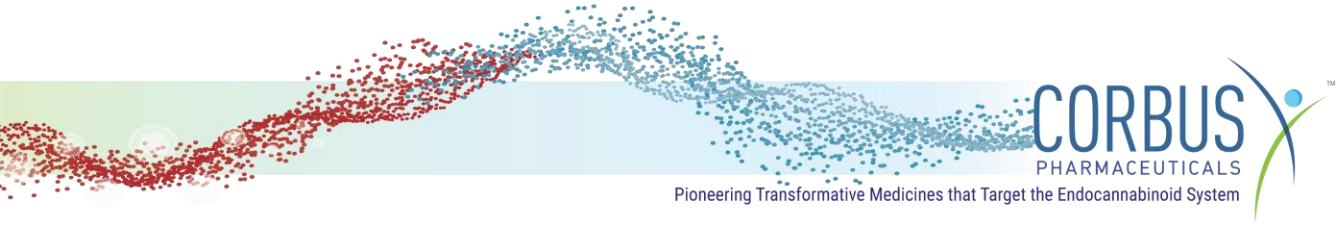

Corbus Pharmaceuticals
Quarterly Update Conference Call and Webcast
November 7, 2019

Operator: Greetings and welcome to the Corbus Pharmaceuticals Quarterly Update Conference Call and Webcast. At this time, all participants are in 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, Investor Relations and Corporate Communications. Please go ahead, sir.

Ted Jenkins: Good morning, everyone. At this time, I would 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 and involve risks and uncertainties. Forward-looking statements on this call are made pursuant 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 the Securities and Exchange Commission's website. We encourage you to review these documents carefully.

Joining me on the call today are Dr. Yuval Cohen, our Chief Executive Officer, Dr. Barbara White, our Chief Medical Officer and Head of Research, Sean Moran, our Chief Financial Officer, and Craig Millian, our Chief Commercial Officer. With that, it is my pleasure to turn the call over to Yuval.

Yuval Cohen: Thank you Ted, and thank you everyone, for joining the call this morning. In the third quarter of 2019, we continued to build our R&D engine, execute on our clinical development programs, prepare for a transformational 2020, and start laying the foundation for a successful commercial launch.

I want to start by reminding you all of our vision as a company. We believe that targeting the body's endocannabinoid system, also known as the ECS, holds the potential to provide new therapies to treat inflammatory, fibrotic, and metabolic diseases. We are focused on developing potential novel medicines that modulate this powerful biological system. We have a deep expertise in medicinal chemistry, endocannabinoid system biology, regulatory and patent strategy, as well as clinical development.

More recently, our attention has turned to laying the groundwork for commercialization. It's exciting to see other pharmaceutical companies engaged in the development of compounds that modulate functions of the ECS. Recent examples include Lundbeck, Takeda, Roche, and Johnson & Johnson. It is our belief that medicines targeting the endocannabinoid system have the potential to reshape the treatment paradigm for inflammatory and fibrotic diseases, giving new hope to patients.

We expect data from our Phase 3 study in systemic sclerosis and our Phase 2b study in cystic fibrosis next summer. In addition, we have an additional candidate being prepared for Phase 1 and a growing portfolio of unique molecules designed to modulate the functions of the endocannabinoid system.

With that, I'd like to turn the call over to our Chief Medical Officer and Head of Research, Dr. Barbara White, to provide you with a quick update on our clinical programs. Barbara?

Barbara White: Thank you, Yuval. Lenabasum is an oral small molecule CB2 agonist that reduces inflammation and fibrosis in cellular and animal models of disease. Promising safety and efficacy data were observed in our initial Phase 2 studies in systemic sclerosis, cystic fibrosis, and dermatomyositis.

Our RESOLVE-1 global Phase 3 study of lenabasum in systemic sclerosis is fully enrolled, with 365 patients dosed. Topline data are on schedule and expected next summer. If data are positive and the safety profile is acceptable, we plan on having discussions with regulatory authorities in the U.S., Europe, and Asia about filing applications for marketing authorizations for lenabasum.

We are optimistic about the upcoming topline data in systemic sclerosis. Our optimism is based on the results of mechanistic studies, Phase 2 safety, efficacy and biomarker data, and supportive safety, efficacy and biomarker data in the Phase 2 study of lenabasum in the related rare autoimmune disease dermatomyositis. Our optimism is further supported by two-year data for our ongoing Phase 2 open-label extension study of lenabasum in systemic sclerosis that followed the double-blind placebo-controlled study. The long-term safety profile of lenabasum is favorable to date, and 80% of the subjects to enter the open-label study remain in it at two years. Durable improvement in clinical outcome measures has been seen in this open-label study. There will be an oral presentation of the latest open-label data at the ACR 2019 Annual Meeting this Sunday. Results and presentations will be available on our website.

The **D**ETER**M**INE global Phase 3 study of lenabasum in dermatomyositis is actively enrolling subjects. We are delighted with the high level of engagement, enthusiasm from patients and investigators. Enrollment goals are currently being met. We expect to complete enrollment in 2020 with topline results in 2021. Again, we are optimistic that the DETERMINE Phase 3 study

will show positive efficacy data and the supportive safety profile for lenabasum and dermatomyositis, for similar reasons as systemic sclerosis.

Our optimism is supported by data from our ongoing Phase 2 open-label extension study of lenabasum and dermatomyositis that followed the double-blind placebo-controlled study. The safety profile of lenabasum and dermatomyositis has also been favorable to date. 90% of subjects who entered the open-label study remain in the study at two years. As in the systemic sclerosis open-label study, durable improvement in clinical outcome measures has been seen. There will be an oral presentation of these latest open-label data at ACR on Tuesday. The results and presentations will also be available on our website.

The 415-patient Phase 2b study is ongoing in people with cystic fibrosis who are at high-risk for recurrent pulmonary exacerbations. I am very pleased to announce that patient screening for this study has ended. Topline data for this 28-week study are expected in summer of 2020.

As a reminder, pulmonary exacerbations in cystic fibrosis are acute events of increased lung inflammation with clinical manifestations of worsening respiratory signs and symptoms, often including a significant worsening in lung function. Failure to fully recover lung function after a pulmonary exacerbation causes about half of long-term decline in lung function experienced by people with cystic fibrosis.

Despite exciting advances in the treatment of cystic fibrosis with CFTR-targeting therapies, people with cystic fibrosis still have exacerbations. There remains an unmet need for additional approaches for the prevention of pulmonary exacerbations.

The 100-patient Phase 2 lenabasum study in people with systemic lupus erythematosus continues to enroll subjects. This study is funded and managed by the National Institutes of Health. We anticipate study completion and topline data in 2020.

The second drug in our pipeline, CRB-4001, is a peripherally restricted CB1 inverse agonist designed to avoid the central nervous system side effects seen with rimonabant. We are targeting NASH with fibrosis as the potential first indication for CRB-4001. Preclinical data show beneficial effects on energy metabolism, inflammation, and fibrosis. A Phase 1 safety study is scheduled for readout in 2020.

Lastly, we highlighted eight promising compounds at our R&D Day in June. These are new CB2 agonists, as well as CB1 inverse agonist. These compounds are progressing through candidate selection. We are excited about the progress we have made to date. We look forward to continuing to share our data at upcoming conferences and through scientific publications. I will now turn the call back to Yuval.

Yuval Cohen: Thank you, Barbara. Given that we are scheduled for data readout from the RESOLVE-1 systemic sclerosis study and the Phase 2b cystic fibrosis study next summer, it is critical that we begin planning for success, laying the groundwork and preparing for the potential approval and the commercial launch. I would now like to turn the call over to our Chief Commercial Officer, Craig Millian, who will provide you with an update on our commercial activities. Craig?

Craig Millian: Thank you, Yuval, and good morning. I would like to take a few minutes to highlight the progress we're making in preparing for the successful launch of lenabasum. As we prepare for upcoming data, we are building best-in-class commercial capabilities that will give us maximum flexibility to commercialize ourselves or partner out specific geographies, such as Asia.

At this point in pre-launch planning, we are focused on three critical elements to ensure success: first, building our commercial leadership team and capabilities; second, establishing a strong foundation of deep market insights; and third, communicating a compelling and concise narrative that will provide an appropriate scientific context ahead of a potential regulatory approval.

We are continuing to build an experienced, lean, cross-functional team that will drive a successful lenabasum launch. Over the past six months, Corbus has hired key leaders for marketing, supply chain, and medical affairs. And in September, we hired Keith White as our Vice President of Market Access. Keith most recently served as VP of Market Access and Pricing at Intercept Pharmaceuticals, where he led global managed access functions for the launch and commercialization of Ocaliva in PBC. Keith is already digging into health economics, value and pricing, payer engagement, and distribution channel strategies.

Next, we recently completed in-depth patient journey research. Blinded interviews were completed with systemic sclerosis patients and with academic and community-based rheumatologists. They told us about the devastating impact of this disease on patients' lives and their frustration regarding the lack of treatment options that alter the course of the disease, but there was acknowledgment that there are a limited number of available treatments, usually immunosuppressants or others selected based on specific organ involvement. There was consensus that there are no therapies that address the totality of this disease. These insights will be foundational to developing our go-to-market strategies, product positioning, value proposition, and market segmentation.

Not surprisingly, when we shared the blinded target efficacy and safety profile for lenabasum, there was considerable interest and enthusiasm from both patients and physicians. Armed with these insights, we are now finalizing an unbranded disease education campaign that will give voice to the unmet need for new treatments in systemic sclerosis. This will begin a dialogue

around new scientific approaches, including the ECS, to address the totality of this devastating disease. This disease education campaign will start in Q1 2020, in conjunction with an increased presence at medical conferences and engagement with thought leaders.

In addition to systemic sclerosis, we have been preparing for lenabasum's potential opportunity in cystic fibrosis. As such, we have conducted market research with pulmonologists from CF treatment centers. We've just come back from the North American Cystic Fibrosis Annual Meeting, where recent advances in CF treatment were celebrated. Conversations with experts at this meeting, combined with the recently completed market research, affirm that there remains a need for new anti-inflammatory treatments, particularly for patients with established lung disease who continue to exacerbate.

To sum up, our market research reinforces the opportunity we have within these first two indications. We are ensuring strong execution around commercial launch fundamentals, and I look forward to engaging with you further in the coming months as we advance our commercial capabilities and prepare for launch. With that, I will turn the call back over to Yuval.

Yuval Cohen: Thank you, Craig. I would like to provide a brief update on our financial position. Corbus has a strong balance sheet, having ended the quarter with approximately $55 million in cash. Given the additional milestone payments expected from the Cystic Fibrosis Foundation for our Phase 2b cystic fibrosis study, our capital should be sufficient to support our operations through topline data readouts and into the third quarter of 2020.

We have important catalysts ahead. We will deliver key data readouts from two late-stage studies of lenabasum in the summer of 2020. We anticipate the first clinical data in lupus. The first human data in CRB-4001 will also be available in 2020. And lastly, we look forward to increasing our global reach by continuing to explore additional partnerships abroad, such as those in Asia.

In closing, I would like to reemphasize that Corbus is pioneering transformative medicines that target the endocannabinoid system. We believe that this biological system holds the potential to improve the treatment of inflammatory and fibrotic diseases. We are pivoting towards executing the successful launch of our first product.

With that, I would like to thank you all for your time and attention and turn it over to the operator for any questions from our listeners today. Operator?

Operator: Thank you. We will now be conducting a question-and-answer session. If you would like to be placed in the question queue, please press star one on your telephone keypad. A confirmation tone will indicate your line is in the question queue. You my 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 star one. One moment, please, while we pull for questions.

Our first question today is coming from Brian Abrahams from RBC. Your line is now live.

Brian Abrahams: Hi, there. Thanks for taking my questions and thanks for all the updates, particularly on the market research progress there. I guess my first question is, I am curious to know what the key learnings have been for patients who have now been systemic sclerosis patients who have now been on treatment for multiple years? And maybe if you could frame expectations for what we might look for in the upcoming ACR data? I know with the last cut, you were starting to see disease stabilization and just curious what we should be looking for there? And then, I have a follow-up.

Barbara White: So, Brian, thanks for the question. This is Barbara. I am delighted to say you should expect to see more of the same. You should expect to see a totally favorable long-term safety profile. Some of these patients, if you consider the amount of time in the double-blind and the amount of time in the open-label and some of them were beyond what we report, continue after multiple years on the drug to have acceptable safety. And I want to position the importance of that, because that is the importance of an extension study. And it's important, if you remember, as Craig pointed out, that many of these patients are on immunosuppressive treatments, and our drug is not immunosuppressive, and the ability to deliver efficacy without immunosuppression in the context of standard of care is super important.

Secondly, the efficacy data are beautifully, boringly persistent. They are durable. We couldn't ask for anything more than that. So, I think you should expect more of the same, and we are delighted with that.

Brian Abrahams: Great. And then on to CF I was curious if you could talk a little bit about the impact you might expect from some of the, likely, very recent changes in the standard of care in terms of the impact to the conduct of the Phase 2b study, and maybe your ability to tease out a benefit and ensure that the arms are balanced?

Barbara White: Sure, I'd be glad to do that. So, first of all, as I said, we've identified all the patients for the study. The U.S. patients came in first, because that's just the way the sites were activated. So, the U.S. patients are in. They have been in the study. Many of them--some of them are out of the study already.

With triple therapy being available, it is only appropriate that if it is in the subject's best interest that they are allowed to begin triple therapy during the study - that is medically appropriate. And we are also looking forward to having those data, because we believe that lenabasum will offer treatment benefit on top of these very important standard of care treatments for the

patients. We actually look forward to having some subjects get on triple combo during the study. We will have patients on the other CFTR modulators. So, we're hopeful that, in fact, some of the patients in the U.S. will actually start triple therapy. We don't think it will be a lot. It will be some. I think it's less likely that the subjects from Europe will get on triple therapy during the context of the study. And I think that it will be dealt with in the terms of sensitivity analysis from a statistical standpoint. So, I am going to turn it over to Craig for some comments about the importance.

Craig Millian: Yeah, thanks, Brian, for the question. When we did our market research, which we conducted with about 20 pulmonologists from CF treatment centers, we really built into the dialogue or the questions, anticipating the introduction of triple combo, and what that would mean for their patients and unmet need and, specifically for a product with the profile of lenabasum.

Based on that research, as well as, frankly, conversations we even just had last week at NACFC with leading pulmonologists, we are very confident that even with the recent approval of Trikafta, there will likely remain a sizable number of patients who would potentially benefit from a safe and effective anti-inflammatory medicine.

As Barbara said, many adults with cystic fibrosis have established lung disease with a considerable infectious and inflammatory component, and it's not clear that CFTR modulators alone will entirely prevent these patients from experiencing pulmonary exacerbations in the future. That's what we heard from physicians in the market research and at the meeting. In fact, many physicians we spoke with expressed their strong belief that those patients with established lung disease who continue to exacerbate will almost certainly still need novel therapies.

Yuval Cohen: Yeah. And, Brian, if I can share an anecdote. So, I was at the booth at NACFC, and we had a patient--there are not many patients, of course, at NACFC. We had a patient approach us, and she's on the triple combo. She's been on it for a while through expanded access. Her lung function is very low, and it was remarkable to hear from her just how keen she was about the potential of being on lenabasum. And to hear, on the one hand, absolutely, the effect that triple combo had on her, but on the other hand, just seeing with your own eyes, the gap that was still left in her treatment, especially around pulmonary exacerbations.

Brian Abrahams: That's really helpful. One more for me if I could. Any updates on the formulation work for 4001 and the timelines for when we might see that PET data next year? I know the latter is in the NIH's hands, I think, but just curious if you had any more visibility on that. And I'll hop back in the queue. Thanks.

Barbara White: Sure. Yes. I'm just delighted to say that while we've got a formulation to take into our Phase 1 study, we have some real experts, and they have driven the formulation to allow us to have the desired solubility and dose-response relationship that we need to enter the clinic. So, we've got this data, and we're very pleased with them. And, as I said, we expect to have the readout from the Phase 1 single-ascending dose and multiple ascending dose in 2020.

I have been in extensive discussions and have visited the NIH a couple of times to move forward the design and the commitment of the NIH for the PET scan. So, because it's the NIH, and we're not there quite yet, I'm actually hesitant to commit on timelines. And I would just say that we appreciate the need to address with human data, whether or not 4001 binds a significant number of CB1 receptors in the brain when it's delivered in therapeutic levels. We will do that. But I ask for a little more time to be firm on timelines with the studies to do that.

Yuval Cohen: And, Brian, if I can butt in--and I don't know how many people picked this up. I think some of these folks have. If you remember, we've always had a competitor in the form of Johnson & Johnson with their Bird Rock monoclonal antibody targeting CB1, so same mechanism, but obviously, very different compound. And it was really intriguing to see, I think, about two, three weeks ago, another entrance to that field, which was Takeda with Goldfinch. Again, targeting the same CB1 receptor, a different organ this time, the kidney, very sensible. CB1 plays pretty much the same deleterious role in the kidney that it does in the liver. So, this is an area focusing on the endocannabinoid system, which seems to be moving very, very rapidly. There are now three companies, including ourselves. Again, the difference is we have an oral systemic drug. The other two entrants have monoclonal antibodies.

Brian Abrahams: Thanks so much.

Operator: Thank you. As a reminder, ladies and gentlemen, that's star one to be placed in the question queue. One moment, please, while we pull for questions. Our next question is coming from Maury Raycroft from Jefferies.

Maury Raycroft: Hey, everyone. Good morning and congrats on the progress, and thanks for taking my questions. Just wondering for ACR coming up, what we should be focused on there with some of the updates that you guys have? And is there anything on the competitive landscape that we should be looking out for at the meeting? And then I was just wondering also for your eventual filing for systemic scleroderma, will you include the long-term safety data from the open-label extension study in that byline?

Barbara White: So, Maury, let me just go with the last one first, because I can remember it, and then I'll go back to the first one. So, in terms of the data that we will submit to support safety at the time of any potential filing, that, of course, will need to be discussed with the FDA and EMA

and PMDA. And we will engage in those discussions. We certainly think it's likely, because that will be–represent long-term safety exposure, certainly not in a placebo group but in a treated group. So, it would be our expectation that, that will go in and help support. So, take a good look at the safety findings in the poster.

And again, I think what we've got at ACR are a couple of things. To remind you, we've got oral presentations. We were just delighted that the ACR leadership felt that the data were important enough to warrant oral presentation in both of these open-label extensions in dermatomyositis and in systemic sclerosis. We think that emphasizes the unmet need that when–for novel treatments in these diseases. So, pay attention to safety and efficacy. I hope you will be delightfully bored with what you see and hear, because you're going to see more favorable safety and more durable efficacy.

We also are going to present in a poster form the baseline characteristics of subjects in the Phase 3. That should be of interest to you, because it's going to show that they look a lot like the folks who are in the Phase 2 study, although they're global. These will be middle-aged white ladies, in large parts, who are sick, who have a lot of disease activity as assessed by baseline MRSS and by the global assessments by the patients, by the physicians, by their functional disability, by their pulmonary involvement. These are sick people who are on background immunosuppressants, the ones that are in very much need of treatment, ones for whom we believe we showed potential clinical benefit in Phase 2. So, I think that would be important for you to just line up, yep, this is what they expected. That's what they got. So, that's why you should take a look at the poster.

I think in terms of competitors, when we look over it, again, I think we're pretty far advanced. We should be the first out with–assuming we find efficacy and safety, we should be the first to go in and look for approval to address the totality of disease, as Craig thought. And I think to that--and we've had a lot of discussions in the past about our primary efficacy outcome with ACR CRISS. And I think you should note that some of the companies or studies that are just a bit behind us are using this now, using the same outcomes in their attempt to say, if there is efficacy here, is there an early read and maybe that's what we move forward. So, I would just say, keep your eyes open for the early studies, what are they doing, what are they using. And I would say keep an eye out for discussions about the ACR CRISS at the meeting.

Maury Raycroft: Great. That was very helpful. And second question just on the preclinical Jenrin molecules, just if there's any more specifics on when those could potentially move into the clinic? Or when you could potentially partner those–partner one of the compounds. Anything on the strategic side, you can comment on those?

Barbara White: Sure. I'll start. It's not just Jenrin. We have our own compounds that we've made ourselves. The CB2 agonist that we're looking at come from internal. I think that we

certainly are making progress internally. We reported on the eight--we've got our own favorites. Among those eight, there are some front runners. We look forward to formally selecting the first candidate from our pipeline that will occur in the next few months, and we would anticipate moving forward, then to do the necessary studies to prepare it to enter clinic in 2021.

Yuval Cohen: And, Maury, what I'm really excited about is this gives us a bunch of things. It creates a real viable platform, no longer depending on just one asset. It also uses that asset to validate the rest of the platform, which I think will be a very powerful synergy. But last, but not least, it gives us the ability to start having dialogue with potential partners at the preclinical stage to look at indications that we ourselves would not be the appropriate company to develop. For example, we are really, really good and are geared towards rare disease commercialization. That's really our bread and butter. That's what we're excited about, especially, obviously, North America versus Asia where we're commercializing. But the platform has applications for multiple inflammatory fibrotic and even metabolic diseases, most of which are not going to be rare. For us to develop, let alone commercialize, common diseases, I think, doesn't make a lot of sense. This allows us to have those discussions and to present what we think are unique compounds with, obviously, fresh IP around them that I think will be more and more interesting, especially as we see more and more Big Pharma coming into the endocannabinoid system.

Maury Raycroft: Got it. That's very helpful. Thanks again for taking my questions.

Operator: Thank you. Our next question today is coming from Leland Gershell from Oppenheimer. Your line is now live.

Leland Gershell: Hey, good morning, Yuval and team. Thanks for taking my questions. Just a quick one back on 4001, if you could remind us, has there been set a sort of an upper limit of acceptability for penetration into the brain as we wait the PET data, and if so, what that might be in terms of permitting a go-forward development? Thanks.

Barbara White: Thanks for the question. This is Barbara. There are a lot of data upon which to develop a range of specific binding to CB1, and those data largely come actually from rimonabant. We know that the 20-milligram dose of rimonabant was associated with just unacceptable CNS adverse events and the 5-milligram was not. So–and their data in the literature about how much receptor occupancy there would be, at least in rodent brains, and one can extrapolate human brains. So, without going through all those calculations, I would say, yes, we have an internal set of ranges that is likely to be acceptable. I don't think it has to be nothing, but it has to be low enough to have reasonable assumptions that we shouldn't see that type of CNS side effects. So, I'll stop there, but say, yes, we can anticipate that.

Yuval Cohen: And Leland, again—if I can butt in. I think--I often find it really interesting to juxtapose lenabasum with CRB-4001 in the following way. With lenabasum, it really is shaping up to be--the seminal question is, does it work? Is the efficacy data going to be positive at the--in this clinical study coming up? I don't think too many people are losing sleep over the safety profile of lenabasum, at least to date, of course. CRB-4001 is the polar opposite of it. The seminal question here--the crux of it is, does it have a meaningful engagement with CB1 in the brain? If it has that engagement, then it's not worth pursuing. But if it doesn't, then oddly enough, the clinical efficacy of it, is I wouldn't say it's predictable, but it's very close to that. Rimonabant was a very, very potent drug for a variety of things. Its clinical efficacy was never in dispute. So, this is a program, which I think is a little bit unusual, because I think the value inflection, oddly enough, here is going to be all about the safety. Once we clear the safety, the rest of it becomes much more easy to predict.

Barbara White: And just as a brief little technical scientific reminder, I forgot, Leland, since you asked. Our drug, 4001, also differs from rimonabant in its binding affinity for the splice variance of CB1 called CB1b that is preferentially expressed in the liver and the one that we think is important in driving some of the pathogenesis of NASH. And that is really just not expressed in the brain. And so, we think that at levels in which we can have adequate receptor occupancy by 4001 of CB1b in the liver that--that differential binding will actually also improve the safety profile and improve the safety margin that we have, because that's the one we need to engage more than the regular CB1.

Leland Gershell: Okay. Thanks for that comprehensive answer. I look forward to ACR.

Operator: Thank you. Our next question today is coming from Liisa Bayko from JMP Securities. Your line is now live.

Jonathan Wolleben: Hi, thanks for taking the question. Jon on for Liisa. I was hoping you could tell us a little bit more about the preclinical CB programs that you unveiled at your R&D Day over the summer. What's kind of looking promising? Any more characterization? Is there something that looks like a lead ahead of the rest? And then, I also noticed a recent kidney partnership for CB1 agonist, and I was hoping if you could discuss kind of maybe branching out in the more nephrology? Thanks.

Barbara White: Sure. Yeah, we, right now, have our current favorite, and that's one called 496. Okay, that's it's number. And it is a CB1 inverse agonist, and it's got some very favorable biologic activity in inflammation and fibrosis assays and some favorable characteristics, and we're really pleased with it so far. It's got a long road to go forward. We acknowledge that. But it's probably the lead horse right now.

I think in terms as we think through potential indications, I couldn't agree more. The beauty of the--targeting and the endocannabinoid system, and CB1 inverse agonist, in particular, is their potential efficacy in fibrosis in multiple organs, whether it's the liver, the kidney, the lung, the heart. There's just a lot of data to think that these have the potential to be efficacious. So, as we move CB1 inverse agonists forward--and right now, our lead horse is 496. That could change. We are thinking about where the best initial indications are for that.

Yuval Cohen: And, Jon, if I can butt in. First of all, kudos. I think you're the one who actually sent us the heads up on that one. So, that was really, really interesting. Talking about CB2 for a second, I think I mentioned it a little bit earlier. So, what's happening there is pretty much out of the blue. Roche came up with a publication looking at a CB2 agonist, so conceptually similar to the lenabasum, preclinical data, early days, looking at the mouse model for uveitis. And my guess here is that they are constrained to a topical application. That's not unusual with some of these synthetic cannabinoids—they're difficult to formulate otherwise. But that was really interesting. Uveitis is a very, very logical approach to dealing with inflammation in the eye through CB2. And it's interesting to see how Big Pharma, again, is dipping their toes into this biology, placing bets on compounds.

And what really excites me about in our preclinical pipeline is we have all of that covered. For a Big Pharma, that's interesting in targeting or neutralizing CB1 - we have those compounds. For Big Pharma interested in agonizing or activating CB2 - we have those covered, as well. And, again, with patents, that are typically much fresher than theirs.

Jonathan Wolleben: Thanks for the color and the updates, guys.

Operator: Thank you. We have reached the end of our question-and-answer session. And, ladies and gentlemen, that does conclude today's teleconference and webcast. You may disconnect your lines at this time and have a wonderful day. We thank you for your participation today.