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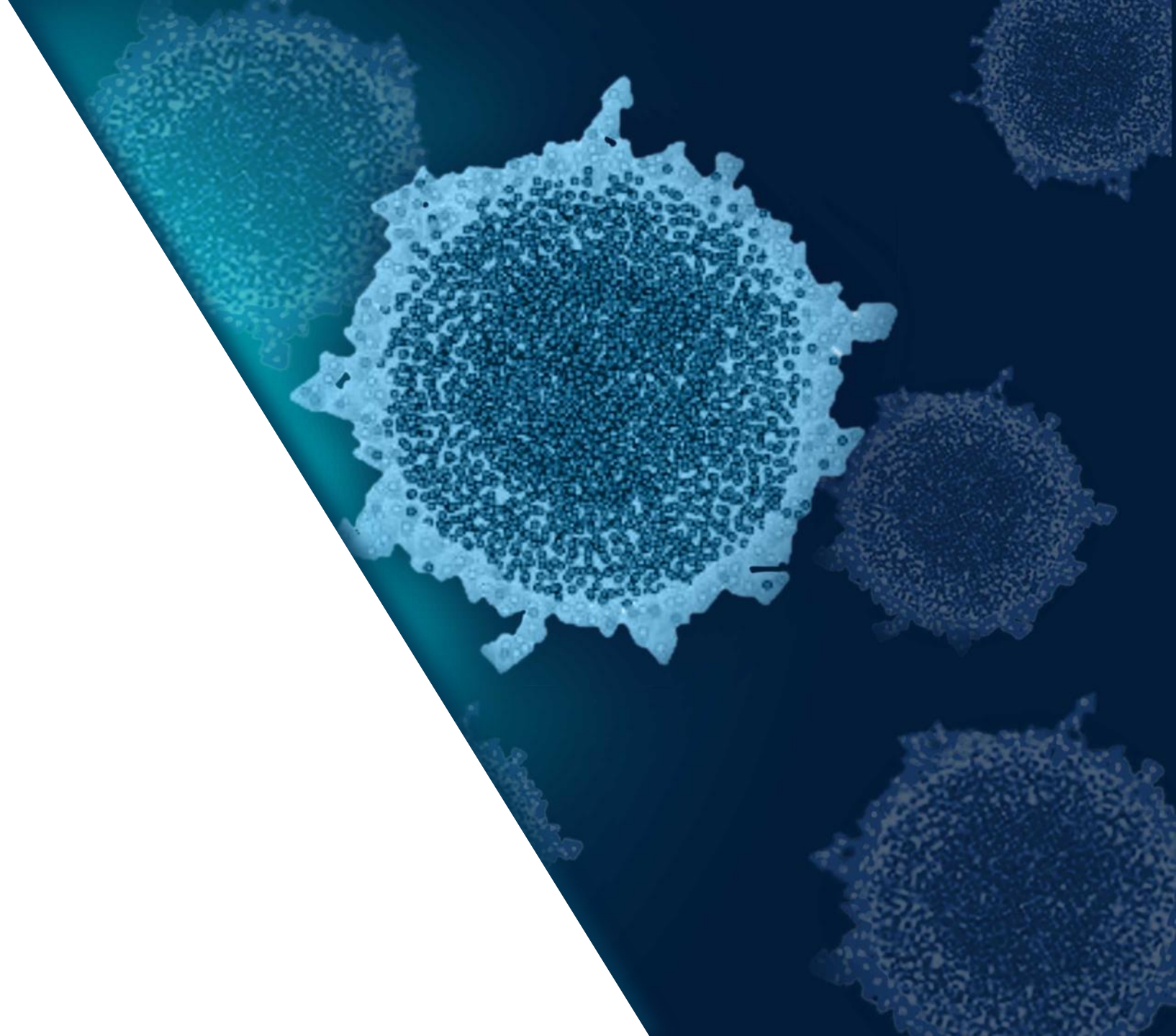


Corporate Presentation

June 2023

Forward-Looking Statements

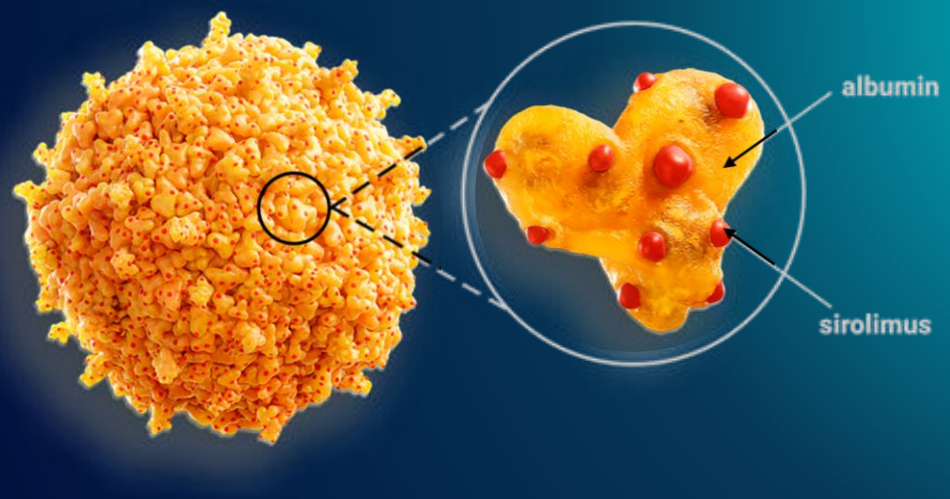
Certain statements contained in this presentation regarding matters that are not historical facts, are forward-looking statements within the meaning of Section 21E of the Securities and Exchange Act of 1934, as amended, and the Private Securities Litigation Act of 1995, known as the PSLRA. These include 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. Forward-looking statements may include, without limitation, statements regarding: the anticipated timing of commencement, enrollment and completion of clinical trials of Aadi Bioscience, Inc. ("Aadi"); the anticipated timing for releasing data for Aadi's clinical trials; Aadi's anticipated cash runway; Aadi's potential to become a leading precision oncology company; and projected annual incidence of cancers with TSC1 and TSC2 alterations and related market opportunities. No forward-looking statement can be guaranteed, and actual results may differ materially from those projected. 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; 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, 2023, filed with the Securities and Exchange Commission (the "SEC") on May 10, 2023, 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
- **$151.2 million in cash and cash equivalents** as of March 31, 2023 with cash runway extending into 2025

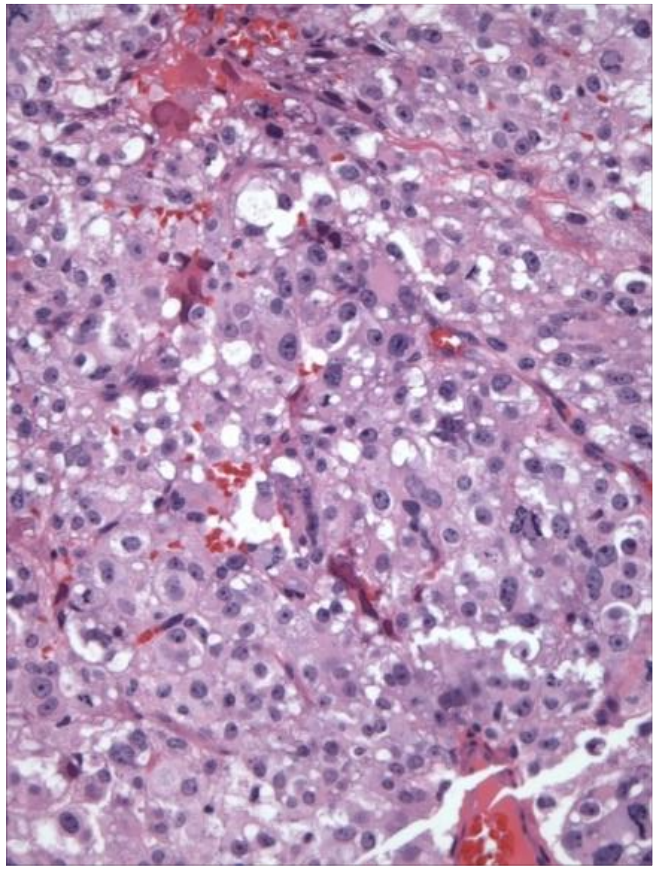


**FYARRO FDA approval Nov 2021*

Great Science. Great Story. Great People.

- **Extensive pharma experience on building blockbuster oncology brands**
- **Large- and small-cap biotech knowhow in effectively managing explosive growth**
- **Strong networks across key functions enable rapid organizational scaling with top talent**
- **Understand the requirements of creating value by building sustainable companies from the bottom up**

FYARRO® First Approved Indication: Advanced Malignant PEComa



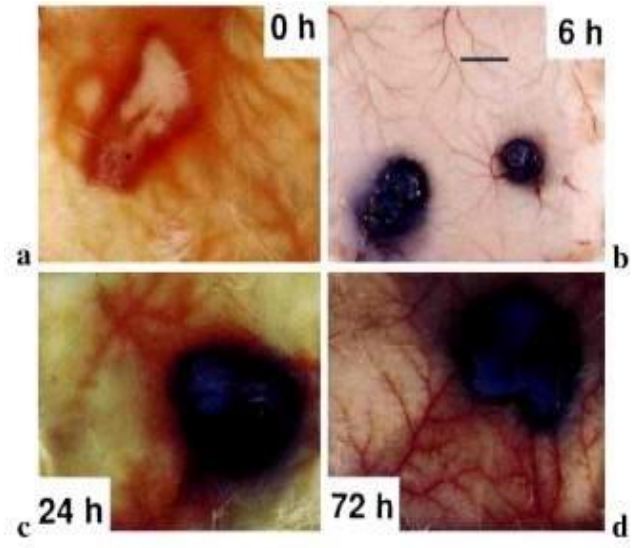
- Ultra rare sarcoma
- Estimated 100-300 new patients per year in the US[1]
- Biological evidence of mTOR pathway activation; cancer type with highest rate of *TSC1* & *TSC2* mutations[2-4]
- Estimated survival of 12-16 months[5]

- 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 walls[6]
  - Usually express both melanocytic and smooth muscle markers[6]

Sources: 1) 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, 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;541626; 6) Ben-Ami et al., Expert Opinion on Orphan Drugs. 2018

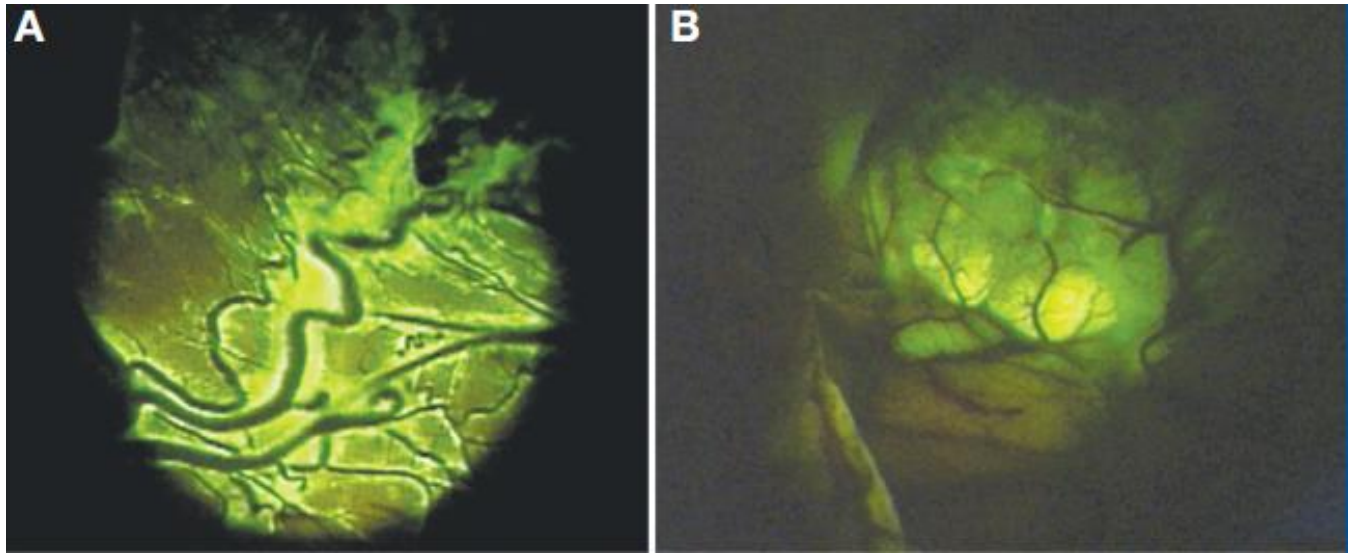
Role of Albumin in Tumor Targeting

Albumin accumulation in tumors established in multiple preclinical models[1]



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 humans[2]

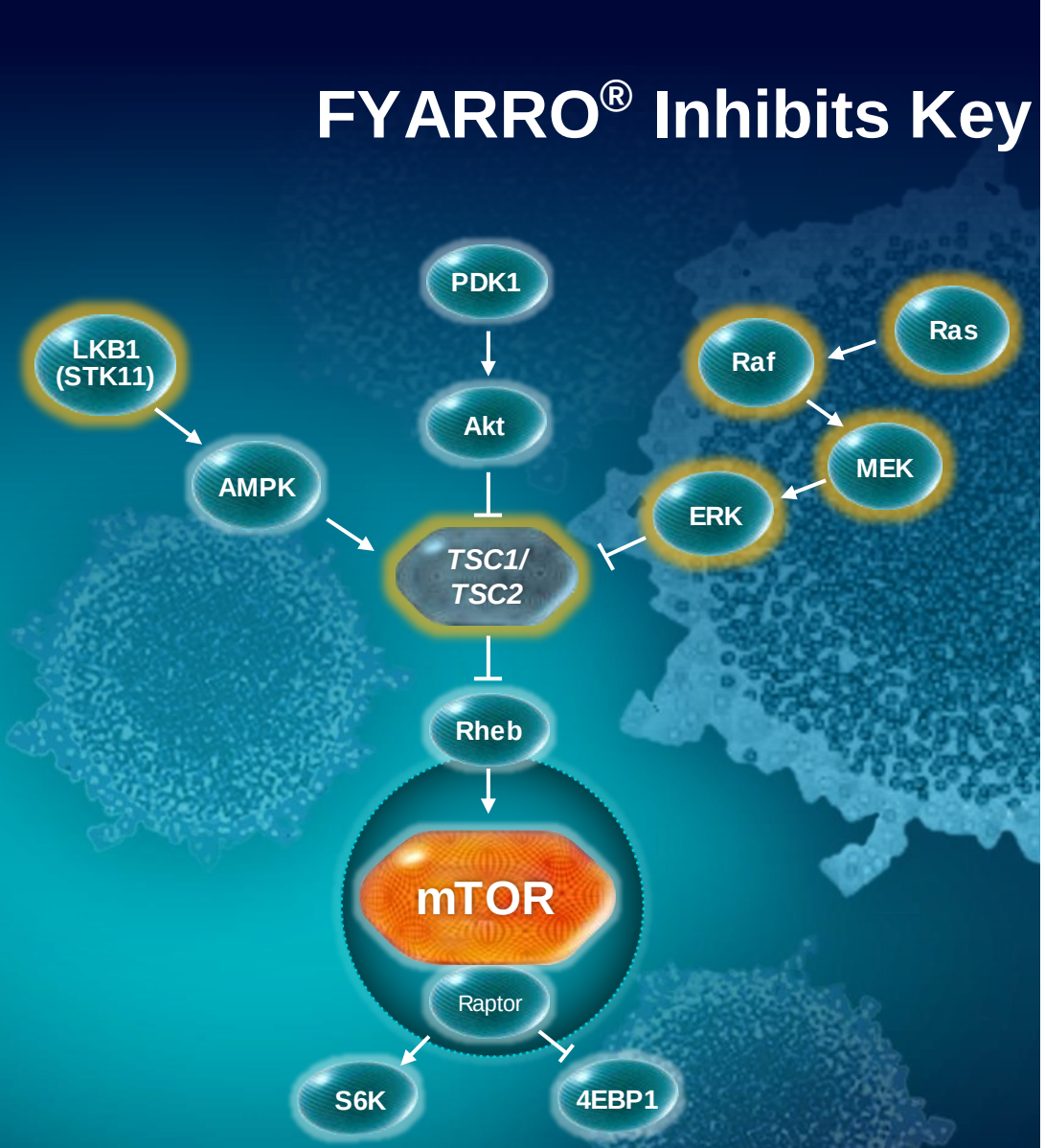


- 5-Amino Fluorescein labelled albumin administered IV (0.5-1 mg/kg) in 13 patients, 0.5-4 days before surgery
- Tumor fluorescence was bright in 11 patients (84%), resulting in complete resection in 9 patients (69%)

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® Inhibits Key Signaling Pathways in Cancer



mTOR Signaling Pathway

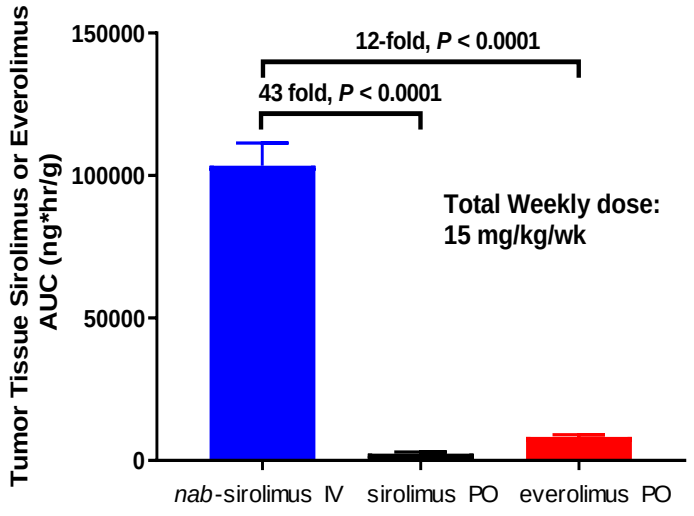
Improvements over other Approved mTOR Inhibitors

- ✓ 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

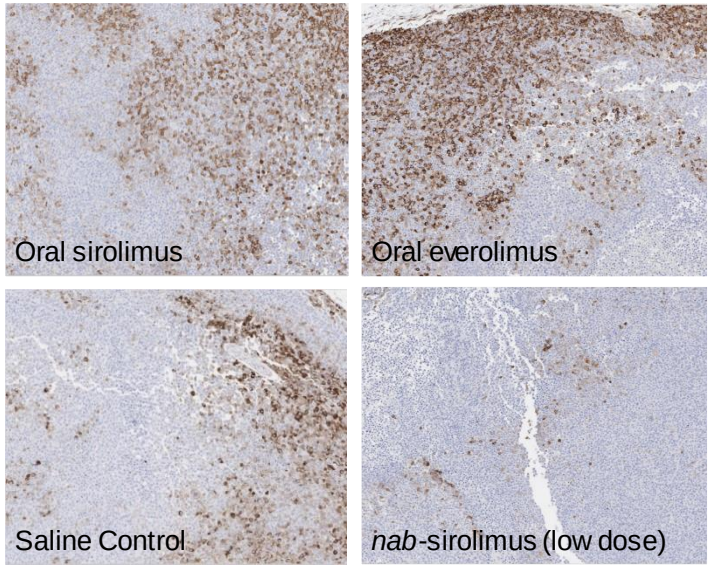
Higher *nab*-sirolimus Intratumoral Concentrations Drive Increased Target Suppression and Tumor Growth Inhibition in a Bladder Cancer Xenograft

Significantly Higher Intratumoral Drug Accumulation



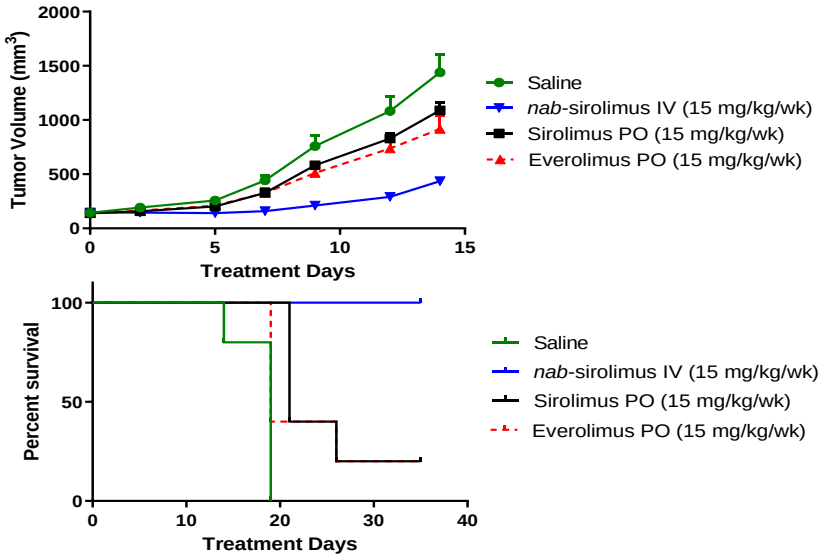
Tumor concentration of *nab*-sirolimus, oral sirolimus, and oral everolimus measured over 7 days at equal weekly dose (15 mg/kg/wk) in mice bearing tumor xenografts

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



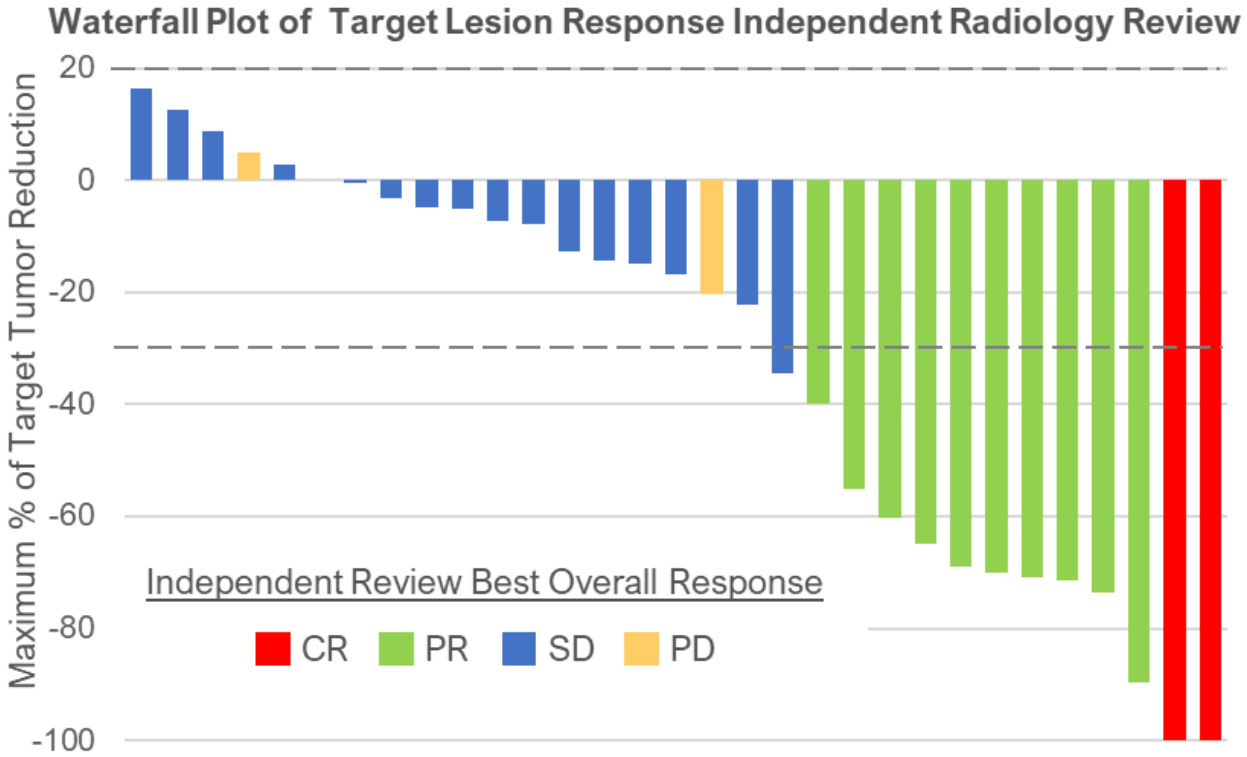
UMUC3 (aggressive human bladder cancer) Xenograft (n=8/group):
Oral Rapamycin and Everolimus 15 mg/kg/wk (3 mg/kg, 5x/wk);
IV *nab*-sirolimus 15 mg/kg/wk (7.5 mg/kg, 2x/wk)
Tumor volume: *nab*-sirolimus vs oral sirolimus: P < 0.0001 (ANOVA)
nab-sirolimus vs oral everolimus P = 0.0023 (ANOVA)
Survival: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

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

Source: S Hou et al., AACR. 2019

AMPECT PEComa Registrational Trial Met Endpoints

Highly durable responses coupled with high disease control rate and manageable toxicities showed *nab*-sirolimus effectiveness, representing an important new treatment option for patients in need



Efficacy Results in AMPECT[1,2]	Independent Radiology Review
Overall Response Rate (95% CI)	**39%** (22%, 58%)
Complete Response	7% (2/31)
Partial Response	32% (10/31)
Stable Disease	52%
Progressive Disease	10%
Disease Control Rate‡	71%
Median Duration of Response	**39.7 months**
Median Progression Free Survival	**10.6 months (5.5-NR)**
Median Overall Survival†	**53.1 months**

Safety Summary[3]

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

Note: ‡Disease control rate defined as complete response + partial response + stable disease ≥12 weeks;
Sources: 1) FYARRO® Prescribing Information; 2) AJ Wagner, CTOS 2022; 3) AJ Wagner, JCO 2021

FYARRO in PEComa: Steady Product Demand Continues

Fyarro®
sirolimus protein-bound particles
for injectable suspension (albumin-bound)

$5.9 million net sales in 1Q 2023
12% growth Q/Q

$21.0 million sales sales-to-date
Achieved in first 13 months on the market

Sustained product demand growth represents a shift from initial bolus to increased depth and breadth of prescribing

PREFERRED
NCCN clinical practice guidelines in oncology listed FYARRO as the only "Preferred" treatment for malignant PEComa

ACCESSIBLE
Utilize 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

> 145
Unique accounts ordering FYARRO

+ 90%
Account reorder rate

~ 50%
Community adoption

FYARRO® Advanced Oncology Development Pipeline

Populations	Phase 1	Phase 2	Registrational	Approved	Current Status
Advanced Malignant PEComa, AMPECT Clinical Trial	Single Agent				First FDA approved therapy for advanced malignant PEComa
PRECISION1 Pan-Tumor *TSC1 / TSC2* Inactivating Alterations	*TSC1* Arm, Single Agent				Tumor-agnostic pivotal study with independent arms for *TSC1* or *TSC2* inactivating alterations; open for enrollment
	TSC2 Arm, Single Agent				
Advanced solid tumors or NSCLC with *KRAS*^{G12C} mutation (Phase 1/2)	*Nab*-sirolimus + adagrasib				Collaboration ongoing with MIRATI THERAPEUTICS

Evaluation of additional new single agent and combination trials ongoing

● Ongoing ● To be initiated / in planning

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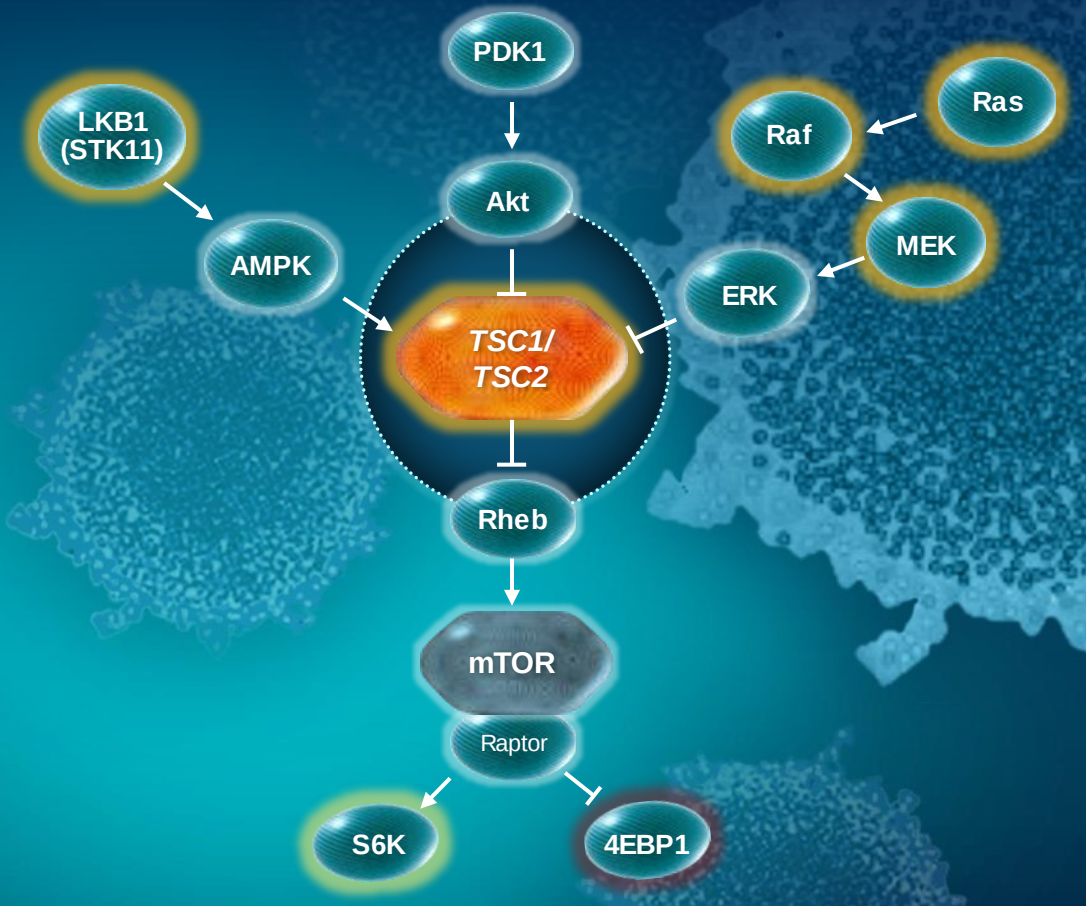
TSC1 and *TSC2* Alterations: Key Oncogenic Drivers in the mTOR Pathway



mTOR Signaling Pathway

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

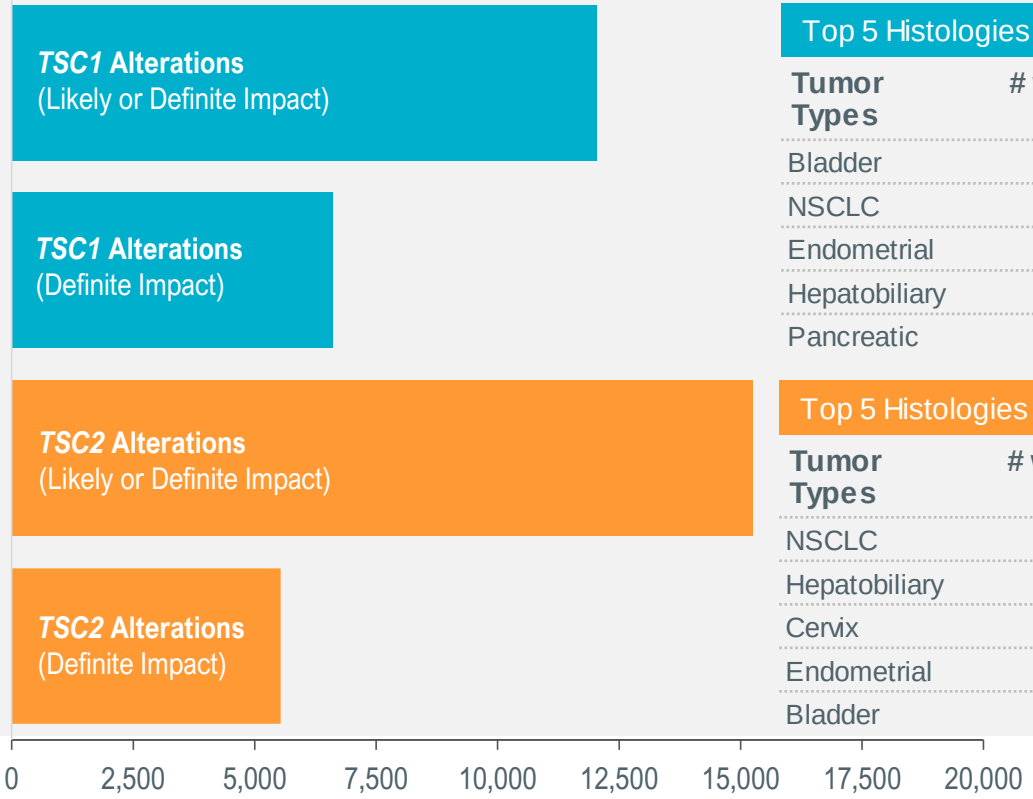
- *TSC1* and *TSC2* are upstream regulators of mTOR activity within the PI3K/Akt/mTOR pathway
- *TSC1* and *TSC2* mutations occur at a rate of approximately 1-2% each across cancers
- No approved therapies for *TSC1* and *TSC2* mutant patients but numerous case reports with durable responses to mTOR 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* Alterations[1]

Estimated US Patients Available for 1st Line Therapy in 2030



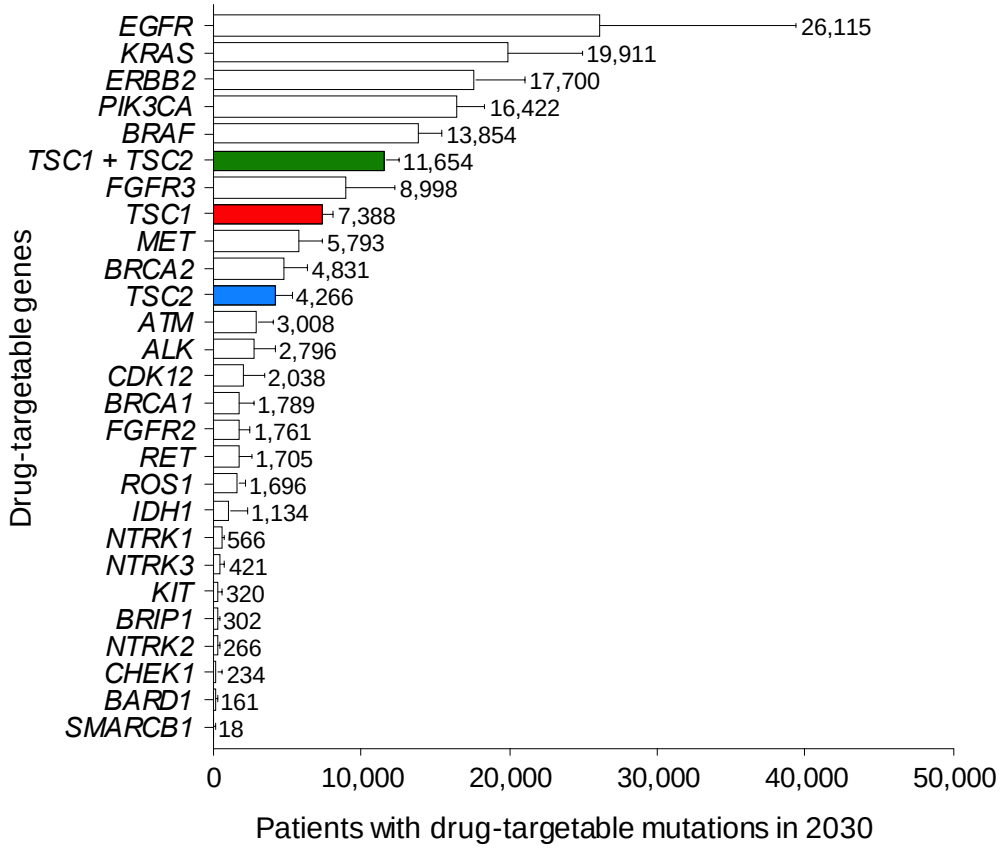
Top 5 Histologies by # of *TSC1* Patients

Tumor Types	# with Definite Impact Mutations (%)
Bladder	1,772 (6.33%)
NSCLC	1,297 (0.77%)
Endometrial	835 (2.10%)
Hepatobiliary	445 (1.27%)
Pancreatic	344 (0.57%)

Top 5 Histologies by # of *TSC2* Patients

Tumor Types	# with Definite Impact Mutations (%)
NSCLC	1,945 (1.16%)
Hepatobiliary	1,157 (3.31%)
Cervix	808 (0.71%)
Endometrial	487 (1.22%)
Bladder	477 (1.70%)

Incidence of *TSC1* and *TSC2* Alterations vs. 26 Other Actionable Genes[2]



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)

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

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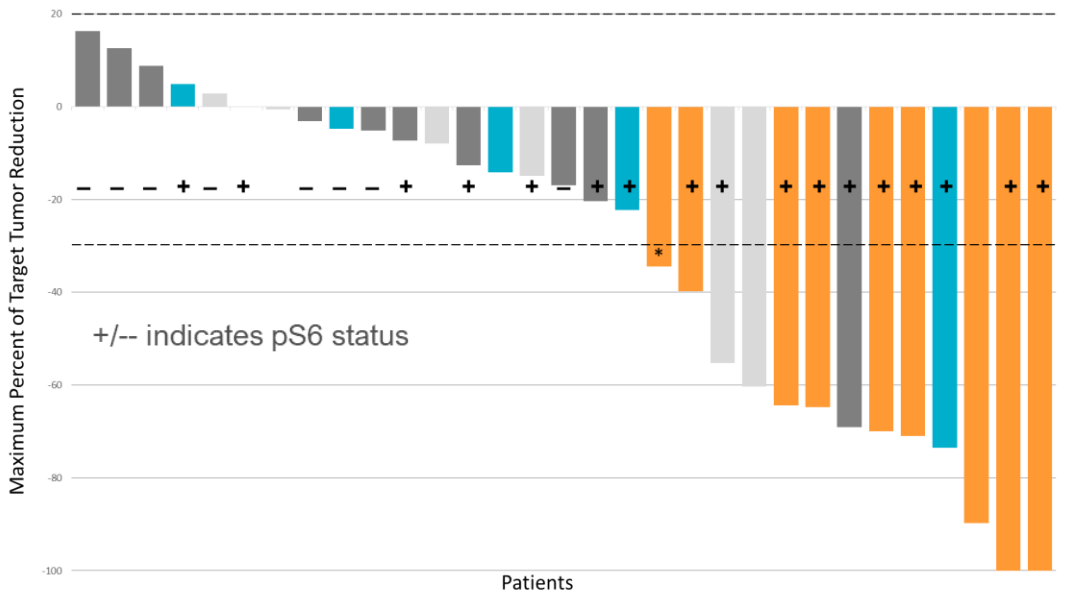
Data from AMPECT in *TSC1* or *TSC2* Inactivating Alterations Supports Further Investigation Across Different Tumor Types



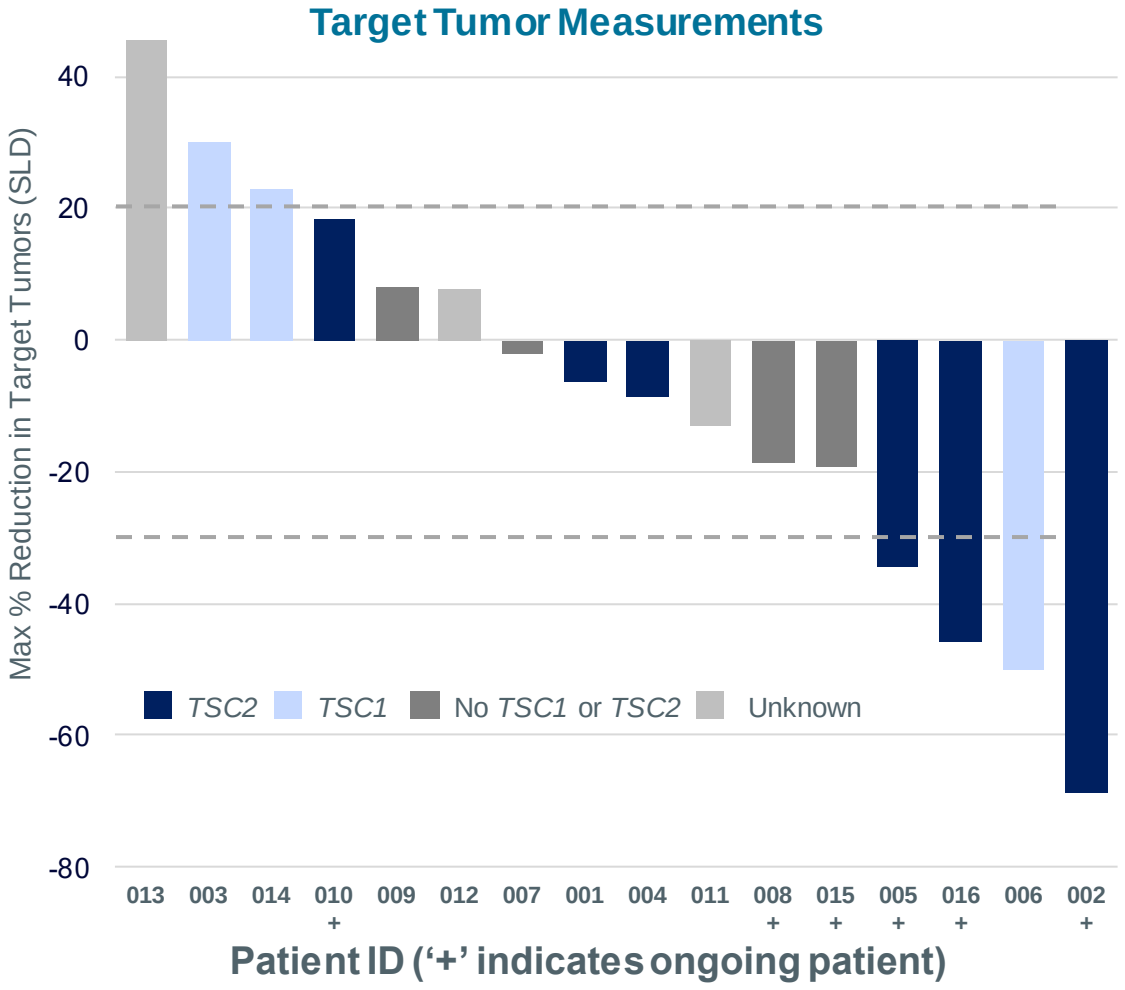
Best Overall Responses Patients with NGS* (N=25)	*TSC1/TSC2* n = 14	Non *TSC1/TSC2* n = 11
Complete or Partial Response	**9/14 (64%)**	**1/11 (9%)**
Stable Disease	**4/14 (29%)**	**8/11 (73%)**
Stable Disease ≥12 weeks	3/14 (21%)	5/11 (45%)
Progressive Disease	**1/14 (7%)**	**2/11 (18%)**

- 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

*Note: *1 patient with TSC2 mutation had an unconfirmed PR and thus best response is an SD as per RECIST 1.1; Source: AJ Wagner et al., JCO. 2021*

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 Patients with NGS* (N=13)	*TSC1/TSC2* n = 9	Non *TSC1/TSC2* 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)

*Note: NE tox- Pt came off for toxicity prior to any evaluation; NE- Not Evaluable; '+' indicates ongoing patient; * 3 patients had Unknown mutational status; NGS reports included MSK-IMPACT, MDA Molecular Diagnostic Lab, Foundation One, Oncopanel; Source: MA Dickinson, CTOS 2021*

Expanding Beyond PEComa

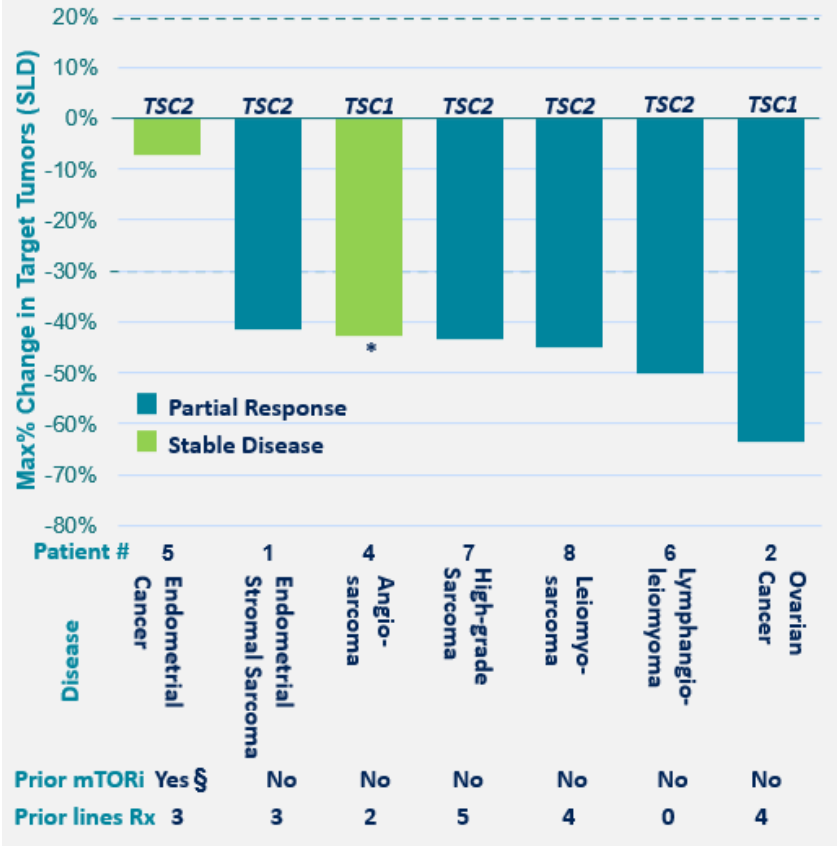
Early Experience Other Tumor Types with TSC1 or TSC2 Inactivating Alterations

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/m^2 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)

Efficacy

8 patients treated, 7 evaluable for response



Safety

- Treatment-emergent AEs (≥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/m^2 to 75 mg/m^2

ABI-009 is an investigational new drug and has not been approved for commercial distribution in the United States.

Source: MA Dickson. ASCO. 2021. Abstract # 3111

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

AMPECT PEComa Registrational Trial

PEComa Patients with *TSC1/TSC2* Alterations[1]

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

FYARRO Expanded Access Program

PEComa Patients with *TSC1/TSC2* Alterations Previously Treated with mTOR inhibitors[2]

- 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
- Response in 5/8 (63%)

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

Sources: 1) AJ Wagner et al., JCO. 2021 2) MA Dickson, CTOS. 2021. Abstract #1080984 3) MA Dickson. ASCO. 2021. Abstract # 3111

PRECISION 1: Registration Directed Tumor-Agnostic Trial of *nab*-sirolimus in *TSC1* or *TSC2* Inactivating Alterations

PRECISION1

- Two independently evaluable arms, one each for *TSC1* and *TSC2*
- Primary endpoint: ORR | Secondary endpoints: DOR, DCR
- Patient accrual based on local NGS results
- First patient dosed March 2022 with expected 24-month enrollment period
- Pre-planned interim analysis on 40 patients with appropriate follow-up expected late in 2023

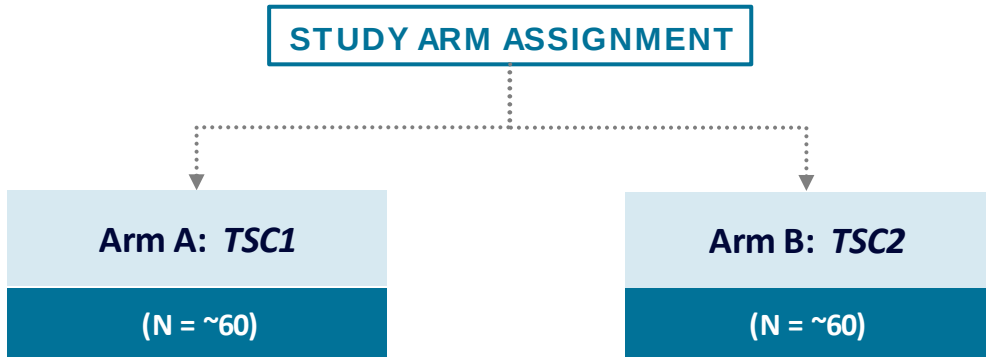
Trial Progress as of May 2023

- The trial is accruing evenly between the TSC1 and TSC2 arms
- More than 15 discreet tumor types enrolled with no more than three of any type
- No new safety signals

FOUNDATION MEDICINE TEMPUS The US Oncology Network

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



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On The Path To Becoming A Leading Precision Oncology Company

FYARRO Approval & Ongoing Tumor Agnostic Registration Directed Trial

PEComa

~100-300 US Patients/yr

Tumor Agnostic *TSC1 & TSC2* Alterations

~10,000 US Patients/yr

KRAS G12C mutant tumors

FYARRO + Krazati

FYARRO Global Expansion

New Assets

Q1 2022:
- Commercial-launch and infrastructure
- Tumor agnostic TSC1/2 registration directed trial initiation

2023:
- PRECISION 1 tumor agnostic TSC1/2 interim analysis on 40 patients expected late in the year
- FYARRO + Krazati combination study initiation

2024:
- Anticipated completion of PRECISION 1 trial

- Expected global launch of tumor agnostic TSC1/2 indication and any additional FYARRO indications, if approved
- Potential portfolio expansion with additional assets

Becoming a Commercial Precision Oncology Company

2022

Potential to Become a Multi-Indication, Precision Oncology Company

2023 - 2024

Potential to Become a Multi-Asset, Global Precision Oncology Company

2025+

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Aadi Bioscience, Inc.

Pacific Palisades, CA

NASDAQ: AADI

www.aadibio.com