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OncoCyte Corp. (OCX)

Q1 2025 Earnings Call

CORPORATE PARTICIPANTS

Joshua Riggs
President, Chief Executive Officer & Director, OncoCyte Corp.

Andrea James
Chief Financial Officer, OncoCyte Corp.

Ekkehard Schütz
Chief Science Officer, OncoCyte Corp.

OTHER PARTICIPANTS

Mark Anthony Massaro
Analyst, BTIG LLC

Mason Carrico
Analyst, Stephens, Inc.

Thomas Flaten
Analyst, Lake Street Capital Markets LLC

Mike Matson
Analyst, Needham & Co. LLC

Yuan Zhi
Analyst, B. Riley Securities, Inc.

MANAGEMENT DISCUSSION SECTION

Operator: Welcome everyone and thank you for joining us to discuss Oncocyte's First Quarter 2025 Results. If you have not seen today's shareholder letter, please visit Oncocyte's Investor Relations page at investors.oncocyte.com. Today's prepared remarks build upon the information already shared in this robust letter.

Joining us today are Oncocyte President and CEO, Josh Riggs; Chief Science Officer Ekke Schütz; and CFO, Andrea James. We also have our analysts with us as panelists. After our prepared remarks, our analysts may ask questions.

Before turning the call over to Josh Riggs, I'd like to go over our Safe Harbor. The company will make projections and forward-looking statements regarding future events. Any statements that are not historical facts are forward-looking statements. These statements are made pursuant to and within the meaning of the Safe Harbor provision of the Private Securities Litigation Reform Act of 1995. We encourage you to review the company's SEC filings, including the company's most recent Form 10-K and subsequent Forms 10-Q, which identify risks and uncertainties that may cause future actual results or events to differ materially. Please note that the forward-looking statements made during today's call speak only to the date that they are made and Oncocyte undertakes no obligation to update them.

And with that, I would like to now turn the call over to Josh Riggs.

Joshua Riggs
President, Chief Executive Officer & Director, OncoCyte Corp.

Hi, everyone. Thanks for joining us today. It's great to be checking in with you about two months after we reported our annual results. We've been heads down executing on our 2025 plan. For those of you who are new to us,

we're a molecular diagnostics company investing in the significant opportunity to improve transplant rejection testing. We are just over two years into a strategic pivot that has now brought us to the cusp of delivering a kitted molecular test kit. Our key areas of focus for 2025 are, first, finalizing our clinical assay and trial design. Second, getting through our clinical trial to submit a data package to the FDA by the end of the year. And third, spring loading back half of 2026 revenue by signing up transplant centers to use our research-use-only kit.

We finalized our clinical trial design and just a few weeks ago we got central IRB approval. This is a key milestone where an external committee has reviewed and approved the safety and ethics of our trial. We've continued to have productive dialogue with the FDA and are now preparing for our final pre-submission meeting ahead of locking in for the trial. The clinical trial itself, which we've gone over in previous quarters, has drawn interest from several university hospitals that would like to participate in both the US and Germany. We expect to welcome at least three of the top 10 transplant centers in the United States as clinical trial participants. And if we look at all of the US transplant hospitals actively engaged in supporting our trial, we see nearly 10% of US transplant volumes represented.

In the near future, we are going to be up on clinicaltrials.gov and on our way to first patient in, and I'm really looking forward to sharing that milestone. We'll follow that with an introduction to one or more of our site principal investigators in a KOL call. We believe the strong interest we are seeing for the trial will translate well to future demand for our IVD assay. We believe we are on track to submit to the FDA by the end of this year, which is the same timeline we communicated in March. Like with any FDA program, there are several work streams that must come together. And from what we can see, we're on pace. So, we continue to target FDA approval in the first half of 2026.

Continuing on, we are on track to have 20 sites trained on our GraftAssure workflow by the end of this year, which is the kick-off to our land and expand strategy to land hospitals with our RUO product and then expand to selling our clinical kitted product post FDA clearance. We now have 10 sites running our RUO assay, they're in the US, Germany, UK, Switzerland, Austria and Southeast Asia. And the researchers at these universities are starting to perform real studies using donor derived cell free DNA and discovering new applications for our tests such as pediatric transplantation, the role of absolute quantification in long-term kidney transplant management and ultrasensitive detection of microchimerism for bone marrow transplants.

We are thrilled that researchers are exploring new ways that our technology could potentially help future patients. You'll see in the shareholder letter that we are starting to prove out the value of digital PCR as a technology differentiator. It's simpler, it's faster and it offers better sample economics than NGS at low volumes. Most transplant centers don't have the sample volumes needed to efficiently run an NGS platform. These machines require a processing chip that costs well north of $1,000 per run. That math just doesn't work when you only have a couple of samples a day. With PCR testing even running a single sample is an affordable option given that the batch size does not meaningfully alter the cost per result.

With only a few pipetting steps and a simple readout, labs don't need sophisticated hands to get the work out. We see a great future for PCR technology to bring testing closer to the patient. Bio-Rad has been investing in improving and simplifying digital PCR workflows for years. And our assay benefits from these ease of use improvements. The net takeaway is that transplant is doing really well. And just a few years after our strategic pivot, we are closer than ever to building a rapidly growing, sustainable business.

Speaking of that pivot, you may have noticed that our company name Oncocyte doesn't really fit our strategic direction, which has broadened considerably. The first market in which we are commercializing is transplant. And while we do have an oncology pipeline, which I will get to in a minute, the name Oncocyte no longer makes

sense. In the coming weeks, we plan to unveil our new name. Also, our CFO is asking me to inform you that this rename is being done on a very tight budget, so we could strategically allocate our capital toward the things that we believe will create real shareholder value.

Onto oncology. Because our main focus on transplant is going well, I want to spend a few minutes updating you about our oncology pipeline and where we are carefully investing to unlock future value. DetermaIO is showing real promise in the drug rescue category. We are really good at finding patients who respond to immunotherapy for certain types of cancer. Enriching for responders is a great way to get a drug with marginal benefit across the finish line. We are out there talking with strategic partners about DetermaIO. One of those potential partners told us never in my wildest dreams did I think the results would look this good on the work that you are doing. So, with all the caveats that our oncology pipeline is still earlier than transplant, we do see future markets for potential long-term revenue growth where we will be able to invest in R&D after our transplant business is healthy and self-sustaining.

Before I turn it over to Andrea, I'll conclude with the fact that from where I sit, I feel good about how far we've come and where we are going. Not only are we successfully building a market for our transplant product, but also we are seeing increased interest from potential corporate partners who see the value in our technology in both transplant and oncology. This type of external validation supports our confidence that we are on the right path, making the right investments and have the right people to build a valuable business.

Let me turn it over to Andrea.

Andrea James

Chief Financial Officer, OncoCyte Corp.

Thanks, Gaby and Josh. Hello, everyone. Just a few financial highlights this quarter. First, pharma services revenue of $2.1 million exceeded our expectations, particularly with a large order that came in late in the quarter that we processed quickly and efficiently. This enabled us to invoice $1.4 million with just a few days left in the quarter. And our Nashville lab team brought more order – automation this quarter, which drove gross margins of 62%. This revenue is great for us. It extends our cash runway and it deepens our relationship with our customers. In Q1, the vast majority of the revenue came from a single corporate customer that was impressed with our lab team's work, and they had asked us to help them meet some of their own deadlines. This customer also is now seeking partnering opportunities on one of our oncology assays, which Josh alluded to in his prepared remarks.

As thrilled as we are to meet this customers' demand, it is situation driven and pharma services revenue, as I had said last quarter, will continue to naturally vary as we balance it with our own strategic priorities. This is particularly true because our sales team doesn't focus it on it. We want our sales team out there moving potential GraftAssure customers through our funnel so that we can meet our goal to have 20 transplant centers by the end of this year, and therefore, spring load our commercial launch and our back half 2026 revenue.

To put it simply, we want our sales team focusing on the land and expand strategy that you just heard Josh talk about. At this time, we expect Q2 pharma services revenue to be less than $500,000 and we did not invoice for any services in the month of April, which really speaks to its lumpiness. We concluded the first quarter with nearly $33 million in cash and that includes restricted cash, which we'll begin having access to later this year. Our free cash flow was negative $6.2 million in the quarter, which is right in line with our target average quarterly cash burn of $6 million. For free cash flow, we're simply calculating cash flow from operations, less purchases of property and equipment.

Finally, we also collected $1.4 million in receivables in the first week of April. As we noted last quarter, we will have a couple of quarters this year where cash burn ticks up a bit, but not a lot before coming back down. The biggest needle mover here is our clinical trial and the instruments that we must purchase to support that trial at our partner sites, albeit at a discount. Also, R&D will continue to reflect the added costs of FDA compliance, software development for our IVD program. We continue to target an average of about $6 million per quarter of cash burn until our commercial launch next year.

Finally, Josh talked about our corporate rename. I'm really excited about this. Along with the rename, we will also announce a new corresponding Nasdaq ticker. We really took a resource conscious approach to the rename. We take capital stewardship seriously and we want to keep the spotlight and our investments where they belong, which is on advancing research, on serving our customer community, so they can in turn better serve their patients, and on investing in the commercialization of our transplant assay, which we expect to translate to real shareholder value creation.

Okay. With that, Gaby, let's come up into gallery view and start taking questions.

QUESTION AND ANSWER SECTION

Operator: Thank you, Andrea. All right, analysts [indiscernible] (00:18:33), we are going to start the queue. Let's see here. Mark Massaro, let's start with you, if you have any questions. You're on mute.

Mark Anthony Massaro
Analyst, BTIG LLC

Q

Okay. Can you hear me okay? Great. All right, guys, thank you for the time today. So, I am intrigued by the larger revenue generating pharma customer that seems to be asking about oncology. And so, I was wondering if you could expand on that a little bit. To what extent can you share if this partner is interested in potential oncology kits in the future or is this more of a function of just perhaps generating revenue that can fund the base transplant business?

Joshua Riggs
President, Chief Executive Officer & Director, OncoCyte Corp.

A

Yeah. Thanks, Mark. No, it's definitely around DetermaIO and a kitted version of that, there's multiple flavors of how that can work either in concert with a larger NGS panel or standalone as a PCR assay. I think the data that keeps coming out there is seen as differentiating and stands well against kind of like MSI and TMB, particularly in the tougher cancers like colon cancer. I think we have some unique advantage there.

Mark Anthony Massaro
Analyst, BTIG LLC

Q

Fantastic. I wanted to ask about just what the next milestones are on DetermaIO. Apologies if I missed it. Can you just share any additional readouts we should be looking for? And when we think that might represent a more maybe tangible opportunity for the company as far as revenue generation occurs?

Joshua Riggs
President, Chief Executive Officer & Director, OncoCyte Corp.

A

Absolutely. So, I think if you stretch the wayback machine, we submitted to MolDX back in December of 2022 for reimbursement. And so, we've been kind of in a holding pattern with them since that time. I think the data that came out at the end of last year helps kind of push things forward. But I think the biggest thing we're looking forward to is the SWOG study that we've talked about a couple of times. That's 800 patients, five years, two years of follow-up. So, started in 2016. We have all of those samples in-house now and are starting to process those. I don't control when that data gets reported out, so that will go up to the study primary investigator. We're hopeful that that comes out towards the end of this year. I think San Antonio Breast is a natural place for a triple negative breast cancer study to read out. But that's me kind of reading some tealeaves there, Mark.

Mark Anthony Massaro
Analyst, BTIG LLC

Q

Yeah. Maybe one more question for me and then I'll hop in the queue. I would love to hear any potentially recent feedback in the last two months, in particular from some of the larger US transplant centers. I think you talked about three of the largest 10 that plan to be trial participants. Just what are you hearing in terms of their enthusiasm for the study? Because presumably these transplant centers today probably use one of the send out tests. So, just curious how we should be thinking about – it's probably a little early for this, but after securing FDA approval, do you have a sense for what percentage of tests they might move perhaps within the first year or two?

Joshua Riggs
President, Chief Executive Officer & Director, OncoCyte Corp.

A

I would say enthusiastic is probably the best word I have to describe their relationship with us. I think you were feeling a lot of pull through from these centers. They want access to the technology. There's a lot of questions that they want to ask that are really hard to do when there's only send out option available. So, having something that they can run in house just makes a lot of sense for these guys. I mean, these are the top academic research institutions. They've got big questions they want a answer.

So, I think we're feeling kind of this partnership approach is creating a lot of friends. It's hard for me to tell how quickly they'll switch. I mean, your transplant centers are generally risk averse. I think like most major academic centers, it's nice that they'll get to interact with it. It's nice that they'll be a part of creating the data that goes to the FDA. So, maybe they'll be the quickest to switch. But I can't really hang a number on how quickly they'll flip, those centers. I think we estimate at a minimum six months of them kind of introducing it to their clinical environment before any kind of meaningful ramp up in volumes.

Mark Anthony Massaro
Analyst, BTIG LLC

Q

All right. Got it. I look forward to the – learning the name change, but I will hop back in the queue. Thanks, guys.

Joshua Riggs
President, Chief Executive Officer & Director, OncoCyte Corp.

A

Thanks, Mark.

Operator: Thank you, Mark. Mason Carrico. You are up next.

Mason Carrico
Analyst, Stephens, Inc.

Q

Hey, guys.

Joshua Riggs
President, Chief Executive Officer & Director, OncoCyte Corp.
A

Hey, Mason.

Mason Carrico
Analyst, Stephens, Inc.
Q

I think the IOTA model is set to kick off mid-year. I was curious what you're hearing from the field around how much of an impact that could have on market growth in the back half or maybe just even moving forward?

Joshua Riggs
President, Chief Executive Officer & Director, OncoCyte Corp.
A

Yeah, we consider it one of the wins in the sales of donor derived cell free DNA in general. I think there was a lot of choice words when the program was announced by some of our partners. They're not very excited about it. I think change is met with skepticism here in an environment that is increasingly full of change. So, I think it's going to be – I think, demand increasing in general. And so, one thing that we've pointed to for the past year that if you use more marginal kidneys or you use more marginal organs, you're going to have more adverse events. And I think that leads to more testing and more demand for tools to help manage those patients. I think we're very hopeful that the anti-CD38 drugs get to market quickly because I think they'll help offset some of the worst effects of using the marginal organs. But I am not a physician, so I think the odds of that – that's my best guess on how it's going to play out.

Mason Carrico
Analyst, Stephens, Inc.
Q

Got it and as we kind of think about your tests rolling out in the clinical market, is there any risk of friction between the transplant centers themselves and the physicians who work there in terms of the tests they order? I guess the way I kind of think about it, is there a scenario where centers may prefer in-house testing because they can participate in the economics, but physicians may tend to continue leaning towards LDTs because that's what they're used to or that's where there's more clinical evidence. And if that is a scenario, I mean, how do incentives align? How does that all shake out exactly?

Joshua Riggs
President, Chief Executive Officer & Director, OncoCyte Corp.
A

Yeah, I would say there's very few centers that we've come across that take a heavy handed approach by like saying, you have to use this, you have to use that. There are some that take that approach. But I think in most cases it's up to the doctor to choose what test is right for their patients. Obviously, we won't have a role in deciding, that'll be up to the institution. But I think there's going to be a lot of show-me in the market once we get out there. They're going to want to see that it performs as well as what they've been using. One of the hardest things to change in the world is physician behavior. But I think we're comfortable that our technology performs and that it will stand up to any kind of comparative analysis.

Mason Carrico
Analyst, Stephens, Inc.
Q

[indiscernible] (00:26:27) okay and last one for me and I'll hop back in the queue. Could you just walk us through how you're thinking about the final Q-sub meeting? What do you expect to be the focus there? And given the discussions you've kind of already had, what's de-risked if that's the right word versus what will be the focus here?

Joshua Riggs
President, Chief Executive Officer & Director, OncoCyte Corp.

A

Yeah, I'd like to invite Ekke to respond on this one because I know he's been doing a lot of prep work and he just had a call with them, teaching the FDA about the digital droplet PCR, but yeah, I'd say we've slimmed down the assay, made it more user friendly and developed a trial design that's really, really simple. But Ekke, I mean maybe you can talk a little bit about sort of the last Q-sub that we've got coming up. And what you see as kind of the big topics there?

Ekkehard Schütz
Chief Science Officer, OncoCyte Corp.

A

Yeah, I mean, we are on track with submitting this week the Q-sub to the FDA. As Josh said, we had the first pre-meeting, I talked about that on the last call what the outcome was, which was kind of a little bit in favor to us. We had this informational meetings and they needed to understand what digital PCR is and what are the specifics. And I think that went very well. And we also had the opportunity to ask about certain things and the FDA was very, very forthcoming and told us, okay, we want to see this, we want to see that, we want to see this. That was actually very, very good. So, we took the opportunity and baked more, as everything what they were asking for, into our Q-sub now. And you know that Q-sub is more a kind of a question and answer game. So, we have five questions that we want to ask that I think will give us a lot of comfort if we get to an agreement with the FDA that our final submission is going to be accepted and is more or less answering and everything that they could think of. And so, that's still on track as Josh said by year's end.

I'm not sure Josh if you've said it, but we have received so-called central IRB already that was approved. And the good news is that our largest center is one of the centers that are using the central IRB. So, that means as soon as we have our documentation, our accompanying documentation ready, which we think is next week and we got the kits produced, which might take another two weeks, that we can collect the first centers for the clinical trial.

Mason Carrico
Analyst, Stephens, Inc.

Q

Got it. Thank you. That's helpful. Appreciate it, guys.

Joshua Riggs
President, Chief Executive Officer & Director, OncoCyte Corp.

A

Yeah, thanks, Mason.

Operator: Thank you, Mason. Thomas Flaten, you are up next.

Thomas Flaten
Analyst, Lake Street Capital Markets LLC

Q

Hey, guys, appreciate you taking the questions. Josh, just following on from the prior questions, aside from the study, is there anything else that you guys need to do from an FDA submission perspective to complete that document or filing?

Joshua Riggs
President, Chief Executive Officer & Director, OncoCyte Corp.

A

No, it's – I mean, it's all about the data generation at this point. There's a lot of work that we do in-house. So, there's a lot of the verification, validation work that's done at our lab in Nashville. That's a big lift. There's a

software development that you heard us talk about. All of that's kind of proceeding on pace, but the biggest piece is getting these clinical samples collected and accrued and ready to run.

Thomas Flaten
Analyst, Lake Street Capital Markets LLC

Q

Got it. And then of the 20 centers that you're hoping to have by year end, and I saw the three of the 10 you have already are in the US, would it be proportional when we get to the end of the year, will 6 of the 20 be in the US or are you trying to skew that more US oriented ahead of the launch?

Joshua Riggs
President, Chief Executive Officer & Director, OncoCyte Corp.

A

I think we'll see more in the US ahead of launch.

Thomas Flaten
Analyst, Lake Street Capital Markets LLC

Q

Got it. And then, Andrea, just a quick one for you. With respect to sales and marketing spend, how are you thinking about ramping that ahead of launch? Is that more of a 2026 activity? Should we anticipate anything towards the tail end of this year?

Andrea James
Chief Financial Officer, OncoCyte Corp.

A

There will be some incremental spend tied to unlocking the RUO sites, which is already baked into the $6 million cash burn. So, we've got some incremental sites associated with the FDA program. And as we get closer to submission, we're going to divert those dollars to sales and marketing at the end of the year. So, we should be okay. I mean, the good thing about this is the customer market is very concentrated. And so, part of the value prop is that we don't have to go out and hire a big sales force. There's just a handful, maybe 100 call points in the US...

Joshua Riggs
President, Chief Executive Officer & Director, OncoCyte Corp.

A

Right.

Andrea James
Chief Financial Officer, OncoCyte Corp.

A

...and similarly in Europe. And so, the sales team, they're doing a really great job with the resources that they have. And as we are able to divert some of the investment from the clinical trial to the RUO site unlock, we'll be able to just divert some of those dollars over there.

Thomas Flaten
Analyst, Lake Street Capital Markets LLC

Q

Awesome. I appreciate it. Thank you.

Operator: Thank you, Thomas. Mike Matson, you're up next.

Mike Matson
Analyst, Needham & Co. LLC

Q

Yeah, thanks. So, just a few on some of the transplant centers that will be in the study. So, you have three US centers right now using GraftAssureIQ. Are any of those that – and you're expecting three more in the study. So, are those three for the study going to be different than the three you have right now?

Joshua Riggs
President, Chief Executive Officer & Director, OncoCyte Corp.

A

Yeah, there's going to be a mix of incremental and some that are current users, but it's going to be much more than three.

Mike Matson
Analyst, Needham & Co. LLC

Q

Okay. And then, for the new ones that come online that are going to be involved in the trial, do they need – is there any kind of learning curve that they need to get some experience with GraftAssureIQ before they move on to the actual trial?

Joshua Riggs
President, Chief Executive Officer & Director, OncoCyte Corp.

A

No, it's a good question. I think fortunately it's PCR. So, it's pretty easy for these guys to come up on the workflow. There'll be an instrument [ph] drop (00:32:44). There'll be about a week and a half of training and then they're ready to go.

Mike Matson
Analyst, Needham & Co. LLC

Q

Okay. All right. And then just the current mix of centers, you've got six in Europe and three in the US. So, I mean, is that reflective at all of the relative kind of interest in demand? I mean, I don't think they have – they don't have the send out tests over there, as I understand it, right. So, maybe there's just even more of an uptake. Not to say that there isn't an uptake here, but can you maybe comment on that?

Joshua Riggs
President, Chief Executive Officer & Director, OncoCyte Corp.

A

Yeah, no, absolutely. So, what happened is we did feel an initial pull from Europe that was much stronger than the United States. But what we did is we kind of poached our funnel for our favorite sites in the United States and held them off for the FDA program. And so, you're going to see a lot more pop up in the US just by virtue of that.

Mike Matson
Analyst, Needham & Co. LLC

Q

Okay. Got it. Thank you.

Operator: Thank you, Mike. And last, we have Yuan Zhi.

Yuan Zhi
Analyst, B. Riley Securities, Inc.

Q

All right. Thank you for taking our questions. Maybe. Josh, can you remind us within the current standard of care, how many tests do you need to run to detect the transplant rejection in the first year of kidney transplant? And what would that look like beyond one year? A follow-up question will be what is the compliance rate for those tests right now?

Joshua Riggs
President, Chief Executive Officer & Director, OncoCyte Corp.
A

Yeah, so we're not out commercializing a ton right now. So, most of my information here is going to be second hand. I mean, there are publications that recommend four or more tests in the first year and then maybe quarterly to biannually after that. I would say in general the average is somewhere around 2.3 to 2.5 tests per patient under management. And that gives you kind of an average to think through as you're looking at market sizes.

Yuan Zhi
Analyst, B. Riley Securities, Inc.
Q

And in your current trial, how frequently do patient receive your tests?

Joshua Riggs
President, Chief Executive Officer & Director, OncoCyte Corp.
A

So, it's single time point in our study.

Yuan Zhi
Analyst, B. Riley Securities, Inc.
Q

Got it. So, for – one of the benefits of your test is you will be able to detect some of the sub clinical rejections? So, if those are detected, what does it mean actually to the patients and doctors? What kind of treatment will they start after that? And in other words, what is the additional benefit to detect such subclinical rejections?

Joshua Riggs
President, Chief Executive Officer & Director, OncoCyte Corp.
A

Yeah, I'd like to hand this one to Ekke because he was part of that ground-breaking research that came out last year. Ekke, if you could talk just a little bit about why catching AMR matters now, especially with the sort of the anti-CD38s that are coming out.

Ekkehard Schütz
Chief Science Officer, OncoCyte Corp.
A

Yeah. Thank you for the question. So, we could show last year that using our test in patients that are at high risk for antibody mediated rejection, which are those patients who have certain types of antibody called donor specific antibodies and it was also up to the same time that you could say it doesn't matter because there's no treatment. But in parallel to that we were evaluating new treatment that should really work very well on anything that is antibody related. And so, that is a drug called which is a drug called felzartamab which is a CD38 antibody.

And so, shortly after we have shown that we can shorten the time to diagnose ABMR, we could show that there is a very effective treatment for ABMR, which actually really changed the complete perspective on testing for ABMR because now we are able, as soon as we catch it, to treat the patient and ABMR especially chronic long lasting ABMR is the major cause of graft loss. So, it was always a very bad prognosis when you have to tell a patient you have antibody mediated rejection that's not going away and most probably you are going to lose your graft over the next three, four years, and that has completely changed.

And there are additional drugs upcoming that are targeted to antibody mediated rejection. We are participating in one Phase 2 trial as the measuring partner for donor derived cell free DNA. And we are also having investigator initiated study that is happening in Germany, Austria and like the German speaking countries, where we are testing another CD38 antibody which is called daratumumab. The beauty of this drug is that it is already approved in the US. It's just not far ABMR, but it's a drug that you can give off label.

And I think the other positive event was that the FDA gave felzartamab the breakthrough device approval. So, in the US now felzartamab can be used for ABMR. And what we have already shown in the studies is that it's really very beneficial if you are also monitoring while you are giving this drug. No drug has no side effects and it's clear that you don't want to give a drug forever. So, that's usually given for about half a year and then you stop.

And what we have seen already in the study that was published in New England Journal is that once the disease, the ABMR, is going into a recurrence, then the donor derived cell free DNA is rising again. So, that's really a good tool that you can say, okay, at this point, the patient who was pretty much cured from his ABMR needs the next cycle of the drug. So, that's I think where it's going to go over the next year and especially in this case, I think the donor derived cell free DNA plays really a pivotal role for these patients.

[indiscernible] (00:39:50).

Yuan Zhi
Analyst, B. Riley Securities, Inc.

Q

Yeah, that's very helpful.

Ekkehard Schütz
Chief Science Officer, OncoCyte Corp.

A

You are welcome.

Joshua Riggs
President, Chief Executive Officer & Director, OncoCyte Corp.

A

Yeah, no, thanks. And I think – we're excited. We've got some more data coming out this year on the recurrence monitoring. We're excited about that. All this ties to the claims expansion that we got last fall where we were looking at the de novo DSA positive patients where we basically got a screening claim there, where you need to test those patients 6 times at the first sign of de novo DSA. So, we're excited. I mean, we feel like the market is growing in general for testing, so the pie is getting bigger for everybody and I think that that feels really good.

Operator: Really quickly I want to do a housekeeping before we do another round to see if anyone has any follow-ups. I just want to get our wonderful analysts joining us. I want to get your firm names into the transcripts. So, we have Mark Massaro at BTIG. Thank you for your question. Mason Carrico, at Stephens. Thank you for your question. Thomas Flaten at Lake Street, thank you. Mike Matson at Needham, thank you. And Yuan Zhi at B Riley Securities. We appreciate you guys being here. We want to get your firm names into the transcript.

Joshua Riggs
President, Chief Executive Officer & Director, OncoCyte Corp.

All right. And if there are no follow up questions, we will say thank you and look forward to catching up with you guys on the follow-ups.

Operator: Thank you. See you next quarter.