

Intellia, and the Difference Between Approval and Demand

NASDAQ: NTLA · Genome editing · In vivo CRISPR · Small capitalization

SHORT INTEREST	SHORT SHARES	DAYS TO COVER
32.7% of float	43.93M	12.89

Short interest as of the 31 August 2026 settlement. FINRA publishes short interest twice a month, about seven business days after each settlement date, so this figure is not a daily number.

FRAMEWORK VIEW: CONSTRUCTIVE

Horizon 18 to 36 months. The first in vivo gene editing approval is about six months away, a third of the float is short, and the reason to own this is probably not the drug that is about to be approved.

Initiated 12 Sep 2026 at **Constructive**. Current view as of 12 Sep 2026: **Constructive**, unchanged.

POSITION DISCLOSURE

No position. Neither Contra Research Group nor its personnel held a position in NTLA at the time of writing or hold one now.

If we open a position in NTLA it will be disclosed here as a dated update. See how we trade what we cover.

Key Data				
Market Capitalization		\$1.65B	Short Interest, % Float	32.7%
Enterprise Value		\$1.09B	Short Interest, Shares	43.93M
Cash and Securities		\$628.4M	Days to Cover	12.89
Net Loss, Q2 2026		\$106.6M	Public Float	134.15M
Shares Outstanding		140.13M	Consensus Target	\$21.15 to \$25.00
52 Week Range		\$7.95 to \$28.25	Cash Runway Guidance	at least into 2028

Sources: Intellia Q2 2026 results and Form 10-Q filed 6 August 2026, company releases, market data as of the 11 September 2026 close. Short interest is the 31 August 2026 settlement, which predates the 8 September BLA acceptance. Percent of float is disputed

between vendors at 31.4% to 39.5% on the same share count; we compute 32.7% against the 134.15M float and flag the dispersion. Analyst counts differ by vendor between 19 and 24, with published average targets between \$21.15 and \$25.00 and a range of \$9 to \$49. Cash runway is company guidance given on 6 August 2026, which predates the OrbiMed facility. Last traded price omitted by request, consistent with house convention.

01 Investment Case

We initiate on Intellia at Constructive. On 27 April 2026 the company delivered the first global Phase 3 win for in vivo gene editing, and on 8 September the FDA accepted the filing with priority review and no advisory committee planned, setting a decision date of 10 March 2027. The equity trades at a \$1.09B enterprise value with 33% of its float sold short. Our view is that the market is discounting a liver safety event the FDA resolved in March, while failing to ask the question that actually decides the outcome, which is whether anyone will take a one-time treatment for a disease that is already well managed.

The clinical result is not in dispute. Lonvoguran ziclumeran, a single infusion that knocks out KLKB1 in the liver, cut monthly hereditary angioedema attacks by 87%, from 2.10 on placebo to 0.26, at $p < 0.0001$. Sixty-two percent of treated patients were completely attack-free and off all other therapy, against 11% on placebo. Every adverse event in the treatment arm was mild or moderate and there were no serious adverse events at all. For a first-in-class modality this is about as clean as a pivotal trial gets.

The commercial question is the one we spent our time on, and the honest answer is uncomfortable. One-time therapies have a poor record in diseases where the chronic alternative works. Pfizer's hemophilia B gene therapy Beqvez was approved in April 2024 and discontinued in February 2025, having **never disclosed a single commercial sale**, with trade reporting that no patient received it commercially in that window. Pfizer cited the limited interest patients and doctors had shown in hemophilia gene therapy, and it left the company with no gene therapy on the market or in development. BioMarin withdrew Roctavian for the same reason. Hereditary angioedema is a disease with good chronic options: an oral daily tablet doing over \$600M a year, an oral rescue drug approved last year, and a three-to-six-month injectable in pivotal trials. On the commercial evidence, HAE resembles hemophilia far more than it resembles sickle cell disease.

We are Constructive anyway, and the reason is what you are paying. At \$1.09B of enterprise value the market is assigning close to nothing to a probable first-in-class approval, and close to nothing to nex-z, the wholly separate ATTR asset that is 25% partnered with Regeneron and sits in front of a market where Pfizer alone sold \$1.7B last year. Two things happened in 2026 that made nex-z more valuable and neither is in the price. AstraZeneca and Ionis failed in ATTR-CM in July, which analysts read as evidence that deep and consistent knockdown is what drives outcomes, and Intellia disclosed in August that the worst liver enzyme elevations

clustered in patients carrying a specific HLA allele. If that holds, the event that halved this company becomes a genotype you screen for.

02 The Asset That Won

Hereditary angioedema is caused by uncontrolled plasma kallikrein activity, which drives bradykinin production and produces unpredictable attacks of swelling in the airway, abdomen and extremities. Laryngeal attacks can be fatal. The established approach is to inhibit kallikrein continuously, for life.

Lonvo-z takes the upstream route. A single infusion of a lipid nanoparticle carrying Cas9 and a guide RNA knocks out *KLKB1*, the gene encoding prekallikrein, in hepatocytes. The edit is permanent. There is no second dose and no discontinuation.

HAELO PHASE 3, TOPLINE AS FILED

ENDPOINT	LONVO-Z	PLACEBO	RESULT
Mean monthly attack rate	0.26	2.10	87% reduction, p<0.0001
Attack-free and off therapy	62%	11%	Over the six month efficacy period
Serious adverse events	None	n/a	All TEAEs mild or moderate at the 10 February 2026 cutoff

Most common treatment-emergent events were infusion-related reactions, headache and fatigue. Longer-term data were presented at EAACI in June 2026.

The regulatory path has gone as well as the trial. The BLA was accepted on 8 September 2026 with priority review, a PDUFA date of 10 March 2027, and the FDA stating it is not currently planning an advisory committee. For a first-in-class permanent edit, declining to convene an adcomm is a meaningful signal about how the agency views the data package. Intellia guides to a US launch in the first half of 2027. Lonvo-z is wholly owned.

03 The Market It Enters

The addressable population is small and the revenue per patient is very large. BioCryst, which sells the leading oral prophylactic, put the injectable prophylaxis pool at **over 5,000 patients** when it acquired a competitor in this space. That is the pool lonvo-z is aimed at.

The competitive set is the part that matters, because every one of these products works.

HEREDITARY ANGIOEDEMA, THE STANDING OPTIONS

PRODUCT	OWNER	FORM	STATUS
Orladeyo	BioCryst	Oral, once daily prophylaxis	\$158.2M in Q2 2026; 2026 guidance \$625M to \$645M
Takhzyro	Takeda	Injectable prophylaxis	The incumbent injectable standard
Ekterly	KalVista, being acquired by Chiesi	Oral, on-demand rescue	Approved 2025; Chiesi agreed to buy KalVista for about \$1.9B at \$27 per share on 29 April 2026
Navenibart	BioCryst, via Astria	Injectable, every three to six months	ALPHA-ORBIT enrollment completed June 2026; topline guided Q3 2027
Haegarda, Berinert, Ruconest	CSL, Pharming	C1 inhibitor replacement	Established

Orladeyo grew 1% year on year in Q2 2026, which is worth noting on its own: the oral prophylaxis market is maturing, not collapsing.

Two transactions frame how strategics value this disease. Chiesi agreed to pay roughly \$1.9B for KalVista on 29 April 2026, two days after HAELO read out. BioCryst paid about \$700M of enterprise value for Astria, closing 23 January 2026, to acquire navenibart. Both buyers were purchasing chronic, repeat-revenue assets. Neither disclosure mentions one-time gene editing as a competitive consideration at all, and BioCryst bought its asset before HAELO reported.

04 The One-Shot Problem

This is the section that decides the note, and it is the work we would want done on us before anyone bought this stock.

A permanent cure priced as a single transaction sounds like an obviously superior product. In practice, in disease after disease, patients have declined it.

APPROVED ONE-TIME THERAPIES AND WHAT ACTUALLY HAPPENED

PRODUCT	DISEASE	OUTCOME
Beqvez	Hemophilia B	Approved April 2024, discontinued February 2025. No commercial sale ever disclosed , with trade reporting no patient treated commercially. Pfizer cited limited patient and physician interest and now has no gene therapy on the market or in development
Roctavian	Hemophilia A	Withdrawn by BioMarin citing limited demand

PRODUCT	DISEASE	OUTCOME
Hemgenix	Hemophilia B	Approved November 2022. Minimal commercial adoption
Zolgensma	Spinal muscular atrophy	A commercial success, and the clearest counterexample
Casgevy	Sickle cell and beta thalassemia	\$76M in Q2 2026, over 100 patient starts for a third consecutive quarter

The reasons are documented and they are structural. At AMCP Annual 2026, Brian MacDonald of Prime Therapeutics set out the two that matter. The first is that patients who are stable do not switch: they are, in his words, well managed on their current therapy, and a permanent irreversible edit is a large decision to take when nothing is currently going wrong.

The second is subtler and more damaging. Because payers may cover a one-time therapy exactly once, patients and physicians face what MacDonald called getting only **one bite at the apple**. If you use your single covered opportunity on the first-generation product, you cannot use it on the better one that arrives in four years. The rational response is to wait. That dynamic does not weaken as a product improves. It gets stronger, because every improvement confirms that waiting was correct.

For lonvo-z the waiting option is unusually attractive. A patient who defers keeps a once-daily oral tablet, gains an oral rescue drug, and can expect a three-to-six-month injectable to read out in Q3 2027. None of those require an irreversible decision.

05 Where One-Shot Works

The pattern in the table above is not random, and stating it plainly is the most useful thing in this note.

One-time therapy succeeds where chronic care is bad, and fails where chronic care is good.

Contra Research Group, 12 September 2026

Sickle cell disease means recurring vaso-occlusive crises, cumulative organ damage, repeated hospitalization and a shortened life. The chronic standard of care is poor, so the calculus favors accepting a one-time procedure, and Casgevy is selling. Spinal muscular atrophy is fatal in infancy without intervention, so Zolgensma sells. Hemophilia, by contrast, is now well managed by factor replacement and by Hemlibra, and every gene therapy launched into it has failed commercially.

Hereditary angioedema belongs with hemophilia. Attacks are frightening and occasionally fatal, but a patient on Orladeyo or Takhzyro is typically living a normal life. The disease that lonvo-z cures is, for most of the addressable pool, already controlled.

We therefore do not expect lonvo-z to be a large commercial product in its first years, and we would treat any model that ramps it like a conventional rare disease launch as unsound. The patients most likely to take it are the ones failing or intolerant of current prophylaxis, and those with the heaviest treatment burden. That is a real population and it is not 5,000 people.

There is a version of this that goes better, and it turns on price. Every product above was priced in the millions against chronic therapies costing a few hundred thousand a year. HAE prophylaxis is unusually expensive, so a one-time price that looks reasonable against three or four years of Orladeyo is arithmetically available in a way it was not for hemophilia. Intellia has disclosed nothing about pricing. That silence is the single largest gap in the investment case.

06 The Liver Event

Everything about this equity's price is downstream of what happened in late 2025, on a different program.

On 27 October 2025 Intellia paused enrollment in the nex-z Phase 3 trials after a patient developed Grade 4 liver transaminase elevations and raised bilirubin. The FDA imposed a clinical hold on 29 October. The patient died on 5 November. The stock fell roughly 48% on the disclosure and a further 9% on the death. Grade 4 elevations affected under 1% of MAGNITUDE patients and none in MAGNITUDE-2.

The holds were lifted on 27 January 2026 for MAGNITUDE-2 and 2 March 2026 for MAGNITUDE, with protocol amendments covering enhanced liver monitoring, short-term steroid guidance for post-dose transaminase elevation, and exclusion of patients with certain liver abnormalities or recent cardiovascular instability. Enrollment has reinitiated. **We have found no further liver signal disclosed since.**

The part that has not been priced came in the Q2 2026 report. Intellia disclosed that after a comprehensive genomic analysis, the highest liver enzyme elevations occurred in patients carrying **a specific HLA allele**, and that it intends to provide HLA genotyping results to investigators and enrolled patients while it engages with regulators.

If that association holds, it reclassifies the risk entirely. An idiosyncratic immune-mediated liver injury tied to an HLA type is a known and manageable pharmacological pattern, and medicine already has the template: abacavir carries a hypersensitivity risk confined to HLA-B*5701 carriers, and genotyping before dosing converted it from a dangerous drug into a routine one. A screenable genetic risk factor is a labeling and diligence problem. An unexplained fatal hepatotoxicity in a permanent edit is closer to a platform problem. The market is still pricing the second.

We are deliberately careful here. This is the company's own disclosure, it is early, the specific allele has not been published in the material we reviewed, and regulators have not accepted anything. It is a hypothesis with genomic support, not a label. But it is dated, sourced, and materially under-discussed.

07 Nex-z, the Larger Asset

Lonvo-z gets the headlines because it is closest to approval. Nex-z is where the value is.

Nexiguran ziclumeran knocks out *TTR* in the liver in a single infusion, for transthyretin amyloidosis. Intellia leads development and commercialization; Regeneron carries 25% of development costs and profits and holds a US co-promotion option. Two Phase 3 trials are running: MAGNITUDE in cardiomyopathy and MAGNITUDE-2 in polyneuropathy. Enrollment in MAGNITUDE-2 is guided to complete in the second half of 2026. **Intellia has not guided to a topline date for either trial**, which is itself informative about how far out this is.

THE ATTR FIELD NEX-Z WOULD ENTER

PRODUCT	OWNER	MECHANISM	POSITION
Vyndaqel and Vyndamax	Pfizer	Stabilizer, oral	\$1.7B worldwide in 2025
Attruby	BridgeBio	Stabilizer, oral	Approved November 2024; \$362.4M in 2025
Amvuttra	Alnylam	RNAi silencer, twice yearly	The only approved silencer in ATTR-CM
Wainua	AstraZeneca and Ionis	Antisense silencer	Failed its ATTR-CM Phase 3 in July 2026
Nex-z	Intellia and Regeneron	One-time knockout	Phase 3, no topline date guided

The Wainua failure is the most useful thing that happened to nex-z all year, and it happened to someone else. A silencer that reduces TTR failed to deliver an outcome benefit in cardiomyopathy. BridgeBio rose 15% on the read-across to stabilizers. The reading that matters for Intellia, and the one analysts took at the time, is that **depth and consistency of knockdown are what drive outcomes**. A one-time knockout produces deeper and more consistent reduction than a drug requiring repeat administration and adherence. If the mechanism thesis is right, nex-z is the best-positioned asset in the class. If TTR reduction simply does not convert to outcomes in cardiomyopathy beyond what stabilizers already deliver, nex-z is worth considerably less and Wainua was the warning.

Note also that the commercial objection from Section 05 applies here too, and with force. ATTR patients have an oral tablet and a twice-yearly injection available, both with characterized safety. The case for an irreversible edit has to be made on efficacy depth, not convenience.

08 Correcting Our House View

Our published house view on the industrialization of genetic cures states that the safety ceiling, listing off-target edits, chromosomal translocations and hepatic toxicity, now sits under stricter FDA guidance requiring deep sequencing screens. Working through the actual regulatory record for this note, that framing is wrong in two ways and we are correcting it here.

The guidance exists. On 14 April 2026 the FDA issued draft guidance on safety assessment of genome editing using next-generation sequencing, recommending off-target analysis at sequencing depth sufficient to detect editing below the on-target rate, and quantitative assessment of chromosomal translocations. But it is **non-binding draft guidance**, it remained in draft at the time of writing, and it addresses **nonclinical** characterization only. It says nothing about hepatic toxicity. The liver monitoring that exists in in vivo editing trials today came from company protocol amendments negotiated to lift a specific clinical hold, not from FDA guidance. We attributed to the regulator something that a sponsor did.

The second error is directional. We described the regulator as tightening. On the evidence it is doing the opposite where it counts. The Plausible Mechanism Framework of 23 February 2026 explicitly addresses genome editing and permits multiple product variants targeting different mutations in one gene to be evaluated under master protocols, which is the single most important cost unlock available to bespoke editing. The Rare Disease Evidence Principles of September 2025 allow approval on one adequate and well-controlled study, which may be single-arm, in populations under roughly 1,000 patients. The FDA is raising the characterization bar and lowering the clinical evidence bar at the same time, and on balance it is making editing easier to approve.

The corrected position: the safety ceiling remains a real constraint on the modality, driven by observed clinical events and by what payers and physicians will accept. It is not currently being driven by FDA guidance, and anyone modeling a regulatory crackdown on genome editing in the United States is modeling something that is not in the record.

09 Positioning and Ownership

The positioning here is as extreme as anything we have covered.

SHORT INTEREST, RECENT SETTLEMENTS

SETTLEMENT	SHARES SHORT	DAYS TO COVER
31 August 2026	43.93M	12.89
14 August 2026	44.88M	13.2
31 July 2026	44.01M	11.96
Peak, around May 2026	~51.8M	not reported

Roughly a third of the float, on a \$1.65B company, with nearly thirteen days of average volume required to cover. The 31 August settlement predates the 8 September BLA acceptance, so the first post-catalyst read publishes later in September.

The register on the other side is thin on fundamental conviction. ARK is the largest holder at about 12%, followed by BlackRock, State Street, Vanguard, D.E. Shaw and Two Sigma. Only one dedicated biotech specialist, RA Capital, appears in the top nine. A shareholder base of thematic and quantitative money against a short base of a third of the float is a structure that moves violently in both directions on a binary date, and there is a binary date on 10 March 2027.

Two behavioral details are worth recording. Director Fred Cohen bought 150,000 shares in the open market on 7 January 2026 at about \$9.35, a purchase of roughly \$1.4M near the cycle low. It is the only substantial open-market insider purchase we found. Separately, on 27 April 2026 the company reported the first Phase 3 success in the history of in vivo gene editing and **the stock fell more than 2%**, after which Intellia priced \$194.6M of equity two days later at \$10.75. Then on 8 September the FDA accepted the filing with priority review and no advisory committee, and not one analyst upgraded. Wedbush raised its target from \$12 to \$13 and stayed Neutral.

10 Capital Structure

Cash and marketable securities were \$628.4M at 30 June 2026. On 4 September 2026 Intellia added a senior secured facility with OrbiMed of up to \$400M, with \$75M funded at closing, a further \$75M on FDA approval, three \$40M revenue-milestone tranches, and \$30M contingent on hitting an equity fundraising target. It is secured on substantially all assets including intellectual property, and it prices at the greater of 3.00% or one-month SOFR plus 6.15%.

Management guidance, given on 6 August and therefore before the OrbiMed facility, is that cash funds operations at least into 2028 and well beyond the anticipated first-half 2027 launch. Operating burn has run roughly \$90M to \$100M a quarter. On that basis the March 2027 decision date is comfortably funded. **The funding question is the launch ramp, not the PDUFA.**

Two details deserve attention. The first is that one OrbiMed tranche is explicitly conditioned on Intellia raising equity, which telegraphs that a further raise is expected. Share count has grown from 98.29M to 140.13M in two years, a 42.6% increase, and the April 2026 offering was priced at \$10.75 two days after a successful Phase 3. This company has consistently sold equity into strength and into weakness alike, and holders should assume it continues.

The second is the cost mix. R&D has fallen about 24% since Q1 2025 while G&A has risen about 30%, which is the commercial build showing up in the numbers before there is anything to sell. Operating expense is unlikely to fall from here.

One governance item we could not resolve. The Chief Medical Officer announced retirement in August 2025, effective August 2026, and we found no successor announced and none listed. Intellia appears to be carrying a vacant CMO seat into a priority review with a March 2027 decision date. We would want that confirmed or corrected directly.

11 Valuation

We do not publish price targets. What follows is the arithmetic of what the current quotation implies, set out to be challenged.

Enterprise value is \$1.09B: a \$1.65B market capitalization against \$628.4M of cash and securities, with no borrowings before September. Against that you are buying two Phase 3 assets, one of them filed with priority review.

Consider what has to be true for \$1.09B to be correct. It requires lonvo-z to be approved and to generate little, and nex-z to be worth close to nothing. The first half of that is a defensible view and Section 05 is our own argument for why lonvo-z may disappoint. The second half is harder. Nex-z addresses a market where the oral stabilizer franchise alone sold \$1.7B in 2025 and a newer stabilizer added \$362.4M in its first full year, and Intellia keeps 75% of it.

A useful cross-check is what strategics have paid nearby. Chiesi agreed to about \$1.9B for KalVista, whose approved asset is an oral on-demand rescue drug in the same disease lonvo-z treats. BioCryst paid roughly \$700M of enterprise value for a single unapproved long-acting injectable. Intellia's entire enterprise value is below the KalVista price with a wholly owned approved-pending asset in the same indication, plus a second Phase 3 program in a larger one.

Sell-side targets span \$9 to \$49 against a quotation under \$12. That dispersion is not analytical disagreement about a discount rate. It is the market saying this resolves to two different companies depending on events, which is the correct read.

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Risk Assessment

RISK	SEVERITY	ASSESSMENT
Lonvo-z commercial failure	HIGH	The central risk and the one we rate most likely to bite. Every one-time therapy launched into a well-managed chronic disease has underperformed, and two were withdrawn. Approval does not solve this, and a first year that looks like Beqvez is a realistic outcome rather than a tail.
Pricing undisclosed	HIGH	Intellia has said nothing about price, payer negotiations, treatment centers, or sales force scale. For a first-in-class one-time launch this is the largest information gap in the file, and it is the variable that decides whether Section 05 resolves well or badly.
Further liver signal in nex-z	HIGH	One patient has already died. No new signal has been disclosed since enrollment restarted, and the HLA finding is encouraging, but the association is unconfirmed and unaccepted by regulators. A second event would likely end the program and would be read across to the platform.
Dilution	MEDIUM	Share count is up 42.6% in two years, roughly \$368.5M of ATM capacity remained at 30 June, and an OrbiMed tranche is explicitly conditioned on raising equity. Assume further issuance, including into strength.
Nex-z mechanism does not convert	MEDIUM	Wainua reduced TTR and failed on outcomes in cardiomyopathy. If knockdown depth is not the explanation, the read-across that currently favors nex-z reverses, and the larger of the two assets is impaired.
Positioning reflexivity	MEDIUM	A third of the float short with thirteen days to cover cuts both ways. It is a source of violent upside on good news and of accelerated decline on bad, and it means the quotation reflects positioning as much as fundamentals.
Key person and organizational gaps	MEDIUM	No Chief Medical Officer appears to be in post entering a priority review. No manufacturing or supply-chain detail has been disclosed for a first-in-class launch. Neither is fatal; both are unusual.

13

Analyst Agenda

Open workstreams, ordered by how much they move the view.

- 01
- Find the price.** Everything in Section 05 turns on what a single administration costs against three or four years of Orladeyo or Takhzyro. Any disclosure from Intellia, any payer

commentary, any analyst assumption with a stated basis. This is the highest-value open item in the file.

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- 02 **Identify the HLA allele.** Section 06 rests on a company disclosure without a published allele. Find the genomic analysis, the allele, the carrier frequency in the treated population, and whatever the FDA has said. If this is screenable, it changes the nex-z risk profile materially.
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- 03 **Survey physician and patient intent.** The one-shot objection is drawn from hemophilia analogues and payer commentary, not from HAE-specific evidence. Any KOL survey or patient-preference study on appetite for an irreversible knockout in HAE would test our core argument directly.
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- 04 **Get a MAGNITUDE timeline.** Intellia has guided MAGNITUDE-2 enrollment completion but no topline date for either trial. Until the ATTR readout is dated, the larger asset cannot be positioned in time.
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- 05 **Confirm the CMO seat.** Straightforward diligence, and it bears on execution through a first-in-class launch.
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- 06 **Amend the house view page.** Section 08 corrects a published claim about FDA posture. That correction belongs on the house view itself as a dated amendment, not only here.
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- 07 **Test the toll-collector layer.** Our house view prefers bottleneck owners over sponsors, and we have now published two sponsors and no bottleneck owner. The capping, sequencing and safety-testing suppliers to this industry remain uncovered.
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§ References and Disclosures

Intellia HAELO Phase 3 topline, 27 April 2026

Intellia BLA acceptance with priority review, 8 September 2026

Intellia Q2 2026 results and Form 10-Q, 6 August 2026

Intellia OrbiMed debt facility and Form 8-K, 4 September 2026

Intellia clinical hold lifts, 27 January and 2 March 2026

FDA draft guidance, safety assessment of genome editing using NGS, 14 April 2026

FDA Plausible Mechanism Framework, 23 February 2026	FDA Rare Disease Evidence Principles, September 2025
BioCryst acquisition of Astria Therapeutics, announced November 2025, closed 23 January 2026	BioCryst Q2 2026 results and ORLADEYO guidance
Chiesi agreement to acquire KalVista, 29 April 2026	AMCP Annual 2026, payer commentary on one-time therapy uptake
Pfizer discontinuation of Beqvez, February 2025	AstraZeneca and Ionis, Wainua ATTR-CM Phase 3 outcome, July 2026
NTLA market data, short interest and analyst coverage, September 2026	Contra Research Group, CRISPR Therapeutics initiation, 5 September 2026
FINRA equity short interest reporting	

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