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

FORM 8-K

CURRENT REPORT
Pursuant to Section 13 or 15(d)
of the Securities Exchange Act of 1934

Date of Report (Date of earliest event reported): February 9, 2015

ARDELYX, INC.
(Exact name of registrant as specified in its charter)

Delaware	**001-36485**	**26-1303944**
(State or other jurisdiction of incorporation)	**(Commission File Number)**	**(IRS Employer Identification Number)**

34175 Ardenwood Blvd.
Fremont, CA 94555
(Address of principal executive offices, including Zip Code)

Registrant's telephone number, including area code: (510) 745-1700

Check the appropriate box below if the Form 8-K filing is intended to simultaneously satisfy the filing obligation of the registrant under any of the following provisions:

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

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

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

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

Item 7.01 Regulation FD Disclosure.

Attached hereto as Exhibit 99.1 is a corporate presentation of Ardelyx, Inc. (the "Company") incorporated by reference herein.

The information furnished under this Item 7.01 shall not be considered "filed" under the Securities Exchange Act of 1934, as amended, nor shall it be incorporated into any future filing under the Securities Act of 1933, as amended, or under the Securities Exchange Act of 1934, as amended, unless the Company expressly sets forth in such future filing that such information is to be considered "filed" or incorporated by reference therein.

Item 9.01 Financial Statements and Exhibits.

(d) Exhibits.

Exhibit No.	Description
99.1	Corporate presentation of Ardelyx, Inc.

SIGNATURES

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

Date: February 9, 2015

ARDELYX, INC.

By: /s/ Mark Kaufmann
Mark Kaufmann
Chief Financial Officer

EXHIBIT INDEX

Exhibit No.	Description
99.1	Corporate presentation of Ardelyx, Inc.

Exhibit 99.1


ARDELYX®
Investor Presentation
Mike Raab
CEO
FEBRUARY
2015

Forward Looking Statements and Further Information

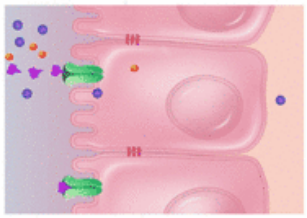
Special Note Regarding Forward-Looking Statements

To the extent that statements contained in this presentation are not descriptions of historical facts regarding Ardelyx, they are forward-looking statements reflecting the current beliefs and expectations of management made pursuant to the safe harbor of the Private Securities Reform Act of 1995, including statements regarding the potential of tenapanor in treating the renal indications for which it is currently being evaluated, the potential for tenapanor in treating IBS-C patients, the availability and timing of data from ongoing tenapanor clinical trials, potential milestone payments from our collaboration partners, and the potential of our drug discovery and design platform. Such forward-looking statements involve substantial risks and uncertainties that could cause the development of tenapanor, or Ardelyx's future results, performance or achievements to differ significantly from those expressed or implied by the forward-looking statements. Such risks and uncertainties include, among others, the uncertainties inherent in the clinical development process, Ardelyx's reliance upon AstraZeneca for the development of tenapanor, and AstraZeneca's right under the license agreement to choose which indication or indications for which tenapanor will be developed, Ardelyx's reliance upon Sanofi for the discovery and development under the licensed NaP2b inhibitor program, and the uncertainties inherent in the research and discovery process. Ardelyx undertakes no obligation to update or revise any forward-looking statements. For a further description of the risks and uncertainties that could cause actual results to differ from those expressed in these forward-looking statements, as well as risks relating to Ardelyx's business in general, please refer to Ardelyx's third quarter report filed with the Securities and Exchange Commission on November 7, 2014.

The Power of Ardelyx

Clinical-Stage Biopharmaceutical Company

Oral, Small Molecule,
Non-Systemic, First-in-Class Drugs



Rapid, Efficient Drug Discovery
& Design Platform Provides
Broad Drug Candidates

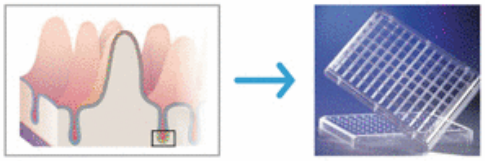


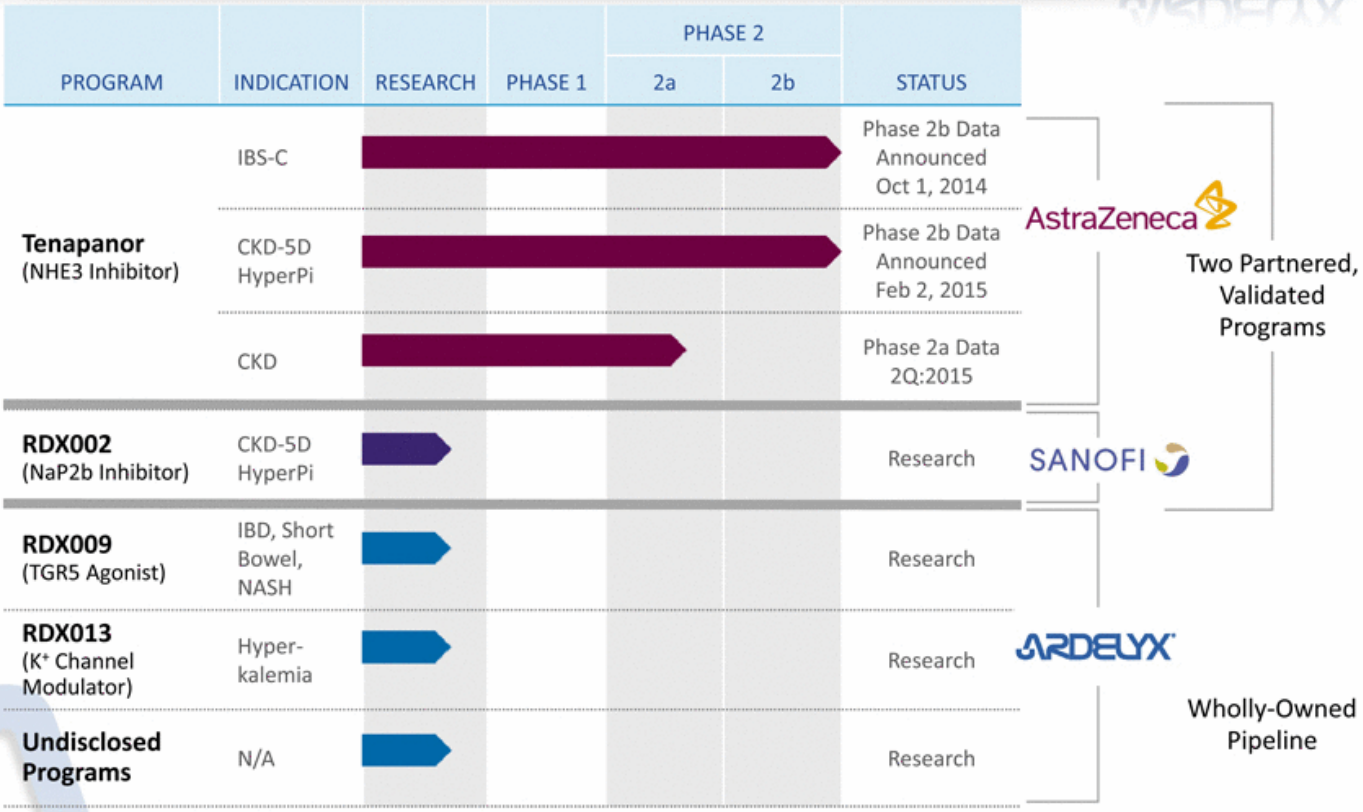
Fig 1

History of Capital Efficiency

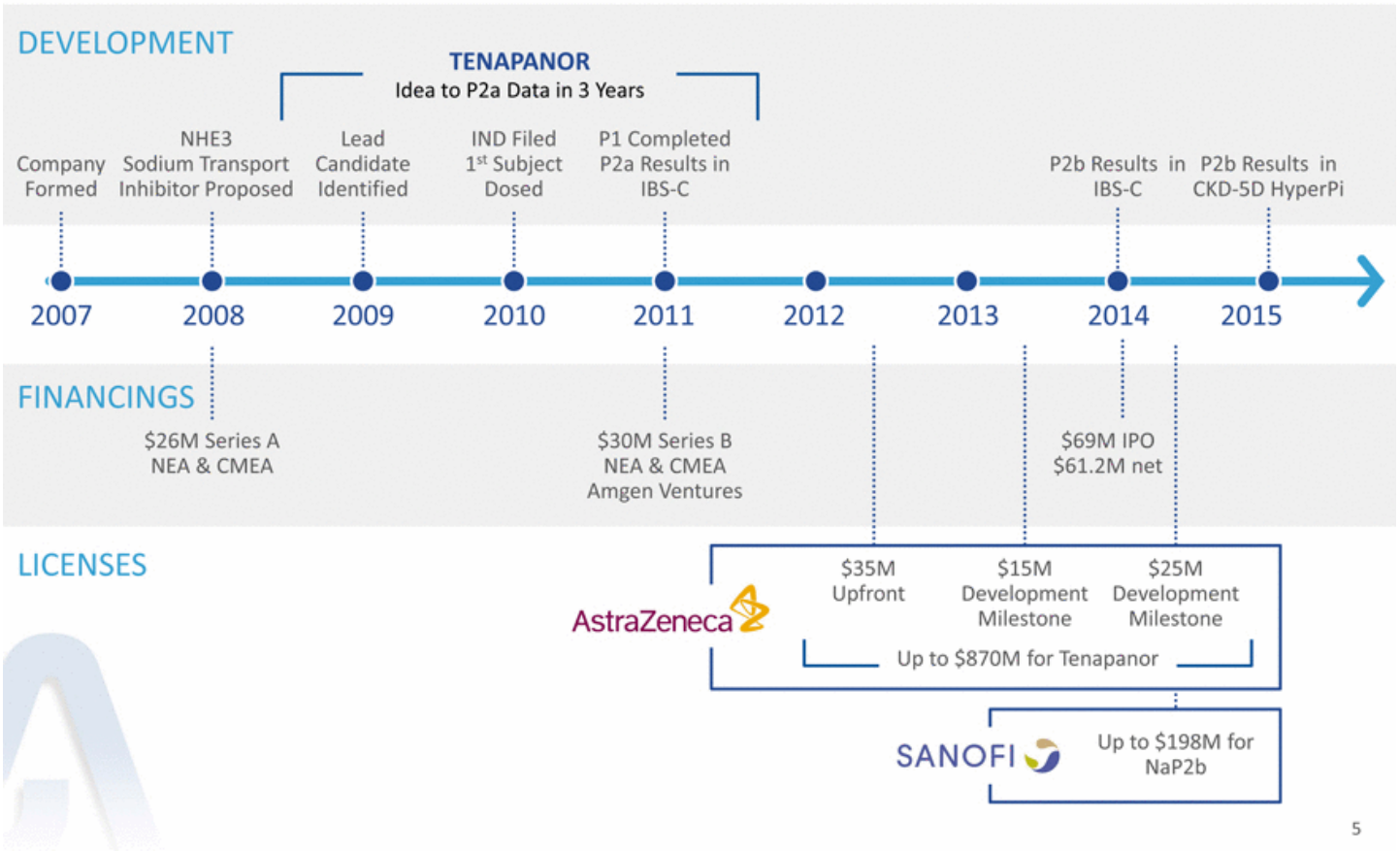
Balanced Portfolio of Early to Mid-
Stage Candidates Across Partnered &
Proprietary Programs

Figure 1 from Sato T and Clevers H., "Growing self-organizing mini-guts from a single intestinal stem cell: mechanism and applications." Science. 2013 Jun 7;340(6137):1190-4

The Result: Robust Product Pipeline



A History of Rapid, Capital Efficient Development



Proven Management Team

MIKE RAAB	President & Chief Executive Officer	NEA, genzyme, Bristol-Myers Squibb
JEREMY CALDWELL, PhD	EVP & Chief Scientific Officer	Third Rock, Merck Research Laboratories, Genomics Institute of the Novartis Research Foundation
MARK KAUFMANN	Chief Financial Officer	MedImmune, CELMED, nexia
DAVID ROSENBAUM, PhD	SVP Drug Development	GelTex, Trine, Arthur D Little
ELIZABETH GRAMMER	VP and General Counsel	genzyme, GelTex, Edwards Angell Palmer & Dodge
JEFF JACOBS, PhD	VP Chemistry	sunesis, GlaxoSmithKline, AFFYMAX
NARANI ARASARATNAM	VP Corporate Controller	Connor Group, EY, Arthur Andersen
GEORGE JUE	VP Operations	Hyperion, PDL BioPharma, Genentech
ROB BLANKS	VP Regulatory Affairs and QA	Idenix, GelTex, RepliGen Corporation
ANDY SPENCER, PhD	VP R&D Alliance Management	Alvine Pharmaceuticals, PDL BioPharma, Mirus

Investment Highlights

ARDELYX

PROPRIETARY PLATFORM	Discovery and Design of Non-Systemic, Small Molecule Therapeutics
2 VALIDATED PROGRAMS	Tenapanor: AstraZeneca Collaboration; Phase 2 in Three Indications NaP2b Inhibition: Sanofi Collaboration
WHOLLY-OWNED PIPELINE	Enhanced Drug Discovery Capabilities with Rapid, Proprietary Screening Process
PROVEN MANAGEMENT TEAM	Deep Domain Expertise

Intestinal Epithelium Is Rich with Potential Targets

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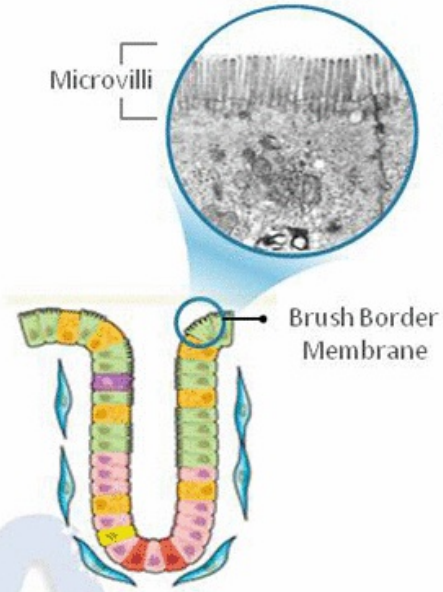
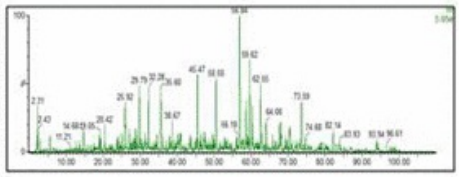
THE INTESTINE

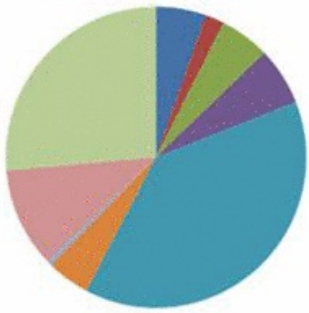


PROTEIN ANALYSIS



MANY POTENTIAL DRUG TARGETS

3,800 Proteins



Enhancing Drug Discovery with APECCS

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Ardelyx Primary Enterocyte and Colonocyte Culture System

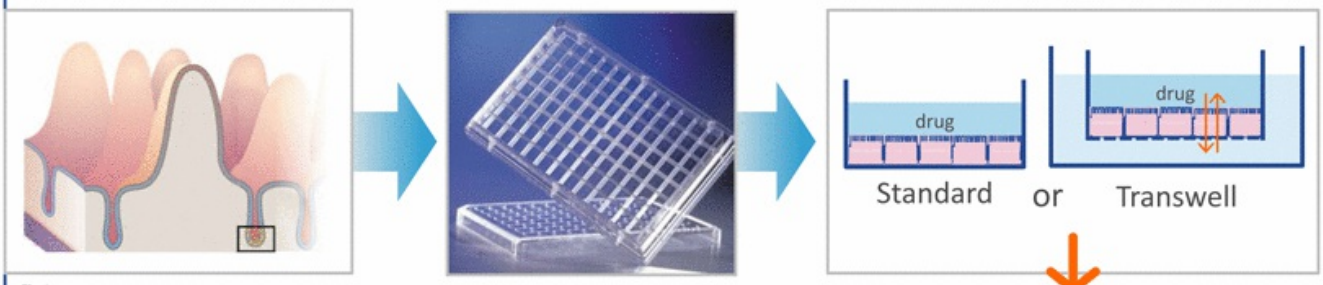

Fig 1

Harvest Stem Cells from Gut

Grow in Monolayer Format

Measure Drug Response

THE BENEFITS

- **Discovery:** Rapid Screening of Drugs
- **Translation to Humans:** Simulate Relevant Gut Cell Physiology
- **Powerful Tool:** Mechanisms, Targets, Phenotypic Screening

Figure 1 from Sato T and Clevers H., "Growing self-organizing mini-guts from a single intestinal stem cell: mechanism and applications." Science. 2013 Jun 7;340(6137):1190-4

Investment Highlights

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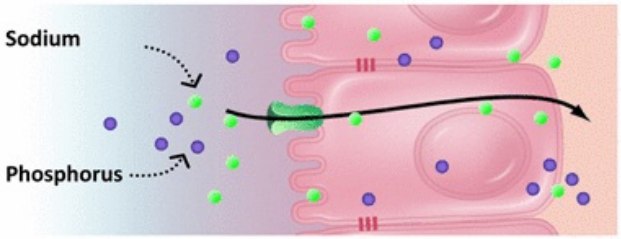
WHOLLY-OWNED PIPELINE	Enhanced Drug Discovery Capabilities with Rapid, Proprietary Screening Process
PROVEN MANAGEMENT TEAM	Deep Domain Expertise

Tenapanor Reduces Sodium and Phosphorus Absorption

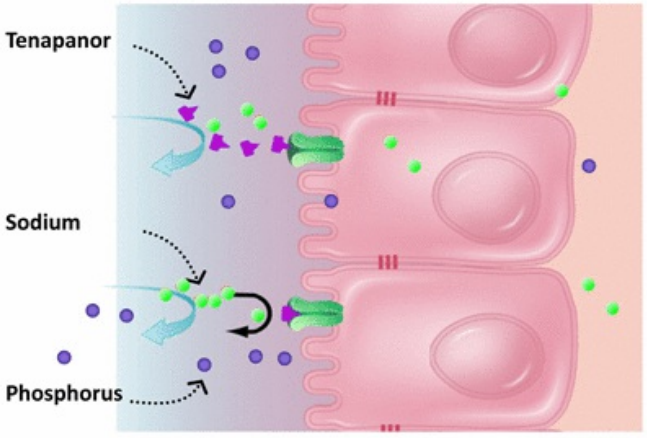
WITHOUT TENAPANOR

Dietary Sodium/Phosphorus Passes Into Circulation



WITH TENAPANOR

Diverts Sodium/Phosphorus from Circulation



Local Activity in the Gut

Significant Market Opportunity for Tenapanor

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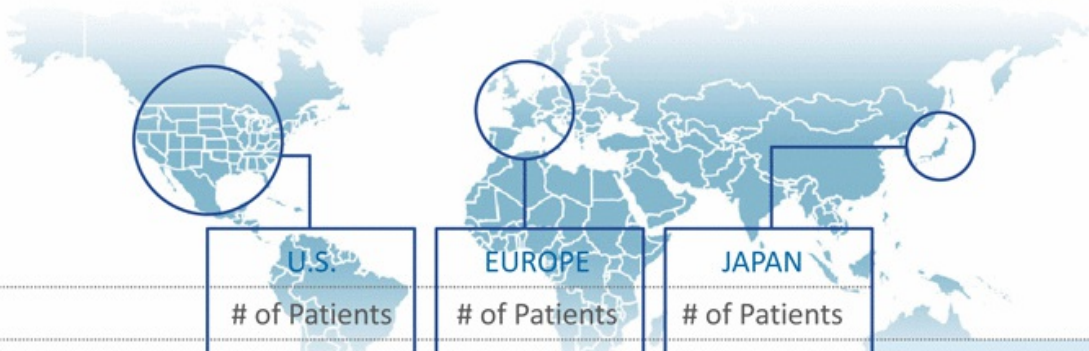

	U.S. # of Patients	EUROPE # of Patients	JAPAN # of Patients	
IBS-C	4.4M	6.6M	3.4M	**14M+**
CKD-5D (ESRD) Hyperphosphatemia	270K	215K	220K	2011 **$1.5B** 2015 **$2.3B** Binder Market Sevelamer: $770M in 2014
Late Stage CKD (3b-4) (with Type 2 Diabetes)	3.6M (1.8M)	8.5M (1.7M)	2.3M (0.6M)	**64M (Type 3-4)**

Sources: Technavio Insights: Global Hyperphosphatemia Drugs Market 2011-2015, USRDS 2013 Atlas of CKD & ESRD, Dialysis Outcomes and Practice Patterns Study (DOPPS), Am J Kidney Dis. 2012 Jul, European ERA-EDTA Registry Annual report 2011, Ther Apher Dial. 2010 Dec, JAMA. 2007 Nov, J Chin Med Assoc. 2010 Oct, BioTrends TreatmentTrends 2013, Patient Prefer Adherence 2008, Clin Gastroenterol Hepatol. 2012, Aliment Pharmacol Ther. 2005, Aliment Pharmacol Ther. 2003; Sanofi press release

Extensive Clinical Experience with Tenapanor in Multiple Indications

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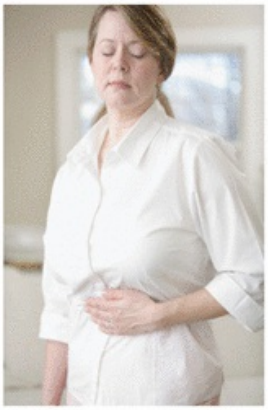
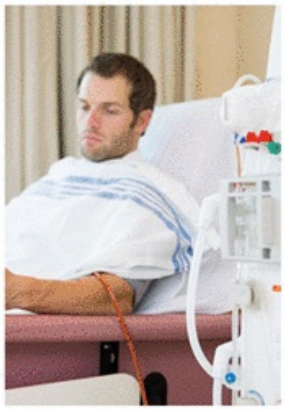
14 Clinical Trials



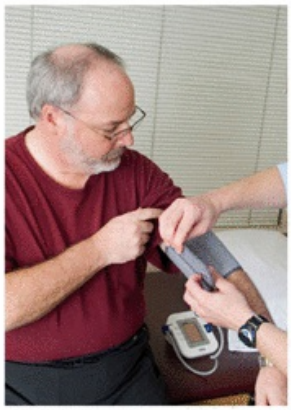
Constipation-Predominant Irritable Bowel (IBS-C) n=417

- *Phase 2b clinical trial met primary endpoint at 50 mg BID*
- *Most secondary endpoints met*
- *Dose response observed*



CKD-5D Hyperphosphatemia n= 178

- *Phase 2b clinical trial met primary endpoint*
- *Decreased serum phosphate levels*
- *Higher rates of diarrhea observed than in previous trials*



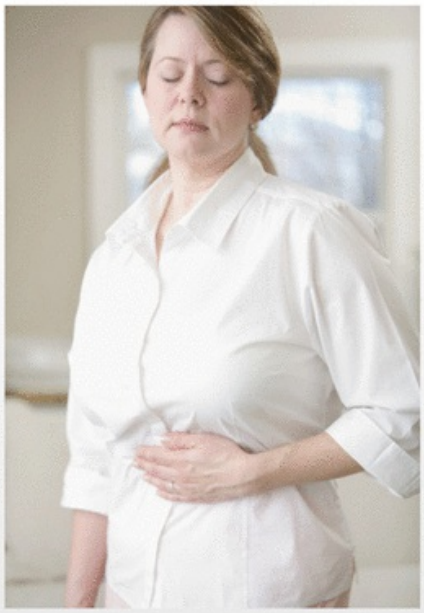
CKD Na & Fluid Overload n=77

- *Data expected 2Q2015, earlier than previously reported (2H2015)*

Tenapanor Generally Well-Tolerated

- >1,000 individuals exposed to drug
- Single Dose Up to 900 mg
- 3 Months Up to 100 mg/Day
- Non-Systemic: >99.3% of All Tested Serum Samples Had No Detectable Levels of Tenapanor (>3,000 samples)
- Most AE's Due to Exaggerated Pharmacology of Drug (e.g. Loose Stools/Diarrhea)

Tenapanor for IBS-C



GI Disorder:
Constipation and
Abdominal Pain

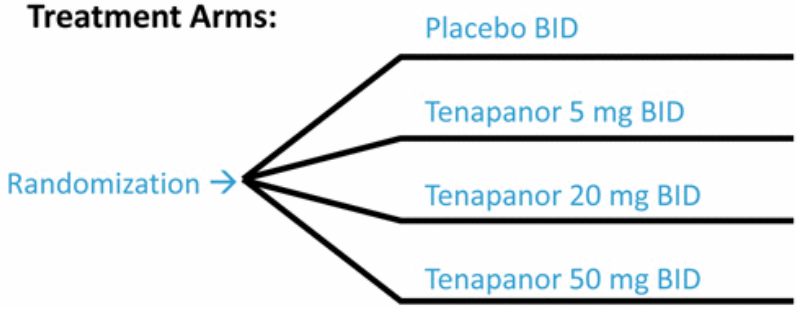
LIMITATIONS OF CURRENT TREATMENTS

- OTC Drugs Inexpensive but Not Very Effective in Moderate to Severe Cases
- Amitiza® and Linzess® Fall Short:
  - Achieve Endpoint in Only 7% to 20% of Patients
  - Side Effects (e.g., Diarrhea)
- Medical Need for Improved Therapies with Better Efficacy, Excellent Safety and Tolerability

Phase 2b Design for Tenapanor in IBS-C

IBS-C Phase 2b Protocol

- **Design:** Double-blind, placebo-controlled, randomized 1:1:1:1 into three treatment arms, 1 placebo arm (approximately 93 patients/group) for a total of 371 patients; 12 weeks treatment, 4 weeks follow-up
- **Primary Endpoint:** Percent complete spontaneous bowel movement (CSBM)* responders (patient needs to have an increase of at least one CSBM from baseline for 6 of the 12 treatment weeks)
- **Secondary Endpoints**: Overall Responder Rate, Abdominal Pain and Abdominal and IBS-C Symptoms
- **Treatment Arms:**



*CSBM defined as a spontaneous bowel movement that feels complete and is not aided by the use of any other medication, like a laxative

Phase 2b IBS-C Results: Responder Rates for 50 mg BID Dose (6 of 12 weeks)

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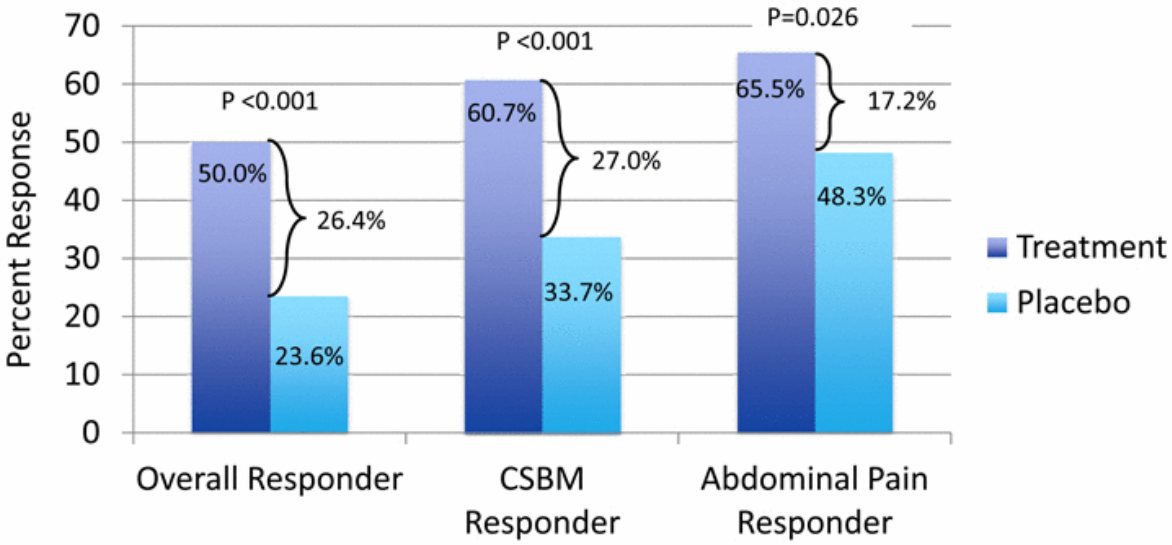
Trial Met Primary Efficacy Endpoint At 50 Mg BID Dose
Complete Spontaneous Bowel Movement (CSBM) Responder



- Overall Responder = dual composite endpoint of CSBM and abdominal pain responders, which is the primary regulatory endpoint in Europe and US (EMA draft guidance 2013, FDA guidance 2012)

Phase 2b IBS-C Results: Responder Rates for 50 mg BID Dose (9 of 12 weeks)

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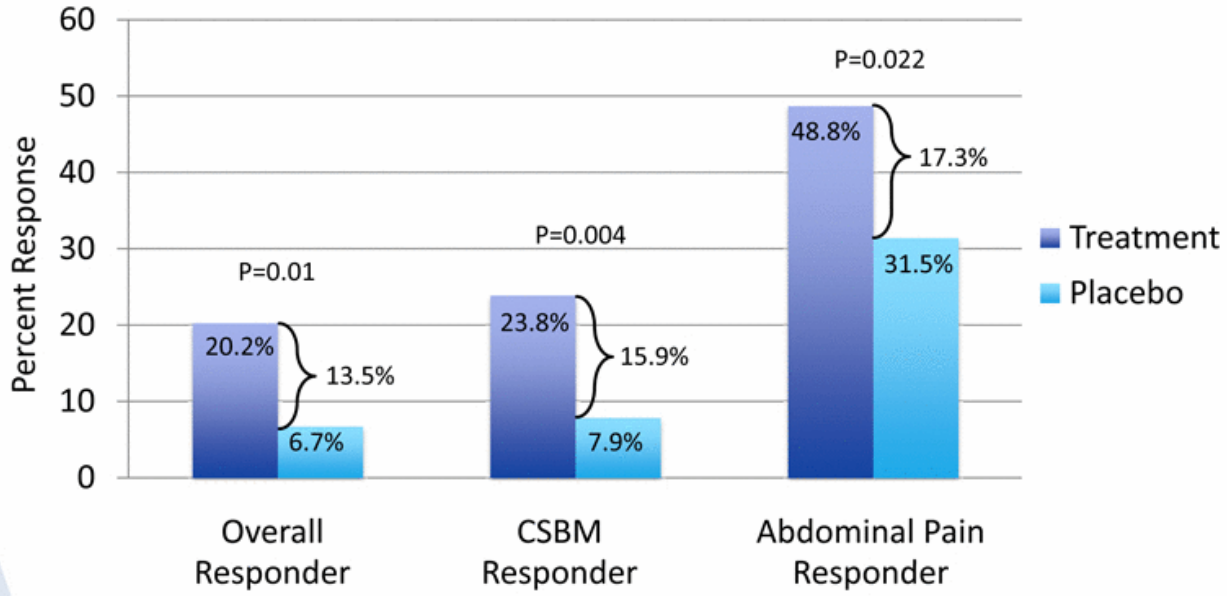
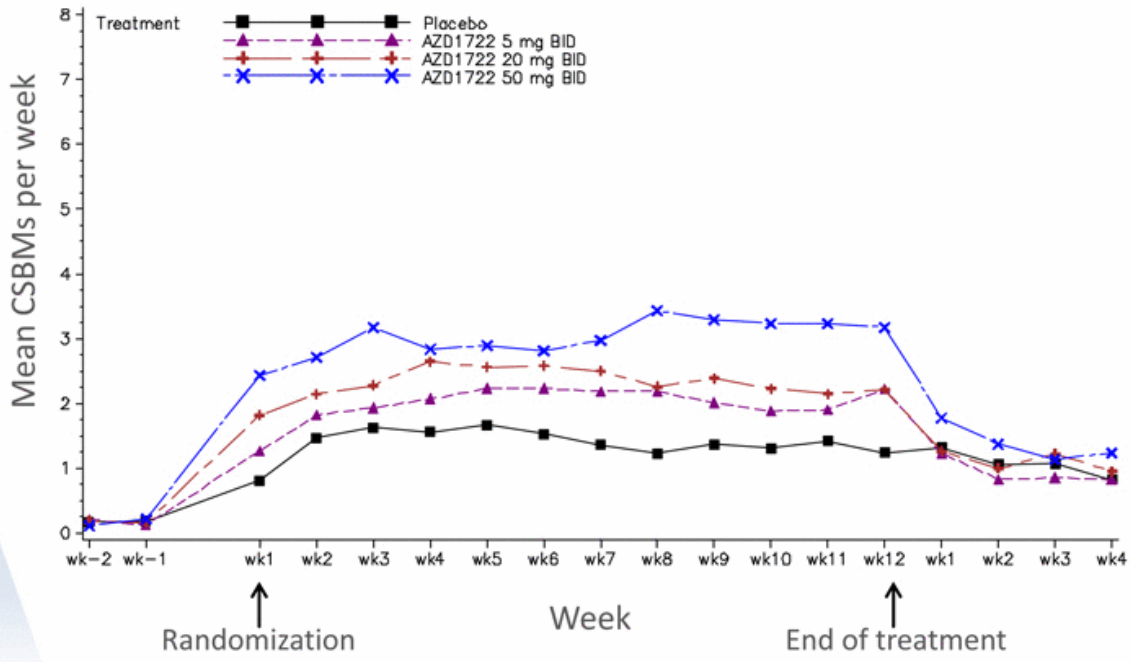
Responder Endpoint Is More Stringent
+≥1 mean CSBM/week from baseline and ≥3 CSBM/week for 9 of 12 weeks



Results: Dose Response Relationship

Dose response relationship was observed in the primary endpoint, as well as in most other secondary endpoints, although statistical significance was not achieved at the 5 mg or 20 mg BID doses; activity of tenapanor was maintained throughout entire 12-week treatment period



Tenapanor in IBS-C Phase 2b Results: Efficacy

- Adequate relief of IBS symptoms was statistically significant (p=0.002) for tenapanor 50 mg BID (63.1%) versus placebo (39.3%) at the endpoint week (week 12 or last valid week)
- Based on the treatment satisfaction patient scale questionnaire, more subjects receiving 50 mg BID responded that they were “quite satisfied” or “very satisfied” with tenapanor* versus placebo (65% vs. 38% placebo; p<0.001)

** “Quite” and “very” are 4 and 5 respectively, on a 5-point scale*

Tenapanor in IBS-C Phase 2b: Clean Safety Profile

- Tenapanor well-tolerated across all treatment arms and there were no drug-related serious adverse events.
- The most common adverse events at 50 mg BID (≥5%) that occurred more frequently in tenapanor-treated patients compared to placebo-treated patients were diarrhea 11.2 percent vs. 0 percent and urinary tract infections 5.6 percent vs. 4.4 percent
- Overall rates of discontinuation due to adverse events were 4.5 percent for the tenapanor-treated patients (50 mg BID) and 3.3 percent for the placebo-treated patients.
- Based on the analysis of plasma samples tested as part of the study, the minimally systemic nature of tenapanor was confirmed

Tenapanor for Hyperphosphatemia in CKD-5D

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LIMITATIONS OF PHOSPHATE BINDERS:

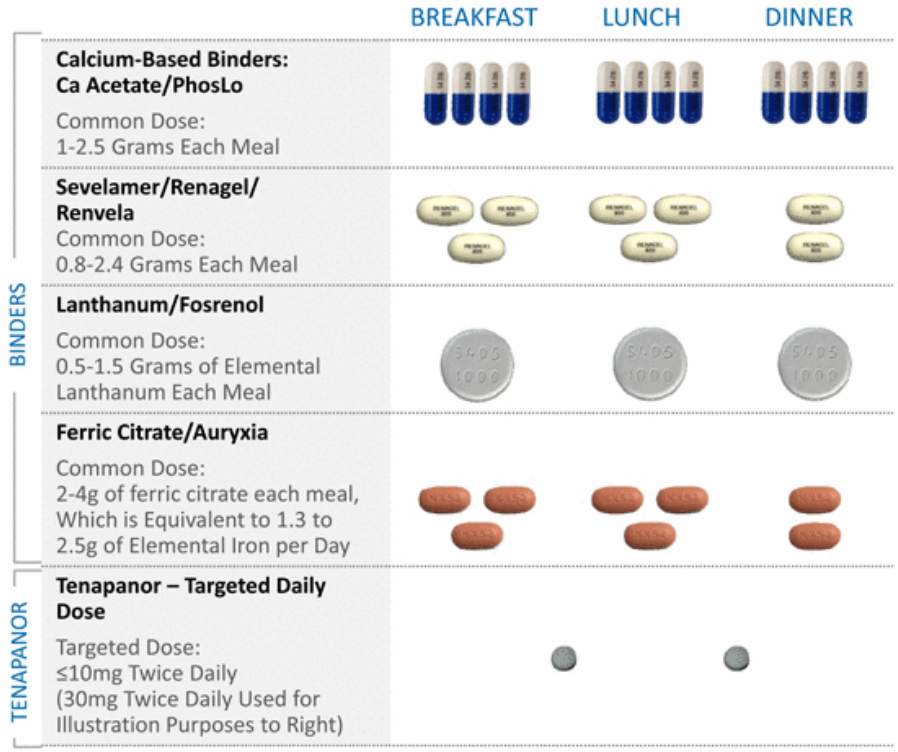
Pill Burden

- CKD-5D Patients Take 10-14 Oral Medications Daily
- Prescribed Binder Doses Intolerable for Many Patients; Water Intake Limited
- Non-Compliance Often Results in Reduced Efficacy

Safety and Tolerability

- Long-Term Vascular Calcification with Calcium-Based Binders
- Gastrointestinal Side Effects

PILL BURDEN: TENAPANOR VS. BINDERS



Not Actual Size; However, Relative Sizes Are to Scale

Phase 2b Design for Tenapanor in CKD-5D Hyperphosphatemia

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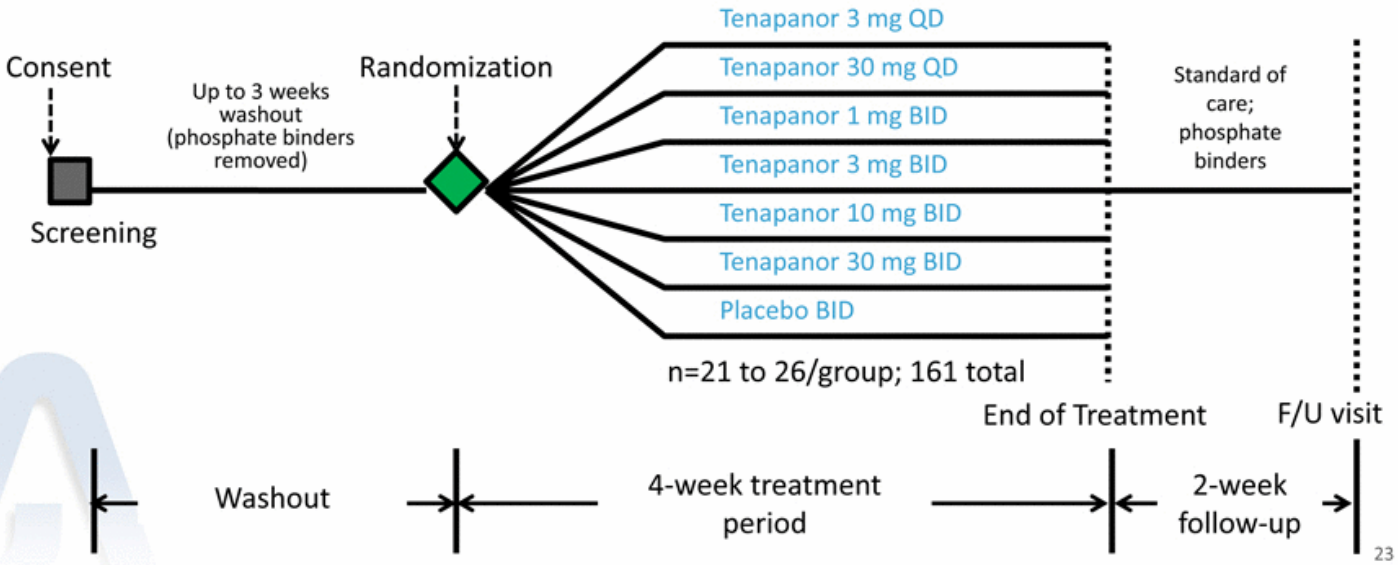
CKD-5D Hyperphosphatemia Phase 2b Protocol

- **Design:** Randomized, double blind, placebo-controlled, multi-center, international study
- **Key Inclusion Criteria**: ≥ 1.5 mg/dL increase in S-phosphate from screening to end of washout and a S-phosphate ≥ 6.0 mg/d at randomization
- **Primary Endpoint:** Change from baseline of S-phosphate levels to end of treatment. Analysed using an ANCOVA with treatment group as a fixed factor, and baseline as a covariate.



CKD-5D Hyperphosphatemia Phase 2b Study: Effects on Serum Phosphate

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Tenapanor Produced A Statistically Significant Dose-related Decrease in Serum Phosphate Levels (P=0.012)

Group	n	LSMean*	95% CI
1 mg BID	23	-0.47	(-1.18, 0.24)
3 mg BID	21	-1.18	(-1.93, -0.44)
10 mg BID	23	-1.70	(-2.41, -0.99)
30 mg BID	24	-1.98	(-2.67, -1.28)
3 mg QD	22	-0.56	(-1.28, 0.17)
30 mg QD	21	-1.11	(-1.85, -0.37)
Placebo	26	-0.54	(-1.21, 0.13)

*LSMean = Least square mean. Change from Baseline at End of Treatment (mg/dL)

Adverse Events: Gastrointestinal Disorders*

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Preferred Term	1 mg BID	3 mg BID	10 mg BID	30 mg BID	3 mg QD	30 mg QD	Placebo
n/group	23	21	23	25	22	21	26
Abdominal Distension		1					
Abdominal Pain				2	1		1
Abdominal Pain Upper			1				
Diarrhea	6	6	11	17	4	11	3
Diverticulum	1						
Dyspepsia		1					
Fecal Incontinence		1	2				2
Feces Soft		1					
GI Hypermotility					1		
GI Sounds Abnormal			1				
Hemorrhoids						1	
Nausea		1	1	1	2	1	1
Rectal Prolapse				1			
Steatorrhea			1				
Vomiting		1			1	2	

*Number of patients who had at least 1 AE in system organ class of gastrointestinal disorders

Adverse Events Leading to Discontinuations

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Discontinuation rate due to diarrhea was higher than expected in 30 mg groups

Adverse Event Term	1 mg BID	3 mg BID	10 mg BID	30 mg BID	3 mg QD	30 mg QD	Placebo
n/group	23	21	23	25	22	21	26
Discontinuations due to AE/group**	3	3	3	9	1	7	2
Abdominal Pain				1			
Diarrhea*	2	3	3	8		6	
Nausea						1	
Vomiting						1	
Serum Calcium Decrease					1		
Hyperphosphatemia	1				1		2
Dizziness						1	
Atherosclerosis		1					

*The term "diarrhea" also includes similar changes in stool form or bowel habits
**There may be multiple reasons for a single discontinuation

Approved Therapies for Hyperphosphatemia in CKD-5D Patients

AE's Due To GI Disorders Are Common In Phosphate Binders

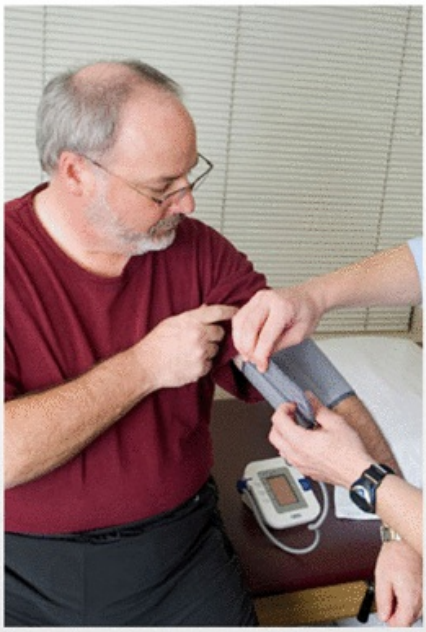
Adverse Events*	Renvela®#	Fosrenol®**	Auryxia®
Abdominal Pain	9%	5%	
Constipation	8%		8%
Diarrhea	19%		21%
Nausea	20%	11%	11%
Vomiting	22%	9%	7%

* Data from package inserts

Label warning: Serious cases of dysphagia, bowel obstruction, and perforation have been associated with sevelamer use, some requiring hospitalization and surgery

**Label warning: Serious cases of GI obstruction, ileus and fecal impaction

Tenapanor for Treating CKD



Sodium and
Fluid Overload

LIMITATIONS OF CURRENT TREATMENTS TO DELAY CKD PROGRESSION

- Poor Compliance with Low Sodium Diets
- Diuretics Lose Efficacy and Cause Electrolyte Disorders
- ACE Inhibitors Reduce Blood Pressure but Hyperkalemia Limits Widespread Use in CKD Patients

CKD Phase 2a Clinical Trial Design

CKD Phase 2a Protocol

- **Design:** Double-Blind, 12 Weeks of Treatment, Targeted n=140 (70 Active/70 Placebo); 154 enrolled
- **Objective:** Safety, Tolerability, and Pharmacodynamics of Tenapanor in CKD Patients with Type 2 Diabetes Mellitus and Albuminuria
- **Primary Endpoint:** Changes in Urine Albumin to Creatinine Ratio (UACR), Baseline to Week 12
- **Other Endpoints**: Pharmacodynamic Effects of Tenapanor on Urinary Na Excretion; Mean Weekly Stool Consistency and Stool Frequency
- **Doses:** 5, 15, 30, or 60 mg Capsules. Starting Dose is 15 mg BID Orally for 12 Weeks
- **Status:** Enrollment Completed, Data Expected Q2 2015

The AstraZeneca/Tenapanor Collaboration

PAYMENTS

Milestones

+

Royalties

- Incremental, Tiered (High Single Digit – High Teen Percentages)
- Co-Funding Option at 1st P3 Trial: Buy Up to 1%, 2% or 3% of Royalties with $20M, $30M or $40M* Respectively

OTHER TERMS

AstraZeneca Responsibilities:

- All R&D and Commercialization Expenses**

Ardelyx Rights:

- Right to Co-Promote in the US

*Exercisable Within 60 Days After Decision to Proceed to P3 Clinical for the First Indication for Tenapanor
**Subject to cap on obligation for IBS-C reimbursement

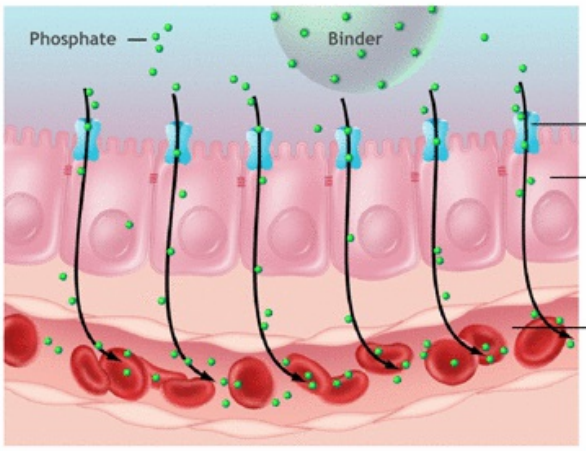
RDX002: NaP2b and Our Collaboration with Sanofi

ARDELYX

PROPRIETARY PLATFORM	Discovery and Design of Non-Systemic, Small Molecule Therapeutics
2 VALIDATED PROGRAMS	Tenapanor: AstraZeneca Collaboration; Phase 2 in Three Indications RDX002 NaP2b Inhibition: Sanofi Collaboration
WHOLLY-OWNED PIPELINE	Enhanced Drug Discovery Capabilities with Rapid, Proprietary Screening Process
PROVEN MANAGEMENT TEAM	Deep Domain Expertise

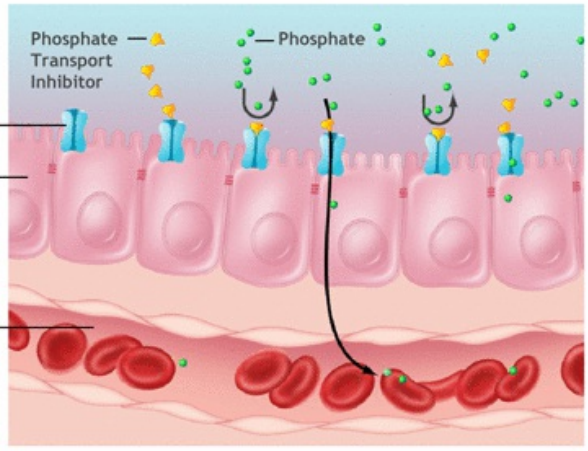
Phosphate Binder vs. Phosphate Transport Inhibitor

Binder



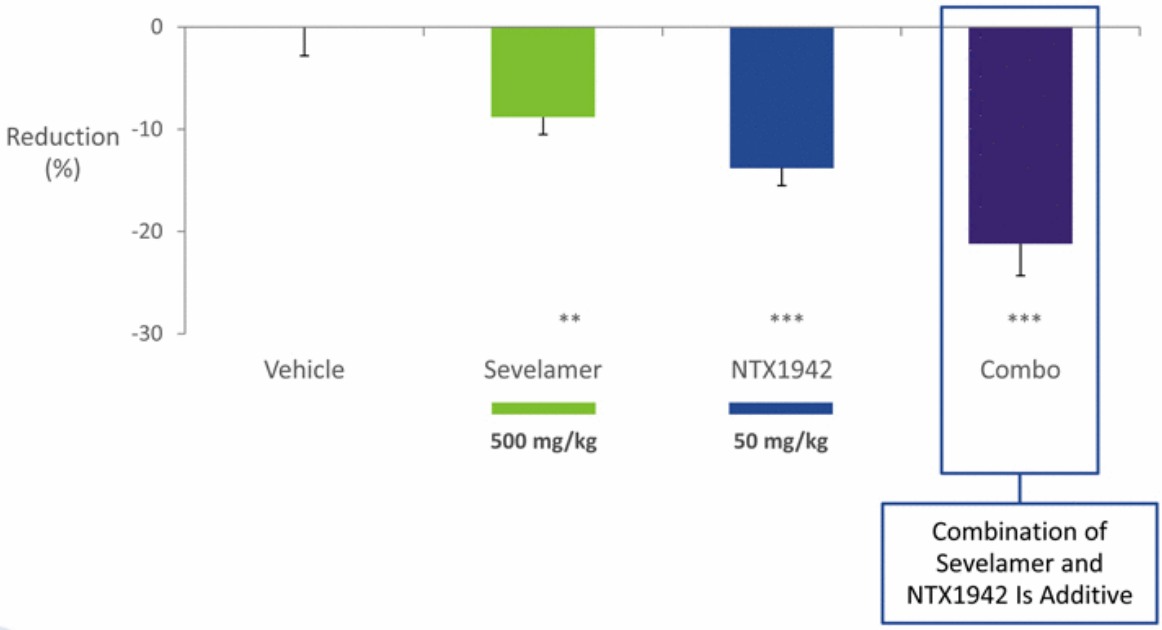
- GI-Upset/Pill-Burden
- Increased Calcium Load with Calcium Based Binders
- Concerns of Metal Accumulation with Metal Based Binders

Phosphate Transport Inhibitor



- Potential for Dramatically Reduced Pill-Burden
- Potential for Use in Combination with Phosphate Binders

RDX002: NTX1942 Reduces Urine Phosphorus Levels in Normal Rats and Is Additive to Sevelamer



NTX1942 Response Is Superior to Sevelamer at ≈ 1/10 of the Dose

Data Shown is the Mean ± SEM; ** = p<0.01; *** =p<0.001, by one-way ANOVA, n= 12

The Sanofi/NaP2b Collaboration

PAYMENTS

Milestones

+

Royalties

- Incremental, Tiered (Mid-Single Digit – Low Teen Percentages)

Licensed Technology

- NaP2b Patent Portfolio and Related Know-how for Research to Complete Activities under Preclinical Development Plan
- Option to Obtain Exclusive License to Develop, Manufacture and Commercialize NaP2b Inhibitors

Other Terms

- Sanofi Responsible for Completing Pre-Clinical Development Plan, and if It Exercises the Option, for All Development and Commercialization at Its Expense
- Ardelyx Has the Right to Co-Promote in the US

Investment Highlights

ARDELYX

PROPRIETARY PLATFORM	Discovery and Design of Non-Systemic, Small Molecule Therapeutics
2 VALIDATED PROGRAMS	Tenapanor: AstraZeneca Collaboration; Phase 2 in Three Indications NaP2b Inhibition: Sanofi Collaboration
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RDX009: TGR5 Agonists for Inflammatory Bowel Disease (IBD), Short Bowel or NASH

TGR5 STIMULATION

- Enhances GLP1 and GLP2 (Incretins) Secretion Directly to the GI Mucosa
- Anti-Inflammation and Mucosal Healing Effects
- Gattex® = GLP2 approved for Short Bowel Syndrome – Studied in Crohn's
  - Daily Injections
- Intercept and Exelixis/BMS Both Have Systemic TGR5 Agonists
  - Gallbladder Emptying Issues
  - Short Lasting Incretin Secretion

ARDELYX TGR5 AGONISTS + DPP4 INHIBITOR

- No Gallbladder Issues
- Long Lasting Incretin Secretion
- Significantly Improves Mucosal Damage In Mouse Model of IBD

RDX013: Hyperkalemia (Elevated Serum Potassium)

THE CHALLENGE

- All Potassium Binders (e.g. Patiromer) Have Limited Efficacy on per Gram Basis
- Therapeutic Dose for Kayexelate, Patiromer or ZS-9 Substantially the Same (15-30 g/day)
- The Limiting Factor in Efficacy is Not Binder Capacity but Availability of Potassium in the Colon

ARDELYX POTASSIUM "SECRETAGOGUE"

- To Move Potassium into Colon and Increase Fecal Excretion
- Used as a Stand Alone or in Combination with Potassium Binder
- Augment Patient Compliance
- Maintain Normal Serum Potassium with Optimal Dosing of Antihypertensives (RAAS Blockade Drugs)

Financial Overview

$ MILLIONS	
Cash and Cash Equivalents	$112.0M (as of 9/30/14)
Annualized Operating Expenses*	$16.2M (Based on 9 Months Ended 9/30/14)
Debt	$0

Capital Raised

Series A $26M

NEA. CMEA CAPITAL

2008

Series B $30M

NEA. CMEA CAPITAL

AMGEN Ventures

2011

IPO $69M

Nasdaq: ARDX

2014

* From Ardelyx's third quarter 10Q: $22,915 total operating expenses for the 9 months ended September 30, 2014 (p3), less $10,744 (p15 "AstraZeneca collaboration development expense" for the 9 months ended September 30, 2014) = $12,171 * 12 month/9 months = $16.2M

Investment Highlights

ARDELYX

PROPRIETARY PLATFORM	Discovery and Design of Non-Systemic, Small Molecule Therapeutics
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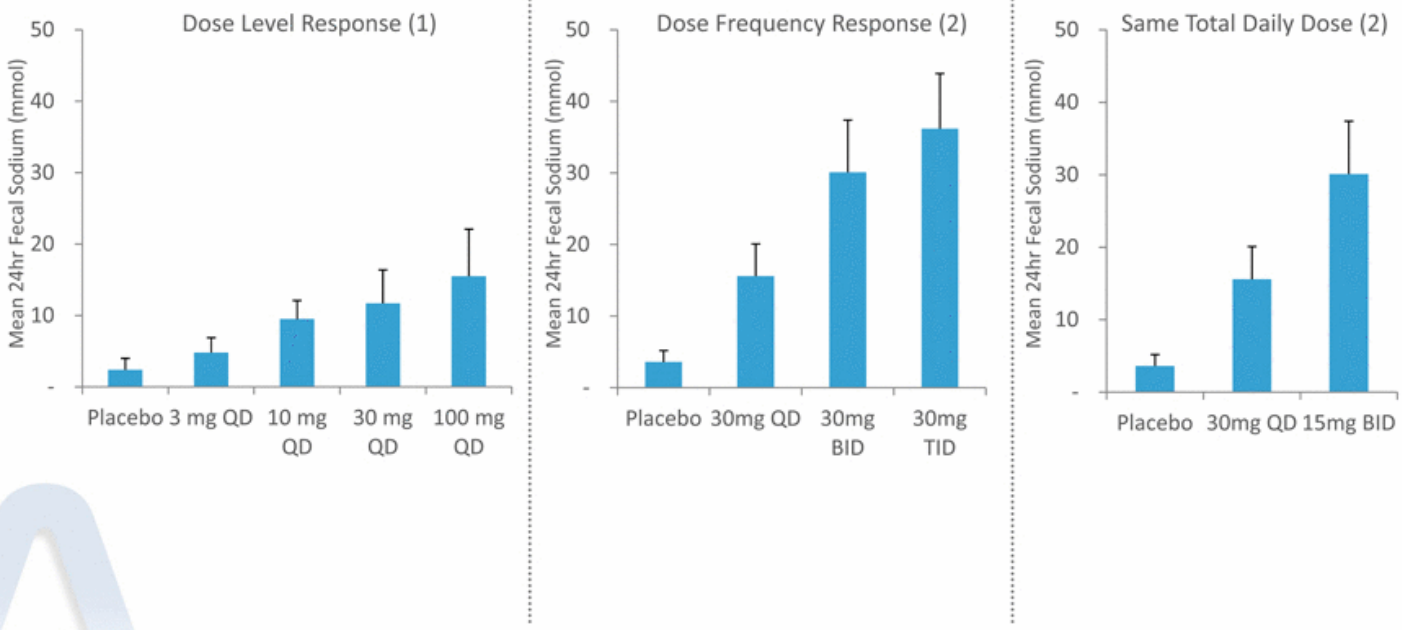
APPENDIX

Tenapanor Demonstrates Dose Level and Dose Frequency Response[1]

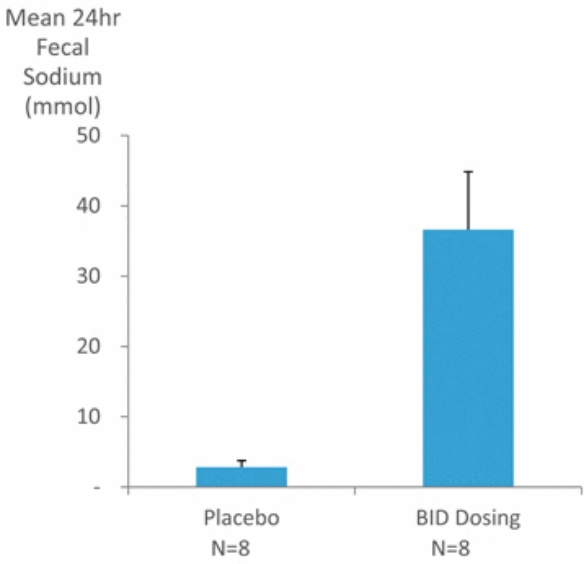
PHASE 1 IN HEALTHY ADULT VOLUNTEERS



[1] *RDX5791-101*
[2] *RDX5791-102; some data published in Spencer et al Sci Transl Med 6, 227ra36 (2014)*

Tenapanor Diverts Dietary Sodium to the Feces CKD-5D Patients

PHASE 2a FLUID IN SUBSET OF CKD-5D PATIENTS[2]

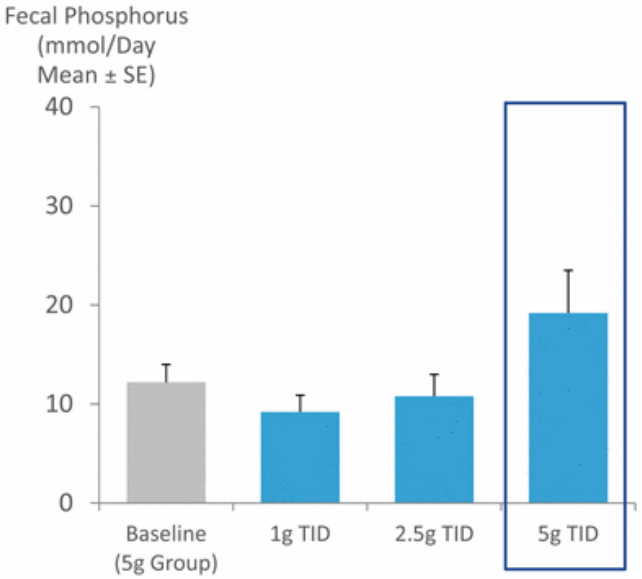


[2] Study D5611C00001

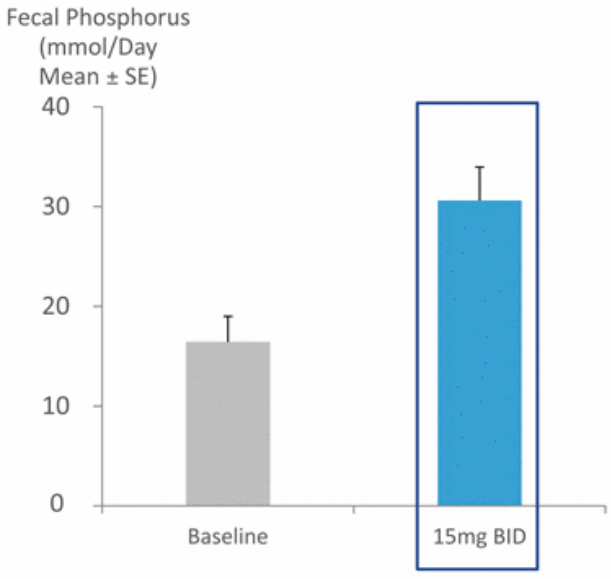
Comparative Human Response: Sevelamer vs. Tenapanor in Healthy Adult Volunteers

ARDELYX

SEVELAMER[1]



TENAPANOR[2]



Dose	15,000 mg/Day	30 mg/Day

Similar Results,
But **1/500th** the Dose

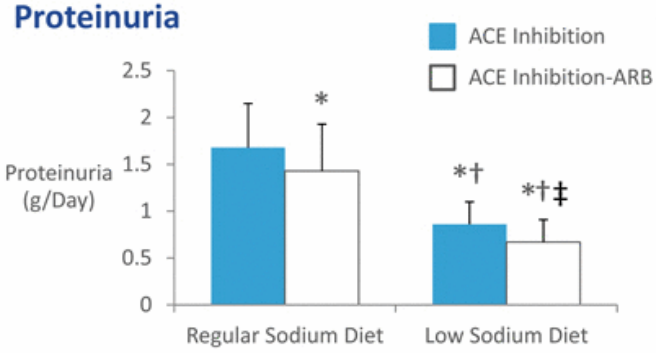
[1] Burke et al. 1997; [2] Study D5611C00002

Studies Support Impact of Treating Elevated Sodium and Phosphorus

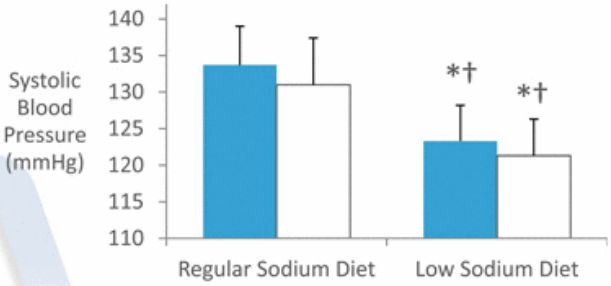
ARDELYX

SODIUM[1]

Proteinuria

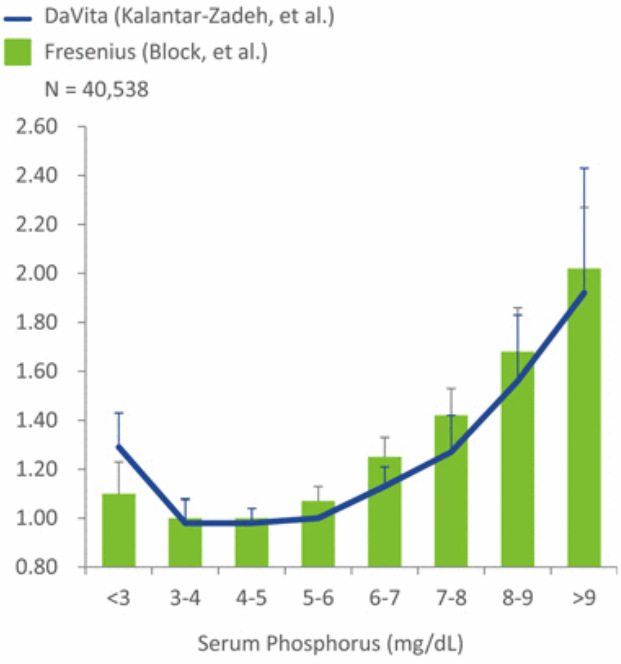


Systolic Blood Pressure



PHOSPHORUS[2]

Relative Risk of Death*



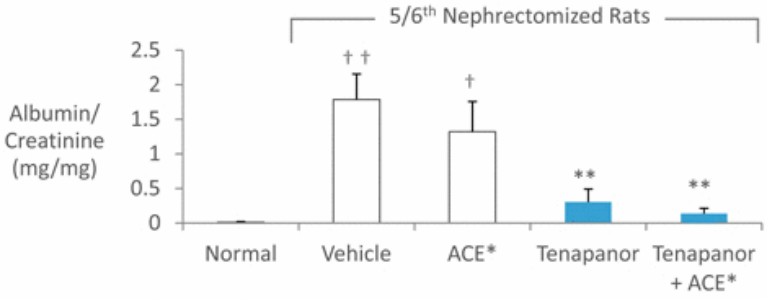
*Not adjusted for active vitamin D intake; serum phosphorus 4-5 mg/dL was normalized to 1.0

1. Slagman, et al., *BMJ* (2011) 343:d4366: 2. Block, et al. *JASN* (2004) 15:2208-2218: 3. Kalantar-Zadeh, et al. *KI* (2006) 70:771-780
*P<0.05 v ACE inhibition on regular sodium diet. †P<0.05 v ACE inhibition plus ARB on regular sodium diet. ‡P<0.05 v ACE inhibition on low sodium diet

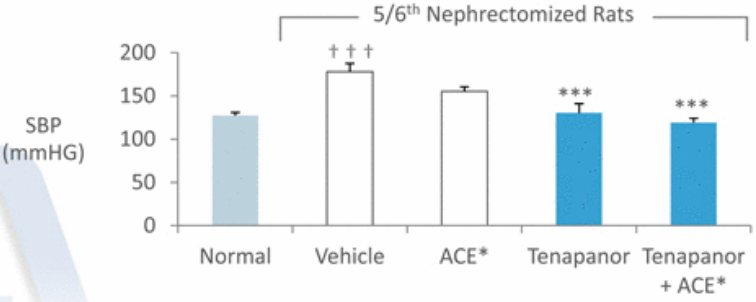
Beneficial Effects of Tenapanor on Sodium and Phosphorus in CKD Models

SODIUM

Urinary Albumin/Creatinine

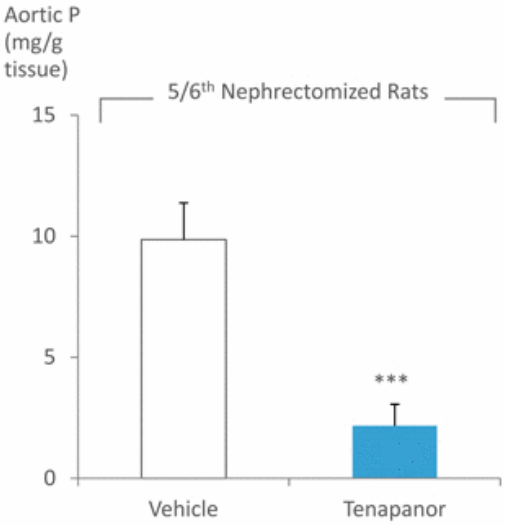


Systolic Blood Pressure



PHOSPHORUS

Aortic Mineral Content



*ACE = Enalapril ; One way Anova, followed by Dunnett's test;
** p<0.01; *** p<0.001 vs. vehicle; † p<0.05; † †; p<0.01; † † † p<0.001 vs. sham; N=12/group