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On behalf of **Imperative Care, Inc.**

By: Joshua J. Stowell (Reg. No. 64,096)
Joseph R. Re (Reg. No. 31,291)
Brian C. Barnes (Reg. No. 75,805)
KNOBBE, MARTENS, OLSON & BEAR, LLP
2040 Main Street, 14th Floor
Irvine, CA 92614
Tel.: (949) 760-0404
Fax: (949) 760-9502
Email: BoxImperative580@knobbe.com

UNITED STATES PATENT AND TRADEMARK OFFICE

BEFORE THE PATENT TRIAL AND APPEAL BOARD

IMPERATIVE CARE, INC.,
Petitioner,

v.

INARI MEDICAL INC.,
Patent Owner.

Case No. IPR2025-01264
Patent No. 12,016,580

**PETITIONER'S REPLY TO PATENT OWNER'S
RESPONSE**

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1003	Expert Declaration of Troy Thornton
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1005	WIPO Publication No. WO 2006/124307 A2 to Goff et al. (“Goff”)
1006	U.S. Patent Publication No. 2015/0173782 A1 to Garrison et al. (“Garrison”)
1007	U.S. Patent Publication US 2003/0225379 A1 to Schaffer et al. (“Schaffer”)
1008	U.S. Patent Publication No. 2003/0116731 A1 to Hartley (“Hartley”)
1009	U.S. Patent Publication No. 2015/0352325 A1 to Quick (“Quick”)
1010	U.S. Patent Publication No. 2010/0042118 A1 to Garrison et al.
1011	U.S. Patent No. 8,734,374 B2 to Aklog et al. (“Aklog”)
1012	U.S. Patent Publication No. 2017/0043066 A1 to Laub (“Laub”)
1013	U.S. Patent No. 6,776,770 B2 to Trerotola (“Trerotola”)
1014	U.S. Patent No. 5,938,645 to Gordon (“Gordon”)
1015	U.S. Patent Publication No. 2014/0296868 A1 to Garrison et al.
1016	Certified File History of U.S. Patent Application 10/371,190 (Schaffer File History)
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1018	U.S. Patent No. 6,481,439 B1 to Lewis et al.
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1020	WIPO Publication No. WO 2018/019829 A1 to Brady et al. (“Brady”)
1021	U.S. Patent No. 12,109,384 B2 to Merritt et al.
1022	Expert Declaration of Dr. Aquilla S. Turk, III, DO
1023	Resume of Dr. Aquilla Turk, III, D.O.
1024	Shani, Jacob M.D., et al., Mechanical Manipulation of Thrombus: Coronary Thrombectomy, Intracoronary Clot Displacement, and Transcatheter Aspiration, 72 Am. J. Cardiol. 116G-118G (1993)
1025	Bose, A et al., The Penumbra System: A Mechanical Device for the Treatment of Acute Stroke due to Thromboembolism, 29 Am. J. Neuroradiol. 1409-1413 (Aug. 2008)
1026	Turk, Aquilla S. et al., Initial clinical experience with the ADAPT technique: A direct aspiration first pass technique for stroke thrombectomy, 6 J. NeuroIntervent. Surg. 231-237 (2014)
1027	Turk, Aquilla S. et al., ADAPT FAST study: a direct aspiration first pass technique for acute stroke thrombectomy, 6 J. NeuroIntervent. Surg. 260-264 (2014)
1028	April 24, 2024 Letter from Inari to Imperative Care
1029	Turk, Aquilla S. et al., Aspiration thrombectomy versus stent retriever thrombectomy as first-line approach for large vessel occlusion (COMPASS): a multicentre, randomized, open label, blinded outcome, non-inferiority trial, 393 Lancet 998-1008 (March 2019)

TABLE OF EXHIBITS
(*cont'd*)

Exhibit No.	Description
1030	Save, Jeffrey L., Time is Brain – Quantified, American Heart Association Journals, available at http://www.stokeaha.org (2005).
1031	Decision Granting Institution of IPR, IPR2024-01157, U.S. Patent No. 11,697,011 B2
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1033	Decision Granting Institution of IPR, IPR2025-00289, U.S. Patent No. 11,554,005 B2
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1037	Plaintiff Inari’s Supplemental Preliminary Disclosure of Asserted Claims and Infringement Contentions Pursuant to Patent Local Rules 3-1 and 3-2 in <i>Inari Medical, Inc. v. Imperative Care, Inc.</i> , 5:24-cv-03117-EKL (N.D. Cal.)
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1041	Order Denying Motion for Preliminary Injunction (Dkt. #136) in <i>Inari Medical, Inc. v. Imperative Care, Inc.</i> , 24-cv-03117-EKL (N.D. Cal.) (issued September 29, 2025)
1042	Decision Denying Patent Owner's Request for Discretionary Denial (Paper 9) in <i>Imperative Care, Inc. v. Inari Medical, Inc.</i> , IPR2025-00289 (P.T.A.B. June 12, 2025)
1043	Decision Referring the Petition to the Board (Paper 9) in <i>Imperative Care, Inc. v. Inari Medical, Inc.</i> , IPR2025-00728 (P.T.A.B. July 31, 2025)
1044	Decision Referring the Petitions to the Board (Paper 11) in <i>Imperative Care, Inc. v. Inari Medical, Inc.</i> , IPR2025-01021 (P.T.A.B. Oct. 10, 2025)
1045	Decision Referring the Petitions to the Board (Paper 11) in <i>Imperative Care, Inc. v. Inari Medical, Inc.</i> , IPR2025-01025 (P.T.A.B. Oct. 10, 2025)
1046	Order Granting In Part Motion To Stay (Dkt. #137) in <i>Inari Medical, Inc. v. Imperative Care, Inc.</i> , 24-cv-03117-EKL (N.D. Cal.) (issued September 29, 2025)
1047	Redacted Excerpts of Deposition Transcript of PO's Expert Brian Brown dated August 27, 2024, submitted as Exhibit 1019 to R. Tyler Kendrick's Declaration in Support of Inari's Statement Regarding Truvic's Administrative Motion Pursuant to Civil L.R. 79-5(C)(1) & (F) (Dkt. #85-1) in <i>Inari Medical, Inc. v. Imperative Care, Inc.</i> , 24-cv-03117-EKL (N.D. Cal.) (filed February 26, 2025)
1048	Deposition Transcript of PO's Expert Paul Zalesky, Ph.D. dated June 23, 2025

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1049	Joint Stipulation to Continue the Stay of Litigation Pending IPR Decisions and Vacate Upcoming Case Management Conference (Dkt. #139) in <i>Inari Medical, Inc. v. Imperative Care, Inc.</i> , 24-cv-03117-EKL (N.D. Cal.) (filed January 21, 2026)
1050	Order Granting Joint Stipulation to Continue the Stay of Litigation Pending IPR Decisions and Vacate Upcoming Case Management Conference (Dkt. #140) in <i>Inari Medical, Inc. v. Imperative Care, Inc.</i> , 24-cv-03117-EKL (N.D. Cal.) (issued January 21, 2026)
1051	Final Written Decision Determining All Challenged Claims Unpatentable (Paper 33) in <i>Imperative Care, Inc. v. Inari Medical, Inc.</i> , IPR2025-00156 (P.T.A.B. Apr. 7, 2026)
1052	Decision Granting Institution of <i>Inter Partes</i> Review for U.S. Patent No. 11,969,333 (Paper 15) in <i>Imperative Care, Inc. v. Inari Medical, Inc.</i> , IPR2025-01021 (P.T.A.B. December 11, 2025)
1053	Decision Granting Institution of <i>Inter Partes</i> Review for U.S. Patent No. 11,974,910 (Paper 15) in <i>Imperative Care, Inc. v. Inari Medical, Inc.</i> , IPR2025-01025 (P.T.A.B. December 11, 2025)
1054	New Oxford American Dictionary Definition of “Material” (3d ed. 2010)
1055-1062	RESERVED
1063	Deposition Transcript of PO’s Expert Brian Brown dated May 13, 2026
1064	Redacted Deposition Transcript of PO’s Expert Brian Brown dated August 27, 2024 in <i>Inari Medical, Inc. v. Imperative Care, Inc.</i> , 24-cv-03117-EKL (N.D. Cal.)
1065	Deposition Transcript of PO’s Expert Dr. Christopher Morris dated May 4, 2026 in IPR2025-01021 and IPR2025-01025

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1066	Deposition Transcript of PO's Expert Dr. Paul Zalesky in IPR2025-00289 dated November 7, 2025
1067	Supplemental Expert Declaration of Troy Thornton
1068	RESERVED
1069	Gibbs, et al., Temporary Stent as a bail-out device during percutaneous transluminal coronary angioplasty: preliminary clinical experience, 71 British Heart J., 372-377 (1994)
1070	Edwards Lifesciences, Fogarty® Occlusion Catheters (product brochure) http://web.archive.org/web/20150228193218/http://www.edwards.com/products/vascular/atraumaticocclusion/pages/occlusioncatheter.aspx
1071	U.S. Patent No. 5,030,201
1072	U.S. Patent No. 8,657,867
1073	U.S. Patent No. 8,721,714
1074	Redacted Deposition Transcript of Troy Thornton dated September 30, 2024 in <i>Inari Medical, Inc. v. Imperative Care, Inc.</i> , 24-cv-03117-EKL (N.D. Cal.)
1075	MitraClip Clip Delivery System Instructions for Use (2013)
1076	FDA Summary of Safety and Effectiveness Data (SSED) for the MitraClip Clip Delivery System (2013)
1077	Troy Thornton and Liz McDermott, MitraClip System Design and History of Development, published as Ch. 7 in <i>Percutaneous Mitral Leaflet Repair</i> (1st ed. 2012)

TABLE OF EXHIBITS
(cont'd)

Exhibit No.	Description
1078	James I. Fann et al., Beating Heart Catheter-Based Edge-to-Edge Mitral Valve Procedure in a Porcine Model Efficacy and Healing Response, 110 Circulation, 988-993 (2004)
1079	U.S. Patent Publication No. 2004/0092962 A1
1080	U.S. Patent Publication No. 2003/0130721 A1
1081	U.S. Patent Publication No. 2010/0145434 A1
1082	U.S. Patent No. 11,638,585

I. INTRODUCTION

The challenged '580 patent claims “treatment of clot material within a blood vessel” by aspirating “a first portion of the clot material” and “engaging the interventional device with a second portion of the clot material remaining within the blood vessel.” Those conventional steps were not novel in 2018. Garrison, for example, discloses aspirating a first occlusion and subsequently inserting an interventional device to treat a second occlusion. (Ex. 1006, [0166].) Garrison similarly discloses deploying thrombectomy devices to engage occlusions that are “too large or too strongly embedded” to be fully removed with aspiration. (*Id.*, [0165].)

PO attempts to distinguish Garrison by narrowing the claims to treating first and second portions of the “same clot.” (POR, 24.) But PO does not identify intrinsic or extrinsic evidence that justifies importing this unrecited “same clot” limitation, and none exists. The claims recite treating “clot material,” not “a clot” or the “same clot.” And the specification uses “clot material” to broadly describe clots or thromboses in a blood vessel, not a single or “same clot.” PO’s attempt to rewrite the claims is unsupported.

The '580 patent also recites pre-charging vacuum in a pressure source and releasing the vacuum to aspirate a first portion of clot material. PO’s related '333 and '910 patents recite similar limitations, and the Board has instituted IPRs

challenging these patents. (Paper 11; Ex. 1052-1053.) In each IPR, the Board preliminarily determined that Garrison discloses pre-charging vacuum while a valve is closed and opening the valve to aspirate clot as recited in the challenged claims. (*Id.*) A U.S. district court similarly determined that Petitioner raised a substantial question of validity regarding PO's '910 patent based on Garrison. (Ex. 1041, 17-22.) In reaching its decision, the district court adopted the opinions of Petitioner's expert, Mr. Thornton, and disregarded the opinions of PO's expert, Mr. Brown. (*Id.*)

PO has identified no reasons for the Board to revise its preliminary decisions or disagree with the district court's conclusions. Instead, PO repeats its POPR arguments that Petitioner allegedly "mixes separate, distinct, and incompatible embodiments in Garrison" and that Garrison's valve is incompatible with reinfusion, which PO presumes is required for treating PE. (POR, 4, 30, 42-47.) The Board preliminarily rejected these arguments in the '333 and '910 IPRs. (Ex. 1052, 31-32, 35-36; Ex. 1053, 32-33, 37-38.) PO does not submit new evidence supporting a different outcome here.

Accordingly, Petitioner respectfully requests a final written decision finding the challenged claims unpatentable.

**II. GROUNDS 1-2: GARRISON ANTICIPATES OR RENDERS OBVIOUS
CLAIMS 1, 5, 9, 11-14, 18, 21-22, 24-28, 30, 33-34**

**A. Garrison Discloses Or Renders Obvious Engaging The Interventional
Device With A Second Portion Of The Clot Material**

The challenged claims recite “treatment of clot material within a blood vessel” by aspirating “a first portion of the clot material” and “engaging the interventional device with a second portion of the clot material remaining within the blood vessel.” (Ex. 1001, Claim 1.)

Garrison discloses these limitations. (Petition, 16-17, 22, 35-37.) Garrison discloses inserting a catheter to aspirate a first occlusion and, “if a secondary more distal treatment site needs to be reached after removal of a first occlusion, a second, smaller diameter catheter may be inserted through the first catheter, and positioned at the distal treatment site.” (Ex. 1006, [0166].) PO does not dispute that Garrison’s “second, smaller diameter catheter” is the claimed “interventional device” or that an occlusion is “clot material.”

Instead, PO attempts to rewrite the claims to exclude Garrison’s method. PO argues that the claims require “treatment of the *same* clot with aspiration and an interventional device.” (POR, 24.) PO contends that Garrison does not disclose the claimed steps because it describes “treating a *separate* and *different clot* (a second occlusion) at a separate treatment site after removing a first clot.” (*Id.*, 21.) However, the challenged claims require treatment of “clot material,” not a “clot.”

(Ex. 1001, claim 1.) The claims never state that the first and second portions of clot material must be from the “same clot” or at the same treatment site. (*Id.*) PO fails to support importing these unrecited limitations into the claims and, therefore, fails to distinguish Garrison.

1. PO Erroneously Argues That The Challenged Claims Require Treating “The Same Clot”

The challenged claims recite “intravascular treatment of *clot material* within a blood vessel.” (Ex. 1001, Claim 1 (emphasis added).) The ’580 patent uses “clot material” to broadly describe clots or thromboses in a blood vessel. For example, the ’580 patent refers to material removed from the patient as “clot material” while simultaneously referring to material remaining in the patient as “clot material.” (*E.g.*, Ex. 1001, 3:46-63.) Similarly, the patent describes pieces of clots trapped within the guide catheter or attachment member generically as “clot material.” (*Id.*, 14:40-50.) It also describes Figure 2G, which depicts two separate clots, as illustrating “clot material.” (*Id.*, 8:24-41, Fig. 2G.)

The ’580 patent’s broad use of “clot material” is consistent with how POSITAs used the term in the art. Mr. Thornton testified that “clot material within a blood vessel” can encompass multiple clots, which is common for patients with embolic disease:

Q. So Claim 1 is directed to treating a pulmonary embolism, correct?

A. It says, treating clot material comprising of pulmonary embolism. I'm sure there could be, you know, more than one in the pulmonary vasculature that this claim is referring to.

...

Q. When the second catheter is positioned proximate to the pulmonary embolism, that's referring to the same clot material, single, continuous clot material, referenced in the Column 35 lines 53 to 54; is that right?

A. Well, I don't know if it's a single piece of clot material in this claim. They're just talking about treating a pulmonary embolism, which could be discrete, and it could be extended and consist of multiple portions of clot, I guess.

Q. And would those multiple portions of clot be located at different locations?

A. They could be.

(See Ex. 2006, 129:4-9, 131:6-132:3.)¹

PO's expert, Brian Brown, similarly testified that "clot material within a blood vessel" is not limited to a single clot:

Q. So if you were reading an article that referred to clot material within a patient's blood vessel, would you understand that to mean that it's only one single piece of clot material? Or could it be multiple pieces of clot material in that vessel?

A. If all it says is they are treating clot material, it is very unclear what it is meant by that, whether it's singular or multiple.

¹ Mr. Thornton's testimony concerned the related '910 patent claims, which recite "treating clot material comprising a pulmonary embolism." (Ex. 2006, 129:4-9, 131:6-132:3.) Mr. Thornton confirmed that a POSITA would have the same understanding of "clot material within a blood vessel" in the '580 patent. (Ex. 2007, 154:12-18.)

Q: So it's possible it could be either one?

A: It is unknown.

(Ex. 1063, 68:23-69:12 (objections omitted).) Mr. Brown also confirmed that patients can have multiple clots in their pulmonary or peripheral vessels. (*Id.*, 68:9-22, 69:18-24.)

PO fails to support a narrower construction of “clot material” to mean the “same clot” at the same treatment site. PO concedes that “the clot material” in the claim body draws antecedent basis from “clot material” in the preamble. (POR, 2, 22.) PO then presumes, without support, that “clot material” in the preamble means a single clot at a single treatment site. (*Id.*, 24.) But PO does not identify any lexicography or disclaimer that would support limiting “clot material within a blood vessel” to “a clot” or the “same clot.” (*See* POR, 19-26); *Thorner v. Sony Comp. Ent. Am. LLC*, 669 F.3d 1362, 1365 (Fed. Cir. 2012). PO similarly fails to identify any prosecution history to support its construction. (*Id.*)

Fundamentally, PO ignores that it did not claim treating “a clot” or the “same clot.” Rather, PO added “material” after clot, broadening the claim scope. PO did not even limit the claims to “treatment of *a* clot material,” but more broadly recited “treatment of clot material.” The plain and ordinary meaning of “material” does not connote a single object but instead connotes a group or collection of matter. (*See*

e.g., Ex. 1054, 1078 (“material” definition: “the matter from which a thing is or can be made: *goats can eat more or less any plant material / materials such as brass / highly flammable materials*”).) If PO wished to restrict the claims to “a clot” or the “same clot,” it could have. For example, PO uses the term “a clot” in the specification to describe the prior art, but PO did not use that term in the claims. (Ex. 1001, 1:37-39.) As the drafter of the patent, PO had the option to select the claim language and now must live with the ramifications. *See, e.g., Int’l Rectifier Corp. v. IXYS Corp.*, 361 F.3d 1363, 1372 (Fed. Cir. 2004) (holding a court may not “excuse the patentee from the consequences of its own word choice”).

Because “clot material” encompasses multiple clots, PO’s focus on “*the* clot material” in the claim body is misplaced. “The subsequent use of definite articles ‘the’ or ‘said’ in a claim to refer back to the same claim term does not change the general plural rule, but simply reinvokes that non-singular meaning.” *Baldwin Graphic Sys., Inc. v. Siebert, Inc.*, 512 F.3d 1338, 1342 (Fed. Cir. 2008). Thus, reference to “the clot material” in the claim body does not limit “clot material” in the preamble to “a clot” or the “same clot.” *Id.*; *see also Rehco LLC v. Spin Master, Ltd.*, 759 F. App’x 944, 950 (Fed. Cir. 2019) (reference to “the bounced signal” in claim body “is irrelevant to whether ‘a signal’ should be limited to a single signal, given that using definite articles ‘the’ or ‘aid’ to refer back to the same claim term simply reinvokes the term’s non-singular meaning”).

Accordingly, the challenged claims encompass methods of aspirating a “first portion of the clot material” and then engaging a “second portion of the clot material remaining within the blood vessel,” regardless of whether the first and second portions come from the same or different clots. PO admits that Garrison describes treating at least two clots (a first and second occlusion). (POR, 21.) Therefore, Garrison anticipates claims 1, 5, 9, 11-14, 18, 21-22, 24-28, 30, 33-34. (Petition, 35-37; Ex. 1003, ¶113.)

2. Garrison Discloses This Limitation Under PO’s Implicit Construction

Even if the Board adopts PO’s unsupported construction that requires aspirating first and second portions of the “same clot,” Garrison discloses this limitation in several ways. (Petition, 35-37; Ex. 1003, ¶¶114-117.)

First, Garrison includes a section titled “Exemplary Methods of Use” that describes methods of using the arterial access device 2010 and catheter 2030 to treat clot material. (Ex. 1006, [0162]-[0164]; Figs. 1, 33-34.) There, Garrison explains that once the aspiration catheter 2030 reaches the occlusion, “[a]spiration is then initiated through the catheter ... with an aspiration pump, or with another aspiration source....” (*Id.*, [0165].) Garrison then discloses: “[i]f the thrombus is too large or too strongly embedded into the vasculature such that it is not possible to remove *the occlusion* via aspiration alone, further steps are taken to remove *the occlusion*.” (*Id.*

(emphasis added).) One “further step[]” uses a “thrombectomy device 15 [which] may be deployed through the arterial access device to remove the clot.” (*Id.*) Thus, Garrison discloses aspirating a first portion of an occlusion with aspiration catheter 2030 and then engaging thrombectomy device 15 with a second portion of that ***same occlusion*** remaining in the vessel. (*Id.*)

PO argues that Garrison’s statement that “if ... it is not possible to remove the occlusion via aspiration alone” means no “first portion” of the occlusion is aspirated. (POR, 33.) That is incorrect. Immediately preceding that statement Garrison explains that “[a]spiration is [] initiated through the catheter,” which indicates to a POSITA that a first portion of the occlusion is aspirated. (Ex. 1006, [0165].) Garrison also recognizes that one aspiration attempt may “not remove enough of the occlusion to restore adequate flow, and additional attempts are needed to remove the occlusion.” (*Id.*, [0145]; *see also id.*, [0173] (“For many stroke procedures, more than one pass is required to completely move the occlusion.”).)

Further, PO’s expert admitted that POSITAs would determine whether a clot is too large or strongly embedded for aspiration alone “through attempts to use aspiration that have failed.” (Ex. 1063, 175:1-181.) He also admitted that aspiration could remove part of an occlusion while leaving the remainder within the vessel. (*Id.*, 175:25-176:7.) A POSITA would have therefore understood that Garrison

encompasses situations where the first aspiration attempt removes a portion of the clot but was insufficient to **completely** remove the clot.

Second, the “Exemplary Methods of Use” section also discloses “if a secondary more distal treatment site needs to be reached after removal of a first occlusion, a second, small diameter catheter may be inserted through the first catheter, and positioned at the distal treatment site.” (Ex. 1006, [0166].) Garrison does not state that the occlusion is “a **separate** and **different clot** (a second occlusion) at a separate treatment site after removing a first clot,” as PO argues. (POR, 21; *see also id.*, 20.)

Rather, a POSITA would have understood the first occlusion to encompass a proximal portion of a clot removed on a first pass, while the second occlusion encompasses a distal portion of the **same clot** removed on the second pass. As PO’s expert testified, if “the clot is four centimeters, five centimeters long[,] [o]ne end of the clot is not going to be at the same location as the other end of the clot, but it’s a continuous clot.” (Ex. 1063, 192:1-8.) PO identifies no disclosure in Garrison that restricts the occlusion at the distal treatment site to a “separate and different clot.”

Thus, Garrison discloses multiple uses of the aspiration catheter 2030 to practice the claimed method, even under PO’s unsupported construction.

3. Garrison Renders This Limitation Obvious Under PO's Implicit Construction

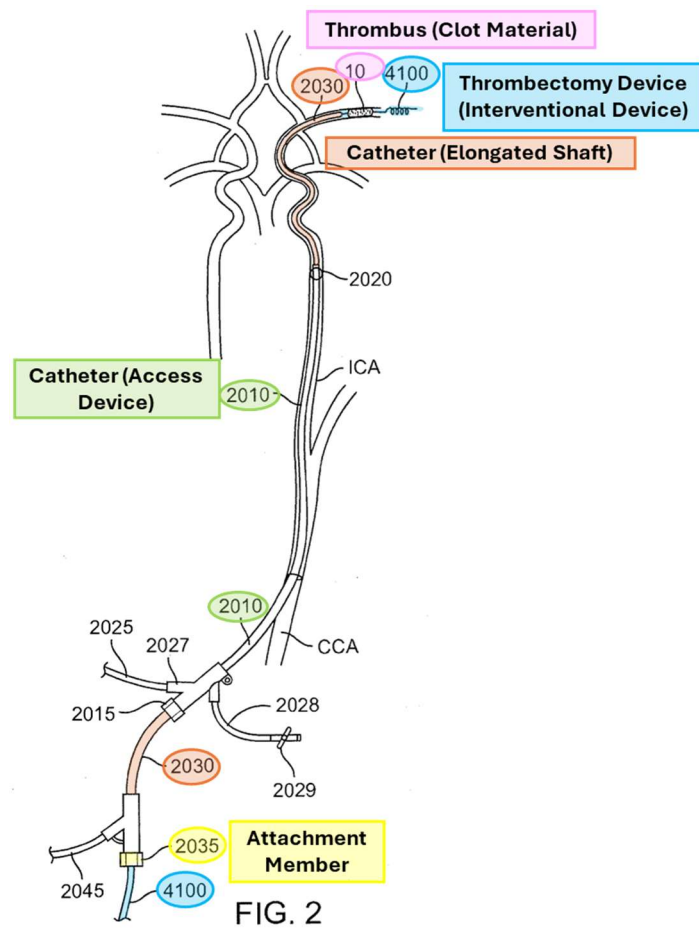
Even if Garrison does not disclose treating two portions of the “same clot,” it renders the treatment obvious. (Petition, 35-37; Ex. 1003, ¶¶114-117.) Garrison recognizes that a clot may be “too large or too strongly embedded into the vasculature such that it is not possible to remove the occlusion via aspiration alone.” (Ex. 1006, [0165]; *see also id.*, [0145]) (a single aspiration attempt may “not remove enough of the occlusion to restore adequate flow, and additional attempts [may be] needed to remove the occlusion”).) Garrison explains that in this situation, “further steps are taken to remove the occlusion,” including a “thrombectomy device ... deployed through the arterial access device to remove the clot.” (*Id.*, [0165].)

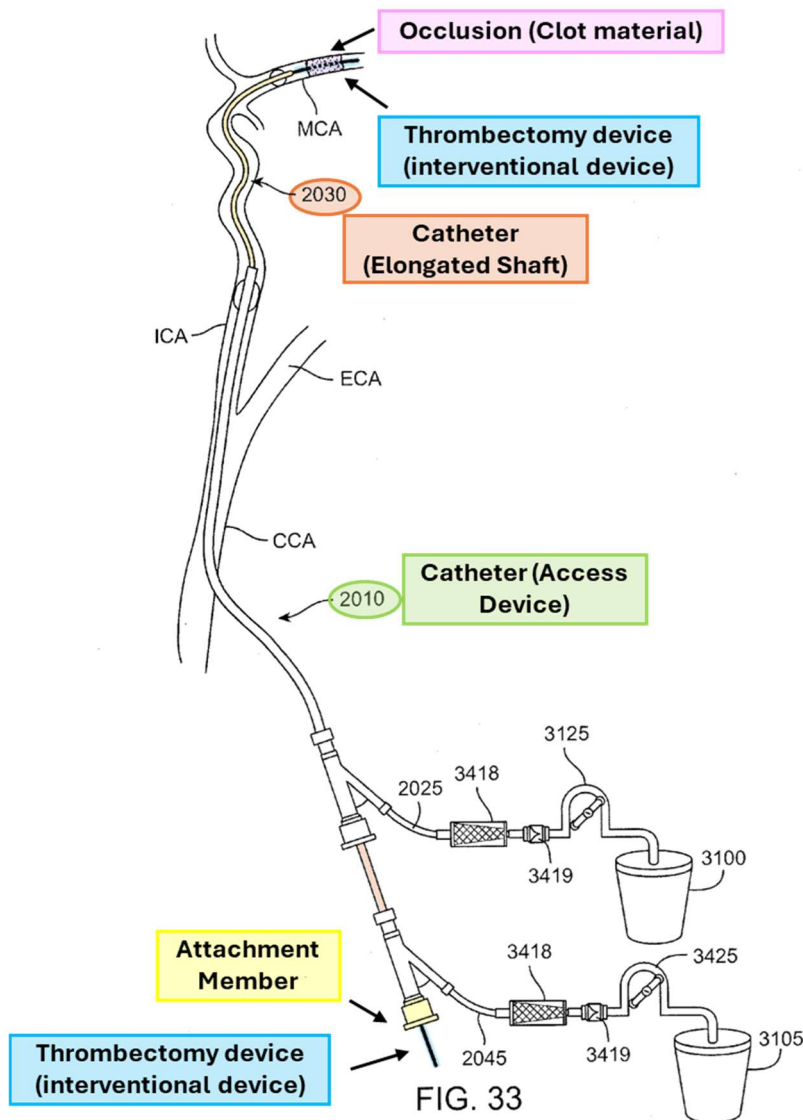
These disclosures would have motivated a POSITA to treat a second portion of the “same clot” with the thrombectomy device if the clot was “too large or too strongly embedded” to be completely removed by aspiration. (*Id.*; Petition, 35-37; Ex. 1003, ¶¶114-117.) Garrison recognizes the risks of leaving small clot pieces in the patient. (Ex. 1006, [0045].) A POSITA would have reasonably expected success using Garrison’s thrombectomy device because Garrison discloses that the aspiration catheter 2030 can “deliver additional catheters and/or interventional devices to the site of the occlusion,” and the “thrombectomy device 15 has a working length that allows it to extend out of the arterial access device 2010 or catheter 2030

with enough length to access and cross the cerebral occlusion.” (Ex. 1006, [0054], [0143].)

PO raises only one argument regarding obviousness. PO disputes that a POSITA would have been motivated to insert a thrombectomy device through Garrison’s aspiration catheter 2030 because paragraph 165 states: “thrombectomy device 15 may be deployed through the arterial access device to remove the clot.” (POR, 32-35.) PO suggests this sentence means that the interventional device is *not* deployed through the aspiration catheter 2030. But PO’s argument ignores Garrison’s full disclosure. *In re Warsaw Orthopedic, Inc.*, 832 F.3d 1327, 1332 (Fed. Cir. 2016) (“When the PTAB examines the scope and content of prior art ... it must consider the prior art in its entirety, i.e., as a *whole*.”) (quotation omitted).

Garrison repeatedly discloses that the aspiration catheter 2030 “is placed through the arterial access device 2010”:





(Ex. 1006, [0164], Figs. 2, 33; POR, 33.) Thus, Garrison’s statement that the thrombectomy device may be inserted through the arterial access device **does not** mean that the device is not also inserted through catheter 2030. Rather, as illustrated by Figures 2 and 33 above, Garrison repeatedly discloses that the thrombectomy device is “deployed through the arterial access device” **and** through the aspiration catheter 2030. (Ex. 1006, [0054]-[0056], [0164], Figs. 2, 33.)

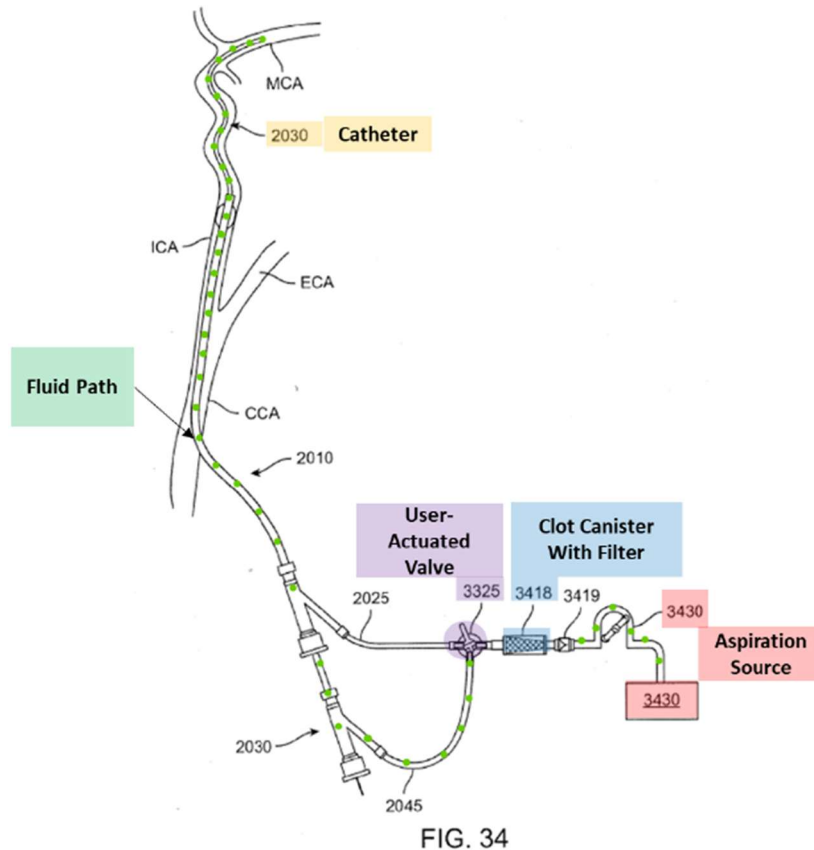
Further, Garrison discloses the aspiration catheter 2030 can “deliver additional catheters and/or *interventional devices* to the site of the occlusion,” and the “thrombectomy device 15 has a working length that allows it to extend out of the arterial access device 2010 *or catheter 2030* with enough length to access and cross the cerebral occlusion.” (*Id.*, [0054], [0143] (emphases added).) Garrison further discloses inserting “a second, smaller diameter catheter” through the first catheter to reach a distal treatment site. (*Id.*, [0166].) These express suggestions to combine interventional devices with catheter 2030 would have motivated a POSITA to advance Garrison’s thrombectomy device through the aspiration catheter 2030 to “remove the clot” if aspiration alone were insufficient, and they would have provided a POSITA with a reasonable expectation of success. (Ex. 1003, ¶¶116-117.) PO’s argument that Garrison contains no disclosure for inserting an interventional device through catheter 2030 is simply incorrect. (POR, 34-35.)

Accordingly, Garrison anticipates claims 1, 5, 9, 11-14, 18, 21-22, 24-28, 30, 33-34 or renders them obvious regardless of construction. (Petition, 35-37.)

B. Garrison Discloses Pre-Charging Vacuum

PO also argues that Garrison does not disclose “pre-charging a vacuum in a pressure source” and “apply[ing] the pre-charged vacuum to the elongated shaft to aspirate a first portion of the clot material into the elongated shaft.” (POR, 26-30.) The Board preliminarily found these arguments unpersuasive in related IPRs. (Ex.

1052, 31-32; Ex. 1053, 32-33.) The Board found that Garrison discloses closing a valve to pre-charge vacuum and opening the valve to apply the vacuum to aspiration catheter 2030:



(Ex. 1052, 31-32; Ex. 1053, 32-33; Ex. 1006, [0131]-[0134], Fig. 34; Petition, 19-21.) PO identifies no new evidence undermining the Board’s preliminary findings.

Instead, PO repeats its POPR argument that Petitioner conflates “disparate” embodiments in Garrison’s Figure 34 and paragraph 134. (POR, 27-30.) The Board preliminarily rejected this argument for several reasons. (Ex. 1052, 32-33.) For example, the description of Figure 34 begins in paragraph 132 and immediately

precedes the paragraph-134 description of closing/opening a valve to build up/release pressure. (*Id.*; Ex. 1006, [0132]-[0134].) The descriptions are not disparate, but part of a short section titled “Exemplary Embodiments of Aspiration and Flow Control,” which describes combining features across embodiments. (Ex. 1052, 32-33; Ex. 1006, [0130], [0134].) Paragraph 134 also references the components in Figure 34, including a pressure source, flow controller, flow lines, and catheter. (*Id.*) Thus, a POSITA would have understood the method described in paragraph 134 applies to Figure 34. (Ex. 1003, ¶¶80-87.)

Additionally, PO’s experts disagree that the embodiments are “disparate.” PO’s expert, Mr. Brown, testified that Figure 34’s aspiration source would build up vacuum when the valve is closed, regardless of whether the aspiration source is a pump or syringe. (Ex. 1063, 163:13-164:4; *see also* Ex. 1064, 96:14-99:13 (testifying Garrison is “configured to generate vacuum pressure while the fluid control device is in the closed position” and apply the vacuum to the catheter when the fluid control device is opened).) Mr. Brown also confirmed that this method of generating vacuum was known before 2018. (Ex. 1064, 42:11-44:4.) PO’s experts from related IPRs, Dr. Morris and Dr. Zalesky, similarly testified that Garrison discloses pre-charging vacuum in Figure 34 while the valve is closed. (Ex. 1065, 150:9-152:10, 158:8-159:1; Ex. 1066, 128:5-129:13.) Thus, PO cannot genuinely dispute that the aspiration method in paragraph 134 applies to Figure 34, and that

the method pre-charges vacuum as claimed in the '580 patent.

PO also repeats its argument that the method in paragraph 134 requires a **syringe** attached **directly** to a flow controller, while Figure 34 requires a **peristaltic** pump. (POR, 26-30.) The Board correctly rejected that paragraph 134 requires a syringe because “Garrison teaches, in the same paragraph where the cited ‘maximum level of aspiration in a rapid fashion’ appears, that several alternative aspiration sources may be used in its systems,” including a pump. (Ex. 1052, 33-34 (citing Ex. 1006, [0134]).) This same broad disclosure also applies to Figure 34, which is never limited to peristaltic pumps. (Ex. 1006, [0131]-[0132]; *see also id.*, [0135] (discouraging peristaltic pumps in some situations).) PO’s experts similarly confirmed that Figure 34 is not limited to peristaltic pumps. (Ex. 1063, 152:13-22; Ex. 1065, 150:9-151:2; Ex. 1066, 114:4-115:19.)

Paragraph 134 also does not require a **direct** attachment between the aspiration source and flow controller. (Ex. 1006, [0134].) Paragraph 134 says that the aspiration source is “attached” to the syringe; not directly attached. (*Id.*) Garrison also discloses substituting a “flow controller” for the stopcock in Figure 34, which is **indirectly** attached to the aspiration source, and Figure 35 includes drafting lines to suggest that the flow controller may be indirectly attached to the aspiration source:

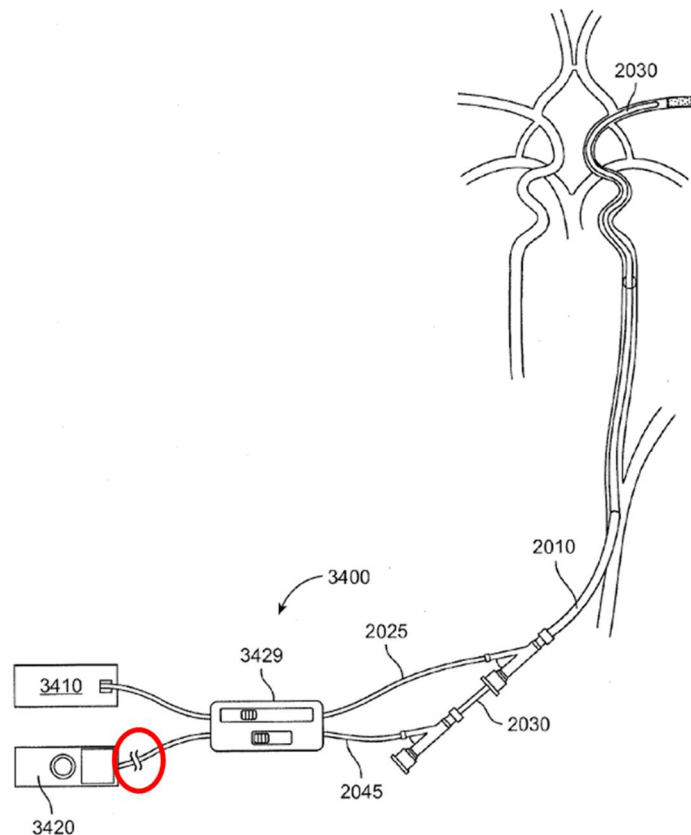


FIG. 35

(*Id.*, [0132]-[0133], Figs. 34-35.) Further, as PO’s expert admitted, Garrison discloses that Figure 33 may use a syringe and includes a filter between the syringe and aspiration catheter. (Ex. 1063, 168:22-25; *see also* Ex. 1006, [0131], Fig. 33.)

PO also argues that Garrison’s aspiration method would work only with a syringe because a pump would not generate “the maximum level of aspiration.” (POR, 28-29.) PO focuses solely on the phrase “maximum level of aspiration,” repeatedly truncating Garrison’s full disclosure that the valve provides this aspiration “in a rapid fashion.” (*Id.*) PO argues that syringes and pumps enable maximum levels of aspiration differently. (*Id.*) PO concludes, without support, that

Garrison’s example of building up pressure with a valve and syringe (*see* Garrison’s paragraph 134) is “not associated with the valve 3325 and other aspects of Figure 34.” (*Id.*)

PO’s focus on the “**maximum** level of aspiration” is misguided. The challenged claims do not require generating a maximum level of aspiration; they require pre-charging vacuum in a pressure source and releasing the vacuum to aspirate a first portion of clot material. (Ex. 1001, claim 1; Ex. 1063, 94:25-95:10.) Moreover, the benefit of utilizing Garrison’s valve to generate vacuum pressure is to improve the system’s temporary aspiration power and aspirate clots “in a rapid fashion.” (Petition, 19-22.) PO does not dispute that closing Garrison’s valve would build up vacuum pressure and opening the valve quickly would release the pressure to improve aspiration, regardless of whether the aspiration source is a syringe or pump. (Ex. 1063, 163:13-164:4.)

The ’580 patent confirms that pumps and syringes can build up pressure in an aspiration system. The ’580 patent states that “the syringe or **other pressure source** can be pre-charged with a vacuum—such as by drawing a plunger of the syringe with the stopcock 1110 closed.” (Ex. 1001, 20:65-21:1 (emphasis added).) Dependent claim 7 recites that the “pressure source is a syringe,” confirming that claim 1 encompasses embodiments where the pressure source is **not** a syringe. (*Id.*, claim 7.) Yet, the ’580 patent does not differentiate between syringes and “other

pressure source[s]” (e.g., a pump) when describing how to pre-charge and release pressure. (*Id.*, 20:65-21:1.) Instead, the ’580 patent treats the pressure sources as interchangeable. (*Id.*)

The evidence also shows that physicians used syringes and pumps to create rapid aspiration before 2018. Dr. Turk, an interventional neuroradiologist, explained, “[o]ne of the techniques my fellow surgeons and I have done since the early 2010s is to place a tube clamp on the tubing running from the aspiration catheter to the syringe or pump [and then] pull back the syringe or turn on the pump to create negative pressure in the tubing before removing the tube clamp [to] increase[] the suction immediately applied to the clot.” (Ex. 1022, ¶23.) Thus, a POSITA would have expected Garrison’s aspiration method to work with syringes and pumps.

C. Garrison Discloses Collecting Aspirated Clot Material Within A Filter Chamber (Claim 18)

PO also argues that Garrison does not disclose “collecting at least some of the first portion of the clot material within a filter chamber fluidly coupled between the pressure source and the elongated shaft” as required by claim 18. (POR, 37-40.) PO does not dispute that Garrison’s Figure 34 discloses a “filter chamber fluidly coupled between the pressure source and the elongated shaft.” (*See* POR, 37-40.) Instead, PO again argues that Garrison’s aspiration method in paragraph 134 is a “disparate

embodiment” that cannot be used with the system in Garrison’s Figure 34. (*See id.*; *see also supra* §II.B.) As demonstrated above, Garrison’s aspiration method is compatible with Figure 34, and PO’s experts agree. (Ex. 1063, 163:13-164:4; Ex. 1065, 150:9-152:10, 158:8-159:1; Ex. 1066, 128:5-129:13.) Garrison therefore anticipates claim 18 or renders it obvious. (*See* Petition, 58-63.)

PO also incorrectly argues that Garrison does not disclose this limitation because the aspiration method in paragraph 134 requires a syringe attached “directly” to a flow controller and cannot include a filter between the syringe and the flow controller. (POR, 38-39.) PO’s argument is incorrect as explained above. (*Supra* §II.B.)

III. GROUNDS 9-14: GARRISON, SCHAFFER, HARTLEY AND/OR GOFF COMBINED WITH AKLOG AND/OR LAUB RENDERS CLAIM 10 UNPATENTABLE

Claim 10 requires “the blood vessel is a pulmonary blood vessel.” (Ex. 1001, claim 10.) POSITAs would have found it obvious to use or optimize Garrison’s aspiration system to treat clot material in a pulmonary vessel based on Laub or Aklog, which disclose treating PE with systems like Garrison’s. (Petition, 81-90.) PO’s only challenge to these combinations is the mistaken argument that Laub and Aklog require continuously reinfusing aspirated blood to treat PE, and that using a valve with Garrison’s Figure 34 is incompatible with reinfusion. (POR, 42-47.) PO raised these same arguments in the ’333 and ’910 IPRs, and the Board preliminarily

found them unpersuasive. (Ex. 1052, 35-36; Ex. 1053, 37-38.) PO fails to identify any errors in the Board's analysis, and PO's arguments are unpersuasive for several reasons.

First, PO presumes that Laub and Aklog require continuous reinfusion. (POR, 42-43.) Yet, both references describe reinfusion as optional (as does Garrison). For example, Laub discloses embodiments having a return catheter to reinfuse blood into the patient. (Ex. 1012, [0045].) While Laub explains that continuous reinfusion can permit greater flow rates, Laub does not disclose that greater flow rates are necessary to aspirate clots or that reinfusion is necessary. (*Id.*) Similarly, Aklog discloses, "the systems and methods of the present invention *may* simultaneously reinfuse aspirated (i.e., removed) and filtered fluid." (Ex. 1011, 5:19-22 (emphasis added); *see also id.*, 6:9-11 ("The suction and reinfusion of blood can occur, in an embodiment, continuously for a desired duration to minimize fluid loss in the patient.").) Aklog does not require blood return.

Further, even if continuous reinfusion were necessary, Garrison's valve would not interfere. PO's expert admitted that reinfusion would occur only *after* aspiration has been applied to the occlusion and blood is withdrawn from the patient. (Ex. 1063, 182:11-183:2.) Garrison discloses closing the valve *before* aspiration, generating vacuum, and then opening the valve to release the vacuum and initiate

aspiration. (Ex. 1006, [0134].) Once the valve is opened, the aspiration is continuous and the blood may be reinfused continuously. (Ex. 1067, ¶29.)

Second, PO argues that Garrison’s method is incompatible with reinfusion because the blood would be “static” while Garrison’s valve is closed. (POR, 43.) The Board preliminarily rejected this argument in the related IPRs because Garrison’s method of pre-charging is “a temporary step to enable a rapid burst of suction—without blood being withdrawn from the patient during this brief window.” (Ex. 1052, 36; *see also* Ex. 1006, [0134].) A POSITA would not have expected substantial thrombus formation during this temporary step. (Ex. 1067, ¶28.)

PO also argues that aspiration sources like syringes where the blood remains “static” and is “exposed to air” are not suitable for blood return. (POR, 43.) However, PO’s FlowTrieve system uses a syringe as its aspiration source, and PO’s expert in related IPRs, Dr. Morris, testified that he “always” reinfuses the patient’s blood when using the FlowTrieve. (Ex. 1065, 94:7-16, 97:12-99:3.) PO therefore cannot credibly assert that “static” blood is unsuitable for reinfusion.

Thus, PO’s blood return arguments are unpersuasive, and PO does not present any other argument for Grounds 9-14. (POR, 37-40.) Accordingly, PO fails to rebut Petitioner’s showing that claim 10 would have been obvious in view of Garrison combined with Laub or Aklog and optionally Schaffer or Hartley.

IV. PETITIONER'S POSITA DEFINITION IS CORRECT

PO incorrectly argues that Mr. Thornton's testimony should be afforded no weight due to his POSITA definition. Mr. Thornton opines that a POSITA would be an engineer with 2-4 years of catheter design experience who would consult with a physician as necessary. (Ex. 1003, ¶35-36.) Mr. Thornton's definition is based on real-world experience. He explains that during his career, he would "assign an engineer with the experience described" to "design catheters, sheaths, and related components such as hemostasis valves for use in cardiovascular procedures." (*Id.*)

PO counters that a POSITA must have "industry experience in the mechanical thrombectomy industry or comparable industry experience." (POR, 13-18.) Yet, PO never defines "comparable industry experience" and never explains why an engineer with years of catheter-design experience and access to physicians does not have it. (Ex. 2005, ¶45.) Experience designing catheters for vascular procedures is comparable to mechanical thrombectomy experience. Mr. Thornton has explained, "[m]ost catheters have a lot of similarities" and therefore "catheter design experience would be beneficial in general for a person of skill in the art." (Ex. 2006, 44:21-24; *see also* Ex. 1063, 61:7-62:5 (PO's expert agreeing that "[w]orking on catheters will assist you in developing other catheters relative to the construction of the catheter").) Many of the references cited on the face of the '580 patent relate to other catheter-based procedures, not mechanical thrombectomy. (*See e.g.*, Exs. 1069-1073.)

PO fails to demonstrate any material distinction between the parties' proposed POSITA definitions, much less a distinction that would warrant wholesale disregard of Mr. Thornton's testimony. *See, e.g., TRW Auto. US LLC v. Magna Elecs. Inc.*, IPR2014-00266, 2014 WL 2965901, at *7 (P.T.A.B. June 26, 2014) (rejecting that petitioner's POSITA definition "infect[ed] [the] entire obviousness analysis" because PO "d[id] not explain sufficiently ... *why* [petitioner's] definition renders [it's] obviousness analyses incorrect").

V. PETITIONER'S EXPERTS ARE QUALIFIED AND CREDIBLE

Even if the Board adopts PO's definition, PO fails to show that the Board should accord Mr. Thornton's or Dr. Turk's testimony little or no weight.

Mr. Thornton has significant "comparable industry experience" to qualify as a POSITA. (Ex. 1074, 59:20-61:10.) PO's expert, Dr. Morris, explained that comparable industry experience requires "experience in clot, and mitigating the effects of clots." (Ex. 1065, 205:17-206:21.) By 2018, Mr. Thornton had considerable experience designing products to avoid and mitigate clots. (Ex. 1067, ¶¶8-18.)

Additionally, Mr. Thornton had 30+ years of experience developing medical devices such as blood pumps and catheters "from small diameters to large diameters, used in multiple locations throughout the body." (Ex. 1074, 59:20-61:10; Ex. 1003, ¶¶5-14.) Mr. Thornton also had considerable experience developing multi-lumen

catheters with “more complex features” than what a “single lumen aspiration catheter would require.” (Ex. 2006, 47:13-23.) Additionally, the catheters Mr. Thornton developed required aspirating fluid or air through the catheter. (*Id.*, 47:24-49:23.) Accordingly, Mr. Thornton qualifies as a POSITA and an expert.

PO also argues that Dr. Turk’s testimony is not relevant to Petitioner’s grounds because Dr. Turk did not opine on the challenged claims or the prior art. (POR, 19-20.) That is incorrect. Dr. Turk provides testimony regarding the procedures used by POSITAs to aspirate clots from the body before 2018, and the real-world adaption of catheters for use across various parts of the vasculature. (Ex. 1022, ¶¶16-41; *see also* Ex. 2008, 36:15-37:1, 48:21-49:13, 51:2-53:4.)

For example, Dr. Turk testified that since the early 2010s, POSITAs have “place[d] a tube clamp on the tubing running from the aspiration catheter to the syringe or pump” to “create negative pressure in the tubing before removing the tube clamp,” “which increases the suction immediately applied to the clot.” (Ex. 1022, ¶23; *see also* Ex. 2008, 27:17-29:6.) This testimony is relevant to Petitioner’s invalidity grounds. It is also undisputed. PO’s expert, Mr. Brown, confirmed that he witnessed this technique “[m]any times” before 2018. (Ex. 1064, 42:11-44:4.)

Dr. Turk also explained why cerebral clots are more challenging to treat and why a POSITA could adapt systems designed for cerebral clots to treat PE/DVT. (Ex. 1022, ¶¶33-37; *see also* Ex. 2008, 64:7-65:18.) Dr. Turk’s testimony is relevant

to Petitioner's invalidity grounds and particularly rebuts PO's argument that a POSITA would have been discouraged from using or adapting Garrison's aspiration system to treat PE/DVT.

VI. GROUNDS 3-8

PO does not present any unique arguments for grounds 3-8, and PO does not present any arguments regarding Goff, Schaffer, or Hartley. (POR, 36-40.) PO therefore fails to rebut Petitioner's evidence that challenged claims 1, 5-6, 9, 11-30, and 33-34 would have been obvious as explained in the Petition.

VII. CONCLUSION

Petitioner has established by a preponderance of the evidence that the challenged claims are unpatentable and, therefore, requests that the Board cancel the claims.

Dated: June 4, 2026

By: /Joshua J. Stowell/

Joshua J. Stowell (Reg. No. 64,096)

Joseph R. Re (Reg. No. 31,291)

Brian C. Barnes (Reg. No. 75,805)

KNOBBE MARTENS OLSON & BEAR, LLP

Attorneys for Petitioner,

Imperative Care, Inc.

CERTIFICATE OF COMPLIANCE

Pursuant to 37 C.F.R. § 42.24(d), the undersigned certifies that this **PETITIONER’S REPLY TO PATENT OWNER’S RESPONSE** contains 5,555 words and therefore complies with the type-volume limitations of 37 C.F.R. § 42.24(c).

Dated: June 4, 2026

By: /Joshua J. Stowell/
Joshua J. Stowell (Reg. No. 64,096)
KNOBBE MARTENS OLSON & BEAR, LLP

CERTIFICATE OF SERVICE

I hereby certify that, pursuant to 37 C.F.R. § 42.6(e), a true and correct copy of **PETITIONER’S REPLY TO PATENT OWNER’S RESPONSE** is being served electronically on June 4, 2026, to the e-mail addresses shown below:

Joseph Hamilton
Reg. No. 51,770
hamilton-ptab@perkinscoie.com
PERKINS COIE LLP
1888 Century Park East, Suite 1700
Los Angeles, CA 90067-1721
Tel: (310) 788-3271

Paul Parker
Reg. No. 38,264
parker-ptab@perkinscoie.com
Matthew Williams
Reg. No. 77,516
williams-ptab@perkinscoie.com
PERKINS COIE LLP
1201 Third Avenue, Suite 4900
Seattle, WA 98101-3099
Tel: (206) 359-8000

Inari-Imperative@perkinscoie.com

Dated: June 4, 2026

By: /Joshua J. Stowell/
Joshua J. Stowell (Reg. No. 64,096)
KNOBBE MARTENS OLSON & BEAR, LLP