ARCELLX

Corporate Presentation

October 2024

Forward-Looking Statements

This presentation contains forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended and Section 21E of the Securities Exchange Act of 1934, as amended, that are based on our management's beliefs and assumptions and on information currently available to our management. All statements other than statements of historical facts contained in this presentation, including statements regarding our future financial condition, results of operations, business strategy, operations and prospects, the potential of and expectations regarding our product candidates and programs, including our ability to launch and scale, and the plans and objectives of management, as well as statements regarding industry trends, are forward-looking statements. In some cases, you can identify forward-looking statements by terminology such as "anticipate," "believe," "can," "contemplate," "continue," "could," "design," "estimate," "expect," "imagine," "intend," "likely," "may," "might," "objective," "ongoing," "plan," "potential," "predict," "project," "should," "target," "will" or "would," or the negative of these terms or other similar expressions or other comparable terminology are intended to identify forward-looking statements, although not all forward-looking statements contain these identifying words.

We have based these forward-looking statements largely on our current expectations and projections about future events and trends that we believe may affect our financial condition, results of operations, business strategy and financial needs, and these statements represent our views as of the date of this presentation. We may not actually achieve the plans, intentions or expectations disclosed in these forward-looking statements, and you should not place undue reliance on these forward-looking statements. Forward-looking statements are inherently subject to risks and uncertainties, some of which cannot be predicted or quantified. Information regarding certain risks, uncertainties and assumptions may be found in our filings with the Securities and Exchange Commission. New risk factors emerge from time to time and it is not possible for our management team to predict all risk factors or assess the impact of all factors on the business or the extent to which any factor, or combination of factors, may cause actual results to differ materially from those contained in, or implied by, any forward-looking statements. While we may elect to update these forward-looking statements at some point in the future, we specifically disclaim any obligation to do so. These forward-looking statements should not be relied upon as representing our views as of any date subsequent to the date of 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 or any other regulatory authority. The presentation also includes select interim and preliminary results from an ongoing clinical trial as of specific data cutoff dates. Such results should be viewed with caution as final results may differ as additional data becomes available. 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 also contains estimates and other statistical data made by independent parties or publicly available information, as well as other information based on our internal sources. These data involve a number of assumptions and limitations, and you are cautioned not to give undue weight to such estimates. We have not independently verified the accuracy or completeness of the data contained in these industry publications and other publicly available information. Accordingly, we makes no representations as to the accuracy or completeness of that data. Cross-trial comparisons are not based on head-to-head studies and no direct comparisons can be made. Cross-trial data interpretation should be considered with caution as it is limited by differences in study population, design and other factors.

Arcellx is a Different Kind of Cell Therapy Company

Potential best-in-class therapy partnered with Kite, the global leader in cell therapy.

Scalable manufacturing and commercial footprint to support leadership in a $12B+ Multiple Myeloma cell therapy market.

Sufficient capital to fund operations into 2027.

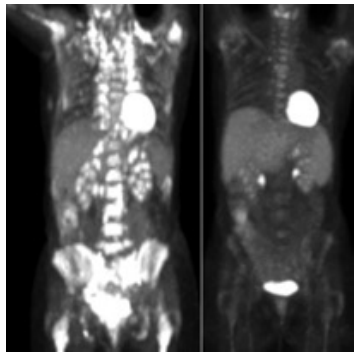
Arcellx Reimagining Cell Therapy

Novel Synthetic Binding Domain

Single-infusion ddCAR platform

and

Dosable, controllable ARC-SparX platform



Positive Interim Phase 1 Clinical Results

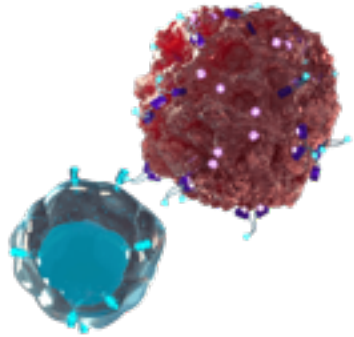
100% ORR; 76% CR/sCR and deep durability in anito-cel multiple myeloma Phase 1 study with mPFS not reached at 26.5 mo. median follow-up

Pivotal study enrolling

ARCELLX + Kite A GILEAD Company

Partnered with Global Leader in Cell Therapy

Combining potential best-in-class program with Kite's established commercial and manufacturing expertise



Platform Potential

ACLX-001 Phase 1 clinical trial in MM initiated in 2Q22

ACLX-002 Phase 1 clinical trial in AML/MDS initiated in 4Q22

Built for Success

Strong investor base

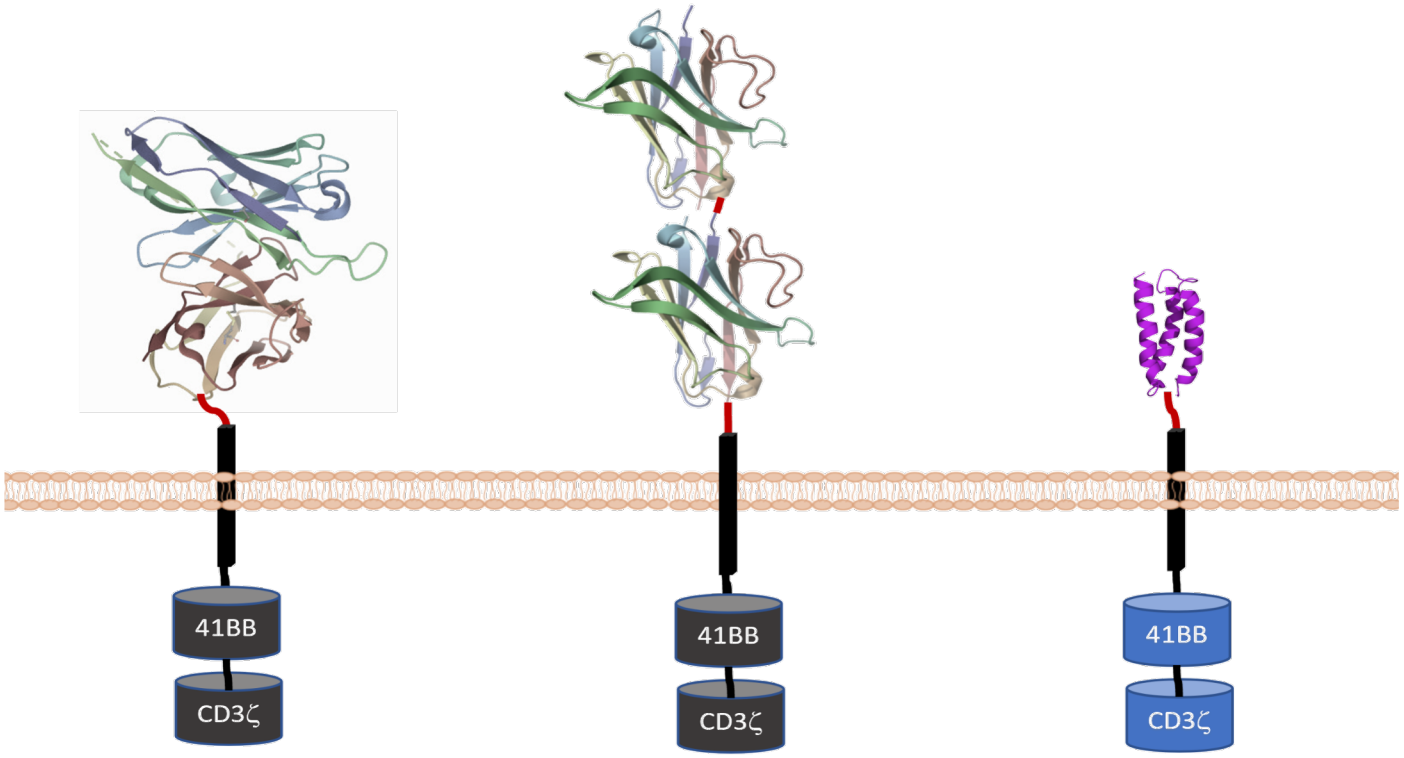
Exceptional team

Wholly owned IP

Well capitalized

Anitocabtagene autoleucel (anito-cel/CART-ddBCMA)

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



scFv
(~25 kDa)

Bivalent camelid VHh
(~25 kDa)

D-Domain
(~8 kDa)

D-Domain Attributes:

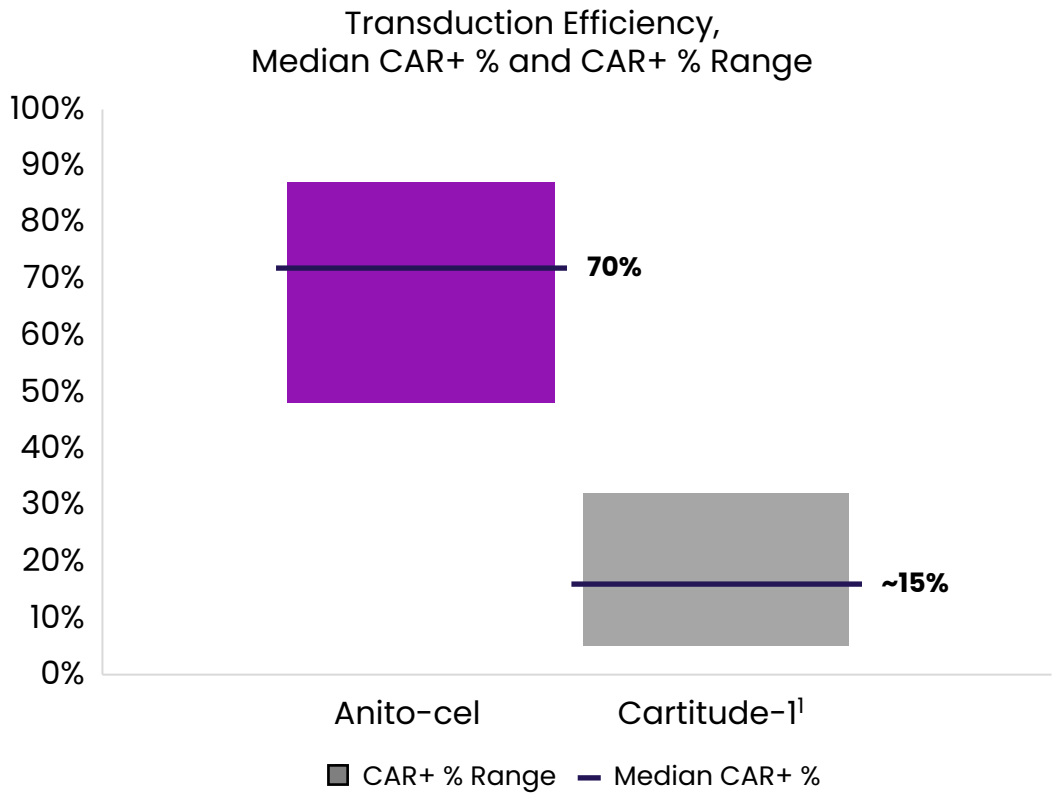
Non-Antibody Derived Synthetic Protein[1,2]

Expression	Small D-Domain construct facilitates high transduction efficiency, CAR positivity, and CAR density on the T-cell surface[2-4]
Stability	Rapid D-Domain folding, lack of disulfide bonds, and a hydrophobic core enables stability at and beyond physiologic conditions[5,6]
Structure	Due to small size and compact structure, D-Domain CARs have a low risk of tonic signaling[6] and potentially more efficient Multiple Myeloma cell killing

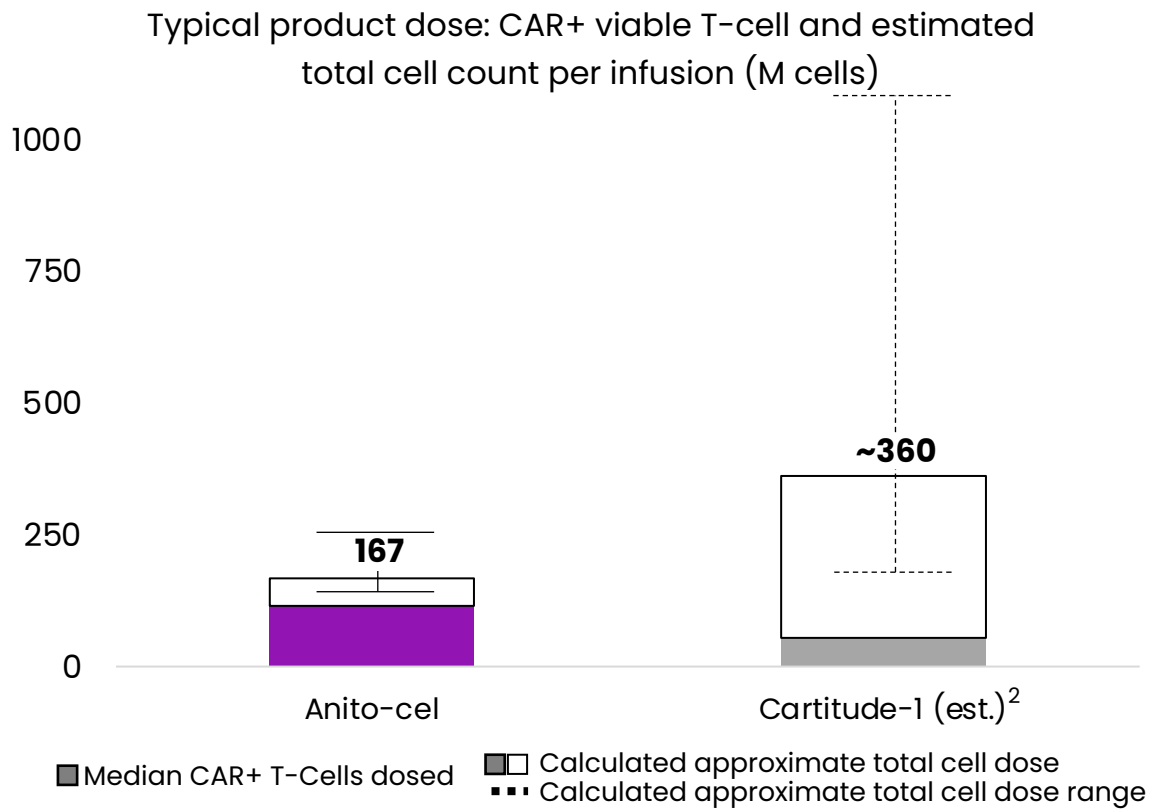
[1]Rotte, et al. *Immuno-Oncology Insights* 2022; 3(1), 13–24; [2]Frigault, et al. *Blood Adv.* 2023; 7(5):768-777; [3]Cante-Barrett, et al. *BMC Res. Notes* 2016; 9:13; [4]Buonato, et al. *Mol. Cancer Ther.* 2022; 21(7):1171-1183; [5]Zhu, et al. *Proc. Nat. Acad. Sci.* 2003; 100(26): 15486-15491; [6]Qin, et al. *Mol. Ther.* 2019; 27(7): 1262-1274.

High CAR+ cell product with lower overall cell dose

Anito-cel has higher transduction efficiency



Enabling higher CAR+ within a lower overall cell dose



Higher total cell dose has been found to be a key risk factor for both severe CRS and severe neurological toxicities[3]

Note: Data above are not from head-to-head studies
[1]Zudair et al.; [2]Foster et al.; [3]Wu et al.

Multiple Myeloma is a Significant Market Opportunity

3rd most common blood cancer

Impacting **100,000** patients annually

Limited Therapies comprise **~$20B** global market today

Multiple Myeloma

Growing opportunity for CAR-T solutions as **more effective** therapies move to **earlier line** patients

Incurable disease with **life expectancy of just over 5 years**

Total addressable market (2L+) of **$12B+** in CAR-T

Anito-cel is well positioned for launch and scale

Leveraging Kite's Large Commercial Footprint and Manufacturing Expertise

ARCELLX™

- 70% CAR+* — D-Domain, a differentiated approach
- 28 mo. Est. mPFS* — Potential Best-in-Class Therapy
- 100%* — Manufacturing success rate
- 50/50 — Partnership with Global Cell Therapy Leader
- $646.8M — Well capitalized; track record of execution

Kite, A GILEAD Company

- >23K — Patients Treated
- 14-Day — TAT for current Yescarta in the U.S.
- ~480 — ATCs Globally
- 96% — Manufacturing success rate
- >24K — YE 2026 cell therapy manufacturing capacity

*Phase 1 Study: October 15, 2023, data cut-off; ASH Annual Meeting, December 2023, abstract #1023

A Rich Development Pipeline with Growth in Mind

Clinical and Preclinical Pipeline

Indication	Platform	Discovery/ Preclinical	Phase 1	Phase 2 / Pivotal	Current Status / Anticipated Milestone
Multiple Myeloma	ddCAR (Kite, A GILEAD Company)	*iMMagine-1 pivotal/ anito-cel*			Present preliminary data YE 2024
		iMMagine-3 Confirmatory RCT / anito-cel			Initiation planned for 2024
	ARC-SparX	ACLX-001: BCMA			Kite exercised option
AML/MDS	ARC-SparX	*ACLX-002: CD123*			Phase 1 enrolling
		ACLX-003			
Solid Tumors	ARC-SparX	*SCLC*			
	ddCAR	*HCC*			

OUR MISSION

Advance humanity by engineering cell therapies that are safer, more effective, and more broadly accessible

ARCELLX

Phase 1 Clinical Profile Supports Potential Best-in-Class Candidate

100% ORR
76% CR/sCR

CR/sCR rate maintained across high-risk subgroups, including EMD, high-risk cytogenetics, age ≥65

38 have had at least the 12-month follow-up visit and are evaluable for efficacy

100% ORR; 76% CR/sCR; 16% VGPR; 8% PR

Median PFS not reached

at median follow-up of 26.5 mos.

In the overall population studied, the estimated median PFS has not been reached at 24 months

24-month PFS estimates %:
Overall: 56.0%
High-risk features: 58.7%
Extramedullary disease: 57.5%
High Risk Cytogenetics: 71.6%
Age ≥65: 61.3%

No Delayed Neurotoxicities

Including no Parkinsonian Symptoms

No grade ≥3 CRS and 1 case of Grade 3 ICANS at RP2D. All events resolved without sequelae with routine management

32 patients at DL1 have had at least the 12-month follow-up visit and are evaluable for safety

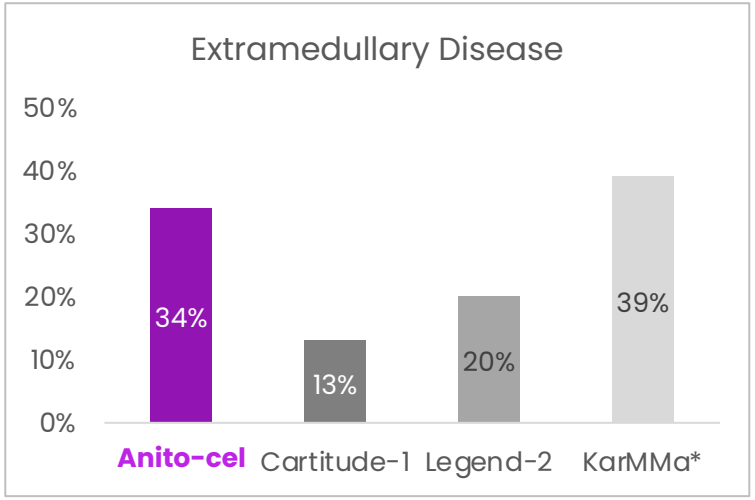
0% Grade ≥3 CRS in DL1 and
3% Grade ≥3 ICANS in DL1

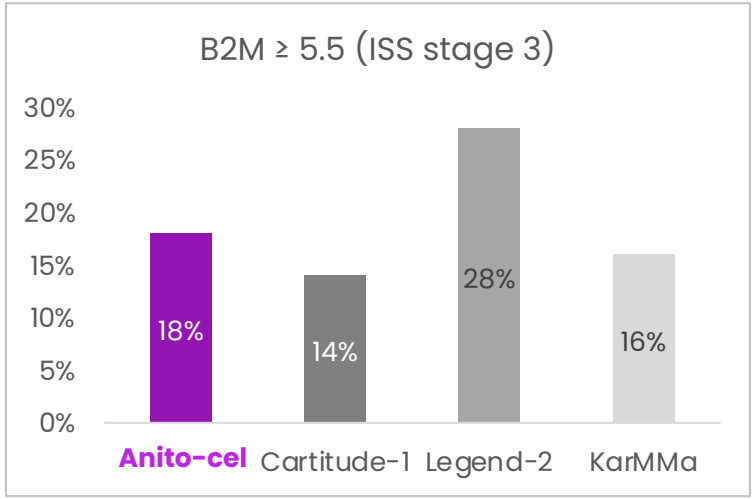
No tissue-targeted toxicities, no Guillain-Barré syndrome, no cranial nerve palsies observed as of latest data cut-off

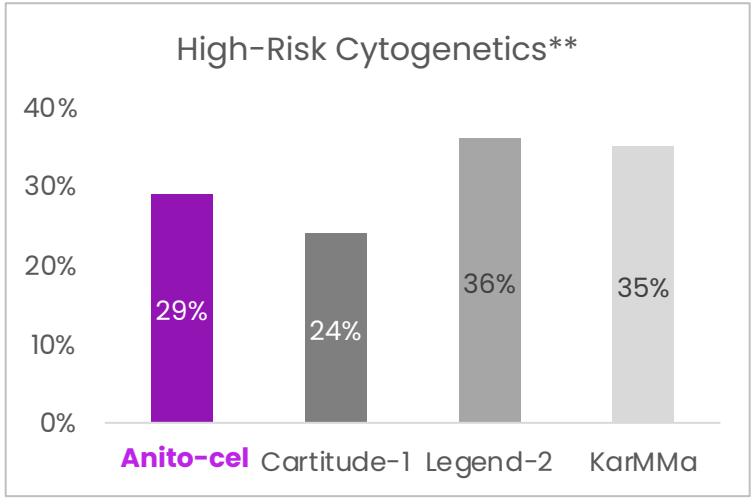
Phase 2 Pivotal Study Currently Enrolling

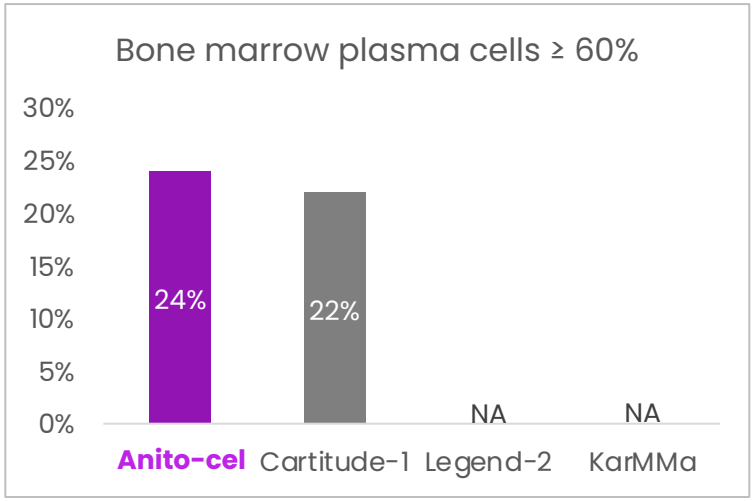
Phase 1 Study: October 15, 2023, data cut-off; ASH Annual Meeting, December 2023, abstract #1023

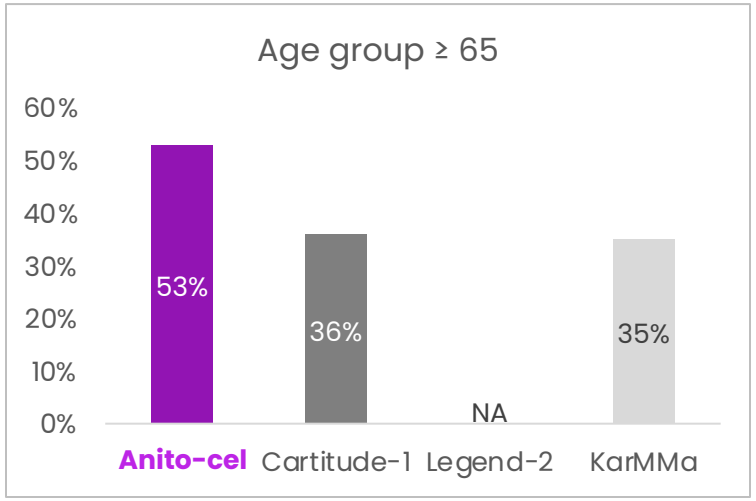
Anito-cel Phase 1 in a higher risk patient population

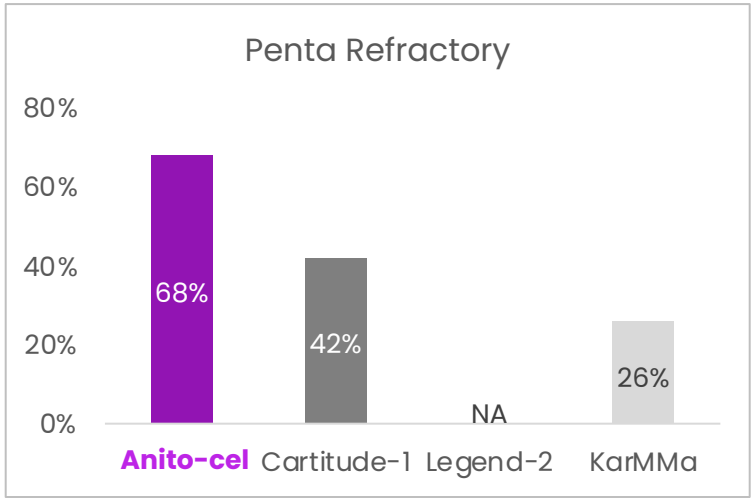






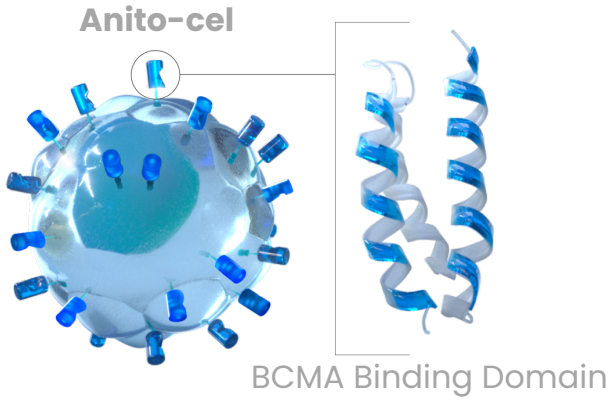






*KarMMa EMD figure includes bone-based lesions; **Defined as the presence of Del 17p, t(14;16), t(4;14); for Anito-cel, high risk cytogenetics including +1q gain is n=26 (68%); Data above are not from head-to-head studies.
KarMMa: [4]Munshi et al.; Legend-2: [6]Zhao et al.; Cartitude-1: [7]Martin et al. (2023)

Anito-cel Phase 1: Background and Methods



Phase 1 first-in-human trial is in patients with relapsed and/or refractory myeloma

- Prior IMiD, PI, and CD38-targeted therapy
- Received ≥3 prior lines of therapies or triple refractory

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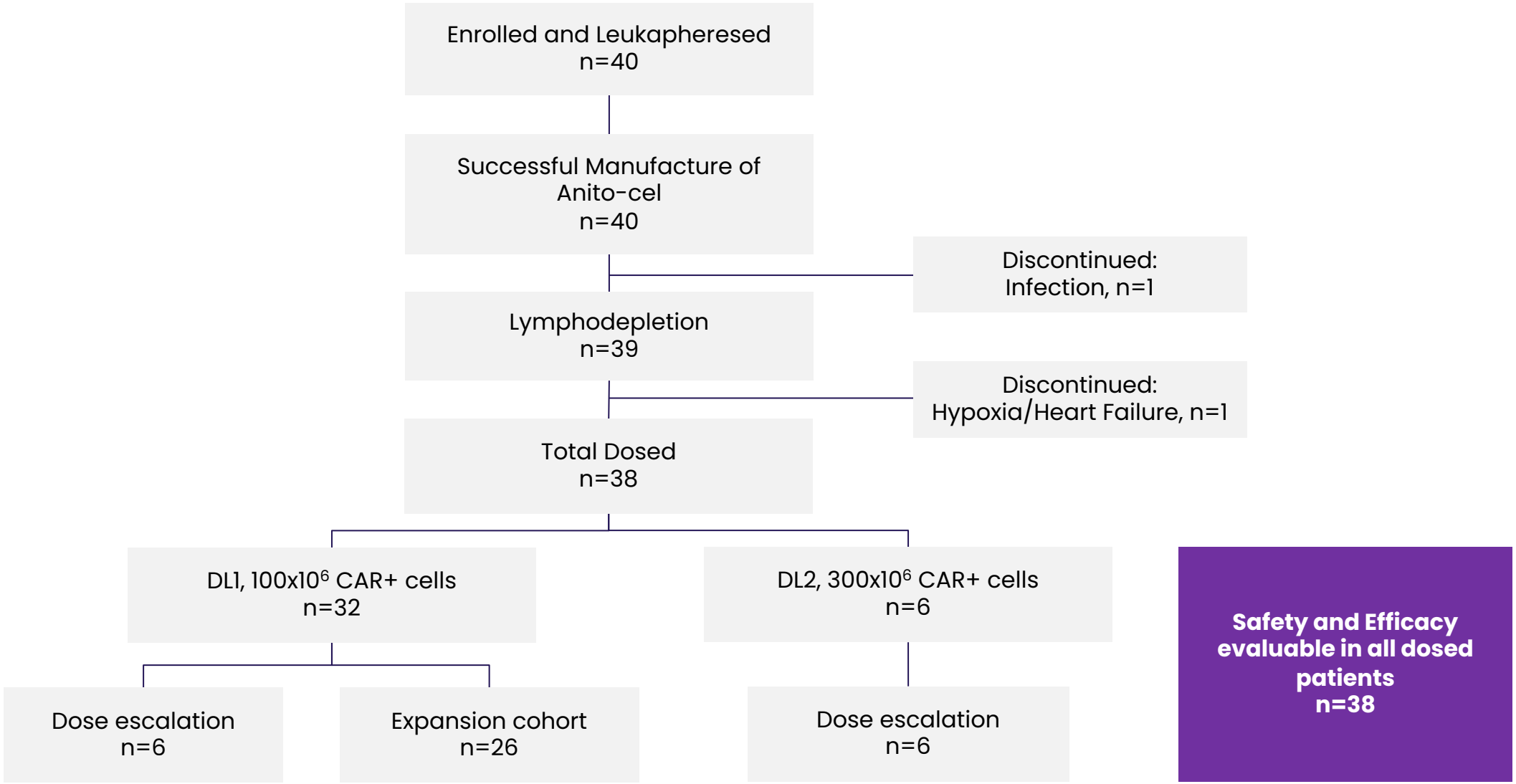
2 Dose Levels evaluated, 6 patients in each dose escalation cohort

- DL1 = 100 ± 20% x 10^6 CAR+ cells
- DL2 = 300 ± 20% x 10^6 CAR+ cells

Expansion cohort is enrolled at DL1

Phase 2 pivotal study (NCT05396885) is enrolling patients

Anito-cel Phase 1: Patient Disposition



Median administered dose at DL1, 115 million cells (range, 112-120 million cells)

Anito-cel Phase 1: A higher risk patient population

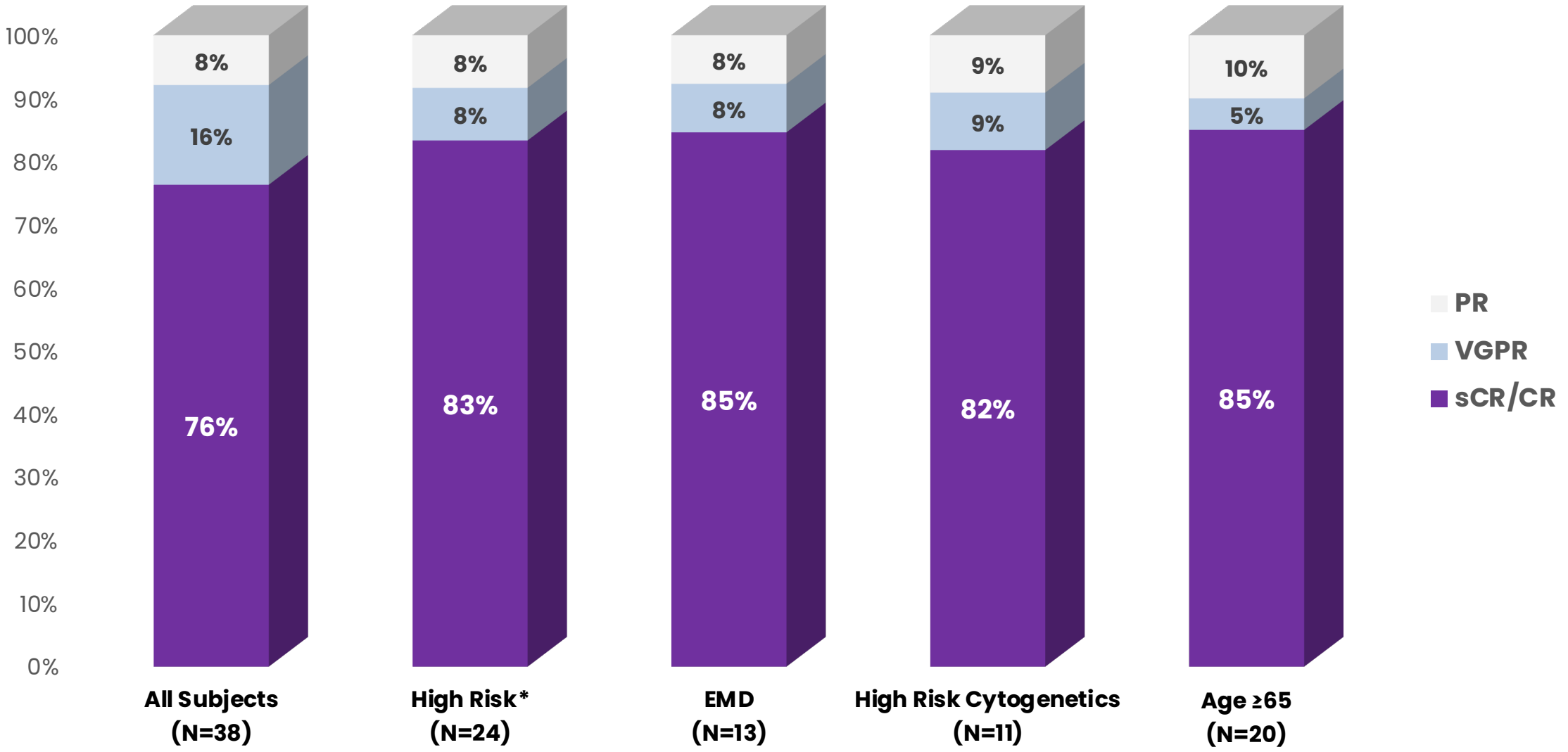
	KarMMa[4]	Legend-2[6]	Cartitude-1[7]	Anito-cel ph1
	N=128	N=74	N=97	N=38
BMPC ≥ 60%, # (%)	NA	NA	21 (22%)	**9 (24%)**
B2M ≥ 5.5 (ISS stage 3), # (%)	21 (16%)	21 (28%)	14 (14%)	**7 (18%)**
EMD, # (%)	50 (39%) *{incl. bone-based lesions}*	15 (20%)	13 (13%)	**13 (34%)**
High risk cytogenetics, # (%)*	45 (35%)	15 (36%)	23 (24%)	**11 (29%)**
ECOG 0	57 (45%)	30 (41%)	39 (40%)	**12 (32%)**
Age group ≥ 65, # (%)	45 (35%)	NA	35 (36%)	**20 (53%)**
Triple refractory, # (%)	108 (84%)	NA	85 (88%)	**38 (100%)**
Penta refractory, # (%)	33 (26%)	NA	41 (42%)	**26 (68%)**
Previous ASCT	120 (94%)	18 (24%)	87 (90%)	**29 (76%)**
Bridging Therapy, # (%)	112 (88%)	NA	73 (75%)	**26 (68%)**
Median prior therapies	6 [3-16]	3 [1-9]	6.0 [3-18]	**4 [3-16]**

- **Greater percentage of patients with poor prognostic features**: Anito-cel Phase 1 has higher rates of patients with high tumor burden, ISS stage III, EMD, and high-risk cytogenetics, which are all poor prognostic features for cell therapy
- **Greater percentage of patients that are difficult to treat:** Anito-cel Phase 1 has older patients (age ≥ 65), higher disease burden (BMPC ≥ 60%) and fewer ECOG 0 patients
- **Greater percentage of refractory patients:** Anito-cel Phase 1 enrolled all triple-refractory patients and had more penta-refractory disease patients, unresponsive to other therapies

*Defined as the presence of Del 17p, t(14;16), t(4;14); Anito-cel high-risk cytogenetics including +1q gain is n = 26 (68%); Cross-trial data interpretation should be considered with caution as it is limited by differences in study population, study design, and other factors

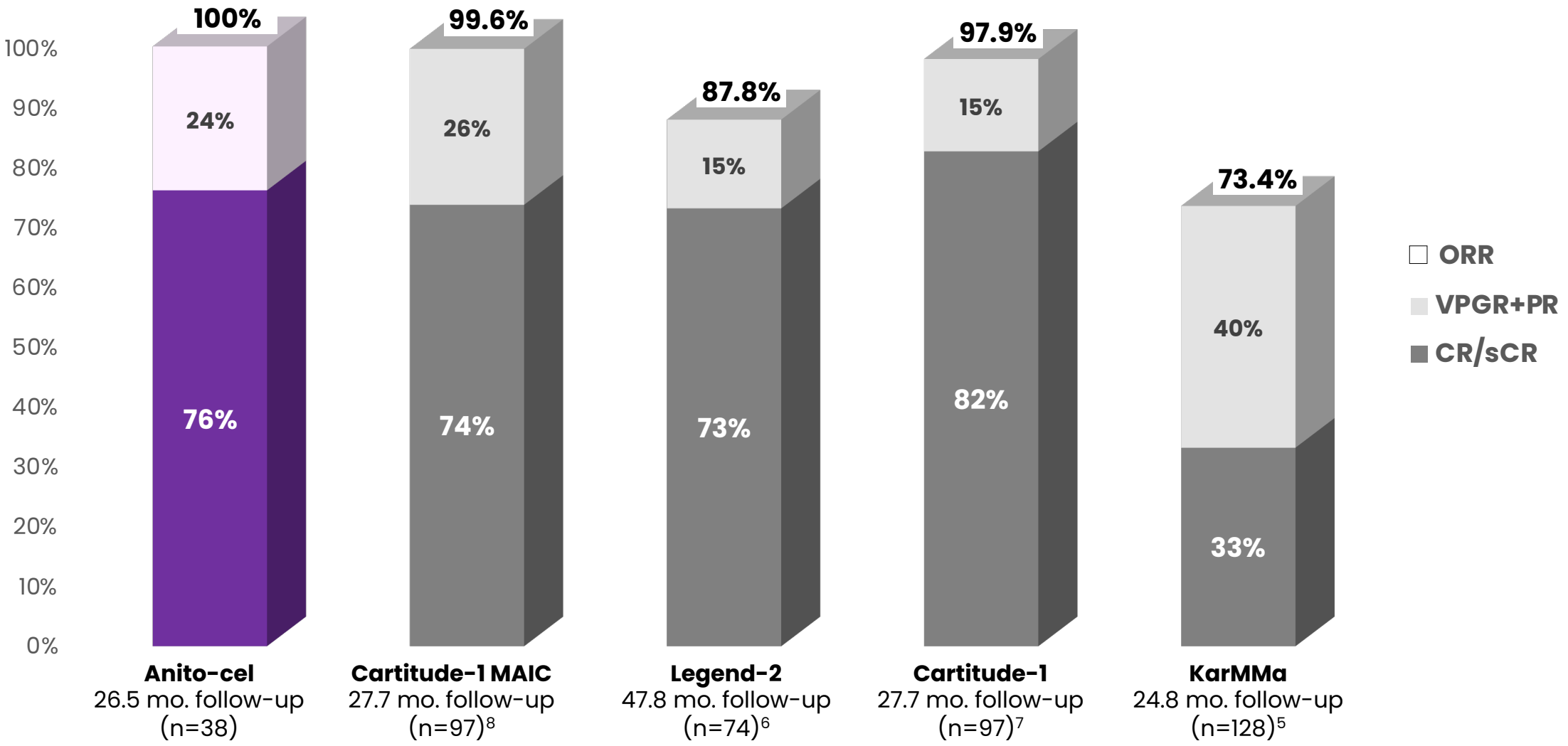
[4]Munshi et al.; [6]Zhao et al.; [7]Martin et al. (2023)

High CR/sCR rate of 76%, maintained across high-risk groups



Note: Data cut-off October 15, 2023; * High Risk defined as a patient with EMD, ISS Stage III (B2M ≥5.5), or BMPC ≥60%

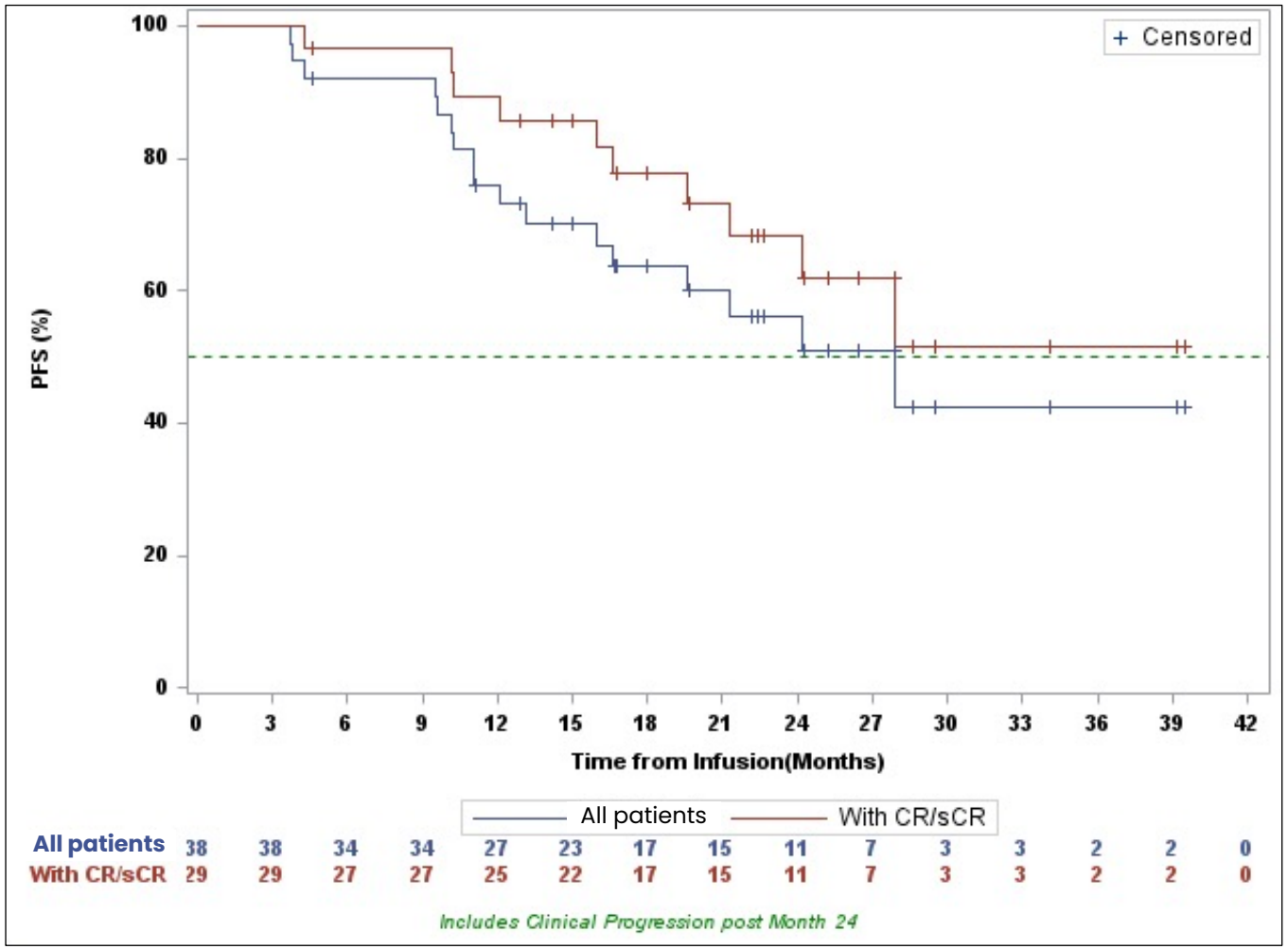
Anito-cel has 100% ORR and 76% CR/sCR in Phase 1



Note: MAIC is matching-adjusted indirect comparison, a J&J study comparing Cartitude-1 results by adjusting its population to match that of KarMMa; Data above are not from head-to-head studies. Cross-trial data interpretation should be considered with caution as it is limited by differences in median follow-up, study population, design and other factors

[5]Anderson et al.; [6]Zhao et al.; [7]Martin et al. (2023); [8]Martin et al. (2022)

mPFS not reached at 26.5 mo median follow-up (all patients)

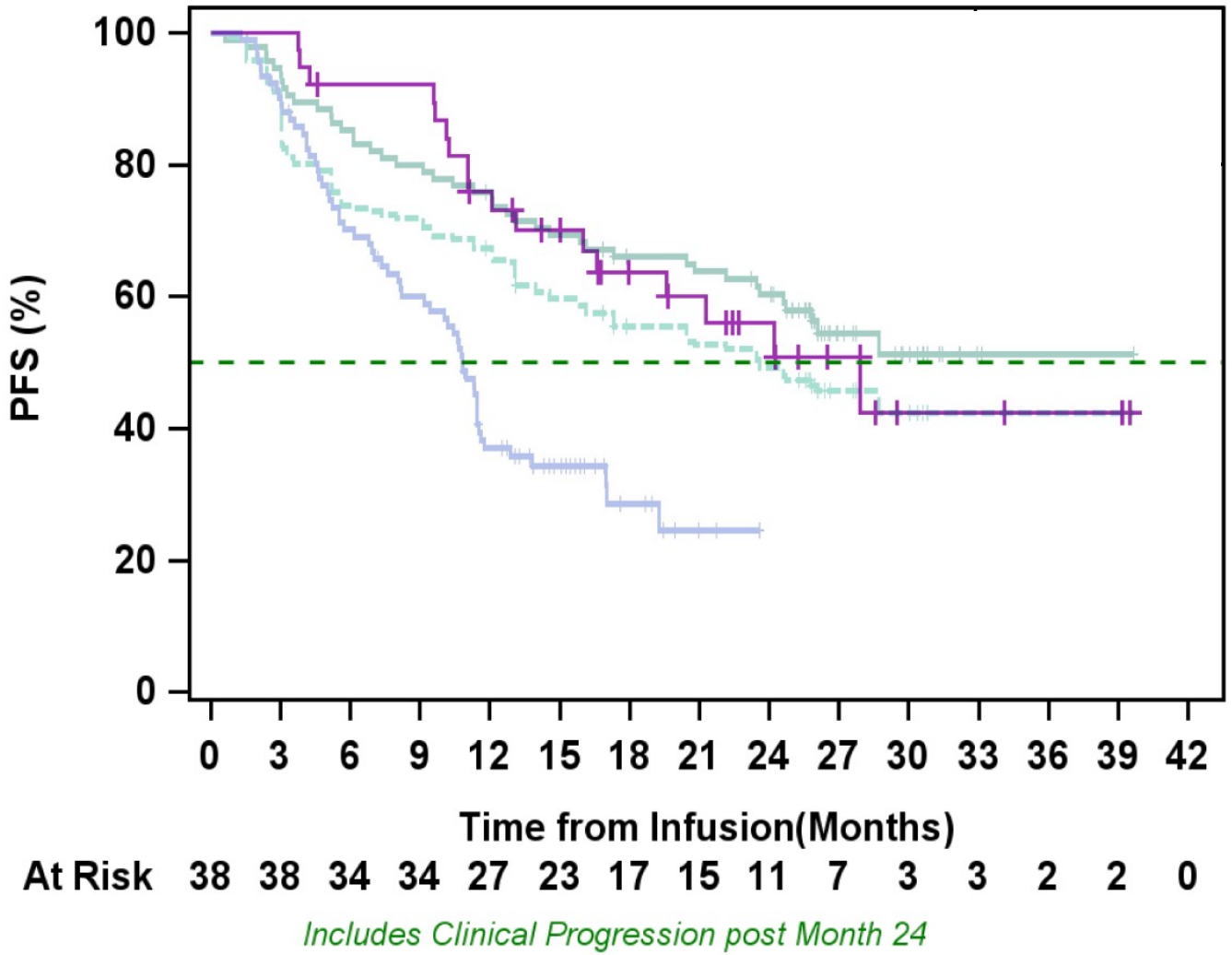


	Time (months)	PFS Estimate (%)	95% Confidence Interval (%)
All Patients (n = 38)	6	92.1	77.5, 97.4
	12	75.9	58.7, 86.6
	18	63.7	45.7, 77.2
	24	56.0	37.3, 71.1

- **Median PFS not reached for all patients (n=38)**
- **Median PFS not reached for CR/sCR patients (n=29, 76%)**
- **89% (n=25/28) of evaluable* patients MRD negative at minimum of 10^{-5} sensitivity**

Note: Data cut-off October 15, 2023; * Evaluable patients had identifiable malignant clone in the baseline bone marrow aspirate

mPFS not reached at 26.5 mo median follow-up (all patients)



Anito-Cel Phase 1
median follow-up 26.5 mos

Cartitude-1
median follow-up 27.7 mos[8]

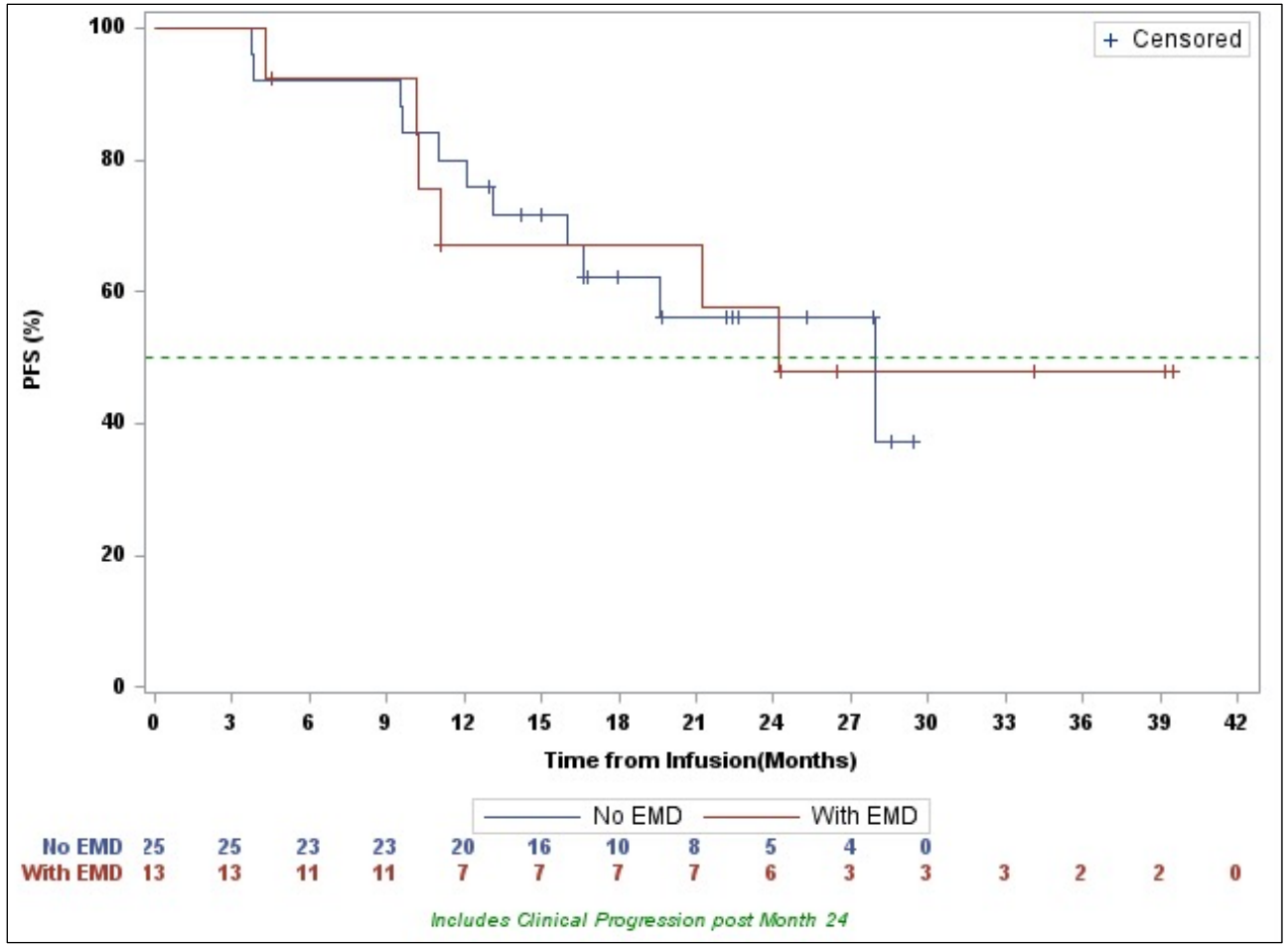
Cartitude-1 MAIC
median follow-up 27.7 mos[8]

KarMMA
median follow-up 15.4 mos[8]

Note: MAIC is matching-adjusted indirect comparison, a J&J study comparing Cartitude-1 results by adjusting its population to match that of KarMMa; Data above are not from head-to-head studies. Cross-trial data interpretation should be considered with caution as it is limited by differences in median follow-up, study population, design and other factors

[8]Martin et al. (2022)

Anito-cel mPFS not reached in EMD and Non-EMD patients



	Time (months)	PFS Estimate (%)	95% Confidence Interval (%)
With EMD (n = 13)	6	92.3	56.6, 98.9
	12	67.1	34.2, 86.2
	18	67.1	34.2, 86.2
	24	57.5	25.7, 79.9

- **Median PFS not reached for patients with EMD (n=13)**
- **Median PFS not reached for Non-EMD patients (n=25)**

Note: Data cut-off October 15, 2023

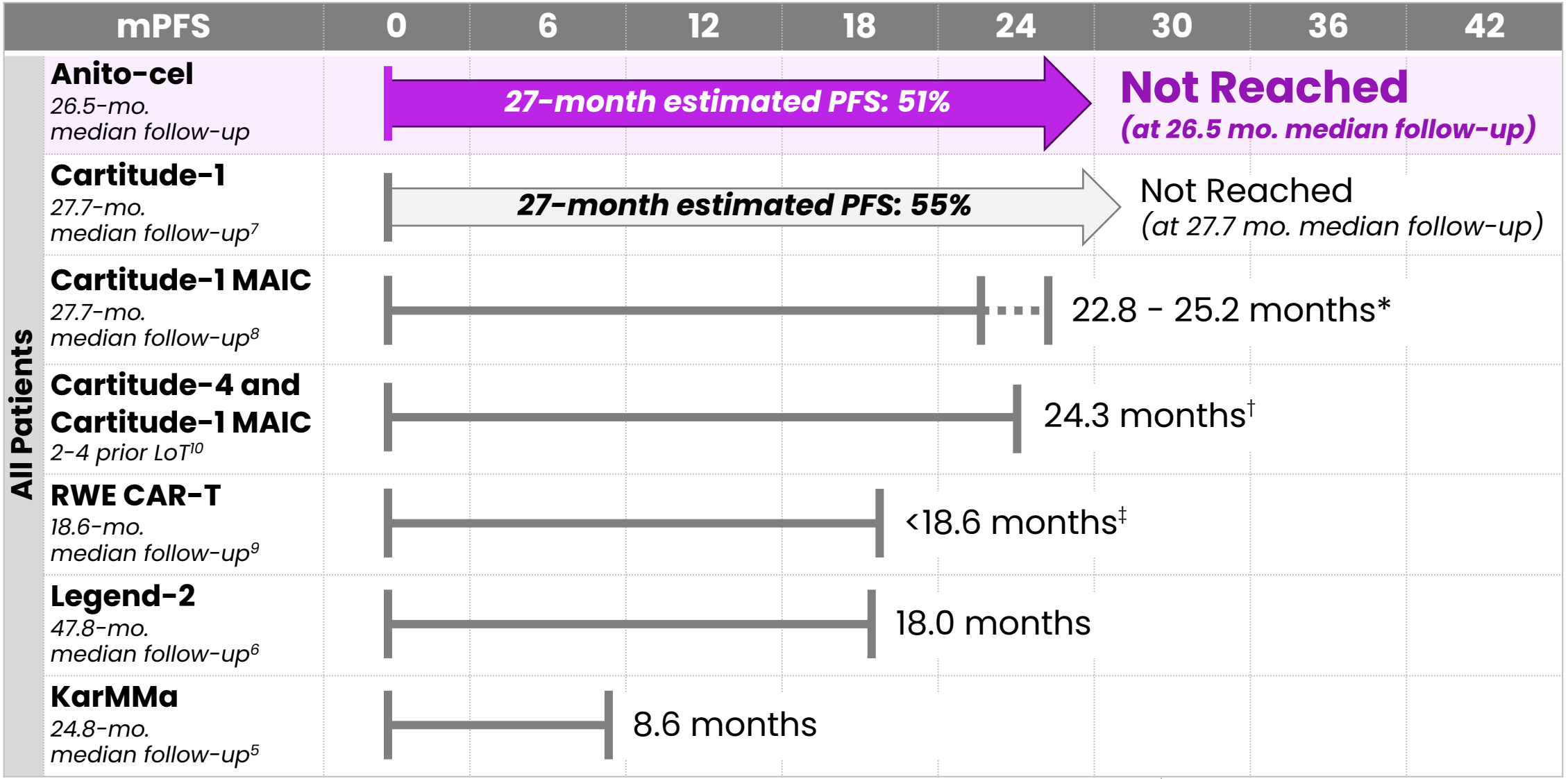
Durability tracking to >24 mo. mPFS in high-risk populations

Kaplan-Meier PFS Estimates	Overall	High Risk Features*	Extramedullary disease	High Risk Cytogenetics	≥ 65 years
Patients n (%)	38 (100%)	24 (63.2%)	13 (34.2%)	11 (28.9%)	20 (52.6%)
6-month PFS % (95% CI)	92.1% (77.5%, 97.4%)	91.7% (70.6%, 97.8%)	92.3% (56.6%, 98.9%)	81.8% (44.7%, 95.1%)	95.0% (69.5%, 99.3%)
12-month PFS % (95% CI)	75.9% (58.7%, 86.6%)	74.2% (51.3%, 87.5%)	67.1% (34.2%, 86.2%)	71.6% (35.0%, 89.9%)	85.0% (60.4%, 94.9%)
18-month PFS % (95% CI)	63.7% (45.7%, 77.2%)	64.6% (41.3%, 80.6%)	67.1% (34.2%, 86.2%)	71.6% (35.0%, 89.9%)	74.3% (48.7%, 88.4%)
24-month PFS % (95% CI)	**56.0% (37.3%, 71.1%)**	**58.7% (35.1%, 76.3%)**	**57.5% (25.7%, 79.9%)**	**71.6% (35.0%, 89.9%)**	**61.3% (34.9%, 79.7%)**

In all risk subgroups, including High Risk, the est. median PFS has not been reached at 24 months

Note: Data cut-off October 15, 2023; * High Risk defined as a patient with EMD, ISS Stage III (B2M ≥5.5), or BMPC ≥60%

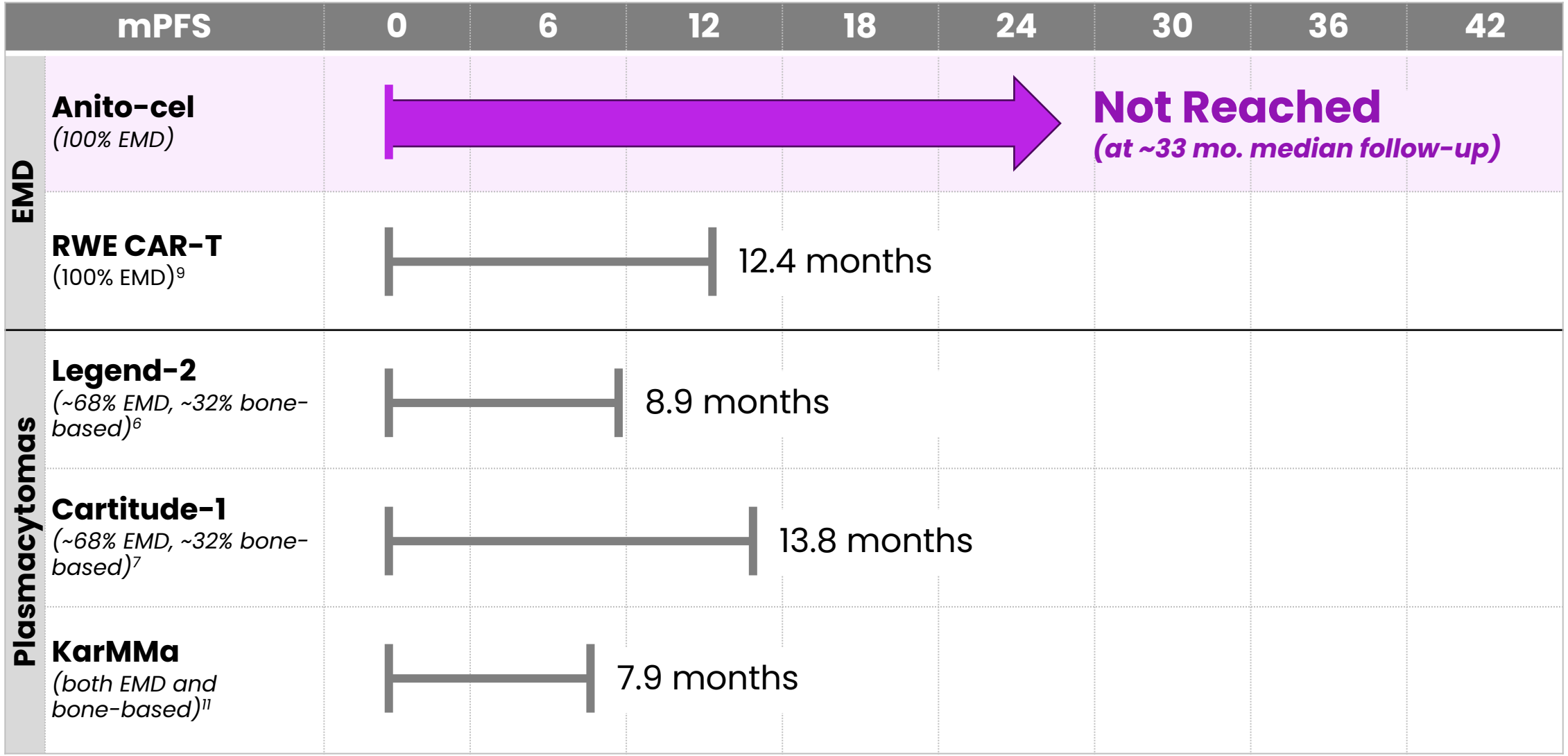
Durability highlights potential best-in-class profile



*All variable adjusted comparison using FDA-approved doses cohort and base case adjusted comparison using "all doses" cohort shown; † Cartitude-4 and Cartitude-1 MAIC had both trials used in matching adjusted indirect comparison; ‡ 77 of 134 patients had a progression event at 18.6 months of median follow-up; MAIC is matching-adjusted indirect comparison, a J&J study comparing Cartitude-1 results by adjusting its population to match that of KarMMa; RWE refers to real world evidence for Carvykti and Abecma. Data above are not from head-to-head studies. Cross-trial data interpretation should be considered with caution as it is limited by differences in median follow-up, study population, design and other factors; LoT is Lines of Therapy

[5]Anderson et al.; [6]Zhao et al.; [7]Martin et al. (2023); [8]Martin et al. (2022); [9]Pan et al.; [10]Bar et al.

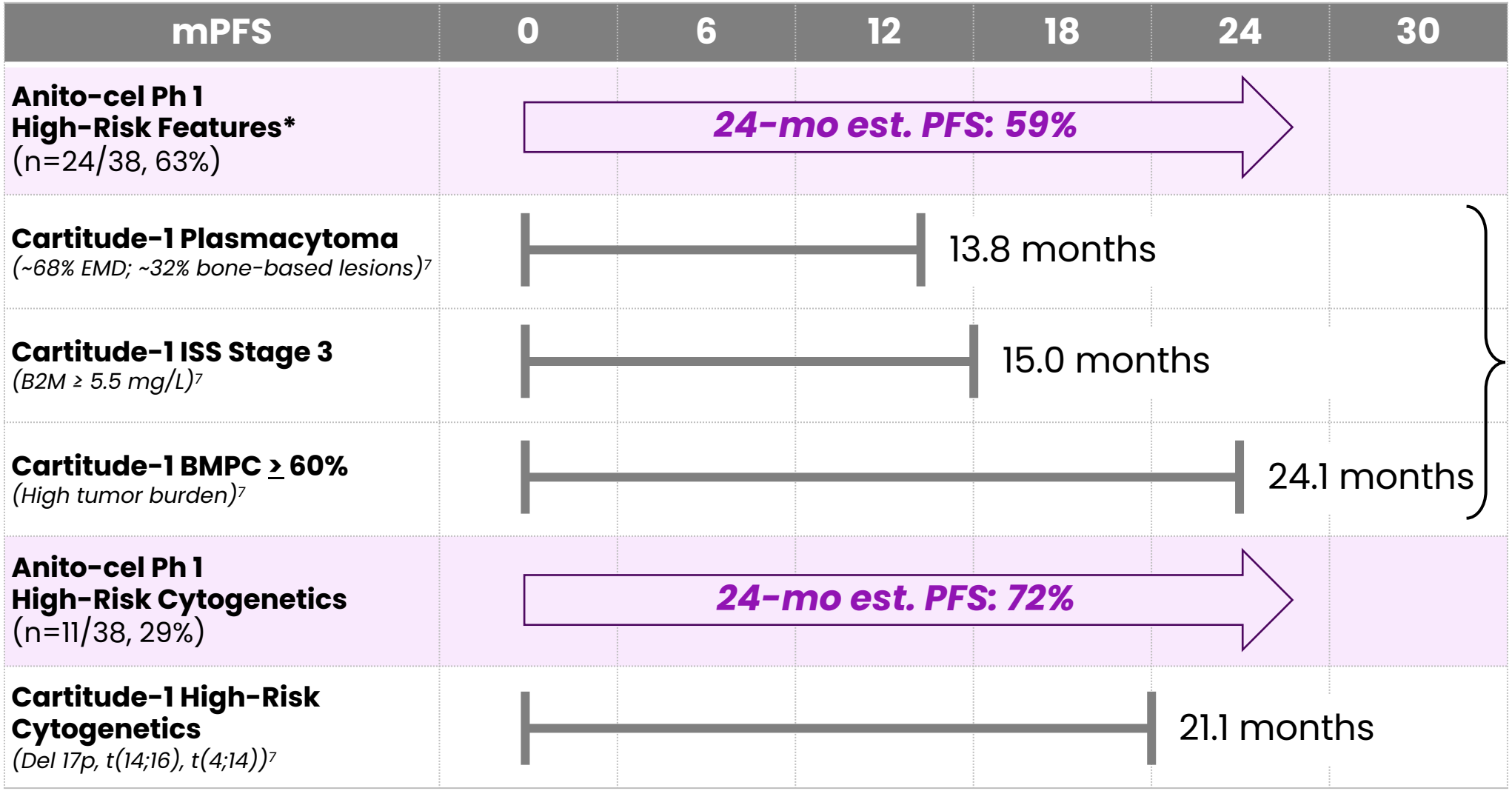
Durability maintained in EMD patients, a poor prognostic factor



RWE refers to real world evidence for Carvykti and Abecma. Data above are not from head-to-head studies. Cross-trial data interpretation should be considered with caution as it is limited by differences in median follow-up, study population, design and other factors

[6]Zhao et al.; [7]Martin et al. (2023); [9]Pan et al.; [11]Raje et al.

The typical patient in the Anito-Cel Phase 1 had a high-risk feature, where approved CAR-Ts have had poor outcomes



* High Risk defined as a patient with EMD, ISS Stage III (B2M ≥5.5), or BMPC ≥60%; Data above are not from head-to-head studies. Cross-trial data interpretation should be considered with caution as it is limited by differences in median follow-up, study population, design and other factors

[7]Martin et al. (2023)

At 2-yrs follow-up, Anito-cel has favorable safety profile

- No delayed neurotoxicities, no Parkinsonian-like syndromes
- No cranial nerve palsies, no Guillain-Barré syndrome, in the entire population through follow-up
- One Grade 5 AE post study treatment (unrelated cardiac arrest due to non-study drug overdose)

CAR-T-associated AEs Per ASTCT criteria	100 million (N=32)		300 million (N=6)	
Cytokine Release Syndrome (CRS)	**Grade 1/2**	**Grade 3**	**Grade 1/2**	**Grade 3**
	30 (94%)	**0**	**5 (83%)**	**1 (17%)**
Median onset (min-max)	2 days (1-12 days)		2 day (1-2 days)	
Median duration (min-max)	6 days (1-10 days)		5 days (3-9 days)	
Neurotoxicity (ICANs)	**Grade 1/2**	**Grade 3**	**Grade 1/2**	**Grade 3**
	5 (16%)	**1 (3%)**	**0**	**1 (17%)**
Median onset (min-max)	4.5 days (3-6 days)		7 days	
Median duration (min-max)	3.5 days (1-9 days)		17 days	
Toxicity Management				
Tocilizumab	27 (84%)		5 (83%)	
Dexamethasone	20 (63%)		2 (33%)	

Grade 3/4 AEs (non-CRS/ICANS) ≥5% after cell infusion (N=38)	
Hematologic	
Neutrophil count dec.	31 (81.6%)
Anemia	22 (57.9%)
Thrombocytopenia	16 (42.1%)
Lymphocyte count decreased	15 (39.5%)
White blood cell count decreased	7 (18.4%)
Febrile Neutropenia	5 (13.2%)
Non-hematologic	
Hypertension	3 (7.9%)
AST increased	2 (5.3%)
Cellulitis	2 (5.3%)
Hypokalemia	2 (5.3%)
Hyponatraemia	2 (5.3%)
Hypophosphatemia	2 (5.3%)
Lung Infection	2 (5.3%)
Pain in extremity	2 (5.3%)
Sepsis	2 (5.3%)

iMMagine-1 Phase 2 Pivotal Trial Currently Enrolling

A multicenter, open-label study of CART-ddBCMA in patients with r/r MM

Primary Endpoint

Overall Response Rate (ORR) per IMWG criteria by Independent Review Committee (IRC)

- The primary analysis is planned when all subjects have a minimum of 13 months follow up after infusion of CART-ddBCMA

Key Secondary Endpoint

Stringent complete response (sCR) or complete response (CR) rate per IMWG criteria

ORR per IMWG by IRC in patients with 3 prior lines

Eligibility Criteria	• At least 3 prior lines of therapy, including PI, ImiD, and anti-CD38 antibody, and refractory to last line • Measurable disease • ECOG 0-1
Enrollment and Dose	• N=~110 • Dose = 115 (+/-10) million CAR+ cells

Conclusions

- **Anito-cel utilizes a novel, synthetic, compact and stable D-Domain binder**
  - D-Domain facilitates high CAR surface expression, low risk of tonic signaling
  - Recommended Phase 2 Dose selected as 115±10 million CAR+ T cells

- **CR/sCR rate 76%; 100% ORR per IMWG**
  - CR/sCR rate >80% in all evaluated sub-groups including high-risk (EMD, high-risk cytogenetics, age ≥65)
  - 89% of MRD evaluable patients (n=25/28) were MRD negative at 10^{-5} or lower

- **Median PFS, DOR, and OS not reached at 2 years of follow-up (median 26.5 months)**
  - CAR-T-ddBCMA continues to demonstrate deep and durable efficacy, including in high-risk patient sub-groups

- **At 2 years of follow-up (median 26.5 months), manageable safety profile**
  - No grade ≥3 CRS and 1 case of Grade 3 ICANS at RP2D. All events resolved without sequelae with routine management
  - No delayed neurotoxicity, no cranial nerve palsy, no Parkinsonian symptoms, no Guillain-Barré syndrome

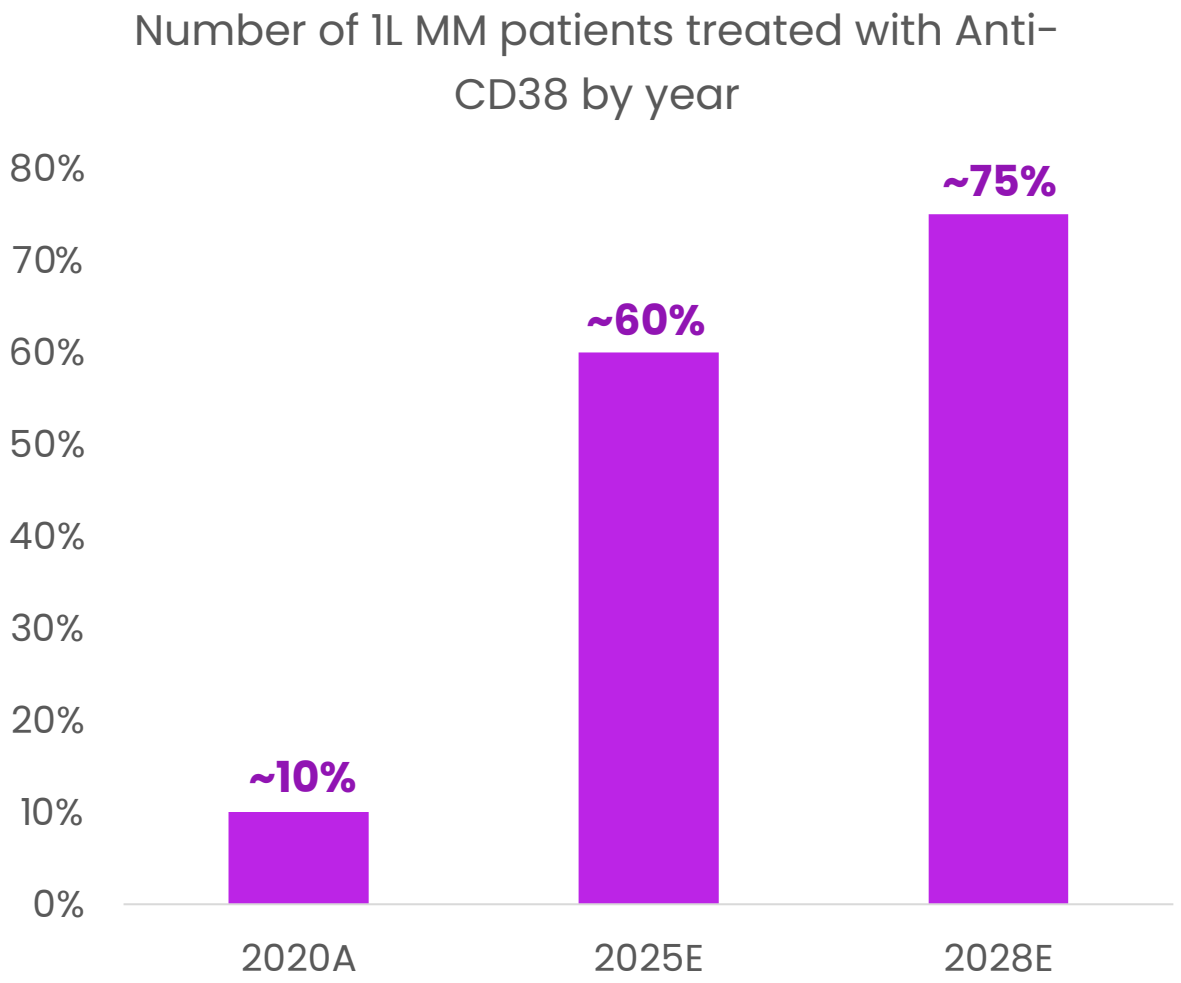
Pivotal phase 2, iMMagine-1 trial (NCT05396885)
is now enrolling in co-development with Kite

iMMagine-3 Trial initiated in 2H 2024 with Kite Best-in-Class Manufacturing

Multi-center, Global, Phase 3 Randomized Control Clinical Trial (RCT) for anti-CD38 mAb and IMiD exposed patients

- Addressing the largest percentage of second line (2L) patients as anti-CD38 mAbs become standard of care in front line (1L)
  - Covers $12B relapsed refractory Multiple Myeloma market
- Anticipate high physician interest in iMMagine-3 based on:
  - Potential best-in-class product profile
  - Relevant standard of care alternatives
  - Rapid and reliable turnaround time with Kite manufacturing
- Easy to identify patient population, expected to streamline access to anito-cel
- Confirmatory RCT will include ~450 patients randomized 1:1 in US and Intl sites

Use of an Anti-CD38 and IMiD are standard of care in frontline regimens for Multiple Myeloma



Anti-CD38 based regimens in 1L have demonstrated strong results[1,2] and are **now used as standard of care**

High uptake of anti-CD38 in the near term will translate to **large 2L population that is anti-CD38 exposed in the future**

1. Phase 3 PERSEUS study (NCT03710603); 2. Phase 3 MAIA study (NCT02252172);
Sources: Komodo Claims Analysis, June 2023; market research, internal analyses, estimates and projections by Kite and Arcellx

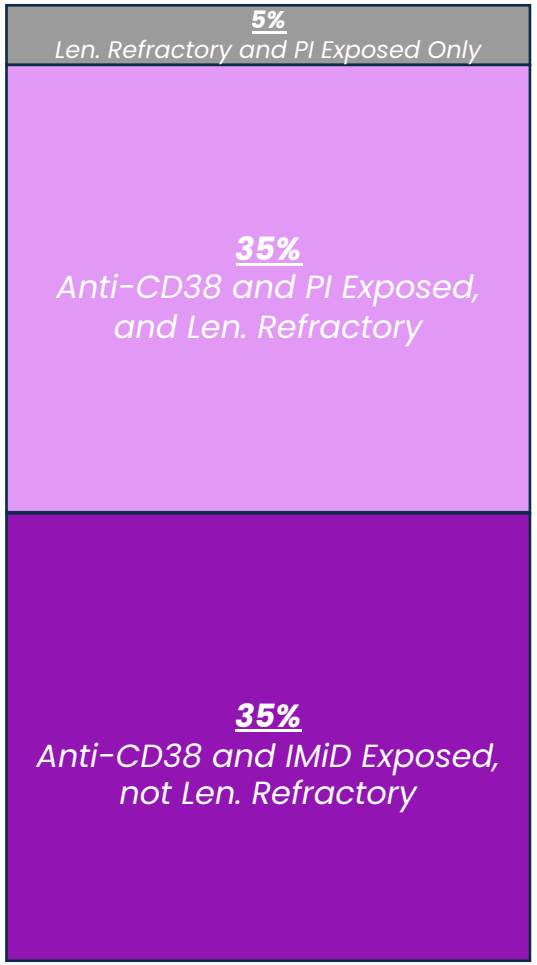
iMMagine-3 Captures Largest Anticipated 2L Population

% of Projected Steady State 2L On Label CAR T Patient Population by Segment[1]

~5% Unique to Other CAR T in 2L

~35% Shared in 2L

~35% Unique to anito-cel in 2L



~70%

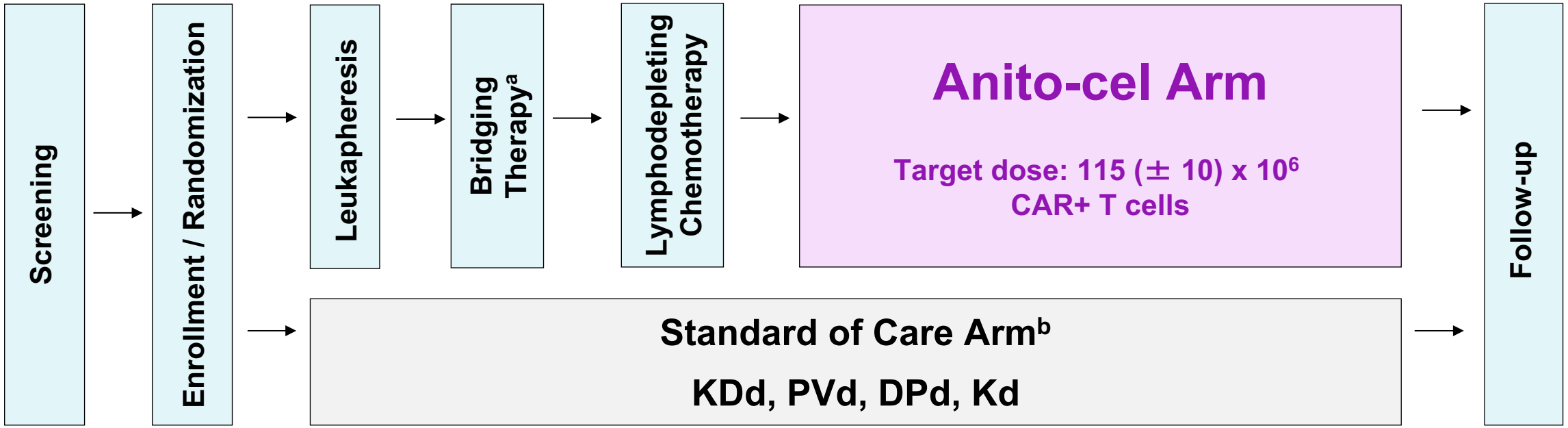
of 2L patients projected to be Anti-CD38 + IMiD exposed

~93%

anito-cel coverage (70% of 75% On Label 2L CAR T patients)

1. Steady state epidemiology assumptions for 2L patient population assumes 2030+
Source: Market research, internal analyses, estimates and projections by Kite and Arcellx

iMMagine-3 Global Phase 3 Randomized Study of Anti-CD38 + IMiD Exposed Patients



STUDY DESIGN

- 1:1 Randomization
- n = Approximately 450, ~130 sites globally

STUDY ENDPOINTS

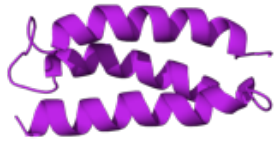
- Primary Endpoint: PFS
- Key Secondary Endpoints: CR rate, MRD, OS, safety

[a] Optional Bridging therapy will be the SOC regimen selected prior to randomization
[b] Cycles will continue until unacceptable toxicity, progression as per IMWG criteria, or patient withdrawal of consent

OUR TECHNOLOGY

With our **novel D-Domain** technology, a synthetic binding scaffold, our goal is to advance cell therapies by **enhancing** safety, efficacy, and access.

D-Domain Designed To Enhance Safety, Efficacy, and Availability

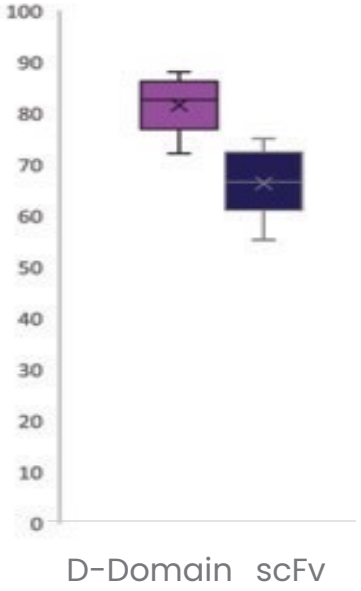


D-Domain

Hydrophobic Core & Stable

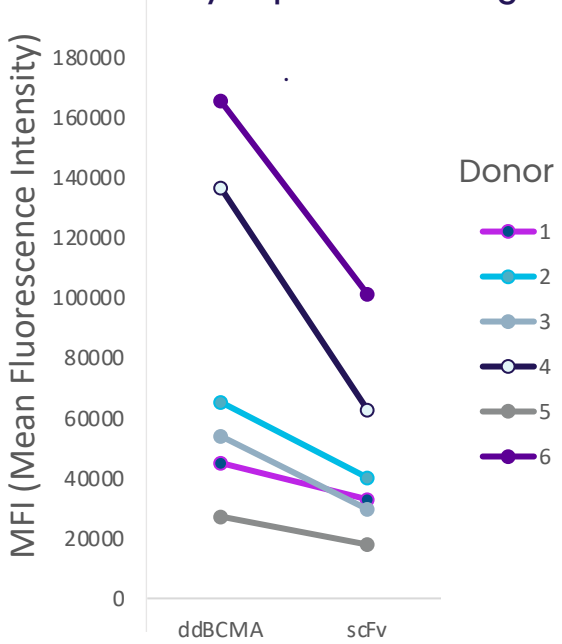
High Transduction Efficiency

Lower dose may lead to lower toxicity



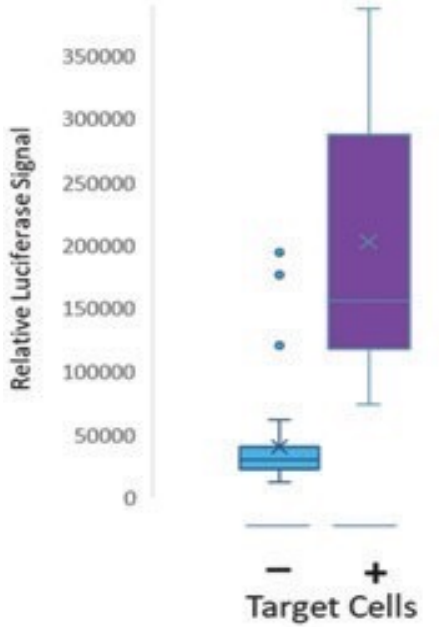
High Surface Expression

Potentially improved binding



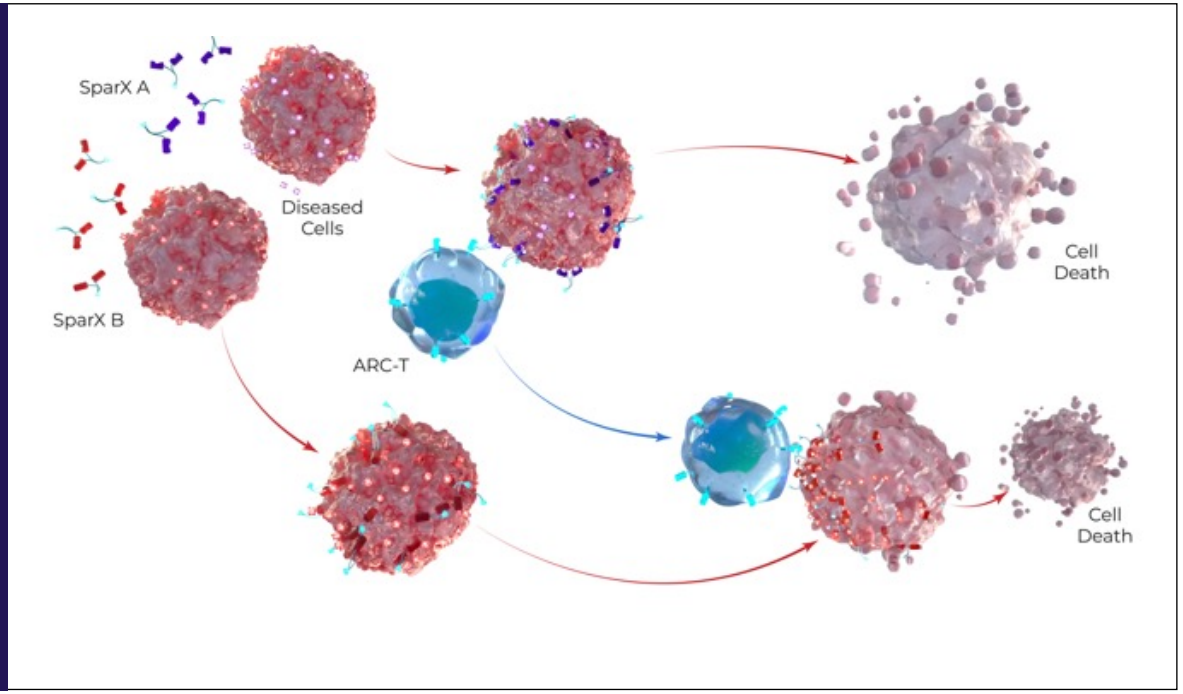
Low Tonic Signaling

Reduced T cell exhaustion



Our ARC-SparX Platform

Powered by the D-Domain
Novel CAR-T modular solution
that is CONTROLLABLE
and ADAPTABLE

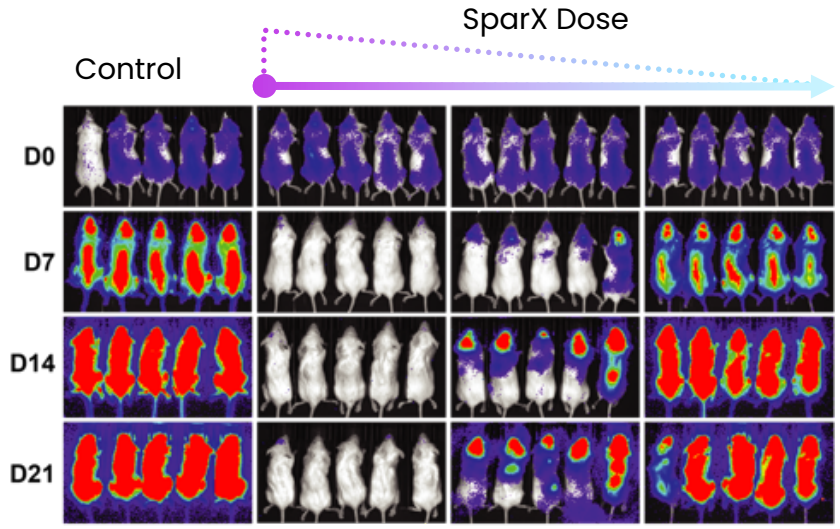


Controllable and Adaptable: The ARC-SparX Advantage

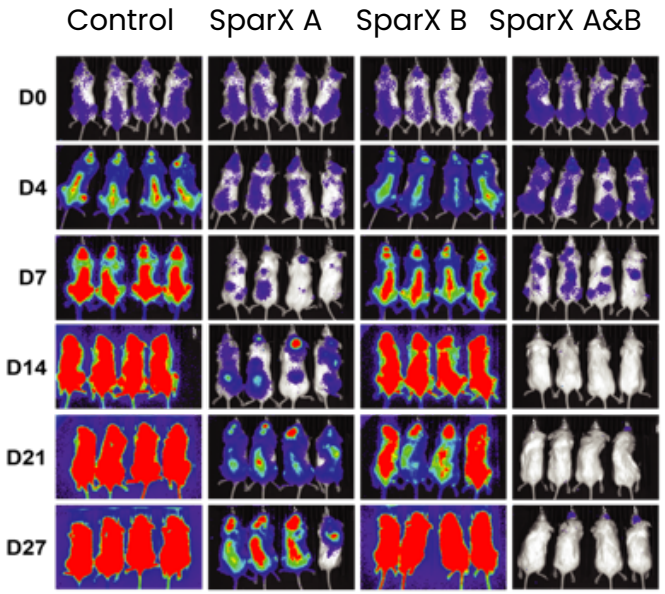
Controllable activity to enhance safety for potential increased access to outpatient and/or community-based settings

Adaptable therapy to personalize the approach with libraries of SparX including logic gated bi-specific formats

Control of ARC-T potency through SparX dosing



Combinatorial potential to combat heterogeneity

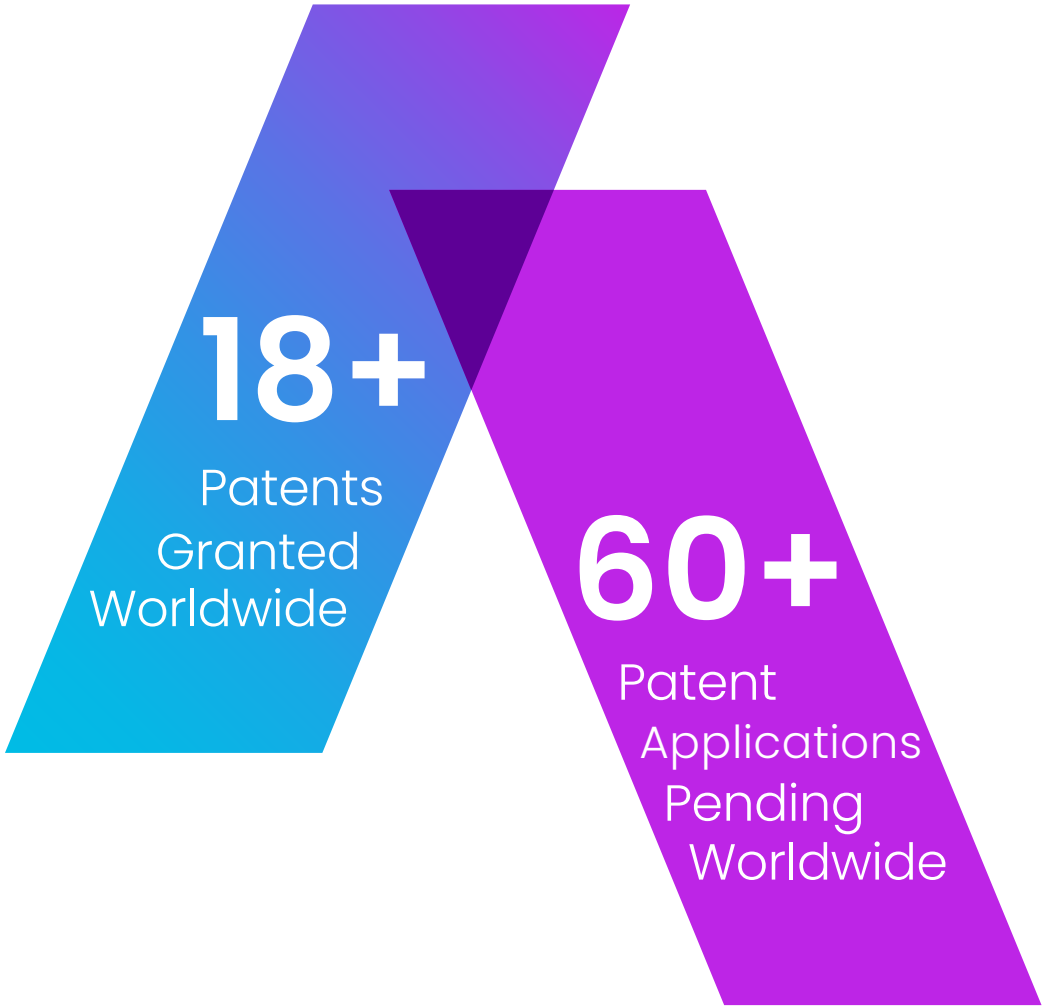


OUR BUSINESS

Delivering results
with every cell of our being.

From the very beginning, our team has been **united** to destroy cancer and challenge convention-while **ensuring patients stay at the forefront.**

Our Global Patent Portfolio



Worldwide patent coverage with issued and pending applications in major market/manufacturing countries

Broad Patent Coverage, including:

- Developing D-Domain Libraries
- Therapeutic and other use of D-Domains
- Adapter Platforms

Worldwide Rights expanding to D-Domain platform applications for ddCARs and ARC-SparX

A Team United Under a Shared Mission

Rami Elghandour
Chairman and CEO

Maryam Abdul-Kareem, JD, MS
General Counsel and Chief Legal Officer

Kate Aiken
Chief People Officer

Doug Alleavitch
VP, Quality

Aileen Fernandes
Chief Business Officer

Michelle Gilson
Chief Financial Officer

Brad Gliner
VP, Clinical Research & Regulatory Affairs

Chris Heery, MD
Chief Medical Officer

Myesha Lacy
Chief Investor and Communications Officer

Brian Murphy, PhD
VP, Cell Product Sciences

Narinder Singh
Chief Technical Officer

Neeraj Teotia
Chief Commercial Officer

David Tice, PhD
Chief Scientific Officer

Reimagining Cell Therapy with Every Cell of Our Being

Technology & IP
Wholly owned differentiated technology

Team
Aligned leaders building a diverse best place to work

CMC
Foundations for scale and commercial launch

Pipeline
Exploring new frontiers including AML, solid tumors, A.I. powered discovery and next gen tools

Strategy
Focused on attractive markets

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