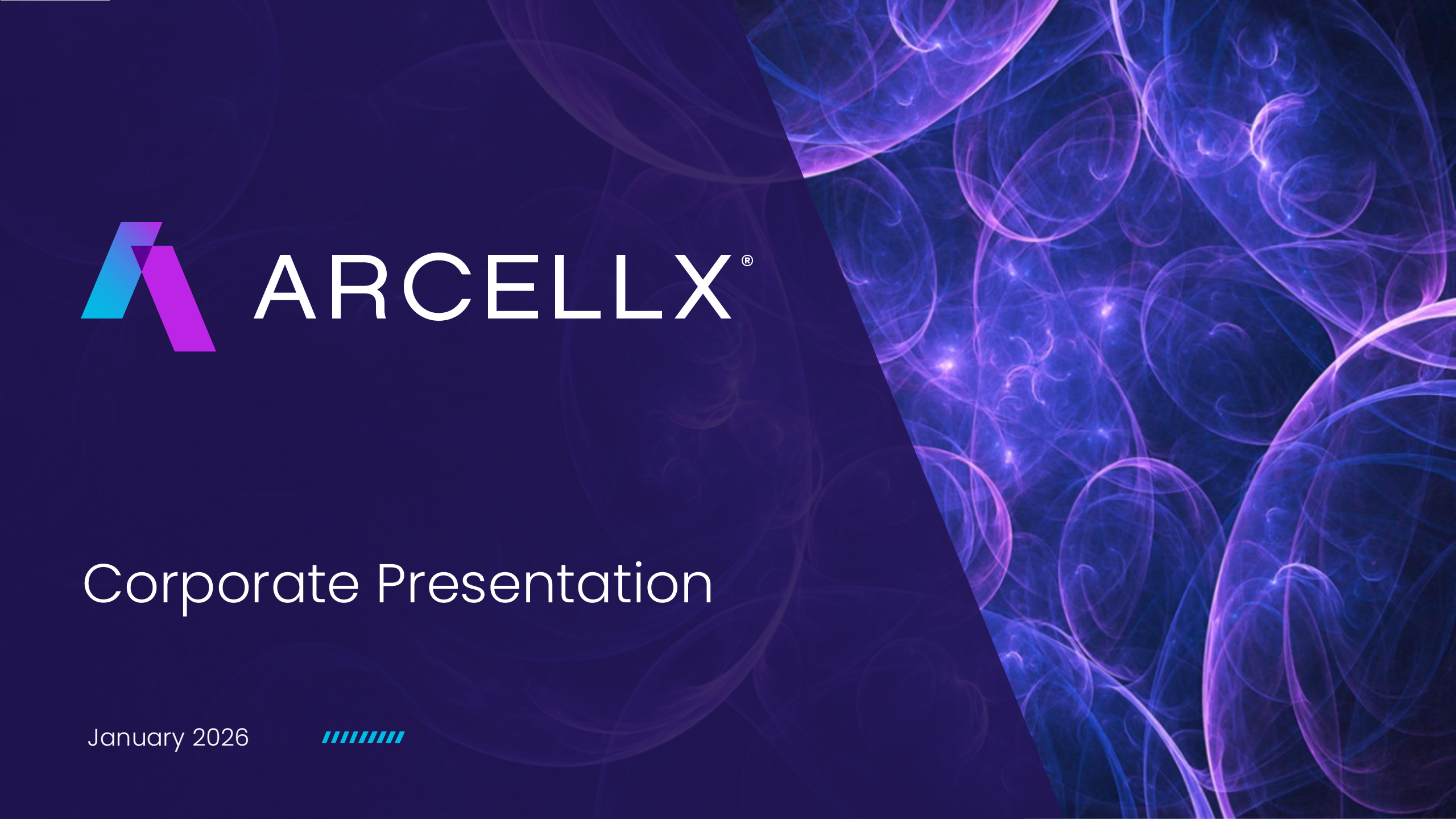


Corporate Presentation

January 2026

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, but not limited to, the following are forward-looking statements: statements regarding our business model and its benefits and features, including, without limitation, the collaboration model with Kite for anito-cel, our expected gross margin profile for anito-cel at launch, and the potential achievement of profitability for anito-cel with less than $1 billion in sales; the attributes of the D-Domain and its potential benefits; benefits of clinical trials of anito-cel; the safety and efficacy profiles of anito-cel, and its potential to be best-in-class and its impact on hospital stay periods and hospital capacity; the curative potential of anito-cel and other cell therapies; the speed, reliability, scalability and capacity of manufacturing of anito-cel and its components, including available doses at launch and beyond; the ability of patients to access anito-cel, including the number of available treatment centers; effect on hospital stay and capacity; expected addressable market, including anticipated market share and anticipated future clinical practice, including use of anti-CD38, bispecifics and other CAR-Ts; impact of anito-cel on market growth, and growth opportunities for anito-cel, including likelihood of healthcare professionals to prescribe; benefits of the collaboration with Kite, including benefits from Kite Konnect, sales coverage and impact on financial metrics; our future financial condition, results, strategy, operations and prospects, including cash runway, costs, margins, and profitability and operational and cash efficiency; and the plans and objectives of management, including plans and expectations relating to launch readiness and commercial launch activities. In some cases, you can identify forward-looking statements by terminology such as "anticipate," "assume," "believe," "can," "contemplate," "continue," "could," "design," "estimate," "expect," "imagine," "intend," "likely," "may," "might," "objective," "ongoing," "plan," "positioned," "potential," "predict," "project," "seek" "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, including those set forth in Part II, Item 1A (Risk Factors) in the Quarterly Report on Form 10-Q for the quarter ended September 30, 2025, filed with the Securities and Exchange Commission (SEC) on November 5, 2025, and the other documents that we may file from time to time with the SEC. New risk factors emerge from time to time and it is no 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. As a result of these risks and others, including those set forth in our filings with the SEC, actual results could vary significantly from those anticipated in this presentation, and our financial condition and results of operations could be materially adversely affected.

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. No representation is made as to the safety or effectiveness of these product candidates for the use for which such product candidates are being studied. The presentation also includes select interim and preliminary results from an ongoing clinical trial as of specific data cutoff dates.

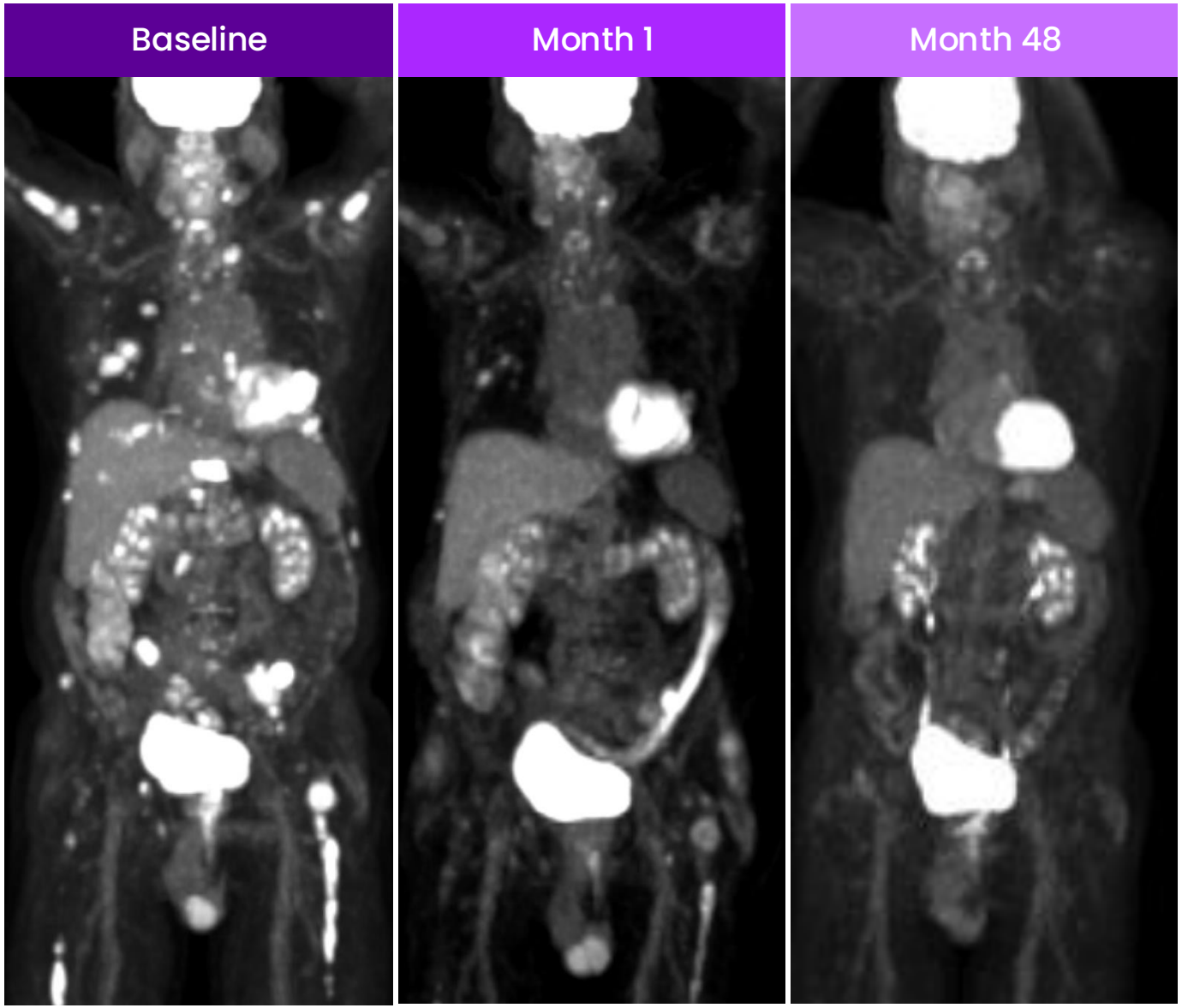
Such results should be viewed with caution as final results may differ as additional data becomes available. Until finalized in a clinical study report, clinical trial data presented herein remain subject to adjustment as a result of clinical site audits and other review processes. Cross-trial comparisons 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. 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 we have not independently verified the accuracy or completeness of the data contained in these industry publications and other publicly available information. Accordingly, we make no representations as to the accuracy or completeness of that data.

ARCELLX®

A Different Kind of Company Delivering A New Class Of CAR T

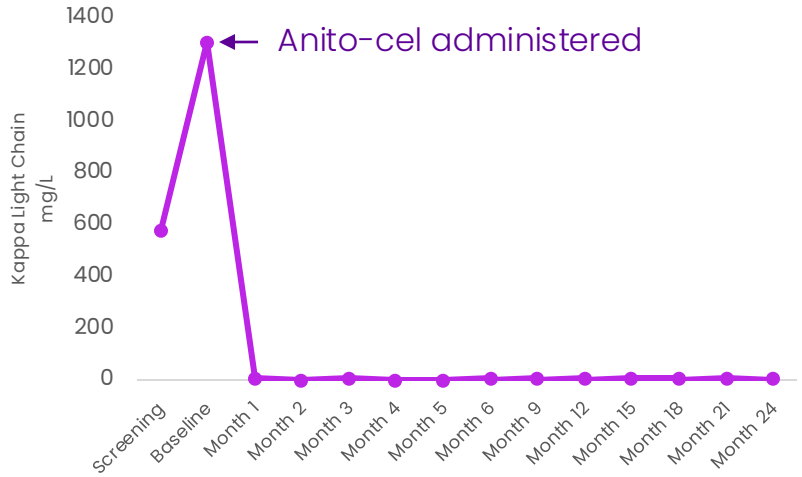
- Designed and developed the potential best RRMM therapeutic option leveraging our novel D-Domain
- Partnered with Kite to reliably deliver anito-cel at scale and rapidly enter a $12B+ RRMM market
- Establishing a scalable business model with anticipated near term profitability; 70% gross margin expected at launch

Early Anito-cel Patient with Extramedullary Disease



Patient Disposition

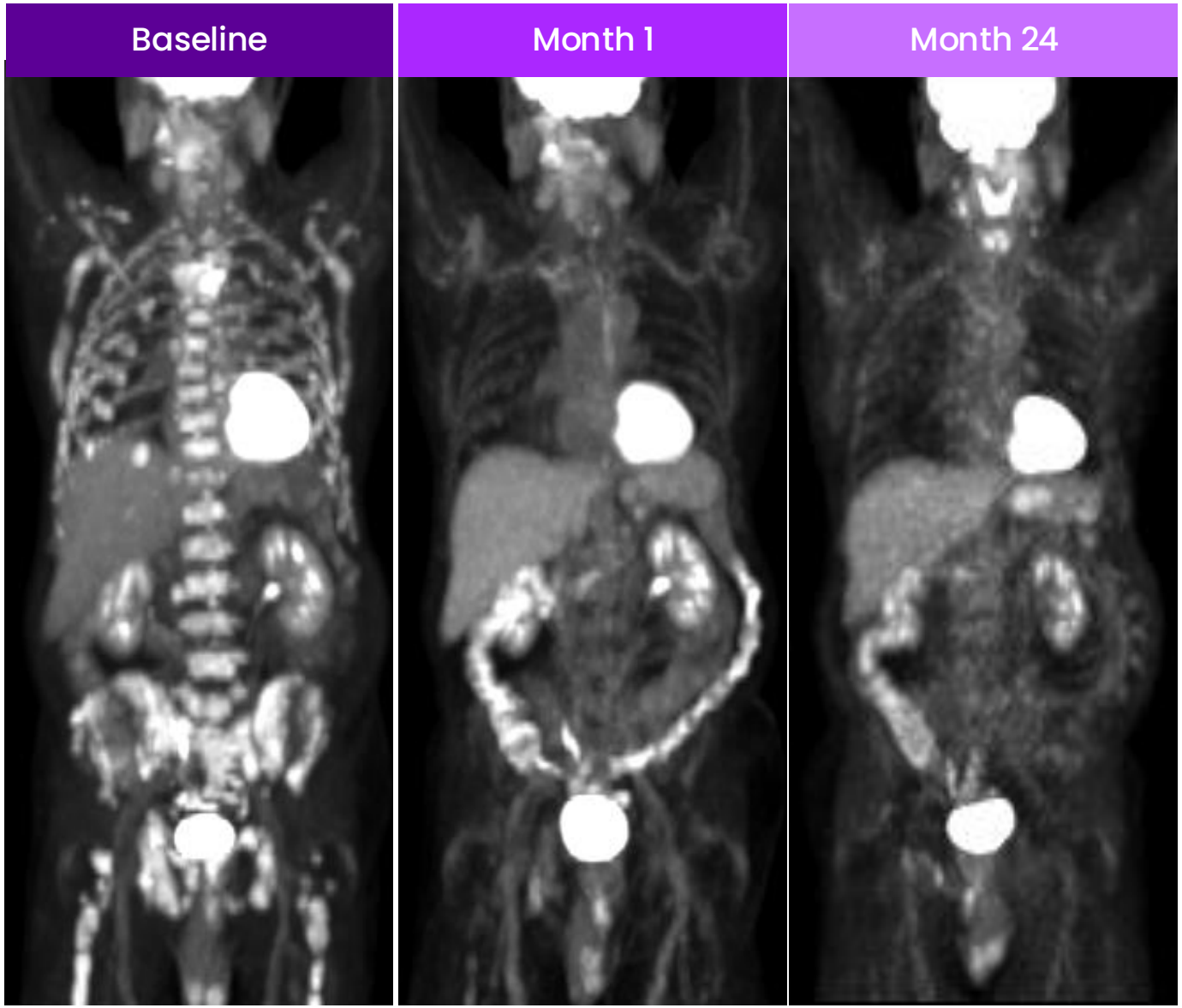
Infusion Date: 4/6/2020



- Patient was a 75-year-old male with 95% BMPC, extensive extramedullary disease, and high-risk cytogenetics with 1q gain
- PET/CT resolution at Month 1
- MRD negative to 10^{-6}
- Patient remains in sCR >5 years after infusion

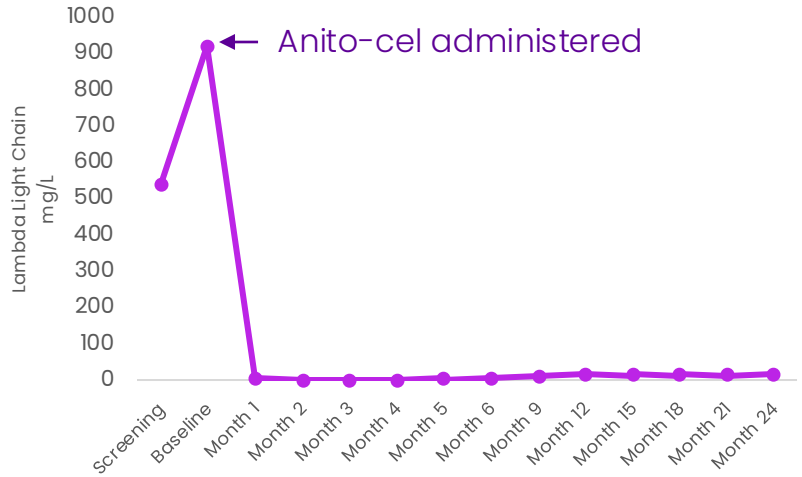
Source: Anito-cel Phase 1 study

First Patient Dosed Still in Complete Response



Complete response maintained >5 years post anito-cel infusion

Infusion Date: 2/10/2020

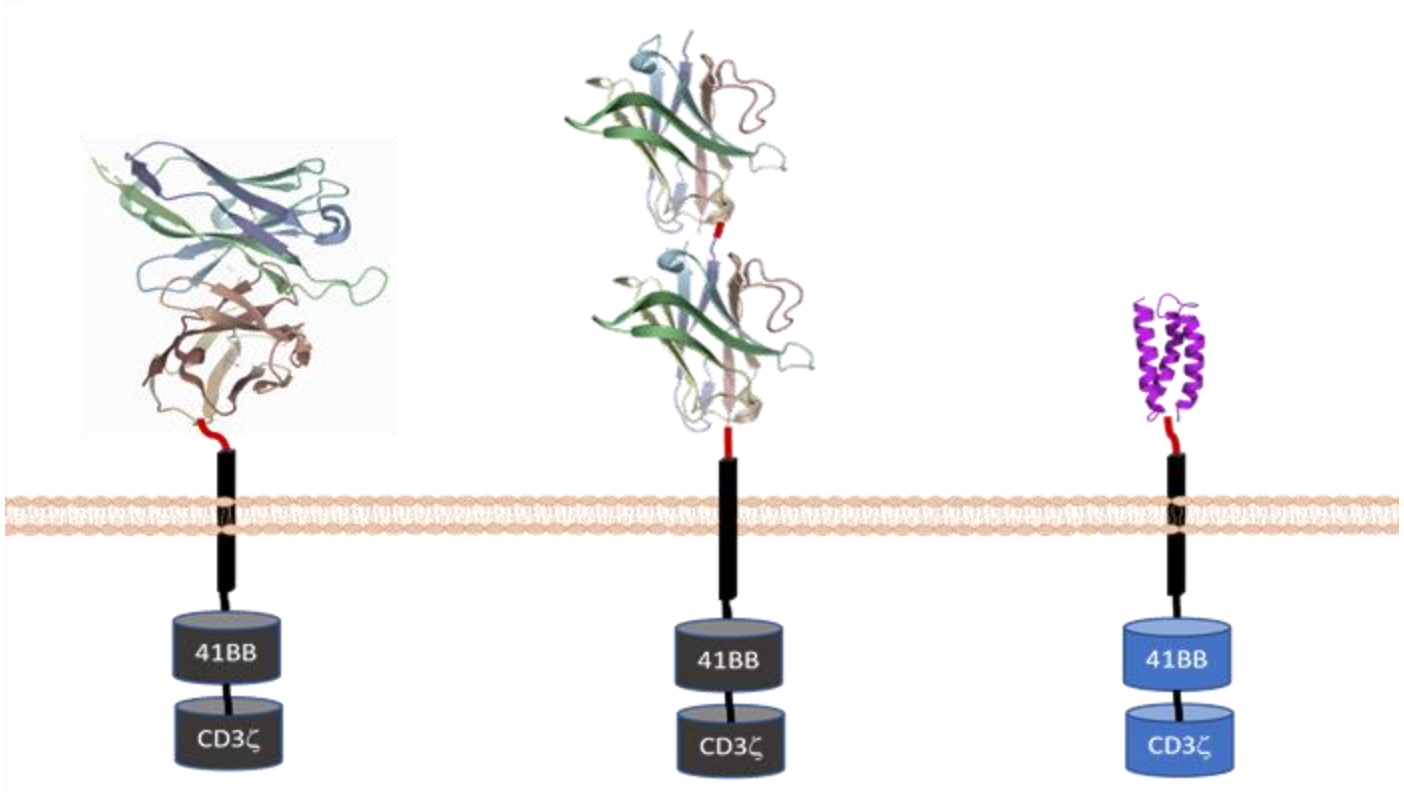


- Patient was a 73-year-old male with 95% BMPC, extensive extramedullary disease, and high-risk cytogenetics with t(4;14)
- PET/CT resolution at Month 1
- MRD negative to 10^{-6}
- Patient remains in sCR >5 years after infusion

Source: Anito-cel Phase 1 study

Anitocabtagene Autoleucel (anito-cel)

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



scFv
(~25 kDa)

Bivalent camelid VHH
(~30 kDa)

D-Domain
(~8 kDa)

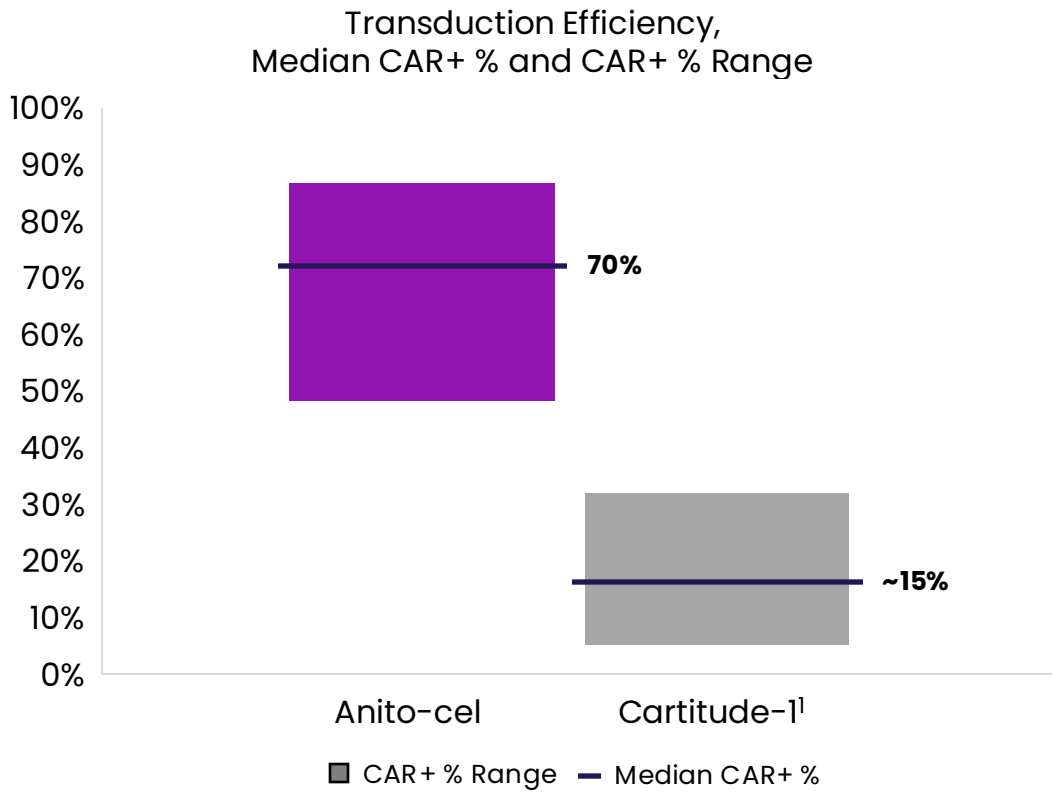
Anito-cel attributes from novel D-Domain	
Low total cell dose	Small D-Domain construct facilitates high transduction efficiency and CAR positivity, which permit a low total cell dose
Lack of tonic signaling	Rapid folding, lack of disulfide bonds, and a hydrophobic core enables D-Domain stability and lack of tonic signaling[5,6]
Optimal tumor cell killing	The D-Domain has a fast off-rate[4] and high CAR surface expression.[3,4] This combination may allow optimal tumor cell killing without prolonged inflammation

BCMA is B-cell Maturation Agent; CAR T is Chimeric Antigen Receptor T cell

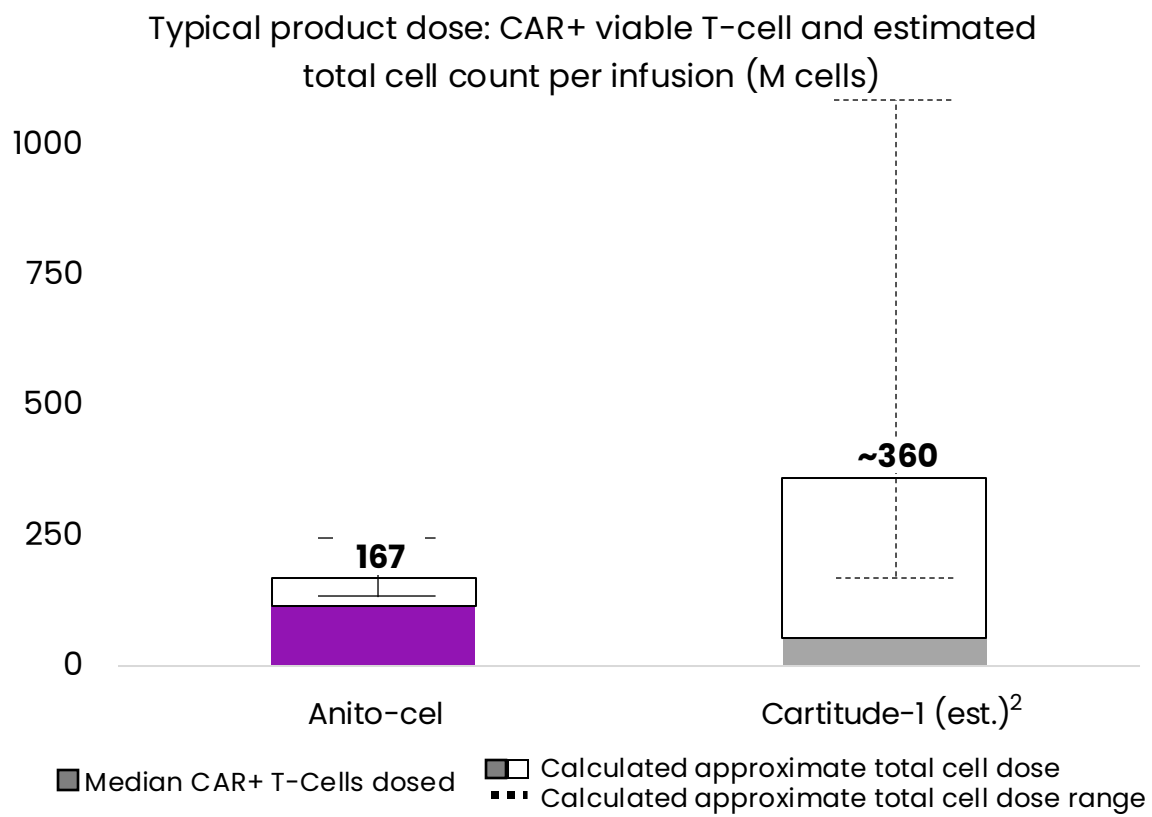
[1]Rotte, et al. Immuno-Oncology Insights 2022; 3(1), 13–24; [2]Frigault, et al. Blood Adv. 2023; 7(5):768-777; [3]Cante-Barrett, et al. BMC Res. Notes 2016; 9:13; [4]Buonato, et al. Mol. Cancer Ther. 2022; 21(7):1171-1183; [5]Zhu, et al. Proc. Nat. Acad. Sci. 2003; 100(26): 15486-15491; [6]Qin, et al.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

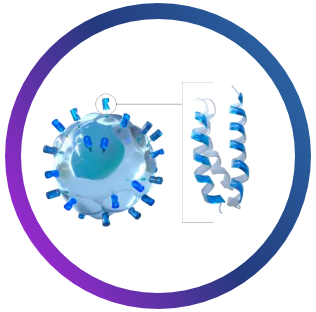


Higher total cell dose has been found to be a key risk factor for both severe CRS and severe neurological toxicities[3]

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

Potential to be the Best Therapeutic Option for RRMM Patients

Anito-cel: A new class of CAR T



Powered by our novel D-Domain

Other BCMA CAR Ts
Best efficacy and high QoL[1,2]

- Highest response rates (ORR and CR)
- Deep and durable response (mPFS, mOS and sustained MRD negativity)
- Curative potential[3]
- Single dose treatment with a treatment free period

- **Potential Best-in-Class CAR T *EFFICACY*** even in high-risk patients
- **Improved *SAFETY*** with no delayed neurotoxicity
- **Rapid & Reliable *MANUFACTURING*** enabled by Kite
- **Reflective of anticipated future *CLINICAL PRACTICE*** (ex: high % anti-CD38 refractory)

BCMA Bispecifics
Broadly available[1,4]

- Low incidence of CRS and ICANS
- No delayed neurotoxicities
- Abundant supply
- Rapid availability (no delays / risk of disease progression)

[1]Slide 15; [2]Myeloma.org, CAR T-cell Therapy; [3]Cancer Network ONCOLOGY® Companion, Volume 39, Supplement 7 Issue 7 Pages: 18-19; [4]Myeloma.org, Bispecific Therapies.
CR, complete response; CRS, cytokine release syndrome; ICANS, immune-effector cell-associated neurotoxicity syndrome; mOS, median overall survival; mPFS, median progression-free survival; MRD, minimal residual disease; ORR, overall response rate; QoL, quality of life

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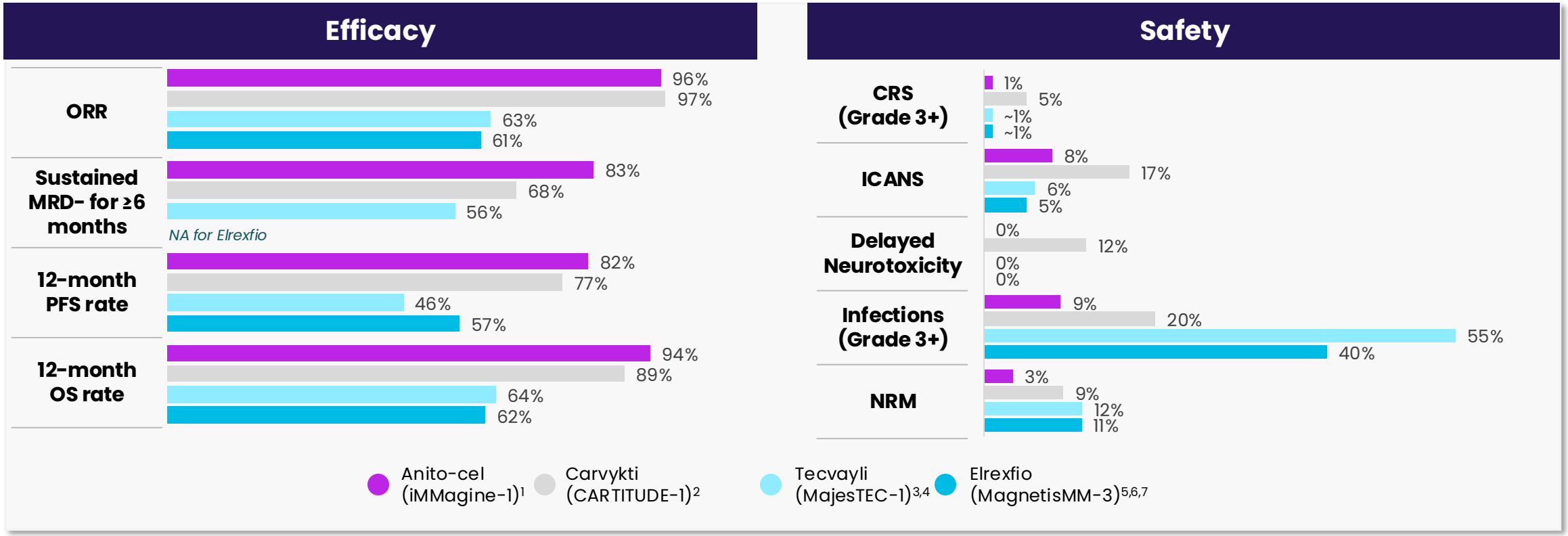
Competitive Landscape

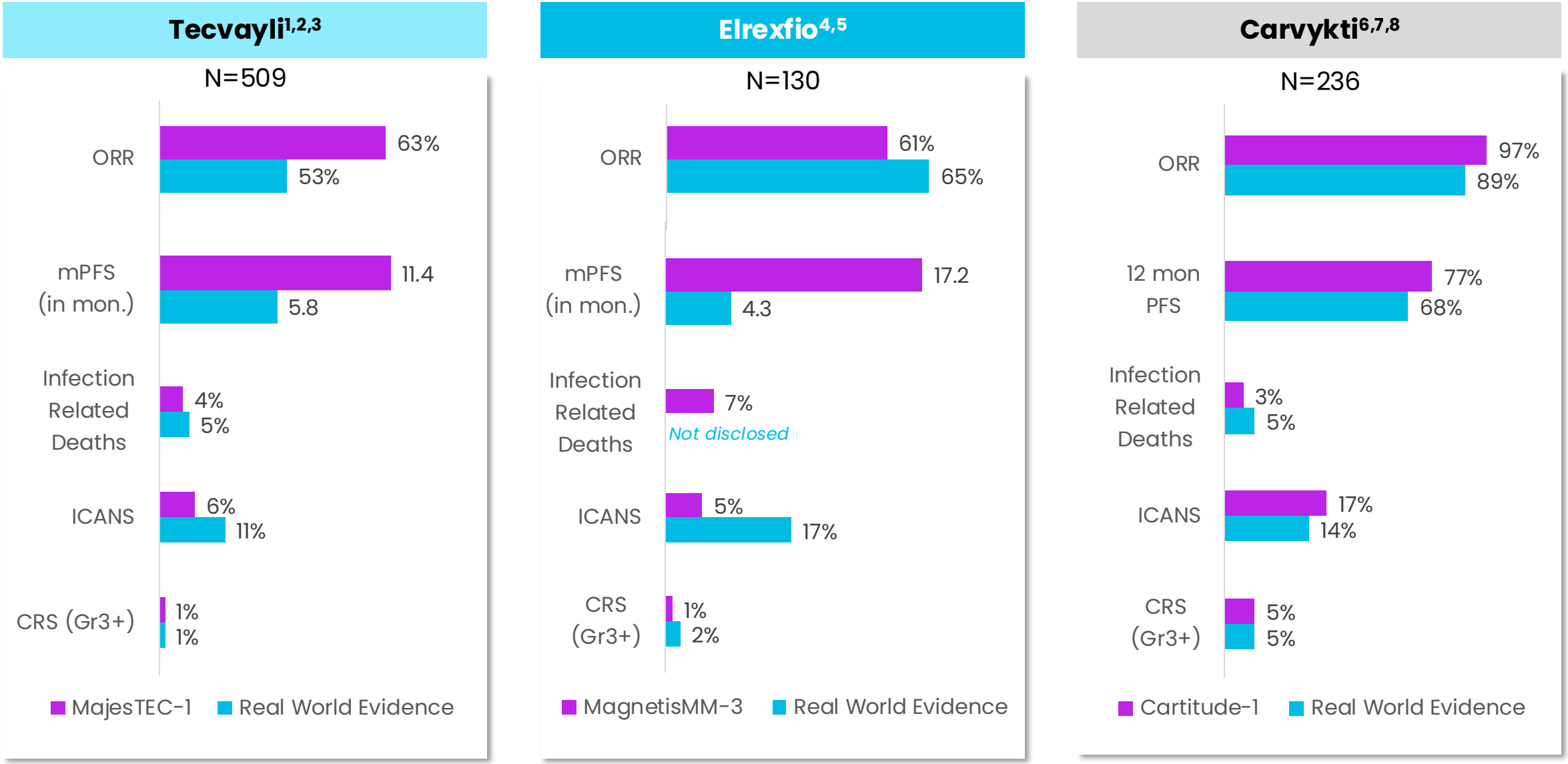
Anito-cel Clinical Profile Uniquely Combines Best of CAR Ts and Bispecifics



- **Bispecifics significantly trail CAR T efficacy**, with lower mPFS (4-7 months) in real world data[8,9]
- **~40-50% of patients experience ≥ Grade 3 infections with bispecifics**, versus 9% with anito-cel
- **~14% of bispecific clinical trial patients discontinued therapy due to AEs**[7]

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.
[1]Patel et al., Oral Presentation, ASH (Dec 2025), Data cut-off Oct 7, 2025; [2]Berdeja et al. (2021); [3]Oriol et al. (2024); [4]Teclistamab FDA label; [5]Mohty et al. (2023); [6]Elranatamab FDA label; [7]Lesokhin et al. (2023); [8]Portuguese et al. ASH 2025 (Abstract 136); [9]Razzo et al. (2025); NRM, non-relapse mortality.

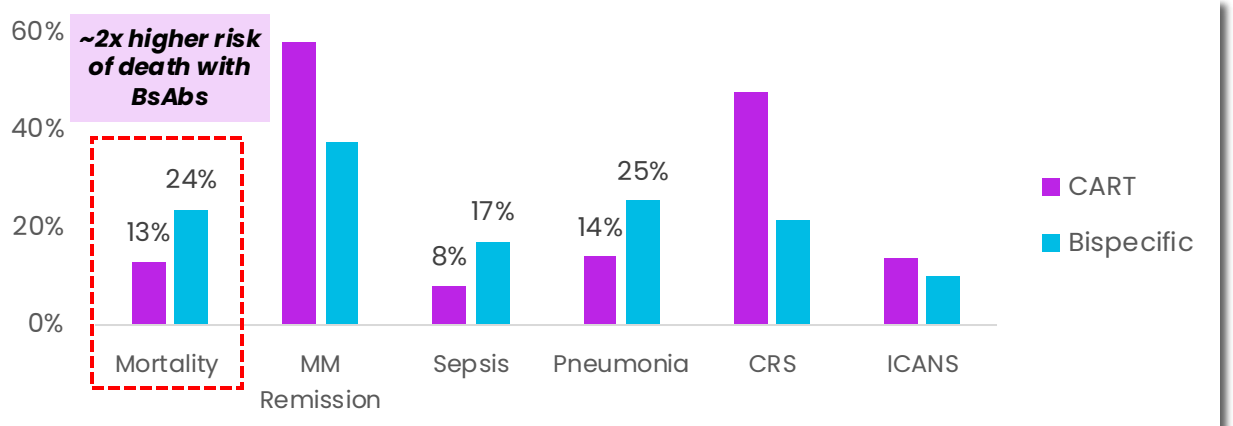
Bispecific Efficacy and Safety Worse in the Real World Compared to Trial Data while CAR T Real World Efficacy and Safety is Largely Consistent with Trial Data



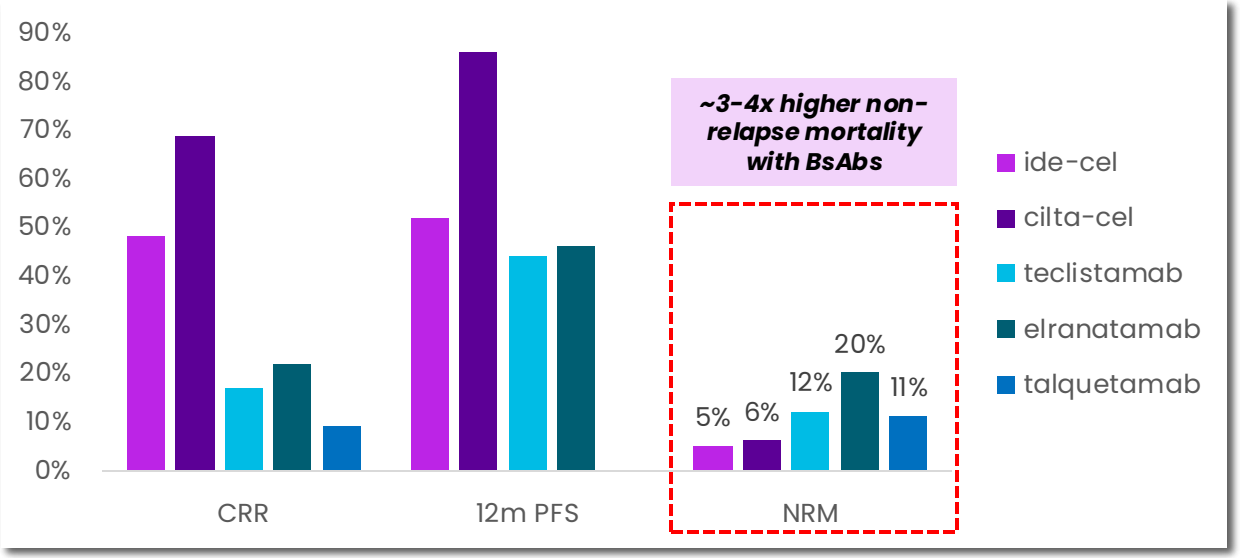
[1]Razzo et al. (2025); [2]Oriol et al (2024); [3]Tecvayli FDA label; [4]Portuguese et al. ASH 2025 (Abstract 136); [5]Tomasson et al. (2024); [6]Sidana et al. (2025); [7]Madduri et al. (2020). [8]Lin et al, ASCO 2023.
Data above are not from head-to-head studies. Cross-trial data interpretation should be considered with caution as it is limited by differences in median follow-up, study population, design, and other factors.

Infections and Low Efficacy Together Drive 2x Higher Mortality and Non-Relapse Mortality (NRM) for Bispecifics versus CAR T in RWE

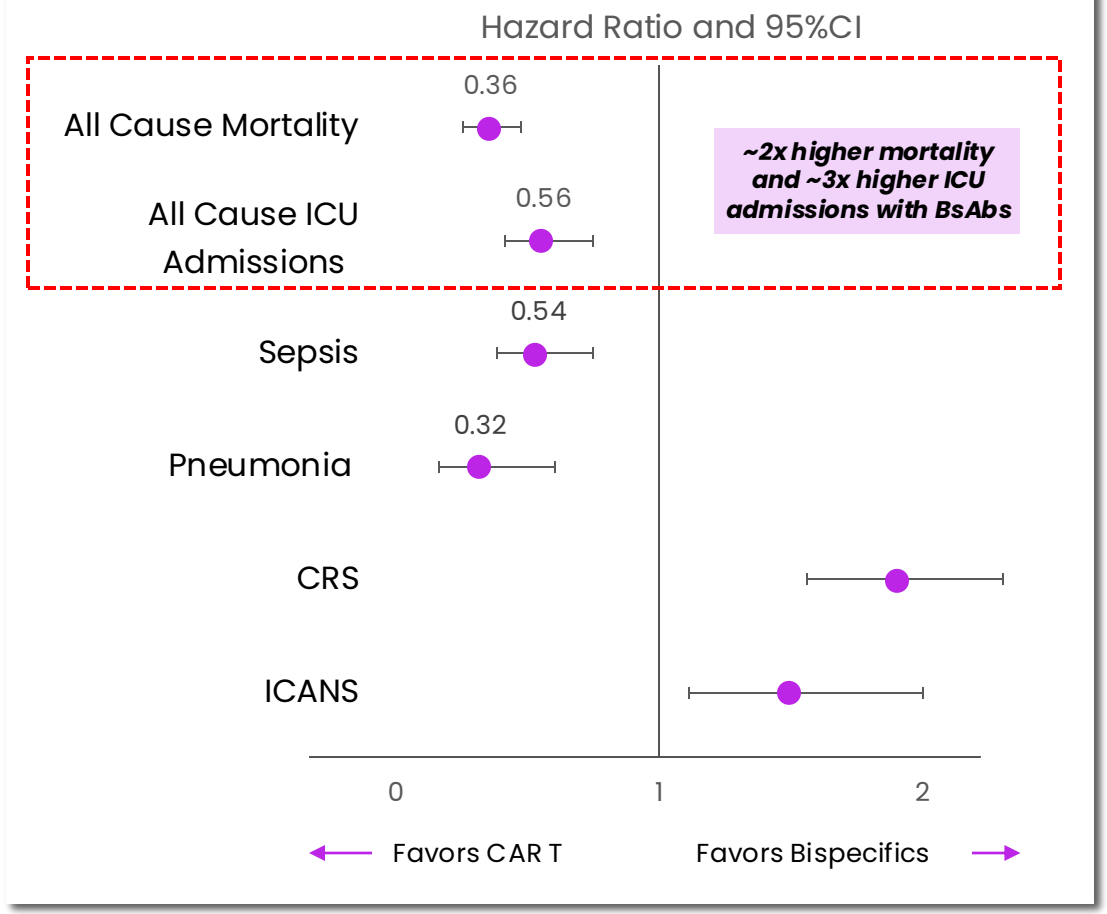
CAR T confers significantly higher remission and survival rates compared to the bispecific antibodies[1]



CAR Ts demonstrated higher PFS and CRR with significantly lower non-relapse mortality[2]

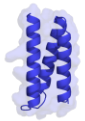
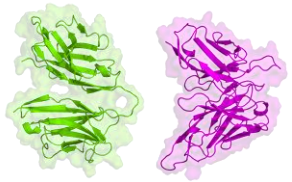


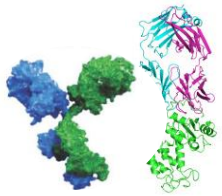
CAR Ts demonstrated substantially lower risk of mortality and ICU admission compared with BsAbs[3]



[1]Qadri et al, ASH 2025 (Abstract 2286); [2]Merz et al, ASH 2025 (Abstract 4590); [3]Tan et al, ASH 2025 (Abstract 2799).
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.

Best-in-Indication Potential Compared to all RRMM Classes of Therapies



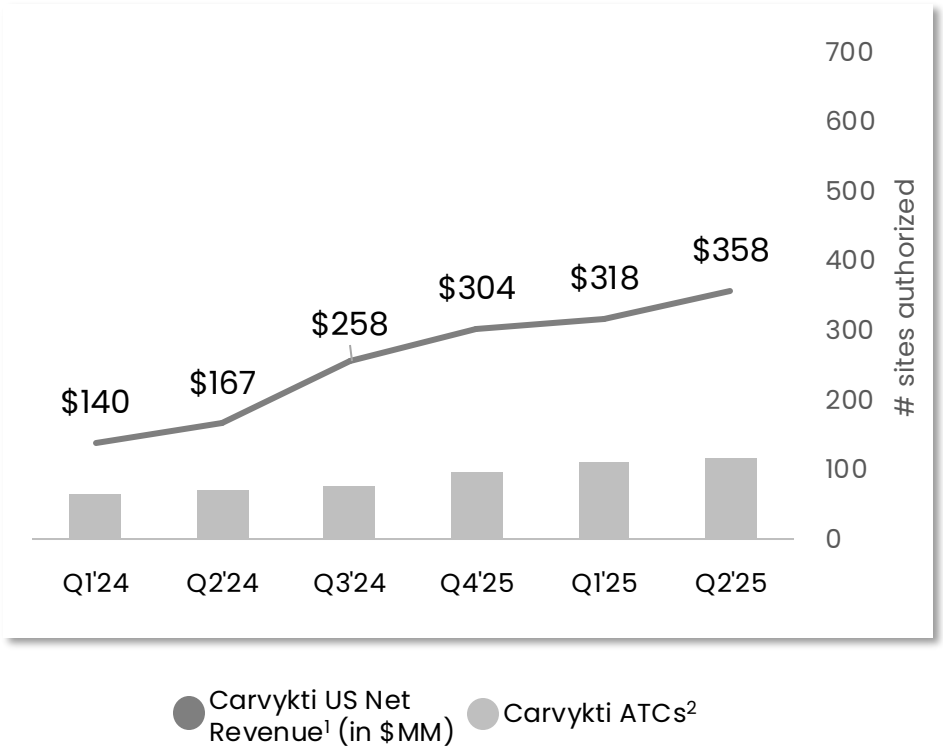
		Anito-cel[1,2,3]	BCMA CAR Ts[3-6]	BCMA Bispecific Monotherapy[7-11]	BCMA Bispecific Combination Therapy[8,12]
Modality Profile	**Single-Dose Treatment**	✓	✓	✗	✗
	Curative Potential	✓	✓	✗	✗
Therapeutic Profile	**High Depth of Response** MRD negativity ≥ 90%	✓	✓	✗	✗
	High PFS mPFS ≥ 30 months	✓	✓	✗	✓
	Low ICANS ≤ 10% (any grade)	✓	✗	✓	✓
	No Delayed or Non-ICANS Toxicities	✓	✗	✓	✓
	Low Grade 3+ infections ≤ 10%	✓	✗	✗	✗
	Low Grade 3+ CRS ≤ 5%	✓	✗	✓	✓
Commercial Profile	**Rapid Turnaround Time** ≤ 3 weeks	✓	✗	✓	✓
	High Scalability Abundant supply at launch	✓	✗	✓	✓

[1]Patel et al., Oral Presentation, ASH (Dec 2025); [2]Bishop et al. (2024); [3]Cancer Network ONCOLOGY® Companion, Volume 39, Supplement 7 Issue 7 Pages: 18-19; [4]Usmani et al 2021; [5]Berdeja et al. 2021, [6]Jangannath et al. 2025; [7]Garfall et al. 2024; [8]Teclistamab FDA label; [9]Tomasson et al. 2024; [10]Lesokhin et al. 2023; [11]Elranatamab FDA label; [12]Mateos et al. ASH 2025, Abstract LBA-6.
Launch period is defined as 12 months post approval.
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.

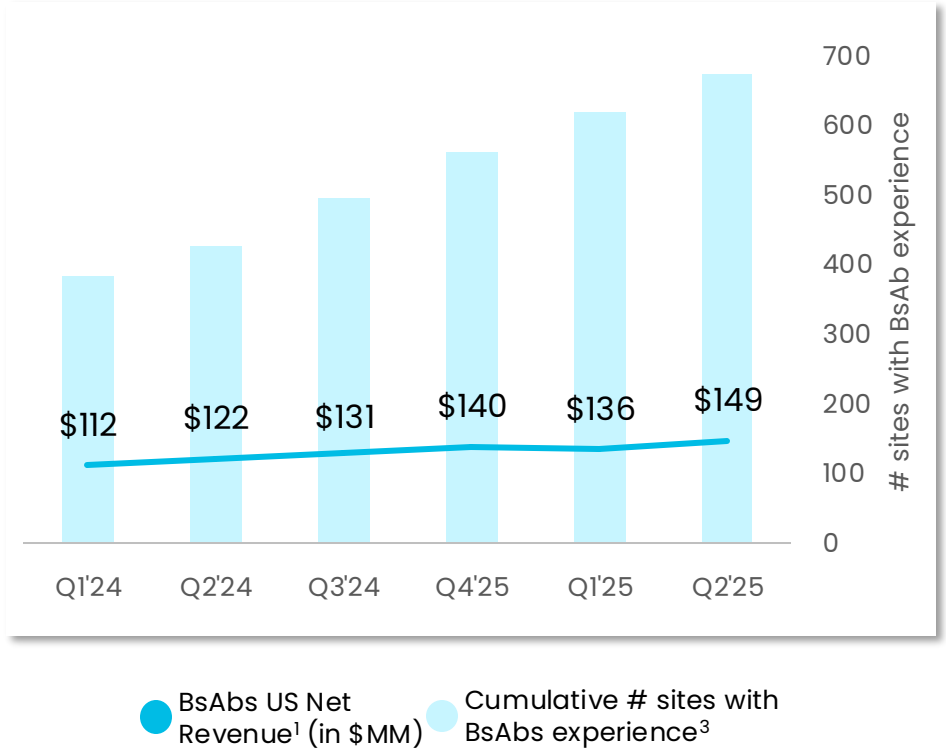
US BCMA CAR T Revenue Has Grown Despite Limited Footprint

Bispecifics Have Not Grown Despite Expanding Footprint

US Carvykti Revenue and ATC Footprint



US BCMA BsAb Revenue and Footprint



- CAR T sales continue to grow despite capacity constraints and limited ATC footprint for current products
- BsAb sales have stayed relatively flat even as community footprint grows

[1]Based on quarterly earning calls
[2]Based on internal quarterly tracking of ATCs (Authorized Treatment Centers); [3]Based on cumulative # sites using BsAb (bispecifics) as observed in Komodo claims data

Anito-cel: Launching the Best Therapeutic Option for RRMM Patients

Expand CAR T Class Share With Potential Best-in-Class Profile

- Anito-cel expected to **expand MM CAR-T class by ~2x** due to differentiated profile
- iMMagine-1 pivotal trial **consistent with Phase 1 findings**[1,2]
- **Zero cases of delayed or other non-ICANS neurotoxicity** in >150 patients treated with anito-cel to date

Launch with Broad Reach and Abundant Supply

- Unparalleled access with **165+ ATCs in US** and 570+ ATCs globally[3]
- **Abundant supply** planned for majority of 4L+ at launch; scaling to all 4L+ in 2027
- Kite's manufacturing enabling rapid target **≤17d turnaround time**[4]

Broadening Access by Reaching Patients Where They Are

- **iMMagine-3 is rapidly enrolling** 2L+ patients with broadest eligibility
- **GEM-AnitoFIRST study**, safety lead-in for **iMMagine-4 (NDMM study)**
- **iMMagine-5 study** to demonstrate anito-cel dosing in the community setting

[1]Interim anito-cel Phase 1 data as of October 3, 2024; [2]Interim iMMagine-1 data, data cut as of Oct 7, 2025; [3]Based on latest ATC tracking and Q3'25 Gilead earnings; [4]Targeting 17 days TAT in US similar to current iMMagine-3 US TAT of 17 days as of Oct 2025

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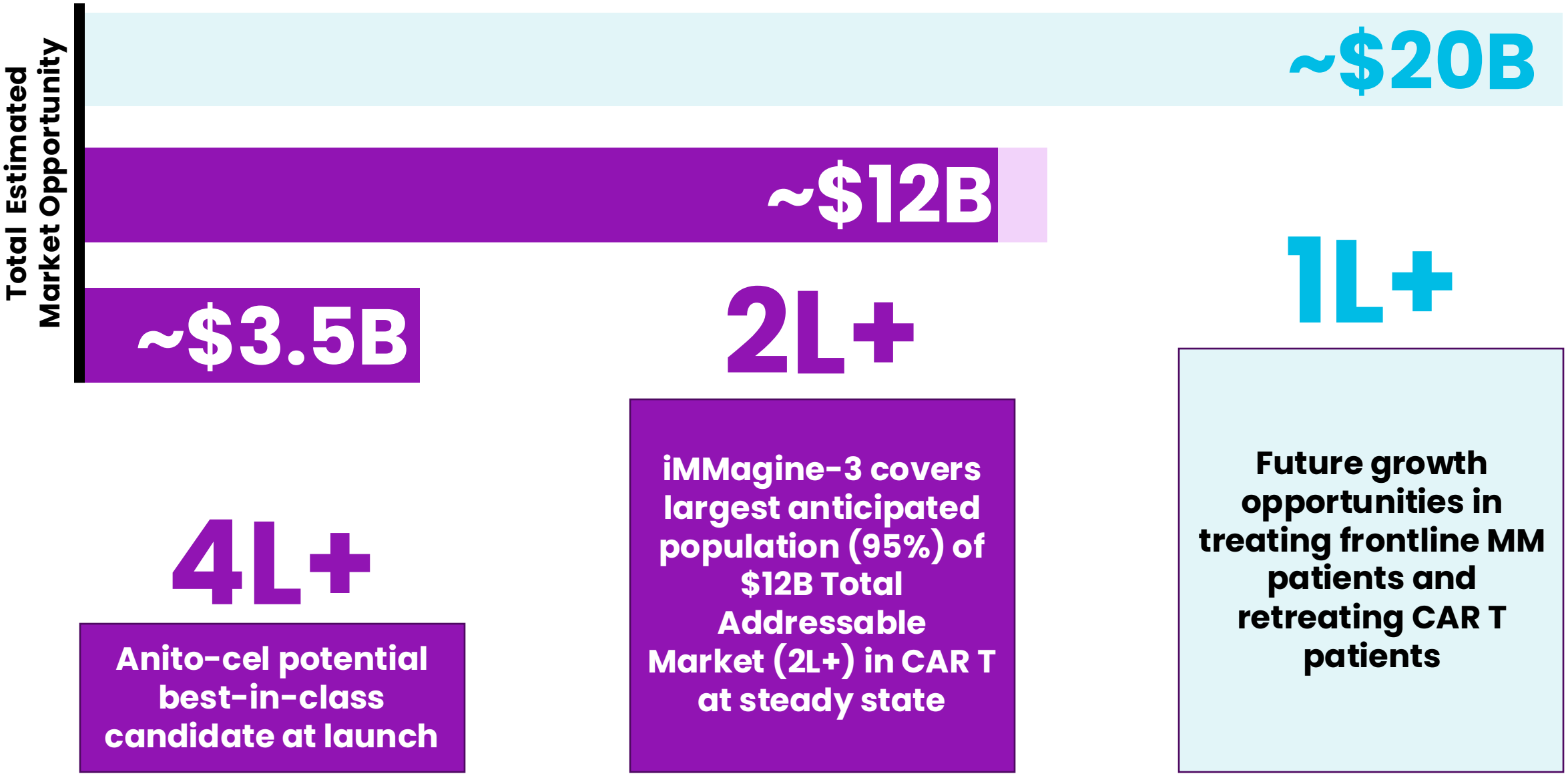
Market Overview and Launch

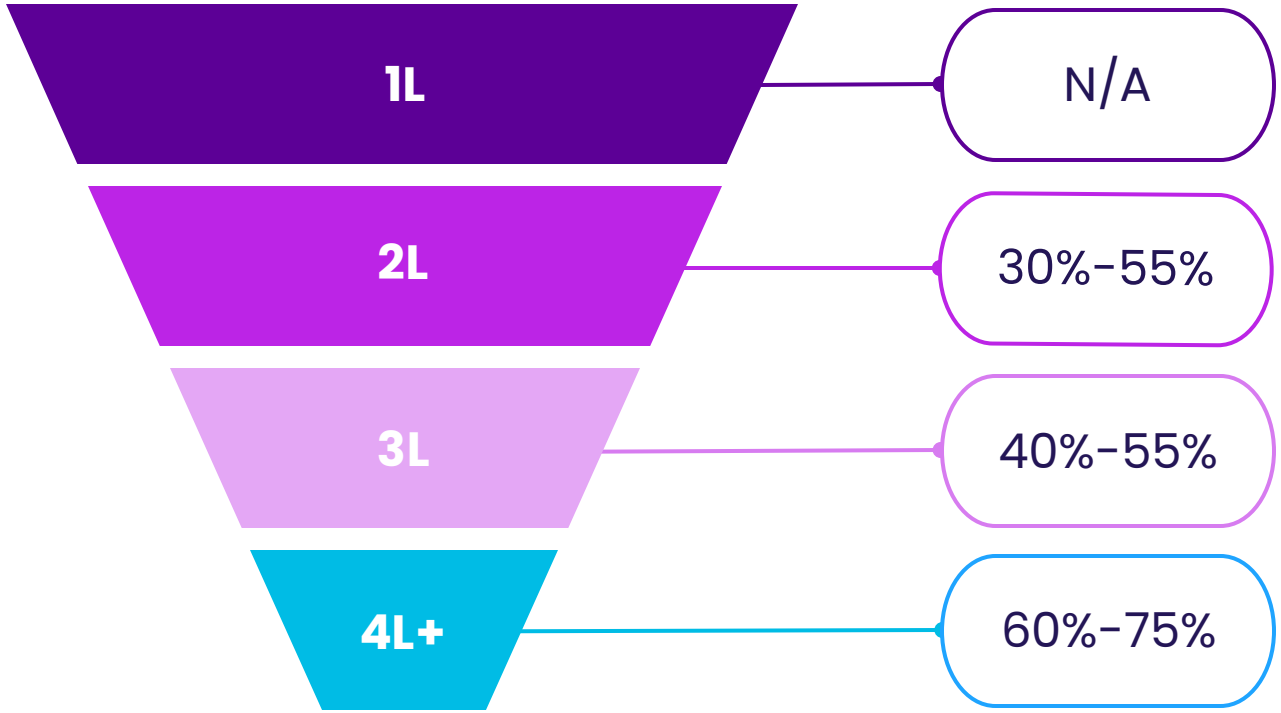
Multiple Myeloma is a Large Global Market Opportunity for CAR T



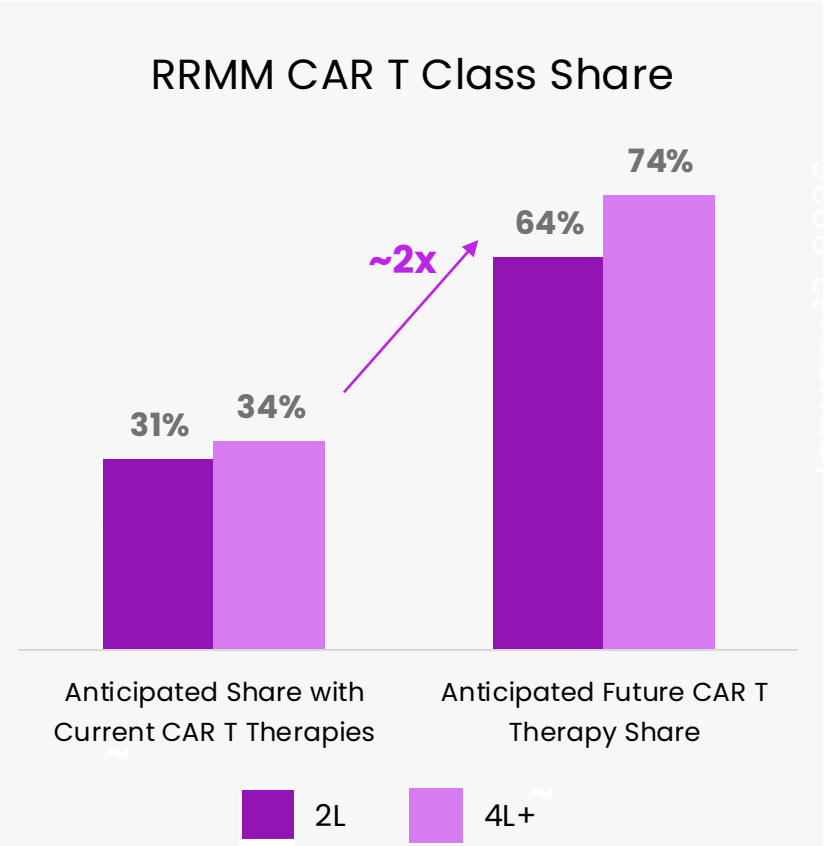
Note: Based on internal projections and estimates of 2024 MM Incidence, which management believes are reasonable and accurate; key assumptions include: 2L+ steady-state figures in US, EU7, Canada, Australia, and Japan and 75% anti-CD38 utilization in frontline by 2028E

Anito-cel Is Expected to Drive Broader Patient Adoption for CAR T

Multiple Myeloma by LoT



Anticipated Future US CAR T Class Shares[1]



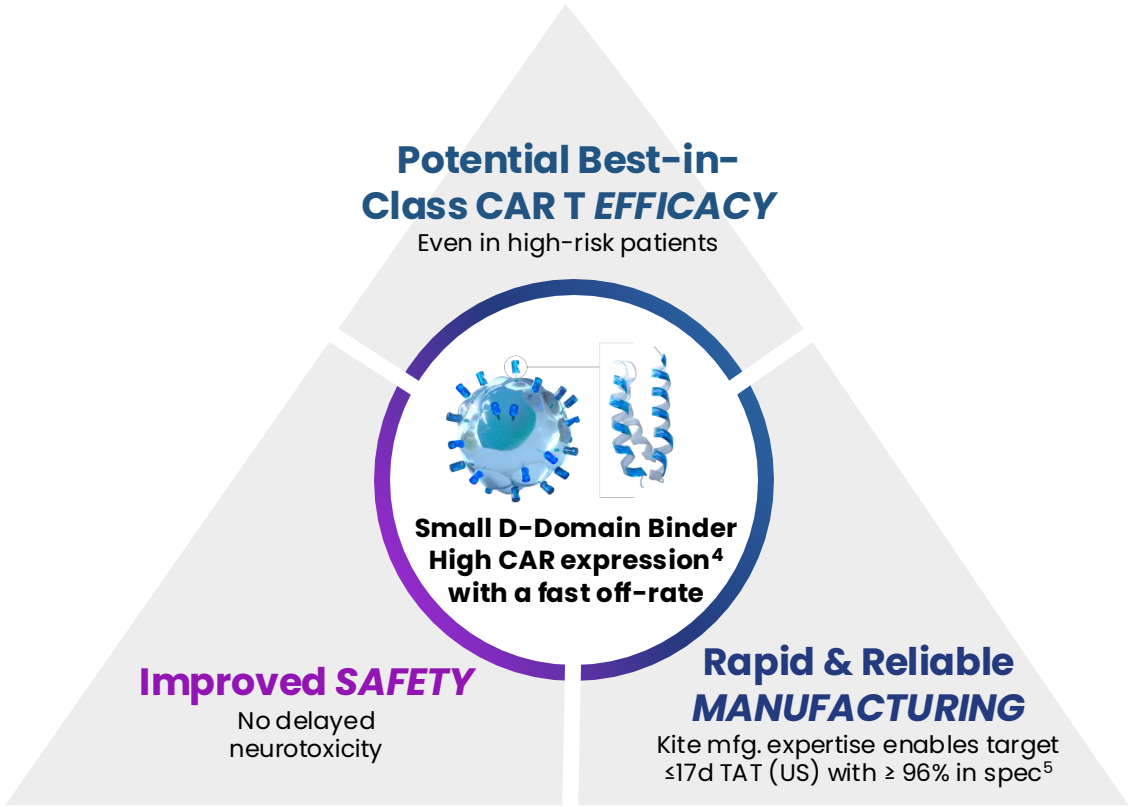
Note: Based on internal projections and estimates of 2024 MM Incidence, and anticipated share byLoT, which management believes are reasonable and accurate, key assumptions include: 2L+ steady-state figures in US, EU7, Canada, Australia, and Japan and 75% anti-CD38 utilization in frontline by 2028E

[1]Peak class share assuming current therapies as cilta-cel (2L+), and ide-cel (3L+), and future including anito-cel (2L+) and arlo-cel (2L+). Based on combination of quantitative market research conducted in 2025 with 152 US Hematologists/Oncologists (including treaters and referrers)

Anito-cel Has the Potential to Be the Best Therapeutic Option for RRMM Patients Expanding CAR T Use

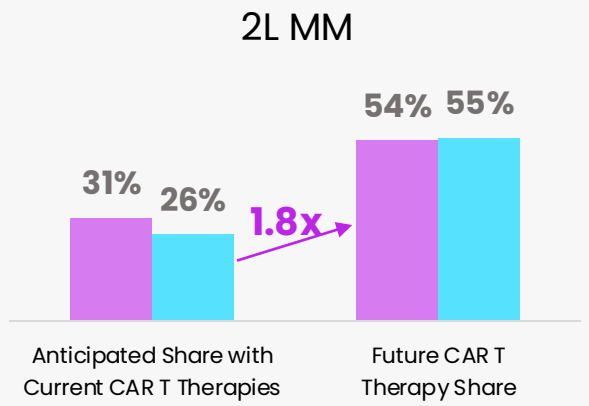
Addressing CAR T Drivers of Adoption:

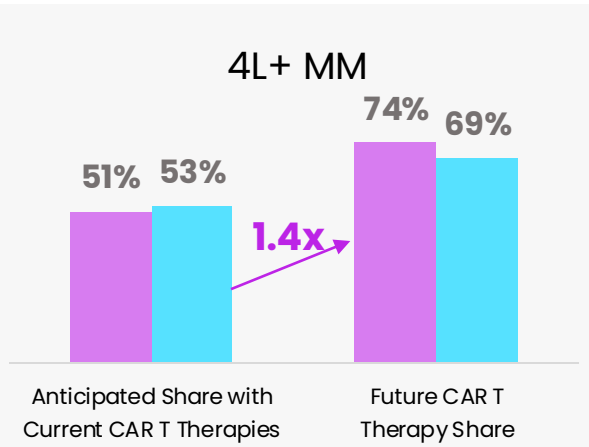
Anito-cel has the potential to unlock broader patient eligibility for CAR T than ever before.



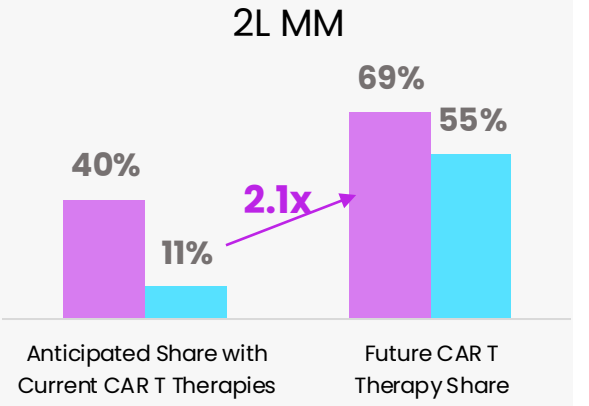
Future US CAR T Class Shares[1]

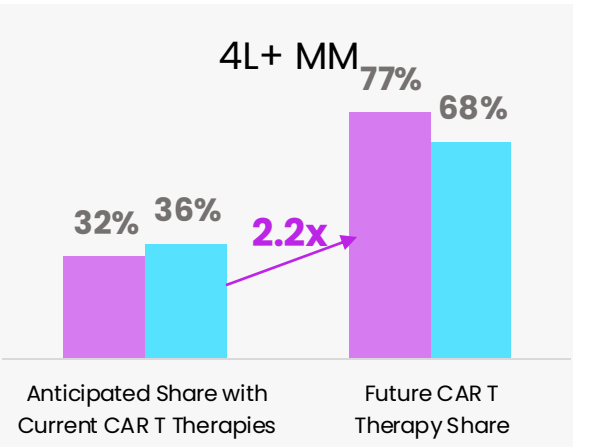
2024 Market Research[2]





2025 Market Research[3]



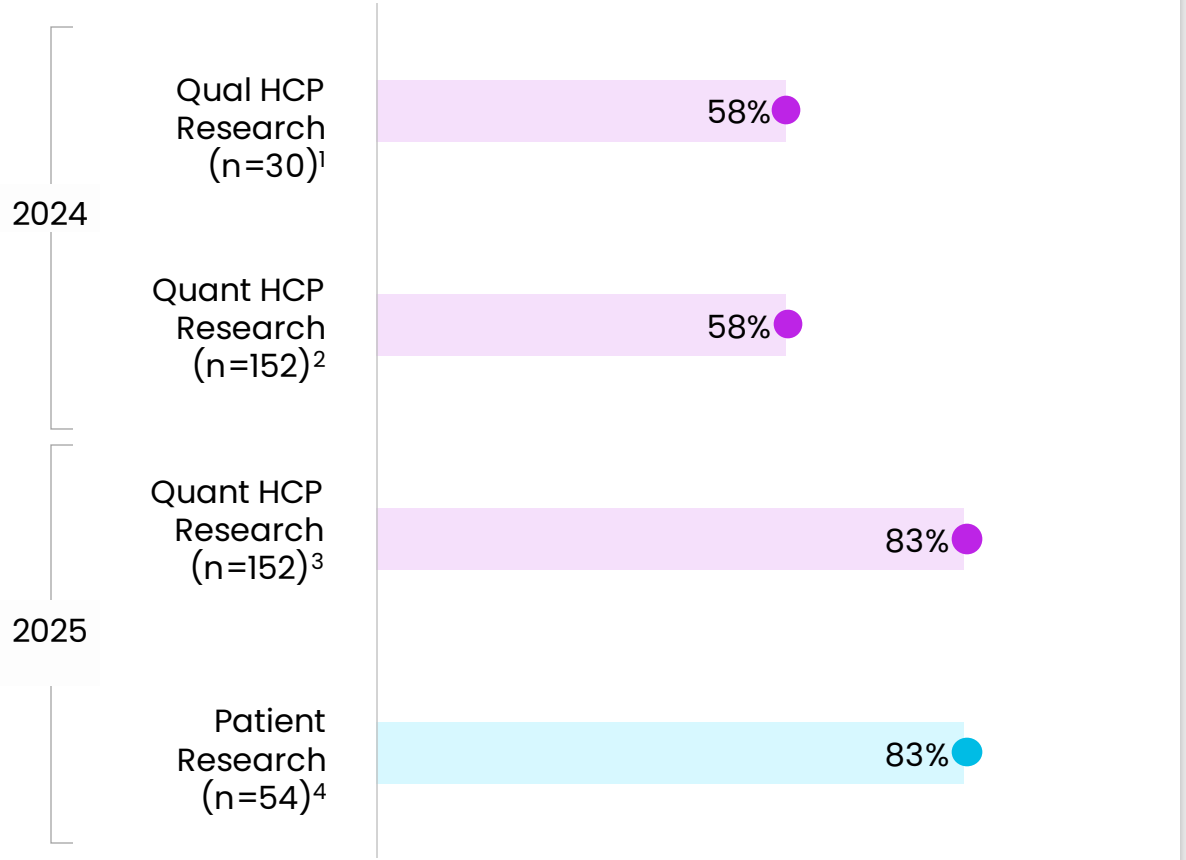


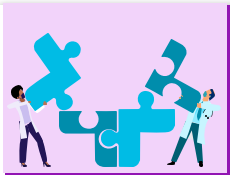
Treaters Referrers

[1]Peak class share assuming current therapies as cilta-cel (2L+), and ide-cel (3L+), and future including anito-cel (2L+) and arlo-cel (2L+)
[2]Based on a quantitative market research conducted in 2024 with 152 US Hematologists/Oncologists (including treaters and referrers)
[3]Based on a quantitative market research conducted in 2025 with 152 US Hematologists/Oncologists (including treaters and referrers)
[4]Fast off rate: Buonato, et al. Mol. Cancer Ther. 2022; 21(7):1171-1183; High CAR expression: Cante-Barrett, et al. BMC Res. Notes 2016 9:13; Buonato, et al. Mol. Cancer Ther. 2022; 21(7):1171-1183
[5]In-spec rate based on experience with Kite's current commercial products in US as of Mar 2024

Anito-cel Poised to Be the Preferred BCMA CAR T in US

Anito-cel BCMA CAR T Product Preference





HCP Reactions to Anito-cel TPP [1,5]

"I would switch all of my patients to [Anito-cel TPP] … the success rate and turnaround time are the reasons I would make this change"
-HemOnc, Academic Hospital

"I would prefer [Anito-cel TPP] in 2L (compared to CARVYKTI). You have all the advantages and no disadvantage. The safety advantage is especially relevant for patients who may have an underlying neurologic disease."
– CAR T Treater

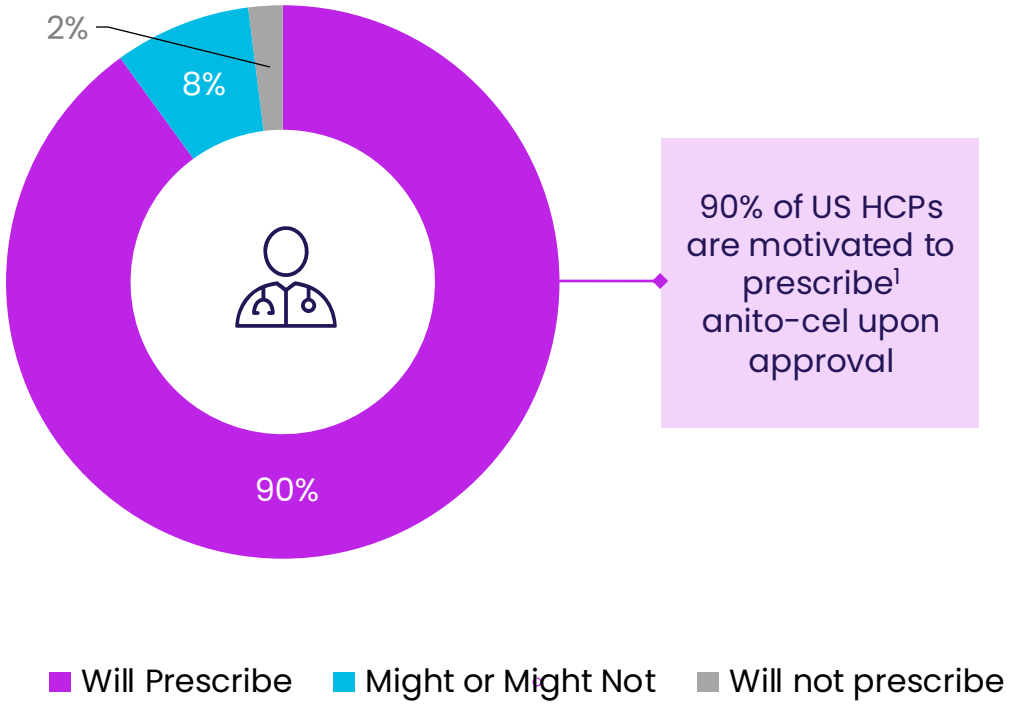
"Especially with Carvykti, there's a plethora of neurological disorders. There's parkinsonism and Bell's palsy. Those are major issues."
– HemOnc, Academic Hospital

"Everything [for Anito-cel TPP] looks favorable to me, when contrasting efficacy, safety, and manufacturing with CARVYKTI…. The best is that there is no delayed neurotoxicity. If the TAT is 2.5 weeks, then perhaps many patients will not need to worry about bridging. I think that's really good."
– CAR T Treater

[1]Based on a qualitative market research conducted in 2024 with 30 US Hematologists/Oncologists; [2]Based on a quantitative market research conducted in 2024 with 152 US Hematologists/Oncologists; [3]Based on a quantitative market research conducted in 2025 with 152 US Hematologists/Oncologists (including treaters and referrers); [4]Based on a quantitative market research from 2024 with 54 US MM patients that are CAR T knowledgeable (discussed CAR T with their oncologists); [5]Based on a qualitative market research from 2025 with 20 US Hematologists/Oncologists; Product preference and physician quotes are based on market research

Anito-cel Has Strong Likelihood to Prescribe and Will Rapidly Onboard within Kite's Leading ATC Footprint

Likelihood to Prescribe[1]

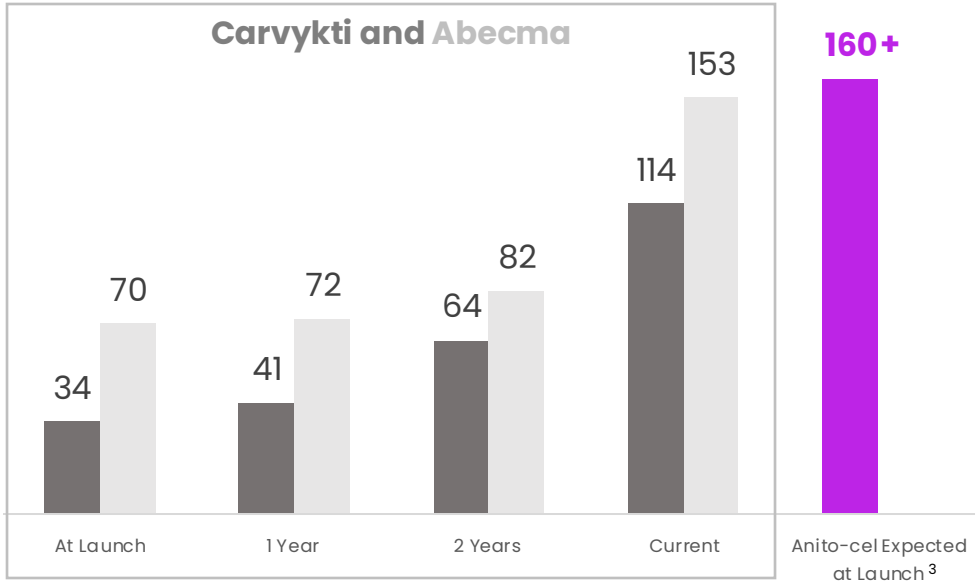


90% of US HCPs are motivated to prescribe[1] anito-cel upon approval

US ATC Onboarding[2]

Robust onboarding activities initiating in Q3 to ensure Kite's leading footprint of ATCs are ready to deliver anito-cel rapidly upon FDA approval

US Authorized Treatment Center Footprint



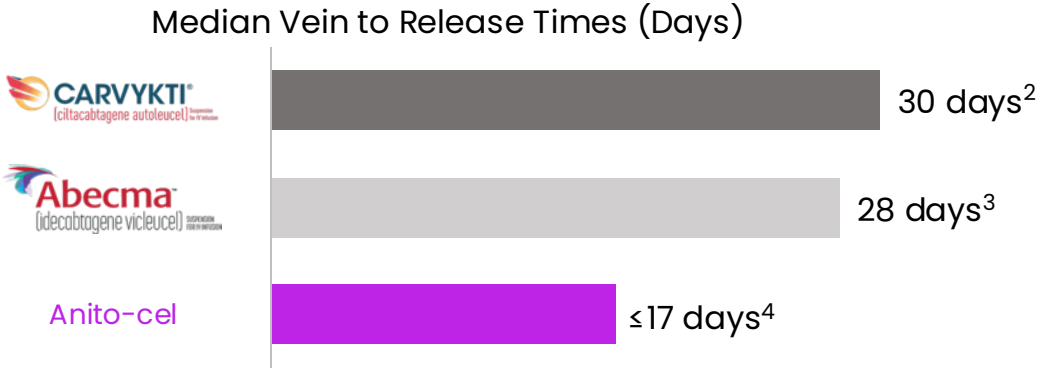
[1]Based on a quantitative market research conducted in 2024 with 152 US Hematologists/Oncologists (including treaters and referrers) who indicated likelihood to prescribe on a scale of 1 to 9, with a score of 6 above being characterized as will prescribe, a score of 5 as might or might not and a score of 4 or below as will not prescribe.;[2]Carvykti and Abecma numbers are based on snapshots of ATCs collected at the end of quarters and earnings presentations and Q4'23 IQVIA CAR T Landscape Report;[3]Anito-cel footprint is based on internal estimates and projections; Launch period is defined 12 months post approval

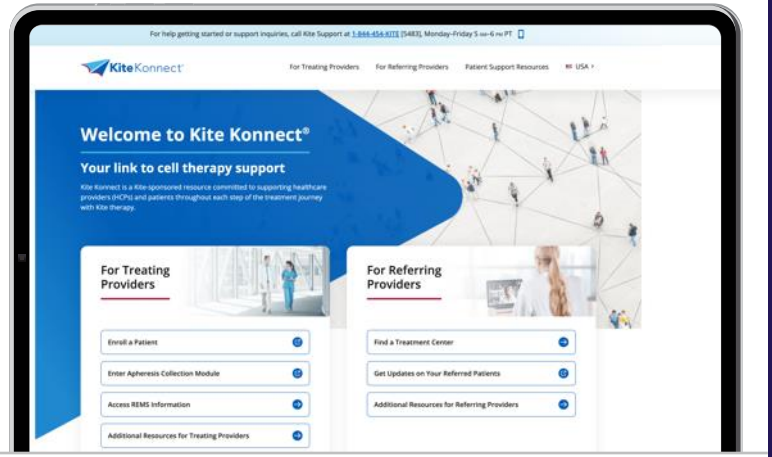
Built to Deliver: Kite's End-to-End System Combines World-Class Manufacturing with the Power of Kite Konnect®

Planning manufacturing capacity to capture majority of 4L+ at launch, scaling to all 4L+ in 2027 with a global potential of >24,000 doses[1]

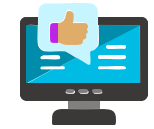
Leveraging Kite leadership in ATC footprint and manufacturing turnaround time

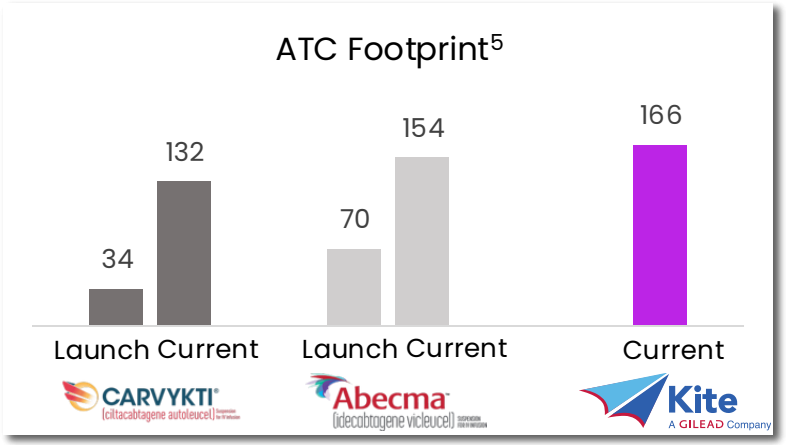
Kite, A GILEAD Company





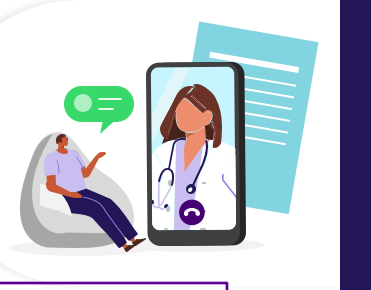
Anito-cel will leverage Kite Konnect®, enabling seamless site onboarding and patient registration





[1] Manufacturing capacity is established based on launch plan and forecast, >24,000 dose capacity by end of 2026 includes Kite's current commercial products and MM; [2] Based on Legend Biotech's Q3'25 earnings call; [3] Based on Abecma website noting approximately four weeks; [4] Targeting 17 days TAT in US similar to current iMMagine-3 US TAT of 17 days as of Oct 2025; Launch period is defined as 12 months post approval; [5] ATC footprint numbers are based on snapshots of ATCs collected at the end of quarters, earnings presentations and Q4'23 IQVIA CAR T Landscape Report

Anito-cel Clinical Trials Designed to Expand Patient Access



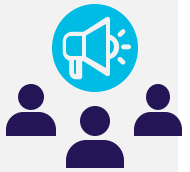
Fully enrolled	*Enrolling*	*To be initiated*	
iMMagine-1	**GEM-AnitoFIRST**	**iMMagine-3**	**iMMagine-4**	**iMMagine-5**
4L+ patients	NDMM patients	2L-4L patients	NDMM Patients	Community Trial
Pivotal phase 2 study assessing anito-cel's efficacy and safety in late line MM patients	Phase 2 trial in NDMM patients as a safety lead-in for iMMagine-4	Confirmatory phase 3 trial enrolling the largest eligible CAR T patient population in RRMM	Expanding anito-cel patient access to NDMM	Demonstrate anito-cel dosing in the community setting, expanding availability beyond existing ATCs

NDMM, newly diagnosed multiple myeloma

Key Commercial Activities Initiated for a Robust Anito-cel Launch[1]

Building Largest MM CAR T Focused Sales Team

- Sales management fully hired and account manager roles posted
- Territories aligned across Kite and Arcellx
- Largest MM CAR T focused sales team across Kite and Arcellx will be trained and deployed on day 1[1]



Anito-cel Will Rapidly Launch Into Largest MM ATC Network[1]

- Initiated anito-cel onboarding process at current Kite ATCs
- ~82%+ ATCs engaged via Pre-approval Information Exchange
- 100%[2] of payers engaged intend to cover anito-cel & 100%[2] of ATCs engaged anticipate adding anito-cel to formulary after FDA approval

Launch Readiness Activities Underway

- Comprehensive HCP, patient and administrator insights gathered and analyzed to inform launch material development
- Partnering with advocacy groups to improve CAR T access

[1]Pending FDA approval; [2]Based on customers (hospital administrators and payers) engaged across 144 Pre-approval Information Exchange meetings

Anito-cel is Expected to Have Broad Payer Coverage at Launch and Be Used Across Payer Segments

Pre-Approval Information Exchange (PIE) Initiated with Access Decision Makers

Anito-cel coverage across payer segments is projected to be >80% of US lives within 30 days and >90% within 90 days post launch[1]

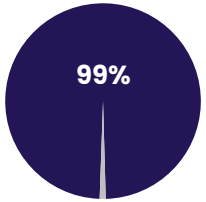
Long-term coverage is expected to be similar to other commercially available CAR Ts

MM CAR T Coverage

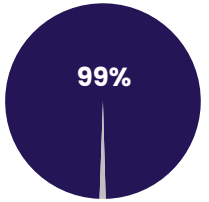
CARVYKTI

Abecma (idecabtagene vicleucel)

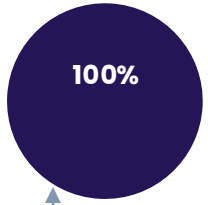
COMMERCIAL LIVES COVERED[2]



MED ADV LIVES COVERED*

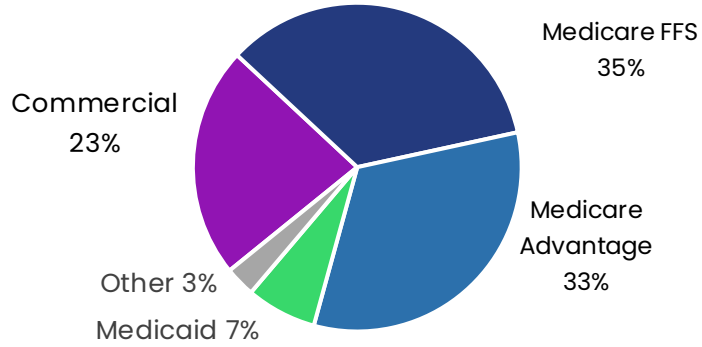


MEDICARE FFS LIVES COVERED

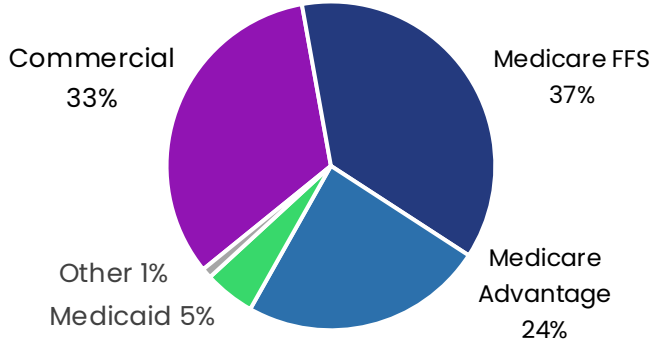


Per CAR T National Coverage Determination (NCD)
(coverage upon FDA approval)

MULTIPLE MYELOMA PAYER MIX
(Komodo Claims Q1-Q4 2024, n = 214,860)



RRMM CAR T PAYER MIX
(Komodo Claims Q1-Q4 2024, n = 663)



MM CAR T payer mix is largely consistent with the overall disease state payer mix
Consistent treatment of Medicare FFS patients with CAR T confirms that use is not driven by reimbursement dynamics. More than 80% of CAR T cases have favorable reimbursement across settings of care (inpatient & outpatient)

[1]Based on internal projections and estimates; [2]Sources: Q2 2025 Dedham Group Multiple Myeloma Payer Quality of 5L+ Access Dashboard (includes 96% of commercial and 94% of MA medical lives); CMS, Medicare Coverage Database.

ARCELLX

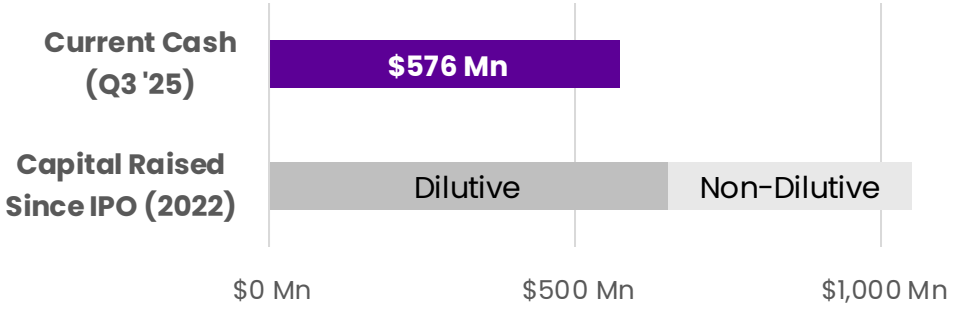
Business Fundamentals

Arcellx Differentiation: Strong Execution with Financial Discipline

Unique financial profile

Q3'25 Cash	$576 Mn
Runway	Into 2028
Q3'25 OpEx (ex-SBC)	$49 Mn[1]
Headcount	~190
Expected Margin Profile for anito-cel[2]	Gross margins ≥70% at launch[2] Profitability achievable with <$1Bn in anito-cel sales

Runway into 2028, beyond 2026 launch



Consistent execution on key milestones since IPO

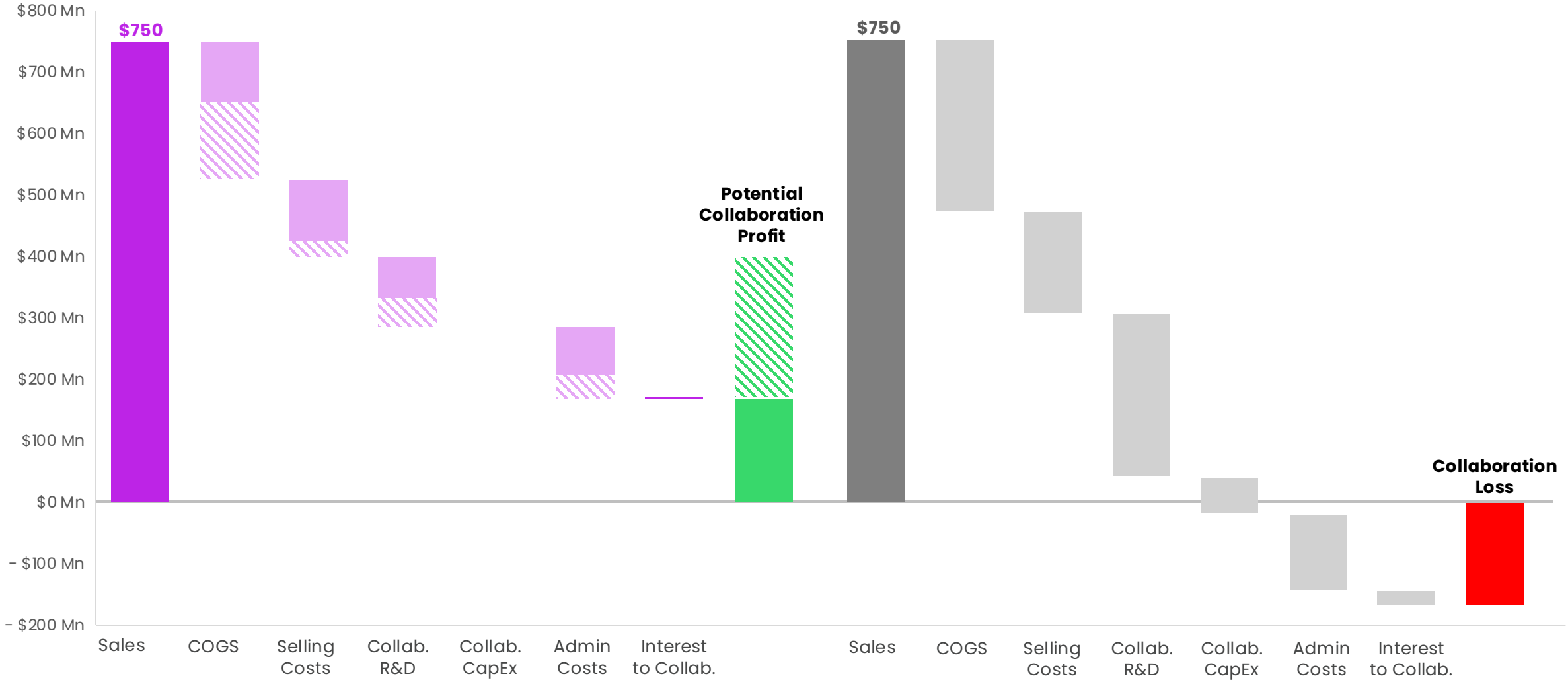
- ✓ Completed tech transfer for Pivotal iMMagine-1 Trial
- ✓ Initiated Pivotal iMMagine-1 Trial
- ✓ Collaboration agreement with Kite for anito-cel
- ✓ Expansion of collaboration with Kite for anito-cel
- ✓ Completed tech transfer for anito-cel to Kite for launch
- ✓ Initiated three additional Phase 1 trials
- ✓ Completed enrollment for Pivotal iMMagine-1 Trial
- ✓ Initiated Phase 3 iMMagine-3 Trial through Kite
- ✓ Reported initial data from Pivotal iMMagine-1 Trial
- ✓ Completed enrollment for GEM-anitoFIRST, lead-in for iMMagine-4 (NDMM study)
- ✓ Conducted pre-BLA meeting with the FDA

[1]$67Mn OpEx less $18Mn Share-based compensation (Arcellx 10-Q); [2]Based on Kite collaboration structure; Launch period is defined as 12 months post approval.

Unique Deal Structure with Kite Capabilities Enables Profitability

Illustrative example of Arcellx's Co/Co economics for anito-cel under Kite collaboration @ $1,500 Mn in Annual Sales[1,2]

Illustrative example of a Sample Cell Therapy's Co/Co economics under a different collaboration structure @ $1,500 Mn in Annualized Sales[3]



[1]Figures do not represent management sales projections or guidance, but are intended to illustrate how a hypothetical amount of sales might flow through the respective collaboration structures; [2]Assumes pricing similar to currently marketed BCMA CAR-Ts; [3]Annualized based on publicly reported numbers in SEC filings.

Anito-cel: A New Class of CAR T

Anito-cel Is Positioned to Expand Use, Drive Preference, and Be Rapidly Available

Anito-cel Expected to be Preferred BCMA CAR T
With potential best-in-class efficacy, improved safety, and rapid turnaround, anito-cel is **favored by ≥80% of HCPs**[1] **and Patients**[2] in 2025 market research

Anito-cel Expands the Market
The global CAR T 2L+ market for MM is projected to reach **~$12B by 2028+** fueled by the launch of anito-cel, indication expansion via **iMMagine-3**. Further potential expansion to **~$20B** with front-line CAR-T trials such as **iMMagine-4**

Anito-cel Expected to Rapidly Launch Into Largest MM ATC Network
Combining **broad and rapid payer coverage** with Kite's expected ATC footprint of **165+ ATCs** and best-in-class **Kite Konnect** patient platform will drive rapid use of anito-cel

Anito-cel Will Expand into the Community Setting
iMMagine-5 will enable community clinics and hospitals to gain experience with anito-cel, broadening the site of care footprint and bringing CAR T closer to patients

Anito-cel Expected to Launch with Excess Capacity
Planning manufacturing capacity to capture **majority of 4L+ at launch**, scaling to all 4L+ in 2027 with a global potential of **>24,000 doses**[3]

Arcellx Is A Differentiated Company
Capital efficiency and favorable collaboration structure with limited expenses enable **clear line of sight to profitability** and **limited near-term capital needs**

[1]Based on quantitative market research conducted in 2025 with 152 Hematologists/Oncologists (including treaters and referrers); [2]Based on quantitative market research from 2024 with 54 MM patients that are CAR T knowledgeable (discussed CAR T with their oncologists); [3]Manufacturing capacity is established based on launch plan and forecast, >24,000 dose capacity by end of 2026 includes Kite's current commercial products and MM

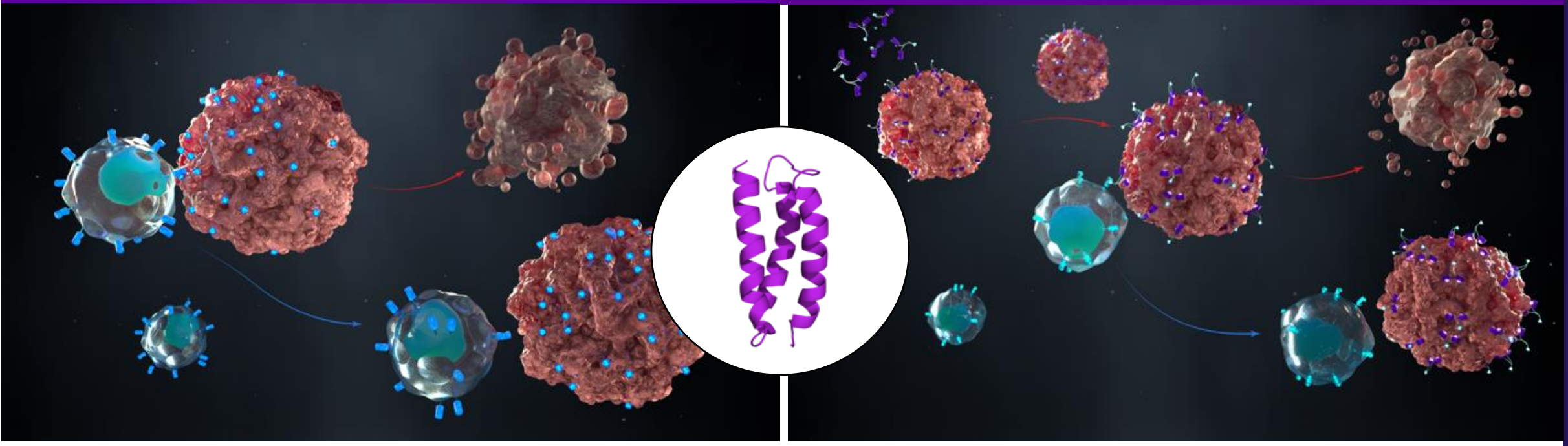
ARCELLX

Platform

D-Domain Technology: Expansive Platform

ddCAR Classical Single Infusion CAR T

ARC-SparX Dosable CAR T

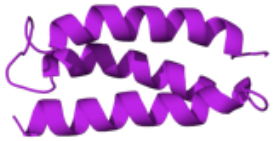


- Ability to leverage autologous or allogeneic strategies
- Therapeutic potential across liquid and solid tumors as well as non-oncology indications

A Rich Development Pipeline with Growth in Mind

	DISCOVERY	PRECLINICAL	PHASE 1	PHASE 2	PHASE 3	PARTNER
Multiple Myeloma						
iMMagine-1: anito-cel (4L+)						Kite, A GILEAD Company
iMMagine-3: anito-cel earlier lines (2L+)						
iMMagine-4: anito-cel frontline (1L)						
ACLX-001: BCMA ARC-SparX						
Acute Myeloid Leukemia						
ACLX-002: CD123 ARC-SparX						
ACLX-003						
ACLX-004: CD33 and CD123 ARC-SparX						
Non-Oncology						
Generalized Myasthenia Gravis: anito-cel						
Solid Tumors						
SCLC						
HCC						

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

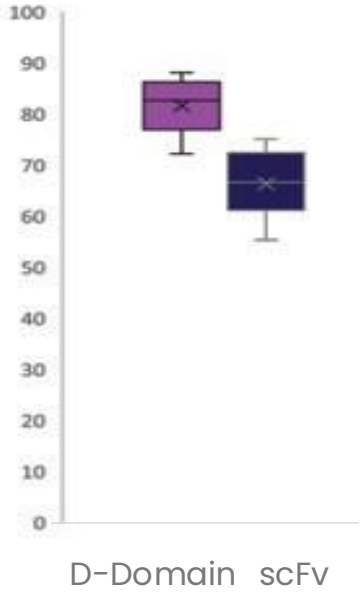


D-Domain

Hydrophobic Core & Stable

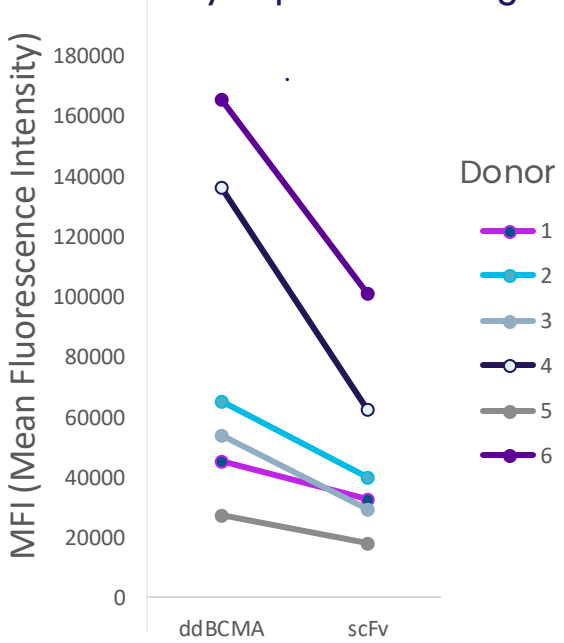
High Transduction Efficiency

Lower dose may lead to lower toxicity



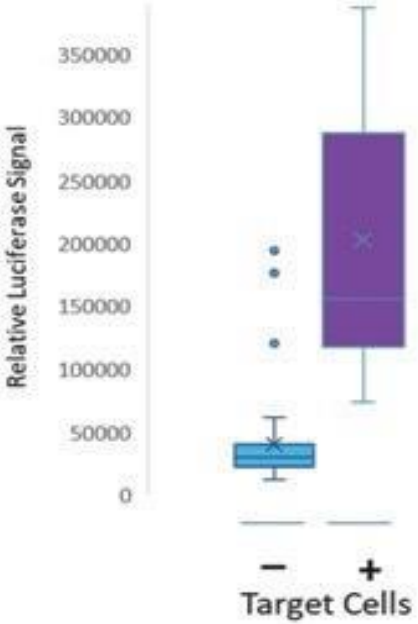
High Surface Expression

Potentially improved binding



Low Tonic Signaling

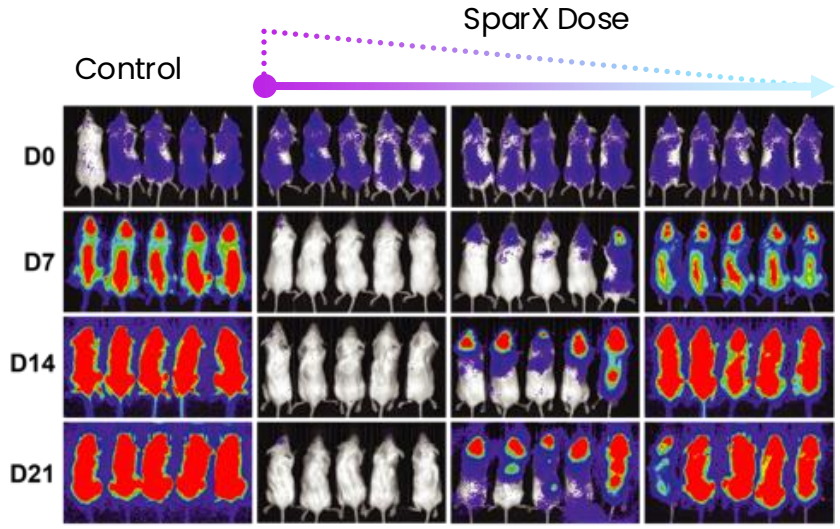
Reduced T cell exhaustion



Controllable and Adaptable: The ARC-SparX Advantage

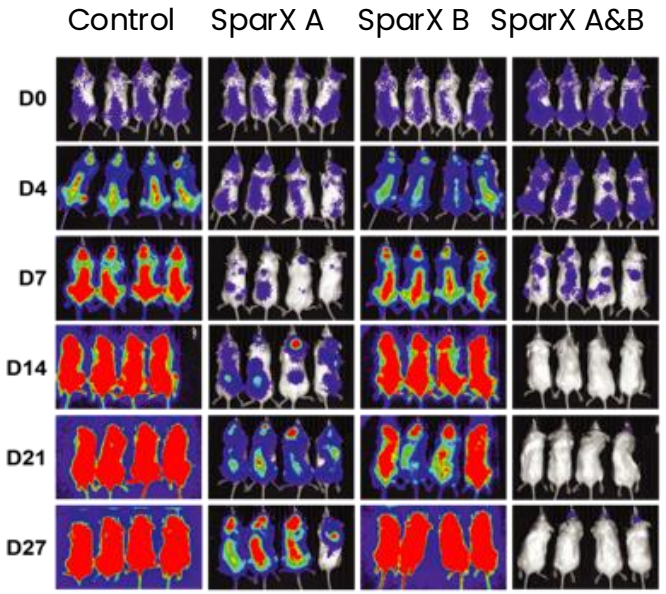
Controllable activity to enhance safety for potential increased access to outpatient and/or community-based settings

Control of ARC-T potency through SparX dosing



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

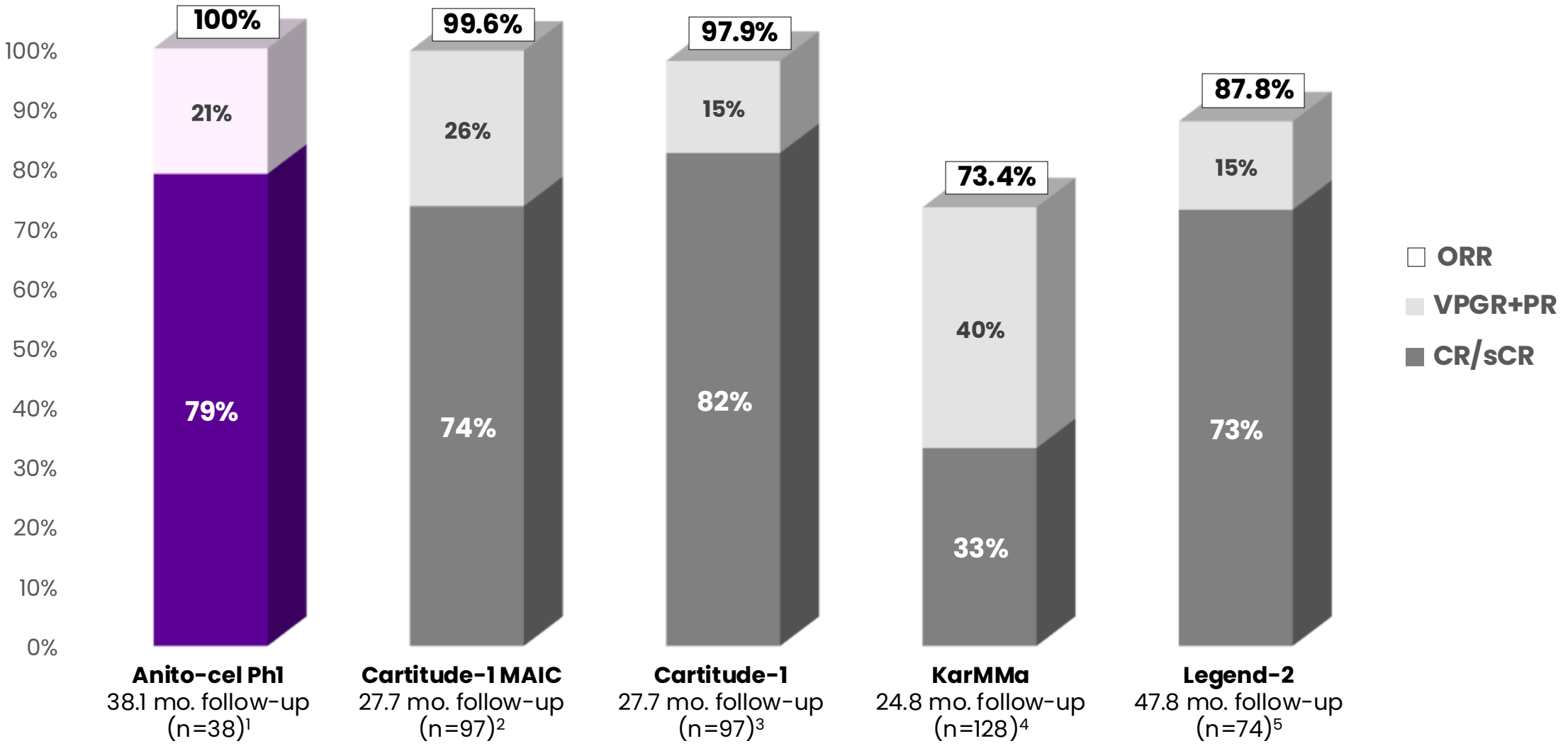
Combinatorial potential to combat heterogeneity



OUR MISSION

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

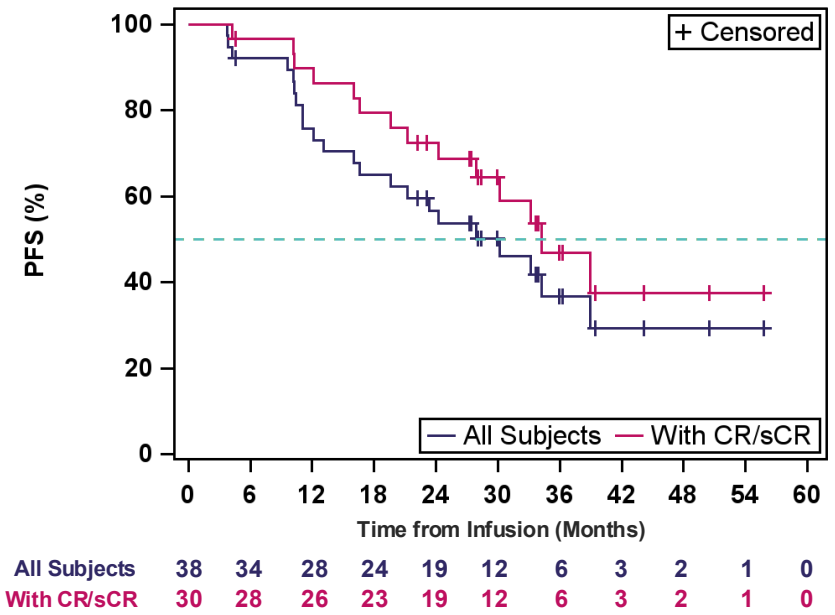
Anito-cel Phase 1: 100% Overall Response and 79% Complete Response



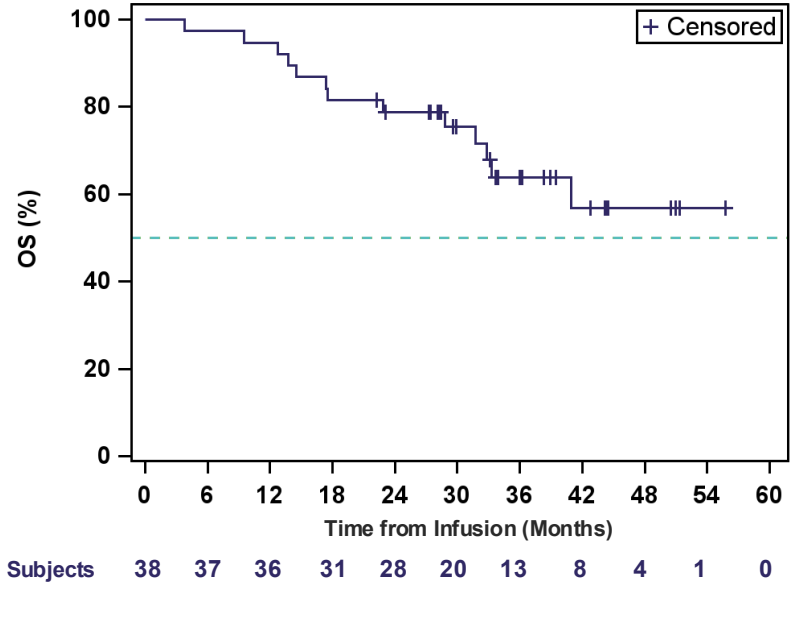
Data cut-off October 3, 2024
Note: MAIC is matching-adjusted indirect comparison, a J&J study comparing Cartitude-1 results by adjusting its population to match that of KarMMa; Data above are not from head-to-head studies. Cross-trial data interpretation should be considered with caution as it is limited by differences in median follow-up, study population, design, and other factors.
[1]Bishop et al. (2024); [2]Martin et al. (2022); [3]Martin et al. (2023); [4]Anderson et al. (2021); [5]Zhao et al.

Anito-cel Phase 1: Median PFS is 30.2 Months

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



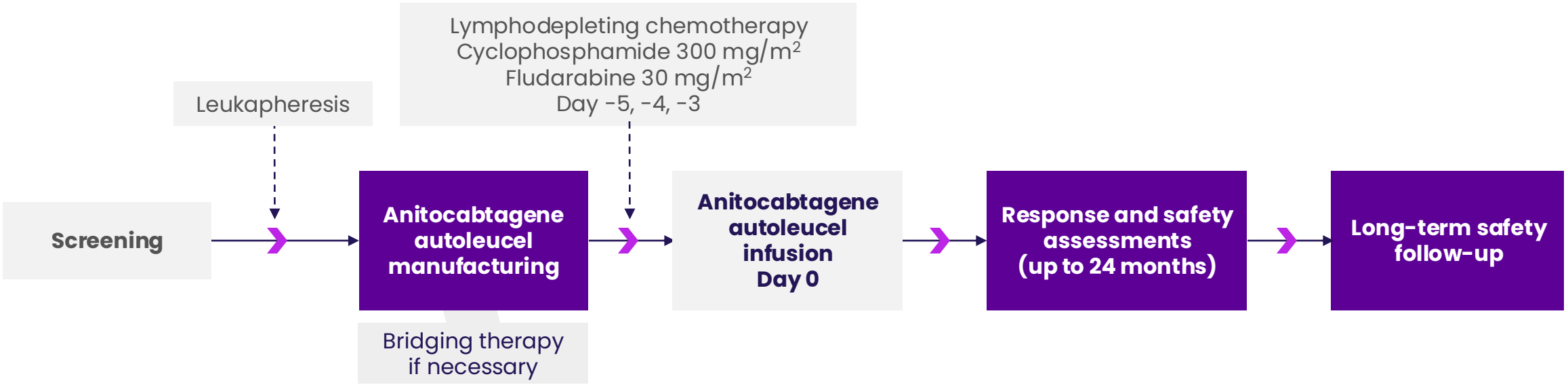
Median Overall Survival Not Reached (N=38)



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

Responses determined by IMWG Consensus Criteria; Data cut-off October 3, 2024
Bishop et al. (2024)

Anito-cel iMMagine-1: Phase 2 Study Design



Key Eligibility Criteria

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

Target Dose of 115 x 10^6 CAR+ T cells

Primary Endpoint:

- ORR, per 2016 IMWG criteria

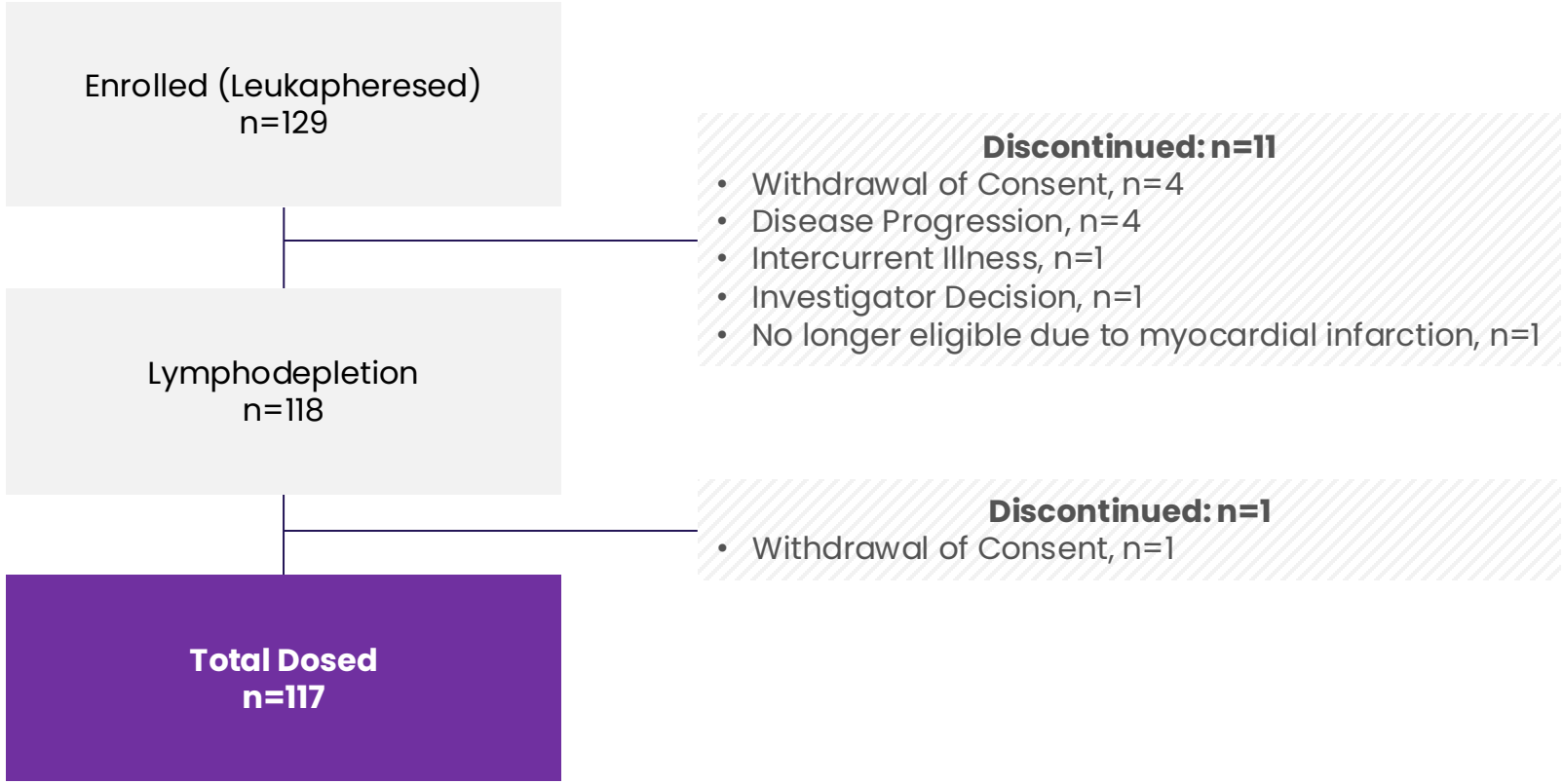
Key Secondary Endpoints:

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

Primary and key secondary endpoints to be assessed per Independent Review Committee (IRC); Investigator assessment of response per IMWG also permitted per protocol.
CR, complete response; ECOG PS, Eastern Cooperative Oncology Group Performance Status; IMiD, immunomodulatory drug; IMWG, International Myeloma Working Group; LoT, line of therapy; ORR, overall response rate; PI, proteosome inhibitor; sCR, stringent complete response.
Patel et al., Oral Presentation, ASH (Dec 2025)

iMMagine-1: Overall Patient Disposition

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



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

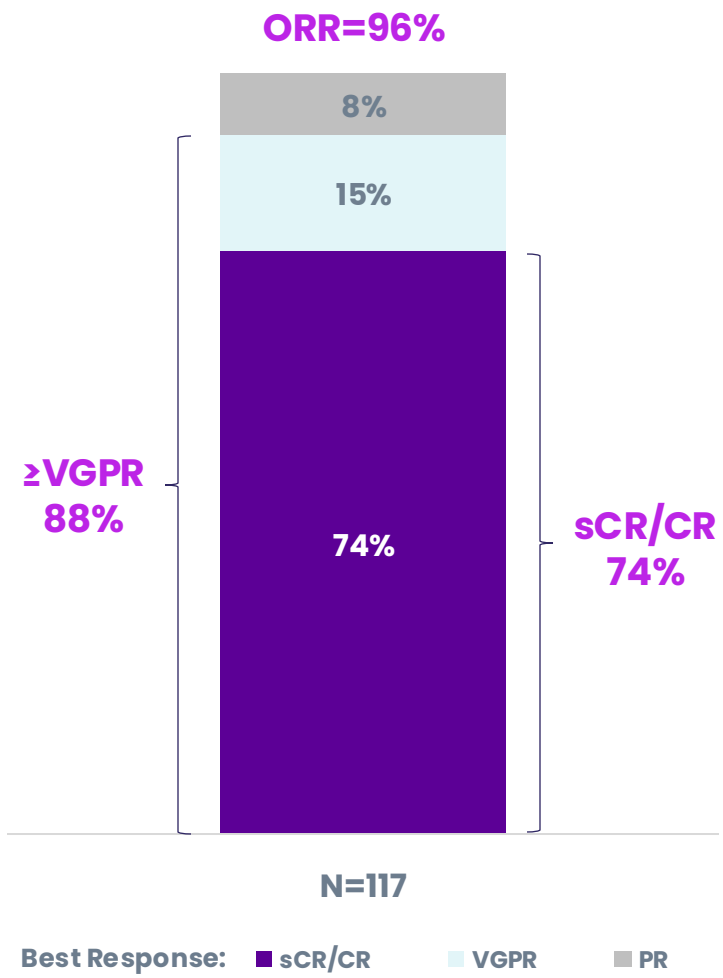
Patel et al., Oral Presentation, ASH (Dec 2025)

iMMagine-1: Patient and Disease Characteristics

	Anito-cel iMMagine-1[1]	Cartitude-1[2]	KarMMa[3]
	N=117	**N=97**	**N=128**
Age group ≥ 65, # (%)	**58 (50%)**	**35 (36%)**	**45 (35%)**
Age group ≥ 70, # (%)	33 (28%)	--	20 (16%)[5]
Gender (Male / Female)	56% / 44%	59% / 41%	59% / 41%
Black / African American, # (%)	17 (15%)	17 (18%)	--
ECOG[a] 0, # (%)	54 (46%)	39 (40%)	57 (45%)
EMD[b], # (%)	**21 (18%)**	**13 (13%)**	**50 (39%)***
Bone marrow plasma cells ≤ 30%[c]	74 (65%)	58 (60%)	--
Bone marrow plasma cells > 30% to < 60%[c]	19 (17%)	17 (18%)	--
Bone marrow plasma cells ≥ 60%[c]	20 (18%)	21 (22%)	65 (51%)**
High risk cytogenetics[d], # (%)	**47 (40%)**	**23 (24%)**	**45 (35%)**
Median prior lines of therapy (min-max)	3 (3-8)	6 (3-18)	6 (3-16)
3 Prior lines of therapy, # (%)	65 (56%)	17 (18%)	15 (12%)
Refractory to last line, # (%)	117 (100%)	96 (99%)	128 (100%)***
Triple refractory, # (%)	**102 (87%)**	**85 (88%)**	**108 (84%)**
Penta refractory, # (%)	**48 (41%)**	**41 (42%)**	**33 (26%)**
Median time since diagnosis (min-max, years)	7.5 (1 – 23)	5.9 (2 – 18)[4]	6.0 (1 – 18)
Prior ASCT, # (%)	92 (79%)	87 (90%)	120 (94%)
Bridging therapy, # (%)	89 (76%)	73 (75%)	112 (88%)
Outpatient administration, # (%)	9 (8%)	0 (0%)	0 (0%)

Anito-cel iMMagine-1 data cut-off Oct 7, 2025; *Includes bone-based lesions (plasmacytomas); **High tumor burden defined as ≥50% bone marrow plasma cells; ***Assumed per protocol requirements
Updates to data resulting from ongoing data review. 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 study population, study design, and other factors; a) Eastern Cooperative Oncology Group Performance Status Scale; b) EMD is a form of MultipleMyeloma characterized by the presence of a non-bone based plasmacytoma; c) 113 patients had bone marrow disease assessments done at screening or baseline; d) Defined as the presence of Del 17p, t(14;16),or t(4;14). [1]Patel et al., Oral Presentation, ASH (Dec 2025); [2]Martin et al. (2023); [3]Munshi et al. (2021); [4]Janssen Carvykti Prior Line of Therapies (Dec 2024); [5]Berdeja et al. (2020)

iMMagine-1: Overall Response Rate and Depth of Response



Responses continue to deepen over time

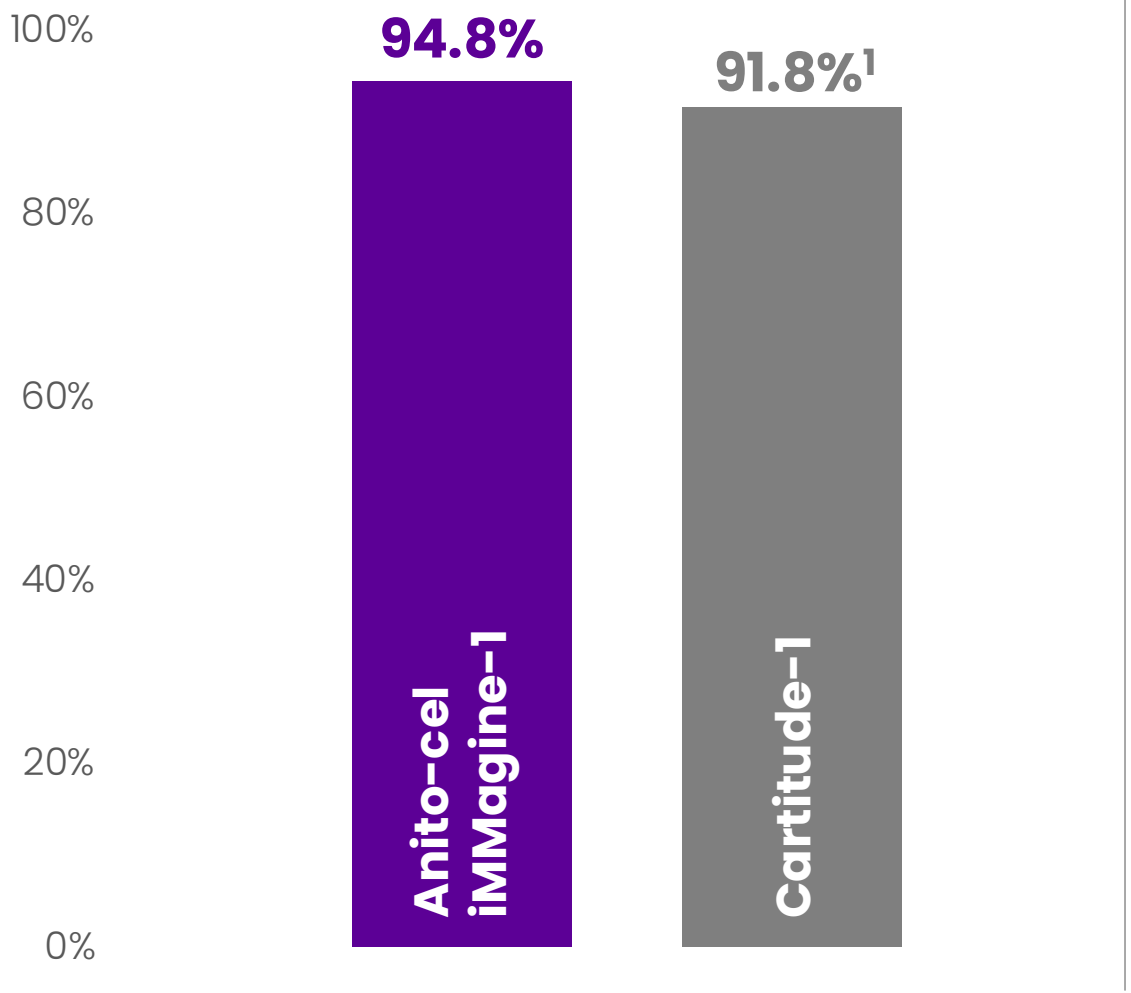
At a median follow-up of 15.9 months, IRC-assessed **ORR was 96% and sCR/CR rate was 74%**

	Median (months)	Interquartile Range	Min, Max
Time to first response	1.0	1.0, 1.9	0.9, 13.8
Time to best response	4.8	2.1, 9.0	0.9, 23.8
Time to sCR/CR	3.2	2.0, 9.2	0.9, 23.8

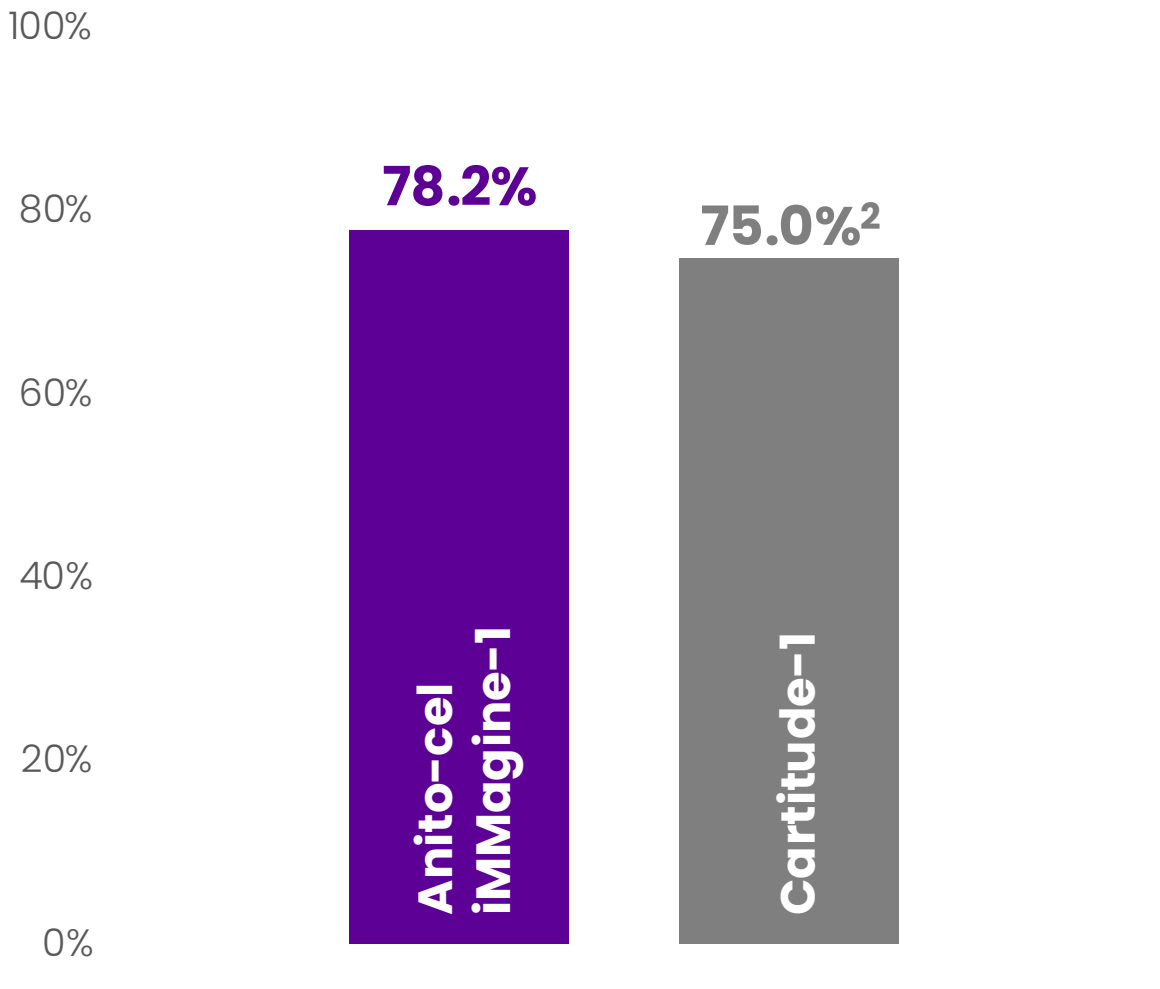
Responses are per IMWG criteria and are IRC assessed; ORR defined as partial response or better.
CR, complete response; IRC, independent review committee; ORR, overall response rate; PR, partial response; sCR, stringent complete response; VGPR, very good partial response
Patel et al., Oral Presentation, ASH (Dec 2025), Data cut-off Oct 7, 2025

iMMagine-1: Minimum Residual Disease

Minimum Residual Disease at 10^{-5} Sensitivity



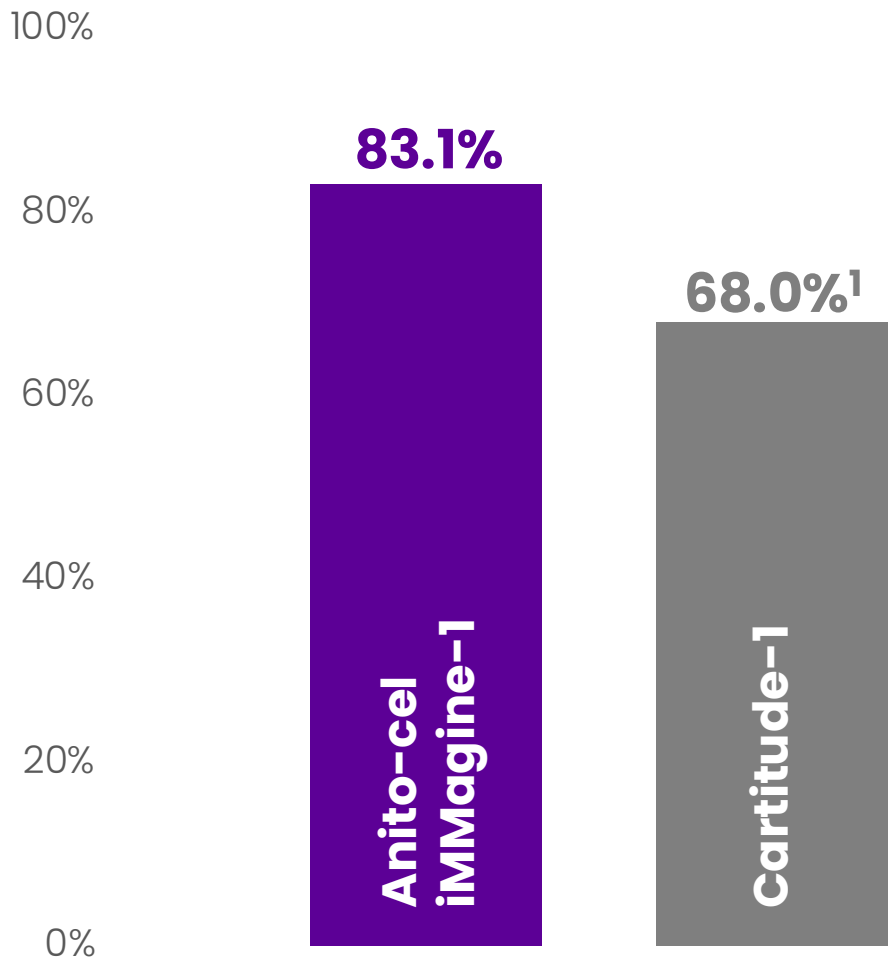
Minimum Residual Disease at 10^{-6} Sensitivity



Evaluable patients for overall MRD negativity had an identifiable malignant clone in the baseline bone marrow sample and had a post-treatment bone marrow sample sufficient to assess MRD negativity at 10^{-5} or at 10^{-6}. Note: Carvykti MRD- at 10^{-5} sensitivity shown as of 18 months of median follow-up; MRD- at 10^{-6} sensitivity shown as of 27.7 months of median follow-up. Median follow-up for anito-cel iMMagine-1 was 15.9 months [Range 0.3 – 33]. 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. Anito-cel Phase 1 data (N=25/28): Bishop et al. (2024); Anito-cel iMMagine-1 data (N=91/96 for 10^{-5} sensitivity; N=68/87 for 10^{-6} sensitivity): Patel et al., Oral Presentation, ASH (Dec 2025); [1]Usmani et al. (2021) (N=56/61); [2]Martin et al. (2022) (N=39/52).

iMMagine-1: Sustained Minimum Residual Disease

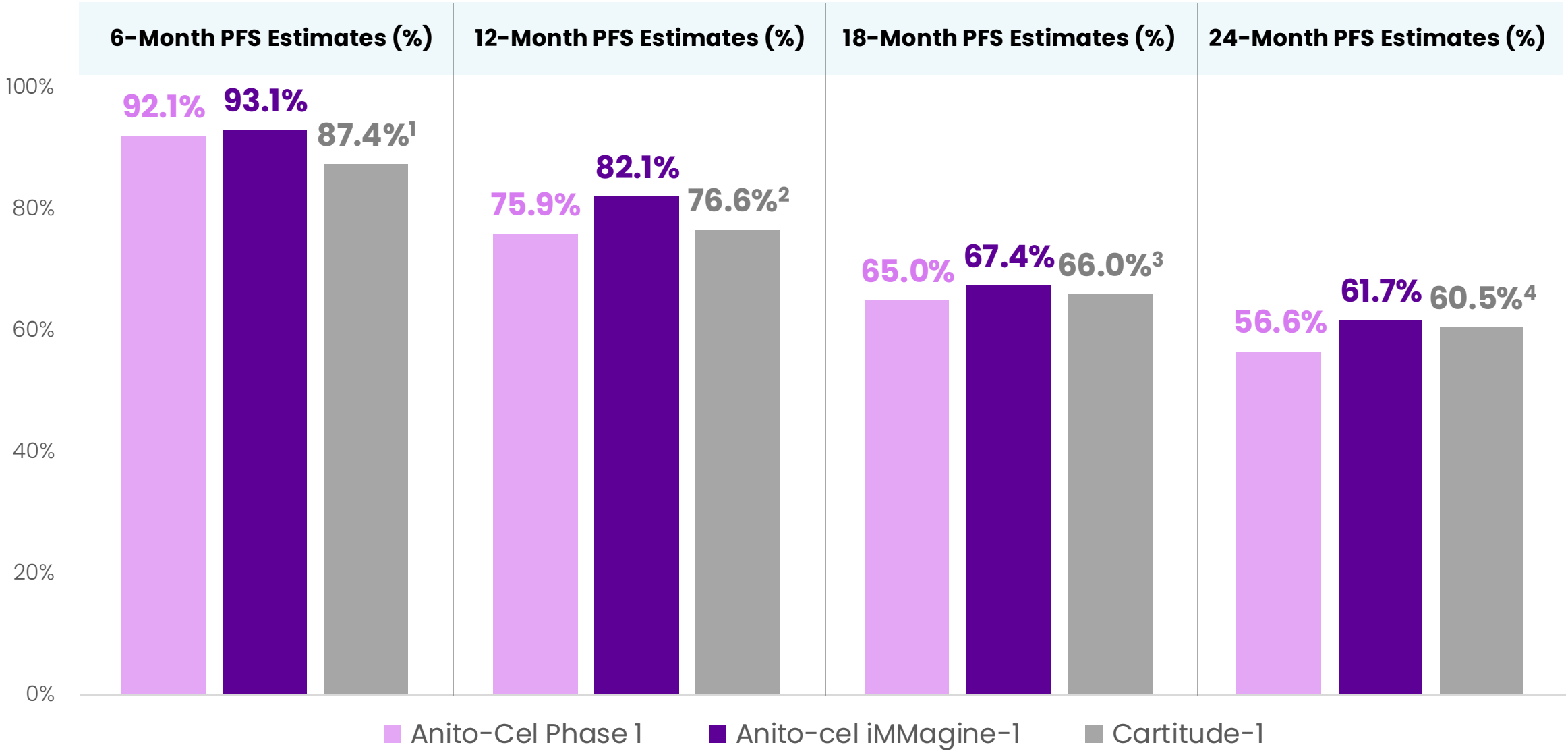
Minimal Residual Disease Sustained for ≥6 Months



- Anito-cel sees **high sustained depth of response**
- Sustained MRD negativity reflects **durability of response**

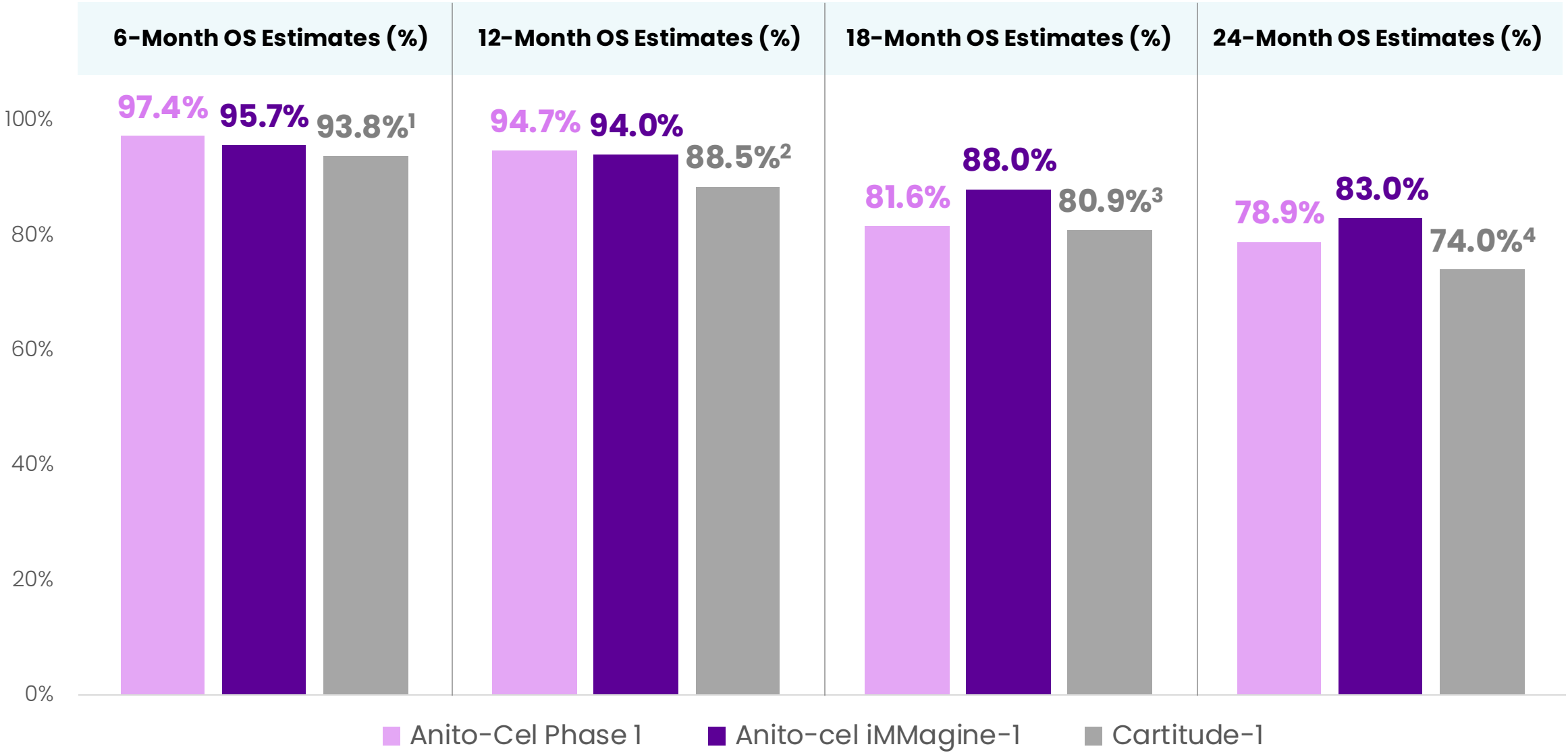
Evaluable patients had 2 post-infusion MRD negative assessments at 10^{-5} level at least 6 months apart while still being in ongoing response
Note: Carvykti sustained MRD negativity shown as of 27.7 months of median follow-up. Median follow-up for anito-cel iMMagine-1 was 15.9 months [Range 0.3 – 33]. 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.
Anito-cel iMMagine-1 data (N=54/65): Patel et al., Oral Presentation, ASH (Dec 2025); [1]Martin et al (2022) (N=34/50).

iMMagine-1: 12-mo PFS Rate is 82%, and 24-mo PFS rate is 62%



Note: Carvykti 6-mo PFS at 8.8 months of median follow-up; 12-mo PFS at 12.4 months of median follow-up, 18-mo PFS at 18 months of median follow-up, and 24-mo PFS at 21.7 months of median follow-up. Median follow-up for anito-cel iMMagine-1 was 15.9 months [Range 0.3 – 33]. 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. Anito-cel Phase 1 data (N=38): Bishop et al. (2024); Anito-cel iMMagine-1 data (N=117): Patel et al., Oral Presentation, ASH (Dec 2025); [1]Madduri et al. (2020) including supplementary materials (N=97); [2]Berdeja et al. (2021); [3]Usmani et al. (2021); [4]Martin et al. (2021).

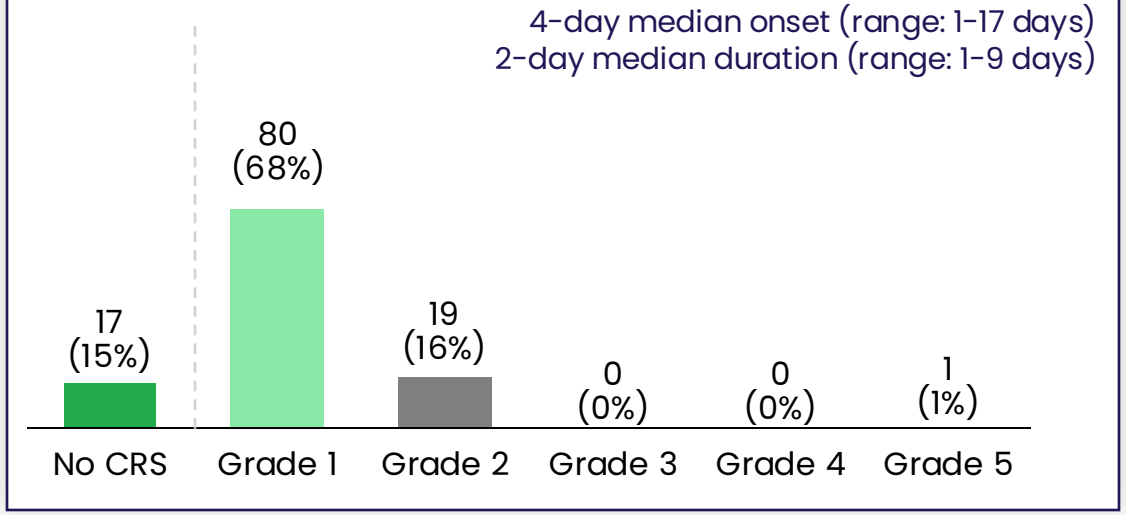
iMMagine-1: 12-mo OS Rate is 94%, and 24-mo OS rate is 83%



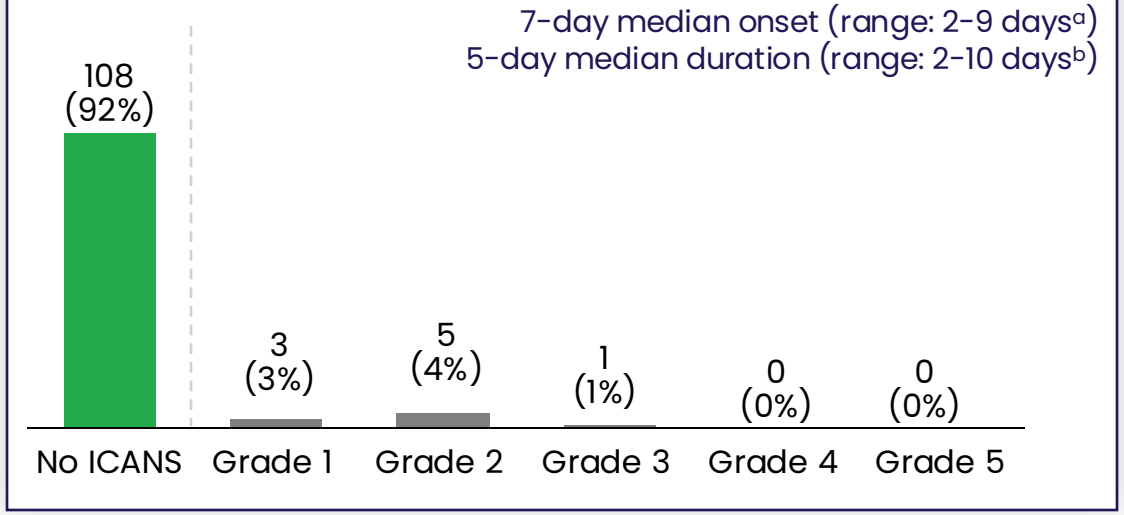
Note: Carvykti 6-mo OS at 8.8 months of median follow up; 12-mo OS at 12.4 months of median follow-up, 18-mo OS at 18 months of median follow-up, and 24-mo OS at 21.7 months of median follow-up. Median follow-up for anito-cel iMMagine-1 was 15.9 months [Range 0.3 – 33]. Data above are not from head-to-head 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. Anito-cel Phase 1 data (N=38): Bishop et al. (2024); Anito-cel iMMagine-1 data (N=117): Patel et al., Oral Presentation, ASH (Dec 2025); [1]Madduri et al. (2020) including supplementary materials (N=97); [2]Berdeja et al. (2021); [3]Usmani et al. (2021); [4]Martin et al. (2021).

iMMagine-1: Safety

Maximum CRS Grade (N=117)



Maximum ICANS Grade (N=117)

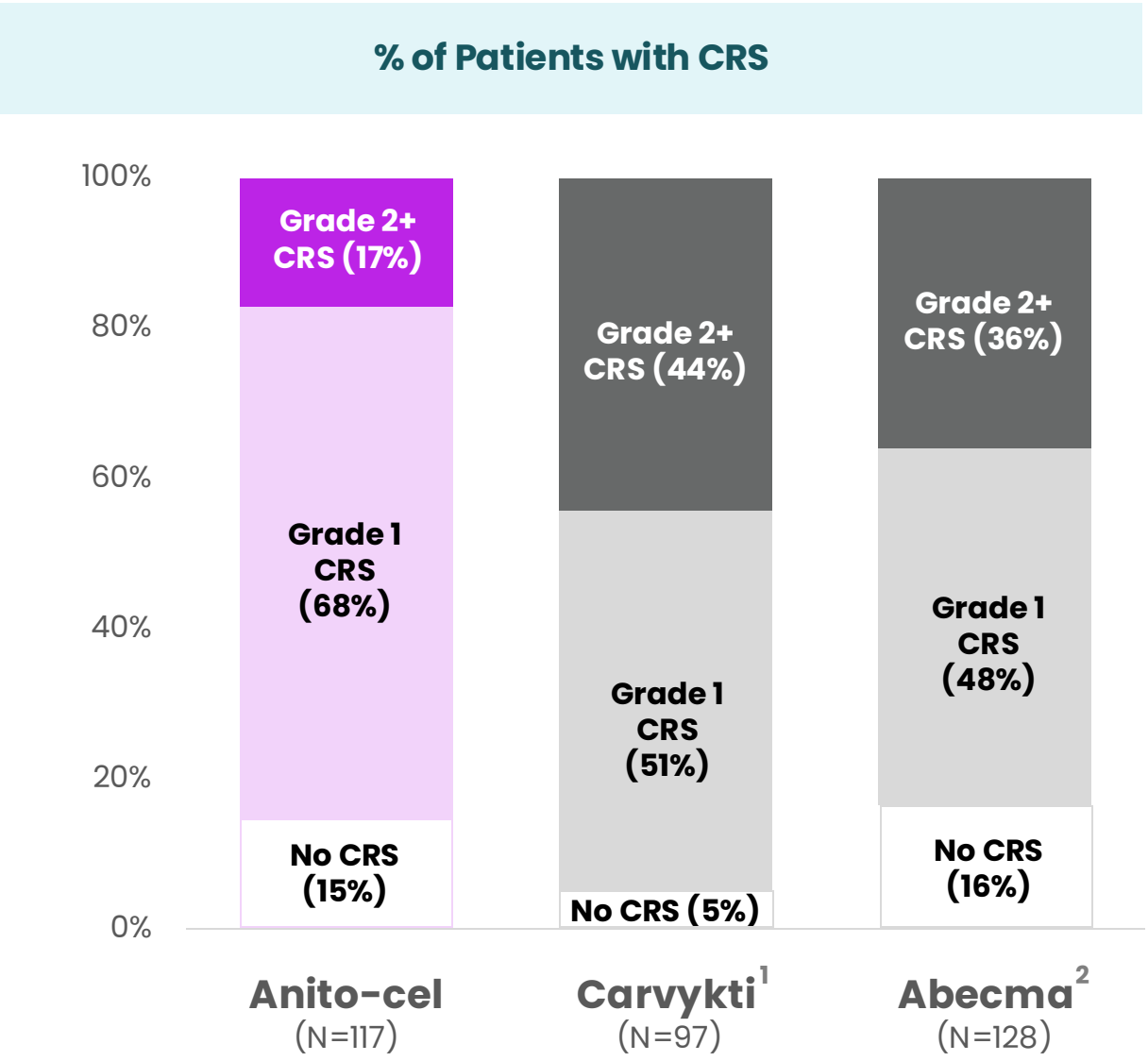


- 95% (111/117) of patients had either no CRS or CRS that resolved by ≤10 days of anito-cel infusion
- No new treatment-related or treatment-emergent deaths have occurred since the previous May 1, 2025 datacut
- No secondary primary malignancies of T-cell origin have occurred
- No replication competent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

No delayed or non-ICANS neurotoxicities, including no Parkinsonism, no cranial nerve palsies, and no Guillain-Barré syndrome, and no immune effector cell-associated enterocolitis have been observed to date at ≥12 months since anito-cel infusion

[a]With the exception of n=1 Grade 1 ICANS (confusion) on day 31 post infusion that rapidly resolved. [b]With the exception of n=1 max Grade 2 ICANS with 29-day duration to resolution
Updates to data resulting from ongoing data review; CRS and ICANS assessed per American Society for Transplantation and Cellular Therapy criteria; CRS, cytokine release syndrome; ICANS, immune-effector cell-associated neurotoxicity syndrome; Patel et al., Oral Presentation, ASH (Dec 2025), Data cut-off Oct 7, 2025

iMMagine-1: Majority of Patients with ≤ Grade 1 CRS



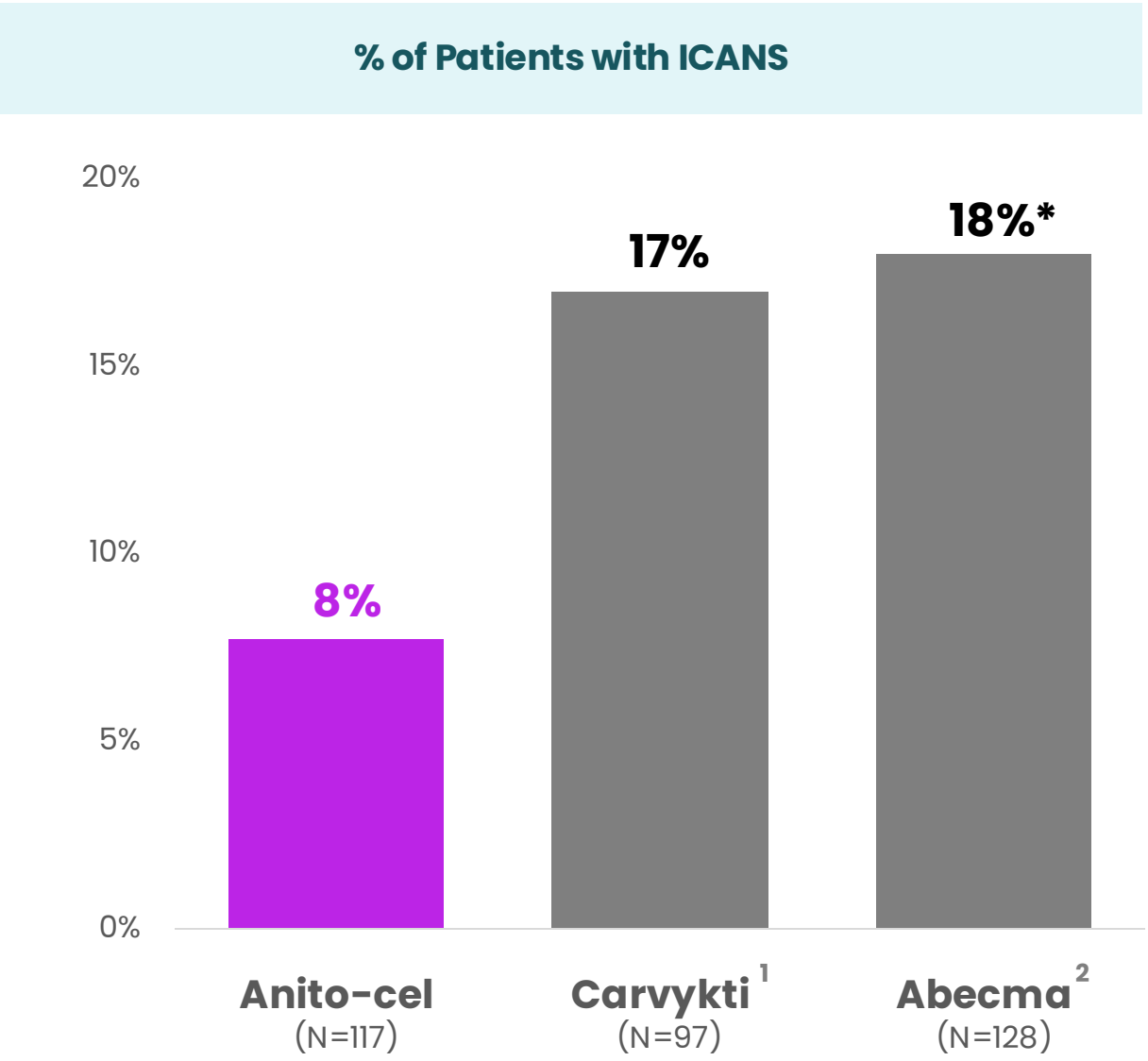
In the 85% of patients with CRS, median onset was 4 days (range: 1-17 days)

83% (97/117) of CRS cases ≤ Gr 1, including 15% of patients with no CRS

95% of patients either had no CRS or CRS that resolved within 10 days of anito-cel infusion

Note: Standard practice CRS management used across studies (no prophylactic steroid or tocilizumab utilization).
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.
Patel et al., Oral Presentation, ASH (Dec 2025); [1]Berdeja et al. (2021); [2]Munshi et al. (2021)

iMMagine-1: Majority of Patients with No ICANS



92% of patients did not have ICANS

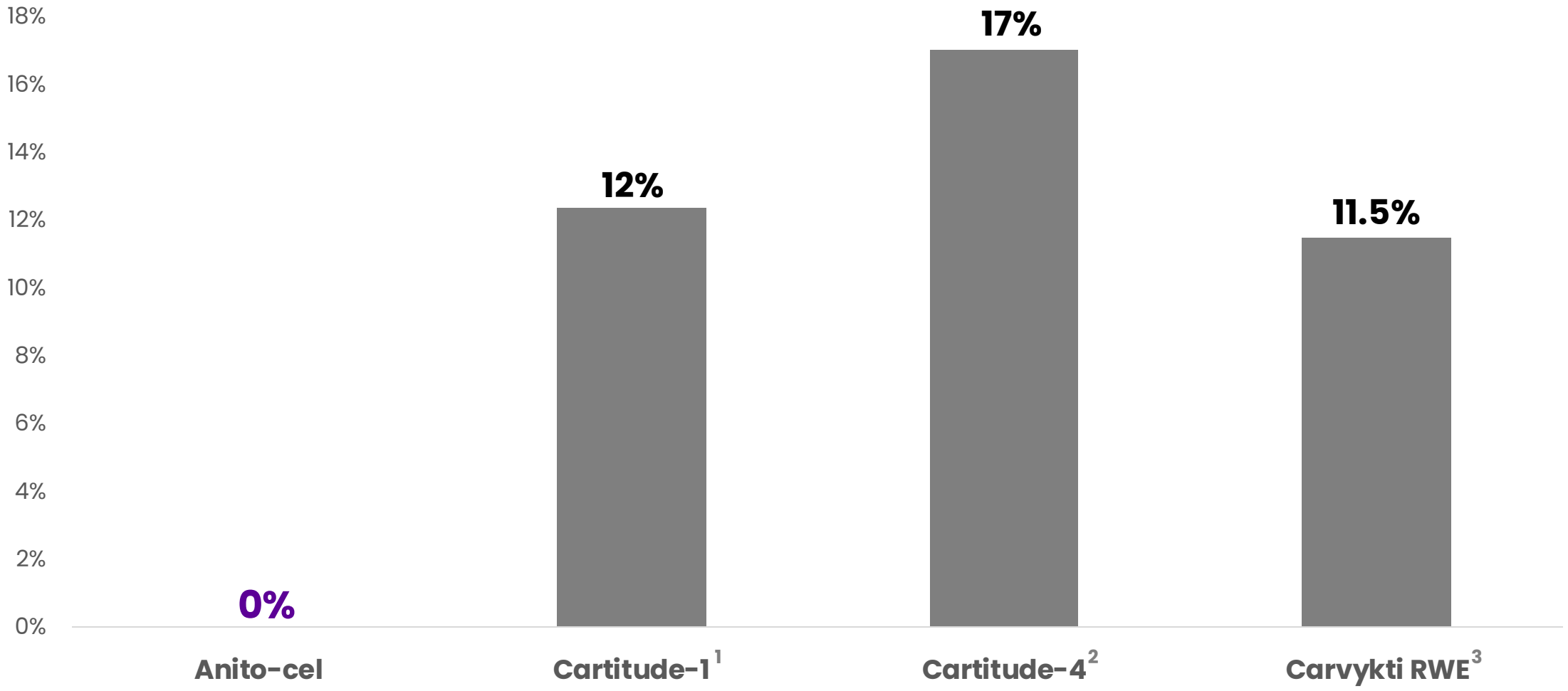
ICANS of any grade was observed in 9 patients (8%), of which 1 (1%) was Grade 3, all cases resolved

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

*All neurotoxic events considered as ICANS and non-ICANS toxicity not separated
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.
Patel et al., Oral Presentation, ASH (Dec 2025); [1]Berdeja et al. (2021); [2]Munshi et al. (2021)

iMMagine-1: Zero Cases of Delayed Neurotoxicity

% of Patients with Delayed or Non-ICANS Neurotoxicity

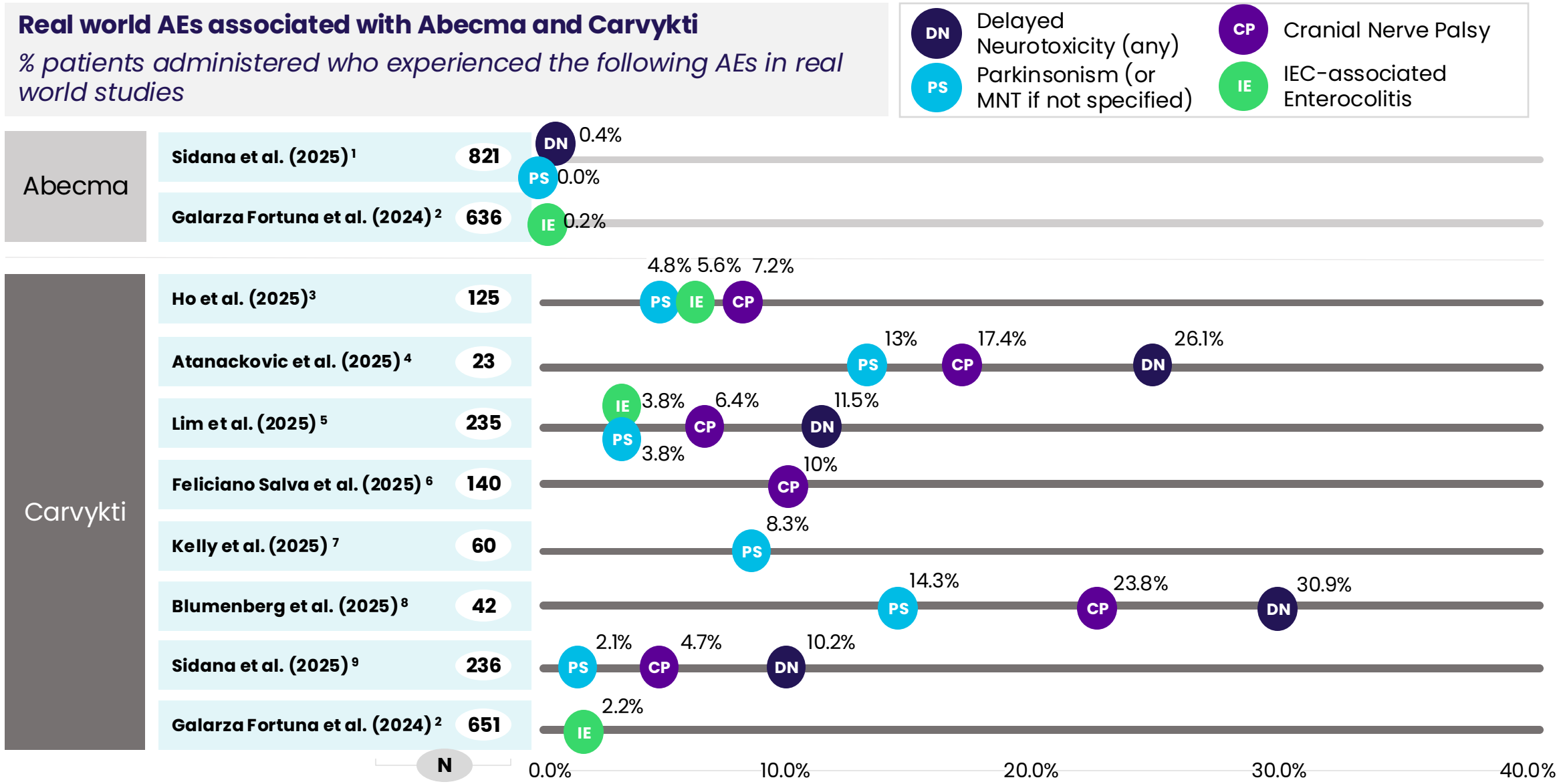


Data above are not from head-to-head studies. Cross-trial data interpretation should be considered with caution as it is limited by differences in median follow-up, study population, design, and other factors.
Patel et al., Oral Presentation, ASH (Dec 2025), Data cut-off Oct 7, 2025; [1]Berdeja et al (2021); [2]San-Miguel et al. (2023); [3]Lim et al. (2025)

Delayed Neurotoxicities in Real World Studies

Real world AEs associated with Abecma and Carvykti

% patients administered who experienced the following AEs in real world studies



[1]Sidana et al. Blood. April 2025, [2]Galarza Fortuna et al. Blood Cancer Journal. 2024, [3]Ho et al. Oral Presentation 04 IMS 2025, [4]Atanackovic et al. Nat Comms. 2025.,[5]Lim et al. Oral Presentation 284 EHA 2025, [6]Feliciano Salva et al. ASCO 2025, [7]Kelly et al. Blood Adv. 2025., [8]Blumenberg et al. Blood. 2025., [9]Sidana et al. Blood. January 2025., Publications grouped by type of neurotoxicities and sorted based on publication date.
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.

Delayed Neurotoxicities in FAERS Data

% Incidence of Carvykti AEs	2024-Q1	2024-Q2	2024-Q3	2024-Q4	2025-Q1	2025-Q2	2025-Q3
Cranial Nerve Palsy[1]	7%	7%	5%	10%	7%	5%	6%
Parkinsonism[2]	6%	2%	5%	4%	6%	6%	4%
Guillain-Barre Syndrome	0%	0%	0%	1%	1%	1%	1%
Immune-Mediated Enterocolitis	0%	0%	0%	2%	1%	1%	2%

% Incidence of Abecma AEs	2024-Q1	2024-Q2	2024-Q3	2024-Q4	2025-Q1	2025-Q2	2025-Q3
Cranial Nerve Palsy[1]	0%	0%	0%	0%	0%	0%	0%
Parkinsonism[2]	0%	0%	3%	0%	0%	0%	1%
Guillain-Barre Syndrome	0%	0%	0%	0%	0%	0%	0%
Immune-Mediated Enterocolitis	0%	0%	0%	0%	0%	0%	0%

[1]Cranial Nerve Palsy includes Bell's palsy, cranial nerve paralysis, facial nerve disorder, facial paralysis, facial paresis, gaze palsy, IIIrd nerve palsy, tongue paralysis, trigeminal palsy, Vith nerve paralysis, vocal cord paralysis
[2]Parkinsonsim includes Parkinsonism and Flat Affect
Based on FAERS data as of 11-10-2025; % incidence is calculated: # of incidences in current quarter divided by # of patients in prior quarter

Other Treatment-Emergent Adverse Events

The most common Grade 3 and higher treatment-emergent AEs (TEAEs) were cytopenias

	Any Grade AEs ≥20% after cell infusion (N=117)	Grade 3 and higher AEs after cell infusion (N=117)
Hematologic		
Neutropenia	83 (71%)	82 (70%)
Anemia	33 (28%)	29 (25%)
Thrombocytopenia	30 (26%)	30 (26%)
Leukopenia	25 (21%)	24 (21%)
Non-hematologic		
Hypogammaglobulinemia	50 (43%)	1 (1%)
Fatigue	43 (37%)	3 (3%)
Hypophosphatemia	37 (32%)	2 (2%)
Headache	35 (30%)	2 (2%)
Nausea	35 (30%)	1 (1%)
Diarrhea	33 (28%)	1 (1%)
Hypokalemia	29 (25%)	2 (2%)
Cough	24 (21%)	0
Hypertension	23 (20%)	12 (10%)
Infections	65 (56%)	11 (9%)
Upper respiratory tract infection	18 (15%)	1 (1%)
COVID-19	11 (9%)	3 (3%)
Urinary tract infection	8 (7%)	1 (1%)

Note: Updates to data resulting from ongoing data review; TEAE is defined as, 1) any AE with onset date on or after the firstanito-cel infusion, until 90 days after the first anito-cel infusion regardless of causality assessment, or until start of subsequent anti-myeloma therapy, whichever is earlier; or 2) any AE occurring at any time assessed by the investigator as related to anito-cel

iMMagine-1: Conclusions

- **Anito-cel utilizes a novel, synthetic, compact, and stable D-Domain binder**
  - D-Domain facilitates high transduction efficiency, CAR positivity, and CAR density on the T-cell surface and has a fast off-rate
- **Anito-cel continues to show deepening responses at a median follow-up of 15.9 months**
  - ORR was 96% and sCR/CR rate was 74%
  - 95% of MRD evaluable patients were MRD negative and 83% had ≥6 months of sustained MRD negativity at $\leq 10^{-5}$ sensitivity
  - Median PFS and OS were not reached; 24-month PFS rate was 62% and OS rate was 83%
- **The anito-cel safety profile is predictable and manageable as demonstrated in more than 150 patients dosed across the Phase 1 and iMMagine-1 Phase 2 trials**
  - iMMagine-1 had the lowest rates of high-grade CRS (≤ Grade 1 CRS of 83%, including 15% with no CRS) and the lowest rates of ICANS (92% with no ICANS) out of all BCMA CAR T pivotal trials to date
  - No delayed or non-ICANS neurotoxicities, including no Parkinsonism, no cranial nerve palsies, and no Guillain-Barré syndrome, and no immune effector cell-associated enterocolitis have been observed to date with anito-cel

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

ARCELLX

iMMagine 3

iMMagine-3 Global Phase 3 Trial with Kite Manufacturing, Currently Enrolling

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

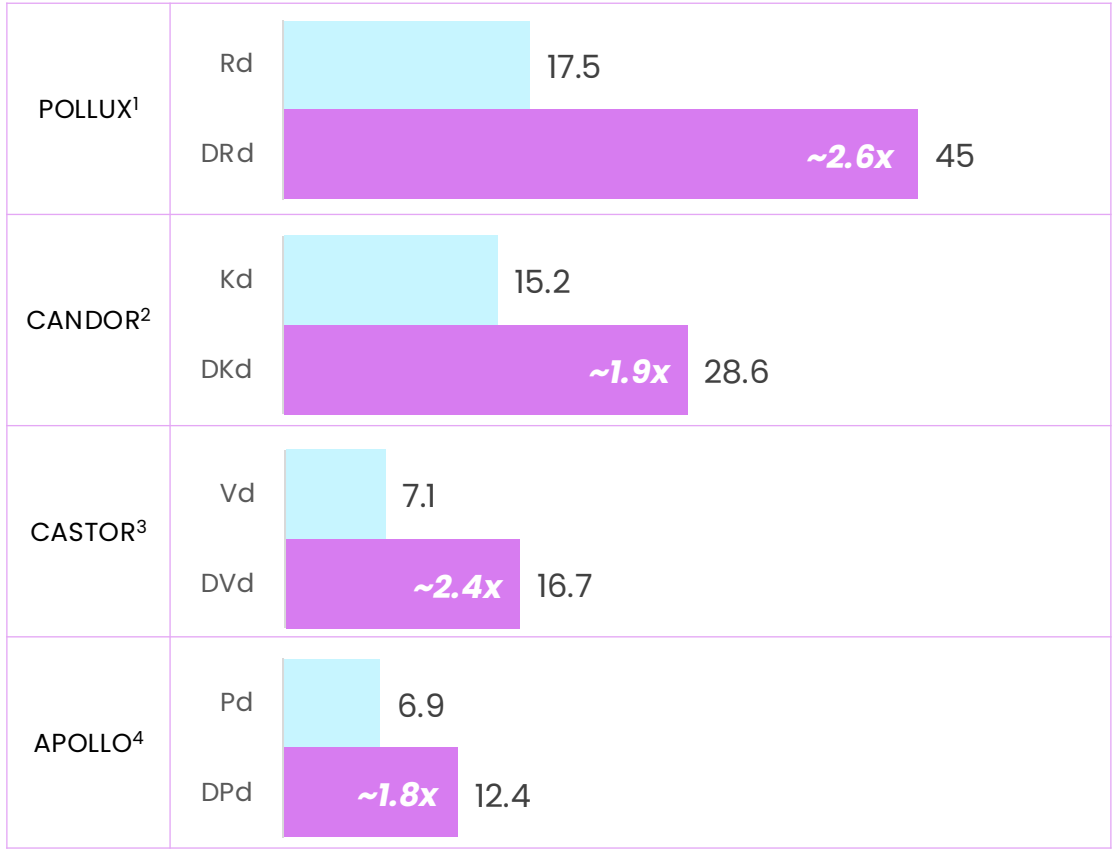
- Largest percentage of second line (2L) patients as anti-CD38 mAbs become standard of care in front line (1L)
- Anticipate high physician interest in iMMagine-3 based on:
  - Potential best-in-class product profile
  - Relevant standard of care alternatives
  - Rapid and reliable turnaround time with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

mAbs is monoclonal antibodies; IMiD is Immunomodulatory drugs

Anti-CD38 Therapies and Low Refractoriness to Anti-CD38 Have Profound Impacts on PFS

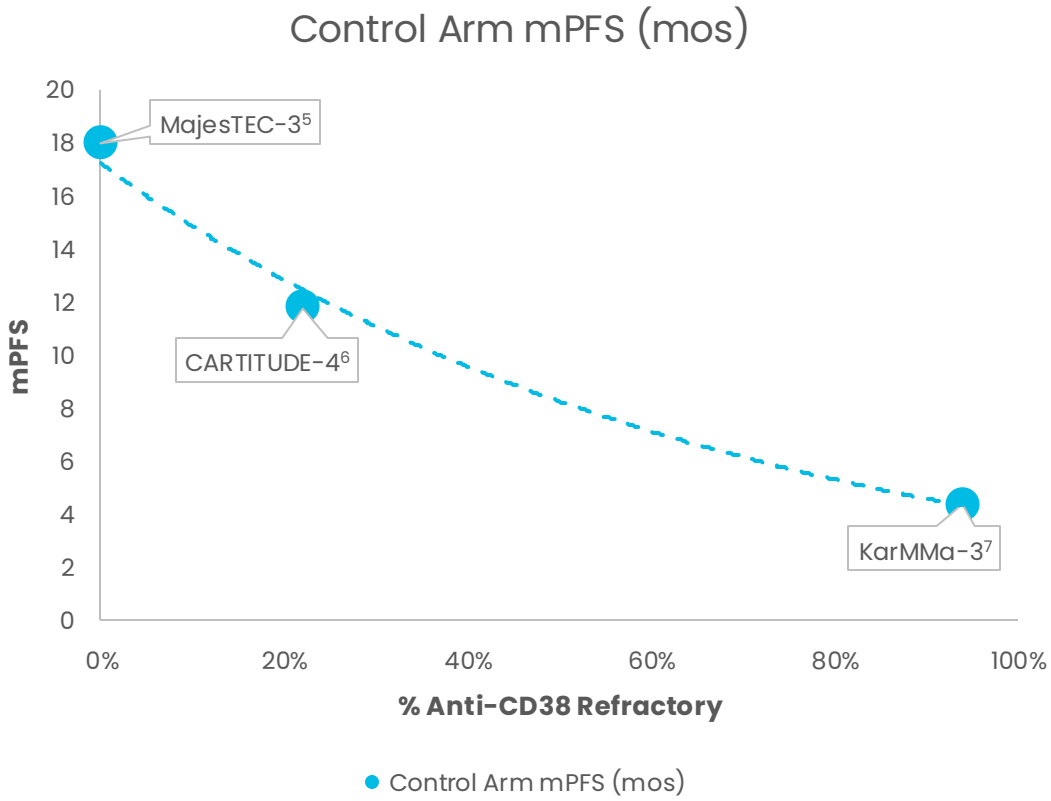
Utilization of Dara in non-Dara refractory patients has historically increased mPFS by ~2x – 2.5x

mPFS (in months): Dara Triplets vs Comparator



In Dara refractory patients, Dara-based regimens have historically demonstrated ~4x lower PFS

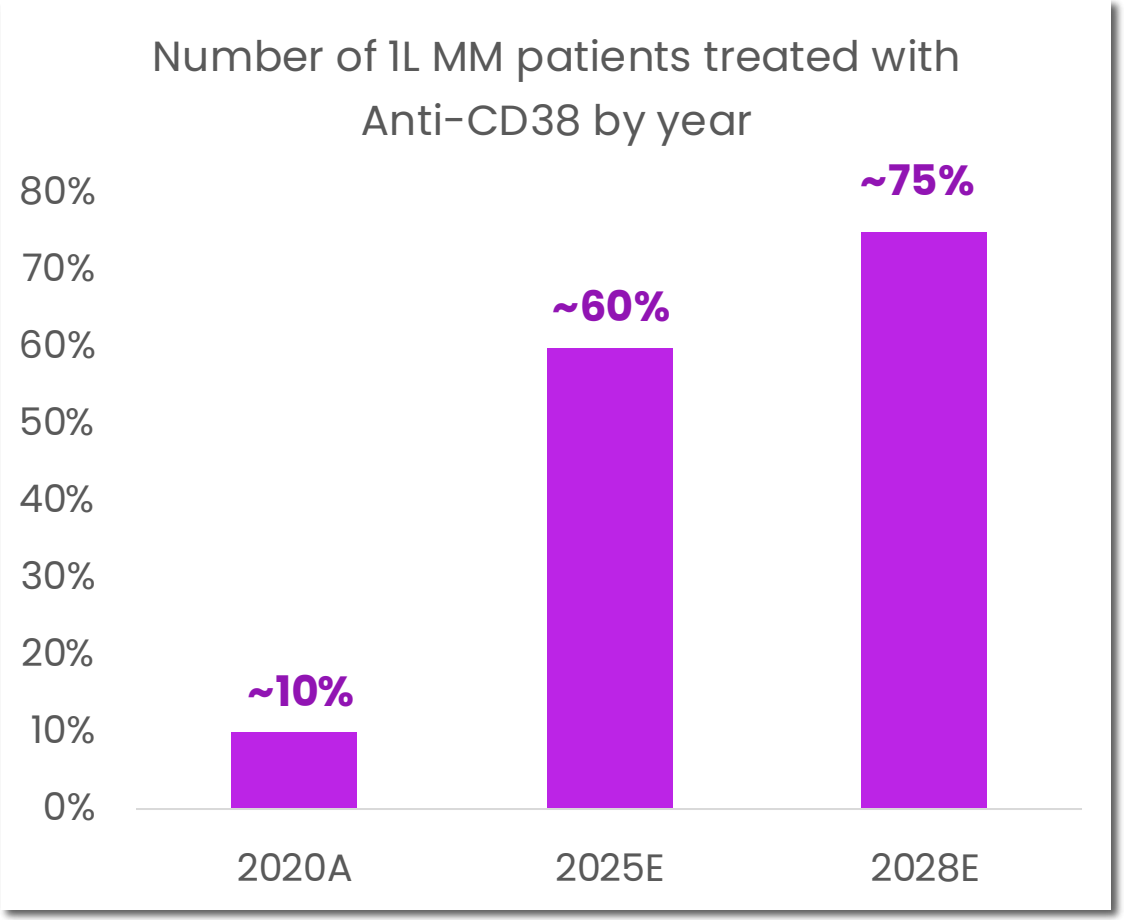
mPFS (in months) versus % Anti-CD38 refractory



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.
[1]Kaufman et al. (2019); [2]Usmani et al. (2023); [3]Sonneveld et al. (2022); [4]Dimopoulos et al. (2021);); [5]Mateos et al ASH 2025, Abstract LBA-6; [6]San-Miguel et al. (2023); [7]Rodriguez-Otero (2023).
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.

Increasing Anti-CD38 in 1L Results in Majority Anti-CD38 Refractory in 2L+

MajesTEC-3 Patient Population Is Not Reflective of Anticipated Clinical Practice



Anti-CD38 based regimens in 1L have demonstrated strong results[1,2] and are **now used as standard of care**[3]

By 2030, **majority of 2L-4L patients are expected to be anti-CD38 refractory**

Anti-CD38 refractory patients are **not eligible for MajesTEC-3 regimen**[4]

[1]Phase 3 PERSEUS study (NCT03710603); [2]Phase 3 MAIA study (NCT02252172);
[3]Based on Komodo claims analysis, market research, syndicated reports; [4]Phase 3 MajesTEC-3 (NCT05083169) inclusion criteria
Sources: Komodo Claims Analysis, June 2023; market research, internal analyses, estimates and projections by Kite and Arcellx

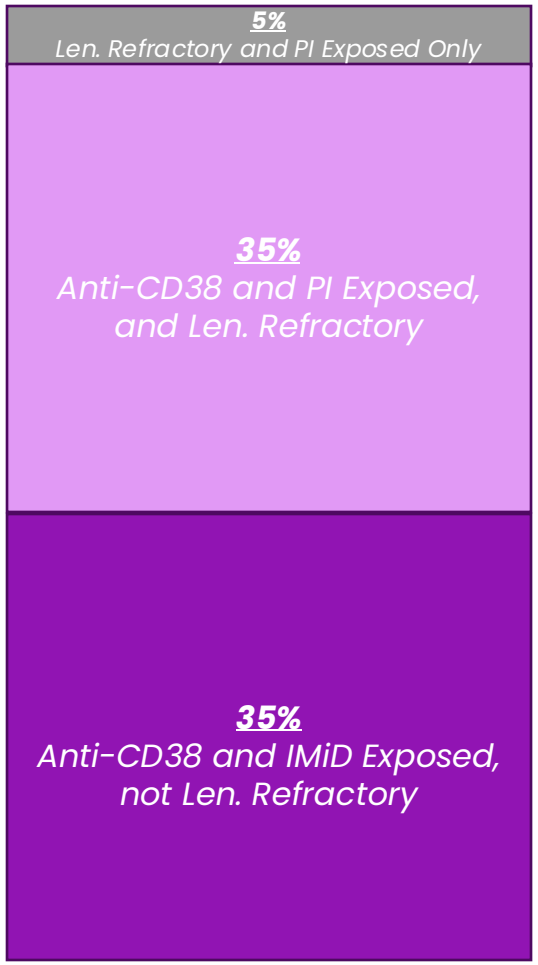
iMMagine-3 Captures Largest Anticipated 2L Population

% 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%

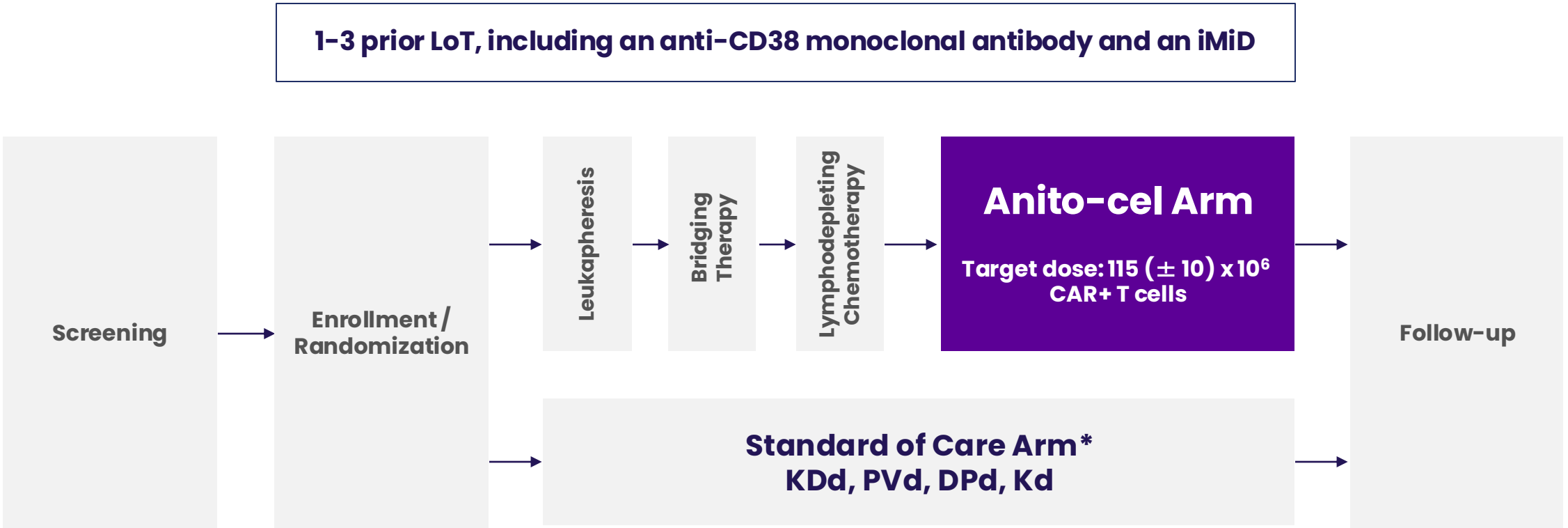
of 2L patients projected to be Anti-CD38 + IMiD exposed

~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

Anito-cel iMMagine-3 (NCT06413498): Global Phase 3 Trial Currently Enrolling



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

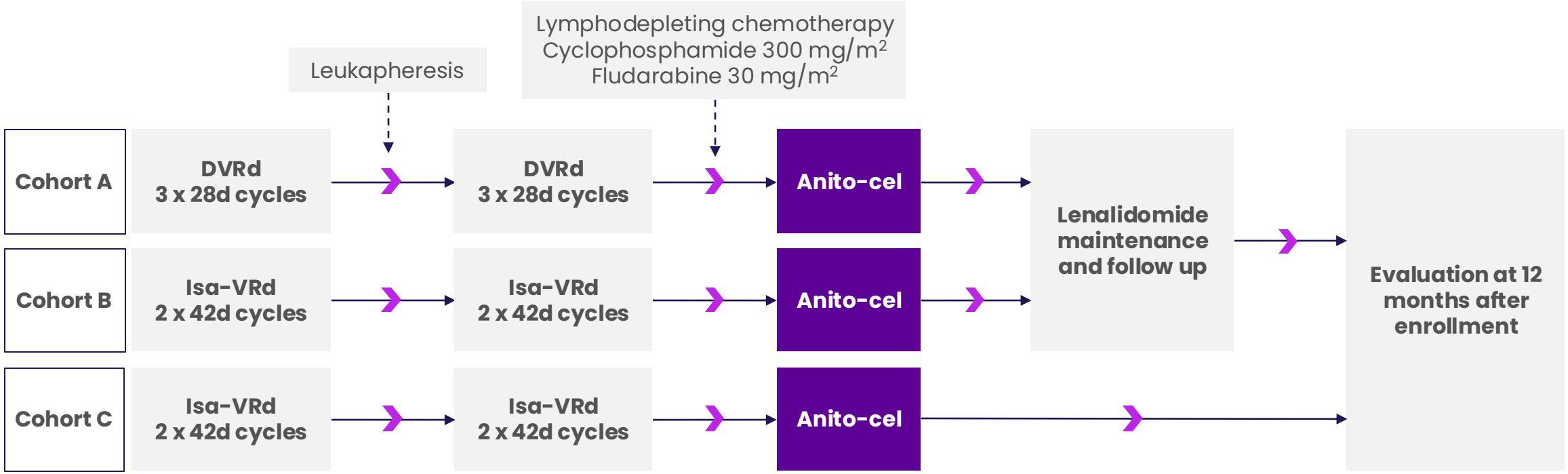
Study Endpoints
- Primary Endpoints:
  - PFS
  - MRD-negative CR rate at 9 months
- Key Secondary Endpoints: CR rate, MRD, OS, safety

*Cycles will continue until unacceptable toxicity, progression as per IMWG criteria, orpatient withdrawal of consent

GEM-AnitoFIRST: Safety Lead-In for NDMM iMMagine-4 Study

Collaborative Study with PETHEMA Foundation and GEM

Phase 2, open-label, multicenter multi-cohort study to evaluate the efficacy and safety of anito-cel in participants with newly diagnosed multiple myeloma (NDMM)



Eligibility

- Newly diagnosed multiple myeloma
- Cohort A: transplant eligible
- Cohorts B and C: not intended for transplant (not eligible or not planned)

Primary Endpoints

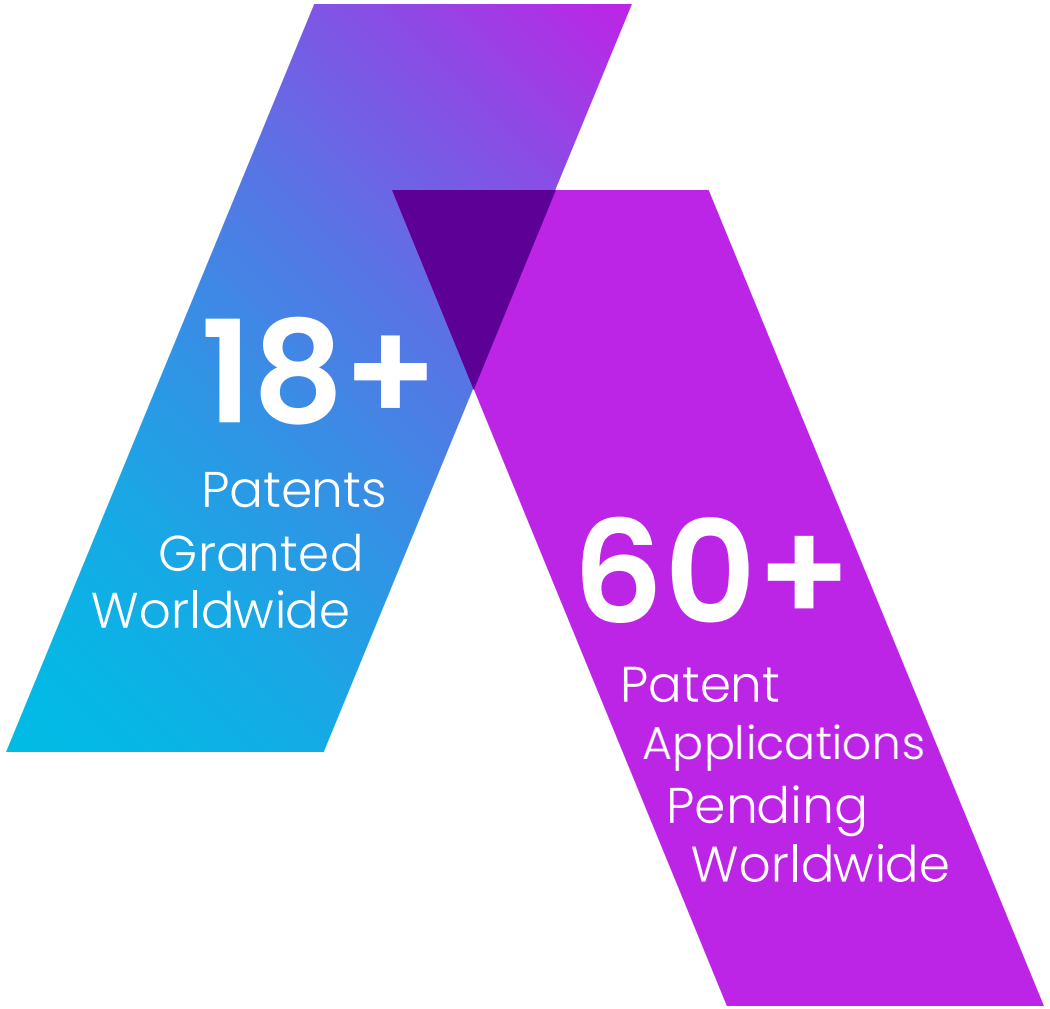
- Safety (Incidence and severity of all adverse events)
- Minimal residual disease (MRD)

DVRd, daratumumab, bortezomib, lenalidomide and dexamethasone; Isa-VRD, isatuximab, bortezomib, lenalidomide and dexamethasone; GEM, Grupo Español De Mieloma

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 Chief Executive Officer

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

Kate Aiken
Chief People Officer

Doug Alleavitch
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Chief IR and Communications Officer

Brian Murphy, PhD
VP, Cell Product Sciences

Heba Nowyhed, PhD
Chief Scientific Officer

Narinder Singh
Chief Technical Officer

Neeraj Teotia
Chief Commercial 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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