AEVION QVenture — Investment Memo

Generated 2026-11-26 · AEVION AI Investment Analyst · not investment advice

FICTIONAL EXAMPLE: the company in this example is made up; any resemblance of names is coincidental. All figures are model output on invented inputs.

RetinaScan

Healthtech / Digital Health · seed · US · raising $5,500,000

Score 61.7/100 — WATCH (conviction: low)

Signal coverage: 44% company-specific (1 metrics parsed from the plan); remainder from sector priors.

Investment memo

RetinaScan is a conditional lead-with-a-tranche, not a pass: the 91% sensitivity signal across 900 patients and $40k MRR in 18 clinics is a genuine clinical and commercial proof point in a fast-growing screening market, and breakthrough-device designation compresses the regulatory moat that defines this category. The single strongest reason for is that a cleared, reimbursed autonomous DR tool is a durable, license-protected franchise. The single strongest reason against is reimbursement dependency—without a durable CPT/NTAP pathway, PCPs will not screen at a loss and the entire revenue thesis collapses, and specificity plus LTV/CAC were not disclosed, leaving the diagnostic and unit economics unstressed. Accordingly, treat this as a staged bet: commit an initial $1.29M for ~6% at roughly $16M pre, gated on a data room confirming specificity, CAC/LTV, and a credible payer roadmap; reserve ~$1.94M for pro-rata contingent on De Novo progress and a signed coverage pathway. Cap total exposure at ~$2.07M.

Narrative engine: model anthropic (per-part source not recorded)

Entry strategy

Ticket: $1,293,180 target (range $646,590–$2,069,088)
Target ownership: 6%
Valuation band (pre-money): $8,280,800 / $16,053,000 / $32,106,000
Modelled return (not a forecast): 6.6x multiple (16.1x base) · horizon 7yr · loss prob 60%

Deployment schedule:

- 40% — Entry: On close, after founder + IP + cap-table diligence.
- 35% — Milestone: Product-market fit signal (retention cohort / first repeatable revenue).
- 25% — Pro-rata: Reserve for next priced round to defend ownership.

Portfolio: Size at ~1.1% of a diversified venture portfolio (fractional-Kelly, conviction-scaled). Reserve 1,939,770 USD for pro-rata follow-on.

Score breakdown

Market size & growth — 66/100 (weight 14%)
~$420B TAM, 23% CAGR (Healthtech / Digital Health).

Timing / tailwinds — 78/100 (weight 5%)
Sector growth 23% vs. 12% neutral baseline.

Moat / defensibility — 63/100 (weight 16%)
regulatory license is the category's mature moat (ceiling 82), but ~61% realized at seed given disclosed traction — an unproven moat is discounted toward the 35 "no demonstrated defensibility" floor.

Unit economics potential — 54/100 (weight 15%)
~60% mature gross margin, capital intensity 60% (sector reference).

Team / execution signal — 64/100 (weight 28%)
Quantified traction: $480k MRR.

Scientific / tech feasibility — 69/100 (weight 7%)
multimodal diagnostic models, FDA SaMD pathways, RWE evidence loops

Regulatory / legal headroom — 42/100 (weight 7%)
Regulatory intensity 90% (higher = more legal drag).

Competitive headroom — 58/100 (weight 8%)
Competitive intensity 60%. reimbursement dependency and long clinical validation cycles.

Analyst council

Research Scientist — Feasibility rests on: multimodal diagnostic models, FDA SaMD pathways, RWE evidence loops.

+ Live frontier: multimodal diagnostic models, FDA SaMD pathways, RWE evidence loops.
+ Tech feasibility score 69/100 — driven by 23% sector innovation rate.
+ Capital intensity 60% sets the R&D burn profile.
! Scientific claims unverified without a technical deep-dive / reference customers.
! reimbursement dependency and long clinical validation cycles.

Data Analyst — ~$420B TAM, 60% mature gross margin.

+ Market factor 66/100; unit-economics factor 54/100.
+ Reference gross margin ~60%; validate against actuals.
+ Execution signal 64/100 — Quantified traction: $480k MRR..
! TAM/SAM/SOM and CAC/LTV unconfirmed — require a live data room.
! Sector benchmarks are directional, not company-specific.

Economist — Real clinical signal in a huge market, but the $420B TAM is a category number — the addressable DR-screening slice is a fraction of that.

+ The 66/100 is generously anchored to a ~$420B digital-health TAM at 23% CAGR. Push back: RetinaScan does not sell into $420B — the relevant serviceable market is US diabetic-retinopathy screening. ~38M US diabetics, ~60% under-screened, reimbursed CPT 92227-92229 at roughly $30-65/screen implies a bottom-up SAM closer to $1-3B, not hundreds of billions. Score is directionally right on tailwinds, w
+ Demand is reimbursement-elastic, not price-elastic: PCP adoption follows whether the screen is billable and margin-positive in-visit. IDx-DR/LumineticsCore already set the CMS precedent (autonomous AI DR screen reimbursed), which de-risks the payer path but also proves an incumbent is 5+ years ahead with FDA De Novo clearance — a disclosed, well-capitalized competitor the 58/100 competitive headro
+ Economic rents here accrue to the regulatory license plus the distribution/EHR-integration layer, not the smartphone lens (commoditizable hardware). Moat at 63 is fair-to-slightly-generous at seed: breakthrough-device is only *filed*, not granted, and 91% sensitivity in 900 patients is a strong pilot but below the ~87-90% sensitivity AND ~90% specificity bar CMS/FDA-cleared comparators cleared — s
+ $40k MRR across 18 clinics = ~$2.2k/clinic/month, a plausible SaaS+per-screen mix but a tiny base; unit economics (LTV/CAC, 60% capital intensity) untested. The composite's 61.7 'watch' is the honest read: real evidence, unproven that it compounds past the incumbent.
! Reimbursement dependency (structural): CMS/private payer coverage for a second autonomous DR tool is not guaranteed; without a durable CPT/NTAP economics, PCP demand collapses since clinics won't screen at a loss.
! Incumbent moat asymmetry: a cleared, reimbursed autonomous competitor can bundle or undercut; RetinaScan must beat specificity and total cost-of-workflow, and specificity was not reported — a material omission for a diagnostic.
! Long validation + FDA cycle burns the $5.5M before revenue inflects; at ~$480k ARR run-rate and 60% capital intensity, runway to clearance and payer contracts likely requires a bridge, raising down-round risk.

Corporate & Regulatory Lawyer — 42/100 legal headroom is fair but conflates regulatory intensity with legal defect — the FDA path is the moat, not just drag

+ The 42 score reads regulatory intensity (90%) as pure drag; I'd push back on framing. For a SaMD diagnostic, FDA clearance IS the durable moat the Moat factor credits (ceiling 82). The 7% weight on 'headroom' understates that clearance, once obtained, converts drag into a 3-5yr competitor barrier. Net: score is defensible as a burn/timeline read, too pessimistic as a value read.
+ Device pathway is unconfirmed. 'Breakthrough-device designation filed' — not granted; De Novo (novel diagnostic, likely) runs ~12-18mo and $1-3M vs a predicate-based 510(k). At $40k MRR the 18 clinics are almost certainly running under a research/adjunct-to-specialist framing, not autonomous marketed diagnosis. Confirm current commercialization is not off-label promotion — that is an FTC §5 / FDA
+ AI/algorithm risk is real and under-scored: an ML diagnostic must lock its algorithm or file a Predetermined Change Control Plan; 91% sensitivity in a 900-patient study is single-site and needs multi-site RWE for generalizability (bias across skin tone/camera hardware). HIPAA BAAs with all 18 clinics and CCPA/CPRA on any CA patient data are table stakes — verify executed, not assumed.
+ Structure the round to price regulatory milestones: Reg D 506(b) priced round or post-money SAFE, 1x non-participating pref, board observer + information rights, and a tranche/milestone release tied to De Novo grant or breakthrough designation. Add reps on FDA correspondence, absence of warning letters, and clean IP assignment from clinical/academic founders (retina algorithms often trace to unive
! Clearance failure or delay: if De Novo stalls past 18mo, the entire moat thesis and reimbursement path collapse; $5.5M seed likely funds to grant only if burn is disciplined — no runway buffer disclosed.
! Reimbursement dependency (flagged as structural risk): even with clearance, no CPT/coverage pathway means clinics pay out-of-pocket — the $40k MRR does not prove payer economics and LTV/CAC was not disclosed, so the revenue moat is unstressed.
! Off-label / promotional-claims exposure now: pre-clearance marketing of a diagnostic claim invites FDA/FTC action that would poison the pending submission and any acquisition due diligence.

Market data sources

- Grand View Research (2026) — Digital health $420.2B in 2026, 23.4% CAGR 2026–2033
  https://www.grandviewresearch.com/industry-analysis/digital-health-market
- Fortune Business Insights (2026) — Digital health $491.6B in 2026 at 21.6% CAGR through 2034
  https://www.fortunebusinessinsights.com/industry-reports/digital-health-market-100227

Assumptions & limitations

- Market size / growth for Healthtech / Digital Health is anchored to Grand View Research (2026): Digital health $420.2B in 2026, 23.4% CAGR 2026–2033. Full citations are listed under "Market data sources".
- Signal coverage: ~44% of the score is backed by the plan's own disclosed metrics (1 quantified field); the remainder uses Healthtech / Digital Health sector priors — add financials to raise it.
- Stage norms reflect US-market seed deals; adjust for geography "US".
- Score is a screening signal, not a substitute for legal, financial, and technical due diligence.

This memo is generated by an AI screening tool for research purposes and is not investment advice, an offer, or a solicitation. Figures are model estimates, not guarantees.