



Ladenburg Thalmann Healthcare Conference

September 29, 2022



Forward-Looking Statements

Certain statements contained in this presentation regarding matters that are not historical facts, are forward-looking statements within the meaning of Section 21E of the Securities and Exchange Act of 1934, as amended, and the Private Securities Litigation Act of 1995, known as the PSLRA. These include statements regarding management's intention, plans, beliefs, expectations or forecasts for the future, and, therefore, you are cautioned not to place undue reliance on them. No forward-looking statement can be guaranteed, and actual results may differ materially from those projected. Aadi Bioscience, Inc. ("Aadi") undertakes no obligation to publicly update any forward-looking statement, whether as a result of new information, future events or otherwise, except to the extent required by law. We use words such as "anticipates," "believes," "plans," "expects," "projects," "intends," "may," "will," "should," "could," "estimates," "predicts," "potential," "continue," "guidance," and similar expressions to identify these forward-looking statements that are intended to be covered by the safe-harbor provisions of the PSLRA.

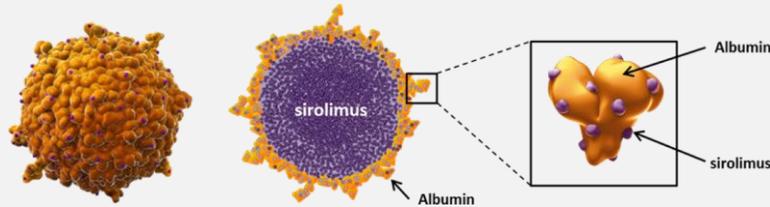
Such forward-looking statements are based on our expectations and involve risks and uncertainties; consequently, actual results may differ materially from those expressed or implied in the statements due to a number of factors, including, but not limited to, Aadi's plans to develop and commercialize its product candidates, including FYARRO® (*nab-sirolimus*, ABI-009); Aadi's commercialization, marketing and manufacturing capabilities and strategy; the clinical utility, potential benefits and market acceptance of FYARRO; risks related to the sufficiency Aadi's cash balance to fund operations; the timing of Aadi's clinical trials; the timing of the availability of data from Aadi's clinical trials; Aadi's plans to research, develop and commercialize its current and future product candidates; Aadi's ability to successfully enter into collaborations, and to fulfill its obligations under any such collaboration agreements; Aadi's ability to identify additional products or product candidates with significant commercial potential; developments and projections relating to Aadi's competitors and our its industry; the impact of government laws and regulations; Aadi's ability to protect its intellectual property position; the impact of the COVID-19 outbreak on Aadi's operations, the biotechnology industry and the economy generally and Aadi's estimates regarding future revenue, expenses, capital requirements and need for additional financing.

These risks are described in detail under the caption "Risk Factors" in Aadi's Quarterly Report on Form 10-Q for the quarter ended March 31, 2022, filed with the Securities and Exchange Commission (the "SEC") on May 12, 2022, and other documents filed from time to time with the SEC. Forward-looking statements included in this presentation are based on information available to Aadi as of the date of this presentation. Except as required by law, Aadi undertakes no obligation to revise or update any forward-looking statement, whether as a result of new information, future events or otherwise.

Aadi Bioscience is a Commercial-Stage Precision Oncology Company

Re-engineering mTOR Inhibition

- Commercializing FYARRO® for treatment of Advanced Malignant PEComa



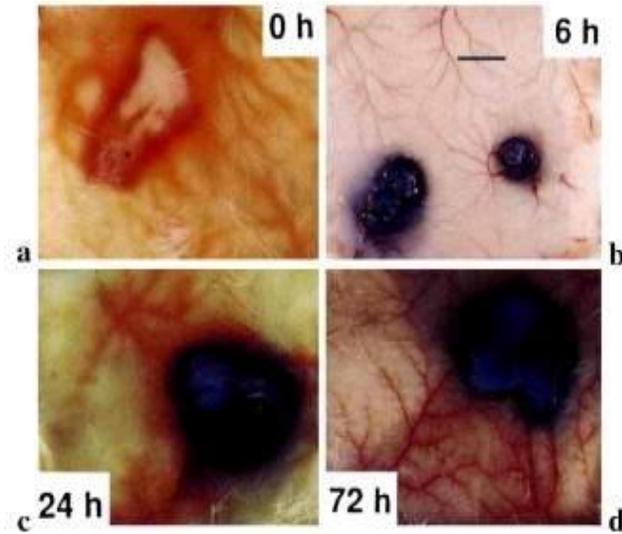
- Technology based on nanoparticle albumin-based (*nab*) platform proven with ABRAXANE®
- Focus on cancers that are highly mTOR dependent
- PRECISION 1 registrational trial in tumor-agnostic *TSC1* or *TSC2* inactivating alterations in solid tumors now actively enrolling
- \$72.5 million financing in Sept 2022 extends cash runway into 2025, supporting expanded development of FYARRO into potential new indications, and the continued progression of PRECISION 1 registrational trial and FYARRO commercialization



*FYARRO FDA approval Nov 2021

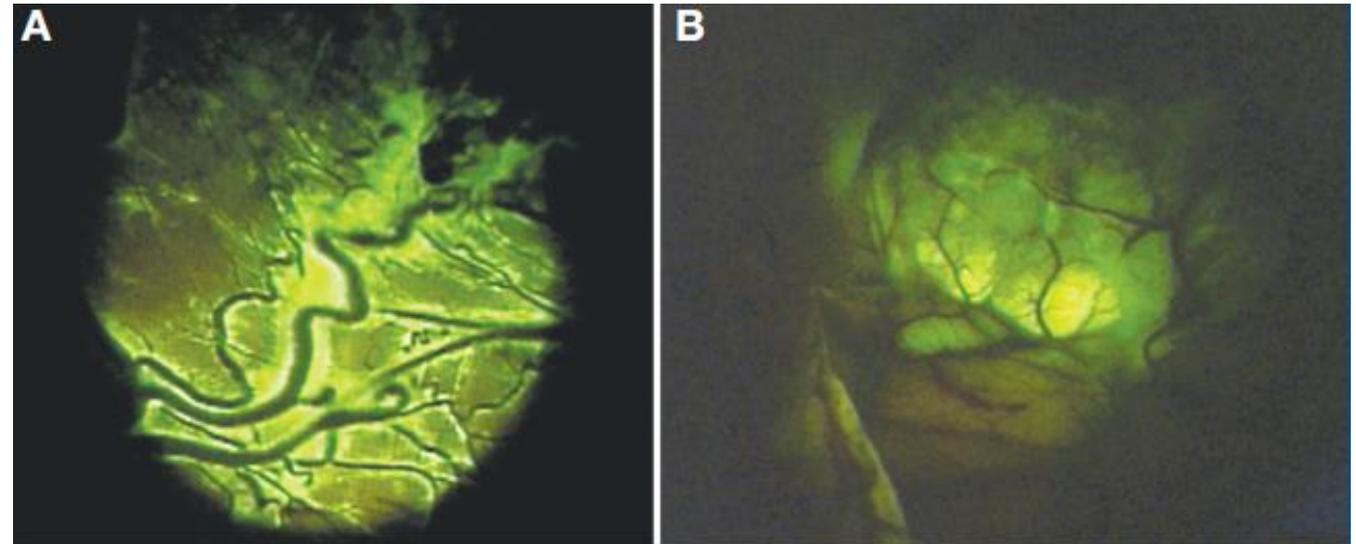
Role of Albumin in Tumor Targeting

Albumin accumulation in tumors established in multiple preclinical models¹



Accumulation of the Evans blue albumin complex in subcutaneously growing sarcoma 180 tumors over 72 h

Labeled albumin can be used intraoperatively to guide surgical resection of tumors in humans²



- 5-Amino Fluorescein labelled albumin administered IV (0.5-1 mg/kg) in 13 patients, 0.5-4 days before surgery
- Tumor fluorescence was bright in 11 patients (84%), resulting in complete resection in 9 patients (69%)

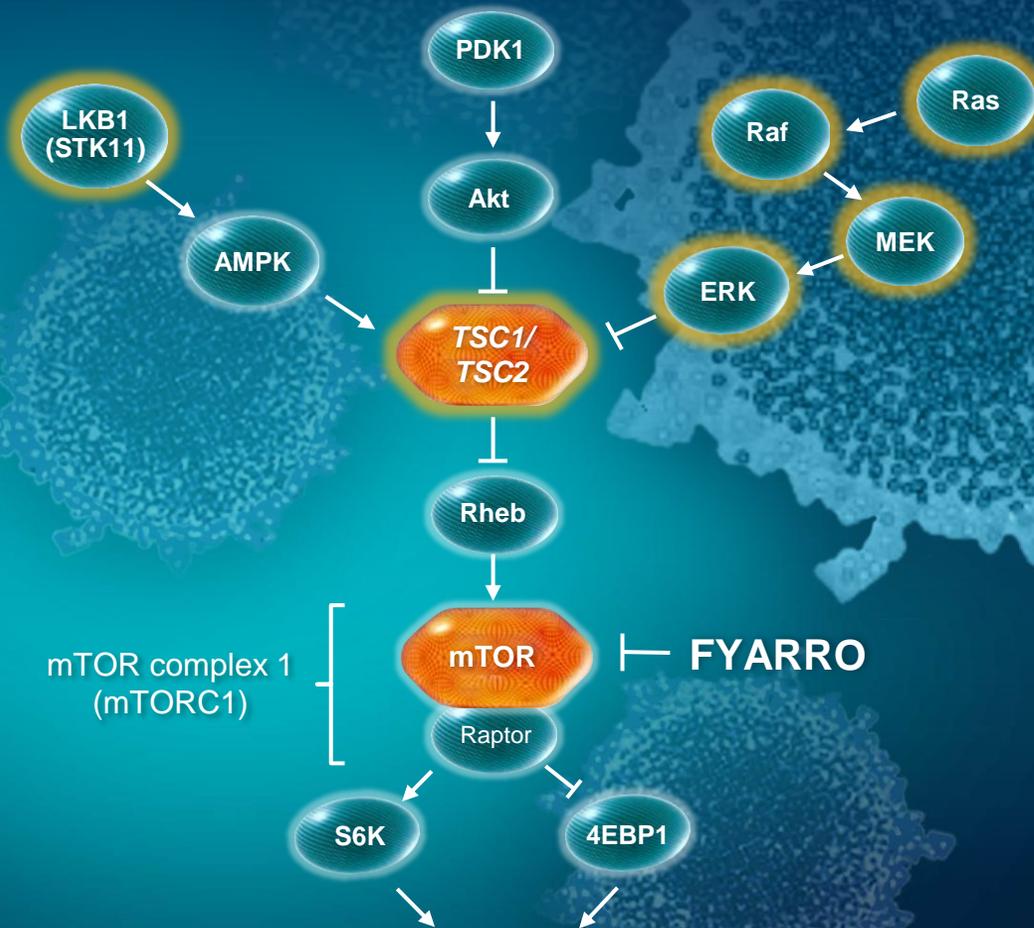
High accumulation of albumin in tumors potentially driven by tumor vessel leakiness (EPR effect); increased caveolar transport; increased albumin catabolism

Note: EPR- Enhanced permeability and retention effect; Sources: 1) Y Shahzad et al., Curr Cancer Drug Targets. 2014;14(8):752-63; 2) P Kremer et al., Neurosurgery. 2009;64(3 Suppl):ons53-60; discussion ons60-1

FYARRO® Targets mTOR:

A Key Signaling Pathway in Cancer

mTOR Signaling Pathway



FYARRO Inhibits Key Signaling Pathways

Improvements over other Approved mTOR Inhibitors:

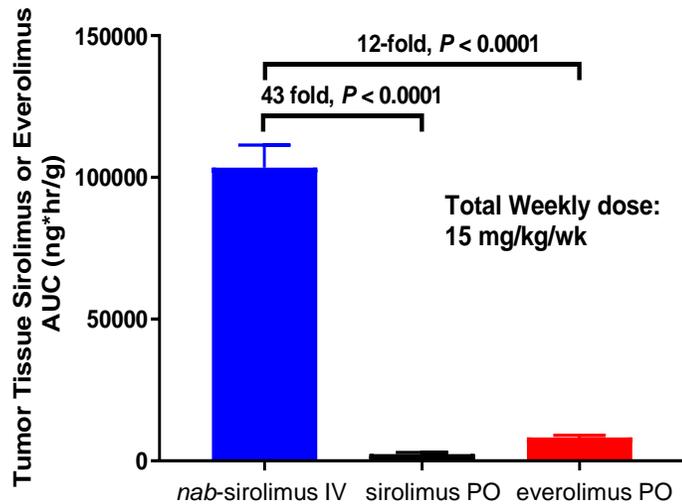
- ✓ High drug levels in tumor result in more complete mTOR target inhibition and greater tumor suppression not achieved with other mTORi's ¹
- ✓ Improved PK, half-life and exposure without compromising safety – wide therapeutic index
- ✓ Flexibility in combination strategies
- ✓ Overcomes limitations of other mTORi's such as highly variable oral absorption, poor PK, narrow therapeutic index
- ✓ Unlocks full potential of mTOR inhibition

 Frequently mutated in cancer and/or validated target

Sources: 1) Hou et al., AACR Molecular Targets 2021 (Abstr P138)

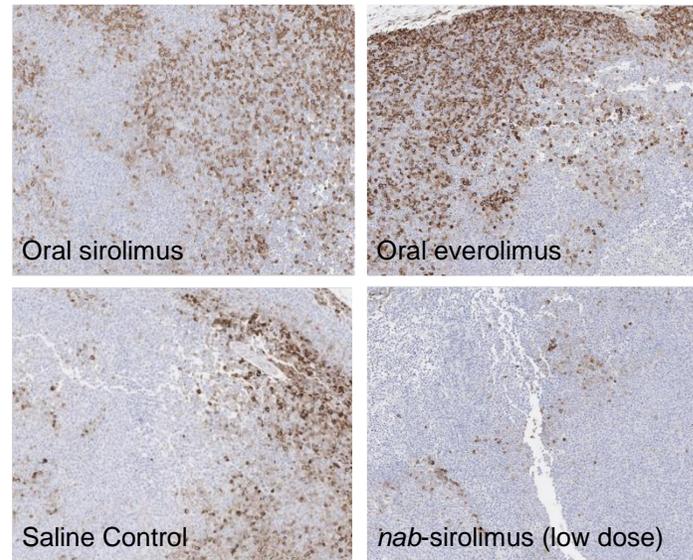
Higher *nab*-sirolimus Intratumoral Concentrations Drive Increased Target Suppression and Tumor Growth Inhibition in a Bladder Cancer Xenograft

Significantly Higher Intratumoral Drug Accumulation



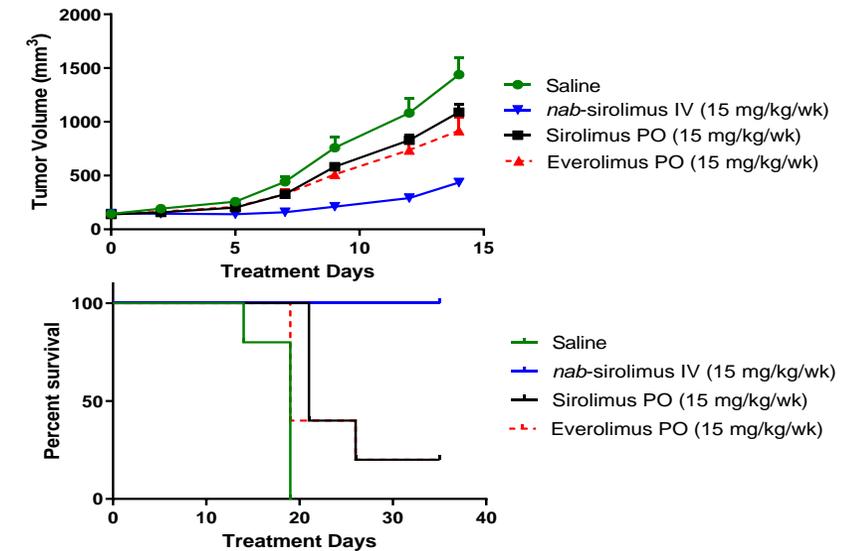
Tumor concentration of *nab*-sirolimus, oral sirolimus, and oral everolimus measured over 7 days at equal weekly dose (15 mg/kg/wk) in mice bearing tumor xenografts

Increased mTOR Target Suppression (pS6)



Tumor IHC pS6 suppression on D7 post dose at equal doses (15 mg/kg/wk). pS6 is a downstream target of mTOR. *nab*-sirolimus vs oral sirolimus: $P = 0.0001$ (ANOVA). *nab*-sirolimus vs oral everolimus $P = 0.0034$ (ANOVA)

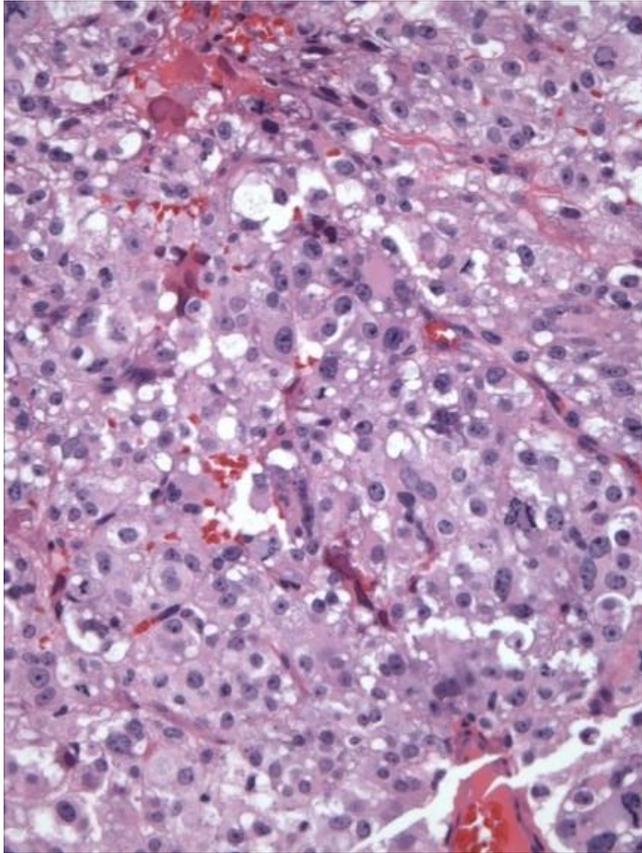
Stronger Inhibition of Tumor Growth and Longer Survival in Animals



UMUC3 (aggressive human bladder cancer) Xenograft (n=8/group): Oral Rapamycin and Everolimus 15 mg/kg/wk (3 mg/kg, 5x/wk); IV *nab*-sirolimus 15 mg/kg/wk (7.5 mg/kg, 2x/wk). Tumor volume: *nab*-sirolimus vs oral sirolimus: $P < 0.0001$ (ANOVA). *nab*-sirolimus vs oral everolimus $P = 0.0023$ (ANOVA). Survival: *nab*-sirolimus vs oral sirolimus: $P < 0.05$ (Log-rank test). *nab*-sirolimus vs oral everolimus $P < 0.05$ (Log-rank test)

***nab*-sirolimus demonstrated enhanced anti-tumor activity vs. currently approved mTOR inhibitors in animal models at clinically relevant doses**

FYARRO® First Approved Indication: Advanced Malignant PEComa



- Ultra rare sarcoma
- Estimated 100-300 new patients per year in the US⁶
- Biological evidence of mTOR pathway activation; cancer type with highest rate of *TSC1* & *TSC2* mutations²⁻⁴
- Estimated survival of 12-16 months⁵
- Can arise at any site but most commonly at visceral (especially gastrointestinal and uterine), retroperitoneal, and abdominopelvic sites and with female predominance
- Mesenchymal tumor (sarcoma) consisting of perivascular epithelioid cells
 - Distinctive cells that show a focal association with blood-vessel walls¹
 - Usually express both melanocytic and smooth muscle markers¹

Sources: 1) Ben-Ami et al., *Expert Opinion on Orphan Drugs*. 2018; 2) Akumalla S, et al. *Oncology*. 2020;98(12):905-912; 3) nab-Sirolimus AMPECT Clinical Trial mutation rates: *TSC1*=20%, *TSC2*=36%; 4) Mutation frequencies based on TCGA database “likely” and “definite” impact mutation rate and published literature rates by cancer type where available (sources available at request); 5) JS Bleeker, JF Quevedo, and AL Folpe, *Sarcoma*. 2012;54:1626; 6) No formal published epidemiology information; Aadi analysis based on multiple sources including Aadi internal data and external research conducted by Tessellon Group and Corsica Life Sciences 7) Primary Oncologist Market Research (N=10) conducted July and August 2019 by Corsica Life Sciences

AMPECT PEComa Registrational Trial Met its Endpoints

AMPECT PEComa Phase II Registrational Trial Design

**Advanced Malignant
PEComa Patients**
(mTOR naïve)

ABI-009 100 mg/m² IV
D1,8 q 21d until progression or
unacceptable toxicity

Primary Endpoint: **ORR**
Secondary Endpoints: DOR,
PFS at 6m, mPFS, mOS, Safety

Sample Size: **Target ORR of ~30% in 30 evaluable patients** to exclude the lower bound of the 95% CI of 14.7%

Efficacy Results in AMPECT^{1,2}

Independent Radiology Review

Overall Response Rate (95% CI) 39% (22%, 58%)

Complete Response^{1,2} 7% (2/31)

Partial Response² 32% (10/31)

Stable Disease² 52%

Progressive Disease² 10%

Disease Control Rate^{‡2} 71%

Median Duration of Response² >36 months

Median Progression Free Survival² 10.6 months (5.5-NR)

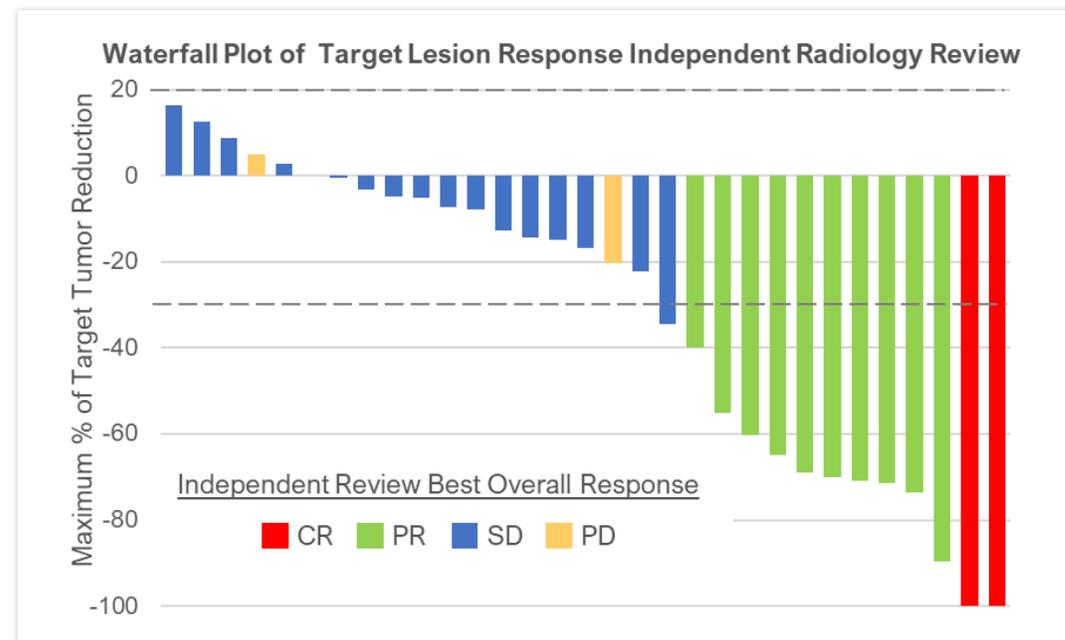
Median Overall Survival^{†3} 40.8 months (22.2-NR)

*At 2.5-year follow-up, data cut-off June 30, 2021²

- 2 patients converted from a PR to complete response (CR) during the follow-up period, after 11mo and 34mo of treatment each
- mDOR has not been reached, 50% of patients had a DOR of 36.1+ months

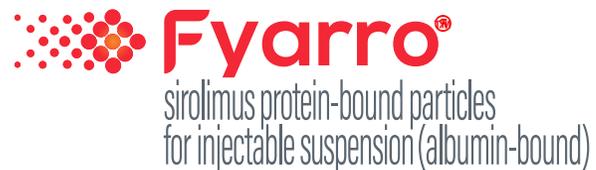
Manageable Safety Profile (N=34)

- Most treatment-related adverse events (TRAEs) grade 1 or 2. No grade 4 or 5 TRAEs
- Most common nonhematologic TRAEs: mucositis (79%), fatigue (59%), and rash (56%)
- Most common hematologic TRAEs: anemia (47%) and thrombocytopenia (32%)
- Noninfectious pneumonitis occurred in 18% of patients and was grade 1 or 2
- Dose reductions occurred in 13/34 (38%) of patients
- Two patients discontinued due to a TRAE (grade 2 anemia and grade 1 cystitis)



The AMPECT Trial met its primary endpoint, exceeding the 30% target ORR agreed upon by the FDA, resulting in approval of FYARRO[®] as the first and only therapy specifically indicated for advanced malignant PEComa

PEComa Commercial Launch (Feb 22, 2022)



1Q 2022, \$2.3M net sales (6 weeks)

2Q 2022, \$3.4M net sales for first full quarter of sales

Steady product demand growth and new patient starts plus bolus of patients carried over into second quarter



PREFERRED

NCCN listed as the only 'Preferred' treatment for malignant PEComa



ACCESSIBLE

Launched Aadi Assist, a comprehensive patient support program, to ensure access to FYARRO; National and Regional payers continue to adopt coverage policies



ENGAGED

Experienced commercial team is in place with Launch execution focused on establishing FYARRO as SOC in malignant PEComa

> 60

Accounts ordering FYARRO® with rapid site activation

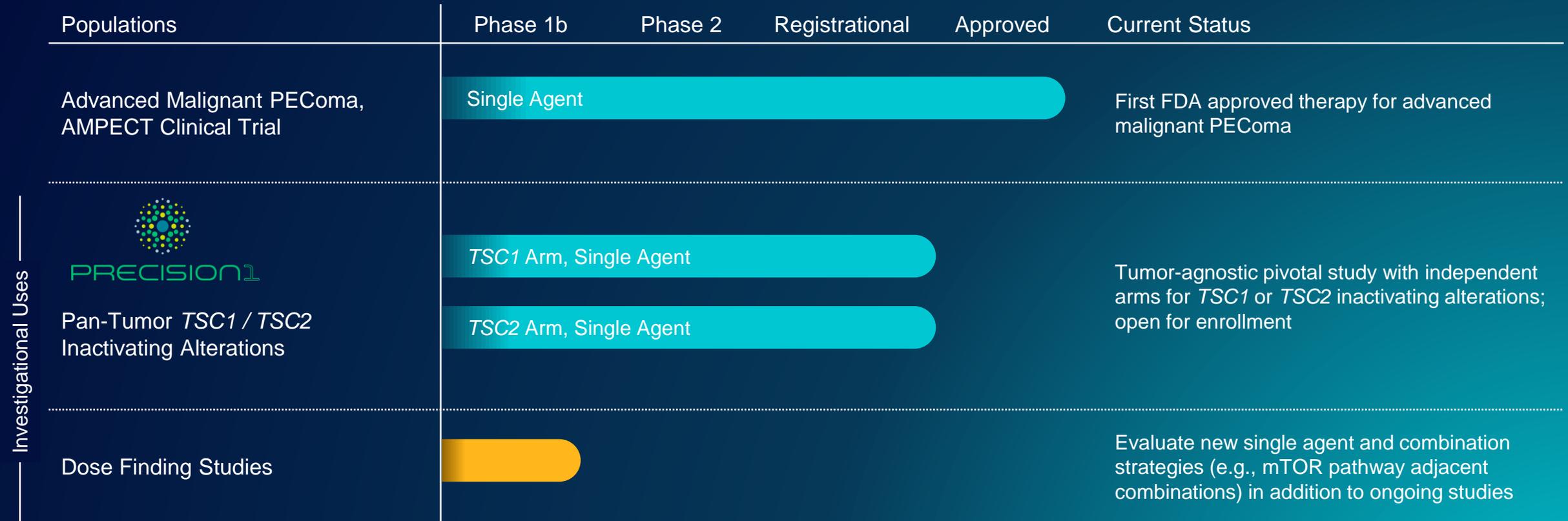
+80%

Account reorder rate

> 40%

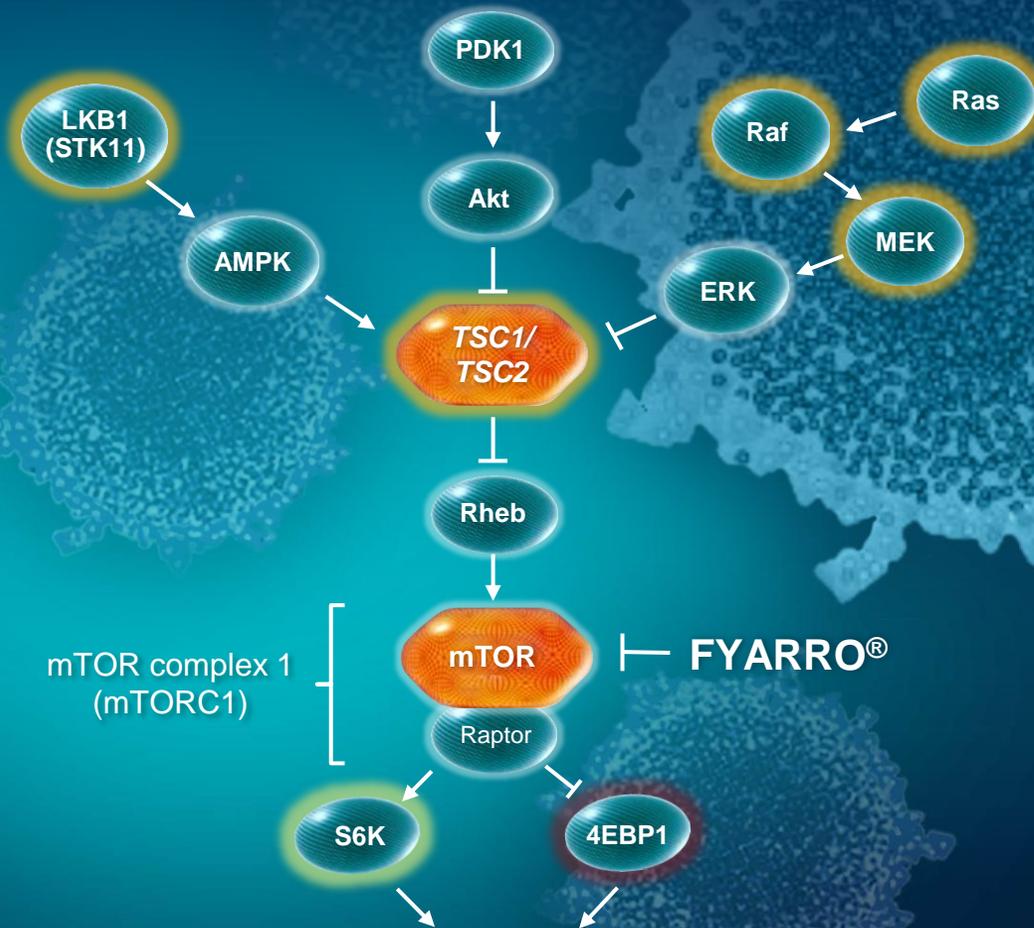
Community adoption

FYARRO[®] Advanced Oncology Development Pipeline



TSC1 and TSC2 Alterations:

mTOR Signaling Pathway



FYARRO® Inhibits Key Signaling Pathways

Key Oncogenic Drivers in the mTOR Pathway

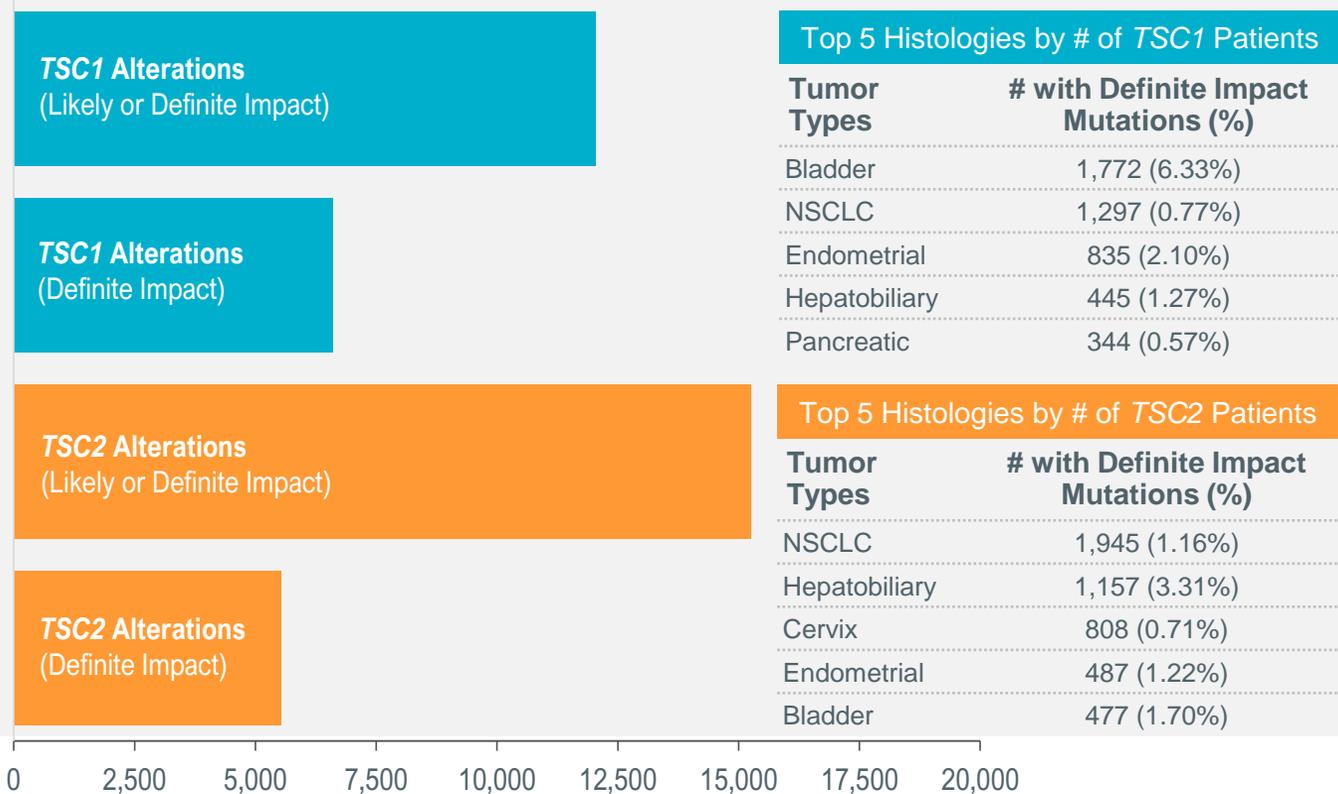
Inactivating mutations in *TSC1* and *TSC2* drive mTOR pathway activation and tumor growth

- *TSC1* and *TSC2* are upstream regulators of mTOR activity within the PI3K/Akt/mTOR pathway
- *TSC1* and *TSC2* mutations occur at a rate of approximately 1-2% each across cancers
- No approved therapies for *TSC1* and *TSC2* mutant patients but numerous case reports with durable responses to mTOR inhibition
- Standard CLIA-certified NGS panels already capture *TSC1* and *TSC2* mutations

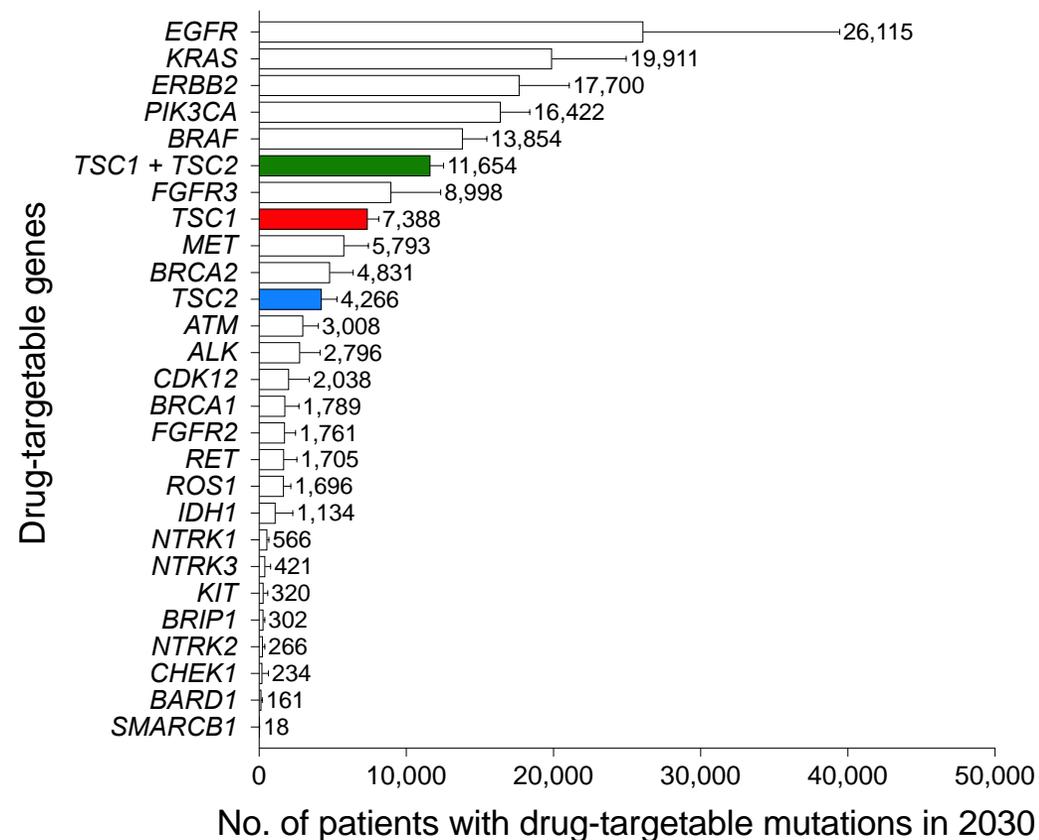
 Frequently mutated in cancer and/or validated target

TSC1 and TSC2 Inactivating Alterations Across All Cancers Represent Significant Opportunities

Projected Annual Incidence of Cancers with TSC1 and TSC2 Alterations¹
 Estimated US Patients Available for 1st Line Therapy in 2030



Incidence of TSC1 and TSC2 Alterations vs. 26 Other Actionable Genes²

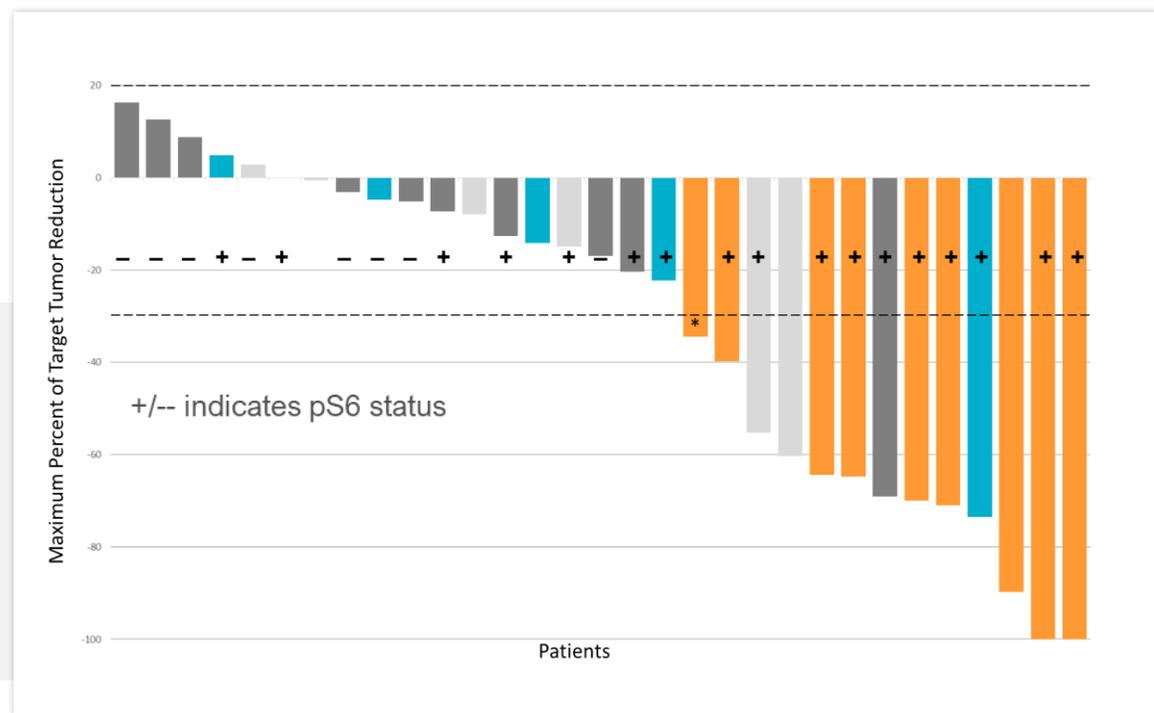


Definitions:
 Likely Impact Alterations (harmful missense variants): missense mutations predicted to be deleterious by SIFT or possibly or probably damaging by PolyPhen
 Definite Impact Alterations (truncating and deep deletions): out-of-frame frameshift insertions/deletions, nonsense mutations, splice-site mutations, and deep deletions (e.g., copy number "-2" in cBioPortal)

12 1) analysis of TCGA, cBioPortal, and SEER databases conducted by Tessellon Group in June 2021 2) G. Gulati, et al. AACR Annual Meeting 2022. Poster #5799



Data from AMPECT in *TSC1* or *TSC2* Inactivating Alterations Supports Further Investigation Across Different Tumor Types



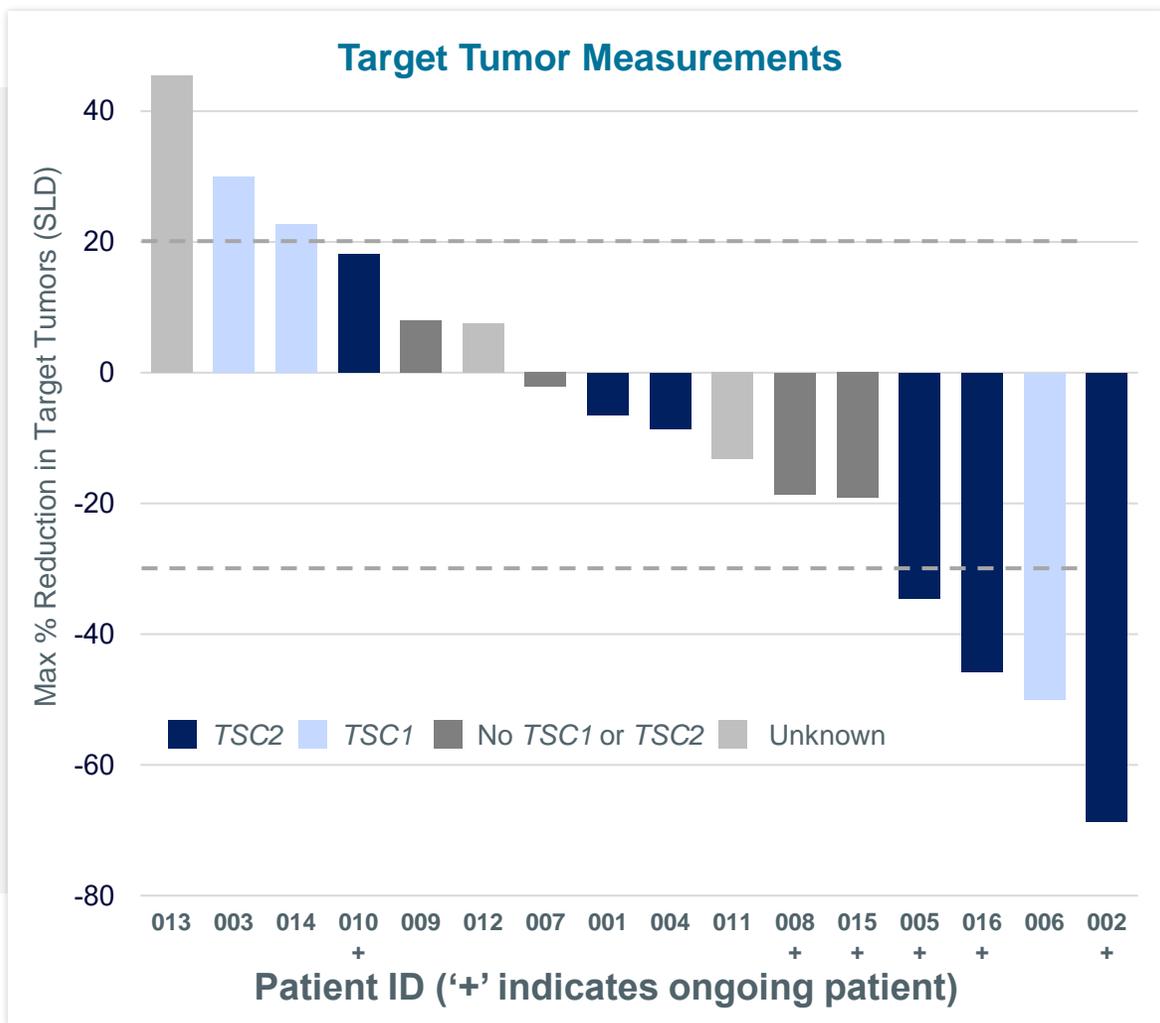
Best Overall Responses Patients with NGS* (N=25)

	<i>TSC1/TSC2</i> n = 14	Non <i>TSC1/TSC2</i> n = 11
Complete or Partial Response	9/14 (64%)	1/11 (9%)
Stable Disease	4/14 (29%)	8/11 (73%)
Stable Disease ≥ 12 weeks	3/14 (21%)	5/11 (45%)
Progressive Disease	1/14 (7%)	2/11 (18%)

- 25 patients had available NGS reports
- Confirmed Responders: 9/14 (64%) pts with *TSC1/TSC2* vs 1/11 (9%) with no *TSC1/TSC2* alterations
- *TSC1/TSC2*: 12/14 (86%) patients had Disease Control (CR or PR or SD ≥ 12 weeks)

● *TSC2* mutation
 ● *TSC1* mutation
 ● No *TSC1* or *TSC2* mutation
 ● UNK mutational status

Expanded Access Program: Efficacy of *nab*-sirolimus in Malignant PEComa Patients after progression/failure of other mTOR inhibitors



Best Overall Responses		All Patients
		n = 16
Partial Response		4/16 (25%)
Stable Disease		8/16 (50%)
Stable Disease ≥12 weeks		6/16 (38%)
Progressive Disease		4/16 (25%)

- 10/16 (63%) patients had Disease Control (CR or PR or SD ≥3 months)
- 4 *nab*-sirolimus responders:
 - BOR on prior mTORi: 1/4 SD, 2/4 PD, 1/4 NE due to toxicity
 - 2/4 had 3 prior lines of Rx

Best Overall Responses		TSC1/TSC2	Non TSC1/TSC2
Patients with NGS* (N=13)		n = 9	n = 4
Partial Response		4/9 (44%)	0
Stable Disease		3/9 (33%)	3/4 (75%)
Stable Disease ≥12 weeks		2/9 (22%)	3/4 (75%)
Progressive Disease		2/9 (22%)	1/4 (25%)

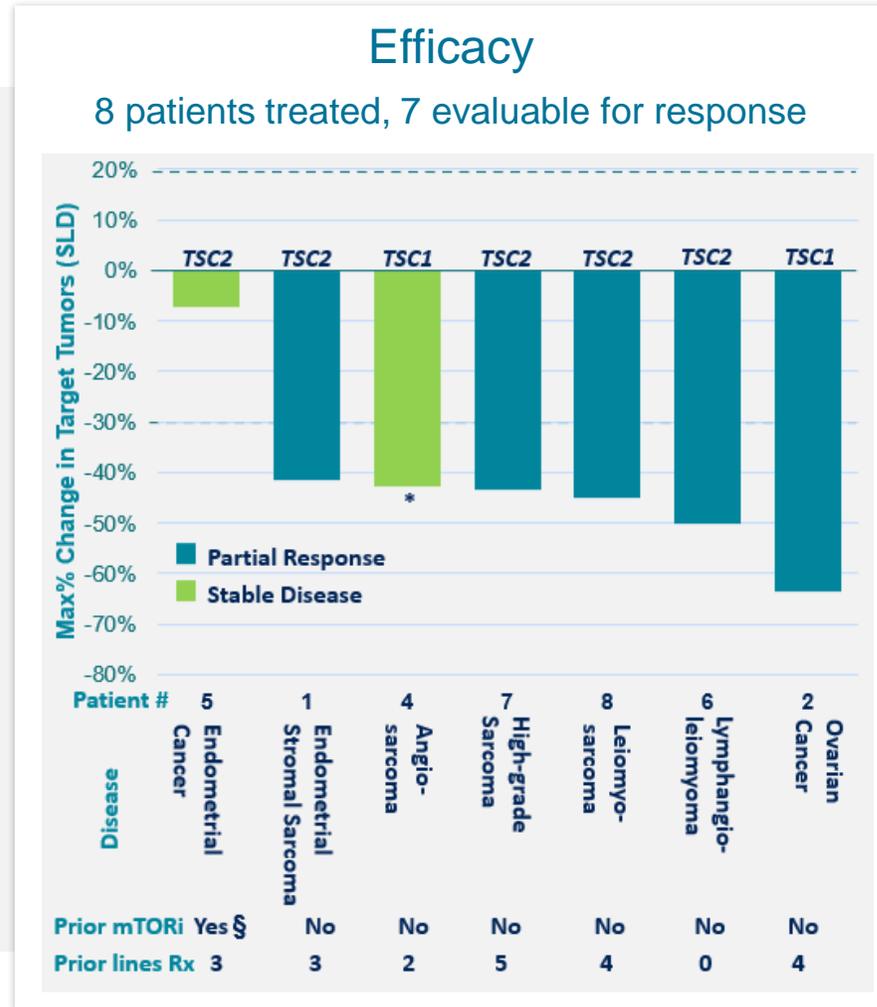
- 13 patients had available NGS reports
- Responders: 4/9 (44%) pts with TSC1/TSC2 vs 0/4 with no TSC1/TSC2 alterations
- TSC1/TSC2: 6/9 (66%) patients had Disease Control (CR or PR or SD ≥3 months)

Expanding Beyond PEComa

Early Experience Other Tumor Types with TSC1 or TSC2 Inactivating Alterations

Multi-institutional Expanded Access for an Intermediate-size Population

- N=8 patients with *TSC1* or *TSC2* inactivating alterations
 - 6 mTOR-naïve
 - 2 previously treated with an mTORi
- 100 mg/m² ABI-009 (*nab-sirolimus*) given D1, D8 of a 21-day cycle
- Response Analysis: RECIST v1.1
- Tumor types: Ovarian cancer, endometrial cancer, angiosarcoma, leiomyosarcoma, lymphangio-leiomyoma, high grade sarcoma, endometrial sarcoma
- Lines of prior therapy: median 3.5 (range 0-6)



Safety

- Treatment-emergent AEs ($\geq 30\%$) included edema, infections, mucositis, and pain (71% each), nail changes and vomiting (57% each), and hypertension and nausea (43% each).
- Majority of events were G1/G2
- Treatment-related SAEs were reported in 2 patients and included hyperglycemia and infection (Pt#4) and acute kidney injury (Pt#7) possibly secondary to administration of contrast
- Dose reductions occurred in 3/8 patients (38%) from 100 mg/m² to 75 mg/m²

Prior Experience in Patients with *TSC1* and *TSC2* Alterations Support Rationale for Tumor-Agnostic Approach

AMPECT PEComa Registrational Trial

mTOR Naïve PEComa Patients with *TSC1/TSC2* Alterations¹

- mTOR naïve
- 14 patients
- Response in 9/14 (64%)

FYARRO Expanded Access Program

PEComa Patients with *TSC1/TSC2* Alterations Previously Treated with mTOR inhibitors²

- Progressed on prior mTOR
- 9 patients
- Response in 4/9 (44%)

FYARRO Expanded Access Program

Non-PEComa Patients with *TSC1/TSC2* Alterations

- 6 mTOR naïve + 2 prior mTOR treated
- 8 patients total
- Response in 5/8 (63%)

Blended data in *TSC1* and *TSC2* alterations: 18/31 (58%)

PRECISION 1: *nab*-sirolimus Basket Study for *TSC1* or *TSC2* Inactivating Alterations Tumor-Agnostic Registrational Trial



- Independently evaluable arms for *TSC1* and *TSC2*
- Primary endpoint : ORR
- Secondary endpoints : DOR, DCR
- Patient accrual based on local NGS results
- First patient dosed (March 2022)
- 24 month enrollment
- Preliminary clinical data expected 1H 2023

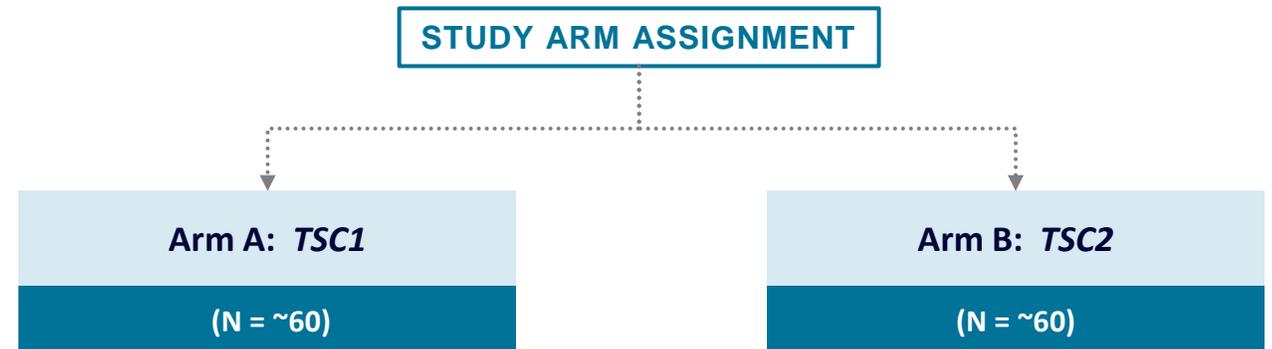
Strategies to expedite enrollment:

- Partnered with NGS providers
- Partnered with US Oncology

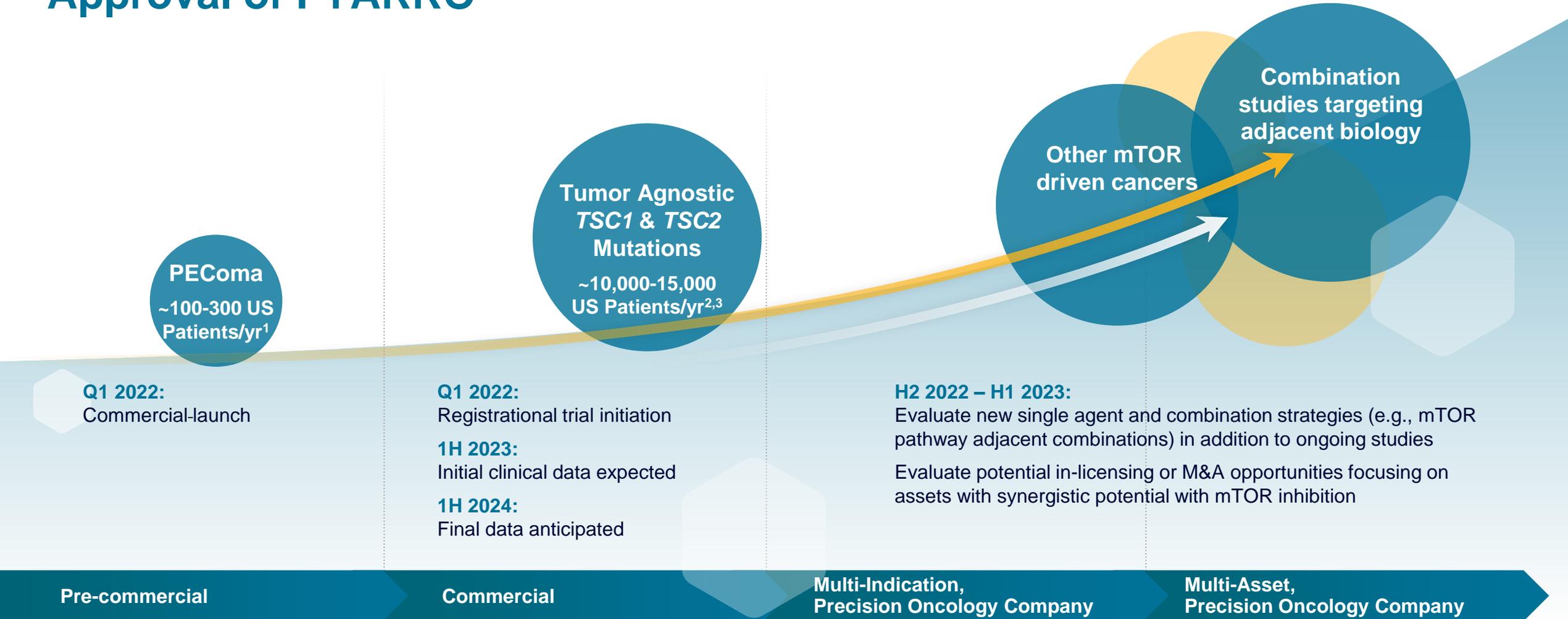


Key Eligibility Criteria

- Metastatic or locally advanced disease ineligible for surgery
- Naïve to mTOR inhibitor treatment
- Pathogenic *TSC1* or *TSC2* inactivating alterations identified through NGS
- Must have received standard therapy for the disease or in investigator opinion unlikely to benefit



Aadi on Path to Becoming a Leading Precision Oncology Company with Approval of FYARRO





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NASDAQ: AADI

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