

# Artiva Biotherapeutics

Post-EULAR Virtual Webcast  
June 8, 2026

# Disclaimers and Forward-looking Statements

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This presentation contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995. Statements in this presentation that are not statements of historical fact are forward-looking statements. Such forward-looking statements include, without limitation, statements regarding: expectations of Artiva Biotherapeutics, Inc. (the “Company”) regarding AlloNK and its potential benefits, mechanism of action, activity, potency, differentiation, safety, tolerability, effectiveness, depth and duration of response, comparability to other products/candidates or modalities, scalability, outpatient administrability, potential for adoption in a community setting, potential to help patients get off immunomodulatory drugs and/or steroids, market opportunity, competitive landscape, ability to address an unmet need, potential timing and outcome of regulatory interactions, registrational strategy (including potential and timing to advance into a registrational trial and design of a potential registrational trial), potential and timing of additional clinical data, potential to move into follow-on indications, and potential to be approved for marketing or be first-in-class; the Company’s plans and expectations regarding its research and development programs, including the design, timing, and results of preclinical and clinical study designs and results, and the timing or likelihood of regulatory filings and approvals; and the Company’s business strategy, IP protection, ability to deliver value creation, future results of operations, and financial position, including cash runway. Words such as “opportunity,” “potential,” “estimate,” “emerging,” “near-term,” “next,” “focus,” “can,” “design,” “TBD,” “target,” “initial,” “future,” “path,” “runway,” references to specific future dates or periods, and similar expressions are intended to identify forward-looking statements, though not all forward-looking statements necessarily contain these identifying words. These forward-looking statements are based on the beliefs of the management of the Company as well as assumptions made by and information currently available to the Company. Such statements reflect the current views of the Company with respect to future events and are subject to known and unknown risks and uncertainties, including business, regulatory, economic and competitive risks and uncertainties about the Company, including, without limitation, risks inherent in developing product candidates, the fact that initial, preliminary, and interim data from the Company’s clinical trials may change as more patient data become available and remain subject to audit and verification procedures that could result in material differences from the financial data, future results from the Company’s ongoing and planned clinical trials, the Company’s ability to obtain adequate financing to fund its planned clinical trials and other expenses, risks that future clinical trial results may not be consistent with interim, initial, preliminary, or topline results or results from prior preclinical studies or clinical trials, trends in the industry, the Company’s relationships with its existing and future collaboration partners, the legal and regulatory framework for the industry, and future expenditures. In light of these risks and uncertainties, the events or circumstances referred to in the forward-looking statements may not occur. The actual results may vary from the anticipated results, and the variations may be material. Other factors that may cause the Company’s actual results to differ from current expectations are discussed in the Company’s filings with the U.S. Securities and Exchange Commission, including the section titled “Risk Factors” in the Company’s Quarterly Report on Form 10-Q for the quarter ended March 31, 2026. You are cautioned not to place undue reliance on these forward-looking statements, which speak only as of the date this presentation is given. Except as required by law, the Company undertakes no obligation to publicly update any forward-looking statements, whether as a result of new information, future events or otherwise.

This presentation discusses product candidates that are under clinical study and have not yet been approved for marketing by the U.S. Food and Drug Administration. 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.

The clinical data for AlloNK in this presentation are based on separate studies and include pooled data from the Phase 2a company-sponsored basket trial (NCT06991114) and investigator-initiated basket trial (NCT06581562), and cross-study comparative data. No head-to-head trial has been conducted evaluating AlloNK against any other products or product candidates included herein. Differences exist between clinical trial design, patient populations, and the product candidates themselves, and caution should be exercised when pooling and/or comparing data across trials as pooled data and cross-study comparisons are inherently limited and such data may not be directly comparable.

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# Agenda

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***Dr. Fred Aslan***  
*CEO*  
*Artiva Bio*



***Dr. Diego Miralles***  
*President and*  
*Head of R&D*  
*Artiva Bio*



***Dr. Paul Emery***  
*Arthritis UK Professor*  
*of Rheumatology*  
*University of Leeds*

|            |                      |
|------------|----------------------|
| <b>10'</b> | Introduction         |
| <b>15'</b> | AlloNK® EULAR update |
| <b>15'</b> | KOL impressions      |
| <b>15'</b> | Q&A                  |



# Introduction

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# Opportunity Summary

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- 1 Deep B-cell depletion – potent mechanism vis-à-vis other novel approaches
- 2 Strategic interest across modalities (auto-CAR-T, TCE, in vivo, allo)
- 3 Refractory RA – approx. \$5B\* being spent on patients unlikely to respond after failed 2+ b/tsDMARDs
- 4 AlloNK activity and tolerability – potentially high impact if first-in-class in RA; other indications
- 5 CY/FLU tolerability in community setting
- 6 Favorable competitive landscape – supports potential multi-billion-dollar opportunity

## Balance Sheet Strengthened by Recent Financing, with Cash Runway into 2029

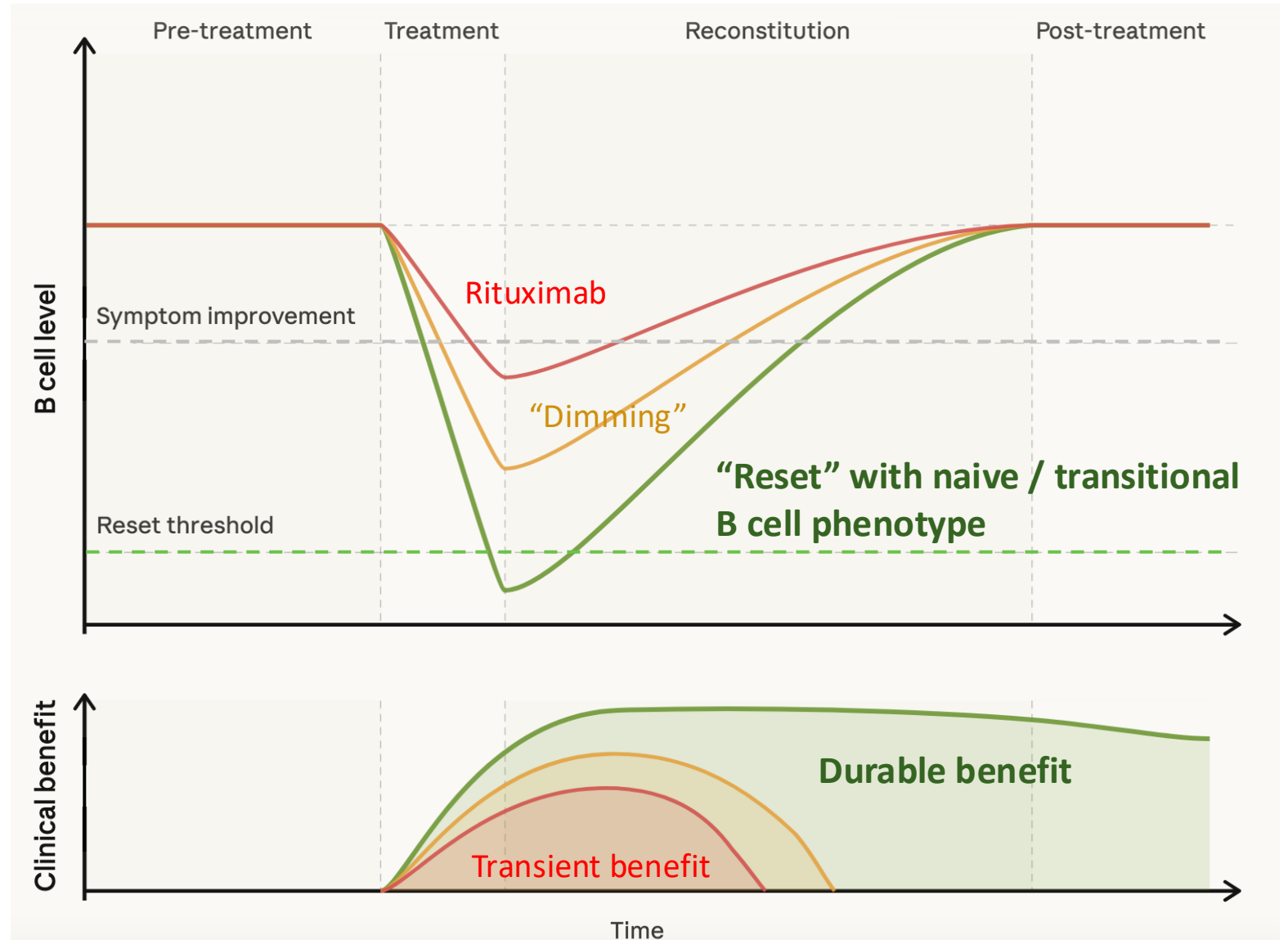
- **\$86.8 million** in cash, cash equivalents and investments as of March 31, 2026
- Estimated net proceeds of **~\$280.5 million** from the May 2026 offering<sup>1</sup>



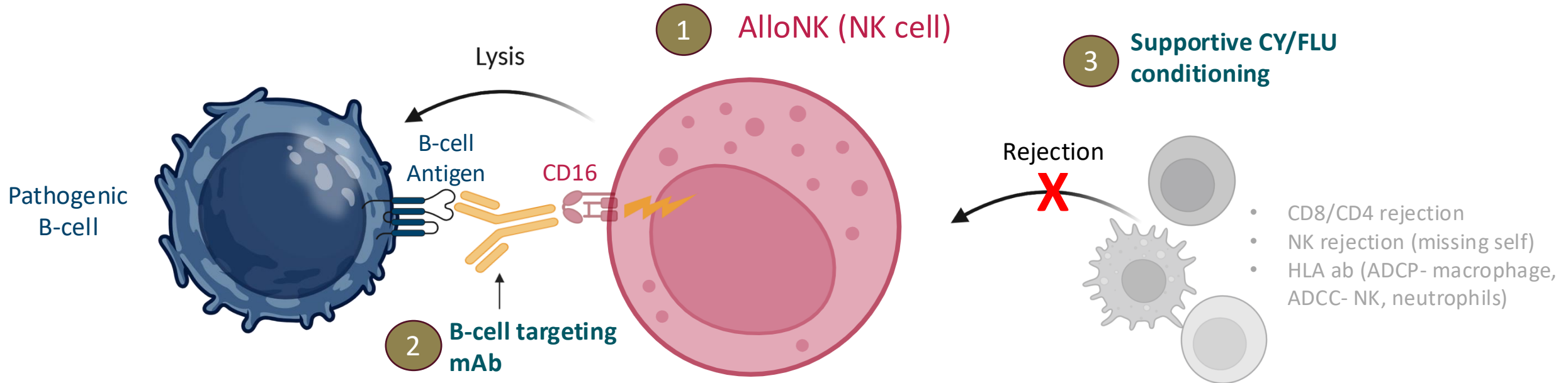
# B-Cell Depletion and “Reset” Hypothesis

## Role of B cells in autoimmune disease:

- 1 Autoantibody production / tissue damage
- 2 Antigen presentation / T cell amplification
- 3 Cytokine secretion / inflammation



# AlloNK: CD16 is a strong cell activating receptor, driving ADCC against B cells



**AlloNK Dose: 4B cells x 2**

**CY/FLU conditioning**

**Monoclonal Antibody**

D1 D2 D3

CY/FLU

D6



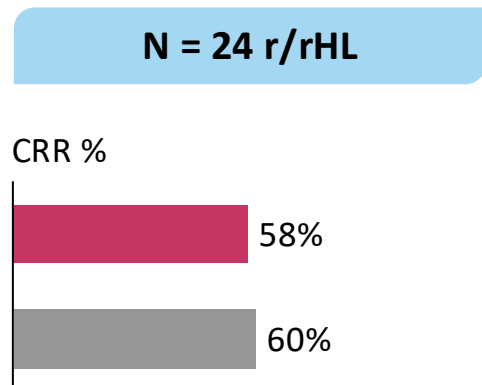
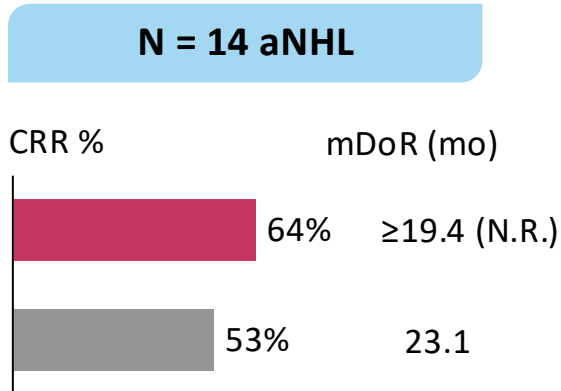
D20



# Consistent Activity Observed Across Indications

*N=14 aNHL, N=24 r/rHL, Over 70 Autoimmune Patients Initiated Treatment as of April 30, 2026*

Includes all patients with 3+ months of follow-up in IIT and Basket Study

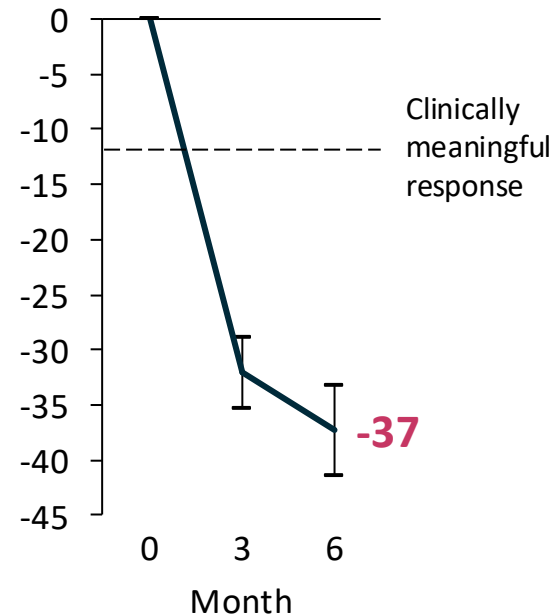


■ AlloNK + rituximab  
■ Auto-CAR-T benchmark\*

**N = 21 RA**

**CDAI (change)**

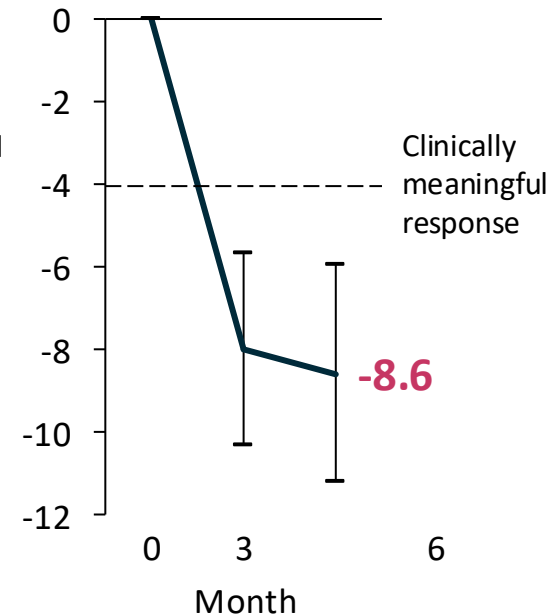
Mean +/- SEM  
(mean 50.7 baseline)



**N = 11 SjD**

**ClinESSDAI (change)**

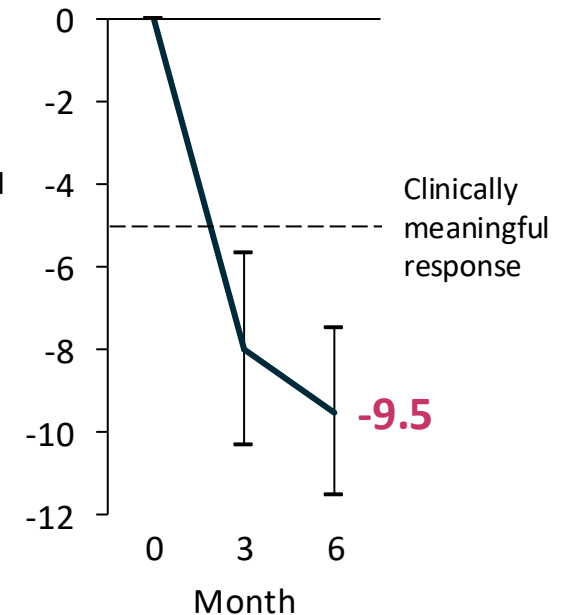
Mean +/- SEM  
(mean 16.1 baseline)



**N = 5 SSc**

**mRSS (change)**

Mean +/- SEM  
(mean 19.8 baseline)



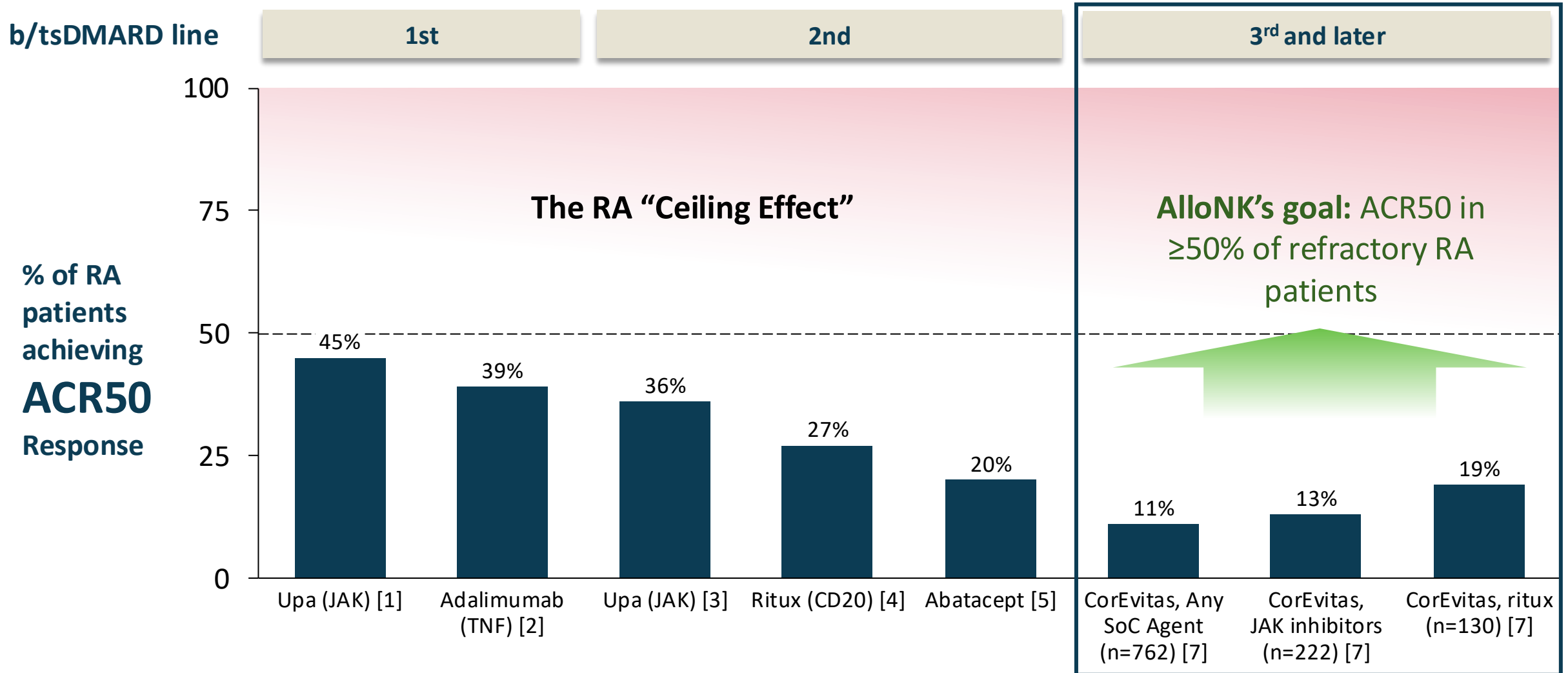
**No discontinuations due to AEs, no patient started a new b/tsDMARD**



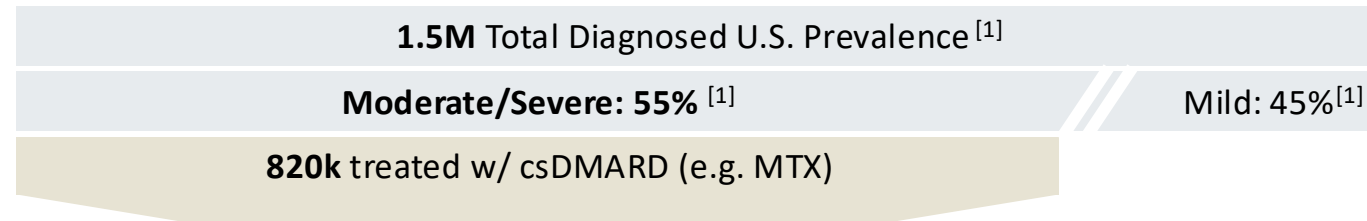
Ariva Biotherapeutics

aNHL: aggressive non-Hodgkin lymphoma; r/rHL: relapsed/refractory Hodgkin lymphoma; SjD: Sjögren's Disease; SSc: Systemic Sclerosis; IIT: investigator-initiated trial; CRR: complete response rate; mDoR: median duration of response; CDAI: Clinical Disease Activity Index; ClinESSDAI: Clinical European League Against Rheumatism Sjögren's Syndrome Disease Activity Index; mRSS: modified Rodnan skin score; SEM: standard error of the mean  
\* Benchmarks: NHL: Breyani (Abramson et al Blood 2024; 143(5): 404-16); HL: CD30 CAR T (Ahmen Blood (2022) 140 (Supplement 1): 7496-7497.)  
Ariva data: NHL: Farooq ASGCT 2025; HL: Maakaron ASCO 2025 Abstr 7008  
Ariva autoimmune: Preliminary data from ongoing autoimmune clinical trials as of April 03, 2026, data cutoff: Phase 2a company-sponsored basket trial (NCT06991114) and investigator-initiated basket trial (NCT06581562).

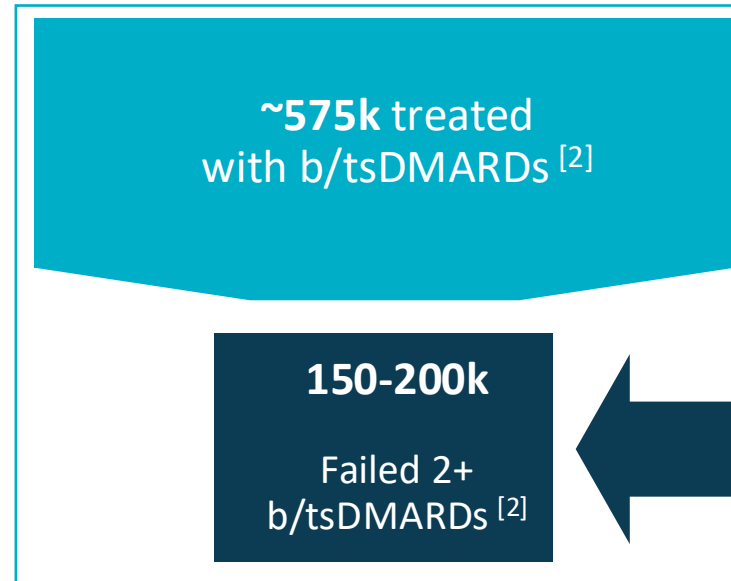
# The Unmet Need in RA: Poor Responses in Patients who Failed 2+ b/tsDMARDs



# ~\$5B Spent on US RA Patients Who Failed 2+ b/tsDMARDs



US RA market:  
~\$20B/yr<sup>[3-6]</sup>



~\$5B/yr (25%\*) spent on patients with 80-90% chance of not achieving an ACR50 response

[1] Black, et al. Lancet Rheumatol. 2023 Sep 25;5(10):e594-e610. From Supplement (Fig. 3), adjusted for population growth

[2] Multiple publications based on real-world registry data, including: Paudel et al 2024 Rheumatology; Watanabe et al 2024 Rheumatology; Roodenrijs et al 2021 Rheumatology; Jung et al 2023 Arthritis Res Ther.; Failed 2+ b/tsDMARDs population represents ~10-15% of all RA patients

[3] Emergen Research est. \$16.5B;

[4] Ken Research est. \$19B;

[5] Precedence Research est. \$26B;

[6] Research & Markets est. \$27B

\* 150k failed 2+ b/tsDMARDs out of 575k total treated with any b/tsDMARD ~25%



# Registrational Strategy

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## Design

- Single registrational RCT
- N = ~150 RA pts with inadequate response to 2+ b/tsDMARDs
- Randomized 2:1 to AlloNK + RTX vs. RTX-only
- RTX-only non-responders may cross over into AlloNK + RTX arm at 6 months

## Endpoint

- Primary efficacy endpoint: ACR50 at 6 months
- Expected ACR50 at 6 months: AlloNK + RTX arm: >50%; RTX-only: 20-25%

## Dosing

- 4B cells AlloNK x 2 doses (Days 6 and 20)

## Execution

- Global trial with 80+ sites; 40+ sites already active in ongoing Basket study
- Proposed safety database: 250 patients treated with AlloNK + RTX in autoimmune diseases



## AlloNK<sup>®</sup> EULAR Update

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# Artiva Data Updates at EULAR 2026

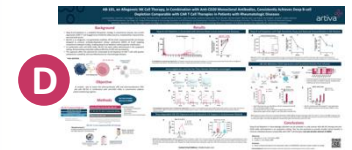
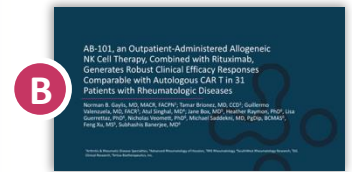
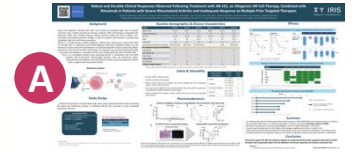
**Poster Session:** Robust and Durable Clinical Responses Observed Following Treatment with AB-101, an Allogeneic NK Cell Therapy, Combined with Rituximab in Patients with Severe Rheumatoid Arthritis and Inadequate Response to Multiple Prior Targeted Therapies

**Late-Breaking Oral:** AB-101, an Outpatient-Administered Allogeneic NK Cell Therapy, Combined with Rituximab, Generates Robust Clinical Efficacy Responses Comparable with Autologous CAR T in 31 Patients with Rheumatologic Diseases

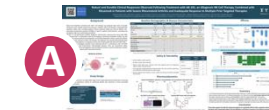
**Oral:** AB-101, an Allogeneic NK Cell Therapy, Combined with Rituximab was Highly Effective in Severe Sjögren Disease: Experience in First Patient Treated

**Poster Tour:** AB-101, an Allogeneic NK Cell Therapy, in Combination with Anti-CD20 Monoclonal Antibodies, Consistently Achieves Deep B-cell Depletion Comparable with CAR T Cell Therapies in Patients with Rheumatologic Diseases

**Publication:** Treatment with an Allogeneic NK Cell Therapy, AB-101, in Combination with Anti-CD20 Antibodies in Immune-mediated Diseases Demonstrates a Favorable Safety Profile and Comparable B-cell Depletion to CD19 CAR T Therapies



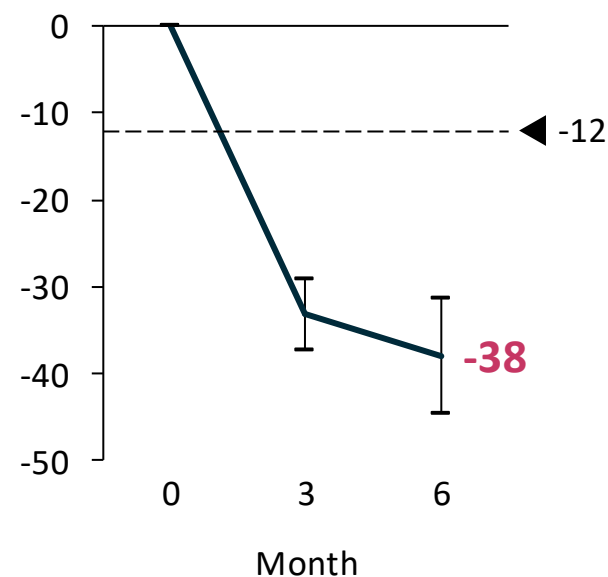
# IIT in RA: First Allogeneic Cell Therapy in RA, Showing Deep CDAI and DAS28 Responses in Highly Refractory Patients



| Parameter                                         | Values (n=6)        |
|---------------------------------------------------|---------------------|
| <i>Demographics</i>                               |                     |
| Age (y), mean (SD)                                | 49.2 (12.0)         |
| Female, %                                         | 100%                |
| Disease Duration (y)                              | 19.0 (9.4)          |
| <i>Disease Activity</i>                           |                     |
| CDAI, mean (SD)                                   | 51 (13.9)           |
| DAS28-ESR, mean (SD)                              | 7.1 (1.3)           |
| <i>Concomitant Medications</i>                    |                     |
| csDMARDs                                          | 67% (MTX, LEF, HCQ) |
| Glucocorticoids                                   | 83%                 |
| <i>Prior Distinct Classes Targeted Therapies*</i> |                     |
| ≥ 2                                               | 100%                |
| ≥ 3                                               | 33%                 |
| Prior RTX                                         | 33%                 |

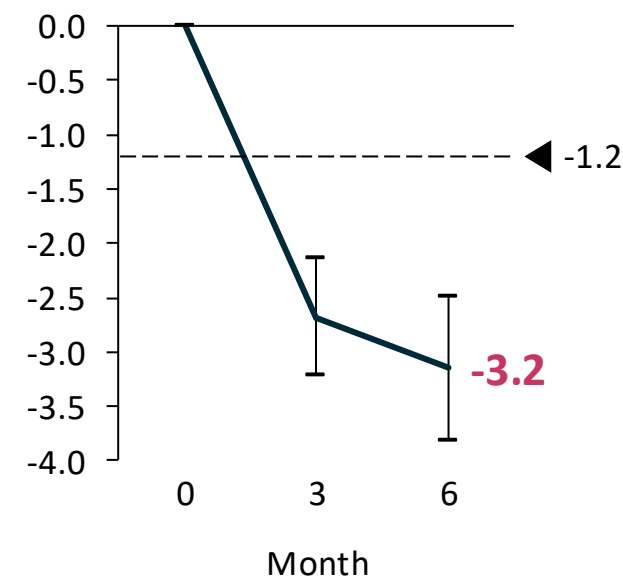
## CDAI

(mean 50.8 baseline)



## DAS28-ESR

(mean 7.1 baseline)



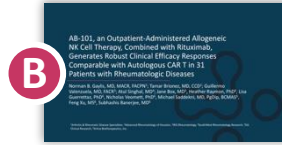
----- MCII\* ( $\geq 12$  for CDAI;  $\geq 1.2$  for DAS28)

MCII: Minimal Clinically Important Improvement

First IND accepted and first patient treated with an allogeneic cell therapy in RA



# Phase 2a Basket: Recruited Highly Refractory RA Patients with High Baseline Disease Activity as of April 3, 2026 Data Cutoff

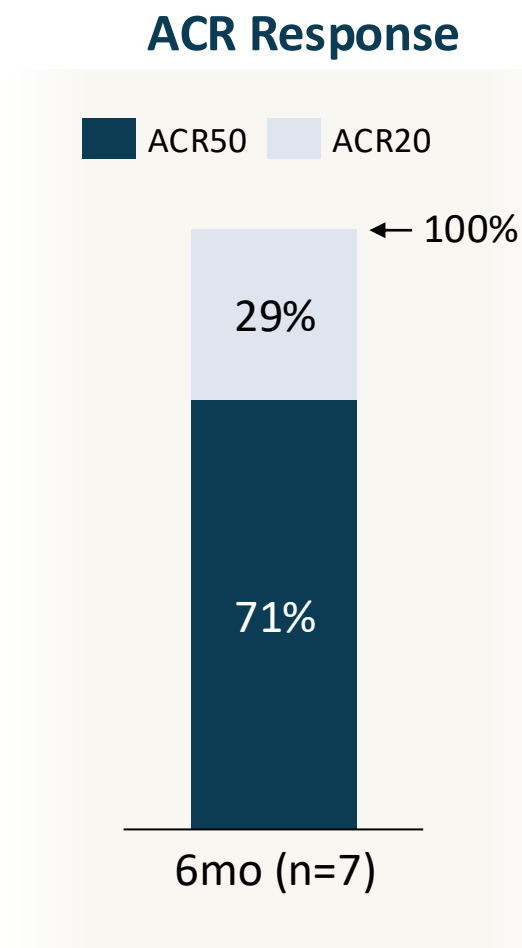
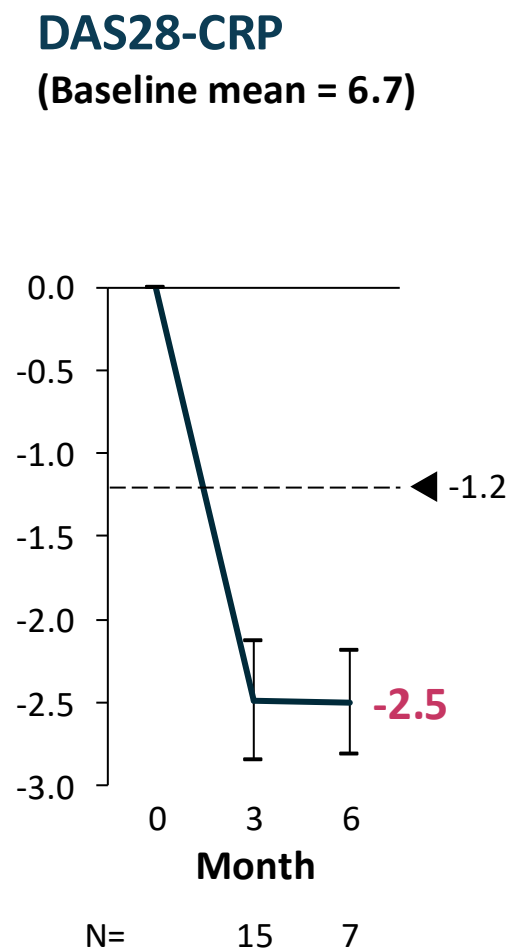
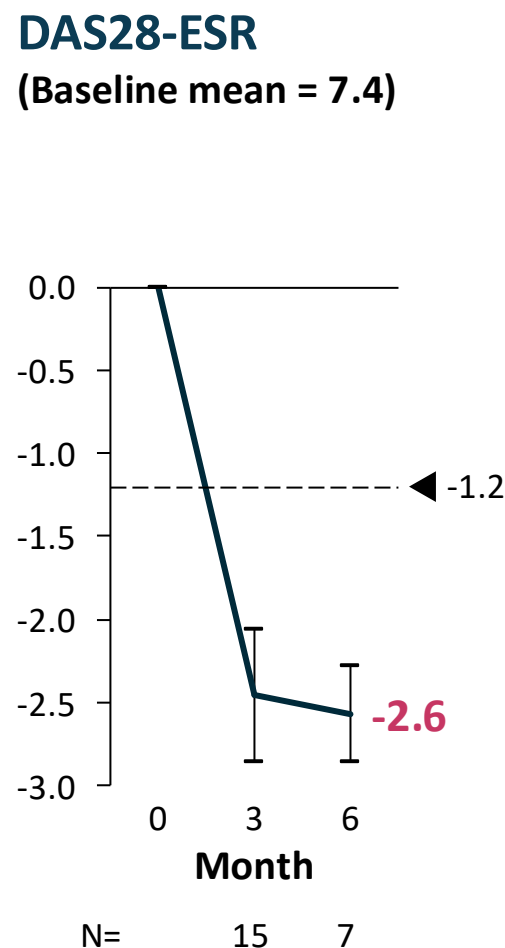
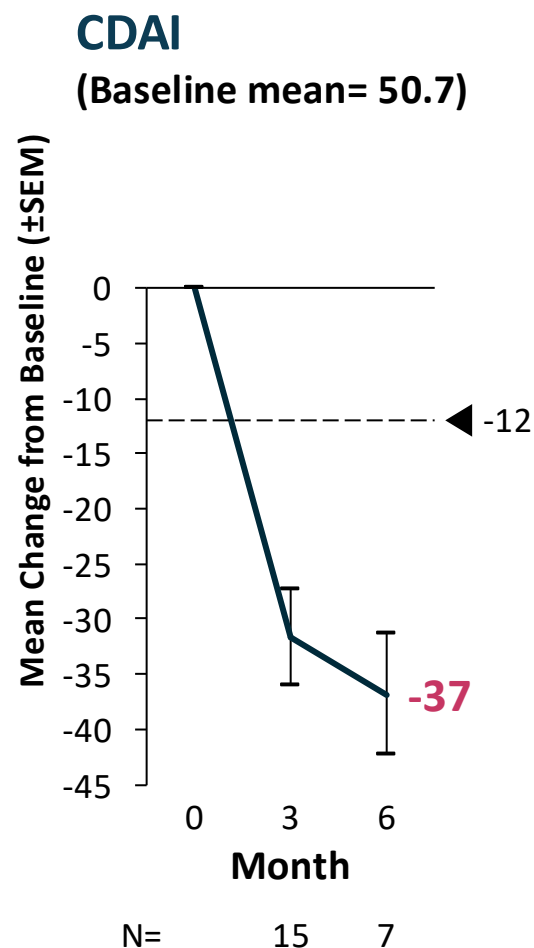


| Parameter                                             | Values (n=15)              |
|-------------------------------------------------------|----------------------------|
| <i>Demographics</i>                                   |                            |
| <b>Age (y), mean (SD)</b>                             | <b>53.9 (11.36)</b>        |
| <b>Female, %</b>                                      | <b>15 (100%)</b>           |
| <b>Disease Duration (y)</b>                           | <b>13.3 (10.98)</b>        |
| <b>Region</b>                                         | <b>US only</b>             |
| <i>Disease Activity</i>                               |                            |
| <b>CDAI, mean (SD)</b>                                | <b>50.7 (13.6)</b>         |
| <b>DAS28-ESR, mean (SD)</b>                           | <b>7.4 (0.74)</b>          |
| <i>Concomitant Medications</i>                        |                            |
| <b>csDMARDs</b>                                       | <b>0</b>                   |
| <b>Glucocorticoid use, n (%); median dose</b>         | <b>9 (60%); 7.5 mg/day</b> |
| <i>Prior Distinct Classes of b/tsDMARD Therapies*</i> |                            |
| <b>≥ 2; ≥ 3 (TNFi, IL-6i, CTLA4-Ig, RTX, JAKi)</b>    | <b>73%; 27%</b>            |

\* Biologic / targeted synthetic (b/tsDMARDs) of separate MoA, e.g. anti-TNF; anti-IL-6; abatacept; anti-CD20; JAK inhibitor



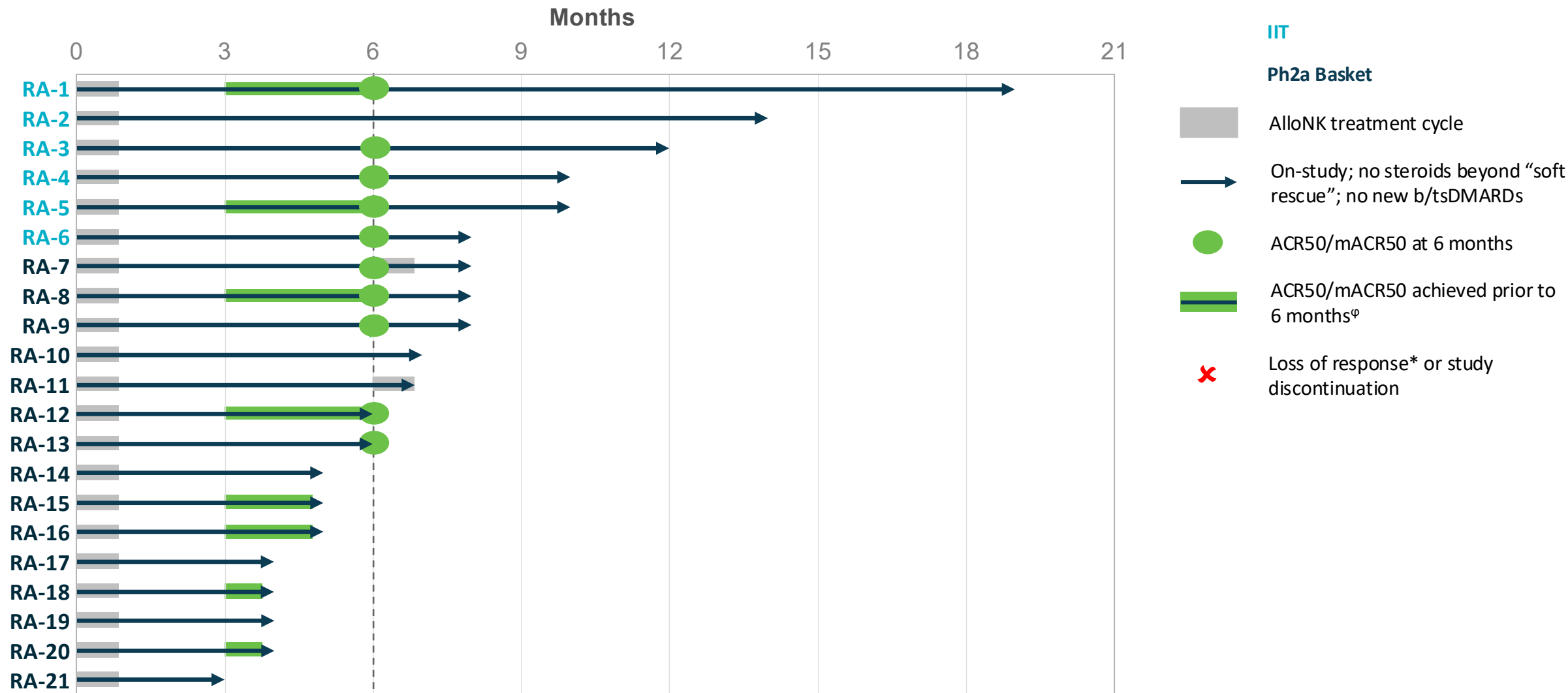
# Consistent Deep CDAI and DAS28 Responses, with 71% ACR50 at 6 Months



**All subjects exceeded MCII\* in CDAI ( $\geq 12$ ) AND DAS28 ( $\geq 1.2$ ) at 6 months**



# Combination of RA Datasets: Durability of Response Observed Across Studies



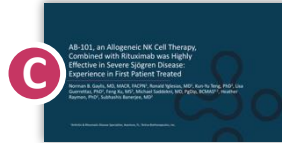
<sup>φ</sup> Noted at 3mo only if subject achieved ACR50 at 6mo (Subject RA-2 had ACR50 at 3mo but not 6mo; all others maintained ACR50 from 3 to 6mo)

\* Loss of response = patient requires rescue steroids beyond "soft rescue" rules similar to those applied in RA registrational trials (up to 20mg/d x 5d or equivalent), and/or started new b/tsDMARD

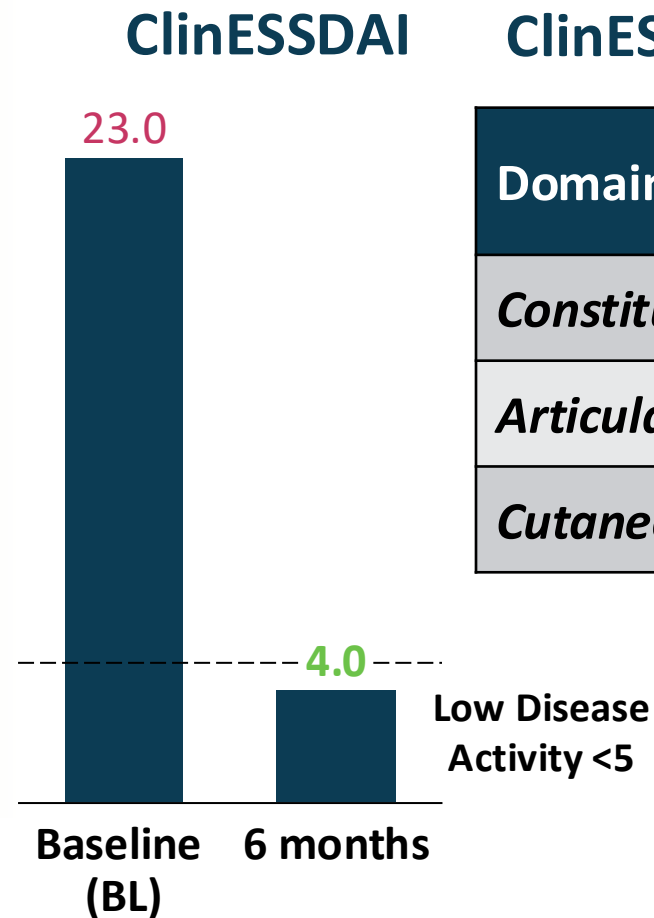
mACR50 calculated only for the IIT, where HAQ-DI and Pain were not collected: TJC&SJC >50% and 2 other components >50%  
 POOLED INITIAL DATA AS OF 03APR2026; Month 6 = 22 or 24 wks; Last Visit Carried Forward for missing data



# SjD Patient Case Study: First Patient Treated Showed Dramatic Initial Response and Improvement Across All Domains of ClinESSDAI and ESSPRI



- Disease Duration: **12.5y**
- Autoab: **Anti-SSA/Ro (52/60)+, anti-SSB/La+**
- Prior Rx: HCQ, Aza
- No concomitant immunomodulators



## ClinESSDAI Domains

| Domain                | BL | 6 mo |
|-----------------------|----|------|
| <i>Constitutional</i> | 2  | 1    |
| <i>Articular</i>      | 3  | 0    |
| <i>Cutaneous</i>      | 2  | 0    |

## Improvement in all clinical measures:

From baseline to 6 months

- **ESSPRI: 5.7 to 1.0** (all domains improved)
- **FACIT-F: 16.0** (severe) to **42.0** (normal)
- **SSF: 0.5mL/min** (hypo-salivation) to **0.8**



- **Age (y)**, mean (SD): 53.6 (14.66)
- **Sex**: 100% female
- **Disease duration (y)**, mean (SD): 12.2 (10.46)
- **Baseline disease activity**, mean (SD):
  - ClinESSDAI: 16.1 (3.94)
  - ESSPRI: 8.0 (1.36)
  - SSF (mL/min): 0.65 (0.49)
- **Refractory** to multiple prior immunomodulators
- **Rituximab IR**: 3/11 (27%)

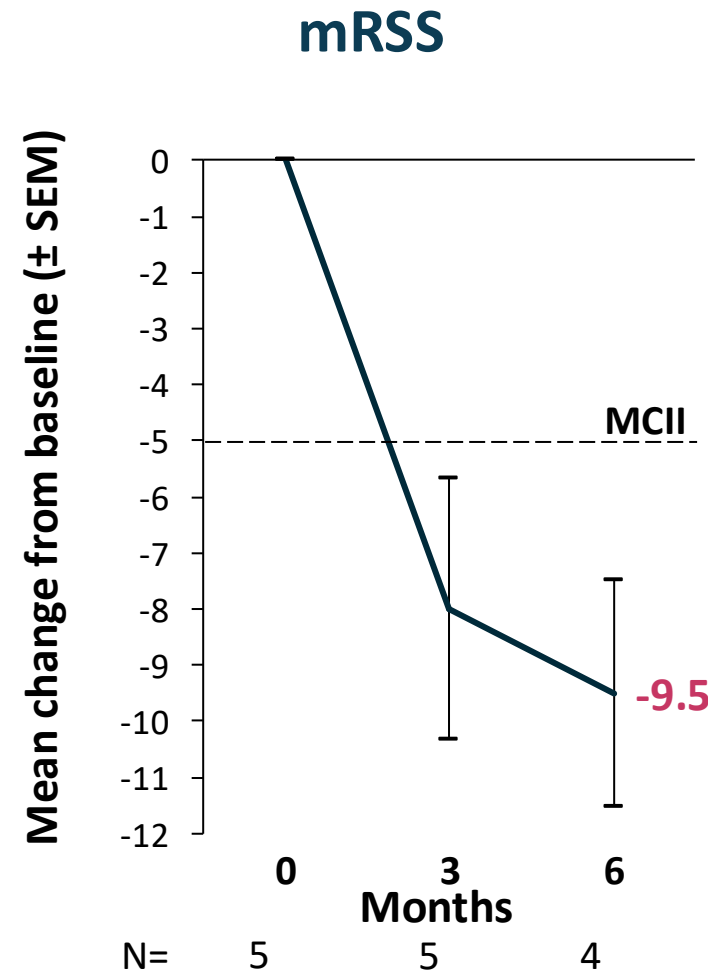


# Phase 2a, SSc: Initial Response Across Clinical Measures

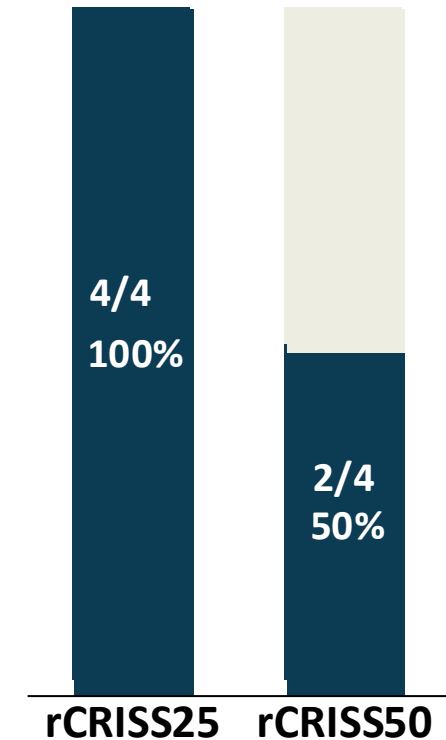


## Baseline Characteristics (n=5)

- **Age (y)**, mean (SD): 54.2 (12.85)
- **Sex**: 40% Female
- **Disease duration (y)**, mean (SD): 4.1 (2.96)
- **Modified Rodnan score (mRSS)**, mean (SD): 19.8 (7.85)
- **Concomitant immunosuppressives**: None
- **Prior immunosuppressives**: 5/5 (100%)
- **Prior rituximab use (all inadequate response)**: 3/5 (60%)



## rCRISS at 6 months (n=4)



*rCRISS25:  $\geq 25\%$  improvement in  $\geq 2$  of 5 domains ( $\geq 5\%$  ppFVC,  $\geq 25\%$  in mRSS, HAQ-DI, PtGA, PhGA with no worsening in more than 1 domain)*  
*rCRISS50:  $\geq 50\%$  improvement in  $\geq 2$  of 5 domains ( $\geq 5\%$  ppFVC,  $\geq 50\%$  in mRSS, HAQ-DI, PtGA, PhGA with no worsening in more than 1 domain).*  
*No significant SSc-related event.*



# Tolerability Profile of AlloNK + RTX Observed Compared Favorably to Autologous CAR-T and BCMA Targeted T-Cell Engagers

## Deep B-cell Depletion Datasets

|                              | <b>AlloNK +<br/>ritux</b> | <i>Auto CAR-T</i><br><b>Schett / CASTLE<sup>1</sup></b> | <i>T-Cell Engager</i><br><b>teclistamab<sup>2</sup></b> |
|------------------------------|---------------------------|---------------------------------------------------------|---------------------------------------------------------|
| <b>No. of Patients</b>       | 55                        | 24                                                      | 10                                                      |
| <b>CRS (any/Gr 3+)</b>       | - / -                     | 75% / -                                                 | 80% / -                                                 |
| <b>Tocilizumab for CRS</b>   | -                         | 58%                                                     | 80%                                                     |
| <b>Infections (any/Gr3+)</b> | 29% / 2%                  | N.R. / 13%                                              | 70% / 30%                                               |
| <b>IVIG for Hypogamm.</b>    | -                         | N.R.                                                    | 100%                                                    |

### Comparable to Serious Infection Rates for Approved RA therapies<sup>3</sup>:

**AlloNK + RTX: 2%**

Rituxan: **2%**

Orencia: **3%**

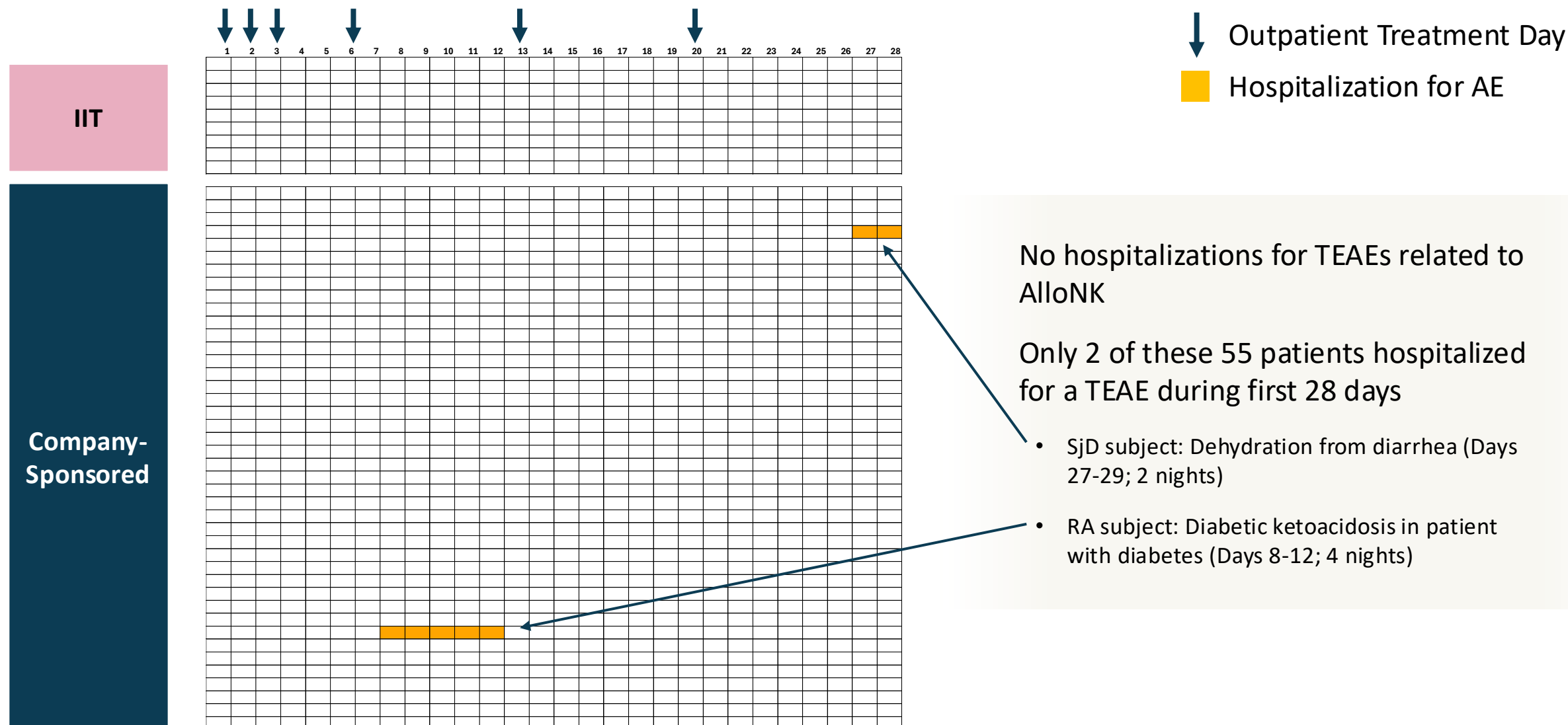
TNF – Humira: **4.3** / 100 patient years

JAK – Rinvoq: **4.6** / 100 patient years

- Most common TEAEs consistent with those associated with rituximab or CY/FLU
  - Any TEAE  $\geq$  20%: Nausea (53%), headache (36%), leukopenia (22%), neutropenia (22%), alopecia (20%), lymphopenia (20%)
  - Any Grade 3+ TEAE  $\geq$  5%: Lymphopenia (5.5%), neutropenia (5.5%)
- Most common infections: UTI (15%), URTI (13%); no patients hospitalized in first 28d for infection
- No discontinuations from any TEAEs; no SAEs related to AlloNK

# Experience in First 55 Autoimmune Patients Treated with AlloNK + RTX

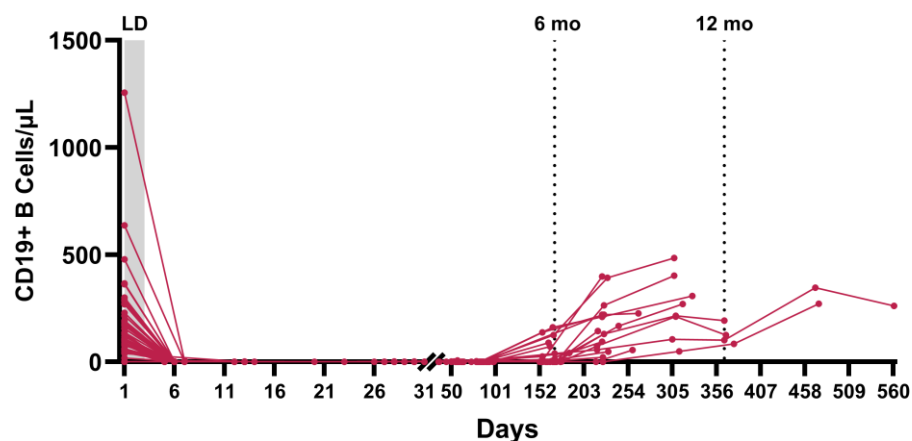
## *Hospitalization Rates Consistent with mAb Alone Showing Ability to Manage Patients as Outpatient*



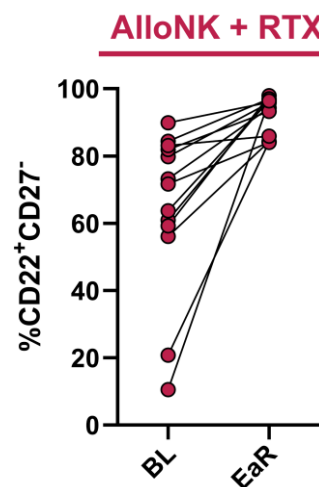
# AlloNK + RTX Showed Consistent Complete B-Cell Depletion in Autoimmune Diseases



**Uniform and consistent B-cell depletion observed by Day 13 in all 51 patients with autoimmune diseases**

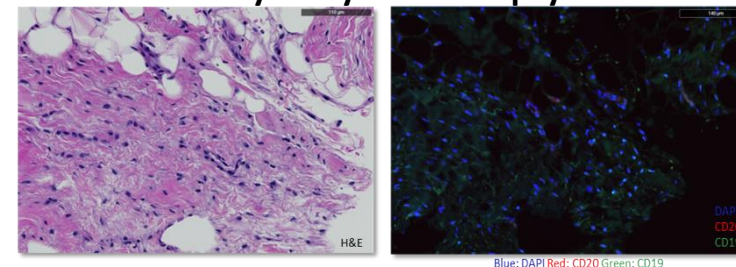


**B-cell Reconstitution Consistent with “Reset”**



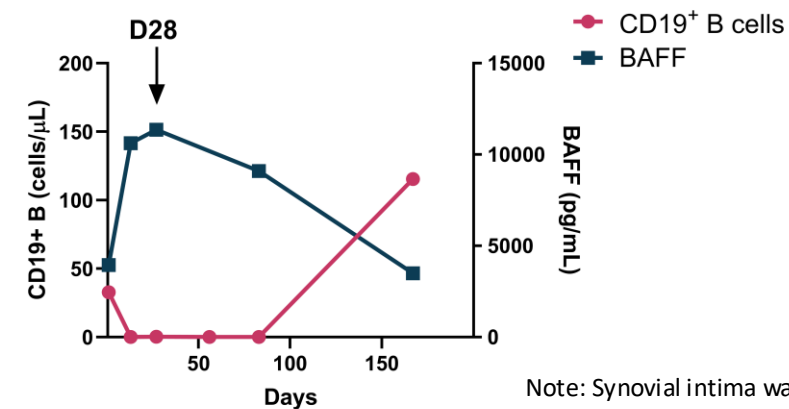
**No CD19+ B cells in single tissue biopsy case study in RA patient**

**Day 28 Synovial Biopsy**



**H&E**

**CD19/CD20 IF**



Note: Synovial intima was not captured in baseline biopsy



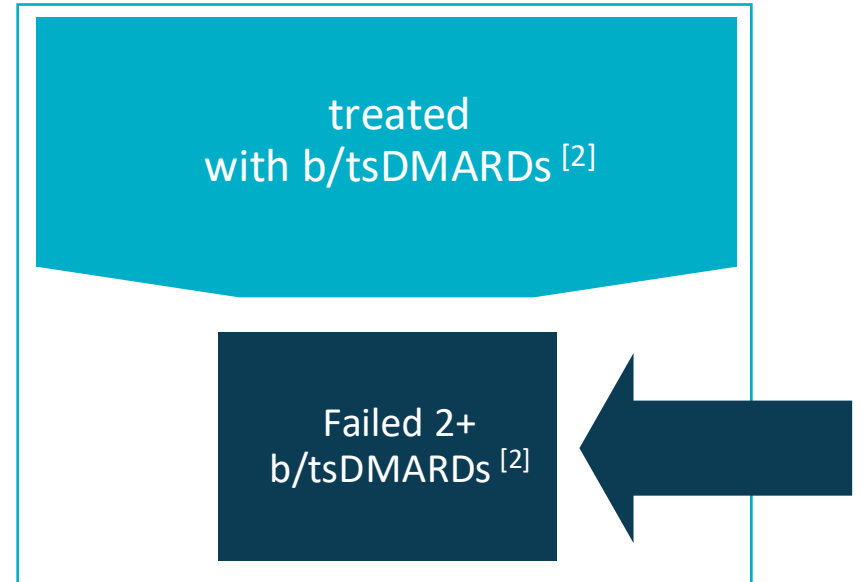
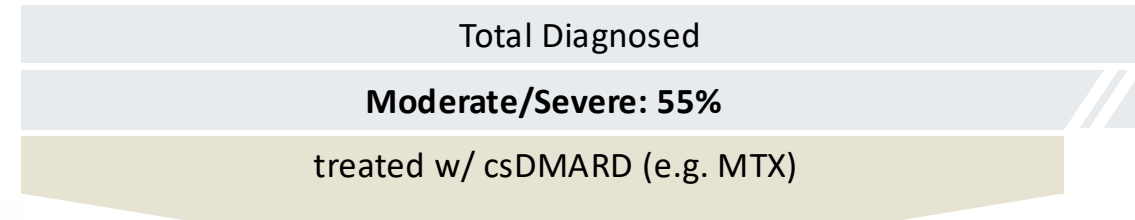
## KOL Perspective

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# The Unmet Need in RA: Many Patients Not Well-Controlled With Std of Care

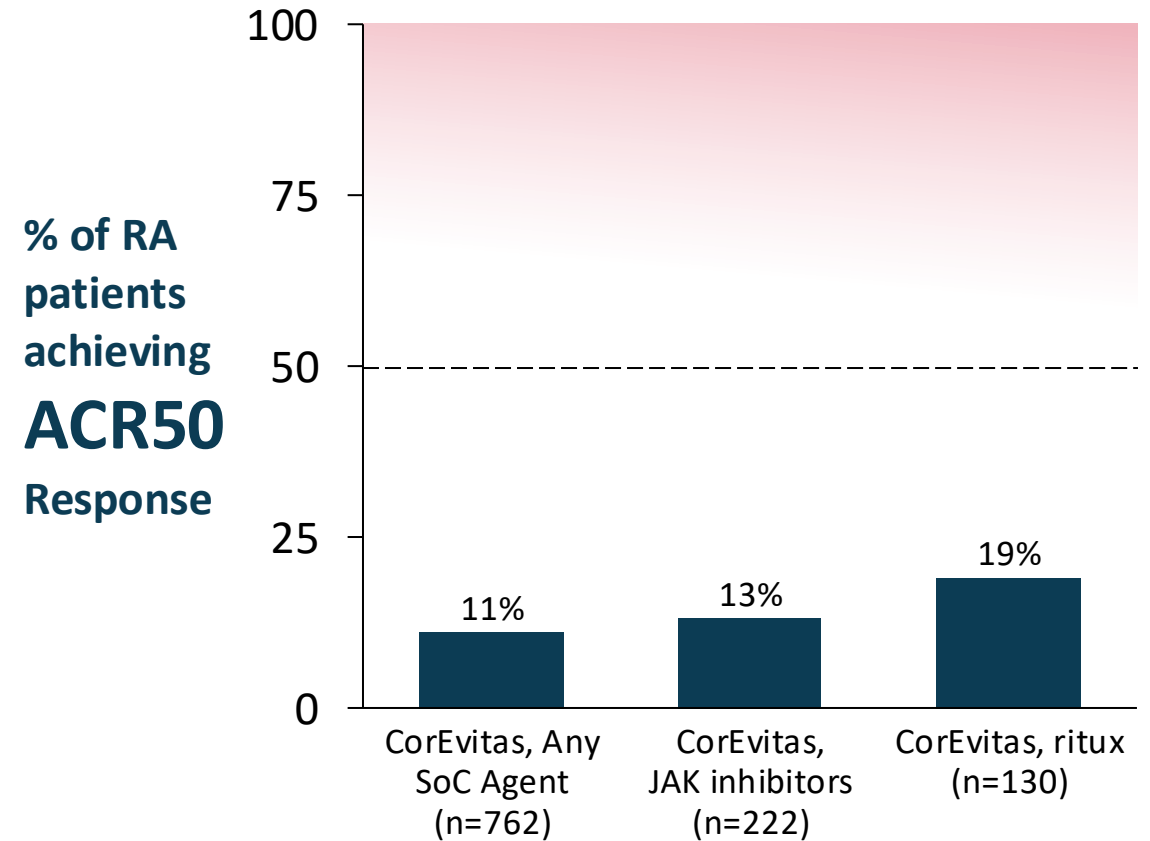
- Many RA patients fail  $\geq 2$  distinct classes b/tsDMARDs
- Despite 5 approved drug classes, there is substantial unmet clinical need among patients who continue to have uncontrolled disease



# The Unmet Need in RA: Poor Responses in Patients who Failed 2+ b/tsDMARDs

- Existing SoC delivers low response rates, leaving physicians to cycle through therapies without achieving disease control
- Patients face ongoing joint damage, functional decline and diminished quality of life

## Real-World ACR50 Response in Patients Who Failed 2+ Prior b/tsDMARD Classes

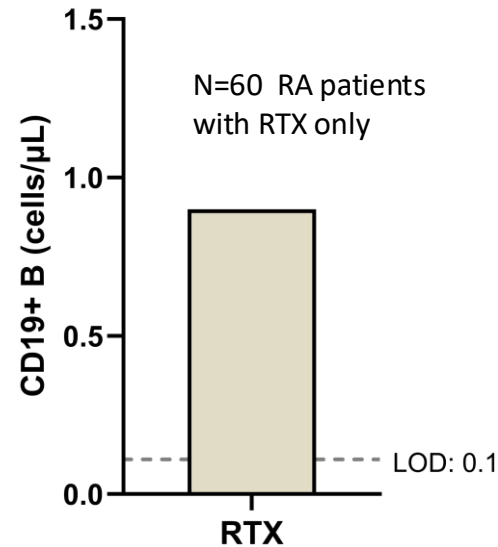


# High-Sensitivity B-Cell Assay Reveals Incomplete Depletion with Rituximab Alone and Higher Response Rate in Patients with Complete Depletion

- 60 RA patients treated at Leeds; RF or CCP+, failed anti-TNF
- B cells measured by high-sensitivity flow cytometry

## Incomplete Depletion with RTX Alone

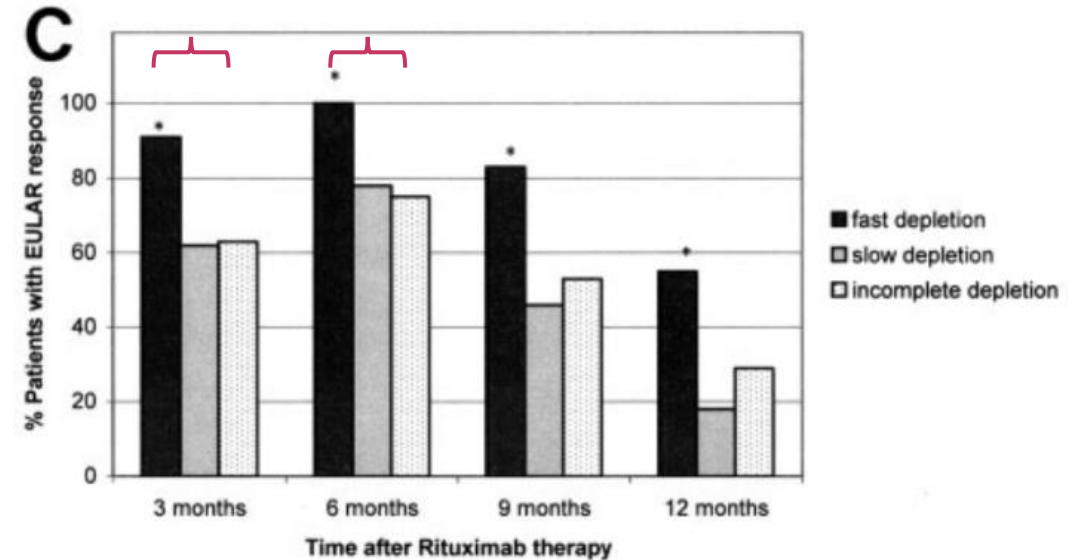
Median level of B-cells (cells/ $\mu$ L) at 2 weeks using high sensitivity assay<sup>1</sup>



B cells detected in **63% of patients** after first rtx infusion

## Higher Response Rate With Complete B-Cell Depletion

Percent of patients with a moderate-to-good EULAR response<sup>1</sup>

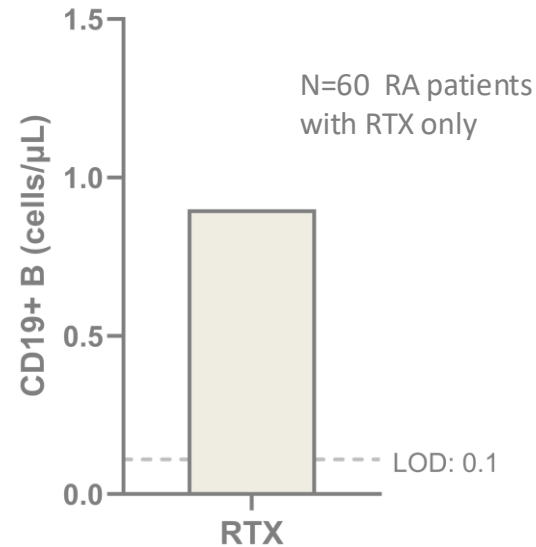


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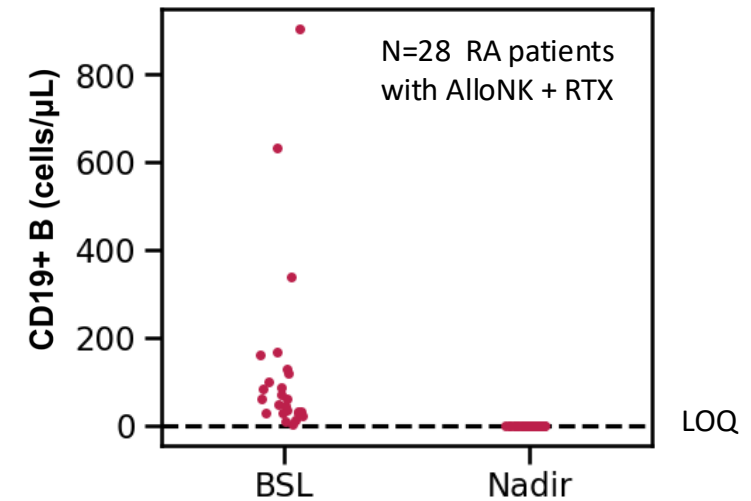
## Incomplete Depletion with RTX Alone

Median level of B-cells (cells/ $\mu$ L) at 2 weeks using high sensitivity assay<sup>1</sup>



## Complete Depletion with AlloNK + RTX

B-cells (cells/ $\mu$ L) at nadir using high sensitivity assay



AlloNK + RTX achieved **complete B-cell depletion in all RA patients**

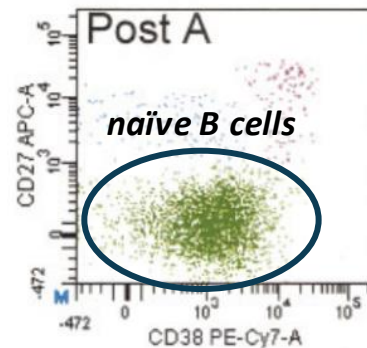


# B-Cell Repopulation Following Complete Depletion is Consistent with “Reset”

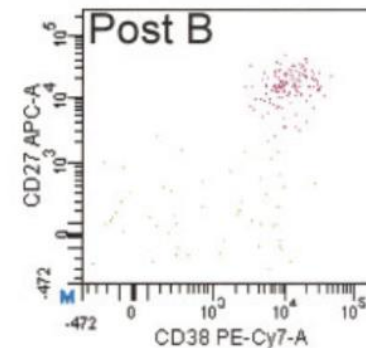
## B-Cell Repopulation with Higher Memory Cell Ratio in Patients with Complete Depletion

*Reconstitution of B cells 6 months after therapy<sup>1</sup>*

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*Patient (A) with  
**complete** depletion*



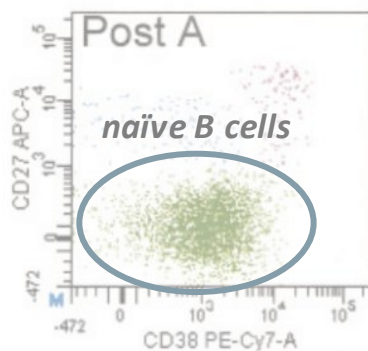
*Patient (B) with  
**incomplete** depletion*

# B-Cell Repopulation Following Complete Depletion is Consistent with “Reset”

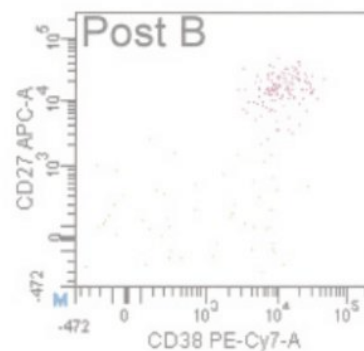
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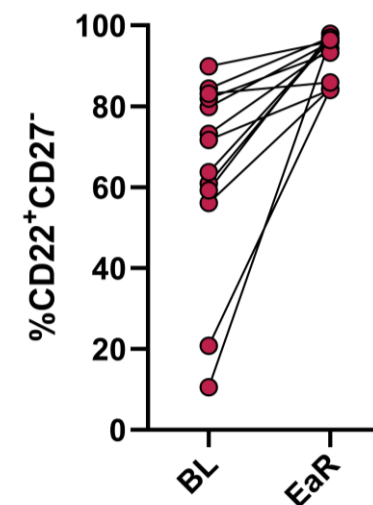
*Patient (A) with complete depletion*



*Patient (B) with incomplete depletion*

## Reconstitution Following AlloNK + RTX

### AlloNK + RTX



*B-cell reconstitution after AlloNK + RTX demonstrated increase in naïve B cells (N=13)*

# Artiva Enrolled Patients with Long-Standing Disease and High Baseline Disease Activity – Very Hard to Treat with Standard of Care

Phase 2a Basket: Also Recruited Highly Refractory RA Patients with High Baseline Disease Activity

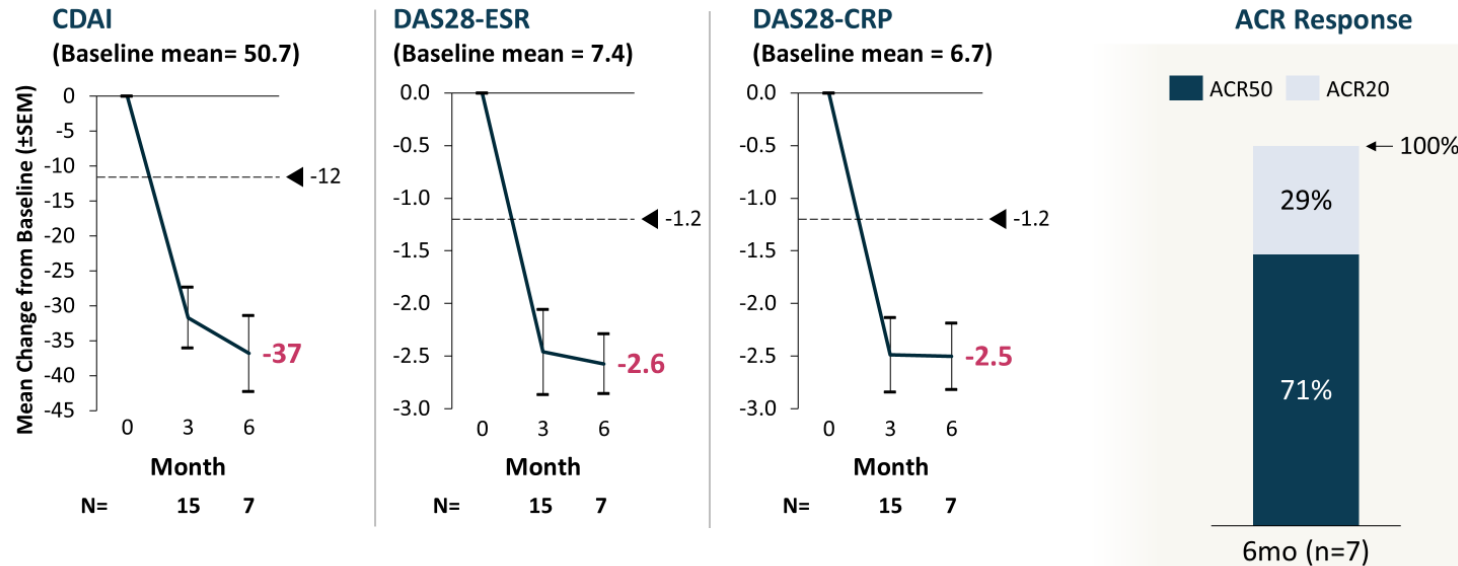
| Parameter                                             | Values (n=15)       |
|-------------------------------------------------------|---------------------|
| <i>Demographics</i>                                   |                     |
| Age (y), mean (SD)                                    | 53.9 (11.36)        |
| Female, %                                             | 15 (100%)           |
| Disease Duration (y)                                  | 13.3 (10.98)        |
| Region                                                | US only             |
| <i>Disease Activity</i>                               |                     |
| CDAI, mean (SD)                                       | 50.7 (13.6)         |
| DAS28-ESR, mean (SD)                                  | 7.4 (0.74)          |
| <i>Concomitant Medications</i>                        |                     |
| csDMARDs                                              | 0                   |
| Glucocorticoid use, n (%); median dose                | 9 (60%); 7.5 mg/day |
| <i>Prior Distinct Classes of b/tsDMARD Therapies*</i> |                     |
| ≥ 2; ≥ 3 (TNFi, IL-6i, CTLA4-Ig, RTX, JAKi)           | 73%; 27%            |

- Long disease duration – likely long-term joint damage that is not fully reversible
- Very high baseline disease activity – unlikely to respond dramatically to existing b/tsDMARDs
- Most failed 2+ prior classes b/tsDMARDs, with some failing 3 or more



# AlloNK + RTX Clinical Responses Were Far Beyond Historical Data with RTX Alone

Consistent Deep CDAI and DAS28 Responses, with 71% ACR50 at 6 Months

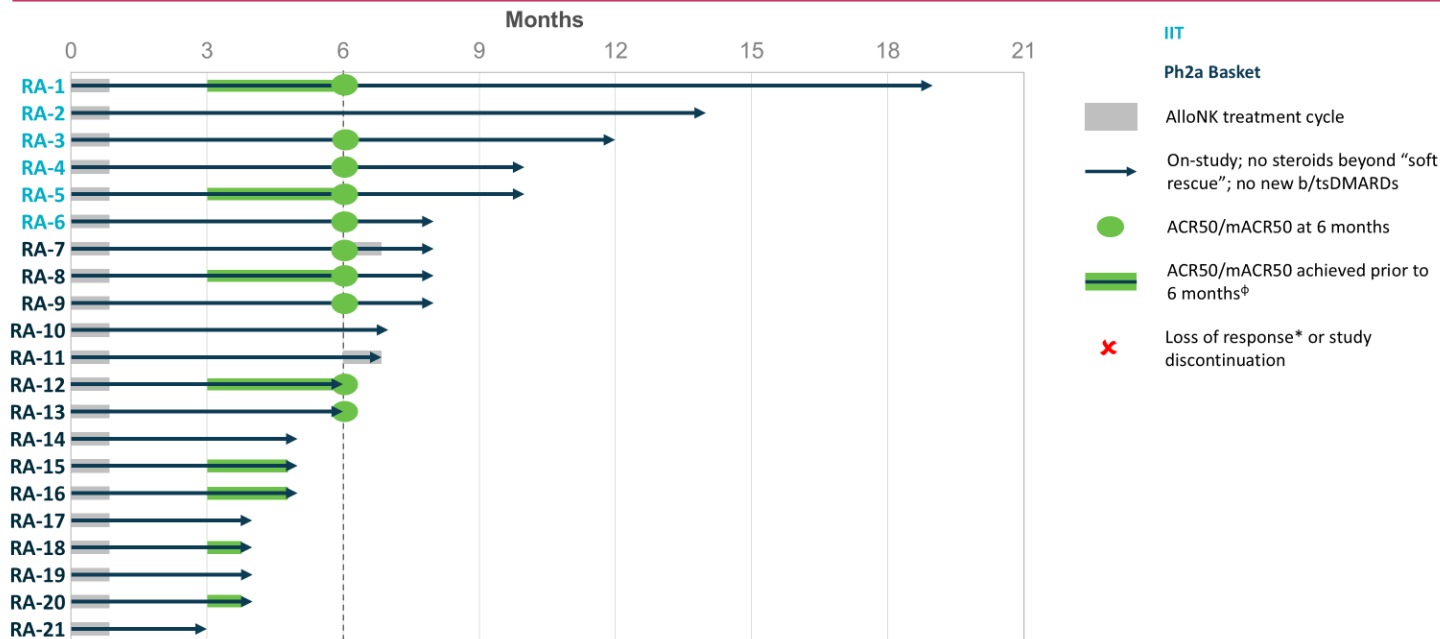


- No controlled clinical trials have specifically been conducted in patients who failed 2+ b/tsDMARD classes
- In less refractory (failed only anti-TNF) RA patients, rituximab showed **2.0 point** decrease in DAS28-ESR and **27% ACR50<sup>1</sup>**



# Emerging Data Shows Durable Response from Single Treatment Cycle

## Combination of RA Datasets: Durability of Response Observed Across Studies



<sup>‡</sup> Noted at 3mo only if subject achieved ACR50 at 6mo (Subject RA-2 had ACR50 at 3mo but not 6mo; all others maintained ACR50 from 3 to 6mo)  
\* Loss of response = patient requires rescue steroids beyond "soft rescue" rules similar to those applied in RA registrational trials (up to 20mg/d x 5d or equivalent), and/or started new b/tsDMARD  
mACR50 calculated only for the IIT, where HAQ-DI and Pain were not collected: TJC&SJC >50% and 2 other components >50%  
POOLED INITIAL DATA AS OF 03APR2026; Month 6 = 22 or 24 wks; Last Visit Carried Forward for missing data

- Patients managed without starting new b/tsDMARD – real-world measure of therapeutic durability
- Many patients with ACR50 by 3 months, but more by 6 months (pivotal study end-point)
- Consistency from initial PoC (IIT) to Phase 2a

## Closing Remarks

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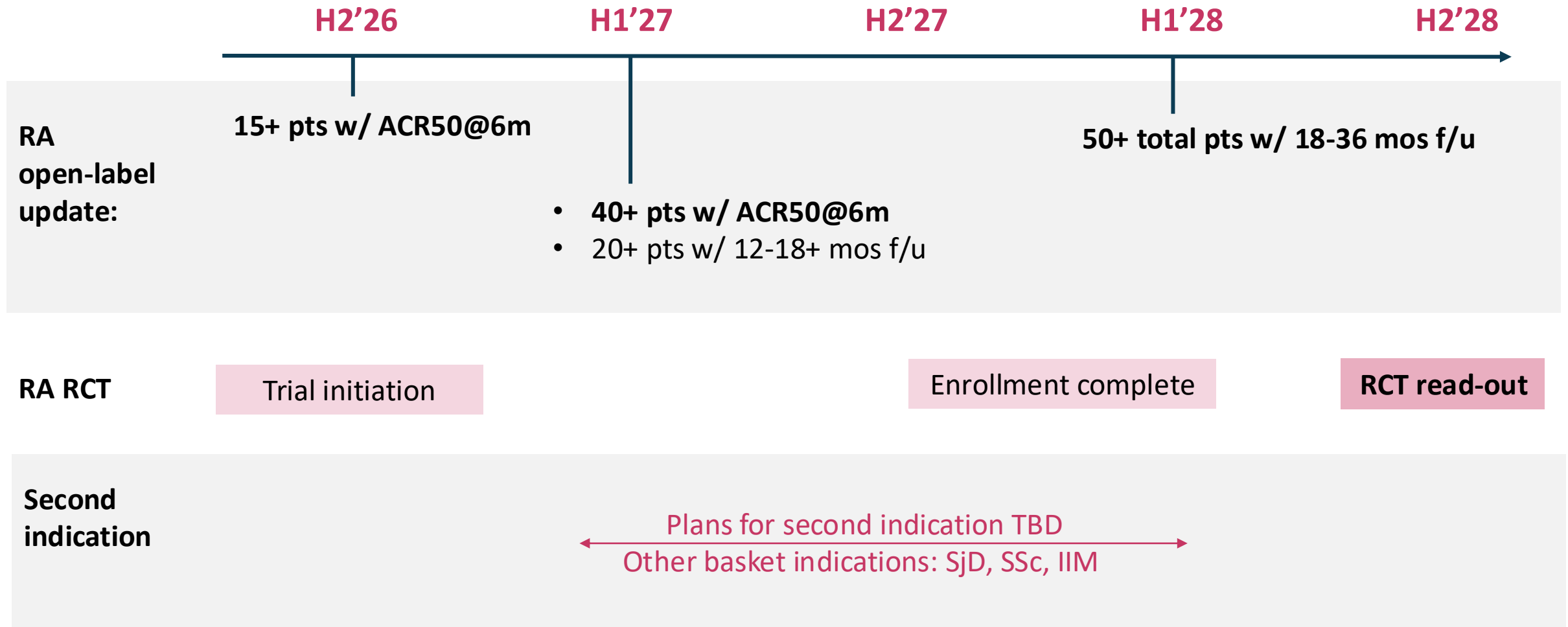
# Program Commercial Objectives

## ***“Enough! Time for cell therapy”***

- To be the first FDA-approved **deep B-cell depleting therapy** for **refractory RA** patients who have **failed 2+ b/tsDMARDs**
- To be a **one-time** treatment (“reset”) lasting more than **18 months** with several patients still benefiting **3 years** later; patients **off other immunomodulatory drugs**
- To have greater than 50% of patients experience an **ACR50 response** at 6 months; **higher than any approved product in RA**
- To be a cell therapy **rheumatologists can “own,”** and **provide in their infusion chair**



# Multiple Potential Catalysts Through RCT Readout



## Q & A

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