

Administration of anitocabtagene autoleucel (anito-cel)

ICD-10 Coordination & Maintenance Committee Update

Fall 2025



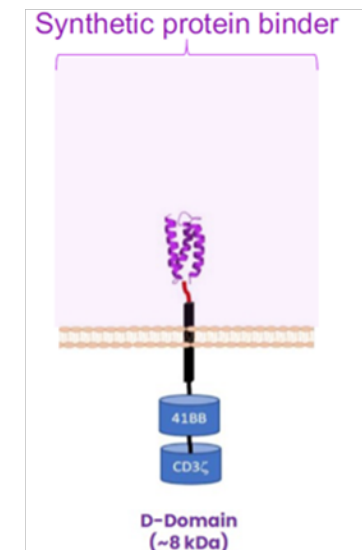
ICD-10 Coordination & Maintenance Committee Update – Fall 2025



Anitocabtagene Autoleucel (anito-cel)

- Anito-cel is an autologous BCMA-directed CAR T-cell therapy using a novel D-Domain with a robust clinical development program:
 - Phase 1 trial for the treatment of patients with relapsed or refractory multiple myeloma (RRMM) after 3 or more lines of therapy, including an immunomodulatory agent, a proteasome inhibitor, and an anti-CD38 monoclonal antibody or who are triple class refractory¹
 - Pivotal Phase 2 iMMagine-1 trial for the treatment of patients with RRMM after 3 or more lines of therapy, including an immunomodulatory agent, a proteasome inhibitor, and an anti-CD38 monoclonal antibody, and who are refractory to their last line of therapy²
 - Phase 3 iMMagine-3 trial for the treatment of patients with RRMM after 1-3 prior lines of therapy, including an immunomodulatory agent and an anti-CD38 monoclonal antibody³
- Anito-cel has been granted Fast Track, Orphan Drug, and Regenerative Medicine Advanced Therapy designations by the U.S. Food and Drug Administration
- Anito-cel launch is targeted for 2026

Anito-cel Novel, D-Domain Binder



*Designed to overcome limitations seen with other
BCMA-directed CAR T-cell therapies*

BCMA, B Cell maturation antigen; CAR, chimeric antigen receptor

1. Bishop et al. American Society of Hematology, Poster 4825. 2. Kaur et al. European Hematology Association, Abstract S201.3. ClinicalTrials.gov (NTC06413498).

Unmet Needs in the Treatment of Patients with Relapsed/Refractory Multiple Myeloma

Multiple Myeloma (MM) is an incurable cancer of plasma cells. ~192,144 patients are estimated to be living with myeloma in the US, with majority of patients being ≥ 65 years old¹

RRMM is characterized by progressively worse outcomes and increased refractoriness with each line of therapy

Current treatment limitations in 4L+ RRMM

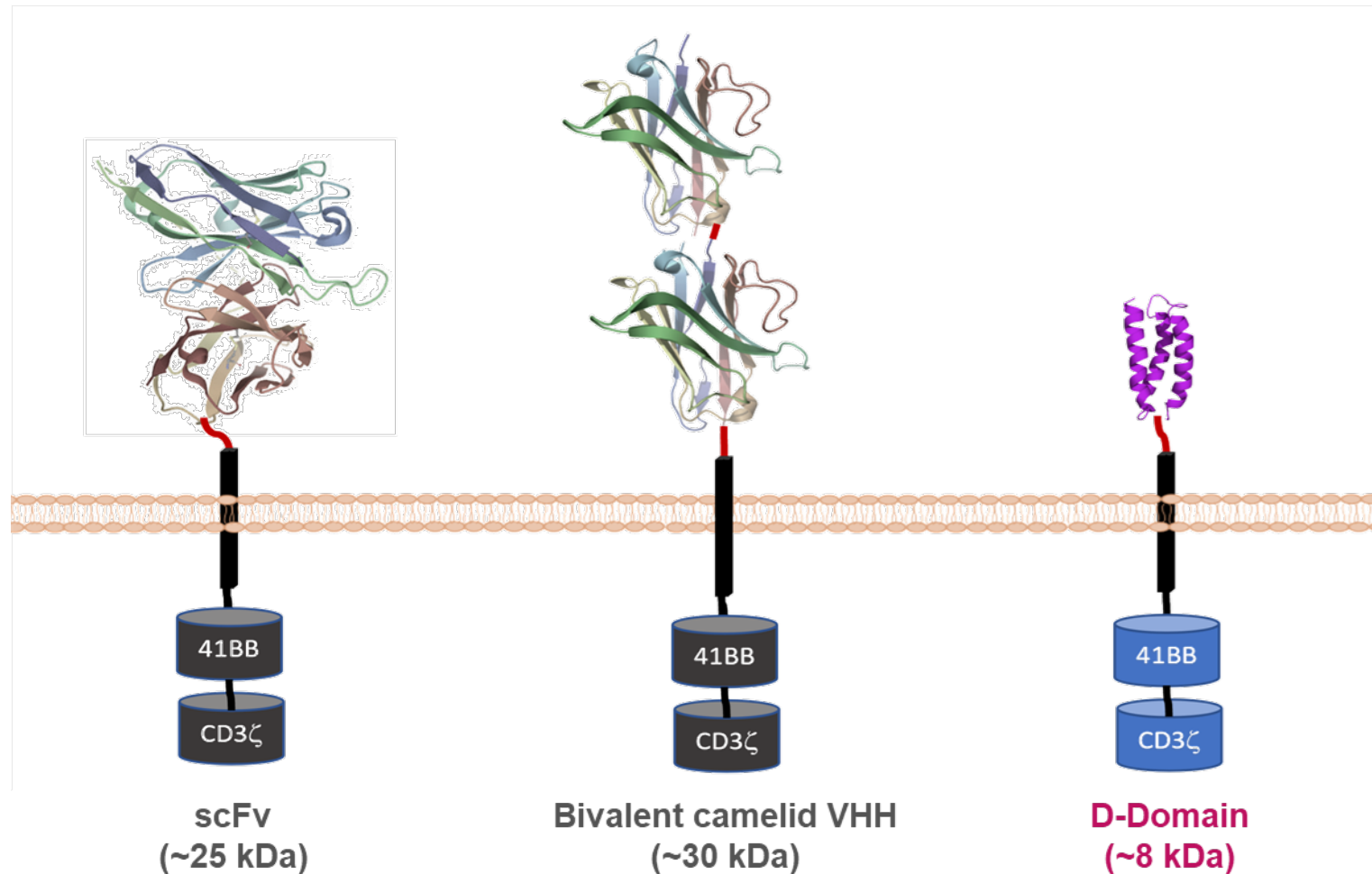
- Median OS decreases from 61.0 months to 14.8 months for patients treated in the 1L and 4L respectively²
- Median PFS decreases from 34.2 months to 5.7 months for patients treated in the 1L and 4L, respectively³
- Prognosis for the 4L+ TCE RRMM population is very poor with median progression-free survival (PFS) and overall survival (OS) of 4.1 and 15.4 months, respectively⁴

- Patients with 4L+ RRMM, including those with high-risk features, have ongoing unmet need⁵⁻⁷
 - Not all currently available bispecific monoclonal antibodies and CAR T-cell therapies produce deep or durable responses⁸⁻¹³
 - Currently available bispecific monoclonal antibodies and CAR T-cell therapies have been associated with serious adverse events, including CRS, ICANS, immune effector cell-associated enterocolitis, delayed neurotoxicities, prolonged cytopenias, and infections⁸⁻¹⁴

4L+, 4th+ line of therapy; CRS, cytokine release syndrome, ICANS, immune effector-cell associated neurotoxicity; MM, multiple myeloma; RRMM, relapsed or refractory multiple myeloma; TCE, triple-class exposed

1. NCI. Cancer Stat Facts: Myeloma. 2. Leleu X, et al. *Eur J Haematol*. 2023;111(1):125-134. 3. Goel U, et al. *Blood Cancer J*. 2023;13(1):11. 4. Sidana S, et al. *Blood*. (2024) 144 (Supplement 1) : 6962.
5. Leleu X, et al. *Eur J Haematol*. 2023;111(1):125-234. 6. Goel U, et al. *Blood Cancer J*. 2023;13(1):11. 7. Costa LJ, et al. *Blood*. 2022;149 (suppl 1):10084-10085. 8. Berdeja JG, et al. *Lancet*. 2021;398(10297):314-324. 9. Cohen A, et al. *Blood Cancer J*. 2022;12:32. 10. Munshi N, et al. *N Engl J Med*. 2021;384(8):705-716. 11. Moreau P, et al. *N Engl J Med*. 2022;187:495-505. 12. Chari A, et al. *N Engl J Med*. 2022;187:2232-2244. 13. Lesokhin A, et al. *Nature Med*. 2023;29:2259-2267. 14. Fortuna G.G, et al. *Blood Cancer J*. 2024;14:180

Anito-cel: Autologous BCMA-Directed CAR T-Cell Therapy Using a Novel D-Domain Binder



D-Domain Attributes: Non-Antibody Derived Synthetic Protein^{1,2}

Size

Small D-Domain construct facilitates high transduction efficiency and CAR positivity²⁻⁴ resulting in a low total cell dose

Structure & Stability

D-Domain CARs are stable and lack tonic signaling^{4,6} due to the rapid folding, lack of disulfide bonds, and hydrophobic core^{5,6} of the D-Domain

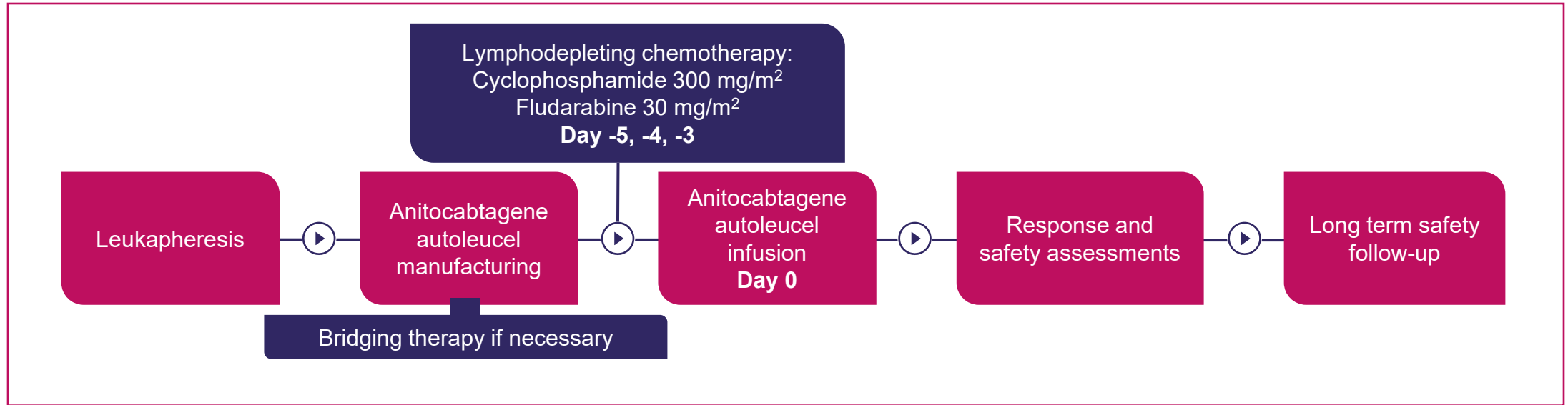
Binding

The D-Domain binder has a fast off-rate⁴ and high CAR surface expression⁴. This combination may allow optimal tumor cell killing without prolonged inflammation

Source: Kaur et al, European Hematology Association 2025, Abstract S201

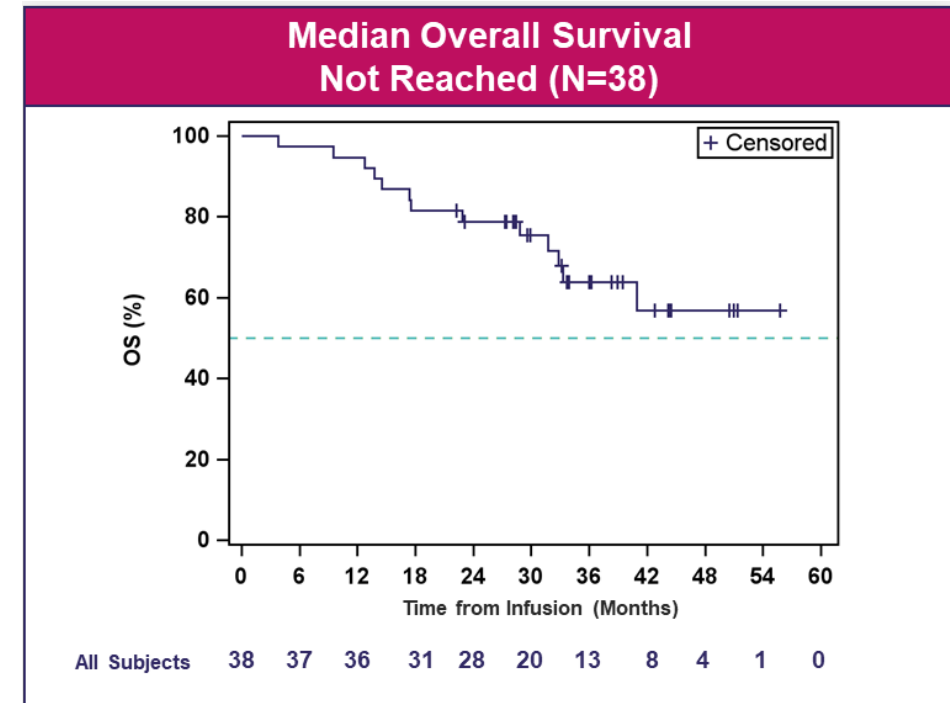
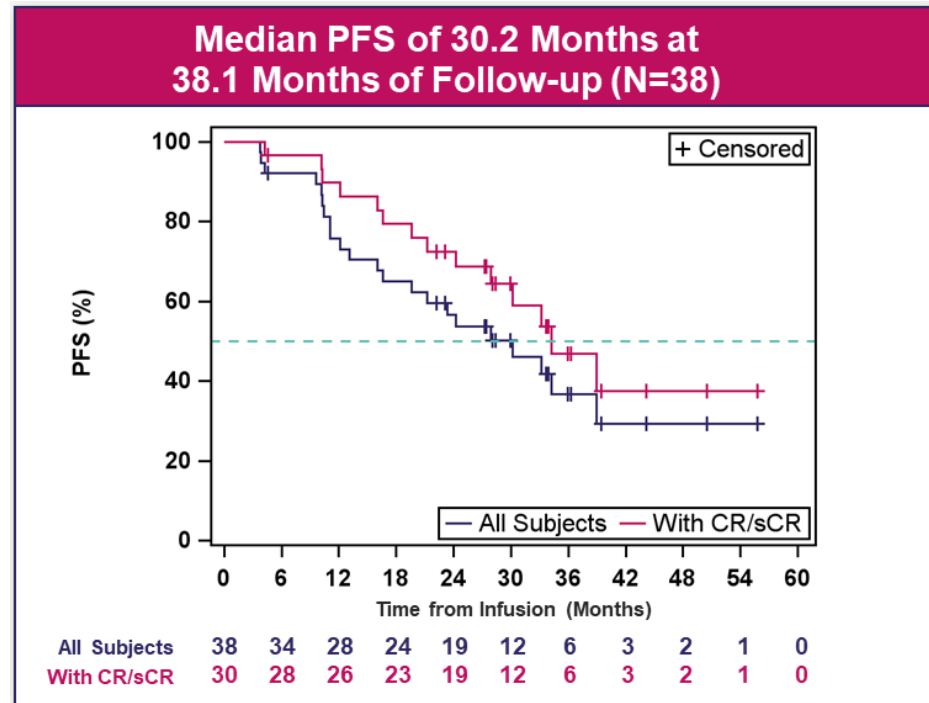
1. Rotte, et al. Immuno-Oncology Insights 2022; 3(1), 13–24.
2. Frigault, et al. Blood Adv. 2023; 7(5):768-777.
3. Cante-Barrett, et al. BMC Res. Notes 2016; 9:13.
4. Buonato, et al. Mol. Cancer Ther. 2022; 21(7):1171-1183.
5. Zhu, et al. Proc. Nat. Acad. Sci. 2003; 100(26): 15486-15491.
6. Qin, et al.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

Anito-cel Treatment Journey and Single-dose Infusion



- Anito-cel is a single-dose infusion consisting of $115 \pm 10 \times 10^6$ autologous CAR-positive viable BCMA-directed T cells.
- Infusion of anito-cel can be administered in either the inpatient or outpatient setting, at the discretion of the provider.
- It is expected that the single-dose anito-cel intravenous infusion procedure will be documented in the medical record in the same manner as other therapies that are administered via intravenous infusion, including within the medication records, physician orders, and progress notes.

In the Phase 1 study, anito-cel achieved rapid, high response rates with long-term durable remissions in a refractory, heavily pre-treated 4L+ RRMM population



- 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

Source: Bishop et al, American Society of Hematology 2024, Poster 4825

CRS, cytokine release syndrome; ICANS, immune effector cell-associated neurotoxicity syndrome; ORR, overall response rate; OS, overall survival; PFS, progression-free survival; sCR, stringent complete response.

iMMagine-1: Pivotal Phase 2 Study

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

Anito-cel Target Dose of 115×10^6 CAR+ T cells

Primary Endpoint:

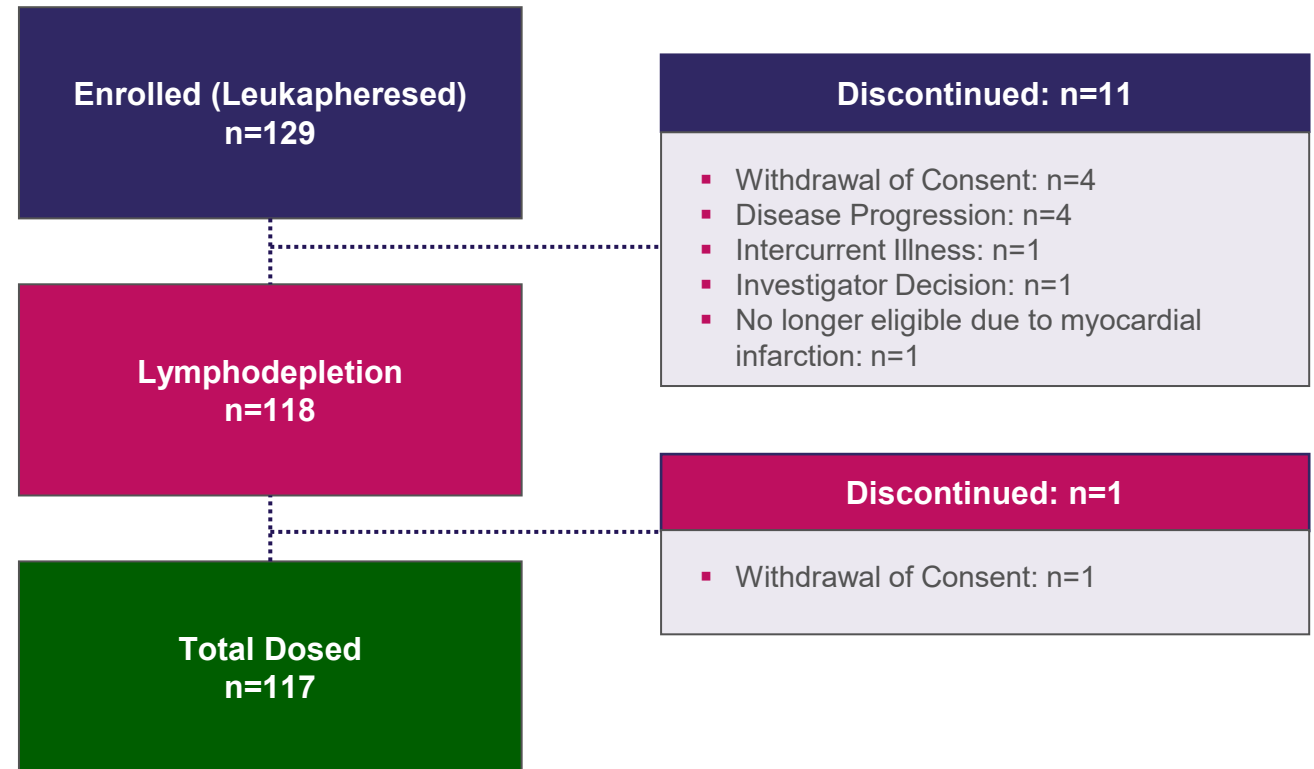
- ORR, per 2016 IMWG criteria

Select Secondary Endpoints:

- | | |
|--|-------|
| ▪ sCR/CR rate, per 2016 IMWG criteria | ▪ DOR |
| | ▪ PFS |
| ▪ ORR in patients limited to 3 prior LoT, per 2016 IMWG criteria | ▪ OS |

Overall Patient Disposition and Evaluable Populations

Data cut-off: May 1, 2025; Median follow-up of 12.6 months (range: 5-29 months)



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

Sources: Kaur et al, European Hematology Association 2025, Abstract S201; ClinicalTrials.gov. NCT05396885.

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; DOR, duration of 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; OS, overall survival; PFS, progression-free survival; PI, proteasome inhibitor; sCR, stringent complete response.

iMMagine-1: Patient and Disease Characteristics

Characteristics	N=117
Age (yrs), median (min - max)	64 (38 – 78)
Age ≥ 65	58 (50%)
Age ≥ 70	33 (28%)
Age ≥ 75	10 (9%)
Gender (male / female)	66 (56%) / 51 (44%)
Race	
White	89 (76%)
Black / African American	17 (15%)
Asian / Other	11 (9%)
ECOG PS 0 / 1	53 (45%) / 63 (54%)
Extramedullary disease ^a	18 (15%)
High risk cytogenetics ^b	44 (38%)
Refractory to last line of therapy	117 (100%)
Triple refractory	100 (86%)
Penta refractory	47 (40%)
Prior lines of therapy, median (min - max)	3 (3 – 8)
3 Prior LoT	60 (51%)
Time since diagnosis (yrs), median (min-max)	7.2 (1.0 – 23.1)
Prior ASCT	92 (79%)
Bridging therapy	88 (75%)
Outpatient administration	10 (9%)

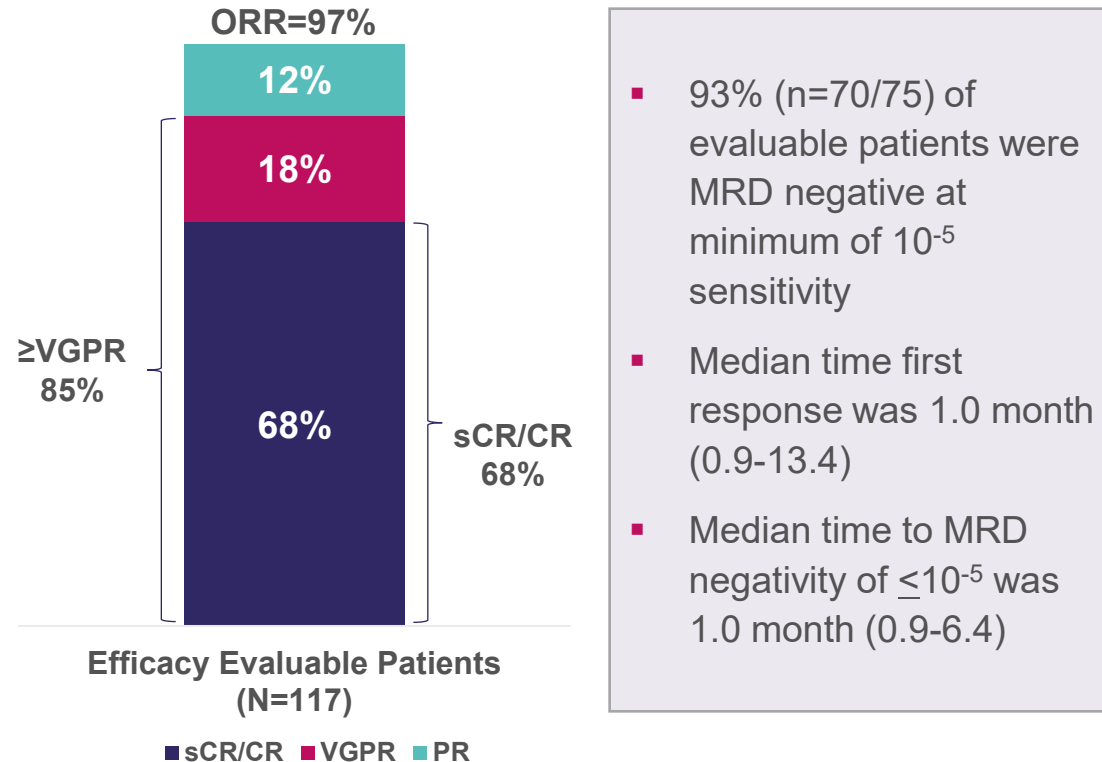
Source: Kaur et al, European Hematology Association 2025, Abstract S201

a) Presence of a non-bone based plasmacytoma; b) Defined as the presence of Del 17p, t(14;16), or t(4;14).

ASCT, autologous stem cell transplant; ECOG PS, Eastern Cooperative Oncology Group Performance Status; LoT, line of therapy

iMMagine-1: Efficacy Evaluable Patients (N=117)

Overall Response Rate & MRD Negativity



PFS and OS Rates Estimated by Kaplan-Meier

	PFS Rate (%) (95% CI)	OS Rate (%) (95% CI)
6-Month	91.9% (85.0%, 95.7%)	96.6% (91.1%, 98.7%)
12-Month	79.3% (68.6%, 86.7%)	95.2% (88.7%, 98.0%)

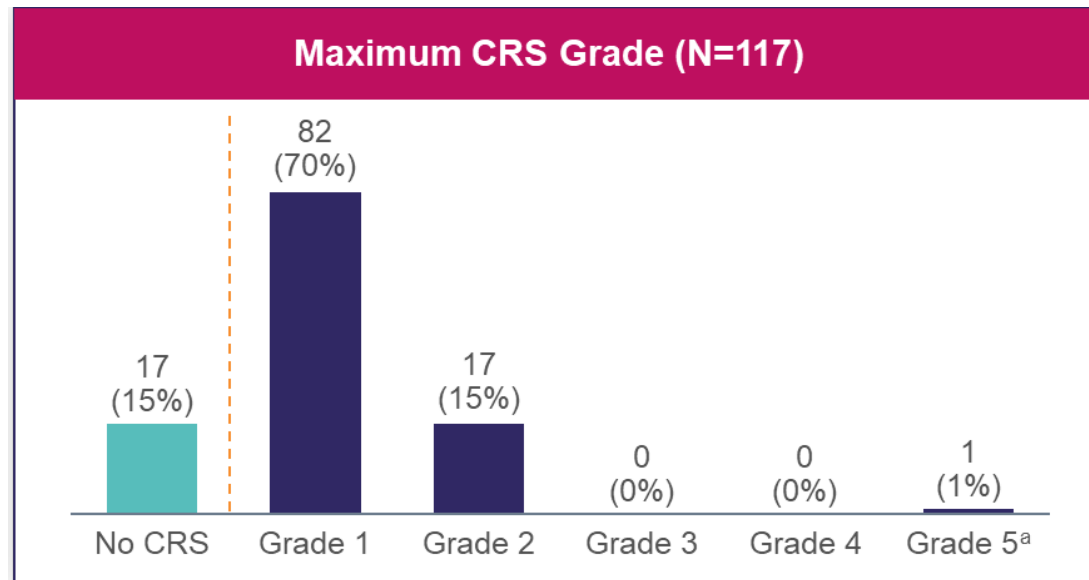
Source: Kaur et al, European Hematology Association 2025, Abstract S201

Responses are investigator assessed per IMWG criteria, ORR defined as partial response or better; MRD evaluable patients had an identifiable malignant clone in the baseline bone marrow sample and had a post-treatment bone marrow sample sufficient to assess MRD negativity

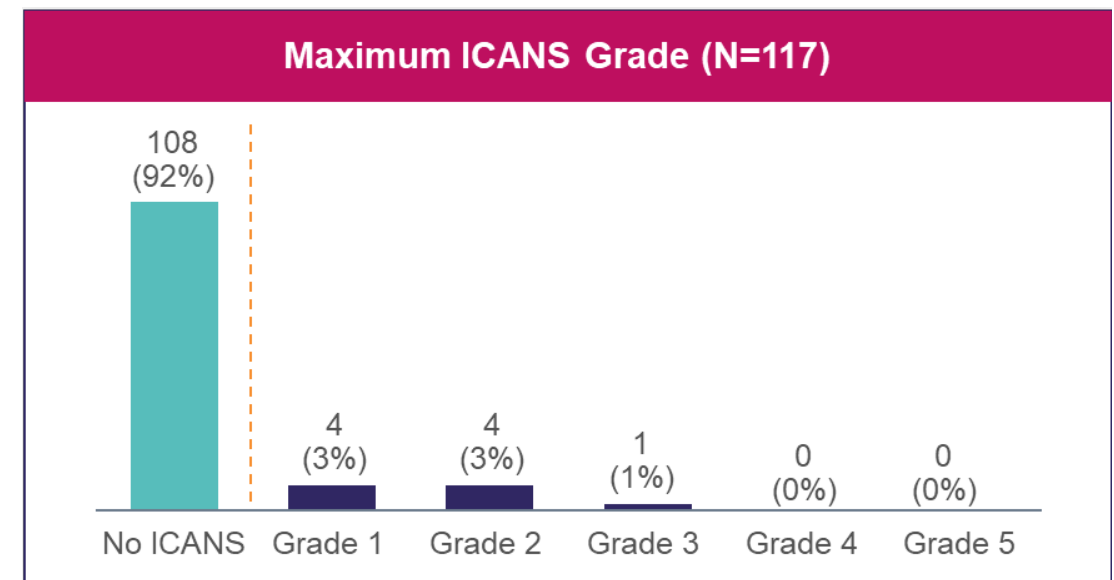
Median follow-up of 12.6 months (range 5 to 29 months) as of the data cut-off date of 05/01/2025

CR, complete response; MRD, minimal residual disease; ORR, overall response rate; OS, overall survival; PFS, progression-free survival; PR, partial response; sCR, stringent complete response; VGPR, very good partial response

iMMagine-1: Cytokine Release Syndrome (CRS) & Immune Effector Cell-Associated Neurotoxicity Syndrome (ICANS)



4-day median onset (range: 1-17 days)
2-day median duration (range: 1-9 days)



7-day median onset (range: 2-10 days^b)
4-day median duration (range: 1-12 days^c)

No delayed or non-ICANS neurotoxicities were observed, including no incidence of Parkinsonism, no cranial nerve palsies, and no Guillain-Barré syndrome^d

Source: Kaur et al, European Hematology Association 2025, Abstract S201

CRS & ICANS graded per American Society for Transplantation and Cellular Therapy (ASTCT) criteria. CRS management was in line with standard medical practice with no prophylactic administration of tocilizumab or dexamethasone; for CRS onset in the first 48 hours of anito-cel infusion, tocilizumab and dexamethasone were protocol recommended.

^aGrade 5 CRS occurred in a 76-year-old patient who had rapidly progressive disease between screening and baseline and did not respond to bridging therapy. ^bWith the exception of n=1 Grade 1 ICANS (confusion) on day 31 post infusion that rapidly resolved. ^cWith the exception of n=1 max Grade 2 ICANS with 29-day duration to resolution ^dMedian follow-up of 12.6 months (range 5 to 29 months) as of the data cut-off date of 05/01/2025

iMMagine-1: Other Treatment-Emergent Adverse Events

	Any Grade AEs ≥20% after cell infusion (N=117)	Grade 3/4 AEs after cell infusion (N=117)
Hematologic		
Neutropenia	79 (68%)	77 (66%)
Anemia	32 (27%)	28 (24%)
Thrombocytopenia	28 (24%)	28 (24%)
Non-hematologic		
Fatigue	42 (36%)	3 (3%)
Hypogammaglobulinemia	40 (34%)	1 (1%)
Headache	35 (30%)	2 (2%)
Hypophosphatemia	34 (29%)	2 (2%)
Nausea	32 (27%)	1 (1%)
Diarrhea	32 (27%)	1 (1%)
Hypertension	23 (20%)	12 (10%)
Hypokalemia	23 (20%)	2 (2%)
Infections	61 (52%)	11 (9%)
Upper respiratory tract infection	15 (13%)	2 (2%)
Urinary tract infection	8 (7%)	2 (2%)
COVID-19	7 (6%)	1 (1%)

- The most common Grade 3 and higher treatment-emergent AEs (TEAEs) were cytopenias
- No cases of immune effector cell-associated enterocolitis have been reported
- No replication competent lentivirus detected
- No secondary primary malignancies of T-cell origin or hematologic malignancies were reported
- Three deaths occurred due to TEAEs (related and unrelated to anito-cel)
 - Retroperitoneal hemorrhage* secondary to biopsy complication
 - Cytokine Release Syndrome
 - Fungal infection

Source: Kaur et al, European Hematology Association 2025, Abstract S201

*At baseline prior to infusion, the patient developed plasma cell leukemia, which was an exclusion criteria. Evidence of Grade 4 hemophagocytic lymphohistiocytosis at time of death (only case to date).

TEAE is defined as, 1) any AE with onset date on or after the first anito-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

Summary

- **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 demonstrated deep and durable efficacy in Phase 1 and iMMagine-1 trials**
 - Phase 1: 100% ORR and 79% sCR/CR with median PFS of 30.2 months in all patients and median OS not reached at a median follow up of 38.1 months
 - iMMagine-1: 97% ORR and 68% sCR/CR per IMWG criteria with median PFS and OS not reached at a median follow up of 12.6 months
- **The anito-cel safety profile is predictable and manageable**
 - CRS and ICANS were predominantly low-grade
 - 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
- **More than 150 patients dosed across Phase 1 and iMMagine-1 Phase 2 trials**

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

Sources: Bishop et al, American Society of Hematology 2024, Poster 4825; Kaur et al, European Hematology Association 2025, Abstract S201

CAR, chimeric antigen receptor; CR, complete response; CRS, cytokine release syndrome; ICANS, immune-effector cell-associated neurotoxicity syndrome; IMWG, International Myeloma Working Group; MRD, minimal residual disease; ORR, overall response rate; OS, overall survival; PFS, progression-free survival; RRMM, relapsed or refractory multiple myeloma; sCR, stringent complete response.