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Transforming the Treatment Paradigm in Neurologic Autoimmune Diseases

November 2026

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Pioneering Differentiated Therapies with Curative Potential to Free People from Life-long Autoimmune Diseases and Chronic Therapy

Transformative Impact of Miv-cel

A **differentiated single-dose CAR T** therapy designed to **reset the immune system** and deliver the potential for **durable, drug-free, disease-free remission**

Focused Neurologic Autoimmune Strategy

Focused strategy, with potential to be the **first CAR T approval in autoimmune** and **first approved therapy for SPS**, with planned expansion into **gMG** and **PMS**

Innovating to Expand Access

Extend leadership by **broadening access and choice for patients**

(e.g., indication expansion, alternative preconditioning regimens, manufacturing enhancements)

gMG, generalized myasthenia gravis; PMS, progressive multiple sclerosis; SPS, stiff person syndrome.

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Kyverna Leads Autoimmune CAR T with First BLA Submission in SPS and Significant Near-term Catalysts Across Focused Pipeline

SPS

✓ **Miv-cel SPS BLA Submission Completed in Q4'26**

Seeking **priority review** under **RMAT** designation

2027 **Potential U.S. Commercial Launch**

Commercial readiness **on track**

gMG

Phase 3 enrollment completion expected in **mid-2027**

PMS

RMAT designation granted in naSPMS

Development strategy expected **early 2027**

Operating Runway Into 2028 Supports SPS Launch and gMG Phase 3 Trial

Operating runway into 2028 includes $170.6 million in cash, cash equivalents, and marketable securities as of September 30, 2026 and amounts available for draw from the Oxford Finance amended loan facility.
BLA, Biologics License Application; naSPMS, non-active secondary progressive multiple sclerosis; RMAT, Regenerative Medicine Advanced Therapy.

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SPS Represents a Valuable Neurologic Autoimmune Commercial Opportunity

Compelling SPS Market Dynamics

- **Progressive rare disease** with **no approved therapies**
- **~6K** U.S. diagnosed patients[1]**; 2-2.5K** immediately addressable*[2]
- Patients **concentrated** at academic centers
- Potential **diagnosis upside** from increased awareness with an approved therapy
- Chronic treatment, disability/job loss drive **substantial economic burden on patients and society**

Targeted Launch Strategy to Maximize Value Creation

- **First-in-indication rare disease launch**
- Expect to price miv-cel at a **significant premium to existing oncology CAR T *(~$500-$600K WAC[3])***
- Targeting **~10 centers** where patients are concentrated
- ATC footprint expected to enable **cost-effective, scalable launch execution and biologics-like margins in SPS**

Total U.S. Diagnosed SPS Market Represents a Multi-Billion-Dollar Rare Disease Opportunity‡

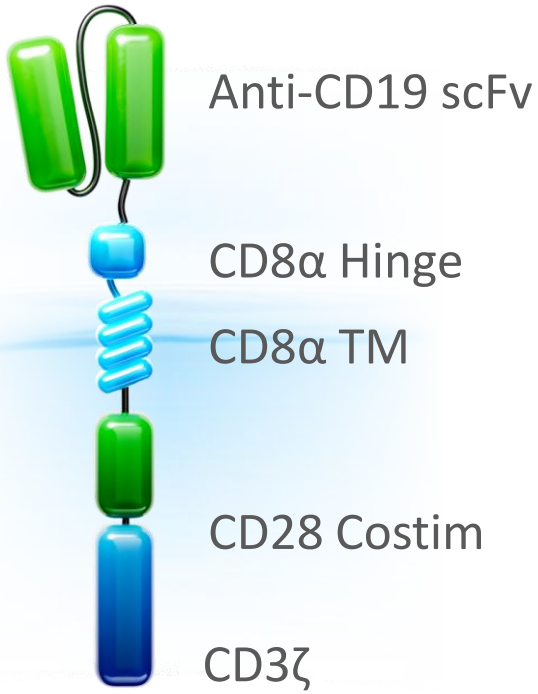
*Reflects patients who are treated with off-label Immunotherapies defined as off-label immunosuppressants (e.g., prednisone), rituximab and/or intravenous immunoglobulin.
‡Internal cumulative estimate based on assumed miv-cel pricing (premium to oncology CAR T pricing) and total diagnosed SPS patients in U.S.
ATC, Academic Treatment Centers
1. Crane PD, et al. *Neurology*. 2024;103(12):e210078. 2. HCP qualitative data and U.S. Claims Data. 3. WAC price for Yescarta®, Breyanzi®, Kymriah®, Carvykti®, Abecma®, and Aucatzyl®.

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Miv-cel's Differentiated CAR Construct Designed for Enhanced Tolerability and Specifically Developed by Kyverna for Autoimmune Disease

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

Fully Human Autologous CD19 CAR T With CD28 Costim



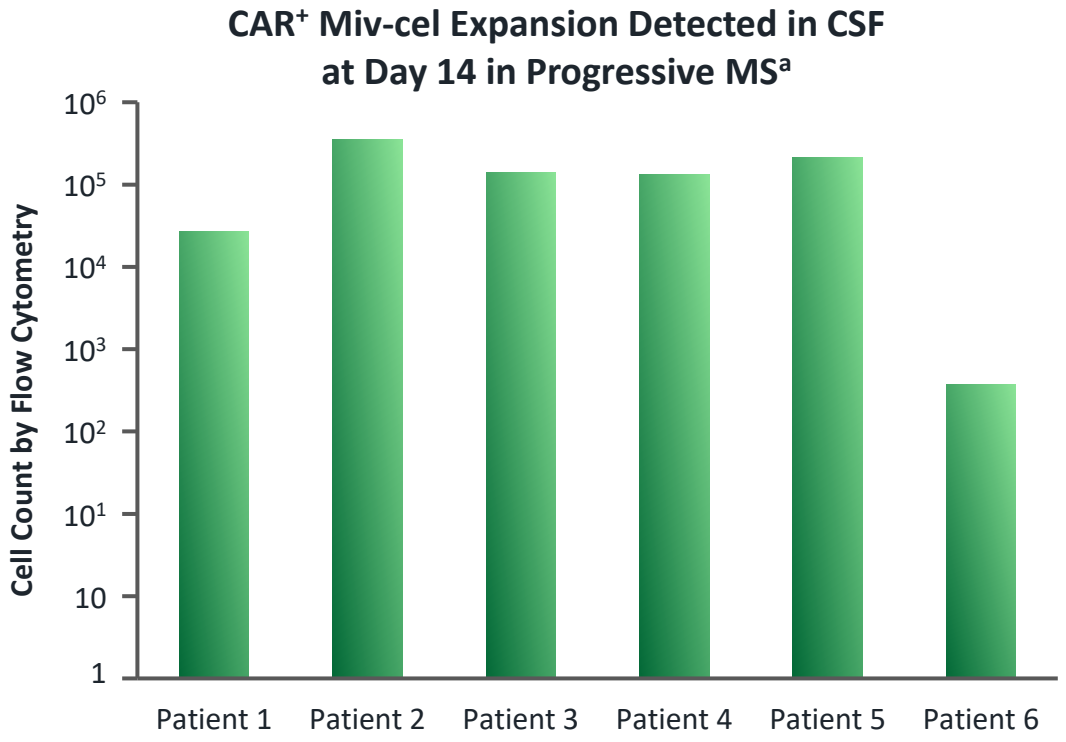
- **Deep depletion of peripheral and tissue-resident B cells** with the potential to support **broad immune reset and durable remission** [3-4]
- First SPS and gMG patients treated with a single dose of miv-cel achieved **durable efficacy beyond 24 months without the need for chronic immunotherapies**[5]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

CRS, cytokine release syndrome; CNS, central nervous system; Costim, co-stimulation; IEC-HS, Immune Effector Cell-Associated Hemophagocytic Lymphohistiocytosis-Like Syndrome; 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. Minopoulou I, et al. *Ann Rheum Dis*.2025;84(3):e4-e7. 4. Albach FN, et al. *Rheumatology*. 2025;64(6):4075-4077. 5. Named patient access data, Kyverna Therapeutics. 6. Data on file, Kyverna Therapeutics.

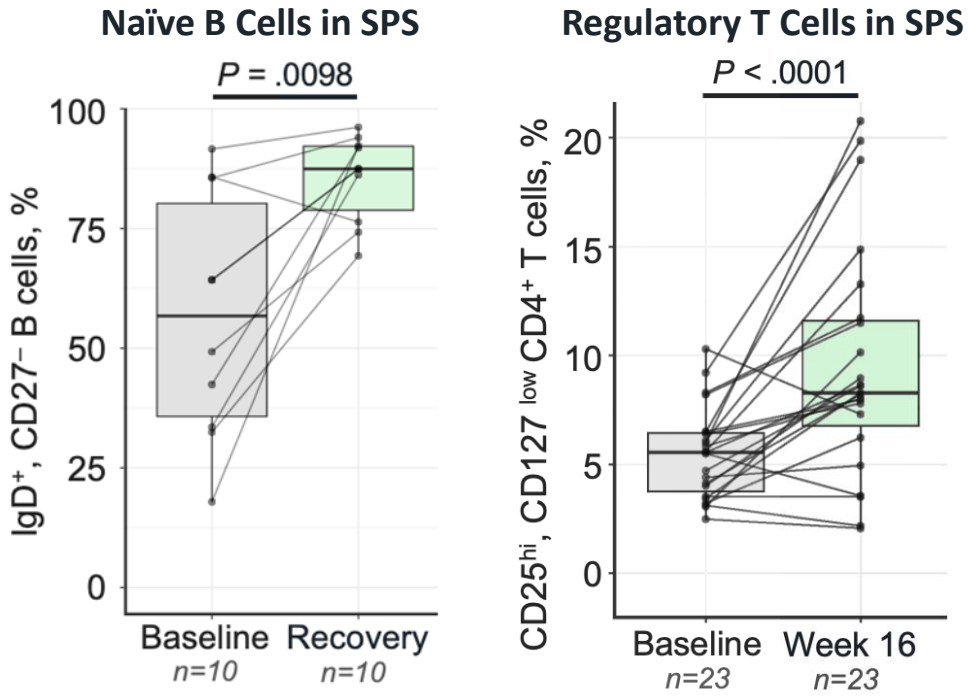
Miv-cel's Profound MOA and Ability to Penetrate the CNS

CNS Penetration and Expansion



Acts directly on cells in the CNS at the site of disease[1]

Broad Immune Reset



Resets B cells and upregulates regulatory T cells, important suppressors of CNS disease inflammation[2-4]

[a]Absolute numbers of CAR T cells in CSF assumed a volume of 140 mL and 150 mL for female and male, respectively.

CAR, chimeric antigen receptor; CNS, central nervous system; CSF, cerebrospinal fluid.

1. Dunn J, et al. Presented at the ACTRIMS Forum 2026; February 5-7, 2026; San Diego, CA. Poster 112. 2. Piquet A, et al. Presented at the AAN Annual Meeting 2026; April 18-22, 2026; Chicago, IL. LBA Poster 8. 3. Goverman JM. *N Engl J Med.* 2021;384:578-580. 4. Harkins AL, et al. *Crit Rev Immunol.* 2022;42:1-27.

Established, Validated, and Scalable Manufacturing Process

- **Established manufacturing process** leverages a **validated platform** built on proven and well-established technology designed to deliver **predictable and consistent cell products**
- **Dual-source** U.S. manufacturing strategy
- **>98%** manufacturing success rate
- Commercial agreement with Elevate **supports SPS and future commercial launches and clinical demand**



elevatebio®



Minaris Advanced Therapies

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Stiff Person Syndrome (SPS)

KYSA-8 Patient Perspectives:
Before and After Treatment with Miv-cel
Case Studies



View Video



View Video

Potential for Miv-cel to Quickly Set Treatment Standard in SPS with >2,000 Patients Immediately Addressable

~6k

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

Miv-cel Addressable Market[2,3]

Immediately Addressable Market

~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

Expect to Capture Total Addressable Market Over Time Due to Progressive Nature of Disease

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

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Focused Strategy Targeting ~10 High-Value SPS Centers Initially with Additional Sites to be Added Post Launch

✓ **Neuro Leadership**	• Thought leaders / SPS high-volume treaters • Institutional support for miv-cel
✓ **Addressable Patients**	• Meaningful portion of immediately addressable patients at ~10 centers • Strong referral network
✓ **CAR T Expertise**	• Existing CAR T treatment infrastructure and accreditation with significant interest to expand into autoimmune
✓ **Economic Potential**	• Robust inpatient and outpatient models • Commercial payer and Medicare dynamics

Targeted Launch Expected to Enable Efficient Go-to-Market Approach

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Clear Miv-cel Treatment Path For Patients with SPS



1

Miv-cel Consultation

- Launch Focus: SPS patients at ATC treated with off-label immunotherapy
- Neurologist assesses eligibility with cell therapist, schedules step 1

2

Apheresis

- Leukapheresis at ATC or third party
- Immediately shipped to ElevateBio

Miv-cel Manufacturing

- Target turn-around time ~30 days to batch release
- 98% manufacturing success rate

3

Infusion & Monitoring

- Under cell therapist's care:
  - Low-dose preconditioning conducted outpatient
  - Miv-cel infused in or outpatient
  - Patients monitored; returns to neurologist for follow-up

Seamless, transparent treatment experience enabled by integrated operations and patient support

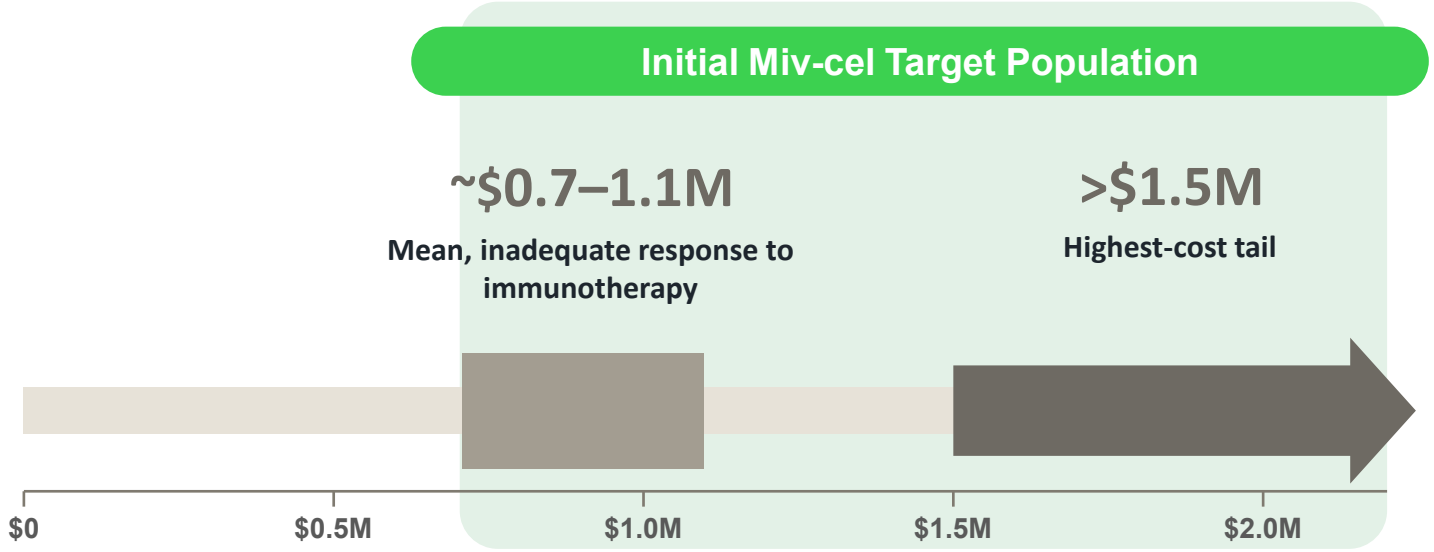
Leveraging Established CAR T Infrastructure and Partnering with Sites to Streamline Treatment Journey

ATC, Academic Treatment Center; COEs, Centers of Excellence; Cy/Flu, cyclophosphamide and fludarabine.

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Significant Direct Cost Burden of SPS Patients Ranges ~$0.7–$1.5M+ Over 3 Years

ESTIMATED 3-YEAR DIRECT MEDICAL COST PER PATIENT, U.S.*



Additional Costs (Not Included):

- **Lost employment** and income
- **Time and travel** for frequent treatment
- **Caregiver burden** and costs
- **Out-of-pocket costs** copays, coinsurance, uncovered care
- **Disability-related care** mobility aids, home changes, support

Miv-cel's Potential to Deliver Durable, Drug-Free, Disease-Free Remission with a Single-Dose Represents a Significant Value Proposition

FFS, fee-for-service; IMT, immunomodulatory therapy (rituximab, IVIG, plasma exchange, autologous stem cell transplant); IVIG, intravenous immunoglobulin.

*Direct medical costs: amounts paid by insurers for inpatient, outpatient and pharmacy care, shown as annual mean × 3 in 2024 USD (commercial perspective). Based on Medicare FFS beneficiaries with SPS receiving IMT, 2017–2023 (n=486); inadequate response defined as adding or switching IMT (n=96). Range low end prices IVIG/rituximab by site of care; high end applies published commercial-to-Medicare multipliers (2.44 inpatient, 2.63 outpatient; pharmacy 2.08×). Highest-cost tail: ≥1 in 7 patients with inadequate response exceeded $500K per year (>$1.5M over 3 years). Sources: Snyder S, et al. Abstract submitted to AAN 2027; data on file. Robinson JC, et al. N Engl J Med. 2024;390(4):338–345. Vaughan LJ. Am J Manag Care. 2019;25(6 Suppl).

Deep Commercial Expertise Across CAR T, Rare Disease, and Neurology to Drive SPS Launch

Seasoned commercial leadership team with average of **20+ years of industry experience**

Robust real-world commercial launch and market access experience across key modalities and therapeutic areas

Cell and Gene Therapy/Hematology/ Rare Diseases:

- Breyanzi (lisocabtagene maraleucel)
- KYMRIAH (tisagenlecleucel)
- TECVAYLI (teclistamab-cqyv)
- Abecma (idecabtagene vicleucel)
- AUCATZYL (obecabtagene autoleucel)
- AMTAGVI (lifileucel)
- YESCARTA (axicabtagene ciloleucel)
- YARTEMLEA
- casgevy (exagamglogene autotemcel)
- TECARTUS (brexucabtagene autoleucel)
- EBVALLO tabelecleucel
- ROCTAVIAN (valoctocogene roxaparvovec-rvox)
- CARVYKTI (ciltacabtagene autoleucel)
- TALVEY (talquetamab-tgvs)

Neurology:

- GILENYA (fingolimod)
- ZEPOSIA (ozanimod)
- COPAXONE (glatiramer acetate injection)
- Vyepti (eptinezumab-jjmr) 100 mg/mL Injection for IV
- TYSABRI (natalizumab)
- AVONEX (interferon beta-1a)
- OCREVUS ocrelizumab

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SPS Registrational Trial Design – BLA Submission Completed

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 preconditioning
+
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

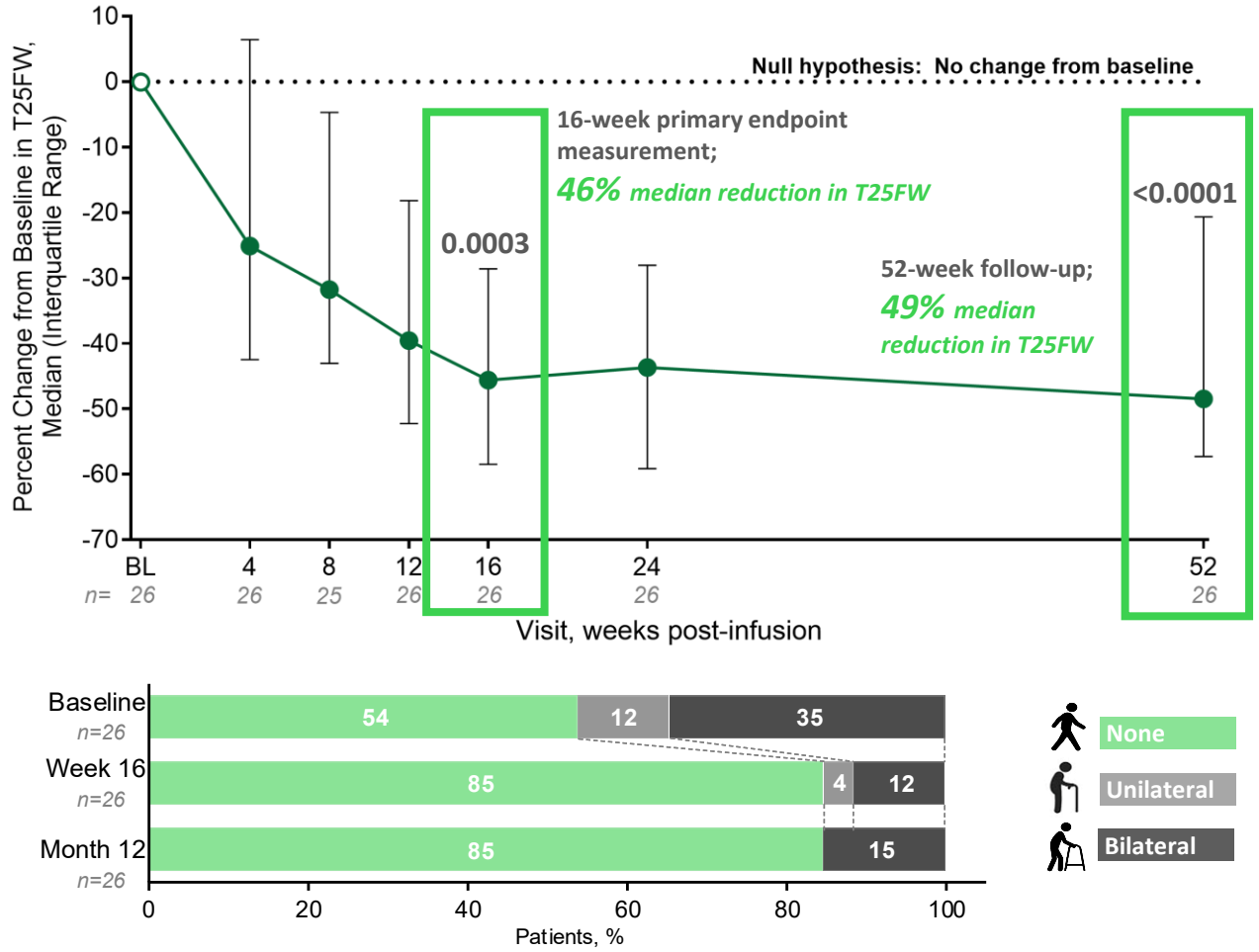
Miv-cel Granted ODD and RMAT Designations by FDA for SPS

BLA, Biologics License Application; Cy/Flu, cyclophosphamide and fludarabine; ODD, Orphan Drug Designation; RMAT, Regenerative Medicine Advanced Therapy; T25FW, Timed 25-Foot Walk.

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Primary Endpoint Met - Continued Reversal of Disability and Nearly All Patients Remaining Off Chronic Immunotherapies Through 1 Year

Significant T25FW Improvement and Reduced Walking Aid Use

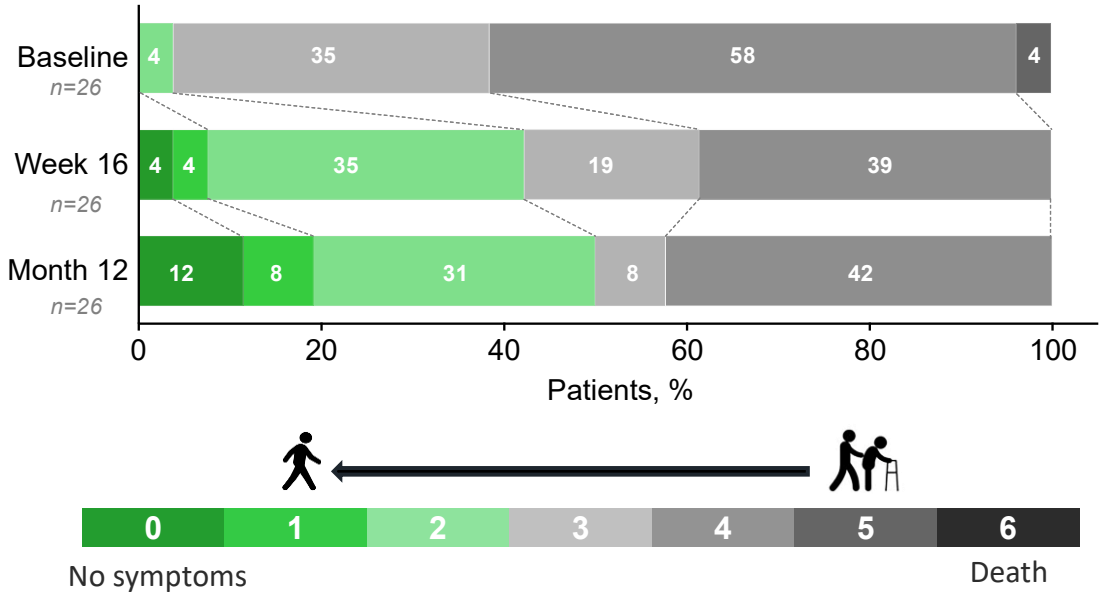


- **Vast majority of patients demonstrated sustained clinical benefit at 1 year**
  - At 16 weeks and 1 year, 81% (21/26) and 77% (20/26) of patients achieved a clinically meaningful improvement (≥20% reduction from baseline) in T25FW, respectively
- **At 1 year, 35% of patients** completed T25FW in <5 seconds, comparable to a **typical time for healthy adults**[2]
- Of the 12 patients requiring a walking aid for T25FW at baseline, **67% continue not to require assistance at 1 year**
- 92% (24/26) of patients continue to remain **free of immunomodulatory or immunosuppressant therapies** for SPS*at 1 year

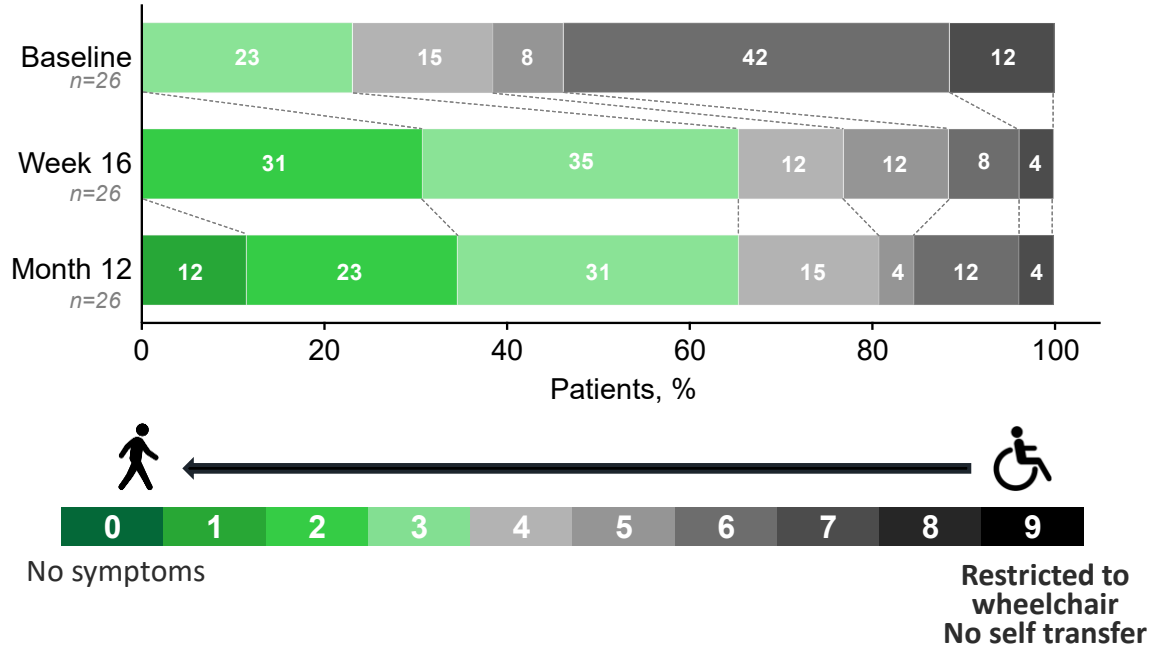
*Includes IVIg/SCIg, PLEX, rituximab and/or prednisone (≥20 mg/day) for SPS symptoms.
N=26. 1-year follow-up data. Database lock: July 2026. Percentages may not total 100% due to rounding.
BL, baseline; T25FW, timed 25-foot walk.
1. Hobart J, et al. *Neurology*. 2013;80(16):1509-17. 2. Motl RW, et al. *Mult Scler*. 2017;23(5):704-710.

All Secondary Endpoints Achieved Significant and Sustained Improvements in Disability, Mobility, Stiffness, and Hypersensitivity

Modified Rankin Scale



Hauser Ambulation Index

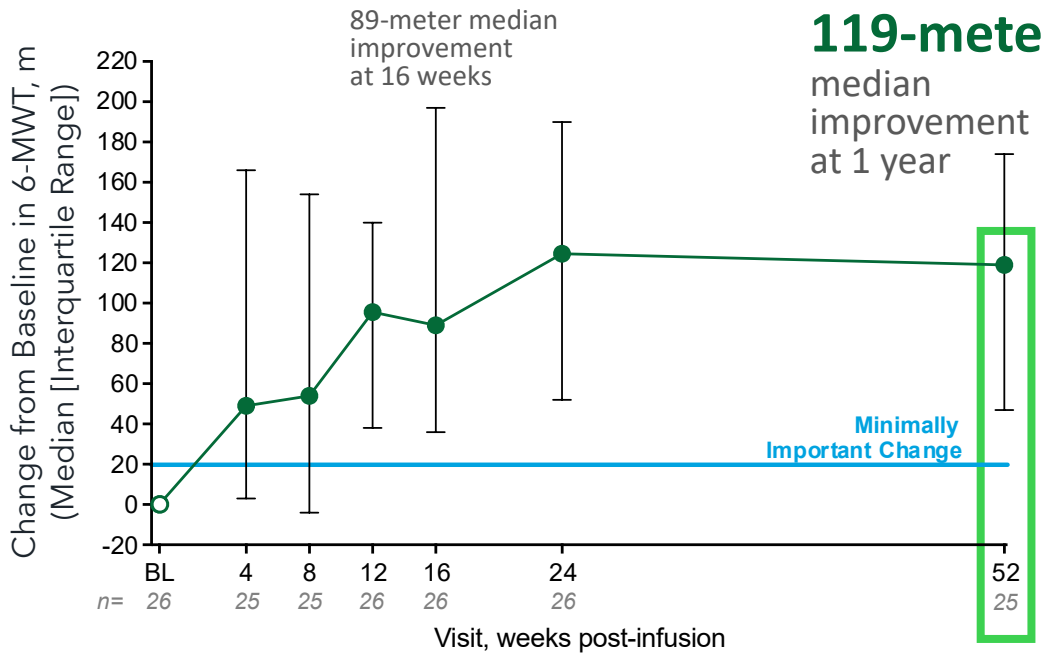


- At 1 year, mRS and HAI, as well as the SPS-specific measures DSI and HSS, showed significant mean improvements of -1.0 (SD, 1.18; *P* = .0003), -1.7 (1.38; *P* < .0001), -1.6 (1.75; *P* < .0001) and -2.8 (2.11; *P* < .0001), respectively

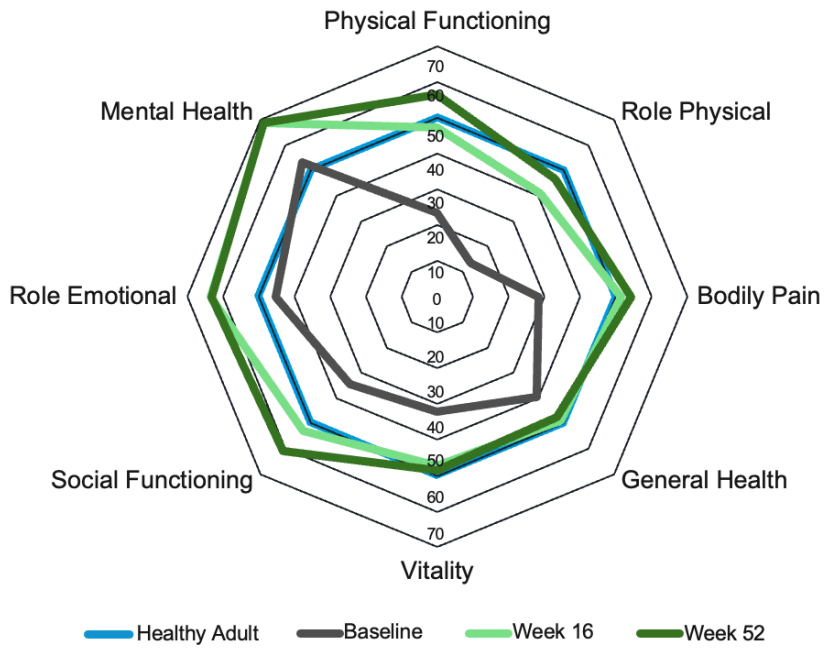
N=26. 1-year follow-up data. Database lock: July 2026. Percentages may not total 100% due to rounding.
DSI, distribution-of-stiffness index; HAI, Hauser ambulation index; HSS, heightened sensitivity scale; mRS, modified Rankin scale; SPS, stiff person syndrome.

Single-dose Miv-cel Led to Substantial and Sustained Improvements in Physical and Mental Functioning

6-Minute walk test



36-Item short form health survey

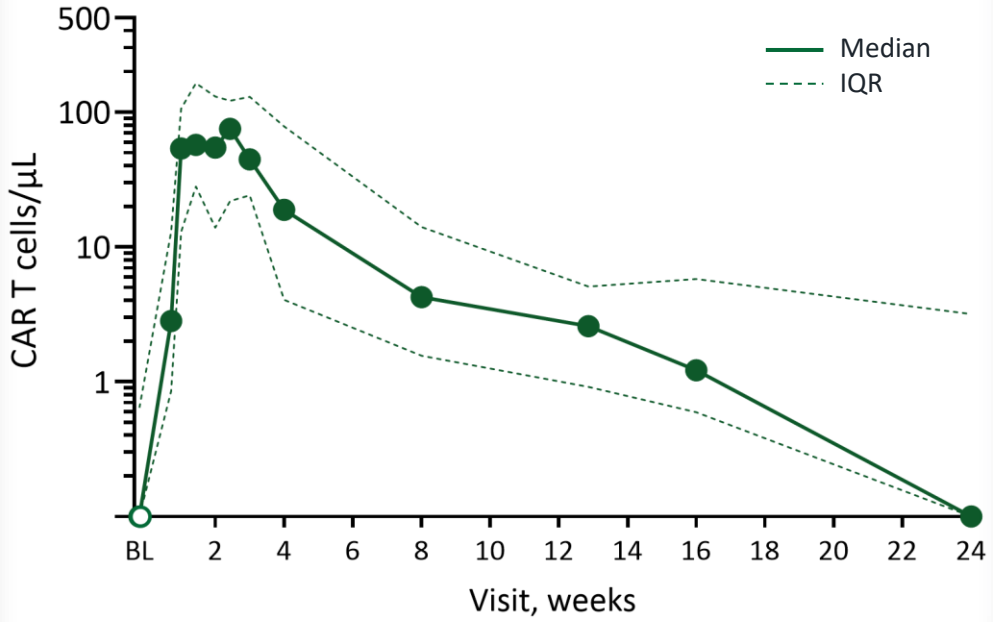


- At 1 year, the 6-MWT improved by a median of 119 meters over baseline, equating to a ~6-fold improvement over clinical minimally important change, and a median increase of 30 meters after the primary analysis[1]
- SF-36 scores at 1 year were comparable to healthy adults for most domains[2,3]

N=26. 1-year follow-up data. Database lock: July 2026.
6-MWT, 6-minute walk test; BL, baseline; SF-36, 36-item short form health survey.
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.

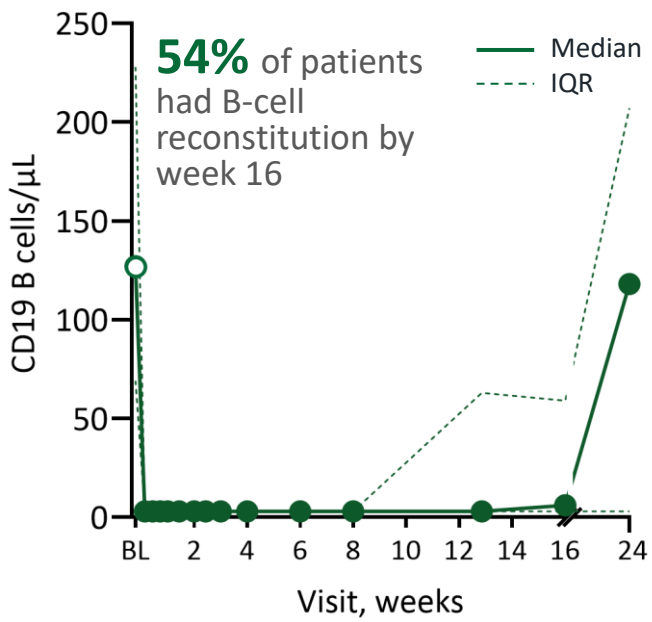
Robust Miv-cel Expansion Led to Complete Peripheral B-cell Depletion and Significant Reductions in Autoantibody Titers

Robust CAR T-cell Expansion



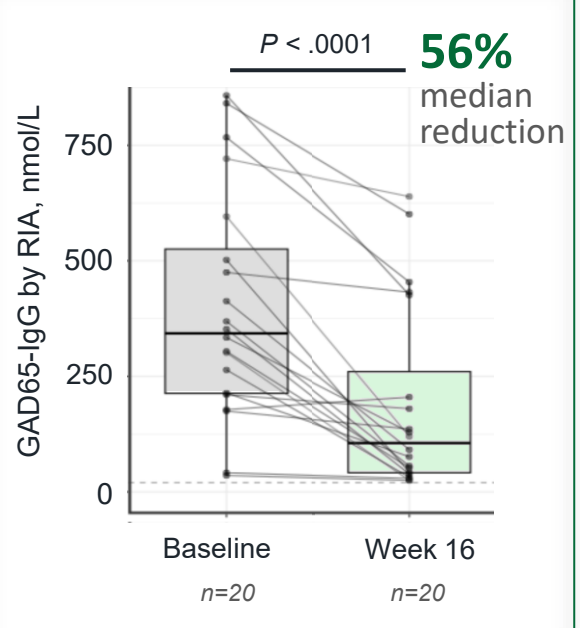
- CAR-positive T cells peaked by day 14

Deep B-cell Depletion



- **65%** (17/26) of patients had B-cell reconstitution by 1 year
- Efficacy was maintained with B-cell reconstitution

Reduced GAD65-IgG

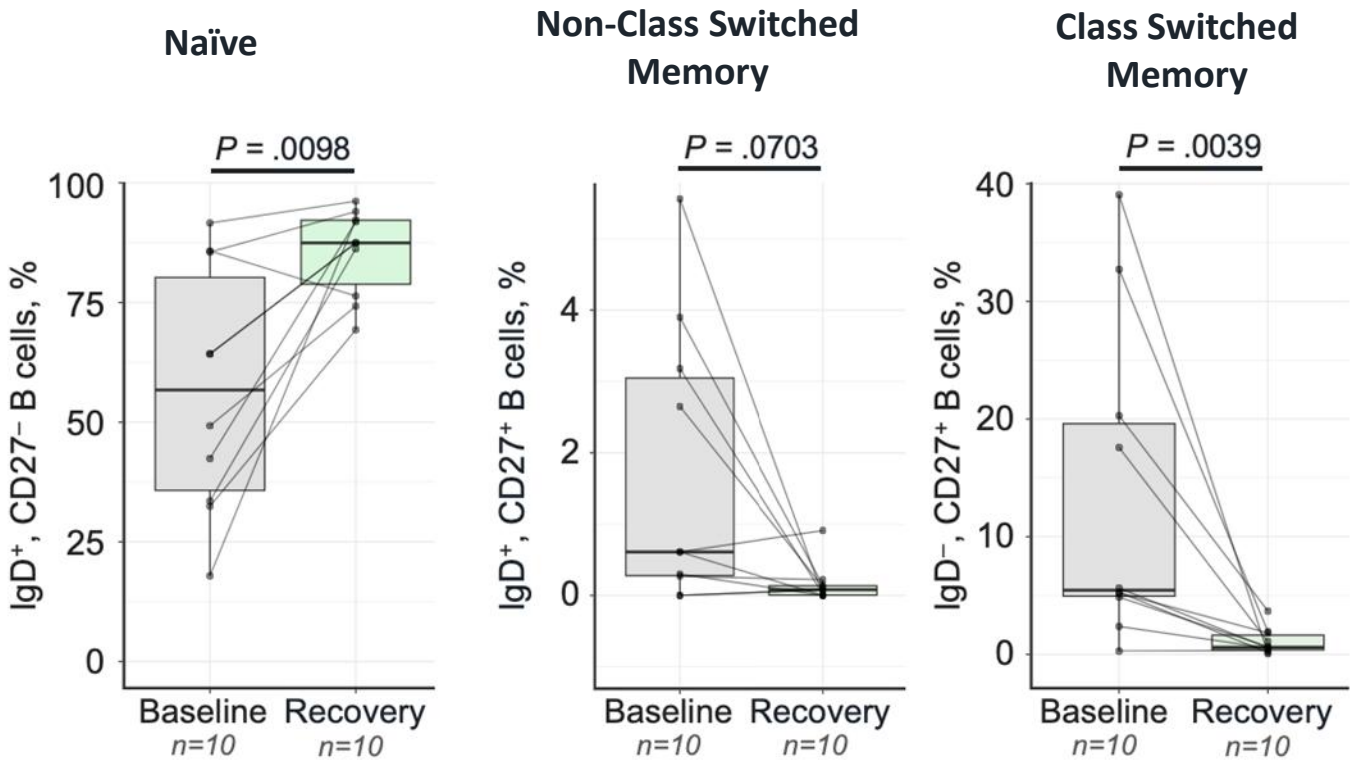


- **83%** median reduction in GAD65-IgG among patients with ≥20 nM GAD65 at baseline at 1 year

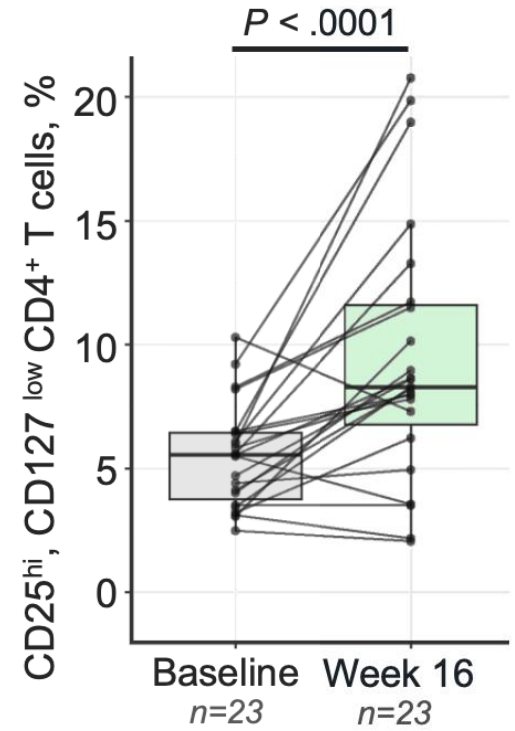
N=26. Figures from the primary analysis; Data cutoff: 26Nov2025. Box and whisker plots showing median line (dark line), and interquartile range (box), and min/max (bars). Bullet points from 1-year follow-up data.
CAR, chimeric antigen receptor; IgG, immunoglobulin G; GAD65, glutamic acid decarboxylase 65.

Single-dose Miv-cel Induced Markers of Broad Immune Reset

B-Cell Phenotypes



Regulatory T Cells



- Newly emerging B-cell population showed significantly increased naïve phenotype with concomitant decrease in memory phenotype
- Significant increase in regulatory T cells at week 16

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

Consistent Safety Profile Maintained in 1-Year Follow-Up With No High-Grade CRS or ICANS and No IEC-HS

Treatment-Related Adverse Events, n (%)	N = 26
Any grade ≥3 CRS	0 (0)
Any grade ≥3 ICANS	0 (0)
Any grade IEC-HS	0 (0)
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	5 (19)
Any treatment-related serious AE	3 (12)

- **No high-grade CRS or ICANS observed**
- **No IEC-HS observed**
- All Grade 3/4 neutropenia (5/26), an expected AE with lymphodepletion and CAR T-cell therapies, were manageable
- All treatment-related serious AEs (3/26) have fully resolved

N=26. 1-year follow-up data. Database lock: July 2026. CRS, ICANS, IEC-HS assessed using ASTCT criteria; other AEs graded using CTCAE criteria.
AE, adverse event; ASTCT, American Society for Transplantation and Cellular Therapy; CTCAE, Common Terminology Criteria for Adverse Events; CRS, cytokine release syndrome; IEC-HS, Immune Effector Cell-Associated Hemophagocytic Lymphohistiocytosis-Like Syndrome; ICANS, immune effector cell-associated neurotoxicity syndrome.

Natural History Study Contextualizes Transformative Miv-cel Data and its Opportunity to Change the Treatment Paradigm

	Natural History Study *Large, multicenter, retrospective study assessing T25FW in patients with SPS (n=153) over 10-year period*	KYSA-8 SPS Registrational Trial
Patient Population	Earlier in disease course (mRS mean 2.6; 55% immunotherapy at index date*)	More severe (mRS mean 3.6; all have failed immunotherapy)
T25FW	✗ No or minimal improvement†	✓ **46%** improvement at 16 weeks, sustained at 24 weeks
Walking Aid Use	↗ 73% increase over average 5 years	↘ **67%** decrease at 16 weeks
mRS score	✗ No improvement	✓ Improvement in disability scores
Immunotherapy Use	↗ 81% had immunotherapy by last datapoint (47% increased usage)	↘ No immunotherapy after single-dose of miv-cel

mRS, Modified Rankin Score; T25FW, Timed 25-foot Walk

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

*Index date is the date of the first T25FW assessment. †Over average ~5 years.

Generalized Myasthenia Gravis (gMG)

Miv-cel's Potential: Durable, Drug-free, Disease-free Remission with Single Dose

~80k

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

Miv-cel Addressable Market[1,3]

Initial Priority

~12k Patients

15% of total diagnosed

Patients with inadequate response to ≥ 1 biologic*

Total Miv-cel Addressable Market

~40k Patients

50% of total diagnosed

Patients with inadequate response to immunosuppressants

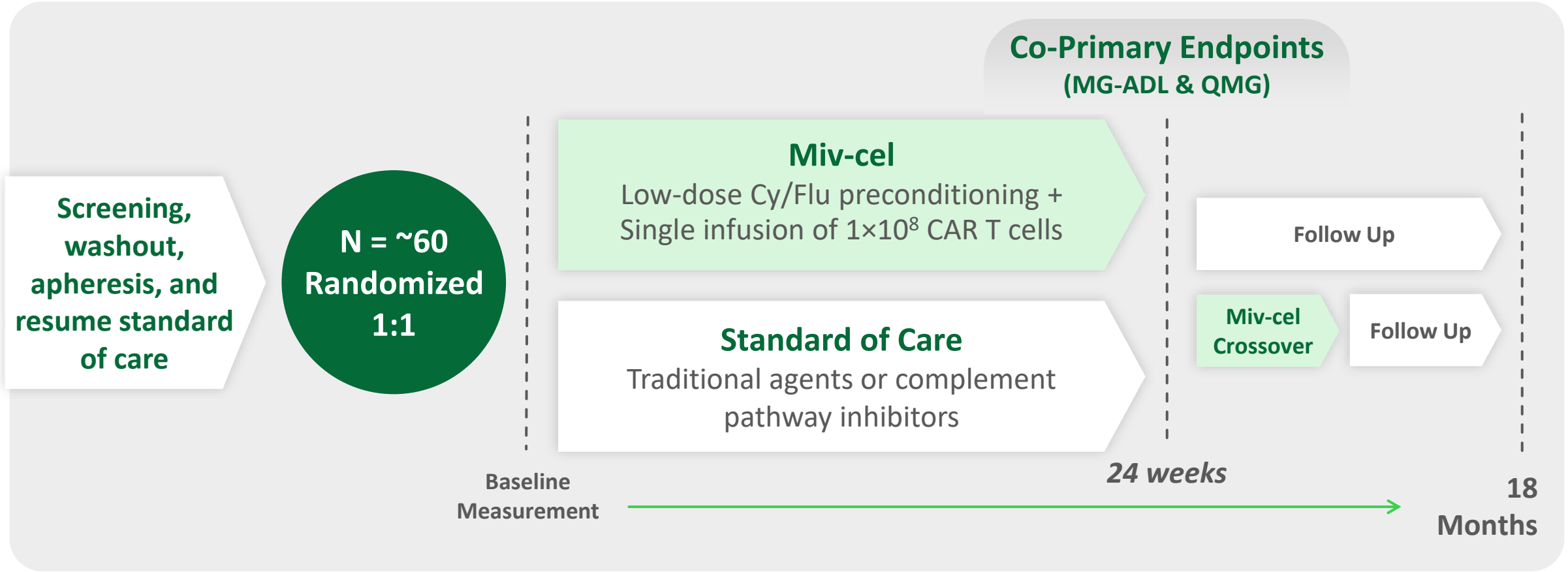
gMG, generalized myasthenia gravis.
*Biologics defined as immunomodulatory therapies including FcRN blockers, complement inhibitors, rituximab or chronic IVIg use.
1. Rodriguez E, et al. *Muscle. Nerve*. 2024;69(2):166-171. 2. Hendricks TM, et al. *Am J Opthamol*. 2019; 205:99-105. 3. Clarivate DRG Report (2024).

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Phase 3 Ongoing with Enrollment Expected to be Completed Mid-2027

Miv-cel Granted RMAT, ODD*, FTD† in gMG

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



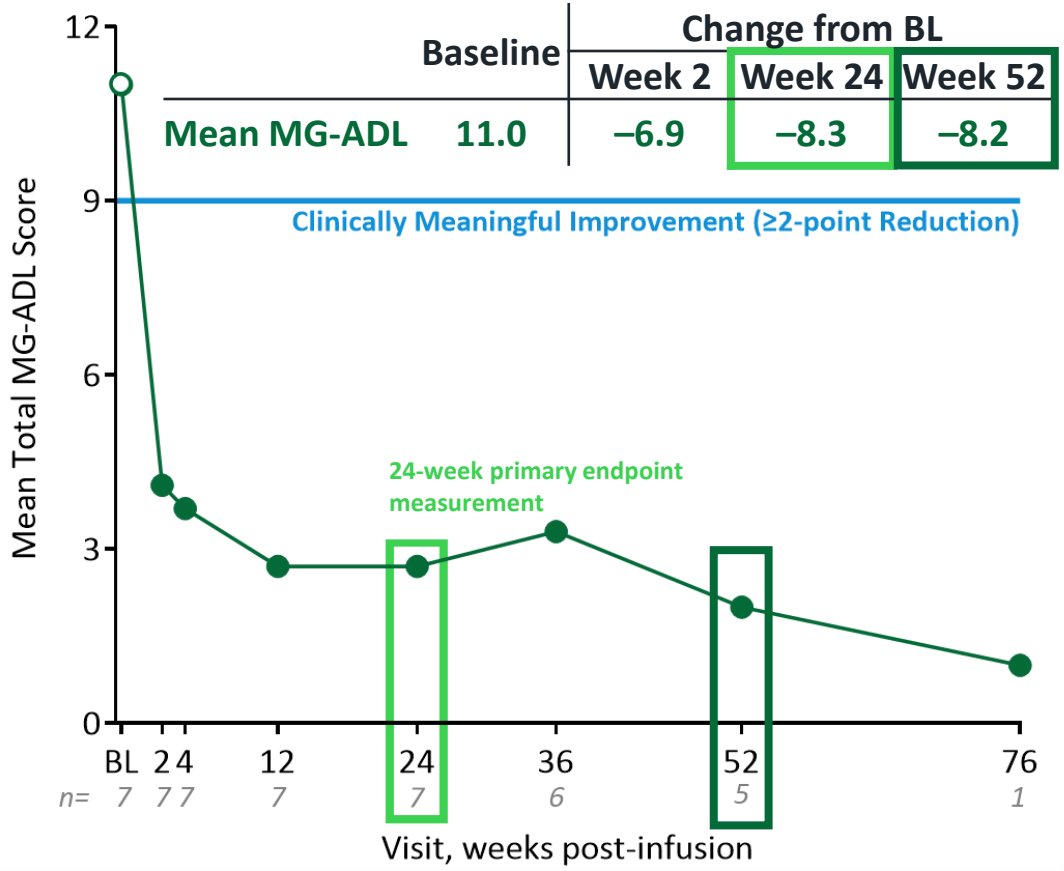
Standard of care may consist of traditional agents (e.g., prednisone, azathioprine, mycophenolate, methotrexate, chronic IVIg/PLEX) or complement pathway inhibitors (e.g., eculizumab, ravulizumab). Anti-CD20 or -CD19 monoclonal antibodies or FcRn inhibitors not allowed as defined in inclusion criteria.

Cy/Flu, cyclophosphamide and fludarabine; FcRn, neonatal fragment crystallizable receptor; FTD, Fast Track Designation; IVIg, intravenous immunoglobulin; MG-ADL, myasthenia gravis activities of daily living; ODD, Orphan Drug Designation; PLEX, plasma exchange; QMG, quantitative myasthenia gravis score; RMAT, Regenerative Medicine Advanced Therapy.
*EU & US. †Fast Track Designation does not assure that we will experience a faster development process, regulatory review or regulatory approval process compared to conventional FDA procedures.

Robust and Durable Effects Sustained Through 1.5 Years Across MG-ADL and QMG

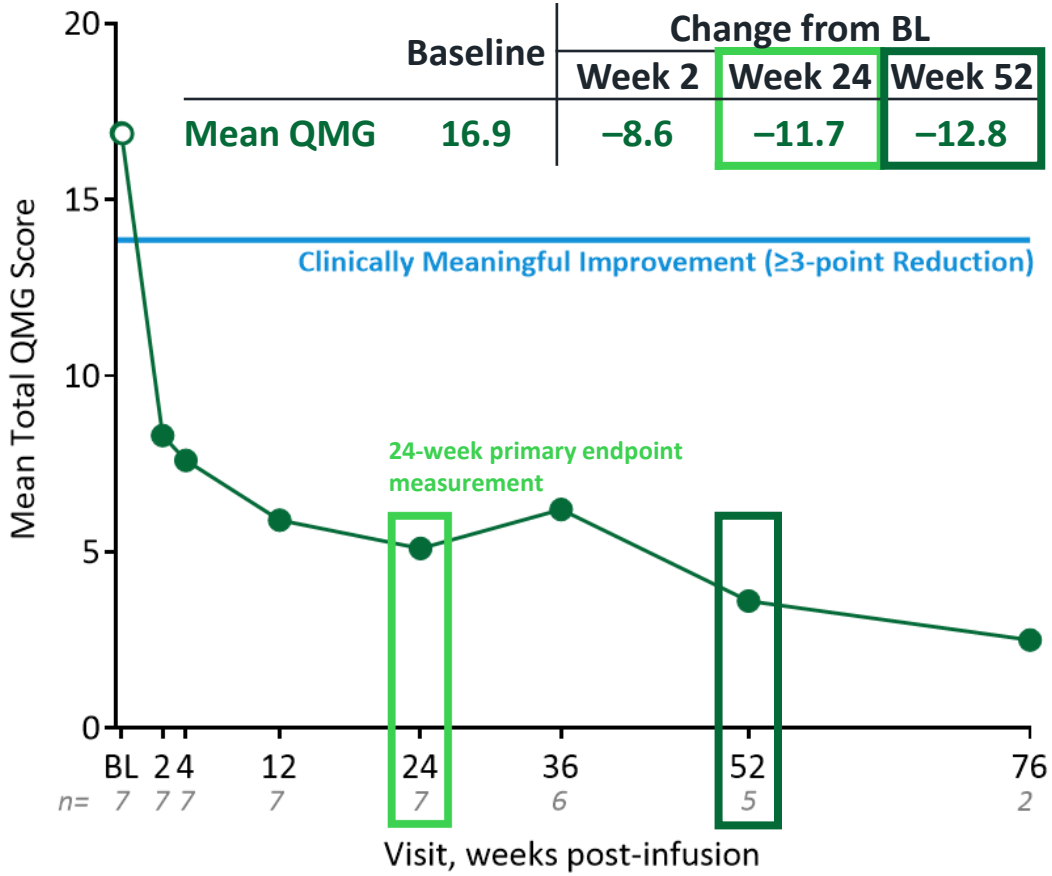
MG-ADL Score

	Baseline	Change from BL		
		Week 2	Week 24	Week 52
Mean MG-ADL	11.0	–6.9	–8.3	–8.2



QMG Score

	Baseline	Change from BL		
		Week 2	Week 24	Week 52
Mean QMG	16.9	–8.6	–11.7	–12.8



N=7. Data cutoff: June 2026. One patient has not yet reported their MG-ADL score at 76 weeks as of the June 2026 data cutoff. Change from baseline is calculated using the baseline values of the corresponding patients at a specified timepoint.
MG-ADL, myasthenia gravis activities of daily living; QMG, quantitative myasthenia gravis.

Single-dose Miv-cel Continues to Deliver Robust 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% sustained 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)
–16.4 mean reduction at 24weeks; –16.8 at 1year

Substantially reduced gMG 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

N=7. Data cutoff: June 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.

Consistent Safety Profile Maintained in Long-term Follow-Up With No High-Grade CRS and No ICANS or IEC-HS

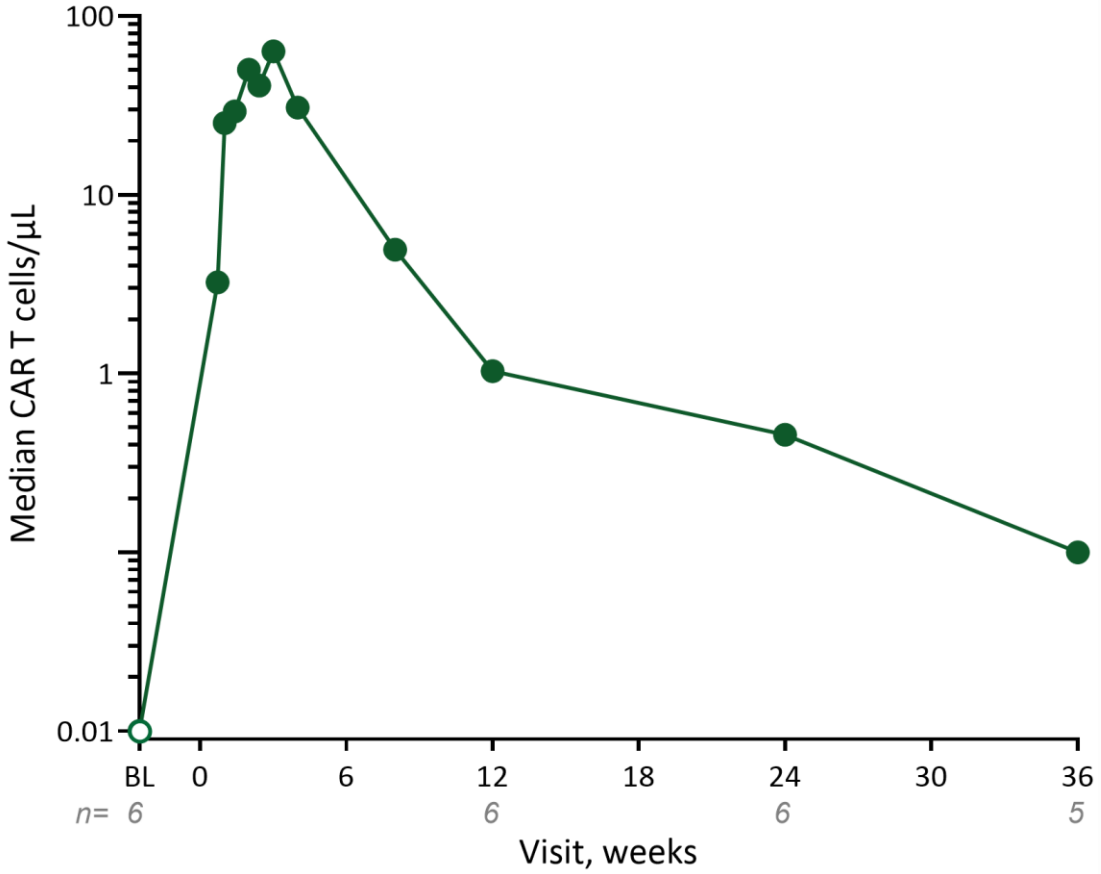
Treatment-related AEs, n (%)	Patients (n=7)
Any grade ≥3 CRS	0 (0)
Any grade ICANS	0 (0)
Any grade IEC-HS	0 (0)
SAE, any grade[a]	0 (0)
CRS (any grade)	7 (100)
Grade 1	5 (71)
Grade 2	2 (29)
Grade 3/4 events	3 (43)
Neutropenia	2 (29)
Lymphopenia	2 (29)

- **No high-grade CRS and no ICANS observed**
- **No IEC-HS observed**
- All Grade 3/4 treatment-related AEs of neutropenia (2/7), an expected AE with lymphodepletion and CAR T-cell therapies; were not associated with infections, were manageable, and fully resolved

N=7. Data cutoff: June 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, ICANS, IEC-HS assessed using ASTCT criteria; other AEs graded using CTCAE criteria.
AE, adverse event; ASTCT, American Society for Transplantation and Cellular Therapy; CTCAE, Common Terminology Criteria for Adverse Events; CRS, cytokine release syndrome; IEC-HS, Immune Effector Cell-Associated Hemophagocytic Lymphohistiocytosis-Like Syndrome; ICANS, immune effector cell-associated neurotoxicity syndrome; SAE, serious adverse event.

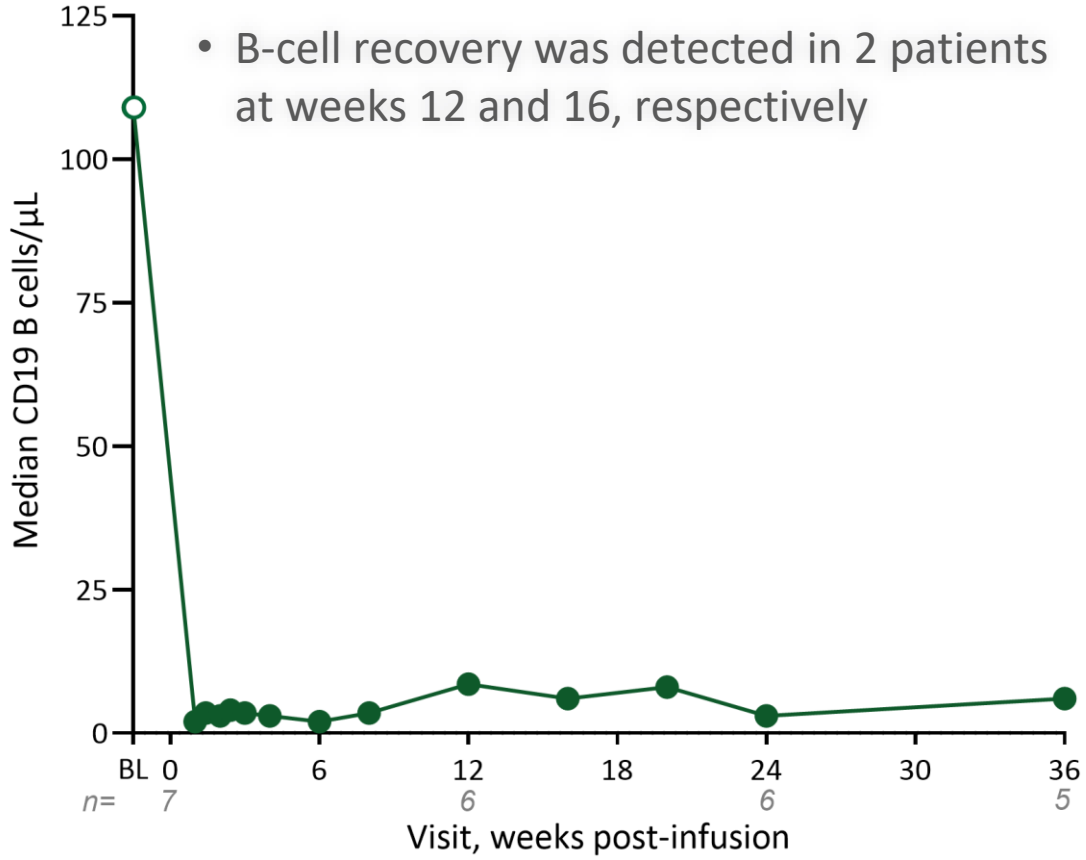
Robust CAR T-cell Expansion Led to Deep B-cell Depletion

Robust CAR T-cell expansion



Deep B-cell depletion

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



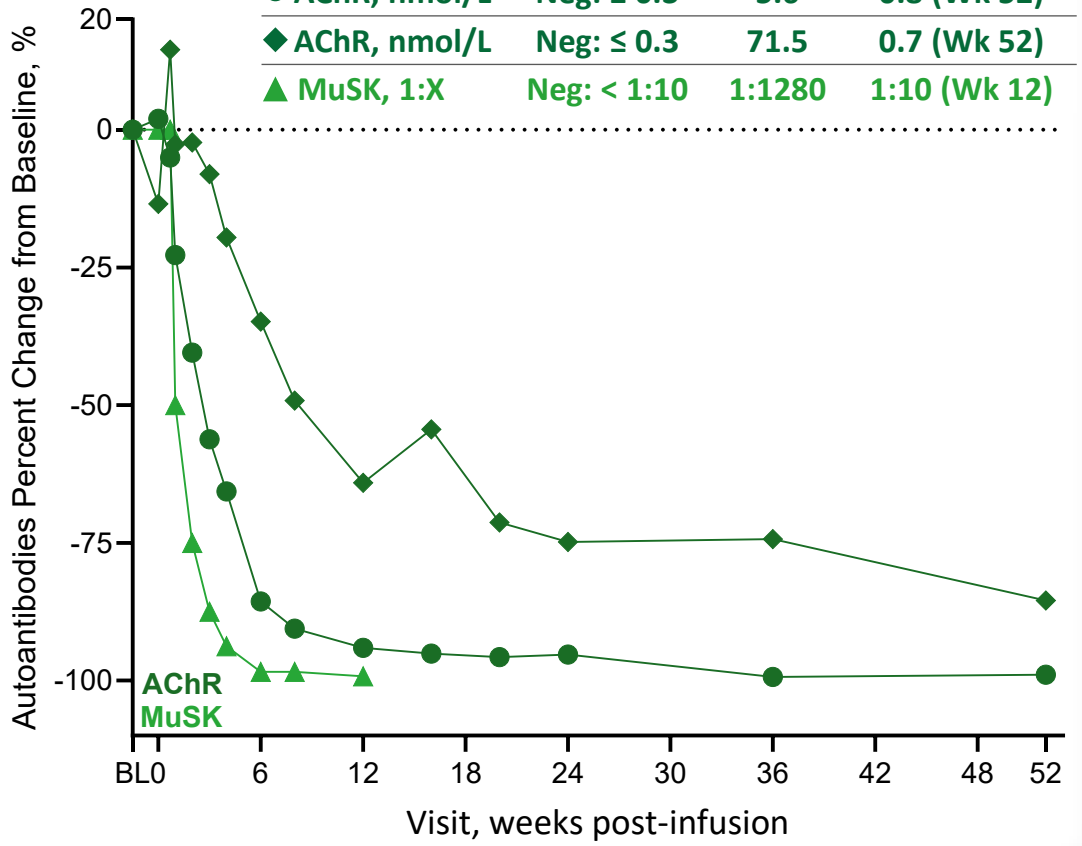
N=7. Data cutoff: February 2026.
BL, baseline.

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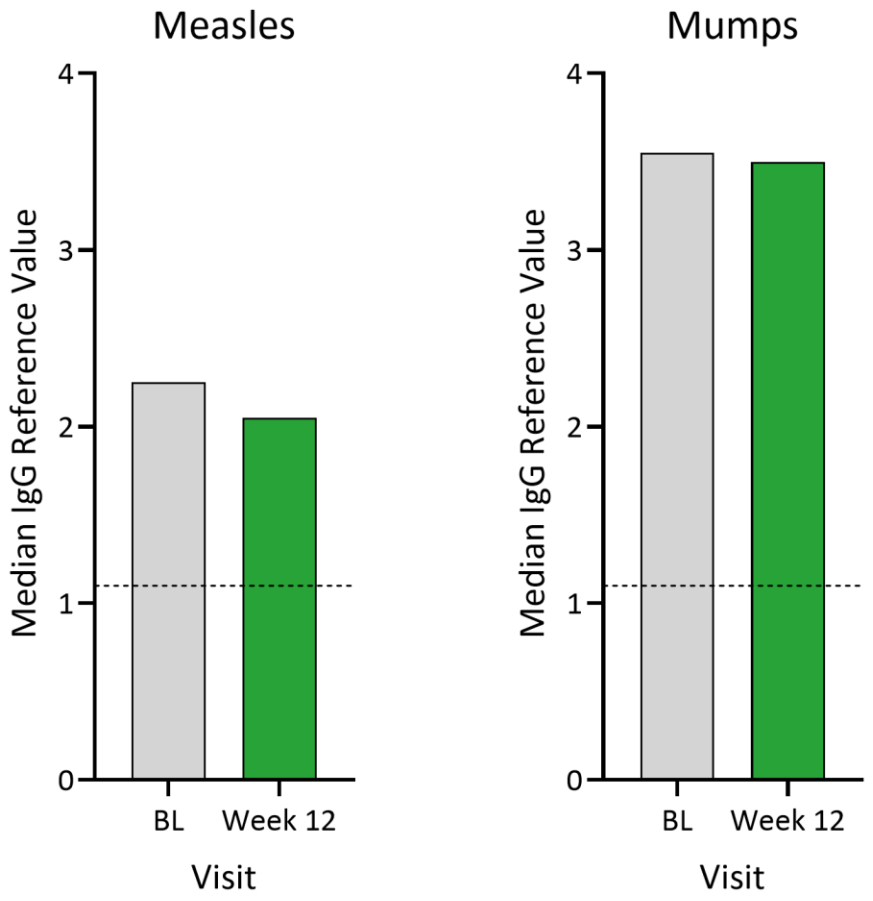
Miv-cel Reduced Autoantibody Levels While Preserving Humoral Immune Responses

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 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.

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Opportunity to Achieve Drug-Free, Disease-Free Remission with Single Dose Miv-cel

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

		Approved			Late-Stage 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=7)
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	**8.3**
	QMG Reduction	~6.2	2.8	4.8	3.9	**11.7**
% Responders *Patients with ≥3-point MG-ADL improvement from baseline to primary endpoint (non-placebo adjusted)*		~73%	~57%	69%	64%	**100%**
Achieve MSE *% of patients achieving MG-ADL of 0 or 1*		40% *At any point before primary endpoint*	43%	Not reported	33% *6 months to 1 year*	**57%** *At any point before primary endpoint*
Free from chronic background immunotherapies		✗	✗	✗	✗	✓

BCMA, b-cell maturation antigen; FcRn, neonatal fragment crystallizable receptor; mAb, monoclonal antibody; MG-ADL, myasthenia gravis activities of daily living; mRNA, messenger RNA; MSE, minimal symptom expression; QMG, quantitative myasthenia gravis score.

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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Progressive Multiple Sclerosis (PMS)

Progressive Multiple Sclerosis (PMS): Encouraging IIT Data Highlight Broad Opportunity with Miv-cel in Neuroimmunology

Phase 1 IIT Studies at Stanford (N=6) and UCSF (N=2)

Stanford uses alternative bendamustine lymphodepletion regimen

Biological Activity

- **Robust CAR T cell expansion** in blood and penetration into CNS
- Reconstitution of naïve B cells supportive of **immune reset**

Efficacy

- All patients with available data **showed improved or stable EDSS**
- All patients remained **off other immunotherapies**

Safety

- Reinforces **well-tolerated safety profile**
- **No high-grade CRS and no reported cases of ICANS or IEC-HS**

Durable Results Beyond 2 Years in First Patient Treated; RMAT Designation Granted for naSPMS

Data from 8 patients treated at dose levels 33M (n=3) and 100M (n=5) CAR+ T cells

EDSS, expanded disability status scale scores; UCSF, University of California, San Francisco, Weill Institute for Neurosciences; CNS, central nervous system; CRS, cytokine release syndrome; ICANS, immune effector cell associated neurotoxicity syndrome; naSPMS, non-active secondary progressive multiple sclerosis; RMAT, Regenerative Medicine Advanced Therapy.

Dunn, J, et al. Oral Presentation MS Toronto October 2026. Gupta S, et al. 2026. medRxiv. doi: 10.64898/2026.09.11.26361992.

Miv-cel's Compelling Value Proposition Supports Strong Commercial Potential Across Multiple Autoimmune Diseases

Today's Treatment Paradigm	Miv-cel's Potential - *Drug-Free, Disease-Free Remission*
Chronic therapy	✓ Single, well-tolerated dose
Inadequate disease management	✓ Immune reset
Transient benefit	✓ Durable benefit beyond one year
Reliance on additional immunotherapies	✓ Elimination of background immunotherapies

Miv-cel's Differentiated Clinical Profile Supported by Unique Construct Design and Well-Established, Validated Manufacturing Process

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Pioneering Differentiated Therapies with Curative Potential to Free People from Life-long Autoimmune Diseases and Chronic Therapy

Miv-cel BLA Submission Completed for SPS

Further strengthened by 1-year efficacy and safety data; Potential 1st approved CAR T for autoimmune and 1st approved treatment for SPS

Potential Best-in-Class Profile

Unique miv-cel construct and validated manufacturing process supporting potential for durable drug-free, disease-free remission with single, well-tolerated dose

Valuable Commercial Opportunity in SPS

Commercial readiness underway; immediately addressable patients; premium pricing potential

Neurologic Autoimmune Strategy

Focused franchise strategy prioritizing SPS, MG, and PMS

Innovation to Expand Access

Potential for new indications and delivery mechanisms, including alternative preconditioning and manufacturing enhancements

Capitalized to Support Initial Miv-cel Launch

Operating runway into 2028 supporting SPS launch and gMG Phase 3 trial

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