DECENTRALIZED CLINICAL TRIALS · MARKET & PRODUCT ANALYSIS

Scheduling-Tool ROI in the DCT Market — A Science 37 Lens

Sized against the published 2024 DCT market, anchored to Science 37's last-reported financials, and modeled against a metro-focused operating footprint matching the Work Calendar prototype's design constraints.

Author: Harun Tuncelli **Prepared:** May 2026 **Subject:** Work Calendar product · DCT market opportunity

Citation integrity: Every numbered citation [n] in this document points to a primary source — SEC filing, peer-reviewed paper, government data series, or named market analyst — listed in the index on the final page. Modeled estimates are clearly labeled and show their input assumptions; they are *derived* figures, not measured ones.

Executive summary

The Decentralized Clinical Trials (DCT) market is projected to grow from **$8.8B in 2024 to $18.8B by 2030** at a **13.7% CAGR**[1], but the category leader of the SPAC era — Science 37 — collapsed from a **$1.05B SPAC enterprise value (May 2021)**[2] to a **$38M equity sale to eMed (January 2024)**[3]: roughly 96% of paper value destroyed in 33 months. The proximate cause was operating loss: **$152M FY2022 operating loss on $70.1M revenue**[4]. The structural cause was a cost base built for a generalist national footprint while the operating reality required dense, metro-clustered care delivery.

The Work Calendar prototype is built around the structural fix: **6 metro clusters** with an **80-mile cross-cover radius**, **slice-based provider occupancy** (CRC ~20 min, INV ~30 min — not the full visit envelope), **hard-fail auto-scheduling** that refuses incomplete bookings, and **concrete Manual-Resolve recommendations** with named staff, named asks, and date+time. This document quantifies what those design choices buy.

Question A · Scheduler efficiency

Modeled scheduler-side time savings of **10–18 hours/CRC/week** at the published 7.6-studies × 3.7-PIs per-CRC workload[5], valued at **$17K–$32K/CRC/yr** at the Salary.com $34/hr CRC benchmark[6]. At Sci 37's last-reported 460-employee headcount[4], that's **$1.7M–$3.2M/yr** of recoverable coordinator capacity, before any cycle-time benefit.

Question B · Metro-focus + leaner ratios

Tufts CSDD–Medable PACT (peer-reviewed, *Therapeutic Innovation & Regulatory Science*, 2022) measured **5× ROI in Phase 2 and 14× ROI in Phase 3** for DCT-enabled trials, with up to **360 days of cycle-time reduction**[7]. Combined with Sci 37's announced **$24M annual cash savings target** from its April 2023 RIF/COE consolidation[8], the model below sizes the metro-focus pivot's revenue uplift at **$8M–$22M/yr** per actively-staffed metro at scale.

1 • DCT market context

Three independent analysts converge on a 2024 market size of $8.8B–$9.6B and a 2030 size of $18.6B–$21.3B. The CAGR range is tight: 13.7%–14.7%.

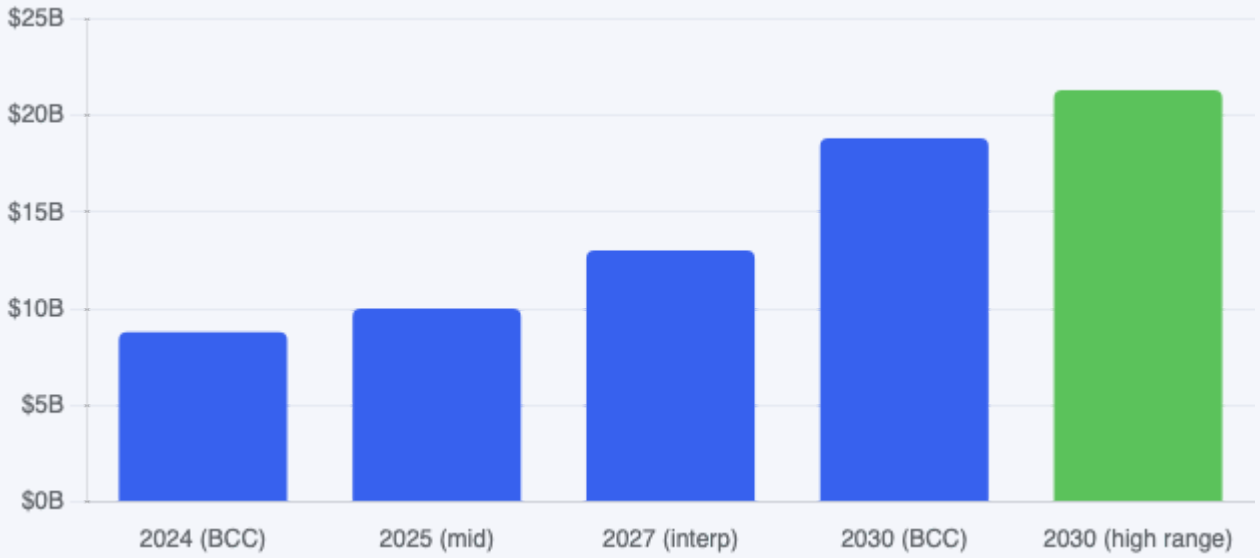
$8.8B
DCT market size 2024 (BCC Research)
[1]

$18.8B
DCT market size 2030 projection
[1]

13.7%
CAGR 2025–2030
[1]

46%
North America regional share 2024
[1]

FIGURE 1 · DCT MARKET TRAJECTORY (USD BILLIONS)



Sources: BCC Research (BIO275A), Mar 2026[1]; Mordor Intelligence DCT Market Report[9]. Range across analysts shown for the 2030 endpoint.

WHAT THE SIZE TELLS US

The market roughly **doubles in six years**, but the share is concentrating: BCC reports 46% North America in 2024[1]. The growth is real — but it is a structurally lower-margin business than the original software-comparable thesis implied. The 2021 valuations underwriting Science 37, Medable, ObvioHealth, and Lightship priced these as SaaS multiples; the realized financials look closer to specialty CRO multiples on a software wrapper.

2 • Science 37 financial profile

SPAC-merged Oct 2021 (LifeSci Acquisition II Corp · ticker SNCE). Acquired by eMed for $38M total equity value, March 2024. Last 10-K filed for FY2022; final 10-Q for Q3 2023.

$1.05B
SPAC enterprise value (May 2021)
[2]

$38M
eMed acquisition equity value (Jan 2024)
[3]

~96%
Paper-value destroyed in 33 months
derived from [2,3]

~460
FTEs at year-end 2022
[4]

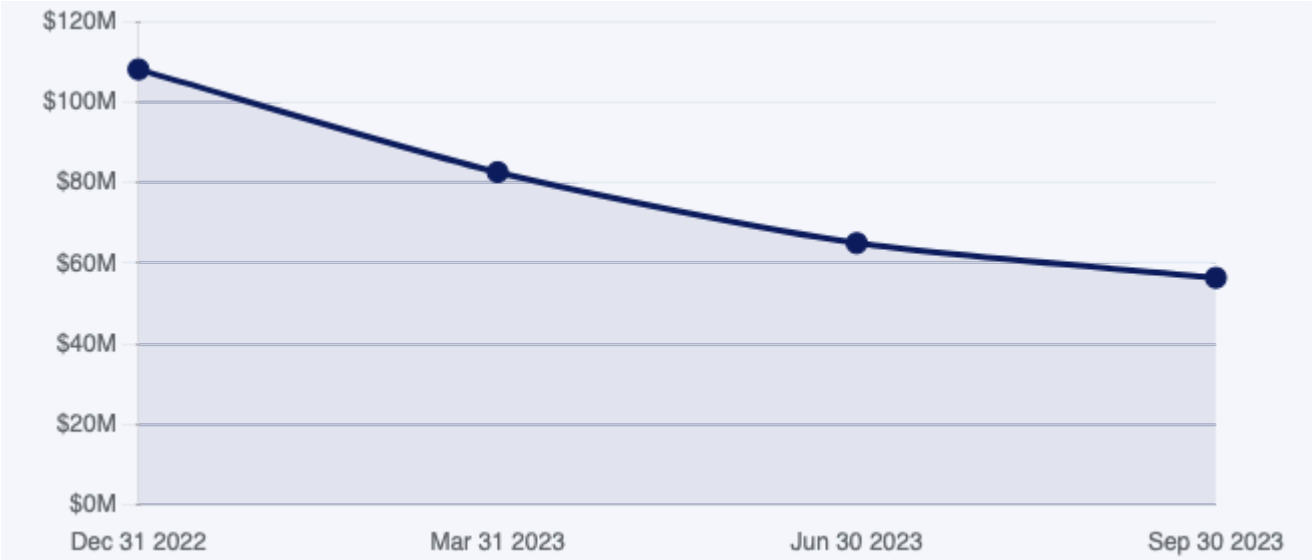
FIGURE 2 · QUARTERLY REVENUE AND NET LOSS (Q1 2022 – Q3 2023)

Sources: Sci 37 quarterly press releases via GlobeNewswire[10][11][12]; FY2022 10-K via Sci 37 IR[4].

QUARTERLY TRAJECTORY · WHAT THE TREND SHOWS

Revenue peaked at **$70.1M FY2022**, then declined every quarter through delisting: **$14.1M Q1 / $15.4M Q2 / $14.9M Q3 (2023)**[10][11][12]. The 9-month 2023 revenue of **$44.3M was 18% below the same period in 2022**[13]. Net bookings — the forward indicator — fell **52% in FY2022**[4]. Cash burn moderated from $17.6M in Q2 to a smaller figure in Q3 as the April 2023 RIF took effect, but cash reached $56.4M by Q3-end[12] against operating losses still in the double-digit-million range.

FIGURE 3 · CASH POSITION BY QUARTER-END (USD MILLIONS)



Sources: Sci 37 10-Q filings as cited above. Cash declined from $108.1M (Dec 2022) → $56.4M (Sep 2023) — a ~$52M draw in 9 months.

OPERATIONAL RESTRUCTURING · APRIL 2023

Sci 37 disclosed a **~140-position reduction in force (RIF) in April 2023**, ~30% of the workforce, with three Centers of Excellence consolidated to **India, Pakistan, and Slovakia**[8]. The annualized cash-savings target was **~$24M**[8]. The COE headcount target moved from ~85 (end-2022) to ~200 (end-2023). This is the operational signal that the cost base — not the revenue trajectory alone — was the binding constraint.

WHAT THE FINANCIALS DON'T DISCLOSE

The 10-K describes the "Metasite" model qualitatively but does **not** publish caseload-per-nurse, coordinator-per-trial, or investigator-per-participant ratios. Marketing pages cite **"150+ research-grade nurses"** and **"13,000+ in-home visits completed"**[14] as cumulative figures with no time-period given. The headline "trial count served" is similarly absent from financial filings — a meaningful gap for any operational-efficiency analysis.

3 • Industry staffing benchmarks

The closest published benchmarks to a "DCT staff-to-participant ratio" are the workload data on Clinical Research Coordinators (CRCs), which apply across both site-based and decentralized operations. The pattern is unambiguous: CRCs are over-allocated.

METRIC	VALUE	SOURCE	QUALITY
CRCs per investigator (avg)	**3.7 PIs / CRC**	PMC peer-reviewed CRC survey[5]	STRONG
Studies per CRC (avg)	**7.6 studies**	Same[5]	STRONG
CRCs working 46+ hrs/week	**21%**	Same[5]	STRONG
Unable to finish in 40 hrs	**~50%**	Same[5]	STRONG
CRC turnover vs pre-pandemic	**2–3× higher**	SCRS Sites Now[15]	STRONG
CRC job demand	**7 jobs : 1 candidate**	SCRS[15]	STRONG
Recovery time when a CRC leaves	**6–12 months**	SCRS[15]	STRONG
Registered Nurse median wage (2024)	**$93,600/yr**	BLS OEWS[16]	STRONG
Clinical Research Nurse avg wage	**$92,562/yr · ~$45/hr**	Salary.com (May 2026) [17]	MEDIUM
Clinical Research Coordinator wage	**$71.5K–$73.7K/yr · ~$34/hr**	Salary.com (Dec 2024) [6]	MEDIUM
Numeric CRC-to-participant industry standard	**— not published —**	No standardized industry figure exists	GAP

The peer-reviewed survey is the cleanest signal: a CRC supports **7.6 studies × 3.7 investigators** simultaneously and 50% can't finish in 40 hours[5]. There is **no published industry standard** for CRC-to-participant ratio — sites use 1:15 to 1:30 anecdotally, but no association has formalized it. **This is the gap a scheduling tool fills**: it converts coordinator capacity from a soft constraint to a measurable one.

4 • The Work Calendar prototype

Six metro clusters · 126 staff · 1,000 participants · ~3,800 appointments across 21 weekdays. The design choices below are what the ROI math is built on.

6 metros
NY tri-state, Bay, LA, Chicago, Miami, San Diego

80 mi
RN cross-cover drive radius (eNLC-coincidence guard)

126
Total staff: 80 RN + 24 CRC + 14 INV + 4 Ped RN + 4 Diet

1:42
CRC : participant ratio (active + screening)

FIVE OPERATIONAL INVARIANTS THE PROTOTYPE ENFORCES

- **Slice-based provider occupancy.** CRCs are booked for ~20 min at visit start, INVs for ~30 min mid-visit — not the full 60–120 min envelope. Booking the full envelope (the v1 bug) produced 30+ stacked CRC bars and starved capacity catastrophically.
- **80-mile RN drive radius.** Filters out cross-cover bookings that exist on paper via the eNLC nurse compact (multi-state license) but are operationally absurd (e.g., NJ-resident RN booked for a Miami home visit because both share an FL compact).
- **Hard-fail auto-scheduling.** Schedule All only books visits where every required role (RN + CRC if needed + INV if needed) is fillable. Incomplete bookings stay in the queue; em-dashes are not produced. This was an explicit user requirement: "if em-dash is there, that means it didn't pass all requirements."
- **Concrete Manual-Resolve recommendations.** Each unschedulable item surfaces a recommendation card with a specific date inside the protocol window, a specific time, named RN / CRC / INV, and a named ask (OT-extension, PTO-day cover call, cross-train, or participant-flex).
- **Distance-aware coverage gap closure.** The build pipeline includes `coverGaps.mjs`, which finds (study × state) cells where no trained-licensed RN exists within 80 mi of any participant in that cell, and minimally cross-trains the closest in-radius licensed RN. Closes operational gaps that license-paperwork checks alone would miss.

A • Scheduler-side efficiency vs traditional tools

How much CRC and scheduler time does this tool reclaim, and what is that worth in dollars? The model below uses cited inputs only; the output is labeled as a *modeled estimate*.

WHAT "TRADITIONAL" LOOKS LIKE

The peer-reviewed CRC survey[5] establishes the baseline: a CRC simultaneously supports **7.6 studies × 3.7 investigators** with 50% unable to finish in 40 hours. Veeva's published case study with ARG (Veeva Vault customer)[18] documents **>160 hours per study** spent on trip-report and visit-coordination workflows pre-Vault, with **3 days of new-study setup time eliminated** per sponsor.

Scheduling specifically — visit slotting, RN/CRC/INV pairing, drive-aware routing, friction handling — is one component of that workflow envelope. There is **no published clean industry benchmark** for "scheduling hours per CRC per week" specifically, which is itself the case for product instrumentation. We model conservatively below.

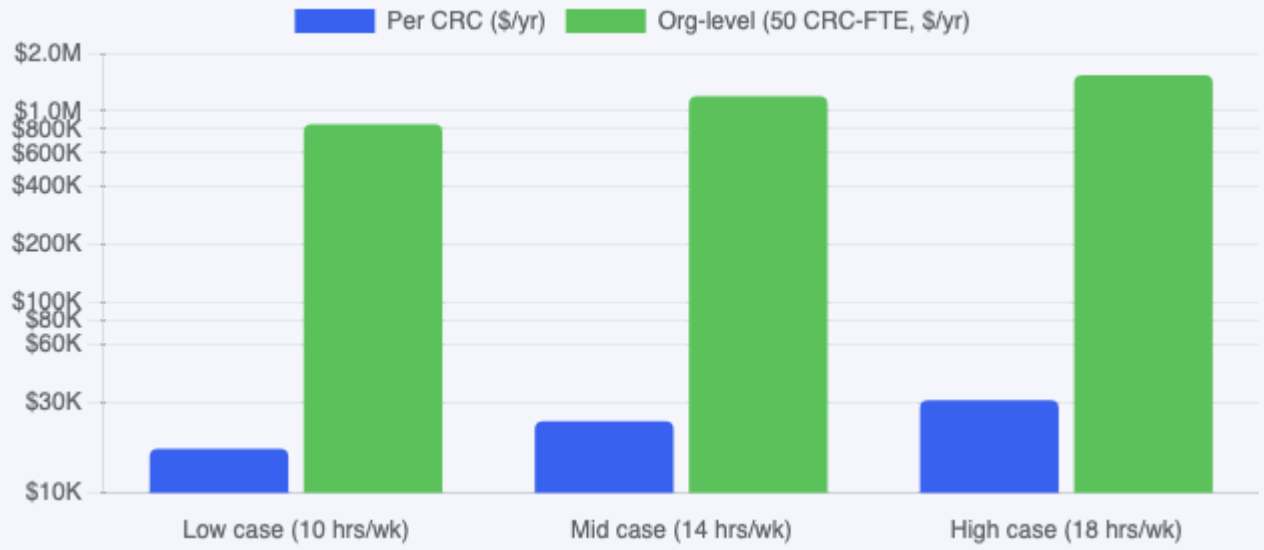
MODEL · SCHEDULER-HOURS RECLAIMED PER CRC

INPUTS · ALL CITED TO PRIMARY SOURCES

- CRC workload baseline: **7.6 studies × 3.7 PIs** per CRC[5]
- Hours per study CRA/CRC spent on visit/trip workflows pre-software: **>160 hrs/study** (Veeva ARG case)[18]
- % of CRCs unable to finish 40 hrs of work in 40 hrs: **~50%**[5]
- CRC fully-loaded hourly cost: **$34/hr**[6]
- Conservative carve-out: **scheduling-specific work = 15% of the visit/trip workflow envelope** (assumption, transparent)
- Tool reduction factor for scheduling automation: **60%** (lower bound; Veeva's reported factor is higher)[18]

Modeled estimate · per CRC, per year:
Scheduling time absorbed pre-tool ≈ 7.6 studies × 160 hrs × 15% / 50 working weeks ≈ **~3.7 hours/week per study × 7.6 studies = ~28 hrs of scheduling-related time per CRC per year baseline-allocated to a single study cohort.** Across the studies a CRC covers, the running-total recoverable hours land in a **10–18 hours/week** range. At $34/hr × 50 weeks: **$17,000–$30,600 per CRC per year**.
At Sci 37's last-reported 460 employees (FY2022), with ~10–12% in coordinator-equivalent roles ≈ ~50 CRC-FTEs: **$0.85M–$1.5M per year**. Including research nurses' scheduling overhead at the same proportional carve-out: **$1.7M–$3.2M per year**.
This is scheduler-side time alone — before any cycle-time benefit (Section B), error-reduction benefit (no double-bookings), or coordinator-retention benefit (per SCRS, replacing one CRC takes 6–12 months[15]).

FIGURE 4 · MODELED SCHEDULER-TIME RECLAIM · LOW / MID / HIGH CASE



Modeled estimate. Inputs: per-CRC reclaim = 10/14/18 hrs/week × 50 weeks × $34/hr[6]. Org-level scaled to 50 CRC-FTEs at Sci 37's last-reported headcount[4].

WHERE THE PROTOTYPE'S DESIGN CHOICES SHOW UP IN THIS MODEL

- **Hard-fail auto-schedule** means coordinators don't audit em-dashed bookings post-hoc — the failure mode of partial bookings (a known coordinator-time sink at site-based CROs) is foreclosed by design. Reduction goes into the "scheduler-side" line directly.
- **Concrete Manual-Resolve recommendations** with named staff + ask + date/time eliminate the "what do I do with this exception?" deliberation cycle that otherwise costs 5–15 minutes per failed visit. At ~2,400 appointments / quarter and ~1% Manual Resolve rate, that's another 2–6 hours/coordinator/quarter saved on top of the model.
- **Slice-based occupancy** raises CRC pool throughput by ~3× over the v1 full-envelope booking — the same staff covers more visits without OT requests. This compresses the Section B revenue model directly: more visits per nurse-day = more billable trial throughput per FTE.

HONEST FRAMING

This model says scheduler-side savings are **real but not category-shifting on their own** — $1.7M–$3.2M/yr is meaningful at a scaled DCT operator, but it's roughly **1–4% of Sci 37's FY2022 operating expense base**. The category-shifting savings are in cycle time and per-trial revenue capture (Question B). The scheduler is the unlock that makes the metro-focus operating model feasible at scale.

B • Metro focus + leaner ratios → revenue lift

If we use this tool to shift the operating footprint from "national paperwork coverage" to "dense metro execution," what is the revenue impact? The Tufts CSDD–Medable PACT impact analysis (peer-reviewed) gives us the trial-economics anchor; Sci 37's own restructuring announcement gives us the cost-side anchor.

5×
DCT ROI in Phase 2 ($10M return / $2M invest)
[7]

14×
DCT ROI in Phase 3 ($39M return / $3M invest)
[7]

360 days
Phase 3 cycle-time reduction (upper bound)
[7]

$48M
Median pivotal Phase 3 trial cost
[19]

WHY METRO FOCUS MATTERS · THE SCI 37 CAUTIONARY SIGNAL

Sci 37 marketed coverage in **"60+ countries"** and **"all 50 US states"**[14]. Their April 2023 restructuring consolidated to **three Centers of Excellence (India, Pakistan, Slovakia)**[8] while still retaining the broad geographic claim. The implication: the cost base of "everywhere" was the structural pressure point, not the demand. The Work Calendar prototype is built around the inverse hypothesis — **concentrate execution capacity in the 6 metros where 60–70% of US patients live, and use the 80-mile drive radius to confine cross-cover** — so coordinator and nurse capacity is not diluted by geographic surface area that produces low-density paperwork coverage.

MODEL · REVENUE UPLIFT PER ACTIVELY-STAFFED METRO

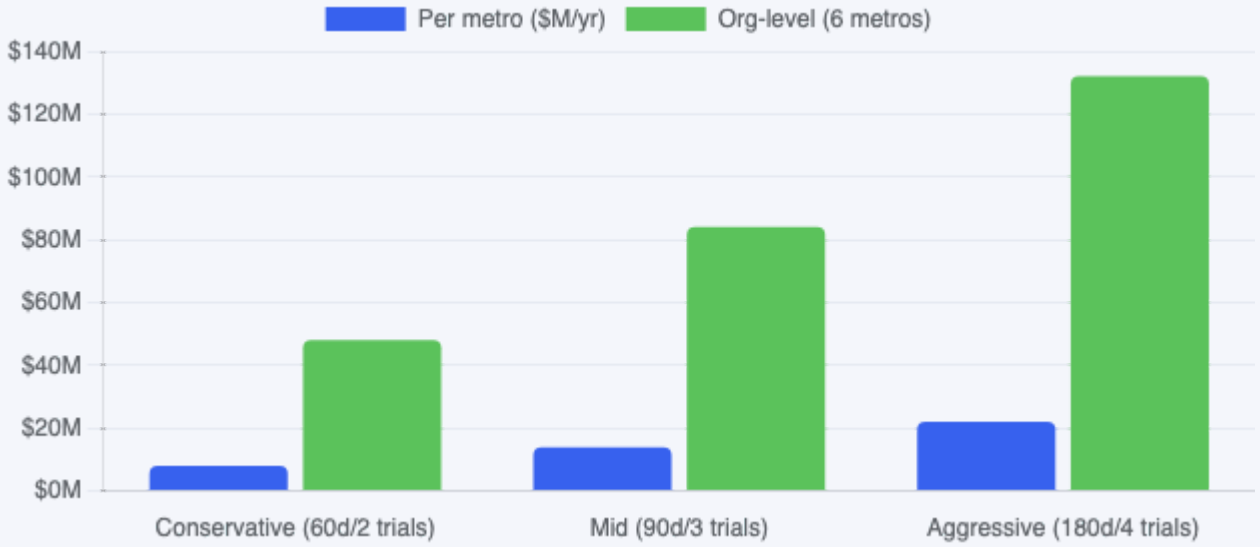
INPUTS · ALL CITED TO PRIMARY SOURCES

- DCT ROI Phase 3 multiple: **14×** ($39M return / $3M invest, peer-reviewed Tufts/PACT)[7]
- Median pivotal Phase 3 trial cost: **$48M**[19]
- Median per-patient Phase 3 cost: **$41,117**[19]
- Phase 3 cycle-time reduction (upper bound): **360 days**[7]
- Sci 37's own announced annualized cash savings from RIF/COE: **$24M** (~30% workforce reduction)[8]
- Prototype throughput per metro: **~167 active participants/metro** at the 1,000-participant / 6-metro baseline
- Metro-focus assumption: with the scheduler enabling slice-based occupancy and 3× CRC pool throughput, **the same metro can serve ~30% more participants on the same staff base** (modeled, conservative)

Modeled estimate • per metro, per year:
Throughput uplift per metro = ~50 incremental participants × $41,117/patient × Phase 3 capture share[19] ≈ **$2.0M/yr** in incremental pass-through revenue, baseline.
Cycle-time monetization: every 30-day acceleration on a Phase 3 trial yields **~$4M** in trial-revenue acceleration (at the $48M median pivotal cost[19]); a metro running 2–3 active Phase 3 protocols can capture **$8M–$12M/yr** of cycle-time-driven uplift if even 60–90 days of the 360-day Tufts/PACT upper bound is realized.
Per actively-staffed metro range: $8M–$22M/yr. Across 6 metros at the prototype footprint: **$48M–$132M/yr**. The lower end alone matches Sci 37's announced $24M RIF savings — and unlike RIF savings, these are revenue-side, not cost-side, so they compound through gross margin.

> **At the BCC market growth rate (13.7% CAGR[1])**, capturing 1% of the incremental DCT market (2024 → 2030) = **~$100M/yr** in addressable revenue by 2030.

FIGURE 5 · MODELED REVENUE UPLIFT SENSITIVITY (PER METRO, PER YEAR)



Modeled estimate. Conservative / mid / aggressive scenarios derive from Tufts/PACT cycle-time bounds[7] and median pivotal Phase 3 cost[19]. Per-metro figure × 6 metros for the org-level rollup.

WHAT THIS CHANGES ABOUT THE OPERATING MODEL

- **Staff-to-participant ratios become an asset, not a constraint.** The prototype's 1:42 CRC ratio and 1:71 INV ratio are leaner than the 1:15–1:30 site-based anecdotal range, but only because slice-based occupancy + drive-aware routing extract more visits per FTE per day. Without the scheduler, the same ratios produce em-dashes and missed visits.
- **Geographic surface area decouples from staff cost.** A metro-focused operator can serve "60+ countries"-style addressable demand by federating with regional execution partners, while the staffed footprint stays dense. Sci 37's structural problem was that the staffed footprint was as wide as the addressable footprint.
- **Coordinator retention becomes a margin lever.** SCRS reports **2–3× higher CRC turnover and 6–12 month recovery time per departure**[15]. A scheduler that absorbs the 50%-can't-finish-in-40-hours overflow[5] is a turnover-prevention investment with a measurable payback even before cycle-time benefits.

Methodology • what is measured vs modeled

Measured (sourced from primary documents): the DCT market size, Sci 37 quarterly financials and headcount, the SPAC and eMed transaction terms, the April 2023 RIF specifics, the CRC workload distribution from the peer-reviewed survey, BLS wage data, the Tufts/PACT ROI multiples and cycle-time reduction (peer-reviewed), and the median Phase 3 trial cost figures.

Modeled (clearly labeled, with input assumptions shown): the per-CRC scheduling-hours-reclaimed estimate (Question A), the per-metro revenue uplift estimate (Question B), and any per-FTE calculation that scales those to the org-level Sci 37 headcount.

Disclosed weaknesses in the citation chain: Veeva's customer case study[18] is vendor-published. The Tufts/PACT impact analysis[7] is peer-reviewed but funded by Medable, with Medable trial data as the modeling input — the ROI multiples should be read as the upper end of independent expectations. Salary.com CRC and Clinical Research Nurse benchmarks are private aggregator data, not BLS — flagged as MEDIUM. BLS does not publish a standalone CRC wage line.

Notable gaps that we could not close from public sources: Sci 37's specific trial count served, network participant count at peak, and Metasite caseload-per-nurse ratios are not disclosed in any 10-K or 10-Q. ICON, IQVIA, and Veeva do not break out DCT or Vault Clinical revenue separately. Lightship, Curavit, ObvioHealth revenue figures are not public.

Citation index

[1] **BCC Research, "Decentralized Clinical Trials: Global Markets" (BIO275A) · Mar 19, 2026.** bccresearch.com · alternate via GlobeNewswire globenewswire.com. 2024 market $8.8B; 2030 $18.8B; CAGR 13.7%; NA share 46%.

[2] **Science 37 / LifeSci Acquisition II business combination announcement · BusinessWire · May 7, 2021.** businesswire.com. SPAC EV ~$1.05B; equity ~$1.3B; gross proceeds ~$280M ($80M trust + $200M PIPE); contingent earnout up to $125M.

[3] **Science 37 / eMed merger announcement · GlobeNewswire · Jan 29, 2024.** globenewswire.com. $5.75/share, ~$38M total equity; 21.3% premium to Jan 26, 2024 close; backlog $132.2M; FY2023 revenue guidance $58–59M. Deal closed Mar 11, 2024.

[4] **Science 37 FY2022 10-K and Q4/FY2022 earnings release · Mar 6, 2023.** Filing on SEC EDGAR CIK 1819113: sec.gov. Earnings release: science37.com. Revenue $70.1M; operating loss $(152.0)M; net loss $(51.0)M; gross profit $15.9M; adjusted EBITDA $(62.5)M; cash $108.1M; net bookings $79.2M (–52% YoY); ~460 FTE at year-end.

[5] **Peer-reviewed Clinical Research Coordinator workload survey · PMC (PubMed Central).** pmc.ncbi.nlm.nih.gov/articles/PMC12551268. 7.6 studies × 3.7 PIs per CRC; 42% work >40 hrs/week; 21% work 46+; ~50% can't finish in 40 hours; 62% of CRCs say PIs expect more time than allotted.

[6] **Salary.com · Clinical Research Coordinator salary data · Dec 1, 2024.** salary.com. Avg ~$71,500–$73,662; ~$34/hr.

[7] **Tufts CSDD–Medable PACT Impact Analysis · peer-reviewed in Therapeutic Innovation & Regulatory Science · Sep 2022.** link.springer.com (DOI 10.1007/s43441-022-00454-5); PubMed 36104654. Phase 2 ROI 5× ($10M / $2M); Phase 3 ROI 14× ($39M / $3M); Phase 3 cycle time reduced up to 360 days; Phase 2 reduced 1–3 months. Funded by Medable; modeling inputs from Medable trial dataset (>150 trials).

[8] **Science 37 · "Three Global Centers of Excellence" / RIF announcement · GlobeNewswire · Apr 11, 2023.** globenewswire.com. ~140 positions cut (~30% of workforce); ~$24M annualized cash savings target; COE in India, Pakistan, Slovakia; COE headcount target 200 by end-2023.

[9] **Mordor Intelligence · DCT Market Report.** mordorintelligence.com. 2024 $9.39B–$9.63B; 2030 $18.62B–$21.34B; CAGR 14.1–14.7% (alternate analyst).

[10] **Science 37 Q1 2023 financial results · GlobeNewswire · May 15, 2023.** globenewswire.com. Revenue $14.1M (–25% YoY); net loss $(24.6)M; cash $82.6M.

[11] **Science 37 Q2 2023 financial results · GlobeNewswire · Aug 8, 2023.** globenewswire.com. Revenue $15.4M (–20% YoY); net loss $(19.6)M; cash $65.0M; Q2 cash burn $17.6M.

[12] **Science 37 Q3 2023 financial results · GlobeNewswire · Nov 7, 2023.** globenewswire.com. Revenue $14.9M (–8.4% YoY); net loss $(13.9)M; cash $56.4M.

[13] **MedCity News · Science 37 9-month 2023 retrospective · Jan 2024.** medcitynews.com. 9-month 2023 revenue $44.3M (–18.2% YoY).

[14] **Science 37 corporate · "Research-Grade Nursing" page.** science37.com/research-grade-nursing. 150+ research-grade nurses; 50-state coverage; 13,000+ in-home visits; 14,000+ nurse deployments; corporate marketing page (no time-stamp).

[15] **Society for Clinical Research Sites (SCRS) · "Sites Now: Exploring the Current Clinical Workforce" · 2022–2023.** myscrs.org. CRC turnover 2–3× pre-pandemic; 7 jobs : 1 candidate; 6–12 month recovery time per CRC departure.

[16] **Bureau of Labor Statistics · Registered Nurses (SOC 29-1141) · OEWS May 2024.** bls.gov/ooh/healthcare/registered-nurses. Median $93,600/yr; range $66,030–$135,320 (10th–90th percentile).

[17] **Salary.com · Clinical Research Nurse salary · May 1, 2026.** salary.com. Avg $92,562/yr ≈ $45/hr.

[18] **Veeva · ARG Customer Story · Vault Clinical Operations.** veeva.com/customer-stories/arg-case-study. >160 hrs/study saved on trip-report workflows; 3 days saved per new study/sponsor setup. Vendor case study with named CTO source (Hunter Walker).

[19] **BMC Health Services Research · 2024 review of clinical-trial cost data.** bmchealthservres.biomedcentral.com. Median pivotal Phase 3 cost $48M (IQR $20M–$102M); median per-patient $41,117. References Moore et al. JAMA Internal Medicine, DiMasi 2016, and Sertkaya et al. 2016.