Welcome to Genomic Health's Post-American Urological Association (AUA) Conference Call

9:30 am

AUA Data Overview and New Report
Phil Febbo, M.D., Chief Medical Officer, Genomic Health

9:50 am

Impact of Oncotype DX® GPS™ Test on Clinical Practice
Neal Shore, M.D., Medical Director, Carolina Urologic Research Center
President of LUGPA

10:00 am

Q&A

Safe Harbor Statement

Various remarks that we make in this presentation that are not historical, including those about our future financial and operating results, business strategy, goals and priorities, plans and prospects, growth opportunities and the potential size of addressable markets, the value of our tests, correlation of test growth to future revenue, ability to secure market access in global markets, our product pipeline and potential new products or applications, timing of future product releases, collaborations, and the occurrence, timing and results of clinical studies, constitute forward-looking statements within the meaning of the Safe Harbor provisions of the Private Securities Litigation Reform Act. Forward-looking statements are subject to risks and uncertainties that could cause actual results to differ materially from our expectations. These risks and uncertainties include, but are not limited to our ability to: achieve profitability and growth targets; increase usage of our tests; address possible regulation of our tests by the FDA or similar regulatory agencies outside of the United States; mitigate risks and uncertainties associated with development and commercialization; obtain or maintain sufficient levels of reimbursement for our existing tests and any future tests we may develop; address risks associated with sales and operations globally; our history of operating losses; the occurrence, timing, results and applicability of clinical study results to actual outcomes; and the other risks set forth in our filings with the Securities and Exchange Commission, including the risks set forth in our most recent Annual Report filed on Form 10-K and subsequently filed Quarterly Report on Form 10-Q for the most recent quarter ended. These forward-looking statements speak only as of the date hereof. We disclaim any obligation to update these forward-looking statements.

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Phil Febbo, M.D.

Chief Medical Officer at Genomic Health

Four New Oncotype DX® Genomic Prostate Score™ (GPS™) Test Studies Presented at AUA

American Urological Association (AUA) 2017 Annual Meeting
A diagnostic biopsy-based Genomic Prostate Score as an independent predictor of prostate cancer death and metastasis in men with localized prostate cancer; - Van Den Eeden et al
A 17-gene panel for prediction of adverse pathology at radical prostatectomy: prospective validation; - Eggener et al
Impact of the 17-gene panel in contemporary urologic practices on active surveillance persistence: an interim analysis in an observational cohort; - Eure et al
A multi-center, pre/post analysis of prostate cancer treatment among Veterans following introduction of the 17-gene assay; - Lynch et al

Compelling Results Continue to Set Oncotype DX GPS Test Apart; GPS Test Now Provides Near- and Long-term Individualized Risk Assessment

1) GPS test now validated as a predictor of prostate cancer death and metastasis following radical prostatectomy (RP) in men with clinically localized prostate cancer.

- **No patient in the Kaiser study with NCCN Very Low-, Low- or Intermediate-risk disease and a GPS < 20 experienced metastasis or death.**

2) First prospective validation study reinforces GPS test independently predicts adverse pathology.

3) GPS testing significantly increases use and persistence on active surveillance.

GPS test is now validated as a predictor for all key clinical endpoints in prostate cancer:

- ✓ Adverse pathology
- ✓ Metastasis within 10 years of diagnosis
- ✓ Death within 10 years of diagnosis

Kaiser Study Objectives Addressed Association Between Oncotype DX GPS Results and Long-term Outcomes

A diagnostic biopsy-based Genomic Prostate Score test as an independent predictor of prostate cancer death and metastasis in men with localized prostate cancer

Primary Endpoint

To validate that the GPS result is a predictor of late clinical endpoints; distant metastasis (Mets) and prostate cancer-specific death (PDC) after radical prostatectomy (RP)

Secondary Endpoint

To confirm that the GPS result is a predictor of biochemical recurrence (BCR) after RP

Kaiser Longitudinal Database Provided Diagnoses and Long-term Outcomes in >6,000 Patients

N = 6,184 — **Clinical database (1995-2010) of RP patients with very low through high NCCN® risk prostate cancer from Kaiser**

N = 404 — **Patients selected using cohort sampling design**

113 PCD vs. 291 non-PCD

N = 334 — **Patients with usable biopsy tissue**

14 (4%) excluded due to clinical ineligibility

41 (12%) excluded based on central path review:

- *Insufficient or no tumor (n=40)*
- *Incorrect tissue type (n=1)*

N = 279 — **Passed central pathology review**

20 (7%) excluded for insufficient RNA quality

N = 259 — **Final evaluable population**

Oncotype DX GPS Result is a Significant Predictor of Metastasis and Death in a Univariate Analysis

Prediction of Distant Metastasis

Variable	N	HR	HR 95% CI	P-value
GPS per 20 Units	259	**2.75**	(1.63, 4.63)	**<0.001**

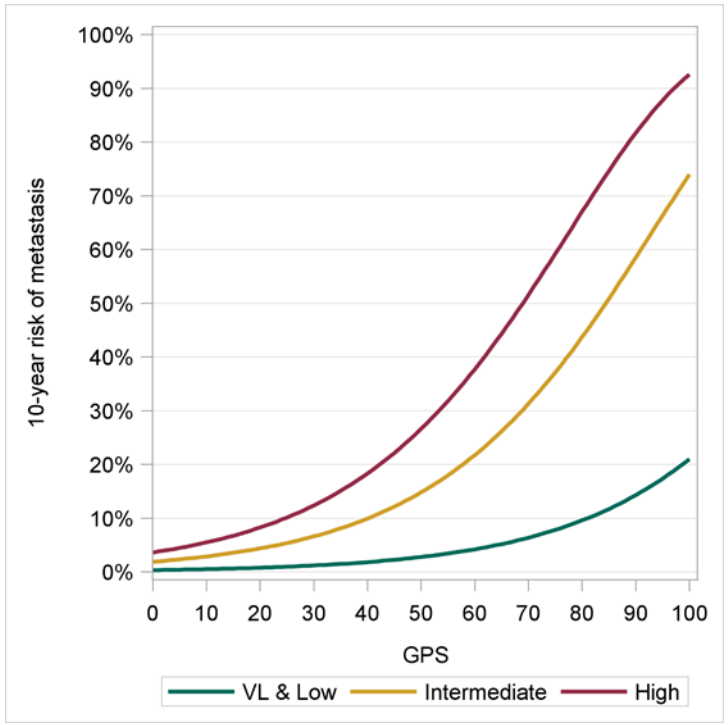
Prediction for Prostate Cancer Death

Variable	N	HR	HR 95% CI	P-value
GPS per 20 Units	259	**3.23**	(1.84, 5.65)	**<0.001**

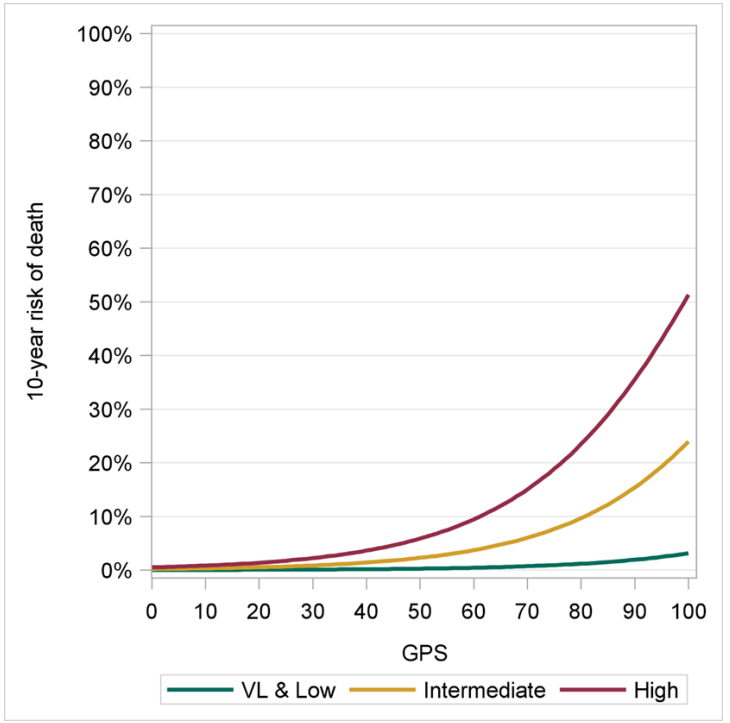
In unadjusted analysis, GPS result a strong predictor of late outcomes in prostate cancer

Risk Profile for Oncotype DX GPS Test Demonstrates Strong Differentiation Between Patients with Low and High Scores

Risk profile for GPS at 10 years for metastasis



Risk profile for GPS at 10 years for PCD



More accurate individualized risk by combining GPS testing with NCCN risk category

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Patients in the Kaiser Study with NCCN Very Low-, Low- or Intermediate-risk Disease and a GPS Result < 20 Did Not Develop Metastasis or Die

✓ A clear cut point of GPS result < 20 was established in this study for identifying patients without risk of metastasis or death from prostate cancer following RP

✓ These are consistent findings when compared to other studies:

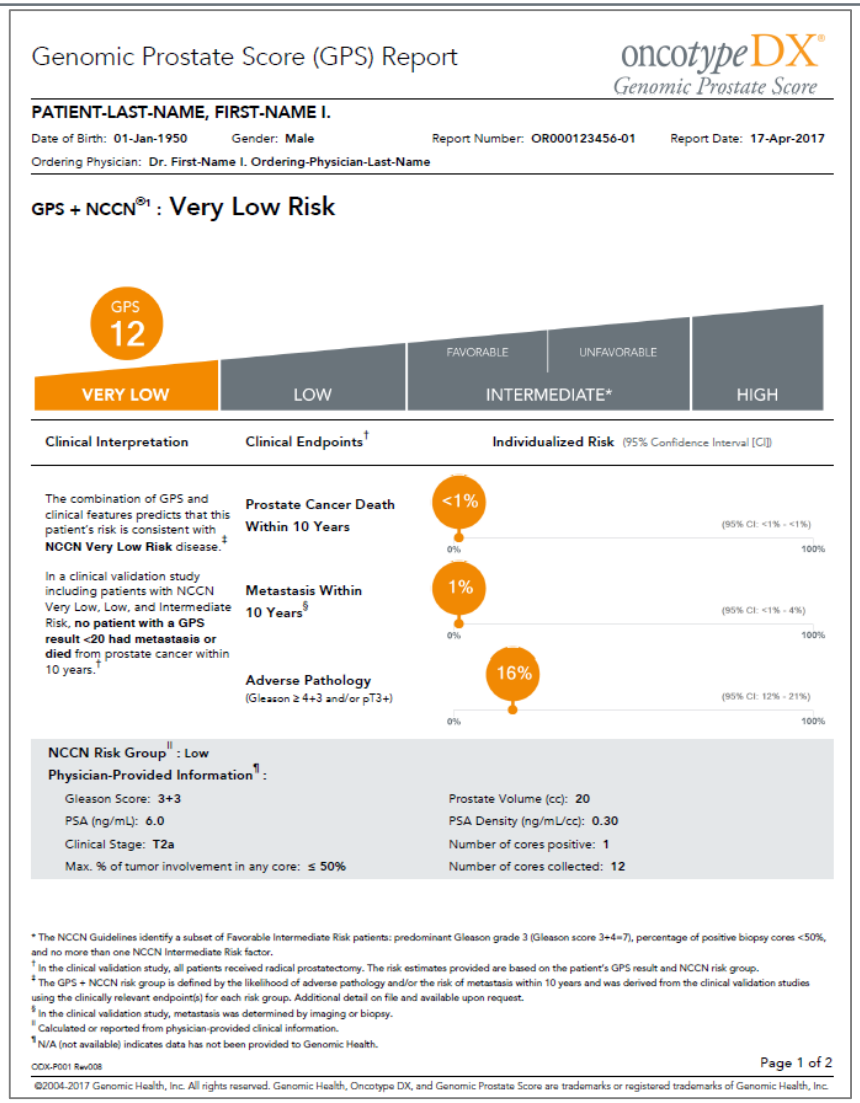
1. Cullen 2015, (n=402, median F/U 5.2 years)

- 5 developed metastases; **all 5 had GPS > 20**

2. Klein 2014, (n=426, median F/U 6.6 years)

- 109 metastases and/or local recurrences and 39 PCD
  - **Only one (< 1%) patient with events had GPS < 20**
  - NB: 28% of patients had GPS < 20

New Enhanced Report Now Provides Individualized Risk of Adverse Pathology, Metastases and Prostate Cancer-specific Death



Genomic Prostate Score (GPS) Report

oncotype DX® Genomic Prostate Score

PATIENT-LAST-NAME, FIRST-NAME I.

Date of Birth: **01-Jan-1950** Gender: **Male** Report Number: **OR000123456-01** Report Date: **17-Apr-2017**

Ordering Physician: **Dr. First-Name I. Ordering-Physician-Last-Name**

GPS + NCCN®[1] : Very Low Risk

GPS 12

VERY LOW | LOW | FAVORABLE / UNFAVORABLE INTERMEDIATE* | HIGH

Clinical Interpretation	Clinical Endpoints[†]	Individualized Risk (95% Confidence Interval [CI])
The combination of GPS and clinical features predicts that this patient's risk is consistent with **NCCN Very Low Risk** disease.[‡]	**Prostate Cancer Death Within 10 Years**	<1% (95% CI: <1% - <1%)
In a clinical validation study including patients with NCCN Very Low, Low, and Intermediate Risk, **no patient with a GPS result <20 had metastasis or died** from prostate cancer within 10 years.[†]	**Metastasis Within 10 Years**[§]	1% (95% CI: <1% - 4%)
	Adverse Pathology (Gleason ≥ 4+3 and/or pT3+)	16% (95% CI: 12% - 21%)

NCCN Risk Group[‖] **: Low**

Physician-Provided Information[¶] **:**

Gleason Score: **3+3**	Prostate Volume (cc): **20**
PSA (ng/mL): **6.0**	PSA Density (ng/mL/cc): **0.30**
Clinical Stage: **T2a**	Number of cores positive: **1**
Max. % of tumor involvement in any core: **≤ 50%**	Number of cores collected: **12**

* The NCCN Guidelines identify a subset of Favorable Intermediate Risk patients: predominant Gleason grade 3 (Gleason score 3+4=7), percentage of positive biopsy cores <50%, and no more than one NCCN Intermediate Risk factor.

† In the clinical validation study, all patients received radical prostatectomy. The risk estimates provided are based on the patient's GPS result and NCCN risk group.

‡ The GPS + NCCN risk group is defined by the likelihood of adverse pathology and/or the risk of metastasis within 10 years and was derived from the clinical validation studies using the clinically relevant endpoint(s) for each risk group. Additional detail on file and available upon request.

§ In the clinical validation study, metastasis was determined by imaging or biopsy.

‖ Calculated or reported from physician-provided clinical information.

¶ N/A (not available) indicates data has not been provided to Genomic Health.

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Two Key Results from an Observational Study

First Prospective Validation of Adverse Pathology Across Very Low-, Low- and Intermediate-risk Patients

Study Objectives	To prospectively validate the GPS test as a predictor of AP in men with clinically low-risk PCa treated with radical prostatectomy (RP)
Study Design	150 men who had RP included in this analysis from a 1,200-patient prospective study performed
Results	Hazard ratio for AP (multivariable analysis): • AP: H.R. 2.1 (1.2, 4.0, p=0.014) • AUC improved from 0.6 to 0.68 • The number of patients with low decision conflict increased from 42% pre-GPS testing to 69% post-GPS testing

Eggener et al; AUA 2017

RESULTS

- In this first **prospective** validation of a biopsy-based genomic marker in prostate cancer, the GPS test is a strong predictor of AP in contemporary PCa patients
- Patient decisional conflict decreased after GPS testing

IMPACT

GPS test is a predictor of adverse pathology, an **immediate and actionable endpoint** in informing treatment decisions for patients with clinically low-risk prostate cancer

GPS Test Greatly Increases Both Use and Persistence on Active Surveillance in Contemporary Urologic Practices

	Interim Analysis in an Observational Cohort
Study Objectives	Impact of GPS testing on the management of clinically low-risk PCa patients in community-based urology practices
Study Design	• The first 300 men (297 evaluable) enrolled in a 1,200-patient prospective study • The primary endpoints were impact of GPS testing on initial management and persistence on active surveillance (AS) at 1 year post-diagnosis in patients who chose to pursue AS
Results	In the GPS-tested cohort, 62% of men chose AS compared to 40% in a similar cohort that did not receive GPS testing Persistence on AS at one year was similar between groups (89% vs 86% for GPS/baseline)

Eure et al; AUA 2017

RESULTS

- Patients who received the GPS test were more likely to make shared decision of AS for initial management compared to untested patients
- Higher utilization of AS and similar persistence in the GPS-tested men resulted in a 21% absolute increase in the proportion of men on AS at 1 year post-diagnosis*

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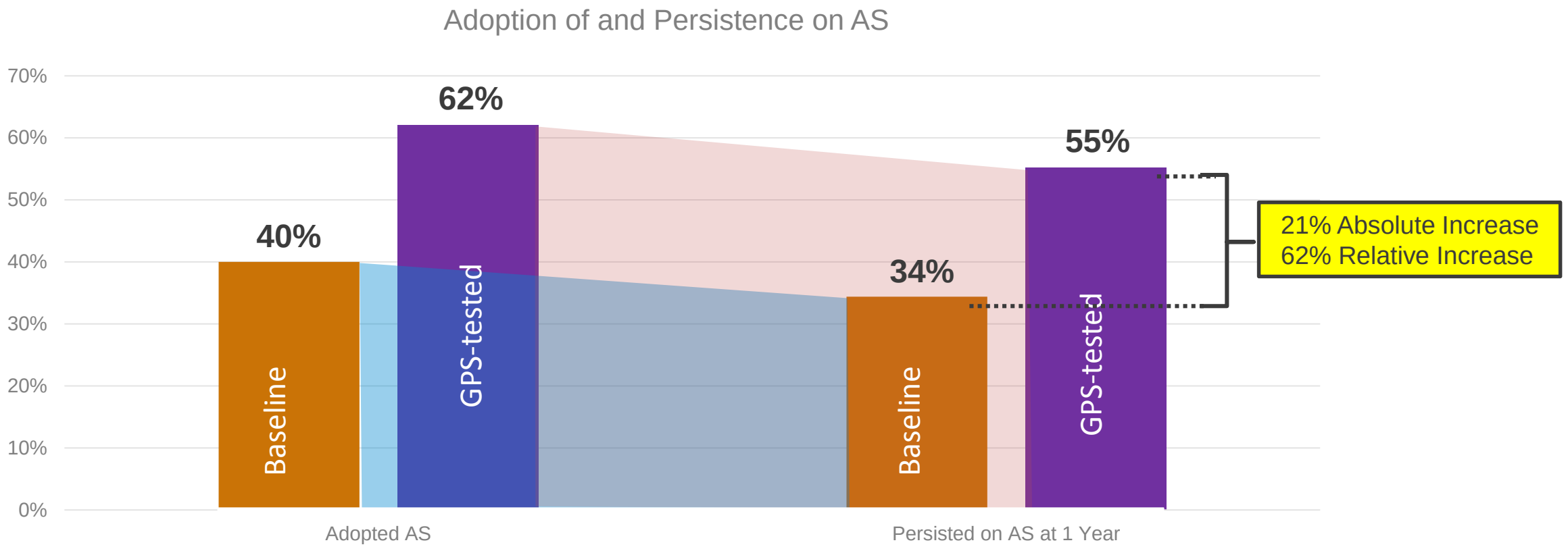
UROLOGY

Patients Tested with Oncotype DX GPS Are More Likely to Continue on Active Surveillance



AS persistence at 1 year was similar (86% in baseline versus 89% in GPS-tested)

Eure et al. Urology In press.

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Neal Shore, M.D.

Medical Director, Carolina Urologic Research Center

President of LUGPA

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Thank You.