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Thursday, Aug. 14, 2025 at 4:30 p.m. ET

Chief Executive Officer ? Vincent Angotti

Chief Medical Officer ? Dr. Shakil Aslam

Chief Financial Officer ? Raffi Asadorian

**Operator**

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Clinical trial enrollment-- Enrollment in the Nephros study more than doubled since May 2025, reaching 15 patients as of the second quarter, with over 90% of recent enrollments in the quarter coming from newly profiled sites focused on medical ICUs led by nephrologist principal investigators.

Trial design adjustment-- The target study size was reduced from 166 to 70 patients after a protocol change approved by the FDA. Study completion is targeted for the end of 2025.

Future site expansion-- Six additional target profile sites are projected to begin enrolling patients in the third quarter, bringing the total to nine sites with the new profile.

Cash operating expense guidance-- Cash operating expense guidance for 2025 was revised down to a range of $16 million to $17 million, compared to the previous range of $17 million to $19 million stated last quarter.

2025 operating expenses-- Year-to-date cash operating expenses for 2025 were $3.7 million, compared to $4.3 million for 2024; excluding non-cash stock-based compensation expense, expenses were $3.5 million for 2025, and $4 million for 2024.

Cash position and financing structure-- Cash totaled $6.8 million as of June 30, 2025, with remaining financing tranches contingent on reaching patient enrollment milestones (17 and 35 patients) and maintaining a minimum share price of $0.73 per share following each milestone.

Compassionate use IDE-- A submission for compassionate use of nafamostat is being advanced to the FDA for patients with contraindications to available anticoagulants, following multiple institutional requests.

Breakthrough FDA designation-- The nafamostat program received FDA breakthrough designation, which management stated provides efficient access and faster review timelines.

Citrate and heparin shortages-- Ongoing supply chain issues and shortages for citrate, and episodic shortages for heparin, were cited as heightening provider demand for nafamostat.

Legacy site performance-- One legacy site was terminated after failing to enroll any patients; legacy sites overall contributed minimally to enrollment.

Talphera(NASDAQ:TLPH) reported a significant acceleration in clinical trial enrollment after a strategic pivot to target sites led by nephrologists in medical ICUs, validated by enrollment data from new sites. Management reduced cash operating expense guidance for 2025 to $16 million to $17 million in response to lower personnel and administrative costs, and reaffirmed the company?s ability to fund the current clinical trial through completion, anticipated by year-end, with existing cash and milestone-based financing. The second quarter call detailed progress toward submitting a compassionate use IDE for nafamostat, and highlighted FDA breakthrough designation and supply disruptions for existing anticoagulants as supportive factors.

Management described anticipated patient enrollment rates at newly activated sites as ?flat? relative to recent trends, specifically referencing the period from September through December 2025, with no further acceleration necessary to achieve the 70-patient target by year-end.

CEO Angotti said, ?The trial design has been agreed with the FDA, including broader inclusion criteria and a reduced number of patients, all of which help minimize study execution risk.?

Chief Financial Officer Asadorian noted that the investors in the staged financing ?have the right to waive? the $0.73 per share price contingency at each enrollment milestone, with primary focus on patient accrual numbers.

Enrollment challenges with legacy sites were attributed by management to mismatched patient populations and lack of focus on CRRT, which was addressed by shifting to nephrologist-led medical ICUs.

Chief Medical Officer Dr. Aslam indicated that safety data from compassionate use cases will support regulatory submissions and publication, but not contribute to efficacy data sets.

CRRT: Continuous Renal Replacement Therapy, a form of dialysis used to treat patients with acute kidney injury, primarily in intensive care units.

IDE: Investigational Device Exemption, a regulatory status permitting investigational use of a medical device or drug under specific circumstances prior to full approval.

PI: Principal Investigator, the lead researcher responsible for study conduct at a clinical trial site.

CTA: Clinical Trial Agreement, the contract governing responsibilities and terms between sponsor and clinical trial site.

SIV: Site Initiation Visit, a meeting conducted to launch a clinical trial at a new site, ensuring readiness for enrollment.

Vincent Angotti: Thanks, Raffi. Afternoon, and thank you to everyone joining our call today. We're excited about the progress made this past quarter, specifically in the acceleration of the Nephros study enrollment. At the end of last year, upon the announcement of Dr. Shakil Aslam becoming the Chief Medical Officer of Talphera, we embarked on a restructuring of the nephro clinical study, which included changing the target profile of our clinical sites, approaching the FDA with various study protocol changes, including reduction of the study size from 166 to 70 patients, and adjusting internal processes to ensure acceleration of study enrollment with the goal of completing the study by the end of 2025.

I'm very pleased to inform you that we now have evidence that all of these changes were indeed the appropriate adjustments, and we're confident that we're on the right path to achieve our goals. We

have seen a strong acceleration of the enrollment rate over the last six weeks from the first three sites with our new target profile. This target profile includes a nephrologist principal investigator and the institution screening patients at medical ICUs. As a result, the number of total enrolled patients has more than doubled since May.

These sites, combined with six additional new target profile sites that are expected to begin enrolling over the rest of this quarter, should keep us on plan to complete the study by the end of this year. Dr. Aslam and I have recently returned from a visit with many of the new study teams at their respective locations. In addition to observing their study engagement, I'm also highly encouraged by the eagerness of these institutions to have nafamostat available. If approved, in their words, nafamostat, based on its profile and use in other countries, will be a preferred anticoagulant for CRRT.

While we still need to complete the study, this feedback from these investigators continues to strengthen my belief that nafamostat, if approved, will become a primary product in the market for CRRT anticoagulation.

The addition of more of the right clinical study sites and principal investigators has been critical to achieving the increased enrollment rates. As a reminder, the new site profile concentrates specifically on one, the type of intensive care unit where the study will be performed, for example, medical ICUs instead of surgical or cardiothoracic ICUs where many of the legacy sites were focused. Two, the specialty of the principal investigator, specifically a nephrologist as a primary lead for selecting patients to enroll compared to an intensivist or other specialist, which were the specialties of the legacy site PIs. And three, the efficiency of the administration to initiate a new study at their institution. Dr.

Aslam identified these characteristics after his review and learnings from assessing the initial sites as critical to successful and timely enrollment. In addition to the acceleration in enrollment at existing new profile sites and the institutional interest in joining the study as we add new sites, we believe there are other tailwinds supporting the market potential of nafamostat. These include one, advancing a compassionate use IDE. As stated on our last call, we have been approached by multiple institutions and are discussing using nafamostat under a compassionate use IDE for a specific patient population that does not do well with other available anticoagulants for CRRT. And two, continued shortages of citrate and potential supply chain issues with heparin.

Healthcare providers are inquiring about the timely availability of nafamostat given the recurrent heparin and citrate shortages. Now before I turn the call over to Dr. Aslam to provide some additional details, let me remind you that if approved, nafamostat would become the only FDA-approved regional anticoagulant for use during continuous renal replacement therapy. This is important in that there are many disadvantages to the currently used products, heparin, which is systemic in nature, and citrate, which is being used off-label. I'll now hand the call over to Dr. Aslam.

Dr. Shakil Aslam: Thank you, Vince, and good afternoon to all. The acceleration in enrollment rate is exciting, and the new site engagement has been excellent as we shift away from the legacy sites to the new target profile sites previously described. We now have a total of seven sites that are actively screening. We have four legacy or old profile sites and three new target profile sites. These new sites have enrolled over 90% of the 15 patients to date. Importantly, the enrollment rate from these three new sites has been impressive and has validated our strategy of changing the target site profile. These sites have enrolled nine patients over the last six weeks, which was in line with our enrollment forecast.

We terminated one legacy site because of its low screening numbers and failure to enroll any

subjects. We expect to add six new sites over the course of the third quarter, all with the new profile. As a matter of fact, a couple of them were recently activated and will begin enrolling shortly. This gives me confidence that the relaunch of the nephro study with significant protocol changes and a pivot to the sites with a different profile has been successful. We expect the study enrollment rate to accelerate further with the addition of the six new sites with a similar profile over the current quarter, as these are large academic institutions with volumes higher than the legacy sites.

As we mentioned on our last call, we continue to advance our compassionate use IDE with a large institution. Physicians at this institution see an immediate and compelling need for a subset of patients with contraindications to currently available anticoagulants and need an alternative. We are in the process of submitting a compassionate use IDE to the FDA. This is an opportunity to provide an alternative to these patients who cannot receive the currently available anticoagulants and, as a result, clot their CRRT circuits frequently. We do not have a timeline finalized, but we wanted to share this information as this was not the first such request we have had.

It is evident that the current anticoagulants for CRRT are not ideal products, and there is no FDA-approved additional anticoagulant on the market. We will provide more information on the progress of this compassionate use IDE submission. And with that, I'll turn the call back over to Vince.

Vincent Angotti: Thank you, Dr. Aslam. Before I hand the call over to Raffi, I want to reiterate our belief that the three critical risk elements, clinical, regulatory, and commercial for the nafamostat program are low for a number of reasons. First, with over thirty years of use as an anticoagulant during CRRT in Japan and South Korea, we know nafamostat's track record of efficacy and safety, minimizing the clinical risk. The trial design has been agreed with the FDA, including broader inclusion criteria and a reduced number of patients, all of which help minimize study execution risk.

Second, we have a clear regulatory path, including breakthrough designation from the FDA, which has provided us with efficient access to the agency, leading to quick review and response times. Lastly, while we know there is always commercial risk, we believe this is mitigated given the disadvantages of the products currently being used for anticoagulation of the CRRT circuit, namely heparin and citrate. As you heard from Dr. Aslam, there's a clear need for an FDA-approved regional anticoagulant. I'll now hand the call over to Raffi for a financial update.

Raffi Asadorian: Thank you, Vince. We continue to focus on our efficiency while accelerating the enrollment in our clinical study. Accordingly, we are reducing the previously communicated 2025 expected cash operating expense guidance to now be in the range of $16 million to $17 million, which includes the estimated expenses related to executing and targeting completion of the nephro CRRT registrational trial by the end of the year. This is a reduction from the $17 million to $19 million range provided last quarter. Our cash operating expenses, or combined R&D and SG&A expenses, for 2025 totaled $3.7 million compared to $4.3 million for 2024. Excluding non-cash stock-based compensation expense, these amounts were $3.5 million for 2025, compared to $4 million for 2024.

The decrease in cash operating expenses in 2025 was primarily due to reductions in personnel expense and other general and administrative expenses. Our cash balance at 06/30/2025 was $6.8 million, including the proceeds from the first tranche of financing that closed on April 2. As a reminder, the financing was structured in three equal tranches, with the first tranche received at the initial closing and the two additional tranches committed upon achieving an enrollment of 17 patients and 35 patients, and with the stock trading above 73¢ per share following the announcement of each milestone.

Expected proceeds from the closing of the two additional tranches, combined with the $6.8 million in cash at 06/30/2025, should support the company through the completion of the study anticipated by the end of the year. I'll now turn the call back to Vince.

Vincent Angotti: Thank you, Raffi. And I'd like to open the line for any questions you might have. Operator?

Operator: Thank you. Ladies and gentlemen, we will now begin the question and answer session. Should you have a question, please press the star followed by the number one on your touch-tone phone. You will hear a prompt that your hand has been raised. Should you wish to decline from the polling process, please press the star followed by the number two. If you are using a speakerphone, please lift the handset before pressing any keys. One moment please for your first question. Your first question is from Ed Arce from Westpark Capital. Please go ahead.

Ed Arce: Hi, guys. Hope all is well, and congrats on the progress with nephro enrollment as well as the expense run rate. One major question and perhaps a follow-up. Just trying to get a better sense for, you know, given all the detail you've provided now on the acceleration with these new profile sites. I just wanted to get a better sense for the acceleration that you expect to get to the 70 enrollment target by year-end, given that the last six weeks saw nine patients enrolled. Maybe just talk through the kind of arc that you're expecting through the remainder of the third quarter and into the fourth quarter? Thanks.

Vincent Angotti: Hey, Ed, this is Vince. And congratulations to you on your new position. Welcome to the call. I can help answer that. The look. The rates of enrollment are significantly increasing, obviously, with the new sites enrolling at the same rate besides the fact that they are bigger in many cases, the newest sites. If you do the math, you look at the nine sites that are gonna come on board

within the, call it, month and a half with our target profile. For an average of four months, September through December, we need a total of 55 patients. That's about one and a half patients per site per month.

Our current run rate in just the last six weeks is higher than that. So we're not seeing an arc or change to the run rate. As a matter of fact, it'll be a little bit lower on a per-site basis. The key is just getting these sites up and running. We've had two, as Dr. Aslam mentioned, over the next six with the new profile just come on board as of really yesterday. And their enrollment should start here shortly. And even without any enrollment through the balance of August, if we just assume everyone's on in September and starts enrolling, again, it'll be a flat run rate to what we've seen historically with these three new profile sites.

So we're not talking about an acceleration on a per-site basis. Although that might happen. We're just talking about producing what they already are.

Ed Arce: Okay. Great. That's helpful. And then just wondering, you mentioned this program where you're providing the products for sites that would like to try it, as you mentioned, given all the issues, especially now with the use and provisioning of heparin and citrate. Is there any opportunity, given their use, I would assume this is more than one site or facility, to leverage the data that they have perhaps not for approval, but perhaps for future publication and to buttress commercial uptake?

Vincent Angotti: Yeah. I'll start with, it's an excellent question, on the background of it, and then Dr. Aslam can certainly comment about why these sites, one in particular that we're moving down this path with fairly rapidly is important. And the requirements to actually capture data with compassionate use. So while we've been at a number of different CRRT meetings over the course of last year and up to date this year, we continuously get approached by experts in the field at

certain institutions whose patient profiles might be unique to their particular situation. And while we can't satisfy everyone for compassionate use, there are one or two that we are heading down this path with in a fairly aggressive fashion.

Based off of their ability to handle the requirements on their side, because there are requirements on their side. And the fact that their patient population is unique, meaning that it doesn't really overlap what we're doing in our current study. So Dr. Aslam, I'll turn it over to you about what those types of patient profiles might look like at these institutions, why these people are requesting nafamostat, and the requirements they might have regarding data capture, etcetera.

Dr. Shakil Aslam: Absolutely. Thanks, Vince. And congratulations, Ed. So, absolutely, you're absolutely right. So the data that we collect from these patients, although this will not be part of our efficacy dataset, however, our larger dataset that will contain safety data from every patient, whoever got exposed to nafamostat, this dataset will be part of our submission for safety reasons. And, obviously, this will be used as a publication to highlight that in patients who currently are not suitable or eligible to receive either heparin or citrate can actually safely and effectively receive nafamostat for CRRT anticoagulation. So these patients that we are providing compassionate use, nafamostat are patients who get chemotherapy, and as a result, their bone marrows are severely compromised.

So they have very low platelet counts, and that contraindicates the use of heparin. And because of low white blood cell count, these patients also get infected and go into sepsis and can end up having liver dysfunction, which contraindicates the use of citrate. So these sites are really struggling with these patients because they cannot give them two of the commonly used agents on the market right now. One, obviously, citrate being off-label use. And they clot very, very frequently because cancer increases your risk of blood clotting. So this is a very specific patient population, which

cannot be captured in our clinical study at this point, but it is a big unmet need in that population.

And so the data that we use there would be very helpful for our commercial needs as we get approved, get to the approval of nafamostat. Does that answer your question, Ed?

Ed Arce: Yeah. That's helpful color. I appreciate that. And, again, congrats on the progress.

Dr. Shakil Aslam: Thank you.

Operator: Your next question is from James Molloy from Alliance Global Partners. Please go ahead.

James Molloy: Hey, guys. Thanks. I was wondering if you could walk through the heparin and citrate shortages you guys mentioned earlier in the call. So what's the status on that? How long is that going on for? And when do you think what's the expectation for that to resolve? And then on the second tranche, when you hit 17, does the fact that it, you know, that's looks like a long road to go to get to 73¢ from here, would that preclude that cash coming in, or do you think investors will waive that requirement?

Vincent Angotti: Yeah, good questions, James. So I'll start on the first one with the supply chain issues that we've continued to hear about or watch and observe with heparin and citrate. So look, heparin is episodic. There's been a well-documented set of historical challenges with the supply chain there, and they continue to happen each year at different periods of time. So the dependency on it becomes difficult because that supply chain isn't always well supplied. Citrate, we often get. We've had a lot this year, sites telling us they're running low or running out. I can't tell you the reasons for that particular shortage. Maybe manufacturing issues at certain plants as well as other maybe supply chain issues.

But, you know, we know citrate's used not just for CRRT, it's used in other areas like blood banks, etcetera. So there's demand for the product in and outside of CRRT. So when you combine the both, each year that we've been involved with this project or this disease state, this therapeutic area, we continue to hear challenges with both. Sometimes they are fixed faster than others. I think the takeaway is that the users of these products for CRRT are always on edge about the supply that they'll have and if it'll be predictable or not. I think the second question was related to the financings. Raffi?

Raffi Asadorian: Yeah. Hey, James. So we'll clearly need capital to get to the PMA filing. And the question about the two conditions that are obligations for the investors to fund are obviously the seventeen and thirty-five patients. And then the stock price. We'll see. Right? We'll see what happens after we announce, I should say, the enrollment of the patients at 17, which should be coming here pretty shortly. But what we do know is the investors do have the right to waive those. And when we are in discussions with them, the overwhelming majority were really just focused on the 17 patient milestone and less so on the stock price.

So we'll have to certainly have discussions with them if we don't achieve that 73¢. But they have the right to waive, and the interest really is focused on the milestone of the 17 patients because that was their most, that's what they really wanted us to see hit to see if we can get that acceleration and the momentum that we now have.

James Molloy: Understood. And kudos to Dr. Aslam for rejiggering the trial design and getting it back moving. So the two-step plan is we're coming for. Thank you. Actually, I guess you're wrapping this quick question. What are the main components of the OpEx that drives down sort of the numbers looking at? If you just run the numbers you had in the current quarter out, you're well below

that $16 million to $17 million OpEx for the year. Do we anticipate a bump here in the second half?

Raffi Asadorian: We do. Yes. It'll bump up. Maybe we're being a little conservative, but it'll bump up because of the enrollment that's increasing now, has just recently increased, and is increasing as we head into the third and the fourth quarter.

James Molloy: Got it. Thank you very much.

Vincent Angotti: Thanks, James.

Operator: Your next question is from Naz Rahman from Maxim Group. Please go ahead.

Naz Rahman: Hi, everyone. Congrats on the progress, and thanks for taking my questions. I only have a couple. The first one is on the new site initiations. Obviously, previously, you had quite a bit of logistical administrative issues on the site initiations. I guess, at this point, what kinda gives you confidence that you could have the new sites up and running and enrolling basically by the end of the third quarter to basically reach the 2025 completion? My first question.

Vincent Angotti: Yeah. No. So I'll turn it over to Shakil because Shakil has done an outstanding job on vetting these institutions before moving into the contracting process. So Shakil, maybe you can comment on that vetting process and what we've actually seen in performance of the administrative advancements.

Dr. Shakil Aslam: Absolutely. Thank you, Naz. So, yes, so when we were looking at new sites, one of the criteria we used was how quickly can they get their sites up and running. And so there is some historical data on those sites, on their paperwork timelines. In addition to that, some of these

sites, which were, you know, very, very comforting for us to know, was they had their internal benchmarks on how long it takes for them to actually from start initiation of the paperwork to open for enrollment. And so some of these sites had that benchmark at ninety days or hundred and twenty days.

Three to four months was their own timeline, and they've got reprimanded or penalized if they were going off that timeline. So that was very helpful for some of these sites. In addition, we also, as Vince mentioned, that we had improved some of our internal processes, how we manage the contracting process with them, and we were very, very, very hands-on. And so we turned things around very, very quickly. We got external resources groups to help us with all the paperwork. The reality is that we are very close to activating all sites by the end of this quarter. Like, every day, we are reaching out to start these initiation visits, get the dates for them.

So we have a very high level of confidence by the end of this quarter. We will have all nine sites with our target profile up and running and enrolling. And some of these new sites are coming on board. They are really large volume sites. And so, yes, as Vince mentioned, the rate of enrollment may not accelerate in our current sites, although I think with time as they get more comfortable with patients and the clinical trials, it will likely accelerate a bit. But some of the new sites are coming in. Their rate is, I expect to be much higher than the current new target profile sites.

Vincent Angotti: Yeah. I think, Naz, what I'll add to that is it's important. None of these sites are starting from scratch right now. I want to emphasize what Shakil said. We're way down the path. As a matter of fact, of the next six sites with the new profile, two have already been activated as of last week and this week. So they should start enrollment imminently here this month. And that leaves us just with a balance of four more sites that we've already got CTAs agreed to, budgets agreed to. We get the SIVs, which are site initiation visits scheduled all here to get by the end of this quarter. So

not starting from scratch on any of these.

If anything, we're on the last leg of the sprint.

Naz Rahman: Got it. That was very helpful. And my next question is kinda on patient enrollment. So once again, obviously, you've, like, course-corrected for some of the site, but you have basically been running the study for just a little over a year at this point. I guess what has been the trepidation from the different sites or, I guess, patients from enrolling in the trial? Has it been the fact that a lot of these patients and other investigators have been concerned about enrolling them? For the patients, they didn't wanna agree to enroll in the trial or the families.

And, like, the most recent initiation or the most recent enrollment, have they more been a function of just the new sites have been more effective understanding the nafamostat, or has it been more of a function of the fact that there's been these shortages? So these investigators decided, okay. Why not enroll into this effort study?

Vincent Angotti: Shakil, I'll start with the first part of this and maybe talk about the characteristics of the new sites. Supply really hasn't been an issue. Look, the original sites that we inherited when we assumed this program from the previous owner of the company, those original sites were sites that company had a relationship with based off of their previous development program in the ICU. That product was a vasopressor. That product utilized PIs that were typically intensivists, and that study typically with those intensivists pulled patients from surgical ICUs, which aren't really the patient populations we'll see for CRRT. These were very good sites, very good investigators, very good people for that disease state of vasopressor.

And I believe they felt because they were intensivists in an ICU, there would be an easy cross to a

CRRT study. And that was basically every site that we inherited. Dr. Aslam, when he came in, evaluated the sites, and quickly, based off his experience as a nephrologist and involvement with CRRT, diagnosed the fact that while these are great institutions and very talented PIs in medical centers, for a study in CRRT, it would need to shift the specialties with nephrology who are pulling patients from the medical ICU. So the original sites, while they were inherited, really weren't the right match for this study moving forward. And with Dr. Aslam's expertise intervening, he changed that profile.

Now Dr. Aslam, you can comment on why this acceleration lately. Maybe you can talk about other metrics you're seeing and why you feel the patient enrollment is occurring.

Dr. Shakil Aslam: Absolutely. Thanks, Vince. So as Vince mentioned, our previous sites, they were great sites, but they were really not very productive for this particular indication. And primarily because of their patient population that they were screening had a lot of cardiac failure, heart failure, and they were postoperative cardiac surgery patients. And most of those patients who had kidney failure also had heart failure and were being treated with heparin for ECMO and other extracorporeal. So they've had systemic heparin for other indications. So that was our biggest challenge, that there were really very few patients consenting per month. So because of very early look at those patients and they were not qualified.

And secondly, with the, my bias perhaps is that nephrologists feel very close to CRRT as opposed to intensivists because intensivists are generally pulmonary critical care people, and they have a focus on lungs and oxygenation and ventilator. And even when they run CRRT, the CRRT is, like, a little bit of, you know, perhaps side business for them. Then CRRT is not their main focus. Whereas nephrologists, you know, that's the only reason they are seeing those patients, just to manage CRRT. So they are very close to this lack of any proper anticoagulants in CRRT use, and they deal

with the complications of CRRT anticoagulation all the time.

Either patients are bleeding or the circuits are clotting, and they have to send their nurses to swap those circuits three to four times a day. So that's what's my bias, that if we have these nephrologists, they will take more ownership of the study and enroll these patients because they are really, really desperate to get some new agent and choices in anticoagulant therapy. So both of them have worked out. We are looking at over the last six weeks or so, our consent rates, looking at patients, you know, who are passing the first screening, has really significantly increased, like, skyrocketed, and many of these patients are now being enrolled in the study.

So I think it really comes down to how passionate the PIs are to get into this indication and get their hands and access to nafamostat, and also if they have the right patient to choose from. And I think that's what's happening with our new sites and new PIs. I do not believe that this is really due to, although there is current, if you go to the FDA's website, they will list, they're listing heparin as still one of the drugs which are in short supply because there's always problems with raw materials, manufacturing, and short half-life and shelf life and all that.

So that's still ongoing, but I don't think that's what's causing a spike or acceleration in our enrollment. I think it really is the interest and enthusiasm by the PIs and the sites.

Naz Rahman: Got it. That was very helpful. Thank you.

Vincent Angotti: Yeah. Of course.

Raffi Asadorian: Thanks, Naz.

Operator: Ladies and gentlemen, as a reminder, should you have any questions, please press the star key followed by the number one. There are no further questions at this time. Please proceed with closing remarks.

Vincent Angotti: Thanks, Andrew. Again, thank you for joining our second quarter earnings call. As you can tell, we're very excited about the progress we've made, all with the goal of completing the nephro trial this year in 2025, with FDA approval of nafamostat in 2026. We'll continue to manage our cash prudently, and we look forward to providing additional updates on our progress. That concludes our call, and thank you for your interest in our company. Have a great day.

Operator: Ladies and gentlemen, this concludes your conference call for today. We thank you for participating and ask that you please disconnect your lines.

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