

# What happens when you evaluate 167 indications with the same effort as six?

- Partner** Epana Bio is a nine-person biotech developing targeted cell depletion therapeutics for autoimmune diseases. CEO Danny Wells needed to make one of the highest-stakes decisions in early-stage drug development: **which indications to pursue first.**
- Challenge** Indication selection comes down to a handful of familiar diseases assessed against the factors your bandwidth allows. You evaluate six indications and hope the right one was among them. The result is structural risk. **You miss strong signal, or walk into a crowded space.**
- Approach** Epana ran a comprehensive indication evaluation at a depth no database could structure and no general AI could reliably source. The output wasn't static. Danny could **challenge scores, shift assumptions, and pressure-test** the framework through iteration.
- Outcome** Epana **selected their lead indications with conviction**, and built the investor-ready narrative and evidence to raise capital. Danny could defend the decision because he'd pressure-tested the reasoning himself.

## Prioritization, unconstrained by bandwidth

Screened across clinical, competitive, and commercial fundamentals

167

Indications Evaluated

Proprietary, Epana-focused fit — the layer most evaluations never reach

25

Program-Specific Evaluation

Full commercial and strategic diligence to maximize long-term asset value

4

Shortlisted

Lead program designed — in a single platform, with refinement at every step

1

Optimized Basket



Danny Wells, PhD  
CEO, Epana Bio

“All the strategy that used to be proprietary to pharma — the ‘game within the game’ that actually drives strategic decisions — Sleuth made that accessible to a nine-person biotech. I think it's the most disruptive, amazing thing for small organizations like ours. A massive, massive unlock.”



# Seeing the full landscape reframed the decision

When Danny mapped indications against what actually mattered for precision cell depletion, mechanism-specific fit (e.g. target expression profiles, preclinical depletion evidence, autoantibody dependence) proved a more compelling driver than market size or unmet need alone. The ranking shifted. Crowded markets where his approach lacked a clear edge gave way to the specific indications Epana could dominate.

### Autoimmune Indication Prioritization

Datasets Uploads (7)

**General Indication Metrics**  
Complete  
Dataset Version 1.1  
Updated: Yesterday 2:15 pm

**Program-Specific Metrics**  
Complete  
Dataset Version 1.1  
Updated: 2 hours ago

Pinned Items (1/5)

#### Indication Scoring

Indication	5-year survival rate	Diagnostic clarity	Pharma deal count	Prevalence	Competition	Early signal potential	Biomarker availability	Target A fit	Target B fit
ITP	0.5	0.2	0.1	0.3	0.4	0.6	0.7	0.8	0.9
AIHA	0.4	0.3	0.2	0.4	0.5	0.7	0.8	0.9	1.0
WAIHA	0.3	0.4	0.3	0.5	0.6	0.8	0.9	1.0	1.0
SSC	0.2	0.5	0.4	0.6	0.7	0.8	0.9	1.0	1.0
SSc-ILD	0.1	0.6	0.5	0.7	0.8	0.9	1.0	1.0	1.0
SLE	0.2	0.4	0.3	0.5	0.6	0.7	0.8	0.9	1.0
LN	0.3	0.5	0.4	0.6	0.7	0.8	0.9	1.0	1.0
DLE	0.4	0.6	0.5	0.7	0.8	0.9	1.0	1.0	1.0
DM	0.5	0.7	0.6	0.8	0.9	1.0	1.0	1.0	1.0
IM	0.6	0.8	0.7	0.9	1.0	1.0	1.0	1.0	1.0
PM	0.7	0.9	0.8	1.0	1.0	1.0	1.0	1.0	1.0
IM	0.8	1.0	0.9	1.0	1.0	1.0	1.0	1.0	1.0
SJD	0.9	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
NMO	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
MG	0.8	0.9	0.8	0.9	1.0	1.0	1.0	1.0	1.0
AAV	0.7	0.8	0.7	0.8	0.9	1.0	1.0	1.0	1.0
IgAN	0.6	0.7	0.6	0.7	0.8	0.9	1.0	1.0	1.0
MN	0.5	0.6	0.5	0.6	0.7	0.8	0.9	1.0	1.0
AMR	0.4	0.5	0.4	0.5	0.6	0.7	0.8	0.9	1.0
IgG4-RD	0.3	0.4	0.3	0.4	0.5	0.6	0.7	0.8	0.9
RA	0.2	0.3	0.2	0.3	0.4	0.5	0.6	0.7	0.8
T2-high asthma	0.1	0.2	0.1	0.2	0.3	0.4	0.5	0.6	0.7
AD	0.2	0.3	0.1	0.2	0.3	0.4	0.5	0.6	0.7
UC	0.3	0.4	0.2	0.3	0.4	0.5	0.6	0.7	0.8

Can you add a column for pharma deal activity and populate for all indications?

Column Added: Pharma deal activity by autoimmune indication

Compare endpoint objectivity across renal indications X Add unmet need column X

Can you shorten the Indication Scoring graphic to be the top 20 overall by fit? >

Epana's indication prioritization workspace in Sleuth. A single environment for structured evaluation across 167 indications and 75+ metrics, with interactive follow-up questions, iterative refinement, and continuous analysis that builds on itself.



# Conviction strong enough to stake Epana's R&D trajectory on

Danny didn't just accept the initial outputs; he actively challenged them by adjusting the weights between biological fit, clinical viability, and competitive density. With every test, the analysis didn't break under scrutiny; it adapted. His skepticism continuously improved the model, sharpening the rankings until he could stake Epana's trajectory on the result. **You aren't just trusting a system; you are actively forging conviction.**

The screenshot shows a software interface titled "Autoimmune Indication Prioritization". It displays a table with columns C, D, and E. Column C is "@Competitive treatment landscape", D is "@Early signal potential", and E is "@Endpoint objectivity". The table contains several rows of text describing different aspects of the evaluation. A pop-up window on the left provides detailed information for the selected cell in column D, row 3, which is "Very High (proteinuria reduction is a recognized surrogate marker with large placebo-adjusted effects at ~9 months)". This pop-up includes a "Cell value" section, an "Explanation Summary", "Details", and a "Sources" section with links to various documents.

C	D	E
@Competitive treatment landscape	@Early signal potential	@Endpoint objectivity
High (only two approved add-on therapies, but >10 Phase 3 programs suggest rapidly expanding competition)	Low (composite endpoints like BICLA/SRI dilute early readouts; no fast, objective biomarker surrogate comparable to renal indications)	Low (registrational endpoints are composite response measures incorporating clinician assessments and patient status)
Low (FcRn category already commercialized with multiple approved entrants and additional blockers under FDA review)	High (MG-ADL is a central efficacy measure with demonstrated significant improvement vs placebo + SOC in controlled trials)	Low (key efficacy endpoints are functional symptom scales that are meaningful but fundamentally patient/clinician-reported)
Low (rapidly evolving market with multiple approved novel therapies and several late-stage programs approaching regulatory milestones)	Very High (proteinuria reduction is a recognized surrogate marker with large placebo-adjusted effects at ~9 months)	High (24-hour urine protein-to-creatinine ratio is a lab-measured quantitative endpoint; longer-term confirmatory eGFR slope adds complexity but remains objective)
Low (mature development paradigm with many standardized activity measures and extensive approved therapeutic options)	Medium (well-established composite indices and response thresholds can detect change, but subjective components introduce variability)	Low (composite scores are standardized and quantifiable but explicitly include patient and provider global assessments)

**IgA Nephropathy × Early Signal Potential**

Cell value: Very High (proteinuria reduction is a recognized surrogate marker with large placebo-adjusted effects at ~9 months, enabling feasible and quantifiable early-phase signal detection)

**Explanation Summary:** Proteinuria reduction (UPCR) is accepted by FDA/EMA as a surrogate endpoint in IgAN, enabling meaningful efficacy readouts at ~9 months rather than waiting for hard renal outcomes. Multiple Phase 3 programs have demonstrated large, reproducible effects on this marker.

**Details:** Sparsentan achieved -49.8% vs -15.1% UPCR reduction versus irbesartan at week 36 in PROTECT. Iptacopan showed 38.3% lower 24h UPCR vs placebo at Month 9 in APPLAUSE-IgAN. Nefecon demonstrated a 41% reduction in time-averaged UPCR between Months 12-24 vs placebo in NeflgArd. Beyond proteinuria, mechanistic biomarkers further strengthen early-phase confidence — iptacopan produced a median -97.6% reduction in urinary sC5b-9 at Month 9, and nefecon significantly reduced Gd-IgA1 and IgA-containing immune complexes by 9 months. Trial designs are streamlined: placebo-controlled, blinded, ~400-500 patients, with high-risk enrichment via proteinuria thresholds enabling larger effect sizes in early readouts.

**Sources**

- CKJ: sfae394.pdf, page 3
- JASN: APPLAUSE-IgAN interim analysis
- OPCO: IgA Nephropathy Primer, page 8
- Travere/VERA: 10-K filing, page 21
- Kidney360: kidney360-5-1881.pdf, page 2

Each cell in the evaluation links to structured reasoning and primary sources. Here, Epana's assessment of IgAN for early signal traces to Ph3 interim results across multiple programs, FDA/EMA surrogate endpoint acceptance, and clinical data.



# How Sleuth changed how Danny Wells and Epana make decisions

## Challenge faced:

Early-stage biotech teams evaluate a handful of indications they already know, against the subset of factors their bandwidth allows. **The constraint isn't intelligence, it's bandwidth.** The result is a decision shaped by familiarity rather than comprehensive analysis.

## Challenge faced:

An indication thesis gets developed, presented, challenged, and then the team is back to square one. New assumptions mean new research, new data dumps, new weekends in ChatGPT. The iteration that builds conviction feels so expensive you stop iterating. **Changing your mind costs more than staying wrong.**

## Challenge faced:

The competitive landscape analysis lives in one spreadsheet. The commercial assessment in another. The pharma pipeline mapping hasn't been started. Nothing connects, nothing compounds, and **every new strategic question starts from scratch.**

## A comprehensive decision space, not a familiar short list

Epana went from evaluating a handful of familiar indications to systematically assessing the full autoimmune landscape. The default posture flipped. Instead of starting narrow and hoping they picked right, they started comprehensive and narrowed with evidence. This created both internal conviction, and external conviction with investors.

## Conviction built through iteration, not a single pass

When the board pushed back, assumptions shifted, or new data emerged — Epana didn't start over. They refined in place. Danny could pressure-test the same analysis from a BD lens, a competitive lens, a clinical lens, a market access lens — the kind of multi-angle scrutiny that used to require assembling an expensive advisory roundtable. Each round of pressure-testing made the answer stronger, not just different.

## A compounding foundation, not disconnected projects

The indication prioritization didn't end with the decision. Epana extended the same foundation into competitive intelligence across 800+ assets, NPV modeling for shortlisted indications, pharma pipeline matching ahead of JPM partnering conversations, and polished materials for the fundraiser that followed. Each project that would have taken weeks was an afternoon's extension of work that already existed.