

# OBR Q&A WITH MICHAEL KING

Director of Research  
at Rodman & Renshaw

by Don Sharpe



Michael King

## Bio

Michael King is a biotechnology industry analyst with an interest and core competency in the field of oncology. In his career, Mr. King has held positions of increasing responsibility at several investment banks, including Bank of America Securities, Robertson Stephens, Vector Securities, and Dillon, Read and Company.

He was ranked 4th for his stock picking accuracy in the *Wall Street Journal's* annual "Best on the Street" survey in 2001 and was given the Institutional Investor Home-Run Hitter award in 2000 for his coverage of OSI Pharmaceuticals. He was most recently ranked as Number 11 in the Institutional Investor Poll of biotechnology analysts, and as a runner-up in the hedge fund subset of the poll.

**We interviewed Michael King about his perspectives on the oncology market and what his thoughts were for oncology in 2007. First let's discuss the industry as a whole and some of the broader topics we hear about.**

**OBR:** We see headlines all the time about oncology advances, many times very preliminary data leading to speculation that is not in line with market realities. As someone tracking the industry closely, especially the financial aspects of the industry, do you think there is too much hype in cancer drugs and markets?

**MK:** We have better, albeit not perfect, surrogates for activity for cancer drugs than we do for, say a schizophrenia or an Alzheimer's drug, for example. It takes a long time for something to show efficacy if it is not in the acute setting and scientists have to wait for those end points to incubate. That's why there is a perception that there is hype around cancer, but it is just the nature of how we gauge the activity of drugs in the space.

The other factor is that companies have gotten very aggressive about marketing their pipeline products earlier on in the development process. It used to be that they waited until they had some positive data to go on, but now even big pharma companies are touting their cancer development programs and very early-stage products; probably because they see a benefit in the image it gives them in a skeptical marketplace.

**OBR:** Some would say that oncology is the last growth segment of the pharmaceutical industry. Do you agree?

**MK:** I wouldn't say that at all. There is great potential throughout the industry—CNS and cardiovascular, for example, are two areas with enormous potential. That said, oncology is one of the more promising areas of research. It's no coincidence when you look at the proportion of companies in the biotech industry that cancer is a critical therapeutic category for the sector. I think that cancer is a very attractive space, because we're gaining knowledge about

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the molecular basis of the disease. As we learn these things, we're going to create new and better treatments.

**Before we dig into your perspectives on the oncology marketplace, we'd like to understand a little more about what you do.**

**OBR:** What are the criteria you evaluate when you are researching a company or the product that a company is developing, and how do you determine whether a product or technology is promising?

**MK:** My evaluations are all data-driven and to loosely generalize, it is a three-step process for us. But first, let me say that we strive to use the same objective criteria that a clinician would in evaluating prospects for a therapy. In this way, we're as close to the market as possible. We use two primary sources of information to formulate our opinions. The criteria are specific to the potential situation—one set of criteria for Avastin® in a front-line colorectal cancer study and a different set of criteria for Sutent® and Nexavar® in renal cell cancer. Then we speak with oncologists and work with any feedback we get from them regarding the merits of a particular drug: Is it a new chemical entity? How novel is this compound? Is this compound another way to replace Avastin or Herceptin® or will the new therapy be used concurrently with the current standard of care? Finally, we read the literature to gain an understanding of the different clinical settings to determine if the product we're evaluating has what it takes to compete and to get incorporated into the regimen.

**OBR:** Do you look at a company with proven research and commercial success differently from a company still in R&D without a marketed product?

**MK:** Yes and no. One thing we take seriously is having frequent interaction with companies we're covering so that we can understand their approach to the marketplace. A lot of the people who work at these smaller start-up companies cut their teeth at pharma companies or big biotechs, so they bring their experience and

knowledge launching drugs with those large companies. As opposed to some other disease areas it is relatively straightforward in the cancer space; it is a data-driven sell. And, because they need to address a relatively small number of doctors, a small company can compete almost as effectively as a large company.

**OBR:** We watched the recent crash of Telik with the announcement of their pivotal data being negative. How do you avoid a Telik?

**MK:** Mostly from talking to the market, the oncologists. They told us that this is another mustard. There wasn't any enthusiasm for the product in the market, and nobody seemed to be saying that the product had big approval potential. Another problem with Telik is that I think that people had a misunderstanding about just how long it takes to do a study. Again, you have to do your research to understand the potential successes and the potential pitfalls in the oncology market.

**And now let's dig into some of the nuances of the oncology marketplace.**

**OBR:** How seriously do you take the reforms underway at CMS when evaluating an oncology company and their products?

**MK:** You have to take it very seriously. CMS pays at least 50 percent of the bills, so you have to take any proposed reforms seriously. But I think the dialogue has been good. Most oncology practices seem to have figured out how to work in the new environment by reducing staff or running their operations more efficiently. The small, one- and two-man shops may have to reconsider their business plans. The reforms at CMS have been more on the margin than on whole tectonic shifts, making adoption to the new environment more palatable.

The oncology industry also takes its cue from Medicare. For example, the ability to use drugs off-label has been crimped pretty dramatically. Looking retrospectively at Rituxan®, I don't think it would be able to repeat its historic performance if it were launched in 2007. Oncologists were still in the adoption phase with Rituxan in the first-line [cont. on pg 20 >>](#)

setting and once the GELA data was presented at ASH in 2000 use of Rituxan exploded in spite of not having the indication.

Today, you pick up very little in the way of off-label use. You have to scrutinize your models very closely these days and make sure your penetration assumptions for additional indications are timed as precisely as they can be. It used to be that a favorable presentation at ASH or ASCO was money in the bank. Because of the changes at CMS in the oncology environment the data presented at those meetings are not as influential as it used to be.

**OBR:** How do you explain the odd economics of the cancer drug market? The cost of cancer drugs is under intense scrutiny, and yet the demand for these drugs does not seem to be letting up. Is this because people will pay, and because insurance companies are forced to pay for anything that extends patients' lives, even if it's just for a few more months?

**MK:** Companies have to be proactive about addressing the pricing issue before the government imposes pricing restrictions on them. Now, pricing restrictions are imposed de facto by both Medicare and by private payers, but if we keep pushing the limit there will be a push back felt by all the companies marketing and developing cancer drugs.

The higher the cost of the therapy, the greater the rationale for payers to try to apply some sort of cost-benefit analysis. The cancer industry doesn't grow by leaps and bounds; it more typically grows incrementally. There are certain therapies that are big breakthroughs, but they are the exception rather than the rule. The incremental four-and-a-half months that Avastin adds to the lives of patients in first-line colorectal cancer is a breakthrough, but that's only if you're able to afford it. I don't think the economics are sustainable if you keep someone on two years worth of Avastin and Folfox after surgery if it's going to cost \$100,000 a year.

**OBR:** Have drug companies finally reached the limit of what they can charge for new cancer drugs? Following its approval for a new indication for NSCLC, for example, Genentech instituted a price cap for Avastin (\$55K/per year). Before that, Amgen decided to price its colon cancer drug, Vectibux™, at 20 percent less than ImClone/BMS's competing drug, Erbitux®. Might this signal a possible trend in lower drug pricing, particularly if the government intervenes and can negotiate directly with manufacturers due to a Democratic congress?

**MK:** I think price caps are a good idea, for a variety of reasons. In today's market, there's an immediate reluctance to start using new agents as they're labeled because of the perception that they are very expensive. Because of this perception, the uptake typically starts in a third-line or salvage setting. For example Avastin was predominantly used in the third-line setting in colorectal cancer initially, even though it wasn't indicated and wasn't going to be very effective in third-line. It was a way for docs to use it and to provide patients with treatment options who most likely weren't going to be on it for very long. With a price cap, docs can write prescriptions for Folfox plus Avastin knowing that the patient's out of pocket costs could be limited to a certain amount, and that patients have ways to address that cost through private insurance or charitable donations. Any easing of the "expensive drug" perception will make an oncologist less reluctant to write that script.

**Finally, let's look into '07 and what we might be able to say about oncology companies and products.**

**OBR:** We hear talk about a softening economy in 2007 and that big biotechs say a market cap of more than \$10 billion is the safest place to invest. Any thoughts?

**MK:** I like big biotech. I like Genentech, certainly a big biotech, because of its fundamentals and projected growth in lung [cont. on pg 22 >>](#)

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and breast cancer. My big reason for liking Genentech stock this year is for Lucentis®. It's clear to me that Lucentis is a drug that could eclipse a billion dollars in less than two years on the market. I focus more on the stock. From an industry perspective, everyone is interested in Avastin, but at the end of the day I have to decide whether Avastin is going to be sufficient to drive the stock.

I am also watching ImClone on what we perceive as underappreciated data from Erbitux. If you put the CRYSTAL data into context, you realize that not only is it a viable competitor, but the distance between Erbitux and Vectibix I think will be more graphic at ASCO '07. Another big biotech stock I think people are going to get excited about this year is Celgene because of the performance of Revlimid®.

**OBR:** You've named some of the big companies in the oncology space that we're all familiar with, so what about some of the smaller oncology focused companies that aren't necessarily on the radar screen?

**MK:** I'm hesitant to discuss companies we're not covering because I'm not as familiar with them, but as far as our coverage it was an exciting year for Allos and for Kosan. We like Allos, because they are not trying to create and develop a new entity, but instead are developing a derivative of a product that is already having a successful commercial impact. Another one we're going to look at this year is Cytokinetics and their product Ispinesib. They just initiated a development program for Ispinesib, which may offer the potential of lower incidence of toxicities compared with existing cancer drugs.

**OBR:** We talked about the crowded oncology development marketplace, some challenging environmental factors such as CMS reform and legislative efforts, and perhaps reaching a point where the market cannot bear the expense of the drugs. Would you then describe oncology as a "slow" venture capital market in '07?

**MK:** I wouldn't describe the oncology sector as "slow" but I wouldn't say it is fast either. I don't know the exact numbers to work from, but I don't see a lot of new start-ups beginning new targeted therapy development programs. It's just not a hot space now because of the competition. You can't be the fourteenth company developing a targeted therapy without having something that clearly differentiates you. Instead it's easier to develop a methotrexate derivative and hopefully show that it is more active and better tolerated. Once they bring the drug into a single indication, that's when they can bring the train up behind them.

**OBR:** Another rumor we hear is that pharma is on the prowl for takeover candidates as their pipelines aren't as robust as they want them to be. Do you think '07 will be a "take-over" year?

**MK:** Yes, I believe it could be. The environment seems appropriate, there is a lot of pressure to perform, and without knowing of any particular take-over examples I wouldn't be surprised if we saw more take-over activity in '07 than we have in previous years. **DS**

### >> OBR DAILY NEWS FLASH

**January 18** - The American Cancer Society (ACS) reported a drop in the cancer death rate for the second year in a row: More than 3,000 fewer Americans died from the disease in 2004 than in 2003. Cancer epidemiologists hailed the statistics as "a milestone in the war on the disease" (*Washington Post*).