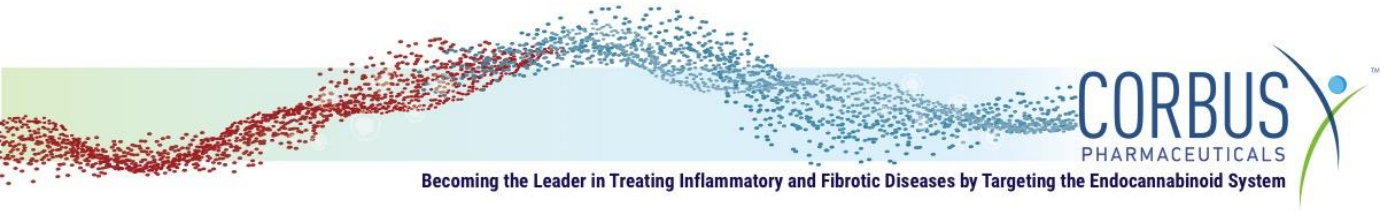

Corbus Pharmaceuticals Holdings, Inc.
Quarterly Update Conference Call and Webcast
November 8, 2018

Operator: Greetings and welcome to the Corbus Pharmaceuticals Quarterly Update Conference Call and Webcast. At this time, all participants are on a listen only mode. A Question and Answer session will follow the formal presentation. If anyone should require operator assistance during the conference, please press star, zero on your telephone keypad. As a reminder, this conference is being recorded.

It is now my pleasure to introduce your host, Ted Jenkins, Senior Director of Investor Relations and Corporate Communications. Thank you. You may begin.

Ted Jenkins: Good morning, everyone, and thank you for joining us for the Corbus Pharmaceuticals Quarterly Update Conference Call and Webcast. At this time, I'd like to remind our listeners that remarks made during this call may state management's intentions, hopes, beliefs, expectations, or projections of the future. These are forward looking statements that involve risks and uncertainties. Forward looking statements on this call are made pursuant to the to the Safe Harbor provisions of the federal securities laws. These forward-looking statements are based on Corbus' current expectations, and actual results could differ materially.

As a result, you should not place undue reliance on any forward-looking statements. Some of the factors that could cause actual results to differ materially from those contemplated by such forward looking statements are discussed in the periodic reports Corbus files with the Securities and Exchange Commission. These documents are available in the Investors section of the Company's website and on Securities and Exchange Commission's website. We encourage you to review these documents carefully.

Joining me on the call today is Yuval Cohen, our Chief Executive Officer, Sean Moran, our Chief Financial Officer, and Barbara White, Chief Medical Officer. It is now my pleasure to turn the call over to Yuval Cohen.

Yuval Cohen: Thank you, Ted.

Good morning, everyone, and thank you for joining us today. With all the developments over the last month, we decided it was time to finally host our inaugural quarterly update call. I will begin by providing a brief overview of our business for those of you who are new to Corbus as well as an update on our clinical programs in our transformational recent transaction with Jenrin Discovery that we announced at the end of September. I will also provide an update on our financial position before we open the call for your questions.

As a company, we've come a long way since we launched Corbus four and a half years ago. From the start, we believed that there would be strong therapeutic rationale to target the

body's endocannabinoid system to modulate inflammation in fibrosis. We're pleased that our core thesis is being validated and that our vision is becoming a reality, to be a leader in the treatment of inflammatory and fibrotic diseases with small molecules specifically designed to target the endocannabinoid system.

At Corbus, we have assembled a team of leading industry experts, from R&D, to manufacturing, to patient advocacy to regulatory affairs who enable us to move forward with a focus on innovation and quality. Our senior leadership team is supported by a dedicated team of professionals across the Company who are our most valuable asset. I want to thank everyone on the Corbus team for their hard work and commitment to our mission and to the patients that we seek to serve.

As we think about the future, there are a few key points I would like to highlight today about our therapeutic approach, research pipeline, and significant market opportunity. The endocannabinoid system is a master regulator of inflammation and fibrosis in the human body. Its major receptors are CB2 and CB1. These are GPCRs that have broad applicability throughout the body.

The pathways involved have been the focus of extensive research for the past 20 years and are fairly well understood. What's been missing are drug candidates that can very specifically target this biology safely and efficiently.

At Corbus, we've taken on this challenge and approached it in a novel way by coupling the well-understood biology of these receptors with traditional pharmaceutical rational drug design approaches. We began these efforts at our inception with our drug candidate lenabasum and recently expanded it dramatically with the Jenrin transaction. We now have a truly diversified pipeline with late and early stage programs and the industry's leading library of more than 600 unique compounds targeting the endocannabinoid system.

With assets ranging from early to late stage development, strong intellectual property, and global commercial rights, Corbus is positioned to take advantage of this significant market opportunity for endocannabinoid system targeting drugs designed to potentially treat a multitude of inflammatory and fibrotic diseases.

We believe the timing of our own pipeline with our recent patents extending well into the mid-2030s and our goal of commercial launch in 2021 is shaping up to be very advantageous since four of the current top drugs that are used to target multiple inflammatory indications are finding themselves at the end of their patent protection, bringing to an end combined annual sales of over $40 billion.

Lenabasum is a drug candidate with a unique mechanism of action, activating the CB2 receptor in immune and other cells, coupled with applicability across a range of potential rare indications. We have demonstrated with lenabasum that rationally designed synthetic small molecules can be successfully applied to target the endocannabinoid system and that there are considerable advantages to doing so. We are excited about lenabasum and the potential it has to treat inflammation and fibrosis in several rare inflammatory indications affecting hundreds of thousands of people. I will review the progress we are making in the clinic shortly.

With the Jenrin transaction, Corbus has transformed from a single-asset company to a multi-asset company with what we believe is one the industry's most innovative pipelines. We believe we are now positioned to be the leader in the treatment of inflammatory and fibrotic diseases with small molecules that specifically design to target the endocannabinoid system.

As a part of the 600 compound transactions, we have chosen to focus first on CR-4001, a second generation, peripherally-restricted CB1 inverse agonist. Initial targets for potential developments are fibrotic liver, lung, heart and kidney diseases. While both lenabasum and CRB-4001 target the endocannabinoid system, they do so through differentiated mechanisms of action. Importantly, CRB-4001's unique mechanism of action opens the door to evaluating potential efficacy in additional indications including common ones like NASH.

While lenabasum is a CB2 agonist targeting immune cells in rare inflammatory diseases, CRB-4001 targets the second endocannabinoid receptor GCPR, CB1. And rather than activating it, CRB-4001 inhibits its activity. This is a known biological mechanism for reversing inflammation in specific organs, such as the liver.

CRB-4001 is also the first time we find ourselves competing directly with a Big Pharma. CRB-4001 is competing directly with an experimental CB1 targeting drug for NASH from Johnson & Johnson. Their program has just completed Phase 1b, but we are confident that we will catch up with them soon. We believe CRB4001 has several advantages, primarily because it is a synthetic oral drug, rather than an injectable monochromal antibody.

Now let me provide more details on lenabasum's key indications, the clinical pipeline, and the anticipated market opportunity. Lenabasum continues to progress through the clinic in late stage clinical studies for four indications. To set the stage in terms of overall market opportunity, earlier this year, we engaged a market research firm, Health Advances, to provide detailed demographic and market opportunity research on our targeted indications for lenabasum including systemic sclerosis, dermatomyositis, and cystic fibrosis. Health Advances determined that, combined, there are approximately 350,000 individuals in the US, Europe, and Japan suffering from these three rare diseases with a total estimated potential annual peak

sales of up to $5 billion. This excludes the potential market for systemic lupus erythematosus or SLE, which we will discuss later on.

For the orphan disease systemic sclerosis, the most lethal of the systemic auto immune diseases causing organ inflammation, fibrosis, and vascular damage, we are currently conducting a single Phase 3 registrational study titled, "RESPVE-1." Enrollment remains on track with topline data expected in 2020. Systemic sclerosis, which affects approximately 200,000 patients in the US, Europe, and Japan, has an estimated annual market opportunity of up to $2.2 billion. There are no approved drugs for systemic sclerosis, and the standard of care involves potent and often toxic immunosuppressive therapies. Sadly, mortality rates for SSC is about 50%.

We recently also presented 18-month data from our systemic sclerosis Phase 2 open label extension study at the American College of Rheumatology 2018 annual meeting in Chicago.

As a reminder, a reduction of five points on the mRSS score is considered medically meaningful. At the six-month mark, mRSS reached a minus 8.4, at the 12-month, minus 9.8, and now at 18 months, it has reached a minus 10.7 points. Similarly, the ACR CRISS at six months reached 65%, at 12 months, it was as high as 77%, and at 18 months, it has reached a high of 99%. Furthermore, at the 18-month high point, 87% of patients have now shown a decrease in mRSS of at least 5 points, and 50% of patients have reached a CRISS score of 100%.

For dermatomyositis, another orphan autoimmune disease categorized by chronic muscle inflammation accompanied by skin and internal organ damage, our development program is currently on track for a phase three study expected to commence at the end of 2018. Dermatomyositis affects approximately 80,000 patients in the US, Europe, and Japan and represents an annual market opportunity of up to $2 billion. Like systemic sclerosis, no drugs are approved for dermatomyositis.

At the recent 2018 ACR annual meeting, we also presented 12-month data from our dermatomyositis Phase 2 open label extension study in which mean improvement in CDASI activity score now reached a minus 17.6 points following the six-month time point of 15.4 points. To put this in context, an improvement of just minus four to five points on CDASI activity score is considered medically meaningful. In fact, at the 12-month time point, 84% of patients have now shown a decrease in CDASI of at least 10 points.

Turning to cystic fibrosis, an orphan genetic disease characterized by chronic lung inflammation that leads to lung damage and fibrosis, our program is currently in its second Phase 2 study, evaluating pulmonary exacerbations as the primary efficacy endpoint, the first time the FDA has agreed to this endpoint for the use as a registrational endpoint. It takes into account the

specific clinical expected benefits from the use of drugs targeting inflammation. The study also remains on track, and we expect to report topline data in 2020.

This Phase 2 CF study was designed with inputs from the Cystic Fibrosis Foundation, Therapeutic Development Network as well as the European Cystic Fibrosis Society, Clinical Trial Network and is funded in part by development awards of up to $25 million from the Cystic Fibrosis Foundation that follows a $5 million that we received in 2015. We wish again to express our gratitude to the Cystic Fibrosis Foundation.

This study is open to people with cystic fibrosis, 12 years and older, regardless of the underlying CFTR mutation or current background medication, including Orkambi, Kalydeco, and Symdeko.

CF effects approximately 70,000 patients in the US and in Europe and represents an estimated market opportunity for Corbus of about $1 billion. It's worth noting that we recently presented data on the positive impact of lenabasum on inflammation of airway macrophages from cystic fibrosis lungs at the 2018 North American Cystic Fibrosis Conference.

Lastly for SLE or systemic lupus erythematosus, an uncommon chronic autoimmune disease that causes inflammation in connective tissues such as cartilage and aligning of blood vessels, our program is currently in an ongoing Phase 2 clinical study. Lupus affects approximately 550,000 patients in the US, EU, and Japan and represents an estimated annual market opportunity, according to Health Advances, of $2 billion to $3 billion.

In short, we are making solid progress across indications for lenabasum and moving ahead with these programs. We are continuing to target 2021 for the commercial launch of lenabasum following FDA approval.

Turning to CRB-4001, as I mentioned earlier, CRB-4001 is a second generation peripherally-restricted CB1 inverse agonist targeting liver, lung, heart and kidney fibrotic diseases, initially being developed as a potential treatment for NASH.

We plan to enter a Phase 1 clinical study for CRB-4001 in 2019 scheduled to be followed by a National Institute of Health funded proof-of-concept Phase 2 study, which will be coordinated by Dr. George Kunos.

In addition to CRB-4001, the transaction with Jenrin enhanced our portfolio with more than 600 more compounds that we believe will fuel the growth of our clinical pipeline. From these compounds, we anticipate advancing one to two new drug candidates into clinical testing each year, starting in 2020. We believe that this portfolio, together with the underlying platform and the intellectual property, position us at the forefront of this field and provides us with the

potential to be leaders across multiple indications with multiple drug candidates well into the mid 2030's and potentially beyond.

Let me briefly comment on our financial position. To date, Corbus has raised $128 million in equity capital and another $45 million of non-diluted financing from the National Institute of Health and the Cystic Fibrosis Foundation. We ended the quarter with $55.6 million of cash, which together with the remaining funds, we expect to receive from the CF foundation fund our operations into the fourth quarter of 2019, in line with our previous guidance provided during the second quarter.

Regarding the Jenrin transaction, we want to remind you that the transaction has a minimal impact on Corbus' cash flow through the end of 2019. Under the terms of the agreement, Corbus provided an upfront cash payment and will provide milestone payments to be paid upon achievement of certain development and regulatory milestones for each compound as well as a royalty payment for eventual sales of any Jenrin compound.

Before I turn over the call to Q & A, let me reiterate that 2018 has been a transformational year for Corbus. During the third quarter, we expanded our pipeline beyond lenabasum with the Jenrin transaction, which we believe has strategically positioned us as the leader in the treatment of inflammatory and fibrotic diseases by targeting the endocannabinoid system with what we believe is the industry's leading pipeline.

The transaction also extended Corpus' strategic optionality thanks to our global rights across our pipeline in all major markets. It is worth noting, for example, that we have an agreement with the Japanese and Korean regulatory authorities that does not require a country specific clinical study beyond our current international Phase 3 study with lenabasum in which we have a member of Japanese and Korean sites already. While our commercialization focus will be in the US and the EU, there are clearly certain territories where seeking strategic partnerships makes much more sense.

During the quarter, we also presented new, robust data from lenabasum across several indications, and we continue to derisk, advance and validate late stage programs. We are excited by the potential of improving the lives of individuals affected by systemic sclerosis, dermatomyositis, cystic fibrosis and systemic lupus erythematosus.

We believe more than ever that we are uniquely positioned to become the leader in the treatment of multiple inflammatory and fibrotic diseases by targeting the endocannabinoid system. We look forward to the next 24 months and the value-creation potential for patients as well as shareholders inherent in our enhanced pipeline.

Barbara, Sean and I will now be happy to take your questions. Operator?

Operator: Thank you. The floor is now open for questions. If you would like to ask a question, please press star, one on your telephone keypad at this time. A confirmation tone will indicate your line is in the question queue. You may press star, two if you would like to remove your question from the queue. For participants using speaker equipment, it may be necessary to pick up your handset before pressing the star keys. Once again, that is star, one to register questions at this time.

Our first question is coming from Justin Kim of Cantor Fitzgerald. Please go ahead.

Justin Kim: Good morning, thank you for taking the question. My first question I suppose might be for Barbara - on the systemic sclerosis treatment landscape, when thinking about the overall population, what proportion of patients does the company expect seeks treatment at a center of excellence, and how many are anticipated to be in the United States?

Barbara White: Justin, I'm sorry, you broke off just a little bit. Could you repeat the very end of that question for me?

Justin Kim: Oh, just how many centers of excellence are there in the United States for the treatment of systemic sclerosis?

Barbara White: Well, I think there are multiple centers, so probably 20 larger ones, and then there are some smaller ones scattered around, but that would be an approximate number for the larger ones.

But, patients--I should say, that patients are cared for, many of them in these large centers, which allows commercial opportunity to be concentrated, and at the same time, there are still patients who remain under the care of their general rheumatologist. But, their care would be influenced by the experts at the care centers.

Justin Kim: Okay, great, thank you. And then, maybe one on the open label extension - it's very impressive to see such high participation rates. Would the team have any additional color on sort of the reasons and timing of discontinuation for the small 17% in the sclerosis study?

Barbara White: We did have, I think, 17% dropout by the end of 18 months, and, you know--I don't have it all just at the top of my head right now. One of them was for a complication of heart--in fact, I think two of them were for complications of their systemic sclerosis. It was unrelated to the drug. None of them were directly related to complications of the drug or

failure of the drug. It was a multitude of other reasons. I'm sorry I don't have them at my fingertips.

Justin Kim: Sure, no problem. And then maybe just the last one - at what point, you know, with the enrollment would we get sort of timelines with the lupus study?

Barbara White: So, the lupus study, as you know, is being run by the NIH, and they are managing the enrollment. At this point, I believe there are 13 to 15 anticipated sites that are up and are enrolling. We know that they're enrolling actively. Usually, you get an uptick of enrollment after you get your sites up. So, we remain optimistic that we will see data. It's a (inaudible) study some time probably late 2019/2020, that would be our estimate. But, of course, at this point, it depends upon the NIH.

Justin Kim: Okay, great. Thank you for taking the question.

Operator: Thank you. Our next question is coming from Liisa Bayko at JMP Securities, please go ahead.

John: Hi this is John, on for Liisa. Congrats on the progress, and thanks for taking the questions. Just a couple on CRB-4001. Can you discuss the decision to go after NASH first? Obviously, it's an attractive field, but very crowded and many late stage players. What kind of gives you confidence moving there? And any initial thoughts on the Phase 1 this will be in patients, and what kind of signals of efficacy or biomarkers are you planning to look at?

Barbara White: Those are great questions. Let me start with the Phase 1 first because we've got to do Phase 1 always to check initial safety, determine maximum tolerated dose, look at who it affects, those kinds of things. So, we will plan to accomplish all the standard testing that one would want to see in a single ascending dose followed by multiple ascending dose stage 1.

We are actually in active discussions with Dr. Kunos about the final design of this study. Of course, whatever biomarkers we can pull out of the Phase 1, we would like to do. That would happen only really realistically in the multiple ascending dose if we enroll patients who are not all healthy volunteers. So, again, not finely determined, but agree it would be nice to get some early biomarker data in the late stages of the Phase 1.

In terms of going into NASH, the next study that will be done after that is a Phase 2. As Yuval said, that would be done at the NIH. And the purpose of that study will be to give us proof-of-mechanism, proof-of-principle, that this drug can alter metabolic abnormalities and underlying biomarkers in patients who would have metabolic syndrome, be prone to NASH, have early enzyme abnormalities, those types of things.

The study is unlikely to be long enough and certainly not big enough to give us any sort of definitive clinical information. It would be designed to show that we've got proof-of-mechanism, and we've got biologic activity that we're looking for. So, it not only opens up the field for NASH, then just knowing that we've a biologically active drug that does what it's expected to allows us to go further.

The logic of NASH is that, certainly, there's a huge unmet medical need and that this drug is scientifically well positioned to target NASH. It impacts the underlying glucose intolerance, metabolic disorders, lipid abnormalities. There's significant pre-clinical data that that's the case. There's data that affects the fibrosis that causes the ultimate liver damage, so scientifically very strong rationale. And this particular drug, CRB-4001, targets an isoform of CB1 that is preferentially-expressed in the liver, so this is a great drug to target liver problems, liver fibrosis metabolic problems.

Yuval Cohen: John, if I can just chime in, in terms of why go into it, given the crowded field, so a couple of things - one, I think that by the time we advance, we will have collectively a much better understanding of what the clinical endpoints are that are needed for registration. I think the folks ahead of us are sort of learning that as they go along. By the time that we get to that position, that will be really much more clarified.

The second thing to think about, there's no question in my mind, at least, that NASH will be a disease treated by multiple drugs in the form of basically a cocktail. And, last but not least, as far as we're concerned, we really only have one competitor in NASH because they're going after the exact same mechanism of action, and that is Johnson & Johnson with their CB1 antagonist monochromal antibody for NASH. I like that dynamic a lot. I like having a Big Pharma competitor, and I also like the fact that we see it as just very significant validation of our approach to this disease.

John: Great. And just one last one for me - with the goal of getting one to two clinical compounds during 2020, can you discuss how you're thinking about prioritizing these preclinical compounds and what efforts you have to do over the next 12 months or so to start getting things rolling as far as that early stage pipeline?

Barbara White: Sure, we--that's certainly an area of very active work around Corbus. And what the preclinical group is doing is extensively characterizing the compounds in this library so that we will be able to identify clusters of compounds with similar activities and then identify the leads within those clusters and allow us to target them to the appropriate diseases.

We would expect some time next year to be able to indicate to the street what we've got in that library in terms of types of activities and potential usefulness and different indications of those compounds. So, we are in that, we're down in deep right now, and we would expect that you would hear more next year.

John: Great, congrats again on the progress, and thanks for taking the questions.

Yuval Cohen: Thank you.

Operator: Thank you. Our next question is coming from Laura Chico of Raymond James, please go ahead.

Laura Chico: Good morning, thanks for taking the question. I just have a couple - first, you've all--could you talk to the recent competitive updates that we got at ACR and just how we should be thinking about the read-throughs, more specifically to lenabasum, and how has this changed your development strategies, if at all in any way.

Yuval Cohen: Sure. So, I'll start by saying that we've never been more excited. I think it's a combination of two things - we have a drug that we think has tremendous potential, and our competition is really getting into a lot of difficulties.

So, what we saw at ACR was a series of failures from big pharma using drugs that are typically already approved, that are typically immunosuppressive and used either for rheumatoid arthritis or IPF or PAH that have been tried in systemic sclerosis and that have failed, the most interesting one of course, being Tocilizumab or Actemra, which failed its Phase 3. I should add that probably is not the most surprising outcome, they also failed their Phase 2.

What is important to remember is the following, though - those drugs, if you look at them, don't actually have a particular logic to them when it comes to systemic sclerosis. The target indications are not necessarily diffuse cutaneous systemic sclerosis, and they're part, I think, of a very sound strategy of Big Pharma to take an approved drug and target multiple other indications in an effort to expand labels.

What I like about it is that puts us now firmly as the most advanced systemic sclerosis program. There's no other program that is this close to market. And of course, lenabasum is radically different in its mechanism of action.

I should also point out that, even though it's a little bit difficult to compare different clinical trials to each other, we certainly believe that our data is considerably, considerably better than

data generated by others and certainly based on historical patient progress. So, we're excited, and we're really looking forward to it.

Similarly, just to add to that, this year has also seen competitors in cystic fibrosis and dermatomyositis also fail - again, same logic, very, very different approaches, radically different approaches, but again clearing the way for us to now be in the lead for those three indications.

Laura Chico: Okay, that's helpful, Yuval. Thank you for the color there. If I could just ask one other question - I wanted to focus on RESOLVE for a moment, and I apologize if I missed this in your remarks, but could you give us an update on where you stand in terms of the enrollment pace in RESOLVE and also relative to your expectations? And I guess--you know, if I work backwards from topline data in early 2020, and then using the 52-week treatment period, you should be completing enrollment soon. I'm just trying to understand how close you are to that target. And using the same math and logic for the CF effort, I think you should also be getting close there. Am I off on my math? Any update you could provide?

Yuval Cohen: So, one of the things we don't do, Laura, is we don't provide updates on patient numbers. We've never done so. We think it's always awfully distracting. These things are not always linear. I will say, though, that we finish every clinical study on time, and I'm delighted to say that we are absolutely on schedule for data in 2020 for all of these indications. We are pleased with how it's going along.

You can imagine that, given for example, your previous question as well as what we've seen from patient advocacy groups, what we heard from patients, and from sites that there is really considerable enthusiasm to be part of this, of all of these indications, and all of these clinical trials.

One of the things that we have found was really interesting is the timing could not be better. There are no big studies competing with us across scleroderma, CF and certainly dermatomyositis. Even the Vertex studies have sort of finished, leaving us with an open window. And so, enrollment is going well, we are on schedule, and we really look forward to sharing data with you when it comes out.

Laura Chico: Alright, thanks. And, you know what, I'll sneak one more in for Sean, if I might. I just wanted to confirm, there was no APM usage in the quarter, correct?

Sean Moran: That's correct, Laura.

Laura Chico: Alright. Thank you, guys.

Yuval Cohen: Thanks, Laura.

Operator: Thank you. Our next question is coming from Ted Tenthoff of Piper Jaffray. Please go ahead.

Ted Tenthoff: I am. Can you hear me okay, or--?

Operator: --Yes, your line is in queue. Please go ahead with your question.

Ted Tenthoff: Okay, apologies, I've been having audio difficulties Thanks for the update, really excited about where the story is going. I apologize if you have already answered this. I wanted to get a sense for kind of what next steps were from the Jenrin compounds and really how you'll be using that to expand your discovery capabilities. Thanks.

Barbara White: Well, let me start with what's ongoing and will be continued in the near future. We are looking at a variety of characteristics of the compounds, not only physical/chemical characteristics, but functional characteristics, both in terms of functional assays, signalling, those kinds of things. Those data allow us to determine the general types of compounds, if I can put it that way.

We anticipate that, within this large library, there will be clusters of drugs that are more similar and that we can aggregate them. And with the information about clusters of similar compounds, that will allow us to then further explore animal models that seem relevant to the activities that those compounds have and animal models that are appropriate to the indications that we think would be relevant to what the mechanisms appears to be for those compounds. So, it's a sequential process. We have started, we will continue, we will be updating next year, and we certainly believe that we'll be able to get one or two new ones advanced into the clinics starting about 2020.

Yuval Cohen: And, Ted, if I can just add to that and--to the listeners at large just how excited we are by this. So, if you think about it, we are targeting a brand new area of biology, which is the endocannabinoid system, using synthetic cannabinoids and we're doing so not just with a single drug, because I think that in and of itself would certainly be worthwhile. And as you can see, lenabasum, just as a stand-alone drug, just for the first three indications, has some really extraordinary financial potential. But, to be able to go then and bring in hundreds and hundreds and hundreds of unique compounds that have the potential collectively to yield novel drugs on this I think is quite remarkable.

The other thing to think about is like with any new era of biology and any new therapeutic, there's a great deal of know how that is proprietary. The ability to be a highly specialized team

that understands the biology I would argue probably better than most and also knows how to develop these types of drugs clinically and from a regulatory point of view, I think can be easily under-appreciated. It's actually a very, very big deal.

Last but not least, if we think about our large eco systems in pharma, and if you think about Big Pharma out there, I'm going to postulate that it's going to become very, very difficult for Big Pharma to ignore this biology. In fact, if I were a betting man, I would say that, in a whole bunch of Big Pharma at the moment, they are rapidly dusting off their own cannabinoid research programs and looking at whether or not they're applicable.

But, the advantage we have is that we're probably a decade ahead of everyone. And so, that opens a very simple possibility as a Big Pharma, if you are interested in this biology, do you develop something on your own that's going to take you a very, very long time and a very steep learning curve, or do you turn to Corbus with our hundreds of potential compounds and our unique expertise? And I really like the way that's shaping up, I have to say.

Ted Tenthoff: Well, excellent. I'm really excited to hear more and certainly excited by the progress of Lenabasum. So, good stuff, guys, thanks so much.

Yuval Cohen: Thank you.

Operator: Thank you. At this time, this brings us to the end of our Q&A session for today. We'd like to thank you all for your interest in Corbus. You may disconnect your lines at this time and have a wonderful day.