. The NICE review indicated that as the current body of evidence on the safety and efficacy of PHP with CHEMOSAT for primary or metastatic liver cancer is limited, the procedure should be performed within the context of research by clinicians with specific training in its use and techniques. NICE stated that this research may take the form of observational studies. With continued enrollment in the UK in our Phase 2 HCC and ICC trial in 2016, we believe the data generated from these studies will help provide supporting clinical data and address the concerns raised by NICE relative to survival, quality of life and adverse events. NICE may decide to conduct a Technology Appraisal of CHEMOSAT thereafter, the outcome of which could influence the long-term reimbursement status.

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Public patients will continue to be treated in the UK through clinical trials and potentially the CTE process. Private patients will continue to be treated through the established private treatment pathway such as private insurance coverage or self-pay.

Other European Markets

Permanent reimbursement coverage in remaining EU markets will require additional time to secure. For France, Spain and the Netherlands, publication of the Phase 3 trial manuscript is a key component of the reimbursement process. The Phase 3 trial manuscript has been accepted for publication in the prestigious *Annals of Surgical Oncology* and will serve as the foundation for the reimbursement efforts in these Countries. In the interim period, we are seeking payment through various avenues, including new technology programs.

Distribution Partners

As a result of the Company's strategy to prioritize resources on the key direct markets of Germany and the United Kingdom, the Company expects that its distribution strategy will play a lesser role in its current commercial activities. In Spain, the Company has determined that there was no benefit to continuing with an indirect model and therefore terminated its relationship with its distributor in Spain and is now represented in Spain through a sales agency.

Regulatory Status

Our products are subject to extensive and rigorous government regulation by foreign regulatory agencies and the FDA. Foreign regulatory agencies, the FDA and comparable regulatory agencies in state and local jurisdictions impose extensive requirements upon the clinical development, pre-market clearance and approval, manufacturing, labeling, marketing, advertising and promotion, pricing, storage and distribution of pharmaceutical and medical device products. Failure to comply with applicable foreign regulatory agency or FDA requirements may result in Warning Letters, fines, civil or criminal penalties, suspension or delays in clinical development, recall or seizure of products, partial or total suspension of production or withdrawal of a product from the market.

United States Regulatory Environment

In the United States, the FDA regulates drug and device products under the Federal Food, Drug, and Cosmetic Act (FFDCA), and its implementing regulations. The Delcath Melphalan/HDS is subject to regulation as a combination product, which means it is composed of both a drug product and device product. If marketed individually, each component would therefore be subject to different regulatory pathways and reviewed by different centers within the FDA. A combination product, however, is assigned to a center that will have primary jurisdiction over its pre-market review and regulation based on a determination of its primary mode of action, which is the single mode of action that provides the most important therapeutic action. In the case of the Melphalan/HDS, the primary mode of action is attributable to the drug component of the product, which means that the Center for Drug Evaluation and Research (CDER), has primary jurisdiction over its pre-market development and review.

The process required by the FDA before drug product candidates may be marketed in the United States generally involves the following:

 submission to the FDA of an investigational new drug application, or IND, which must become effective before human clinical trials may begin and must be updated annually;

completion of extensive preclinical laboratory tests and preclinical animal studies, all performed in accordance with the FDA's Good Laboratory Practice, or GLP, regulations;

performance of adequate and well-controlled human clinical trials to establish the safety and efficacy of the product candidate for each proposed indication;

submission to the FDA of an NDA after completion of all pivotal clinical trials;

a determination by the FDA within 60 days of its receipt of an NDA to file the NDA for review;

satisfactory completion of an FDA pre-approval inspection of the manufacturing facilities at which the product is produced and tested to assess compliance with current good manufacturing practice, or cGMP, regulations; and

FDA review and approval of an NDA prior to any commercial marketing or sale of the drug in the United States.

The development and approval process requires substantial time, effort and financial resources, and we cannot be certain that any approvals for our product will be granted on a timely basis, if at all.

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The results of preclinical tests (which include laboratory evaluation as well as GLP studies to evaluate toxicity in animals) for a particular product candidate, together with related manufacturing information and analytical data, are submitted as part of an IND to the FDA. The IND automatically becomes effective 30 days after receipt by the FDA, unless the FDA, within the 30-day time period, raises concerns or questions about the conduct of the proposed clinical trial, including concerns that human research subjects will be exposed to unreasonable health risks. In such a case, the IND sponsor and the FDA must resolve any outstanding concerns before the clinical trial can begin. IND submissions may not result in FDA authorization to commence a clinical trial. A separate submission to an existing IND must also be made for each successive clinical trial conducted during product development. Further, an independent institutional review board, or IRB, for each medical center proposing to conduct the clinical trial must review and approve the plan for any clinical trial before it commences at that center and it must monitor the study until completed. The FDA, the IRB or the sponsor may suspend a clinical trial at any time on various grounds, including a finding that the subjects or patients are being exposed to an unacceptable health risk. Clinical testing also must satisfy extensive good clinical practice regulations and regulations for informed consent and privacy of individually identifiable information. Similar requirements to the U.S. IND are required in the EEA and other jurisdictions in which we may conduct clinical trials.

Clinical Trials

For purposes of NDA submission and approval, clinical trials are typically conducted in the following sequential phases, which may overlap:

Phase I Clinical Trials. Studies are initially conducted in a limited population to test the product candidate for safety, dose tolerance, absorption, distribution, metabolism and excretion, typically in healthy humans, but in some cases in patients.

Phase 2 Clinical Trials. Studies are generally conducted in a limited patient population to identify possible adverse effects and safety risks, explore the initial efficacy of the product for specific targeted indications and to determine dose range or pharmacodynamics. Multiple Phase 2 clinical trials may be conducted by the sponsor to obtain information prior to beginning larger and more expensive Phase 3 clinical trials.

Phase 3 Clinical Trials. These are commonly referred to as pivotal studies. When Phase 2 evaluations demonstrate that a dose range of the product is effective and has an acceptable safety profile, Phase 3 clinical trials are undertaken in large patient populations to further evaluate dosage, provide substantial evidence of clinical efficacy and further test for safety in an expanded and diverse patient population at multiple, geographically dispersed clinical trial centers.

Phase IV Clinical Trials. The FDA may approve an NDA for a product candidate, but require that the sponsor conduct additional clinical trials to further assess the drug after NDA approval under a post-approval commitment. In addition, a sponsor may decide to conduct additional clinical trials after the FDA has approved an NDA. Post-approval trials are typically referred to as Phase IV clinical trials.

Sponsors of clinical trials may submit proposals for the design, execution, and analysis for their pivotal trials under a Special Protocol Assessment (SPA). A SPA is an evaluation by the FDA of a protocol with the goal of reaching an agreement that the Phase 3 trial protocol design, clinical endpoints, and statistical analyses are acceptable to support regulatory approval of the drug product candidate with respect to effectiveness for the indication studied. Under a

SPA, the FDA agrees to not later alter its position with respect to adequacy of the design, execution or analyses of the clinical trial intended to form the primary basis of an effectiveness claim in an NDA, without the sponsor's agreement, unless the FDA identifies a substantial scientific issue essential to determining the safety or efficacy of the drug after testing begins. Prior to initiating our Phase 3 clinical trial, we submitted a proposal for the design, execution and analysis under a SPA, and we conducted our Phase 3 trial under a SPA.

New Drug Applications

The results of drug development, preclinical studies and clinical trials are submitted to the FDA as part of a New Drug Application (NDA). NDAs also must contain extensive chemistry, manufacturing and control information. An NDA must be accompanied by a significant user fee, which may be waived in certain circumstances. Once the submission has been accepted for filing, the FDA's goal is to review applications within ten months of submission or, if the application relates to an unmet medical need in a serious or life-threatening indication, six months from submission. The review process is often significantly extended by FDA requests for additional information or clarification. The FDA may refer the application to an advisory committee for review, evaluation and recommendation as to whether the application should be approved. For new oncology products, the FDA will often solicit an opinion from an Oncologic Drugs Advisory Committee (ODAC), a panel of expert authorities knowledgeable in the fields of general oncology, pediatric oncology, hematologic oncology, immunologic oncology, biostatistics, and other related professions. The ODAC panel reviews and evaluates data concerning the safety and effectiveness of marketed and investigational human drug products for use in the treatment of cancer, and makes appropriate recommendations to the Commissioner of Food and Drugs. The FDA is not bound by the recommendation of an advisory committee. The FDA may deny approval of an NDA by issuing a Complete Response Letter (CRL) if the applicable regulatory criteria are not satisfied. A CRL may require additional clinical data and/or an additional pivotal Phase 3 clinical trial(s), and/or other significant, expensive and time-consuming requirements related to clinical trials, preclinical studies or manufacturing. Data from clinical trials are not always conclusive and the FDA may interpret data differently than we or our collaborators interpret data. Approval may be contingent on a Risk Evaluation and Mitigation Strategy (REMS) that limits the

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labeling, distribution or promotion of a drug product. Once issued, the FDA may withdraw product approval if ongoing regulatory requirements are not met or if safety problems occur after the product reaches the market. In addition, the FDA may require testing, including Phase IV clinical trials, and surveillance programs to monitor the safety effects of approved products which have been commercialized, and the FDA has the power to prevent or limit further marketing of a product based on the results of these post-marketing programs or other information.

There are three primary regulatory pathways for a New Drug Application under Section 505 of The Federal Food Drug and Cosmetics Act (FFDCA): Section 505 (b)(1), Section 505 (b)(2) and Section 505(j). A Section 505 (b)(1) application is used for approval of a new drug (for clinical use) whose active ingredients have not been previously approved. A Section 505 (b)(2) application is used for a new drug that relies on data not developed by the applicant. Section 505(b)(2) of the FFDCA was enacted as part of the Drug Price Competition and Patent Term Restoration Act of 1984, also known as the Hatch-Waxman Act. This statutory provision permits the approval of an NDA where at least some of the information required for approval comes from studies not conducted by or for the applicant and for which the applicant has not obtained a right of reference. The Hatch-Waxman Act permits the applicant to rely in part upon the FDA's findings of safety and effectiveness for previously approved products. Section 505(j) application, also known as an abbreviated NDA, is used for a generic version of a drug that has already been approved.

Orphan Drug Exclusivity

Some jurisdictions, including the United States, may designate drugs for relatively small patient populations as orphan drugs. Pursuant to the Orphan Drug Act, the FDA grants orphan drug designation to drugs intended to treat a rare disease or condition, which is generally a disease or condition that affects fewer than 200,000 individuals in the United States. The orphan designation is granted for a combination of a drug entity and an indication and therefore it can be granted for an existing drug with a new (orphan) indication. Applications are made to the Office of Orphan Products Development at the FDA and a decision or request for more information is rendered in 60 days. NDAs for designated orphan drugs are exempt from user fees, obtain additional clinical protocol assistance, are eligible for tax credits up to 50% of research and development costs, and are granted a seven-year period of exclusivity upon approval. The FDA cannot approve the same drug for the same condition during this period of exclusivity, except in certain circumstances where a new product demonstrates superiority to the original treatment. Exclusivity begins on the date that the marketing application is approved by the FDA for the designated orphan drug, and an orphan designation does not limit the use of that drug in other applications outside the approved designation in either a commercial or investigational setting.

The FDA has granted Delcath six orphan drug designations. In November 2008, the FDA granted Delcath two orphan drug designations for the drug melphalan for the treatment of patients with cutaneous melanoma as well as patients with ocular melanoma. In May 2009, the FDA granted Delcath an additional orphan drug designation of the drug melphalan for the treatment of patients with neuroendocrine tumors. In August 2009, the FDA granted Delcath an orphan drug designation of the drug doxorubicin for the treatment of patients with primary liver cancer. In October 2013, the FDA granted Delcath an orphan drug designation of the drug melphalan for the treatment of HCC. In July 2015, the FDA granted Delcath an orphan drug designation of the drug melphalan for the treatment of cholangiocarcinoma, which includes ICC.

The granting of orphan drug designations does not mean that the FDA has approved a new drug. Companies must still pursue the rigorous development and approval process that requires substantial time, effort and financial resources, and we cannot be certain that any approvals for our product will be granted at all or on a timely basis.

Other Regulatory Requirements

Products manufactured or distributed pursuant to FDA approvals are subject to continuing regulation by the FDA, including recordkeeping, annual product quality review and reporting requirements. Adverse event experience with the product must be reported to the FDA in a timely fashion and pharmacovigilance programs to proactively look for these adverse events are mandated by the FDA. Drug manufacturers and their subcontractors are required to register their establishments with the FDA and certain state agencies, and are subject to periodic unannounced inspections by the FDA and certain state agencies for compliance with ongoing regulatory requirements, including cGMPs, which impose certain procedural and documentation requirements upon us and our third-party manufacturers. Following such inspections, the FDA may issue notices on Form 483 and Untitled Letters or Warning Letters that could cause us or our third-party manufacturers to modify certain activities. A Form 483 Notice, if issued at the conclusion of an FDA inspection, can list conditions the FDA investigators believe may have violated cGMP or other FDA regulations or guidelines. In addition to Form 483 Notices and Untitled Letters or Warning Letters, failure to comply with the statutory and regulatory requirements can subject a manufacturer to possible legal or regulatory action, such as suspension of manufacturing, seizure of product, injunctive action or possible civil penalties. We cannot be certain that we or our present or future third-party manufacturers or suppliers will be able to comply with the cGMP regulations and other ongoing FDA regulatory requirements. If we or our present or future third-party manufacturers or suppliers are not able to comply with these requirements, the FDA may require us to recall our products from distribution or withdraw any potential approvals of an NDA for that product.

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The FDA closely regulates the post-approval marketing and promotion of drugs, including standards and regulations for direct-to-consumer advertising, dissemination of off-label information, industry-sponsored scientific and educational activities and promotional activities involving the Internet. Drugs may be marketed only for the approved indications and in accordance with the provisions of the approved label. Further, if there are any modifications to the drug, including changes in indications, labeling, or manufacturing processes or facilities, we may be required to submit and obtain FDA approval of a new or supplemental NDA, which may require us to develop additional data or conduct additional preclinical studies and clinical trials. Failure to comply with these requirements can result in adverse publicity, Warning Letters, corrective advertising and potential civil and criminal penalties.

Physicians may prescribe legally available products for uses that are not described in the product's labeling and that differ from those tested by us and approved by the FDA. Such off-label uses are common across medical specialties, in particular in oncology. Physicians may believe that such off-label uses are the best treatment for many patients in varied circumstances. The FDA does not regulate the behavior of physicians in their choice of treatments. The FDA does, however, impose stringent restrictions on manufacturers' communications regarding off-label use.

European Regulatory Environment

In the EEA, the CHEMOSAT system is subject to regulation as a medical device. The EEA is composed of the 27 Member States of the European Union plus Norway, Iceland and Liechtenstein. Under the EU Medical Devices Directive (Directive No 93/42/ECC of 14 June 1993, as last amended), drug delivery products such as the CHEMOSAT system is governed by the EU laws on pharmaceutical products only if they are (i) placed on the market in such a way that the device and the pharmaceutical product form a single integral unit which is intended exclusively for use in the given combination, and (ii) the product is not reusable. In such cases, the drug delivery product is governed by the EU Code on Medicinal Products for Human Use (Directive 2001/83/EC, as last amended), while the essential requirements of the EU Medical Devices Directive apply to the safety and performance-related device features of the product. Because we do not intend to place the CHEMOSAT system on the EEA market as a single integral unit with melphalan, the product is governed solely by the EU Medical Devices Directive, while the separately marketed drug is governed by the EU Code relating to Medicinal Products for Human Use and other EU legislation applicable to drugs for human use.

Before we may commercialize a medical device in the EEA, we must comply with the essential requirements of the EU Medical Devices Directive. Compliance with these requirements entitles a manufacturer to affix a CE conformity mark, without which the products cannot be commercialized in the EEA. To demonstrate compliance with the essential requirements and obtain the right to affix the CE conformity mark, medical device manufacturers must undergo a conformity assessment procedure, which varies according to the type of medical device and its classification. In April 2011, we obtained authorization to affix a CE Mark for the Generation One CHEMOSAT system and began European commercialization with this version of the CHEMOSAT system in early 2012. In April 2012, the Company obtained authorization to affix a CE Mark for the Generation Two CHEMOSAT system, and since this time all procedures in Europe have been performed with this version of the system.

The Medical Devices Directive establishes a classification system placing devices into Class I, IIa, IIb, or III, depending on the risks and characteristics of the medical device. For certain types of low risk medical devices (i.e., Class I devices which are non-sterile and do not have a measuring function), the manufacturer may issue an EC Declaration of Conformity based on a self-assessment of the conformity of its products with the essential requirements of the EU Medical Devices Directives. Other devices are subject to a conformity assessment procedure requiring the intervention of a Notified Body, which is an organization designated by a Member State of the EEA to conduct conformity assessments.

CHEMOSAT is regulated as a Class IIb medical device. As a Class IIb medical device, the Notified Body is not required to carry out an examination of the product's design dossier as part of its conformity assessment prior to commercialization. The Company must continue to comply with the essential requirements of the EU Medical Devices Directive (Directive 93/42 EC) and is subject to a conformity assessment procedure requiring the intervention of a Notified Body. The conformity assessment procedure for Class IIb medical devices requires the manufacturer to apply for the assessment of its quality system for the design, manufacture and inspection of its medical devices by a Notified Body. The Notified Body will audit the system to determine whether it conforms to the provisions of the Medical Devices Directive. If the Notified Body's assessment is favorable it will issue a Full Quality Assurance Certificate, which enables the manufacturer to draw a Declaration of Conformity and affix the CE mark to the medical devices covered by the assessment. Thereafter, the Notified Body will carry out periodic audits to ensure that the approved quality system is applied by the manufacturer.

A manufacturer without a registered place of business in a Member State of the European Union which places a medical device on the market under its own name must designate an authorized representative established in the European Union who can act before, and be addressed by, the Competent Authorities on the manufacturer's behalf with regard to the manufacturer's obligations under the EU Medical Devices Directive. We appointed such a representative prior to establishing our infrastructure in the EEA and expect that we will not need a third party representative in the future.

In the EEA, we must also comply with the Medical Device Vigilance System, which is designed to improve the protection of health and safety of patients, users and others by reducing the likelihood of recurrence of incidents related to the use of a medical device.

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Under this system, incidents are defined as any malfunction or deterioration in the characteristics and/or performance of a device, as well as any inadequacy in the labeling or the instructions for use which, directly or indirectly, might lead to or might have led to the death of a patient, or user or of other persons or to a serious deterioration in their state of health. When a medical device is suspected to be a contributory cause of an incident, its manufacturer or authorized representative in the European Union must report it to the Competent Authority of the Member State where the incident occurred. Incidents are generally investigated by the manufacturer. The manufacturer's investigation is monitored by the Competent Authority, which may intervene, or initiate an independent investigation if considered appropriate. An investigation may conclude in the adoption of a Field Safety Corrective Action (FSCA). An FSCA is an action taken by a manufacturer to reduce a risk of death or serious deterioration in the state of health associated with the use of a medical device that is already placed on the market. An FSCA may include device recall, modification exchange and destruction. FSCAs must be notified by the manufacturer or its authorized representative to its customers and/or the end users of the medical device via a Field Safety Notice.

In the EEA, the off-label promotion of a pharmaceutical product is strictly prohibited under the EU Community Code on Medicinal Products, which provides that all information provided within the context of the promotion of a drug must comply with the information contained in its approved summary of product characteristics. Our product instructions and indication reference the chemotherapeutic agent melphalan hydrochloride. However, no melphalan labels in the EEA reference our product, and the labels vary from country to country with respect to the approved indication of the drug and its mode of administration. In the exercise of their professional judgment in the practice of medicine, physicians are generally allowed, under certain conditions, to use or prescribe a product in ways not approved by regulatory authorities. Physicians intending to use our device must obtain melphalan separately for use with the CHEMOSAT system and must use melphalan independently at their discretion.

In the EEA, the advertising and promotion of our products is also subject to EEA Member States laws implementing the EU Medical Devices Directive, Directive 2006/114/EC concerning misleading and comparative advertising and Directive 2005/29/EC on unfair commercial practices, as well as other EEA Member State legislation governing the advertising and promotion of medical devices. These laws may further limit or restrict the advertising and promotion of our products to the general public and may also impose limitations on our promotional activities with health care professionals.

Failure to comply with the EEA Member State laws implementing the Medical Devices Directive, with the EU and EEA Member State laws on the promotion of medicinal products or with other applicable regulatory requirements can result in enforcement action by the EEA Member State authorities, which may include any of the following: fines, imprisonment, orders forfeiting products or prohibiting or suspending their supply to the market, or requiring the manufacturer to issue public warnings, or to conduct a product recall.

The European Commission reviewed the medical devices legislative framework in 2012 with the aim of simplifying it and ensuring a more uniform application of the provisions contained in the medical devices directives across the EEA. We do not believe the adopted regulatory changes will impact our business at this time, though future changes to the medical device legislation may adversely affect our business, financial condition and results of operations or restrict our operations.

Other International Regulations

The CHEMOSAT device has received registrations in the following countries: Australia, New Zealand, Argentina, Taiwan, and Singapore. With limited resources and our attention focused on European commercial and clinical adoption efforts, pursuing other markets at this time is not practical. We will continue to evaluate commercial opportunities in these and other markets when resources are available and at an appropriate time.

Competition

The healthcare industry is characterized by extensive research, rapid technological progress and significant competition from numerous healthcare companies and academic institutions. Competition in the cancer treatment industry is intense. We believe that the primary competitive factors for products addressing cancer include safety, efficacy, ease of use, reliability and price. We also believe that physician relationships, especially relationships with leaders in the medical and surgical oncology communities, are important competitive factors. We also believe that the current global economic conditions and new healthcare reforms could put competitive pressure on us, including reduced selling prices and potential reimbursement rates, and overall procedure rates. Certain markets in Europe are experiencing the effects of continued economic weakness, which is affecting healthcare budgets and reimbursement.

The CHEMOSAT/Melphalan/HDS competes with all forms of liver cancer treatments, including surgery, systemic chemotherapy, focal therapies and palliative care. In the disease states we are targeting there are also numerous clinical trials sponsored by third-parties, which can compete for potential patients in the near term and may ultimately lead to new competitive therapies.

For ocular melanoma liver metastases, there are currently no approved or effective treatment options, and patients are generally treated with a variety of focal and regional techniques. There are numerous companies developing and marketing devices for the performance of focal therapies, including Covidian, Biocompatibles, Merit, CeleNova, SirTex, AngioDynamics, and many others.

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For HCC, sorafenib (Nexavar, Onyx Pharmaceuticals) remains the only targeted drug approved for the treatment of HCC in patients who are not candidates for surgery.

Several therapies have been recently approved for unresectable or metastatic cutaneous melanoma, which may encompass liver metastases. Dabrafenib (Tafinlar, GlaxoSmithKline), is indicated as single agent for the treatment of patients with unresectable or metastatic melanoma with BRAF V600E mutation, and in combination with trametinib in unresectable or metastatic melanoma with BRAF V600E or V600K mutations. Furthermore, trametinib (MEKINIST, GlaxoSmithKline) is indicated as single agent (in addition to in combination with dabrafenib) for treatment of patients with unresectable or metastatic melanoma with BRAF V600E or V600K mutations. Previously approved melanoma therapies such as the biologic ipilimumab (Yervoy, Bristol Myers Squibb) and the B-RAF targeted drug vemurafenib (Zelboraf, Genentech) may also make up the competitive landscape for the treatment of metastatic liver disease.

Many of these treatments are approved in Europe and other global markets.

Many of our competitors have substantially greater financial, technological, research and development, marketing and personnel resources. In addition, some of our competitors have considerable experience in conducting clinical trials, regulatory, manufacturing and commercialization capabilities. Our competitors may develop alternative treatment methods, or achieve earlier product development, in which case the likelihood of us achieving meaningful revenues or profitability will be substantially reduced.

Manufacturing and Quality Assurance

We manufacture certain components including our proprietary filter media, and assemble and package the CHEMOSAT/Melphalan/HDS at our facility in Queensbury, New York. We have established our European headquarters and distribution facility in Galway, Ireland where we intend to conduct final manufacturing and assembly in the future. Delcath currently utilizes third-parties to manufacture some components of the CHEMOSAT/Melphalan/HDS. The CHEMOSAT/Melphalan/HDS and its components must be manufactured and sterilized in accordance with approved manufacturing and pre-determined performance specifications. In addition, certain components will require sterilization prior to distribution and Delcath relies on third-party vendors to perform the sterilization process.

We are committed to providing high quality products to our customers. To honor this commitment, Delcath has implemented updated quality systems throughout our organization. Delcath's quality system starts with the initial product specification and continues through the design of the product, component specification process and the manufacturing, sale and servicing of the product. These systems are designed to enable us to satisfy the various international quality system regulations including those of the FDA with respect to products sold in the United States and those established by the International Standards Organization (ISO) with respect to products sold in the EEA. The Company is required to maintain ISO 13485 certification for medical devices to be sold in the EEA, which requires, among other items, an implemented quality system that applies to component quality, supplier control, product design and manufacturing operations. On February 17, 2011, we announced that we had achieved ISO 13485 certification for our Queensbury manufacturing facility. On December 28, 2011, we announced that we had achieved ISO 13485 certification for our Galway, Ireland facility.

Intellectual Property and Other Rights

Our success depends in part on our ability to obtain patents and trademarks, maintain trade secret and know-how protection, enforce our proprietary rights against infringers, and operate without infringing on the proprietary rights of

third parties. Because of the length of time and expense associated with developing new products and bringing them through the regulatory approval process, the health care industry places considerable emphasis on obtaining patent protection and maintaining trade secret protection for new technologies, products, processes, know-how, and methods. The Company currently holds eight U.S. utility patents, one U.S. design patent, six pending U.S. utility patent applications (one of which has been allowed), four issued foreign counterpart utility patents (including the validation of one European patent in two European countries, and the validation of another European patent in four European countries), six issued foreign counterpart design patents, and eight pending foreign counterpart patent applications (one of which has been allowed).

When appropriate, the Company actively pursues protection of our proprietary products, technologies, processes, and methods by filing United States and international patent and trademark applications. We seek to pursue additional patent protection for technology invented through research and development, manufacturing, and clinical use of the CHEMOSAT/Melphalan/HDS that will enable us to expand our platform beyond the treatment of cancers in the liver. There can be no assurance that the pending patent applications will result in the issuance of patents, that patents issued to or licensed by us will not be challenged or circumvented by competitors, or that these patents will be found to be valid or sufficiently broad to protect our technology or provide us with a competitive advantage.

To maintain our proprietary position, we also rely on trade secrets and proprietary technological experience to protect proprietary manufacturing processes, technology, and know-how relating to our business. We rely, in part, on confidentiality agreements with our

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marketing partners, employees, advisors, vendors and consultants to protect our trade secrets and proprietary technological expertise. In addition, we also seek to maintain our trade secrets through maintenance of the physical security of the premises where our trade secrets are located. There can be no assurance that these agreements will not be breached, that we will have adequate remedies for any breach, that others will not independently develop equivalent proprietary information or that third parties will not otherwise gain access to our trade secrets and proprietary knowledge.

Certain of our United States and foreign patents have already expired and other patents relating to the CHEMOSAT/Melphalan/HDS will expire in 2016. In certain circumstances, United States patent law allows for the extension of a patent's duration for a period of up to five years after FDA approval. The Company intends to seek extension for one of our patents after FDA approval if it has not expired prior to the date of approval. In addition to our proprietary protections, the FDA has granted Delcath five orphan drug designations that provide us a seven-year period of exclusive marketing beginning on the date that our NDA is approved by the FDA for the designated orphan drug. While the exclusivity only applies to the indication for which the drug has been approved, the Company believes that it will provide us with added protection once commercialization of an orphan drug designated product begins.

There has been and continues to be substantial litigation regarding patent and other intellectual property rights in the pharmaceutical and medical device areas. If a third party asserts a claim against Delcath, the Company may be forced to expend significant time and money defending such actions and an adverse determination in any patent litigation could subject us to significant liabilities to third parties, require us to redesign our product, require us to seek licenses from third parties, and, if licenses are not available, prevent us from manufacturing, selling or using our system. Additionally, Delcath plans to enforce its intellectual property rights vigorously and may find it necessary to initiate litigation to enforce our patent rights or to protect our trade secrets or know-how. Patent litigation can be costly and time consuming and there can be no assurance that the outcome will be favorable to us.

Employees

During 2015, Delcath added 8 employees or approximately 30% (25-35 employees) in anticipation and support of clinical trial implementations in the E.U. and U.S, as well as in order to meet the demands of commercial sales. As of December 31, 2015, Delcath had 35 full-time employees. None of our employees is represented by a union and we believe relationships with our employees are good.

Management Transition

In October 2015, Jennifer Simpson, Ph.D., M.S.N., C.R.N.P., President and Chief Executive Officer, was appointed to the Company's Board of Directors. Dr. Simpson was named President and Chief Executive Officer in May 2015 and served as Interim President and Chief Executive Officer of Delcath from September 2014 to May 2015, and served as Interim Co-President and Co-Chief Executive Officer from September 2013 to September 2014. She joined Delcath in 2012 as Executive Vice President, Global Marketing. In addition, Roger G. Stoll, Ph.D., formerly Executive Chairman, was appointed as Chairman of the Board. With Dr. Simpson's appointment, Delcath Systems has seven directors.

Available Information

Delcath maintains a website at www.delcath.com. The Company makes available, free of charge on our website, our Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended, as soon as reasonably practicable after the Company electronically files those reports with, or furnishes them to, the Securities and Exchange

Commission, or the SEC. The Company is not including the information contained at www.delcath.com or at any other internet address as part of, or incorporating by reference into, this Annual Report on Form 10-K.

Item 1A. Risk Factors

Risks Related to Our Business and Financial Condition

Drug development is an inherently uncertain process with a high risk of failure at every stage of development. We received a complete response letter from the FDA regarding our Melblez Kit system, which precludes approval of our existing New Drug Application, or NDA.

Preclinical testing and clinical trials are long, expensive and highly uncertain processes and failure can unexpectedly occur at any stage of clinical development. Drug development is very risky and it takes several years to complete clinical trials. The start or end of a clinical trial is often delayed or halted due to changing regulatory requirements, manufacturing challenges, required clinical trial administrative actions, slower than anticipated patient enrollment, changing standards of care, availability or prevalence of use of a comparator treatment or required prior therapy, clinical outcomes including insufficient efficacy, safety concerns, or our own financial constraints.

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In September 2013, the FDA issued a complete response letter (CRL) with respect to our NDA seeking an indication for ocular melanoma liver metastases for our Melblez Kit system. A CRL is issued by the FDA when the review of a file is completed and questions remain that precludes approval of the NDA in its current form. The FDA comments in the CRL included, but were not limited to, a statement that we must perform additional well-controlled randomized trial(s) to establish the safety and efficacy of Melblez Kit using overall survival as the primary efficacy outcome measure and which demonstrates that the clinical benefits of Melblez Kit outweigh its risks. The FDA also requires that the additional clinical trial(s) be conducted using the product the company intends to market. Prior to conducting additional clinical trials, we must satisfy certain other requirements of the CRL, including, but not limited to, product quality testing and human factors.

As a part of the regulatory process of obtaining marketing clearance for Melphalan/HDS, we will conduct and participate in numerous clinical trials with a variety of study designs, patient populations and trial endpoints. In 2014, we initiated a Phase 2 clinical trial for HCC in both the United States and Europe. In 2015, we expanded the Phase 2 clinical trial for HCC to include a cohort of patients with ICC. The trial for this cohort will be conducted at the same centers participating in the Phase 2 HCC trial. Additionally, in January 2016 we received agreement on a Special Protocol Assessment from the FDA and have initiated a pivotal Phase 3 overall survival clinical trial in ocular melanoma liver metastases. Unfavorable or inconsistent clinical data from clinical trials, including the Phase 2 clinical trial for HCC, the market's perception of this clinical data or FDA's perception of this clinical data, may adversely impact our ability to obtain approval, and the financial condition. Additionally, even if the results of our Phase 2 clinical trial for HCC and ICC are positive, there is a substantial risk that it will fail to have positive results in Phase 3 clinical trials with regard to efficacy, safety or other clinical outcomes and may never obtain regulatory approval.

Our independent registered public accounting firm has expressed substantial doubt about our ability to continue as a going concern.

Our independent registered public accounting firm issued its report dated March 18, 2016 in connection with the audit of our financial statements as of December 31, 2015, which included an explanatory paragraph describing the existence of conditions that raise substantial doubt about our ability to continue as a going concern. In addition, our notes to our financial statements for the year ended December 31, 2015 included a disclosure describing the existence of conditions that raise substantial doubt about our ability to continue as a going concern. Our ability to continue as a going concern is dependent upon our ability to obtain substantial additional funding in connection with our continuing operations. Adequate additional financing may not be available to us on acceptable terms, or at all. If we are unable to raise additional capital and/or enter into strategic alliances when needed or on attractive terms, we would be forced to delay, reduce or eliminate our research and development programs or any commercialization efforts. Our financial statements do not include any adjustments that might result from the outcome of this uncertainty. If we are not able to continue as a going concern, it is likely that holders of our common stock will lose all of their investment.

We do not expect to generate significant revenue for the foreseeable future.

Our entire focus has been on developing, commercializing, and obtaining regulatory authorizations and approvals of CHEMOSAT/Melphalan/HDS and currently we have only developed this system for the treatment of cancers in the liver. If CHEMOSAT/Melphalan/HDS for the treatment of cancers in the liver fails as a commercial product, we have no other products to sell. In addition, since CHEMOSAT is currently only authorized for marketing in the European Economic Area (EEA) and limited other jurisdictions, if we are unsuccessful in commercializing the product in the EEA and if Melphalan/HDS is not approved in the United States and elsewhere, we will have no means of generating revenue. In September 2013, the FDA issued a CRL with respect to our NDA for our Melblez Kit system. A CRL is issued by the FDA when the review of a file is completed and questions remain that precludes approval of the NDA in its then current form. Accordingly, we do not expect to realize any revenues from product sales in the United States in

the next several years, if at all. As a result, our revenue sources are, and will remain, extremely limited until our product candidates are approved by the FDA or other additional foreign regulatory agencies and successfully marketed. CHEMOSAT/Melphalan/HDS may not be successful in clinical trials, approved by the FDA or other additional foreign regulatory agency or marketed at any time in the foreseeable future or at all.

Continuing losses may exhaust our capital resources.

As of December 31, 2015, we had \$12.6 million in cash and cash equivalents. We have had minimal revenue to date, and we have a substantial accumulated deficit, recurring operating losses and negative cash flow. For the years ended December 31, 2015, 2014, and 2013, we incurred net losses of approximately \$14.7 million, \$17.4 million and \$30.3 million, respectively, and we expect to continue to incur losses in 2016. To date, we have funded our operations through a combination of private placements and public offerings of our securities. If we continue to incur losses, we may exhaust our capital resources, and as a result may be unable to complete our clinical trials, product development, regulatory approval process and commercialization of CHEMOSAT/Melphalan/HDS or any other versions of the system.

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If we cannot raise additional capital, our potential to generate future revenues will be significantly limited since we may not be able to further commercialize CHEMOSAT/Melphalan/HDS, complete our clinical trials or conduct future development and clinical trials.

We will require additional financing to complete our clinical trial program or seek other approvals, to conduct future development and clinical trials and to further commercialize our product in the EEA and any other markets where we receive approval for our system. In addition, we are obligated to make payments under long-term research and development obligations and lease agreements. If financing is unavailable to make the required payments under these agreements, we could be subject to legal liability and our ability to complete our development projects or our clinical trials could be impaired. We do not know if additional financing will be available when needed at all or on acceptable terms. If we are unable to obtain additional financing as needed, we may not be able to commercialize CHEMOSAT/Melphalan/HDS, obtain regulatory approvals or complete our development projects or our clinical trials.

Our liquidity and capital requirements will depend on numerous factors, including:

clinical studies, including a Phase 2 clinical trial to establish proof of concept in HCC and ICC and a Phase 3 clinical trial to investigate overall survival in ocular melanoma liver metastases;

the timing and costs of our various U.S. and foreign regulatory filings, obtaining approvals and complying with regulations;

the timing and costs associated with developing our manufacturing operations;

the timing of product commercialization activities, including marketing and distribution arrangements overseas;

the timing and costs involved in preparing, filing, prosecuting, defending and enforcing intellectual property rights; and

the impact of competing technological and market developments.

Form S-3 limits the aggregate market value of securities that we are permitted to offer in any 12 month-period under Form S-3 to one-third of our public float. Our ability to raise capital may be impaired and we may not be able to utilize the Form S-3 or access our at the market equity offering program.

Insufficient funds may require us to curtail or stop our commercialization activities, regulatory submissions or ongoing activities for regulatory approval, research and development and clinical trials, which will significantly limit our potential to generate future revenues.

Risks Related to FDA and Foreign Regulatory Approval

Our failure to obtain, or delays in obtaining, regulatory approvals may have a material adverse effect on our business, financial condition and results of operations.

CHEMOSAT/Melphalan/HDS is subject to extensive and rigorous government regulation by the FDA and other foreign regulatory agencies. The FDA regulates the research, development, pre-clinical and clinical testing, manufacture, safety, effectiveness, record keeping, reporting, labeling, storage, approval, advertising, promotion, sale, distribution, import and export of pharmaceutical and medical device products. Failure to comply with FDA and other applicable regulatory requirements may, either before or after product approval, subject us to administrative or judicially imposed sanctions.

In the United States, the FDA regulates drug and device products under the Federal Food, Drug, and Cosmetic Act (FFDCA), and its implementing regulations. Melphalan/HDS is subject to regulation by the FDA as a combination product, which means it is composed of both a drug product and device product. If marketed individually, each component would therefore be subject to different regulatory pathways and reviewed by different centers within the FDA. A combination product, however, is assigned to a center that will have primary jurisdiction over its pre-market review and regulation based on a determination of the product's primary mode of action, which is the single mode of action that provides the most important therapeutic action. In the case of Melphalan/HDS, the primary mode of action is attributable to the drug component of the product, which means that the Center of Drug Evaluation and Research (CDER) has primary jurisdiction over its pre-market development and review.

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We are not permitted to market Melphalan/HDS in the United States unless and until we obtain regulatory approval from the FDA. To market the product in the United States, we must submit to the FDA and obtain FDA approval of an NDA. An NDA must be supported by extensive clinical and preclinical data, as well as extensive information regarding chemistry, manufacturing and controls, or CMC, to demonstrate the safety and effectiveness of the applicable product candidate. The number and types of preclinical studies and clinical trials that will be required varies depending on the product candidate, the disease or condition that the product candidate is designed to target and the regulations applicable to any particular product candidate. Despite the time and expense associated with preclinical and clinical studies, failure can occur at any stage, and we could encounter problems that cause us to repeat or perform additional preclinical studies, CMC studies or clinical trials. The FDA and similar foreign authorities could delay, limit or deny approval of a product candidate for many reasons, including because they:

may not deem a product candidate to be adequately safe and effective;

may not find the data from preclinical studies, CMC studies and clinical trials to be sufficient to support a claim of safety and efficacy;

may interpret data from preclinical studies, CMC studies and clinical trials significantly differently than we do;

may not approve the manufacturing processes or facilities associated with our product candidates;

may change approval policies (including with respect to our product candidates' class of drugs) or adopt new regulations; or

may not accept a submission due to, among other reasons, the content or formatting of the submission. Undesirable side effects caused by any product candidate that we develop could result in the denial of regulatory approval by the FDA or other regulatory authorities for any or all targeted indications or cause us to evaluate the future of our development programs. The regulatory review and approval process is lengthy, expensive and inherently uncertain. As part of the U.S. Prescription Drug User Fee Act, the FDA has a goal to review and act on a percentage of all submissions in a given time frame. In August 2012, we submitted the Melblez Kit system NDA seeking an indication for ocular melanoma liver metastases. In September 2013, the FDA issued a CRL. A CRL is issued by the FDA when the review of a file is completed and questions remain that precludes approval of the NDA in its current form. The FDA comments in the CRL included, but were not limited to, a statement that we must perform additional well-controlled randomized trial(s) to establish the safety and efficacy of Melblez Kit using overall survival as the primary efficacy outcome measure and which demonstrates that the clinical benefits of Melblez Kit outweigh its risks. The FDA also requires that the additional clinical trial(s) be conducted using the product the company intends to market. Prior to conducting additional clinical trials, we must satisfy certain other requirements of the CRL, including, but not limited to, product quality testing and human factors. However, even if we complete clinical trials and satisfy all the requirements of the CRL, we may not obtain regulatory approval from the FDA. Continued failure to obtain, or additional delays in obtaining, regulatory approvals may:

adversely affect the commercialization of the current version of CHEMOSAT/Melphalan/HDS or any products that we develop in the future;

impose additional costs on us;

diminish any competitive advantages that may be attained; and

adversely affect our ability to generate revenues.

We have obtained the right to affix the CE Mark for the Delcath Hepatic CHEMOSAT Delivery System as a medical device for the delivery of melphalan. Since we may only promote the device within this specific indication, if physicians are unwilling to obtain melphalan separately for use with CHEMOSAT, our ability to commercialize CHEMOSAT in the EEA will be significantly limited.

In the EEA, CHEMOSAT is regulated as a Class IIb medical device indicated for the intra-arterial administration of a chemotherapeutic agent, melphalan hydrochloride, to the liver with additional extracorporeal filtration of the venous blood return. Our ability to market and promote CHEMOSAT is limited to this approved indication. To the extent that our promotion of CHEMOSAT is found to be outside the scope of our approved indication, we may be subject to fines or other regulatory action, limiting our ability to commercialize CHEMOSAT in the EEA.

We are limited to marketing CHEMOSAT in the EEA as a medical device for the delivery of melphalan. If physicians are unwilling to obtain melphalan separately for use with CHEMOSAT, our ability to commercialize CHEMOSAT in the EEA will be significantly limited. Our product instructions and indication reference the chemotherapeutic agent melphalan. However, no melphalan labels in the EEA reference our product, and the labels vary from country to country with respect to the approved indication of the drug and its mode of administration. As a result, the delivery of melphalan with our device may not be within the applicable label with respect to some indications in some Member States of the EEA where the drugs are authorized for marketing. Physicians intending to use our device must obtain melphalan separately for use with CHEMOSAT and must use melphalan independently at their discretion. If physicians are unwilling to obtain melphalan separately from our product and/or to prescribe the use of melphalan independently, our sales opportunities in the EEA will be significantly impaired.

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While we have obtained the right to affix the CE Mark, we will be subject to significant ongoing regulatory obligations and oversight in the EEA and in any other country where we receive marketing authorization or approval.

In April 2012, we obtained the required certification from our European Notified Body, enabling us to complete an EC Declaration of Conformity with the essential requirements of the EU Medical Devices Directive and affix the CE Mark to the Generation Two CHEMOSAT system. In order to maintain the right to affix the CE Mark in the EEA, we are subject to compliance obligations, and any material changes to the approved product, such as manufacturing changes, product improvements or revised labeling, may require further regulatory review. Additionally, we are subject to ongoing audits by our European Notified Body, and the right to affix the CE Mark to the Generation Two CHEMOSAT system may be withdrawn for a number of reasons, including the later discovery of previously unknown problems with the product.

To the extent that CHEMOSAT/ Melphalan/HDS is approved by the FDA or any other regulatory agency, we will be subject to similar ongoing regulatory obligations and oversight in those countries where we obtain approval. For example, we may be subject to limitations on the approved indicated uses for which the product may be marketed or to the conditions of approval, or requirements for potentially costly post-marketing testing, including Phase IV clinical trials, and surveillance to monitor the safety and efficacy of the product candidate. In addition, if the FDA approves a product candidate, the manufacturing processes, labeling, packaging, distribution, adverse event reporting, storage, advertising, promotion and recordkeeping for the product will be subject to extensive and ongoing regulatory requirements. These requirements include submissions of safety and other post-marketing information and reports, registration, as well as continued compliance with cGMPs, good clinical practices, or GCPs, and good laboratory practices, which are regulations and guidelines enforced by the FDA for all products in clinical development, for any clinical trials that we conduct post-approval. In addition, post-marketing requirements for CHEMOSAT/Melphalan/HDS may include implementation of a risk evaluation and mitigation strategies (REMS) program to ensure that the benefits of the product outweigh its risks. A REMS may include a Medication Guide, a patient package insert, a communication plan to healthcare professionals and/or other elements to assure safe use of the product.

Later discovery of previously unknown problems with a product, including adverse events of unanticipated severity or frequency, or with our third-party manufacturers or manufacturing processes, or failure to comply with regulatory requirements, may result in, among other things:

refusals or delays in the approval of applications or supplements to approved applications;

refusal of a regulatory authority to review pending market approval applications or supplements to approved applications;

restrictions on the marketing or manufacturing of the product, withdrawal of the product from the market or voluntary or mandatory product recalls or seizures;

fines, Warning Letters or holds on clinical trials;

import or export restrictions;

injunctions or the imposition of civil or criminal penalties;

restrictions on product administration, requirements for additional clinical trials or changes to product labeling or REMS programs; or

recommendations by regulatory authorities against entering into governmental contracts with us.

If we are not able to maintain regulatory compliance, we may lose any marketing approval that we may have obtained and we may not achieve or sustain profitability, which would have a material adverse effect on our business, results of operations, financial condition and prospects.

The development and approval process in the United States will take many years, require substantial resources and may never lead to the approval of Melphalan/HDS by the FDA for use in the United States.

We cannot sell or market Melphalan/HDS with melphalan or other chemotherapeutic agents in the United States without prior FDA approval of an NDA for Melphalan/HDS. Although melphalan and other drugs have been approved by the FDA for use as chemotherapeutic agents, regulatory approval is required in the United States for the combined medical device component and drug component and the specific indication, dose and route of administration of melphalan or other chemotherapeutic agent used in our system. We are seeking approval of Melphalan/HDS for a substantially higher dose of melphalan than prior approved doses of melphalan and such other drugs. We must obtain separate regulatory approvals for Melphalan/HDS with melphalan and every other chemotherapeutic agent or other compound used with our system that we intend to market, and all the manufacturing facilities used to manufacture components or assemble our system must be inspected and meet legal requirements. Securing regulatory approval requires the submission of extensive pre-clinical and clinical data and other supporting information for each proposed therapeutic indication in order to establish to the FDA's satisfaction the product's safety, efficacy, potency and purity for each intended use. The pre-clinical testing and clinical trials of Melphalan/HDS with melphalan or any other chemotherapeutic agent or compound we use in our system must comply with the regulations of the FDA and other federal, state and local government authorities in the United States. Clinical development is a long, expensive and uncertain process and is subject to delays. We may encounter delays or rejections for

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various reasons, including our inability to enroll enough patients to complete our clinical trials. Moreover, approval policies or regulations may change. If we do not obtain and maintain regulatory approval for our system and our use of melphalan or other chemotherapeutic agents, the value of our company, our results of operations and our ability to raise additional capital will be harmed.

In August 2012, we submitted a NDA seeking an indication for ocular melanoma liver metastases for our Melblez Kit system. In September 2013, the FDA issued a complete response letter (CRL). A CRL is issued by the FDA when the review of a file is completed and questions remain that precludes approval of the NDA in its current form. The FDA comments in the CRL included a statement that we must perform additional well-controlled randomized trial(s) to establish the safety and efficacy of Melblez Kit using overall survival as the primary efficacy outcome measure and which demonstrates that the clinical benefits of Melblez Kit outweigh its risks. Failure to obtain FDA approval will have a material adverse effect on our business, financial condition and results of operations.

Even if we obtain regulatory approval for the Melblez Kit system in the United States, our ability to market the Melblez Kit system would be limited to those uses that are approved.

The FDA closely regulates the post-approval marketing and promotion of drugs, including standards and regulations for direct-to-consumer advertising, dissemination of off-label information, industry-sponsored scientific and educational activities and promotional activities involving the Internet. Drugs may be marketed only for the approved indications and in accordance with the provisions of the approved label. If the FDA approves an application for the Melblez Kit, our ability to market and promote the Melblez Kit system would be limited to the approved indication, so even with FDA approval, the Melblez Kit system may only be promoted in this limited market. Physicians may prescribe legally available drugs for uses that are not described in the product's labeling and that differ from those tested by us and approved by the FDA. The FDA does not regulate the behavior of physicians in their choice of treatments. The FDA does, however, impose stringent restrictions on manufacturers' communications regarding off-label use, and FDA approval may otherwise limit our sales practices and our ability to promote, sell and distribute the product. Thus, we may only market the Melblez Kit system, if approved by the FDA, for its approved indication and we could be subject to enforcement action for off-label marketing. Further, if there are any modifications to the product, including changes in indications, labeling or manufacturing processes or facilities, we may be required to submit and obtain FDA approval of a new or supplemental NDA, which may require us to develop additional data or conduct additional preclinical studies and clinical trials. Failure to comply with these requirements can result in adverse publicity, Warning Letters, corrective advertising and potential civil and criminal penalties.

If future clinical trials are unsuccessful, significantly delayed or not completed, we may not be able to market Melphalan/HDS for other indications.

The clinical trial data on our product is limited to specific types of liver cancer. In 2010, we concluded a Phase 3 clinical trial of Melphalan/HDS in patients with metastatic ocular and cutaneous melanoma to the liver and also completed a multi-arm Phase 2 clinical trial of Melphalan/HDS in patients with primary and metastatic melanoma stratified into four arms.

In 2014, we initiated a Phase 2 clinical trial for HCC in both the United States and Europe. In 2015, we expanded the Phase 2 clinical trial for HCC to include a cohort of patients with ICC. Additionally, in January 2016 we received agreement on a Special Protocol Assessment from the FDA and have initiated a pivotal Phase 3 overall survival clinical trial in ocular melanoma liver metastases.

It may take several years to complete the testing of Melphalan/HDS for use in the treatment of these indications, and failure can occur at any stage of development, for many reasons, including:

any pre-clinical or clinical test may fail to produce results satisfactory to the FDA or foreign regulatory authorities;

pre-clinical or clinical data can be interpreted in different ways, which could delay, limit or prevent regulatory approval;

negative or inconclusive results from a pre-clinical study or clinical trial or adverse medical events during a clinical trial could cause a pre-clinical study or clinical trial to be repeated or a program to be terminated, even if other studies or trials relating to the program are successful;

the FDA or foreign regulatory authorities can place a clinical hold on a trial if, among other reasons, it finds that patients enrolled in the trial are or would be exposed to an unreasonable and significant risk of illness or injury;

we may encounter delays or rejections based on changes in regulatory agency policies during the period in which we are developing a system or the period required for review of any application for regulatory agency approval;

our clinical trials may not demonstrate the safety and efficacy of any system or result in marketable products;

the FDA or foreign regulatory authorities may request additional clinical trials, including an additional Phase 3 trial, relating to our NDA submissions;

the FDA or foreign regulatory authorities may change its approval policies or adopt new regulations that may negatively affect or delay our ability to bring a system to market or require additional clinical trials; and

a system may not be approved for all the requested indications.

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The failure or delay of clinical trials could cause an increase in the cost of product development, delay filing of an application for marketing approval or cause us to cease the development of Melphalan/HDS for other indications. If we are unable to develop Melphalan/HDS for other indications the future growth of our business could be negatively impacted. In addition, we have limited clinical data relating to the effectiveness of Melphalan/HDS in certain types of cancer. Such limited data could slow the adoption of CHEMOSAT/ Melphalan/HDS and significantly reduce our ability to commercialize CHEMOSAT/Melphalan/HDS.

We rely on third parties to conduct certain elements of the clinical trials for CHEMOSAT/Melphalan/HDS, and if they do not perform their obligations to us, we may not be able to obtain regulatory approvals for our system.

We design the clinical trials for Melphalan/HDS, but we rely on academic institutions, corporate partners, contract research organizations and other third parties to assist us in managing, monitoring and otherwise carrying out these trials. We rely heavily on these parties for the execution of our clinical studies and control only certain aspects of their activities. Accordingly, we may have less control over the timing and other aspects of these clinical trials than if we conducted them entirely on our own. We rely upon third parties to conduct monitoring and data collection of our ongoing and future clinical trials, including our Phase 2 HCC clinical trial with an ICC cohort and our Phase 3 ocular melanoma trial. Although we rely on these third parties to manage the data from these clinical trials, we are responsible for confirming that each of our clinical trials is conducted in accordance with its general investigational plan and protocol. Moreover, the FDA and foreign regulatory agencies require us to comply with GCPs for conducting, recording and reporting the results of clinical trials to assure that the data and results are credible and accurate and that the trial participants are adequately protected. The FDA enforces these GCP regulations through periodic inspections of trial sponsors, principal investigators and trial sites. Our reliance on third parties does not relieve us of these responsibilities and requirements, and if we or the third parties upon whom we rely for our clinical trials fail to comply with the applicable GCPs, the data generated in our clinical trials may be deemed unreliable and the FDA or other foreign regulatory agencies may require us to perform additional trials before approving our marketing application. We cannot assure you that, upon inspection, the FDA will determine that any of our clinical trials comply or complied with GCPs. In addition, our clinical trials must be conducted with product that complies with the FDA's cGMP requirements. Our failure to comply with these regulations may require us to repeat clinical trials, which would delay the regulatory approval process, and we may fail to obtain regulatory approval for Melphalan/HDS if these requirements are not met.

Purchasers of CHEMOSAT in the EEA may not receive third-party reimbursement or such reimbursement may be inadequate. Without adequate reimbursement, we may not be able to successfully commercialize CHEMOSAT in the EEA.

We have obtained the right to affix the CE Mark for CHEMOSAT, and we intend to seek third-party or government reimbursement within those countries in the EEA where we expect to market and sell CHEMOSAT. In Germany, we have received issued a ZE diagnostic-related group code, which permits hospitals in Germany to obtain reimbursement for CHEMOSAT procedures beginning in 2016. Negotiations on the amount of reimbursement to be received under the code are currently underway and will continue through most of 2016. Consequently, reimbursement obtained may not be for the full amount sought. In countries where we are able to obtain reimbursement, local policy could limit our ability to obtain adequate and consistent reimbursement and limit other sales opportunities in those countries. In the United Kingdom, we began seeking a block fund grant in 2014. Ongoing changes to the process and funding streams have resulted in delays that made the award and timing of any block grant funding difficult to predict. Accordingly, we may not receive the grant in a timely manner or at all.

In other countries, until we obtain government reimbursement, we will rely on private payors or local pre-approved funds where available. New technology payment programs may provide interim funding, but there are no assurances

that we will qualify for such funding. Even if we do qualify, the amount and the duration of this funding may be limited. There are also no assurances that third-party payors or government health agencies of members states of the EEA will reimburse the product's use in the long term or at all. For example, throughout 2015, physicians and patients in Germany submitted and received approvals for Individual Funding Requests (IFRs) granting reimbursement for the treatment of liver metastases with CHEMOSAT. We expect that IFRs will continue to be the main reimbursement vehicle in the German market in 2016 until the ZE reimbursement is fully negotiated. Further, each country has its own protocols regarding reimbursement, so successfully obtaining third party or government health agency reimbursement in one country does not necessarily translate to similar reimbursement in other EEA countries. Physicians, hospitals and other health care providers may be reluctant to purchase CHEMOSAT if they do not receive substantial reimbursement for the cost of using our product from third-party payors or government entities. The lack of adequate reimbursement may significantly limit sales opportunities in the EEA.

The success of our products may be harmed if the government, private health insurers and other third-party payers do not provide sufficient coverage or reimbursement.

Our ability to commercialize our systems successfully will depend in part on the extent to which reimbursement for the costs of such products and related treatments will be available from government health administration authorities, private health insurers and other third-party payors. Melphalan/HDS is currently not approved by the FDA. Medicare, Medicaid, private health insurance plans and their foreign equivalents will not reimburse the use of Melphalan/HDS since the product is currently not approved outside the EEA. We will seek reimbursement by third-party payors of the cost of Melphalan/HDS after its use is approved, but there are no assurances that adequate third-party coverage will be available for us to establish and maintain price levels sufficient for us to realize an appropriate return on our investment in developing new therapies. Government, private health insurers and other third-party payors are

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increasingly attempting to contain healthcare costs by limiting both coverage and the level of reimbursement for new therapeutic products approved for marketing. Accordingly, even if coverage and reimbursement are provided by government, private health insurers and third-party payors for uses of our products, market acceptance of these products would be adversely affected if the reimbursement available proves to be unprofitable for healthcare providers.

Implementation of healthcare reforms in the United States and in significant overseas markets may limit the ability to commercialize CHEMOSAT/Melphalan/HDS and the demand for CHEMOSAT/Melphalan/HDS. Healthcare providers may respond to such cost-containment pressures by choosing lower cost products or other therapies. In March 2010, the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010 were enacted into law in the United States, which included a number of provisions aimed at improving quality and decreasing costs. It is uncertain what consequences these provisions will have on our efforts to commercialize CHEMOSAT/Melphalan/HDS.

CHEMOSAT/Melphalan/HDS may not achieve sufficient acceptance by the medical community to sustain our business.

The commercial success of CHEMOSAT/Melphalan/HDS will depend upon its acceptance by the medical community and third-party payers as clinically useful, cost effective and safe. Acceptance by the medical community may depend on the extent to which leaders in the scientific and medical communities publish scientific papers in reputable academic journals. If testing and clinical practice do not confirm the safety and efficacy of CHEMOSAT/Melphalan/HDS or even if further testing and clinical practice produce positive results but the medical community does not view these favorably, CHEMOSAT/Melphalan/HDS as effective and desirable, our efforts to market CHEMOSAT/Melphalan/HDS may fail, which would have an adverse effect on our business, financial condition and results of operations.

Consolidation in the healthcare industry could lead to demands for price concessions.

The cost of healthcare has risen significantly over the past decade and numerous initiatives and reforms initiated by legislators, regulators and third-party payors to curb these costs have resulted in a consolidation trend in the medical device industry. Group purchasing organizations, independent delivery networks and large single accounts in the United States and foreign markets may result in a consolidation of purchasing decisions for potential healthcare provider customers. We expect that market demand, government regulation, third-party reimbursement policies and societal pressures will continue to change the worldwide healthcare industry, resulting in further business consolidations and alliances which may exert further downward pressure on the price of CHEMOSAT/Melphalan/HDS and adversely impact our business, financial condition and results of operations.

Further, third-party payors may deny reimbursement if they determine that CHEMOSAT/Melphalan/HDS is not used in accordance with established payor protocols regarding cost effective treatment methods or is used outside its approved indication or for forms of cancer or with drugs not specifically approved by the FDA or other foreign regulatory bodies in the future. Without reimbursement, physicians, hospitals and other health care providers will be less likely to purchase CHEMOSAT/Melphalan/HDS, thereby harming our results of operations.

If we engage in acquisitions, reorganizations or business combinations, we will incur a variety of risks that could adversely affect our business operations or our stockholders.

We may consider strategic alternatives, such as acquiring businesses, technologies or products or entering into a business combination with another company. If we do pursue such a strategy, we could, among other things:

issue equity securities that would dilute our current stockholders' percentage ownership;

incur substantial debt that may place strains on our operations;

spend substantial operational, financial and management resources in integrating new businesses, personnel, intellectual property, technologies and products;

assume substantial actual or contingent liabilities;

reprioritize our programs and even cease development and commercialization of CHEMOSAT/Melphalan/HDS;

suffer the loss of key personnel, or

merge with, or otherwise enter into a business combination with, another company in which our stockholders would receive cash or shares of the other company or a combination of both on terms that certain of our stockholders may not deem desirable.

Although we intend to evaluate and consider different strategic alternatives, we have no agreements or understandings with respect to any acquisition, reorganization or business combination at this time.

Table of Contents**Risks Related to Manufacturing, Commercialization and Market Acceptance of the CHEMOSAT/Melphalan/HDS**

There is only one approved third-party manufacturer of melphalan in the EEA. If this manufacturer fails to provide end-users with adequate supplies of melphalan or fails to comply with the requirements of regulatory authorities, we may be unable to successfully commercialize our product in the EEA.

Under the regulatory scheme in the EEA, CHEMOSAT is approved for marketing as a device only, and doctors will separately obtain melphalan for use with CHEMOSAT. Although melphalan has been approved in the EEA for over a decade, we are aware that there is currently only one approved manufacturer of melphalan in the EEA, with whom we have no supply arrangements or other affiliation, and therefore we will not have any control over the quality, availability, price or labeling of melphalan in that market. As a result, there may not be sufficient supply of melphalan for use with our system, and any adverse change in the sole manufacturer's commercial operations or regulatory approval status may seriously impair our sales opportunities in the EEA. Additionally, melphalan is not available in certain foreign countries outside the EEA where we may seek to market CHEMOSAT. If supply of melphalan remains limited or unavailable, we will be unable to commercialize our product in these markets, thereby limiting future sales opportunities.

We purchase components for CHEMOSAT/Melphalan/HDS from third parties, some of which are sole-source suppliers.

The components of CHEMOSAT/Melphalan/HDS, including catheters, filters, introducers and chemotherapy agents, must be manufactured and assembled in accordance with approved manufacturing and predetermined performance specifications and must meet cGMP and quality systems requirements. Some states also have similar regulations. Many of the components of CHEMOSAT/Melphalan/HDS are manufactured by sole-source suppliers that may have proprietary manufacturing processes. If we or any of our suppliers fails to meet those regulatory obligations, we may be forced to suspend or terminate our clinical trials, and, once a product is approved for marketing, the manufacture, assembly or distribution thereof. Further, if we need to find a new source of supply, we may face long interruptions in obtaining necessary components for CHEMOSAT/Melphalan/HDS, in obtaining FDA or foreign regulatory agency approval of these components and in establishing the manufacturing process, which could jeopardize our ability to supply CHEMOSAT/Melphalan/HDS to the market.

All of the manufacturers of the components for CHEMOSAT/Melphalan/HDS must comply with a number of FDA and International Organization for Standardization, or ISO, and foreign regulatory agency requirements and regulations. If we or one of our suppliers fails to meet such requirements, we may need to change suppliers. If we are unable to successfully change suppliers, the successful completion of some of our future clinical trials and/or commercialization of CHEMOSAT/Melphalan/HDS could be jeopardized. CHEMOSAT/Melphalan/HDS and its components must be manufactured and sterilized with approved manufacturing and pre-determined performance specifications. Certain components will require sterilization prior to distribution and we rely on third-party vendors to perform the sterilization process. A third-party vendor's failure to properly sterilize a component may cause manufacturing or assembly delays.

If we cannot maintain or enter into acceptable arrangements for the production of melphalan and other chemotherapeutic agents we will be unable to successfully commercialize the Delcath system in the United States or complete our Phase 2 clinical trial for HCC and ICC in the U.S., our global Phase 3 in ocular melanoma liver metastases or any future clinical trials.

We have entered into a manufacturing and supply agreement with Synerx Pharma, LLC, or Synerx, and Bioniche Teoranta, or Bioniche, an affiliate of Mylan, Inc., for the supply of our branded melphalan for injection. The agreement with Synerx and Bioniche currently represents our sole source of branded melphalan in the United States. We intend to use the melphalan supplied by Synerx and Bioniche to conduct our Phase 2 clinical trial for HCC and ICC in the United States and our global Phase 3 trial for ocular melanoma liver metastases. We may pursue agreements with additional contract manufacturers to produce melphalan and other chemotherapeutic agents that we will use in the future for our clinical trial program and the commercialization of CHEMOSAT/Melphalan/HDS, as well as for labeling and finishing services. We may not be able to enter into such arrangements on acceptable terms or at all. To manufacture melphalan or other chemotherapeutic agents on our own, we would first have to develop a manufacturing facility that complies with FDA requirements and regulations for the production of melphalan and each other chemotherapeutic agent we choose to manufacture for our system. Developing these resources would be an expensive and lengthy process and would have a material adverse effect on our revenues and profitability. If we are unable to obtain sufficient melphalan and labeling services on acceptable terms, if we should encounter delays or difficulties in our relationships with our current and future suppliers or if our current and future suppliers of melphalan do not comply with applicable regulations for the manufacturing and production of melphalan, our business, financial condition and results of operations may be materially harmed.

If we cannot successfully manufacture CHEMOSAT/Melphalan/HDS, our ability to develop and commercialize the system would be impaired.

We manufacture CHEMOSAT/Melphalan/HDS for distribution worldwide in our Queensbury, NY facility. We have a limited manufacturing history and we may not be able to manufacture the system in sufficient commercial quantities, in a cost-effective manner or in compliance with the regulatory requirements applicable to such manufacturing. Additionally, we may have difficulty obtaining components for the system from our third-party suppliers in a timely manner or at all which may adversely affect our ability to deliver CHEMOSAT/Melphalan/HDS to purchasers.

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In addition to limiting sales opportunities, delays in manufacturing CHEMOSAT/Melphalan/HDS may adversely affect our ability to obtain regulatory approval in other jurisdictions. Our ability to conduct timely clinical trials in the United States and abroad depends on our ability to manufacture the system, including sourcing the chemotherapeutic agents or other compounds through third parties in accordance with FDA and other regulatory requirements. If we are unable to manufacture CHEMOSAT/Melphalan/HDS in a timely manner, we may not be able to conduct the clinical trials required to obtain regulatory approval and commercialize our product.

If our Queensbury, NY facility fails to maintain compliance with ISO 13485, a comprehensive management system for the design and manufacture of medical devices, and FDA cGMP or fails to pass facility inspection or audits, our ability to manufacture at the facility could be limited or terminated. In the future, we may manufacture and assemble CHEMOSAT/Melphalan/HDS in the EEA, and any facilities in the EEA would have to obtain and maintain similar approvals or certifications of compliance.

We do not have written contracts with all of our suppliers for the manufacture of components for CHEMOSAT/Melphalan/HDS.

We do not have written contracts with all our suppliers for the manufacture of components for CHEMOSAT/Melphalan/HDS. If we are unable to obtain an adequate supply of the necessary components or negotiate acceptable terms, we may not be able to manufacture the system in commercial quantities or in a cost-effective manner, and commercialization of CHEMOSAT/Melphalan/HDS in the EEA may be delayed. In addition, certain components are available from only a limited number of sources. Components of CHEMOSAT/Melphalan/HDS are currently manufactured for us in small quantities and we may require significantly greater quantities to further commercialize the product. We may not be able to find alternate sources of comparable components. If we are unable to obtain adequate supplies of components from our existing suppliers or need to switch to an alternate supplier and obtain FDA or other regulatory agency approval of that supplier, commercialization of CHEMOSAT/Melphalan/HDS may be delayed.

We have limited experience in marketing and commercializing our products, and as a result, we may not be successful in commercializing CHEMOSAT in the EEA.

We have not previously sold, marketed or distributed any products and have limited experience in building a sales and marketing organization and in entering into and managing relationships with third-party distributors. Even though we have obtained the right to affix the CE Mark, we currently have limited sales, marketing, commercial or distribution capabilities in any countries in the EEA. In order to pursue our strategy to commercialize CHEMOSAT in the EEA, we must acquire or internally develop a sales, marketing and distribution infrastructure and/or enter into strategic alliances to perform these services. The development of sales, marketing and distribution infrastructure is difficult, time consuming and requires substantial financial and other resources. If we cannot successfully develop the infrastructure to market and commercialize CHEMOSAT, our ability to generate revenues in the EEA may be harmed, and we may not generate sufficient revenue to sustain our business or we may be required to enter into strategic alliances to have such activities carried out on our behalf, which may not be on favorable terms.

Competition for sales and marketing personnel is intense, and we may not be successful in attracting or retaining such personnel. Our inability to attract and retain skilled sales and marketing personnel or to reach an agreement with a third party could adversely affect our business, financial condition and results of operations. Further, since our marketing strategy in the EEA includes establishing a network of third-party distributors, we must enter into collaborative arrangements with these third-party distributors. We may not be able to enter into such arrangements on reasonable terms or at all.

Even if we receive FDA or other foreign regulatory approvals, we may be unsuccessful in commercializing CHEMOSAT/Melphalan/HDS in markets outside the EEA, because of inadequate infrastructure or an ineffective commercialization strategy.

Outside the EEA, even if we obtain regulatory approval from the FDA or other foreign regulatory agencies, our ability to commercialize CHEMOSAT/Melphalan/HDS may be limited due to our inexperience in developing a sales, marketing and distribution infrastructure. If we are unable to develop this infrastructure in the United States or elsewhere or to collaborate with an alliance partner to market our products in the United States or foreign countries, particularly in Asia, our efforts to commercialize CHEMOSAT/Melphalan/HDS or any other product outside of the EEA may be less successful.

Even if we are successful in commercializing CHEMOSAT/Melphalan/HDS in the EEA, we may not be successful in the United States and other foreign countries. Each country requires a different commercialization strategy, so our EEA strategy may not translate to other markets. Without a successful commercialization strategy tailored for each market, our efforts to promote and market CHEMOSAT in each of our target markets may fail in any or all of those markets.

Our plan to use collaborative arrangements with third parties to help finance and to market and sell CHEMOSAT/Melphalan/HDS may not be successful.

We may be unable to enter into collaborative agreements without additional clinical data or unable to continue a collaborative agreement as a result of unsuccessful future clinical trials. Additionally, we may face competition in our search for alliances. As a result, we may not be able to enter into any additional alliances on acceptable terms, if at all. Our collaborative relationships may never result in the successful development or commercialization of CHEMOSAT/Melphalan/HDS or any other product. The success

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of any collaboration will depend upon our ability to perform our obligations under any agreements as well as factors beyond our control, such as the commitment of our collaborators and the timely performance of their obligations. The terms of any such collaboration may permit our collaborators to abandon the alliance at any time for any reason or prevent us from terminating arrangements with collaborators who do not perform in accordance with our expectations or our collaborators may breach their agreements with us. In addition, any third parties with which we collaborate may have significant control over important aspects of the development and commercialization of our products, including research and development, market identification, marketing methods, pricing, composition of sales force and promotional activities. We are not able to control or influence the amount and timing of resources that any collaborator may devote to our research and development programs or the commercialization, marketing or distribution of our products. We may not be able to prevent any collaborators from pursuing alternative technologies or products that could result in the development of products that compete with CHEMOSAT/Melphalan/HDS or the withdrawal of their support for our products. The failure of any such collaboration could have a material adverse effect on our business.

If we fail to overcome the challenges inherent in international operations, our business and results of operations may be materially adversely affected.

Currently we have only received authorization to market CHEMOSAT in the EEA, and intend to seek similar authorization or approvals in other foreign countries. As a result, we expect international sales of our products to account for a significant portion of our revenue, which exposes us to risks inherent in international operations. To accommodate our international sales, we will need to further invest financial and management resources to develop an international infrastructure that will meet the needs of our customers. Accordingly, we will face additional risks resulting from our international operations including:

difficulties in enforcing agreements and collecting receivables in a timely manner through the legal systems of many countries outside the United States;

the failure to fulfill foreign regulatory requirements to market our products on a timely basis or at all;

availability of, and changes in, reimbursement within prevailing foreign healthcare payment systems;

difficulties in managing foreign relationships and operations, including any relationships that we establish with foreign sales or marketing employees and agents;

limited protection for intellectual property rights in some countries;

fluctuations in currency exchange rates;

the possibility that foreign countries may impose additional withholding taxes or otherwise tax our foreign income, impose tariffs or adopt other restrictions on foreign trade;

the possibility of any material shipping delays;

significant changes in the political, regulatory, safety or economic conditions in a country or region;

protectionist laws and business practices that favor local competitors; and

trade restrictions, including the imposition of, or significant changes to, the level of tariffs, customs duties and export quotas.

If we fail to overcome the challenges we encounter in our international operations, our business and results of operations may be materially adversely affected.

CHEMOSAT has been used a limited number of times in a clinical setting in the EEA, so market acceptance of our product will depend on EEA healthcare professionals' efforts to learn about our product.

Since all of our prior clinical studies were conducted in the United States and CHEMOSAT has had limited use in a clinical setting in the EEA, physicians in the EEA have no clinical experience with our product. As a result, CHEMOSAT may not gain significant market acceptance among physicians, hospitals, patients and healthcare payors in the EEA until healthcare professionals are properly educated about the procedure. Market acceptance of CHEMOSAT in the EEA will depend upon a variety of factors including:

whether our future clinical trials demonstrate significantly improved patient outcomes;

our ability to educate and train physicians to perform the procedure and drive acceptance of the use of CHEMOSAT;

our ability to obtain adequate reimbursement and convince healthcare payors that use of CHEMOSAT results in reduced treatment costs and improved outcomes for patients;

whether CHEMOSAT replaces and/or complements treatment methods in which many hospitals have made a significant investment; and

whether doctors and hospitals are willing to replace their existing technology with a new medical technology until the new technology's value has been demonstrated.

We intend to establish clinical training and centers of excellence to educate and train physicians and healthcare payors in the EEA, but the key opinion thought leadership required for initial market acceptance within the healthcare arena may take time to develop. Without effort from healthcare professionals to become educated about our product, the market may not accept CHEMOSAT and our efforts to commercialize CHEMOSAT in the EEA may be unsuccessful.

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Similar considerations apply in any other market where we receive approval. Successful commercialization of CHEMOSAT in these markets will depend on market acceptance by healthcare professionals.

Rapid technological developments in treatment methods for liver cancer and competition with other forms of liver cancer treatments could affect our ability to achieve meaningful revenues or profit.

Competition in the cancer treatment industry is intense. CHEMOSAT/Melphalan/HDS competes with all forms of liver cancer treatments that are alternatives to the gold standard treatment of surgical resection. Many of our competitors have substantially greater resources and considerable experience in conducting clinical trials and obtaining regulatory approvals. If these competitors develop more effective or more affordable products or treatment methods, or achieve earlier product development, our revenues or profitability will be substantially reduced.

Our ability to develop CHEMOSAT/Melphalan/HDS for other indications could affect our orphan drug exclusivity. In November 2008, the FDA granted us two orphan drug designations for the drug melphalan for the treatment of patients with cutaneous melanoma as well as patients with ocular melanoma. In May 2009, the FDA granted us an additional orphan drug designation of the drug melphalan for the treatment of patients with neuroendocrine tumors. In August 2009, the FDA granted us an orphan drug designation of the drug doxorubicin for the treatment of patients with primary liver cancer. The FDA granted us orphan drug designation of the drug melphalan for the treatment of HCC in October 2013 and for the treatment of MCC in July 2015. If CHEMOSAT/Melphalan/HDS is approved for an indication different than the indications for which we have received orphan drug designations, we will not obtain orphan drug exclusivity, which could increase our competition. If another company has orphan drug designations for these same indications and receives marketing approval before we do, then we will be blocked from marketing approval for seven years from the date of their approval for the same indication of use.

The loss of key personnel could adversely affect our business.

The loss of a member of our senior executive staff could harm our business. Competition for experienced personnel is intense. If we cannot retain our current personnel or attract additional experienced personnel, our ability to compete could be adversely affected.

Risks Related to Intellectual Property

Intellectual property rights may not provide adequate protection, which may permit third parties to compete against us more effectively.

Our success depends significantly on our ability to maintain and protect our proprietary rights in the technologies and inventions used in or embodied by our product. To protect our proprietary technology, we rely on patent protection, as well as a combination of copyright, trade secret and trademark laws, as well as nondisclosure, confidentiality, license and other contractual restrictions in our manufacturing, consulting, employment and other third party agreements. These legal means may afford only limited protection, however, and may not adequately protect our rights or permit us to gain or keep any competitive advantage.

We have not and may not be able to adequately protect our intellectual property rights throughout the world.

Filing, prosecuting and defending patents on our product and technologies in all countries throughout the world would be prohibitively expensive. The requirements for patentability may differ in certain countries, particularly developing countries, and the breadth of patent claims allowed can be inconsistent. In addition, the laws of some foreign countries may not protect our intellectual property rights to the same extent as laws in the United States. Consequently, we may

not be able to prevent third parties from practicing our inventions in all countries outside the United States. Competitors may use our technologies in jurisdictions where we have not obtained patent protection that covers the commercial products to develop their own competing products that are the same or substantially the same as our commercial product and, further, may export otherwise infringing products to territories where we have patent protection, but judicial systems do not adequately enforce patents to cause infringing activities to be ceased.

We do not have patent rights in certain foreign countries in which a market exists or may exist in the future. Moreover, in foreign jurisdictions where we do have patent rights, proceedings to enforce such rights could result in substantial costs and divert our efforts and attention from other aspects of our business, could put our patents at risk of being invalidated or interpreted narrowly, and our patent applications at risk of not issuing, and could provoke third parties to assert claims against us. We may not prevail in any lawsuits that we initiate and the damages or other remedies awarded, if any, may not be commercially meaningful. Thus, we may not be able to stop a competitor from marketing and selling in foreign countries products that are the same as or similar to our product.

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Obtaining and maintaining our patent protection depends on compliance with various procedural, document submission, fee payment and other requirements imposed by governmental patent agencies, and our patent protection could be reduced or eliminated for non-compliance with these requirements.

Moreover, the United States Patent and Trademark Office (USPTO) and various foreign governmental patent agencies require compliance with a number of procedural, documentary, fee payment and other similar provisions during the patent application process. In addition, periodic maintenance fees on issued patents often must be paid to the USPTO and foreign patent agencies over the lifetime of the patent. While an unintentional lapse can in many cases be cured by payment of a late fee or by other means in accordance with the applicable rules, there are situations in which noncompliance can result in abandonment or lapse of the patent or patent application, resulting in partial or complete loss of patent rights in the relevant jurisdiction. Non-compliance events that could result in abandonment or lapse of a patent or patent application include, but are not limited to, failure to respond to official actions within prescribed time limits, non-payment of fees and failure to properly legalize and submit formal documents. If we fail to maintain the patents and patent applications covering our product or procedures, we may not be able to stop a competitor from marketing products that are the same as or similar to our product and technologies.

Our success depends in part on our ability to obtain patents, which can be an expensive, time consuming, and uncertain process, and the value of the patents is dependent in part on the breadth of coverage and the relationship between the coverage and the commercial product.

The patent position of medical drug and device companies is generally highly uncertain. The degree of patent protection we require may be unavailable or severely limited in some cases and may not adequately protect our rights or permit us sufficient exclusivity, or to gain or keep our competitive advantage. For example:

we might not have been the first to invent or the first to file patent applications on the inventions covered by each of our pending patent applications and issued patents;

others may independently develop similar or alternative technologies or duplicate any of our technologies;

the patents of others may have an adverse effect on our business;

any patents we obtain or license from others in the future may not encompass commercially viable products, may not provide us with any competitive advantages or may be challenged by third parties;

any patents we obtain or license from others in the future may not be valid or enforceable; and

we may not develop additional proprietary technologies that are patentable

Our patent portfolio consists of eight U.S. utility patents, one U.S. design patent, six pending U.S. utility patent applications (one of which has been allowed), four issued foreign counterpart utility patents, six issued foreign counterpart design patents, and eight pending foreign counterpart patent applications (one of which has been allowed). Certain other of our U.S., European and other foreign patents have already expired. Certain of our U.S. and foreign

patents will expire in 2016 and 2017.

The process of applying for patent protection itself is time consuming and expensive and we cannot assure you that we have prepared or will be able to prepare, file and prosecute all necessary or desirable patent applications at a reasonable cost or in a timely manner. It is possible that innovation over the course of development and commercialization may lead to changes in the CHEMOSAT/Melphalan/HDS methods and/or devices that cause such methods and/or devices to fall outside the scope of the patent protection we have obtained and the patent protection we have obtained may become less valuable. It is also possible that we will fail to identify patentable aspects of inventions made in the course of development and commercialization activities before it is too late to obtain patent protection on them. In addition, our patents and applications may not be prosecuted and enforced in a manner consistent with the best interests of our business. It is possible that defects of form in the preparation or filing of our patents or patent applications may exist, or may arise in the future, for example, with respect to proper priority claims, inventorship, claim scope or patent term adjustments. Moreover, we cannot assure you that all of our pending patent applications will issue as patents or that, if issued, they will issue in a form that will be advantageous to us.

Our success depends in part on our ability to commercialize CHEMOSAT/Melphalan/HDS prior to the expiration of our patent protection.

Due to the uncertainty of the patent prosecution process, there are no guarantees that any of our pending patent applications will result in the issuance of a patent. Even if we are successful in obtaining a patent, patents have a limited lifespan. In the United States, the natural expiration of a utility patent typically is generally 20 years after it is filed. Various extensions may be available; however, the life of a patent, and the protection it affords, is limited. Without patent protection for our CHEMOSAT/Melphalan/HDS methods and devices, we may be open to competition from generic versions of such methods and devices.

We may in the future become involved in lawsuits to protect or enforce our intellectual property, or to defend our products against assertion of intellectual property by a third party, which could be expensive, time consuming and unsuccessful.

Competitors may infringe our patents or misappropriate or otherwise violate our intellectual property rights. To stop any such infringement or unauthorized use, litigation may be necessary. Our intellectual property has not been tested in litigation. There is no

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assurance that any of our issued patents will be upheld if later challenged or will provide significant protection or commercial advantage. A court may declare our patents invalid or unenforceable, may refuse to stop the other party from using the technology at issue on the grounds that our patents do not cover the technology in question, or may interpret the claims of our patents narrowly, thereby substantially narrowing the scope of patent protection they afford. Because of the length of time and expense associated with bringing new medical drugs and devices to the market, the healthcare industry has traditionally placed considerable emphasis on patent and trade secret protection for significant new technologies. Other parties may challenge patents, patent claims or patent applications licensed or issued to us or may design around technologies we have patented, licensed or developed.

In addition, third parties may initiate legal or administrative proceedings against us to challenge the validity or scope of our intellectual property rights, or may allege an ownership right in our patents, as a result of their past employment or consultancy with us. Many of our current and potential competitors have the ability to dedicate substantially greater resources to defend their intellectual property rights than we can. Accordingly, despite our efforts, we may not be able to prevent third parties from infringing upon or misappropriating our intellectual property. Competing products may also be sold in other countries in which our patent coverage might not exist or be as strong. If we lose a foreign patent lawsuit, alleging our infringement of a competitor's patents, we could be prevented from marketing our product in one or more foreign countries.

The medical device industry has been characterized by frequent and extensive intellectual property litigation. Our competitors or other patent holders may assert that our products and the methods employed in our products are covered by their patents. Although we have performed a search for third-party patents and believe we have adequate defenses available if faced with any allegations that we infringe these third-party patents, it is possible that CHEMOSAT/Melphalan/HDS could be found to infringe these patents. It is also possible that our competitors or potential competitors may have patents, or have applied for, will apply for, or will obtain patents that will prevent, limit or interfere with our ability to make, have made, use, sell, import or export our product. If our products or methods are found to infringe, we could be prevented from manufacturing or marketing our product.

Companies in the medical drug/device industry may use intellectual property infringement litigation to gain a competitive advantage. In the United States, patent applications filed in recent years are confidential for 18 months, while older applications are not publicly available until the patent issues. As a result, avoiding patent infringement may be difficult. Litigation may be necessary to enforce any patents issued or assigned to us or to determine the scope and validity of third-party proprietary rights. Litigation could be costly and could divert our attention from our business. There are no guarantees that we will receive a favorable outcome in any such litigation. If a third party claims that we infringed its patents, any of the following may occur:

we may become liable for substantial damages for past infringement if a court decides that our technologies infringe upon a competitor's patent;

a court may prohibit us from selling or licensing our product without a license from the patent holder, which may not be available on commercially acceptable terms or at all, or which may require us to pay substantial royalties or grant cross-licenses to our patents; and

we may have to redesign our product so that it does not infringe upon others' patent rights, which may not be possible or could require substantial funds or time.

Litigation related to infringement and other intellectual property claims such as trade secrets, with or without merit, is unpredictable, can be expensive and time-consuming, and can divert management's attention from our core business. If we lose this kind of litigation, a court could require us to pay substantial damages, treble damages, and attorneys' fees, and could prohibit us from using technologies essential to our product, any of which would have a material adverse effect on our business, results of operations, and financial condition. If relevant patents are upheld as valid and enforceable and we are found to infringe, we could be prevented from selling our product unless we can obtain licenses to use technology or ideas covered by such patents. We do not know whether any necessary licenses would be available to us on satisfactory terms, if at all. If we cannot obtain these licenses, we could be forced to design around those patents at additional cost or abandon the product altogether. Furthermore, because of the substantial amount of discovery required in connection with intellectual property litigation, there is a risk that some of our confidential information could be compromised by disclosure during this type of litigation. There could also be public announcements of the results of hearings, motions or other interim proceedings or developments. If securities analysts or investors perceive these results to be negative, it could cause the price of our common stock to decline.

If others have filed patent applications with respect to inventions for which we already have patents issued to us or have patent applications pending, we may be forced to participate in interference or derivation proceedings declared by the USPTO to determine priority of invention, which could also be costly and could divert our attention from our business. If the USPTO declares an interference and determines that our patent or application is not entitled to a priority date earlier than that of the other patent application, our ability to maintain or obtain those patent rights will be curtailed. Similarly, if the USPTO declares a derivation proceeding and determines that the invention covered by our patent application was derived from another, we will not be able to obtain patent coverage of that invention.

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Because of the extensive time required for development, testing and regulatory review of a potential product, it is possible that, before CHEMOSAT/Melphalan/HDS or any other product can be commercialized, any related patent may expire or remain in force for only a short period following commercialization, thereby reducing any advantages of the patent. Not all of our U.S. patent rights have corresponding patent rights effective in Europe or other foreign jurisdictions. Similar considerations apply in any other country where we are prosecuting patent applications, have been issued patents, or have decided not to pursue patent protection relating to our technology. The laws of foreign countries may not protect our intellectual property rights to the same extent as do laws of the United States.

We maintain a patent license arrangement with a third party, and our future business may depend, in part, upon the maintenance of that arrangement.

Certain aspects of our next generation products may be covered by U.S. patents and U.S. patent applications owned by a third party and exclusively licensed to us. If we breach the terms of the license agreement, the license may be terminated by the licensor. If we do not meet certain commercialization obligations by 2019, the license may be converted to a non-exclusive license by the licensor. We cannot guarantee that the license will not be terminated or converted in the future. Without the patent license we will not be able to prevent others from practicing the technology covered by the licensed patent. Moreover, without the patent license, we may be subject to allegations of patent infringement by the patent owner. We cannot guarantee that the third party will fulfill its responsibilities under the license arrangement.

Changes in patent law could diminish the value of patents in general, thereby impairing our ability to protect our product and our technologies.

Recent patent reform legislation could increase the uncertainties and costs surrounding the prosecution of our patent applications and the enforcement or defense of our issued patents. On September 16, 2011, the Leahy-Smith America Invents Act, or the Leahy-Smith Act, was signed into law. The Leahy-Smith Act includes a number of significant changes to U.S. patent law. These include provisions that affect the way patent applications are prosecuted, redefine prior art, may affect patent litigation, and switch the U.S. patent system from a first-to-invent system to a first-to-file system. Under a first-to-file system, assuming the other requirements for patentability are met, the first inventor to file a patent application generally will be entitled to the patent on an invention regardless of whether another inventor had made the invention earlier. The U.S. Patent and Trademark Office, or USPTO, recently developed new regulations and procedures to govern administration of the Leahy-Smith Act, and many of the substantive changes to patent law associated with the Leahy-Smith Act, in particular, the first-to-file provisions, only became effective on March 16, 2013. Accordingly, it is not clear what, if any, impact the Leahy-Smith Act will have on the operation of our business. However, the Leahy-Smith Act and its implementation could increase the uncertainties and costs surrounding the prosecution of our patent applications and the enforcement or defense of our issued patents.

In addition, patent reform legislation may pass in the future that could lead to additional uncertainties and increased costs surrounding the prosecution, enforcement, and defense of our patents and applications. Furthermore, the U.S. Supreme Court and the U.S. Court of Appeals for the Federal Circuit have made, and will likely continue to make, changes in how the patent laws of the United States are interpreted. Similarly, foreign courts have made, and will likely continue to make, changes in how the patent laws in their respective jurisdictions are interpreted. We cannot predict future changes in the interpretation of patent laws or changes to patent laws that might be enacted into law by United States and foreign legislative bodies. Those changes may materially affect our patents or patent applications and our ability to obtain and enforce or defend additional patent protection in the future.

Our trademarks may be infringed or successfully challenged, resulting in harm to our business.

We rely on our trademarks as one means to distinguish our product from the products of our competitors, and we have registered or applied to register many of these trademarks. The USPTO or foreign trademark offices may deny our trademark applications, however, and even if published or registered, these trademarks may be ineffective in protecting our brand and goodwill and may be successfully opposed or challenged. Third parties may oppose our trademark applications, or otherwise challenge our use of our trademarks. In addition, third parties may use marks that are confusingly similar to our own, which could result in confusion among our customers, thereby weakening the strength of our brand or allowing such third parties to capitalize on our goodwill. In such an event, or if our trademarks are successfully challenged, we could be forced to rebrand our product, which could result in loss of brand recognition and could require us to devote resources to advertising and marketing new brands. Our competitors may infringe our trademarks and we may not have adequate resources to enforce our trademark rights in the face of any such infringement.

We may rely primarily on trade secret protection for important proprietary technologies in the European Economic Area (EEA).

In addition to patent and trademark protection, we also rely on trade secrets, including unpatented know-how, technology and other proprietary information, to maintain our competitive position. We presently have issued utility and design patents with claims related to certain features of the current version of CHEMOSAT/Melphalan/HDS in the United States and Japan and a design patent protection in Argentina, Australia, Canada, and China. Other parts of CHEMOSAT/Melphalan/HDS are protected by trade secret in these jurisdictions. In the EEA, we rely on design patent and trade secret protection for CHEMOSAT/Melphalan/HDS. Without utility patent protection in the EEA covering the current version of CHEMOSAT/Melphalan/HDS, CHEMOSAT/Melphalan/HDS will only be covered by design patent and trade secret protection. Unlike patents, trade secrets are only recognized under applicable law if they

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are kept secret by restricting their disclosure to third parties. We protect our trade secrets and proprietary knowledge in part through confidentiality agreements with employees, consultants and other parties. However, certain consultants and third parties with whom we have business relationships, and to whom in some cases we have disclosed trade secrets and other proprietary knowledge, may also provide services to other parties in the medical device industry, including companies, universities and research organizations that are developing competing products. In addition, some of our former employees who were exposed to certain of our trade secrets and other proprietary knowledge in the course of their employment may seek employment with, and become employed by, our competitors. We cannot be assured that consultants, employees and other third parties with whom we have entered into confidentiality agreements will not breach the terms of such agreements by improperly using or disclosing our trade secrets or other proprietary knowledge. Monitoring unauthorized uses and disclosures of our intellectual property is difficult, and we do not know whether the steps we have taken to protect our intellectual property will be effective. In addition, we may not be able to obtain adequate remedies for any such breaches. Enforcing a claim that a party illegally disclosed or misappropriated a trade secret is difficult, expensive and time-consuming, and the outcome is unpredictable. In addition, some courts inside and outside the United States are less willing or unwilling to protect trade secrets.

Trade secret protection does not prevent independent discovery of the technology or proprietary information or use of the same. Competitors may independently duplicate or exceed our technology in whole or in part. If any of our trade secrets were to be lawfully obtained or independently developed by a competitor, we would have no right to prevent them, or those to whom they communicate it, from using that technology or information to compete with us. If we are not successful in maintaining the confidentiality of our technology, the loss of trade secret protection or know-how relating to CHEMOSAT/Melphalan/HDS will significantly impair our ability to commercialize CHEMOSAT in the EEA, and our value and results of operations will be harmed. In particular, we rely on trade secret protection for the filter media, which is a key component of our system.

Similar considerations apply in other foreign countries not mentioned above where we receive approval. Since we do not have issued patents for the current version of CHEMOSAT/Melphalan/HDS in these countries, our ability to successfully commercialize CHEMOSAT/Melphalan/HDS will depend on our ability to maintain trade secret protection in these markets.

We may be subject to damages resulting from claims that we or our employees have wrongfully used or disclosed alleged trade secrets of our competitors or are in breach of non-competition or non-solicitation agreements with our competitors.

We could in the future be subject to claims that we or our employees have inadvertently or otherwise used or disclosed alleged trade secrets or other proprietary information of former employers, competitors, or other third parties. Although we endeavor to ensure that our employees and consultants do not use the intellectual property, proprietary information, know-how or trade secrets of others in their work for us, we may in the future be subject to claims that we caused an employee to breach the terms of his or her non-competition or non-solicitation agreement, or that we or these individuals have, inadvertently or otherwise, used or disclosed the alleged trade secrets or other proprietary information of a former employer or competitor. Litigation may be necessary to defend against these claims. Even if we are successful in defending against these claims, litigation could result in substantial costs and could be a distraction to management. If our defense to those claims fails, in addition to paying monetary damages, a court could prohibit us from using technologies or features that are essential to our product, if such technologies or features are found to incorporate or be derived from the trade secrets or other proprietary information of the former employers or other third parties. An inability to incorporate technologies or features that are important or essential to our product may prevent us from selling our product. In addition, we may lose valuable intellectual property rights or personnel. Moreover, any such litigation or the threat thereof may adversely affect our ability to hire employees or contract with independent sales representatives. A loss of key personnel or their work product could hamper or

prevent our ability to commercialize our product.

Risks Related to Products Liability

We may be the subject of product liability claims or product recalls, and we may be unable to maintain insurance adequate to cover potential liabilities.

Our business exposes us to potential liability risks that may arise from clinical trials and the testing, manufacture, marketing, sale and use of CHEMOSAT/Melphalan/HDS. In addition, because CHEMOSAT/Melphalan/HDS is intended for use in patients with cancer, there is an increased risk of death among the patients treated with our system which may increase the risk of product liability lawsuits related to clinical trials or commercial sales. We may be subject to claims against us even if the injury is due to the actions of others. For example, if the medical personnel that use our system on patients are not properly trained or are negligent in the use of our system, the patient may be injured through the use of our system, which may subject us to claims. Were such a claim asserted we would likely incur substantial legal and related expenses even if we prevail on the merits. Claims for damages, whether or not successful, could cause delays in clinical trials and result in the loss of physician endorsement, adverse publicity and/or limit our ability to market and sell the system, resulting in loss of revenue. In addition, it may be necessary for us to recall products that do not meet approved specifications, which would also result in adverse publicity, as well as resulting in costs connected to the recall and loss of revenue. A successful products liability claim or product recall would have a material adverse effect on our business, financial condition and results of operations. We currently carry product liability and clinical trial insurance coverage, but it may be insufficient to cover one or more large claims.

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Risks Related to Our Common Stock

The market price of our common stock has been, and may continue to be volatile and fluctuate significantly, which could result in substantial losses for investors.

The trading price for our common stock has been, and we expect it to continue to be, volatile. The price at which our common stock trades depends upon a number of factors, including our historical and anticipated operating results, our financial situation, announcements of technological innovations or new products by us or our competitors, our ability or inability to raise the additional capital we may need and the terms on which we raise it, and general market and economic conditions. Some of these factors are beyond our control. Broad market fluctuations may lower the market price of our common stock and affect the volume of trading in our stock, regardless of our financial condition, results of operations, business or prospect. Among the factors that may cause the market price of our common stock to fluctuate are the risks described in this Risk Factors section and other factors, including:

fluctuations in our quarterly operating results or the operating results of our competitors;

variance in our financial performance from the expectations of investors;

changes in the estimation of the future size and growth rate of our markets;

changes in accounting principles or changes in interpretations of existing principles, which could affect our financial results;

failure of our products to achieve or maintain market acceptance or commercial success;

conditions and trends in the markets we serve;

changes in general economic, industry and market conditions;

success of competitive products and services;

changes in market valuations or earnings of our competitors;

changes in our pricing policies or the pricing policies of our competitors;

announcements of significant new products, contracts, acquisitions or strategic alliances by us or our competitors;

changes in legislation or regulatory policies, practices or actions;

the commencement or outcome of litigation involving our company, our general industry or both;

recruitment or departure of key personnel;

changes in our capital structure, such as future issuances of securities or the incurrence of additional debt;

actual or expected sales of our common stock by our stockholders; and

the trading volume of our common stock.

In addition, the stock markets, in general, The NASDAQ Capital Market and the market for pharmaceutical companies in particular, may experience a loss of investor confidence. Such loss of investor confidence may result in extreme price and volume fluctuations in our common stock that are unrelated or disproportionate to the operating performance of our business, financial condition or results of operations. These broad market and industry factors may materially harm the market price of our common stock and expose us to securities class action litigation. Such litigation, even if unsuccessful, could be costly to defend and divert management's attention and resources, which could further materially harm our financial condition and results of operations.

Our warrants contain anti-dilution provisions that, if triggered, could cause dilution to our existing stockholders.

The warrants issued in our February 2015 and July 2015 offerings are subject to an exercise price adjustment upon certain equity issuances below \$0.355 per share (as may be further adjusted). In addition to the potential dilutive effect of these provisions, there is the potential that a large number of the shares may be sold in the public market at any given time, which could place additional downward pressure on the trading price of our common stock.

Anti-takeover provisions in our Certificate of Incorporation and By-laws may reduce the likelihood of a potential change of control, or make it more difficult for our stockholders to replace management.

Certain provisions of our Certificate of Incorporation and By-laws could have the effect of making it more difficult for our stockholders to replace management at a time when a substantial number of our stockholders might favor a change in management. These provisions include:

providing for a staggered board; and

authorizing the board of directors to fill vacant directorships or increase the size of our board of directors. Furthermore, our board of directors has the authority to issue up to 10,000,000 shares of preferred stock in one or more series and to determine the rights and preferences of the shares of any such series without stockholder approval. Any series of preferred stock is likely to be senior to the common stock with respect to dividends, liquidation rights

and, possibly, voting rights. Our board's ability to

issue preferred stock may have the effect of discouraging unsolicited acquisition proposals, thus adversely affecting the market price of our common stock.

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Our common stock is listed on The NASDAQ Capital Market and if we do not maintain compliance with NASDAQ Marketplace Rules our common stock may be delisted from the NASDAQ Capital Market.

To keep our listing on The NASDAQ Capital Market, we are required to maintain: (i) a minimum bid price of \$1.00 per share, (ii) a certain public float, (iii) a certain number of round lot shareholders and (iv) one of the following: a net income from continuing operations (in the latest fiscal year or two of the three last fiscal years) of at least \$500,000, a market value of listed securities of at least \$35 million or a stockholders' equity of at least \$2.5 million. On August 11, 2015, we were notified by the NASDAQ Listing Qualifications Department that we do not comply with the \$1.00 minimum bid threshold as our common stock has traded below the \$1.00 minimum bid price for 30 consecutive business days. We were automatically provided with a 180-calendar day period within which to regain compliance and we subsequently qualified for an additional 180-day grace period, which ends on August 8, 2016. To regain compliance, our common stock is required to close at or above the \$1.00 minimum bid price for at least 10 consecutive days or more at the discretion of NASDAQ. We may fail to comply with this requirement. We may need to seek shareholder approval for a reverse stock split to regain compliance with this requirement.

We are also required to maintain certain corporate governance requirements. In the event that in the future we are notified that we no longer comply with NASDAQ's corporate governance requirements, and we fail to regain compliance within the applicable cure period, our common stock could be delisted from The NASDAQ Capital Market.

If our common stock is delisted, trading of the stock will most likely take place on an over-the-counter market established for unlisted securities, such as the Pink Sheets or the OTC Bulletin Board. An investor is likely to find it less convenient to sell, or to obtain accurate quotations in seeking to buy, our common stock on an over-the-counter market, and many investors may not buy or sell our common stock due to difficulty in accessing over-the-counter markets, or due to policies preventing them from trading in securities not listed on a national exchange or other reasons. For these reasons and others, delisting would adversely affect the liquidity, trading volume and price of our common stock, causing the value of an investment in us to decrease and having an adverse effect on our business, financial condition and results of operations, including our ability to attract and retain qualified executives and employees and to raise capital.

If our common stock is delisted from The NASDAQ Capital Market, we may be subject to the risks relating to penny stocks.

If our common stock were to be delisted from trading on The NASDAQ Capital Market and the trading price of the common stock were below \$5.00 per share on the date the common stock were delisted, trading in our common stock would also be subject to the requirements of certain rules promulgated under the Exchange Act. These rules require additional disclosure by broker-dealers in connection with any trades involving a stock defined as a penny stock and impose various sales practice requirements on broker-dealers who sell penny stocks to persons other than established customers and accredited investors, generally institutions. These additional requirements may discourage broker-dealers from effecting transactions in securities that are classified as penny stocks, which could severely limit the market price and liquidity of such securities and the ability of purchasers to sell such securities in the secondary market. A penny stock is defined generally as any non-exchange listed equity security that has a market price of less than \$5.00 per share, subject to certain exceptions.

We have never declared or paid any dividends to the holders of our common stock and we do not expect to pay cash dividends in the foreseeable future.

We currently intend to retain all earnings for use in connection with the expansion of our business and for general corporate purposes. Our board of directors will have the sole discretion in determining whether to declare and pay dividends in the future. The declaration of dividends will depend on our profitability, financial condition, cash requirements, future prospects and other factors deemed relevant by our board of directors. Our ability to pay cash dividends in the future could be limited or prohibited by the terms of financing agreements that we may enter into or by the terms of any preferred stock that we may authorize and issue. We do not expect to pay dividends in the foreseeable future. As a result, holders of our common stock must rely on stock appreciation for any return on their investment.

The issuance of additional stock in connection with acquisitions or otherwise will dilute all other stockholdings.

We are not restricted from issuing additional shares of our common stock, or from issuing securities that are convertible into or exchangeable for, or that represent the right to receive, common stock. As of December 31, 2015, we had an aggregate of 129.6 million shares of common stock authorized but not issued or outstanding, including 18.1 million shares issuable upon the exercise of outstanding warrants or options to purchase warrants at a weighted average exercise price of \$1.00. Subject to certain volume limitations imposed by The NASDAQ Capital Market in certain circumstances, we may issue all of these shares without any action or approval by our shareholders. We have established an at the market equity offering program, and we may issue shares under this program without any action or approval by our shareholders. We may expand our business through complementary or strategic business combinations or acquisitions of other companies and assets, and we may issue shares of common stock in connection with those transactions. The market price of our common stock could decline as a result of our issuance of a large number of shares of

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common stock, particularly if the per share consideration we receive for the stock we issue is less than the per share book value of our common stock or if we are not expected to be able to generate earnings with the proceeds of the issuance that are as great as the earnings per share we are generating before we issue the additional shares. In addition, any shares issued in connection with these activities, the exercise of warrants or stock options or otherwise would dilute the percentage ownership held by our investors. We cannot predict the size of future issuances or the effect, if any, that they may have on the market price of our common stock.

Item 1B. Unresolved Staff Comments.

None.

Item 2. Properties.

Our corporate offices currently occupy 5,818 square feet of office space at 1301 Avenue of the Americas, New York, New York under a license agreement that expires in May 2016. The Company leases two additional spaces in the United States including approximately 6,000 square feet at 95-97 Park Road in Queensbury, New York and 17,320 square feet of office space at 810 Seventh Avenue, New York, New York. The lease agreements expire in October 2016 and March 2021 respectively. The Company has subleased the office space at 810 Seventh Avenue. See Note 12 to the Company's audited financial statements contained in this Annual Report on Form 10-K for more details. Delcath owns a building containing approximately 10,320 square feet at 566 Queensbury Avenue in Queensbury, NY. These facilities house manufacturing, quality assurance and quality control, research and development, and office space. The Company also owns approximately four acres of land at 12 and 14 Park Road in Queensbury, New York. In addition, Delcath Systems Limited leases a facility for office and manufacturing containing approximately 19,200 square feet at 19 Mervue, Industrial Park in Galway, Ireland under a lease agreement that expires August 2, 2021. The Company has sublet 5,662 square feet of this facility. The Company believes substantially all of our property and equipment is in good condition and that we have sufficient capacity to meet our current operational needs.

Item 3. Legal Proceedings.

None.

Item 4. Removed and Reserved.

Table of Contents**Part II****Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities.**

Our common stock is traded on The NASDAQ Capital Market under the symbol DCTH .

The following table sets forth the high and low last reported sales prices of our common stock for the fiscal quarters indicated as reported on The NASDAQ Capital Market:

Common Stock Price Range

	2015	
	High	Low
Quarter ended March 31, 2015	\$ 1.56	\$ 0.96
Quarter ended June 30, 2015	1.44	0.81
Quarter ended September 30, 2015	0.92	0.40
Quarter ended December 31, 2015	0.62	0.39

	2014	
	High	Low
Quarter ended March 31, 2014	\$ 6.24	\$ 4.16
Quarter ended June 30, 2014	4.88	2.53
Quarter ended September 30, 2014	2.68	1.93
Quarter ended December 31, 2014	1.96	1.11

On March 18, 2016 there were 43 stockholders of record of our common stock.

Dividend Policy

The Company has never declared or paid cash dividends on our common stock and has no intention to do so in the foreseeable future.

Recent Sales of Unregistered Securities

The Company did not sell any equity securities that were not registered under the Securities Act of 1933, as amended, in the years ended December 31, 2015, 2014 and 2013.

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The graph below matches the cumulative 5-Year total return of holders of Delcath Systems Inc.'s common stock with the cumulative total returns of the NASDAQ Composite index and a customized peer group of thirteen companies that includes: Acura Pharmaceuticals, Inc., Adamis Pharmaceuticals Corporation, Alkermes Public Limited Company, Aradigm Corporation, Delcath Systems, Inc., Flamel Technologies S.a., Genex Biotechnology Corporation, Intellipharma International Inc., Juniper Pharmaceuticals, Inc., Novadel Pharma Inc., Petmed Express, Inc., Psivida Corp. and Valeant Pharmaceuticals International, Inc.. The graph assumes that the value of the investment in our common stock, in each index, and in the peer group (including reinvestment of dividends) was \$100 on 12/31/2010 and tracks it through 12/31/2015.

	12/10	12/11	12/12	12/13	12/14	12/15
Delcath Systems Inc.	100.00	31.12	12.55	2.60	0.77	0.32
NASDAQ Composite	100.00	100.53	116.92	166.19	188.78	199.95
Industry Group 513 - Drug Delivery	100.00	147.77	180.01	354.37	440.22	356.99
	12/10	12/11	12/12	12/13	12/14	12/15
Delcath Systems Inc.		-68.88%	-59.67%	-79.27%	-70.34%	-58.68%
NASDAQ Composite		0.53%	16.30%	42.14%	13.59%	5.92%
Industry Group 513 - Drug Delivery		47.77%	21.82%	96.86%	24.23%	-18.91%

The stock price performance included in this graph is not necessarily indicative of future stock price performance.

Item 6. Selected Financial Data.

The selected financial data set forth below should be read together with Management's Discussion and Analysis of Financial Condition and Results of Operations and our consolidated financial statements and related notes included in this Annual Report on Form 10-K.

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The selected financial data set forth below as of December 31, 2015, 2014, 2013, 2012, and 2011 and for the years ended December 31, 2015, 2014, 2013, 2012, and 2011 are derived from our audited financial statements included in this Annual Report on Form 10-K. All other selected financial data set forth below is derived from our audited financial statements not included in this Annual Report on Form 10-K. Our historical results are not necessarily indicative of our results of operations to be expected in the future.

<i>(Dollars in thousands)</i>	Year Ended December 31,				
	2015	2014	2013	2012	2011
Statement of Operations Data					
Total revenue	\$ 1,747	\$ 1,069	\$ 790	\$ 346	\$
Total operating expenses	16,495	20,082	33,345	54,178	46,456
Operating loss	15,210	19,304	33,019	53,871	46,456
Net loss	14,704	17,381	30,324	51,868	30,885
Basic loss per share	(0.91)	(1.84)	(4.81)	(13.54)	(0.68)

<i>(Dollars in thousands)</i>	Year Ended December 31,				
	2015	2014	2013	2012	2011
Balance Sheet Data					
Current assets	\$ 14,601	\$ 21,966	\$ 34,028	\$ 26,432	\$ 31,988
Total assets	15,733	23,764	37,097	30,474	35,241
Current liabilities	6,312	4,576	6,632	10,156	8,837
Stockholder's equity	8,601	18,145	30,099	20,009	26,104

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations.**Overview**

Delcath Systems, Inc. is a late-stage clinical development company with early commercial activity in Europe focused on cancers of the liver. We are a specialty pharmaceutical and medical device company developing our proprietary product Melphalan Hydrochloride for Injection for use with the Delcath Hepatic Delivery System (Melphalan/HDS). In Europe, our proprietary system to deliver and filter melphalan hydrochloride is marketed as a device under the trade name Delcath Hepatic CHEMOSAT® Delivery System for Melphalan (CHEMOSAT).

Our primary focus is on the execution of our clinical development program (CDP) in ocular melanoma liver metastases (mOM), intrahepatic cholangiocarcinoma (ICC), hepatocellular carcinoma (HCC or primary liver), and certain other cancers that are metastatic to the liver. We believe the disease states we are investigating represent a multi-billion dollar global market opportunity and a clear unmet medical need.

Our clinical development program for CHEMOSAT/Melphalan/HDS is comprised of: The FOCUS Clinical Trial for Patients with Hepatic Dominant Ocular Melanoma, a Global Phase 3 clinical trial that is investigating overall survival in mOM, and a Global Phase 2 clinical trial program investigating Melphalan/HDS with and without sorafenib in HCC and Melphalan/HDS in ICC. Our CDP also includes a commercial registry for CHEMOSAT non-clinical commercial cases performed in Europe and sponsorship of select investigator initiated trials (IITs) in HCC and colorectal cancer liver metastases (mCRC).

The direction and focus of our CDP for CHEMOSAT/Melphalan/HDS is informed by prior clinical development conducted between 2004 and 2010, non-clinical, commercial CHEMOSAT cases performed on approximately 150

patients in Europe, and prior regulatory experience with the FDA. Experience gained from this research, development, early European commercial and U.S. regulatory activity has led to the implementation of several safety improvements to our product and the associated medical procedure.

In the United States, Melphalan/HDS is considered a combination drug and device product, and is regulated as a drug by the FDA. The FDA has granted us six orphan drug designations, including three orphan designations for the use of the drug melphalan for the treatment of patients with mOM, HCC and ICC. Melphalan/HDS has not been approved for sale in the United States.

In Europe, the current version of our CHEMOSAT product is regulated as a Class IIb medical device and received its CE Mark in 2012. We are in an early phase of commercializing the CHEMOSAT system in select markets in the European Union where the prospect of securing adequate reimbursement for the procedure is strongest. In 2015 national reimbursement coverage for CHEMOSAT procedures was awarded in Germany, with coverage levels to be determined by German authorities in mid to late 2016. Currently there are few effective treatment options for certain cancers in the liver. Traditional treatment options include surgery, chemotherapy, liver transplant, radiation therapy, interventional radiology techniques, and isolated hepatic perfusion. We believe that CHEMOSAT/Melphalan/HDS represents a potentially important advancement in regional therapy for primary liver cancer and certain other cancers metastatic to the liver. We believe that CHEMOSAT/Melphalan/HDS is uniquely positioned to treat the entire liver either as a standalone therapy or as a complement to other therapies.

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Our Ability to Continue as a Going Concern

Our independent registered public accounting firm has issued its report dated March 18, 2016 in connection with the audit of our financial statements as of December 31, 2015 that included an explanatory paragraph describing the existence of conditions that raise substantial doubt about our ability to continue as a going concern. Our financial statements as of December 31, 2015 have been prepared under the assumption that we will continue as a going concern. If we are not able to continue as a going concern, it is likely that holders of our common stock will lose all of their investment. Our financial statements do not include any adjustments that might result from the outcome of this uncertainty.

Liquidity and Capital Resources

The Company's future results are subject to substantial risks and uncertainties. Delcath has operated at a loss for its entire history and anticipates that losses will continue over the coming year. There can be no assurance that Delcath will ever generate significant revenues or achieve profitability. The Company expects to use cash, cash equivalents and investment proceeds to fund its operating activities. Delcath's future liquidity and capital requirements will depend on numerous factors, including the progress of clinical trials and research and product development programs, obtaining approvals and complying with regulations; the timing and effectiveness of product commercialization activities, including marketing arrangements; the timing and costs involved in preparing, filing, prosecuting, defending and enforcing intellectual property rights; and the effect of competing technological and market developments.

At December 31, 2015, the Company had cash and cash equivalents totaling \$12.6 million, as compared to cash and cash equivalents totaling \$20.5 million at December 31, 2014. During the year ended December 31, 2015, the Company used \$16.4 million of cash for its operating activities, which compares to \$15.6 million used for operating activities during the year ended December 31, 2014. The increase of \$0.8 million is primarily driven by an increase in expenses related to our clinical trial initiatives which was offset by continued efforts to improve efficiency in the Company's organization and operations. The Company believes it has sufficient capital to fund its operating activities through the third quarter of 2016.

Our consolidated financial statements as of December 31, 2015 have been prepared under the assumption that we will continue as a going concern for the next twelve months. We expect to incur significant expenses and operating losses for the foreseeable future. These factors raise substantial doubt about our ability to continue as a going concern. Because Delcath's business does not generate positive cash flow from operating activities, the Company will need to obtain substantial additional capital in order to fund clinical trial research and support development efforts relating to Ocular Melanoma liver metastases, ICC, HCC or other indications, and to fully commercialize the product. The Company believes it will be able to raise additional capital in the event it is in its best interest to do so. The Company anticipates raising such additional capital by either borrowing money, selling shares of Delcath's capital stock, or entering into strategic alliances with appropriate partners. To the extent additional capital is not available when needed or on acceptable terms, the Company may be forced to abandon some or all of its development and commercialization efforts, which would have a material adverse effect on the prospects of our business. Further, the Company's assumptions relating to its cash requirements may differ materially from its actual requirements because of a number of factors, including significant unforeseen delays in the regulatory approval process, changes in the timing, scope, focus and direction of clinical trials and costs related to commercializing the product.

The Company has funded its operations through a combination of private placements of its securities, public offerings in 2000, 2003, 2009, 2010, 2011, 2012, 2013, and 2015, registered direct offerings in 2007, 2009 and 2013, and at the market equity offering programs initiated in 2012 and 2013. For a detailed discussion of the Company's various sales

of securities and the at the market equity offering program see Note 10 to the Company s audited financial statements contained in this Annual Report on Form 10-K.

As of December 31, 2015, the Company had two active registration statements. Pursuant to SEC regulations, so long as the Company s public float remains below \$75 million, we cannot sell securities from the shelf registration statement which represent more than one third of the market value of our non-affiliated public float during any 12-month period.

In March 2013, the Company filed a registration statement on Form S-3 with the SEC and also entered into a new sales agreement (the March 2013 Sales Agreement) with Cowen and Company, LLC to sell shares of the Company s common stock, par value \$.01 per share, having aggregate sales proceeds of \$50.0 million, from time to time, through an at the market equity offering program under which Cowen and Company, LLC will act as sales agent. The registration statement became effective on May 1, 2013 (333-187230). As of December 31, 2015, Delcath had approximately \$39.9 million available under this registration statement subject to market conditions and certain SEC limitations discussed above. The Company intends to use this for its at the market equity offering program.

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In October 2015, the Company filed a registration statement on Form S-3 with the SEC, which was declared effective on October 20, 2015 and allows the Company to offer and sell, from time to time in one or more offerings, up to \$77.4 million of common stock, preferred stock, warrants, debt securities and stock purchase contracts as it deems prudent or necessary to raise capital at a later date. This registration statement replaces the shelf registration filed in October 2012. As of December 31, 2015, Delcath had approximately \$77.4 million available under this registration statement subject to market conditions and certain SEC limitations discussed above.

The Company intends to use the net proceeds from any future offerings for general corporate purposes, including, but not limited to, funding clinical trials, obtaining regulatory approvals, commercialization of its products, capital expenditures and working capital.

On February 24, 2014, shareholders of the Company approved, through a shareholder vote, an amendment to the Company's Amended and Restated Certificate of Incorporation authorizing the Board of Directors to effect a reverse stock split of Delcath's common stock. The reverse stock split became effective on April 8, 2014 at which time Delcath's common stock began trading on the NASDAQ Stock Exchange on a one-for-sixteen (1:16) split-adjusted basis. All owners of record as of the close of the NASDAQ market on April 8, 2014 received one share of Delcath common stock in exchange for sixteen issued and outstanding shares of Delcath common stock. No fractional shares were issued in connection with the reverse stock split. All fractional shares created by the one-for-sixteen exchange were rounded up to the next whole share. The reverse stock split had no impact on the number of common shares authorized or the par value per share of Delcath common stock, which remain 170,000,000 and \$0.01, respectively. All current and prior period amounts related to shares, share prices and earnings per share, presented in these Consolidated Financial Statements and the accompanying Notes have been restated to give retrospective presentation for the reverse stock split.

Contractual Obligations, Commercial Commitments and Off-Balance Sheet Arrangements

The Company is obligated to make future payments under various operating lease agreements. The following table provides a summary of significant contractual obligations at December 31, 2015:

<i>(in millions)</i>	Total	Payments Due by Period			More than 5 years
		Less than 1 year	1-3 years	3-5 years	
Operating Activities:					
Future minimum lease payments, net of receipts due under subleases	\$ 2.5	\$ 0.5	\$ 1.4	\$ 0.6	\$

Our operating lease obligations at December 31, 2015 include: the annual rent for our office space at 1301 Avenue of the Americas, New York, New York, which will expire in May 2016; the annual rent under the lease for our office space at 810 Seventh Avenue, New York, New York, which will expire in March 2021 and of which a certain amount of expense has been offset by two sub-leases; the annual rent under the lease for a facility in Queensbury, New York, which will expire in October 2016; and the annual rent for our facility in Galway, Ireland, which will expire in August 2021 and of which a certain amount of expense has been offset by a sub-lease. See Part I, Item 2, "Properties" and Notes 8 and 12 to the Company's audited financial statements contained in this Annual Report on Form 10-K.

Future Capital Needs; Additional Future Funding

Our future results are subject to substantial risks and uncertainties. The Company has operated at a loss for its entire history and there can be no assurance that it will ever achieve consistent profitability. The Company believes that it has adequate resources to fund operations through the third quarter of 2016 and anticipates that additional working capital will be required to continue our operations. There can be no assurance that such working capital will be available on acceptable terms, if at all.

Results of Operations for the Year Ended December 31, 2015; Comparisons of Results of the Years Ended December 31, 2014 and 2013

Revenue

The Company recorded approximately \$1.7 million in total revenue during the year ended December 31, 2015. During the same period in 2014, Delcath recorded \$1.1 million in total revenue related to product sales. During the same period in 2013, Delcath recorded \$0.8 million of which \$0.3 million is related to the recognition of previously deferred revenue as a result of satisfying certain requirements of the Company's agreement with Chi-Fu Trading Co. Ltd. The remainder of the revenue is related to product sales. The year over year increases are a result of greater product sales each year as Delcath continues to see increased market acceptance of its product in the EU.

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Cost of Goods Sold

During the year ended December 31, 2015, the Company recognized cost of goods sold of approximately \$0.5 million related to product revenue of \$1.7 million.

During the year ended December 31, 2014, the Company recognized cost of goods sold of approximately \$0.3 million related to product revenue of \$1.1 million.

During the year ended December 31, 2013, the Company recognized cost of goods sold of approximately \$0.5 million related to product revenue of \$0.5 million. Due to adjustments in the anticipated use of inventory, the Company recorded \$0.3 million cost for expired, obsolete and slow-moving inventory during the year ended December 31, 2013.

The Company continues to expect a certain amount of volatility in both the average selling price and gross margin for the next several years. This volatility will be related to several factors, including: adjustments to volume forecasts; the gradual increase in cost of goods sold as the Company exhausts raw materials that were purchased and expensed in prior periods and begins to recognize the actual costs of materials, labor and overhead; and an improvement in efficiencies as the Company increases its production of CHEMOSAT.

Selling, General and Administrative Expenses

For the year ended December 31, 2015, selling, general and administrative expenses decreased to \$10.0 million from \$15.8 million for the year ended December 31, 2014. During 2014, the Company recorded approximately \$2.0 million in workforce and lease restructuring expenses. The remaining decrease of \$3.8 million is primarily attributable to the Company's successful efforts to increase organizational efficiencies as a result of the workforce restructurings as discussed in Note 8 to the Company's audited financial statements contained in this Annual Report on Form 10-K, as well as the completion of its evaluation of potential strategic options during the leadership transition period.

For the year ended December 31, 2014, selling, general and administrative expenses decreased to \$15.8 million from \$20.7 million for the year ended December 31, 2013. The decrease reflects a reduction in severance and compensation related expenses following the Company's significant workforce restructurings throughout 2013. As discussed further in Note 8 to the Company's audited financial statements contained in this Annual Report on Form 10-K, in 2014 the Company recognized \$1.3 million in expenses related to vacating its 810 Seventh Avenue office space, offsetting a portion of the decrease in year over year expenses.

Research and Development Expenses

For the year ended December 31, 2015, research and development expenses increased to \$6.5 million from \$4.3 million for the year ended December 31, 2014. During 2015, the Company had an increase of approximately 2.6 million in expenses related to its clinical development initiatives. This increase was partially offset by savings related to efforts to increase organizational efficiencies through a phase out of the medical science liaison program and workforce restructurings discussed in Note 8.

For the year ended December 31, 2014, research and development expenses decreased to \$4.3 million from \$12.7 million for the year ended December 31, 2013. The decrease is primarily due to a significant reduction in regulatory and clinical expenses related to the Company's NDA submission to the FDA, as well as a reduction in severance and compensation related expenses following the Company's significant workforce restructurings throughout 2013.

Interest Income

Interest income is from a money market account and interest earned on operating accounts. For the year ended December 31, 2015, the Company had interest income of \$8,617 as compared to interest income of \$5,232 for the same period in 2014.

For the year ended December 31, 2014, the Company had interest income of \$5,232 as compared to interest income of \$19,777 for the same period in 2013.

Other Expense and Interest Expense

Other expense is primarily related to currency gains and losses. Interest expense is related to the commitment fee paid in 2012 upon entering into a Loan and Security Agreement with Silicon Valley Bank (SVB) and an ongoing Revolving Line Facility Fee as required by the agreement with SVB as discussed in Note 11 to the Company's audited financial statements contained in this Annual Report on Form 10-K.

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Net Loss

The Company had a net loss for the year ended December 31, 2015 of \$14.7 million, a decrease of \$2.7 million, or 15.4%, compared to the net loss for the same period in 2014. This decrease is primarily due to a \$3.6 million decrease in operating expenses and a \$0.5 million improvement in gross profit, which was offset by a \$1.4 million change in the fair value of the warrant liability, a non-cash item. As detailed above, the Company has reduced operating costs through workforce restructurings that began in 2013, lease restructurings in 2014, and continuing efforts to improve efficiency in the Company's organization and operations as discussed above.

The Company had a net loss for the year ended December 31, 2014 of \$17.4 million, a decrease of \$12.9 million, or 42.6%, compared to the net loss for the same period in 2013. This decrease is primarily due to a \$13.3 million decrease in operating expenses. The decrease in operating expenses reflects a significant decrease in severance and compensation related expenses following the Company's workforce restructurings throughout 2013 as well as a reduction in costs related to the Company's NDA submission.

Application of Critical Accounting Policies

The Company's financial statements have been prepared in accordance with generally accepted accounting principles in the United States of America (GAAP). Certain accounting policies have a significant impact on amounts reported in the financial statements. A summary of those significant accounting policies can be found in Note 3 to the Company's audited financial statements contained in this Annual Report on Form 10-K.

The Company considers the valuation allowance for the deferred tax assets to be a significant accounting estimate. In applying ASC 740 management estimates future taxable income from operations and tax planning strategies in determining if it is more likely than not that the Company will realize the benefits of its deferred tax assets. Management believes the Company does not have any uncertain tax positions.

The Company has adopted the provisions of ASC 718, which establishes accounting for equity instruments exchanged for employee services. Under the provisions of ASC 718, share-based compensation is measured at the grant date, based upon the fair value of the award, and is recognized as an expense over the option holders' requisite service period (generally the vesting period of the equity grant). The Company expenses its share-based compensation under the ratable method, which treats each vesting tranche as if it were an individual grant.

The Company has adopted the provisions of ASC 505-50, which establishes accounting for equity-based payments to non-employees. Measurement of compensation cost related to common shares issued to non-employees for services is based on the value of the services provided or the fair value of the shares issued. Each transaction is reviewed to determine the more reliably measurable basis for the valuation. The measurement of non-employee stock-based compensation is subject to periodic adjustment as the underlying equity instrument vests. Non-employee stock-based compensation charges are amortized over the vesting period or period of performance of the services.

The Company has adopted the provisions of ASC 820, which defines fair value, establishes a framework for measuring fair value, and expands disclosures about fair value measurements.

ASC 820 emphasizes that fair value is a market-based measurement, not an entity-specific measurement. Therefore, a fair value measurement should be determined based on the assumptions that market participants would use in pricing the asset or liability. As a basis for considering market participant assumptions in fair value measurements, ASC 820 establishes a fair value hierarchy that distinguishes between market participant assumptions based on market data obtained from sources independent of the reporting entity (observable inputs that are classified within Levels 1 and 2

of the hierarchy) and the reporting entity's own assumptions about market participant assumptions (unobservable inputs classified within Level 3 of the hierarchy).

Level 1 inputs utilize quoted prices (unadjusted) in active markets for identical assets or liabilities that the Company has the ability to access. Level 2 inputs are inputs other than quoted prices included in Level 1 that are observable for the asset or liability, either directly or indirectly. Level 2 inputs may include quoted prices for similar assets and liabilities in active markets, as well as inputs that are observable for the asset or liability (other than quoted prices), such as interest rates, foreign exchange rates, and yield curves that are observable at commonly quoted intervals. Level 3 inputs are unobservable inputs for the asset or liability which are typically based on an entity's own assumptions, as there is little, if any, related market activity. In instances where the determination of the fair value measurement is based on inputs from different levels of the fair value hierarchy, the level in the fair value hierarchy within which the entire fair value measurement falls is based on the lowest level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular input to the fair value measurement in its entirety requires judgment, and considers factors specific to the asset or liability. See Note 9 to the Company's audited financial statements contained in this Annual Report on Form 10-K for assets and liabilities the Company has evaluated under ASC 820.

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Item 7A. Quantitative and Qualitative Disclosure About Market Risk

The Company may be exposed to market risk through changes in market interest rates that could affect the interest earned on its cash balances.

The Company measures all derivatives, including certain derivatives embedded in contracts, at fair value and recognizes them on the balance sheet as an asset or a liability, depending on the Company's rights and obligations under the applicable derivative contract.

In July 2015, the Company completed the sale of 9.4 million Units consisting of 9.4 million shares of its common stock, Series A Warrants to purchase up to 7.0 million common shares (July 2015 Series A Warrants) and Series B Warrants to purchase Units consisting of up to 9.4 million common shares (July 2015 Series B Warrants) and 7.0 million July 2015 Series A Warrants pursuant to an underwriting agreement. The Company received proceeds of \$7.0 million, with net cash proceeds after related expenses from this transaction of \$6.0 million. Of those proceeds the Company allocated an estimated fair value of \$3.4 million to the July 2015 Series A and Series B Warrants. The exercise price of both series of warrants is subject to appropriate adjustment in the event of stock dividends, stock splits, reorganizations or similar events affecting our common stock and is subject to anti-dilution adjustments for any issuance of common stock or rights to acquire common stock for consideration per share less than the exercise price of the warrants. At December 31, 2015, the July 2015 Series A Warrants were exercisable at \$0.87 with approximately 7.0 million warrants outstanding and the July 2015 Series B Warrants were exercisable at \$0.75 with approximately 9.4 million outstanding. The July 2015 Series A Warrants have a five-year term. July 2015 Series B Warrants expired January 29, 2016. There were no July 2015 Series A or Series B Warrants exercised during the year ended December 31, 2015.

In February 2015, the Company completed the sale of 2.5 million shares of its common stock and the issuance of warrants to purchase 1.1 million common shares (the February 2015 Warrants) pursuant to an underwriting agreement. The Company received proceeds of \$2.6 million, with net cash proceeds after related expenses from this transaction of \$2.5 million. Of those proceeds, the Company allocated an estimated fair value of \$0.8 million to the February 2015 Warrants. The exercise price is subject to appropriate adjustment in the event of stock dividends, stock splits, reorganizations or similar events affecting our common stock. The exercise price of the warrants is subject to anti-dilution adjustments for any issuance of common stock or rights to acquire common stock for consideration per share less than the exercise price of the warrants. For purposes of these adjustments, dilutive issuances do not include securities issued under existing instruments, under board-approved equity incentive plans or in certain strategic transactions. At December 31, 2015, the February 2015 Warrants were exercisable at \$0.74 per share with approximately 1.1 million warrants outstanding. The February 2015 Warrants have a five-year term. There were no February 2015 Warrants exercised during the year ended December 31, 2015.

In October 2013, the Company completed the sale of 1.3 million shares of its common stock and the issuance of warrants to purchase approximately 0.6 million common shares (the 2013 Warrants) pursuant to a placement agency agreement. The Company received proceeds of \$7.5 million, with net cash proceeds after related expenses from this transaction of approximately \$6.9 million. Of those proceeds, the Company allocated an estimated fair value of \$1.9 million to the 2013 Warrants. The exercise price is subje