CG ONCOLOGY

Attacking Bladder Cancer
for a Better Tomorrow™



Disclaimer and Forward-Looking Statements

We caution you that this presentation contains forward-looking statements about us and our industry. All statements other than statements of historical facts contained in this presentation, including statements regarding our future results of operations and financial position, business strategy, research and development plans, the anticipated timing, costs, design and conduct of our ongoing and planned clinical trials and preclinical studies for cretostimogene and any future product candidates, the timing and likelihood of regulatory filings and approvals for cretostimogene and any future product candidates, our ability to commercialize cretostimogene and any future product candidates, if approved, the potential that cretostimogine may be a best-in-disease product, if approved, the pricing and reimbursement of cretostimogene and any future product candidates, if approved, the potential to develop future product candidates, the potential benefits of strategic collaborations and potential to enter into any future strategic arrangements, the timing and likelihood of success, plans and objectives of management for future operations, and future results of anticipated product development efforts, are forward-looking statements. These statements involve known and unknown risks, uncertainties and other important factors that may cause our actual results, performance or achievements to be materially different from any future results, performance or achievements expressed or implied by the forward-looking statements. In some cases, you can identify forward-looking statements by terms such as "may," "will," "should," "expect," "plan," "anticipate," "could," "intend," "target," "project," "contemplates," "believes," "estimates," "predicts," "potential" or "continue" or the negative of these terms or other similar expressions.

The inclusion of forward-looking statements should not be regarded as a representation by us that any of our plans will be achieved. Actual results may differ from those set forth in this presentation due to the risks and uncertainties inherent in our business, including, without limitation: we currently depend entirely on the success of cretostimogene, which is our only product candidate and is based on a novel approach to the treatment of cancer; potential delays in the commencement, enrollment, and completion of clinical trials and preclinical studies; results from earlier clinical trials and preclinical studies not necessarily being predictive of future results; unfavorable results from clinical trials; unexpected adverse side effects or inadequate efficacy of cretostimogene that may limit its development, regulatory approval, and/or commercialization; preliminary or interim data results are not necessarily indicative of final results and one or more of the clinical outcomes may materially change as patient enrollment continues, following more comprehensive reviews of the data and more patient data become available; our dependence on third parties in connection with manufacturing, shipping and clinical and preclinical testing; regulatory developments in the United States and foreign countries; our ability to obtain, maintain and enforce intellectual property protection for cretostimogene; we may use our capital resources sooner than we expect; we face significant competition who may develop products which are more effective, safer, or less expensive than our product candidate; and other risks described in our filings with the SEC, including under the heading "Risk Factors" in our annual report on Form 10-K, our quarterly Form 10-Q and any subsequent filings with the SEC. You are cautioned not to place undue reliance on these forward-looking statements, which speak only as of the date of this presentation, and except as required by applicable law, we do not plan to publicly update or revise any forward-looking statements contained herein, whether as a result of any new information, future events, changed circumstances or otherwise. All forward-looking statements are qualified in their entirety by this cautionary statement, which is made under the safe harbor provisions of the Private Securities Litigation Reform Act of 1995.

This presentation also contains estimates and other statistical data made by independent parties and by us relating to market size and growth and other data about our industry. This data involves a number of assumptions and limitations, and you are cautioned not to give undue weight to such estimates. In addition, projections, assumptions, and estimates of our future performance and the future performance of the markets in which we operate are necessarily subject to a high degree of uncertainty and risk. These and other factors could cause results to differ materially from those expressed in the estimates made by the independent parties and by us.

This presentation concerns products that are under clinical investigation and which have not yet been approved for marketing by the U.S. Food and Drug Administration. It is currently limited by federal law to investigational use, and no representation is made as to its safety or effectiveness for the purposes for which it is being investigated.

Cretostimogene grenadenorepvec is an investigational engineered oncolytic immunotherapy (OIT). It is an investigational drug and is not approved by any regulatory agency. Its safety and efficacy has not been established. In BCG-unresponsive, Non-Muscle Invasive Bladder Cancer (NMIBC), cretostimogene has shown clinical benefit and has been generally well-tolerated as both a monotherapy and in combination with other therapies in clinical trials.

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The Promise of Cretostimogene

Potential Best-in-Disease Durability and Efficacy Results

BOND-003 Cohort C (BCG UR CIS only)[1]:

76% CR anytime
46.4% (12-mo)
41.8% (24-mo)

BOND-003 Cohort P (BCG UR Papillary only)[2]

95.7% (3-mo) HG-EFS
84.6% (6-mo)
80.4% (9-mo)

CORE-008 Cohort A (BCG Naïve HR CIS)[2]

88% CR anytime

PIVOT-006 (Intermediate-Risk + HG Ta)[3]

68% improvement in RFS with hazard ratio **0.32 (p<0.0001)**

Potential Best-in-Disease Safety/Tolerability Results[4]

- Favorable safety & tolerable profile
- **0 Grade ≥ 3 TRAEs** or deaths reported
- Most AEs were Grade 1-2

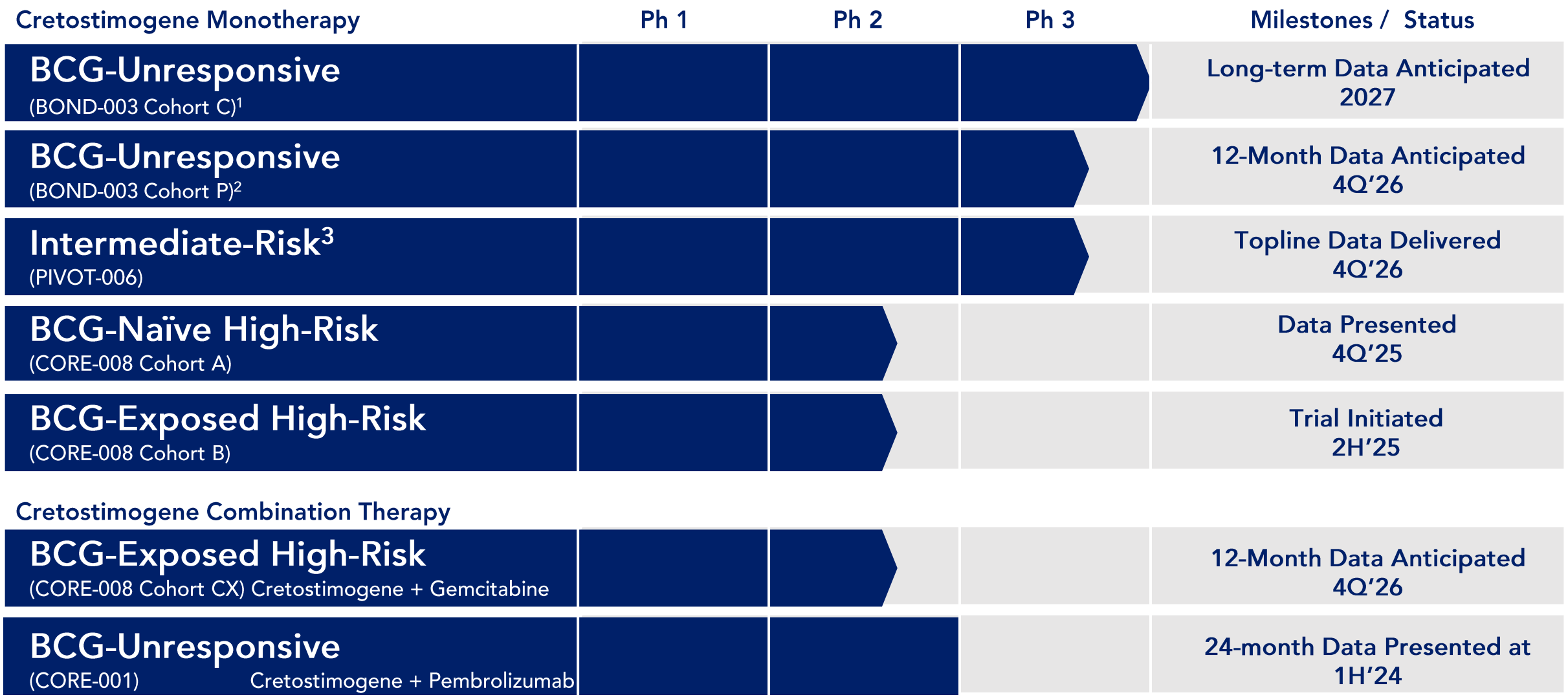
Regulatory Status & Commercial Readiness

- Breakthrough Therapy & Fast Track designations
- Current capacity: 40-50k vials/year; 10x scale-up process to support future indications underway
- Commercial prep activities ongoing - MSLs/HSDs, site / payor engagement
- Administered like BCG, seamlessly integrating into established clinical workflows without re-training
- Physicians in top key accounts treat >70% of NMIBC patients by volume

Dual MOA designed to selectively drive tumor killing & trigger durable anti-tumor immune response resulting in potential for best-in-disease profile across a broad range of NMIBC patients

TRAEs = Treatment-related adverse events; HR = high-risk; NMIBC = Non-muscle invasive bladder cancer; MSL = Medical science liaison; HSD = Health system directors; MOA = Mechanism of action. 1. Ph 3 registrational study in HR BCG-unresponsive NMIBC CIS 2. Data presented at SUO Annual Meeting Dec. 2025, data as of September 1, 2025 3. From PIVOT-006 topline data announced Nov. 2026. 4. Observed in clinical trials of cretostimogene including BOND-003, CORE-008 and PIVOT-006

Comprehensive Programs in High-Risk and Intermediate-Risk NMIBC to Address a Multi-Billion Dollar Market Opportunity



1 Patients with carcinoma in situ, with or without papillary disease. 2 Patients with papillary only. Cohort P is a Phase 2 cohort of BOND-003 and currently not intended for regulatory approval. 3 Includes HG **Ta ≤ 3cm** Notes: Timing and achievement of milestone events are based on Company estimates and subject to risks and uncertainties. Actual results may be materially different than projected.

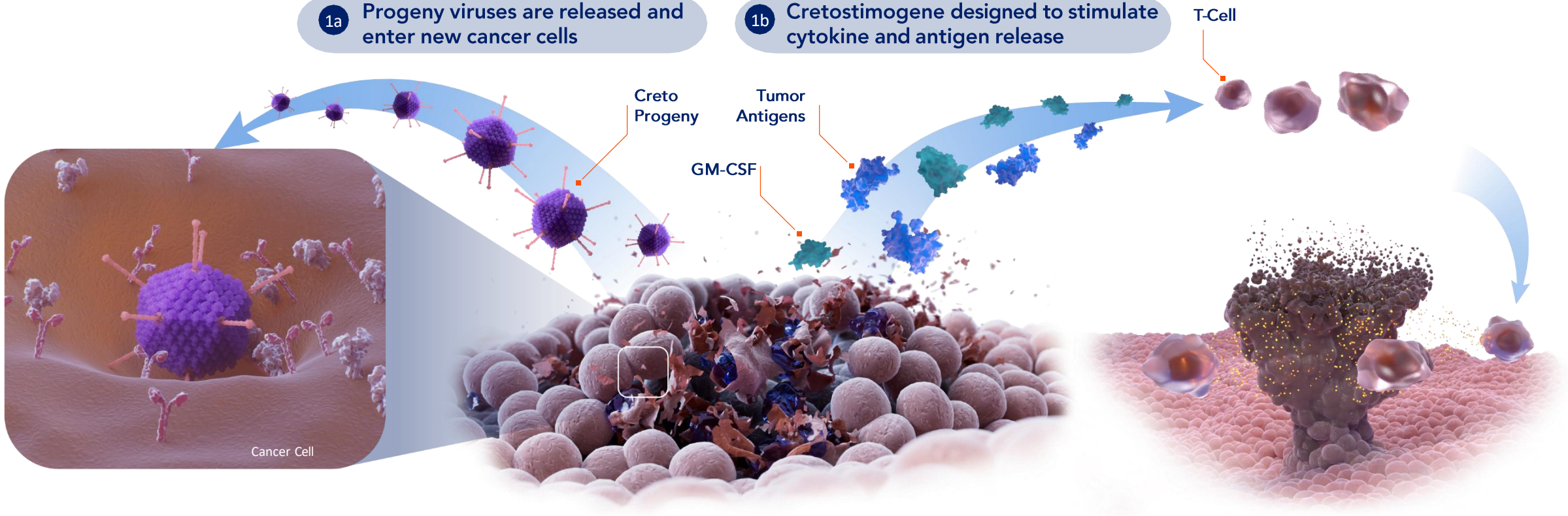
Cretostimogene's Dual Mechanism of Action: Selective Tumor Killing Triggers Durable Anti-Tumor Immune Response

1 Cretostimogene designed to selectively replicate in and kill cancer cells

2 Immune cells attack and kill additional cancer cells

1a Progeny viruses are released and enter new cancer cells

1b Cretostimogene designed to stimulate cytokine and antigen release

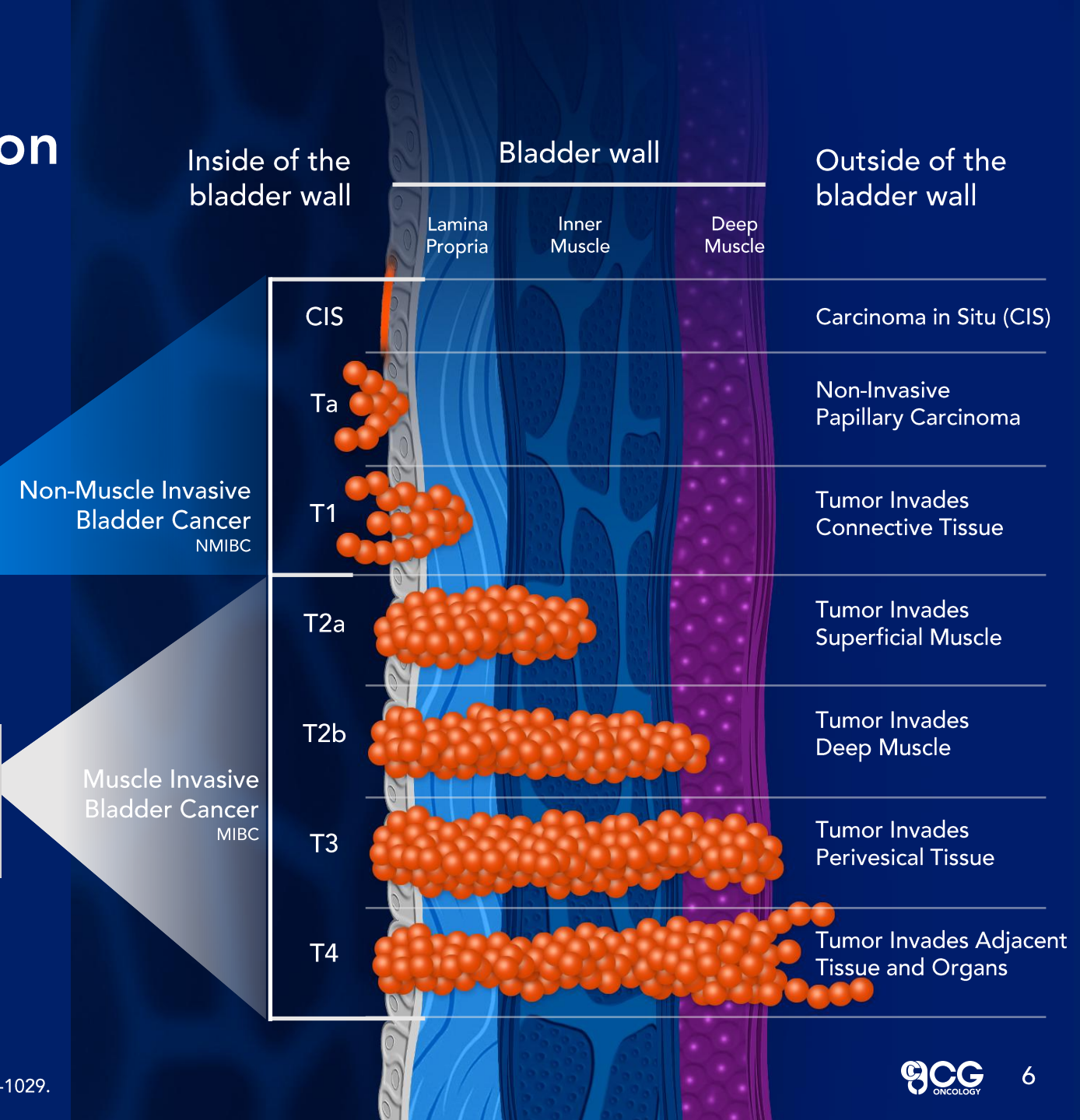


Oncolytic Immunotherapy

NMIBC Represents a Multi-Billion Dollar Market Opportunity in Bladder Cancer

~75% of Newly Diagnosed Bladder Cancer Cases are NMIBC

~25% of Newly Diagnosed Bladder Cancer Cases are MIBC



Cancer of the Urinary Bladder - Cancer Stat Facts. SEER. Chang et al 2016. J Urol. 196:1021-1029.

Patient Journey

1 Symptoms

Patient presents to primary care and/or urologist with symptoms (hematuria, urinary frequency)

2 Testing

Work-up may include cystoscopy, urine cytology, and imaging (CT scan, MRI)

Suspicion of Cancer

3 TURBT[1]



TURBT, followed by tumor staging and grading

4 Ongoing Treatment

Require surveillance and/or treatment every 3 to 6 months for 2 to 5 years

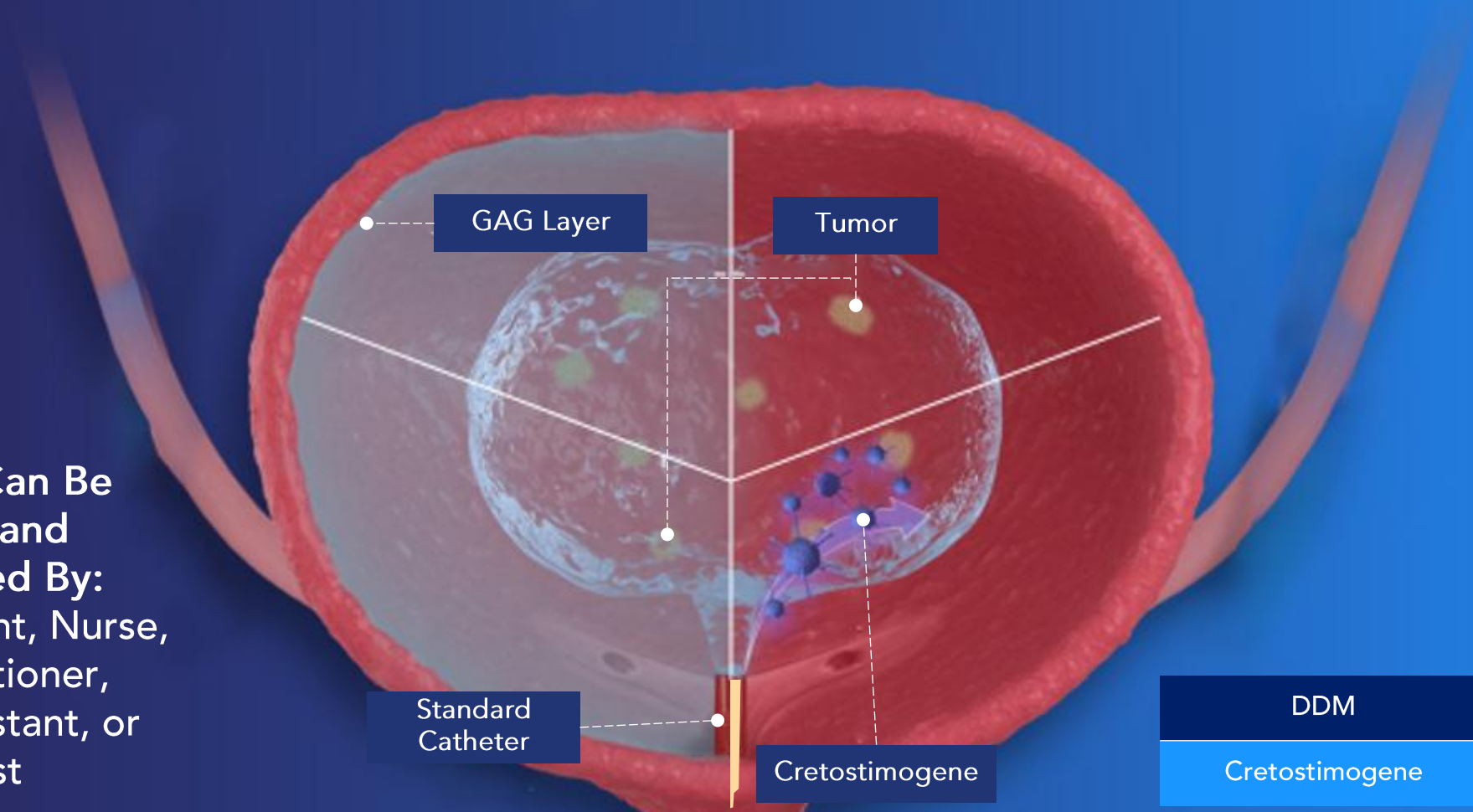
NMIBC

Low-Risk	Intermediate-Risk	High-Risk
TURBT	TURBT	Intravesical BCG (Induction ± Maintenance)
Perioperative Chemotherapy	Perioperative Chemotherapy	Intravesical Chemotherapy
	Intravesical BCG[2]	Cystectomy
		Pembrolizumab, Nadofaragene, N-803 + BCG, TAR-200

[1] TURBT = Transurethral Resection of Bladder Tumor.
[2] Due to BCG shortage, NCCN guidelines no longer recommend BCG therapy for Intermediate-Risk patients.

Note: Per NCCN guidelines, management of High-Risk NMIBC involves cystoscopy (Q3M for Year 1-2, Q6M for Year 3-5), upper tract imaging (baseline imaging and at Year 1, Q1-2Y for Year 3-5), abdomen/pelvis imaging (baseline imaging and as clinically indicated), and urine cytology (Q3M for Year 1-2, Q6M for Year 3-5). Biopsy is conducted during staging and for confirmation of disease when urine cytology is positive or presence of suspicious lesions.

Cretostimogene is Intravesically Administered into the Bladder, Similar to Standard-of-Care BCG Therapy Which Urology Practices Perform Regularly



Procedure Can Be Prepared and Administered By:
Medical Assistant, Nurse, Nurse Practitioner, Physician Assistant, or Urologist

DDM	~15 minutes
Cretostimogene	~45 to 60 minutes

BCG = Bacillus Calmette Guerin. DDM = n-Dodecyl β-D-maltoside. GAG = glycosaminoglycan.

Cretostimogene Programs Across High-Risk & Intermediate-Risk NMIBC Potential to Address More Than 70% of NMIBC Market

85K+ Bladder Cancer (U.S. Incidence)

730K+ Bladder Cancer (U.S. Prevalence)

75% NMIBC

NMIBC (75%)

Intermediate-Risk (30%)

PIVOT-006
Ph 3 Monotherapy

High-Risk (40%)

BCG-Exposed

CORE-008[1]
Cohort B

CORE-008[1]
Cohort CX

BOND-003
Ph 3 Monotherapy
Cohort C / Cohort P

CORE-001
Ph 2 Checkpoint Combo

BCG-Naïve

CORE-008[1]
Cohort A

Note: CORE-001, CORE-008 Cohort B, and PIVOT-006 are in partnership with SUO-CTC. [1] CORE-008 is a multi-cohort study evaluating cretostimogene in High-Risk NMIBC.
NMIBC = Non-muscle invasive bladder cancer

BOND-003

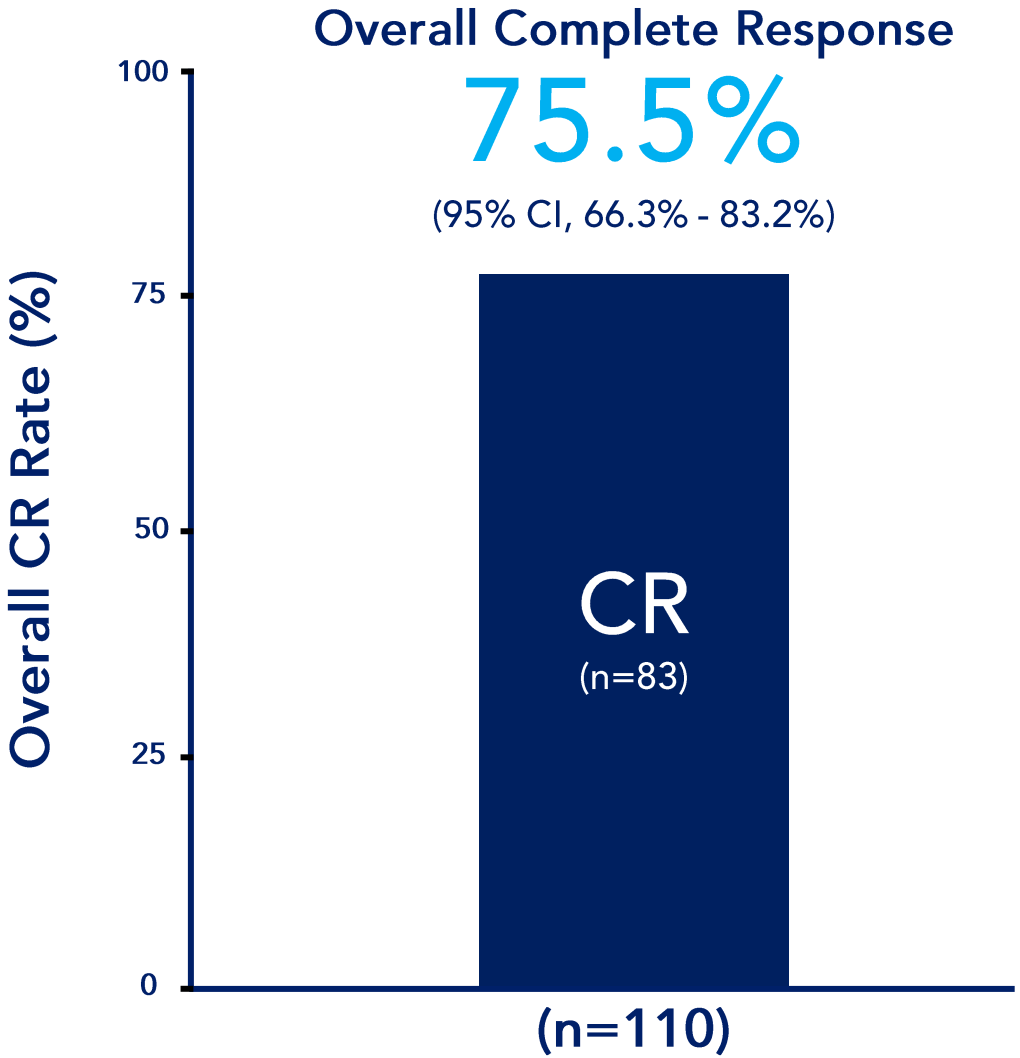
Phase 3 Cretostimogene Monotherapy for BCG-Unresponsive NMIBC (NCT04452591)

BCG-Unresponsive NMIBC	Cretostimogene Single-Arm, Open-Label, Intravesical Administration	CR at Any Time (CIS) EFS (Ta/T1)
Trial Design	**Study Design / Regimen**	**Additional Endpoints**
▪ Pathologically confirmed BCG-Unresponsive CIS or HG Ta/T1 ▪ Have all Ta/T1 disease resected prior to treatment ▪ Trial designed to be compliant with 2018 FDA guidance ▪ Mandatory bladder mapping at 12-mos[2]	▪ Cohort C = BCG-unresponsive CIS with or without Ta/T1 (n=112) Induction course = Weekly x 6 (1 x 10^{12} vp) ○ Second induction course[1] = Weekly x 6 for non-responders ○ Maintenance courses = Weekly x 3 for complete responders every 3 mos for first 12 mos, every 6 mos for next 24 mos ▪ Cohort P = BCG-unresponsive HG Ta/T1 without CIS (n=54) ○ Same as Cohort C	▪ Cohort C ○ DoR ○ CR at 12 months ○ PFS ▪ Cohort P ○ RFS ○ PFS

RFS = recurrence free survival. PFS = progression free survival. Note: Patients undergo urine cytology and cystoscopy every 3 months for first 2 years, as well as mandatory bladder mapping at month 12. [1] Second induction course of weekly x 6 for non-responders at month 3. [2] All patients required to undergo mandatory, systematic bladder mapping of 5 locations, biopsy of the prostatic urethra, and upper tract imaging to confirm CR.

BOND-003
Cohort C

Cretostimogene Demonstrated Favorable Efficacy and Durability Data in NMIBC



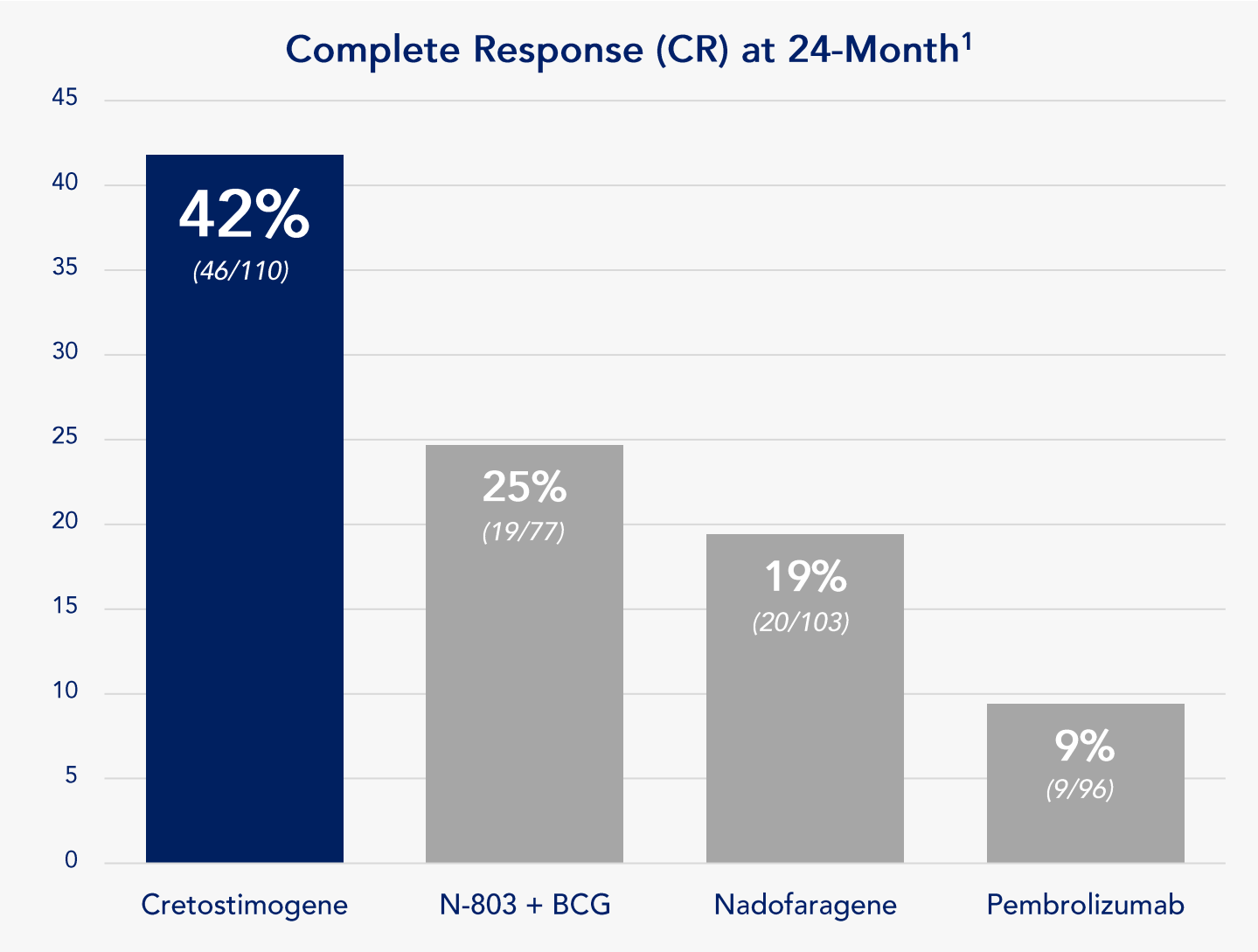
CR Landmark Analysis	CR Rate, % (95% CI)	CR by K-M Est, % (95% CI)
12-month	**46.4%** (36.8-56.2) *51/110 patients*	**50.7%** (40.9, 59.8)
24-month	**41.8%** (32.5, 51.6)[1] *46/110 patients*	**42.4%** (32.7-51.7%)

- 96.4% treated patients progression-free to MIBC at 24 months
- 81.2% cystectomy-free survival rate at Month 24
  - Among RCs, 83.3% (15/18) were T0 or NMIBC
- All complete responses have been centrally confirmed[2]

Efficacy data cutoff as of June 23, 2025. Efficacy analysis are centrally confirmed. All patients have active disease at baseline prior to enrollment. Received adequate BCG per FDA 2018 guidance.
[1] Based on centrally confirmed responders who have reached 24-month evaluation timepoint. All 9 ongoing CRs remained in response at the 24-month assessment, as well as 3 additional patients confirmed to be in CR at Month 24 after further follow-up and central pathologic adjudication. [2] A CR is defined as having a negative cystoscopy, a negative urine cytology, and a negative biopsy. In addition, all patients at 12-month timepoint undergo mandatory, systematic bladder mapping of 5 locations, biopsy of the prostatic urethra, and upper tract imaging to confirm CR and detect potential occult disease in the bladder.

Cretostimogene

Cretostimogene Has Delivered Remarkable Complete Response (CR) Rate at 24 Months



- Cretostimogene demonstrated long-term DoR compared to approved drugs[1] in NMIBC with **41.8% of patients in CR at 24 months**
- **90%** of patients in CR at 12 months **maintained in CR at 24 months**
- **No grade 3+ TRAEs** – favorable safety and tolerability results

Note: These data are not based on head-to-head or comparator studies. Differences exist between study designs and subject characteristics, and caution should be exercised when comparing data across studies.

1. Compared to approved drugs with publicly available observed 24-Month CR data. From published data.

CIS with or without Ta/T1

Cretostimogene is Well Positioned as Backbone Therapy in NMIBC with Potential Best-in-Disease Durability & Safety in BCG-UR [1]

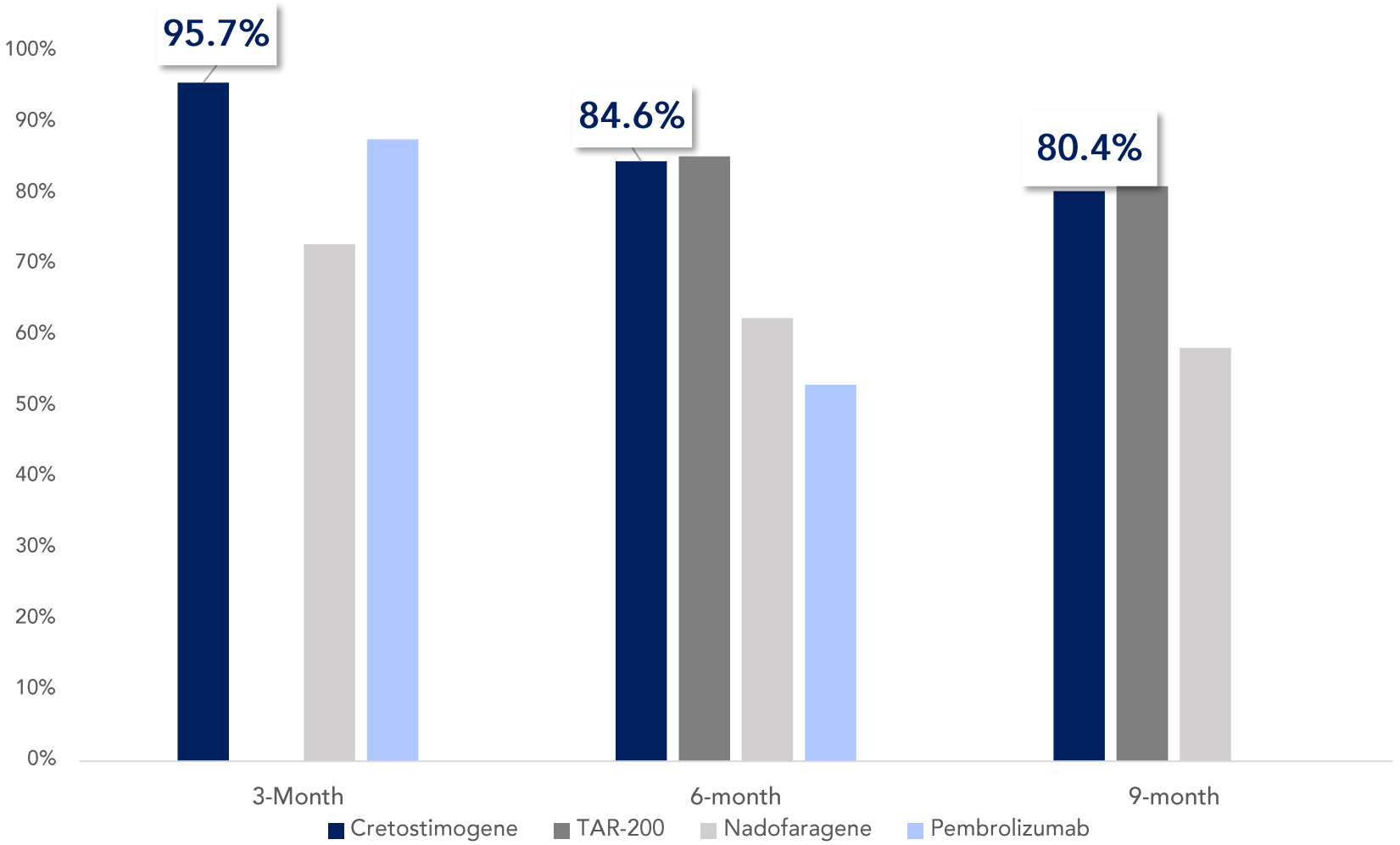
Trial (Status)	BOND-003 COHORT C (Ph3 Ongoing)	SunRISe-1 (Approved)	QUILT 3.032 (Approved)	NCT02773849 (Approved)	KEYNOTE-057 (Approved)
Drug	Cretostimogene	TAR-200	N-803 + BCG	Nadofaragene	Pembrolizumab
Mechanism	Oncolytic Immunotherapy	Gemcitabine via In-Dwelling Device	IL-15 Superagonist + BCG combo	Gene Therapy Secreting IFN	Checkpoint Inhibitor
RoA	Intravesical	Transurethral Procedure	Intravesical	Intravesical	Intravenous
Efficacy Population	110	83	77	98	96
CR at Any Time	75.5% (83/110) *[95% CI: 66% - 83%]*	82.4% (70/83) *[95% CI: 73% - 90%]*	62.3% (48/77) *[95% CI: 51% - 73%]*	51.0% (50/98)[5] *[95% CI: 41% - 61%]*	40.6% (39/96) *[95% CI: 31% - 51%]*
CR at 12 Mo	46.4% (51/110) *[95% CI: 37% - 56%]*	K-M: 45.9% (39/83)	36.4% (28/77)[4]	24.3% (25/103)	18.8% (18/96)
CR at 24 Mo	*41.8% (46/110)*[2] *[95% CI: 33% - 52%]*	Not Reported	24.7% (19/77)[4]	19.4% (20/103)	9.4% (9/96)[6]
12M DOR	K-M: 64.2% *[95% CI: 52% - 74%]*	Observed: 52.9% K-M: 56.2%	58%	46%	46%
24M DOR	K-M: 60.1% *[95% CI: 48% - 70%]*	K-M: 51.8%	40%	Not Reported	Not Reported
Free from Progression to MIBC	96.4% at 24 month	94.3%	90%	94%	89%
Cystectomy Free Survival	89.2% at 12 month 81.3% at 24 month[3]	86.6% at 12 month[3]	59%[3]	64% at 24-month	84%
Median Time to AE Resolution	1 Day	3.1 weeks	Not Reported	Not Reported	Not Reported
Grade 3+ TRAE	0%	13%	Not reported; 16% SAE	4%	13%
TR discontinuation	0%	3.5%	7%	3%	11%

[1] These data are not based on head-to-head or comparator studies. Differences exist between study designs and subject characteristics, and caution should be exercised when comparing data across studies. From published data. [2] All 9 ongoing CRs remained in response at the 24-month assessment, as well as 3 additional patients confirmed to be in CR at Month 24 after further follow-up and central pathologic adjudication.. [3] CFS in responders. [4] Derived from ANKTIVA® plus BCG Package Insert (April 2024) using DOR ≥ 12 months and DOR ≥ 24 months to estimate 12 months and 24 months landmark CR rate. [5] ADSTILADRIN® Package Insert (December 2022) and Summary Basis for Regulatory Action. [6] Derived from GU ASCO 2021, Balar et al presentation DOR ≥ 24 months to estimate 24-months landmark CR. References: Merck: (FDA & ODAC presentation slides, NDA/BLA# 125514s-066 for pembrolizumab (https://www.fda.gov/media/133956/download), Balar, AB et al. Lancet Onc. Epub ahead of print. 2021 May 26.; 2021 ASCO GU presentation); FerGene: (Boorjian et al. Lancet Oncol. 2021 Jan;22(1):107-117. Epub 2020 Nov 27) (Narayan et al. Journal of Urology. April 2024 doi:10.1097/JU.0000000000004020). ImmunityBio (ANKTIVA® plus BCG Package Insert; FDA Approval Letter). Janssen (SunRISe-1 – ESMO 2024; Daneshmand et al, Journal of Clinical Oncology, July 24, 2025). CG Oncology (BOND-003 – SUO 2024 and NE AUA 2025; CORE-001 – ASCO 2024).

BOND-003
Cohort P

BCG-Unresponsive Papillary (HG Ta/T1) Patients

Creto High-Grade Event-Free Survival (HG-EFS) vs. DFS/RFS (by K-M)[1]



- BOND-003 Cohort P reported 95.7%, 84.6% and 80.4% HG Event-Free Survival (EFS) at 3, 6 and 9 months, respectively
- No serious treatment-related adverse events (TRAEs) and no discontinuations related to cretostimogene
- No dose delays, missed doses due to TRAEs
- 0% Grade ≥ 3 TRAEs, Serious TRAE, deaths

Note: These data are not based on head-to-head or comparator studies. Differences exist between study designs and subject characteristics, and caution should be exercised when comparing data across studies.

1. Compared to approved drugs with publicly available EFS by K-M From published data.

Papillary Only (HG Ta/T1)

Cretostimogene is Well Positioned in BCG-UR Papillary Only NMIBC with Potentially Best-in-Disease EFS Endpoint[1]

Trial (Status)	BOND-003 COHORT P (Ph3 Ongoing)[1]	SunRISe-1[2]	QUILT 3.032[3]	NCT02773849[4,5]	KEYNOTE-057[6]
Drug	Cretostimogene	TAR-200	N-803 + BCG	Nadofaragene	Pembrolizumab
Mechanism	Oncolytic Immunotherapy	Gemcitabine via In-Dwelling Device	IL-15 Superagonist + BCG combo	Gene Therapy Secreting IFN	Checkpoint Inhibitor
RoA	Intravesical	Transurethral Procedure	Intravesical	Intravesical	Intravenous
Efficacy Population	N=54	N=52	N=72	N=50	N=132
EFS/DFS/HG-RFS					
3 month	95.7 [95% CI: 83.8, 98.9]	Not Reported	92.8% [95% CI]*	72.9 [95% CI: 58.2-84.7]	87.7 [95% CI: 80.7-92.3]
6 month	84.6 [95% CI: 68.6, 92.9]	85.3 [95% CI: 71.6-92.7]	75.9% [95% CI]*	62.5 [95% CI: 47.4-76.0]	53.1 [95% CI: 44.1-61.2]
9 month	80.4 [95% CI: 62.3, 90.4]	81.1 [95% CI: 66.7- 89.7]	Not Reported	58.3 [95% CI: 43.2–72.4]	Not Reported
12 month	Not Yet Reached	70.2% [95% CI: 59.2-84.6]	55.4 [95% CI: 42.0-66.8]	43.8 [95% CI: 29.5-58.8]	43.5 [95% CI: 34.9-51.9]
24 month	Not Yet Reached	Not Reported	48.3 [95% CI: 34.5-60.7]	33.3 [95% CI: 20.4-48.4]	34.9 [95% CI: 26.4-43.4]
Safety					
Grade 3+ TRAE	0 (0%)	13.5%	Not Reported	4%	14%
TR discontinuation	0 (0%)	7.7%	7%	3%	11%
SAEs	0 (0%)	5.8% including sepsis, spinal fracture (procedure related), and UTI	16%**	11%	13%

Note: These data are not based on head-to-head or comparator studies. Differences exist between study designs and subject characteristics, and caution should be exercised when comparing data across studies. 1. SUO 2025 Annual Meeting; 2. JCO - https://doi.org/10.1200/JCO-25-01651 Phase IIb SunRISe-1 study and SUO 2025 Annual Meeting presentation; 3. Chamie K, et al. NEJM Evid. 2023; 2(1):EVIDoa2200167 *estimated from subsequent landmark reports; **SAEs are combined across multiple cohorts as listed in package insert; 4. Boorjian S, et al. Lancet Oncology. 2021; 22(1):107-117. 5. Narayan VM, et al. J Urol. 2024;212(1):74-86; 6. Necchi A, et al. Lancet Oncology. 2024; 25(6):720-730.

PIVOT-006

Ph 3 Adjuvant Cretostimogene for IR NMIBC, Enrollment Completed Ahead of Schedule in Broad Population of IR NMIBC Patients

Intermediate-Risk (IR) NMIBC (Enrollment Completed)	Cretostimogene vs Surveillance/TURBT Randomized (1:1), Two Arms, Open-Label (n=367)	Primary Endpoint: RFS Rate
Population	**Study Design / Regimen**	**Additional Endpoints**
▪ Pathologically confirmed IR per AUA/SUO Guidelines* ○ Recurrent LG Ta < 12mo ○ Solitary LG Ta > 3cm ○ LG Ta multifocal ○ **Solitary HG Ta ≤ 3cm** ○ LG T1 ▪ All disease removed by TURBT at baseline	▪ Arm A: Cretostimogene following TURBT ○ Induction course = Weekly x 6 (1×10^{12} vp) ○ Maintenance courses[1] = Weekly x 3 (1×10^{12} vp) for complete responders ▪ Arm B: Surveillance following TURBT ○ Patients with disease recurrence eligible to receive cretostimogene	▪ RFS at 12-month and 24-month ▪ PFS ▪ Safety

RFS = recurrence free survival. PFS = progression free survival. *Guidelines at the time of enrollment and study start
Note: Patients undergo urine cytology and cystoscopy every 3 months for first 2 years; mandatory, site-directed biopsy at month 12.
[1] Maintenance course for complete responders weekly x 3 at month 3 and month 6, and once every 3 months at month 9 and month 12.

Intermediate-Risk Landscape

PIVOT-006 Designed to Evaluate Cretostimogene in a Broad Patient Population Across Intermediate-Risk (IR) NMIBC

	Cretostimogene (PIVOT-006) (investigational)	TAR-210 (MoonRIse-1) (investigational)	UGN-102 (Approved)
IR NMIBC LG Newly Diagnosed	◍	◍	
IR NMIBC LG Recurrent	◍	◍	✓
HG Ta ≤3cm (solitary)	◍		
Adjuvant (non-chemoablative)	◍	◍	

◍ = under development for indication
✓ = FDA approved indication

PIVOT-006 Ph 3 Trial

Study designed to enroll:
- All intermediate-risk patients
- First Ph 3 randomized trial in broad IR NMIBC population[1]



MoonRIse-1 Ph 3 Trial

Study not designed to enroll:
- Solitary HG Ta ≤3cm
- FGFR wildtype

Prescribing Information[3]

Not indicated for:
- Solitary HG Ta ≤3cm
- Newly diagnosed LG

1. PIVOT-006 is the first Ph 3 randomized trial in this patient population, encompassing the broadest range of patient types per AUA/SUO Guidelines including HG Ta solitary lesions <3cm. 2. NIH SEER secondary claims data analytics, and management assumptions. 3. Indicated for the treatment of adult patients with recurrent low-grade intermediate-risk non-muscle invasive bladder cancer (LG-IR-NMIBC)

PIVOT-006

Cretostimogene Significantly Improved Recurrence-Free Survival (RFS) in Intermediate-Risk and HG Ta NMIBC

68% Improvement in RFS

0.32 Hazard Ratio

95% CI 0.23–0.45 | p<0.0001

- No Grade ≥3 treatment-related adverse events
- No treatment-related discontinuations
- PIVOT-006 topline results to be presented as a late-breaking podium presentation at SUO on December 2, 2026
- PIVOT-006 data will support a second BLA submission in intermediate-risk and high-grade Ta NMIBC anticipated in Q2 2027

The median follow-up was 17 months at the time of data cutoff Oct. 26,2026. Recurrence was dated to the first evaluable assessment documenting recurrence. Participants were censored at randomization if no evaluable post-randomization assessment was available; otherwise, censoring occurred at the last evaluable recurrence-free assessment for no recurrence, death, or recurrence/death following ≥1 missed or nonevaluable assessment, and before initiation of new anticancer therapy. Death was not considered an RFS event. CI, confidence interval; HG, high-grade; HR, hazard ratio; NMIBC, non-muscle invasive bladder cancer

CORE-008
Cohort CX

Ph 2 Cretostimogene in Combination for BCG-Exposed HR & BCG-Unresponsive NMIBC (Cohort CX)

HR BCG-Exposed & BCG Unresponsive NMIBC	Cretostimogene + Gemcitabine 1:1 Randomized, Two Arm, Open-Label	Primary Endpoint: HG-EFS
Population	**Study Design / Regimen**	**Additional Endpoints**

- Pathologically confirmed BCG-exposed HR & BCG-UR
  - Persistent or recurrent HG Ta or CIS at first evaluation after adequate BCG dose
  - HG recurrence outside of BCG-UR window within 24 mos after last adequate BCG dose
  - HG recurrence within 24 mos after last inadequate BCG dose

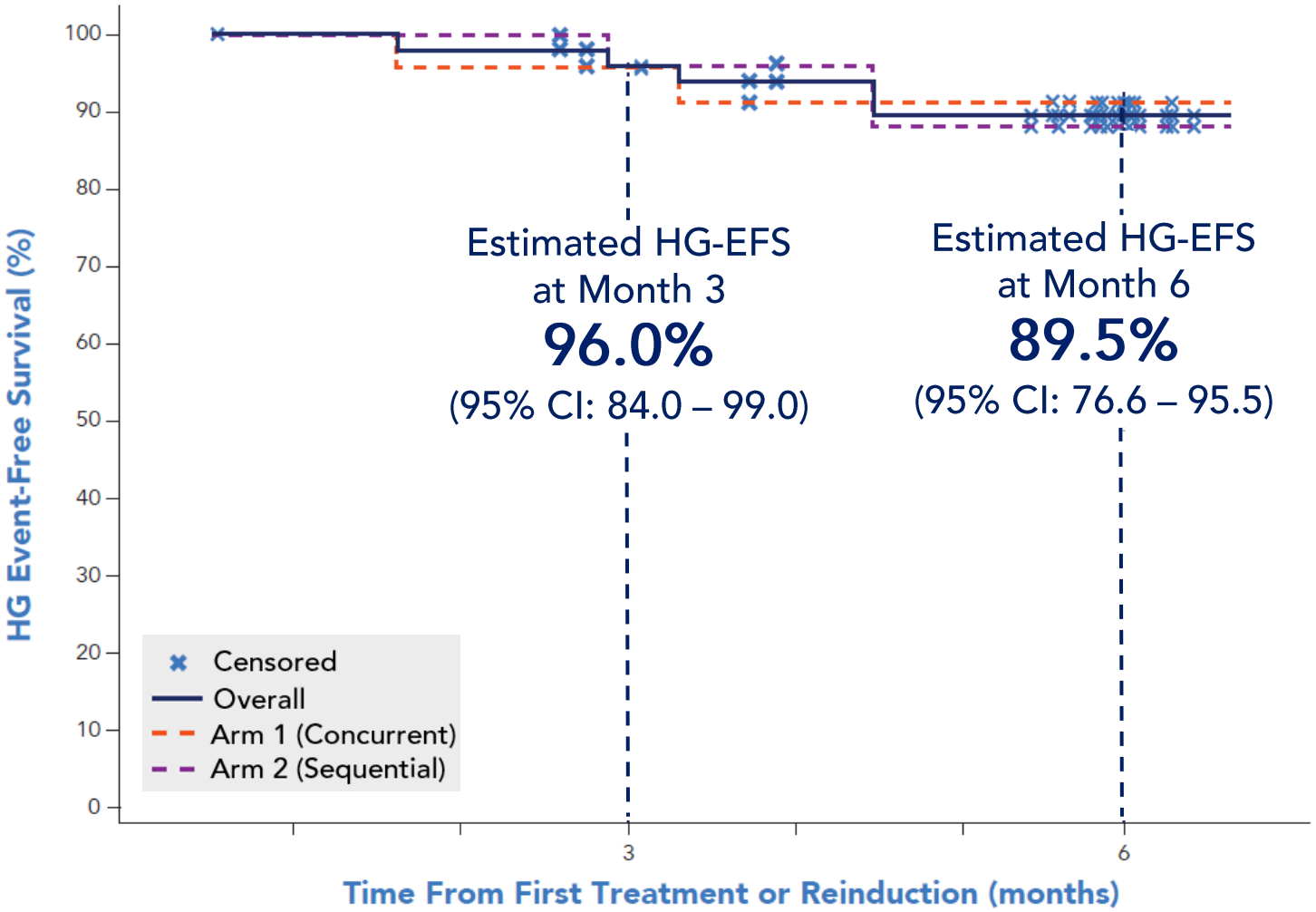
- Cohort CX (CIS-containing or HG Ta/T1)
  - Arm 1 = cretostimogene + gemcitabine (concurrent)
  - Arm 2 = cretostimogene + gemcitabine (sequential)
  - Standard weekly x 6 induction, reinduction and weekly x 3 maintenance until Year 3[1]

- CR at any time
- CR at 12 months
- DoR
- PFS
- CFS

HR = high risk. HG = high grade. LG = low grade. DoR = duration of response. EFS = event free survival. RFS = recurrence free survival. PFS = progression free survival. CFS = cystectomy free survival. Note: Patients undergo urine cytology and cystoscopy every 3 months for first 2 years

[1] Second induction course of weekly x 6 for non-responders at month 3. Maintenance course for complete responders weekly x 3 every 3 months in Year 1, and every 6 months in Year 2 and Year 3.

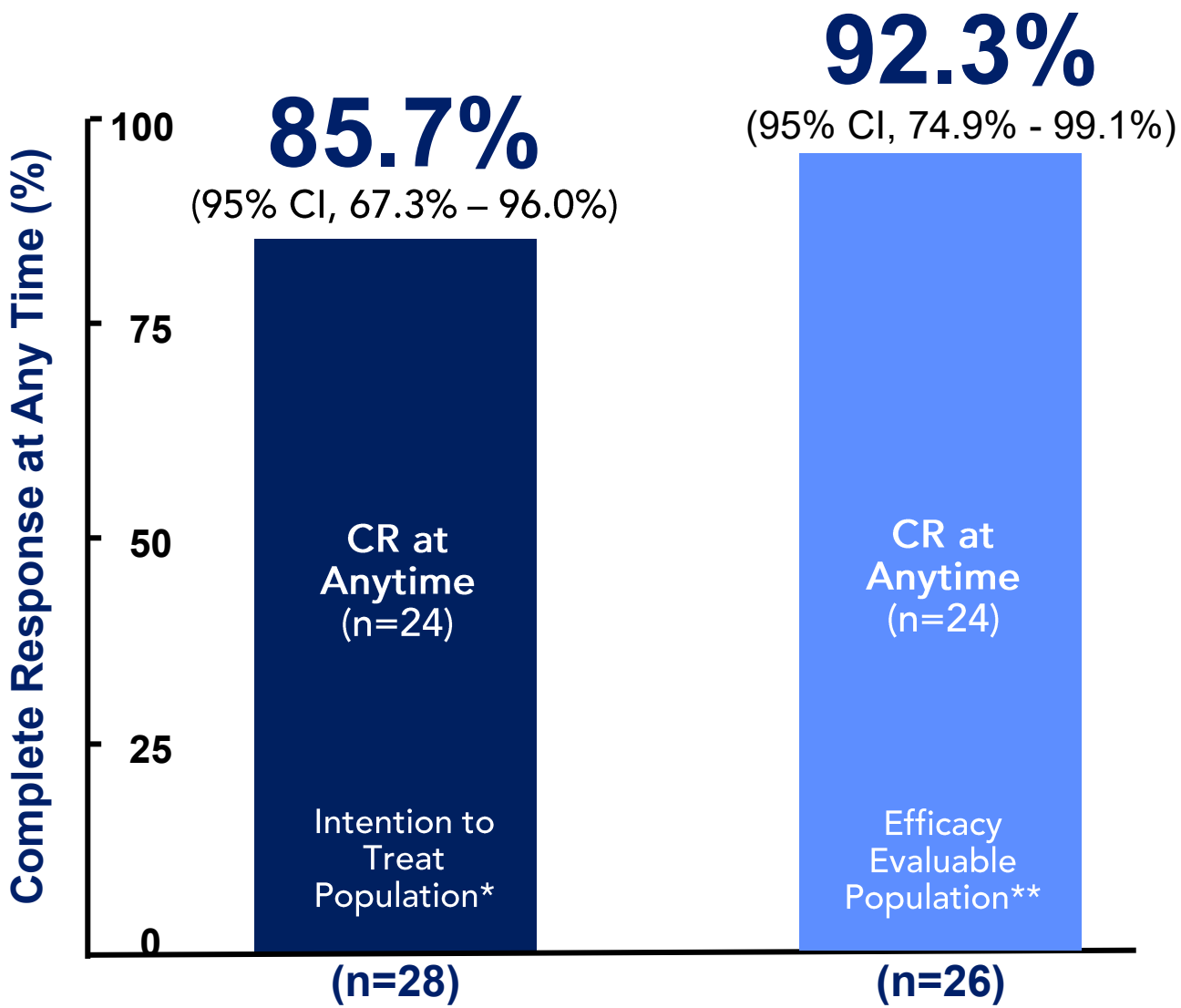
CORE-008 Cohort CX High-Grade Event-Free Survival at 3 and 6-Months (ITT Population)



- Median follow-up: 6.6 months
- No significant differences in HG-EFS by arm
- Consistent response among BCG-UR and BCG-exposed subgroups

BCG-UR= BCG-Unresponsive; CIS= Carcinoma in Situ; HG-EFS= High-Grade Event-Free Survival; MIBC= Muscle Invasive Bladder Cancer; mUC= Metastatic Urothelial Carcinoma; HG-EFS defined as high-grade recurrence/persistence, progression to T1, progression to T2+ and death from any cause; Efficacy data cutoff as of 13MAR2026; Efficacy assessments based on local pathology review; HG-EFS presented in intention to treat (ITT) population representative of all patients randomized on CORE-008 Cohort CX (Arm 1/Concurrent; Arm 2/Sequential); Two patients with CIS at baseline were found with HGT1 at Month 6.

CORE-008 Cohort CX High Complete Response Rates Observed Within CIS-Containing Population



- Includes BCG-Exposed and BCG-Unresponsive patients
- **0% Grade ≥ 3 TRAEs, SAEs or deaths**
- 85.5% (47/55) completed all protocol-defined treatments
  - Arm 1 (Concurrent)- 71.4% (20/28)
  - Arm 2 (Sequential)- 100% (27/27)
- **No patients discontinued on Arm 2 (sequential) due to TRAE**
  - 4 patients withdrew from Arm 1 (concurrent) for persistent grade 1-2 localized TRAEs
- No difference in the proportion of patients with AEs between arms

CIS= Carcinoma in Situ; CR=Complete Response; CR defined as having negative cystoscopy, urine cytology, and biopsy (as indicated). Efficacy data cutoff as of 13MAR2026. Efficacy assessments based on local pathology review. * Intention to treatment (ITT) population includes all participants who are randomized in Cohort CX (Arm 1/Concurrent; Arm 2/Sequential). ** Efficacy evaluable population includes patients who have received at least four doses of cretostimogene, meet the definition of BCG-Unresponsive/BCG-Exposed and have completed a protocol-defined efficacy assessment at Month 3

CORE-008
Cohort A & B

Phase 2 Cretostimogene Monotherapy for BCG-Naïve High-Risk (HR) and BCG-Exposed HR NMIBC (Cohort A and B)

BCG-Naïve & BCG-Exposed
(Actively Enrolling)

Cretostimogene
Two Cohorts (A and B), Two Arms Each, Open-Label

Primary Endpoint:
CR Rate; HG-EFS[2]

Population

- Cohort A
  - Pathologically confirmed BCG-naïve HR NMIBC
  - No prior treatment with BCG within past 24 months
- Cohort B
  - Pathologically confirmed BCG-exposed HR NMIBC
  - Recurrence within 24 months after last adequate BCG dose

Study Design / Regimen

- Cohort A (BCG-naïve HR NMIBC)
  - CIS ± HG Ta/T1 (n=~50)
  - HG Ta/T1 only (n=~75)
  - Standard weekly x 6 induction, reinduction and weekly x 3 maintenance until Year 3[1]
- Cohort B (BCG-exposed HR NMIBC)
  - CIS ± HG Ta/T1 (n=~75)
  - HG Ta/T1 only (n=~75)
  - Standard dosing as above[1]

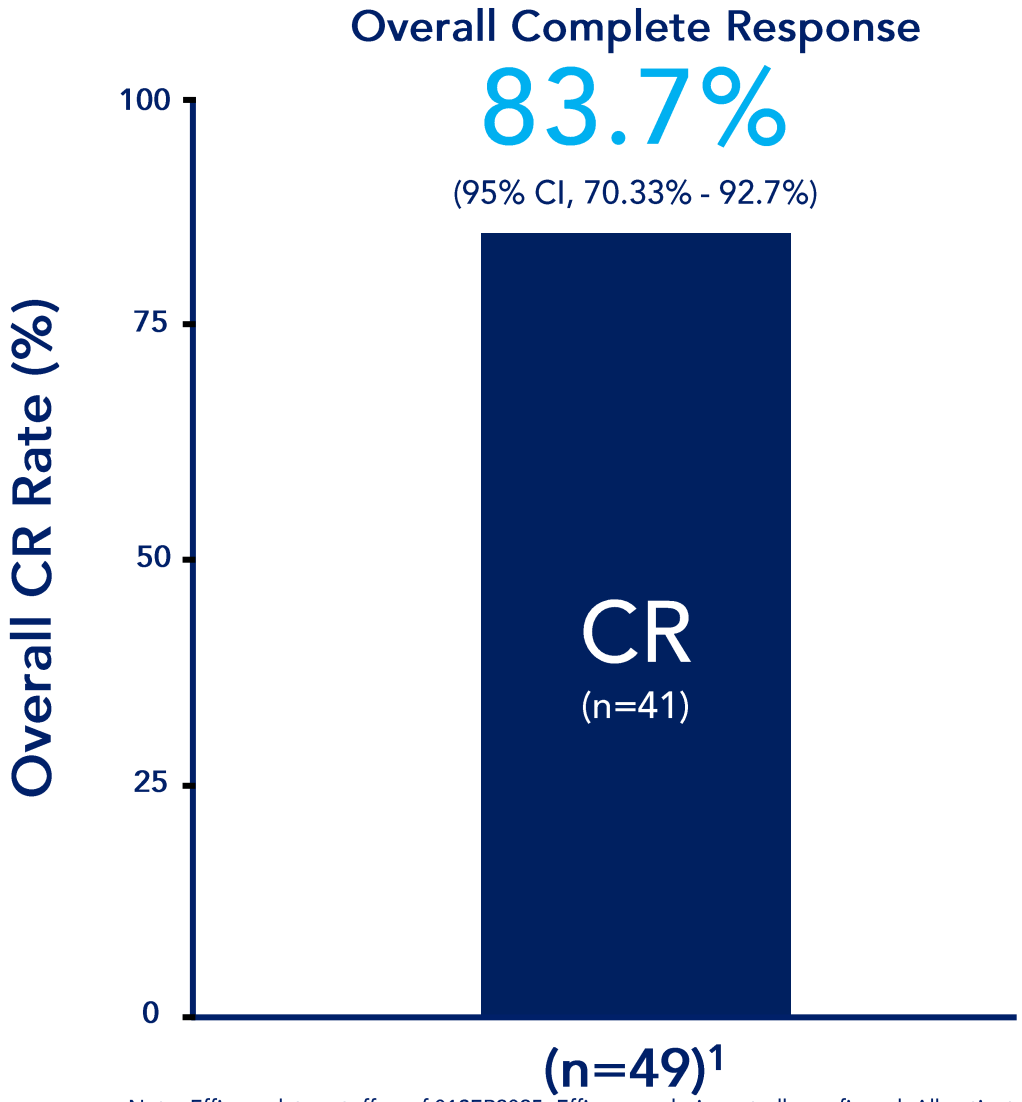
Additional Endpoints

- Cohort A
  - DoR (in CIS)
  - EFS, LG-RFS, CFS
- Cohort B
  - DoR (in CIS)
  - EFS, LG-RFS, CFS

HR = high-risk. HG = high grade. LG = low grade. DoR = duration of response. EFS = event free survival. RFS = recurrence free survival. PFS = progression free survival. CFS = cystectomy free survival. Note: Patients undergo urine cytology and cystoscopy every 3 months for first 2 years; mandatory, site-directed biopsy at month 12.
1. Second induction course of weekly x 6 for non-responders at month 3. Maintenance course for complete responders weekly x 3 every 3 months in Year 1, and every 6 months in Year 2 and Year 3. 2. CIS (CR Rate) and HG Ta/T1 (HG-EFS)

CORE-008
Cohort A

High Initial Response Rates from CORE-008 Cohort A



CR Landmark Analysis	CR Rate, % (95% CI)
Original Instillation[2] *(5-step)*	**79.2%** (57.8, 92.9) *19 out of 24 patients*
Optimized Instillation[3] *(2-step)*	**88.0%** (68.8, 97.5)[1] *22 out of 25 patients*

- **0% Grade ≥ 3 TRAEs, SAEs or deaths**
- **No treatment related discontinuations**
- No patients required radical cystectomy
- No treatment-related progression to MIBC or mUC

Note: Efficacy data cutoff as of 01SEP2025. Efficacy analysis centrally confirmed. All patients have active disease at baseline prior to enrollment. A CR is defined as having a negative cystoscopy, a negative urine cytology, and a negative biopsy (as indicated). Analysis based on both landmark CR rate assessed in clinical trial and DoR by Kaplan-Meier estimate. [1] 49 patients were assessed for efficacy at the time of data cutoff. 4 re-induced patients are pending 6-month assessments. [2] Original instillation included 5-step instillation with series of bladder saline washes followed by DDM and cretostimogene instillations. [3] Optimized instillation streamlined the process to 2-steps inclusive of DDM followed by cretostimogene instillations.

Optimized Instillation

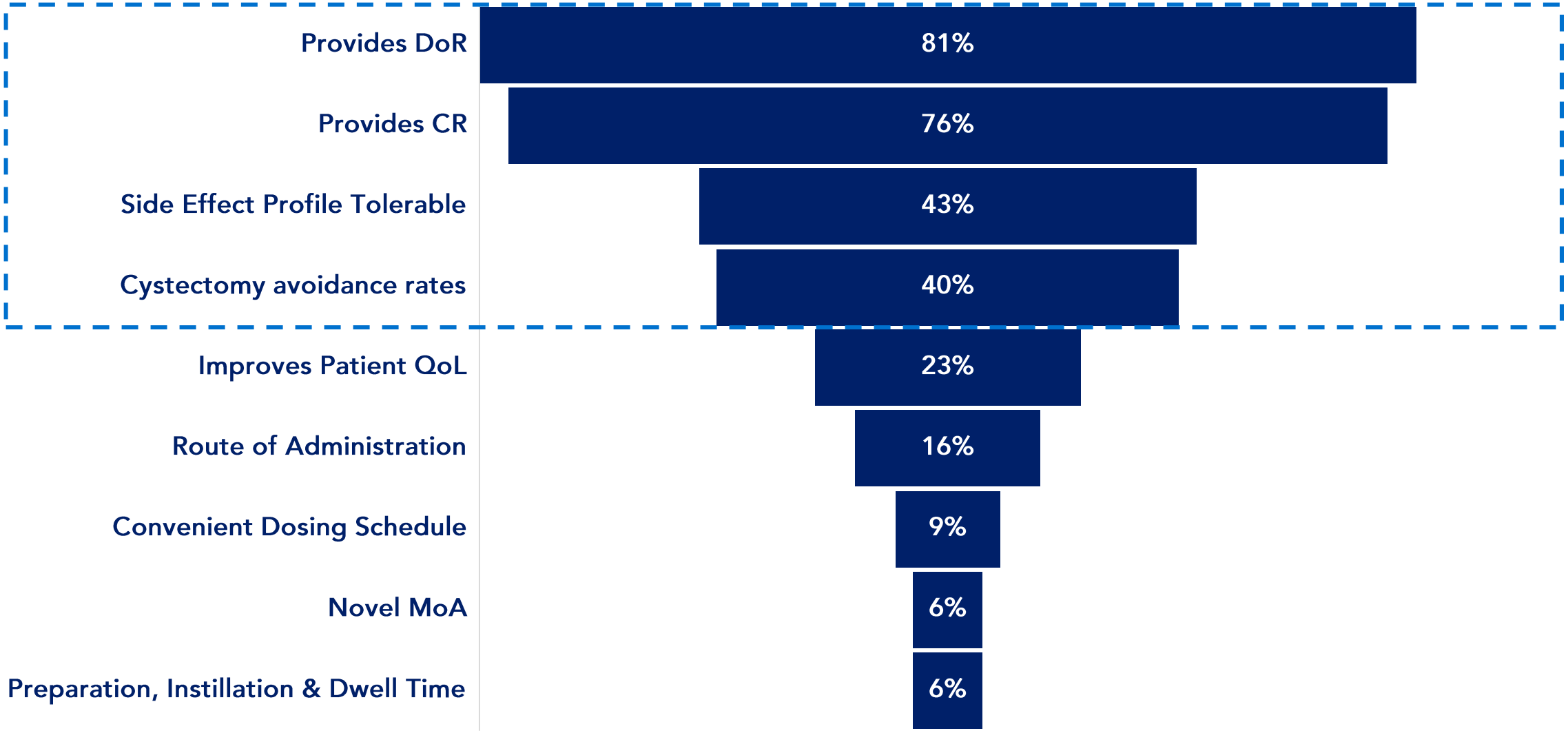
Advancing Cretostimogene to Optimized Instillation

Original Process Five-Step	Optimized Process Two-Step
Step 1: Saline Wash	Step 1: DDM Dwell
Step 2: DDM Rinse	Step 2: Creto Dwell
Step 3: DDM Dwell	
Step 4: Saline Wash	
Step 5: Creto Dwell	

- Cohort A data supports optimized instillation
- Potential meaningful benefit to patients and sites (esp. high-volume centers) with estimated ~20-minute time savings
- Administered via soft catheter by medical assistant, **a urologist or MD does not have to be involved in process**
- **Seamless transition** for BCG sites, seamless integration into established clinical workflows without re-training
- Closed System Drug Transfer Devices (CSTD) enables direct vial>syringe>bladder delivery
- All studies beyond BOND-003 Cohort C use optimized instillation protocol

~25% Time Savings | 3 Steps Eliminated | Improved Benefit to Site & Patient

Key Clinical Metrics Driving HCP Treatment Decisions in BCG-Unresponsive NMIBC*



*Market Research across ~100 US HCPs (n=46 urologists, n=54 uro-oncologists), Survey was fielded Nov-Dec 2025
Chart represents percentages ranking as top 3 factors that drive treatment decisions

CG is Building a Capital-Efficient, High-Touch Approach in Anticipation of a Successful Launch Across a Concentrated Prescriber Network

Field Organization

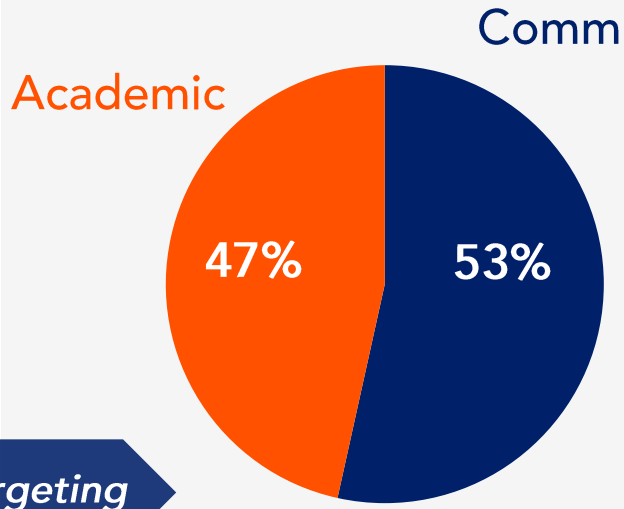
<75
field team



Key Account Managers
Health System Directors
Regional Business Directors
National Account Leads
Medical Science Liaisons
Field Reimbursement Managers

Targeting

Sites



Leading urology center network represent >70% of the market opportunity by volume

Reaching

Prescribers



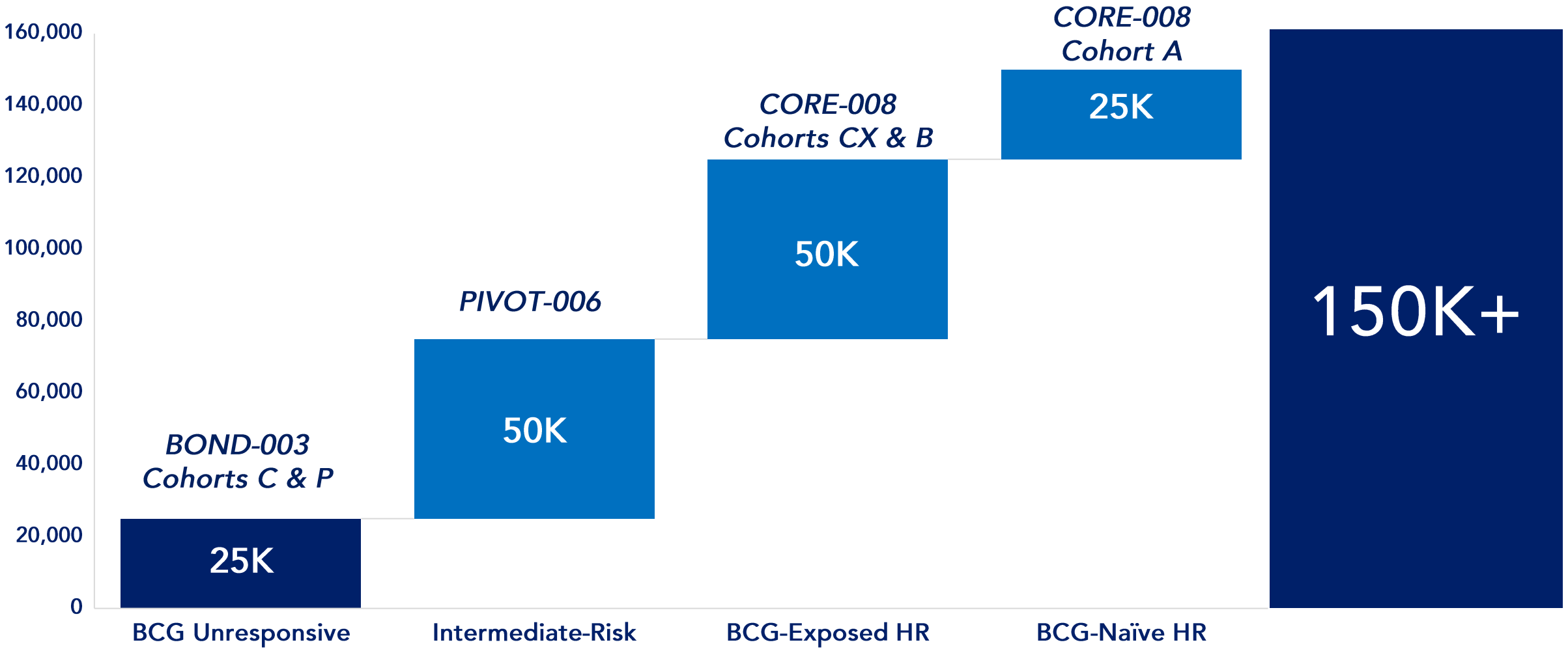
Physicians Treating NMIBC Patients

Top decile (~10 network urology centers) alone account for ~10% of national volume

Community (LUGPA, Independent) | **Academic** (Health Systems, Federal, Comprehensive Care)

The Path to 150K+ Addressable Patients

Annualized WAC of approved therapies in HR NMIBC range from $200K to $690K



NMIBC = Non-muscle invasive bladder cancer; HR = high-risk; IR = Intermediate-risk + HG Ta ≤ 3cm
TAM derived from NIH SEER, secondary claims data analytics, and management assumptions

Anticipated Milestones*

Catalyst Rich Calendar Through Potential First Approval and Launch Followed by Potential Frontline Bladder Indication Expansion

Program	2025	2026*	2027*
High Risk (HR) NMIBC	☑ BOND-003 Cohort C BCG-UR Long-Term Durability Data	☑ CORE-008 Cohort CX BCG-Exp. Topline Data (Creto + Gem)	Completion of BLA Submission BCG-UR (1st Indication)[1]
	☑ BOND-003 Cohort P BCG-UR Topline Data	CORE-008 Cohort CX BCG-Exposed Durability Data	CORE-008 Cohort A BCG-Naïve Durability Data
	☑ CORE-008 Cohort A BCG-Naive Data*	BOND-003 Cohort P BCG-UR Durability Data	Initiation of BCG-Exposed Ph 3 Trial
	☑ Initiation of Cretostimogene BLA Submission		BOND-003 Cohort C BCG-UR Long-Term Data
Intermediate Risk (IR) NMIBC	☑ PIVOT-006 Enrollment Completed	☑ PIVOT-006 Topline Data	Completion of BLA Submission (2nd Indication)

Clinical Regulatory

BCG-UR = BCG-unresponsive. *Note: Timing and achievement of milestone events are based on Company estimates and subject to risks and uncertainties. Actual results may be materially different than projected. 1. BCG-unresponsive NMIBC indication expansion to now include high-grade papillary-only disease

CG ONCOLOGY

Attacking Bladder Cancer for a Better Tomorrow™



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Leadership with Deep Industry Experience with Track Record of Success in Drug Development and Commercialization



Arthur Kuan
Chairman, President & Chief Executive Officer

- 13 years of expertise within the NMIBC space
- 2020 Forbes 30 Under 30 featured honoree in healthcare



Swapnil Bhargava, Ph.D.
Chief Technical Officer

- Supported multiple INDs, BLAs, and modalities to the clinic and market (TIVDAK®, PADCEV®, and ADCETRIS®)



Jim DeTore
Chief Financial Officer

- 30+ years of life sciences expertise
- Raised over a billion dollars in equity capital



Vijay Kasturi, M.D.
Chief Medical Officer

- 25+ years as GU Medical Oncologist
- Managed launch plan for BAVENCIO® and FOTIVDA®



Isabel Kalofonos
Chief Commercial Officer

- 20+ years driving launches and commercial execution
- Led launches of ELAHERE®, PALSONIFY™ and TAKHZYRO®



Josh Patterson, Esq.
General Counsel & CCO

- 25 years as in-house counsel in biopharmaceutical industry
- Over $2.25B in transaction experience

Our Vision

We see a world where urologic cancer patients can benefit from our innovative immunotherapies to live with dignity and have an enhanced quality of life.

Our Mission

We are focused on developing bladder-sparing therapeutics for patients afflicted with bladder cancer.

CG ONCOLOGY

Attacking Bladder Cancer for a Better Tomorrow™