March 2016

Globe Small Cap Research, LLC

Company Report

OncBioMune, Inc. (OTC:OBMP)

Summary of Our Research Findings

- This report offers an analysis of OncBioMune Pharmaceuticals, Inc. We believe there is a positive risk/reward ratio to these shares at the current price.
- OncBioMune is a fully reporting early clinical stage pharmaceutical company developing a new type of cancer treatment based on a proprietary vaccine technology. The initial target market is prostate cancer.
- With very encouraging Phase 1 results, the Company is expected to soon announce details of its Phase 2 study.
- Approximately 230,000 new cases of prostate cancer will be diagnosed this year and there will be more than 28,000 deaths. Current treatments are lacking, especially for early stages cases. OBMP's prostate cancer vaccine can treat patients at any stage of the disease and, importantly, is specifically targeting the unaddressed early stage treatment market.
- Financing has recently been put into place, which should allow the Company to fully finance the Phase 2 clinical study.
- OncBioMune in March signed an agreement with Vitel Laboratorios S.A. de C.V. to establish a Joint Venture for the purpose of development and commercialization of ProscaVax for the Mexican and Latin American markets.
- With a total market capitalization of only about $25 million, the price of shares is very reasonable considering the potential size of the market opportunity and the likely positive news flow.
- In addition to its therapy for prostate cancer, the Company has an attractive pipeline, with its ovarian cancer therapy called OvcaVax, targeted transferrin transport technologies and biosimilars to approved drugs, including the blockbuster Abraxane.
- Over the coming weeks, we will be watching closely for news relative details of the pending Phase 2 trial.

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Report Contents:

Executive Summary

OncBioMune Pharmaceuticals, Inc., headquartered in Baton Rouge, Louisiana, is a fully reporting early clinical stage pharmaceutical company developing a new type of cancer treatment based on a proprietary vaccine technology. The Company's shares trade on the OTC Markets Venture Market (OTCQB), which is a mid-tier market above the Pink Sheets, but below national exchanges. With an approximate market capitalization of $27 million, we think the shares are less than fairly priced especially considering investors will likely be seeing details of two upcoming Phase 2 clinic studies over the coming months.

Phase 1 studies were a significant success with sound results and no adverse effects. The Company has received approximately $5.2 million from the Department of Defense Navy Cancer Vaccine Program and has recently signed a stock purchase agreement ($10.1 million) that will provide more than sufficient funding to get the Company through the upcoming Phase 2 clinical studies, one of which will be conducted in conjunction with Harvard Medical Centers and the other through a Joint Venture with Vitel Laboratorios in Mexico.

The Company's proprietary technologies, which are based on the first patented breast cancer vaccine, were created by Dr. Jonathan Head and Dr. Robert Elliott, the founders of the Company. The first product, called ProscaVax, is a cancer vaccine, which is considerably different than other products currently under development. The therapy can be administered at any stage of prostate cancer, including at disease presentation, whereas the only other approved prostate cancer vaccine therapy, Provenge, is approved for cancer that has spread beyond the prostate and into other parts of the body.

In this report we examine many of the drawbacks of the current prostate cancer therapies and discuss how many men are more afraid of the prostate cancer treatments than of the disease. Considering there are nearly 300,000 new cases of prostate cancer each year in the in the U.S. and that there will be slightly more than 28,000 deaths this year, we believe there is certainly room for innovative therapies, especially considering the drawbacks to current approved therapies we discuss in this report. If Phase 2 studies go as well as did the Phase 1 study, ProscaVax could develop into a revolutionary treatment potentially worth billions of dollars to a major pharmaceutical company.

In addition to its therapy for prostate cancer, the Company has an attractive pipeline, with its ovarian cancer therapy called OvcaVax, targeted transferrin transport technologies and biosimilars to approved drugs, including the blockbuster Abraxane. We recognize OncBioMune's vaccine technology as a "platform," for which the Company can modify the vaccine by bootstrapping different antigens to target different types of cancer.

We see the shares as less than fairly valued based on the market opportunity, what appears to be strong results from the Phase 1 study, the pending Phase 2 study, and finally due to the significant size of the market opportunity.

We do not believe that the vast majority of potential investors within the life sciences investing arena have ever heard of this Company. OncBioMune is only just now receiving exposure among the investment community as it has only been public since September of 2015.

As the word spreads relative to its innovative therapies and the pending Phase 2 study, we believe significant investor interest will likely result.

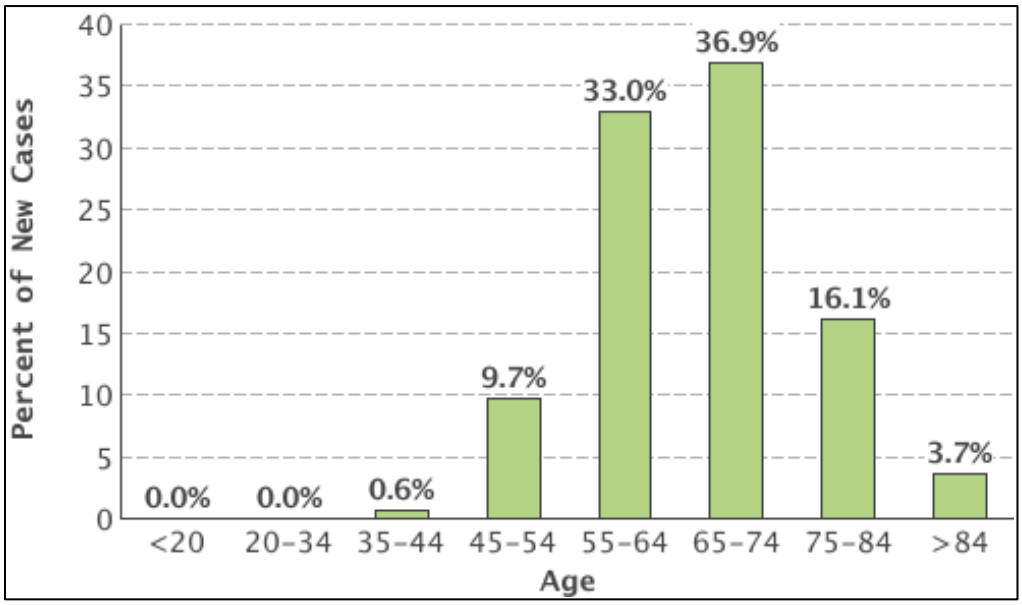
Background

Background on Prostate Cancer – Is an Effective Vaccine on the Way?

Considering that most investors in microcap growth companies are men over the age of 35, this report should be particularly interesting to the average reader. The subject is a potential new vaccine for various types of cancers, especially prostate cancer.

Prostate cancer is by far the most common cancer in North American men. While age is the most important risk factor for developing prostate cancer, it is not considered a rare cancer for any man over the age of 50 years old. However, more than 80% of all cases occur in men over the age of 65, as is outlined in Exhibit One. Unfortunately, the incidence of prostate cancer is approximately 40% higher for African American men compared to white men, and even more unfortunate, the mortality rate is approximately double. There is also some evidence of hereditary links to prostate cancer with increased risk for family members of roughly twice fold if a father or brother has, or has had, prostate cancer. It is estimated that approximately 10% of all new cases can be attributed to hereditary factors.

Exhibit One – Prostate Cancer Older Men, But on Exclusively



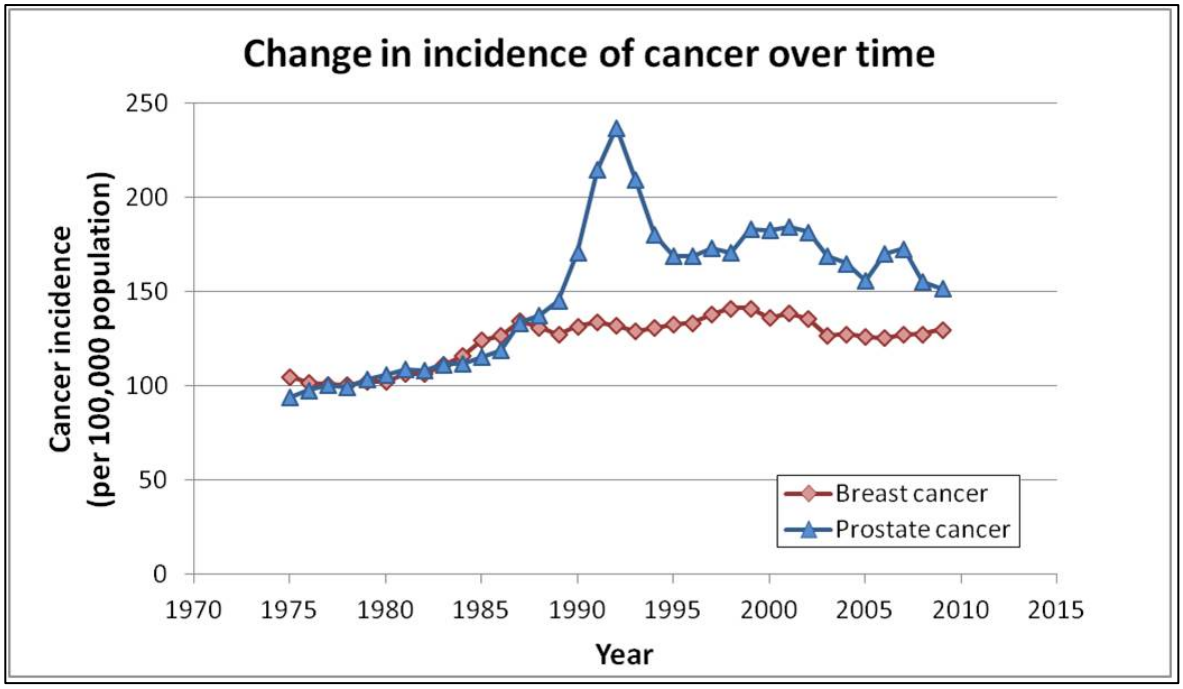
Source: SEER Cancer Statistics

The modern North American lifestyle is also a significant contributor to prostate cancer with most non-hereditary cases likely been caused by environmental factors such as a high-fat diet, excessive caloric intake, environmental pollution, and likely the most significant factor of all, a sedentary lifestyle.

Some of the statistics on prostate cancer are quite scary for most men over 50 years old. According to *SEER Cancer Statistics Review*, is estimated that there were approximately 230,000 new cases of prostate cancer in 2015, which equals approximately 13% of all cancers. These will result in approximately 28,000 deaths each year, or approximately 5% of all cancer deaths.

As is outlined in Exhibit Two, while prostate cancer rates are declining modestly, it is still estimated that approximately 14% of all men alive today in North America will be diagnosed with prostate cancer at some point during their lifetime. It is also very interesting to note that as of the end of 2012 there were an estimated 2.8 million men within the United States living with prostate cancer. Certainly, the addressable market for therapies is very large.

Exhibit Two – Risk Scary Risks of Prostate Cancer



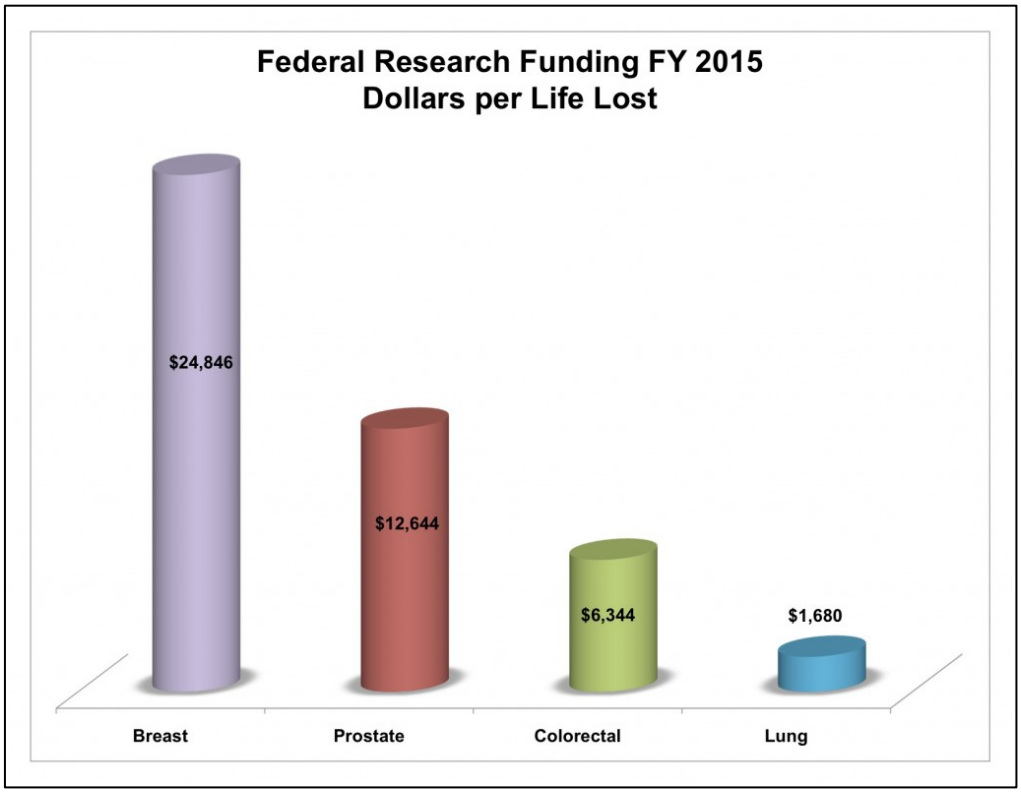
Source: SEER Cancer Statistics

While the amount of money spent on prostate cancer research has grown over the past ten years, it is still significantly less than that spent on breast cancer research, not only in the actual total dollars, but also in the amount of funding per life lost to the disease. As is outlined in Exhibit Three, the U.S. Federal research budget is almost 100% higher relative to each life lost due to breast cancer compared to prostate cancer. In total, the U.S. National Institutes of Health will likely spend approximately $700 million during 2017 on breast cancer research and only approximately $300 million on prostate cancer research.

On the surface this may seem inherently unfair to the North American male population, especially considering that only 12% of women will develop invasive breast cancer, while nearly 60% of men over 65 will eventually develop prostate cancer. These two cancers are very different, however, because prostate cancer is a slow killer of mainly older men, while breast cancer usually affects women

who are much younger age with many of these women still having minor children. There is also a considerable difference in the amount of research funding between the two cancers simply because women have rallied around the breast cancer issue and have been able to gain significant community involvement. Most men still do not like talking about prostate cancer, and since they don't talk about it, they don't engage nearly as much in the awareness movements that focus public attention on particular issues.

Exhibit Three – Prostate Cancer Research Budget Has Grown, But Breast Cancer Spending Still Dominates



Source: National Institutes of Health

Screening and Treatment

Early symptoms of prostate cancer develop with the gradual enlargement of the prostate gland, which often affects urinary function, the ability to fully empty the bladder, and often results in sexual dysfunction. These symptoms occur because as the prostate gland enlarges it can squeeze the urethra and as swelling continues, pressure can be exerted on other structures in the vicinity.

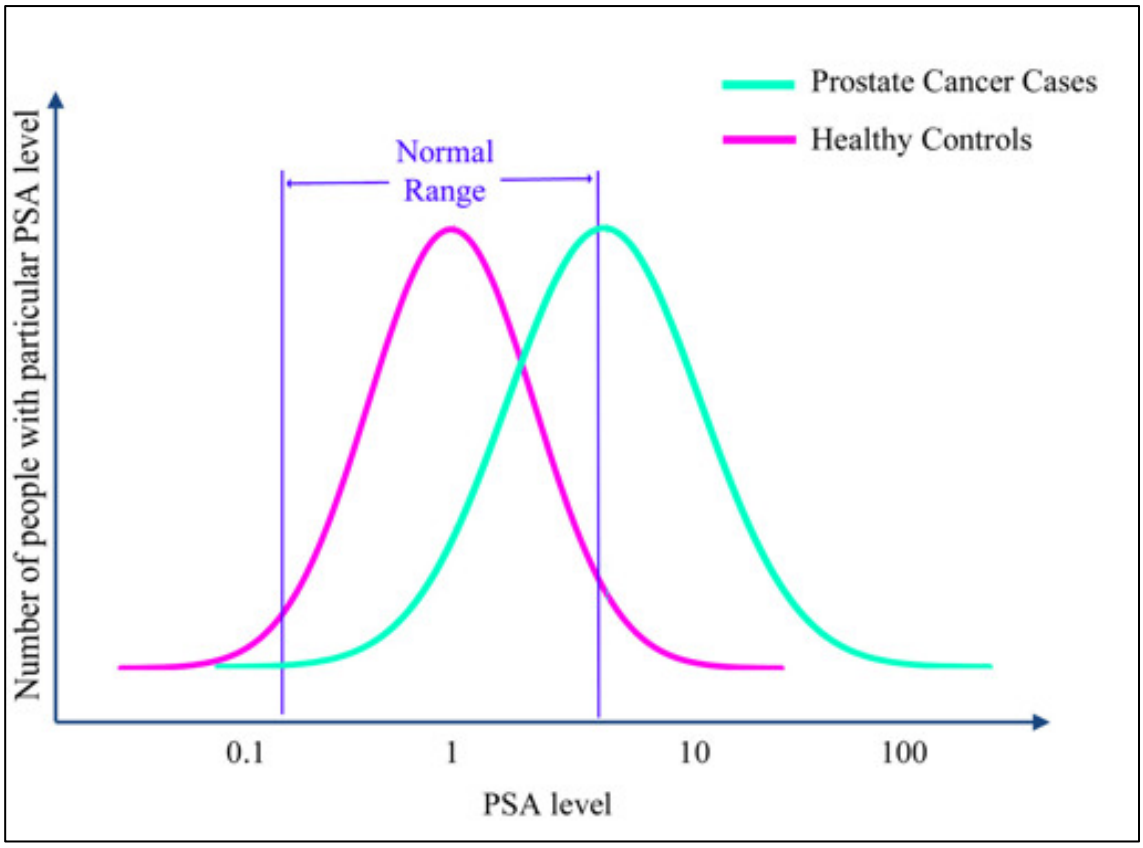
The diagnosis for a prostate related condition is usually based on many factors including the symptoms being experienced, family history, degree of enlargement or unusual lumps on the prostate, and most importantly the level of Prostate Specific Antigen (PSA) in the blood.

Any discussion of prostate cancer treatments needs to begin with a bit of background on the PSA test. PSA is a protein that is produced in healthy prostate tissue. Cancerous cells within the prostate also

make PSA, but do so at a rate higher than normal noncancerous cells. The measurement of PSA in the blood has become almost a routine part of blood work for middle-age men during their physical examinations. While there is considerable debate within the many sectors of the medical community relative to false positives, false negatives, and whether or not there is a survival advantage for men who have PSA's done regularly, such issues are outside the scope of our discussion. What is clear is that the level of PSA in the bloodstream is an important indicator of the potential for prostate cancer, and more importantly, an indicator the overall progression of the cancer after diagnosis.

As is outlined in Exhibit Four, it is clear that while men with prostate cancer have higher PSA on average, we can also see that there is a lot of overlap between the two groups. Generally speaking, a PSA of 3.0 or less would be considered a "normal" range, but it is also important to point out that there are many prostate cancer patients who have a PSA of below 3.0. Also, a PSA above 4.0 would usually be considered elevated, but there are also a significant number of men with normal prostates who have a PSA at, or above, this range.

Exhibit Four – Wide Variability on "Normal" or "Problematic" PSA Levels

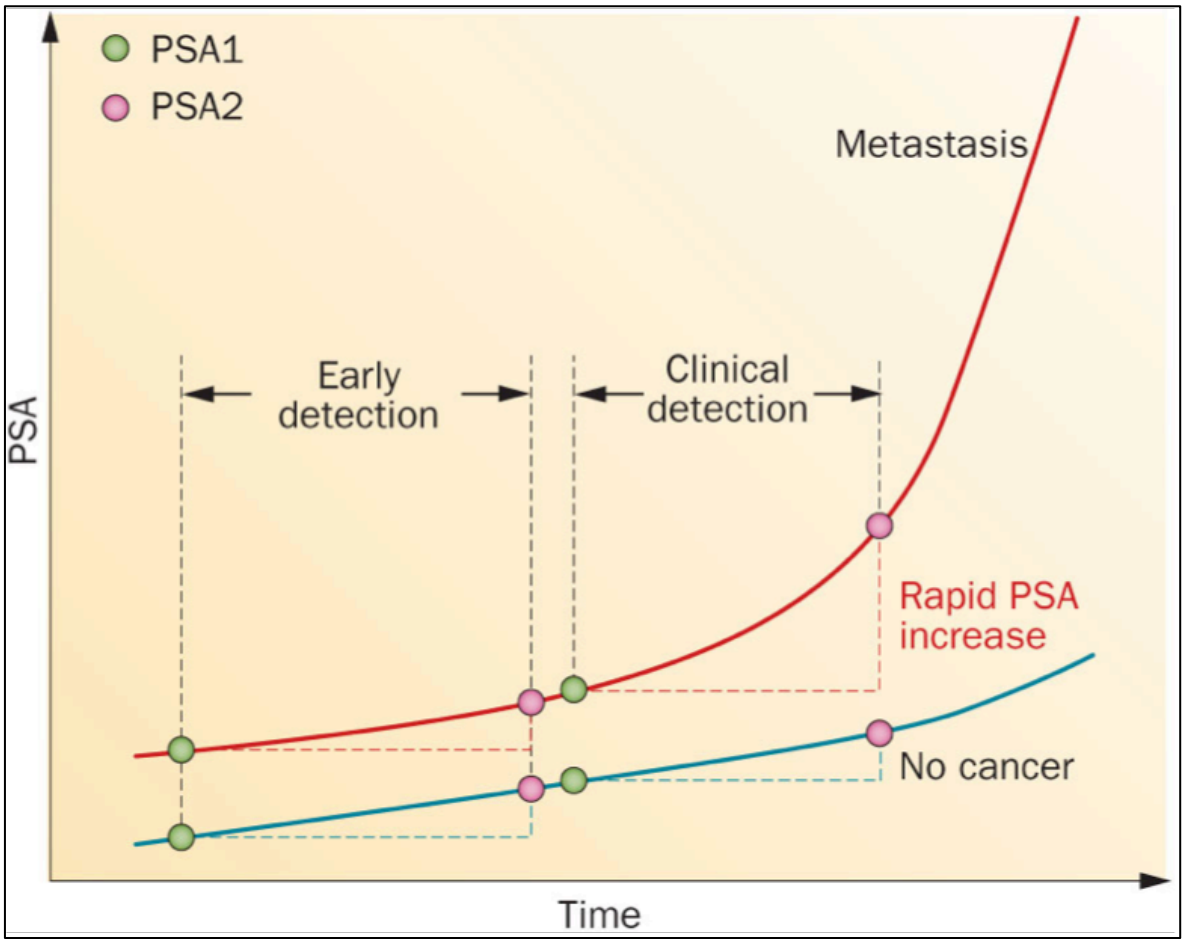


Source: CDC

While it is clear the PSA test is far from perfect, it remains one of the best diagnostic tools for early detection of prostate cancer potential. Used in conjunction with other factors, the PSA test remains vital for early detection and determination of ongoing advancement of prostate cancer. As is outlined

in Exhibit Five, early detection is vital so that appropriate treatments, if any, can be determined by the physician. Screening can bring forward a diagnosis of prostate cancer by many years leading to detection of the cancer prior to the exponential PSA level increase in tumor growth that almost always occurs given enough time.

Exhibit Five – PSA Overtime for Men with Prostate Cancer



Source: Nature reviews Urology10, 38-48 (January 2013)

The Bottom Line on PSA Screening and Levels

The bottom line on PSA levels is that the actual level is an important factor, but far from the only factor the physician will consider relative to diagnosis and treatment. Generally speaking, however, most physicians agree that a PSA greater than 4 ng/ml warrants further investigation, but this also is dependent on many factors. For example, a PSA of 4 ng/ml would likely cause some concern relative to a man who is between the ages of 40 and 60, but likely would be far less concerning relative to a man in his 60s or 70s.

Interpretation of PSA level is simply the one step in an overall cancer screening or diagnosis process. When elevated PSA levels are detected and other risk factors closely examined, physicians will typically take the next step in the investigation process by ordering a biopsy, which involves the removal of a very small amount of prostate gland tissue via a needle guided by ultrasound probe.

The Good News on Prostate Cancer

The good news, if there really is any good news, relative to prostate cancer, is that it is usually a very slow growing cancer. Typically, it can take five to ten years after an elevated PSA level is detected for symptoms to appear.

Considering this relatively long survivability, a rising PSA level in a man who is in his late 70s or 80s is usually not considered to be a significant threat with physicians usually recommending a "wait and see" approach relative to treatment. Conversely, the situation is very different in a man who is in his early to mid-fifties where a rising PSA level may trigger a much more aggressive treatment approach.

The other good news relative to prostate cancer, is the rising survivability rate. Over the past decade the median survival time, defined as the period for which 50% of men survive with treatment, has risen significantly, currently standing at approximately 17.5 years. When comparing survivability rates for the current decade compared to survivability rates in the 1970s are 1980s, there is a dramatic leap forward with some studies suggesting increases of greater than 25%. These increased survival rates had been attributed to better early screening, better overall understanding among the North American male population, and most importantly, better treatment protocols, albeit with morbidities.

Prostate Cancer Treatment Options – No Good Ones – Yet!

For men with elevated PSA levels or a diagnosis of prostate cancer, there are many treatment options available. The proper course of treatment depends on many factors including how far the cancer has progressed, the age of the patient and the expected lifespan, and other serious health conditions that may be present. There are also a host of additional factors concerning the patient's feelings concerning the potential side effects of each of the treatments as many of the treatments we discuss below are rather terrifying for many men.

Typically, a general practitioner or internist may order and interpret the PSA test is part of a routine physical or during routine blood work. Depending on the PSA level detected and other risk factors, the general practitioner or internist will usually refer the patient to a urologist, who is a specialist in treating the urinary tract system and the male reproductive system. The urologist will either work in conjunction with radiation oncologist or medical oncologist who will treat the cancer with a variety of medications or radiation therapy.

Treatment options include, doing nothing - often referred to as active surveillance or watchful waiting, surgery, radiation therapy, hormone therapy, chemotherapy, or vaccine treatment.

Below we cover each of these briefly:

- Watchful Waiting - The lowest level of treatment is simply watching for the progression of symptoms in conjunction with periodic PSA testing. This is certainly a viable option especially for older men.

- Active Surveillance - Active Surveillance involves monitoring the cancer closely for a period of time with the Physician periodically monitoring PSA levels and other factors, in addition to periodic biopsies. If advancement is detected, then the physician may recommend a full treatment protocol.

- Surgery - Surgery is a viable option if the physician believes the cancer has not spread outside the prostate gland or possibly in other specific situations. Surgery usually involves the removal of the entire prostate gland and some of the tissue around it, including the seminal vesicles. Aside from the normal risks of general anesthesia and surgery on an older person, there are other major risks associated with prostate surgery, including urinary incontinence, and erectile dysfunction.

- Radiation Therapy - Radiation therapy involves using high-energy rays or particles to kill the cancer cells while preserving as much of healthy tissue as possible. Radiation therapy is used for both situations where cancer is isolated to the prostate and as part of an overall treatment protocol when the cancer has spread outside the prostate and into surrounding tissues. Radiation therapy is also used as a follow-up after surgery if the cancer returns to the general area or in cases where cancer is advanced in order to keep the cancer under control for as long as possible and to prevent or relieve symptoms. There are two basic types of radiation therapy. External beam radiation utilizes an external device that focuses radiation onto the prostate in order to kill cancer cells. The second form is called brachytherapy, which uses small radioactive pellets, often called "seeds" which are inserted directly into the prostate gland and left in place in order to kill the cancer cells.

- Hormone Therapy - Hormone therapy is a more radical approach to prostate cancer treatment. The goal is to reduce the levels of hormones in the body that are causing the cancer to grow. This therapy is often used when the cancer has spread too far to be cured by either surgery or radiation treatments or if the cancer process after other treatments have been attempted. Hormone therapy is also sometimes used in an attempt to shrink the cancer so that other treatments are more effective. The side effects of hormone therapies are often significant, which include various levels of reduction in sex drive and erectile dysfunction, and many of the typical effect that go along with low testosterone levels, including weight gain, loss of muscle mass, depression, increased cholesterol levels, and many other issues.

- Chemotherapy - For cancers that are advanced or have metastasized, aggressive chemotherapy may be the best choice. With the significant side effects, chemotherapy is very rarely used for early-stage cancers.

The Terror of Prostate Cancer Therapies

Many men faced with prostate cancer are more afraid of the treatments than they are of the disease. It is clear that the average North American male takes his dog to the veterinarian more often than he takes himself to the doctor. Combine this with the fact that prostate cancer is directly related to his most prized possession - his genitals - and then combine the fact that prostate cancer is so closely related to the area of the human body that Western culture most scorns - the rectum and anus - it is little wonder,

the prospect of prostate cancer treatments so terrifies men.

Consider the barbarity of current prostate cancer regimes:

Surgery involves either an incision into the perineum (the skin between the anus and scrotum), an incision into the abdomen, or smaller laparoscopic incisions for the insertion of devices to remove the prostate. Two of the biggest risk factors for such surgeries are incontinence and impotence - clearly pretty scary stuff for most men.

Radiation therapy involves the insertion of radioactive "seeds" into the prostate, usually through the perineum, which are left in the prostate to release radioactivity over period of time. Depending on the type of radiation approach used relative to this treatment (brachytherapy) the patient can be so radioactive that isolation from family or friends is required. Other forms of radiation involve the insertion of a probe into the rectum to deliver radiation to the prostate - of course, neither would be pleasant.

The approach of hormone therapy treatments is basically stripping some of the masculinity from the individual by significantly reducing male hormone levels, which can radically accelerate the normal testosterone-related aging process inherit to all primates. This approach is basically feminization and a significantly scary prospect for most men. Of course, chemotherapy is a radical approach, with significant side effects. However, chemotherapy may be the only alternative relative to severe or advanced cases where the cancer has metastasized and may be the only approach to prolong life for certain individuals.

All current therapies for prostate cancer prolong longevity to varying extents, however, these treatments are far from perfect. Considering the significant unpleasantness of the above outlined therapies and the significant side effects that can occur it is little wonder that prostate cancer is a terrifying experience for most men.

Surely, there must be a better way!

Vaccine Treatment For Prostate Cancer

Vaccines for the treatment of cancer are similar to the vaccines for other diseases, but there are also important differences. When a foreign microbe enters the human body the body's immune system produces various types of cells that attack the invading entity. The immune system also elicits a response where it will remember what it has destroyed in order to prevent reinvasion. Most commonly known vaccines take advantage of this process by introducing a harmless version of the pathogen into the body. This is usually accomplished by introducing either a killed or weakened version of the microbe into the body. The body's immune system upon encountering this less dangerous version of the microbe not only destroys the microbe, but also remembers it to enabling the body to prevent infection if the microbe is encountered at a later date. At a later time, if the active version of the microbe is encountered the immune system will be prepared with a more robust defense in place.

Prophylactic or preventative cancer vaccines are designed to prevent the cancer from developing in otherwise normal healthy individuals. Two examples of such vaccines are Gardasil, which is approved to prevent certain HPV infections and Recombivax, which is approved to prevent hepatitis B infections. Both of these are designed to be administered before the body "sees" the virus preparing the body to

prevent infection if the offending virus is introduced at a later date. Both are considered cancer vaccines because HPV infection can lead to cervical and other cancers and hepatitis be infection can lead to liver cancer.

Most cancer vaccines under development, work differently in that these are designed to treat cancers that have already developed. The therapies are designed to delay or stop cancer cell growth, shrink tumors, or in best-case scenarios, eliminate all specific types of cancer cells from the body.

The full details of how cancer vaccines reduce or limit cancer cells is quite complex and beyond the scope of this report, but usually the therapies are designed to activate T-cells and/or to direct the T-cells to recognize and to take action against specific types of cancer cells. Other types of cancer vaccines being developed work through the introduction of various antigens into the body which cause the immune system to produce other substances that bind to cancer cells ultimately attracting the killer T-cells to the cancer.

There are several clinical trials underway for various types of cancer vaccines designed to treat different forms of cancer. Relative to prostate cancer only one vaccine has been approved, which is Provenge. Approved in early 2010, Provenge is indicated only for advanced prostate cancer cases where the cancer has spread to other parts of the body.

Provenge has been considered a commercial failure and a major cause of the 2014 bankruptcy of Dendreon, the manufacture. The cost of nearly $100,000 for an increase in life expectancy of only four months, combined with it being a custom-made vaccine involving specimen collection and laboratory preparation based on each patient's cells, were both major factors that contributed to the vaccine's failure.

OncBioMune's ProscaVax

OncBioMune has developed the prostate specific cancer vaccine called ProscaVax. With its quality to treat prostate cancer in the early stages, it is therefore a unique approach to the treatment of prostate cancer.

ProscaVax is designed to trigger the immune system to eradicate the cancer cells within the prostate. Typically, the human immune system does not immediately recognize cancer cells as abnormal and in need of eradication. In fact, not only does the immune system not generally attack many cancer cells, but also can sometimes elicits a response that protects the cancerous cells. Certain types of T-cells in the body are the first to recognize cancerous cells. These specific types of cells often protecting cancer cells from the killer T-cells they would normally eradicate cancer cells before proliferation can occur.

In the case of prostate cancer, the immune system typically does not have an effective response to PSA and therefore the cancer cells can proliferate widely. ProscaVax introduces specific molecules, called antigens, into the body that stimulate the immune system to produce the cells that are capable of both identifying the cancer cells and destroying these cells, while leaving healthy cells untouched.

The Company has shown positive results for its Phase 1 clinical trial, which is hosted by the University of California San Diego Moores Cancer Center and Veterans Hospital in La Jolla California. Patients in the trial had recurrent prostate cancer disease with rising PSA levels after initial treatment, which involved surgery, radiation or brachytherapy (seeds). 15 patients were enrolled in Phase 1a of the trial.

Of these, 12 patients received all six vaccinations with none of these patients suffering any adverse effect. Eight of these patients demonstrated increased immune responses to PSA. Based on these results the Company is now planning to move into a Phase 2 clinical trial.

Relative to clinical trials, the Company has received funding support of $5.2 million from the Defense Department Navy Cancer Vaccine Program. Phase 2 trials are expected to be completed in conjunction with several departments of Harvard Medical Centers.

We expect investors to show significant interest in this upcoming trial. These positive results of Phase 1 are outlined in Exhibits Six and Seven.

Exhibit Six – Initial Trail Results

PATIENT #	WEEK 1 LBA	WEEK 7 LBA AFTER 3 VACCINES	WEEK 19 LBA AFTER 6 VACCINES
1	------	------	------
2	1.56	1.72	0.91
3	0.76	1.12	1.21
4	2.08	1.41	1.52
5	1.60	1.75	1.64
6	3.27	3.57	1.46
7	1.10	------	------
8	1.16	1.31	1.93
9	1.43	40.16	1.72
10	0.82	1.19	1.00
11	1.24	0.89	1.05
12	1.49	0.90	------

Source: OncBioMune, Inc.

Exhibit Seven- Initial Trial Results

Patient Number	PSA Doubling Time Before Vaccine (Days)	PSA Doubling Time After Vaccine (Days)	Improvement in Doubling Time	Increase in Immunity to PSA After Vaccine	Increase in Immunity to PAP After Vaccine	Increase in Immunity to PSMA After Vaccine	Increase in Immunity to CEA After Vaccine	Increase in Immunity to CA-125 After Vaccine
1p	121	54	NO	---	---	---	---	---
2	478	302	NO	YES	YES	YES	YES	YES
3	522	1235	YES	YES	YES	YES	YES	YES
4	324	429	YES	NO	YES	YES	NO	NO
5pr	259	807	YES	YES	YES	YES	NO	YES
6	659	672	YES	YES	YES	YES	YES	NO
7*	---	---	---	---	---	---	---	---
8	314	511	YES	YES	YES	NO	NO	
9	76	70	NO	YES	YES	NO	YES	YES
10	463	657	YES	YES	YES	YES	YES	YES
11	579	167	NO	YES	YES	NO	NO	NO
12**	---	---	---	---	---	---	---	---
			6/10	8/9	9/9	6/9	5/9	5/8

Source: OncBioMune, Inc.

It is particularly noteworthy relative to this early clinical trail that there was a 100% lack of toxicity and that no adverse events were realized. Management believes it will also experience no adverse events in Phase 2 of its clinical trial, which is expected to begin later in 2016.

The Phase 2 trial will involve 120 patients, 80 of them will receive ProscaVax with 40 in the untreated control group. Whereas the first stage of the trial was on patients who had reoccurrence and elevated PSA after initial treatment, Phase 2 will be exclusively on patients who are in the very early stages of cancer who have elevated PSA levels, but who have yet to be treated. This is an important distinction as Phase 2 of the trial, assuming success, could establish ProscaVax as a potential early stage, first treatment option for some 300,000 patients that will be diagnosed with early-stage prostate cancer each year.

The success of the Phase 2 trial will be important in the Company's attempts to seek accelerated FDA designations, hopefully leading to interest from mid and large pharmaceutical companies.

Joint Venture: ProscaVax In Mexico and Latin America

OncBioMune released some significant news on March 29, 2016, disclosing the signing of a Memorandum of Understanding with Vitel Laboratorios S.A. de C.V. for the purpose of establishing a Joint Venture, to be named OncBioMune Mexico S.A. de C.V., or "OncBioMune Mexico", to develop and commercialize OncBioMune's portfolio of innovative cancer therapies in Mexico and Latin America. The initial thrust of work for OncBioMune Mexico will be focused on designing and conducting a Phase 2A/2B trial of ProscaVax for prostate cancer in Mexico.

We expect the MOU to materialize into a definitive agreement, which carries with it substantial value for OBMP shareholders. Assuming an even split of developmental costs in exchange for Vitel getting a piece of future sales of ProscaVax, the JV will save millions of dollars for OBMP and leverage Vitel principals' relationships and knowledge of the regulatory framework in Mexico and throughout Latin America. In Mexico alone, prostate cancer is an area of unmet medical need, as the most frequent cancer in men over age 50 resulting in more than 300,000 diagnoses and in excess of 5,000 deaths annually. According to Cancer.org, prostate cancer is the leading cause of cancer death among males in Latin America and the Caribbean, with about 51,000 deaths each year. There is clearly a large market for a vaccine like ProscaVax in this region of the world.

The planned 100-patient clinical trial will be structured as a two-stage study of ProscaVax for the treatment of PSA recurrent prostate cancer in hormone-naïve and hormone-independent patients. The trial is expected to last 36 months, but should preliminary data show efficacy, the plan is to pursue a Preliminary Marketing Authorization to commercialize ProscaVax in Mexico. This could happen in as little as 24 months from the commencement of the Phase 2A/2B study, meaning there is a potential future revenue stream for OncBioMune to build corporate value, attract partners and advance its pipeline.

By sharing the financial burden and ultimately increasing veteran staff without associated expenses, OncBioMune's operations and clinical trials in the U.S. will be able to run concurrently, adding value without a strain on resources.

Pipeline for Other Therapies

The Company began development on its breast cancer vaccine 1993 at which time early testing began. The first patent was awarded in 1994. This early vaccine yielded some positive results with some in the study having dramatic responses.

OvcaVax, the Company's ovarian cancer vaccine is now ready to move out of preclinical and into Phase 1 trials. These therapies utilize the same concepts as the prostate cancer vaccine.

OncBioMune also has a portfolio of targeted therapies, some of which are biosimilars to blockbuster drugs, including Celgene's Abraxane. The assets are protected through 15 patents and patents pending covering approximately 50 countries worldwide for the Company's vaccine and paclitaxel gallium transferrin (PGT) technologies.

The Company's product pipeline is shown in Exhibit Eight

Exhibit Eight – OncBioMune, Inc. Pipeline

Product	Indication	Preclinical	Phase 1	Phase 2	Phase 3
VACCINES					
ProscaVax	Prostate Cancer[1]				
OvcaVax	Ovarian Cancer				
PA-OBC					
PA-BC	Breast Cancer				
PGT-OBM					
PGT-RC	Renal Cancer				

Corporate Structure and Financing

While the Company was initially formed in 2005, it was not until late September of 2015 that OncBioMune became a public entity. Most of the technology brought to the Company comes from prior experience gained by the Company's Chief Medical Officer, Robert Elliott, MD and CEO, Jonathan Head, PhD, based on the research and development activities in association with their breast cancer and treatment facility, which is called the Elliott-Elliott-Head Breast Cancer Research and Treatment Center. This facility, located in Baton Rouge, Louisiana, treats average of 40 patients each day.

As of the date of the last quarterly filing with the SEC, there were 54.5 million common shares outstanding of 500 million authorized. There also one million shares of preferred stock outstanding. Each share of preferred stock has rights to vote the equivalent of 500 common shares.

We do not view the corporate share structure as anything out of the ordinary for this type of early-stage pharmaceutical operation.

The Company has not yet reported results for the period ending December 31, 2015. As of the September 30, 2015 balance sheet the Company had approximately $185,000 in cash and about $206,000 and total assets, which is too lean to complete upcoming clinical trial commitments.

On November 20, 2015 the Company filed a registration statement to register up to 4.5 million shares of stock in conjunction with Lincoln Park Capital Fund, LLC. In October the Company signed a common stock purchase agreement where Lincoln Park made an initial investment of $100,000 and agreed to purchase up to $10 million in common stock over 36 month period after the effective date of the registration statement.

The financing is designed to position the Company through its Phase 2 clinical trials. The securing of financing is always a critical component for a company like OncBioMune. With this financing agreement now in place, OncBioMune can confidently move into its Phase 2 clinical research.

Conclusions

As of the last quarterly filing there were approximately 55 million shares outstanding and with approximately 4.5 million shares to be issued in conjunction with the Lincoln Park financing, the fully loaded share count is approximately 60 million. We believe it is noteworthy that there is very little debt on the Company's balance sheet. As of the end of the September quarter total liabilities were only approximately $250,000, with much of this owed to corporate insiders.

Considering the recent stock closing price of approximately $0.45, total market capitalization is only approximately $25 million.

We view this valuation as very interesting considering the extremely large size of the market opportunity. There are very few therapies designed for early-stage prostate cancer treatment and considering the Company will be moving into a very important Stage 2 clinical trial over the coming months, we can easily see how this Company could attract significant attention among life sciences-oriented investors.

According to GBI Research, the prostate cancer therapy market is expected to grow at nearly 10% per year from approximately $7.6 billion in 2014 to nearly $14 billion by 2021, with novel therapies expected to gain a significant portion of this growth over the coming years.

The markets for other cancer therapies relating to OncBioMune, particularly the ovarian and breast cancers the markets, are valued at tens of billions of additional dollars each year with both expected to continue to grow for at least the next ten years.

Considering the large size of these markets, positive results achieved in Phase 1 trials, including lack of adverse events, and especially considering over the coming months the likelihood of announcements relating to details of what will likely be a hotly anticipated Phase 2 clinical trial, we believe the Company's valuation of $25 million is easily justifiable.

We can see a scenario where these shares could see rapid appreciation upon the release of details of the Phase 2 trials.

Management and The Board of Directors

Dr. Jonathan Head PhD - CEO, Chairman

Dr. Head has been instrumental in the development of our new chemotherapy and immunotherapy programs. Dr. Head and Dr. Elliott are the co-developers and patent holders of one of the first patented autologous breast cancer vaccines in the United States. His major goal is to implement translational research – the movement of laboratory-developed technologies into the clinical setting. This is the taking of new therapies from cell culture to an accepted therapy for cancer patients.

Dr. Head is an Adjunct Associate Professor of Biochemistry at Tulane University School of Medicine, an Adjunct Professor of Physical and Biological Sciences at Delta State University and an Adjunct Associate Professor at Louisiana State University School of Veterinary Medicine. He is an active member of the American Association for Cancer Research and the American Society of Clinical

Oncology. Although patients rarely meet Dr. Head, the new treatments we offer are the result of his and Dr. Elliott's work.

Dr. Robert Elliott, M.D., Ph.D. - Chief Medical Officer, Director

Dr. Robert Elliott is the driving force behind our The Elliott-Elliott-Head Breast Cancer Research and Treatment Center. Colleagues often remark that his energy seems boundless. Indeed, it often is.

In 1973, when the Center was founded, Dr. Elliott's dream was to create the finest center for total breast care. With that step behind us, the dream continues. Dr. Elliott continues doing research to discover new treatments and drug therapies, and has implemented a team approach to bring total breast care to the patients.

Dr. Elliott sees patients from all over Louisiana, the Southeast and across the United States. He collaborates on research projects with other scientists around the world. Dr. Elliott has spoken to medical audiences in the United States and Europe and has authored many papers and abstracts. He has also published a book, Breast Cancer, Anger at the Enemy, which deals with the lack of total breast care available for women. He shares his own frustration and heartaches of caring for dying cancer patients as they struggle for survival, and finally sends a message of hope as he and his research team search for a cure for breast cancer.

Trained as a general surgeon, Dr. Elliott feels that breast care should be a specialty of itself, with patients being able to receive the highest quality of care from one physician who reads their mammograms, examines them, performs their surgery and administers their therapies.

To advance this concept and to share his experience with other physicians like himself who specialize in breast care, Dr. Elliott founded the American Mastology Association. He currently serves as President of this society. In spite of a busy calendar of meetings and research, Dr. Elliott's first love is his patients. He devotes the majority of his time to the Center and to helping women overcome breast disease.

Andrew Kucharchuk - Chief Financial Officer

Andrew "Al" Kucharchuk is a graduate of Louisiana State and Tulane Universities Freeman School of Business, where he earned an MBA with a Finance Concentration. He currently serves as the Company's Chief Financial Officer and oversees the business and administrative processes. In addition to these duties, Al also directs business development efforts including the expansion of operations to accommodate increased research and clinical development. Al has assisted Dr. Head in the administration of the three contracts that have lead to the clinical studies for the Company's lead product, ProscaVax™.

Mr. Kucharchuk is a member of Kappa Alpha Order fraternity. He lives in Baton Rouge with his wife Jessica and their sons Henry and Davis.

Charles L. Rice, Jr. - Director

Mr. Rice is the President and Chief Executive Officer of Entergy New Orleans, Inc., an $800 million a year electric and gas utility and subsidiary of NYSE-listed Entergy Corporation. After his first legal private practice position in Louisiana with Jones, Walker, Waechter, Poitevent, Carrere & Denegre,

L.L.P, Rice joined Entergy in the legal department in 2000, serving as senior counsel in the Entergy Services, Inc. litigation group and then as manager of labor relations litigation support in human resources.

Rice was recruited into New Orleans city government in 2002 as the city attorney and later took the critical role of chief administrative officer for the City of New Orleans, where he managed 6,000 employees and the city's $600 million budget. In 2005, the law firm of Barrasso, Usdin, Kupperman, Freeman & Sarver, L.L.C. recruited him back to private practice, where he was named partner.

Returning to Entergy in 2009, Rice served as director of utility strategy where he was responsible for coordinating regulatory, legislative, and communications efforts to develop and execute strategies that advanced commercial objectives for the company's regulated service areas. He then served as director of regulatory affairs for Entergy New Orleans.

Rice holds a bachelor's degree in business administration from Howard University, a juris doctorate from Loyola University's School of Law and master's degree in business administration from Tulane University. After graduating from Howard University, he was commissioned as a second lieutenant in the United States Army and served as a military intelligence officer with the 101st Airborne Division (Air Assault) at Fort Campbell, KY. While in the Army, he earned the Airborne Badge, Air Assault badge and was awarded the Army Commendation and the Army Achievement medals.

He is a member of the Alabama and Louisiana State Bar Associations, the American Bar Association, the New Orleans Bar Association, and the National Bar Association.

Daniel Hoverman - Director

Daniel Hoverman is a Director at NYSE-listed Houlihan Lokey, a leading global investment bank, where he is a senior member of the firm's Corporate Finance Group. Mr. Hoverman is also actively involved with Houlihan Lokey's efforts in equity capital markets.

Mr. Hoverman has extensive mergers and acquisitions advisory and financing experience, having completed over $100 billion of transactions for both private and public companies across multiple industries and geographies. Before joining Houlihan Lokey, he was a Director with Credit Suisse in Hong Kong as a member of the office of the General Counsel, and was responsible for oversight and management of investment banking transactions. Prior to Credit Suisse, he was a Director with UBS Investment Bank in New York as a member of the firm's Equity Capital Markets Group and Equity Corporate Finance Team, where he was responsible for origination, oversight and management of securities offerings. He began his career with Kirkland & Ellis LLP as a corporate attorney focusing on capital markets and mergers and acquisition transactions.

Mr. Hoverman received a B.A. from Yale University, where he graduated cum laude with distinction in history and was a Robert C. Bates Fellow and New Prize recipient, and received a J.D. and M.B.A. from Columbia University, where he was a James Kent Scholar and a John C. Olin Fellow. Mr. Hoverman holds Series 7, 24, 63 and 79 licenses and the designation of Chartered Financial Analyst, and is an inactive member of the New York Bar.

Dr. J. Jacques Carter – Scientific Advisory Board

Dr. Carter currently serves as a physician at the Beth Israel Deaconess Medical Center in Boston, MA

and is an assistant professor at Harvard Medical School. From 2005 to 2014, he also served as the Medical Director of the Prostate Cancer Screening and Education Program at the Dana-Farber Cancer Institute.

Dr. Carter completed his residency training in Internal Medicine at Beth Israel Deaconess Medical Center in Boston, followed by a graduate program at the Harvard School of Public Health, where he received his MPH degree. He then completed a clinical fellowship in Primary Care Medicine at the Massachusetts General Hospital.

Dr. Carter has held a number of clinical and administrative positions, including Medical Directorships of several local and national health care organizations. A former director of one of the major clerkships, he now serves as a teacher/advisor/mentor for students at Harvard Medical School and the Harvard School of Public Health. Dr. Carter has been active in a number of civic and community organizations, including past president of the board of Family Service of Greater Boston and past chair of the Brookline Advisory Council on Public Health. He regularly gives talks on medical and health related issues to community groups and students throughout greater Boston. He also lectures nationally and internationally on medical and public health topics. Dr. Carter serves as a medical consultant and resource for members of the media. He is a past President of the Harvard School of Public Health Alumni Association and a current director of the Harvard Alumni Association. Dr. Carter is a founding member of the Georgetown University African American Advisory Board. He is the recipient of the 2010 Harvard Medical School/Harvard School of Dental Medicine Community Service Lifetime Achievement Award. His bio has been included in "Who's Who in the East, "Who's Who in Medicine and Healthcare", Who's Who in Science and Engineering, and "Who's Who in America".

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