



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.

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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	Potential Best-in-Disease Safety/Tolerability	Regulatory & Commercial Readiness
- BOND-003 Cohort C (HR BCG UR CIS only)¹: 76% CR anytime 46.4% (12-mo) 41.8% (24-mo) - BOND-003 Cohort P (HR BCG UR Ta/T1 Disease)² 95.7% (3-mo) HG-EFS 84.6% (6-mo) 80.4% (9-mo) - CORE-008 Cohort A (HR BCG Naïve CIS)² 88% CR anytime (optimized instillation)	- Favorable safety & tolerable profile 0 Grade ≥ 3 TRAEs or deaths reported - Most AEs were Grade 1-2	- Granted Breakthrough Therapy & Fast Track designations - Current capacity: 40-50k vials/year; 10x scale-up process to support future indications underway - Pre-launch 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

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

COMPOUND/INDICATION	PHASE 1	PHASE 2	PHASE 3	MILESTONES
Cretostimogene Monotherapy High-Risk BCG-Unresponsive NMIBC (BOND-003 Cohort C) ¹				BOND-003 Cohort C long-term data expected 2026
Cretostimogene Monotherapy High-Risk BCG-Unresponsive NMIBC (BOND-003 Cohort P) ²				BOND-003 Cohort P data presented at SUO 2025
Cretostimogene Monotherapy Intermediate-Risk NMIBC (PIVOT-006)				PIVOT-006 topline data anticipated 2026
Cretostimogene Monotherapy High-Risk BCG-Naïve NMIBC (CORE-008 Cohort A)				CORE-008 Cohort A updated results expected 2H'26
Cretostimogene Monotherapy High-Risk BCG-Exposed NMIBC (CORE-008 Cohort B)				CORE-008 Cohort B initiated 2H'25, data expected 2026
Cretostimogene + Gemcitabine High-Risk BCG-Exposed NMIBC (CORE-008 Cohort CX)				CORE-008 Cohort CX topline data expected 2026
Cretostimogene + Pembrolizumab High-Risk BCG-Unresponsive NMIBC (CORE-001)				CORE-001 24-month data presented at ASCO 2024

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

1

Cretostimogene selectively replicates in and kills cancer cells

2

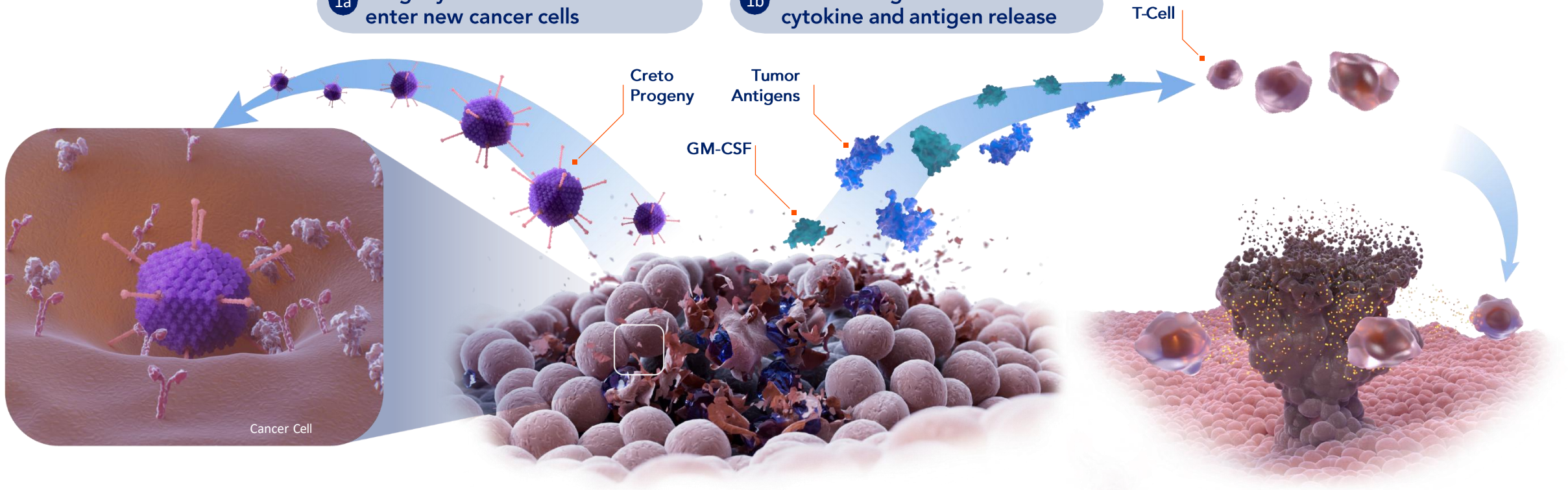
Immune cells attack and kill additional cancer cells

1a

Progeny viruses are released and enter new cancer cells

1b

Cretostimogene stimulates 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

Non-Muscle Invasive Bladder Cancer
NMIBC

Muscle Invasive Bladder Cancer
MIBC

Inside of the bladder wall

Bladder wall

Outside of the bladder wall

Lamina Propria

Inner Muscle

Deep Muscle

CIS

Carcinoma in Situ (CIS)

Ta

Non-Invasive Papillary Carcinoma

T1

Tumor Invades Connective Tissue

T2a

Tumor Invades Superficial Muscle

T2b

Tumor Invades Deep Muscle

T3

Tumor Invades Perivesical Tissue

T4

Tumor Invades Adjacent Tissue and Organs

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 TURBT¹

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

TURBT

Perioperative
Chemotherapy

→ Intermediate-Risk

TURBT

Perioperative
Chemotherapy

Intravesical BCG²

↑ High-Risk

Intravesical BCG
(Induction ± Maintenance)

Intravesical
Chemotherapy

Cystectomy

Pembrolizumab,
Nadofaragene, N-803 + BCG,
TAR-200

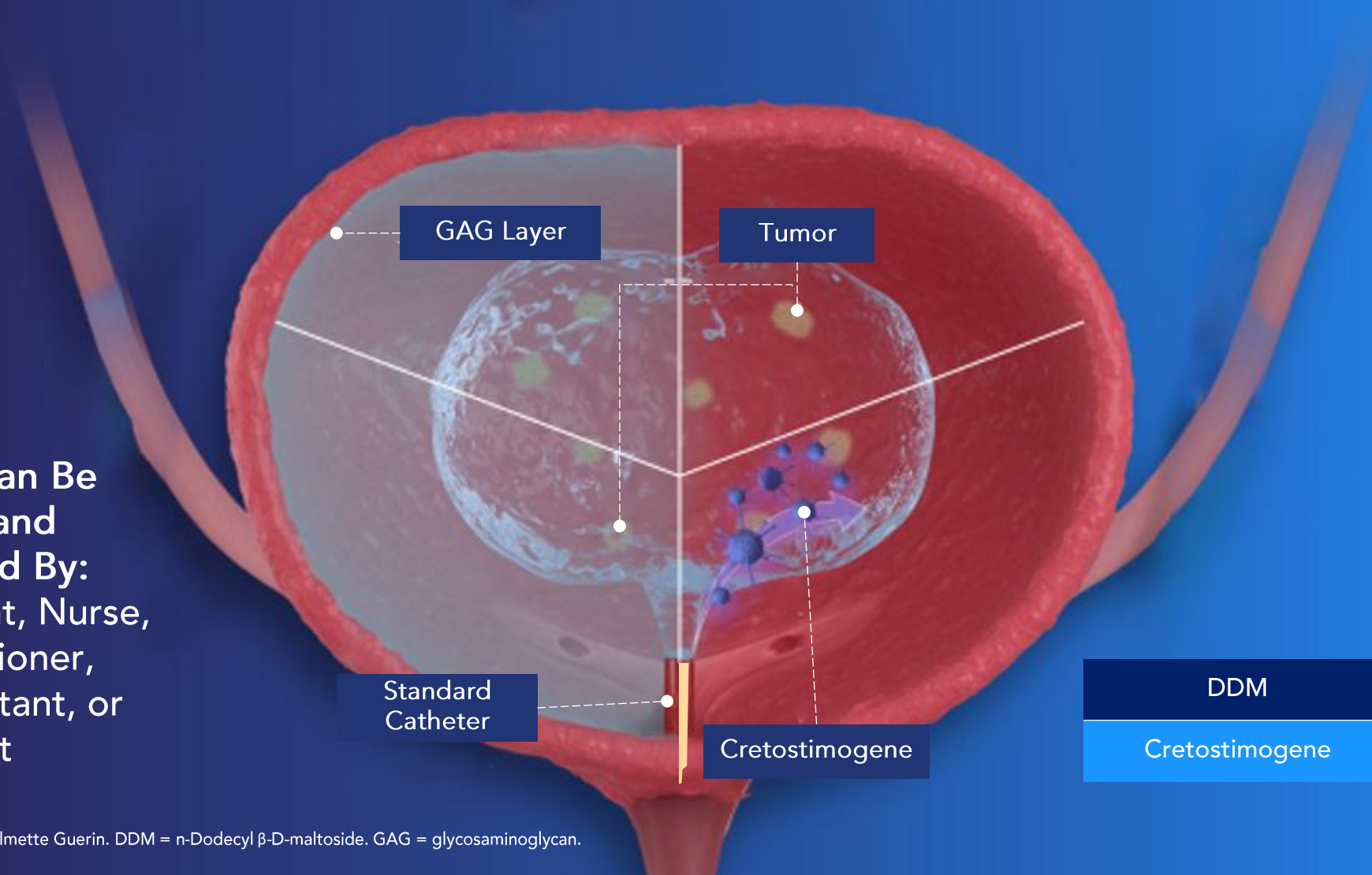
¹ TURBT = Transurethral Resection of Bladder Tumor.

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

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

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

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

75% NMIBC

NMIBC (75%)				
Intermediate-Risk (30%)	High-Risk (40%)			
	BCG-Exposed		BCG-Unresponsive	
	BCG-Naïve			
 PIVOT-006 <i>Ph 3 Monotherapy</i>	 CORE-008¹ <i>Cohort B</i>	CORE-008¹ <i>Cohort CX</i>	BOND-003 <i>Ph 3 Monotherapy</i> <i>Cohort C / Cohort P</i>	 CORE-001 <i>Ph 2 Checkpoint</i> <i>Combo</i>
	CORE-008¹ <i>Cohort A</i>			

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

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

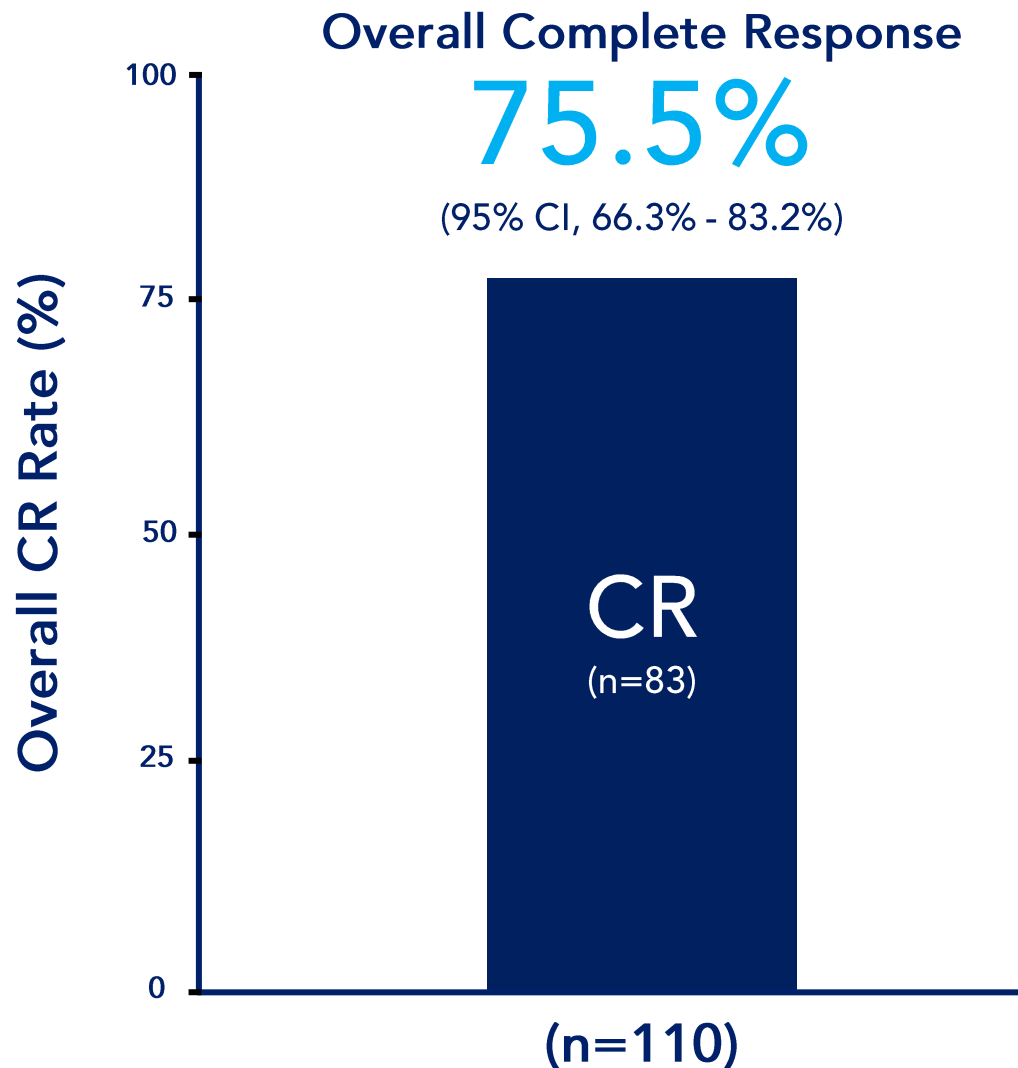
HR BCG-Unresponsive NMIBC	Cretostimogene Single-Arm, Open-Label, Intravesical Administration	CR at Any Time (CIS) EFS (Ta/T1)
Trial Design	Study Design / Regimen	Additional Endpoints
- Pathologically confirmed HR BCG-Unresponsive CIS or HG Ta/T1 - Have all Ta/T1 disease resected prior to treatment - Trial designed to be compliant with 2018 FDA guidance - Mandatory bladder mapping at 12-mos²	- Cohort C = HR BCG-unresponsive CIS with or without Ta/T1 (n=112) - Induction course = Weekly x 6 (1×10^{12} vp) - Second induction course¹ = 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 = HR 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.

Cretostimogene Demonstrated Favorable Efficacy and Best-in-Disease 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
- 83.6% responders avoided radical cystectomy by Month 24
 - Among RCs, 83.3% (15/18) were T0 or NMIBC
- All complete responses have been centrally confirmed²

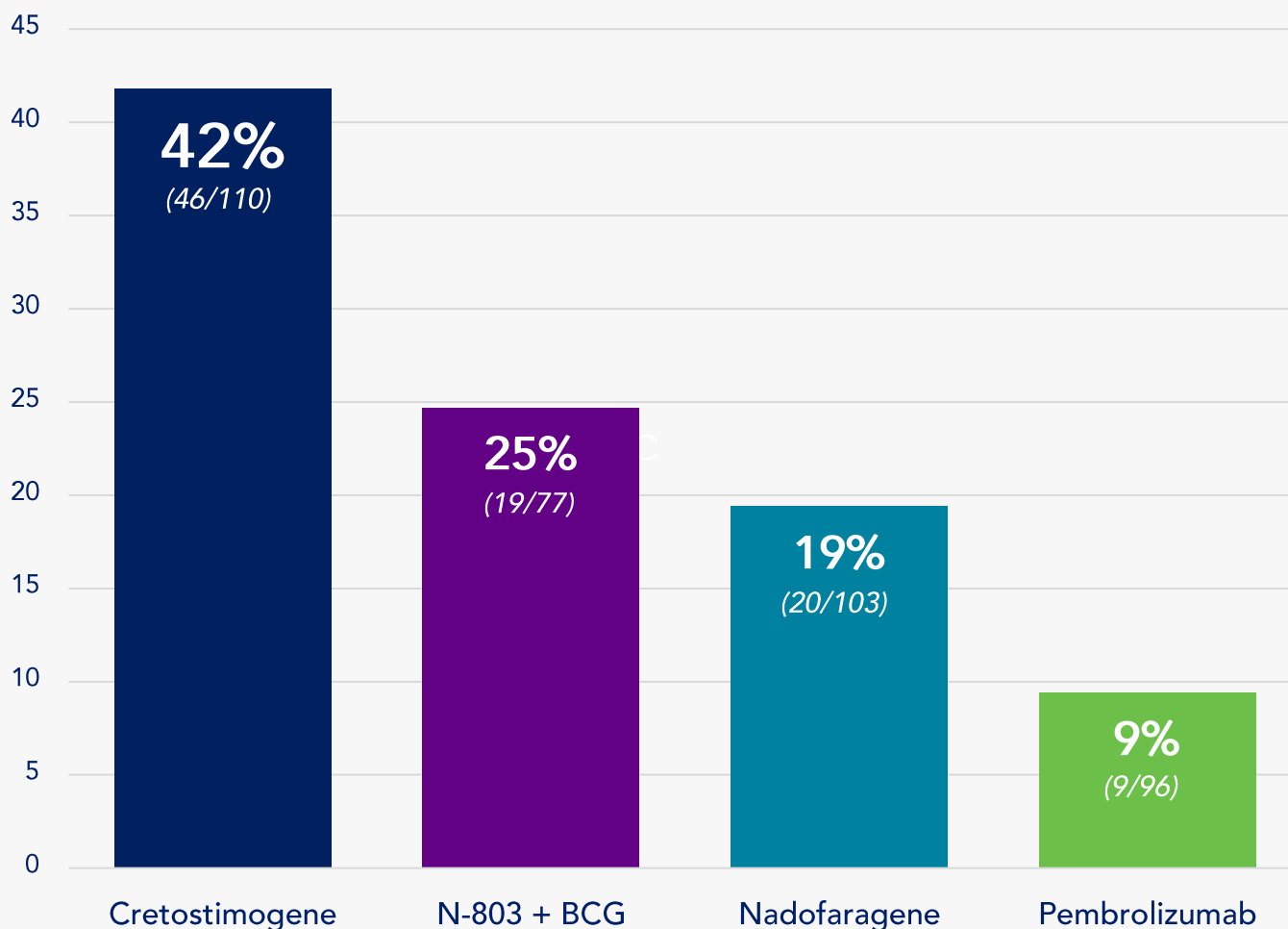
Efficacy data cutoff as of June 23, 2025. Efficacy analysis are centrally confirmed. All patients have active disease at baseline prior to enrollment. Received adequate BCG per FDA 2018 guidance.

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 Has Delivered Best-in-Disease Complete Response (CR) Rate at 24 Months

Complete Response (CR) at 24-Month



- Cretostimogene demonstrated best-in-disease long-term DoR compared to approved drugs¹ 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 – best-in-disease safety and tolerability profile

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

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. From published data.

CIS with or without Ta/T1

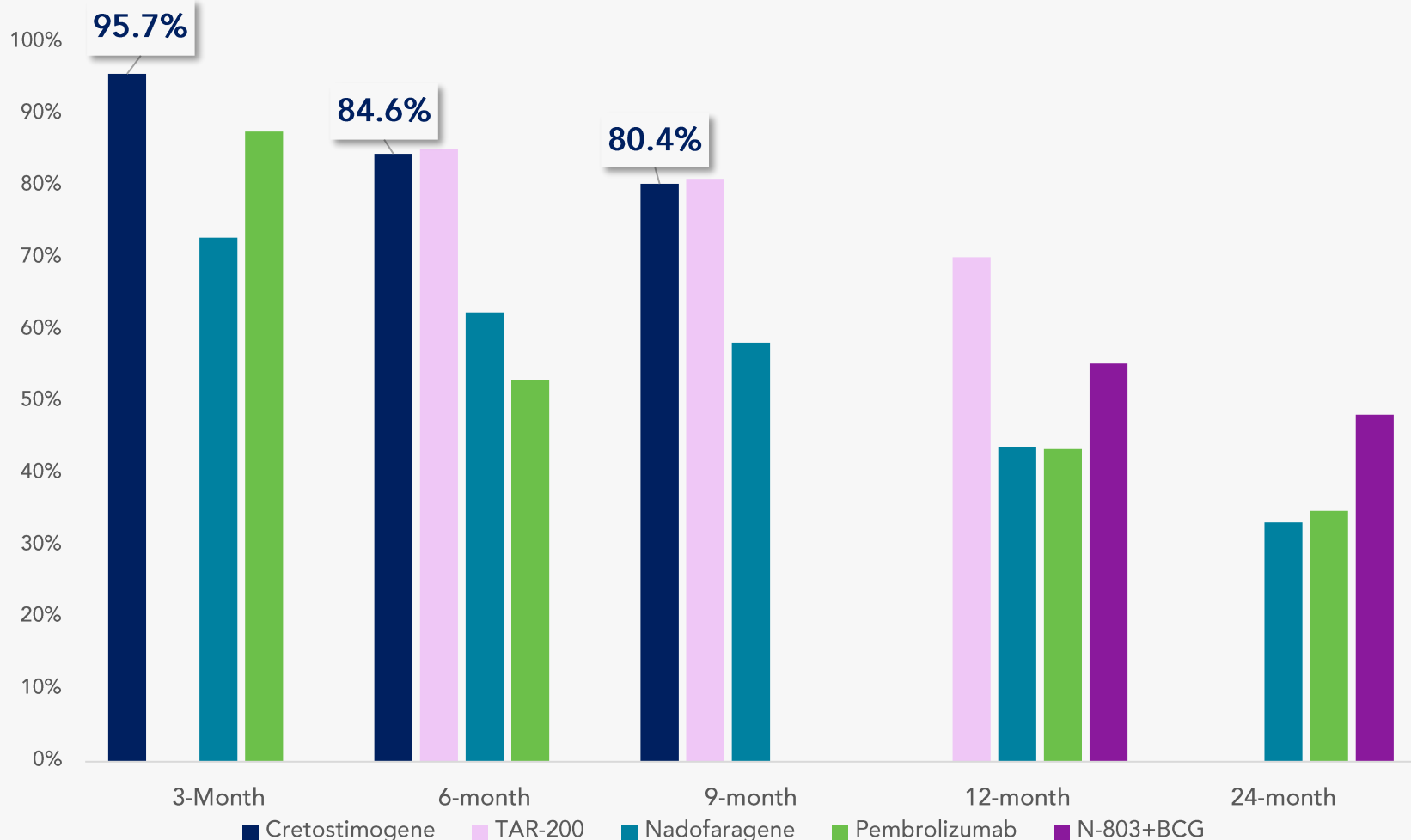
Cretostimogene is Well Positioned as Backbone Therapy in NMIBC with Best-in-Disease Durability & Safety in HR BCG-UR ¹

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).

High-Risk 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 $\geq$ 3 TRAEs, Serious TRAE, deaths

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

Cretostimogene is Well Positioned in HR BCG-UR NMIBC with HG Ta/T1 with Potentially Best-in-Disease EFS Endpoint¹

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	74.3% [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):EVID0a2200167 *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.


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Ph 3 Adjuvant Cretostimogene for IR NMIBC, Enrollment Completed Ahead of Schedule in Broadest 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 x 10¹² vp) - Maintenance courses¹ = Weekly x 3 (1 x 10¹² 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.

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.

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			
IR NMIBC HG Ta ≤3cm (solitary)			
Adjuvant (non-chemoablative)			
	<u>PIVOT-006 Ph 3 Trial</u> Study designed to enroll: ▪ <u>All</u> intermediate-risk patients ▪ First Ph 3 randomized trial in broad IR NMIBC population¹ 50K² Pts (US TAM)	<u>MoonRIse-1 Ph 3 Trial</u> Study <u>not</u> designed to enroll: ▪ Solitary HG Ta ≤3cm ▪ FGFR wildtype	<u>Prescribing Information³</u> <u>Not</u> indicated for: ▪ Solitary HG Ta ≤3cm ▪ Newly diagnosed LG

 = under development for indication

 = FDA approved indication

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)

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

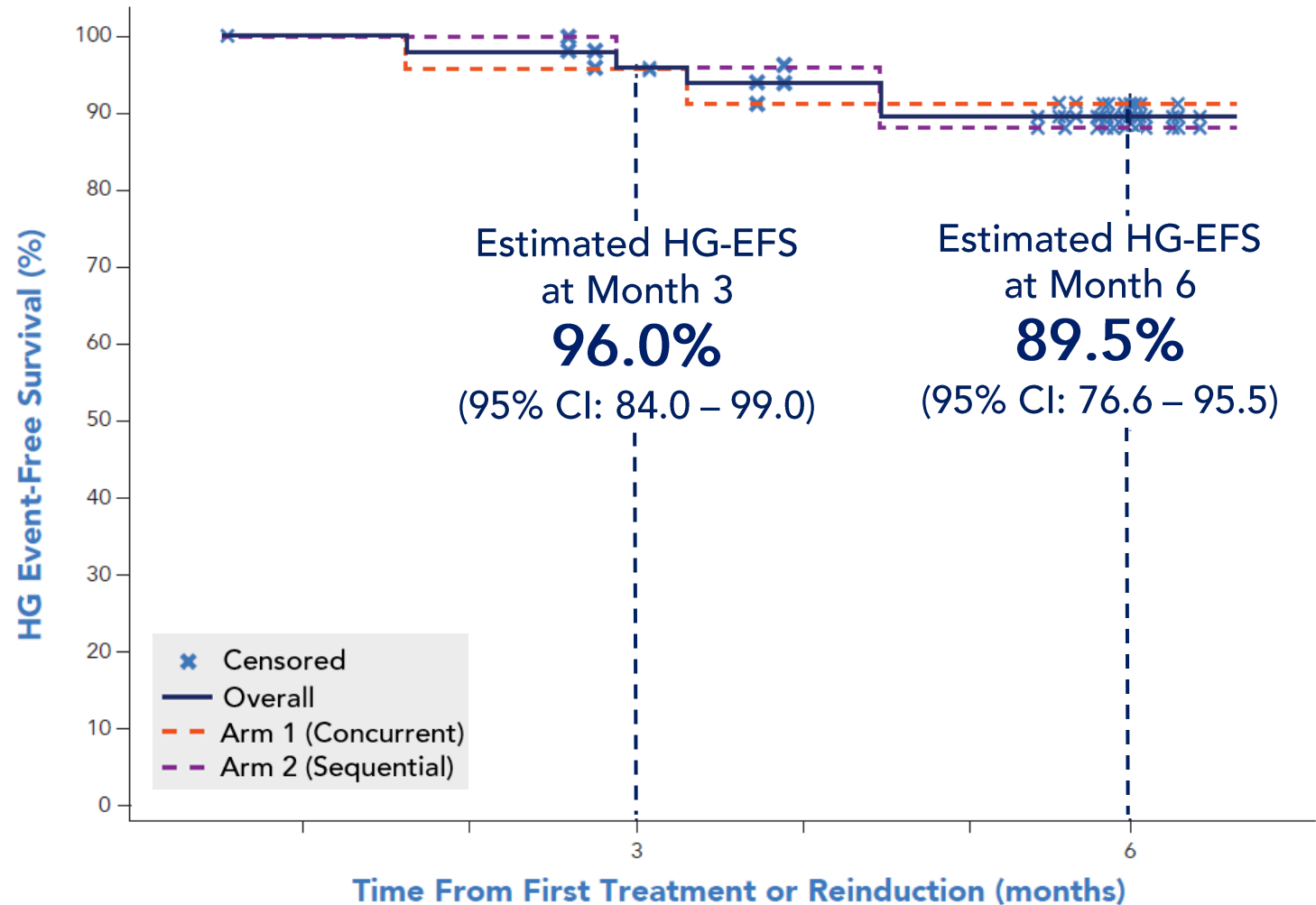
HR BCG-Exposed & BCG Unresponsive NMIBC	Cretostimogene + Gemcitabine 1:1 Randomized, Two Arm, Open-Label	Primary Endpoint: HG-EFS
Population	Study Design / Regimen	Additional Endpoints
▪ Pathologically confirmed HR BCG-exposed & BCG-UR ○ Persistent or recurrent HG Ta or CIS at first evaluation after 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 3¹	▪ 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.

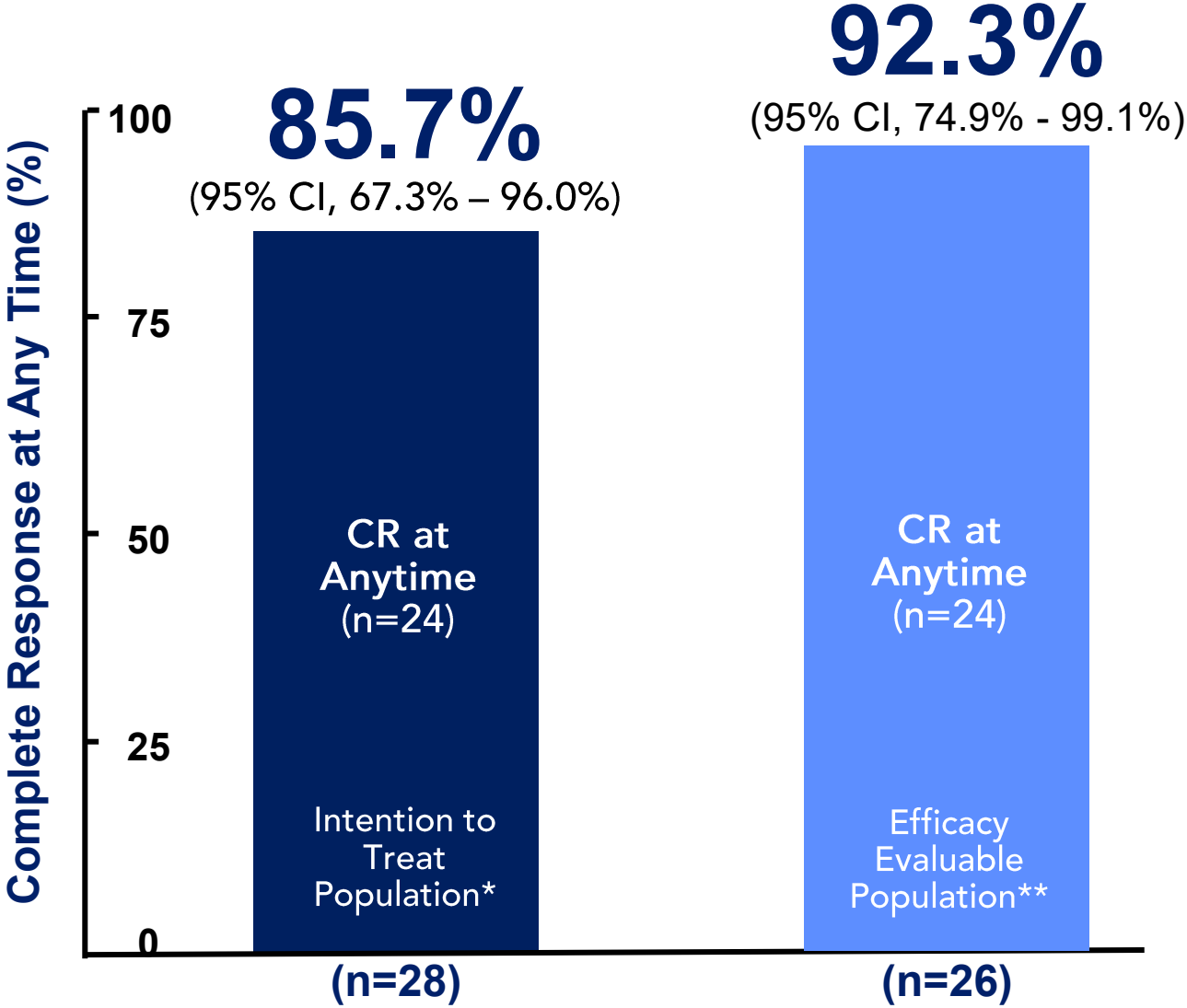
CORE-008 Cohort CX High-Grade Event-Free Survival at 3 and 6-Months (ITT Population)



- Median follow-up: 6.6 months
- No significant differences in HG-EFS by arm
- Consistent response among BCG-UR and BCG-exposed subgroups
- No treatment-related progression to MIBC or mUC
 - 2 patients experienced NMIBC stage reclassification

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 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

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

HR 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	Study Design / Regimen	Additional Endpoints
■ Cohort A ○ Pathologically confirmed HR BCG-naïve NMIBC ○ No prior treatment with BCG within past 24 months ■ Cohort B ○ Pathologically confirmed HR BCG-exposed NMIBC ○ Recurrence within 24 months after last adequate BCG dose	■ Cohort A (HR BCG-naïve 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 3¹ ■ Cohort B (HR BCG-exposed NMIBC) ○ CIS ± HG Ta/T1 (n=~75) ○ HG Ta/T1 only (n=~75) ○ Standard dosing as above¹	■ Cohort A ○ DoR (in CIS) ○ EFS, LG-RFS, CFS ■ Cohort B ○ DoR (in CIS) ○ EFS, LG-RFS, CFS

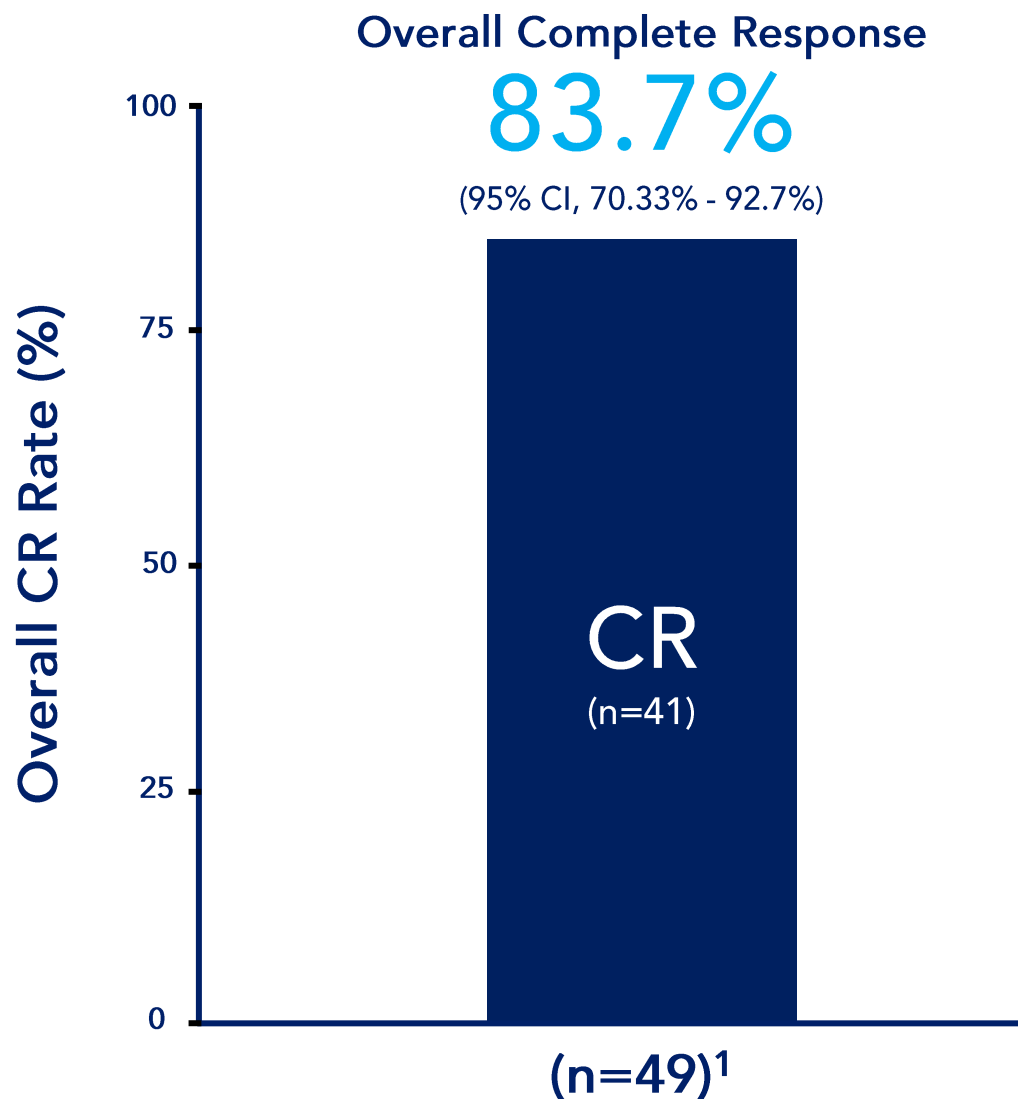
HR = high-risk. HG = high grade. LG = low grade. DoR = duration of response. EFS = event free survival. RFS = recurrence free survival. PFS = progression free survival. CFS = cystectomy free survival.

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)

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 $\geq$ 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.

Advancing Cretostimogene to Optimized Instillation



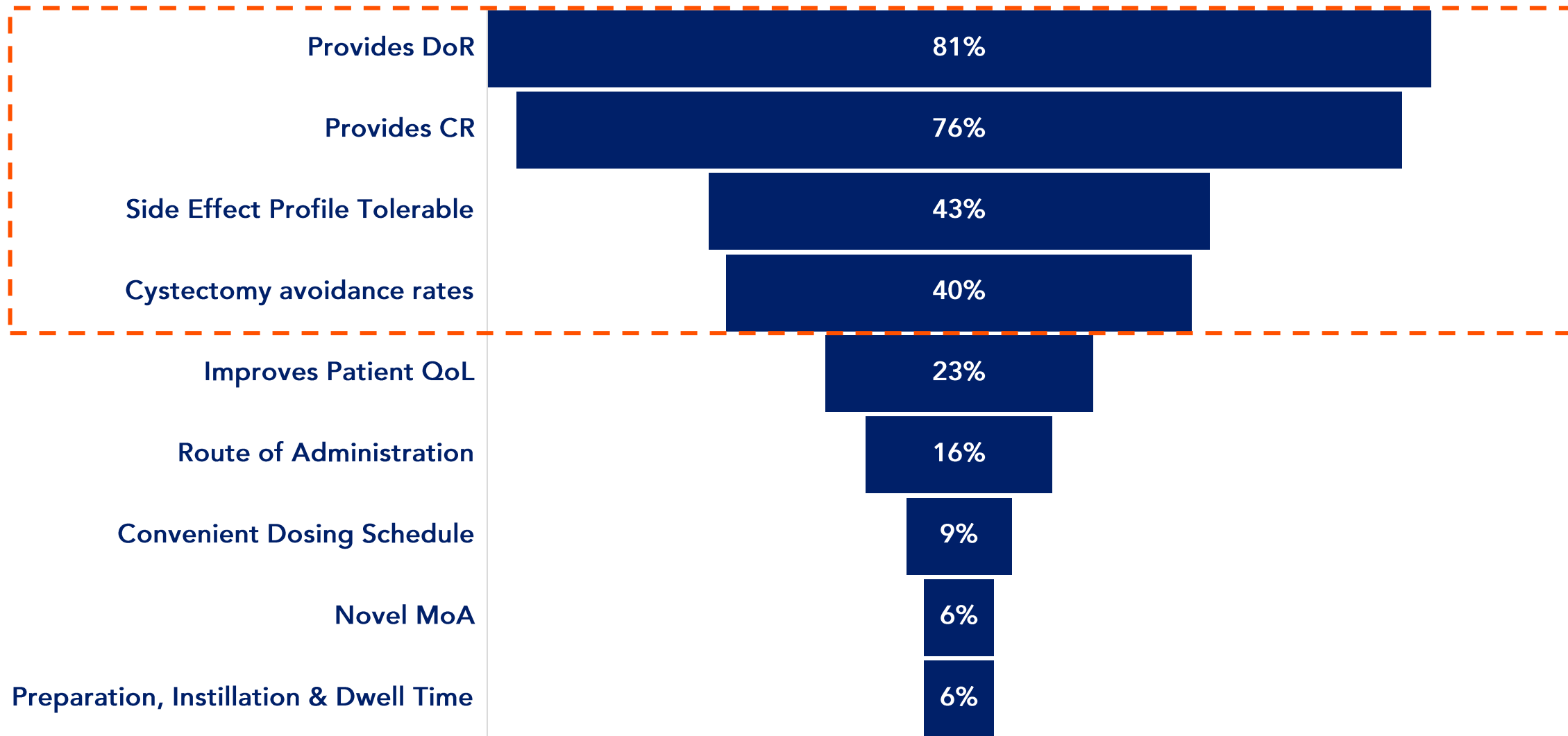
- Cohort A data supports optimized instillation
- Meaningful benefit to patients and sites (esp. high-volume centers) with ~20-minute time savings
- Administered via soft catheter by medical assistant, a **urologist or MD does not have to be involved in process**
- **Seamless transition** for BCG sites, 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

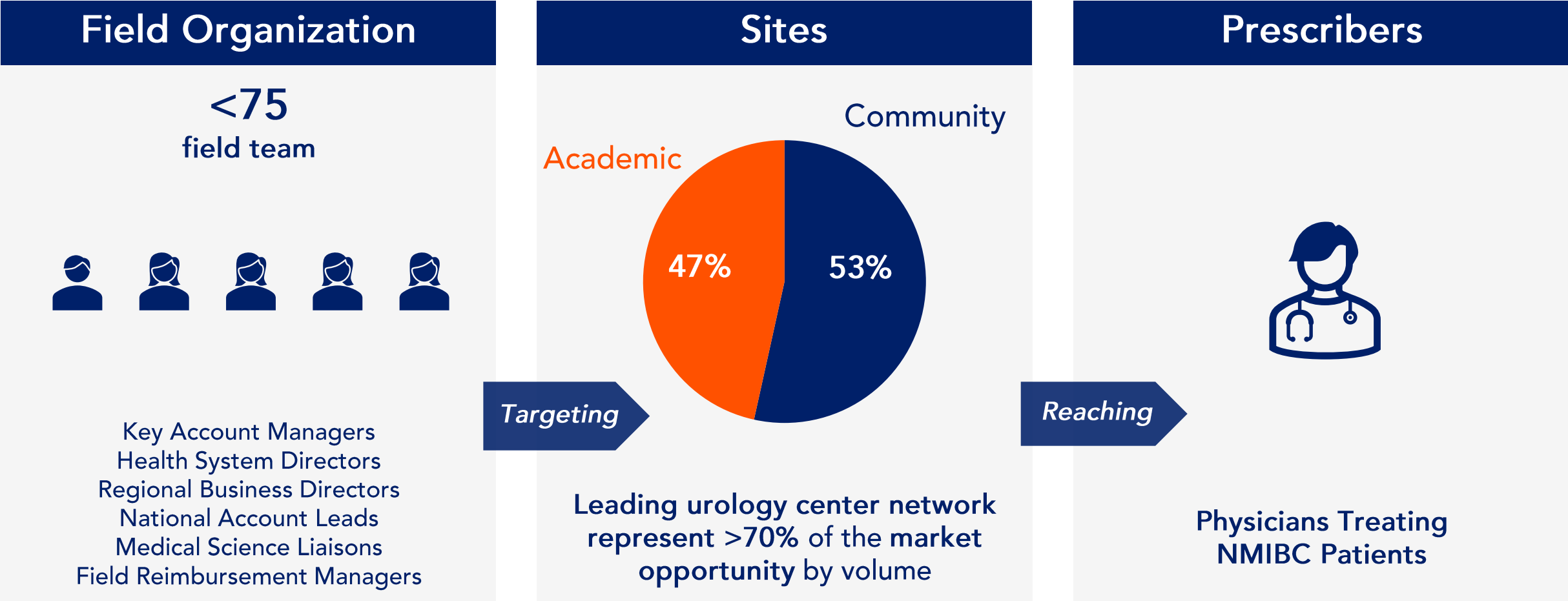
Improved Benefit to Site & Patient

Key Clinical Metrics Driving HCP Treatment Decisions in High-Risk 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

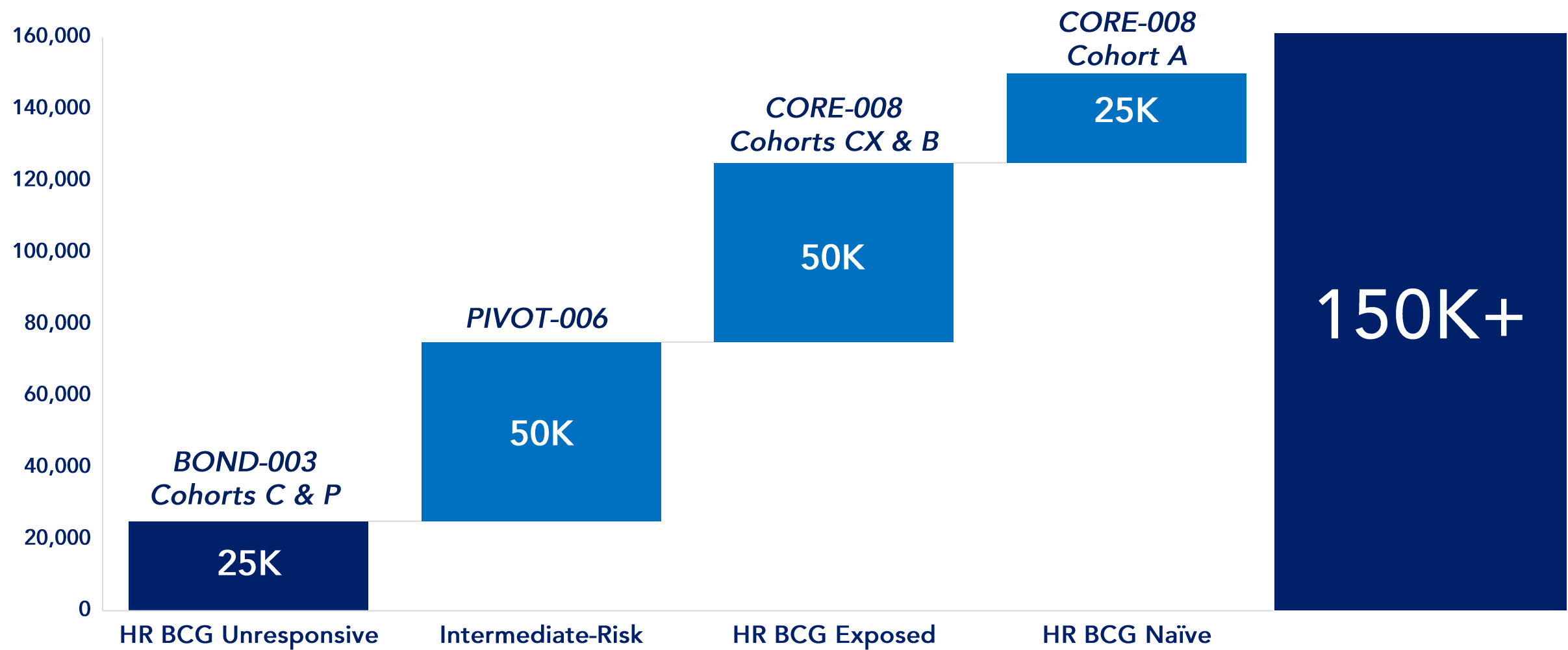
CG is Building a Capital-Efficient, High-Touch Approach in Anticipation of a Successful Launch Across a Concentrated Prescriber Network



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

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
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 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-Exposed Topline Data (Creto + Gem)	CORE-008 Cohort CX BCG-Exposed Durability Data
	 BOND-003 Cohort P BCG-UR Topline Data	BOND-003 Cohort C BCG-UR Long-Term Data	CORE-008 Cohort A BCG-Naïve Durability Data
	 CORE-008 Cohort A BCG-Naïve Data*	BOND-003 Cohort P BCG-UR Durability Data	CORE-008 Cohort B BCG-Exposed Data
	 Initiation of Cretostimogene BLA Submission	CORE-008 Cohort A BCG-Naïve Durability Data	
		Completion of BLA Submission BCG-UR (1st Indication)	
Intermediate Risk (IR) NMIBC	 PIVOT-006 Enrollment Completed	PIVOT-006 Topline Data	
			Completion of sBLA 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.



Attacking
Bladder Cancer
for a Better
Tomorrow™

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(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.

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Josh Patterson, Esq.

General Counsel & CCO

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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.



Attacking Bladder Cancer
for a Better Tomorrow™