



ARCELLX

Investor Relations Event at the 67th ASH Annual Meeting

December 6, 2025



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 not possible for our management team to predict all risk factors or assess the impact of all factors on the business or the extent to which any factor, or combination of factors, may cause actual results to differ materially from those contained in, or implied by, any forward-looking statements. While we may elect to update these forward-looking statements at some point in the future, we specifically disclaim any obligation to do so. These forward-looking statements should not be relied upon as representing our views as of any date subsequent to the date of this presentation. 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.



Agenda

Opening Remarks 20 min

Rami Elghandour

Chairman and Chief Executive Officer, Arcellx

iMMagine-1 Oral Presentation 20 min

Krina Patel, M.D., M.Sc.

iMMagine-1 Clinical Study Investigator

Physician Panel Discussion 20 min

Q&A 30 min





**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

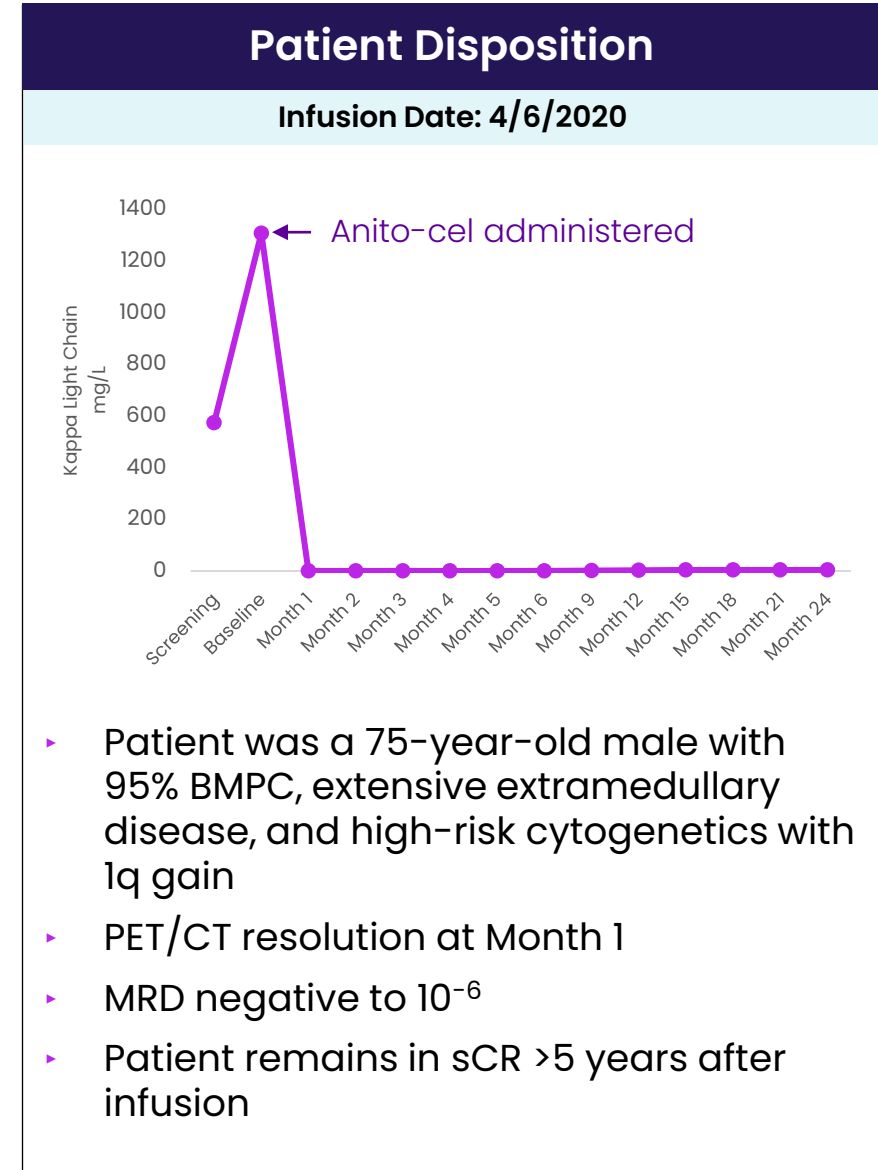
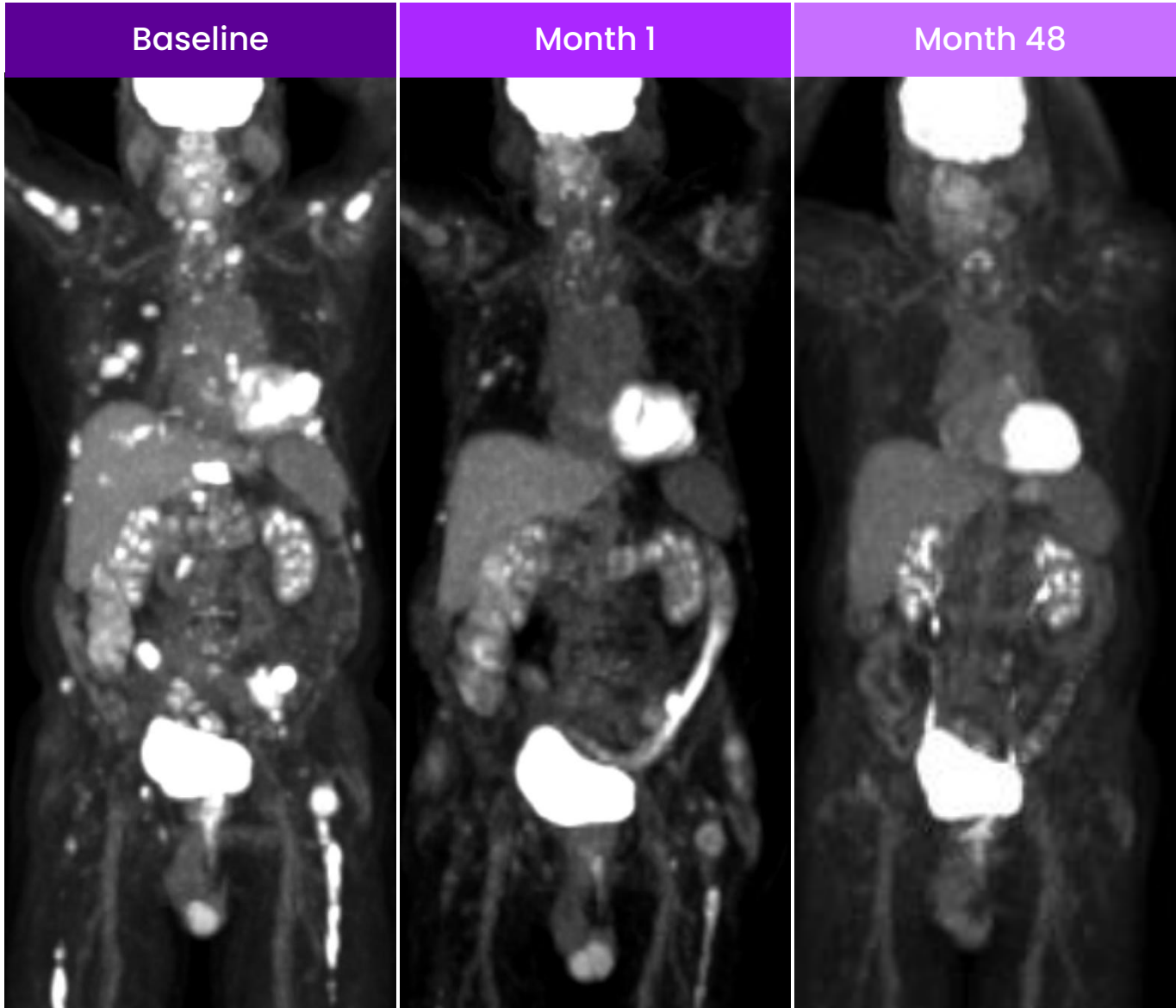


Partnered with Kite to reliably deliver anito-cel at scale and rapidly enter a \$12B+ RRMM market

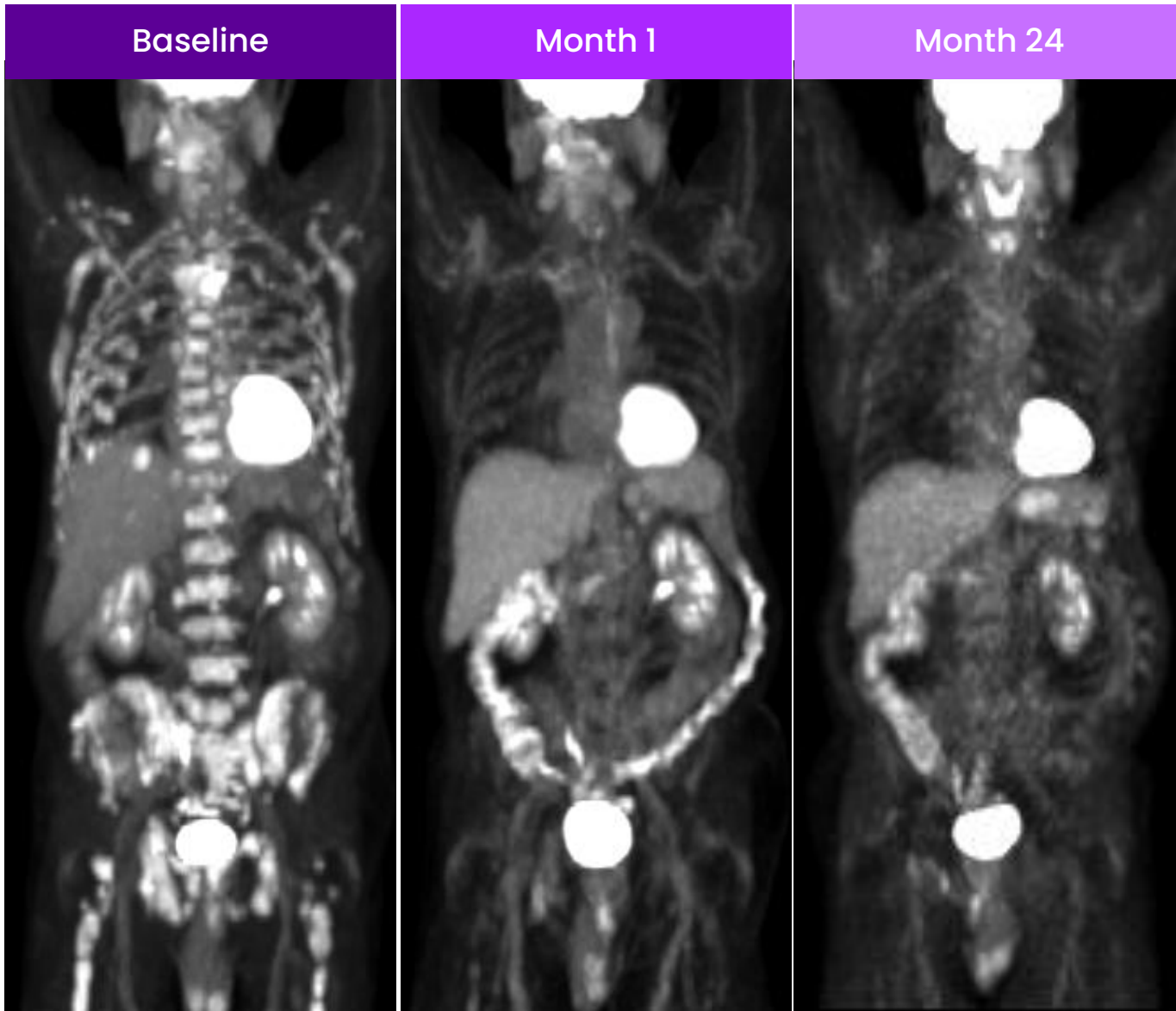


Establishing a scalable business model with anticipated near term profitability; 70% gross margin expected at launch

Early Anito-cel Patient with Extramedullary Disease

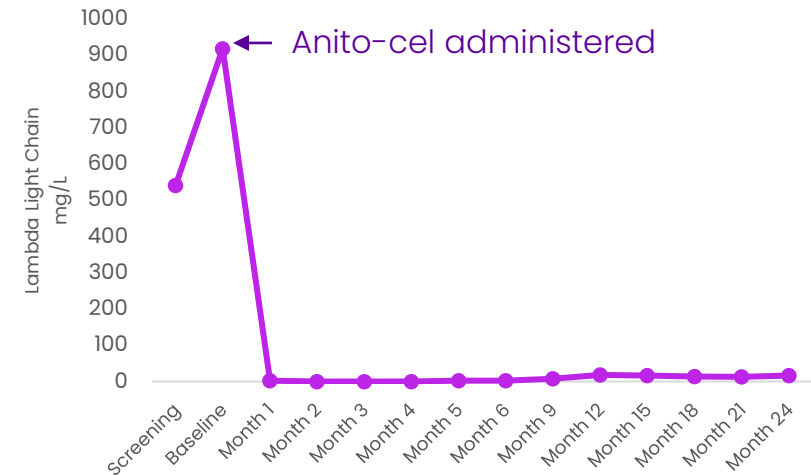


First Patient Dosed Still in Complete Response



Complete response maintained >5 years post anito-cel infusion

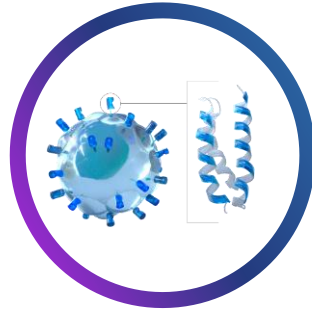
Infusion Date: 2/10/2020



- ▶ 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

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 potential³
- 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}

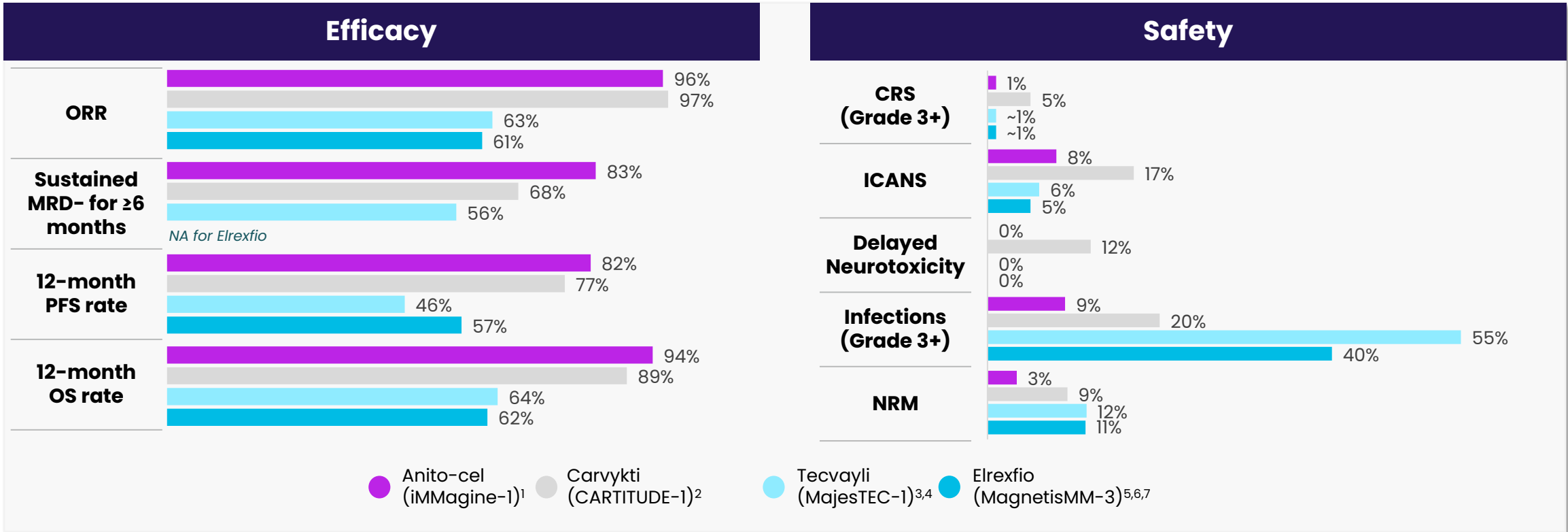
- Low incidence of CRS and ICANS
- No delayed neurotoxicities
- Abundant supply
- Rapid availability (no delays / risk of disease progression)

¹Slide 15; ²Myeloma.org, CAR T-cell Therapy; ³Cancer Network ONCOLOGY® Companion, Volume 39, Supplement 7 Issue 7 Pages: 18-19; ⁴Myeloma.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



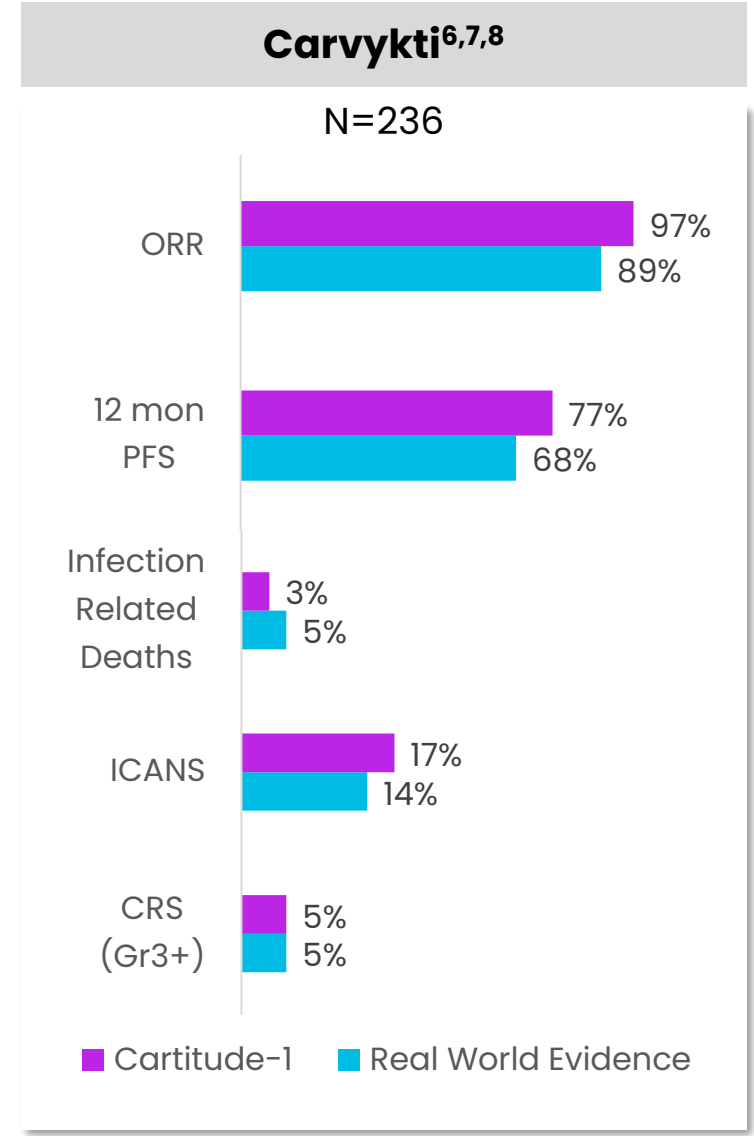
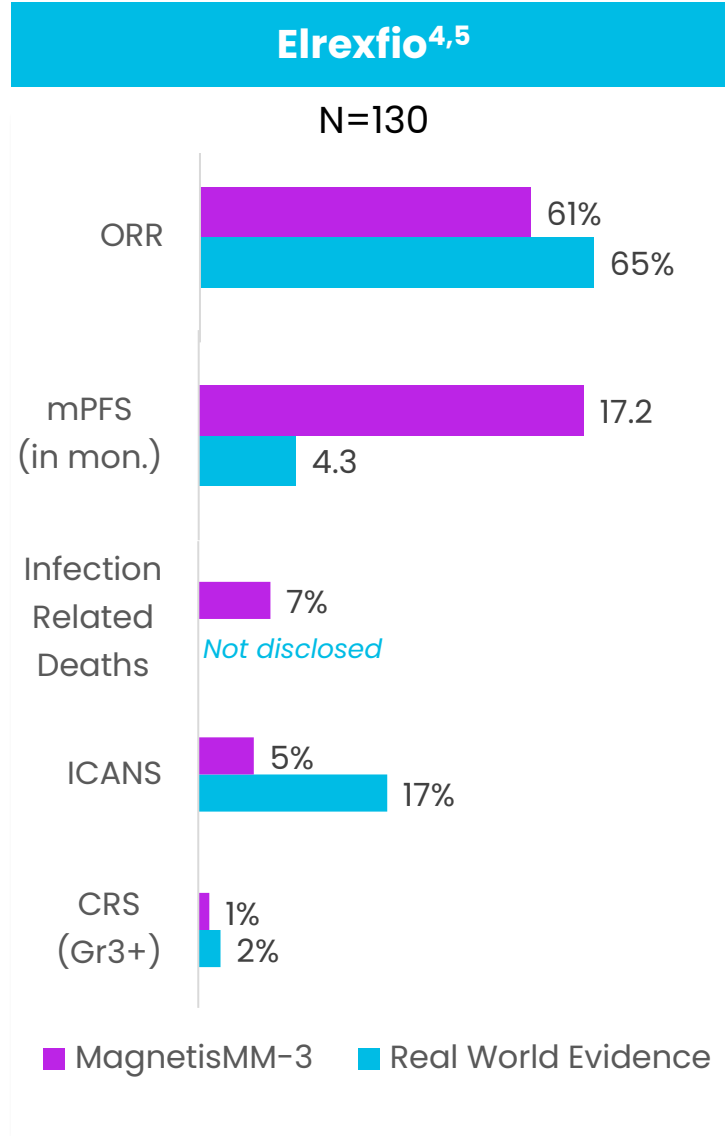
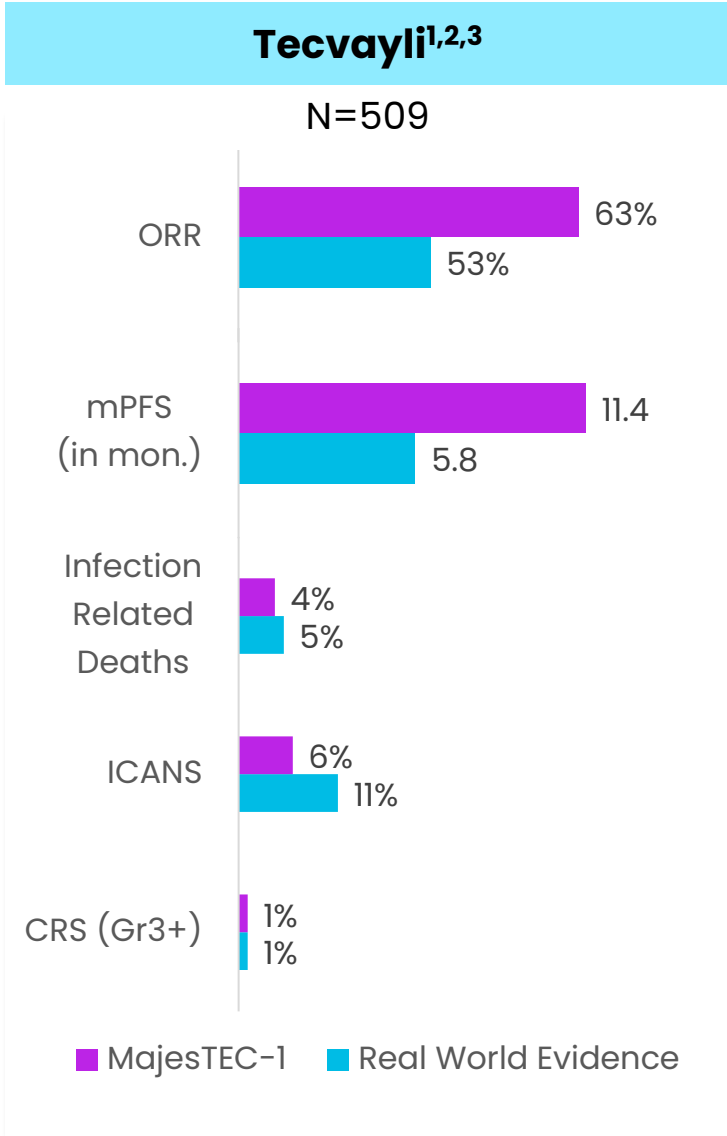
Anito-cel Clinical Profile Uniquely Combines Best of CAR Ts and Bispecifics



- **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 AEs⁷**

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

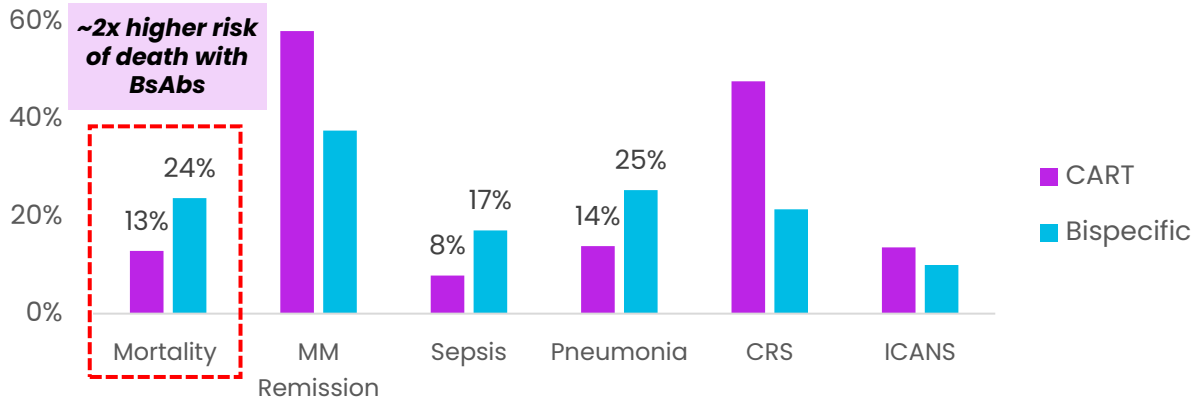


¹Razzo et al. (2025); ²Oriol et al (2024); ³Tecvayli FDA label; ⁴Portuguese et al. ASH 2025 (Abstract 136); ⁵Tomasson et al. (2024); ⁶Sidana et al. (2025); ⁷Madduri et al. (2020). ⁸Lin et al, ASCO 2023. Data above are not from head-to-head studies. Cross-trial data interpretation should be considered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

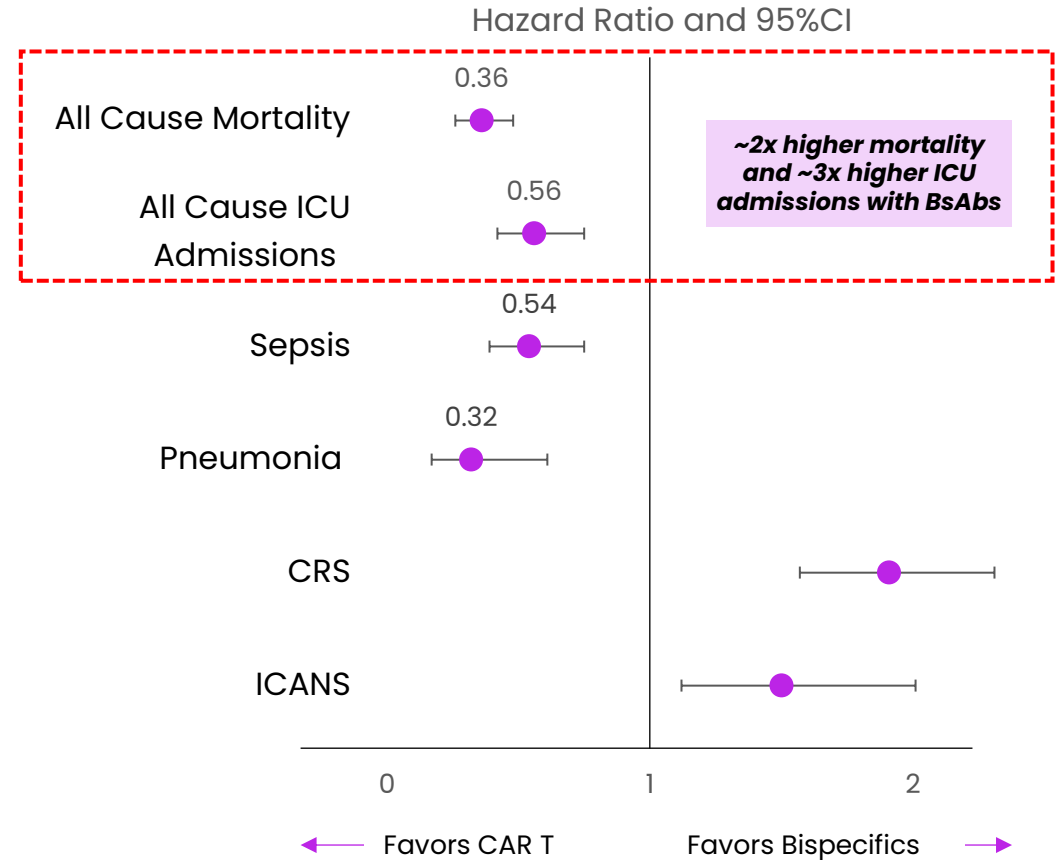


Infections and Low Efficacy Together Drive 2x Higher Mortality and Non-Relapse Mortality (NRM) for Bispecifics versus CAR T in RWE

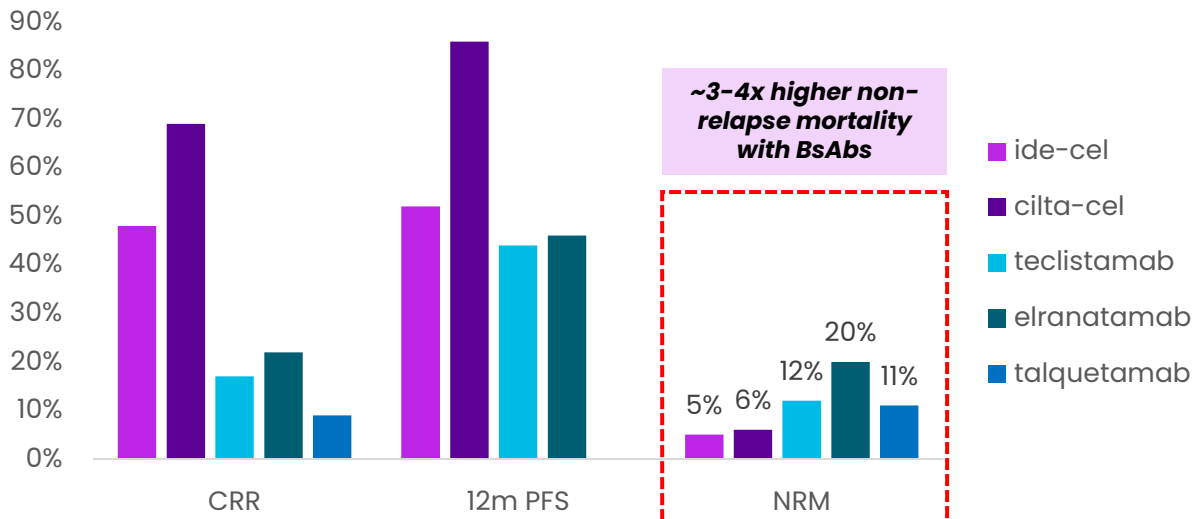
CAR T confers significantly higher remission and survival rates compared to the bispecific antibodies¹



CAR Ts demonstrated substantially lower risk of mortality and ICU admission compared with BsAbs³



CAR Ts demonstrated higher PFS and CRR with significantly lower non-relapse mortality²



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

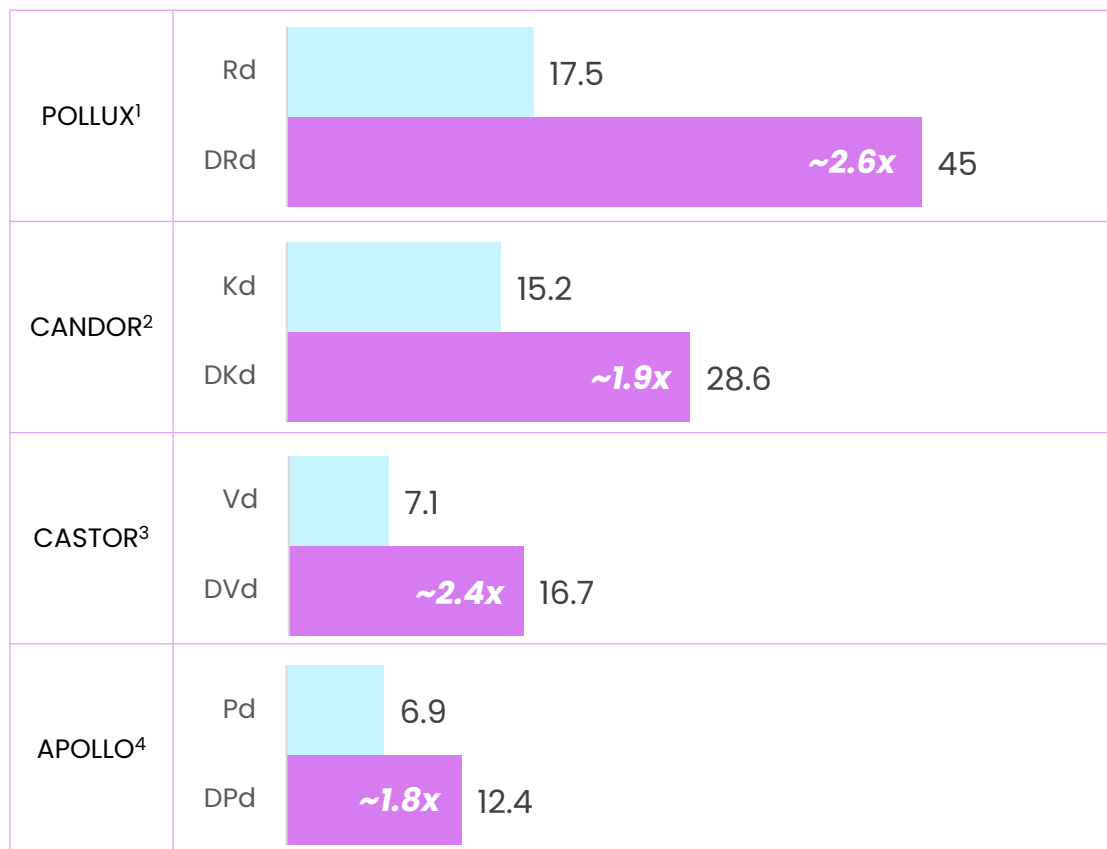
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Anti-CD38 Therapies and Low Refractoriness to Anti-CD38 Have Profound Impacts on PFS

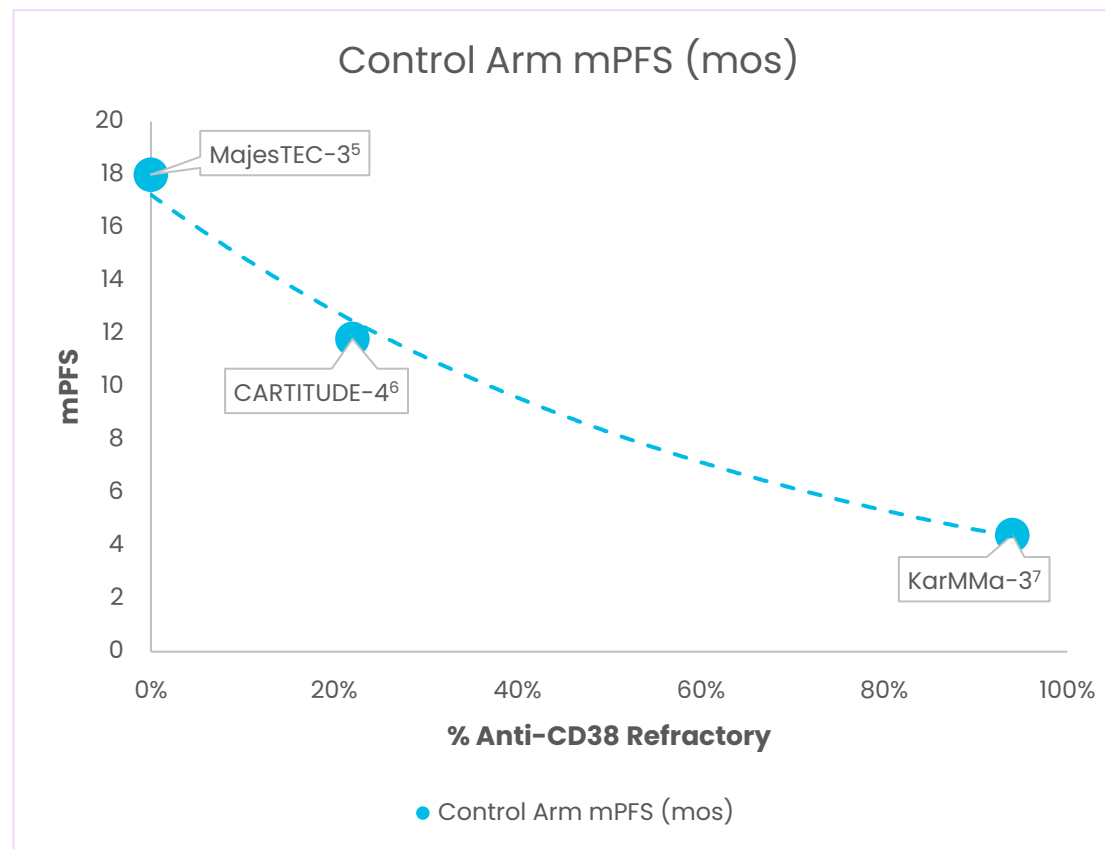
Utilization of Dara in non-Dara refractory patients has historically increased mPFS by ~2x – 2.5x

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

mPFS (in months): Dara Triplets vs Comparator



mPFS (in months) versus % Anti-CD38 refractory

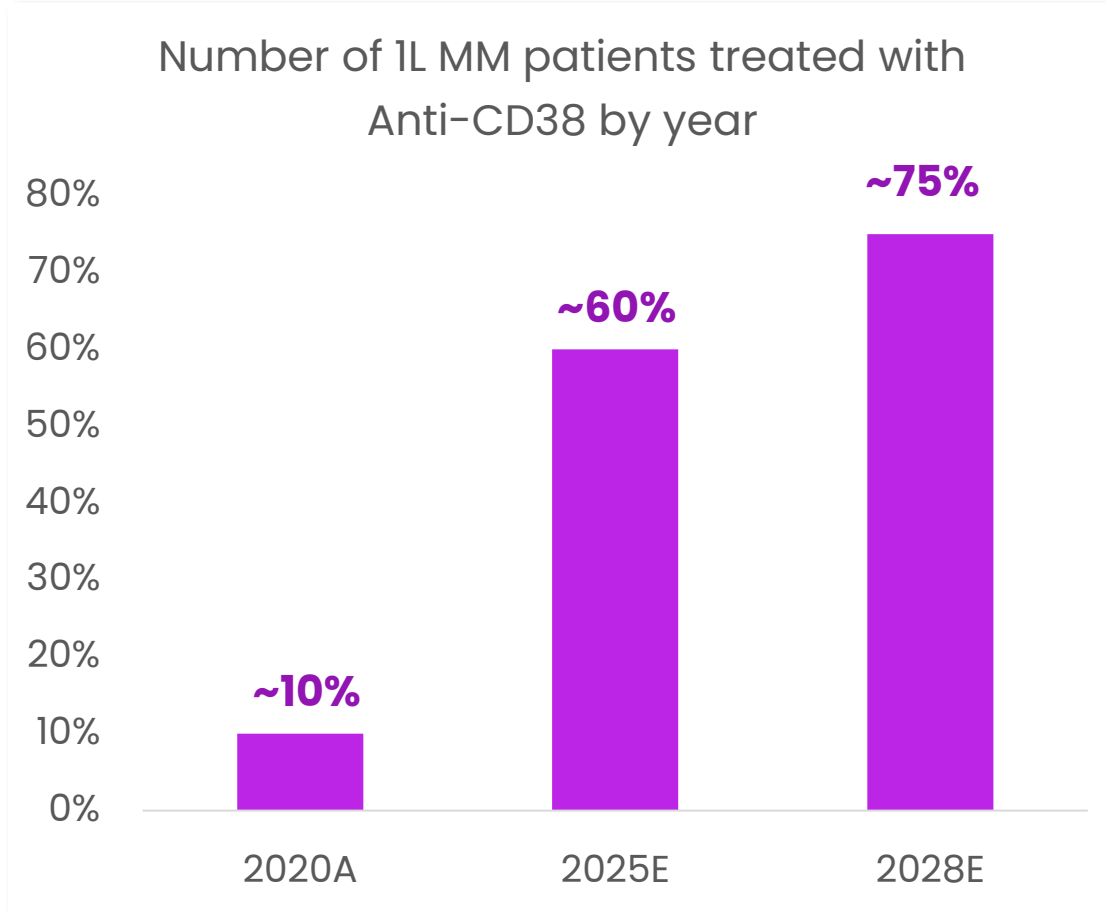


Data above are not from head-to-head studies. Cross-trial data interpretation should be considered with caution as it is limited by differences in median follow-up, study population, design, and other factors. ¹Kaufman et al. (2019); ²Usmani et al. (2023); ³Sonneveld et al. (2022); ⁴Dimopoulos et al. (2021); ⁵Mateos et al ASH 2025, Abstract LBA-6; ⁶San-Miguel et al. (2023); ⁷Rodriguez-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



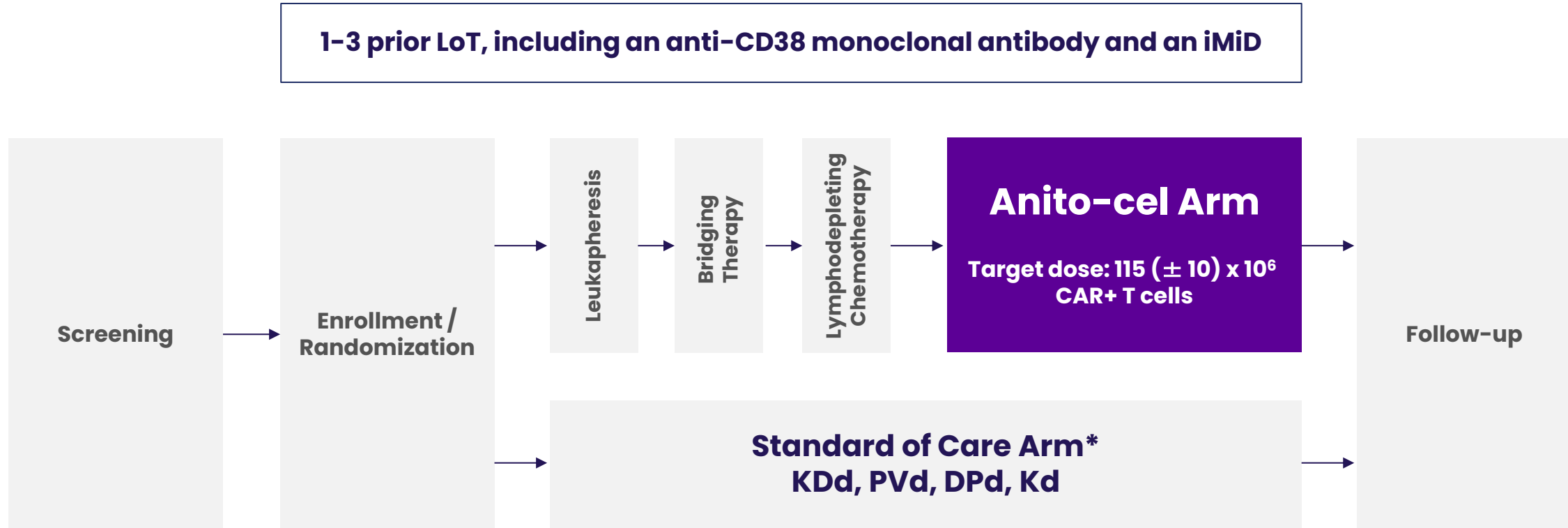
Anti-CD38 based regimens in 1L have demonstrated strong results^{1,2} and are **now used as standard of care**³

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

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

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



Study Design

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

Study Endpoints

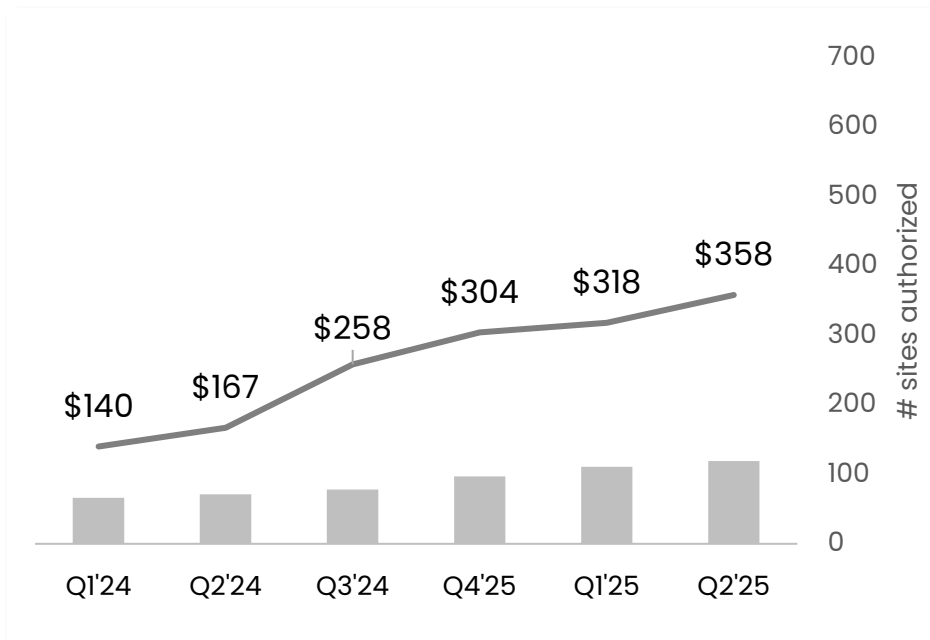
- Primary Endpoints:
 - PFS
 - MRD-negative CR rate at 9 months
- Key Secondary Endpoints: CR rate, MRD, OS, safety

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

US BCMA CAR T Revenue Has Grown Despite Limited Footprint

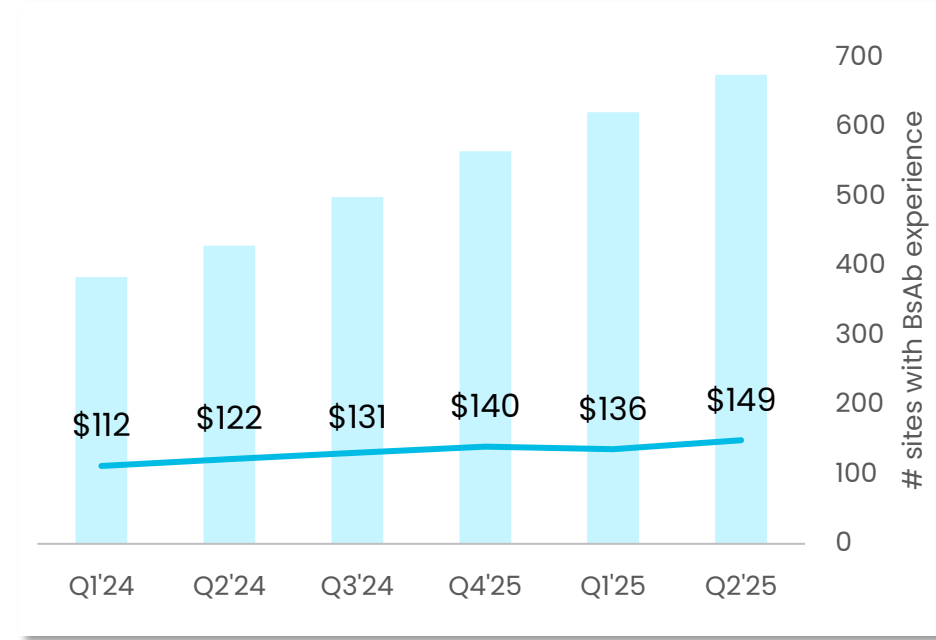
Bispecifics Have Not Grown Despite Expanding Footprint

US Carvykti Revenue and ATC Footprint



● Carvykti US Net Revenue¹ (in \$MM) ● Carvykti ATCs²

US BCMA BsAb Revenue and Footprint



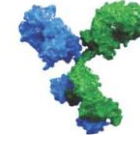
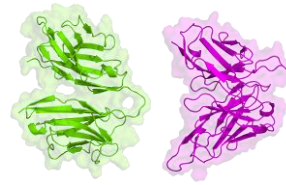
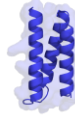
● BsAbs US Net Revenue¹ (in \$MM) ● Cumulative # sites with BsAbs experience³

- 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

¹Based on quarterly earning calls

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

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



		Anito-cell ^{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	✓	⊗	✓	✓

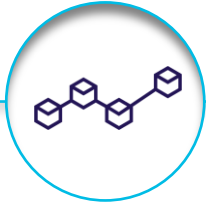
¹Patel et al., Oral Presentation, ASH (Dec 2025); ²Bishop et al. (2024); ³Cancer Network ONCOLOGY® Companion, Volume 39, Supplement 7 Issue 7 Pages: 18-19; ⁴Usmani et al 2021; ⁵Berdeja et al. 2021, ⁶Jangannath et al. 2025; ⁷Garfall et al. 2024; ⁸Teclistamab FDA label; ⁹Tomasson et al. 2024; ¹⁰Lesokhin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



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



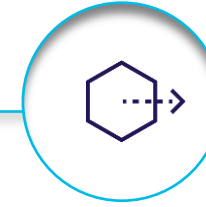
Expand CAR T Class Share With Potential Best-in-Class Profile

- ▶ 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 globally³
- ▶ **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

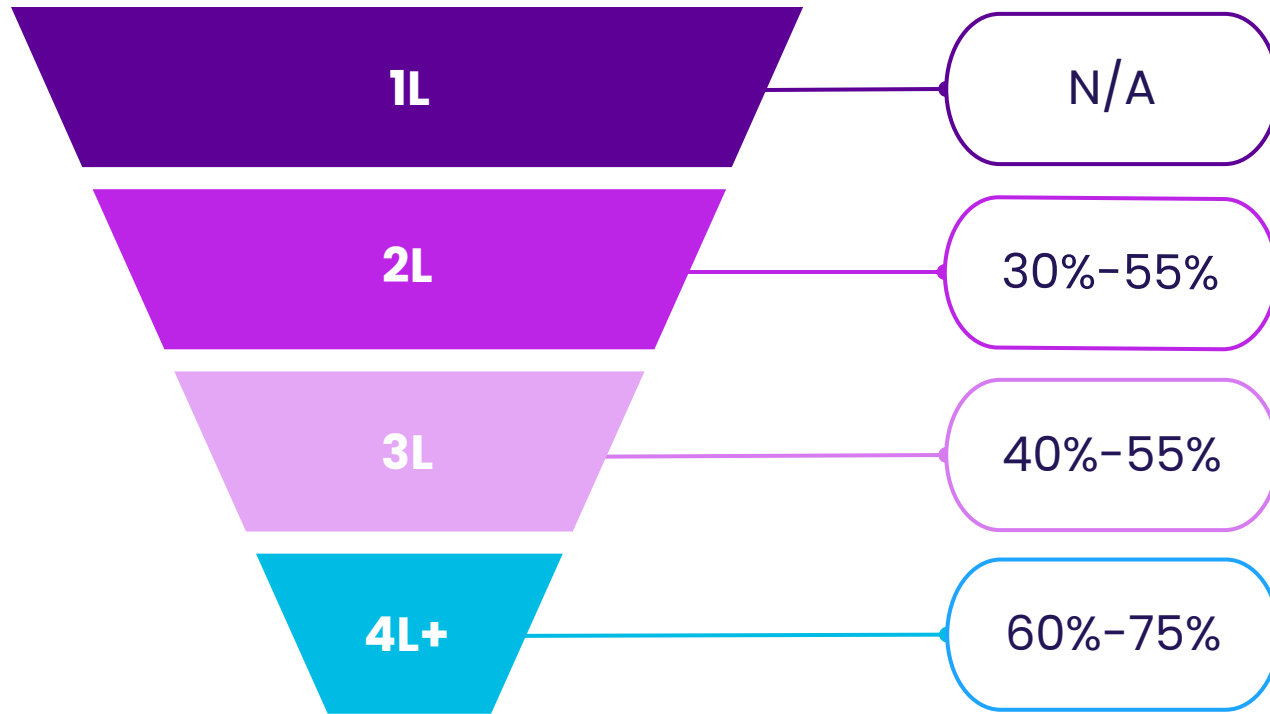
- ▶ **iMMagine-3 is rapidly enrolling** 2L+ patients with broadest eligibility
- ▶ **GEM-AnitoFIRST study**, safety lead-in for **iMMagine-4 (NDMM study)**
- ▶ **iMMagine-5 study** to demonstrate anito-cel dosing in the community setting

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

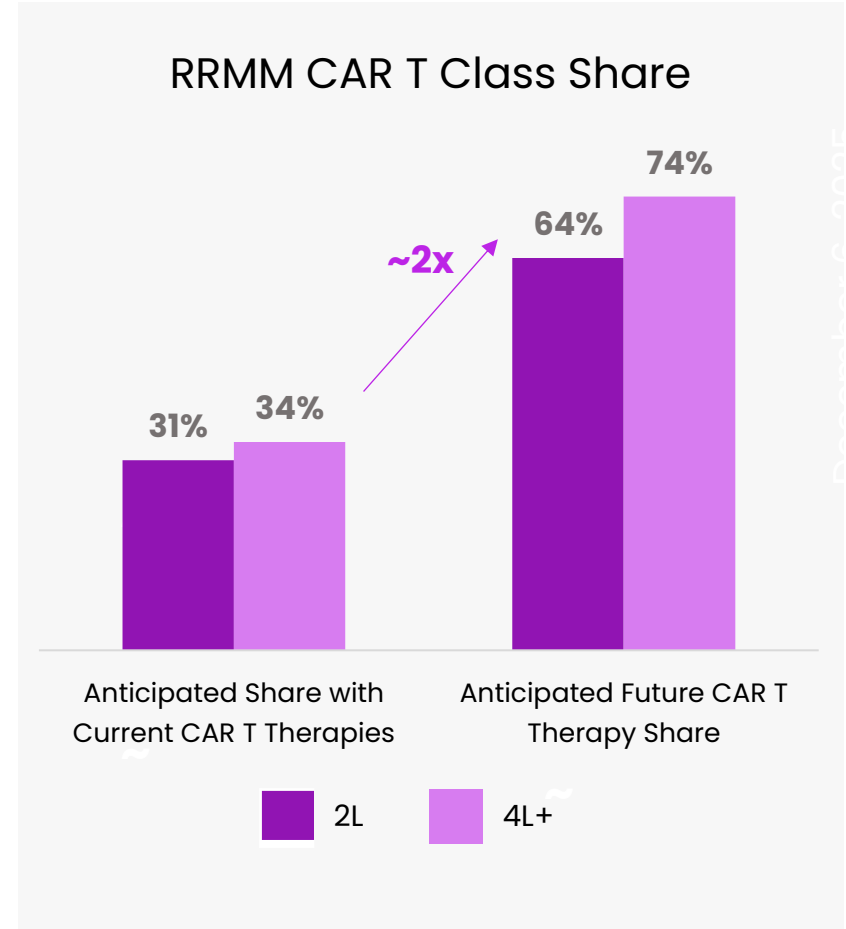
Anito-cel Is Expected to Drive Broader Patient Adoption for CAR T



Multiple Myeloma by LoT



Anticipated Future US CAR T Class Shares¹



Note: Based on internal projections and estimates of 2024 MM Incidence, and anticipated share by LoT, 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

¹Peak 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)



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



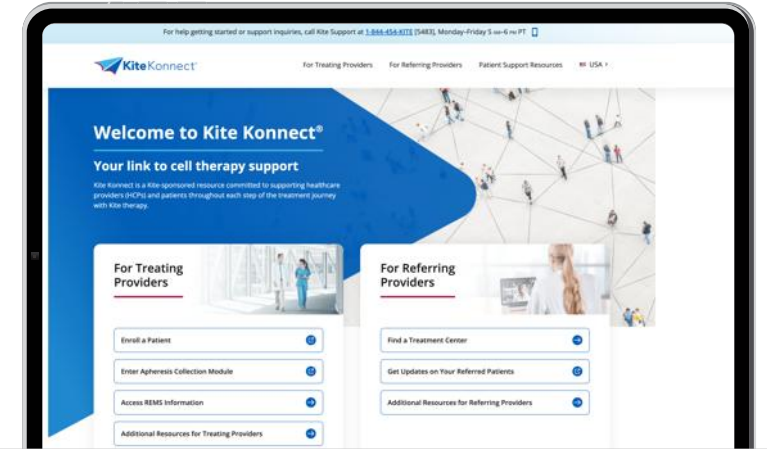
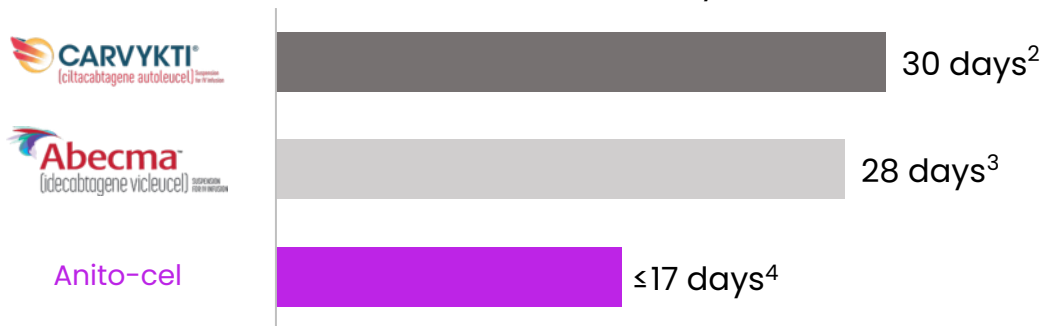
Planning manufacturing capacity to capture majority of 4L+ at launch, scaling to all 4L+ in 2027 with a global potential of >24,000 doses¹



Leveraging Kite leadership in ATC footprint and manufacturing turnaround time



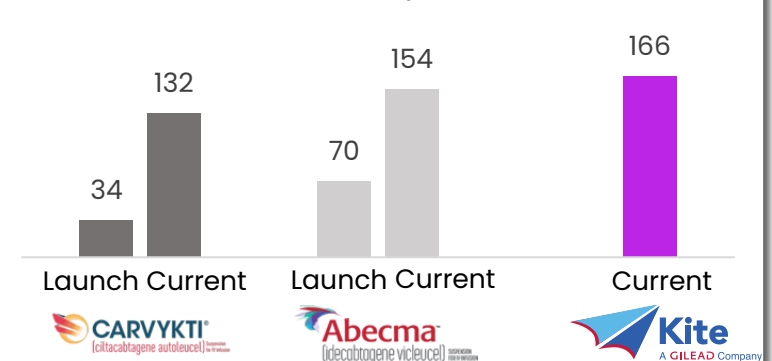
Median Vein to Release Times (Days)



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



ATC Footprint⁵











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		
 <p>Pivotal phase 2 study assessing anito-cel's efficacy and safety in late line MM patients</p>	 <p>Phase 2 trial in NDMM patients as a safety lead-in for iMMagine-4</p>	 <p>Confirmatory phase 3 trial enrolling the largest eligible CAR T patient population in RRMM</p>	 <p>Expanding anito-cel patient access to NDMM</p>	 <p>Demonstrate anito-cel dosing in the community setting, expanding availability beyond existing ATCs</p>		

NDMM, newly diagnosed multiple myeloma



Key Commercial Activities Initiated for a Robust Anito-cel Launch¹

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 1¹



Anito-cel Will Rapidly Launch Into Largest MM ATC Network¹

- ✓ 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



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

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-cel²	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); ²Based on Kite collaboration structure; Launch period is defined as 12 months post approval.



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 **avored by ≥80% of HCPs¹ and Patients²** 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 **iMImagine-3**. Further potential expansion to **~\$20B** with front-line CAR-T trials such as **iMImagine-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 Connect** patient platform will drive rapid use of anito-cel



Anito-cel Will Expand into the Community Setting

iMImagine-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 doses³**



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**



¹Based on quantitative market research conducted in 2025 with 152 Hematologists/Oncologists (including treaters and referrers); ²Based on quantitative market research from 2024 with 54 MM patients that are CAR T knowledgeable (discussed CAR T with their oncologists); ³Manufacturing 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

Agenda

Opening Remarks 20 min

Rami Elghandour

Chairman and Chief Executive Officer, Arcellx

iMMagine-1 Oral Presentation 20 min

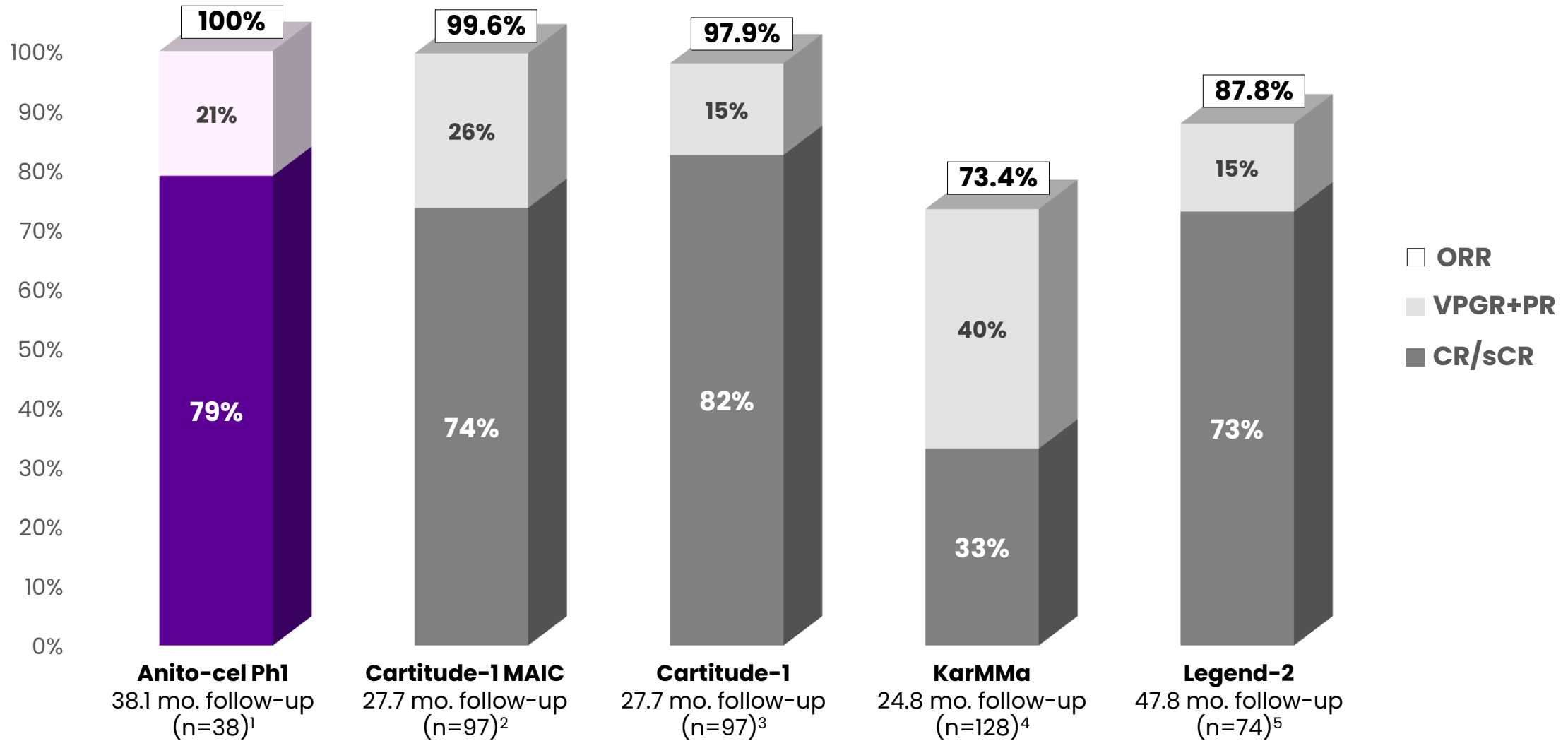
Krina Patel, M.D., M.Sc.

iMMagine-1 Clinical Study Investigator

Physician Panel Discussion 20 min

Q&A 30 min

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

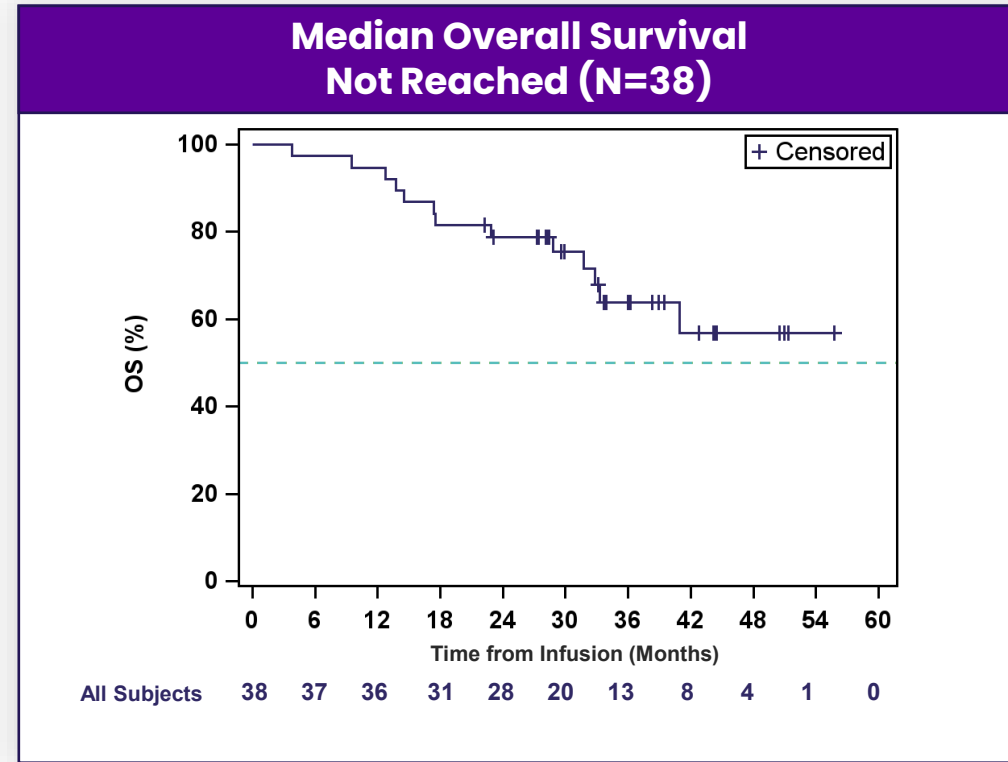
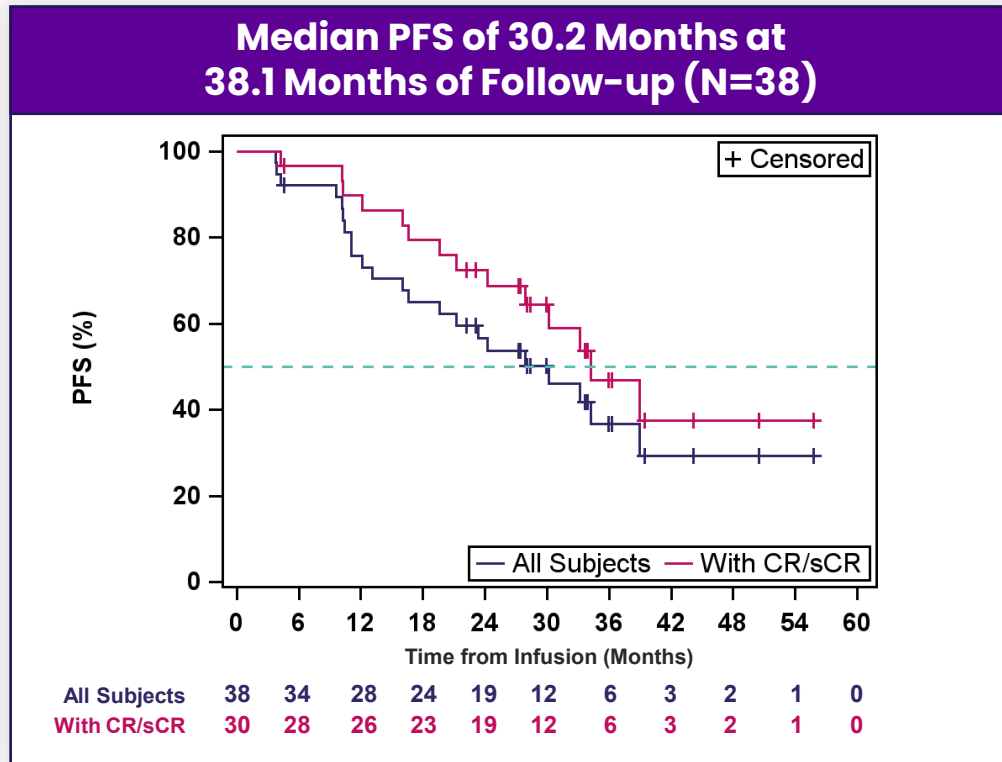


Data cut-off October 3, 2024

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.

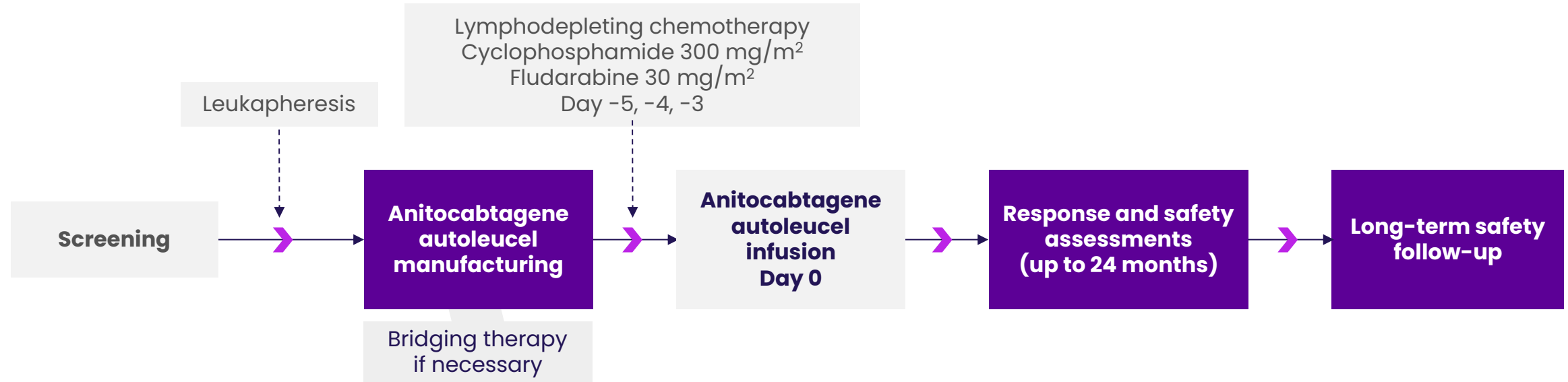
¹Bishop et al. (2024); ²Martin et al. (2022); ³Martin et al. (2023); ⁴Anderson et al. (2021); ⁵Zhao et al.

Anito-cel Phase 1: Median PFS is 30.2 Months



- **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**

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 115×10^6 CAR+ T cells

Primary Endpoint:

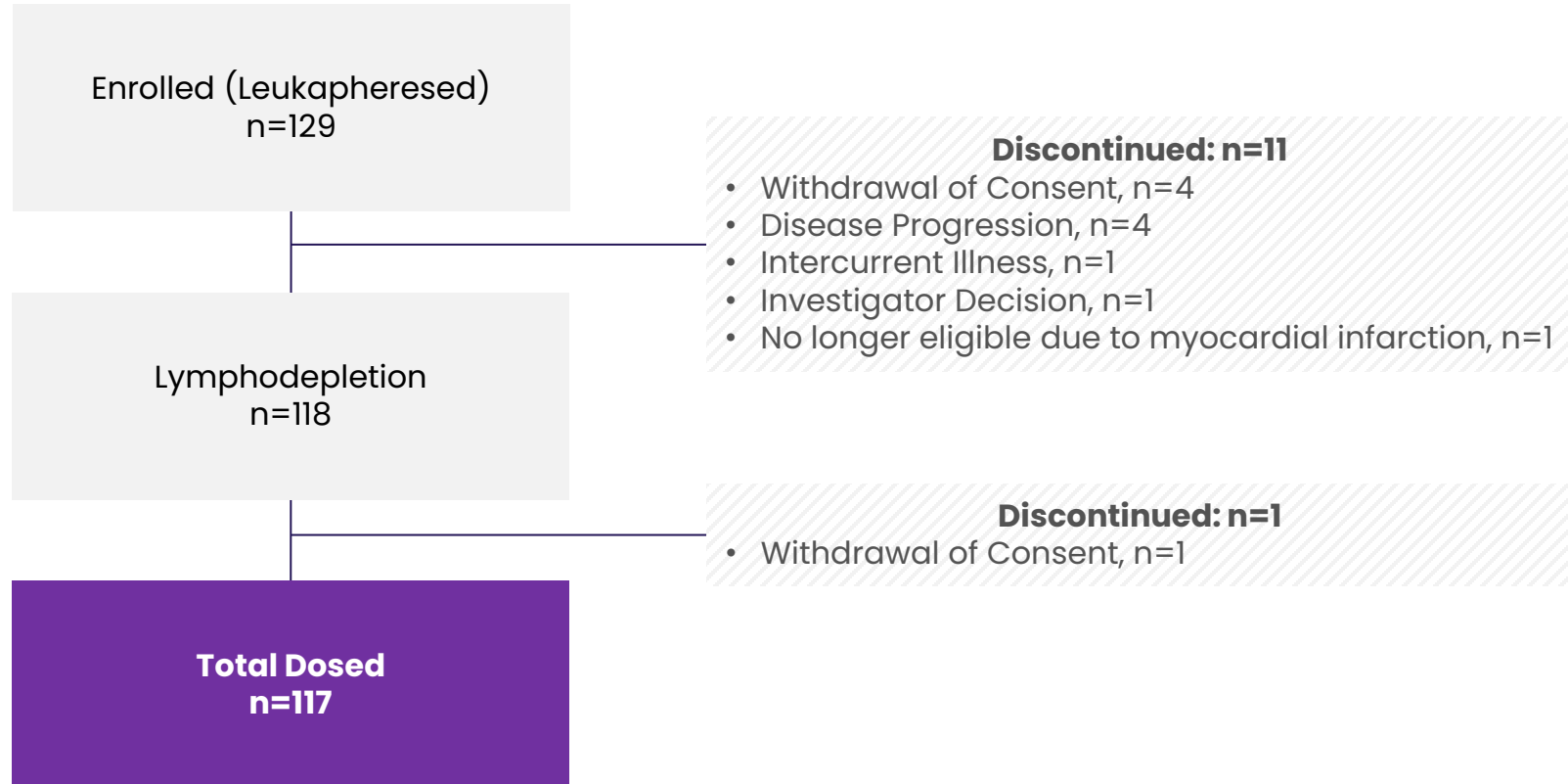
- ORR, per 2016 IMWG criteria

Key Secondary Endpoints:

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

iMImagine-1: Overall Patient Disposition

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



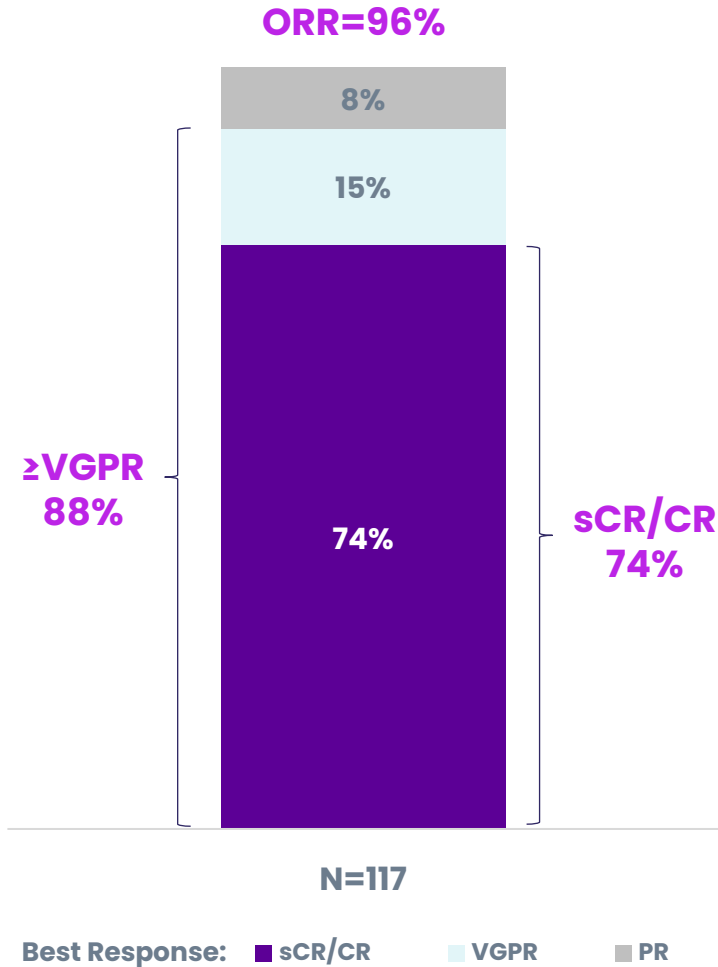
Anito-cel was successfully manufactured for 99% of patients enrolled

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 Multiple Myeloma 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). ¹Patel et al., Oral Presentation, ASH (Dec 2025); ²Martin et al. (2023); ³Munshi et al. (2021); ⁴Janssen Carvykti Prior Line of Therapies (Dec 2024); ⁵Berdeja et al. (2020)

iMMagine-1: Overall Response Rate and Depth of Response



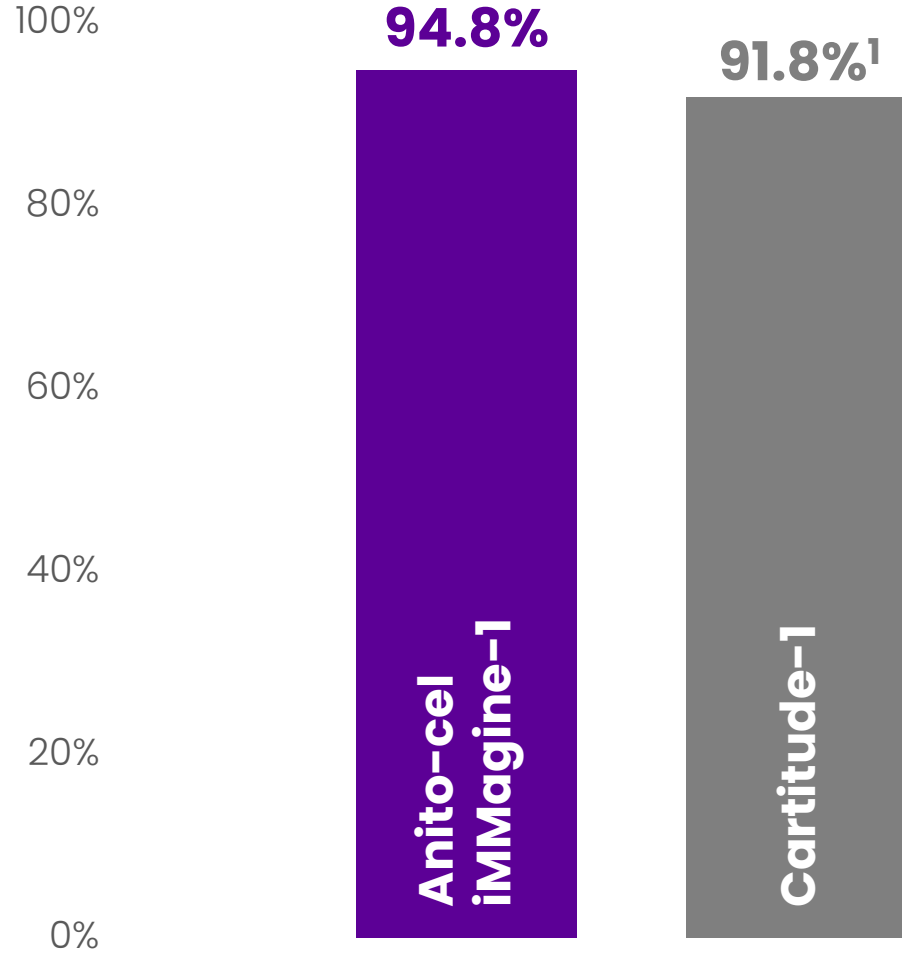
Responses continue to deepen over time

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

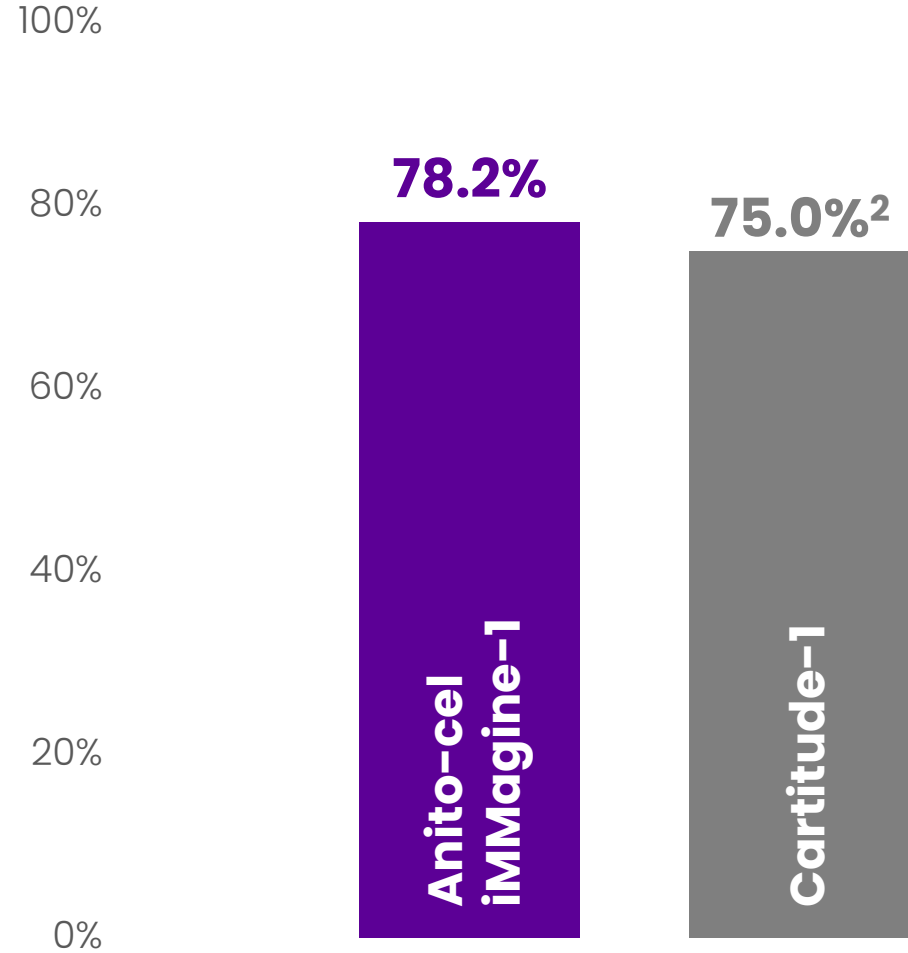
	Median (months)	Interquartile Range	Min, Max
Time to first response	1.0	1.0, 1.9	0.9, 13.8
Time to best response	4.8	2.1, 9.0	0.9, 23.8
Time to sCR/CR	3.2	2.0, 9.2	0.9, 23.8

iMMagine-1: Minimum Residual Disease

Minimum Residual Disease at 10⁻⁵ Sensitivity



Minimum Residual Disease at 10⁻⁶ Sensitivity

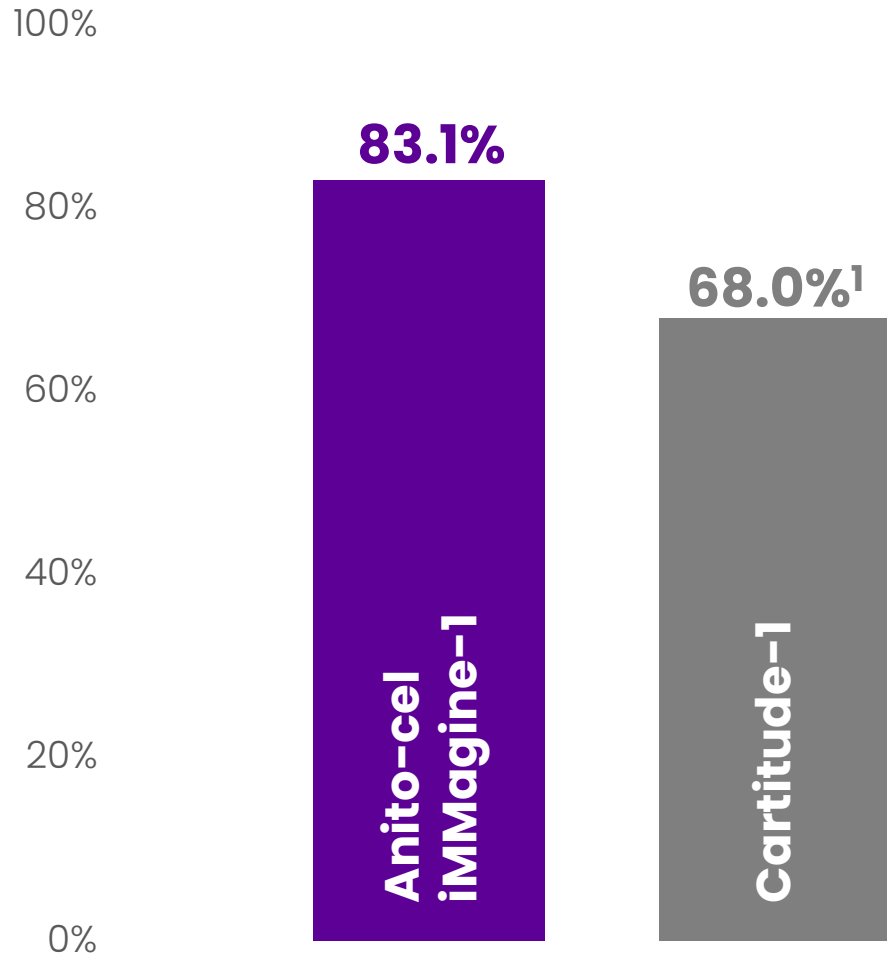


Evaluable patients for overall MRD negativity had an identifiable malignant clone in the baseline bone marrow sample and had a post-treatment bone marrow sample sufficient to assess MRD negativity at 10⁻⁵ or at 10⁻⁶. Note: Carvykti MRD- at 10⁻⁵ sensitivity shown as of 18 months of median follow-up; MRD- 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);¹Usmani et al. (2021) (N=56/61);²Martin et al. (2022) (N=39/52).



iMMagine-1: Sustained Minimum Residual Disease

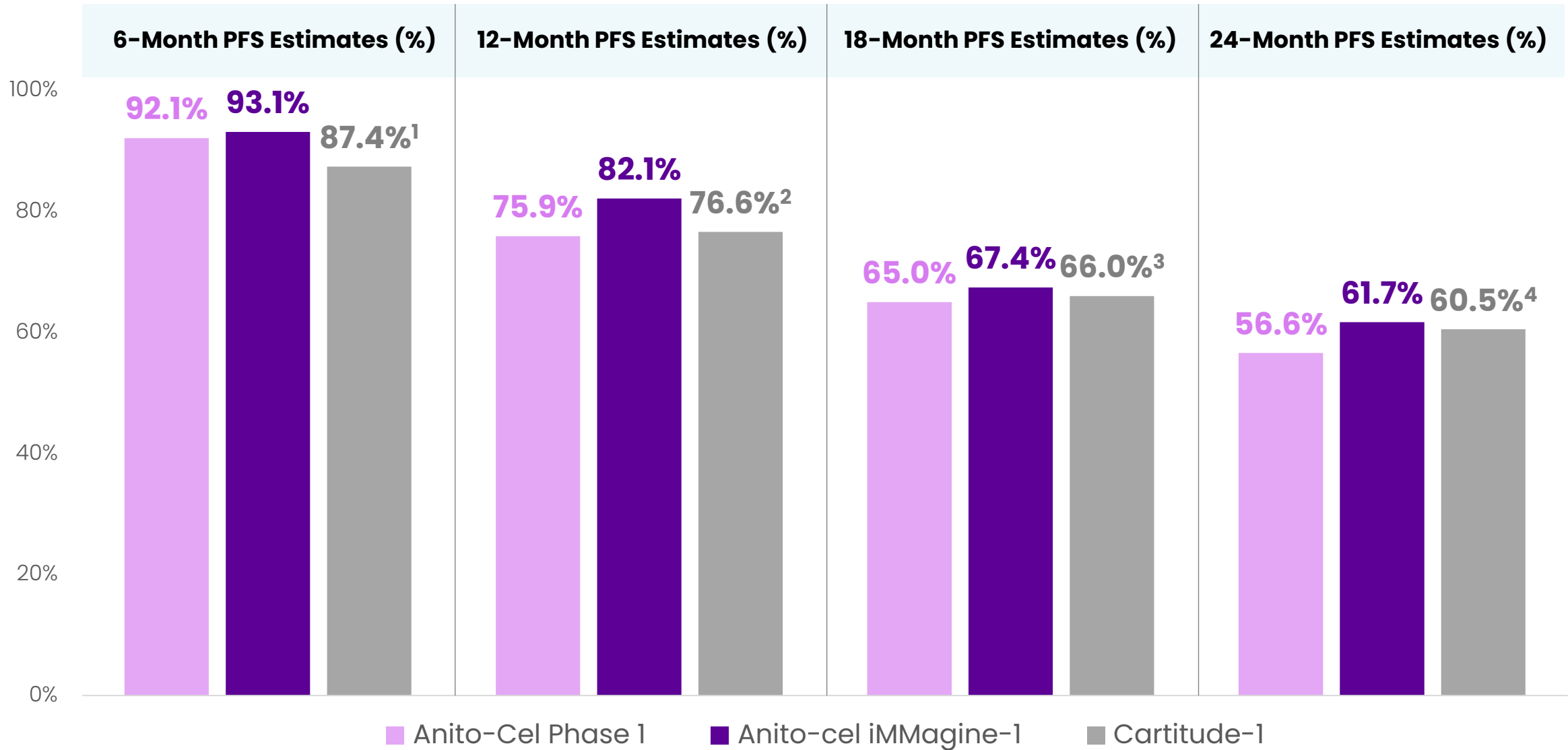
Minimal Residual Disease Sustained for ≥6 Months



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

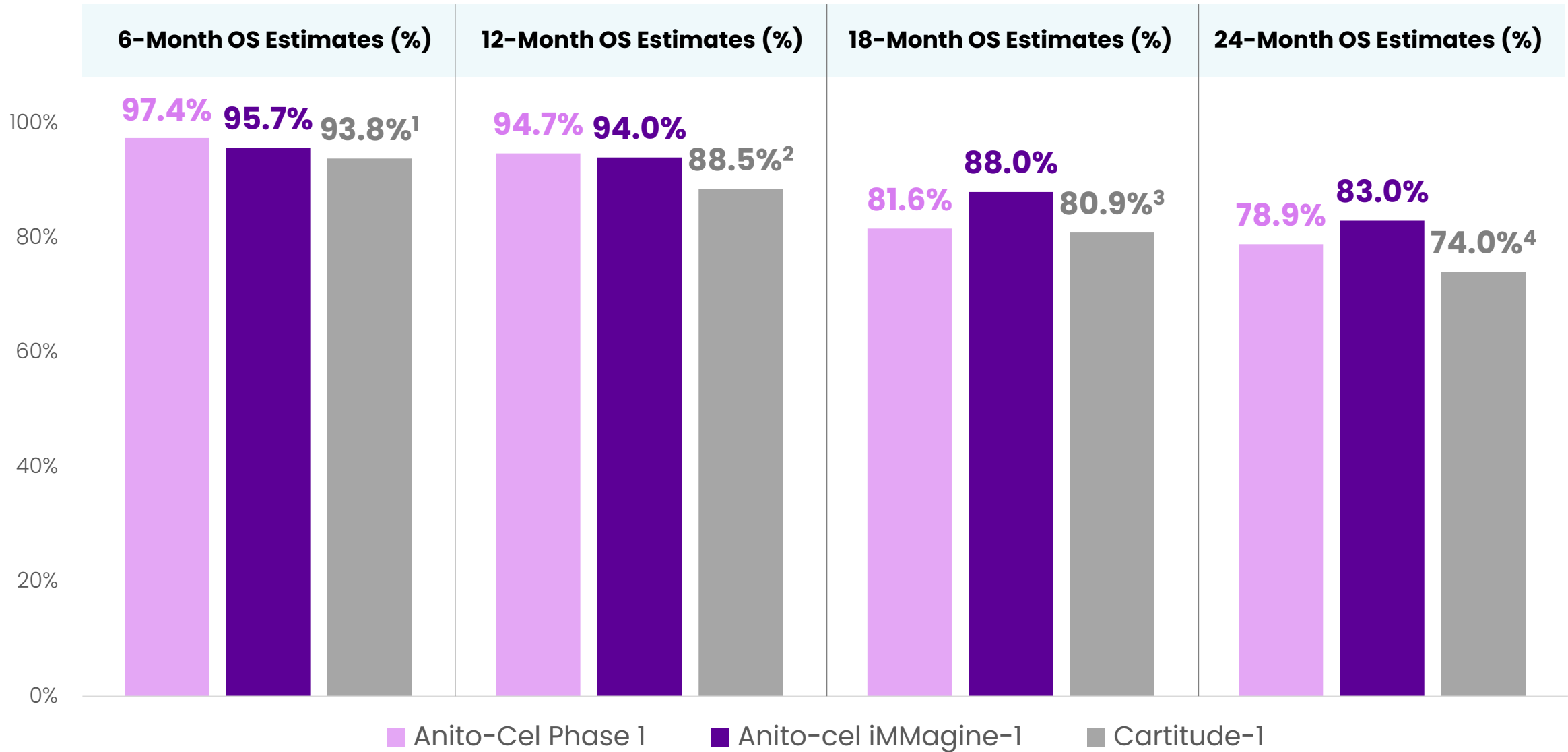
Evaluable patients had 2 post-infusion MRD negative assessments at 10^{-5} level at least 6 months apart while still being in ongoing response
Note: Carvykti sustained MRD negativity shown as of 27.7 months of median follow-up. Median follow-up for anito-cel iMMagine-1 was 15.9 months [Range 0.3 – 33].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

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



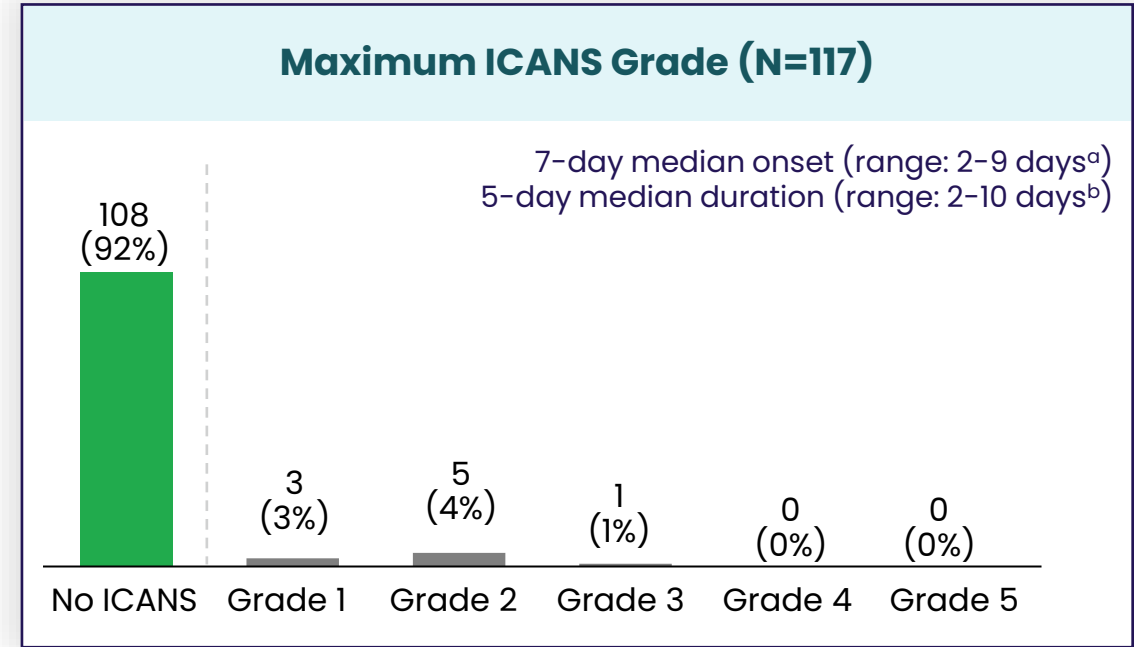
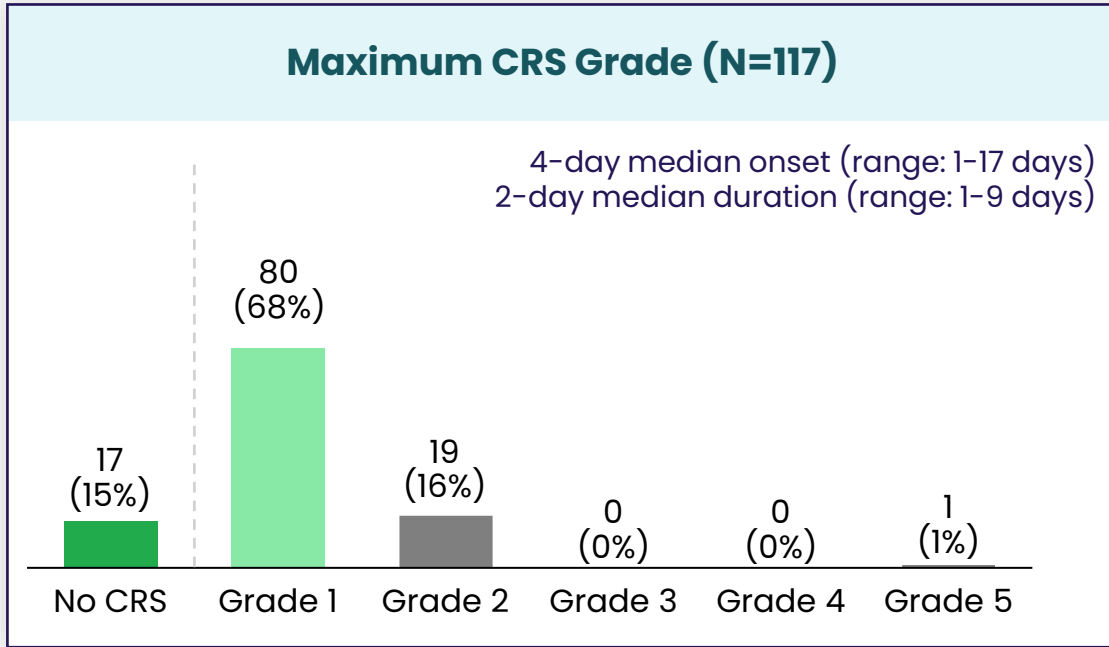
Note: Carvykti 6-mo PFS at 8.8 months of median follow-up; 12-mo PFS at 12.4 months of median follow-up, 18-mo PFS at 18 months of median follow-up, and 24-mo PFS at 21.7 months of median follow-up. Median follow-up for anito-cel iMMagine-1 was 15.9 months [Range 0.3 – 33]. Data above are not from head-to-head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

iMImagine-1: Safety



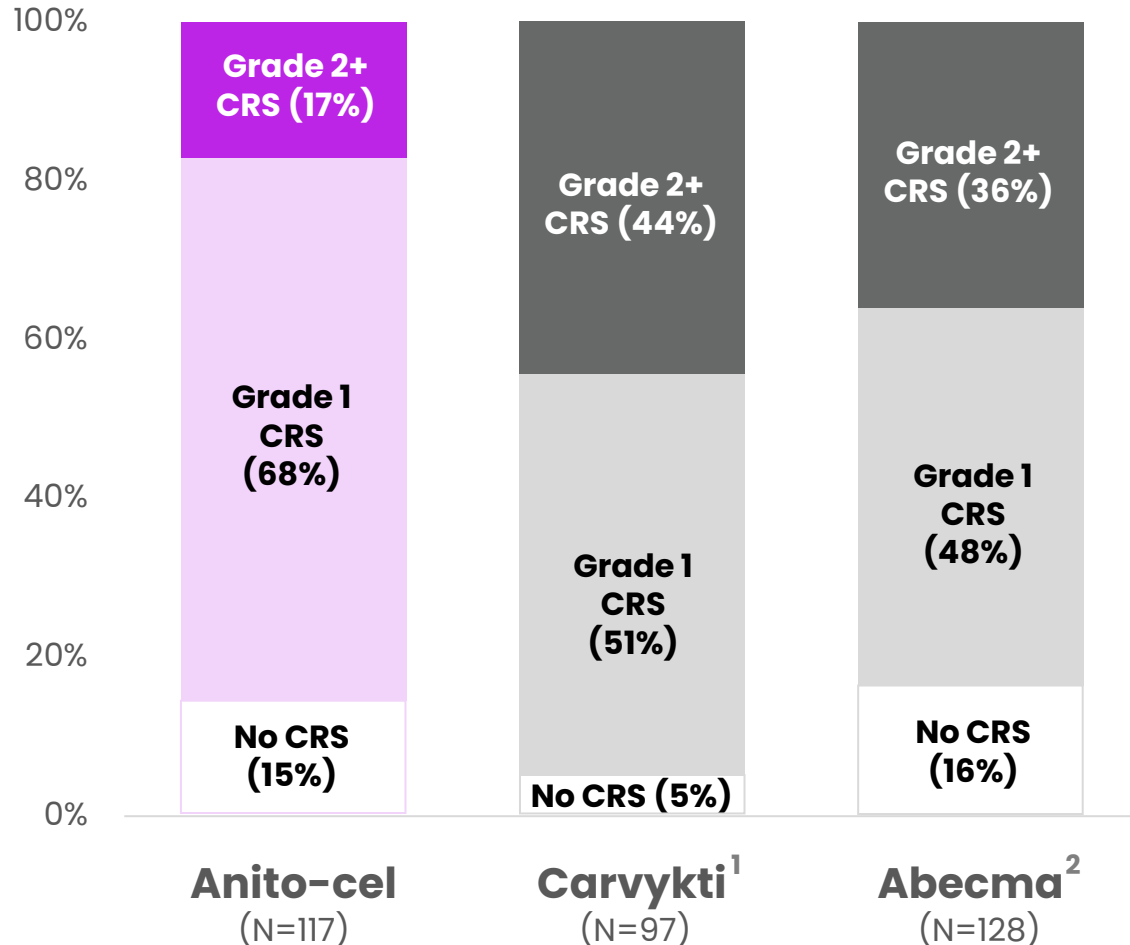
- 95% (111/117) of patients had either no CRS or CRS that resolved by ≤ 10 days of anito-cel infusion
- No new treatment-related or treatment-emergent deaths have occurred since the previous May 1, 2025 datacut
- No secondary primary malignancies of T-cell origin have occurred
- No replication competent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

^aWith the exception of n=1 Grade 1 ICANS (confusion) on day 31 post infusion that rapidly resolved. ^bWith 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 \leq Grade 1 CRS

% of Patients with CRS



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

83% (97/117) of CRS cases \leq 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

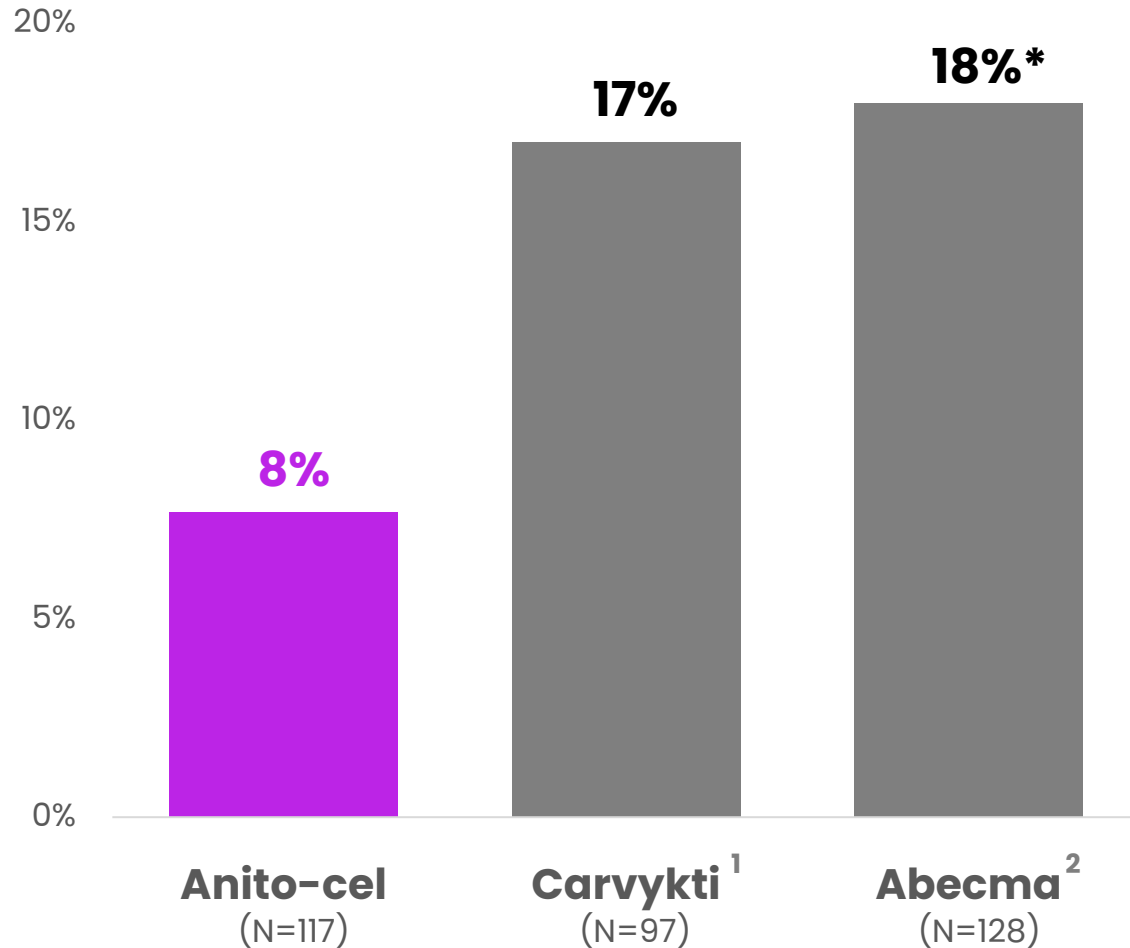
Note: Standard practice CRS management used across studies (no prophylactic steroid or tocilizumab utilization).

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); ¹Berdeja et al. (2021); ²Munshi et al. (2021)

iMMagine-1: Majority of Patients with No ICANS

% of Patients with 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

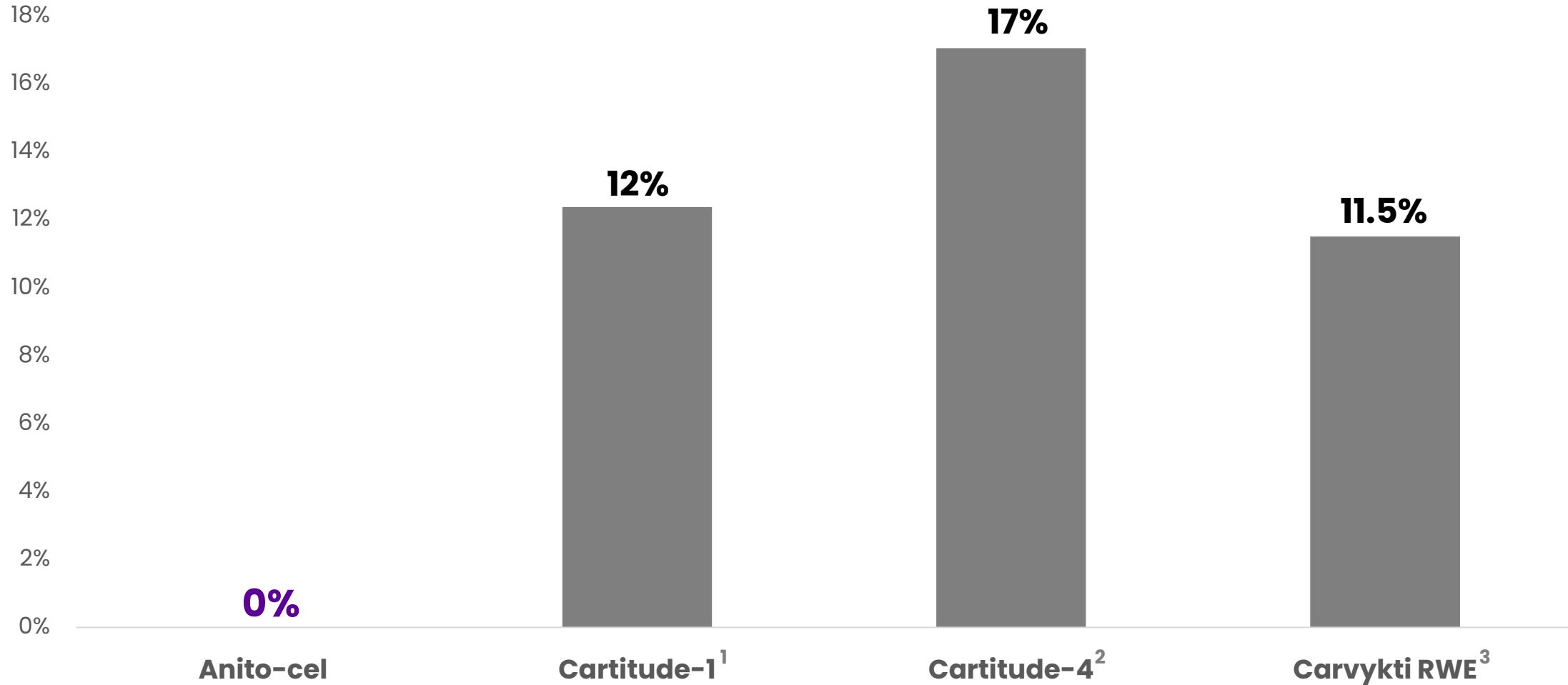
No delayed or non-ICANS neurotoxicities, including no Parkinsonism, no cranial nerve palsies, and no Guillain-Barré syndrome, and no immune effector cell-associated enterocolitis have been observed to date with anito-cel

*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); ¹Berdeja et al. (2021); ²Munshi 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; ¹Berdeja et al (2021); ²San-Miguel et al. (2023); ³Lim et al. (2025)



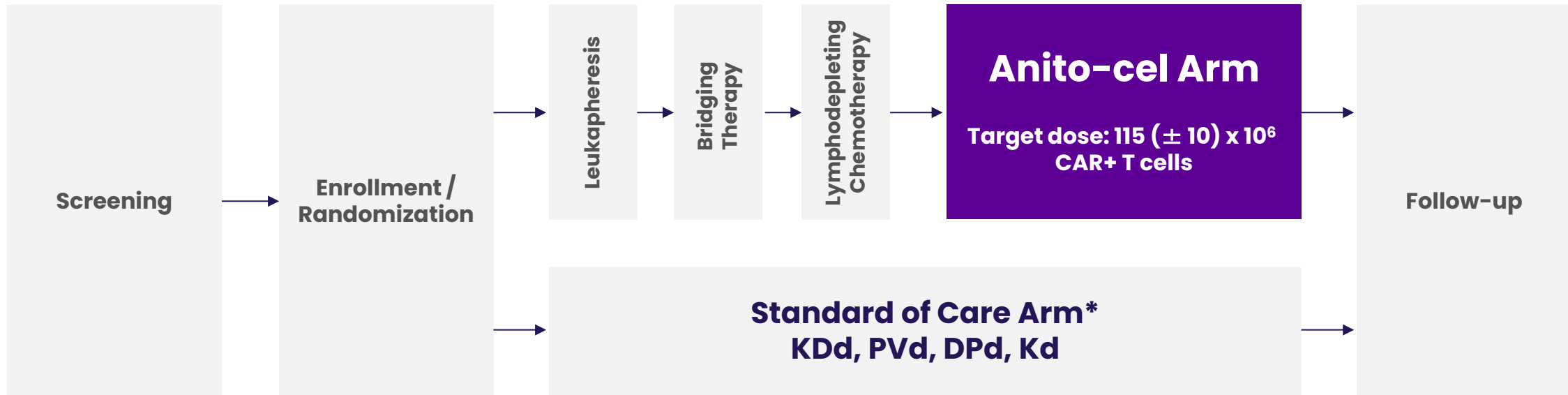
iMMagine-1: Conclusions

- ▶ **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 (\leq 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

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

1-3 prior LoT, including an anti-CD38 monoclonal antibody and an iMiD



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, or patient withdrawal of consent

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Agenda

Opening Remarks 20 min

Rami Elghandour

Chairman and Chief Executive Officer, Arcellx

iMMagine-1 Oral Presentation 20 min

Krina Patel, M.D., M.Sc.

iMMagine-1 Clinical Study Investigator

Physician Panel Discussion 20 min

Q&A 30 min

Panel Discussion



**Christopher Heery,
M.D.**

Chief Medical Officer
Arcellx



**Krina Patel,
M.D., M.Sc.**

iMMagine-1 and iMMagine-3
Clinical Study Investigator;
Associate Professor in the
Department of Lymphoma
and Myeloma at The
University of Texas MD
Anderson Cancer Center



**Matthew J. Frigault,
M.D., M.S.**

ACLX-001, iMMagine-1, and
iMMagine-3 Clinical Study
Investigator; Clinical Director
of the Cellular Therapy Service
at Mass General Cancer
Center and Assistant Professor
at Harvard Medical School



**Larry D. Anderson,
M.D., Ph.D.**

iMMagine-1 Clinical Study
Investigator; Professor of
Internal Medicine and Director
of Myeloma, Waldenstrom's,
and Amyloidosis Program at
University of Texas
Southwestern



Thank You