
cullinan
THERAPEUTICS
SCIENCE THAT moves™
CORPORATE OVERVIEW
November 2026

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Leading T Cell Engager Portfolio of Potential Best-In-Class Clinical Stage Programs Across Immunology and Oncology

T cell engagers engineered against high-impact, validated targets, with best-in-class, disease-modifying potential

IMMUNOLOGY

CLN-978
CD19xCD3 TCE

Ph 1/2

Velinotamig
BCMAxCD3 TCE

Ph 1/2

Unmet Need in Immunology and Inflammation

- Patients endure a lifelong, chronic treatment burden with most patients failing to attain remission and accumulating infection risk and organ damage

WHY TCEs in I&I

- **Deep B cell / plasma cell depletion**
- **Off-the-shelf, subcutaneous therapy with dosing flexibility**
- **Potential for treatment-free remissions and immune reset**

ONCOLOGY

CLN-049
FLT3xCD3 TCE

Ph 2

FDA Orphan Drug Designation and Fast Track Designation in relapsed/refractory Acute Myeloid Leukemia

Unmet Need in Acute Myeloid Leukemia

- Patients need a broadly applicable therapy that can produce high rates of durable response – 5-year survival rate is less than 10% in the relapsed setting.

WHY TCEs in AML

- **Demonstrated ability to revolutionize standard of care in B cell malignancies and multiple myeloma**
- **Represent a broad immunotherapeutic approach to an increasingly fragmented treatment landscape**

Demonstrated promising efficacy data in broad AML population at ASH 2025

Cash and investments of **$314 million** on hand at **September 30, 2026*** to advance these **priority programs**, expected to fund operations into **2029**

*Unaudited. Includes cash, cash equivalents, investments, and interest receivable.

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Leveraging Novel Technologies and Differentiated Mechanisms Across Immunology and Oncology

Immunology

Program Modality/MOA	Study Population	IND-Enabling	Phase 1	Phase 2	Phase 3	Status/ Next Milestone	Geographic Rights
CLN-978 CD19xCD3 T cell engager	Systemic lupus erythematosus (SLE)					Multi-dose and updated single target dose regimen data in **December**	cullinan THERAPEUTICS worldwide rights
	Rheumatoid arthritis					Multi-dose and updated single target dose regimen data in **December**	
	Sjögren's disease					Initial single target dose and multi-dose regimen data in **December**	
Velinotamig (GR-1803) BCMAxCD3 T cell engager	Autoimmune cytopenias					Phase 1/2 study in **ITP and wAIHA** underway	cullinan THERAPEUTICS worldwide rights outside of Greater China*
	SLE*					Multi-dose regimen data presented at **ACR 2026**	

Oncology

Program Modality/MOA	Study Population	IND-Enabling	Phase 1	Phase 2	Phase 3	Status/ Next Milestone	Geographic Rights
Zipalertinib (CLN-081/TAS6417) EGFR ex20ins inhibitor	NSCLC with EGFR exon 20 insertion mutations (ex20ins)		REZILIENT1 NSCLC with ex20ins 2L+ line			**U.S. FDA accepted NDA** for treatment of relapsed EGFR ex20ins NSCLC: **PDUFA** target action date of **February 27, 2027**	cullinan THERAPEUTICS holds US co-development/ commercialization rights with TAIHO ONCOLOGY
	NSCLC with EGFR ex20ins and uncommon non-ex20ins EGFR mutations		REZILIENT3 NSCLC with ex20ins frontline			**Primary endpoint of PFS met**; **NDA** submission **completed** under RTOR program	
			REZILIENT2 Parallel Cohort Study			Parallel cohort study ongoing	
CLN-049 FLT3xCD3 T cell engager	R/R AML, MDS					Potentially registrational Phase 2 study ongoing; Phase 1 dose escalation update at **ASH 2026**	cullinan THERAPEUTICS worldwide rights
	1L AML					Phase 1/2 study underway	
	AML and MRD					Phase 1 study ongoing in patients with AML and MRD	

*China, including the Hong Kong Special Administrative Region, Macao Special Administrative Region, and Taiwan. Genrix Bio is enrolling a Phase 1 study in China in patients with autoimmune diseases, initially in patients with SLE, followed by future expansion into other indications.

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T CELL ENGAGERS IN AUTOIMMUNE DISEASES

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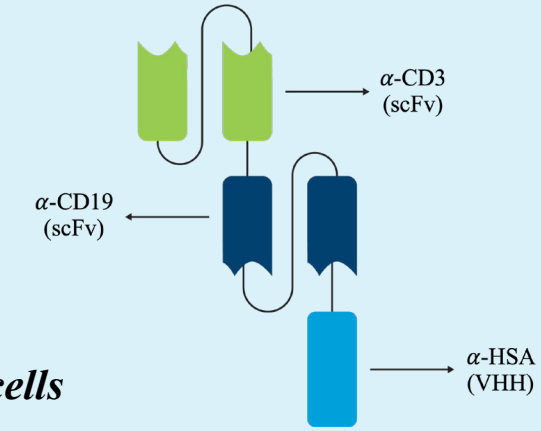
Complementary Immunology Portfolio Designed to Expand Reach To Broadest Range of Autoimmune Diseases

CLN-978

CD19 is the optimal target for B cell driven rheumatic diseases

- Potential best-in-class CD19 TCE in autoimmunity
- High CD19 affinity enables broad B cell lineage depletion
- Deep tissue penetration enabled by compact format

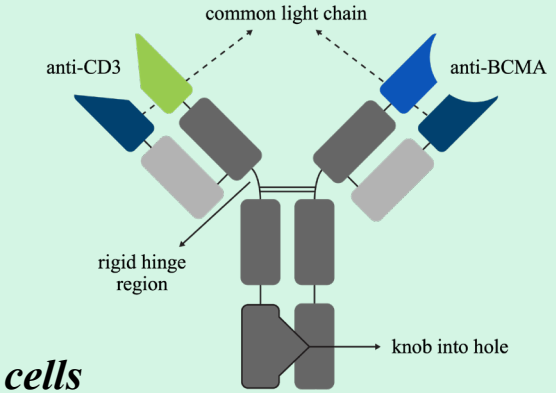


Spares long-lived plasma cells

Velinotamig

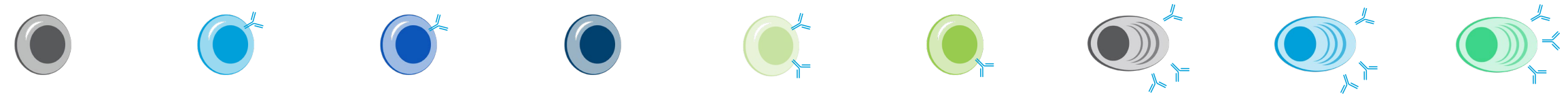
BCMA is the optimal target for diseases driven by pathogenic autoantibodies

- Potential best-in-class BCMA TCE in autoimmunity
- High BCMA / lower CD3 affinity and rigid hinge region drive efficient elimination of BCMA+ plasma cells



Depletes long-lived plasma cells

Portfolio addresses full spectrum of disease-driving B cells to access more autoimmune indications than either CD19 or BCMA alone



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CLN-978: Going Deep Into Large, High Unmet Need Rheumatology Indications

CLN-978 Opportunity

Rheumatologic Diseases

Systemic Lupus Erythematosus	Rheumatoid Arthritis
Sjögren's Disease	Lupus Nephritis *CLN-978 next step*
Systemic Sclerosis	ANCA-AV
Dermatomyositis	Anti-synthetase Syndrome

- CLN-978 (CD19 TCE) – Rheum primary focus
- Potential expansion indications
- Ongoing Cullinan studies

Validated markets with significant remaining unmet need

>$3B
2025 global SLE sales[1]

- Currently approved biologics have modest efficacy and relatively limited uptake
- Unmet need: Disease modifying treatments

>$29B
Est. 2025 global RA sales[2]

- Large, high value market
- Unmet need: Effective therapies for treatment of refractory patients

>$5B
Est. 2026 TAM for systemic therapy in Sjögren's Disease US market[3]

- Large patient pool
- Underdeveloped market with limited competition and no approved treatments outside of China
- Unmet need: Efficacious treatments that address disease drivers

1. AstraZeneca 2025 Annual Report; GlaxoSmithKline 2025 Annual Report 2. GlobalData, Rheumatoid Arthritis: 68-Market Analysis and Sales Forecast (June 2023) – 2025 sales in 8MM 3. TD Cowen Insight, "Shining A Light On Sjogren's: A New Autoimmune Opportunity" (May 18, 2026)

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Velinotamig: Broad Opportunity to Address Diverse Plasma Cell Driven Diseases

Velinotamig Opportunity

Nonmalignant Hematology

- Warm Autoimmune Hemolytic Anemia
- Immune Thrombocytopenia

Nephrology

- IgA nephropathy
- Membranous nephropathy
- IgG4-RD

Neurology

- Myasthenia gravis
- NMOSD

Endocrinology

- Thyroid eye disease
- Graves' disease

Transplant

- Organ Transplant Rejection

Velinotamig (BCMA TCE) — Heme initial focus

Ongoing Cullinan studies

Potential expansion indications

High unmet need indications representing significant opportunities

- Hematology is sizeable market opportunity
- Current therapies require chronic treatment with lack of durable remissions
- Unmet need: Disease modifying treatments inducing durable treatment free remission

~$3.7B
2025 global sales[1,2]

IgA Nephropathy

>$4B
Estimated global peak sales potential[3]

Myasthenia Gravis

~$6.5B
Estimated global peak sales potential[4]

Thyroid Eye Disease

~$1.9B
2025 global sales[1]

~$4B
Total estimated cost of re-transplantation in 2025 US kidney recipients, with antibody-mediated rejection, a leading driver of graft failure[5]

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1. Amgen 2025 Annual Report 2. Goldman Sachs Research, Novartis (January 21, 2026) 3. Consensus analyst future peak revenue estimates for Voyxact and felzartamab 4. Consensus analyst future peak revenue estimates for Vyvgart 5. Internal Company estimate

CLN-978

CD19xCD3 T cell engager

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CLN-978: Bringing the Promise of Immune Reset to the Broad Population of Patients with Autoimmune Diseases

IMMUNE RESET POTENTIAL

Deep B cell depletion consistent with breakthrough CAR T observations

- Near-complete clearance of pathogenic B cells in blood, tissue and lymph nodes
- Dose-dependent depletion and recovery
- Disruption of follicular architecture, previously achieved only with CAR T

BROAD CLINICAL IMPACT

Clinical activity and remissions across complex heterogeneous diseases

- Remissions observed in both SLE and RA, including heavily-pretreated, poly-refractory patients
- ≥71% of SLE patients achieved meaningful disease improvement
- Swift reduction in autoantibodies and other biomarkers aligns with disease modifying effect

OUTPATIENT ADMINISTRATION

Delivered as a medicine in the community, where patients live and work

- Subcutaneous, fixed-dose therapy without manufacturing complexity
- Favorable safety: primarily low-grade CRS, no ICANS
- Enables treatment beyond specialized centers into community settings

Shifting the paradigm from chronic disease management to immune reset and remission

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CLN-978 SLE and RA Dose Escalation Design

SLE Study Population

1. SLE meeting 2019 EULAR/ACR criteria
2. One or more of the following SLE autoantibodies:
   - anti-nuclear antibody
   - anti-dsDNA
   - anti-Smith
3. hSLEDAI ≥6 at screening
4. Inadequate response to oral corticosteroids, antimalarials and at least one standard immunosuppressant or biologic agent used for the treatment of SLE

RA Study Population

1. RA meeting 2010 EULAR/ACR criteria
2. Seropositive or B cell infiltrate in synovial biopsy
3. Inadequate response to at least two DMARDs (tsDMARD and/or biologic) after csDMARD treatment
4. DAS28-ESR ≥ 3.2, at least one swollen joint

Single Ascending Dose Cohorts

Multi-dose Cohorts

Patients discontinued chronic immunosuppressants at least 2 weeks prior to starting CLN-978

Cohort 4
Day 1: 10 micrograms
Day 8: 45 micrograms

Cohort 3
Day 1: 10 micrograms
Day 8: 30 micrograms

Cohort 2
Day 1: 10 micrograms
Day 8: 20 micrograms

Cohort 1
Day 1: 10 micrograms

Target dose levels deemed safe in the SAD portion can be explored in the MAD portion

Part B (SLE)
Day 1: 10 micrograms
Day 8, 15, 22: 20 or 30 micrograms

Cohort 5 (RA)
Day 1: 10 micrograms
Day 8, 15, 22: 20 or 30 micrograms

All patients received premedication with corticosteroid, H1 and H2 blockade and paracetamol.

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Enrolled SLE and RA Patients Have Highly Refractory Disease

	SLE (n = 21)	RA (n=11)
Sex, n (%)		
Male	0	1 (9.1)
Female	21 (100)	10 (90.9)
Median age (range), years	43 (22, 61)	59 (45, 72)
Ethnicity, n (%)		
Hispanic or Latino	4 (19.0)	0
Race, n (%)		
American Indian or Alaska Native	1 (4.8)	0
Asian	1 (4.8)	0
Black or African American	4 (19)	0
White	12 (57.1)	10 (90.9)
Other/Not reported	3 (14.3)	1 (9.1)
Prior treatment		
Number of prior immunosuppressants/biologics median (range)	3 (2-6)	6 (1-12)
Prior treatment with immunosuppressants, n (%)	18 (85.7)	11 (100)
Prior treatment with biologics, (non-B cell-directed) n (%)	3 (14.3)	11 (100)
Prior treatment with rituximab n (%)	1 (4.8)	3 (27.2)
Prior treatment with belimumab n (%)	5 (23.8)	0

SLE safety includes patients treated at the following target dose levels who have cleared the dose-limiting toxicity (DLT) period: 10µg (n=3), 20µg (n=7), 30µg (n=7), 45µg (n=1), 10µg+20/20/20µg (n=3)
*RA safety includes patients treated at the following dose levels, who have cleared the DLT period:*10µg (n=1), 20µg (n=3), 30µg (n=3), 10µg+20/20/20µg (n=4)

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CLN-978 Generally Well Tolerated Across Single Target Doses and Multiple Target Doses in SLE and RA

OUTRACE STUDIES

N = 32	Any grade n (%)	Grade ≥ 3 n (%)
Number of Subjects with at least 1 TEAE	28 (87.5)	5 (15.6)
Number of Subjects with Serious TEAE [a]	5 (15.6)	2 (6.3)
Any grade TEAEs occurring in ≥ 3 patients:		
Cytokine release syndrome (CRS)	13 (40.6)	1 (3.1)
Headache	8 (25)	0
Fatigue	7 (21.9)	0
Injection site reaction	5 (15.6)	0
Tachycardia	5 (15.6)	0
Diarrhea	4 (12.5)	0
Hypokalemia	4 (12.5)	0
Alanine aminotransferase increased	3 (9.4)	0
Anaemia	3 (9.4)	0
Body temperature increased [b]	3 (9.4)	0
Nasopharyngitis	3 (9.4)	0
Urinary tract infection	3 (9.4)	1 (3.1)

TEAE=treatment-emergent adverse event

[a]Serious TEAEs included CRS (1 patient Grade 1, 1 patient Grade 2, 1 patient Grade 3), 1 patient arthritis flare, and 1 patient with UTI at Week 5 (related) SAEs during the Follow-up Period that were considered unrelated (hyperglycemia at Week 17, UTI and seizure at Week ~23). [b]Elevated temperature < 38°C.

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Primarily Grade 1 CRS Across Single and Multi-Dose Cohorts in Both SLE and RA Patients

CRS, n	Cohort 1 (n = 4) D1: 10µg	Cohort 2 (n = 10) D1: 10µg D8: 20µg	Cohort 3 (n = 10) D1: 10µg D8: 30µg	Cohort 4 (n = 1) D1: 10µg D8: 45µg	Cohort 5 RA Part B SLE (n = 7) D1: 10µg D8/15/22: 20µg
Grade 1	0	5	2	0	4
Grade 2	0	0	1	0	0
Grade 3	0	0	0	1	0
Grade 4	0	0	0	0	0

- Most CRS events occurred after the initial dose of 10µg
- In seven patients treated with the 20µg multi-dose regimen, only Grade 1 CRS events were observed
- A single case of Grade 3 CRS was observed following administration of the 45µg target dose; enrollment was discontinued for this cohort, and additional step-up dosing may be implemented in subsequent cohorts.
- No immune effector cell–associated neurotoxicity syndrome (ICANS) was observed.

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SLE: Disease-Modifying Efficacy in Patients Observed with Single Target Doses of CLN-978

OUTRACE SLE STUDY

Among 14 patients with ≥4 weeks follow up, a ≥4-point reduction in hSLEDAI was observed in 10 patients (71%), with 5 achieving a DORIS remission

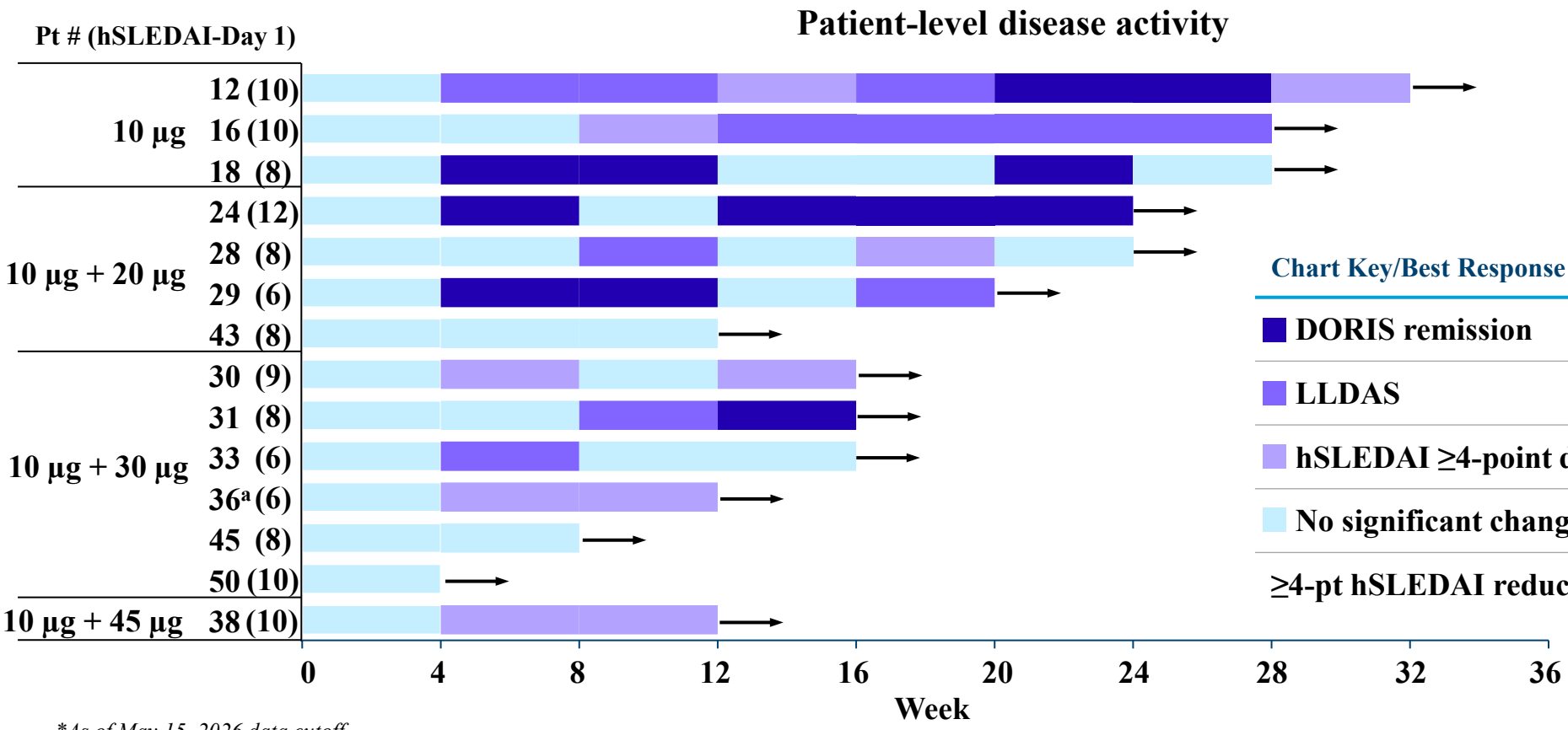

Chart Key/Best Response	Patients (N = 14)
DORIS remission	5
LLDAS	3
hSLEDAI ≥4-point decrease vs baseline[a]	2
No significant change[a]	4
≥4-pt hSLEDAI reduction (responders)	10 (71%)

**As of May 15, 2026 data cutoff*

[a]Only 1 patient (#36) had increase in SLE background therapy; prednisone increased at Week 3 and MMF initiated at Week 8 for ongoing pleuritic pain.

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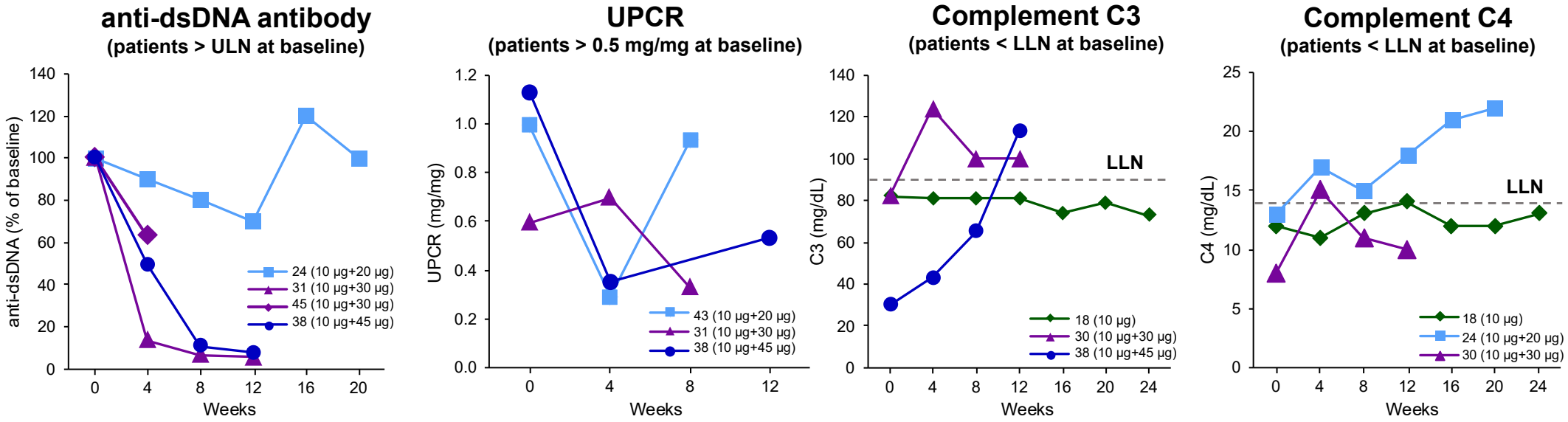
DORIS: Definition of Remission in SLE; LLDAS: Lupus Low Disease Activity State; hSLEDAI: hybrid Systemic Lupus Erythematosus Disease Activity Index

SLE: Significant Biomarker Impact Aligns with Clinical Response and Underlying Disease Modification

OUTRACE SLE STUDY

Anti-dsDNA, UPCR, Complement protein levels all improved after single target doses of CLN-978



**As of May 15, 2026 data cutoff*

Anti-dsDNA antibody titers, UPCR, C3, and C4 in patients on-treatment with CLN-978 shown as % from Baseline (anti-dsDNA abs) or concentration (mg/mL (dL)) for several patients treated in Cohorts 1-4.
Anti-dsDNA decreased to below ULN in patients 31 and 38, starting from 17 X ULN and 11 X ULN, respectively.
LLN=lower limit of normal; ULN=upper limit of normal.

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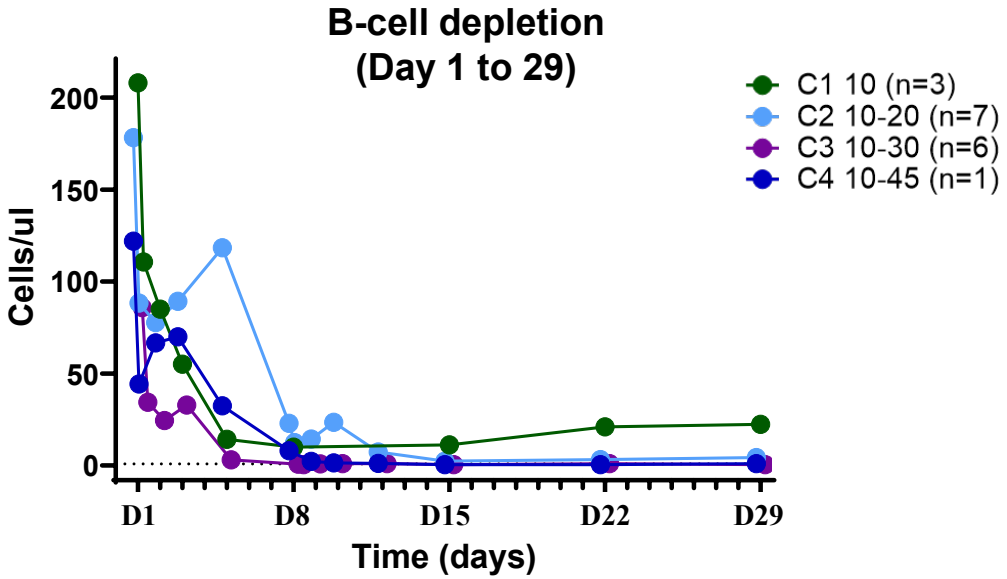
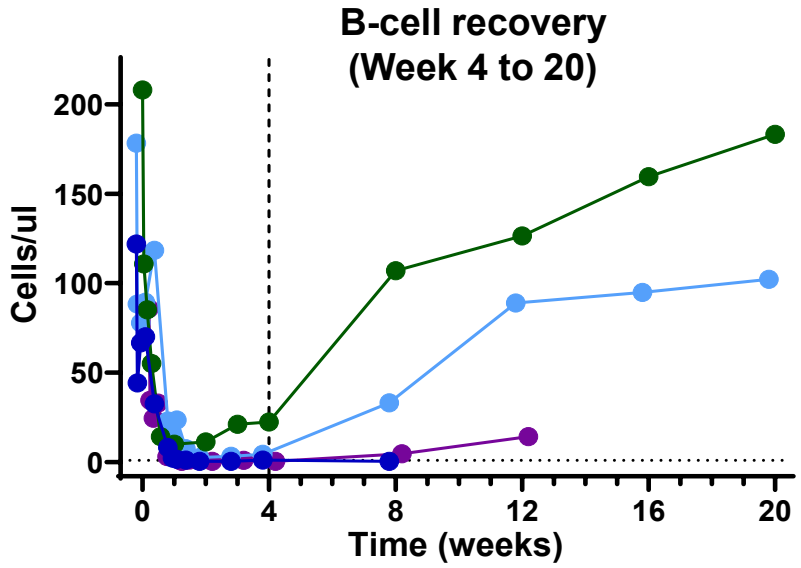
SLE: Complete B Cell Depletion at Go-Forward Doses, with Dose-Dependent Time to Recovery

OUTRACE SLE STUDY





Peripheral B cell counts were reduced by >80% in 14/17 SLE patients (82%) treated in single target dose cohorts (Cohorts 1-4) with dose-dependent recovery observed

- 7 of 14 patients (50%) treated at target doses ≥20µg (Cohorts 2, 3 and 4) achieved peripheral B cell depletion below the limit of quantification (BLOQ)

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OUTRACE-SLE: Advancing Toward Registration-enabling Studies

Monotherapy Efficacy Facilitates More Efficient Development

COMPLETED

Part A: Phase 1 Single Ascending Dose

Complete Multi-Dose Cohorts

Objective
Identify candidate dosing regimens for further study

Select candidate schedules for Phase 2

Anticipated additional data in Dec. 2026

Phase 2a Dose Selection

Objective
Select dosing regimen for registration-enabling studies

Patients with SLE

R

- **Schedule A** n = 20
- **Schedule B** n = 20

Patients with Lupus Nephritis

Higher of Dose/Schedule A or B n = 20

Global study ongoing in United States, Europe, and Australia

Clinicaltrials.gov identifier: NCT06613360
*Pending protocol amendment

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OUTRACE-SLE: Accelerating the Path Toward Future Registration Across SLE Patient Populations

Phase 2 Lupus Nephritis

- **High unmet need** despite recent introduction of less potent B cell depleting therapies
- Efficacy in Phase 2a could support **special regulatory designations (e.g. BTD)** and inform pathway toward **potential accelerated approval**

Phase 3 General SLE
CLN-978 vs SOC

- **Supports full approval** in the broader SLE population
- Based on **clear monotherapy efficacy**, placebo control arm not required

Current global study may inform an accelerated path to registration-enabling studies

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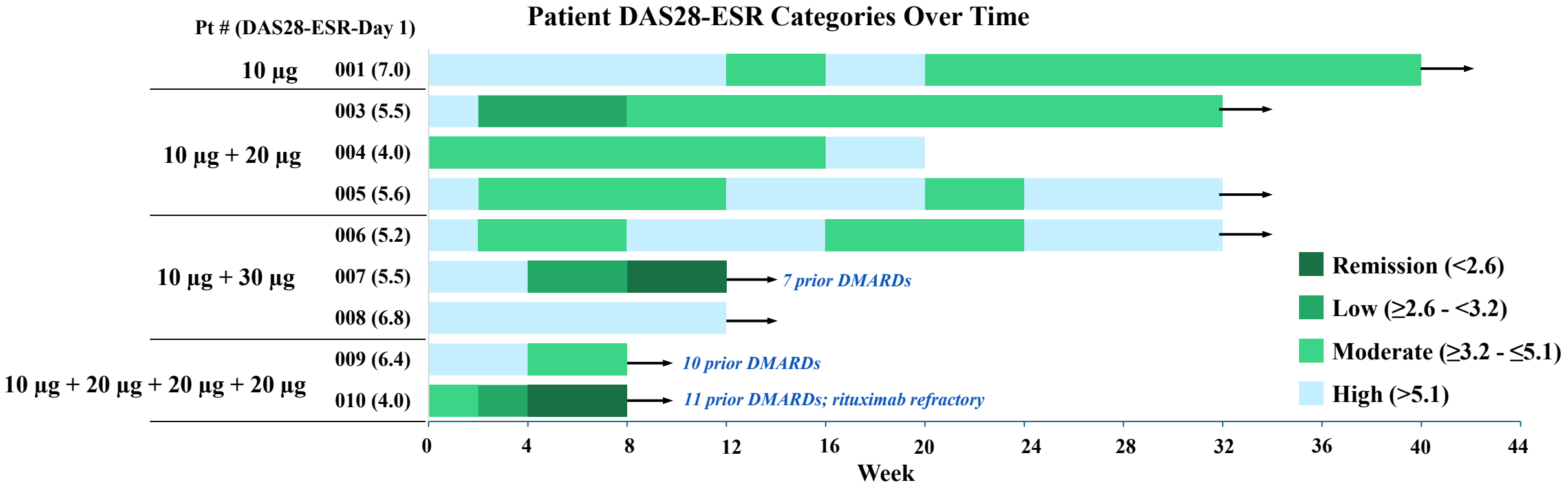
RA: Robust Disease Impact Observed in Heavily Pretreated Patients, Including Two Remissions

OUTRACE RA STUDY



- In this heavily pretreated population, 7 of 9 patients had high baseline disease activity
- 7 of 9 patients experienced improved disease activity, including DAS28-ESR remission in one patient treated with 30µg target dose (Cohort 3) and one rituximab-refractory patient in the multi-dose cohort
- The 30µg target dose was also associated with greater improvements in ultrasound-assessed synovitis

Single target dose data as of May 15, 2026 data cutoff. Multi-dose regimen data as of May 20, 2026 data cutoff.

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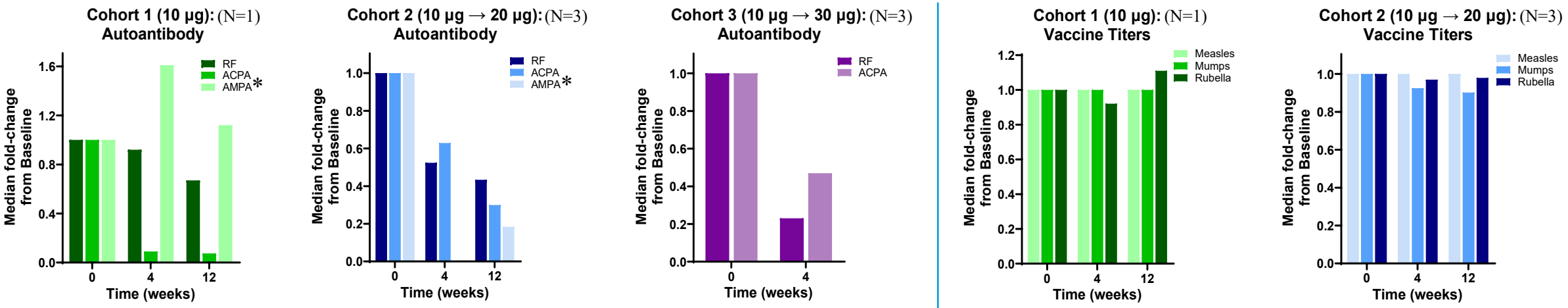
RA: CLN-978 Rapidly Reduced Autoantibody Levels without Impacting Protective Vaccine Titers

OUTRACE RA STUDY

Reduction in autoantibody levels >50% of baseline were observed in most patients treated with 20 µg or 30 µg target doses (Cohorts 2 and 3)



**As of May 15, 2026 data cutoff*

Graphs depict median fold change from baseline for RF, ACPA and AMPA autoantibodies and measles, mumps, rubella vaccine titers.

*AMPA was measured in two patients on study.

ACPA, anti-citrullinated protein antibodies; AMPA, anti-modified peptide antibodies; RA, rheumatoid arthritis; RF, rheumatoid factor.

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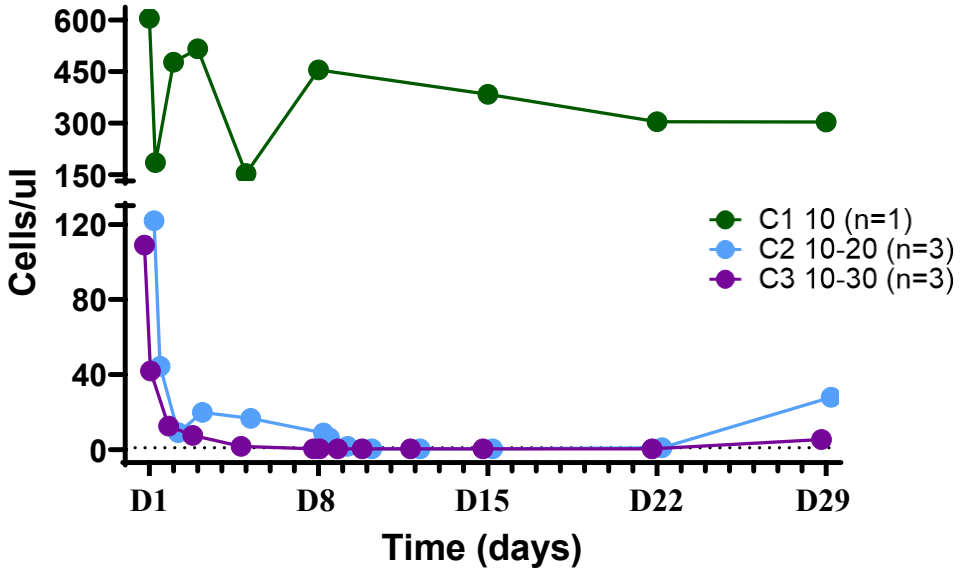
RA: Complete B Cell Depletion at Go-Forward Doses, with Dose-Dependent Time to Recovery, Consistent with SLE Observations

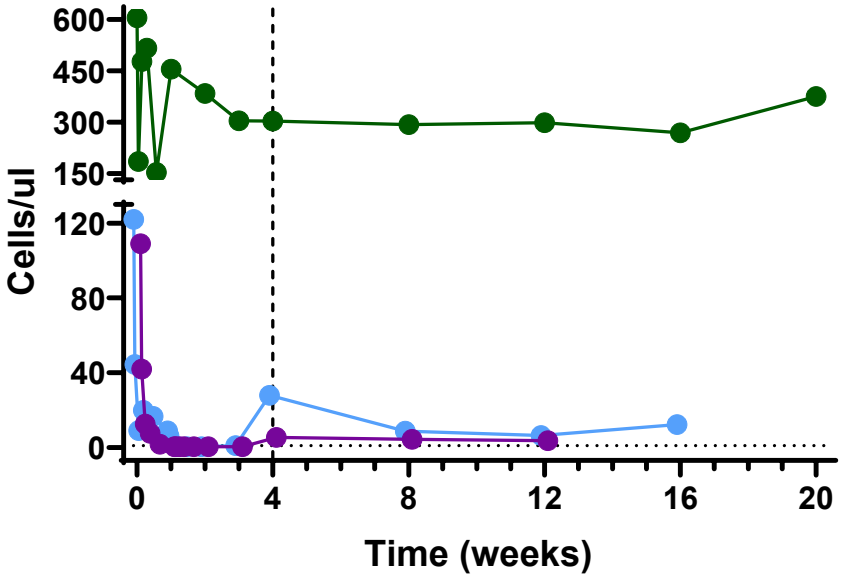
OUTRACE RA STUDY

Peripheral B cell depletion BLOQ was achieved in 4/6 RA patients treated at target doses ≥20µg (Cohorts 2 and 3)

B-cell depletion (Day 1 to 29)



B-cell kinetics follow-up (Week 4 to 20)



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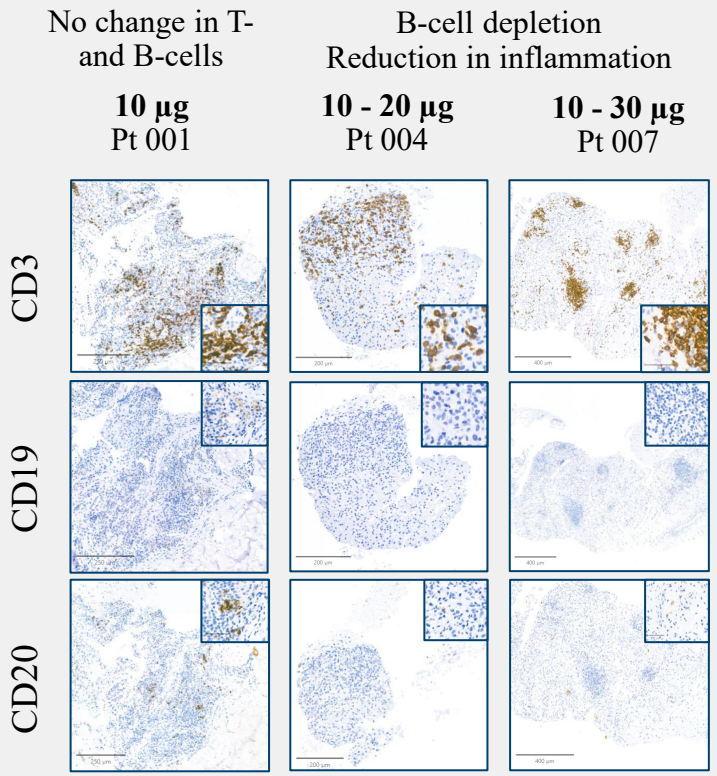
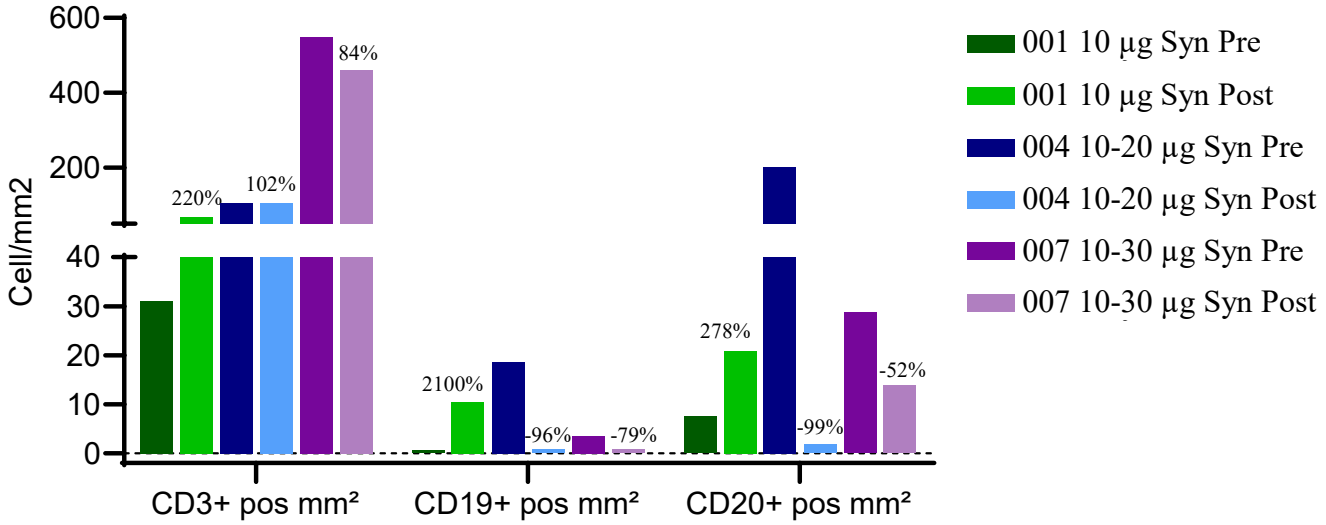
RA: ≥20 µg Target Doses Result in Profound B Cell Depletion in Synovium

OUTRACE RA STUDY

Post-treatment synovial biopsy (Day 29)



Change in immune cell density in the pre-treatment (screening) vs post-treatment synovial biopsy (Day 29)



Number above bars shows % change from baseline (cells/mm2 post (Day 29) / cells/mm2 pre-treatment)

As of May 15, 2026 data cutoff, representative case from each dose level

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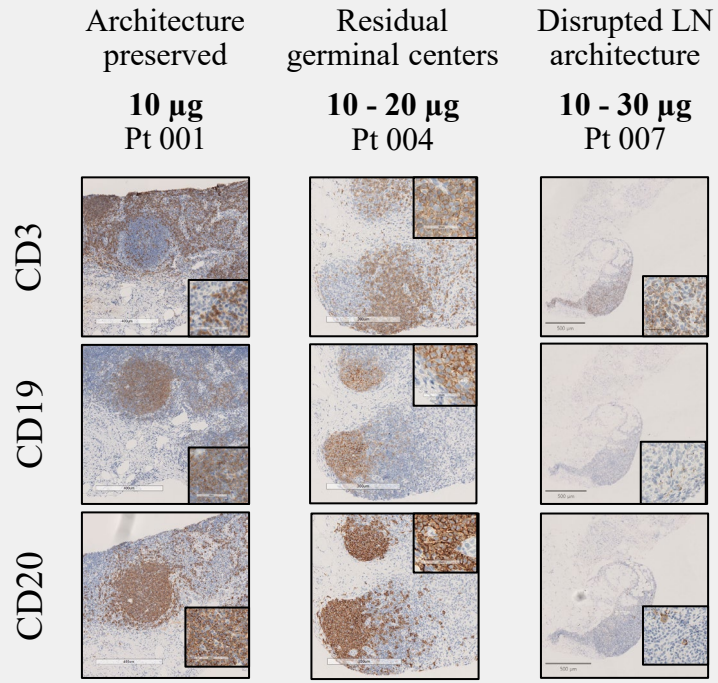
RA: 30 µg Target Dose Substantially Depleted B Cells in Lymph Node Tissue

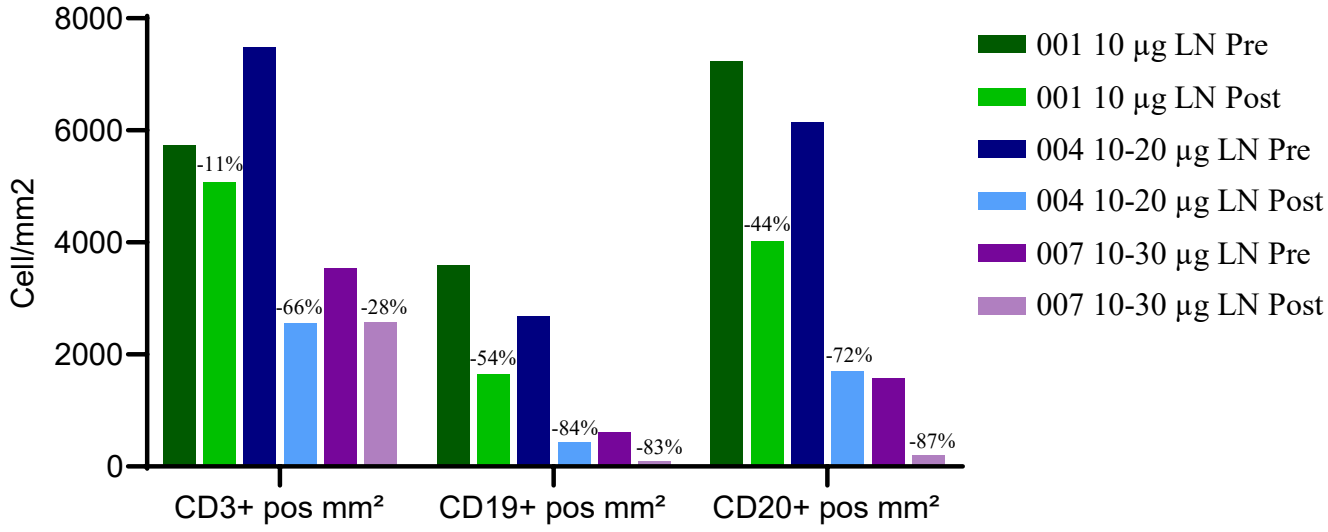
OUTRACE RA STUDY

Lymph node B cell depletion in Patient 007 accompanied by clinical remission

Post-treatment lymph node biopsy (Day 29)



Change in immune cell density in the pre-treatment (screening) vs post-treatment lymph node biopsy (Day 29)



Number above bars shows % change from baseline (# cells/mm² post (Day 29) / # cells/mm² pre-treatment)

**As of May 15, 2026 data cutoff, representative case from each dose level*

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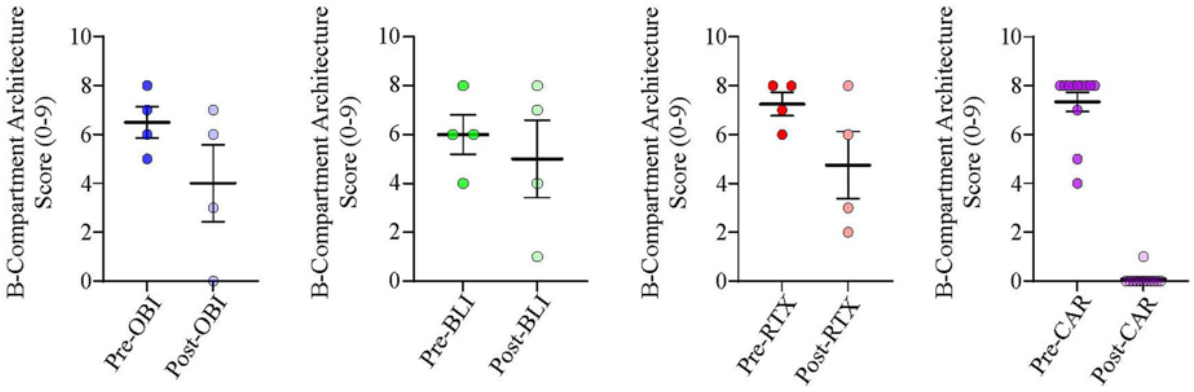
RA: CLN-978 is the First TCE to Demonstrate Complete Disruption of Follicular Architecture, Associated with Immune Reset

OUTRACE RA STUDY

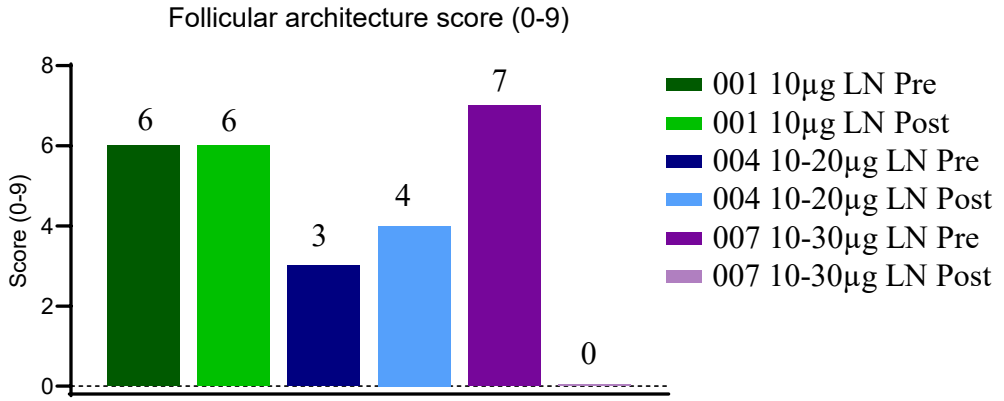
Erlangen Precedent

- Until now, CAR T only modality capable of completely disrupting follicular architecture[1]



CLN-978

- 30 ug dose achieved full disruption of follicular architecture, induced clinical remission in Patient 007



Follicular architecture score: a semiquantitative score integrating general distribution and presence of B cells, architecture of the FDC network (CD21), proliferation rate of germinal center B cells (Ki67), and presence of TFH cells (PD1).

Score = 0, complete disruption – associated with treatment-free remission

**As of May 15, 2026 data cutoff*

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[1] *Tur C, Eckstein M, Bucci L .Effects of different B-cell-depleting strategies on the lymphatic tissue Annals of the Rheumatic Diseases, 2025; 84, 2065-2074*

OUTRACE-RA: Advancing Toward Registration-enabling Studies

Monotherapy Efficacy Facilitates More Efficient Development

COMPLETED

Part A: Phase 1 Single Ascending Dose

Complete Multi-Dose Cohorts

Objective

Identify candidate dosing regimens for further study

Select candidate schedules for Phase 2

Anticipated additional data in Dec. 2026

Phase 2a Dose Selection

Objective

Select dosing regimen for registration-enabling studies

Patients with RA

R

Schedule A
n = 20

Schedule B
n = 20

Future

Phase 3
CLN-978 vs SOC

Study ongoing in Europe

Clinicaltrials.gov identifier: NCT06613360
*Pending protocol amendment

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OUTRACE-SjD Study Design

OUTRACE SJÖGREN'S STUDY

Study Population

1. Sjögren's disease meeting 2016 EULAR/ACR criteria with a disease duration ≥ 24 weeks
2. Moderate to severe disease (ESSDAI ≥ 5) at screening
3. Inadequate or loss of response to at least two SOC immunosuppressive or biologic therapies

Part A: Single Ascending Dose Study

Cohort 3 *(n=3)*
- Day 1: 10 micrograms
- Day 8: 30 micrograms

Cohort 2 *(n=3)*
- Day 1: 10 micrograms
- Day 8: 20 micrograms

Cohort 1 *(n=3)*
- Day 1: 10 micrograms

Multi-Dose Cohorts

Objective
Identify candidate dosing regimens for further study

Select candidate schedules for Phase 2

Objectives

Primary Objective:

Safety and tolerability of CLN-978 for treatment of patients with active Sjögren's disease

Secondary Objectives:

- PK
- B cell kinetics in peripheral blood and salivary biopsies
- Immunogenicity
- Clinical activity

Global Phase 1 study ongoing in the U.S. and Europe; Initial multi-dose and single target dose regimen data in Dec. 2026

Clinicaltrials.gov identifier: NCT07041099

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VELINOTAMIG

BCMAxCD3 T cell engager

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Velinotamig Unlocks Broad Opportunities in Plasma-cell Derived Autoantibody-driven Disorders

Velinotamig: BCMAxCD3 T Cell Engager
Strategic Rationale and Development Status

Genrix Bio autoimmune development in ongoing China Phase 1/2 study unlocks further opportunity:

- Initial data from Genrix study in China suggests velinotamig is a **potent autoantibody depleter**
- Provides **robust PK/PD data** to inform global sponsored development across indications

Cullinan's leadership position in TCE development for autoimmune diseases enables rapid execution outside China in multiple indications

- Initial clinical development plan leverages internal subject matter expertise and clinical trial network

Collective development strategy and global trial network positions the program for accelerated worldwide expansion[1]

[1]Cullinan worldwide rights to velinotamig exclude China, including the Hong Kong Special Administrative Region, Macao Special Administrative Region, and Taiwan. Genrix Bio is enrolling a Phase 1/2 study in China in patients with autoimmune diseases, initially in patients with SLE, followed by future expansion into other

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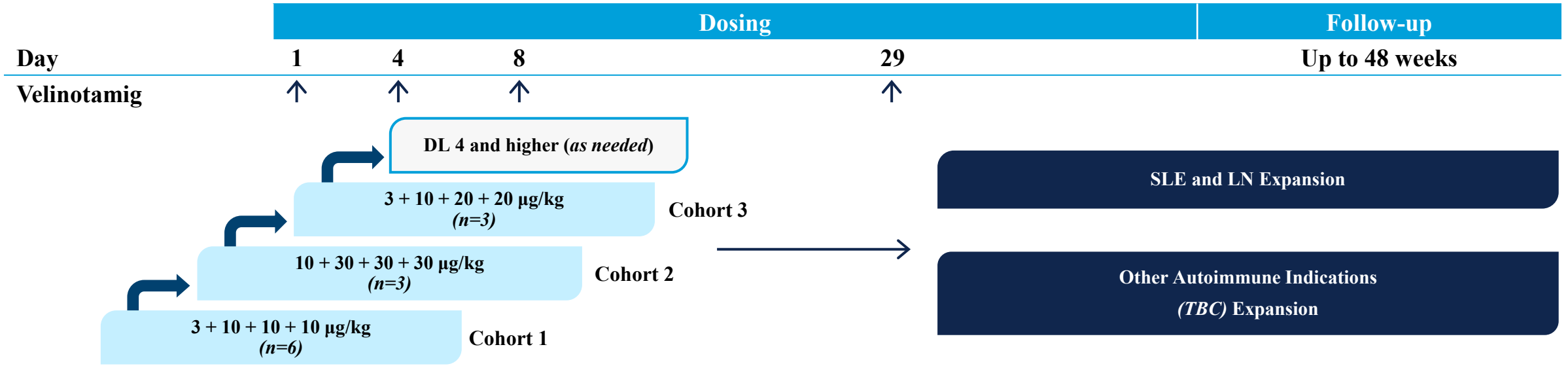
Genrix Bio Phase 1/2 Study Explores Short Duration BCMA-Therapy With Velinotamig in Patients With Refractory SLE in Data Presented at ACR 2026

STUDY DESIGN



SLE patient population:

- SLE meeting 2019 ACR/EULAR criteria
- SLE duration ≥6 months
- Baseline SLEDAI-2K ≥6
- Inadequate response to ≥3 months of standard-of-care treatment

Key assessments:

- Safety: CRS and ICANS (ASTCT), AEs (CTCAE v5.0), DLTs
- Efficacy and Pharmacodynamics (PD): SLEDAI-2K, proteinuria (24h), eGFR, anti-dsDNA, C3/C4, B-cell depletion

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Patients Exhibited Substantial Baseline Disease Activity and High Prevalence of Renal Involvement

Baseline parameter	Cohort 1 (N=6)	Cohort 2 (N=3)	Cohort 3 (N=3)
Age, years (mean ± SD)	34.3 ± 11.9	28.7 ± 2.3	27.3 ± 4.0
Female sex, n (%)	6 (100)	3 (100)	3 (100)
SLEDAI-2K score (mean ± SD)	11.3 ± 4.5	10.0 ± 3.5	15.3 ± 6.4
Prior CD19 CAR-T failure, n (%)	1 (16.7)	0	0
24-hour Urine Protein > 500mg/24 h, n (%)	5 (83.3)	2 (66.7)	3 (100)

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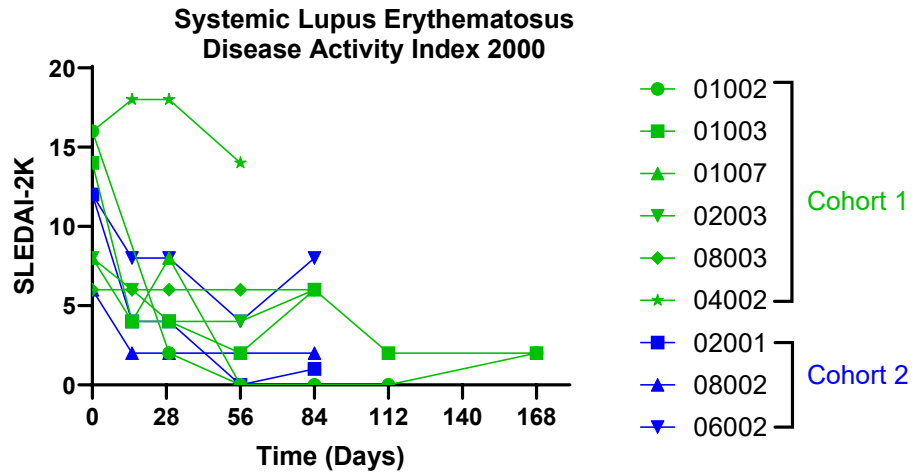
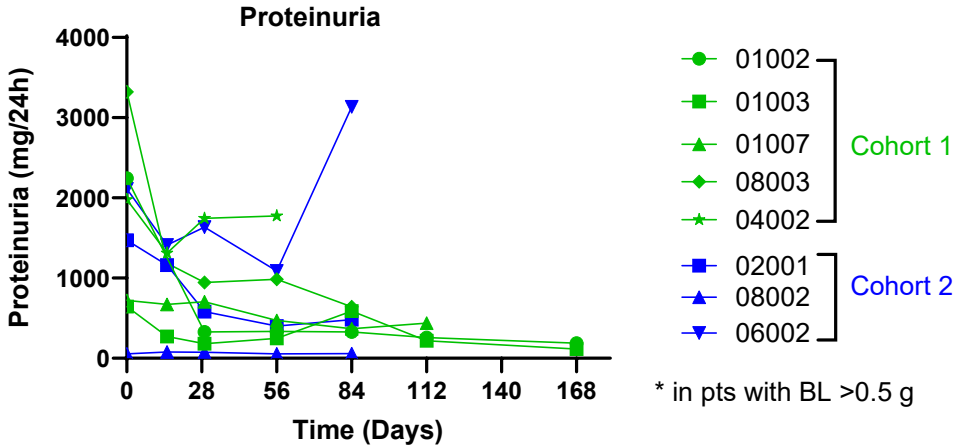
Velinotamig Demonstrated Rapid and Meaningful Clinical and Renal Activity

- **Improvement in disease activity:** 8 of 9 evaluable patients achieved a ≥4-point reduction in SLEDAI-2K
- **Compelling preliminary renal activity:** Marked proteinuria reductions observed in 5 of 7 evaluable patients with elevated baseline levels
- **Deep renal responses:** 4 of 7 patients achieved complete renal response within 24 weeks as demonstrated by proteinuria levels below 500 mg/24 hours

SLEDAI-2K



Proteinuria



* in pts with BL >0.5 g

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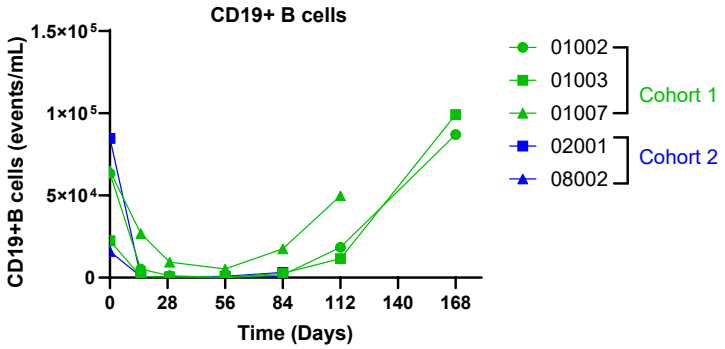
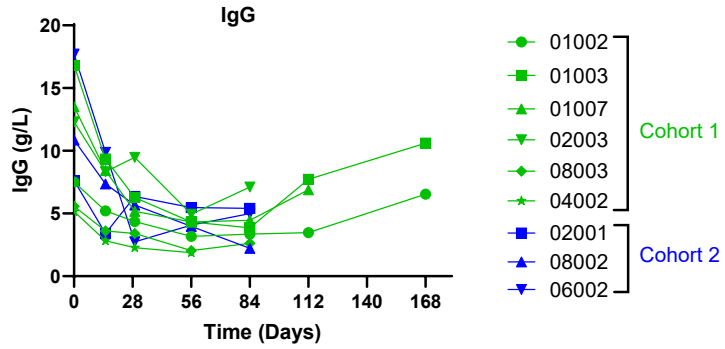
Velinotamig Efficacy Correlated with Impact on Key Biomarkers

- **Robust pharmacodynamic activity:** Rapid depletion of circulating CD19+ B cells accompanied by substantial reductions in total IgG
- **Meaningful serological improvements:** Marked reductions in pathogenic anti-dsDNA antibodies and improvements in complement C3 levels
- **Consistent biological evidence:** Changes across multiple disease-associated biomarkers reinforce the clinical findings

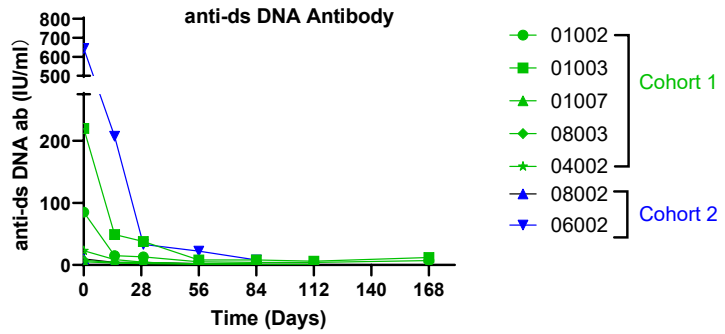
Peripheral Blood B Cells



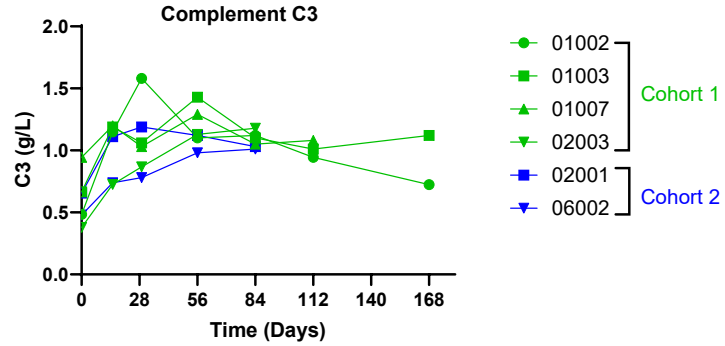
Total IgG



Anti-dsDNA Autoantibodies



Complement C3



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Velinotamig Demonstrated a Favorable Safety Profile with Only Low-Grade CRS

Velinotamig was well tolerated. No DLTs or ICANS were observed. No Grade ≥3 CRS.

N=12	Any grade	Grade ≥3
Patients with ≥1 TEAE	12 (100.0%)	1 (8.3%)[a]
Cytokine release syndrome (CRS)	2 (16.7%)[b]	0
ICANS	0	0
Other TEAEs by preferred term (≥25%)		
Hypogammaglobulinemia	11 (91.7%)[c]	0
Hypoalbuminemia	6 (50.0%)	0
Vomiting	4 (33.3%)	0
Upper respiratory tract infection	4 (33.3%)	0
Hyperuricemia	3 (25.0%)	0
Anemia	3 (25.0%)	0

a) 1 Grade 3 serious sinusitis; Grade 3-4 lymphocyte count decreased reported as a laboratory finding(an expected PD effect). b) CRS was limited to Grade 1-2; 1 patient in Cohort 1 had 2 episodes of Grade 1 CRS. c) All were Grade 1-2, managed appropriately with IVIG. TEAE-treatment-emergent adverse event

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Patient Case Studies Illustrate Deep and Sustained Clinical and Renal Improvements

Patient 01002 (Cohort 1)
24-week follow-up

Patient 02001 (Cohort 1)
12-week follow-up

Parameter	Baseline	Week 12	Week 24	Baseline	Week 12
CRR	-	YES	YES	-	YES
SLEDAI-2K	16	0	2	12	1
Proteinuria (mg/24h) RR (<150)	2246	328	189	1470	480
eGFR (mL/min/1.73 m²) RR (90-120)	83.8	108.7	103.1 (Week 16)	160.6	134.8
Anti-dsDNA IU/mL RR (<10)	85	4	7	Weakly +	4.3
C3 (g/L) RR (0.790-1.520)	0.484	1.120	0.725	0.655	1.030
C4 (g/L) RR (0.160-0.380)	<0.100	0.250	0.160	0.122	0.311

**As of September 8, 2026 data cutoff; illustrative only, patient case studies may not be representative of overall data set*

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Velinotamig Data Provide Encouraging Clinical Evidence Supporting BCMA-Directed Therapy in Autoimmune Disease

Results strongly support velinotamig as a potential treatment for a broad range of autoimmune diseases:

1. Significant reductions in SLE disease activity, with 8 of 9 evaluable patients achieving ≥4-point SLEDAI-2K improvement
2. Marked proteinuria reductions in 5 of 7 evaluable patients, with 4 achieving complete renal response threshold within 24 weeks
3. Clinical responses accompanied by concordant improvements in key serological and pharmacodynamic markers, such as anti-dsDNA
4. Favorable safety profile with CRS occurring in only 2 of 12 patients, with only Grade 1/2 events, no ICANS, and no dose-limiting toxicities

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Beyond Rheumatology: Genrix Data Informs Cullinan-led Global Development Plan in Autoimmune Cytopenias

Initial focus on autoimmune cytopenias with high unmet need offers several advantages:

- ✓ Exploits Cullinan's existing **hematology expertise** and physician familiarity with both cytopenias and TCEs
- ✓ Minimizes time to **clinical proof of concept** outside rheumatology
- ✓ Unlocks opportunity for broader development in other disease areas, such as **neurology, nephrology and endocrinology**

Step 1: Unlock rapid POC in area of high unmet need - autoimmune cytopenias

Unpredictable disease course with **high morbidity risk**	**Persistent quality-of-life impact** driven by fatigue, anxiety around acute events	**Suboptimal durability of response** with current chronically administered therapies	**Treatment burden and toxicity remain high**, particularly from chronic immunosuppression	**Limited targeted therapies** that address underlying immune dysregulation	Many patients relapse or **cycle through treatments**

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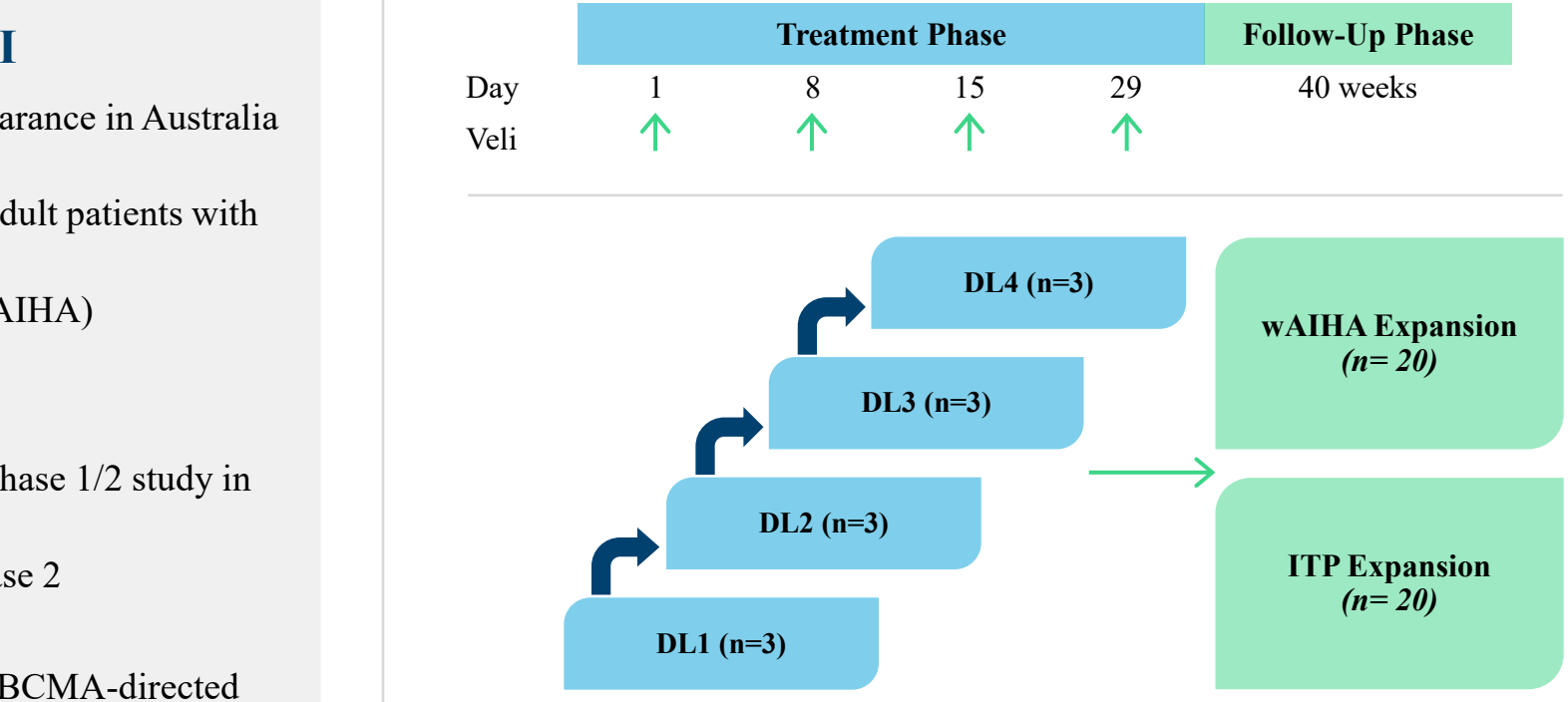
Advancing Velinotamig into Multi-Indication, Global Clinical Development

GLOBAL DEVELOPMENT STATUS

Ongoing clinical development in I&I

- IND clearance by the U.S. FDA and HREC clearance in Australia in autoimmune cytopenias
- Cullinan-led global Phase 1/2 basket study in adult patients with relapsing and refractory:
  - Warm Autoimmune hemolytic anemia (wAIHA)
  - Immune thrombocytopenia (ITP)
- Genrix Bio continues dose escalation in their Phase 1/2 study in treatment refractory SLE patients
  - Additional indications are planned for Phase 2
- Data are expected to further inform the role of BCMA-directed plasma cell depletion across autoimmune diseases

Illustrative Autoimmune Cytopenia Study Design



Failed at least 2 prior therapies (conventional or biologic)

Hb<10 g/dL (wAIHA); platelet <30,000/uL (ITP)

Clinicaltrials.gov identifier: NCT07738822

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CLN-049

FLT3xCD3 T cell engager

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Significant Unmet Need in Adult AML

- The only curative therapy is intensive chemotherapy +/- stem cell transplantation
- Curative therapy remains out of reach for most AML patients: 85% patients >60 years old are ineligible for intensive chemotherapy
- Recent treatment advancements have not significantly improved the likelihood of cure for the majority of AML patients
- **A significant unmet need remains for –**
  - a broadly applicable therapy that can produce high rates of durable response
  - eradication of measurable residual disease (MRD) that portends relapse even when patients meet clinical criteria for complete remission



US AML incidence **22,270**[1]



Average age at diagnosis **69**[1]



5-year survival **10% or less** in relapsed setting[2]

References 1. American Cancer Society (2026) 2. DeWolf and Tallman. Blood 2020.

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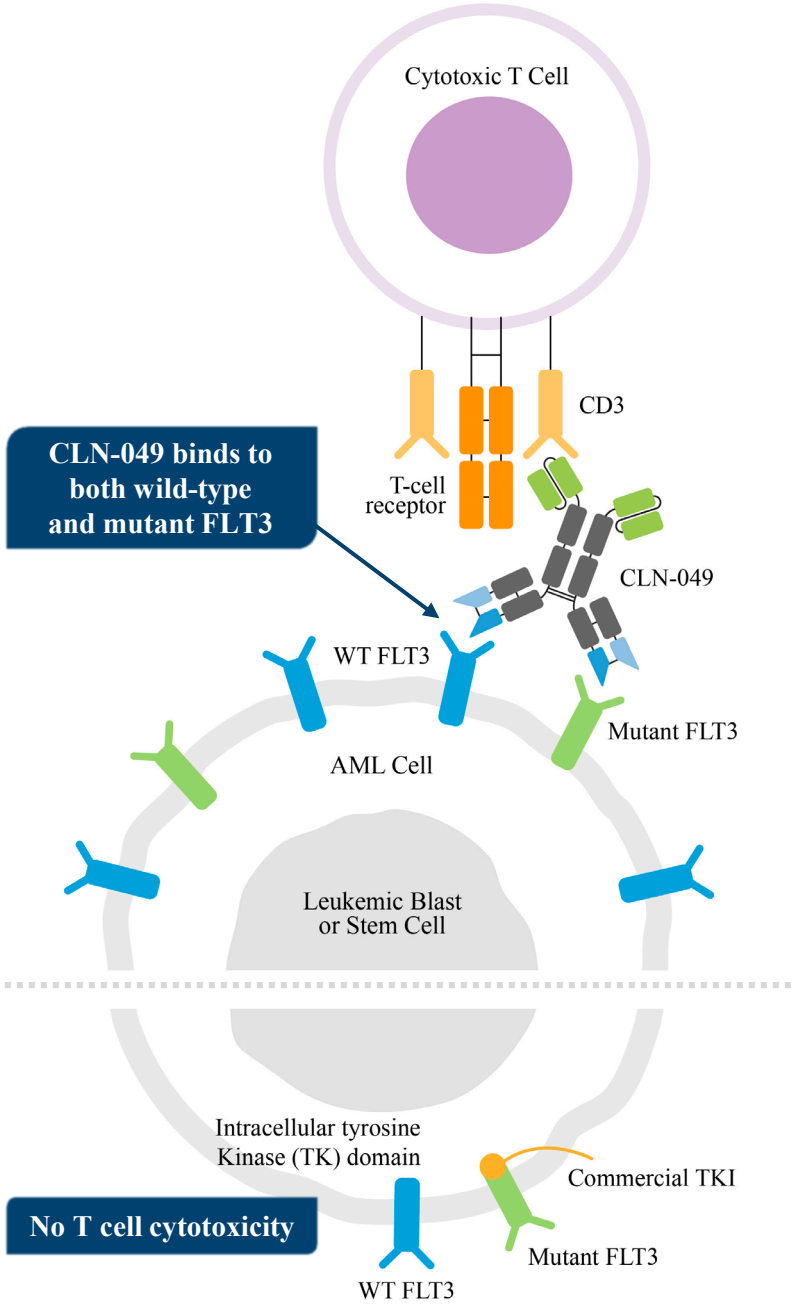

CLN-049 is an Optimal AML Immunotherapy

1. **First-in-class opportunity:** CLN-049 binds to the extracellular domain of FLT3, both wildtype and mutated forms, redirecting a patient's own T cells to recognize and eliminate leukemic cells.

2. **Potential to treat a broad AML population:** FLT3 is expressed on more than 80%[1] of AML blasts and only a limited number of normal hematopoietic precursors and dendritic cells.

3. **Promising therapeutic potential:** FLT3 is expressed on leukemic stem cells as well as blast cells, which may increase response durability. Since FLT3 is an oncogenic driver, target loss is unlikely.

4. **Potential for reduced toxicity risk:** FLT3 expression is very low on most mature normal myeloid cells. FLT3 expression is also very low on normal pluripotent stem cells.

1. Gebru, M.T., Wang, HG. Therapeutic targeting of FLT3 and associated drug resistance in acute myeloid leukemia. J Hematol Oncol 13, 155 (2020). https://doi.org/10.1186/s13045-020-00992-1

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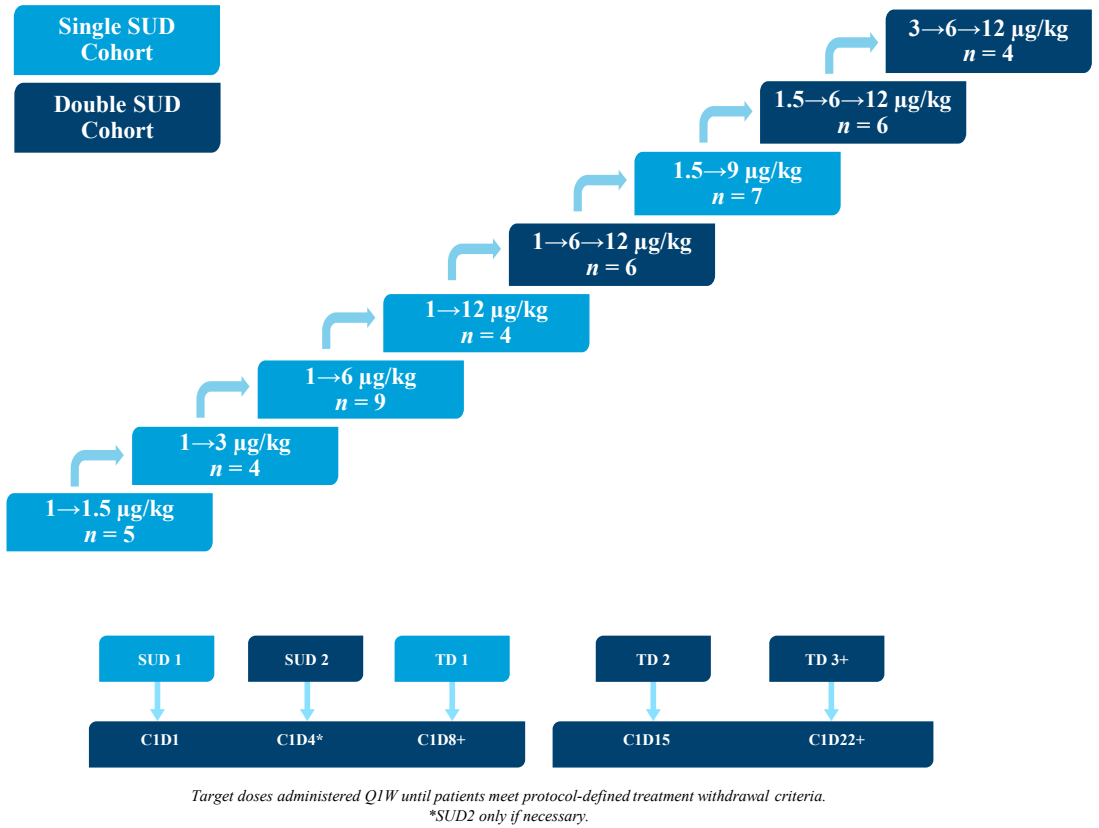
CLN-049 Phase 1 Study in Patients with R/R AML or MDS: Initial Results from Dose-escalation Presented at ASH 2025

Study Design – IV Dose Escalation Cohorts



Target doses administered Q1W until patients meet protocol-defined treatment withdrawal criteria.
**SUD2 only if necessary.*

Study Objective

- **To assess preliminary efficacy, safety, tolerability, PK, pharmacodynamics, and immunogenicity of IV-administered CLN-049 in patients with R/R AML or MDS**

Study Enrollment and Eligibility

- **45 patients ≥18 years with R/R AML or MDS (ECOG 0 to 2) enrolled as of August 2025 data cutoff**
  - 45 patients assessed for safety
  - 41 patients with available efficacy data
  - Efficacy assessments for 3→6→12 µg/kg cohort (*n*=4) not available at time of data cutoff
- **No requirement for baseline testing for FLT3 expression**

Study Efficacy Endpoints: Complete response (CR) rate; Composite complete response (CRc) rate: (CR/CRi/CRh in AML or CR/CRL/CRh in MDS); ORR: (CRc + MLFS + PR in AML or CRc + PR + HI in MDS); Response assessed using ELN 2022 (AML) or IWG 2023 (MDS) criteria
C, cycle; CRh, complete remission with partial hematologic recovery; CRi, complete remission with incomplete recovery; CRL, complete remission with limited response; D, day; ECOG, Eastern Cooperative Oncology Group; ELN, European LeukemiaNet; FIH, first in human; HI, hematologic improvement; IV, intravenous; IWG, International Working Group; MDS, myelodysplastic syndrome; MLFS, morphologic leukemia-free state; ORR, objective response rate; PK, pharmacokinetics; PR, partial response; Q1W, every week; R/R, relapsed/refractory; SUD, step-up dose; TD, target dose.

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CLN-049 Phase 1: Enrolled Patients Representative of the Broad R/R AML Population

Characteristic	All cohorts *n*=45	1→6 µg/kg cohort *n*=9	1.5→9 µg/kg cohort *n*=7	12 µg/kg cohorts[1] *n*=20
Diagnosis, n (%)				
AML	39 (87)	9 (100)	5 (71)	19 (95)
MDS/AML	3 (7)	0	2 (29)	0
MDS	3 (7)	0	0	1 (5)
ECOG at baseline, n (%)				
0	13 (29)	2 (22)	2 (29)	6 (30)
1	24 (53)	4 (44)	4 (57)	10 (50)
2	8 (18)	3 (33)	1 (14)	4 (20)
Prior therapies				
Median (range)	2 (1–8)	2 (1–7)	2 (1–5)	1.5 (1–8)
HMA/Venetoclax as last prior therapy, n (%)	27 (60)	7 (78)	2 (29)	12 (60)
Prior transplant, n (%)	10 (22)	2 (22)	3 (43)	4 (20)
BMA blasts[2] at screening, n (%)				
<30%	27 (60)	6 (67)	4 (57)	12 (60)
≥30–50%	6 (13)	0	2 (28)	3 (15)
>50%	7 (16)	0	1 (14)	4 (20)
Risk at time of diagnosis (AML), n (%)				
Favorable	2 (5)	0	1 (20)	0
Intermediate	6 (15)	1 (11)	2 (40)	1 (5)
Adverse	28 (72)	8 (89)	1 (20)	6 (84)
Cytogenetics/molecular annotation, n (%)				
Any abnormality	39 (87)	9 (100)	6 (86)	18 (90)
Complex cytogenetics	7 (16)	3 (33)	0	3 (30)
–5; −7; −17/abn(17p)	6 (13)	2 (22)	0	4 (20)
FLT3-ITD mutation[3]	6 (13)	2 (22)	0	1 (5)
***TP53* mutation[4]**	**16 (36)**	**3 (33)**	**0**	**11 (55)**

August 2025 data cutoff

[1]12 µg/kg cohorts include 1 → 12 µg/kg, 1 → 6 → 12 µg/kg, 1.5 → 6 → 12 µg/kg, and 3 → 6 → 12 µg/kg dose levels.
[2]Bone marrow biopsy data used where bone marrow aspirate data was not available.
[3]FLT3-ITD identified through cytogenic/molecular annotation in EDC and eligibility packets, or prior treatment with an approved FLT3 inhibitor
[4]TP53 mutation identified through cytogenetic/molecular annotation in EDC and eligibility packets
BMA, bone marrow aspirate; Unknown or not-specified values not shown

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CLN-049 Phase 1: Treatment-emergent Adverse Events Demonstrate a Favorable Safety Profile

	Single step-up cohorts					Double step-up cohorts			Total *n*=45
TEAEs by preferred term, >15% of patients, n (%)	**1→1.5 µg/kg *n*=5**	**1→3 µg/kg *n*=4**	**1→6 µg/kg *n*=9**	**1.5→9 µg/kg *n*=7**	**1→12 µg/kg *n*=4**	**1→6→12 µg/kg *n*=6**	**1.5→6→12 µg/kg *n*=6**	**3→6→12 µg/kg *n*=4**	
Patients with ≥1 TEAE	5 (100.0)	4 (100.0)	8 (88.9)	7 (100.0)	4 (100.0)	6 (100.0)	6 (100.0)	2 (50.0)	**42 (93.3)**
Cytokine release syndrome (CRS)	0	1 (25.0)	2 (22.2)	3 (42.9)	4 (100.0)	3 (50.0)	2 (33.3)	1 (25.0)	**16 (35.6)**
Infusion-related reaction	1 (20.0)	1 (25.0)	4 (44.4)	3 (42.9)	0	1 (16.7)	3 (50.0)	2 (50.0)	**15 (33.3)**
Febrile neutropenia	1 (20.0)	1 (25.0)	3 (33.3)	0	1 (25.0)	2 (33.3)	1 (16.7)	0	**9 (20.0)**
White blood cells decreased	1 (20.0)	1 (25.0)	1 (11.1)	1 (14.3)	2 (50.0)	1 (16.7)	0	1 (25.0)	**8 (17.8)**
Pneumonia	0	1 (25.0)	2 (22.2)	1 (14.3)	0	2 (33.3)	2 (33.3)	0	**8 (17.8)**
Diarrhea	0	1 (25.0)	2 (22.2)	0	2 (50.0)	1 (16.7)	1 (16.7)	0	**7 (15.6)**
Hypomagnesemia	0	1 (25.0)	2 (22.2)	1 (14.3)	2 (50.0)	0	0	1 (25.0)	**7 (15.6)**
Stomatitis	2 (40.0)	1 (25.0)	1 (11.1)	0	1 (25.0)	2 (33.3)	0	0	**7 (15.6)**
Hypokalemia	1 (20.0)	1 (25.0)	3 (33.3)	2 (28.6)	0	0	0	0	**7 (15.6)**

Frequency and severity of CRS can be mitigated through step-up dosing

August 2025 data cutoff

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CLN-049 Phase 1: Preliminary Efficacy Data Highlights Potential to Achieve Deep Responses in a Heavily Pre-treated Population

Response rate (best response), n (%)	Single step-up cohorts					Double step-up cohorts		All cohorts *n* = 41*	≥6 µg/kg cohorts *n* = 32	12 µg/kg cohorts *n* = 16*
	1→1.5 µg/kg *n* = 5	1→3 µg/kg *n* = 4	1→6 µg/kg *n* = 9	1.5→9 µg/kg *n* = 7	1→12 µg/kg *n* = 4	1→6→12 µg/kg *n* = 6	1.5→6→12 µg/kg *n* = 6			
CR	0	0	3 (33)	0	1 (25)	0	1 (17)	5 (12)	5 (16)	2 (13)
CR+CRh	0	0	3 (33)	0	2 (50)	2 (33)	1 (17)	8 (20)	8 (25)	5 (31)
CRc	0	1 (25)	3 (33)	1 (14)	2 (50)	2 (33)	1 (17)	10 (24)	9 (28)	5 (31)
ORR	0	1 (25)	4 (44)	1 (14)	3 (75)	4 (67)	3 (50)	16 (39)	15 (47)	10 (63)

*Enrollment into 3→6→12 µg/kg cohort (n = 4) ongoing at time of data cutoff; efficacy data not available for this cohort.

31% CR+CRh rate at the 12µg/kg dose in this heavily pre-treated R/R AML population

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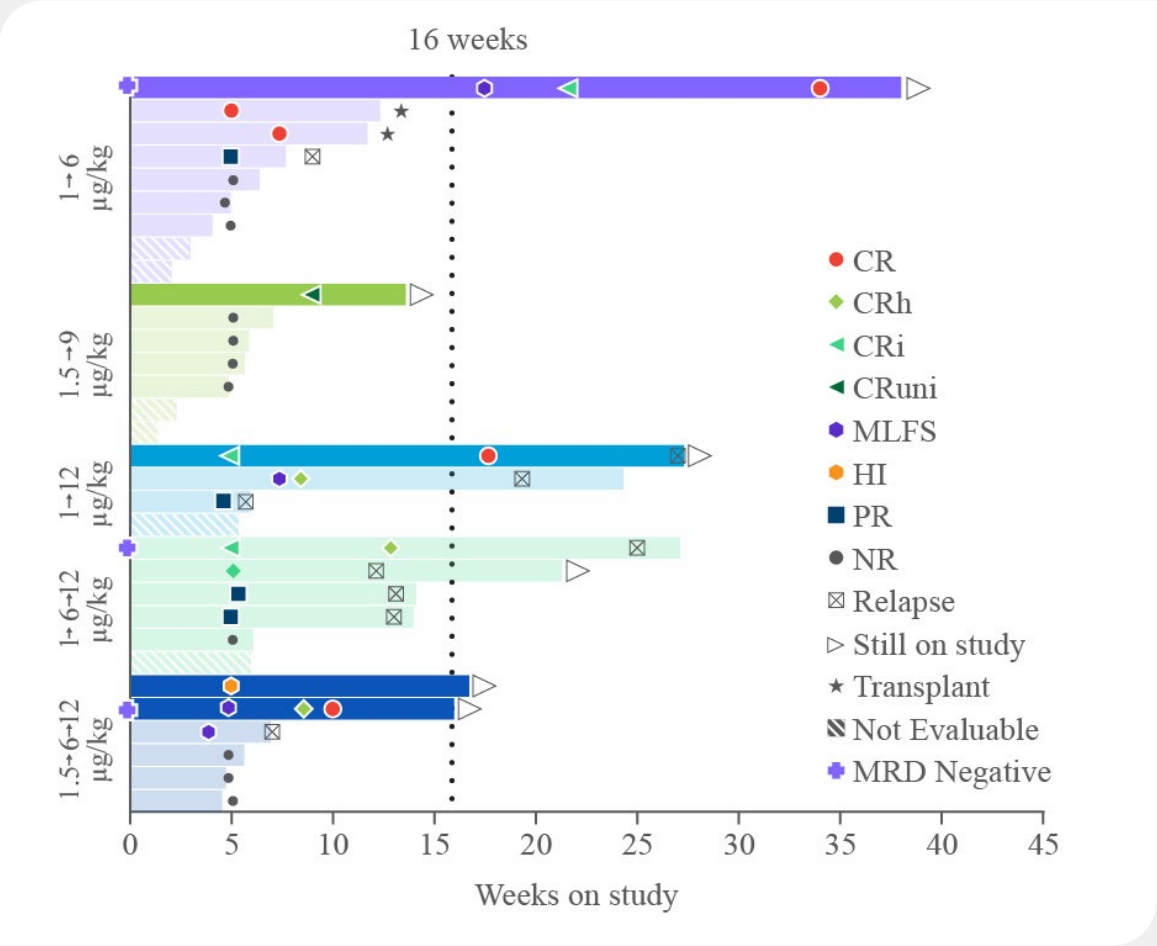
CLN-049 Phase 1: Promising Initial Response Durability Data



8 patients achieved CR or CRh at a TD of ≥6 µg/kg:

- 5 patients had DoR >16 weeks
  - 3 MRD-negative patients all achieved DoR >16 weeks, including 1 patient with an ongoing response for >36 weeks
- 2 additional patients attained CR and proceeded to HSCT

BM, bone marrow; CRuni, complete remission unilineage; MRD, measurable residual disease.; DoR, duration of response; HSCT, hematopoietic stem cell transplant; NR, no response.

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Recent Monotherapy Approvals in R/R AML Provide Regulatory Efficacy Benchmarks for CLN-049 Development

	Gilteritinib[1]	Enasidenib[2]	Ivosidenib[3]	Revumenib[4]	Revumenib[4]	Ziftomenib[5]
Year approved	2018	2017	2018	2024	2025	2025
Target population	FLT3	IDH2	IDH1	KMT2A	NPM1	NPM1
AML Population Prevalence	~30%	~8% to 12%	~6% to ~9%	~3%	~28% to ~35%	~28% to ~35%
No. of patients	138	199	174	104	65	112
CR	11.6%	19%	24.7%	12.5%	18.5%	17.0%
CR+CRh	21%	23%	32.8%	21.2%	23.1%	21.4%
mDoCR+CRh	4.6 months	8.2 months	8.2 months	6.4 months	4.5 months	5.0 months

- **Recent FDA approvals target molecularly defined subsets of R/R AML with single arm studies of ~ 100 patients**
- **Regulatory endpoints of relevance (CR+CRh and mDoCR+CRh) establish a reference benchmark -**
  - CR+CRh of 20% to 30% with response duration of approximately 4 to 6 months

1. https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/211349s001lbl.pdf
2. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/209606s007lbl.pdf
3. https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/211192_s008lbl.pdf
4. https://cms.syndax.com/wp-content/uploads/Revuforj-full-prescribing-info.pdf
5. https://kuraoncology.com/wp-content/uploads/prescribinginformation.pdf
6. *Prevalence reference: NCCN Guidelines Version 3.2026*

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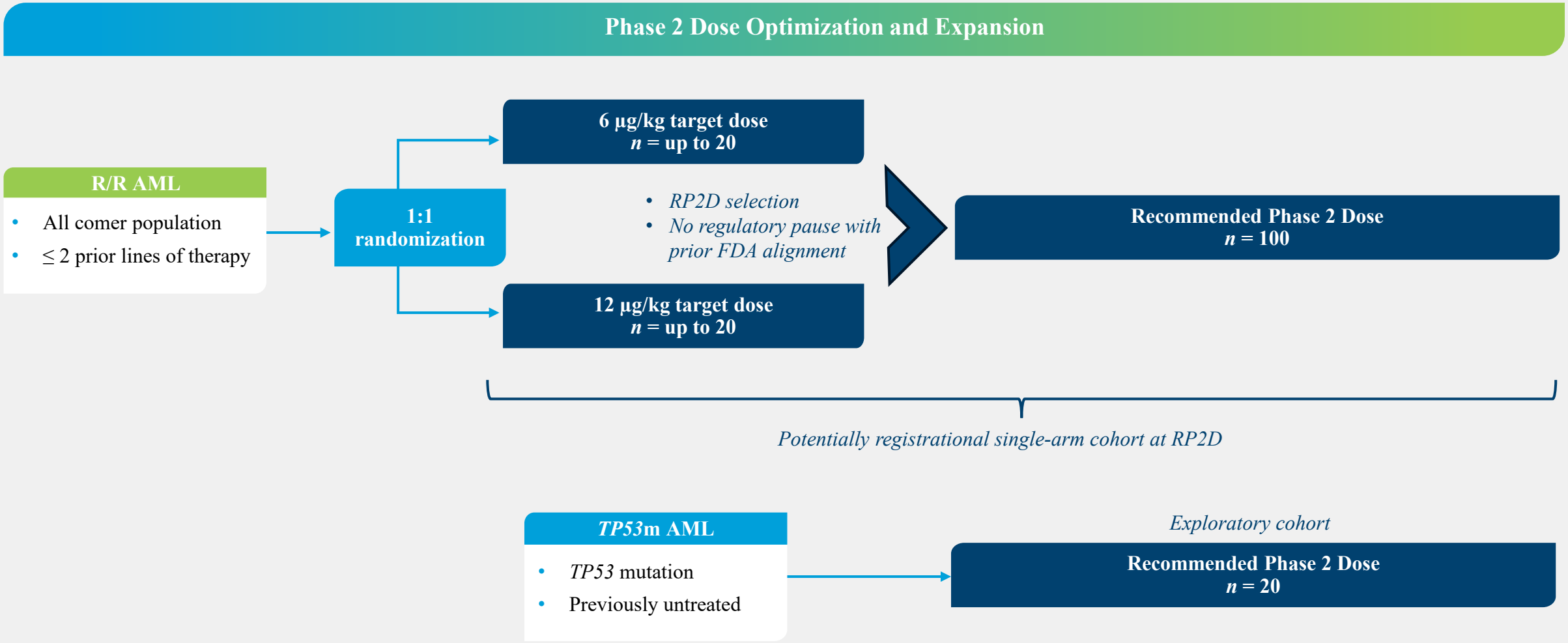
CLN-049 Phase 2: Progressing to Potentially Registrational Phase 2 Study in R/R AML



Clinicaltrials.gov identifier: NCT05143996

RP2D = recommended phase 2 dose

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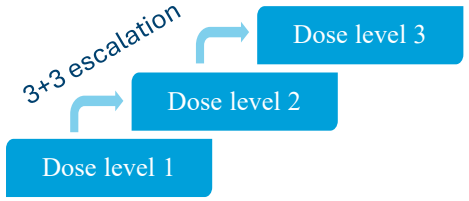
CLN-049: Expanding to Frontline AML in Combination with SOC in Phase 1/2 Study

Phase 1/2 Study
Part A: Dose Escalation

CLN-049
Target dose initiated weekly after SUD regimen



Azacitidine
75 mg/m² (IV or subcutaneous)
Days 1-7 of each 28-day cycle

Venetoclax
400 mg orally once daily
Days 1-28 (Days 1-14 in consolidation)

Part A to be followed by Part B dose expansion at CLN-049 dose determined in Part A

Treatment initially given in 28-day induction cycles (up to 4 cycles if patient's bone marrow blasts remain ≥5%); after induction, patient is moved to consolidation dosing; and in patients achieving MRD, CLN-049 dosing is also reduced to Q2W; dosing is continued until patients meet protocol defined treatment withdrawal criteria

Study Objective

- **To assess preliminary efficacy, safety, tolerability, PK, pharmacodynamics, and immunogenicity of IV-administered CLN-049 in combination with azacitidine and venetoclax in patients with newly diagnosed, previously untreated AML**

Key Study Eligibility Criteria

- **Patients aged ≥ 18 years of age with newly diagnosed, previously untreated AML (including MDS/AML)**
- **Patients are not candidates for intensive induction chemotherapy because they are either unfit or otherwise clinically unsuitable for anthracycline/ cytarabine-based induction therapy**
- **Eastern Cooperative Oncology Group (ECOG) performance status is 0 to 2**

Clinicaltrials.gov identifier: NCT07722767

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CLN-049: Compelling Efficacy Enables Accelerated Approval Pathway and Drives Attractive Commercial Opportunity

- CLN-049 is a first-in-class differentiated molecule demonstrating compelling monotherapy efficacy with promising initial response durability and favorable safety in R/R AML; dose escalation is still ongoing
- CLN-049 can address a broad, all-comer population of AML patients with no biomarker testing required
- Rapid development under U.S. FDA Orphan Drug Designation and Fast Track Designation for R/R AML

- Initial efficacy data presented at ASH 2025 meets the benchmark for recently approved agents with clear pathway to accelerated approval in R/R AML; updated data at ASH 2026
- Potentially registrational Phase 2 study in R/R AML underway
- Expanding to frontline AML with a Phase 1/2 in combination with ven/aza also underway
- CLN-049 provides a commercially attractive opportunity in AML, with R/R segment alone representing a $1B+ opportunity[1]

1. Internal company estimate - based on available historical sales data and consensus estimates for commercially approved drugs

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ZIPALERTINIB

(CLN-081/TAS6417)

EGFR ex20ins inhibitor

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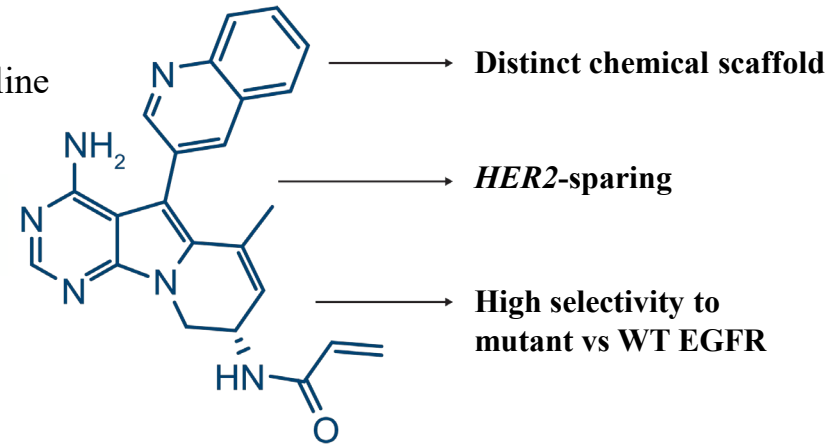
Zipalertinib: Compelling Profile for NSCLC Patients With EGFR Exon20 Insertion Mutations

Potentially Best-in-Disease First-Line Option

- ✓ **Unprecedented** 6-month improvement in median progression-free survival for zipalertinib plus chemotherapy over chemotherapy alone demonstrated early at interim analysis
- ✓ **Best median PFS and median DoR results** observed to date in clinical trials in the front-line setting in patients with EGFR exon20ins NSCLC



Robust Clinical Activity Across Patient Subsets

- ✓ **2L+:** Clinically meaningful efficacy and durability in 2L+ patients
- ✓ **Brain metastases:** Clinically meaningful intracranial antitumor activity

Comprehensive Clinical Development

- ✓ **2L+:** NDA for treatment of relapsed EGFR exon20ins NSCLC under review by the U.S. FDA
- ✓ **1L:** NDA submission completed under FDA Real-Time Oncology Review program
- ✓ **Uncommon mutations:** Parallel cohort study in uncommon mutations, ongoing
- ✓ **Adjuvant study** in EGFR exon20ins and uncommon mutations, ongoing

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REZILIENT3: Zipalertinib Plus Chemotherapy in First-Line EGFR exon20ins NSCLC

Part B: Randomized Phase 3

Primary analysis: At 162 PFS events to detect HR 0.60, 2-sided α: 0.05, 90% power
Pre-specified interim analysis: At 122 PFS events; if one-sided P<0.0098, superiority to be claimed

Study Population

1. First-line, locally advanced or metastatic nonsquamous NSCLC
2. *EGFR* exon20ins mutations by local test
3. Measurable disease per RECIST v1.1
4. ECOG PS 0 or 1
5. Stable brain metastases permitted
6. Archival tumor tissue available for submission

R 1:1

Zipalertinib (100 mg PO BID) + Pemetrexed + Carboplatin OR Cisplatin
140 patients enrolled

Pemetrexed + Carboplatin OR Cisplatin
139 patients enrolled

Pemetrexed 500 mg/m² every 3 weeks; carboplatin (AUC5) or cisplatin 75 mg/m² will be administered for 4 cycles

(Crossover is only allowed after BICR confirms disease progression)

Optional Crossover to Zipalertinib Monotherapy

REZILIENT3 endpoints

Type of endpoint	Endpoint	
Primary	PFS per RECIST v1.1 by BICR	
Secondary	• OS • Investigator-assessed PFS, ORR, DCR, and DoR • ORR, DoR, and DCR per RECIST v1.1 by BICR • Intracranial ORR, DCR, and DoR	• Adverse events per CTCAE v5.0 • PK profile • PROs

Clinicaltrials.gov identifier: NCT05973773; PFS, progression-free survival; BICR, blinded independent central review; ORR, objective response rate; DCR, disease control rate; DoR, duration of response; OS, overall survival; ECOG PS, Eastern Cooperative Oncology Group Performance Status; HR, hazard ratio; IDMC, Independent Data Monitoring Committee; NSCLC, non-small cell lung cancer; PROs, patient reported outcomes

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REZILIENT3: Patient Demographics and Baseline Characteristics

	Zipalertinib + Chemotherapy (n=140)	Chemotherapy (n=139[1])
Age, *n* (years)		
Median (range)	66.5 (30, 89)	64.0 (27, 82)
Sex, n (%)		
Male	48 (34.3)	51 (36.7)
Female	92 (65.7)	88 (63.3)
Region, n (%)		
Asia	56 (40.0)	56 (40.3)
Rest of world	84 (60.0)	83 (59.7)
History of smoking, n (%)		
Yes	57 (40.7)	54 (38.8)
No	83 (59.3)	85 (61.2)
ECOG performance status, n (%)		
0	58 (41.4)	56 (40.3)
1	82 (58.5)	83 (57.6)
Histology Adenocarcinoma		
Adenocarcinoma	136 (97.1)	135 (97.1)
Large cell carcinoma	1 (0.7)	0
Non-squamous cell carcinoma	2 (1.4)	3 (2.2)
Other	1 (0.7)	1 (0.7)
Brain Metastasis		
Yes	44 (31.4)	44 (31.7)
No	96 (68.6)	95 (68.3)

1. Three patients were enrolled but not randomized; included in efficacy population and excluded from safety population

ECOG, Eastern Cooperative Oncology Group

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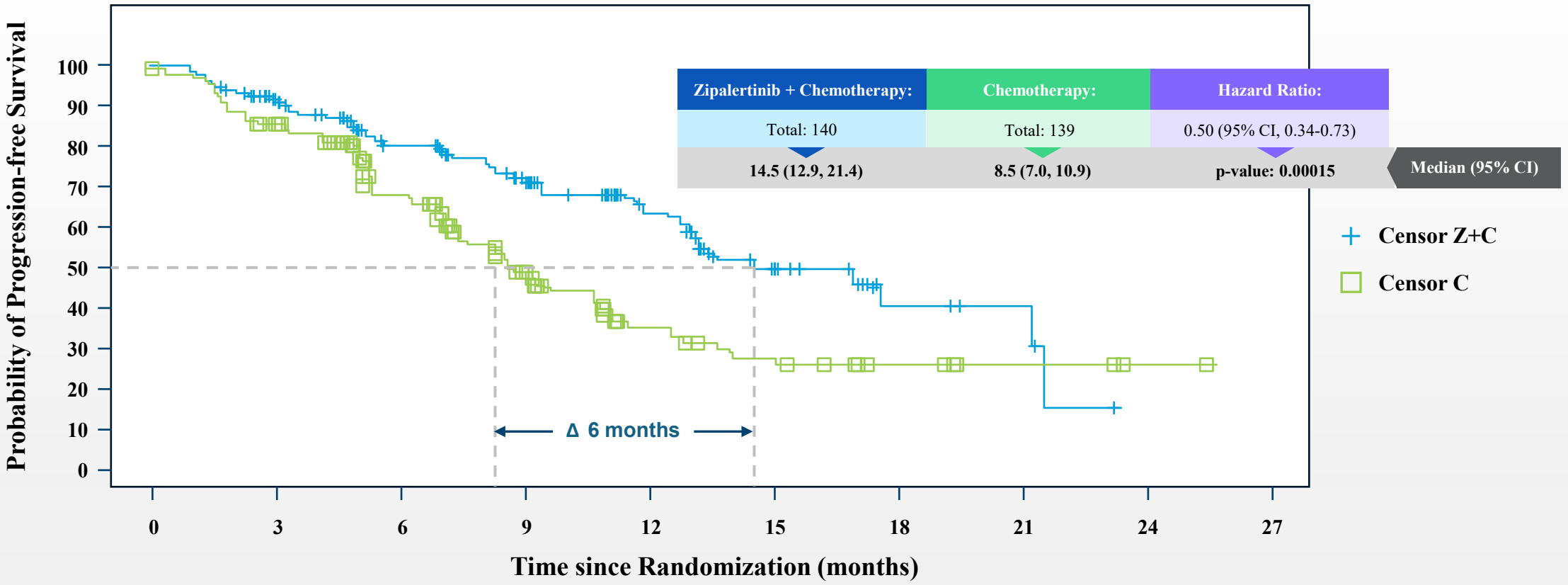
REZILIENT3: Unprecedented Median Progression-free Survival (PFS) of 14.5 Months per Blinded, Independent Central Review



Number at Risk										
Zipalertinib + Chemotherapy	140	109	81	59	40	22	7	4	0	•
Chemotherapy	139	102	73	36	20	14	6	3	1	0

C, chemotherapy; NE, not estimable; Z+C, zipalertinib + chemotherapy; CI, confidence interval

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REZILIENT3: Clinical Benefit in First-Line EGFR exon20ins NSCLC

Zipalertinib + chemotherapy demonstrated clinically meaningful efficacy in the first-line setting with a median DoR of 14.2 months – the best result observed to date in clinical trials for first-line EGFR exon20ins NSCLC.

	Zipalertinib + Chemotherapy (n=140)	Chemotherapy (n=139)
Best Overall Response, *n* (%)		
Complete Response (CR)	9 (6.4)	3 (2.2)
Partial Response (PR)	82 (58.6)	53 (38.1)
Stable Disease (SD)	29 (20.7)	55 (39.6)
Progressive Disease (PD)	4 (2.9)	12 (8.6)
Objective Response Rate, n (%)	**91 (65.0)[1]**	**56 (40.3)**
(95% CI of Rate)	(56.49, 72.86)	(32.06, 48.94)
Disease Control Rate, n (%)	125 (89.3)	113 (81.3)
(95% CI of Rate)	(82.94, 93.88)	(73.81, 87.4)
Duration of Response, (DoR) (months), Median (95% CI)	**14.2 (10.51, NE)**	**9.9 (6.80, NE)**
Median Time to Response (CR/PR) (months)	1.4	2.6

1. P-value < 0.0001 vs. chemotherapy alone

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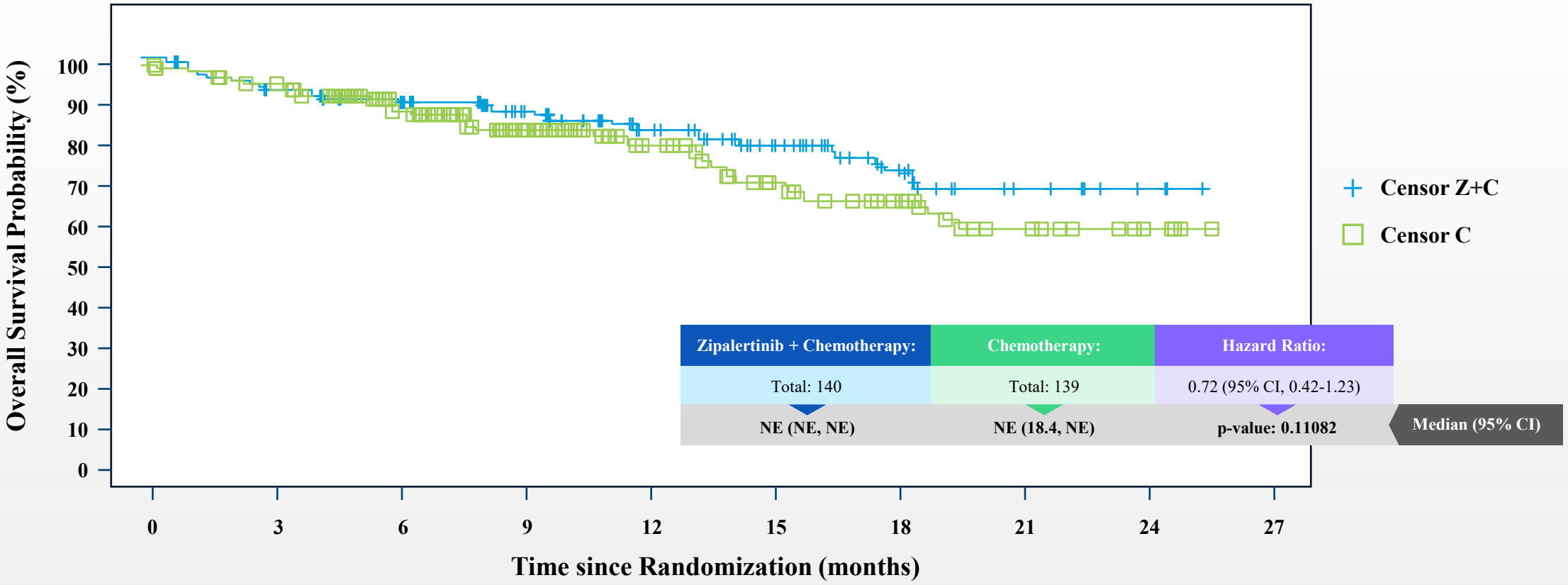
REZILIENT3: At Interim Analysis, Maturing OS Demonstrated a Positive Trend for Improvement in Overall Survival



Number at Risk										
Zipalertinib + Chemotherapy	140	127	98	79	56	38	19	8	3	0
Chemotherapy	139	126	97	67	47	31	22	11	4	0

C, chemotherapy; NE, not estimable; Z+C, zipalertinib + chemotherapy; CI, confidence interval

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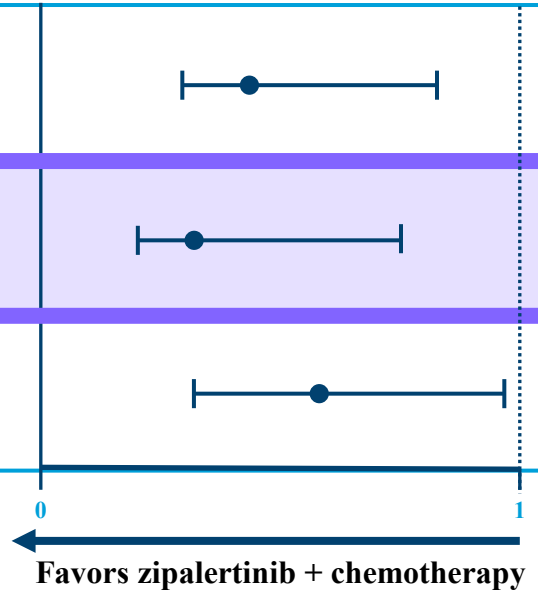
REZILIENT3: Zipalertinib Plus Chemotherapy Significantly Reduced the Risk of Disease Progression in Patients With Brain Metastases versus Chemotherapy Alone

Zipalertinib + chemotherapy demonstrated more durable disease control and a greater PFS benefit in the high-risk population with a 0.38 HR.

Subgroup	Zipalertinib + Chemotherapy with Event n/N (%)	Chemotherapy with Event n/N (%)	PFS Hazard Ratio	Hazard Ratio (95% CI)
All Patients	50/140 (35.7%)	72/139 (51.8%)		0.55 (0.38-0.79)
Brain Metastases = Yes	**21/44 (47.7%)**	**30/44 (68.2%)**		**0.38 (0.21-0.67)**
Brain Metastases = No	29/96 (30.2%)	42/95 (44.2%)		0.62 (0.38-0.99)



PFS, progression-free survival; HR, hazard ratio; CI, confidence interval

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REZILIENT3: Summary of Adverse Events (AEs)

n (%)	Zipalertinib + Chemotherapy (n=140)			Chemotherapy (n=136)	
Treatment-Related Adverse Events (TRAEs)	138 (98.6)			120 (88.2)	
Grade ≥3 TRAEs	113 (80.7)			55 (40.4)	
Serious Adverse Events	71 (50.7)			45 (33.1)	
Treatment-related Serious Adverse Events	53 (37.9)			17 (12.5)	
Adverse Events with outcome of death[1]	13 (9.3)			4 (2.9)	
TRAEs with outcome of death	3 (2.1)			0	
Sepsis/septic shock	3 (2.1)			0	
	Zipalertinib	**Pemetrexed**	**Carbo/cisplatin**	**Pemetrexed**	**Carbo/ cisplatin**
TEAEs leading to treatment interruption	116 (82.9)	104 (74.3)	70 (50)	60 (44.1)	40 (29.4)
TEAEs leading to dose reduction	61 (43.6)	68 (48.6)	46 (32.9)	29 (21.3)	21 (15.4)
TEAEs leading to drug discontinuation[2]	24 (17.1)	44 (31.4)	22 (15.7)	16 (11.8)	7 (5.1)

1. *Death events were as follows – zipalertinib + chemotherapy: sepsis (3), pneumonia (1), respiratory tract infection (1), septic shock (1), acute respiratory failure (1), dyspnea (1), hemoptysis (1), respiratory failure (1), death (1), sudden death (1), diabetic ketoacidosis (1). chemotherapy: sepsis (1), pneumonia (1), acute respiratory failure (1), cerebrovascular accident (1)*
2. *Refers to the regimen where a component was the primary reason for treatment discontinuation.*

TEAE, treatment-emergent adverse event

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REZILIENT3: Safety Profile

- **The safety profile of zipalertinib + chemotherapy was consistent with the known profile of the individual agents**
- **The most common adverse events were chemotherapy-related cytopenias and EGFR-associated toxicities**

Most common AEs of any cause by preferred term (≥25%), (%)	Zipalertinib + Chemotherapy (n=140)		Chemotherapy (n=136)	
	Any Grade	Grade ≥3	Any Grade	Grade ≥3
Associated with EGFR inhibition				
Rash	45.7	10.7	6.6	0
Paronychia	31.4	1.4	0	0
Stomatitis	28.6	5.0	7.4	0.7
Diarrhea	27.1	1.4	8.8	0
Other				
Anemia[1]	80.7	48.6	50.0	12.5
Thrombocytopenia[2]	56.4	30.0	19.9	8.1
Neutropenia[3]	50.7	33.6	40.4	22.1
Nausea	44.3	3.6	41.9	0.7
Constipation	32.1	0	30.9	0

1. Includes anemia and/or reduced red blood cells 2. Includes thrombocytopenia and/or platelets decreased 3. Includes neutropenia and/or decreased neutrophils

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Compelling Profile of Zipalertinib Regimens Creates Opportunity to Address Large Unmet Need

1L

	Zipalertinib + Chemotherapy*	Amivantamab + Chemotherapy[1]	Sunvozertinib monotherapy[2]
ORR	65.0%	73%	58.9%
Median duration of response	14.2 months	9.7 months	11.2 months
Median PFS	14.5 months	11.4 months	10.3 months
Control arm median PFS	8.5 months	6.7 months	7.5 months
History of brain metastases	31.4%	23%	12.9%

2L+

	Zipalertinib monotherapy[3]	Amivantamab monotherapy[4]	Sunvozertinib monotherapy[5]
ORR in patients treated with prior platinum-based chemotherapy only	40%	40%	45.9%
Median duration of response	8.8 months	11.1 months	11.1 months
Median PFS	9.5 months	8.3 months	8.4 months
History of brain metastases	35%	22%	25%

Data provided for context only; no head-to-head studies have been conducted. Other studies may not be directly comparable. Results should be interpreted with caution.

1. *Girard N; PAPILLON Investigators. Amivantamab plus Chemotherapy in NSCLC with EGFR Exon 20 Insertions. N Engl J Med. 2023 Nov 30;389(22):2039-2051.*
2. *Heymach JV; First-Line Sunvozertinib in NSCLC with EGFR Exon 20 Insertion Mutations. N Engl J Med. 2026 Aug 20;395(8):765-775.*
3. *Yu HA; REZILIENT1 Investigators. Zipalertinib in Patients With EGFR Exon 20 Insertion-Positive NSCLC Previously Treated With Platinum-Based Chemotherapy With or Without Amivantamab. J Clin Oncol. 2025 Jul 20;43(21):2387-2397.*
4. *Park K, Haura EB, Leighl NB, et al. Amivantamab in EGFR Exon 20 Insertion-Mutated Non-Small-Cell Lung Cancer Progressing on Platinum Chemotherapy: Initial Results From the CHRYSALIS Phase I Study. J Clin Oncol. 2021;39(30):3391-3402.*
5. *Jänne PA; WU-KONG1B. Phase II Dose-Randomized Study of Sunvozertinib in Platinum-Pretreated Non-Small Cell Lung Cancer With Epidermal Growth Factor Receptor Exon 20 Insertion Mutations (WU-KONG1B). J Clin Oncol. 2025 Oct 10;43(29):3198-3208.*

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Zipalertinib Plus Chemotherapy Achieves Compelling Efficacy with a Manageable AE Profile

Zipalertinib + chemotherapy showed differentiated rates of EGFR related AEs

AEs associated with EGFR inhibition	Zipalertinib + Chemotherapy*		Amivantamab + Chemotherapy[1]		Sunvozertinib monotherapy[2]	
	Any Grade (%)	Grade ≥3 (%)	Any Grade (%)	Grade≥3 (%)	Any Grade (%)	Grade ≥3 (%)
Notable skin-related toxicities						
Rash	45.7%	10.7%	54%	11%	52.8%	0.6%
Paronychia	31.4%	1.4%	56%	7%	48.5%	3.7%
Dermatitis acneiform	18.6%	1.4%	31%	4%	1.2%	1.2%
Stomatitis	28.6%	5.0%	25%	1%	19.0%	2.5%
Diarrhea	27.1%	1.4%	21%	3%	87.1%	14.1%
Pneumonitis	5.7%	2.1%	2%	2%	n/a	n/a

Data provided for context only; no head-to-head studies have been conducted. Other studies may not be directly comparable. Results should be interpreted with caution.

1. *Girard N; PAPILLON Investigators. Amivantamab plus Chemotherapy in NSCLC with EGFR Exon 20 Insertions. N Engl J Med. 2023 Nov 30;389(22):2039-2051.*
2. *Heymach JV; First-Line Sunvozertinib in NSCLC with EGFR Exon 20 Insertion Mutations. N Engl J Med. 2026 Aug 20;395(8):765-775.*

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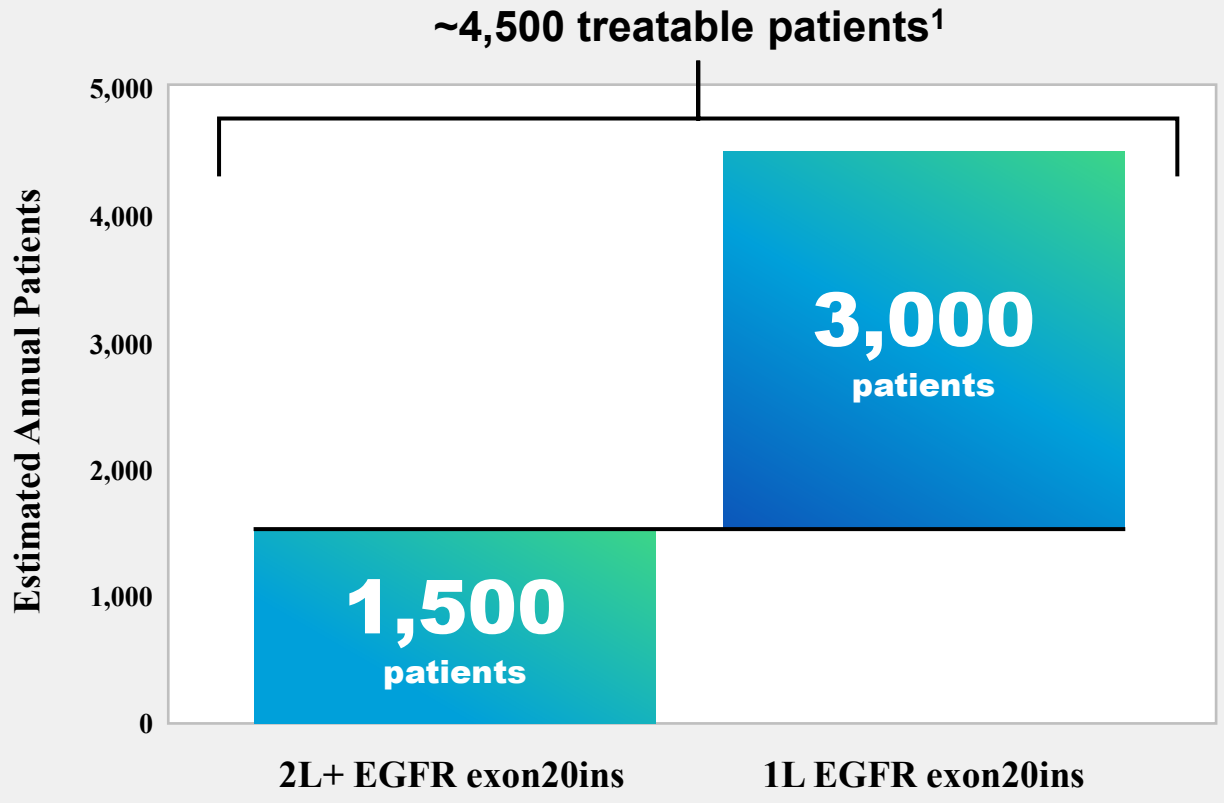
Exon20 Insertions Is an Estimated Billion-Dollar Plus Commercial Opportunity in the U.S.

$1B to $1.5B opportunity in the U.S.[1]



Potential opportunities for future revenue expansion

~6,000+ treatable patients[2]

- Adjuvant NSCLC exon20ins
- NSCLC EGFR uncommon
- Adjuvant NSCLC EGFR uncommon

1. *Internal Company estimate for 2026 total addressable market based on current price of TKIs for EGFR exon20ins NSCLC*
2. *Internal Company estimate for 2026 incidence for first-line NSCLC EGFR uncommon mutation patients*

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Taiho Zipalertinib Collaboration Provides Cullinan With Significant Non-Dilutive Financial Benefits



Upfront Payment
$275 million to Cullinan received in 2022 in exchange for worldwide rights to Taiho[1]



Milestone Payments
Cullinan is eligible to receive **$30 million** and up to **$100 million** upon 2L and 1L U.S. regulatory approvals, respectively



U.S. Profit Sharing
Parties share 50/50 U.S. commercialization costs and potential profits

1. Excludes rights to Japan, which were already held by Taiho, and rights to Greater China, which were previously licensed to Zai Labs.

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Zipalertinib Combination Therapy is Potentially Practice Changing

The compelling results support zipalertinib combination therapy as a highly competitive regimen with the potential to become a new SOC in the 1L setting for patients with EGFR exon20ins NSCLC

- Supports combination approach over single agent TKI
- Best observed median PFS
- Best observed median DoR
- Clinically meaningful activity in patients with brain metastases
- At interim analysis, positive OS trend
- Manageable rates of EGFR-associated AEs

Regulatory

- **2L+:** NDA for treatment of relapsed EGFR exon20ins NSCLC under review by the U.S. FDA
- **1L:** NDA submission completed under FDA Real-Time Oncology Review program

Commercial Opportunity

- **Potential for $130M** in cumulative milestones in the near-term
- Potential to unlock **significant U.S. commercial opportunity** through 50/50 profit share with Taiho

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