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Health and Life Sciences Rx PODCAST

EPISODE 9: CHOOSING THE RIGHT BIOTECH EXIT STRATEGY

INSIGHTS FROM THE BDO CENTER FOR HEALTHCARE EXCELLENCE & INNOVATION AND LIFE SCIENCES PRACTICE

INTRODUCTIONS

Steven: The final panel is choosing the right biotech exit strategy. And, well, we've seen IPOs, M&As, partnerships, licensing agreements, etc. There's just a huge, varied number of opportunities for biotech companies out there. In this session, we've got a great panel that are going to discuss all the exits and growth opportunities, and what makes sense, what doesn't make sense, and what the specific company's needs are. So, we're going to cover these key challenges and roadblocks, through some real-life examples and lessons learned. Moderating this panel is my colleague Todd Berry, who is the co-leader of our National Life Sciences practice, and he's joined by Claudia Mitchell, the chief operating officer of Universal Cells, a Seattle-based biotech and an Astellas company, and Lindsay A. Rosenwald, chairman, president and chief executive officer of Fortress Biotech, who also sits on the board of numerous companies in the industry. And lastly, Krist Werling, a partner at McDermott Will & Emery and the co-chair of the firm's Life Sciences practice. So, let's get the conversation started.

Todd: All right, well, welcome to our esteemed panelists and I think what we're going to try and do is keep this to sort of 45 minutes. We do have lunch waiting in the wings, so we'll move it along. As Steven said, really what the topic is today is to talk about exits. There are various forms of exits that you can think of in terms of M&A and IPO. I for one don't believe that an IPO is necessarily an exit, but Lindsay, I know you've got a unique platform that you've got at one of your companies, and so I'd love to hear [about] that. But I think the first question is really pretty basic, so we just want to ease into this, and then we'll talk about risks and alternative strategies as we get on into it. But generally speaking, from your different perspectives, what

TOPICS DISCUSSED INCLUDE:

have you seen and what are the trends in terms of typical exits today? And then maybe take us to what you think the trends are going forward.

CURRENT EXIT TRENDS [02:45]

Lindsay: Sure. So, I guess it depends on the stage of development of the company. Most exits are sales to large pharma and large biotech companies. We certainly have never viewed an IPO as an exit. I guess if you're a VC and a company goes public then that could be an exit if you're not a controlling shareholder. But for operators like us, and controlling shareholders, or larger shareholders that sit on the boards, the IPO is just another funding mechanism and not at all an exit.

Todd: Okay. Krist?

Krist: Yeah, and in that sale to a large pharma, even many of those transactions are not full exits. In that, in my work as a mergers and acquisitions lawyer in the biotech and pharma industry, we're frequently selling a product where some amount cash is received on the closing date, but there's hundreds of millions of dollars that is paid in the back end. So, even that level of exit on a closing date is not a true exit because you need to monitor that product development through clinical and through commercial launch for three, five, 10 years to get that full cash. So, I think a theme that you will hear from the panel is that these are all really iterations of different financing events to get extraordinarily costly therapies out to patients that need them.

Lindsay: I agree that it's not an exit in that it's over and done. But again, from an operator's standpoint, the good news is when you sell something, even with a backend and things like that, at least for you, the hard part is over. Now, it's up to them [the buyer].

Claudia: As a founder of a biotech company who recently exited, throughout the life of our company as an independent company, my thoughts were choosing between M&A and IPO as an exit, as a founder and CEO, and I did exit. I still remain. I did that because I do believe in the product that we're developing, and I wanted to stay but it was definitely an exit for us. And all employees did cash out their stock options, so, it was an exit for everybody in the company. Financial exit. But everybody remained. That was also the interesting part, we kept all our employees.

CHOOSING THE RIGHT EXIT [05:16]

Todd: And so, there are myriad of different avenues we can go down, whether it's selling to a strategic, to a financial buyer, IPO, M&A, license, milestone, etc. So, I think we all know that things change in this industry. If there's one constant, it's change in the industry. And so, when you think of starting out in the lab and getting it through preclinical, clinical and eventually to launch, there's a lot of stuff that happens there. There's the regulatory environment, there's market environment, there's data coming out of the lab, and it changes, right? So, I'm sure there's an evolution of 'Well, what is the best strategy to choose to exit,' right? So how do those dynamics affect your reasoning or your ability to choose which exit? How do you choose?

Lindsay: Well again, from my perspective, mine has always been sales to large pharma and large biotech. And what we look for is first, hire a banker, see what level of interest there is. It's two things you look for, the highest price, but you're also looking, especially if there's going to be backend, for the company that's most likely to do the best job. So, for instance, when we sold Cougar [Biotech] to J&J, we thought the drug would be a $700-$800 million a year drug. J&J wasn't the highest bidder, but they knew the drug well, and we felt that they would do the best job selling it. Last quarter for them, the drug sold a billion dollars for them, in just a quarter, so that made a big difference.

Todd: What precipitated that sort of change?

Lindsay: In what?

Todd: In the difference in the valuation.

Lindsay: Two things. Number one, when you talk to the management, they understood the market better. There's a prostate cancer drug. They had a good presence there. And also, they were smart enough to really want to keep the senior management. And a lot of times when you sell a drug to a big company, they'll take the drug and get rid of you. Other times, they want people to stay because they're much closer to it, and they really wanted these people to stay. They really were making a big commitment to the program, and that was really important to us.

Claudia: For me, choosing the right exit, it's a matter of combination, it's a timely thing. It's a combination at a certain point of time how your internal aspects of a company, where you're at, and your development combined to the stages in the market. So, for example, how's the M&A market, how's the IPO window? Is that open or not? So, it's always a combination, and you have to be fortunate to be at the right place at the right time. So, your product, or you have to be at an inflection point that allows you to be looking for an exit at the time when either the IPO window is open, or the M&A market is very hot. For us, the decision to sell was because we were at an inflection point where we either would raise more capital and then further dilute and have to wait a number of years before we could realize the same gains that we were going to realize at that sale. So, we sold early. Our company was only four and a half years old, but it was the

right time because if we hadn't sold at that point we would have to raise capital, take all the risk, and we made the calculation that the probability of us having the same kind of return after the new raise and taking all the risk would only happen if everything went really well. So, we made the decision and I truly believe it was the right decision. My investors made 30x which is very rare and very high.

Krist: Is that 3-0?

Claudia: 3-0, yeah, 3-0. So, we don't usually see that in biotech. We see that a lot in tech but not in biotech, so it was the right time.

Krist: And what was the clinical inflection point? Curious, that you were about to…

Claudia: We were preclinical. We were preclinical.

Krist: You were about to commence with phase one or?

Claudia: So, we were about to start preclinical studies and then the next inflection point would be IND submission first in humans, proof-of-concept, so it would take many years and that was really where the biggest risk was. So, we decided, okay, well, let's do that while the appetite for our technology is very high. We didn't have to have any big proof. We didn't have tox studies. We only have the mouse proof-of-concept of our technology, so very early stage.

Krist: I was going to say, I just have one other question. And the acquirer was?

Claudia: Astellas Pharma. So, the second-largest Japanese biotech. And our technology, just to place that in context, is we developed potent stem cells that are universally compatible, so the cells are not rejected. This is a platform that really enables cell-therapy products. So, it can be very widely used. It could be the Holy Grail of cell therapies. We had something with great potential. Unproven still, in the clinic, but the market was really looking for this kind of thing. We were at the right time having this asset there, so it married well. So, sometimes you have technologies that are great, but you just are not at the appetite and the market is not there for you. So, it is a combination between internal factors and external factors.

Lindsay: I was going to say, it's remarkable and I'm sure the next time you're doing a startup, let us all know. We'd all love to invest. Don't forget us. Don't forget us.

Krist: And maybe to tail off your point, you were actually a lucky one in 2018 because 2018 was not a big year for exits. If you look at total transaction volume in 2018 … and I'm talking about across all M&A activity within biotech, pharma, the Shire-Takeda transaction was about 50 percent of the total transaction volume. So, I think we know that the cause of the market's stagnation in M&A in 2018 was the simple fact that stock prices were too high. Lindsay, [I] would be interested in your comment on that, but people would like to bring some of these technologies into the larger pharmas, but the cost has to be right.

Lindsay: Right. The drug companies are very sophisticated and for instance, only after Celgene came down did Bristol-Myers buy them for 70, 80, whatever the number is. They've been looking at it seriously for a couple of years, but they felt the price was too high is my understanding. Then we've seen a lot of M&A activity, right, this year. Loxo was just acquired for $8 billion after the stock had come right down. So, they're very pricey. They must have a room somewhere with every target and what they're willing to pay.

Krist: Yeah. Yeah, the pricing was high, and I think people saw that it was a little bit of a bubble caused by interest rate and the effect of Google and Amazon stock price just pulling up the overall market. I don't think in 2018, the public markets really priced in some of the reimbursement risk that's currently out there, and we'll probably be hearing more about it in the coming months. I don't think the public markets just priced, in general, risk very accurately, and I think the pharma executives knew that.

Lindsay: Just like they say in the stock market, in general, when insiders are buying that's a great sign. When insiders are selling, it's a bad sign in general. It's the same thing for development-stage biotech and pharmas which is when there's a lot of M&A activity after prices have come down, that tells you the bottom is probably coming in and we're probably seeing the bottom there. So, I think there'll be a lot of activity this year. Certainly, at JPMorgan, our companies must have had 120 different meetings with companies, and they were all very acquisitive right now.

OUTLOOK ON FUTURE INVESTMENTS [14:39]

Todd: So, I guess just to flip it here a little bit, if you look at where the money's gone, oncology continues to get more of its fair share of money, whether it's venture capital or R&D spend, if you will. But just from your perspective, where is the money going maybe in the future? What are the new technologies, if you will, that we can expect to see more activity in the investment community?

Lindsay: So first off, you go back 20 or 25 years, pharma companies did their own research. Today, there's much less of that, and they're relying on entrepreneurs to set up the companies and then they'll buy what they think has value. So, most entrepreneurs are not going to develop drugs that have billion-dollar costs to develop because it's too much money. What's really hot right

now, are rare diseases and gene therapies because they command premium pricing, because they're truly meeting an unmet medical need, and they're pretty cheap to develop. You don't have to do large clinical trials. Gene therapy, you can get approved with 10 or 12 patients if it's really viable. So that's where entrepreneurs are going. But because the pricing is so premium, the big companies, it's amazing, these little things they'll buy on five or six patients worth of data. Last year, a Chinese company had a CAR-T for multiple myeloma, the CAR-T being BCMA. And on a pretty small clinical trial, J&J ponied up $300 million pretty quickly and a huge backend. And that's very refractory, multiple myeloma. So again, it has to be an unmet medical need. If it's rare disease, anything that's cheap to develop, that's where the entrepreneurs are going to look, and more and more big pharma is relying on the entrepreneurs as their clinical-stage pipeline.

Claudia: I totally agree on the gene and cell therapy. I've been in gene and cell therapy since the '90s, and it was always in fringe. And now, hearing what's going on, I think we're ready for primetime. And what kind of shocked me, because I've always been involved in looking at companies that are developing gene therapy for rare diseases, was listening to Novartis' CEO say that he's expecting the SMA drug to be a blockbuster. And I was like, "Wow." And of course, he's pricing it at $4 million, but even though, there weren't that many SMA patients. And so, hearing that an ultra-rare disease can have a blockbuster drug was something that really surprised me. But I think that it's going to all come down to pricing. During our choice of where we were going with our technology at Universal Cells, we had been thinking about rare hematological diseases that have 30 patients a year. And we were really trying to find a justification, "How can we make money and survive?" But apparently, this is no longer an issue. And we see a lot of companies with a viable business model with ultra-rare diseases. So that has shifted.

Lindsay: That was amazing. They said they'll charge between $4- 5 million. The pushback is that, probably the way it's going to work is, it's going to be phased over time as long as the patient continues to do well. So as far as phase-out, paid over three to 10 years, is my guess. But they've got to incentivize companies and people to take these risks, otherwise, there'll be no risk-taking. And like you said, it's a small number of patients that if you can't get a premium, you know it's not a charity, this business. Not intentionally anyway.

Krist: I think we're seeing the money go into different types of drug discovery tools. Some of the flow we're seeing through the McDermott deals that we're involved in, including uses of artificial intelligence and different types of things that in the past, we wouldn't really consider a drug-focused deal. But the use of databases, artificial intelligence to discover drugs differently, is something that we see equal appetite from large pharmas for that technology, as we see for the new therapeutic candidate. So, money is going into that. I don't think that money is necessarily being diverted from new therapeutic candidates, but some of it's coming from newer investors in life science, and others are just allocating portions of their portfolio in that area. It's an extraordinarily hot area right now.

Claudia: And we have Microsoft, Google and Amazon in the space too.

Todd: It's interesting. So do you think that machine learning, data analytics, those sort of tools, because I think, and correct me if I'm wrong, if you look at the time horizon from the lab to launching a product, I think it hasn't really changed much for a long period of time. I think it still costs as much. So, do you think that these new tools and technologies will change that, will shorten the window?

Lindsay: It certainly will change the discovery process and make it shorter and more efficient, but that's not where, as far as I understand, that's not where the bulk of the cost is. The bulk is the clinical trial cost and the time. I think eventually, technology will be there, that you'll be able to do fewer patients because pre-clinically you'll better enable the characterization of any toxicities and things like that. But I don't see that happening soon. Again, I'm not an economist, and I'm certainly not looking at the whole industry, but I think certainly in our companies, costs keep going up year after year, and the FDA gets more and more, not less rigorous. So that's the bulk of, I think, the overhead in this business, the cost in this business.

Krist: And we're seeing some technologies that are trying to hit that cost head on. The cost of doing clinical trials and kind of mining data that already exists to design the drug for a clinical trial. And using as much of that information that already exists in a database of oncology patients or a database of rare disease patients' history for that to specifically try to limit down the number of participants that are needed in a clinical trial to get it through FDA. I mean, that's the eventual goal here. I agree with Lindsay that, that's still many years away towards achieving success in that, but that's the goal in that hot technology right now.

Claudia: Yeah, I agree. And I think it's a few years away, and I also think that there will be a lot of data mining, the clinical data mining, getting faster to clinical endpoints and getting better, more meaningful primary endpoints. And that could maybe help accelerate the product development process of some disrupted technologies there with data mining, more predictive, better clinical trial designs.

Krist: Lindsay, from your perspective, I'd be curious to hear kind of what are some of the hot therapeutic areas aside from oncology right now?

Lindsay: The way we work, we don't really start with what diseases we want to go after. What we look for, we're bottom fishers, we're not venture capitalists. So, we look for drugs that really are already probably working in humans, or almost totally de-risked as much as can be and have fallen through the cracks, because we don't really like to pay up for these drugs. And so, you know what we won't do, we're not going to go after a drug where you need 10,000 patients' worth of clinical data. It's got to be something where, for a relatively small investment, you can dress it up for a big pharma company. So again, most of what we're seeing is rare diseases, gene therapy and oncology. If you look at the pie chart of the industry today, the drugs that are in the clinic, half of it's oncology, and [the area of] rare diseases is another big slice. And that's where we fish. The individual diseases, we got 15, 16 people working fulltime, that's all they do is focus on those areas, but I, off the top of my head, I can't think about it. Certainly, neurologic diseases have been a horrible area for drug development. Most neurologic diseases are not well-treated, and there is a lot of discovery and interesting drugs and development, but not many in the clinic. And like I said, we're going to look for stuff that's in the clinic that's just fallen through the cracks. So, for instance, we have a drug for a form of 'bubble boy disease' that we licensed out of St. Jude. Again, it's a risky business, full disclosure, but they've treated 13 children that don't have an immune system, and it looks like they may be curing every one of these kids. And we were able to license that on good terms because it's a small market of patients, and I think we licensed it before Novartis came out with what they're charging. But if you could cure these kids, you're entitled to a fair return. So again, we're driven by data and unmet medical need. We don't start looking for every drug in a certain category.

Krist: Interesting.

WHAT'S KEEPING BIOTECH UP AT NIGHT? [25:14]

Todd: Okay. So earlier on, I think we said, and I hate to turn this into what keeps you up at night, right? But what keeps you up at night? And so, if you think about just risks and uncertainties, and you talked a little bit about them earlier, whether it's regulatory, or market risk, or scientific, what's coming out of the lab, geopolitical, whatever your poison is? How does the risk, and what do you view the risk and uncertainties that most affect valuation and deal flow?

Lindsay: Sure. So, what keeps me up at night is, it's simple. It's politics. It's people who don't understand the risk reward in this business being in charge. So, I don't think people understand that between 85 and 90 percent of all prescriptions written in this country are for generic drugs, which are available relatively very cheaply. So, for instance, years ago, and I've done a lot of lobbying over the years for the biotech industry, when Ted Kennedy was the senior Democrat in the Senate for healthcare, I had to get to know Ted Kennedy pretty well. And so, we were pretty good friends, and he used to say to me, "How are we going to pay for these drugs? Lindsay, what are you doing? You're going to bankrupt us."

So, I said, "Let me ask you something, Senator. Every year, the defense department budget goes up, right? Every year it goes up." I said, "And it's important. We need defense, and yet it never goes down. It only goes up." I said, "The drug business is different." Back then, the hot drug was the statins. It was like a $20 billion class of drugs 10 or 15 years ago, and I said, "Here's a drug with lots of them out there. They've spent billions developing them, but they are having an unbelievable effect in reducing cardiovascular disease in this country, and when you add up all the sales for all the statin drugs before they went generic"—and I think, now, they're probably all generic—"that was probably well over $100 or $200 billion." I said, "But now they're going generic, and you can buy them at Walmart for $4 a month."

Krist: I'm on the same plane as you Lindsay. I worry a little. I opened up the *Journal* this morning and it's got the Bluebird Bio article about them planning to charge $2.4 million for their rare blood disease drug. And I just kind of cringe when I see that because that's going to get a gut reaction from our current president or certain politicians, who, in their mind, they think a drug could cost $60 because that's what they see as their copayment when they pick it up at CVS or Walgreens. They don't see that underneath they've had people negotiate that price for them, that their employer is paying a portion of it, and so the delta between $60 dollars and $2.4 million is so dramatic. And they don't understand that, that's a rare blood disease that has 10,000 patients a year and the $2.4 million cost is saving $5 million of lifetime expense for the patient and letting a patient live who otherwise would've had to go through annual or biannual transfusions.

Lindsay: Right. It's like when Gilead put out the hepatitis C drug and they were charging $80,000 list price. People went nuts. But these were the first patients. The early adopters were the ones that were waiting for a transplant or about to die. The average hep C patient, over a lifetime, costs society hundreds of thousands of dollars, and for 80 grand you can cure them. So as long as industry manages the investment, so in other words they do it through PBMs, they do it through insurance companies, then you can reason with the payers and I think it'll be fine.

Claudia: Yeah. And it also keeps me up at night because it has a ripple effect not only for those who are developing late-stage

drugs, but it will affect the entire industry. And people are talking about drug price, but people forget that healthcare costs are not only drug-based, there is a lot of inefficiency in the system and nobody's talking about that. So, I know it's very complex. It's easier to pinpoint to drug prices because it's one specific thing but all the system is full of inefficiencies. So why don't we address that and let the pharma companies keep them viable and keep the drug discovery model viable by having some high-priced drugs and the majority will be cheap but keep that the same way. Find the balance there but focus on the rest because that's also very costly.

Krist: When you look at the $3.5 trillion spend in healthcare per year, well over a third of it goes into what happens in hospitals, and I think less than a tenth of it goes to pharma-biotech. So, kind of looking at the inefficiencies in hospitals, the waste in spending in end-of-life care in a hospital setting would be a dramatically better place to address cost issues. So, I'm curious, value-based contracting is something that we had talked about it in organizing. I think that's something that, it's not a risk, but it's something new for biotech executives to just factor in and plan for. And planning for it early, well before an exit. Planning for how you're going to create that data throughout the product development lifecycle, I think is extremely important right now and that can be an uncertainty if the drug companies are not prepping for it and planning for that value-based contracting. Kind of goes right along with the pricing issues but it's something that is evolving with more power held by the PBMs and these combined CVS-Aetna type entities. At some point, they're going to wake up and really focus on that value-based contracting. It'll be accelerated if we have $2.4 and $5 million costs for therapies.

FINDING POTENTIAL BUYERS [32:04]

Todd: So, I guess, as we sort of bring it back towards exits, and if the thought is a sale, and it can be outright sale or a big license deal, etc., so, when is the right time, and maybe there's different circumstances for this answer, but when's the right time to just start looking for buyers? And how do you sort of go about that? And then, how do you prepare yourself for the scrutiny, and the diligence, and all that, that you're going to go through?

Lindsay: So, I mean, we're here. We have tons of meetings for all our different companies. We're willing to sell anything at any time for the right price. So, it just has to be, you know, we have to receive a net present value that's at least equal to our net present value. And if we have other areas we want to put the capitals, we think we can get a higher NPV, we'll do it. So, I think that's really the answer. Now, on a deal-by-deal basis, there's lots of different timing questions, like, "Okay. I've done the phase two. Now, I've got to go raise a $100 million to do two phase threes or I've got to raise $200 million. What's the cost-benefit to us? We'll take dilution for that capital. Are we better off selling it to a drug company where we'll have less, but we'll spend less, we'll have less dilution?" I mean, there's a million variables to go into it and there's no simple formula. So, that's how we look at it.

Todd: Okay. Claudia?

Claudia: For me, because I think it's all about being in the right place at a right time, you always have to be prepared. And being prepared is always to be talking to potential buyers because you never know when the right opportunity is going to come. So, be communicating, be engaging and be scouting who might be the potential partners and potential acquirers. For us, for example, we had a lot of interest from our partners because they knew us very well. But partnership for me is a steppingstone before you get acquired because these are the people who are really closest to you and know your company and the value of your assets the most. So, I think that being out there communicating and partnering, it's a good way to position yourselves to become acquired if that's one of the possibilities. And I think that you should always be looking at all scenarios, so an acquisition and while you continue to do your research and development and maybe do an IPO or further, so you have to play both scenarios, I think, all the time. You can't concentrate only on one scenario, it's too risky.

Krist: I tell people that the day they incorporate the company is the right time to start thinking about the exit really, which is just a theme on what you just said. Really, it's a constant iteration of thinking about 'Where will be the right place for this asset once it's being distributed and used in patients? Who's the right caretaker for it to get it out to patients?' Now that's going to change over the lifecycle of the product, and exactly what you just said Claudia, I mean, it's going to be updated based on who the players are, what the options are. It sounds like you never really dreamt that you'd have an exit as early as you did, but that changes as strategies and different opportunities within the broader market change. So, it really should be thought of from day one and it's something to be talking to folks in the market about. We were talking about bankers earlier. I'm a big fan of creating banker relationships early and, not signing an engagement letter necessarily, but talking with smart and connected bankers in the market can help you understand what potential exit opportunities are out there. But more importantly, really what the buyers are looking for in their candidates at any given time. So constantly kind of communicating with a couple of the bankers that regularly play in your therapeutic area I think is critical. And understanding what the market is saying because that opportunity might come up earlier rather than later or it may impact some of your trial design and it may impact some of your timing plans. It may impact the financing levels that you go and seek. So, I use bankers as a real tool to be communicating with early. And they will do

that without any compensation to get in there and help you kind of think through your design and your decisions. I really advise people to start talking with them early.

Lindsay: In fact, that's what we do when we get serious about licensing in an asset, we'll reach out to the five or 10 companies that are in that space and say, "Look, if I have an asset like this and we can de-risk it, is it something you'd be interested in? Where are you guys headed? Where's your business headed?"

They'll let us know, "We're working on something that's way beyond that. Forget about it. We're not going to bother." Or, "You'll never get reimbursement from it." They know their business. Like I said, you go to the people who know. And that is one of the biggest de-risking steps we have. The worst thing is to spend tens of millions of dollars on an asset and then when it works go to sell it and it's like, "We don't want it." So, you have to do your homework. That's what my mother used to tell me.

Todd: And she was right. She was right.

Lindsay: She was right, but I didn't find out till much later.

UNDERSTANDING INVESTORS [38:20]

Todd: So maybe, and I guess we're sort of getting near the end here, but just because I thought this was an interesting question. So, flip it now, and you're not the company, you're the investor, right? So, you've invested early and you're not to product yet, who knows when you'll be able to get there. But so, what do you think about, "Hey when am I going to get a return on my investment?" When should you start really thinking about it? Obviously, day one you're looking to get one, but when should you start maybe getting anxious about it or picking up the phone and calling people?

Lindsay: So, if you're relatively sophisticated when you go to make the investment, assuming you're a passive investor and somebody's given you a pitch, what's the stage of development? What's the milestone where they'll be a big increase in valuation with a good chance for an exit? And then you map that out. Whoever's selling you the deal, or the CEO, or whoever, should be able to give you quarter-by-quarter, once the money comes in, "This is where we're going to be, and this is the exit right there." And then, stay in touch with the company. Make sure they're hitting those milestones.

Claudia: Yeah, I agree. The investors more than us founders, they're thinking about the exit all the time. And I found that it was very important to keep the relationship and talking to them all the time, quarterly sending newsletters and getting input from them as well.

Lindsay: It's a lot like, at least from my perspective, playing golf or going to Vegas and gambling. If you don't get the occasional 30-1 or the occasional good drive or the occasional pay off at the roulette wheel, you don't go back. And so, if they kill off the 30-1s, nobody's in the business and that's how I simplify it in my mind.

Krist: Yeah, I mean we see investors with ranges of expectations but many investors in this market have that flexibility. They understand that we're going to set timelines, they're going to be missed or we're going to shift therapeutic programs entirely. It's called development work because you're doing that work to see what happens out of the molecule or the asset and it's going to take shifts and turns and things like that. Last year we sold an ADHD product to Otsuka Pharmaceuticals, which was under development for definitely I think 10 years longer than the initial investors thought it would be, but the end result was good. And the investors obviously were thinking about an exit much earlier and they had some blue-chip investors, including the Novartis [Venture] Fund, but there was a twist and turn and this great product came out of one of those twists and turns. So, investors in this industry have that flexibility. They understand that there's going to be things that are longer out there. It's going to decrease their IRR (internal rate of return) but they're going to offset it with IRRs from earlier exits than expected.

Steven: Thank you to all our panelists for taking the time out to spend with us. Thank you so much.

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