
cullinan™ THERAPEUTICS

# Cullinan Therapeutics Immunology Day

June 10, 2026

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# Cullinan Therapeutics Immunology Day

## AGENDA

**Cullinan Therapeutics T Cell Engager Strategy**
*Nadim Ahmed*

**Emerging Clinical Profile for CLN-978**
*Dr. Jeff Jones*

**Achieving Immune Reset: B Cell Depletion and the Future of the Field**
*Dr. Ricardo Grieshaber-Bouyer*

**T Cell Engagers in the Community: A Case Study for CLN-978**
*Dr. John Tesser*

**Next Steps for CLN-978 and Initial Data for Velinotamig**
*Dr. Jeff Jones*

**Strategic Perspective and Next Steps**
*Nadim Ahmed*

**Panel Q&A**

**Nadim Ahmed**
*President and Chief Executive Officer, Cullinan Therapeutics*

**Jeff Jones, MD, MBA**
*Chief Medical Officer, Cullinan Therapeutics*

**Ricardo Grieshaber-Bouyer, MD, PhD**
*Professor of Clinical Systems Immunology, FAU Erlangen-Nürnberg*

**John Tesser, MD, FACP, FACR**
*Arizona Arthritis & Rheumatology Associates*

# 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 1/2a

### Velinotamig
BCMAxCD3 TCE

Ph 1/2a

**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 1

**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**

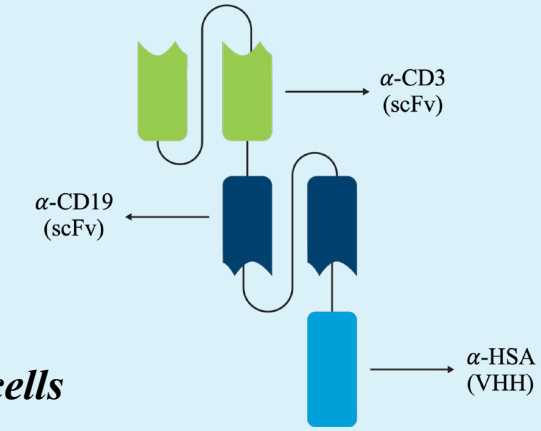
**Demonstrated promising efficacy data in broad AML population at ASH 2025**

# 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

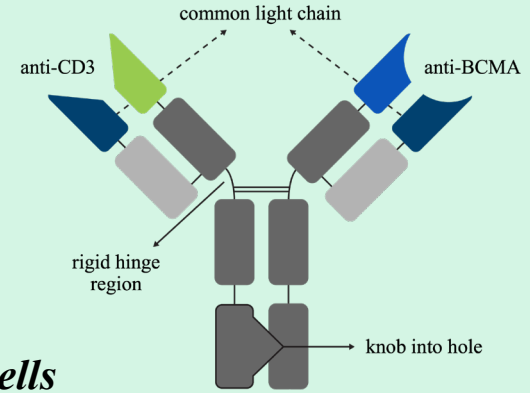



***Spares long-lived plasma cells***

## 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**

# 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 studies as of June 2026

## 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)*

# Velinotamig: Broad Expansion Opportunity To Address Diverse Plasma Cell Driven Diseases

## Velinotamig Opportunity

**Nonmalignant Hematology**

- Autoimmune Hemolytic Anemia *Velinotamig next step*
- Immune Thrombocytopenia *Velinotamig next step*

**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

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]*

*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*

# Differentiated Programs Establishing Clinical Proof of Concept and Clear Paths Forward

**Redefining Standards of Care:**
**Moving from chronic disease management toward immune reset and durable treatment free remissions**

## CLN-978

- First CD19 TCE with company sponsored data – over 40 patients treated across all disease areas
- Focus on rheumatology indications based on B cell depletion mechanism
- Single target dose efficacy in SLE and RA in ongoing Phase 1 studies, with multi-dose regimens under study in both disease areas
- Potential to be among first CD19 TCEs approved in autoimmune diseases

## Velinotamig

- De-risked BCMA TCE mechanism extends opportunity into plasma cell driven autoimmune diseases
- Early clinical validation of attractive product profile

## Clinical Positioning for TCEs

**Near Term:** Delivering unprecedented treatment free remissions in later lines of therapy

**Long Term:** Utilized as first line, disease modifying treatment choice

# Emerging Clinical Profile of CLN-978

**Jeff Jones, MD, MBA**
*Chief Medical Officer*

# Execution with Momentum: 42 Patients Treated with CLN-978 Across the OUTRACE Studies

| | CLN-978-SL-101 | CLN-978-RA-101 | CLN-978-SJ-101 |
|---|---|---|---|
| **10 ug** | n = 4 | n = 1 | n = 3 |
| **10/20 ug** | n = 7 | n = 3 | n = 3 |
| **10/30 ug** | n = 8 | n = 3 | Enrolling |
| **10/45 ug** | n = 1 | -- | -- |
| **10/20/20/20 ug** | n = 5 | n = 4 | -- |
| **Total Patients Dosed** | **25** | **11** | **6** |

**Data as of 5/29/2026*

# 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.*

# 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)

**As of May 20, 2026 data cutoff*

# 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.

**As of May 20, 2026 data cutoff*

# 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 |

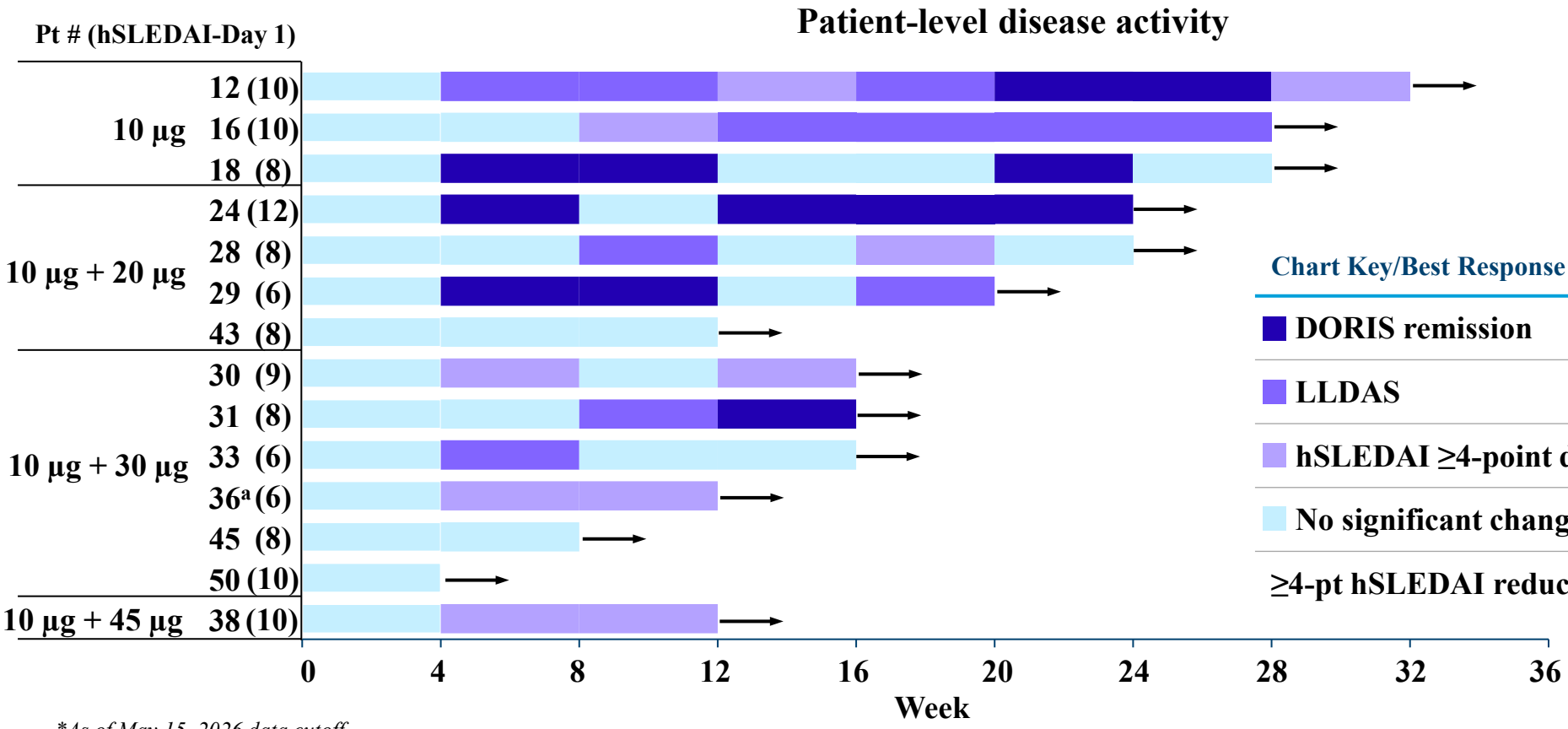
- Most CRS events occurred after the initial dose of 10µg
- In seven patients treated with the 20µg multi-dose regimen, only Grade 1 CRS events were observed
- A single case of Grade 3 CRS was observed following administration of the 45µg target dose; enrollment was discontinued for this cohort, and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

**As of May 20, 2026 data cutoff*

# 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.

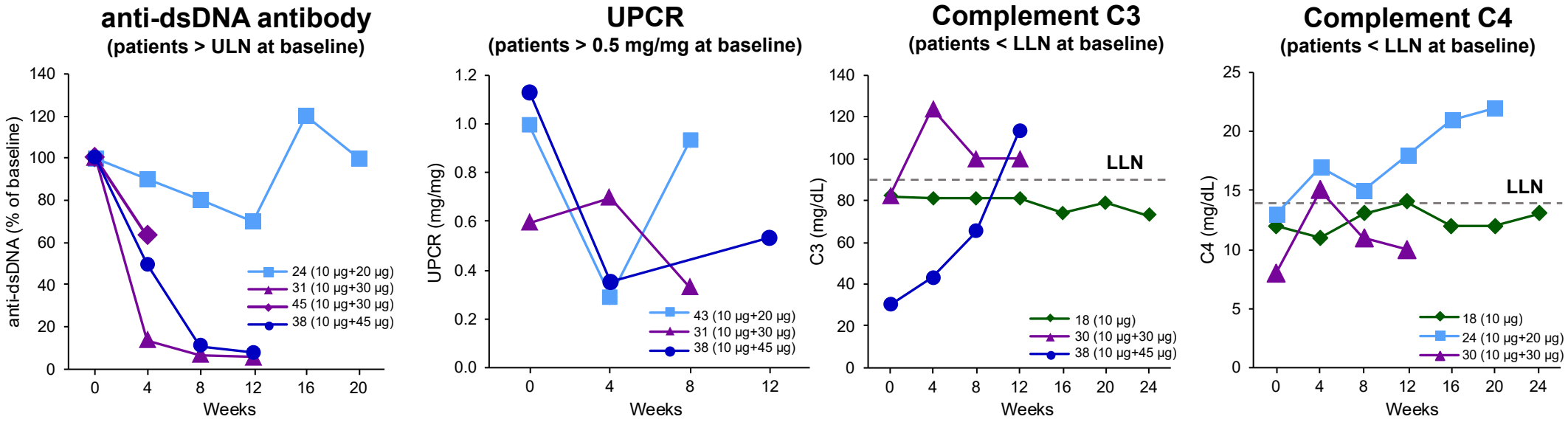



*DORIS: Definition of Remission in SLE; LLDAS: Lupus Low Disease Activity State; hSLEDAI: hybrid Systemic Lupus Erythematosus Disease Activity Index*

# 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



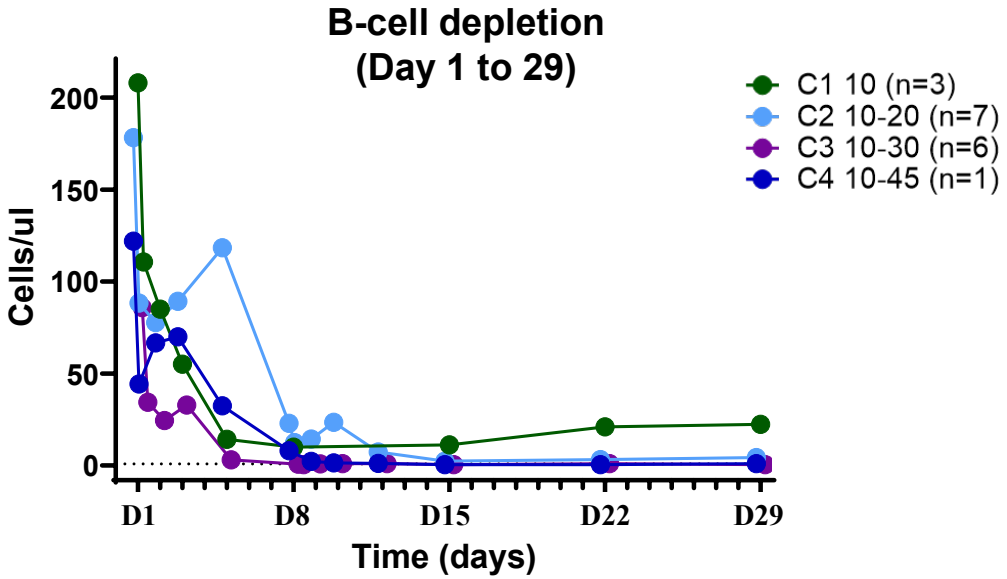

**As of May 15, 2026 data cutoff*

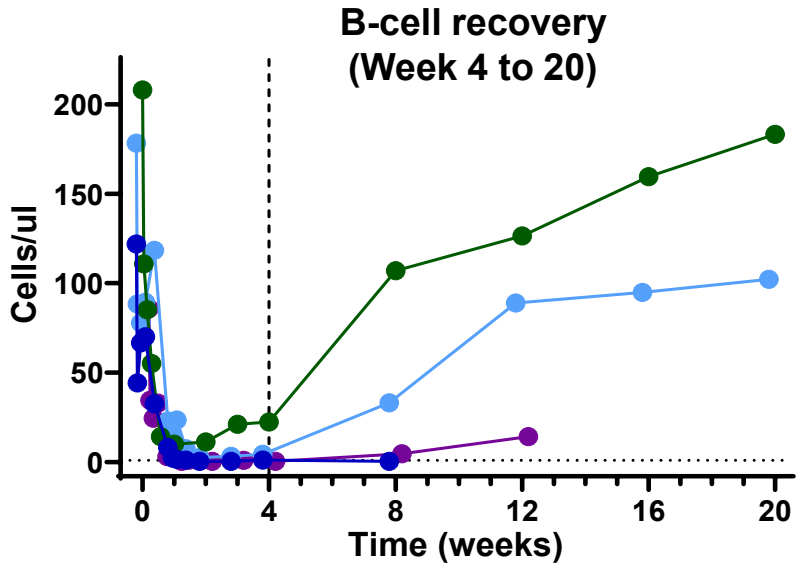
Anti-dsDNA antibody titers, UPCR, C3, and C4 in patients on-treatment with CLN-978 shown as % from Baseline (anti-dsDNA abs) or concentration (mg/mL (dL)) for several patients treated in Cohorts 1-4.
Anti-dsDNA decreased to below ULN in patients 31 and 38, starting from 17 X ULN and 11 X ULN, respectively.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

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

OUTRACE SLE STUDY



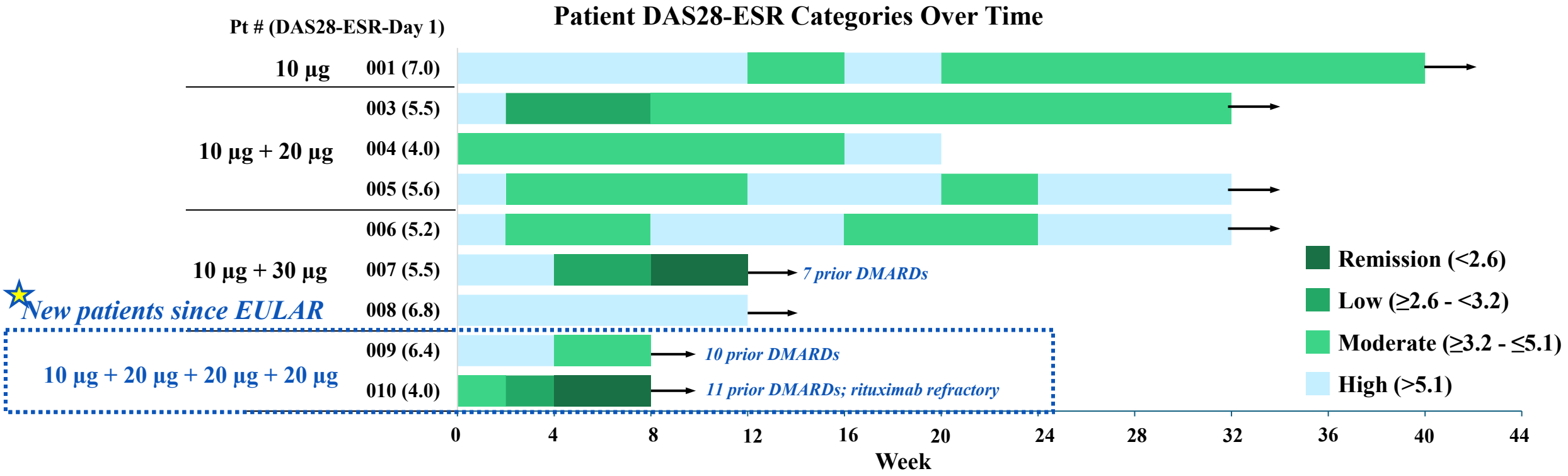

Peripheral B cell counts were reduced by >80% in 14/17 SLE patients (82%) treated in single target dose cohorts (Cohorts 1-4) with dose-dependent recovery observed

- 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)

**As of May 15, 2026 data cutoff*

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

OUTRACE RA STUDY



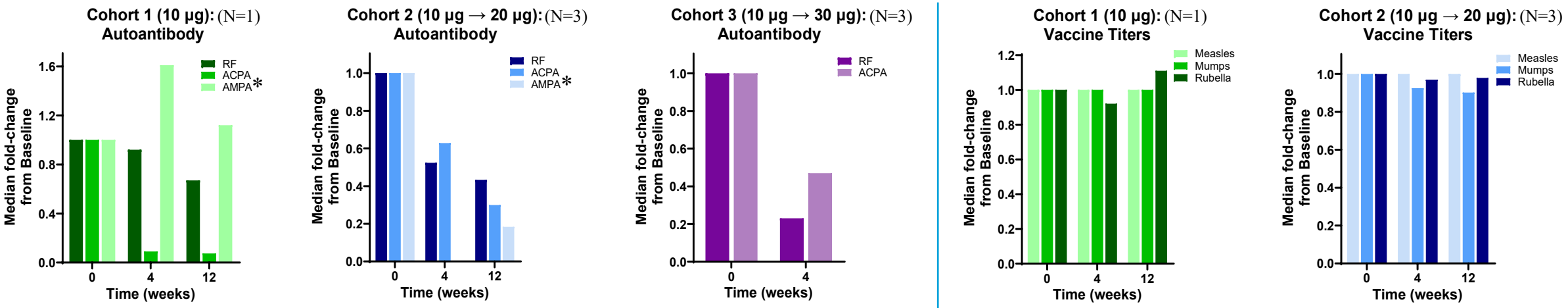

- In this heavily pretreated population, 7 of 9 patients had high baseline disease activity
- 7 of 9 patients experienced improved disease activity, including DAS28-ESR remission in one patient treated with 30µg target dose (Cohort 3) and one rituximab-refractory patient in the multi-dose cohort
- The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

# 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.

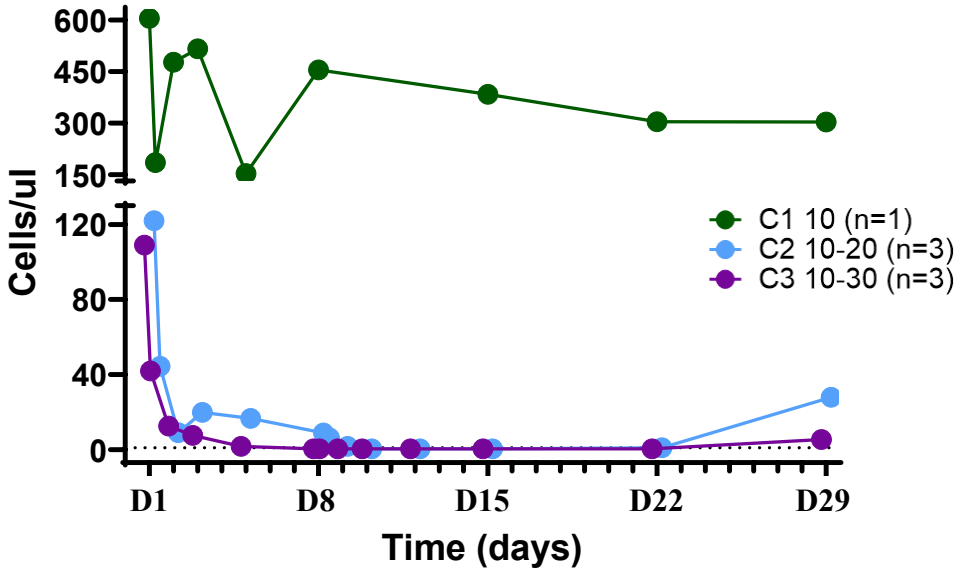
 

# RA: Complete B Cell Depletion at Go-Forward Doses, with Dose-Dependent Time to Recovery, Consistent with SLE Observations

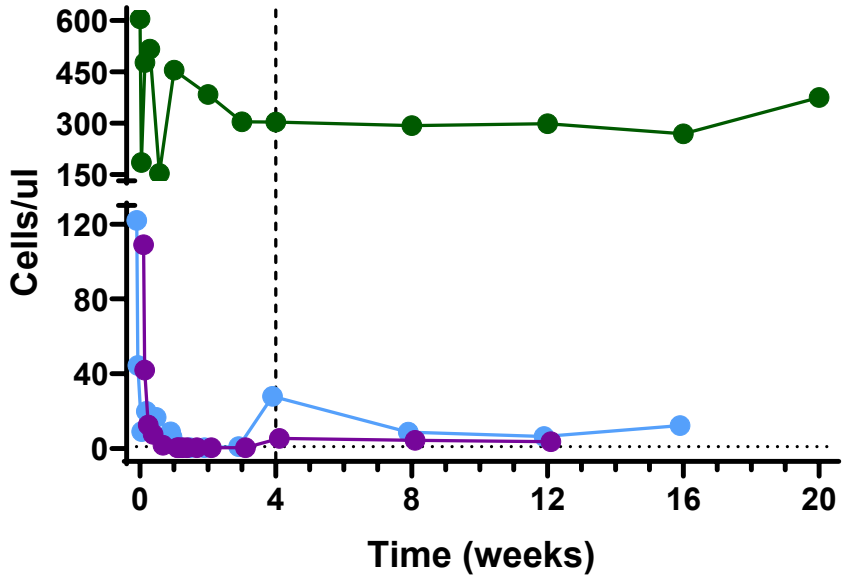
OUTRACE RA STUDY

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)**




**As of May 15, 2026 data cutoff*

# RA Patient Case Study: 10µg + 30µg

## *Patient 007*

OUTRACE RA STUDY

### Patient Demographics:

**Age**: 53 **Sex**: F **Tx Start:** Jan. 2026

- **Diagnosis Date**: 2000 (**26+ years of continuous therapy**)
- **Other Diagnosis:** RF+ , ACPA+

### 7 Prior Therapies

- Methotrexate
- Etanercept
- Adalimumab
- Leflunomide
- Sarilumab
- Baricitinib
- Filgotinib (last received December 2025)

### Treatment Course

| | Day 1 | Wk 4 | Wk 8 | Wk 12 |
|---|---|---|---|---|
| DAS28-ESR Score | 5.5 | 2.6 | 1.9 | 1.4 |
| DAS28-ESR Category | High | Low | Remission | Remission |
| TJC | 5 | 3 | 1 | 0 |
| SJC | 4 | 2 | 2 | 3 |
| PtGA (mm) | 50 | 50 | 35 | 30 |
| ESR (mm/h) | 67.0 | 2.0 | 2.0 | 2.0 |

### Disease Modifying Impact of CLN-978

- ✓ DAS28-ESR remission achieved following only a single target dose
- ✓ Rapid onset of clinical remission
- ✓ Profound disease activity impact despite prior therapy with 7 DMARDs
- ✓ Subtotal B cell depletion in tissue, with disruption of lymph node follicular architecture

### Treatment-Emergent Adverse Events

- Day 1 CRS: Grade 1, treated with acetaminophen
- Day 8 CRS: Grade 2, treated with tocilizumab

*DAS-28-ESR: Disease Activity Score 28 using Erythrocyte Sedimentation Rate; TJC: Tender Joint Count; SJC: Swollen Joint count; PtGA: Patient Global Assessment; ESR: Erythrocyte Sedimentation Rate; DAS-28-ESR Scale: Remission (<2.6), Low (≥2.6 - <3.2), Moderate (≥3.2 - ≤5.1), High (>5.1)*

**As of May 15, 2026 data cutoff*

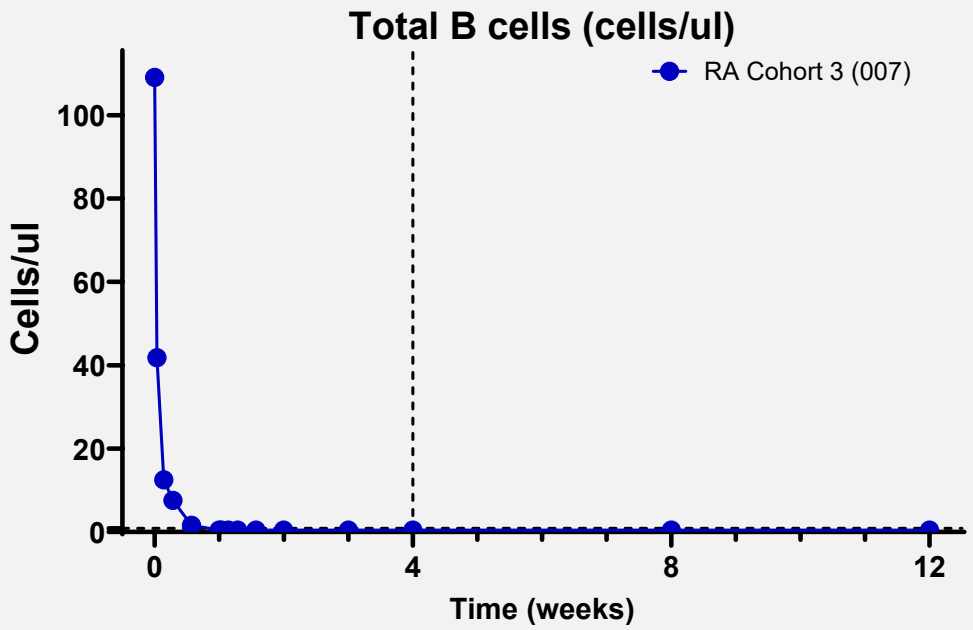
***Illustrative only; patient case studies may not be representative of overall data set*

# RA Patient Case Study: 10µg + 30µg

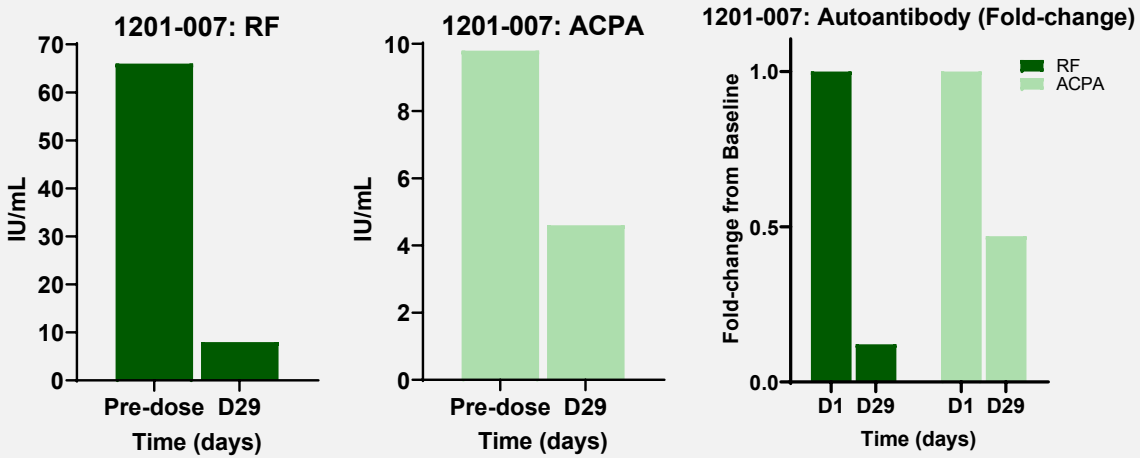
## *Patient 007*

OUTRACE RA STUDY

### Rapid, deep and durable B cell depletion in peripheral blood




### Rapid and clinically meaningful reduction in disease autoantibodies




**As of May 15, 2026 data cutoff*

***Illustrative only; patient case studies may not be representative of overall data set*

# RA Patient Case Study: 10µg + 20/20/20µg

## *Patient 010*

OUTRACE RA STUDY

### Patient Demographics:

**Age**: 59 **Sex**: F **Tx Start:** Feb. 2026

- **Diagnosis Date**: 1983 (**43+ years of disease and continuous therapy**)
- **Transient response** to initial course of **rituximab, refractory to re-treatment**

### 11 Prior Therapies

- Sulfasalazine
- Gold
- Methotrexate
- Leflunomide
- Cyclosporine
- Golimumab
- Adalimumab
- Abatacept
- Tocilizumab
- Sarilumab
- Rituximab (last received April 2025)

### Treatment Course

| | Day 1 | Wk 4 | Wk 8 |
|---|---|---|---|
| DAS28-ESR Score | 4.0 | 2.2 | 2.2 |
| DAS28-ESR Category | Moderate | Remission | Remission |
| TJC | 6 | 2 | 1 |
| SJC | 2 | 0 | 1 |
| PtGA (mm) | 30 | 1 | 54 |
| ESR (mm/h) | 14 | 7 | -- |

### Disease Modifying Impact of CLN-978

- ✓ Rapid DAS28-ESR remission achieved in patient with long-standing and complex history of RA
- ✓ Profound disease activity impact despite prior therapy with 11 DMARDs
- ✓ Response after prior rituximab failure demonstrates the ability of CLN-978 to achieve therapeutic levels of B cell depletion not typically achieved with mAbs

### Treatment-Emergent Adverse Events

- Grade 1 CRS following Day 1 dosing, treated with acetaminophen

*DAS-28-ESR: Disease Activity Score 28 using Erythrocyte Sedimentation Rate; TJC: Tender Joint Count; SJC: Swollen Joint count; PtGA: Patient Global Assessment; ESR: Erythrocyte Sedimentation Rate; DAS-28-ESR Scale: Remission (<2.6), Low (≥2.6 - <3.2), Moderate (≥3.2 - ≤5.1), High (>5.1)*

**As of May 20, 2026 data cutoff*

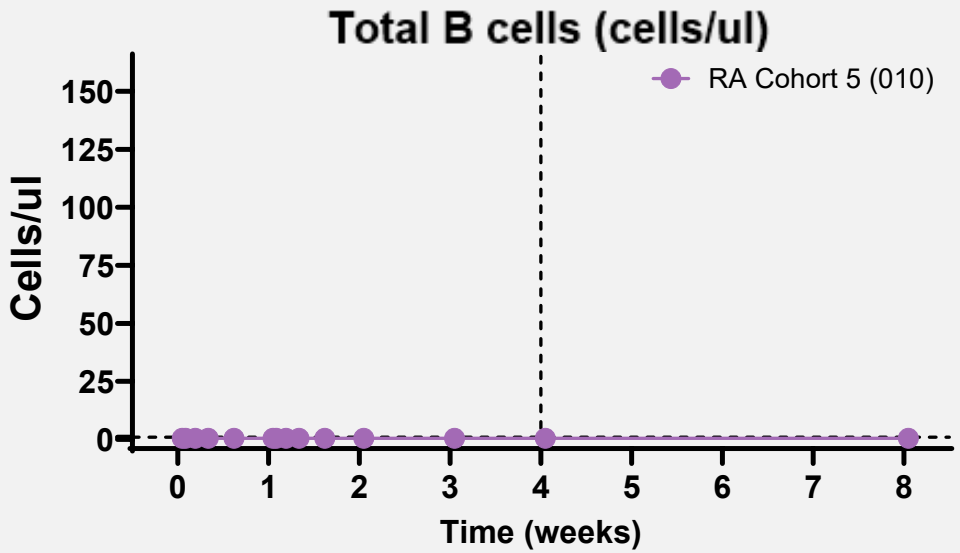
***Illustrative only; patient case studies may not be representative of overall data set*

# RA Patient Case Study: 10µg + 20/20/20µg

## *Patient 010*

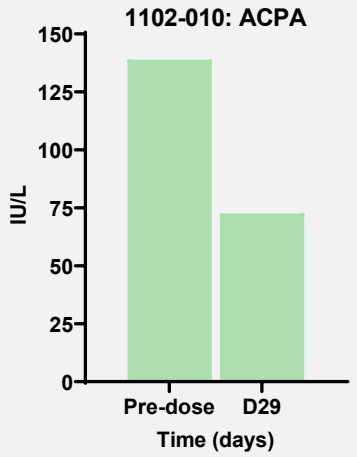
OUTRACE RA STUDY

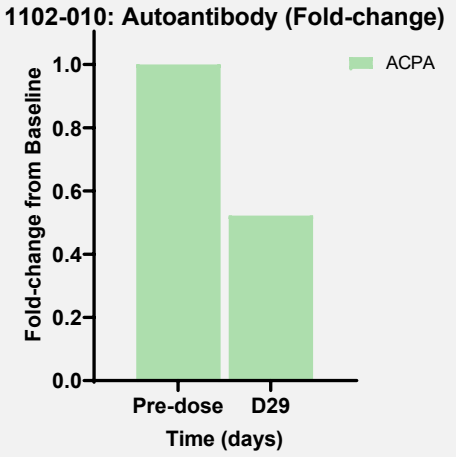
### No peripheral B Cells at baseline owing to prior rituximab treatment




*Achievement of remission here implies that CLN-978 has depleted B cells in the tissue beyond what rituximab could achieve*

### Rapid and clinically meaningful reduction in disease autoantibodies




**As of May 20, 2026 data cutoff*

***Illustrative only; patient case studies may not be representative of overall data set*

# CLN-978: Initial Data Creates Momentum to Rapidly Advance Development Across Indications

## Summary of Results

- **Promising initial efficacy in SLE and RA Phase 1 clinical trials, including DORIS and DAS-28-ESR remissions** ***following a single target dose***
- **Favorable safety profile observed in both SLE and RA**
- **Efficacy positively correlated with impact on:**
  - ✓ Key disease-associated biomarkers, such as autoantibodies, proteinuria, and laboratory measures of inflammation.
  - ✓ Complete B cell depletion in the peripheral blood and dose-dependent recovery

## What's Up Next: Clinician Perspectives

**Ricardo Grieshaber-Bouyer, MD, PhD**, shares his perspective on the translational data in RA and the potential for CLN-978 to effect immune reset

**John Tesser, MD, FACP, FACR**, shares his perspective on the significant unmet need in lupus and the potential for CLN-978 in the community setting

# Achieving Immune Reset: B Cell Depletion and the Future of the Field

**Ricardo Grieshaber-Bouyer, MD, PhD**
*Professor of Clinical Systems Immunology, FAU Erlangen-Nürnberg*

# Length of B Cell Depletion is Associated with Clinical Response

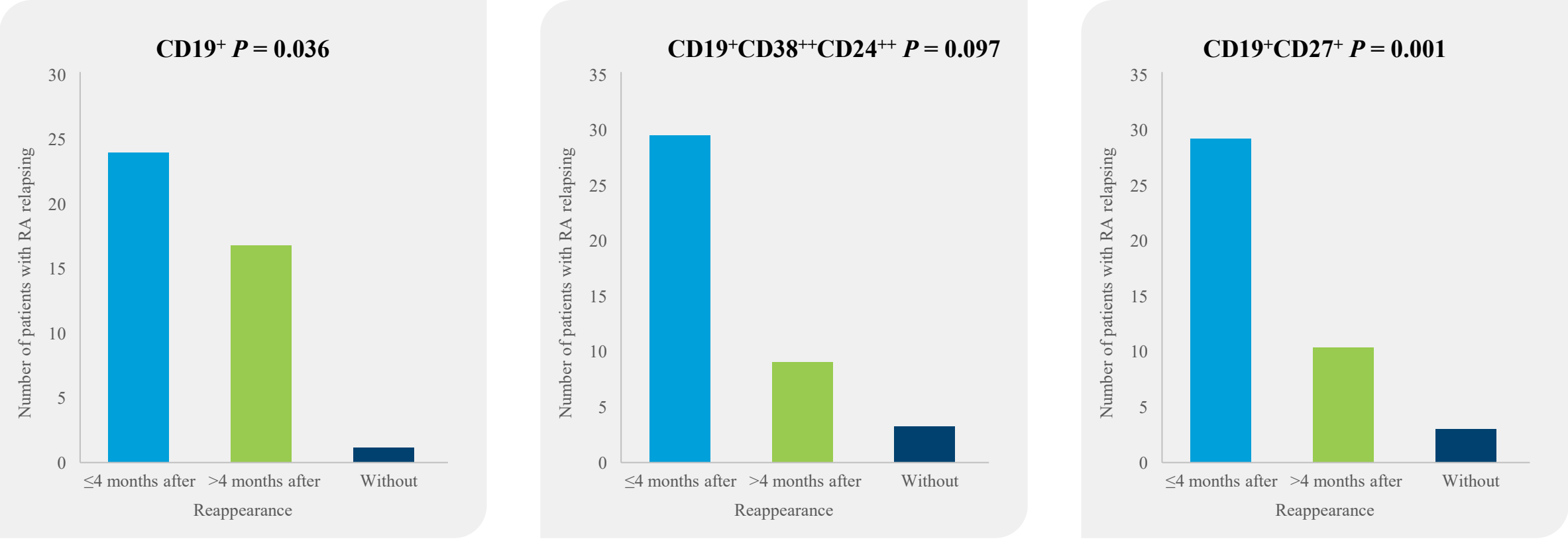
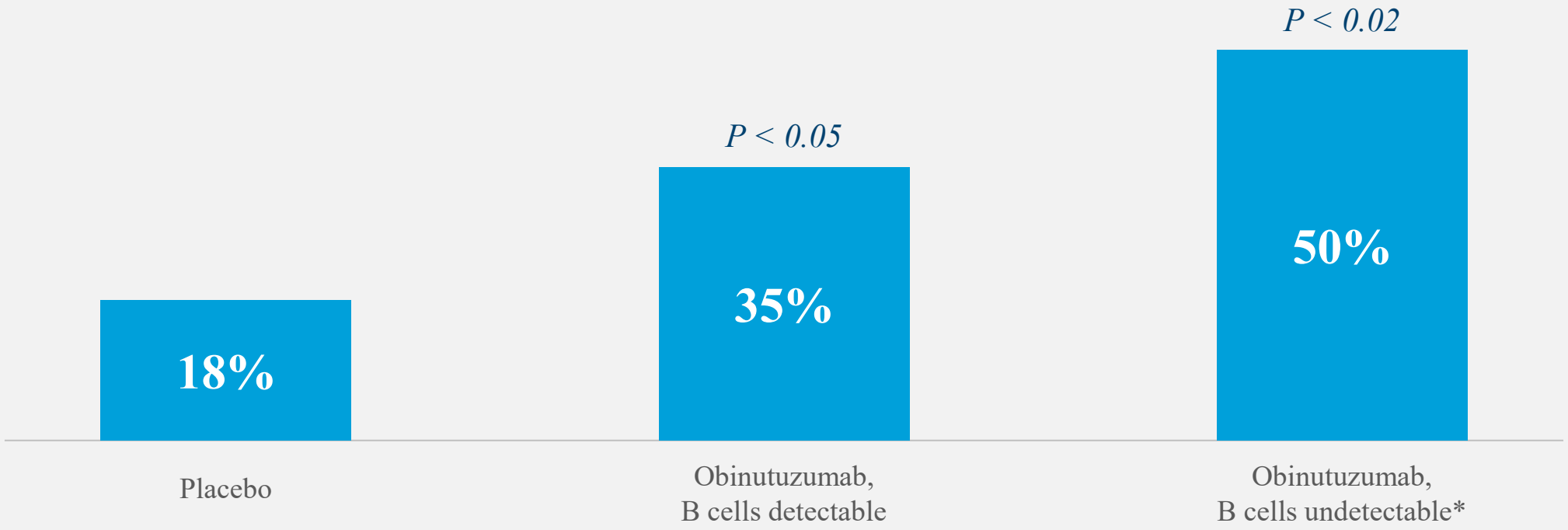



Fig. 4. Distributions of the numbers of patients with clinical rheumatoid arthritis (RA) relapses as a function of the time of their occurrence or context: ≤4 months (■) >4 months after (■) or without re-emergence (■) of the different B lymphocyte subsets.

Trouvin et al. Clin Exp Immunol 2015

# Full B Cell Depletion is Required for Best Clinical Responses



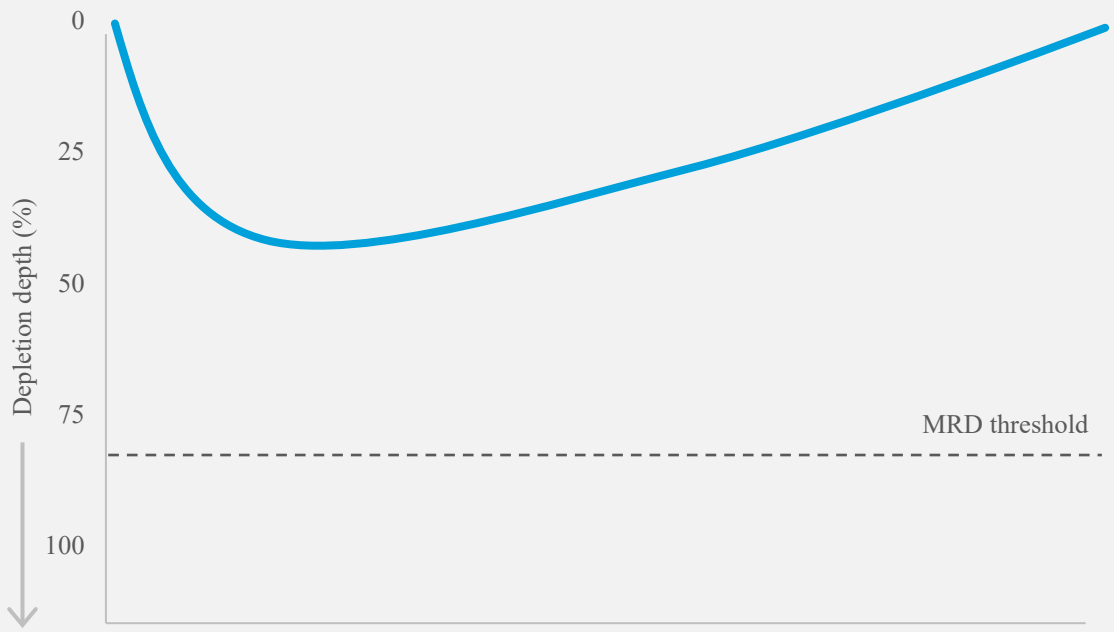

% of patients reaching complete renal response in the NOBILITY trial of Obinutuzumab in lupus nephritis *B cells < 0.4/µl at weeks 24 and 52

Furie RA, Tas SW, Malvar A, Looney CM, Raghu H, Anania VG, et al. O33 Longitudinal assessment of biomarkers in NOBILITY, a randomized, phase II clinical trial of obinutuzumab for treatment of proliferative lupus nephritis. Lupus Science & Medicine. 2024;11:. https://doi.org/10.1136/lupus-2024-el.42

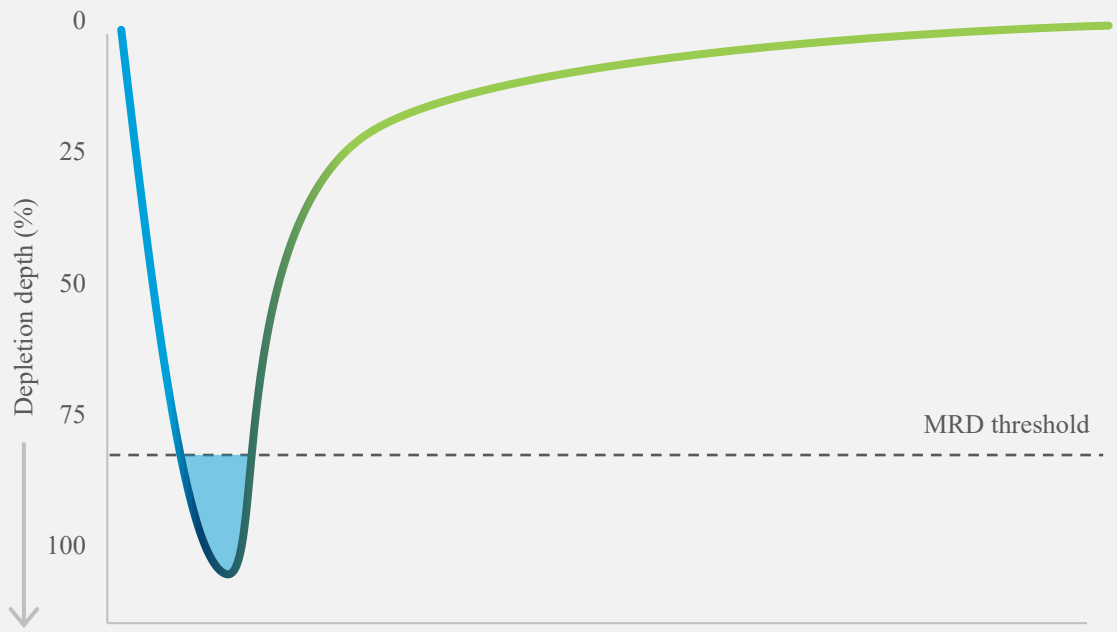
# Hypothesis: A Sustained Remission in Autoimmune Diseases Requires the Depletion of Autoreactive Cells Below an MRD Threshold

## Superficial cell depletion




**Persistence of autoreactive clones**

## "Deep" cell depletion



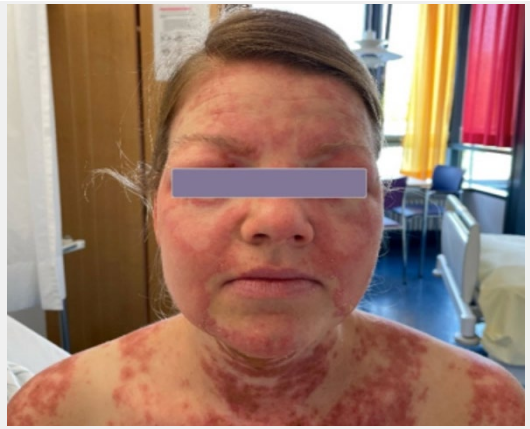

Eradication of autoreactive clones
→ **Successful immune reset**

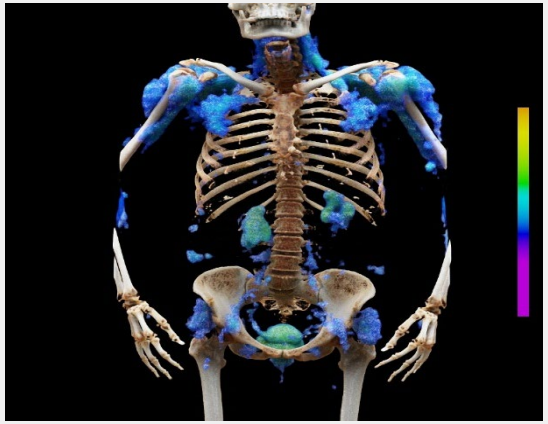
Junt T, Calzascia T, Traggiai E, da Costa AN, Gergely P, Schett G, Dörner T, Siegel RM. Defining immune reset: achieving sustained remission in autoimmune diseases. Nat Rev Immunol. 2025 Jul;25(7):528-541. doi: 10.1038/s41577-025-01141-w. Epub 2025 Mar 5. PMID: 40044810.

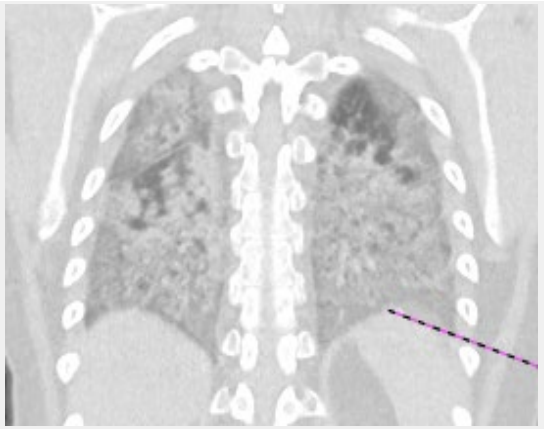
 

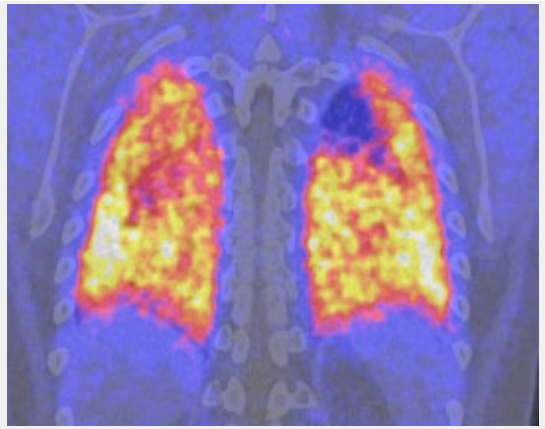
# Deep B Cell Depletion Is Revolutionizing Autoimmune Disease Therapy

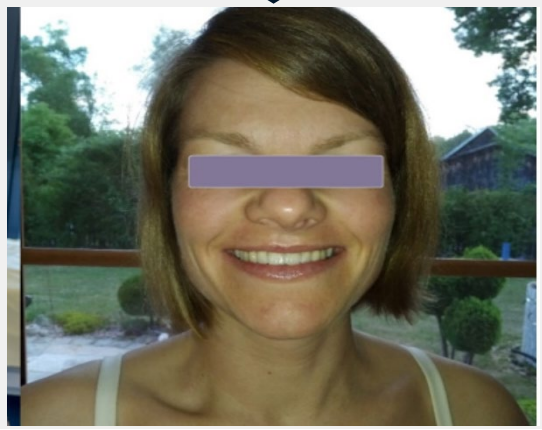
| Acute cutaneous lupus | Myositis | Interstitial lung disease | ILD (FAPI PET-CT) |
|---|---|---|---|

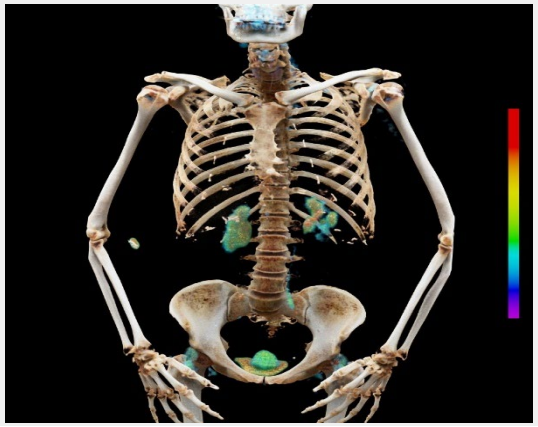


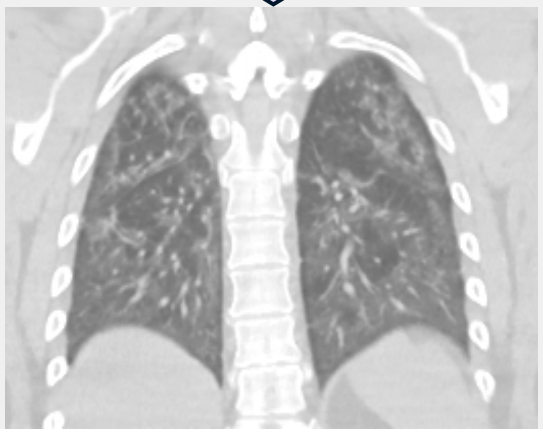


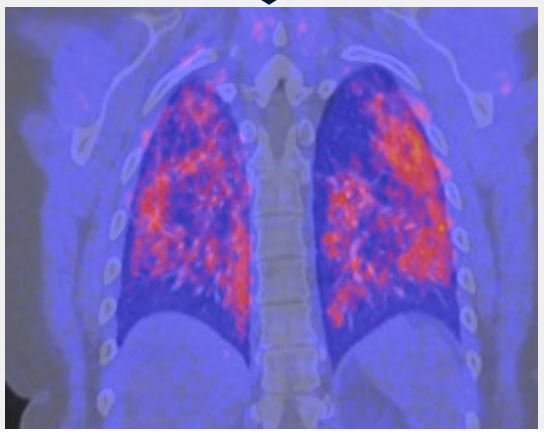




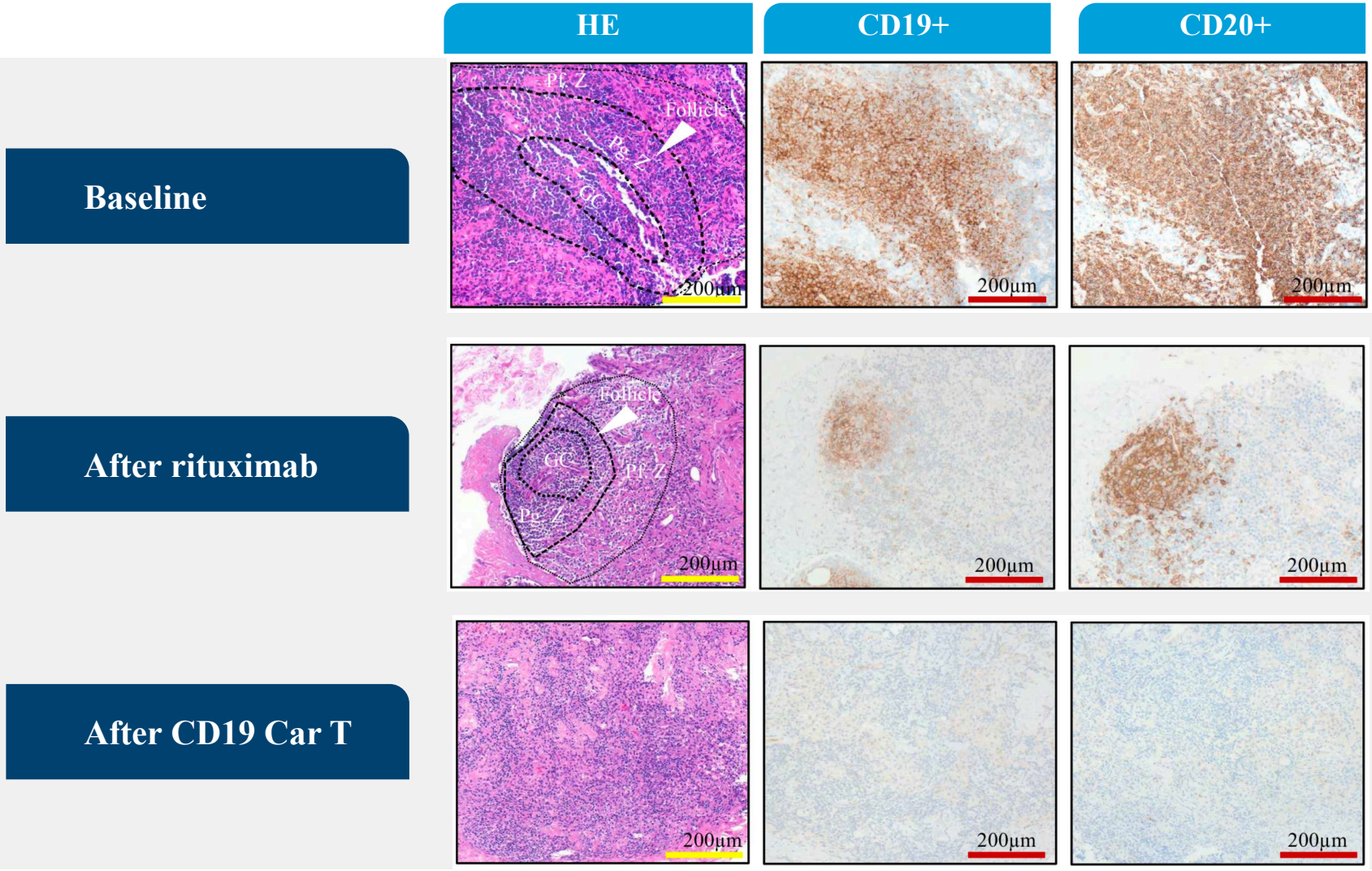








# Why Does Car T Cell Therapy Succeed Where Rituximab Failed?



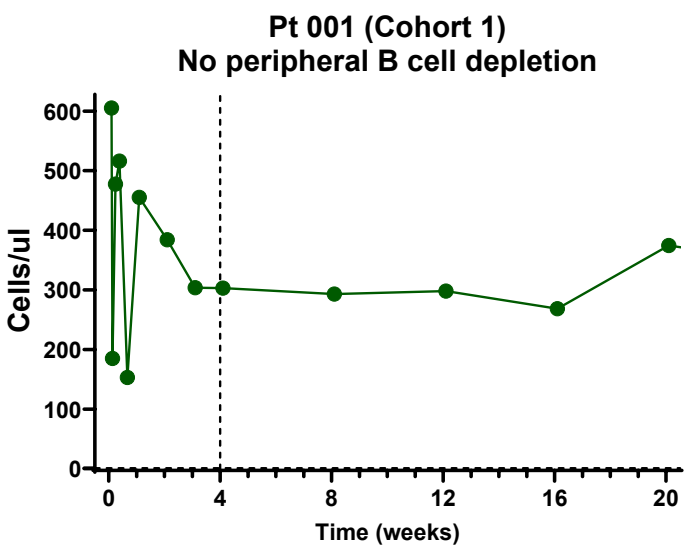

 

[1]*Tur C, Eckstein M, Bucci L .Effects of different B-cell-depleting strategies on the lymphatic tissue Annals of the Rheumatic Diseases, 2025; 84, 2065-2074*

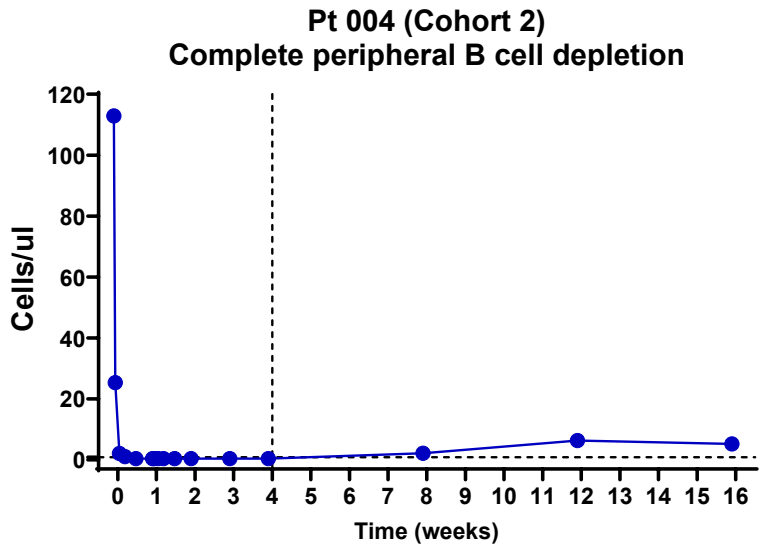
# Dose-Dependent B Cell Depletion is Associated with Clinical Outcomes in CLN-978 Treated RA Patients

OUTRACE RA STUDY

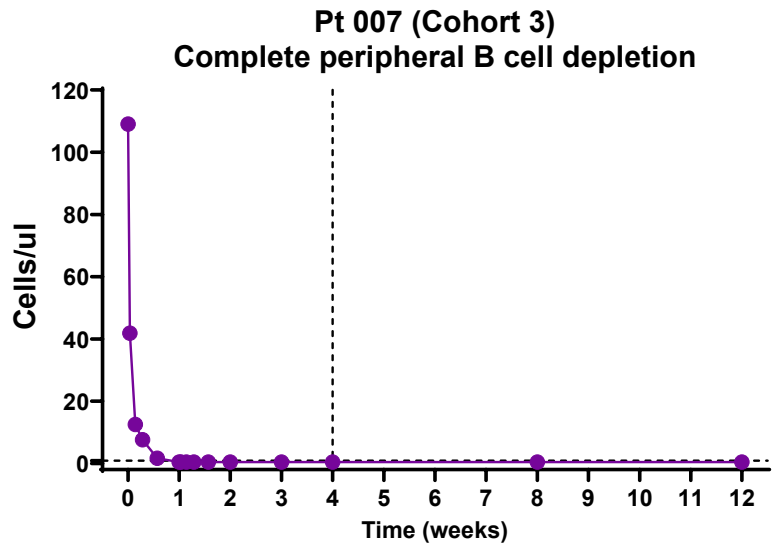
## Peripheral B-cell depletion observed after 20ug and 30ug target doses of CLN-978




**Disease activity remained similar to baseline**




**Disease activity remained similar to baseline and then increased after Week 12**




**Low Disease activity by Week 4, remission by Week 8**

**As of May 15, 2026 data cutoff, representative case from each dose level; patient case studies may not be representative of overall data set*

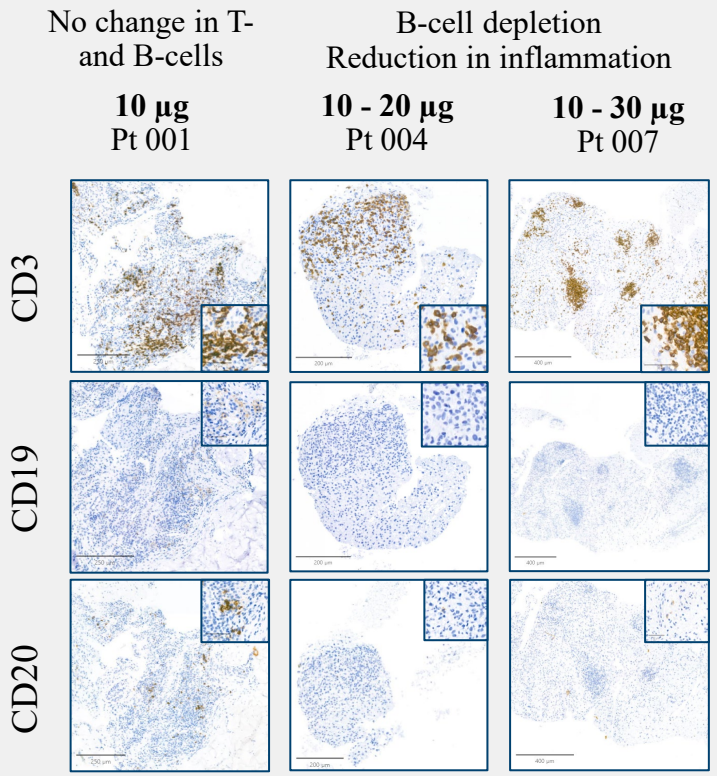
B-cell LLOQ=0.9 cells/ul

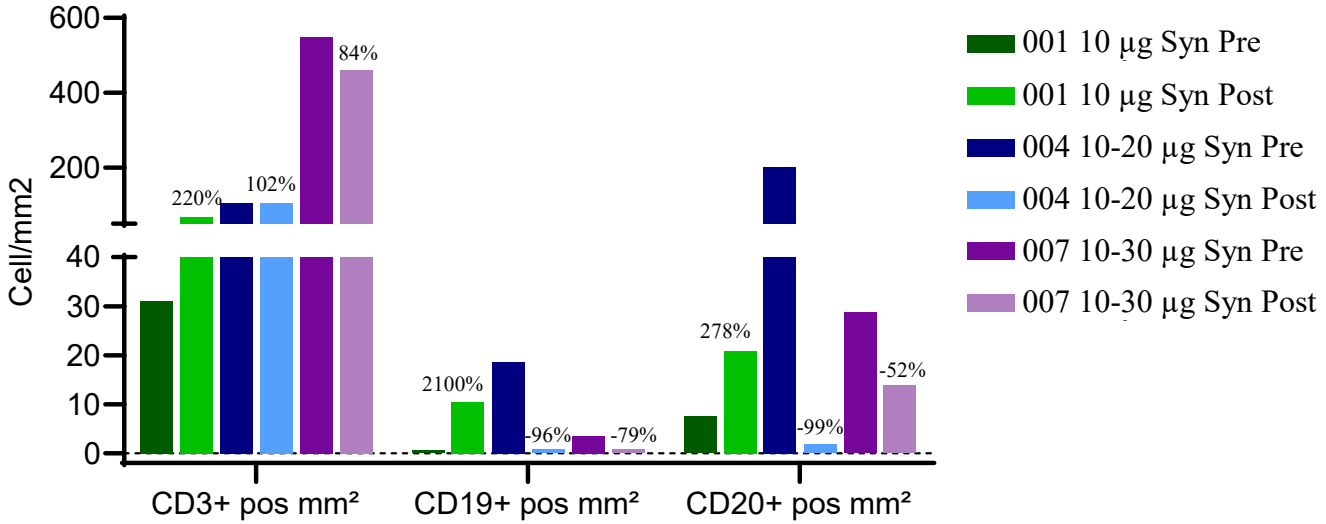
# ≥20 µg Target Doses Result in Profound B Cell Depletion in Synovium of RA Patients

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)

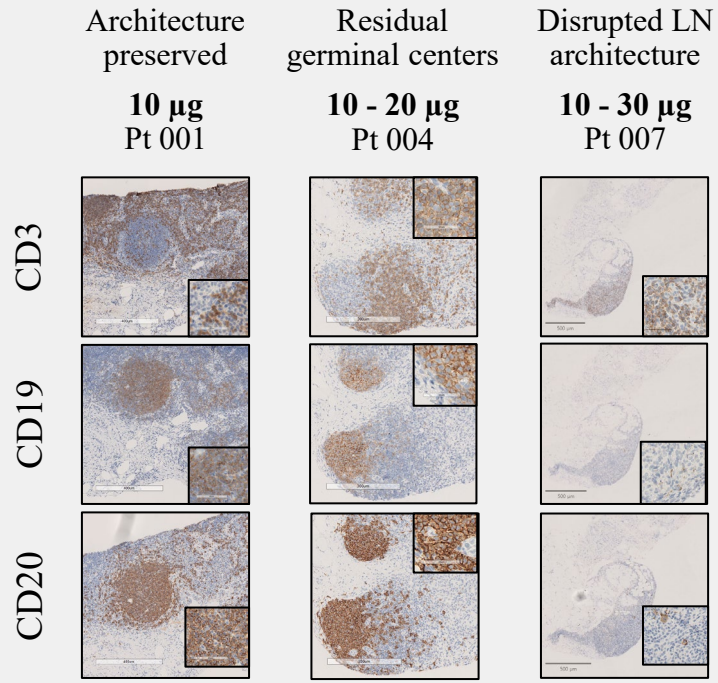
**As of May 15, 2026 data cutoff, representative case from each dose level*

# 30 µg Target Dose Substantially Depleted B Cells in Lymph Node Tissue of RA Patients

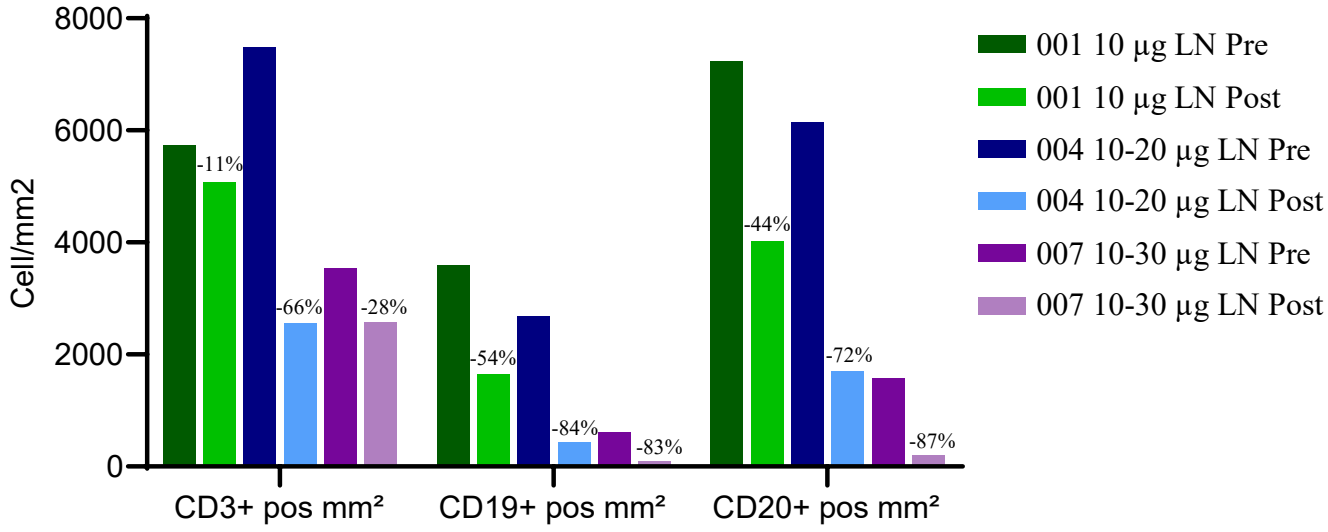
OUTRACE RA STUDY

## 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)

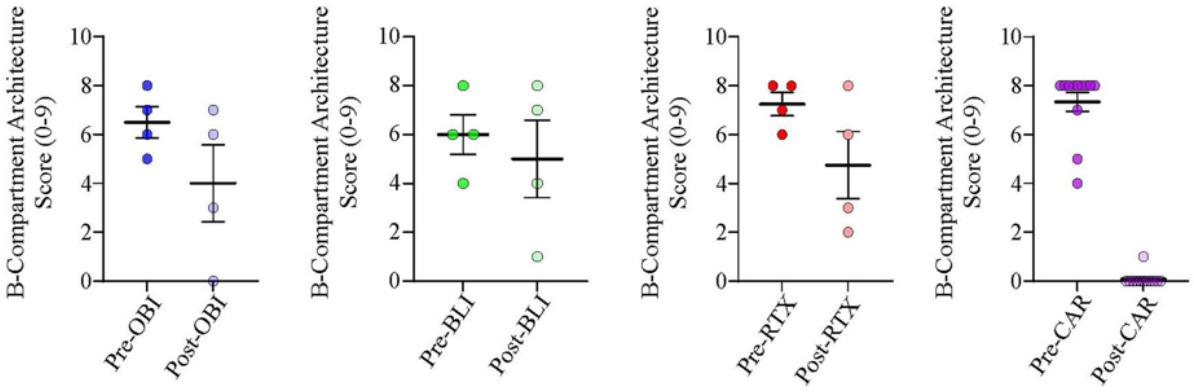
**As of May 15, 2026 data cutoff, representative case from each dose level*

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

OUTRACE RA STUDY

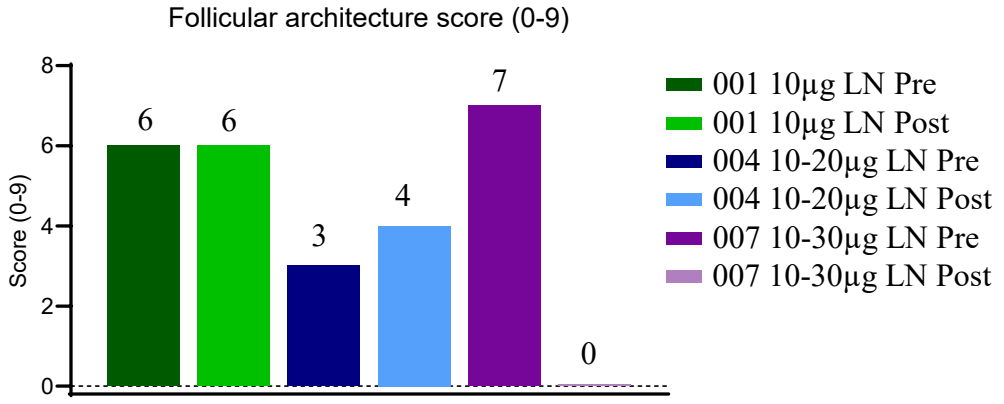
## Erlangen Precedent

- 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*

[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*

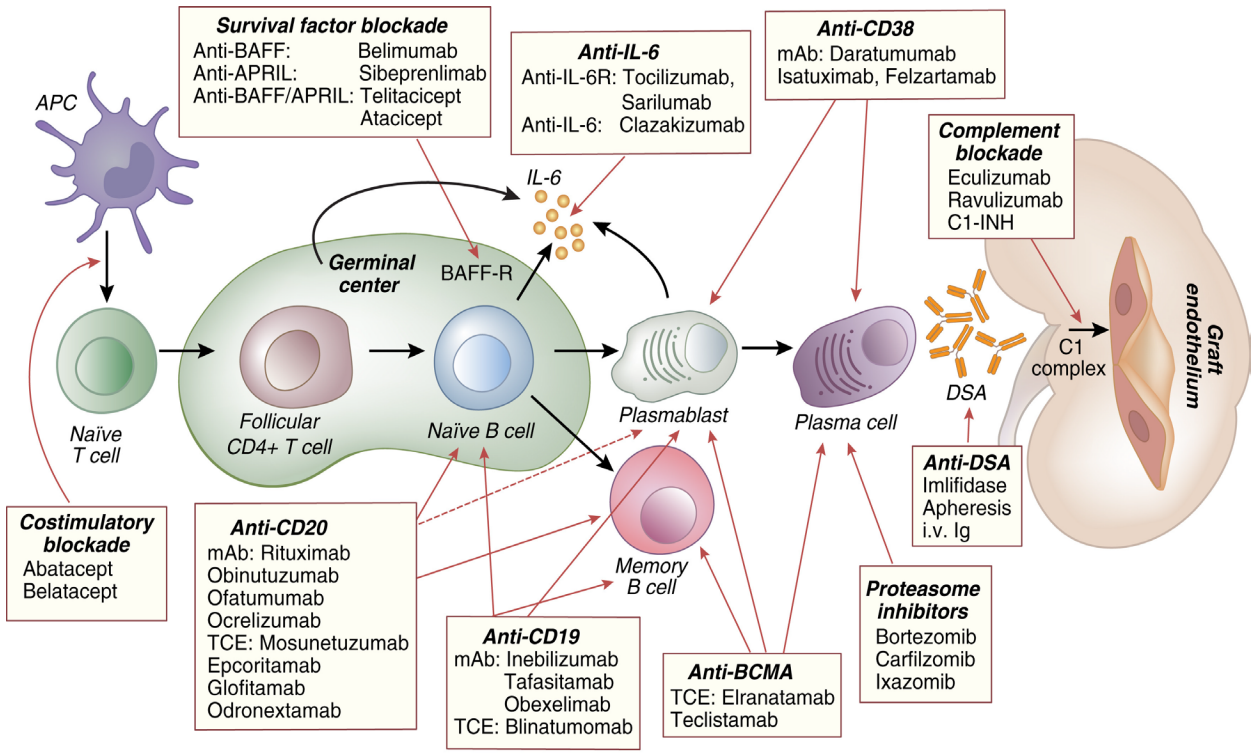
# CLN-978 Demonstrates an Encouraging Profile for Immune Reset

- **Clinical remissions were achieved in heavily pretreated patients with complex and long-standing history of disease**
- **Dose dependent B cell depletion in the peripheral blood was associated with greater impact on disease assessments in patients with RA**
- **Robust depletion observed in synovium and lymph node after a single target dose**
- **First TCE to demonstrate complete disruption of follicular architecture comparable to autologous CAR T, indicative of immune reset**
- **Favorable safety profile and initial clinical observations underscore potential for more profound and durable efficacy outcomes with multi-dose regimens**

# Potential for T Cell Engager Deep Immune Cell Depletion Beyond Autoimmunity

## Therapeutic options for addressing pathogenic B cell lineages




- **Significant, high unmet need opportunity in transplant desensitization:** Donor-specific antibodies (DSAs) preclude eligibility for a subset of patients requiring solid organ transplants. Current HLA desensitization approaches are limited and often ineffective at eliminating DSAs.
- **First proof-of-principle for BCMA TCEs in desensitization:** A kidney failure patient with extreme HLA sensitization, refractory to daratumumab, was successfully de-sensitized with elranatamab. The patient remains DSA-negative and rejection-free 10 months post-transplant.
- **Next frontier for TCEs extends beyond AIDs:** TCEs may emerge as a viable treatment approach in diseases beyond autoimmunity, such as **transplantation tolerance, severe IgE-mediated allergic disease, and other immune indications**.

Johanna T. Kurzhagen, William Laqua, Mario Schiffer, Ricardo Grieshaber-Bouyer, T-cell engagers mediate deep cell depletion beyond autoimmunity, Kidney International, Volume 109, Issue 6, 2026, Pages 1081-1084, ISSN 0085-2538, https://doi.org/10.1016/j.kint.2026.03.010.

# T Cell Engagers in the Community: A Case Study for CLN-978

**John Tesser, MD, FACP, FACR**
*Arizona Arthritis & Rheumatology Associates*

# Practicing Rheumatology in the Community

## What does rheumatology community practice look like?

- **Arizona Arthritis & Rheumatology Associates: 14 AZ offices + Lone Star Arthritis & Rheumatology: 3 offices**
  - ✓ 400 employees (including overseas vendors)
  - ✓ 25 rheumatologists: 50 advanced practice clinicians
- **Arizona Arthritis & Rheumatology Research: AZ, TX and 8 other states**
  - ✓ 22 clinical trial sites conducting 400 studies of which 75 are currently enrolling

## Who are your patients in the community?

- **Over 65,000 patients – of which 3,550 patients are diagnosed with various forms of SLE**
- **Patients across all disease areas treated have a breadth of over 100 disorders affecting the musculoskeletal and all organ systems**

## Why are you a community physician?

- **For the science**
- **For the challenges**
- **For the art: physical and cognitive - the rheumatologist's sixth sense**
- **Most importantly, for the patients: empathy and compassion**

# Significant Unmet Need in Lupus Demands New Treatment Approaches in Community Practice

## Substantial Unmet need

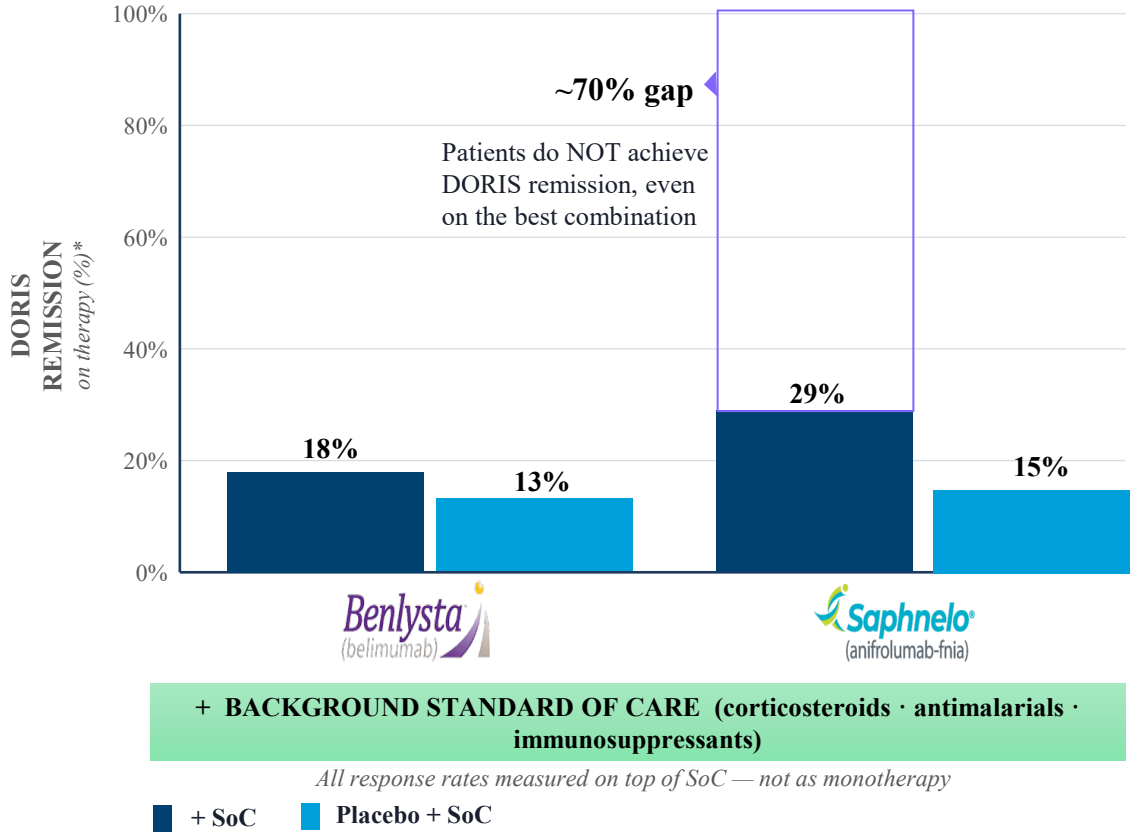
Currently approved therapies can reduce the signs and symptoms of SLE.

These potentially lifelong treatments result in frequent repeated dosing delivered IV or SQ and can result in non-compliance and missed dosing and disease flare

Additionally, many patients stop responding or are not able to tolerate these treatments and remain with significant disease activity.

Approved biologics do not induce treatment-free remission in majority of patients

## DORIS remission in pivotal SLE trials, all arms received background standard of care




*DORIS = Definitions of Remission in SLE; measured on therapy, ≠ treatment-free remission*
*Sources: ScienceDirect POS0767 (belimumab DORIS post-hoc, 5 Ph3 trials). ACR Journals (anifrolumab Ph3 subcutaneous).*

# SLE Patient Case Study: Cohort 10µg + 30µg

## *Patient 031*

OUTRACE SLE STUDY

### Patient Demographics:

**Age**: 29 **Sex**: F **Tx Start:** Jan. 2026

- **Diagnosis Date**: 2019
- **Diagnosis:** Pos ANA, anti-SM, dsDNA; Joint involvement, Renal biopsy Class II or V Lupus nephritis, Low C3/C4, pleuritis, pericarditis, Raynaud's, seizure disorder

### Prior Therapies

| | |
|---|---|
| • Hydroxychloroquine | 2020 to ongoing |
| • Mycophenolate | 2024 to 2025 |
| • Belimumab | June 2024 to August 2025 |
| • Methotrexate | March 2024 to June 2024 |

### Treatment Course

| Disease Assessment | | Day 1 | Wk 4 | Wk 8 | Wk 12 |
|---|---|---|---|---|---|
| **hSLEDAI** | *Proteinuria* | X | X | | |
| | *Rash* | X | | | |
| | *Increased DNA binding* | X | X | | |
| | **Total Score** | 8 | 6 | 0 | 0 |
| **PGA** (mm) | | 60 | 22 | 17 | 6 |
| **LLDAS** | | | | Yes | Yes |
| **DORIS** | | | | | Yes |

### Disease Modifying Impact of CLN-978

- ✓ DORIS remission achieved following a single target dose despite prior biologics failure
- ✓ Complete resolution of proteinuria
- ✓ Good tolerability, with Grade 1 CRS resolving with only acetaminophen treatment

### Treatment-Emergent Adverse Events

- CRS Grade 1: following Day 1 and Day 8 dosing
  - Max temp 38.6 °C, treated with acetaminophen and resolved

*DORIS: Definition of Remission in SLE; Lupus Low Disease Activity State; hSLEDAI: hybrid Systemic Lupus Erythematosus Disease Activity Index: PGA: Physician Global Assessment*

**As of May 15, 2026 data cutoff*

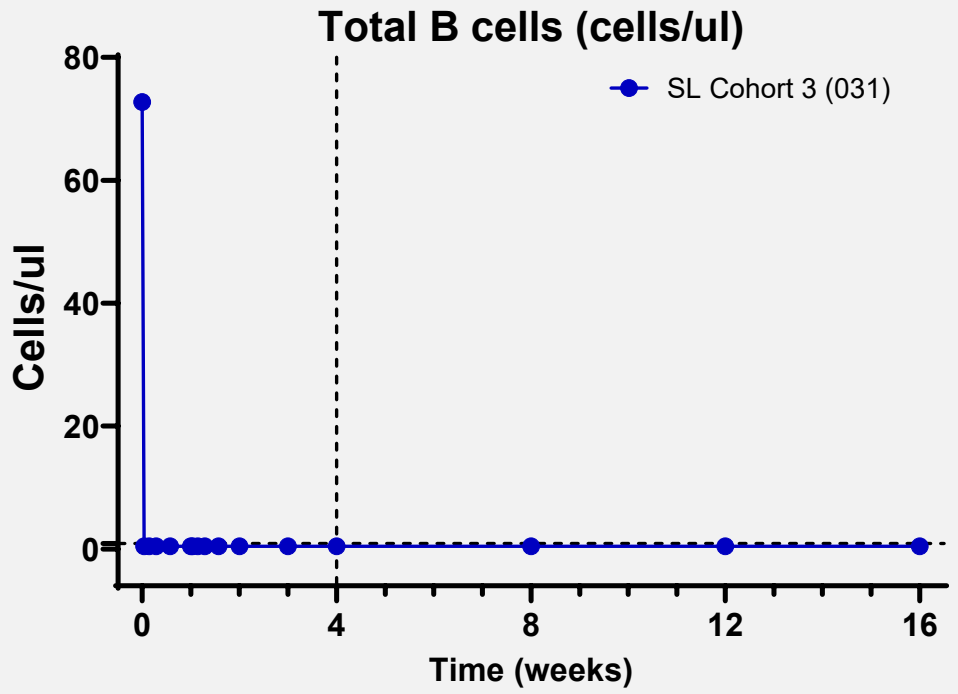
***Illustrative only; patient case studies may not be representative of overall data set*

# SLE Patient Case Study: Cohort 10µg + 30µg

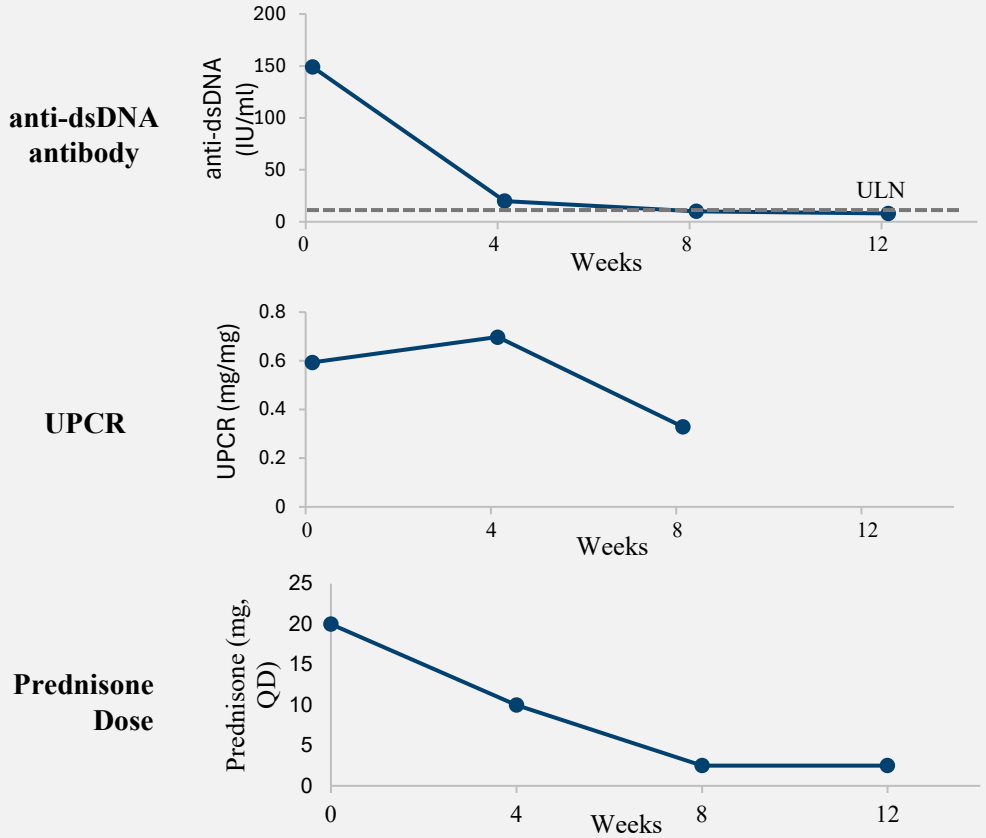
## *Patient 031*

OUTRACE SLE STUDY

### Rapid, deep and durable B cell depletion in peripheral blood




### Clinically meaningful reduction in anti-dsDNA antibody and UPCR, significant prednisone tapering




**As of May 15, 2026 data cutoff*

***Illustrative only; patient case studies may not be representative of overall data set*

# CLN-978 is the Ideal Therapy for Community Rheumatologists

- **Clinical and immunologic response in CLN-978 treated patients contributes to the growing body of evidence supporting the benefit of TCEs generally and CLN-978 specifically**
- **Discontinuation of background therapy –** CLN-978 monotherapy efficacy may allow for elimination of concomitant therapy, including steroids
- **Rapid response at therapeutic doses -** swift onset of clinical response and significant reduction in laboratory markers of disease observed, including prompt resolution of proteinuria and dsDNA antibodies
- **Low patient and physician burden –** a practical solution with greater accessibility through ease of administration (SC), off-the-shelf availability, no lymphodepletion, and a manageable safety profile
- **TCEs bring the deeper immune depletion similar to CAR T therapy with the accessibility, scalability, and controllability of conventional biologics to the community setting**

# Next steps for CLN-978

**Jeff Jones, MD, MBA**
*Chief Medical Officer*

# 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

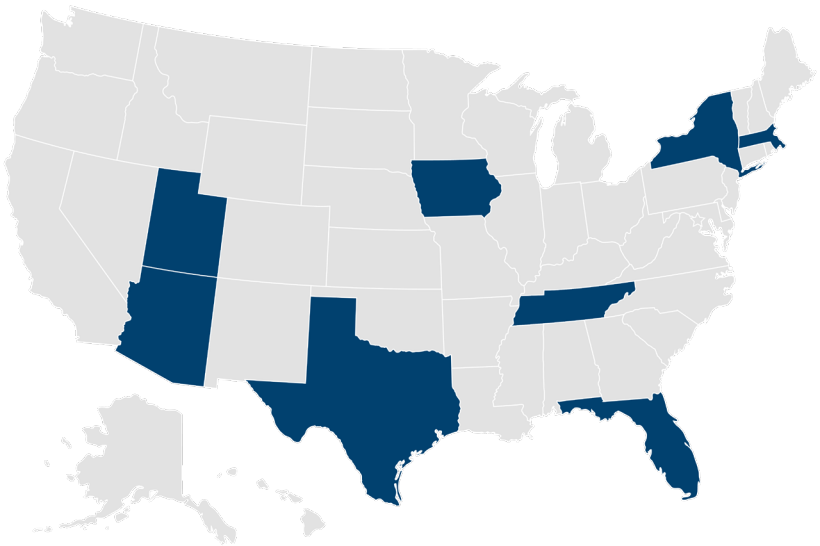
**Delivered as a medicine in the community, where patients live and work**

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

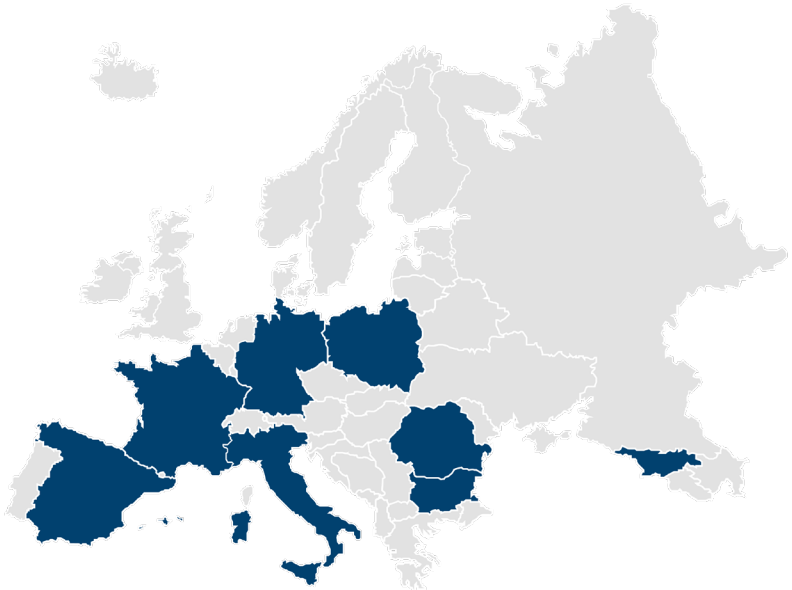
**Shifting the paradigm from chronic disease management to immune reset and remission**

# OUTRACE: An Established, Phase 2-Ready Clinical Trial Footprint

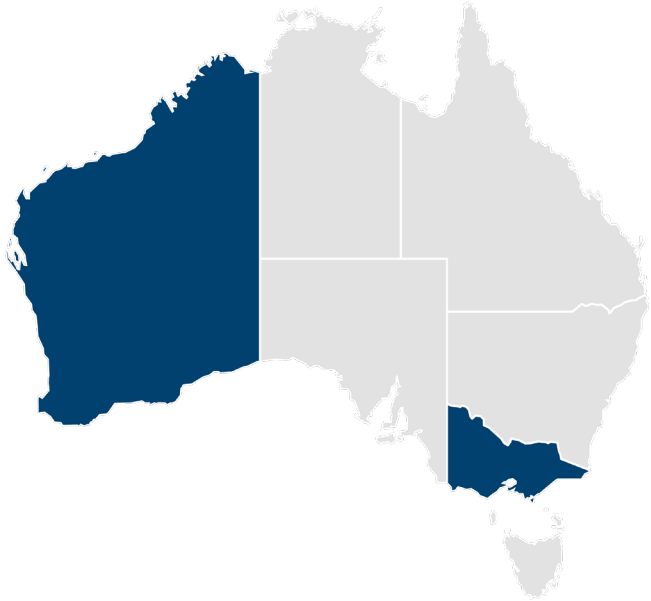
UNITED STATES



EUROPE



AUSTRALIA



SLE RA SjD

**In collaboration with:**

LUPUS FOUNDATION OF AMERICA

LUPUS RESEARCH ALLIANCE

LUPUS and ALLIED DISEASES Association, Inc.

LUPUS LA

LUPUS EUROPE

GLOBAL HEALTHY LIVING FOUNDATION

Sjögren's FOUNDATION

Sjögren europe

Sjögren's Australia

*As of May 31, 2026*

# OUTRACE-SLE: Advancing Toward Registration-enabling Studies

## *Monotherapy Efficacy Facilitates More Efficient Development*

**COMPLETED**

### Part A: Phase 1 Single Ascending Dose

Cohort 4 (*optional; n=3*)
- Day 1: 10 micrograms
- Day 8: 45 micrograms

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

### Complete Multi-Dose Cohorts

***Objective***

*Identify candidate dosing regimens for further study*

**Select candidate schedules for Phase 2**

**Anticipated additional data in Q4 2026**

### Phase 2a Dose Selection Target Initiation in Early 2027

***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

# 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**

# OUTRACE-RA: Advancing Toward Registration-enabling Studies

## *Monotherapy Efficacy Facilitates More Efficient Development*

**COMPLETED**

**Part A: Phase 1 Single Ascending Dose**

- **Cohort 4** (*optional; n=3*)
  - Day 1: 10 micrograms
  - Day 8: 45 micrograms
- **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=1*)
  - Day 1: 10 micrograms

### Complete Multi-Dose Cohorts

***Objective***

*Identify candidate dosing regimens for further study*

**Select candidate schedules for phase 2**

**Anticipated additional data in Q3 2026**

### Phase 2a Dose Selection
### Target Initiation in Early 2027

***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

# Velinotamig Initial Clinical Data and Development Plan

**Jeff Jones, MD, MBA**
*Chief Medical Officer*

# 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 1b/2a 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 study in China in patients with autoimmune diseases, initially in patients with SLE, followed by future expansion into other indications.

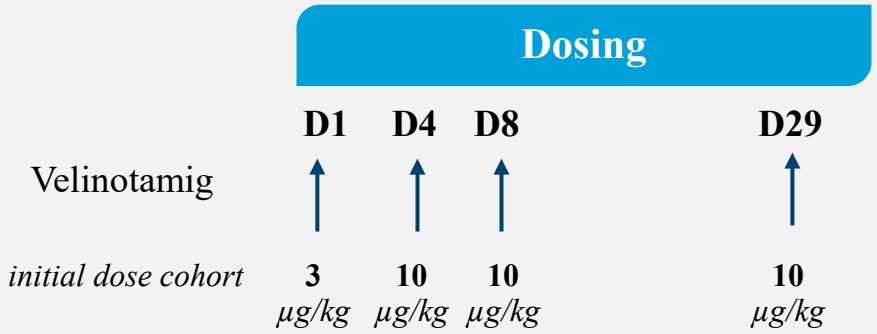
# Genrix Phase 1b/2a Study Explores Defined Duration, Multi-dose Regimens of Velinotamig in Patients With Refractory SLE

## Genrix Bio is conducting this study at 5 sites in China

### Dose Escalation Study Design

#### Treatment Schedule

**Treatment Period**: 4 doses administered IV over 4 weeks
**Follow-Up Period**: 48 weeks




#### Patient Eligibility

- Age 18 to 60
- Diagnosis of SLE by 2019 EULAR/ACR criteria for at least 6 months
- SLEDAI-2K ≥6
- Poor response to or relapsed after standard treatment including glucocorticoids and/or antimalarial drugs and/or immunosuppressants for ≥ 3 months

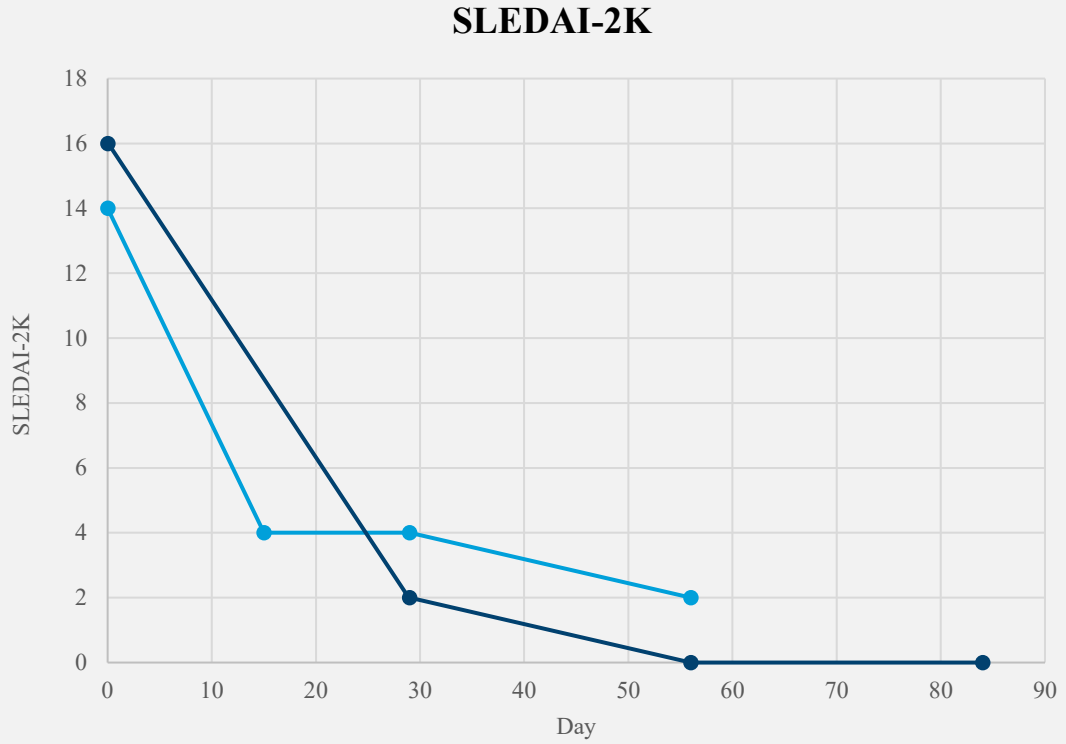
Dose escalation ongoing; Initiation of Phase 2 expansion anticipated by **YE 2026**

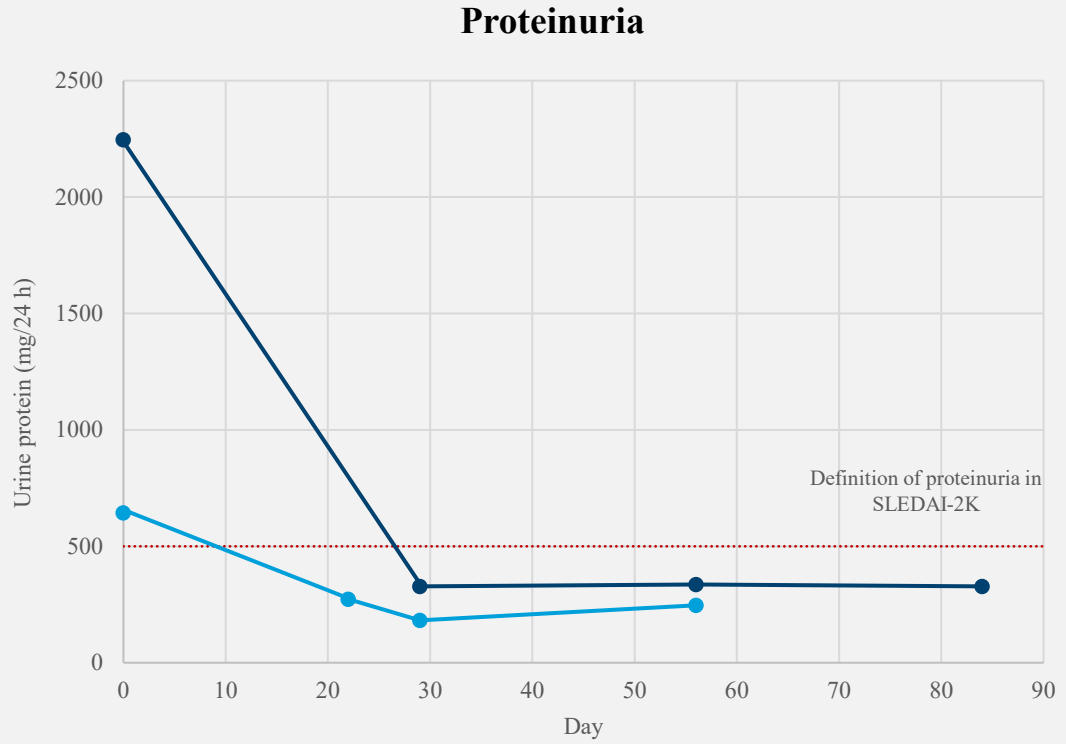
**As of May 15, 2026 data cutoff*

# Velinotamig Demonstrated Convincing Initial Efficacy

Rapid clinical improvement observed at the starting dose level (10 ug), including rapid declines in proteinuria

**Initial Clinical Efficacy:** Rapid and robust reductions in SLEDAI-2K and proteinuria




● Patient 1 ● Patient 2

**As of May 15, 2026 data cutoff*

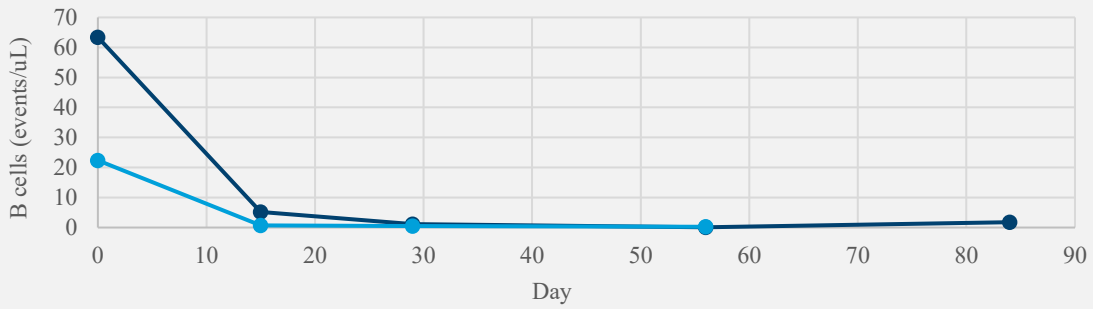
 

# Velinotamig Initial Efficacy Correlated with Impact on Key Biomarkers

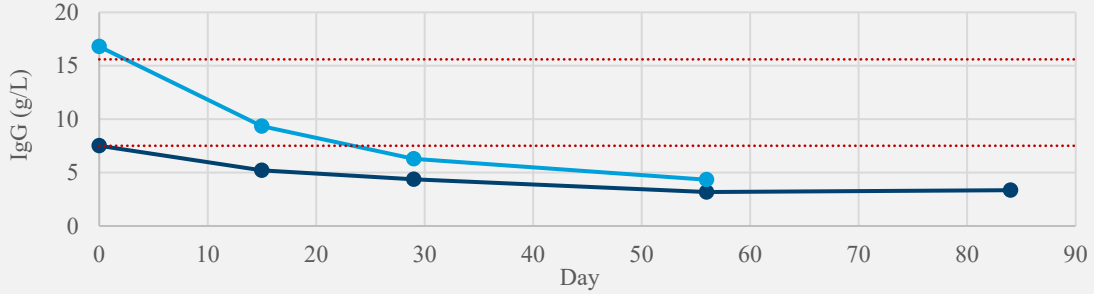
Clinical response correlated with rapid decline in both normal and pathogenic antibodies

## **Pharmacodynamics:** Total IgG and dsDNA reduction, B cell depletion, and complement normalization

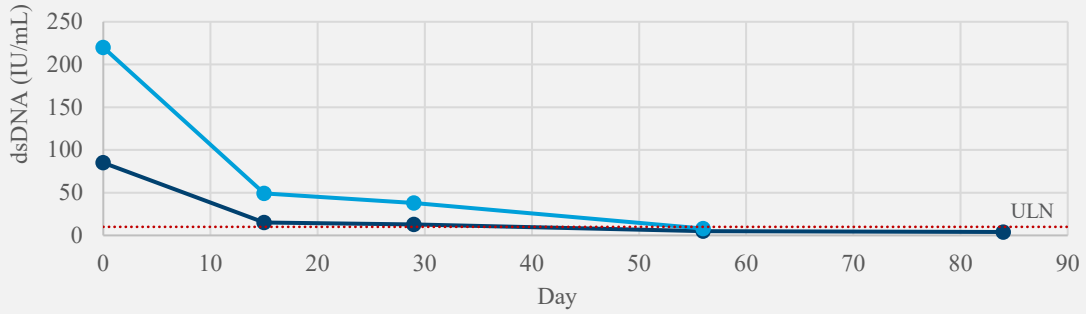
### Peripheral Blood B Cells



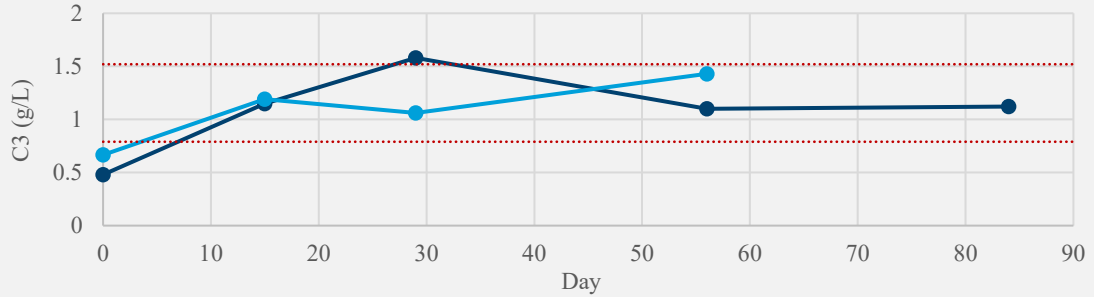

### Total IgG




### dsDNA Autoantibodies




### Complement C3




● Patient 1 ● Patient 2

**As of May 15, 2026 data cutoff*

# Velinotamig Demonstrates Favorable Initial Safety at Clinically Active Doses When Administered in a Multi-dose, Defined Duration Regimen

## Favorable safety at the clinically active initial dose level: No CRS or ICANS in first two patients

| | Patient 1 | Patient 2 |
|---|---|---|
| **CRS** | None | None |
| **ICANS** | None | None |
| **SAEs** | None | None |
| **Grade ≥3 Infections** | None | None |
| **Grade ≥3 Cytopenias** | Lymphocyte count decreased* | Lymphocyte count decreased* |
| **Other AEs** | Viral infection† Gr 2<br>Low Immunoglobulins Gr 2 | Viral infection† Gr 2<br>Low Immunoglobulins Gr 1 |

Notes: *transient, mechanistically based;†mandatory antiviral prophylaxis implemented

*As of May 15, 2026 data cutoff*

# Velinotamig: Initial Data Support Broad Potential

**In patients with refractory SLE, at the starting target dose of 10 mcg/kg, velinotamig demonstrated:**

Initial efficacy: complete renal responses in both patients

Efficacy correlated with rapid depletion of pathogenic and normal antibodies, as well as normalization of serum complement

Marked, antibody depleting effects achieved at a dose and schedule with a favorable initial safety profile

**As of May 15, 2026 data cutoff*

# Beyond Rheumatology: Initial 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** |

# Advancing Velinotamig Global Clinical Development to Accelerate Upcoming Anticipated Milestones

## GLOBAL DEVELOPMENT STATUS

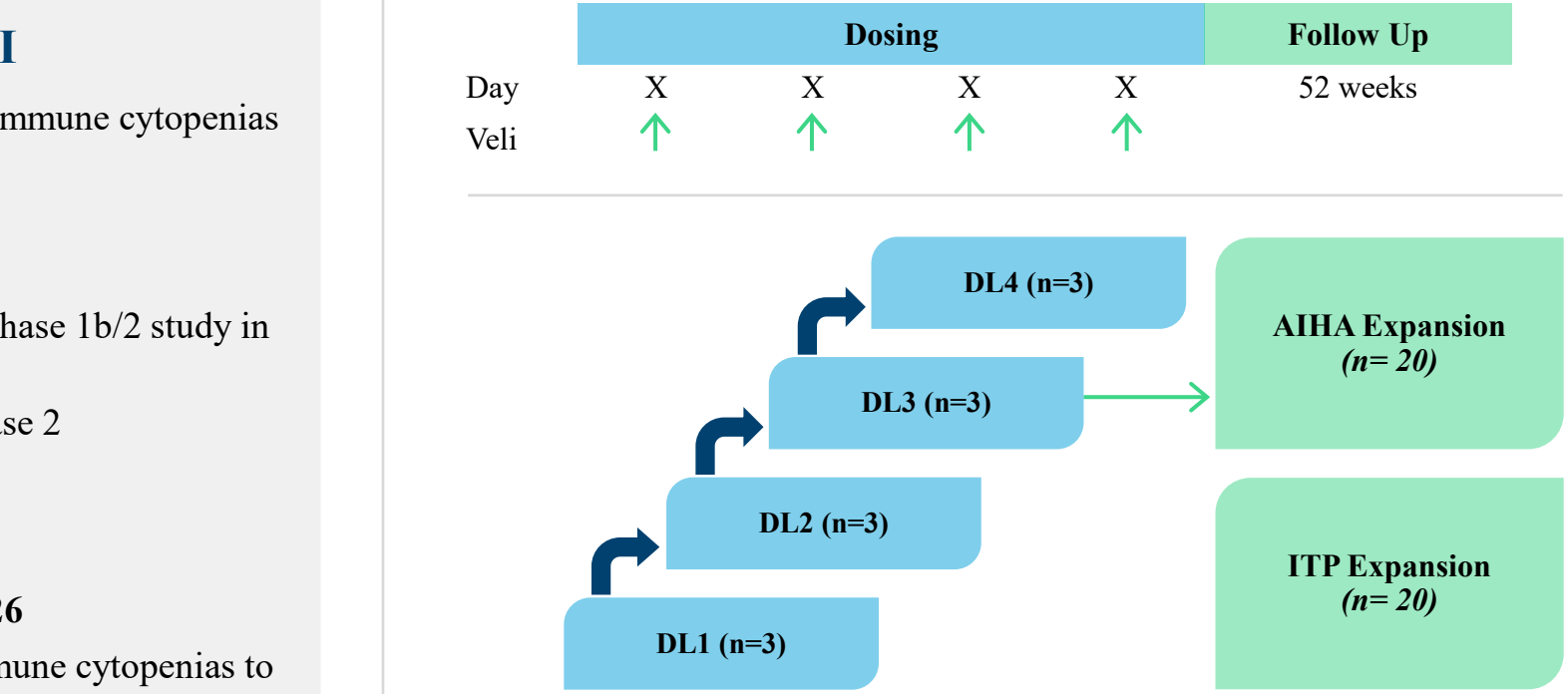
### Ongoing clinical development in I&I

- Initiate Cullinan-led POC basket study in autoimmune cytopenias including:
  - Autoimmune hemolytic anemia (AIHA)
  - Immune thrombocytopenia (ITP)
- Genrix Bio continues dose escalation in their Phase 1b/2 study in treatment refractory SLE patients
  - Additional indications are planned for Phase 2

### Upcoming Anticipated Milestones

- Updated data from Genrix Bio study in **Q4 2026**
- Cullinan-led Phase 1/2 basket study in autoimmune cytopenias to begin in **Q1 2027**
- Genrix Bio expects to initiate Phase 2 expansion by **YE 2026**

## Illustrative Autoimmune Cytopenia Trial Design




Failed 2 lines of treatment

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

# Strategic Perspective & Next Steps

**Nadim Ahmed**
*President and Chief Executive Officer*

# Key Takeaways

## CLN-978 clinical profile and mechanism of action now validated with single target doses:

- ✓ Promising clinical efficacy in SLE and RA, including clinical remissions
- ✓ Deep B cell depletion in peripheral blood and tissue; demonstrating indicators of immune reset
- ✓ Clinically significant reductions in autoantibodies; supporting disease modifying effect
- ✓ Encouraging safety profile for autoimmune diseases; facilitating potential out-patient administration

## CLN-978 OUTRACE global program; rapid execution through positive momentum:

- ✓ Immunology infrastructure in place for rapid trial accrual and indication expansion
- ✓ Potential rapid and efficient regulatory path driven by monotherapy efficacy, including accelerated approval
  - Target: First CD19 TCE approval in immunology

## Velinotamig initial data validates clinical profile:

- ✓ Initial efficacy with rapid depletion of pathogenic autoantibodies

**Immunology programs now significantly derisked ahead of multiple near-term, value-driving catalysts**

# Clear Path to Additional Near-term Catalysts and Next Steps

## Q3 2026

**CLN-978**:
RA multi-dose regimen data

## Q4 2026

**CLN-978**:
**Update:** SLE multi-dose regimen data

Initial single target dose data in Sjögren's Disease

**Velinotamig**:
SLE multi-dose regimen data update

## Early 2027

**CLN-978**:
Begin Phase 2a expansion in SLE
Begin Phase 2a expansion in LN

**Velinotamig**:
Initiate Phase 1/2 basket trial in autoimmune cytopenias in Q1 2027

# Q&A

**Nadim Ahmed**
*President and Chief Executive Officer*

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*Chief Medical Officer*

**Dr. Ricardo Grieshaber-Bouyer, PhD**
*Professor of Clinical Systems Immunology,*
*FAU Erlangen-Nürnberg*

**Dr. John Tesser, FACP, FACR**
*Arizona Arthritis & Rheumatology Associates*

 


THANK YOU
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THERAPEUTICS