PROVECTUS BIOPHARMACEUTICALS
Quarterly Year-End 2015 Financial Business Update
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Operator: Greetings, and welcome to the Provectus Biopharmaceuticals fourth quarter and 2015 year-end business update conference call. At this time, all participants are in a listen-only mode. A question-and-answer session will follow the formal presentation. If anyone should require operator assistance during the conference, please press star-zero on your telephone keypad. As a reminder, this conference is being recorded.

I would now like to turn the conference over to your host Ms. Lori B. Metrock, Outside Securities Counsel for Provectus Biopharmaceuticals. Thank you, Ms. Metrock. You may begin.

Ms. Lori Metrock: Thank you, operator. Good afternoon and welcome to Provectus Biopharmaceuticals fourth quarter and 2015 year-end business update call.

At this time, I must advise all listeners that this call contains forward-looking statements as defined under the U.S. federal securities laws. These statements reflect management's current knowledge, assumptions, beliefs, estimates, and expectations and express management's current view of future performance, results, and trends. And such forward-looking statements may be identified by the use of terms such as anticipate, believe, could, 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 such statements are made. We undertake no obligation to update such statements after this date.

Having taken care of that housekeeping matter, we can move onto the main portion of the call. And to get us started, I want to introduce Peter Culpepper, COO, CFO, and Interim CEO of Provectus. Good afternoon, Pete.

Mr. Peter Culpepper: Thank you, Lori, for that introduction, and welcome to our call, everybody. This is our third conference call this month of March. And that deserves some explanation.

Our first call, March 1st, addressed the resignation of Dr. Craig Dees as our Chairman and CEO. We held that call as a pledge to be transparent about all major events affecting Provectus. Given his years of service and contributions to Provectus, Craig's resignation was indeed a major event and necessitated our full disclosure of the situation and our actions going forward.

To accommodate the travel plans of our CTO Eric Wachter and to coincide with our projected 10-K filing, we postponed our scheduled March 10th call to March 16th. When we realized our need to file an extension for the 10-K, we faced a decision: postpone the call yet again, or go ahead as scheduled and not discuss certain matters that were not yet public and specific to the 10-K. We decided, in the interest of transparency, to go ahead with that call, even though we would've preferred to have filed the 10-K by then.

Today's call takes into account today's filing of the 10-K. Its chief focus is to cover the issues that we weren't able to talk about on the 16th. We will touch on the numbers in the 10-K and the warrant exchange transaction and then briefly review the status of each of the studies on PV-10 and PH-10. In particular, we will discuss the upcoming AACR poster presentation by Moffitt Cancer Center, other data on the PV-10 mechanism of action, our Phase 3 study, and the combination Phase 1b/2 study with PV-10 and Merck's Keytruda.

Beginning with our cash position, as of December 31st, 2015, we had cash and cash equivalents of approximately 14.2 million compared with 17.4 million at December 31, 2014. The decrease of approximately 3.2 million was due primarily to a decrease in net cash provided by financing activities and a net increase of approximately 3.5 million used in operating activities.

Additionally, thus far in 2016, the company received gross proceeds of approximately 4 million in cash due to the warrant exchange transaction closed on Monday, two days ago. The warrant exchange, which is discussed in the subsequent events of the filing, expired at 4:00 p.m. Eastern Time on Monday, March 28th. We were offering, pursuant to an offer letter prospectus, shares of our common stock for issuance upon exercise of the existing warrants.

Our offer was to temporarily modify the terms of certain of our existing warrants so that each holder who tendered existing warrants during the offer period for early exercise to be able to do so at a discounted exercise price of 50 cents per share.

Each existing warrant holder who tendered existing warrants per early exercise during the offer period received, in addition to the shares of common stock purchased upon exercise, an equal number of replacement warrants. Each replacement warrant had a cash exercise price of 85 cents per share and expires on June 19, 2020, unless sooner exercised.

Approximately 8 million warrants were exercised, resulting in an increase in our common stock outstanding to approximately 213 million shares. This cash infusion enables our capital structure to remain strong, which is discussed on page 42 of our recently filed 10-K.

Based on our capital structure, we believe our relationship with the New York Stock Exchange NKT [sp] remains strong and will continue to be as we intend to remain adequately capitalized. We continue to be in regular communication with the New York Stock Exchange, which includes informing the exchange of periodic events like press releases.

Focusing on the events in connection with the resignation of Dr. Dees, our Audit Committee retained independent counsel and an advisory firm with forensic accounting expertise to assist the Audit Committee in conducting an investigation into his travel expenses along with the review of the company's financial policies and procedures, including management's expenses.

On March 15, 2016, the Audit Committee completed this investigation. And we disclosed the findings in our form 8-K filing and related press release on March 16th, 2016, as well as now in note 10 to the financial statements in the 10-K.

The company intends to pursue collection efforts on all of Dr. Dees's unsubstantiated travel expenses, including those which did not appear to be authentic. The company treats all

relevant travel expenses of Dr. Dees as a theft loss. And therefore, any uncollectable amounts will be treated as income to Dr. Dees. And a form 1099 miscellaneous will be issued by the company to him in 2016 in that regard.

As we state in item 9a of the 10-K, our internal control testing identified inadequate supporting documentation for the travel advances to Dr. Dees. Dr. Dees did not produce appropriate receipts for his travel expense advances he received from 2013 to 2015, even though his travel advances were properly authorized.

We are now replacing the independent consulting group previously utilized by the company to aid us in its documentation and testing of internal controls over financial reporting. Also, the company has taken remedial action with respect to this material weakness by eliminating travel advances, although they only pertained to Dr. Dees. Our remediation efforts have been swift and comprehensive to enable effective internal controls over financial reporting going forward.

The resignation of Dr. Dees has also given us the opportunity to reorganize our corporate governance. Al Smith IV has taken over as Chairman of the Board. Eric Wachter, our CTO, has joined the board. And I'm now the interim CEO as well as the COO and CFO. We will retain a permanent CEO as soon as possible, and our Audit Committee has engaged a search firm for a replacement CEO.

Continuing updates on legal matters, I want to note that a stipulation settlement in our class-action lawsuit was filed on March 8, 2016. The hearing on preliminary settlement approval is April 7, 2016. It provides for the methodology of administering and calculating claims, final awards to stockholders, and supervision and distribution of the settlement funds.

If the settlement is not approved and consummated, the company intends to defend vigorously against all claims in the consolidated complaint. The stipulation merely offers us an expedited way to put this matter behind us and focus on clinical development and monetization of assets for the benefit of patients and stockholders alike.

Now, to focus on our medical, scientific, clinical, and business development of PV-10 and PH-10, since we went into this in some detail just on March 16th, I will highlight. Starting with our Phase 3 clinical trial of PV-10 as a treatment for locally advanced cutaneous melanoma, we recently amended the protocol. As Eric said in our previous call, these kind of amendments are not unusual for Phase 3 trials.

Significant amendments to the protocol included the addition of TVEC, Imlygic brand name, as an option for use as comparator. The amended protocol also extends eligibility to include

certain Stage 4 M1a patients and clarifies eligibility for patients not having access to immune checkpoint inhibitors as well as inclusion of patients who have failed targeted therapy.

The key important point to underscore is that we have expanded patient eligibility in our Phase 3 study, which should accelerate patient recruitment. The first patients have been enrolled, and we are assessing the impact these changes in eligibility and comparator may have on the study timeline.

We will complete this assessment by the time of the next quarterly investor call. We have additional sites actively recruiting, like MD Anderson in Houston, Texas, and more preparing to recruit. You can refer to this at clinicaltrials.gov, a service of the U.S. National Institutes of Health.

As the trial progresses over the course of 2016, we will assess the paths for expedited development, which includes fast track, accelerated approval, marketing approval with the FDA in the U.S. and with their counterpart, the TGA in Australia.

Next, we have our Phase 1b/2 testing of PV-10 in combination with Merck's Keytruda in patients with late Stage 4 melanoma. The first patients have been treated. And we announced this in the same release as the PV-10 monotherapy study earlier this year.

We believe we can successfully combine PV-10 with Bristol's Opdivo, another anti-PD-1 systemic immunotherapy just like Merck's Keytruda. For that matter, as we disclosed earlier in the week on Monday from our presentation last week at the Biopharma Asia Convention 2016 in Singapore, we expect to be able to combine PV-10 with many different agents due to the unique mechanism of action and delivery approach of PV-10. We chose to start with Merck's Keytruda because it lines up well for purposes of our Phase 1b/2 clinical study design and as a leading new drug in melanoma.

Use of PV-10 with any immune checkpoint blockade is possible we believe, our joint patent that is co-owned with Pfizer is basis for this approach to combine locally administered PV-10 with systemically administered immunomodulatory agents, such as Keytruda and Opdivo.

Our Phase 1 study of PV-10 as a treatment of hepatocellular carcinoma, HCC, and cancers metastatic to the liver has demonstrated preliminary evidence of efficacy in treatment of cancers of the liver with PV-10.

We have therefore been developing a Phase 1b/2 protocol to pursue development of PV-10 to treat HCC. And the Phase 1b portion of the study will commence in Asia based on input from KOLs under the auspices of our collaboration with Boehringer Ingelheim.

Next month, a team of researchers from Moffitt Cancer Center in Tampa, led by Dr. Shari Pilon-Thomas, will be presenting data on intralesional PV-10 and co-inhibitory blockade in a melanoma model at the American Association for Cancer Research's annual meeting. This important work continues to build on the evidence of unique PV-10 immunologic signaling activity.

Results of an in vitro testing of PV-10 on colon cancer, murine CT-26 cells, that have been presented by the University of Illinois Chicago researchers, are consistent with immunologic cell death caused by PV-10 on melanoma. We are continuing to work on protocols for further development with PV-10 to treat colon cancer as a result.

We intend to move forward with PV-10 as a treatment for other indications as the data supports, such as in prostate, breast, bladder, pancreas, and other solid tumors. In tandem, we are determined to fully harness our compassionate use program for the benefit of patients now and in the future. As we know, as we have trademarked, when patients win, we all win.

As mentioned in our March 16 call, we expect to report on our investigational dermatologic drug PH-10 Phase 2 results, a projected end of Phase 2 meeting with the FDA, and toxicology work necessary to support PH-10 approval. Mechanism of action studies have been critical, and

the company will be seeking a licensing agreement based on the strength of those MOA studies and clinical data.

Turning to business and corporate developments, we remain committed to the Chinese market, and our relationships with Sinopharm and especially Boehringer remain in place, helping to optimize PV-10 use and monetization in mainland China and elsewhere in Asia.

In addition, we have signed a confidentiality agreement with Spectrum Oncology Private Limited, a company based in Mumbai, India. We will be exchanging certain protected information with spectrum and have a meeting scheduled in the next couple of weeks to advance matters of common interest with melanoma and liver cancer-focused KOLs in order to advance work in India with potential collaborators and pharma partners.

We are making preparations for an aggressive media push in the coming months aligned with several key prestigious healthcare conferences. These conferences include American Association for Cancer Research, AACR, American Society of Clinical Oncology, ASCO, and the Third International Conference on Regenerative Medicine at the Vatican.

We are looking forward to telling the story of PV-10 and positioning it among the top investigational cancer therapies in the industry. We remain passionate and committed in our

media outreach efforts, recognizing it is an important channel to amplify and educate key audiences about the implications of Provectus and PV-10.

Just as today's focus is on the cancer moonshot [sp] and private--public-private partnerships, we are not trying to make incremental change. We are looking to make quantum leaps. We believe PV-10 is part of that solution to treating cancer in far more safe and effective ways than have been done so in the past.

We are ready for questions, operator.

Operator: At this time, we will be conducting a question-and-answer session. If you would like to ask a question, please press star-one on your telephone keypad. A confirmation tone will indicate your line is in the question queue. You may press star-two if you would like to remove your question from the queue. For participants using speaker equipment, it may be necessary to pick up your handset before pressing the star keys. One moment, please, while we poll for questions.

Our first question comes from the line of Carl Burns [sp] of Lake Street Capital. Please proceed with your question.

Mr. Carl Burns: Thanks much. Just a real quick question. I would imagine that the amended protocol would make enrollment and recruiting much, much easier. So, what I wanted to confirm, that that's in fact the case. And are you able to cite where enrollment is at this juncture? I know you mentioned that you expect enrollment to be--the target to be completed in the next quarter. And the target enrollment according to clinicaltrials.gov is 225. And I wanted to make sure that that number remained correct with the amended protocol.

Mr. Peter Culpepper: Yes, we are assessing--thank you. We are assessing the study timeline. We do have on clinicaltrial.gov that we expect the full study to be completed at the end of Q3, beginning Q4 of 2017. We also have said that we expect interim data this year. We are assessing that.

We are trying at this juncture to add as many sites in the U.S., Australia. We have sites in process in the E.U., Brazil, China, throughout the world that are going through the process to come online. So, certainly, we'll communicate status of Phase 3 in our next call, which would be when we file the 10-Q in May. However, I should also point out that we do not expect to comment on patient enrollment details until the interim data is communicated when 50 percent of the events have been triggered.

Mr. Carl Burns: Great. Thanks so much.

Mr. Peter Culpepper: Thank you.

Operator: I would like to remind all participants that, at this time, if you would like to ask a question, please press star-one on your telephone keypad.

Our next question comes from the line of Joseph Baffle [sp] of ATIS. Please proceed with your question.

Mr. Joseph Baffle: Hi, Peter. That was a very exciting update on the development side. My question concerning the Shari Pilon-Thomas was her work at Moffitt completed on the method of action. I believe it was 18 patients. And they presented some of that last year. And then we thought that maybe they submitted that I think to a peer review. Are they trying to time the AACR conference? Do you expect that peer-review article to be out and coincidal with the AACR presentation?

Mr. Peter Culpepper: We do plan to be at the AACR presentation, which as you know is April 20th in New Orleans. We will be leading with Shari and her team at Moffitt. We will be communicating as soon as we can any information on the peer-review publication status. We do fully expect that to be forthcoming. And we are very excited about that because that's the

kind of clinical data, mechanism clinical data, that's extremely important in our efforts to advance PV-10 in combination with the immune checkpoint blockade agent.

So, we're very excited about that. We're very focused on that. And we'll certainly have comments on the presentation from AACR. And as soon as we have more intel on the peer-review publication status, we will make that known in conjunction with our media efforts, etc.

Mr. Joseph Baffle: Right. I would assume that would dovetail nicely with the combo data. And, Peter, you mentioned ASCO. Do you have an understanding of who will be presenting at ASCO? And then I would assume that--basically guess that there would be an abstract submitted.

Mr. Peter Culpepper: Yeah, that's another very exciting conference, obviously very prestigious. We do expect to be at ASCO. I cannot comment on specific details. But, I can say that we will communicate as we and others can see on the ASCO Website when it's appropriate to discuss next month the acceptance of a abstract and when it's appropriate to discuss the information from--through April into May when the abstract itself embargo lifts and then of course at ASCO proper. So, we're very excited about the forthcoming data. And so, that builds on AACR we believe.

Mr. Joseph Baffle: Thank you, Peter.

Mr. Peter Culpepper: Thank you.

Operator: Our next question comes from the line of Bruce Denzel [sp], a private investor. Please proceed with your question.

Mr. Bruce Denzel: Good afternoon, Peter. I have two questions about the trials. Apparently, this month, Dr. Agarwala mentioned that the combo trial was in Phase 2, while you've talked about still recruiting for Phase 1b. Can you explain that confusion of what phase the trial is and why some people say Phase 2, your corporate event factsheet shows the arrow pointing that we're in Phase 2? Can you explain that confusion?

Mr. Peter Culpepper: Sure. So, the 1b/2 protocol is one protocol. So, it's a very effective way for sponsors, such as Provectus, to be able to have one protocol filing with the agency. So, that's what allows for a seamless enrollment in 1b and then going into 2.

We're not going to comment on specific data until it's matured. But, we can say, and we've already communicated this, that we expect to be able to communicate status on 1b this year. We expect 1b to be complete this year. We also expect to communicate in the second quarter more information on this topic.

It is a--I agree. It is a challenge for investors, given that it's a fast-moving, and it's a very, very tremendous area of focus by the different investigators. So, we can see on clinicaltrials.gov there will be other sites that go from not yet recruiting to recruiting. We've actually met with multiple sites that want to be in that study that have not yet shown up on clinicaltrials.gov. So, it's fast moving. There's lots of attention to this. So, that's the best I can do at this juncture.

Mr. Bruce Denzel: Yeah, some people speculate that some of the Phase--or all of the Phase 1b people, that they will be included in the Phase 2 by currently blinding some--the control arm people at the same time. So, they believe that you're enrolling people in the Phase 1b and assigning some people to a control arm so that the Phase 1b people will also be in the Phase 2 data. Is that--is there any truth to that guess?

Mr. Peter Culpepper: I don't believe that would be accurate because the purpose of the 1b, as you know, is ascending dose. So, the objective there is to optimize the dose of PV-10 in combination with Keytruda. And so, when the dose optimization occurs, and that can occur quickly, so if that--we have a very good idea of the dose escalation on the frontend. So, we believe that we can both optimize in the 1b, and that does allow us to go rapidly into the 2 piece, where it's randomized, the PV-10 plus Keytruda versus Keytruda.

So, that can happen very quickly. But, still, the 1b piece is for dose escalation. So, I don't see that that would be possible, although it's fluid. It's dynamic. I want to say it's possible for the same patients, although we have seen in prior studies that patients that needed more PV-10, we did find ways to allow and facilitate that. We saw that in the Phase 2 PV-10 melanoma study. Patients were doing well. They cannot continue on the Phase 2 protocol, yet we were able to get them adequate PV-10 in another fashion. We've seen that in other studies. And you'll see more about this sort of topic with data forthcoming we believe this year. But, that's the best I can do on that topic as well.

Operator: Mr. Denzel, you still there?

Mr. Bruce Denzel: I am here. To take a site--the projection in August of 2015 was that it would take three weeks to go from not yet recruiting to recruiting. And we've seen something closer to three months. Can you comment on what's making it harder than you expected to get the sites up and running? And do you see at any point--has Eric considered a meeting, orientation meeting, when you have enough sites ready?

Mr. Peter Culpepper: This is going to be--this is an ongoing high priority, probably the biggest priority of the company right now. I mean, when you talk about all of the focus, it's on data generation and the randomized studies. So, absolutely.

We know--Eric has commented in the past about the Australia matter in terms of one site becomes active. So, that's the site in Brisbane. Once the one site becomes active, it makes it very easy for all the other sites to become active because there's a national ethics process now in place under the auspices of the TGA. So, Australia has that factor.

We have other sites--because of the addition of Imlygic as a comparator, other sites in the U.S. that are wanting to join in the existing Phase 3 quickly. We have--for, say, E.U. and Brazil and China, we have completed an international conversion of the file, the IND file with the FDA, the analogous file for rest of world, for regulatory bodies. That's now available. So, that facilitates the other sites becoming active.

So, this is going to be very dynamic. We appreciate the critical importance to generating data. There's no hold up from the company. We have adequate PV-10 under--the supply chain is well established so as--we have plenty of drug supplies for PV-10 in all the studies. We have the investigators who want to do it. We have the support of the regulatory bodies. We have the entire infrastructure of global CROs, the top names that exist and throughout the world that are focused on sites coming up. So, I would see that this is going to be dynamic. And best I can communicate is this is our top priority right now.

Mr. Bruce Denzel: Do you see yourself getting to a three-week standard from going from not yet recruiting to recruiting?

Mr. Peter Culpepper: I--well, I think that's a great question. I myself cannot comment on any standards other than to say the reason Eric--I can add this. The reason Eric is not on this call right now is he is focused at this moment on getting additional sites, not just for the Phase 3, but also for the 1b/2 combo, and very similarly the 1b/2 liver.

So, those three studies right now are critical to generating the kind of data that we're already engaged with big pharma discussing. I get regular e-mails from big pharma interested parties asking for data. So, there's very, very significant focus on what you are focused on, all stockholders, and of course, patients need these studies and the sites open. We know that's the case as well. So, we'll have more specifics I'm sure from Eric at our next call when we do the Q1 10-Q conference call.

Mr. Bruce Denzel: Thank you, Pete.

Mr. Peter Culpepper: Thank you.

Operator: I would like to remind everyone, if you would like to ask a question, press star-one on your telephone keypad.

As there are no further questions, at this time, I would like to turn the conference back over to management for closing remarks.

Mr. Peter Culpepper: Thank you, operator, and thanks to all of you for listening and for your questions. The first quarter of 2016 ends this week. And so, we will be filing our Q1 form 10-Q in less than 45 days. And another conference call will be held to coincide with that event. Until then, stay tuned for more news from Provectus. Goodbye for now.

Operator: This concludes today's conference. Thank you for your participation. And you may disconnect your lines at this time.