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Transcript of
Inovio Pharmaceuticals, Inc.
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Participants

Jeff Richardson - Vice President-Strategic Relations
J. Joseph Kim - Chief Executive Officer
Peter Kies - Chief Financial Officer

Analysts

Charles Duncan - Piper Jaffray
Ram Selvaraju - Rodman & Renshaw
Jason McCarthy - Maxim Group

Presentation

Operator
Greetings, and welcome to the Inovio Pharmaceuticals Second Quarter 2017 Financial Results Conference Call. At this time, all participants are in a listen-only mode. A question-and-answer session will follow the formal presentation. [Operator instructions]. As a reminder, this conference is being recorded.

It is now my pleasure to introduce your host, Jeff Richardson, Vice President of Strategic Relations. Thank you, sir. You may begin.

Jeff Richardson - Vice President-Strategic Relations
Good afternoon, ladies and gentlemen. Thank you for joining us today. Today's call may contain certain forward-looking statements relating to our business, including our plans to develop DNA immunotherapies and electroporation-based delivery technologies, products and product candidates, as well as our capital resources, all of which involve certain assumptions, risks and uncertainties that are beyond our control, and could cause actual results to differ materially from these statements. A description of these risks can be found in the latest SEC disclosure documents and recent press releases. These statements speak only as of today's date and we undertake no duty to update or revise them.

Presenting today will be Dr. J. Joseph Kim, Inovio's President and CEO; and Peter Kies, our CFO. Now Dr. Kim.

J. Joseph Kim - Chief Executive Officer
Thank you, Jeff. Good afternoon, everyone. The focus of today's call is on executing our strategy, executing our strategy to advance Inovio's phase 3 and phase 2 immuno-oncology products into key data and business milestones. When we spoke last in May, I told you we delivered a strong package to the FDA in response to their device-related questions and comments pertaining to our VGX-3100 phase 3 pre-cancer program.

The FDA agreed with us and lifted our clinical hold, allowing Inovio to deliver on our promise to initiate the phase 3 study for our lead product in the first half of 2017. We also told you that during the whole period, we were moving ahead on our trial preparations. Our preparation paid off, and in just over one month since we initiated phase 3, we have activated 27 sites in the United States – up, running, and recruiting patients. By the year end, we expect to have activated at least 50 sites in the US, Europe, Asia and Africa.

Initiating Inovio's first phase 3 program marks a significant milestone for the company, for DNA-based immunotherapy, and most importantly, for women suffering from cervical pre-cancer caused by chronic HPV infection. The pivotal data from this program, if positive, could support the licensure application of VGX-3100 as the first immunotherapy for this disease. But beyond treating this one HPV-associated disease, Inovio's goal is to own HPV treatments, period.

Here is the clinical roadmap with my vision for Inovio's HPV therapeutic ownership. First we began with our first phase 3 program for HPV-associated cervical dysplasia. We combined that with the company's now initiated phase 2 clinical trial of VGX-3100 for treating HPV-related vulvar neoplasia, and to that we'll add planned 2018 clinical trial for treating HPV-associated anal neoplasia. To those in-house trials, we add MEDI0457, formerly called INO-3112, checkpoint inhibitor-based combination study with AstraZeneca's MedImmune targeting HPV-associated metastatic head and neck cancers.

With this broad clinical roster, we are well-positioned to comprehensively treat HPV-associated pre-cancers and cancers across the continuum of HPV infection through to cancer in both women and men. We want to become the go-to therapeutic solution provider for all diseases caused by HPV infection.

To that end, in April, Inovio commenced a randomized open-label phase 2 trial to evaluate the efficacy of VGX-3100 in women with high-grade HPV-related vulvar intraepithelial neoplasia, or VIN, a disease with a high unmet medical need. You may not know this, but HPV-induced VIN is one of the major causes of morbidity for young and middle-aged women with HPV-induced pre-cancer. It is also associated with repetitive need for surgery, multiple biopsies and a major cause of pain and sexual dysfunction.

Extending our immuno-oncology franchise, in May, Inovio announced that MedImmune commenced a new phase 1/2a clinical trial investigating the combination of MEDI0457 and immunotherapy designed by Inovio to generate antigen-specific killer T-cells targeting HPV-associated tumors and Infimzi, MedImmune's PD-L1 checkpoint inhibitor. The combination trial is intended to enroll 50 patients with metastatic HPV-associated head and neck cancer with persistent or recurrent disease after chemotherapy treatment.

This study marks a significant moment for Inovio. As you might recall, in 2015, MedImmune acquired exclusive rights to Inovio's INO-3112 immunotherapy for all HPV-associated cancers. MedImmune provided an upfront payment of $27.5 million to Inovio, as well as potential future payments upon reaching development and commercial milestones totaling up to $700 million. MedImmune will also fund all development costs, while Inovio is entitled to receive up to double-digit tiered royalties on MEDI0457 product sales. In this current combo study, we expect that the phase 2 portion of the trial will trigger a milestone payment from Medi by early 2018.

As a part of this deal, the two companies have also collaborated on a new funded research program, which MedImmune has now selected a new cancer immunotherapy candidate to advance into the clinic. This new product candidate was designed and constructed by Inovio to treat an undisclosed cancer and will also trigger milestone payments from MedImmune as well as royalties based on sales.

In addition to MedImmune, our technology's promise in cancer has attracted significant attention from other pharma companies developing or marketing oncology products. Just in the past quarter, we struck two independent collaboration agreements with Regeneron and Genentech.

In May, Inovio and Regeneron entered into an immuno-oncology clinical study agreement for glioblastoma combination therapy. The phase 1/2a clinical study will combine Regeneron's PD-1 inhibitor, REGN2810, and

Inovio's T-cell activator, INO-5401, and immune activator INO-9012 in brain cancer. INO-5401 includes three of Inovio's top SynCon cancer antigens. These are WT1, hTERT and PSMA which are expressed widely in multiple tumor types. Thus INO-5401 has the potential to be a powerful and broad cancer immunotherapy in combination with checkpoint inhibitors. The open-label trial, which is expected to begin before year end, is designed to evaluate the safety and efficacy of the combination therapy in approximately 50 patients.

To focus on the disease for a moment, and Senator John McCain's recent diagnosis, GBM, is the most aggressive form of brain cancer and its prognosis is extremely poor. Therefore if this combination treatment shows at least a moderate level of efficacy against this aggressive cancer, we would expect to have an expedited approval path for INO-5401.

Building on our INO-5401 cancer product development, in June, Inovio entered into a collaboration agreement with Genentech to commence a clinical trial to evaluate the combination of 5401 and Genentech's PD-L1 checkpoint inhibitor, TECENTRIQ, in patients with advanced bladder cancer.

This phase 1/2 immuno-oncology trial is also anticipated to start later this year, and is designed to evaluate the safety, immune response and clinical efficacy of the combination therapy in approximately 80 patients with advanced bladder cancer. Combining INO-5401/INO-9012 with TECENTRIQ may provide a synergistic therapeutic effect as a result of generating high levels of activated T-cells and simultaneously inhibiting PD-L1. We have chosen metastatic bladder cancer as the second cancer indication to test for INO-5401 with a checkpoint inhibitor because it is a highly immune responsive cancer. Bladder cancer has often been described as an immunogenic tumor, and here our approach is to augment the anti-PD-1/PD-L1 driven efficacy by further enhancing the T-cells against the tumor in a tumor antigen-specific manner.

As you can see from our recent collaborations, I'm a strong believer in combination immuno-oncology regimens employing an immunotherapy to generate significant antigen-specific killer T-cell than blocking T-cell suppression via checkpoint inhibition. With our strategic selection of our first combo efficacy studies in GBM and bladder cancer, we believe we can demonstrate the immense potential of INO-5401 as a universal cancer immunotherapy to treat patients with multiple cancers. This is why, unlike our MedImmune license deal, Inovio decided to retain the full economic rights to INO-5401 under these collaboration studies.

As you know well, Inovio is not just a promising immuno-oncology development company. Our technology is nimble enough to target challenging infectious diseases – ID products that may become stockpiled vaccines and those that also have commercial potential. And we are accomplishing all this vaccine development with an extensive non-dilutive external funding. Inovio will continue to advance these vaccines for combating emerging infectious diseases with external funding.

Recently Inovio reported that its HIV vaccine, PENNVAX-GP, produced amongst the highest overall levels of immune responses rates ever observed in a human study by an HIV vaccine. These significant results are consistent with Inovio's recent data reported from Ebola, Zika and MERS clinical trials in terms of achieving nearly 100% vaccine response rates with a favorable safety profile.

Rounding out our infectious disease results for this quarter, in June, we announced full enrollment of our second phase 1 clinical trial in Puerto Rico, evaluating our Zika vaccine, GLS-5700, in 160 volunteers. Along with safety and immune responses, the study is also assessing differences in Zika infection rates in participants given either placebo or vaccine as part of an exploratory efficacy endpoint being evaluated over one year.

Inovio is very proud to be at the forefront of Zika vaccine development and to produce foundational data that clearly supports advancement of DNA technology and our vaccine candidates. We were the first to clinical vaccine testing and the first to report positive immune data from the clinical trial. We look forward to the prospects of securing external funding for phase 2 efficacy studies in our effort to potentially commercialize our Zika vaccine.

We expect to report on additional data from our vaccine clinical studies and publish the data in the top medical journals this year.

Now I'd like to introduce our CFO, Peter Kies, who will discuss our recent capital raise and our financial results. Peter?

Peter Kies - Chief Financial Officer

Thank you, Joseph. Before I walk through our financials, let me focus on our recent financing. On July 25th, we closed an underwritten public offering of 12.5 million shares of our common stock for gross proceeds of $75 million. After deducting underwriter discounts and commissions and estimated offering expenses payable by us, the net proceeds to us were $70.2 million. We have granted the underwriters an option through August 18th to purchase up to 1.875 million additional shares of our common stock on the same terms and conditions.

Looking at the big picture, our July financing will fund our future to the benefit of the shareholders and patients in need. It nearly doubles Inovio cash position and allows for a runway that will allow us to meaningfully fund our development programs. With these proceeds, we expect to be able to advance our VGX-3100 phase 3 trials, four phase 2 immunotherapy oncology trials and fund other pipeline advancements. This financing actually also added new institutional investors to our shareholder base. We also look forward to reporting on new data from INO-5150, INO-1400 and INO-1800 immunotherapy phase 1 data, all in the second half of this year.

We previously announced, back in February, Inovio entered into a collaboration and license agreement with ApolloBio Corporation. If the agreement receives the appropriate approvals from Apollo's stock exchange, its board of directors and its shareholders, then the agreement will become effective, at which time, we will expect to receive up to $50 million in payments from Apollo, consisting of $15 million in upfront payment for the license of 3100 in greater China and up to $35 million in the form of an equity investment in our common stock.

I'll refer you to our Q2 press release for more details but our top line financials are total revenue was $20.4 million for the three months ended June 30, 2017, compared to $6.2 million for the same period in 2016. Total operating expenses for the three months ended June 30, 2017, were $30 million compared to $24.4 million for the same period in 2017. Net loss attributed to common stockholders for the quarter ended June 30, 2017 was $9.5 million, or $0.13 per share, compared to $8.7 million, or $0.26 per share, for the same quarter ended June 30, 2016.

The increase in revenue was primarily due to $13.8 million in revenue recognized from our MedImmune agreement from the initial $27.5 million upfront payment received in September 2015. This revenue recognition occurred upon MedImmune's definitive selection of a new cancer product candidate to be tested in the clinical trials as a new immunotherapy against an undisclosed cancer target for our ongoing research. A successful advancement of this new product candidate by MedImmune will also trigger future milestone payments and sale-based royalties.

Joseph, back to you.

J. Joseph Kim - Chief Executive Officer

Thanks, Peter. I would like to follow up on our recent financing as well. As the largest individual shareholder of Inovio and the CEO, I try to avoid dilution as much as possible. In fact we have funded much of the advancement of our technology and platform with over $150 million in non-dilutive grants and contracts received over the last few years from top funders like the NIH, DARPA and the Gates Foundation, as well as corporate partnerships with MedImmune and Roche. Still we are in a new drug development business and this business requires a lot of capital. We undertook the last round of equity financing to make sure we have the sufficient balance sheet to fund our important late-stage efficacy studies in immuno-oncology.

I don't have to remind our long-term shareholders we have licensed just one of our phase 1 product candidates to MedImmune for a $700 million overall deal. I believe that both VGX-3100 and INO-5401 could each be worth several times more. Our current financial resources will allow us the development time to prove this.

Let me close with this message. We said we would start our pivotal phase 3 trial in an HPV-caused cervical pre-cancer in the first half, and we did. In addition to our phase 3 trial and the phase 2 trial for vulvar pre-cancer, we have three different PD-1 or PD-L1 immuno-oncology combo efficacy studies with three different top companies, MedImmune, Regeneron and Genentech. That's three shots on goal with three different checkpoint inhibitors. In fact, I believe Inovio already has the most extensive and dynamic T-cell immunotherapy combo portfolio in our field.

Our focus now is on executional excellence, a focus on the execution of our efficacy studies to bring meaningful data to the market and our shareholders. I have no doubt that Inovio will accomplish this because we have a superior technology and products. We have sufficient financial and supporting resources, as well as the right partners and collaborators. But most of all, we have an extremely dedicated and experienced team executing our programs.

We get up every day with the real sense of urgency because we all know that the patients are waiting.

Thank you for your attention. The floor is now open for Q&A with the analysts.

Operator
Thank you. Ladies and gentlemen, at this time we will be conducting a question-and-answer session. [Operator instructions]. Our first question is coming from the line of Charles Duncan with Piper Jaffray. Please proceed with your question.

Q: Hi, guys. Congratulations on the progress in the quarter and thanks for taking my question, Joe. Also let me add that I actually think, I've covered lot of stocks for many years, and you guys have actually done, in my opinion, a very nice job of monetizing the platform and seeking out non-dilutive financing. So that's just my perspective.

Quick question, VGX-3100 in cervical dysplasia, nice update in terms of the number of sites opened. I'm wondering if you could provide us a goal by the end of the year in terms of not only sites opened, I think you mentioned that, but also percentage of patients enrolled by year end '17.

J. Joseph Kim - Chief Executive Officer
Thank you, Charles, for a helpful comment and the question as well. Our policy is not to update on our goals or an actual accrual until we're done. So we know we have two sets of 198 patient studies that we are conducting for REVEAL 1 and REVEAL 2 studies. We plan to open a total of 100 total sites across the globe. So I've

already stated that we'll have about 50 sites up and running. Just between you and me and all of our employees here, we would like to accrue and recruit as rapidly as possible.

Q: And I'm sure that's the case then. When you say that sites are up and running, does that mean that some patients have been enrolled or at least in screening for those sites that have been opened?

J. Joseph Kim - Chief Executive Officer
Yes, we have multiple patients in screening. And again, I'm going to refrain from referring to an actual dosing and so on. But we were preparing, as we discussed before, during the device hold, we were preparing our sites getting all the paperwork and our approvals. So when we had finally the clinical hold removed on our 5PSP device, we were able to hit the road running. I can assure you our overall objective number one is to accrue and these patients as rapidly as possible.

Q: Okay. And then I believe in your prepared remarks, you mentioned that you anticipated patients or sites in the US, in Asia and in Africa. Can you give us a target in terms of the percentage of patients that are US, Asia and African patients? Is it a third each or is it 40/40/20?

J. Joseph Kim - Chief Executive Officer
We expect a couple of countries in Asia, we have South Africa as one of our sites. But other than that US and Europe will be the predominant sites that—countries and regions which will provide patients for us. But once they're up, we don't have any quotas for each country. It's first-come, first-serve. So if we enroll everyone in the US it's however unlikely because of the ex-US patients, there are lot more of them outside the US. But our primary commercial initial target markets are US and Europe, so we would expect most of the patients will come out of those two regions.

Q: Okay. And then one last question hopping over to vulvar neoplasia with 3100. Can you give us some sense of time to date? Would you anticipate that next year, top line data under that study?

J. Joseph Kim - Chief Executive Officer
Yes, so it's 36 patients. So it's dramatically smaller than our CIN trials. It's an open-label trial because there is very little regression in a placebo group, so that allows us to track the progress of the patients visually. So I think by late next year or even early following year, we may have a very good idea. But all of these are predicated upon the enrollment of the first percentages of patients. We are again pressing the pedal to the metal with our VIN study.

Q: Okay. Thanks for the added color, and congrats on the progress recently in the last quarter.

J. Joseph Kim - Chief Executive Officer
Thank you, Charles. Thank you.

Operator
Thank you. The next question is coming from the line of Ram Selvaraju with Rodman & Renshaw. Please proceed with your question.

Q: Thanks very much for taking my questions and congratulations once again on all the progress. I wanted to ask firstly with respect to 3100, if you could just clarify for us what you expect to be the sequence of data release from the phase 3 program, if there's only going to be a single readout of data or if we can expect to see some interim indications of efficacy as the trial program progresses.

Secondly, I wanted to ask about the plan for ApolloBio to advance VGX-3100 in the greater China territory and when this clinical development might start and what kind of shape or form it might take in terms of the sort of trial or trials they might decide to run.

And finally, if you could perhaps comment on the potential utilization of your technology platform, including but not limited to MEDI0457, within the immuno-oncology context and when you anticipate that this might potentially be expanded beyond combination with PD-1 and PD-L1 alone into other checkpoint inhibitor and other IO strategies. Thank you.

J. Joseph Kim - Chief Executive Officer
Thank you, Ram. These are all great questions. And I'm going to briefly go through each of them directly. So VGX-3100, both REVEAL 1 and 2 are designed to unblind at the end of the study including the safety follow-up. So REVEAL 1, very quickly, is first three months of dosing, three times, month nine efficacy readout. But there's a 12-month safety on top of that. It will be unblinded at the end of that time. REVEAL 2, although it will be started about a quarter behind REVEAL 1, and the on-drug time is identical to REVEAL 1, REVEAL 2 will have a shorter follow-up, safety follow-up.

So our goal is to unblind those studies at the same time in 2020 and file for a BLA application in 2021. The market should expect the data in 2020 from both REVEAL 1 and REVEAL 2 phase 3 studies.

Obviously, if we can enroll patients faster, we'll report as that much faster. Our focus is on enrollment, enrollment, enrollment and we have a very dedicated team working on that.

And number two, ApolloBio, we're waiting for their approval process for this agreement. We'll report on the exact development path in China. But I think what I can tell you about this is there will be a lot of leveraging of our global trial going on REVEAL 1 and REVEAL 2, and we're doing this deal with ApolloBio for two reasons. One, upfront and equity investment, obviously $50 million is important. Number two, though, it's more important that in our lone development plan, our primary markets, as I stated earlier, is US and Europe. And China is way down. But there are perhaps 10 times, if not 50 times as many patients who can benefit from VGX-3100 who live currently in greater China. So it's our efforts to both access the market quicker in China and bring economic value back to Inovio through our collaboration with ApolloBio but also to be able to bring this important immunotherapy for this condition to women who are suffering from pre-cancerous lesions in China.

And then lastly PD-1, PD-L1, it seems like the PD-1 and PD-L1 are special in that they're able to bring important levels of efficacy in a very important number of cancers. We feel that for the most part other than melanoma, overall efficacy for PD-1 and PD-L1 checkpoint inhibitors are about 20%, 15% to 20% ORR is what you're seeing for bladder, less than that for head and neck alone, and so on. Ovarian is less and GBM is certainly much, much less.

We think the combination of our T-cell generating immunotherapy, like MEDI0457 as well as INO-5401 is a great one-two punch. Generate the antigen-specific, tumor-specific T-cells, knock down the defensive mechanism that the tumor cells have in PD-1 and PD-L1, and then let the T-cells go at the tumor. So we think that's a great strategy.

But also your last comment about combining with other immunomodulatory molecules. Yes, PD-1 and PD-L1 inhibitors are not the only games in town. They are just the biggest games in town right now. But as right now

there are 5 products from that class already on the market with over 40 others in the clinical development from what I heard at ASCO this year.

That's going to be a very crowded market. So obviously the folks who have the T-cell generating immunotherapies are going to, like Inovio, will continue to have the leverage, and we're looking for other combinations that can bring higher impact besides PD-1 and PD-L1 because we think we have that covered pretty well between MedImmune, Regeneron and Genentech.

I think we have the best combination therapy strategy out there in the whole field. So I feel very good about that and we're looking for other combination, collaboration or partnerships going forward as well.

Q: Thank you very much.

J. Joseph Kim - Chief Executive Officer
Thank you, Ram.

Operator
Thank you. The next question is coming from the line of Jason McCarthy with Maxim Group. Please proceed with your question.

Q: Hi, Joe. Thanks for taking the questions. Congratulations on all the progress. I was wondering if you can give us a sense of the speed of enrollments in the other HPV studies, the particular in vulvar neoplasia and when can we expect data, and what's the progress [audio disruption] expect to see some data, even interim data there.

J. Joseph Kim - Chief Executive Officer
So, thank you, Jason. And yes, I agree with you. I think we had a great quarter on multiple fronts. We got our phase 3 approved. We got the phase 2 approved for VIN, as you referred to, and we are able to add to our balance sheet since then.

All systems are firing for us at this point. I feel extremely fortunate to have Inovio where it is and having all the resources and trials at disposal, including our partnership program with MedImmune and our recent collaboration studies with Regeneron and Genentech for 5401.

Back to VIN, we just got the approval to start that phase 2 trial in the second quarter. We have sites up. We will have more sites up and we expect to have the patients moving forward. It's a 36-patient study, so it's a much smaller in scale than even our phase 2b study was for our CIN indication. And unlike the CIN indication, the VIN study is going to be an open-label. So it's a randomized but it's an open-label. There is very few self regressors out there with high recurrence rates even after surgery. This is a horrible disease for these patients and our goal is to bring this immunotherapy by leveraging the same antigen-specific T-cells that we've seen generated in cervical dysplasia patients, same power to clear the virus HPV 16 and 18 in cervical dysplasia patients. We hope to see that in our VIN study.

And in terms of data, I think, I'm going to wait before I can project beyond late 2018 or 2019 type of projections because I think it's too early. But this study will have an advantage that it's an open-label and it's a disease, unlike cervix, that doctors can follow the progress visually. We have reporting mechanisms written into the protocol that will help us guide the progress of the program much earlier even. So we're quite excited about the progress and the second indication for VGX-3100.

Q: Okay. And if I could, one more question. I want to diverge from the oncology and maybe talk a little bit about infectious disease, and particularly PENNVAX. You had great data back in May. Can you just give us an update, what are the plans for PENNVAX going forward and where do you see that fitting into Inovio's priorities right now?

J. Joseph Kim - Chief Executive Officer
Yes. Thank you, Jason. I agree with you. The data that was presented, as a surprise, it was a late-breaker. It was in HVTN conference. It was not originally slated to be presented at the plenary session. I think the data was so overwhelming impressive.

As I remarked, the T-cells and antibody responses were at the highest observed by any vaccine that the HVTN has tested over the last 25, 30 years. So I think their actions speak volumes. It was an interim look that provided at very high levels of PENNVAX-GP's ability to generate both antibodies and T-cells in 94 healthy volunteers for that study. So what's going on since May is more complete analysis is being done by the HVTN.

The other part of this trial is not that we don't trust our own numbers, but it's great to see similar levels of consistent immune responses in these vaccines whether you're doing an HIV vaccine with HVTN where, just to jog your memory, this was a funded program by the NIH with a $25 million contract to Inovio. And HVTN is also funded by the NIH and they designed, conducted and executed the trial. Their core labs are doing all the assays.

So it's a true third-party observation and reporting of our vaccine program that validates the similar level of almost 100% response rates that we have seen with MERS and Ebola, as well as an actual 100% response rate we have seen in the Zika vaccine program. More complete analysis, immune analysis will be done, will be presented further at future vaccine conferences and that will be published.

Where do we go from here in terms of the product development? We're working with the HVTN and looking for securing a next round of funding for moving this to a preventive phase 2 setting or more advanced setting. That could be a larger trial of similar nature or even a field study as a bona fide phase 2b study. Those details have to get worked out.

In the meantime, we and our collaborators have received almost a $7 million direct grant from the NIH to test PENNVAX-GP in a therapeutic setting. So our previous 94-person study were done in healthy volunteers, so it was being looked at as a preventive vaccine. One of the hallmarks of Inovio's therapies and vaccines are we can use it, in most cases, to treat the disease or prevent the infection in terms of infectious diseases.

So we have a very ambitious study that we're planning with the NIH funding that will start, we expect, in the first half of 2018. Our goal is to suppress or eliminate HIV virus in chronically-infected patients who are on highly active antiretroviral drugs. So for instance, no one is really suffering in the developed countries because of the advent and the extensive use of these combination drug therapies, but no one has been able to clear the virus from their body.

So all these patients are living chronically. They're not getting sick per se but they're having to take the drug for the rest of their lives and the virus is lurking in the reservoir hiding away. Our ambitious plan is to combine a checkpoint inhibitor with PENNVAX-GP. We're throwing the heavy artillery with the highly active antiretroviral drugs. And in a small number of patients, our ambitious goal is to see if we can displace the virus by one-two punch of drugs and immunotherapy, and we hope we can see some signal of this. So again it's a high-risk, high benefit potential. Just can you imagine if you can cure a person, HIV infected person, using PENNVAX-GP along with these other regimens, I think it's one of the most exciting programs for us.

Thankfully we have the full external funding to do these things and that's what I wanted to stress earlier in the prepared remarks. All of our vaccine programs have received external secure funding to advance them. And Inovio will continue to use this business model to advance, what I think, are highly important global health products for these emerging infectious diseases.

Q: Okay, great. Thank you for taking the questions.

J. Joseph Kim - Chief Executive Officer
Thank you, Jason.

Operator
Thank you. And it appears we have no further questions at this time, so I'd like to pass the floor back over to Dr. Kim for any additional concluding comments.

J. Joseph Kim - Chief Executive Officer
Thank you. I'd like to thank you all for listening. I think we had a great quarter. We expect to have even more exciting future with our phase 3 program as well as four phase 2s. We have the sufficient resources to execute. So it's all about executional excellence going forward. Thank you very much.