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 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; and other risks described in our filings with the SEC, including under the heading "Risk Factors" in our annual report on Form 10-K 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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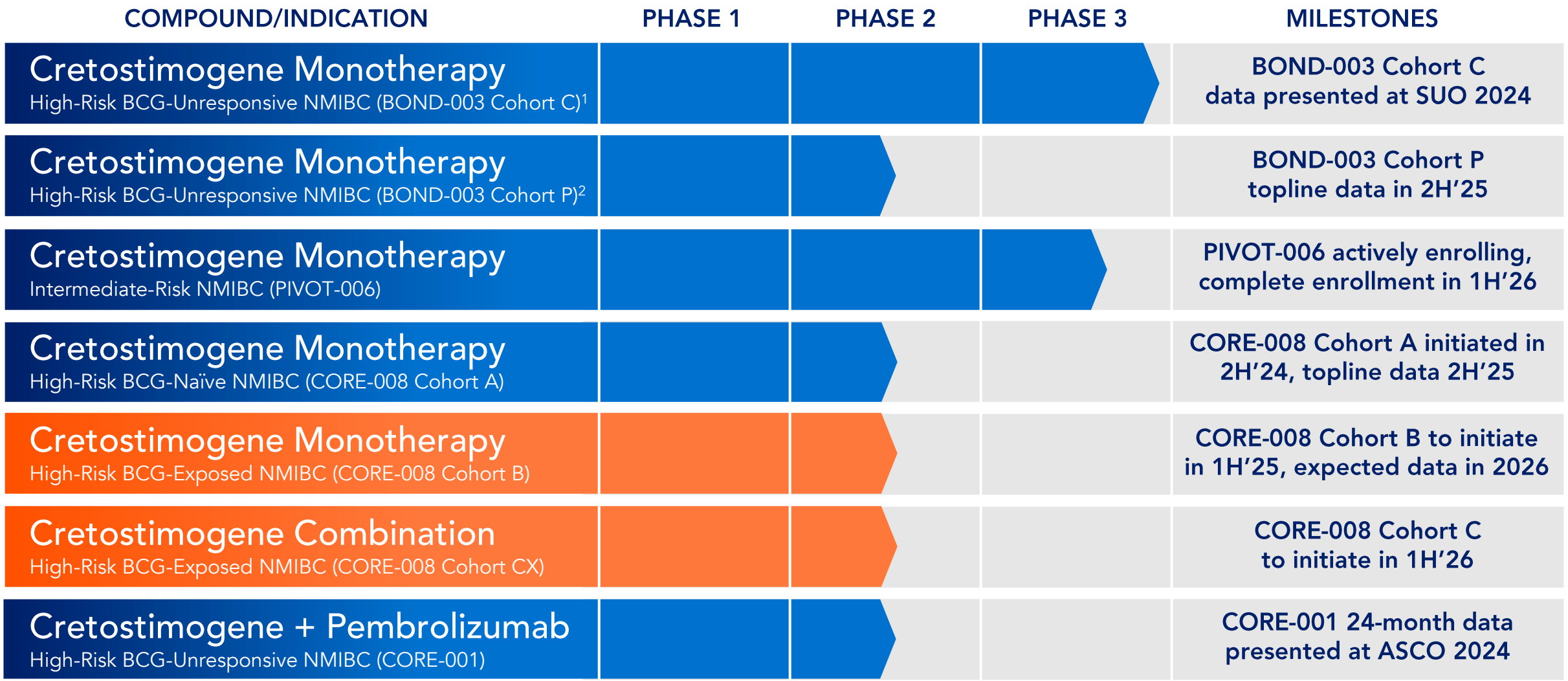
Our mission at CG is to develop bladder-sparing therapeutics for patients afflicted with bladder cancer

- **Comprehensive clinical development program covers 70% of market potential** across High-Risk & Intermediate-Risk NMIBC, a multi-billion dollar market opportunity
- **Cretostimogene is an oncolytic immunotherapy with a dual mechanism of action**
- **Potential best-in-class efficacy data observed** with sustained **complete responses** beyond 30 months in a Phase 3 registrational study
- **Favorable safety profile and tolerable regimen** with 0% Grade 3+ TRAE observed
- **Strong balance sheet to drive commercialization for a successful launch and indication expansion**

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

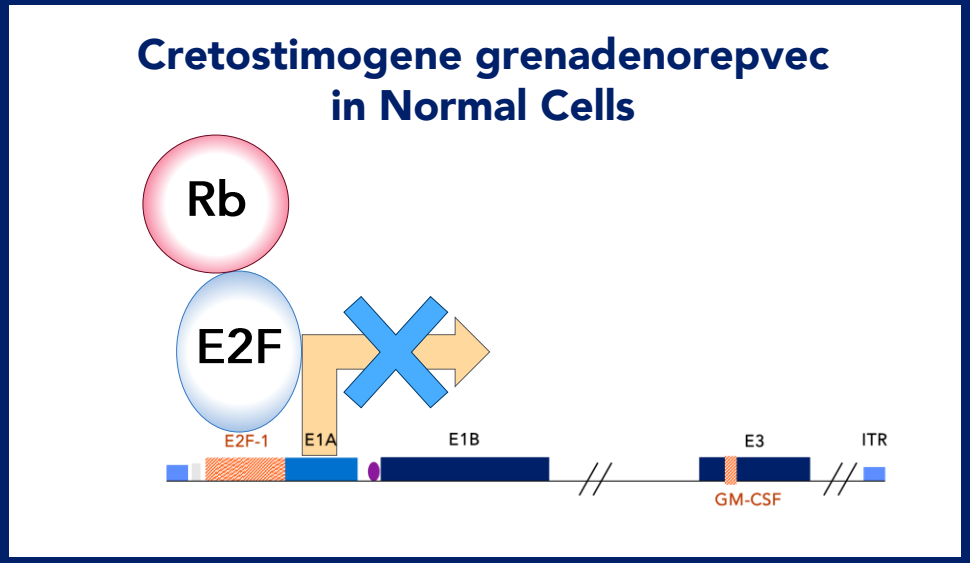


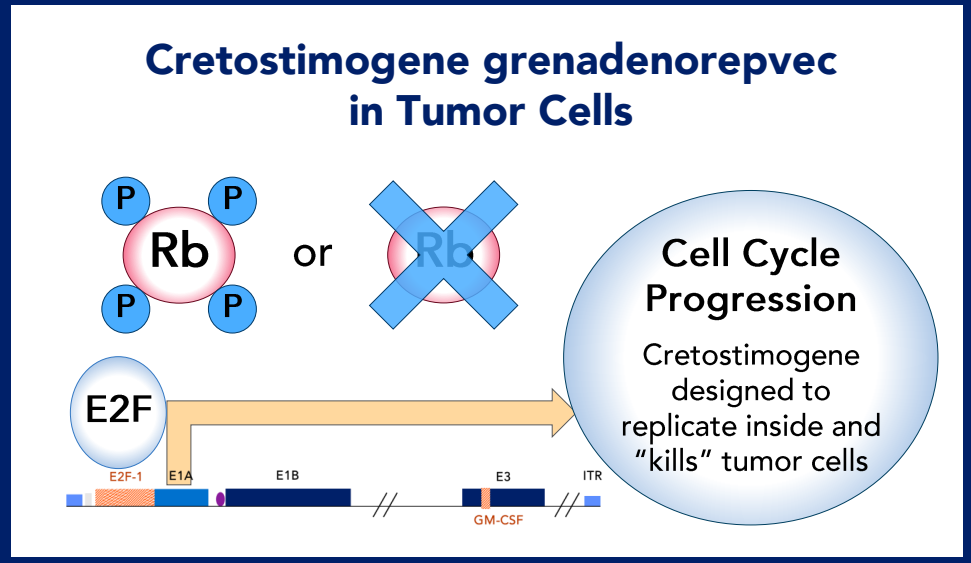
Ongoing Study Planned Study

[1] Patients with carcinoma in situ, with or without high-grade Ta/T1 disease. [2] Patients with high-grade Ta/T1. Cohort P is a Phase 2 cohort of BOND-003 and currently not intended for regulatory approval.

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 Selectively Targets Rb-E2F Pathway Altered Cancers





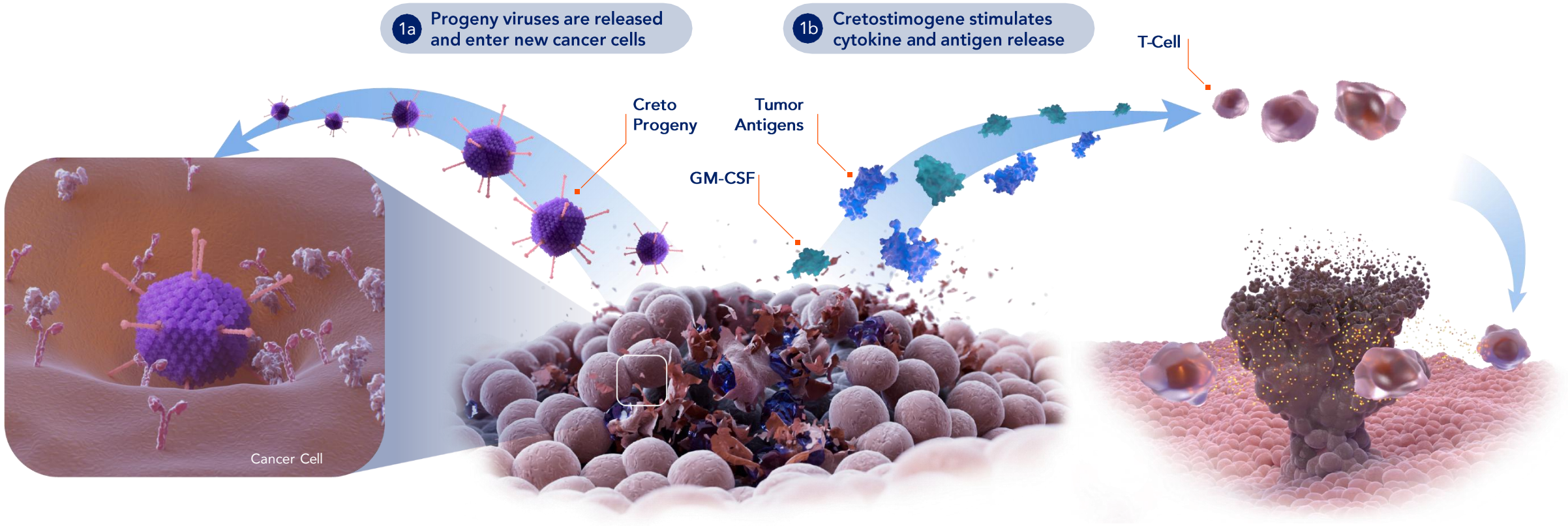
- E2F is a master regulator of gene expression and Cell Cycle Progression
- In human cancers, which consistently have retinoblastoma (Rb) pathway-defective cells, Rb cannot bind to E2F due to reasons including:
  - Rb is hyper-phosphorylated (P)
  - Rb is deleted / silenced
- As a result, Cretostimogene selectively replicates inside tumor cells with dysfunctional Rb pathways to cause selective cancer cell lysis and immunogenic cell death

Laine, et al. Molecular Pathways: Harnessing E2F1 Regulation for Prosenescence Therapy. Molecular Therapy. Vol. 10, No. 4, October 2004.

Oncolytic Immunotherapy: Cretostimogene's Dual Mechanism of Action

1 Cretostimogene selectively replicates in and kills cancer cells

2 Immune cells attack and kill additional cancer cells



Significant Need for Innovation and Disruption in Bladder Cancer Treatments

A Very Common Cancer

83,000+
people will be diagnosed with bladder cancer this year[1]

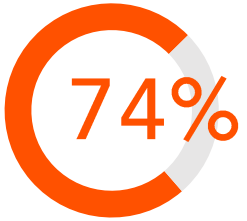
725,000+
people estimated living with bladder cancer in 2020 in the United States[8]

Highly Recurrent Disease With Few Treatment Options

~15%-61%
of high-risk patients will recur within 1 year[7]

$$$$M
Bladder Cancer is one of the most expensive cancers to treat[9]

Patients are from High-risk Populations



74% are over **65** years old

73 years is the median age

Risk factors

Smoking

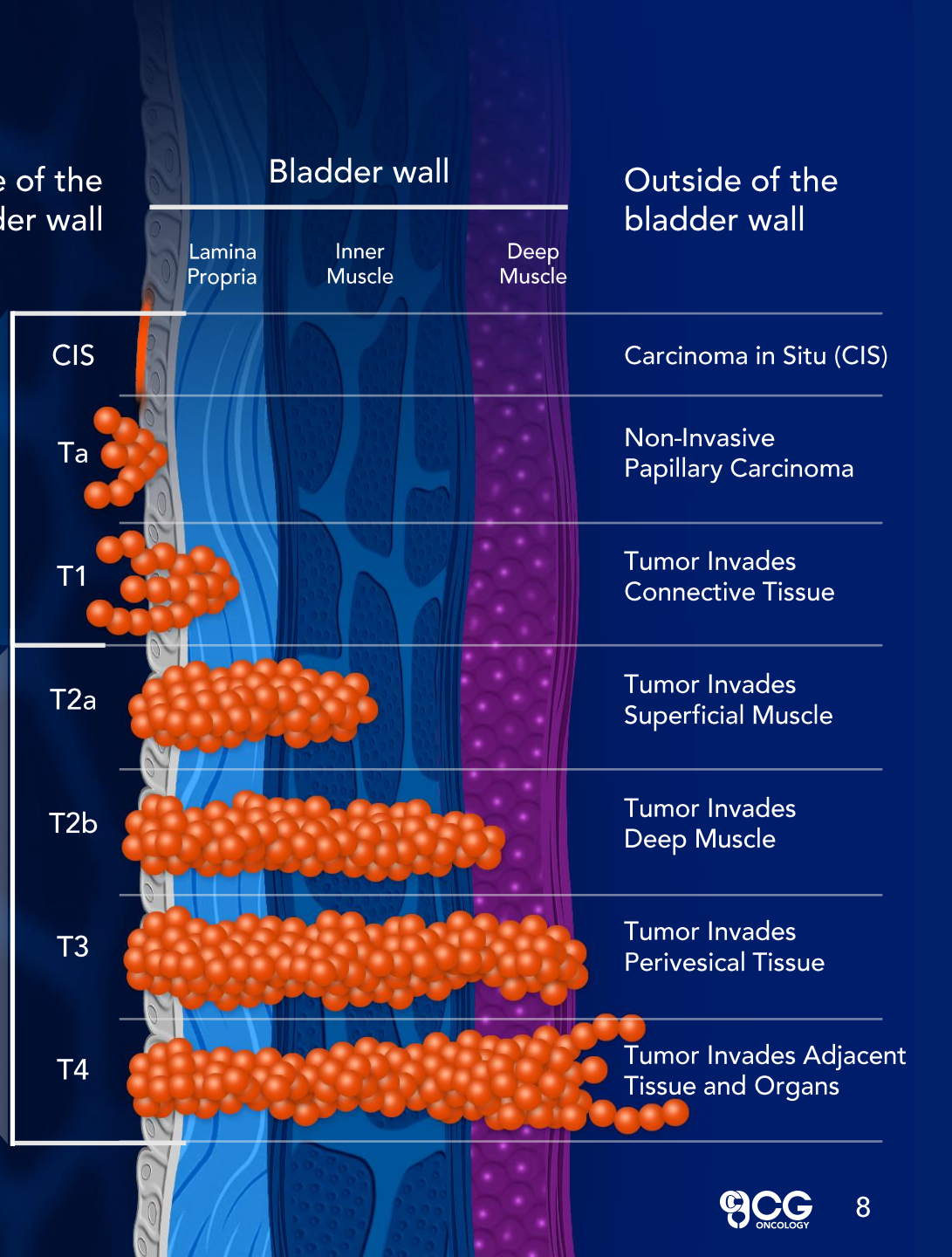
Exposure to carcinogens including agent orange

[1] ACS (American Cancer Society) 2024 Cancer Facts and Figures Annual Report. [2] Chang et al 2016. J Urol. 196:1021-1029. [3] Mossanen et al. World J Urol. 2019;37(10):2059-2065. [4] Berger et al. Can Urol Assoc J. 2018;13(7):E190-e201. [5] Sadowski et al. Urol Oncol. 2018;36(3):89.e87-89.e11. [6] Pak et al. Urology. 2017;103:117-123. [7] Sylvester et al. Eur Uro. 2006 Mar;49(3):466-5; discussion 475-7. [8] SEER Cancer Stat Facts: Bladder Cancer. https://seer.cancer.gov/statfacts/html/urinb.html. [9] Abdalla Aly, et al. J Clin Pathw. 2020 May; 6(4): 51-60.

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.

The Patient Journey

1 Symptoms

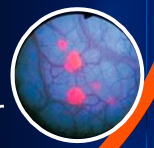
Patient presents to primary care and/or urologist with symptoms (hematuria, urinary frequency)

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
Perioperative Chemotherapy	Perioperative Chemotherapy	Intravesical BCG (Induction ± Maintenance)
TURBT	Intravesical BCG[2]	Intravesical Chemotherapy
	Repeat TURBT	Cystectomy
		Pembrolizumab, Nadofaragene, N-803 + BCG

[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.

FDA Guidance on BCG-Unresponsive NMIBC De-Risks Development & Regulatory Pathway to BLA Approval

Single-arm trials with complete response rate as primary endpoint in the context of **duration of response** may be appropriate for a **full approval**.

BCG-unresponsive disease defined as either:

- **Persistent or recurrent CIS** alone or with recurrent Ta/T1 disease within **12 months** of adequate BCG therapy
- **Recurrent high-grade Ta/T1** disease within **6 months** of completion of adequate BCG therapy, or
- T1 high-grade disease following a BCG induction course.

Adequate BCG therapy is defined as at least **5 doses of induction** course plus at least **2 doses of maintenance** therapy, or at least 5 doses of induction plus at least 2 doses of second induction.

– 2018 FDA Guidance for BCG-Unresponsive NMIBC

Three Therapeutic Agents Approved for Full Approval Following Issuance of FDA Guidance*

Pembrolizumab
Approved in January 2020

Nadofaragene
Approved in December 2022

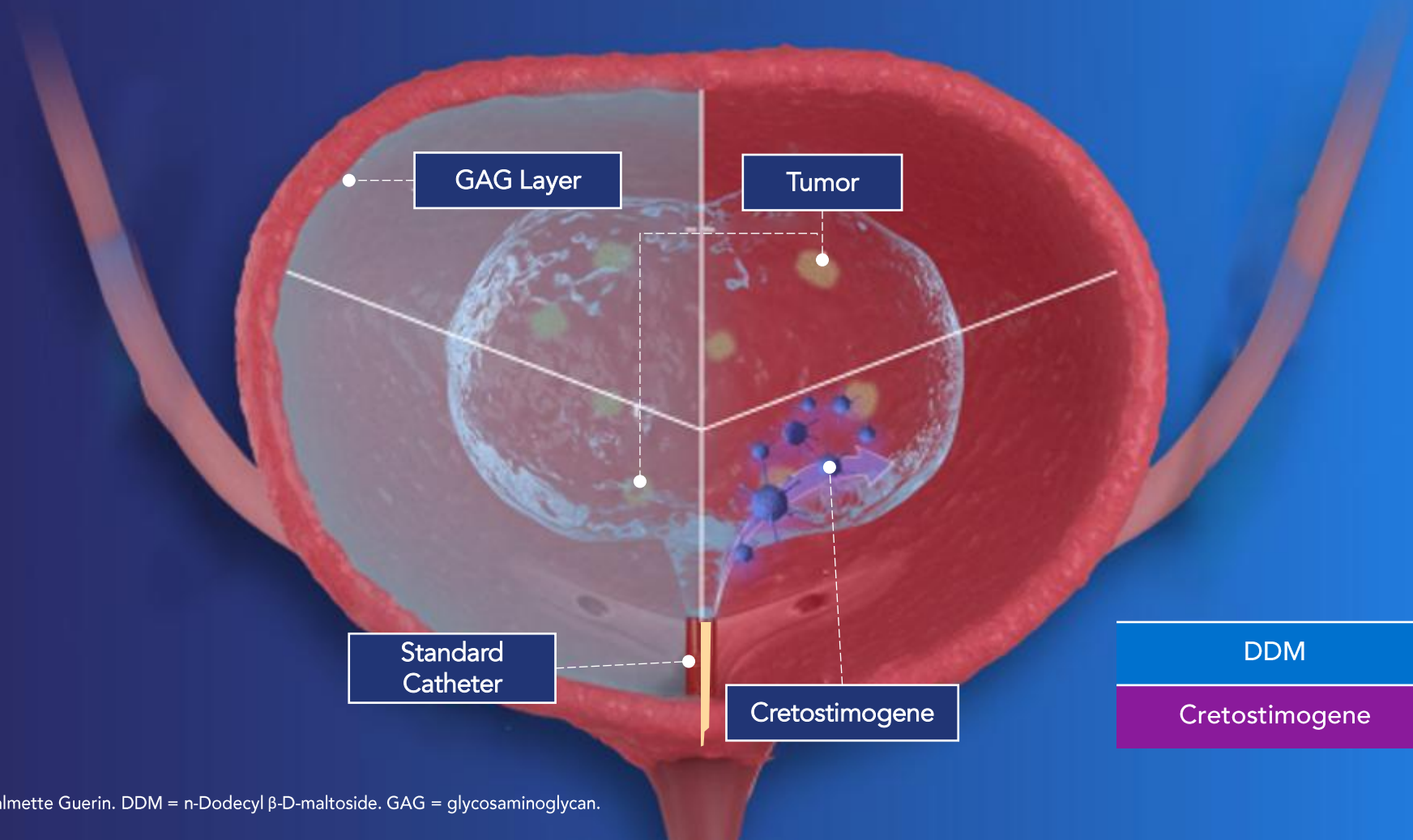
N-803 plus BCG combo
Approved in April 2024

Patient aversion to radical cystectomy associated with significant change in daily routine, surgery-related complications, and mortality rate drives regulatory and sponsor development pathways.

Kamat et al, JCO, 2016; Lerner et al, Bladder Cancer, 2016; FDA Guidance Document, 2018.
Note: FDA guidance is not binding and the FDA has not yet provided the Company with formal advice regarding potential registrational programs.

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

Ease of Delivery and Administration for Patients, Physicians, and Practice Providers

Cold chain and stability	Commercial product will be shipped via Just-In-Time delivery with multi-day stability in the box; and at least 4 weeks at 2-8°C in a regular fridge until administration
Prepared and administered by	Medical Assistant, Nurse, Nurse Practitioner, Physician Assistant, or Urologist via urinary catheter (no pre-administration of anti-cholinergics required)
Biosafety handling (BSL-2)	Any site that administers BCG or intravesical chemotherapy can prepare and administer cretostimogene
Monitoring time after administration	No monitoring requirement expected for commercial setting; 30 minutes in clinical trials setting

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

All Bladder Cancer (U.S. Incidence ~83,000 Patients/Year; Prevalence ~725,000 Patients)

NMIBC (75%) *(Non-Muscle Invasive Bladder Cancer)*

Intermediate Risk (30%)

BCG-Naïve

PIVOT-006
Phase 3 Monotherapy

High Risk (40%)

BCG-Naïve

CORE-008[1]
Cohort A

BCG-Exposed

CORE-008[1]
Cohort B

CORE-008[1]
Cohort CX

BCG-Unresponsive

BOND-003
Phase 3 Monotherapy
Cohort C and Cohort P

CORE-001
Phase 2 Checkpoint Combo

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.

BOND-003

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

BCG-Unresponsive NMIBC → **Cretostimogene** Single-Arm, Open-Label, Intravesical Administration → **CR at Any Time (CIS) EFS (Ta/T1)**

Trial Design

- Pathologically confirmed BCG-Unresponsive, High-Risk NMIBC CIS or 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-months[2]

Study Design / Regimen

- Cohort C = BCG-unresponsive, High-Risk NMIBC CIS with or without Ta/T1 (n=112)
  - Induction course = Weekly x 6 ($1x10^{12}$ vp/mL)
  - Second induction course[1] = Weekly x 6 ($1x10^{12}$ vp/mL) for non-responders
  - Maintenance courses = Weekly x 3 ($1x10^{12}$ vp/mL) for complete responders every 3 months for first 12 months, every 6 months for next 24 months
- Cohort P = BCG-unresponsive, High-Risk NMIBC Ta/T1 without CIS (up to n=75)
  - Same as Cohort C

Additional Endpoints

- 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

Patient Demographics & Baseline Characteristics

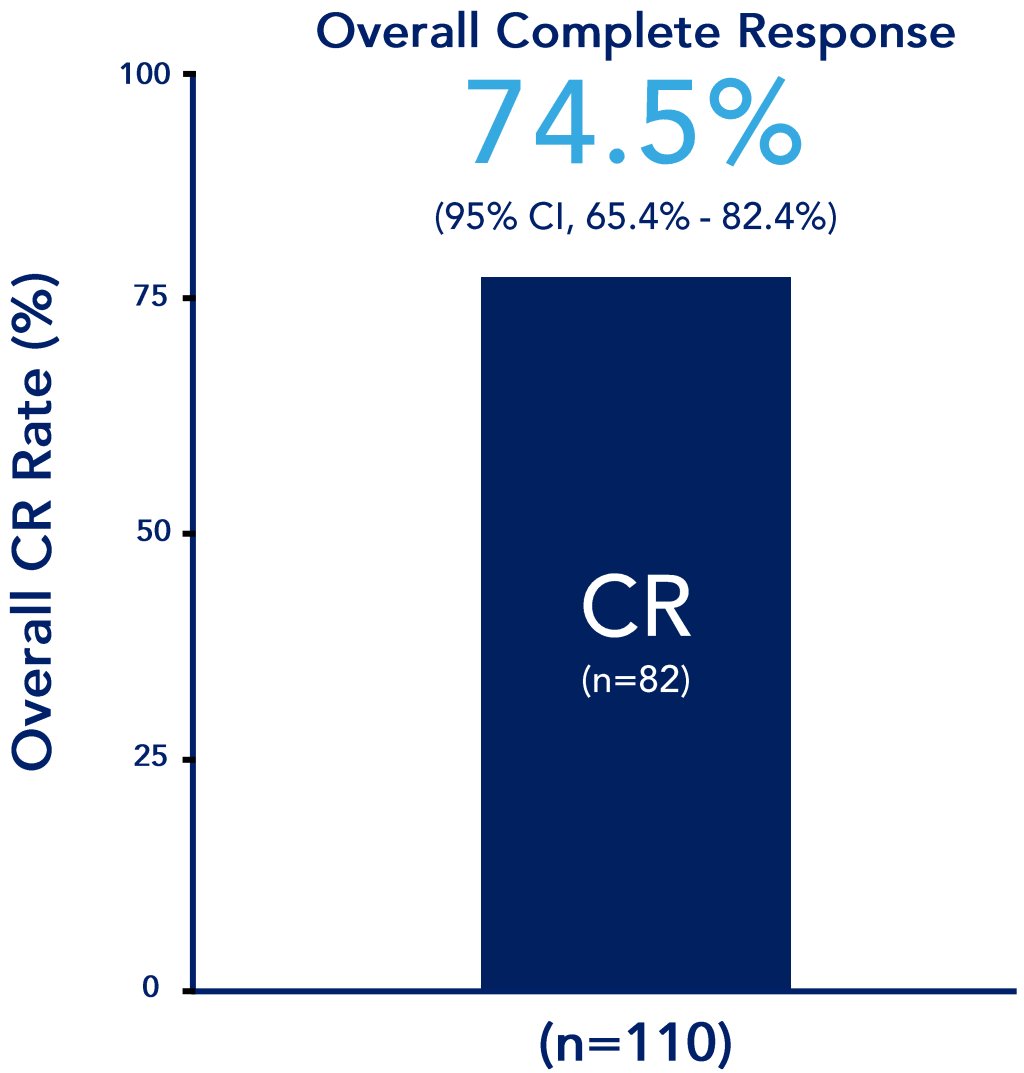
	N=112	%
Gender		
Male	83	74.1
Female	29	25.9
Age (Years)		
Mean (SD)	72.9 (9.19)	
Median (Range)	74.0 (43-90)	
Age (Categories)		
< 65	19	17.0
> 65	93	83.0
BCG History: Number of Prior Instillations		
Median (Range)	12 (7 – 66)	
High-Risk NMIBC T-Stage at Study Entry		
CIS with HG Ta/T1	22	19.6
CIS alone	90	80.4

- Majority of patients are:
  - Male (74%)
  - White (61%)
  - > 65 years (83%)
- 63.4% of patients in U.S.
- Study included highly pre-treated population
  - Patients with prior intravesical chemotherapy and systemic immunotherapy were allowed on study

Safety data cutoff as of September 30, 2024.

BOND-003 Cohort C

Cretostimogene Favorable Efficacy and Durability Data



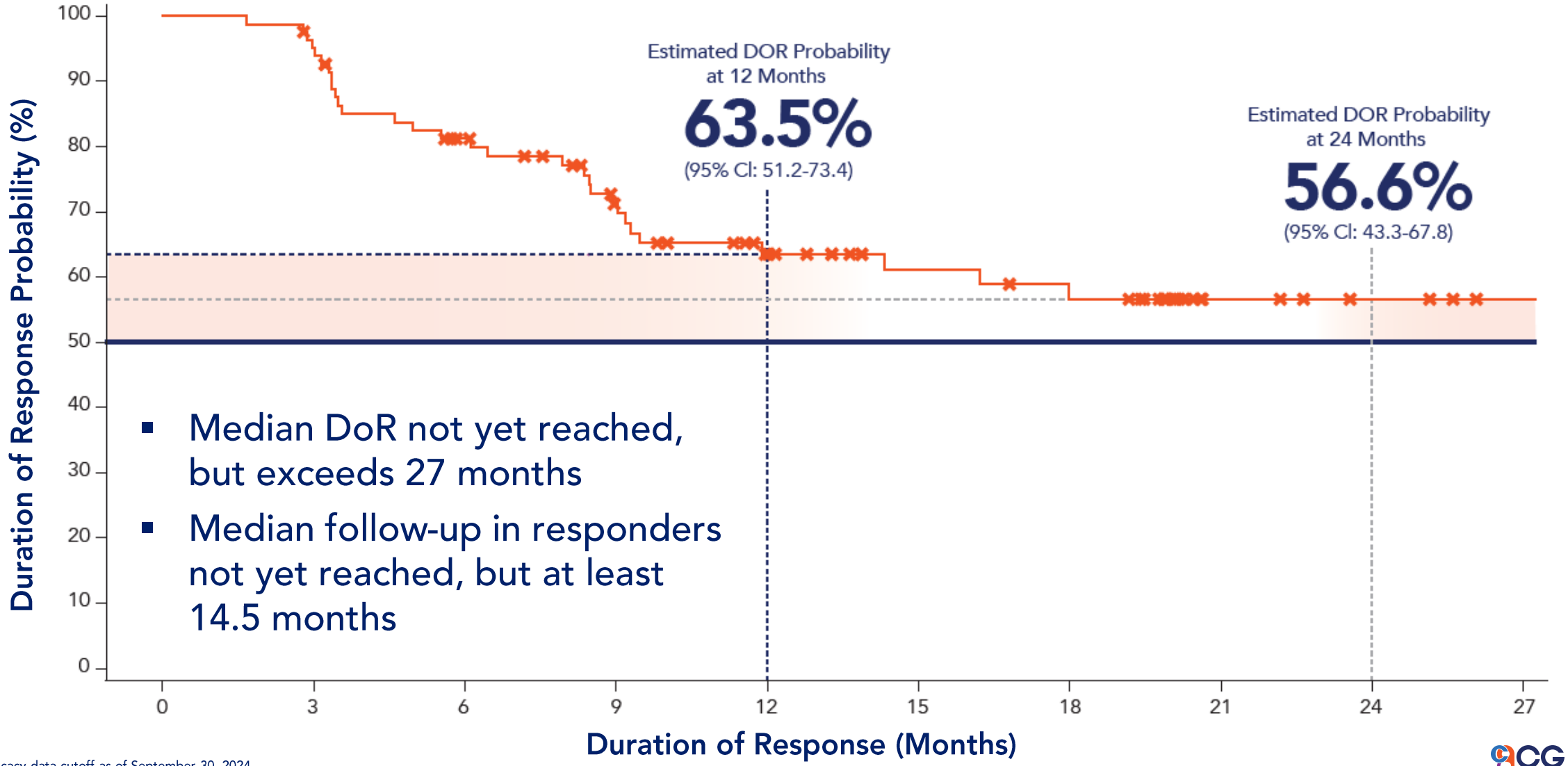
CR Landmark Analysis	CR Rate, % (95% CI)	CR by K-M Est, % (95% CI)
12-month	**46%** (36.9, 56.1)[1] *51 out of 110 patients*	**50%** (39.6, 58.9)
24-month	*There are 25 confirmed CRs that have reached 24-month timepoint and beyond*[2]	**41%** (30.4, 50.8)

- 97.3% free from progression to MIBC at 12 months
- 90.0% Cystectomy-Free Survival at 12 months
- All complete responses have been centrally confirmed[3]

Efficacy data cutoff as of September 30, 2024. 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 assessments as of September 30, 2024 efficacy cutoff including two additional responders centrally confirmed past the data cutoff. [2] Based on centrally confirmed responders who have reached 24-month evaluation timepoint. [3] 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.

BOND-003 Cohort C

Cretostimogene Demonstrates Sustained Duration of Response in HR BCG-UR NMIBC

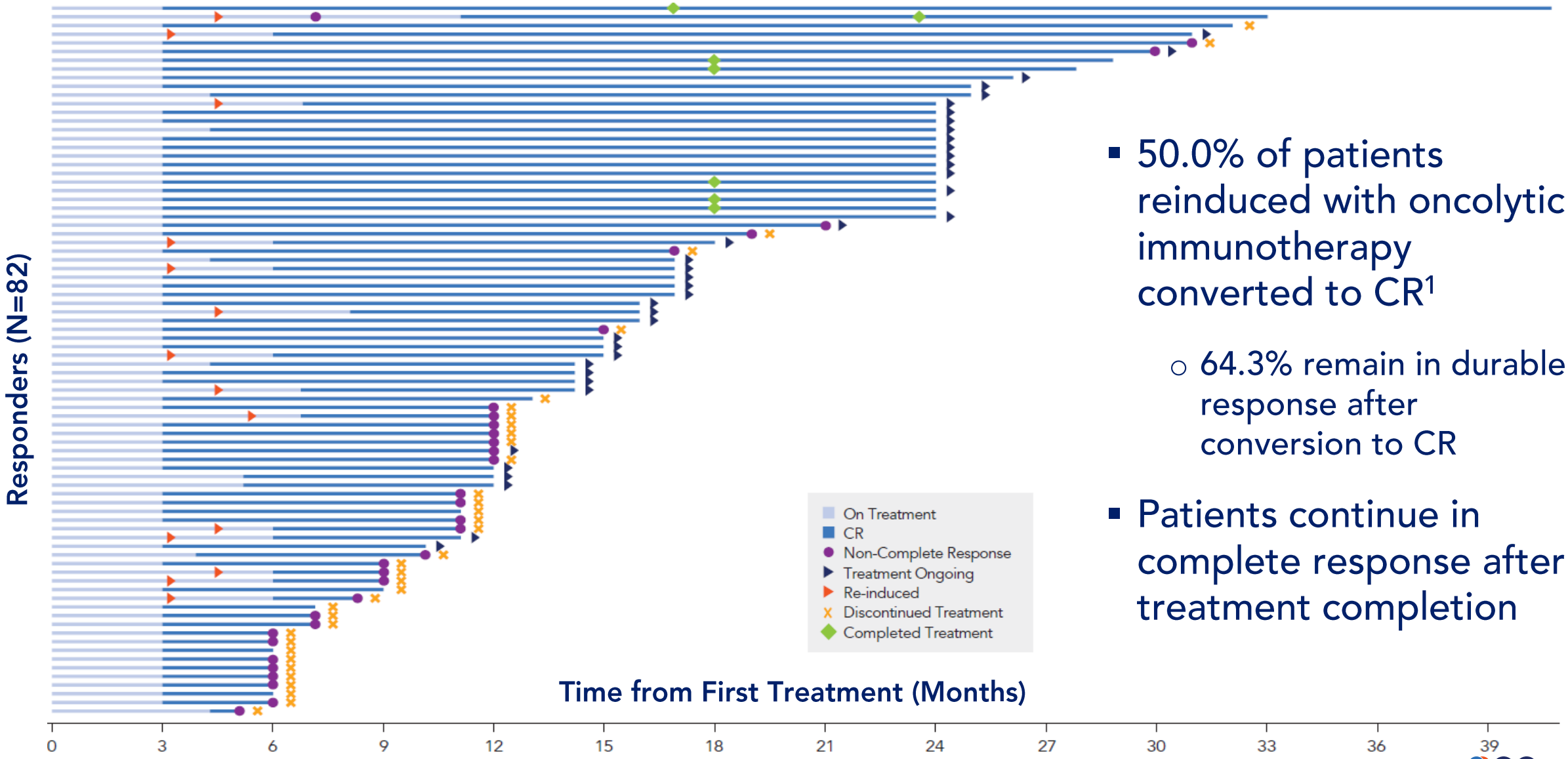


- Median DoR not yet reached, but exceeds 27 months
- Median follow-up in responders not yet reached, but at least 14.5 months

Efficacy data cutoff as of September 30, 2024.

BOND-003 Cohort C

Sustained Responses Observed Beyond 30 Months

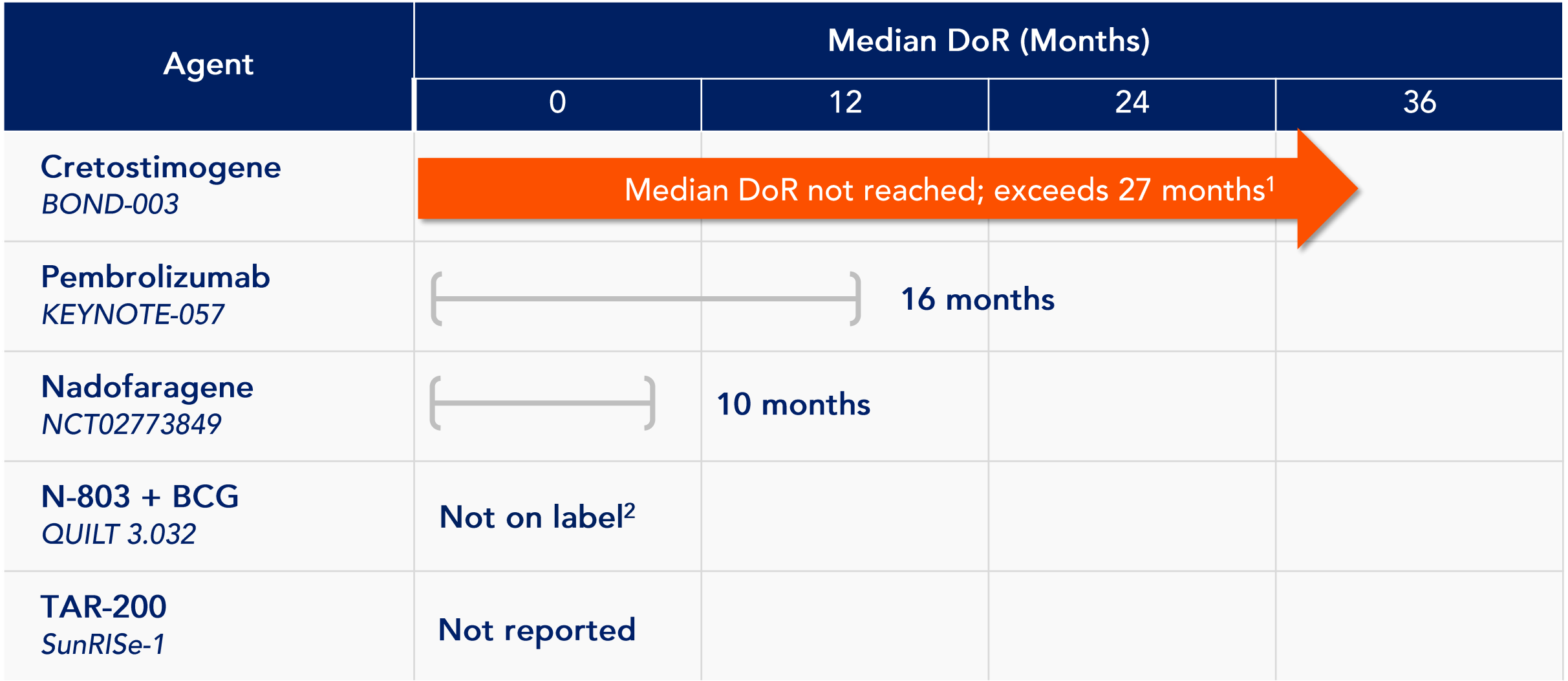


- 50.0% of patients reinduced with oncolytic immunotherapy converted to CR[1]
  - 64.3% remain in durable response after conversion to CR
- Patients continue in complete response after treatment completion

Based on centrally confirmed assessments as of September 30, 2024 efficacy cutoff including two additional responders centrally confirmed past the data cutoff at 12-month timepoint. [1] Per 2018 FDA Guidance Document on BCG-Unresponsive NMIBC (page 6), sponsors should consider and discuss with FDA a patient's disease history, type of disease present at 3 months, and the mechanism of action of the investigational drug regarding patients with CIS who do not achieve a CR at their 3-month assessments.

BOND-003 Cohort C

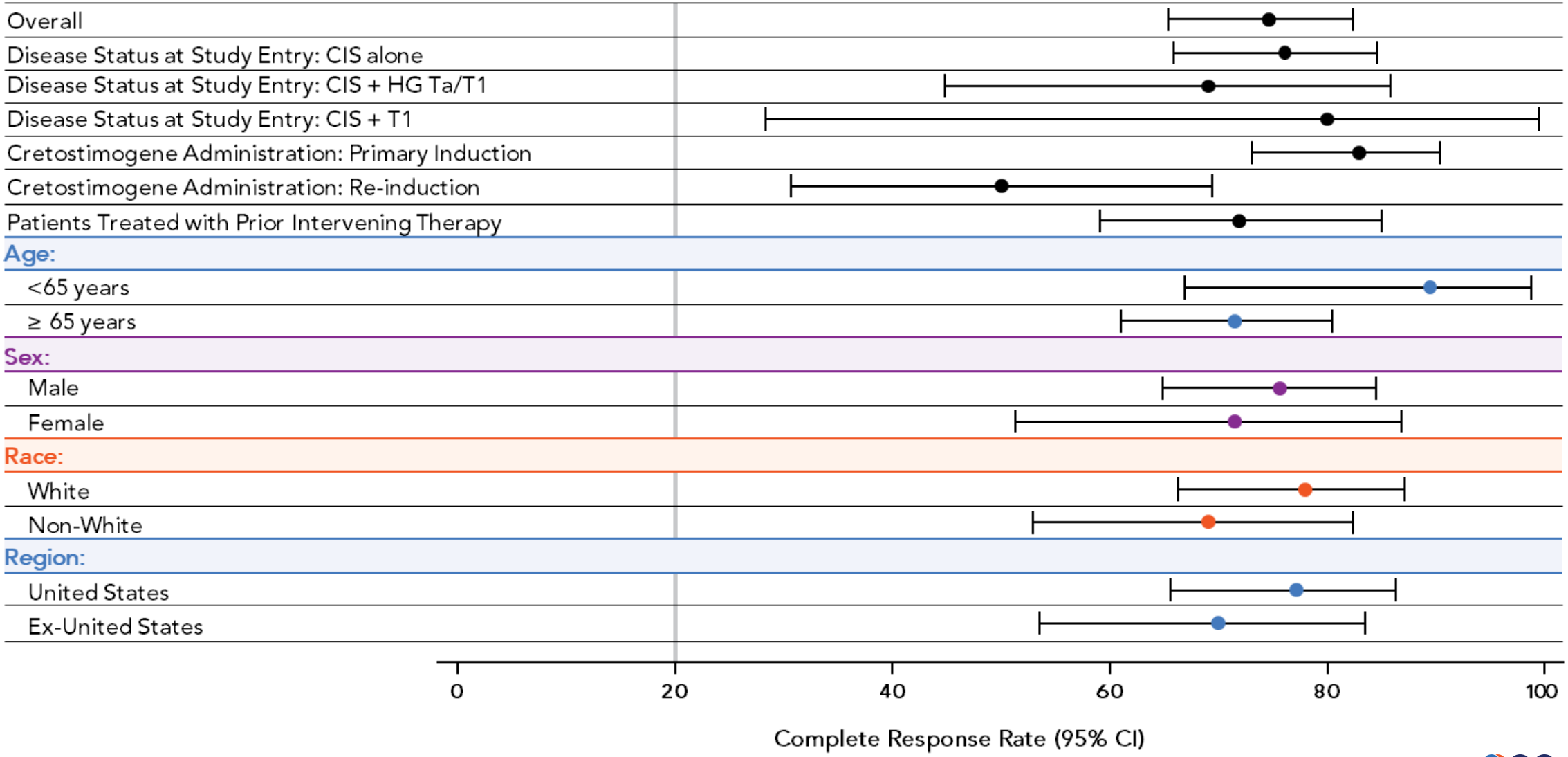
Cretostimogene Median Duration of Response Exceeds 27 Months and Ongoing



Note: These data are not based on head-to-head or comparator studies, but have all enrolled FDA guidance defined BCG-Unresponsive High-Risk NMIBC CIS-containing patients according to their inclusion/exclusion criteria. [1] Efficacy data cutoff as of September 30, 2024. [2] https://www.accessdata.fda.gov/drugsatfda_docs/nda/2024/761336Orig1s000MultidisciplineR.pdf

BOND-003 Cohort C

High CR Rate Consistent Across Patient Subgroups, Including Patients Treated with Prior Chemotherapy



Efficacy data cutoff as of September 30, 2024.

BOND-003 Cohort C

Favorable and Well Tolerated Safety Profile

Preferred Term (MedDRA v.26.1)	Cretostimogene (n=112)	
	Any Grade (%)	Grade ≥ 3
Patients with ≥ 1 TRAE	72 (64.3%)	0 (0)
Treatment-Related AE reported in >10% patients		
Bladder Spasm	28 (25.0%)	0 (0)
Pollakiuria	23 (20.5%)	0 (0)
Dysuria	22 (19.6%)	0 (0)
Micturition Urgency	17 (15.2%)	0 (0)
Hematuria	15 (13.4%)	0 (0)

- 0% Grade ≥ 3 treatment-related AEs or deaths reported
- Most AEs were Grade 1-2
- No treatment-related discontinuations observed
- 97.3% completed all protocol-defined treatments
- 1.8% patients (n=2) had serious treatment-related AEs (Grade 2)[1]

AE = adverse event. Safety data cutoff as of September 30, 2024.
[1] Treatment-related SAEs were noninfective cystitis (Grade 2) and clot retention (Grade 2). [2] Unrelated AE leading to treatment discontinuation was Hematuria (Grade 2).

Emerging Target Product Profile Positions Cretostimogene Well in NMIBC[1]

Trial (Status)	BOND-003 (Ph3 Ongoing)	CORE-001 (Ph2 Complete)	QUILT 3.032 (Approved)	NCT02773849 (Approved)	KEYNOTE-057 (Approved)	SunRISe-1 (Ph2 Ongoing)	SunRISe-1 (Ph2 Ongoing)
Drug	Cretostimogene	Cretostimogene + Pembrolizumab	N-803 + BCG	Nadofaragene	Pembrolizumab	TAR-200	TAR-200 + cetrelimab
Mechanism	Oncolytic Immunotherapy	Oncolytic Immunotherapy + Checkpoint Inhibitor	IL-15 Superagonist + BCG combo	Gene Therapy Secreting IFN	Checkpoint Inhibitor	Local Delivery of Gemcitabine via In-Dwelling Device	Local Delivery of Gemcitabine + Checkpoint Inhibitor
RoA	Intravesical	Intravesical + Intravenous	Intravesical	Intravesical	Intravenous	Transurethral Procedure	Transurethral Procedure + IV
Efficacy Population	110	35	77	98	96	85	53
CR at Any Time	**75% (82/110)** *[95% CI: 65% - 82%]*	83% (29/35) *[95% CI: 70% - 95%]*	62% (48/77) *[95% CI: 51% - 73%]*	51% (50/98)[4] *[95% CI: 41% - 61%]*	41% (39/96) *[95% CI: 31% - 51%]*	84% (71/85) *[95% CI: 74% - 91%]*	68% (36/53) *[95% CI: 54% - 80%]*
CR at 12 Mo	**46% (51/110)[2]** *[95% CI: 37% - 56%]*	57% (20/35) *[95% CI: 40% - 73%]*	36% (28/77)[3]	24% (25/103)	19% (18/96)	39% (12/31)[6]	Not Reported
CR at 12 Mo ***(By K-M Est.)***	**K-M: 50%** *[95% CI: 40% - 59%]*	K-M: 77% *[95% CI: 58% - 88%]*	Not Reported	Not Reported	Not Reported	K-M: 57% *[95% CI: 41% - 71%]*	K-M: 57% *[95% CI: 41% - 70%]*
CR at 24 Mo	***25 confirmed CRs at 24 month & beyond***	54% (19/35) *[95% CI: 37% - 71%]*	25% (19/77)[3]	19% (20/103)	9% (9/96)[5]	Not Reported	Not Reported
CR at 24 Mo ***(By K-M Est.)***	**K-M: 41%** *[95% CI: 30% - 51%]*	K-M: 70% *[95% CI: 50% - 83%]*	Not Reported	Not Reported	Not Reported	Not Reported	Not Reported
Grade 3+ TRAE	**0%**	0% (creto)	Not reported; 16% SAE	4%	13%	9.4%	35.8%; 13.2% SAE
Treatment-related discontinuation	**0%**	0% (creto)	7%	3%	11%	5.9%	26.4% (TAR-200)

[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] Based on centrally confirmed assessments as of September 30, 2024 efficacy cutoff including two additional responders centrally confirmed past the data cutoff. [3] 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. [4] ADSTILADRIN® Package Insert (December 2022) and Summary Basis for Regulatory Action. [5] Derived from GU ASCO 2021, Balar et al presentation DOR ≥ 24 months to estimate 24-months landmark CR rate [6] Goldman Sachs Equity Research – May 6, 2024. 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). CG Oncology (BOND-003 – SUO 2024; CORE-001 – ASCO 2024).

CORE-001

Phase 2 Cretostimogene + Pembrolizumab for BCG-Unresponsive, High-Risk NMIBC CIS (NCT04387461)

BCG-Unresponsive NMIBC → **Cretostimogene**
Single-Arm, Open-Label, IVe Creto + IV Pembrolizumab → CR at 12-months

Trial Design

- Pathologically confirmed high-risk NMIBC BCG-unresponsive CIS with or without Ta/T1
- Have all Ta/T1 disease resected prior to treatment
- Trial designed and compliant with 2018 FDA guidance
- Mandatory bladder mapping at 12-months[3]

Study Design / Regimen

- Cretostimogene Induction = Weekly x 6 ($1x10^{12}$ vp/mL)
- Second induction course[1] = Weekly x 3 or 6 ($1x10^{12}$ vp/mL) for responders, 6 for non-responders
- Maintenance courses[2] = Weekly x 3 ($1x10^{12}$ vp/mL) for complete responders
- Pembrolizumab = Every 6 weeks (400 mg) through Year 2

Additional Endpoints

- CR at Any Time
- DoR
- CR at 24-months
- PFS
- Safety

CR = complete response. DoR = duration of response. PFS = progression free survival.
[1] Second induction course of weekly x 6 for non-responders at month 3. [2] Maintenance course for complete responders starts at month 3 every 3 months for 1st year, and every 6 months for 2nd year. [3] All patients required to undergo mandatory, systematic bladder mapping of 5 locations, biopsy of the prostatic urethra, and upper tract imaging to confirm CR.

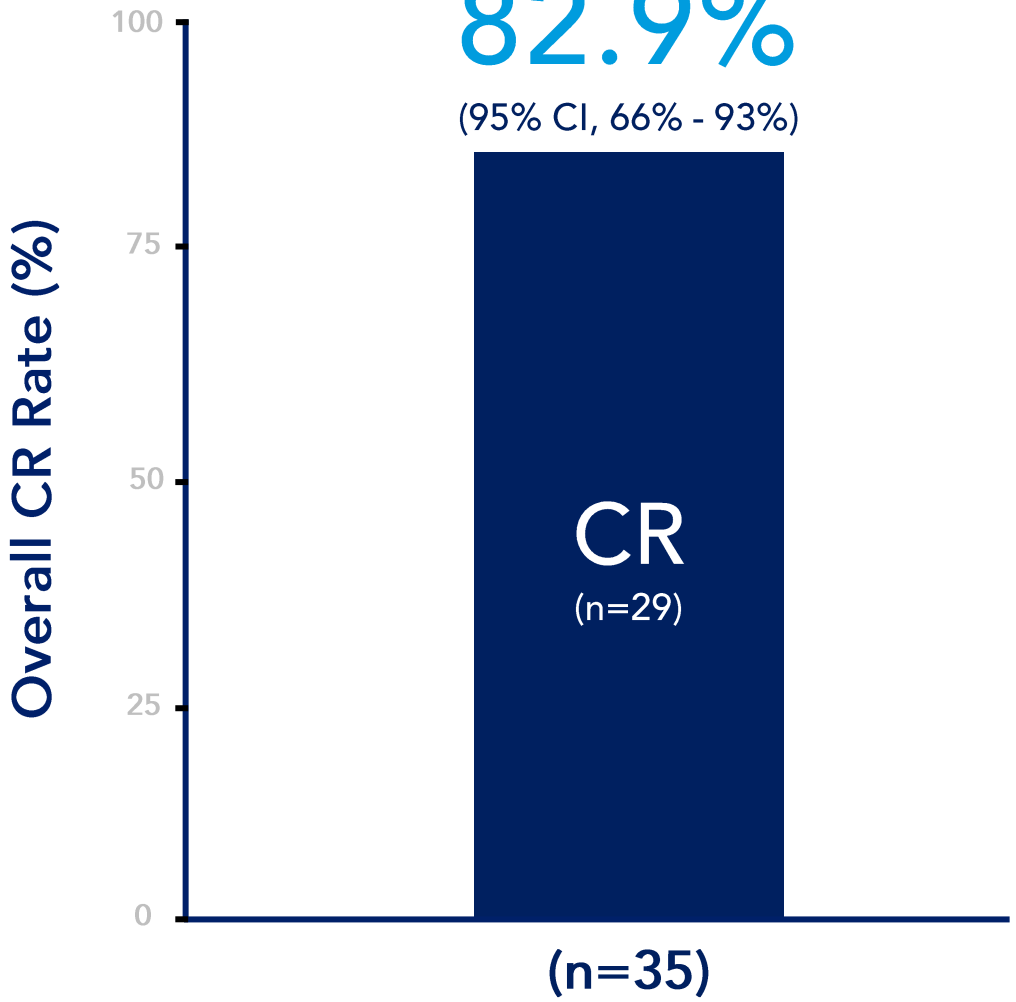
CORE-001

Cretostimogene Combo with Pembrolizumab: Potential Class-Leading Response

Overall Complete Response

82.9%

(95% CI, 66% - 93%)



CR Landmark Analysis	Actual CR Rate, % (95% CI)	CR by KM Estimate, % (95% CI)
12-month	**57.1%** (39.5, 73.2) *20 of 35 patients*	**77.3%** (58.1, 88.5)
24-month	**54.3%** (36.9, 70.8) *19 of 35 patients*	**69.6%** (49.4, 83.0)

Landmark analysis based on both actual landmark CR rate assessed in clinical trial and CR by Kaplan-Meier estimate[1].

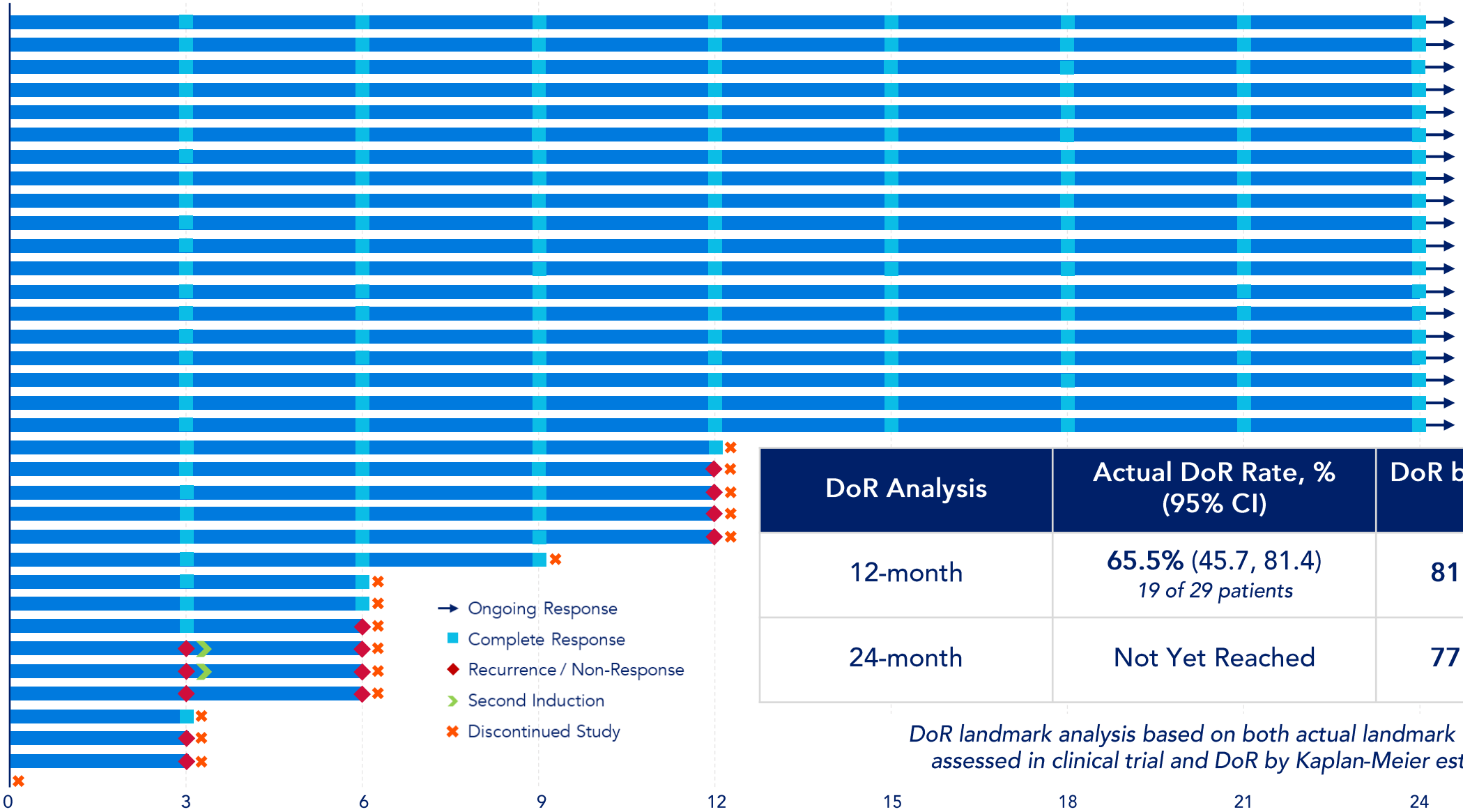
- 95% of patients in a CR at 12-months (19 of 20) maintained a CR for another 12 months
- 100% PFS at 24-months with 0 patients progressing to muscle-invasive disease
- 80.0% CFS at 24-months; 100% CFS for patients in CR
- Median follow-up 26.5 months
  - Median DoR not met, > 21 months

Efficacy data cutoff as of May 17, 2024. Efficacy analysis centrally confirmed. All patients have active disease at baseline prior to enrollment. Received adequate BCG per FDA 2018 guidance.
[1] CR by Kaplan-Meier estimate is based on HG RFS.

CORE-001

ASCO 2024: Updated Long-Term Durability Data

Cretostimogene + Pembrolizumab Combo for BCG-Unresponsive, High-Risk NMIBC



DoR Analysis	Actual DoR Rate, % (95% CI)	DoR by KM Estimate, % (95% CI)
12-month	**65.5%** (45.7, 81.4) *19 of 29 patients*	**81.6%** (61.3, 91.9)
24-month	Not Yet Reached	**77.3%** (56.2, 89.1)

DoR landmark analysis based on both actual landmark DoR rate assessed in clinical trial and DoR by Kaplan-Meier estimate.

Efficacy data cutoff as of May 17, 2024.

CORE-001

Favorable Safety Profile with No Overlapping or Synergistic Toxicity in Combination of Cretostimogene and Pembrolizumab

Preferred term, n (%)	Maximum Severity					
	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5	Total
Participants reporting at least one study drug-related treatment-emergent AE	9 (25.7)	18 (51.4)	5 (14.3)	0	0	32 (91.4)
Bladder Spasm	13 (37.1)	4 (11.4)	0	0	0	17 (48.6)
Fatigue	11 (31.4)	2 (5.7)	0	0	0	13 (37.1)
Dysuria	8 (22.9)	1 (2.9)	0	0	0	9 (25.7)
Pollakiuria	8 (22.9)	1 (2.9)	0	0	0	9 (25.7)
Hematuria	5 (14.3)	1 (2.9)	0	0	0	6 (17.1)
Micturition urgency	4 (11.4)	2 (5.7)	0	0	0	6 (17.1)
Diarrhea	4 (11.4)	0	1 (2.9)	0	0	5 (14.3)
Nocturia	3 (8.6)	1 (2.9)	0	0	0	4 (11.4)
Hypothyroidism	1 (2.9)	3 (8.6)	0	0	0	4 (11.4)
Urinary tract infection	3 (8.6)	1 (2.9)	0	0	0	4 (11.4)
Blood alkaline phosphatase increased	0	0	1 (2.9)	0	0	1 (2.9)
Ejection fraction decreased	0	0	1 (2.9)	0	0	1 (2.9)
Neutrophil count decreased	0	0	1 (2.9)	0	0	1 (2.9)
Adrenal insufficiency	0	0	1 (2.9)	0	0	1 (2.9)
Immune-mediated hepatitis	0	0	1 (2.9)	0	0	1 (2.9)

Data are n(%). The table presents study drug-related AEs that occurred in at least 10% or more of all treated patients (n=35) and all study drug-related grade 3 events. AEs include all events that occurred or worsened after the first dose of cretostimogene or pembrolizumab. There were no grade 3-5 cretostimogene treatment-related AEs. There were no grade 4-5 pembrolizumab treatment-related AEs.

- AEs attributed to cretostimogene were low grade and self-limited
- No Grade 3-5 cretostimogene treatment-related AEs
- irAEs exclusively associated with pembrolizumab
- 5 treatment discontinuations observed prior to 12-month timepoint, all unrelated AEs
- No treatment-related deaths

Safety data cutoff as of May 17, 2024. AUA 2024, Abstract #4601 - Final results of CORE-001 trial of Cretostimogene Grenadenorepvec in Combination with Pembrolizumab in Patients with BCG-Unresponsive, Non-Muscle Invasive Bladder Cancer with Carcinoma in Situ

PIVOT-006

Phase 3 Adjuvant Cretostimogene Following TURBT Versus Surveillance Following TURBT for Intermediate-Risk NMIBC

Intermediate-Risk NMIBC
(Actively Enrolling)

Cretostimogene vs Surveillance/TURBT
Randomized (1:1), Two Arms, Open-Label (n=364)

Primary Endpoint:
RFS Rate

Population

- Pathologically confirmed Intermediate-Risk NMIBC
  - Recurrent LG Ta < 12mo
  - Solitary LG Ta > 3cm
  - LG Ta multifocal
  - HG Ta ≤ 3cm
  - LG T1
- All disease removed by TURBT at baseline

Study Design / Regimen

- Arm A = Cretostimogene following TURBT
  - Induction course = Weekly x 6 ($1x10^{12}$ vp/mL)
  - Maintenance courses[1] = Weekly x 3 ($1x10^{12}$ vp/mL) for complete responders
- Arm B = Surveillance following TURBT
  - Patients with disease recurrence eligible to receive cretostimogene

Additional Endpoints

- RFS at 12-month and 24-month
- PFS
- Safety

RFS = recurrence free survival. PFS = progression free survival.
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.

CORE-008

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

BCG-Naïve & BCG-Exposed NMIBC

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

Primary Endpoint:
CR Rate; HG EFS

Population

- Cohort A *(actively enrolling)*
  - 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)
  - Arm 1 = CIS ± HG Ta/T1 (n=~75)
  - Arm 2 = HG Ta/T1 only (n=~100)
  - Standard weekly x 6 induction, reinduction and weekly x 3 maintenance until Year 3[1]
- Cohort B (BCG-exposed HR NMIBC)
  - Arm 1 = CIS ± HG Ta/T1 (n=~75)
  - Arm 2 = HG Ta/T1 only (n=~75)
  - Standard dosing as above[1]

Additional Endpoints

- Cohort A
  - DoR (Arm 1 only)
  - EFS, LG RFS, CFS
- Cohort B
  - DoR (Arm 1 only)
  - 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.

CG's high yielding and scalable process is positioned to address BCG-Unresponsive HR NMIBC market at launch

- **Single-use bioreactors** allow for optimized manufacturing campaigns that support multiple production runs and results in **higher efficiency and throughput**
- **Highly stable product** enables **inventory build** to address significant unmet need in BCG-UR HR NMIBC at launch and expansion in IR populations
- Manufactured by **seasoned US-based CDMOs** with expertise in **oncolytic immunotherapy**
- **Distributed partnerships** across suppliers creates additional redundancy in manufacturing approach

Commercial

Our Goal is to Establish Cretostimogene as a Backbone Therapeutic Option for NMIBC

Bladder Cancer Market Insights

Significant NMIBC Unmet Need

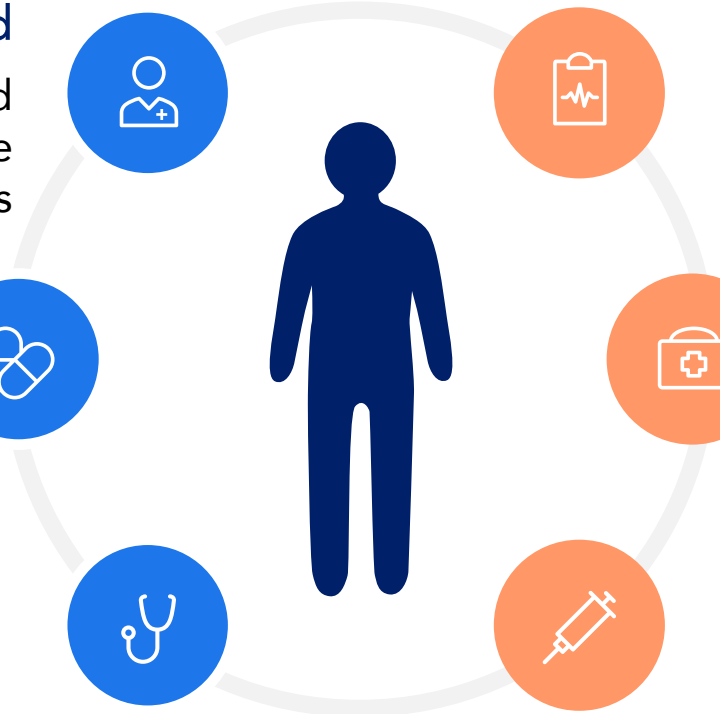
High recurrence rates and limited alternatives for BCG-unresponsive High-Risk NMIBC patients

Concentrated Pool of Physicians

Physicians in top key accounts treat more than 70% of NMIBC patients by volume

Substantial Clinical Inertia

Surgery and BCG (*currently in shortage*) have been the established standard-of-care treatments for decades



Cretostimogene Commercial Opportunity

Establish Motivating Differentiation

Cretostimogene has demonstrated durable efficacy and tolerability, key for elderly patients with multiple recurrences

Focus on Key Physicians & Centers

We believe CG's experienced commercial team will be able to efficiently address significant share of bladder cancer market

Change Therapy, Not Behavior

Cretostimogene is administered like BCG, seamlessly integrating into established clinical workflows without re-training

Anticipated Milestones

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

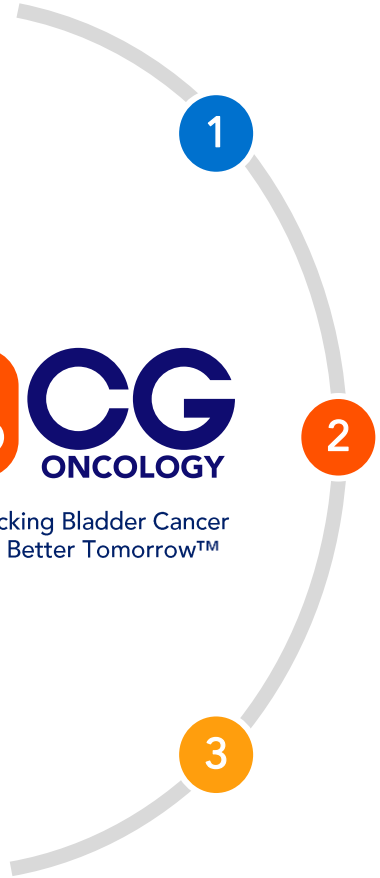
4Q'24	1H'25	2H'25	2026	2027
BOND-003 Cohort C Topline Data	BOND-003 Cohort C 30M+ Durability Data	Cretostimogene BLA Submission	Anticipated Cretostimogene Commercial Launch	PIVOT-006 Topline Data
		BOND-003 Cohort C 36M+ Durability Data	PIVOT-006 Enrollment Completion	
		BOND-003 Cohort P Topline Data	Anticipated CORE-008 Cohort B Topline Data	
		CORE-008 Cohort A Topline Data		

- BCG-UR HR NMIBC
- BCG-exposed HR NMIBC
- BCG-naïve HR NMIBC
- Intermediate-Risk NMIBC
- Regulatory/Commercial

BCG-UR = BCG-unresponsive. HR = High-Risk.
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.

Cretostimogene

CG Oncology Investment Highlights



CG ONCOLOGY

Attacking Bladder Cancer for a Better Tomorrow™

Differentiating oncolytic immunotherapy targeting a multi-billion dollar market opportunity in High-Risk and Intermediate-Risk NMIBC

Demonstrated potential best-in-class durability, safety, and tolerability in BCG-unresponsive setting, with potential frontline expansion into BCG-naïve and BCG-exposed NMIBC

Highly concentrated U.S. customer base enables an agile and focused execution towards a potential successful commercial launch

BCG-UR = BCG-unresponsive. HR = High-Risk.

CG ONCOLOGY

Attacking Bladder Cancer for a Better Tomorrow™

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Executive Leadership Team

Deep Industry Experience with Track Record of Success in Drug Development

Arthur Kuan
Chairman & CEO

Business Insider's 30 People Under 40 Who Are Transforming Healthcare

2020 Forbes 30 Under 30 featured honoree in healthcare

Ally Bridge Group · DNV Capital · MOFFITT CANCER CENTER

Ambaw Bellete
President & COO

30+ Years in Biotech & Life Sciences with multiple BLA approvals & launch experience

Chairman of the Board for OncoSTING

Board member of Axiom Reach Foundation

FerGene · Pfizer · PHOTOCURE · SANOFI

Vijay Kasturi, M.D.
Chief Medical Officer

25+ Years as GU Medical Oncologist

Managed Launch Plan for BAVENCIO®

AVEO ONCOLOGY · FerGene · EMD SERONO · NIH NATIONAL CANCER INSTITUTE

Swapnil Bhargava, Ph.D.
Chief Technical Officer

Supported multiple INDs, BLAs, and modalities to the clinic and market

(TIVDAK®, PADCEV®, and ADCETRIS®)

AbCellera · Seagen · AMGEN · novozymes

Corleen Roche
Chief Financial Officer

30+ Years in Biotech & Life Sciences

CFO to publicly-traded companies with extensive commercial experience

(PREVNAR 13®, ZARXIO®, GLATOPA™)

immunome · Biogen · SANDOZ · Pfizer

Joshua Patterson, Esq.
General Counsel & CCO

20+ Years as In-House Counsel in Biopharmaceutical Industry

Over $2.25B in transaction experience

gamida Cell · AKCEA THERAPEUTICS · IONIS · AMYLIN PHARMACEUTICALS

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™