

Inovio Pharmaceuticals, Inc.
Q2 2019 Earnings Call
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Executives

Ben Matone, Director of Investor Relations
J. Joseph Kim, Chief Executive Officer, President and Director
Peter Kies, Chief Financial Officer

Analysts

Pete Stavropoulos; Cantor Fitzgerald & Co.
Shawn Egan; Citigroup Inc.
Ellen Sands; Stifel, Nicolaus & Company
Gregory Renza; RBC Capital Markets

Presentation

Operator: Good day, and welcome to the Inovio Second Quarter 2019 Financial Results Conference Call.

(Operator Instructions)

Please note this event is being recorded.

I would now like to turn the conference over to Ben Matone, Director of Investor Relations. Please go ahead.

Ben Matone: Thank you, operator. Good afternoon, and welcome to the Inovio Pharmaceuticals second quarter 2019 investor conference call. With me today are Inovio's President and CEO, Dr. J. Joseph Kim; and our Chief Financial Officer, Peter Kies.

Today's call is being webcast live, and a replay of today's call will be made available on our website, ir.inovio.com. Following a general business update, we will conduct a question-and-answer segment, which will be reserved for equity research analysts.

During the call, we will be making certain forward-looking statements that relate to our business, which include our plans to develop our immunotherapy platform in combination with our proprietary delivery devices as well as developments and timing of certain clinical data readouts and our capital resources.

All of these statements are based on the beliefs and expectations of management as of today. These statements involve certain assumptions, risks and uncertainties and could cause actual results to differ materially. We assume no obligation to revise or update

forward-looking statements whether as a result of new information, future events or otherwise. Investors should read carefully the risks and uncertainties described in today's press release, as well as the risk factors included in our filings with the SEC.

I would now like to turn the call over to our President and CEO, Dr. J. Joseph Kim.

J. Joseph Kim: Thanks, Ben. Good afternoon, everyone, and thank you for joining us. We recently spoke with you regarding the company's realignment last month, and while I intend to provide some updates since our call, I will focus on major accomplishments and developments of the second quarter, as well as the major value drivers that we expect to deliver before year-end.

As we stated during our last conference call, the recent realignment will enable Inovio to focus on 2 main areas -- first, HPV immunotherapies, and second, accelerating product candidates which hold a potential for an expedited time to market.

Let's begin with the first area, HPV immunotherapy. Staying on the commercial path for VGX-3100, last quarter, we announced the completion of our target enrollment of 198 patients for REVEAL 1, bringing Inovio another step closer to providing an innovative treatment alternative to the patients suffering with high-grade cervical dysplasia. In regard to the confirmatory portion of our Phase 3 program known as REVEAL 2, enrollment is ongoing and on track. We are utilizing the top-performing sites from REVEAL 1 and we also expect to expand recruitment for REVEAL 2 outside of the U.S. Our goal is to submit the BLA in 2021.

In May, we announced a very important and exciting collaboration with QIAGEN to develop a pretreatment biomarker diagnostic kit for VGX-3100 based on the REVEAL 1 and REVEAL 2 studies. Together with QIAGEN's extensive experience in cervical cancer and HPV-related molecular testing, we're building a liquid-biopsy-based complementary diagnostic that will identify patients who would most benefit from VGX-3100. Having the ability to offer this diagnostic kit for screening patients would greatly enhance the commercial utility and profile for Inovio's HPV therapy.

Further complementing VGX-3100 are our Phase 2 trials for high-grade vulvar and anal pre-cancers associated with HPV. Just this past month, we completed the full enrollment of patients in our Phase 2 trial for vulvar dysplasia. The primary endpoint of this study is histologic clearance of high-grade lesions and virologic clearance of HPV virus in vulvar tissue samples. Let me remind you that there are no FDA-approved nonsurgical treatments for high-grade vulvar dysplasia, and surgical treatment can severely impact quality of life, and recurrence after surgery is observed in over 50% of the patients. As for the anal pre-cancer Phase 2 study, we're also nearing complete enrollment as well. Mark your calendars; before the end of this year, we'll get back to you with interim data from both our VIN and AIN trials.

We are also pleased to say that AstraZeneca has completed the planned enrollment of the Phase 2 study of MEDI0457 in head and neck cancer, and they expect to complete this

study by August 2020. Inovio received a third Phase 2 milestone payment from AZ last quarter from a dosing of a patient with the third HPV-related cancer indication. Two previous milestone payments resulted from initiating Phase 2 combination trials targeting head and neck cancer and cervical cancer. AstraZeneca continues to expand and evaluate MEDI0457 in 3 different Phase 2 trials.

Rounding out my remarks on our HPV immunotherapy platform, we have deployed our resources to rapidly advance INO-3107 to treat RRP, or recurrent respiratory papillomatosis. RRP is a rare orphan disease caused by HPV 6 and 11 infections, for which Inovio recently demonstrated clinical benefit in a pilot study. Surgery is the current standard of care, and if left untreated, RRP obstructs air pathways and impairs vocal ability of the patients. The problem is that the RRP almost always recurs after surgery. In fact, 2 patients in our pilot study required surgery every 6 months prior to our treatment. After the treatment, 1 patient was able to delay surgery for over 18 months, and another patient remains surgery-free for almost 3 years and counting. In addition to adults being affected, RRP symptoms are often even more severe in children, so taking overall prevalence rates of roughly 20,000 people in the U.S., as well as the disease occurrence among pediatrics, we're planning to meet with the FDA before year-end to determine the best path forward for INO-3107, where ideally we would look to evaluate both adults and pediatrics in a Phase 2 clinical study. The near-term goal for us is to initiate the next clinical trial of INO-3107 before mid-2020.

As we continue to build off our prior efficacy and clinical results, we feel Inovio has the proper resources to bring these multiple HPV therapies to market, which provides ultimate validation of our technology and increases near-term value drivers.

Turning now to our oncology combination programs. As part of our sharpened clinical strategy, we announced that Inovio will focus its INO-5401 development efforts on treating glioblastoma multiforme, or GBM, while discontinuing our I-O study in advanced bladder cancer. We will continue to follow the patients who are already enrolled from the bladder study and share any important or relevant data in the future. For GBM data, we anticipate progression-free survival at Month 6 results to read out in November, followed by overall survival data next year. If positive, given the extreme medical need and lack of effective treatments for GBM, we believe INO-5401 immediately becomes a fast-to-market candidate, while additionally giving a boost to the company's strategy combining our T-cell-activating immunotherapy with checkpoint inhibitors.

During our last call in July, I mentioned that we are advancing a novel cancer combination trial with the Parker Institute for Cancer Immunotherapy. I am now able to share that as part of Inovio's clinical collaboration agreement with Parker and the Cancer Research Institute, Inovio's prostate cancer product, INO-5151, will be combined with Celldex Therapeutics' FLT3 ligand and Bristol-Myers' PD-1 checkpoint inhibitor, nivolumab, targeting metastatic castration-resistant prostate cancer.

Just remember, INO-5151 is a formulation that combines INO-5150 with INO-9012.

Specifically, this trial is an open-label, nonrandomized, exploratory platform study consisting of 3 different cohorts that are designed to assess the safety and antitumor activity of multiple immunotherapy-based combinations in participants with metastatic castration-resistant prostate cancer who have received prior secondary androgen inhibition. INO-5151 is being utilized in 1 arm, specifically Cohort C, of this Parker-supported study.

Our Phase 1 data for INO-5150 in prostate cancer, including T cell responses and limiting PSA increase, played an important role in encouraging the Parker Institute to select our DNA-based therapy for this innovative combination trial that targets a major unmet medical need. We're very excited to see this study get started, as this trial helps to further complement our thesis of combination therapies in treating cancer while also demonstrating how Inovio's working with top cancer immunotherapy pioneers to investigate the potential significance of our T-cell-activating immunotherapy in an innovative immuno-oncology combination regimen.

This development speaks to our sharpened focus and cost-effective strategy in cancer. Why? Because Inovio maintains 3 shots on goal incorporating our immuno-oncology combo strategy, and we have established partnerships with leaders in the field to fully fund 2 of them. AstraZeneca is funding their MEDI0457 trials and Parker is fully funding our combo prostate program. Of the 3 approaches currently being evaluated in clinical studies, Inovio's only financially responsible for INO-5401 in GBM, which is being done in collaboration with Regeneron Pharmaceuticals.

Collectively, we feel Inovio maintains an important presence for developing novel therapies for cancer within areas that build upon positive Phase 1 data from MEDI0457 in HPV-related head and neck cancer patients while also targeting high-risk, high-reward cancer candidates like GBM. Taken together, our programs highlight the synergistic effect of combining our T-cell-activating immunotherapy with checkpoint inhibitors.

Certainly there is more work to be done and data to be shown, but we're in a great position with multiple shots on goal within I-O while being fiscally responsible and efficient.

Staying on the theme for game-changing cancer therapies, I'm also pleased to say that last quarter, 3 clinical data results for Inovio's transformative dBTE technology were published in *JCI Insight*. This new application of our platform dramatically improves the current shortcoming of BiTE, or bispecific T-cell engager, technology. The currently approved BiTE product has only a few hours of half-life in patients and requires several weeks of continuous intravenous infusion. Inovio developed a novel dBTE targeting the HER2 molecule, which was tested successfully in therapeutic models for treatment of ovarian and breast cancers. More importantly, a single injection of the HER2 dBTE candidate produced bispecific antibodies that lasted for several weeks in the bloodstream of mice and effectively killed HER2-expressing tumor cells, resulting in a near-complete tumor clearance. These results open up a new cancer therapy platform for Inovio, and we plan to rapidly advance dBTE products alone and with partners.

Before I turn it over to Peter for a financial update, I wanted to provide a brief update on our infectious disease programs as this still continues to be an important pillar for our technology and global business strategy.

In May, we dosed the first subjects in a Phase 1 first-in-human clinical trial to evaluate INO-4500 to prevent infection from the Lassa fever virus. This study, which is fully funded through a \$56-million global partnership with CEPI, plans to enroll approximately 60 volunteers in a placebo-controlled, blinded, dose-escalation study in the U.S. Excitingly, this trial represents the first Lassa candidate vaccine to enter the clinic. In a previously published paper, we reported that INO-4500 provided 100% protection in nonhuman primates challenged with a lethal dose of Lassa virus in a study funded by a \$3.5-million grant from the NIAID. Leveraging results from our current clinical study, we expect to advance this Lassa vaccine candidate into a Phase 2 field trial in endemic countries of West Africa in 2020.

Moving to our MERS vaccine. We recently announced positive results that were published in *The Lancet Infectious Diseases*. Impressively, INO-4700 was advanced into the clinic within 9 months of vaccine candidate selection, the first MERS vaccine to be tested in humans. Looking ahead, we're planning to initiate a larger Phase 2 trial in the Middle East in 2020 through our partnership with CEPI, based on Phase 1b/2a data for INO-4700 from Korea.

Lastly, and as it relates to continued innovations associated with our delivery technology, in June, we announced that the medical arm of the U.S. Defense Threat Reduction Agency, or DTRA, will fund the further development of our new commercial intradermal delivery device. The DTRA will provide \$8.1 million to support Inovio in developing our battery-powered intradermal device branded as CELLECTRA 3PSP to be used in the administration of our vaccines and therapies. The CELLECTRA 3PSP is a small, portable, user-friendly device which will allow broader access to Inovio's vaccines and immunotherapies, whether the vaccine is administered to our troops ready to be deployed around the world, at a local pharmacy or in challenging settings such as rural Africa. So while we did narrow our resources and focus within infectious diseases, we will continue to utilize and embrace our previously established global partnerships for the development of both vaccines and delivery devices.

With that, I will now ask our CFO, Peter Kies, to provide a financial update. Peter?

Peter Kies: Thanks, Joseph, and good afternoon, everyone. As of June 30, 2019, cash and short-term investments were \$106 million, compared to \$128 million for the previous quarter. Total revenue was \$136,000 for the 3 months ended June 30, 2019, compared to \$24.4 million for the same period in 2018. Total operating expenses were \$28.3 million for the 3 months ended June 30, 2019, compared to \$29.7 million for the same period in 2018.

Net loss for the quarter ended June 30, 2019, was \$29.4 million, or \$0.30 per share basic

and diluted, compared to \$6.6 million, or \$0.07 per share basic and \$0.08 per share diluted for the quarter ended June 30, 2018. The year-over-year decrease in revenue and an increase in net loss was primarily due to the recognition of the gross upfront payment from ApolloBio of \$23 million during the second quarter of 2018.

In July, we announced a strategic organizational restructuring to focus on the commercial development of our late-stage HPV assets and reallocate capital to develop fast-to-market product candidates. We have cut selected early-stage R&D programs and discontinued further development of our Phase 1/2 study in advanced bladder cancer while reducing our annual burn by 25% and our workforce by 28%.

Earlier this week we announced the closing of a private placement of convertible bonds with an aggregate principal amount of approximately \$15 million issued to institutional investors led by Korea Investment Partners. We expect to use these proceeds for the continued advancement of development activities for our clinical-stage product pipeline, working capital and other general corporate purposes. You can read the details in our 10-Q.

As a reminder, our financial statements for the second quarter of 2019 can be found in today's press release and in our Form 10-Q, filed with the SEC. This can also be accessed on our website under Investor Relations, Financial Reports.

Thank you, and back to you, Joseph.

J. Joseph Kim: Thanks, Peter. Inovio's product candidates address important medical needs globally. We conduct our trials across 5 continents and partner with organizations with both regional and global reach.

In coordination with the private placement that Peter just shared with you, we also announced this week our intent to pursue a dual listing of Inovio securities on the KOSDAQ market of the Korean Exchange in the form of Korean Depositary Receipts, or KDRs. Just focusing on the private placement, I want to highlight that this investment is from fundamental long-only institutional investors led by Korea Investment Partners, and while I can't say too much at this time around our pursuit of a KOSDAQ listing, I can make 2 points. First, we remain committed to our primary listing on the NASDAQ exchange. Second, the Korean capital market and investors represent an expanding opportunity for Inovio to secure an additional and attractive new source of capital while also building on our extensive business development efforts in Asia. Given our history of strategic partnerships and clinical development in Asia, especially in Korea, this opportunity will expand Inovio's presence in Asia and in particular capture the increased market opportunity for HPV-caused diseases while advancing our goal on becoming a global contributor to fight against cancer and emerging infectious diseases.

Now I look forward to taking your questions. Operator, please open the line for the analysts.

Questions and Answers

Operator: (Operator Instructions)

Our first question comes from Charles Duncan of Cantor Fitzgerald.

Pete Stavropoulos: Hi, this is Pete Stavropoulos on for Charles. A couple of questions. For -- in reference to REVEAL 2 study, you had previously mentioned that you're exploring with your partners in China, ApolloBio, about the possibility of adding sites to boost recruitment efforts. Can you provide us with any updates on those efforts?

J. Joseph Kim: Yes, ApolloBio has announced that they have submitted an IND with Chinese FDA, or the Chinese regulatory agency. So we're waiting to hear from the regulators in China. And we're doing a lot of the background work. So while all efforts will be provided and expanded to see if we can bring in Chinese sites and patients to our REVEAL 2 study, that would have a positive impact to Inovio in terms of our timeline. It would also accelerate ApolloBio's efforts to apply for product licensure in China as expediently as possible. So we think this is a way for us to kill two birds with one stone or have our cake and eat it too. So more to be reported when it's ready.

Pete Stavropoulos: And for VGX-3100, beyond the current Phase 3 studies, what work is completed or being completed to support an NDA, like tox studies, which I know you have plenty, or manufacturing scale-up for commercial batches?

J. Joseph Kim: Yes, so we're doing all of that. So we're preparing for manufacturing PPQ runs. We have potency assays validated. We have other pro-tox and other pre-BLA preparations ongoing at the same time. So behind the scenes, that hasn't been that public, besides REVEAL 1 and REVEAL 2 studies. There's a lot of moving parts, I would say, in a well-oiled fashion that will support our launch when our clinical results come in.

Pete Stavropoulos: All right, and one last question for the RRP program. I'd just like to get your perspective and thoughts. Those 2 patients who had these strong durable responses, do you think that they had a complete viral clearance, or do you believe, like, the immune system kind of keeps the infection in check? And sort of leading into, in other words, if you think there would be additional benefit to boosting these patients with additional doses of 3107 now?

J. Joseph Kim: Yes and yes, meaning we're not 100% sure whether we have cleared the virus. We don't think that's as important as delaying or eliminating surgery over time. So yes, we want to be as ambitious as possible in this arena. We'd also like to bring the product to the market as soon as possible, and while I can't speak too definitively until we get the concurrence with the FDA that we hope later this year, we expect to provide a booster shot every few months in these patients. Because the name of the game is to make sure that the RRP does not come back. So currently, as I mentioned, surgery is only temporary. The RRP almost always -- and maybe I'll just say always -- comes back. So having an immunotherapy that can be provided in a very tolerable fashion, that keeps

RRP from coming back, I think that's a huge win for the patients and great step forward in terms of commercially for our shareholders as well.

Operator: Our next question comes from Joel Beatty of Citi.

Shawn Egan: Joseph, this is Shawn Egan calling in for Joel. I have a few on your liquid-biopsy-based companion diagnostic. Maybe could you just provide, like, a high level on what specifically this is evaluating? Are you looking at circulating tumor cells or is it more kind of HPV in general? And then also, will you be validating this in REVEAL 1 and 2, and is it your expectation that this could be included on the label?

J. Joseph Kim: The last question first, no, we don't think it's going to be in the label itself. It's going to be filed as a complementary kit. Now, to give a little more insight, this is a pretreatment biomarker, and we don't want to give out too much, but these were the diagnostics that we were able to discover utilizing the Phase 2b data set from the patients and -- in a postop analysis. Currently, QIAGEN is validating those results, in their hands. And we will utilize the validated kits to test our REVEAL 1 and REVEAL 2 samples from our Phase 3 studies. We will be utilizing those data, or QIAGEN will be utilizing those data, to submit a diagnostic application that should nearly concurrently go in with our BLA application for VGX-3100. So this is a true collaborative effort between Inovio and QIAGEN, and we're very excited to have such a very well-experienced and resourced partner to help us develop this diagnostic kit.

Shawn Egan: Perfect. And then as a brief follow-up, could you maybe provide an update on 2 of your infectious disease programs that you didn't mention, the HIV eradication study and also the Zika Puerto Rico study? Will we be getting data for those in 2019 as well?

J. Joseph Kim: Yes. So for those 2 studies, Zika first. The Zika (indiscernible) study, our partner, GeneOne Life Science, is in charge of running those assays and providing those results, so we are waiting for them to provide that. In terms of the HIV therapeutic study, those trials are -- trial is enrolling and those assays are also getting done. So we expect sometime later this year or early 2020 we will be able to report on safety and immune responses from our HIV therapy study that's being funded fully by a grant from the National Institute of Health. So we're very excited about those, and as soon as we have those data, we will present those and release that, either as a publication or a conference presentation.

Operator: Our next question comes from Stephen Willey of Stifel.

Ellen Sands: Hi, this is Ellen on for Steve. So I'm wondering, what does the bar look like for PFS and OS in the GBM study? What would you need to see to move this trial forward and to constitute success in this setting? Thanks.

J. Joseph Kim: Yes, thanks, Ellen. So the true bar that we want to see, the needle-mover, is an improvement in overall survival. Mean overall survival of 3 months or more in this,

newly diagnosed GBM patients, would have us do backflips and really move the program fast to market. In terms of progression-free survival, at 6 months, we expect pretty high levels. And PFS-6 is going to just provide an entry, an early look, into an efficacy. So we don't think that's end-all-be-all, but that's the beginning of a road that leads to the overall survival numbers that we expect in 2020.

Now, remember, we fully enrolled the 52-patient GBM study a full 3 months ahead of our very aggressive schedule, so we think we're on track to get to the data as excitedly and expediently as possible, but it's a very difficult disease to treat. What that provides, also, is the bar to show improvements over this dire disease with very little effective treatment options provides us with a great opportunity, and I think we have a great shot at showing the survival improvements, certainly in 2020. And what we hope to see in the fourth quarter this year will just provide a window to a potential efficacy data that we hope to see in 2020.

Ellen Sands: Okay, great. And do you expect to communicate that data via a medical conference or would it likely be in the form of a press release? And I'm talking specifically about the PFS update expected in November. And then I have one follow-up, thanks.

J. Joseph Kim: Yes. For this data, as well as any other data, our preference always is to present our data at a conference presentation or a medical journal publication of substance. So that would be our preference. But obviously we would do a press release along with that. Will we ever do a press release as a standalone? Yes, if the conference schedule doesn't really fit our business needs, we could also choose to do that, but that's not our preference. We'd like to present at a cancer conference in the fall or winter this year.

Ellen Sands: Okay, great, thanks. And then with regards to dBTE program, how confident are you around the safety profile of that program as you think about moving it into development in the future?

J. Joseph Kim: Yes. So there's 2 parts to the safety question. So the first part is, is our DNA-based technology safe? And the answer to that question is a resounding yes. And that's based on over 2,000 patients with 7,000 different administrations' worth of data from the clinical trials of our platform over the last several years, without a real safety signal coming from over 2,000 subjects and patients. So the platform part of that we're not concerned about.

The bispecific T-cell engagers carry, as a whole class of cancer compounds, a certain level of toxicity concerns. Now, as you're force-fitting T cells with cancer and binding them together by force with double-sided tape or double-sided antibodies, you are bound to see some safety signals. Now, could we ameliorate that using our DNA technology? That's what we're doing, and since we have been developing this platform, since our presentation at AACR, since our *JCI Insight* publication, we have been working very hard to find the best candidate to move forward, number one, and get the clarification

from the FDA which candidate and what type of toxicity profile is amenable for dBTE technology.

So we have a team that's really dedicated in providing the right answers. My gut feeling is the BiTEs overall are going to compete very, very well to comparable technologies like the CAR-Ts, which have the safety and tox concerns of their own. And also, using our dBTE technology, we'll be able to show the superior both efficacy and safety profiles going forward, and I'm very excited to bring our first program as a harbinger for our whole platform of dBTEs behind it, in the next several quarters. So we're going to take some time, but move them as quickly as possible, knowing the safety and efficacy spectrum that we're going for.

Operator: Our next question comes from Gregory Renza of RBC Capital.

Gregory Renza: Joseph, I just wanted to start on the AIN and VIN 3100 programs that you indicated for interim data before year-end. Could you just touch a little bit more about, perhaps, the timing there and the potential venue? And also, what, if possible, could we expect to look out for? Thank you.

J. Joseph Kim: Yes. Thanks, Greg. VIN, we completed enrollment of a 33-patient study about a month ago. AIN, we are about to complete the enrollment of 24 patients soon. So we're on track to maybe have about 50% of each study. These are open-label studies, as you know, looking at the lesion regression as well as viral clearance from these patients, similar to our Phase 3 study for cervical dysplasia.

In terms of the venues, just to repeat what I said earlier, to Ellen's question, our preference will be to present at conferences, and there are several in the late fall, winter, that we could fit for VIN and AIN indications. So we're in the process of investigating those venues in the coming months.

Gregory Renza: Got it. And just a follow-up on the timing there, just with respect to the 24-patient AIN, and perhaps noticing that that trial, on clinicaltrials.gov, was pushed out a few months -- perhaps the VIN was actually pushed forward a bit. Just talk a little bit, if you could, about each of those indications and some of the nuances between the two. Thank you.

J. Joseph Kim: Yes, absolutely. Both VIN and AIN are orphan-designated indications, right? So -- with high unmet medical need. Surgery is the only treatment option available today, and it's highly disfiguring, and the quality of life is low with those surgeries. And there's very high recurrence rates for VIN and AIN. And that seems to be the theme for all of these HPV-caused diseases, where we think, based on our Phase 2 data from our cervical dysplasia study where we've shown we can regress the lesions and viral -- clear the virus as well, we think we have the solution at Inovio utilizing our immunotherapies to first clear the disease but also clear the virus that caused the disease in the first place and limit any reoccurrences, as possible.

So that's the consistent theme for CIN. That's a consistent theme for our vulvar and anal dysplasia, and, as a matter of fact, that's the consistent theme for head and neck cancer with our partner AstraZeneca, as well as RRP, where -- and in particular with RRP, the true clinical indication could be a delay or avoidance of surgery, because it's such a horrible disease where you have to have repeated surgeries, sometimes 4, 5, 6 times a year or more, for many of these patients.

So back to AIN and VIN, what we see is a high unmet medical need. We hope to show that our immunotherapy can treat the disease and potentially clear the virus that caused -- the underlying cause of the disease as well.

Gregory Renza: Great, thank you. And lastly from me, on the pursuit of the dual listing, why now? What is the logic behind it? What are you seeing in the market that's prompting you to pursue this? And what is Inovio, in its current state, perhaps, its current global reach, lacking that this will actually enable to enhance? Thank you very much.

J. Joseph Kim: Yes, thank you. Great question. So why now? We've always been a globally phased company. All of our trials have been done in multiple regions, including North America, but also in Asia and Africa and Europe as well. From our global reach of our business development, our very last deal was with ApolloBio for VGX-3100 in Asia, for China, specifically. We have done multiple co-development deals in Korea. We have received multiple grants and contracts that are globally phased organizations like CEPI, Gates and others.

Why Korea? Korea has incredibly vibrant biotech investment market. Quotes from the capital markets for public companies as well as the private venture capital investor communities, they're mostly long-only, very little shorts, in small and medium capital market for biotech companies, which will be fabulous here as well.

But we're not going to neglect our NASDAQ listing. So let me just say that our primary listing is going to be on NASDAQ. By nature, our primary investor and shareholder base is going to be U.S. institutional investors. And by the way, we just peaked over 50% in institutional holding of our shareholder makeup, and that's the first time in our corporate history. So we will continually cater to and listen to the needs and wishes of our institutional investors in the U.S. and elsewhere, but what Korea provides opportunity for us is a new avenue of long-only investors who have a lot of investing capital available, and biotech valuations; our peers listed on KOSDAQ exchange, has much more attractive valuation profile as well.

So I think that those are several reasons for us. Additional streams of capital, better and more attractive valuations and cost of capital, and our ability to expand and build on our business development focus. In Korea, we expect to see potentially multiple deals with Korean potential partners. China, we're going to leverage on what we've already done with ApolloBio, potentially do additional deals, and we don't want to neglect Japan and other areas in Asia either. So we think this is an untapped market for what Inovio is, which is a company that focuses on treating diseases, cancer and infectious diseases,

globally.

Operator: This concludes our question-and-answer session. I would like to turn the conference back over to Dr. J. Joseph Kim for any closing remarks.

J. Joseph Kim: Thank you, everyone, for your questions and continued interest. Have a nice evening.