



To innovate the future of cancer care to cure
patients and preserve organ function



March 24, 2025

aura

Legal disclosure

This presentation contains forward-looking statements, all of which are qualified in their entirety by this cautionary statement. Many of the forward-looking statements contained herein can be identified by the use of forward-looking words such as "may", "anticipate", "believe", "could", "expect", "should", "plan", "intend", "estimate", "will", "potential" and "ongoing", among others, although not all forward-looking statements contain these identifying words. These forward-looking statements include statements about the initiation, timing, progress, results and cost of our research and development programs and our current and future preclinical studies and clinical trials, including statements regarding the timing of initiation and completion of studies or trials and related preparatory work, the period during which the results of the trials will become available and our research and development programs; statements regarding our expectations for an improved quality of life of patients after treatment with bel-sar and changes to the treatment paradigm for patients; statements regarding our beliefs and expectations for the high unmet medical need for an effective local treatment in urologic oncology to preserve organ function; and the size and growth potential of the markets for our product candidates and our ability to serve those markets.

Except as otherwise noted, these forward-looking statements speak only as of the date of this presentation, and we undertake no obligation to update or revise any of such statements to reflect events or circumstances occurring after this presentation. Because forward-looking statements are inherently subject to risks and uncertainties, some of which cannot be predicted or quantified and some of which are beyond our control, you should not rely on these forward-looking statements as predictions of future events. For a discussion of these and other risks and uncertainties, and other important factors, any of which could cause our actual results to differ from those contained in the forward-looking statements, see the section entitled "Risk Factors" in our most recent Annual Report on Form 10-K and Quarterly Report on Form 10-Q filed with the Securities and Exchange Commission (SEC), as well as discussions of potential risks, uncertainties, and other important factors in our other subsequent filings with the SEC, which are available on the SEC's website at www.sec.gov. The events and circumstances reflected in our forward-looking statements may not be achieved or occur and actual results could differ materially from those projected in the forward-looking statements. We caution you not to place undue reliance on the forward-looking statements contained in this presentation.

This presentation discusses product candidates that are under preclinical or clinical evaluation and that have not yet been approved for marketing by the U.S. Food and Drug Administration (FDA) or any other regulatory authority. Until finalized in a clinical study report, clinical trial data presented herein remain subject to adjustment as a result of clinical site audits and other review processes. No representation is made as to the safety or effectiveness of these product candidates for the use for which such product candidates are being studied.

This presentation shall not constitute an offer to sell or the solicitation of an offer to buy, nor shall there be any sale of these securities in any state or other jurisdiction in which such offer, solicitation or sale would be unlawful prior to registration or qualification under the securities laws of any such state or other jurisdiction.

Urologic oncology key opinion leaders participating on today's call



Jennifer Linehan, MD

St. John's Cancer Institute



Neal Shore, MD, FACS

Carolina Urologic
Research Center



Gary Steinberg, MD, FACS

RUSH University

Aura leadership participating on today's call



Sabine Brookman-May, MD

SVP, Therapeutic Area Head
Urologic Oncology



Elisabet de los Pinos, PhD

Founder and CEO



Jill Hopkins, MD

Chief Medical Officer
And President of R&D



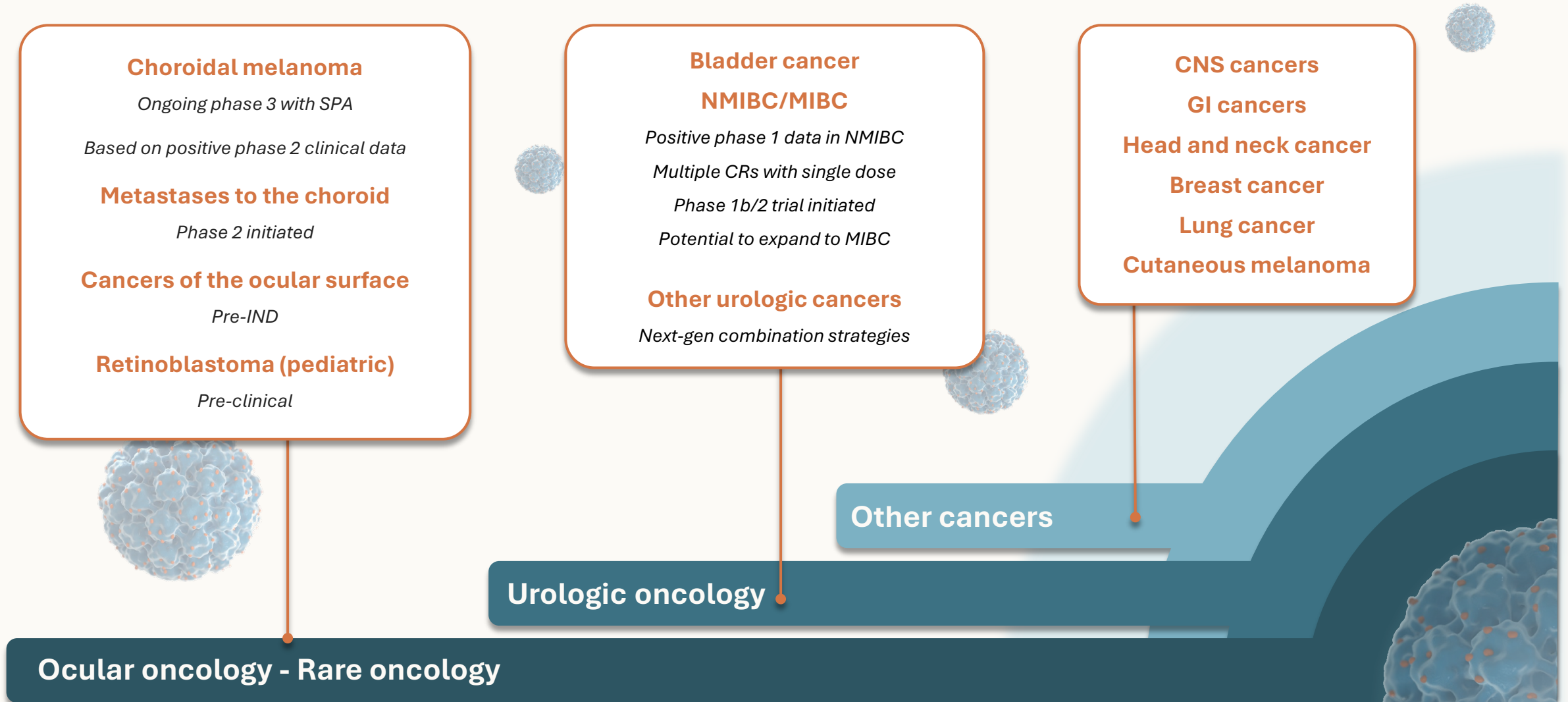
Joseph McQuaid, MD

Executive Medical Director,
Clinical Development



Bel-sar seeks to **redefine** the treatment
of bladder cancer with a novel and
disruptive approach

Bel-sar's unique platform technology is potentially applicable across multiple cancers



Bladder cancer: High unmet medical need for function-preserving organ-sparing therapies

9th most common cancer worldwide¹

>600,000
cases/year globally¹

614,298 diagnosed in 2022¹
(>7% increase from 2020)^{1,2}

Ranked 13th for mortality¹

One of the highest lifetime treatment costs of all cancers

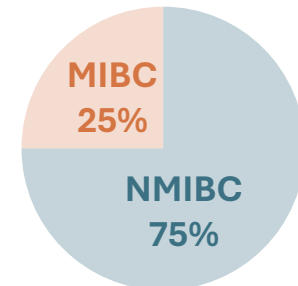
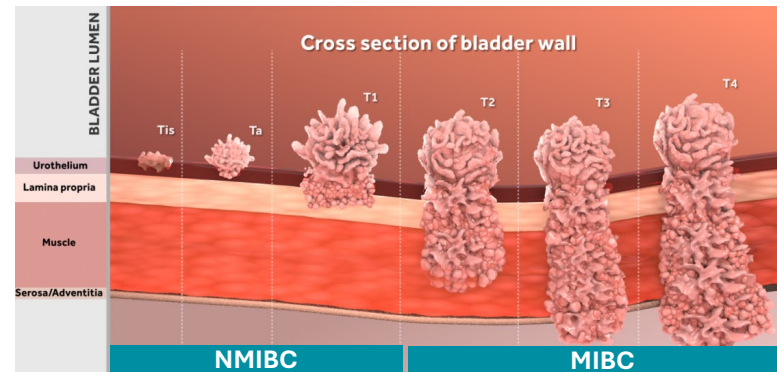
>\$6 billion
Annual cost of treatment in US⁵

Conventional bladder cancer treatments are suboptimal

- Short- and long-term side effects
- Considerable impact on QoL
- Inadequate efficacy
- Multiple TURBT surgeries
- Disease progression/metastasis
- Loss of bladder/cystectomy

84% of patients do not complete a full course of BCG treatment⁶

Patients are receiving fewer courses of BCG due to global shortage⁷



The majority of bladder cancer patients present with NMIBC³

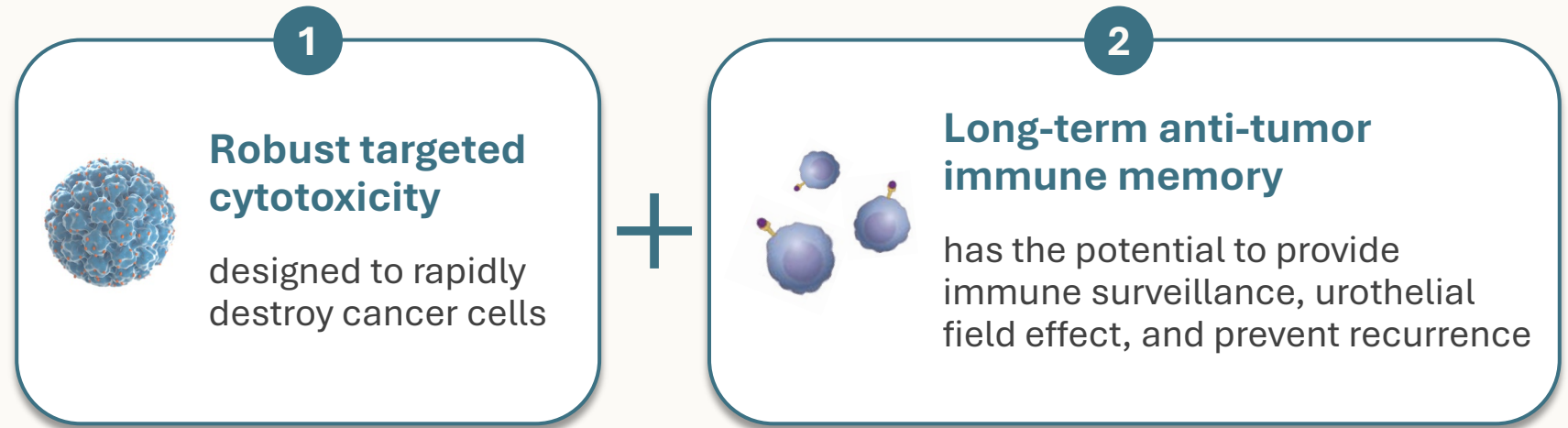


~70-80% of patients with NMIBC develop recurrence after treatment⁸

1. GLOBOCAN 2022. Bladder. Available at: <https://gco.iarc.who.int/media/globocan/factsheets/cancers/30-bladder-fact-sheet.pdf>. [Accessed October 1, 2024]. 2. Sung H, et al. *CA Cancer J Clin*. 2021;71(3):209–49. 3. Burger M, et al. *Eur Urol*. 2013;63(2):234–41. 4. Flaig TW, et al. *J Natl Compr Canc Netw*. 2018;16(9):1041–53. 5. Clark O, et al. *Pharmacoecon Open*. 2024 Aug 18. doi: 10.1007/s41669-024-00512-8. [Online ahead of print]. 6. Lamm DL, et al. *J Urol*. 2000;163(4):1124–9. 7. Shore ND, et al. *Urol Oncol*. 39(10):642–63. 8. Shalata AT, et al. *Cancers (Basel)*. 2022;14(20):5019. BCG, Bacillus Calmette-Guerin; MIBC, muscle-invasive bladder cancer; NMIBC, non-muscle-invasive bladder cancer; QoL, quality of life; TURBT, transurethral resection of bladder tumor.

Bel-sar has an innovative dual MoA

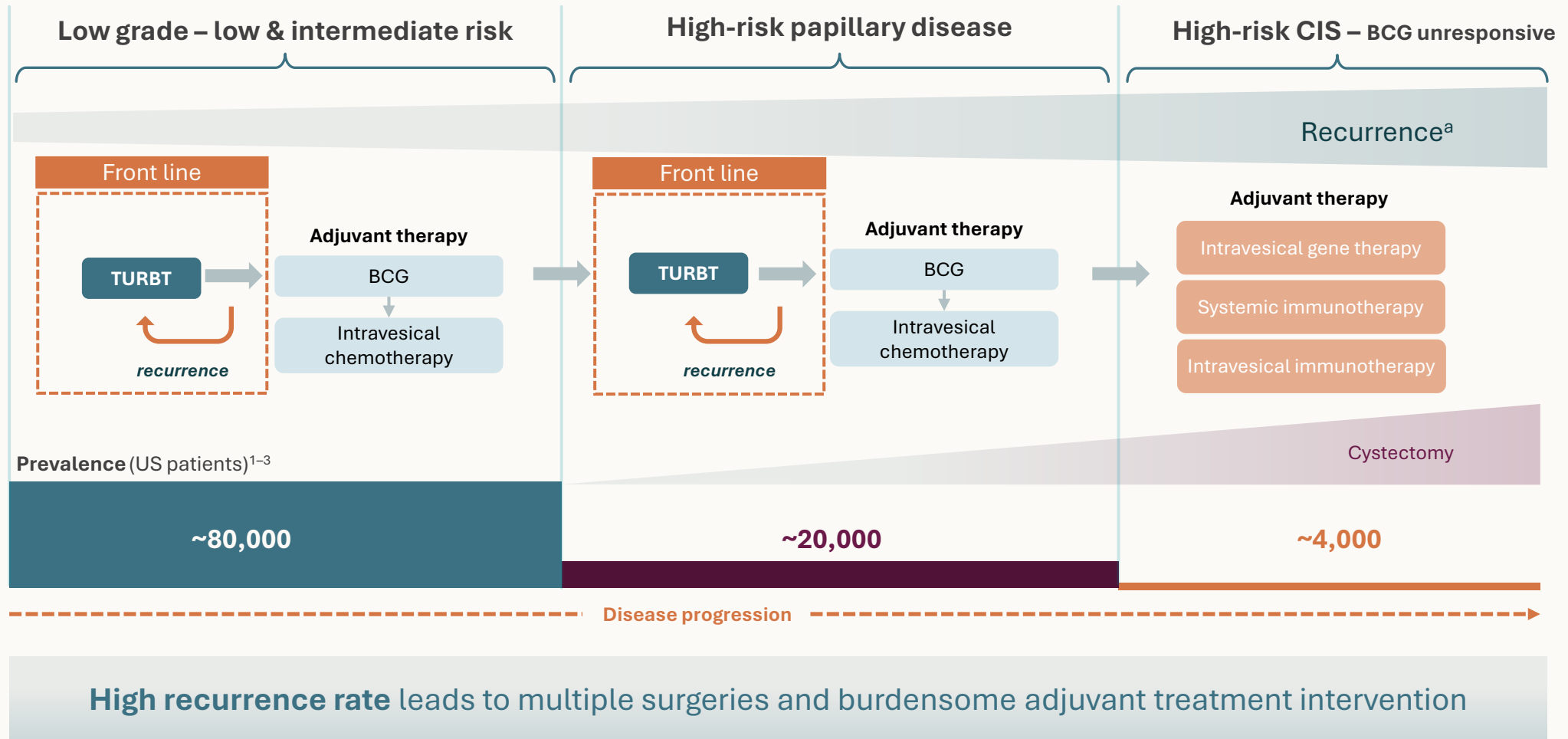
Bel-sar is designed to increase bladder preservation while reducing risk of recurrence and treatment burden



Immune ablation offers an effective front-line therapy, leveraging the immune system to fight cancer at an early stage

- +** **Focal administration** treats the tumor, not the entire urothelium
- +** **No need for general anesthesia** – administration is aligned with current urology office practice
- +** **Procedure is brief (<15 min for both injection and activation) and familiar to urologists**, using standard cystoscopy needles and common technique for laser application

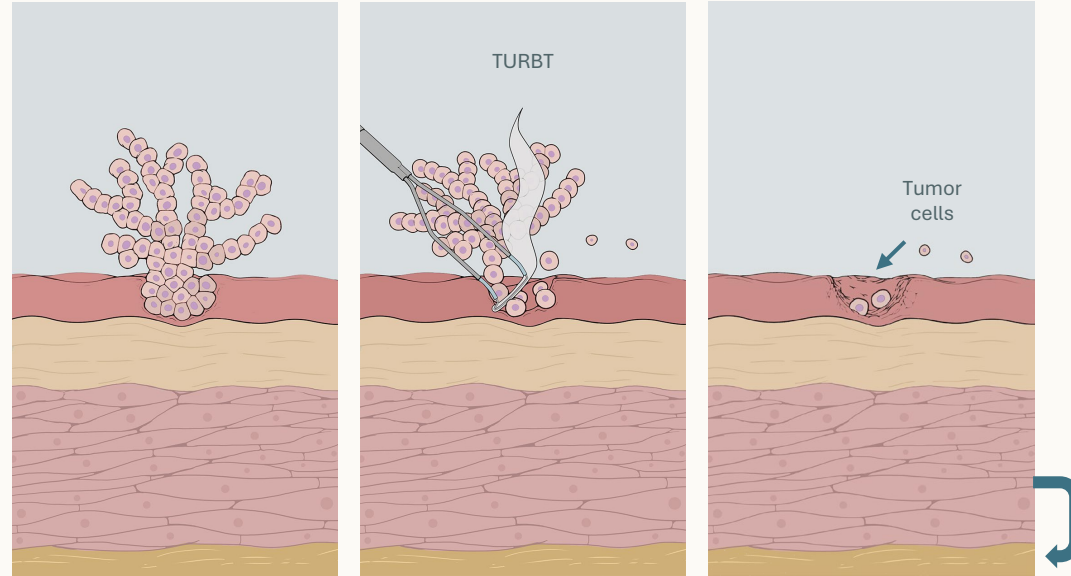
Current treatment paradigm based on upfront resection leads to recurrence



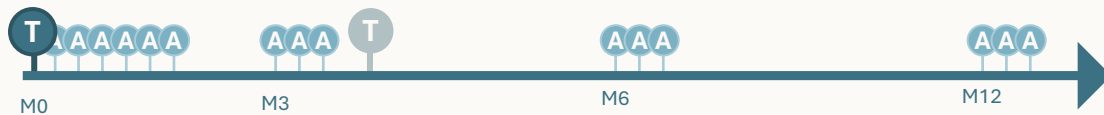
^a42–84% of low-grade IR patients develop recurrence.^{4,5} 1. Holzbeierlein JM et al. *J Urol*. 2024;212(1):3–10. 2. Holzbeierlein JM et al. *J Urol*. 2024 Apr;211(4):533–58. 3. Internal Aura epidemiology of market size; data on file. 4. Shalata AT, et al. *Cancers (Basel)*. 2022;14(20):5019. 5. van Rhijn BWG, et al. *Eur Urol*. 2009;56(3):430–42. **BCG**, Bacillus Calmette-Guérin; **CIS**, carcinoma in situ; **TURBT**, transurethral resection of bladder tumor.

Bel-sar shifts the treatment paradigm from resection-based to immune-ablative front-line treatment

Current SoC: TURBT + adjuvant treatment



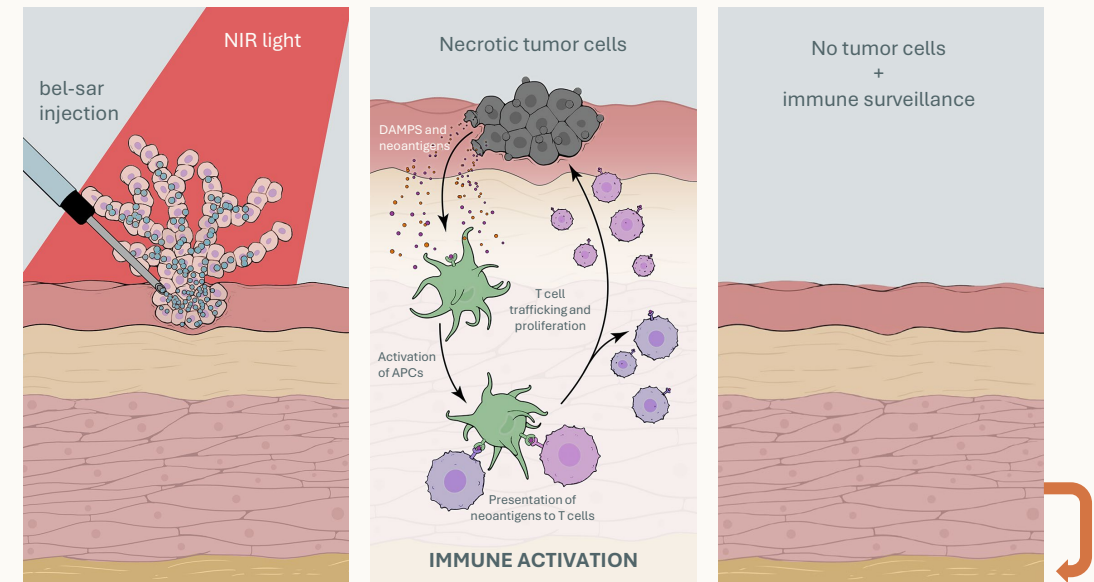
TURBT followed by multiple adjuvant treatments (maintenance for up to 12 months or longer)



High treatment burden (potential multiple surgeries)

High risk of recurrence

Bel-sar has an immune-mediated MoA



Direct tumor cell killing + long-term anti-tumor immunity

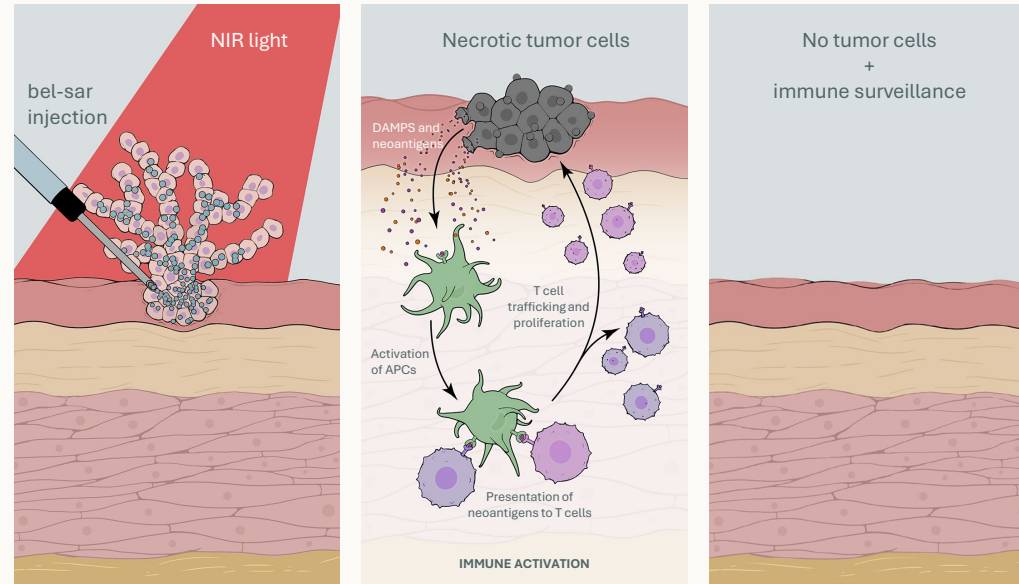


Anti-tumor immunity has the potential to provide immune surveillance and long-term protection

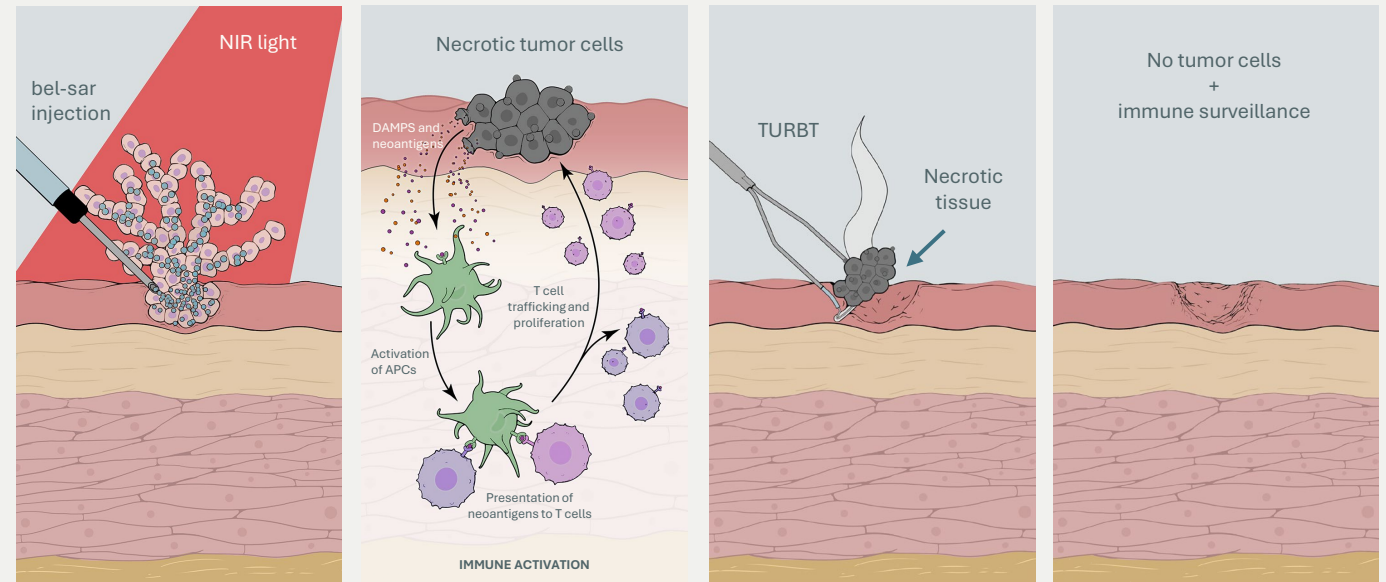
Bel-sar has potential as a standalone immune-ablative treatment or as a neoadjuvant to TURBT

Immune-ablative approach could eliminate the need for TURBT, or be used prior to resection to improve treatment outcomes

1
Immune-ablative treatment without TURBT
(LR/IR NMIBC)

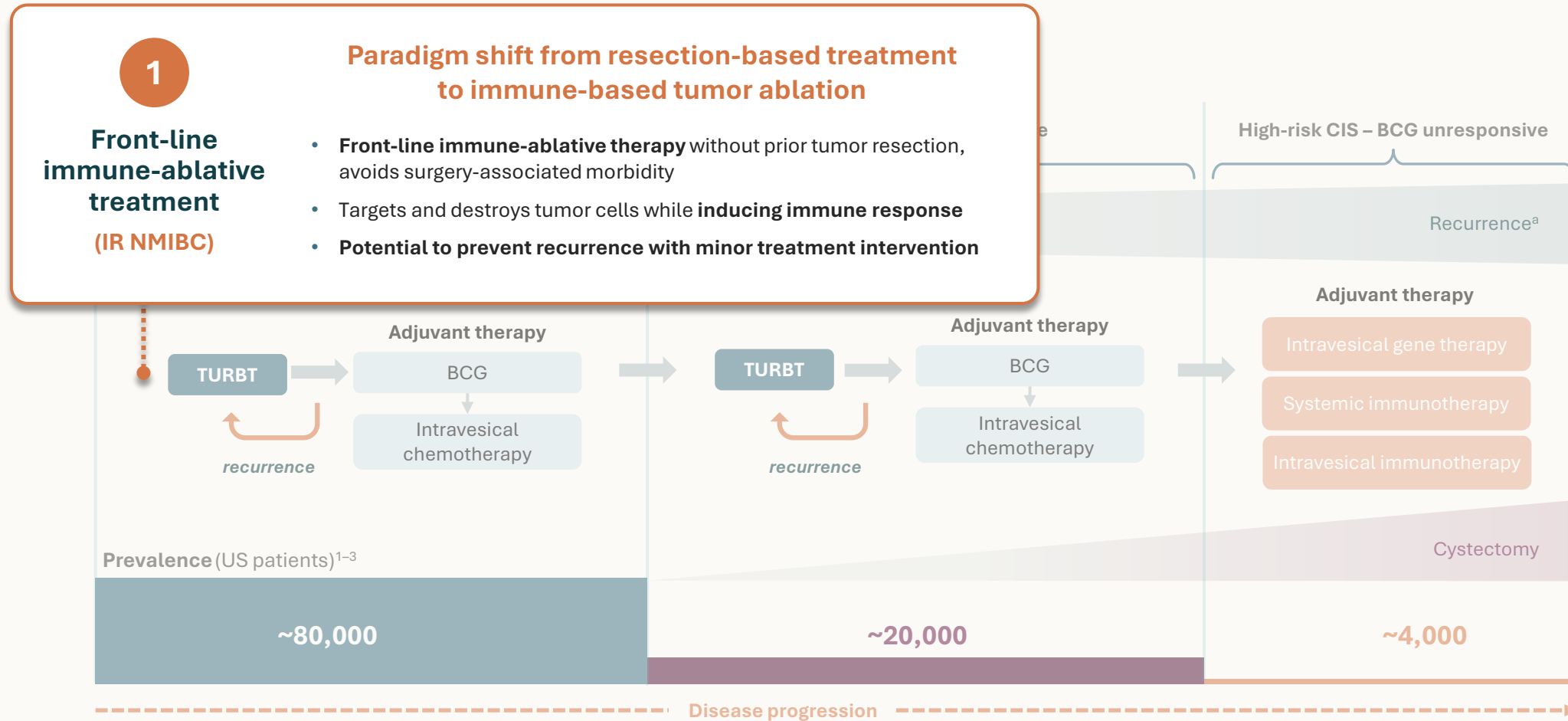


2
Neoadjuvant/multimodal therapy followed by TURBT
(IR/HR NMIBC)



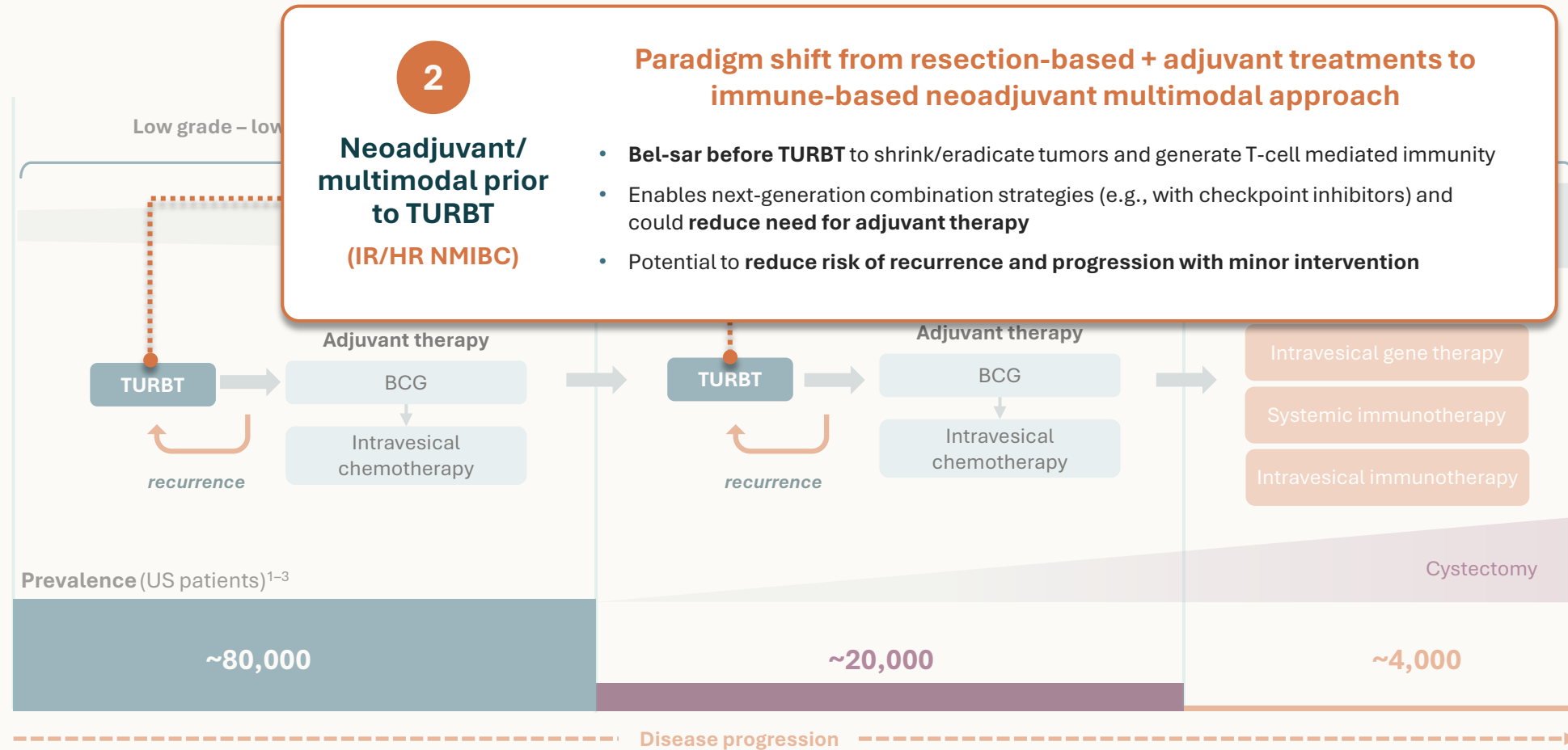
APC, antigen-presenting cell; bel-sar, belzupacap sarotalocan; DAMPs, damage-associated molecular patterns; HR, high-risk; IR, intermediate risk; LR, low-risk; NIR, near-infrared; NMIBC, non-muscle-invasive bladder cancer; TURBT, transurethral resection of bladder tumor.

Bel-sar has the potential to transform the disease trajectory for intermediate-risk patients



^a42–84% of low-grade IR patients develop recurrence.^{4,5} 1. Holzbeierlein JM et al. *J Urol.* 2024;212(1):3–10. 2. Holzbeierlein JM et al. *J Urol.* 2024 Apr;211(4):533–58. 3. Internal Aura epidemiology of market size; data on file. 4. Shalata AT, et al. *Cancers (Basel).* 2022;14(20):5019. 5. van Rhijn BWG, et al. *Eur Urol.* 2009;56(3):430–42. **bel-sar**, belzupacap sarotalocan; **BCG**, Bacillus Calmette-Guérin; **CIS**, carcinoma in situ; **IR**, intermediate risk; **NMIBC**, non-muscle-invasive bladder cancer; **TURBT**, transurethral resection of bladder tumor.

Bel-sar has the potential to **transform the disease trajectory** for **high-risk patients**



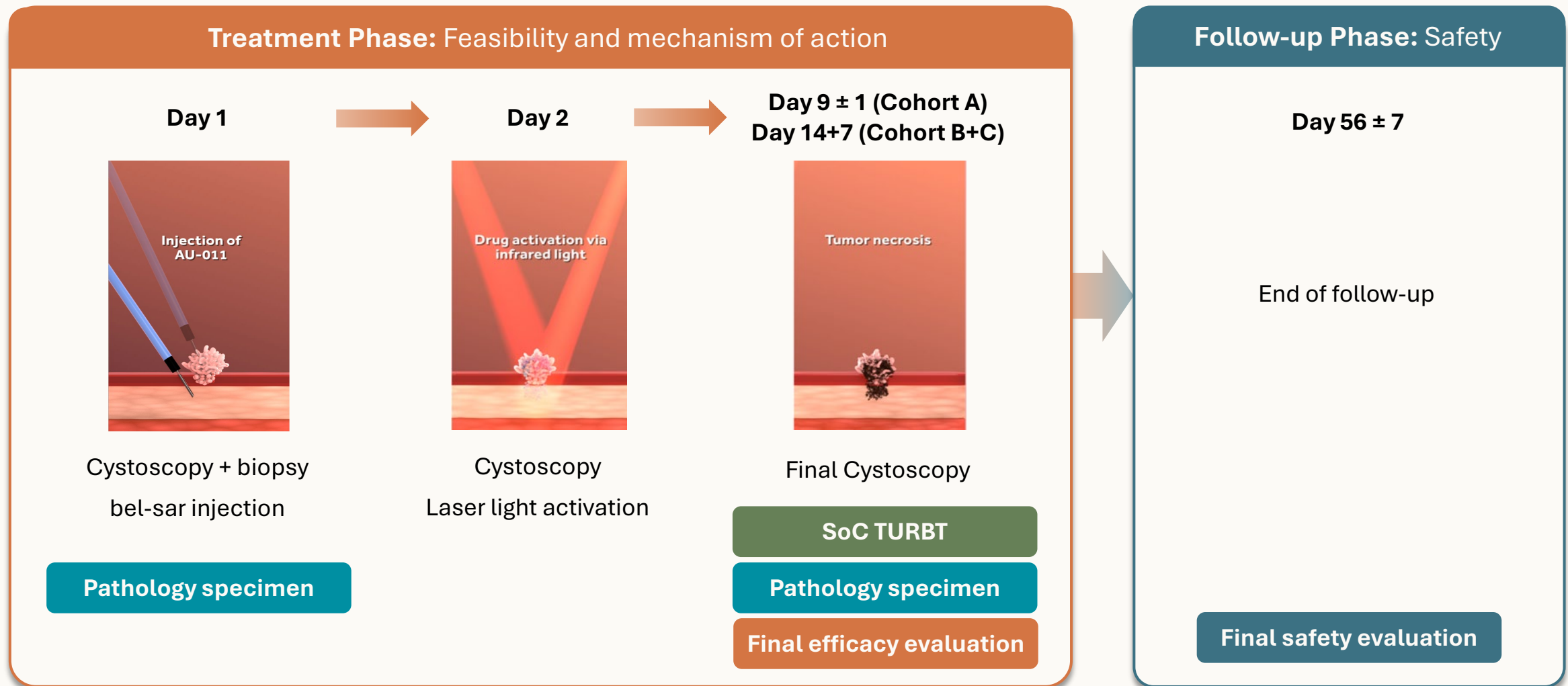
42–84% of low-grade IR patients develop recurrence.^{4,5} **1.** Holzbeierlein JM et al. *J Urol.* 2024;212(1):3–10. **2.** Holzbeierlein JM et al. *J Urol.* 2024 Apr;211(4):533–58. **3.** Internal Aura epidemiology of market size; data on file. **4.** Shalata AT, et al. *Cancers (Basel).* 2022;14(20):5019. **5.** van Rhijn BWG, et al. *Eur Urol.* 2009;56(3):430–42. **bel-sar**, belzupacap sarotalocan; **BCG**, Bacillus Calmette-Guérin; **CIS**, carcinoma in situ; **HR**, high risk; **IR**, intermediate risk; **NMIBC**, non-muscle-invasive bladder cancer; **TURBT**, transurethral resection of bladder tumor.

Phase 1 trial of bel-sar in bladder cancer

Phase 1 data

Bel-sar is administered before scheduled biopsy and standard of care (SoC) TURBT

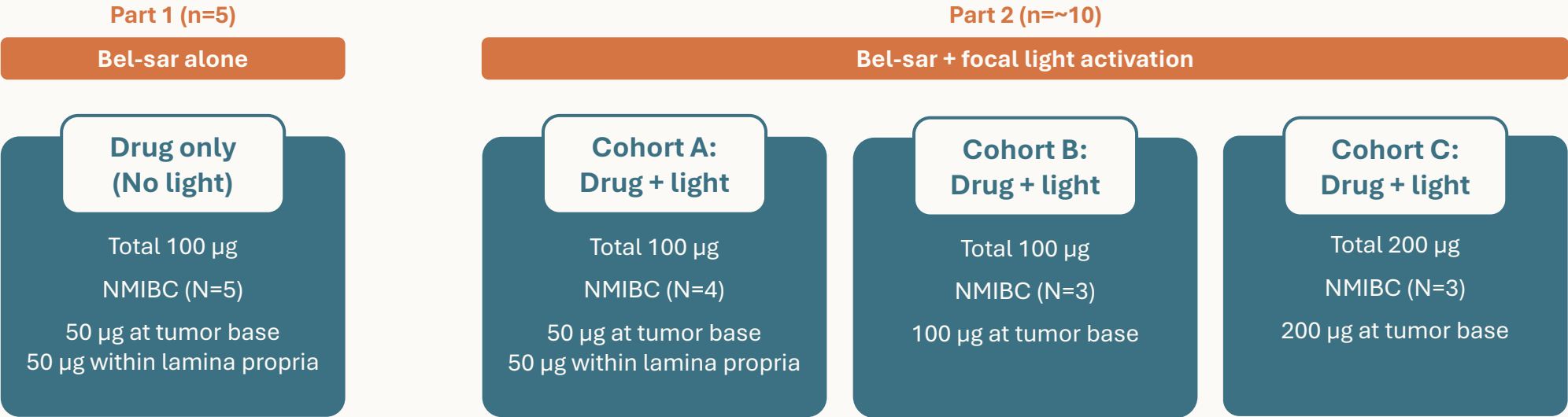
Clinical response data up to 21 days; safety data up to 56 days



Phase 1 trial of bel-sar for bladder cancer designed to evaluate safety, feasibility, and mechanism of action

Single dose window of opportunity study in NMIBC all-comers

Histopathological assessment completed at time of standard of care TURBT



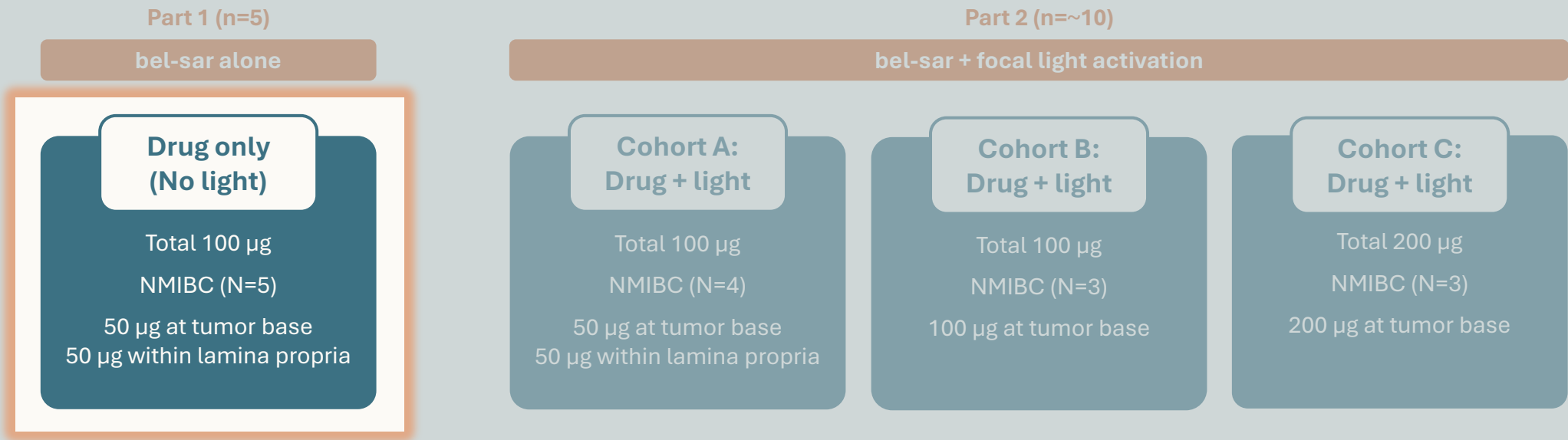
Safety Review Board completed after each cohort. Patients followed for safety after TURBT to 56 days.

Study objectives	Safety & dose-limiting toxicity	Feasibility of technique	Focal distribution of bel-sar	Focal necrosis	Markers of immune activation
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Phase 1 trial of bel-sar for bladder cancer designed to evaluate safety, feasibility, and mechanism of action

Single dose window of opportunity study in NMIBC all-comers

Histopathological assessment completed at time of standard of care TURBT



Safety Review Board completed after each cohort. Patients followed for safety after TURBT to 56 days.

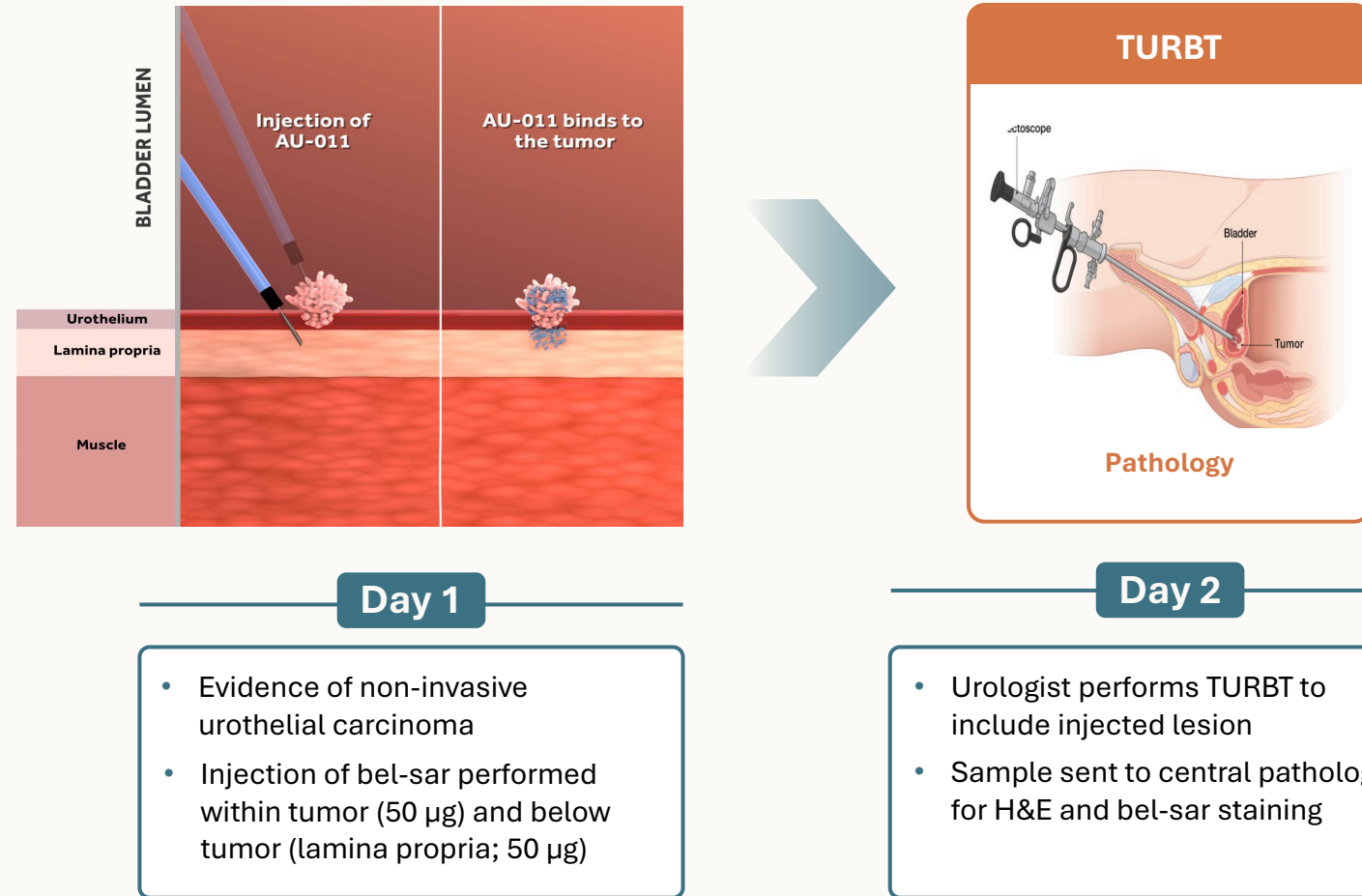
Study objectives	Safety & dose-limiting toxicity	Feasibility of technique	Focal distribution of bel-sar	Focal necrosis	Markers of immune activation
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Drug only: Treatment schedule

Total dose: 100 µg

- 50 µg into base of tumor
- 50 µg into lamina propria

Drug only without light activation (n=5)



Drug only (no light activation):

First in human in bladder –
safety cohort as required
by FDA

No signs of clinical activity
in the absence of light
activation as anticipated

Drug only without light activation (n=5)

Safety Data

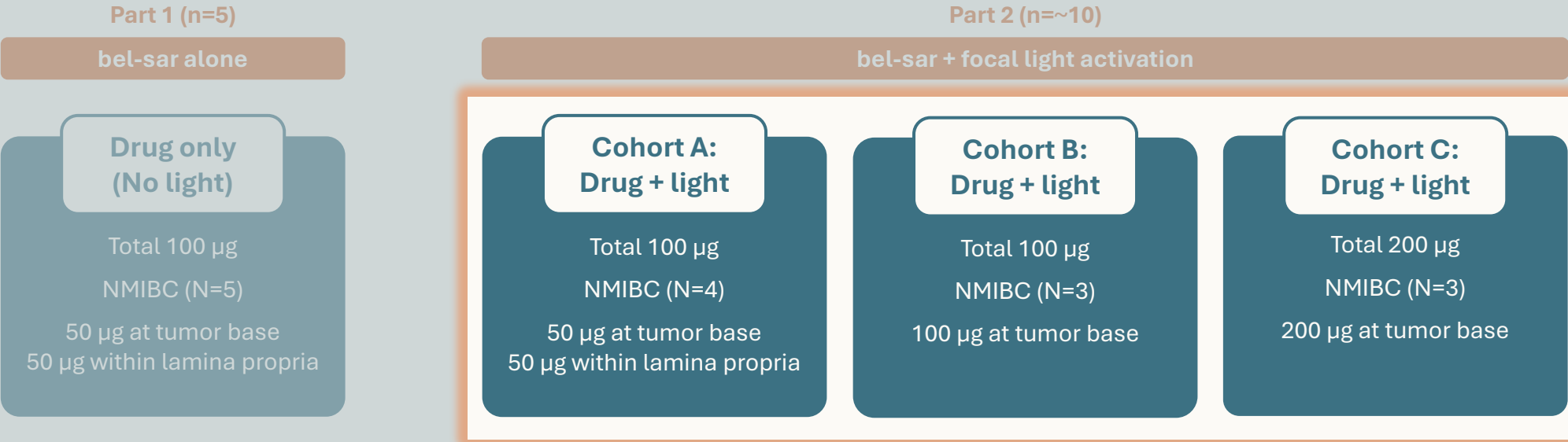
Event	Grade	Number of patients
Adverse events (related to study drug)		
None	None	0/5
Adverse events (related to injection or laser procedure)		
Hematuria	1	1/5

- No treatment emergent adverse events related to study drug
- No serious adverse events
- No dose limiting toxicities

Phase 1 trial of bel-sar for bladder cancer designed to evaluate safety, feasibility, and mechanism of action

Single dose window of opportunity study in NMIBC all-comers

Histopathological assessment completed at time of standard of care TURBT



Safety Review Board completed after each cohort. Patients followed for safety after TURBT to 56 days.

Study objectives	Safety & dose-limiting toxicity	Feasibility of technique	Focal distribution of bel-sar	Focal necrosis	Markers of immune activation
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Cohorts A–C: Single-dose drug with light activation

Treatment schedule

Cohort A:

- 50 µg into base of tumor
- 50 µg into lamina propria

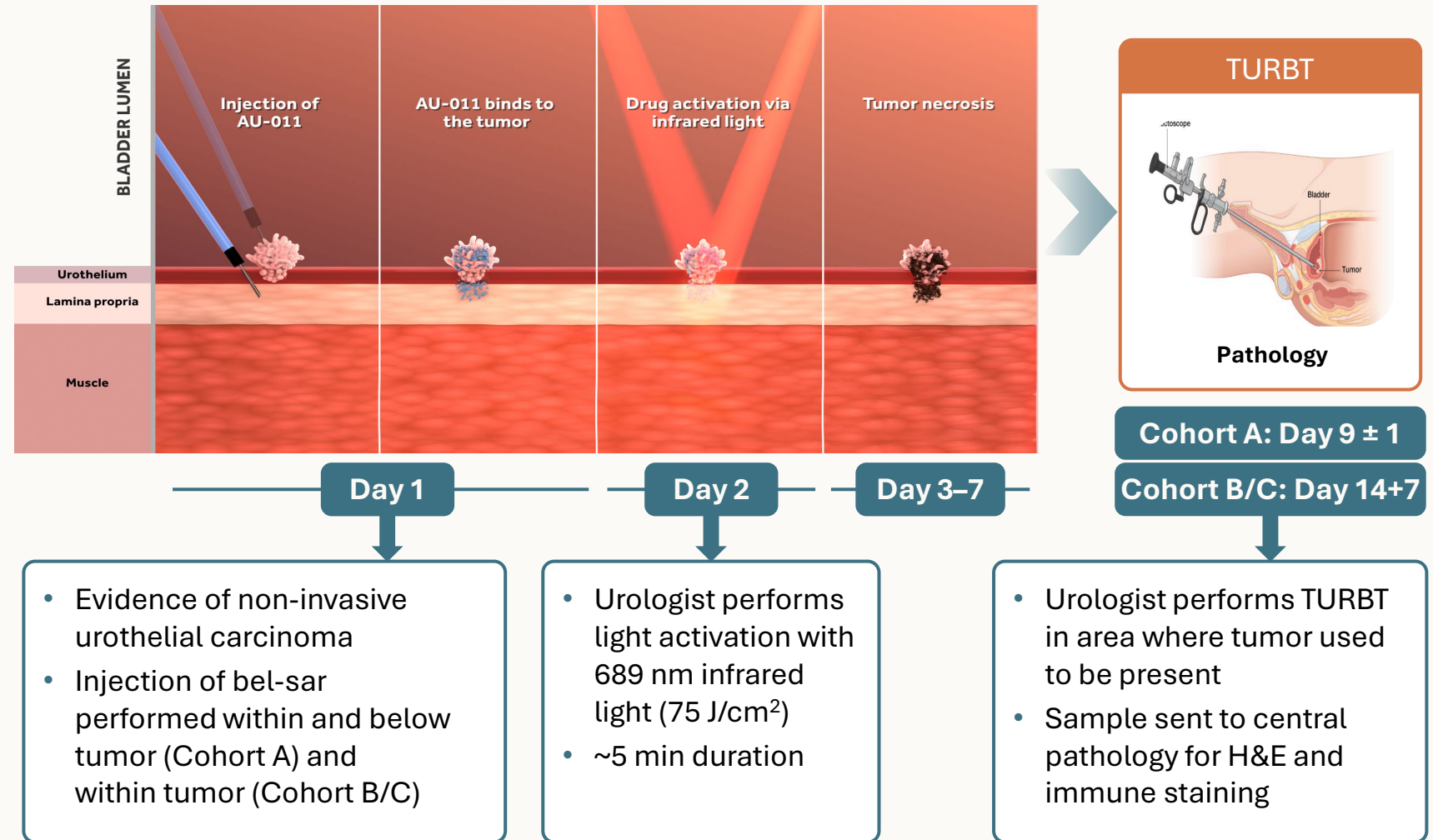
Cohort B:

- 100 µg into base of tumor

Cohort C:

- 200 µg into base of tumor

Cohort A–C: Single-dose drug with light activation (n~10)



Cohort A-C: Single-dose drug with light activation

Safety data

- No serious adverse events
- No dose limiting toxicities

Cohort A-C: Single-dose drug with light activation (n=11)^a

Event	Grade	Number of patients
Adverse events (related to study drug)		
Nocturia	1	1/11
Urinary urgency	1	1/11
Adverse events (related to injection or laser procedure)		
Hematuria	1	1/11
Urinary blood clots	1	1/11
Nocturia	1	1/11
Urinary urgency	1	1/11
Dysuria	1	1/11

Favorable safety profile

- <10% of patients experienced Grade 1 TEAEs related to study drug
- No grade 2/3 adverse events related to study drug (n=16)

^aCompiled safety data includes all completed light-activated cohorts (A, B, and C), including one patient treated but not efficacy evaluable. Data cutoff date of March 3, 2025.
TEAE, treatment-emergent adverse event.
Clinicaltrials.gov identifier: NCT05483868; bel-sar-102.

Efficacy data: Ta intermediate-risk NMIBC

Cohorts A–C (single-dose drug with light activation)

4/5 patients demonstrated CR; 5/5 patients with immune response in target tumor

	Patient A1	Patient A3	Patient A4 ^c	Patient B2	Patient C1 ^d
Screening diagnosis	Multiple (TURBT) Ta low-grade	Multiple Ta low-grade	Multiple Ta low-grade Prior Ta high-grade	Multiple Ta low-grade	Multiple Ta low-grade
Screening AUA risk classification	Intermediate (TURBT) ^f	Intermediate	Intermediate	Intermediate	Intermediate
AU-011 dose/delivery	100 µg IT/IM	100 µg IT/IM	100 µg IT/IM	100 µg IT	200 µg IT
Clinical complete response: Target tumor ^a	✓	✓	✓	-	✓
Clinical complete response: Non-target tumor ^a (bladder urothelial field effect ^b)	2/2	1/2	1/1	0/1	0/1
Immune response ^e : Target tumor	✓	✓	✓	✓	✓
Immune response ^e : Non-target tumor	✓	✓	✓	✓	✓
Necrosis	✓	✓	✓	-	-
Visual changes on cystoscopy	✓	✓	-	Tumor visually smaller	✓

^aFor purposes of this analysis, Clinical complete response defined as absence of tumor cells on histopathologic evaluation. ^bBladder urothelial field effect: absence of tumor cells in non-target lesions. ^cPreviously treated tumor demonstrated high-grade disease but pathology at time of treatment revealed low-grade disease in non-target tumor. ^dLocal pathology with no evidence of carcinoma in 3/3 target specimens. Central pathology demonstrated single fibrovascular core in 1/3 target specimens consistent with small area of papillary disease of unclear distance from target injection. ^eImmune response is defined by immunocyte infiltration on post-treatment histopathology. ^fSingle lesion visualized at screening on office cystoscopy. Multiple lesions subsequently seen with improved visualization at time of TURBT qualifying for intermediate risk classification. AUA, American Urological Association; IM, intramural; IT, intratumoral; NMIBC, non-muscle-invasive bladder cancer; TURBT, transurethral resection of bladder tumor; CR, clinical complete response. Clinicaltrials.gov identifier: NCT05483868; AU-011-102.

Efficacy data: Ta high-risk NMIBC

Cohorts A–C (single-dose drug with light activation)

1/5 patients demonstrated CR; 5/5 patients with immune response in target tumor					
	Patient A2	Patient B1	Patient B3	Patient C2	Patient C3 ^d
Screening diagnosis	Single Ta high-grade	Multiple Ta high-grade	Single Ta high-grade	Multiple Ta high-grade	Multiple Ta low-grade Prior Ta high-grade
Screening AUA risk classification	High	High	High	High	High (BCG Failure)
AU-011 dose/ delivery	100 µg IT/IM	100 µg IT	100 µg IT	200 µg IT	200 µg IT
Clinical complete response: Target tumor ^a	-	-	-	-	✓
Clinical complete response: Non- target tumor ^a (bladder urothelial field effect ^b)	NA	0/1	NA	NA	1/3
Immune response ^c : Target tumor	✓	✓	✓	✓	✓
Immune response ^c : Non-target tumor	NA	✓	NA	NA	✓
Necrosis	-	-	-	-	✓
Visual changes on cystoscopy	Tumor visually smaller	Tumor visually smaller	-	Tumor visually smaller	✓

^aClinical complete response defined as absence of tumor cells on histopathologic evaluation. ^bBladder urothelial field effect: absence of tumor cells in non-target lesions. ^cImmune response is defined by immunocyte infiltration on post-treatment histopathology. ^dTwo tumors in target tumor field with 1/2 tumors with clinical complete response. BCG failure qualifying as high risk by AUA criteria. AUA, American Urological Association; BCG, Bacillus Calmette-Guerin; NMIBC, non-muscle-invasive bladder cancer; CR, clinical complete response; IM, intramural; IT, intratumoral. Clinicaltrials.gov identifier: NCT05483868; AU-011-102.

Patient A3

72-year-old Hispanic male

Screening diagnosis: (2024)

- Multiple
- **Ta low-grade (<3 cm)**
- No CIS

Screening AUA risk classification: **Intermediate**

Initial diagnosis: (2019)

- Ta high-grade <3 cm
- No CIS
- Intermediate risk

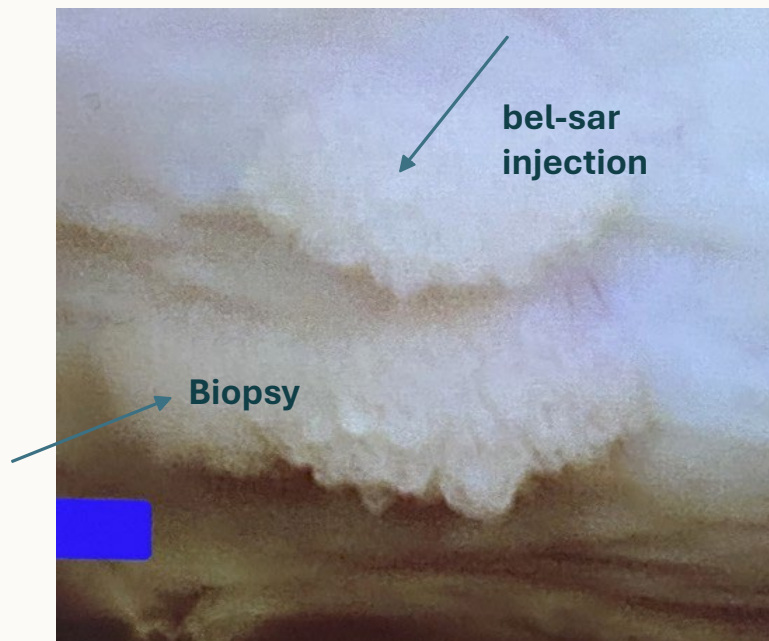
Prior TURBT:

- 2019, 2020 (x2), 2021 (x2), 2023

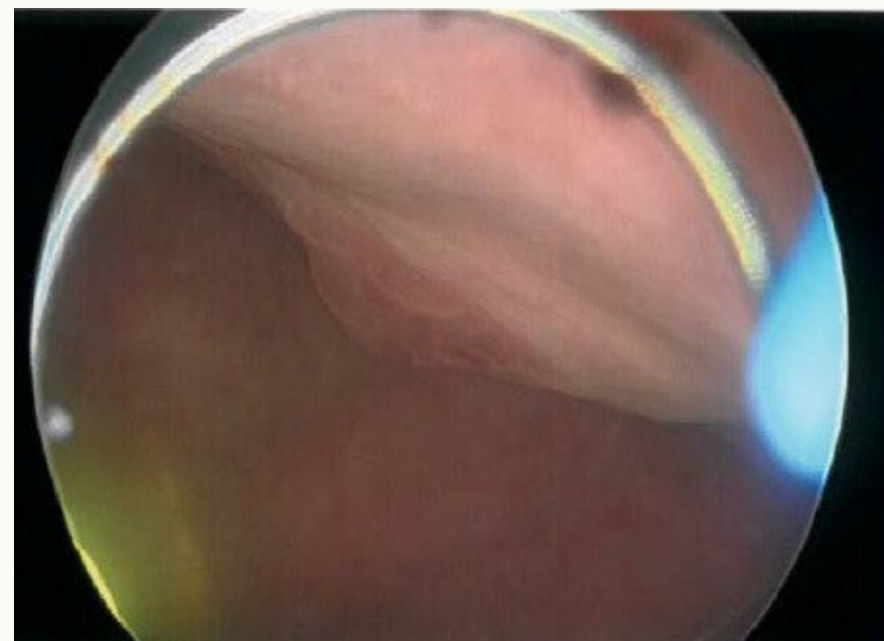
Prior adjuvant therapies:

- BCG induction and maintenance (2020-2021)

Clinical complete response visualized at time of TURBT confirmed with histopathologic evaluation



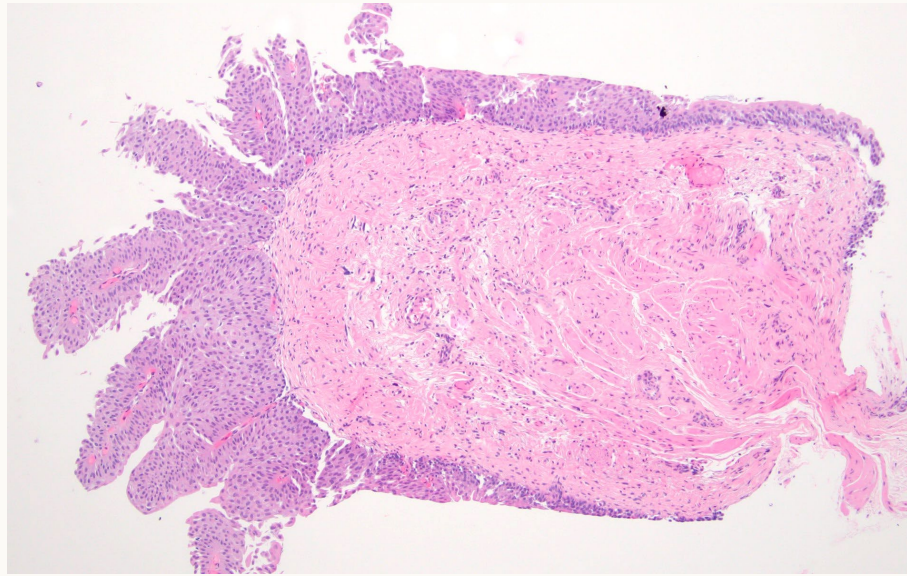
Pre-injection/pre-biopsy appearance of tumor on office cystoscopy



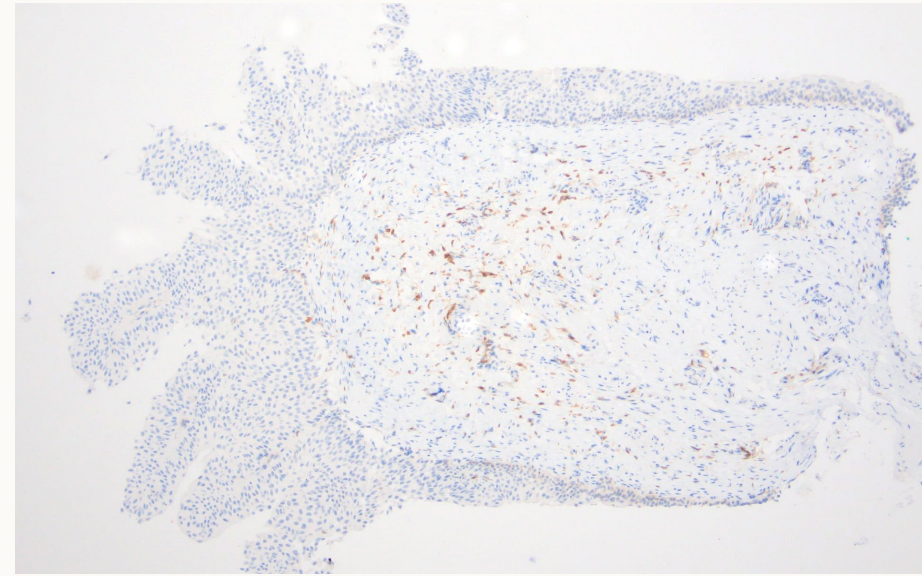
Post-injection edema and ecchymosis at injection site

Patient A3:
Post-treatment
generation of
secondary lymphoid
follicles and increase
in CD3, CD4, and
CD8 infiltration

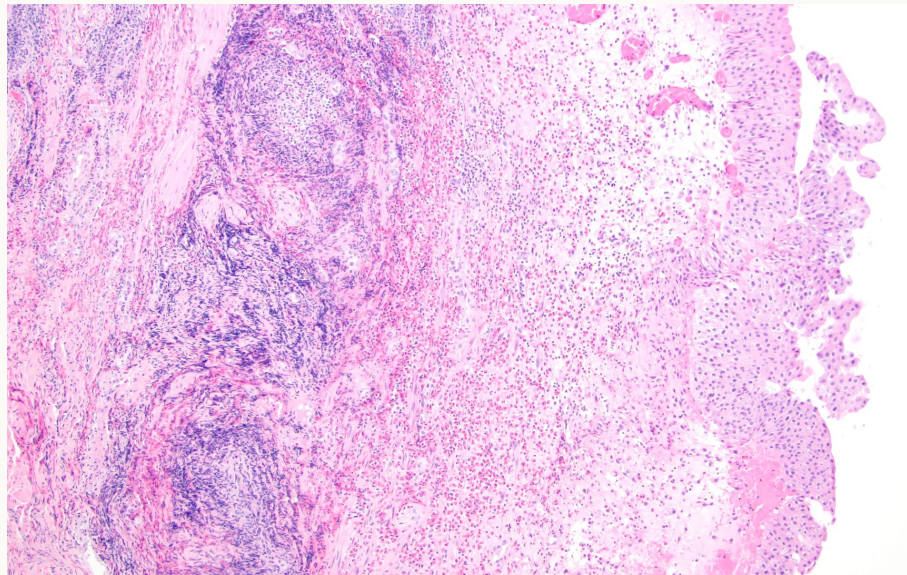
H&E: Pre-treatment



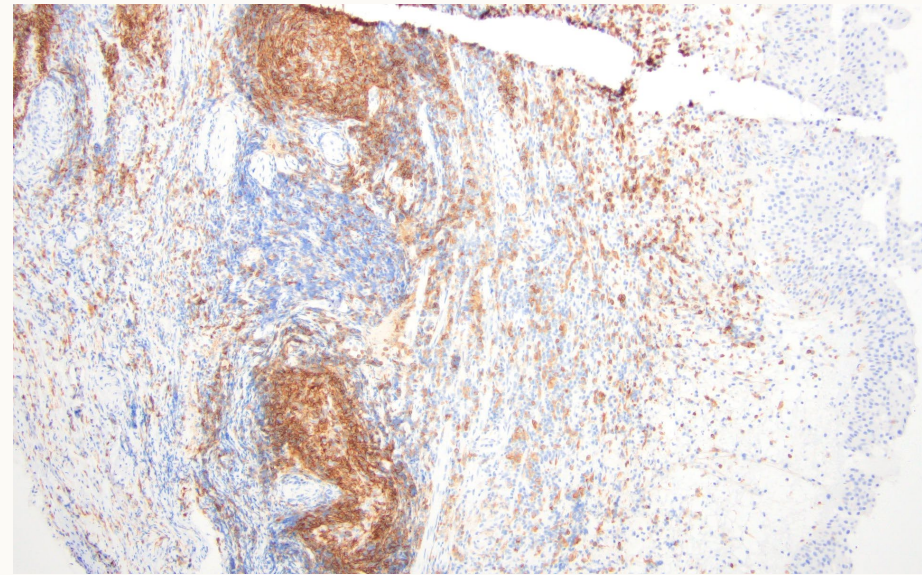
CD4: Pre-treatment



H&E: Post-treatment



CD4: Post-treatment



H&E, hematoxylin and eosin.
Clinicaltrials.gov identifier: NCT05483868; AU-011-102.

Mature Tertiary Lymphoid Structures (TLS) in Target (Treated) Lesion:

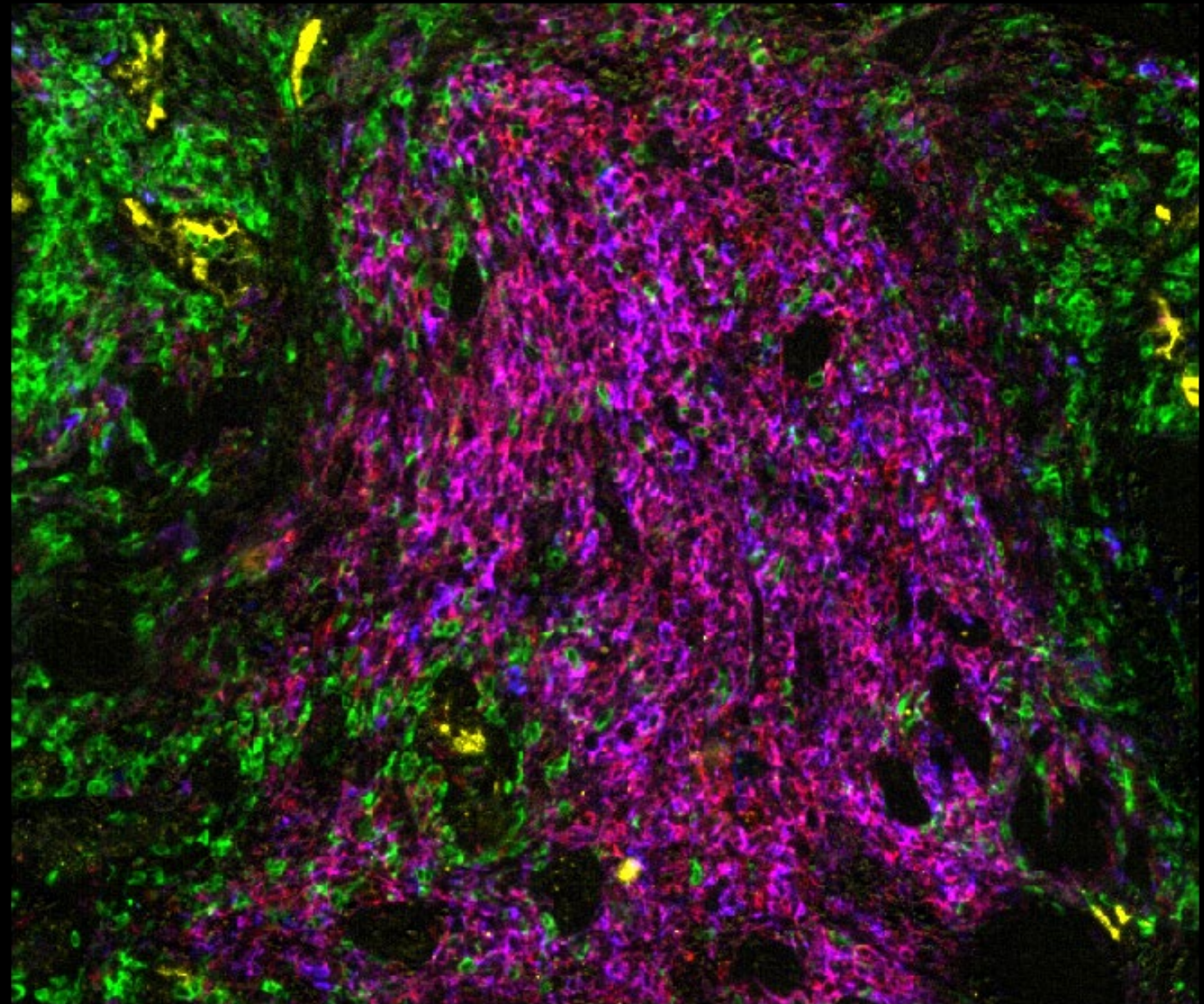
Active Immunosurveillance After Bel-sar Treatment

CD3: T cells

CD20: B cells

CD23: Follicular Dendritic Cells (FDC)
(Found in B cell follicles, only present in mature TLS)

PNAd: Peripheral Node Addressin
(Stains for high endothelial venules, evidence of lymphocyte trafficking from periphery)



Multiplex Immunofluorescence: Patient A3 (Intermediate-Risk NMIBC)

TLS Not Present in Lesion Prior to Treatment

Early Tertiary Lymphoid Structures (TLS) in Distant Non-Target (Non-Treated) Lesion:

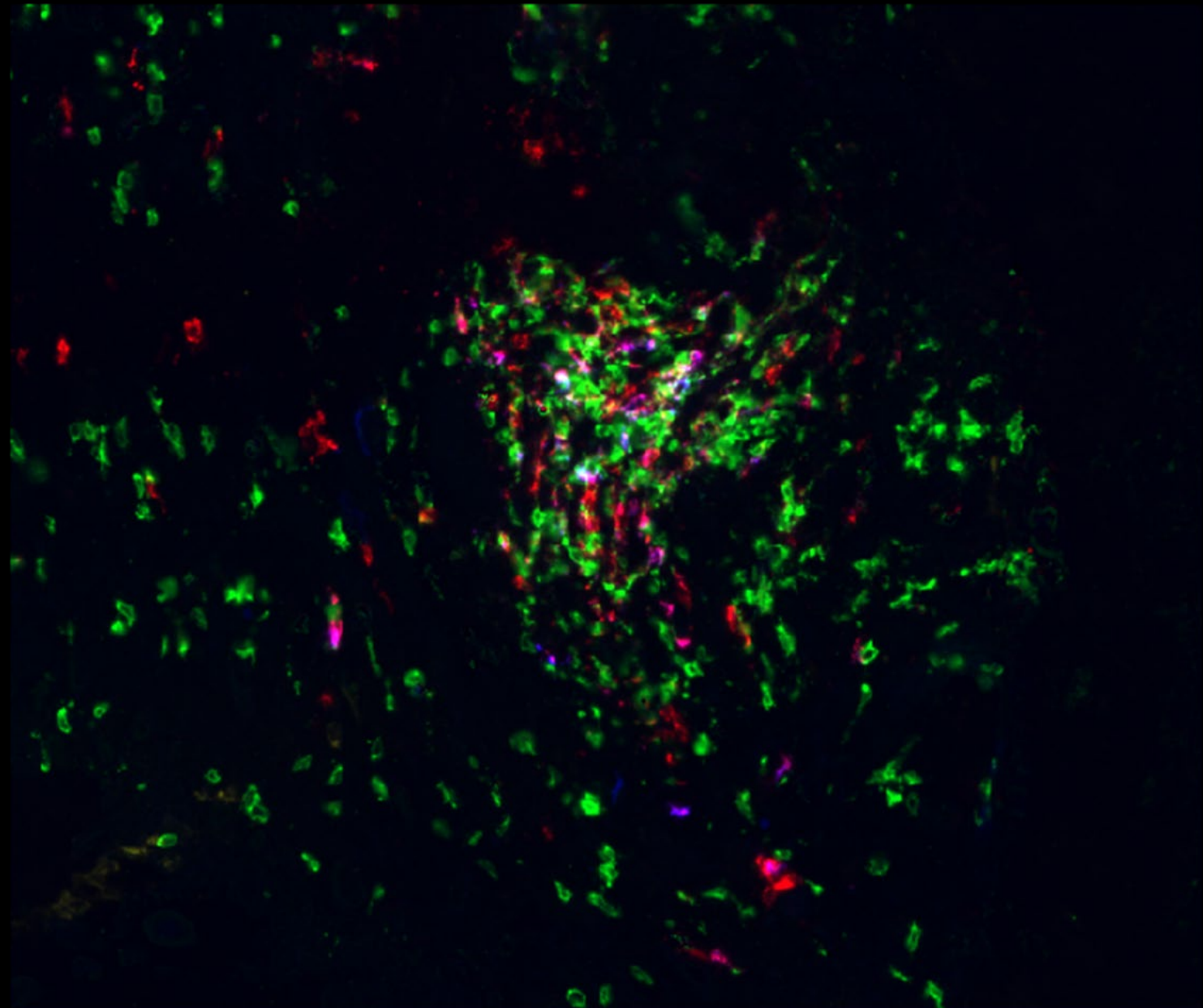
Urothelial Immune Field Effect After Bel-sar Treatment

CD3: T cells

CD20: B cells

CD23: Follicular Dendritic Cells (FDC)
(Found in B cell follicles, only present in mature TLS)

PNAd: Peripheral Node Addressin
(Stains for high endothelial venules, evidence of lymphocyte trafficking from periphery)



Multiplex Immunofluorescence: Patient A3
(Intermediate-Risk NMIBC)

Light-activated cohorts (A–C) after single, low-dose of bel-sar

Clinical complete responses and immune responses demonstrated induction of **effector immunity**, **relief from immunosuppression**, and development of **active immunosurveillance**

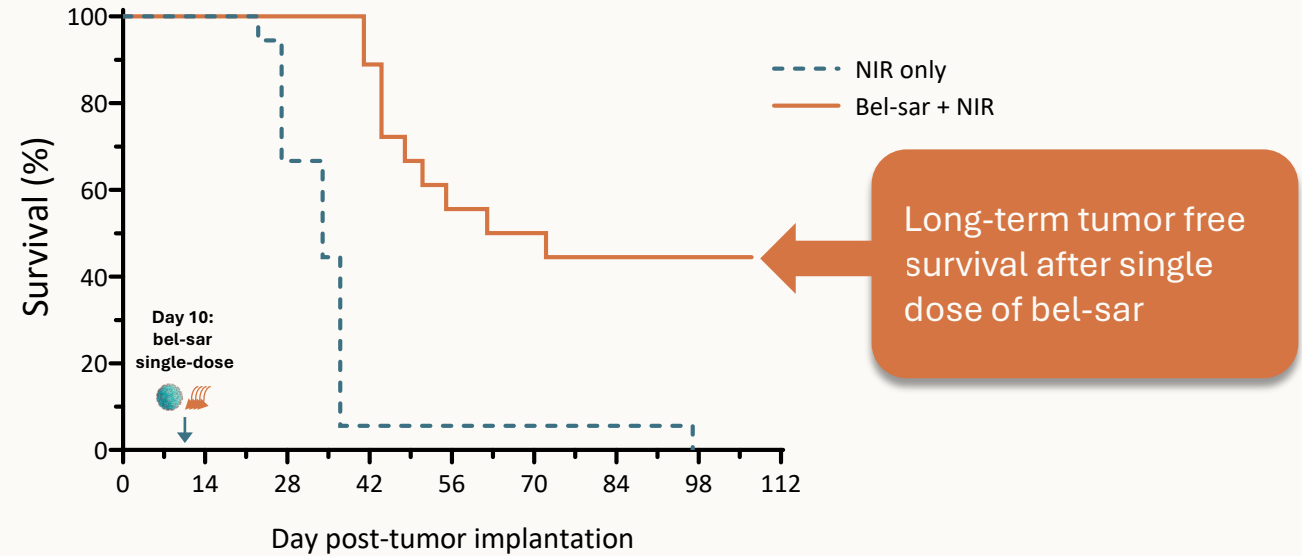
- **100% (10/10)** of patients showed **target tumor infiltration of effector CD8+ T and CD4+ cells** as early as 7 days after laser activation
- **100% (11/11)** of non-target tumors^a showed **T cell infiltration**, supportive of a **bladder urothelial field effect**
- **Focal eosinophilic infiltration** was observed in target tumors in **60% (6/10)** of patients. **9% (1/11)** of non-target tumors showed eosinophilic infiltration, supportive of a **local innate immune response** to tumor necrosis
- **Generation of lymphoid follicles^b** was observed in target tumors in **80% (8/10)** of patients, supportive of a **local adaptive immune response**

^aTotal of 7 patients with non-target tumors. ^bOrganized aggregates of immune cells.
Bel-sar, belzupacap sarotalocan; MOA, mechanism of action.
Clinicaltrials.gov identifier: NCT05483868; AU-011-102.

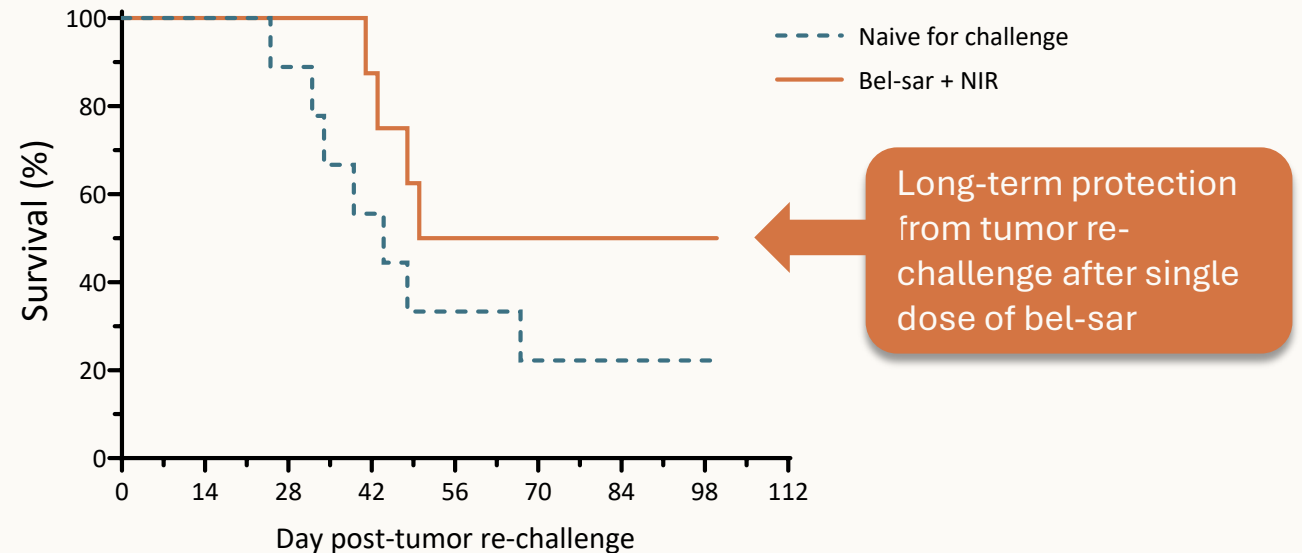
A single systemic treatment of bel-sar resulted in long-term tumor-free survival and induction of anti-tumor responses in TC-1 murine tumor model

- Long-term tumor-free survival and protection from tumor re-challenge
- CD4+ and CD8+ T-cells are required both at the time of treatment and at the time of re-challenge

Tumor-free survival after single dose of bel-sar

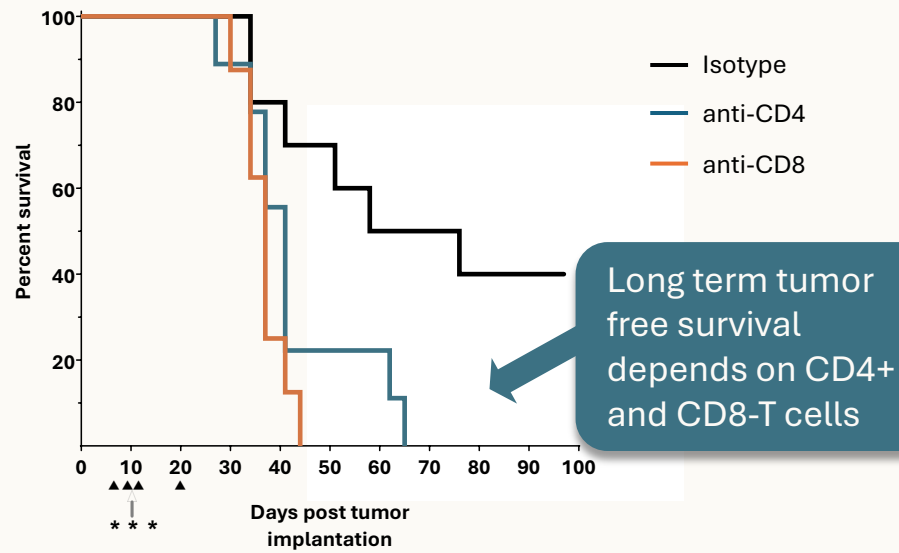
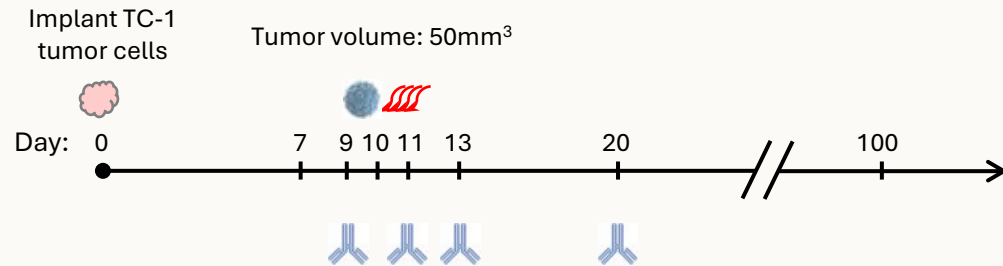


Tumor-free survival after tumor re-challenge



CD4+ and CD8+ T-cells are key to the **long-term durability of response** and protection of rechallenge with bel-sar

Depletion of CD4+ and CD8+T cells at the time of treatment



Intravenous bel-sar

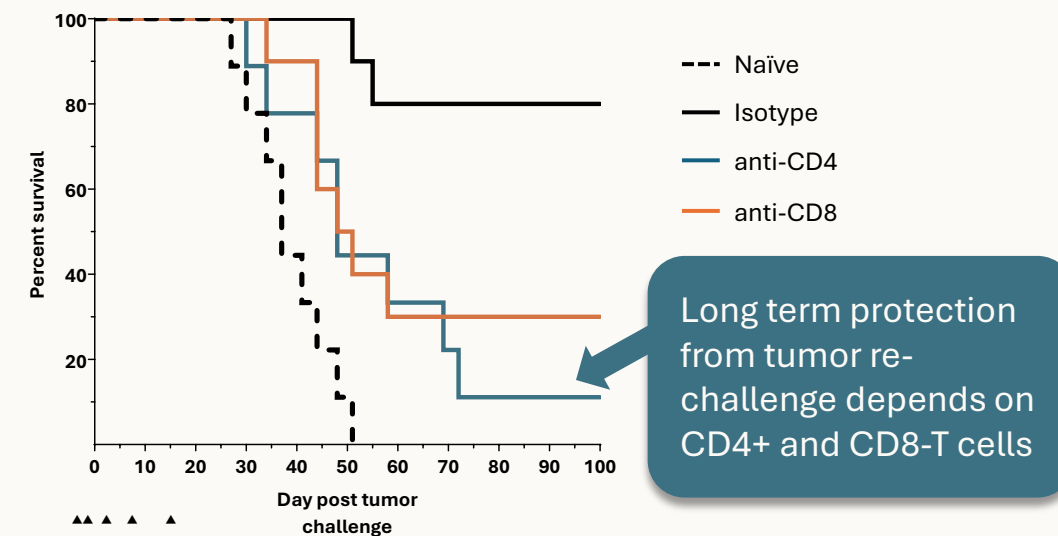
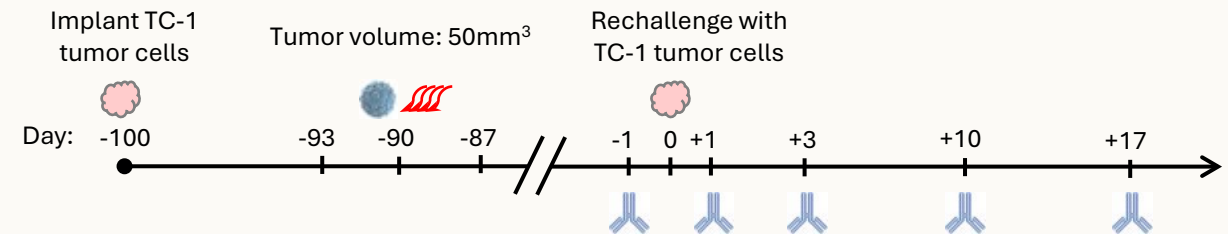


NIR treatment



Depleting or matched isotype

Depletion of CD4+ and CD8+T cells at the time of rechallenge



Phase 1 trial of bel-sar in non-muscle invasive bladder cancer

Summary

Bel-sar's novel MoA has the potential to be a **paradigm-shifting approach** to generate T-cell-mediated immunity



Favorable safety profile

Only grade 1 drug-related adverse events reported in <10% of patients

No drug-related grade 2 or higher AEs; no SAEs or DLTs

Focal treatment with no systemic adverse events observed



Rapid immune activation

100% of patients showed immune cell infiltration in target and non-target lesions

Cell mediated immunity and urothelial field effect



Tumor shrinkage and clinical response

4/5 patients with intermediate-risk and 1/5 patients with high-risk disease had a clinical complete response

Clinical complete responses in target and non-target tumors



Accelerated development plan

Phase 1b/2 trial to evaluate optimal treatment regimen in intermediate and high-risk patients

Evaluation of bel-sar in both immune ablative and neoadjuvant treatment approaches

Phase 1b/2 trial of bel-sar in bladder cancer

Paradigm-shifting treatment approach

Treat the tumor first to generate cell-mediated immunity (CMI)

Immune-ablative (-TURBT)

*Treat tumor with bel-sar first
and avoid the need for TURBT*

Value proposition:

- Prevent recurrence and progression by treating the tumor and generating CMI
- Avoid surgery (TURBT) and general anesthesia
- Office-based procedure

Patient population:

- Intermediate-risk NMIBC patients

Neoadjuvant/multimodal (+ TURBT)

*Treat tumor with bel-sar first
ahead of TURBT*

Value proposition:

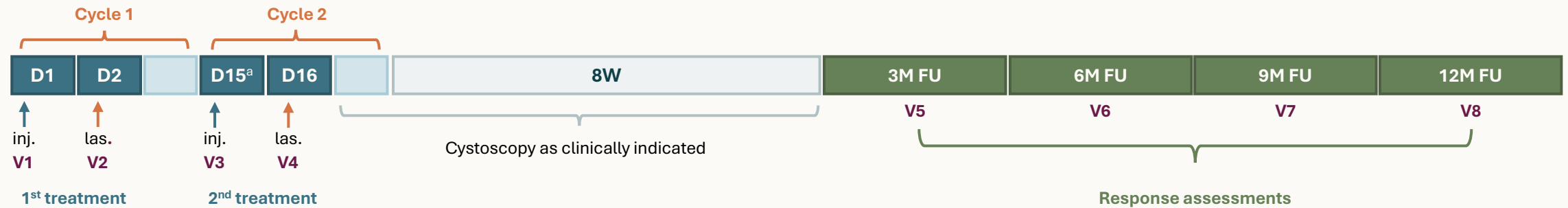
- Prevent recurrence and progression by treating the tumor first and generating CMI
- Avoid multiple cycles of adjuvant treatments (e.g., BCG, chemotherapy)
- Office-based procedure

Patient population:

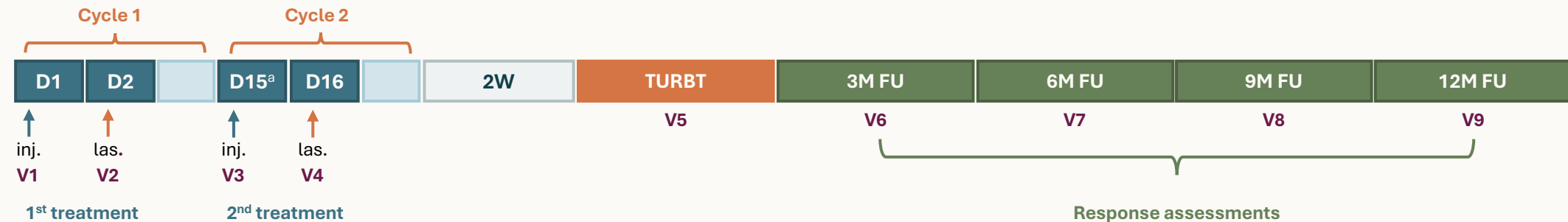
- Intermediate-risk and high-risk NMIBC patients; potential to expand to MIBC

Phase 1b/2 treatment schedule in intermediate and high-risk NMIBC patients

Immune ablative design: *Intermediate Risk Patients*



Accelerated neoadjuvant design: *Intermediate and High-Risk Patients*



Established Regulatory Endpoints to Assess Durability of Response at 3 and 12 months

Phase 1b/2 study design

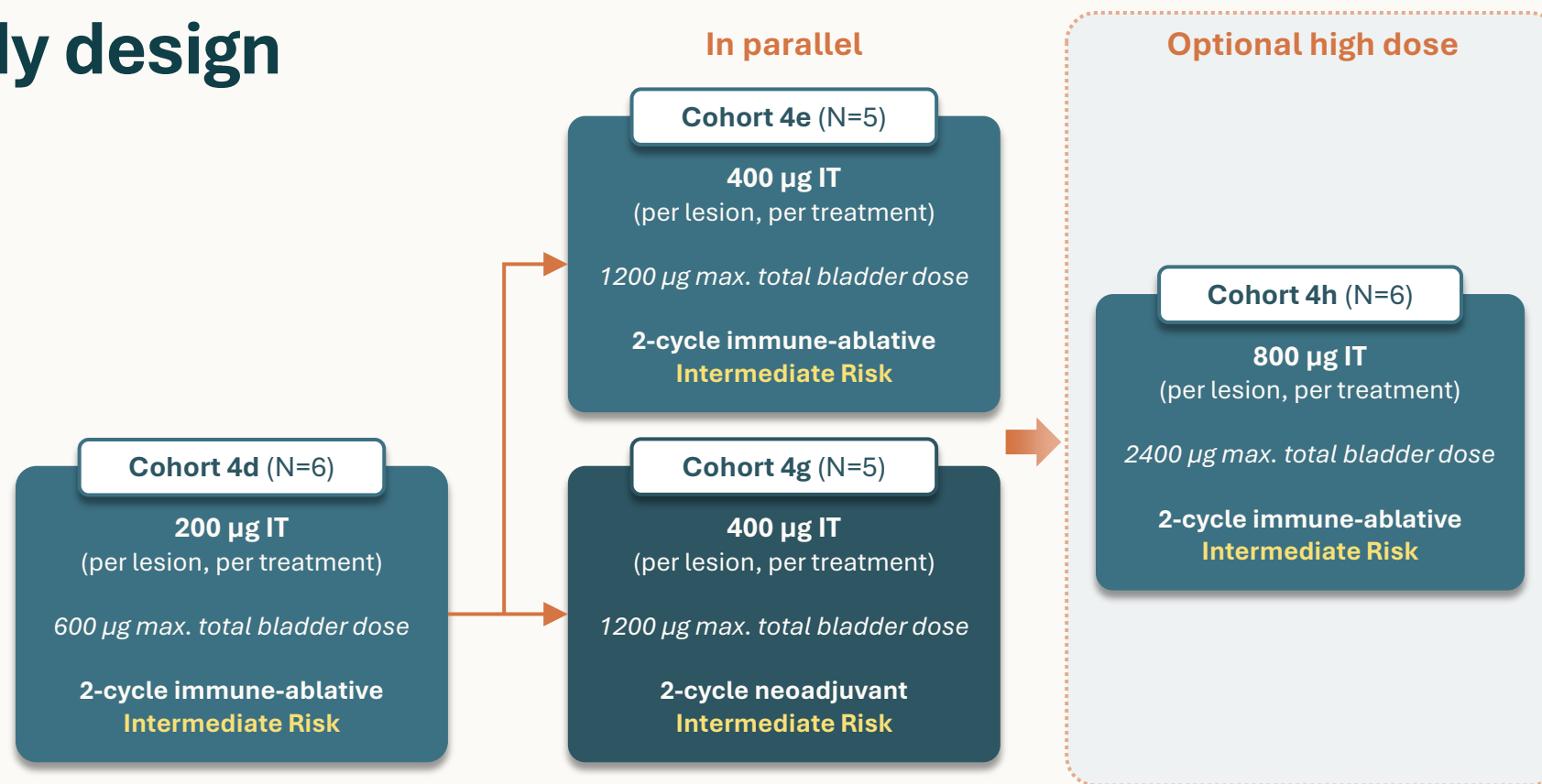
Key updates

Part 1: Dose escalation

- 21–26 participants
- Recurrent LG IR (4d + 4e + 4g)
- High risk (4f)
- Up to 3 tumors per patient
- TURBT required for neoadjuvant

Part 2: Optional cohorts

- 12 participants
- High risk
- Up to 3 tumors per patient
- TURBT required for neoadjuvant



Phase 1b/2 study design

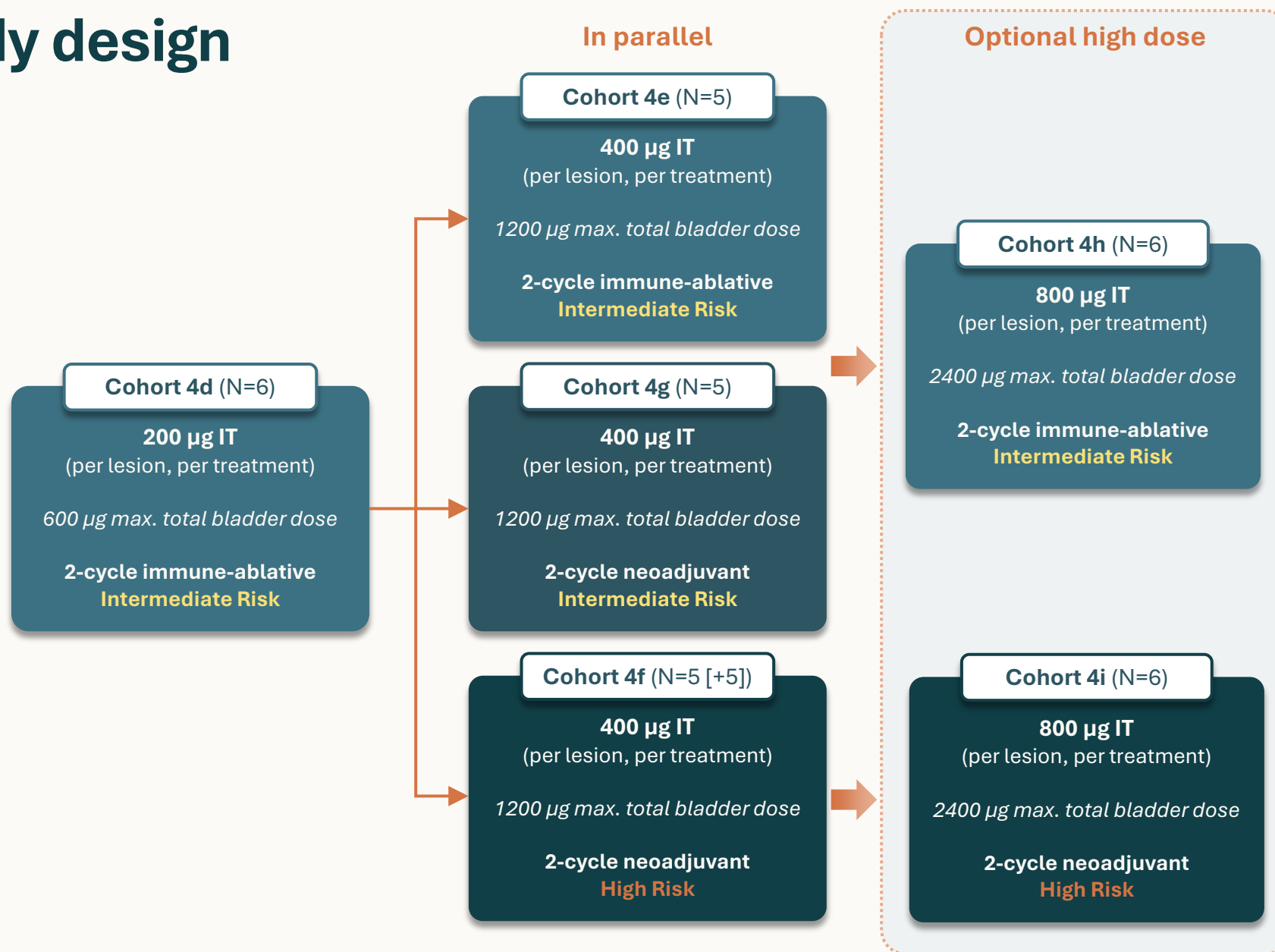
Key updates

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Bel-sar seeks to redefine the treatment of bladder cancer with a novel and disruptive approach

Dual Mechanism of Action

**Targeted cytotoxicity
+ cell mediated anti-tumor
immunity**



Active immunosurveillance



Urothelial field effect

Transformative Clinical Impact

Front-line approach

Immediate application in clinic

Does not preclude
downstream therapies

Reduces total treatment burden

Cell-mediated immunity

has potential to generate
long-term durable responses

Broad Market Opportunity

Early clinical activity demonstrated across the disease spectrum

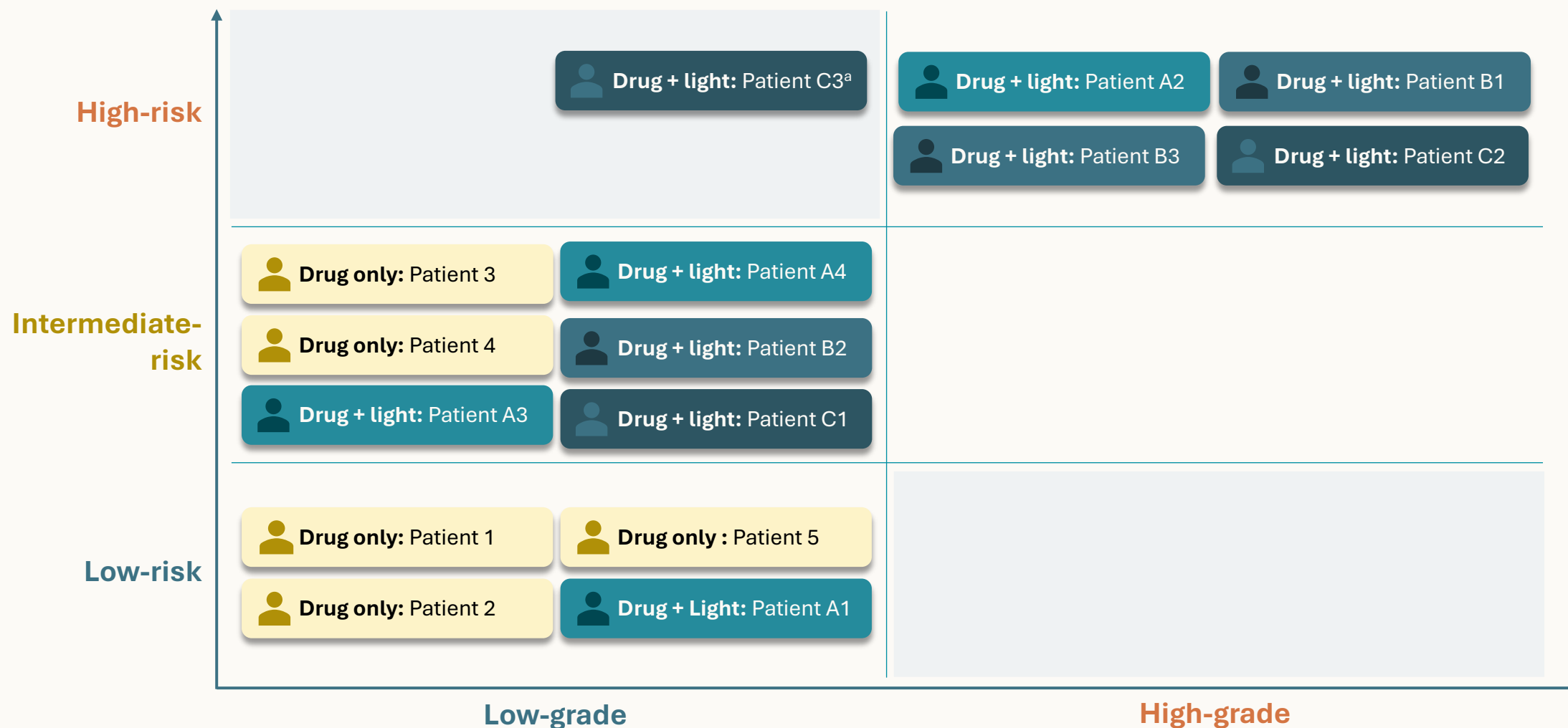
Intermediate to high-risk NMIBC
patients

BCG-unresponsive patients

Potential in additional indications
(e.g. MIBC)

Appendix

Patient population: AUA risk classification and grade at screening



^aBCG failure in patient C3 qualifying as high risk by AUA criteria.

AUA, American Urological Association.

Clinicaltrials.gov identifier: NCT05483868; AU-011-102.