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# Leaders in Developing Allogeneic γδ1 CAR-T Cell Therapies to Fight Autoimmune Diseases and Cancer

# Forward-Looking Statements

This presentation contains “forward-looking statements” of Adicet within the meaning of the Private Securities Litigation Reform Act of 1995 relating to the business and operations of Adicet. The words “anticipate,” “believe,” “continue,” “could,” “estimate,” “expect,” “intend,” “may,” “plan,” “potential,” “predict,” “project,” “should,” “target,” “would” and similar expressions are intended to identify forward-looking statements, although not all forward-looking statements contain these identifying words. These forward-looking statements include, but are not limited to, express or implied statements regarding: clinical development of Adicet’s product candidates, including future plans or expectations for prula-cel in autoimmune diseases and the potential safety, tolerability and efficacy for the treatment of autoimmune diseases and cancer; timing and success of the Phase 1 clinical trial of prula-cel in multiple autoimmune indications, including timing and expectations for enrollment and future data releases; expectations regarding regulatory alignment with the FDA to allow LN and SLE patients to be dosed with prula-cel in the outpatient setting; expectations regarding the timing and initiation of a pivotal study for prula-cel in LN or LN and SLE patients; expectations regarding the preclinical and clinical development of ADI-212, including the timing of regulatory filings, clinical startup activities, clinical updates and future data releases; expectations regarding the timing of initiation of enrollment of a Phase 1 trial for ADI-212; expectations regarding the potential potency of ADI-212; and expectations regarding Adicet’s uses of capital, expenses and financial results, including the expected cash runway. Any forward-looking statements in this presentation are based on management’s current expectations and beliefs of future events, and are subject to a number of risks and uncertainties that could cause actual results to differ materially and adversely from those set forth in or implied by such forward-looking statements, including without limitation, the effect of global economic conditions and public health emergencies on Adicet’s business and financial results, including with respect to disruptions to our preclinical and clinical studies, business operations, employee hiring and retention, and ability to raise additional capital; Adicet’s ability to execute on its strategy including obtaining the requisite regulatory approvals on the expected timeline, if at all; that positive results, including interim results, from a preclinical or clinical study may not necessarily be predictive of the results of future or ongoing studies; clinical studies may fail to demonstrate adequate safety and efficacy of Adicet’s product candidates, which would prevent, delay, or limit the scope of regulatory approval and commercialization; and regulatory approval processes of the U.S. Food and Drug Administration and comparable foreign regulatory authorities are lengthy, time-consuming, and inherently unpredictable; and Adicet’s ability to meet production and product release expectations. For a discussion of these and other risks and uncertainties, and other important factors, any of which could cause Adicet’s actual results to differ from those contained in the forward-looking statements, see the section titled “Risk Factors” in Adicet’s most recent annual report on Form 10-K, as well as discussions of potential risks, uncertainties, and other important factors in Adicet’s other filings with the U.S. Securities and Exchange Commission, including its quarterly report on Form 10-Q. All information in this presentation is as of the date of the presentation, and Adicet undertakes no duty to update this information unless required by law.

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# Developing Broad Pipeline of Allogeneic γδ1 T Cell Therapies for Autoimmune Diseases and Cancer

| Program | Target | Indication | Research | IND-Enabling | Clinical | Status |
|---|---|---|---|---|---|---|
| **AUTOIMMMUNE DISEASES** | | | | | | |
| **Prula-cel** | CD20 | LN & SLE | | | | Enrolling multiple cohorts<br>FTD: LN, SLE, SSc<br>Outpatient dosing LN/SLE (aligned with FDA)<br>1H/2026 Clinical update (LN/SLE)<br>1H/2026 Clinical update (SSc)<br>2Q/2026 FDA meeting (pivotal) |
| | | SSc | | | | |
| | | IIM/ SPS | | | | |
| | | AAV | | | | |
| | | RA | | | | Enrolling<br>Cy/Flu vs Cy only LD |
| **ONCOLOGY** | | | | | | |
| **ADI-212** | PSMA (gene-edited w/ armor) [+] | mCRPC | | | | Planned regulatory filing 3Q/26<br>Initiate study 4Q/26 |

AAV= Anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis; Cy/Flu= Cyclophosphamide / fludarabine; IIM= Idiopathic inflammatory myopathy; FTD= Fast track designation; LN= Lupus nephritis; LD= Lymphodepletion; mCRPC= Metastatic castration-resistant prostate cancer; PSMA= Prostate specific membrane antigen; RA= Rheumatoid arthritis; SLE= Systemic lupus erythematosus; SPS= Stiff person syndrome; SSc= Systemic sclerosis; Timing subject to site activation, patient enrollment, data readouts and regulatory feedback; [+] License agreement with CRISPR for gene-editing technology. CRISPR has opt-in right to participate in a 50/50 cost and profit split. RA is in a separate Phase 1 study of prula-cel.



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# Adicet Bio: Leaders in Developing Allogeneic γδ CAR T Cell Therapies

## Adicet's γδ1 CAR T Pipeline is Uniquely Positioned to Deliver Best-in-Class Cell Therapies

- Demonstrated Clinical POC
- Off-the-shelf
- Robust exposure
- Favorable safety profile
- Traffic to tissues

## Prula-cel clinical data suggest transformational approach to treating autoimmune diseases*

- **Single dose prula-cel demonstrated meaningful clinical improvements**; all patients discontinued immunosuppressants and either discontinued or tapered corticosteroids to zero or physiological levels
- **Well tolerated profile** with no SAE's, no ICANS no Gr2 ≥ CRS; supports outpatient administration
- **Immune reset observed** and emergence of naïve B-cell repertoire to support one-time therapy
- **Enrolling across multiple autoimmune conditions**
- **Clinical updates throughout 2026**

## ADI-212: Next generation, gene-edited and armored anti-PSMA γδ1 CAR T for mCRPC

- Designed to enhance potency and deliver multiple anti-tumor mechanisms to tumor microenvironment
- **Regulatory filing 3Q/2026; Initiate enrollment 4Q/2026**



*Cut-off date: August 31, 2025; seven patients (5 LN & 2 SLE) with a follow-up ranging from 2-9 months
CRS= Cytokine release syndrome; DORIS= Definitions of emission in SLE initiative; ICANS= Immune effector cell-associated neurotoxicity syndrome; SAE's= Serious adverse events; mCRPC= Metastatic castration-resistant prostate cancer

# Prula-cel Phase I Clinical Data Suggest a Transformational Approach to Treating Autoimmune Disorders

- Well tolerated safety profile: **no ICANS, no Gr 2 ≥ CRS. Appropriate for outpatient administration**
- Rapid and sustained **reductions in SLEDAI-2K and PGA across all patients (five LN and two SLE)**
- Improved kidney function in all five LN patients, including **three complete renal responses and two partial renal responses**
- Clear evidence of immune reset with subsequent emergence of naïve B cell repertoire following single treatment
- All patients discontinued immunosuppressants and **tapered corticosteroids to zero or physiological levels**
- **'Off-the-shelf' availability** and **no need for leukapheresis**

* Cut-off date: August 31, 2025; seven patients (5 LN & 2 SLE) with a follow-up ranging from 2-9 months.
CRS= Cytokine release syndrome; ICANS= Immune effector cell-associated neurotoxicity; LN= Lupus nephritis; PGA= Physician's global assessment; SLE= systemic lupus erythematosus; SLEDAI-2K= Systemic lupus erythematosus disease activity index 2000.



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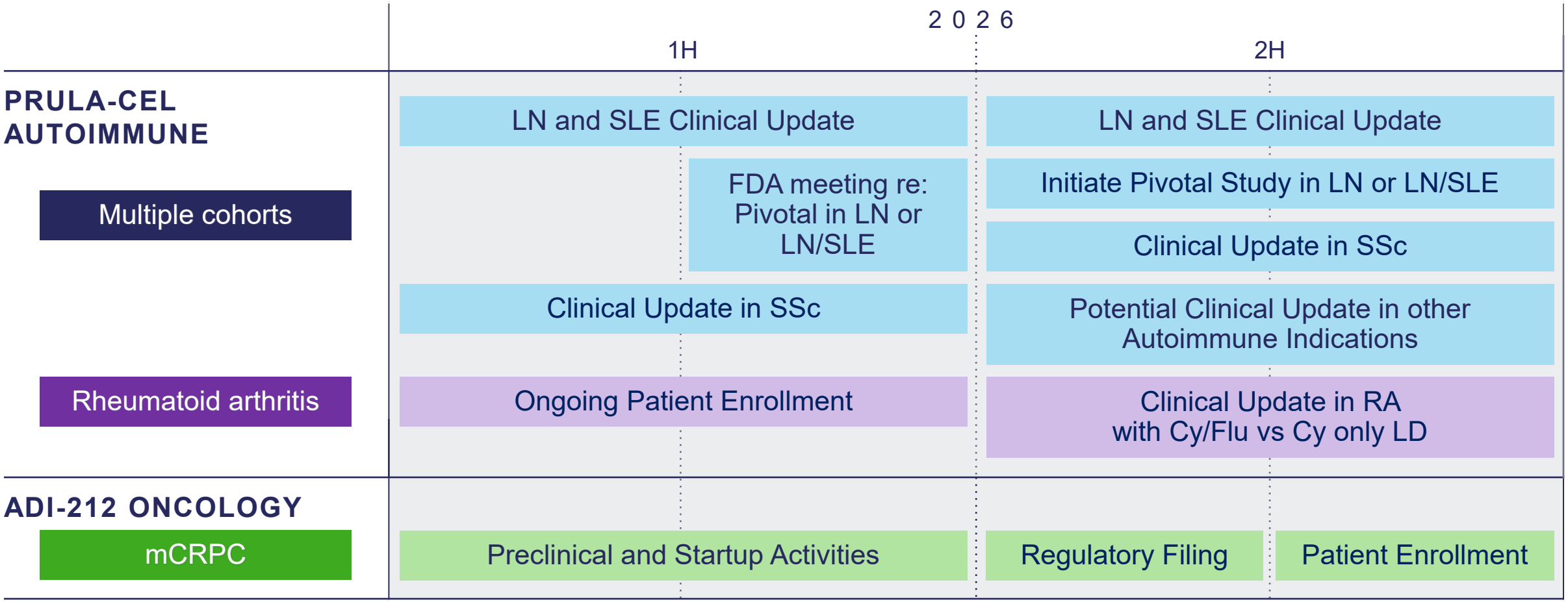
# Upcoming Potential Milestones




Cash and cash equivalents: $158.5M (12/31/25)
Projected cash runway into 2H 2027

Subject to site activation, patient enrollment, data readouts and regulatory feedback



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# Adicet Bio Leadership Team

**Chen Schor**
President and CEO

teva
resTORbio

**Don Healey, Ph.D.**
Chief Technology Officer

OPEXA THERAPEUTICS
KBI BIOPHARMA
Argos THERAPEUTICS

**Blake Aftab, Ph.D.**
Chief Scientific Officer

ATARA BIO
UCSF University of California San Francisco

**Amy Locke**
Head of Human Resources

natera
ZS

**Nick Harvey**
Chief Financial Officer

CENTREXION THERAPEUTICS
Radius

**Julie Maltzman, M.D.**
Chief Medical Officer

Genentech
morphotek
ICONOVIR BIO



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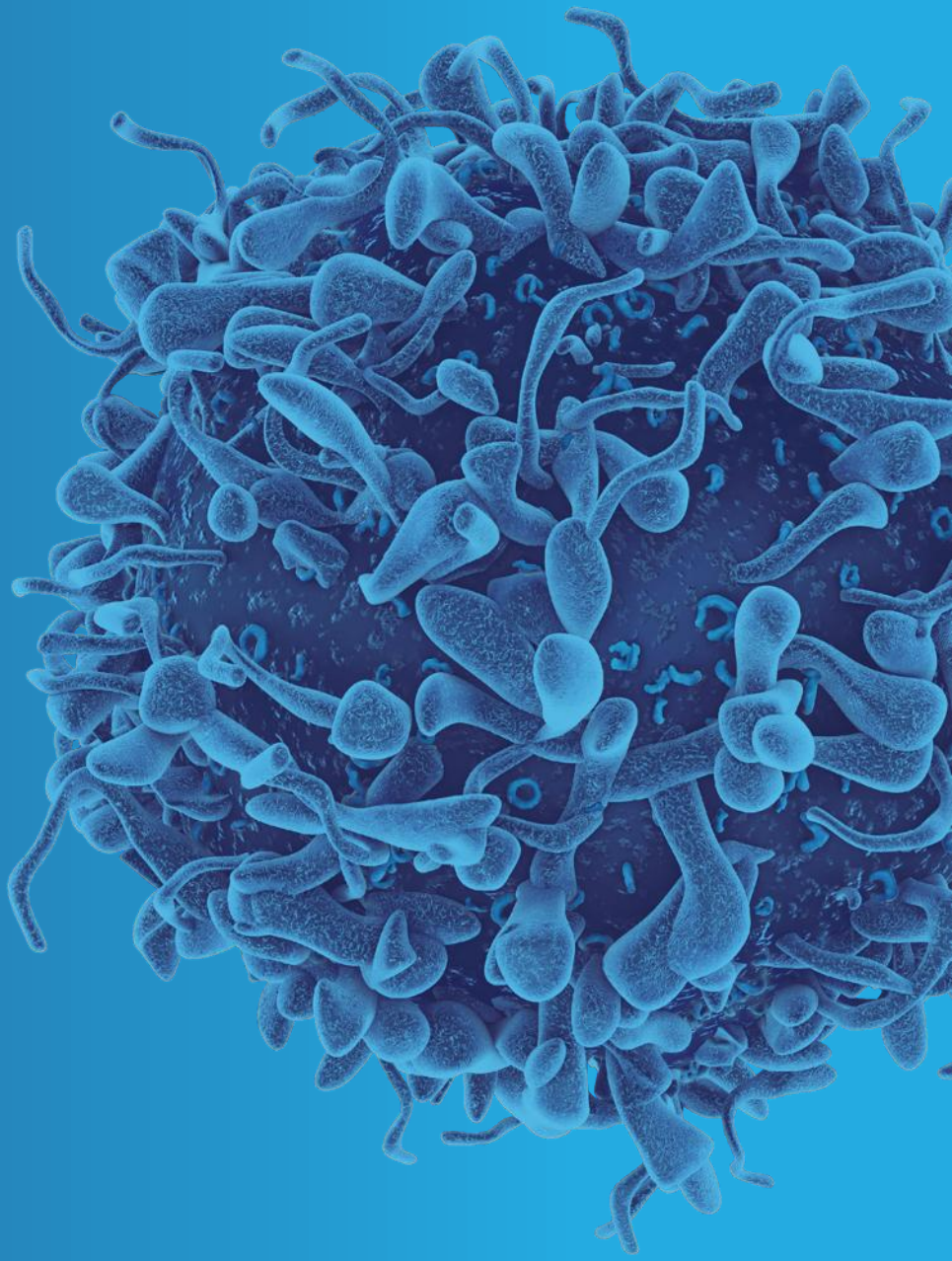
# Prula-cel

## A Transformational Approach to Treating Autoimmune Disorders



# Prula-cel Data Summary

- **Rapid and sustained reductions in SLEDAI-2K and PGA** across all patients
- **Improved kidney function** in all five LN patients, including three complete renal responses (and DORIS remissions) and two partial renal responses
- **Well tolerated**: No ≥Gr2 CRS, no ICANS, 1 low grade infection
- **Clear evidence of immune reset** with subsequent emergence of naïve B cells repertoire following single treatment
- **All patients discontinued immunosuppressants and tapered corticosteroids to zero or physiological levels**

Cut-off date: August 31, 2025; Data cut includes 7 patients with a follow-up ranging from 2-9 months.

DORIS= Definitions of remission in SLE initiative



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# Major Unmet Needs in LN/SLE Remain

**Limited disease control with existing therapies**

- **Treatment-free remissions are rare**
- **Flares are common** despite chronic therapy, reflecting ongoing disease activity
- **Increased early mortality** due to organ damage, cardiovascular disease, infections, renal disease and other causes

**Significant side effects associated with chronic therapies**

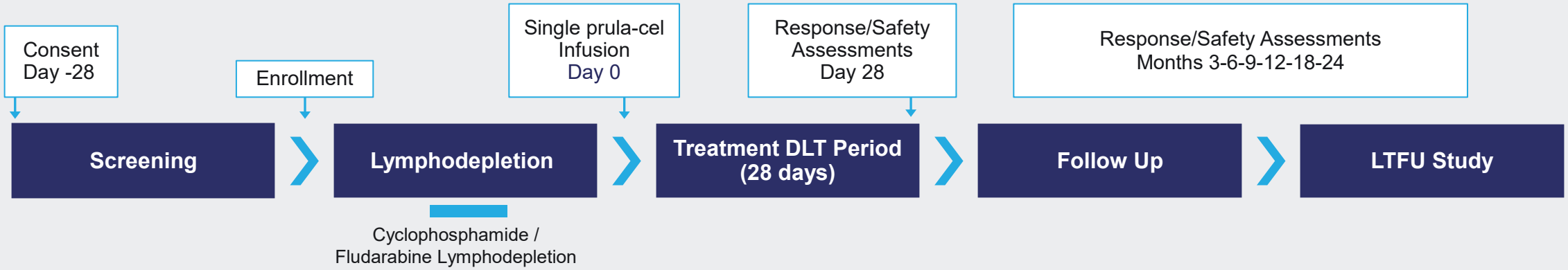
- **Current chronic therapy with high dose corticosteroids and immunosuppressants associated with serious side effects** - infections, bone fractures and diabetes
- Disease and chronic therapies **negatively impact patients' QoL -** fatigue, emotional problems, rash, pain and ability to work

Need for one-time therapy with favorable safety profile that can deliver treatment-free remissions



QoL= Quality of life

# Prula-cel Phase 1 Autoimmune Study Design




## Part 1: Advancing study in multiple cohorts

- LN / SLE
- SSc
- IIM/ SPS
- AAV

3+3 design
1E8 starting dose*

## Part 2

**Dose Expansion Cohorts**

*The starting study dose was amended for all other cohorts to 3E8 with potential to escalate up to 1E9 (based on 3+3 design); DLT= Dose-limiting toxicity; LTFU= Long term follow up



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# Prula-cel Phase 1 Autoimmune Study Endpoints

**Primary Endpoints**

Incidence of treatment-emergent adverse events (TEAEs), including severity, seriousness and relatedness

Incidence of DLTs at each dose (in Part 1 only)

**Secondary & Exploratory Endpoints**

## Pharmacodynamic endpoints:

- Dynamics of B cell depletion and reconstitution; immune reset
- Dynamics of host immune cell recovery in peripheral blood
- Autoantibody titers
- Cellular kinetics

## Efficacy endpoints:

- LN: CR/PR based on kidney function
- SLE: SLEDAI-2K/DORIS remission
- SSc: CRISS score, mRSS in diffuse cutaneous, FVC% predicted in ILD
- IIM: changes in MMT-8 and muscle enzymes, Total Improvement Score
- DM: CDASI
- SPS: Distribution of Stiffness Index, Timed 25-foot walk, Rankin scale
- AAV: CR per BVAS



BVAS= Birmingham Vasculitis Activity Score; CRISS= American College of Rheumatology Composite Response Index in Systemic Sclerosis; ; CR= Complete response; CDASI= Cutaneous Dermatomyositis Disease Area and Severity Index; DORIS= Definition of remission in systemic lupus erythematosus; DM= Dermatomyositis; FVC% predicted= Percent predicted forced vital capacity; IIM= Idiopathic inflammatory myopathies; ILD= Interstitial lung disease; MMT-8 = Manual muscle test-8; mRSS = Modified rodnan skin score; PR= Partial response; SLEDAI-2K = Systemic lupus erythematosus disease activity index 2000; SPS= Stiff person syndrome

# Patient Baseline Characteristics

| | LN-1 | LN-2 | LN-3 | LN-4 | LN-5 | SLE-1 | SLE-2 |
|---|---|---|---|---|---|---|---|
| Disease | LN (Class III) | LN (Class III) | LN (Class III/V) | LN (Class IV) | LN (Class III/V) | Non-Renal SLE | Non-Renal SLE |
| Dose | 1E8 | 1E8 | 1E8 | 3E8 | 3E8 | 1E8 | 3E8 |
| Age / Sex | 48 / F | 37 / M | 32 / F | 32 / F | 22 / F | 46 / M | 37 / F |
| Disease duration (SLE/LN; y) | 4/3 | 22/8 | 6/4 | 10/3 | 2/2 | 2/-- | 17/-- |
| Autoantibodies | ANA+ | ANA+ antidsDNA+ | ANA+ antidsDNA+ | ANA+ antidsDNA+ | ANA+ antidsDNA+ | ANA+ | ANA+ antidsDNA+ |
| SLEDAI-2K | 13 | 14 | 14 | 14 | 16 | 14 | 12 |
| UPCR | 2.05 | 1.64 | 4.78 | 2.56 | 2.78 | 0.21 | 0.06 |
| # of prior therapies | 3 | 4 | 7 | 4 | 5 | 4 | 4 |
| Corticosteroid dose (mg Pred equiv/day) | 10 | 10 | 15 | 20 | 5 | 7.5 | 15 |



Cut-off date: August 31, 2025

Data cut includes 7 patients with a follow-up ranging from 2-9 months; ANA= antinuclear antibodies; dsDNA= Anti-double stranded DNA; UPCR= Urine protein-to-creatinine ratio

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# Well-Tolerated Safety Profile: Appropriate for Dosing in Outpatient Setting

| | 1E8 | 3E8 | All dose levels |
|---|---|---|---|
| **# of Patients** | 4 | 3 | 7 |
| **SAEs** | -- | -- | -- |
| **CRS** | 1 (Grade 1) | 1 (Grade 1) | 2 (28%) |
| **ICANS** | 0 | 0 | 0 |
| **Infections** | 1 (Grade 1) | 0 | 1 (14%) |

- Both cases of CRS were Grade 1 (fever)
- Infection was Grade 1 (respiratory tract infection)
- No cases of GvHD, HLH-MAS or prolonged neutropenia



Cut-off date: August 31, 2025
Safety assessment was performed using the Common Terminology Criteria for Adverse Events (v5) and the American Society for Transplantation and Cellular Therapy criteria (Lee 2018); CTCAE v5 Common Terminology Criteria for Adverse Events (CTCAE); Lee DW. Biol Blood Marrow Transplant. 2019 Apr;25(4):625-638; CRS= Cytokine release syndrome; GvHd= Graft vs host disease; Hemophagocytic lymphohistiocytosis (HLH) - Macrophage activation syndrome (MAS);

# Prula-cel Tolerability Profile Compares Favorably With Autologous αβ CAR-T Therapies in Autoimmune Patients

| | Prulacabtagene leucel (Prula-cel) | BMS-986353[1] | Rapcabtagene autoleucel (Rap-cel)[2] | Obecabtagene autoleucel (Obe-cel)[3] | Resecabtagene autoleucel (Rese-cel)[4] |
|---|---|---|---|---|---|
| **# of Patients** | 7 SLE/LN | 26 SLE/LN (@RP2D) | 21 SLE/LN | 6 LN | 9 SLE/LN |
| **CRS (any Gr / ≥Gr3)** | 28% / -- | 77% / 4% | 57% / -- | 50% / -- | 33% / -- |
| **ICANS (any Gr / ≥Gr3)** | -- / -- | 4% / -- | 5% / -- | -- / -- | 11% / 11% |
| **Infections (any Gr / ≥Gr3)** | 14% / -- | 15% / Not reported | 71% / 5% | 100% / 33% | Not reported* |

Prula-cel safety profile is appropriate for dosing in outpatient setting


1. Schett et al. ACR 2025
2. Morand et al. EULAR 2025
3. Leandro M. et al. ACR 2025
4. Sheikh et al. ACR 2025


* CABA only reports 'Serious infections";
These data are derived from different trials at different points in time, with differences in trial design, including endpoints, and patient populations. As a result, cross-trial comparisons cannot be made, it is only provided for illustrative purposes, and no head-to-head clinical trials have been conducted.
Cut-off date: August 31, 2025.



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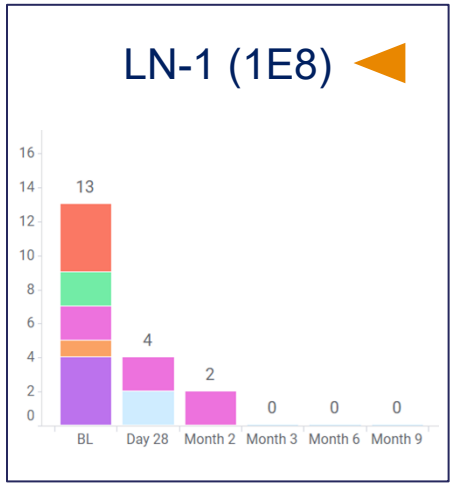
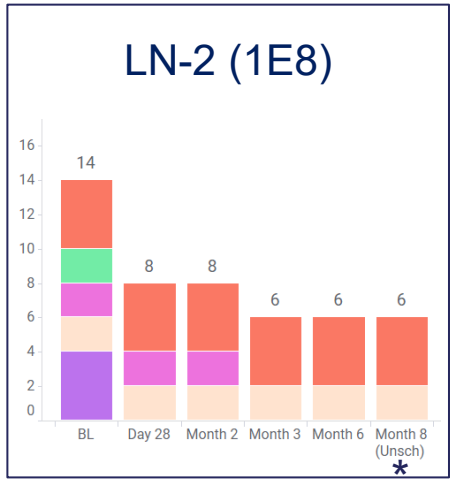
# All Five LN Patients Achieved Renal Responses, Including Three Complete Responses & DORIS Remissions

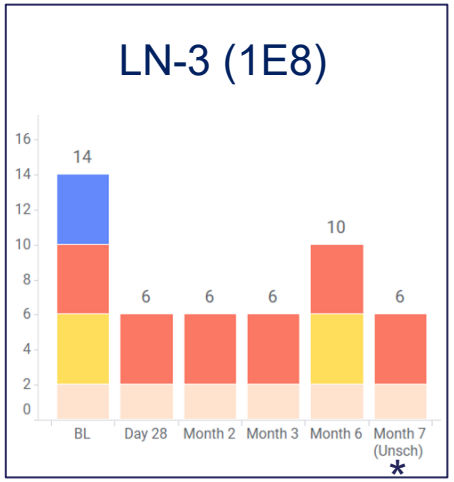
| | | UPCR | | eGFR | | Renal response^ | DORIS Remission |
|---|---|---|---|---|---|---|---|
| Subj# | Follow-Up (Months) | Baseline | Last Follow Up | Baseline | Last Follow Up | | |
| LN-1 | 9 | 2.05 | 0.05 | 87 | > 90 | CRR at M1 | DORIS at M6 |
| LN-2 | 8 | 1.64 | 0.67 | 89 | 79 | PRR at M8 | |
| LN-3 | 7 | 4.78 | 1.05 | 89 | 60 | PRR at M7 | |
| LN-4 | 6 | 2.56 | 0.33 | > 90 | > 90 | CRR at M5 | DORIS at M5 |
| LN-5 | 2 | 2.78 | 0.16 | > 90 | > 90 | CRR at M2 | DORIS at M2 |

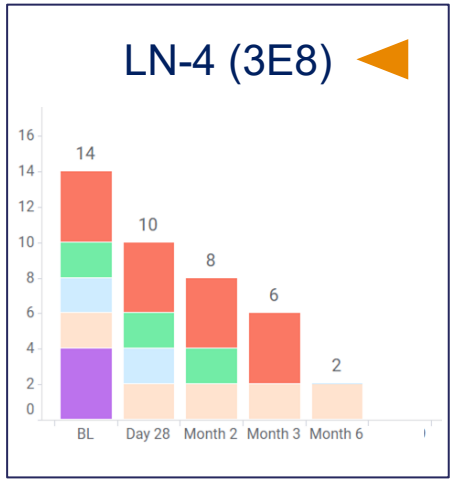
^ Complete Renal Response (CRR)= UPCR ≤0.5 & EITHER eGFR ≥60 mL/min/1.73m$^2$ OR no confirmed decrease from baseline in eGFR of >15% and no treatment or disease related eGFR-associated event; Partial Renal Response (PRR)= Reduction in baseline UPCR of ≥50% & final UPCR >0.5 to ≤3.0; DORIS Remission= Clinical SLEDAI (irrespective of serology)= 0 AND Physician global assessment score < 0.5; the subject may be on antimalarials, low-dose glucocorticoids (prednisolone ≤ 5 mg/day), and/or stable immunosuppressives including biologics; Cut-off date: August 31, 2025.

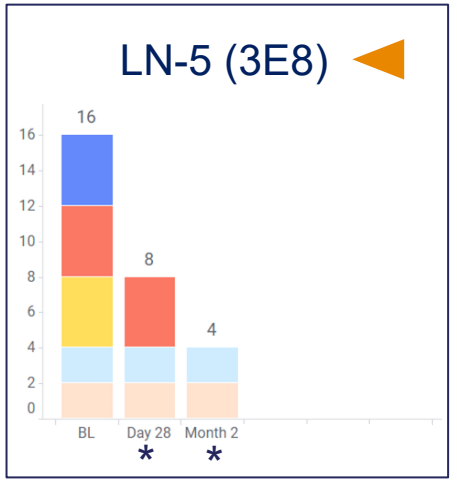
# Significant Decline in SLEDAI-2K Across All Patients Highlights Prula-cel Durable Effect On Broad Range of Lupus Symptoms

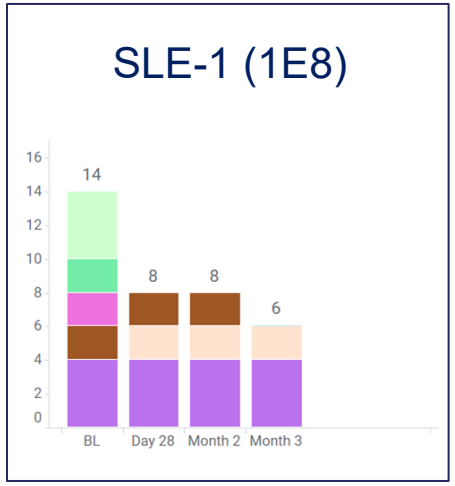




Myositis (4)
Hematuria (4)
Proteinuria (4)
Pyuria (4)
Rash (2)
Alopecia (2)
Pericarditis (2)
Low complement (2)
Anti-dsDNA Positive (2)
Fever (1)
Arthritis (4)
Patient in DORIS remission

* *Unavailable Anti-dsDNA and/or Complement samples were assumed present in SLEDAI scores (conservative assumption)*



Cut-off date: August 31, 2025

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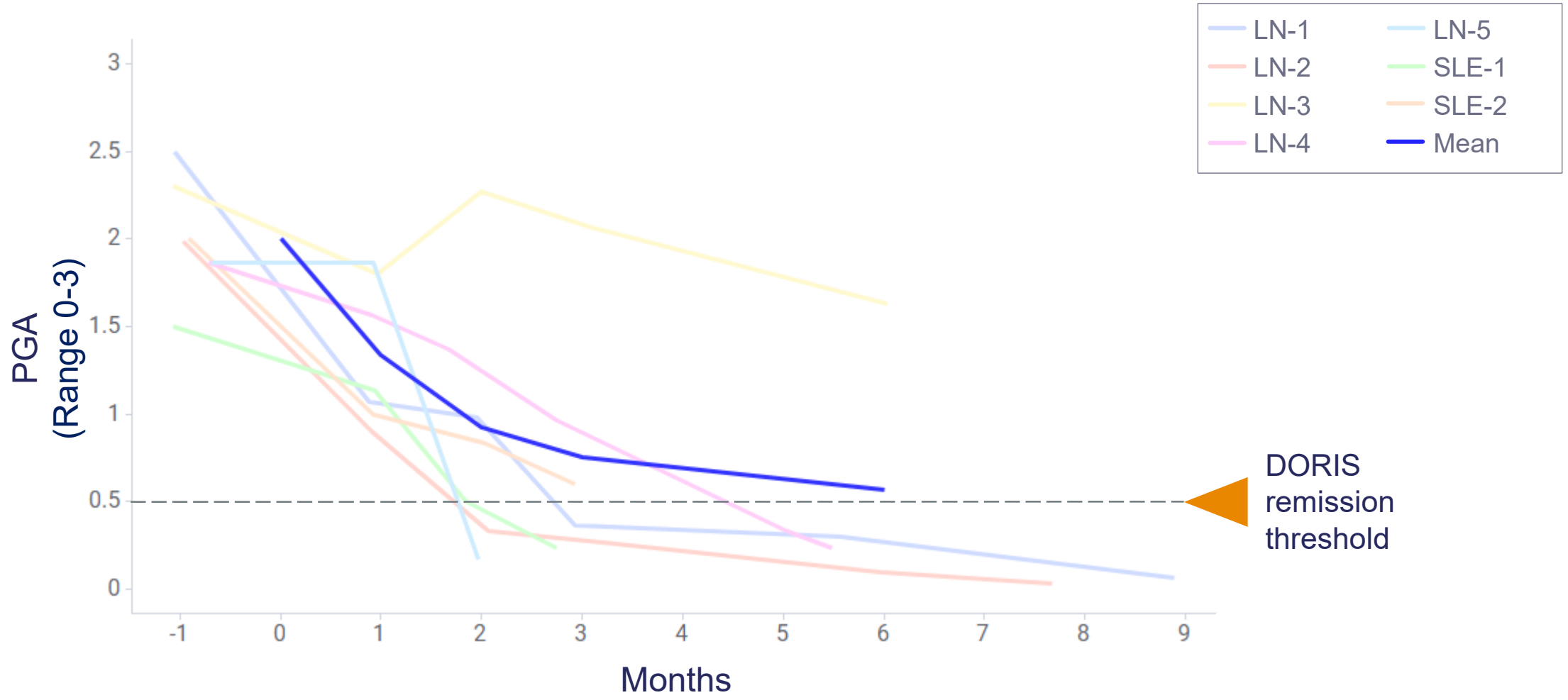
# Rapid and Sustained Reductions in PGA Across All Patients Further Highlight Prula-cel's Impact On Overall Disease Activity




Cut-off date: August 31, 2025; PGA= Physician Global Assessment



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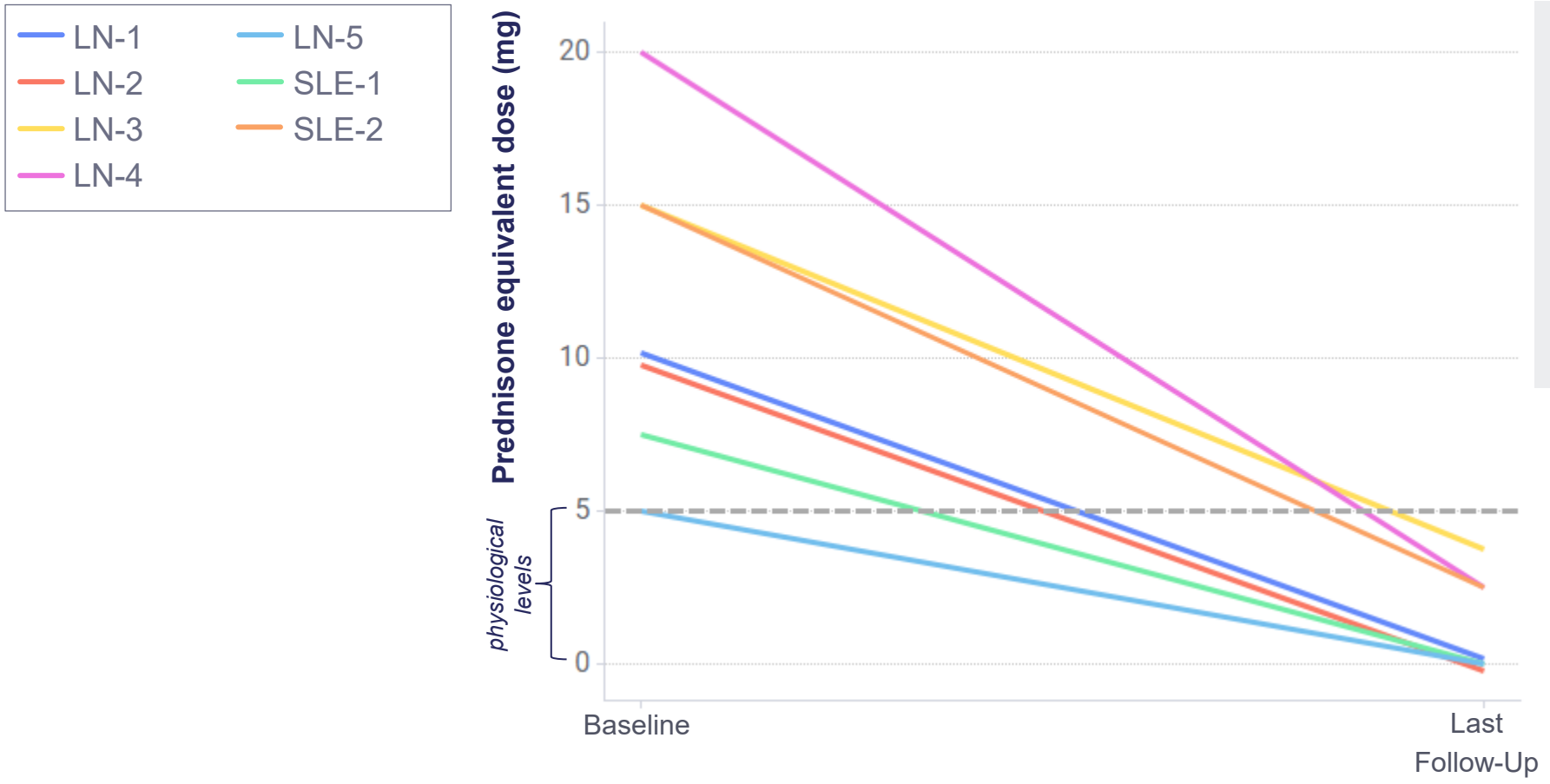
# All Patients Discontinued Immunosuppressants and Discontinued or Tapered Steroids to Physiological Levels




- All patients discontinued immunosuppressants
- Four/seven patients discontinued corticosteroids
- Remaining three/seven patients tapered to physiological levels



Cut-off date: August 31, 2025; Data cut includes 7 patients with a follow-up ranging from 2-9 months

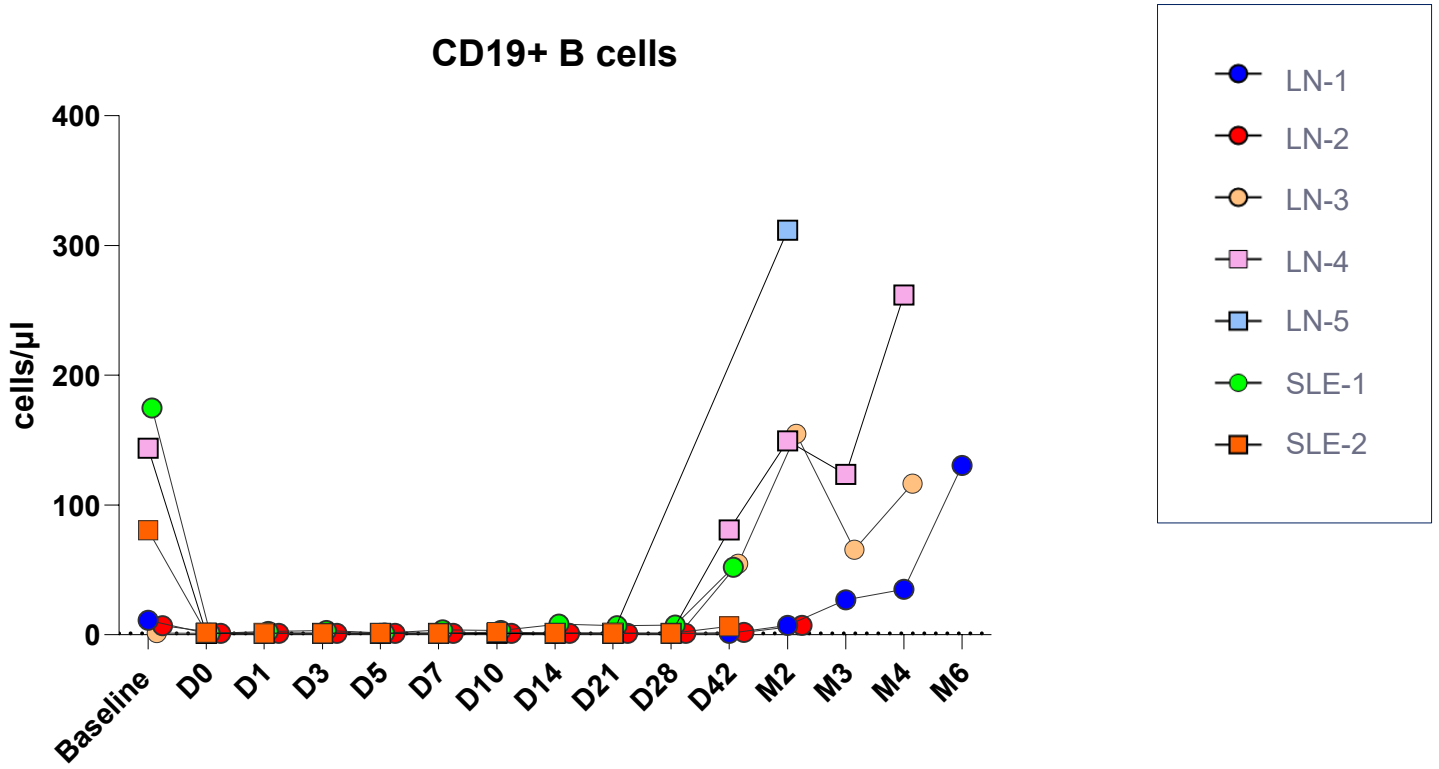
# Prula-cel Demonstrated Hallmarks of Immune Reset

- Deep and Broad B Cell Depletion
- Reconstitution Driven by Naïve, Non-Class Switched B Cells
- Depletion of Clonally Dominant and Potentially Pathogenic Clones
- Emergence and Diversification of New BCR Repertoire



BCR= B-cell receptor; Cut-off date: August 31, 2025; Data cut includes 7 patients with a follow-up ranging from 2-9 months.

# Deep and Broad B Cell Depletion Following Prula-cel Treatment




In all patients, B cells were undetectable post-treatment with Prula-cel

*Circles = 1E8 dose; squares = 3E8 dose*

Cut-off date: August 31, 2025; Data cut includes 7 patients with a follow-up ranging from 2-9 months.



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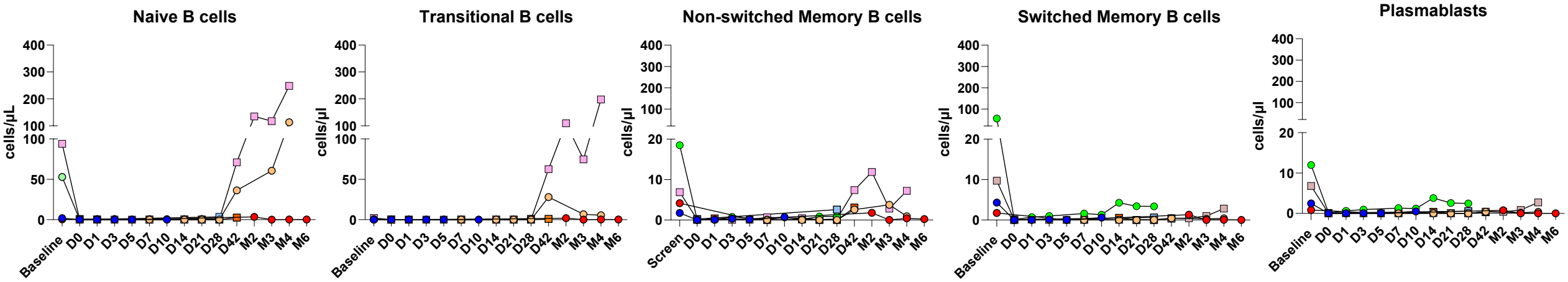
# Reconstitution Driven by Naïve, Non-Class Switched B Cells




- Complete elimination of circulating B cells and plasmablasts
- Reconstitution of naïve B cells observed

*Circles = 1E8 dose; squares = 3E8 dose*



Naïve (CD19+CD20+IgD+CD27-), Transitional (CD19+CD20+IgD+CD27-CD24+CD38+), Pre-class switched memory (CD19+CD20+IgD+CD27+), Memory B cells (CD19+CD20+IgD-CD27+), Plasmablasts (CD19+CD20+/-IgD-CD27highCD38highCD138-); Cut-off date: August 31, 2025; Data cut includes 7 patients with a follow-up ranging from 2-9 months.

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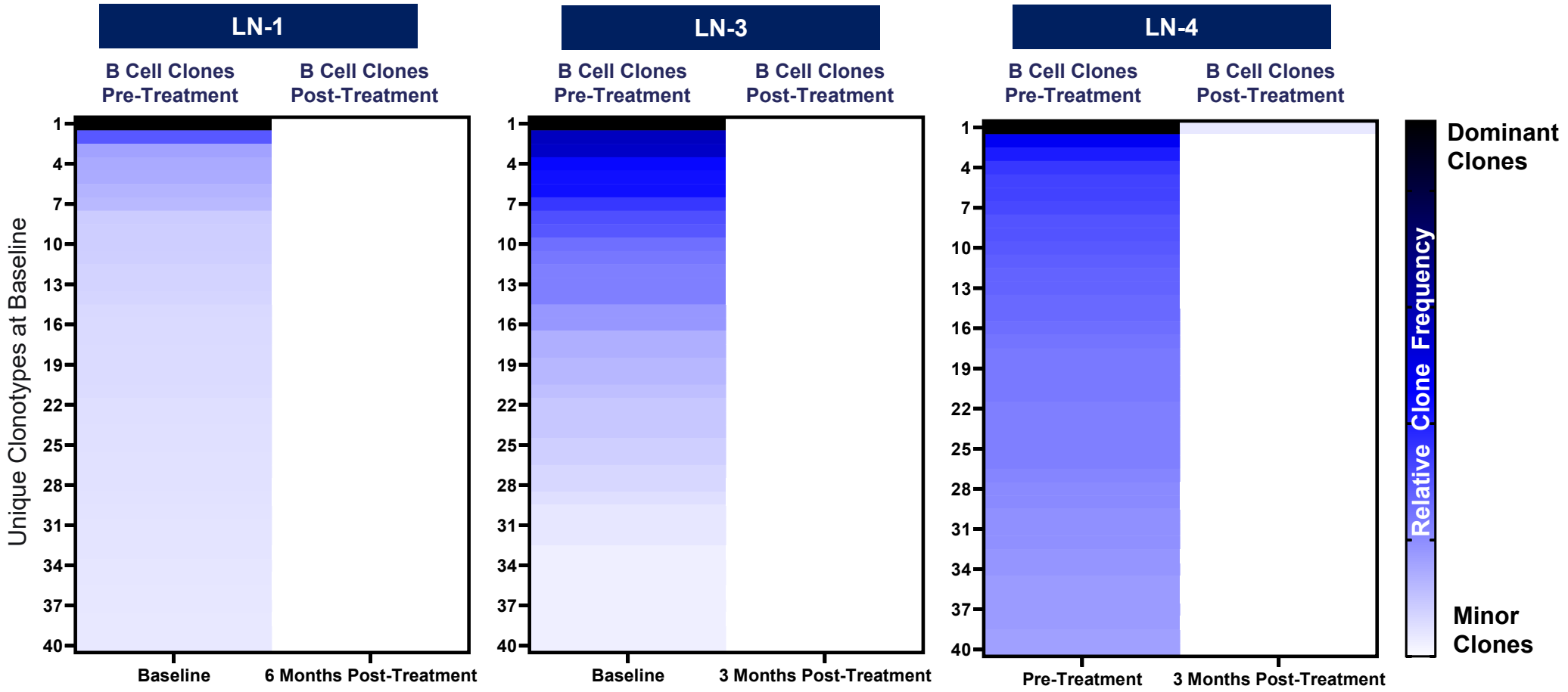
# Dominant BCR Clones Were Depleted Post Treatment with Prula-cel




Depletion of dominant, potentially pathogenic B cell clones present at baseline

Relative Clonal Frequency= B cell receptor (BCR) read count normalized to total population of BCR's detected. As of August 31, 2025, exploratory analysis was initiated and completed on initial subset of 3 patients for which samples were available; Cut-off date: August 31, 2025.



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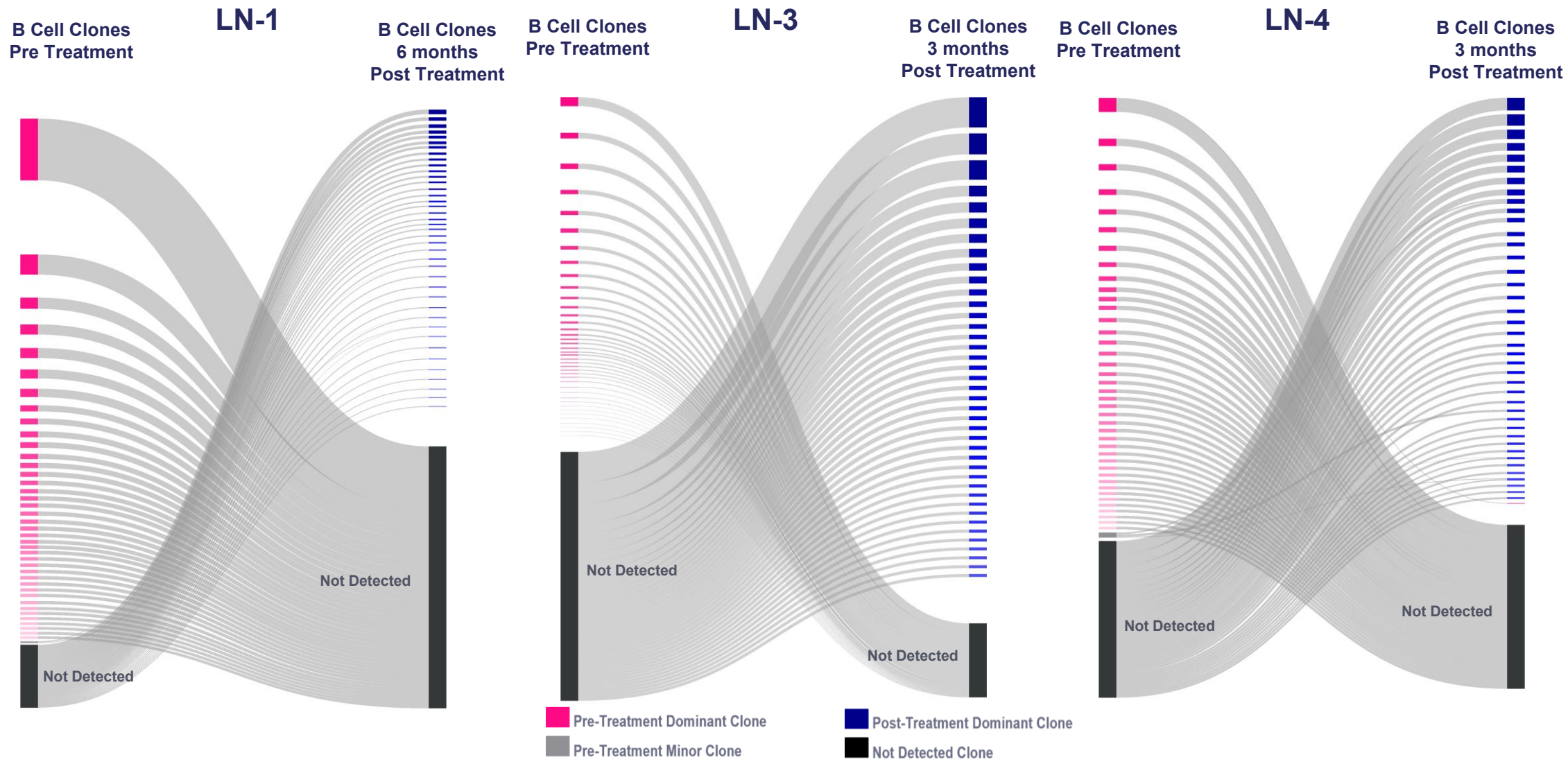
# Immune Reset of Clonally Dominant and Potentially Pathogenic Clones with Emergence of New B Cell Repertoire




Post Treatment= 3 Months (LN-3 and LN-4) or 6 Months (LN-1); Tracking of dominant BCR clonotypes pre- and post-treatment. Node sizes are proportional to clone read count at each timepoint.
Dominant Clones= Most abundant detectable clones achieving >1 read counts (cutoff of 40 defined by lowest limits for a sample in the cohort), Minor Clones= Detected clones with read counts below those quantified as dominant.
As of August 31, 2025, exploratory analysis was initiated and completed on initial subset of 3 patients for which samples were available; Cut-off date: August 31, 2025.



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# Prula-cel Phase 1 Clinical Data Suggest a Transformational Approach to Treating Autoimmune Disorders

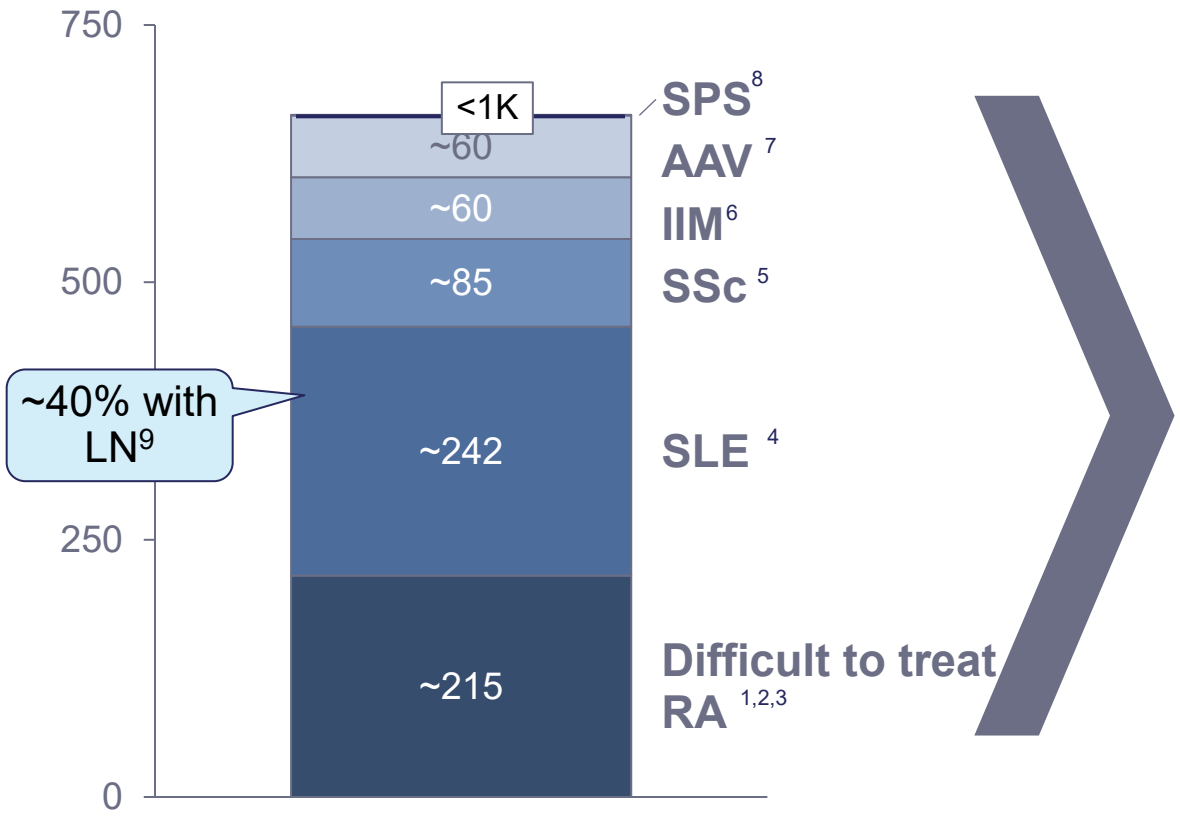
| WHAT WE OBSERVED | WHAT IT MEANS |
| --- | --- |
| Well tolerated safety profile: **No ≥Gr2 CRS, no ICANS** **Appropriate for outpatient administration** | Off-the-shelf with no delay in treatment due to scheduling leukapheresis and the time required for manufacturing |
| Rapid and sustained **reductions in SLEDAI-2K and PGA across all patients (five LN and two SLE)** | Potential for outpatient administration; Off-the-shelf |
| Improved kidney function in all five LN patients, including **three complete renal responses and two partial renal responses** | Potential for one-time therapy |
| Clear evidence of immune reset with subsequent emergence of naïve B cell repertoire following single treatment | Discontinuation of chronic immunosuppression and discontinuation or reduction to below physiological levels of corticosteroids |
| All patients discontinued immunosuppressants and **tapered corticosteroids to zero or physiological levels** | Prevent progression to chronic renal failure in LN |
| 'Off-the-shelf' availability and **no need for leukapheresis** | |



Cut-off date: August 31, 2025; data cut includes 7 patients (5 LN; 2SLE) with a follow up ranging from 2-9 months

# Expanding Prula-cel Development Across Seven Indications

## US Prevalence (thousand patients)




Prula-cel has the potential to change clinical practice across multiple autoimmune indications



1. Hunter TM et al. Rheumatol Int. (2017)
2. Xu Y & Wu Q J Clin Med. (2021)
3. Hofman ZLM et al. Rheumatology (2024)
4. Helmick CG et al. Arthritis & Rheumatism (2008)
5. Bairkdar M et al. Rheumatology (2021)
6. Lundberg IE et al. Nature Reviews (2021)
7. Berti A et al. Arthritis & Rheumatology (2017)
8. Ortiz JF et al. Cureus (2020)
9. Morales E et al. Nephron (2021)

This slide has not been updated to include RA patient population; Numbers are under review

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# Prula-cel Phase 1 RA Randomized Controlled Study Design

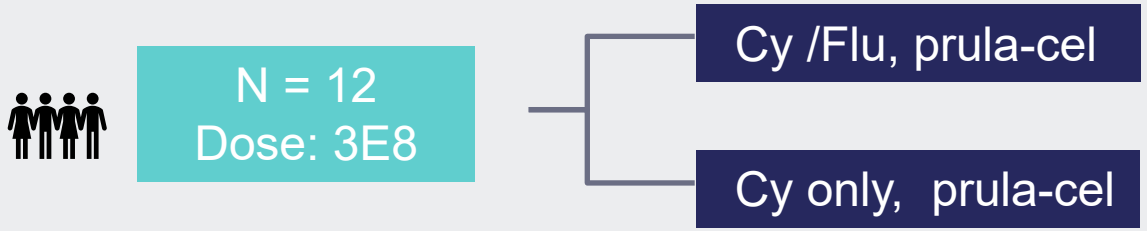
## Primary Endpoints

- Incidence of TEAEs, including severity, seriousness, and relatedness
- Incidence of DLT

## Secondary & Exploratory Endpoints

- Pharmacodynamics: B cell depletion in subjects who received Cy/Flu LD compared to Cy-only LD
- Cellular kinetics
- Efficacy
  - Proportion of subjects who achieve DAS28-ESR remission and are DMARD-free at week 12
  - DAS28-CRP remission and DMARD-free at week 12
  - SDAI remission and DMARD-free at week 12

## Evaluating Potential to Reduce Need for Reconditioning




**Potential to escalate to 1E9 following first 6 patients*



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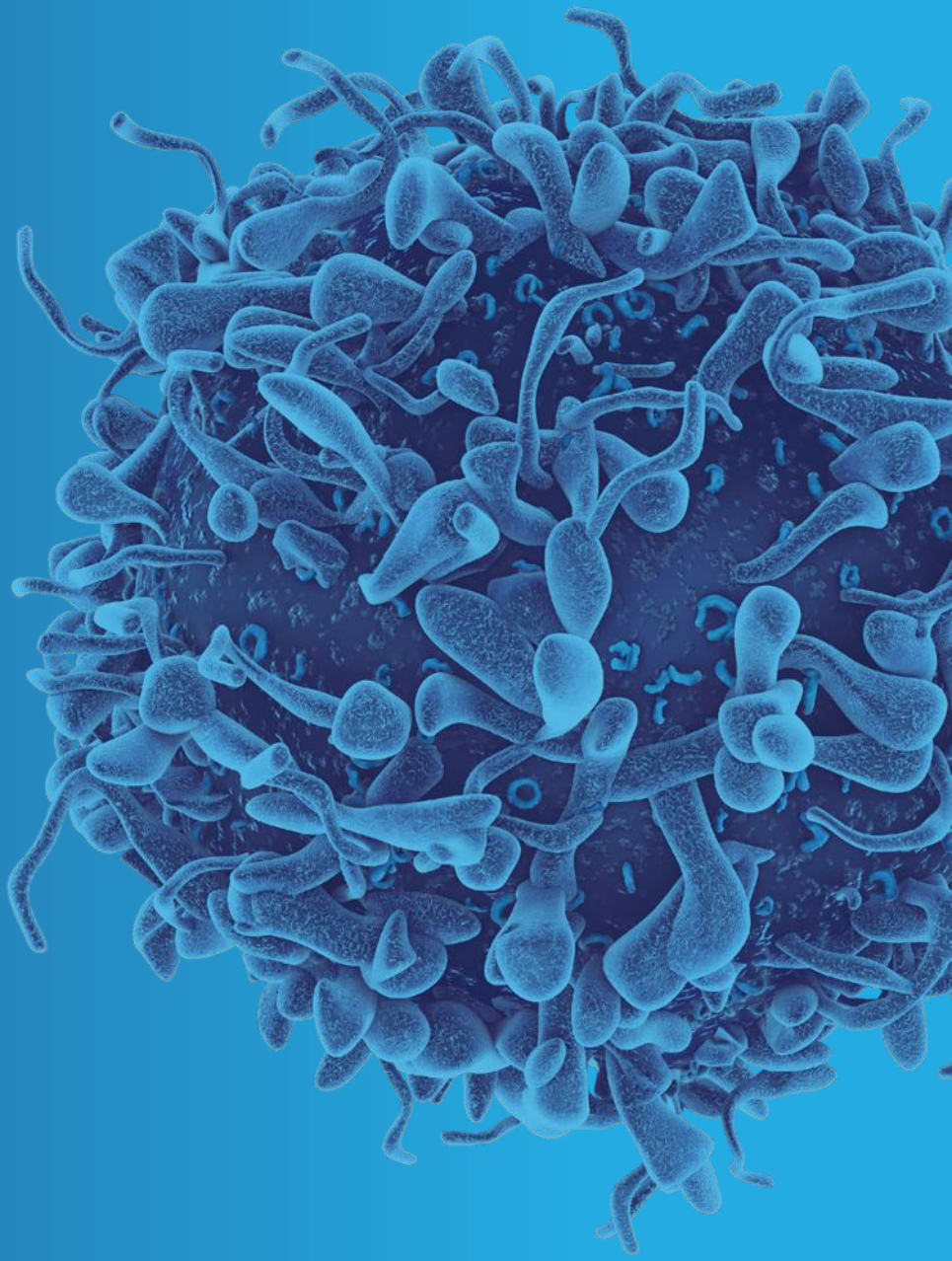
# ADI-212
## Prostate Cancer



# ADI-212: Next Generation γδ CAR T Candidate Targeting PSMA

## ADI-212: Differentiated

- Optimized, next-generation, gene-edited and armored, γδ1 CAR T program
- Inclusion of multi-functional armoring to address suppressive TME
- Designed to enhance potency in solid tumors and deliver multiple anti-tumor mechanisms of action to tumor microenvironment

## Preclinical Studies Underway to Support Regulatory Filing

- Non-clinical toxicology
- Pharmacology and immunotoxicity safety assessments
- GMP manufacturing

## Opportunity for Adicet and γδ T cells

- **Differentiated mechanisms of action for improved potency and tumor-cell killing capacity in tumor microenvironment** compared to previous generation αb and γδ CAR T programs in oncology
- **Homing** of γδ 1 T cells to tumors well documented
- **Favorable safety**, tolerability, CRS and ICANS profile compared to alpha-beta CAR T in clinical studies to date

**Regulatory Filing 3Q/2026**

**Initiate Enrollment 4Q/2026**

# ADI-212: Significant Market Opportunity in Prostate Cancer

**Well-validated target**

- PLUVICTO® lutetium Lu 177 vipivotide tetraxetan INJECTION FOR INTRAVENOUS USE — PSMA-targeted radiotherapy **has demonstrated clinical benefit in multiple prostate cancer clinical studies**
- Early POC data with cell therapies, T-cell engagers, ADCs, and radiotherapies have also demonstrated clinical efficacy while also highlight need for improved safety profiles

**Significant unmet need**

- **Poor outcomes post AR inhibitors in the mCRPC setting** – retrospective real-world study of >800 AR experienced patients reported a **median rPFS of 7.0 months and OS of 15.1 months** following subsequent therapy[1]
- AR inhibitors (i.e., abitraterone and enzalutamide) and Pluvicto moving into the hormone sensitive setting creating **greater opportunity in the castration resistant setting[2]**

**Substantial market opportunity[3]**

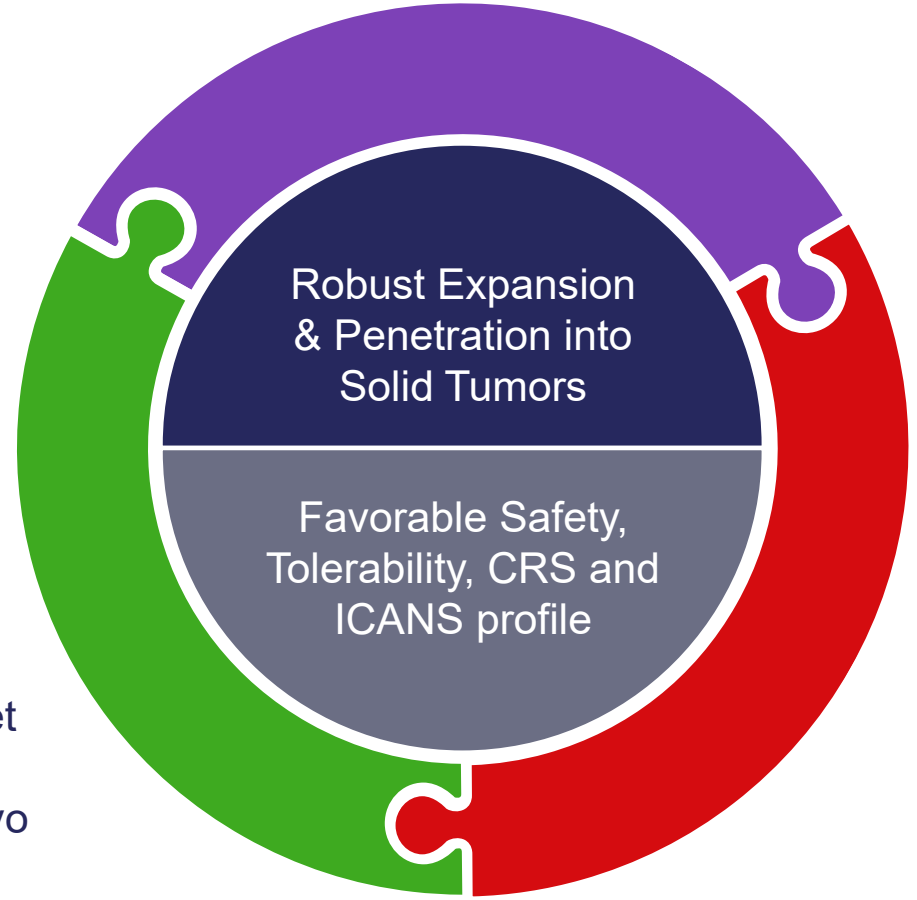
- **~75K 2L+ treated mCRPC patients** (~60K across U.S., JPN & EU5 w/ 15K in China)
- Pluvicto peak sales expected to reach $5B+ globally



[1] DOI: 10.1016/j.clgc.2024.102188; [2] https://www.onclive.com/view/defining-unmet-needs-in-the-management-of-mcrpc; [3] Novartis November 2024; ADC= antibody-drug conjugate; AR= androgen receptor; rPFS= radiographic progression-free survival; OS=overall survival

# Complimentary Technologies to Optimize Potency in Solid Tumors

Adicet's γδ CAR-T cell platform demonstrated superior expansion and tumor penetrating capability while also demonstrating favorable safe and CRS/ICANs profile




## 1 CAR Design

Platform with proven capacity for killing target cells and providing significant level of in vivo product expansion

## 2 Genetic Enhancement

Fundamental rewiring of lymphocyte activation and differentiation pathways to elicit maximum killing and durable function

## 3 Delivery of a Multi-Functional Cytokine

Controlled delivery of chemotactic cytokine:

- Enhanced CAR-T cell potency
- Conversion of a suppressive "cold" tumor microenvironment to "hot"
- Recruitment of multi-functional anti-tumor effector cells



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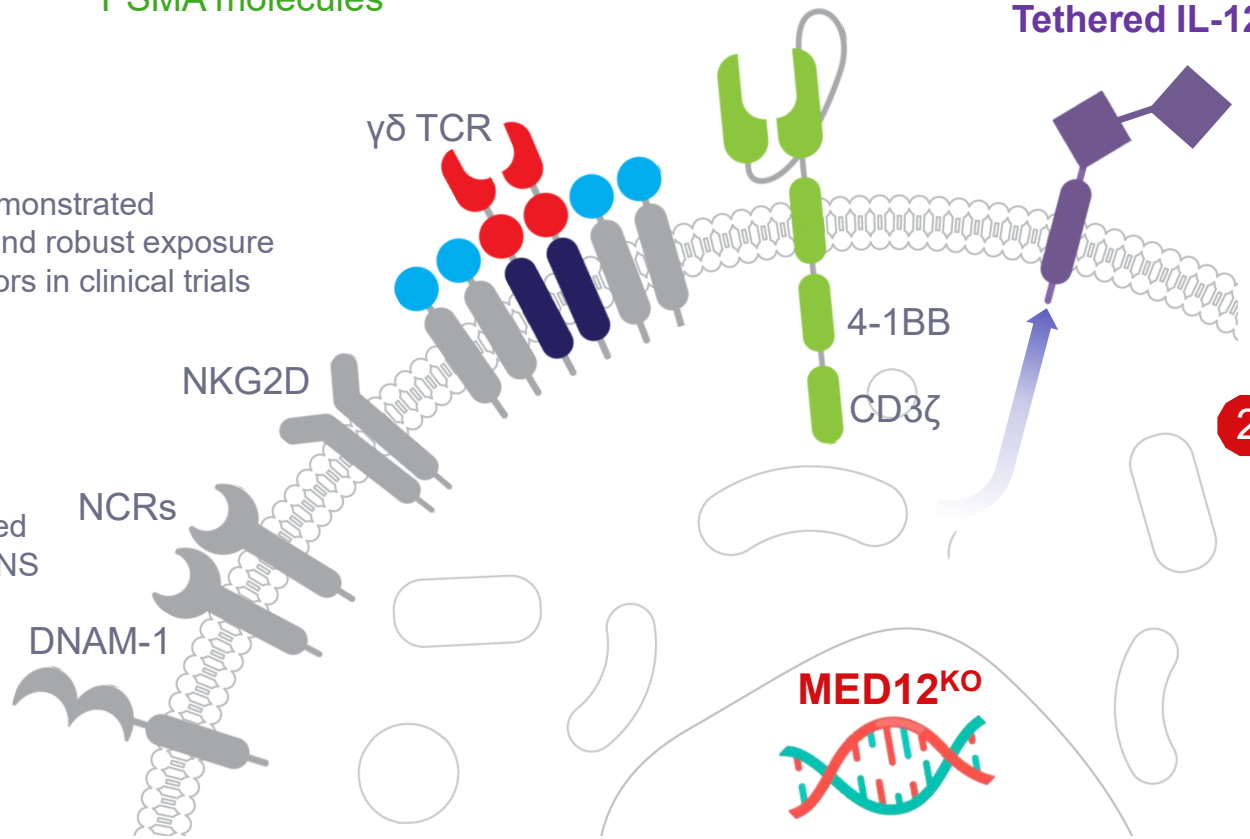
# ADI-212: Gene Edited and IL-12 Armored PSMA CAR T

## 1 PSMA-Directed CAR

with clinically supported binding determinants against functional PSMA molecules




Platform demonstrated consistent and robust exposure in solid tumors in clinical trials

Platform demonstrated low risk for CRS/ICANS in clinical trials

## 3 Tethered IL-12 Cytokine

designed to localize and enhance anti-tumor mechanisms to the tumor microenvironment

- Improved potency & cytotoxicity of CAR-T platform
- Localize IL-12 anti-tumor activity
- Reshape the immunosuppressive microenvironment

## 2 MED12$^{KO}$

for improved potency and tumor-cell killing capacity compared to previous generation alpha-beta and γδ CAR T programs in oncology

- Enhance proliferation and survival
- Improve potency & metabolic fitness advantages



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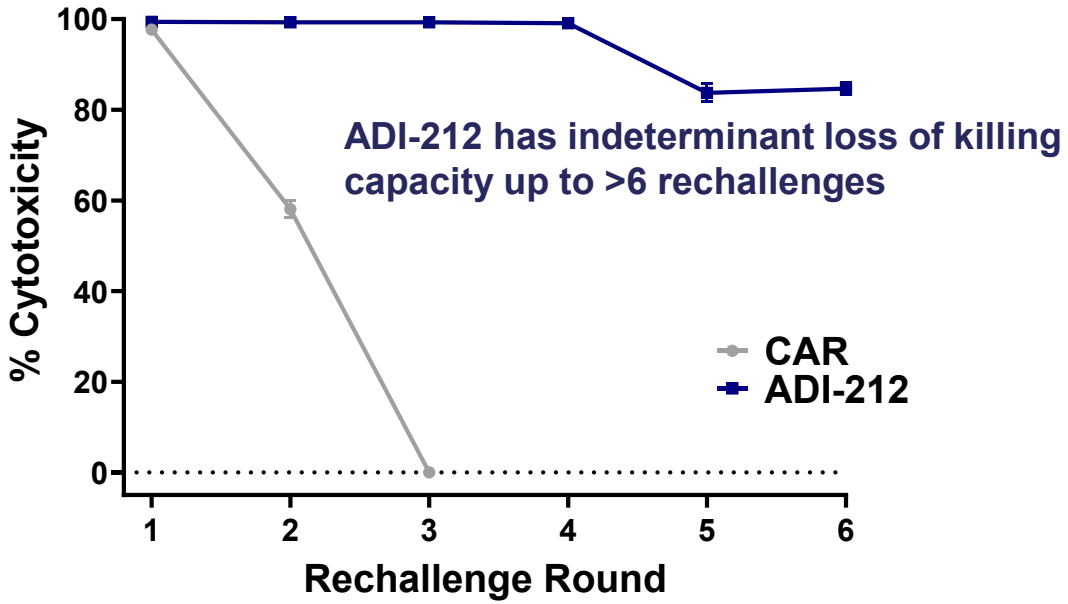
# MED12 KO and mbIL-12 Armoring Enhanced the Potency of ADI-212 in a Tumor Rechallenge In Vitro Assay

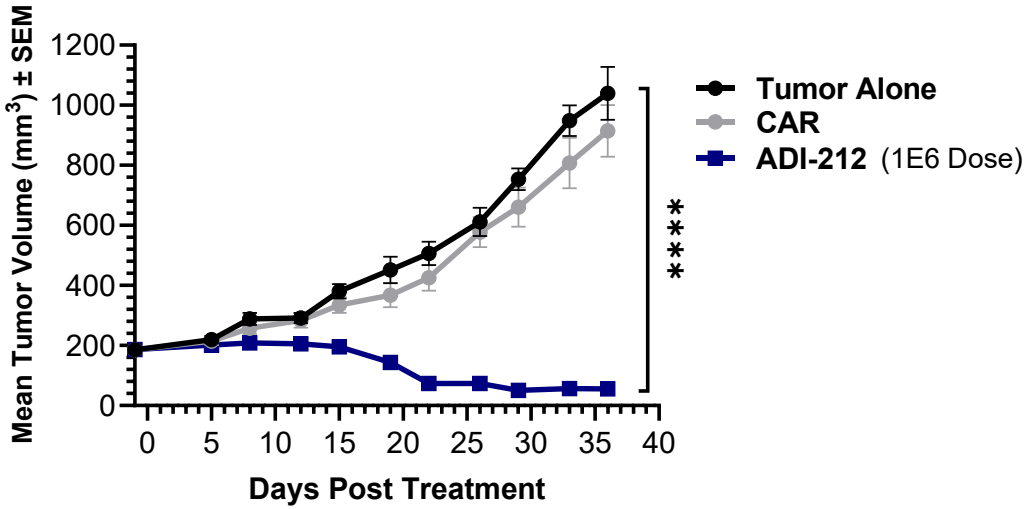
With these technologies, ADI-212 demonstrated the most preclinical activity we have characterized for a clinical development candidate to-date

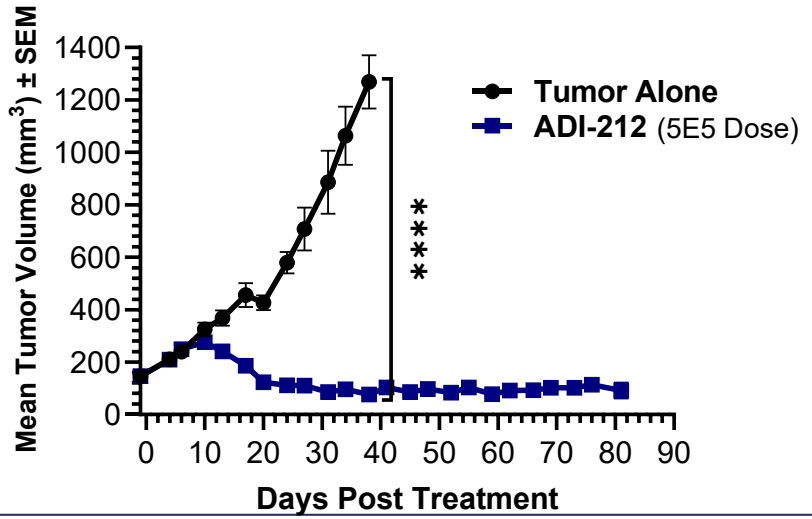
## Durable Cytotoxicity Demonstrated Against PSMA+ Prostate Cancer Cells




3:1 E:T for rechallenge assessments

## Highly Potent as Single Dose in mCRPC Tumor Model



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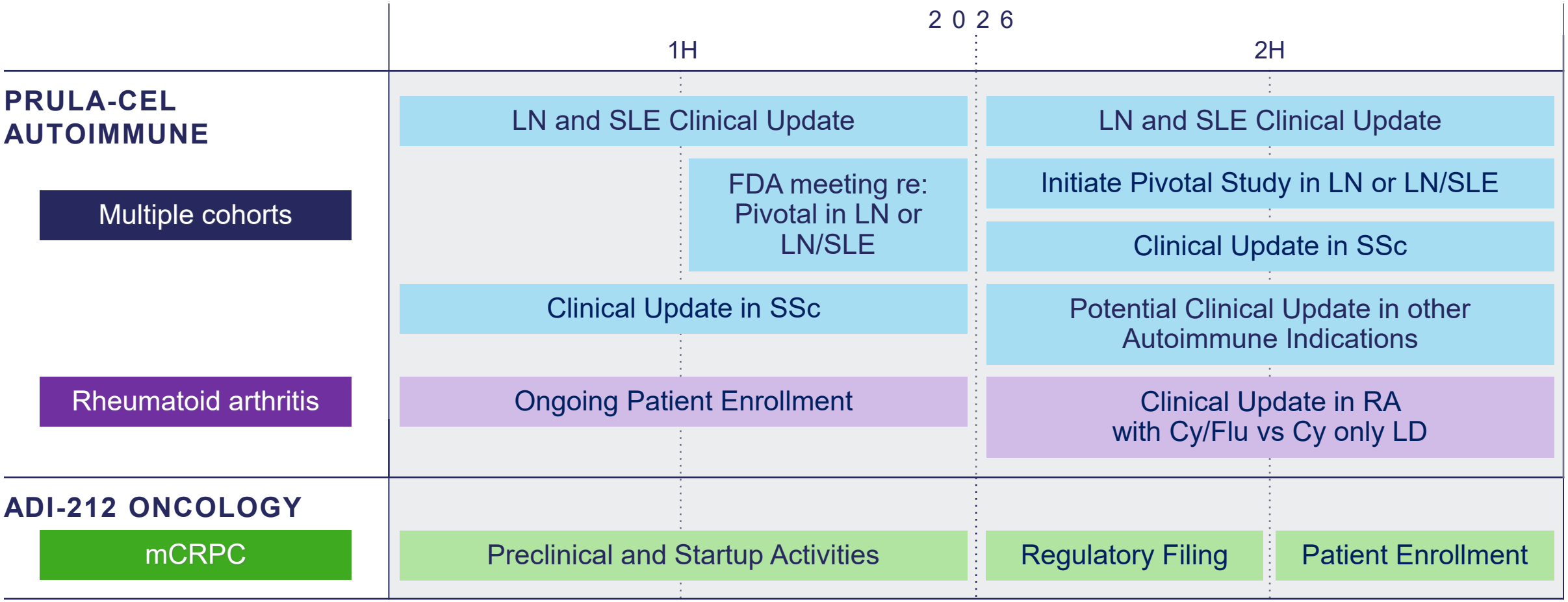
# Upcoming Potential Milestones




Cash and cash equivalents: $158.5M (12/31/25)
Projected cash runway into 2H 2027

Subject to site activation, patient enrollment, data readouts and regulatory feedback



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# Leaders in Developing Allogeneic γδ1 CAR-T Cell Therapies to Fight Autoimmune Diseases and Cancer