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PRESENTATION

Operator

Good day, ladies and gentlemen. Welcome to the Onconova Therapeutics full year 2016 earnings conference call.

(Operator Instructions)

As a reminder, this conference call is being recorded. I would now like to turn the conference over to Lisa Sher. You may begin.

Lisa Sher - *MBS Value Partners - IR*

Good morning. Welcome to Onconova's full-year 2016 earnings call and webcast.

(Operator Instructions)

Please note that the remarks today will include forward-looking statements and actual results could differ materially from those projected or implied in our forward-looking statements.

For a description of important factors that could cause actual results to differ, we refer you to the forward-looking statements in today's press release and the note on forward-looking statements in the Company's SEC filings.

It is now my pleasure to turn the call over to Onconova's CEO and President Dr. Ramesh Kumar. Dr. Kumar, please proceed.

Ramesh Kumar - *Onconova Therapeutics, Inc. - CEO, President, Co-Founder*

Thank you, Lisa. Good morning. Welcome to our full-year 2016 results call. Joining me from Onconova's management team is our Chief Financial Officer, Mark Guerin.

2016 was a very productive and transformational year for Onconova. We are excited about 2017 as we anticipate multiple key milestones in the advancement of our lead clinical candidate rigosertib and innovation for the treatment of patients with myelodysplastic syndromes also known as MDS.

We made significant progress in advancing our late stage clinical trials in 2016 as we seek to address the needs of growing and underserved MDS market. Enrollment for our targeted Phase III pivotal study of IV rigosertib in second line higher-risk MDS is proceeding on track and towards interim analysis.

We are continuing to move the oral formulation of rigosertib towards a pivotal Phase III study in frontline MDS following positive Phase II results and a productive end of Phase II meeting with the FDA last September. We also begin 2017 with a cash position sufficient to support the advancement of our clinical programs this year. Rigosertib is currently partnered only in Japan and Korea, and we are encouraged by the interest from potential partners for other territories.

Before I update you on our clinical program, I would like to explain why we believe MDS represents a compelling market opportunity and what differentiates Onconova in our quest to bring a new product for MDS patients to market.

Our late stage trials are investigating rigosertib as a potential therapeutic for higher-risk MDS or HR MDS, which are a rare group of cancers affecting bone marrow blood cells, both approved products for HR MDS are hypomethylating agents, or HMAs.

Our lead candidate has a differentiated mechanism of action as published last year in the prestigious journal, Cell; rigosertib exerts its anti-cancer activity by targeting RAS effector pathways, which play a key role in regulating cell growth and malignant transformation. We believe this mechanism may have therapeutic potential for many other indications including acute myelogenous leukemia, AML in the future.

MDS is a growing and underserved market with more than 17,000 patients in the U.S. with higher-risk MDS. Despite the large number of MDS patients and the unmet need, there have been no new FDA approved treatments for higher-risk MDS in more than a decade. The current standard of care consists of HMAs, which only work for a subset of patients and are not curative, in addition to carrying significant side effects.

Higher-risk MDS patients who fail to respond to HMAs typically have life expectancy of four months to six months, and there are no FDA-approved second line treatments. Our Phase III trial, the INSPIRE trial is seeking to show that IV-administered rigosertib has the potential to be an effective life extending second line therapy for MDS patients, for whom HMAs have failed.

The INSPIRE study design permits two shots on goal with the data. Rigosertib could be approved based on overall survival, achieving statistical significance in the intent to treat ITT population or in a subgroup of patients classified as having very high-risk MDS or VHR MDS as defined by the IPSS-R, International Prognostic Scoring System-Revised scoring system.

The INSPIRE trial is highly targeted and was designed based on data from our previous Phase III ONTIME trial, which was published last year in the journal, Lancet Oncology. This study help defined subgroups of patients who appear to experience improvement in the primary endpoint of overall survival, meaning life extension is possible from rigosertib IV treatment.

The INSPIRE pivotal trial is a global project. Currently Onconova has activated sites in 16 countries on four continents. Multiple sites are open in each country including 39 in North America. Our partner, SymBio Pharmaceuticals of Tokyo has open an additional 33 sites in Japan under the same INSPIRE protocol.

We expect the trial to be active in 19 countries in the second quarter following the activation of sites in Switzerland and the Netherlands. Trial sites have been activated in a staggered fashion with the first sites in the U.S. The first patient was enrolled at the MD Anderson Cancer Center in December of 2015 followed by the first patient in Europe in March in Austria and in Japan in July 2016.

Due to the lessons learned from our ONTIME experience, the INSPIRE trial is highly selective and requires us to search extensively to identify appropriate candidates meeting the stringent entry criteria. I would like to point out that the INSPIRE trial is supported by many key opinion leaders, KOLs in the MDS, including investigators from high- recruiting sites in the ONTIME trial.

These include Dr. Garcia-Manero from the MD Anderson Cancer Center, Dr. Lewis Silverman from Mount Sinai School of Medicine, Dr. Pierre Fenaux from Paris, and Dr. Al-Kali from the Mayo Clinic, highly experienced investigators from Israel, the UK, Canada, Australia and Japan, who were not

included in the ONTIME study are also participating in INSPIRE. We believe that the support of these investigators is an indication of the unmet medical need and strong rationale for rigosertib in this indication.

The primary efficacy endpoint of the INSPIRE trial is overall survival, which will be evaluated first at an interim point, which will be reached after 88 death events. Topline analysis will be performed after 176 events. At both points, the results of the entire study population and a pre-specified subgroup of patients with very high risk VHR MDS will be analyzed.

In addition to survival analysis at two intervals, the study design incorporates multiple periodic Drug Safety Monitoring Committee evaluations. The first of these DSMC assessments was successfully completed last November.

Pre-planned interim analysis is currently on track and is expected to occur in the second half of the year. Full enrollment is expected by the first quarter of 2018 or sooner if enrollment further accelerates with all sites active from the second quarter of 2017.

Final data is anticipating in 2018, allowing for filings globally, if all goes to plan, this could position us for U.S. commercial launch in 2019. With very limited, to no options available for patients, we believe that adoption of the drug could be rapid as we expect this orphan opportunity to represent a compelling commercial opportunity worldwide.

While the Phase III pivotal study of IV rigosertib in second line higher-risk MDS patients continues towards results, we are moving on our oral formulation of rigosertib closer to a pivotal study in frontline MDS. Frontline MDS represents a much larger medical need and opportunity due to the larger number of patients and longer potential duration of treatment.

As we design the protocol for oral rigosertib in combination with azacitidine based on our dialogue with the FDA, we are encouraged by the positive Phase II results we reported at the American Society of Hematology, ASH Annual Meeting in San Diego last December.

The data showed that a complete remission rate among HMA naive higher-risk MDS patients was higher and with faster responses with oral rigosertib combination versus single agent azacitidine without substantially changing the adverse event profile.

At the time data was compiled for our presentation, 76% of available patients responded to the combination therapy, including 85% of HMA naive patients and 62% of HMA resistant patients, the 21% of the patients displaying complete remission. Importantly the complete remission rate was 35% in frontline and 8% in second line patients. The complete remission rate and immediate CR duration of eight months in patients with the treatment na.ve MDS compares very favorably to azacitidine.

Based on this encouraging data and our successful end of Phase II meeting with the FDA, we are advancing our oral formulation of rigosertib towards a pivotal program in frontline patients. The pivotal trial will be designed as a 1:1 randomized placebo controlled trial of oral rigosertib plus azacitidine, compared to azacitidine plus placebo.

We plan to use full dose of azacitidine, as defined in the product insert. The primary endpoint will be composite of complete remission plus partial response rates, CR plus PR.

We expect to submit the trial protocol for review by regulatory agencies in the U.S. and Europe in the second or third quarter of this year through the special protocol assessment mechanism of the FDA in scientific advice mechanism of EMA prior to commencing the trial. Notably during our meeting with the FDA, we were able to determine that the expected endpoint for the upcoming combination Phase III trial will be related to response rather than overall survival which should reduce the cost and duration of the trial. Since all study patients will be receiving an approved or experimental treatment, we expect enrollment to be relatively fast. Further details, including sample size and other criteria will be available post regulatory review, anticipated in the second half of 2017.

While the pivotal trial is being designed, the participating sites in the Phase II trial have agreed to expand the trial cohort with the view of providing interested patients access to the therapy; we plan to use the expanded cohorts to explore dose optimization by varying the timing and dose of oral rigosertib to achieve optimization of tolerability and efficacy.

In addition to our clinical trials with rigosertib, we are excited about two pipeline compounds in pre-clinical trials for which we will present data at the upcoming American Association of Cancer Research or AACR annual meeting on April 3rd. The data relates to ON 123300 a first in class dual inhibitor of CDK4/6 and ARK5 in breast cancer. A compound is comparable to palbociclib, Pfizer's Ibrance, a blockbuster agent.

The other agent for which we will present data is ON 150030 a dual inhibitor of Flt3 and Src kinases, both validated targets for treatment of AML and other cancers. ON 150030 is a Type I inhibitor, which is differentiated from a Type II inhibitor such as Quizartinib, that does not work against mutated kinases.

I will now hand the call over to our CFO, Mark Guerin for a discussion of our full-year financial results. Mark?

Mark Guerin - *Onconova Therapeutics, Inc. - CFO*

Thank you, Ramesh. Alongside making progress on our lead programs in 2016, we were able to reduce costs and secure the necessary funding from our oversubscribed rights offering in July to advance our pipeline in 2017.

At year-end our cash and cash equivalents totaled $21.4 million compared to $19.8 million at December 31, 2015. We believe that our current cash and cash equivalents will be sufficient to fund our ongoing trials and operations into the fourth quarter of 2017.

Our net loss was $19.7 million in 2016, compared to $24 million in the prior year, primarily due to the change in fair value of warrant liability related to warrants issued in our rights offering.

Our research and development expenses were $20.1 million for the full-year, compared to $25.9 million a year earlier and full-year general and administrative expenses were $9.2 million, down from $9.5 million in 2015.

I will now hand the call back to Ramesh for his closing remarks.

Ramesh Kumar - *Onconova Therapeutics, Inc. - CEO, President, Co-Founder*

Thanks Mark. We had a very productive year in 2016, reporting promising data on our late stage trials, securing the funding necessary to advance our pipeline in 2017, and positioning Onconova for multiple key milestones this year.

We look forward to presenting updates on our advanced trials and collaboration this year and to presenting non-clinical data on pipeline compounds at multiple conferences starting with the upcoming AACR and European Hematology Association meetings.

2017 represents a crucial year in our clinical development. We expect interim analysis of our INSPIRE pivotal trial for second-line higher-risk MDS in the second half of the year and full enrollment by the first quarter of next year. We also look forward to finalizing our protocol for the pivotal Phase III trial of oral rigosertib in combination with azacitidine for first line MDS patients after review by regulatory agencies during the second or third quarter of this year.

I am pleased with our achievements and grateful to our investigators, patients, and team members who are helping to make these advances for the unmet needs of MDS patients. We are excited about the opportunities for Onconova in the year ahead and look forward to updating you periodically on our progress. I'd now like to open the call to questions.

QUESTIONS AND ANSWERS

Operator

(Operator Instructions). The first question is from Jason McCarthy of Maxim Group. Your line is open.

Jason McCarthy - *Maxim Group - Analyst*

Good morning, guys. Thanks for taking the questions. Ramesh, maybe you can walk us back through or remind us where is the enrollment in the INSPIRE study now? What are the powering assumptions in the trial? What's the delta in overall survival that you would expect?

And what I'm really getting at is that 88 events mark the data to be significant enough to stop the trial?

Ramesh Kumar - *Onconova Therapeutics, Inc. - CEO, President, Co-Founder*

Thank you, Jason. Very, very insightful set of questions.

I can say first of all, that we are not at this time disclosing actual numbers of patients and there are two reasons for that. One is simply comparative. There's a lot of activity in our field. And secondly, since all of our sites are not active, it's probably unfair for the -- yet to be active sites to know too much about where we are. All we can say is that we are on track to deliver interim analysis this year.

Second question you had is to do with the powering and the deltas. As you know, we are fortunate in some ways to have conducted a full randomized study in a very similar patient group, the ONTIME study of 300 patients to 99 patients. And the data published in Lancet Oncology allowed us to confirm what was believed to be the survival of MDS second line patients.

There was a range of about four months to seven months. We confirmed that the range is actually more like four months to six months. Further we confirm that the higher the risk status by the IPSS scoring system, the lower of the survival expectation of the patients. Therefore, we were able to develop a hypothesis for our new trial, the INSPIRE trial.

The INSPIRE trial hypothesis is to shoot for an HR of 0.625 or 37.5% improvement in survival and so that's our ITT expectation, and what we have agreed with the FDA is that we will shoot for p-value of 0.04 and also do a subsequent analysis that's necessary, which will focus on the very high risk group, where we will shoot for a p-value of 0.01.

Why these hypotheses and why these expectations? These are all driven from our previous data. As I mentioned published in Lancet Oncology, where we had very robust survival improvement in the corresponding groups, doubling or more benefit to sub-groups of very high risk patients and a very robust survival benefit to the ITT groups of the new trail. I hope that's answers all of your questions?

Jason McCarthy - *Maxim Group - Analyst*

Thank you. And for the doubling, the oral rigosertib plus azacitidine, I know you're putting the protocol together, I guess depending on if its second and third quarter for submission to the FDA for approval, how long after that do you think you'd be able to initiate that study? Thanks.

Ramesh Kumar - *Onconova Therapeutics, Inc. - CEO, President, Co-Founder*

There are two factors to that. As in the script that I read there is a lot of interest for our frontline patients to get something better than HMAs. So our ability to continue expansion of the cohorts reflects that interest. So the investigator interest is there worldwide, for example we will probably add more countries in the new pivotal trial -- countries which are not included in INSPIRE and were definitely not included in the ONTIME trial.

So the second factor of course is financing. As you know, we are committed to deliver milestones on our IV rigosertib trial. At this point, the exact starting date and the scope and the size of the trial will be discussed in future earnings calls or in future meetings.

Jason McCarthy - *Maxim Group - Analyst*

Okay, great. Thanks for taking the questions.

Operator

Thank you. The next question is from Yale Jen of Laidlaw. Your line is open.

Yale Jen - *Laidlaw & Company - Analyst*

Good morning. Thanks for taking the questions. The first question is that would that be a hypothesis using or actually -- that MDS, is a very diverse file, a heterogeneous group of patients and therefore sometime patient need a more specific treatment versus across the board treatment at least on the second line settings, which is probably the crux of your approach to be potentially successful?

Ramesh Kumar - *Onconova Therapeutics, Inc. - CEO, President, Co-Founder*

Thank you, Yale. That's really the crux of the issue and unfortunately we learned this through our topline ONTIME data and what we found out is that even though all of the patients in the trial qualify to the ONTIME eligibility criteria, which is that they must have been treated previously by with HMAs. We found out that there was way too much heterogeneity.

So the major challenge in INSPIRE was how could we reduce that heterogeneity, increase the homogeneity of the INSPIRE population. I think we have been successful as shown by a couple of things. One, when we conduct an analysis of the old data, using the new parameters, we see quite encouraging and quite substantial improvement in survival in those cohorts.

Secondly, as we screened for patients from the beginning, our first patient at MD Anderson, we found out that we have substantially increased the homogeneity, reduced the heterogeneity, but by the fact that more of the patients appear to be similar in their outcomes and in their outlook.

Yale Jen - *Laidlaw & Company - Analyst*

Okay, great. That's very helpful. And get to the oral drug in combination study that Phase II data obviously was very, very impressive both from ORR as well as for CR perspective particularly from CR.

So value proposition here is to really hopefully move that to -- the pivotal study hopefully move that up compare to what the current HMA agents. That will be the key sort of value proposition as you see it?

Ramesh Kumar - *Onconova Therapeutics, Inc. - CEO, President, Co-Founder*

Yale, thank you.

As you know, HMAs were the first and unfortunately the only approved agents for MDS today, high risk MDS today, and when you look at the MDS patients heterogeneity and if you look at the mutations that they carry, there are two dozen of different mutations, only four or five of them are methylation mutations.

So what that means and the clinical data supports it is that is that these drugs that are effective only for a subset of HMA patients who are getting the drug. So if you look at overall response rate is in the 40% range at best if you look at complete remission, you are talking about single-digits, the Vidaza label says 6%, some people believe 6% to 10%, 12% is the complete remission rate for HMAs in the frontline setting.

So given that we felt that an agent, which affects other mutations, which addresses other problems that the MDS genome has, would be at the very least useful to patients who don't respond to HMAs and could be additive to HMAs, but what we found surprisingly through our own research and a patent that we have been issued is that our drug rigosertib when combined with azacitidine is actually synergistic, and we don't exactly know what's the basis of the synergism, but we see the proof of that synergism in our Phase I and Phase II trials that we've reported.

So thus we believe that this combination could represent a new paradigm for these patients and this could expand the utility of Vidaza combination to a much larger group of patients.

Yale Jen - *Laidlaw & Company - Analyst*

Okay, great. That's really helpful. And a last question here is on the competitive side that MDS does have a lot of competing program at this point, just overall would you maybe say or restate what you think will be the sort of benefits of this oral azacitidine combination over -- maybe some other progress currently also in mid to late stage of development? Thanks.

Ramesh Kumar - *Onconova Therapeutics, Inc. - CEO, President, Co-Founder*

Yale, as you know there are no oral medications available, which are approved for a higher-risk HMA patient. We know that Revlimid is available for del(5q) low risk patients as a small group, but in general MDS patients today don't have access to an oral therapy. So having an oral is a big deal because it's not only convenience, but it also allows them to comply with the therapy for a much longer period of time. So those are the advantages we think we have.

From a comparative landscape in the second line, we just don't see too much. As a matter of fact, we feel that we are the most advanced second line program. In the oral front line setting, you are right there are other approaches, but most of those approaches are also HMAs or hypomethylating agents.

So they don't represent new mechanism. So they won't be expected to be additive or synergistic. They will be just old versions of hypomethylating agents. Based on what we see in the landscape number of patients, potential duration of treatment. We think that oral rigosertib could be quite competitive and quite welcome for patients with MDS.

Yale Jen - *Laidlaw & Company - Analyst*

Okay, great. Thanks a lot and again appreciate the taking the questions.

Operator

Thank you. The next question is from Robert LeBoyer of Aegis Capital. Your line is open.

Robert LeBoyer - *Aegis Capital - Analyst*

Good morning. Congratulations on all the progress you've made. I just have a question for Dr. Kumar on the publications coming up in April at the meeting?

Could you just elaborate a little bit on the publications and what's discussed in the abstract if you could just add a little more to what's already in there without jeopardizing the presentation, some pointers to look for just a little elaboration that would be helpful.

Ramesh Kumar - *Onconova Therapeutics, Inc. - CEO, President, Co-Founder*

Thank you, Robert. As you know, there is an embargo, so I can't really discuss data. But I can give you some context.

Robert LeBoyer - *Aegis Capital - Analyst*

Yes. That would be great.

Ramesh Kumar - *Onconova Therapeutics, Inc. - CEO, President, Co-Founder*

One of the two presentations is in the area of CDK4/6 inhibitors, and these drugs are really taking cancer by storm. 2015 Pfizer launched Ibrance, the first second generation CDK4/6 compound. Currently the expectations are in 3 billion plus annual sales. Just a couple of weeks ago Novartis start approval for their CDK4/6 inhibitor in many analysts have that that to be the next billion dollar molecule.

So there is a strong interest in a great market potential for CDK4/6 compound. So what we have done is we've really created a third generation CDK4/6 compound. So our compound 123300 possesses the low highly important nanomolar activities at Ibrance or Kisqali, which is the Novartis drug have. In addition we've added engineered in a new specificity we have ARK5 or AMP regulated kinase 5 activity.

So the result of which we have publicly announced before is that our drug can work as a single agent, all of their CDK compounds required a second drug and enabling agent to be active. So we could good work single agent and the ARK5 target allows us to go beyond breast cancer.

We should be active in multiple myeloma. We should be active in mantle cell lymphoma and other hematological indication in addition to solid tumor.

Having said all of that, third generation molecules are new and it's going to take some time for us to define the right clinical mortality and as you know since we have focus our efforts to MDS and rigosertib, we are looking actively for partnerships on the 123300 molecule. Hope I answered your question?

Robert LeBoyer - *Aegis Capital - Analyst*

Yes. You did and gave some great detail. Thank you very much.

Operator

Thank you. (Operator Instructions). The next question is from Jerry Isaacson of LifeSci Capital. Your line is open.

Jerry Isaacson - *LifeSci Capital - Analyst*

Thank you. Good morning gentlemen, appreciate you taking the questions. The first thing I'd like to ask about Ramesh, if you could give a little bit more color on this expansion of the Phase II trial, where will be able to report any data from that and how many patients might you enroll and if they also want to confirm you said that these will be the same sites that you'll be using for Phase III?

Ramesh Kumar - *Onconova Therapeutics, Inc. - CEO, President, Co-Founder*

Thanks, Jerry. We will be presenting data because as you know we presented data as of August in the December ASH meeting and the lot of patients continue to beyond on the drug. So at the MDS Foundation meeting in May in Valencia, Spain and EHA meeting in Madrid, Spain in June, we expect to present additional data particularly focusing on AML patients in the Phase I/II trials.

So we will be continuing to present data including longevity of benefit, including duration of treatment and including continued response in the patients we will presenting all of the data. Now to your specific question about expansion cohorts, we are just trying to make best use of the time. As you know getting an SPA from the FDA takes time. It's just iterative process, there is a calendar set by law.

So we have the time. We have the drug. We have the interested investigators. So yes, we will continue at the sites where we were open, but we actually plan to add more sites. We plan to add more sites in the U.S. and we plan to add more sites in Europe. And the reason again is that the doctors are really looking to improve on HMAs as soon as possible when the patients are willing to going into these trials where they won't be randomized to placebo control, everybody gets a drug.

So given that I think the two goals of our expanded access or expanded cohort program is to continue to study the drug, continue to see ways in which we could change the timing of the dosing in the patient since we have a BID dosing schedule twice a day capsules for rigosertibe are playing with how best we could give it to the patients, so that we could go into the pivotal trial, which is an important in a big undertaking for us, we can go in with their eyes wide open and with the best knowledge behind it.

Jerry Isaacson - *LifeSci Capital - Analyst*

Thank you. I really appreciate that. One more question speaking of the SPA. I wonder if you wouldn't mind expanding a little bit on the decision with -- inlaying your conversations with the FDA to use complete response or state of overall survival for the Phase III trial and I assume that will be part of your SPA negotiations?

Ramesh Kumar - *Onconova Therapeutics, Inc. - CEO, President, Co-Founder*

Thank you, Jerry. This was a breakthrough for us because as you know in the frontline setting, particularly in MDS and AML, FDA is always insisted on overall survival as the brass ring as the critical requirement and what we felt that doing that would really make this a very long trial, could take multiple years because frontline patients could live for a long period of time, which is great and we could further enhance their survival based on our IV expectation.

So we were able to talk to them about what they believe we felt the combination represented both mechanistically and both from the result that we had in hand and they agreed with us. They said, yes you could do a response based study and they specifically suggested that the response must be complete remission, CR plus partial remission, PR.

So it's not overall response, but response as I say objective response. So as you know in any trial, which is going to take one, two or more years to complete, then you go in with such a typical endpoint, it is best to nail it down and we think the SPA mechanism allows us to nail it down, get the FDAs written agreement that this is the approval endpoint and this is the expectation that we must meet to get the drug approved.

Jerry Isaacson - *LifeSci Capital - Analyst*

Great. Thank you very much. Appreciate that.

Operator

Thank you. We have another question from Yale Jen of Laidlaw. Your line is open.

Yale Jen - *Laidlaw & Company - Analyst*

Thanks to offer the follow-up -- Just follow that previous one, I just want to be confirming that the potential endpoint, Phase III endpoint is the response related to which will be CR plusPR, but do you call that -- so you may not call that ORR. But is that something else or -- and just want to be clarify on that?

Ramesh Kumar - *Onconova Therapeutics, Inc. - CEO, President, Co-Founder*

As I said, one way to look that it is objective ORR.

Yale Jen - *Laidlaw & Company - Analyst*

Okay.

Ramesh Kumar - *Onconova Therapeutics, Inc. - CEO, President, Co-Founder*

And when I say that in a typical ORR, you can include hematological improvement for example, or a change in hemoglobin for example, or increasing number of platelets for example and those are a little bit what I would say less than cut and dry objective criteria So FDA's asked us to focus only on the very objective CR plus PR.

Yale Jen - *Laidlaw & Company - Analyst*

So essentially this is a potentially much more stringent criteria, but if you are successful that you can translate both the patient benefits as well as potential market sort of a benefits compared to a different metrics measuring the outcome?

Ramesh Kumar - *Onconova Therapeutics, Inc. - CEO, President, Co-Founder*

Yes, I agree with you. Thank you. Obviously we will measure all of their outcomes in the patients.

Yale Jen - *Laidlaw & Company - Analyst*

Right.

Ramesh Kumar - *Onconova Therapeutics, Inc. - CEO, President, Co-Founder*

And we'll report that. For approval, you want it to be very clean and clear cut and CR plus PR allows us to go in that direction and since from your question and Jerry's question, I can see that it would be much better to really nail it down, and enhance the SPA mechanism you're seeking.

Yale Jen - *Laidlaw & Company - Analyst*

Okay, great. Thanks a lot. I appreciate for the conformation on that.

Operator

Thank you. And there are no further questions at this time. I'd like to turn the call back over to Ramesh for closing remarks.

Ramesh Kumar - *Onconova Therapeutics, Inc. - CEO, President, Co-Founder*

Thank you all for participating in this call and we will keep you inform the periodic updates at future earnings calls as well as conferences. I appreciate your interest and look forward to meeting with you and answering additional questions. Thank you and have a great day.

Operator

Thank you. Ladies and gentlemen, this concludes today's conference. You may now disconnect. Good day.