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Investor Call on ASCO Findings
June 1, 2026
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# Forward-looking statements

This presentation contains forward-looking statements, including, but not limited to our statements related to our plans, objectives, and expectations (financial and otherwise), including with respect to the timeline for commercial availability of our MRD platform and indications and our Prosigna Breast Cancer Assay and key readouts; the timing for broader availability of Decipher Prostate for use in the metastatic population; expected completion of our IVD development and manufacturing work for our Decipher PCR and Prosigna NGS tests; enrollment in our studies and trials; our strategic focuses for the business; and our intentions with respect to our tests and products, for use in diagnosing and treating diseases, in and outside of the United States. Forward-looking statements can be identified by words such as: "appears," "anticipate," "intend," "plan," "expect," "believe," "should," "may," "could," "would," "will," "enable," "positioned," "offers," "designed," "look forward," "vision," "strategic," "on track," "progress," "outlook," "guidance," "forecast," "target," "goal" and similar references to future periods. Actual results may differ materially from those projected or suggested in any forward-looking statements. These statements involve risks and uncertainties, which could cause actual results to differ materially from our predictions, and include, but are not limited to: our ability to launch, commercialize and receive reimbursement for our products; our ability to execute on our business strategies relating to the C2i Genomics acquisition, integration of the business and the realization of expected benefits and synergies; our ability to demonstrate the validity and utility of our genomic tests and biopharma and other offerings; our ability to continue executing on our business plan; our ability to continue to scale our global operations and enhance our internal control environment; the impact of the war in Ukraine, and other regional conflicts, on European economies; the impact of foreign currency fluctuations, volatile interest rates, inflation, the impact of legislation and policies enacted by the current U.S. administration; turmoil in the global banking and finance system; the ongoing conflict in the Middle East and the performance and utility of our tests in the clinical environment. Additional factors that may impact these forward-looking statements can be found under the caption "Risk Factors" in our Annual Report on Form 10-K filed on February 26, 2026, as well as in other documents that we may file from time to time with the Securities and Exchange Commission. Copies of these documents, when available, may be found in the Investors section of our website at investor.veracyte.com. These forward-looking statements speak only as of the date hereof and, except as required by law, we specifically disclaim any obligation to update these forward-looking statements or reasons why actual results might differ, whether as a result of new information, future events or otherwise.

This presentation also contains information gathered from market research, estimates and other statistical data made by independent parties and by us relating to addressable market size 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.

# Practice-changing evidence demonstrating how our tests can guide treatment decisions

Prosigna

## Predictive evidence in early-stage breast cancer

### OPTIMA

Abstract title: “First results from the OPTIMA phase III randomized non-inferiority trial of test-directed chemotherapy in patients with high clinical risk ER-positive HER2-negative early breast cancer.”

Decipher

## Predictive evidence in metastatic prostate cancer

### ENZAMET

Abstract title: “Assessment of the ability of Decipher Prostate Genomic Classifier (DGC) >0.85 to identify patients who benefit from adding docetaxel (DOC) to Androgen Deprivation Therapy (ADT) plus enzalutamide (ENZ): Level 1B evidence from the ENZAMET study.”

# Today's participants

**Marc Stapley**
Chief Executive Officer, Veracyte

**Iain Macpherson, Ph.D.** Principal Investigator of OPTIMA
Professor of Breast Oncology at the University of Glasgow

**John Leite, Ph.D.**
Chief Commercial Officer, Veracyte

**Phil Febbo, M.D.**
Chief Scientific Officer & Chief Medical Officer, Veracyte

**Rebecca Chambers**
Chief Financial Officer, Veracyte

# OPTIMA Prelim supported the selection of the Prosigna test for the Phase III OPTIMA trial

**OPTIMA Prelim served as a head-to-head comparison**
evaluating the performance of the Prosigna test and other genomic tests in patients with high-risk breast cancer.

**The Prosigna test had higher prognostic accuracy in high-risk patients**
compared to the test that was initially used to assign patients to treatment groups, as demonstrated in the positive 10-year clinical outcomes[1].

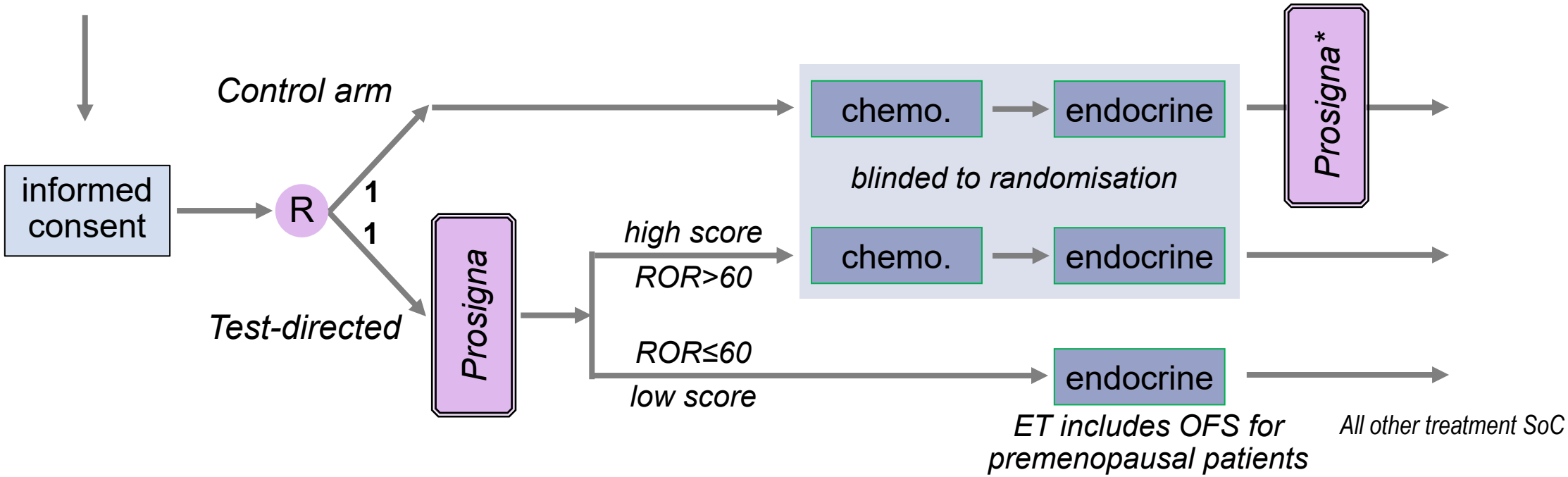
**The Prosigna test identified 22% of patients as having a high risk of recurrence (ROR)**
after they had initially been classified as low-risk. These patients did not receive chemotherapy and went on to have adverse outcomes.


1. Presented at the 2025 ESMO Breast Cancer Annual Congress

# OPTIMA design

**Main eligibility criteria**

- Women & men age ≥40 with excised breast cancer
- ER-pos (IHC>10%) & HER2-neg
- Nodes: ▸0-9N+,
  ▸minimum T-size requirement if N0/ N1mi
- Neoadjuvant chemotherapy prohibited




*Control arm Prosigna testing used for analysis only. U.K. control arm testing performed following recruitment completion

# Statistical design

## Primary outcome: Invasive Breast Cancer Free Survival (IBCFS) endpoint

Local / regional / distant relapse; second primary breast cancer; death from any cause

Does not include new, non-breast cancers

## Primary analysis: per-protocol population – minimum follow-up of one year

Non-inferiority hypothesis – 3% absolute non-inferiority margin for IBCFS

83% power at one-sided 5% significance assuming 87.5% five-year IBCFS in control arm for primary analysis

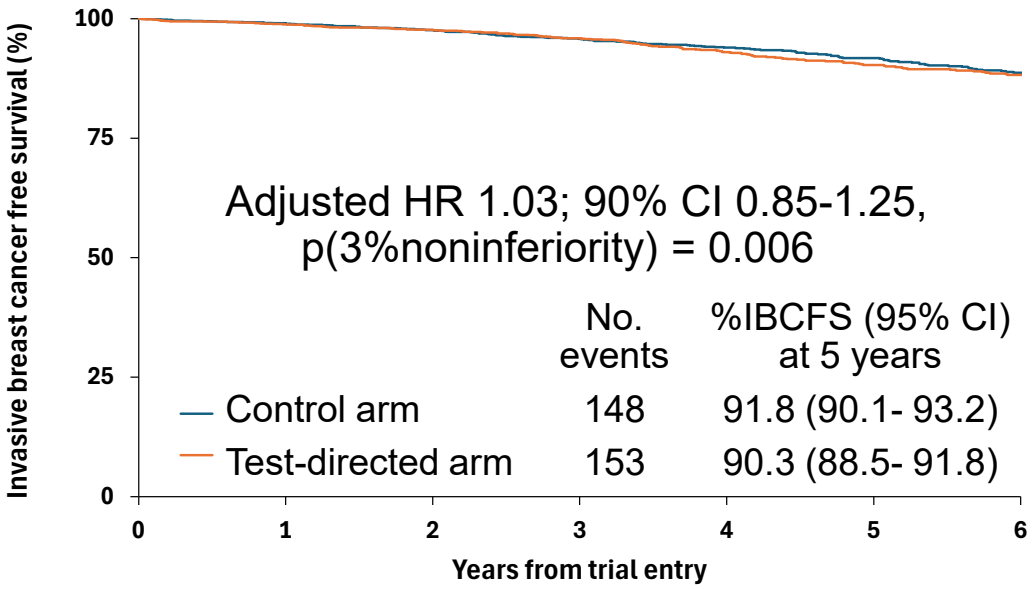
## Key secondary analysis: performed in per-protocol population with tumor Prosigna ROR ≤60

Non-inferiority hypothesis – absolute 3.5% non-inferiority margin for IBCFS

Defines clinical utility

# Invasive Breast Cancer Free Survival

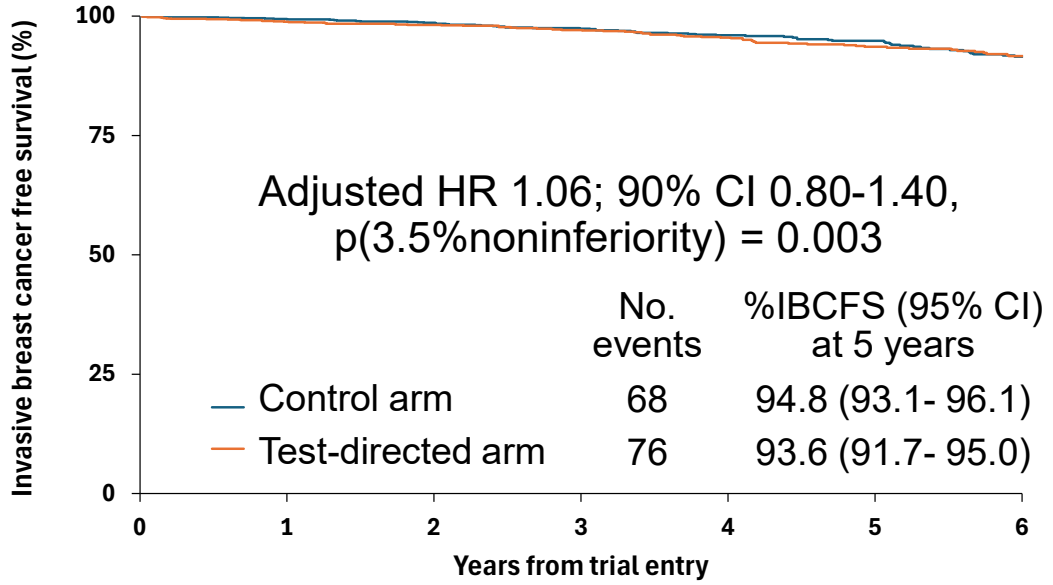
## Complete Per Protocol population




| Number at risk: | | | | | | | |
|---|---|---|---|---|---|---|---|
| Control | 2059 | 1818 | 1563 | 1283 | 999 | 741 | 485 |
| Test-directed | 2094 | 1857 | 1591 | 1303 | 989 | 724 | 481 |

Demonstrated non-inferiority limit = 2%

## ROR ≤60 subpopulation

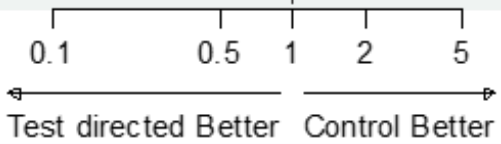



| Number at risk: | | | | | | | |
|---|---|---|---|---|---|---|---|
| Control | 1358 | 1207 | 1043 | 862 | 672 | 504 | 337 |
| Test-directed | 1421 | 1257 | 1086 | 905 | 694 | 503 | 342 |

Demonstrated non-inferiority limit = 2%

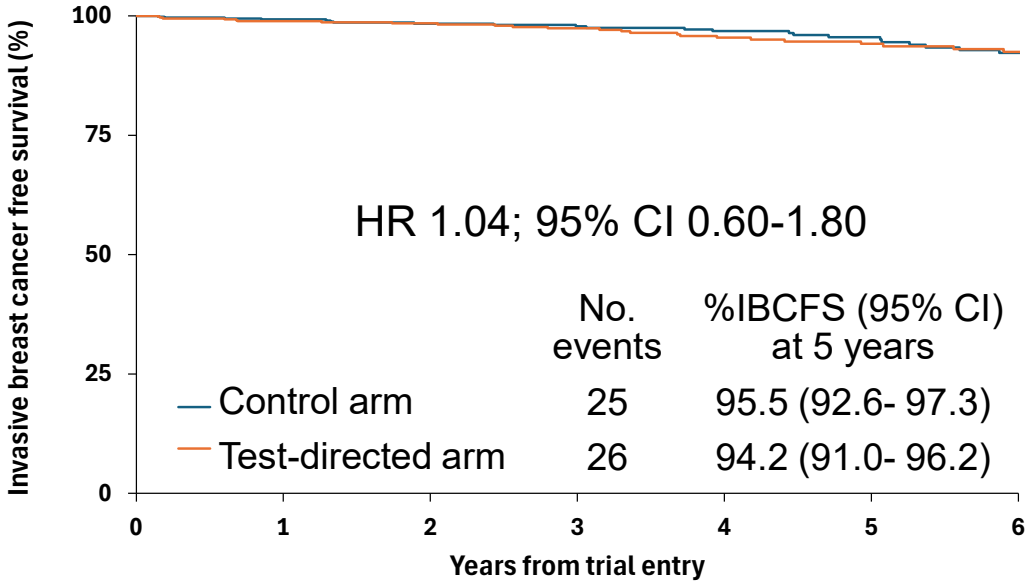
# **Subgroup analysis:** low ROR score population

| Subgroup | Test directed | Control | HR (95% CI) |
|---|---|---|---|
| | *No. of events/No. of patients* | | |
| Overall | 76/1421 | 68/1358 | 1.06 (0.77 to 1.48) |
| Menopausal status | | | |
| Pre-menopausal | 26/559 | 25/561 | 1.04 (0.60 to 1.80) |
| Post-menopausal | 50/858 | 42/791 | 1.14 (0.76 to 1.71) |
| Grade | | | |
| 1 or 2 | 60/1184 | 48/1126 | 1.22 (0.84 to 1.78) |
| 3 | 16/237 | 20/232 | 0.78 (0.40 to 1.50) |
| Tumour size | | | |
| <=30mm | 39/809 | 28/770 | 1.30 (0.81 to 2.10) |
| >30mm | 37/612 | 40/588 | 0.93 (0.60 to 1.46) |
| Nodal status | | | |
| pN1(+/-sn) | 56/1063 | 48/1015 | 1.11 (0.76 to 1.64) |
| pN2 | 20/268 | 17/243 | 1.19 (0.62 to 2.29) |
| Intended Chemotherapy | | | |
| Anthracycline containing | 6/176 | 6/163 | 0.89 (0.29 to 2.76) |
| Taxane containing | 5/163 | 5/142 | 1.05 (0.30 to 3.65) |
| Anthracycline+Taxane | 65/1082 | 57/1053 | 1.12 (0.79 to 1.60) |



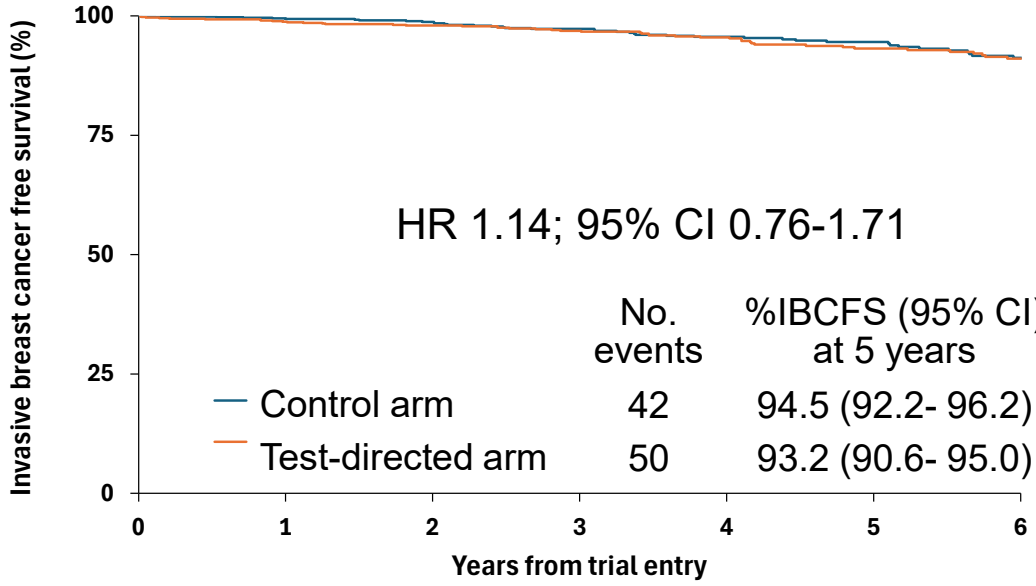
# **IBCFS vs menopausal status:** low ROR score population

## Premenopausal




| Number at risk: | | | | | | | |
|---|---|---|---|---|---|---|---|
| Control | 561 | 481 | 409 | 338 | 258 | 200 | 140 |
| Test-directed | 559 | 487 | 410 | 347 | 256 | 195 | 135 |

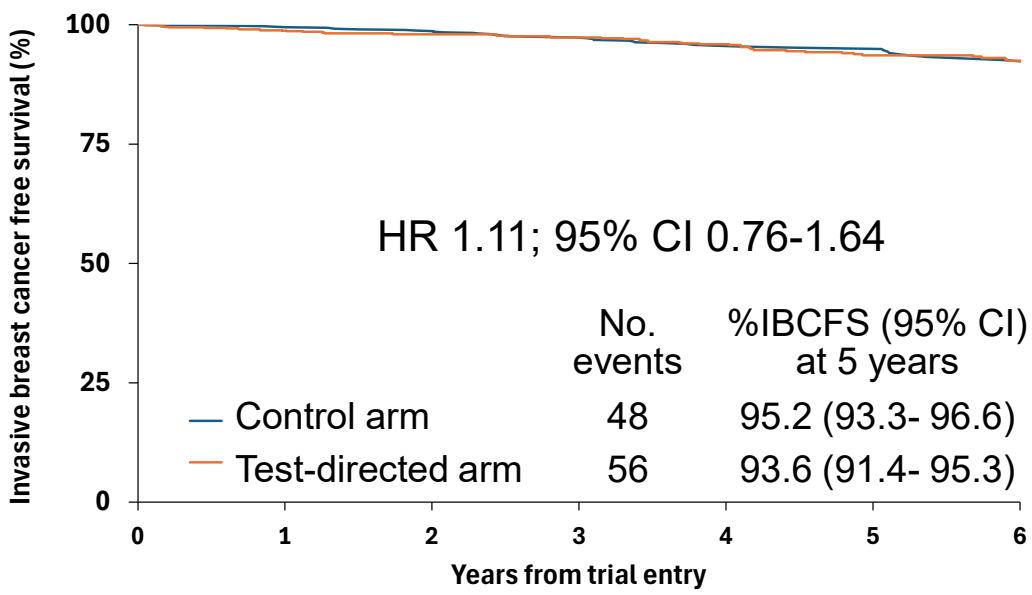
## Postmenopausal




| Number at risk: | | | | | | | |
|---|---|---|---|---|---|---|---|
| Control | 791 | 721 | 631 | 522 | 414 | 304 | 197 |
| Test-directed | 858 | 766 | 673 | 556 | 437 | 307 | 207 |

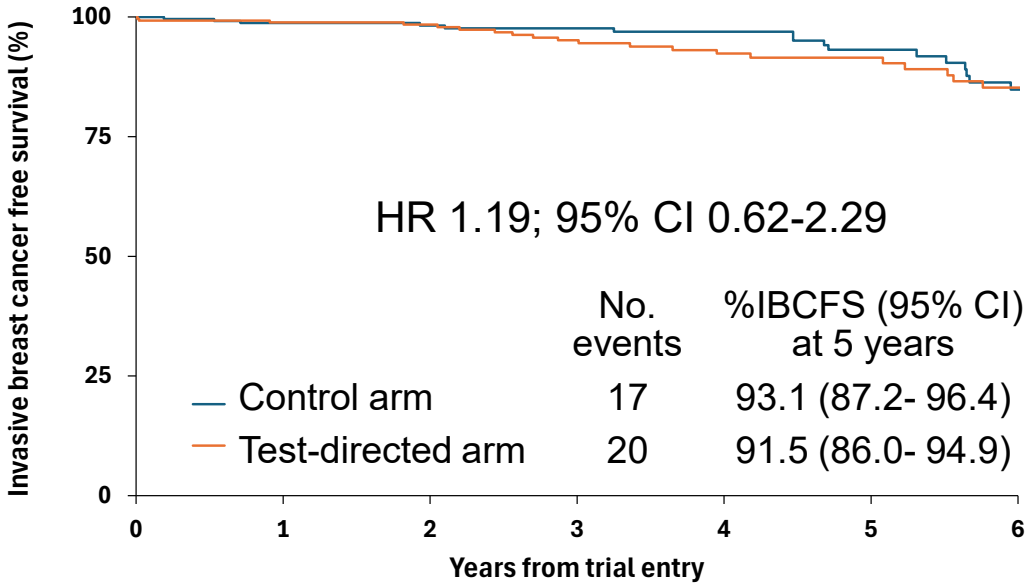
# **IBCFS vs nodal status:** low ROR score population

## 1-3 involved nodes




| Number at risk: | | | | | | | |
|---|---|---|---|---|---|---|---|
| Control | 1015 | 914 | 798 | 651 | 499 | 382 | 264 |
| Test-directed | 1063 | 953 | 829 | 700 | 539 | 389 | 270 |

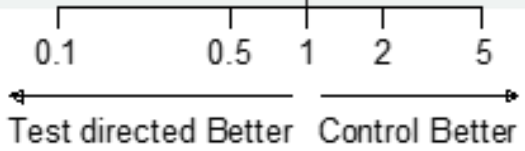
## 4-9 involved nodes




| Number at risk: | | | | | | | |
|---|---|---|---|---|---|---|---|
| Control | 243 | 214 | 181 | 155 | 125 | 84 | 48 |
| Test-directed | 269 | 232 | 197 | 158 | 118 | 86 | 49 |

# **IBCFS vs stage prognostic groups:** low ROR score population

| Subgroup | Test directed | Control | HR (95% CI) |
|---|---|---|---|
| | *No. of events/No. of patients* | | |
| Overall | 76/1421 | 68/1358 | 1.06 (0.77 to 1.48) |
| Tumor stage | | | |
| IIA | 14/412 | 10/399 | 1.39 (0.62 to 3.09) |
| IIB | 35/585 | 33/550 | 1.04 (0.65 to 1.68) |
| IIIA | 27/414 | 23/389 | 1.11 (0.64 to 1.93) |



# Conclusions

## Chemotherapy can be safely avoided for many patients

The Prosigna test identified that more than two thirds of high-risk node-positive patients, who previously would have received chemotherapy, could safely forgo it entirely without compromising outcomes or increasing recurrence risk.

## Robust results across high-risk subgroups

Molecular biology, not clinical factors alone, should guide chemotherapy decisions for premenopausal women treated with ovarian function suppression and patients with extensive nodal involvement (4–9 positive nodes).

## Highest level of clinical evidence

OPTIMA provides Level 1A prospective evidence by Simon Hayes criteria showing that the Prosigna test can accurately predict chemotherapy benefit and guide safe de-escalation across patient populations.

# Prosigna will uniquely benefit from insights learned from the OPTIMA trial due to discordant results with other tests

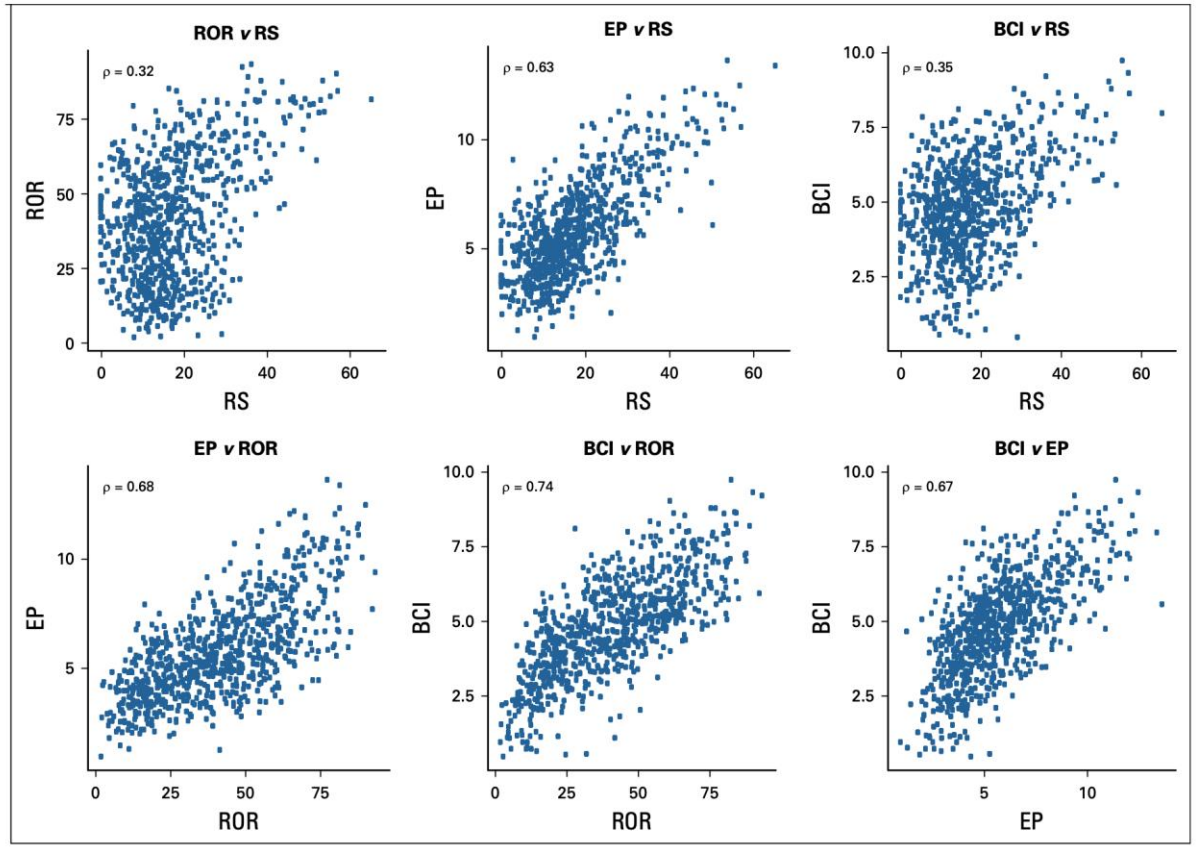



**FIG 2.** Scatter plots and Spearman's ρ correlation coefficients of the Recurrence Score (RS), Risk of Recurrence (ROR), EndoPredict (EP), and Breast Cancer Index (BCI) molecular scores in TransATAC.

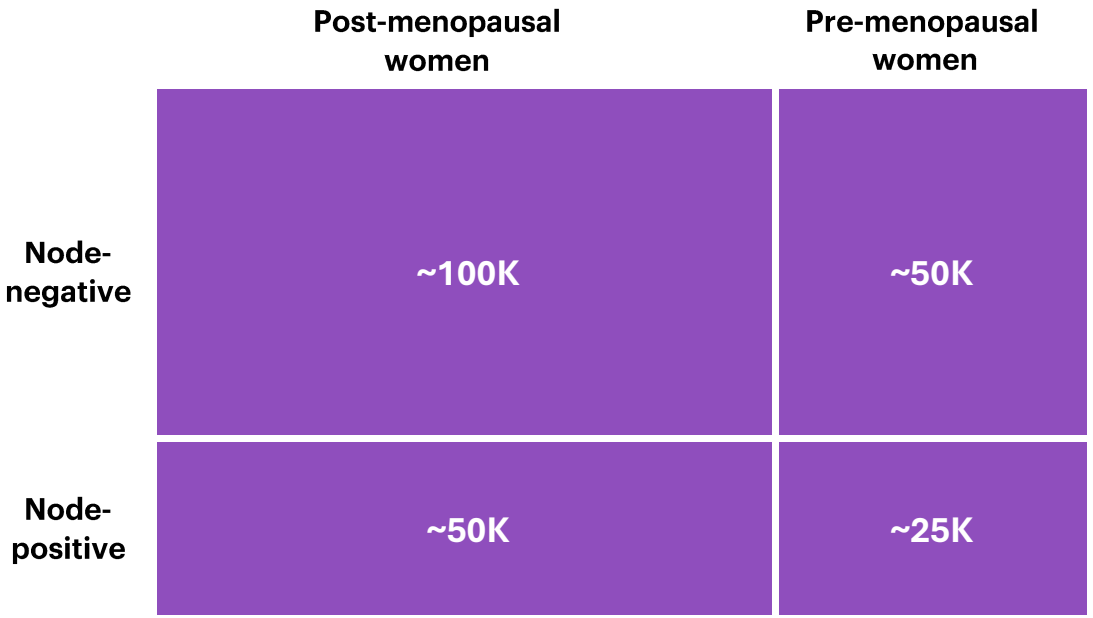
**TransATAC Study**

Journal of Clinical Oncology®



Richard Buus et al.; Molecular Drivers of Oncotype DX, Prosigna, EndoPredict, and the Breast Cancer Index: A TransATAC Study. *J Clin Oncol* 39, 126-135(2021).

# OPTIMA supports Prosigna-directed chemotherapy decisions in broadest high-risk population to-date




**~225,000 patients diagnosed annually**[1]
with early-stage hormone receptor positive disease and
**all are eligible and appropriate for Prosigna testing**

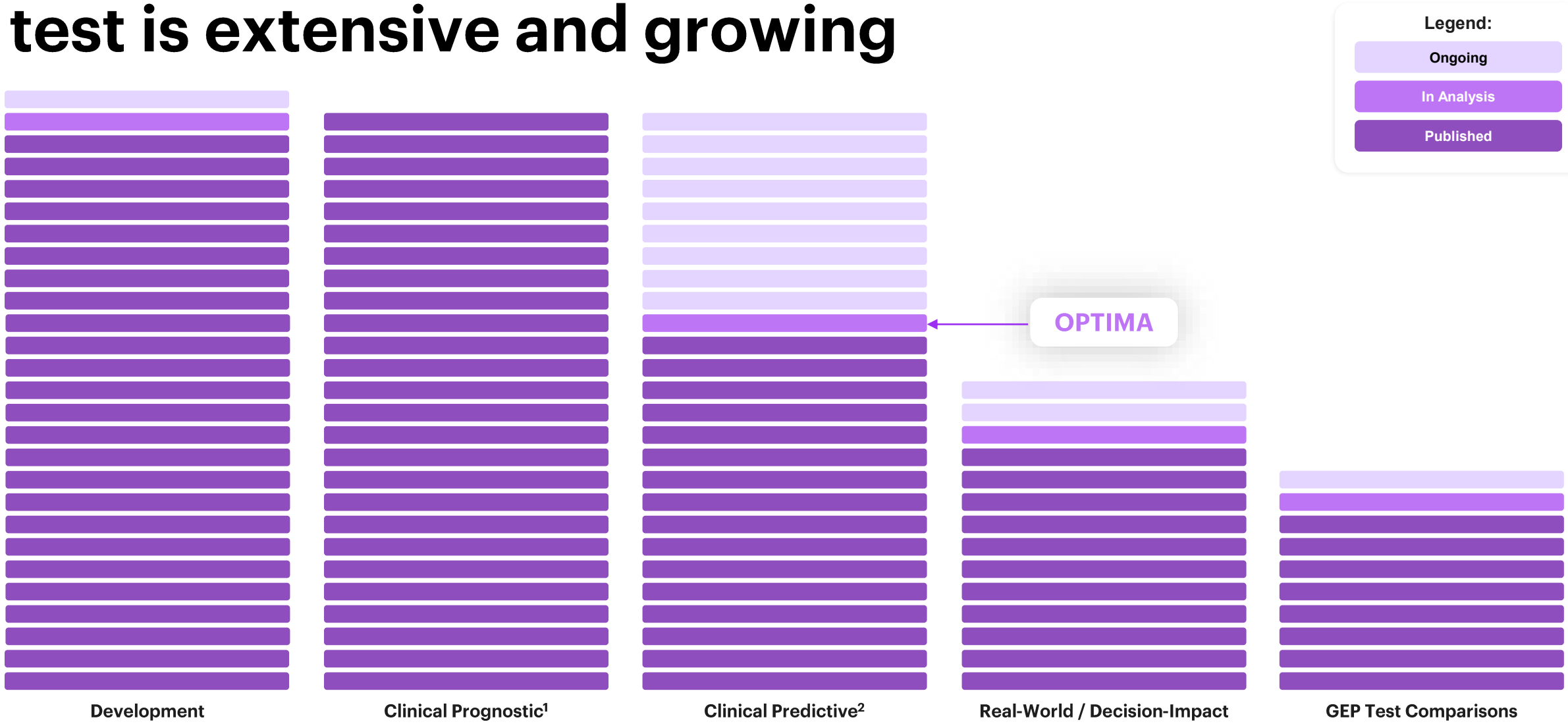
The Prosigna test is the **only test to predict chemotherapy benefit** regardless of menopausal status and for patients with up to 9 positive nodes

Prior studies demonstrate that the Prosigna test **delivers greater prognostic accuracy** than other assays, **including in the node-negative population**

**Prosigna LDT will launch commercially on June 8, 2026**

1. Company estimates based on breastcancer.org estimate of ~317,000 women in the US that were diagnosed with breast cancer in 2025 & komen.org estimate that about 70% to 80% of newly diagnosed breast cancers are HR+

# Clinical evidence supporting the Prosigna test is extensive and growing




1. Demonstrates that PAM50 or the Prosigna test can predict recurrence.
2. Demonstrates that PAM50 or the Prosigna test can identify a subset of patients that have a higher probability of responding to a particular therapy.

# ENZAMET study provides Level 1B evidence for Decipher in metastatic prostate cancer

International, randomized Phase III study conducted by the Australian and New Zealand Urogenital and Prostate Trials Group (ANZUP)

Pre-specified biomarker analysis using the Decipher Prostate test in 634 patients with a median follow-up of 5.6 years

| | |
|---|---|
| **Low Decipher score (≤0.85)** | Patients with lower Decipher scores showed no benefit from adding chemotherapy, suggesting it can be safely avoided. |
| **High Decipher score (>0.85)** | Patients with higher Decipher scores who received triplet therapy had significantly improved five-year overall survival compared to those on standard hormonal therapy alone.<br><br>These patients had more aggressive disease features, yet achieved comparable survival to lower-risk patients on doublet therapy. |

Decipher

# ENZAMET study expands the Decipher evidence base for high-risk and metastatic prostate cancer into triplet therapy

## STAMPEDE & CHAARTED

Predicting chemotherapy benefit when added to ADT

## ENZAMET

Predicting chemotherapy benefit when added to standard hormonal therapy (ADT + enzalutamide)

Of the ~334K[1] patients diagnosed with prostate cancer each year, **~30K[2] patients have metastatic disease**

**Decipher Prostate is validated across the full disease continuum,** from active surveillance through metastatic disease, including triplet therapy

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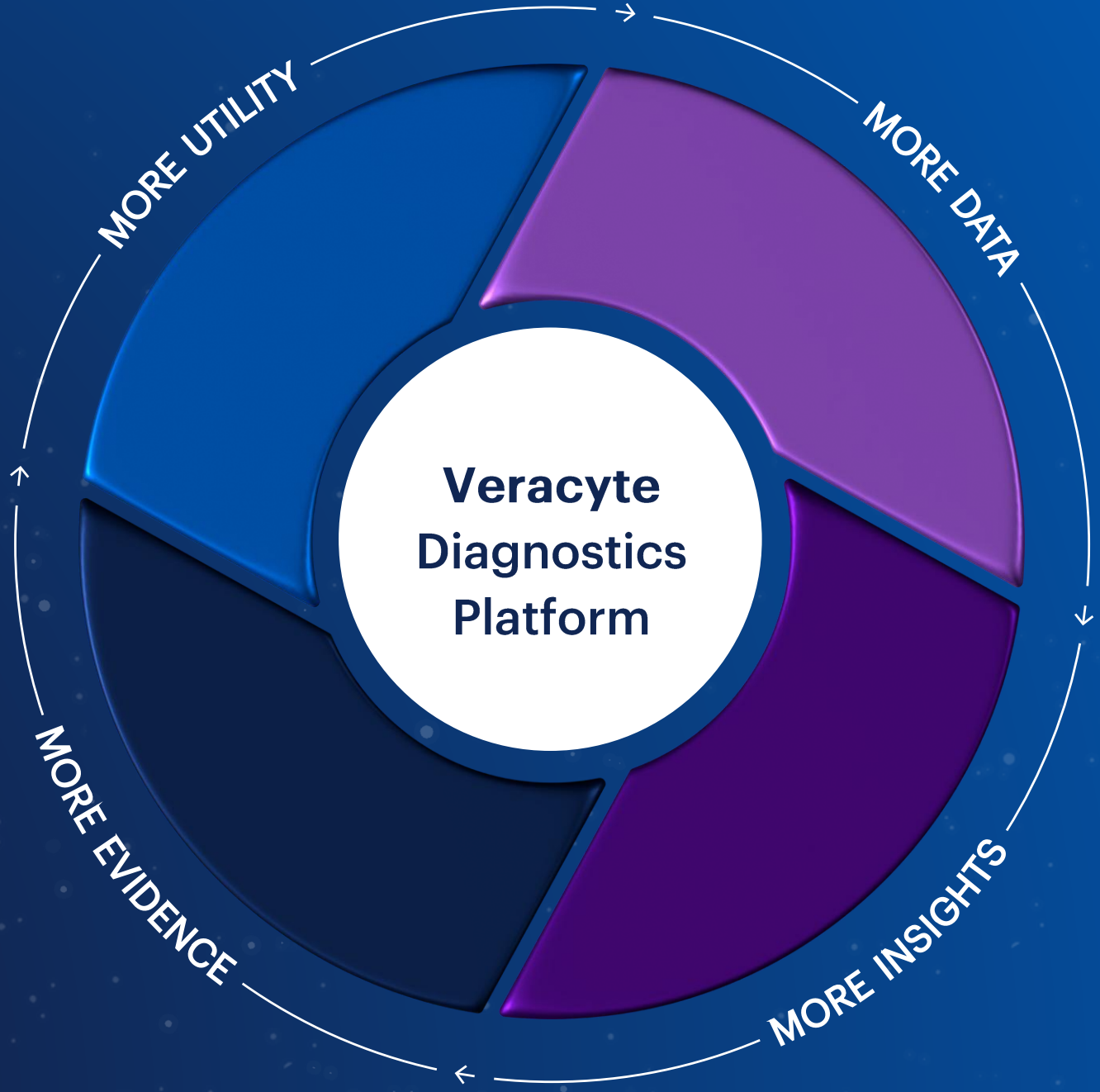
1. https://www.cancer.org/cancer/types/prostate-cancer/about/key-statistics.html
2. https://www.cdc.gov/united-states-cancer-statistics/publications/prostate-cancer.html

# A novel platform for growth

Broad genomic assays, expansive clinical data, and robust evidence generation



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