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) January 11, 2016

Heron Therapeutics, Inc.
(Exact name of registrant as specified in its charter)

Delaware	**001-33221**	**94-2875566**
(State or other jurisdiction of incorporation)	**(Commission File Number)**	**(I.R.S. Employer Identification No.)**

123 Saginaw Drive **Redwood City CA** **(Address of principal executive offices)**	**94063** **(Zip Code)**

Registrant's telephone number, including area code (650) 366-2626

N/A
(Former name or former address, if changed since last report)

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

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

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

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

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

ITEM 8.01 Other Events.

A copy of presentation materials describing the business of Heron Therapeutics, Inc. (the "Company"), all or a part of which may be used by the Company in investor or scientific presentations from time to time, is furnished as Exhibit 99.1 hereto. These materials include updates to information previously furnished by the Company regarding the Company's research and development programs. The fact that these updated presentation materials are being furnished should not be deemed an admission as to the materiality of any information contained in the materials. The attached materials have also been posted on the Company's website at *www.herontx.com*. The Company does not undertake any obligation to update this presentation.

ITEM 9.01 Financial Statements and Exhibits.

(d) Exhibits.

Exhibit No.	Description
99.1	Corporate Presentation, dated January 2016

SIGNATURE

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

Heron Therapeutics, Inc.

Date: January 11, 2016

/s/ Brian Drazba

Brian Drazba
Vice President, Finance & Chief Financial Officer

Exhibit 99.1

HERON
THERAPEUTICS
Developing Best-in-Class Medicine. Improving Lives.™

Company Update

January 11, 2016

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THERAPEUTICS
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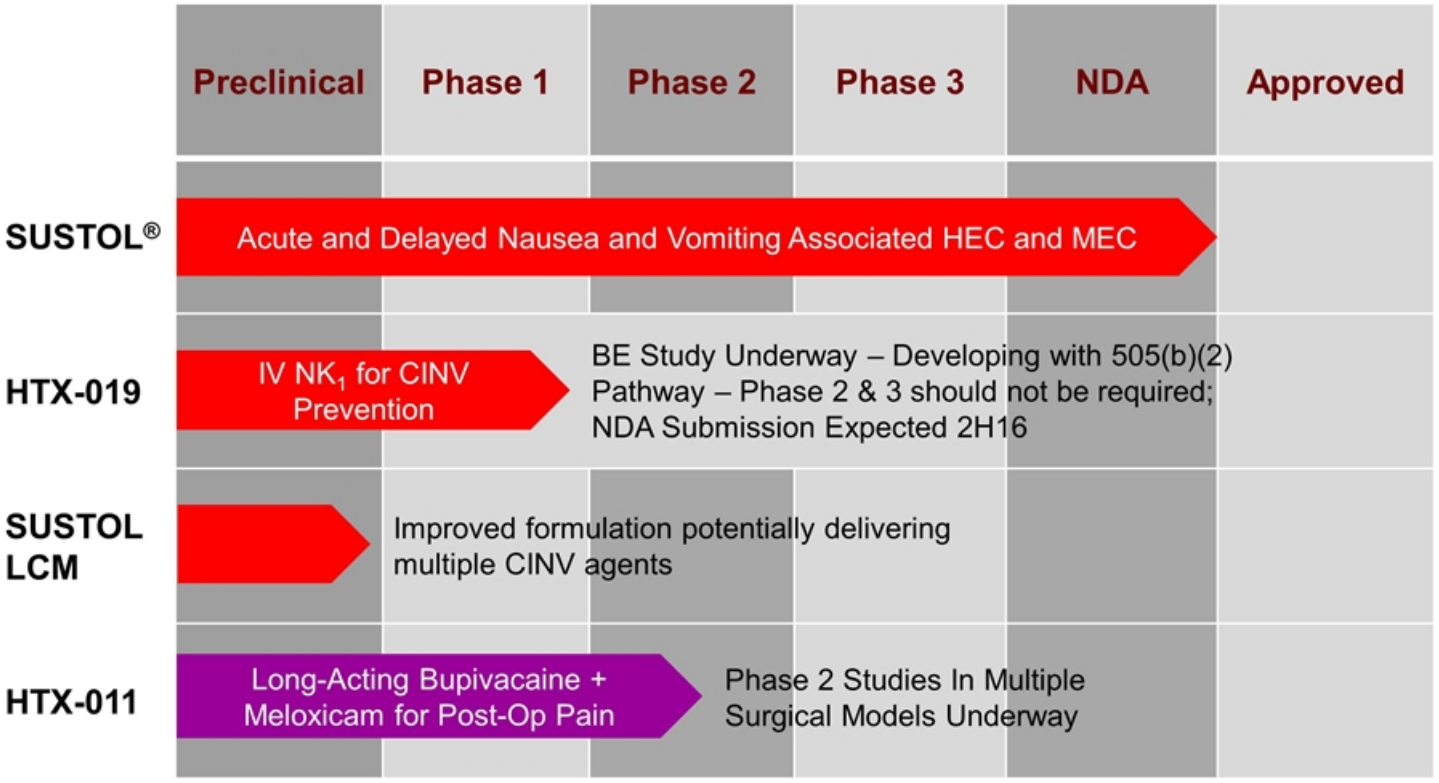
Legal Disclaimer

This presentation contains "forward-looking statements" as defined by the Private Securities Litigation Reform Act of 1995. These forward-looking statements involve risks and uncertainties, including uncertainties associated with the development, regulatory approval, manufacture, launch and acceptance of new products, completion of clinical studies and the results thereof, the ability to establish strategic alliances and execute on business alliances or initiatives, progress in research and development programs, intellectual property, third-party relationships, regulatory oversight and developments, potential market acceptance of new products, financial results, adequacy and duration of capital resources and other risks and uncertainties identified in the Company's filings with the Securities and Exchange Commission. None of the Company's product candidates discussed in this presentation have been approved by the FDA or any other regulatory agency. Actual results may differ materially from the results anticipated in our forward-looking statements. We caution investors that forward-looking statements reflect our analysis only on their stated date. We do not intend to update them except as required by law.

Status of Product Portfolio



Because SUSTOL is under active review, we will not discuss the NDA or answer any questions regarding the NDA

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CINV FRANCHISE

SUSTOL®

- **SUSTOL®** (granisetron) Injection, extended release, is a long-acting, injectable product for the prevention of chemotherapy-induced nausea and vomiting (CINV)
  - *1,341-patient, randomized, controlled, Phase 3 study demonstrated activity in acute and delayed CINV after moderately emetogenic chemotherapy (MEC), and acute CINV after highly emetogenic chemotherapy (HEC)*
  - *MAGIC: Complete Response in delayed nausea and vomiting in patients receiving HEC was significantly greater with the SUSTOL-based, three-drug regimen compared to standard-of-care. Significantly more patients had no nausea or infrequent nausea with SUSTOL and SUSTOL patients reported a significantly greater satisfaction with therapy*
  - ***SUSTOL, as part of a three-drug regimen, is the first 5-HT$_3$ antagonist to demonstrate superiority to a standard-of-care, three-drug regimen in delayed nausea and vomiting in patients receiving HEC***
- NDA resubmitted to FDA July 17, 2015
- **PDUFA goal date January 17, 2016**
  - **Because SUSTOL is under active review, we will not discuss the NDA or answer any questions regarding the NDA**

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SUSTOL Has the Potential to be the Next Generation 5-HT_3 Receptor Antagonist

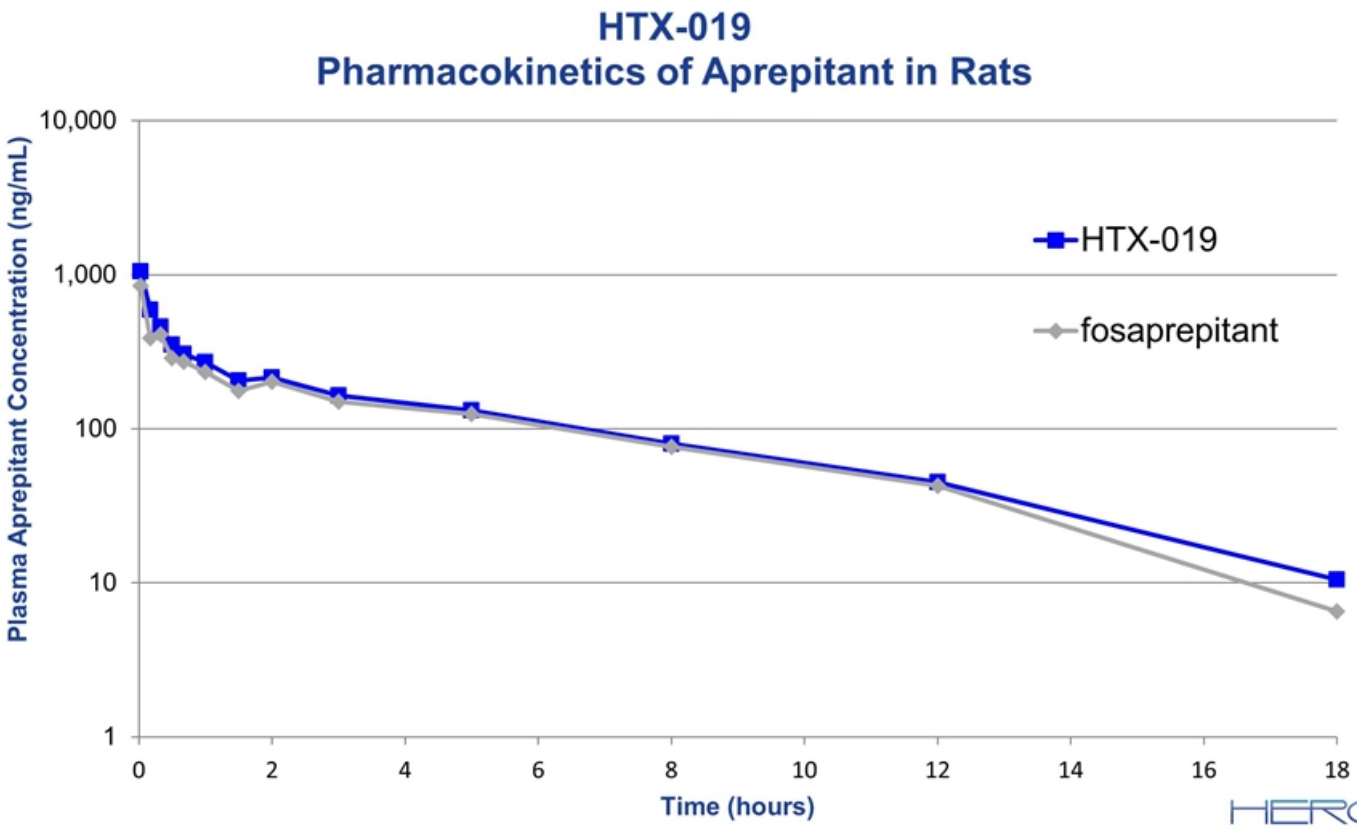
5-HT_3 RAs	1st generation	2nd generation	3rd generation
Products	ondansetron granisetron	palonosetron	**SUSTOL**
Duration of action	Short acting ~ 8 hr half-life	Longer acting ~40 hr half-life	**Long acting** **PK profile 5-7 days**
Indications	Prevention of CINV in emetogenic chemo including high-dose cisplatin	MEC – acute & delayed CINV HEC – acute CINV	**MEC – acute & delayed CINV** **HEC – acute & delayed CINV***

*Obtaining an indication for delayed nausea and vomiting after HEC will be based on FDA's assessment of MAGIC trial results

HTX-019

- **HTX-019** is a proprietary intravenous (IV) formulation of aprepitant, an NK_1 receptor antagonist and is distinguished from EMEND IV®, the only IV NK_1 receptor antagonist presently approved in the U.S., in that it does not contain polysorbate 80, which may cause infusion site reactions, hypersensitivity or other adverse reactions in some patients.
  - *Bioequivalency study comparing HTX-019 to EMEND IV (fosaprepitant) conducted in late 2015, pk analyses underway*
  - *Rapid development utilizing the 505(b)(2) registration pathway is anticipated to achieve NDA submission in 2H2016*
- Direct competitor to the approximately 1 million units of EMEND IV used annually

HTX-019 Demonstrated Bioequivalence to Fosaprepitant



HTX-019 Potential Tolerability Benefit

- Fosaprepitant is currently the only injectable NK_1 RA approved in the U.S.
- Fosaprepitant contains polysorbate 80, which may cause:
  - Hypersensitivity reactions, including flushing, itching or shortness of breath, and has the potential to cause severe anaphylaxis reactions
  - Infusion site reactions, including infusion site pain, erythema, swelling, superficial thrombosis, infusion site hives, and phlebitis/thrombophlebitis
- In review of cancer drugs containing polysorbate 80, hypersensitivity reactions linked to at least 23 deaths in spite of premedication
- HTX-019 does not contain polysorbate 80 and may have a lower incidence of certain adverse reactions than reported with fosaprepitant

SAFETY BENEFIT NOW CONFIRMED

Sources: Leal et al, Support Care Cancer, 22:1313–1317, 2014; Norris et al, Community Oncology, 7:425-428, 2010

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HTX-019 vs EMEND IV Human BE Study: HTX-019 Shows Clear Safety Advantage

- 100 subjects received HTX-019 and EMEND IV in standard cross-over design

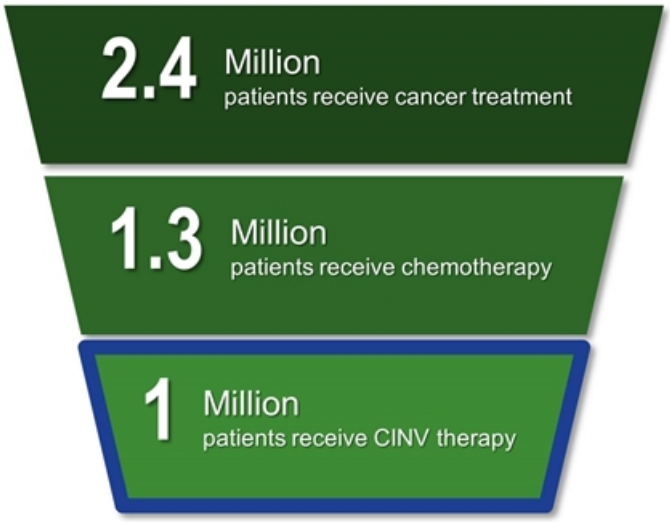
SAFETY	HTX-019	EMEND IV
All AEs	28%	56%
AEs considered at least possibly related	20%	52%
Moderate AEs	0	6%
Hypersensitivity Reactions	0	3%
Premature Discontinuations	0	2%

Conclusion: HTX-019 was clearly better tolerated than EMEND IV, with 62% fewer AEs at least possibly related to treatment, no AEs of greater than mild severity, no premature discontinuations and no hypersensitivity reactions

CINV FRANCHISE
COMMERCIAL OPPORTUNITY

The Management of CINV Remains a Significant Clinical Challenge

- > In the U.S., over 1 million people receive CINV therapy each year
- > On average, they each receive 5-6 cycles of CINV therapy



Unmet Need

- Despite treatment with existing therapies, many patients experience breakthrough CINV particularly in the delayed phase (days 2-5)
- CINV has a high clinical burden – impacting patients' QOL and cancer treatment
- Historically, there have been no single-agent 5-HT_3 antgonists indicated to prevent delayed CINV in HEC (including palonosetron)
- HCPs cite the need for new therapies that deliver long-acting CINV prevention in both MEC and HEC

Source: IPSOS Q2 2015 Cancer Tracking

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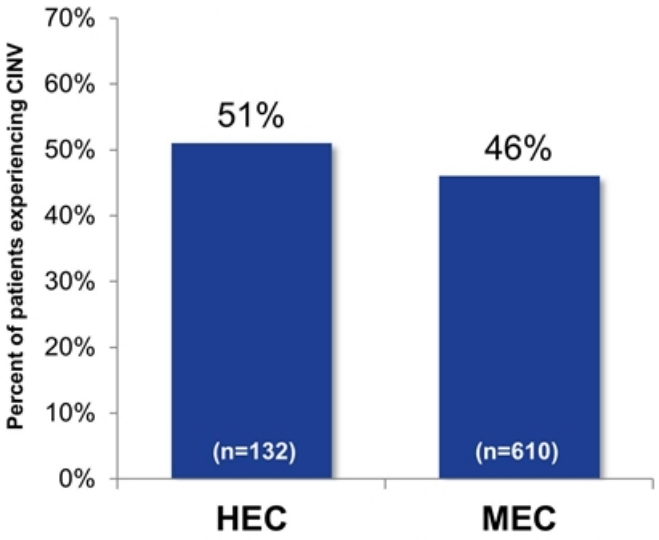
Despite Available Therapies, a Large Percentage of Patients Experience Breakthrough CINV

% of MEC/HEC patients with breakthrough CINV despite prophylaxis

Community practice observational study

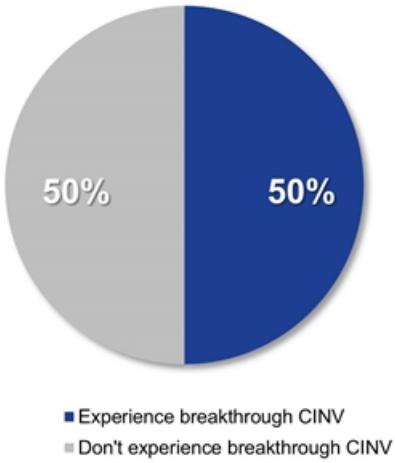


Data from a prospective observational study enrolling chemotherapy-naive patients who received single-day HEC or MEC at four oncology practice networks, all using electronic medical record (EMR) systems, in Georgia, Tennessee, and Florida. CINV = emesis or clinically significant nausea on days 1-5. For HEC=5-HT3+NK-1+CS on Day 1; NK-1 on Days 2-3; CS on Days 2-4; For MEC=5-HT3+NK-1+CS on Day 1; 5-HT3, NK-1, or CS on Days 2-3

Source: Gilmore JW et al. *J Oncol.* 2014;10:68-74.

% of MEC/HEC patients with breakthrough CINV despite prophylaxis

Physician perception



Source: Instar Market Research, Dec 2015, N=75 oncologists

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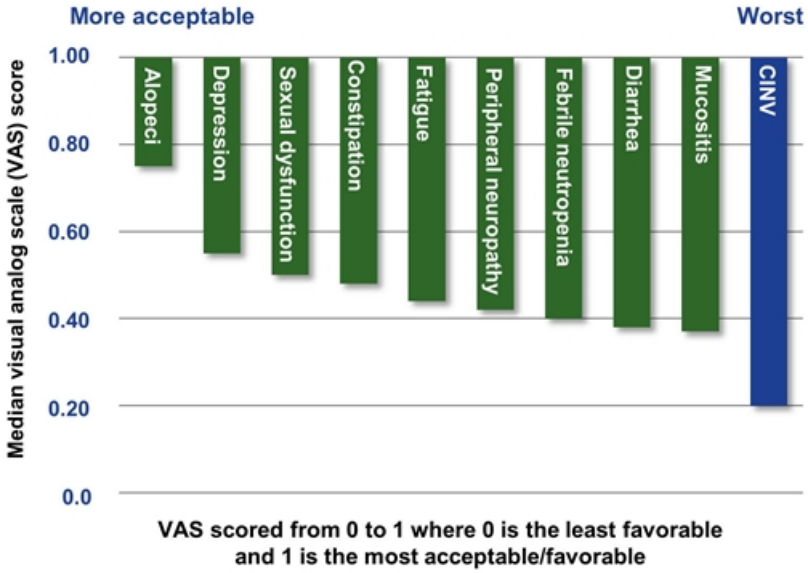
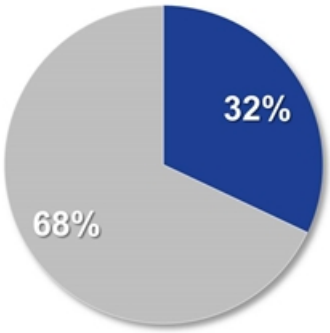
CINV Has a High Clinical Burden – Impacting Patients' QOL and Cancer Treatment

Patients identified CINV as the side effect of chemotherapy they most wanted to avoid



VAS scored from 0 to 1 where 0 is the least favorable and 1 is the most acceptable/favorable

CINV commonly disrupts patients' cancer treatment



32% of oncology HCPs delayed or discontinued chemotherapy due to CINV within the prior year

Sun CC et al. *Support Care Cancer*. 2005;13:219-227.
Van Laar ES et al. *Support Care Cancer*. 2015;23:151-7

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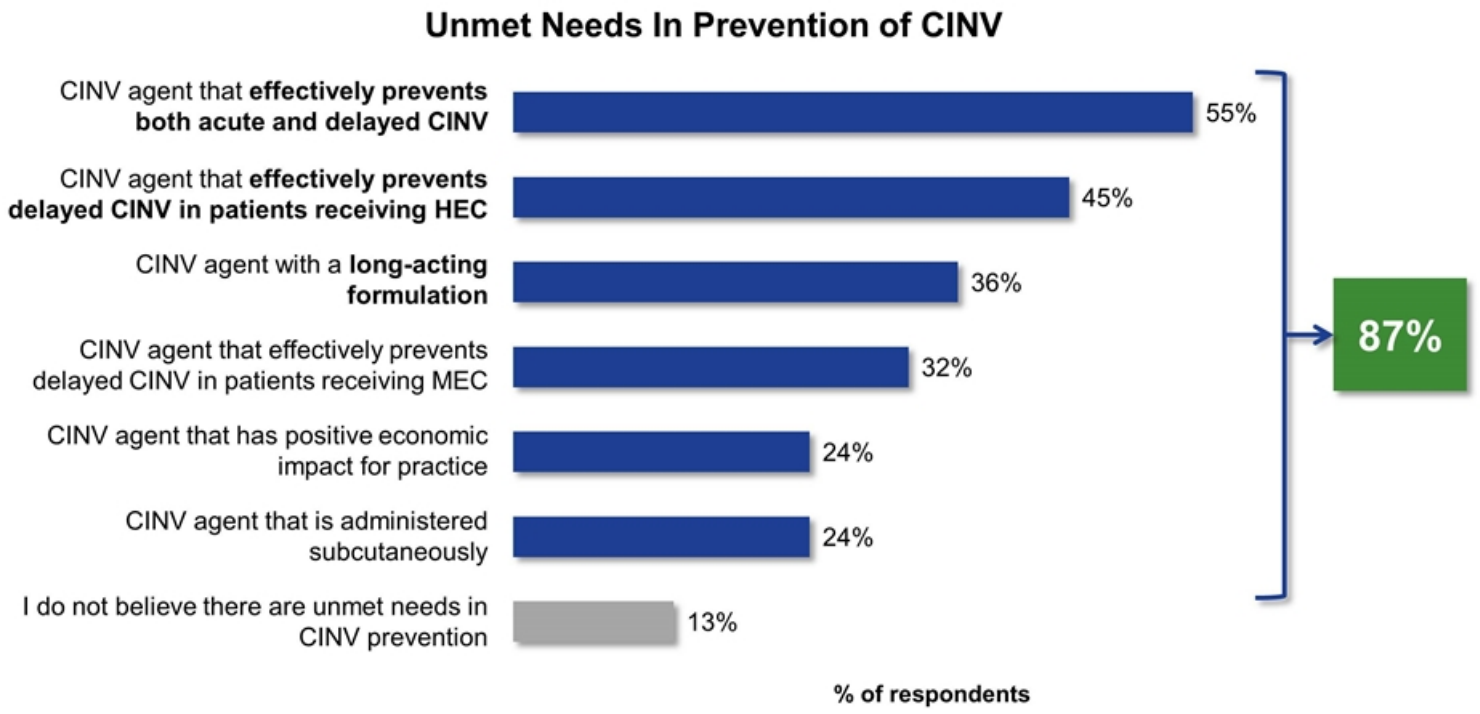
87% of Oncologists Believe New Agents are Needed to Address Unmet Needs in CINV Prevention



Source: Instar Market Research, Dec 2015, N=75 oncologists

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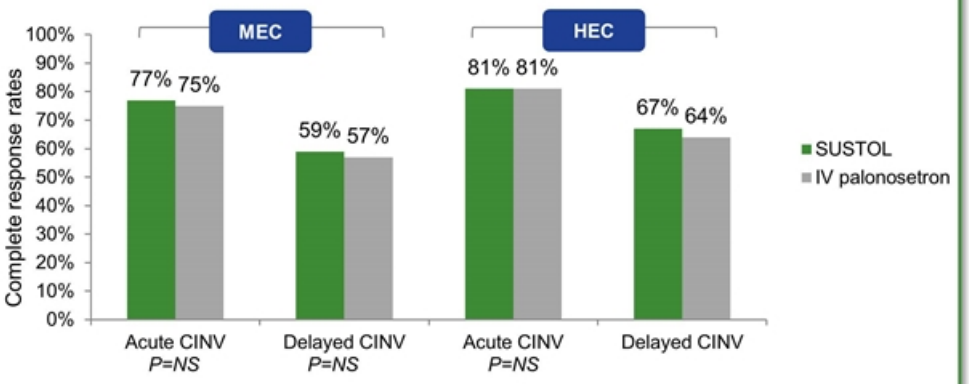
Across 2 Phase 3 Studies, SUSTOL Was Effective in Preventing Acute and Delayed CINV in MEC and HEC

STUDY C2006

SUSTOL was non-inferior to IV palonosetron in preventing acute and delayed CINV in MEC and acute CINV in HEC

Although not statistically significant, there was a trend favoring SUSTOL vs. palo in preventing delayed CINV in HEC, signaling an opportunity that led to the MAGIC study

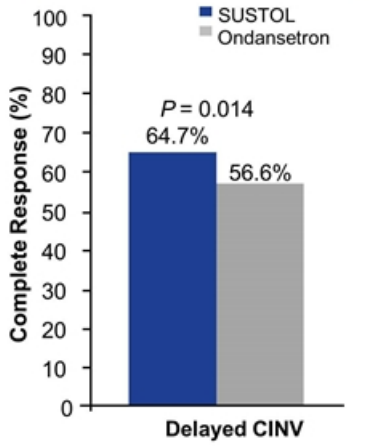


Because the study was designed to show non-inferiority, *P=NS* indicates that the endpoint of non-inferiority was reached, and that SUSTOL was as effective as IV palonosetron

Raftopoulos H et al. *Support Care Cancer.* 2014 Epub; Sep 2:1-10; Fig 2; p6 col2, ¶5.

MAGIC STUDY

SUSTOL is the first and only 5-HT$_3$ to demonstrate superiority vs. another in HEC



- In overall population, 14.2% relative improvement with SUSTOL vs ondansetron (95% CI, 1.7 to 14.4 P=0.014)
- In cisplatin randomization stratum, 19.4% relative improvement with SUSTOL vs ondansetron (95% CI, 1.4 to 22.7 P=NS)
- Source: Heron data on file

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MAGIC is the First Pivotal HEC Trial to Incorporate a Guideline-Recommended 3-Drug Regimen in Both Arms

- *In MAGIC, the efficacy advantage of SUSTOL vs. the standard-of-care 5-HT$_3$ was similar to the benefit shown in recent trials of adding an NK-1*
- *SUSTOL is the first 5-HT$_3$ to demonstrate superiority vs. another in HEC*

HEC Studies	Study Arm	Comparator Arm	Delayed CR	
			Absolute Difference	Relative Difference
SUSTOL* (SC)[1]	**3 drug**	**3 drug**	**8.0%**	**14.2%**
NEPA* (PO)[2]	3 drug	2 drug	7.4%	10.6%
NEPA (PO)[2]	3 drug	2 drug	10.3%	12.9%
Rolapitant* (PO)[3]	3 drug	2 drug	9.8%	15.7%
Rolapitant (PO)[3]	3 drug	2 drug	14.3%	24.5%
Rolapitant (PO)[3]	3 drug	2 drug	8.2%	13.2%

3 drug = 5-HT$_3$ receptor antagonist, NK-1 receptor antagonist, dexamethasone
2 drug = 5-HT$_3$ receptor antagonist, dexamethasone

*Predominately anthracycline/cyclophosphamide
1 Heron data on file; 2 NEPA PI; 3 rolapitant PI

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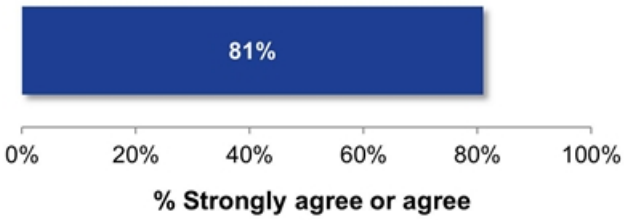
More Than 80% of Oncologists Found the MAGIC Trial Design and Results to be Clinically Meaningful

Clinically relevant design: The trial's 3-drug vs. 3-drug design is more clinically relevant than those with a 3-drug vs. 2-drug design

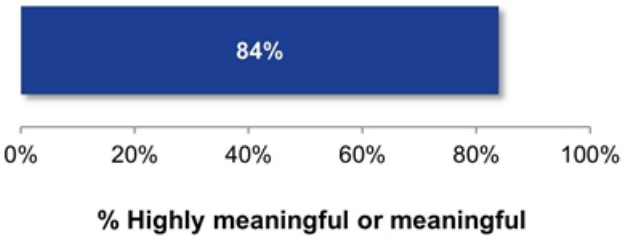


Mean score

4.0

1 = Strongly disagree
2 = Disagree
3 = Neither agree nor disagree
4 = Agree
5 = Strongly agree

Clinically meaningful results: the 8.1% absolute CR difference (*P*=.014) makes Product X the first 5-HT_3 to show superiority vs. another in HEC



Mean score

4.0

Scale 1-5 where 1 is not at all meaningful and 5 is highly meaningful

Source: Instar Market Research, Dec 2015, N=75 oncologists

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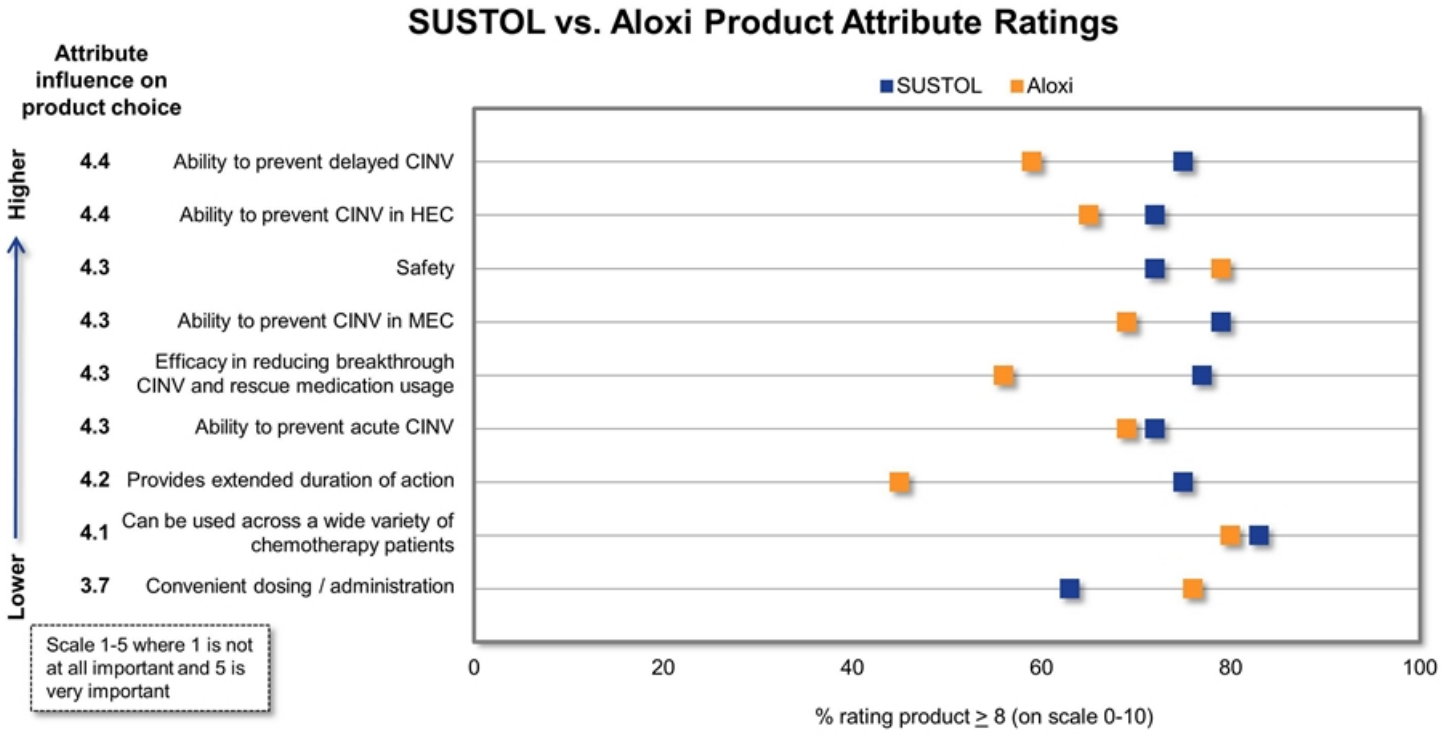
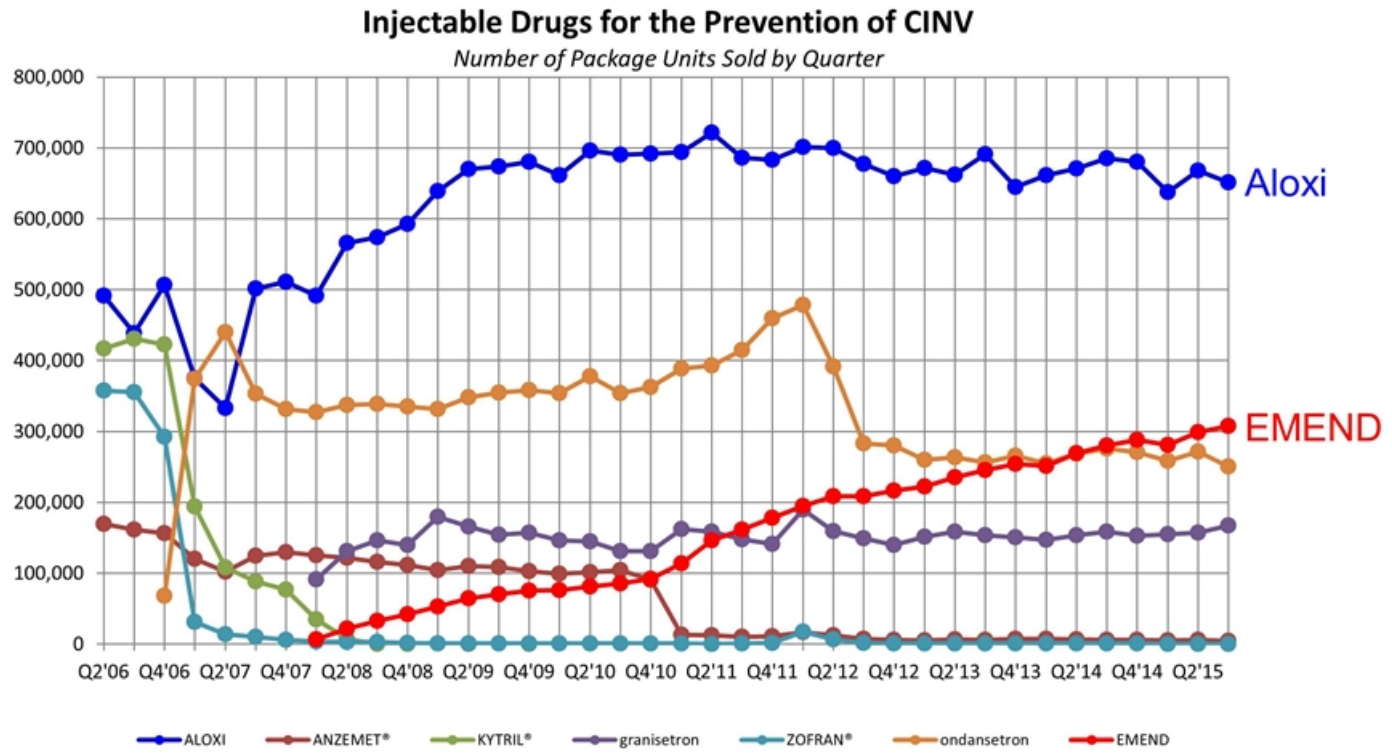
SUSTOL was Rated Higher than Aloxi® on Most Clinical Attributes Including Those That Influence Product Choice the Most



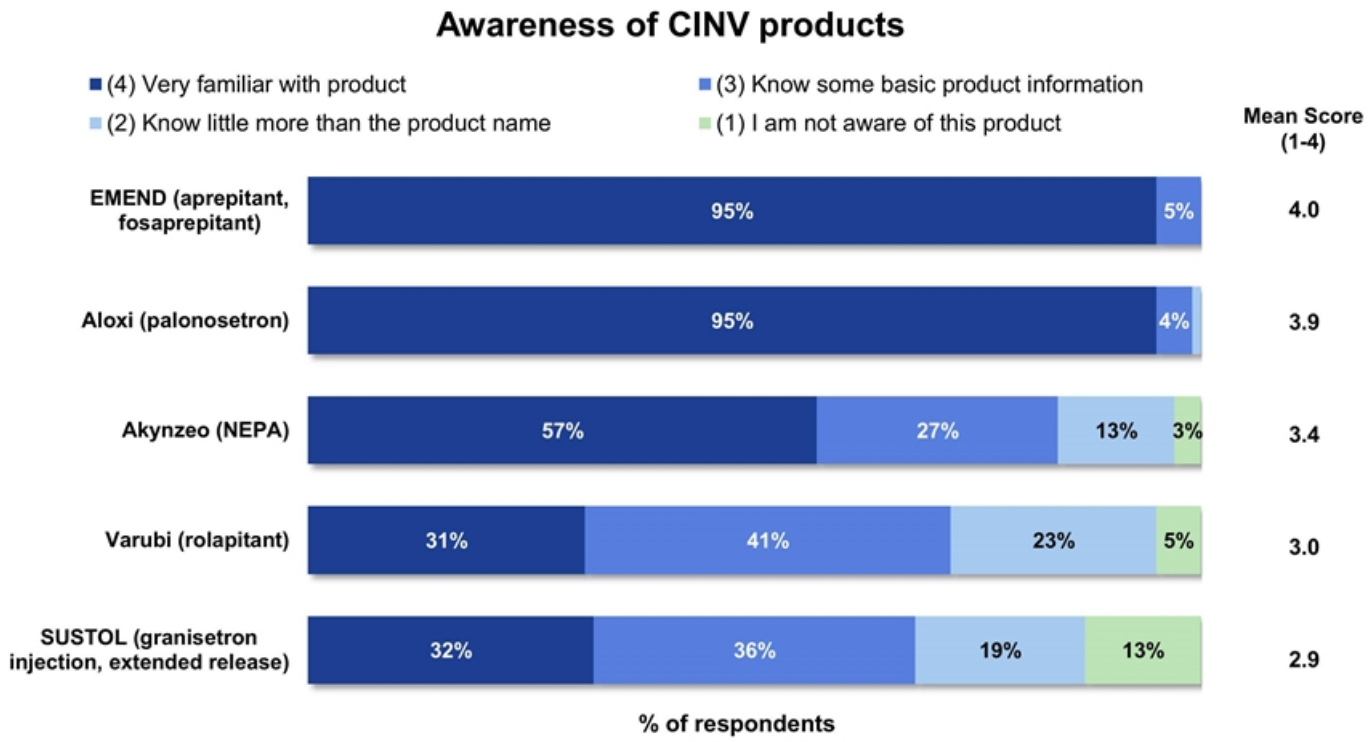
Source: Instar Market Research, Dec 2015, N=75 oncologists

The Branded 5-HT$_3$ Market (Aloxi) Consists of 2.6 Million Units



Source: Symphony Health Solutions data, 2015

Despite No Promotion to Date, Significant Awareness of SUSTOL Exists Among Oncologists Surveyed

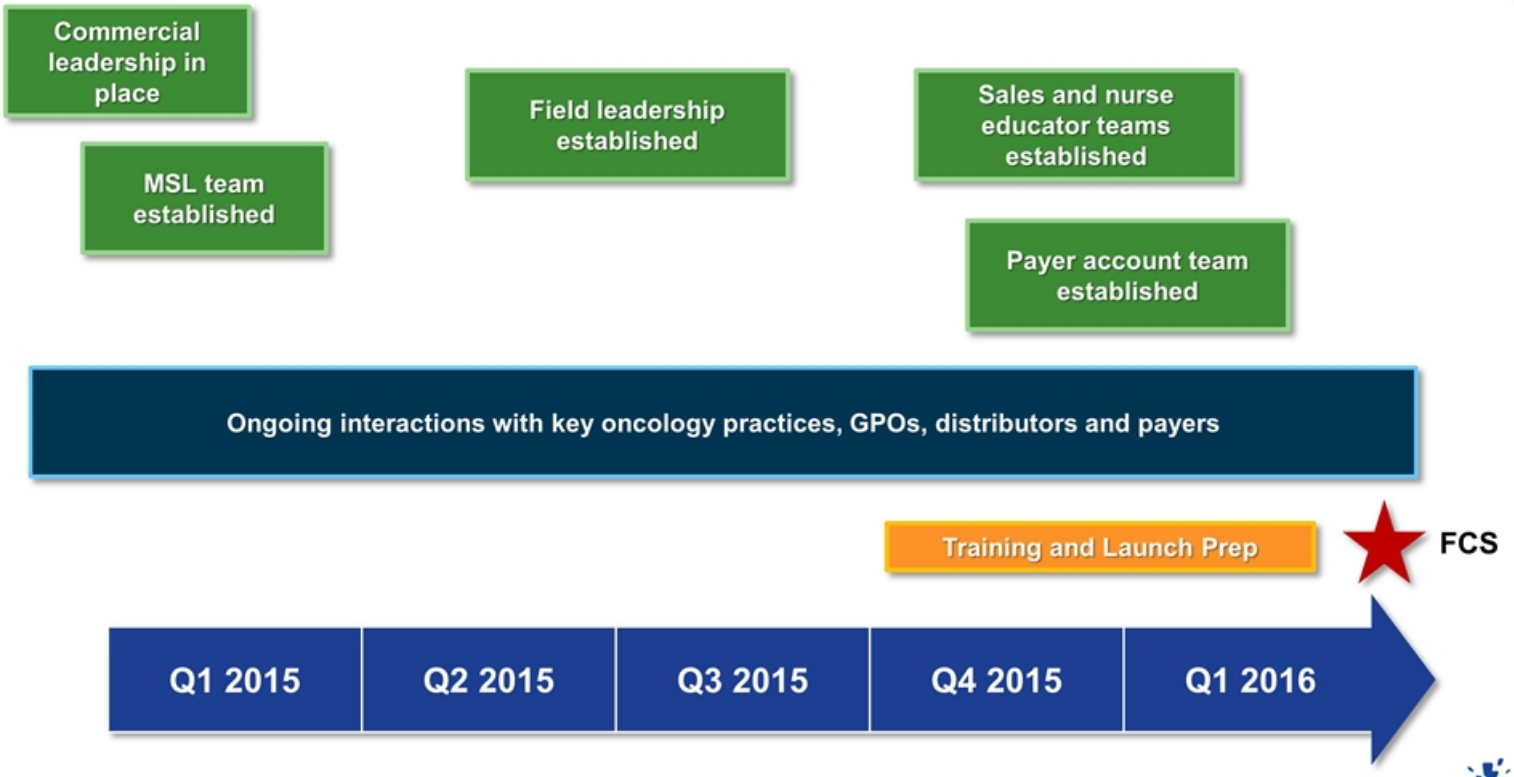


Source: Instar Market Research, Dec 2015, N=75 oncologists

Heron's Commercial Plans will Address Traditional Launch Barriers for Providers, Patients, and Payers

	Objectives	The Heron Approach
Providers	**Establish SUSTOL as preferred agent**	• Differentiated ER technology and broadest clinical data set • Robust in-office and peer-to-peer education via multiple channels • Antiemetic guidelines inclusion
	Create "coverage confidence"	• Best-in-class reimbursement support services • Extended payment terms • Innovative "stand by your drug" program (qualified payer denials)
	Build differentiated value proposition	• Performance-based contract that delivers sustained value
Patients	**Educate & optimize access**	• Comprehensive in-office and on-line educational resources • Zero patient co-pay for commercially insured patients • Strong uninsured patient program
Payers	**Optimize access**	• Compelling value story (clinical data, guidelines, HEOR data) • Proactive payer engagement with traditionally restrictive plans • Engagement between community practices and regional payers

U.S. Commercial Organization Has Been Built and is Poised for Launch



SUSTOL Pricing Strategy Will Consider CINV Product Benchmarks

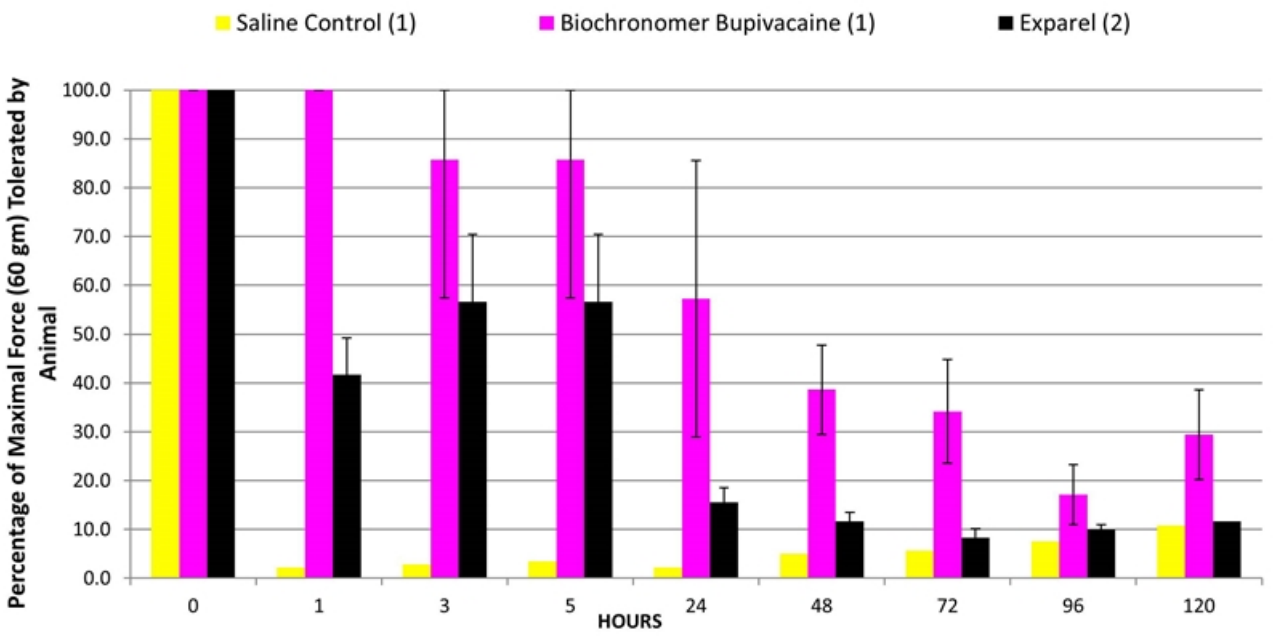
Product	WAC
AKZYNEO (NEPA) (300-0.5mg capsule)	$499.80
EMEND (aprepitant) (TriPack – 1x 120mg and 2x 80mg)	$539.60
VARUBI (rolapitant) (2x 90mg tablet)	$533.00
ALOXI (palonosetron) (0.25mg/5mL vial)	$434.00
EMEND IV (fosaprepitant) (150mg vial)	$268.52

Source: BluePrint Market Research, Dec 2015

POST-OPERATIVE PAIN PROGRAM

Biochronomer® Bupivacaine Superior to EXPAREL® at 24-72 Hours

Pig Post-Operative Pain Model

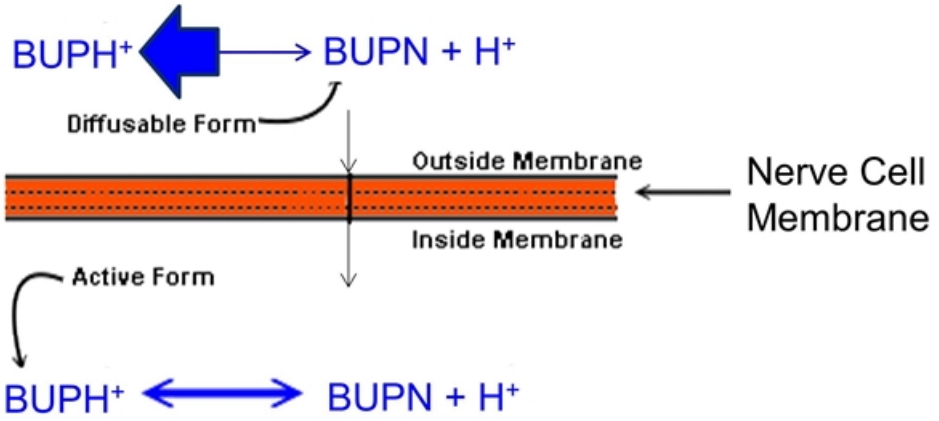


1. Study #1; All studies used the post-operative pain model in pigs from Castle et al, 2013 EPJ
2. Study #2 used the human dose of EXPAREL with 40% smaller incision

(n=4 pigs)

Local Anesthetics Exist in a Balance Between Water-Soluble and Lipid-Soluble Forms

Acidic Environment Shifts the Balance to Ionized Form Unable to Penetrate Nerve Cell Membrane

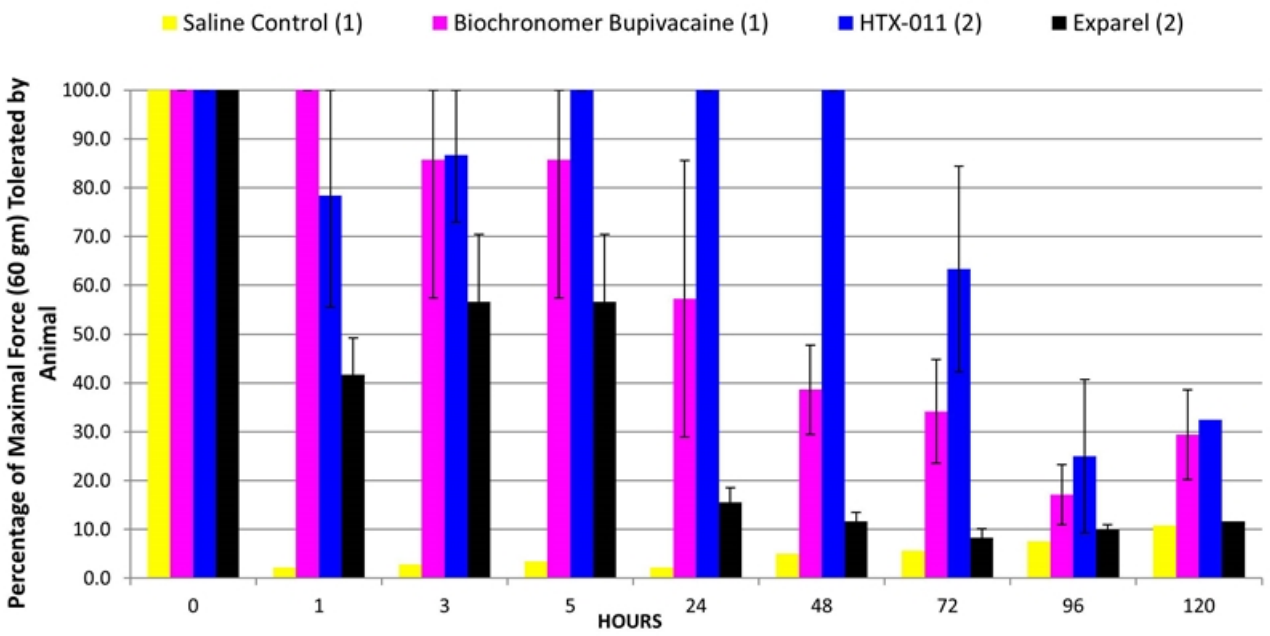


- The acidic environment associated with inflammation shifts the balance further to the left, resulting in far less drug penetrating the nerve membrane and reduced anesthetic effects.
- With a pKa of 8.1, bupivacaine is very sensitive to reduced pH

Local anesthetic nerve penetration model adapted from Becker and Reed, Anesth Prog 53:98–109 2006

HTX-011 Significantly Superior to EXPAREL at 24-72 Hours

Pig Post-Operative Pain Model



1. Study #1; All studies used the post-operative pain model in pigs from Castle et al, 2013 EPJ
2. **Study #2 compared <½ expected human dose of Biochronomer bupivacaine/meloxicam formulation to the human dose of EXPAREL (40% smaller incision used with EXPAREL)**

(n=4 pigs)

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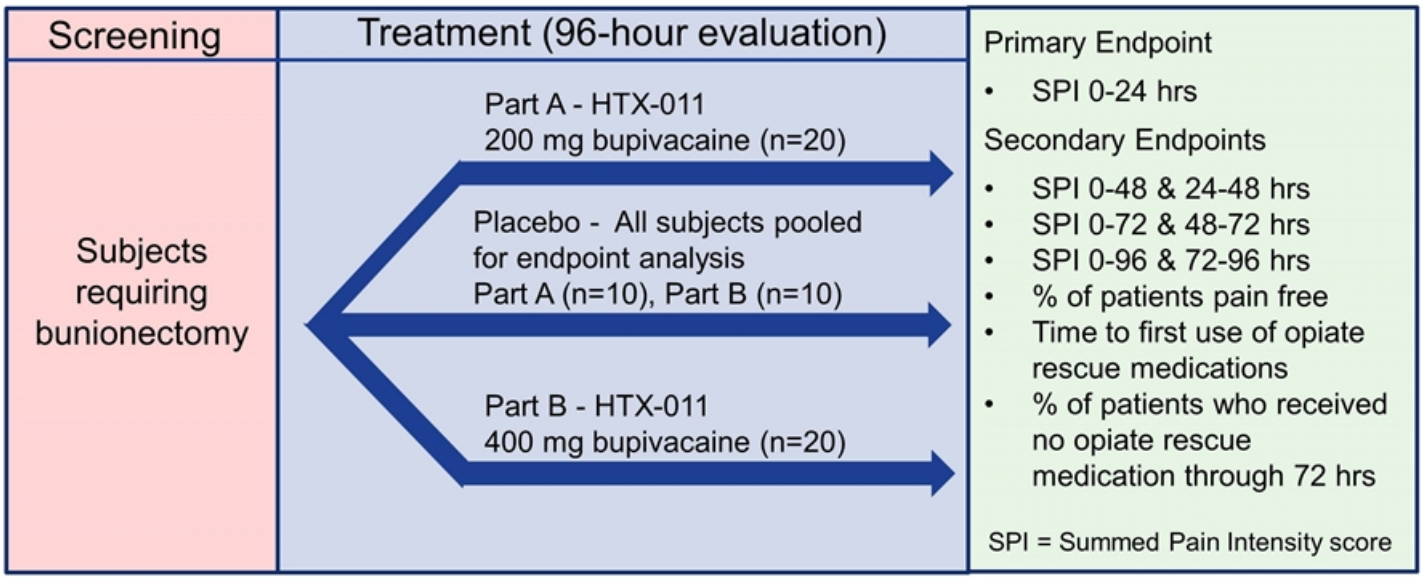
A Randomized, Placebo-Controlled, Double-Blind, Phase 2 Study of HTX-011 in the Management of Post-Operative Pain in 64 Patients Undergoing Bunionectomy

Phase 2a Bunionectomy Study Design



Efficacy assessments:

- Pain intensity scores (NPRS) using 0-10 point scale at 1, 2, 4, 6, 8, 10, 12, 14, 18, 24, 30, 36, 42, 48, 54, 60, 72, 78, 84, and 96 hours after administration of study medication
- Patient's global assessment of pain control at 24, 48, 72, and 96 hours after administration of study medication
- Percent of patients who are pain free, use of rescue medication, and nausea assessments (NNRS) at 6, 24, 48 and 72 hours after administration of study medication

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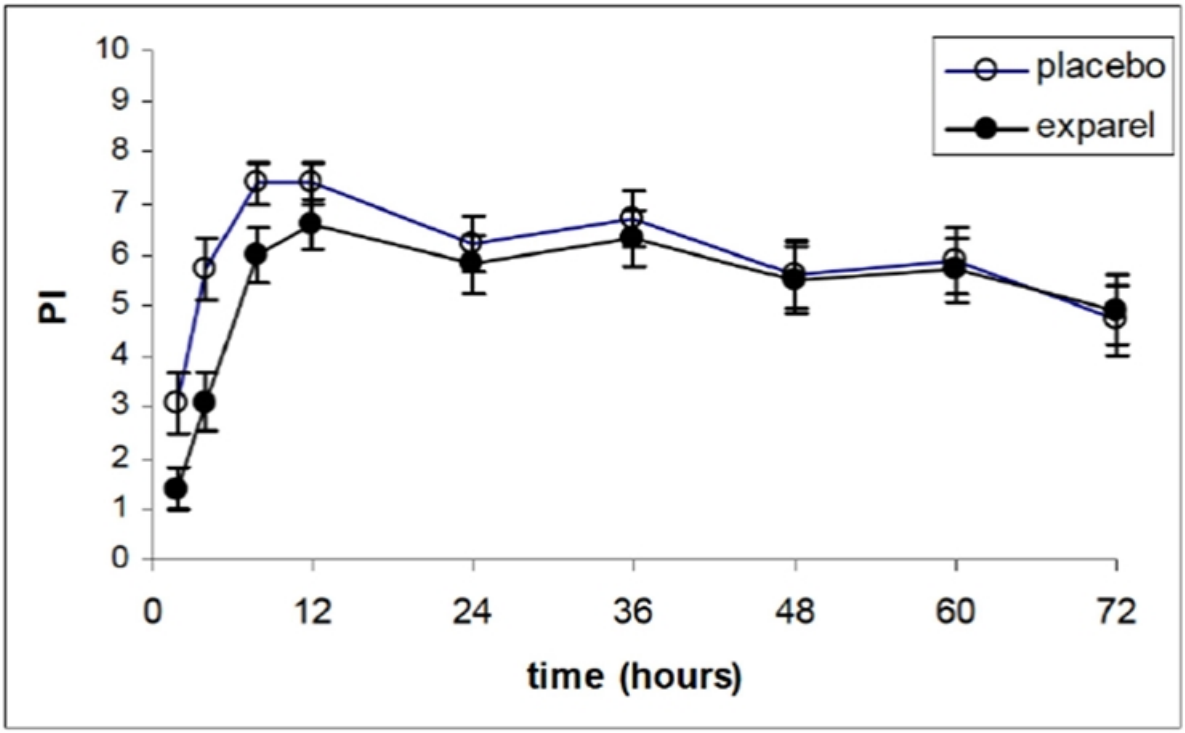
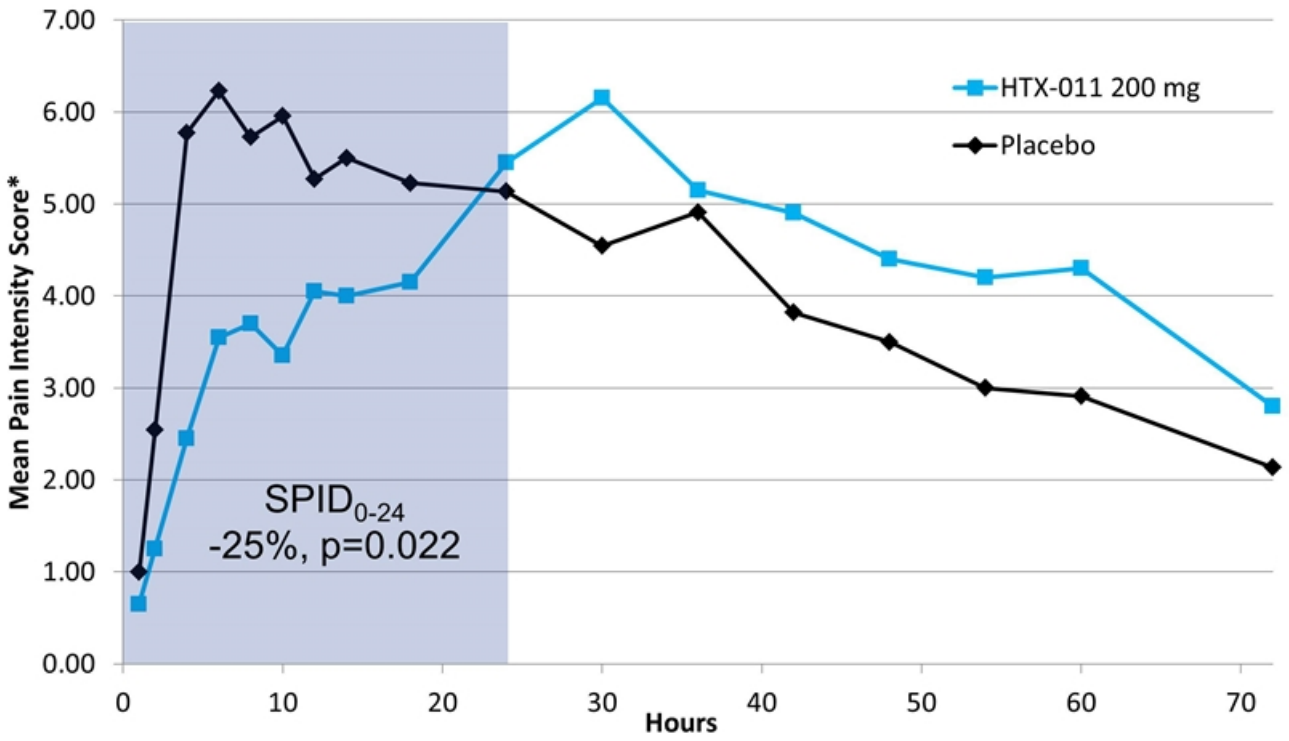
Historical Context: Exparel Pivotal Bunionectomy Study

Figure 2. Mean Pain Intensity versus Time plot for bunionectomy study (C-317)



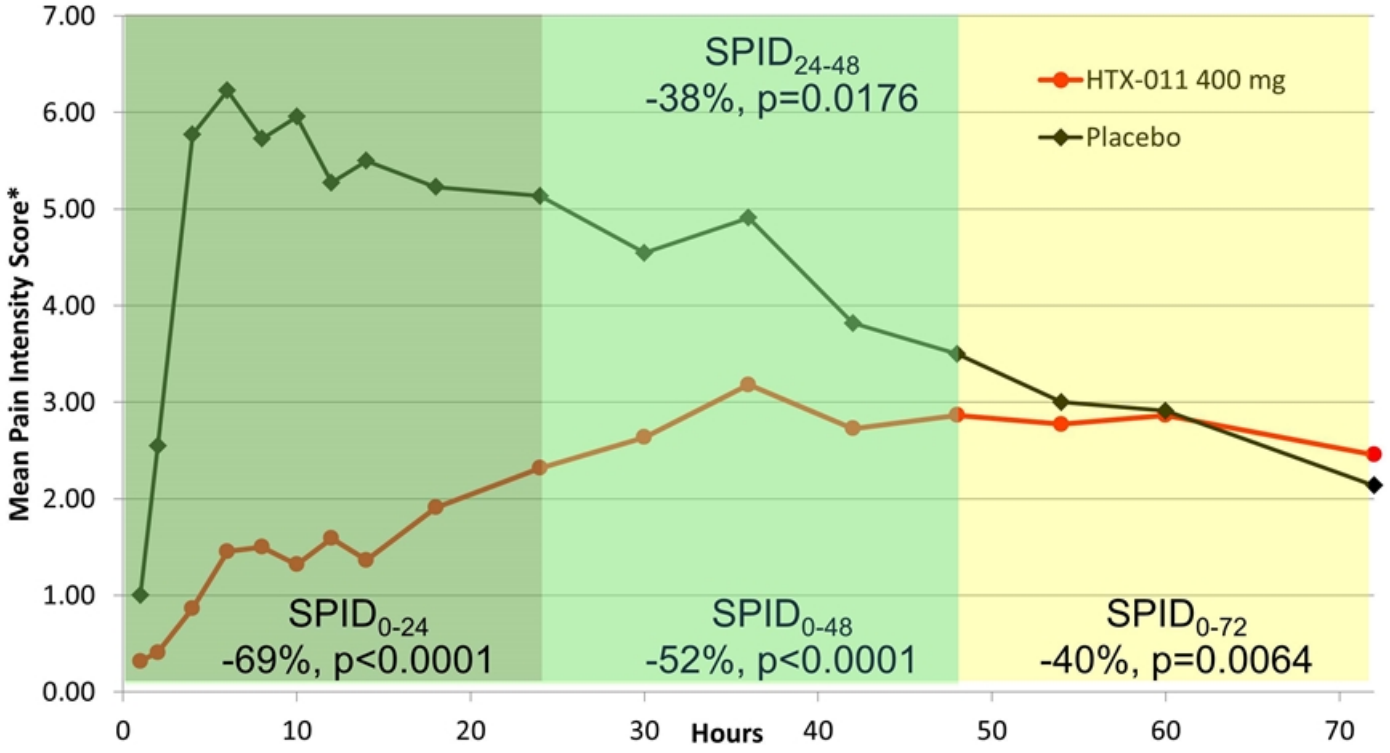
Source: FDA Clinical Review of NDA 022-496, page 48

Pain Intensity Difference at 200 mg



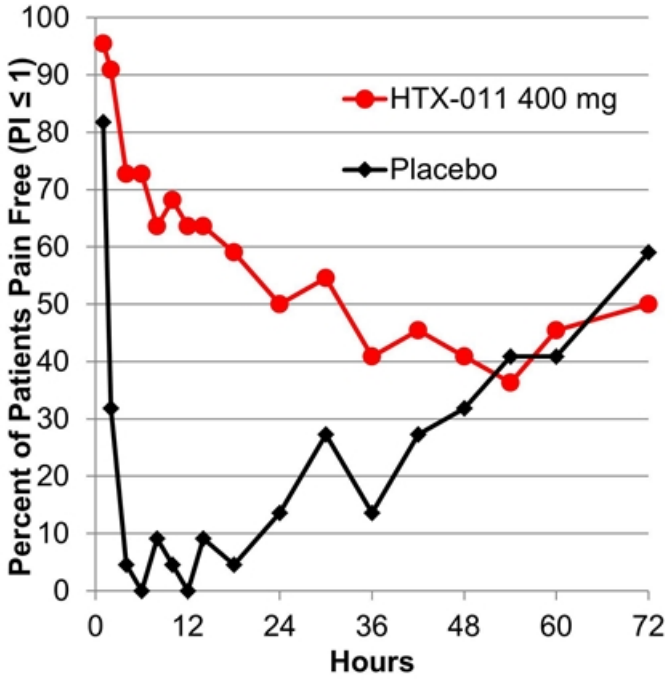
*Standard LOCF method used to account for use of rescue medications from *Golf et al, Adv Ther, 28(9):776-788, 2011*

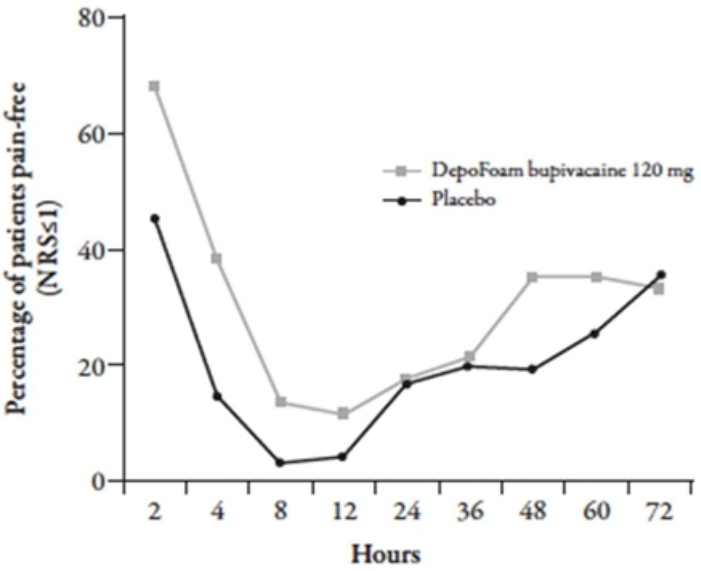
Pain Intensity Difference at 400 mg



*Standard LOCF method used to account for use of rescue medications from *Golf et al, Adv Ther, 28(9):776-788, 2011*

Historical Context: Percent of Patients Pain Free, Cross-Study Comparison to Exparel





Source: Golf et al, Adv Ther, 28(9):776-788, 2011

Mean Time to First Use of Opiate Rescue Medication

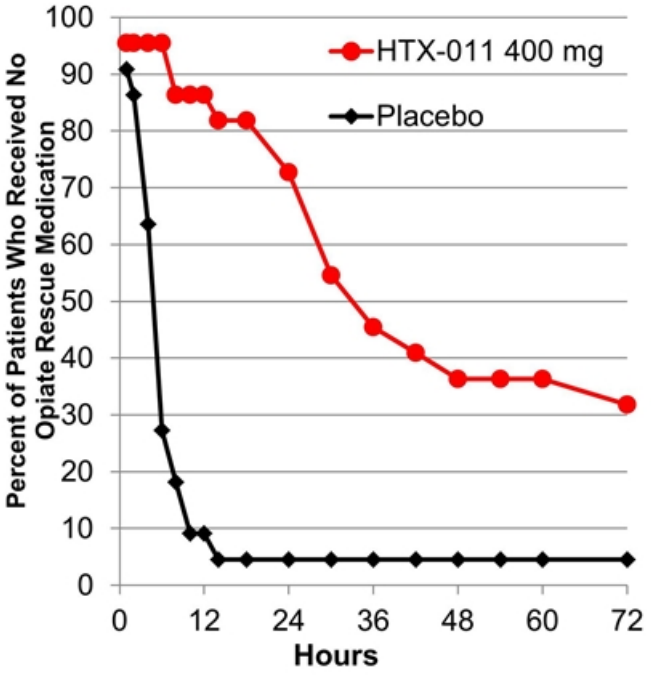
- 488% longer time to first use of rescue medications with 400 mg dose compared to placebo

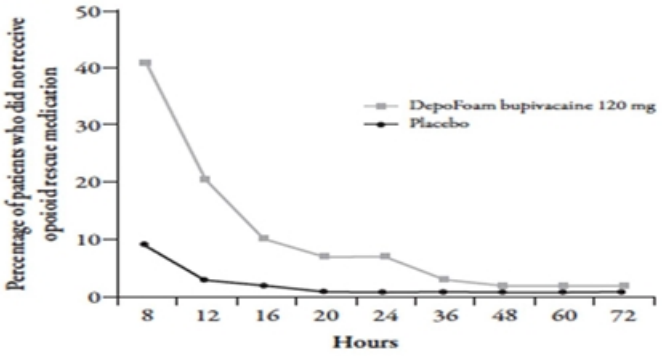
Placebo	HTX-011 200 mg	HTX-011 400 mg
8.2 hours	20.8 hours p=0.15	48.2 hours p<0.0001

Cross-study comparison: Mean time with Exparel was 7.2 hours versus 4.3 hours on placebo

Source: Golf et al, Adv Ther, 28(9):776-788, 2011

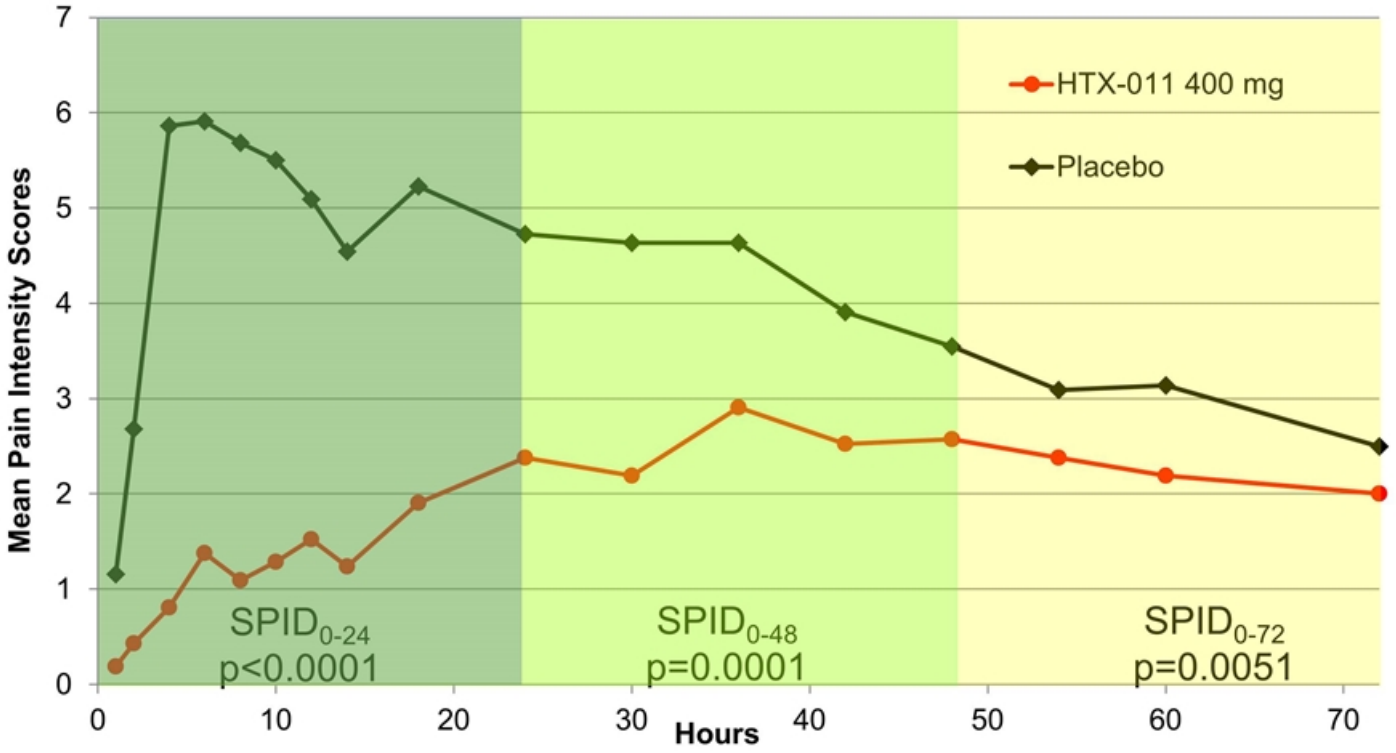
Historical Context: Percent of Patients Who Received No Opiate Rescue Medication, Cross-Study Comparison to Exparel





Source: Golf et al, Adv Ther, 28(9):776-788, 2011

Pain Intensity NOT Adjusted for Opiate Use: HTX-011 Significantly Better Than Unlimited Opiates*



*Patients were permitted to take 5 mg oxycodone every 2 hours as needed for pain; data not adjusted for opiate use

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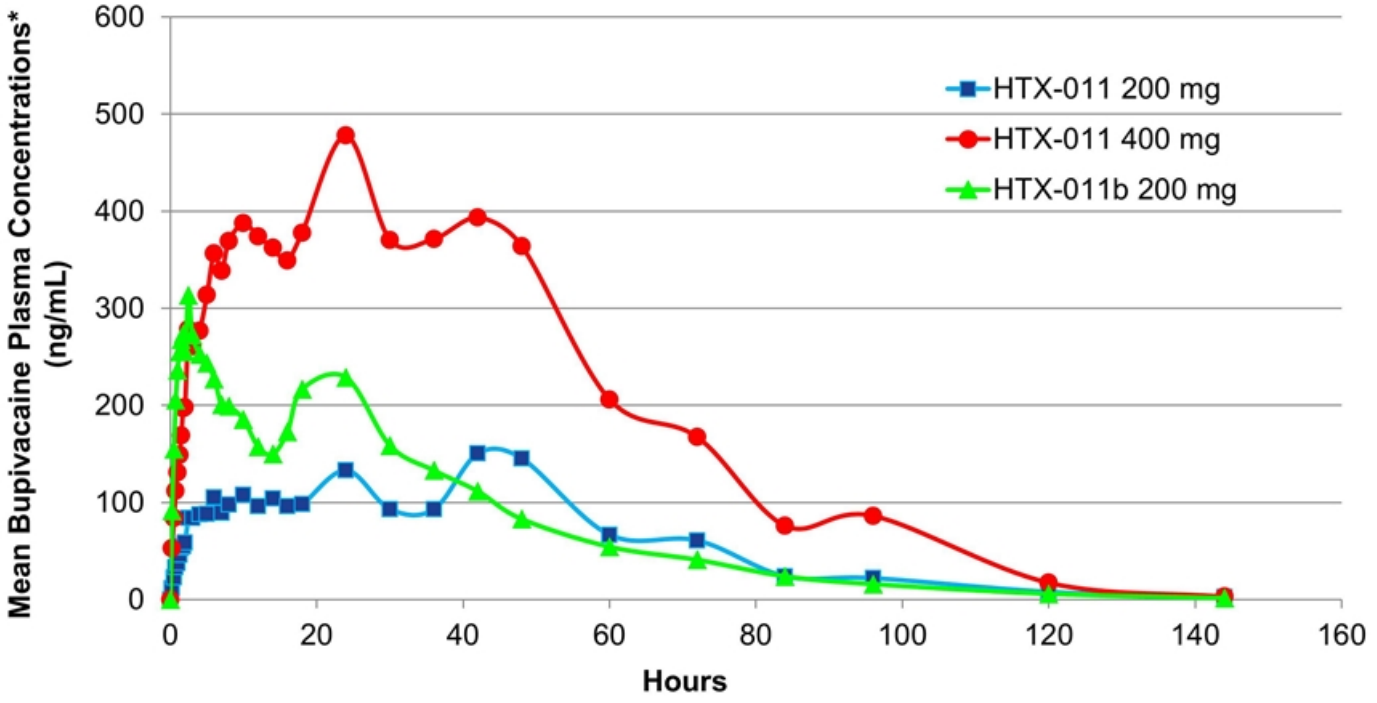
Preliminary Safety

- HTX-011 was generally well tolerated
- The most common adverse events were: headache, nausea, vomiting, constipation, erythema, cellulitis, dizziness, and hypoxia, none of which were considered drug-related

HTX-011b: Second Formulation with Distinct Properties

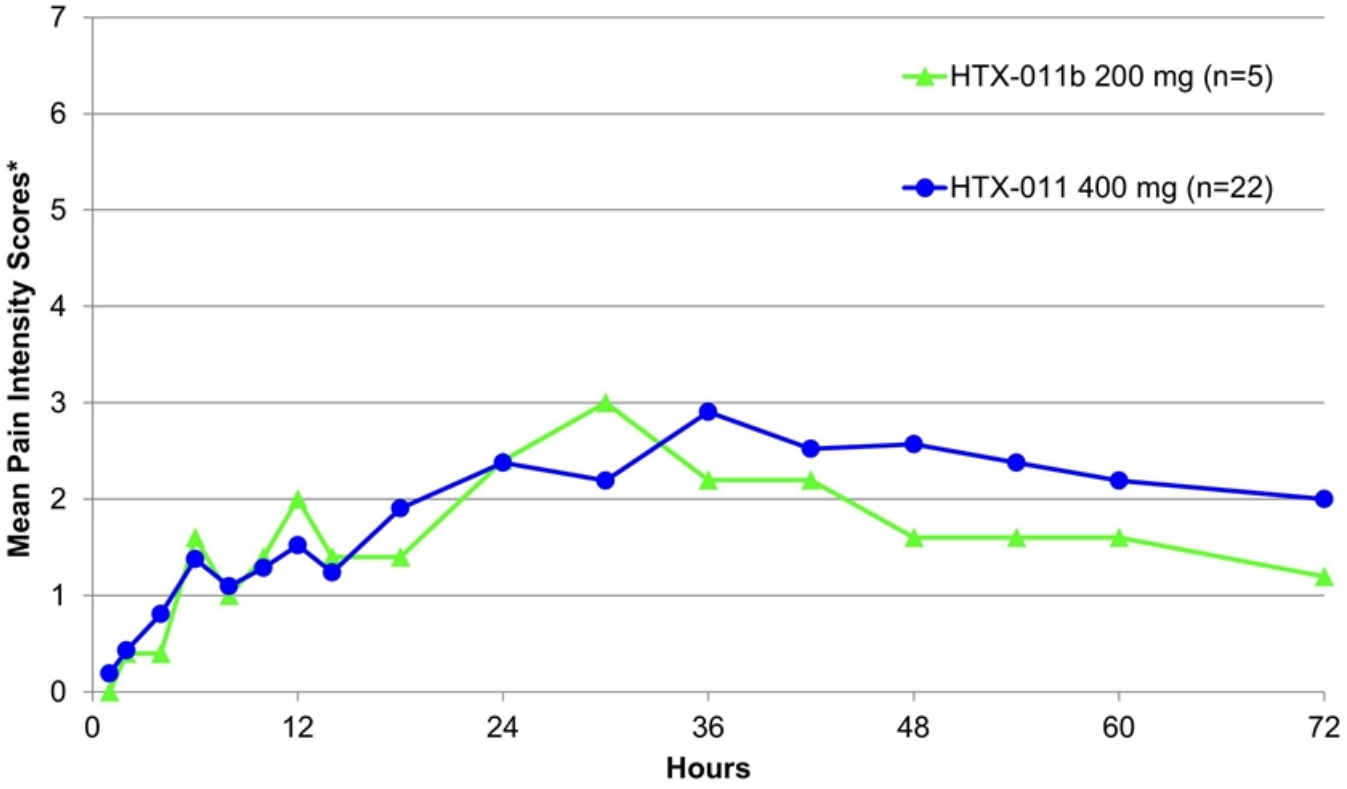
- HTX-011b is our second formulation with greater volume (potentially up to 20 ml)
- Phase 1 study in healthy volunteers showed:
  - Therapeutic drug levels achieved faster
  - Higher drug levels achieved
- First cohort of Phase 2 study in 5 patients undergoing bunionectomy demonstrated 200 mg of HTX-011b comparable to 400 mg of HTX-011

HTX-011b is a Higher Volume Formulation (Potentially up to 20 ml)



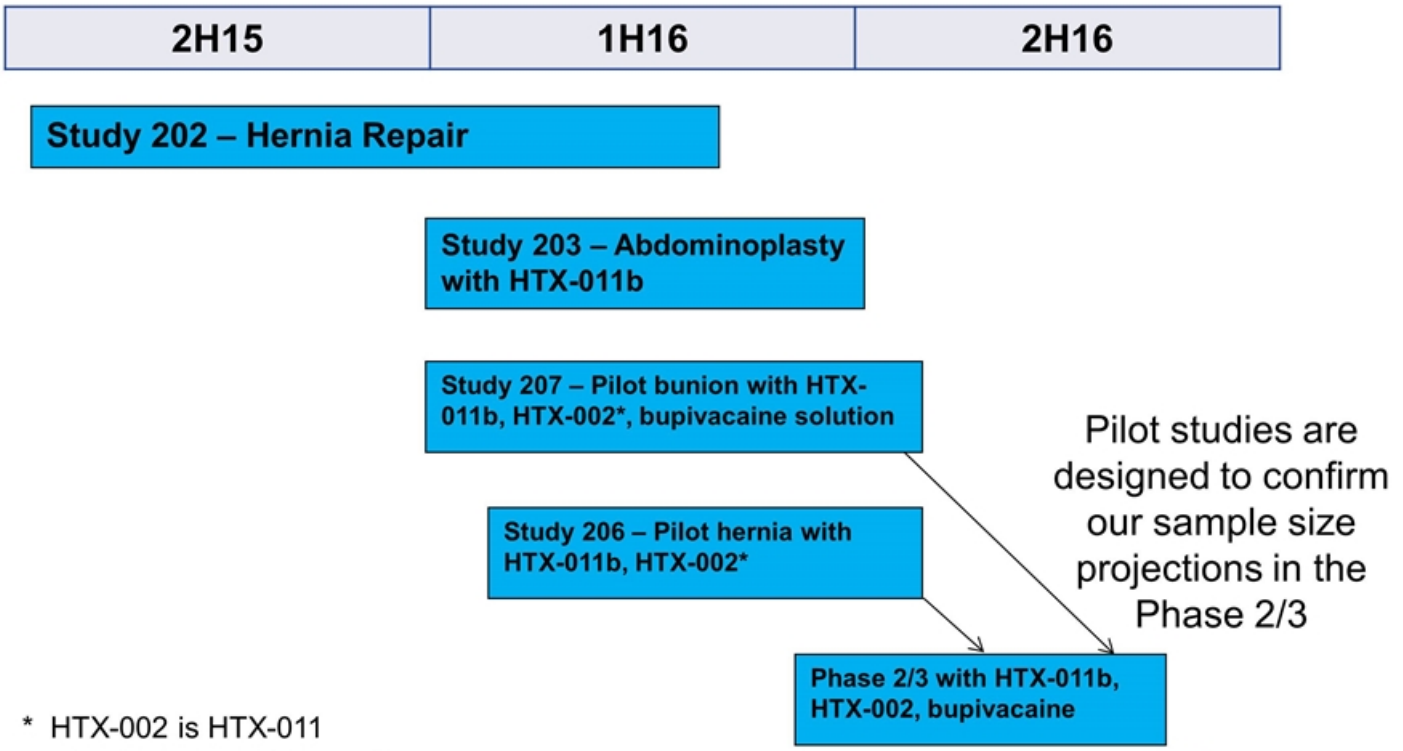
*From Phase 1 Study in healthy volunteers

Pain Intensity:
HTX-011b 200 mg vs. HTX-011 400 mg



*Not adjusted for use of rescue medications

HTX-011 Clinical Development Program



* HTX-002 is HTX-011 minus the meloxicam; will be added to protocols by amendment

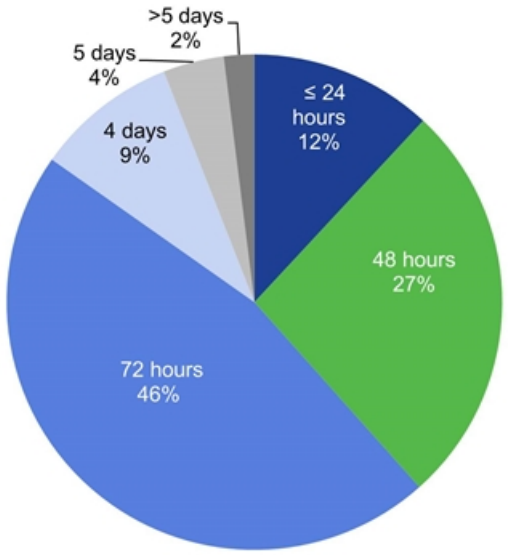
Long-Acting Injectable Products Contain Many Times the Single Dose
HTX-011 is at the Low End of the Range

Short-Acting Injectable Drug	Indication	Maximum Approved Daily Dose	Long-Acting Injectable (LAI) Drug	Maximum Approved LAI Dose	Maximum LAI Dose vs. Maximum Short-Acting Daily Dose Ratio
Sandostatin	Acromegaly	150 mcg	Sandostatin LAR	20 mg Q4W	**133.3**
Byetta	Diabetes	20 mcg	Bydureon	2 mg QW	**100.0**
Lupron	Prostate cancer	1 mg	Eligard	45 mg Q24W	**45.0**
Sandostatin	Carcinoid tumors	600 mcg	Sandostatin LAR	20 mg Q4W	**33.3**
Abilify	Schizophrenia	30 mg	Aristada	882 mg Q4W	**29.4**
Nutropin	Pediatric growth hormone deficiency	0.1 mg/kg	Nutropin Depot	2.25 mg/kg Q2W	**22.5**
Invega	Schizophrenia	12 mg	Invega Sustenna	234 mg Q4W	**19.5**
Zyprexa	Schizophrenia	20 mg	Zyprexa Relprevv	300 mg Q2W	**15.0**
Abilify	Schizophrenia	30 mg	Abilify Maintena	400 mg Q4W	**13.3**
Provera	Endometriosis	20 mg	Depo Provera	200 mg Q4W	**10.0**
Naltrexone	Alcohol and opioid dependence	50 mg	Vivitrol	480 mg Q4W	**9.6**
Risperdal	Schizophrenia	16 mg	Risperdal Consta	50 mg Q2W	**3.1**
Mean					**36.2**

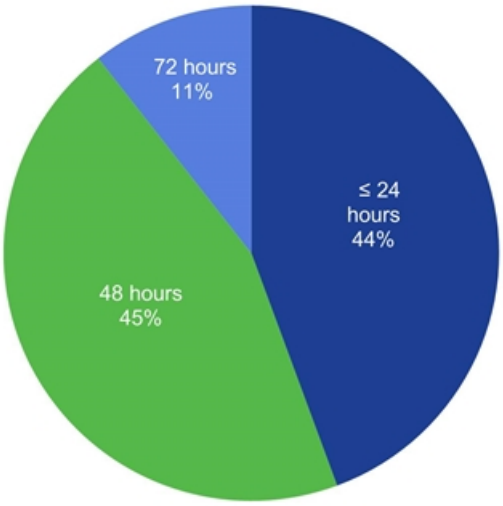
Bupivacaine	Post-operative pain	175 mg	Exparel	266 mg	**1.5**
Bupivacaine	**Post-operative pain**	**175 mg**	**HTX-011**	**400 mg**	**2.3**

≥ 72 hour Duration of Action Seen as "Ideal" by Physicians, With 48 hours Minimally Acceptable

***Ideal* Duration of Efficacy for Long-Acting Local Anesthetic**



***Minimally Acceptable* Duration of Efficacy for Long-Acting Local Anesthetic**



Source: Decision Resources Post-Operative Pain Physician Research Initiative 2014 (N=30 qualitative interviews; N=184 quantitative survey)

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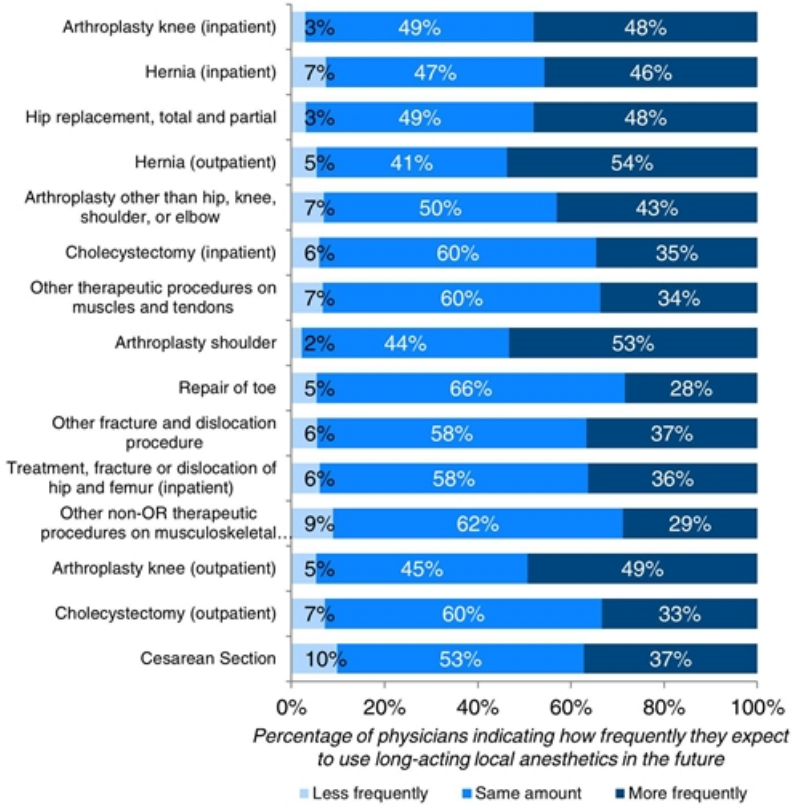
Across Procedures, Many MDs Expect the Use of Long-Acting Local Anesthetics to Increase

Use of Long-Acting Local Anesthetics in the Future, by Procedure



"Minimizing opioid use by using long-acting local anesthetics is the trend. I think the long-acting local anesthetics have great promise in the future."
– General surgeon

Source: Decision Resources Post-Operative Pain Physician Research Initiative 2014 (N=30 qualitative interviews; N=184 quantitative survey)

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Financial Summary

- $128.2M raised June 2015 (net proceeds)

Summary Statement of Operations (In thousands, except per share data)	Nine Months Ended September 30, 2015
Revenue	$ –
Operating expenses	65,865
Other income (expenses)	(484)
Net loss	$ (66,349)
Net loss per share[1]	$ (2.07)

Condensed Balance Sheet Data (In thousands)	September 30, 2015
Cash and cash equivalents	$ 152,989
Total assets	$ 158,151
Total stockholders' equity	$ 141,701

[1] Based on 32.1 million weighted average common shares outstanding for the period ended September 30, 2015

Condensed Balance Sheet Data – December 31, 2015

Condensed Balance Sheet Data (In thousands, Unaudited)	As of December 31, 2015
Cash and cash equivalents	$ 131,000

Current cash resources expected to fund operations through 2016, including potential SUSTOL commercial launch