UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

FORM 8-K

Current Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934

Date of Report (Date of earliest event Reported): **September 27, 2015**

THERAVANCE, INC.

(Exact Name of Registrant as Specified in its Charter)

Delaware	**000-30319**	**94-3265960**
(State or Other Jurisdiction of Incorporation)	(Commission File Number)	(I.R.S. Employer Identification Number)

951 Gateway Boulevard
South San Francisco, California 94080
(650) 238-9600
(Addresses, including zip code, and telephone numbers, including area code, of principal executive offices)

Check the appropriate box below if the Form 8-K filing is intended to simultaneously satisfy the filing obligation of the registrant under any of the following provisions (see General Instruction A.2. below):

☐ Written communications pursuant to Rule 425 under the Securities Act (17 CFR 230.425)

☐ Soliciting material pursuant to Rule 14a-12 under the Exchange Act (17 CFR 240.14a-12)

☐ Pre-commencement communications pursuant to Rule 14d-2(b) under the Exchange Act (17 CFR 240.14d-2(b))

☐ Pre-commencement communications pursuant to Rule 13e-4(c) under the Exchange Act (17 CFR 240.13e-4(c))

Item 7.01. Regulation FD Disclosure.

On September 27, 2015, GlaxoSmithKline plc (GSK) and Theravance, Inc. issued a press release announcing that data presented by GSK at the European Respiratory Society (ERS) International Congress from an exploratory post-hoc analysis of phase III data showed that patients with moderate-to-severe chronic obstructive pulmonary disease (COPD) who received Anoro® Ellipta® (UMEC/VI 62.5/25mcg) had a reduced risk of experiencing a clinically important deterioration compared to tiotropium 18mcg or placebo over a 12-week treatment period. Clinically important deterioration is a novel, composite endpoint which was used in the post-hoc analysis to assess the effect of treatment on a number of factors that are each believed to represent a worsening of a patient's COPD. The poster presented by GSK at the ERS International Congress and the press release are furnished as Exhibits 99.1, 99.2 and 99.3, respectively, to this Current Report on Form 8-K and are incorporated by reference herein. UMEC/VI has been developed under the LABA collaboration agreement between GSK and Theravance, Inc.

The information disclosed in this Item 7.01 is being furnished and shall not be deemed "filed" for purposes of Section 18 of the Securities Exchange Act of 1934, as amended (the "Exchange Act"), or otherwise subject to the liabilities under that section, nor shall it be deemed incorporated by reference in any filing under the Securities Act of 1933, as amended, or the Exchange Act except as expressly set forth by specific reference in such filing.

Item 9.01. Financial Statements and Exhibits.

(d) Exhibits

99.1 Poster: "Effect of Umeclidinium/Vilanterol (UMEC/VI) on Inspiratory Capacity/Total Lung Capacity Ratio in Hyperinflated COPD Patients"

99.2 Poster: “Clinically Important Deterioration in Patients With COPD Using Umeclidinium/Vilanterol, Tiotropium or Placebo: Pooled Data”

99.3 Press Release dated September 27, 2015.

SIGNATURE

Pursuant to the requirements of the Securities Exchange Act of 1934, as amended, the registrant has duly caused this report to be signed on its behalf by the undersigned hereunto duly authorized.

THERAVANCE, INC.

Date: September 28, 2015

By: /s/ Eric d’Esparbes
Eric d’Esparbes
Vice President and Chief Financial Officer

Effect of Umeclidinium/Vilanterol (UMEC/VI) on Inspiratory Capacity/Total Lung Capacity Ratio in Hyperinflated COPD Patients

Poster No. PA1493

Singh S(1), Maltais F(2), Tombs L(3), Church A(4), Iqbal A(4), Riley JH(5)

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Aims

- Lung hyperinflation in patients with chronic obstructive pulmonary disease (COPD) is strongly associated with poor patient outcomes including increased breathlessness, reduced exercise tolerance, reduced quality of life and increased mortality.(1),(2)
- There are several measures of hyperinflation that are important in predicting COPD outcomes:
  - The ratio of inspiratory capacity (IC) to total lung capacity (TLC) has been shown to be an independent predictor of mortality in patients with COPD; studies show a 1% decrease in IC/TLC increased the mortality risk by 5%.(1)
  - The ratio of residual volume (RV) to TLC has been shown to be a predictor of improvement in forced vital capacity (FVC) following lung volume reduction surgery. A minimal clinically important difference has been determined in patients with severe COPD who are undergoing bronchoscopic lung volume reduction surgery (-2.8 to -4.0% change from baseline).(3)
  - IC is also presented as it can be more readily assessed by spirometry rather than plethysmography.
- The long-acting muscarinic receptor antagonist umeclidinium (UMEC; 62.5 mcg/day) and the combination of UMEC with the long-acting β_2 agonist (LABA), vilanterol (UMEC/VI; 62.5/25 mcg/day) are approved once-daily maintenance treatments for COPD in the EU, US, Canada, and several other countries.(4)-(8)
- The aim of this *post hoc* analysis of two studies was to investigate whether UMEC/VI, UMEC or VI treatment could improve IC/TLC, RV/TLC and IC versus placebo in hyperinflated patients with COPD.

Methods

Study design

- Pooled data from two cross-over studies (DB2114417, NCT01328444; DB2114418, NCT01323660) in patients with COPD classified as hyperinflated (resting functional residual capacity [FRC]>120% predicted) were analysed.(9)
- Eligible patients were randomised to one of 26 treatment sequences consisting of two of the following treatments: UMEC/VI 125/25 mcg (delivered dose 113/22 mcg), UMEC/VI 62.5/25 mcg (delivered dose 55/22 mcg), UMEC 125 mcg (delivered dose 113 mcg), UMEC 62.5 mcg (delivered dose 55 mcg), VI 25 mcg (delivered dose 22 mcg) or placebo once-daily via an ELLIPTA® dry power inhaler. Each treatment period was 12 weeks with three clinic visits per treatment period.(9) Further details of the study design have been previously published.(9)

Patients

- Current and former smokers ≥40 years of age with a smoking history of ≥10 pack-years and a clinical diagnosis of moderate-severe stable COPD (post-bronchodilator forced expiratory volume in 1 second [FEV_1]/FVC <70% and FEV1 ≥35% and ≤70% predicted). The presence of co-morbid respiratory conditions or a diagnosis of asthma was exclusionary.(9) Stable doses of inhaled corticosteroids (ICS) were permitted throughout the study.

Endpoints

- Analyses of IC/TLC, RV/TLC and IC were pre-specified for each study. This *post hoc* analysis combined data from both studies (GSK study no. for *post hoc* analysis: 203170).
- Plethysmography assessments were conducted at screening and each clinic visit according to American Thoracic Society/European Respiratory Society guidelines.(10) All data were included in the analyses. However, only data from UMEC/VI 62.5/25 mcg, UMEC 62.5 mcg, VI 25 mcg and placebo treatments are reported here; data from the UMEC 125 mcg and UMEC/VI 125/25 mcg treatments have not been included in this poster as they are not approved treatments.
- Safety endpoints included collection of adverse events (AEs), and serious AEs (SAEs).

Results

Demographics and baseline characteristics

- Demographics were characteristic of patients with COPD with hyperinflation and were similar between the studies and treatments (data not shown). (9) Baseline hyperinflation measures are shown in **Table 1**.

Table 1. Baseline Hyperinflation Measures (ITT population)

	UMEC/VI 62.5/25 N=282	UMEC 62.5 N=89	VI 25 N=140	Placebo N=321
IC (L), mean (SD)	2.24 (0.73)	2.21 (0.54)	2.26 (0.68)	2.21 (0.64)
Min, max	0.78-4.44	0.82-3.82	0.97-4.07	0.67-4.55
IC/TLC %, mean (SD)	32 (8)	32 (6)	33 (7)	32 (7)
Min, max	10-52	18-47	16-48	13-53
RV/TLC, mean (SD)	0.57 (0.10)	0.56 (0.09)	0.57 (0.09)	0.57 (0.09)
Min, max	0.27-0.88	0.31-0.78	0.35-0.77	0.32-0.84

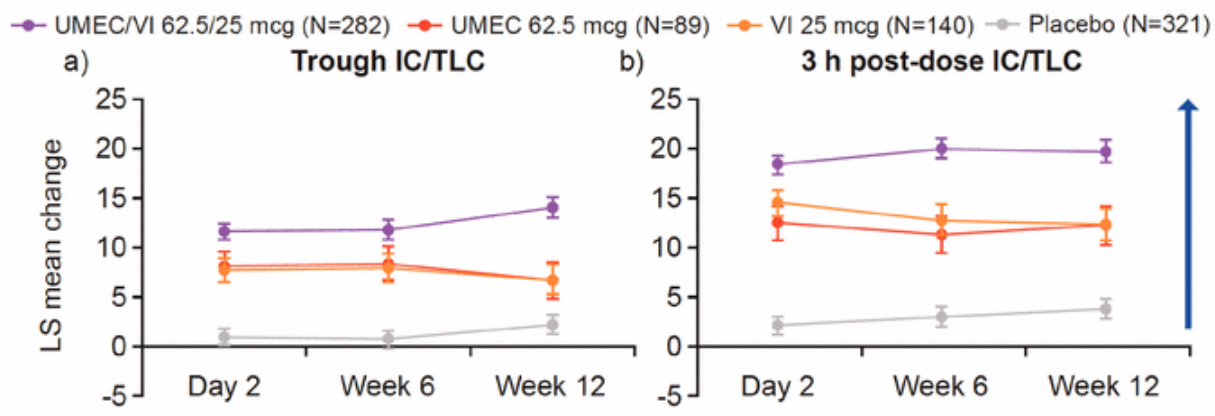
Measures of hyperinflation - IC/TLC ratio

- At 12 weeks, statistically significant improvements in the change from baseline trough IC/TLC ratio as a percentage versus placebo were shown for UMEC/VI (3.2%; 95% confidence interval [CI]: 2.5, 3.9; p<0.001), UMEC (1.3%; 95% CI: 0.4, 2.2; p<0.05) and VI (1.4%; 95% CI: 0.3, 2.4; p<0.05).

- At 12 weeks, statistically significant improvements in percentage change from baseline trough IC/TLC ratios versus placebo were shown for UMEC/VI (11.7%; 95% CI: 9.0, 14.5; p<0.001), UMEC (4.4%; 95% CI: 0.4, 8.3; p=0.032) and VI (4.5%; 95% CI: 1.0, 7.9; p=0.011; **Figure 1a**). UMEC/VI showed a statistically significant improvement in trough IC/TLC ratio compared with UMEC or VI (both p<0.001).

- When 3 h post-dose IC/TLC ratio was assessed, statistically significant improvements in percentage change from baseline IC/TLC ratio versus placebo were shown at 12 weeks for UMEC/VI (15.7%; 95% CI: 12.8, 18.6), UMEC (8.4%; 95% CI: 4.2, 12.5) and VI (8.5%; 95% CI: 4.8, 12.1; all p<0.001; **Figure 1b**). UMEC/VI showed a statistically significant improvement in 3 h post-dose IC/TLC ratio compared with UMEC or VI (both p<0.001).

Figure 1. Percentage Change from Baseline in IC/TLC ratio (ITT population)

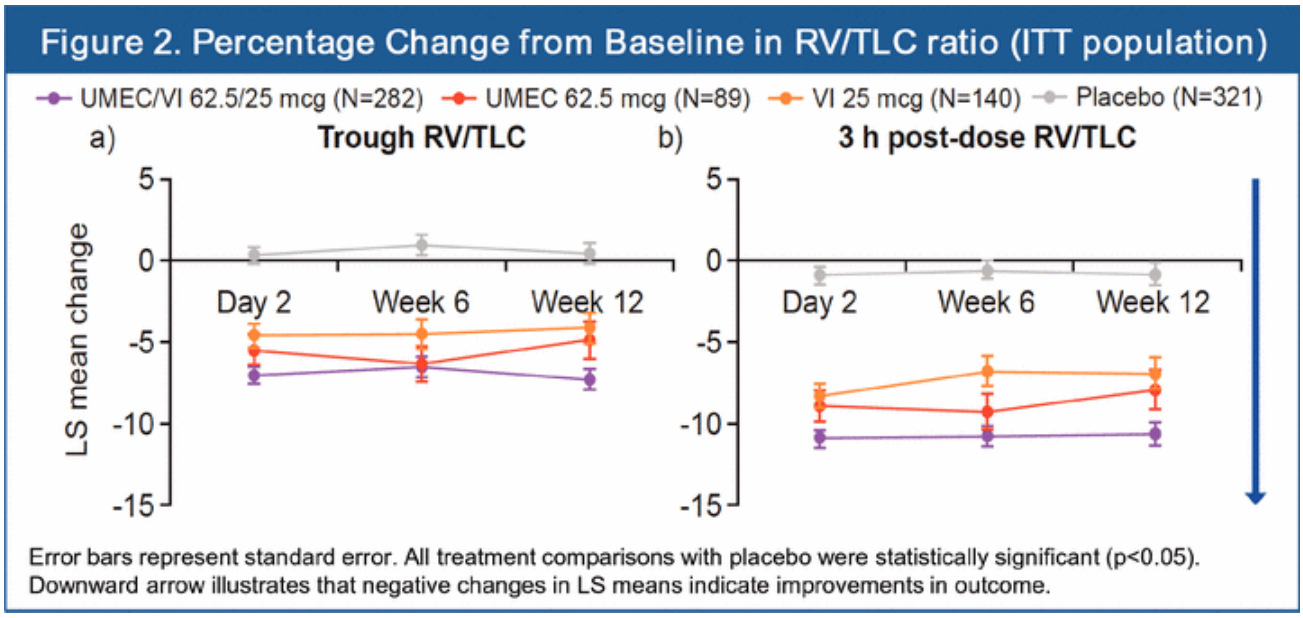


Error bars represent standard error. All treatment comparisons with placebo were statistically significant (p<0.05). Upward arrow illustrates that positive changes in LS means indicate improvements in outcome. LS, least squares; ITT, intention-to-treat.

Measures of hyperinflation – RV/TLC ratio

- At 12 weeks, percentage change from baseline of trough RV/TLC ratios versus placebo was significant for UMEC/VI (-7.7%; 95% CI: -9.4, -6.0), UMEC (-5.3%; 95% CI: -7.8, -2.8) and VI (-4.5%; 95% CI: -6.7, -2.4) (all p<0.001; **Figure 2a**). UMEC/VI showed a statistically significant improvement in trough RV/TLC ratio compared with VI (p=0.005) but not UMEC (p=0.064).

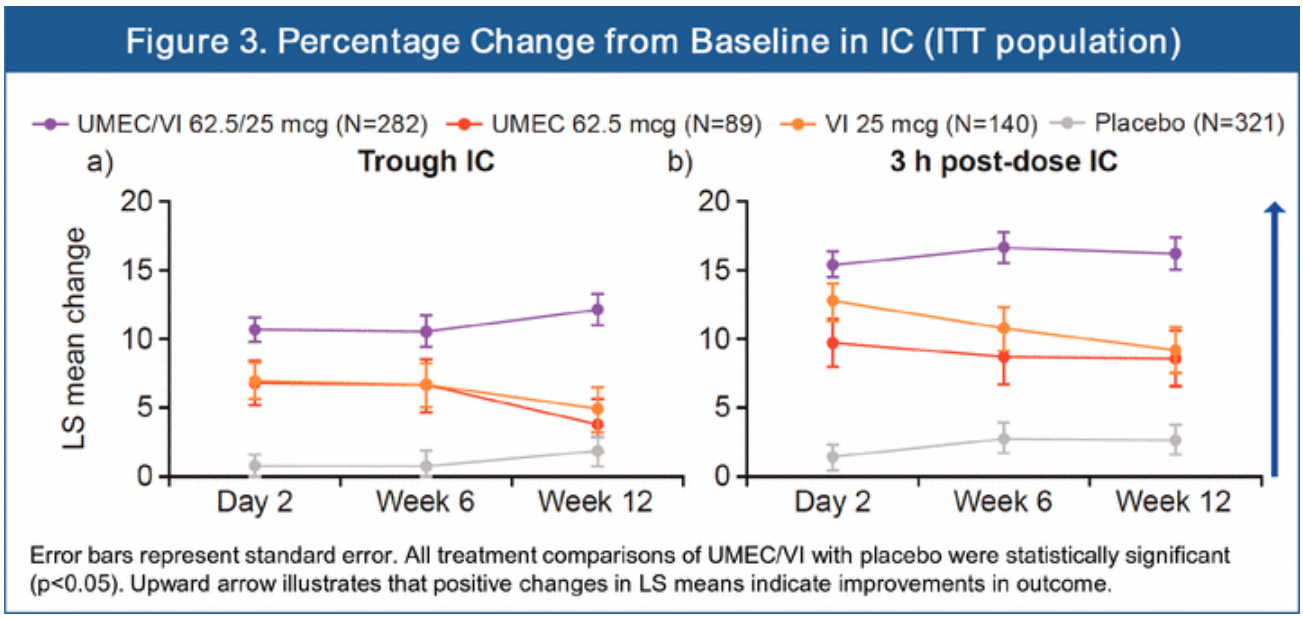
- Significant improvements in percentage change from baseline of 3 h post-dose RV/TLC ratios versus placebo were shown at 12 weeks for UMEC/VI (-9.8%; 95% CI: -11.6, -8.0), UMEC (-7.1%; 95% CI: -9.7, -4.5) and VI (-6.1%; 95% CI: -8.3, -3.8; all p<0.001; **Figure 2b**). UMEC/VI showed a statistically significant improvement in 3 h post-dose RV/TLC ratio compared with UMEC (p=0.042) and VI (p=0.001).



Measures of hyperinflation – IC

- At 12 weeks, statistically significant improvements in percentage change from baseline of trough IC versus placebo were shown for UMEC/VI (10.3%; 95% CI: 7.3, 13.2; p<0.001). The percentage change from baseline versus placebo for UMEC was 1.8% (95% CI:-2.5, 6.1; p=0.399) and VI was 3.0% (95% CI: -0.7, 6.7; p=0.113; **Figure 3a**). UMEC/VI showed a statistically significant improvement in trough IC compared with UMEC or VI (both p<0.001).

- Statistically significant improvements in percentage change from baseline of 3 h post-dose IC versus placebo were seen at 12 weeks for UMEC/VI (13.5%; 95% CI: 10.5, 16.5: p<0.001) UMEC (5.9%; 95% CI: 1.6, 10.3; p=0.008) and VI (6.5%; 95% CI: 2.7, 10.2; p<0.001; **Figure 3b**). UMEC/VI showed a statistically significant improvement in 3 h post-dose IC compared with UMEC or VI (both p<0.001).



Safety

- The incidence of AEs was similar between all treatments within each study (including placebo).(9) The most common AEs in both studies were headache and nasopharyngitis.

Conclusions

- Improvements in measures of hyperinflation were observed (both trough and 3 h post-dose) at Day 2 with UMEC/VI and maintained over 12 weeks. At 12 weeks, dual therapy provided statistically significant improvements over placebo in IC/TLC, RV/TLC and IC.

- Dual therapy with UMEC/VI provided statistically significant greater improvements in hyperinflation measures at 12 weeks than either monocomponent alone with the exception of trough RV/TLC versus UMEC.

- Treatment with UMEC/VI provided percentage changes in RV/TLC ratio that are similar to those shown to be clinically important post lung volume reduction surgery.(3)

- Longer term clinical studies are required to determine if the positive effect of UMEC/VI on IC/TLC ratio is associated with reductions in future mortality risk in COPD.

References

1. Casanova C, et al. *Am J Respir Crit Care Med* 2005;171:591–7; **2.** O'Donnell DE, et al. *Eur Respir J* 2004;23:832–40; **3.** Hartman JE, et al. *Eur Respir J* 2012;40:1137–41; **4.** GSK ANORO™ ELLIPTA® prescribing information, https://www.gsksource.com/gskprm/htdocs/documents/ANORO-ELLIPTA-PI-MG.PDF [accessed June 2015]. **5.** GSK ANORO™ ELLIPTA® summary of product characteristics. http://www.medicines.org.uk/emc/medicine/28949#INDICATIONS [accessed June 2015]; **6.** GSK INCRUSE™ ELLIPTA® prescribing information, http://www.gsksource.com/gskprm/htdocs/documents/INCRUSE-ELLIPTA-PI-PIL.PDF [accessed June 2015]; **7.** GSK INCRUSE™ ELLIPTA® summary of product characteristics http://www.medicines.org.uk/emc/medicine/29394 [accessed June 2015]; **8.** Blair HA, Deeks ED. *Drugs* 2015;75:61–74; **9.** Maltais F, et al. *Ther Adv Respir Dis* 2014;8:169–81; **10.** Wanger J, et al. *Eur Respir J* 2005;26:511–522.

Acknowledgements

The authors declare the following real or perceived conflicts of interest during the last 3 years in relation to this presentation: SS has served on advisory boards for GSK, Novartis and Pfizer; FM has received fees for speaking at conferences sponsored by Boehringer Ingelheim (BI), Pfizer, GSK and Grifols, and has served on advisory boards for GSK and BI. He has also received research grants from GSK, BI, Altana Pharma, Merck, AstraZeneca, Nycomed and Novartis, and has received an unrestricted research grant from BI and GSK.; LT is contracted to work for GSK; §AI was an employee of GSK at the time the analyses were completed and the abstract submitted and holds GSK stock/shares; AC and JHR are employees of GSK and hold stock options in the company.

This study was funded by GSK (DB2114417, clinicaltrials.gov ID NCT01328444; DB2114418, clinicaltrials.gov ID NCT01328444; GSK study no. for combined *post hoc* analysis: 203170).

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Presented at the European Respiratory Society International Congress, Amsterdam, The Netherlands, 26–30 September 2015

Clinically Important Deterioration in Patients With COPD Using Umeclidinium/Vilanterol, Tiotropium or Placebo: Pooled Data

Poster No. PA1001

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Aims

- The long-acting muscarinic antagonist/long-acting β_2-agonist (LAMA/LABA) combination, umeclidinium and vilanterol (UMEC/VI) is an approved maintenance treatment for chronic obstructive pulmonary disease (COPD) in the EU, the US, Canada and several other countries.(1)-(3)
- UMEC/VI treatment results in greater improvements in lung function and health status compared with the LAMA tiotropium (TIO) in patients with moderate-to-severe COPD.(4),(5)
- Early treatment in maintenance-naïve (MN) patients may improve lung function and health status.(6),(7) The ability of early treatment to reduce the risk of deteriorations in lung function, and health status in patients with COPD is not well characterised.
  - Deterioration in patients with COPD can be measured using an exploratory composite endpoint (clinically important deterioration [CID]) which assesses recognised deteriorations in disease control including the incidence of COPD exacerbations, and clinically relevant deteriorations in lung function and health status from baseline.
- The objective of this analysis was to investigate the efficacy of UMEC/VI in preventing CIDs in patients with moderate-to-severe COPD in both intent-to-treat (ITT) and MN populations.

Methods

Analysis Plan

- This was a *post hoc* analysis of data from four Phase III multicentre, randomised, blinded, parallel-group, 24-week trials comparing once-daily inhaled UMEC/VI 62.5/25 mcg (delivering 55 mcg and 22 mcg, respectively) versus TIO 18 mcg (delivering 10 mcg; (ZEP117115 [NCT01777334](5), DB2113360 [NCT01316900](4); DB2113374 [NCT01316913](4), data pooled into a single analysis) or placebo (PBO; DB2113373 [NCT01313650](8)).
  - The DB2113373 trial also included UMEC 62.5 mcg and VI 25 mcg treatment groups. DB2113360 and DB2113374 included VI 25 mcg and UMEC/VI 125/25 mcg (delivering 113 mcg and 22 mcg), treatment groups (data not presented in this poster).
- Key inclusion criteria included a diagnosis of symptomatic COPD, modified Medical Research Council (mMRC) Dyspnea Scale score >2, post-bronchodilator forced expiratory volume in 1 second (FEV_1) $\leq$70% predicted and FEV_1 forced vital capacity <0.70.
- The analyses below were performed on the ITT population and a subgroup of MN patients (defined as no maintenance therapy for $\geq$30 days before screening).
- The primary endpoint in all studies was change from baseline in trough FEV_1 on Day 169, defined as the mean of the FEV_1 values obtained 23 h and 24 h after dosing on Day 168.
- This *post hoc* analysis also examined the time to first CID, defined as a decrease of $\geq$100 mL(9) from baseline in trough FEV_1; or deterioration in health-related quality of life defined as $\geq$4 unit increase(10) from baseline in St George's Respiratory Questionnaire (SGRQ) total score; or the occurrence of an on-treatment moderate-to-severe COPD exacerbation (defined as a worsening of COPD symptoms requiring the use of any additional treatment other than study drug or rescue salbutamol and an emergency department visit or hospitalisation).
  - Lung function was determined at 7 visits post randomisation and SGRQ at 3 trial visits (4, 12, and 24 weeks).

Results

Patient Demographics

- In the pooled analysis of ZEP117115, DB2113374 and DB2113360 trials, the ITT population (randomised and receiving at least one dose of study medication), treated with UMEC/VI or TIO comprised 1,747 patients, and 533 (31%) were included in the MN population.
- In the DB2113373 trial, the ITT population treated with UMEC/VI or PBO comprised 693 patients and 257 (37%) were included in the MN population.

· Overall, patient demographics and characteristics in the UMEC/VI, TIO and PBO groups were generally similar in both the ITT (**Table 1**) and MN populations (data not shown), though the MN population of Study DB2113373 had a mean baseline FEV_1 approximately 100 mL higher in the UMEC/VI group compared with the PBO group.

Table 1. Summary of Patient Demographics and Baseline Characteristics (ITT Population)

	ZEP117115, DB2113374, DB2113360		DB2113373	
	UMEC/VI 62.5/25 (N=878)	TIO (N=869)	UMEC/VI 62.5/25 (N=413)	PBO (N=280)
Age, years	63.0 (8.58)	63.4 (8.70)	63.1 (8.71)	62.2 (9.04)
Male, n (%)	596 (68)	594 (68)	305 (74)	195 (70)
Current smoker at screening(a), n (%)	457 (52)	439 (51)	203 (49)	150 (54)
Smoking pack-years(b) mean (%)	45.1 (25.57)	46.1 (27.01)	46.5 (25.80)	47.2 (27.21)
Baseline FEV_1, L	1.24 (0.50)	1.24 (0.49)	1.28 (0.56)	1.20 (0.47)
GOLD stage, n (%)				
II	393 (45)	385 (44)	201 (49)	119 (43)
III	372 (42)	375 (43)	166 (40)	133 (48)
IV	111 (13)	106 (12)	45 (11)	28 (10)
ICS use at screening(c), n (%)				
Yes	443 (50)	445 (51)	212 (51)	137 (49)
Maintenance naïve at baseline(d) n (%)	275 (31)	258 (30)	152 (37)	105 (38)
SGRQ total score at baseline(e)	49.28 (17.68)	49.19 (17.05)	48.58 (18.24)	51.28 (18.12)
Exacerbation history(f), n (%)				
Required corticosteroid and/or antibiotic (without hospitalisation)	193 (22)	215 (25)	99 (24)	78 (28)
Required hospitalisation	73 (8)	80 (9)	39 (9)	31 (11)

All data shown are mean (standard deviation) unless otherwise specified; GOLD, Global initiative for chronic Obstructive Lung Disease; ICS, inhaled corticosteroid.

(a)Patient reclassified as current smoker if smoked within 6 months; (b)smoking pack-years = (number of cigarettes smoked per day/20) x number of years smoked; (c)ICS use was defined as those patients who were currently taking ICS medications at the Screening Visit; (d)defined as no maintenance therapy for ≥30 days before screening; (e)DB2113373: UMEC/VI, n=403; PBO, n=274; (f)patients experiencing ≥1 exacerbation during the 12 months prior to screening.

Trough FEV_1 at Day 169

· UMEC/VI provided a statistically significant improvement in trough FEV_1 of 95 mL in the ITT and 146 mL in the MN populations at Day 169 versus TIO (both $p<0.001$).

· Similarly UMEC/VI provided an improvement in trough FEV_1 of 167 mL in the ITT and 156 mL in the MN populations at Day 169 versus PBO (both $p<0.001$; **Table 2**).

Table 2. Change from Baseline In Trough FEV_1 on Day 169

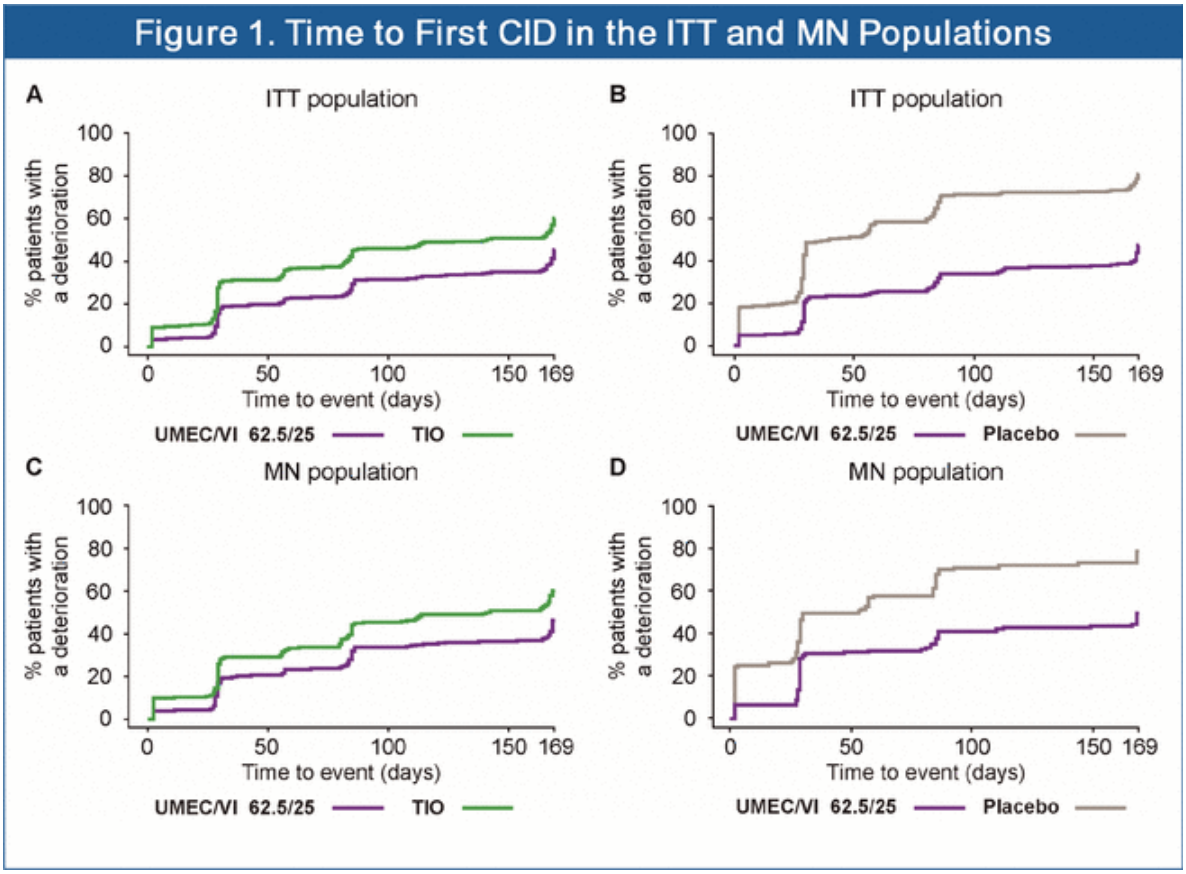
	ZEP117115, DB2113374, DB2113360		DB2113373	
	UMEC/VI 62.5/25	TIO	UMEC/VI 62.5/25	PBO
ITT population, n(a)	738	736	330	201
LS mean change, mL (SE)	211 (8.7)	116 (8.7)	171 (12.6)	4 (15.8)
UMEC/VI vs TIO or PBO, difference (95% CI)(b)	95 (71, 118)*		167 (128, 207)*	
MN population, n(a)	230	216	120	74
LS mean change, mL (SE)	252 (15.6)	107 (16.2)	152 (22.0)	-4 (27.5)
UMEC/VI vs TIO or PBO, difference (95% CI)(b)	146 (102, 189)*		156 (87, 225)*	

(a)Number of patients with analysable data at the current time point; (b)analysis performed using a repeated measures model with covariates of study, baseline FEV_1 (the mean of the two FEV_1 assessments made 30 min and 5 min pre-dose on Day 1), treatment, smoking status, centre group, Day, Day by baseline and Day by treatment interactions.
CI, confidence interval; LS, least squares; SE, standard error; *$p<0.001$.

The Proportion of Patients With a Composite CID

· The proportion of patients with a first composite CID was lower in the ITT population with UMEC/VI versus TIO (41% vs 56%) or PBO (44% vs 75%), respectively (**Figure 1A, B**).

· The proportion of patients with a first composite CID was lower in the MN population with UMEC/VI versus TIO (41% vs 55%) or PBO (49% vs 72%), respectively (**Figure 1C, D**).



Risk of a First Composite CID

- In both the ITT and MN populations, the risk of a first composite CID was significantly decreased with UMEC/VI versus TIO or PBO (**Table 3 and 4**, hazard ratios).
  - UMEC/VI significantly reduced the risk of deteriorations in lung function and SGRQ score in the ITT population versus TIO (**Table 3**).
  - UMEC/VI significantly reduced the risk of all types of CID in the ITT population versus PBO (**Table 3**).
  - Similar results were found in the MN population with UMEC/VI versus TIO or PBO, with the exception that SGRQ deterioration was not significantly reduced with UMEC/VI versus PBO or TIO (**Table 4**).

Table 3. Summary of the Risk of a First CID (ITT Population)

	ZEP117115, DB2113374, DB2113360		DB2113373	
Deterioration Criteria	**UMEC/VI 62.5/25 (N=878)**	**TIO (N=869)**	**UMEC/VI 62.5/25 (N=413)**	**PBO (N=280)**
Composite (any event), n (%)	362 (41)	486 (56)	182 (44)	209 (75)
HR (95% CI)(a)	0.62 (0.54, 0.71)*		0.37 (0.30, 0.45)*	
≥100 mL decrease in trough FEV_1	159 (18)	308 (35)	81 (20)	147 (53)
HR (95% CI)(a)	0.44 (0.36, 0.53)*		0.26 (0.20, 0.34)*	
≥4 unit SGRQ total score increase	208 (24)	236 (27)	112 (27)	110 (39)
HR (95% CI)(a)	0.83 (0.69, 1.00)†		0.58 (0.44, 0.75)*	
Moderate-to-severe COPD exacerbation	56 (6)	54 (6)	27 (7)	35 (13)
HR (95% CI)(a)	1.02 (0.70, 1.48)		0.48 (0.29, 0.79)‡	

*p<0.001; †p=0.045; ‡p=0.004; (a)Hazard ratios (HRs) and CIs are presented for UMEC/VI vs TIO or UMEC/VI vs PBO and derived using a Cox proportional hazards model with covariates of treatment, study, smoking status at screening and geographical region.

Table 4. Summary of the Risk of a First CID (MN population)

	ZEP117115, DB2113374, DB2113360		DB2113373	
Deterioration criteria	**UMEC/VI 62.5/25 (N=275)**	**TIO (N=258)**	**UMEC/VI 62.5/25 (N=152)**	**PBO (N=105)**
Composite (any event), n (%)	114 (41)	141 (55)	74 (49)	76 (72)
HR (95% CI)(a)	0.66 (0.51, 0.85)*		0.45 (0.33, 0.62)*	
≥100 mL decrease in trough FEV_1	53 (19)	93 (36)	34 (22)	60 (57)
HR (95% CI)(a)	0.44 (0.32, 0.62)*		0.26 (0.17, 0.40)*	
≥4 unit SGRQ total score increase	66 (24)	69 (27)	53 (35)	33 (31)
HR (95% CI)(a)	0.92 (0.65, 1.29)		1.07 (0.69, 1.65)	
Moderate-to-severe COPD exacerbation	13 (5)	9 (3)	6 (4)	12 (11)
HR (95% CI)(a)	1.33 (0.57, 3.13)		0.32 (0.12, 0.85)†	

*p<0.001; †p=0.023; (a)HRs and CIs are presented for UMEC/VI vs TIO or UMEC/VI vs PBO and derived using a Cox proportional hazards model with covariates of treatment, study, smoking status at screening and geographical region.

Safety

- In the ITT population, headache (UMEC/VI [9%] vs TIO [6%]; UMEC/VI [8%] vs PBO [9%]) and nasopharyngitis (UMEC/VI [7%] vs TIO [7%]; UMEC/VI [9%] vs PBO [6%]) were the most commonly reported adverse events (AEs).

- Similar results were seen in the MN population.

Conclusions

- In this *post hoc* analysis in patients with moderate-to-severe COPD, UMEC/VI treatment resulted in similar improvements in trough FEV_1 from baseline versus TIO or PBO in both the ITT and MN populations.

- UMEC/VI treatment also reduced the risk of a first composite CID to a similar extent in both the ITT and MN populations versus TIO or PBO.

- The incidence of AEs was similar between treatment groups in the ITT and MN populations.

- These findings may provide a rationale for the use of dual bronchodilator therapy in MN populations.

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PRESS RELEASE

Issued: Sunday 27th September 2015, London UK

GSK presents post-hoc analysis of Anoro® Ellipta® data assessing markers of COPD deterioration compared to tiotropium or placebo using a novel composite endpoint

GlaxoSmithKline plc (GSK) and Theravance, Inc. (NASDAQ: THRX) today announced data presented by GSK at the European Respiratory Society (ERS) International Congress (poster PA1001), from an exploratory post-hoc analysis of phase III data, which showed that patients with moderate-to-severe chronic obstructive pulmonary disease (COPD) who received Anoro® Ellipta® (UMEC/VI 62.5/25mcg) had a reduced risk of experiencing a clinically important deterioration compared to tiotropium 18mcg or placebo over a 12-week treatment period.

This post-hoc analysis used a novel, composite endpoint, defined as a clinically important deterioration, to assess the effect of treatment on a number of factors that are each believed to represent a worsening of a patient's COPD. The analysis examined the time to a first clinically important deterioration which was determined by the occurrence of any of the following events: A decrease in lung function of $\geq$100 ml from baseline as measured by trough FEV_1; a deterioration in health-related quality of life defined as $\geq$4 unit increase from baseline in St George's Respiratory Questionnaire (SGRQ) total score; or the occurrence of an on-treatment moderate-to-severe COPD exacerbation.

The results of the analysis showed that the risk of experiencing a clinically important deterioration was significantly lower for patients on UMEC/VI 62.5/25mcg once daily compared to tiotropium 18mcg once daily (hazard ratio: 0.62; 95% confidence interval [CI]: 0.54, 0.71; $p<0.001$) or placebo (hazard ratio: 0.37; 95% CI: 0.30, 0.45; $p<0.001$) in an intention to treat population, based on analysis of time to first deterioration.

Eric Dube, Senior Vice President and Head, Global Respiratory Franchise at GSK said: "Most studies are designed to show whether COPD medicines improve outcomes however, there are currently limited data to assess whether they also prevent a worsening, or deterioration, in a patient's condition which is a key part of the management of COPD. Helping physicians understand the relevance of our medicines as they make decisions in the treatment of COPD is important therefore we performed this post-hoc analysis to explore the potential impact of Anoro on disease deterioration. This is a new area of research and we will be conducting prospective studies to further evaluate these findings in the future."

Michael W. Aguiar, President and Chief Executive Officer of Theravance, Inc. said: "We already have a substantial amount of evidence which demonstrates the efficacy and safety of Anoro across a number of individual endpoints. However, this is a novel concept which evaluates time to a first clinically important deterioration, and may in the future help our understanding of the factors which drive clinical stability in COPD, once more evidence accumulates on this concept."

Study design

The findings are from a post-hoc analysis of data from four multicentre, randomised, blinded, parallel-group, 24-week trials: three comparing once-daily inhaled UMEC/VI 62.5/25mcg delivered in the Ellipta® inhaler, versus tiotropium 18mcg once daily delivered in the HandiHaler® inhaler (ZEP117115; DB2113360; DB2113374; data pooled into a single analysis) and one comparing once-daily inhaled UMEC/VI 62.5/25mcg to placebo (DB2113373).

These four studies (ZEP117115; DB2113360; DB2113374; DB2113373) also included additional treatment arms however, these data were not included in the poster presented at ERS 2015. Complete details of each of the study arms and the full results of these studies have been previously announced and are available on the GSK Clinical Study Register.

In the pooled analysis of ZEP117115, DB2113374 and DB2113360 trials, the intention to treat population (randomised and receiving at least one dose of study medication) comprised of 2,597 patients, 1,747 patients received either UMEC/VI 62.5/25mcg or tiotropium 18mcg. In the analysis of the DB2113373 study, the intention to treat population comprised of 1,532 patients, 693 patients received either UMEC/VI 62.5/25mcg or placebo.

About COPD

COPD is a disease of the lungs that includes chronic bronchitis, emphysema or both. COPD is characterised by obstruction to airflow that interferes with normal breathing. COPD is thought to affect around 329 million people worldwide.(1)

Long-term exposure to lung irritants that damage the lungs and the airways are usually the cause of COPD. Cigarette smoke, breathing in second hand smoke, air pollution, chemical fumes or dust from the environment or workplace can all contribute to COPD. Most people who have COPD are at least 40 years old when symptoms begin.(2)

About Anoro Ellipta

Anoro Ellipta is a combination long-acting muscarinic antagonist (LAMA) (also known as an anticholinergic) / long-acting $beta_2$-adrenergic agonist (LABA). In the US, Anoro Ellipta is indicated for the long-term, once-daily, maintenance treatment of airflow obstruction in patients with COPD, including chronic bronchitis and/or emphysema. Anoro Ellipta is not indicated for the relief of acute bronchospasm or for the treatment of asthma. The FDA-approved strength is umeclidinium/vilanterol 62.5/25mcg.

Full US prescribing information, including BOXED WARNING and Medication Guide are available at: https://www.gsksource.com/gskprm/htdocs/documents/ANORO-ELLIPTA-PI-MG.PDF.

In Europe, Anoro is indicated as a once-daily, maintenance bronchodilator treatment to relieve symptoms in adult patients with chronic obstructive pulmonary disease (COPD). The approved strength in Europe is UMEC/VI 55mcg/22 mcg (delivered dose, equivalent to 62.5mcg/25mcg pre-dispensed dose).

For the EU Summary of Product Characteristics (SmPC), please visit: http://www.medicines.org.uk/emc/medicine/28949/SPC/Anoro+Ellipta+55+micrograms+22+micrograms+inhalation+powder%2c+pre-dispensed/

Important Safety Information for Anoro Ellipta

The following Important Safety Information (ISI) is based on the Highlights section of the US Prescribing Information for Anoro Ellipta. Please consult the full Prescribing Information for all the labelled safety information for Anoro Ellipta.

Long-acting beta$_2$-adrenergic agonists (LABAs), such as vilanterol, one of the active ingredients in Anoro Ellipta, increase the risk of asthma-related death. A placebo-controlled trial with another LABA (salmeterol) showed an increase in asthma-related deaths in subjects receiving salmeterol. This finding with salmeterol is considered a class effect of all LABAs, including vilanterol. The safety and efficacy of Anoro Ellipta in patients with asthma have not been established. Anoro Ellipta is not indicated for the treatment of asthma.

Anoro Ellipta is contraindicated in patients with severe hypersensitivity to milk proteins or who have demonstrated hypersensitivity to either umeclidinium, vilanterol, or any of the other ingredients.

Anoro Ellipta should not be initiated in patients during rapidly deteriorating or potentially life-threatening episodes of COPD, or as rescue therapy for the treatment of acute episodes of bronchospasm, which should be treated with an inhaled, short-acting beta$_2$-agonist.

Anoro Ellipta should not be used more often than recommended, at higher doses than recommended, or in conjunction with additional medicine containing a LABA, as an overdose may result.

Anoro Ellipta should be used with caution when considering coadministration with long-term ketoconazole and other known strong cytochrome P450 3A4 inhibitors because increased cardiovascular adverse effects may occur.

Anoro Ellipta can produce paradoxical bronchospasm, which may be life-threatening.

Anoro Ellipta should be used with caution in patients with cardiovascular disorders, especially coronary insufficiency, cardiac arrhythmias, and hypertension.

Anoro Ellipta should be used with caution in patients with convulsive disorders, thyrotoxicosis, diabetes mellitus, ketoacidosis, and in patients who are unusually responsive to sympathomimetic amines.

Anoro Ellipta should be used with caution in patients with narrow-angle glaucoma. Instruct patients to contact a physician immediately should any signs or symptoms of narrow-angle glaucoma occur.

Anoro Ellipta should be used with caution in patients with urinary retention, especially in patients with prostatic hyperplasia or bladder neck obstruction. Instruct patients to contact a physician immediately should any signs or symptoms of urinary retention occur.

Beta-adrenergic agonist medicines may produce significant hypokalemia and transient hyperglycemia in some patients.

The most common adverse reactions (incidence $\geq$1% and more common than placebo) reported in four 6-month clinical trials with Anoro Ellipta (and placebo) were pharyngitis, 2% (<1%); sinusitis 1% (<1%); lower respiratory tract infection, 1% (<1%); constipation, 1% (<1%); diarrhea, 2% (1%); pain in extremity 2% (1%); muscle spasms, 1% (<1%); neck pain, 1% (<1%); and chest pain 1% (<1%). In addition to the 6-month efficacy trials with Anoro Ellipta, a 12-month trial evaluated the safety of umeclidinium/vilanterol 125 mcg/25 mcg in subjects with COPD. Adverse reactions (incidence $\geq$1% and more common than placebo) in subjects receiving umeclidinium/vilanterol 125 mcg/25 mcg were: headache, back pain, sinusitis, cough, urinary tract infection, arthralgia, nausea, vertigo, abdominal pain, pleuritic pain, viral respiratory tract infection, toothache, and diabetes mellitus.

Beta$_2$-agonists, such as vilanterol should be administered with extreme caution to patients being treated with monoamine oxidase inhibitors, tricyclic antidepressants, or drugs known to prolong the QTc interval or within 2 weeks of discontinuation of such agents, because the effect of adrenergic agonists on the cardiovascular system may be potentiated.

Use beta blockers with caution as they not only block the pulmonary effect of beta-agonists, such as vilanterol, but may produce severe bronchospasm in patients with COPD.

Use with caution in patients taking non—potassium-sparing diuretics, as electrocardiographic changes and/or hypokalemia associated with non—potassium-sparing diuretics may worsen with concomitant beta-agonists.

Avoid co-administration of Anoro Ellipta with other anticholinergic-containing drugs as this may lead to an increase in anticholinergic adverse effects such as cardiovascular effects, worsening of narrow-angle glaucoma, and worsening of urinary retention.

HANDIHALER® is a trade mark of the Boehringer Ingelheim group of companies.

GSK — one of the world's leading research-based pharmaceutical and healthcare companies — is committed to improving the quality of human life by enabling people to do more, feel better and live longer. For further information please visit www.gsk.com.

Theravance, Inc. — is focused on bringing compelling new medicines to patients in areas of unmet need by leveraging its significant expertise in the development, commercialization and financial management of bio-pharmaceuticals. Theravance's portfolio is anchored by the respiratory assets partnered with Glaxo Group Limited (GSK), including RELVAR®/BREO® ELLIPTA® and ANORO® ELLIPTA®, which were jointly developed by Theravance and GSK. Under the agreement with GSK, Theravance is eligible to receive associated royalty revenues from RELVAR®/BREO® ELLIPTA®, ANORO® ELLIPTA® and, if approved and commercialized, VI monotherapy, as well. In addition, Theravance retains a 15% economic interest in future payments made by GSK for earlier-stage programs under the agreements with GSK. For more information, please visit Theravance's website at www.thrxinc.com.

ANORO®, RELVAR®, BREO® and ELLIPTA® are trade marks of the GlaxoSmithKline group of companies.

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Cautionary statement regarding forward-looking statements

GSK cautions investors that any forward-looking statements or projections made by GSK, including those made in this announcement, are subject to risks and uncertainties that may cause actual results to differ materially from those projected. Such factors include, but are not limited to, those described under Item 3.D 'Risk factors' in the company's Annual Report on Form 20-F for 2014.

Theravance forward-looking statements

This press release contains certain "forward-looking" statements as that term is defined in the Private Securities Litigation Reform Act of 1995 regarding, among other things, statements relating to goals, plans, objectives and future events. Theravance intends such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in Section 21E of the Securities Exchange Act of 1934 and the Private Securities Litigation Reform Act of 1995. Such forward-looking statements involve substantial risks, uncertainties and assumptions. Examples of such statements include statements relating to: the commercialization of Anoro® Ellipta®, the strategies, plans and objectives of the company, the timing, manner and amount of anticipated potential capital returns to stockholders (including without limitation, expectations of future cash dividends or future share repurchases), the status and timing of clinical studies, data analysis and communication of results, the potential benefits and mechanisms of action of product candidates, expectations for product candidates through development and commercialization, the timing of seeking regulatory approval of product candidates, and projections of revenue, expenses and other financial items. These statements are based on the current estimates and assumptions of the management of Theravance as of the date of this press release and are subject to risks, uncertainties, changes in circumstances, assumptions and other factors that may cause the actual results of Theravance to be materially different from those reflected in the forward-looking statements. Important factors that could cause actual results to differ materially from those indicated by such forward-looking statements include, among others, risks related to: the disruption of operations during the transition period following the spin-off, including the diversion of managements' and employees' attention, disruption of relationships with collaborators and increased employee turnover, lower than expected future royalty revenue from respiratory products partnered with GSK, delays or difficulties in commencing or completing clinical studies, the potential that results from clinical or non-clinical studies indicate product candidates are unsafe or ineffective, dependence on third parties to conduct its clinical studies, delays or failure to achieve and maintain regulatory approvals for product candidates, and risks of collaborating with third parties to discover, develop and commercialize products. Other risks affecting Theravance are described under the headings "Risk Factors" and "Management's Discussion and Analysis of Financial Condition and Results of Operations" contained in Theravance's Annual Report on Form 10-K for the year ended December 31, 2014 and Theravance's Quarterly Report on Form 10-Q for the quarter ended June 30, 2015, which are on file with the Securities and Exchange Commission (SEC) and available on the SEC's website at www.sec.gov. In addition to the risks described above and in Theravance's other filings with the SEC, other unknown or unpredictable factors also could affect Theravance's results. No forward-looking statements can be guaranteed and actual results may differ materially from such statements. Given these uncertainties, you should not place undue reliance on these forward-

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