
cullinan
THERAPEUTICS
SCIENCE THAT moves™
CORPORATE OVERVIEW
March 2026

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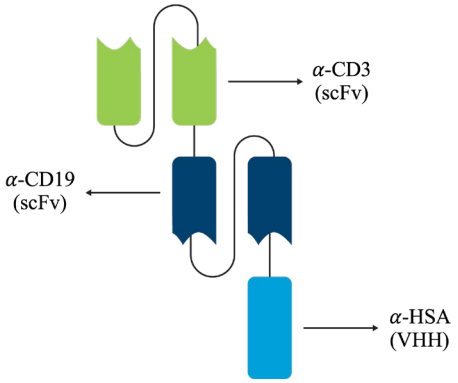
Advancing T cell engagers across high-impact, validated targets in immunology and oncology

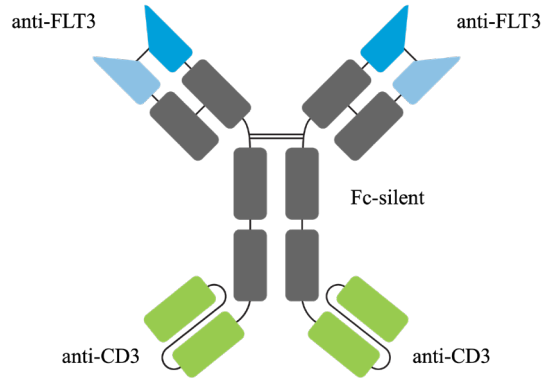
CLN-978 in autoimmune diseases:
CD19xCD3 bispecific T cell engager

- **Potential best-in-class** CD19xCD3 T cell engager in autoimmune diseases
- Prior observations from Phase 1 B-NHL study showed rapid, deep, and sustained B cell depletion and anti-tumor efficacy
- Off the shelf, potential disease modifying treatment across autoimmune diseases
- Experienced immunology team dedicated to CLN-978
- Phase 1 studies ongoing in SLE, RA and Sjögren's disease, with **initial data across all three indications in 2026**



CLN-049 in AML and MDS:
FLT3xCD3 bispecific T cell engager

- **Potential first-in-class** T cell engager in AML, where FLT3 is a well-validated therapeutic target
- U.S. FDA **Fast Track designation** in R/R AML
- Internal deep expertise in hematology
- Phase 1 study ongoing in patients with relapsed/refractory AML or MDS; **dose expansion to be completed in Q4 2026 for RP2D determination**
- Promising clinical activity observed, including multiple complete responses, (oral presentation at **ASH 2025)**



Cash and investments of **$439 million** on hand at **December 31, 2025*** to advance these **priority programs**, expected to fund operations into **2029**

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

Leveraging novel technologies and differentiated mechanisms across immunology and oncology

Immunology

Program Modality/MOA	Study Population	IND-Enabling / Phase 1 / Phase 2 / Phase 3	Status/ Next Milestone	Geographic Rights
CLN-978 CD19xCD3 bispecific T cell engager	Systemic lupus erythematosus (SLE)		Initial data in SLE in **Q2 2026**	cullinan THERAPEUTICS worldwide rights
	Rheumatoid arthritis		Initial data in RA in **Q2 2026;** Repeat dosing data in **Q3 2026**	
	Sjögren's disease		Initial data in Sjögren's disease in **Q4 2026**	
Velinotamig (GR-1803) BCMAxCD3 bispecific T cell engager	Autoimmune diseases		Initial data in autoimmune diseases in **Q4 2026**	cullinan THERAPEUTICS worldwide rights outside of Greater China*

Oncology

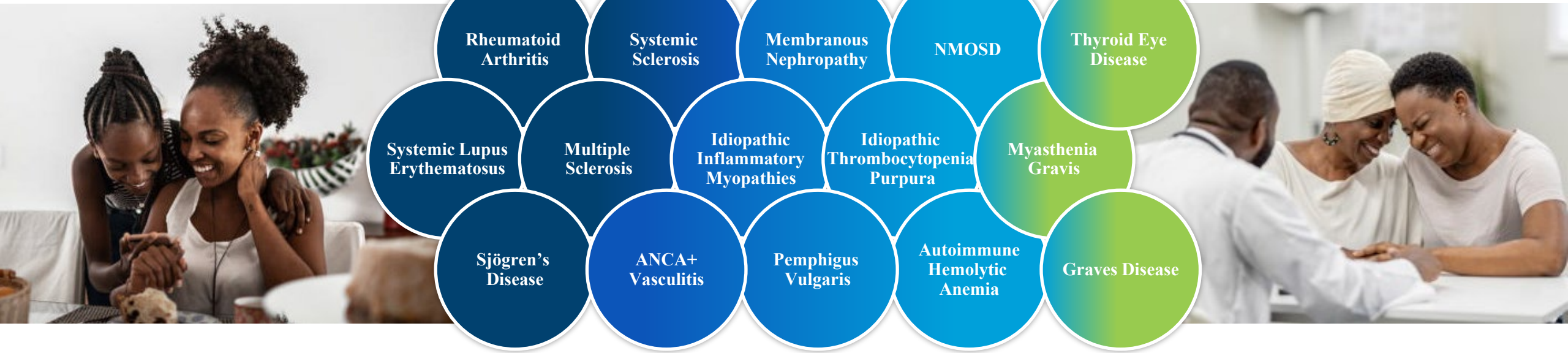
Program Modality/MOA	Study Population	IND-Enabling / Phase 1 / Phase 2 / Phase 3	Status/ Next Milestone	Geographic Rights
Zipalertinib (CLN-081/TAS6417) EGFR ex20ins inhibitor	NSCLC with EGFR exon 20 insertion mutations (ex20ins)	REZILIENT1 NSCLC with ex20ins 2L+ line	Rolling NDA submission in relapsed EGFR ex20ins NSCLC completed in **February 2026**	cullinan THERAPEUTICS holds US co-development/ commercialization rights with TAIHO ONCOLOGY
	NSCLC with EGFR ex20ins and uncommon non-ex20ins EGFR mutations	REZILIENT3 NSCLC with ex20ins frontline	Phase 3 1L study **fully enrolled**; Taiho expects to obtain top-line results by the **end of 2026**	
		REZILIENT2 Parallel Cohort Study	Parallel cohort study ongoing	
CLN-049 FLT3xCD3 bispecific T cell engager	R/R AML, MDS		Dose escalation data update in **H2 2026**; Dose expansion to initiate in **Q2 2026** and complete in **Q4 2026**	cullinan THERAPEUTICS worldwide rights
	AML and MRD		Phase 1 study ongoing in patients with AML and MRD	

*China, including the Hong Kong Special Administrative Region, Macao Special Administrative Region, and Taiwan. Genrix Bio is enrolling a Phase 1 study in China in patients with autoimmune diseases, initially in patients with SLE, followed by future expansion into other indications. Following the completion of the Genrix Bio Phase 1 study, we will conduct all further development of velinotamig in autoimmune diseases.

T CELL ENGAGERS IN AUTOIMMUNE DISEASES

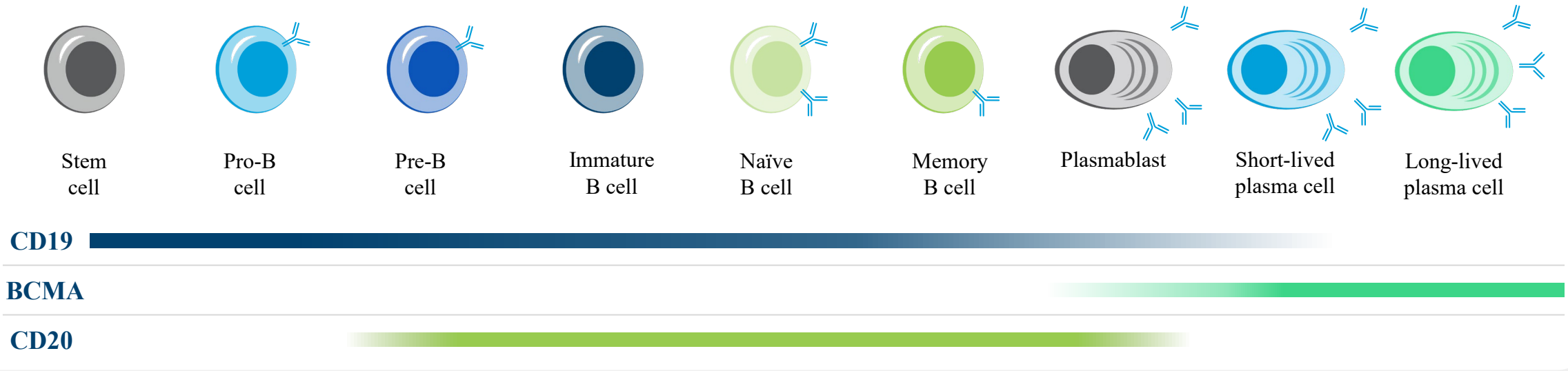
Growing global prevalence of autoimmune diseases underscores need for treatments that deliver durable remissions

Opportunity to address autoimmune diseases through B cell and long-lived plasma cell depletion



B cells and plasma cells play key roles in pathogenic processes in autoimmune diseases, making them attractive, well-validated therapeutic targets

Targeting CD19 or BCMA may be central to the disease modification of certain autoimmune diseases



- B cell dysfunction is central to the pathogenesis of many autoimmune diseases, and broadly and deeply depleting these cells by targeting **CD19** appears necessary to affect an immune system reset
- Autoantibodies central to the pathogenesis of other autoimmune diseases are predominantly produced by plasma cells, particularly long-lived plasma cells, so depleting these cells by targeting **BCMA** could potentially improve outcomes[1,2,3]
- **CD20** expression on B cells may not be sufficiently broad enough to induce an immune reset nor does it directly deplete plasma cells

[1] Dong N., Zhang H., Song J., et al. B-cell maturation antigen expression and clinical features of plasmablastic lymphoma. EJHaem. 2024 Jan 18;5(1):285-289. doi: 10.1002/jha2.807. PMID: 38406544; PMCID: PMC10887266.
[2] Pillarisetti K., Powers G., Luistro L., et al. Teclistamab is an active T cell-redirecting bispecific antibody against B-cell maturation antigen for multiple myeloma. Blood Adv. 2020 Sep 22;4(18):4538-4549. doi: 10.1182/bloodadvances.2020002393. PMID: 32956453; PMCID: PMC7509877.
[3] Tian D.S., Qin C., Dong M.H., et al. Cell lineage reconstitution underlies CAR-T cell therapeutic efficacy in patients with refractory myasthenia gravis. EMBO Mol Med. 2024 Apr;16(4):966-987. doi: 10.1038/s44321-024-00043-z. Epub 2024 Feb 26. PMID: 38409527; PMCID: PMC11018773.

T cell engagers: Optimal modality with potential to be disease modifying, convenient, and off-the-shelf treatment option

T cell engagers: Protein constructs engineered to redirect T cells to eliminate malignant or autoreactive cells expressing a specific cell surface target

mAbs	TCEs	CAR T
Lower efficacy; limited tissue penetration	High efficacy; B cell depletion in tissue	High efficacy; B cell depletion in tissue
Symptomatic relief	Potentially disease modifying	Potentially disease modifying
Immune modulating	Potential for immune reset	Potential for immune reset
Off-the-shelf and ease of administration	Off-the-shelf and ease of administration	Lengthy manufacturing process tailored to each patient; complex administration
Dosing flexibility	Dosing flexibility to extend remissions	Single dose without opportunity to re-dose
Free from access issues and complex interdisciplinary coordination	Free from access issues and complex interdisciplinary coordination	Can have access issues and involves complex interdisciplinary coordination
Free from lymphodepleting preconditioning regimen	Free from lymphodepleting preconditioning regimen	Requires lymphodepleting preconditioning regimen

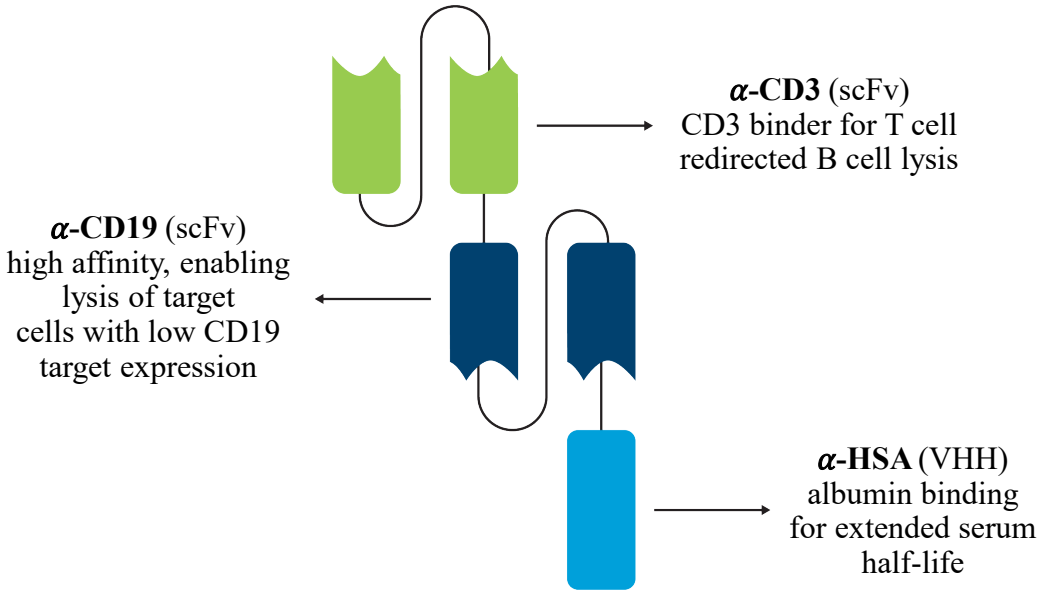
T CELL REDIRECTING THERAPIES

CLN-978

CD19xCD3 bispecific T cell engager

CLN-978: A highly differentiated and potentially best-in-class CD19XCD3 bispecific T cell engager

CLN-978
BISPECIFIC CD19XCD3 T CELL ENGAGER



CLN-978
POTENTIAL ADVANTAGES IN AUTOIMMUNE DISEASES

Therapeutic modality

Predictable PK/PD properties, engaging all subsets of T cells to lyse target cells with variable CD19 expression levels. Dosing flexibility and ability to redose to extend remissions

Optimal target

CD19 best balances the potential for deep and broad B cell depletion (vs CD20) necessary to affect an immune reset while limiting risk for infection (vs BCMA)

Convenience

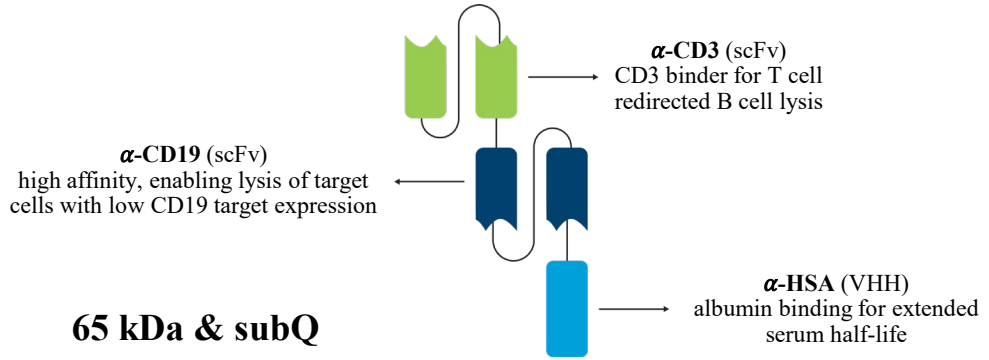
Off-the-shelf availability, subQ administration, lower manufacturing burden, dosing flexibility, potential for outpatient administration

HSA, human serum albumin binding domain.

CLN-978 is well differentiated relative to other CD19 TCES in development*

POTENTIAL ADVANTAGES OF CLN-978

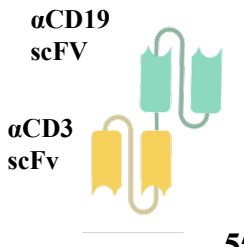
1. Broader B cell lineage depletion due to very high affinity binding to CD19
2. Wider therapeutic index due to "cytokine window" (10X higher potency for B cell depletion relative to cytokine induction)
3. More efficient deep tissue penetration due to smaller size
4. Published clinical data for blinatumomab supports promising potential for a half-life extended bispecific TCE in autoimmune diseases



Half-Life Extended Bispecific TCE

Short Half-Life

Blinatumomab
AMGEN



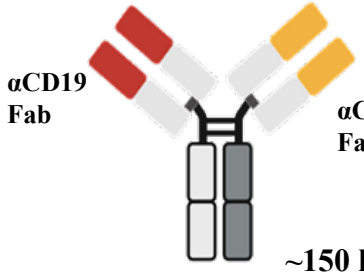
SubQ
55 kDa
BiTE

A-319
iTabMed

IV
~67 kDa
TCE

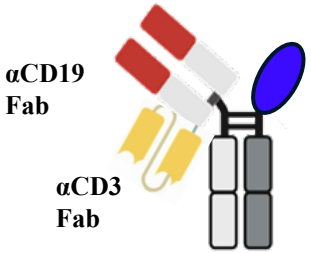
Larger Molecular Format

RO7507062
ROCHE



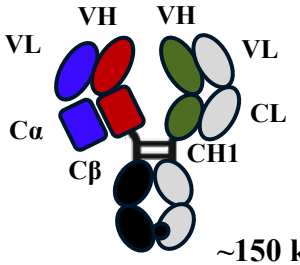
SubQ
~150 kDa
IgG-like

PIT565
NOVARTIS



SubQ
~150 kDa
IgG-like

CN201
MERCK



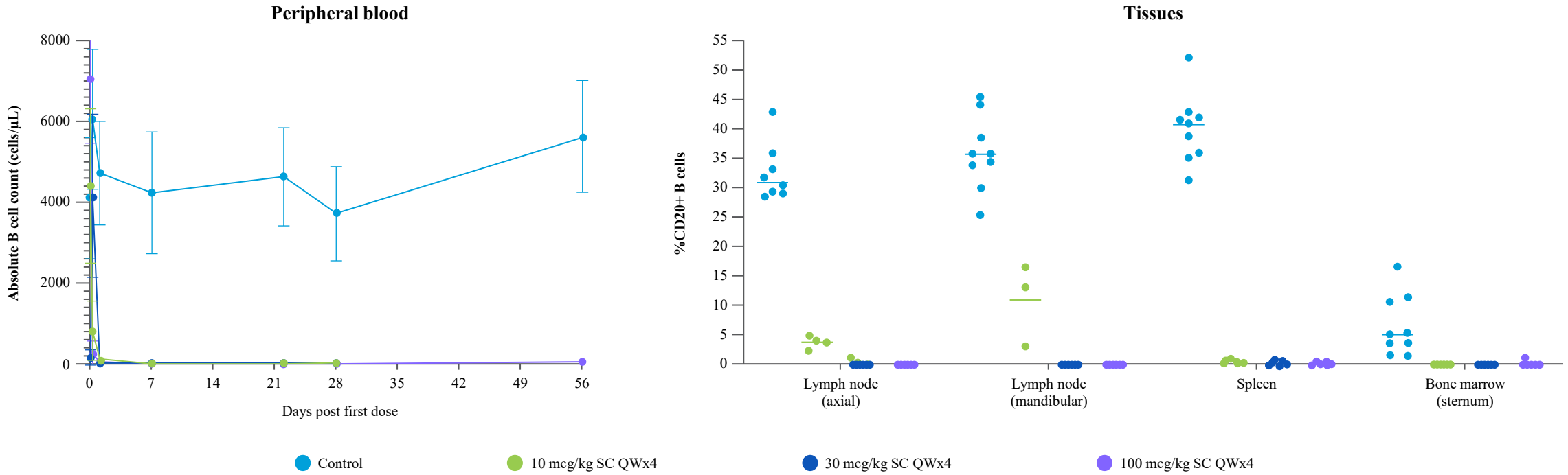
IV
~150 kDa
IgG-like

*The above list of CD19 TCEs in development is indicative only and not exhaustive; molecule size assumptions based on publicly available data.

CLN-978 achieved deep and sustained B cell depletion in NHP tissues, suggesting the potential to achieve meaningful B cell depletion in patients

New Preclinical Highlights Shared at ACR 2025

Subcutaneous administration of CLN-978 induced B cell depletion in tissues of NHPs



SC = subcutaneous administration

In a study of B-NHL patients, CLN-978 achieved sustained B cell depletion with promising clinical results

Clinically Active at 30µg SC Weekly Starting Dose for NHL Patients

2 of 3 patients demonstrated objective clinical benefit, including a complete response

Class toxicity: max Gr 1 CRS, no ICANS

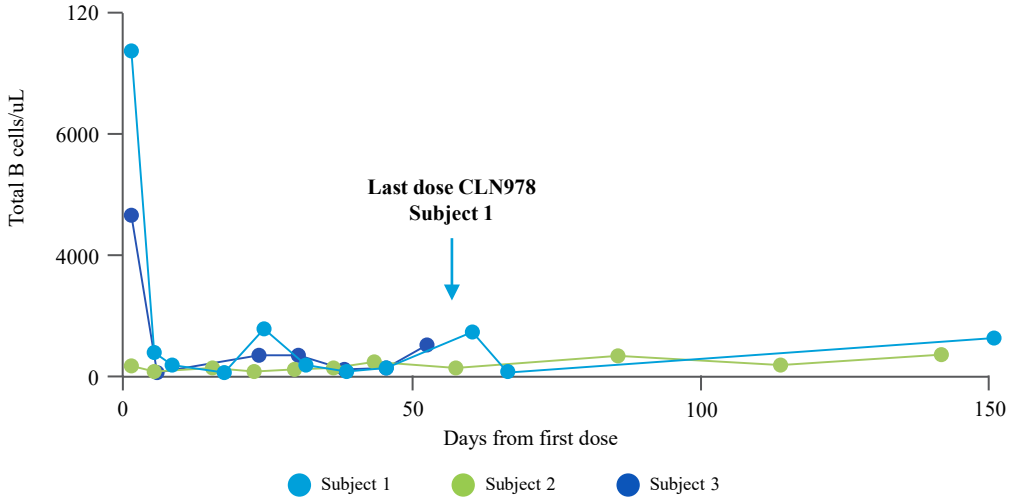
- Subject #3: transient Gr 1 tremor in the context of acute influenza infection during cycle 1; transient (~24h) Gr 2 confusion during cycle 2; neither event associated with CRS/ICANS

Other adverse events were low-grade and/or mechanistically based (e.g., lymphopenia)

Further enrollment discontinued given reprioritization for development in autoimmune diseases

Rapid, Deep, and Sustained B Cell Depletion Demonstrated in B-NHL Patients

Rapid, deep, and sustained B cell depletion was demonstrated in 2 of 2 subjects with measurable B cells at baseline; all patients treated at the starting dose level of 30 ug SC weekly



Peripheral blood TBNK flow assay
Data cut-off 20 March 2024

B-NHL, B cell non-Hodgkin lymphoma; CRS, cytokine release syndrome; Gr, grade; ICANS, immune effector cell associated neurotoxicity syndrome.

OUTRACE trials: Our comprehensive, global clinical development program for CLN-978

	Focus	Aim	Trial Locations	Unmet Need
OUTRACE SLE STUDY	Active, moderate to severe **systemic lupus erythematosus**	**Phase 1 sponsor-led studies evaluating safety as well as potential effects on disease activity and the immune system**	Global study across U.S., Europe and Australia	• Currently approved therapies can reduce the signs and symptoms of SLE. However, these therapies result in chronic immune suppression, increasing infection and cancer risk
OUTRACE RA STUDY	Active, treatment-refractory **rheumatoid arthritis**		Europe	• Currently approved therapies do not obtain sustained remissions and require chronic immune suppression, increasing infection, especially in elderly people with RA • Many patients stop responding or are not able to tolerate these treatments and remain with significant disease activity
OUTRACE SJÖGREN'S STUDY	Active, moderate to severe **Sjögren's disease**		Global study across U.S. and Europe	• Currently, there are no approved medicines that treat Sjögren's disease • No treatment has been shown to comprehensively slow disease progression or treat all aspects of Sjögren's disease

OUTRACE-SLE global study design

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. SLEDAI ≥6 at screening
4. Inadequate response to at least one standard immunosuppressant or biologic agent used for the treatment of SLE

Part A: Dose Escalation

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

Part B: Dose Expansion

Further exploration of 2 or more dosing schedules

Schedule 1 (*n= 3 to 6*)
- Dose level and schedule to be determined by PK/PD findings observed in Part A

Schedule 2 (*n=3 to 6*)
- Dose level and schedule to be determined by PK/PD findings observed in Part A

Objectives

Primary Objective:

Safety and tolerability of CLN-978 for treatment of active SLE

Secondary Objectives:
- PK
- B cell kinetics
- Immunogenicity
- Clinical activity

Global Phase 1 study ongoing in United States, Europe, and Australia. Initial safety and B cell depletion data expected in Q2 2026

Clinicaltrials.gov identifier: NCT06613360

Systemic lupus erythematosus (SLE): High unmet need in complex disease with few approved therapies, limited efficacy, and chronic immunosuppression

High Unmet Need

- Systemic disease characterized by autoantibodies produced by B cells, leading to multiple affected organ systems (renal, CNS, cardiovascular, respiratory, skin)
- Largely impacts young, women of color
- ~40% of SLE patients develop lupus nephritis[1], which has a 10-year 30% mortality rate

SLE - Select Market Opportunity Estimate (US, EU5, JP, AU)

430,000	**Diagnosed patients** (18-70 y/o)[2-9]
285,000	**Estimated addressable patients**[10]
193,000	**Estimated moderate/severe patients**[11]

Opportunity: Current standards of care do not routinely induce treatment-free remission, most patients require lifelong immune suppression, treating symptoms without modifying course of disease

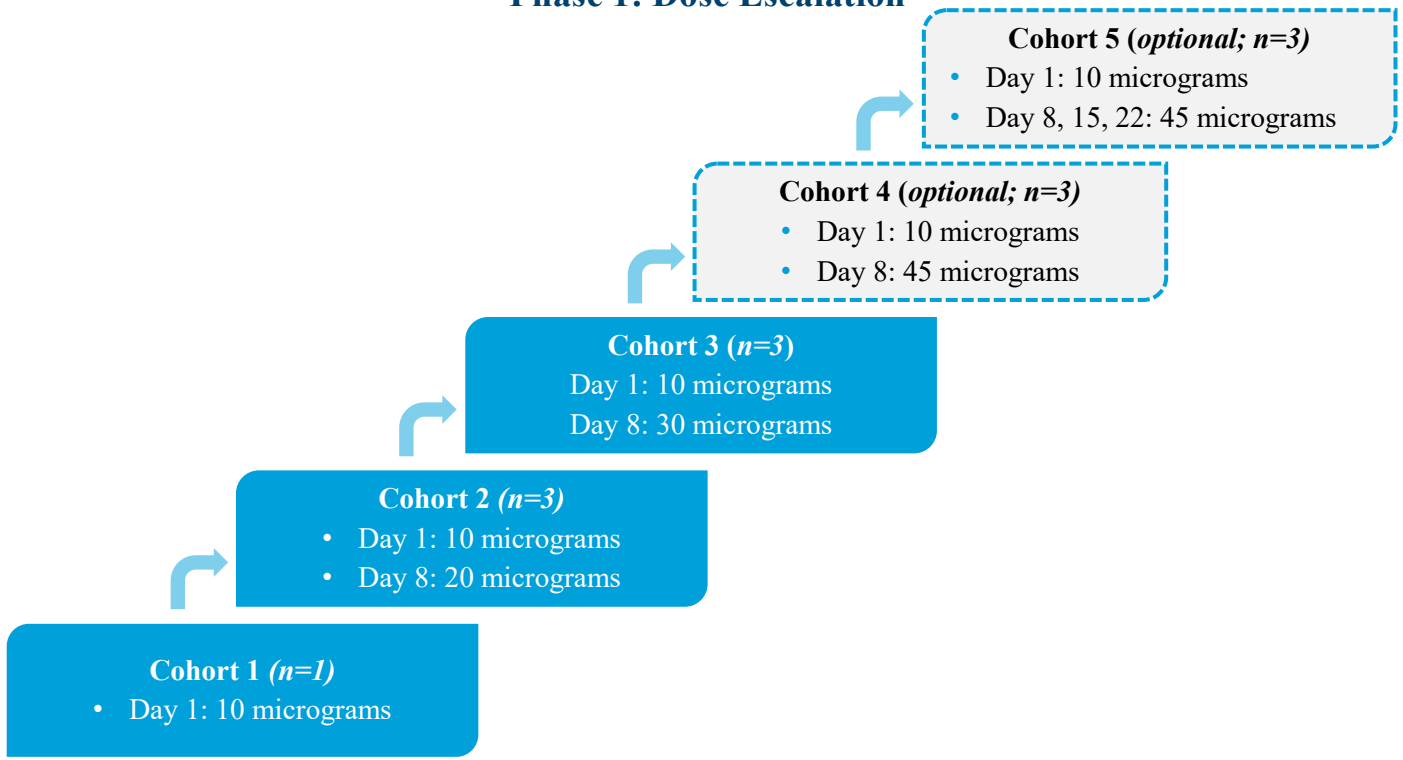
1. Mahajan, A. et al. Lupus. 2020 Aug; 29(9): 1011–1020.
2. US: Izmirly, P. M. et al. (2021b) 'Prevalence of systemic lupus erythematosus in the United States: estimates from a meta-analysis of the centers for disease control and prevention national lupus registries', Arthritis and Rheumatology, 73(6), pp. 991–996. doi: 10.1002/art.41632.
3. UK: Rees, F. et al. (2016) 'The incidence and prevalence of systemic lupus erythematosus in the UK, 1999-2012', Annals of the Rheumatic Diseases, 75(1), pp. 136–141. doi: 10.1136/annrheumdis-2014-206334.
4. FR: Arnaud, L. et al. (2014) 'Prevalence and incidence of systemic lupus erythematosus in France: a 2010 nation-wide population-based study', Autoimmunity Reviews, 13(11), pp. 1082–1089. doi: 10.1016/j.autrev.2014.08.034.
5. IT: Tsioni, V. et al. (2015) 'The prevalence and incidence of systemic lupus erythematosus in children and adults: a population-based study in a mountain community in northern Italy', Clinical and Experimental Rheumatology, 33(5), pp. 681–687.
6. DE: Brinks, R. et al. (2014) 'Age-specific prevalence of diagnosed systemic lupus erythematosus in Germany 2002 and projection to 2030', Lupus, 23(13), pp. 1407–1411. doi: 10.1177/0961203314540352.
7. ES: Alonso, M. D. et al. (2011) 'Systemic lupus erythematosus in northwestern Spain: a 20-year epidemiologic study', Medicine, 90(5), pp. 350–358. doi: 10.1097/MD.0b013e31822edf7f.
8. JP: Bae, E. H. et al. (2020) 'Trend of prevalence and incidence of systemic lupus erythematosus in South Korea, 2005 to 2015: a nationwide population-based study', Korean Journal of Internal Medicine, 35(3), pp. 652–661. doi: 10.3904/kjim.2018.303.
9. AU: Nikpour M, Bridge JA, Richter S. A systematic review of prevalence, disease characteristics and management of systemic lupus erythematosus in Australia: identifying areas of unmet need. Intern Med J. 2014 Dec;44(12a):1170-9. doi: 10.1111/imj.12568. PMID: 25169712.
10. Internal company estimate - Antinuclear Antibody (ANA) positive without Central Nervous System (CNS) patients based on historical systemic therapy treatment rates.
11. Internal company estimate - portion of addressable patients who present with moderate or severe SLE.

OUTRACE-RA initial Phase 1 design

Study Population

1. RA meeting 2010 EULAR/ACR criteria
2. Inadequate response to at least two DMARDS (tsDMARD and/or biologic) after csDMARD treatment
3. DAS28-ESR ≥ 3.2, at least one swollen joint

Phase 1: Dose Escalation



Objectives

Primary Objective:

Safety and tolerability of CLN-978 for treatment of active RA

Secondary Objectives:

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

Phase 1 study ongoing in Europe. Initial safety and B cell depletion data expected in Q2 2026 and repeat dosing data expected in Q3 2026

EUCT number: 2024-519114-31-00

Rheumatoid Arthritis (RA): Large pool of highly refractory patients

High Unmet Need

- Rheumatoid arthritis (RA) is a chronic inflammatory disease that mainly affects the joints with pathogenesis associated with autoantibodies
- ~77% of RA patients present with moderate or severe disease activity
- Large poly-refractory population with no available treatments
- Current therapies result in chronic immune suppression, increasing infection risk, especially in elderly patients

RA - Select Market Opportunity Estimate (US, EU5, JP, AU)

5,300,000	**Diagnosed patients** (≥18 years of age)[1-8]
3,386,000	**Estimated addressable patients**[9]
2,315,000	**Estimated moderate/severe RA patients**[10]
163,000	**Estimated number of patients who are multi-drug resistant or poly-refractory**[11]

Opportunity: Large group of RA patients who fail available therapies

1. US: Hunter, T. M. et al. (2017) 'Prevalence of rheumatoid arthritis in the United States adult population in healthcare claims databases, 2004–2014', Rheumatology International. Springer Berlin Heidelberg, 37(9), pp. 1551–1557. doi: 10.1007/s00296-017-3726-1.
2. UK: Abhishek, A. et al. (2017) 'Rheumatoid arthritis is getting less frequent-Results of a nationwide population-based cohort study', Rheumatology (United Kingdom), 56(5), pp. 736–744. doi: 10.1093/rheumatology/kew468.
3. FR: Guillemin, F. et al. (2005) 'Prevalence of rheumatoid arthritis in France: 2001', Annals of the Rheumatic Diseases, 64(10), pp. 1427–1430. doi: 10.1136/ard.2004.029199.
4. IT: Rossini, M. et al. (2014) 'Prevalence and incidence of rheumatoid arthritis in Italy', Rheumatology International, 34(5), pp. 659–664. doi: 10.1007/s00296-014-2974-6.
5. DE: Steffen, A. et al. (2017) 'Epidemiologie der rheumatoiden Arthritis in Deutschland – eine Analyse anhand bundes- weiter vertragsärztlicher Abrechnungsdaten', Zentralinstitut für kassenärztliche Versorgung in Deutschland, (17), pp. 1–20. doi: 10.20364/VA-17.08.
6. ES: Fina-Aviles, F. et al. (2016) 'The descriptive epidemiology of rheumatoid arthritis in Catalonia: a retrospective study using routinely collected data', Clinical Rheumatology, 35(3), pp. 751–757. doi: 10.1007/s10067-014-2801-1.
7. JP: Kojima, M. et al. (2019) 'Epidemiological characteristics of rheumatoid arthritis in Japan: Prevalence estimates using a nationwide population-based questionnaire survey', Modern Rheumatology, 7595. doi: 10.1080/14397595.2019.1682776.
8. AU: Ackerman IN, Pratt C, Gorelik A, Liew D. Projected Burden of Osteoarthritis and Rheumatoid Arthritis in Australia: A Population-Level Analysis. Arthritis Care Res (Hoboken). 2018 Jun;70(6):877-883. doi: 10.1002/acr.23414. Epub 2018 Apr 12. PMID: 28898565.
9. Internal company estimate - addressable patients is estimated according to observed rheumatoid factor (RF) or anti-citrullinated protein autoantibodies (ACPA) seropositivity rates and historical systemic therapy treatment rates.
10. Internal company estimate - portion of addressable patients who present with moderate to severe rheumatoid arthritis.
11. Internal company estimate - portion of moderate to severe patients who are multi-drug resistant or poly-refractory.

OUTRACE-SjD study design

Study Population

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

Part A: Dose Escalation

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

Part B: Dose Expansion

Further exploration of 2 or more dosing schedules

Schedule 1 (*n=3 to 6*)
- Dose level and schedule to be determined by PK/PD findings observed in Part A

Schedule 2 (*n=3 to 6*)
- Dose level and schedule to be determined by PK/PD findings observed in Part A

Objectives

Primary Objective:

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

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

Global Phase 1 study ongoing in the U.S. and Europe. Initial safety and B cell depletion data expected in Q4 2026.

Clinicaltrials.gov identifier: NCT07041099

Sjögren's disease: Complex and debilitating disease occurring in isolation or in association with other systemic conditions

High Unmet Need

Sjögren's disease is a chronic autoimmune disease characterized by lymphocytic infiltration of the salivary and lacrimal glands

Autoantibodies play crucial roles in both the diagnosis and prognosis of Sjögren's disease

Patients with Sjögren's disease have an average of five other health conditions, including but not limited to conditions such as GERD, Raynaud's, neuropathy, sinusitis, hypertension, anemia, fibromyalgia, and irritable bowel syndrome[1]

Primary Sjögren's disease- Select Market Opportunity Estimate (US, EU5, JP, AU)

836,000	**Diagnosed patients** (≥18 years of age)[2-9]
482,000	**Estimated addressable patients**[10]
148,000	**Estimated moderate/severe patients**[11]

Opportunity: A prevalent B cell driven disease with no approved advanced systemic therapies

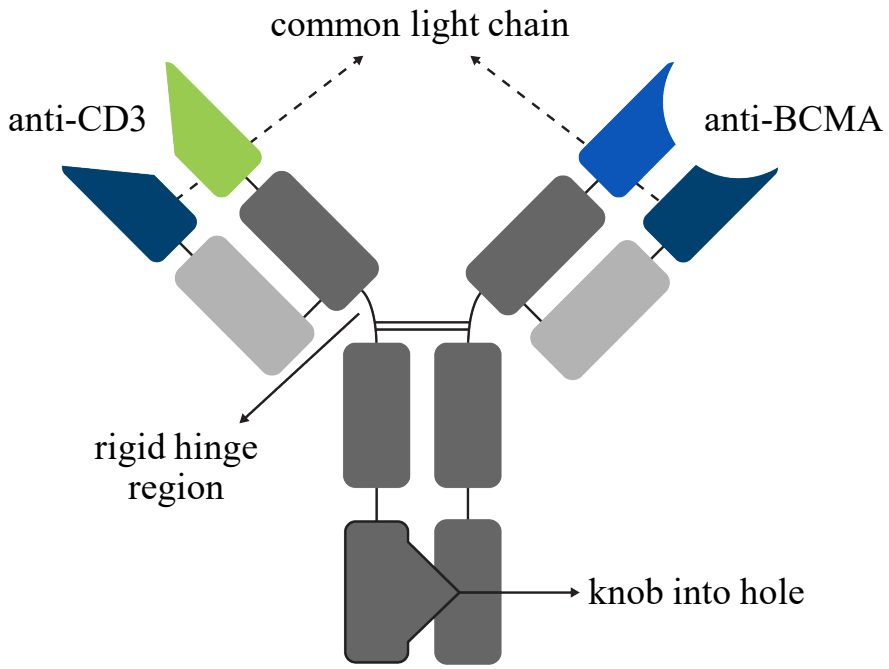
1. Sjogren's Foundation.
2. US: Maciel, G. et al. (2017) 'FRI0278 Prevalence of primary Sjögren's syndrome in a population-based cohort in the United States', Arthritis Care and Research, 69(10) p. 591.2. doi: 10.1136/annrheumdis-2017-eular.1179.
3. UK: United Kingdom Primary Sjögren's Syndrome Registry (UKPSSR) (2011). National Research Biobank. Available from: https://www.sjogrensregistry.org/for-patients (Accessed: 17 July 2020).
4. FR: Maldini, C. et al. (2014) 'Epidemiology of primary Sjögren's syndrome in a French multiracial/multiethnic area', Arthritis Care and Research, 66(3), pp. 454–463. doi: 10.1002/acr.22115.
5. IT: Sardu, C. et al. (2012) 'Population based study of 12 autoimmune diseases in Sardinia, Italy: prevalence and comorbidity', PLoS ONE, 7(3). doi: 10.1371/journal.pone.0032487.
6. DE: Westhoff, G. and Zink, A. (2010) 'Epidemiology of primary Sjögren's syndrome', Journal of Rheumatology, 69(1), pp. 1–9. doi: 10.1007/s00393-009-0518-3.
7. ES: Cortes, J. B. et al. (2019) 'Prevalence of Sjögren's syndrome in the community of Madrid', Annals of the Rheumatic Diseases, p. 791.2–792. doi: 10.1136/annrheumdis-2019-eular.3949.
8. JP: Tsuboi, H. et al. (2014) 'Primary and secondary surveys on epidemiology of Sjögren's syndrome in Japan', Modern Rheumatology, 24(3), pp. 464–470. doi: 10.3109/14397595.2013.843765.
9. AU: Lyne SA, Downie-Doyle S, Lester SE, Quinlivan A, Toby Coates P, Gordon TP, Rischmueller M. Primary Sjögren's syndrome in South Australia. Clin Exp Rheumatol. 2020 Jul-Aug;38 Suppl 126(4):57-63. Epub 2020 Sep 15. PMID: 32940213.
10. Internal company estimate - anti-SSA/RO antibodies and/or rheumatoid factor patients based on historical systemic therapy treatment rates.
11. Internal company estimate - portion of addressable patients who present with moderate to severe Sjögren's disease.

VELINOTAMIG

BCMAxCD3 bispecific T cell engager

Velinotamig: A BCMAXCD3 bispecific T cell engager with clinical evidence of robust plasma cell depletion

Velinotamig
BISPECIFIC BCMAXCD3 T CELL ENGAGER



Velinotamig
A HIGHLY SELECTIVE, DIFFERENTIATED MOLECULE

- Binds to the BCMA and CD3 antigens, **redirecting cytotoxic T cells to target BCMA-expressing cells**
- **High affinity for BCMA and lower affinity for CD3:** affinity for BCMA is two orders of magnitude higher than for CD3, promoting recruitment and activation of T cells while minimizing non-specific T cell activation
- A rigid hinge region enhances synapse formation between T cells and target cells to **eliminate BCMA+ plasma cells**
- Similar structure as classic monoclonal antibody and possible lower immunogenicity by using **common light chain; subcutaneous administration** (in development) is feasible

Velinotamig current clinical development status in China

Clinical trial in autoimmune diseases

- In **December 2025**, Genrix Bio initiated a **Phase 1** study in China in patients with **autoimmune diseases, initially in patients with SLE,** followed by future planned expansion into other indications**.** Initial clinical data from the trial will be shared in **Q4 2026.**
- **Cullinan expects the data generated to accelerate the global clinical development of velinotamig in autoimmune diseases**
- Following the completion of the Genrix Bio Phase 1 study, **Cullinan will conduct all further development of velinotamig in autoimmune diseases**

Completed/ongoing clinical trials in multiple myeloma

- **GR1803-001:** A (follow-up) completed **Phase 1** study **in patients with relapsed/refractory multiple myeloma**
- **GR1803-002:** A Phase 2 pivotal study **in patients with relapsed/refractory multiple myeloma**
- **GR1803-003:** A Phase 2 pivotal study **in patients with relapsed/refractory multiple myeloma with extramedullary lesions**
- **Velinotamig** received **Breakthrough Therapy Designation** by the Center for Drug Evaluation (CDE) for the treatment of relapsed/refractory multiple myeloma
- In **January 2026**, Genrix announced **acceptance and priority review by the NMPA in China for a BLA** for velinotamig for the treatment of adult patients with **relapsed or refractory multiple myeloma**

Velinotamig has demonstrated meaningful efficacy in late-line patients with relapsed/refractory multiple myeloma: Phase 1 results at RP2D target dose

- **Higher ORR** rate observed relative to approved BCMA TCEs
- **Higher ORR** in patients with extramedullary disease **(EMD), a particularly poor prognosis subset of MM patients**
- Similar **CR and ≥VGPR** rate versus the majority of approved BCMA TCEs, despite a **larger proportion of EMD patients**

		Approved molecules[b] *(in U.S. and or EU)*		
	Velinotamig[a] (n=48)	**Elranatamab[1,2] (n=97)**	**Teclistamab[3,4,5] (n=110)**	**Linvoseltamab[6] (n=117)**
ORR **(sCR + CR + VGPR + PR)**	87.5%	57.7%	61.8%	70.9%
≥VGPR **(sCR + CR + VGPR)**	70.8%	51.5%	57.3%	63.2%
CR **(sCR + CR)**	37.5%	25.8%	28.2%	49.6%
MRD-neg rate (in all patients)	54.2%	*n/a*	26.7%	*n/a*
Proportion of EMD patients in study	50.0%	34.0%	25.5%	16.2%
ORR in EMD	83.3%	38.5%	35.7%	52.6%

a. Data from trial: *Phase 1 clinical study of the safety, pharmacokinetics, immunogenicity and preliminary efficacy of single and multiple administrations of GR1803 (velinotamig) in patients with relapsed/refractory multiple myeloma*. Velinotamig data as of July 1, 2025, cutoff date from published ASH abstract; includes patients who have received the target dose of 180 ug/kg, which was explored with (n=25) and without a step-up priming regimen (n=23). The recommended Phase 2 dose (RP2D) for further development includes a step-up priming regimen.

b. Data provided for context only; direct comparisons between molecules can not be made in the absence of head-to-head clinical trials.

1. https://labeling.pfizer.com/ShowLabeling.aspx?id=19669#ID_b883b50f-6abb-40b6-ab24-68b9b6e74ac3.
2. Lesokhin AM, Tomasson MH, Arnulf B, et al. Elranatamab in relapsed or refractory multiple myeloma: phase 2 MagnetisMM-3 trial results. Nat Med. 2023;29:2259-2267. doi:10.1038/s41591-023-02528-9
3. https://www.janssenlabels.com/package-insert/product-monograph/prescribing-information/TECVAYLI-pi.pdf.
4. https://www.jnjmedicalconnect.com/products/tecvayli/medical-content/tecvayli-use-in-patients-with-extramedullary-disease.
5. Moreau P, Garfall A, van de Donk C, et al. Teclistamab in relapsed or refractory multiple myeloma. N Engl J Med. 2022;387:495-505.
6. Naresh Bumma et al. Linvoseltamab for Treatment of Relapsed/Refractory Multiple Myeloma. JCO 42, 2702-2712(2024). doi:10.1200/JCO.24.01008.

Overview of velinotamig safety data at RP2D target dose in patients with relapsed/refractory multiple myeloma

	Any grade	≥Grade 3
	Velinotamig (n=48)*	
Cytokine release syndrome	89.6%	6.3%
Infection	81.3%	50.0%
ICANS	0%	0%
Neutrophil count decreased	87.5%	75.0%
Platelet count decreased	81.3%	41.7%
White blood cell count decreased	87.5%	41.7%
Lymphocyte count decreased	62.5%	60.4%

- Opportunities to further mitigate **CRS** are being implemented:
  - Alternative **step-up dosing** regimen
  - Introduction of **subcutaneous formulation**
- **No ICANS** of any grade at the RP2D
- Augmented supportive care measures to reduce the risk of infection will be implemented in autoimmune studies

*Data from trial: *Phase 1 clinical study of the safety, pharmacokinetics, immunogenicity and preliminary efficacy of single and multiple administrations of GR1803 (velinotamig) in patients with relapsed/refractory multiple myeloma*. Velinotamig data as of July 1, 2025, cutoff date from published ASH abstract; includes patients who have received the target dose of 180 ug/kg, which was explored with (n=25) and without a step-up priming regimen (n=23). The recommended phase 2 dose (RP2D) for further development includes a step-up priming regimen.

CLN-049

FLT3xCD3 bispecific T cell engager

Significant unmet need in adult AML

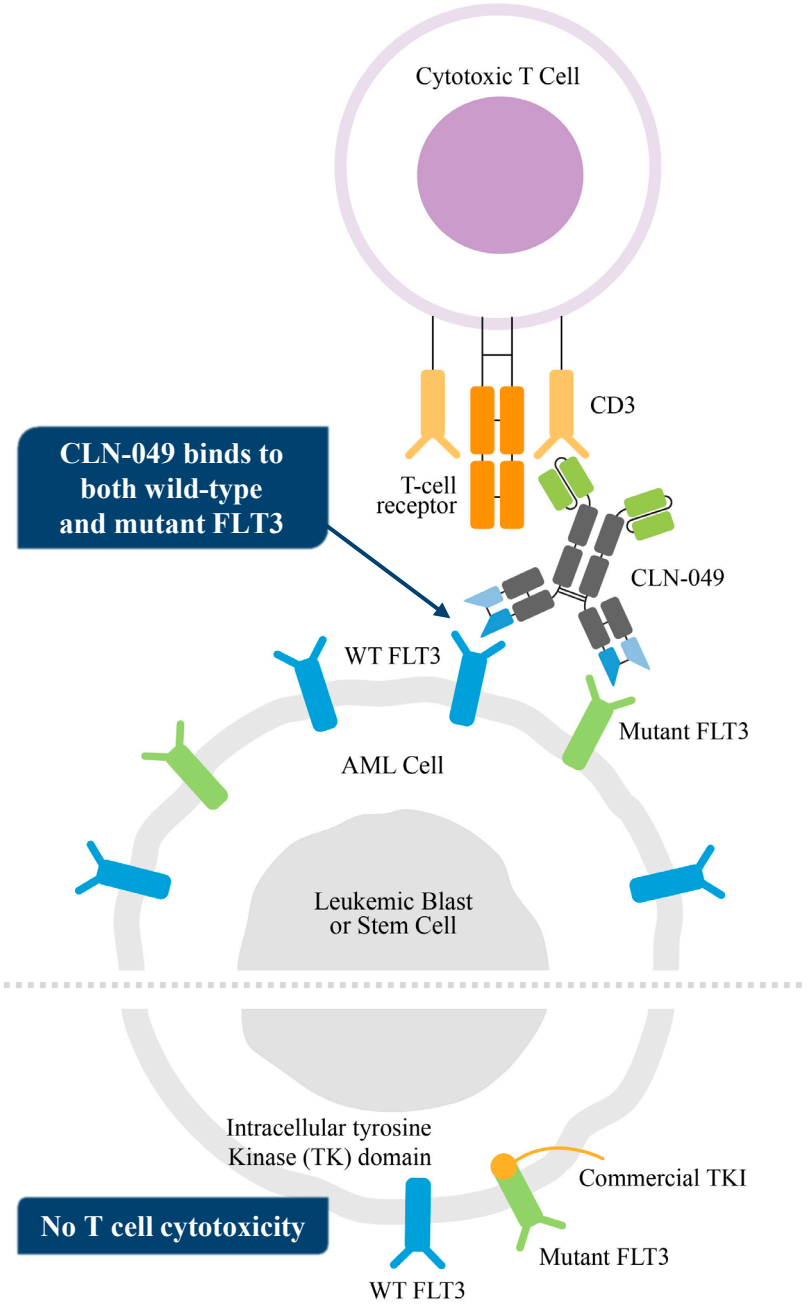
- The only curative therapy is intensive chemotherapy +/- stem cell transplantation
- Curative therapy remains out of reach for most AML patients: 85% patients >60 years old are ineligible for intensive chemotherapy
- Recent treatment advancements have not significantly improved the likelihood of cure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

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

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

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

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



CLN-049 is an optimal AML immunotherapy

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

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

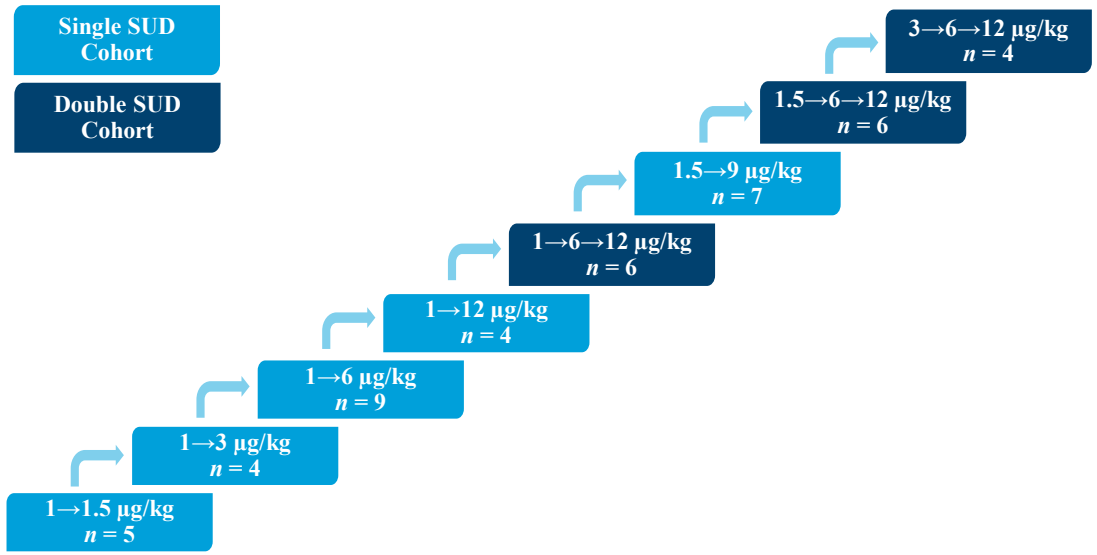
3. **Promising therapeutic potential:** FLT3 is expressed on leukemic stem cells as well as blast cells, which may increase response durability. Since FLT3 is an oncogenic driver, target loss is unlikely.

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

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

CLN-049 Phase 1 study in patients with R/R AML or MDS: Initial results from the ongoing dose-escalation presented at ASH 2025

Study Design – IV Dose Escalation Cohorts



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

Study Objective

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

Study Enrollment and Eligibility

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

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

CLN-049 Phase 1: Enrolled patients are representative of the broad R/R AML population

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

August 2025 data cutoff

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

CLN-049 Phase 1: Treatment-emergent adverse events demonstrate a favorable safety profile

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

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

August 2025 data cutoff

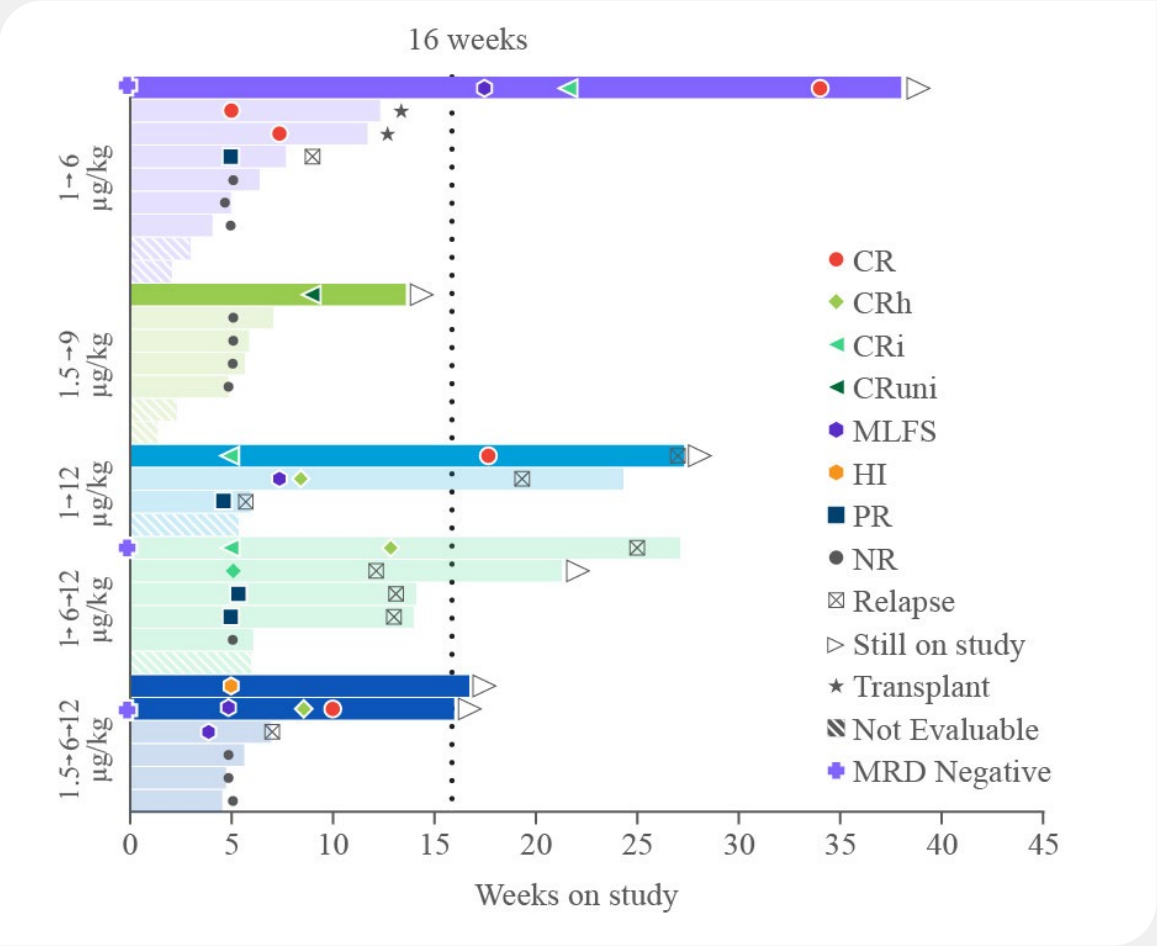
CLN-049 Phase 1: Preliminary efficacy data highlights potential to achieve deep responses in a heavily pre-treated population

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

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

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

CLN-049 Phase 1: Promising initial response durability data



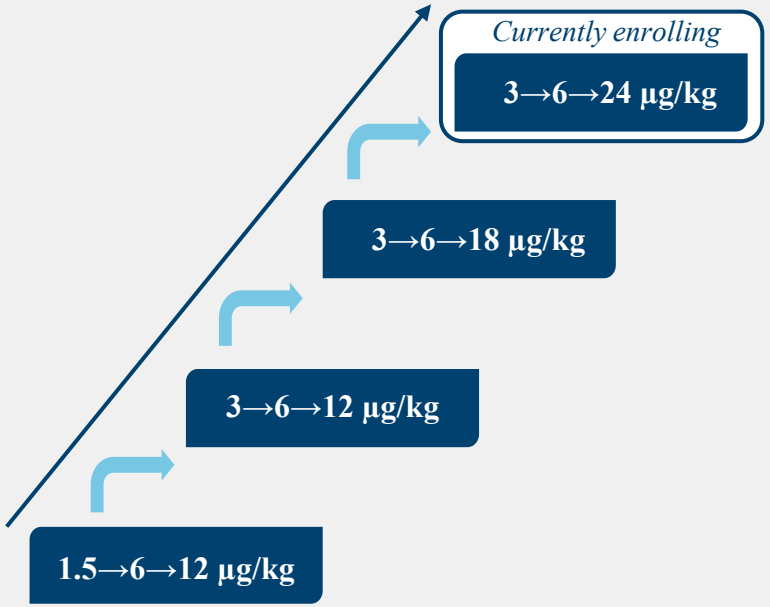
8 patients achieved CR or CRh at a TD of ≥6 µg/kg:

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

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

Next steps: Dose expansion cohorts in parallel AML subpopulations

Phase 1 IV Dose Escalation



Data update in H2 2026

Phase 1 Dose Expansion/RP2D Determination

R/R AML
- *TP53* mutation negative
- ≤ 3 prior lines of therapy

Alternate Assignment

- **Dose Level 1** *n* = 20
- **Dose Level 2** *n* = 20

TP53m AML
- *TP53* mutation
- Frontline or R/R AML
- ≤ 3 prior lines of therapy

- **Dose Level 1** *n* = 20

Expected completion in Q4 2026

RP2D = recommended phase 2 dose

Recent monotherapy approvals in R/R AML provide regulatory efficacy benchmarks for CLN-049 development

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

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

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

CLN-049 AML development strategy: Clear and expeditious development pathway to regulatory approval

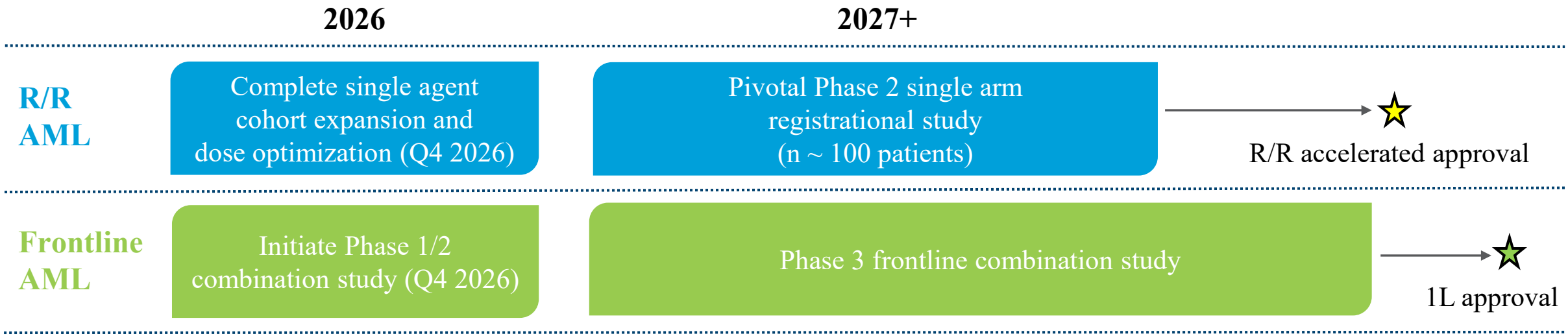
CLN-049 development strategy in AML

Monotherapy in R/R AML

- Execute single agent dose expansion/optimization study
- Identify RP2D and move to pivotal Phase 2 single arm registrational trial for accelerated approval

Combination therapy in 1L AML

- Generate initial POC data in combination with standard of care therapies in frontline AML
- Confirm efficacy and safety in randomized Phase 3 study for full approval and label expansion into frontline setting



CLN-049: Compelling efficacy enables accelerated approval pathway and drives attractive commercial opportunity

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

- **Initial efficacy data for CLN-049 meets the benchmark for recently approved agents with clear pathway to accelerated approval in R/R AML**
  - Single-arm Phase 2 study likely sufficient to support initial registration via accelerated approval
- **Internal deep hematology expertise facilitates rapid development of CLN-049**
- **CLN-049 provides a commercially attractive opportunity in AML, with R/R segment alone representing a $1B+ opportunity[1]**

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

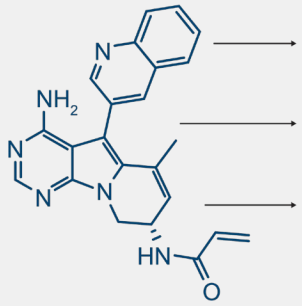
ZIPALERTINIB

(CLN-081/TAS6417)

EGFR ex20ins inhibitor

Zipalertinib: Selective EGFR inhibitor with best-in-class potential and strong profile for NSCLC patients with EGFR exon20 mutations

Unique Design Properties



Distinct chemical scaffold

HER2-sparing

High selectivity to mutant vs WT EGFR

Taiho zipalertinib collaboration provides Cullinan with financial benefits:

Profit sharing: Parties will share 50/50 U.S. development costs and potential profits

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

REZILIENT1

- **ASCO 2025 and IASLC WCLC 2025:** Zipalertinib demonstrated **clinically meaningful efficacy and durability** in patients after progression on platinum-based chemotherapy, including patients previously treated with amivantamab
  - **Manageable safety profile**, consistent with previously reported data
- **Rolling NDA submission** seeking accelerated approval in relapsed EGFR ex20ins NSCLC completed in **February 2026**

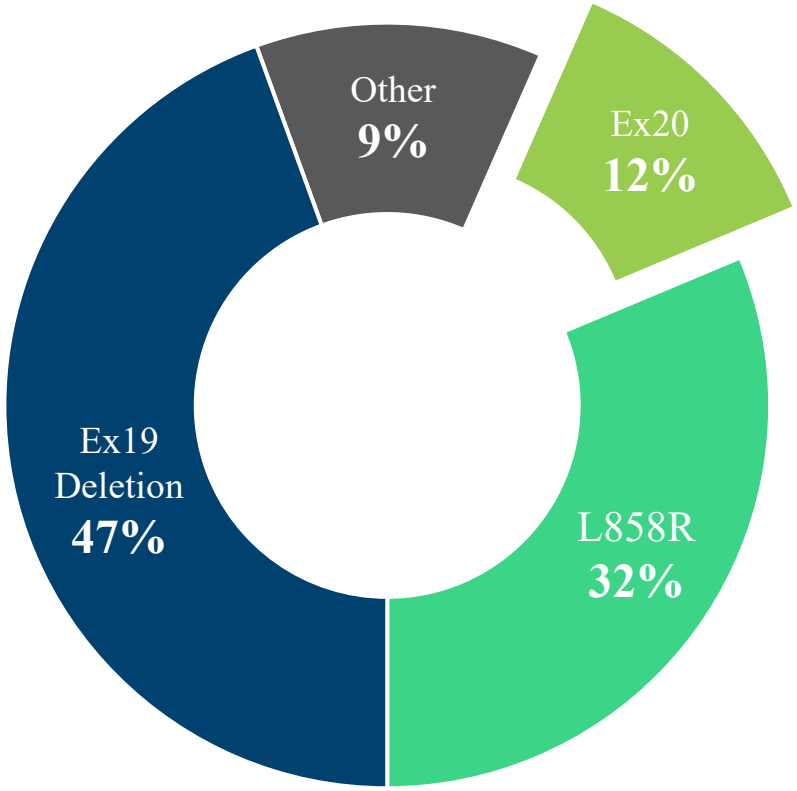
REZILIENT2 Cohorts

- **IASLC WCLC 2025**: Initial data demonstrated the **clinical activity** of zipalertinib in patients with **uncommon EGFR mutations**
- **ESMO 2025:** Initial data demonstrated **intracranial responses** with zipalertinib in patients with active **brain metastases**

REZILIENT3 Phase 3 frontline study fully enrolled; Taiho expects to obtain top-line results by the end of 2026

Patients with insertions at exon 20 make up the largest unmet need segment of the lung cancer population with EGFR mutations

EGFR mutated NSCLC[1]



U.S. Exon 20 incidence

U.S. lung cancer incidence[1]:	**~230,000**
NSCLC[2]:	**80%-85%**
Exon 20[3-5]:	**1.5%-2.5% of NSCLC ~3,000 to ~5,000 patients**

References 1. Lung Cancer Research Foundation (2026) . **2.** https://www.cancer.org/content/dam/CRC/PDF/Public/8703.00.pdf **3.** Riess JW et al. J Thorac Oncol 2018. **4.** Zhang YL et al. Oncotarget 2016. **5.** Burnett H et al. PLoS ONE 2021.

ASCO 2025 data update: REZILIENT1 Phase 2b trial results

REZILIENT1[1]

NCT04036682

Pivotal Phase 2b (met primary endpoint)

- Prior chemo* only
- Prior chemo* + amivantamab +/- other exon20ins directed therapy

Data presented at ASCO 2025

**platinum-based*

Primary endpoint: ORR + DOR

REZILIENT2[2]

Phase 2 Parallel Cohort Study

- Active brain mets (+/- prior treatment)
- 1st Line ex20 (zipalertinib monotherapy)
- Non-exon20ins uncommon (PACC+) EGFRm (prior systemic therapy)

Primary endpoint: ORR

REZILIENT3[3]

1L Randomized Phase 3 (fully enrolled)

R 1:1
N=~300**

- Zipalertinib + pemetrexed + carboplatin or cisplatin
- Placebo + pemetrexed + carboplatin or cisplatin

Primary endpoint: PFS

Clinicaltrials.gov identifiers: [1]NCT04036682, [2]NCT05967689 and 3NCT05973773; * includes both approved and investigational exon20 therapies ** following 6-12 patient safety lead in. PACC, P-loop and αC-helix.

REZILIENT1: Heavily pre-treated patient population, many with brain metastases, relapsed after chemotherapy +/- amivantamab

Characteristic	Primary efficacy population (N=176)	Platinum-based chemotherapy without ex20ins-targeted therapy (n=125)	Prior amivantamab ± other ex20ins-target therapy (n=51)[a]
Median number of prior systemic regimens, No. (range)	**2 (1, 7)**	**1 (1, 6)**	**3 (1, 7)**
Prior chemotherapy, No. (%)	173 (98)	125 (100)	48 (94)
Prior anti–PD-(L)1, No. (%)	84 (48)	62 (50)	22 (43)
Prior targeted therapy, No. (%)	87 (49)	36 (29)	51 (100)
Amivantamab	52 (30)	0	51 (100)
Mobocertinib	17 (10)	0	17 (33)
Bevacizumab	21 (12)	14 (11)	7 (14)
Osimertinib	16 (9)	12 (10)	4 (8)
BLU-451	3 (2)	0	3 (6)
Cetuximab	4 (2)	0	4 (3)
Poziotinib	2 (1)	0	2 (4)
Sunvozertinib	1 (1)	0	1 (2)
Other[a]	21 (12)	17 (14)	4 (8)
Prior brain radiation, No. (%)	**23 (13)**	**16 (13)**	**7 (14)**
Brain metastasis untreated, No. (%)	**45 (26)**	**28 (22)**	**17 (33)**

[a]Includes first/second generation EGFR tyrosine kinase inhibitors, ALK inhibitors, CDK4/6 inhibitors, NTRK/ROS1 inhibitors, angiokinase inhibitors. ALK, anaplastic lymphoma kinase; EGFR, epidermal growth factor receptor; ex20ins, exon 20 insertions; PD-(L)1, programmed death-(ligand) 1.

REZILIENT1: Zipalertinib demonstrated meaningful clinical efficacy, including in patients previously treated with amivantamab

Outcome	Primary efficacy population (N=176)	Platinum-based chemotherapy without ex20ins-targeted therapy (n=125)	Prior amivantamab ± other ex20ins-target therapy (n=51)[a]
BOR, No. (%)[b]			
CR	1 (1)	0	1 (2)
PR	61 (35)	50 (40)	11 (22)
Unconfirmed PR[c]	7 (4)	6 (5)	1 (2)
SD	88 (50)	55 (44)	33 (65)
PD	11 (6)	8 (6)	3 (6)
Not evaluable[d]	8 (5)	6 (5)	0
Confirmed ORR, No. (%) [95% CI][e]	**62 (35) [28–43]**	**50 (40) [31–49]**	**12 (24) [13–38]**
DCR, No. (%) [95% CI][f]	157 (89) [84–93]	111 (89) [82–94]	46 (90) [79–97]
CBR, No. (%) [95% CI][g]	113 (64) [57–71]	85 (68) [59–76]	28 (55) [40–69]
Median time to response, days (range)	44 (31–295)	44 (39–232)	44 (39–232)
Median DOR, months (95% CI)	**8.8 (8.3–12.7)**	**8.8 (8.3–12.7)**	**8.5 (4.2–14.8)**

Patients were evaluable for response if they had received at least one dose of zipalertinib and had at least one post-dose tumor assessment or had discontinued prior to the first efficacy assessment due to clinical disease progression or toxicity. [a]Including 30 patients who received prior amivantamab without and 21 patients with other ex20ins-targeted therapy. [b]Response confirmed ≥4 weeks after response first noted. [c]Patients had PR but confirmatory scan had not yet been performed. [d]No post-baseline imaging. [e]Proportion of patients with confirmed CR or PR. [f]Proportion of patients with CR, PR, or SD. [g]Proportion of patients with CR, PR, or with SD lasting ≥24 weeks.
BOR, best overall response; CBR, clinical benefit rate; CI, confidence interval; CR, complete response; DCR, disease control rate; DOR, duration of response; ex20ins, exon 20 insertions; ICR, independent central review; ORR, objective response rate; PD, progressive disease; PR, partial response; SD, stable disease.

REZILIENT1: Durable clinical benefit observed in patients relapsing after prior treatment with amivantamab

Despite the approval of amivantamab for EGFR ex20ins NSCLC, patients can still face poor outcomes after exhausting a range of prior therapies

Zipalertinib demonstrated clinically meaningful efficacy in the post-amivantamab setting, a significant and growing unmet need

Outcome	Prior amivantamab without other ex20ins-targeted therapy (n=30)	Prior amivantamab and other ex20ins-targeted therapy (n=21)	Total (n=51)
BOR, No. (%)[a]			
CR	1 (3)	0	1 (2)
PR	8 (27)	3 (14)	11 (22)
Unconfirmed PR[b]	1 (3)	0	1 (2)
SD	19 (63)	14 (67)	33 (65)
PD	0	3 (14)	3 (6)
Confirmed ORR, No. (%) [95% CI][c]	**9 (30) [15–49]**	**3 (14) [3–36]**	**12 (24) [13–38]**
DCR, No. (%) [95% CI][d]	29 (97) [83–100]	17 (81) [58–95]	46 (90) [79–97]
CBR, No. (%) [95% CI][e]	18 (60) [41–77]	10 (48) [26–70]	28 (55) [40–69]
Median time to response, days (range)	43 (39–232)	98 (40–103)	44 (39–232)
Median DOR, months (95% CI)	**14.7 (4.2–NE)**	**4.2 (3.9–NE)**	**8.5 (4.2–14.8)**

Patients were evaluable for response if they had received at least one dose of zipalertinib and had at least one post-dose tumor assessment or had discontinued prior to the first efficacy assessment due to clinical disease progression or toxicity. [a]Including 30 patients who received prior amivantamab without and 21 patients with other ex20ins-targeted therapy. [b]Response confirmed ≥4 weeks after response first noted. [c]Patients had PR but confirmatory scan had not yet been performed. [d]No post-baseline imaging. [e]Proportion of patients with confirmed CR or PR. [f]Proportion of patients with CR, PR, or SD. [g]Proportion of patients with CR, PR, or with SD lasting ≥24 weeks.
BOR, best overall response; CBR, clinical benefit rate; CI, confidence interval; CR, complete response; DCR, disease control rate; DOR, duration of response; ex20ins, exon 20 insertions; ICR, independent central review; ORR, objective response rate; PD, progressive disease; PR, partial response; SD, stable disease.

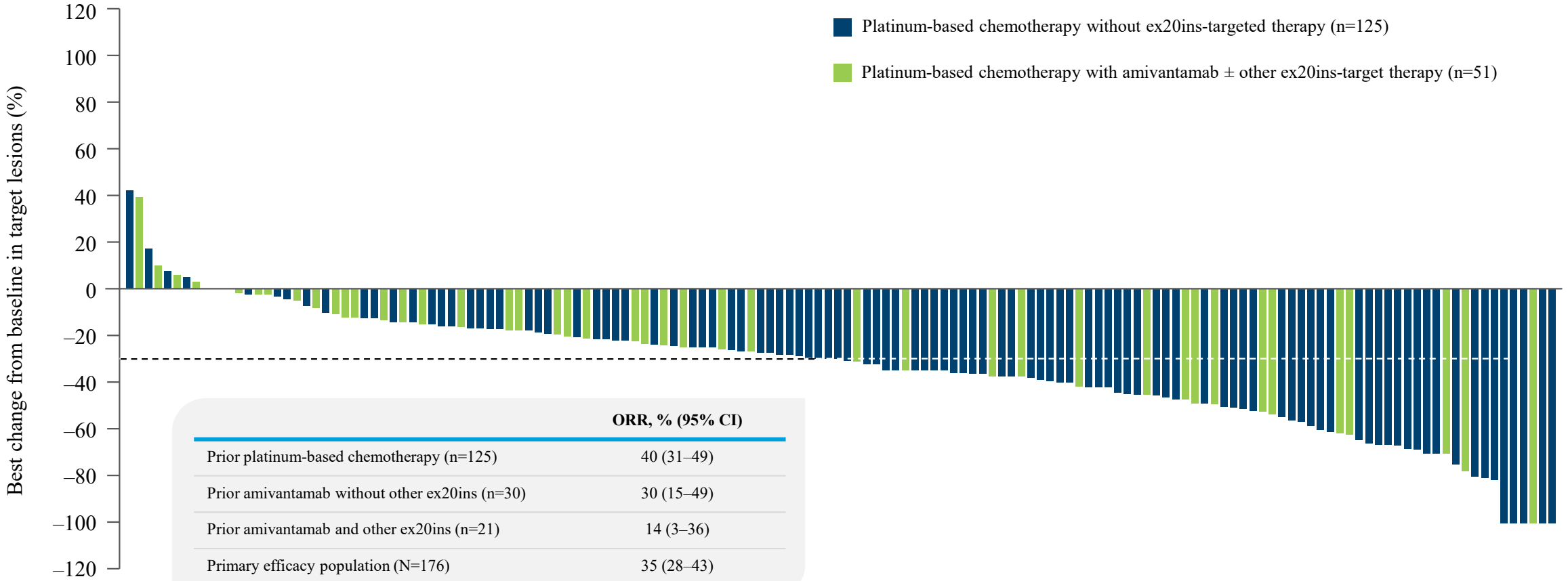
REZILIENT1: Efficacy per ICR in patients with brain metastases

Results provide preliminary evidence supporting the activity of zipalertinib in the high-risk patient population with brain metastases

Outcome	Primary efficacy population (N=176)	Patients with brain metastases[a] (n=68)
BOR, No. (%)[b]		
CR	1 (1)	1 (2)
PR	61 (35)	20 (29)
Unconfirmed PR[c]	7 (4)	2 (3)
SD	88 (50)	37 (54)
PD	11 (6)	5 (7)
Not evaluable[d]	8 (5)	3 (4)
Confirmed ORR, No. (%) [95% CI][e]	**62 (35) [28–43]**	**21 (31) [20–43]**
DCR, No. (%) [95% CI][f]	157 (89) [84–93]	60 (88) [78–95]
CBR, No. (%) [95% CI][g]	113 (64) [57–71]	38 (56) [43–68]
Median time to response, days (range)	**44 (31–295)**	**98 (35–232)**

Patients were evaluable for response if they had received at least one dose of zipalertinib and had at least one post-dose tumor assessment or had discontinued prior to the first efficacy assessment due to clinical disease progression or toxicity. [a]Including 30 patients who received prior amivantamab without and 21 patients with other ex20ins-targeted therapy. [b]Response confirmed ≥4 weeks after response first noted. [c]Patients had PR but confirmatory scan had not yet been performed. [d]No post-baseline imaging. [e]Proportion of patients with confirmed CR or PR. [f]Proportion of patients with CR, PR, or SD. [g]Proportion of patients with CR, PR, or with SD lasting ≥24 weeks.
BOR, best overall response; CBR, clinical benefit rate; CI, confidence interval; CR, complete response; DCR, disease control rate; DOR, duration of response; ex20ins, exon 20 insertions; ICR, independent central review; ORR, objective response rate; PD, progressive disease; PR, partial response; SD, stable disease.

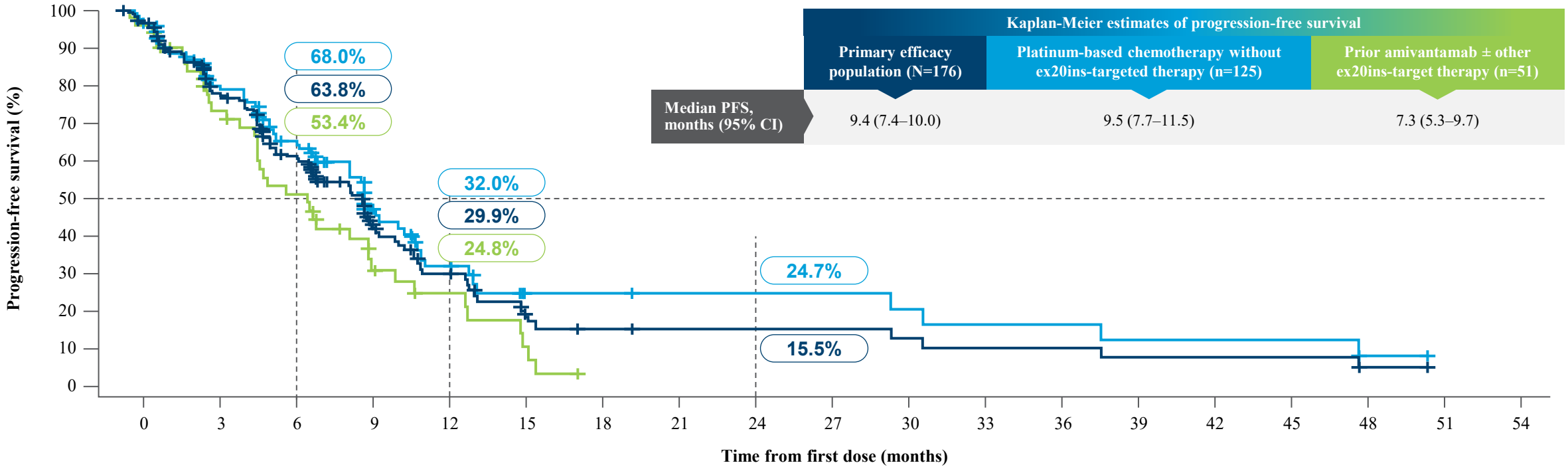
REZILIENT1: Confirmed ORR of 35.2% in the primary efficacy population; best change from baseline of target lesions



	ORR, % (95% CI)
Prior platinum-based chemotherapy (n=125)	40 (31–49)
Prior amivantamab without other ex20ins (n=30)	30 (15–49)
Prior amivantamab and other ex20ins (n=21)	14 (3–36)
Primary efficacy population (N=176)	35 (28–43)

CI, confidence interval; ex20ins, exon 20 insertions; ORR, objective response rate.

REZILIENT1: Zipalertinib shows median progression-free survival (PFS) of 9.4 months per ICR in primary efficacy population



No. at risk																			
Total	176	144	95	57	22	15	7	6	6	6	6	4	4	3	3	3	3	1	0
Platinum-based chemotherapy only	125	103	71	42	15	10	7	6	6	6	6	4	4	3	3	3	3	1	0
Prior amivantamab ± other ex20ins	51	41	24	15	7	5	0	0	0	0	0	0	0	0	0	0	0	0	0

Progression-free survival was defined as the time between the day of the first dose of zipalertinib and the first documentation of progressive disease or death, whichever occurred earlier. CI, confidence interval; ex20ins, exon 20 insertions; ICR, independent central review; PFS, progression-free survival.

REZILIENT1: Most common treatment-related adverse events

Most common treatment-related adverse events were paronychia, rash, dermatitis acneiform, dry skin, and diarrhea

Any-grade TRAEs reported in ≥10% of patients, No. (%)	Any grade	Grade 3
Paronychia	94 (38.5)	0
Rash	74 (30.3)	6 (2.5)
Dermatitis acneiform	60 (24.6)	1 (0.4)
Dry skin	60 (24.6)	0
Diarrhea	53 (21.7)	5 (2.0)
Stomatitis	49 (20.1)	4 (1.6)
Anemia	48 (19.7)	17 (7.0)
Pruritus	44 (18.0)	1 (0.4)
Nausea	35 (14.3)	2 (0.8)
Rash maculopapular	34 (13.9)	3 (1.2)
Fatigue	29 (11.9)	0

- Anemia was the most common grade 3 TRAE
- Other grade ≥3 TRAEs reported in ≥5 patients included pneumonitis and rash (6 patients [2.5%] each), and alanine aminotransferase increased, diarrhea, and platelet count decreased (5 patients [2.0%] each)
- Twelve patients (4.9%) had treatment-related pneumonitis, 5 of whom had received prior immunotherapy
  - Grade 1, n=3; grade 2, n=3; grade 3, n=5; grade 5, n=1

TRAE, treatment-related adverse event.

IASLC 2025 WCLC data update: Patients with prior amivantamab

REZILIENT1[1]

NCT04036682

Pivotal Phase 2b
(met primary endpoint)

- **Prior chemo* only**
- **Prior chemo* + amivantamab +/- other exon20ins directed therapy**

Data presented at IASLC 2025 WCLC

**platinum-based*

Primary endpoint: ORR + DOR

REZILIENT2[2]

Phase 2 Parallel Cohort Study

- **Active brain mets (+/- prior treatment)**
- **1st Line ex20 (zipalertinib monotherapy)**
- **Non-exon20ins uncommon (PACC+) EGFRm (prior systemic therapy)**

Primary endpoint: ORR

REZILIENT3[3]

1L Randomized Phase 3
(fully enrolled)

R 1:1
N=~300**

- **Zipalertinib + pemetrexed + carboplatin or cisplatin**
- **Placebo + pemetrexed + carboplatin or cisplatin**

Primary endpoint: PFS

Clinicaltrials.gov identifiers: [1]NCT04036682, [2]NCT05967689 and 3NCT05973773; * includes both approved and investigational exon20 therapies ** following 6-12 patient safety lead in. PACC, P-loop and αC-helix.

With longer-term follow-up data, zipalertinib continues to demonstrate meaningful efficacy in patients relapsing after prior treatment with amivantamab

Outcome	Prior amivantamab only (N=54)	Prior amivantamab + other ex20ins-targeted therapy (n=30)	Total (N=84)[a]
BOR, No. (%)[b]			
CR	0	0	0
PR	17 (31.5) [19.5–45.6]	6 (20.0) [7.7–38.6]	23 (27.4) [18.2–38.2]
Unconfirmed PR[c]	2 (3.7) [0.5–12.7]	1 (3.3) [0.1–17.2]	3 (3.6) [0.7–10.1]
SD	28 (51.9) [37.8–65.7]	17 (56.7) [37.4–74.5]	45 (53.6) [42.4–64.5]
PD	1 (1.9) [0.0–9.9]	3 (10.0) [2.1–26.5]	4 (4.8) [1.3–11.7]
Not evaluable[d]	6 (11.1) [4.2–22.6]	3 (10.0) [2.1–26.5]	9 (10.7) [5.0–19.4]
Confirmed ORR, No. (%) [95% CI][e]	**17 (31.5) [19.5–45.6]**	**6 (20.0) [7.7–38.6]**	**23 (27.4) [18.2–38.2]**
DCR, No. (%) [95% CI][f]	47 (87.0) [75.1–94.6]	24 (80.0) [61.4–92.3]	71 (84.5) [75.0–91.5]
CBR, No. (%) [95% CI][g]	30 (55.6) [41.4–69.1]	13 (43.3) [25.5–62.6]	43 (51.2) [40.0–62.3]
Median DOR, months (95% CI)	9.5 [6.2–NE]	8.3 [3.9–NE]	8.5 [6.2–14.8]
Median PFS, months (95% CI)	**7.4 [5.4–9.7]**	**5.2 [3.4–11.5]**	**6.5 [5.4–8.9]**

Zipalertinib was well tolerated and demonstrated a manageable safety profile in patients who progressed on prior chemotherapy and amivantamab with or without other ex20ins-targeted therapy. No new safety signals have been identified.

Patients were evaluable for response if they had received at least one dose of zipalertinib and had at least one post-dose tumor assessment or had discontinued prior to the first efficacy assessment due to clinical disease progression or toxicity. [a]Including 30 patients who received prior amivantamab without and 21 patients with other ex20ins-targeted therapy. [b]Response confirmed ≥4 weeks after response first noted. [c]Patients had PR but confirmatory scan had not yet been performed. [d]No post-baseline imaging. [e]Proportion of patients with confirmed CR or PR. [f]Proportion of patients with CR, PR, or SD. [g]Proportion of patients with CR, PR, or with SD lasting ≥24 weeks. BOR, best overall response; CBR, clinical benefit rate; CI, confidence interval; CR, complete response; DCR, disease control rate; DOR, duration of response; ex20ins, exon 20 insertions; ICR, independent central review; ORR, objective response rate; PD, progressive disease; PR, partial response; SD, stable disease.

REZILIENT program: Broad development of zipalertinib across multiple studies and indications in collaboration with Taiho Oncology

REZILIENT1[1]

Pivotal Phase 2b
(met primary endpoint)

- **Prior chemo* only**
- **Prior chemo* + amivantamab +/- other exon20ins directed therapy**

Data presented at ASCO 2025 and IASLC 2025 WCLC

**platinum-based*

Primary endpoint: ORR + DOR

REZILIENT2[2]

Phase 2 Parallel Cohort Study

- **Active brain mets (+/- prior treatment)**
  Initial data shared at ESMO Congress 2025
- **1st Line ex20 (zipalertinib monotherapy)**
- **Non-exon20ins uncommon (PACC+) EGFRm (prior systemic therapy)**
  Initial data shared at IASLC 2025 WCLC

Primary endpoint: ORR

REZILIENT3[3]

1L Randomized Phase 3
(fully enrolled)

R 1:1
N=~300**

- **Zipalertinib + pemetrexed + carboplatin or cisplatin**
- **Placebo + pemetrexed + carboplatin or cisplatin**

Primary endpoint: PFS

Clinicaltrials.gov identifiers: [1]NCT04036682, [2]NCT05967689 and 3NCT05973773; * includes both approved and investigational exon20 therapies ** following 6-12 patient safety lead in. PACC, P-loop and αC-helix.

Potential best-in-class profile of zipalertinib creates opportunity to address large unmet need left by currently approved therapies

Despite the approval of amivantamab, an unmet need remains for well-tolerated oral targeted therapies with durable clinical benefit

	Zipalertinib	Amivantamab[1, 2]
Efficacy in patients treated with platinum-based chemotherapy	**40%**	**40%**
Median duration of response	**8.8 months**	**11.1 months**
Median PFS	**9.5 months**	**8.3 months**
History of brain metastases	**35%**	**22%**
Route of administration	• Oral • 100mg twice daily	• IV infusion • Weekly for 5 weeks (split dose over 2 days, 1st week) • Then every 2 weeks • Premedicate with antihistamines and antipyretics for all doses and IV glucocorticoids during week 1
Select AEs (All / Grade 3+)	• Rash (30% / 3%) • Diarrhea (22% / 2%) • Anemia (20% / 7%) • ILD/Pneumonitis (5% / 2%)	• Rash (84% / 4%) • Diarrhea (16% / 3%) • Infusion reactions (64% / 3%) • ILD/Pneumonitis (3% / 1%) • Ocular toxicity (1% / -)

Data provided for context only; direct comparisons between molecules can not be made in the absence of head-to-head clinical trials.

1. https://www.janssenlabels.com/package-insert/product-monograph/prescribing-information/RYBREVANT-pi.pdf.
2. Park K, Haura EB, Leighl NB, et al. Amivantamab in EGFR Exon 20 Insertion-Mutated Non-Small-Cell Lung Cancer Progressing on Platinum Chemotherapy: Initial Results From the CHRYSALIS Phase I Study. J Clin Oncol. 2021;39(30):3391-3402. doi:10.1200/JCO.21.00662.

Taiho zipalertinib collaboration provides Cullinan with financial and strategic benefits

Upfront Payment
$275 million to Cullinan received in 2022 in exchange for providing 50% of U.S. and 100% of ex-U.S. rights to Taiho[1]

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

Collaboration
Taiho and Cullinan entered into a U.S. co-development and co-commercialization agreement, providing Cullinan with a co-promote option

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

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


THANK YOU!
cullinan
THERAPEUTICS