PROVECTUS BIOPHARMACEUTICALS
First Quarter 2016 Business Update Conference Call
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Operator: Greetings, and welcome to Provectus Biopharmaceuticals First Quarter 2016 business update conference call. At this time, all participants are in a listen-only mode. A brief 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.

I would now like to turn the conference over to Michael Porter. Thank you. Please go ahead.

Mr. Michael Porter: Greetings, and welcome to the Provectus Biopharmaceutical First Quarter 2016 business update call. Thank you, Brenda. Good afternoon, and welcome to our call.

At this time, I must advise all listeners that this call contains forward-looking statements as defined under the U.S. Federal Security laws. These statements reflect management's current knowledge, assumptions, beliefs, estimates and expectations and express management's current view of further performance--future performance, results and trends. And such forward-looking statements may be identified by the use of the terms such as anticipate, believe, could, should, estimate, expect, intend, may, plan, predict, project, will, and other similar terms.

Forward-looking statements are subject to a number of risks and uncertainties that could cause our actual results to materially differ from those described in the forward-looking statements. You should not place undue reliance on forward-looking statements. Such statements are made as of the date of such statements. We undertake no obligation to update such statements after this date.

Risk and uncertainty that could cause our actual results to material difference from the described in forward-looking statements, including those discussed in our filings with the Securities and Exchange Commission, including those in item 1A of our annual report on Form 10-K for the year ended December 31, 2015 filed with the SEC.

It is now my please to introduce you to Peter Culpepper, Interim CEO and COO of Provectus. Good afternoon, Peter.

Mr. Peter Culpepper: Thank you, Mike, and welcome, everyone to Provectus Biopharmaceuticals First Quarter 2016 business update conference call.

This year is shaping up to be a year of significant change for Provectus. Among other things, we expect to have interim data from our Phase 3 study of PV-10 as a treatment for locally advanced cutaneous melanoma. See initial data from our Phase 1b/2 trial of PV-10 in combination with Pembrolizumab for metastatic melanoma, expand our clinical program in hepatic cancers, and advance our interactions with perspective corporate partners. Our clarity on these topics will be more precise with each passing quarterly conference call.

I believe that in our third quarter call this coming November, we will be in an excellent position to discuss the status and timing of data and the effects on our business becomes with evermore advanced clinical data.

To get to this potentially important infraction point, we can expand a number of sites and increase the speed at which we recruit patients and we are working to do that. Currently,

clinicaltrials.gov shows that our Phase 3 study has five sites recruiting patients and another two sites in process of so doing. We expect many more sites in the coming weeks.

I remind listeners that even though there may be other sites in the process of opening that are not public, but until they list them on clinicaltrials.gov site, we aren't able to publicly comment on them with any specificity. In addition to increasing the number of sites, we have expanded the pool of potential patients in the trial by amending the protocol. This extended eligibility to include Stage IV M1A patients having no active nodal or distant cutaneous or subcutaneous metastatic disease.

These patients have disease characteristics and prognosis similar to that of the Stage 3B and 3C patients, but initially defined the study patient population.

The amended protocol also clarified eligibility for patients not having access to immune checkpoint inhibitors due to standard of care and those not having access to targeted therapy due to standard of care as well as inclusion of patients who have failed targeted therapy.

In short, there are now more patients who can participate in the study and that should optimize recruitment.

While we wait for the interim results from the Phase 3 study, there is still a lot of other work to do on the clinical development for PV-10 and PH-10. We continue with our Phase 1b/2 trial of PV-10 in combination with Pembrolizumab, an anti-PD-1 drug approved by the FDA and marketed by Merck as Keytruda.

As I said in our yearend 2015 call held on March 30th, we believe we can also successfully combine PV-10 with Bristol-Myers Squibb's Opdivo, which, like Keytruda, is an anti-PD-1 systemic immunotherapy.

We also expect to be able to combine PV-10 with many different additional agents due to the unique mechanism of action and delivery approach of PV-10.

While I am on the subject of the mechanism of action, let me provide some insight on developments there. Dr. Shari Pilon-Thomas of the Moffitt Cancer Center recently presented some of her team's non-clinical research at the American Association for Cancer Research, AACR, annual meeting 2016 in New Orleans. She said, "Our results show that combining intralesional PV-10 with anti-PD-1 co-inhibitor [unintelligible] not only suppresses tumor growth versus either agent alone, but also yields market increases in tumor specific T-cell activation against injected tumor."

This helps illustrate the potential value of PV-10 in combination therapy constructs and may delineate possible new strategy that could harness additional targets in T-cell signaling. The work on the mechanism of action continues, but I firmly believe the important point for investors to know is that there is an identifiable mechanism for PV-10 already characterized in that PV-10 has potential growth as a standalone treatment and as part of a combination treatment.

Moving beyond melanoma to other indications, we initiated a protocol for a Phase 1 study of PV-10 in treating neuroendocrine tumors, NET, metastatic to the liver. Timothy Price, MD will serve as principal investigator for the study at the Queen Elizabeth Hospital in Woodville, South Australia.

The 12 patient Phase 1 study will run up to 48 months with interim data anticipated at the halfway point of the two cohort study. In addition, as discussed in the yearend call, we have been developing a Phase 1b/2 protocol to pursue development of PV-10 to treat hepatocellular carcinoma, HCC. The Phase 1b portion of the study will commence in Asia based on input from [unintelligible] under the auspices of our collaboration with Boehringer Ingelheim.

Colon cancer is another indication for which PV-10 may offer exciting potential. Data on the immunologic effects of PV-10 on colon cancer cells were presented in February at the 11th

Annual Academic Surgical Congress in Jacksonville, Florida. They came from the University of Illinois at Chicago, reported the testing of PV-10 on colon cancer mirroring CT26 cells show cytotoxicity consistent with immunogenic apoptosis. Researchers also observed cellular apoptosis, [unintelligible], and endoplasmic reticulum, RE, stress.

These results are consistent with immunogenic cell death caused by PV-10. In other words, not only does this study prepare the way for a Phase 1 study of PV-10 for colon cancer, but it also further corroborates the mechanism of action seen in other studies. The studies shows PV-10 as an abrasive immunotherapy for solid tumors and parallels immunologic signaling noted upon ablation of melanoma with PV-10.

As time goes by, we expect to comment on further studies of PV-10 as a treatment for prostate, breast, bladder, pancreas, and other solid tumors.

The progress we have made with PV-10 resulted in Provectus being invited to attend Cellular Horizons the Third International Conference on the Progress of Regenerated Medicine and Its Cultural Impact. This conference was held April 28 through 30, 2016 in Vatican City and hosted by the Vatican's Pontifical Council for Culture, The Stem for Life Foundation, and the STOQ, Science, Theology, and the Ontological Quest Foundation.

The Stem for Life Foundation is the educational and advocacy subsidiary of the Cura Foundation and is devoted to fostering global awareness of the potential for regenerative medicine to treat and cure a range of deadly diseases and debilitating medical conditions as opposed to merely treating their symptoms.

The Foundation stands at the forefront of the fundamental shift away from traditional drug treatment in favor of amplifying the body's natural repair mechanisms to vanquish disease, including cancer. We were there with one of our investigators, Grant McArthur, who leads investigations into new cancer treatments that control cell growth, division, and differentiation.

What I think caught the eye of the organizers was our research into the mechanism of action for PV-10. It suggests that there are treatments such as PV-10 that augment the body's own disease fighting powers and could bring new tools to the medical profession in treating many kinds of disease. We quoted Dr. Robin Smith, president of The Stem for Life Foundation, in our press release who said that the idea behind the conference was the grand motion, "That the cells of our bodies hold the potential to vanquish disease, reduce global suffering, and inspire hope for people around the globe living with illness."

The immune response that PV-10 appears to trigger after PV-10 ablates cancerous tumors is indeed very much in that spirit and we applaud the efforts of Dr. Smith and others throughout

the world as we endeavor to further utilize agents like PV-10 to improve patient outcomes with safe, effective, and globally sustainable capacity.

This kind of conference raises our profile in scientific and commercial circles and we believe that awareness and visibility will assist us in bringing PV-10 to market.

Turning briefly to our work with PH then, our investigational dermatologic drug, we anticipate reporting on our Phase 2 results. They projected in a Phase 2 meeting with the FDA and toxicology work necessary support--to support PH-10 approval. This will be communicated as soon as we can.

Mechanism of action study has been critical and the company will be seeking a licensing agreement based on the strength of these MOA studies and clinical data.

Leaving clinical development, let's move on to corporate developments.

We will communicate the results of our 10Q as soon as possible and we will also continue to update the market with respect to our cash balance and New York Stock Exchange relationship, et cetera, in the coming short period of time.

Our search for a permanent CEO continues and the board is in the process of forming a search committee to oversee this process. When the board has appointed a candidate, we will issue a press release and file a form 8K with the SEC announcing his appointment. The resignation of Dr. Dees as our CEO was addressed in a special call in March and I just want to reiterate that his primary recent role in the development of PV-10 was on the immunology understanding of the way PV-10 works. That part of his contribution has received external validation. And so, his departure has no material effect on our work with the characterization of the mechanism of PV-10 or with the FDA, which has been the responsibility of our CTO, Dr. Eric Wachter.

At this point, I can certainly say that we will further disclose in the form 10Q more information with respect to Dr. Dees.

We are moving past that part of our company's history to what we hope are brighter days ahead as we strive for additional milestones in our development of both PV-10 and PH-10.

Provectus's business strategy rests on five clinical and business value proposition pillars of PV-10 and PH-10. And our company has four key focus areas. The first pillar is our intellectual property portfolio. The second pillar is our management and control of the drug substance and drug product supply chain. Third is the regulatory guidance and support we receive from the FDA in the US and its counterparts in other nations. The fourth pillar is the knowledge of the

mechanisms of action of--for both PV-10 and PH-10, which we continue to better understand and more comprehensively discuss publicly. And fifth is the clinical study designs that generate randomized pivotal and otherwise significant clinical data to support potential approval of PV-10 and PH-10 for the respective indications.

Our four focus areas in business and corporate development are a higher public profile for both Provectus and PV-10 through the company's engagement of Allison and Partners and intensive media relations outreach efforts related there, co-development discussions based on rational drug combinations with big pharma sponsorship, other strategic activity, such as regional licenses, collaborations, investments, et cetera. And grant programs, including those in the EU, Singapore, and Australia via R&D expense in fact offsets. Although there can be no assurance that such events will occur.

In addition to clinical operations, regulatory and commercial aspects are main focus areas from a corporate perspective. We are looking at whether fast track, accelerated approval, or marketing approval with the FDA in the US and the TGA in Australia will get PV-10 to market the quickest avenue possible. We want to be ready to take action the moment we know what the results are.

As part of these commercialization considerations, we continue to work with our partners in China, Phil Vulgar [sp], as I mentioned, with the HCC Phase 1b/2 study design and execution and with [unintelligible]. We believe China-based partners are crucial for success in China and we believe that when our interim data are ready, things in China could move very quickly because of the ground work we have done there.

India and Brazil remain areas of interest for us and we continue to develop ties in both of those markets. Based on the recent trip Eric and I made to Mumbai, we believe we have potential partners not just in India, but also the Indian subcontinent and [unintelligible] as well.

In each of these markets and in the US and G8 as well, protecting our intellectual property is vital to our success. In March 2016, we received notice of an issues patent from the US Patent and Trademark Office that extends the scope of protection of the manufacturing process conferred initially by 2013 patent to cover--to include coverage of the use of an alternative raw material in manufacturing the active ingredient API and PV-10 and PH-10. This new patent, wholly owned by Provectus, and conferring coverage to at least 2031, will provide further protection around the proposed commercial process for manufacturing PV-10.

Investigational drug product generated using this proprietary technology is being used in all of our ongoing clinicals trials, including the pivotal Phase 3 trial in melanoma.

To continue building awareness--public awareness for Provectus and PV-10, we have been conducting aggressive media outreach and meetings with key members of the media. Most recently, at the third international conference on the progress of regenerative medicine and its cultural impact, Dr. Grant McArthur was featured as a panelist on combination therapies for cancers. During the conference, which featured world leaders in cell therapy and immune oncology, we met with several potential partners and journalists to build relationships and explore opportunities.

Resulting from the conference, two videos aligned with Provectus were produced and shared on social media, one featuring myself and Dr. McArthur while the second featured Dr. McArthur as well. These videos resulted in significant social media reach with a total of 16,200 impressions via Twitter.

In addition, we recently attended the American Association for Cancer Research annual meeting where we supported the Moffitt Cancer Center in unveiling the research on PV-10 in combination therapy via poster presentation. We remain committed to building these valuable relationships and ultimately securing more news coverage to continue telling the powerful story of Provectus and the implications of PV-10. We expect heightened interest in PV-10 and Provectus to continue this month as we close in on ASCO in Chicago an our publicly known

presentation on June 4th. A King Peer [sp] youth publication is anticipated and other evidences of progress through data communication, such as the two recent abstracts with compassionate youth data from two separate sites in Australia.

To the point on telling the Provectus and PV-10 story, we have just launched a newly redesigned website at provectusbio.com in an effort to better showcase the Provectus mission while offering a more interactive and quality experience with our company. The new site, we've [unintelligible] the advancement and evolution of Provectus with modern branding that underscores the company's philosophy, "When patients win, we all win."

Additionally, we have launched an official company Facebook page, offering our stakeholders, included, of course, stockholders, a new channel to receive news and updates. We invite you to connect with us through these new platforms.

I'd like to now turn the call over to Eric Wachter, our Chief Technology Officer, for the key added insight and perspective that he brings to our unique opportunity with both PV-10 and PH-10. Eric?

Mr. Eric Wachter: Thanks for that overview, Pete. I'll start my remarks with a brief synopsis of major technical aspects before going into detail on key elements of our business.

As Pete noted, in the first quarter, we announced a major update of our Phase 3 clinical trial for locally advanced cutaneous melanoma. Among the number of key changes, this expanded patient eligibility and added Imlygic, the first intralesional agent for melanoma approved by the FDA as an option for comparator.

We've been busy implementing the amended protocol since February and I'll provide an update on status in a few minutes.

We've also been active since the fourth quarter 2015 when Provectus started a combination therapy trial in late stage cancer patients, assessing safety and preliminary efficacy of PV-10 in combination with Pembrolizumab, also known as Keytruda.

For tumors of the liver, we have--continue to add patients to our Phase 1 study of hepatic cellular carcinoma and metastasises to the liver and have been actively engaged with the investigative community throughout Asia to expand this program to this important region.

We announced during the quarter initiation of a companion study assessing potential of PV-10 in symptomatic neuroendocrine tumors, or NETs, metastatic to the liver. Additional mechanism data on PV-10 was presented in April, further advancing our understanding of the immunologic

signaling that can occur after ablation of tumors with PV-10 and possible strategies for combining PV-10 with other classes of immune oncology agents beyond that of anti-PD-1 antibodies like Keytruda.

And a topical program--topical PH-10 program continues to move ahead with completion of clinical work in our recent mechanisms of action study in December. Analysis of tissue collected from study participants has been completed and we are reviewing these results--skin biopsies collected free and post-PH-10.

In addition to our toxicology and pharmacology meeting with FDA in November on PV-10, we had another productive meeting with the agency in January to address supply chain topics in support of a possible NDA filing.

And on the intellectual property front, as Pete mentioned, we received additional patent coverage for the manufacturing process for [unintelligible], an important aspect for [unintelligible] commercialization of PV-10 and PH-10.

So much for the synopsis. Now, to the details.

Starting with our Phase 3 clinical trial of PV-10 for locally advanced melanoma, we announced in March that the protocol for randomized--for the randomized control Phase 3 trial was amended to reflect current and evolving standards of care in applicable patient population for a global study in melanoma.

Major changes to the protocol included addition of telimogene laherparepvec, aka, Imlygic as an option for use as comparator. We also extended eligibility to include Stage IV M1A patients with no active nodal metastatic disease. In addition, we clarified eligibility requirements for patients not having access to immune checkpoint inhibitors due to differences in standard of care. And we clarified eligibility requirements for those patients not having access to targeted therapy due to standard of care and extended eligibility to patients who have failed targeted therapy. And we relaxed the eligibility criteria for patients who may be candidates for crossover upon documented progression in the comparator.

These kinds of amendments are common place in Phase 3 studies and serve to fine tune the patient population and study procedures to match changing care standards for a large global study. In our case, this amendment is a direct result of revolving options for patients and was developed with extensive input from leading melanoma investigators in the United States, Australia, Europe, Mexico, Brazil, and China.

Addition of Imlygic, approved in late October by the FDA, is the first and only enclitic viral therapy, gives investigators the option of use in chemotherapy or Imlygic in those regions where Imlygic is available.

As I first noted in my remarks during the November investor call, approval of Imlygic not only validates our approach for seeking approval of PV-10 in patients with locally advanced cutaneous melanoma, but it also allows us to offer a comparator that is more attractive to patients and investigators.

Nonetheless, despite approval of Imlygic and a number of new drugs for melanoma in recent years, the body that defines standard of care for the US for patients with cancer, the National Comprehensive Cancer Network, still recommends clinical trial as the preferred option for patients with locally advanced cutaneous melanoma. I believe this clearly indicates that there's still room for new therapies, such as PV-10.

We began implementing the amended protocol as soon as it was complete in February and have been and will continue to assess potential impact these changes may have on study timelines. None of these changes are expected to have a negative impact on execution of the study and all were carefully considered to assure that they would not compromise integrity of the study design.

While all these amendments were designed to enhance patient eligibility and enrollment in this global study and are necessary to adapt to a constantly changing playing field in oncology and the evolving process for starting and executing clinical trials on a global scale, these necessary changes have led to delays in execution of our study.

I must, unfortunately, report that we are behind with regard to our initial schedule for reaching the interim and final analysis triggers for the study. I'm confident that we're--we are implementing the proper study to support licensure of PV-10, but at present estimate that we are approximately six months behind schedule with regard to site start up, patient recruitment, and eventual data readout.

What are we doing to address this? First, we've enlisted the support of a very prominent clinical investigator in Germany to lead the European portion of our study. He joins similarly selected leads for each of the geographic regions, North America, Oceania, Brazil, and China, but the study stands.

Second, we've been working with our lead site in Australia to ensure that it can fill--fulfill a nationwide regulatory role under the National Ethics Application System, or NEAF, as additional Australian sites join the study.

Third, we've begun exploring expansion of our study to additional regions, including Argentina, a country with demographics and melanoma incidents similar to the US.

And four, we begun streamlining clinical operations to ensure that human and capital resources are focused on our core mission.

As an example of the last item, after very careful consideration, we've recently announced to our clinical investigators that we will be winding down our expanded access program for PV-10 during the remainder of 2016. Our expanded access protocol was opened in May 2009 to provide access to PV-10 for cancer patients with cutaneous or subcutaneous lesions who are not eligible for another PV-10 trial. At that time, we were completing our Phase 2 study and beginning design of what would become the current Phase 3 study.

In the interval between then and now, we commenced the Phase 3 study, opened to patients with Stage III melanoma, and started our Phase 1b/2 combination study open to melanoma patients with Stage IV disease.

While these studies were in the formative state, the expanded access protocol was expanded from initial target of 25 to 50 patients to eventually provide for enrollment of up to

approximately 150 patients. As of the end of 2015, the expanded access protocol had accrued 160 patients in the US and Australia with more accrued to date.

We are required to closely track all patients receiving PV-10 under all protocols to meet global reporting obligations with regard to documenting use and safety of our investigational product. Since we are now in Phase 3, this tracking requires markedly greater diligence.

We initiated the expand access protocol to meet needs not addressed within the context of formal clinical trials. Now that we have two active trials underway, open to a substantial fraction of Stage III and IV melanoma patients and have reached the accrual target for the extend access protocol, it is necessary and appropriate that we wrap up enrollment under the EA02 protocol.

To minimize disruption, we will continue to allow enrollment of new patients until the end of June and we'll continue to supply PV-10 until at least the end of December for patients commencing PV-10 on or before our June cut-off date.

We appreciate the enthusiasm of our--the enthusiasm our investigators have shown for PV-10 under this program and I'm sure you will appreciate that it is of upmost importance that use is conducted within the context of clinical trials needed to support approval of PV-10 in the USA,

Australia, and the rest of the world. There'll be trials, such as our Phase 3 melanoma trial, and our Phase 1b/2 combination therapy trial.

As I mentioned in our November 2015 conference call, we're also working with the team in Australia that has been conducting an investigator initiated trial of PV-10 in combination with radiation for regional melanoma to complete this work and report results in a suitable venue.

Concluding non-core projects such as these not only allow us to focus on our core mission, but also to assure that we comply with global regulatory requirements. Data from these projects won't directly support approval the way a pivotal study does, but can provide important supportive evidence of safety, efficacy, and clinical relevance. And hence that value from regulatory and partnering perspectives.

Turning to our combination study, we began enrollment in the fourth quarter of 2015 and continue to expect that enrollment in this portion of the study will be completed this year. We've been working with the sites listed on clinicaltrials.gov to get each one open for enrollment of patients and working to add several additional sites in the US and Australia, still with the goal of having five to seven sites participate in Phase 1B.

We've also been working with our global CRO to prepare for smooth transition of the study to phase two and expansion of the study to include sites in Europe when that phase commences. We'll hold an investigator meeting in Germany next month to gather input as we have multiple times with our phase three study to allow us to assure that the study addresses needs across all regions when it expands to phase two.

This study was designed to demonstrate the potential benefits of combining the ablative immunotherapy of PV-10 with an immune checkpoint inhibitor, and, if successful, should pave the way for potential combination with many other agents. The mechanism data on PV-10, both non clinical and clinical, including that reported by our collaborators from Moffitt Cancer Center last month at the AACR annual meeting suggests that this should be the case, but, of course, we can't be sure until we see initial data expected later this year.

Turning to tumors of the liver, we continue to add patients to our phase one study of hepatocellular carcinoma and metastases to the liver and expect to add one or two additional centers in the U.S. this year to facilitate completion of enrollment. We plan to report additional data later this year as a follow up to our initial reporting in mid-2015 both at a major international oncology meeting and in published literature.

Because HCC is a major health issue throughout Asia, we've been actively engaged with the investigator community there to expand this program into this important region. Following up on productive meetings with key investigators from greater China in October, we met with leading investigators in Singapore and India within the last two months to review and refine our Asia strategy and assure that our plans meet the needs for development of PV-10 for HCC. These meetings have confirmed relevance of our development strategy and potential importance of PV-10 for this indication and point the way to one or more Phase 1B/2 studies of PV-10 alone or PV-10 plus standard of care.

I'm especially grateful to our colleagues at Boehringer Ingelheim in China, in Singapore, and in the U.S. who have facilitated this effort via crucial advice and the contacts throughout Asia.

As Pete noted, we announced in March that we have initiated a companion study assessing potential of PV-10 in symptomatic neuroendocrine tumors or NETs metastatic to liver. This study builds on what we've learned so far in our initial study, PV-10 [unintelligible] one with tumors of the liver. We expect patient enrollment to commence next month, and if initial results appear encouraging, we may elect to expand the study to additional sites to accelerate study completion.

PV-10 mechanism action--the PV-10 methods of action clinical trial conducted by Moffitt Cancer Center completed follow up of last study participation in the fourth quarter of 2015, and additional mechanism data on PV-10 from this study and from companion non-clinical research were presented in November at the CTSI annual meeting in Washington D.C. Related data on combination of PV-10 with immune checkpoint inhibition or co-inhibitory blockade were presented last month at the AACR meeting by the same research team from Moffitt. These data further advance our understanding of the immunologic signaling that can occur after ablation of tumors with PV-10 and underpin the efficacy endpoints in both our phase three and phase 1B/2 clinical trial.

As alluded to by Pete and common in our field, we expect further detail on these topics to be published sometime this year. I think it's likely we will continue to learn more about signaling and its potential use as the translational team at Moffitt continues to mine data from specimens collected during the clinical phase of the mechanism trial.

As I noted earlier, we've also been busy on the methods of action for topical PH-10 and completed clinical work for our mechanism action study in psoriasis patients in December. We're finalizing compilation of clinical data from the study with immunohistopathologic analysis of tissue collected from study participants now also complete, and we are reviewing these data together to assess changes in skin biopsies collected pre and post PH-10 application.

This study was designed to allow us to pro a possible immunologic, structural, and hyperproliferative changes in psoriatic plaque and detect any evidence of cellular atypia upon application of PH-10. It'll also allow us to assess concordance of any such changes with clinical observations in those plaques. We continue to expect these data to inform decisions on anticipated--on an anticipated request to meet with FDA to assess the strategies for advancing the program from phase two into phase three, including whether any additional clinical or non-clinical safety data are necessary to advance to phase three.

To summarize, we continue to actively pursue existing clinical programs in support of our core development mission in melanoma while moving towards implementation of companion programs in related areas such as our Asia HCC initiative. We're also continuing to expand our knowledge of the mechanisms of both PV-10 and PH-10 which allow us to plan appropriate strategy for future work, and we remain very active in both U.S. and global regulatory and intellectual property matters.

There's an expression attributed to Hughe Knatchbull-Hugessen, the British Ambassador to China in the mid-1930s. Goes, "May you live in interesting times." And these are certainly interesting times. We have significant, interesting work ahead that the methods of action, regulatory strategy, and clinical and supply chain operations framework that brought us this far

has me more excited about the path ahead than ever before. We appreciate our stakeholders' patience while we endeavor to move Provectus forward.

However, most important stakeholder in all this are the patients. Our clinical programs have always been mindful of unmet patient need and, if current studies are successful, patients may gain more options. We encourage patients and the caregivers to consider clinical trials and we encourage everyone to remember that, as Pete noted earlier, when patients win, we all win. With that, I believe we're ready for questions. Operator?

Operator: Currently, ladies and gentlemen, we will now be conducting a question and answer session. If you'd like to ask a question, please press star one on your telephone keypad. A confirmation tone will indicate that your line is in the question queue, and 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 key.

In the interest of time, and so that other participants have the opportunity to as their questions during the conference as well, we ask that you please limit yourself to one question and one follow up question during the Q & A. Afterward, you may reenter the queue to ask follow up questions. Once again, that is star one to ask a question at this time.

Our first question comes from the line of Greg Katanic [sp] who is a private investor. Please go ahead with your question.

Mr. Greg Katanic: Good morning, everyone. Regarding the phase three trial, Pete, in his opening remarks that expects sites to start showing up and recruiting in the--on the clinical trial site in the coming weeks. Now, we've heard before that you anticipate clinical trial sites to open within weeks or months since the trial started patient enrollment in, I believe, April of 2015, and those promises never seemed to have transpired. So it's been over a year, and we only have five sites recruiting at this time. So is this--my question is really is this the still the same unfilled promise, or what's different this time that we can actually expect additional sites to begin showing up and recruiting on the clinical trial site in the coming weeks?

Dr. Eric Wachter: Okay. I can address that. So we've amended the protocol, effective in February of this year to improve the ability to enroll patients. We have assessed, assessed the rate of patient accrual, site startup, sites in the queue for startup, various factors that affect startup at various sites in the U.S. and Australia and global locations, and we've come to the projection that we believe we're six months behind schedule.

Mr. Greg Katanic: Okay. So what I'm hearing is we've, we've enhanced [unintelligible] make things a little bit easier so in the coming weeks we'll start seeing some sites showing up and we won't necessarily have the same question again next fall.

Dr. Eric Wachter: That's correct. So we did, in effect, reset the clock on a number of sites with that major protocol upgrade. Pete spent some--a little bit of time outlining it. I spent some time outlining and we talked about it at great length in the previous call. It really was a substantial change that necessitated renegotiation of certain aspects of contracts, IRB approvals, and we're, we've left that behind us now. We're moving forward.

Mr. Peter Culpepper: And, perhaps, we could just remind ourselves that the drug and that Eric is referring to, Amgen's [unintelligible] was just approved by the FDA in Q4 of last year.

Dr. Eric Wachter: End of October.

Mr. Peter Culpepper: End of October. So it's a recent approval. It's really a landmark development in our field. So that's a very important protocol amendment.

Operator: Thank you, and our next question comes from the line of Peter Eshouse [sp] with TD Bank. Please proceed with your questions.

Mr. Peter Eshouse: All right. Thank you. I just want to follow up, and just as a result of you being behind by six months, did I hear Peter right by him saying that interim data from P3 will still be coming out this year even though you're six months behind schedule? How can that be?

Dr. Eric Wachter: We were projecting mid-year previously, and now that would occur near the end of the year or early next year with current projections.

Mr. Peter Eshouse: Okay. And can I follow up--?

Dr. Peter Culpepper: --It could be a--we can certainly say we're going to be very attuned to updating the market. We know how critical this is for the market, for patients, for stockholders, so as we try to highlight, we are going to get more and more precise on all the guidance from conference call to conference call, and we did reference the Q3 conference call in November as a particular, from a planning standpoint, a timeframe to focus on.

Mr. Peter Eshouse: And you said I could have a follow up. Can I--can I pivot to the PV combo with Keytruda. Peter, you made comments that now there's a chance for Provectus to maybe do a combo with the Opdivo and potentially other agents. How can you make that comment unless you've actually go Opdivo lined up to do this combination?

Mr. Peter Culpepper: Well, the basis for that, Pete, is we have the preclinical data to support such combination. Opdivo, as you know, is approved by the FDA just like Keytruda is approved by the FDA so it--so we're just making the, the practical observation that there's nothing special about Keytruda that would preclude combining PV-10 with Opdivo. It's a comment to highlight how flexible PV-10 is in combination regimens with a number of agents including the most prominent, Opdivo and Keytruda. That's the point. Eric and--.

Dr. Eric Wachter: --And I'd like to add that we haven't talked about it in this context for this particular call, but we did mention combination studies, PV-10 plus standard of care with regard to HCC, for example. In this context, PV-10 plus Keytruda is PV-10 plus standard of care for melanoma. Opdivo is also standard of care for melanoma. Opdivo is also standard of care for some other cancers that we might combine PV-10 with.

So we don't have any real difficulty in terms of making design of a study that would include Opdivo versus Keytruda. It's the same mechanisms of action. They're very similar drugs. We chose Keytruda based on a selection that best matched our anticipated schedule for administering PV-10 versus the schedule for Opdivo in melanoma.

Operator: Thank you. Our next question comes from the line of Dominica Rodriguez, a private investor. Please go ahead with your questions.

Mr. Dominica Rodriquez: Good afternoon, Dr. Wachter. Could you describe what non-pivotal clinical studies you have undertaken or completed in support of your NDA for PV-10 as a single agent?

Dr. Eric Wachter: I won't comment on that in any detail. I will say that as a consequence of preparation for our meeting in November with FDA to delineate what steps were necessary on the toxicologic and pharmacologic side to finish our regulatory portfolio leading up to NDA, we identified a few areas where non-pivotal clinical studies would be appropriate. One of them is, for example, looking at the pharmacokinetics of PV-10. I should say Rose Bengal, in this case, in the bloodstream as a way to bridge historic data in the literature from the intravenous diagnostic to our observations with the [unintelligible] route of administration. We have a number of similar sorts of studies that may or may not be required.

What we learned from the meeting in November was that some of the tests that we expected we might have to run, the agency does not seem to be expecting from us. So we don't anticipate a large additional nonclinical program in support of NDA.

Mr. Dominica Rodriguez: [Unintelligible]. Thank you.

Dr. Eric Wachter: [Unintelligible] We don't anticipate a significant number of additional non-pivotal clinical studies in support of NDA.

Mr. Dominica Rodriguez: Super. And as a follow up question, as you know, there is a clinical study called Qualitative Interviews with People with Locally Advanced Cutaneous Melanoma being conducted at Moffitt, Gabriel, and Huntsman. Is that your all's study, and how does it fit into the NDA for PV-10 as a single agent?

Dr. Eric Wachter: We announced at the ESMO Congress in Spain in 2014 that we were designing a study to look at the patient experience in melanoma, and there are a number of activities that we've undertaken. And I would point out that we sponsored a very small, informal study by the Melanoma Research Foundation last year, resulted in a brochure, "Managing Stage Three Melanoma Diagnosis" that looked at the physical and emotional impact of melanoma on patients. The study that you reference is a more formal version of that and would potentially be supportive of patient reported outcome endpoints such as the ones that we have as exploratory endpoints in the phase three study looking at changes in Skindex Score, looking at changes in patient reported pain, for example.

Operator: Thank you, and once again, as a reminder, you may press star one on your telephone keypad to ask a question at this time, and we ask that you please limit yourself to one question

and one follow up question during the Q & A after which, you may reenter the queue to ask follow up questions.

Our next question comes from the line of Joe Buffel [sp] with Catalyst Capital. Please go ahead with your questions. Joe, your line is live. Please check if you are muted.

Mr. Joe Buffel: Eric, I'm--good afternoon, Peter and Eric, and sorry. I had my phone on mute. But Eric, so understand you're saying you're shutting the cup because you want to focus on those trials and put the effort into those trials and the resources in the firm on those trials that are clinical trials that advance the drug forward to finally getting approval, and then I think you mentioned something about Matthew Foote's work with the combination with the radiation that you wanted to bring that too, and then there. Are we going to have data on that, his data? And then how do you view the MOA trial data from Moffitt? Do you believe that those two trials for the PH-10 and for the PV-10, the demo A trials are not diverting our resources away from getting the drug to approval or when we get those data read outs, will that be the end of the MOA studies?

Dr. Eric Wachter: Okay, Joe. Appreciate those questions. With regard to the compassionate use or expanded access protocol, as we refer to it, we are closing that down for several reasons. One, it's achieved its design goals in terms of fulfilling an unmet need. We now have studies

that meet that requirement, and we've reached the size limit for the study [unintelligible] as we are now in phase three embarking on a global program. We have to meet regulatory requirements that have very strict timelines and very stringent requirements in terms of reporting, monitoring and reporting use and safety of our drug, and it turns out that this makes continued expanded access use of PV-10 challenging for us. And so yes. You're correct. We have made, with much reservation, the conclusion that it's in the best interest of getting the drug approved to conclude that program to allow us to devote our resources to our core mission.

As I mentioned in my comments, we have been working with the group in Brisbane, [unintelligible] investigational team to conclude the XRT study in the investigator initiated protocol and, as I mentioned, we do expect that they will report those results.
In terms of mechanisms of action studies, those to the extent that they would apply to core missions. That might be, for example, understanding how to apply PV-10 in combination with some hypothetical agent. We would continue to pursue activity in those areas, but as it stands right now, we have no ongoing clinical activity either with PV-10 or PH-10 for mechanisms of action.

So, when I delineated my comments [unintelligible] streamlining the clinical program to focus very, very finally on execution of our core programs in melanoma, core programs in hepatic

tumors to allow us to move towards approval of the drug. The sooner we get that accomplished, the better everyone is.

Mr. Joe Buffel: So my follow up question, I guess, is that I don't know if it was Peter or yourself that mentioned that you had a new investigator, I believe, in Germany. So, and then I just heard you say that we're about to embark on a global. So when we're talking about in the weeks and months to come we should be seeing additional sites outside of the U.S. that will be a change in basically for the clinical. We're going to start having outside investigators.

Dr. Eric Wachter: Yeah. So our strategy in moving clinical programs to different geographic regions is based on finding a very well established lead investigator. They are often called the coordinating investigator, that's the term that's used in the EU, who has overall responsibility for keeping the step investigators, the sub principle investigators under him moving forward in a proper fashion. So they are basically the concert master for their particular regions. So we have an investigator that we've been working with for China that can handle that responsibility.

Sanjivago Walla [sp] handles that responsibility for North America. We have someone designated for Brazil. We expect to be able to designate someone very soon for Argentina. I mentioned that we expect to expand the study to Argentina, and we have a very prominent

investigator that will be working for us in that role in Germany. They will have oversight over all sites in the EU.

Mr. Peter Culpepper: And related to that, we can mention we have a calendar of events on our website where we do mention that there's the sixth European post-Chicago melanoma skin cancer meeting. We expect to be there with these key opinion leaders in the EU including this coordinator that Eric refers to.

Dr. Eric Wachter: Yeah.

Operator. Okay. Thank you. Our next question comes from the line of Max Asenheimer [sp] who is a private investor. Please go ahead with your questions.

Mr. Max Asenheimer: Hey. Good afternoon, gentlemen. My question concerning the Australia. You had some recent news out of there. Very promising. Some of it has taken place since 2010. What's a timeframe to go for early approval in Australia? Also, I just wanted to check the PH-10, are we expecting that news to come this month, or was it--or are we looking more into June?

Dr. Eric Wachter: Okay. Pete mentioned that early or accelerated or expedited, we can use all sorts of terms maybe in the vague fashion. Processes for approval in Australia, we are assessing. We've been assessing them for, since inception of our clinical work in Australia. One of the aspects of closing the expanded access protocol is that we now have an opportunity to collate all of the data from that process to be able to actually use it for at least supportive purposes if not some, a better, higher purpose in terms of regulatory approval. So we'll be continuing to review that opportunity in Australia on an ongoing basis and as the case dictates, we may elect to move forward in Australia on a regulatory stance that's faster or slower than in the U.S.

The second question was?

Mr. Max Asenheimer: The PH-10 results. Are we expecting them this month, or are we waiting until June?

Mr. Peter Culpepper: We expect to have analysis of the PH-10 dataset completed this quarter, so by the end of June. We haven't determined yet when and how that would be reported. We're, presumably, try to report that in some sort of conference fashion in the second half of the year as is typically the case for these types of data leading if it looks favorable to publication.

I've only seen portions of the data as I stated in previous conference calls. I expect it to be quite interesting. What I've seen looks quite interesting, but until we've done the full analysis we can't make any quantitative statements.

Operator: Okay. Thank you. Our next question comes from the line of Ted Kidd who is a private investor. Please go ahead with your questions.

Mr. Ted Kidd: Hello, Eric, Pete. I don't know if you can touch on this right now or not. Are we going to have sufficient funds to carry us through interim phase three reporting without a capital raise?

Mr. Peter Culpepper: I think that's an excellent question. We are--it's something that we'll comment on that in the 10Q, and we'll comment on that this, you know, this quarter to the extent that we can. I can say on the topic, this is why our focus area on media awareness and visibility with [unintelligible] and our partners is so important to get the stock profile in better shape, and that also relates very much to the code development discussions.

Hopefully, Eric and I, when we're at ESCO will be meeting with potential partners. We expect that's the case. We already have one potential partner that we'll be meeting with. We would

expect more. We know the data between now and ESCO is very important for the industry, and that includes the Moffitt clinical data, the ESCO related data, data that's not public yet that we're aware of that we're excited about coming out.

So very much we as large stock holders, we're all aligned here, want to minimize dilution. We're going to be very sensitive to minimizing dilution, but I can tell you, to be up front, that we will need to raise funds if we have to in order to ensure we're in good stead with Markham, our external auditor, and the New York Stock Exchange. That's the best I can do it. We don't, we don't want to say that we're not going to be imprudent or not exercising due care with respect to our, our capital structure. At the same time, we're trying to minimize dilution. So this is a stay tuned until we have further information.

Mr. Ted Kidd: Okay. I understand that. So as a follow up, could you classify the closure of the expanded access programs as a measure to, you know, save funds and as an attempt to herd patients into clinical trials?

Dr. Eric Wachter: I think I would characterize it as the right thing to do because we have achieved the objectives of that program. We do have a core mission, which is executing the--those melanoma clinical trials and devoting, as I mentioned, human and capital resources to those is paramount importance to us. I wouldn't comment further, other than that.

Operator: Thank you. Our next question comes from the line Nick Copano [sp], who's a private investor. Please go ahead with your questions.

Mr. Nick Copano: Yeah, question number one is--question number one is how we stand on the financial end of the corporation? Do you need money, and if you do need money, how are you going to raise it? That's question number one.

Mr. Peter Culpepper: Well, it relates a little bit to the last question from Joe Kidd [sp], and I can certainly reemphasize that we're all cognizant of our—as stockholders of minimizing dilution. So, right now when we file the 10-Q, we will comment on cash position and how we're handling it. We're looking forward to the 10-Q being filed ASAP. So, that's one point.

I can also comment that we're trying to minimize dilution, just like we've highlighted with, for instance, the warrant exchange transaction that we concluded at the end of Q1. That was a type of transaction that was, albeit dilutive, minimally dilutive, and for current warrant holders. So, we had that in Q1 as a mechanism to raise additional funds. We want to minimize whatever we do going forward.

Right now, we're operating to generate the kind of bidding [sp] that we need. But, just like we emphasized with the last call this is a stay tuned. We're very cognizant of what you're saying. We're very--regarding our stockholders, we're very committed to ensuring we're successful, and with our dilution is as minimal as possible. That's how we can address that.

Mr. Nick Copano: Question to follow up, is anybody else in the corporation under investigation on the excessive spending that went on with your previous officer?

Mr. Peter Culpepper: I should certainly say we announced on March 16th and March 30th that the investigation was concluded. That was with respect to Dr. Dees. Some stockholders are aware there was a follow-up. It's public. We'll comment on it later, but it was a follow-up on we're seeking collection against Dr. Dees for his unsubstantiated travel-related expenses. But, that's the only individual that's been named, and that's the only one we expect to be named for purposes of any investigation or any follow-up action. Again, we'll communicate anything publicly whenever it's appropriate.

Operator: Thank you. And our next question's a follow-up from the line of Dominic Rodriguez, private investor. Please go ahead with your questions.

Mr. Dominico Rodriguez: Dr. Wachter, the Moffett [sp] feasibility work, as you know, was initially made for, what, 18 months' worth of study in terms of at least looking at ClinicalTrials.gov from when they began recruiting to when they anticipated finishing the study. Looking at the last update for that work, they recently updated it for completion, let's say anticipated completion at the end of this year, which is almost about four years from the start. Can you put some context with respect to the length of time that has elapsed from your original expectations and what value that would provide shareholders and patients, community at large, in terms of what they've learned and the length of time they've taken to learn it?

Dr. Eric Wachter: Absolutely, Dominic. So, the clinical aspect of that study was completed roughly within the target that was established at the beginning by Moffett. That listing is under their control. We sponsored that study, but they maintain that clinical trials listing for that particular study.

What happened in this case is that the study was a classic example of translational [sp] medication. We had some non-clinical data. That's data from mice that suggested some things that we wanted to look for in humans regarding immunologic signalling. We began to look at the humans and found that there were some other interesting things going on in the humans that we hadn't looked at in the mice. So, they went back to the mice, did some more work with

the mice, found some more interesting things with those mice, went back to the humans and back and forth several times.

So, since the clinical portion of that study has wrapped, they've been able to continue mining data on human immune response to PV-10 from samples that were collected, now up to two or three years ago. And as that understanding has evolved, what we've seen is publication. There was a Plus One article that came out two years ago. We've seen multiple presentations at scientific meetings delineating different aspects of the immunologic signalling as they worked their way through the immunooncology [sp] cycle. What's missing so far is one or two small but important steps to be reported regarding how all of that fits together, and I just think that will come in the form of a high impact journal publication sometime this year.

Mr. Dominic Rodriguez: Thank you. And as a follow up question, with your original Phase I liver trial that expanded to treat patients on a stable dose of Sorafenib, have you treated--has the company treated patients with Sorafenib and then PV-10 in that trial? And do you have any guidance with respect to when you might initiate a Phase IB-II program of PV-10 plus standard of care, which in this case would be Sorafenib for HTC?

Dr. Eric Wachter: Okay. So, I can comment on both of those topics. I'll start by saying that we have conducted nonclinical testing to determine whether there was any anticipated safety issue

with regard to combining PV-10 with Sorafenib using standard assays and found that there was minimal concern with that regard. We developed a bioassay to allow us to monitor PV-10 and Sorafenib exposure to patients, and we have commenced that expansion cohort in the Phase I study. That accrual has been disappointing for us, and I anticipate that we will at some point wrap that up with a transition to conducting that work in Asia.

The problem with that design in the West is finding clinical trial participants that are appropriate for Sorafenib and PV-10 is relatively rare. When we go to parts of the world where there are 10 times or 100 times as many patients with this disease, then it becomes easier to conduct those studies. So, I anticipate that we will start work with--dedicate a study looking at PV-10 plus Sorafenib in Asia either this year or early next year.

Operator: Thank you. Our next question comes from line of Hassim Mohammed [sp], private investor. Please go ahead with your questions.

Hassim Mohammed, please check if you are muted.

Okay, our next question comes from the line of Wayne Colby [sp], private investor. Please go ahead with your questions.

Mr. Wayne Colby: Hello, Peter. How are you?

Mr. Peter Culpepper: Thanks for calling in, Wayne.

Mr. Wayne Colby: Okay, Peter, just one question over here with a follow-up. You mentioned something about you're going to report on our relationship with the New York Stock Exchange. Is there any reason to believe that they are questioning our listing stats over here, and are we in danger of anything?

Mr. Peter Culpepper: Yeah, thanks for that follow-up on that remark I made. So, what we have commented on, of course, in previous calls, is the New York Stock Exchange requirement to stockholder equity be in excess of $6 million. We're well above that. We have been well above that. So, I'm only commenting that we are focused on ensuring our stockholder equity remains in excess of $6 million. So, that's the New York Stock Exchange records in particular that we're just cognizant of that. We have some flexibility in cash raises. We were trying to minimize dilution, but we have to keep in mind certain constraints, like that particular one. At this point, we have a very good relationship with the New York Stock Exchange, and we expect that to continue.

Mr. Wayne Colby: Okay, that's great. And as a follow-up, our former auditors, is there any culpability on their part for not discovering the Greg Dees not submitting authorized expenses for the advances that he received? Where does--where does culpability actually lie in this case?

Mr. Peter Culpepper: Well, we can only comment, Wayne, on what we have publicly disclosed in the 10-K filing, of course, referencing March 30th. We can also state that we have the--certainly, we have dismissed BDO as the external auditor, and we--and obviously, as you know, we have Marcum LLP as our new external auditor.

So, what we can certainly say is we are very focused as a company to be as proactive and as transparent, and as Eric highlighted, doing what's right, doing the right thing, on all fronts. That includes corporate governance. That includes clinical development. That includes communication with our stockholders. So, at this point, from our standpoint, we're just trying to make sure that the market and investors and patients know that we're here to get this done right so that patients can win.

And so, whatever we need to do to ensure that the market understands that we are being proactive, that's what we're going to do. But, we--but, I don't think it's appropriate for us to comment on anything that's not already public or--and I don't have any questions or any indications that there's anything with respect BDO, as you indicated.

Operator: Thank you. Our next questions come from the line of Ted Kidd [sp], private investor. Please go ahead with your questions.

Mr. Ted Kidd: Hey, I just wanted to touch again on Australia. The last few weeks, there's been a lot of buzz about physicians in Australia widely using PV-10 to treat melanoma. I'm just trying to find out if there's any validity to that. I mean there have even been mentions that--and I don't know how this could take place, but it being used as a standard of care in Australia. What is the skinny on that?

Dr. Eric Wachter: Okay, Ted, I think I can address that. So, there was a meeting of the Royal Australian College of Surgery last week in Brisbane where there was a session on melanoma, and two of our expanded access investigators presented summaries of their history using PV-10 in their practice. In the one case, the patients were exclusively under the expanded access profile—or expanded access protocol. And in the second case, about half of the patients were under expanded access protocol, and the other half were from the Phase II study. They pulled the patient records for all of those patients and analyzed what happened to the patients in their wake of having PV-10.

Both abstracts, I have not seen the ex-presentations [sp] as of now, but both abstracts told a remarkably similar story that is quite consistent with what we reported in the definitive journal article on the Phase II study. And so, I think that it represents in something of a real world case what could be expected with PV-10. Now that being said, it is a limited patient population in both cases, certainly an inadequate number of patients to support regulatory filing. And most of the work was done in the context of the expanded access protocol.

So, the detail in terms of the data from these treatments is not of the same level that we would have, say, for example, with a pivotal study. The reference to standard of care comes from some information that one of the investigators has written with regard to describing their practice and how PV-10 has been used to address the needs of patients in their practice. And I think it's a very loose use of the term standard of care. Standard of care comes from a--typically from a very formal decision among a group of experts. I referenced in my scripted comments of the National Comprehensive Cancer Network, which defines standard of care in the US. And this is a panel of 30 or 40 very prominent oncologists that get together, meet regularly, and determine how to treat cancer in a standard fashion. They define standard of care. But, that being said, there are less formal standards of care. And that example from Australia was representative of a practice or an institutional standard of care. It does not infer that the drug is widely available or in fact is available outside of the context of that expanded access protocol.

And we'll have some discussion, presumably, in the coming months with that particular group on how to address the needs for their standard of care.

Mr. Ted Kidd: Okay, very good. Thanks.

Operator: Thank you. Our next question comes from the line of Joseph Bethel [sp] with Catalyst Capital. Please go ahead with your questions.

Mr. Joseph Bethel: I just had one follow-up. Peter, I thought you mentioned this. It was probably more Eric, but I thought you mentioned Australian investigators that came out with their two abstracts that were just recent. Is there a chance for more than one presentation at ASCO this year?

Mr. Peter Culpepper: Well, I can certainly say, Joe, on this point, stay tuned for May 18th. That's a critical day when abstracts are unveiled, and we'll communicate publicly as soon as possible, probably on the 19th, the day after, as soon as we have information. That's the best I can say. We're very excited about ASCO. We're very excited about News Flow [sp], but that's all I can say publicly.

Mr. Joseph Bethel: And my follow-up is to Eric. Eric, one of the issues regarding--I believe, regarding PH-10 that we heard over the years was that the FDA was also looking at toxicity. They wanted to know in order for you to go to a Phase III. Has that question been answered through the MOA work that has been completed?

Dr. Eric Wachter: I have not completed analyses of those data, but I--as I did mention in my prepared remarks, that study was designed to provide potentially an answer to that topic. And I'm optimistic that we will have some very useful discussion points to go over with the agency in that regard based on what was or wasn't seen in those patients.

Mr. Ted Kidd: And do you have any information on—will we get a data readout from that trial?

Dr. Eric Wachter: As I mentioned to a couple of callers ago, we expect to have initial analyses of those data completed by the end of the June, at which point we would do a number of things. We would decide if we're going to submit that to a scientific or a medical conference, we're going to try and publish that at some point or presumably get that to FDA as quickly as possible because it is the results of the clinical study. We may show that to corporate—perspective corporate partners under CDA, and certainly it will provide, as I mentioned, lots of flutter [sp] for planning what the next steps are in all those regards. So, end of June, we expect to have greater clarity on that topic as we have had a chance to look at the data in some detail.

Operator: Thank you. Our next question comes from the line of Gary Meyer [sp] with Meyer Financial [sp]. Please go ahead with your questions.

Mr. Gary Meyer: Hi. This is Gary. Hey, thanks very much for your conference call today. Can you hear me okay?

Unidentified Man: Yes, yes, Gary.

Mr. Gary Meyer: Okay. Okay, great. Could you rephrase that last answer a little bit here, yeah, the last response? And then, could you expand a little bit more on the kinds of things that you think are going to be critical to finding a partner, say, that could help with some of this funding?

There's an interesting interview done in the press of a Pfizer executive here. Oh, I can't remember. I saw it, what, six or seven months ago, something like that. And they were being asked, "What kind of things would be important to them in terms of partners going forward?" And, of course, this interview was done because they had just announced a significant acquisition. And so, the writer—the analyst, actually, was asking, "What kind of things are you looking for going forward?" And I thought it was kind of interesting 'cause Pfizer commented, they said, "Well first of all, it won't be real large--you know, the things we're looking for in the

future are not real large, but perhaps smaller, but they'd have several things in common." One, he said, "It would have to be innovative." Number two, he said, "It's probably going to have to do with immunology." And number three, "It would probably have to do with combination therapies." And I thought those were just really very interesting because I see and sense that that's really where Provectus is, and it seemed to me there's got to be some kind of trigger point or some kind of an expectation that is met in terms of bringing in partners like Pfizer or somebody from China, licensing partners, etc. Could you comment a little bit more on what you think needs to happen and what some potential opportunities might be?

Dr. Eric Wachter: Okay, Gary, I'll start, and then I'll hand it over to Pete. So, with regard to Mechanism of Action study for PH-10, we're hoping to achieve very similar results to what we've been achieving with the PV-10 mechanism of action work, that is understanding whether in fact we have an innovative drug, an innovative pharmacologic action, understanding the immunology of the drug, and understanding how to use it going forward. Certainly for PV-10 the path forward looks very favorable to me for combination with multiple immunotherapies. We're looking as a first example at combining it with anti-PD-1 antibodies in the form of pembrolizumab or Keytruda. As Pete mentioned, we could equally contemplate using another anti-PD-1 optevio [sp]. There are anti-PD-L drugs on the verge of approval. We've seen from mechanism of action studies that PV10 may work very well with PD-L-1 drugs, and we have

data reported at AACR last month by the group at Moffett showing that there are even other classes of immunotherapies that PV-10 may be compatible with.

So that being said, with both compounds we're trying to establish checkboxes for each of those items that would be enumerated by that Pfizer executive that you mentioned.

Mr. Peter Culpepper: And I'm really pleased that you asked this question, because what we're finding in our discussions with potential partners is that PV-10 is completely unique. It's, of course, innovative. It is an immunotherapy, and it can be combined with different agents.

So, PV-10's uniqueness and its ability to ablate disease, its preponderance of ability to completely—to have complete responses in different tumor types is very exciting and very promising. And so, what we can do is combine PV-10 with a whole host of different agents and different tumor types. And this—even though this may be a form of resubstance [sp] in the sense that this is late stage disease, it's still critically important for the global acceptance of PV-10 by regulatory bodies and big pharma—the big pharma that we know and appreciate well: Bristol and Merck and Pfizer and Rosh, Novartis, AstraZenecra, etc.

So, what we can see is PV-10 gaining traction in the industry in combination and then being used presumably upon approval as a monotherapy earlier stage. So, we really have an

opportunity to treat disease earlier, like as in neoadjuvant surgery and, of course, in Stage 3, and then also later with combination. So, we're very excited. The PV-10 opportunity is profound and that's a perfect way to think about it.

Operator: Thank you. Our next question comes from the line of Hassim Mohammed, a private investor. Please go ahead with your questions.

Mr. Hassim Mohammed: Good afternoon, gentlemen. I wanted to inquire about the bonuses that were issued to you and your team, and I wanted to just ask about the bases of the bonuses. And also what is the function of Mr. Tim Scott? Thank you.

Mr. Peter Culpepper: Tim Scott is, of course, the President, and he's also one of the founders, and he's also critical in the technical capability of understanding the unique aspect of PV-10 in the way that it's manufactured, the synthesis. You'll notice on the intellectual property, the recently issued patents, the synthesis patents. He's critical in his understanding of the unique aspect of the way Rose McGawl [sp] and PV-10 and PH-10 are formulated, the global supply. So, he's critical. And even though it's behind the scenes, it's absolutely essential to have him involved and the way Eric on more of a public fashion can speak to the drug supply and the intellectual property. Also, Tim is critical in the way that he has been enabling the understanding of the corporate strategy, much that we discussed in the MD&A filings with

respect to how we're going to raise valuation of the company prior to how we characterize the traction for the benefit of stockholders and in terms with the MD&A and the 10-K filing on March 30th.

With regard to the proxy filing that you referenced, this relates to the independent competition consultants and the independent competition committee with documentation so specified that allowed for the bonuses, the cash, and stock options that relates to milestones that have been specified and delineated, documented with respect to the independent competition consultants and competition committee. So, that's appropriate in the industry with peer companies, etc., and that's the basis for that, and that's why that amount—those particular amounts [unintelligible] and supported as they were.

Mr. Hassim Mohammed: Just to follow-up, what was the total amount of the bonuses?

Mr. Peter Culpepper: It was actually a total. And is—we have to keep in the context of there has been no bonuses, as you're probably aware since 2012. So, this $200,000 amount was the first cash bonus since 2012, and then the stock option grants were the first stock option grants since even before 2012. So, let's keep that in context in terms of, again, the Independent Competition Consultant Group that prepares the analysis in context of peer companies, as well as what the Competition Committee is—and its ability to authorize based on guidance from the

Competition Consultants and peer companies in our industry. So, it's very much appropriate given what has been done at Provectus and what is in the context of, again, comparable or peer companies.

Operator: Thank you. This concludes today's question-and-answer session. I would like to turn the floor back over to management for any closing remarks.

Mr. Peter Culpepper: Thank you, operator, and thank you, everyone, for your questions, for your interest, for your very obvious commitment to our success. We will be speaking to you again when we file our 10-Q, covering the quarter that ends June 30, 2016. We anticipate that to occur in the first half of August. And between now and then, we expect to denounce—to be announcing additional news to support our Phase 3 trials and progress at ASCO on June 4th, our other PV-10 studies, and other expected positive news flow. It is conceivable the interim data will be available prior to one of our upcoming conference calls. And if so, it is possible that we will hold a special update call separate from the filing related call. Additionally, for any significant corporate events, we expect to communicate publicly when the event becomes known rather than wait for a quarterly conference call.

Until then, thank you for your support for Provectus Biopharmaceuticals, and we'll look forward to speaking to you and seeing you perhaps even during our global travels as the case may be. Thank you, again.

Operator: Thank you. This concludes today's teleconference. You may disconnect your lines at this time and thank you for your participation