67th ASH® Annual Meeting and Exposition

STARTING DECEMBER 3, 2025 | VIRTUAL

DECEMBER 6-9, 2025 | ORLANDO, FLORIDA

CART MM – ASH UPDATES

NOA LAVI Jan 2026

LBA-1

MRD-negative outcomes following a novel, *in vivo* gene therapy generating anti-BCMA CAR-T cells in patients with RRMM: Preliminary results from inMMyCAR, the first-in-human Phase 1 study of KLN-1010

Simon Harrison[1], P. Joy Ho[2], Sueh-li Lim[3], Stephanie Talam[2], Hannah Pahl[1], Dharmesh Dingar[4], Scott Currence[4], Travis Quigley[4], Andrew Spencer[3]

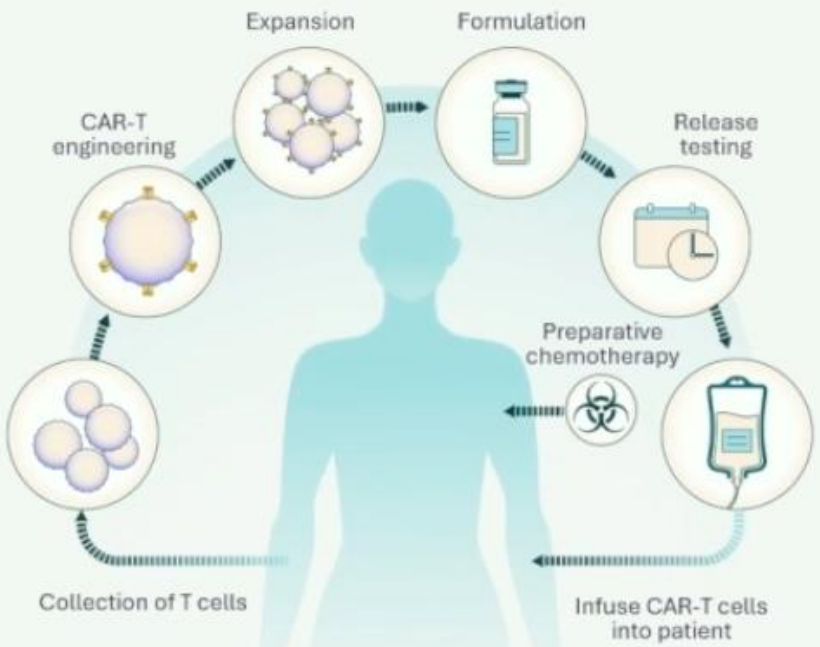
[1]Peter MacCallum Cancer Centre, Melbourne, Victoria, Australia; [2]Royal Prince Alfred Hospital, Sydney, New South Wales, Australia; [3]The Alfred Hospital, Melbourne, Victoria, Australia; [4]Kelonia Therapeutics, Inc., Boston, Massachusetts, United States.

kelonia inMMyCAR

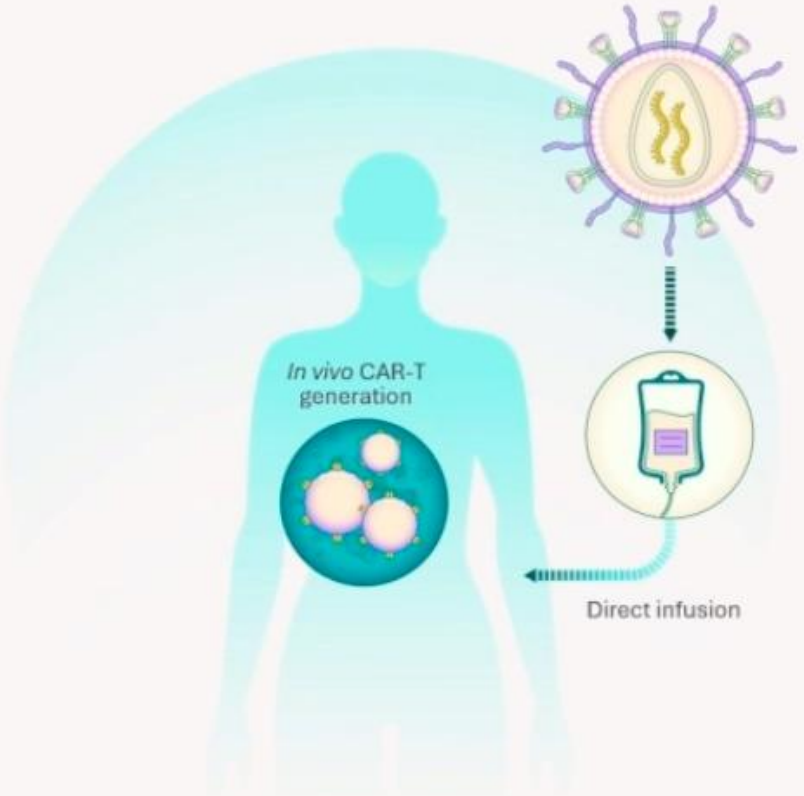
Presented at the 67th ASH Annual Meeting and Exposition; December 6-9, 2025; Orlando, FL, USA.

Expanding the reach of CAR-T cells with *in vivo* gene delivery[1,2]

Ex vivo CAR T



In vivo CAR T with KLN-1010 lentiviral particles



- Eliminates preconditioning lymphodepletion ☑
- Greatly simplified logistics to expand access ☑
- No *ex vivo* culture may increase T-cell fitness ☑
- Reduced cost of goods and manufacturing ☑

CAR, chimeric antigen receptor.

1. Bot A et al. *Nat Rev Drug Discov*. 2025 Sep 30. doi: 10.1038/s41573-025-01291-5; **2.** Najibi AJ. T cell-specific *in vivo* transduction with preclinical candidate KLN-1010 generates BCMA-directed CAR-T cells with potent anti-multiple myeloma activity (abstract #48). Poster presented at: AACR Annual Meeting; April 5-10, 2024.

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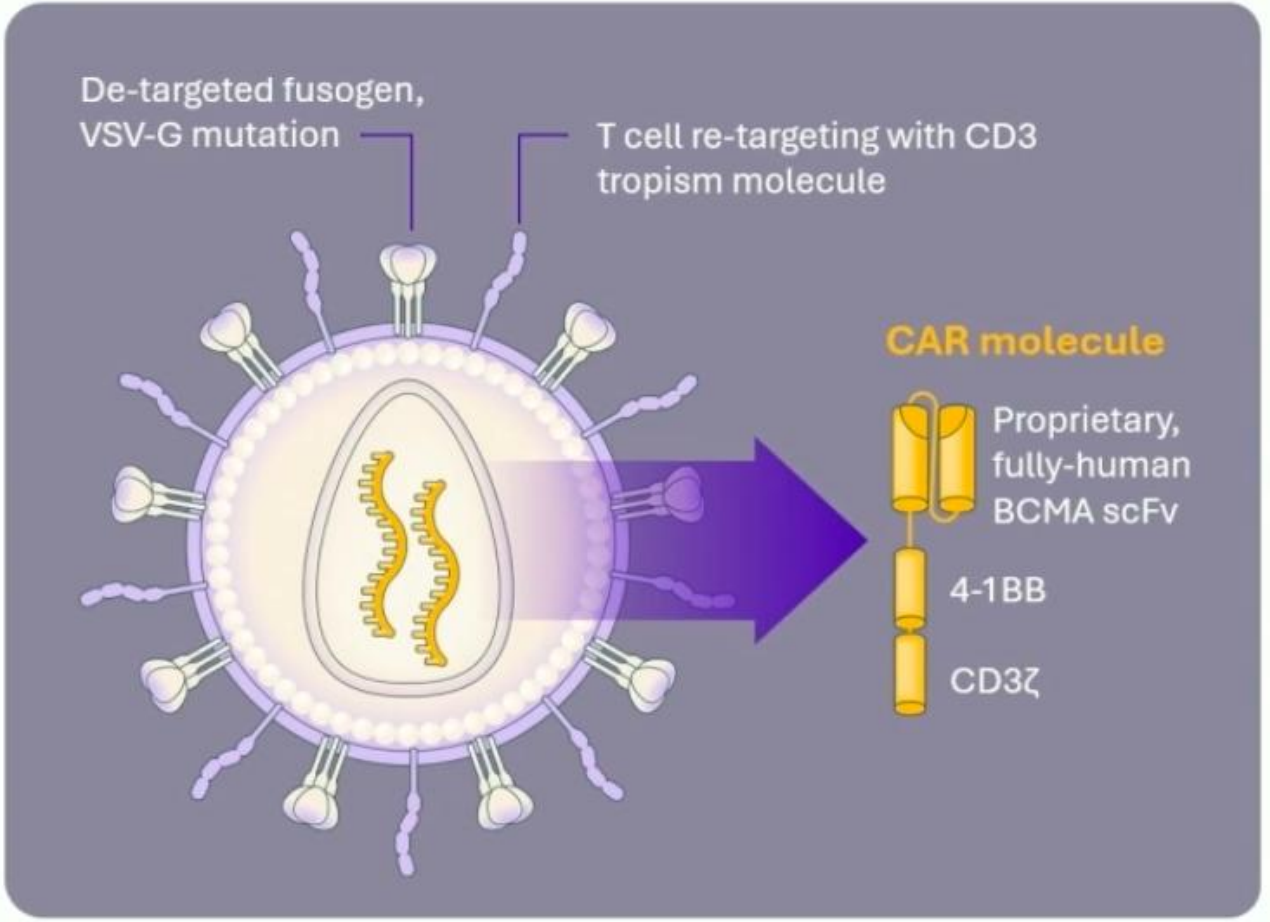
KLN-1010: a modified LVV generating anti-BCMA CAR-T cells *in vivo*

- **Envelope-modified, replication-incompetent, self-inactivating lentiviral vector**
- **De-targeted VSV-G fusogen** avoids delivery to LDL-expressing cells while maintaining high transduction efficiency
- **Precise re-targeting to T cells** with a CD3 scFv; avoids liver uptake and drug sinks
- Anti-BCMA CAR was **selected based on high levels of activity to BCMA-positive tumors**



BCMA, anti–B-cell maturation antigen; CAR, chimeric antigen receptor; CD3, cluster of differentiation 3; CD3ζ, cluster of differentiation 3 zeta chain; LDL, low-density lipoprotein; LVV, lentiviral vector; scFv, single-chain variable fragment; VSV-G, vesicular stomatitis virus glycoprotein.

Wood JT et al. Toward treatment with gene-modified B cells engineered *in vivo* using iGPS particles (abstract #1281). Poster presented at: ASGCT 28th Annual Meeting; May 13-17, 2025.

inMMyCAR, a first-in-human Phase 1 study of KLN-1010

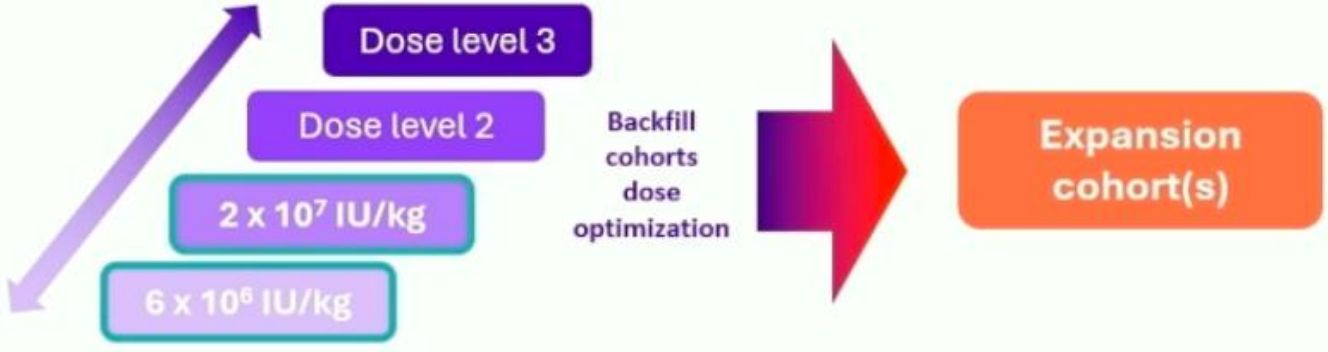
Dose escalation: 3+3 and backfill (N~20) → **Expansion (N~20), RP2D**

Patient population

- RRMM after ≥3 lines of therapy; prior PI, IMiD, CD38 mAb
- ECOG Performance Status of 0, 1
- Adequate bone marrow and end organ function

Endpoints

- **Primary:** Safety & tolerability, RP2D
- **Secondary:**
  - CAR T-cell expansion and persistence
  - ORR (IMWG criteria), MRD, DOR, PFS



Study sites

Peter MacCallum Cancer Center
The Alfred Hospital
Royal Prince Alfred Hospital

ClinicalTrials.gov ID: NCT07075185

CAR, chimeric antigen receptor; CD38, cluster of differentiation 38; DOR, duration of response; ECOG, Eastern Cooperative Oncology Group; IMiD, immunomodulatory drug; IMWG, International Myeloma Working Group; IU, infectious unit; mAb, monoclonal antibody; MRD, minimal residual disease; ORR, objective response rate; PFS, progression-free survival; PI, proteosome inhibitor; RP2D, recommended Phase 2 dose; RRMM, relapsed and refractory multiple myeloma.

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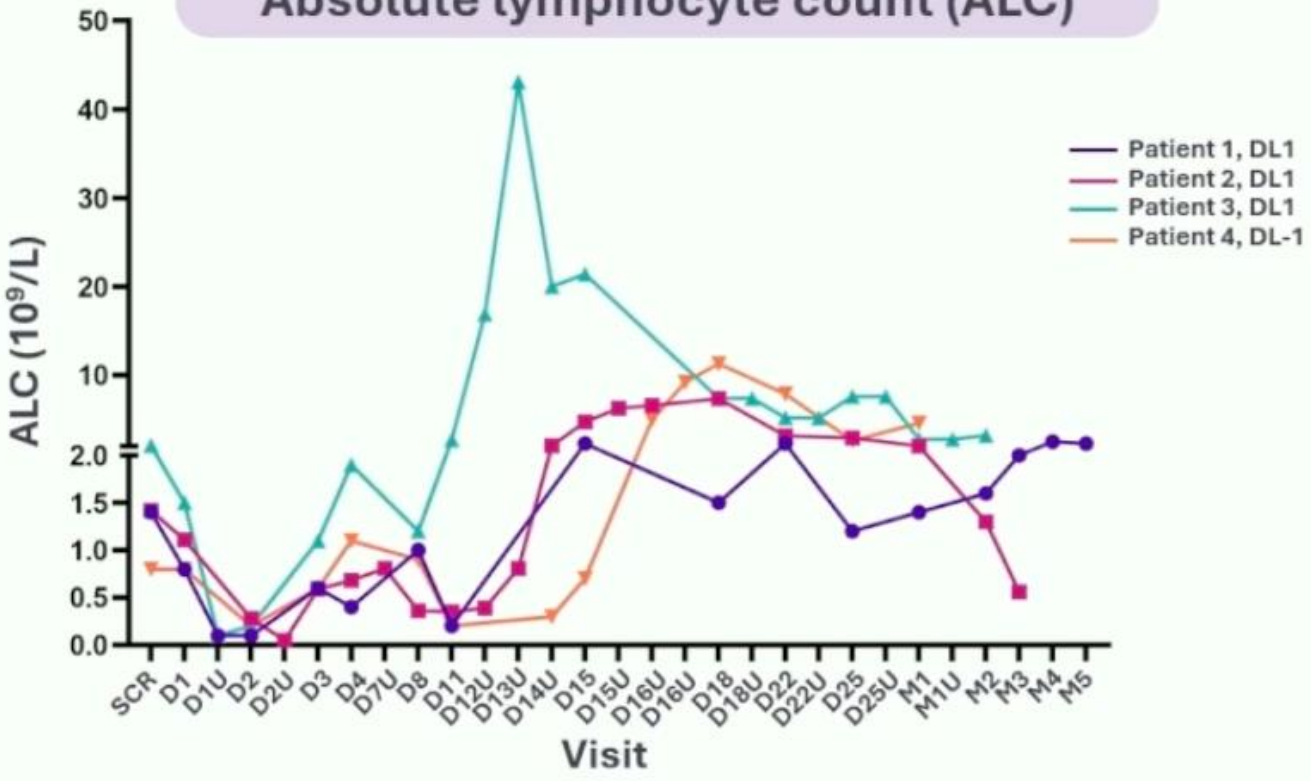
Baseline characteristics of initial 4 patients

Patient	Dose level	Age, years Sex	Diagnosis date	MM subtype	High-risk cytogenetics	EMD (Y/N)	BMPC	Prior ASCT (Y/N)	Prior lines, n	Refractoriness
1	DL 1 2×10^7 IU/kg	72 Male	Feb 2018	IgG lambda	del17p, +1q	N	30%	Y	4	PI, IMiD, α-CD38
2		62 Female	Apr 2017	IgG lambda	del17p, t(4;14), del1p32	N	<5%	Y	3	IMiD, α-CD38
3		61 Female	Oct 2017	IgG lambda	t(4;14)	N	10%	Y	3	PI, IMiD, α-CD38
4	DL -1 6×10^6 IU/kg	70 Male	Sep 2018	IgM kappa	del17p, +1q	N	60%	Y	5	PI, IMiD, α-CD38

ASCT, autologous stem cell transplant; BMPC, bone marrow plasma cells; CD38, cluster of differentiation 38; del, deletion; DL, dose level; EMD, extramedullary disease; Ig, immunoglobulin; IMiD, immunomodulatory drug; IU, infectious unit; MM, multiple myeloma; p, short arm of chromosome; PI, proteosome inhibitor; q, long arm of chromosome; t, translocation.

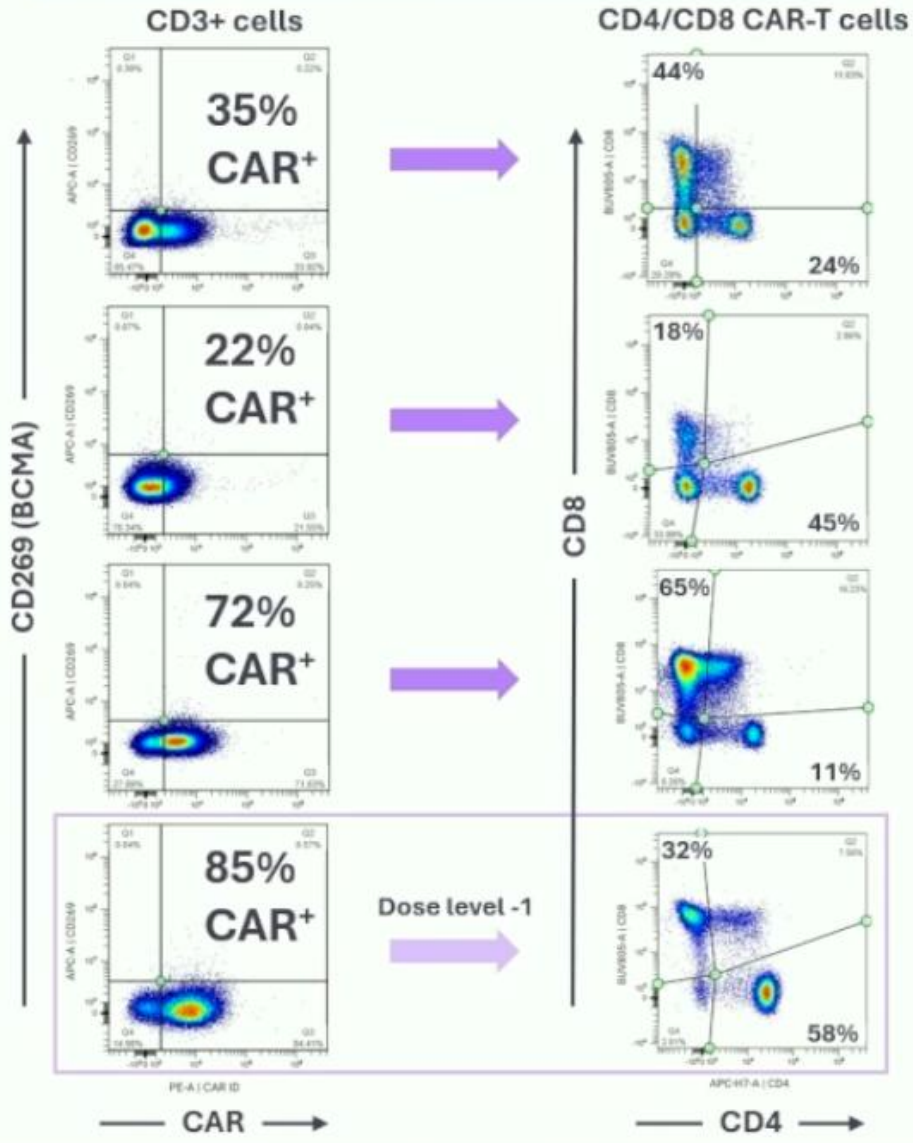
CAR-T expansion without lymphodepleting chemotherapy

Absolute lymphocyte count (ALC)



- **Dexamethasone** administered to patients 3 and 4
- **No clinical sequalae** related to lymphocytosis

Blood CAR-T cells (day 15)



BCMA, B-cell maturation antigen; CAR, chimeric antigen receptor; CD, cluster of differentiation; D, study day; DL, dose level; IU, infectious unit; M, month; SCR, screening; U, unscheduled measurements outside study specified schedule.

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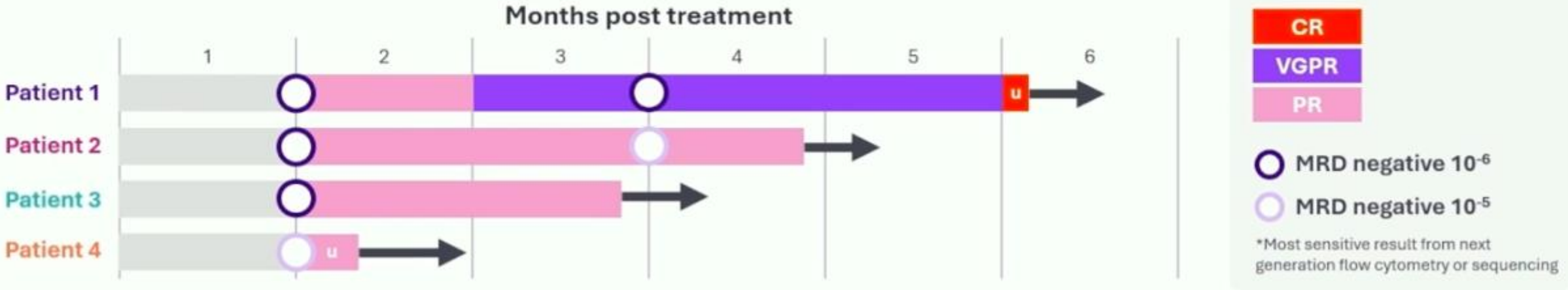
Deep, ongoing MRD-negative responses were observed across first 4 patients



BCMA, B-cell maturation antigen; BL, baseline; CR, complete response; D, study day; M, study month; M-spike, monoclonal protein spike; MRD, minimal residual disease; PR, partial response; SCR, screening; sFLC, serum free light chain; u, unconfirmed response; VGPR, very good partial response.

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No ICANS or delayed neurotoxicity; all instances of CRS were Grade 1-2

CRS (patient population, N=4)		
Onset, study day (range)		
Median onset	10 (10-12)	
Duration, days (range)		
Median duration	5.5 (2-8)	
Event, n	**Grade 1-2**	**Grade ≥3**
Dose level 1	2	0
Dose level -1	1	0
Supportive care, n		
Dexamethasone	3	
Tocilizumab	3	

ICANS, delayed neurotoxicity (patient population, N=4)		
Event, n	**Grade 1-2**	**Grade ≥3**
ICANS	0	0
Delayed neurotoxicity *(parkinsonism, cranial nerve palsy, peripheral neuropathy)*	0	0

CRS, cytokine release syndrome; ICANS, Immune Effector Cell-Associated Neurotoxicity Syndrome.

Favorable toxicity profile compared to *ex vivo* CAR T

- Minimal events of cytopenia; only 1 case of Grade 4 (transient neutropenia related to margination)
- Markedly lower number of events compared to *ex vivo* CAR-T therapies

TEAEs in >1 patient	Grade 1-2, n	Grade ≥3, n
IRR	2	1 (DLT)
Lymphocytosis	1	1
Hypomagnesemia	2	0
Hypokalemia	2	0

TEAEs Grade ≥3	Patients, n	Study day	Duration, days
Febrile neutropenia	1	1	2
IRR	1	1	3
Lymphopenia	1	2, 8	2, 5
Lymphocytosis	1	13	3
Anemia	1	15	2
Vasovagal syncope	1	27	1
Pneumonia	1	86	8

Cytopenia			
	Grade ≥3, n	Study day	Duration, days
Anemia	1	15	2
Thrombocytopenia	1	16	2
Neutropenia	2	1, 15	2, 2
		14	3

Infusion-related reactions			
	Grade 1-2, n	Grade ≥3, n	Supportive care
Dose level 1	1	1	Tocilizumab, steroid
Dose level -1	1	0	Paracetamol

CAR, chimeric antigen receptor; DLT, dose-limiting toxicity; IRR, infusion-related reaction; TEAE, treatment-emergent adverse event.

Conclusions

- **Lymphodepletion not required** for *in vivo* CAR-T cell generation and expansion in the peripheral blood
  - CAR-T cell expansion peaked around day 15; memory-phenotype T cells persisted in the bone marrow and blood through month 3
  - Similar outcomes have been associated with durable remissions with *ex* vivo CAR-T cells in MM
- **Favorable safety and tolerability profiles** using **off-the-shelf** product make outpatient therapy feasible
  - CRS was consistent with those seen with *ex vivo* CAR-T therapies, while cytopenias were notably limited
- **100% early MRD-negative responses** with deepening of IMWG response over time; MRD-negative BM response is **sustained through 3 months** in the first 2 patients with longest follow-up
- **Initial MRD-negative response and persistent CAR-T cells prognostic of ongoing clinical responses**
  - Establishing durability of response remains a priority in continued follow-up; updated results will be presented at future meetings

BM, bone marrow; CAR, chimeric antigen receptor; CRS, cytokine release syndrome; IMWG, International Myeloma Working Group; MM, multiple myeloma; MRD, minimal residual disease.

Long-Term Progression-Free Survival Benefit With Ciltacabtagene Autoleucel in Standard-Risk Relapsed/Refractory Multiple Myeloma

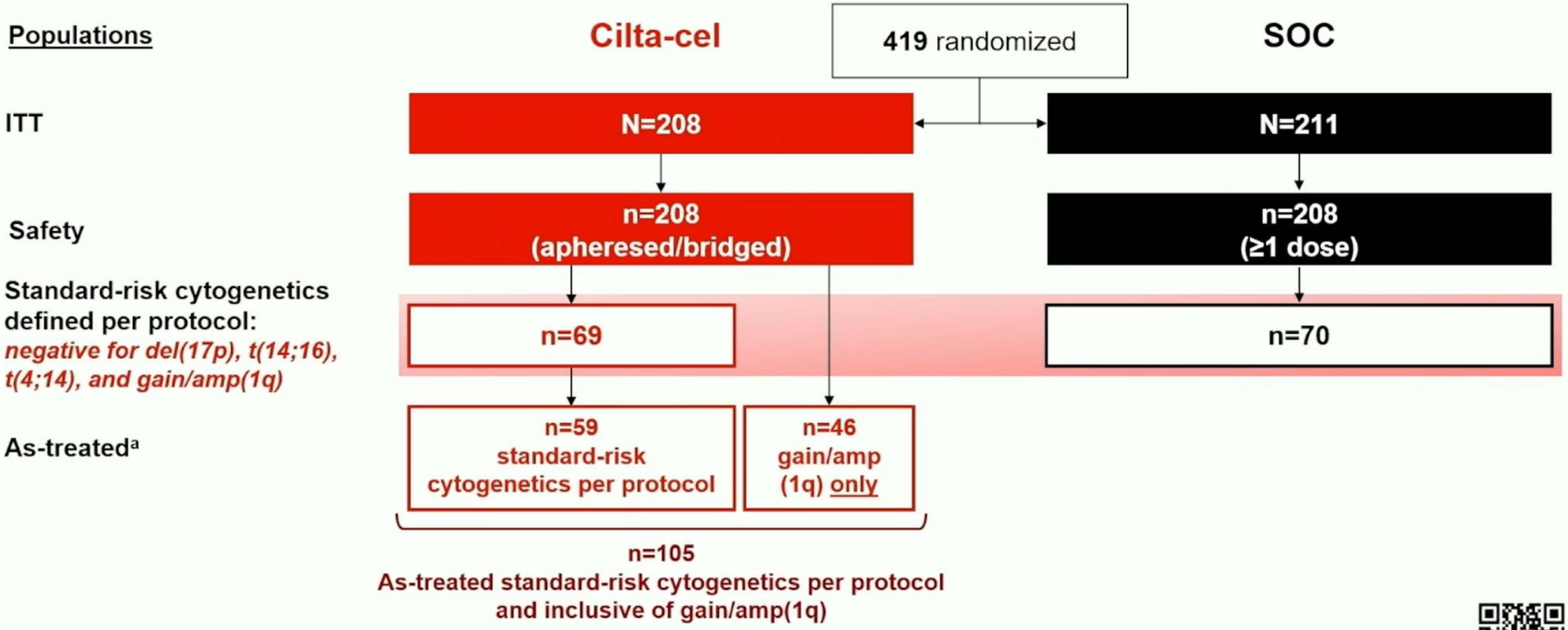
Luciano Costa[1], Albert Oriol[2], Dominik Dytfeld[3], Salomon Manier[4], Peter Voorhees[5], Yi Lin[6], Myo Htut[7], Wilfried Roeloffzen[8], Phoebe Joy Ho[9], Urvi Shah[10], Man Zhao[11], Quanlin Li[12], Agnes Balogh[13], Katherine Li[14], Ana Slaughter[15], Nina Benachour[13], Carolina Lonardi[16], Arnab Ghosh[17], Huabin Sun[17], Nikoletta Lendvai[17], Tamar Lengil[17], Nitin Patel[18], Mythili Koneru[18], Erika Florendo[18], Octavio Costa[18], Vrinda Mahajan[18], Paula Rodríguez-Otero[19], Christopher Strouse[20], A. Keith Stewart[21], Surbhi Sidana[22]

[1]University of Alabama at Birmingham, Birmingham, AL, United States; [2]Institut Català d'Oncologia and Institut Josep Carreras, Hospital Germans Trias i Pujol, Badalona, Barcelona, Spain; [3]Poznan University of Medical Sciences, Poznań, Poland; [4]University of Lille, CHU Lille, Lille, France; [5]Atrium Health/Levine Cancer Institute, Wake Forest University School of Medicine, Charlotte, NC, United States; [6]Mayo Clinic, Rochester, MN, United States; [7]Department of Hematology and Hematopoietic Cell Transplantation, City of Hope Comprehensive Cancer Center, Duarte, CA, United States; [8]Department of Hematology, University Medical Center Groningen, Groningen, Netherlands; [9]Royal Prince Alfred Hospital, Sydney, Australia; [10]Myeloma Service, Memorial Sloan Kettering Cancer Center, and Weill Cornell Medical College, New York, NY, United States; [11]IQVIA, Shanghai, China; 12Johnson & Johnson, Apex, NC, United States; [13]Johnson & Johnson, Beerse, Belgium; [14]Johnson & Johnson, Spring House, PA, United States; [15]Johnson & Johnson, Zug, Switzerland; [16]Johnson & Johnson, Buenos Aires, Argentina; [17]Johnson & Johnson, Raritan, NJ, United States; [18]Legend Biotech USA Inc, Somerset, NJ, United States; [19]Cancer Center Clínica Universidad de Navarra, Cima, Pamplona, Spain; [20]Hematology, Oncology, and Blood & Marrow Transplantation, University of Iowa, Iowa City, IA, United States; [21]University Health Network and the Princess Margaret Cancer Centre, Toronto, ON, Canada; [22]Stanford University School of Medicine, Stanford, CA, United States

Presented by L Costa at the 67th American Society of Hematology (ASH) Annual Meeting; December 6-9, 2025; Orlando, Florida, USA

CARTITUDE-4: Study Population

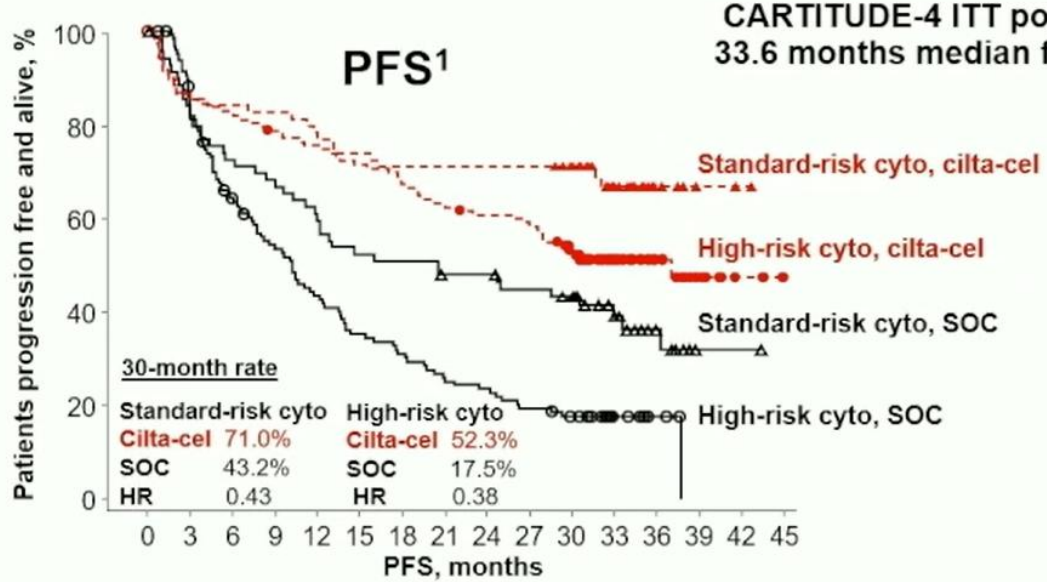
- Here, we report outcomes in CARTITUDE-4 patients with standard-risk cytogenetics[5]



[a]10 patients with standard-risk cytogenetics did not receive cilta-cel as study treatment due to disease progression prior to cilta-cel infusion.

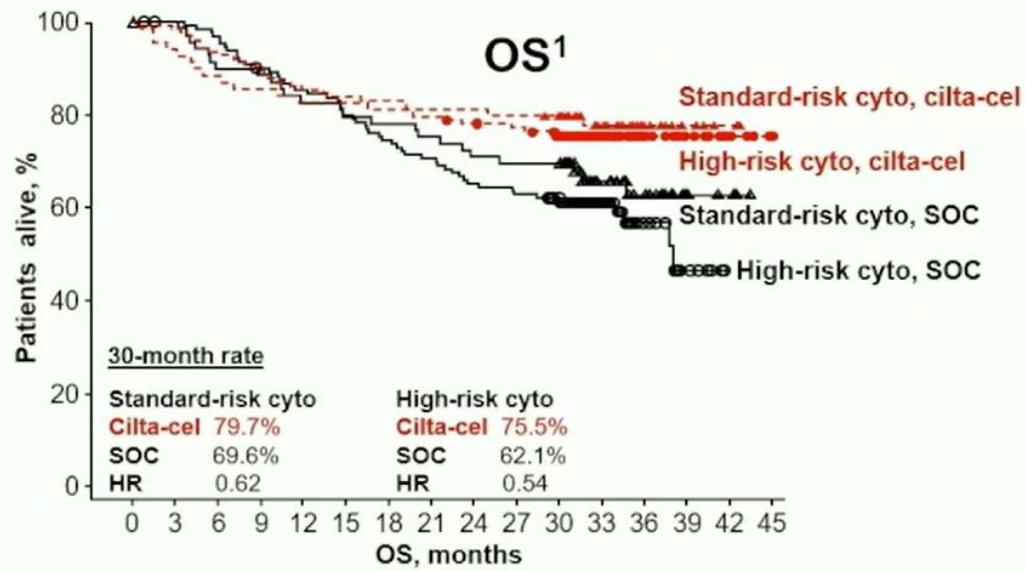
PFS and OS in Patients With High-Risk and Standard-Risk Cytogenetics (ITT)

CARTITUDE-4 ITT population
33.6 months median follow-up



Patients at risk

High risk, SOC	132	111	79	65	52	42	37	31	28	23	20	7	3	0	0	0
High risk, cilta-cel	123	106	102	96	92	87	84	76	73	70	55	31	14	7	2	0
Standard risk, SOC	70	58	50	47	41	36	35	32	32	29	27	18	9	1	1	0
Standard risk, cilta-cel	69	59	58	57	53	51	49	49	49	49	46	27	9	2	1	0



Patients at risk

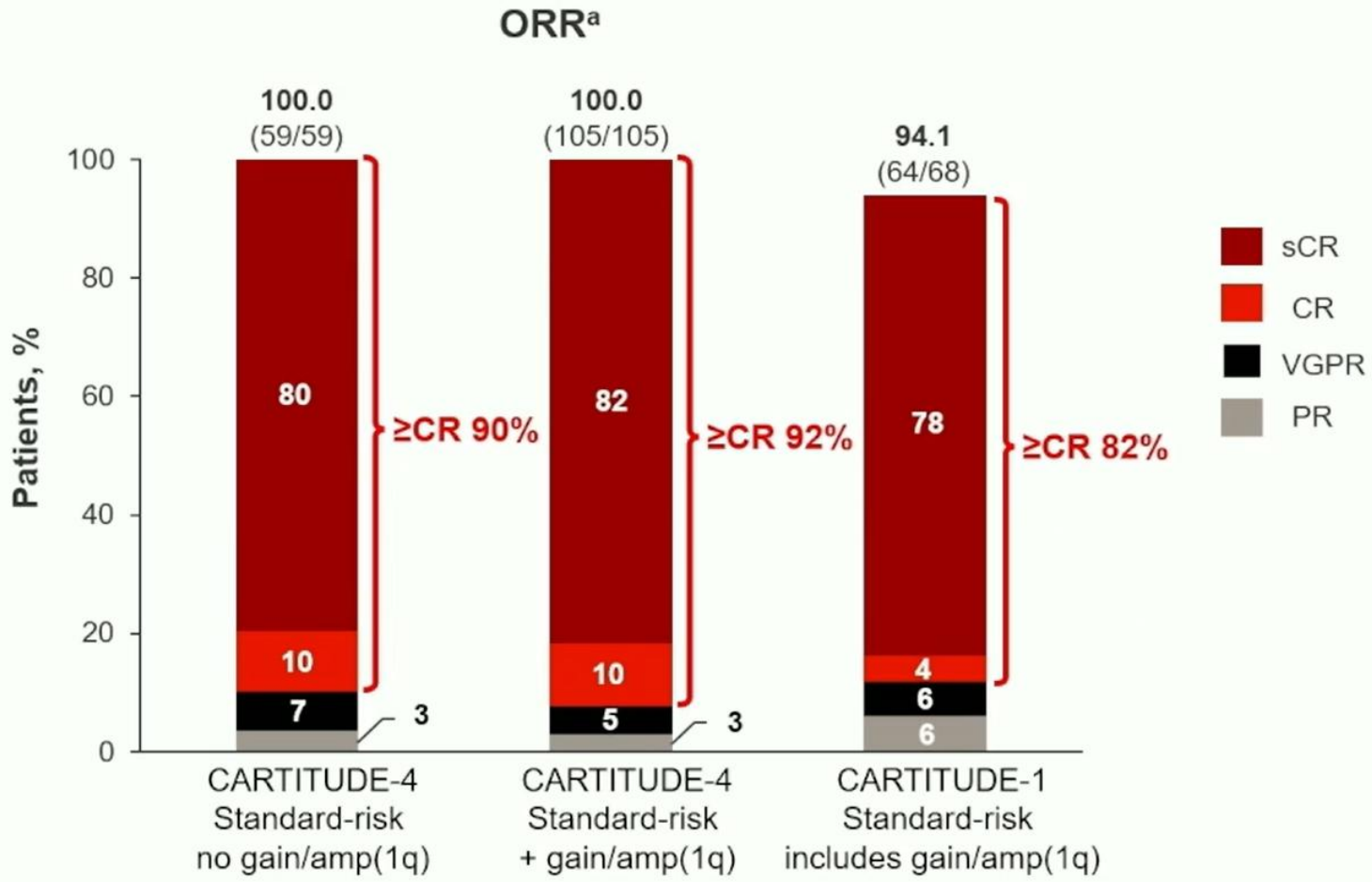
High risk, SOC	132	130	126	116	110	103	96	91	84	81	75	38	14	6	0	0
High risk, cilta-cel	123	121	115	111	105	103	102	98	95	93	83	50	23	14	5	0
Standard risk, SOC	70	69	62	61	57	55	54	52	49	48	48	29	18	5	3	0
Standard risk, cilta-cel	69	65	61	59	57	57	56	56	56	55	52	35	13	5	2	0

In CARTITUDE-4, cilta-cel improved PFS and OS in prespecified subgroups with standard- and high-risk cytogenetics[1]

1. Sidana S, et al. *J Clin Oncol* 2025;43:7539.

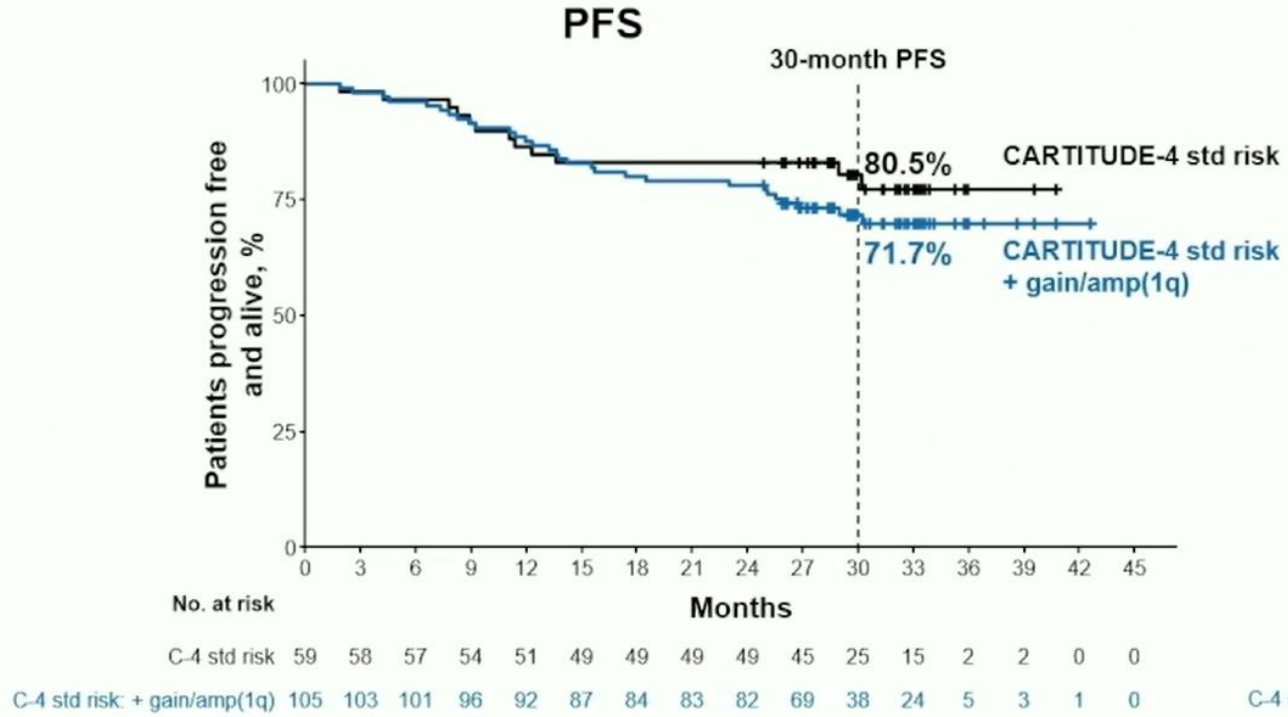
Presented by L Costa at the 67th American Society of Hematology (ASH) Annual Meeting; December 6–9, 2025; Orlando, FL, USA

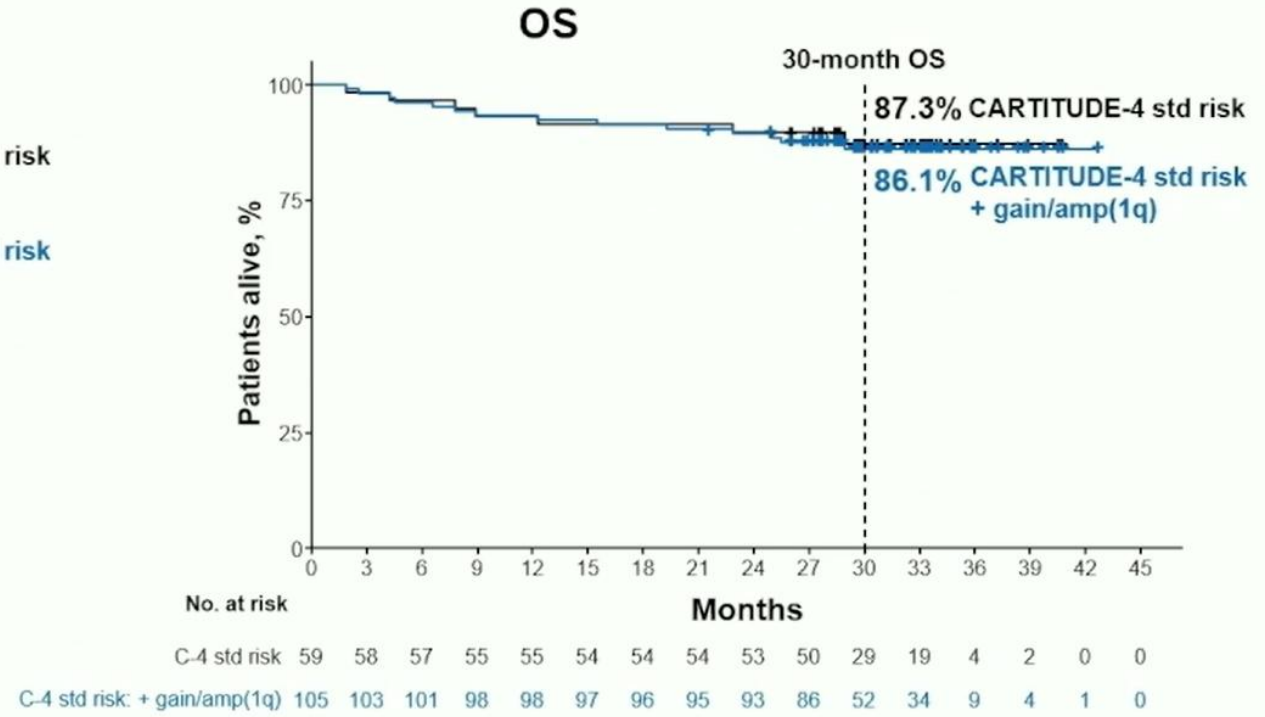
CARTITUDE-4 and CARTITUDE-1: Response Rates for Patients With Standard-Risk Cytogenetics (As-Treated)



[a]Assessed using a computerized algorithm based on IMWG consensus criteria (2016). Percentages may not add up to an exact 100% due to rounding.
IMWG, International Myeloma Working Group; PR, partial response; sCR, stringent complete response; VGPR, very good partial response.

CARTITUDE-4: PFS and OS in Patients With Standard-Risk Cytogenetics (As-Treated)





80% of CARTITUDE-4 patients with standard-risk disease who received cilta-cel as study treatment remained progression free and off treatment at 30 months

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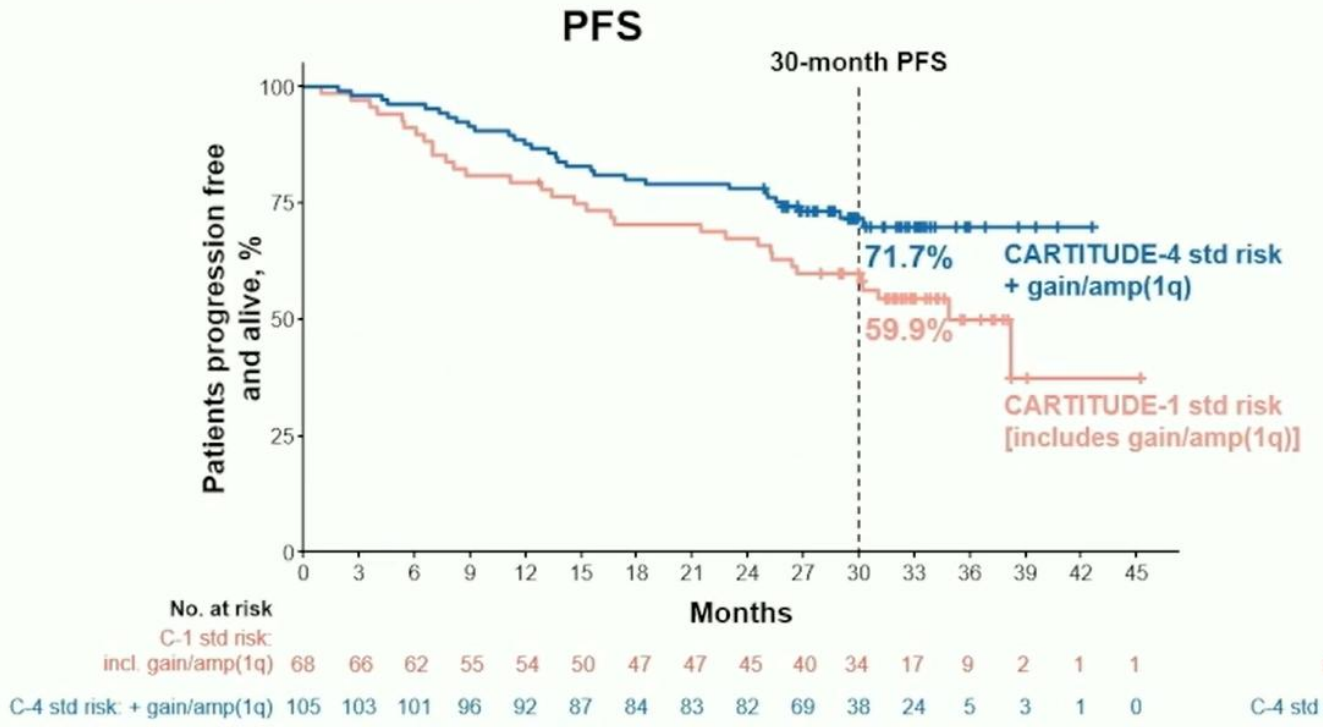
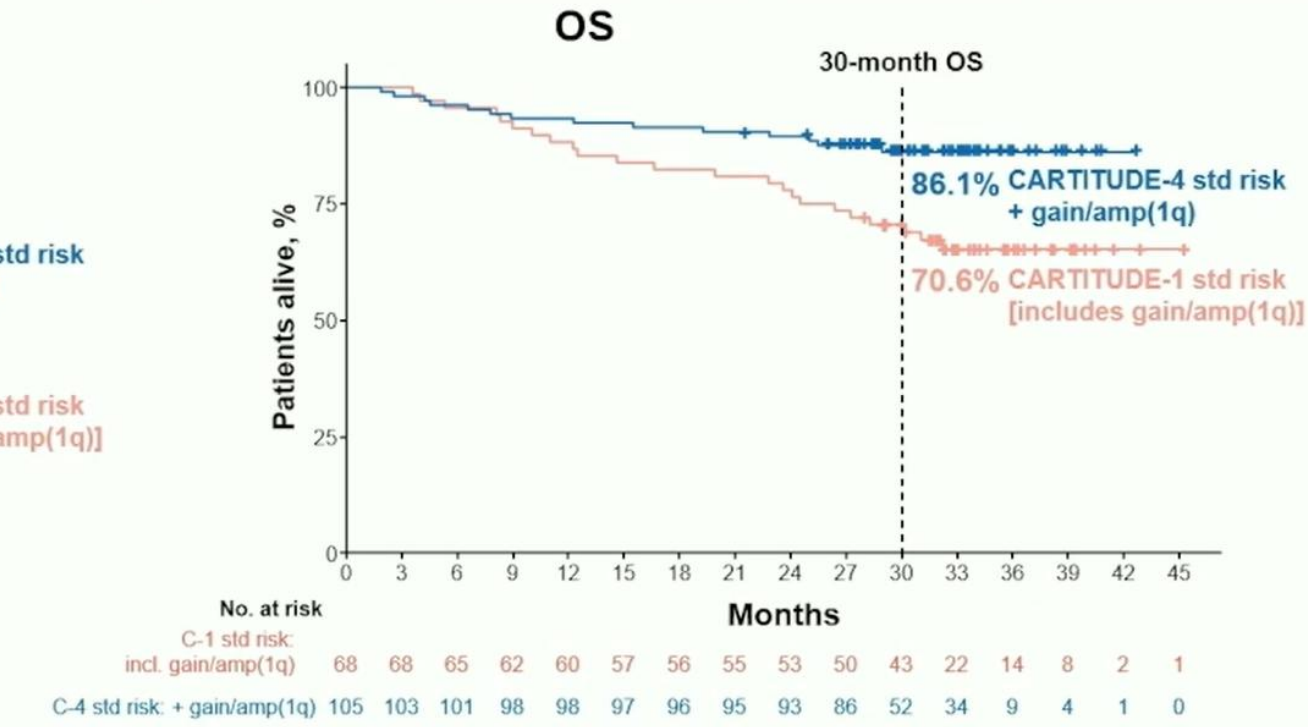
CARTITUDE-4 and CARTITUDE-1: PFS and OS in Patients With Standard-Risk Cytogenetics (As-Treated)





Survival rates were higher when cilta-cel was used earlier in standard-risk disease

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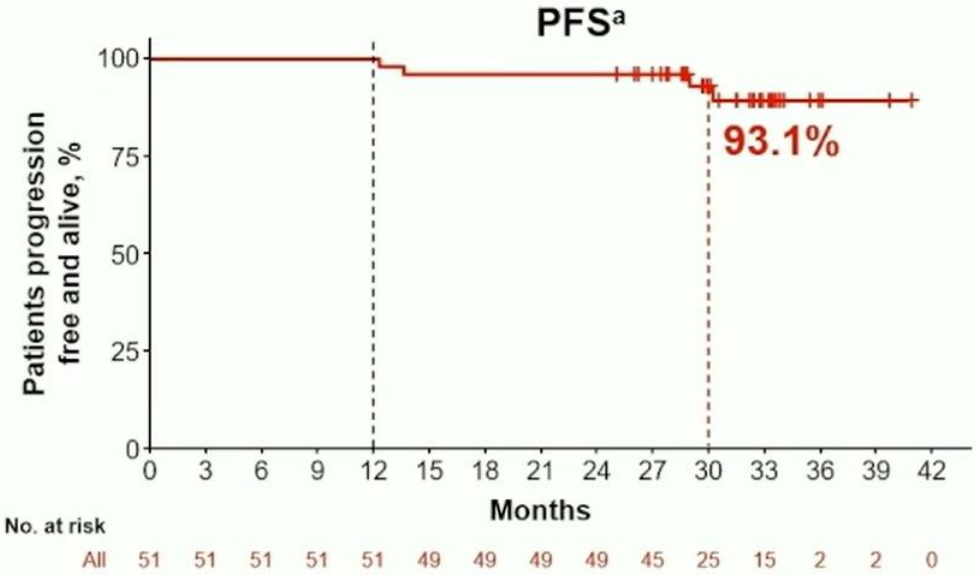
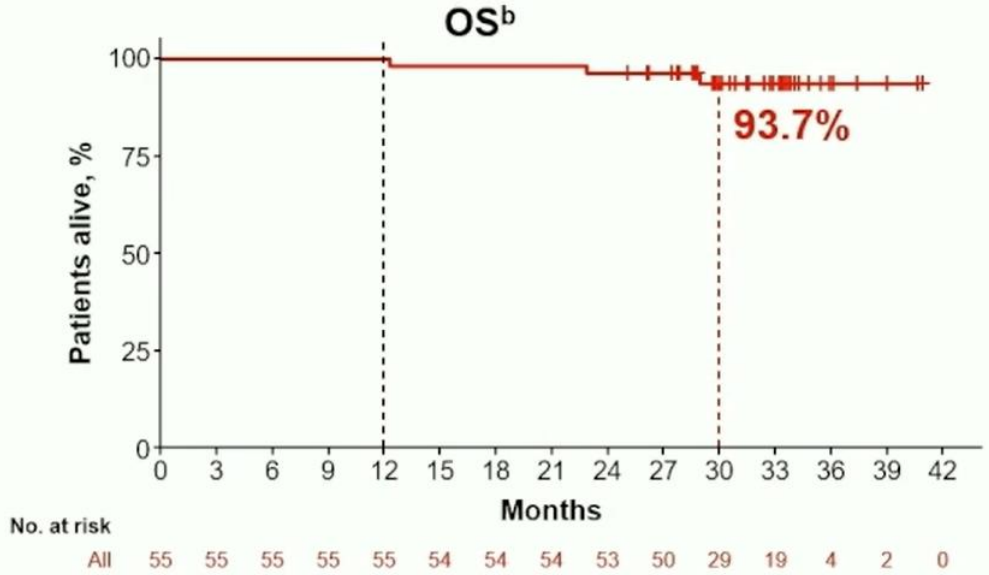
CARTITUDE-4: Survival Outcomes for Patients With Standard-Risk Cytogenetics Who Were Progression Free and Alive at 1 Year

- 86% (51/59) of patients with standard-risk cytogenetics were progression free and alive ≥1 year
  - PFS and OS rates were **~93% at 30 months** for these patients with early sustained responses





- MRD-negative CR rate at 1 year was **81%** (26/32; MRD-evaluable population at 1 year)
  - **All 26** patients remained progression free at 30 months

Treating standard-risk RRMM early with cilta-cel delivered high rates of durable remissions that extended time off treatment

[a]Includes 51 patients who were alive and progression free at 12 months. [b]Includes 55 patients alive at 12 months.

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Summary of Cilta-cel Outcomes in Standard-Risk Myeloma (As-Treated Population)

	30-month PFS rate, %	30-month OS rate, %
CARTITUDE-4 (median 2 prior lines)		
Cilta-cel *Standard-risk cytogenetics per protocol*	80.5	87.3
Cilta-cel *Standard-risk cytogenetics per protocol + gain/amp(1q)*	71.7	86.1
CARTITUDE-1 (median 6 prior lines)		
Cilta-cel *Standard-risk cytogenetics per protocol including gain/amp(1q)*	59.9	70.6

Earlier use of cilta-cel in standard-risk RRMM led to higher survival rates

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CARTITUDE-4 Standard-Risk Disease: Conclusions

- The cilta-cel benefit-risk profile in the CARTITUDE-4 standard-risk as-treated population supports early use:
  - 80% of patients were free from progression and without treatment at 2.5 years
  - 93% of patients who were progression free at 1 year remained alive and progression-free at 2.5 years
  - Of patients in MRD-negative CR, 100% remained progression-free at 2.5 years
- Safety was consistent with the overall population
  - There were no IEC-parkinsonism events and low non-relapse mortality after 1 year in this patient population
- Earlier treatment with a single infusion of cilta-cel (CARTITUDE-4 vs CARTITUDE-1) improved survival outcomes for patients with standard-risk disease, extending time free from treatment and progression

The low rate of progression events in patients with standard-risk RRMM is indicative of a potential cure fraction, which will be further defined with additional study follow-up

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KEY TAKEAWAY

1. With 2.5 yrs PFS and OS of ~80% in Standard Risk patients, Cilta-cel is the most effective 'single one-time treatment' option for RRMM at First Relapse
2. While CRS, ICANS, and infections are common, transient, and manageable; late onset motor and neurocognitive toxicities can be challenging to manage; access to therapy can be a barrier
3. Advantages of one-time treatment vs life long therapy, risk of infections vs neurological complications, resistance patterns to future BCMA directed therapies need to be discussed with patients

CARTITUDE-4 PFS&OS update: 3 years follow-up:

Lancet Oncol 2026

PFS benefit impressive—but is there a plateau?

🔍 Critical question: Does standard-risk disease show a plateau? we need ≥5-year data in standard- and high-risk subsets to be sure!

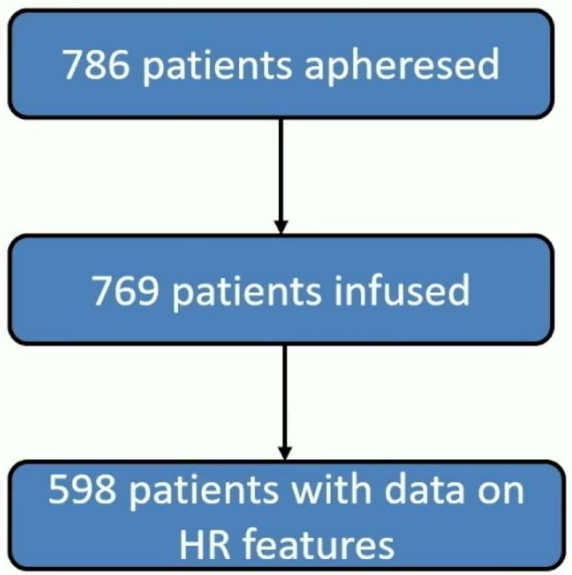
2. Safety signals: The good and the concerning

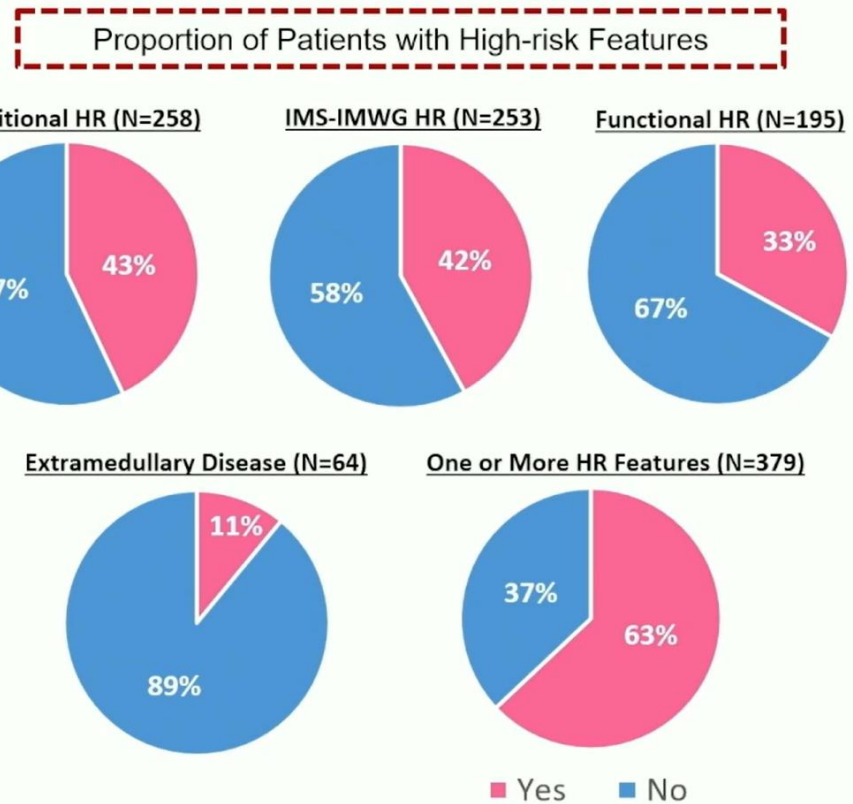
✅ GOOD: Parkinsonism <1% (vs 6% in CARTITUDE-1)—very reassuring!

⚠️ CONCERNING: Secondary hematologic malignancies (MDS/AML/CTTLN) at 3.4% vs 0.5% in control arm. Is this a class effect or product-specific?

Predictors of Early Relapse Following Ciltacabtagene Autoleucel Informing Risk-adapted Therapy in Relapsed/Refractory Multiple Myeloma

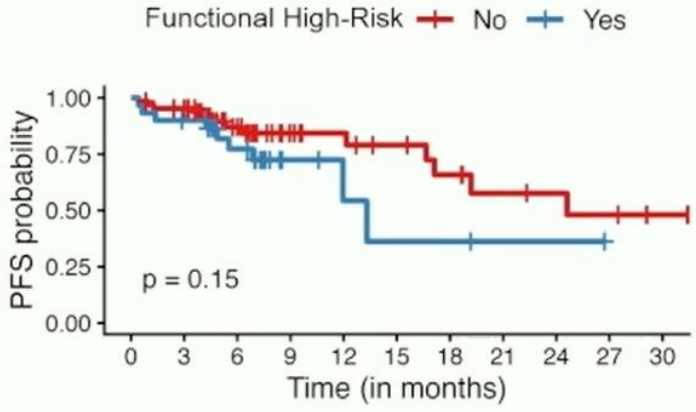
Flow Diagram: Multicenter Retrospective Study Population

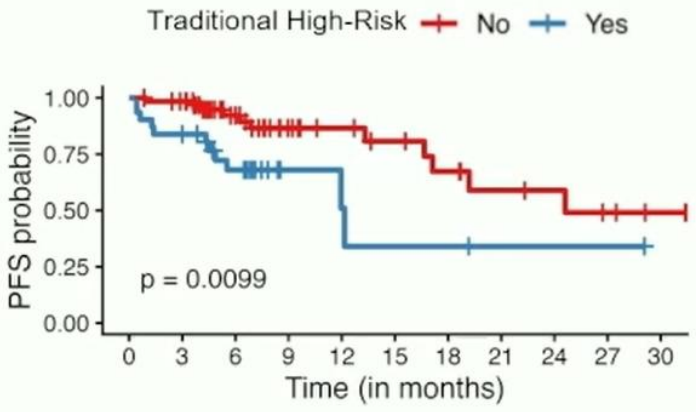


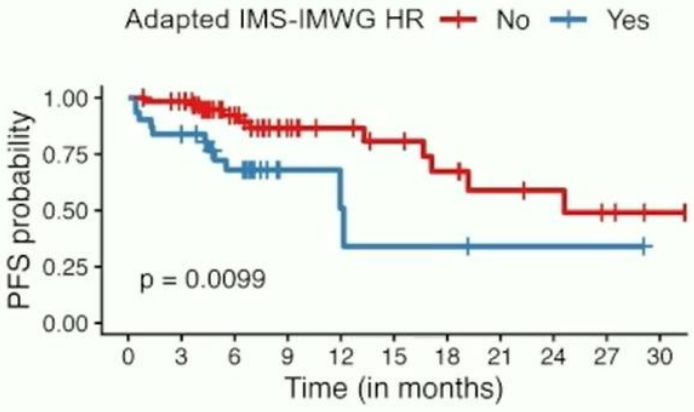


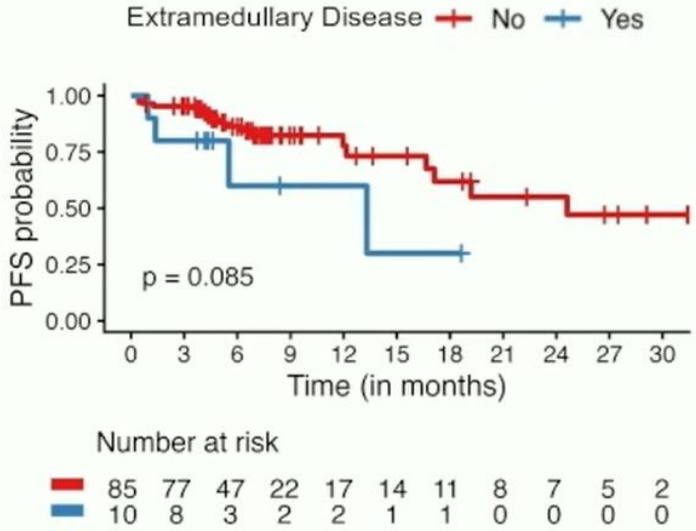
Hansen et al. ASH 2025 [Abstract #93]

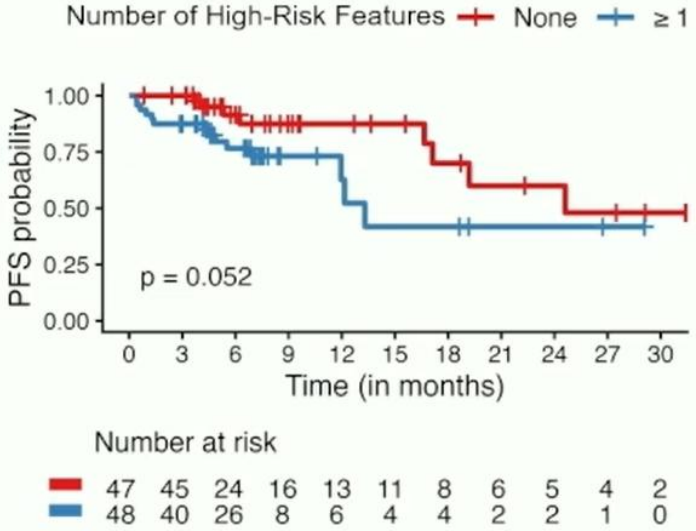
PFS Remains Inferior Across High-Risk Features in 1-3 pLOT











12-month PFS (95% CI) for each HR vs no HR:

- ❖ FHR: 54% (29-100) vs 84% (75-95)
- ❖ THR: 51% (27-95) vs 87% (77-98)
- ❖ IMS HR: 51% (27-95) vs 87% (77-98)
- ❖ EMD: 60% (32-100) vs 78% (66-91)
- ❖ ≥ 1 HR: 63% (44-90) vs 88% (76-100)

❖ These findings inform risk-adapted therapeutic strategies to improve outcomes in HRMM

Hansen et al. ASH 2025 [Abstract #93]

Abstract 256
Phase 2 Registrational Study of Anitocabtagene Autoleucel for the Treatment of Patients with Relapsed and/or Refractory Multiple Myeloma (RRMM): Updated Results from iMMagine-1

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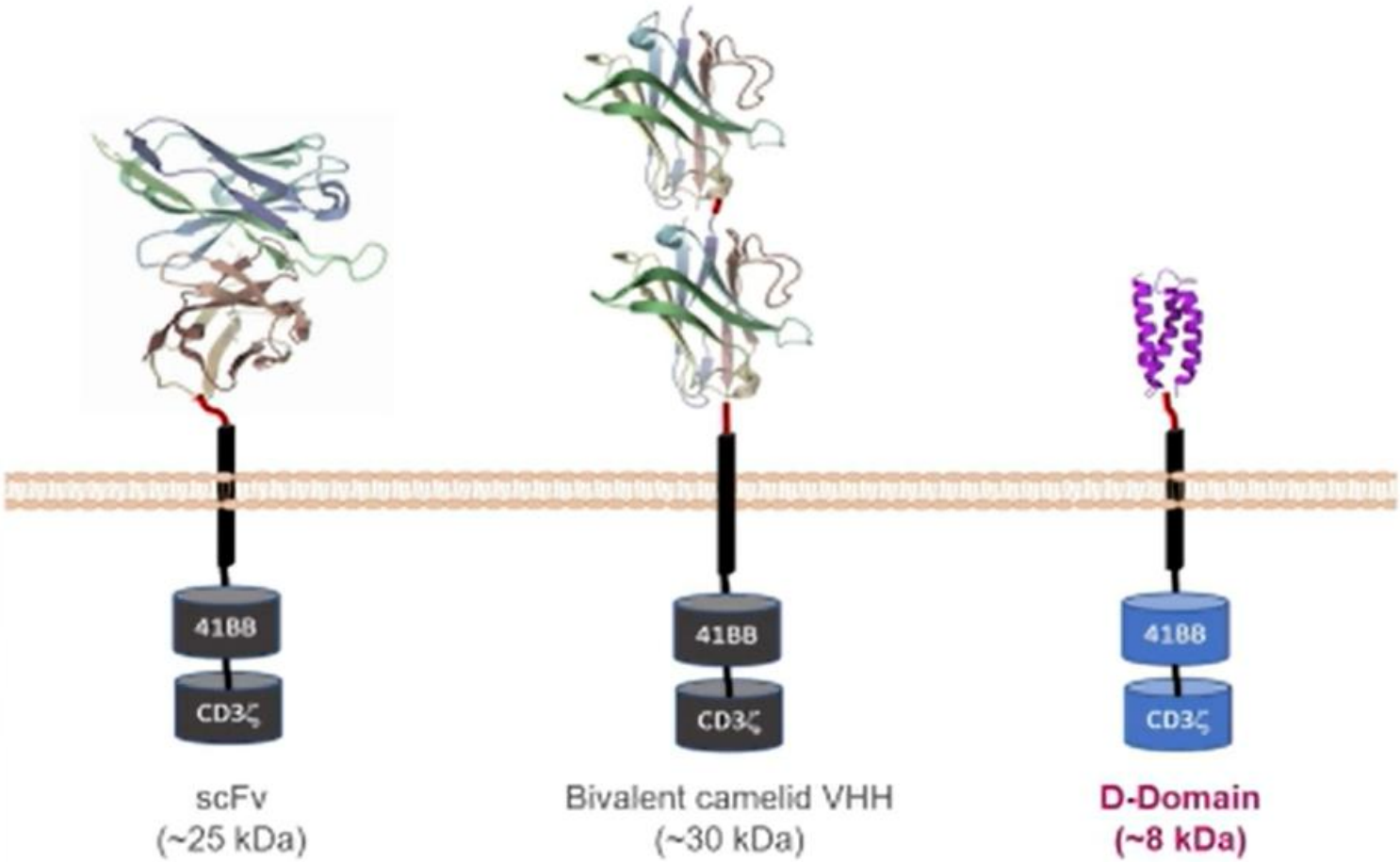
Anitocabtagene autoleucel (anito-cel/CART-ddBCMA)

Autologous BCMA-directed CAR T-cell therapy using a novel, D-Domain binder[1,2]



scFv
(~25 kDa)

Bivalent camelid VHH
(~30 kDa)

D-Domain
(~8 kDa)

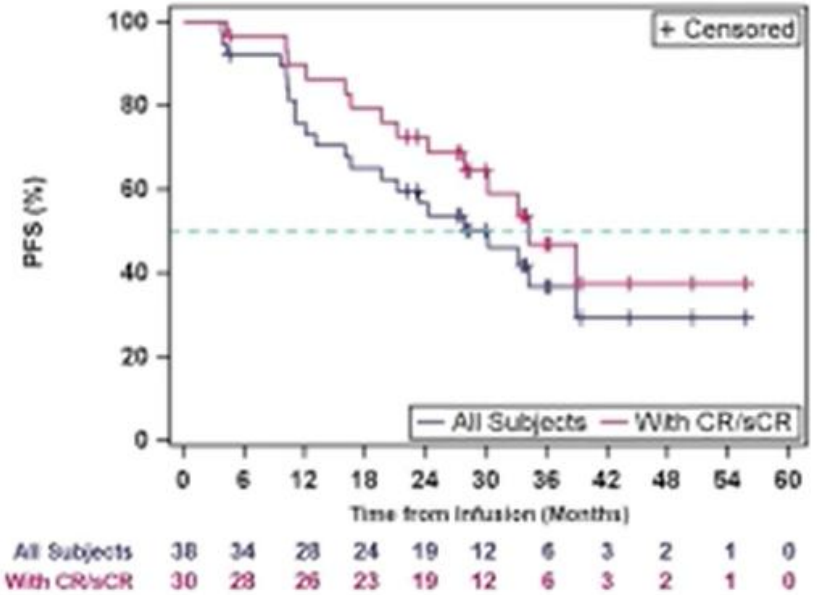
D-Domain Attributes:
Non-Antibody Derived Synthetic Protein[1,2]

Size	Small D-Domain construct facilitates high transduction efficiency and CAR positivity[2-4] resulting in a low total cell dose
Structure & Stability	D-Domain CARs are stable and lack tonic signaling[4,5] due to the rapid folding, lack of disulfide bonds, and hydrophobic core[5,6] of the D-Domain
Binding	The D-Domain binder has a fast off-rate[4] and high CAR surface expression[4]. This combination may allow optimal tumor cell killing without prolonged inflammation

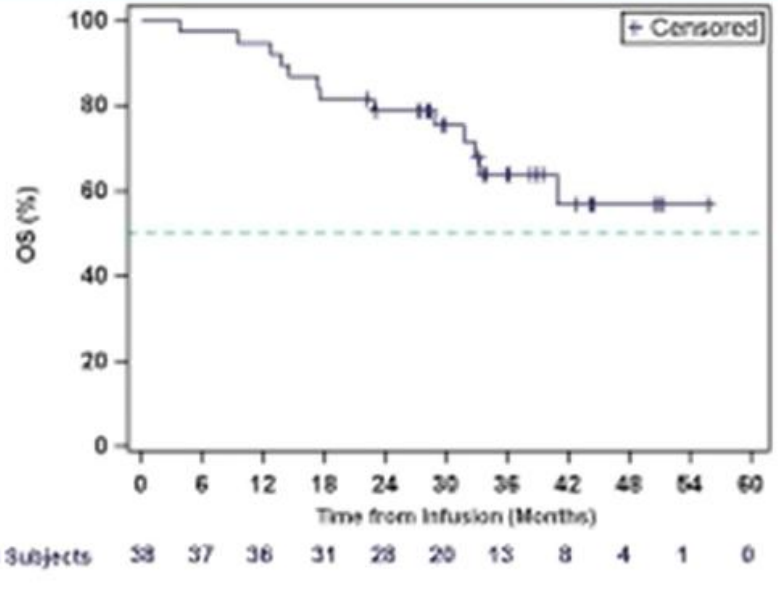
[1]Rolfe, et al. Immuno-Oncology Insights 2022; 3(1), 13-24; [2]Frigault, et al. Blood Adv. 2023; 7(5):768-777; [3]Canto-Barrett, et al. BMC Res. Notes 2016; 9:13; [4]Buoniato, et al. Mol. Cancer Ther. 2022; 21(7):1171-1183; [5]Zhu, et al. Proc. Nat. Acad. Sci. 2003; 100(28): 15486-15491; [6]Qin, et al. Mol. Ther. 2019; 27(7): 1262-1274.

Background: Anito-cel Phase 1 Demonstrated mPFS of 30.2 Months in a 4L+ RRMM Population

Median PFS of 30.2 Months at 38.1 Months of Follow-up (N=38)



Median Overall Survival Not Reached (N=38)



- **With a median follow-up of 38.1 months, anito-cel achieved rapid, high response rates with long-term durable remissions in a refractory, heavily pre-treated 4L+ RRMM population :**
  - sCR/CR achieved in 79% of patients
  - Median PFS of 30.2 months in all patients and 34.3 months in patients with sCR/CR
  - Median OS not reached
  - Similar efficacy and durable remissions were observed across high-risk subgroups (68% of patients had high-risk features)
- **The safety profile is predictable and manageable with no delayed or non-ICANS neurotoxicities, including no Parkinsonism, no cranial nerve palsies, and no Guillain-Barré syndrome**

Responses determined by IMWG Consensus Criteria; Bishop MR, et al. Blood (2024) 144 (Supplement 1): 4925 as presented in poster #4925 at ASH 2024; Data cut off: October 3, 2024

iMMagine-1: Overall Patient Disposition

Data cut-off: October 7, 2025; Median follow-up of 15.9 months

Key Eligibility Criteria

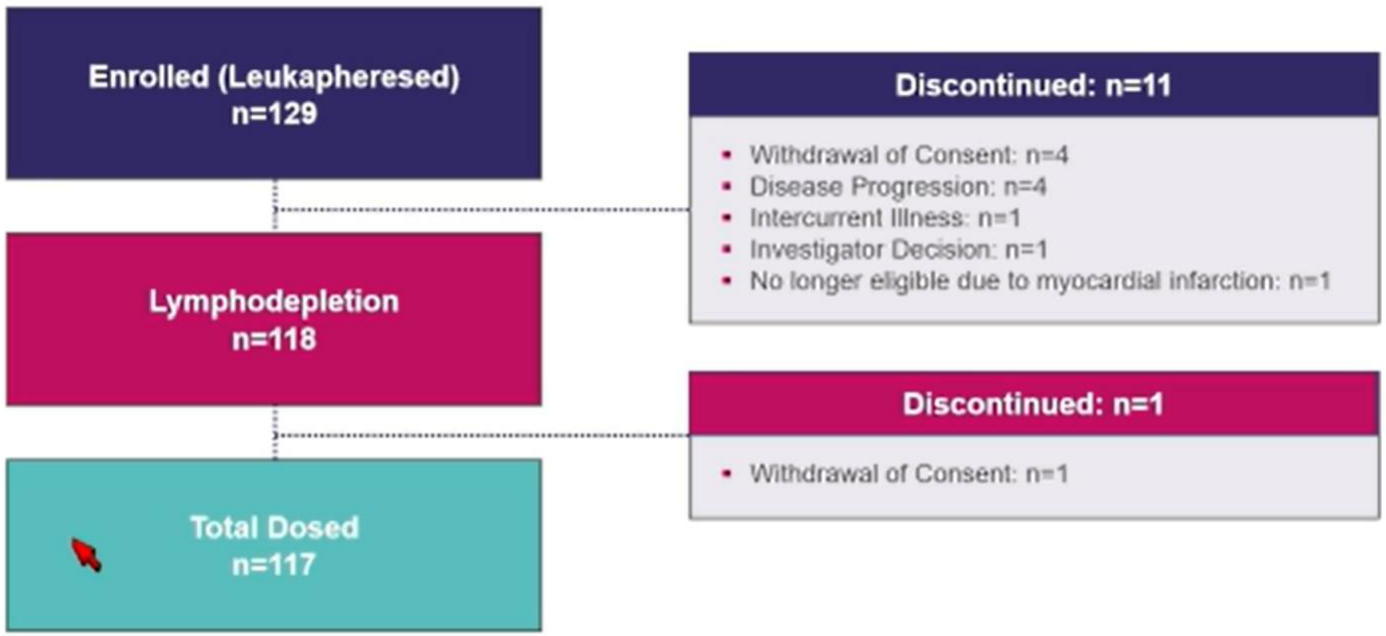
- Prior IMiD, PI, and CD38-targeted therapy
- Received ≥3 prior lines of therapy
- Refractory to the last line of therapy
- ECOG PS of 0 or 1
- Evidence of measurable disease

Primary Endpoint:

- ORR, per 2016 IMWG criteria

Key Secondary Endpoints:

- sCR/CR rate, per 2016 IMWG criteria
- ORR in patients limited to 3 prior LoT, per 2016 IMWG criteria



Anito-cel was successfully manufactured for 99% of patients enrolled

Patient and Disease Characteristics

Extramedullary disease[a]	21 (18%)
High risk cytogenetics[c]	47 (40%)
Refractory to last line of therapy	117 (100%)
Triple refractory	102 (87%)
Penta refractory	48 (41%)
Prior lines of therapy, median (min - max) 3 Prior LoT	3 (3 – 8) 65 (56%)
Time since diagnosis (years), median (min - max)	7.5 (1.0 – 23.1)
Prior ASCT	92 (79%)
Bridging therapy	89 (76%)

iMMagine-1: Overall Response Rate and Depth of Response

Efficacy Evaluable Patients, N=117

- Responses continue to deepen over time
- At a median follow-up of 15.9 months, IRC-assessed ORR was 96% and sCR/CR rate was 74%

MRD Negativity at 10^{-5} Sensitivity Level	
Overall MRD negativity, % (n/N)	95% (91/96)
Median time to MRD negativity, months (min – max)	1.0 (0.9 – 6.4)
MRD negativity sustained for ≥ 6 months, % (n/N)	83% (54/65)
MRD Negativity at 10^{-6} Sensitivity Level	
Overall MRD negativity, % (n/N)	78% (68/87)

Responses are per IMWG criteria and are IRC assessed; ORR defined as partial response or better.
CR, complete response; IRC, independent review committee; ORR, overall response rate; PR, partial response; sCR, stringent complete response; VGPR, very good partial response

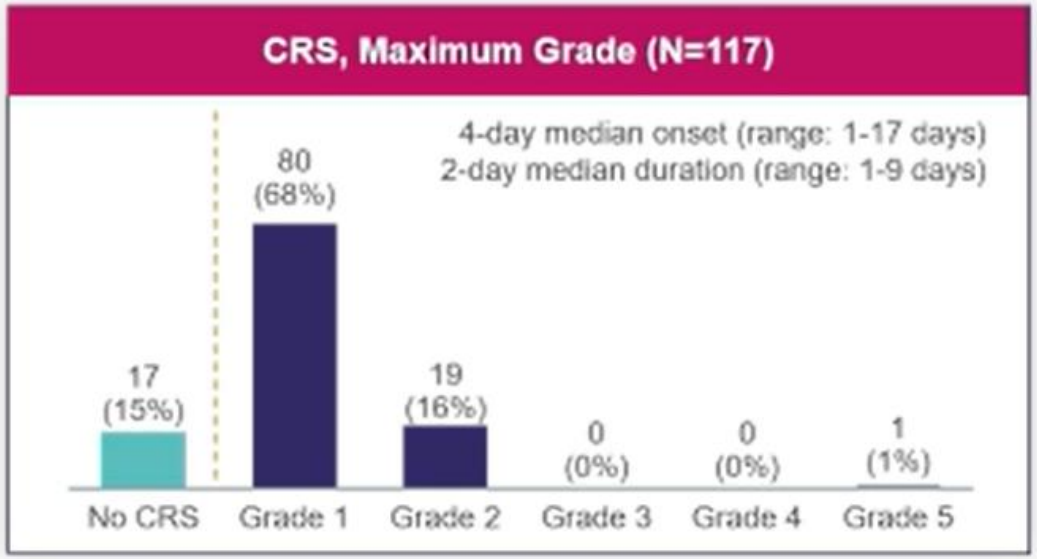
iMMagine-1: PFS and OS Rates Estimated by Kaplan-Meier

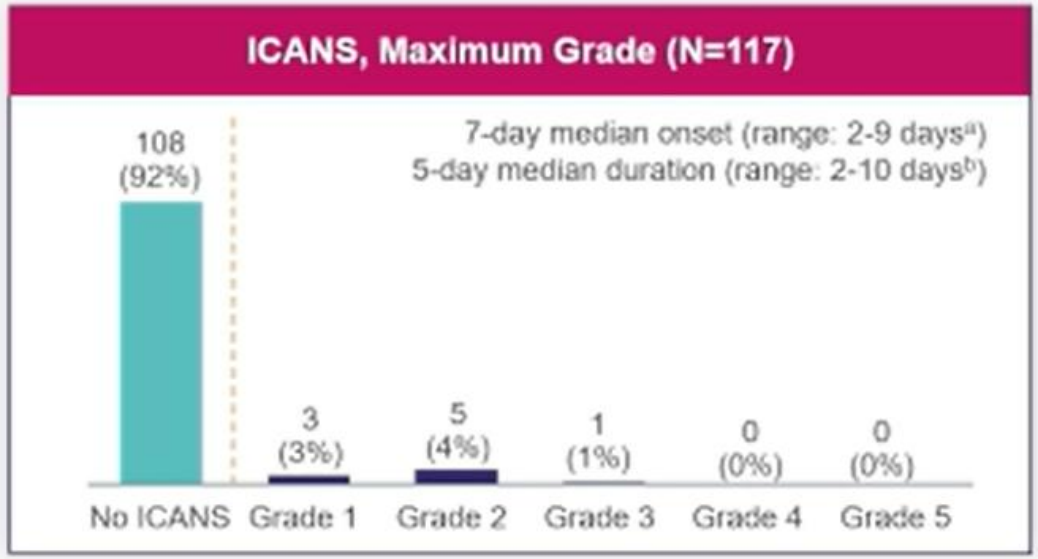
Median PFS and OS were not reached

N=117	PFS Rate (%) (95% CI)	OS Rate (%) (95% CI)
6-Month	93.1 (86.7, 96.5)	95.7 (90.0, 98.2)
12-Month	82.1 (73.6, 88.1)	94.0 (87.8, 97.1)
18-Month	67.4 (55.4, 76.8)	88.0 (78.8, 93.4)
24-Month	61.7 (48.0, 72.8)	83.0 (70.7, 90.5)

Median follow-up of 15.9 months (range: 0.3 – 33.1 months)
PFS, progression-free survival; OS, overall survival

iMMagine-1: Safety Update





- 95% (111/117) of patients had either no CRS or CRS that resolved by ≤10 days of anito-cel infusion
- No new treatment-related or treatment-emergent deaths have occurred since the previous May 1, 2025 datacut
- No secondary primary malignancies of T-cell origin have occurred
- No replication competent lentivirus detected

No delayed or non-ICANS neurotoxicities, including no Parkinsonism, no cranial nerve palsies, and no Guillain-Barré syndrome, and no immune effector cell-associated enterocolitis have been observed to date at ≥10 months since anito-cel infusion

[a]With the exception of n=1 Grade 1 ICANS (confusion) on day 31 post infusion that rapidly resolved. [b]With the exception of n=1 prior Grade 2 ICANS with 29-day duration to resolution
Note: Updates to data resulting from ongoing data review; CRS and ICANS assessed per American Society for Transplantation and Cellular Therapy criteria
CRS, cytokine release syndrome; ICANS, immune effector cell-associated neurotoxicity syndrome

iMMagine-1: Conclusions

- **Anito-cel utilizes a novel, synthetic, compact and stable D-Domain binder**
  - D-Domain facilitates high transduction efficiency, CAR positivity, and CAR density on the T-cell surface and has a fast off-rate
- **Anito-cel continues to show deepening responses at a median follow-up of 15.9 months**
  - ORR was 96% and sCR/CR rate was 74%
  - 95% of MRD evaluable patients were MRD negative and 83% had ≥ 6 months of sustained MRD negativity at $\leq 10^{-5}$ sensitivity
  - Median PFS and OS were not reached; 24-month PFS rate was 62% and OS rate was 83%
- **The anito-cel safety profile is predictable and manageable as demonstrated in more than 150 patients dosed across the Phase 1 and iMMagine-1 Phase 2 trials**
  - No delayed or non-ICANS neurotoxicities, including no Parkinsonism, no cranial nerve palsies, and no Guillain-Barré syndrome, and no immune effector cell-associated enterocolitis have been observed to date with anito-cel

Anito-cel demonstrated deep, durable responses in 4L+ RRMM with a manageable safety profile, including no delayed or non-ICANS neurotoxicities and no immune effector cell-associated enterocolitis

KEY TAKEAWAY

1. Anito-Cel is as effective as Cilta-Cel without delayed neurotoxicity (ORR 95%, MRD neg 95%, 24m PFS 60%, 24m OS 83%)
2. Anito-cel has rapid and reliable manufacturing. May need to be administered inpatient given early onset CRS
3. Needs longer follow up and more patients to study late onset neurotoxicity

iMMagine-3 Design, Global Phase 3 Study – Now Enrolling

iMMagine-3 (NCT06413498) is a global, Phase 3 trial comparing anito-cel to standard of care therapy in patients with RRMM after 1-3 prior LoT, including an anti-CD38 monoclonal antibody and an iMiD