

Cabaletta Bio[®]

A microscopic view of several cells, likely cancer cells, with prominent red nuclei. The cells are shown in various stages of focus, with one cell in the foreground being sharp and others in the background being blurred.

Corporate Presentation

SEPTEMBER 2026

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Words such as, but not limited to, “look forward to,” “believe,” “expect,” “anticipate,” “estimate,” “intend,” “plan,” “would,” “should” and “could,” and similar expressions or words, identify forward-looking statements.

Various risks, uncertainties and assumptions could cause actual results to differ materially from those anticipated or implied in our forward-looking statements. Such risks and uncertainties include, but are not limited to, risks related to the success, cost, and timing of our development activities and clinical trials, risks related to our ability to demonstrate sufficient evidence of safety, efficacy, durability and tolerability in our clinical trials, the risk that preliminary, interim or longer-term clinical data may not be predictive of future or final clinical results or the results of registrational studies; risks related to patient enrollment, site activation and trial execution, risks that modifications to trial design or development strategy may not achieve the intended benefits and that the trial design may need to be further modified; risks related to our manufacturing strategy, including automation, supply chain, comparability and commercial readiness; our ability to protect and maintain our intellectual property position, risks related to our relationships with third parties, uncertainties related to regulatory agencies’ evaluation of regulatory filings and other information related to our product candidates, our ability to retain and recognize the intended incentives conferred by any regulatory designations, risks related to regulatory filings, potential clearance and potential approval pathways, the risk that any of our product candidates may not be successfully developed, approved or commercialized, the risk that the results of preclinical studies or clinical studies will not be predictive of future results in connection with future studies, risks related to reimbursement, pricing and market acceptance, risks related to volatile market and economic conditions and our ability to fund operations and continue as a going concern. New risks and uncertainties may emerge from time to time, and it is not possible to predict all risks and uncertainties. Except as required by applicable law, we do not plan to publicly update or revise any forward-looking statements contained herein, whether as a result of any new information, future events, changed circumstances or otherwise. Although we believe the expectations reflected in such forward-looking statements are reasonable, we can give no assurance that such expectations will prove to be correct. Accordingly, you are cautioned not to place undue reliance on these forward-looking statements. No representations or warranties (expressed or implied) are made about the accuracy of any such forward-looking statements. For a discussion of these and other risks and uncertainties, and other important factors, any of which could cause our actual results to differ materially from those contained in the forward-looking statements, see the section entitled “Risk Factors” in our most recent annual report on Form 10-K and quarterly report on Form 10-Q, as well as discussions of potential risks, uncertainties, and other important factors in our other filings with the Securities and Exchange Commission. Certain information contained in this Presentation relates to or is based on studies, publications, surveys and other data obtained from third-party sources and the Company’s own internal estimates and research. While the Company believes these third-party sources to be reliable as of the date of this Presentation, it has not independently verified, and makes no representation as to the adequacy, fairness, accuracy or completeness of, any information obtained from third-party sources. The Company is the owner of various trademarks, trade names and service marks. Certain other trademarks, trade names and service marks appearing in this Presentation are the property of third parties. Solely for convenience, the trademarks and trade names in this Presentation are referred to without the ® and TM symbols, but such references should not be construed as any indicator that their respective owners will not assert, to the fullest extent under applicable law, their rights thereto.



Develop and launch the first curative
targeted cellular therapies for patients
with autoimmune diseases

Cabaletta Bio[®]

Rese-cel: Delivering on the promise of CD19-CAR T in autoimmunity

2H27 BLA planned to include adult and juvenile DM for potential PRV; PC-free & automated mfg advancing

- **Rese-cel Phase 1/2 data with preconditioning: 64 myositis, SSc, lupus and MG patients; up to 1.5 years of f/u¹**
 - Data suggest a single rese-cel dose after discontinuation of all IMs can deliver immune reset with compelling outcomes
- **Myositis: 2H27 BLA submission plans to include adult DM and JDM data, facilitating potential PRV**
 - 83% of Phase 1/2 adult DM patients would have met the registrational endpoint; responses maintained through latest f/u²
 - First JDM patient with clinical and PK/PD data consistent with adult DM patients and response maintained at 32 weeks²
- **SSc: 2nd pivotal indication; ~25 patient, single-arm registrational cohort expected to start in 4Q26**
- **Favorable safety profile in first 64 patients dosed with PC supports outpatient administration¹**
 - 94% - Either no CRS (69%) or Grade 1 CRS (25%); 97% - No ICANS; No IEC-HS observed across clinical experience
- **PC-free lowest dose data: Lupus (1/2 pts) & PV (2/4 pts) achieved deep B cell depletion → potential threshold dose**
 - Published low dose PV data in *Blood*³, next higher dose cohorts enrolling; PC-free being incorporated in RESET-MG
- **Automated manufacturing by Cellares offers potential scale to thousands of patients with minimal capital investment**
 - Consistent manufacturing & translational data; commercial supply agreement includes among lowest COGS in industry

A single dose of rese-cel after discontinuation of all immunomodulators is reliably delivering immune reset with compelling safety & efficacy profile; initial BLA submission including adult and juvenile DM patients in 2H27

BLA – biologics license application; DM – dermatomyositis; f/u – follow-up; JDM – juvenile dermatomyositis; IM – immunomodulator; MG – myasthenia gravis; PC – preconditioning; PRV – priority review voucher; PV – pemphigus vulgaris; rese-cel – resecabtagene autoleucel (CABA-201); SLE – systemic lupus erythematosus; TIS – total improvement score.

1. As of data cut-off on 16 Apr 2026 (4 Sep 2026 for MG data).

2. As of data cut-off on 16 Apr 2026.

3. Nunez, Daniel, et al. "CD19 CAR T Therapy Is Feasible in Patients with Pemphigus Vulgaris Treated Without Lymphodepletion in the RESET-PV Trial." *Blood Journal* (2026): blood-2025032093.

Immune reset with a single infusion and a favorable safety profile

Beyond myositis and scleroderma, advancing innovation with PC-free rese-cel & industrialized automated mfg

Elimination of PC

- Expands the market
- Simplifies outpatient use
- Reduces resource utilization
- Improves patient and provider experience



Automated Manufacturing

- Minimizes capital investment
- Scalable to efficiently produce thousands of patient runs per year
- Substantially-reduced COGS
- Facilitates global expansion



Transformative Value Proposition

- Differentiated product profile
- Typical 'biologic' margins
- Potential to address larger autoimmune indications including UC, T1D and RA

PC-free rese-cel can expand access while automated manufacturing can reduce COGS & increase scale

Innovative clinical strategy to support accelerated regulatory path

Myositis and SSc programs advancing to registrational trials with preconditioning

Program	Trial	Preclinical	Phase 1/2	Registrational
Rese-cel (CABA-201) <i>4-1BB CD19-CAR T</i>	RESET-Myositis®	<i>Dermatomyositis / Antisynthetase syndrome</i>		
		<i>Juvenile dermatomyositis</i>	<i>Rare Pediatric Disease Designation</i>	Plan to include JDM data in 2H27 myositis BLA submission, facilitating potential for PRV
		<i>Immune-mediated necrotizing myopathy</i>		
	RESET-SSc®	<i>Skin + Organ Cohort</i>		
		<i>Skin Cohort</i>		
	RESET-SLE®	<i>Lupus Nephritis</i>		
		<i>Non-Renal SLE</i>		
	RESET-MG®	<i>AChR-Ab pos. gMG</i>		
		<i>AChR-Ab neg. gMG</i>		
	RESET-PV®	<i>Pemphigus vulgaris</i>		

- Rheumatology¹
- Neurology
- Dermatology
- PC-free evaluation²
- Pediatric Indication

RESET™ – REstoring SElf-Tolerance; Ab – Antibody; AChR – Acetylcholine receptor; gMG – Generalized myasthenia gravis; JDM – Juvenile dermatomyositis; PC – Preconditioning; PRV – Priority review voucher; PV – Pemphigus vulgaris; SLE – Systemic lupus erythematosus; SSc – Systemic sclerosis

1. Myositis patients can also be treated by neurologists or dermatologists; lupus nephritis patients can also be treated by nephrologists.

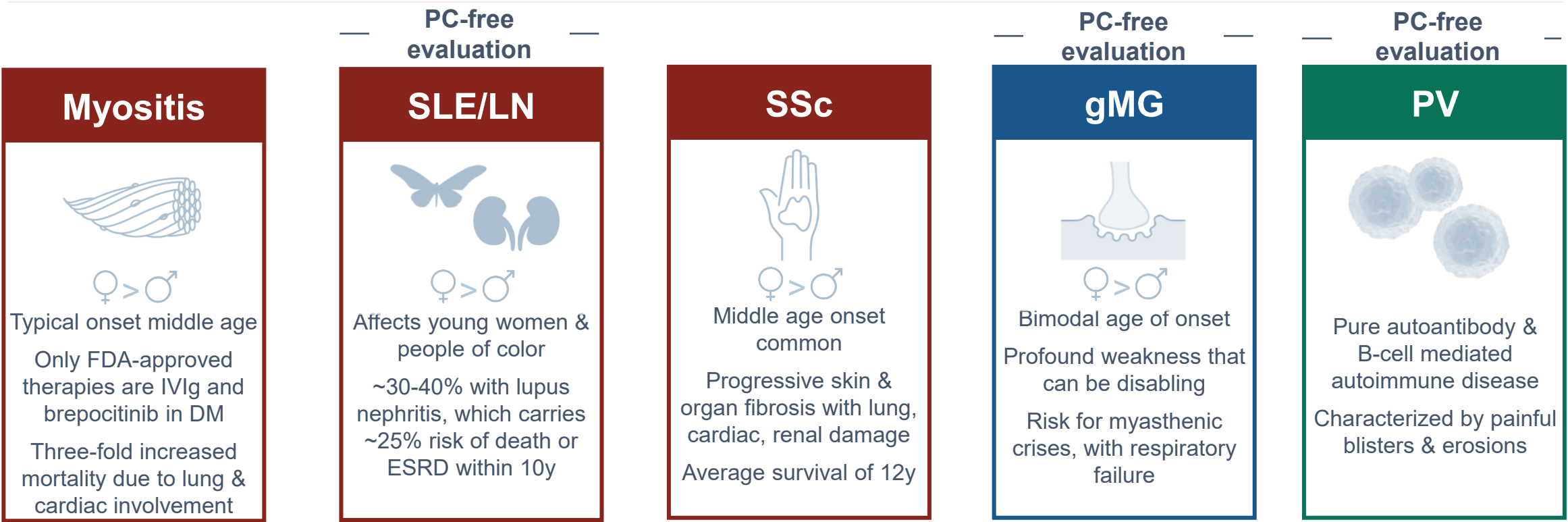
2. Includes planned and ongoing evaluation of the PC-free approach.

● FDA Fast Track Designation received in dermatomyositis, SLE and lupus nephritis, systemic sclerosis, generalized myasthenia gravis and multiple sclerosis.

■ FDA Regenerative Medicine Advanced Therapy (RMAT) received in myositis, SLE, LN, systemic sclerosis, and generalized myasthenia gravis.

RESET™ program advancing trials in a broad portfolio of diseases

Broad portfolio of trials designed to address high unmet need and realize the potential of rese-cel



U.S. Prevalence

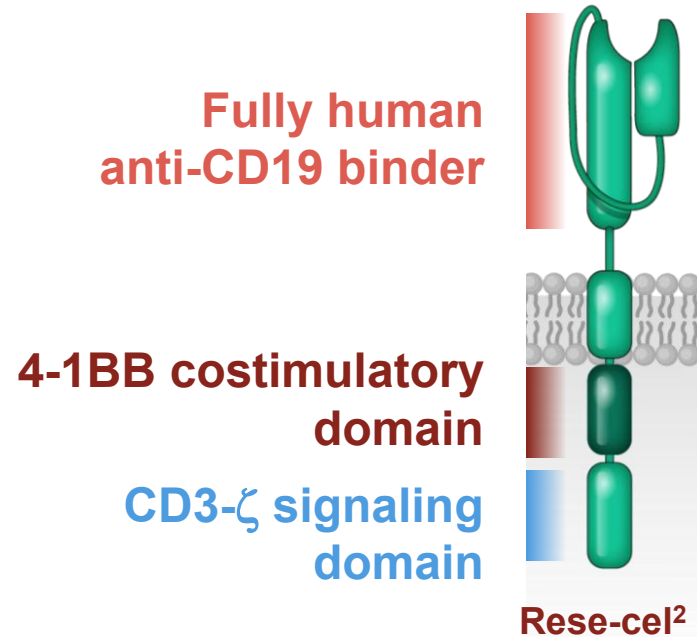


Rese-cel:
Construct Design, PK/PD and Safety Data

Caballetta Bio[®]

Rese-cel: CD19-CAR T specifically designed for autoimmunity

Risk-benefit profile reinforced by compelling clinical responses with safety data supporting outpatient use^{5,8}



Rese-cel designed to optimize risk-benefit for autoimmune patients

- 1) Manufacturing uses standard, well-characterized 9-day expansion protocol
 - Leveraged academic CD19-CAR T clinical data¹
 - Shorter processes yield more pro-inflammatory T cells³
- 2) Same weight-based dose employed as in academic studies
 - Safety data supports potential outpatient use for autoimmune patients^{4,5}
 - Facilitates pediatric evaluation where weight-based dosing is common
- 3) Fully human anti-CD19 binder
 - Reduces anti-CAR immune rejection to enable re-dosing, if required^{6,7}
- 4) 4-1BB costimulatory domain
 - Associated with lower CRS/ICANS risk in large oncology analyses⁷

1. Müller, F., Hagen, M., Wirsching, A. et al. "CD19 CAR-T cells for treatment-refractory autoimmune diseases: the phase 1/2 CASTLE basket trial." *Nature Medicine* 32, 1142-1151 (2026).

2. Maschan, Michael, et al. "Multiple site place-of-care manufactured anti-CD19 CAR-T cells induce high remission rates in B-cell malignancy patients." *Nature Communications* 12, 7200 (2021)
Transmembrane domain in rese-cel is CD8 α vs. TNFRSF19 (Troy) utilized in the academic construct. The two transmembrane domains have not been shown to have a significant difference in function or IFN- γ production in preclinical studies. The CD8 α transmembrane domain is employed in tisagenlecleucel.

3. Dias J, et al. "CAR-T cell manufacturing landscape-Lessons from the past decade and considerations for early clinical development." *Molecular Therapy. Methods and Clinical Development*. 32.2 (2024):101250

4. Volkov, Jenell, et al. "Case study of CD19 CAR T therapy in a subject with immune-mediate necrotizing myopathy treated in the RESET-Myositis phase I/II trial." *Molecular Therapy* 32.11 (2024): 3821-3828.

5. Abstract 1733: Safety and Efficacy of CABA-201, a Fully Human, Autologous 4-1BB Anti-CD19 CAR T Cell Therapy in Patients with Immune-Mediated Necrotizing Myopathy and Systemic Lupus Erythematosus from the RESET-MyositisTM and RESET-SLETM Clinical Trials. ACR 2024.

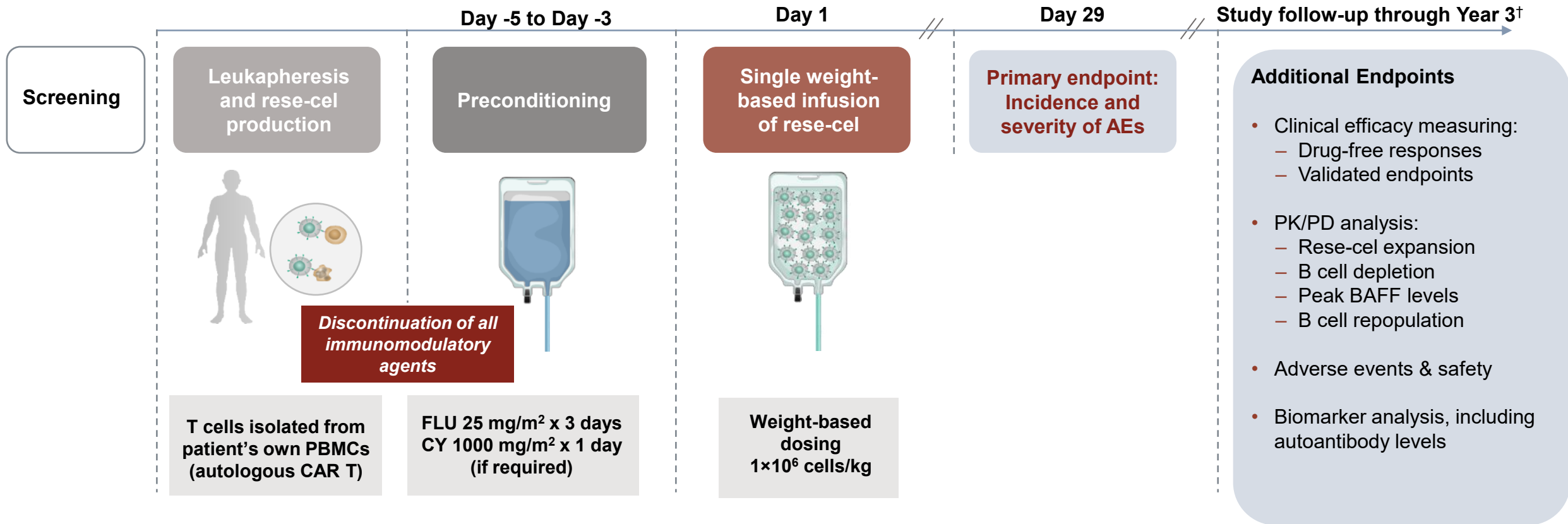
6. Peng BJ, et al. *Mol Ther Methods Clin Dev*. 2024;32(2):101267.

7. Dai, Zhenyu, et al. "Development and functional characterization of novel fully human anti-CD19 chimeric antigen receptors for T-cell therapy." *Journal of Cellular Physiology* 236.8 (2021): 5832-5847.

8. Müller, Fabian, et al. "CD19 CAR T-Cell Therapy in Autoimmune Disease—A Case Series with Follow-up." *New England Journal of Medicine* 390.8 (2024): 687-700.

RESET™ clinical trials have consistent design principles¹

Many of the RESET trials share common elements of preconditioning, dose, and study design



[†]Follow up period encompasses at least 15 years in total, ed to regulatory guidance for CAR T cell therapies.

AE, adverse event; CABA, Cabaletta Approach to B cell Ablation; FLU, fludarabine; CY, cyclophosphamide; PBMC, peripheral blood mononuclear cell; PD, pharmacodynamics; PK, pharmacokinetics; RESET, REStoring SElf-Tolerance; SLE, systemic lupus erythematosus; SSc, systemic sclerosis.

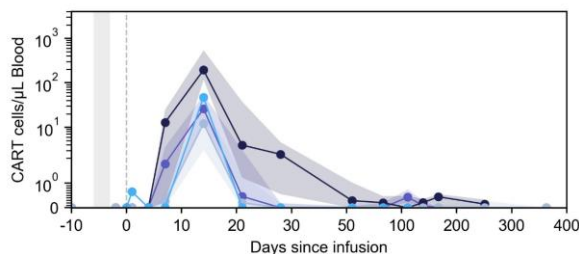
Cabaletta Bio: Data on file; 1. Peng BJ, et al. Mol Ther Methods Clin Dev. 2024;32(2):101267.

Rese-cel expansion & B cell kinetics across indications*

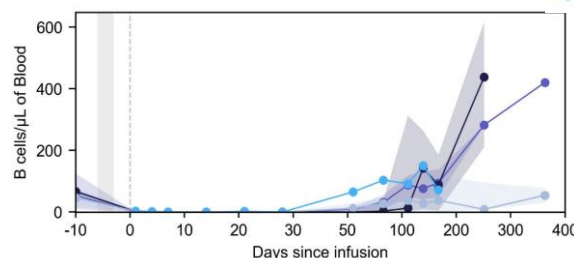
Peak rese-cel expansion and transient peripheral B cell depletion occurred by ~2 weeks post infusion

RESET-Myositis[†]

Rese-cel Pharmacokinetics

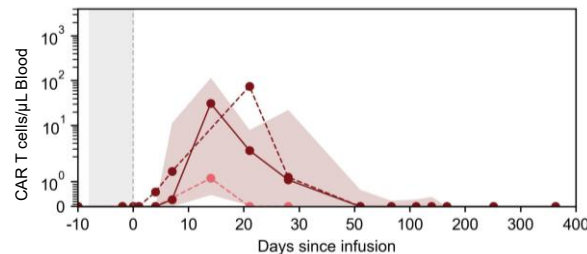


B Cell Kinetics[‡]

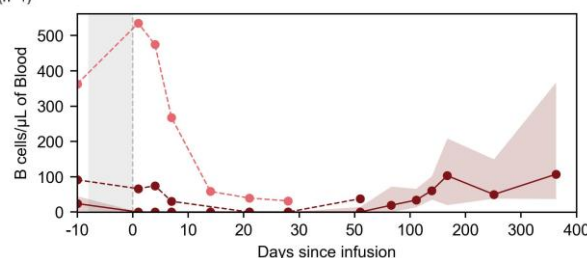


RESET-SLE

Rese-cel Pharmacokinetics

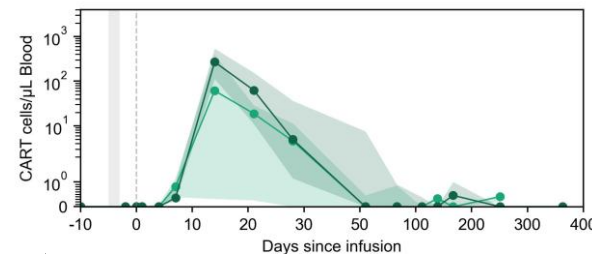


B Cell Kinetics

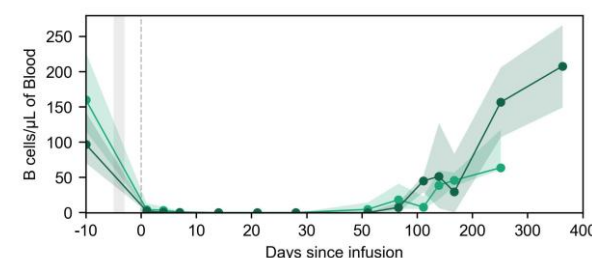


RESET-SSc

Rese-cel Pharmacokinetics[§]

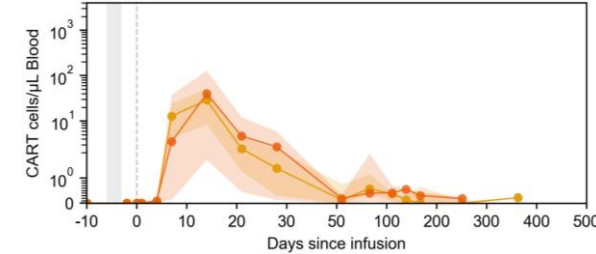


B Cell Kinetics

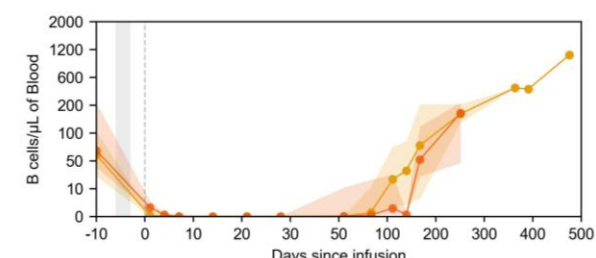


RESET-MG

Rese-cel Pharmacokinetics



B Cell Kinetics



Peripheral B cells begin repopulating ~2 to 3 months after rese-cel in patients with sufficient follow-up*

All data is as of 16 Apr 2026, except MG which is as of 4 September 2026.

*Data shown as median and IQR for myositis, SLE and SSc. [†]Note baseline (pre-preconditioning) B cell count for the JDM patient was not available. [‡]B cell count data excluded from any patient after receiving B cell-depleting rescue therapy. [§]Median time includes subjects with depletion and repopulation; one Organ subject did not exhibit peripheral B cell depletion at the time points sampled.

AChR, acetylcholine receptor; ASyS, antisynthetase syndrome; CAR, chimeric antigen receptor; DM, dermatomyositis; IMNM, immune-mediated necrotizing myopathy; IQR, interquartile range; JDM, juvenile dermatomyositis; JIIM, juvenile idiopathic inflammatory myopathy; LN, lupus nephritis; MG, myasthenia gravis; PC, preconditioning; rese-cel, resecabtagene autoleucel; RESET, REStoring SELF-Tolerance; SLE, systemic lupus erythematosus, SSc, systemic sclerosis. Cabaletta Bio: Data on file.

Demographics & CRS/ICANS in first 64 rese-cel patients by indication

Across 4 RESET™ studies, 94% of patients have either no CRS or Grade 1 (fever) and 97% have no ICANS¹

Baseline characteristics of autoimmune disease patients treated with rese-cel

	RESET-Myositis	RESET-SLE	RESET-SSc	RESET-MG
Number of patients	17	18	15	14
Age, years, mean (SD)	57.0 (15.1)	29.9 (7.4)	50.4 (14.6)	54.1 (9.7)
Sex, % female	52.9	88.9	73.3	64.3
Duration of disease, years, mean (SD)	4.9 (3.7)	10.2 (5.0)	1.9 (1.2)	7 (6.4)

Incidence, severity and onset of CRS and ICANS in the 1st 28 days in patients treated with rese-cel

	RESET-Myositis	RESET-SLE	RESET-SSc	RESET-MG	Total
CRS [‡] , n (%)	5 (29.4)	6 (33.3)	7 (46.7)	2 (14.3)	20 (31.2% CRS)
CRS Grade 1, n (%)	5 (29.4)	5 (27.7)	5 (33.3)	1 (7.1)	16 (25.0% G1 CRS)
CRS Grade 2, n (%)	–	1 (5.6)	2 (13.3)	1 (7.1)	4 (6.3% G2 CRS)
Time to CRS onset, days* (mean)	7.4	6.7	9.0	5.5	7.6 days
CRS duration [†] , days (mean)	4.6	3.0	2.9	5.0	3.6 days
ICANS [‡] n (%) (Grade)	–	1 (5.6) (G4)	1 (6.7) (G3)	–	2 (3.1% ICANS)
Time to ICANS onset, days (mean)	–	9.0	8.0	–	8.5 days
ICANS duration, days (mean)	–	3.0	3.0	–	3.0 days

*Days relative to rese-cel infusion.

[†]Events occurring within 7 days of each other are considered as 1 episode. IMNM-3 CRS duration includes preceding event of fever which was consistent with CRS definition.

[‡]Graded per ASTCT Consensus Grading Criteria.

1. Presented at EULAR 2026 with data cut-off as of 16 Apr 2026 (Myositis, SLE and SSc), Presented at AANEM 2026 with data cut-off as of 4 Sep 2026 (MG).



Myositis: Unmet Need, Clinical Data and Commercial Opportunity

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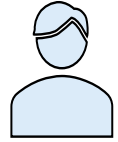
Myositis: High rates of disability & increased risk of mortality

Highly concentrated treatment network in the US; dermatomyositis represents ~75% of this market

> High disease burden: disability & mortality

- Typical patient is a middle-aged female who experiences muscle weakness, fatigue, pain, shortness of breath and difficulty swallowing
 - Moderate to severe disability (40% to 65%)¹
 - Assisted walking devices (18% to 38%)¹
- The **risk of mortality is ~3 times higher** than the general population, primarily due to cancer and lung & cardiac complications²
 - ~20% mortality < 5 years with standard immunosuppressive treatment³

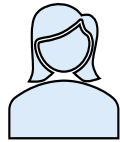
*"I find it **very difficult** to get up from a regular chair, I need boosters or assistance from somebody else. Walking, my **gait has really suffered**. My stability walking has suffered as well, and I **can't lift anything more than five or eight pounds**. So doing stuff is difficult. Bending down is very difficult. I **can't get up from the floor if I fall**."*



"John"

61-year-old male with ASyS⁴
~10 yrs since diagnosis

*"It just **affected every aspect of my life**. Just work, family, social life, own wellbeing. It just pours into everything else with that."*



"Erica"

44-year-old female with DM⁴
~2.5 yrs since diagnosis

Subtype prevalence in the U.S.

~60,000 pts^{5,6}

Dermatomyositis (DM)

~15,000 pts^{7,8}

Anti-synthetase syndrome (ASyS)

~2,000 pts⁹

Juvenile-onset disease (JDM)

1. Opinc AH, Brzezinska OE, Makowska JS. Disability in idiopathic inflammatory myopathies: questionnaire-based study. Rheumatol Int. 2019;39(7):1213-1220.

2. Marie I. Morbidity and mortality in adult polymyositis and dermatomyositis. Curr Rheumatol Rep. 2012;14(3):275-285.

3. Schiopu E, Phillips K, MacDonald PM, Crofford LJ, Somers EC. Predictors of survival in a cohort of patients with polymyositis and dermatomyositis: effect of corticosteroids, methotrexate and azathioprine. Arthritis Res Ther. 2012;14(1):R22.

4. Primary market research conducted via third-party, blinded interviews with myositis patients, conducted in 2024.

5. Khoo 2023 6. Kronzer 2023 7. Coffey 2021 8. Dahal 2022 9. Papadopoulou 2022

Dermatomyositis (DM): Limited treatment options for ~60k U.S. patients

Approved treatments limited to adults and require chronic use on top of immunomodulators

➤ Limited treatment options¹

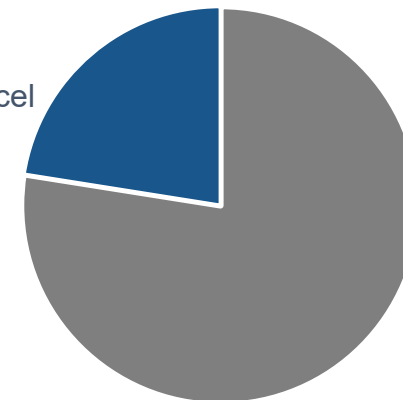
- Common therapies: steroids plus an immunomodulator (i.e. methotrexate, azathioprine, mycophenolate, rituximab)
- Therapies can carry potential long-term side effects such as serious infections and organ damage
- Despite existing therapies, disease is often refractory
- Approved adult dermatomyositis therapies, brepocitinib and IVIg, and emerging investigational approaches, including efgartigimod, are chronic, add-on therapies that do not eliminate the need for concurrent immunomodulators

Eligible U.S. adult DM patients²

*Adult DM patients with moderate to severe, refractory disease
potentially eligible for rese-cel*

(per analysis of quantitative research with ~240 myositis-treating physicians)

**~12k to 15k
U.S. patients**
potentially eligible for rese-cel



U.S. Prevalence: ~60k adult DM patients

1. Lundberg, Ingrid E., et al. "Idiopathic inflammatory myopathies." Nature Reviews Disease Primers 7.1 (2021): 86.

2. Analysis from quantitative survey of U.S. myositis-treating physicians, conducted 2Q25. N = ~240.

Myositis registrational cohort – Key design elements

Single-arm cohort including DM/ASyS patients with a primary endpoint at 16 weeks



- ✓ RESET-Myositis trial now enrolling registrational cohort in DM (14 patients) / ASyS (3 patients)
 - Plan to include JDM data in myositis BLA submission¹
- ✓ **Primary Endpoint:** Moderate or Major TIS response @ Week 16 off all immunomodulators and off or on low-dose³ steroids
- ✓ Weight-based single dose of rese-cel at 1 million cells/kg with safety profile appropriate for outpatient dosing
- ✓ Safety database ~100 autoimmune patients at ≥1-month of follow-up (with at least 35 myositis patients)

Inclusion of JDM in 2H27 myositis BLA submission facilitates potential for priority review voucher, pending supportive data, based on rare pediatric disease designation

JDM, juvenile dermatomyositis; TIS, total improvement score.

1. Pediatric JDM submission based on data available at the time of adult submission from ongoing Ph 1/2 study (no new study) to support pediatric label claim

2. Size of myositis registrational cohort based on key statistical parameters and estimated background remission rate in myositis.

3. Low dose steroids is defined as 50% reduction from baseline or ≤7.5 mg/day.

Baseline characteristics: First 17 patients in RESET-Myositis

All patients had active, refractory disease despite multiple medications, including IVIg and B cell-targeting therapies

	DM N=6	ASyS N=4	IMNM N=6	JDM N=1
Age, years, median (min, max)	57 (45, 72)	44 (26, 57)	59 (33, 64)	14
Female, n (%)	5 (83)	2 (50)	1 (17)	1 (100)
Disease duration, years, median (min, max)	3.5 (2.0, 10.3)	2.7 (0.9, 14.8)	4.7 (1.4, 8.8)	8.5
Myositis-specific autoantibody	50% TIF1-γ 17%: NXP, SAE, MDA-5	100% Jo-1	67% HMGCR 33% SRP	NXP-2
Baseline disease activity, median*				
MMT-8	123.0	129.5	127.5	134.0
CK	40.0	257.5	2214.5	176.0
CDASI-A	23.5	N/A	N/A	5
Prior RTX[†] (%)	50%	100%	83%	100%
Prior IVIg[†] (%)	67%	75%	83%	100%
Therapies at Screening				
Systemic GCs	67%	75%	67%	0
≤2 IMs	67%	75%	100%	0
≥3 IMs	33%	25%	0	100%

As of 16 Apr 2026.

*Baseline disease activity = activity before preconditioning. †Reflects any exposure to RTX and IVIg prior or at time of study entry. RTX is not allowed within approximately 6 months of screening.

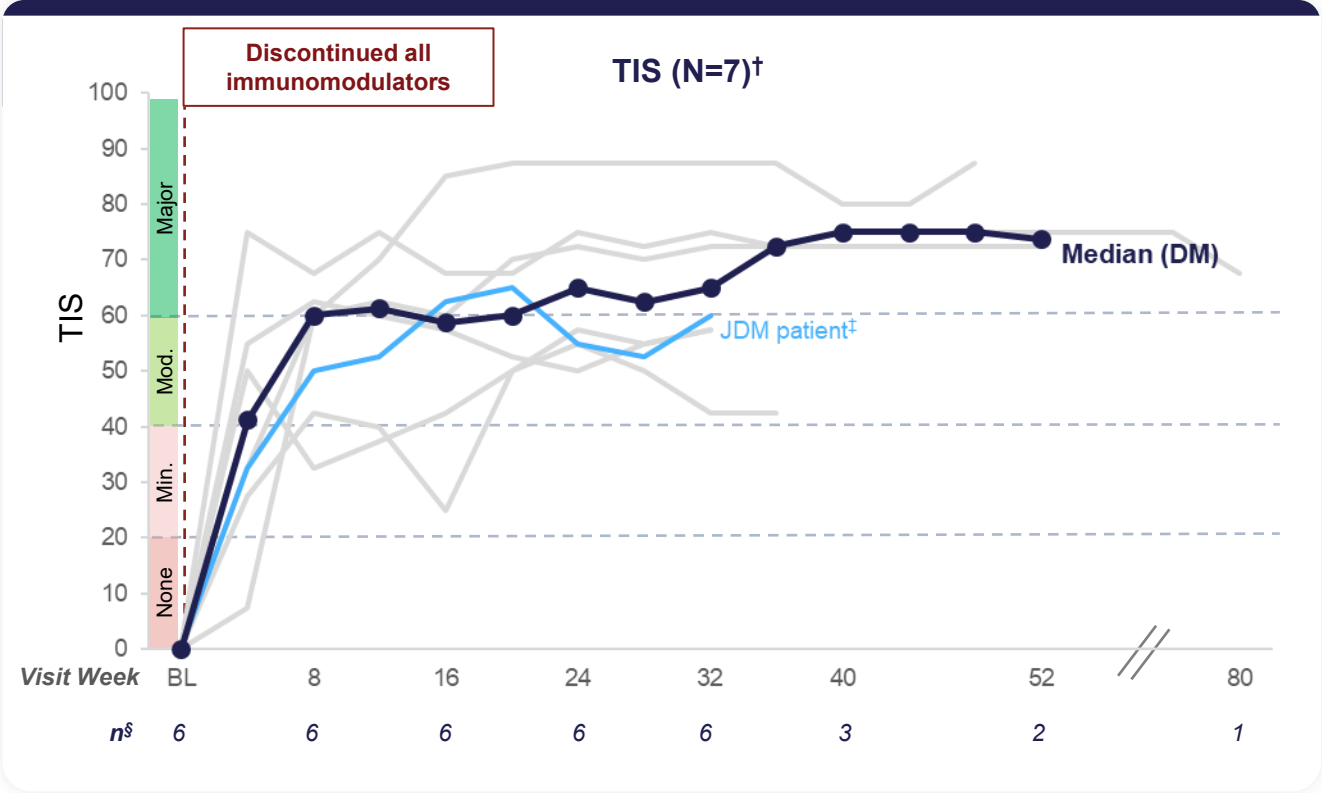
ASyS, antisynthetase syndrome; CDASI-A, Cutaneous Dermatomyositis Disease Area and Severity Index – Activity; CK, creatine kinase; DM, dermatomyositis; GC, glucocorticoid; HMGCR, 3-hydroxy-3-methylglutaryl-coenzyme A reductase; IM, immunomodulatory medication; IMNM, immune-mediated necrotizing myopathy; IVIg, intravenous immunoglobulin; JDM, juvenile dermatomyositis; MDA-5, melanoma differentiation-associated gene 5; MMT-8, manual muscle testing 8; NXP, nuclear matrix protein; N/A, not applicable; RESET, REStoring SElf-Tolerance; RTX, rituximab; SAE, small ubiquitin-like modifier activating enzyme; SRP, signal recognition particle; TIF1, transcription intermediary factor 1; U/L, units per liter.

Cabaletta Bio – Data on File.

Efficacy data in DM and JDM patients following rese-cel infusion

6 of 7 patients achieved moderate or major IM-free TIS response at Week 16 which was maintained through latest follow-up

Assessment at Week 16	DM and JDM patients (N=7)
Complete B cell depletion (%)	100%
IM-free & low-dose* or no GC (%)	100%
Moderate or major TIS response (%)	86%
Meets moderate or major TIS off IM therapy & on low-dose or no GCs* (Pivotal primary endpoint)	86%



5 of 6 adult Phase 1/2 DM patients and the JDM patient would have achieved the 16-week primary endpoint for the pivotal study and all of them maintained IM-free TIS response through latest follow-up, as long as 1.5 years

As of 16 Apr 2026.
*Low-dose steroids is defined as 50% reduction from baseline or ≤7.5 mg/day. [†]Missing data were imputed using last observation carried forward. [‡]TIS threshold for a moderate response is ≥45 in patients with JDM; TIS scale on the Y-axis reflects adult thresholds. [§]Median and n numbers are based on DM patients (excluding JDM patient) not receiving rescue immunomodulatory medications.
BL, baseline; DM, dermatomyositis; GC, glucocorticoids; IM, immunomodulatory medication; JDM, juvenile dermatomyositis; mg, milligrams; rese-cel, rescabtagene autoleucel; TIS, total improvement score.
Cabaletta Bio: Data on File.

CAR T may eliminate active disease & use of expensive medications

Rese-cel safety profile facilitates outpatient administration which could allow for favorable reimbursement

✗ Cancer CAR T: Safety profile often requires inpatient infusion, affecting reimbursement

Cancer patients experience early and frequent CRS/ICANS following CAR T therapy, which increases inpatient admissions and shifts Medicare reimbursement to the DRG system.

Majority of oncology patients treated with CAR T therapy experience CRS within first 5 days post-infusion¹

Many cancer patients are insured under Medicare, which has inpatient **DRG-018** reimbursement

✓ Rese-cel: Safety profile facilitates outpatient infusion, which could favorably impact reimbursement

Commercial

Myositis & SSc patients often commercially insured (60%-75%)^{2,3}



CRS less frequent & severe, delayed onset → potential outpatient administration



Outpatient CAR T infrastructure exists at many centers

Medicare

Outpatient administration supports viable Part B Medicare payments



RESET clinical site footprint can be leveraged to generate early adopters

1. Ferreri, Christopher J., and Manisha Bhutani. "Mechanisms and management of CAR T toxicity." *Frontiers in Oncology* 14 (2024): 1396490.

2. Smoyer-Tomic KE, et al. *BMC Musculoskelet. Disord.* 2012 Jun 15;13:103. doi: 10.1186/1471-2474-13-103.

3. Gale, Sara L., et al. "Characterizing disease manifestations and treatment patterns among adults with systemic sclerosis: a retrospective analysis of a US healthcare claims population." *Rheumatology and therapy* 7.1 (2020): 89-99.

RESET™ program designed for outpatient administration at launch

Outpatient administration reduces administrative burden and improves patient and provider accessibility



INPATIENT MODEL

Limited patient beds
and resource infrastructure

- ✗ Increases inpatient resource pressure:
↑ total cost of care, human resource
and bed space demands
- ✗ Reduces eligible patients treated



OUTPATIENT MODEL

More favorable safety profile
reduces need for inpatient admission

- ✓ Reduces use of hospital resources;
Increases throughput
- ✓ Reduces conflicts with cancer patient
use of in-patient beds

Rese-cel commercial model – manufacturing and COGM

Health status of patient population and slower disease progression improve manufacturing cost efficiency

✗ In oncology, disease progress & out of specification (OOS) rates increase costs and reduce margins

Late-stage oncology patients have high drop-off rate due to rapid disease progression and compromised T cell fitness, leading to higher manufacturing OOS rates^{1,2,3}

Increased OOS rates; ↑ COGM
+ ↓ revenue since out of spec
products not reimbursed



Disease progression reduces
revenue capture because unused
product is not reimbursed



Reduced eligible patients,
resulting in economies of scale
not being achieved



Manufacturing capacity constraints
→ delayed commercial ramp-up

✓ In autoimmunity, patients less pretreated & automated rese-cel mfg should support lower COGM



Autoimmune patients are not heavily pretreated
with chemotherapy → more fit immune cells⁴ that
support reliable manufacture, reducing COGM



Autoimmune patients rarely progress as rapidly as
cancer patients → more reliable revenue
realization for manufactured product



Building manufacturing capacity at CDMOs to
support successful launch; Cellares automation
has the potential to facilitate post-approval
expansion

COGM – Cost of goods manufactured

1. U.S. Food and Drug Administration. Kymriah (tisagenlecleucel) Prescribing Information. Revised 2025, U.S. Food and Drug Administration, <https://www.fda.gov/media/107296/download>

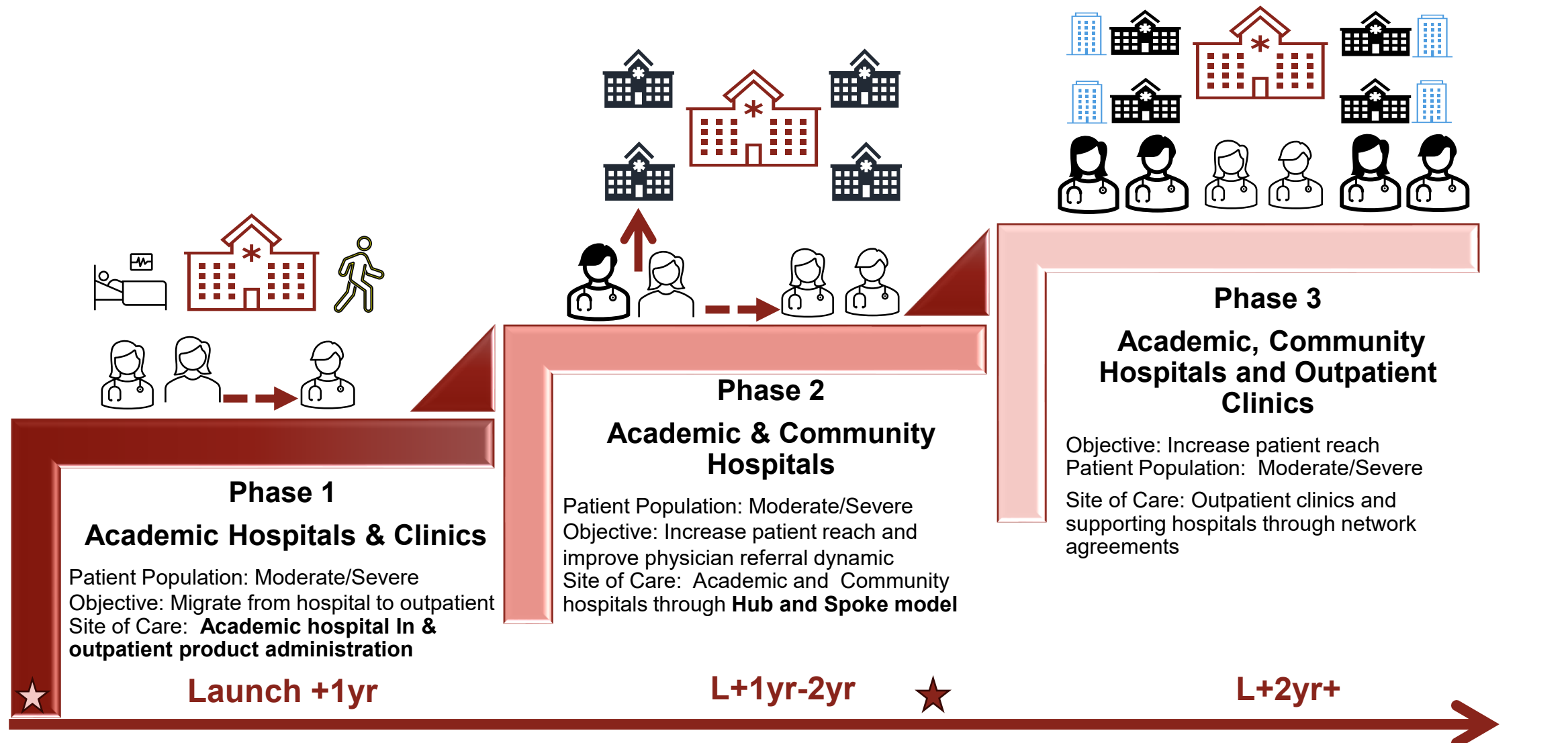
2. U.S. Food and Drug Administration. Breyanzi (lisocabtagene maraleucel) Prescribing Information. Revised 2025, U.S. Food and Drug Administration, <https://www.fda.gov/media/145711/download>

3. U.S. Food and Drug Administration. Yescarta (axicabtagene ciloleucel) Prescribing Information. Revised 2025, U.S. Food and Drug Administration, <https://www.fda.gov/media/108377/download>

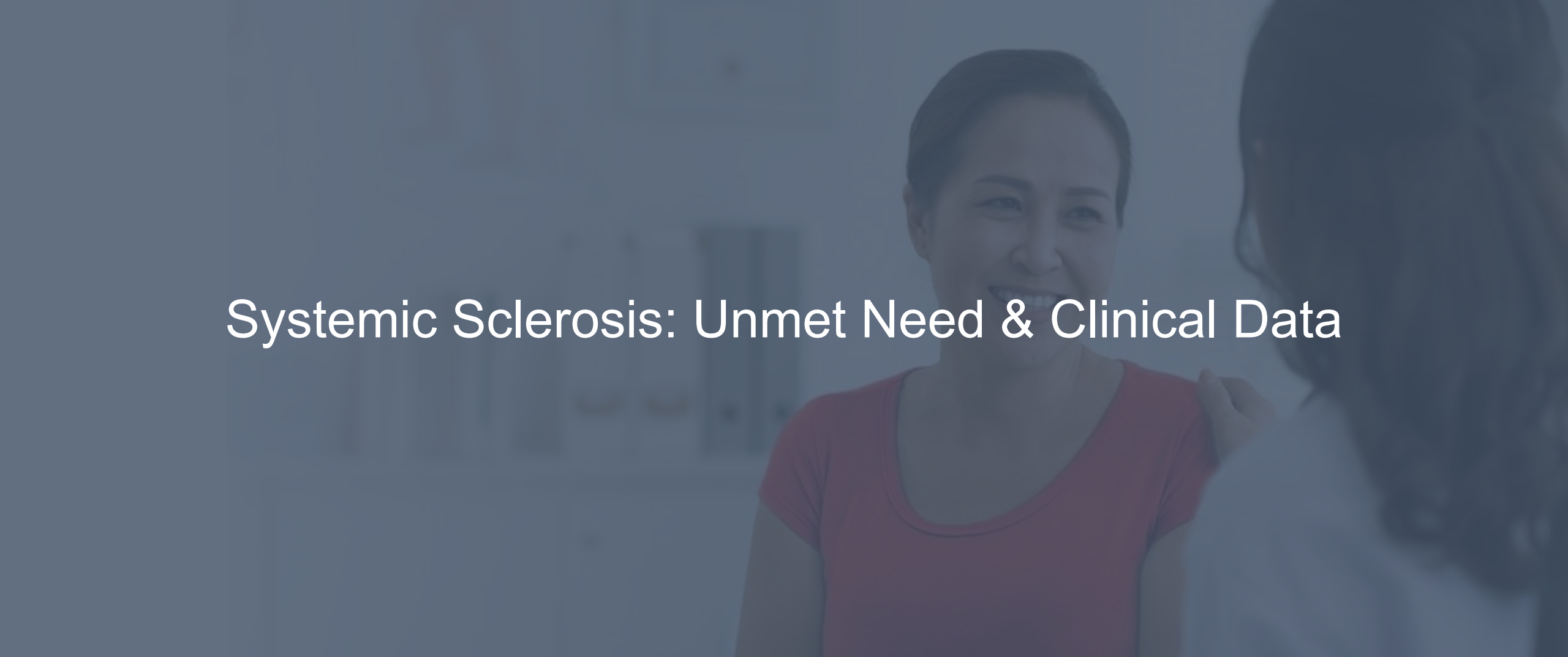
4. Sharma, Sagar, et al. Consistency in rescabtagene autoleucel product quality across RESET phase 1/2 clinical trials and manufacturing platforms American Society of Gene & Cell Therapy (ASGCT) 2026 Annual Meeting, 12 May 2026, Boston, MA. Oral presentation.

Three-phase approach to rese-cel launch in myositis and beyond¹

Rese-cel safety data facilitates plan to target academic centers at launch with rapid community expansion



1. Rese-cel is an investigational product candidate and has not been approved by the FDA.

A photograph of a woman with dark hair, smiling and looking towards the right. She is wearing a red top. Another person's hand is visible on her right shoulder, suggesting a supportive or comforting gesture. The background is slightly blurred, showing what appears to be a clinical or office setting.

Systemic Sclerosis: Unmet Need & Clinical Data

Cabaletta Bio[®]

Systemic sclerosis: Profound unmet need & limited options

Associated with progressive morbidity and high mortality^{1,2}

> Rare, potentially life-threatening autoimmune disease¹

- Characterized by progressive skin & internal organ fibrosis¹
- Deep, tissue-level B cell-driven autoimmunity, with activated B cells & autoantibodies, promotes inflammation & organ damage³

> Patients experience a progressive & often fatal course

- Typically, middle age onset and more common in females¹
- Highest mortality of all rheumatological diseases & significant burden from persistent skin & organ manifestations^{4,5}
 - **Mean survival is ~12 years from diagnosis**
- Need for disease-modifying therapies across all SSc subsets⁵
 - **FDA-approved agents for SSc-ILD slow but do not stabilize or improve lung progression**
 - Approved based on 1-year primary endpoints
 - No existing treatments capable of halting SSc pathology other than AHSCT, which carries high risk

Eligible U.S. SSc patients⁶

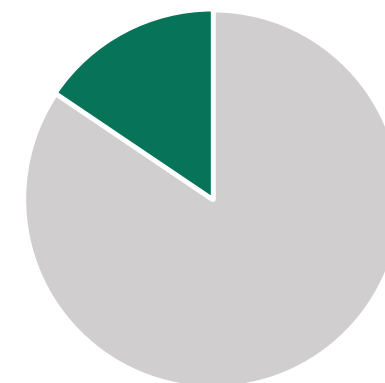
SSc patients with early, active disease potentially eligible for rese-cel

(per quantitative research with ~100 SSc-treating physicians)

~12,000-15,000

U.S. SSc patients

potentially eligible for rese-cel



~90k SSc patients

(~40% with clinically significant ILD)

AHSCT, autologous hematopoietic stem cell transplantation; ILD, interstitial lung disease; SSc, systemic sclerosis.

1. Allanore Y, et al. Nat Rev Dis Primers. 2015;1:15002. 2. Denton CP, et al. Lancet. 2017;390(10103):1685–1699. 3. Thoreau B, et al. Front Immunol. 2022;13:933468. 4. Truchetet ME, et al. Clin Rev Allergy Immunol. 2023;64(3):262–283. 5. Pope JE, et al. Nat Rev Rheumatol. 2023;19(4):212–226. 6. Results from quantitative survey of U.S. SSc-treating physicians (rheumatologists), conducted 3Q25. N = ~100.

Baseline characteristics: First 15 Patients in RESET-SSc

All patients had active, refractory disease despite multiple SSc therapies, and 12/15 had ILD

Cohort	Severe skin cohort [§] (N=6)	Organ cohort [§] (N=9)	All (N=15)	ILD (N=12)
Age, years, median (min, max)	57 (42, 66)	43 (19, 70)	54 (19, 70)	54.5 (19, 70)
Female, n (%)	4 (67)	7 (78)	11 (73)	9 (75)
Disease duration,* years, median (min, max)	1.6 (0.5, 2.2)	2.1 (0.4, 5.0)	1.8 (0.4, 5.0)	1.7 (0.4, 5.0)
ILD at screening, [†] n (%)	4 (67)	8 (89)	12 (80)	12 (100)
Cardiac involvement at screening, n (%)	0 (0)	3 (33)	3 (20)	2 (17)
Autoantibodies, %				
Scl-70	17	78	53	58
Anti-RNA pol III	83	11	40	25
Baseline disease activity, median [‡]				
mRSS	40	19	24	23
HAQ-DI	2.19	1.63	1.88	1.81
FVC (% predicted)	92 [¶]	77	79	78.5
DLCO (% predicted)	75.5 [¶]	66	72	68
PGA	6	5.5 ^{**}	6 ^{**}	6 ^{**}
Therapies at screening, n (%)				
MMF/MPA	5 (83)	7 (78)	12 (80)	11 (92)
Tocilizumab	1 (17)	5 (56)	6 (40)	6 (50)
Prednisone	1 (17)	2 (22)	3 (20)	3 (25)
Methotrexate	1 (17)	1 (11)	2 (13)	2 (17)
HCQ	0 (0)	3 (33)	3 (20)	2 (17)
IVIg	0 (0)	2 (22)	2 (13)	2 (17)
Number of prior SSc therapies, median (min, max)	3 (2, 5)	4 (3, 6)	4 (2, 6)	3 (2, 6)

As of 16 Apr 2026.

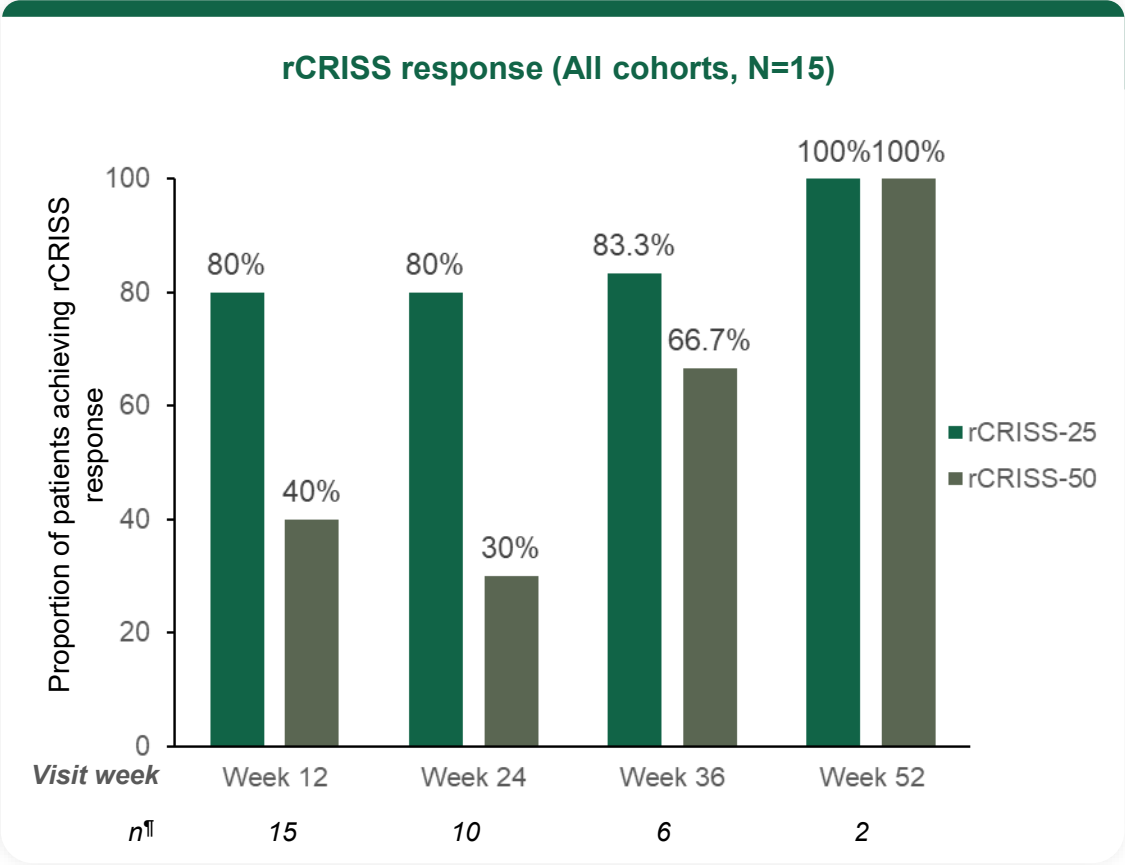
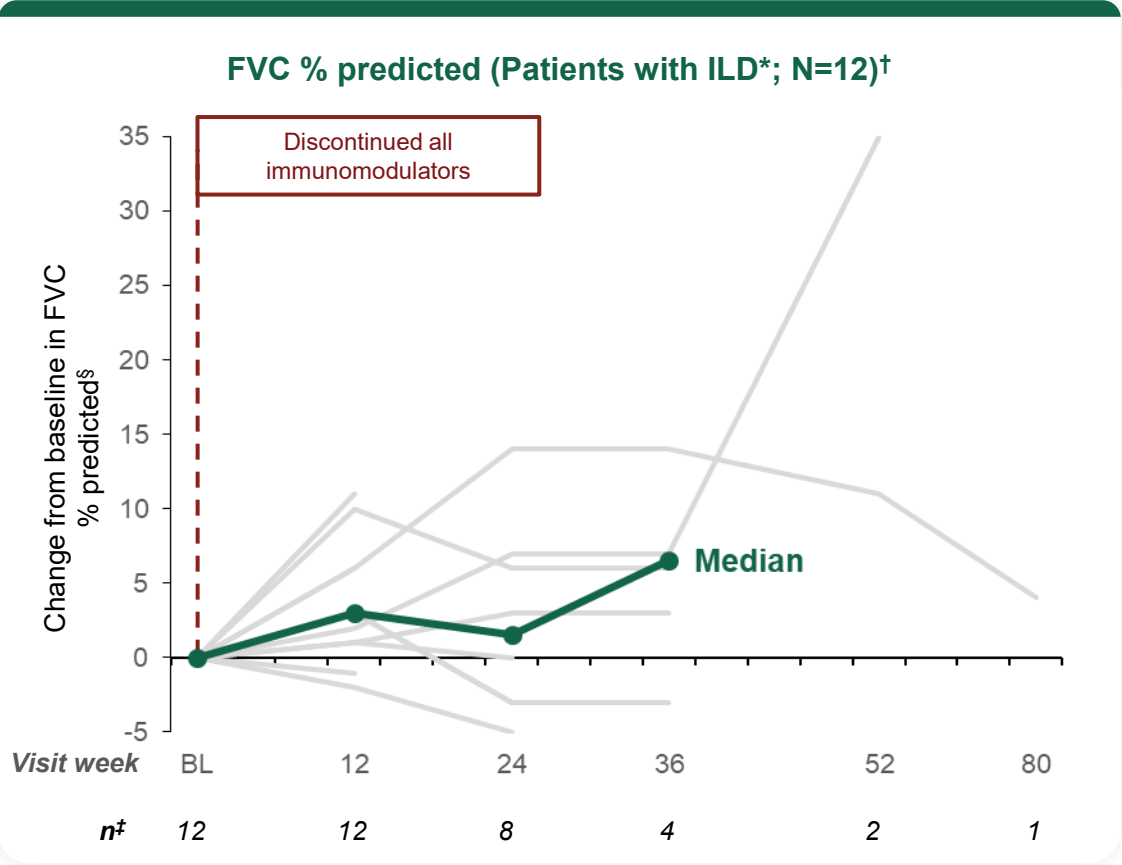
*Time of diagnosis to screening. [†]Per HRCT. [‡]Baseline disease activity = activity before preconditioning. [§]The severe skin cohort includes patients with severe skin involvement and the organ cohort includes patients with significant organ involvement (e.g., pulmonary, renal, or cardiac involvement), irrespective of skin disease severity. [¶]Missing data were imputed using last observation carried forward; FVC and DLCO data for 1 patient were imputed using values from screening visit. ^{**}Missing baseline data for SSc-Organ-9.

DLCO, % predicted diffusing capacity for carbon monoxide; FVC, forced vital capacity; HAQ-DI, Health Assessment Questionnaire Disability Index; HCQ, hydroxychloroquine; HRCT, high-resolution computed tomography; ILD, interstitial lung disease; IVIg, intravenous immunoglobulin; MMF, mycophenolate mofetil; MPA, mycophenolic acid; mRSS, modified Rodnan skin score; PGA, Physician Global Assessment; RESET[™], REstoring SElf-Tolerance; RNA pol, ribonucleic acid polymerase; Scl-70, anti-topoisomerase I antibody; SSc, systemic sclerosis.

Cabaletta Bio: Data on File.

Efficacy data in SSc following rese-cel infusion

After discontinuing immunomodulators, FVC improvement or stabilization was observed in most patients with ILD*



Based on these data and FDA discussions, Cabaletta plans to advance a single-arm registrational study of ~25 patients with SSc-associated ILD using an FVC-based primary endpoint at 52 weeks with initiation anticipated in 4Q26

As of 16 Apr 2026.
*Based on HRCT at screening. †Missing data were imputed using last observation carried forward. ‡Median and n numbers are based on SSc patients not receiving rescue immunomodulatory medications.
§Absolute change. ¶n numbers are based on evaluable SSc patients.
BL, baseline; FVC, forced vital capacity; ILD, interstitial lung disease; HRCT, high-resolution computed tomography; rCRISS, revised Composite Response Index in Systemic Sclerosis; rese-cel, rescabtagene autoleucel; SSc, systemic sclerosis.
Cabaletta Bio: Data on File.



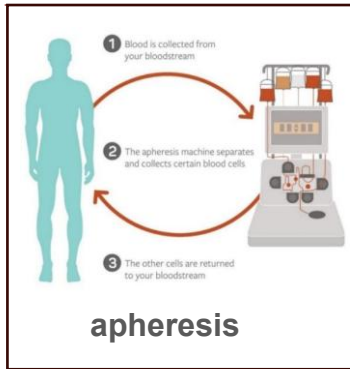
Rese-cel Manufacturing Strategy & Innovation

Caballetta Bio[®]

Rese-cel Manufacturing Process – Commercial Readiness

Partial automation anticipated at launch with full automation planned for post-launch supply

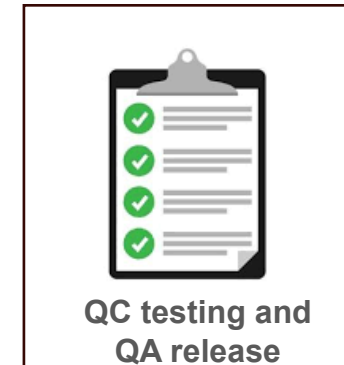
T cell collection



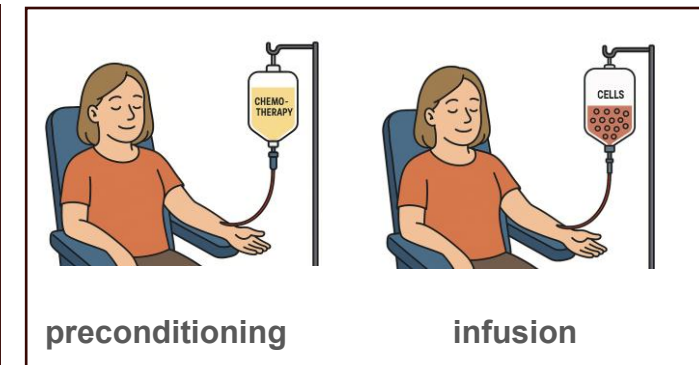
Rese-cel manufacture (9 day)



Product release



Rese-cel administration



- Process B – Commercial-ready manufacturing process
 - Substantially closed and partially automated to improve process capacity and consistency over original process
 - Implemented prior to IIM registrational study, with FDA alignment on comparability¹
 - Planned for initial launch through proven commercial CDMO partners
- Process C – Industrialized, automated manufacturing process with Cellares
 - Comparability data, including multiple engineering runs, supported treatment of Phase 1/2 patients²
 - Planning for commercial implementation ~1-year post-launch³

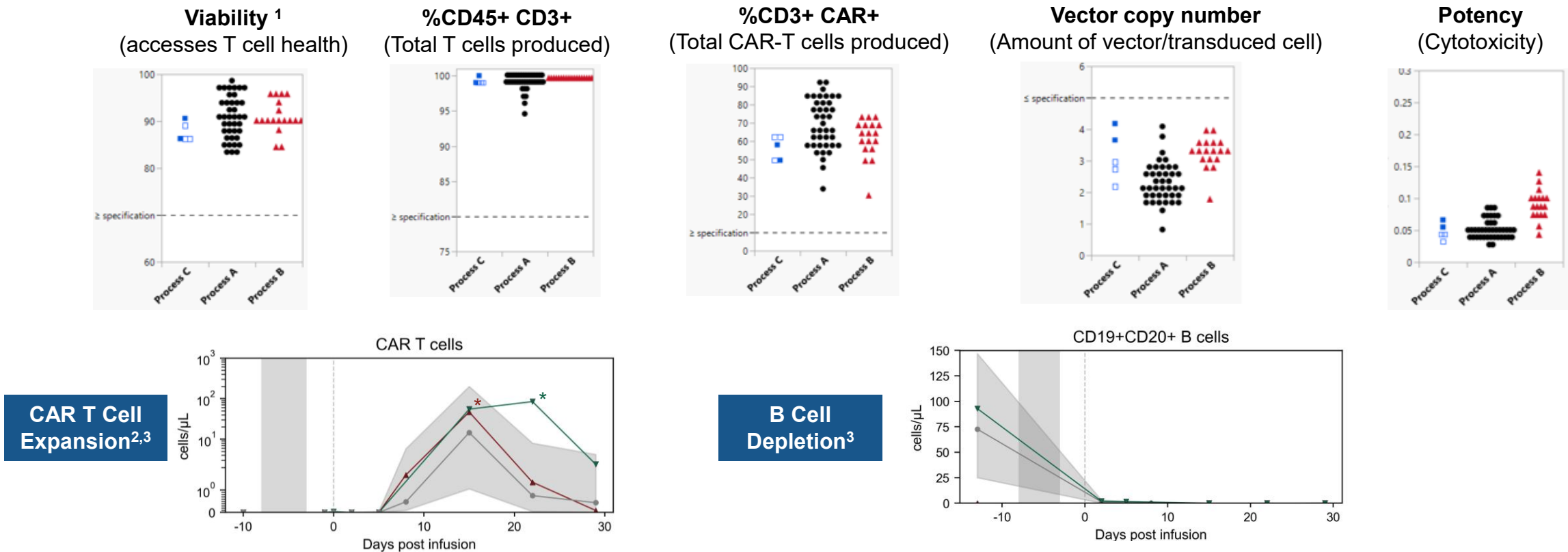
¹ Current comparability data allows use of safety data from patients treated with original process ("Process A") and Process B; additional data submission planned in 2026 to allow inclusion of efficacy data.

² Current comparability data allows use of safety data from patients treated with Process A, full analytical comparability between Process A, B and C pending process optimization.

³ Following completion of process optimization, process validation work, and based on full analytical comparability data set.

Initial automated manufacturing & translational data

Cellares automation: consistent manufacturing and translational rese-cel data in 1st 2 patients vs. traditional CDMOs



1st 2 rese-cel clinical manufacturing runs met release specifications including product quality attributes within historical ranges; initial data suggest rese-cel manufactured by Cellares exhibited comparable in vivo behavior to rese-cel products manufactured using conventional processes

1. Cellares uses Celleca for viability measurement to enable automated testing. Viability data for Process C shown in this figure were measured using NC200 to enable direct comparison with Process A and Process B, for which NC200 was also used

2. Data points with asterisks had low DNA input per assay recommendation.

3. Median and 50th percentile intervals of values from subjects manufactured with conventional manufacturing (conv) shown in gray.

Cabaletta Bio[®]

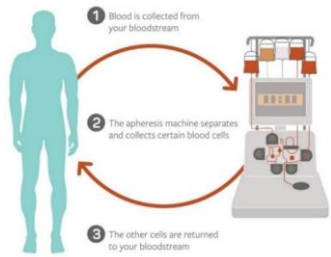
29

Advancing breakthrough innovations to improve scalability and costs

Automation plus elimination of preconditioning and apheresis could impact patient preference & experience

CURRENT

T cell collection



apheresis

Rese-cel manufacture and harvest (9 day)

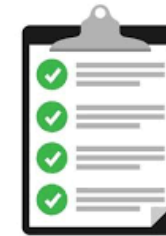


cell selection and
activation

cell expansion

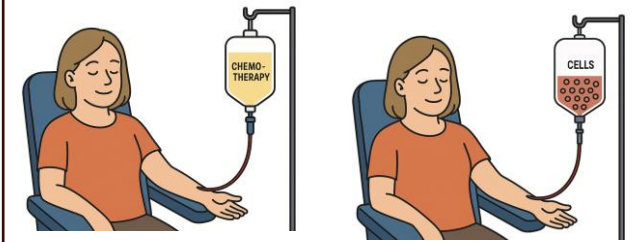
cell harvest

Product release



post-production
testing and QA review

Rese-cel administration



preconditioning

infusion

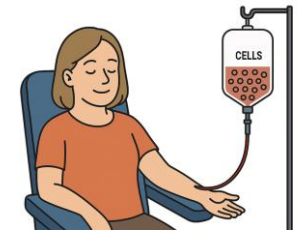
INNOVATIONS

**Blood draw to
replace
apheresis^{1,2}**



Cellares Cell Shuttle³

- Fully closed, end-to-end automation
- Rapid & global scalability
- Shorter turn-around-time



**One outpatient infusion
without preconditioning⁴**

1. Stratton et al, ESGCT 2024. Poster available at <https://www.cabalettabio.com/technology/posters-publications>

2. (https://d1io3yog0oux5.cloudfront.net/_cdcc45a1b07d9c1e0fc529e815f21ec3/cabalettabio/db/947/8240/pdf/Whole+Blood+Mfg+Poster+ESGCT+2024.pdf)

3. Automation run feasibility completed under TAP program. Video on Cellares technology can be viewed here: <https://vimeo.com/947203843/cd59569f16>.

4. Under evaluation in an ongoing study in Pemphigus Vulgaris (NCT004422912); presented at ESGCT Conference 2025, presentation is available at <https://www.cabalettabio.com/technology/posters-publications>.

A woman with dark hair tied back, wearing a red shirt, is smiling and looking towards a doctor. The doctor, whose back is to the camera, is wearing a white lab coat and glasses. They are in a clinical setting with a whiteboard in the background.

Rese-cel – PC-Free Data at Lowest Dose in PV and Lupus

Cabaletta Bio[®]

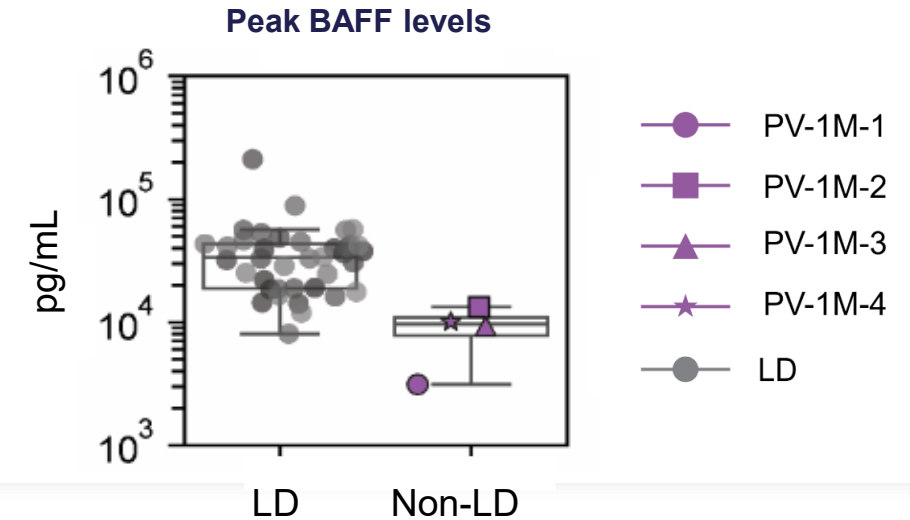
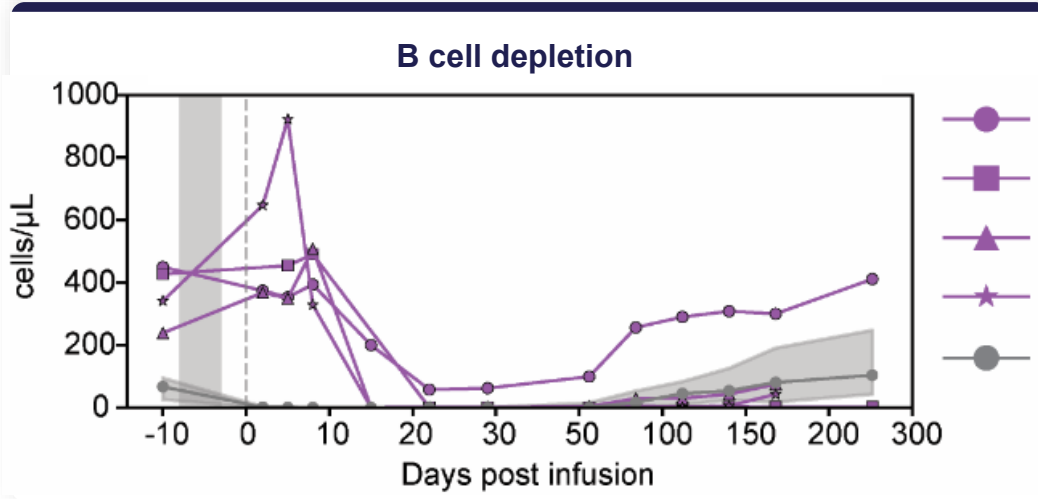
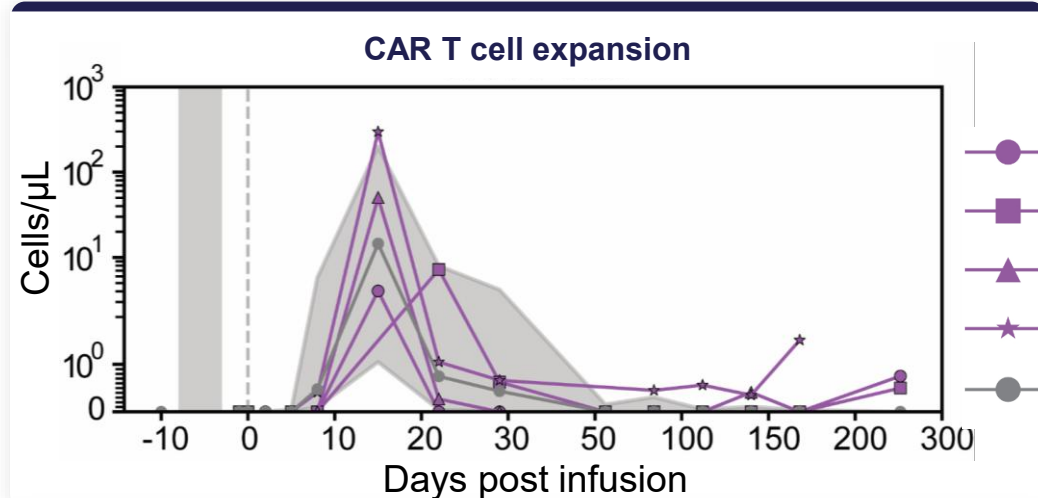
Summary of rese-cel without preconditioning (PC), lowest dose cohort¹

After discontinuing all immunomodulators (IM), unanticipated activity observed without PC at lowest dose

- In the RESET-PV trial, 4 refractory patients received rese-cel at the lowest dose without preconditioning and had follow-up between 24 and 36 weeks as of the data cut-off
 - 2 of 4 patients demonstrated compelling clinical activity through 6 months follow-up
 - Complete peripheral B cell elimination was observed in 3 of 4 patients
 - CRS was observed in 1 patient (Grade 1); ICANS – none
- Based on the safety profile observed at the lowest dose, multiple additional patients have been enrolled at a higher dose cohort in the RESET-PV trial
- In the RESET-SLE trial evaluating PC-free rese-cel in patients with lupus, 1 of 2 patients experienced deep B cell depletion as measured by flow cytometry and peak BAFF levels

Pemphigus Vulgaris: PC-free PK and PD¹

Similar CAR T expansion to PC-treated rese-cel pts with complete B cell depletion in 3 of 4 PC-free patients



- PV-1M-2, PV-1M-3 & PV-1M-4 had complete depletion of peripheral B cells at lowest rese-cel dose
- BAFF levels in these three patients were at the low end of the range observed with rese-cel with PC

LD, lymphodepletion

Note: Gray vertical dotted line indicates day of rese-cel infusion (study visit Day 1). Median and 50th percentile intervals of values from LD subjects shown in gray. The LD group consisted of 38 rese-cel treated subjects that were evaluated across the RESET program in myositis, lupus, systemic sclerosis and myasthenia gravis.

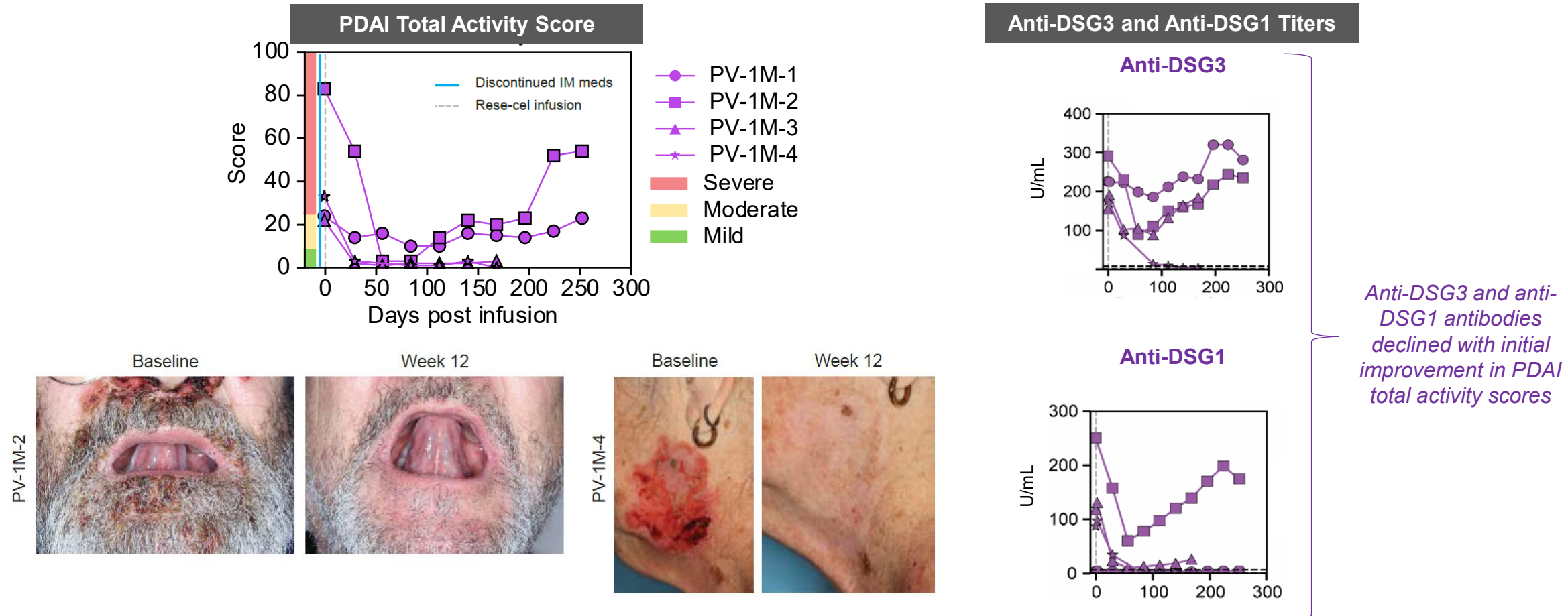
Cabaletta Bio: Data on file.

As of 2 April 2026.

1. Nunez, Daniel, et al. "CD19 CAR T Therapy Is Feasible in Patients with Pemphigus Vulgaris Treated Without Lymphodepletion in the RESET-PV Trial." *Blood Journal* (2026): blood-2025032093.

Unanticipated efficacy at lowest PC-free dose supports dose escalation

Near complete resolution of clinical symptoms off all medicines in 2 of 4 patients through 6 months follow-up¹



**PDAI improvements were the greatest in the three patients who experienced complete peripheral B cell depletion;
Next higher dose cohort enrolling based on efficacy, translational data and favorable safety profile to date**

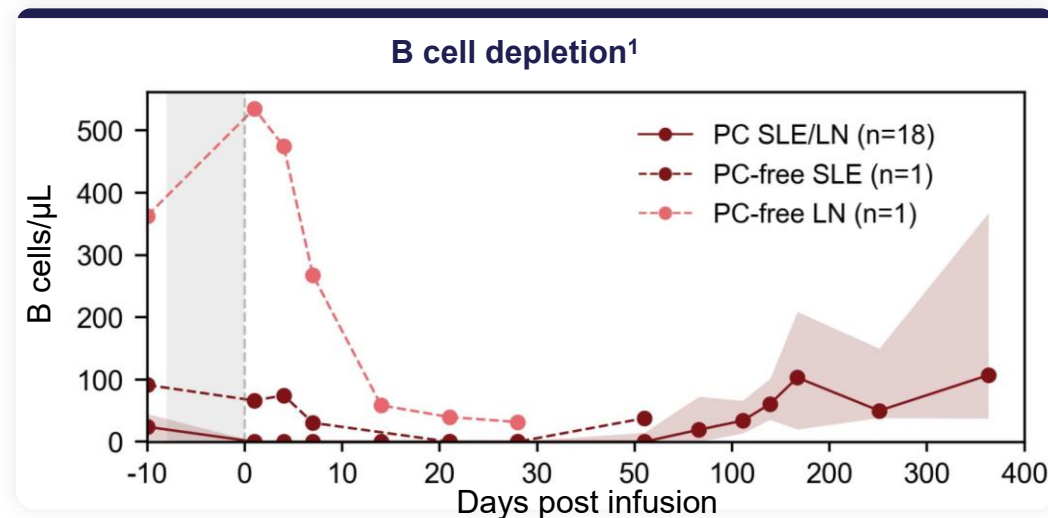
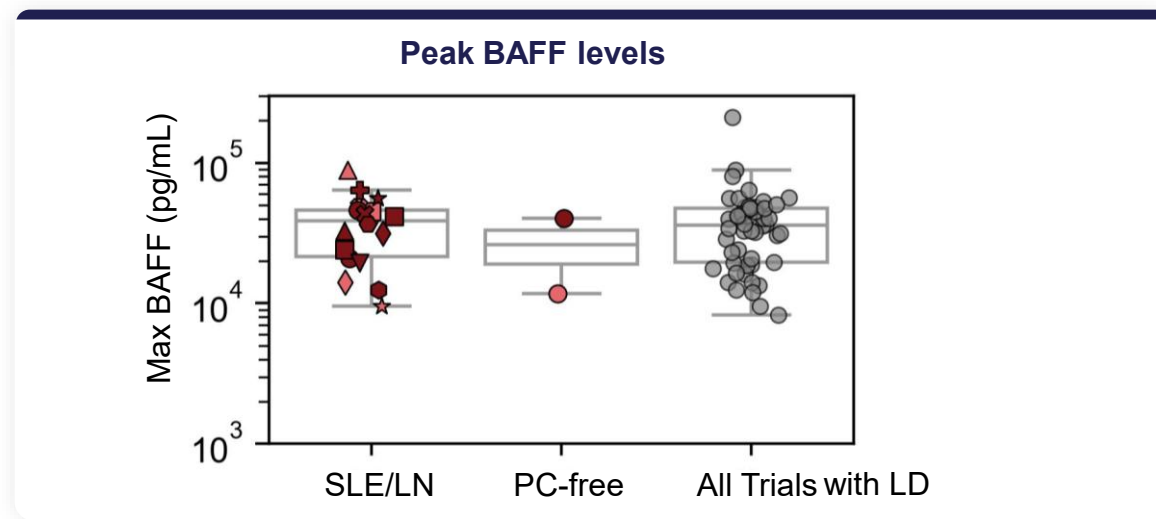
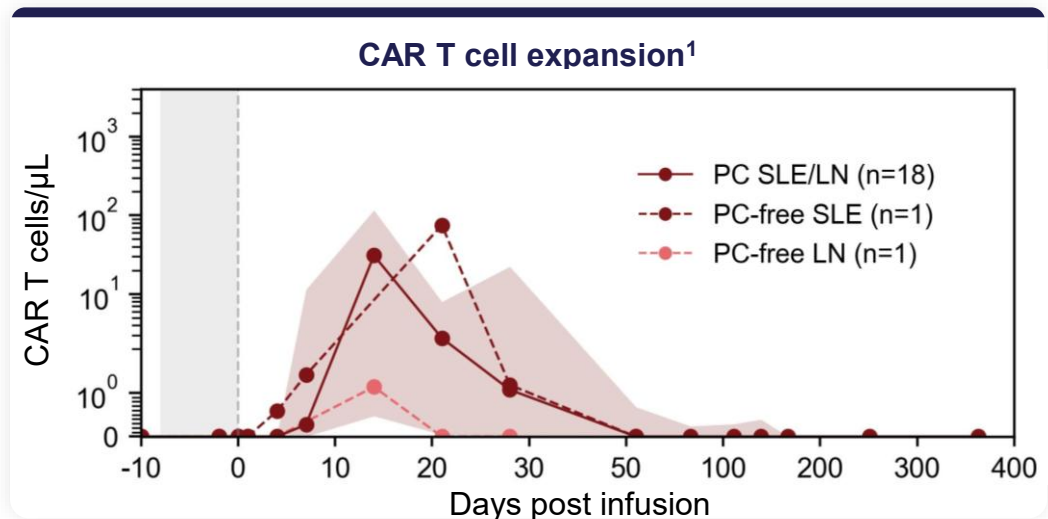
*As of 2 April 2026. Cabaletta Bio: Data on file. Disease severity intervals as defined Krain RL, et al. Br J Dermatol. 2021;184(5): 975–977.

Gray vertical dotted line indicates day of rese-cel infusion (study visit Day 1).

1. Nunez, Daniel, et al. "CD19 CAR T Therapy Is Feasible in Patients with Pemphigus Vulgaris Treated Without Lymphodepletion in the RESET-PV Trial." Blood Journal (2026): blood-2025032093.

Lupus: PC-free rese-cel PK and PD¹

Similar CAR T expansion as PC-treated patients with deep B cell depletion in 1 of 2 PC-free patients



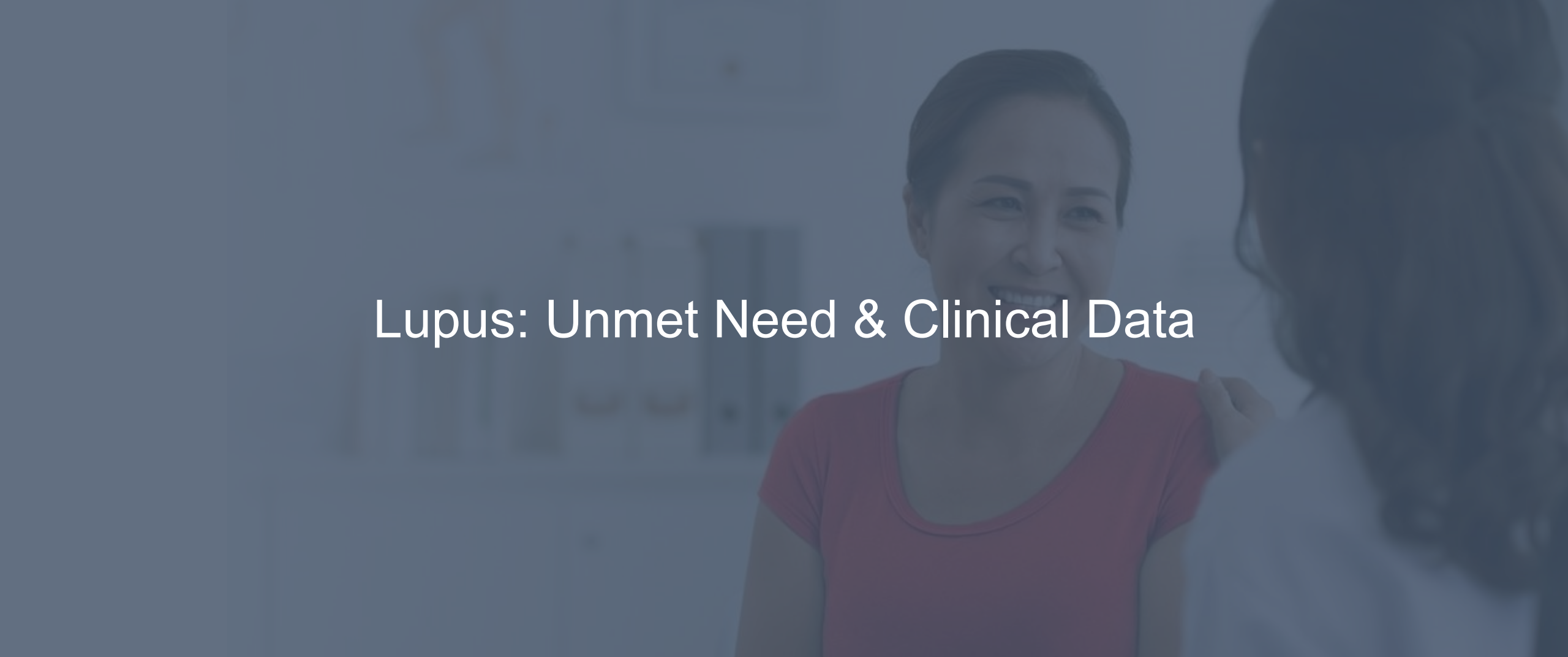
- PK profiles with the lowest dose of PC-free rese-cel were similar to rese-cel with PC
- Deep B cell depletion observed in 1 of 2 patients based on flow cytometry and peak BAFF levels
- Gr 1 CRS observed in 1 of 2 patients; no ICANS observed

LD, lymphodepletion

1. Shading indicates interquartile range, IQR. Individual dashed lines represent PC-free SLE and LN subjects. Rese-cel infusion shown as vertical gray dotted line and PC window represented as vertical gray shading.

Cabaleta Bio: Data on file.

As of 16 April 2026 for PC SLE/LN, as of 16 May 2026 for PC-free patients.

A photograph of a woman with dark hair tied back, wearing a red top, smiling warmly. Another person's hand is visible on her right shoulder, suggesting a supportive or comforting gesture. The background is slightly blurred, showing what appears to be a clinical or office setting.

Lupus: Unmet Need & Clinical Data

Cabaletta Bio[®]

SLE & LN: Represent a high unmet clinical need

Increased mortality risk & negative impact on quality of life for patients with SLE & LN

> SLE is a chronic autoimmune condition that can affect nearly every organ system¹

- Most common in women, with disease onset generally between ages of 20-40 years
- Common symptoms include severe fatigue, joint pain and swelling, skin rashes, ulcers & Raynaud's phenomenon
- >50% of patients develop permanent widespread organ damage, caused by disease & current treatments²
- Standardized mortality ratio from 2.4-4.5 for SLE patients^{3,4}

> ~30-40% of SLE patients develop LN, with inflammation & damage within the kidneys

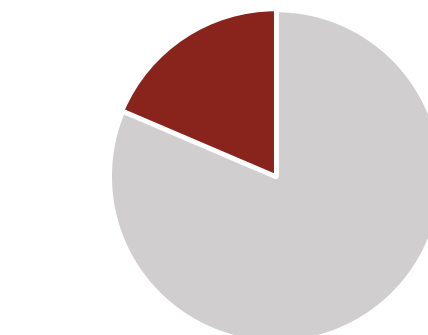
- LN may present silently or with symptoms such as proteinuria, hematuria, swelling & elevated blood pressure
- 10-30% of patients with LN will progress to ESRD, requiring dialysis or transplantation within the first decade of their disease^{5,6}

Eligible U.S. Non-Renal SLE & LN patients⁷

SLE patients with moderate to severe, refractory disease & LN patients with refractory disease potentially eligible for rese-cel

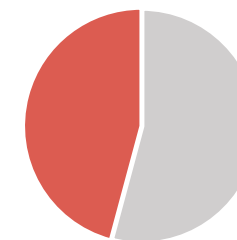
(per analysis of quantitative research with ~150 lupus-treating physicians)

~40,000
U.S. non-renal SLE patients
potentially eligible for rese-cel



~210k non-renal SLE patients

~50,000
U.S. LN patients
potentially eligible for rese-cel



~110k LN patients

Market research indicates opportunity to achieve superior penetration and potentially further expand the market through introducing a PC-free CAR T alternative for patients

ESRD, end-stage renal disease; LN, lupus nephritis; SLE, systemic lupus erythematosus.

1. Zen M, et al. Eur J Intern Med. 2023;112:45–51. 2. Rahman P, et al. Lupus. 2001;10(2):93-96. 3. Singh, R, et al. Lupus 27.10 (2018): 1577-1581.4. Murimi-Worstell, I., et al. BMJ 10.5 (2020): e031850. 5. Lichtnekert, J. Nature reviews rheumatology 20.11 (2024): 699-711. 6. Tektonidou, M. Arthritis & rheumatology 68.6 (2016): 1432-1441. 7. Results from quantitative survey of U.S. lupus-treating physicians (rheumatologists & nephrologists), conducted 2Q25. N = ~150.

Baseline characteristics: First 18 patients in RESET-SLE

All patients had active, refractory disease and had failed multiple B cell-targeted therapies

Cohort	Non-renal SLE (N=12)	LN (N=6)
Age, years, median (min, max)	31 (21, 44)	26 (18, 35)
Female, n (%)	11 (92)	5 (83)
Disease duration,* years, median (min, max)	12 (5, 17)	6 (2, 16)
Autoantibodies (%) dsDNA Sm	75 67	67 83
Baseline disease activity†	SLEDAI-2K (mean)	
	12.75	16
	UPCR (mg/mg) (mean)	
	1.7§	3.1
Therapies at screening (%): Systemic GCs ≤2 SLE immunomodulators‡ ≥3 SLE immunomodulators‡	92 50 50	50 33 67
GC dose at screening, mg/day, mean (min, max)	13.25 (0, 30)	5.83 (0, 20)

As of 16 Apr 2026.

*Time from diagnosis to screening.

†Baseline disease activity = activity before preconditioning.

‡SLE medications may include biologics, antimalarials, and immunosuppressants.

§Four patients in the non-renal SLE cohort had renal involvement that did not meet criteria for the LN cohort.

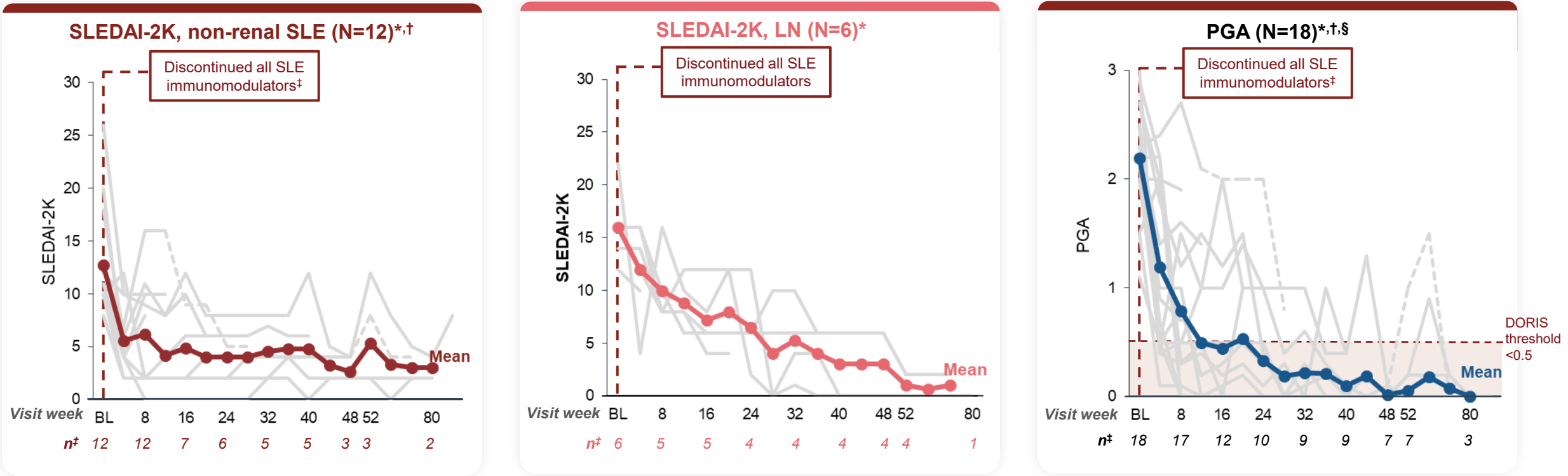
dsDNA, double-stranded DNA; GC, glucocorticoid; LN, lupus nephritis; RESET, REstoring SElf-Tolerance; SLE, systemic lupus erythematosus; SLEDAI-2K, SLE Disease Activity Index 2000; Sm, Smith;

UPCR, urine protein-to-creatinine ratio.

Cabaletta Bio: Data on File.

Efficacy data in SLE following rese-cel infusion

Improvements in SLEDAI-2K and PGA over time after discontinuing immunomodulators



These data suggest the potential for rese-cel to reset the immune system and achieve meaningful clinical responses off immunomodulators with no or low-dose GCs in non-renal SLE and LN

As of 16 Apr 2026.

*Missing data were imputed using last observation carried forward.

†Dashed single patient trend lines represent patients receiving rescue immunomodulatory medications.

‡Mean/median and n numbers are based on SLE/LN patients not receiving prohibited rescue immunomodulators.

§PGA measured on a 0–3 scale.

CAR, chimeric antigen receptor; DORIS, definition of remission in SLE; GC, glucocorticoid; LN, lupus nephritis; PD, pharmacodynamic; PGA, Physician Global Assessment; PK, pharmacokinetic; rese-cel, resecabtagene autoleucel; SLE, systemic lupus erythematosus; SLEDAI-2K, Systemic Lupus Erythematosus Disease Activity Index 2000.

Cabaletta Bio: Data on File.

A photograph of a woman with dark hair, wearing a red top, smiling warmly. Another person's hand is visible on her right shoulder, suggesting a supportive or comforting gesture. The background is slightly blurred, showing what appears to be a clinical or office setting.

Myasthenia Gravis: Unmet Need & Clinical Data

Caballetta Bio[®]

Myasthenia gravis: Significant disease & treatment burden

High impact of disease due to patient symptoms & cost burden, particularly for refractory patients

> Serious, chronic autoimmune neuromuscular disorder¹

- Characterized by defective transmission at the neuromuscular junction, resulting in weakness of the skeletal muscles
- Typically associated with autoantibodies (e.g. AChR, MuSK, LRP4)
- Symptoms range from ocular involvement, including double vision and ptosis, to severe weakness of the limb, bulbar, trunk, and respiratory muscles, which is worsened with exertion

> Treatments have transient effect & involve long-term broad immunosuppression¹

- Available therapeutic options focus on specific symptoms and can be associated with serious long-term side effects
- Mainstays include steroids, immunosuppressants (e.g., mycophenolate), FcRn antagonists, complement inhibitors and rituximab
- MG represents a significant healthcare cost burden in the US, particularly for patients whose disease is inadequately controlled

Eligible U.S. MG patients²

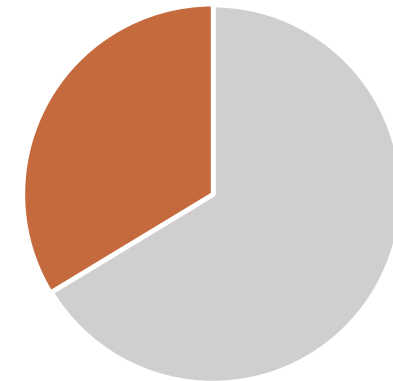
**Generalized MG patients with refractory disease
potentially eligible for rese-cel**

(per quantitative research with ~100 MG-treating physicians)

~35,000

U.S. MG patients

potentially eligible for rese-cel



~100k MG patients

Baseline Characteristics: 14 RESET-MG Patients

All patients had active, refractory disease despite multiple immunomodulatory agents

	AChR Positive (n=8)	AChR Negative (n=6)
Age , years, mean (min, max)	54.6 (41, 65)	53.3 (37, 70)
Female , n (%)	3 (37.5%)	6 (100.0%)
Time from diagnosis to screening , years, mean (min, max)	7.2 (1.4, 19.1)	6.8 (0.6, 16.2)
Autoantibodies (%)	AChR: 100%	Seronegative: 50% MuSK: 33.3% LRP4: 16.7%
Baseline disease activity*	MG-ADL mean (min, max)	
	11.5 (7, 15)	12.8 (8, 17)
	QMG mean (min, max)	
	14.1 (10, 20)	16.8 (10, 22)
Prior MG therapies (excluding GCs) , mean (min, max)	5 (0, 8)	3.7 (1, 6)
Therapies at screening:		
Systemic GCs	63%	50%
≤2 MG therapies†	75%	83%
≥3 MG therapies†	25%	17%
GC dose at screening ,‡ mg/day, mean (min, max)	10.6 (0, 25)	10.8 (0, 30)

As of 4 September 2026.

*Baseline disease activity = activity before preconditioning.

†MG therapies include acetylcholinesterase inhibitors, neonatal Fc receptor inhibitors, biologics, intravenous immunoglobulins, and immunosuppressants.

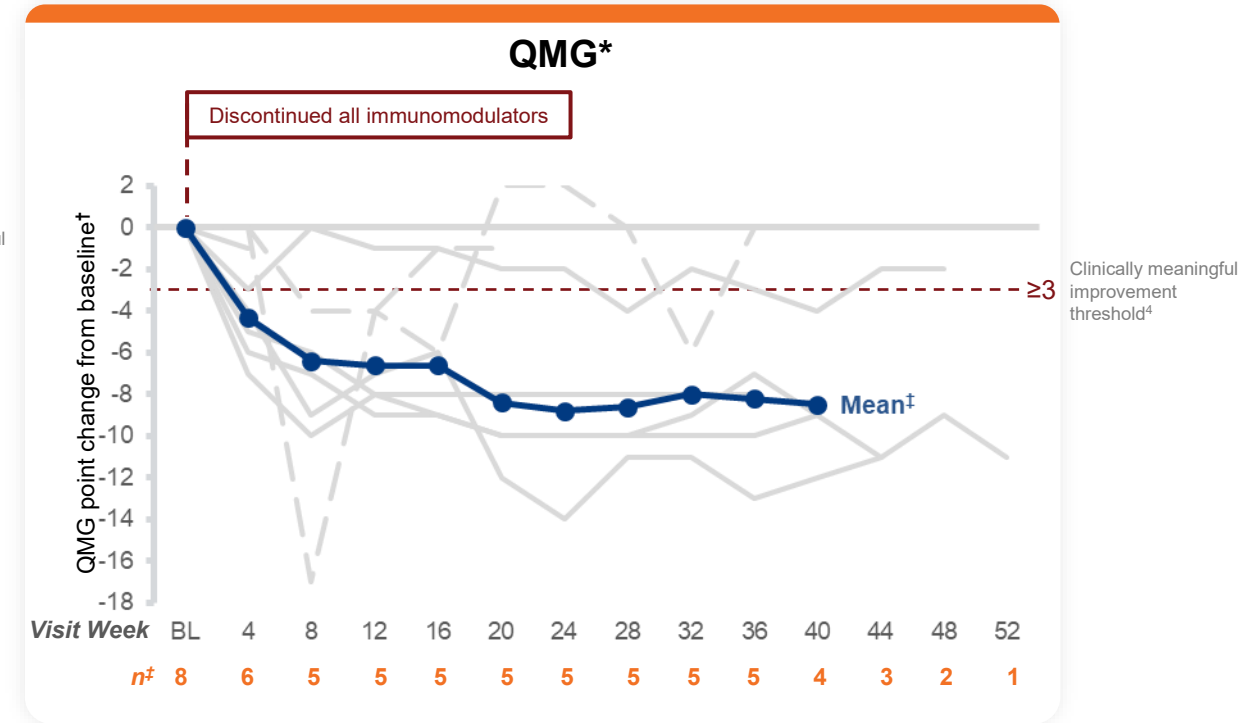
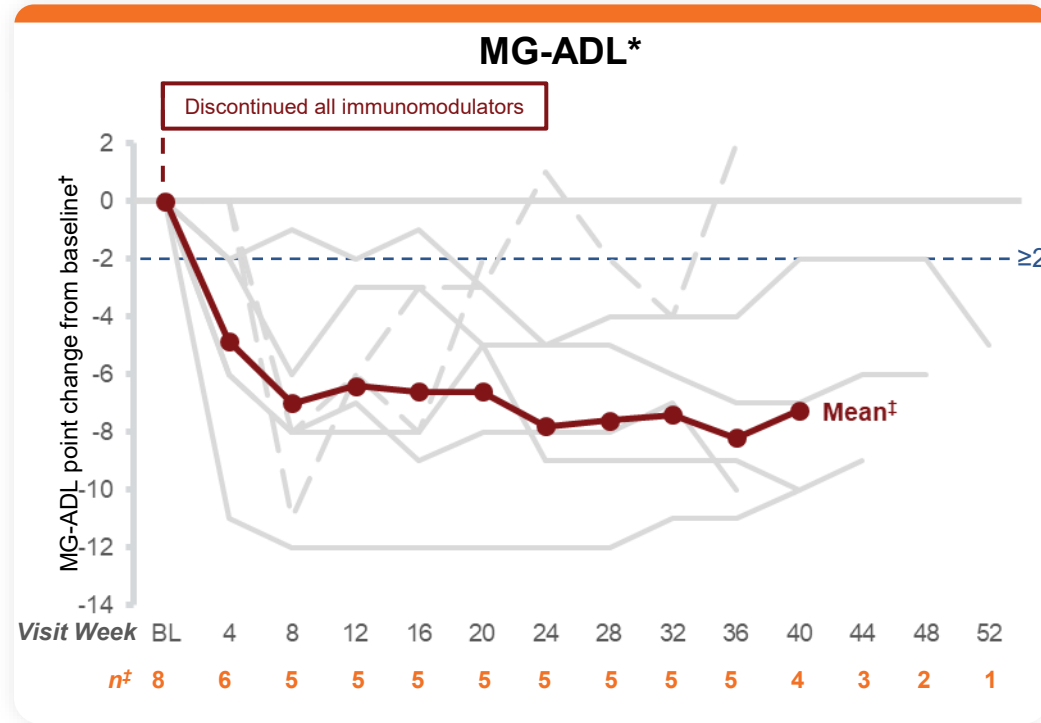
‡GC dose = glucocorticoid dose expressed in equivalent dose of prednisone (mg/day).

AChR, acetylcholine receptor; GC, glucocorticoid; LRP4, low-density lipoprotein receptor-related protein 4; MG, myasthenia gravis; MG-ADL, MG – Activities of Daily Living; MuSK, muscle-specific tyrosine kinase; QMG, Quantitative Myasthenia Gravis Score; RESET, REStoring SElf-Tolerance; rese-cel, resecabtagene autoleucel.

Cabaletta Bio – Data on File.

Efficacy Data in AChR-Positive Patients Following Rese-cel Infusion¹

6 of 8 AChR-positive patients showed clinically meaningful improvements on the MG-ADL scale while 2 patients required rescue medications, as of latest follow-up



In patients who did not receive rescue immunomodulators for MG and had sufficient follow-up, at 24 weeks (n=5) mean overall change from baseline in MG-ADL was -7.8 and for QMG -8.8

As of 4 September 2026.

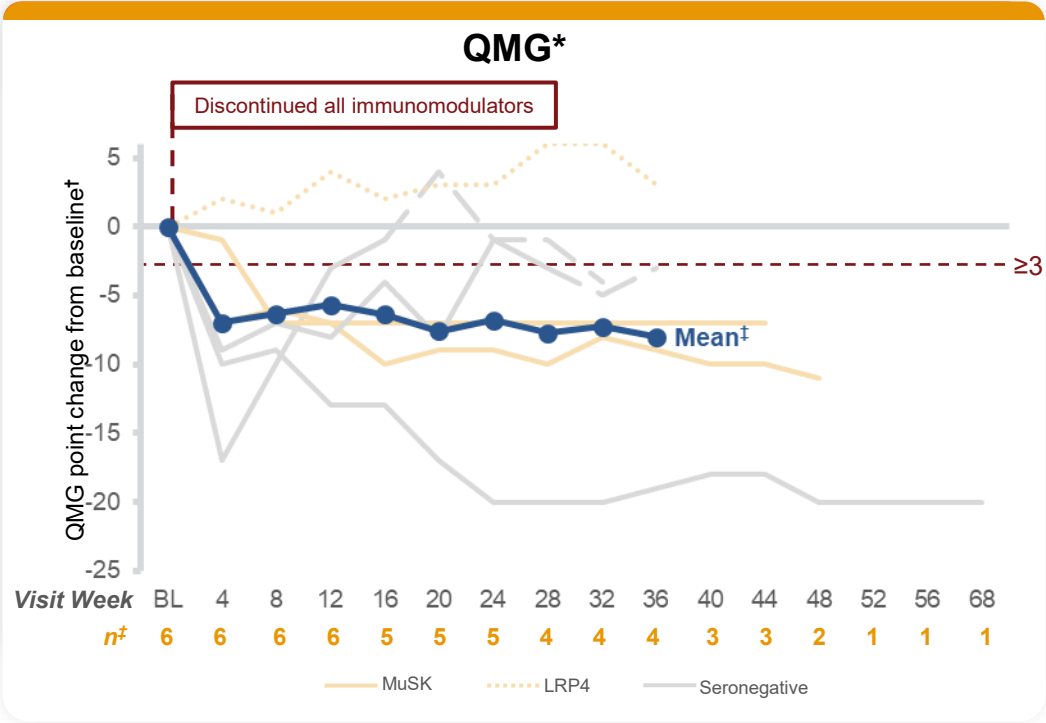
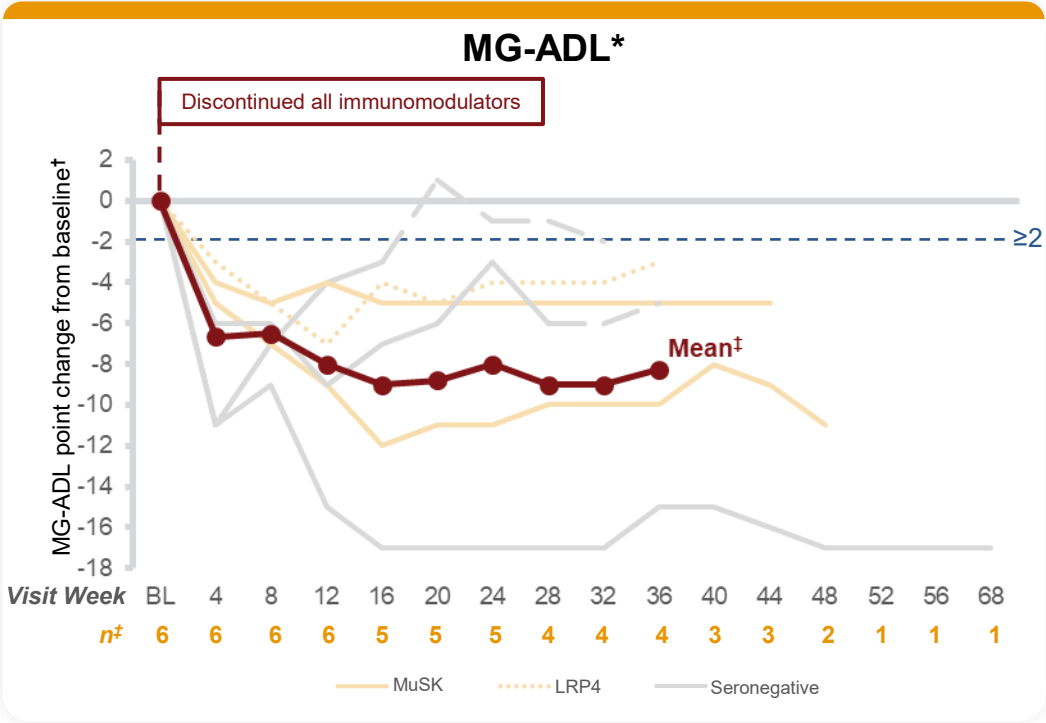
*Missing data were imputed using last observation carried forward. Dashed single patient trend lines represent patients receiving rescue immunomodulatory medications for MG. †Baseline disease activity = activity before preconditioning. ‡Mean and n numbers are based on dosed patients not receiving rescue medication for MG.

AChR, acetylcholine receptor; MG, myasthenia gravis; MG-ADL, MG – Activities of Daily Living; QMG, Quantitative Myasthenia Gravis Score; rese-cel, resecabtagene autoleucel.

1. Cabaletta Bio – Data on File. 2. Muppidi S, et al. Muscle Nerve. 2022;65(6):630–639. 3. EMA. Soliris EPAR. Available at: www.ema.europa.eu/en/documents/overview/soliris-epar-medicine-overview_en.pdf (accessed September 2026). 4. Barnett C, et al. Neurol Clin. 2018;36(2):339–353.

Efficacy Data in AChR-Negative Patients Following Rese-cel Infusion¹

4 of 6 AChR-negative patients showed clinically meaningful improvements on the MG-ADL scale while 2 patients received rescue medications, as of latest follow-up



In patients who did not receive rescue immunomodulators for MG, at 24 weeks (n=5) mean overall change from baseline in MG-ADL was -8.0 and for QMG -6.8

As of 4 September 2026.
*Missing data were imputed using last observation carried forward. Dashed single patient trend line represent patients receiving rescue immunomodulatory medications for MG. One patient was followed for safety only from Week 36 onwards and died at approx. 52 weeks post infusion (unrelated AE). †Baseline disease activity = activity before preconditioning. ‡Mean and n numbers are based on dosed patients not receiving rescue medication for MG.
AChR, acetylcholine receptor; AE, adverse event; LRP4, low-density lipoprotein receptor-related protein 4; MG, myasthenia gravis; MG-ADL, MG – Activities of Daily Living; MuSK, muscle-specific tyrosine kinase; QMG, Quantitative Myasthenia Gravis Score; rese-cel, resacetabtagene autoleucel;
1. Cabaletta Bio – Data on File. 2. Muppidi S, et al. Muscle Nerve. 2022;65(6):630–639. 3. EMA. Soliris EPAR. Available at: www.ema.europa.eu/en/documents/overview/soliris-epar-medicine-overview_en.pdf (accessed September 2026). 4. Barnett C, et al. Neurol Clin. 2018;36(2):339–353.



Corporate Summary

Cabaletta Bio[®]

Cabaleta Bio leadership

Track record of operational success evaluating & developing novel cell therapy candidates in autoimmunity

LEADERSHIP TEAM



Steven Nichtberger, M.D.
President, CEO & Chairman



Samik Basu, M.D.
Chief Scientific Officer



Gwendolyn Binder, Ph.D.
President, Science & Technology



David J. Chang, M.D., M.P.H., FACR
Chief Medical Officer



Arun Das, M.D.
Chief Business Officer



Steve Gavel
Chief Commercial Officer



Michael Gerard
General Counsel



Heather Harte-Hall
Chief Compliance Officer



Anup Marda
Chief Financial Officer



Nicolette Sherman
Chief HR Officer



Sarah Yuan
Chief Technology Officer



SCIENTIFIC ADVISORY BOARD

Aimee Payne, M.D., Ph.D.
Co-Founder and Co-Chair

Carl June, M.D.

Iain McInnes, Ph.D., FRCP, FRSE, FMedSci

Francisco Ramírez-Valle, M.D., Ph.D.

Michael C. Milone, M.D., Ph.D.
Co-Founder and Co-Chair

Georg Schett, M.D.

Jay Siegel, M.D.

Immune reset with a single infusion and a favorable safety profile

Beyond myositis and scleroderma, advancing innovation with PC-free rese-cel & industrialized automated mfg

Elimination of PC

- Expands the market
- Simplifies outpatient use
- Reduces resource utilization
- Improves patient and provider experience



Automated Manufacturing

- Minimizes capital investment
- Scalable to efficiently produce thousands of patient runs per year
- Substantially-reduced COGS
- Facilitates global expansion



Transformative Value Proposition

- Differentiated product profile
- Typical 'biologic' margins
- Potential to address larger autoimmune indications including UC, T1D and RA

PC-free rese-cel can expand access while automated manufacturing can reduce COGS & increase scale

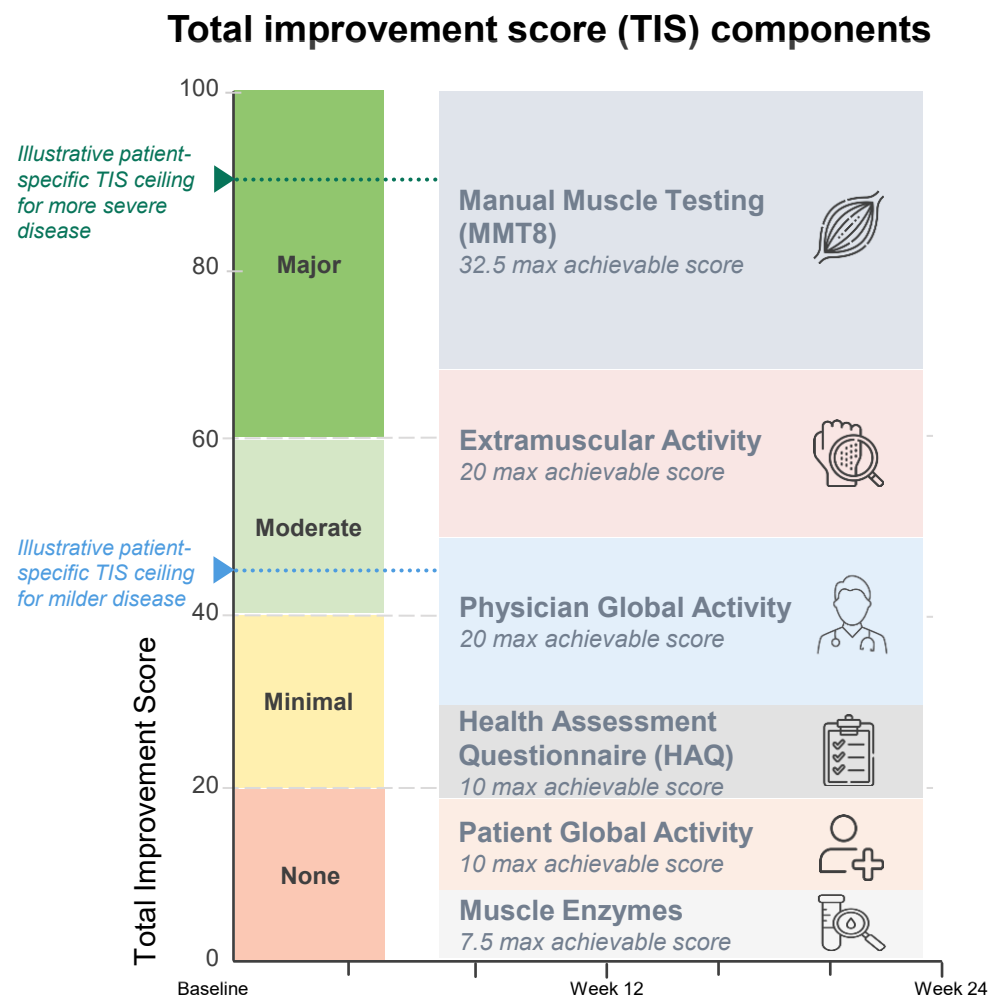


Appendix

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Myositis outcomes captured through validated composite endpoint

TIS is a composite tool measuring a patient's relative improvement from their baseline



- TIS developed via conjoint analysis based continuous model using **absolute percentage change** in 6 core set measures (CSM): MMT8, Extramuscular Activity, Physician Global Activity, Health Assessment Questionnaire, Patient Global Activity, and Muscle Enzymes
- TIS is the sum of improvement scores in the 6 CSMs, with **ceiling of potential effect likely higher in DM and ASyS than in IMNM given minimal extramuscular involvement**

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A microscopic view of several cells, likely cancer cells, with prominent red nuclei. The cells are shown in various stages of focus, with one cell in the foreground being sharp and others in the background being blurred.

Corporate Presentation

SEPTEMBER 2026