Revance Therapeutics, Inc. (NasdaqGM:RVNC) Transcript Details

Executives
Jacob Waugh
Jeanie D. HerbertSenior Director of Investor Relations
L. Daniel BrowneFounder, Chief Executive Officer, President and Director
Lauren P. SilvernailChief Financial Officer, Principal Financial & Accounting Officer, Executive Vice President of Corporate Development and Secretary

Analysts
David A. AmsellemPiper Jaffray Companies, Research Division
Ken CacciatoreCowen and Company, LLC, Research Division
Shibani MalhotraNomura Securities Co. Ltd., Research Division
Tim LugoWilliam Blair & Company L.L.C., Research Division

Presentation

Operator

Welcome to the Revance Therapeutics BELMONT 6-month Interim Results Conference Call. [Operator Instructions] As a reminder, this conference is being recorded today, October 29, 2015. I would now like to turn the conference over to Jeanie Herbert, Senior Director of Investor Relations for Revance. Please go ahead.

Jeanie D. Herbert

Thank you, Stephanie. Joining us on the call today from Revance Therapeutics is President and Chief Executive Officer, Dan Browne; Chief Financial Officer and Executive Vice President of Corporate Development, Lauren Silvernail; and Jacob Waugh, Co-Founder and Scientific Adviser.

Earlier this morning, Revance Therapeutics issued 6-month interim results for the BELMONT Phase II active comparator trial for RT002 injectable for the treatment of glabellar lines. If you have not received this press release or you would like to be added to the company's distribution list, you can do so on the Investor Relations page of the company's website at www.revance.com.

During the course of this conference call, Revance management will make forward-looking statements including, but not limited to, statements related to Revance Therapeutics' clinical development of our product candidates, business strategy and goals, plans and prospects, the markets in which we compete, potential product candidates and benefits of our current and future product candidates and our technologies, regulatory risks and ability to obtain regulatory approval and uncertainties and future performance.

These forward-looking statements are based on the company's current expectations and inherently involve significant risks and uncertainties. Our actual results and the timing of events could differ materially from those anticipated in such forward-looking statements as a result of these risks and uncertainties.

Factors that could cause results to be different from these statements include factors the company describes in the section entitled Risk Factors in our annual report on Form 10-K for the year ended December 31, 2014, as filed by the SEC on March 4, 2015, and subsequent quarterly reports on Form 10-Q.

Revance cautions you not to place undue reliance on forward-looking statements and undertakes no duty or obligation to update any forward-looking statements as a result of new information, future events or changes in its expectations.

If you are on a webcast, we'll be walking through the set of slides. If you are on a call only, the slides will be available on the Investors section of our website for reference. After we complete the slide deck, we will open the call for questions.

I will now turn the call over to Dan Browne. Dan?

L. Daniel Browne

Thank you, Jeanie. Good morning, and thank you for joining our BELMONT interim results webcast and conference call. I must tell you it feels really good to be here at the office at 5 in the morning because we are very excited to share with our top -- our top line readout

from our BELMONT active comparator trial, as it indicates that we indeed have the next-generation neurotoxin with really the potential to offer a superior duration of effect to BOTOX Cosmetic and possibly other commercially available botulinum toxin products.

Our botulinum toxin product, combined with our proprietary TransMTS peptide, provides a significant scientific advancement in neurotoxin therapy that has the potential, when approved, to meaningfully expand the injectable market.

Before jumping into data, I'd like to thank our Co-Founder, Jacob Waugh, and Art Bertolino for their design and execution of this study but also the larger clinical, regulatory, manufacturing teams and the entire Revance organization for their efforts to execute such a well-controlled and positive study. While I have the distinct pleasure and privilege to present the summary findings this morning, the results, it's really the larger group of people who've made this happen.

Turning to Slide #3. We all need to remember that these are 24-week top line interim results. This is a very rich data set. It's an exciting data set, and we'll continue to do analysis over the coming months and report the final data in the first half of 2016.

As you look at Slide #3 as a summary, I just wanted to make one introductory comment that we had an interesting amount of feedback on this study of whether it should be a study compared to placebo or whether it should be an active comparator trial. We had tremendous confidence based on the informed nonclinical and clinical data that the next best step for RT002 was an active comparator trial.

As you look at the 3 doses that were studied in this active comparator trial, all 3 doses, 20 units, 40 units, 60 units, achieved highly statistically significant investigator-reported primary efficacy at a p-value of 0.001 at the week 4 primary efficacy assessment. This is the historical assessment interval for efficacy for all neurotoxins.

As measured by the investigator scoring, all 3 RT00 (sic) [RT002] doses achieved 100% 1 point or greater response rates at weeks 4, which was maintained all the way through to week 8. As measured by patients, RT002 achieved at or near 100% response rates for no to mild wrinkles in all dose groups at week 4.

As we look at the safety profile, it was excellent. The drug appeared well tolerated with no serious adverse events at any dose based on the interim analysis. We had 0 eyelid ptosis for the 20 and 40 units of RT002 and a very strong, excellent risk/benefit ratio at all doses. We also saw very encouraging dose response that was observed. And most importantly, through this data set, we've been able to select a dose to move into Phase III. And we plan to engage the FDA and other regulatory authorities to accelerate the 40-unit dose into pivotal Phase III trials next year.

Turning to Slide #4. As we look at the most important characteristic of this trial, our focus on the extended duration of RT002, I'm pleased to report that RT002 achieved a 6-month duration of effect with very high responder rates. This was statistically superior in duration to the BOTOX Cosmetic product, a 6-month duration of at least 1 point improvement as measured by the investigators, and the 40-unit dose provided a 23.6-week duration versus 18.8 weeks for the BOTOX Cosmetic.

So in this one, the statistical significance was not only superior to the BOTOX at the 24 weeks, it also allowed us to extend the duration in our labeling, if confirmed in Phase III trials, to 6 months compared to the current labeling for other commercial products, which is only up to 4 months' duration, so 2 additional months of duration.

At week 24, RT002 at the 40- and 60-unit doses continued to deliver clinically meaningful higher response rates versus BOTOX Cosmetic. More specifically, the 40-unit dose is statistically superior in duration to BOTOX on all key responder definitions measured by the investigators, including at least 1-point and 2-point improvement in none and mild wrinkles. This is the critical attribute that patients look at when they look at the duration of their underlying neurotoxin treatment.

These results were consistent with the labeling of a 6-month product, if confirmed in Phase III trials. So in essence, we did better than BOTOX, and it did rely on BOTOX doing worse than previous trials either cited in the literature or in the label. In this case, RT002 outperformed BOTOX Cosmetic.

Turning to Slide #5 on the actual study design. This was a Phase II randomized double-blind, dose-ranging, active and placebo-controlled, multicenter study to evaluate the safety and efficacy and duration of RT002 to treat glabellar lines. The objectives of the study were to determine the safety and efficacy of a single treatment of RT002 at the 3 dose levels for the treatment of glabellar lines versus the current market leader, BOTOX Cosmetic, which has the trademark VISTABEL in Canada.

The 3 doses studied were RT002 at 20 units, at 40 units and at 60 units. The active comparator was BOTOX Cosmetic at 20 units using the labeled dose, the labeled reconstitution and dosing and injection pattern that has been cited in the literature. And then finally, the fifth group was the placebo group.

To assess the duration of effect of a single treatment of RT002 at 3 dose levels versus the cosmetic BOTOX, we used very high experienced injectors in Canada and the consistent labeling and use of the toxin that's been developed over time.

Looking at Slide #6. As I mentioned at the start, this is an interim analysis. We'll continue to conduct additional analyses as we work to finalize the report in the first half of 2016. But the efficacy evaluations versus baseline were every 4 weeks for up to 36 weeks using the Investigator Global Assessment-Facial Wrinkle Severity scale. This is the IGA-FWS. We also used subjects that were followed for at least 24 weeks using the primary efficacy assessments of greater than 1-point improvement in the IGA-FWS, the duration of response as well as the risk-to-benefit ratio.

The secondary efficacy assessments were investigator IGA-FWS at both 1- and 2-point improvement; Subject Global Aesthetic Improvement Scales, the GAIS; and finally, the Patient Facial Wrinkle Scale, the PFWS. These are all historically the news in neurotoxin development and the news to support labeling and approval with the FDA.

As we dig a little deeper on Slide #8, we'll look first at the 4-week primary efficacy assessment. This is the efficacy assessment that all neurotoxins have been regulated and looked at as far as their primary efficacy at the 4-week follow-up interval. I think it's very encouraging to see that 100% response rates for RT002 at all doses.

Here, if you look more specifically at the placebo, BOTOX and as well as the RT002 at 20 and 40 and 60 units, here you can see the 1-point improvement. Here, in this case, placebos provide little to no efficacy. You have BOTOX that had 1 point efficacy of approximately 95%. This is consistent with the literature. This is consistent with the label. But as you look at the performance at the 1-point threshold at 4 weeks, you see 100% responder rates for all 3 dose groups. Very encouraging that the physicians pick this up.

At the 2-point threshold, you see no efficacy for the placebo groups. You've got 76% for BOTOX Cosmetic, roughly in line with the 2-point -- with the 20-point -- excuse me, the 20-unit doses. But where you really start to see very strong separation and performance at 4 weeks is at the 40 and 60 units, with 85% and 95% separation to the 76% for BOTOX. The 60-unit dose was statistically significant to the BOTOX Cosmetic test.

Finally, looking at the attributes of none to mild wrinkles at the 4-week follow-up interval. Once again, we had 0 efficacy for the placebo group. We had 93% for the BOTOX group, but yet we see even elevated efficacy in the 20, 40 and 60 units with 97% for the 20-unit, 97% for the 40-unit and then finally 98% for the 60-unit.

As we look at Slide #9 and the summary of safety, this is for the entire population of patients enrolled in the study. All 5 groups exhibited an excellent overall safety profile in the interim data. There were no serious adverse events in any of the 5-dose groups. The adverse events that were seen were typically localized, transient and mild in severity and were typically injection-related complications that you see with injectables, mainly erythema and pain.

The 2 most common adverse events reported by subjects were headache and erythema. We've listed these in the numeric values for each of the dose groups. You see that all the groups were well tolerated and generally recognized as safe to the 6-week -- or excuse me, the 24-week follow-up interval.

As we look at the incidence of ptosis, we had 0 ptosis at the 20- and 40-unit doses. The BOTOX group had 1.9%, a small number with an n of 1. This is consistent with the labeling for BOTOX as well as what's been reported in the literature. As you look at the 60-unit dose, there was a 3 mild transient, 1 moderate ptosis, all of which resolved fairly quick. Highest doses at roughly 3x the dose of BOTOX, you're starting to see some downward diffusion, but all the events that reported were mild and resolved quickly.

As you look at Slide #10, this really is the most powerful graphic to look at the duration of how RT002 begins to separate for BOTOX. This is a Kaplan-Meier curve, which will look at the 40-unit dose that we'll take into Phase III pivotal trials.

Here, as you look at the bottom line at the bottom, you can see that consistent with the prior tables in the earlier slides, there are no efficacy for the placebo group. Here, you start to see the duration for the BOTOX group at 20 units, where it drops off at 24 weeks. Here, you look at the 40-unit dose. Here, we have the Kaplan-Meier groups that show the superiority of the 40-unit dose over BOTOX. I would also mention as we look at subsequent analysis that both the 20- and the 60-unit doses are above the BOTOX line of 20 units.

Turning to Slide #11. 02 at 40 units outperformed BOTOX at all time points. It showed consistently higher response rates for the none or mild wrinkles by the investigator assessment at all time points. Here, walking you through the intervals from the 4-week primary assessment all the way up to week 24, you see consistently higher response rates for the none to mild.

And here, as you look at where both products end up at roughly 1/3 of none to mild wrinkle severity, we're 2 months over BOTOX, I think a very encouraging efficacy profile and once again another demonstration of extended duration.

I also wanted to mention that this is not just a dose effect. We are not getting this efficacy just because we put in 20 additional units. If you look at the 20 units versus the BOTOX units, you see consistently higher numeric values that are clinically meaningful in favor of the 20-unit dose. And at week 16, you see highly -- or excuse me, you see statistical significance of 53% in favor of 20 units of RT002 versus 32 units in the BOTOX 20-unit dose.

Turning to just a couple of photographic examples on Slides 12, 13 and 14. The first one is the example of the 1-point improvement on the IGA-FWS scale. This is the 40-unit dose at maximum frown. Maximum frown is the assessment interval that will be used for

regulatory approval. Here you can look at the pretreatment baseline severity of the glabellar complex. You can see those 11 lines that originate from the center of that complex. Following single treatment, you see very nice flattening of the glabellar complex. You see good effect of that -- the complex is able to withstand wrinkling at forced maximum contraction. Hard to tell in this photos are cropped but yet you see really nice improvement 6 months following administration.

Another example on Slide 13 at 40-unit at maximum frown. Here a little less pronounced, starting baseline severity of the glabellar wrinkles here following single treatment. Very nice moving at 6 months as far as 1-point improvement.

But as you also look at the typical examples of the response we see at 20 units, here's another patient on Slide 14 that looks at the underlying glabellar severity at baseline versus the type of treatment that we see at 24 weeks or 6 months. Once again, great flattening, a nice consistent symmetry across the glabellar. No evidence of ptosis, a very satisfied patient at the 6-month follow-up interval.

So at this point, based on the analysis that we've been over the last couple of days, and it's been an exciting couple of days that we've crunched a lot of data. The 5 predominant conclusions are the 02 product achieved statistically significant 6-month duration of with higher responders compared to BOTOX.

The 02 product achieved 100%, investigator and near 100% patient response in all doses at the 28-day primary efficacy assessment. The 02 at the 40-unit dose was well tolerated with no ptosis. Efficacy was statistically superior at the majority of time points compared to BOTOX.

02 at 40 units resulted -- had 31%, and I want to emphasize this 31% maintained none or mild wrinkles compared to BOTOX 12% at 6 months. So even though the median duration is at 6 months, those patients were still beyond that are continuing to hold their response, continuing to hold that 1 point in benefit, which is clinically meaningful and therefore will be able to sort of delay subsequent treatments.

And then finally, the BELMONT results support the selection of the 40-unit dose to move into Phase III. It's really based on the totality of the data across all the efficacy assessments, the duration, the high-risk safety profile for us gives us the confidence to move into Phase III next year.

I also wanted to mention on Slide #16, as part of the BELMONT study, we spend a lot of time with questionnaires, with patients to look at the importance of duration. And I think this is consistent with the market research that we presented in previous calls, that duration is the most evasive attribute in neurotoxin development today.

And when you look at this data, you've got nearly 87% of the subjects who said duration was somewhat important, important or very important. Patients get this, and I think physician response from this concept of longer duration has also been enthusiastically received. And we've got more than 50% of patients who rated the duration as very important.

So as we look at 02 as differentiation from the existing commercial products, we think this is the attribute, when combined the strong efficacy and signals that we're seeing, gives us great confidence moving into Phase III.

So with that, I'll -- just next steps -- planned next steps for 02 in the glabellar lines. We plan to complete the study in the first half of 2016. This will be predicated on getting all these patients back and finalized. We would like to get this data into one of the major clinical meetings in 2016 and then turn into a manuscript after that. We expect to complete our End-of-Phase II meeting with the FDA in the first half of 2016, and we anticipate initiating 2 major Phase III pivotal trials in the second half of 2016.

So with that, I'll stop and open it up for questions.

Question and Answer

Operator

[Operator Instructions] Our first question comes from Ken Cacciatore with Cowen and Company.

Ken Cacciatore

Congratulations on the data. Very exciting. I guess I wanted to just step backwards first before we talk more specific and maybe go into what you did in the presentation, the why behind the longer duration. If you could talk a little bit about the science behind it and then maybe differentiate 002 to BOTOX as some folks may wonder if you double the BOTOX dose, would you accomplish something similar. So if you could first just step back and give some of the explanation behind the technology. And then I'll have a follow-up.

L. Daniel Browne

Great, Ken. This is obviously a technology that we're exploiting both in the longer duration as well as topical. And I'm going to ask Jacob to comment on mechanism because he's really the architect of this technology.

Jacob Waugh

Great. So it appears that the peptide affords us essentially some high affinity binding, so that while you were actually injecting the liquid containing the toxin, the toxin particles are not diffusing uniformly to the fluid front. So essentially, you're restricting the toxin to where you inject it better so you see less spread. Basically, it stays where the needle tip is as opposed to flowing away from that point. And the end result of that is that you see essentially more effect where it was injected and the end result is a longer duration as well.

Ken Cacciatore

Great, that's really helpful. And then also maybe, Dan, what wasn't talked about is plans from a therapeutic perspective. It would seem as if this product could actually be as exciting, if not more so, on the therapeutic side. So could you just discuss those development plans, what you're thinking and how quickly we could go into the clinic? And maybe from a dose perspective, clearly talk about the potential for maybe higher doses or how are you even just thinking about the therapeutic side?

L. Daniel Browne

Yes, no, I think given this molecule, it is impressive in its ubiquitous way to be used across the aesthetic and therapeutic indications. I think in our view based on the clinical discussions, the scientific work, we felt that glabellar was the perfect indication to assess duration. There was a well-characterized scale. There was lots of history to compare both the label, but more importantly, the expanded clinical literature. And as you look at a very targeted anatomy with specific doses in an active comparator trial, it gave us a very focused ability to differentiate doses and competitive products. We have the CD trial underway, as you know, Ken, and we're excited about that coming back with the safety, efficacy and duration. And our belief based on this data, that if we see this type of response, we see this type of duration, as far as a working thesis, a working hypothesis, it's reasonable to believe that it's going to work in other indications where neuromodulators are used. So we'll have that data with CD here in the coming months, and we'll just have to see what that looks like. But I agree. We think having a product with longer duration will be a particular benefit in the therapeutic because of the pharmacoeconomics, the safety, potential safety issues that may present with larger doses in larger anatomies. And we're excited to take this data, digest it and apply it to other therapeutic indications, and hopefully, we can do that as quickly as possible.

Operator

Our next question comes from David Amsellem with Piper Jaffray.

David A. Amsellem

Congratulations, and a couple of questions on my end. So first, I realize you're going to have to have your End-of-Phase II meeting with the FDA, but maybe give us your sense of what the design of the pivotals will look like. And specifically, is it safe to assume that there will have to be a BOTOX comparator? Or is it -- or can you just do a standard neuromodulator trial where it's just placebo controlled? So help me understand how we should think about that. And then also in terms of pivotals in the cosmetic setting, maybe walk us through time lines in terms of doing long-term safety, your safety database and just remind us when you think you'd be in, at least, in a position to file what's the earliest time line to filing. And then lastly, in terms of the therapeutic indications, and I know you alluded to this, but what areas -- I mean, what, right now, would you prioritize? I mean, is it migraine? Is it overactive bladder? Is it cervical dystonia? I mean, just give us a sense of what you think makes the most sense in terms of prioritizing, realizing that you may not be able to greenlight all of these therapeutic indications at the same time.

L. Daniel Browne

Quite a run of questions there. Let me sort of see if I've got them. We'll start with the design first. And I think we feel, obviously, pleased with the data that -- as I mentioned at the start, we caught a fair amount of grief that the safest, least risk path would have been to do the BELMONT trial compared to a placebo. Why take on the additional risk with an active comparator? Particularly, one, is we have the greatest respect for that product. It has really been wonderfully developed and its performance is quite good. And this was less about development to an approval but really understanding our technology and how it compared to the current market leader. In our view, and I appreciate the board's support for getting behind Jacob, Art and the clinical scientific teams, to do that active comparator trial early. Let's just see, right? We know the drug is going to work based that all the neurotoxins are good sponsors, they're good products, but let's just see if we can differentiate and we felt that duration was one that we should take a look at. So this is a data set and I think that it's consistent with the previous trial, which informed the design of this one as well as the nonclinical literature. But moving forward in the pivotal Phase III, I think you'll look at more classic development in the U.S., which will be RT002 versus placebo. You're not going to have to carry an active comparator trial all the way throughout development. You'll go back to the way all the other products have been developed. You'll use those approval endpoints of 2 point and 1 point. You'll look at a composite endpoint based on the most recent approvals. And we would expect to follow that same road map to mitigate and lessen our clinical regulatory risk. Look at the time lines. It's really sort of predicated, David, based on where we end up on the totality of this data and get it all in and moving forward. But I'll let Lauren comment specifically where we're following on specific time lines.

Lauren P. Silvernail

Great. Thanks, Dan and Jacob. Good morning, David. We're very excited from a time line standpoint with this duration and it starts to allow us to really nail down more what the development schedule is. So as we -- as Dan has mentioned, our next big step, of course, is to wrap up this study, see what the final duration is. And then we'll be doing an End-of-Phase II meeting, allowing us to start Phase III later in 2016 in the second half. That then allows us to wrap up the efficacy work in '17, the safety work in '18 and file that BLA in late '18 to '19.

L. Daniel Browne

As far as the therapeutic uses, that's probably the most challenging of the 3 main questions you asked, David, is the issue -- constraints you have with this molecule was not what you work on but what you don't work on. There's just so many potential indications. I think for us on the therapeutic side, it's really looking at muscle movement. It's collectively the largest of all the therapeutic uses for BOTOX. Secondly, by the pain indications, in general, from the prophylactic treatment of chronic migraine headache to other potential indications that could be muscular, skeletal or neuropsychiatric or some of the other opportunities. And I think we'll look at this data set, we'll look at our capital, and we'll have to make choices. We can't work on all the indications for toxin nor can many of the current market leaders. But we'll pick indications where this technology, this product, will be differentiated from the current uses. And we expect you'll see some potential new uses, which is equally exciting.

Operator

[Operator Instructions] Our next question is Tim Lugo with William Blair.

Tim Lugo

Congratulations on the data. I know 02 has always been discussed as a more -- potentially having a more durable effect, and we're obviously seeing that in the data. But can you maybe talk about the week 4 results? It looked like an improvement over BOTOX. And does that change at all how you're framing this product development and maybe even health divisions eventually?

L. Daniel Browne

Jacob, do you want to take that one, first?

Jacob Waugh

Yes. So we're looking very high efficacy at week 4, but all the toxins are highly efficacious at week 4. So just in terms of how I would think about it, it's a not fundamental shift, particularly across all of the toxins.

L. Daniel Browne

Yes, I think, Tim, we, as I mentioned, think the data collectively historically for all the injectables are at very good at 4 weeks. It would be really hard -- the numbers would be quite large show superiority at that. I think we've come away from that. We're feeling really good that regardless of whether you're at the low dose or the high dose, you're seeing higher response rates. And I think we'd be hesitant to say that based on this data set, that they're better than. We just think that we're encouraged to come away with -- at the same level of efficacy at that 4-week time period.

Tim Lugo

Okay. I know we have -- these are all interim results. When will we have the final meeting duration? And do you expect the BOTOX meeting duration to move at all between now and the final results?

L. Daniel Browne

I'll let Jacob sort of comment on the math, but we don't think, based on where we're at and the patients that are in, all patients have completed their 6-month follow-up, that the median duration mathematically will change. So the intervals on the right-hand side of the Kaplan-Meier will tighten up. That sensitivity will improve and become more acute, but the meeting duration isn't going to change at this point.

Operator

Our next question comes from Shibani Malhotra with Nomura.

Shibani Malhotra

I think I just have a couple. So one is going back to Ken's question, the first question, mechanism of action. Again, can you explain why -- how this compares to BOTOX specifically. And then along those lines, when we've looked at this with physicians, I think they said that duration is extremely important, but precision and being able to kind of control the patient's response, et cetera, is the most important. And given that physicians are very familiar with using BOTOX, can you just talk about what data you have to show that there's no kind of -- we're not compromising on that side at all? And then, finally, Dan, can you talk about plans going forward? Like, are you looking for a partner? Or are you looking to kind of move this forward on your own?

L. Daniel Browne

I'll let Jacob take the first 2 and I'll take the last one. Jacob, do you want to...

Jacob Waugh

Okay. So the mechanism of action, essentially, we're looking, based on our nonclinical data, at a reduced spread toxin at the time of injection. It is more highly localized where the needle is placed. That then results in essentially a more complete takedown of neuronal signaling there, which then leads to a longer duration. So essentially, it's the things we've said. This is a reduced diffusion toxin and the end result is that, even at comparable doses, we'll see now better efficacy. But as we increase the dose, we are seeing that we don't see an increase so far in AEs, but we do see an increase in duration.

Shibani Malhotra

Okay. And then patients and physicians kind of saw this as a similar effect to BOTOX in terms of the facial aesthetics, correct?

Jacob Waugh

Yes, the facial aesthetics, the outcomes were similar. In that 4 weeks, they're both seeing a similar overall efficacy profile. It's just we're seeing better durability in what that effect is.

L. Daniel Browne

Shibani, what was the third question?

Shibani Malhotra

It was about commercial plans, like are you going to do this alone? Or are you looking for a partner?

L. Daniel Browne

Look, I think we feel really good about this platform and the combination of this neurotoxin molecule with the TransMTS peptide. We're well capitalized at this point. We've got a number of products in dermatology, seen a number of indications in neurology and dermatology. We don't feel compelled at this point to partner but really to continue the development and really sort of this is all about data. And at the appropriate time, we'll look at that, but right now, we feel really good about moving forward as a standalone entity and keeping our rights intact globally. And as we get closer to commercialization, we'll take a look at that. But at this point, we feel like moving forward by ourselves is the most prudent way to move forward to create value.

Operator

And I'm showing no further questions. Ladies and gentlemen, that does conclude today's conference. You may all disconnect, and everyone, have a great day.