



Investor Presentation

August 2026

Adicet Bio

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; expectations regarding future alignment with the FDA on regulatory path to approval and discussions to date; 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 the timing and initiation of a pivotal study for prula-cel in LN or LN and SLE patients; the preclinical and clinical development of ADI-212, including the timing of regulatory filings, clinical startup activities, clinical updates and future data releases; the timing of initiation of enrollment of a Phase 1 trial for ADI-212 in mCRPC; expectations regarding the potential potency of ADI-212; timing of updates to the Company’s *in vivo* CAR T platform pipeline; ongoing preclinical programs and activities relating to autoimmune diseases, hematological malignancies and solid tumors; 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 release, and Adicet undertakes no duty to update this information unless required by law.

Industry and Market Information

Information regarding market share, market position and industry data pertaining to Adicet’s business contained in this presentation consists of estimates based on data and reports compiled by industry professional organizations and analysts and Adicet’s knowledge of their industry. Although Adicet believes the industry and market data to be reliable, this information could prove to be inaccurate. You should carefully consider the inherent risks and uncertainties associated with the market and other industry data contained in this presentation. Forward-looking information obtained from third-party sources is subject to the same qualifications and the additional uncertainties as the other forward-looking statements in this presentation.

Developing Broad Pipeline of Allogeneic $\gamma\delta$ 1 T Cell Therapies for Autoimmune Diseases and Cancer

Program	Target	Indication	Research	IND-Enabling	Clinical	Upcoming Milestones
AUTOIMMUNE DISEASES						
Prula-cel	CD20	LN & SLE				• 3Q/2026 Clinical update (LN/SLE) • 2H/2026 Clinical update (SSc) • 2H/2026 Initiate pivotal study (LN/LN+SLE)
		SSc				
		IIM/ SPS				
		AAV				
		RA				2H/2026 Clinical Update (RA) Enrolling Cy/Flu vs Cy only LD
ONCOLOGY						
ADI-212	PSMA (gene-edited w/ armor) *	mCRPC				Planned regulatory filing 3Q/2026 Initiate study 4Q/26
EARLY-STAGE PROGRAMS						
in vivo CAR T γδ CAR T	Not disclosed	Autoimmune, heme malignancies and solid tumors				2H/2026 Program Updates

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.

Adicet Bio: Leaders in Developing Allogeneic $\gamma\delta$ CAR T Cell Therapies

▶ Adicet's $\gamma\delta 1$ 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 $\geq$ 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 update 3Q/2026**

▶ ADI-212: Next generation, gene-edited and armored anti-PSMA $\gamma\delta 1$ 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**

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.

Adicet Bio Leadership Team



Chen Schor
President and CEO



Don Healey, Ph.D.
Chief Technology
Officer



Blake Aftab, Ph.D.
Chief Scientific Officer



Amy Locke
Head of Human Resources



Nick Harvey
Chief Financial Officer



Lloyd Klickstein, M.D., Ph.D.
Interim Chief Medical Officer



Prula-cel

Autoimmune Indications



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 $\geq$ Gr2 CRS, no ICANS, 1 low grade infection
- **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**

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

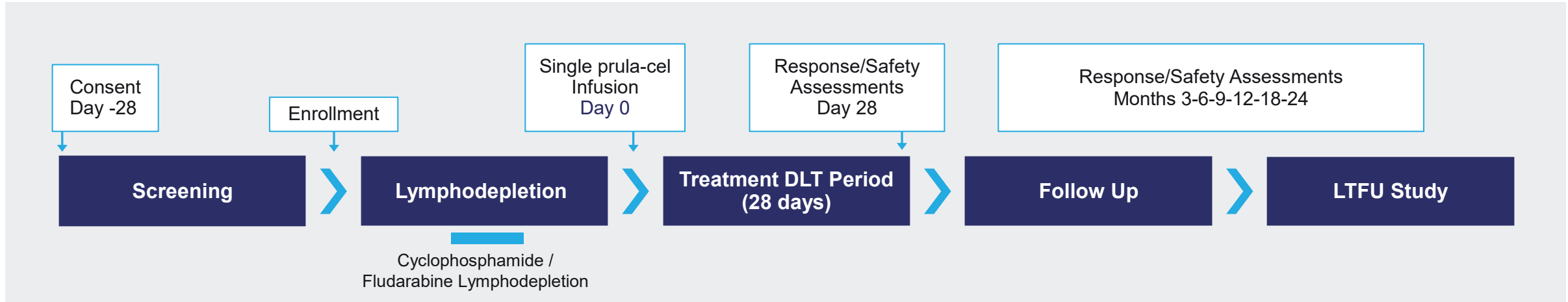
Significant side effects associated with chronic therapies

- **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

Prula-cel Phase 1 Autoimmune Study Design



Part 1: Advancing study in multiple cohorts



3+3 design
1E8 starting dose*



Part 2

Dose Expansion
Cohorts

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: CRIS 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

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/IV)	LN (Class IV)	LN (Class III/IV)	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

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

Prula-cel Tolerability Profile Compares Favorably With Autologous $\alpha\beta$ 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 / $\geq$Gr3)	28% / --	77% / 4%	57% / --	50% / --	33% / --
ICANS (any Gr / $\geq$Gr3)	-- / --	4% / --	5% / --	-- / --	11% / 11%
Infections (any Gr / $\geq$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

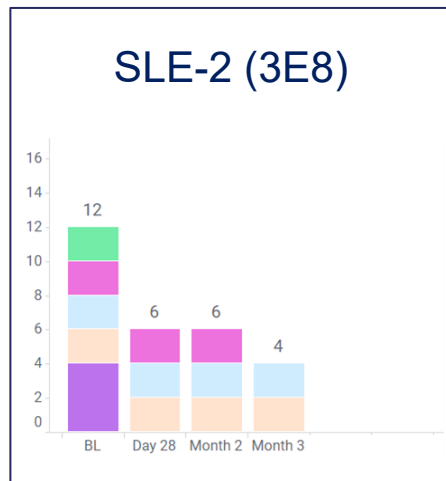
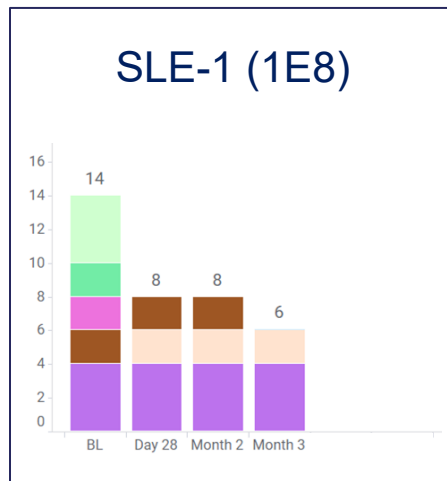
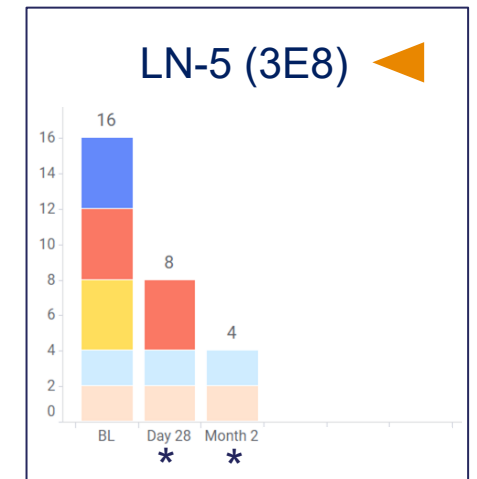
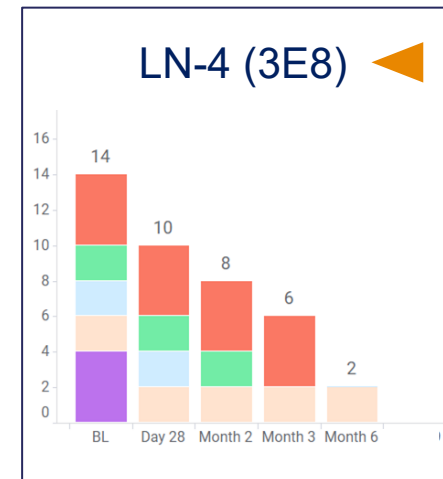
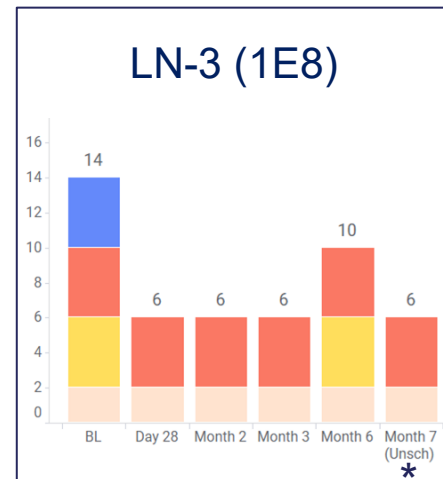
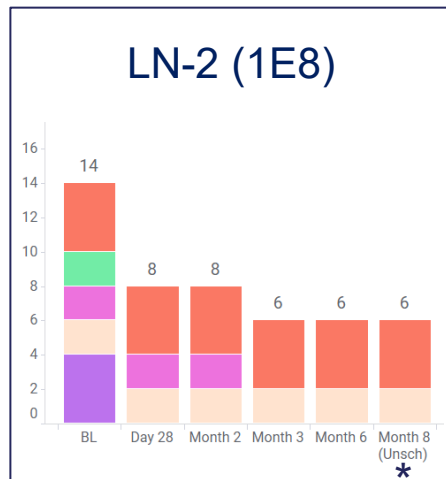
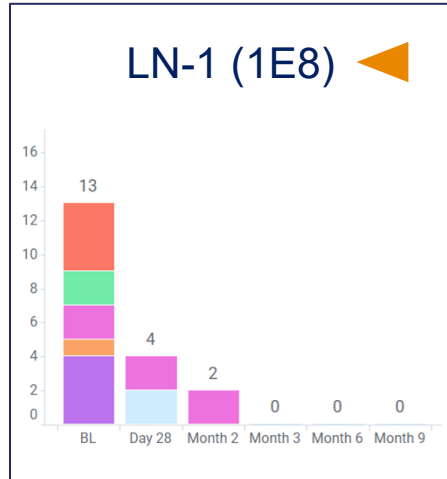
* CABA only reports "Serious infections";
 These data are derived from different trials at different points in time, with differences in trial design, including endpoints, and patient populations. As a result, cross-trial comparisons cannot be made, it is only provided for illustrative purposes, and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

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

Subj#	Follow-Up (Months)	UPCR		eGFR		Renal response [^]	DORIS Remission
		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/1.73m² 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.

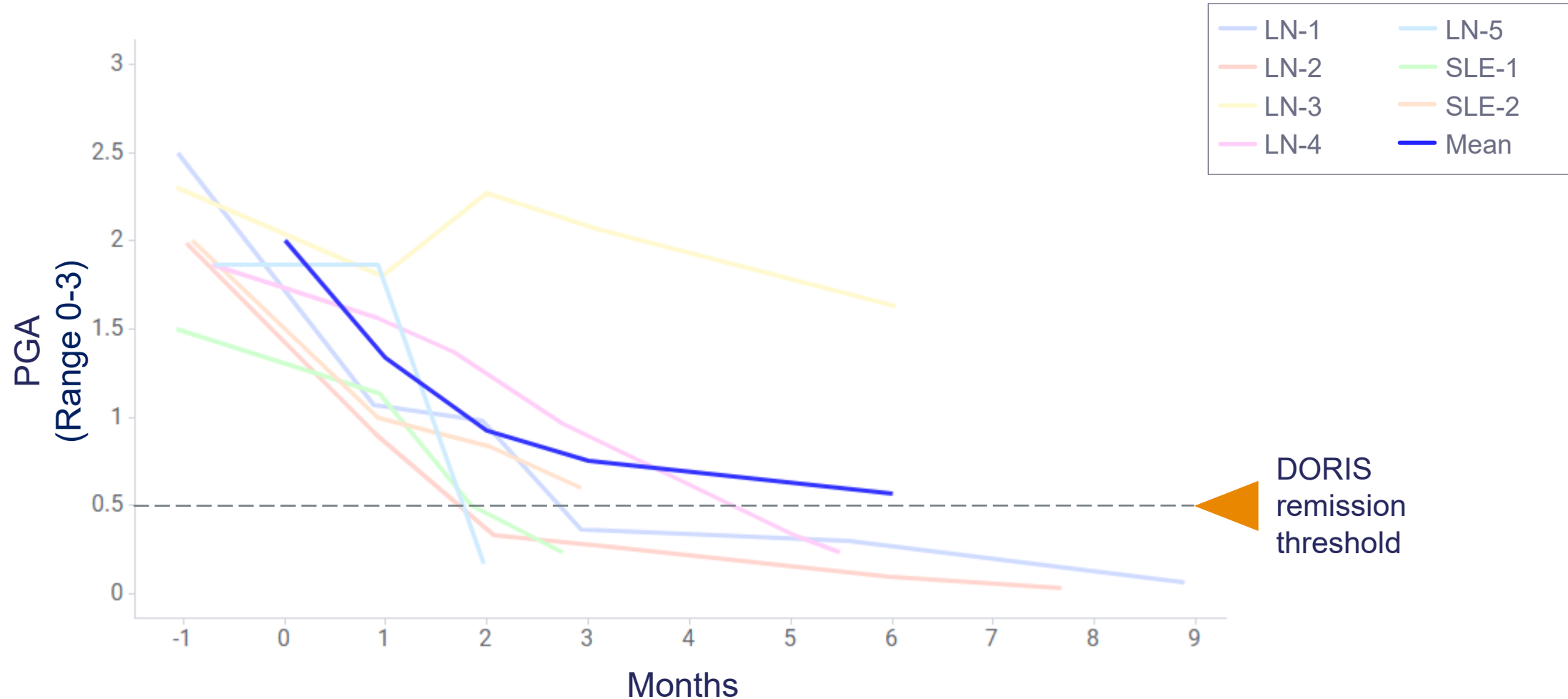
Significant Decline in SLEDAI-2K Across All Patients Highlights Prula-cel Durable Effect On Broad Range of Lupus Symptoms



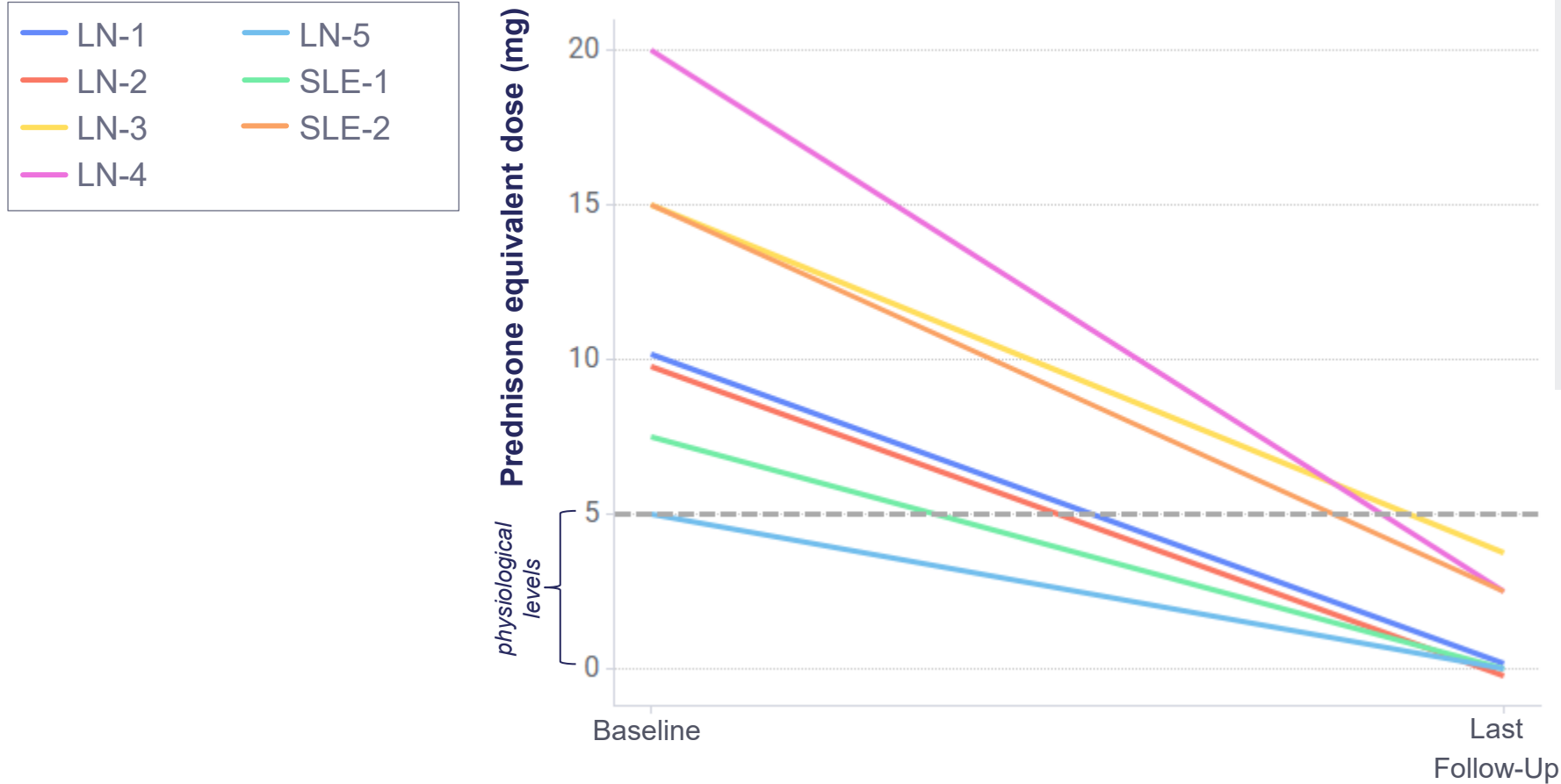
- Myositis (4)
- Hematuria (4)
- Proteinuria (4)
- Pyuria (4)
- Rash (2)
- Alopecia (2)
- ◀ Patient in DORIS remission
- Pericarditis (2)
- Low complement (2)
- Anti-dsDNA Positive (2)
- Fever (1)
- Arthritis (4)

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

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



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

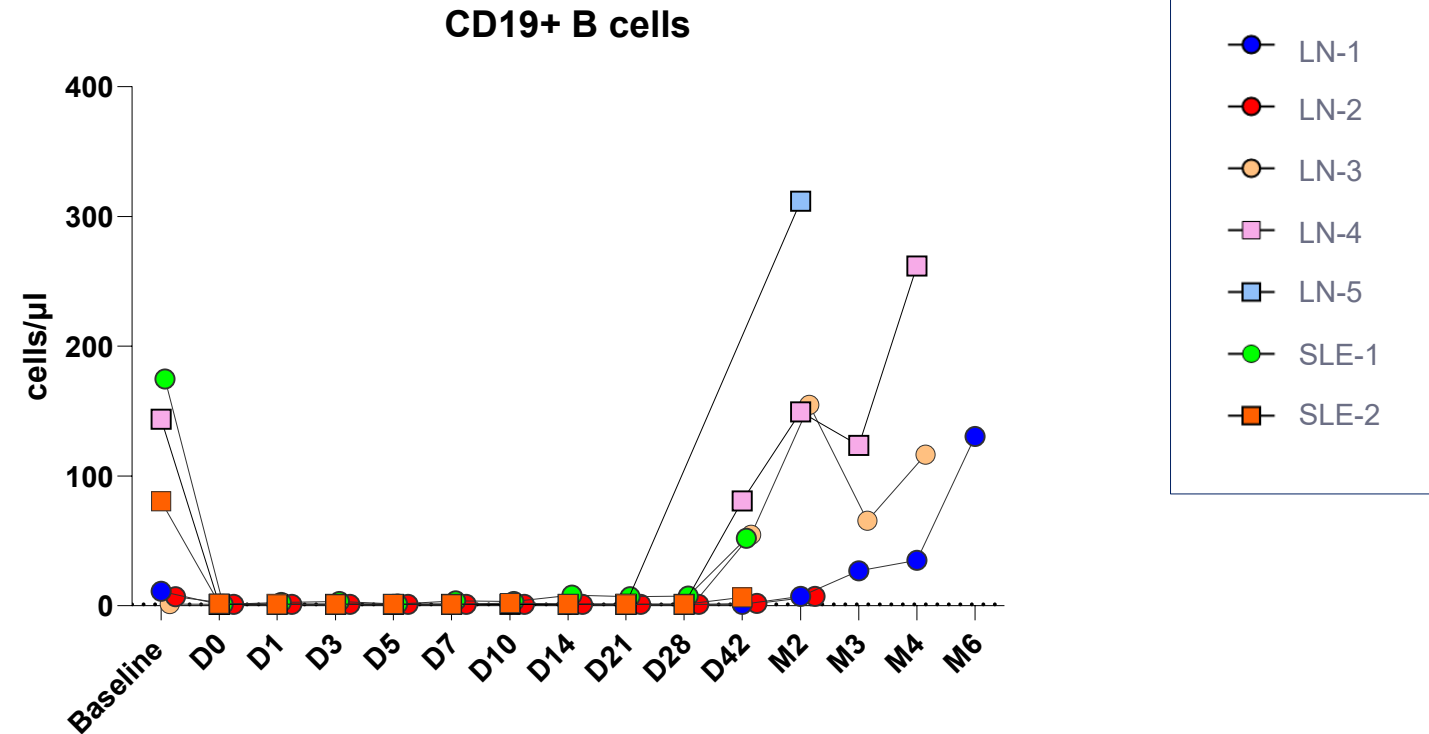


- All patients discontinued immunosuppressants
- Four/seven patients discontinued corticosteroids
- Remaining three/seven patients tapered to physiological levels

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

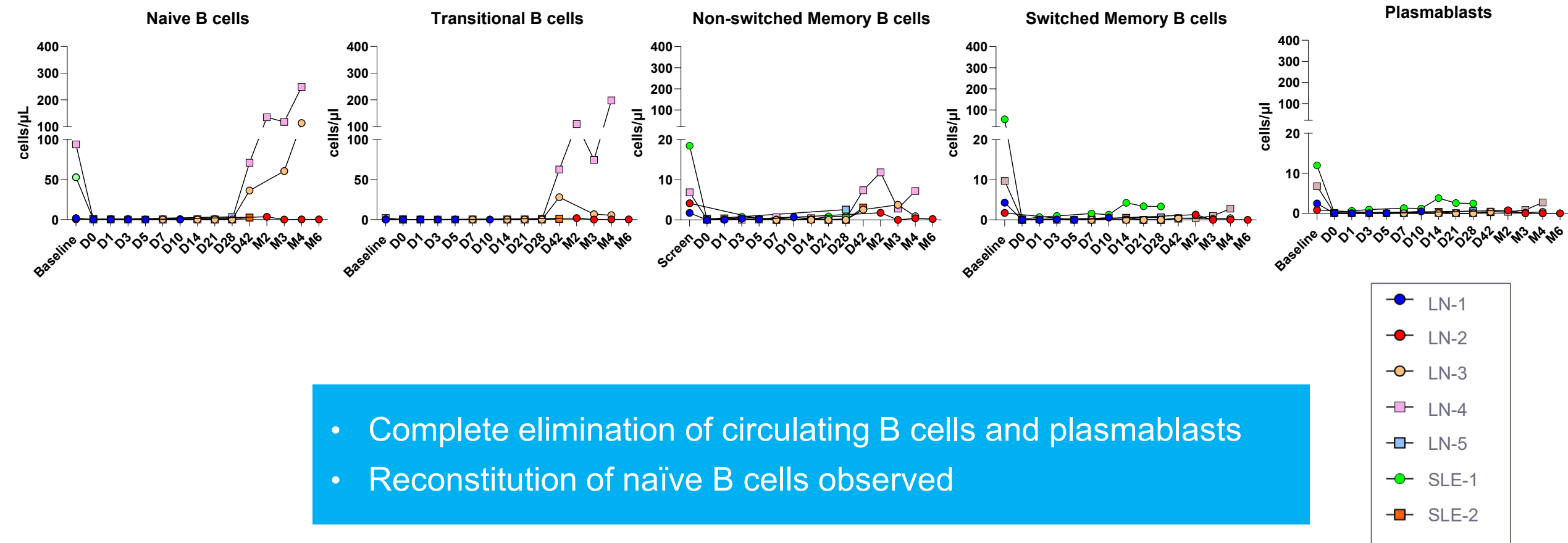
Deep and Broad B Cell Depletion Following Prula-cel Treatment



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

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

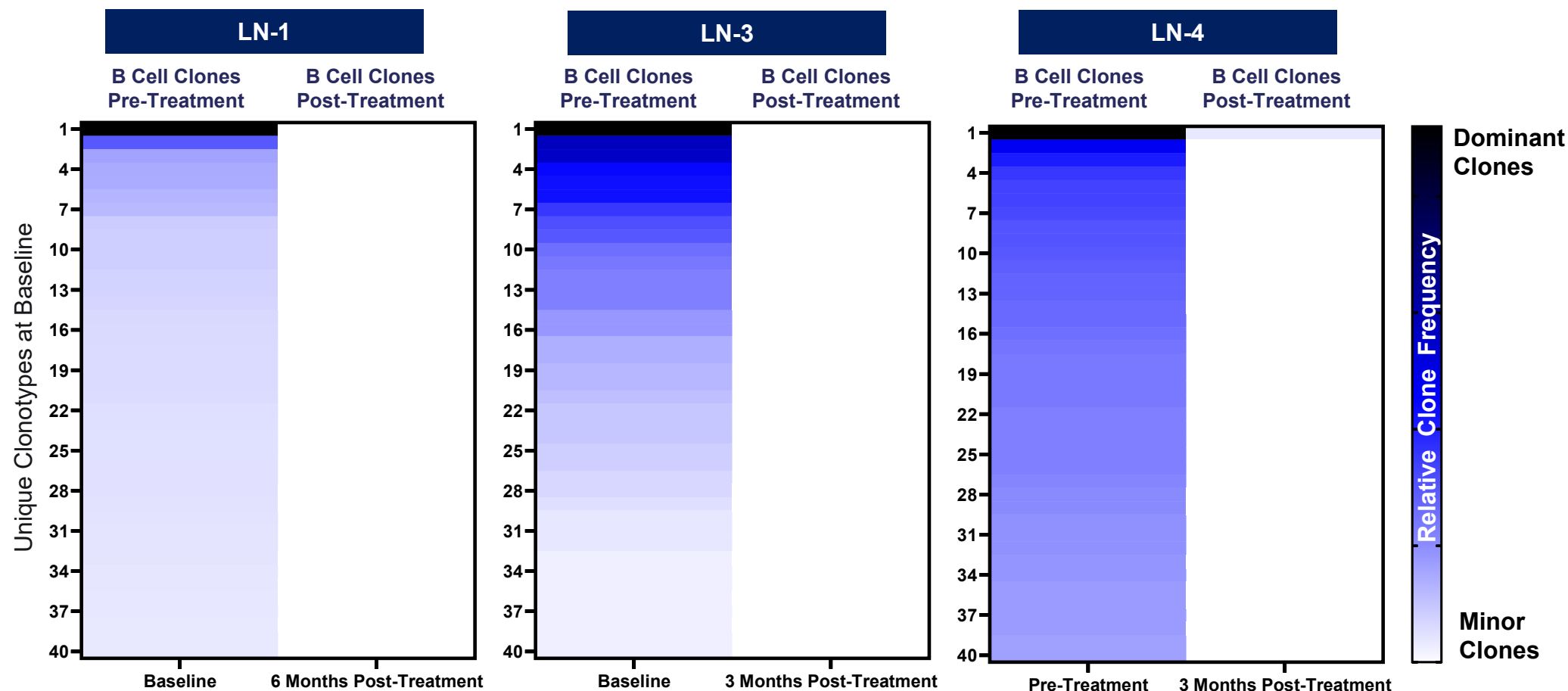
Reconstitution Driven by Naïve, Non-Class Switched B Cells



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

Circles = 1E8 dose; squares = 3E8 dose

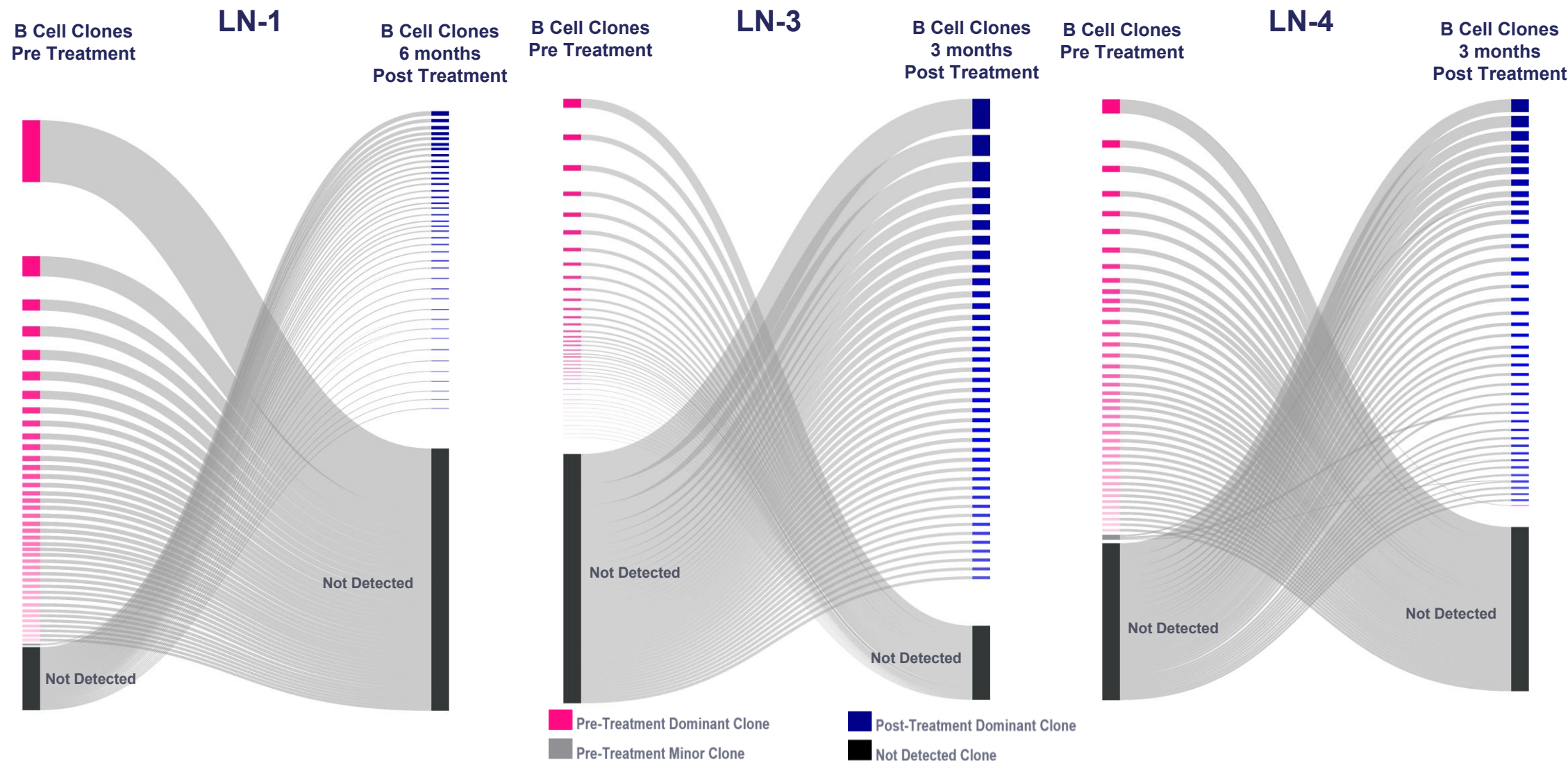
Dominant BCR Clones Were Depleted Post Treatment with Prula-cel



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.

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.

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

WHAT WE OBSERVED



Well tolerated safety profile: **No $\geq$ Gr2 CRS, no ICANS**
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**

WHAT IT MEANS

Off-the-shelf with no delay in treatment due to
scheduling leukapheresis and the time required for
manufacturing

Potential for outpatient administration; Off-the-shelf

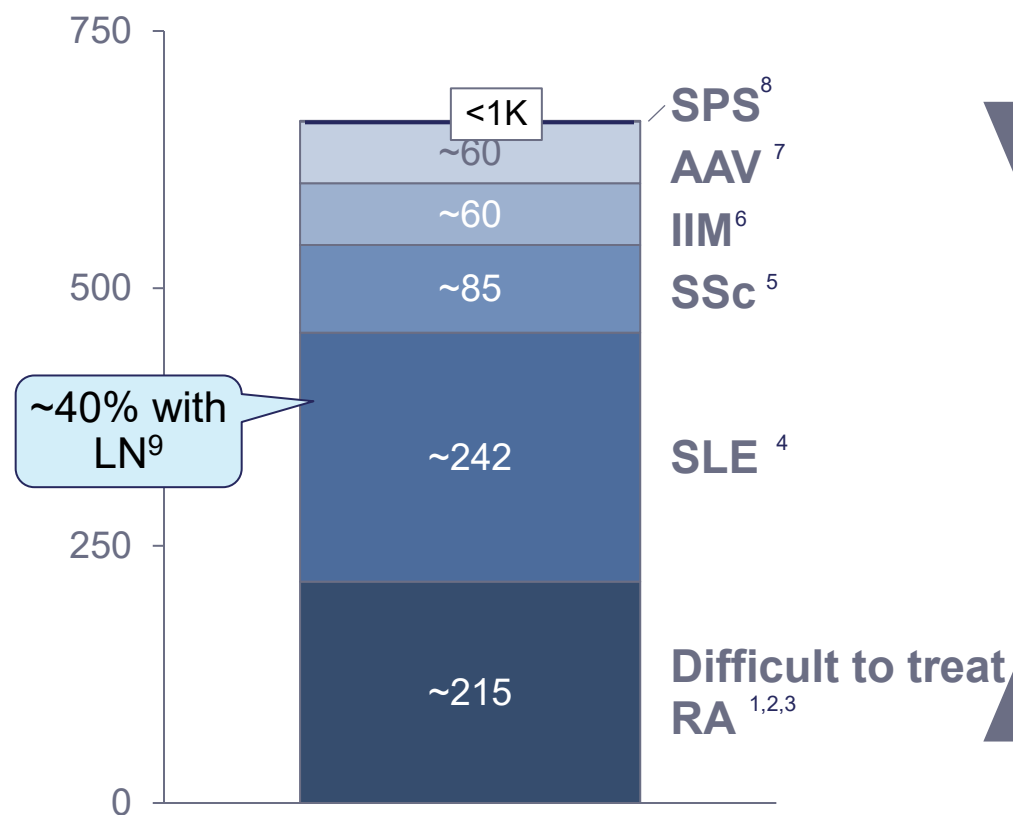
Potential for one-time therapy

Discontinuation of chronic immunosuppression and
discontinuation or reduction to below physiological
levels of corticosteroids

Prevent progression to chronic renal failure in LN

Expanding Prula-cel Development Across Seven Indications

US Prevalence (thousand patients)



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

ADI-212

Prostate Cancer



ADI-212: Next Generation $\gamma\delta$ CAR T Candidate Targeting PSMA

ADI-212: Differentiated

- Optimized, next-generation, gene-edited and armored, $\gamma\delta$ 1 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 $\gamma\delta$ T cells

- Differentiated mechanisms of action for improved potency and tumor-cell killing capacity in tumor microenvironment compared to previous generation $\alpha\beta$ and $\gamma\delta$ CAR T programs in oncology
- **Homing** of $\gamma\delta$ 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



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 therapy¹
- AR inhibitors (i.e., abiraterone and enzalutamide) and Pluvicto moving into the hormone sensitive setting creating **greater opportunity in the castration resistant setting**²

Substantial market opportunity³

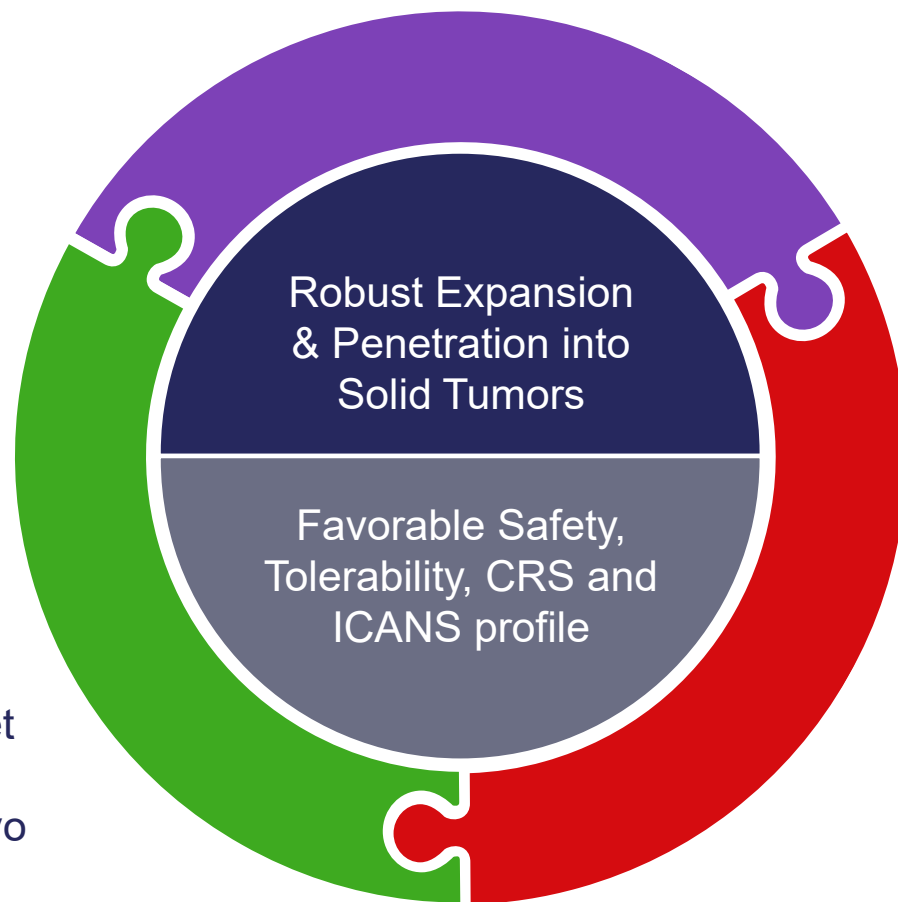
- **~75K 2L+ treated mCRPC patients** (~60K across U.S., JPN & EU5 w/ 15K in China)
- Pluvicto peak sales expected to reach \$5B+ globally

Complementary Technologies to Optimize Potency in Solid Tumors

Adicet's $\gamma\delta$ 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



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

2 Genetic Enhancement

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

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

1 PSMA-Directed CAR

with clinically supported binding determinants against functional PSMA molecules

PSMA-Directed CAR

Inducible Membrane-Tethered IL-12

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

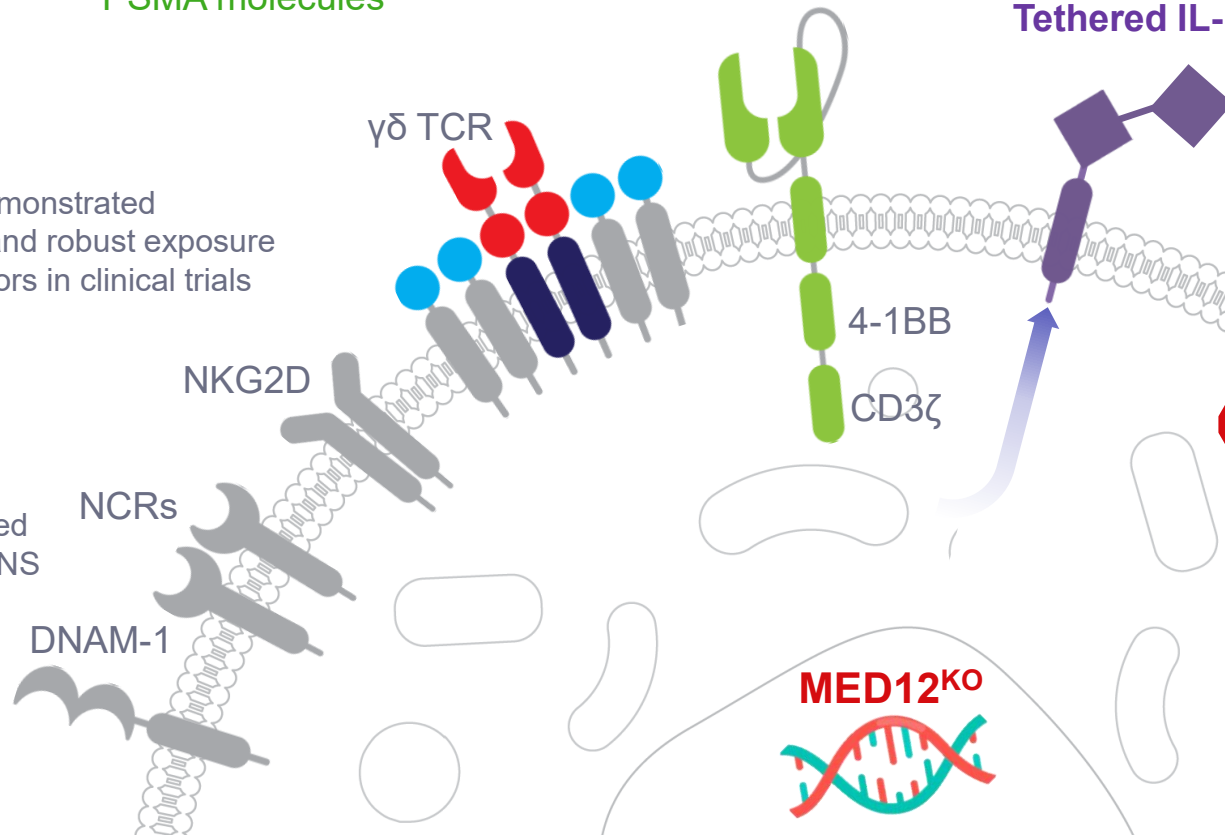
2 MED12^{KO}

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

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

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

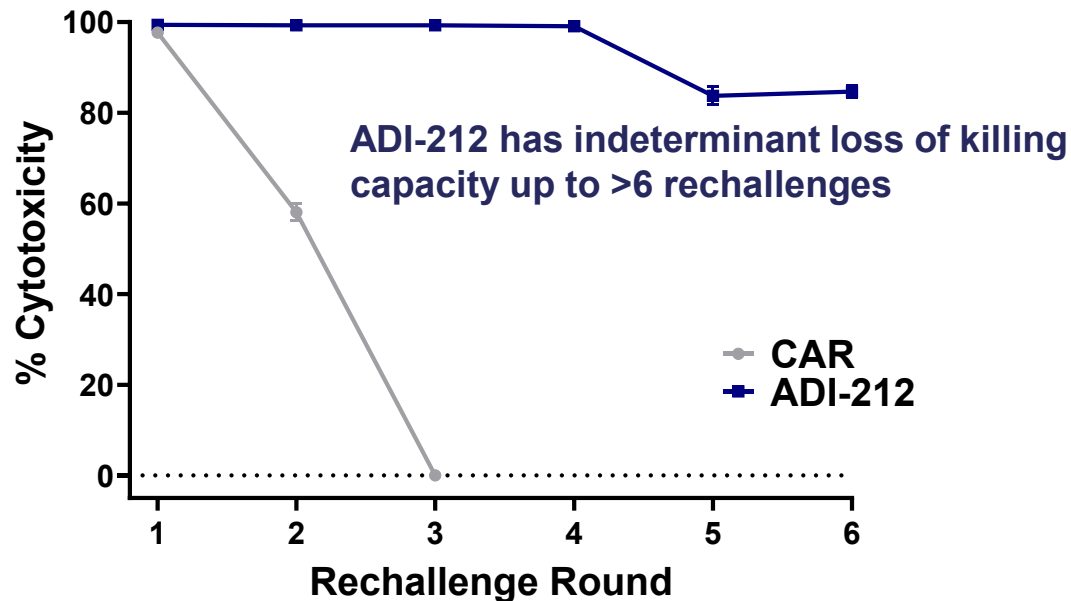
Platform demonstrated low risk for CRS/ICANS in clinical trials



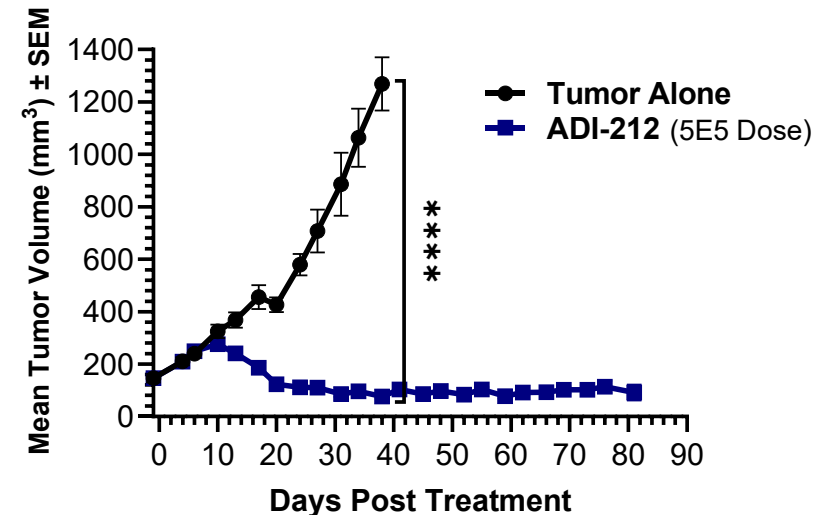
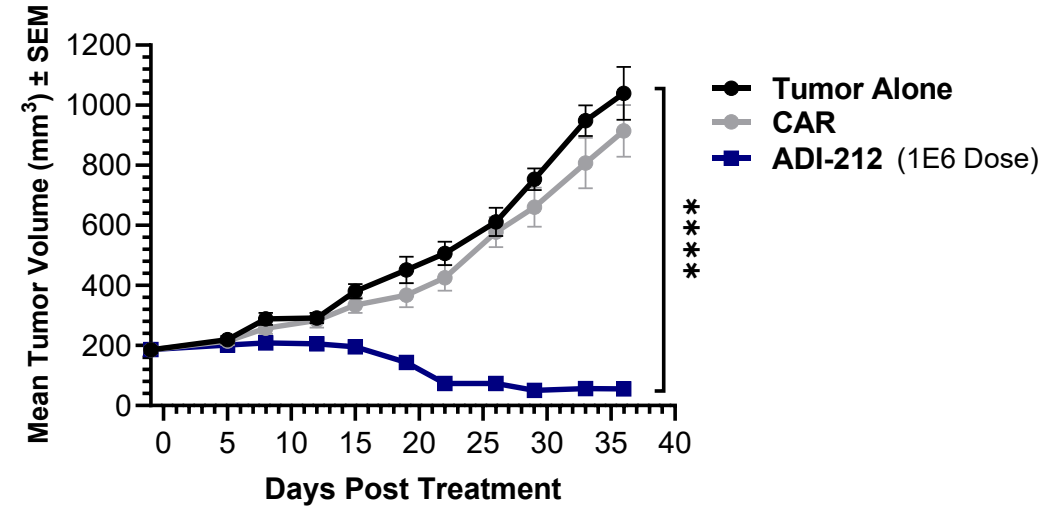
MED12 KO and mbIL-12 Armoring Enhanced the Potency of ADI-212 in a Tumor Rechallenge In Vitro Assay

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

Durable Cytotoxicity Demonstrated Against PSMA+ Prostate Cancer Cells



Highly Potent as Single Dose in mCRPC Tumor Model



Developing Broad Pipeline of Allogeneic $\gamma\delta$ 1 T Cell Therapies for Autoimmune Diseases and Cancer

Program	Target	Indication	Research	IND-Enabling	Clinical	Upcoming Milestones
AUTOIMMUNE DISEASES						
Prula-cel	CD20	LN & SLE				3Q/2026 Clinical update (LN/SLE) 2H/2026 Clinical update (SSc) 2H/2026 Initiate pivotal study (LN/LN+SLE)
		SSc				
		IIM/ SPS				
		AAV				
		RA				2H/2026 Clinical Update (RA) Enrolling Cy/Flu vs Cy only LD
ONCOLOGY						
ADI-212	PSMA (gene-edited w/ armor)*	mCRPC				Planned regulatory filing 3Q/2026 Initiate study 4Q/26
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in vivo CAR T γδ CAR T	Not disclosed	Autoimmune, heme malignancies and solid tumors				2H/2026 Program Updates

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.



Investor Presentation

August 2026

Adicet Bio