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 Securities and Exchange Commission (SEC), including under the heading "Risk Factors" in our annual report on Form 10-K and any subsequent filings with the SEC (which are available at http://www.sec.gov). 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.

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Investment Summary

Cretostimogene grenadenorepvec is an oncolytic immunotherapy with backbone therapy potential targeting multi-billion dollar market opportunities in NMIBC:

- Monotherapy achieved 75.2% (79/105) Complete Response at any time and compares favorably to approved and other investigational agents in lead indication BCG-Unresponsive, High-Risk NMIBC
- Generally well-tolerated with no Grade 3 or higher treatment-related AEs
- Combination with pembrolizumab achieved 83% (29/35) CR at any time, 57% CR at 12-month landmark (78% CR by Kaplan-Meier estimate) and 54% CR at 24-month landmark (70% CR by Kaplan-Meier estimate)

Multiple near-term clinical milestones:

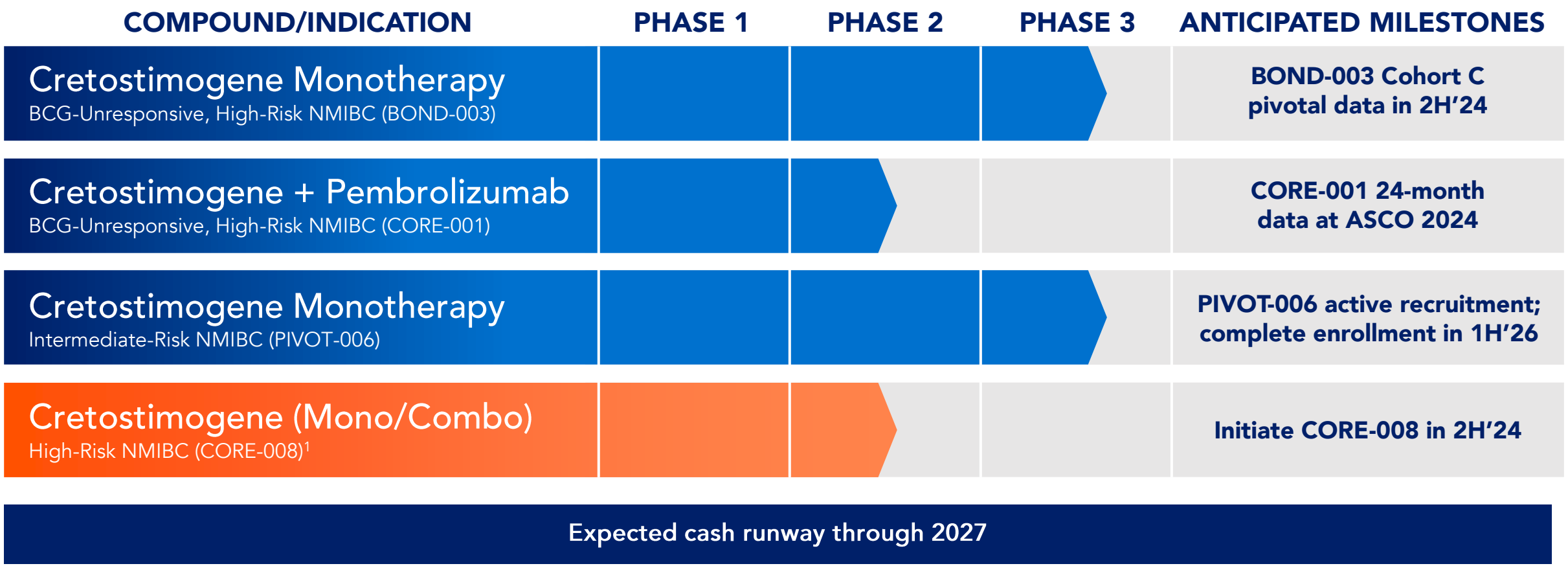
- Pivotal Phase 3 monotherapy results from BOND-003 Cohort C expected by the end of 2024
- Active recruitment in Phase 3 Intermediate-Risk NMIBC trial (PIVOT-006) in collaboration with SUO-CTC
- Launch CORE-008, a multi-cohort study in High-Risk NMIBC planned in 2H'24
- Initiated Expanded Access Program in BCG-Unresponsive, High-Risk NMIBC in 2Q'24 to provide real-world patients with access to cretostimogene

Strong financial position:

- Cash runway expected to fund operations through 2027

NMIBC = non-muscle invasive bladder cancer. CR = complete response. AE = adverse event. SUO-CTC = Society of Urologic Oncology Clinical Trials Consortium.

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



[1] Planned clinical trials to be conducted under existing Investigational New Drug application (IND) previously approved by the FDA. Preliminary and unaudited estimate subject to revision based on further review.

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. The BLA filing is subject to completion and positive results of pivotal trials and FDA feedback.

Current Program

Planned Studies

Executive Leadership Team

Deep Industry Experience with Track Record of Success in Drug Development

Arthur Kuan
CEO & Board Director

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™

Bladder Cancer is a Significant Unmet Medical Need Well Positioned for Innovation and Disruption

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

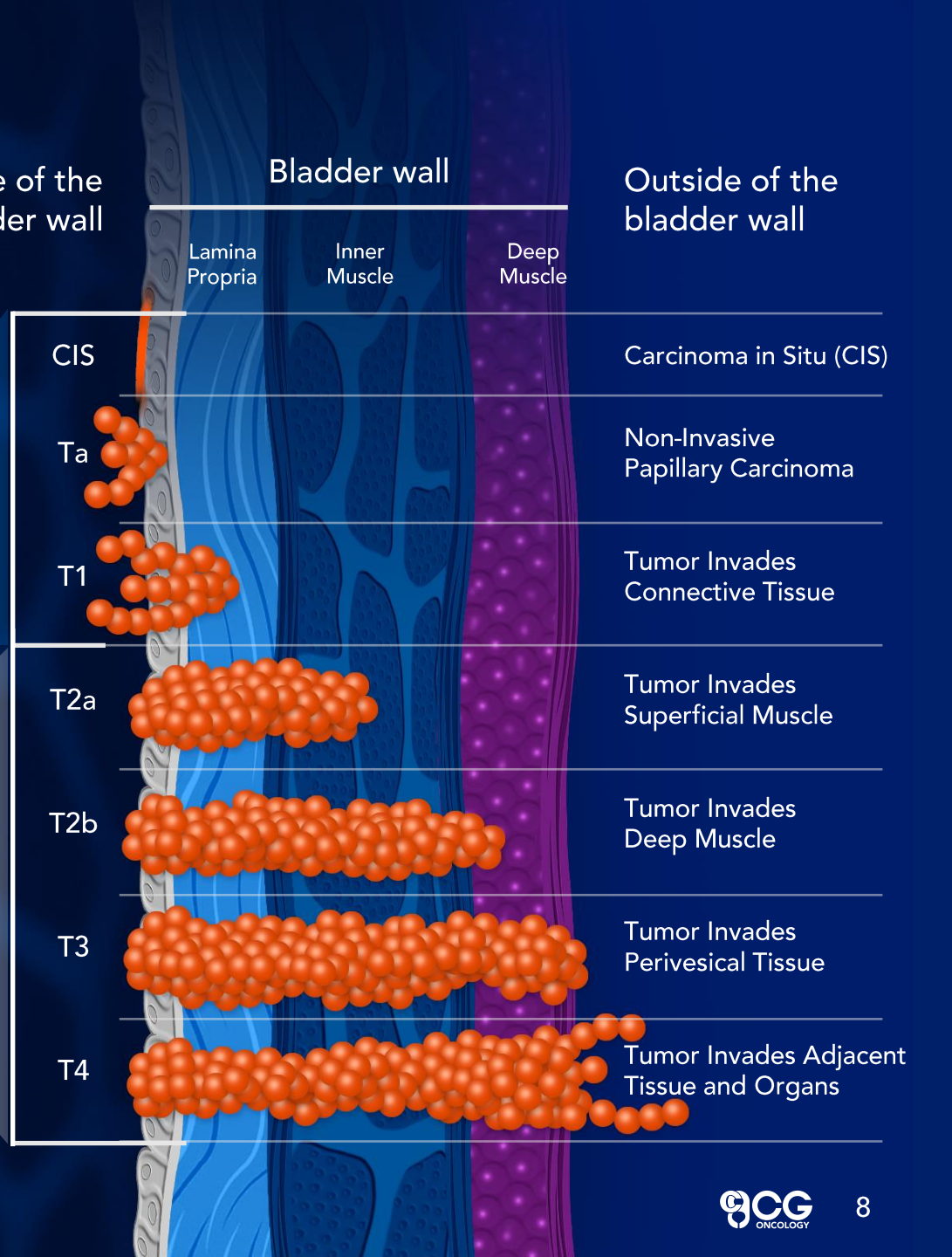
- Smoking
- Exposure to carcinogens including agent orange

[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

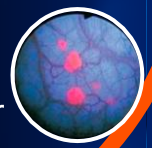
Patient presents to primary care and/or urologist with symptoms (hematuria, urinary frequency)

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.

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

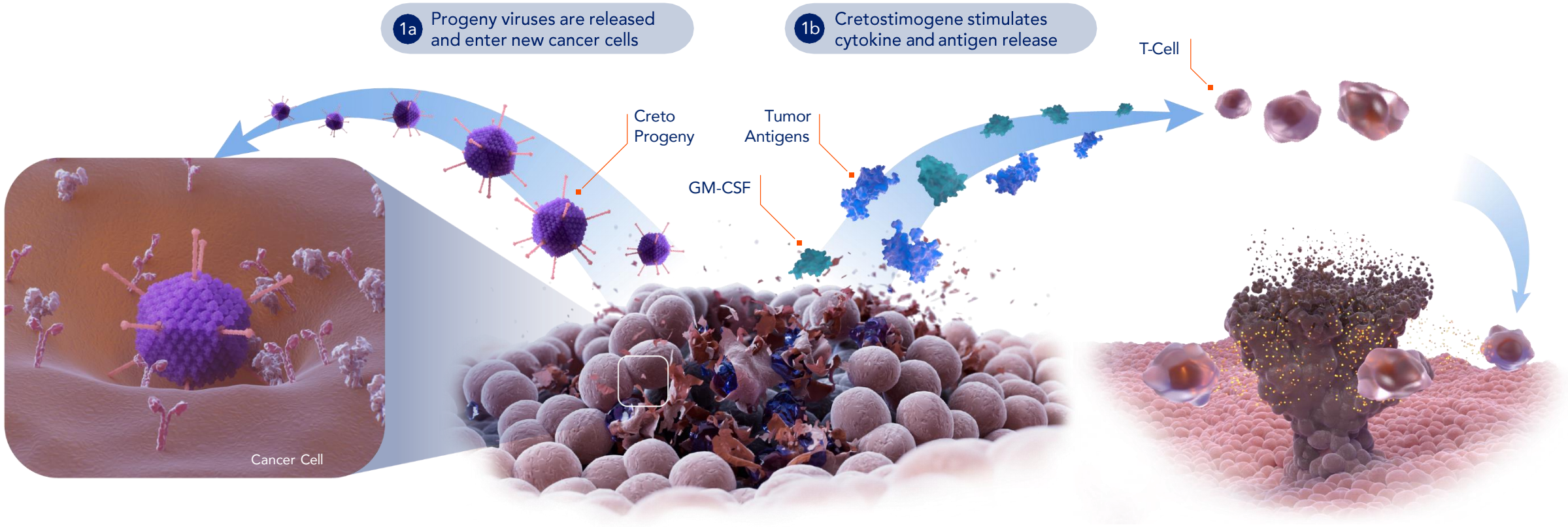
Patient aversion to radical cystectomy associated with significant change in daily routine, surgery-related complications, and mortality rate drives regulatory and sponsor development pathways.

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.

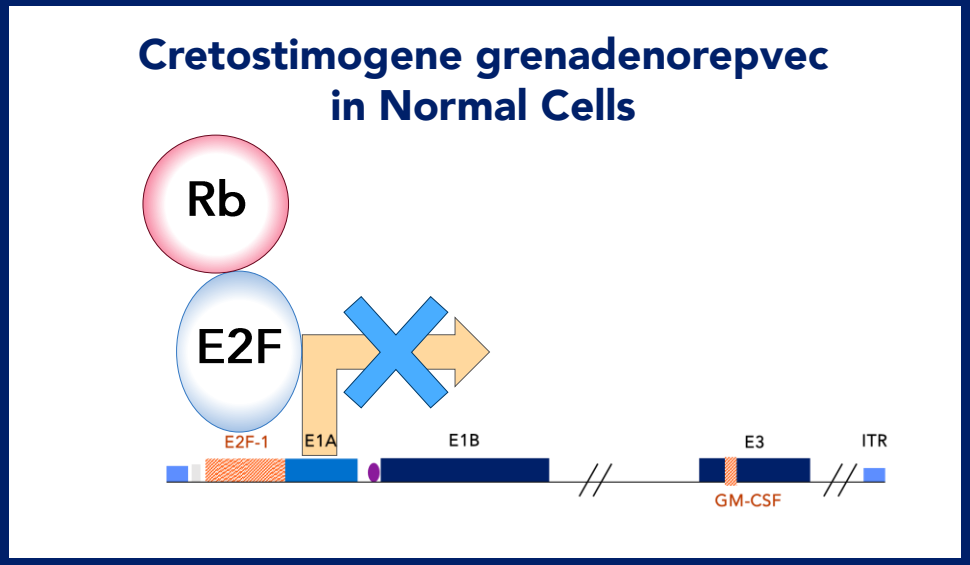
Oncolytic Immunotherapy: Cretostimogene's Dual Mechanism of Action

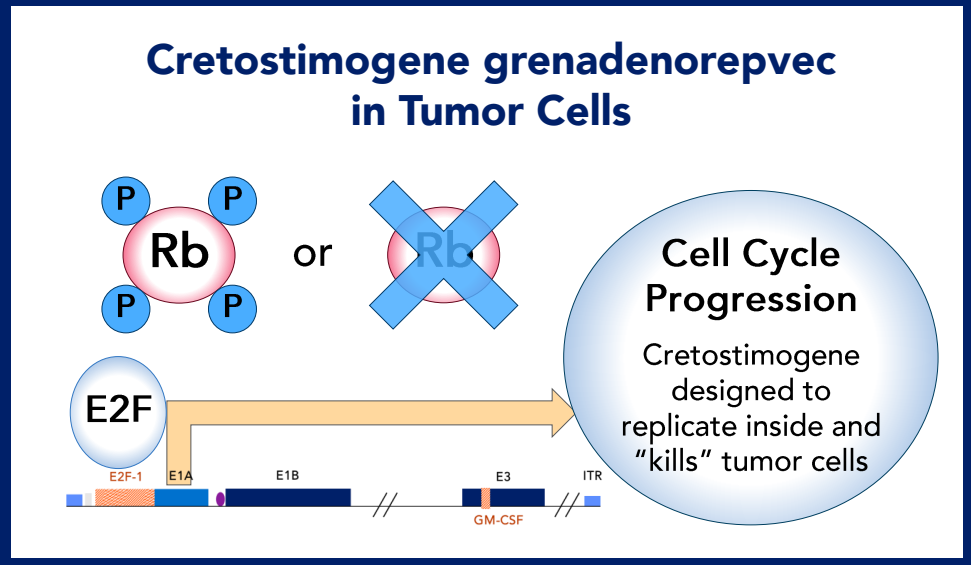
1 Cretostimogene selectively replicates in and kills cancer cells

2 Immune cells attack and kill additional cancer cells



Cretostimogene Selectively Targets Rb-E2F Pathway Defective Cancers



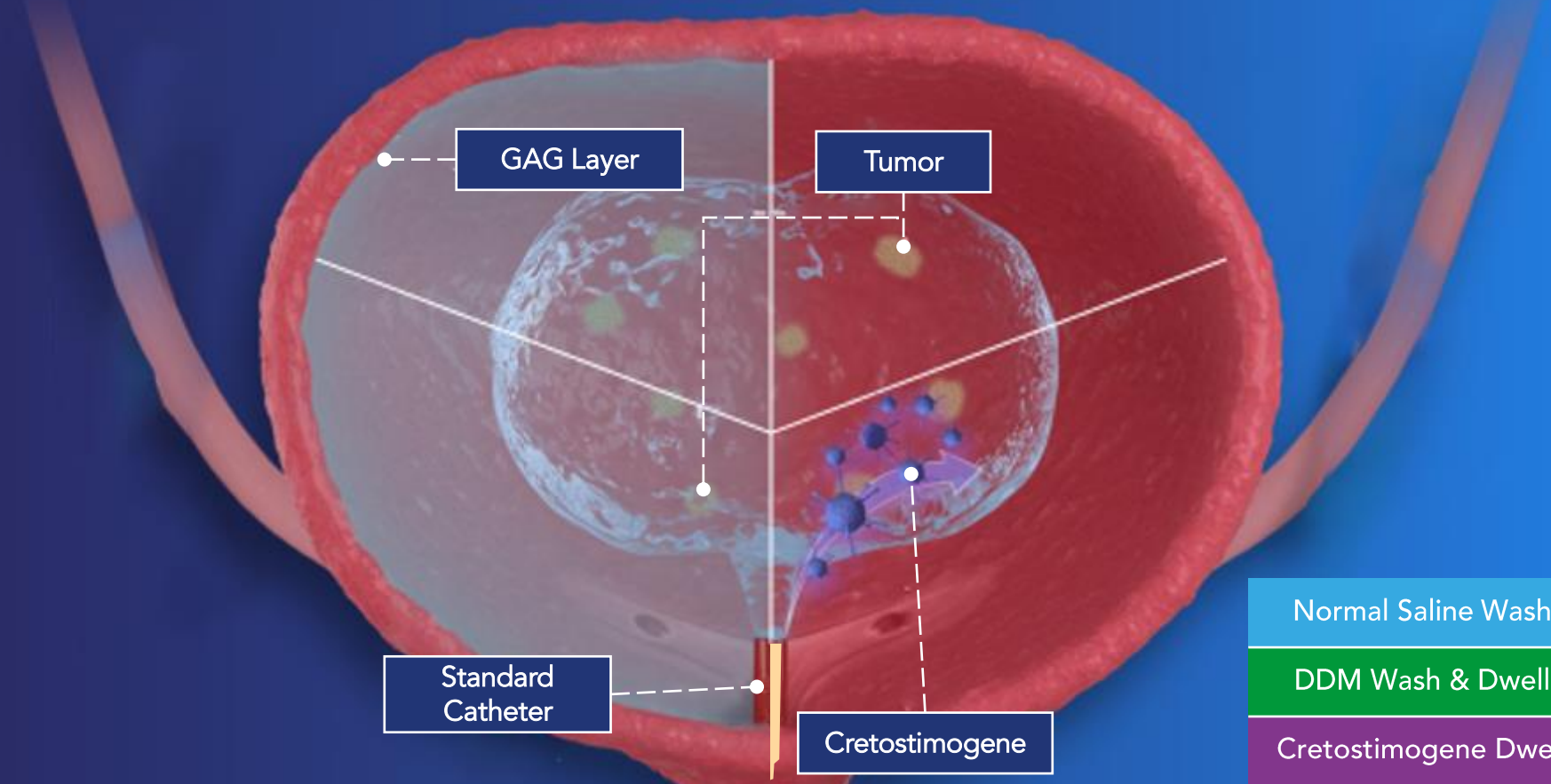


- E2F is a master regulator of gene expression and Cell Cycle Progression
- In human cancers, which consistently have retinoblastoma (Rb) pathway-defective cells, Rb cannot bind to E2F due to reasons including:
    - Rb is hyper-phosphorylated (P)
    - Rb is deleted / silenced
- As a result, Cretostimogene 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.

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



Normal Saline Wash	~5 minutes
DDM Wash & Dwell	~15 to 20 minutes
Cretostimogene Dwell	~45 to 60 minutes

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

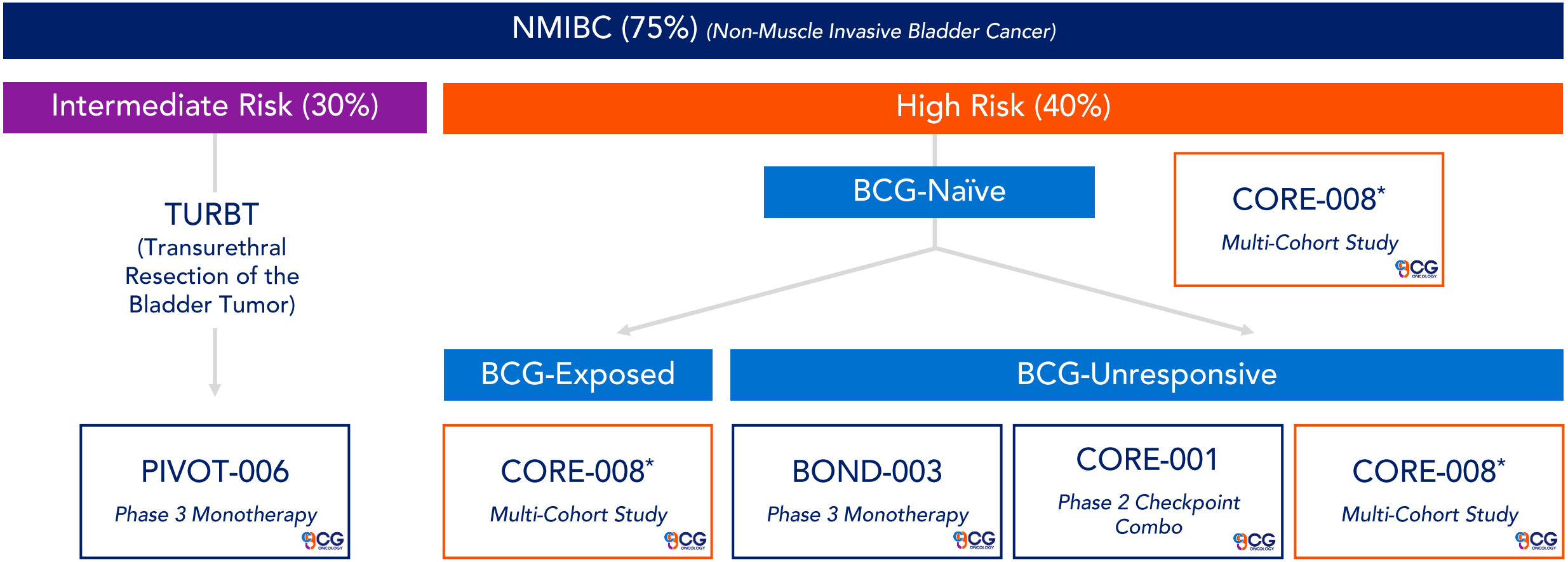
Cretostimogene

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

	Delivery and Administration
Cold chain and stability	Commercial product will be shipped via Just-In-Time delivery with multi-day stability in the box until administration
Time required for thaw	~10 minutes
Time required for preparation	~10 minutes
Prepared and administered by	Medical Assistant, Nurse, Nurse Practitioner, Physician Assistant, or Urologist via urinary catheter
Biosafety handling	Any site (community or academic) that administers BCG or intravesical chemotherapy can prepare cretostimogene
Monitoring time after administration	No monitoring requirement for commercial setting; 30 minutes in clinical trials setting

Our Goal is to Establish Cretostimogene as Backbone Therapy for High-Risk and Intermediate-Risk NMIBC Patients

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



Current Program Planned Studies

* CORE-008 is a multi-cohort planned study to evaluate cretostimogene in High-Risk NMIBC.

BOND-003

Fast Track Designation

Breakthrough Therapy Designation

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

Note: Patients undergo urine cytology and cystoscopy every 3 months for first 2 years, as well as mandatory, site-directed biopsy 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

Patient Demographics & Baseline Characteristics

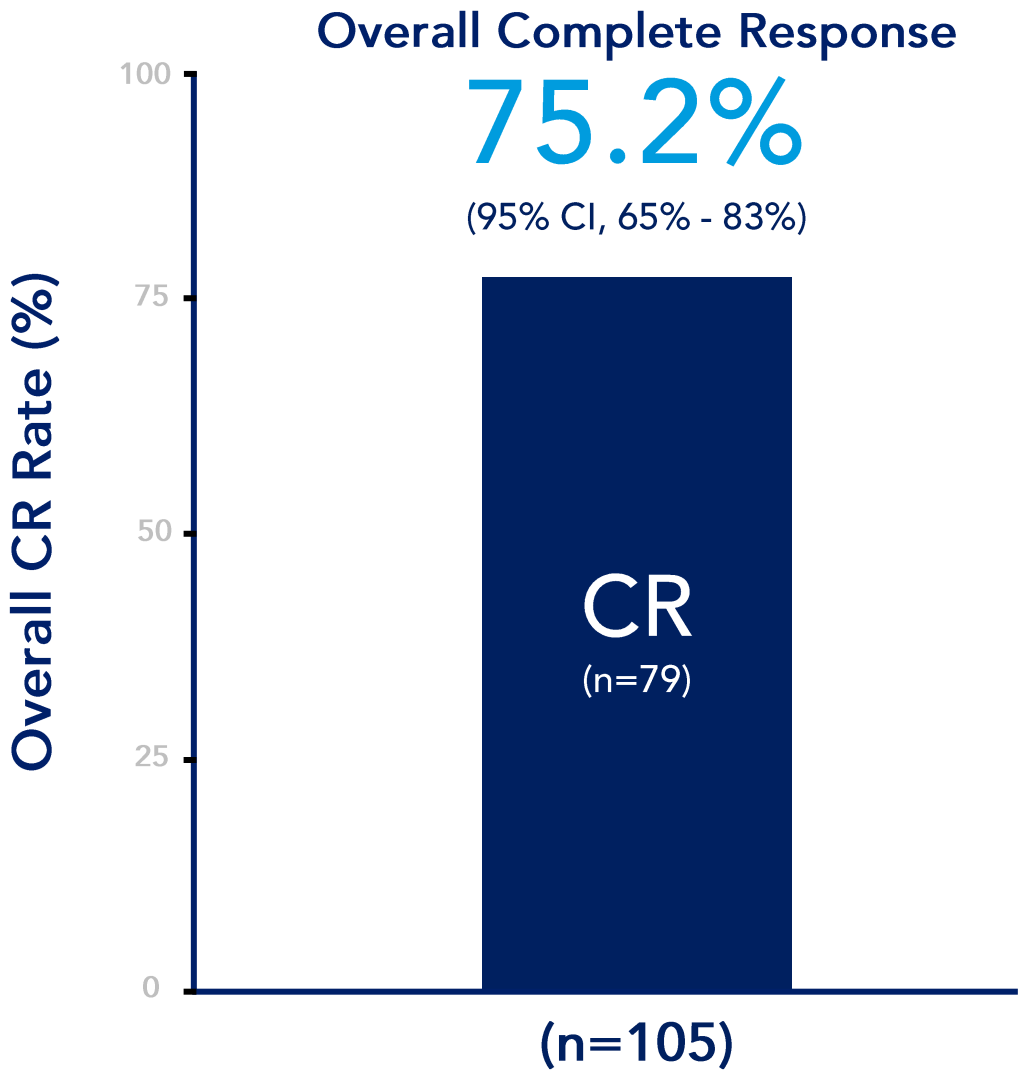
Subjects in Efficacy Dataset	N=112	%
Gender		
Male	83	74.1
Female	29	25.9
Age (Years)		
Mean (SD)	72.9 (9.19)	
Median (Range)	74.0 (43-90)	
Age (Categories)		
< 65	19	17.0
> 65	93	83.0
BCG History: Number of Prior Instillations		
Median (Range)	12 (7 – 66)	
High-Risk NMIBC T-Stage at Study Entry		
CIS with T1	6	5.3
CIS with Ta HG	16	14.3
CIS	90	80.4

Efficacy data cutoff as of April 1, 2024.

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

BOND-003

Cretostimogene Monotherapy Results in Cohort C: Largest Dataset in BCG-Unresponsive, High-Risk NMIBC



Landmark Analysis	Actual CR Rate, % (95% CI)
6-month	**64.8%** (54.8, 73.7) *68 out of 105 patients*
12-month	**43.3%** (33.1, 54.2) *39 out of 90 patients*

Landmark analysis based on actual landmark CR rate assessed in clinical trial, not Kaplan-Meier estimate.

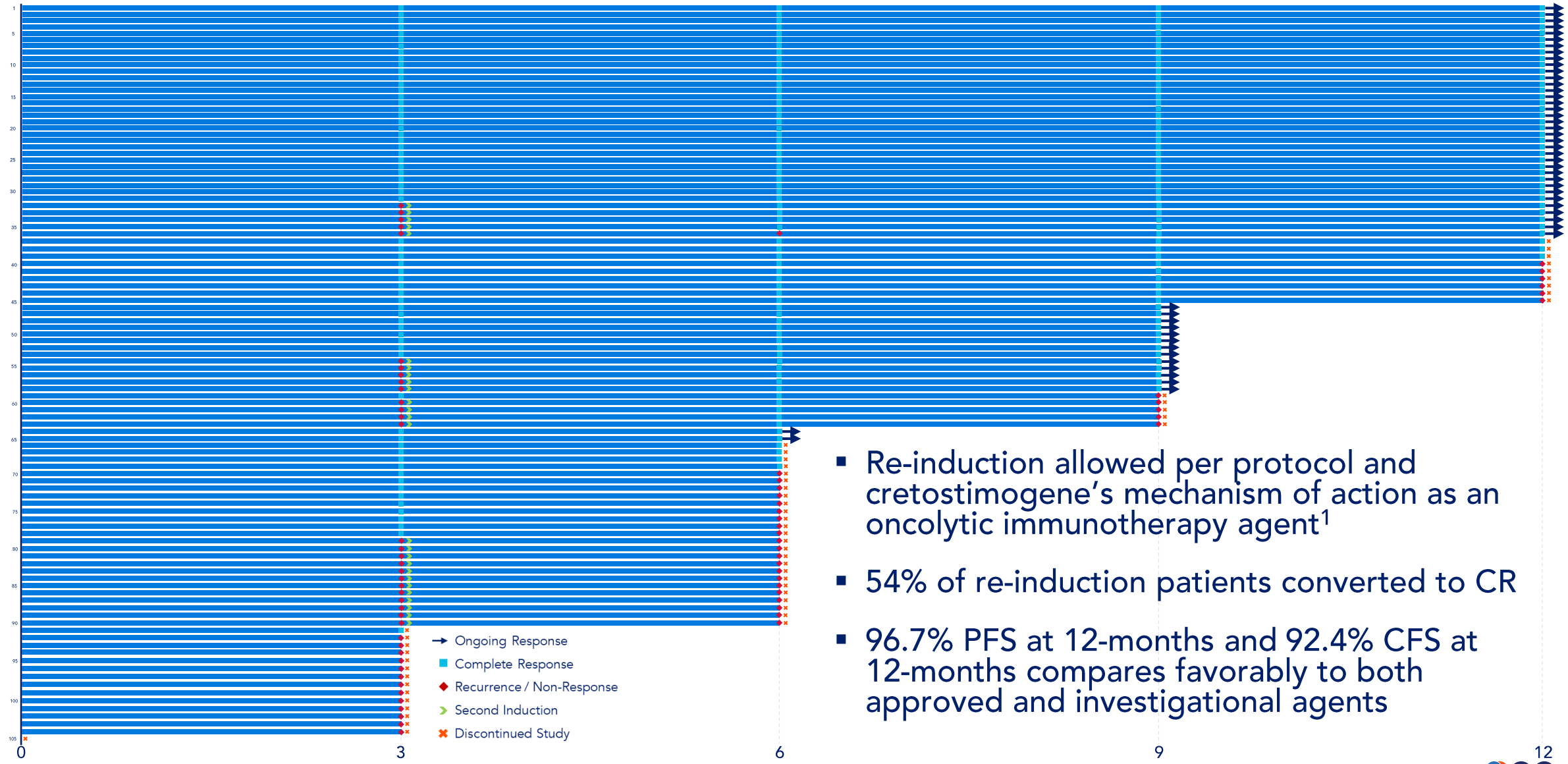
- As of data cutoff, there are 15 patients in CR pending further assessment and evaluation at 12-month landmark timepoint
- All complete responses are centrally confirmed[1]
- Landmark analysis at all timepoints compare favorably to approved agents

Efficacy data cutoff as of April 1, 2024. Efficacy analysis are centrally confirmed. All patients have active disease at baseline prior to enrollment. Received adequate BCG per FDA 2018 guidance.
[1] 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

AUA 2024: Updated Results from BOND-003 Cohort C

Cretostimogene Monotherapy for BCG-Unresponsive, High-Risk NMIBC



- Re-induction allowed per protocol and cretostimogene's mechanism of action as an oncolytic immunotherapy agent[1]
- 54% of re-induction patients converted to CR
- 96.7% PFS at 12-months and 92.4% CFS at 12-months compares favorably to both approved and investigational agents

Efficacy data cutoff as of April 1, 2024. [1] Per 2018 FDA Guidance Document on BCG-Unresponsive NMIBC (page 6), sponsors should consider and discuss with the Agency 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

Cretostimogene Has Been Generally Well-Tolerated

Preferred Term (MedDRA v.26.1)	Cretostimogene (n=112)	
	Any Grade (%)	Grade ≥ 3
Patients with ≥ 1 TRAE	70 (62.5%)	0 (0)
Treatment-Related AE reported in >10% patients		
Bladder Spasm	26 (23.2%)	0 (0)
Pollakiuria	22 (19.6%)	0 (0)
Dysuria	17 (15.2%)	0 (0)
Micturition Urgency	17 (15.2%)	0 (0)
Hematuria	16 (14.2%)	0 (0)

- No Grade ≥ 3 treatment-related AEs or deaths reported
- Most AEs were Grade 1-2
- 2 patients (1.8%) had serious treatment-related AEs (Grade 2)[1]
- 1 patient discontinued treatment due to unrelated AE[2]
- 94.5% of patients completed all protocol-mandated treatments and had a 100% instillation success rate

AE = adverse event. Safety data cutoff as of January 31, 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).

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.

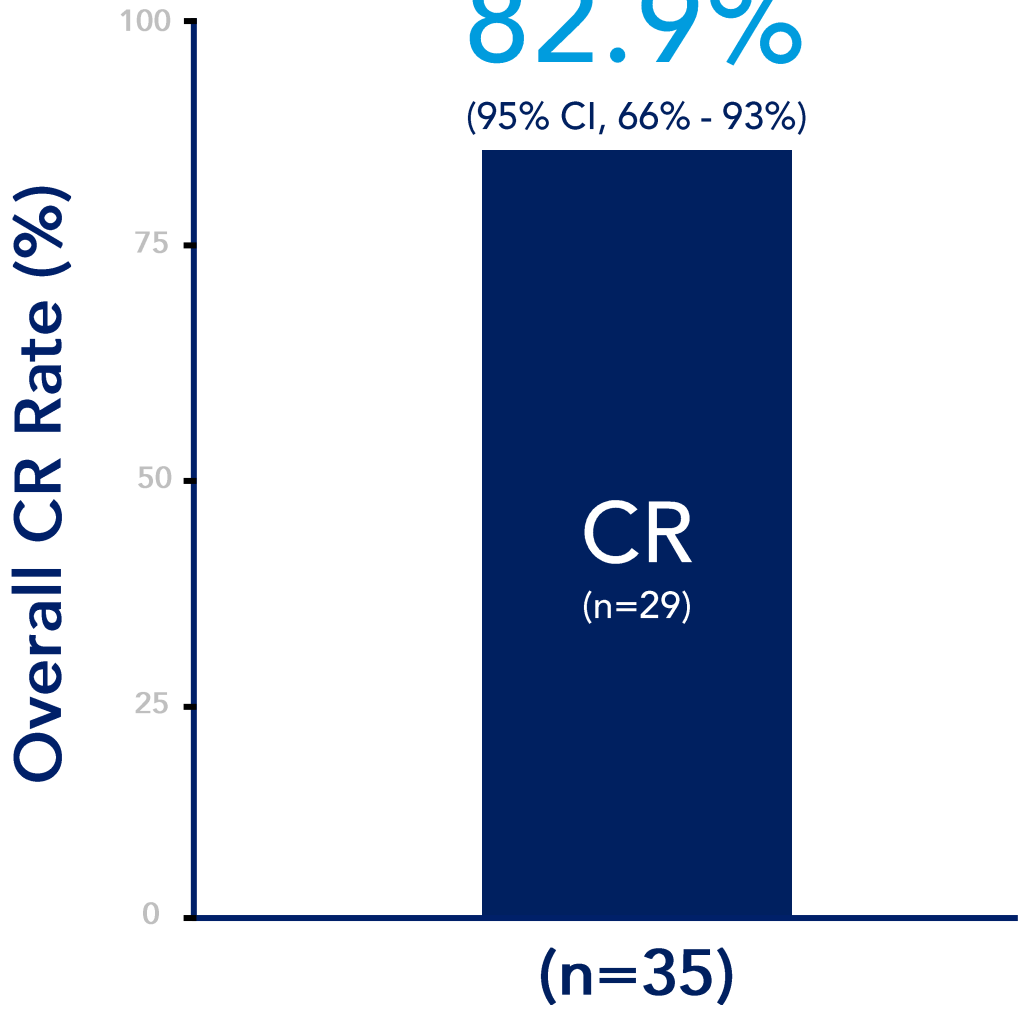
CORE-001

Cretostimogene Combo with Pembrolizumab: Potential Class-Leading Response

Overall Complete Response

82.9%

(95% CI, 66% - 93%)



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.

- 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.

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

Landscape

Pioneering Class-Leading Oncolytic Immunotherapy with Differentiated Clinical Profile Against Approved and Investigational NMIBC Agents[1]

Trial	BOND-003	CORE-001	QUILT 3.032	NCT02773849	KEYNOTE-057	SunRISe-1	LEGEND
Intervention	Cretostimogene	Cretostimogene + Pembrolizumab	N-803 + BCG	Nadofaragene	Pembrolizumab	TAR-200	EG-70
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	RIG-I Agonist + IL-12
RoA	Intravesical	Intravesical + Intravenous	Intravesical	Intravesical	Intravenous	Transurethral Procedure	Intravesical
Stage	Phase 3 Enrollment Complete	Phase 2 Complete	Approved	Approved	Approved	Phase 2 Ongoing	Phase 1/2 Ongoing
Sample Size	N=112	N=35	N=77	N=98	N=96	N=85	N=<24 (Phase 1) N=~100 (Phase 2)
CR at Any Time	75% (79/105) [95% CI: 65% - 83%]	83% (29/35) [95% CI: 70% - 95%]	62.3% (48/77) [95% CI: 51% - 73%]	51% (50/98)[3] [95% CI: 41% - 61%]	41% (39/96) [95% CI: 31% - 51%]	83% (48/58) [95% CI: 70% - 91%]	73% (16/22)[4] [95% CI: Not Reported]
CR at 12 Mo	43% (39/90)[4]	57% (20/35)	36% (28/77)[2]	24% (25/103)	19% (18/96)	39% (12/31)[4]	Not Reported
CR at 24 Mo	Pending Assessment	54% (19/35)	25% (19/48)[2]	19% (20/103)	Not Reported	Not Reported	Not Reported
DoR ≥ 12 Mo (Non-KM)	Pending Assessment	65%	58%	46%	46%	Not Reported	Not Reported
DoR ≥ 12 Mo (KM Estimate)	Pending Assessment	82%	Not Reported	Not Reported	Not Reported	75%	Not Reported
Safety Profile	0% Grade 3+ TRAE 0% treatment-related discontinuation	0% Grade 3+ creto-related AEs irAEs exclusively pembro-associated; 5 unrelated treatment discontinuations	16% SAE, including fatal adverse reaction of cardiac arrest in one patient on treatment; 7% treatment-related discontinuation	4% Grade 3+ TRAE 3% treatment-related discontinuation	11% Grade 3 TRAE 2% Grade 4 TRAE 11% treatment-related discontinuation	8.2% Grade 3 treatment-related AEs 4.7% serious TRAE 4.7% treatment-related discontinuation	5% Grade 3+ TEAE Discontinuation not disclosed

[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] 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. [3] ADSTILADRIN® Package Insert (December 2022) and Summary Basis for Regulatory Action. [4] LifeSci Capital Analyst Report – May 3, 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.) ; 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 – AUA 2024). CG Oncology (BOND-003 – AUA 2024, Abstract #24-11358; CORE-001 – ASCO 2024 – Abstract #4601).

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)

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

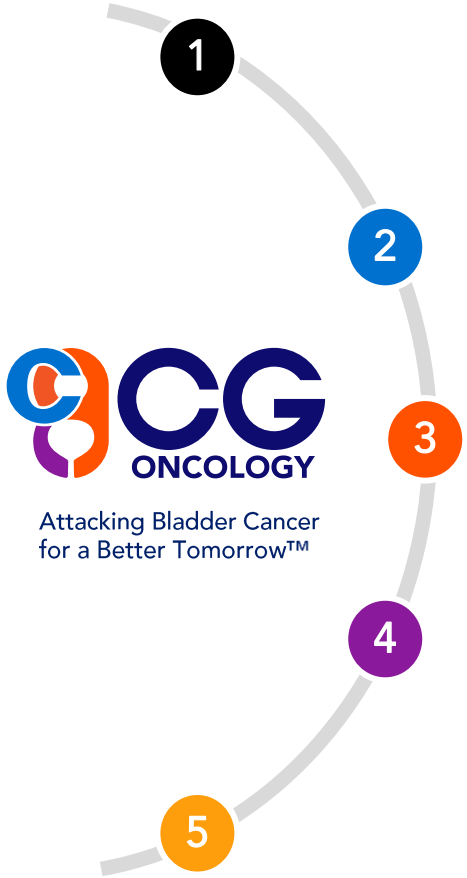
- Arm A = Cretostimogene following TURBT
  - Induction course = Weekly x 6 ($1x10^{12}$ vp/mL)
  - Maintenance courses[1] = Weekly x 3 ($1x10^{12}$ vp/mL) for complete responders
- Arm B = Surveillance following TURBT
  - Patients with disease recurrence eligible to receive cretostimogene

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.

CG Oncology Highlights



1. Potential backbone oncolytic immunotherapy targeting a multi-billion dollar market opportunity in lead indication with significant unmet need
2. Opportunity to expand into additional billion-dollar bladder indications
3. Demonstrated clinical utility and observed tolerability drives further combination development strategies
4. Highly concentrated U.S. customer base enables focused execution in sales and marketing for commercialization
5. Experienced leadership team, seasoned CMC advisory board, and quality Life Sciences-focused investors

CG ONCOLOGY

Attacking Bladder Cancer for a Better Tomorrow™

CONTACT US

CG Oncology Inc.
400 Spectrum Center Dr
Suite #2040
Irvine, CA 92618

GENERAL INQUIRIES

Information@cgoncology.com

MEDIA

MediaRelations@cgoncology.com

www.CGOncology.com