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Highlighting New Data from Our Neuroimmunology Franchise at AAN

April 22, 2026

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Today's Agenda

- Solidifying our Leadership in Autoimmune CAR T
- Stiff Person Syndrome (SPS) – Primary Analysis Review
- Generalized Myasthenia Gravis (gMG) – Phase 2 Data Update
- Advancing Valuable Market Opportunity in SPS
- Q&A

Speakers

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Céline Dion Foundation Endowed Chair

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Stanford Medicine

Positioned to Deliver the First Approved Autoimmune CAR T, Miv-cel

- **Lead indications, SPS and gMG, addressing significant unmet medical need**
- **Transformative clinical results** reinforce potential to change the treatment paradigm by delivering **drug-free, disease-free remission with a single dose**
- **BLA submission preparations underway for SPS, a valuable commercial opportunity**
- **Phase 3 gMG trial** paves way to significant market opportunity underpinned by miv-cel's **differentiated clinical profile**

New Data Reinforce Kyverna's Differentiated Neuroimmunology Franchise Opportunity

SPS Registrational Primary Analysis

Further supports path to approval & confidence in launch

- ✓ **Statistically significant, durable clinical benefit across all endpoints, with reversal of disability scores**
- ✓ **New secondary endpoint results and translational data** demonstrate **full spectrum** of miv-cel clinical benefit

gMG Phase 2 Longer-Term Follow-Up

Further supports confidence in Phase 3 Trial

- ✓ **Even deeper** responses as data mature, with **durability out to 52 weeks**
- ✓ **100%** of patients **achieved clinically meaningful response across MG-ADL, QMG, and MGC**
- ✓ **Majority** of patients **achieved MSE**

100% free of immunotherapies and a well-tolerated safety profile

SPS – 100% free of immunotherapies for SPS as of Week 16 and through last follow-up. gMG – 100% free of immunotherapies, including NSISTs, high-dose steroids (>10 mg), and FcRn and complement inhibitors up to 24 weeks.
MG-ADL, myasthenia gravis Activities of Daily Living; MGC, Myasthenia Gravis Composite; MSE, minimal symptom expression; QMG, Quantitative Myasthenia Gravis.

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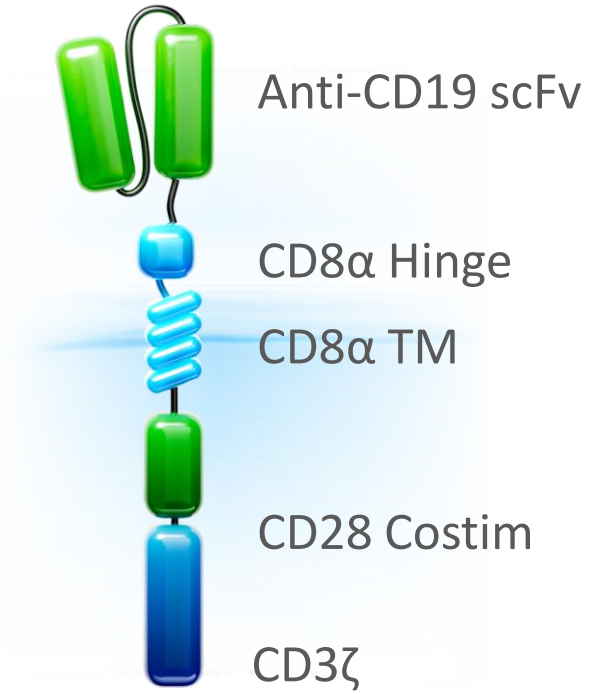
Miv-cel: Potential First-in-Class and Best-in-Class CAR T Designed for Potency & Tolerability

Mivocabtagene Autoleucel (miv-cel)[1,2]

Fully Human Autologous CD19 CAR T
With CD28 Costim



- **More than 100** patients dosed with miv-cel across multiple indications[3]
- **Deep and broad depletion of peripheral- and tissue-resident B cells to support broad immune reset and durable remission[4,5]**
- **No high-grade CRS or ICANS[3]**
- First SPS and gMG patients treated with a single dose of miv-cel achieved **durable efficacy beyond 24 months without the need for chronic immunotherapies[6]**

CRS, cytokine release syndrome; Costim, co-stimulation; gMG, generalized myasthenia gravis; ICANS, immune effector cell-associated neurotoxicity syndrome; scFv, single-chain fragment variable; TM, transmembrane.

1. Brudno JN, et al. *Nat Med.* 2020;26:270-280. 2. Alabanza L, et al. *Mol Ther.* 2017;25:2452-2465. 3.Data on file, Kyverna Therapeutics. 4. Minopoulou I, et al. *Ann Rheum Dis*.2025;84(3):e4-e7. 5. Albach FN, et al. *Rheumatology*. 2025;64(6):4075-4077. 6. Named patient access data, Kyverna Therapeutics.

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Patient Perspective from KYSA-8: Before and After Treatment with Miv-cel

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SPS – Primary Analysis Results from KYSA-8 Registrational Trial

Naji Gehchan, M.D., MSc, MBA – Chief Medical and Development Officer

Amanda Piquet, M.D., FAAN – University of Colorado Anschutz, Céline Dion Foundation Endowed Chair

SPS is a Debilitating, Progressive Autoimmune Disease with No FDA-Approved Therapies

- **SPS impacts the inhibitory signaling pathways,** which are the body's braking system and the **target of autoantibodies** produced by B cells in SPS[1,2]
- Symptoms characterized by **muscle stiffness** and **painful muscle spasms**, impacting mobility[1-3]
- **Inadequate response** with off-label symptomatic and immunomodulatory therapies[1,2,5]

Devastating Impact on Patients

80% of patients lose mobility, needing walking aid assistance or wheelchair[1-3]

Only ~19% of patients remained able to work after 4 years[4]

"Freezing attacks" and sudden falls requiring ER care[1,2]

Risk of **permanent disability** and **increased mortality[3]**

ER, emergency room.

1. Rakocevic G, et al. *BMC Neurol*. 2019;19:1. 2. Dalakas MC. *Nat Rev Neurol*. 2024;20(10):587-601. 3. Duddy ME, Baker MR. *Front Neurol Neurosci*. 2009;26:147-165. 4.NCBI. https://www.ncbi.nlm.nih.gov/sites/books/NBK573078/
5. Dalakas MC. *Neurol Neuroimmunol Neuroinflamm*. 2023;10(3):e200109.

SPS Natural History Study Reinforces Significant Unmet Medical Need

Large, multicenter, retrospective study assessing T25FW in patients with SPS (n=153)

Key Takeaways

- Majority of patients had **no or limited (<20%) improvement in T25FW**
- **Disability (mRS) did not improve** over time
- **Walking aid use increased** over time
- **All patients treated** with off-label immunomodulators or symptomatic medication

Study Contextualizes Transformative Miv-cel Data and Supports the T25FW as a Valid Longitudinal Measure of Mobility in SPS

Newsome SD, et al. Presented at the 2026 AAN Annual Meeting [abstract 966].

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Registrational Trial Designed to Support Path to BLA

Received Both ODD and RMAT Designations

KYSA-8: Open-label, single-arm, multicenter study

N = 26

- Age 18 to 75 years
- Diagnosis of SPS
- Inadequate response to immunomodulatory therapy
- Stiffness index ≥2

Miv-cel

Low-Dose Cy/Flu lymphodepletion

+

Single infusion of 1×10^8 CAR T cells

SPS immunotherapies are discontinued

Primary endpoints:

- Change from baseline in T25FW at 16 weeks
- Safety

Secondary endpoints: change from baseline at 16 weeks

- Modified Rankin Scale (mRS)
- Distribution of Stiffness Index (DSI)
- Hauser Ambulation Index (HAI)
- Heightened Sensitivity Scale (HSS)

One-year Follow Up

Rapid Clinical Enrollment Underscores Significant Unmet Need and Kyverna's Ability to Execute

Cy/Flu, cyclophosphamide and fludarabine; ODD, Orphan Drug Designation; RMAT, Regenerative Medicine Advanced Therapy; T25FW, timed 25-foot walk test.

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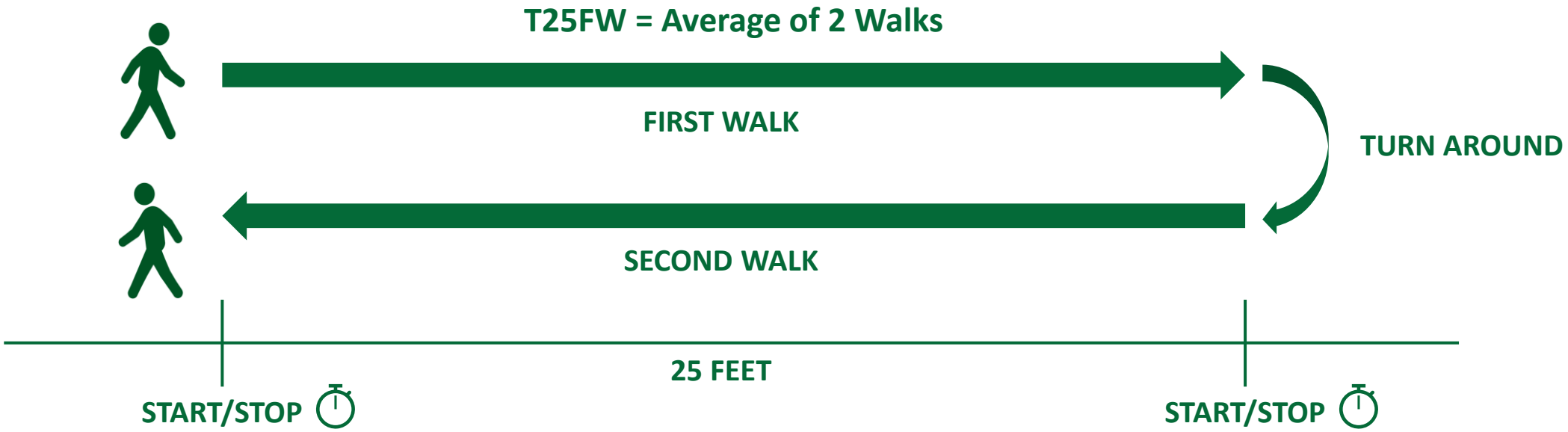
Primary Endpoint Outcome Assesses Impact of SPS on Walking Ability

Timed 25-Foot Walk (T25FW)

- Validated tool to assess walking ability[1]
- Used to evaluate stiffness and loss of mobility in SPS[2]
- Healthy adults can perform the T25FW in ~4-5 seconds[3]

20% improvement considered clinically meaningful[1]

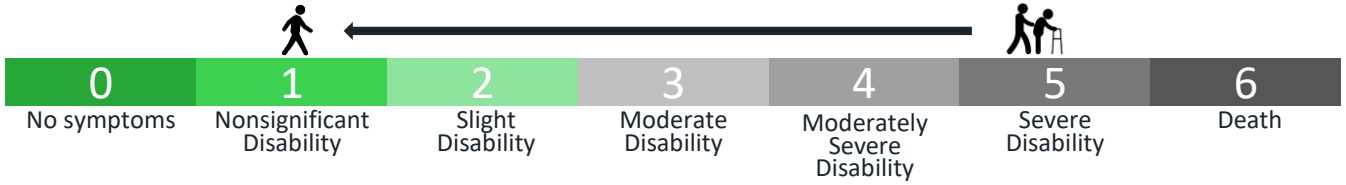


1. Hobart J, et al. *Neurology*. 2013; 80: 1509-1517. 2. Newsome SD and Johnson T J. *Neuroimmunol*. 2022;369:577915. 3. Motl RW, et al. *Mult Scler J*. 2017; 23(5): 704-710.

Secondary Endpoint Outcomes Assess Extent of Disability and SPS-Specific Symptoms

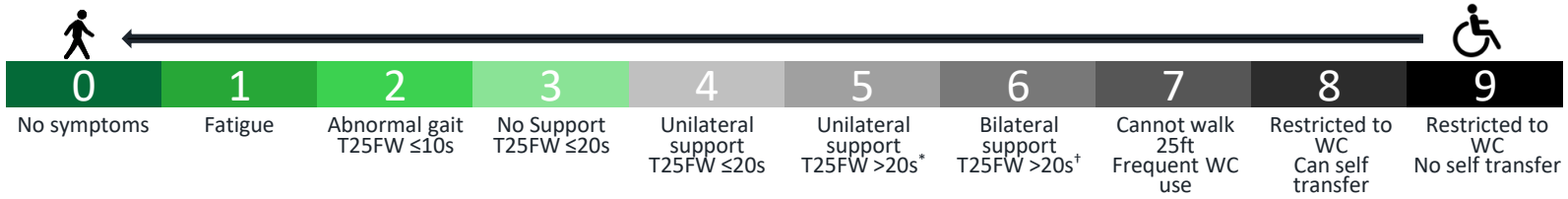
Modified Rankin Scale (mRS)

Degree of disability[1]



Hauser Ambulation Index (HAI)

Time and degree of assistance to complete T25FW[2]



Distribution-of-Stiffness Index (DSI)

Muscle stiffness across body regions[3,4]

1 point for each stiff body region (0-6)

Heightened Sensitivity Scale (HSS)

Number of triggers of muscle spasms[3,4]

1 point for each trigger/stimulus (1-7)

T25FW, timed 25-foot walk; WC, wheelchair.

1. van Swietin JC, et al. *Stroke*. 1988; 19(5): 604-607. 2. Hauser SL, et al. *New Engl J Med*. 1983; 308(4): 173-180. 3. Dalakas MC, et al. *N Engl J Med*. 2001; 345(26): 1870-1876. 4. Dalakas MC, et al. *Ann Neurol*. 2017; 82(2): 271-277.

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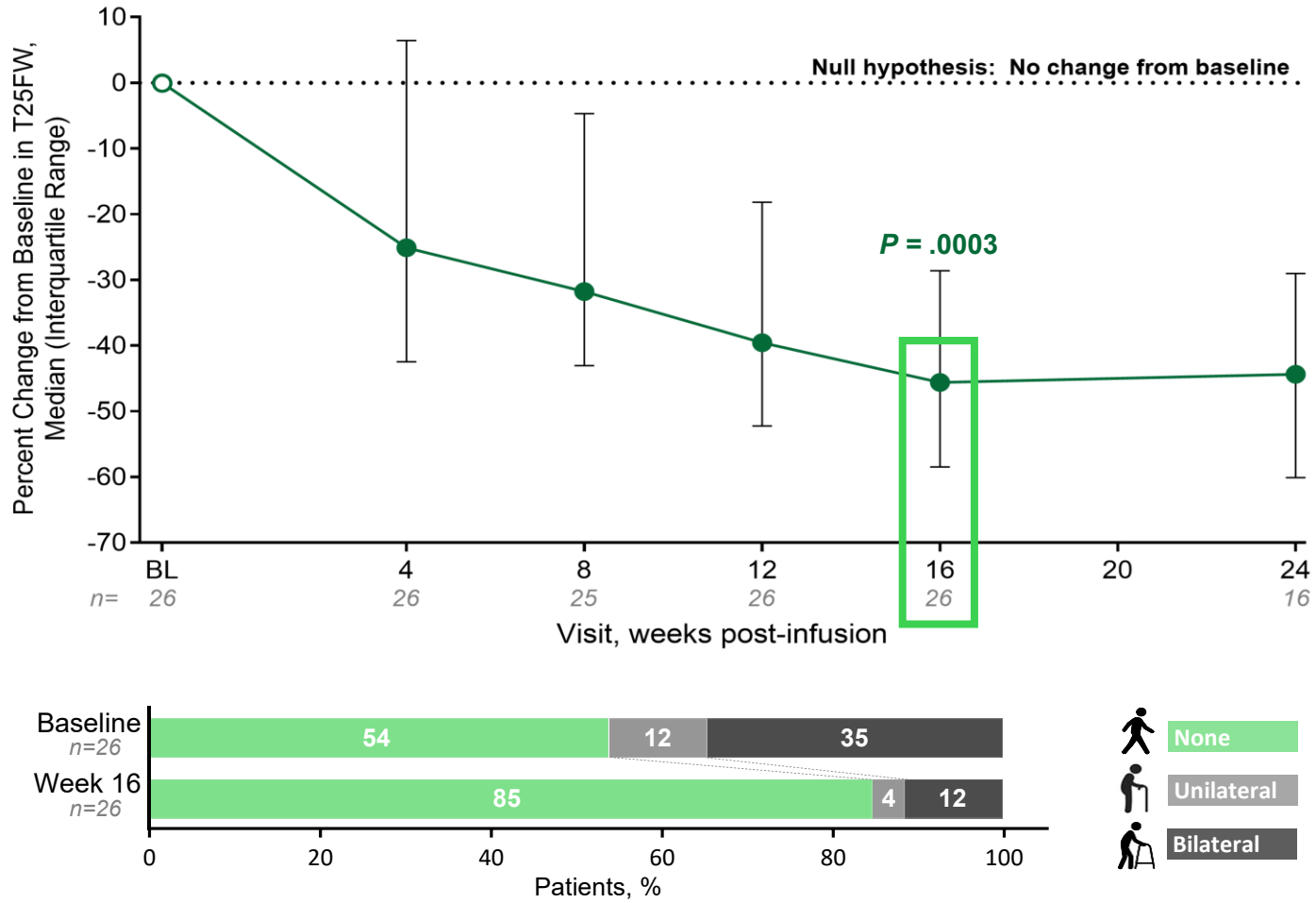
Primary Endpoint Met: Significant Improvement in T25FW

46% Median Improvement at Week 16

Significant T25FW Improvement and Reduced Walking Aid Use

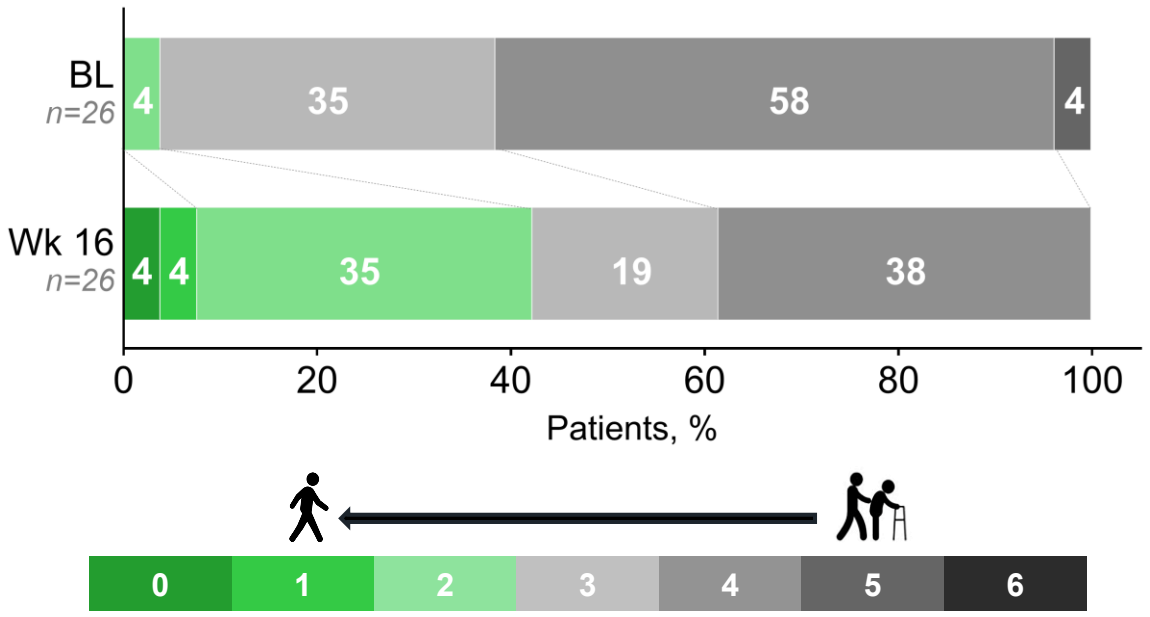


- 81% of patients achieved **clinically meaningful improvement** (≥20% reduction from baseline)[1]
- 31% completed T25FW in <5 seconds; **typical time for healthy adults**[2]
- Of the 12 patients requiring a walking aid for T25FW at baseline, 67% (8/12) **no longer needed assistance** at week 16
- As of week 16 and through last follow-up, all 26 (100%) patients remained **free of immunomodulatory or immunosuppressant therapies** for SPS*

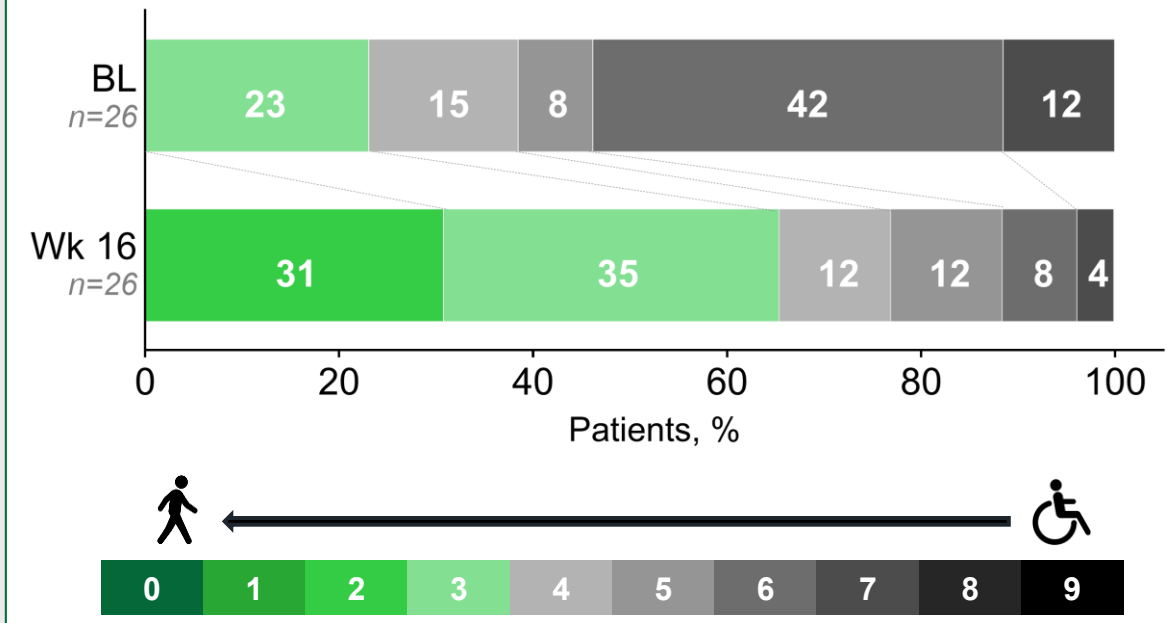
*Includes Includes IVIg/SCIg, PLEX, rituximab and/or prednisone (≥20 mg/day) for SPS symptoms.
Data cutoff: 26Nov2025. Percentages may total more than 100% due to rounding. BL, baseline; T25FW, timed 25-foot walk.
1. Hobart J, et al. *Neurology*. 2013;80(16):1509-17. 2. Motl RW, et al. *Mult Scler*. 2017;23(5):704-710.

Secondary Endpoints Met: Miv-cel Achieved Significant (*P* < .0001) Improvements in Disability, Mobility, Stiffness, and Hypersensitivity

Modified Rankin Scale



Hauser Ambulation Index

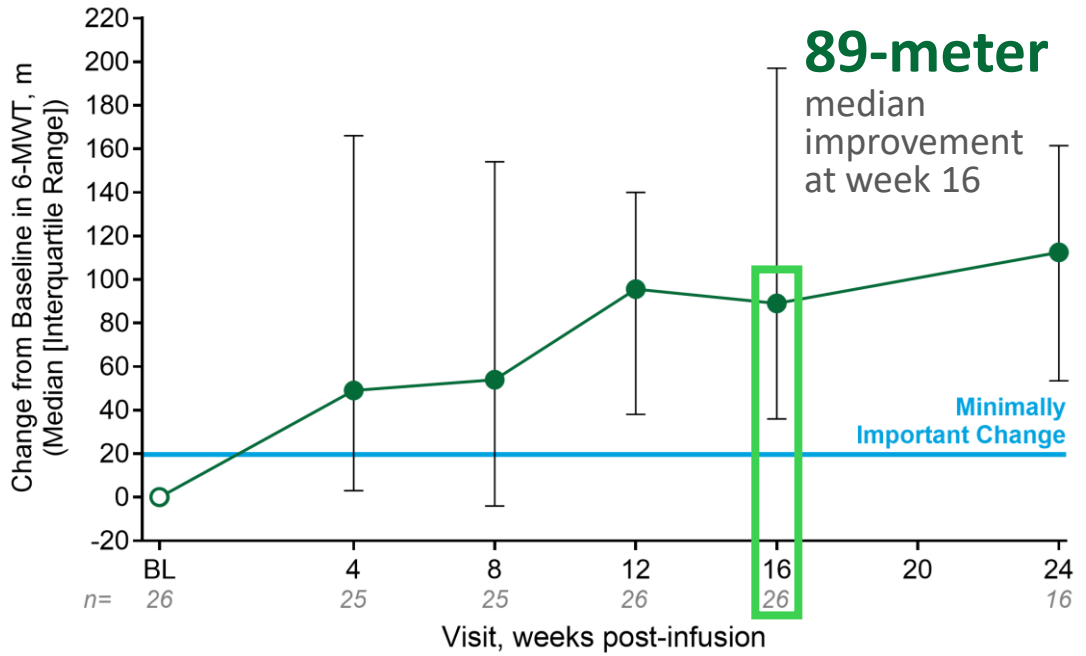


- Significant (*P* < .0001) mean improvements in mRS and HAI of -0.8 (SD, 0.86) and -1.6 (1.13) and SPS-specific measures, DSI and HSS, of -1.5 (1.75) and -3.2 (2.01), respectively
- 96% of patients (25/26) had improvement in ≥1 primary or secondary efficacy endpoint

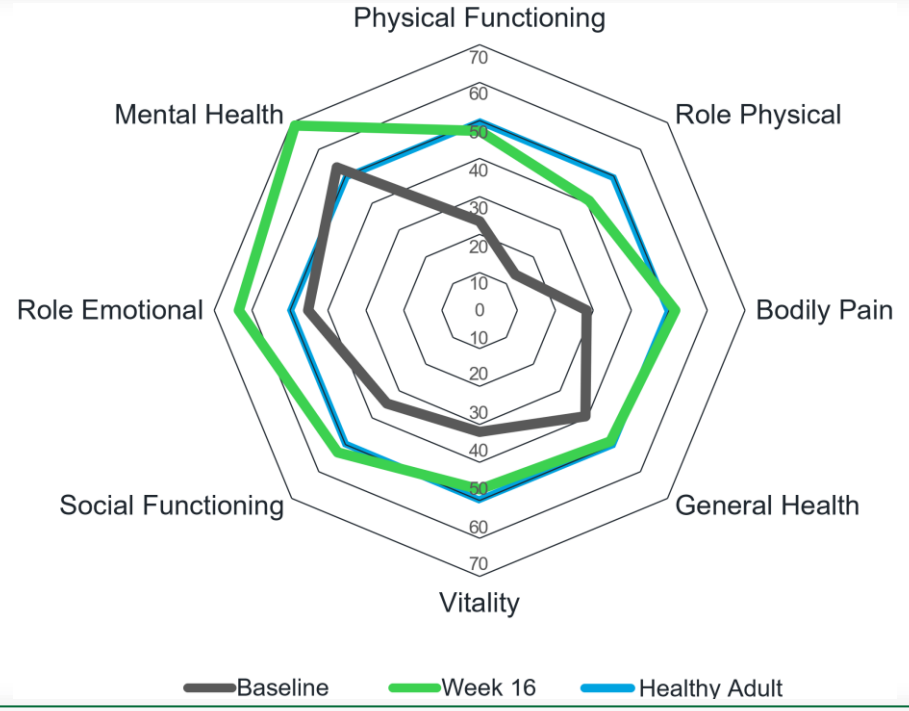
Data cutoff: 26Nov2025. Percentages may total more than 100% due to rounding.
BL, baseline; DSI, Distribution-of-Stiffness Index; HAI, Hauser Ambulation Scale; HSS, Heightened Sensitivity Scale; mRS, Modified Rankin Scale; wk, week.

Additional Efficacy Measures: Substantial Improvements in Physical and Mental Functioning

6-Minute Walk Test (MWT): >4-fold improvement over clinical minimally important change[1]



36-Item Short Form Health Survey (SF-36): Week 16 scores comparable to healthy adults for most domains[2,3]

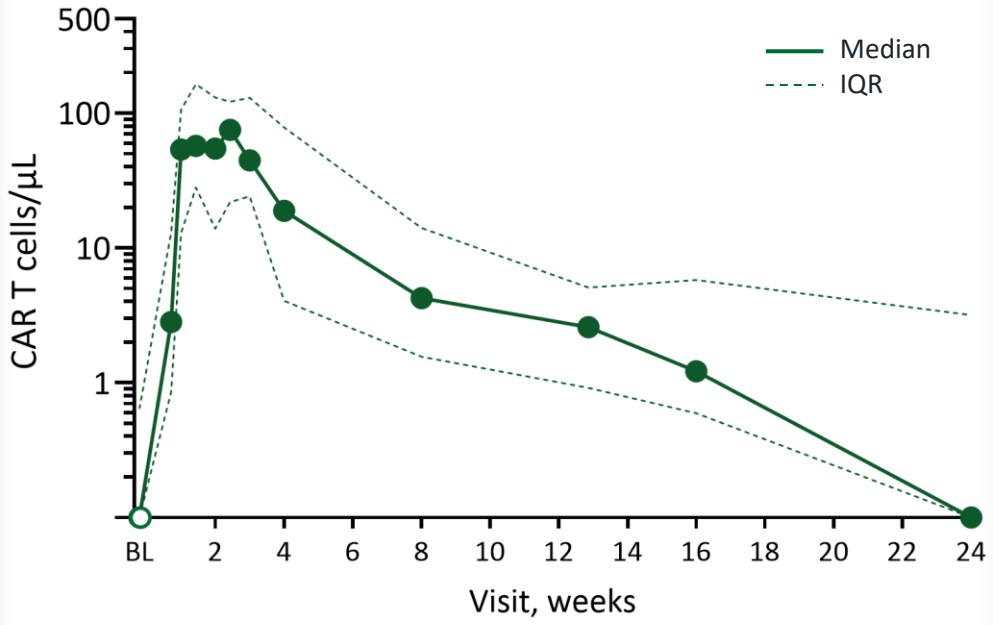


Data cutoff: 26Nov2025.

1. Oosterveer DM, et al. *Mult Scler Relat Disord*. 2022;57:103438. 2. Maglinte GA, et al. *J Clin Epidemiol*. 2012;65(5):497-502. 3. Wu Q, et al. *Medicine (Baltimore)*. 2023;102(24):e33979.

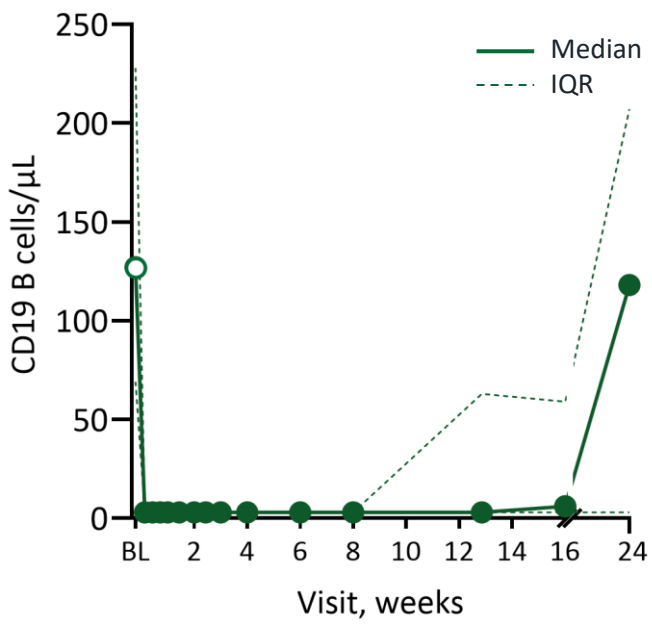
Robust Miv-cel Expansion Led to Complete Peripheral B-cell Depletion and Significant Reductions in Autoantibody Titers

Robust CAR T-cell Expansion



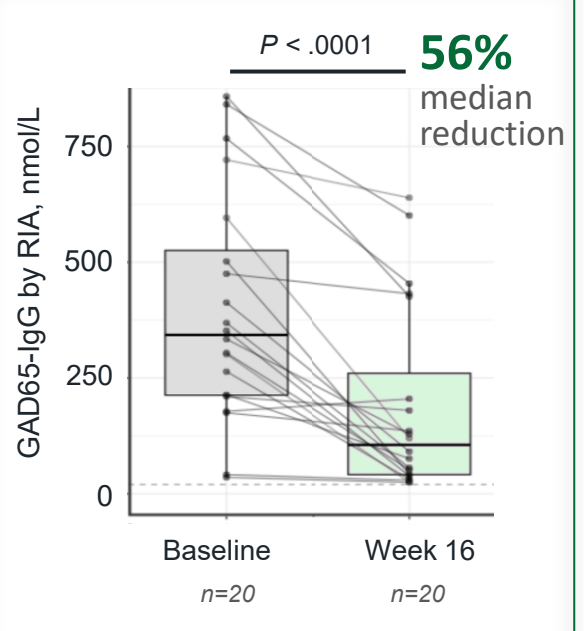
- CAR-positive T cells peaked by day 14

Deep B-cell Depletion



- 54% of patients had B-cell reconstitution by week 16
- Efficacy was maintained with B-cell reconstitution

Reduced GAD65-IgG

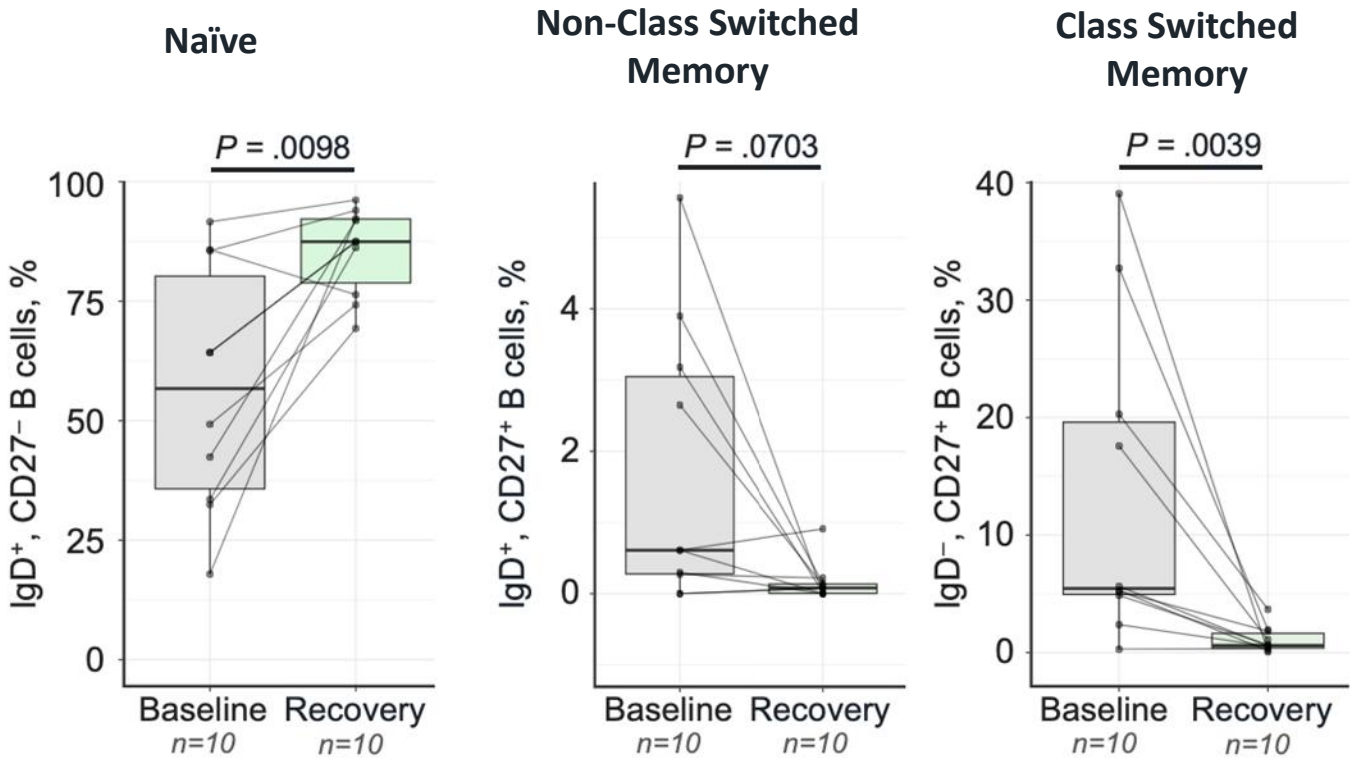


- GAD65-IgG was reduced in 19/20 patients with ≥20 nM GAD65 at baseline

Data cutoff: 26Nov2025. Box and whisker plots showing median line (dark line), and interquartile range (box), and min/max (bars).
CAR, chimeric antigen receptor; IgG, immunoglobulin G; GAD65, glutamic acid decarboxylase 65.

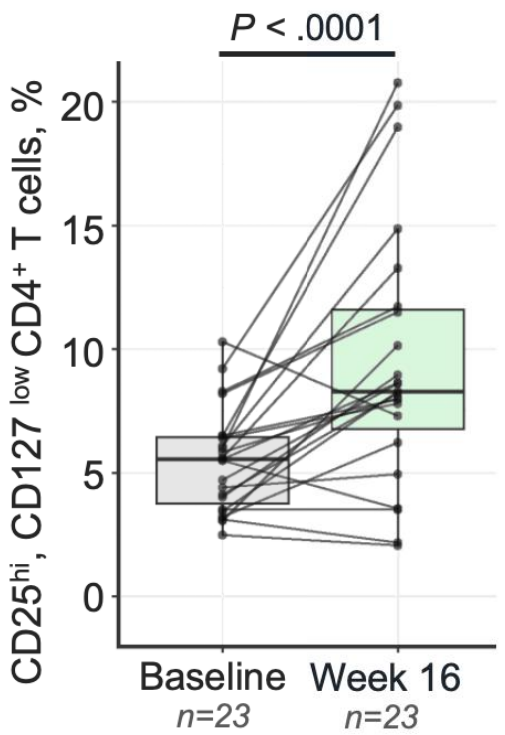
Miv-cel Treatment Induced Markers of Broad Immune Reset

B-Cell Phenotypes



- Newly emerging B-cell population showed significantly increased naïve phenotype with concomitant decrease in memory phenotype

Regulatory T Cells



- Significant increase in regulatory T cells at week 16

Data cutoff: 26Nov2025. Box and whisker plots showing median line (dark line), and interquartile range (box), and min/max (bars).
IgD, immunoglobulin D.

Miv-cel Demonstrated a Well-Tolerated Safety Profile

Treatment-Related Adverse Events, n (%)	N=26
CRS (any Grade)	24 (92)
Grade 1	10 (38)
Grade 2	14 (54)
ICANS (any Grade)	3 (12)
Grade 1	3 (12)
Grade 3/4 neutropenia	4 (15)
Any treatment-related serious AE	3 (12)

- **No high-grade CRS or ICANS observed**
- Most common treatment-related AEs were CRS (92%), fatigue (54%), diarrhea (38%), and headache (31%)
- 4 patients had Grade 3/4 neutropenia, an expected AE with lymphodepletion and CAR T-cell therapies
  - All events were manageable with treatment including G-CSF, fully resolved in 3 patients (median duration of 85 days), and was ongoing in 1 patient
  - No serious infections associated with neutropenia
- Treatment-related serious AEs occurred in 3 patients; all fully resolved without sequalae

Data cutoff: 26Nov2025

CRS and ICANS graded using ASTCT criteria; other AEs graded using CTCAE criteria.

AE, adverse event; ASTCT, American Society for Transplantation and Cellular Therapy; CAR, chimeric antigen receptor; CTCAE, Common Terminology Criteria for Adverse Events; CRS, cytokine release syndrome; ICANS, immune effector cell-associated neurotoxicity syndrome; LD, lymphodepletion.

Potential to Achieve Durable, Drug-Free, Disease-Free Remission and Reverse Disability

In KYSA-8 trial, a single dose of miv-cel resulted in:

- Significant, robust, rapid improvements in mobility, disability, stiffness, and hypersensitivity
- 100% free of immunomodulatory or immunosuppressive therapies for SPS as of last follow-up
- A consistent, well-tolerated, and manageable safety profile, with the potential for outpatient administration
- Sustained clinical benefit following deep B-cell depletion and broad immune reset

gMG – Updated Data from Phase 2 KYSA-6 Trial

Naji Gehchan, M.D., MSc, MBA – Chief Medical and Development Officer

Sri Muppidi, M.D. – Stanford University

Patient Perspective from IH Pathway: Before and After Treatment with Miv-cel

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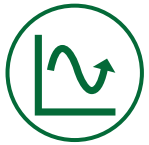
Despite Available Treatment Options, High Disease Burden Remains in Generalized Myasthenia Gravis

- gMG is a B-cell and antibody-mediated neuromuscular autoimmune disease that causes fluctuating muscle weakness and fatigue[1,2]

Novel therapies are needed that minimize or eliminate symptoms of disease while reducing risks associated with chronic immunosuppression

Current State of Treatment for Patients With gMG

Inadequate symptom control[3,4]



Few reach minimal symptom expression (MSE)[1,5-6]

Majority require ongoing immunosuppressant therapy[1-4]

Costly and chronic treatment options[1,7]

1. Howard Jr JF, et al. *Lancet Neurol*. 2021;20(7):526-536. 2. Vu T, et al. *NEJM Evid*. 2022;1(5):EVIDoa2100066. 3. DeHart-McCoyle M, et al. BMJ Med. 2023;2(1):e000241. 4. Dewilde S, et al. *BMJ Open*. 2023;13(1):e066445. 5. AstraZeneca. ULTOMIRIS® efficacy data from CHAMPION-MG. https://ultomirishcp.com/gmg/efficacy. Accessed 20 Aug 2025. 6. Vu T, et al. AAN 2025. S34.002. 7. Data on File, Kyverna Therapeutics.

KYSA-6: Phase 2/3 Study of Miv-cel in gMG

Phase 2 design: Open-label, single-arm, multicenter study

N = 7

- Age 18 to 75 years
- Diagnosis of gMG, Class IIB-IV per MGFA criteria
- Autoantibodies to AChR, MuSK, or LRP4
- MG-ADL ≥6
- Failed ≥2 immunosuppressive/ immunomodulatory therapies OR failed ≥1 immunosuppressive therapy and required chronic plasmapheresis or IVIg to control symptoms

Miv-cel

Low-Dose Cy/Flu lymphodepletion
+
Single infusion of 1×10^8 CAR T cells

MG immunotherapies are discontinued

Primary endpoints

- MG-ADL at 24 weeks
- Adverse events

Key secondary endpoints

- QMG and MGC scores
- PK/PD

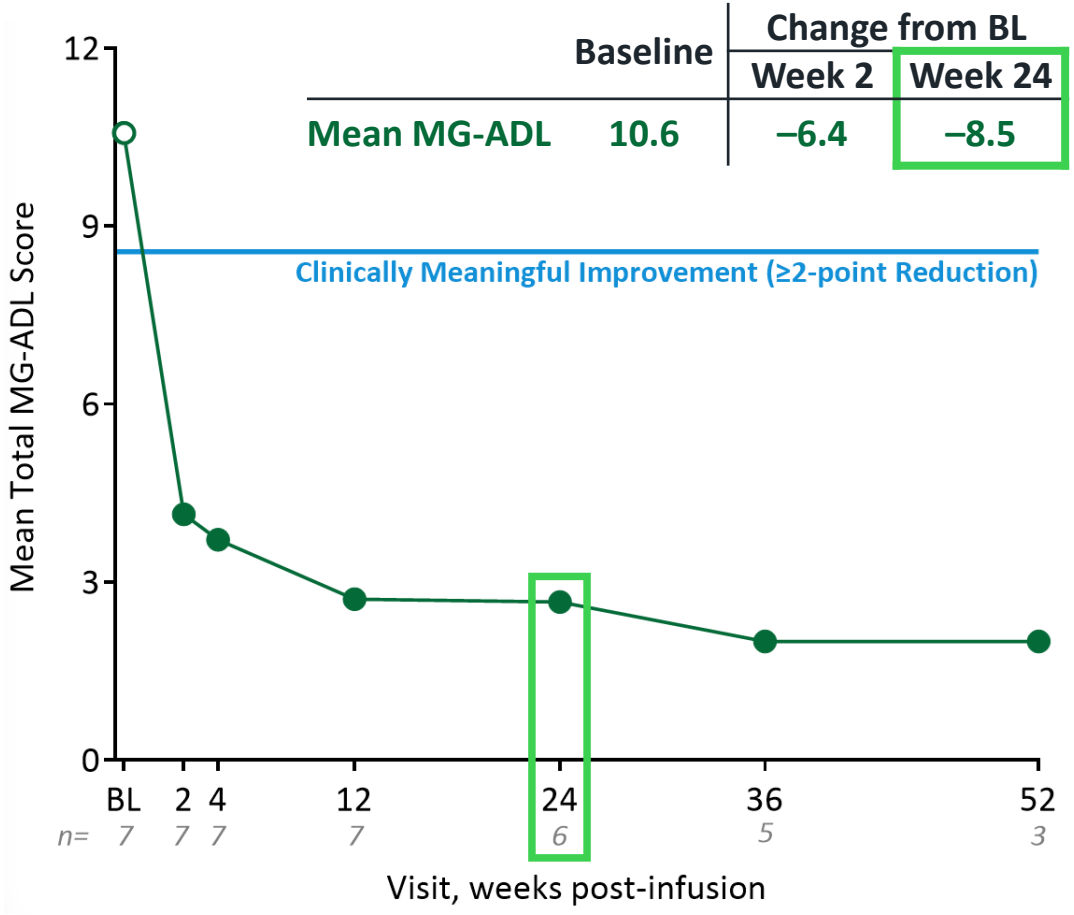
18-month follow up

Longer-Term Follow-Up Data Cut Off as of February 25, 2026

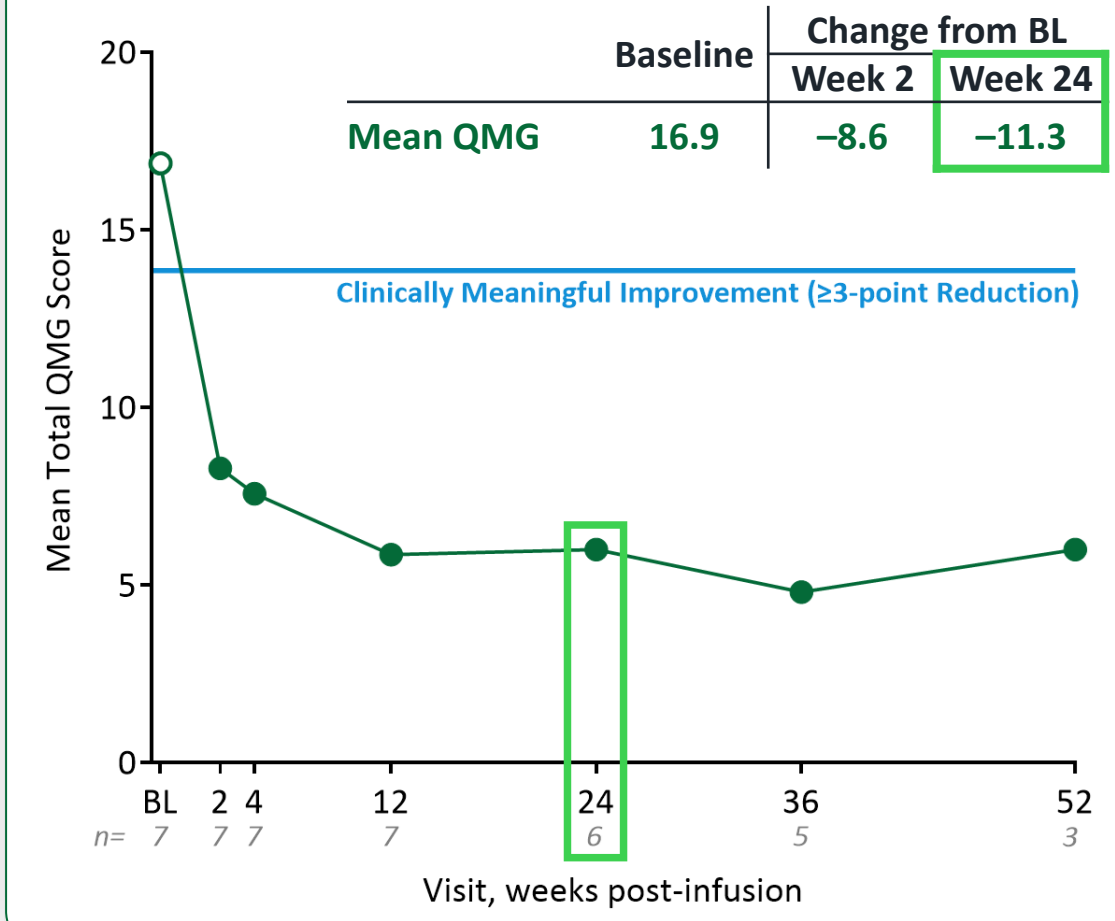
AchR, acetylcholine receptor; Cy/Flu, cyclophosphamide and fludarabine; IVIg, Intravenous Immunoglobulin; LRP4, low-density lipoprotein receptor-related protein 4; MG-ADL, myasthenia gravis Activities of Daily Living; MGC, Myasthenia Gravis Composite; MGFA, Myasthenia Gravis Foundation of America; MuSK, muscle-specific kinase; PD, Pharmacodynamics; PK, Pharmacokinetics; QMG, Quantitative Myasthenia Gravis.

Miv-cel Demonstrated Rapid and Robust Reductions in MG-ADL and QMG Sustained Out to 52 Weeks

MG-ADL score



QMG score



Data cutoff: February 25, 2026.
BL, baseline; MG-ADL, myasthenia gravis activities of daily living; QMG, quantitative myasthenia gravis.

After a Single Dose of Miv-cel, Patients Achieved Substantial and Clinically Meaningful Reductions in MG Outcome Scores and Treatment Burden

Substantially improved clinical outcomes

MG-ADL

100% had clinically meaningful response
(≥2-point reduction vs baseline)

100% were responders
(≥3-point reduction vs baseline)

57% reached MSE at last follow-up
(MG-ADL score of 0-1)

QMG

100% had clinically meaningful response
(≥3-point reduction vs baseline)

MGC

100% had clinically meaningful response
(≥3-point reduction vs baseline)
–16.0 mean reduction at 24 weeks

Substantially reduced MG treatment burden

100% free of immunotherapies, including NSISTs, high-dose steroids (>10 mg), and FcRn and complement inhibitors up to 24 weeks
6 of 7 patients remained free of these agents at last follow-up

Data cutoff: February 25, 2026.
BL, baseline; FcRn, neonatal fragment crystallizable receptor; MG-ADL, myasthenia gravis activities of daily living; MGC, Myasthenia Gravis Composite; MSE, minimal symptom expression; NSIST, nonsteroidal immunosuppressive therapy; QMG, quantitative myasthenia gravis.

Miv-cel Demonstrated a Well-Tolerated Safety Profile

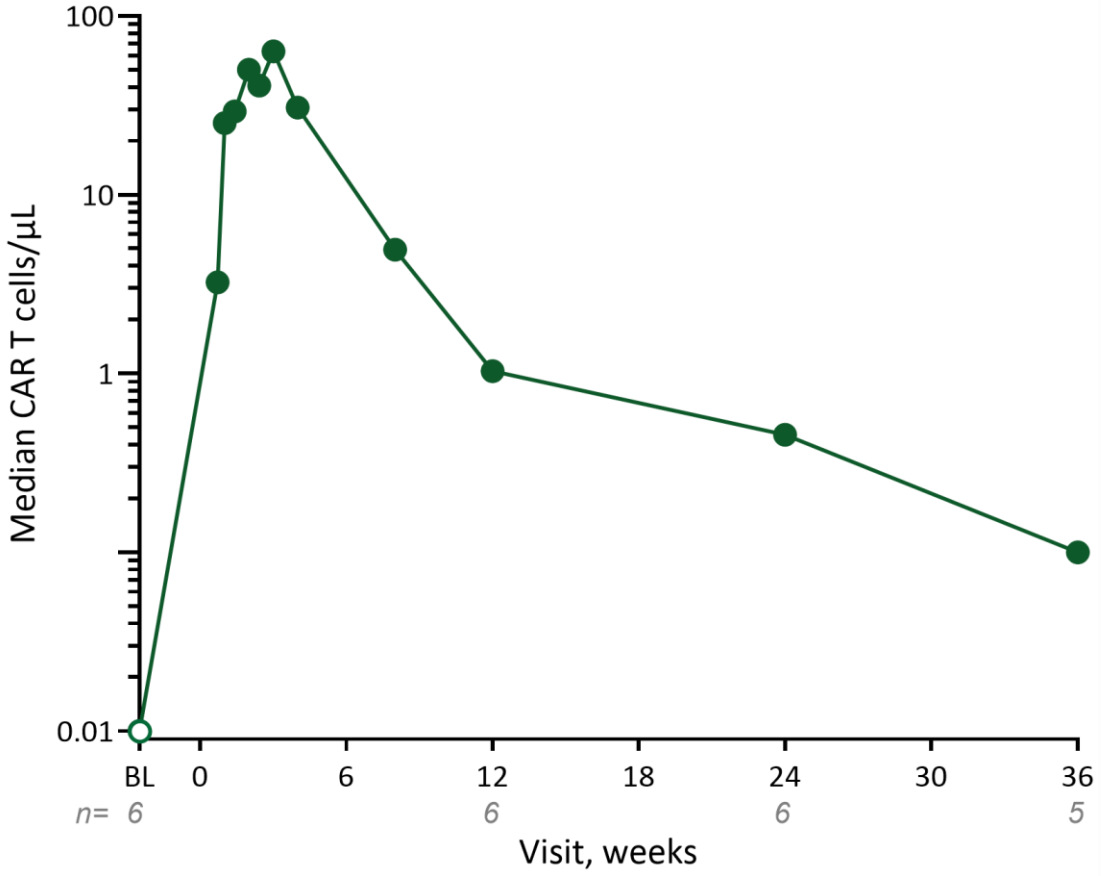
Treatment-related AEs, n (%)	Patients (n=7)
CRS (any grade)	7 (100)
Grade 1	5 (71)
Grade 2	2 (29)
ICANS (any grade)	0 (0)
Grade 3/4 events	3 (43)
Neutropenia	2 (29)
Lymphopenia	1 (14)
Lymphocyte count decreased	1 (14)
SAE (any grade)[a]	0 (0)

- **No high-grade CRS and no ICANS observed**
- CRS was low-grade and manageable in all patients
  - 5 of 7 patients only experienced fever (grade 1 CRS)
- 2 patients with Grade 3/4 treatment-related AEs of neutropenia; an expected AE with lymphodepletion and CAR T-cell therapies; neither was associated with infections
  - 1 patient had transient Grade 4 neutropenia that resolved within 10 days post-infusion
  - 1 patient had Grade 4 neutropenia was manageable with G-CSF, and resolved within 2 months post-infusion

Data cutoff: February 25, 2026.
[a]After the prior data cut (October 3, 2025), a previously reported treatment-related SAE was reclassified by the Investigator as 'not serious', reflecting his clinical assessment of the AE per protocol-defined seriousness criteria.
CRS and ICANS graded using ASTCT criteria; other AEs graded using CTCAE criteria.
AE, adverse event; ASTCT, American Society for Transplantation and Cellular Therapy; CAR, chimeric antigen receptor; CTCAE, Common Terminology Criteria for Adverse Events; CRS, cytokine release syndrome; DLT, dose-limiting toxicity; G-CSF, granulocyte colony-stimulating factor; ICANS, immune effector cell-associated neurotoxicity syndrome; LD, lymphodepletion; SAE, serious adverse event; TEAE, treatment-emergent adverse event.

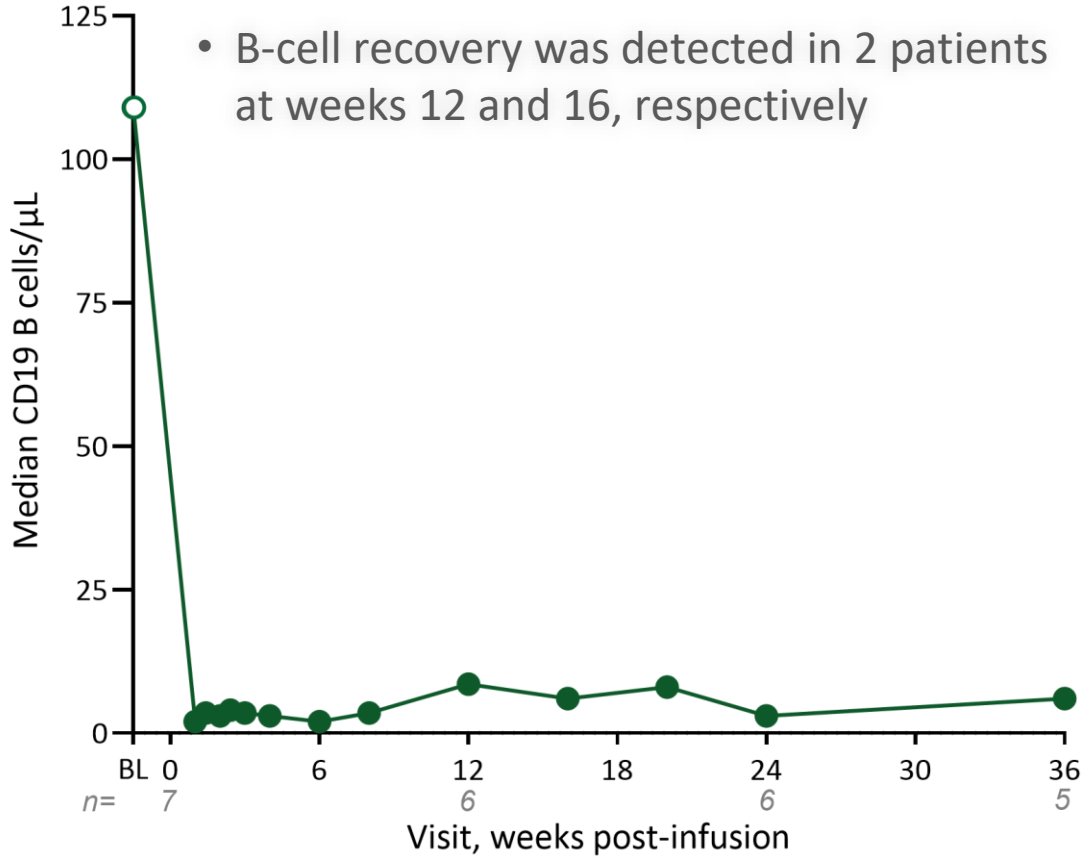
Robust CAR T-cell Expansion Led to Deep B-cell Depletion

Robust CAR T-cell expansion



Deep B-cell depletion

- B-cell recovery was detected in 2 patients at weeks 12 and 16, respectively

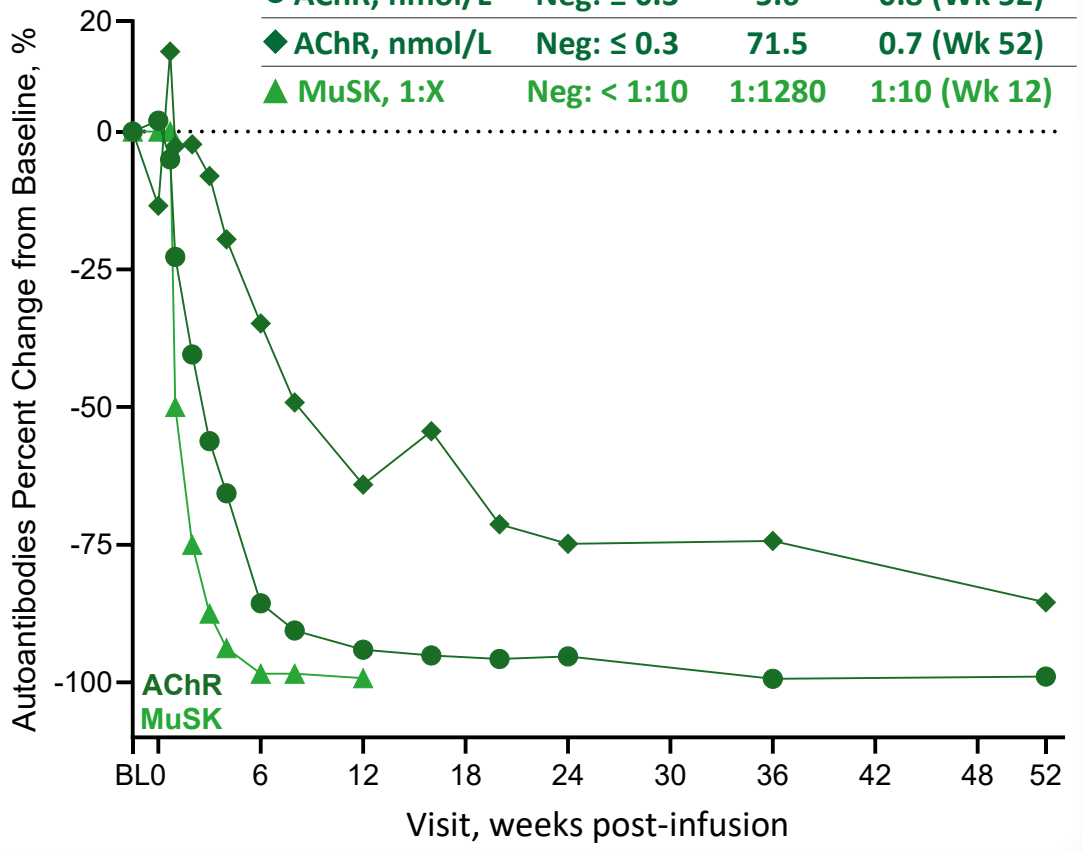


Data cutoff: February 25, 2026.
BL, baseline.

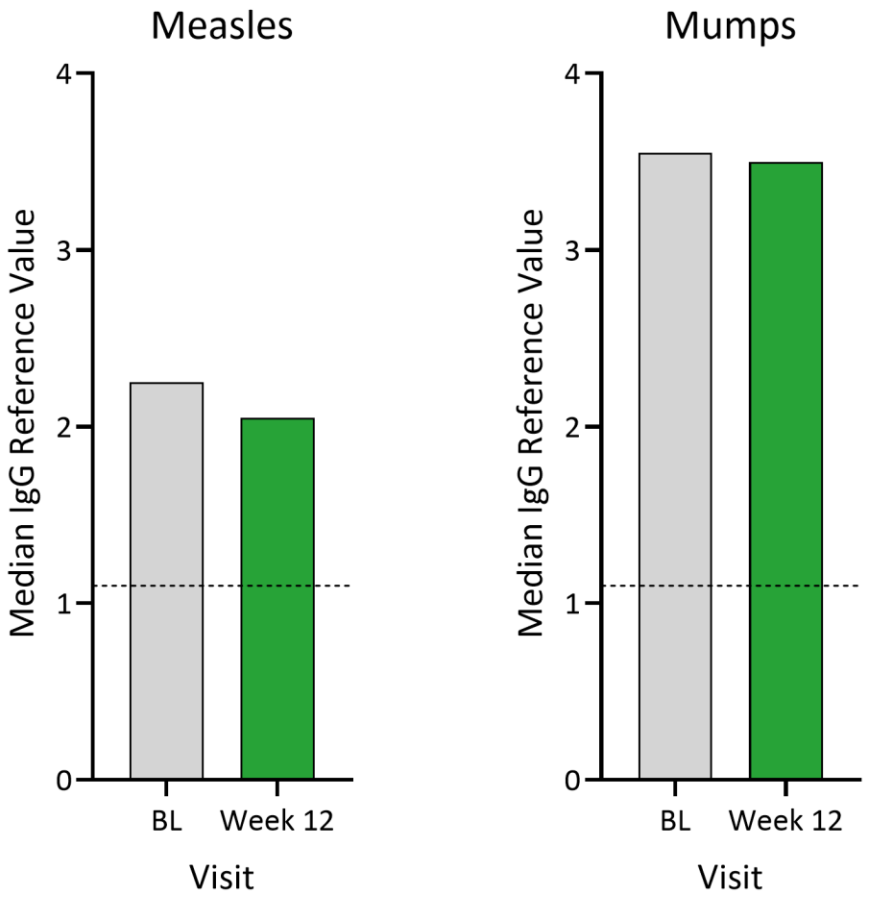
Miv-cel Reduced Autoantibody Levels While Preserving Humoral Immune Responses

Reduction of autoantibodies

Autoantibody	Ref Range	BL	Last visit (Wk)
● AChR, nmol/L	Neg: ≤ 0.3	5.6	0.8 (Wk 52)
◆ AChR, nmol/L	Neg: ≤ 0.3	71.5	0.7 (Wk 52)
▲ MuSK, 1:X	Neg: < 1:10	1:1280	1:10 (Wk 12)



Preservation of humoral immunity



Data cutoff: February 25, 2026. Humoral immunity data was not available for patient 7; dashed line on humoral immunity graph shows the threshold above which indicates prior exposure or vaccination.
AChR, acetylcholine receptor; BL, baseline; IgG, immunoglobulin G; MuSK, muscle-specific kinase; neg, negative value; Ref, reference; Wk, week..

Potential to Change the gMG Treatment Paradigm by Delivering Durable, Drug-Free, Disease-Free Remission

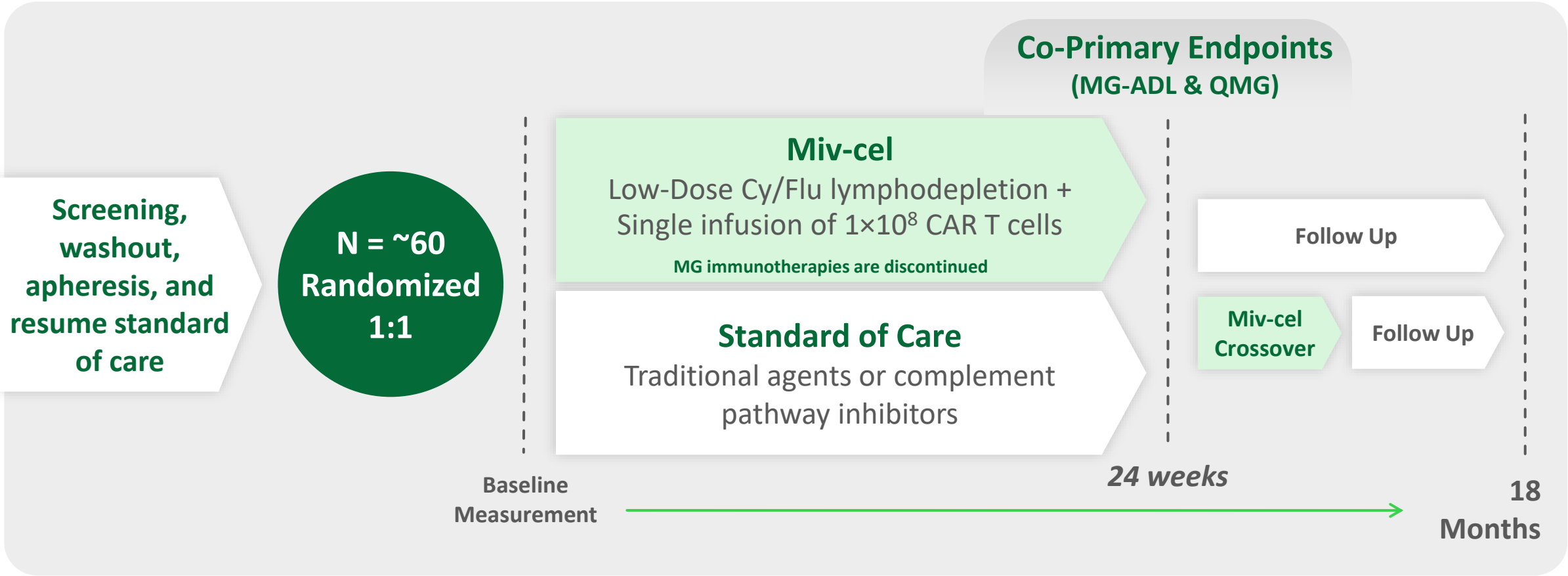
In KYSA-6 trial, a single dose of miv-cel resulted in:

- Robust, rapid, and sustained improvements regardless of prior biologic exposure
- 100% free of immunotherapies, including NSISTs, high-dose steroids (>10 mg), and FcRn and complement inhibitors up to 24 weeks
- Consistent, well-tolerated, and manageable safety profile with no high-grade CRS or ICANS
- Evidence of immune reset and preserved humoral immunity

CRS, cytokine release syndrome; FcRn, neonatal fragment crystallizable receptor; ICANS, immune effector cell-associated neurotoxicity syndrome; NSIST, nonsteroidal immunosuppressive therapy.

Phase 3 Trial Advancing with First Patients Enrolled and 14 Sites Activated Globally

~60-patient, global, open-label, randomized controlled Phase 2/3 trial with crossover design



Standard of care may consist of traditional agents (e.g., prednisone, azathioprine, mycophenolate, methotrexate, chronic IVIG/PLEX) or complement pathway inhibitors (e.g., eculizumab, ravulizumab). Anti-CD20 or -CD19 monoclonal antibodies or FcRn inhibitors not allowed as defined in inclusion criteria.

Cy/Flu, cyclophosphamide and fludarabine; FcRn, neonatal fragment crystallizable receptor; IVIG, Intravenous Immunoglobulin; MG-ADL, myasthenia gravis activities of daily living; PLEX, plasma exchange; QMG, quantitative myasthenia gravis score.

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Single Dose Miv-cel Achieved Unprecedented gMG Clinical Outcomes

All other therapies require chronic background immunotherapies

		Approved			Investigational*	
		FcRn Inhibitor[1] *VYVGART®*	**Complement Inhibitor[2,3]** *ULTOMIRIS®*	**CD19 mAb[4]** *UPLIZNA®*	**BCMA mRNA CAR T[5]** *Descartes-08*	**Miv-cel CD19 CAR T** (KYSA-6, n=6)
Primary Endpoint		4 weeks	6 months	6 months	3 months	**6 months**
Depth of Response *Mean reduction from baseline to primary endpoint (non-placebo adjusted)*	**MG-ADL Reduction**	~4.6	3.1	4.2	4.1	**8.5**
	QMG Reduction	~6.2	2.8	4.8	3.9	**11.3**
% Responders *Patients with ≥3-point MG-ADL improvement from baseline to primary endpoint (non-placebo adjusted)*		~73%	~57%	69%	64%	**100%**
Achieve Minimal Symptom Expression (MSE) *% of patients achieving MG-ADL of 0 or 1*		40%	43%	Not reported	33%	**57%**
		At any point before primary endpoint			*6 months to 1 year*	*At any point before primary endpoint*

Note: These observations are derived from separate clinical settings; comparisons across trials are not based on head-to-head studies.

BCMA, b-cell maturation antigen; FcRn, neonatal fragment crystallizable receptor; mAb, monoclonal antibody; MG-ADL, myasthenia gravis activities of daily living; mRNA, messenger RNA; QMG, quantitative myasthenia gravis score.
*Under investigation in gMG.

1. Howard Jr JF, et al. *Lancet Neurol.* 2021;20(7):526-536. 2. Vu T, et al. *NEJM Evid*. 2022;1(5):EVIDoa2100066. 3. AstraZeneca. ULTOMIRIS® efficacy data from CHAMPION-MG. https://ultomirishcp.com/gmg/efficacy. Accessed 20 Aug 2025.
4. Nowak RJ, et al. *N Engl J Med.* 2025;392(23):2309-2320. 5. Vu T, et al. *Nat Med.* 2026;32:1131-1141.

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Advancing Valuable Market Opportunity in SPS

Warner Biddle – Chief Executive Officer

Miv-cel: Potential to Be First and Only Approved Therapy in SPS with Patients Ready for an Effective Treatment Option

~6k

U.S. Diagnosed SPS Patients[1,2]

Miv-cel Addressable Market[2,3]

Initial Priority

~2.0 to 2.5k Patients

30-40% of total diagnosed

Patients treated with off-label immunotherapy*

Total Miv-cel Addressable Market

~5.5k Patients

90% of total diagnosed

Patients treated with symptomatic therapies

*Immunotherapy defined as off-label immunosuppressants (e.g., prednisone), rituximab and/or IVIg.
IVIg, intravenous immunoglobulin.

1. Crane PD, et al. *Neurology*. 2024;103(12):e210078. 2. Analysis of 2024 Komodo U.S. Claims Data.
3. Kyverna Patient Journey and Demand Study (data on file).

SPS Treaters Show Strong Enthusiasm for Early Adoption of Miv-cel

Survey of 20 high volume SPS treaters in U.S.

Product profile based on miv-cel topline data

80% view efficacy data and one-time treatment as key attributes

90% view profile as compelling versus current treatment options

85% would use miv-cel for moderate-to-severe patients at launch

Source: February 2025 Demand and Patient Journey Research; February 2026 Demand Survey.

Focused Launch Strategy Targets ~10 High-Value SPS Centers

✓ **SPS Leadership**	• Thought leaders / high-volume treaters • Institutional support for miv-cel
✓ **Addressable Patients**	• Existing patients ready at center • Strong referral network
✓ **CAR T Expertise**	• Commercial CAR T experience • Accreditation
✓ **Economic Potential**	• Robust inpatient and outpatient models • Commercial payer and Medicare dynamics

Meaningful Portion of Immediately Addressable Patients at ~10 Centers

kyverna®

Kyverna: Delivering the Curative Potential of CAR T in Autoimmune Diseases

CAR T Leadership
Potentially first approved autoimmune CAR T

Best-in-Class Profile
Demonstrated durable drug-free, disease-free remission

Focused Strategy
Neuroimmunology-led franchise

Valuable Commercial Opportunity in SPS
Immediately addressable market and premium pricing potential

Pipeline-in-a-Product
Clinical data supports expansion into broader indications

Strong Financial Position
Supporting SPS BLA submission, anticipated commercial launch and gMG Phase 3 trial

Q&A

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