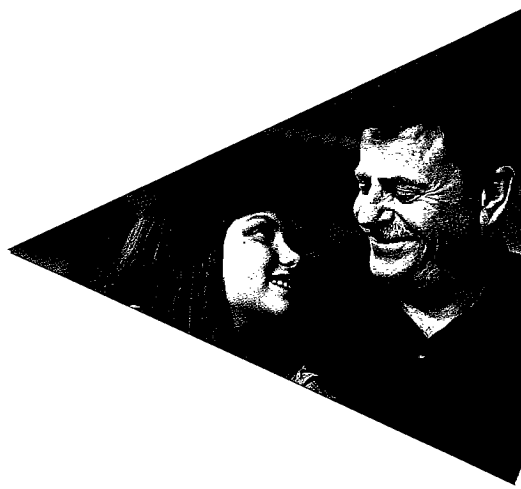





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Received SEC
APR 20 2011
Washington, DC 20549

*"For as long
as I can remember,
I never knew what it
was like to not feel pain
from my disease."
- Stanley Clement*





*In 2010, ViroPharma
presented encouraging
VP20621 data for the
prevention of the
recurrence of
C. difficile.*

*Alexandra
Dudeney*

Market Access, Europe

2010 Business Highlights

1. Delivered record \$439 million in net product sales

Highlighted by \$177 million in net Cinryze® (C1 Esterase Inhibitor [Human]) sales

2. Ended 2010 with over \$505 million in cash and cash equivalents

3. Submitted Marketing Authorization Application (MAA) to European Medicines Agency (EMA) for Cinryze

4. Successfully completed Phase 2 study of subcutaneous administration of Cinryze

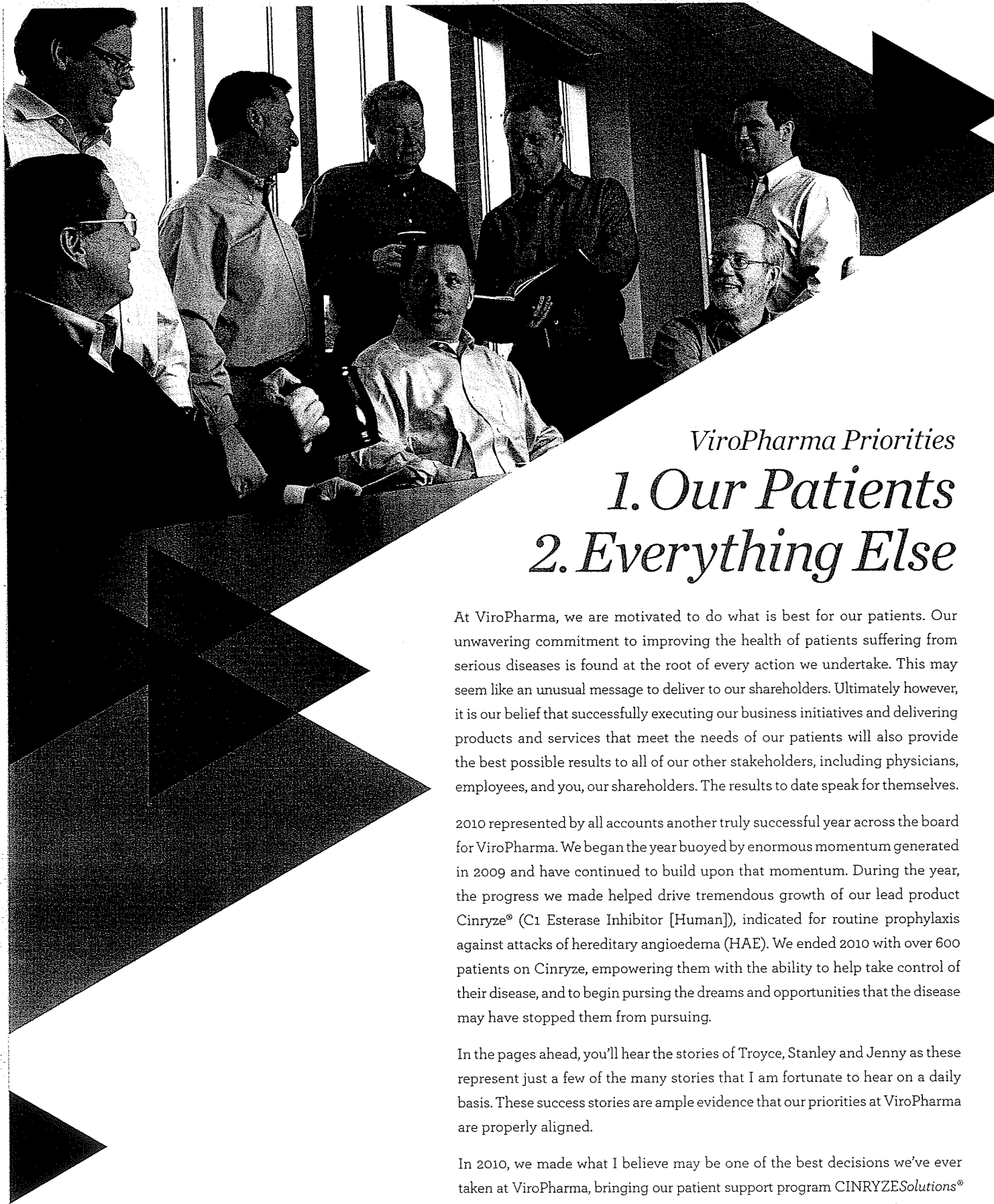
Plans to advance into Phase 3 in 2011

5. Ended 2010 with over 600 patients on Cinryze therapy

2010 Financial Highlights

| (Dollars in thousands, except per share data.) | 2010 | 2009 | 2008 | 2007 | 2006 |
|--|-----------|-----------|-----------|-----------|-----------|
| Consolidated Statement of Operations Data | | | | | |
| Net Product Sales | \$439,012 | \$310,449 | \$232,307 | \$203,770 | \$167,181 |
| Total Operating Expenses ⁽¹⁾ | 227,312 | 278,319 | 153,652 | 87,974 | 68,375 |
| Operating Income | 211,700 | 32,130 | 78,655 | 115,796 | 98,806 |
| Net (Loss) Income | 125,608 | (11,077) | 63,960 | 92,105 | 66,666 |
| Diluted (Loss) Income Per Share | 1.47 | (0.14) | 0.84 | 1.21 | 0.95 |
| Consolidated Balance Sheet Data | | | | | |
| Cash, Cash Equivalents & Short-term Investments | \$505,171 | \$331,672 | \$275,839 | \$584,328 | \$255,409 |
| Working Capital | 561,019 | 406,375 | 317,413 | 596,819 | 266,443 |
| Total Assets | 1,287,574 | 1,084,451 | 1,086,129 | 771,605 | 429,694 |
| Long-term Debt | 145,743 | 138,614 | 161,003 | 153,572 | — |
| Total Stockholders' Equity | 891,135 | 750,387 | 749,334 | 558,530 | 411,899 |

(1) Includes \$69 million and \$2 million in 2009 and 2008, respectively, for non-recurring impairment charges.



ViroPharma Priorities

1. Our Patients

2. Everything Else

At ViroPharma, we are motivated to do what is best for our patients. Our unwavering commitment to improving the health of patients suffering from serious diseases is found at the root of every action we undertake. This may seem like an unusual message to deliver to our shareholders. Ultimately however, it is our belief that successfully executing our business initiatives and delivering products and services that meet the needs of our patients will also provide the best possible results to all of our other stakeholders, including physicians, employees, and you, our shareholders. The results to date speak for themselves.

2010 represented by all accounts another truly successful year across the board for ViroPharma. We began the year buoyed by enormous momentum generated in 2009 and have continued to build upon that momentum. During the year, the progress we made helped drive tremendous growth of our lead product Cinryze® (C1 Esterase Inhibitor [Human]), indicated for routine prophylaxis against attacks of hereditary angioedema (HAE). We ended 2010 with over 600 patients on Cinryze, empowering them with the ability to help take control of their disease, and to begin pursuing the dreams and opportunities that the disease may have stopped them from pursuing.

In the pages ahead, you'll hear the stories of Troyce, Stanley and Jenny as these represent just a few of the many stories that I am fortunate to hear on a daily basis. These success stories are ample evidence that our priorities at ViroPharma are properly aligned.

In 2010, we made what I believe may be one of the best decisions we've ever taken at ViroPharma, bringing our patient support program CINRYZESolutions® in-house. This action, while certainly not a headline grabber or market mover, significantly strengthened our ability to listen and respond to the needs of our patients, and to help patients who could benefit from Cinryze have access. Thanks to this effort, we also have significantly reduced the time it takes for HAE patients to move through the reimbursement process and ultimately begin their therapy.

Our 24 HAE Specialists, deployed throughout the United States, continue to work closely with physicians and their staffs to identify additional patients suffering from HAE who would benefit from Cinryze. The relationship between our HAE specialists and their target audiences is very unique, and quite different from what you would expect from the typical pharmaceutical sales model. Our specialists play a critical role in providing physicians with essential information on the role of Cinryze in preventing attacks of HAE, and to help improve institutional knowledge of the disease. These efforts dovetail well with the excellent work of our Regional Medical Scientists, whose goal is to provide medical education to raise the overall awareness of HAE, which until very recently was not particularly well-known or understood.

Cinryze has thus far positively impacted the lives of many people. We know there are many more out there that this therapy can ultimately help. It was with that mindset that we continued in our efforts throughout 2010 to increase our production capabilities of Cinryze, with our partner Sanquin Blood Supply Foundation. For example, we introduced a parallel chromatography process early in 2010 which essentially doubled our production capability and also worked toward the approval of our larger industrial scale line. While the FDA asked questions that precluded a first cycle approval of our supplement for industrial scale, we and our partner, Sanquin, are committed to achieving our goal of approval in 2011. In addition, increased manufacturing capacity is being developed to help ensure we continue to provide Cinryze to all patients who choose to begin therapy.

Moving beyond the borders of the United States, in 2010 we made tremendous progress toward realizing our goal of building ViroPharma Europe into a commercial organization, and ultimately expanding our ability to provide solutions to patients with unmet medical needs in other territories. In March 2010, we filed our Marketing Authorization Application (MAA) to the European Medicines Agency for Cinryze. We expect a final decision on the filing in 2011 and in anticipation of approval, we've been establishing our presence throughout Europe and to ensure that our infrastructure is in place for a successful commercial launch.

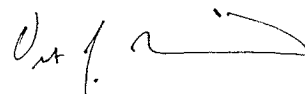
So, beyond the patient needs that we address with our currently marketed products, we made significant progress in 2010 toward supplying solutions to additional needs that still remain. During the year, we successfully conducted a Phase 2 study of a subcutaneous administration of Cinryze, which now propels us toward initiating a Phase 3 study in 2011. We believe that a subcutaneous delivery of Cinryze would not only offer a novel method of delivery for existing Cinryze patients, but may also serve as an additional incentive for other HAE patients to consider the option. There are a number of other investigator-initiated and clinical studies that we expect to commence in 2011 with C1 esterase inhibitor, such as our two planned transplant-focused studies, in the areas of antibody mediated rejection (AMR) and delayed graft function (DGF).

For patients suffering from severe cases of *Clostridium difficile* infections or CDI, our product Vancocin® (vancomycin HCl, USP) remains the gold standard. Our disagreement with the proposed path forward to demonstrate bioequivalence of generic copies of Vancocin continues and the final outcome of this disagreement to this day still is not clear. Rest assured that we will continue to do everything we can to ensure that the best interests and safety of patients are being served.

And, though Vancocin is the trusted drug to treat primary CDI, no product available today or in late stage development can prevent recurrence. In 2010, we made considerable progress advancing our non-toxicogenic *C. difficile* therapy, or VP20621 for prevention of recurrent disease. We completed our Phase 1 study earlier in the year and presented very encouraging data at the 2010 Interscience Conference on Antimicrobial Agents and Chemotherapy (ICAAC). This program will move forward into Phase 2 studies in 2011 as well.

Finally, as a result of all of the progress we made in 2010 and our commitment to meeting the needs of our patients, the financial results for our company have been extremely impressive. We set new revenue records each quarter in 2010, finished the year with record annual product revenue, and continued to improve upon our excellent balance sheet, ending the year with over \$500 million in cash and cash equivalents. This financial strength provides us with numerous options and flexibility to identify other products which ultimately will help more and more patients as well as continue to position ViroPharma to continue demonstrating growth for years to come.

2010 to me represented another consecutive year of positive momentum and excellent execution. It is my goal to continue to execute on all of our plans and keep our focus squarely on the needs of patients. If we are successful, we will be in a similar position next year, telling you about another year of strong momentum and execution, and having met the needs of many more patients suffering from serious diseases. For both the successes in 2010 and the exciting prospects for 2011 and beyond, I would like to thank my colleagues. I am proud to be your teammate.



Vincent J. Milano

March 31, 2011

President, Chief Executive Officer
and Chairman of the Board of Directors

Spend a few minutes with Troyce and you'll know.

Troyce Venturella started having attacks at the age of 12. They came out of the blue. They were debilitating right from the outset and got worse over the years. She went to doctors and saw specialists; she was sent to hospitals and was ambulated to emergency rooms. The answer was always a slightly different version of the same old story. It's probably stress, emotional troubles or some kind of mental disorder. Nobody really believed there was anything physically wrong with her.

Then, in 1989 an ER doctor recognized the disease as hereditary angioedema (HAE). Finally, there was a name for Troyce's condition and someone who understood and could help her. But unfortunately, at the time understanding the disease was a long way from having a therapy that worked for her. Steroids didn't work for her, and she had to have a tracheotomy to open her airway as a result of a laryngeal attack. Then another, and another.

Troyce had to be given a permanent tracheostomy so she could survive a laryngeal episode outside of the hospital. Through it all, she kept her head high and her spirits up. Troyce and her husband were able to have a son in 1992, which she considers a miracle. What is most interesting, is that because of the inflammation and pain from her gastrointestinal attacks, she didn't even realize she was pregnant until five months into the pregnancy. She even went so far as to have a hysterectomy in 1995 because doctors said it might help alleviate attacks. When it didn't bring her relief, her whole family moved to Orlando because it was thought cold weather might be a trigger.

Troyce, like many HAE sufferers, was willing to do anything and everything to prevent the frequency and severity of her attacks. What bothered Troyce the most was the uncertainty that was part of the disease, she felt she could never be counted upon to do anything — whether it be a family function, neighborhood get-together or a work commitment.

In 2006, Troyce was still seeking answers, and she enrolled into a Cinryze® (C1 Esterase Inhibitor [Human]) clinical trial and finally found relief.

And now that she takes Cinryze as a prophylaxis to prevent future attacks, she has also found her freedom from attacks.

She has had her tracheostomy removed and is thrilled that she can be there for her son and her husband.

For the first time in her adult life, Troyce Venturella is able to lead a life free from painful HAE attacks.

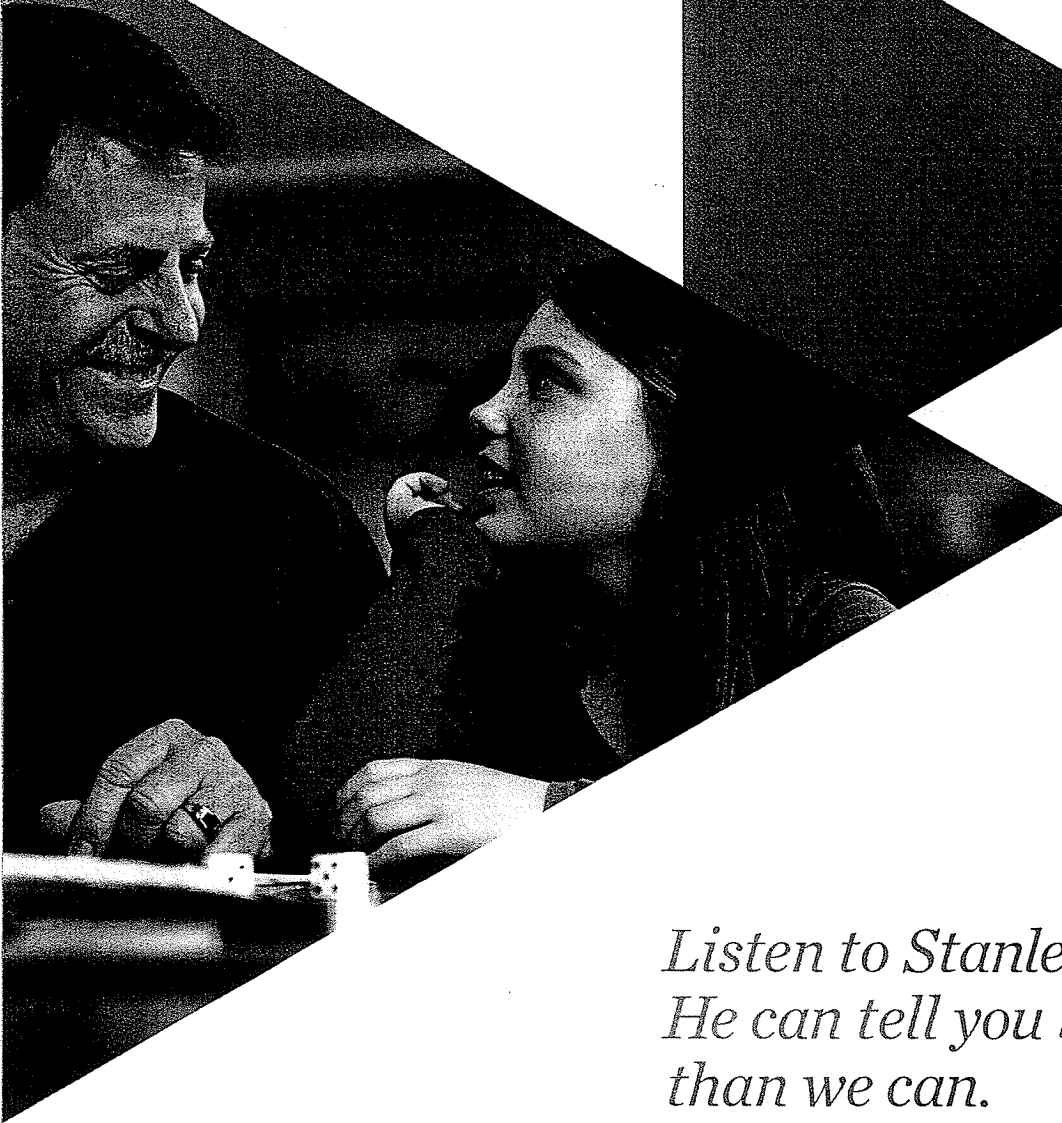
She works full time. She travels wherever she wishes, with her medicine of course. She recently told her personal CINRYZESolutions® program representative, "I often go days without even thinking about that fact that I have HAE."

But perhaps most important of all, Troyce is finally able to help others in her role as a missionary nurse — a dream she had almost given up a few years ago. All of this is possible because she ended a long, painful journey by discovering Cinryze in a 2006 clinical trial. Before Cinryze, it's a journey she wouldn't wish on anyone.

Patients like Troyce are the reason we do what we do. Because of them we'll never be satisfied until our job is done — and thousands of people with diseases like HAE are able find effective therapies the moment they realize they have a problem.



/ Why We Do What We Do /



*Listen to Stanley Clement.
He can tell you better
than we can.*

“The doctor looked at me and he said, ‘Stan, you’re fine. You’re not supposed to feel your stomach.’ I am finally free of the pain. I can’t tell you how good that feels.”

“I can’t remember a time when HAE didn’t control my life. I never lived without pain. The pains would come on, especially in my stomach, and I’d have to stop what I was doing and get help. I couldn’t travel, and I couldn’t commit to many things at work and with friends because I never knew when I’d get an attack.”

“Then I got my first dose of Cinryze® (C1 Esterase Inhibitor [Human]). I wasn’t having an attack or anything before they put in the IV – I felt exactly like I normally felt. But after I got the medicine, I was worried and scared. Something wasn’t right! I called the doctor over and told him I couldn’t feel my stomach anymore.”

“The doctor looked at me and he said, ‘Stan, you’re fine. You’re not supposed to feel your stomach.’

“I am finally free of the pain. I can’t tell you how good that feels.”

Helping people like Stanley live their lives the way they want instead of the way their disease dictates is more than just important to us, it’s why we do what we do.

Because for Jenny, feeling good about herself is just as important as feeling good.

The physical manifestations of HAE are often debilitating. Swelling, nausea and pain, among other symptoms, can keep a patient on the sidelines unable to participate in many of life's activities. But often it's the mental aspects of coping with the disease that prove the hardest to overcome. Helping people like Jenny Ryan regain their positive outlook and the belief that anything is possible is an important reason why we do what we do.

"Living with HAE had kept me on a short leash, close to my parents and familiar places. I lived in fear of HAE attacks. I was afraid of sports, afraid of getting hurt, afraid of sleepovers. Most of all, I feared living a sheltered and isolated life because of my disease. Being able to take a medicine such as Cinryze® routinely to help prevent my attacks of HAE, has given me the seemingly unattainable freedom and independence I longed for. I feel confident about going to college six hours from home this fall. Cinryze has allowed me to find hope for a better future living on my own, and has opened doors to achieving my dreams."

"I can't even begin to express how much it means to me that ViroPharma works so hard to ensure I have my medicine — and saw to it that I received the proper medical education on how to self-administer this life-saving drug."

HAE is not a contagious condition, but the incredible feeling of being burdened by a life-crippling disease definitely is. Being symptom-free has helped Jenny regain her life and laugh when she used to cry.

"Living with HAE had kept me on a short leash, close to my parents and familiar places. I lived in fear of HAE attacks. I was afraid of sports, afraid of getting hurt, afraid of sleepovers. Most of all, I feared living a sheltered and isolated life because of my disease."

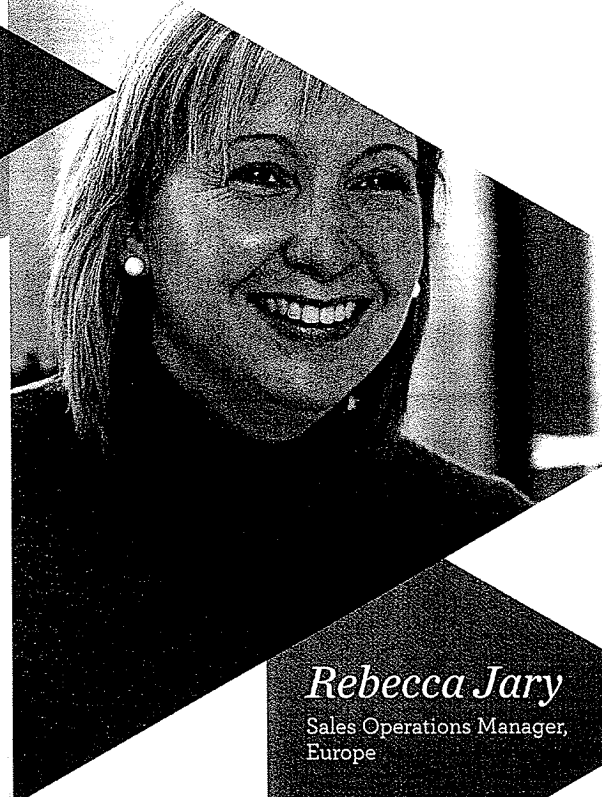


/Who's Doing What and Where/



Iftikhar Ali

Associate Director,
Regulatory Affairs,
Europe



Rebecca Jary

Sales Operations Manager,
Europe



*Samantha
Pilling*

Administrative Assistant,
Europe



*Mark
Sampson*

Vice President,
Clinical Development/
Medical Affairs, Europe

More patients are getting the medicine they need. Here and abroad.

Every biotech company preparing to launch a new drug faces a myriad of challenges. Launch strategies need to be developed, manufacturing and commercial systems need to be established and tested, and markets need to be analyzed and understood. These are just a few examples among countless priorities necessary for success. And most of all, the best people need to be hired to execute the plan.

Of course, all of this must be completed with precision so that the manufacturing, commercialization and delivery process is seamless to patients, caregivers, and doctors from day one.

Those were certainly the circumstances in late 2008 for ViroPharma when Cinryze® (C1 Esterase Inhibitor [Human]) was launched in the United States. And thanks to the work done to prepare for the U.S. approval of the therapy, the launch to date has been the most successful in the history of U.S. ultra-orphan drugs. Those same circumstances apply in Europe as well, where ViroPharma has committed to introducing Cinryze to an additional population of patients suffering from HAE who could benefit from the option of routine prevention against their attacks in addition to pre-procedure prevention, and treatment of attacks.

It's not often that a U.S. biotech company the size of ViroPharma builds an independent organization on another continent. Many companies our size would choose to find partners or license out the rights to their assets in foreign territories. ViroPharma, on the other hand, knew that with Cinryze there was a real opportunity to successfully commercialize the therapy in Europe to provide it to countless other HAE patients in need of therapeutic options – and to further build a foundation that could ultimately establish us as a partner of choice for many of those other companies.

Thierry Darcis M.D., ViroPharma's General Manager, Europe, set about the difficult task of putting all the pieces together with the ultimate goal of ensuring the availability of Cinryze to patients throughout the European Union – all with the goal of preparing for a 2011 approval and launch. Recruiting talented individuals to join the ViroPharma team, though essential to success, was the easy part. Our global team is a unique group of individuals whose core goal is to provide life-changing products to patients in need. Our European staff has grown more than 100 percent in the last year, from under 20 people to over 45 today located in our European offices.

As part of the preparatory work for the launch of Cinryze, in 2010 ViroPharma acquired Auralis, a small company based in Manchester, U.K. with a diamorphine product, which is indicated for use in the treatment of severe pain associated with surgical procedures, myocardial infarction, pain in the terminally ill and for the relief of dyspnea in acute pulmonary edema. This acquisition enabled ViroPharma to test the commercial, supply chain and pharmacological systems, and also to acquire the pharmaceutical sales licenses and contact information needed to insure a smooth introduction for Cinryze.

ViroPharma filed a Marketing Authorization Application (MAA) for Cinryze in March of 2010, and anticipates a regulatory decision by the European Medicines Agency (EMA) in mid-2011.

ViroPharma has created five "clusters," with the intent of growing the business over the next few years as the regulatory process evolves. The clusters as currently in place or envisioned are:

- The United Kingdom
- France, Belgium
- Italy
- Spain, Portugal
- Germany, Austria, Switzerland, Poland,
The Czech Republic, Slovenia

2011 will be an exciting year for ViroPharma in Europe, introducing the first and only centralized product for treatment of attacks, pre-procedure prevention, and routine prevention of HAE attacks – to help numerous patients who suffer from the manifestations of HAE, and to further ViroPharma's evolution to becoming a global, multi-product company.

We do it with commitment and passion. And always in the best interest of our patients.

Because hereditary angioedema (HAE) is an ultra-orphan disease, we require a completely different commercial approach than companies that target more common conditions. The biggest and most important difference is that we personally know, care about, and will do everything in our power to help each and every one of our patients. If a patient asks for help with any aspect of their therapy, ViroPharma will deliver that help.

To ensure that the focus is always on the patient, ViroPharma doesn't hire sales reps with job descriptions similar to other pharmaceutical or biotech companies. Instead, we train and nurture HAE specialists who are responsible to their customers - not to a territory. They are intimately involved with every step in the process, starting with educating physicians and their staff on the signs and symptoms of HAE, so they can better diagnose it. While most typical pharma sales reps are fighting for their 10-second drop off at the office, our HAE specialists are welcomed in by the entire staff. In fact, it is not uncommon for one of our specialists to spend the better part of an entire day with the physician and staff at one office. This year, ViroPharma HAE specialists expanded their reach to educate allergists, immunologists, gastroenterologists and dermatologists about the disease because often these specialties are the patient's most frequent point of contact within the healthcare industry.

This past year was also very important for HAE patients because ViroPharma brought CINRYZESolutions® support program in-house in an effort to help them get quicker access to medication and optimize the management of their disease. ViroPharma Patient Care Coordinators work directly with appropriate patients, doctors, caregivers and benefits investigators to ensure timely access to Cinryze® (C1 Esterase Inhibitor [Human]) and to determine the best site of care. These professionals work tirelessly to ensure that every person who needs Cinryze is able to get it, without regard to income, insurance or personal circumstances.

The goal for many patients is self-administration, but if that's not practical our team will help arrange for treatment in the doctor's office, at an infusion center or at home with a qualified healthcare professional.

To assist in the process, this year we developed the Path to Independence™ program to train appropriate patients and family members in self-infusion.

Patient Care Coordinators respond routinely to the needs of our patients and regularly make proactive calls to them to make sure they are getting their Cinryze and are responding to the therapy. ViroPharma also developed Ryze Above,™ a program that assists appropriate patients in many ways, including a monthly newsletter, patient journals, and a genetic family health tree to identify other family members who might be suffering from HAE. Our travel kit gives many patients the ability to leave home for the first time without the fear of a disabling HAE attack. Many of these initiatives were developed as a direct result of listening to patients' needs and responding to their requests.

ViroPharma is committed to meeting the serious unmet medical needs of patients suffering from diseases such as HAE. To do this requires that we look beyond traditional practices and processes and place our focus where it truly belongs — on our patients.



Jen Bailey
HAE Specialist

1

Preventing recurrence of C. difficile.

Despite the historically high rate of clinical success with Vancocin® (vancomycin HCl, USP), its Achilles' heel has been the approximately 20 to 30 percent of incidents of recurrence. The goal of ViroPharma's novel VP20621 (non-toxigenic *C. difficile*) program is to prevent such recurrence of disease.

ViroPharma acquired VP20621 in February 2006 from Dr. Dale Gerding, of the Hines VA. The concept behind this novel treatment approach aims to prevent disease recurrence and involves the oral administration of non-toxin producing spores of *C. difficile* following initial treatment of acute CDI. The underlying concept is to first treat the disease with an effective product like Vancocin and eradicate the dangerous toxin-producing *C. difficile* which causes severe CDI. The treated patient could potentially then be dosed with oral VP20621 to re-colonize the GI tract and prevent the "bad", or toxic bugs from re-infecting the colon until normal GI flora returns and the patient is no longer susceptible to disease.

We presented data in late 2010 which was very encouraging and showed that we could achieve potentially protective colonization the GI tract of subjects at risk of infection with toxigenic *C. difficile*, and in December of 2010, we filed our U.S. IND. We intend to begin Phase 2 studies in the first half of this year.

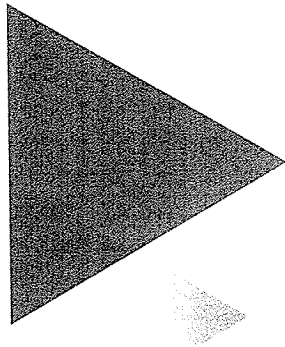
***Christina
Kennedy***

Manager, Budget,
Planning and Analysis

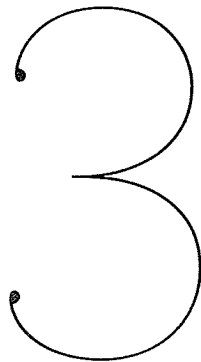
2

Making the administration of Cinryze® (CI Esterase Inhibitor [Human]) easier.

In 2010, we made great strides in advancing our plans to one day introduce to Cinryze patients the option of a subcutaneous administration of the therapy. We completed a Phase 2 repeat dose study of Cinryze utilizing this administration and this study has given us confidence to advance the program into Phase 3 development. In 2011, we will meet with the FDA to review our Phase 2 data as well as our plans for the phase 3 study. Our goal is to commence the study in the 2nd half of the year. We are encouraged by what we have seen to date and look forward to the potential of being able to offer patients an additional administration option for administering their Cinryze.



What's next? Answering the needs that still remain unmet.



Helping transplant patients.

According to the United Network for Organ Sharing (UNOS), there are approximately 100,000 people waiting for a kidney transplant. Physicians focused in transplant medicine must contend with the repercussions of the suppressed immune systems of patients undergoing transplant, including organ failure and rejection, a variety of opportunistic infections, and other transplant complications.

Many of these waiting patients will never have access to life-saving organ transplants because they have antibodies in their system against any potential donor. These antibodies, called donor specific antibodies (DSA), couple with the body's immune proteins, also known as complement, to destroy the transplanted organ in a process called antibody mediated rejection (AMR). As a result of the presence of DSA, these patients – many of whom have a willing live donor – unnecessarily burden the deceased donor wait list, and many will die waiting for a transplant. There is also a great need for new therapeutics to prevent ischemia-reperfusion injury, called delayed graft function (DGF), in kidney transplantation. This complement-mediated damage occurs as a result of preservation of the organ, and the time it takes to remove, transport, and transplant the new organ into the waiting donor.

Because C1 esterase inhibitor is a complement inhibitor, we may be able to impact these complement mediated transplant diseases. We are planning to assess the utility of C1 esterase inhibitor in AMR and DGF, not only to research its utility in these indications, but also to examine the potential of complement inhibition to address a variety of other complement-mediated conditions. Our goal is to begin the AMR and DGF Phase 2 studies this year.



*Gayatri
Raj*

Senior Manager,
Projects and
Business Analysis,
Europe

Paul A. Brooke⁽¹⁾
Managing Director and
Co-Founder, venBio

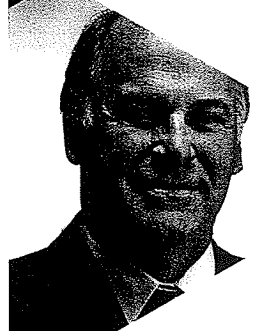


**Vincent J.
Milano**
Chairman of the
Board of Directors,
ViroPharma
Incorporated

**William D.
Claypool, M.D.**⁽²⁾
Senior Partner,
Pennmark
Associates, LLC



**Robert J.
Glaser**⁽²⁾
Senior Partner,
Pennmark
Associates, LLC



**Howard H.
Pien**⁽³⁾
Lead Independent
Director of Board
of Directors,
ViroPharma
Incorporated

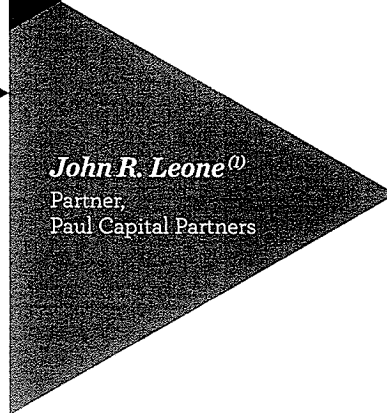


**Michael R.
Dougherty**^(1,3)
President and
Chief Executive
Officer, Adolor
Corporation



**Vincent J.
Milano**
President and Chief
Executive Officer,
ViroPharma
Incorporated

John R. Leone⁽¹⁾
Partner,
Paul Capital Partners



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Vice President and Chief Scientific Officer

John C. Carlisle

Vice President, Plasma Operations

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Thomas F. Doyle, Esq.

Vice President, Strategic Initiatives

Paul E. Firuta

Vice President and Director,
Reimbursement and Managed Care

R. Clayton Fletcher

Vice President, Business Development
and Project Management

Peter A. Galiano

Vice President, Sales

Steven P. Gelone, Pharm. D.

Vice President, Clinical Development Programs

Judith A. Johnson, M.S., M.B.A.

Vice President, Clinical Pharmacology
and Non-Clinical Development

Thomas R. B. Lembck

Vice President, Information Technology and Facilities

Thomas G. Macnamara

Vice President, Human Resources

Vincent J. Milano

Chairman of the Board of Directors,
President and Chief Executive Officer

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Vice President, Technology Development and Operations

Robert G. Pietrusko, Pharm. D.

Vice President, Global Regulatory Affairs and Quality

Wesley N. Riemer

Vice President, Tax

William C. Roberts

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Mark R. Sampson, M.D.

Vice President, Clinical Development
and European Medical Affairs, Europe

Daniel B. Soland

Vice President and Chief Operating Officer

Stephan A. Villano, M.D.

Vice President, Clinical Research and Development

J. Peter Wolf, Esq.

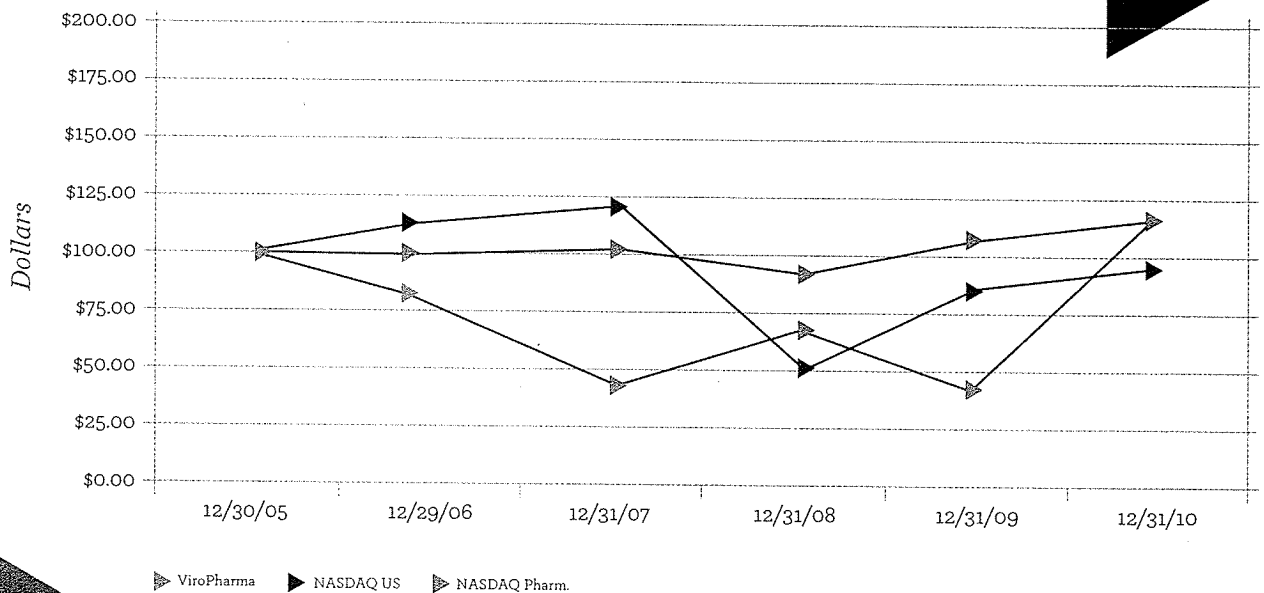
Vice President, General Counsel and Secretary



In Memoriam

Frank Baldino, Jr. was larger than life. His indomitable will and energy was infectious. ViroPharma enjoyed the great fortune of having Frank serve as a member of our board of directors from inception through 2006 and then return in 2009. In December 2010, Frank lost his courageous battle with cancer and we all lost a dear friend, a biotech giant, and valuable member of the ViroPharma family. Our thoughts and prayers remain with his family and we will draw on our experiences with Frank's outstanding qualities as we continue to build our company.

Stock Performance Chart



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This annual report contains forward looking statements relating to our goals of developing and commercializing innovative products addressing life threatening unmet medical needs and improving the lives of patients suffering from serious diseases. Forwarding looking statements include, but are not limited to, those related to, the goals, timing, and potential indications and markets of our clinical and preclinical development programs, our ability to achieve commercial success with Cinryze in the U.S., EU, or other territories; our ability to assure that every patient who needs Cinryze will have access; regulatory approval timelines, including our ability to receive regulatory approval for Cinryze in the EU, and approvals related to the expansion of manufacturing capabilities in the capacities and timeframes currently anticipate, or at all; our opposition to changes to OGD recommendations regarding the path for approval of a generic oral vancomycin; and our plans regarding business development. There can be no assurance that our efforts related to our clinical and preclinical development programs will occur on our estimated timelines, will yield positive results, that the FDA or EMEA would approve any of our product candidates, including NTCD. The FDA or other regulatory authorities may require additional or unanticipated studies or clinical trial outcomes before granting regulatory approval of NTCD or Cinryze. The commercial success of Cinryze will depend on several factors, including: the number of patients with HAE that may be treated with Cinryze; acceptance by physicians and patients of Cinryze as a safe and effective treatment; our ability to effectively market and distribute Cinryze in the U.S. and EU; cost effectiveness of HAE treatment using Cinryze; relative convenience and ease of administration of Cinryze; potential advantages of Cinryze over alternative treatments; the market acceptance of other products approved to treat acute HAE such as Berinert and Kalbitor; patients' ability to obtain sufficient coverage or reimbursement by third-party payors; sufficient supply and reasonable pricing of raw materials necessary to manufacture Cinryze; manufacturing or supply interruptions and capacity which could impair our ability to acquire an adequate supply of Cinryze to meet demand for the product; and our ability to achieve expansion of manufacturing capabilities in the capacities and timeframes currently anticipated. In addition, our ability to develop life cycle management plans for Cinryze, including designing and commencing clinical studies for additional indications and methods of administration, commercializing Cinryze in additional geographic territories and pursuing regulatory approvals in such territories will impact our ability to generate future revenues from Cinryze. There can be no assurance that our efforts to oppose the FDA's bioequivalence guidance for Vancocin will be successful. If FDA's proposed bioequivalence method for Vancocin becomes effective, the time period in which a generic competitor may enter the market would be reduced and multiple generics may enter the market, which would materially impact our operating results, cash flows and possibly asset valuations. We may require additional financing in connection with a business development opportunity. These statements are based on management's current expectations, but the development and commercialization of pharmaceutical products are subject to many risks and uncertainties. Our actual results could differ materially from those results expressed in, or implied by, these forward looking statements. Factors that could cause our actual results to differ significantly from these expectations are described in detail in our annual report on Form 10-K filed with the Securities and Exchange Commission. The forward-looking statements contained in this annual report may become outdated over time. We do not assume any responsibility for updating any forward looking statements. ViroPharma commercializes Cinryze® (C1 Esterase Inhibitor [Human]) for routine prophylaxis against angioedema attacks in adolescent and adult patients with hereditary angioedema (HAE) and Vancocin® (Vancomycin Hydrochloride Capsules, USP), approved for oral administration for treatment of antibiotic-associated pseudomembranous colitis caused by Clostridium difficile and enterocolitis caused by Staphylococcus aureus, including methicillin-resistant strains.

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

FORM 10-K

(Mark One)

Annual report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934
For the fiscal year ended December 31, 2010

OR

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: 000-21699

VIROPHARMA INCORPORATED

(Exact name of registrant as specified in its charter)

Delaware
(State or other jurisdiction of
incorporation or organization)

23-2789550
(I.R.S. Employer
Identification No.)

730 Stockton Drive,
Exton, Pennsylvania
(Address of principal executive offices)

19341
(Zip Code)

Registrant's telephone number, including area code: 610-458-7300

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

| <u>Title of each class:</u> | <u>Name of each exchange on which registered:</u> |
|---------------------------------|---|
| Common Stock, par value \$0.002 | The NASDAQ Stock Market LLC |

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

Title of each class: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined by 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 Section 15(d) of the Exchange 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 is not contained herein, and will not be contained, to the best of 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, or a non-accelerated filer. See definition of "accelerated filer and large accelerated filer" in Rule 12b-2 of the Exchange Act. (Check one):

Large Accelerated Filer Accelerated Filer Non-accelerated filer Smaller Reporting Company

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

The approximate aggregate market value of the voting stock held by non-affiliates of the registrant was approximately \$761.4 million as of June 30, 2010, based upon the closing sale price per share of the Common Stock as quoted on the Global Market segment of the NASDAQ Stock Market on that date.

The number of shares of the registrant's Common Stock outstanding as of February 11, 2011 was 78,189,666 shares.

DOCUMENTS INCORPORATED BY REFERENCE

As stated in Part III of this Annual Report on Form 10-K, portions of the registrant's definitive proxy statement for the registrant's 2011 Annual Meeting of Stockholders scheduled to be held on May 23, 2011 are incorporated by reference in Part III of this Annual Report on Form 10-K.

VIROPHARMA INCORPORATED
FORM 10-K ANNUAL REPORT
For Fiscal Year Ended December 31, 2010
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“ViroPharma,” “ViroPharma” plus the design, “Cinryze”, CinryzeSolutions and “Vancocin” are trademarks and service marks of ViroPharma or its licensors. We have obtained trademark registration in the United States for the marks in connection with certain products and services. All other brand names or trademarks appearing in this Annual Report on Form 10-K are the property of others.

Unless the context requires otherwise, references in this report to “we,” “our,” “us,” “Company” and “ViroPharma” refer to ViroPharma Incorporated and its subsidiaries.

PART I

ITEM 1. BUSINESS

ViroPharma Incorporated and subsidiaries is a global biotechnology company dedicated to the development and commercialization of products that address serious diseases, with a focus on products used by physician specialists or in hospital settings. We intend to grow through sales of our marketed products, through continued development of our product pipeline, expansion of sales into additional territories outside the United States, through potential acquisition or licensing of products and product candidates and the acquisition of companies. We expect future growth to be driven by sales of Cinryze, both domestically and internationally, and by our primary development programs, including C1 esterase inhibitor and a non-toxicogenic strain of *C. difficile* (VP20621).

We market and sell Cinryze in the United States for routine prophylaxis against angioedema attacks in adolescent and adult patients with hereditary angioedema (HAE). Cinryze is a C1 esterase inhibitor therapy for routine prophylaxis against HAE, also known as C1 inhibitor (C1-INH) deficiency, a rare, severely debilitating, life-threatening genetic disorder. Cinryze was obtained in October 2008, when we completed our acquisition of Lev Pharmaceuticals, Inc. (Lev). In January 2010, we acquired expanded rights to commercialize Cinryze and future C1-INH derived products in certain European countries and other territories throughout the world as well as rights to develop future C1-INH derived products for additional indications. In March 2010, our Marketing Authorization Application (MAA) for Cinryze for acute treatment and prophylaxis against HAE was accepted by the European Medicines Agency (EMA). We intend to seek to commercialize Cinryze in Europe in 2011 in countries where we have distribution rights. We are currently evaluating our commercialization plans in additional territories. We also intend to conduct ViroPharma sponsored studies and support investigator-initiated studies (IIS) to identify further therapeutic uses and potentially expand the labeled indication for Cinryze to include other C1 mediated diseases, such as Antibody-Mediated Rejection (AMR) and Delayed Graft Function (DGF). Additionally, we are currently undertaking studies on the viability of subcutaneous administration of Cinryze.

We also market and sell Vancocin HCl capsules, the oral capsule formulation of vancomycin hydrochloride, in the U.S. and its territories. Vancocin is a potent antibiotic approved by the U.S. Food and Drug Administration, or FDA, to treat antibiotic-associated pseudomembranous colitis caused by *Clostridium difficile* infection (CDI), or *C. difficile*, and enterocolitis caused by *Staphylococcus aureus*, including methicillin-resistant strains.

Our product development portfolio is primarily focused on two programs, C1 esterase inhibitor [human] and VP20621. We are working on developing further therapeutic uses; potential additional indications in other C1 mediated diseases, and alternative modes of administration for C1 esterase inhibitor. We are also developing VP20621 to prevent recurrence of CDI using a novel non-antibiotic approach. On August 6, 2009 we announced that dosing had begun in the Phase 1 clinical trial for VP20621 to determine the safety and tolerability of VP20621 dosed orally as a single and as repeat escalating doses in healthy young and older adults. We have successfully completed our Phase 1 clinical trial, filed an IND in December of 2010 and anticipate moving the compound into a Phase 2 clinical trial in the first half of 2011.

In addition to these programs, we have several other assets in which we may make additional investments. These investments will depend on our assessment of the potential future commercial success of or benefits from the asset. On May 28, 2010 we acquired Auralis Limited, a UK based specialty pharmaceutical company. The acquisition of Auralis provides us with the opportunity to accelerate our European commercial systems for potential future product launches and additional business development acquisitions.

We intend to continue to evaluate in-licensing or other opportunities to acquire products in development, or those that are currently on the market. We plan to seek products that treat serious or life threatening illnesses with a high unmet medical need, require limited commercial infrastructure to market, and which we believe will provide both revenue and earnings growth over time.

We were incorporated in Delaware in September 1994 and commenced operations in December 1994. Our executive offices are located at 730 Stockton Drive, Exton, Pennsylvania 19341, our telephone number is 610-458-7300 and our website address is www.viropharma.com. Information contained on our website is not incorporated into this Annual Report on Form 10-K or any other filings we make with the SEC.

The following chart generally describes our approved products:

| <u>Product</u> | <u>Marketplace</u> | <u>Disease</u> | <u>Program Indication</u> | <u>Product Status</u> |
|----------------|--------------------|----------------|---------------------------|-----------------------|
| Cinryze - IV | US | HAE | Prophylaxis | Marketed |
| Vancocin | US | CDI | Treatment | Marketed |

The following chart generally describes our investigational products:

| <u>Product</u> | <u>Marketplace</u> | <u>Disease</u> | <u>Proposed Indication</u> | <u>Product Status</u> |
|---|--------------------|---|----------------------------|-----------------------|
| C1 esterase inhibitor [human] – IV | EU | HAE | Prophylaxis and acute | MAA filed |
| C1 esterase inhibitor [human] – IV | ROW* | HAE | Prophylaxis and acute | Prefiling |
| Non-toxicogenic strain of <i>C. difficile</i> (VP20621) | Worldwide | CDI | Treatment and prevention | Entering Phase 2 |
| C1 esterase inhibitor [human] – subcutaneous administration | Worldwide | HAE | Prophylaxis | Phase 2 |
| C1 esterase inhibitor [human] – IV | Worldwide | Additional indications under evaluation | | Preclinical |

* ROW is defined in the Strategic Relationships section of the document.

Marketed Products

Cinryze

The FDA granted approval for Cinryze in October 2008 for routine prophylaxis against attacks in adolescent and adult patients with hereditary angioedema (HAE). HAE is a genetic disorder characterized by episodes of edema (swelling) in the extremities, face, abdomen, and airway passages. The majority of patients have episodes of severe abdominal pain, nausea and vomiting that is caused by swelling in the intestinal wall. Attacks that involve the face and throat must be taken seriously and medical treatment should be sought without delay. Swelling of the throat can close the air passage and cause death by suffocation. The mortality rate from untreated airway obstruction has been reported to be over 40% with death most frequently caused by asphyxiation due to airway closure. The course of the disease is diverse and unpredictable, even within a single patient over his or her lifetime. Swelling caused by HAE usually lasts for 24-72 hours, but the length of an attack can range from four hours to four days. On average, patients experience approximately one attack per month, but the frequency is highly variable.

HAE is caused by a defective gene for C1 inhibitor (C1-INH), and this defect is passed on in families, such that a child has a 50% chance of inheriting this disease if one parent is affected. The absence of family history, however, does not rule out HAE diagnosis, and as many as 20% of HAE cases involve patients who appear to have had a spontaneous mutation of the C1-INH gene. This genetic defect results in the production of either inadequate levels or poorly functioning C1-INH protein.

C1-INH is a normal constituent of human blood and primarily regulates activation of key inflammatory and coagulation biochemical pathways, specifically the contact and complement pathways in addition to the fibrinolytic system. Regulation of these systems is performed through the formation of complexes between

pathway proteinase enzyme and C1-INH, resulting in inactivation of both and consumption of C1-INH. HAE patients have low levels of endogenous or functional C1-INH. Although the events that induce angioedema attacks in HAE patients are not well defined, it is thought that increased blood vessel permeability leading to swelling and the clinical manifestations of HAE attacks are mediated primarily through contact system activation. Administration of Cinryze increases plasma levels of C1-INH activity. Increased levels of functional C1-INH are thought to suppress contact system activation through the inactivation of plasma kallikrein and factor XIIa, preventing the generation of bradykinin, a natural peptide thought to be responsible for modulation of blood vessel permeability.

Because HAE is rare and has a wide variability in disease expression, it is not uncommon for patients to remain undiagnosed or misdiagnosed for many years. Many patients report that their frequent and severe abdominal pain was inappropriately diagnosed as psychosomatic. Although rare, HAE is a disease with potentially catastrophic consequences for those affected. Aside from the potentially fatal acute respiratory compromise, unnecessary exploratory surgery has been performed on patients experiencing gastrointestinal edema because abdominal HAE attacks mimic conditions requiring surgery.

Traditionally, HAE has been classified into two types (I and II). The most common form of the disease, Type I, is characterized by low levels of C1-INH and affects about 85% of patients, whereas Type II HAE affects 15% of patients and is characterized by poorly functioning C1-INH. A third type of HAE has been identified in which the abnormal C1-INH protein binds to albumin, effectively reducing the amount of functional C1-INH.

Current Treatments of HAE

Treatment of HAE can be categorized as: (i) mitigation or acute treatments to remedy the symptoms of infrequent episodic acute attacks; and (ii) preventive or prophylactic treatments for patients severely affected by HAE.

Current therapies primarily focus upon treating the symptoms of an acute attack. Two therapeutic agents that can be used for treatment of acute attacks were approved by the FDA in 2009, a kallikrein inhibitor and a C1-INH. For swelling of the intestinal wall, which can cause debilitating pain, narcotics such as morphine and antiemetics for nausea are often given. For severe laryngeal swelling, which can be life threatening, rescue therapy such as intubation or tracheotomy may be required. The use of fresh frozen plasma, which contains C1-INH but which also contains a wide variety of other factors that may activate multiple inflammatory pathways and exacerbate an attack, is also used in some instances.

Cinryze is the only FDA approved C1-INH product for prevention of HAE attacks. Prior to the approval of Cinryze, patients who experience more than one attack per month have historically been treated with anabolic steroids that reduce the frequency of attacks of edema. The most commonly used steroids are alpha-alkylated androgens. Use of such anabolic steroids can have numerous side effects ranging from hepatotoxicity (liver toxicity), virilization (development of male sexual characteristics in a female), weight gain, acne and hirsutism (unwanted hair growth).

The FDA granted Cinryze seven years of marketing exclusivity for routine prophylaxis of HAE upon FDA approval pursuant to the Orphan Drug Act. The Office of Orphan Products Development originally granted orphan drug designation for Cinryze on July 16, 2004. We are currently conducting a phase 4 study to evaluate the safety and effect of escalating doses of Cinryze as prophylactic therapy which was a post approval requirement of the FDA.

Vancocin

In November 2004, we acquired all rights in the U.S. and its territories to manufacture, market and sell Vancocin, as well as rights to certain related vancomycin products, from Eli Lilly and Company (Lilly). Lilly retained its

rights to Vancocin outside of the U.S. and its territories. Vancocin is approved by the FDA for treatment of enterocolitis caused by *S. aureus* (including methicillin-resistant strains) and antibiotic associated pseudomembranous colitis caused by *C. difficile*. Both are potentially serious infections of the gastrointestinal (GI) tract. *S. aureus* enterocolitis is rare; accordingly, infection with *C. difficile* is the indication that accounts for the majority of Vancocin's use.

CDI is an infection of the GI tract. The clinical manifestations, ranging from diarrhea to toxic megacolon and sometimes death, are a result of toxins produced by the bacterium that cause inflammation in the colon. Hospitalized patients, those residing in long-term care centers, those greater than 65 years of age, and patients that have received broad-spectrum antibiotic therapy, are at greatest risk to acquire CDI.

CDI is not a nationally reportable disease and as such it is difficult to estimate the actual incidence of disease with precision. Based on reports from the Centers for Disease Control and Prevention (CDC) and peer-reviewed publications, we estimate that at least 500,000 patients were affected by CDI in 2008. From 2004 to 2008, many clinicians reported treating increasing numbers of patients with severe CDI and increased mortality rates. Clinicians have also noted that some patients progressed from mild/moderate disease to severe disease or death more rapidly than had previously been observed. The overall incidence of CDI may have plateaued or even decreased since 2008, however reliable data on current incidence are limited.

Although the causes for this change in CDI remain under active investigation, the CDC has postulated that a combination of changes in antibiotic use and infection control practices, along with the emergence of a hypervirulent strain of *C. difficile*, are likely contributors to the increased incidence seen during the 2004 to 2008 time period. As of late 2008, this strain (referred to as the toxinotype III, BI, or NAP1/027 strain) has been identified in at least 40 states in the U.S.

Vancocin is the only drug approved by the FDA for the treatment of antibiotic-associated pseudomembranous colitis caused by *C. difficile*. Historically metronidazole has been commonly used as first-line treatment for CDI, while Vancocin has been reserved for those patients who have failed metronidazole, have recurrent disease, or who are suffering from severe CDI. We believe that changes in the epidemiology of CDI, in particular the increasing frequency of severe disease, and data suggesting that failure or relapse occur more commonly in patients treated with metronidazole have led to an increase in the use of Vancocin.

In December 2008, FDA changed OGD's 2006 bioequivalence recommendation, which we have opposed since its original proposal in March 2006, by issuing draft guidance for establishing bioequivalence to Vancocin which would require generic products that have the same inactive ingredients in the same quantities as Vancocin ("Q1 and Q2 the same"), and that meet certain other conditions, to demonstrate bioequivalence through comparative in vitro dissolution testing. Under this latest proposed method, any generic product that is not Q1 and Q2 the same as Vancocin would need to conduct an in vivo study with clinical endpoints to demonstrate bioequivalence with Vancocin. On August 4, 2009 the FDA's Pharmaceutical Science and Clinical Pharmacology Advisory Committee voted in favor of the portion of the OGD's 2008 draft guidelines on bioequivalence for Vancocin that restricts in vitro bioequivalence testing for generic products that are, among other things, Q1 and Q2 the same as Vancocin.

Product Pipeline

Our product development portfolio is primarily focused on two programs: Cinryze (C1 esterase inhibitor [human]) for management of hereditary angioedema and VP 20621 for the management of *C. difficile* infection (CDI). We are also working on developing alternative modes of administration for Cinryze and additional therapeutic uses for C1 esterase inhibitor in other complement-mediated diseases.

HAE Program

Cinryze IV – Outside the United States

In January 2010, we obtained expanded rights to commercialize Cinryze in certain countries in Europe and ROW as well as rights to develop future C1-INH derived products for additional indications. We intend to commercialize Cinryze in Europe when the product has received the EMA commission approval which we anticipate during 2011. HAE affects between 1 in 30,000 and 1 in 50,000 individuals in Europe. We are seeking approval to market intravenous (IV) Cinryze to patients in Europe for the treatment and prevention of angioedema attacks in patients with HAE. Part of this commercialization plan was obtaining Orphan Drug designation for Europe which was initially granted in October 2009.

C1-INH concentrate has been marketed to HAE patients for acute treatment in Europe for 25 years. Our ability to compete in this marketplace is contingent upon our success in differentiating Cinryze IV over existing C1-INH products.

We are currently in the process of identifying the steps necessary to launch in territories outside of the US and EU.

Cinryze IV – Other formulations and other complement-mediated diseases

We are currently evaluating with our partner Sanquin, the feasibility of other (non-IV) formulations and modes of administration for Cinryze. We have conducted a Phase 1 study utilizing subcutaneous administration of Cinryze, and results of this study supported the conduct of a Phase 2 study. In October 2010 we announced the completion of enrollment in this Phase 2 study which is designed to evaluate the safety, pharmacokinetics and pharmacodynamics of subcutaneous versus intravenous administration of Cinryze in adolescent and adult subjects with hereditary angioedema (HAE). The data from this Phase 2 study was supportive of advancement with the current formulation and we anticipate initiating a Phase 3 study in the later part of 2011. We are also evaluating a recombinant C1-INH technology which may be included in future clinical studies.

We continue to evaluate Cinryze for additional therapeutic applications and potential indications in other complement-mediated diseases. Our initial focus includes investigating Cinryze in transplant patients, and we anticipate initiation of a pilot study in the first quarter of 2011 to evaluate Cinryze for the treatment of antibody-mediated rejection following certain high-risk kidney transplants.

CDI Program

VP20621

In February 2006, we announced that we had entered into a licensing agreement with Dr. Dale Gerding, of the Hines VA, for the rights to develop a non-toxic strain of *C. difficile* (VP 20621) for the treatment and prevention of CDI. Under the license agreement, we are required to make royalty payments to Dr. Gerding based on a low single digit percentage of our net sales of the product. If certain milestones are achieved, we will be obligated to pay Dr. Gerding additional milestone payments if and when certain regulatory developments are achieved, in an aggregate amount equal to \$850,000 in total, with no single milestone payment exceeding \$250,000. The license agreement will remain in effect for ten years from the date any product is first commercialized, on a country-by-country basis, unless earlier terminated. The agreement contains a standard early termination provision which provides for early termination by either party in the event certain conditions have occurred, including, but not limited to, either party's breach of the agreement, either party's filing for bankruptcy or either party making an assignment for the benefit of its creditors.

We plan to initially focus our efforts on the opportunity to prevent recurrence of CDI, using oral administration of VP 20621 spores. According to published literature, approximately 20 to 30 percent of patients suffering from

CDI will have at least one episode of relapse of disease. The goal of this VP20621 program is to prevent such recurrence of disease using a novel non-antibiotic approach. The underlying concept of this approach is to first treat the disease with an effective product like Vancocin and eradicate the dangerous toxin-producing *C. difficile* which causes severe CDI. The treated patient could potentially then be dosed with oral VP20621 to re-colonize the GI tract and prevent the pathogenic *C. difficile* bacteria from re-infecting the colon until normal GI flora returns and the patient is no longer susceptible to disease.

In September 2010 we announced results of a completed Phase 1 study which was designed to determine the safety and tolerability of VP20621 dosed orally as single and repeat escalating doses in healthy young (18 to 45 years of age) and older (60 years of age and older) adults. After VP20621 was shown to be generally well tolerated following single and repeat doses in younger and older healthy subjects, we also performed repeat dosing in older adults following exposure to oral antibiotic. Subjects above 60 years of age were pre-dosed with oral vancomycin to disrupt their gastrointestinal flora and render them potentially susceptible to *C. difficile* colonization; these subjects were subsequently given either placebo or VP20621 doses of $10^{(4)}$, $10^{(6)}$, or $10^{(8)}$ spores once daily for 14 days. The study demonstrated that VP20621 was generally well tolerated at all dose levels; there were no serious or severe adverse events, and no discontinuations from study drug due to adverse events. All 27 volunteers (100%) who were given VP20621 had positive non-toxicogenic *C. difficile* stool cultures by day 6, suggesting that VP20621 rapidly colonizes the susceptible GI tract. No subject dosed with VP20621 tested positive for toxin-producing strains of *C. difficile* during the 28-day study period. By comparison, 5 of 9 subjects (56%) who received placebo (i.e. did not receive VP20621) tested positive for either toxin-negative or toxin-positive *C. difficile* during the study period. Based on these results, we anticipate moving the compound into a Phase 2 clinical trial for the prevention of recurrence of CDI in patients recently treated with an antibiotic for CDI. Separately, we are also evaluating the potential for VP20621 to be used as primary prevention for CDI in certain high-risk populations.

Other Assets

In addition to the marketed products and the programs described above, we have several other assets in which we may make additional investments. These investments will be dependent on our assessment of the potential future commercial success of or benefits from the asset. These assets include a compound for the treatment of acute pain, maribavir for CMV and a compound for the treatment of pediatric epilepsy.

Business Development

We intend to continue to evaluate in-licensing or other opportunities to acquire development stage or marketed products. We plan to seek products that treat serious or life threatening illnesses with a high unmet medical need, require limited commercial infrastructure to market, and that have the potential to provide both top and bottom line growth over time.

Competition for products currently in clinical development, or that are currently on the market, is intense and may require significant resources. There is no assurance that we will be successful in acquiring such products, or that such products can be acquired on terms acceptable to us. Additionally, if we are successful in acquiring a marketed product, we may have to expand our sales and marketing infrastructure both in the US and internationally. There is no assurance that we would be successful in expanding our commercial capabilities, that we would be able to penetrate the markets for any such products or that we could achieve market acceptance of our products. The costs associated with evaluating or acquiring any additional product or product candidate can vary substantially based upon market size of the product, the commercial effort required for the product, the product's current stage of development, and actual and potential generic and non-generic competition for the product, among other factors. Due to the variability of the cost of evaluating or acquiring business development candidates, it is not feasible to predict what our actual evaluation or acquisition costs would be, if any, however, the costs could be substantial. There are also no assurances that we will be able to obtain financing for acquiring such products or to expanding our operations to realize the products potential.

In May 2010, we acquired Auralis, a UK based specialist pharmaceutical company focused on ensuring the availability and appropriate formulation of important medicinal products which address unmet medical needs for £10 million Pounds Sterling (\$14.5M US dollars) in upfront consideration. ViroPharma has agreed to pay an additional payment of £10 million Pounds Sterling (approximately \$15.5 million based on the December 31, 2010 exchange rate) upon the first European Medicines Agency (EMA) regulatory approval of a product in late stage development.

In October 2008, we completed our acquisition of Lev. Lev was a biopharmaceutical company focused on developing and commercializing therapeutic products for the treatment of inflammatory diseases. The terms of the merger agreement provided for the conversion of each share of Lev common stock into upfront consideration in the aggregate amount of \$453.1 million, or \$2.75 per Lev share, comprised of \$2.25 per share in cash and \$0.50 per share in ViroPharma common stock, and contingent consideration (CVRs) of up to \$1.00 per share which may be paid upon the achievement of certain regulatory and commercial milestones.

As part of the merger consideration payable to the former stockholders of Lev, we agreed to make up to two CVR payments upon the achievement of regulatory and commercial targets. Only the second CVR as described below remains achievable. The target for the first CVR payment of \$0.50 per share (or \$87.5 million) will not be paid as a third party's human C1 inhibitor product was approved for the acute treatment of HAE and granted orphan exclusivity. The second CVR payment of \$0.50 per share (\$87.5 million) becomes payable if Cinryze reaches at least \$600 million in cumulative net product sales by October 2018 and we anticipate achieving this milestone in 2012.

Strategic Relationships

Cinryze and Sanquin

Pursuant to the terms of an existing Distribution and Manufacturing Services Agreement between our subsidiary ViroPharma Biologics, Inc. ("VP Biologics") with Stichting Sanquin Bloedvoorziening (Sanquin Blood Supply Foundation) ("Sanquin") (the "Original Sanquin Agreement"), we held (i) the exclusive right to distribute, market, offer for sale, sell, import and promote C1-INH derived from human plasma (including Cinryze) manufactured by Sanquin for the treatment of HAE in all countries in North America and South America (other than the Dutch Overseas Territories, Argentina and Brazil) and Israel, and (ii) a right of first refusal to distribute, market, offer for sale, sell, import and promote C1-INH derived from human plasma manufactured by Sanquin for the treatment of HAE in certain other geographic regions and under certain conditions.

On January 8, 2010, we amended and restated the Original Sanquin Agreement (the "Restated US Agreement"). Pursuant to the terms of the Restated US Agreement, we retained the rights to distribute, market, offer for sale, sell, import and promote C1-INH derived from human plasma (including Cinryze) manufactured by Sanquin for the treatment of HAE in all countries in North America and South America (other than the Dutch Overseas Territories, Argentina and Brazil) and Israel.

The initial term of the Restated US Agreement ends on December 31, 2015. The term will automatically renew for up to eighteen years (comprised of six three-year periods), unless the Restated US Agreement is earlier terminated by either party. Sanquin may terminate this Restated US Agreement by providing written notice to us at least three years prior to the end of the initial term or any subsequent renewal period. We may terminate the Restated US Agreement by providing written notice to Sanquin at least two years prior to the end of the initial term or any subsequent renewal period. Each party may terminate the Restated US Agreement upon written notice in the event of: (i) an uncured material breach of the other party or (ii) the other party is declared insolvent or bankrupt, a voluntary petition of bankruptcy is filed by the other party, the other party makes or executes any assignment for the benefit of creditors or a receiver is appointed to control the business of the other party.

Also, on January 8, 2010 we obtained the exclusive rights to research, develop, import, use, sell and offer for sale C1-INH derived products (other than Ceter) worldwide, other than the Excluded Territory (as defined below) for

all potential indications pursuant to a Manufacturing and Distribution Agreement (Europe and ROW) between our European subsidiary, ViroPharma SPRL (“VP SPRL”) and Sanquin (the “ROW Agreement”). The Excluded Territory includes (i) certain countries with existing distributors of Cinryze, Cetor and Cetor NF namely France, Ireland, the United Kingdom, Egypt, Iran, Israel, Indonesia, Turkey, Argentina and Brazil (the “Third Party Distributors”) and (ii) countries in which Sanquin has historically operated namely, Belgium, Finland, Luxemburg and The Netherlands (including the Dutch Overseas Territories) (the “Precedent Countries” and collectively, the “Excluded Territory”). In the event that any agreement with a third party distributor in the Excluded Territory is terminated, we have a right of first refusal to obtain the foregoing exclusive licenses to the C1-INH derived products with respect to such terminated country.

The initial term of the ROW Agreement will end on December 31, 2019, but shall automatically renew for up to eighteen years (comprised of six three-year periods), unless the ROW Agreement is earlier terminated by either party. Sanquin may terminate the ROW Agreement by providing written notice to us at least three years prior to the end of the initial term or any subsequent renewal period. We may terminate the ROW Agreement by providing written notice to Sanquin at least two years prior to the end of the initial term or any subsequent renewal period. Each party may terminate the ROW Agreement upon written notice to the other in the event of: (i) an uncured material breach of the other party or (ii) in the event that other party (1) applies for or consents to an appointment of a receiver for itself or all or substantially all of its assets, (2) makes an assignment for the benefit of creditors, (3) commences a voluntary case or bankruptcy or consents to any bankruptcy or restructuring relief or the appointment of or taking possession of its property in any such proceeding or (4) takes any corporate action to effect any of the foregoing.

In January 2010, both parties established a Joint Steering Committee comprised of an equal number of representatives from each of the parties to the agreements. The Joint Steering Committee shall serve as a forum to establish and discuss progress under, among others, (i) a global commercialization plan; (ii) clinical development programs of ViroPharma and Sanquin early stage research programs; (iii) manufacturing capacity schedules; (iv) pharmacovigilance matters; (v) quality matters; (vi) manufacturing improvement programs; and (vii) regulatory matters.

Subject to certain terms of each of the Restated US Agreement and the ROW Agreement, if we do not use commercially reasonable efforts to file applications for marketing authorization of Cinryze or launch Cinryze in accordance with a commercialization plan for the applicable territories, as approved by the Joint Steering Committee, Sanquin may (upon prior written notice to us) terminate our rights in the applicable country.

In addition, pursuant to the terms of the ROW Agreement, Sanquin may conduct certain early stage research programs (the “Early Stage Research Programs”), and we will provide to Sanquin €1,000,000 (approximately \$1.3 million based on the December 31, 2010 exchange rate) per year for a period of five years to support such Early Stage Research Programs. We have a right of first refusal to further develop and commercialize the subject matter of each such Early Stage Research Program worldwide (except for the Excluded Territory) subject to Sanquin’s and its research partners’ right to use any such intellectual property for their internal, non-commercial research purposes. Except for the Early Stage Research Programs, we will be solely responsible for conducting all clinical trials and other development activities necessary to support our efforts to obtain regulatory approval of Cinryze in additional territories as well as any future C1-INH derived products developed pursuant to the ROW Agreement. Sanquin has the right to approve any such clinical trials and development activities through the Joint Steering Committee.

Sanquin may include in its regulatory dossiers improvements to Cinryze for the hereditary angioedema (“HAE”) indication, solely for the marketing and sale of Cetor or Cetor NF in the Excluded Territory. If there are (i) new indications relating to any C1-INH product or (ii) improvements relating to the HAE-indication that cannot be included in Sanquin’s regulatory dossiers, Sanquin will receive a royalty-free license to sell Cinryze or the future product for these new indications or improvements in the Precedent Countries.

Sanquin has agreed to indemnify us and our affiliates for certain losses, except to the extent we have an obligation to indemnify Sanquin. We have agreed to indemnify Sanquin and its affiliates for all losses arising from (i) our infringement of any third party's intellectual property as a result of the sale of Cinryze or any future C1-INH derived products in the territories covered by the agreements, (ii) a breach by us of the terms of the agreements, (iii) certain tax liabilities and (iv) our negligence or willful misconduct, except, in each case, to the extent Sanquin has an obligation to indemnify us.

Without Sanquin's prior written consent, we shall not enter into a merger, be acquired by or sell substantially all of our assets to a manufacturer and/or distributor of a plasma derived C1 esterase inhibitor or another plasma-derived product approved under applicable law for marketing for the same or comparable clinical indications as Cinryze or any future C1-INH derived products. We may not, without the consent of Sanquin, distribute, market, offer for sale, sell, import or promote any competitive product in the territory covered by the Restated US Agreement until December 31, 2018. In addition, we may not, without the consent of Sanquin, distribute, market, offer for sale, sell, import or promote any competitive product in the territories covered by the ROW Agreement until December 31, 2019.

In the event that VP Biologics has become bankrupt or insolvent and has committed an uncured breach of the Restated US Agreement, Sanquin will immediately obtain VP Biologics' rights to the marketing authorizations for Cinryze obtained by us and the applications for marketing authorization of Cinryze filed by us. ViroPharma Incorporated will guarantee VP Biologics' performance under the Restated US Agreement. In the event that VP SPRL becomes bankrupt or insolvent and commits an uncured breach of the ROW Agreement, Sanquin will immediately obtain our rights to the regulatory approvals for the products obtained by us under the ROW Agreement and the applications for regulatory approval of the product filed by us under the ROW Agreement. ViroPharma Incorporated will guarantee VP SPRL's performance under the ROW Agreement in the event of a bankruptcy.

Vancocin Capsules and Lilly

In November 2004, we acquired all rights in the U.S. and its territories to manufacture, market and sell Vancocin, the oral capsule formulation of vancomycin hydrochloride, as well as rights to certain related vancomycin products, from Lilly. Vancocin is a potent antibiotic approved by the FDA to treat antibiotic-associated pseudomembranous colitis caused by *C. difficile* and enterocolitis caused by *S. aureus*, including methicillin-resistant strains. Lilly retained its rights to vancomycin outside of the U.S. and its territories.

We paid Lilly an upfront cash payment of \$116.0 million and we are obligated to pay additional purchase price consideration based on annual net sales of Vancocin through 2011. As of December 31, 2010, we have paid an aggregate of \$44.1 million to Lilly in additional purchase price consideration, as our net sales of Vancocin surpassed the maximum obligation level of \$65 million in 2005 through 2010.

We are obligated to pay Lilly additional amounts based on 35% of annual net sales between \$45 and \$65 million of Vancocin in 2011. No additional payments are due to Lilly on net sales of Vancocin below or above the net sales levels. We account for additional purchase price consideration as contingent consideration and record an adjustment to the carrying amount of the related intangible assets and a cumulative adjustment to the intangible amortization upon achievement of the related sales milestones.

In the event we develop any product line extensions, revive discontinued vancomycin product lines (injectable or oral solutions), make improvements of existing products, or expand the label to cover new indications, Lilly would receive a royalty on net sales on these additional products for a predetermined time period.

Cytomegalovirus and GlaxoSmithKline

In August 2003, we entered into a license agreement with GlaxoSmithKline (GSK) under which we acquired worldwide rights (excluding Japan) to an antiviral compound, maribavir, for the treatment of CMV disease. Maribavir is a benzimidazole compound that was in development by GSK for the treatment of CMV retinitis in HIV positive patients.

Under the terms of the agreement, we have exclusive worldwide rights (excluding Japan) to develop and commercialize maribavir for the prevention and treatment of cytomegalovirus infections related to transplant (including solid organ and hematopoietic stem cell / bone marrow transplantation), congenital transmission, and in patients with HIV infection. The patents covering maribavir expire in 2015. We paid GSK a \$3.5 million up-front cash licensing fee and will pay additional milestone payments based upon defined clinical development and regulatory events. In the third quarter of 2006, we recorded a \$3.0 million milestone payment due to GSK associated with the initiation of the phase 3 study of maribavir, which was paid in February 2007. No additional amounts were recorded in 2007. We also will pay royalties to GSK and its licensor on product sales in the U.S. and rest of world (excluding Japan). We will be dependent on GSK to prosecute and maintain the patents related to maribavir, and to file any applications for patent term extension. We also may be dependent on GSK to protect such patent rights. We have the right to sublicense our rights under the agreement, which under certain circumstances requires consent from GSK.

Manufacturing and Distribution

We currently utilize a virtual supply manufacturing and distribution chain in which we do not have our own facilities to manufacture commercial or clinical trial supplies of drugs and we do not have our own distribution facilities. Additionally, we do not intend to develop such facilities for any product in the near future. Instead, we contract with third parties for the manufacture, warehousing, order management, billing and collection and distribution of our products and product candidates. This virtual approach allows us the flexibility to adapt as our pipeline advances.

We expect to continue to rely solely on third-party manufacturers to manufacture drug substance and final drug products for both clinical development and commercial sale.

Cinryze

In conjunction with the Lev acquisition, we acquired a Distribution and Manufacturing Services Agreement with Sanquin, which was amended and restated in January 2010 as described above. Additionally, in January 2010, we entered into the ROW Agreement as described above.

Restated U.S. Agreement

The terms of the Restated US Agreement related to manufacturing provide that Sanquin shall manufacture Cinryze for us on a toll manufacturing basis, using plasma supplied by us, for a manufacturing fee. During the term, we shall purchase from Sanquin an annual minimum quantity of Cinryze established by the parties for such calendar year.

Sanquin is implementing structural and equipment changes to its Amsterdam and Brussels manufacturing facilities. We previously funded such changes to the Brussels manufacturing facility and a portion of such changes to the Amsterdam manufacturing facility, each through a loan facility of an aggregate amount of €7,500,000 (approximately \$9.9 million based on the December 31, 2010 exchange rate). Pursuant to the Restated US Agreement, Sanquin will implement additional structural and equipment changes to the Brussels manufacturing facility, financed through an additional €5,000,000 (approximately \$6.6 million based on the December 31, 2010 exchange rate) loan facility provided by us. Sanquin will repay all such loan amounts by January 1, 2015 by providing us with a discount to the per unit purchase price of product.

Sanquin will use commercially reasonable efforts to obtain regulatory approval to manufacture Cinryze in the Amsterdam manufacturing facility prior to a date agreed to by the parties. Sanquin will enter into manufacturing agreements with one or more third party manufacturers, which may include affiliates of Sanquin, (reasonably acceptable to us) pursuant to which such third party manufacturers shall provide certain back-up manufacturing facilities for Cinryze. In the event that certain events occur which result in Sanquin permanently ceasing to

manufacture Cinryze, Sanquin will grant us a perpetual license under its intellectual property related to Cinryze and assign to us each of the agreements with such third party manufacturers. In consideration thereof, we will pay a one-time fee to Sanquin as well as a royalty on future sales of Cinryze or any future C1-INH product.

ROW Agreement

The terms of the ROW Agreement related to manufacturing provide that Sanquin will manufacture Cinryze either based on a supply of plasma provided by Sanquin or on a toll-manufacturing basis using plasma supplied by us for a manufacturing fee. The manufacturing fee will be comprised of a base fee and a royalty which shall vary based upon the source of the plasma utilized. The parties will negotiate in good faith a new purchase price and manufacturing fee for any additional new products developed in accordance with the terms of the ROW Agreement. Beginning in 2015, we shall purchase at least a minimum quantity of Cinryze or future C1-INH product from Sanquin annually, which quantities shall be determined by the Joint Steering Committee in 2013.

Sanquin will enter into manufacturing agreements with one or more third party manufacturers, which may include affiliates of Sanquin, (reasonably acceptable to us) pursuant to which such third party manufacturers shall provide certain back-up manufacturing facilities for the products. In the event that certain events occur which result in Sanquin permanently ceasing to manufacture Cinryze or future C1-INH derived products, Sanquin will grant us a perpetual license under its intellectual property related to Cinryze or any future C1-INH product and assign to us each of the agreements with such third party manufacturers. In consideration thereof, we will pay a one-time fee to Sanquin as well as a royalty on future sales of Cinryze or any future C1-INH product.

Plasma

Cinryze is derived from human plasma sourced from commercial plasma suppliers. The sourcing of plasma, and the production of products derived from plasma, is regulated extensively by the FDA and other medical product and health care regulatory agencies. We rely on a combination of sources for plasma including (i) long term supply agreements, (ii) periodic "spot purchases" of plasma from third party plasma suppliers, and (iii) we have an option to acquire our own plasma centers.

Supply Agreement with DCI Management Group, LLC

In connection with our acquisition of Lev, we became party to a supply agreement for the purchase and sale of plasma with DCI Management Group, LLC pursuant to which we will purchase quantities of U.S. Source Plasma to be utilized in the production of product under our Distribution and Manufacturing Services Agreement with Sanquin Blood Supply Foundation. In July 2009 we amended the terms of the agreement. Under the amended agreement, the supplier agreed to sell us specified annual quantities of plasma in accordance with applicable good manufacturing practices. Our annual purchase commitment is between \$19.3 million and \$25.4 million for the balance of the term of the agreement. Our contractual purchase commitments are subject to annual percentage increases based on market conditions and do not include the cost of additional pre-delivery testing which we may require the supplier to undertake. We estimate our remaining commitment under this agreement to be approximately \$139.0 million.

The amended agreement expires December 31, 2013, unless sooner terminated in accordance with its terms. Either party may terminate the agreement upon written notice if the other party is in material breach of any provision thereof, subject to applicable cure periods. Subject to the supplier's ability to mitigate damages, in the event we are in default of our payment obligation under the contract, we will be liable to purchase the minimum quantities of plasma specified under the contract for the balance of the term. Upon expiration of the agreement, or in the event the agreement is terminated for reasons other than as set forth above, we will be obligated to purchase a closing inventory of plasma in the quantity specified in the agreement.

In February 2010 we amended the agreement to extend the term to December 31, 2015. The amendment also fixed the pricing of product for the remainder of 2010 and the full year 2011. Thereafter, annual price adjustment shall depend on market conditions and increases or decreases shall be limited to maximum percentage per year.

Intermediate Supply Agreement with Biotest AG

On June 19, 2009, we entered into an intermediate supply agreement (the "Supply Agreement") with Biotest AG ("Biotest") pursuant to which we will sell to Biotest all excess output of specific intermediate plasma products (the "Intermediates") derived from the plasma processed by Sanquin in manufacturing Cinryze. In addition, we offered Biotest a right of first refusal to purchase unprocessed plasma in the event we elect to sell unprocessed plasma to a third party. Biotest also agreed to provide us with a right of first refusal, subject to certain exceptions, to repurchase certain by products derived from the Intermediates. The Supply Agreement has an initial term expiring December 31, 2014, unless sooner terminated. In addition we established pricing for a pre-determined volume of source plasma (the "Target Volume"), provided that the parties shall renegotiate pricing terms upon achievement of the Target Volume. Either party may terminate the Supply Agreement upon written notice if the other party is in material breach of any provision thereof, subject to applicable cure periods. In the event of a breach of the Supply Agreement by Biotest, Biotest shall be liable to purchase all amounts of Intermediates deliverable under the Supply Agreement during its remaining term.

Strategic Supply Agreement with Biotest Pharmaceuticals Corporation

In February 2010 we entered into a Strategic Supply Agreement with Biotest Pharmaceuticals Corporation (Biotest) pursuant to which we will purchase certain quantities of plasma. Our contractual purchase commitments are subject to annual percentage increases based on changes in the consumer price index and is subject to other market conditions. Biotest shall also build three additional plasma centers to be dedicated to our plasma requirements during the term of the agreement. Such plasma centers shall receive regulatory approval for operations no later from 21, 27 and 29 months from the effective date of the agreement. On or after December 31, 2012 we shall have a right but not the obligation, with twelve month prior notice, to purchase the three plasma centers at a pre-determined purchase price. The agreement expires December 31, 2015. We estimate our remaining commitment under this agreement to be approximately \$76.6 million.

In May 2010 the agreement was amended to adjust the anticipated volume of plasma to be required by us during 2011.

Vancocin

In December 2005 we entered into a toll manufacturing agreement with Norwich Pharmaceuticals, Inc. (NPI) (formerly OSG Norwich Pharmaceuticals, Inc.) to produce finished Vancocin product. The qualification process required to transfer Vancocin manufacturing from Lilly to NPI was completed in February 2006. All approvals were finalized in the second quarter of 2006 and, since June 30, 2006, all of our finished product has been supplied from NPI. In April 2006, we also entered into an agreement with Alpharma, Inc. for the manufacturing of API for Vancocin. In October, 2007, we amended this agreement with Alpharma to extend the agreement until December 2011 and identified an additional production facility from which we began to acquire API during 2010. In January 2011 we extended our agreement with Xellia Pharmaceuticals, Inc. (formerly Alpharma Inc.) through December 2015.

We require in our manufacturing and processing agreements that all third-party contract manufacturers and processors produce drug substance and product in accordance with the FDA's current Good Manufacturing Practices and all other applicable laws and regulations. We maintain confidentiality agreements with potential and existing manufacturers in order to protect our proprietary rights related to our marketed drug and drug candidates.

Customers

We sell our products directly to wholesale drug distributors and specialty pharmacies/ specialty distributors who then distribute the product to pharmacies, hospitals, patients, physicians and long term care facilities, among

others. Net product sales to customers who accounted for 10% or more of our net product sales during the years ended December 31, 2010, 2009 and 2008 are as follows:

| | Percentage of total revenues | | |
|------------------|------------------------------|------------|------------|
| | 2010 | 2009 | 2008 |
| Customer A | 25% | 29% | 39% |
| Customer B | 24% | 25% | 38% |
| Customer C | 21% | 13% | 17% |
| Customer D | 16% | 12% | — |
| Customer E | 10% | — | — |
| Total | <u>96%</u> | <u>79%</u> | <u>94%</u> |

In 2010, five customers represented approximately 96% of our total net product sales. We do not believe that the loss of any one of these customers would have a material adverse effect on product sales because product sales would shift to other customers or alternative forms of distribution. However, the loss of a customer could increase our dependence on a reduced number of customers. We have entered into distribution service agreements with the parties identified in the table above.

Marketing and Sales

Our initial sales organization was established in 2008 in the Northeastern U.S. to target doctors and hospitals to promote Vancocin. With the commercial launch of Cinryze, we have transitioned our existing sales force and expanded our sales force to target doctors who treat patients who have been diagnosed with HAE. Given the relatively limited HAE patient population, our U.S. sales force is small compared to other drugs with similar gross revenues. Our sales force primarily focuses its efforts towards allergists, immunologists and home healthcare providers.

Foreign Operations

We conduct business in European countries through wholly-owned subsidiaries. Our international businesses are subject to risks customarily encountered in foreign operations, including fluctuations in foreign currency exchange rates and controls, import and export controls and other economic, political and regulatory policies of local governments. We currently have operations in Belgium, the United Kingdom, France, Germany and Switzerland. In anticipation of our commercial sales launch of Cinryze in Europe and certain other countries, we have begun to expand our own commercial organizations in such territories in order to market and sell Cinryze through our own sales force in these territories. Outside of the United States and European territories, we will evaluate sales efforts on a country-by-country basis, and it is possible that we will rely on relationships with one or more companies with established distribution systems and direct sales forces in such countries.

Patents and Proprietary Technology

We believe that patent protection and trade secret protection are important to our business and that our future will depend, in part, on our ability to maintain our technology licenses, maintain trade secret protection, obtain patents and operate without infringing the proprietary rights of others both in the U.S. and abroad. The last core patent protecting Vancocin expired in 1996. There are no core patents protecting Cinryze. We have one pending U.S. patent application covering technology related to Cinryze. In order to continue to obtain commercial benefits from Vancocin, we will rely on product manufacturing trade secrets, know-how and related non-patent intellectual property, and regulatory barriers to competitive products. We own three pending U.S. patent applications covering vancomycin related technology. We have one pending U.S. patent application covering technology relating to non-toxicogenic *Clostridium difficile*. We have three pending U.S. patent applications covering benzimidazole related technology. We also file international, regional and non-U.S. national patent applications as appropriate in order to pursue patent protection in major foreign countries.

As patent applications in the U.S. are maintained in secrecy until patents are issued (unless earlier publication is required under applicable law or in connection with patents filed under the PCT) and as publication of discoveries in the scientific or patent literature often lags behind the actual discoveries, we cannot be certain that we or our licensors were the first to make the inventions described in each of these pending patent applications or that we or our licensors were the first to file patent applications for such inventions. Furthermore, the patent positions of biotechnology and pharmaceutical companies are highly uncertain and involve complex legal and factual questions, and, therefore, the breadth of claims allowed in biotechnology and pharmaceutical patents or their enforceability cannot be predicted. We cannot be sure that any patents will issue from any of these patent applications or, should any patents issue, that we will be provided with adequate protection against potentially competitive products. Furthermore, we cannot be sure that should patents issue, they will be of commercial value to us, or that private parties, including competitors, will not successfully challenge these patents or circumvent our patent position in the U.S. or abroad. In the absence of adequate patent protection, our business may be adversely affected by competitors who develop comparable technology or products.

Pursuant to the terms of the Uruguay Round Agreements Act, patents filed on or after June 8, 1995 have a term of twenty years from the date of filing, irrespective of the period of time it may take for the patent to ultimately issue. This may shorten the period of patent protection afforded to our products as patent applications in the biopharmaceutical sector often take considerable time to issue. Under the Drug Price Competition and Patent Term Restoration Act of 1984, a sponsor may obtain marketing exclusivity for a period of time following FDA approval of certain drug applications, regardless of patent status, if the drug is a new chemical entity or if new clinical studies were used to support the marketing application for the drug. Pursuant to the FDA Modernization Act of 1997, this period of exclusivity can be extended if the applicant performs certain studies in pediatric patients. This marketing exclusivity prevents a third party from obtaining FDA approval for a similar or identical drug under an Abbreviated New Drug Application or a "505(b)(2)" New Drug Application.

The Drug Price Competition and Patent Term Restoration Act of 1984 also allows a patent owner to obtain an extension of applicable patent terms for a period equal to one-half the period of time elapsed between the filing of an Investigational New Drug Application, or IND, and the filing of the corresponding New Drug Application, or NDA, plus the period of time between the filing of the NDA and FDA approval, with a five year maximum patent extension. We cannot be sure that we will be able to take advantage of either the patent term extension or marketing exclusivity provisions of this law.

In order to protect the confidentiality of our technology, including trade secrets and know-how and other proprietary technical and business information, we require all of our employees, consultants, advisors and collaborators to enter into confidentiality agreements that prohibit the use or disclosure of confidential information. The agreements also oblige our employees, and to the extent practicable, our consultants, advisors and collaborators, to assign to us ideas, developments, discoveries and inventions made by such persons in connection with their work with us. We cannot be sure that these agreements will maintain confidentiality, will prevent disclosure, or will protect our proprietary information or intellectual property, or that others will not independently develop substantially equivalent proprietary information or intellectual property.

The pharmaceutical industry places considerable importance on obtaining patent and trade secret protection for new technologies, products and processes. Our success depends, in part, on our ability to develop and maintain a strong patent position for our products and technologies in clinical development, both in the U.S. and in other countries. Litigation or other legal proceedings may be necessary to defend against claims of infringement, to enforce our patents, or to protect our trade secrets, and could result in substantial cost to us and diversion of our efforts. We intend to file applications as appropriate for patents describing the composition of matter of our drug candidates, the proprietary processes for producing such compositions, and the uses of our products and drug candidates.

Government Regulation

The FDA and comparable regulatory agencies in state and local jurisdictions and in foreign countries impose substantial requirements on the clinical development, licensure, manufacture, distribution and marketing of

pharmaceutical products. These agencies and other federal, state and local entities regulate research and development activities and the testing, manufacture, processing, quality control, safety, effectiveness, labeling, packaging, storage, handling, distribution, record keeping, approval, advertising, marketing, and promotion of our products. All of our products will require FDA regulatory approval before commercialization. In particular, therapeutic products for human use are subject to rigorous preclinical and clinical testing and other requirements of the Federal Food, Drug, and Cosmetic Act, implemented by the FDA, as well as similar statutory and regulatory requirements of foreign countries. Obtaining these marketing approvals and subsequently complying with ongoing statutory and regulatory requirements is costly and time consuming. Any failure by us or our collaborators, licensors or licensees to obtain or maintain, or any delay in obtaining, regulatory approval or in complying with other requirements, could adversely affect the commercialization of products then being developed by us and our ability to receive product or royalty revenues.

The steps required before a new drug product may be distributed commercially in the U.S. generally include:

- conducting appropriate preclinical laboratory evaluations of the product's chemistry, formulation and stability, and animal studies to assess the potential safety and efficacy of the product;
- submission to the FDA of an Investigational New Drug Application, including the results of preclinical evaluations and tests, along with manufacturing information and analytical data plus any clinical data if the product previously was administered to humans including outside the US;
- obtaining approval of Institutional Review Boards, or IRBs, to introduce the drug into humans in clinical studies;
- conducting adequate and well-controlled human clinical trials that establish the safety and efficacy of the drug product candidate for the intended use, typically in the following three sequential, or slightly overlapping stages:
 - Phase 1: The drug is initially introduced into healthy human subjects or patients and tested for safety, dose tolerance, absorption, metabolism, distribution, excretion and evidence of biological activity;
 - Phase 2: The drug is studied in controlled, exploratory therapeutic trials in a limited number of patients to identify possible adverse effects and safety risks, to determine dose tolerance and the optimal effective dosage, and to collect initial efficacy data of the product for specific targeted diseases or medical conditions;
 - Phase 3: The drug is studied in an expanded, adequate, well-controlled patient population at multiple clinical study sites to demonstrate efficacy and safety at the optimized dose by measuring a primary endpoint established at the outset of the study;
- submitting the results of basic research, including pharmacology and mechanisms of action animal studies, and clinical studies as well as chemistry, manufacturing and controls information and patent information on the drug to the FDA in a NDA or BLA;
- undergoing a successful FDA pre-approval inspection prior to approval of an NDA or BLA; and
- obtaining FDA approval of the NDA or BLA prior to any commercial sale or shipment of the drug or biologic product.

This process generally takes a number of years and typically requires substantial financial resources, and we cannot be certain that any approval will be granted on a timely basis, if at all. The results of preclinical studies and initial clinical trials are not necessarily predictive of the results from large-scale clinical trials, and all clinical trials may be subject to additional costs, delays or modifications due to a number of factors, including the difficulty in obtaining enough patients, clinical investigators, drug supply, or financial support, or because of unforeseen adverse effects or efficacy issues. In addition, an independent IRB at each clinical site proposing to

conduct the clinical trials must review and approve each study protocol and oversee the conduct of the trial. The FDA may also raise questions about the conduct of the trials as outlined in the IND and impose a clinical hold on the trial. If a clinical hold is imposed, all of FDA's concerns must be resolved before the trial may begin again. Preclinical and clinical studies take several years to complete, and there is no guarantee that an IND we submit will result in a submission of an NDA or BLA within any specific time period, if at all. Similar risks and uncertainties apply to the conduct and approval for licensure and marketing a product in non-U.S. markets around the world.

The FDA has issued regulations intended to expedite the approval process for the development, evaluation and marketing of new therapeutic products intended to treat life-threatening or severely debilitating diseases, especially where no alternative therapies exist. If applicable, these provisions may streamline the traditional product development process in the U.S. Similarly, products that represent a substantial improvement over existing therapies may be eligible for priority review and a FDA expedited review time of six months. Nonetheless, even if a product is eligible for these programs, or for priority review, approval may be denied or delayed by the FDA or additional trials may be required. As a condition of approval FDA also can require further testing of the product and monitoring of the effect of commercialized products such as in a Risk Evaluation and Mitigation Strategy (REMS) requirement, including restricted access to the product and potential registries in the US and to a greater extent in Europe, formalized requirements to access pediatric safety and effectiveness. The Agency has the power to prevent or limit further marketing of a product based on the results of these post-approval commitments. Upon approval, a drug or biologic product may be marketed only in those dosage forms and for those indications approved in the NDA or BLA.

Any products manufactured or distributed by us pursuant to FDA approval are subject to extensive continuing post-approval regulation by the FDA, including record-keeping requirements, obligations to investigate, analyze and report adverse experiences, and possible restrictions on advertising and promotional activities. In addition to continued compliance with standard regulatory requirements, the FDA also may require post-marketing testing and surveillance to monitor the safety and efficacy of the marketed product. Results of post-marketing studies may limit or expand the further marketing of the products. If we propose any modifications to a product, including changes in indication, manufacturing process, manufacturing facility or labeling, we may need to submit a NDA or BLA supplement to the FDA, and will not be able to commercialize any product with these modifications until FDA approval is received. Product approvals may be withdrawn if compliance with regulatory requirements is not maintained or if problems concerning safety or efficacy of the product are discovered following approval.

An abbreviated approval process is currently available under the Federal Food, Drug and Cosmetic Act (FDCA) for generic versions of conventional chemical drug products, sometimes referred to as small molecule drugs. The applicant for a generic version of a small molecule drug must refer to an approved drug for which full clinical data demonstrating safety and effectiveness were submitted (the "reference drug"). Generally, the generic applicant must show that its product has the same active ingredients, dosage form, strength, route of administration, and labeling as the reference drug, and is absorbed in the body at the same rate and to the same extent as the referenced drug. It is possible to obtain permission to deviate from some of these requirements. A generic applicant must seek approval for conditions of use for which FDA approved the reference drug, it must include certifications to patents listed with FDA for the reference drug, and it must wait for the expiry of any applicable non-patent exclusivity. A generic applicant must also manufacture its product in accordance with current good manufacturing practices. FDA also permits abbreviated applications that cite to reference drugs and propose new conditions of use or other changes that require clinical data. For these applications, FDA may require substantially less data and information than it requires for reference drugs. These abbreviated approval processes could have a material impact on our business as generic products may be significantly less costly to bring to market and may be priced significantly lower than our products.

An abbreviated approval process is also available under the Public Health Service Act (PHSA) for biosimilar versions of biologics licensed under full BLAs ("reference biologics"). A biosimilar applicant generally must

submit analytical, animal, and clinical data showing that the proposed product is “highly similar” to the reference product and has no “clinically meaningful differences” from the reference product in terms of the safety, purity, and potency. The proposed product also must have the same route of administration, dosage form, strength, and mechanism(s) of action (if known) as the reference biologic, and the application must seek approval for a condition of use for which FDA already approved the reference biologic. FDA cannot license a biosimilar until 12 years after it first licensed the reference biologic. After expiry of the applicable exclusivity, our biologics may face direct competition from licensed biosimilar products. Biosimilar manufacturers may price these products at material discounts to our products. Therefore, this competition could have a negative effect on sales and gross profits for our product, and on our overall profitability and financial condition.

In addition to obtaining FDA approval for each indication for which we plan to market product, each drug or biologic product manufacturing establishment must register with the FDA, list its drug products with the FDA, comply with current Good Manufacturing Practices (cGMPs) and undergo periodic inspections by the FDA.

In complying with the FDA’s cGMP regulations, manufacturers must continue to spend time, money and effort on facilities and equipment, process control, recordkeeping, personnel training, quality control validation, and auditing to ensure that the marketed product meets applicable specifications and other requirements. The FDA periodically inspects drug or biologic product manufacturing facilities to ensure compliance with cGMPs. Failure to comply with FDA requirements, including cGMPs, subjects the manufacturer to possible FDA enforcement action, such as untitled letters, Warning Letters, suspension of manufacturing operations, seizure of the product, voluntary or mandatory recall of a product, injunctive action, consent decrees and/or suspension or revocation of product approval, as well as possible civil and criminal penalties. We currently rely on, and intend to continue to rely on, third parties to manufacture our compounds and products. Such third parties will be required to comply with FDA requirements, including cGMPs. We cannot be certain that we, or our present or future suppliers or third-party manufacturers, will be able to comply with all FDA regulatory requirements, and potential consequences of non-compliance could have a material adverse impact on our business.

Products manufactured in the U.S. for distribution abroad will be subject to FDA regulations regarding export, as well as the requirements of the country to which they are shipped. These latter requirements are likely to cover the conduct of clinical trials, the submission of marketing applications and all aspects of product manufacture and marketing. Such requirements can vary significantly from country to country. As part of possible strategic relationships, our collaborators may be responsible for the foreign regulatory approval process of our products, although we may be legally liable for noncompliance. Foreign establishments manufacturing drug or biologic products for distribution in the U.S. also must register their establishments and list their products with the FDA, and comply with cGMPs. They also are subject to periodic inspection by the FDA or by local authorities under agreement with the FDA.

The FDA’s laws, regulations and policies may change, and additional governmental regulations or requirements may be enacted that could delay, limit or restrict, or prevent regulatory approval of our products or affect our ability to test, manufacture, market, or distribute our products following approval.

On December 8, 2003, the Medicare Prescription Drug, Improvement and Modernization Act (MMA) was signed into law and provides outpatient prescription drug coverage to eligible Medicare beneficiaries. The primary prescription drug benefit under the MMA, the new Medicare Part D coverage, began in January 2006. The new Part D prescription drug benefit is administered regionally through Medicare-approved insurance plans. The legislation allows for the importation of prescription drugs from Canada, but only if the Secretary of the U.S. Department of Health and Human Services certifies to Congress that such importation would pose no additional risk to the public’s health and safety and would result in significant reduction in the cost to customers, which the Secretary thus far has not done. There can be no assurance that this certification requirement will be maintained in future legislation or that the certification will continue to be withheld. The impact could also be negative over the intermediate and longer term for our business generally as greater federal involvement and budget constraints may increase the likelihood of additional pricing pressures or controls in the future.

In March 2010, the Patient Protection and Affordable Care Act (PPACA) was signed into law, which was amended by the Health Care and Education Reconciliation Act of 2010. The PPACA, as amended, is a sweeping measure intended to expand healthcare coverage within the United States, primarily through the imposition of health insurance mandates on employers and individuals and expansion of the Medicaid program. Several provisions of the new law, which have varying effective dates, will affect us. These include new requirements on private insurance companies that prohibit coverage denials because of a pre-existing condition; prohibit the application of annual and lifetime benefits limits on health insurance policies; and prohibit coverage rescissions (except for fraud) and health-based insurance rating. In addition, the PPACA, as amended, funds an interim high risk pool that states can draw on; following the expiration of this high risk pool funding, it provides for the creation of state-run "exchanges" that will allow people without employer-provided coverage, or who cannot afford their employer's plan, to buy health insurance; and provides federal subsidies to those who cannot afford premiums. Collectively, these factors may increase the availability of reimbursement for patients seeking the products that ViroPharma commercializes. However, the Act, as amended, will likely increase certain of our costs as well. For example, an increase in the Medicaid rebate rate from 15.1% to 23.1% was effective as of January 1, 2010, and the volume of rebated drugs has been expanded to include beneficiaries in Medicaid managed care organizations, effective as of March 23, 2010. In 2011, the PPACA also imposes a manufacturer's fee on the sale of branded Pharmaceuticals (excluding orphan drugs) to specified government programs, expands the 340B drug discount program (excluding orphan drugs), and includes a 50% discount on brand name drugs for Medicare Part D participants in the coverage gap, or "doughnut hole". Our evaluation of PPACA, as amended, will continue to enable us to determine not only the immediate effects on our business, but also the trends and changes that may be encouraged by the legislation that may potentially impact on our business over time.

Federal and state governments also have pursued direct methods to reduce the cost of drugs for which they pay. We participate in state government-managed Medicaid programs as well as certain other qualifying federal and state government programs whereby discounts and mandatory rebates are provided to participating state and local government entities. We also participate in other programs with government entities, the most significant of which are the U.S. Department of Defense and the U.S. Department of Veterans Affairs. These entities receive minimum discounts based off a defined "non-federal average manufacturer price" for purchases. Additional programs in which we participate provide mandatory discounts for outpatient medicines purchased by certain Public Health Service entities and "disproportionate share" hospitals (hospitals meeting certain criteria regarding the percentage of needy population served).

Our operations are also subject to federal and state anti-kickback laws. Certain provisions of the Social Security Act prohibit entities such as us from knowingly and willingly offering, paying, soliciting or receiving any form of remuneration (including any kickbacks, bribe or rebate) in return for the referral of items or services for which payment may be made under a federal health care program, or in return for the recommendation, arrangement, purchase, lease or order of items or services for which payment may be made under a federal health care program. Violation of the federal anti-kickback law is a felony, punishable by criminal fines and imprisonment for up to five years or both. In addition, the Department of Health and Human Services may impose civil penalties and exclude violators from participation in federal health care programs such as Medicare and Medicaid. Many states have adopted similar prohibitions against payments intended to induce referrals of products or services paid by Medicaid or other third party payors. Several states have also enacted laws requiring recordkeeping, compliance requirements, and reporting of gifts and other value given to healthcare providers. Because of the far-reaching nature of these laws, there can be no assurance that the occurrence of one or more violations of these laws would not result in a material adverse effect on our business, financial condition and results of operations.

We are also subject to various other federal, state and local laws, rules, regulations and policies relating to safe working conditions, clinical, laboratory and manufacturing practices, environmental protection, the experimental use of animals and the use and disposal of hazardous or potentially hazardous substances, including radioactive compounds and infectious disease agents, previously used in connection with our research work. Although we believe that our safety procedures for handling and disposing of such materials comply with current federal, state

and local laws, rules, regulations and policies, the risk of accidental injury or contamination from these materials cannot be entirely eliminated. We may also incur significant costs to comply with such laws and regulations now and in the future, and the failure to comply may have a material adverse impact on our business.

Moreover, we anticipate that Congress, state legislatures and the private sector will continue to review and assess controls on health care spending. Any such proposed or actual changes could cause us or our collaborators to limit or eliminate spending on development projects and may otherwise affect us. We cannot predict the likelihood, nature, or extent of adverse governmental regulation that might result from future legislative or administrative action, either in the U.S. or abroad. Additionally, in both domestic and foreign markets, sales of our proposed products will depend, in part, upon the availability of reimbursement from third-party payors, such as government health administration authorities, managed care providers, private health insurers and other organizations. Significant uncertainty often exists as to the reimbursement status of newly approved health care products. In addition, third-party payors are increasingly challenging the price and cost effectiveness of medical products and services. There can be no assurance that our proposed products will be considered cost-effective or that adequate third-party reimbursement will be available to enable us to maintain price levels sufficient to realize an appropriate return on our investment in product research and development.

In the United States, the Orphan Drug Act provides incentives to drug manufacturers to develop and manufacture drugs for the treatment of rare diseases, currently defined as diseases that affect fewer than 200,000 individuals in the United States, or for a disease that affects more than 200,000 individuals in the United States, where the sponsor does not realistically anticipate its product becoming profitable. The FDA has granted Cinryze seven years of marketing exclusivity to Cinryze (C1 esterase inhibitor [human]) for routine prophylaxis in adolescent and adult patients with hereditary angioedema (HAE) pursuant to the Orphan Drug Act. Lev originally received orphan drug designation for Cinryze by the Office of Orphan Products Development on July 16, 2004. Under the Orphan Drug Act, a manufacturer of a designated orphan product can seek certain tax benefits, and the holder of the first FDA approval of a designated orphan product will be granted a seven-year period of marketing exclusivity for that product for the orphan indication. While the marketing exclusivity of an orphan drug would prevent other sponsors from obtaining approval of the same drug compound for the same indication unless the subsequent sponsors could demonstrate clinical superiority or a market shortage occurs, it would not prevent other sponsors from obtaining approval of the same compound for other indications or the use of other types of drugs for the same use as the orphan drug. The U.S. Congress has considered, and may consider in the future, legislation that would restrict the duration or scope of the market exclusivity of an orphan drug and, thus, we cannot be sure that the benefits of the existing statute will remain in effect. Additionally, we cannot be sure that other governmental regulations applicable to our products will not change. We rely on the marketing exclusivity provided by the Orphan Drug Act for Cinryze as there are no core patents protecting Cinryze.

Foreign Regulation

In addition to regulations in the United States, we are subject to a variety of foreign regulatory requirements governing human clinical trials and marketing approval for drugs. The foreign regulatory approval process includes all of the risks associated with FDA approval set forth above, as well as additional country-specific regulations. Whether or not we obtain FDA approval for a product, we must obtain approval of a product by the comparable regulatory authorities of foreign countries before we can commence clinical trials or marketing of the product in those countries. The approval process varies from country to country, and the time may be longer or shorter than that required for FDA approval. The requirements governing the conduct of clinical trials, product licensing, pricing and reimbursement vary greatly from country to country.

For example, under European Union regulatory systems, we may submit marketing authorizations either under a centralized or decentralized procedure. The centralized procedure provides for the grant of a single marketing authorization that is valid for all European Union member states. The decentralized procedure provides for mutual recognition of national approval decisions, and the holder of a national marketing authorization may submit an application to the remaining member states. We submitted our Marketing Authorization Application

for Cinryze for the acute treatment and prophylaxis of HAE to the European Medicines Agency (EMA), using the centralized procedure.

Before submitting a Marketing Authorization Application (MAA) in the EU, a company must obtain approval of a Paediatric Investigation Plan (PIP) from the EMA's Paediatric Committee (PDCO). The PIP describes the pediatric development of a product and may include pharmaceutical development, non-clinical and clinical activities. The PIP will also define the age ranges of the children for whom the product must be developed and the timelines that the sponsor must meet, including, for example, the deferral of some studies. The PIP is updated as new information is obtained. The incentives for completing the PIP include 6 months patent extension and, for orphan medicinal products, an additional 2 years orphan exclusivity. In October 2009 a PIP was approved for Cinryze.

Legislation similar to the Orphan Drug Act has been enacted in other countries outside of the United States, including the European Union. The orphan legislation in the European Union is available for therapies addressing conditions that affect five or fewer out of 10,000 persons. The market exclusivity period is for ten years, although that period can be reduced to six years if, at the end of the fifth year, available evidence establishes that the product is sufficiently profitable not to justify maintenance of market exclusivity. In October 2009 and December 2007, the Company was granted orphan medical product designation for Cinryze and maribavir, respectively, by the Committee for Orphan Medicinal Products of the EMA. In addition, the EMA must reconfirm the orphan designation in connection with the approval of an MAA.

In some foreign countries, the proposed pricing for a drug must be approved before it may be lawfully marketed. The requirements governing drug pricing vary widely from country to country. For example, the European Union provides options for its member states to restrict the range of medicinal products for which their national health insurance systems provide reimbursement and to control the prices and/or reimbursement of medicinal products for human use. A member state may approve a specific price or level of reimbursement for the medicinal product, or it may instead adopt a system of direct or indirect controls on the profitability of the company placing the medicinal product on the market. In the event we receive regulatory approval of Cinryze in the EU, we will need to engage with appropriate authorities on the operational, reimbursement, price approval and funding processes that are separately required in each country.

Competition

Other companies are developing treatments for the disease states for which we market products or are developing product candidates, including compounds in preclinical and clinical development for HAE, *C. difficile*, and CMV. These companies include both public and private entities, including well-known, large pharmaceutical companies, chemical companies, biotechnology companies and research institutions. Our ability to compete successfully will be based on our ability to:

- develop proprietary products;
- attract and retain scientific personnel;
- obtain patent or other protection for our products;
- obtain required regulatory approvals; and
- manufacture and successfully market our products either alone or through outside parties.

HAE

We do not have patent protection for the composition of Cinryze and we rely on the exclusivity provided by the Orphan Drug Act. The FDA granted Cinryze seven years of marketing exclusivity to Cinryze C1 inhibitor (human) for routine prophylaxis of HAE pursuant to the Orphan Drug Act. Steroid based products are currently

used for prophylaxis of HAE. In the fourth quarter of 2009 the FDA has granted marketing approval of CSL Behring's product, Berinert® C1-Esterase Inhibitor, Human, for the treatment of acute abdominal or facial attacks of hereditary angioedema and Berinert has received exclusivity pursuant to the Orphan Drug Act. This approval will prevent us from obtaining FDA licensure and marketing our C1-INH product for the treatment of acute abdominal or facial attacks HAE for up to seven years. Additionally, in the fourth quarter of 2009, Dyax received approval for their product candidate for the acute treatment of HAE. In addition, Pharming NV and Shire are currently developing products for the acute treatment of HAE.

CDI

The last core patent protecting Vancocin expired in 1996. As a result, there is a potential for significant competition from generic versions of Vancocin. Such competition would result in a significant reduction in sales of Vancocin. We believe that regulatory hurdles (notwithstanding the recent actions taken by the OGD, described below), as well as product manufacturing trade secrets, know-how and related non-patent intellectual property may impact market entry of generic competition. However, there can be no assurance that these barriers will actually impact generic competition.

In December 2008, FDA changed OGD's 2006 bioequivalence recommendation, which we have opposed since its original proposal in March 2006, by issuing draft guidance for establishing bioequivalence to Vancocin which would require generic products that have the same inactive ingredients in the same quantities as Vancocin ("Q1 and Q2 the same"), and that meet certain other conditions, to demonstrate bioequivalence through comparative in vitro dissolution testing. Under this latest proposed method, any generic product that is not Q1 and Q2 the same as Vancocin would need to conduct an in vivo study with clinical endpoints to demonstrate bioequivalence with Vancocin.

On August 4, 2009 the FDA's Pharmaceutical Science and Clinical Pharmacology Advisory Committee voted in favor of the OGD's 2008 draft guidelines on bioequivalence for Vancocin. If FDA's proposed bioequivalence method for Vancocin becomes effective, the time period in which a generic competitor could be approved would be reduced and multiple generics may enter the market, which would materially impact our operating results, cash flows and possibly intangible asset valuations. This could also result in a reduction to the useful life of the Vancocin-related intangible assets. Management currently believes there are no indicators that would require a change in useful life as management believes that Vancocin will continue to be utilized along with generics that may enter the market, and the number of generics and the timing of their market entry is unknown.

In November 2010 Optimer Pharmaceuticals completed submission of a rolling NDA for the treatment and recurrence prevention of CDI. In July 2010 they had submitted an MAA to the EMA for the treatment of CDI and are investigating the product for the potential treatment of vancomycin-resistant enterococcus infection. Additionally, several other companies, including, Sanofi-Aventis and Cubist Pharmaceuticals have clinical development programs with therapeutic agents for the treatment of *C. difficile* infection that could be found to have competitive advantages over Vancocin. Approval of new products, or expanded use of currently available products, to treat CDI, and particularly severe disease caused by *C. difficile* infection, could materially and adversely affect our sales of Vancocin. The number of units sold of Vancocin for the treatment of antibiotic-associated pseudomembranous colitis caused by *C. difficile* has decreased over the past 12 months and Vancocin's share of the U.S. market for this indication may continue to decrease due to competitive forces and market dynamics. Metronidazole, a generic product, is regularly prescribed to treat CDI at costs which are substantially lower than for Vancocin. In addition, products which are currently marketed for other indications by other companies may also be prescribed to treat this indication.

Employees

As of December 31, 2010 we had 232 employees of which 194 were employed in the United States and 38 were located in Europe. A significant number of our management and professional employees have had prior experience with pharmaceutical, biotechnology or medical products companies. None of our employees are

covered by collective bargaining agreements. We believe that we have been successful in attracting skilled and experienced personnel; however, competition for such personnel is intense. We believe that our relations with our employees are good.

Executive Officers

| <u>Name</u> | <u>Age</u> | <u>Position</u> |
|-------------------------|------------|---|
| Vincent J. Milano | 47 | President, Chief Executive Officer and Chairman of the Board of Directors |
| Charles A. Rowland, Jr. | 52 | Vice President, Chief Financial Officer |
| Colin Broom, M.D. | 55 | Vice President, Chief Scientific Officer |
| Thomas F. Doyle | 50 | Vice President, Strategic Initiatives |
| Daniel B. Soland | 52 | Vice President, Chief Operating Officer |
| Robert G. Pietrusko | 62 | Vice President, Regulatory Affairs and Quality |
| J. Peter Wolf | 41 | Vice President, General Counsel and Secretary |
| Richard S. Morris | 37 | Controller and Chief Accounting Officer |

Vincent J. Milano joined the company in 1996, and has served as President and Chief Executive Officer since March 31, 2008. He became Chairman of the Board of Directors in December 2008. He served as our Chief Operating Officer from January 2006 to March 2008 and as Vice President, Chief Financial Officer of ViroPharma from November 1997 to March 2008. Mr. Milano has also previously served as our Vice President, Finance & Administration, as Treasurer, and as Executive Director, Finance & Administration. Prior to joining ViroPharma, Mr. Milano was with KPMG LLP, independent certified public accountants, where he was a Senior Manager. Mr. Milano served on the board of directors of Verticalnet, Inc. from August 2003 until the company was acquired by BravoSolution S.p.A. in January 2008. Mr. Milano received his Bachelor of Science degree in Accounting from Rider College.

Charles A. Rowland, Jr. has served as our Vice President, Chief Financial Officer since he joined the company in October 2008. Prior to joining ViroPharma, Mr. Rowland served as Executive Vice President, Chief Financial Officer of Endo Pharmaceuticals from December 2006 to September 2008. Prior thereto, Mr. Rowland was Senior Vice President and CFO of Biovail Pharmaceuticals, Inc. from 2004 to 2006. From 2001 to 2004, he was Chief Operating and Financial Officer for Breakaway Technologies, a management consulting company. His pharmaceutical industry career includes positions of increasing scope and responsibility at Pharmacia Corp., where he had global responsibility for Finance and Information Technology for the Pharmaceutical Business and financial responsibility for the Global Supply organization as Vice President, Finance Global Supply and VP Finance & IT-Global Pharma Ops; Novartis Pharmaceuticals Corp., where he was Vice President, Planning and Decision Support, and Bristol-Myers Squibb, where he served as Director of Finance. Mr. Rowland received his Bachelor of Science degree in Accounting from St. Joseph's University and a MBA from Rutgers University.

Colin Broom, M.D. has served as Vice President, Chief Scientific Officer of ViroPharma since May 2004. From 2000 until 2003, Dr. Broom served as Vice President of Clinical Development and Medical Affairs, Europe, for Amgen. From 1998 to 1999, Dr. Broom served as Senior Vice President of Global Clinical Development for Hoechst Marion Roussel, now Sanofi-Aventis. From 1984 until 1998, Dr. Broom was with Glaxo and then SmithKline Beecham, where he held positions of increasing seniority in clinical pharmacology in Europe before moving to the U.S. to head global oncology and subsequently becoming Vice President of CNS/GI. Dr. Broom holds a Bachelor of Science degree in Pharmacology from University College London, and a Bachelor of Medicine and Bachelor of Surgery degree from St. George's Hospital Medical School. Dr. Broom is a Member of the Royal College of Physicians and a Fellow of the Faculty of Pharmaceutical Medicine of the UK Colleges of Physicians. Dr. Broom has been a director of NPS Pharmaceuticals since July 2009.

Thomas F. Doyle is Vice President, Strategic Initiatives as of January 2008. Mr. Doyle previously served as Vice President, General Counsel of ViroPharma from November 1997 to January 2008, as Secretary from February 1997 to January 2008 and as Executive Director, Counsel since joining ViroPharma in November 1996 to

February 1997. From 1990 until 1996, Mr. Doyle was a corporate attorney with the law firm of Pepper Hamilton LLP. Mr. Doyle received his J.D. from Temple University School of Law. Prior to attending Temple University, Mr. Doyle was a Certified Public Accountant. Mr. Doyle received his Bachelor of Science degree in Accounting from Mt. St. Mary's College.

Daniel B. Soland joined ViroPharma in November 2006 as our Vice President, Chief Commercial Officer and has served as our Chief Operating Officer since March 2008. From February 2005 until June 2006, Mr. Soland served as President of Chiron Vaccines. From March 2003 until February 2005, Mr. Soland was President and Chief Executive Officer at Epigenesis Pharmaceuticals, a privately held biopharmaceutical company. Prior to that, Mr. Soland spent nine years with GlaxoSmithKline as the Vice President and Director of Worldwide Marketing Operations, and five years as GSK's Vice President and Director of the U.S. Vaccines Business Unit. Mr. Soland holds a Bachelor of Science degree in Pharmacy from the University of Iowa, in Iowa City, IA.

Robert G. Pietrusko, Phrm.D., has served as Vice President, Global Regulatory Affairs and Quality since joining ViroPharma in 2007. Prior to joining ViroPharma, Dr. Pietrusko served as Senior Vice President of Worldwide Regulatory Affairs for Millennium Pharmaceuticals, Inc. from 2001 through May 2007. Dr. Pietrusko spent 19 years at GlaxoSmithKline, culminating in his tenure as Vice President and Director, Anti-infective and Antiviral Therapeutic Areas, U.S. Regulatory Affairs. Dr. Pietrusko holds a Bachelor of Science degree in Biology and a Bachelors of Pharmacy degree from Rutgers University, and a Doctor of Pharmacy degree from the Philadelphia College of Pharmacy and Science.

J. Peter Wolf has served as Vice President, General Counsel, and Secretary since January 1, 2008. Mr. Wolf previously served as Associate General Counsel of ViroPharma since 2004. From 2000 to 2004 Mr. Wolf was a corporate attorney at private law firms. Mr. Wolf received his J.D. from the George Washington University National Law Center and his Bachelor of Arts from the University of Delaware.

Richard S. Morris, CPA has served as Chief Accounting Officer of ViroPharma since April 2008. From December 2001 until April 2008, Mr. Morris has served in increasing levels of responsibility at ViroPharma, most recently as Controller from January of 2005 through April 2008. Prior to joining ViroPharma, Mr. Morris worked for KPMG LLP in their Healthcare Assurance practice. Mr. Morris holds a bachelor's degree in Accounting from Saint Joseph's University and has been a CPA since 1999.

Available Information

Our Internet website is www.viropharma.com and you may find our SEC filings on the "Investors" tab of that website. We provide access to all of our filings with the SEC, free of charge, as soon as reasonably practicable after filing with the SEC on such site. Our Internet website and the information contained on that website, or accessible from our website, is not intended to be incorporated into this Annual Report on Form 10-K or any other filings we make with the SEC.

PART II—OTHER INFORMATION

ITEM 1A. Risk Factors

We have historically depended heavily on the continued sales of Vancocin.

If revenue from Vancocin materially declines, our financial condition and results of operations will be materially harmed because sales of Vancocin represented approximately 59 percent of our revenue in 2010. In addition, to the extent that revenue from Vancocin materially declines prior to Cinryze achieving significant commercial success, our financial condition and results of operations may be further harmed because sales of Cinryze may be our only other material source of revenue for at least the next several years.

Vancocin product sales could be adversely affected by a number of factors, including:

- the development and approval of competitive generic versions of oral Vancocin, approval of products which are currently marketed for other indications by other companies or new pharmaceuticals and technological advances to treat the conditions addressed by Vancocin;
- manufacturing or supply interruptions which could impair our ability to acquire an adequate supply of Vancocin to meet demand for the product;
- changes in the prescribing or procedural practices of physicians in the areas of infectious disease, gastroenterology and internal medicine, including off-label prescribing of other products;
- decreases in the rate of infections for which Vancocin is prescribed;
- the level and effectiveness of our sales and marketing efforts;
- decrease in the sensitivity of the relevant bacterium to Vancocin;
- changes in terms required by wholesalers, including “fee-for-service” contracts;
- marketing or pricing actions by one or more of our competitors;
- our ability to maintain all necessary contracts or obtain all necessary rights under applicable federal and state rules and regulations;
- the approval of legislative proposals that would authorize re-importation of Vancocin into the United States from other countries;
- regulatory action by the FDA and other government regulatory agencies;
- changes in the reimbursement or substitution policies of third-party payors or retail pharmacies; and
- product liability claims.

Revenues from the sale of Vancocin may not remain at or above current levels or achieve the level of net product sales that we expect. We believe the rate of infections for which Vancocin is prescribed decreased during the second half of 2007 and remained flat or declined during the period of 2008 to 2010. A decrease in sales of Vancocin could have a material adverse effect on our business, financial condition, results of operations and liquidity.

If we are unable to continue to successfully commercialize Cinryze in the United States, or are delayed in our ability to commercialize Cinryze in Europe and additional territories or are significantly limited in doing so, our business will be materially harmed.

The FDA approved Cinryze for routine prophylaxis against angioedema attacks in adolescent and adult patients with hereditary angioedema on October 10, 2008. Cinryze became commercially available for routine prophylaxis against HAE in December 2008. We are in the process of seeking regulatory approval for Cinryze in Europe and anticipate that our Marketing Authorization Application (MAA) could be approved by the European Medicines Agency (EMA) in the first half of 2011. The commercial success of Cinryze will depend on several factors, including the following:

- the number of patients with HAE that may be treated with Cinryze;

- our ability to receive regulatory approvals to market Cinryze in Europe and other territories in the timeframes we anticipate;
- manufacturing or supply interruptions which could impair our ability to acquire an adequate supply of Cinryze to meet demand for the product;
- acceptance by physicians and patients of Cinryze as a safe and effective treatment;
- our ability to effectively market and distribute Cinryze in the United States, Europe and additional territories;
- cost effectiveness of HAE treatment using Cinryze;
- relative convenience and ease of administration of Cinryze;
- potential advantages of Cinryze over alternative treatments;
- the timing of the approval of competitive products including another C1 esterase inhibitor for the acute treatment of HAE;
- patients' ability to obtain sufficient coverage or reimbursement by third-party payors in the United States and our ability to receive sufficient reimbursement and price approvals that are separately required in each country in Europe; and
- sufficient supply and reasonable pricing of raw materials necessary to manufacture Cinryze.

If we are not able to continue to successfully commercialize Cinryze in the United States, Europe and additional territories, or are significantly delayed or limited in doing so, we could fail to maintain profitability and our financial condition, results of operations and liquidity will be materially adversely impacted.

Because the target patient population for Cinryze is small and has not been definitively determined, we must be able to successfully identify HAE patients and maintain a significant market share in order to increase revenue and maintain profitability.

The prevalence of HAE patients has not been definitively determined but has been estimated, through market research we have conducted, at up to 11,000 total patients in the United States while the Hereditary Angioedema Association estimates there are 6,500 patients in the United States. Additionally, we believe that HAE affects between 1 in 10,000 and 1 in 50,000 individuals in Europe and other territories worldwide. There can be no guarantee that any of our programs will be effective at identifying HAE patients and the number of HAE patients in the United States or other territories may turn out to be lower than expected or such patients may not be amenable to treatment with Cinryze as not all HAE patients are appropriately treated through routine prophylaxis. Accordingly, our product sales of Cinryze and overall business could be adversely affected if we are unable to identify additional HAE patients to increase revenue and maintain profitability.

Our core patent protection for Vancocin has expired, which could result in significant competition from generic products and lead to a significant reduction in sales of Vancocin.

The last core patent protecting Vancocin expired in 1996. As a result, there is a potential for significant competition from generic products that treat the same conditions addressed by Vancocin. Such competition could result in a significant reduction in sales of Vancocin. We believe that regulatory hurdles (notwithstanding the recent actions taken by the FDA's Office of Generic Drugs, Center for Drug Evaluation and Research (OGD), which are described in more detail below and which we are vigorously opposing), as well as product manufacturing trade secrets, know-how and related non-patent intellectual property, may present barriers to market entry of generic competition. However, these barriers may not actually delay or prevent generic competition. The effectiveness of these non-patent-related barriers to competition will depend primarily upon:

- the current or future regulatory approval requirements for any generic applicant;
- the complexities of the manufacturing process for a competitive product;

- the nature of the market which Vancocin serves and the position of Vancocin in the market from time to time;
- the growth of the market which Vancocin serves; and
- our ability to protect Vancocin know-how as a trade secret.

Generic competitors may take advantage of the absence of patent protection for Vancocin to attempt to develop a competing product. We have become aware of information suggesting that other potential competitors are attempting to develop a competing generic product. For example, multiple generic manufacturers have publicly stated that they have filed to receive product approval and commence a marketing launch of a generic version of oral Vancocin. We are not able to predict the time period in which a generic drug may enter the market, as this timing will be affected by a number of factors, including:

- whether an in-vitro method of demonstrating bioequivalence for a locally acting GI drug that has neither been correlated with, nor demonstrated to be predictive of, human *in vivo* bioavailability data is available to an applicant to gain marketing approval by the FDA in lieu of performing clinical studies;
- the nature of any clinical trials which are required, if any;
- the timing of filing an Abbreviated New Drug Application, or an ANDA, the amount of time required by the FDA to review the ANDA and whether a generic drug application is afforded an accelerated review by the FDA;
- the specific formulation of drug for which approval is being sought; and
- the time required to develop appropriate manufacturing procedures.

On March 17, 2006, we learned that the OGD changed its approach regarding the conditions that must be met in order for a generic drug applicant to request a waiver of in-vivo bioequivalence testing for vancomycin hydrochloride capsules. Specifically, we were informed that a generic applicant may be able to request such a waiver provided that dissolution testing demonstrates that the test product is rapidly dissolving at certain specified conditions. This deviated from our understanding of OGD's historical practices which would require, for a poorly-absorbed, locally acting gastrointestinal drug (such as Vancocin) a demonstration of bioequivalence through clinical studies or a demonstration of bioequivalence using an appropriately validated in-vitro methodology.

On March 17, 2006, we filed a Petition for Stay of Action with the FDA regarding the requirements for waivers of in-vivo bioequivalence testing for Vancocin, and we have amended that petition several times through additional filings in support of our opposition to any approach that does not require rigorous scientific methods to demonstrate a rate and extent of drug release to the site of action consistent with good medicine and science.

In December 2008, the FDA changed OGD's 2006 bioequivalence recommendation by issuing draft guidance for establishing bioequivalence to Vancocin which would permit generic products that have the same inactive ingredients in the same quantities as Vancocin, or Q1 and Q2 the same, and that meet certain other conditions, to demonstrate bioequivalence through comparative dissolution testing. Under this latest proposed method, any generic product that is not Q1 and Q2 the same as Vancocin would need to conduct an in vivo study with clinical endpoints to demonstrate bioequivalence with Vancocin.

The FDA convened a meeting of its Advisory Committee for Pharmaceutical Science and Clinical Pharmacology to discuss bioequivalence recommendations for oral vancomycin hydrochloride capsule drug products on August 4, 2009. The Advisory Committee was asked if the proposed guidelines are sufficient for establishing bioequivalence for generic vancomycin oral capsules. The Advisory Committee voted unanimously in favor of the component of the proposed OGD recommendation that requires bioequivalence to be demonstrated through comparable dissolution in media of pH 1.2, 4.5 and 6.8 for potential vancomycin HCl capsule generic products

that (a) contain the same active and inactive ingredients in the same amounts as Vancocin HCl capsules; (b) meet currently accepted standards for assay, potency, purity, and stability (equivalent to those in place for Vancocin HCl capsules); and (c) are manufactured according to cGMP.

We have opposed both the substance of the FDA's bioequivalence method and the manner in which it was developed. In the event the OGD's revised approach regarding the conditions that must be met in order for a generic drug applicant to demonstrate bioequivalence to Vancocin through comparative in-vitro dissolution testing remains in effect, the time period in which a generic competitor may enter the market would be reduced. There can be no assurance that the FDA will agree with the positions stated in our Vancocin related submissions or that our efforts to oppose the OGD's March 2006 and December 2008 recommendation to determine bioequivalence to Vancocin through in-vitro dissolution testing will be successful. We cannot predict the timeframe in which the FDA will make a decision regarding either our citizen petition for Vancocin or the approval of generic versions of Vancocin. If we are unable to change the recommendation set forth by the OGD in March 2006 as revised in December 2008 and voted upon by the Advisory Committee for Pharmaceutical Science and Clinical Pharmacology, the threat of generic competition will be high.

We do not have patent protection for the composition of Cinryze and we rely on the exclusivity provided by the Orphan Drug Act.

The Orphan Drug Act was created to encourage companies to develop therapies for rare diseases by providing incentives for drug development and commercialization. One of the incentives provided by the act is seven years of market exclusivity for the first product in a class licensed for the treatment of a rare disease. HAE is considered to be a rare disease under the Orphan Drug Act, and companies may obtain orphan drug status for therapies that are developed for this indication. The FDA granted Cinryze seven years of marketing exclusivity to Cinryze C1 inhibitor (human) for routine prophylaxis of HAE pursuant to the Orphan Drug Act. The FDA has granted marketing approval of CSL Behring's product, Berinert® C1-Esterase Inhibitor, Human, for the treatment of acute abdominal or facial attacks of hereditary angioedema and Berinert has received exclusivity pursuant to the Orphan Drug Act. In addition, the EMEA has enacted similar orphan drug legislation and we have received an orphan drug designation under this legislation for Cinryze. We believe Pharming NV is currently developing products that the EMEA may determine to be in the same class as Cinryze for the acute treatment of HAE in Europe. In addition, the EMA must reconfirm the orphan designation in connection with the approval of an MAA.

While the marketing exclusivity of an orphan drug would prevent other sponsors from obtaining approval of the same drug compound for the same indication unless the subsequent sponsors could demonstrate clinical superiority or a market shortage occurs, it would not prevent other sponsors from obtaining approval of the same compound for other indications or the use of other types of drugs for the same use as the orphan drug. In the event we are unable to fill demand for Cinryze, it is possible that the FDA may view such unmet demand as a market shortage which could impact the market exclusivity provided by the Orphan Drug Act. Additionally, the United States Congress has considered, and may consider in the future, legislation that would restrict the duration or scope of the market exclusivity of an orphan drug and, thus, we cannot be sure that the benefits of the existing statute will remain in effect.

We do not know whether Vancocin and Cinryze will continue to be competitive in the markets which they serve.

We currently generate revenues from sales of Vancocin in the United States for the treatment of antibiotic-associated pseudomembranous colitis caused by *Clostridium difficile* infection, or CDI or *C. difficile*, and enterocolitis caused by *S. aureus*, including methicillin-resistant strains. Vancocin sales for the treatment of antibiotic-associated pseudomembranous colitis caused by *C. difficile* decreased in 2009 from the sales achieved in 2008. Vancocin's share of the United States market for this indication may decrease further due to competitive forces and market dynamics, including an increase in the oral use of intravenous vancomycin. Metronidazole, a

generic product, is regularly prescribed to treat CDI at costs which are substantially lower than for Vancocin. In addition, products which are currently marketed for other indications by other companies may also be prescribed to treat this indication. Other drugs that are in development by our competitors, including Salix Pharmaceuticals and Optimer Pharmaceuticals, could be found to have competitive advantages over Vancocin. In November 2010, Optimer Pharmaceuticals completed submission of a rolling NDA for the treatment and recurrence prevention of CDI. Approval of new products, or expanded use of currently available products, to treat CDI, and particularly severe disease caused by CDI, could materially and adversely affect our sales of Vancocin.

The FDA approved Cinryze for routine prophylaxis against angioedema attacks in adolescent and adult patients with hereditary angioedema on October 10, 2008 and Cinryze became commercially available for prophylaxis against HAE in December 2009. While we are not aware of other companies which are developing a product for the prophylaxis of HAE in the United States, CSL Behring and Dyax had products approved for the treatment of acute attacks of HAE during 2009 and steroid based products are currently used for prophylaxis of HAE. In addition, Pharming NV and Jerini/Shire are currently developing products for the acute treatment of HAE. Approval of new products, or the expanded use of currently available products, to prophylax or treat HAE, could materially and adversely affect our United States sales of Cinryze. In addition, there are currently several products approved for the acute treatment of HAE in Europe. Even if we are successful in receiving regulatory approval for Cinryze in Europe, there can be no assurance that we will be able to achieve market share in accordance with our expectations.

We currently depend, and will in the future continue to depend, on third parties to manufacture raw, intermediate and finished goods for Vancocin, Cinryze and our product candidates. If these manufacturers fail to meet our requirements and the requirements of regulatory authorities, our future revenues may be materially adversely affected.

We do not have the internal capability to manufacture quantities of pharmaceutical products to supply our clinical or commercial needs under the current Good Manufacturing Practice regulations, or cGMPs, required by the FDA and other regulatory agencies. In order to continue to develop products, apply for regulatory approvals and commercialize our products, we will need to contract with third parties that have, or otherwise develop, the necessary manufacturing capabilities.

There are a limited number of manufacturers that operate under cGMPs that are capable of manufacturing our products and product candidates. As such, if we are unable to enter into supply and processing contracts with any of these manufacturers or processors for our development stage product candidates, there may be additional costs and delays in the development and commercialization of these product candidates. For example, Cinryze is a biologic which requires processing steps that are more difficult than those required for most chemical pharmaceuticals and therefore the third party contracts must have additional technical skills and multiple steps to attempt to control the manufacturing processes.

Problems with these manufacturing processes such as equipment malfunctions, facility contamination, labor problems, raw material shortages or contamination, natural disasters, power outages, terrorist activities, or disruptions in the operations of our suppliers and even minor deviations from the normal process, could result in product defects or manufacturing failures that result in lot failures, product recalls, product liability claims and insufficient inventory.

If we are required to find an additional or alternative source of supply, there may be additional costs and delays in the development or commercialization of our product candidates. Additionally, the FDA and other regulatory agencies routinely inspect manufacturing facilities before approving a new drug application, or NDA, or biologic application, or BLA, for a drug or biologic manufactured at those sites. If any of our manufacturers or processors fails to satisfy regulatory requirements, the approval and eventual commercialization of our products and product candidates may be delayed.

In addition, regulatory agencies subject a marketed therapy, its manufacturer and the manufacturer's facilities to continual review and periodic inspections. The discovery of previously unknown problems with a therapy or the facility or process used to produce the therapy could prompt a regulatory authority to impose restrictions on us or delay approvals for new products or could cause us to voluntarily adopt restrictions, including withdrawal of one or more of our products or services from the market.

In September 2010, in connection with an FDA pre-approval inspection of the larger scale manufacturing line developed by our contract manufacturer for Cinryze, FDA issued a notice of observations at the close of the inspection on FDA Form 483. The FDA also issued a complete response letter regarding Cinryze™ (C1 Esterase Inhibitor [Human]) industrial scale manufacturing expansion activities. The FDA requested additional information related to observations from the pre-approval inspection and review of the technical processes. In addition, during 2009, FDA inspected two sites maintained by our contract manufacturer for Cinryze and issued a notice of observations at the close of the inspection on FDA Form 483 for each site. The observations at one site were subsequently remedied and a notice to this effect was issued by the FDA. Responses to the observations made at the second site have been provided to the FDA, however, several of the responses remain the subject of continuing corrective and preventive action procedures. Also, at the close of the pre-approval inspection of the facility at which the Cinryze industrial scale manufacturing expansion activities will occur, the FDA issued a notice of observations on FDA Form 483. If any of our manufacturers or processors fails to satisfy regulatory requirements, operations at such facility may be halted which could result in our inability to supply product to patients and reduce our revenues.

All of our contract manufacturers must comply with the applicable cGMPs, which include quality control and quality assurance requirements as well as the corresponding maintenance of records and documentation. If our contract manufacturers do not comply with the applicable cGMPs and other FDA regulatory requirements, we may be subject to product liability claims, the availability of marketed products for sale could be reduced, our product commercialization could be delayed or subject to restrictions, we may be unable to meet demand for our products and may lose potential revenue and we could suffer delays in the progress of clinical trials for products under development. We do not have control over our third-party manufacturers' compliance with these regulations and standards. Moreover, while we may choose to manufacture products in the future, we have no experience in the manufacture of pharmaceutical products for clinical trials or commercial purposes. If we decide to manufacture products, we would be subject to the regulatory requirements described above. In addition, we would require substantial additional capital and would be subject to delays or difficulties encountered in manufacturing pharmaceutical products. No matter who manufactures the product, we will be subject to continuing obligations regarding the submission of safety reports and other post-market information.

We depend on single manufacturers for certain components used in Vancocin and Cinryze and the loss of either of these suppliers or any supplier in general would have a negative impact on our operations.

We rely on a single supplier of vancomycin, the active pharmaceutical ingredient (API) of Vancocin, and also rely on a single manufacturer of Vancocin capsules. Our third party API supplier and finished product supplier are the only manufacturers qualified by the FDA to manufacture API and Vancocin capsule finished product for distribution and sale in the United States. We are therefore dependent upon these suppliers and attempt to maintain Vancocin inventory levels to meet our current projections, plus a reasonable stock in excess of those projections.

We rely on a single manufacturer of Cinryze. Pursuant to our distribution agreement, Sanquin Blood Supply Foundation will supply us with certain annual minimum and maximum amounts of CINRYZE. In the event that certain events occur which result in Sanquin permanently ceasing to manufacture Cinryze, Sanquin will grant us a perpetual license under its intellectual property related to the Product and assign to us each of the agreements with such third party manufacturers. In consideration thereof, we will pay a one-time fee to Sanquin as well as a royalty on future sales of products. In the event demand for Cinryze is greater than the amount supplied by Sanquin, we will not be able to meet such demand as there are no other sources of supply of Cinryze available to

us. In the event Sanquin permanently ceases to manufacture Cinryze, we will need to find an alternate manufacturer of Cinryze. Currently, to our knowledge, there is only one other commercial supplier of C1 esterase inhibitor and that supplier has recently received marketing approval for their product in the United States. Accordingly, in the event Sanquin permanently ceases to manufacture Cinryze, we cannot be certain that we would be able to locate another willing supplier for our product on the terms we require.

The risks associated with the numerous factors that could cause interruptions in the supply of our products, including manufacturing capacity limitations, regulatory reviews, changes in our sources for manufacturing, disputes with a manufacturer, our failure to timely locate and obtain replacement manufacturers as needed and conditions affecting the cost and availability of raw materials, are magnified when the suppliers are limited in number. Any interruption in the supply of finished products could hinder our ability to timely distribute our products and satisfy customer demand. If we are unable to obtain adequate product supplies to satisfy our customers' orders, we may lose those orders, our customers may cancel other orders, and they may choose instead to stock and purchase competing products. Supply interruptions may occur, and our inventory may not always be adequate. This in turn could cause a loss of our market share and negatively affect our revenues. We maintain limited property insurance which would only protect us from physical damage to our assets caused by certain types of occurrences to the extent of the value of the property damaged and would not cover lost revenue.

During time periods that patient demand approaches our manufacturing capacity we will manage the rate at which additional new patients will receive Cinryze and will limit the number of doses provided to patients. This would result in a reduction of potential future revenues.

Pursuant to our distribution agreement, Sanquin Blood Supply Foundation supplies us with certain annual minimum and maximum amounts of C1 INH. We and Sanquin are undertaking process improvements and facility expansions to increase the capacity of the facilities involved in manufacturing Cinryze. Our manufacturing scale up effort is a two-tiered approach including a parallel chromatography process, which was completed in the first quarter of 2010, with the product becoming available for commercial sale in the second quarter of 2010. The second phase of our scale up plan involves a larger scale construction project to significantly increase the production facilities of Sanquin. Pursuant to an agreement with Sanquin we have financed a portion of the costs of the project to increase the manufacturing capacity of its facilities. Following the completion of construction, Sanquin would need to obtain the requisite regulatory approvals for the facility on a timely basis in order to manufacture Cinryze for us at an increased capacity. On October 21, 2010, the United States Food and Drug Administration (FDA) issued a complete response letter regarding the facility to be utilized for the Cinryze industrial scale manufacturing expansion activities. The FDA requested additional information related to both (i) observations at the close of the pre-approval inspection and (ii) review of the technical processes. In order to manufacture Cinryze at the industrial scale we must respond to all FDA questions and satisfactorily complete the FDA review.

While we believe that the data collected from our industrial scale manufacturing process demonstrates equivalence with the existing manufacturing process, we cannot guarantee that the FDA will agree with us in the timeframes we anticipate or at all as biologics such as Cinryze require processing steps that are more complex than those required for most chemical pharmaceuticals. The FDA may view the data regarding equivalence of the industrial scale manufacturing process as insufficient or inconclusive, request additional data, require additional conformance batches, delay any decision past the time frames anticipated by us, or deny the approval of the industrial scale manufacturing process. In addition, our plans to increase manufacturing capacity through the construction of another small scale manufacturing line and another parallel chromatography process may not be completed in the time frame we anticipate or may not yield the volume of Cinryze we anticipate. Delays could arise as a result of many factors, including but not limited to, the availability of necessary equipment, validation of such equipment, the timing of regulatory reviews and approvals, and labor matters.

The number of patients enrolling into our treatment support service for patients with HAE and their healthcare providers, *CinryzeSolutions*, has periodically exceeded our expectations. As a result, in 2010 we began to temporarily limit the rate at which additional patients are started on drug to ensure that those already receiving commercial product continue with a supply of Cinryze until capacity increases. If the manufacturing capacity

expansion projects at Sanquin are delayed, or do not result in the capacity we anticipate, or if Sanquin cannot obtain necessary regulatory approvals for the contemplated facility expansions in the time frames we anticipate, or if we are not able to manufacture the anticipated volume of product at the existing scale, we may not be able to satisfy patient demand. Our inability to obtain adequate product supplies to satisfy our patient demand may create opportunities for our competitors and we will suffer a loss of potential future revenues.

The distribution of our commercial products is dependent upon a limited number of third party service providers and disruptions in these relationships could result in our failure to achieve the sales of our products that we expected.

We rely on a single third party to provide all necessary distribution and logistics services with respect to our sales of Vancocin and Cinryze, including warehousing of finished product, accounts receivable management, billing, collection and recordkeeping. The third party logistics service provider stores and distributes Vancocin from two warehouses located in the central United States and western United States and Cinryze from one of these warehouses. A disaster occurring at or near these facilities could materially and adversely impact our ability to supply Vancocin and Cinryze to our distribution partners, which would result in a reduction in revenues from sales.

Approximately 95 percent of our Vancocin sales are to the three largest pharmaceutical wholesalers. If any of these wholesalers ceases to purchase our product for any reason, then unless and until the remaining wholesalers increase their purchases of Vancocin or alternative distribution channels are established:

- our commercial operations could be significantly disrupted;
- the availability of our products to patients could be disrupted; and
- we may not achieve the sales of our products that we expected, which could decrease our revenues and potentially affect our ability to maintain profitability.

Additionally, we do not require collateral from our wholesalers but rather maintain credit limits and as a result we have an exposure to credit risk in our accounts receivable. The highest account receivable during 2010 we experienced from any one wholesaler was approximately \$19.6 million and we anticipate that this amount could increase if Vancocin sales increase. While we have experienced prompt payment by wholesalers and have not had any defaults on payments owed, a default by a large wholesaler could have a material adverse effect on our results of operations.

We have entered into agreements with two specialty distributors / specialty pharmacies that distribute Cinryze to physicians, hospitals, pharmacies, home health providers and patients. We also entered into an agreement with a single service provider who will provide patient support services including benefit coverage investigations, assistance with prior authorizations, appeals assistance, and broad based reimbursement assistance.

If our third party service providers cease to be able to provide us with these services, or do not provide these services in a timely or professional manner, it could significantly disrupt our commercial operations, and may result in our not achieving the sales of Vancocin and Cinryze that we expected. Additionally, any interruption to these services could cause a delay in delivering product to our customers, which could have a material adverse effect on our business.

If we are unable to obtain reimbursement for Cinryze from government health administration authorities, private health insurers and other organizations, Cinryze may be too costly for regular use and our ability to generate revenues would be harmed.

Our future revenues and profitability will be adversely affected if governmental, private third-party payors and other third-party payors, including Medicare and Medicaid, do not sufficiently defray the cost of Cinryze to the

consumer. If these entities do not provide coverage and reimbursement for Cinryze or determine to provide an insufficient level of coverage and reimbursement, Cinryze may be too costly for general use, and physicians may not prescribe it. Cinryze is significantly more expensive than traditional drug treatments. Many third-party payors cover only selected drugs, making drugs that are not preferred by such payor more expensive for patients, and often require prior authorization or failure on another type of treatment before covering a particular drug. Third-party payors may be especially likely to impose these obstacles to coverage for higher-priced drugs such as Cinryze.

In addition to potential restrictions on coverage, the amount of reimbursement for our products may also reduce our profitability and worsen our financial condition. In the United States and elsewhere, there have been, and we expect there will continue to be, actions and proposals to control and reduce healthcare costs. Government and other third-party payors are challenging the prices charged for healthcare products and increasingly limiting and attempting to limit both coverage and level of reimbursement for prescription drugs.

Because Cinryze is too expensive for most patients to afford without sufficient health insurance coverage, if adequate coverage and reimbursement by third-party payors is not available, our ability to successfully commercialize Cinryze may be adversely impacted. Any limitation on the use of Cinryze or any decrease in the price of Cinryze will have a material adverse effect on our business.

Even where patients have access to insurance, their insurance co-payment amounts may be too expensive for them to afford. We financially support the HAE financial assistance programs established by Patient Services Incorporated (PSI), which, among other things, assists patients in acquiring drugs such as Cinryze. Organizations such as PSI assist patients who have no insurance coverage for drugs, locate insurance, and also provide financial assistance to patients whose insurance coverage leaves them with prohibitive co-payment amounts or other expensive financial obligations. In addition to assistance from organizations such as PSI, we provide Cinryze without charge for related charitable purposes. We are not able to predict the financial impact of the support we may provide for these and other charitable purposes; however, substantial support could have a material adverse effect on our ability to maintain profitability.

In furtherance of our efforts to facilitate access to Cinryze, we have established the CinryzeSolutions™ program, a treatment support service for patients with HAE and their healthcare providers. CinryzeSolutions personnel provide education about HAE and Cinryze and help facilitate solutions for reimbursement, coverage and access. Although case managers assist patients and healthcare providers in locating and accessing Cinryze, we cannot guarantee a sufficient level of coverage, reimbursement or financial assistance.

If supplies of United States human plasma are interrupted or if we are unable to acquire adequate supplies of United States human plasma to meet demand for Cinryze, our ability to maintain inventory levels could suffer and future revenues may be delayed or reduced.

We have relied exclusively and are dependent on certain third party sources to supply United States human plasma for Cinryze. In connection with our commercial sales of Cinryze and our ongoing and future clinical trials, we will need increased supplies of plasma.

We have a contract for the purchase and sale of plasma with DCI Management Group, LLC, pursuant to which we purchase specified quantities of United States source plasma. Under this agreement, DCI agreed to sell us specified annual quantities of plasma in accordance with applicable good manufacturing practices. In addition to DCI, we entered into a Strategic Supply Agreement with Biotest Pharmaceuticals Corporation (Biotest) pursuant to which we will purchase certain quantities of plasma. Our contractual purchase commitments are subject to annual percentage increases based on change in the consumer price index and are subject to other market conditions. Biotest shall also build three additional plasma centers to be dedicated to our plasma requirements during the term of the agreement. We have also made periodic spot purchases of plasma.

Plasma markets have historically been subject to price fluctuations as a result of changes in the production capacity available in the industry, the availability and pricing of plasma, development of competing products and the availability of alternative therapies. In recent years, there has been consolidation in the industry as several plasma derivatives manufacturers have acquired plasma collectors and reduced capacity. As a result, it could be difficult to resolve any significant disruption in the supply of plasma. In addition, concern over the safety of blood products (which has led to increased domestic and foreign regulatory control over the collection and testing of plasma and the disqualification of certain segments of the population from the donor pool), have reduced the potential donor pool.

If we are unable to obtain or maintain the level of plasma supply we require, we will need to obtain our supply from other parties in order to satisfy our expected needs. Establishing additional or replacement suppliers for plasma may take a substantial amount of time. In addition, we may have difficulty obtaining similar supplies from other suppliers that are acceptable to the FDA. If we have to switch to a replacement supplier, we may face additional regulatory delays and the manufacture and delivery of Cinryze could be interrupted for an extended period of time, which may decrease sales of Cinryze or result in increased costs.

Cinryze is derived from human plasma, and is therefore subject to the risk of biological contamination inherent in plasma-derived products. This risk could adversely affect our ability to obtain raw materials and market our products.

Cinryze is derived from donated human plasma. Many disease-causing viruses, bacteria and other pathogens are present in the plasma of infected individuals. If infected individuals donate plasma, the plasma would likely contain those pathogens. As a result, the sourcing of plasma, and the production of products derived from plasma, is regulated extensively by the FDA and other medical product and health care regulatory agencies. We rely on our suppliers to maintain compliance with the regulations promulgated by such agencies. The failure to comply with these regulations or the accidental contamination of plasma could adversely affect our ability to source plasma at commercially reasonable prices. Moreover, public perception about the safety of plasma-derived products could adversely affect the market for our products. Concern over the safety of plasma-derived products, driven in part by past screening failures in the industry and the appearance of infectious agents like HIV, has resulted in the adoption of rigorous screening procedures by regulatory authorities, and screening procedures are likely to become stricter and more complex over time. As screening procedures have become more rigorous, potential donors have been disqualified and other potential donors have been discouraged from donating due to their reluctance to undergo the required screening procedures. Increasingly stringent measures could adversely affect plasma supplies, with a corresponding adverse effect on our ability to obtain raw materials at a commercially acceptable price, or at all. The safety concerns associated with plasma-derived products also affect our ability to market our products. Medical events or studies that raise or substantiate concerns about the safety of our or other similar products would negatively impact public perception of all plasma-derived products and of the plasma donation process. Further, any failure in screening, whether by us or by other manufacturers of these products, could adversely affect our reputation, the support we receive from the medical community and overall demand for our products.

We may be subject to product liability claims, which can be expensive, difficult to defend and may result in large judgments or settlements against us.

The administration of drugs or biologics to humans, whether in clinical trials or after marketing clearance is obtained, can result in product liability claims. Product liability claims can be expensive, difficult to defend and may result in large judgments or settlements against us. In addition, third party collaborators and licensees may not protect us from product liability claims.

We currently maintain product liability insurance in connection with our clinical development programs and marketing of Vancocin, Cinryze and a product marketed in Europe. We may not be able to obtain or maintain adequate protection against potential liabilities arising from clinical development or product sales. If we are

unable to obtain sufficient levels of insurance at acceptable cost or otherwise protect against potential product liability claims, we will be exposed to product liability claims. A successful product liability claim in excess of our insurance coverage could harm our financial condition, results of operations, liquidity and prevent or interfere with our product commercialization efforts. In addition, any successful claim may prevent us from obtaining adequate product liability insurance in the future on commercially desirable terms. Even if a claim is not successful, defending such a claim may be time-consuming and expensive.

In order to continue to expand our business and sustain our revenue growth, we will need to acquire additional marketed products or product candidates in clinical development through in-licensing or the acquisitions of businesses that we believe are a strategic fit with us. We may not be able to in-license or acquire suitable products at an acceptable price or at all. In addition, engaging in any in-licensing or acquisitions will incur a variety of costs, and we may never realize the anticipated benefits of any such in-license or acquisition.

As part of our long-term strategy and in order to sustain our revenue growth, we intend to seek to acquire or in-license additional marketed products or product candidates in clinical development that treat serious or life threatening illnesses, which treat high unmet medical needs, which require limited commercial infrastructure, and that have the potential to provide both top and bottom line growth. Even if we are able to locate products, product candidates in clinical development or businesses that fit within our strategic focus, we cannot assure you that we will be able to negotiate agreements to acquire or in-license such additional products or product candidates in clinical development on acceptable terms or at all. Further, if we acquire a product, product candidates in clinical development or business, the process of integrating the acquired product, product candidates in clinical development or business may result in unforeseen operating difficulties and expenditures and may divert significant management attention from our ongoing business operations. Moreover, we may fail to realize the anticipated benefits for a variety of reasons, such as an acquired product candidate proving to not be safe or effective in later clinical trials. We may fund any future acquisition by issuing equity or debt securities, which could dilute the ownership percentages of our existing stockholders. Acquisition efforts can consume significant management attention and require substantial expenditures, which could detract from our other programs. In addition, we may devote resources to potential acquisitions that are never completed. We cannot assure you that an acquired product, product candidates in clinical development or business will have the intended effect of helping us to sustain our revenue growth. If we are unable to do so, our business could be materially adversely affected.

Our long-term success depends upon our ability to develop, receive regulatory approval for and commercialize drug product candidates and, if we are not successful, our ability to generate revenues from the commercialization and sale of products resulting from our product candidates will be limited.

All of our drug candidates will require governmental approvals prior to commercialization. Our failure to develop, receive regulatory approvals for and commercialize our development stage product candidates successfully will prevent us from generating revenues from the sale of products resulting from our product candidates. Our product candidates are in the development stage and may not be shown to be safe or effective.

Cinryze

We are currently evaluating with our partner Sanquin, the feasibility of additional indications and/or other formulations for Cinryze. We plan to initially focus on C-1 mediated diseases affecting transplant patients, including AMR and DGF. In addition, we have submitted a MAA for Cinryze for acute treatment of HAE and prophylaxis of HAE to the EMA and anticipate that the filing will be accepted in the first half of 2010. We also intend to seek approval to market Cinryze in certain additional territories throughout the world outside of the United States and Europe.

Non-toxigenic difficile

In February 2006, we entered into a licensing agreement for the rights to develop non-toxigenic strains of *C. difficile*, or VP20621, for the treatment and prevention of CDI. We plan to initially focus our efforts on the opportunity to prevent recurrence of CDI following treatment with antibiotics such as Vancocin. On August 6, 2009 we announced that dosing had begun in the phase 1 clinical trial for VP20621 to determine the safety and tolerability of VP20621 dosed orally as a single and as repeat escalating doses in healthy young and older adults. We have successfully completed our phase 1 clinical trial, filed an IND in December of 2010 and anticipate moving the compound into a phase 2 clinical trial in the first half of 2011. We may not be successful in starting the phase 2 study in the time frame we anticipate. Following completion of the phase 2 study, a phase 3 study is planned although the results of the clinical trials may not support further clinical development.

We cannot be certain that our efforts and the efforts of our partners regarding our product candidates will lead to commercially viable products. Negative, inconclusive or inconsistent clinical trial results could prevent regulatory approval, increase the cost and timing of regulatory approval, cause us to perform additional studies or to file for a narrower indication than planned. We do not know what the final cost to manufacture product candidates in commercial quantities will be, or the dose required to treat patients and, consequently, what the total cost of goods for a treatment regimen will be.

If we are unable to successfully develop our product candidates, we will not have a source of revenue other than Vancocin and Cinryze. Moreover, the failure of one or more of our product candidates in clinical development could harm our ability to raise additional capital. Furthermore, results from our clinical trials may not meet the level of statistical significance required by the FDA or other regulatory authorities for approval of a drug candidate.

The development of any of our product candidates is subject to many risks, including that:

- the product candidate is found to be ineffective or unsafe;
- the clinical test results for the product candidate delay or prevent regulatory approval;
- the FDA or other regulatory authorities forbid us to initiate or continue testing of the product candidates in human clinical trials;
- the product candidate cannot be developed into a commercially viable product;
- the product candidate is difficult and/or costly to manufacture;
- the product candidate later is discovered to cause adverse effects that prevent widespread use, require withdrawal from the market, or serve as the basis for product liability claims;
- third party competitors hold proprietary rights that preclude us from marketing the product candidate; and
- third party competitors market a more clinically effective, safer, or more cost-effective product.

Even if we believe that the clinical data sufficiently demonstrates the safety and efficacy of a product candidate, regulators may disagree with us, which could delay, limit or prevent the approval of such product candidate. In addition, regulatory approval may take longer than we expect as a result of a number of factors, including failure to qualify for priority review of our application. All statutes and regulations governing the approval of our product candidates are subject to change in the future. These changes may increase the time or cost of regulatory approval, limit approval, or prevent it completely.

The foreign regulatory approval process includes all of the risks associated with FDA approval set forth above, as well as additional country-specific regulations. Whether or not we obtain FDA approval for a product, we must obtain approval of a product by the comparable regulatory authorities of foreign countries before we can commence clinical trials or marketing of the product in those countries. The approval process varies from

country to country, and the time may be longer or shorter than that required for FDA approval. The requirements governing the conduct of clinical trials, product licensing, pricing and reimbursement vary greatly from country to country.

Even if we receive regulatory approval for our product candidates, or acquire the rights to additional products which have received regulatory approvals, the later discovery of previously unknown problems with a product, manufacturer or facility may result in adverse consequences, including withdrawal of the product from the market. Approval of a product candidate may be subject to a risk evaluation mitigation strategy may be conditioned upon certain limitations and restrictions as to the drug's use, or upon the conduct of further studies, and may be subject to continuous review.

The regulatory process is expensive, time consuming and uncertain and may prevent us from obtaining required approvals for the commercialization of our product candidates.

We have a product candidate, VP20621, for the treatment and prevention of CDI in clinical development. In addition, we are currently evaluating with our partner Sanquin, the feasibility of additional therapeutic uses and potential indications as well as other modes of administration for Cinryze. We expect to conduct clinical studies during 2011 to assess at least one additional therapeutic use of Cinryze as well as a study related to another mode of administration. We must complete significant laboratory, animal and clinical testing on these product candidates before submitting marketing applications in the United States and abroad.

The rate of completion of clinical trials depends upon many factors, including the rates of initiation of clinical sites and enrollment of patients. If we are unable to initiate a sufficient number of clinical sites and accrue sufficient clinical patients who are eligible to participate in the trials during the appropriate period, we may need to delay our clinical trials and incur significant additional costs. In addition, the FDA, Independent Safety Monitoring Boards or Institutional Review Boards may require us to delay, restrict, or discontinue our clinical trials on various grounds, including a finding that the subjects or patients are being exposed to an unacceptable health risk. In addition, we may be unable to submit a NDA to the FDA or marketing petitions to other regulatory authorities such as the EMEA for our product candidates within the time frame we currently expect, or at all. Once an NDA or other form of petition for marketing authority is submitted, it must be approved by the FDA or other regulatory authority before we can commercialize the product described in the application. The cost of human clinical trials varies dramatically based on a number of factors, including:

- the number, order and timing of clinical indications pursued;
- the number of patients required for enrollment;
- the length of time required to enroll these patients;
- the costs and difficulty of obtaining clinical supplies of the product candidate; and
- the difficulty in obtaining sufficient patient populations and clinicians.

Even if we obtain positive preclinical or clinical trial results in initial studies, future clinical trial results may not be similarly positive. As a result, ongoing and contemplated clinical testing, if permitted by governmental authorities, may not demonstrate that a product candidate is safe and effective in the patient population and for the disease indications for which we believe it will be commercially advantageous to market the product. The failure of our clinical trials to demonstrate the safety and efficacy of our product candidate for the desired indications could delay the commercialization of the product.

In 2003, Congress enacted the Pediatric Research Equity Act requiring the development and submission of pediatric use data for new drug products. In Europe, a Pediatric Investigational Plan must be agreed before a MAA can be submitted. Our failure to obtain these data, or to obtain a deferral of, or exemption from, these requirements could adversely affect our chances of receiving regulatory approval, or could result in regulatory or legal enforcement actions.

Healthcare reform could adversely affect our revenue and financial results.

Our industry is highly regulated and changes in law may adversely impact our business, operations or financial results. The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010, or PPACA, is a sweeping measure intended to expand healthcare coverage within the United States, primarily through the imposition of health insurance mandates on employers and individuals and expansion of the Medicaid program. Several provisions of the new law, which have varying effective dates, may affect us and will likely increase certain of our costs. For example, an increase in the Medicaid rebate rate from 15.1% to 23.1% became effective as of January 1, 2010, and the volume of rebated drugs was expanded to include beneficiaries in Medicaid managed care organizations, effective as of March 23, 2010. The PPACA also imposes an annual fee on pharmaceutical manufacturers beginning in 2011, based on the manufacturer's sale of branded pharmaceuticals and biologics (excluding orphan drugs); expands the 340B drug discount program (excluding orphan drugs) including the creation of new penalties for non-compliance; and includes a 50% discount on brand name drugs for Medicare Part D participants in the coverage gap, or "doughnut hole". The law also revises the definition of "average manufacturer price" for reporting purposes (effective October 1, 2010), which could increase the amount of the Company's Medicaid drug rebates to states, once the provision is effective. Substantial new provisions affecting compliance also have been added, which may require us to modify our business practices with health care practitioners. In addition, the new law establishes an abbreviated licensure pathway for products that are biosimilar to FDA-approved biological products, such as Cinryze, with provisions covering exclusivity periods and a specific reimbursement methodology for biosimilars.

The reforms imposed by the new law will significantly impact the pharmaceutical industry; however, the full effects of the PPACA cannot be known until these provisions are implemented and the Centers for Medicare & Medicaid Services and other federal and state agencies issue applicable regulations or guidance. Moreover, in the coming years, additional changes could be made to governmental healthcare programs that could significantly impact the success of our products. We will continue to evaluate the PPACA, as amended, the implementation of regulations or guidance related to various provisions of the PPACA by federal agencies, as well as trends and changes that may be encouraged by the legislation and that may potentially impact on our business over time.

Organizations, states and lawmakers who opposed the passage of PPACA threatened to take legal action against it upon its passage and several court challenges are currently at various stages of development. In addition, there have been several bills introduced in Congress to repeal PPACA. The uncertainty regarding the probability of success of these efforts could cause delays in the implementation of various provisions of PPACA. In the event PPACA is either overturned by a court proceeding or repealed through a legislative process, a disruption in reimbursement of our products may occur.

In addition, Federal, state, and foreign governmental authorities are likely to continue efforts to control the price of drugs and reduce overall healthcare costs. These efforts could impact our ability to market products and generate revenues in the United States and foreign countries.

Our strategic plan may not achieve the intended results.

We made the strategic decision to focus on the development of later stage opportunities by expanding our product portfolio through the acquisition of complementary clinical development stage or commercial product opportunities as a means to accelerate our path toward becoming a profitable pharmaceutical company. As a result of this strategic decision, we substantially discontinued our early stage activities, and do not maintain discovery research or significant internal preclinical development capabilities. Our restructuring efforts have placed, and may continue to place, a strain on our managerial, operational, financial and other resources.

We may not be successful in executing our strategy. We may not be able to in-license or acquire suitable products at an acceptable price, or at all. In addition, engaging in any in-licensing or acquisition will incur a variety of costs, and we may never realize the anticipated benefits of any such in-license or acquisition. We may

need additional financing in order to acquire additional new products or product candidates. Acquisition efforts can consume significant management attention and require substantial expenditures, which could detract from our other programs. In addition, we may devote resources to potential acquisitions that are never completed.

We cannot assure you that an acquired product, product candidates in clinical development or business will have the intended effect of helping us sustain our revenue growth in the near term or longer term. If we are unable to do so, our business could be materially adversely affected.

We depend on collaborations with third parties, which may reduce our product revenues or restrict our ability to commercialize products, and also ties our success to the success of our collaborators.

We have entered into, and may in the future enter into additional, sales and marketing, distribution, manufacturing, development, licensing and other strategic arrangements with third parties.

Sales of Cinryze are dependent on distribution rights that we have received from Sanquin pursuant to a distribution agreement relating to the treatment of HAE in the United States and a separate agreement related to other territories. During the term of the agreement, Sanquin will supply us with our commercial requirements for C1 INH for the treatment of HAE in each country where we have received regulatory approval, subject to minimum annual purchase requirements in Euros equal to approximately €24.8 (approximately \$32.9 million) million per year, net of the agreed upon discount.

In August 2003, we entered into a license agreement with GSK under which we acquired exclusive worldwide rights, excluding Japan, from GSK to develop and commercialize an antiviral compound, maribavir, for the prevention and treatment of CMV infections related to transplant, including solid organ and hematopoietic stem cell / bone marrow transplantation, congenital transmission, and in patients with HIV infection. GSK retained the exclusive right to market and sell products covered by these patents and patent applications in Japan.

We are currently engaged in additional discussions relating to other arrangements. We cannot be sure that we will be able to enter into any such arrangements with third parties on terms acceptable to us or at all. Third party arrangements may require us to grant certain rights to third parties, including exclusive marketing rights to one or more products, or may have other terms that are burdensome to us.

Our ultimate success may depend upon the success of our collaborators. We have obtained from Sanquin and GSK, and will attempt to obtain in the future, licensed rights to certain proprietary technologies and compounds from other entities, individuals and research institutions, for which we may be obligated to pay license fees, make milestone payments and pay royalties. In addition, we may in the future enter into collaborative arrangements for the marketing, sales and distribution of our product candidates, which may require us to share profits or revenues. We may be unable to enter into additional collaborative licensing or other arrangements that it needs to develop and commercialize its drug candidates. Moreover, we may not realize the contemplated benefits from such collaborative licensing or other arrangements. These arrangements may place responsibility on our collaborative partners for preclinical testing, human clinical trials, the preparation and submission of applications for regulatory approval, or for marketing, sales and distribution support for product commercialization. We cannot be certain that any of these parties will fulfill their obligations in a manner consistent with our best interest. These arrangements may also require us to transfer certain material rights or issue our equity securities to corporate partners, licensees or others. Any license or sublicense of our commercial rights may reduce our product revenue. Moreover, we may not derive any revenues or profits from these arrangements. In addition, our current strategic arrangements may not continue and we may be unable to enter into future collaborations. Collaborators may also pursue alternative technologies or drug candidates, either on their own or in collaboration with others, that are in direct competition with us.

If we fail to comply with our obligations in the agreements under which we license development or commercialization rights to products or technology from third parties, we could lose license rights that are important to our business.

Our rights to Cinryze is based upon intellectual property that we have licensed from Sanquin and one of our current product candidates is based on intellectual property that we have licensed from GSK. We depend, and will continue to depend, on these license agreements. All of our license agreements may be terminated if, among other events, we fail to satisfy our obligations as they relate to the development of the particular product candidate. All of our license agreements, other than the agreements with Lilly regarding Vancocin, may also be terminated if we breach that license agreement and do not cure the breach within specified time periods or in the event of our bankruptcy or liquidation. Our agreement with Lilly permits us to suspend the licenses granted to us by Lilly in the event of uncured defaults by us until such time as the default is cured or otherwise resolved.

Our agreement with Sanquin includes minimum purchase requirements and our license agreement with GSK imposes various obligations on us, including milestone payment requirements and royalties. If we fail to comply with these obligations, Sanquin and GSK may have the right to terminate the license, in which event we would not be able to market products covered by the license.

Disputes may arise with respect to our licensing agreements regarding manufacturing, development and commercialization of any of the particular product candidates. These disputes could lead to delays in or the termination of the development, manufacture and commercialization of our product candidates or to litigation.

Many other entities seek to establish collaborative arrangements for product research and development, or otherwise acquire products, in competition with us.

We face competition from large and small companies within the pharmaceutical and biotechnology industry, as well as public and private research organizations, academic institutions and governmental agencies in acquiring products and establishing collaborative arrangements for product development. Many of the companies and institutions that compete against us have substantially greater capital resources, research and development staffs and facilities than we have. These entities represent significant competition to us as we seek to expand further our pipeline through the in-license or acquisition of additional products in clinical development, or that are currently on the market. Moreover, while it is not feasible to predict the actual cost of acquiring additional product candidates, that cost could be substantial. We may need additional financing in order to acquire additional new products.

There are many potential competitors with respect to our product candidates under development, who may develop products and technologies that make our products and/or technologies non-competitive or obsolete.

There are many entities, both public and private, including well-known, large pharmaceutical companies, chemical companies, biotechnology companies and research institutions, engaged in developing pharmaceuticals for applications similar to those targeted by our products under development.

We are aware of several product candidates in clinical development which may compete with VP20621. Optimer Pharmaceuticals is developing a narrow spectrum antibiotic which completed two Phase III clinical trials for treatment and recurrence of CDI infection. In November 2010, Optimer Pharmaceuticals completed submission of a rolling NDA for the treatment and recurrence of prevention of CDI. Merck & Co., Inc. licensed a monoclonal antibody developed by Massachusetts Biological Labs which is in Phase II clinical trials for treatment of CDI infection. Additionally, SanofiAventis is developing a *C. difficile* vaccine which is in Phase II studies for the prevention and recurrence of CDI. Developments by these or other entities may render our product candidates non-competitive or obsolete. Furthermore, many of our competitors have greater resources available to them to assist with development and commercialization, obtaining regulatory approvals and product manufacturing and marketing. Accordingly, our competitors may succeed in obtaining regulatory approval for

products more rapidly and more effectively than we do for product candidates. Competitors may succeed in developing products that are more effective and less costly than any that we develop and also may prove to be more successful in the manufacturing and marketing of products.

Any product that we successfully develop and for which we gain regulatory approval must then compete for market acceptance and market share. Accordingly, important competitive factors, in addition to completion of clinical testing and the receipt of regulatory approval, will include product efficacy, safety, timing and scope of regulatory approvals, availability of supply, marketing and sales capacity, reimbursement coverage, pricing and patent protection. Our products could also be rendered obsolete or uneconomical by regulatory or competitive changes.

Any of our future products may not be accepted by the market, which would harm our business and results of operations.

Even if our product candidates are approved by the FDA and other regulatory authorities, they may not achieve market acceptance by patients, prescribers and third-party payors. As a result, we may not receive revenues from these products as anticipated. The degree of market acceptance will depend upon a number of factors, including:

- the receipt and timing of regulatory approvals, and the scope of marketing and promotion activities permitted by such approvals (e.g., the “label” for the product approved by the FDA);
- the availability of third-party reimbursement from payors such as government health programs and private health insurers;
- the establishment and demonstration in the medical community, such as doctors and hospital administrators, of the clinical safety, efficacy and cost-effectiveness of drug candidates, as well as their advantages over existing treatment alternatives, if any;
- the effectiveness of the sales and marketing force that may be promoting our products; and
- the effectiveness of our contract manufacturers.

If our product candidates do not achieve market acceptance by a sufficient number of patients, prescribers and third-party payors, our business will be materially adversely affected.

Funding, especially on terms acceptable to us, may not be available to meet our future capital needs.

Global market and economic conditions have been, and continue to be, disruptive and volatile. The debt and equity capital markets have been impacted by significant write-offs in the financial services sector and the re-pricing of credit risk in the broadly syndicated market, among other things.

If funding is not available when needed, or is available only on unfavorable terms, meeting our capital needs or otherwise taking advantage of business opportunities, such as acquisitions, may become challenging, which could have a material adverse effect on our business plans, revenues and results of operations.

Historically, Vancocin has been subject to limitations on the amount of payment and reimbursement available to patients from third party payors.

Historically, only a portion of the cost of Vancocin prescriptions has been paid for or reimbursed by managed care organizations, government and other third party payors. This reimbursement policy makes Vancocin less attractive, from a net-cost perspective, to patients and, to a lesser degree, prescribing physicians. For example, metronidazole, a drug frequently prescribed for CDI, is significantly less expensive than Vancocin. If adequate reimbursement levels are not provided for Vancocin, or if reimbursement policies increasingly favor other products, our market share and net sales could be negatively affected, as could our overall business and financial condition.

Our successful commercialization of our product candidates will depend, in part, on the availability and adequacy of third party reimbursement.

Our ability to commercialize our product candidates successfully will depend, in part, on the extent to which reimbursement for the cost of such products and related treatments will be available from government health administration authorities, such as Medicare and Medicaid in the United States, private health insurers and other organizations. Federal and state regulations govern or influence the reimbursement to health care providers of fees in connection with medical treatment of certain patients. In the United States, there have been, and we expect there will continue to be, a number of state and federal proposals that could limit the amount that state or federal governments will pay to reimburse the cost of drugs. Continued significant changes in the health care system could have a material adverse effect on our business. Decisions by state regulatory agencies, including state pharmacy boards, and/or retail pharmacies may require substitution of generic for branded products, may prefer competitors' products over our own, and may impair our pricing and thereby constrain our market share and growth. In addition, we believe the increasing emphasis on managed care in the United States could put pressure on the price and usage of our product candidates, which may in turn adversely impact future product sales.

Significant uncertainty exists as to the reimbursement status of newly approved health care products, particularly for indications for which there is no current effective treatment or for which medical care typically is not sought. Adequate third-party coverage may not be available to enable us to maintain price levels sufficient to realize an appropriate return on our investment in product development. If adequate coverage and reimbursement levels are not provided by government and third-party payors for use of our products, our products may fail to achieve market acceptance and we could lose anticipated revenues and experience delayed achievement of profitability.

In recent years, various legislative proposals have been offered in the United States Congress and in some state legislatures that include major changes in the health care system. These proposals have included price or patient reimbursement constraints on medicines and restrictions on access to certain products. We cannot predict the outcome of such initiatives, and it is difficult to predict the future impact of the broad and expanding legislative and regulatory requirements affecting us.

We rely on our employees, consultants, contractors, suppliers, manufacturers and collaborators to keep our trade secrets confidential.

We rely on trade secrets, trademarks, and unpatented proprietary know-how and continuing technological innovation in developing and manufacturing our products, including Vancocin, in order to protect our significant investment in these products from the risk of discovery by generic drug manufacturers and other potential competition. We require each of our employees, consultants, advisors, contractors, suppliers, manufacturers and collaborators to enter into confidentiality agreements prohibiting them from taking our proprietary information and technology or from using or disclosing proprietary information to third parties except in specified circumstances. The agreements also provide that all inventions conceived by an employee, consultant or advisor, to the extent appropriate for the services provided during the course of the relationship, are our exclusive property, other than inventions unrelated to us and developed entirely on the individual's own time. Nevertheless, these agreements may not provide meaningful protection of our trade secrets and proprietary know-how if they are used or disclosed. Despite all of the precautions we may take, people who are not parties to confidentiality agreements may obtain access to our trade secrets or know-how. In addition, others may independently develop similar or equivalent trade secrets or know-how.

We depend on patents and proprietary rights for our products which are in clinical development, which may offer only limited protection against potential infringement, and if we are unable to protect our patents and proprietary rights, we may lose the right to develop, manufacture, market or sell products and lose sources of revenue.

The pharmaceutical industry places considerable importance on obtaining patent and trade secret protection for new technologies, products and processes. Our success depends, in part, on our ability to develop and maintain a

strong patent position for our products and technologies in clinical development, both in the United States and in other countries. Litigation or other legal proceedings may be necessary to defend against claims of infringement, to enforce our patents, or to protect our trade secrets, and could result in substantial cost to us and diversion of our efforts. We intend to file applications as appropriate for patents describing the composition of matter of our drug candidates, the proprietary processes for producing such compositions, and the uses of our drug candidates. We own three issued United States patents, one non- United States patents and have a number of pending United States patent applications, some of which we co-own with collaborators. We also have filed international, regional and non- United States national patent applications in order to pursue patent protection in major foreign countries.

Many of our scientific and management personnel were previously employed by competing companies. As a result, such companies may allege trade secret violations and similar claims against us.

To facilitate development of our proprietary technology base, we may need to obtain licenses to patents or other proprietary rights from other parties. If we are unable to obtain such licenses, our product development efforts may be delayed. We may collaborate with universities and governmental research organizations which, as a result, may acquire certain rights to any inventions or technical information derived from such collaboration.

We may incur substantial costs in asserting any patent rights and in defending suits against us related to intellectual property rights, even if we are ultimately successful. If we are unsuccessful in defending a claim that we have infringed or misappropriated the intellectual property of a third party, we could be required to pay substantial damages, stop using the disputed technology, develop new non-infringing technologies, or obtain one or more licenses from third parties. If we or our licensors seek to enforce our patents, a court may determine that our patents or our licensors' patents are invalid or unenforceable, or that the defendant's activity is not covered by the scope of our patents or our licensors' patents. The United States Patent and Trademark Office or a private party could institute an interference proceeding relating to our patents or patent applications. An opposition or revocation proceeding could be instituted in the patent offices of foreign jurisdictions. An adverse decision in any such proceeding could result in the loss of our rights to a patent or invention.

If our licensors do not protect our rights under our license agreements with them or do not reasonably consent to our sublicense of rights or if these license agreements are terminated, we may lose revenue and expend significant resources defending our rights.

We have licensed from GSK worldwide rights, excluding Japan, to an antiviral compound, maribavir, for the prevention and treatment of CMV infections related to transplant. This compound and a related compound are subject to patents and patent applications in a variety of countries throughout the world. We depend on GSK to prosecute and maintain many of these patents and patent applications and protect such patent rights. Failure by GSK to prosecute or maintain such patents or patent applications and protect such patent rights could lead to our loss of future revenue. Under certain circumstances, our ability to sublicense our rights under these license agreements is subject to the licensor's consent. If our license agreement with GSK is terminated, our ability to manufacture, develop, market and sell products under those agreements would terminate.

We depend on key personnel and may not be able to retain these employees or recruit additional qualified personnel, which would harm our ability to compete.

We are highly dependent upon qualified scientific, technical and managerial personnel, including our President and CEO, Vincent J. Milano, our Vice President, Chief Operating Officer, Daniel B. Soland, our Vice President, Chief Financial Officer, Charles Rowland, our Vice President, Chief Scientific Officer, Colin Broom, our Vice President, Global Regulatory Affairs and Quality, Robert Pietrusko and our Vice President, Strategic Initiatives, Thomas Doyle. Our ability to grow and expand into new areas and activities will require additional expertise and the addition of new qualified personnel in both the United States and Europe. There is intense competition for qualified personnel in the pharmaceutical field. Therefore, we may not be able to attract and retain the qualified

personnel necessary for the development of our business. Furthermore, we have not entered into non-competition agreements or employment agreements with our key employees. The loss of the services of existing personnel, as well as the failure to recruit additional key scientific, technical and managerial personnel in a timely manner, would harm our development programs, and our ability to manage day-to-day operations, attract collaboration partners, attract and retain other employees and generate revenues. We do not maintain key man life insurance on any of our employees.

Even after regulatory approval is received, as with Vancocin and Cinryze, if we fail to comply with regulatory requirements, or if we experience unanticipated problems with our approved products, they could be subject to restrictions or withdrawal from the market.

Cinryze and Vancocin are, and any other product for which we obtain marketing approval from the FDA or other regulatory authority will be, subject to continual review and periodic inspection by the FDA and other regulatory bodies. After approval of a product, we will have, and with Cinryze and Vancocin, we currently have, significant ongoing regulatory compliance obligations related to manufacturing processes, quality control, labeling, post-approval clinical data collection and promotional activities for each such product. Later discovery of previously unknown problems with our products or manufacturing processes, or failure to comply with regulatory requirements, may result in penalties or other actions, including:

- warning letters;
- class restrictions or “black-box” warnings
- fines;
- product recalls;
- withdrawal of regulatory approval;
- operating restrictions, including restrictions on such products or manufacturing processes;
- disgorgement of profits;
- injunctions; and
- criminal prosecution.

As part of the approval for Cinryze, we are required to conduct a clinical study designed to evaluate safety, including thrombotic adverse events, efficacy and immunogenicity of higher than 1000 Units doses of Cinryze every three or four days for routine prophylaxis. Collection and periodic reporting of CMC data also have been requested as a post-approval commitment. In the event we are unable to comply with these requirements and commitments, we may be subject to penalties or other actions. In addition, in June 2009, we received an untitled letter from the Office of Compliance and Biologics Quality in the FDA Center for Biologics Evaluation and Research alleging promotional materials were false or misleading because they present efficacy claims for Cinryze but failed to reveal, and they minimize, material facts; they make unsubstantiated comparative claims; and they overstate the efficacy of Cinryze. We have revised our marketing materials and the FDA has closed the review of these materials.

Over the past few years, a significant number of pharmaceutical and biotechnology companies have been the target of inquiries and investigations by various federal and state regulatory, investigative, prosecutorial and administrative entities, including the DOJ and various United States Attorney’s Offices, the Office of Inspector General of the Department of Health and Human Services, the FDA, the FTC and various state Attorneys General offices. These investigations have alleged violations of various federal and state laws and regulations, including claims asserting antitrust violations, violations of the Food, Drug and Cosmetic Act, the False Claims Act, the Prescription Drug Marketing Act, anti-kickback laws, and other alleged violations in connection with off-label promotion of products, pricing and Medicare and/or Medicaid reimbursement. It is both costly and time-consuming for us to comply with these extensive regulations to which it is subject. Additionally, incidents

of adverse drug reactions, unintended side effects or misuse relating to our products could result in additional regulatory controls or restrictions, or even lead to withdrawal of a product from the market.

Companies may not promote drugs for “off-label” uses — that is, uses that are not described in the product’s labeling and that differ from those approved by the FDA. Physicians may prescribe drug products for off-label uses, and such off-label uses are common across some medical specialties. Although the FDA and other regulatory agencies do not regulate a physician’s choice of treatments, the Federal Food, Drug and Cosmetics Act and FDA regulations restrict communications on the subject of off-label uses of drug products by pharmaceutical companies. The Office of Inspector General of the Department of Health and Human Services (OIG) and FDA both actively enforce laws and regulations prohibiting promotion of off-label uses and the promotion of products for which marketing clearance has not been obtained. A company that is found to have improperly promoted off-label uses may be subject to significant liability, including civil and administrative remedies as well as criminal sanctions.

Notwithstanding the regulatory restrictions on off-label promotion, the OIG and the FDA allow companies to engage in truthful, non-misleading, and non-promotional speech concerning their products. Although we believe that all of our communications regarding all of our products are in compliance with the relevant legal requirements, the OIG or the FDA may disagree, and we may be subject to significant liability, including civil and administrative remedies, as well as criminal sanctions. In addition, management’s attention could be diverted from our business operations and our reputation could be damaged.

The FDA provides guidelines with respect to appropriate promotion and continuing medical and health education activities. Although we endeavor to follow these guidelines, the FDA or the OIG may disagree, and we may be subject to significant liability, including civil and administrative remedies as well as criminal sanctions. Should the government choose to initiate action against us, we could face substantial penalties, which could have a material adverse effect on our business, financial condition and results of operations. In addition, management’s attention could be diverted and our reputation could be damaged.

In addition, anti-kickback laws make it illegal for a prescription drug manufacturer to solicit, offer, or pay any remuneration in exchange for purchasing, leasing or ordering any service or items including the purchase or prescription of a particular drug for which payment may be made under a federal health care program. Because of the sweeping language of the federal anti-kickback statute, many potentially beneficial business arrangements would be prohibited if the statute were strictly applied. To avoid this outcome, the United States Department of Health and Human Services has published regulations—known as “safe harbors”—that identify exceptions or exemptions to the statute’s prohibitions. Arrangements that do not fit within the safe harbors are not automatically deemed to be illegal, but must be evaluated on a case-by-case basis for compliance with the statute. We seek to comply with anti-kickback statutes and to fit within one of the defined “safe harbors”. However, due to the breadth of the statutory provisions and the absence of uniform guidance in the form of regulations or court decisions, there can be no assurance that our practices will not be challenged under anti-kickback or similar laws. Violations of such restrictions may be punishable by civil and/or criminal sanctions, including fines and civil monetary penalties, as well as the possibility of exclusion from United States federal healthcare programs (including Medicaid and Medicare). Any such violations could have a material adverse effect on our business, financial condition and results of operations.

In recent years, several states and localities, including California, the District of Columbia, Maine, Massachusetts, Minnesota, Nevada, New Hampshire, New Mexico, Vermont, Texas, and West Virginia, have enacted legislation requiring pharmaceutical companies to establish marketing compliance programs, and file periodic reports with the state or make periodic public disclosures on sales, marketing, pricing, clinical trials, and other activities. Similar legislation was approved by the federal government in 2010 and will take effect in 2012. Many of these requirements are new and uncertain, and the penalties for failure to comply with these requirements are unclear. If we are found not to be in full compliance with these laws, we could face enforcement action and fines and other penalties, and could receive adverse publicity.

Any of these events could result in a material adverse effect on our revenues and financial condition.

Our future product revenues from sales of Vancocin and Cinryze could be reduced by imports from countries where similar products are available at lower prices.

Vancocin has been approved for sale outside of the United States, including but not limited to Canada, Brazil and Europe, and Lilly or its licensees continue to market Vancocin outside of the United States. There are products similar to Cinryze which are approved in the E.U. There have been cases in which pharmaceutical products were sold at steeply discounted prices in markets outside the United States and then imported to the United States where they could be resold at prices higher than the original discounted price, but lower than the prices commercially available in the United States. If this happens with Vancocin or Cinryze our revenues would be adversely affected. Additionally, there are non-United States, Internet-based companies supplying Vancocin directly to patients at significantly reduced prices.

In recent years, various legislative proposals have been offered in the United States Congress and in some state legislatures that would authorize re-importation of pharmaceutical products into the United States from other countries including Canada. We cannot predict the outcome of such initiatives, which if adopted, could result in increased competition for our products and lower prices.

Risks associated with our international business relationships could materially adversely affect our business.

We are engaged in clinical trials and have employees located in Europe, have established manufacturing relationships, are marketing a product and are seeking approval to market Cinryze and other products in Europe. We have also established our own commercial sales and marketing personnel in Europe and plan to increase the number of personnel in certain European countries. In the future, we may enter into distribution arrangements with third parties to market our products and product candidates in countries outside of the United States and Europe. Consequently, we are, and will continue to be, subject to risks related to operating in foreign countries. Risks associated with conducting operations in foreign countries include:

- differing regulatory requirements for drug approvals in foreign countries;
- changes in tariffs, trade barriers and regulatory requirements;
- economic weakness, including inflation, or political instability in particular foreign economies and markets;
- compliance with tax, employment, immigration and labor laws for employees living or traveling abroad;
- foreign taxes, including withholding of payroll taxes;
- foreign currency fluctuations, which could result in increased operating expenses or reduced revenues, and other obligations incident to doing business or operating a subsidiary in another country;
- workforce uncertainty in countries where labor unrest is more common than in the United States;
- production shortages resulting from any events affecting raw material supply or manufacturing capabilities abroad; and
- business interruptions resulting from geo-political actions, including war and terrorism.

In Europe, we market a product and are developing a product candidate that both contain active ingredients that are controlled substances, and are therefore subject to additional regulation by European regulatory authorities relating to the procurement, manufacture, labeling, packaging, security controls, shipment, sale and use of these products. In addition, incidents of product misuse, product diversion or theft may occur with products containing controlled substances. These and other risks associated with our international operations may materially adversely affect our ability to attain or maintain profitable operations.

Our indebtedness and other financial obligations may harm our financial condition and results of operations.

Our total consolidated long-term debt as of December 31, 2010 is \$205.0 million. Our level of indebtedness could have important consequences to you, because:

- a portion of our cash flows from operations will have to be dedicated to interest and may not be available for operations, working capital, capital expenditures, expansion, acquisitions or general corporate or other purposes;
- it may impair our ability to obtain additional financing in the future;
- it may limit our flexibility in planning for, or reacting to, changes in our business and industry; and
- it may make us more vulnerable to downturns in our business, our industry or the economy in general.

Our operations may not generate sufficient cash to enable us to service our debt. If we fail to make a payment on the senior convertible notes, we could be in default on the senior convertible notes, and this default could cause us to be in default on our other outstanding indebtedness. Conversely, a default on our other outstanding indebtedness may cause a default under the senior convertible notes.

We have a future liability in the form of a contingent value payments to the former stockholders of Lev upon the achievement of a commercial target. The CVR payment of \$0.50 per share (\$87.5 million) would become payable when Cinryze reaches at least \$600 million in cumulative net product sales within 10 years of closing of the acquisition. We cannot predict if or when the payment may be payable or if it could materially adversely affect our business at the time of payment. We also have a future liability arising from our acquisition of Auralis Limited upon achievement of a regulatory target. We have agreed to pay an additional payment of £10 million Pounds Sterling (approximately \$15.5 million based on the December 31, 2010 exchange rate) upon the first regulatory approval of a product in late stage development. We cannot predict if or when these payments may be payable or if they could materially adversely affect our business at the time of payment.

Our stock price could continue to be volatile.

Our stock price, like the market price of the stock of other pharmaceutical companies, has been volatile. For example, during the twelve months ended December 31, 2010, the market price for our common stock fluctuated between \$8.41 and \$18.37 per share. The following factors, among others, could have a significant impact on the market for our common stock:

- period to period fluctuations in sales of Vancocin and Cinryze;
- approvals of generic products that compete with Vancocin;
- our ability to successfully manufacture sufficient amounts of Cinryze to meet demand and increase manufacturing capacity;
- results of clinical trials with respect to our product candidates in development or those of our competitors;
- developments with our collaborators;
- announcements of technological innovations or new products by our competitors;
- litigation or public concern relating to our products or our competitors' products;
- developments in patent or other proprietary rights of our or its competitors (including related litigation);
- any announcement regarding our acquisition of product candidates or entities;
- future announcements concerning our industry;

- governmental regulation;
- changes in federal, state and foreign tax laws and related regulations;
- actions or decisions by the SEC, the FDA or other regulatory agencies;
- changes or announcements of changes in reimbursement policies;
- period to period fluctuations in our operating results, including changes in accounting estimates;
- our cash and cash equivalents balances;
- changes in our capital structure;
- changes in estimates of our performance by securities analysts;
- market conditions applicable to our business sector; and
- general market conditions.

The rights that have been and may in the future be granted to holders of our common or preferred stock may adversely affect the rights of other stockholders and may discourage a takeover.

Our board of directors has the authority to issue up to 4,800,000 shares of preferred stock and to determine the price, privileges and other terms of such shares. Our board of directors may exercise this authority without the approval of, or notice to, our stockholders. Accordingly, the rights of the holders of our common stock may be adversely affected by the rights of the holders of any preferred stock that may be issued in the future. In addition, the issuance of preferred stock may make it more difficult for a third party to acquire a majority of our outstanding voting stock in order to effect a change in control or replace our current management. We are also subject to the anti-takeover provisions of Section 203 of the Delaware General Corporation Law. The application of Section 203 could also delay or prevent a third party or a significant stockholder of ours from acquiring control of us or replacing its current management. In general, Section 203 prohibits a publicly held Delaware corporation from engaging in a business combination with an interested stockholder for a period of three years following the date the person became an interested stockholder, unless the business combination or the transaction in which the person became an interested stockholder is approved in a prescribed manner. Generally, a business combination includes a merger, asset or stock sale, or other transaction resulting in a financial benefit to the interested stockholder. Under Delaware law, an interested stockholder is a person who, together with affiliates and associates, owns 15% or more of a corporation's voting stock.

In addition, our charter and bylaws contain certain provisions that could discourage a hostile takeover, such as a staggered board of directors and significant notice provisions for nominations of directors and proposals. Our charter and bylaws may make it more difficult for a third party to acquire a majority of our outstanding voting stock in order to effect a change in control or replace our current management.

The convertible note hedge and warrant transactions may affect the value of the senior convertible notes and our common stock.

In connection with the issuance of the senior convertible senior notes, we have entered into privately-negotiated transactions with two counterparties, or the counterparties, comprised of purchased call options and warrants sold. These transactions are expected to generally reduce the potential equity dilution of our common stock upon conversion of the senior convertible notes.

In connection with establishing their initial hedge of these transactions, the counterparties may have entered into various derivative transactions with respect to our common stock concurrently with, or shortly after, the pricing of the senior convertible notes. The counterparties (and/or their affiliates) may modify their hedge positions from time to time by entering into or unwinding various derivative transactions with respect to our common stock or by purchasing or selling our common stock in secondary market transactions, which could adversely affect the

value of our common stock or could have the effect of increasing or preventing a decline in the value of our common stock. Additionally, these transactions expose us to counterparty credit risk for nonperformance. We manage our exposure to counterparty credit risk through specific minimum credit standards, and diversification of counterparties.

The potential effect, if any, of any of these transactions and activities on the market price of our common stock will depend in part on market conditions and cannot be ascertained at this time. Any of these activities could adversely affect the value of our common stock.

We do not make any representation or prediction as to the direction or magnitude of any potential effect that the transactions described above may have on the price of the senior convertible notes or the shares of our common stock. In addition, we do not make any representation that the counterparties will engage in these transactions or that these transactions, once commenced, will not be discontinued without notice.

The fundamental change purchase feature of the senior convertible notes may delay or prevent an otherwise beneficial attempt to take over our company.

The terms of the senior convertible notes require us to purchase the senior convertible notes for cash in the event of a fundamental change. A takeover of our company would trigger the requirement that we purchase the senior convertible notes. Alternatively, if certain transactions that constitute a fundamental change occur, under certain circumstances, we will increase the conversion rate by a number of additional shares of our common stock to compensate holders for the lost option time value of the senior convertible notes as a result of such transaction. This increased conversion rate will apply only to holders who convert their senior convertible notes in connection with any such transaction. The number of the additional shares of our common stock will be determined based on the date on which the transaction becomes effective and the price paid per share of our common stock. This may have the effect of delaying or preventing a takeover of our company that would otherwise be beneficial to investors.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

In March 2008, we entered into a lease, comprising 78,264 square feet of office and related space, for the Company's headquarters located in Exton, Pennsylvania. The lease expires in April 2015. In connection with the lease, we also received a leasehold improvement allowance of \$2.3 million.

In May 2008, we entered into a lease in Maidenhead, United Kingdom, comprising 8,000 square feet of office space, for our U.K. operations. The lease expires in May 2018. We are also a party to a short term lease for a shared services facility in Brussels and anticipate that during 2010 we will evaluate potential opportunities to accommodate our continued expansion in Europe.

On January 30, 2007, we purchased 33,000 square feet facility located in Exton, PA. We vacated this space in October 2008 when we moved into our new headquarters. In October 2009, we leased this facility to a third party for an initial term of five years.

We also lease office space for our European operations in Belgium and Germany and intend to lease additional office space in several additional European countries in the next two years.

ITEM 3. LEGAL PROCEEDINGS

On September 10, 2010, we brought an action for declaratory relief (the "Complaint") against the Food and Drug Administration, Margaret A. Hamburg, M.D., in her official capacity as Commissioner of Food and Drug Administration, the United States Department of Health and Human Services ("HHS"), and Kathleen Sebelius, in her official capacity as Secretary of HHS, (collectively "FDA") in the United States District Court for the District of Columbia (the "Court"). Pursuant to the Complaint, we are seeking review under the Administrative Procedure Act ("APA") of the FDA's decision to change its regulations to abandon its longstanding rule that applicants for an Abbreviated New Drug Application ("ANDA") seeking waiver of the requirement of 21 C.F.R. § 320.21 (2010) that bioequivalence must be demonstrated by *in vivo* evidence must satisfy one of the enumerated waiver criteria set forth in 21 C.F.R. § 320.22. We have requested that the Court determine that (i) the plain reading of FDA's regulations requires an ANDA applicant seeking a waiver of the *in vivo* bioequivalence testing requirement to first meet one of the criteria set forth in 21 C.F.R. § 320.22 and (ii) FDA's amendment of its regulations governing waiver of submission of *in vivo* bioequivalence evidence, without engaging in notice-and-comment rulemaking, violates 5 U.S.C. § 553 of the APA and is therefore invalid. Subsequently, the DOJ filed a motion to dismiss the Complaint and the parties have filed briefs supporting their positions regarding the motion to dismiss.

From time to time we are a party to litigation in the ordinary course of our business. We do not believe these matters, even if adversely adjudicated or settled, would have a material adverse effect on our financial condition, results of operations or cash flows.

PART II

ITEM 5. MARKET FOR THE REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

Market Information

Our common stock is traded on the Global Market segment of The NASDAQ Stock Market under the symbol "VPHM." We commenced trading on The NASDAQ Stock Market on November 19, 1996. The following table sets forth the high and low sale prices as quoted on The NASDAQ Stock Market for each quarter of 2009 and 2010 and through February 11, 2011.

| | <u>High</u> | <u>Low</u> |
|--|-------------|------------|
| Year ended December 31, 2009 | | |
| First Quarter | \$14.15 | \$ 3.98 |
| Second Quarter | \$ 7.08 | \$ 4.73 |
| Third Quarter | \$ 9.98 | \$ 5.53 |
| Fourth Quarter | \$ 9.80 | \$ 7.30 |
| Year ended December 31, 2010 | | |
| First Quarter | \$14.40 | \$ 8.41 |
| Second Quarter | \$14.33 | \$10.78 |
| Third Quarter | \$15.45 | \$10.29 |
| Fourth Quarter | \$18.37 | \$14.28 |
| First Quarter 2011 (through February 11, 2011) | \$18.70 | \$16.00 |

Holders and Dividends

There were approximately 644 record holders of our common stock as of February 11, 2011. We have never declared or paid any cash dividends on our common stock. We have declared and paid dividends in the past on our previously outstanding Series A convertible participating preferred stock. As of February 24, 2011, we had no shares of preferred stock outstanding. Any future determination to pay dividends will be at the discretion of our board of directors and will be dependent on then existing conditions, including our financial condition, results of operations, contractual restrictions, capital requirements, business and other factors our board of directors deems relevant. We anticipate for the foreseeable future, we will retain our earnings in order to finance investments in our business.

ITEM 6. SELECTED FINANCIAL DATA

The selected financial data presented below under the caption "Consolidated Statement of Operations Data" for the years ended December 31, 2010, 2009, 2008, 2007, and 2006 and under the caption "Consolidated Balance Sheet Data" as of December 31, 2010, 2009, 2008, 2007, and 2006 are derived from our consolidated financial statements which have been audited. The data set forth below should be read in conjunction with Management's Discussion and Analysis of Financial Condition and Results of Operations, the Consolidated Financial Statements and the notes thereto and the other financial information included elsewhere in this Report.

In October 2008, we acquired Lev Pharmaceuticals, Inc., and in May 2010 we acquired Auralis Limited.

| | Year Ended December 31, | | | | |
|--|-------------------------|-------------|------------|------------|------------|
| | 2010 | 2009 | 2008 | 2007 | 2006 |
| <i>(in thousands, except per share amounts)</i> | | | | | |
| Consolidated Statement of Operations Data: | | | | | |
| Net product sales | \$ 439,012 | \$ 310,449 | \$ 232,307 | \$ 203,770 | \$ 167,181 |
| Operating expenses: | | | | | |
| Cost of sales (excluding amortization of product rights) | 61,288 | 40,214 | 8,874 | 8,934 | 18,984 |
| Research and development | 39,613 | 52,083 | 64,434 | 33,925 | 17,890 |
| Selling, general and administrative | 95,664 | 89,316 | 67,270 | 38,995 | 25,832 |
| Intangible amortization and acquisition of technology rights | 29,357 | 28,183 | 10,809 | 6,120 | 5,669 |
| Goodwill impairment | — | 65,099 | — | — | — |
| Impairment loss | — | 3,424 | 2,265 | — | — |
| Other operating expenses | 1,390 | — | — | — | — |
| Total operating expenses | 227,312 | 278,319 | 153,652 | 87,974 | 68,375 |
| Operating income | 211,700 | 32,130 | 78,655 | 115,796 | 98,806 |
| Interest income | 372 | 352 | 14,296 | 24,265 | 9,853 |
| Interest expense | (11,616) | (11,609) | (12,951) | (9,612) | (686) |
| Other income, net | 430 | — | — | — | 555 |
| Gain on long-term debt repurchase | — | 9,079 | — | — | — |
| Income tax expense | 75,278 | 41,029 | 16,040 | 38,344 | 41,862 |
| Net income (loss) | \$ 125,608 | \$ (11,077) | \$ 63,960 | \$ 92,105 | \$ 66,666 |
| Net income (loss) per share: | | | | | |
| Basic | \$ 1.61 | \$ (0.14) | \$ 0.90 | \$ 1.32 | \$ 0.97 |
| Diluted | \$ 1.47 | \$ (0.14) | \$ 0.84 | \$ 1.21 | \$ 0.95 |
| Shares used in computing net income (loss) per share: | | | | | |
| Basic | 77,820 | 77,423 | 71,391 | 69,827 | 68,990 |
| Diluted | 90,081 | 77,423 | 85,712 | 80,891 | 70,338 |
| As of December 31, | | | | | |
| Consolidated Balance Sheet Data: | | | | | |
| Cash, cash equivalents and investments | \$ 505,171 | \$ 331,672 | \$ 275,839 | \$ 584,328 | \$ 255,409 |
| Working capital | 561,019 | 406,375 | 317,413 | 596,819 | 266,443 |
| Total assets | 1,287,574 | 1,084,451 | 1,086,129 | 771,605 | 429,694 |
| Long-term debt | 145,743 | 138,614 | 161,003 | 153,572 | — |
| Total stockholders' equity | 891,135 | 750,387 | 749,334 | 558,530 | 411,899 |

We have never paid dividends on our common stock.

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

Background

ViroPharma Incorporated and subsidiaries is a global biotechnology company dedicated to the development and commercialization of products that address serious diseases, with a focus on products used by physician specialists or in hospital settings. We intend to grow through sales of our marketed products, through continued development of our product pipeline, expansion of sales into additional territories outside the United States and through potential acquisition or licensing of products or acquisition of companies. We expect future growth to be driven by sales of Cinryze, both domestically and internationally, and by our primary development programs, including C1 esterase inhibitor and a non-toxicogenic strain of *C. difficile* (VP20621).

We market and sell Cinryze in the United States for routine prophylaxis against angioedema attacks in adolescent and adult patients with hereditary angioedema (HAE). Cinryze is a C1 esterase inhibitor therapy for routine prophylaxis against HAE, also known as C1 inhibitor (C1-INH) deficiency, a rare, severely debilitating, life-threatening genetic disorder. Cinryze was obtained in October 2008, when we completed our acquisition of Lev Pharmaceuticals, Inc. (Lev). In January 2010, we acquired expanded rights to commercialize Cinryze and future C1-INH derived products in certain European countries and other territories throughout the world as well as rights to develop future C1-INH derived products for additional indications. In March 2010, our Marketing Authorization Application (MAA) for Cinryze for acute treatment and prophylaxis against HAE was accepted by the European Medicines Agency (EMA). We intend to seek to commercialize Cinryze in Europe in 2011 in countries where we have distribution rights. We are currently evaluating our commercialization plans in additional territories. We also intend to conduct ViroPharma sponsored studies and support investigator-initiated studies (IIS) to identify further therapeutic uses and potentially expand the labeled indication for Cinryze to include other C1 mediated diseases, such as Antibody-Mediated Rejection (AMR) and Delayed Graft Function (DGF). Additionally, we are currently undertaking studies on the viability of subcutaneous administration of Cinryze.

We also market and sell Vancocin HCl capsules, the oral capsule formulation of vancomycin hydrochloride, in the U.S. and its territories. Vancocin is a potent antibiotic approved by the U.S. Food and Drug Administration, or FDA, to treat antibiotic-associated pseudomembranous colitis caused by *Clostridium difficile* infection (CDI), or *C. difficile*, and enterocolitis caused by *Staphylococcus aureus*, including methicillin-resistant strains.

Our product development portfolio is primarily focused on two programs, C1 esterase inhibitor [human] and VP20621. We are working on developing further therapeutic uses; potential additional indications in other C1 mediated diseases, and alternative modes of administration for C1 esterase inhibitor. We are also developing VP20621 for the treatment and prevention of CDI. On August 6, 2009 we announced that dosing had begun in the Phase 1 clinical trial for VP20621 to determine the safety and tolerability of VP20621 dosed orally as a single and as repeat escalating doses in healthy young and older adults. We have successfully completed our Phase 1 clinical trial, filed an IND in December of 2010 and anticipate moving the compound into a Phase 2 clinical trial in the first half of 2011.

In addition to these programs, we have several other assets that we may make additional investments in. These investments will be limited and dependent on our assessment of the potential future commercial success of or benefits from the asset. On May 28, 2010 we acquired Auralis Limited, a UK based specialty pharmaceutical company. The acquisition of Auralis provides us with the opportunity to accelerate our European commercial systems for potential future product launches and additional business development acquisitions.

We intend to continue to evaluate in-licensing or other opportunities to acquire products in development, or those that are currently on the market. We plan to seek products that treat serious or life threatening illnesses with a high unmet medical need, require limited commercial infrastructure to market, and which we believe will provide both top and bottom line growth over time.

Executive Summary

Since December 31, 2009, we experienced the following:

Business Activities

Cinryze:

- Shipped approximately 46,000 doses of Cinryze to specialty pharmacy/specialty distributors (SP/SD's);
- Acquired expanded rights to commercialize Cinryze and future C1-INH derived products in certain European countries and other territories throughout the world as well as rights to develop future C1-INH derived products for additional indications;
- EMA accepted the filing of our MAA for Cinryze for acute treatment and prophylaxis against HAE;
- Initiated an open-label, single-dose Phase 2 study to evaluate doses of Cinryze for treatment of acute angioedema attacks in children less than 12 years of age with HAE;
- Presented Cinryze data at 2010 Annual Meeting of the American College of Allergy, Asthma & Immunology (ACAAI), and International Scientific Conference of the World Allergy Organization (WAO);
- Conducted a multi-dose Phase 2 study to evaluate the safety, pharmacokinetics and pharmacodynamics of subcutaneous formulation Cinryze; and,
- Submitted the Cinryze industrial scale manufacturing Prior Approval Supplement (PAS) to FDA and received a complete response letter regarding the Cinryze industrial scale manufacturing expansion activities requesting additional information related to observations from the pre-approval inspection and review of the technical processes;

C. difficile infection (CDI):

- Completed Phase 1 clinical trial for VP20621;
- Presented data from Phase 1 study of non-toxicogenic *C. difficile* (VP20621) at the Interscience Conference on Antimicrobial Agents and Chemotherapy (ICAAC); and,
- Vancocin scripts decreased 5.8% in 2010 as compared to 2009;

Financial Results

- Net sales of Cinryze increased to \$176.8 million for the year ended December 31, 2010 from \$97.3 million for the year ended December 31, 2009;
- Net sales of Vancocin increased to \$259.6 million for the year ended December 31, 2010 from \$213.1 million for the year ended December 31, 2009; and,
- Reported net income of \$125.6 million for the year ended December 31, 2010;

Liquidity

- Generated net cash from operations of \$193.5 million;
- Ended 2010 with working capital of \$561.0 million which includes cash and cash equivalents of \$426.7 million and investments of \$78.4 million.

During 2011 and going forward, we expect to face a number of challenges, which include the following:

The commercial sale of approved pharmaceutical products is subject to risks and uncertainties. There can be no assurance that future Vancocin sales will meet or exceed the historical rate of sales for the product, for reasons that include, but are not limited to, generic and non-generic competition for Vancocin and/or changes in prescribing habits or disease incidence.

The FDA convened a meeting of its Advisory Committee for Pharmaceutical Science and Clinical Pharmacology to discuss bioequivalence recommendations for oral vancomycin hydrochloride capsule drug products on August 4, 2009. The Advisory Committee was asked if the proposed guidelines are sufficient for establishing bioequivalence for generic vancomycin oral capsules. The Advisory Committee voted unanimously in favor of the component of the proposed OGD recommendation that requires bioequivalence to be demonstrated through comparable dissolution in media of pH 1.2, 4.5 and 6.8 for potential vancomycin HCl capsule generic products that (a) contain the same active and inactive ingredients in the same amounts as Vancocin HCl capsules; (b) meet currently accepted standards for assay, potency, purity, and stability (equivalent to those in place for Vancocin HCl capsules); and (c) are manufactured according to cGMP. We have opposed both the substance of the FDA's bioequivalence method and the manner in which it was developed. In the event the OGD's revised bioequivalence recommendation for Vancocin remains in effect, the time period in which a generic competitor may enter the market would be reduced. There can be no assurance that the FDA will agree with the positions stated in our Vancocin related submissions or that our efforts to oppose the OGD's March 2006 and December 2008 recommendation to determine bioequivalence to Vancocin through in-vitro dissolution testing will be successful. We cannot predict the timeframe in which the FDA will make a decision regarding either our citizen petition for Vancocin or the approval of generic versions of Vancocin. If we are unable to change the recommendation set forth by the OGD in March 2006 as revised in December 2008 and voted upon by the Advisory Committee for Pharmaceutical Science and Clinical Pharmacology, the threat of generic competition will be high.

The FDA approved Cinryze for routine prophylaxis against angioedema attacks in adolescent and adult patients with hereditary angioedema on October 10, 2008. Cinryze became commercially available for routine prophylaxis against HAE in December 2008 and the commercial success of Cinryze will depend on several factors, including: the number of patients with HAE that may be treated with Cinryze; acceptance by physicians and patients of Cinryze as a safe and effective treatment; our ability to effectively market and distribute Cinryze in the United States; cost effectiveness of HAE treatment using Cinryze; relative convenience and ease of administration of Cinryze; potential advantages of Cinryze over alternative treatments; the timing of the approval of competitive products including another C1 esterase inhibitor for the acute treatment of HAE; the market acceptance of competing approved products such as Berinert; patients' ability to obtain sufficient coverage or reimbursement by third-party payors; variations in dosing arising from physician preferences and patient compliance; sufficient supply and reasonable pricing of raw materials necessary to manufacture Cinryze; manufacturing or supply interruptions and capacity which could impair our ability to acquire an adequate supply of Cinryze to meet demand for the product; and our ability to achieve expansion of manufacturing capabilities in the capacities and timeframes currently anticipated. In addition, our ability to develop life cycle management plans for Cinryze, including designing and commencing clinical studies for additional indications and pursuing regulatory approvals in additional indications or territories will impact our ability to generate future revenues from Cinryze.

In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA), which was amended by the Health Care and Education Reconciliation Act of 2010. The PPACA, as amended, is a sweeping measure intended to expand healthcare coverage within the United States, primarily through the imposition of health insurance mandates on employers and individuals and expansion of the Medicaid program. Several provisions of the new law, which have varying effective dates, will affect us. These include new requirements on private insurance companies that prohibit coverage denials because of a pre-existing condition; prohibit the application of annual and lifetime benefits limits on health insurance policies; and prohibit

coverage rescissions (except for fraud) and health-based insurance rating. In addition, the PPACA, as amended, funds an interim high risk pool that states can draw on; following the expiration of this high risk pool funding, it provides for the creation of state-run "exchanges" that will allow people without employer-provided coverage, or who cannot afford their employer's plan, to buy health insurance; and provides federal subsidies to those who cannot afford premiums. Collectively, these factors may increase the availability of reimbursement for patients seeking the products that ViroPharma commercializes. However, the Act, as amended, will likely increase certain of our costs as well. For example, an increase in the Medicaid rebate rate from 15.1% to 23.1% was effective as of January 1, 2010, and the volume of rebated drugs has been expanded to include beneficiaries in Medicaid managed care organizations, effective as of March 23, 2010. In 2011, the PPACA also imposes a manufacturer's fee on the sale of branded Pharmaceuticals (excluding orphan drugs) to specified government programs, expands the 340B drug discount program (excluding orphan drugs), and includes a 50% discount on brand name drugs for Medicare Part D participants in the coverage gap, or "doughnut hole". Our evaluation of PPACA, as amended, will continue to enable us to determine not only the immediate effects on our business, but also the trends and changes that may be encouraged by the legislation that may potentially impact on our business over time.

We will face intense competition in acquiring additional products to further expand our product portfolio. Many of the companies and institutions that we will compete with in acquiring additional products to further expand our product portfolio have substantially greater capital resources, research and development staffs and facilities than we have, and greater resources to conduct business development activities. We may need additional financing in order to acquire new products in connection with our plans as described in this report.

The outcome of our clinical development programs is subject to considerable uncertainties. We cannot be certain that we will be successful in developing and ultimately commercializing any of our product candidates, that the FDA or other regulatory authorities will not require additional or unanticipated studies or clinical trial outcomes before granting regulatory approval, or that we will be successful in obtaining regulatory approval of any of our product candidates in the timeframes that we expect, or at all.

We cannot assure you that our current cash and cash equivalents and investments or cash flows from product sales will be sufficient to fund all of our ongoing development and operational costs, as well as the interest payable on our outstanding senior convertible notes, over the next several years, that planned clinical trials can be initiated, or that planned or ongoing clinical trials can be successfully concluded or concluded in accordance with our anticipated schedule and costs. Moreover, the results of our business development efforts could require considerable investments.

Our actual results could differ materially from those results expressed in, or implied by, our expectations and assumption described in this Annual Report on Form 10-K. The risks described in this report, our Form 10-K for the year ended December 31, 2010 are not the only risks facing us. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial also may materially adversely affect our business, financial condition and/or operating results. Please also see our discussion of the "Risk Factors" in Item 1A, which describe other important matters relating our business.

Results of Operations

Years ended December 31, 2010 and 2009

| (in thousands, except per share data) | For the years ended December 31, | |
|---|-------------------------------------|------------|
| | 2010 | 2009 |
| Net product sales | \$439,012 | \$310,449 |
| Cost of sales (excluding amortization of product rights) | \$ 61,288 | \$ 40,214 |
| Operating income | \$211,700 | \$ 32,130 |
| Net income (loss) | \$125,608 | \$(11,077) |
| Net income (loss) per share: | | |
| Basic | \$ 1.61 | \$ (0.14) |
| Diluted | \$ 1.47 | \$ (0.14) |

The \$211.7 million in operating income for the twelve months ended December 31, 2010 increased \$179.6 million as compared to the same period in 2009. The primary drivers of this increase are increased net sales of \$128.6 million, the \$65.1 million goodwill impairment charge in the first quarter of 2009 for which no impairment occurred in 2010, and, a decrease in our research and development expense of \$ 12.5 million primarily due to the wind-down of our CMV program. These were partly offset from increased cost of sales \$21.1 million due to the increase in Cinryze sales volume and a \$6.3 million increase in selling, general and administrative expense.

Revenues

Revenues consisted of the following:

| (in thousands) | For the years ended December 31, | |
|----------------------|-------------------------------------|------------------|
| | 2010 | 2009 |
| Net product sales | | |
| Vancocin | \$259,567 | \$213,138 |
| Cinryze | 176,815 | 97,311 |
| Other | 2,630 | — |
| Total revenues | <u>\$439,012</u> | <u>\$310,449</u> |

Revenue—Vancocin and Cinryze product sales

We sell Vancocin only to wholesalers who then distribute the product to pharmacies, hospitals and long-term care facilities, among others. Our sales of Vancocin are influenced by wholesaler forecasts of prescription demand, wholesaler buying decisions related to their desired inventory levels, and, ultimately, end user prescriptions, all of which could be at different levels from period to period.

We sell Cinryze to specialty pharmacy/specialty distributors (SP/SD's) who then distribute to physicians, hospitals and patients, among others. During 2010, we continued work to expand our manufacturing capacity to insure the availability of Cinryze to meet growing patient needs and believe our efforts will allow us to continue to meet this growing patient demand for the foreseeable future. In the second quarter of 2010, we introduced parallel chromatography produced Cinryze into the trade which increased our supply so that we were able to start new patients on Cinryze as needed without undue concern of any disruption of the availability of Cinryze to those already receiving it. In order to meet the anticipated longer term demand, we submitted to the FDA a Prior Approval Supplement (PAS) in the second quarter of 2010. The PAS involves a larger scale manufacturing

project to significantly increase the Cinryze production capabilities at Sanquin. In October 2010, the FDA issued a complete response letter regarding the Cinryze industrial scale manufacturing expansion activities. In the complete response letter the FDA has requested additional information related to observations from the pre-approval inspection and review of the technical processes. We anticipate filing a response to the complete response letter during 2011 and in parallel will continue advancing additional initiatives intended to increase our capacity.

During the year ended December 31, 2010, net sales of Vancocin increased 21.8% compared to 2009. The increase is primarily due to price increases during 2010, offset by lower sales volumes. Based upon data reported by IMS Health Incorporated, prescriptions during the year ended December 31, 2010 decreased from the same period in 2009 by 5.8%, which we believe is due to a decrease in the severity of the disease state, improved aseptic techniques and a suspected increase in compounding seen both in the hospital and long-term care marketplace. The units sold for the year ended December 31, 2010 decreased by 1.4% compared to the same period in 2009. Our net sales of Cinryze during the year ended December 31, 2010 increased \$79.5 million compared to the same period in 2009 due to an increase in the number of patients receiving Cinryze.

Vancocin product sales are driven by demand fluctuations in trade inventories which could be at different levels from period to period. Cinryze product sales are influenced by prescriptions and the rate at which new patients are placed on Cinryze. We receive inventory data from our three largest wholesalers through our fee for service agreements and our two SP/SD's through service agreements. We do not independently verify this data. Based on this inventory data and our estimates, we believe that as of December 31, 2010, the wholesalers and SP/SD's did not have excess channel inventory of either product.

Cost of sales (excluding amortization of product rights)

Cost of sales increased for the year ended December 31, 2010 by \$21.1 million as compared to the same period in 2009 due to increased Cinryze volume, partially offset by the impact of the step-up on 2009 cost of sales related to the acquisition of Lev (\$6.9 million). We utilized the entire inventory that was recorded at fair value as part of the Lev purchase during 2009. Additionally, included in the cost of sales for the year ended December 31, 2010 are expenses of \$1.5 million related to non-refundable start up costs paid to a new plasma supplier and a \$2.8 million write-off of inventory, produced as part of our effort to receive FDA approval for a larger scale manufacturing line.

Vancocin and Cinryze cost of sales includes the cost of materials and distribution costs and excludes amortization of product rights. Since units are shipped based upon earliest expiration date, we would expect the cost of product sales of both Vancocin and Cinryze to fluctuate from quarter to quarter as we may experience fluctuations in quarterly manufacturing yields.

Research and development expenses

For each of our research and development programs, we incur both direct and indirect expenses. Direct expenses include third party costs related to these programs such as contract research, consulting, cost sharing payments or receipts and clinical and development costs. Indirect expenses include personnel, facility, stock compensation and other overhead costs. Due to advancements in our VP20621 preclinical program, and our Cinryze Phase 4 commitment and Phase 2 study in children, we expect future costs in these programs to exceed historical costs.

Research and development expenses were divided between our research and development programs in the following manner:

| (in thousands) | For the years ended December 31, | |
|---|-------------------------------------|-----------------|
| | 2010 | 2009 |
| Direct—Core programs | | |
| Non-toxicogenic strains of C. difficile (VP20621) | \$ 7,643 | \$ 9,801 |
| Cinryze | 7,113 | 7,067 |
| Vancocin | 1,151 | 675 |
| Direct—Other assets | | |
| CMV | 866 | 15,715 |
| New Initiatives | 2,279 | — |
| Other assets | 1,604 | 8 |
| Indirect | | |
| Development | 18,957 | 18,817 |
| Total | <u>\$39,613</u> | <u>\$52,083</u> |

Direct Expenses—Core Development Programs

The decrease in costs of VP20621 for the year ended December 31, 2010 compared to the same period in 2009 relates to timing associated with costs of our Phase 1 clinical trial.

Our costs associated with our Cinryze program during 2010 are flat compared to 2009, as we incurred costs related to our Phase 4 clinical trial and the development of our life cycle program during 2010, while during 2009, we incurred costs related to our open label trials which closed on March 31, 2009 and preparation of our Phase 4 clinical trial.

Vancocin costs in 2010 and 2009 related to additional research activities.

Direct Expenses—Other Assets

Our direct expenses related to our CMV program decreased in 2010 compared to 2009 as we wound down our stem cell and liver transplant studies in 2009. In February 2009, based upon preliminary analysis of the data, we announced that our Phase 3 trial evaluating maribavir used as prophylaxis in allogeneic stem cell, or bone marrow, transplant patients did not achieve its primary endpoints. In addition, the study failed to meet its key secondary endpoints. Additionally, we announced that our Phase 3 trial evaluating maribavir in liver transplant patients was discontinued and that all patients on study drug were moved to current standard of care. During 2009 we continued enrollment in our solid organ (liver) study through February 2009, conducted follow-up visits necessary to complete both our Phase 3 studies following receipt of the results of our stem cell transplant study and continued to evaluate the results of our Phase 3 programs. We continue to evaluate any potential alternative development strategies for maribavir.

Our costs related to New Initiatives represent expenses associated with our evaluation of a recombinant C1-INH technology and spending under our collaboration agreement with Sanquin supporting their Early Stage Research Programs. Included in the 2010 Other assets is a one-time charge of approximately \$1.1 million associated with a re-negotiation of a royalty arrangement on a product in late stage development.

Anticipated fluctuations in future direct expenses are discussed under “**Liquidity—Development Programs.**”

Indirect Expenses

These costs primarily relate to the compensation of and overhead attributable to our development team. During the second half of 2009 and through 2010, our development team shifted its focus from our CMV program to our Cinryze and VP20621 programs.

Selling, general and administrative expenses

Selling, general and administrative expenses (SG&A) increased \$6.3 million during 2010 compared to 2009. The increase was driven by increased marketing expenses (\$2.9 million), legal costs (\$2.2 million), compensation expense (\$1.7 million) and increased costs associated with our activities in Europe, partly offset by decreased medical education expenses (\$2.6 million).

Included in SG&A are legal and consulting costs incurred related to our opposition to the attempt by the OGD regarding the conditions that must be met in order for a generic drug application to request a waiver of in-vivo bioequivalence testing for copies of Vancocin, which were \$6.4 million and \$5.5 million for the years 2010 and 2009, respectively. We anticipate that these additional legal and consulting costs will continue at the current level, or possibly higher, in future periods as we continue this opposition. We anticipate continued increased spending in selling, general and administrative expenses in future periods as we continue to implement additional commercial programs related to Cinryze and continue our European initiatives.

Intangible amortization and acquisition of technology rights

Intangible amortization for the year ended December 31, 2010 was \$29.4 million, as compared to \$28.2 million in 2009.

On an ongoing periodic basis, we evaluate the useful life of our intangible assets and determine if any economic, governmental or regulatory event has modified their estimated useful lives. This evaluation did not result in a change in the life of the intangible assets during the year ended December 31, 2010. We will continue to monitor the actions of the FDA and OGD surrounding the bioequivalence recommendation for Vancocin and consider the effects of our opposition efforts, any announcements by generic competitors or other adverse events for additional impairment indicators. We will reevaluate the expected cash flows and fair value of our Vancocin-related assets, as well as estimated useful lives, at such time.

Impairment losses

During the first quarter of 2009, the market capitalization of ViroPharma fell below the carrying value of ViroPharma's net assets due to the announcements surrounding our maribavir development program. This situation required us to test for impairment of our goodwill and other intangible assets which lead to a goodwill impairment charge of \$65.1 million in 2009. There was no impairment of goodwill during 2010.

During 2009 we incurred an impairment charge related to our previous corporate headquarters of \$3.4 million due to the down turn in the real estate market.

Other operating expenses

The re-measurement of the fair value of the contingent consideration given relating to the acquisition of Auralis resulted in a charge to income during the period ended December 31, 2010 of \$1.4 million. There was no such charge during 2009.

Other Income (Expense)

Interest Income

Interest income for year ended December 31, 2010 was \$0.4 million is flat compared to \$0.4 million in 2009.

Interest Expense

| (in thousands) | For the years ended December 31, | |
|--|-------------------------------------|-----------------|
| | 2010 | 2009 |
| Interest expense on senior convertible notes | \$ 4,100 | \$ 4,343 |
| Amortization of debt discount | 7,129 | 6,854 |
| Amortization of finance costs | 387 | 412 |
| Total interest expense | <u>\$11,616</u> | <u>\$11,609</u> |

Interest expense and amortization of debt discount and finance costs in 2010 and 2009 relates entirely to the senior convertible notes issued on March 26, 2007.

Other income, net

Our other income, net includes net foreign exchange gains and the rental income attributable to our previous corporate headquarters.

Income Tax Expense

Our income tax expense was \$75.3 million and \$41.0 million for the year ended December 31, 2010 and 2009, respectively. The effective tax rate in 2010 was 37.5% compared to 137.0% in 2009. The effective tax rate in 2010 exceeded the federal statutory tax rate due to state income taxes and certain share-based compensation that is not tax deductible. The effective tax rate in 2009 exceeded the statutory tax rate because of a goodwill impairment charge which is not deductible for tax purposes and state income taxes, partially offset by an orphan drug credit.

Results of Operations

We adopted the new accounting provisions for our convertible debt securities as of January 1, 2009 and retrospectively applied this change in accounting to all prior periods presented for which we had applicable outstanding convertible debt, as required by this new standard.

Years ended December 31, 2009 and 2008

| (in thousands, except per share data) | For the years ended December 31, | |
|--|-------------------------------------|-----------|
| | 2009 | 2008 |
| Net product sales | \$310,449 | \$232,307 |
| Cost of sales (excluding amortization of product rights) | \$ 40,214 | \$ 8,874 |
| Operating income | \$ 32,130 | \$ 78,655 |
| Net (loss) income | \$ (11,077) | \$ 63,960 |
| Net (loss) income per share: | | |
| Basic | \$ (0.14) | \$ 0.90 |
| Diluted | \$ (0.14) | \$ 0.84 |

The \$32.1 million in operating income for the year ended December 31, 2009 decreased as compared to \$78.7 million in the same period in 2008 which resulted primarily from the impairment of goodwill in the first quarter of 2009 (\$65.1 million), increased cost of sales (\$31.3 million), increased intangible amortization associated with our acquisition of Lev (\$17.4 million) and increased SG&A costs related to the launch of Cinryze (\$22.0 million), partially offset by increased net sales of Vancocin and Cinryze (\$78.1 million).

Revenues

Revenues consisted of the following:

| (in thousands) | For the years ended December 31, | |
|-------------------|-------------------------------------|------------------|
| | 2009 | 2008 |
| Net product sales | \$ | |
| Vancocin | 213,138 | 232,284 |
| Cinryze | 97,311 | 23 |
| Total Revenues | <u>\$310,449</u> | <u>\$232,307</u> |

Revenue—Vancocin and Cinryze product sales

We sell Vancocin only to wholesalers who then distribute the product to pharmacies, hospitals and long-term care facilities, among others. Our sales of Vancocin are influenced by wholesaler forecasts of prescription demand, wholesaler buying decisions related to their desired inventory levels, and, ultimately, end user prescriptions, all of which could be at different levels from period to period.

We sell Cinryze to specialty pharmacy/specialty distributors (SP/SD's) who then sell and distribute to physicians, hospitals and patients, among others. Beginning in the second quarter of 2009, we recognized revenue based upon shipments of Cinryze to SP/SD's due to our ability to meet the revenue recognition criteria specifically our ability to estimate our payor mix. We previously recognized revenue upon shipment of Cinryze from SP/SD's to patients.

During the year ended December 31, 2009, net sales of Vancocin decreased 8.2% compared to the same period in 2008. The decrease for the year ended December 31, 2009 is primarily due to lower sales volumes driven by lower rates of severe disease, as compared to last year at this time, and a suspected increase in compounding seen both in the hospital and long-term care marketplace, partially offset by the price increases in 2009. Based upon data reported by IMS Health Incorporated, prescriptions during the year ended December 31, 2009 decreased from the same period in 2008 period by 9.3%. The units sold for the year ended December 31, 2009 decreased by 17.0% compared to the same period in 2008.

Vancocin product sales are influenced by prescriptions and wholesaler forecasts of prescription demand, which could be at different levels from period to period. Cinryze product sales are influenced by prescriptions. In the third quarter of 2009, we began to manage patients added to Cinryze therapy to ensure patients on drug will continue to receive Cinryze in future periods. We receive inventory data from our three largest wholesalers through our fee for service agreements and our two SP/SD's through service agreements. We do not independently verify this data. Based on this inventory data and our estimates, we believe that as of December 31, 2009, the wholesalers and SP/SD's did not have excess channel inventory.

Cost of sales (excluding amortization of product rights)

Cost of sales increased for the year ended December 31, 2009 by \$31.3 million as compared to the same period in the prior year due to Cinryze which was launched in December 2008. Included in the Cost of sales for the year ended December 31, 2009 was \$1.8 million that was previously deferred. Cost of sales during the year ended December 31, 2008 did not include Cinryze as we acquired Lev Pharmaceuticals in October 2008. Vancocin and Cinryze cost of sales includes the cost of materials and distribution costs and excludes amortization of product rights. As part of our October 2008 purchase of Lev, we acquired Cinryze inventory which was recorded at fair value in purchase accounting. This step-up of inventory value increased the cost of sales during the year ended December 31, 2009 by \$6.9 million. We have utilized all inventory that was recorded at fair value as part of the Lev purchase in 2009.

Since units are shipped based upon earliest expiration date, we would expect the cost of product sales of both Vancocin and Cinryze to fluctuate from quarter to quarter as we may experience fluctuations in quarterly manufacturing yields.

Research and development expenses

For each of our research and development programs, we incur both direct and indirect expenses. Direct expenses include third party costs related to these programs such as contract research, consulting, cost sharing payments or receipts, and preclinical and development costs. Indirect expenses include personnel, facility, stock compensation and other overhead costs. Due to advancements in our NTCD preclinical program, the start of our Phase 4 commitment for Cinryze, and our plan to conduct additional clinical studies using Cinryze we expect costs in these programs to exceed current costs. We are evaluating our maribavir program which was discontinued in February 2009.

Research and development expenses were divided between our research and development programs in the following manner:

| (in thousands) | For the years ended December 31, | |
|---|-------------------------------------|-----------------|
| | 2009 | 2008 |
| Direct—Core programs | | |
| CMV | \$15,715 | \$35,200 |
| Cinryze | 7,067 | 5,226 |
| Non-toxigenic strains of C. difficile (VP20621) | 9,801 | 4,702 |
| Vancocin | 675 | 603 |
| HCV | 8 | 762 |
| Indirect | | |
| Development | 18,817 | 17,941 |
| Total | <u>\$52,083</u> | <u>\$64,434</u> |

Direct Expenses—Core Development Programs

Our direct expenses related to our CMV program decreased during the year ended December 31, 2009 as we wound-down our stem cell and liver transplant studies. Costs incurred during 2009 include enrollment in our solid organ (liver) study through February 2009, conducting follow-up visits and continuing to evaluate the results of our Phase 3 programs. In February 2009, based upon preliminary analysis of the data, we announced that our Phase 3 trial evaluating maribavir used as prophylaxis in allogeneic stem cell, or bone, marrow, transplant patients did not achieve its primary endpoints. In the primary analysis, there was no statistically significant difference between maribavir and placebo in reducing the rate of CMV disease. In addition, the study failed to meet its key secondary endpoints. We are continuing to analyze the study results. Additionally, we announced that our Phase 3 trial evaluating maribavir in liver transplant patients was discontinued and that all patients on study drug were moved to the current standard of care. During 2008, we continued recruitment and site initiations into ongoing phase 3 studies of maribavir in patients undergoing allogeneic stem cell transplant at transplant centers in the U.S., Canada and several European Countries and patients undergoing liver transplantation in the U.S. and Europe. Additionally, we began executing on our pre-launch plans for our clinical, regulatory and commercial activities for maribavir in the U.S. and Europe.

In April 2008, we announced that ViroPharma and Wyeth jointly discontinued the development of HCV-796 due to the safety issue that emerged in the Phase 2 trial in patients with hepatitis C. We also announced that ViroPharma and Wyeth do not expect to continue to collaborate on future development of hepatitis C treatment candidates and the agreement expired in accordance with its terms during the third quarter of 2009.

In October 2008, we acquired Cinryze, a C1 inhibitor, which has been approved by the FDA for routine prophylaxis of HAE. During 2009, we incurred costs related to the Cinryze open label trials which closed on March 31, 2009 and for our Phase 4 clinical trial.

The increase in costs of NTCD in 2009 over 2008 relate to increased research and development activities, costs associated with manufacturing NTCD spores and costs associated with our Phase 1 clinical trial.

Vancocin costs in 2009 and 2008 related to additional research activities.

Anticipated fluctuations in future direct expenses are discussed under “**Liquidity—Development Programs.**”

Indirect Expenses

These costs primarily relate to the compensation of and overhead attributable to our development team. During the second half of 2009, our development team has shifted its focus from our CMV program to our Cinryze and NTCD programs.

Selling, general and administrative expenses

Selling, general and administrative expenses (SG&A) increased for the year December 31, 2009 by \$22.0 million over the same period in 2008. This increase was driven by the expansion of our Cinryze field force (\$13.2 million), increased professional fees (\$2.7 million), and increased marketing efforts (\$2.6 million). Included in SG&A are legal and consulting costs incurred related to our opposition to the attempt by the OGD regarding the conditions that must be met in order for a generic drug application to request a waiver of in-vivo bioequivalence testing for copies of Vancocin, which were \$5.5 million and \$4.0 million in the year of 2009 and 2008, respectively. We anticipate that these additional legal and consulting costs will gradually diminish in future periods. We anticipate continued increased spending in selling, general and administrative expenses in future periods as we continue the commercial launch of Cinryze.

Intangible amortization and acquisition of technology rights

Intangible amortization for the year ended December 31, 2009 was \$28.2 million, as compared to \$10.8 million in 2008. Amortization increased in 2009 as compared to 2008 due to the full year inclusion of the intangible asset acquired in our acquisition of Lev Pharmaceuticals.

On an ongoing periodic basis, we evaluate the useful life of our intangible assets and determine if any economic, governmental or regulatory event has modified their estimated useful lives. This evaluation did not result in a change in the life of the intangible assets during the year ended December 31, 2009. We will continue to monitor the actions of the FDA and OGD surrounding the bioequivalence recommendation for Vancocin and consider the effects of our opposition efforts, any announcements by generic competitors or other adverse events for additional impairment indicators. We will reevaluate the expected cash flows and fair value of our Vancocin-related assets, as well as estimated useful lives, at such time.

Impairment losses

During the first quarter of 2009, the market capitalization of ViroPharma fell below the carrying value of ViroPharma's net assets due to the announcements surrounding our maribavir development program. This situation required us to test for impairment of our goodwill and other intangible assets which lead to a goodwill impairment charge of \$65.1 million.

During 2009 and 2008, we incurred impairment charges related to our previous corporate headquarters of \$3.4 million and \$2.3 million, respectively due to the down turn in the real estate market.

Other Income (Expense)

Interest Income

Interest income for year ended December 31, 2009 was \$0.4 million as compared to \$14.3 million in 2008. Interest incomes in 2009 as compared to 2008 decreased due to lower amounts of cash on hand and lower interest rates.

Interest Expense

We adopted the new accounting provisions for our convertible debt securities as of January 1, 2009 and retrospectively applied this change in accounting to all prior periods presented for which we had applicable outstanding convertible debt, as required by this new standard.

| (in thousands) | For the years ended December 31, | |
|--|-------------------------------------|-----------------|
| | 2009 | 2008 |
| Interest expense on senior convertible notes | \$ 4,343 | \$ 4,980 |
| Amortization of debt discount | 6,854 | 7,181 |
| Amortization of finance costs | 412 | 790 |
| Total interest expense | <u>\$11,609</u> | <u>\$12,951</u> |

Interest expense and amortization of finance costs in 2009 and 2008 relates entirely to the senior convertible notes issued on March 26, 2007.

Income Tax Expense

Our income tax expense was \$41.0 million and \$16.0 million for the year ended December 31, 2009 and 2008, respectively. Our income tax expense includes federal, state and foreign income taxes at statutory rates and the effects of various permanent differences. The income tax expense for 2009 reflects the full impact of our gain on the repurchase of a portion of our convertible notes. In addition, our tax expense for the year includes our current estimate of the impact of the orphan drug credit for maribavir. The increase in the 2009 expense as compared to 2008 is primarily due to the decrease in our orphan drug qualified expenses, offset by the decrease in our taxable income from 2008.

During the twelve months ended December 31, 2009, we paid approximately \$1.2 million as a result of the IRS audit of our 2006 federal income tax return and results in a reduction of our taxes payable liability.

Liquidity

We expect that our sources of revenue will continue to arise from Cinryze and Vancocin product sales. However, future sales of Vancocin will vary based on the number of generic competitors that could enter the market if approved by the FDA, the timing of entry into the market of those generic competitors and/or the sales we may generate from an authorized generic version of Vancocin. In addition, there are no assurances that demand for Cinryze will continue to grow or that demand for Vancocin will continue at historical or current levels.

Our ability to generate positive cash flow is also impacted by the timing of anticipated events in our Cinryze and VP20621 development programs, including the timing of our expansion as we intend to seek to commercialize Cinryze in Europe and certain other countries, the scope of the clinical trials required by regulatory authorities, results from clinical trials, the results of our product development efforts, and variations from our estimate of future direct and indirect expenses.

The cash flows we have used in operations historically have been applied to research and development activities, marketing and commercial efforts, business development activities, general and administrative expenses, debt service, and income tax payments. Bringing drugs from the preclinical research and development stage through phase 1, phase 2, and phase 3 clinical trials and FDA approval is a time consuming and expensive process. Because we have product candidates that are currently in the clinical stage of development, there are a variety of events that could occur during the development process that will dictate the course we must take with our drug development efforts and the cost of these efforts. As a result, we cannot reasonably estimate the costs that we will incur through the commercialization of any product candidate. However, our future costs may exceed current costs as we anticipate we will continue to invest in our pipeline on our initiative to develop non-toxicogenic strains of *C. difficile*, our phase 4 program for Cinryze, any additional studies to identify further therapeutic uses and expand the labeled indication for Cinryze to potentially include other C1 mediated diseases as well as new modes of administration for Cinryze. Also, we will incur additional costs as we intend to seek to commercialize Cinryze in Europe in countries where we have distribution rights and certain other countries beginning in 2011 as well as conduct studies to identify additional C1 mediated diseases, such as AMR and DGF, which may be of interest for further clinical development, and to evaluate new forms of administration for Cinryze. The most significant of our near-term operating development cash outflows are as described under "**Development Programs**" as set forth below.

We are required to pay contingent consideration to Lev shareholders upon achievement of a commercial milestone related Cinryze sales, additional consideration to Lilly based on the net sales of Vancocin in 2011 and additional consideration to Auralis shareholders upon achievement of a regulatory milestone. Additionally, our operating expenses will not decrease significantly if there is the introduction of a generic Vancocin.

In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA). The PPACA, as amended, will likely increase certain of our costs as well. For example, an increase in the Medicaid rebate rate from 15.1% to 23.1% was effective as of January 1, 2010, and the volume of rebated drugs has been expanded to include beneficiaries in Medicaid managed care organizations, effective as of March 23, 2010. In 2011, the PPACA also imposes a manufacturer's fee on the sale of branded Pharmaceuticals (excluding orphan drugs) to specified government programs, expands the 340B drug discount program (excluding orphan drugs), and includes a 50% discount on brand name drugs for Medicare Part D participants in the coverage gap, or "doughnut hole".

Overall Cash Flows

During the year ended December 31, 2010, we generated \$193.5 million of net cash from operating activities, primarily from our net income after adjustments for non-cash items. We used \$101.9 million of cash from investing activities mainly in the purchase of short-term investments, as well as in the purchase of Auralis and the additional purchase price consideration for Vancocin. Our net cash provided by financing activities was \$3.6 million which relates to stock option exercises. For the year ended December 31, 2009, we were provided with \$84.8 million of net cash from operating activities, primarily from our net income adjusted for our non-cash items such as our goodwill impairment, depreciation and amortization expense and our deferred tax provision, partially offset by changes in working capital, specifically increases in accounts receivable and inventory due to the Cinryze launch. We used \$8.9 million of cash from investing activities primarily related to the additional purchase price consideration for Vancocin and our net cash used in financing activities was \$20.5 million, mainly from the repurchase of a portion of our senior convertibles notes.

Development Programs

For each of our development programs, we incur both direct and indirect expenses. Direct expenses include third party costs related to these programs such as contract research, consulting, cost sharing payments or receipts, and preclinical and clinical development costs. Indirect expenses include personnel, facility and other overhead costs. Additionally, for some of our development programs, we have cash inflows and outflows upon achieving certain milestones.

Core Development Programs

Cinryze—We acquired Cinryze in October 2008 and through December 31, 2010 have spent approximately \$19.4 million in direct research and development costs related to Cinryze since acquisition. During 2011, we continue to expect research and development costs related to Cinryze to increase as we complete our Phase 4 commitment and initiate our Phase 2 study to evaluate Cinryze for treatment of acute HAE in children. Additionally, we will incur costs related to evaluating additional indications, formulations and territories as we develop our life cycle program related to Cinryze such as our efforts on sub-subcutaneous, AMR and DGF. We are solely responsible for the costs of Cinryze development.

VP20621—We acquired VP20621 in February 2006 and through December 31, 2010 have spent approximately \$23.9 million in direct research and development costs. During 2011, we expect our research and development activities related to VP20621 to increase as we continue our development program. We are solely responsible for the costs of VP20621 development.

Vancocin—We acquired Vancocin in November 2004 and through December 31, 2010, we have spent approximately \$2.8 million in direct research and development costs related to Vancocin activities since acquisition.

Other Assets

In addition to the programs described above, we have several other assets that we may make additional investments in. These investments will be dependent on our assessment of the potential future commercial success of or benefits from the asset. These assets include maribavir for CMV, and other compounds. We will continue to incur costs associated with our other development assets for direct research and development costs for medicinal products which will address unmet medical needs such as our current evaluation of a recombinant C1-INH technology which may be included in future clinical studies.

Business development activities

On May 28, 2010 we acquired a 100% ownership interest in Auralis Limited, a UK based specialty pharmaceutical company for approximately \$14.5 million in upfront consideration for the acquisition of the company and its existing pharmaceutical licenses and products. We have also agreed to pay an additional payment of £10 million Pounds Sterling (approximately \$15.5 million based on the December 31, 2010 exchange rate) upon the first regulatory approval of a product in late stage development.

On October 21, 2008, we completed our acquisition under which ViroPharma acquired Lev Pharmaceuticals, Inc. (Lev). Lev is a biopharmaceutical company focused on developing and commercializing therapeutic products for the treatment of inflammatory diseases. The terms of the merger agreement provided for the conversion of each share of Lev common stock into upfront consideration of \$453.1 million, or \$2.75 per Lev share, comprised of \$2.25 per share in cash and \$0.50 per share in ViroPharma common stock, and contingent consideration of up to \$1.00 per share which may be paid on achievement of certain regulatory and commercial milestones. The target for the first CVR payment of \$0.50 per share (or \$87.5 million) will not be paid as a third party's human C1 inhibitor product was approved for the acute treatment of HAE and granted orphan exclusivity. The second CVR payment of \$0.50 per share (\$87.5 million) becomes payable if Cinryze reaches at least \$600 million in cumulative net product sales by October 2018 and we anticipate achieving this milestone in 2012.

We intend to continue to seek to acquire additional products or product candidates. The costs associated with evaluating or acquiring any additional product or product candidate can vary substantially based upon market size of the product, the commercial effort required for the product, the product's current stage of development, and actual and potential generic and non-generic competition for the product, among other factors. Due to the variability of the cost of evaluating or acquiring business development candidates, it is not feasible to predict what our actual evaluation or acquisition costs would be, if any, however, the costs could be substantial.

Senior Convertible Notes

On March 26, 2007, we issued \$250.0 million of 2% senior convertible notes due March 2017 (the "senior convertible notes") in a public offering. Net proceeds from the issuance of the senior convertible notes were \$241.8 million. The senior convertible notes are unsecured unsubordinated obligations and rank equally with any other unsecured and unsubordinated indebtedness. The senior convertible notes bear interest at a rate of 2% per annum, payable semi-annually in arrears on March 15 and September 15 of each year commencing on September 15, 2007.

As of January 1, 2009 we account for the debt and equity components of our convertible debt securities as bifurcated instruments which are accounted for separately. Accordingly, the convertible debt securities will recognize interest expense at effective rates of 8.0% as they are accreted to par value.

On March 24, 2009 we repurchased, in a privately negotiated transaction, \$45.0 million in principal amount of our senior convertible notes due March 2017 for total consideration of approximately \$21.2 million. The repurchase represented 18% of our then outstanding debt and was executed at a price equal to 47% of par value. Additionally, in negotiated transactions, we sold approximately 2.38 million call options for approximately \$1.8 million and repurchased approximately 2.38 million warrants for approximately \$1.5 million which terminated the call options and warrants that were previously entered into by us in March 2007. We recognized a \$9.1 million gain in the first quarter of 2009 as a result of this debt extinguishment. For tax purposes, the gain qualifies for deferral until 2014 in accordance with the provisions of the American Recovery and Reinvestment Act.

As of December 31, 2010, we have accrued \$1.2 million in interest payable to holders of the senior convertible notes. Debt issuance costs of \$4.8 million have been capitalized and are being amortized over the term of the senior convertible notes, with the balance to be amortized as of December 31, 2010 being \$2.4 million.

The senior convertible notes are convertible into shares of our common stock at an initial conversion price of \$18.87 per share. The senior convertible notes may only be converted: (i) anytime after December 15, 2016; (ii) during the five business-day period after any five consecutive trading day period (the "measurement period") in which the price per note for each trading day of that measurement period was less than 98% of the product of the last reported sale price of our common stock and the conversion rate on each such day; (iii) during any calendar quarter (and only during such quarter) after the calendar quarter ending June 30, 2007, if the last reported sale price of our common stock for 20 or more trading days in a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter exceeds 130% of the applicable conversion price in effect on the last trading day of the immediately preceding calendar quarter; or (iv) upon the occurrence of specified corporate events. Upon conversion, holders of the senior convertible notes will receive shares of common stock, subject to ViroPharma's option to irrevocably elect to settle all future conversions in cash up to the principal amount of the senior convertible notes, and shares for any excess. We can irrevocably elect this option at any time on or prior to the 35th scheduled trading day prior to the maturity date of the senior convertible notes. The senior convertible notes may be required to be repaid on the occurrence of certain fundamental changes, as defined in the senior convertible notes. As of December 31, 2010, the fair value of the principal of the \$205.0 million convertible senior notes outstanding was approximately \$229.8 million, based on the level 2 valuation hierarchy of the fair value measurements standard. The carrying value of the debt at December 31, 2010 is \$145.7 million.

Concurrent with the issuance of the senior convertible notes, we entered into privately-negotiated transactions, comprised of purchased call options and warrants sold, to reduce the potential dilution of our common stock upon conversion of the senior convertible notes. The transactions, taken together, have the effect of increasing the initial conversion price to \$24.92 per share. The net cost of the transactions was \$23.3 million.

The call options allowed ViroPharma to receive up to approximately 13.25 million shares of its common stock at \$18.87 per share from the call option holders, equal to the number of shares of common stock that ViroPharma

would issue to the holders of the senior convertible notes upon conversion. These call options will terminate upon the earlier of the maturity dates of the related senior convertible notes or the first day all of the related senior convertible notes are no longer outstanding due to conversion or otherwise. Concurrently, we sold warrants to the warrant holders to receive shares of its common stock at an exercise price of \$24.92 per share. These warrants expire ratably over a 60-day trading period beginning on June 13, 2017 and will be net-share settled.

The purchased call options are expected to reduce the potential dilution upon conversion of the senior convertible notes in the event that the market value per share of our common stock at the time of exercise is greater than \$18.87, which corresponds to the initial conversion price of the senior convertible notes, but less than \$24.92 (the warrant exercise price). The warrant exercise price is 75.0% higher than the price per share of \$14.24 of our price on the pricing date. If the market price per share of our common stock at the time of conversion of any senior convertible notes is above the strike price of the purchased call options (\$18.87), the purchased call options will entitle us to receive from the counterparties in the aggregate the same number of shares of our common stock as we would be required to issue to the holder of the converted senior convertible notes. Additionally, if the market price of our common stock at the time of exercise of the sold warrants exceeds the strike price of the sold warrants (\$24.92), we will owe the counterparties an aggregate of approximately 13.25 million shares of our common stock. If we have insufficient shares of common stock available for settlement of the warrants, we may issue shares of a newly created series of preferred stock in lieu of our obligation to deliver common stock. Any such preferred stock would be convertible into 10% more shares of our common stock than the amount of common stock we would otherwise have been obligated to deliver under the warrants. We are entitled to receive approximately 10.87 million shares of our common stock at \$18.87 from the call option holders and if the market price of our common stock at the time of exercise of the sold warrants exceeds the strike price of the sold warrants (\$24.92), we will owe the counterparties an aggregate of approximately 10.87 million shares of our common stock.

The purchased call options and sold warrants are separate transactions entered into by us with the counterparties, are not part of the terms of the senior convertible notes, and will not affect the holders' rights under the senior convertible notes. Holders of the senior convertible notes will not have any rights with respect to the purchased call options or the sold warrants. The purchased call options and sold warrants meet the definition of derivatives. These instruments have been determined to be indexed to our own stock and have been recorded in stockholders' equity in our Consolidated Balance Sheet. As long as the instruments are classified in stockholders' equity they are not subject to the mark to market requirements of US GAAP.

Contractual Obligations

Future contractual obligations and commercial commitments at December 31, 2010 are as follows:

(in thousands)

| Contractual Obligations (1)(2) | Total | 1 year or less | 2-3 years | 4-5 years | More than 5 years |
|--|------------------|-----------------------|------------------|------------------|--------------------------|
| Operating leases (3) | \$ 10,973 | \$ 1,846 | \$ 3,765 | \$ 3,813 | \$ 1,549 |
| Senior convertible notes (4) | 233,700 | 4,100 | 8,200 | 8,200 | 213,200 |
| Collaboration agreements (5) | 5,301 | 1,325 | 2,651 | 1,325 | — |
| Purchase obligations (6) | 362,989 | 77,151 | 135,556 | 150,282 | — |
| Total | \$612,963 | \$84,422 | \$150,172 | \$163,620 | \$214,749 |

(1) This table does not include the contingent consideration of £10 million Pounds Sterling (approximately \$15.5 million based on the December 31, 2010 exchange rate) which may be payable to the former shareholders of Auralis, which we acquired on May 28, 2010, upon the first regulatory approval of a product in late stage development. We account for this contingent consideration as a liability and recognize changes in its fair value in operating income. We will continue to recognize such fair value changes in income until the ultimate disposition or settlement of this liability.

This table does not include any milestone payments under our agreement with GSK in relation to our in-licensed technology, as the timing and likelihood of such payments are not known.

The table does not include an additional payment which may be due to Lilly in connection with the Vancocin acquisition, as the amount and timing of future additional payments are not determinable. Under the terms of the agreement with Lilly, Lilly is entitled to an additional payment of 35% of annual net sales of Vancocin between \$45 and \$65 million during 2011.

The table does not include additional payments to Lev CVR holders. As of December 31, 2010, only the second CVR as described below remains achievable. The second CVR payment of \$0.50 per share (\$87.5 million) becomes payable if Cinryze reaches at least \$600 million in cumulative net product sales by October 2018 and we anticipate achieving this milestone in 2012.

- (2) This table does not include various agreements that we have entered into for services with third party vendors, including agreements to conduct clinical trials, to manufacture product candidates, and for consulting and other contracted services due to the cancelable nature of the services. We accrue the costs of these agreements based on estimates of work completed to date. We estimate that approximately \$23.0 million will be payable in future periods under arrangements in place at December 31, 2010. Of this amount, approximately \$4.9 million has been accrued for work estimated to have been completed as of December 31, 2010 and approximately \$18.1 million relates to future performance under these arrangements.
- (3) Operating leases represent building and equipment leases.
- (4) These payments represent interest and principal related to our 2% senior convertible notes due March 2017.
- (5) Pursuant to the terms of the ROW Agreement, Sanquin may conduct certain early stage research programs for which we will provide to Sanquin €1,000,000 (approximately \$1.3 million based on the December 31, 2010 exchange rate) per year for a period of five years.
- (6) We have committed to purchase up to 290,000 liters of plasma in 2011 and up to 210,000 liters of plasma per year in 2012 through 2015 from our suppliers. Additionally, we are required to purchase a minimum number of units from our third party toll manufacturer. Excluded from these amounts is the manufacturing fee for Cinryze produced under the EU and ROW agreement as the minimum purchase shall be determined by the Joint Steering Committee in 2013.

Capital Resources

While we anticipate that cash flows from Cinryze and Vancocin, as well as our current cash, cash equivalents and short-term investments, should allow us to fund our ongoing development and operating costs, as well as the interest payments on our senior convertible notes, we may need additional financing in order to expand our product portfolio. At December 31, 2010, we had cash, cash equivalents and short-term investments of \$505.2 million. Our investments consist of high quality fixed income securities and high quality debt securities or obligation of departments or agencies of the United States. We generally invest in financial instruments with maturities of less than one year. At December 31, 2010, the annualized weighted average nominal interest rate on our investment portfolio was 0.40% and the weighted average length to maturity was 7.1 months.

Should we need financing, we would seek to access the public or private equity or debt markets, enter into additional arrangements with corporate collaborators to whom we may issue equity or debt securities or enter into other alternative financing arrangements that may become available to us.

Financing

If we raise additional capital by issuing equity securities, the terms and prices for these financings may be much more favorable to the new investors than the terms obtained by our existing stockholders. These financings also may significantly dilute the ownership of existing stockholders.

If we raise additional capital by accessing debt markets, the terms and pricing for these financings may be much more favorable to the new lenders than the terms obtained from our prior lenders. These financings also may require liens on certain of our assets that may limit our flexibility.

Additional equity or debt financing, however, may not be available on acceptable terms from any source as a result of, among other factors, our operating results, our inability to achieve regulatory approval of any of our product candidates, and our inability to file, prosecute, defend and enforce patent claims and or other intellectual property rights. If sufficient additional financing is not available, we may need to delay, reduce or eliminate current development programs, or reduce or eliminate other aspects of our business.

From time to time, we may seek approval from our board of directors to evaluate additional opportunities to repurchase our common stock or convertible notes, including through open market purchases or individually negotiated transactions.

Critical Accounting Policies

Our consolidated financial statements and accompanying notes are prepared in accordance with accounting principles generally accepted in the United States of America. Preparing consolidated financial statements requires us to make estimates and assumptions that affect the reported amounts of assets, liabilities, revenues and expenses and contingent assets and liabilities. Actual results could differ from such estimates. These estimates and assumptions are affected by the application of our accounting policies. Critical policies and practices are both most important to the portrayal of a company's financial condition and results of operations, and require management's most difficult, subjective or complex judgments, often as a result of the need to make estimates about the effects of matters that are inherently uncertain.

Our summary of significant accounting policies is described in Note 2 to our Consolidated Financial Statements contained in our Annual Report on Form 10-K for the year ended December 31, 2010. However, we consider the following policies and estimates to be the most critical in understanding the more complex judgments that are involved in preparing our consolidated financial statements and that could impact our results of operations, financial position, and cash flows:

- **Product Sales**—Our net sales consist of revenue from sales of our products, Vancocin, Cinryze and Diamorphine, less estimates for chargebacks, rebates, distribution service fees, returns and losses. We recognize revenue for product sales when title and risk of loss has passed to the customer, which is typically upon delivery to the customer, when estimated provisions for chargebacks, rebates, distribution service fees, returns and losses are reasonably determinable, and when collectability is reasonably assured. Revenue from the launch of a new or significantly unique product may be deferred until estimates can be made for chargebacks, rebates and losses and all of the above conditions are met and when the product has achieved market acceptance, which is typically based on dispensed prescription data and other information obtained during the period following launch.
- At the end of each reporting period we analyze our estimated channel inventory and we would defer recognition of revenue on product that has been delivered if we believe that channel inventory at a period end is in excess of ordinary business needs. Further, if we believe channel inventory levels are increasing without a reasonably correlating increase in prescription demand, we proactively delay the processing of wholesaler orders until these levels are reduced.

We establish accruals for chargebacks and rebates, sales discounts and product returns. These accruals are primarily based upon the history of Vancocin and for Cinryze they are based on information on payee's obtained from our SP/SD's and CinryzeSolutions. We also consider the volume and price of our products in the channel, trends in wholesaler inventory, conditions that might impact patient demand for our product (such as incidence of disease and the threat of generics) and other factors.

In addition to internal information, such as unit sales, we use information from external resources, which we do not verify, to estimate the Vancocin channel inventory. Our external resources include

prescription data reported by IMS Health Incorporated and written and verbal information obtained from our three largest wholesaler customers with respect to their inventory levels. Based upon this information, we believe that inventory held at these warehouses are within normal levels.

Chargebacks and rebates are the most subjective sales related accruals. While we currently have no contracts with private third party payors, such as HMO's, we do have contractual arrangements with governmental agencies, including Medicaid. We establish accruals for chargebacks and rebates related to these contracts in the period in which we record the sale as revenue. These accruals are based upon historical experience of government agencies' market share, governmental contractual prices, our current pricing and then-current laws, regulations and interpretations. We analyze the accrual at least quarterly and adjust the balance as needed. These analyses have been adjusted to reflect the U.S. healthcare reform acts and their affect on governmental contractual prices and rebates. We believe that a 10% change in our estimate of the actual rate of sales subject to governmental rebates would affect our operating income and accruals by approximately \$0.5 million in the period of adjustment, which we believe is immaterial.

Annually, as part of our process, we performed an analysis on the share of Vancocin and Cinryze sales that ultimately go to Medicaid recipients and result in a Medicaid rebate. As part of that analysis, we considered our actual Medicaid historical rebates processed, total units sold and fluctuations in channel inventory. We also consider our payee mix for Cinryze based on information obtained at the time of prescription.

Product return accruals are estimated based on Vancocin's history of damage and product expiration returns and are recorded in the period in which we record the sale of revenue. Cinryze has a no returns policy.

- **Impairment of Long-lived Assets**—We review our fixed and long-lived intangible assets for possible impairment annually and whenever events occur or circumstances indicate that the carrying amount of an asset may not be recoverable. The impairment test is a two-step test. Under step one we assess the recoverability of an asset (or asset group). The carrying amount of an asset (or asset group) is not recoverable if it exceeds the sum of the undiscounted cash flows expected from the use and eventual disposition of the asset (or asset group). The impairment loss is measured in step two as the difference between the carrying value of the asset (or asset group) and its fair value. Assumptions and estimates used in the evaluation of impairment may affect the carrying value of long-lived assets, which could result in impairment charges in future periods. Such assumptions include, for example, projections of future cash flows and the timing and number of generic/competitive entries into the market, in determining the undiscounted cash flows, and if necessary, the fair value of the asset and whether impairment exists. These assumptions are subjective and could result in a material impact on operating results in the period of impairment. In the fourth quarter of 2009, we reviewed the fair value of our property and building held for sale and have determined that an additional impairment charge was required.

On an ongoing periodic basis, we evaluate the useful life of intangible assets and determine if any economic, governmental or regulatory event has modified their estimated useful lives.

On August 4, 2009 the FDA's Pharmaceutical Science and Clinical Pharmacology Advisory Committee voted in favor of the OGD's 2008 draft guidelines on bioequivalence for Vancocin. If FDA's proposed bioequivalence method for Vancocin becomes effective, the time period in which a generic competitor could be approved would be reduced and multiple generics may enter the market, which would materially impact our operating results, cash flows and possibly intangible asset valuations. This could also result in a reduction to the useful life of the Vancocin-related intangible assets. Management currently believes there are no indicators that would require a change in useful life as management believes that Vancocin will continue to be utilized along with generics that may enter the market, and the number of generics and the timing of their market entry is unknown.

A reduction in the useful life, as well as the timing and number of generics, will impact our cash flow assumptions and estimate of fair value, perhaps to a level that could result in an impairment charge. We will continue to monitor the actions of the OGD and consider the effects of our opposition actions and any announcements by generic competitors or other adverse events for additional impairment indicators. We will reevaluate the expected cash flows and fair value of our Vancocin-related assets at such time a triggering event occurs.

- **Impairment of Goodwill and Indefinite-lived Intangible Assets**—We review the carrying value of goodwill and indefinite-lived intangible assets, to determine whether impairment may exist. The goodwill impairment test consists of two steps. The first step compares a reporting unit's fair value to its carrying amount to identify potential goodwill impairment. If the carrying amount of a reporting unit exceeds the reporting unit's fair value, the second step of the impairment test must be completed to measure the amount of the reporting unit's goodwill impairment loss, if any. Step two requires an assignment of the reporting unit's fair value to the reporting unit's assets and liabilities to determine the implied fair value of the reporting unit's goodwill. The implied fair value of the reporting unit's goodwill is then compared with the carrying amount of the reporting unit's goodwill to determine the goodwill impairment loss to be recognized, if any. The impairment test for indefinite-lived intangible assets is a one-step test, which compares the fair value of the intangible asset to its carrying value. If the carrying value exceeds its fair value, an impairment loss is recognized in an amount equal to the excess. Based on accounting standards, it is required that these assets be assessed annually for impairment unless a triggering event occurs between annual assessments which would then require an assessment in the period which a triggering event occurred.

During the first quarter of 2009, our market capitalization dropped below the carrying value of our net assets due to the results of our Phase 3 trial evaluating maribavir used as prophylaxis in allogeneic stem cell or bone marrow transplant patients. We concluded that the drop in our market cap was a triggering event which required us to perform an impairment test of our intangible assets and a step 2 test for goodwill impairment. As part of this process, we also assessed our intangible and fixed assets for impairment. Based on the analysis performed under step two, there was no remaining implied value attributable to goodwill and accordingly, we wrote off the entire goodwill balance and recognized a goodwill impairment charge in the first quarter of 2009.

- **Share-Based Employee Compensation**—The calculation of this expense includes judgment related to the period of time used in calculating the volatility of our common stock, the amount of forfeitures and an estimate of the exercising habits of our employees, which is also influenced by our Insider Trading Policy. Changes in the volatility of our common stock or the habits of our employees could result in variability in the fair value of awards granted.
- **Income Taxes**—Our income provision and related balance sheet accounts are determined based on enacted tax laws, published guidance and the statutory tax rates in the jurisdictions in which we operate. Significant judgment is required in determining tax expense and related assets and liabilities including the expenses that qualify for income tax credits, such as the orphan drug credit. Deferred tax assets are evaluated to determine if they are more likely than not to be realized through future income, reversal of temporary differences or tax planning strategies. A valuation allowance is established if realization is not considered more likely than not. If future results differ from those expected when the deferred tax asset is established, an additional valuation allowance may be required. Tax benefits are recognized on filed tax return positions that are more likely than not to be sustained. Challenges by the tax authorities could impact our income tax provision in future years.
- **Acquisition Accounting**—The application of the purchase accounting requires certain estimates and assumptions especially concerning the determination of the fair values of the acquired intangible assets and property, plant and equipment as well as the liabilities assumed at the date of the acquisition. Moreover, the useful lives of the acquired intangible assets, property, plant and equipment have to be determined.

The total purchase price of businesses acquired will be allocated to the net tangible assets and identifiable intangible assets based on their fair values as of the date of the acquisition and the fair value of any contingent consideration. Changes in the fair value of contingent consideration will be expensed in the period in which the change in fair value occurs. Additionally, acquired IPR&D projects will initially be capitalized and considered indefinite-lived assets subject to annual impairment reviews or more often upon the occurrence of certain events. For those compounds that reach commercialization, the assets are amortized over the expected useful lives.

Measurement of fair value and useful lives are based to a large extent on anticipated cash flows. If actual cash flows vary from those used in calculating fair values, this may significantly affect our future results of operations. In particular, the estimation of discounted cash flows of intangible assets of newly developed products is subject to assumptions closely related to the nature of the acquired products. Factors that may affect the assumptions regarding future cash flows:

- long-term sales forecasts,
- anticipation of selling price erosion after the end of orphan exclusivity due to follow-on biologic competition in the market,
- behavior of competitors (launch of competing products, marketing initiatives etc.).

For significant acquisitions, the purchase price allocation is carried out with assistance from independent third-party valuation specialists. The valuations are based on information available at the acquisition date.

As our business evolves, we may face additional issues that will require increased levels of management estimation and complex judgments.

Recently Issued Accounting Pronouncements

In September 2009, the FASB issued ASU No. 2010-06, Fair Value Measurements and Disclosures (Topic 820): Improving Disclosures about Fair Value Measurements. This ASU amends certain disclosure requirements of Topic 820 to provide for additional disclosures for transfers in and out of Levels 1 and 2 and for activity in Level 3. The ASU also clarifies certain other disclosure requirements including level of desegregation and disclosures around inputs and valuation techniques. We adopted this ASU on January 1, 2010. The new disclosures about the purchases, sales, issuances and settlements in the roll forward activity for Level 3 fair value measurements are effective for fiscal years beginning after December 15, 2010 and we will adopt this provision effective January 1, 2011.

In October 2009, the FASB issued ASU No. 2009-13, Multiple-Deliverable Revenue Arrangements, or ASU 2009-13. ASU 2009-13, amends existing revenue recognition accounting pronouncements that are currently within the scope of FASB ASC Topic 605. This consensus provides accounting principles and application guidance on how the arrangement should be separated, and the consideration allocated. This guidance changes how to determine the fair value of undelivered products and services for separate revenue recognition. Allocation of consideration is now based on management's estimate of the selling price for an undelivered item where there is no other means to determine the fair value of that undelivered item. This new approach is effective prospectively for revenue arrangements entered into or materially modified in fiscal years beginning on or after June 15, 2010. The adoption of this guidance will not have a material impact on our results of operations, cash flows, and financial position.

In February 2010, the Financial Accounting Standards Board (FASB) amended the disclosure requirements of ASC Topic 855, Subsequent Events so that SEC filers are no longer required to disclose the date through which subsequent events have been evaluated in originally issued and revised financial statements. This revised guidance is effective immediately and we adopted this pronouncement on March 31, 2010 and have revised the disclosures as required.

In March 2010, the FASB ratified EITF Issue No. 08-9, *Milestone Method of Revenue Recognition* and as a result of this ratification the FASB issued ASU 2010-17 in April 2010, which states that the milestone method is a valid application of the proportional performance model for revenue recognition if the milestones are substantive and there is substantive uncertainty about whether the milestones will be achieved. The Task Force agreed that whether a milestone is substantive is a judgment that should be made at the inception of the arrangement. To meet the definition of a substantive milestone, the consideration earned by achieving the milestone (1) would have to be commensurate with either the level of effort required to achieve the milestone or the enhancement in the value of the item delivered, (2) would have to relate solely to past performance, and (3) should be reasonable relative to all deliverables and payment terms in the arrangement. No bifurcation of an individual milestone is allowed and there can be more than one milestone in an arrangement. The new guidance is effective for interim and annual periods beginning on or after June 15, 2010. The adoption of this guidance will not have a material impact on our results of operations, cash flows, and financial position.

Off-Balance Sheet Arrangements

In conjunction with our acquisition of Lev, we acquired purchase obligations related to the supply and manufacturing of Cinryze. We have committed to purchase a minimum number of liters of plasma per year through 2015 from our supplier. Additionally, we are required to purchase a minimum number of units from our third party toll manufacturer. The total minimum purchase commitments for these continuing arrangements as of December 31, 2010 are approximately \$363.0 million.

In October 2009, we terminated our agreement with Plasma Centers of America (PCA) and our obligation to purchase plasma collected from centers own by PCA.

ITEM 7A. Quantitative and Qualitative Disclosures About Market Risk

Our holdings of financial instruments are primarily comprised of money market funds holding only U.S. government securities and fixed income securities, including a mix of corporate debt and government securities. All such instruments are classified as securities available for sale. Our debt security portfolio represents funds held temporarily pending use in our business and operations. We manage these funds accordingly. Our primary investment objective is the preservation of principal, while at the same time optimizing the generation of investment income. We seek reasonable assuredness of the safety of principal and market liquidity by investing in cash equivalents (such as Treasury bills and money market funds) and fixed income securities (such as U.S. government and agency securities, municipal securities, taxable municipals, and corporate notes) while at the same time seeking to achieve a favorable rate of return. Our market risk exposure consists principally of exposure to changes in interest rates. Our holdings are also exposed to the risks of changes in the credit quality of issuers. We generally invest in financial instruments with maturities of less than one year. The carrying amount, which approximates fair value based on the level 1 valuation hierarchy of the fair value measurement standard, and the annualized weighted average nominal interest rate of our investment portfolio at December 31, 2010, was approximately \$78.4 million and 0.40%, respectively. The weighted average length to maturity was 7.1 months. A one percent change in the interest rate would have resulted in a \$0.8 million impact to interest income for the year ended December 31, 2010.

At December 31, 2010, we had principal outstanding of \$205.0 million of our senior convertible notes. The senior convertible notes bear interest at a rate of 2% per annum, payable semi-annually in arrears on March 15 and September 15 of each year commencing on September 15, 2007. The senior convertible notes are convertible into shares of our common stock at an initial conversion price of \$18.87 per share. The senior convertible notes may only be converted: (i) anytime after December 15, 2016; (ii) during the five business-day period after any five consecutive trading day period (the "measurement period") in which the price per note for each trading day of that measurement period was less than 98% of the product of the last reported sale price of our common stock and the conversion rate on each such day; (iii) during any calendar quarter (and only during such quarter) after the calendar quarter ending June 30, 2007, if the last reported sale price of our common stock for 20 or more

trading days in a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter exceeds 130% of the applicable conversion price in effect on the last trading day of the immediately preceding calendar quarter; or (iv) upon the occurrence of specified corporate events. Upon conversion, holders of the senior convertible notes will receive shares of common stock, subject to our option to irrevocably elect to settle all future conversions in cash up to the principal amount of the senior convertible notes, and shares for any excess. We can irrevocably elect this option at any time on or prior to the 35th scheduled trading day prior to the maturity date of the senior convertible notes. The senior convertible notes may be required to be repaid on the occurrence of certain fundamental changes, as defined in the senior convertible notes. As of December 31, 2010, the fair value of the principal of the \$205.0 million convertible senior notes outstanding was approximately \$229.8 million, based on the level 2 valuation hierarchy of the fair value measurements standard. The carrying value of the debt at December 31, 2010 is \$145.7 million.

In connection with the issuance of the senior convertible senior notes, we have entered into privately-negotiated transactions with two counterparties (the "counterparties"), comprised of purchased call options and warrants sold. These transactions are expected to generally reduce the potential equity dilution of our common stock upon conversion of the senior convertible notes. These transactions expose us to counterparty credit risk for nonperformance. We manage our exposure to counterparty credit risk through specific minimum credit standards, and diversification of counterparties.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

Our financial statements required by this item are attached to this Report beginning on page 77.

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

Not Applicable.

ITEM 9A. CONTROLS AND PROCEDURES

Evaluation of Disclosure Controls and Procedures

An evaluation was performed under the supervision and with the participation of our management, including our Chief Executive Officer, or CEO, and our Chief Financial Officer, or CFO, of the effectiveness of our disclosure controls and procedures, as such term is defined under Rule 13a-15(e) promulgated under the Securities Exchange Act of 1934, as amended (the "Exchange Act"), as of December 31, 2010. Based on that evaluation, our management, including our CEO and CFO, concluded that as of December 31, 2010 our disclosure controls and procedures were effective to ensure that information required to be disclosed by us in reports that we file or submit under the Exchange Act, is recorded, processed, summarized and reported within the time periods specified in the rules and forms of the Securities and Exchange Commission and that such information is accumulated and communicated to the Company's management, including our CEO and CFO, as appropriate to allow timely decisions regarding required disclosure.

Changes in Internal Control over Financial Reporting

During the quarter ended December 31, 2010, there were no significant changes in our internal control over financial reporting identified in connection with the evaluation of such controls that occurred during our most recent fiscal quarter that have materially affected, or are reasonably likely to materially affect our internal control over financial reporting.

Management Report on Internal Control over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting. Our internal control system was designed to provide reasonable assurance to the company's management and board of directors regarding the preparation and fair presentation of published consolidated financial statements. Internal control over financial reporting is defined in Rule 13a-15(f) or 15d-15(f) promulgated under the Exchange Act as a process designed by, or under the supervision of, our principal executive and principal financial officers and effected by our board of directors, management and other personnel, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles and includes those policies and procedures that:

- pertain to the maintenance of records that in reasonable detail accurately and fairly reflect the transactions and dispositions of the assets of the company;
- provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and
- provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the company's assets that could have a material effect on the financial statements.

Our management, including our Chief Executive Officer and Chief Financial Officer, do not expect that our internal control over financial reporting will prevent all error and all fraud. A control system, no matter how well designed and implemented, can provide only reasonable, not absolute, assurance that the control system's objectives will be met. Further, the design of a control system must reflect the fact that there are resource constraints, and the benefits of controls must be considered relative to their costs. Because of the inherent limitations in all control systems, no evaluation of controls can provide absolute assurance that all control issues within a company are detected. The inherent limitations include the realities that judgments in decision-making can be faulty, and that breakdowns can occur because of simple errors or mistakes. Controls can also be circumvented by the individual acts of some persons, by collusion of two or more people or by management override of the controls. Because of the inherent limitations in a cost-effective control system, misstatements due to error or fraud may occur and may not be detected.

Our management assessed the effectiveness of its internal control over financial reporting as of December 31, 2010. In making this assessment, it used the criteria based on the framework set forth by the Committee of Sponsoring Organizations of the Treadway Commission in "Internal Control—Integrated Framework" (COSO). Based on our assessments we believe that, as of December 31, 2010, our internal control over financial reporting is effective based on those criteria.

Our independent registered public accounting firm, KPMG LLP, has issued a report on the effectiveness of the Company's internal control over financial reporting which appears on the next page.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
ViroPharma Incorporated:

We have audited ViroPharma Incorporated's (the Company's) internal control over financial reporting as of December 31, 2010, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the effectiveness of the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audit also included performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2010, based on criteria established in Internal Control—Integrated Framework issued by COSO.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of the Company as of December 31, 2010 and 2009, and the related consolidated statements of operations, comprehensive income (loss), stockholders' equity and cash flows for each of the years in the three-year period ended December 31, 2010, and our report dated February 24, 2011 expressed an unqualified opinion on those consolidated financial statements.

/s/ KPMG LLP

Short Hills, New Jersey
February 24, 2011

ITEM 9B. OTHER INFORMATION

Not Applicable.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

The information concerning our directors and regarding compliance with Section 16 of the Securities Exchange Act of 1934 required by this Item will be set forth in our Proxy Statement, to be filed within 120 days after the end of the fiscal year covered by this Annual Report on Form 10-K, and is incorporated by reference to our Proxy Statement.

The information concerning our executive officers required by this Item is incorporated by reference herein to the section of this Annual Report in Part I entitled "Executive Officers of the Registrant".

Our Board of Directors has adopted a code of business conduct and ethics that applies to our principal executive officers, principal financial officer, and controller, as well as all other employees. A copy of this code of business conduct and ethics has been posted on our Internet website at www.viopharma.com under the investing—corporate governance section. In addition, hard copies can be obtained free of charge through our investor relations department. Any amendments to, or waivers from, a provision of our code of ethics that applies to our principal executive officer, principal financial officer, controller, or persons performing similar functions and that relate to any element of the code of ethics enumerated in paragraph (b) of Item 406 of Regulation S-K shall be disclosed by posting such information on our website.

The information concerning our corporate governance required by this Item will be set forth in our Proxy Statement, to be filed within 120 days after the end of the fiscal year covered by this Annual Report on Form 10-K, and is incorporated by reference to our Proxy Statement.

ITEM 11. EXECUTIVE COMPENSATION

The information required by this Item will be set forth in our Proxy Statement, to be filed within 120 days after the end of the fiscal year covered by this Annual Report on Form 10-K, and is incorporated by reference to our Proxy Statement.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

Equity Compensation Plans

We maintain the 2005 Equity Incentive Plan (the "2005 Plan"), the 1995 Stock Option and Restricted Share Plan (the "1995 Plan"), the 2001 Equity Incentive Plan (the "2001 Plan") and the 2000 Employee Stock Purchase Plan (the "ESPP"), pursuant to which we may grant equity awards to eligible persons. The 1995 Plan expired in September 2005, although there remain options outstanding that were previously granted under that plan. The 2001 Plan is described more fully below.

The following table gives information about equity awards under our 1995 Plan, 2001 Plan, 2005 Plan and ESPP as of December 31, 2010:

| <u>Plan Category</u> | <u>(a)</u> <u>Number of securities to be issued upon exercise of outstanding options, warrants and rights</u> | <u>(b)</u> <u>Weighted-average exercise price of outstanding options, warrants and rights</u> | <u>(c)</u> <u>Number of securities remaining securities available for future issuance under equity compensation plans (excluding securities reflected in column (a))</u> |
|--|--|--|---|
| Equity compensation plans approved by securities holders (the 1995 Plan, 2005 Plan and the ESPP) | 8,370,357(1) | \$10.48(1) | 6,334,221 |
| Equity compensation plans not approved by security holders (the 2001 Plan) | <u>214,641</u> | \$ 8.73 | <u>59,709</u> |
| Total | <u>8,584,998</u> | \$10.44 | <u>6,393,930</u> |

(1) Does not include rights granted under the ESPP for which rights were granted in connection with the 6-month offering period that commenced in January 2010. The next scheduled purchase date under the Employee Stock Purchase Plan is June 30, 2011.

2001 Equity Incentive Plan

In November 2001, our board of directors adopted the 2001 Plan, which has not been submitted to or approved by stockholders. The 2001 Plan reserves for issuance up to 500,000 shares of our common stock, of which a maximum of 10% may be awarded and sold or granted as restricted shares and the remainder may be issued pursuant to the exercise of options granted under the plan. The number of shares available for future grant and previously granted but unexercised options are subject to adjustment for any future stock dividends, splits, mergers, combinations, or other changes in capitalization as described in the 2001 Plan.

Eligibility for Participation. Generally, any employee, consultant or advisor to our company or our subsidiaries is eligible to receive grants under the 2001 Plan; provided, however, our officers or officers of our subsidiaries are not eligible to receive any type of grant under the 2001 Plan. Similarly, no options or restricted shares may be granted to any member of our board of directors under the 2001 Plan.

Terms of Options and Restricted Shares. Nonstatutory stock options (NSOs) and restricted shares are available for grant under the 2001 Plan. The exercise price of options granted under the 2001 Plan may be equal to, more or less than the fair market value of our common stock on the date of grant, and the price (if any) of restricted shares will be determined by our board or a committee. Payment of the exercise price or the price of restricted shares may be made in cash, or by personal or certified check. The board or committee has the discretion to permit a participant to exercise or make payment for restricted shares by delivering a combination of shares and cash. The term of an NSO may not exceed ten years.

Options granted to employees may become exercisable based on the attainment of certain vesting conditions as may be set forth in the award agreement (as determined by the board or committee)—for example, an option may become exercisable if the optionee remains employed by us until a specified date, or if specified performance goals have been met. If a participant's employment terminates for any reason, the vested portion of an option remains exercisable for a fixed period of three months from the date of the participant's termination, and all of the restricted shares then subject to restrictions will be forfeited. If restricted shares are forfeited, we will refund to the participant the amounts paid for the restricted shares.

Acceleration in Connection with a Change of Control. Our 2001 Plan also has provisions that take effect if we experience a change of control. In general, a "Change of Control" will be deemed to have occurred upon the

approval of a plan to dissolve, liquidate, sell substantially all our assets, merge or consolidate with or into another corporation in which we are not the surviving entity or upon a significant change in the composition of the majority of the board.

If a Change of Control occurs and the 2001 Plan is not continued by a successor corporation, the participant is not offered substantially equivalent employment with the successor corporation or the participant's employment is terminated during the six month period following the Change of Control, then depending on whether the participant has been employed by us for at least 2 years, either 50% or 100% of such participant's unvested options will be fully vested and the restrictions on his or her restricted shares will lapse.

Deduction to our company. We will be entitled to an income tax deduction equal to the amount of ordinary income recognized by the participant. The deduction generally will be allowed for our taxable year in which occurs the last day of the calendar year in which the participant recognizes ordinary income.

The remainder of the information required by this Item will be set forth in our Proxy Statement, to be filed within 120 days after the end of the fiscal year covered by this Annual Report on Form 10-K, and is incorporated by reference to our Proxy Statement.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by this Item will be set forth in our Proxy Statement, to be filed within 120 days after the end of the fiscal year covered by this Annual Report on Form 10-K, and is incorporated by reference to our Proxy Statement.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

The information required by this Item will be set forth in our Proxy Statement, to be filed within 120 days after the end of the fiscal year covered by this Annual Report on Form 10-K, and is incorporated by reference to our Proxy Statement.

PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

| <u>Exhibit No.</u> | <u>Description</u> |
|--------------------|---|
| 3.1 | Amended and Restated Certificate of Incorporation of the Company. (31) (Exhibit 3.1) |
| 3.2 | Amended and Restated By-Laws of the Company. (2) (Exhibit 3.3) |
| 4.1 | Form of Indenture dated March 19, 2007 between the Company and Wilmington Trust Company, as Trustee. (21) (Exhibit 4.1) |
| 4.2 | First Supplemental Indenture, dated as of March 26, 2007, by and between the Company and Wilmington Trust Company, as Trustee. (21) (Exhibit 4.2) |
| 10.1†† | Form of Employment Agreement. (14) (Exhibit 10.1) |
| 10.2 | Form of Indemnification Agreement. (14) (Exhibit 10.2) |
| 10.3 | Investment Agreement among ViroPharma Incorporated and Perseus-Soros Biopharmaceutical Fund, L.P. dated May 5, 1999. (5) (Exhibit 10.20) |
| 10.4†† | 2001 Equity Incentive Plan. (8) (Exhibit 10.33) |
| 10.5† | License Agreement dated August 8, 2003 by and between GlaxoSmithKline and ViroPharma Incorporated. (4) (Exhibit 10.35) |
| 10.6† | Assignment, Transfer and Assumption Agreement between ViroPharma Incorporated and Eli Lilly and Company dated October 18, 2004. (10) (Exhibit 2.1) |
| 10.7† | Amendment No. 1 to the Assignment, Transfer and Assumption Agreement between ViroPharma Incorporated and Eli Lilly and Company dated November 8, 2004. (10) (Exhibit 2.2) |
| 10.8†† | ViroPharma Severance Plan. (14) (Exhibit 10.37) |
| 10.9†† | ViroPharma Cash Bonus Plan. (22) (Exhibit 10.2) |
| 10.10††* | ViroPharma Board Compensation Policy. |
| 10.11†† | Amended and Restated 1995 ViroPharma Stock Option and Restricted Share Plan. (13) |
| 10.12†† | 2005 Equity Incentive Plan. (19) |
| 10.13†† | Form Of Non-Qualified Stock Option Agreement For Members Of The Board Of Directors. (15) (Exhibit 10.2) |
| 10.14†† | Form Of Non-Qualified Stock Option Agreement. (15) (Exhibit 10.3) |
| 10.15†† | Form of Incentive Stock Option Agreement. (15) (Exhibit 10.4) |
| 10.16† | Master Agreement by and between OSG Norwich Pharmaceuticals, Inc. and ViroPharma Incorporated effective as of December 1, 2005. (16) (Exhibit 10.41) |
| 10.17† | Project Agreement No. 1 by and between OSG Norwich Pharmaceuticals, Inc. and ViroPharma Incorporated. (16) (Exhibit 10.42) |
| 10.18† | Bulk Supply Agreement between ViroPharma and Alpharma Inc. dated April 13, 2006. (17) (Exhibit 10.1) |
| 10.19† | Project Agreement No. 2 by and between OSG Norwich Pharmaceuticals, Inc. and ViroPharma Incorporated dated May 15, 2006. (17) (Exhibit 10.2) |

| <u>Exhibit No.</u> | <u>Description</u> |
|--------------------|--|
| 10.20 | Real Estate Purchase Agreement between LV Associates, L.P. and the Company dated December 22, 2006. (22) (Exhibit 10.33) |
| 10.21 | Confirmation of Convertible Bond Hedge Transaction, dated as of March 20, 2007, by and between ViroPharma Incorporated and Credit Suisse International and Credit Suisse, New York Branch, as agent for Credit Suisse International. (21) (Exhibit 10.1) |
| 10.22 | Confirmation of Convertible Bond Hedge Transaction, dated as of March 20, 2007, by and between ViroPharma Incorporated and Wells Fargo Bank, National Association. (21) (Exhibit 10.2) |
| 10.23 | Confirmation of Issuer Warrant Transaction dated as of March 20, 2007, by and between ViroPharma Incorporated and Credit Suisse International and Credit Suisse, New York Branch, as agent for Credit Suisse International. (21) (Exhibit 10.3) |
| 10.24 | Confirmation of Issuer Warrant Transaction, dated as of March 20, 2007, by and between ViroPharma Incorporated and Wells Fargo Bank, National Association. (21) (Exhibit 10.4) |
| 10.25 | Amendment to Confirmation of Issuer Warrant Transaction dated as of March 22, 2007, by and between ViroPharma Incorporated and Credit Suisse International and Credit Suisse, New York Branch, as agent for Credit Suisse International. (21) (Exhibit 10.4) |
| 10.26 | Amendment to Confirmation of Issuer Warrant Transaction, dated as of March 22, 2007, by and between ViroPharma Incorporated and Wells Fargo Bank, National Association. (21) (Exhibit 10.5) |
| 10.27† | Amended and Restated Bulk Supply Agreement between ViroPharma and Alpharma Inc. dated October 26, 2007. (18) (Exhibit 10.38) |
| 10.28 | Agreement and Plan of Merger, dated as of July 15, 2008, by and among ViroPharma Incorporated, HAE Acquisition Corp., and Lev Pharmaceuticals, Inc. (3) (Exhibit 2.1) |
| 10.29 | Form of Contingent Value Rights Agreement, by and among ViroPharma Incorporated, Lev Pharmaceuticals, Inc. and StockTrans, Inc. (3) (Exhibit 2.1) |
| 10.30†† | Separation Agreement, dated July 15, 2008, by and between Lev Pharmaceuticals, Inc., ViroPharma Incorporated and Joshua Schein. (6) (Exhibit 10.5) |
| 10.31†† | Separation Agreement, dated July 15, 2008, by and between Lev Pharmaceuticals, Inc., ViroPharma Incorporated and Judson Cooper. (6) (Exhibit 10.6) |
| 10.32† | Plasma Supply Agreement dated April 12, 2007 (24) (Exhibit 10.4) |
| 10.33† | Agreement for the Purchase and Sale of Blood Plasma dated July 12, 2007 (25) (Exhibit 10.1) |
| 10.34 | Lease Agreement with 730 Stockton Drive Associates, L.P. dated March 14, 2008. (27) (Exhibit 10.1) |
| 10.35†† | Letter Agreement with Michel de Rosen dated March 30, 2008 (28) (Exhibit 10.1) |
| 10.36†† | Letter Agreement between the Company and Robert Pietrusko dated January 9, 2009 (22) (Exhibit 10.1) |
| 10.37 | Form of Partial Unwind Agreement with respect to the Note Hedge Transaction Confirmation between ViroPharma Incorporated and Credit Suisse International (32) (Exhibit 10.1) |
| 10.38 | Form of Partial Unwind Agreement with respect to the Warrant Confirmation between ViroPharma Incorporated and Credit Suisse International (32) (Exhibit 10.2) |

| <u>Exhibit No.</u> | <u>Description</u> |
|--------------------|---|
| 10.39 | Form of Partial Unwind Agreement with respect to the Note Hedge Transaction Confirmation between ViroPharma Incorporated and Wells Fargo Bank, National Association (32) (Exhibit 10.3) |
| 10.40 | Form of Partial Unwind Agreement with respect to the Warrant Confirmation, dated July 11, 2007 between ViroPharma Incorporated and Wells Fargo Bank, National Association (32) (Exhibit 10.4) |
| 10.41†† | Amended and Restated ViroPharma Incorporated 2000 Employee Stock Purchase Plan. (33) (Annex A) |
| 10.42†† | Form of Amended and Restated Change of Control Agreement with the Executive Officers. (38) (Exhibit 10.1) |
| 10.43† | Intermediate Supply Agreement with Biotest AG dated as of June 19, 2009 by and between ViroPharma SPRL, a wholly owned subsidiary of ViroPharma Incorporated, and Biotest AG. (35) (Exhibit 10.1) |
| 10.44† | First Amendment to the Agreement for the Purchase and Sale of Blood Plasma, dated as of July 9, 2009 by and between ViroPharma Biologics, Inc., a wholly owned subsidiary of ViroPharma Incorporated, and DCI Management Group LLC. (36) (Exhibit 10.1) |
| 10.45† | Manufacturing and Distribution Agreement (Europe and ROW) dated as of January 8, 2010, by and between ViroPharma SPRL, a wholly-owned subsidiary of ViroPharma Incorporated, and Sanquin Bloedvoorziening (Sanquin Blood Supply Foundation) (31) (Exhibit 10.63) |
| 10.46† | Distribution and Manufacturing Services Agreement For the Americas and Israel dated as of January 8, 2010, by and between ViroPharma Biologics, Inc., a wholly-owned subsidiary of ViroPharma Incorporated, and Sanquin Bloedvoorziening (Sanquin Blood Supply Foundation) (31) (Exhibit 10.64) |
| 10.47† | Exclusive License Agreement dated as of February 20, 2006 by and between ViroPharma Incorporated and Dale N. Gerding, M.D. (31) (Exhibit 10.65) |
| 10.48† | Strategic Supply Agreement dated as of February 26, 2010, by and between ViroPharma Biologics, Inc., a wholly-owned subsidiary of ViroPharma Incorporated, and Biotest Pharmaceuticals Corporation. (36) |
| 10.49† | Amendment Number 2 to the Agreement for the Purchase and Sale of Blood Plasma dated as of February 5, 2010, by and between ViroPharma Biologics, Inc., a wholly owned subsidiary of ViroPharma Incorporated and DCI Management Group LLC. (37) |
| 10.50†* | Second Amended and Restated Bulk Material Supply Agreement, effective January 1, 2011, by and between ViroPharma Incorporated and Xellia Pharmaceuticals, Inc. |
| 10.51†* | Amended and Restated Bulk Material Supply Letter Agreement dated December 14, 2010 by and between ViroPharma Incorporated and Xellia Pharmaceuticals, Inc. |
| 10.52††* | Form of Restricted Share Unit Award Agreement |
| 10.53†† | Form of Performance Share Unit Award Agreement (38) |
| 14 | Code of Conduct and Ethics. (23) (Exhibit 14) |
| 21* | List of Subsidiaries. |
| 23* | Consent of KPMG LLP, Independent Registered Public Accounting Firm. |
| 24* | Power of Attorney (included on signature page). |

| <u>Exhibit No.</u> | <u>Description</u> |
|--------------------|--|
| 31.1* | Certification by Chief Executive Officer pursuant to Rule 13a-14(a) and 15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002. |
| 31.2* | Certification by Chief Financial Officer pursuant to Rule 13a-14(a) and 15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002. |
| 32.1* | Certification Pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002. |

* Filed herewith.

† Portions of this exhibit were omitted and filed separately with the Secretary of the Commission pursuant to an application for confidential treatment filed with the Commission pursuant to Rule 24b-2 under the Securities Exchange Act of 1934, as amended.

†† Compensation plans and arrangements for executives and others.

(1) Filed as an Exhibit to Registrant's Form 10-Q for the quarter ended June 30, 2000.

(2) Filed as an Exhibit to the Company's Current Report on Form 8-K filed with the Commission on November 14, 2008.

(3) Filed as an Exhibit to the Company's Current Report on Form 8-K filed with the Commission on July 18, 2008.

(4) Filed as an Exhibit to Registrant's Form 10-Q for the quarter ended September 30, 2003.

(5) Filed as an Exhibit to Registrant's Form 10-Q for the quarter ended March 31, 1999.

(6) Filed as an Exhibit to the Current Report on Form 8-K filed with the Commission on July 18, 2008 by Lev Pharmaceuticals, Inc.

(7) Filed as an Exhibit to Registrant's Form 10-Q for the quarter ended March 31, 2001.

(8) Filed as an Exhibit to Registrant's Form 10-K for the year ended December 31, 2001.

(9) Filed as an Exhibit to Registrant's Current Report on Form 8-K filed with the Commission on April 11, 2008.

(10) Filed as an Exhibit to the Company's Current Report on Form 8-K/A filed with the Commission on November 24, 2004.

(11) Filed as an Exhibit to the Company's Current Report on Form 8-K filed with the Commission on November 29, 2004.

(12) Filed as an Exhibit to the Company's Current Report on Form 8-K filed with the Commission on February 15, 2005.

(13) Filed as an Annex to Registrant's Proxy Statement filed with the Commission on April 8, 2002.

(14) Filed as an Exhibit to Registrant's Form 10-K for the year ended December 31, 2004.

(15) Filed as an Exhibit to Registrant's Form 10-Q for the quarter ended June 30, 2005.

(16) Filed as an Exhibit to Registrant's Form 10-K for the year ended December 31, 2005.

(17) Filed as an Exhibit to Registrant's Form 10-Q for the quarter ended June 30, 2006.

(18) Filed as an Exhibit to Registrant's Form 10-K for the year ended December 31, 2008.

(19) Filed as Annex to Registrant's Proxy Statement filed with the Commission on April 11, 2008.

(20) Filed as an Exhibit to the Company's Registration Statement on Form S-3 (333-141411) filed with the Commission on March 19, 2007.

(21) Filed as an Exhibit to the Company's Current Report on Form 8-K filed with the Commission on March 26, 2007.

(22) Filed as an Exhibit to Registrant's Current Report on Form 8-K filed with the Commission on January 8, 2009.

(23) Filed as an Exhibit to the Company's Current Report on Form 8-K filed with the Commission on February 24, 2010.

(24) Filed as an Exhibit to Form 10-QSB/A filed by Lev Pharmaceuticals, Inc. on August 27, 2007.

(25) Filed as an Exhibit to Form 8-K filed by Lev Pharmaceuticals, Inc. on July 25, 2007.

(26) Filed as an Exhibit to Form 10-Q filed by Lev Pharmaceuticals, Inc. on April 30, 2008.

(27) Filed as an Exhibit Registrant's Form 10-Q for the quarter ended March 31, 2008.

- (28) Filed as an Exhibit to Registrant's Current Report on Form 8-K filed with the Commission on April 3, 2008.
- (29) Filed as an Exhibit to Form 10-KSB filed by Lev Pharmaceuticals, Inc. on March 31, 2006.
- (30) Filed as an Exhibit to Form 10-KSB filed by Lev Pharmaceuticals, Inc. on March 31, 2006.
- (31) Filed as an Exhibit to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2009 filed with the Commission on February 25, 2010.
- (32) Filed as an Exhibit to the Company's Current Report on Form 8-K filed with the Commission on March 24, 2009.
- (33) Filed as Annex A to the Company's Proxy Statement filed with the Commission on April 10, 2009.
- (34) Filed as an Exhibit to the Company's Quarterly Report on Form 10-Q filed with the Commission on July 29, 2009.
- (35) Filed as an Exhibit to the Company's Quarterly Report on Form 10-Q filed with the Commission on October 29, 2009.
- (36) Filed as an Exhibit to the Company's Amendment No. 1 to Quarterly Report on Form 10-Q for the quarter ended March 31, 2010 filed with the Commission on October 27, 2010.
- (37) Filed as an Exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2010 filed with the Commission on April 28, 2010.
- (38) Filed as an Exhibit to the Company's Current Report on Form 8-K filed with the Commission on January 7, 2010.

Copies of the exhibits are available to stockholders from Peter Wolf, Vice President, General Counsel and Secretary, ViroPharma Incorporated, 730 Stockton Drive, Exton, Pennsylvania 19341. There will be a fee to cover the Company's expenses in furnishing the exhibits.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on our behalf by the undersigned, thereunto duly authorized.

VIROPHARMA INCORPORATED

By: /s/ Vincent J. Milano

Vincent J. Milano
President, Chief Executive Officer

POWER OF ATTORNEY

KNOW ALL PERSONS BY THESE PRESENTS, that each person whose signature appears below constitutes and appoints each of Vincent J. Milano and Charles A. Rowland, Jr. as his or her attorney-in-fact, with the full power of substitution, for him or her in any and all capacities, to sign any amendments to this Report, and to file the same, with exhibits thereto and other documents in connection therewith, with the Securities and Exchange Commission, hereby ratifying and confirming all that said attorney-in-fact, or his substitute or substitutes, may do or cause to be done by virtue hereof.

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated:

| <u>Name</u> | <u>Capacity</u> | <u>Date</u> |
|---|--|-------------------|
| <u>/s/ VINCENT J. MILANO</u> Vincent J. Milano | President, Chief Executive Officer (Principal Executive Officer) | February 24, 2011 |
| <u>/s/ CHARLES A. ROWLAND, JR.</u> Charles A. Rowland, Jr. | Chief Financial Officer (Principal Financial Officer) | February 24, 2011 |
| <u>/s/ RICHARD S. MORRIS</u> Richard S. Morris | Chief Accounting Officer and Controller (Principal Accounting Officer) | February 24, 2011 |
| <u>/s/ VINCENT J. MILANO</u> Vincent J. Milano | Chairman of the Board | February 24, 2011 |
| <u>/s/ PAUL A. BROOKE</u> Paul A. Brooke | Director | February 24, 2011 |
| <u>/s/ WILLIAM CLAYPOOL, M.D.</u> William Claypool, M.D. | Director | February 24, 2011 |
| <u>/s/ MICHAEL R. DOUGHERTY</u> Michael R. Dougherty | Director | February 24, 2011 |
| <u>/s/ ROBERT J. GLASER</u> Robert J. Glaser | Director | February 24, 2011 |
| <u>/s/ JOHN R. LEONE</u> John R. Leone | Director | February 24, 2011 |
| <u>/s/ HOWARD H. PIEN</u> Howard H. Pien | Director | February 24, 2011 |

VIROPHARMA INCORPORATED
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Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders
ViroPharma Incorporated:

We have audited the accompanying consolidated balance sheets of ViroPharma Incorporated as of December 31, 2010 and 2009, and the related consolidated statements of operations, comprehensive income (loss), stockholders' equity and cash flows for each of the years in the three-year period ended December 31, 2010. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of ViroPharma Incorporated as of December 31, 2010 and 2009, and the results of their operations and their cash flows for each of the years in the three-year period ended December 31, 2010, in conformity with U.S generally accepted accounting principles.

As discussed in Note 9 to the consolidated financial statements, the Company retrospectively changed its method of accounting for convertible debt instruments that may be settled in cash upon conversion due to the adoption of a new accounting standard issued by the FASB, as of January 1, 2009.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the effectiveness of ViroPharma Incorporated's internal control over financial reporting as of December 31, 2010, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO), and our report dated February 24, 2011 expressed an unqualified opinion on the effective operation of internal control over financial reporting.

/s/ KPMG LLP

Short Hills, New Jersey
February 24, 2011

ViroPharma Incorporated
Condensed Consolidated Balance Sheets

| (in thousands, except share and per share data) | <u>December 31, 2010</u> | <u>December 31, 2009</u> |
|--|------------------------------|------------------------------|
| Assets | | |
| Current assets: | | |
| Cash and cash equivalents | \$ 426,732 | \$ 331,672 |
| Short-term investments | 78,439 | — |
| Accounts receivable, net | 43,879 | 41,243 |
| Inventory | 54,388 | 41,582 |
| Prepaid expenses and other current assets | 13,959 | 9,546 |
| Prepaid income taxes | 2,000 | 2,256 |
| Deferred income taxes | 13,744 | 20,065 |
| Total current assets | <u>633,141</u> | <u>446,364</u> |
| Intangible assets, net | 619,712 | 618,510 |
| Property, equipment and building improvements, net | 11,468 | 10,508 |
| Goodwill | 6,228 | — |
| Debt issuance costs, net | 2,397 | 2,784 |
| Deferred income taxes | 4,252 | — |
| Other assets | 10,376 | 6,285 |
| Total assets | <u>\$1,287,574</u> | <u>\$1,084,451</u> |
| Liabilities and Stockholders' Equity | | |
| Current liabilities: | | |
| Accounts payable | \$ 10,215 | \$ 5,866 |
| Contingent consideration | 10,973 | — |
| Accrued expenses and other current liabilities | 48,990 | 33,374 |
| Income taxes payable | 1,944 | 749 |
| Total current liabilities | <u>72,122</u> | <u>39,989</u> |
| Other non-current liabilities | 2,463 | 2,958 |
| Deferred tax liability, net | 176,111 | 152,503 |
| Long-term debt | 145,743 | 138,614 |
| Total liabilities | <u>396,439</u> | <u>334,064</u> |
| Stockholders' equity: | | |
| Preferred stock, par value \$0.001 per share. 5,000,000 shares authorized; Series A convertible participating preferred stock; no shares issued and outstanding | — | — |
| Common stock, par value \$0.002 per share. 175,000,000 shares authorized; issued and outstanding 78,141,491 shares at December 31, 2010 and 77,442,716 shares at December 31, 2009 | 156 | 156 |
| Additional paid-in capital | 717,375 | 701,063 |
| Accumulated other comprehensive (loss) income | (258) | 914 |
| Retained earnings | 173,862 | 48,254 |
| Total stockholders' equity | <u>891,135</u> | <u>750,387</u> |
| Total liabilities and stockholders' equity | <u>\$1,287,574</u> | <u>\$1,084,451</u> |

See accompanying notes to consolidated financial statements.

ViroPharma Incorporated
Consolidated Statements of Operations

| (in thousands, except per share data) | Years ended December 31, | | |
|--|--------------------------|-----------|-----------|
| | 2010 | 2009 | 2008 |
| Revenues: | | | |
| Net product sales | \$439,012 | \$310,449 | \$232,307 |
| Costs and Expenses: | | | |
| Cost of sales (excluding amortization of product rights) | 61,288 | 40,214 | 8,874 |
| Research and development | 39,613 | 52,083 | 64,434 |
| Selling, general and administrative | 95,664 | 89,316 | 67,270 |
| Intangible amortization | 29,357 | 28,183 | 10,809 |
| Goodwill impairment | — | 65,099 | — |
| Impairment loss | — | 3,424 | 2,265 |
| Other operating expenses | 1,390 | — | — |
| Total costs and expenses | 227,312 | 278,319 | 153,652 |
| Operating income | 211,700 | 32,130 | 78,655 |
| Other Income (Expense): | | | |
| Interest income | 372 | 352 | 14,296 |
| Interest expense | (11,616) | (11,609) | (12,951) |
| Other income, net | 430 | — | — |
| Gain on long-term debt repurchase | — | 9,079 | — |
| Income before income tax expense | 200,886 | 29,952 | 80,000 |
| Income tax expense | 75,278 | 41,029 | 16,040 |
| Net income (loss) | 125,608 | (11,077) | 63,960 |
| Net income (loss) per share: | | | |
| Basic | \$ 1.61 | \$ (0.14) | \$ 0.90 |
| Diluted | \$ 1.47 | \$ (0.14) | \$ 0.84 |
| Shares used in computing net income (loss) per share: | | | |
| Basic | 77,820 | 77,423 | 71,391 |
| Diluted | 90,081 | 77,423 | 85,712 |

See accompanying notes to consolidated financial statements.

ViroPharma Incorporated

Consolidated Statements of Comprehensive Income (Loss)

| <u>(in thousands)</u> | <u>Year ended December 31,</u> | | |
|---|--------------------------------|-------------------|-----------------|
| | <u>2010</u> | <u>2009</u> | <u>2008</u> |
| Net income (loss) | \$125,608 | \$(11,077) | \$63,960 |
| Other comprehensive income: | | | |
| Unrealized gains on available for sale securities, net of income taxes of \$300 in 2008 | — | — | 550 |
| Currency translation adjustments, net | <u>(1,172)</u> | <u>1,569</u> | <u>(659)</u> |
| Comprehensive income (loss) | <u>\$124,436</u> | <u>\$ (9,508)</u> | <u>\$63,851</u> |

See accompanying notes to consolidated financial statements

ViroPharma Incorporated

Consolidated Statements of Stockholders' Equity

| | Preferred Stock | | Common Stock | | Additional paid-in capital | Accumulated other comprehensive income (loss) | Retained Earnings | Total stockholders' equity |
|--|------------------|--------|------------------|--------|----------------------------|---|-------------------|----------------------------|
| | Number of shares | Amount | Number of shares | Amount | | | | |
| (in thousands) | | | | | | | | |
| Balance, December 31, 2007 | — | \$— | 69,905 | 140 | 593,565 | (546) | (4,629) | 588,530 |
| Issuance of common stock | — | — | 21 | — | 180 | — | — | 180 |
| Exercise of common stock options | — | — | 112 | 1 | 359 | — | — | 360 |
| Acquisition of Lev Pharmaceuticals, Inc. | — | — | 7,360 | 15 | 86,020 | — | — | 86,035 |
| Unrealized gains on available-for-sale securities, net | — | — | — | — | — | 550 | — | 550 |
| Share-based compensation | — | — | — | — | 8,932 | — | — | 8,932 |
| Tax benefit on convertible note hedge | — | — | — | — | 1,262 | — | — | 1,262 |
| Stock option tax benefits | — | — | — | — | 184 | — | — | 184 |
| Cumulative translation adjustment, net | — | — | — | — | — | (659) | — | (659) |
| Net income | — | — | — | — | — | — | 63,960 | 63,960 |
| Balance, December 31, 2008 | — | — | 77,398 | 156 | 690,502 | (655) | 59,331 | 749,334 |
| Exercise of common stock options | — | — | 13 | — | 22 | — | — | 22 |
| Share-based compensation | — | — | — | — | 11,828 | — | — | 11,828 |
| Employee stock purchase plan | — | — | 32 | — | 356 | — | — | 356 |
| Stock option tax benefits | — | — | — | — | 44 | — | — | 44 |
| Cumulative translation adjustment, net | — | — | — | — | — | 1,569 | — | 1,569 |
| Termination of call spread options, net | — | — | — | — | 274 | — | — | 274 |
| Repurchase of conversion options on long-term debt | — | — | — | — | (1,963) | — | — | (1,963) |
| Net loss | — | — | — | — | — | — | (11,077) | (11,077) |
| Balance, December 31, 2009 | — | — | 77,443 | 156 | 701,063 | 914 | 48,254 | 750,387 |
| Exercise of common stock options | — | — | 633 | — | 3,342 | — | — | 3,342 |
| Employee stock purchase plan | — | — | 65 | — | 202 | — | — | 202 |
| Share-based compensation | — | — | — | — | 11,172 | — | — | 11,172 |
| Cumulative translation adjustment, net | — | — | — | — | — | (1,172) | — | (1,172) |
| Stock option tax benefits | — | — | — | — | 1,596 | — | — | 1,596 |
| Net income | — | — | — | — | — | — | 125,608 | 125,608 |
| Balance, December 31, 2010 | — | \$— | 78,141 | \$156 | \$717,375 | \$ (258) | \$173,862 | \$891,135 |

See accompanying notes to consolidated financial statements.

ViroPharma Incorporated
Consolidated Statements of Cash Flows

| (in thousands) | For the years ended December 31, | | |
|--|----------------------------------|-------------|------------|
| | 2010 | 2009 | 2008 |
| Cash flows from operating activities: | | | |
| Net income (loss) | \$ 125,608 | \$ (11,077) | \$ 63,960 |
| Adjustments to reconcile net income (loss) to net cash provided by operating activities: | | | |
| Non-cash share-based compensation expense | 11,176 | 11,817 | 8,938 |
| Non-cash building impairment | — | 3,424 | 2,265 |
| Non-cash interest expense | 7,517 | 7,291 | 7,888 |
| Non-cash charge for contingent consideration | 1,390 | — | — |
| Gain on long-term debt repurchase | — | (9,079) | — |
| Non-cash goodwill impairment | — | 65,099 | — |
| Deferred tax provision | 19,211 | 28,161 | 10,389 |
| Depreciation and amortization expense | 31,206 | 29,660 | 11,989 |
| Other, net | (370) | — | — |
| Changes in assets and liabilities, net of businesses acquired: | | | |
| Accounts receivable | (2,099) | (26,000) | 2,991 |
| Inventory | (12,320) | (13,622) | (3,129) |
| Prepaid expenses and other current assets | (4,277) | (4,447) | 4,977 |
| Prepaid income taxes/ income taxes payable | 1,451 | 4,447 | (6,084) |
| Other assets | (4,061) | 3,432 | (8,279) |
| Accounts payable | 4,014 | (1,489) | 1,843 |
| Accrued expenses and other current liabilities | 15,565 | (2,456) | (6,387) |
| Non-current income tax payable and other non-current liabilities | (494) | (382) | 76 |
| Net cash provided by operating activities | 193,517 | 84,779 | 91,437 |
| Cash flows from investing activities: | | | |
| Purchase of Lev Pharmaceuticals, Inc., net of cash acquired | — | — | (380,218) |
| Purchase of Auralis, net of cash acquired | (13,152) | — | — |
| Purchase of Vancocin assets | (7,000) | (7,000) | (7,000) |
| Purchase of property, plant and equipment | (2,807) | (1,929) | (2,529) |
| Purchase of investments | (86,975) | — | — |
| Maturities of investments | 8,000 | — | 405,187 |
| Net cash (used in) provided by investing activities | (101,934) | (8,929) | 15,440 |
| Cash flows from financing activities: | | | |
| Long-term debt repurchase | — | (21,150) | — |
| Repayment of debt | (1,575) | — | (12,056) |
| Termination of call spread options, net | — | 274 | — |
| Net proceeds from issuance of common stock | 3,544 | 378 | 540 |
| Excess tax benefits from share-based payment arrangements | 1,596 | 44 | 184 |
| Tax benefit on convertible note hedge | — | — | 1,262 |
| Net cash provided (used in) by financing activities | 3,565 | (20,454) | (10,070) |
| Effect of exchange rate changes on cash | (88) | 437 | (659) |
| Net increase in cash and cash equivalents | 95,060 | 55,833 | 96,148 |
| Cash and cash equivalents at beginning of period | 331,672 | 275,839 | 179,691 |
| Cash and cash equivalents at end of period | \$ 426,732 | \$331,672 | \$ 275,839 |

See accompanying notes to consolidated financial statements.

ViroPharma Incorporated
Notes to the Consolidated Financial Statements

Note 1. Organization and Business Activities

ViroPharma Incorporated and subsidiaries is a global biotechnology company dedicated to the development and commercialization of products that address serious diseases, with a focus on products used by physician specialists or in hospital settings. We intend to grow through sales of our marketed products, through continued development of our product pipeline, expansion of sales into additional territories outside the United States and through potential acquisition or licensing of products or acquisition of companies. We expect future growth to be driven by sales of Cinryze, both domestically and internationally, and by our primary development programs, including C1 esterase inhibitor and a non-toxicogenic strain of *C. difficile* (VP20621).

We market and sell Cinryze in the United States for routine prophylaxis against angioedema attacks in adolescent and adult patients with hereditary angioedema (HAE). Cinryze is a C1 esterase inhibitor therapy for routine prophylaxis against HAE, also known as C1 inhibitor (C1-INH) deficiency, a rare, severely debilitating, life-threatening genetic disorder. Cinryze was obtained in October 2008, when we completed our acquisition of Lev Pharmaceuticals, Inc. (Lev). In January 2010, we acquired expanded rights to commercialize Cinryze and future C1-INH derived products in certain European countries and other territories throughout the world as well as rights to develop future C1-INH derived products for additional indications. In March 2010, our Marketing Authorization Application (MAA) for Cinryze for acute treatment and prophylaxis against HAE was accepted by the European Medicines Agency (EMA). We intend to seek to commercialize Cinryze in Europe in 2011 in countries where we have distribution rights. We are currently evaluating our commercialization plans in additional territories. We also intend to conduct ViroPharma sponsored studies and investigator-initiated studies (IIS) to identify further therapeutic uses and potentially expand the labeled indication for Cinryze to include other C1 mediated diseases, such as Antibody-Mediated Rejection (AMR) and Delayed Graft Function (DGF). Additionally, we are currently undertaking studies on the viability of subcutaneous administration of Cinryze.

We also market and sell Vancocin HCl capsules, the oral capsule formulation of vancomycin hydrochloride, in the U.S. and its territories. Vancocin is a potent antibiotic approved by the U.S. Food and Drug Administration, or FDA, to treat antibiotic-associated pseudomembranous colitis caused by *Clostridium difficile* infection (CDI), or *C. difficile*, and enterocolitis caused by *Staphylococcus aureus*, including methicillin-resistant strains.

Our product development portfolio is primarily focused on two programs, C1 esterase inhibitor [human] and VP20621. We are working on developing further therapeutic uses; potential additional indications in other C1 mediated diseases, and alternative modes of administration for C1 esterase inhibitor. We are also developing VP20621 for the treatment and prevention of CDI. On August 6, 2009 we announced that dosing had begun in the Phase 1 clinical trial for VP20621 to determine the safety and tolerability of VP20621 dosed orally as a single and as repeat escalating doses in healthy young and older adults. We have successfully completed our Phase 1 clinical trial and anticipate moving the compound into a Phase 2 clinical trial.

In addition to these programs, we have several other assets that we may make additional investments in. These investments will be limited and dependent on our assessment of the potential future commercial success of or benefits from the asset. These assets include maribavir for CMV and other compounds. On May 28, 2010 we acquired Auralis Limited, a UK based specialty pharmaceutical company. The acquisition of Auralis provides us with the opportunity to accelerate our European commercial systems for potential future product launches and additional business development acquisitions. The acquisition also provides immediate revenue from sales of Diamorphine (Diamorphine Hydrochloride BP Injection) for palliative care and acute pain relief in the United Kingdom.

ViroPharma Incorporated
Notes to the Consolidated Financial Statements (continued)

Note 2. Basis of Presentation

Principles of Consolidation

The consolidated financial statements include the accounts of ViroPharma and its wholly-owned subsidiaries. All intercompany accounts and transactions have been eliminated in consolidation.

Cash and cash equivalents

The Company considers all highly liquid investments with an original maturity of three months or less when purchased to be cash equivalents.

Concentration of credit risk

The Company invests its excess cash and short-term investments in accordance with a policy objective that seeks to ensure both liquidity and safety of principal. The policy limits investments to certain types of instruments issued by the U.S. government and institutions with strong investment grade credit ratings and places restrictions in their terms and concentrations by type and issuer to reduce the Company's credit risk.

The Company has an exposure to credit risk in its trade accounts receivable from sales of product. Vancocin is distributed through wholesalers that sell the product to pharmacies and hospitals and Cinryze is distributed through specialty pharmacy/ specialty distributors (SP/SD's) who then sell and distribute to physicians, hospitals and patients, among others. Five customers represent approximately 87% of our trade accounts receivable at December 31, 2010 and approximately 96% of our 2010 net product sales.

The Company, in connection with the issuance of the senior convertible senior notes, have entered into privately-negotiated transactions with two counterparties (the "counterparties"), comprised of purchased call options and warrants sold. These transactions will reduce the potential equity dilution of our common stock upon conversion of the senior convertible notes. These transactions expose the Company to counterparty credit risk for nonperformance. The Company manages its exposure to counterparty credit risk through specific minimum credit standards, and diversification of counterparties.

Single source supplier

The company currently outsources all toll manufacturing to single source manufactures for Vancocin and Cinryze. A change in suppliers for Vancocin or Cinryze could cause a delay in manufacturing and a possible loss of sales, which would affect operating results adversely.

Accounts receivable

Accounts receivable are recorded at the invoiced amount, net of related cash discounts, rebates and estimated returns and do not bear interest. At December 31, 2010 and 2009, there was no allowance for doubtful accounts as all net amounts recorded are deemed collectible. The Company does not have any off-balance sheet exposure related to its customers.

Inventories

Inventories are stated at the lower of cost or market using actual cost. At December 31, 2010 and 2009, inventory consists of finished goods, work-in-process (WIP) and certain starting materials required to produce inventory of finished product.

ViroPharma Incorporated

Notes to the Consolidated Financial Statements (continued)

Property, equipment and building improvements

Property, equipment and building improvements are recorded at cost. Depreciation and amortization are computed on a straight-line basis over the useful lives of the assets or the lease term, whichever is shorter, ranging from three to thirty years.

The Company leases certain of its equipment and facilities under operating leases. Operating lease payments are charged to operations on a straight-lined basis over the related period that such leased assets are utilized in service. Expenditures for repairs and maintenance are expensed as incurred.

Goodwill and Intangible Assets

Goodwill is not amortized, but is evaluated annually for impairment or when indicators of a potential impairment are present. Our impairment testing of goodwill is performed separately from our impairment testing of intangible assets. The goodwill impairment test consists of two steps. The first step compares a reporting unit's fair value to its carrying amount to identify potential goodwill impairment. If the carrying amount of a reporting unit exceeds the reporting unit's fair value, the second step of the impairment test must be completed to measure the amount of the reporting unit's goodwill impairment loss, if any. Step two requires an assignment of the reporting unit's fair value to the reporting unit's assets and liabilities to determine the implied fair value of the reporting unit's goodwill. The implied fair value of the reporting unit's goodwill is then compared with the carrying amount of the reporting unit's goodwill to determine the goodwill impairment loss to be recognized, if any.

During the first quarter of 2009 and as of March 31, 2009, the market capitalization of ViroPharma fell below the carrying value of the our net assets due to the results of our Phase 3 clinical trial evaluating maribavir used as prophylaxis in allogeneic stem cell transplant patients and our decision to discontinue dosing in our Phase 3 trial of maribavir in solid organ (liver) transplant patients. The fact that our market capitalization fell below our carrying value required us to test for impairment of our goodwill and other intangible assets. See Note 7 for further discussion of this impairment test.

Indefinite-lived intangible assets acquired as part of the Auralis acquisition are used in research and development activities (IPR&D) are not amortized, but are evaluated annually for impairment or when indicators of a potential impairment are present. The impairment test for indefinite-lived intangible assets is a one-step test, which compares the fair value of the intangible asset to its carrying value. If the carrying value exceeds its fair value, an impairment loss is recognized in an amount equal to the excess. The fair value of the assets for purposes of the impairment test is based on valuation models that incorporate assumptions and internal projections of expected future cash flows and operating plans. IPR&D assets are initially recognized at fair value and classified as indefinite-lived assets until completion or abandonment of the project at which time a useful life would be determined.

We tested our indefinite-lived intangible assets and goodwill during the fourth quarter of 2010 and there was no impairment as a result of these tests.

Long-lived intangible assets acquired as part of the Vancocin and Lev acquisitions are being amortized on a straight-line basis over their estimated useful lives of 25 years and the long-lived intangible assets acquired as part of the Auralis acquisition are being amortized on a straight-line basis over their estimated useful lives of 12 years. The Company estimated the useful life of the assets by considering competition by products prescribed for the same indication, the likelihood and estimated future entry of non-generic and generic competition with the same or similar indication and other related factors. The factors that drive the estimate of the life are often uncertain and are reviewed on a periodic basis or when events occur that warrant review.

ViroPharma Incorporated

Notes to the Consolidated Financial Statements (continued)

Impairment or Disposal of Long-Lived Assets

The Company assesses the recoverability of long-lived assets for which an indicator of impairment exists, as necessary. Specifically, the Company determines if a long-lived asset or asset group is impaired by comparing the carrying value of these assets to their estimated undiscounted future operating cash flows. If impairment is indicated, a charge is recognized for the difference between the asset's carrying value and fair value.

Revenue recognition

Revenue is recognized when all four of the following criteria are met (1) the Company has persuasive evidence an arrangement exists, (2) the price is fixed and determinable, (3) title has passed, and (4) collection is reasonably assured. The Company's credit and exchange policy includes provisions for return of its product when it (1) has expired, or (2) was damaged in shipment.

Product revenue is recorded upon delivery to either our wholesalers or distributors and when title has passed. Product demand from wholesalers during a given period may not correlate with prescription demand for the product in that period. As a result, the Company periodically estimates and evaluates the wholesalers' inventory position and would defer recognition of revenue on product that has been delivered if the Company believes that channel inventory at a period end is in excess of ordinary business needs and if the Company believes the value of potential returns is materially different than the returns accrual.

Contract revenues are earned and recognized according to the provisions of each agreement. Contract milestone payments related to the achievement of substantive steps or regulatory events in the development process are recognized as revenues upon the completion of the milestone event or requirement. Payments, if any, received in advance of performance under a contract are deferred and recognized as revenue when earned. Up-front licensing fees where the Company has continuing involvement are deferred and amortized over the estimated performance period. Revenue from government grants is recognized as the related performance to which they are related occurs.

Sales Allowances

The Company records appropriate sales allowances upon the recognition of product revenue. The Company's return policy for Vancocin is limited to damaged or expired product. Cinryze has a no return policy. The return allowance is determined based on analysis of the historical rate of returns associated with Vancocin, which is then applied to sales, and is analyzed considering estimated wholesaler inventory and prescriptions. The chargeback and rebate allowances are determined based on analysis of the historical experience of government agencies' market share and governmental contractual prices relative to current selling prices, as well as the payor mix information provided by our wholesalers and from information obtained through Cinryze Solutions.

Customers

The Company's net product sales are related to Vancocin and Cinryze. For Vancocin, our customers are wholesalers who then distribute the product to pharmacies, hospitals and long term care facilities, among others. For Cinryze, our customers are specialty pharmacy and specialty distributors (SP/SD) who will distribute the product to physicians, hospitals and patients.

ViroPharma Incorporated

Notes to the Consolidated Financial Statements (continued)

Five wholesalers and/or SP/SD's represent the majority of the Company's consolidated total revenue, as approximated below:

| | Percentage of total revenues | | |
|------------------|------------------------------|------|------|
| | 2010 | 2009 | 2008 |
| Customer A | 25% | 29% | 39% |
| Customer B | 24% | 25% | 38% |
| Customer C | 21% | 13% | 17% |
| Customer D | 16% | 12% | — |
| Customer E | 10% | — | — |
| Total | 96% | 79% | 94% |

Research and development expenses and Collaborations

Research and product development costs are expensed as incurred. Reimbursements of research and development costs under cost sharing collaborations are recorded as a reduction of research and development expenses. Research and development costs include costs for discovery research, pre-clinical and clinical trials, manufacture of drug supply, supplies and acquired services, employee-related costs and allocated and direct facility expenses.

We evaluate our collaborative agreements for proper income statement classification based on the nature of the underlying activity. If payments to and from our collaborative partners are not within the scope of other authoritative accounting literature, the income statement classification for these payments is based on a reasonable, rational analogy to authoritative accounting literature that is applied in a consistent manner. Amounts due to our collaborative partners related to development activities are reflected as a research and development expense.

Income taxes

Income taxes are accounted for under the asset and liability method. Deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases and operating loss and tax credit carryforwards. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in operations in the period that includes the enactment date.

A valuation allowance is provided when it is more likely than not that some portion or all of a deferred tax asset will not be realized. The ultimate realization of deferred tax assets is dependent upon the generation of future taxable income and the reversal of deferred tax liabilities during the period in which the related temporary difference becomes deductible. The benefit of tax positions taken or expected to be taken in the Company's income tax returns are recognized in the consolidated financial statements if such positions are more likely than not of being sustained.

Use of estimates

The preparation of the Company's consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

ViroPharma Incorporated

Notes to the Consolidated Financial Statements (continued)

Share-based payments

The Company measures the cost of employee services received in exchange for an award of equity instruments based on the grant-date fair value of the award. That cost is recognized over the period during which an employee is required to provide service in exchange for the award—the requisite service period (vesting period). The grant-date fair value of employee share options are estimated using the Black-Scholes option-pricing model adjusted for the unique characteristics of those instruments. See Note 12 for the disclosures related to share-based compensation.

Compensation expense for options granted to non-employees is determined in accordance with the standard as the fair value of the consideration received or the fair value of the equity instruments issued, whichever is more reliably measured. Compensation expense for options granted to non-employees is remeasured each period as the underlying options vest.

Earnings per share

Basic earnings per share (EPS) is calculated by dividing net income by the weighted average shares of common stock outstanding during the period. Diluted EPS reflects the potential dilution of securities that could share in the earnings, including the effect of dilution to net income of convertible securities, stock options and warrants see Note 14.

Segment information

The Company is managed and operated as one business. The entire business is managed by a single management team that reports to the chief executive officer. There is no segment or business unit management that reviews separate or discrete financial information. The Company does not operate separate lines of business or separate business entities with respect to any of its products or product candidates.

Foreign Currency Translation

The financial statements of the Company's international subsidiaries are translated into U.S. dollars using the exchange rate at each balance sheet date for assets and liabilities, the historical exchange rate for stockholders' equity and an average exchange rate for each period of revenues, expenses, and gain and losses. The functional currency of the Company's non-U.S. subsidiaries is the local currency. Adjustments resulting from the translation of financial statements are reflected in accumulated other comprehensive income. Transaction gains and losses are recorded within operation results.

Subsequent Events

We have evaluated all subsequent events through the date the financial statements were issued, and have not identified any such events.

Reclassification

Certain prior year amounts have been reclassified to conform to the current year presentation.

New Accounting Standards

In September 2009, the FASB issued ASU No. 2010-06, Fair Value Measurements and Disclosures (Topic 820): Improving Disclosures about Fair Value Measurements. This ASU amends certain disclosure requirements of

ViroPharma Incorporated

Notes to the Consolidated Financial Statements (continued)

Topic 820 to provide for additional disclosures for transfers in and out of Levels 1 and 2 and for activity in Level 3. The ASU also clarifies certain other disclosure requirements including level of desegregation and disclosures around inputs and valuation techniques. We adopted this ASU on January 1, 2010. The new disclosures about the purchases, sales, issuances and settlements in the roll forward activity for Level 3 fair value measurements are effective for fiscal years beginning after December 15, 2010 and we will adopt this provision effective January 1, 2011.

In October 2009, the FASB issued ASU No. 2009-13, Multiple-Deliverable Revenue Arrangements, or ASU 2009-13. ASU 2009-13, amends existing revenue recognition accounting pronouncements that are currently within the scope of FASB ASC Topic 605 and provides accounting principles and application guidance on how the arrangement should be separated, and the consideration allocated. This guidance changes how to determine the fair value of undelivered products and services for separate revenue recognition. Allocation of consideration is now based on management's estimate of the selling price for an undelivered item where there is no other means to determine the fair value of that undelivered item. This new approach is effective prospectively for revenue arrangements entered into or materially modified in fiscal years beginning on or after June 15, 2010. The adoption of this guidance will not have a material impact on our results of operations, cash flows, and financial position.

In February 2010, the Financial Accounting Standards Board (FASB) amended the disclosure requirements of ASC Topic 855, Subsequent Events so that SEC filers are no longer required to disclose the date through which subsequent events have been evaluated in originally issued and revised financial statements. This revised guidance is effective immediately and we adopted this pronouncement on March 31, 2010 and have revised the disclosures as required.

In March 2010, the FASB ratified EITF Issue No. 08-9, *Milestone Method of Revenue Recognition* and as a result of this ratification the FASB issued ASU 2010-17 in April 2010, which states that the milestone method is a valid application of the proportional performance model for revenue recognition if the milestones are substantive and there is substantive uncertainty about whether the milestones will be achieved. The Task Force agreed that whether a milestone is substantive is a judgment that should be made at the inception of the arrangement. To meet the definition of a substantive milestone, the consideration earned by achieving the milestone (1) would have to be commensurate with either the level of effort required to achieve the milestone or the enhancement in the value of the item delivered, (2) would have to relate solely to past performance, and (3) should be reasonable relative to all deliverables and payment terms in the arrangement. No bifurcation of an individual milestone is allowed and there can be more than one milestone in an arrangement. The new guidance is effective for interim and annual periods beginning on or after June 15, 2010. The adoption of this guidance will not have a material impact on our results of operations, cash flows, and financial position.

Note 3. Short-Term Investments

Short-term investments consist of fixed income and debt securities with remaining maturities of greater than three months at the date of purchase. At December 31, 2010, all of our fixed income securities were classified as available for sale investments and measured as level 1 instruments of the fair value measurements standard.

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Notes to the Consolidated Financial Statements (continued)

The following summarizes the Company's available for sale investments at December 31, 2010:

| (in thousands) | <u>Cost</u> | <u>Gross unrealized gains</u> | <u>Gross unrealized losses</u> | <u>Fair value</u> |
|--|-----------------|---------------------------------------|--|-------------------|
| December 31, 2010 | | | | |
| Debt securities: | | | | |
| U.S. Treasury | \$50,259 | \$ 17 | \$12 | \$50,264 |
| Corporate bonds | 28,180 | 9 | 14 | 28,175 |
| | <u>\$78,439</u> | <u>\$ 26</u> | <u>\$26</u> | <u>\$78,439</u> |
| Maturities of investments were as follows: | | | | |
| Less than one year | \$67,299 | \$ 26 | \$13 | \$67,312 |
| Greater than one year | 11,140 | — | 13 | 11,127 |
| Total | <u>\$78,439</u> | <u>\$ 26</u> | <u>\$26</u> | <u>\$78,439</u> |

Note 4. Inventory

Inventory is stated at the lower of cost or market using actual cost. The following represents the components of the inventory at December 31, 2010 and December 31, 2009:

| (in thousands) | <u>December 31, 2010</u> | <u>December 31, 2009</u> |
|-----------------------|------------------------------|------------------------------|
| Raw Materials | \$37,994 | \$26,780 |
| Work In Process | 10,570 | 8,533 |
| Finished Goods | 5,824 | 6,269 |
| Total | <u>\$54,388</u> | <u>\$41,582</u> |

Note 5. Property, Equipment and Building Improvements

Property, equipment and building improvements consists of the following at December 31, 2010 and 2009:

| (in thousands) | <u>2010</u> | <u>2009</u> |
|--|-----------------|-----------------|
| Land | \$ 156 | \$ 156 |
| Building | 3,039 | 3,039 |
| Computers and equipment | 9,953 | 7,176 |
| Leasehold improvements | 5,234 | 5,191 |
| | 18,382 | 15,562 |
| Less: accumulated depreciation and amortization | 6,914 | 5,054 |
| Property, equipment and building improvements, net | <u>\$11,468</u> | <u>\$10,508</u> |

During 2009, we reclassified property and a building that was previously held for sale to a held and use long term asset. Accordingly, we adjusted the carrying value of the building to fair value at the time of the reclassification and incurred a \$3.4 million impairment charge related to the building. During 2008, we incurred a \$2.3 million impairment related to this building.

The useful life for the major categories of property and equipment are 30 years for the building, 3 to 5 years for computers and equipment and 15 years for building improvements.

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Notes to the Consolidated Financial Statements (continued)

Note 6. Intangible Assets

The following represents the balance of the intangible assets at December 31, 2010:

| (in thousands) | <u>Gross Intangible Assets</u> | <u>Accumulated Amortization</u> | <u>Net Intangible Assets</u> |
|-------------------------------|--|-------------------------------------|--------------------------------------|
| Cinryze Product rights | \$521,000 | \$45,714 | \$475,286 |
| Vancocin Intangibles | 161,099 | 39,629 | 121,470 |
| Auralis Contract rights | 12,365 | 601 | 11,764 |
| Auralis IPR&D | 11,192 | — | 11,192 |
| Total | <u>\$705,656</u> | <u>\$85,944</u> | <u>\$619,712</u> |

The following represents the balance of the intangible assets at December 31, 2009:

| (in thousands) | <u>Gross Intangible Assets</u> | <u>Accumulated Amortization</u> | <u>Net Intangible Assets</u> |
|------------------------------|--|-------------------------------------|--------------------------------------|
| Cinryze Product rights | \$521,000 | \$24,873 | \$496,127 |
| Vancocin Intangibles | 154,099 | 31,716 | 122,383 |
| Total | <u>\$675,099</u> | <u>\$56,589</u> | <u>\$618,510</u> |

In December 2008, FDA changed OGD's 2006 bioequivalence recommendation, which we have opposed since its original proposal in March 2006, by issuing draft guidance for establishing bioequivalence to Vancocin which would permit generic products that have the same inactive ingredients in the same quantities as Vancocin ("Q1 and Q2 the same"), and that meet certain other conditions, to demonstrate bioequivalence through comparative in vitro dissolution testing. Under this latest proposed method, any generic product that is not Q1 and Q2 the same as Vancocin would need to conduct an in vivo study with clinical endpoints to demonstrate bioequivalence with Vancocin.

On August 4, 2009 the FDA's Pharmaceutical Science and Clinical Pharmacology Advisory Committee voted in favor of the OGD's 2008 draft guidelines on bioequivalence for Vancocin. If FDA's proposed bioequivalence method for Vancocin becomes effective, the time period in which a generic competitor could be approved would be reduced and multiple generics may enter the market, which would materially impact our operating results, cash flows and possibly intangible asset valuations. This could also result in a reduction to the useful life of the Vancocin-related intangible assets. Management currently believes there are no indicators that would require a change in useful life as management believes that Vancocin will continue to be utilized along with generics that may enter the market, and the number of generics and the timing of their market entry is unknown.

A reduction in the useful life, as well as the timing and number of generics, will impact our cash flow assumptions and estimate of fair value, perhaps to a level that could result in an impairment charge. We will continue to monitor the actions of the OGD and consider the effects of our opposition actions and the announcements by generic competitors or other adverse events for additional impairment indicators. We will reevaluate the expected cash flows and fair value of our Vancocin-related assets at such time a triggering event occurs.

We are obligated to pay Eli Lilly and Company (Lilly) additional purchase price consideration based on net sales of Vancocin within a calendar year. The additional purchase price consideration is determined by the annual net sales of Vancocin, is paid quarterly and is due each year through 2011. We account for these additional payments

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Notes to the Consolidated Financial Statements (continued)

as additional purchase price which requires that the additional purchase price consideration is recorded as an increase to the intangible asset of Vancocin and is amortized over the remaining estimated useful life of the intangible asset. In addition, at the time of recording the additional intangible assets, a cumulative adjustment is recorded to accumulated intangible amortization, in addition to ordinary amortization expense, in order to reflect amortization as if the additional purchase price had been paid in November 2004.

As of December 31, 2010, we have paid an aggregate of \$44.1 million to Lilly in additional purchase price consideration, as our net sales of Vancocin surpassed the maximum annual obligation level of \$65 million every year since. The \$44.1 million paid to Lilly was based upon 35% of \$20 million in 2010, 2009 and 2008, 35% of \$17 million in 2007, 35% of \$19 million in 2006 and 50% of \$21 million in 2005. We are obligated to pay Lilly an additional amount based on 35% of annual net sales between \$45 and \$65 million of Vancocin during in 2011.

No additional payments are due to Lilly on net sales of Vancocin below or above the net sales levels reflected above.

At the time of recording the additional intangible assets, the Company recorded a cumulative adjustment in 2010, 2009 and 2008 of approximately \$1.5 million, \$1.3 million and \$1.0 million, respectively, to accumulated intangible amortization, in addition to ordinary amortization expense, in order to reflect amortization as if the additional purchase price had been paid in November 2004.

On May 28, 2010 we acquired Auralis Limited, a UK based specialty pharmaceutical company. With the acquisition of Auralis we have added one marketed product and several development assets to our portfolio. We recognized an intangible asset related to certain supply agreements for the marketed product and one of the development assets. Additionally, we have recognized in-process research and development (IPR&D) assets related to the compounds under development which are currently not approved for commercial use. We determined that these assets meet the criterion for separate recognition as intangible assets and the fair value of these assets have been determined based upon discounted cash flow models. The supply agreements will be amortized over their useful life of 12 years. The IPR&D assets used in research and development activities are classified as indefinite-lived and will be subject to periodic impairment testing. The IPR&D assets will remain as indefinite-lived intangible assets until the projects are completed or abandoned. Upon completion of the projects, we will make a separate determination of the useful life of the asset and begin amortization. If a project is abandoned such amounts will be written off at that time.

Amortization expense for the years ended December 31, 2010, 2009 and 2008 was \$29.4 million, \$28.2 million and \$10.8 million, respectively. The estimated aggregated amortization expense for each of the next five years will be approximately \$29.0 million, excluding any future increases related to additional purchase price consideration that may be payable to Lilly or any new amortization related to any additional long-lived intangible asset.

Note 7. Goodwill and Goodwill Impairment

During the first quarter of 2009 and as of March 31, 2009, the market capitalization of ViroPharma fell below the carrying value of the our net assets due to the results of our Phase 3 clinical trial evaluating maribavir used as prophylaxis in allogeneic stem cell transplant patients and our decision to discontinue dosing in our Phase 3 trial of maribavir in solid organ (liver) transplant patients. The fact that our market capitalization fell below our carrying value required us to test for impairment of our goodwill and other intangible assets. We conducted this analysis at March 31, 2009 and concluded that our goodwill was impaired due to our market capitalization being below the carrying value of our net assets for an extended period of time. We incurred a \$65.1 million charge in the first quarter related to this goodwill impairment. As a result of this impairment we had no goodwill remaining at December 31, 2009.

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Notes to the Consolidated Financial Statements (continued)

In May 2010 we acquired a 100% ownership interest in Auralis Limited, a UK based specialty pharmaceutical company. As a result of this acquisition we recorded initial goodwill of approximately \$5.9 million. The increase in goodwill since acquisition is attributable to foreign currency fluctuations.

Note 8. Accrued expenses and other current liabilities

Accrued expenses and other current liabilities consist of the following at December 31, 2010 and 2009:

| (in thousands) | <u>2010</u> | <u>2009</u> |
|--|-----------------|-----------------|
| Rebates and returns | \$24,352 | \$15,460 |
| Payroll, bonus and employee benefits liabilities | 7,283 | 6,411 |
| Clinical development and research liabilities | 3,964 | 3,365 |
| Selling and commercial liabilities | 2,880 | 2,308 |
| Interest payable | 1,196 | 1,196 |
| Other current liabilities | 9,315 | 4,634 |
| | <u>\$48,990</u> | <u>\$33,374</u> |

Note 9. Long-Term Debt

Long-term debt as of December 31, 2010 and December 31, 2009 is summarized in the following table:

| (in thousands) | <u>December 31, 2010</u> | <u>December 31, 2009</u> |
|--------------------------------|------------------------------|------------------------------|
| Senior convertible notes | \$145,743 | \$138,614 |
| less: current portion | — | — |
| Total debt principal | <u>\$145,743</u> | <u>\$138,614</u> |

As of December 31, 2010 senior convertible notes representing \$205.0 million of principal debt are outstanding with a carrying value of \$145.7 million.

On March 26, 2007, we issued \$250.0 million of 2% senior convertible notes due March 2017 (the “senior convertible notes”) in a public offering. Net proceeds from the issuance of the senior convertible notes were \$241.8 million. The senior convertible notes are unsecured unsubordinated obligations and rank equally with any other unsecured and unsubordinated indebtedness. The senior convertible notes bear interest at a rate of 2% per annum, payable semi-annually in arrears on March 15 and September 15 of each year commencing on September 15, 2007.

We adopted a new accounting standard issued by the FASB for convertible debt securities as of January 1, 2009. The debt and equity components of our senior convertible debt securities are bifurcated and accounted for separately based on the value and related interest rate of a non-convertible debt security with the same terms. The fair value of a non-convertible debt instrument at the original issuance date was determined to be \$148.1 million. The equity (conversion options) component of our convertible debt securities is included in Additional paid-in capital on our Consolidated Balance Sheet and, accordingly, the initial carrying value of the debt securities was reduced by \$101.9 million. Our net income for financial reporting purposes is reduced by recognizing the accretion of the reduced carrying values of our convertible debt securities to their face amount of \$250.0 million as additional non-cash interest expense. Accordingly, the senior convertible debt securities will recognize interest expense at effective rates of 8.0% as they are accreted to par value.

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On March 24, 2009 we repurchased, in a privately negotiated transaction, \$45.0 million in principal amount of our senior convertible notes due March 2017 for total consideration of approximately \$21.2 million. The repurchase represented 18% of our then outstanding debt and was executed at a price equal to 47% of par value. Additionally, in negotiated transactions, we sold approximately 2.38 million call options for approximately \$1.8 million and repurchased approximately 2.38 million warrants for approximately \$1.5 million which terminated the call options and warrants that were previously entered into by us in March 2007. We recognized a \$9.1 million gain in the first quarter of 2009 as a result of this debt extinguishment. For tax purposes, the gain qualifies for deferral until 2014 in accordance with the provisions of the American Recovery and Reinvestment Act.

As of December 31, 2010, we have accrued \$1.2 million in interest payable to holders of the senior convertible notes. Debt issuance costs of \$4.8 million have been capitalized and are being amortized over the term of the senior convertible notes, with the balance to be amortized as of December 31, 2010 being \$2.4 million.

The senior convertible notes are convertible into shares of our common stock at an initial conversion price of \$18.87 per share. The senior convertible notes may only be converted: (i) anytime after December 15, 2016; (ii) during the five business-day period after any five consecutive trading day period (the "measurement period") in which the price per note for each trading day of that measurement period was less than 98% of the product of the last reported sale price of our common stock and the conversion rate on each such day; (iii) during any calendar quarter (and only during such quarter) after the calendar quarter ending June 30, 2007, if the last reported sale price of our common stock for 20 or more trading days in a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter exceeds 130% of the applicable conversion price in effect on the last trading day of the immediately preceding calendar quarter; or (iv) upon the occurrence of specified corporate events. Upon conversion, holders of the senior convertible notes will receive shares of common stock, subject to ViroPharma's option to irrevocably elect to settle all future conversions in cash up to the principal amount of the senior convertible notes, and shares for any excess. We can irrevocably elect this option at any time on or prior to the 35th scheduled trading day prior to the maturity date of the senior convertible notes. The senior convertible notes may be required to be repaid on the occurrence of certain fundamental changes, as defined in the senior convertible notes. As of December 31, 2010, the fair value of the principal of the \$205.0 million convertible senior notes outstanding was approximately \$229.8 million, based on the level 2 valuation hierarchy of the fair value measurements standard.

Concurrent with the issuance of the senior convertible notes, we entered into privately-negotiated transactions, comprised of purchased call options and warrants sold, to reduce the potential dilution of our common stock upon conversion of the senior convertible notes. The transactions, taken together, have the effect of increasing the initial conversion price to \$24.92 per share. The net cost of the transactions was \$23.3 million.

The call options allowed ViroPharma to receive up to approximately 13.25 million shares of its common stock at \$18.87 per share from the call option holders, equal to the number of shares of common stock that ViroPharma would issue to the holders of the senior convertible notes upon conversion. These call options will terminate upon the earlier of the maturity dates of the related senior convertible notes or the first day all of the related senior convertible notes are no longer outstanding due to conversion or otherwise. Concurrently, we sold warrants to the warrant holders to receive shares of its common stock at an exercise price of \$24.92 per share. These warrants expire ratably over a 60-day trading period beginning on June 13, 2017 and will be net-share settled.

The purchased call options are expected to reduce the potential dilution upon conversion of the senior convertible notes in the event that the market value per share of ViroPharma common stock at the time of exercise is greater than \$18.87, which corresponds to the initial conversion price of the senior convertible notes, but less than \$24.92 (the warrant exercise price). The warrant exercise price is 75.0% higher than the price per share of \$14.24

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Notes to the Consolidated Financial Statements (continued)

of our common stock on the pricing date. If the market price per share of ViroPharma common stock at the time of conversion of any senior convertible notes is above the strike price of the purchased call options (\$18.87), the purchased call options will entitle us to receive from the counterparties in the aggregate the same number of shares of our common stock as we would be required to issue to the holder of the converted senior convertible notes. Additionally, if the market price of ViroPharma common stock at the time of exercise of the sold warrants exceeds the strike price of the sold warrants (\$24.92), we will owe the counterparties an aggregate of approximately 13.25 million shares of ViroPharma common stock. If we have insufficient shares of common stock available for settlement of the warrants, we may issue shares of a newly created series of preferred stock in lieu of our obligation to deliver common stock. Any such preferred stock would be convertible into 10% more shares of our common stock than the amount of common stock we would otherwise have been obligated to deliver under the warrants. We are entitled to receive approximately 10.87 million shares of our common stock at \$18.87 from the call option holders and if the market price of ViroPharma common stock at the time of exercise of the sold warrants exceeds the strike price of the sold warrants (\$24.92), will owe the counterparties an aggregate of approximately 10.87 million shares of ViroPharma common stock.

The purchased call options and sold warrants are separate transactions entered into by us with the counterparties, are not part of the terms of the senior convertible notes, and will not affect the holders' rights under the senior convertible notes. Holders of the senior convertible notes will not have any rights with respect to the purchased call options or the sold warrants. The purchased call options and sold warrants meet the definition of derivatives. These instruments have been determined to be indexed to our own stock and have been recorded in stockholders' equity in our Consolidated Balance Sheet. As long as the instruments are classified in stockholders' equity they are not subject to the mark to market provisions.

Note 10. Acquisitions, License and Research Agreements

Lev Pharmaceuticals, Inc. Acquisition

In October 2008, we acquired all the outstanding common stock of Lev Pharmaceuticals, Inc. (Lev). Lev was a biopharmaceutical company focused on developing and commercializing therapeutic products for the treatment of inflammatory diseases. The terms of the merger agreement provided for the conversion of each share of Lev common stock into upfront consideration of \$453.1 million, or \$2.75 per Lev share, comprised of \$2.25 per share in cash and \$0.50 per share in ViroPharma common stock, and contingent consideration (CVR's) of up to \$1.00 per share which may be paid on achievement of certain regulatory and commercial milestones. As of December 31, 2009, only the second CVR as described below remains achievable. The target for the first CVR payment of \$0.50 per share (or \$87.5 million) will not be paid as a third party's human C1 inhibitor product was approved for the acute treatment of HAE and granted orphan exclusivity. The second CVR payment of \$0.50 per share (\$87.5 million) becomes payable if Cinryze reaches at least \$600 million in cumulative net product sales by October 2018.

The value of the CVR's has not been included in the cost of the acquisition, as the payment of these amounts is not reasonably assured at this time. Should any of the contingently issued payments be made, that value would be added to the purchase price, in accordance with SFAS 141, Accounting for Business Combinations which was the effective GAAP at the time of the acquisition,

As a result of the acquisition, we obtained Cinryze, a C1 inhibitor, which has been approved by the FDA for routine prophylaxis of hereditary angioedema (HAE) also known as C1 inhibitor deficiency, a rare, severely debilitating, life-threatening genetic disorder. We determined that Cinryze product rights have a fair value of \$521.0 million. The estimated fair value of the identifiable product rights for Cinryze was determined based upon a discounted cash flows model using a discount rate of 19%. Additionally, we have determined that the estimated useful life for the Cinryze product rights is 25 years.

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Notes to the Consolidated Financial Statements (continued)

Sanquin Rest of World (ROW) Agreement

On January 8, 2010 we obtained, as part of the Sanquin ROW Agreement, expanded rights to commercialize Cinryze and future C1-INH derived products in certain European countries and other territories throughout the world as well as rights to develop future C1-INH derived products for additional indications. We intend to seek to commercialize Cinryze in European countries in which we have distribution rights commencing in 2011, as well as in additional territories.

Auralis Acquisition

In May 2010 we acquired a 100% ownership interest in Auralis Limited, a UK based specialty pharmaceutical company for approximately \$14.5 million in upfront consideration for the acquisition of the company and its existing pharmaceutical licenses and products. We have also agreed to pay an additional payment of £10 million Pounds Sterling (approximately \$15.5 million based on the December 31, 2010 exchange rate) contingent upon the first regulatory approval of a product in late stage development.

The acquisition provides us with the opportunity to accelerate our European commercial systems, which will be utilized in the commercial launch of Cinryze™ (C1 esterase inhibitor [human]) in Europe if approved, for future product launches and potential additional business development acquisitions. The acquisition also provides immediate revenue from sales of a marketed product in the UK and access to two late stage development products.

The results of Auralis's operations have been included in the Consolidated Statement of Operations beginning June 1, 2010.

The following tables summarize the consideration transferred to acquire Auralis and the amounts of identified assets acquired and liabilities assumed at the acquisition date. This allocation of purchase price to assets acquired and liabilities assumed is preliminary and may change when final purchase price allocation is completed.

The purchase price was as follows:

| | <u>(in thousands)</u> |
|--------------------------------|-----------------------|
| Cash | \$14,514 |
| Contingent Consideration | 9,000 |
| Total purchase price | <u>\$23,514</u> |

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The total cost of the acquisition was allocated to Auralis assets acquired and liabilities assumed as follows:

| | <u>(in thousands)</u> |
|-------------------------------------|-----------------------|
| Assets acquired: | |
| Cash | \$ 1,362 |
| Trade receivable | 741 |
| Inventory | 1,623 |
| Property, plant and equipment | 23 |
| Contract rights | 11,600 |
| IPR&D | 10,500 |
| Goodwill | 5,851 |
| Deferred tax assets | 317 |
| Total assets | <u>\$32,017</u> |
| Liabilities assumed: | |
| Trade and other payables | \$ 519 |
| Loan Payable | 1,545 |
| Deferred tax liabilities | 6,439 |
| Total liabilities | <u>\$ 8,503</u> |
| Total purchase price | <u>\$23,514</u> |

The Auralis contingent consideration will be payable upon the first regulatory approval of a product in late stage development. The fair value of the contingent consideration recognized on the acquisition date was estimated by applying a discount rate based on an implied rate of return from the acquisition to the risk probability weighted asset cash flows and the expected approval date. This fair value is based on significant inputs not observable in the market, which are referred to in the guidance as Level 3 inputs. The contingent consideration is classified as a liability and is subject to the recognition of subsequent changes in fair value.

The fair value of the contract rights and IPR&D assets has been determined using an income approach based upon a discounted cash flow model. That measure is based on significant inputs not observable in the market, which are referred to in the guidance as Level 3 inputs. Key assumptions include (i) a discount rate of 17.5 percent applicable to the probability weighted cash flows, and (ii) probability adjusted levels of net income and cash flows based assumptions regarding contract renewals, development and market risks and, where applicable, approval dates.

The fair value of inventory represents net realizable value for finished goods less a normal profit on selling efforts. The fair value of the remaining assets and liabilities acquired are based on the price that would be received on the sale of the asset or the price paid to transfer the liability to a market participant and approximates its carrying value on the measurement date.

As a result of the transaction, we recognized \$5.9 million of goodwill which is not deductible for tax purposes. The amounts of revenue and earnings of Auralis since the acquisition date and had the acquisition occurred on January 1, 2010 are immaterial to our consolidated results.

GlaxoSmithKline Agreement

In August 2003, the Company announced the acquisition of worldwide rights (excluding Japan) from GlaxoSmithKline (GSK) to an antiviral compound (Maribavir, maribavir, or VP41263) that is an inhibitor of cytomegalovirus (CMV). The Company plans to advance maribavir initially for the prevention and treatment of CMV infection in transplant patients.

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Under the terms of the agreement, the Company has exclusive worldwide rights (excluding Japan) to develop and commercialize maribavir for the prevention and treatment of cytomegalovirus infections related to transplant (including solid organ and hematopoietic stem cell transplantation), congenital transmission, and in patients with HIV infection. The Company will focus initially on patients who have received a hematopoietic stem cell (bone marrow) transplant, and are at risk for or have been infected with CMV. The Company paid GSK a \$3.5 million up-front licensing fee and may pay additional milestones based upon the achievement of defined clinical development and regulatory events, if any. The Company also will pay royalties to GSK and its licensor on product sales in the U.S. and the rest of the world (excluding Japan). The \$3.5 million up-front licensing fee was recorded as an acquisition of technology rights expense during 2003 as the underlying technology has not reached technological feasibility and has no alternative uses. In the third quarter of 2006, a milestone related to the initiation of the phase 3 study occurred and \$3.0 million was charged to research and development and paid in February 2007.

Other Agreements

The Company has entered into various other licensing, research and other agreements. Under these other agreements, the Company is working in collaboration with various other parties. Should any discoveries be made under such arrangements, the Company would be required to negotiate the licensing of the technology for the development of the respective discoveries. There are no significant funding commitments under these other agreements.

Note 11. Stockholder's Equity

Preferred Stock

The Company's Board of Directors has the authority, without action by the holders of common stock, to issue up to 4,800,000 shares of preferred stock from time to time in such series and with such preference and rights as it may designate.

Note 12. Share-based Compensation

Share-based compensation expense has been included in both research and development expense (R&D) and selling, general and administrative expense (SG&A). Share-based compensation expense consisted of the following for the year ended December 31, 2010 and 2009:

| (in thousands) | 2010 | | |
|------------------------------------|---------|---------|----------|
| Plan | R&D | SG&A | Total |
| Employee Stock Option Plans | \$3,286 | 7,757 | \$11,043 |
| Employee Stock Purchase Plan | 39 | 90 | 129 |
| Non-employee Stock Options | 4 | — | 4 |
| Total | \$3,329 | \$7,847 | \$11,176 |
| | 2009 | | |
| Plan | R&D | SG&A | Total |
| Employee Stock Option Plans | \$3,113 | \$8,445 | \$11,558 |
| Employee Stock Purchase Plan | 90 | 180 | 270 |
| Non-employee Stock Options | (11) | — | (11) |
| Total | \$3,192 | \$8,625 | \$11,817 |

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Notes to the Consolidated Financial Statements (continued)

| Plan | 2008 | | |
|------------------------------------|----------------|----------------|----------------|
| | R&D | SG&A | Total |
| Employee Stock Option Plans | \$2,948 | \$5,899 | \$8,847 |
| Employee Stock Purchase Plan | 57 | 28 | 85 |
| Non-employee Stock Options | 6 | — | 6 |
| Total | <u>\$3,011</u> | <u>\$5,927</u> | <u>\$8,938</u> |

No amounts of share-based compensation cost have been capitalized into inventory or other assets during the years ended December 31, 2010, 2009 and 2008.

Employee Stock Option Plans

We currently have three option plans in place: a 1995 Stock Option and Restricted Share Plan (“1995 Plan”), a 2001 Equity Incentive Plan (“2001 Plan”) and a 2005 Stock Option and Restricted Share Plan (“2005 Plan”) (collectively, the “Plans”). In September 2005, the 1995 Plan expired and no additional grants will be issued from this plan. The Plans were adopted by our board of directors to provide eligible individuals with an opportunity to acquire or increase an equity interest in the Company and to encourage such individuals to continue in the employment of the Company.

Stock options granted under the 2005 Plan must be granted at an exercise price not less than the fair value of the Company’s common stock on the date of grant. Stock options granted under the 2001 Plan can be granted at an exercise price that is less than the fair value of the Company’s common stock at the time of grant. Stock options granted under the 1995 Plan were granted at an exercise price not less than the fair value of the Company’s common stock on the date of grant. Stock options granted from the Plans are exercisable for a period not to exceed ten years from the date of grant. Vesting schedules for the stock options vary, but generally vest 25% per year, over four years. Shares issued under the Plans are new shares. The Plans provide for the delegation of certain administrative powers to a committee comprised of company officers.

Options granted during the 2010, 2009 and 2008 had weighted average fair values of \$6.68, \$6.73 and \$7.66 per option. The fair value of each option grant was estimated throughout the year using the Black-Scholes option-pricing model using the following assumptions for the Plans:

| | 2010 | 2009 | 2008 |
|--|---------------|---------------|---------------|
| Expected dividend yield | — | — | — |
| Range of risk free interest rate | 1.9% – 3.4% | 1.6% – 3.4% | 1.9% – 3.7% |
| Weighted-average volatility | 71.4% | 77.2% | 87.0% |
| Range of volatility | 69.3% – 72.4% | 71.5% – 79.9% | 76.6% – 90.2% |
| Range of expected option life (in years) | 5.50 – 6.25 | 5.50 – 6.25 | 5.50 – 6.25 |

Risk free interest rate is based on the U.S. Treasury yield curve in effect at the time of grant. Volatility is based on the Company’s historical stock price using the expected life of the grant.

We estimate forfeiture rates for all share-based awards and monitor stock options exercises and employee termination patterns in estimating the forfeiture rate.

On May 23, 2008, the 2005 Plan was amended and an additional 5,000,000 shares of common stock was reserved for issuance upon the exercise of stock options or the grant of restricted shares or restricted share units. This amendment was approved by stockholders at our Annual Meeting of Stockholders in May of 2010. As of

ViroPharma Incorporated

Notes to the Consolidated Financial Statements (continued)

December 31, 2010, there were 5,963,870 shares available for grant under the Plans. The following table lists the balances available by Plan at December 31, 2010:

| | <u>1995 Plan</u> | <u>2001 Plan</u> | <u>2005 Plan</u> | <u>Combined</u> |
|---|------------------|------------------|------------------|------------------|
| Number of shares authorized | 4,500,000 | 500,000 | 12,850,000 | 17,850,000 |
| Number of options granted since inception | (6,997,515) | (1,255,472) | (7,540,646) | (15,793,633) |
| Number of options cancelled since inception | 3,359,352 | 822,932 | 638,851 | 4,821,135 |
| Number of shares expired | (861,837) | (7,751) | (44,044) | (913,632) |
| Number of shares available for grant | <u>—</u> | <u>59,709</u> | <u>5,904,161</u> | <u>5,963,870</u> |

The following table lists option grant activity for the year ended December 31, 2010:

| | <u>Share Options</u> | <u>Weighted average exercise price per share</u> |
|--|--------------------------|--|
| Balance at December 31, 2007 | 4,973,990 | \$11.10 |
| Granted | 1,609,635 | 10.29 |
| Exercised | (112,159) | 3.20 |
| Forfeited | (115,914) | 12.81 |
| Expired | <u>(53,838)</u> | <u>17.05</u> |
| Balance at December 31, 2008 | 6,301,714 | 10.95 |
| Granted | 1,571,009 | 9.94 |
| Exercised | (51,125) | 10.67 |
| Forfeited | (167,062) | 11.72 |
| Expired | <u>(64,341)</u> | <u>16.13</u> |
| Balance at December 31, 2009 | 7,590,195 | 10.68 |
| Granted | 2,114,784 | 10.12 |
| Exercised | (649,311) | 5.53 |
| Forfeited | (99,022) | 10.21 |
| Expired | <u>(371,648)</u> | <u>22.74</u> |
| Balance at December 31, 2010 | <u>8,584,998</u> | <u>\$10.44</u> |

The total intrinsic value of share options exercised during the year ended December 31, 2010, 2009 and 2008 was approximately \$5.9 million, \$0.1 million and \$0.7 million, respectively.

We have 8,584,998 option grants outstanding at December 31, 2010 with exercise prices ranging from \$0.99 per share to \$38.70 per share and a weighted average remaining contractual life of 6.84 years. The following table lists the outstanding and exercisable option grants as of December 31, 2010:

| | <u>Number of options</u> | <u>Weighted average exercise price</u> | <u>Weighted average remaining contractual term (years)</u> | <u>Aggregate intrinsic value (in thousands)</u> |
|-----------------------|------------------------------|--|--|---|
| Outstanding | 8,584,998 | \$10.44 | 6.84 | \$61,523,899 |
| Exercisable | 4,538,078 | \$10.44 | 5.39 | \$33,675,643 |

ViroPharma Incorporated

Notes to the Consolidated Financial Statements (continued)

As of December 31, 2010, there was \$19.5 million of total unrecognized compensation cost related to unvested share-based payments (including share options) granted under the Plans. That cost is expected to be recognized over a weighted-average period of 2.5 years. The total fair value of shares vested during the year ended December 31, 2010 was \$10.8 million.

Employee Stock Purchase Plan

In 2000, the stockholders of the Company approved an employee stock purchase plan. A total of 300,000 shares originally were available under this plan. Since inception of the plan, the stockholders of the Company have approved amendments to the plan to increase the number of shares available for issuance under the plan by 600,000 shares. Under this plan, 48,909, 69,806 and 24,478 shares were sold to employees during 2010, 2009 and 2008. As of December 31, 2010 there are approximately 430,060 shares available for issuance under this plan.

Under this plan, employees may purchase common stock through payroll deductions in semi-annual offerings at a price equal to the lower of 85% of the closing price on the applicable offering commencement date or 85% of the closing price on the applicable offering termination date. Since the total payroll deductions from the plan period are used to purchase shares at the end of the offering period, the number of shares ultimately purchased by the participants is variable based upon the purchase price. Shares issued under the employee stock purchase plan are new shares. There are two plan periods: January 1 through June 30 ("Plan Period One") and July 1 through December 31 ("Plan Period Two"). The plan qualifies under Section 423 of the Internal Revenue Code.

The fair value of the share-based payments was approximately \$130,000. The fair value was estimated using the Type B model, with the following assumptions:

| | 2010 Plan Period Two | 2010 Plan Period One |
|---|-------------------------|-------------------------|
| Risk free interest rate | 0.22% | 0.20% |
| Volatility | 46.0% | 54.9% |
| Expected option life (in years) | 0.5 | 0.5 |

Under Plan Period Two, 21,305 shares were sold to employees on December 31, 2010 at \$9.13 per share, which represents the closing price on the offer termination date of \$10.74 per share at 85%.

Under Plan Period One, 27,604 shares were sold to employees on June 30, 2010 at \$7.34 per share, which represents the closing price on the offer termination date of \$8.63 per share at 85%.

The fair value of the non-employee share options was estimated using the Black-Scholes option-pricing model using the following range of assumptions:

| | December 31, 2010 | December 31, 2009 | December 31, 2008 |
|--|----------------------|----------------------|----------------------|
| Expected dividend yield | — | — | — |
| Range of risk free interest rate | 0.3% – 0.3% | 0.2% – 1.1% | 0% – 1.0% |
| Weighted average volatility | 43.50% | 67.40% | 57.90% |
| Range of volatility | 43.2% – 45.1% | 51.8% – 84.4% | 44.0% – 66.8% |
| Contractual option life (in years) | 0.72 – 1.28 | 0.53 – 2.28 | 0.04 – 3.29 |

There were no non-employee share options vested or exercised during the year ended December 31, 2010 or 2009. Shares issued to non-employees upon exercise of stock options are new shares.

ViroPharma Incorporated

Notes to the Consolidated Financial Statements (continued)

Note 13. Income Taxes

For the years ended December 31, 2010, 2009 and 2008, the following table summarizes the components of income before income taxes and the provision for income taxes:

| (in thousands) | Year ended December 31, | | |
|------------------------------------|-------------------------|----------|----------|
| | 2010 | 2009 | 2008 |
| Income (loss) before income taxes: | | | |
| Domestic | 210,819 | 37,020 | 79,406 |
| Foreign | (9,933) | (7,068) | 594 |
| Income before income taxes | \$200,886 | \$29,952 | \$80,000 |
| Income tax expense (benefit): | | | |
| Current: | | | |
| Federal | 45,727 | 7,614 | 145 |
| State and local | 9,684 | 4,018 | 3,763 |
| Foreign | (33) | 16 | 209 |
| Subtotal | 55,378 | 11,648 | 4,117 |
| Deferred: | | | |
| Federal | 26,926 | 21,588 | 11,123 |
| State and local | (4,198) | 10,684 | 431 |
| Foreign | (2,828) | (2,891) | 369 |
| Subtotal | 19,900 | 29,381 | 11,923 |
| Income tax expense | \$ 75,278 | \$41,029 | \$16,040 |
| Effective income tax rate | 37.5% | 137.0% | 20.1% |

For the year ended December 31, 2010, 2009 and 2008, the following table reconciles the federal statutory income tax rate to the effective income tax rate:

| (% of pre-tax income) | Year ended December 31, | | |
|--|-------------------------|--------|--------|
| | 2010 | 2009 | 2008 |
| U.S. federal statutory income tax rate | 35.0% | 35.0% | 35.0% |
| State and local income tax, net of federal tax benefit | 1.8 | 44.3 | 3.6 |
| Share-based compensation | 0.6 | 5.0 | 1.3 |
| Orphan drug credit | (0.2) | (20.5) | (16.0) |
| Change in valuation allowance | 0.1 | (1.6) | (3.8) |
| Goodwill impairment | — | 75.8 | — |
| Other | 0.2 | (1.0) | — |
| Effective income tax rate | 37.5% | 137.0% | 20.1% |

In 2010, 2009 and 2008, respectively, \$1.6 million, \$0.1 million and \$0.2 million related to current stock option tax benefits were allocated directly to stockholders' equity.

ViroPharma Incorporated

Notes to the Consolidated Financial Statements (continued)

The following table summarizes the components of deferred income tax assets and liabilities:

| (in thousands) | December 31, | |
|--|--------------|-------------|
| | 2010 | 2009 |
| Deferred tax assets: | | |
| Net operating loss carryforwards | \$ 13,421 | \$ 15,755 |
| Capitalized research and development costs | 6,419 | 11,339 |
| Orphan drug credit carryforward | 1,482 | 24,036 |
| Research and development credit carryforward | 3,449 | 6,840 |
| Non-deductible reserves | 5,385 | 3,593 |
| Depreciation | 670 | 1,518 |
| Intangible asset amortization | 6,965 | 7,687 |
| Equity compensation | 9,770 | 7,684 |
| Other | 1,316 | 779 |
| Subtotal | 48,877 | 79,231 |
| Valuation allowance | (6,238) | (5,949) |
| Deferred tax assets | 42,639 | 73,282 |
| Deferred tax liabilities: | | |
| Intangible asset amortization | 192,963 | 197,731 |
| Convertible note | 6,584 | 6,905 |
| Prepaid expenses | 1,207 | 1,084 |
| Deferred tax liabilities | 200,754 | 205,720 |
| Net deferred tax assets (liability) | \$(158,115) | \$(132,438) |

At December 31, 2010 and 2009, deferred tax assets and liabilities were classified on the Company's balance sheets as follows:

| (in thousands) | December 31, | |
|----------------------------------|--------------|-------------|
| | 2010 | 2009 |
| Current assets | \$ 13,744 | \$ 20,065 |
| Non-current assets | 4,252 | — |
| Non-current liabilities | (176,111) | (152,503) |
| Net deferred tax liability | \$(158,115) | \$(132,438) |

The following table summarizes the change in the valuation allowance:

| (in thousands) | Year ended December 31, | | |
|---|-------------------------|---------|-----------|
| | 2010 | 2009 | 2008 |
| Valuation allowance at beginning of year | \$5,949 | \$6,436 | \$ 38,742 |
| Tax expense (benefit) | 289 | (487) | (4,087) |
| Adoption of new accounting for convertible debt | — | — | (28,219) |
| Valuation allowance at end of year | \$6,238 | \$5,949 | \$ 6,436 |

Due to uncertainty about the ability to realize the benefit of deferred tax assets relating to certain net operating loss carryforwards, a valuation allowance has been established to reduce deferred tax assets to a level that is

ViroPharma Incorporated

Notes to the Consolidated Financial Statements (continued)

more likely than not to be realized. Realization of the remaining net deferred tax assets will depend on the generation of sufficient taxable income in the appropriate jurisdiction, the reversal of deferred tax liabilities tax planning strategies and other factors prior to the expiration date of the carryforwards. A change in the estimates used to make this determination could require a reduction in deferred tax assets if they are no longer considered realizable.

As of December 31, 2010, our foreign subsidiaries have incurred cumulative losses and consequently no deferred tax liability has been established for any future distribution of funds from foreign subsidiaries.

The following table summarizes carryforwards of net operating losses and tax credits as of December 31, 2010.

| (in thousands) | <u>Amount</u> | <u>Expiration</u> |
|--|---------------|-------------------|
| Foreign net operating losses | \$ 12,476 | Indefinite |
| State net operating losses | 136,936 | 2024 – 2028 |
| Orphan drug credits | 1,482 | 2028 |
| Research and development credits | 3,449 | 2020 – 2024 |

At December 31, 2010 and 2009, the Company had no gross unrecognized tax benefits. The Company does not expect any material increase or decrease in its gross unrecognized tax benefits during the next twelve months.

The following table summarizes the change in our gross unrecognized tax benefits for the years 2008, 2009 and 2010:

| | <u>(in thousands)</u> |
|--|-----------------------|
| Balance at January 1, 2008 | \$ 1,133 |
| Additions for tax positions of prior years | <u>76</u> |
| Balance at December 31, 2008 | 1,209 |
| Payments made to settle uncertain tax position | <u>(1,209)</u> |
| Balance at December 31, 2009 | — |
| Additions for tax positions of prior years | — |
| Payments made to settle uncertain tax position | <u>—</u> |
| Balance at December 31, 2010 | <u>\$ —</u> |

The Company and its domestic subsidiaries file consolidated income tax returns in the U.S. and certain states. In addition, separate income tax returns are filed in other states. The Company's foreign subsidiaries file separate income tax returns in the foreign jurisdictions in which they are located. We are currently under IRS examination for the 2008 year and in certain states for years after 2004. The results of these examinations are not expected to have a material impact on the financial statements.

Our policy is to record interest and penalties related to tax matters in income tax expense.

ViroPharma Incorporated

Notes to the Consolidated Financial Statements (continued)

Note 14. Earnings (Loss) per share

| (in thousands, except per share data) | For the years ended December 31, | | |
|--|----------------------------------|------------|----------|
| | 2010 | 2009 | 2008 |
| Basic Earnings (Loss) Per Share | | | |
| Net income (loss) | \$125,608 | \$(11,077) | \$63,960 |
| Common stock outstanding (weighted average) | 77,820 | 77,423 | 71,391 |
| Basic net income (loss) per share | \$ 1.61 | \$ (0.14) | \$ 0.90 |
| Diluted Earnings (Loss) Per Share | | | |
| Net income (loss) | \$125,608 | \$(11,077) | \$63,960 |
| Add interest expense on senior convertible notes, net of income tax | 7,193 | — | 7,994 |
| Diluted net income (loss) | \$132,801 | \$(11,077) | \$71,954 |
| Common stock outstanding (weighted average) | 77,820 | 77,423 | 71,391 |
| Add shares from senior convertible notes | 10,864 | — | 13,248 |
| Add “in-the-money” stock options | 1,397 | — | 1,073 |
| Common stock assuming conversion and stock option exercises | 90,081 | 77,423 | 85,712 |
| Diluted net income (loss) per share | \$ 1.47 | \$ (0.14) | \$ 0.84 |

The following common shares that are associated with stock options were excluded from the calculations as their effect would be anti-dilutive:

| (in thousands) | For the years ended December 31, | | |
|--|----------------------------------|--------|-------|
| | 2010 | 2009 | 2008 |
| “Out-of-the-money” stock options | 5,447 | 5,034 | 4,447 |
| Shares from senior convertible notes | — | 11,406 | — |
| “In-the-money” stock options | — | 849 | — |

Note 15. Fair Value Measurement

Valuation Hierarchy—GAAP establishes a valuation hierarchy for disclosure of the inputs to valuation used to measure fair value. This hierarchy prioritizes the inputs into three broad levels as follows. Level 1 inputs are quoted prices (unadjusted) in active markets for identical assets or liabilities. Level 2 inputs are quoted prices for similar assets and liabilities in active markets or inputs that are observable for the asset or liability, either directly or indirectly through market corroboration, for substantially the full term of the financial instrument. Level 3 inputs are unobservable inputs based on our own assumptions used to measure assets and liabilities at fair value. A financial asset or liability’s classification within the hierarchy is determined based on the lowest level input that is significant to the fair value measurement.

ViroPharma Incorporated

Notes to the Consolidated Financial Statements (continued)

The following table provides the assets and liabilities carried at fair value measured on a recurring basis as of December 31, 2010:

| (in thousands of dollars) | Total Carrying Value at December 31, 2010 | Fair Value Measurements at December 31, 2010 Using | | |
|-------------------------------------|--|---|-----------|-----------|
| | | (Level 1) | (Level 2) | (Level 3) |
| Cash and cash equivalents | \$426,732 | \$426,732 | \$— | \$ — |
| Short-term investments | \$ 78,439 | \$ 78,439 | \$— | \$ — |
| Contingent consideration | \$ 10,973 | \$ — | \$— | \$10,973 |

Valuation Techniques—Cash and cash equivalents and short-term investments are measured at fair value using quoted market prices and are classified within Level 1 of the valuation hierarchy. There were no changes in valuation techniques during the year ended December 31, 2010.

The fair value of the contingent consideration is measured using significant inputs not observable in the market, which are referred to in the guidance as Level 3 inputs. This fair value is estimated by applying a discount rate based on an implied rate of return from the acquisition to the risk probability weighted asset cash flows and the expected approval date to the probability adjusted payment amount. There were no changes in the valuation technique from the acquisition date. The contractual amount of contingent consideration related to the Auralis acquisition is £10.0 million (or approximately \$15.5 million based on exchange rates at December 2010), see Note 10 Acquisitions. The fair value of the contingent consideration at acquisition was approximately £6.2 million or approximately \$9.0 million. At December 31, 2010 the fair value of the contingent consideration is approximately £7.1 million or approximately \$11.0 million. Of the total change in the carry amount approximately \$1.4 million is attributable to the change in the fair value, reflected in Other operating expenses in the Consolidated Statement of Operations, with the balance attributable to the change in the GBP/\$US exchange rate during the period.

We believe that the fair values of our current assets and current liabilities approximate their reported carrying amounts.

Note 16. 401(k) Employee Savings Plan

The Company's 401(k) Employee Savings Plan (the "401(k) Plan") is available to all employees meeting certain eligibility criteria. The 401(k) Plan permits participants to contribute up to 92% of their compensation not to exceed the limits established by the Internal Revenue Code. Participants are always fully vested in their contributions. The Company matches of 25% on the first 6% of participating employee contributions. The Company contributed approximately \$534,000, \$413,000 and \$214,000 to the 401(k) Plan in each of the years ended December 31, 2010, 2009 and 2008, respectively. The Company's contributions are made in cash. The Company's common stock is not an investment option available to participants in the 401(k) Plan.

Note 17. Commitments and Contingencies

We have committed to purchase up to 290,000 liters of plasma in 2011 and up to 210,000 liters of plasma per year in 2012 through 2015 from our suppliers. Additionally, we are required to purchase a minimum number of units from our third party toll manufacturer.

In March 2008, we entered into a lease, comprising 78,264 square feet of office and related space, for the Company's new headquarters located in Exton, Pennsylvania. The lease expires seven years and six months from

ViroPharma Incorporated
Notes to the Consolidated Financial Statements (continued)

the point in which we began to occupy the space, which was in the fourth quarter of 2008. In connection with the new lease, we also received a leasehold improvement allowance of \$2.3 million.

Our future minimum lease payments under our operating leases related to buildings and equipment for periods subsequent to December 31, 2010 are as follows (in thousands):

| <u>Year ending December 31,</u> | <u>Commitments</u> |
|---------------------------------|--------------------|
| 2011 | 1,846 |
| 2012 | 1,880 |
| 2013 | 1,884 |
| 2014 | 1,892 |
| 2015 | 1,922 |
| Thereafter | <u>1,549</u> |
| Total minimum payments | <u>\$10,973</u> |

We have severance agreements for certain employees and change of control agreements for executive officers and certain other employees. Under its severance agreements, certain employees may be provided separation benefits from us if they are involuntarily separated from employment. Under our change of control agreements, certain employees are provided separation benefits if they are either terminated or resign for good reason from ViroPharma within 12 months from a change of control.

In addition to the merger consideration paid at closing as described in Note 10, Lev shareholders received the non-transferrable contractual right to two contingent payments (“CVR Payments”) of \$0.50 each that could deliver up to an additional \$174.6 million, or \$1.00 per share in cash, if Cinryze meets certain targets. The target for the first CVR payment of \$0.50 per share (or \$87.5 million) will not be paid as a third party’s human C1 inhibitor product was approved for the acute treatment of HAE and granted orphan exclusivity. The second CVR payment of \$0.50 per share (\$87.5 million) becomes payable if Cinryze reaches at least \$600 million in cumulative net product sales by October 2018.

Also, in connection with the Auralis acquisition, we have also agreed to pay an additional payment of £10 million Pounds Sterling (approximately \$15.5 million based on the December 31, 2010 exchange rate) upon the first regulatory approval of a product in late stage development. See Note 10.

Note 18. Collaborations

In January 2010, we entered into a collaboration agreement with Sanquin to establish a Joint Steering Committee. The Joint Steering Committee shall serve as a forum to establish and discuss progress under, among others, (i) a Global Commercialization Plan; (ii) clinical development programs of ViroPharma and the Sanquin Early Stage Research Programs; (iii) manufacturing Capacity Schedules; (iv) pharmacovigilance matters; (v) quality matters; (vi) manufacturing improvement programs; and (vii) regulatory matters.

Sanquin may conduct certain early stage research programs and we will provide to Sanquin €1,000,000 (approximately \$1.3 million based on December 31, 2010 exchange rate) per year for a period of five years to support such Early Stage Research Programs. We have a right of first refusal to further develop and commercialize the subject matter of each such Early Stage Research Program worldwide (except for the Excluded Territory) subject to Sanquin’s and its research partners’ right to use any such intellectual property for their internal, non-commercial research purposes. Except for the Early Stage Research Programs, we will be solely responsible for conducting all clinical trials and other development activities necessary to support our

ViroPharma Incorporated

Notes to the Consolidated Financial Statements (continued)

efforts to obtain regulatory approval of Cinryze in additional territories as well as any future C1-INH derived products developed pursuant to the Rest of World Agreement. Sanquin has the right to approve any such clinical trials and development activities through the Joint Steering Committee.

Note 19. Supplemental Cash Flow Information

| (in thousands) | For the years ended December 31, | |
|--|-------------------------------------|----------|
| | 2010 | 2009 |
| Supplemental disclosure of non-cash transactions: | | |
| Employee share-based compensation | \$11,172 | \$11,828 |
| Liability classified share-based compensation benefit | 4 | (11) |
| Non-cash increase in contingent consideration | 10,390 | — |
| Debt buy back deferred tax impact | — | 308 |
| Supplemental disclosure of cash flow information: | | |
| Cash paid for income taxes | \$52,484 | \$10,466 |
| Cash paid for interest | 4,100 | 4,550 |
| Cash received for stock option exercises | 3,342 | 22 |
| Cash received for employee stock purchase plan | 377 | 356 |

Note 20. Quarterly Financial Information (unaudited)

This table summarizes the unaudited consolidated financial results of operations for the quarters ended (amounts in thousands except per share data):

| | March 31, | June 30, | September 30, | December 31, |
|---|-----------|-----------|---------------|--------------|
| 2010 Quarter Ended | | | | |
| Net product sales | \$ 90,647 | \$108,961 | \$117,781 | \$121,623 |
| Cost of sales (excluding amortization of product rights) | 13,958 | 13,641 | 15,755 | 17,934 |
| Operating expenses | 38,235 | 42,263 | 42,790 | 42,736 |
| Other (expense) income | (3,329) | (6,096) | 2,336 | (3,725) |
| Income tax expense | 13,843 | 18,440 | 23,233 | 19,762 |
| Net income | 21,282 | 28,521 | 38,339 | 37,466 |
| Basic net income per share(1) | \$ 0.27 | \$ 0.37 | \$ 0.49 | \$ 0.48 |
| Diluted net income per share(1) | \$ 0.26 | \$ 0.34 | \$ 0.45 | \$ 0.43 |
| 2009 Quarter Ended | | | | |
| Net product sales | \$ 60,190 | \$ 81,873 | \$ 80,551 | \$ 87,835 |
| Cost of sales (excluding amortization of product rights) | 3,929 | 14,121 | 10,216 | 11,948 |
| Operating expenses | 51,319 | 43,503 | 37,910 | 36,850 |
| Goodwill Impairment | 65,099 | — | — | 3,424 |
| Other income (expense) | 5,914 | (2,572) | (2,752) | (2,768) |
| Income tax expense | 4,972 | 5,625 | 9,601 | 20,831 |
| Net (loss) income | (59,215) | 16,052 | 20,072 | 12,014 |
| Basic net (loss) income per share(1) | \$ (0.77) | \$ 0.21 | \$ 0.26 | \$ 0.16 |
| Diluted net (loss) income per share(1) | \$ (0.77) | \$ 0.20 | \$ 0.24 | \$ 0.15 |

- (1) Net income per share amounts will not agree to the per share amounts for the full year due to the use of weighted average shares for each period.

SUBSIDIARIES OF THE COMPANY

| <u>Entity</u> | <u>Name of State/Country of Incorporation</u> |
|----------------------------|---|
| ViroPharma Biologics, Inc. | Delaware |
| VCO Incorporated | Delaware |
| VPDE Incorporated | Delaware |
| VPINT, Inc. | Delaware |
| ViroPharma Limited | United Kingdom |
| ViroPharma SPRL | Belgium |
| ViroPharma SAS | France |
| | |
| ViroPharma GmbH | Germany |
| ViroPharma LLC | Switzerland |
| Auralis Limited | United Kingdom |

Consent of Independent Registered Public Accounting Firm

The Board of Directors
ViroPharma Incorporated:

We consent to the incorporation by reference in the registration statements on Form S-8 (No. 333-168420, No. 333-160910, No. 333-152724, No. 333-136447, No. 333-34129, No. 333-38248, No. 333-60951, No. 333-38256, No. 333-109600 and No. 333-127188) registration statements on Form S-3 (No. 333-156422, No. 333-37960, No. 333-64482, No. 333-99533, No. 333-122315, No. 333-123994, and No. 333-141411) and registration statement on Form S-4 (No. 333-153088) of ViroPharma Incorporated of our reports dated February 24, 2011, with respect to the consolidated balance sheets of ViroPharma Incorporated as of December 31, 2010 and 2009, and the related consolidated statements of operations, comprehensive income (loss), stockholders' equity and cash flows for each of the years in the three-year period ended December 31, 2010 and the effectiveness of internal control over financial reporting as of December 31, 2010, which reports appear in the December 31, 2010 Annual Report on Form 10-K of ViroPharma Incorporated.

Our report on the consolidated financial statements refers to the Company's retrospective change in accounting for convertible debt instruments that may be settled in cash upon conversion due to the adoption of a new accounting standard issued by the FASB, as of January 1, 2009.

/s/ KPMG LLP

Short Hills, NJ
February 24, 2011

**CHIEF EXECUTIVE OFFICER'S
CERTIFICATION UNDER
SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002**

I, Vincent J. Milano, President and Chief Executive Officer of the registrant, certify that:

1. I have reviewed this Annual Report on Form 10-K of ViroPharma Incorporated;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
 - a. Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
 - b. Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
 - c. Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
 - d. Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors:
 - a. All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
 - b. Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/s/ Vincent J. Milano

Vincent J. Milano
President and Chief Executive Officer

February 24, 2011

**CHIEF FINANCIAL OFFICER'S
CERTIFICATION UNDER
SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002**

I, Charles A. Rowland, Jr., Chief Financial Officer of the registrant, certify that:

1. I have reviewed this Annual Report on Form 10-K of ViroPharma Incorporated;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
 - a. Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
 - b. Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
 - c. Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
 - d. Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors:
 - a. All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
 - b. Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/s/ Charles A. Rowland, Jr.

Charles A. Rowland, Jr.
Chief Financial Officer

February 24, 2011

**CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002**

In connection with the Annual Report of ViroPharma Incorporated (the "Company") on Form 10-K for the period ending December 31, 2010 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), each of the undersigned officers of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

- (1) The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and
- (2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ Vincent J. Milano

Vincent J. Milano
President and Chief Executive Officer
February 24, 2011

/s/ Charles A. Rowland, Jr.

Charles A. Rowland, Jr.
Chief Financial Officer
February 24, 2011

* A signed original of this written statement required by Section 906 has been provided to the Company and will be retained by the Company and furnished to the Securities and Exchange Commission or its staff upon request.

Stockholders' Information

Corporate Headquarters

730 Stockton Drive • Exton, PA 19341
Phone: (610) 458-7300 • Fax: (610) 458-7380
www.viopharma.com

Corporate Communications

William Roberts, Vice President
Corporate Communications
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will.roberts@viopharma.com

Investor Relations

Robert Doody, Assistant Director
Investor Relations
Phone: (610) 321-6290
robert.doody@viopharma.com

Public Relations

Kristina Broadbelt, Associate Director
Public Relations and Advocacy
Phone: (610) 321-2358
kristina.broadbelt@viopharma.com

Business Development

R. Clayton Fletcher, Vice President
Business Development
Phone: (610) 321-6789
clayton.fletcher@viopharma.com

Independent Auditors

KPMG LLP
150 John F. Kennedy Parkway • Short Hills, NJ 07078

Annual Shareholders' Meeting

The shareholders' meeting will be held on Monday, May 23, 2011 at 10:00 a.m. at The Desmond Hotel and Conference Center, One Liberty Boulevard, Malvern, PA 19355.

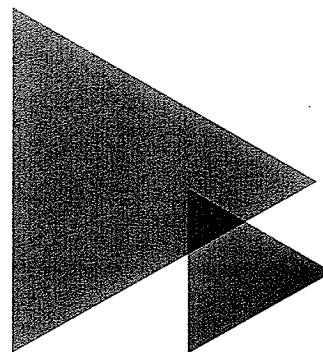
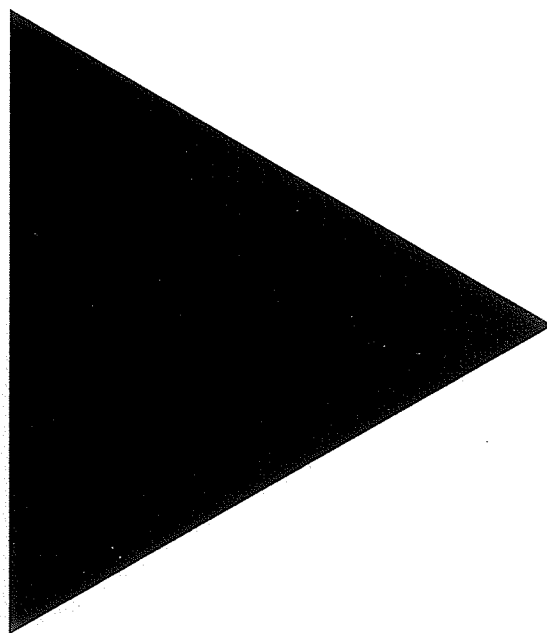
Securities Information

NASDAQ Global Select Market
Symbol: VPHM

Transfer Agent

For shareholder questions regarding lost certificates, address changes, and change of ownership or name in which the shares are held, please direct inquiries to:

StockTrans[®], a Broadridge Company
44 West Lancaster Avenue • Ardmore, PA 19003
Phone: (610) 649-7300
www.stocktrans.com





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