Inhibikase Therapeutics

**4Q23** | BUSINESS PRESENTATION

# Clinical Development of Disease-Modifying Therapeutics for Neurodegenerative Disease & Cancer

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# Developing innovative medicines across the therapeutic spectrum

- Multi-therapeutic pipeline across neurodegenerative disease, cancer and infectious disease
- **Risvodetinib (IkT-148009):** Lead Selective Abelson Tyrosine Kinase (c-Abl) inhibitor with potential to be a disease-modifying treatment for Parkinson's disease (PD) and related disorders. Phase 2, 201 trial ongoing with 94% of sites open, 25% enrolled in the U.S. The 201 trial planned to be expanded for 12 additional months providing 15 months of data to evaluate clinical benefit.
- **IkT-001Pro:** Prodrug of imatinib mesylate with improved safety/tolerability profile for treatment of stable-phase chronic myelogenous leukemia. Bioequivalent 501 trial completed and FDA pre-NDA meeting January 2024 to discuss approval for 8 adult indications under 505(b)(2).
- Robust patent portfolio with protection to 2033 (oncology) and 2036 (neurodegeneration).
- Orphan designations: **Rivsodetinib** in Multiple System Atrophy, **IkT-001Pro** in up to 8 oncology indications
- Cash/cash equivalent runway into 4Q24. Continue to seek non-dilutive capital through Federal Government and private foundation sources.
- Highly-experienced management team, consultants, Board of Directors and Scientific Advisory Board

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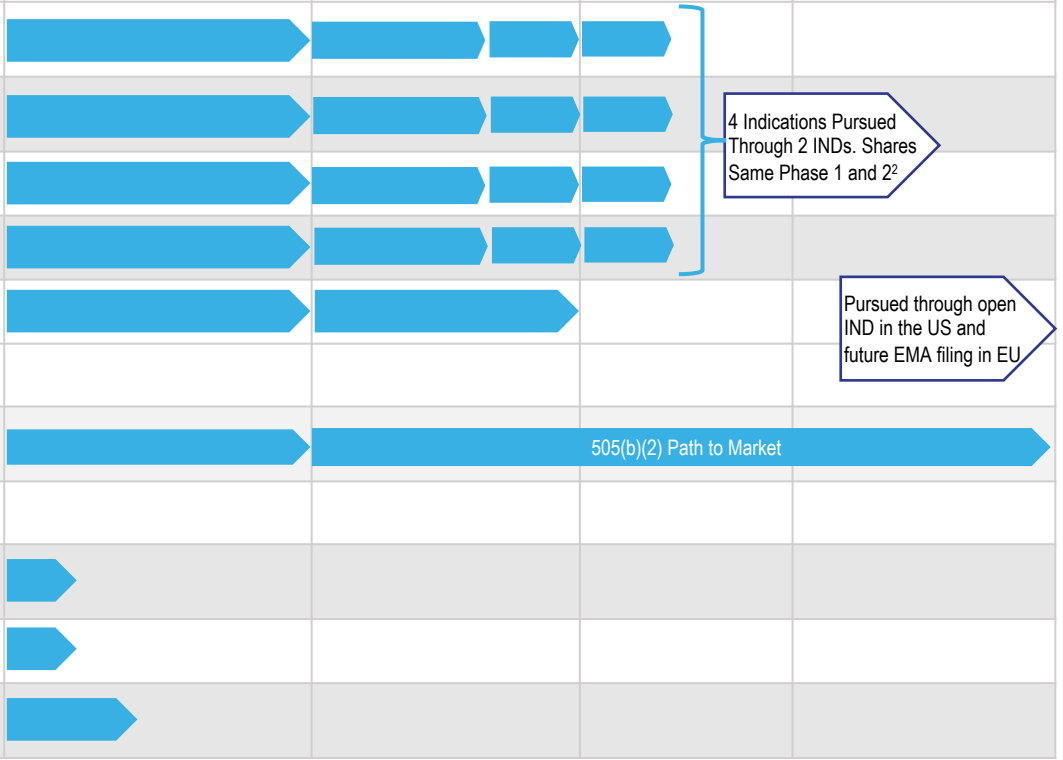
# Multi-Indication Pipeline in Neurodegeneration, Oncology and Infectious Disease

| DRUG TARGET | DRUG CANDIDATE | MODALITY | DISEASE INDICATION | CLINICAL DEVELOPMENT[1] |
|---|---|---|---|---|
| | | | | PRECLINICAL DEVELOPMENT / PHASE 1/1B / PHASE 2 / PHASE 3 |
| **Neurodegeneration** | | | | |
| c-Abl | **Risvodetinib** | Small molecule | Parkinson's Disease: Treatment Naive | |
| c-Abl | **Risvodetinib** | Small molecule | Parkinson's Disease: Early Stage | |
| c-Abl | **Risvodetinib** | Small molecule | Neurogenic Constipation | |
| c-Abl | **Risvodetinib** | Small molecule | Dysphagia | |
| c-Abl | **Risvodetinib** | Small molecule | Multiple System Atrophy | |
| **Oncology** | | | | |
| BCR-Abl | **IkT-001Pro** | Small molecule | Stable-phase CML (orphan indication) | |
| **Research Phase** | | | | |
| c-Abl | **IkT-148x, BIP 4-7** | Small molecule | Dementia with Lewy Body | |
| c-Abl | **IkT-148x, BIP4-7** | Small molecule | Multiple System Atrophy | |
| c-Abl | **IkT-14xx** | Small molecule | Infectious Disease | |




**(1).** 'Clinical Development' progress bars represent the current state of the indicated programs. Blue arrows represent completed or in progress studies; white arrows represent planned approaches for future clinical studies.

**(2).** Four indications will be pursued for IkT-148009 in PD, which will be pursued through studies of treatment naïve and early-stage patients, including their GI complications. MSA is an orphan, aggressive form of Parkinson's-like disease to enter clinical development at Phase 2 following completion and positive outcomes from animal model studies of IkT-148009 in prophylactic and therapeutic dosing studies.

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# Parkinson's and Related Disorders

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# Parkinson's disease and MSA in the U.S.[1]

## Parkinson's: Slowly Progressing

1/3 of a Patient's Lifespan to death = 25 years

**90,000**
New Cases / Year

**38,000**
Deaths / Year

**930,000 – 1,200,000**
**U.S. Patients[1]**

**60**
Average Age Of Onset

## MSA: Rapidly Progressing

1/10 of a Patient's Lifespan to death = 8 years

**15,000 -50,000**
Cases

**Orphan Disease**

**55**
Average Age Of Onset

**Men twice** as likely as **women** to contract disease

## Co-morbid indications

**47%**
Arthritis

**36%**
Heart/Circulatory

**35%**
Psychosis

**30%**
Dementia

Global treatment sales for PD by 2030 are expected to exceed

**$12.2 BILLION**

Vision Research, 2022

Current treatments cannot alter course of Parkinson's disease

MSA has no beneficial treatments

The country with the highest diagnosed prevalence is

**THE U.S.**

Vision Research, 2022

[1]Parkinson's Disease Foundation Decisions Resources 2016, Lewin Report in the Economic Burden and Future Impact of Parkinson's disease, 2019.

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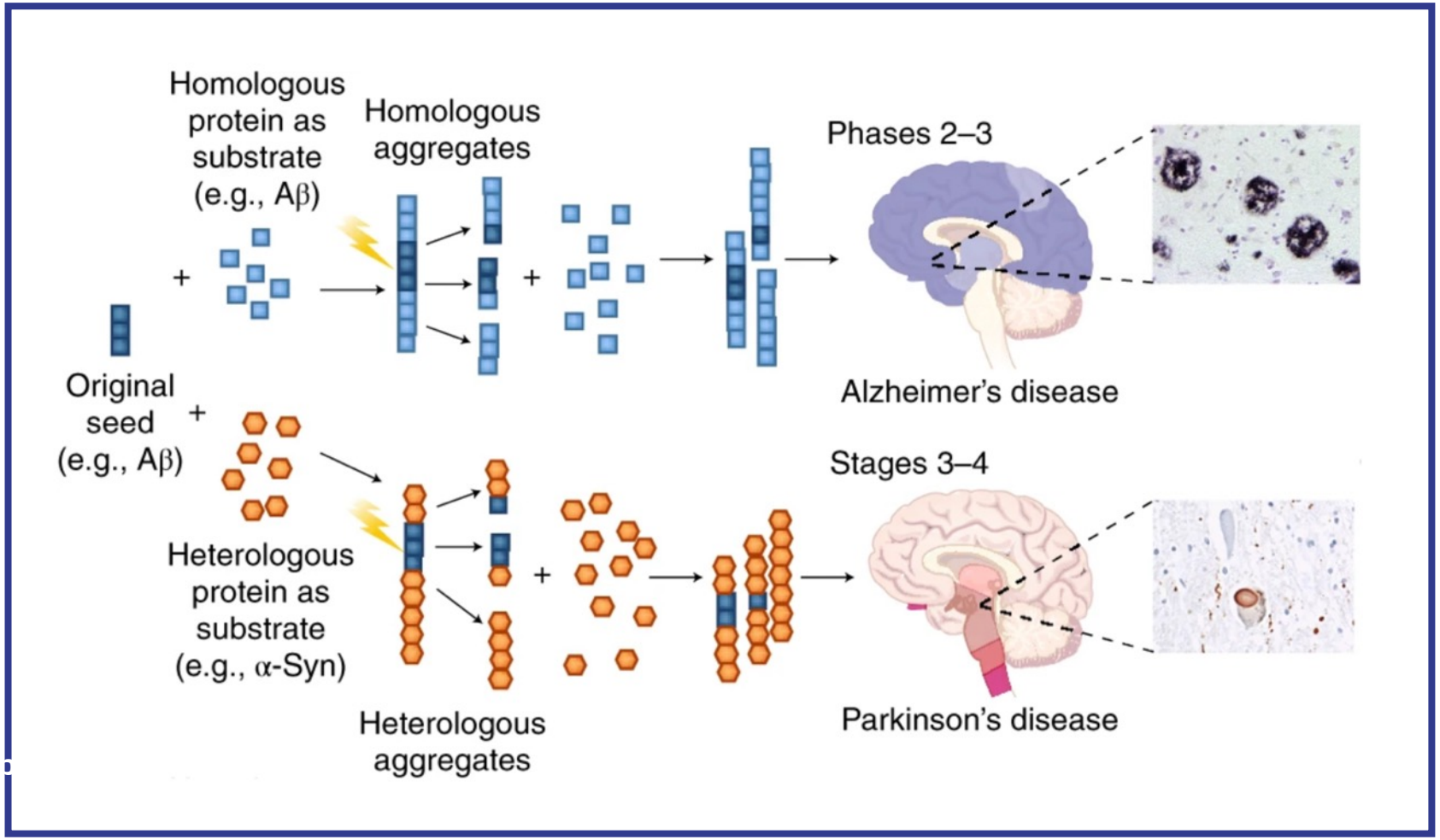
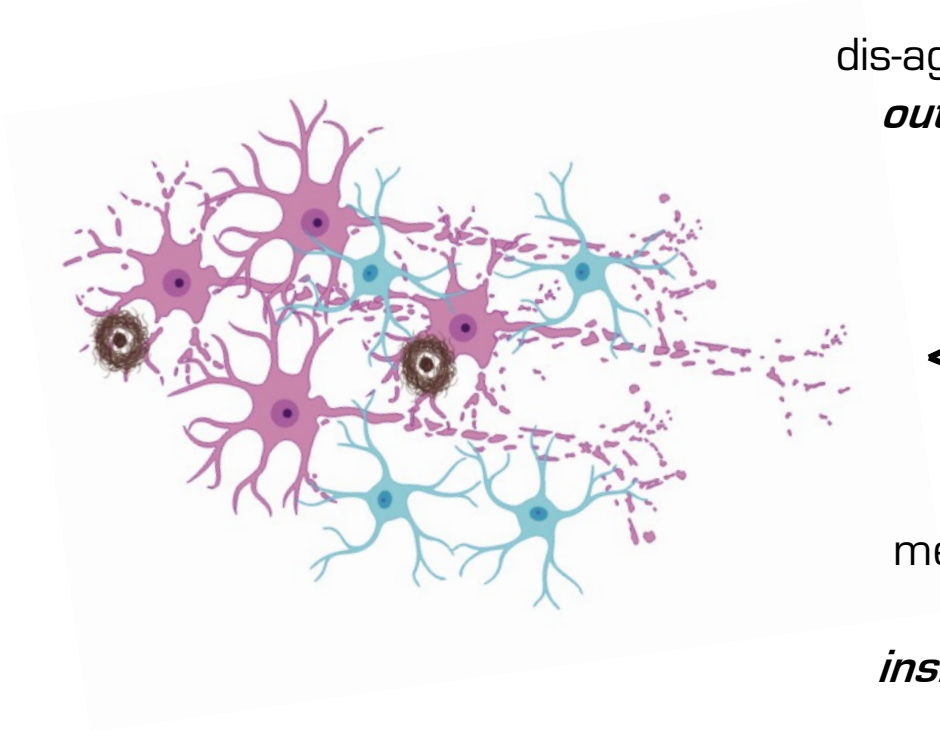
Different proteins, similar pathological effect

**β-amyloid and Tau in Alzheimer's**

**α-synuclein in PD, MSA, DLB**




[1]Nat. Neurosci. 21: 1332-1340 (2018)



antibody or
dis-aggregator targets plaque
***outside*** affected neurons

→ Clearance of pathological plaque unknown
NOT restorative

mechanistic inhibitors
target plaque
***inside*** affected neurons

→ Does clear pathological plaques
CAN BE restorative

- Risvodetinib, an inhibitor of c-Abl

# How does Risvodetinib work?

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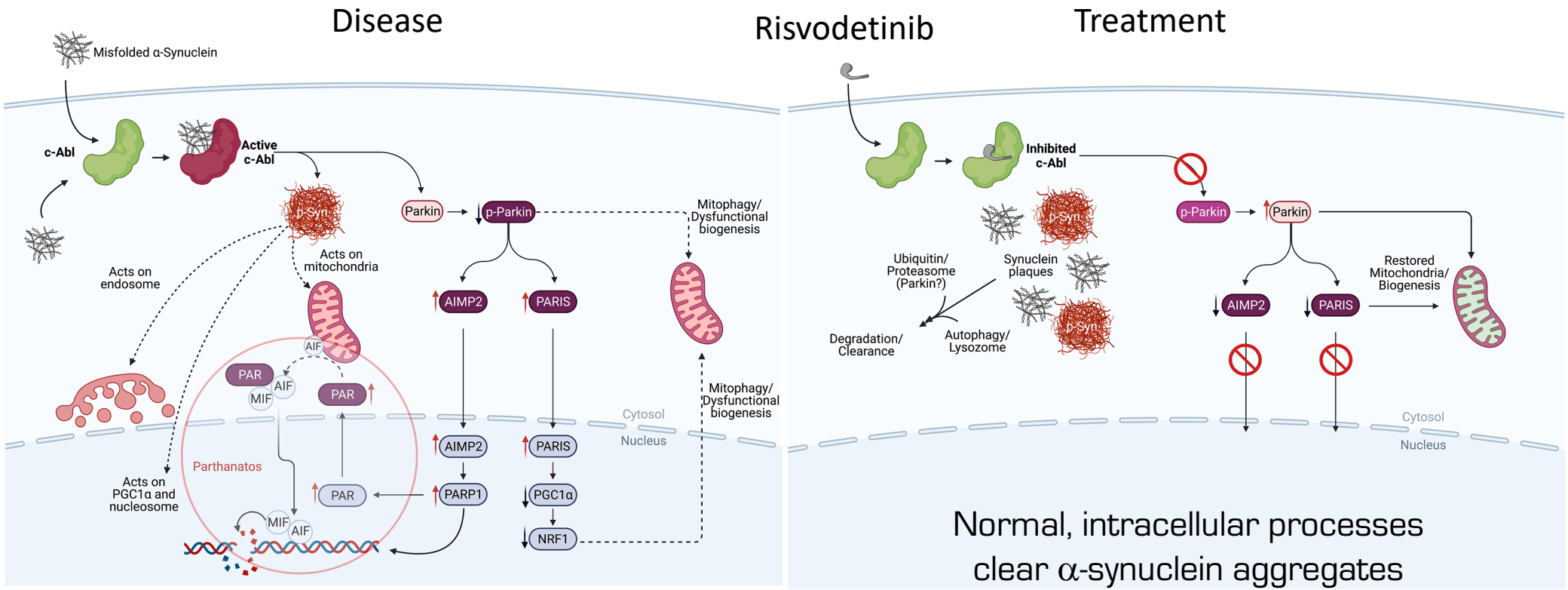
# Biochemistry of disease initiation and its treatment response[1]




[1]Werner and Olanow **37**, 6-15 (2022)

# c-Abl inhibition by Risvodetinib restores lost function in Validated Animal Models of Parkinson's disease[1]

**Neurodegeneration**

Risvodetinib

**preserves as much as 85% of brain neurons**

**Motor Dysfunction**

Risvodetinib

**restores as much as 90% of lost function**

**α-Synuclein Toxicity**

Risvodetinib

**clears to baseline in the organs of disease**

**Neuroinflammation**

Risvodetinib

**suppresses to near baseline in the organs of disease**

[1]Werner and Olanow , Mov Disorders 2021, doi: 10.1002/mds.28858
Karuppagounder, Werner, et al., Sci Transl. Med 2023 doi: 10.1126/scitranslmed.abp9352

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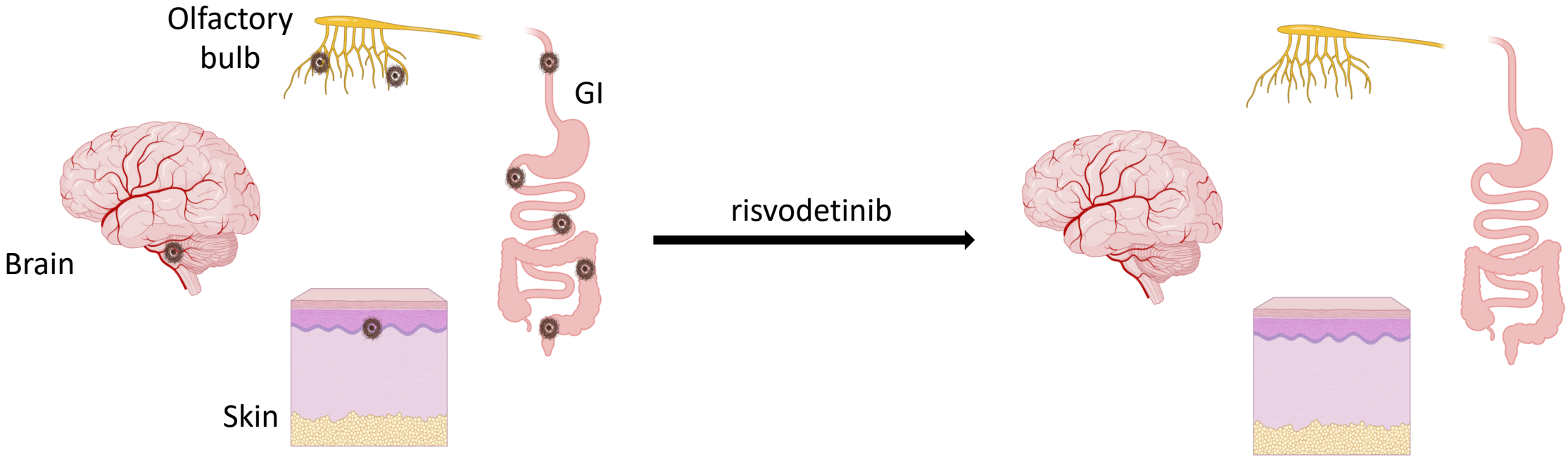
# c-Abl inhibition by Risvodetinib clears plaques systemically and restores lost function in multiple organ systems in validated animal models




[1]Werner and Olanow , Mov Disorders 2021, doi: 10.1002/mds.28858

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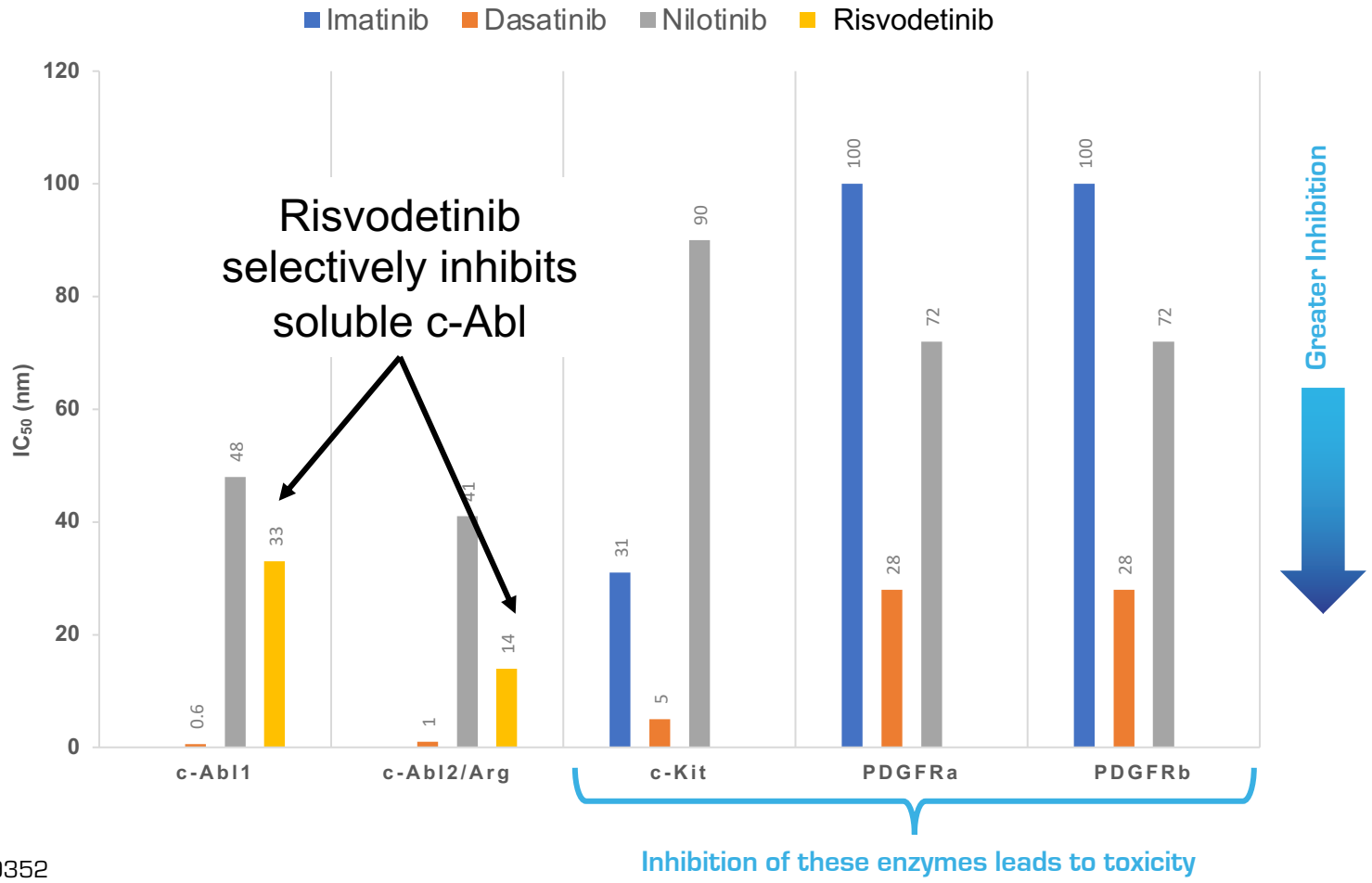
# Risvodetinib for Treatment of Parkinson's and Related Disorders

# Risvodetinib is Low Toxicity, Selective, Brain Penetrant c-Abl Inhibitor

- **Selective Inhibitor of c-Abl1 and Abl2/Arg**
- **Design suppressed toxicity of cancer drugs in this class**
- **Low or no apparent organ toxicity**
- **High brain penetrance**




[1]Karuppagounder, et al., (2023), DOI: 10.1126/scitranslmed.abp9352

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# Demographics Across 119 Healthy Subjects and Parkinson's Patients

| Category | Demographic | Healthy Subjects Value (% of Total N=94) | Parkinson Patient Value (% of Total, N=25) |
|---|---|---|---|
| **Gender** | Female | 36 (37.9) | 9 (36) |
| | Male | 58 (61.1) | 15 (60) |
| **Age** | Average (SD) | 57.9 | 61.9 |
| | Median | 58.0 | 63 |
| | Range | 40, 70 | 48, 71 |
| **Ethnicity** | Hispanic or Latino | 14.9 (14.8) | 4 (16) |
| | Not Hispanic or Latino | 80 (85.1) | 20 (80) |
| **Race** | Black or African American | 55 (58.5) | 3 (12) |
| | White | 37 (39.4) | 20 (80) |
| | Other | 2 (2.1) | 0 (0) |
| **Adverse events** | | 13, none clinically significant, only 9 possibly drug related | 12, none clinically significant, only 5 possibly drug related |

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| Category | Dose mg | Dose Duration | # Occurrences Healthy Subjects (N=94) | # Occurrences PD patients (N=25) | Severity |
|---|---|---|---|---|---|
| Cardiovascular | | | | | |
| | 75 mg | Single Dose | 1 Palpitations[1] | | Mild |
| Gastrointestinal | | | | | |
| | 325 mg | Single Dose | 2 Diarrhea | | Mild |
| | 100 mg | 7-day, 1x/day | | 1 Constipation[2] | Mild |
| | 100 mg | 4 wk, 1x/day | | 1 Elevated Amylase/Lipase[3] | Moderate |
| | 200 mg | 7-day, 1x/day | 1 Elevated Lipase[5] | | Mild |
| | 50 mg | 4 wk | | 1 Gastric pain[4] | Mild |
| | 50 mg | 4 wk | | 1 Nausea[4] | Mild |
| Dermatological | | | | | |
| | 50 mg | 7-day, 1x/day | | 1 Dermatitis | Mild |
| Musculoskeletal | | | | | |
| | 200 mg | 7-day, 1x/day | 5 Myalgias, joint pain, fatigue,edema[5] | | Mild |

[1]Appeared 2 weeks post-dose, no clinical basis found even after following by 3-day Holter monitoring; [2]Appeared one day after last dosing day; [3]Amylase and Lipase abnormalities were asymptomatic. Patient reported regular consumption of alcohol prior to the baseline visit and while enrolled in the trial; [4]Single occurrence on first dose; [5]Five AEs in a single subject, mild severity. Lipase elevation occurred on one day of a 7-day dosing period.

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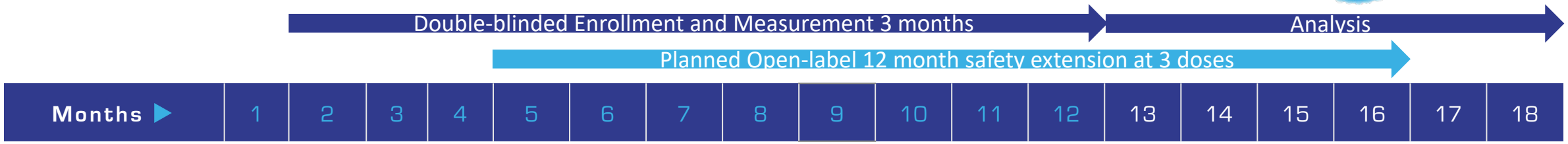
# CLINICAL PHASE 2: the '201' Trial 3 doses




**Double-blinded: 3 Month Dosing Across 3 Doses**

| | |
|---|---|
| Primary: | Safety/Tolerability |
| Secondary: | MDS-UPDRS II+III |
| | PGI-S |
| | CGI-S |
| | MDS-UPDRS II |
| | MDS-UPDRS III |
| | MDS-UPDRS I |
| | Non-motor Symptom Scale |
| | CSBM |
| | Epworth Sleepiness Scale |
| | GI Measures |
| Exploratory: | Skin α-synuclein aggregates |
| | Seed amplification assays (proprietary) |

**12 Month Extension Study: Quarterly Assessments**

| | |
|---|---|
| Primary: | Safety/Tolerability |
| Secondary: | MDS-UPDRS II+III |
| | PGI-S |
| | CGI-S |
| | MDS-UPDRS II |
| | MDS-UPDRS III |
| | MDS-UPDRS I |
| | Non-motor Symptom Scale |
| | CSBM |
| | Epworth Sleepiness Scale |
| | GI Measures |
| Exploratory: | Skin α-synuclein aggregates |
| | Seed amplification assays (proprietary) |
| | Time to supportive medication start |
| | Time from diagnosis to supportive medication start |

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## Double-blinded: 12 Weeks Dosing Across 3 Doses

- Participants have Untreated Parkinson's Disease with measurable disability
- Enrollment Status
  - 32 of 34 sites enrolling
  - 30 enrolled, 12 in screening, 13 in consent as of December 4, 2023
  - >165 leads through the201trial.com
  - Top-line readout 2H24

## Planned 12-month extension

- Participants remain on same dose assigned for 12-week study
- Placebo moves to 200 mg
- Will measure time to initiation of dopamine replacement, if initiated
- Could overlap with Phase 3 program
- Full readout:  2025

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| Assessment[1] | Mean Change from Baseline @ 4 weeks | | | | Mean Change from Baseline @ End of Study | | | |
|---|---|---|---|---|---|---|---|---|
| | 50 mg N=3 | 100 mg N=2 | 200 mg N=2 | Placebo N=3 | 50 mg N=3 | 100 mg N=2 | 200 mg N=3 | Placebo N=3 |
| **PGI-S** | -0.33 | 0 | -1 | -0.33 | 0 | 0 | 0 | -0.33 |
| **CGI-S** | 0.33 | -0.5 | -2 | -0.33 | 0.33 | -2 | -0.67 | -0.33 |
| **PDQ-39** | -1 | 0 | -3.5 | -8.3 | -0.67 | 0 | -1.67 | ND |
| **UPDRS II** | -0.33 | 1 | -0.33 | -0.66 | -0.33 | 0 | -4.33 | 0 |
| **UPDRS III** | 0.33 | -1 | -4 | -0.33 | 2 | -1.33 | -4.33 -10.4 | 1.7 |
| **II + III** | 0 | 0 | -4.3 | -0.99 | 1.67 | -1.33 | -8.67 | 1.7 |
| **NMSS** | -1.33 | -2 | -0.5 | 0.66 | -3.67 | -1 | 1 -6.6 | 0 |
| **S&E ADL** | 0 | 0 | -5 | 6.7 | 0 | -5 | -3.33 | 3.33 |
| **ESS** | ND | ND | ND | ND | -0.33 | -0.5 | 1.67 | -1 |

[1]Lower numbers (or negative changes) may suggest improvement

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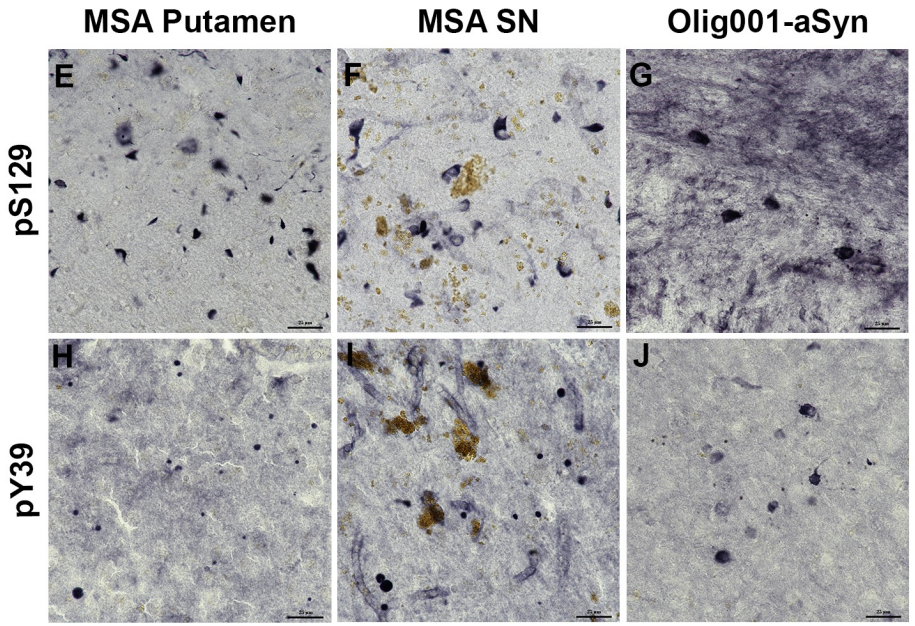
# c-Abl in other neurodegenerative disease

## MSA[1]




## AD

Prog Neurobiol. 2021;202:102031
Autophagy. 2021;17(5):1278-1280.
J Biol Chem. 2020 ;295(23):7905-7922
Front Cell Neurosci. 2019;13:526
Biochim Biophys Acta Mol Basis Dis. 2018; 1864(4 Pt A):1148-1159
Biomol Struct Dyn. 2017;35(4):883-896
J Alzheimers Dis. 2016 ;54(3):1193-1205
PLoS One. 2014 ;9(3):e92309
Curr Alzheimer Res. 2011;8(6):643-51.
Neurobiol Aging. 2011;32(7):1249-61.
J Alzheimers Dis. 2011;25(1):119-33.
J Alzheimers Dis. 2010;19(2):721-33.
J Alzheimers Dis. 2009;18(1):1-9
J Alzheimers Dis. 2009;17(2):409-22
Brain. 2008;131(Pt 9):2425-42
Neurobiol Dis. 2004;17(2):326-36
Proc Natl Acad Sci U S A. 2003;100(21):12444-9.

## ALS

J Neurol Sci. 2018;393:80-82
Sci Transl Med. 2017;9(391):eaaf3962
Front Cell Neurosci. 2015 9;9:203
PLoS One. 2012;7(9):e46185

[1]Marmion, Werner, Kordower et al, (2021) Neurobiol Dis 148:105184

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# IkT-001Pro for Treatment of Stable-Phase Chronic Myelogenous Leukemia

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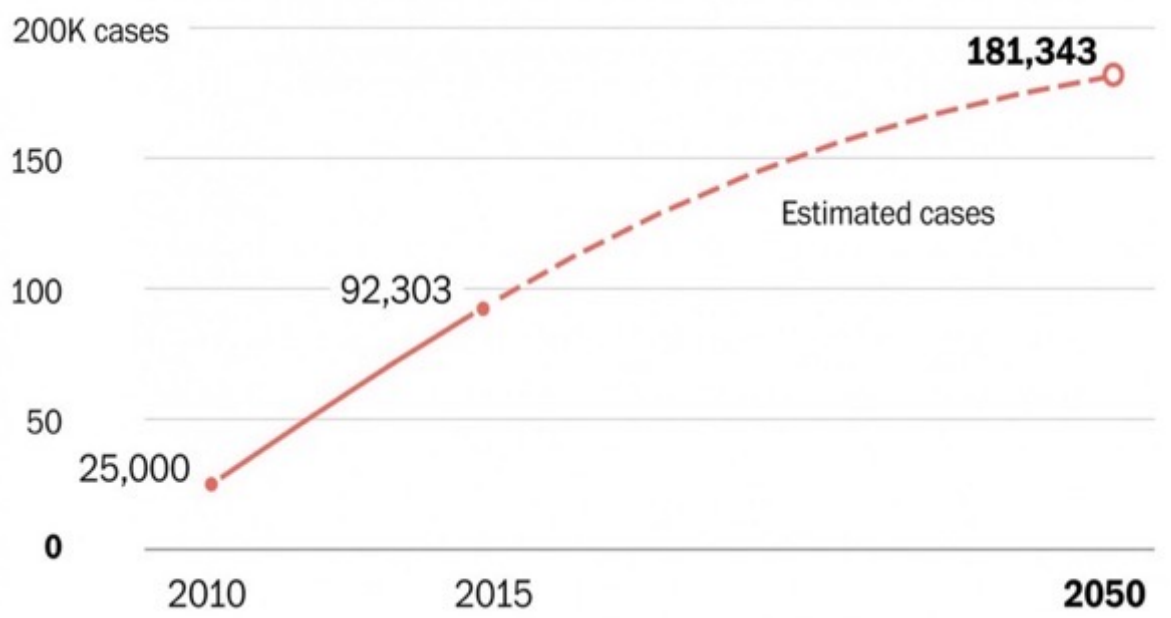
# CML in the U.S.[1] Accessible Market Opportunity Despite Presence of Generic Gleevec®

## Prevalence of Chronic Myeloid Leukemia in the U.S.




- Patients commonly switch due to intolerance or lack of response[3]
- Intolerance to Gleevec® occurs in 30% of patients, leading to lack of treatment compliance and relapse[4]
- Second generation treatments have severe adverse events (i.e. Sprycel® or Tasigna®)
- Best approach: reduce Gleevec® side effects

[1]Jabbour E, Kantarjian H. Am. J. Hematol. 89:548–556
[2]IMS-Iqvia retail sales data 2016-2020
[3]Am J. Hematology (2019) 94:46-54
[4]Annals of Hematology (2018) 97:1357–1367

- **$330.5 million in net U.S. Sales for branded and generic Gleevec®[2]**
- **> 57% market share Generic Gleevec®**
- **50% of recipients experience Grade 2 GI adverse events**

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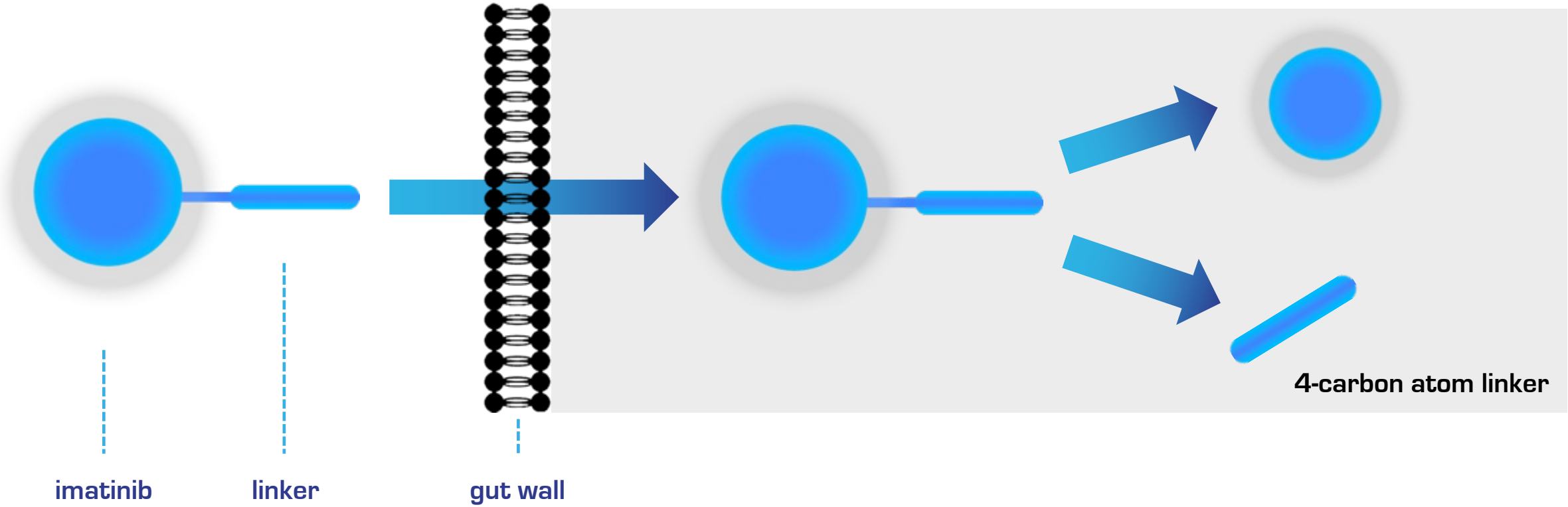
# IkT-001Pro releases the active ingredient imatinib only in blood




**pH 2-6**
(stomach, ileum, duodenum)

**pH 7⁺ (blood)**
**Lifetime in blood < 10 min**

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## IkT-001Pro:
# Lower GI Toxicity Alternative to Generic Gleevec®

**Measurement of IkT-001Pro in Non-Human Primates**

| | No Adverse Event Level (mg/kg) **NOAEL** | Cmax (mean, ng/mL) | Tmax (mean, h) | $AUC_{0-T}$ (mean, ng-h/mL) |
|---|---|---|---|---|
| **Imatinib (Day 91)[1]** | 15 | 176/206 (M/F) | 4/3 (M/F) | 1540/1960 (M/F) |
| **IkT-001Pro (Day 28)** | **75** | 400/318 (M/F) | 5.3/3.7 (M/F) | **5220/3890 (M/F)** |

[1]FDA summary data for approval 21-335

**RESULTS SUGGEST THAT:**

- ✓ Achieve dose flexibility, including use of higher dosing due to lower AEs
- ✓ Suppress GI and other adherence-related adverse events

**NO ADVERSE EVENTS**

**Up to 3.4x**
higher dose of imatinib delivered as 001Pro

**Up to 3.4x**
increased exposure

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# Clinical Development of IkT-001Pro: Summary

- 600 mg IkT-001Pro bioequivalent to 400 mg imatinib mesylate
  - Only 25 mild adverse events observed across 58 participants, 12 each for prodrug and standard-of-care
  - IkT-001Pro showed less inter-patient variability and longer rise time to maximum plasma concentration relative to 400 mg imatinib mesylate
  - Mean $C_{max}$ and $AUC_{0\text{-}inf}$ 16% higher than standard-of-care
- 900 mg IkT-001Pro bioequivalent to 600 mg imatinib mesylate ('high dose imatinib')
- Pre-NDA meeting January, 2024

# Clinical Development of IkT-001Pro: Adverse Events

| Category | # Occurrences IKT-001Pro (N=64)[1] | # Occurrences 400 mg imatinib mesylate (N=55)[1, 2] | Severity |
|---|---|---|---|
| **Ocular** | 1<br>Dry eyes | | Mild |
| **Gastrointestinal** | 5<br>Gassy, bloated, abdominal discomfort or loose stool | 3<br>Loose stool, reduced appetite, nausea | Mild |
| **Respiratory** | 1<br>Labored breathing | 1<br>Labored breathing | Mild |
| **Dermatological** | | 1<br>Itchy ankles | Mild |
| **Musculoskeletal** | 5<br>Myalgias, joint pain | 6<br>Myalgias, joint pain | Mild |
| **Neurological** | | | |
| | 2<br>Headache | 2<br>Headache | Mild |
| | | 1<br>Anxiety | Mild |
| | | 1<br>Sleepiness | Mild |

[1]One subject accounts for 14 of the 25 adverse events observed; 6 of the total events on IkT-001Pro and 8 of the total events on 400 mg imatinib mesylate; [2]The 300 mg 001Pro cohort did not have a 400 mg imatinib mesylate comparator (N=3)

| Category | # occurrences 800 mg IkT-001pro[1] (n=8) [1] | # occurrences 600 mg imatinib mesylate (n=8)[1] | Severity |
|---|---|---|---|
| **Gastrointestinal** | 2<br>Sporadic loose stool | 1<br>Nausea | Mild |
| **Neurological** | | 1<br>Loss of appetite (7 days) | Mild |

[1]800 mg IkT-001Pro studied, 900 mg computed equivalent dose

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# Selected Financial Data

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# Selected Financial and Stock Data

| Capitalization Table | October 4, 2023 |
|---|---|
| Common Shares Outstanding | 6,174,280[1] |
| Options (WAEP: $12.04) | 835,913[1] |
| Warrants (WAEP: $7.64) | 2,266,136[1] |
| **Fully Diluted Shares Outstanding** | **9,276,329[1]** |

$20.8M non-dilutive grant revenue pre-IPO (NIH, DoD, State govt's)
[1]Reflects 1:6 reverse split effectuated June 30, 2023

| Balance Sheet | September 30, 2023 |
|---|---|
| **Current Assets:** | |
| Cash, Cash Equivalents, Marketable Securities | $16,831,569 |
| Accounts Receivable | $0 |
| Prepaid research and development | $347,565 |
| Prepaid expenses and other current assets | $371,538 |
| **Total Current Assets** | **$17,550,672** |
| Total Current Liabilities | $2,741,806 |
| Working Capital | $14,808,866 |
| Active grant funding available in accounts held by the U.S. treasury | $0 |
| **Total Working Capital + Available Grant Funds** | **$14,808,866** |

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# Management Team with Deep Experience in Drug Development and Commercialization

## Milton Werner, PhD
**President & CEO**

Previously, Dr. Werner served as Director of Research at Celtaxsys. From September 1996 until June 2007, Dr. Werner was a Head of the Laboratory of Molecular Biophysics at The Rockefeller University in New York City. Throughout his scientific career, Dr. Werner has been an innovator integrating chemistry, physics, and biology into a comprehensive approach to solving problems in medicine. Dr. Werner is the author or co-author of more than 70 research articles, reviews, and book chapters and has given lectures on his research work throughout the world.

## Joseph Frattaroli, CPA
**Chief Financial Officer**

Mr. Frattaroli is a certified public accountant with more than 15 years of experience in public company filings and compliance for Nasdaq and OTC Markets companies. Previously, he provided chief financial officer and consulting services for several emerging biopharmaceutical and medical device companies, with responsibilities that included capital formation, deal structuring, and assisting private companies in their transition to becoming publicly traded SEC registrants.

## C. Warren Olanow, MD,
**Medical Consultant**
**and Chief Executive Officer of Clintrex Research Corporation**.

Dr. Olanow is the former Henry P. and Georgette Goldschmidt Professor and Chairman of the Department of Neurology at the Mount Sinai School of Medicine  Prior to joining Mount Sinai, he served on the faculties of McGill University, Duke University, and the University of South Florida. He is the former President of the Movement Disorder Society, past President of the International Society of Motor Disturbances, and former Treasurer of the American Neurological Association. He has served on the executive committee of the Michael J. Fox Foundation Scientific Advisory Board, and he is the former Chairman of the Scientific Advisory Board of the Bachmann-Strauss Parkinson Foundation and of the Dystonia Foundation. Dr. Olanow is the former Co-Editor-in-Chief of the journal Movement Disorders. Dr. Olanow received his medical degree from the University of Toronto, performed his neurology training at the New York Neurological Institute at Columbia Presbyterian Medical Center at Columbia University, and undertook postgraduate studies in neuroanatomy at Columbia University and authored more than 600 articles in the field of neurodegeneration.

Inhibikase Therapeutics

## Mr. Dennis Berman

- Co-founder, board member, and/or seed investor in many private biotechnology and technology companies, five of which have gone public.
- Currently serves as the President of Molino Ventures, LLC a board advisory and venture capital firm and was co-founder and Executive Vice President of Corporate Development of Tocagen.
- Seed investor, co-founder, and/or board member of Intervu, Kintera, Inc., Gensia, Calabrian

## Dr. Milton H. Werner, PhD

- President & CEO, Inhibikase Therapeutics, Inc.

## Ms. Gisele Dion

- Senior Vice President, Chief Accounting Officer and Corporate Controller at Takeda Pharmaceutical Ltd
- Senior Advisor to the Chief Financial Officer of Takeda Pharmaceutical Ltd.
- Vice President, Chief Accounting Officer and Corporate Controller at Shire Pharmaceuticals LLC,
- Corporate Controller and Senior Director of Technical Accounting at Biogen Inc.,
- Currently Director and Audit Committee Chair, Cytek Biosciences, Inc.
- Staff Member of the Financial Accounting Standards Board (FASB)
- Audit Advisor Group Member for the Pharmaceutical Research and Manufacturers of America (PhRMA).
- B.S. in Accounting and Management Information Systems from Fairfield University

## Dr. Roy Freeman, MD

- Professor of Neurology at the Harvard Medical School and Director of the Center for Autonomic and Peripheral Nerve Disorders in the Department of Neurology at Beth Israel Deaconess Medical Center
- Former chairman of the World Federation of Neurology research group on the autonomic nervous system, former President of the American Autonomic Society, and former chairman of the Autonomic Section of the American Academy of Neurology.
- Editor-in-Chief of Autonomic Neuroscience: Basic and Clinical and on the editorial boards of The Clinical Journal of Pain, Pain: Clinical Updates, and Clinical Autonomic Research.
- Serial founder of several companies in pain and neurodegenerative disease and is on the scientific advisory boards of many large and small pharmaceutical and biotechnology companies.

## Dr. Paul Grint, MD

- 20+ years experience in biologics and small-molecule research and development, including the successful approval and commercialization of products in the infectious diseases, immunology, and oncology therapeutic areas.
- Director of Amplyx Pharmaceuticals and Synedgen.
- Served in senior management roles at Cerexa, Forest Laboratories, Kalypsys, Pfizer, IDEC Pharmaceuticals, and Schering-Plough Corporation.
- Fellow of the Royal College of Pathologists and a medical degree from St. Bartholomew's Hospital College, University of London.

Inhibikase Therapeutics

## Dr. Robert Hauser, MD
Professor of Neurology, University of South Florida College of Medicine - Director USF Parkinson's Disease and Movement Disorders Center

## Dr. Jeffrey Kordower, PhD
Founding Director
ASU-Banner Neurodegenerative Disease Research Center (NDRC)
The Charlene and J. Orin Edson Distinguished Director at the Biodesign Institute
Professor of Life Sciences
Arizona State University

## Dr. Ken Marek
President and Senior Scientist, Institute of Neurodegenerative Disorders

## Dr. Ted Dawson, MD, PhD
Neurodegeneration and Stem Cell Programs, Institute for Cell Engineering, Departments of Neurology, Physiology, Pharmacology, and Molecular Sciences - The Johns Hopkins University School of Medicine

## Dr. Valina Dawson, PhD
Neurodegeneration and Stem Cell Programs, Institute for Cell Engineering, Departments of Neurology and Physiology
The Johns Hopkins University School of Medicine

## Dr. Warren Olanow, MD, FRCPC
Henry P. and Georgette Goldschmidt Professor and Chairman Emeritus, Mount Sinai School of Medicine
CEO, Clintrex Research Corporation

## Dr. Karl Kieburtz, MD, MPH
Robert J. Joynt Professor in Neurology, Senior Associate Dean for Clinical Research, Director of the Clinical &Translational Science Institute, Founder Center for Human Experimental Therapeutics (CHET)- University of Rochester Medical Center
President Clintrex Research Corporation

## Dr. Jay Pasricha, MBBS, MD
Director, Johns Hopkins Center for Neurogastroenterology
Professor of Medicine