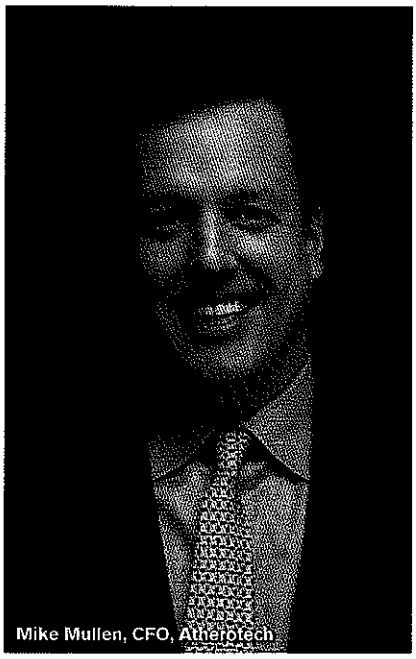
Mike Mullen, CFO, Atherotech

# Atherotech: Raising the Cholesterol Testing Bar

## Building on existing technology, Atherotech seeks to make its Vertical Auto Profile (VAP) cholesterol test a medical standard

Any company deciding to make its mark in the world of medicine has a tough task ahead of it. In 1996, a group of private investors acquired the assets of Birmingham, Alabama-based Atherotech and, more importantly, the rights to a different kind of cholesterol test, called the Vertical Auto Profile (VAP), developed by Dr. Jere Segrest of The University of Alabama at Birmingham's Atherosclerosis Research Unit in the early 1990s. The goal: to create a new standard in lipid and cholesterol testing.

Whenever an accepted method, technology or product in the clinical diagnostic market exists—in this case the Standard Lipid Panel, developed in the early 1970s—changing the habits or mindsets of users can be tough. After almost a decade of building the business and awareness around the VAP, Atherotech now has less than a half-percent of the Standard Lipid Panel market share. That may not seem like great progress, but it translates out to monthly use by more than 15,000 different doctors nationwide, from Alaska to Miami to New York City, and, as CFO Mike Mullen points out, Boise, Idaho.

We spoke with Mullen about what differentiates the VAP test, how the company grew its market and what the future might hold for Atherotech.

**COB: Can you tell us about the current state of Atherotech's operations?**

**Mike Mullen:** In addition to our 30,000-square-foot laboratory facility in Birmingham, Alabama, which houses the bulk of our 160 employees, we have a smaller research-and-development technology center in Southern California.

**COB: Why did Dr. Segrest develop the VAP test? How does it differ from other cholesterol tests on the market?**

**MM:** He developed it because he saw a clinical need for a deeper understanding of bad and good cholesterol. While the current Standard Lipid Panel accurately measures HDL, or good cholesterol, and triglycerides, the LDL, or bad cholesterol, isn't measured, but calculated. The VAP test is a directly measured Standard Lipid Panel. It's more accurate in the case of elevated triglycerides and less expensive than typical multiple tests.

The VAP test not only directly measures those basic standard lipid components, but it also measures more detailed clinically relevant subclasses. For example, you may find that a patient has a high HDL. That's good, but there's a component within HDL—called the large buoyant HDL, or HDL 2—that many clinicians believe to be the most important piece. The VAP technology measures these components, whereas the Standard Lipid Panel doesn't. The same is true for LDL. Overall, the test measures cholesterol subclasses that play important roles in the development of heart disease and other states, such as secondary diabetes. These subclasses—all contained within one test—indicate different disease states and treatment paths. This additional information allows doctors to improve the detection of heart disease risk from about 40% to 90%, and provides a foundation for patient-specific treatment plans.

**COB: You've used the term "medical inertia" in describing what it takes to have the VAP diagnostic become more accepted. Can you explain that?**

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**MM:** First, you have Standard Lipid Panel technology that's been around for 30 years. It is one of many diagnostic tools and bits of information used by the clinician. Doctors also use family history, high blood pressure and many other tests to arrive at the patient's diagnosis. The VAP test is a newer technology with information that is more familiar to the lipid specialist or cardiologist, and not the general physician population. As such, they may not have a thorough understanding of the test. Our strategy has been to employ cardiologists, lipidologists, and even endocrinologists to help educate the physician on the lipid subclasses—not about VAP, but the subclasses and their clinical relevance. That education then opens the door to the VAP and allows us to ensure the doctor has access via the major lab distribution channels.

The other challenge has been reimbursement. Although Medicare and most of the BlueCross BlueShield organizations pay for our test, the multi-payer/administrator third party network is extremely complicated in that it is not necessarily standardized across the U.S. If an out-of-network HMO or PPO patient gets the test, there is a risk the patient may receive a bill from the provider. They'll then call the doctor to question this bill. This is not a seamless process, as it typically is with the current test. So, it requires service to the doctor to move things along. The doctor wants to close the patient's file and to not be bothered with these things; however, as awareness and greater acceptance occurs, this will change. Looking forward, we have to ensure the market we work in has access to the VAP.

**COB: Why did you decide to take the three-pronged approach of marketing to consumers, medical professionals and lab professionals?**

**MM:** It was really an organic growth. Early in the game, we started out marketing directly to consumers, believing they would ask their doctors for the test. Then we moved into having salespeople sell directly to doctors, as though we were an individual lab. In 2003, clinical demand was picking up. As a result, we began contracting with the labs—including two of the largest reference labs in the country—that had interest in adding the test to their accounts. As soon as we began working directly with the labs, a network that now includes over 200 regional and local providers, we hit the broad base of 15,000 physicians pretty quickly. By providing greater access, the labs helped ease the barriers we had in dealing directly with physicians. We were able to lay our technology on their infrastructure and get good connectivity, which meant doctors could get their information more quickly—usually within three days, depending on the electronic access the labs have—which had been an issue in the past.

**COB: Your website is set up similarly to that of many public companies–is that an eventual goal?**

**MM:** If we had a need for that type of financing, which we might in the future, it would be something that we would consider. We might want to implement a larger sales force or bring equipment directly into our lab partners' facilities. So if we had the need for several million dollars in growth capital, we would consider the public market. We do have plenty of debt capacity now—and going public can be costly—but if the need exceeded those capabilities, and we could demonstrate potential return, we'd do it.

**COB: Atherotech has raised nearly $30 million in financing since its founding. Are you in a place now where you can succeed without additional financing?**

**MM:** 'Success' is a relative term. Right now, we're cash-flow positive and we have capacity within our current credit facility, thanks to Compass Bank, so we can continue going on as we have. But if there was an opportunity that demonstrated valuable return, such as an acquisition or some other growth need, we'd go out and raise more. It has to make sense. It still comes back to return on equity.

**COB: Where do you see Atherotech five years from now?**

**MM:** I don't think of it as where Atherotech will be, but where the VAP will be. Our value should be based more on the VAP than on Atherotech as an entity. We're the company that delivers the test right now, but someone else might have the rights to the technology by then. Going forward, I see the VAP being a part of a broad offering within the diagnostic community. Think of it this way: Five years ago we were doing about 100,000 tests a year. Now we're doing better than a million annually. This includes clinical studies, pharmaceutical studies, physician and wellness channels. That half-percent market share we have now could easily be 4% by then. With the return on this technology and our margins, it will be a nice position to be in. ■

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