



— PROTOCOL CARE · INFRASTRUCTURE-FIRST

The rails others will *run on.*

MyDose is the operating system for GLP-1, HRT, and peptide protocol care. We built the full stack — intake, prescribing, four-pharmacy fulfillment, telehealth, employer admin, broker portals, compliance — and went live this quarter. Three reference deployments. One platform.

A *once-in-a-decade* category is forming — on infrastructure that doesn't exist.

01 · CATEGORY SCALE

\$190B

Global GLP-1 market by 2035 · Morgan Stanley

More than 2× today's \$79B. GLP-1, HRT, and peptides are now the fastest-compounding category in pharma — and the only one without dedicated multi-protocol rails.

02 · ADOPTION VELOCITY

588%

GLP-1 Rx growth · adults 18–39 · '19–'24

GLP-1 claims grew from 6.9% to 10.5% of total employer health claims in two years. 57M U.S. adults are clinically eligible. Demand is structural, not faddish.

03 · BUYER URGENCY

77%

of large employers rank GLP-1 cost “extremely important” for 2026

Mercer's 2026 survey: self-insured employers are actively procuring managed protocol programs. The B2B channel barely existed 18 months ago. It's now a procurement priority.

THE WINDOW

The window to define the infrastructure layer for protocol care is open — but not for long.

Every protocol care company is *rebuilding the same stack*.

Hims, Ro, Henry Meds, Mochi — every one of them built a vertical brand on a monolithic stack. None of them sell their rails. *No neutral infrastructure exists for the next wave.*

WHAT THE BRAND CAN'T DO

Add a new protocol — in under 18 months

Hims, Ro, and Henry Meds built monolithic stacks around a single category. Every new protocol or pharmacy partner forces them to re-architect intake, prescribing, fulfillment, and compliance. Build velocity caps their TAM.

WHAT THE CLINIC CAN'T DO

Run protocols on EMRs

Clinics offering GLP-1 and peptide care operate on EMRs, spreadsheets, and faxes — tools built for one-off prescriptions, not ongoing protocol management. Multi-protocol care simply cannot scale on that stack.

WHAT THE EMPLOYER CAN'T BUY

A managed program

Employers can buy point solutions for GLP-1 access. None of them deliver enrollment, clinical care, fulfillment, and outcomes tracking together — which is what self-insured plans actually need to manage cost.

The full stack — *built, live, routing.*

Most telehealth companies spend 18–24 months building infrastructure before their first patient. We shipped *the entire stack* — and went live this quarter.

9

Platform capabilities live
Intake → audit

4

Pharmacy partners routing
503A + retail

3

Channels deployed
Opus · Apex · Partners

50

Operators on platform
Eng · clinical · ops

CAPABILITIES LIVE IN PRODUCTION

- Patient intake & qualification
- Telehealth — sync & async
- Employer admin portal
- Provider prescribing workflow
- Patient tracking & dosing
- Broker portal & commissions
- Pharmacy routing & fulfillment
- Lab ordering
- Compliance audit trail

One platform. *Three live deployments.*

Each channel proves the platform against a different buyer. Opus validates clinical and unit economics on patients we own. Apex proves the employer GTM motion. Partners proves the platform travels.

Opus 01

Direct-to-consumer · Membership

● Live · onboarding patients

Multi-protocol care membership active. Founders Circle launching with a 500-seat cap.

Longitudinal care relationship — labs, peptides, ongoing optimization. Proves clinical economics and protocol layering (GLP-1 → HRT → peptides) on patients we own end-to-end.

Apex 02

Employer & union · Managed program

● 1 LOI signed · paid pilot starting

Broker channel active across construction, logistics, and hospitality verticals.

First-to-market peptide-driven employer benefit. GLP-1 weight management, peptide therapy, baseline blood work. Broker-distributed with a real commission plan.

Partners 03

White-label · Telehealth & clinics

● Multiple in active conversation

Inbound from existing telehealth brands and clinic groups seeking neutral rails.

Vendor-neutral infrastructure other brands can run on. The long-term venture-scale outcome — and the channel that compounds platform leverage.

THE POSITION

We don't compete with Hims, Ro, or Henry Meds. We sit beneath them — or replace them.

Three things *no competitor can replicate in twelve months.*

Capital can be raised. Brands can be marketed. Pharmacy relationships, regulatory architecture, and multi-protocol clinical scope cannot be shortcut.

01

Four-pharmacy direct network

Direct routing to four licensed U.S. pharmacy partners — 503A compounding and brand-name retail. No PBM. No distributor markup. Cross-channel volume aggregates real pricing leverage.

4 pharmacies live · Day 30

02

Multi-protocol clinical scope

GLP-1, HRT, and peptide protocols delivered through one care relationship. Single-protocol competitors can't layer LTV; new protocols require re-architecture they don't have.

3 protocol families · 1 platform

03

PC-MSO compliance posture

NVP Medical Group P.A. + MyDose.ai Health LLC structured from day one. Every Rx through licensed providers and U.S. pharmacies. SOC 2 Type II in progress; LegitScript active.

PC-MSO · HIPAA · audit trail

WHY IT HOLDS

Pharmacy partnerships take 6–18 months each to negotiate and integrate. Multi-protocol scope requires three independent clinical workflows. PC-MSO is expensive to retrofit. By the time competitors notice, the network effect across our three channels is already pricing-in.

Two revenue streams. *Same engine. Every channel.*

01 · RECURRING

Per-patient platform fees

Recurring management fee on every active patient — whether they came in through Opus, an Apex employer, or a Partners white-label brand. Same engine, same economics, same margin profile.

02 · FULFILLMENT

Pharmacy revenue per Rx

Revenue per prescription routed through the MyDose pharmacy network. Cross-channel volume drives pricing leverage with our four partners — leverage no single-channel competitor can match.

FLYWHEEL More deployments → More patients → More volume → Better pharmacy pricing → Better margin for every tenant

WHY IT COMPOUNDS

Every new patient — DTC, employer, or white-label — feeds the same pharmacy volume. Pharmacy leverage improves margin across every channel simultaneously. The platform gets more valuable as it gets used.

Operators who've *shipped this stack.*

Five founders, one CCO, fifty operators — across healthcare, regulatory, and commercial disciplines, with prior exits and regulated-industry GTM experience.



Stefanie Morgan

CEO

Leads strategy, fundraising, and commercial direction across all three channels.



Matt Barberi

CO-FOUNDER

Capital formation and GTM. Prior exit: Ohana Roofing acquired by Koa Capital.



Greg Hadley

CO-FOUNDER

Operations, employer GTM, and clinical partnerships.



Keli'i Heen

CO-FOUNDER

Founding operator on platform, partnerships, and channel build-out.



Matt Pakkala

CO-FOUNDER

Founding operator on platform, partnerships, and channel build-out.



Vivek Chander

CHIEF COMPLIANCE OFFICER

Regulatory architecture, HIPAA, telehealth, and compounding compliance.

OPERATING FOOTPRINT

50 operators across engineering, clinical, operations, and design. Supported by NVP Medical Group P.A. as licensed prescribing entity and outside regulatory counsel.

SEED ASK

\$4M

18 months of runway. Revenue is live across three channels. This round funds the GTM engine to reach a Series A on proven multi-channel economics.

USE OF FUNDS

- Paid acquisition — performance media post-LegitScript across Opus and Apex.
- White-label BD — integration engineering, SLAs, dedicated business development.
- Compliance infrastructure — SOC 2 Type II completion, audit posture at scale.

SERIES A MILESTONES

\$500k

MRR target

3+

Apex employer contracts

10+

White-label deployments

Stefanie Morgan · Matt Barberi

stefanie@mydose.ai · matt@mydose.ai

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