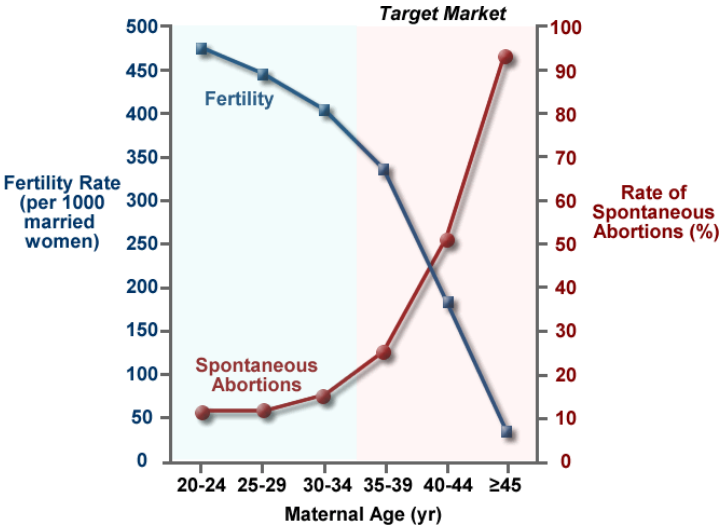
Executive Summary

Overview

Pregmama, LLC is a biopharmaceutical company dedicated to significantly improving the ability of women in their late thirties and early forties to conceive and achieve healthy, full-term pregnancies.

Dr. Lori R. Bernstein, Chief Science Officer and Co-Founder, of Pregmama, LLC has invented a novel, noninvasive hormonal therapy for preventing infertility, miscarriages, and trisomic birth defects. As shown to the right, fertility drops dramatically in women over 34 while spontaneous abortions (miscarriages) increase dramatically. These events are caused by "egg infertility," which is an increased likelihood of the ovulated eggs from women of advanced maternal age (AMA) to have chromosomal abnormalities. These abnormalities cause infertility, miscarriages, and trisomic birth defects, including Down Syndrome. Dr. Bernstein has invented a therapy to prevent abnormal eggs by intervening during egg development. Our "Fertamax™" therapy rolls back the clock to allow the eggs of an older woman to develop in a hormonal environment similar to that of a 25 year old woman**.**



There are no current therapies to prevent the underlying problem of chromosomal abnormalities in women over 34. The only means of having children for women with "egg infertility" are *in vitro* fertilization (IVF) with eggs donated by a younger woman, preimplantation genetic selection (PGS) to screen out aneuploid embryos, or adoption. Pregmama is committed to developing its new technology to **prevent** chromosomal abnormalities and bring healthy babies into this world.

Value Proposition

- **Pregmama provides a safe, noninvasive therapy for women who are experiencing difficulty in conceiving a baby or achieving a full term pregnancy.**

Clinical Indications

Fertamax™ will be used to treat women over 34 who have "egg infertility" and suffer from:

- Repeated implantation failure (when IVF fertilized eggs fail to implant in the uterus) or
- Diminished ovarian reserve (when fertility is diminished and follicle stimulating hormone and/or estradiol levels are elevated, or
- Karyotypically abnormal miscarriages

Markets

The worldwide annual addressable market of 284,000 includes 71,000 U.S. patients, and 213,000 international patients. According to the U.S. 2002 National Survey of Family Growth, there were an estimated 2.1 million infertile couples. Of these, 1.2 million sought infertility care. Each year the CDC requires every fertility clinic to report their statistics in great detail. The 2006 CDC statistics show 138,198 IVF cycles performed, with about 60% for AMA patients. Pregmama's addressable U.S. market includes over half of the current AMA IVF patients.

U.S. Patient Population	Addressable U.S. Market
Donor Egg Cycles	10,419
Diminished Ovarian Reserve Cycles	10,057
Unexplained Infertility Cycles	1,383
Multiple Female Factor Infertility Cycles	2,5414
Infertility patients who only underwent IUI	16,584
Infertility patients not currently undergoing IVF	18,514
2006 Total	59,472
2010 Projected Total	**71,000**
Based on latest CDC statistics and clinician input on patient eligibility	

Substantial international markets are expected in Europe, Canada, Australia, Israel, Japan, Taiwan, and Korea. Pregmama's market may be expandable to include younger women with similar underlying fertility defects.

Market Trends

The worldwide delay in childbearing puts more and more women at risk of infertility, miscarriages and birth defects. Advanced maternal age women in the U.S. had 612,336 babies in 2007. The average age for women to have a baby has increased dramatically in the last 25 years. This trend is particularly evident in westernized societies where education and career opportunities often delay marriage and childbearing. Although modern medicine has extended life expectancy, there have been no therapeutic advances to prevent ovulation of eggs with chromosomal abnormalities. The addition of a novel AMA therapy which increases success rates significantly should drive a steep increase in the number of cycles due to the entrance of new patients and the fact that AMA women make up 60% of women seeking treatment at IVF clinics.

Business Model

Fertamax™ will quickly attain significant utilization and market penetration, resulting in hundreds of millions of dollars in revenue and creating significant value for Pregmama's shareholders. Although a patient under a physician's care could purchase the components of Fertamax™ separately (they would still need a prescription for the drugs), the Fertamax™ kit will offer substantial advantages:

Advantage 1: *Convenience of all the components in one kit*. Patients prefer all-in-one kits that minimize their chance of error. This can be seen with kits for administering oral contraceptives. Like Fertamax™, OCPs vary the identities and dosages of medicines throughout the menstrual cycle. Although the medications for birth control are inexpensive and readily available for purchase separately, patients prefer OCP kits, which define and simplify the dosage regimen. This alleviates stress and improves patient compliance.

Advantage 2: *Proven clinical trial efficacy of a specific combination of drugs*. Since there are multiple drugs being used for a number of months, it is important to remove variability in outcome as the result of variability of manufacturers and drug lots. Considering the multiple month duration of the therapy, patients will be willing to do everything possible to enhance the likelihood of success.

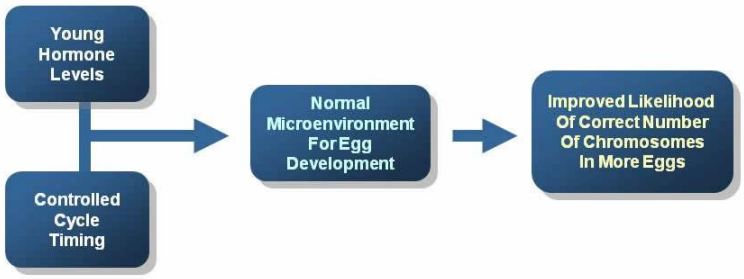
Patents

The timing of administration, dosage regimen, and duration of the combination of administered drugs are novel. Pregmama is pursuing patent protection in the U.S. and in Europe (PCT) to cover the Fertamax™ drug kit and Fertamax™ therapy. Future intellectual property includes proprietary diagnostic screening and monitoring systems, advanced delivery systems, and novel drug formulations. Patent applications USSN 60/928,713 (Filed May 12, 2008) and USSN 12/291,639 (Filed November 12, 2008) entitled "Hormone normalization therapy and uses thereof" claim:

- A method of reducing the incidence of infertility, miscarriage, and trisomic liveborns to a woman in need of such treatment comprising: regulating levels of estrogen, progesterone, luteinizing hormone and follicle stimulating hormone, wherein said method reduces the incidence of infertility, miscarriage, and trisomic liveborns in the woman.
- A kit, for reducing the incidence of infertility, miscarriage, and trisomic liveborns in a woman…

Technology

Fertamax™ treats AMA women with a combination of drugs that have been previously approved by the FDA. This significantly reduces the duration and cost of clinical trials. Fertamax™ creates and sustains a young microenvironment for egg development and thereby prevents chromosomal problems in the developing egg. This is achieved by:



1. Approximating young levels of reproductive hormones throughout the menstrual cycle
2. Lengthening the cycle to provide sufficient time for healthy egg maturation, so that the egg is permitted to ovulate once its maturation process is completed.

Fertamax™ is a hormone and drug therapy administered to women who have experienced infertility and/or multiple miscarriages. It consists of restoring the patient's hormonal profile to that of a young woman for multiple months during egg development so that chromosomal abnormalities do not develop. It uses the following drugs:

- **Leuprolide Acetate-** Suppresses pituitary secretion of FSH and LH
- **FSH: Follicle Stimulating Hormone-**Stimulates follicular development
- **hCG: human chorionic gonadotropin-**Triggers ovulation

Fertamax™ must be prescribed by a physician who is providing on-going care to the patient. The Fertamax™ kit will include the above drugs in sufficient quantity to administer treatment for 2-3 menstrual cycles. A training video along with syringes, swabs, and diagnostic collection devices will also be included in the kit.

The Fertamax™ therapy takes several months and consists of the following treatment regimen. Initially, pituitary secretion of FSH and LH are downregulated with leuprolide acetate for 10-15 days. Then, administration of fertility drugs is performed for two to three cycles (three cycles are shown below):

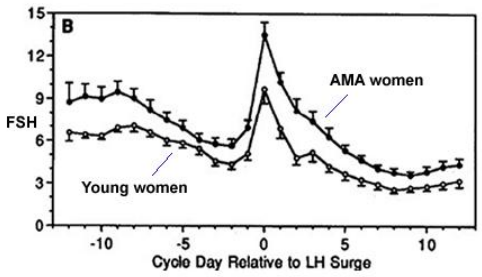
Cycle 1:	Find FSH threshold; reconstitute young hormone levels and trigger ovulation without attempting pregnancy
Cycle 2:	Reconstitute young hormone levels and trigger ovulation without attempting pregnancy
Cycle 3:	Reconstitute young hormone levels, trigger ovulation, and fertilize the egg via intercourse, intrauterine insemination, or in vitro fertilization with or without ICSI (for patients who also have male factor or tubal infertility)

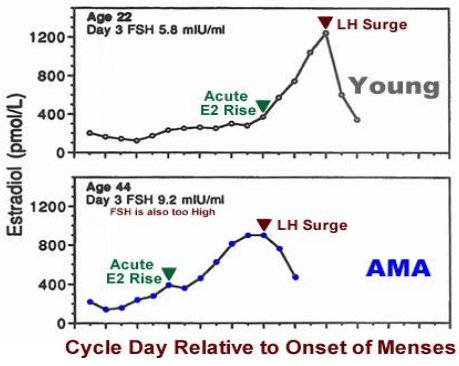
A supplemental kit will also be available for women who do not get pregnant in their first try but wish to try an additional pregnancy cycle.

Scientific Background. Normal egg maturation produces an egg with 23 chromosomes, so that when it combines with a sperm's 23 chromosomes there will be the normal 46. An egg with one too many or one too few chromosomes is called "aneuploid," due to its incorrect chromosome number. The sperm that fertilizes the egg cannot correct this condition, so the fertilized egg and the embryo that develops from it are also aneuploid. When the egg or sperm has extra or missing chromosomes, the fertilized egg usually is not viable. It will fail implant in the uterus, or develop abnormally. While most of these trisomies lead to infertility and miscarriages, there are three that produce live births: Trisomy 21 in Down Syndrome, Trisomy 18 in Edwards Syndrome, and Trisomy 13 in Patau Syndrome.

What is needed is a way to get an egg to mature so that it has the normal 23 chromosomes. The process of egg chromosome segregation is called meiosis and is controlled by reproductive hormones, which have reached abnormal levels in AMA women. Fertamax™ goes to the root of the problem by providing a hormonal environment for the egg to mature normally.

The menstrual cycle is a highly timed set of events, each of which must function correctly to produce a healthy egg and to allow that egg to be ovulated, fertilized, and implanted in the uterus. These processes are regulated by a variety of reproductive hormones that are made in the body. These hormones control the menstrual cycle, including the process of making a healthy egg that has the correct number of chromosomes. These hormones include follicle stimulating hormone (FSH), estradiol (E2), and luteinizing hormone (LH). In healthy young women FSH, E2 and LH levels are constantly changing in a highly controlled and predictable cyclic pattern of secretion. FSH and E2 guide the egg's preparation for chromosome segregation during meiosis. A burst of LH secreted from the pituitary in the middle of the cycle actually triggers the process of chromosome "segregation" so that the egg segregates its chromosomes (twenty three) and ovulates. AMA women often have abnormally high levels of FSH, elevated levels of E2, and/or an LH surge that occurs before the egg is fully prepared to segregate its chromosomes. Fertamax™ optimizes reproductive hormone levels in AMA women to approximate levels in young women as they change throughout the menstrual cycle.





Adapted From: Klein, N., et al. J. Clin. Endocrinol. Metab. 81: 1035-45, 1996.

Eggs are responsive to FSH during the last 2-3 menstrual cycles before they are ovulated. Chronic exposure to high FSH during this long period of egg development may be a fundamental reason for the decline in egg quality. Fertamax therapy lowers FSH during this entire sensitive period of egg development. While patients are on Fertamax therapy, poor quality eggs that were exposed to chronic high FSH before the initiation of therapy are ovulated prior to attempted pregnancy, and the eggs with which pregnancy will be attempted have only been exposed to young hormonal levels for the duration of their development, thus increasing egg quality, and decreasing the incidence of aneuploidy. Whereas Fertamax™ therapy is 1-2 months longer than a conventional IVF cycle, it is worth the wait to get the best egg, so that a healthy baby will be conceived.

The benefits of Fertamax™ compared to donor egg IVF

- The ability to use one's own eggs (cost, convenience, and emotional satisfaction)
- No need for surgery to retrieve eggs (cost, risk of invasive surgery and anesthesia)
- No risk of ovarian hyperstimulation that is commonly risked in IVF protocols
- Lower risk of multiple births compared to IVF, where more than one embryo is usually put into the uterus

Proof of Principle Summary

- **Molecular:** Administration of exogenous FSH and estradiol cause spindle defects and chromosomal disorganization in mouse eggs and cow eggs.
- **Cellular:** Women with high FSH and high estradiol are more likely to have trisomic conceptions.
- **Organismal:** High FSH, high estradiol, and a short follicular phase are associated with infertility and recurrent pregnancy loss. IVF who have undergone treatment with high dose fertility drugs have higher rates of aneuploid pregnancy losses than naturally cycling IVF patients.
- In addition, women over 34 have escalating levels of FSH, escalating rates of miscarriage due to aneuploidy, and escalating difficulty conceiving. Collectively, this work suggests compelling support that Pregmama's approach can provide a beneficial therapy that can positively enhance the odds of having a healthy baby.

Competitors

There are no current therapies that prevent chromosomal abnormalities in oocytes. **Fertamax™ increases the likelihood of achieving pregnancy, in addition to decreasing deleterious karyotypes.** The primary market competition for Fertamax™ includes IVF with donor eggs from a younger woman and adoption. Current therapies and their advantages/disadvantages include the following:

Treatment	Description	Advantages	Disadvantages	Prevent s conception of an aneuploid fetus?	Increase s likelihood of the birth of a chromosomally normal baby?
Trying naturally	Intercourse	No cost	Success rates are low in infertile AMA patients	No	No
Ovulation induction	For women who have difficulty with their menstrual cycles and/or ovulating there are a number of drugs such as Clomiphene Citrate to create regular periods and induce one or more eggs to be ovulated.	Noninvasive and lower cost	Potential for multiple births. Does not treat egg infertility.	No	No
IUI (intrauterine insemination)	Sperm is placed directly into the uterus and bypasses infertility that may be caused by structural or biochemical defects	Lower cost	Does not treat egg infertility.	No	No
Surgery	Some women have ovarian, fallopian tube, or uterine physical defects that can be corrected surgically	May be only therapy that works	Risk of surgery and anesthesia		
IVF (*in vitro* fertilization); **GIFT**(gamete intrafallopian transfer); **ZIFT** (zygote intrafallopian transfer)	Uses multiple drugs to induce multiple eggs to be ovulated, which are then harvested by surgical retrieval of the eggs. These eggs can be fertilized and implanted back into the uterus; laparoscope transfer of unfertilized eggs and sperm (GIFT) or fertilized eggs (ZIFT) into the woman's fallopian tubes.	More than one embryo increases odds of pregnancy	Potential for multiple births Risk of surgery and anesthesia. Does not treat egg infertility.	No	No
Gentle IVF	Instead of superovulation of multiple eggs, this revised form of IVF aims to produce fewer eggs		FSH still high during therapy. Does not treat egg infertility.	No	No
IVF with (Preimplantation	Allows one cell of an embryo created using IVF to be removed and analyzed for genetic defects	Allows disposal of genetically	Expensive Potential for multiple	Yes	Yes

Genetic Diagnosis screening with FISH)	such as aneuploidy or translocations by fluorescent in situ hybridization (FISH) analyses	aberrant embryos	births. Value for preventing trisomic pregnancies under dispute.		
IVF with CGH or SNP	Comparative genomic hybridization or single nucleotide polymorphism analyses: Similar to PGD but more comprehensive chromosome screen	More comprehensive than PGD	Very expensive; Potential for multiple births. Experimental, Does not prevent egg aneuploidy.	Yes	Yes
Donor Eggs	Uses eggs from a younger woman	Substantially improves fertility	Does not satisfy the procreation desire to propagate one's own genes	No	Yes
Adoption		Certainty of getting a child	Very expensive and does not propagate the parent's genes	NA	NA

Drug Kit Component Producers

Companies with fertility drugs in the marketplace are shown in the table below. The industry leader is Serono, which was acquired by Merck KGaA. Fertamax™ may eventually use generic, urine-derived FSH to get around recombinant protein patents, however, for current clinical trials, the recombinant FSH purity (and hence reproducibility of results) is important. Pregmama believes that in addition to potential interest by Serono in order to protect their market share, those companies wishing to compete against Serono will be interested in sourcing recombinant and urine-derived drugs.

Company	Drugs (Generic Name)
Abbott from TAP/Takeda	Lupron (Leuprolide acetate)
AstraZeneca	Arimidex (anastrozole), Zoladex(goserelin)
Ferring Pharmaceuticals	Novarel (hCG: human chorionic gonadotrophin, Urine-derived); Menopur (Menotropins: FSH+LH, Urine-derived); Repronex (Menotropins, Urine-derived); Bravelle (Urofollitropin, highly-purified FSH, Urine-derived) ; Endometrin (Progesterone vaginal insert)
Ipsen	Decapeptyl (Triptorelin: GnRH agonist)
Merck KGaA from Serono	Gonal-F/ Gonalef (Follitropin alfa); Ovidrel/Ovitrelle (choriogonadotropin alfa); Profasi (human chorionic gonadotrophin); Ovidrel/Ovitrelle (choriogonadotropin alfa); Gonal-F/Gonalef (follitropin alfa (FSH)); Pergonal (Menotropin); Serophene (clomiphene citrate); Luveris (lutropin alfa); Metrodin HP/ Fertinex (Urofollitropin); Cetrotide (Cetrorelix); Crinone (Progesterone)
Par Pharmaceuticals;	Leuprolide Acetate
Merck & Company	Puregon/Follistim (follitropin beta, Recombinant FSH); Humegon (Menotropin, Urine-derived FSH); TBN (Corifollitropin alpha long acting FSH); Pregnyl (human chorionic gonadotrophin, Urine-derived)
Solvay Pharmaceuticals	Prometrium (Progesterone Oral)

Product Development

In order to get products to market and begin generating meaningful revenue as quickly as possible, Pregmama intends to pursue the clinical development of Fertamax™ for the treatment of egg infertility in AMA women based on the following:

1. Recognized need for a treatment of the underlying cause of egg infertility
2. Pre-clinical evidence that suggests Fertamax™ therapy can be effective Previous FDA approval and good safety record for drugs that are part of the Fertamax™ kit
3. Straight-forward patient accrual for clinical trials

Animal studies, consisting of the Phase I MIPS study, will commence in August 2010 and are expected to take 1 year. In these studies we will demonstrate that an FSH-lowering therapy in mice prevents chromosome and spindle disorganization in the egg. Pilot clinical trials treating 5-10 women with HNT will comprise the Phase II MIPS study. This initial clinical trial has been designed by Dr. Bernstein in consultation with Reproductive Endocrinology and Infertility physicians from two major clinical centers. A draft IRB protocol is currently in preparation for a pilot clinical study, which will commence in September of 2011. An FDA phase II efficacy trial is planned for Q3 2012. During this time, Pregmama expects to execute commercial licenses with current companies in the field for the production and/or sale of the drug kit. Final product commercialization may entail sales by Pregmama or by its licensee. The first generation kit is expected to use currently available delivery technologies, while second generation products may incorporate novel formulations that increase efficacy and enable alternative delivery mechanisms. Pregmama is also developing additional clinical indications/alternative formulations of Fertamax™ in the field of anti-aging medicine.

Target Indication: Prevention of Infertility in AMA women suffering from diminished ovarian reserve

The Fertamax™ kit for initial clinical trials will consist of the following commercially available drugs:

- Leuprolide acetate (LA) –to be administered throughout the follicular and luteal phases of all Fertamax cycles.
- Injectable FSH – Gonal-F® from Serono (recombinant)
- hCG – Novarel® from Ferring (urine-derived). Since there are more cycles than IVF, the Fertamax™ drug kit will offer convenience and reliability. Syringes will have mixtures of FSH and hCG and leuprolide daily according to the dose schedule needed. Several different kits will be made available based on the prescribed threshold dosage determined during the first cycle. Since the duration of treatment in the late follicular phase varies with the cycle and the patient, the kit comes with a number of doses for that treatment interval, some of which will be discarded by those patients with shorter cycles. Discarding some of the FSH at the end of the cycles will not be as cost prohibitive, as the dosage is much lower than IVF.

Clinical Trials:

- **Phase I Clinical Trial (Phase II MIPS Study): 5-10 Patients: Cost: $120K: Duration: 6 months)** The purpose of this trial is to **demonstrate that we can safely normalize the hormones** in infertile AMA patients. This trial will be performed by Mishka Terplan, MD, OB/Gyn, and colleagues at the University of Maryland. Dr. Terplan has expertise in clinical gynecology including infertility, and he is the Director of the Maryland Woman's Center at UMMC. The Maryland Women's Center is a clinical center that provides OB/Gyn patient care and performs clinical research in infertility and other related OB/Gyn disciplines including maternal fetal medicine.
- **Phase II Multisite Clinical Trial: (92 Patients: Cost: $3M; Duration: ~2 years)** The purpose of this trial in infertile AMA patients is to **show efficacy of Fertamax™ in decreasing oocyte aneuploidy rates and increasing pregnancy rates.**
- **Phase III Multisite Clinical Trial: (340 Patients: Cost: $5.5M; Duration: 3-4 years**). The purpose of this trial in infertile AMA patients is to **show efficacy of Fertamax™ in improving pregnancy rates in comparison with standard infertility therapy.**

Manufacturing and Production

The Fertamax™ kit can be made using entirely generic compounds. Current drug makers may be willing to source proprietary materials for additional compensation. We plan a protein production facility in Maryland for the urine-derived components of the kit.

Applied Research and Future Product Development

Delivery-related Projects: Pregmama will test potential novel delivery mechanisms in future versions of the therapy.
Diagnostic-related Projects: Pregmama will develop screening of potential patients both to remove those patients who have other underlying defects that cannot be addressed by Fertamax™ and to encourage those patients who are most likely to benefit from Fertamax™. A "fertility index" similar to the concept of a PSA score will be used to simplify eligibility. In addition to the drugs and hardware, Pregmama will develop appropriate training videos, web-based tutorials, and therapy-enhancing projects.

Marketing

Fertamax™ Kit: Pregmama will directly market its kit to the reproductive endocrinologists at the 426 American fertility clinics. Clinical trial proof of significant increases in healthy babies being born will ultimately drive market adoption. The largest clinics account for a disproportionate share of the market for women over 34, as donor eggs and more difficult infertility problems require more specialty expertise that is only available in larger clinics located in major metropolitan areas. A contract sales force can be utilized in the U.S., as all the potential customers are known. Distribution through the specialty pharmaceutical distributors for the infertility market is planned.

Financials (annual)

Assumptions:	**71,000**	Estimated U.S. AMA Pregmama Patient Cycles (Addressable Market)
	$355,000,000	U.S. drug kit market (Estimated kit price of $5,000)
	$28,400,000	U.S. drug additional cycle kit market (40% of users) (Estimated kit price of $1000)

International markets are expected to be 2-3 times the size of the U.S. market, but at a lower cost basis due to national health coverage and market price sensitivity. In some countries Pregmama expects to license its intellectual property

portfolio to a current player in the pharmaceutical market in exchange for clinical trial funding, upfront and milestone payments, and a royalty on sales. The most likely exit strategy is sale of the company to a major pharmaceutical partner.

Attracting Angel and Venture Capital

Pregmama currently seeks Angel capital partner(s) willing to invest $1 million to advance Pregmama's Fertamax™ technology into the clinic. The MIPS Phase One Study will provide prospective investors additional confidence in the project, as well as significant data. In addition to monetary support, Pregmama will team up with individuals and groups who have past successes building early-stage companies. They will understand and appreciate the unique challenges facing a clinical trial stage biosciences company. Also they will have a network of professional contacts in the biomedical industry and on Wall Street that can be accessed in the future to help Pregmama grow and prosper.

Pregmama believes that it possesses several characteristics that will strongly appeal to investors in today's funding environment. These include:

1. A drug kit that addresses a significant unmet medical need
2. A proprietary therapy
3. Unique mechanisms of action
4. Valuable intellectual property protection
5. A management team that recognizes that additional personnel will need to be brought in to help take Pregmama to the next level; and that has reasonable expectations with regard to valuation.

Economic Impact and Company Growth

While Pregmama begins as an R&D company, its ultimate goal of biopharmaceutical production and sales is expected to contribute substantial staff and manufacturing facilities to Maryland. The drugs in the Fertamax™ kit that can be urine-derived can be manufactured and brought to market sooner and less expensively than recombinant proteins. Baltimore and the 270 Technology Corridor have skilled workforces from which to recruit and a number of contract biomanufacturing companies for clinical trial grade materials. The physical facilities and personnel for a full production facility, in addition to expanding R&D and clinical trial activities, represent an excellent addition to the Maryland biotech community

Management

Stephen S. Perry, Jr. is Pregmama's President and CEO. Mr. Perry has 25 years of executive management experience in both for-profit and not-for-profit healthcare organizations. Mr. Perry was President and CEO of a multi-site healthcare holding company. He was one of the originators of the Child Health Corporation of America (CHCA), a for-profit corporation designed to bring about consolidation and efficiency in children's hospitals throughout the country. Mr. Perry has been involved in leading small healthcare companies through significant growth and subsequent sales and/or mergers. Mr. Perry served as the President of the Larry King Cardiac Foundation, where he led the re-structuring of the foundation for rapid growth.

Lori R. Bernstein, Ph.D. is Pregmama's lead inventor, co-founder, and Chief Scientific Officer. She has 22 years of experience as a basic science researcher in biochemistry, cellular and molecular biology, cancer, and more recently reproduction. For twelve years Dr. Bernstein ran her research laboratory as a professor in the Texas A&M Health Science Center College of Medicine. In 2007-2008 Dr. Bernstein supervised a team of scientists studying aneuploidy in mouse oocytes in collaboration with Dr. Duane Kraemer at Texas A&M.

Bruce F. Mackler, Ph.D., J.D. is Pregmama's Vice President for Regulatory Affairs. He advises in all FDA and international regulatory matters and is developing and implementing FDA strategies for product approval. Dr. Mackler couples his scientific knowledge (M.S., Ph.D. Immunology) with practical, hands-on regulatory experience of 27 years of FDA legal work on traditional and biotechnology derived products.

Barry M. Datlof, MBA is Pregmama's co-founder and Vice President for Business Development. He is the former COO of TolerGenics, Inc., an autoimmune cellular therapy company. He was the VP of Business Development for MicroDiagnosis, Inc., a pathogen diagnostics company. Mr. Datlof was the Director of Patents and Licensing for the American Red Cross and he established the Office of Technology Transfer at the Dana-Farber Cancer Institute. Mr. Datlof currently commercializes biomedical technology for the U.S. Army Medical Command.

Collaborating Investigators

Istvan Merchenthaler, M.D., Ph.D., D.Sc., is a Professor in the Department of Epidemiology and Preventative Medicine at the University Maryland Medical School in Baltimore. He is an expert in the field of female reproductive aging on the hypothalamic-pituitary-ovarian axis as it pertains to menopausal aging conditions and diseases, with over 150 publications dedicated to this area.

Mishka Terplan, M.D., M.P.H., is an Assistant Professor in the Department of Obstetrics, Gynecology and Reproductive Sciences at the University Maryland Medical School in Baltimore. Dr. Terplan has expertise in clinical gynecology including infertility. He is the Medical Director of the Maryland Women's Center, UMB, a clinical center that provides clinical OB/Gyn patient care and performs clinical research in infertility and other related disciplines, including maternal fetal medicine and other OB/Gyn disciplines.

Robert Koos, Ph.D., is a Professor in the Department Physiology at the University Maryland Medical School in Baltimore. He is an established reproductive biologist with important contributions in the fields of ovarian and uterine physiology, estrogen action, and estrogen receptors.

Dagan Wells, Ph.D. is Director of the IVF lab and a Senior Scientific Leader in Reproductive Genetics at in the Department of OB/Gyn at the University of Oxford, and the Director at Reprogenetics UK. He is at the forefront of the field of preimplantation genetic diagnosis of human embryos. He specializes in applications of Comparative Genomic Hybridization to karyotypic diagnosis of preimplantation embryos. Dr. Wells also participates on our Scientific Advisory Board.

Other collaborators not pictured include Texas A&M professors Duane Kraemer, D.V.M., Ph.D., Bhanu Chowdhary, Ph.D., and Les Dees, Ph.D., and St. Louis University professors John Morley, M.D., and Susan Farr, Ph.D.

Scientific Advisory Board

In addition to Dr. Dagan Wells, we have the following board members:

Karin J. Blakemore, M.D., is the head of Maternal Fetal Medicine in the Department of Gynecology and Obstetrics at the Johns Hopkins School of Medicine in Baltimore. She is also the director of the Prenatal Diagnostic Center of the Johns Hopkins Medical Institutions. Her areas of expertise include high risk pregnancy; maternal or fetal genetic abnormalities, disorders and risk; and prenatal testing.

Fuller Bazer, Ph.D., is a Distinguished Professor & O. D. Butler Chair, Physiology of Reproduction, and he is the Associate Vice President for Research at Texas A&M University. He is a renowned reproductive biologist, with over 430 research publications. Dr. Bazer's research focuses on uterine biology and pregnancy. He has received many honors recognizing his research, including awards from the Society of Reproduction, and the Society for Research and Fertility. Dr. Bazer serves as a consultant to the University of Maryland Reproductive Biology Program.

Mary Ann Ottinger, Ph.D., is Professor of Animal and Avian Sciences, and Associate Vice President for Research at The University of Maryland, College Park. Dr. Ottinger's research focus for many years has been in the study of endocrine mechanisms that modulate reproduction, with over 140 publications devoted to this area. Major research interests include the ovarian and neuroendocrine bases of reproductive senescence, early processes in embryo development, and technologies to extend reproductive lifespan.

Summary

Pregmama's therapy is a straight forward and logical method of treatment with a low risk, high return profile, and a well defined path to an established market. The market is expanding and is expected to grow further in the U.S. and worldwide as more women over 34 seek to have children. Join us in helping to bring healthy babies into the world for thousands of couples who would otherwise not have the joy of parenthood.