PharmaVOICE 100 Celebration Executive Forum
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NYC

Please welcome Taren Grom, editor-in-chief and co-founder of PharmaVOICE to the stage.

Taren: Thank you all, it's so great to see you here. On behalf of Lisa Banket and Marah Walsh, and the entire PharmaVOICE enterprise, we want to thank you for being here with us tonight at the lovely Chelsea Piers. What a venue!

We launched the PharmaVOICE 100, fifteen years ago – hard to believe, but there it is – with the vision to identify that intangible measure of a person's influence, inspiration. Over the past 15 years our aspiration has turned into a movement. Look at you all. We are delighted to have more than a 110 honorees with us here this evening, as well as scores of other of our friends who have raised their voices on the topics and trends that impact the industry from molecule to market. All of you have made our goal of creating a forum of industry executives a success. And for that we sincerely thank you.

Each year the celebration is centered around a unifying theme. This year is no different. We asked our PharmaVOICE 100 honorees to imagine the possibilities of what might the future of healthcare look like. These aspirational responses can be seen on the various screens around the venue, as well as in the celebration publication. We hope you will be inspired to think about what might be possible for yourself, for your company, and more importantly for patients.

Imagine if, by following the science we made disease a word of the past. Imagine if, healthcare was a right and not a privilege. Imagine if, there were no social determinants of health. Imagine if, new drugs were developed in weeks not years. Imagine if, our leadership was as diverse as our population. Imagine if, we could bring humanity back to healthcare. Our esteemed panel of PharmaVOICE 100 and red jacket honorees will also explore why it might be possible if we think beyond our current boundaries and unleash our imagination to create a healthier world.

Before I introduce our panel, I would like to thank our diamond sponsor Sunovion for its generous support of the Executive Forum. Sunovion is committed to bringing forward therapies for serious medical conditions and innovating to help transform people's lives. At the same time the company plays an increasingly active role in the future of global health. The company's spirit of innovation is driven by the conviction that scientific excellence paired with meaningful adversity and relevant education can improve lives. President and CEO of Sunovion, Dr. Antony Loebel, a 2019 and 2013 PharmaVOICE 100 honoree has said that one of the company's core

values is to serve and create value for patients. As such, he is fostering an environment of disciplined intellectual and scientific freedom while ensuring that the company keeps focused on the end goal of making its medicines and solutions accessible to patients worldwide.

Thank you so much Sunovion.

It's now my great privilege to introduce our dynamic panel of thought leaders for tonight. Moderating tonight's discussion is Melinda Richter, global head Johnson & Johnson Innovation, JLABS. With the tenacity and resolve of a patient looking for a better solution, Melinda set out to create a better model which now forms the basis for JLABS operational infrastructure, which includes at current count nine global innovation centers. But knowing Melinda by the end of the panel there might be a tenth.

Her passion, energy, and vision have earned her accolades across the industry, including the PharmaVOICE Red Jacket award, Fierce Biotech top 15 women, most influential women in business MM&Ms, 2017 Healthcare Technology Transformer, BIO Super Hero, Medicine Maker, Champions of Change, Top 100 Power List, and the list goes on.

Thank you, Melinda, for leading our panel.

Melinda is joined by David Epstein, executive partner at Flagship Pioneering. He is also chairman of Axcella Health and chairman of Rubius Therapeutics. David has more than 25 years of extensive drug development, deal-making, commercialization, and leadership experience on a global scale. Over the course of his career, six years in which serving as CEO of Novartis Pharmaceuticals he led the development and commercialization of more than 30 new molecular entities including major breakthroughs such as Gleevec, Tasigna, Galenia, Cosentyx, and Entresto. His teams develop three pre-Galleon award winners and he has been responsive for developing and fostering several CEOs.

Welcome, David.

Next to David is Amy Heymans, founder and chief experience officer of Mad*Pow. She is also managing director of Mad*Pow Center for Health Experience Design. Amy plays an essential role in Mad*Pow visualization of a changed healthcare system. Her work with Dartmouth-Hitchcock, Brigham and Women's Hospital and CBS has helped shape them improve the customer experience, leverage designed to drive change, and facilitate human centric innovation. As the chief and instigator behind Mad*Pow's Healthcare Experience Design Conference, HXD

and the managing director of the Center for Health Experience Design, Amy has successfully connected and networked to spare parts of a challenging and siloed system.

Thank you for being here, Amy.

Ritesh Patel is Chief Digital Officer, Ogilvy Consulting. Ritesh is a digital evangelist and he has been evangelizing digital since the early days of the dot.com boom in the late 1990s. Working for the recently rebranded Ogilvy, he consults with major clients on digital transformation and innovation. He is passionate about educating peers and clients about what the future of digital looks like for healthcare. He has recently taken his mission on the road and speaks at a wide variety of digital and healthcare centered events across the world.

Ritesh, thank you for bringing your expertise to the panel.

And last but by no means least, Michelle Keefe, President Commercial Solutions at Syneos Health. Her group executes every phase and function and commercialization for biopharmaceutical companies including sales teams, market access, public relations, medical communications, medication engagement, and more. In her role, Michelle designs pathways to share commercial market insights and proprietary data with Syneos Health Clinical Solutions Group to improve clinical trial design and accelerate patient recruitment. She combines deep commercial experience with extensive knowledge of the pharmaceutical sector drawn from decades of leadership at the life sciences services and pharmaceutical companies.

Michelle, welcome and thank you.

Melinda: Thank you so much, Taren and thank you all of you for joining us here tonight. We're going to talk about imagining the future as Taren was talking about but before we do that, I just want to take a moment to say how thankful I am for how much we've accomplished. As an industry up until now we've always thought about 2020 as the future. And now here we are, we're on the cusp of 2020 and we have so much to be grateful for what you have all invested in. So for example, who would have thought we would have been able to turn HIV from a death sentence into a chronic disease and now, in fact, work on a vaccine for HIV. Who would have thought we'd go from having a 3 percent survival rate of children with leukemia to having a 93 percent survival rate. Who would have thought we'd have a cure for hepatitis C. These are amazing things and it's because of the dedication and commitment of many people like you every day who make this work. So thank you for all of that.

And yet, there are so many more hurdles yet to overcome, so many more things we have yet to do and we cannot go without saying that the challenges we hear whether they're on the campaign trails like tonight I'm sure they'll be on and we'll be all watching in TVs later or in the rallies about patients struggling with co-pays and insurance coverage, so we have a ways to go. So imagine if statements are about setting a goal for the future of what we aspire to get to and so I couldn't be more excited to hear from this panel because they represent every segment of the system. We have R&D from big company to small company. We have clinical trials to commercial. We have the experience of patients and how the system works and we have all things digital. So we're going to hear a little bit of everything.

So with that, I'm going to ask each of the panelists to give their statement about what they imagine-if this system, if it could be. So we're going to start with David. Tell us what's your imagine-if statement?

David: So when I started in this industry almost all medicines were small molecules and antibodies were just being thought about and of course, we all take it for granted now most of the biggest drugs in the world or in fact antibody therapeutics. But we're actually on the cusp of multiple new modalities bringing new life saving and life changing therapies to market based on engineered red blood cells, mRNAs, the microbiome, multitude of different approaches to gene therapy. We're going to have a whole new set of options to improve patients' lives. Imagine if, those patients had access to those drugs right away. Imagine if, American citizens could get those drugs as quickly as they can now get them in Europe. There's quite a difference now given all the things you mentioned like co-pays and restrictions.

Melinda: So tell us what's the difference between the two systems? People may not know.

David: When I started, Americans always got their drugs first. The FDA was quicker. The insurance companies let the products basically made them freely available. Co-pays were tiny. In Europe some will negotiate for years to get thier drugs available. The insurers in this country for lots of good reasons and also maybe not some good reasons have made it a bit more difficult co-pays. There was some study recently that said patients have a monthly co-pay of $200 and 40 percent of them will fill a prescription. In Europe, that system just doesn't exist. You walk into the pharmacy, you get your drug maybe there's a de minimis co-pay. I think it's kind of sad that we're literally spending tens of billions of dollars on our industry. We're finally on the cusp of actual real cures with things like gene therapies and yet people won't be able to get them, so imagine if they could.

Melinda: Imagine if they could, that is the billion dollar question right now certainly here in America. In Europe, do you get access to the same kinds of treatment? So here you can get access to pretty innovative treatments for example, I was in Brazil a few months ago and this woman who is leading a cancer center there and who is doing remarkable work was telling me a story about one of her family members who had a brain tumor and I said, "so what did you do?" She said, "I sent them to the states." Do they still have access to the same kinds of innovation?

David: So the innovation is pretty much the same. So when the European Commission approves a drug and the FDA and in fact the Japanese as well, they tend to happen within months of each other these days. The difference is that you negotiate with one payer in a country, in Europe and the entire market opens. As you know the system in the US is a bit more complex, multiple payers, multiple ways to essentially slow adoption sometimes for good reason but often for not and that's the biggest difference. I agree with you if you want to have high quality medical care and you live in another country and you have the money sure FLT3 to New York or Boston, there are really good hospitals that will take care of you.

Melinda: So what do you think it would take to get us back on track to where we were before?

David: I think this is a lot of what we're hearing about in around the world now particularly in this country. It's the centerpiece of some of the political conversations. How can patients get their medicines? How can the price of medicines be reasonable but how can we at the same time eliminate the barriers to access which usually or high out-of-pocket costs? I think ultimately drug prices will need to come down. Co-pays will need to go away. We will need to have an accelerated rate to bring biosimilars onto the market which will reduce costs overall and hopefully, one day the real conversation will occur because the political rhetoric doesn't really always line up with reality.

Melinda: Yeah, and getting everybody to work together like one of the biggest things would be to get everybody, all the stakeholders in the room and say, how would we redesign the system? Because if we were to design it from scratch this is not how we would design it.

David: People have tried to get them all in the same room.

Melinda: Well thank you for that. So I'm going to now go over into that clinical trial commercial side. Michelle, you've heard the R&D side of the equation. From the commercial and clinical trial side of the equation what is your imagine-if statement?

Michelle: So I think one of the things that we think about is imagine if, healthcare represented everyone and that it was completely inclusive. We talked a little bit about access, that everybody could access it but it was inclusive globally. It was inclusive of the population globally. And you think about today even though there's been a lot of strides made and when you think about just 25 years ago there was the NIH Revitalization Act that really was thinking about how do we get more women represented in clinical trials. Now there are a large majority actually more than men represented in clinical trials but you don't always even see their data carved out. What's specific to that and they're inclusive and they're included but maybe they're not segmented to understand the uniqueness of that population. I don't have to go through the data. When you think about other ethnicities African-Americans, Hispanics they're woefully underrepresented.

Melinda: And what is that? Tell us why that is?

Michelle: I think there are a lot of reasons. If you start with just how we do clinical trials in general there's been a lot of advancement lately in how we do clinical trials but traditionally the way they're done, most of the investigators and the KOLs are of European descent. Whether you're in America or globally they tend to be of European descent and their patient populations aren't as diverse as they are. They don't represent a diverse population and so that's part of the problem; the patients are not where the actual clinical trial investigators are, so you have that challenge. I also think it's information. How people like to receive information or how their culture and communities work and understanding the different things that are going on and the opportunities for them. The information is not out equally or systematically for people to know that there' opportunity.

Melinda: Education, awareness, access, all these things. So what would change all of that? What would make that imagine-if?

Michelle: I think there's a couple of things that would change that. I think we have to think about diversity of the investigators. I also think we have to figure out how you can make every single doctor available to become part of a clinical trial like how do you go to the actual doctor's office where the patients are. One of the things we're doing at Syneos Health is we have a partnership with Elligo Health Research to try to do this. How do we give any patient at any office the opportunity to be part of a clinical trial? We are going where those patients are.

The reason that I got really excited about this lab to life you can call it molecule to market as Taren talks about it, is trying to figure out how do we take what we know about all the things that we do on the commercial side to market drugs and bring it to the R&D side. So many of the things we do on the commercial side to market drugs are so important when you're trying to

identify patients and communicate to patients. Thinking what channels they like to receive information through and how they like to be talked to, whether it's through their patient advocacy groups. It's not always the physician's office.

So if we just took some of the basic things we do as marketers of brands and think about bringing those back to the patient recruitment experience, I think this could change a lot of things.

Melinda: So to do it from an incentive perspective like you are going to be selling to all of these patients, therefore, you need to be able to identify with those patients. What about requirements? Is there somewhere that we should have requirements, a certain percentage of different population?

Michelle: I think we're trying to go there. I think there's been a huge effort on both the life sciences and biotech groups as well as challenging their CRO partners to think about how do we do a better job of identifying those patients. I think there's a large willingness. Alistair who is our CEO, he's part of a CRO and they have these great conversations around like, "what should we really be doing to diversify the patient populations to address these issues?" I think they're proactively looking for ways to do that. I never like to be in a place where we're requiring things to be done because I think we all know then there's gaps in that and people find ways to work within the rules that are given to them. So that's why I think that one of the things we have to do is really think about how to reach communities in the way they want to be reached to get them more excited and see the opportunity about being part of a clinical trial. But if we have to go to regulations, I think we failed.

Melinda: Certainly from an incentive perspective when you think about the world's population you have this incredible huge population in Asia and Africa, 66 percent of the world's middle class will exist in Asia Pacific by 2030. The world is changing and so we need to keep pace with all of that.

Michelle: Absolutely. I totally agree.

Melinda: I'm going to come over to the design experience of healthcare. Amy, tell us what's your imagine-if statement?

Amy: So my imagine-if is, imagine if we could humanize the health system. So we've done thousands of interviews with patients, clinicians, caregivers, family members, stakeholders, and the health system is sort of broken. No news there. The patients are left in the center of a

disconnected ecosystem and they're trying to navigate on their own. They don't know what companies they're even interacting with. We place the burden on them. They're sort of inmates of the asylum. The system and the experience of the system have sort of happened by default. It was never designed. The experience is the result of transactions and money flow and business relationships.

So I think what needs to happen and what is happening and I've been very grateful to bear witness to is the understanding that we need to understand what is going on in the real lives of patients? What is the context? What are their barriers? What are the social determinants? What's their goal? What's their value proposition? What is success for them? What are patient defined outcomes and what does that success look like? So taking that understanding and letting it inspire us to improve experiences for them but the sort of cognitive and emotional empathy isn't enough, then what? What do we do with that? So what we see being the hugest barrier is the lack of collaboration of course within siloed organizations or the left hand doesn't know what the right hand is doing, but also from organization to organization. So if you were to ask me how do we fix the system? To really fix it we're going to have to do the messy work of collaborating across from insurance to pharma, from insurance to health systems, from health systems to pharma. We're going to need to keep the patient in the center and invite them to the table of innovation and design with them continuously and not lose sight of that. Because we're in our fancy offices and we're in our collaboration spaces and the patients aren't there. So how do we bring them into the fold? Yes, through clinical trial innovation but also throughout the process as well.

Melinda: So what's it going to take for that to happen? Is it going to take some orthogonal player to come in and blow it up? Like is Amazon is going to come in and completely to mediate the system and then we're finally going to get it or what is it that's going to make that happen?

Amy: It's hard for organizations to disrupt themselves. It's going to take good people like you who keep fighting the good fight and don't give up to start to kind of move the ship in the right direction. But I think partnerships, skunkworks operations, people building bridges whether it's startups or whether it's large corporations to do experiments, to do pilots, to look at not just business outcomes absolutely clinical outcomes but really what's our goal and does our goal align with the human goal? Once we align those things it becomes quite clear through the ecosystem who we need to collaborate with to actually make those things happen. So it's sort of orienting our business strategy in the direction of what people actually need. I think the more we talk about it the better it's going to get. I mean, 10 years ago empathy was like not even talked about, patient centricity and experience wasn't like a thing and now it is and that's encouraging.

Melinda: Do you have an example of something like this?

Amy: Bringing parties together?

Melinda: Yeah for example where we've transformed the experience. So for example, I come from the tech industry back in the day, years ago we would invest in a psychologist for the user experience, so how are people using technology? How are they going to look at a website and we'd have them come say, "well when somebody comes up, they do this and they do that. And they sit here and they sit there and their families around them." That was a critical component of tech. So when is that going to happen in healthcare and do you have any examples of that or even people working across process systems?

Amy: So we're actually piecing together a multi-stakeholder collaboration to explore around shared objectives and bringing the patient at the table and doing participatory design designing with folks. But in a spirit of disruption, we work with a large health system who said, "what if there were no hospital?" "What if we were able to meet patients needs in their home?" That led to some technology innovation that allowed for chronic condition management and clinical support 24/7, where if you took a measure and it was out of whack you would get a call from a clinician in two minutes or sort of closed loop; in addition, AI, health coaching, the whole kit and caboodle. The health system was stepping out and didn't want the rest of the health system to know about it because they're saying, "okay we need to step out of our comfort zone" and we did it and it worked. So there are health outcomes associated so when you sort of do it right it can work.

Ritesh: Did they roll it out?

Amy: They rolled it out. They actually had to sell off the asset to a European health companies. So now people in Sweden are enjoying this innovation.

Melinda: So to bridge to that because Ritesh you are all things digital, right?

Ritesh: I've got the answer for all of you just digitizing. Apply the machine you could go home relax, everything is good.

Melinda: So tell us, what is your imagine-if statement?

Ritesh: So I think we are seeing the advent of some really amazing things from a digital perspective. Who would have thought two years ago pharma companies were looking at digital therapeutics as a business. You're talking about biologics and molecules and DNA but there are people who are looking at technology as the answer not a pill, not chemicals but a piece of technology that may fix something like migraine.

Melinda: So describe what that means to people so they know what you mean by digital therapeutics.

Ritesh: So that's basically instead of a pill or an injection you're actually using technology to fix the problem whatever that is. So in the case of migraine what I saw recently from a French company it's a wearable, put it on your head, connect it to a device that takes your baseline migraine, tracks it against a number of people and then it starts using magnetic resonance on your head to fix your migraines. So is that a potential and will that put Botox for migraine and Emgality out of business, that's what we're talking about. So that's a digital therapeutic. So there are about 20 companies that I work with that are doing that. They're looking at digital as a way of fixing something unique that won't require chemicals or a pill or an injection or an infusion. It's technology.

Melinda: In some cases, people talk about digital therapeutics and it's really about behavior change. So we invest in a company called CureApp, which is smoking cessation. Which you blow into a breathalyzer-like device after you smoke and it gives you carbon dioxide measurements and how much nicotine is going into your system as a way to deter you from smoking. So it requires behavior change which is difficult, unless you're properly motivated to do it.

Ritesh: I think it's a generational thing. I think the generation that's coming through now are more used to these kinds of things that they are tracking their diets, they are tracking. You see those Instagram pictures or photos of the food, hopefully they're tracking what they're eating. I mean those kinds of technologies are coming through. The imagine-if for me would be who's seen Big Hero 6 movie? Big Hero 6, the white robots.

So Big Hero 6 is your personal health person. It's a robot and as soon as they hear something's wrong with you, they come out of their little box and they scan you and they say 'okay, this is what's wrong with you.' And they fix it and it's all AI and it's all right in your house, so your own personal physician. So that's possible. It's actually if you can hack six things together today you could actually do that today. The problem we have in the US is the system that's designed around it won't enable that because somebody has to insure it, somebody else has to

deliver it, somebody else has to pay for it, somebody else has to manage it. Whereby, if you look at what NHS is doing in the UK they've blown the entire thing out.

Melinda: They have Babylon right? In the UK, Babylon is actually an official GP. Babylon is your phone and you tap into your phone and they'll ask you questions and it diagnoses what your issue.

Ritesh: Is it the same thing in Germany. It has done exactly the same thing for the German population. So now every German resident gets Ada as part of their health system.

Melinda: Why won't this work here in US?

Ritesh: Well who'd pay for it?

Melinda: Because it's prevention. So what are the issues with payers covering these things?

Ritesh: Payers are trying to do it but they're only one place. They're one piece of the puzzle. Somebody is going to have to prescribe it, doctors won't. Telemedicine technology's been around for 10 years but it's only recently we've seen the uptake because CMS finally gave you a code to bill against. So until the billing system caught up, the technology wasn't being used. But you still have another barrier which is you cannot provide medical services from Wisconsin to Iowa. You have to be accredited in both states. Where in the UK you can be in the Shetland Islands you're part of the UK and the doctor sitting in London can give you advice and there's no bill. So that's the major ramification that we have. So we've got a siloed infrastructure in this country but the technology is there. It can do all of these things and the Swedes and the Brits and the Germans and the Japanese are taking advantage of it because they have a different system.

Melinda: So they have a single payer system so they can coordinate and make those decisions?

Ritesh: Yeah and the NHS was very smart in their innovation. They took 10 use cases of stress that was being applied into the health system. So the first one was people walking through the doctor's office saying, 'I've Googled my malady. My finger is going to fall off, I've got cancer.' And it was just a boo-boo, put a Band-Aid on and off you go. So they created Your.MD, and then Ada came along and Babylon came along because they wanted to provide care to remote parts of the UK.

Melinda: Which is a big issue everywhere. Wherever you go, whether it's here with the VA with veterans, most of them don't live in urban centers because they can't deal with all of that stimulation, but they can't get care. Same with France, Brazil… it's a very common problem all over the world.

Ritesh: So I'd digitize everything and get rid of the silos.

Melinda: Deal, you're on.

Amy: Melinda, you mentioned about behavior change and how we're very complicated human beings and we are. We look at designing for behavior change and leveraging behavior science, psychology and motivation, human-centered design, data science, and leverage various models for identifying what are the person's obstacles to change. Is it capability? Is it opportunity and motivation? What is it? What can empower change and what's an obstacle to change? And that's helpful because in the US specifically. Again in Europe, the knee jerk reaction is penalties and rewards and education. If people just knew they would do it. If we gave them 50 bucks they would do it or if we said, "your insurance will cost more." They would do it and that's just not true. There's more mature models for designing for behavior change and it does come down to taking an evidence-based approach to design and leveraging psychology and of course test and learn. But the problem too though is that we put the onus on everybody else to change like, oh new patient. You need to be adherent. You need to be obedient. You need to do what we say. But there is a systemic problem in our society yield sickness. So talking through partnerships even partnerships with food industry or looking at how urban environments or design or employment environments in our schools, that is speaking of prevention.

Melinda: Sure, yeah. The ultimate is could we imagine a world without disease which does require a lot of behavior change in psychology and speaking of which, speaking of behavior change. Imagine David, if the healthcare system particularly all the big healthcare giants whether it's pharmas or payers could act more like a startup. So you've had the experience of bringing the most pivotal drugs to market here in the US and around the world and was part of a big company and now you're on the other side, you're on the venture side working with and part of small companies; so you had the experience of both. What's preventing some of these bigger players acting more like startups? Because if they acted more like startups maybe we could get some of these changes going on. What's preventing it from happening?

David: I think, first of all, Ritesh convinced me we should digitize everything, it is clearly the right solution, so you're very persuasive. I absolutely agree, there's going to be digital solutions. I would also argue there still will be surgery and there will still be medicines and a bunch of

other things. I don't know if the question really is, should big companies be like startups. We would like big companies, however, probably to move more quickly and still leverage what they do well.

So big companies for example, if you want to run a global phase 3 trial, don't ask some little startup to do it. They just don't have the infrastructure to do it. But a big global company can get that trial started and get the patients enrolled very, very quickly. Big global companies when it comes to educating, commercializing their products have skill sets all over the world that the scale provides all kinds of benefits.

Having said that, there is a reason why there are lots of startups in San Francisco, in Boston, in Philadelphia, in Cambridge, in the UK, and it's because there is a lot of new science. The ability to manipulate biology has never been greater in our lifetimes. Bigger companies will take much longer to go down those paths because they want to be a bit more certain. And that really creative scientists, maybe it's a slightly crazy person who doesn't fit into the corporate culture who doesn't want to make PowerPoint presentation after PowerPoint presentation about his or her project, just sort of gives up and then goes and works for the small companies. One of the things I've noticed working now with small firms for the last three years, you are really focused on that one thing. It's life or death for you. Either your technology or your project works or you go work somewhere else. So there's no distraction. It's all about learning, getting there quickly, bringing the best people together and there's just quite limited bureaucracy.

Ritesh: Is it a risk issue, David? I think the big company, a lot of it is risk mitigation. The first question….

David: Thinking of an even bigger picture. So if you're the CEO of a big pharma company you're being paid something on called total shareholder return; 75 percent of your income is equity and half of that is based upon whether your stock outperforms the stock of the other big 15 companies. You're really probably not too worried about some technology that's going to come out in maybe five years and then you're going to be losing money on it for another five years before it changes the world. However, if you're in a small company there are investors, whether they be venture capitalists or others, who are willing to put that money at risk because they do get a return when the big pharma company decides finally 'I need to buy that asset' and now they pay you 100 times what the original investment was. So it is an issue of risk, I would argue it's more about risk capital and it's about the risk that the CEO and his executive team wants to take given an incentive system which is not designed to take real risk.

Ritesh: And it goes all the way through the organization. You can go down to the brand manager level and its like three years launch and move on so it'll be somebody else's problem. So do I take the risk to innovate or do I do what I do best for the next two years.

David: It's not to say they don't innovate. They're clearly – I have some pharma friends in the room – there's lots of innovation going on in pharma. But it's different. To answer your question, everybody's focused on this thing every single day. Every hour you're making progress against this goal, doesn't always work, but you're always moving forward. We're not going to the next meeting where we're going to sit there all day and not be sure why we were in the room at the end of the day. Those meetings don't exist.

Melinda: We used to call it in the tech industry, living on a burning platform. So I think it originally came from the CEO of Nokia who wrote to his employees, "we have to live like we're on a burning platform." Like the oil rig when it's on fire, you have only two choices – put the fire out or jump a 100 feet into freezing cold water. So you're going to work your butt off to put out that fire. That's what it's like to be in a startup, because you're not going to get paid, you're not going to get your reward, you're not going to realize your dream until you make it work. So you are singularly focused on that mission.

David: But there's a natural marriage between the two because as I started, the smaller companies can't do what the big companies can do, and it seems like the big companies are not doing what the smaller companies are doing. So at the right moment, they come together and that's how you develop and you launch drugs currently.

Melinda: Yeah that's right. So that requires us all to think a little bit differently and some of it is behavior change, some of it is knowing what we're good at and complimenting each other at the right time, and some of it is reflecting, having leadership that reflects the diversity of the people we're trying to serve. So Michelle, imagine if the leadership of all of the big companies, the payers, the hospital systems reflected our patients and our customer base and by virtue of not respecting them, I think we're failing are our customers. So tell us why you think that's so?

Michelle: I don't know if we're completely failing our customers but I think we could do more for them. I think that's the way I would describe it. Listen, there's so much research that diverse teams get better results. I mean, the research people don't want to read it but it's clear; there's so much documentation that diverse teams get better outcomes. And so you go back to shareholder value, I had a pull on that because I think that's great. If 75 percent of your compensation is tied to shareholder value, the number one thing you could do is build a diverse team to deliver medicines for patients. Because you're going to get different ways of thinking, you're going to

get things that people maybe never thought were possible because they have a way they've always done it that has made them successful and you kind of disrupt that way of thinking about things. I think if you do that and you start really, in a perfect world you look exactly like your customers. So whoever your customer base is, your leadership looks like that and you're going to continue to develop things that really meet the needs. In our business the ultimate customer is the patient.

So if we're smarter about that and we're more deliberate, and I think we have to be deliberate because I think diversity is an imperative in all of business. But I think in healthcare, you know if you will have a much better representation of diversity. You're going to go back to what I imagine which is that healthcare really represents everyone and you really understand the uniqueness of different populations. We can kind of leapfrog where we've been today.

David: Some leaders do it. I realize it's the minority, but some leaders do it.

Ritesh: Some industries do it as well.

David: Yeah, and as a leader you have to go out and look for these people and then you have to invest. Because frankly, if you hire seven or eight people who look just like you with all the downsides that come with it that you've articulated, it's a little bit easier to get them to do what you want them to do. If you hire seven or eight people that have completely different backgrounds – and I believe in this model – you have to invest a lot of time to make that team high performing.

Ritesh: But David, you were in Switzerland for a while, so how did that work there? Because you've got a base that's a bit far out and you've got a population base around you. I mean, part of it is geography, part of it is where you are, part of it is the organization.

David: The beauty of Swiss companies is that their home market doesn't matter. I mean, the reality is it was 2 to 3 percent of the sales volume. So it forced you to be truly global in your thinking. Having said that, you can still hire people that look like the CEO or you can go out of your way and hire men and women, people of different sexual orientation, people with different life experiences and then you have to invest the time. I used to take my executive team up to the top of Swiss mountains where they couldn't do anything else and we would spend days together talking about what's the vision for this company, what are our priorities, how do we interact, what does governance look like, how do we make decisions? And it was time consuming but the payoff was enormous because you have a more diverse group of people that brings different

ideas and gets really excited about what you're doing and they can mobilize the rest of the workforce.

But not everybody is going to make that effort. If your time horizon is short as a leader, I would tell you not to bother doing it. If your time horizon is one year, two years, or three years don't bother because the payoff takes longer. The problem with total shareholder return it pays you on that one year. It's a one-year time horizon for most of these companies. So they have to get the stock price up this year; otherwise, your equity doesn't vest and the CEO doesn't get paid. It's a really short-term focused system.

Ritesh: Note to self – don't be a CEO. ☺

Melinda: That's the difference between an American system which is…

Ritesh: But it is a talent issue as well. I think one of the biggest things as I wander around, if you look at a hospital they've got the talent base and it's fairly diverse, nurses, doctors, et cetera. But as you go further out of that, the talent base isn't there. People aren't entering those things. People aren't going into these. So how do we get those diverse people to think about this industry as a place that they should come and work? What are those things that we need to do to do that?

Melinda: So what is it? What is the answer to that?

Ritesh: I don't know. I'll digitize it. [TALKING OVER]

Amy: It's the hard work of getting people to see their blind spot and understand their bias toward hiring people like them. It takes intentionality. You have to be choiceful about it and you have to make the choice because it's a good business strategy. Period.

Ritesh: How do you do it in your organization? It's tough, right?

Michelle: I don't think we're perfect at it, but I do think that we're very intentional about it. I think to your point, it creates a lot more work. The traditional ways you recruit people you can't traditionally recruit that way anymore because you're going to see the same people over and over again that look just like all of us. I think you have to be intentional about it. I think you have to invest in people early. I think you have to teach a lot of people things that traditionally we don't train people on.

Melinda: Like what?

Michelle: I think about data scientists. That's a great subject right now. Everybody is focused on data science and data and how do you really manage these big data sets to get into really understanding what's going on. When you think about data scientists, they traditionally wouldn't think of coming to work for a life sciences company. Maybe a hospital system, maybe. Maybe. It's not on their top 10 list.

Ritesh: Google?

Michelle: That's why you think about Google and Amazon and everybody else, where the disruption could occur. In that space you have to really go and build a value proposition. I'll give you an example. Right now we're in India in MBA programs pulling data scientists right out of school right now and helping them understand the value of working in life sciences and how what they do every day will impact huge populations of patients. We're starting with right out of school. We give offers in the fall for them to come out in the spring. To your point, it's a long game, David; it's not a short game.

Melinda: It's interesting, we just announced a partnership with UC Berkeley and UCSF to do these fellowships for data scientists over the course of a five-year period and pay for something like Stanford [bio design 46:47] and we barely advertise it and we had, I think, 275 people apply, barely advertising it. So I think there is a desire to get into it now with the younger people coming in, and I think it will be a different future for the young leadership that is coming out of school now. Then there's the bridge from here to there and how do you have leadership in these companies demonstrate the right behaviors and the right practices.

Michelle: Exactly. You've got to work on people's potential, not necessarily what they know today.

Melinda: Ritesh, you are all things digital and you believe in the power of technology [TALKING OVER/joking around about being a hologram]. So the power of technology is an amazing thing, and when I came into the healthcare industry from the tech industry, I was astounded by how little technology had infused itself into the industry. People were very suspicious of it. When you think about how enabling, how powerful tech can be, I was really quite shocked by that. And over time I think we've been slowly assimilating it and getting better at it, but there is a cultural difference here. What is that cultural difference? What is the suspicion come from and how are we going to bridge that divide?

Ritesh: If I knew the answer to that, I would be on a beach in Jamaica running a bar.

Melinda: I thought you were. That this is a hologram.

Ritesh: No, it's a hologram. I think part of it is very cultural. It is about the science of healthcare. So it's the touch and the feel and we do it this way, we've been doing it this way for years. I asked recently why do we do faxes for prior authorization…

Melinda: Sometimes we're still getting faxes from your doctor.

Ritesh: Yeah, if you want prior authorization you have to fax the application in, today 2020 coming up. Work at Mount Sinai there's a room with seven fax machines in it. Type these faxes out, drop in a bucket, and there's a lady who goes around picking them up and distributes it.

David: Maybe we're hoping the faxes get lost so we don't have…

Ritesh: There you go! Aaah, there you go! So I think part of it is structural as I said to you before, we've always done it this way. Something new comes along, we're not sure.

The other bit is I think the silos here, particularly, and the curiosity isn't there to go explore these things. That's my biggest thing that I work on is get people curious about this, get people excited about something. Because if you get them curious and excited then they'll start wanting to do it. Otherwise, it's just like, okay that's really good but I'm going to go back to my e-Detail because I know the iPad works, and that's not the answer at the moment. Because not many doctors want to see the e-Detailing [inaudible 49:57] and they're doing all sorts of things like that. I think that's one of the issues.

I think the second issue is, we always – and I find particularly in life sciences companies – fall behind the medical and regulatory will never approve it.

Melinda: Say that again.

Ritesh: Medical or regulatory will never approve it. The biggest conversation is show me something innovative. So we do and they go, "have you done it for somebody else?" Well it wouldn't be innovative if I've already done it. What's the point.

David: That's obviously very convenient, right?

Ritesh: Exactly.

David: The reality – I don't know if we have any FDA people in the room – but when a company does something for the first time it's not like the FDA has the answer either. They work together to put the new guidelines in place.

Ritesh: Exactly. Exactly. In my first medical legal regulatory review I was looking for people with books coming in looking at paragraphs and the guy looked at the other guy and said, "what do you think?" He said, "I don't know?" "Should we approve it?" "Yeah, why not. Let's go for golf." So that's the problem.

So there's a whole sort of it is unknown, there's no regulatory framework, how do I do it. What are my guardrails? And if they're not defined, people won't take that risk. That's why I think the startups, the ones that are being brave and going through this, as you described are saying, 'I'm not going to adhere to those things. I'm not from that industry. I'm going to see if I can…' it's a trillion dollar business, I'm happy with two billion. I'm happy with a billion. So that's what they're doing, and I think that's the issue we face.

So get more curiosity going, go experiment and try and figure these things out I think is the biggest thing I would suggest.

Melinda: One of the privileges I have is to travel around the world and see many different technologies, as many of you do, and one of the systems that I've been most amazed by, impressed by is WeDoctor in China which is invested in by Tencent and it's a completely end-to-end digital system where every patient has their portal on their phone or they have a portal at home and they can go on and they can talk to their doctor. They can see all their doctors on their phone and they put a bolt on in Babylon that they can talk to a diagnosis what they have, which are the doctors that can serve you, they can pick them and they can schedule them right there and how much they cost, they can pay from their phone All of the rural hospitals have a very standardized set of equipment and technologies.

Ritesh: Did you see the red pods they're putting in the villages?

Melinda: Yes. So they have the pods all over the villages and then you have a big TV screen where you can do a satellite into a specialist in the urban hospital, and the urban hospitals are the specialist hospital. And on the back end of it, you can see on these big screens all over population statistics. You can see symptoms ebb and flow across the country and where there is pockets of chronic diseases or if flu symptoms are coming up, it's the most remarkable thing.

Because of that, when you get an intervention into the system – let's say a therapeutic, then you can calculate the savings to the entire system for that drug, which we can't do here in the US right now, and therefore, you say 'oh this is a good system to use.' So everybody wins in this system.

So what's it going to take for us to have a system like that in the US? Is it possible?

Ritesh: No. Digitize it.

Melinda: That is digitizing it.

Ritesh: Because again, I go back to my original statement – who's going to pay for it? Who's going to prescribe it? Like somebody has to have a cut. Which PBM is going to approve it alone. That's a big conversation by itself.

Melinda: Right, PBMs, yeah.

Ritesh: So I am hoping Haven and Verily and Apple are very, very successful because they're the only ones with the heft and the balance sheets to be able to disrupt this thing. I don't think the startups will be able to do it by themselves. I think to your point, bringing the entire ecosystem together to serve a human and looking at the human in the middle to fix it is the only way to fix this thing. I think otherwise, it's just going to be this I've got a payer solution that's going to hopefully entice you to lose weight because you're a diabetic and then I've got a hospital solution that has a virtual nurse that will look after you, but they're not connected. That sort of thing.

Amy: It's very siloed and it's a lot of solutions looking for problems. There's not the leisure to look at holistically what are the gaps, what are the unmet needs, and how might we stretch our offering, our services and integrate with others to actually bring something. What you were talking about is insurance with care delivery, with technology, with public health. It literally is connecting all the dots, which hopefully digitizing things and AI will help us start to connect those dots. But it's going to require human collaboration. And even inside of an organization, again, creating the mindset of curiosity, of innovation, of human centricity, of iteration, of an interdisciplinary approach, even just starting internally but looking at what is our medium. Is our medium molecules, is our medium digital, is our medium a product, is our medium a service, or is our medium the partnerships and the ecosystem? It's a kind of a systems-based approach and hopefully a mixture of academia and government and NIH funding and some nifty experiments.

But honestly, we don't learn from what works many times. There's sort of already answers for some of this stuff and it doesn't get going.

Ritesh: I think somebody closer Jeff Arnold at Sharecare and what they're doing. They're pretty close. Sharecare down in Atlanta and what they've done. They've got 90 million people now using their application, tracking everything and they've got all the data on the back end. So I asked him one day I said, "Jeff, what are you doing with that data? Are you going to payers and saying I can give you statistics? Or are you going to the CMS and saying the population… because you've got 90 million people on this platform, you've got data about them. Are you giving it to the NIH or the CDC or whoever?" He said, "No I didn't even think about that." But someone like that has that capability. They've got the infrastructure. They've got the people. They've got the apps. They've got the data. They're giving wearables to people and they're connecting it to the EHR. So that could be something.

Melinda: We only have a couple of minutes left before we turn the control over to the audience.

Ritesh: Wait, hold on, they get to ask something?

Melinda: Yeah, get ready. So I'm going to ask each of you to give our incredible leaders out here one piece of advice. As we go into the future, as we hit 2020 and we go into the next decade and start talking about 2030, what one piece of advice do you have for our leaders here in the room about how they can make their imagine-if statements happen?

Michelle: I would say be brave. Be brave. Don't just do the status quo, because nothing worth doing is easy. So be brave. Do the things that you need to do to make a difference.

Ritesh: I'd say be curious and pick one thing. Don't try to boil the ocean. Go pick one thing that you're really passionate about that you want to change and figure that out.

Amy: I'd say get comfortable being uncomfortable, because none of this is easy and keep getting up and doing it because people need you. This is one industry where lives absolutely depend on us. And also a spirit of humility. We don't have the answers and that's going to give some openness and kill that curiosity.

David: I would argue that very few of you will make big change on your own, it's going to be the people you hire and the effort you invest in them to make them into high performing teams. And to make that happen, you need to take care of yourself, eat well, sleep, don't spent so much

time in an airplane and go to the gym. Find time to go to the gym, you'll live longer and you'll have a bigger impact. {*applause}*

Ritesh: What about you, Melinda?

Melinda: I guess it would be say yes. Say yes. When people come to you with opportunities or challenges or here's something that you can do, many times you're like 'no, no, no somebody else is doing that' or 'somebody else is going to take that on.' But say yes, because you can do it. If you surround yourself with good people, you get comfortable being uncomfortable and if you're curious and ask a lot of questions and you're brave enough to do it, you can make a change happen.

Listen, we always think somebody else is going to do it. Somebody else isn't going to do it. *You* can do it and imagine the difference you can make in someone's life. It can be big – maybe you can cure a certain kind of cancer or maybe you can empower a group of people that never believed in themselves before anyone else believed in them. What an amazing difference you can make in somebody's life by just saying, "I believe in you." So you can make a difference, say yes. That's my answer. {*applause}*

Taren: Can we have a big round of applause. Amazing. {*applause}*

Would you all like to be brave and ask a question and make yourself uncomfortable. I'll find my way to the gym someday but in the meantime.

David: Tell us who you are because we can't see anything.

Taren: Dr. Jules Mitchel, would you like to ask the first question?

Jules: Jules Mitchel, Target Health. I think this was the best conversation that PharmaVOICE has ever had. I want to congratulate you. {*applause}* I don't necessarily want to be digitized.

But all that aside. The whole issue of change is a really big thing. I think the other thing with change has to do with regulators, not just the pharma industry. Part of the problem is we have to educate the regulators. So we're involved with Harvard on educating regulators on ICH E6(R2) kind of stuff as opposed to just doing training. But I think the regulators have to really be educated. Today we were on a call wherein Rett syndrome where they turned something down – not a drug – but they said there's no placebo in Rett syndrome. Therefore, they won't give them breakthrough therapy or something like that, beyond silly. So I think we also have to educate

them not just the pharma industry, which is risk averse there's no question about it, but I think we also have to work on the regulators. Worrying about whether or not an audit trail is a 27 becomes a 28 things like that, which I'm sure Microsoft is interested in. But we have to start thinking about educating people about the things that matter. The quality is the absence of errors that matter and all the data fit for purpose, not whether someone enters a 2 or a 3. And therefore, we beat them up because 3 is the wrong number. So just think about it, it's not just the pharma industry which has their own problems. Thank you.

Kamala: Hi, I'm Kamala Maddali, I'm the president of Health Collaborations. I'm an MS patient diagnosed eight years ago. I'm a cancer scientist and a business strategist. Very inspiring really, I would say brainstorming session mostly since 10 plus years. I've been at Merck, Quest Diagnostics and Quintiles. One take home for everybody through my own personal and professional journey is be the change you want to see. If there is an idea, communicate. If there is a gap, connect. My journey has been we are walking galaxies.

So Ritesh, to your comment, not just digital, I think we need to really research into telescopes within our own human body. Forget about Mars. Forget about the moon. Really, this is phenomenal. I think everyone should really serve on a patient advocacy organization right here and then connect the voice of the patients to the changes that needs to come from regulators and insurance companies and the government, obviously. Thank you. {*applause}*

Taren: We have time for one more question, anybody? I have a question, what are they going to do with all those fax machines when you become completely digitized?

Ritesh: They're turning into robots. They're going to be drone delivery guys for Amazon.

Melinda: They're going to recycle the parts.

Taren: I'd like to say that's upcycling. I love it. I want to thank our panel again. Please join me in a round of applause. {*applause}*

While they're exiting the stage, if anyone who is a 2019 PharmaVOICE honoree who came in a little bit late I would ask you to please make your way down to the area right up here in front and find your seat. It's important thank you. So thank you again to Sunovion, our Executive Forum sponsor for your generous support. We'd also like to thank our other sponsors who made tonight possible. Our platinum sponsor Parexel. Our gold sponsors Calcium, Cognizant, Ogilvy, Publicis. Our silver sponsors Advanced Clinical, Alnylam, Bioclinica, MediData, Microsoft,

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We would also like to thank our celebration publication advertisers for their support. Thank you all so very much.

So this is our transition into the award ceremony part of the evening. In 2015, we initiated our version of a Hall of Fame, the Red Jacket Awards. One of the criteria for being named a Red Jacket is having been recognized as a PharmaVOICE 100 but it's so much more than that. These extraordinary individuals cross a multitude of industry sectors. They raise the bar and what it means to be an inspired theater for their teams, their companies, their communities, and for the industry at large. Our Red Jacket honorees challenge us to think differently, act differently, and lead differently. They are creating new opportunities to make what was once impossible possible. They are focused beyond short term gains and are committed to executing their long term visions and a tightly regulated and competitive industry. They have a persistence of vision. They are truly transforming the life sciences industry to create better healthcare comes for all. They are inspiring leaders for today and for tomorrow. In 2019, we recognize six new inductees to the Red Jacket community.

Before I call to the stage the 2019 Red Jacket Honorees who are here with this evening, I would like to acknowledge Nancy Berg, CEO and executive director of ISPOR, the Professional Society for Health Economics and Outcomes Research. Chris Perkin, CEO of Altasciences. Dr. Ryan Saadi, VP Global Evidence, Market Access and Pricing at CSL Behring and Tim Walbert, Chairman, President and CEO and founder of Horizon Therapeutics who regretfully quit in joining us tonight. I do encourage you to read all about these amazing leaders in the July, August issue.

But tonight is the night for a couple of our folks. Our first Red Jacket inductee tonight is Craig Lipset, who is all about democratizing the future of healthcare, clinical innovator, disrupter, visionary, technologist, and patient. These are just a few of the adjectives that describe Craig and the incredible impact he has had on the field of clinical research. His focus on patient engagement, patient centricity, 21st century digital clinical trials, and collaborations with industry consortia, federal agencies and technology companies are just a few examples of where he is making a huge difference. He self-identifies as a patient and he passionately, passionately believes that we can no longer live with fictional boundaries and deny that all patients and our caregivers. He aspires to create a legacy that transforms how patients participate in research through the democratization of the process and remove the silos that create barriers to care. Craig who recently left Pfizer as head of clinical innovation is now entering the next chapter of

his innovative journey. And I for one can't wait to see what he does next. Please join me and warmly welcoming Craig Lipset, 2019 Red Jacket Honoree to the stage

Craig: Thank you PharmaVOICE.

Taren: It's now my pleasure to introduce Dr. Ahnal Purohit who has been charting her own course for more than three decades. Ahnal has broken all the conventional rules in her own unique way as a woman and as a minority. As a result she has evolved pro in navigation the company she co-founded into a successful, enduring, and innovative company that is redefining the label of advertising agency. Ahnal entered into the healthcare communications world almost 35 years ago with a PhD in psychometrics and the goal to offer life sciences companies research-based insights, deep strategic and scientific thinking, and breakthrough creative that would truly change behavior. Ever since under Ahnal stewardship, Purohit Navigation has been at the forefront of some of the industry's most groundbreaking ideas and campaigns, Ahnal's humor, warmth, passion, compassion, creativity, and intelligence are evident to everyone she engages with. Coincidentally these seem the same traits are at the heart of a company culture that is designed to consistently innovate and one that fosters deep loyalty among its employees and its clients. She is not just a champion for women in the life sciences. She has also co-found the non-profit organization African women's alliance in support of health. Ahnal has unselfishly laid the ground for the next generation of leadership at the company. It's my privilege and delight to welcome 2019 Red Jacket Honorary, Dr. Ahnal Purohit to the stage.

Finally, we are delighted to recognize Dr. Freda Lewis-Hall who was named a Red Jacket Honoree in 2015. Freda was recently named as Pfizer's first chief patient officer. During her 35-year career in medicine Freda has been on the frontlines of healthcare as a clinician, researcher, and leader in the biopharmaceutical and life sciences industries. An award winning advocate for health equity and improved outcomes for all patients, she provides advice and consumer information on national program such as Dr. Phil and the Doctors and is a regular speaker making dozens of appearances a year at consumer and healthcare conferences. Additionally, Freda was recognized as the Woman of the Year by the Healthcare Business Women's Association in 2011. Congratulations again Freda.

Please join me in a warm round of applause for all of our Red Jacket Honorees. Joining Craig, Ahnal, and Freda tonight are several of their fellow Red Jacket honorees as well. As I say your names please stand to be recognized, Jeff Berkowitz, Michelle Keefe, Andrea McGonigle, Dr. Jules Mitchel, Melinda Richter, and Wendy Weiss. Thank you for being here with us this evening.

We have recognized more than thirteen hundred people throughout the healthcare ecosystem. The majority of whom, continue to make a significant difference in all aspects of the industry solidifying the legacy and body of work on the behalf of patients. We believe that once you are a PharmaVOICE 100 you're always a PharmaVOICE 100 so you're stuck with us. We would like to salute you for the invaluable inspiration you continue to provide to your peers, companies, and healthcare community at large.

Please stand to be recognized as I say your name, Gil Bash, Judy Capano, Olivier Chateau, Terry Clevenger, Lori Cook, Dr. Ubavka DeNoble, Joe DePinto, Eve Dryer, David Epstein, Timmy Guard, Steve Hamburg, Amy Heymans, Thomas Hospodar, Mark Jara, Julie Kemp, Bonnie Lappin, RJ Lewis, Mike Merritt, Michelle Marlborough, Steven Michelson, Dr. Georgia Mitsi, Ann Mohamadi, Michael O'Gorman, Michael Parisi, Michelle Petroff, Caroline Redeker, Linda. Richardson, Vera Rulon, Bhaskar Sambasivan, Laurent Schockmel, Shideh Sedgh Bina, Lorna Weir, and Dr. Mark Wildgust. You are an amazing group of leaders and we're so grateful you are part of our PharmaVOICE 100 community.

Now we would like to honor our 2019 PharmaVOICE 100s and we're switching it up a little bit this year.

Dan: As your name is called please come to the stage to be recognized. Jody Andrews, Paul Balagot, Jack Barrette, Lew Bender, Joni Bradley, Amy Bucher, Amy Bybee, Sharon Callahan, Jason Casarella, Kara Dennis, Drew Desjardins, John Donovan, Dr. Susan Dorfman, Thomas Dudynuk, Dan Duran, Jeffrey Erb, Asaf Evenhaim, Kendra Fanara, Don Feiler, Dr. Jonathan Fox, Susan Garfield, Jennifer Gottlieb, Barry Greene, Adam Hanina, Peyton Howell, Angela Howes, Daemion Johnson, Jackie Kent, Sheila Mahoney, Dr. Melissa Moore, Chet Moss, Sriraman Nagarajan, Paul Navarre, Sam Osman, Lori Parisi, Gisela Paulsen, Liz Paulson, Noah Pines, Dr. Paula Ragan, Susan Raiola, Dr. Chris Schaber, David Shronk, Paula Swain, Lisa Tamborello, Robert Taylor, Christine Verini, Sherri Wilkins, Michael Zilligen, and Jen Zimmer.

Please join me in a warm round of applause for our 2019 PharmaVOICE 100 honorees. {*applause}*

Taren: So thank you again to all of our sponsors. We couldn't do it without you. Now for those who know me you know what time it is – it's cocktails. Thank you all for coming. Please enjoy our signature drink of the evening, the Red Jacket.