# CB-011, an allogeneic anti-BCMA CAR-T cell therapy with immune cloaking, in patients with relapsed/refractory multiple myeloma

## Long-term follow-up results from the CaMMouflage phase 1 trial

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# Disclosures

Advisory board for Janssen, BMS, Takeda, Sanofi, Pfizer, Genentech, Legend, Karyopharm, Menarini, Kite, Arcellx, AstraZeneca, Caribou, and Natera

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# CB-011: delivering on the allogeneic CAR-T cell therapy promise with high response rates and low rates of infection for patients with r/r multiple myeloma

| | Bispecifics | CB-011 |
|---|---|---|
| Treatment burden | **Repeat dosing** until relapse  | **Single-dose** treatment  |
| Efficacy | Weekly or bi-weekly treatment required for durability  | **High response rates[2]** with single dose  |
| Infection | High rates with **limited or no B cell recovery[1]**  | Low rates of infection[2] and **rapid immune recovery**  |

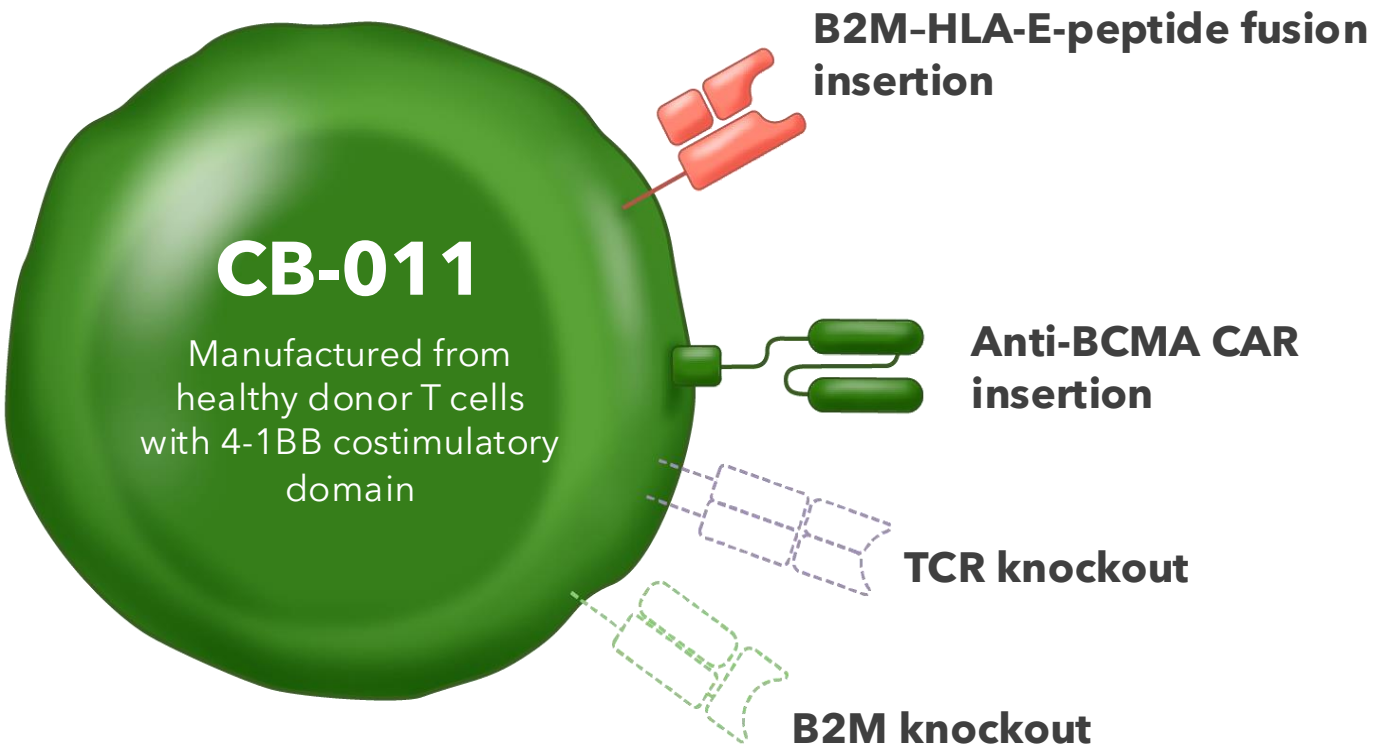
[1]Frerichs, KA, et al. Blood Adv. 2024 Jan 9;8(1):194-206; Jelinek T, et al. Blood 144 (2024) 1934-1936; Schreiber S, et al. Mol. Therapy 3 (9) 4130-4134; 2025
[2]Based on Grade 3+ infections, at recommended dose for expansion as seen in results from dose escalation portion of the CaMMouflage clinical trial
Based on previously reported data from approved bispecific therapies; Caribou has not performed any comparative analysis directly with bispecifics
r/r: relapsed or refractory

# CB-011: delivering on the allogeneic CAR-T cell therapy promise with broad access, rapid treatment, and scalability for r/r multiple myeloma

| | Bispecifics | CB-011 | Autologous CAR-T | |
|---|---|---|---|---|
| Treatment burden | **Repeat dosing** until relapse | **Single-dose** treatment | Overcomes access challenges to **treat more patients** | **1 of 10 MM patients** receive auto CAR-Ts[3] |
| Efficacy | Weekly or bi-weekly treatment required for durability | **High response rates[2]** with single dose | **No wait** needed between eligibility and lymphodepletion | **Weeks to months** from eligibility to lymphodepletion[4] |
| Infection | High rates with **limited or no B cell recovery[1]** | Low rates of infection[2] and **rapid immune recovery** | Potential for **50-100 doses** per manufacturing batch at commercial launch | **1 dose** per manufacturing batch |
| | | | | Access / Speed / Scale |

[1]Frerichs, KA, et al. Blood Adv. 2024 Jan 9;8(1):194-206; Jelinek T, et al. Blood 144 (2024) 1934-1936; Schreiber S, et al. Mol. Therapy 3 (9) 4130-4134; 2025
[2]Based on Grade 3+ infections, at recommended dose for expansion as seen in results from dose escalation portion of the CaMMouflage clinical trial
[3]Gilead Q3 2024 earnings call transcript; Poseida Therapeutics International Myeloma Society Meeting data call 2024
[4]Kourelis, T. et al. Transplant Cell Ther 2023 29(4):255-258
Based on previously reported data from approved bispecific and autologous CAR-T therapies; Caribou has not performed any comparative analysis directly with such therapies

# CB-011: a differentiated allogeneic CAR-T cell therapy for r/r MM




CB-011 immune cloaking strategy **enhances functional persistence and antitumor activity**

450M cell dose selected as RDE following **deep, durable responses and manageable safety profile[1]**

CB-011 demonstrates potential to **address unmet need in both BCMA-naïve and BCMA-exposed patients**



[1]Rossi A et al. TANDEM 2026 presentation
RDE: recommended dose for expansion
r/r MM: relapsed/refractory multiple myeloma

# CB-011 CaMMouflage phase 1 trial (NCT05722418)

## Eligibility

- ≥3 prior lines of therapy, including a PI, an IMiD, and an anti-CD38 antibody
- Could have received BCMA-targeted therapy >3 months prior

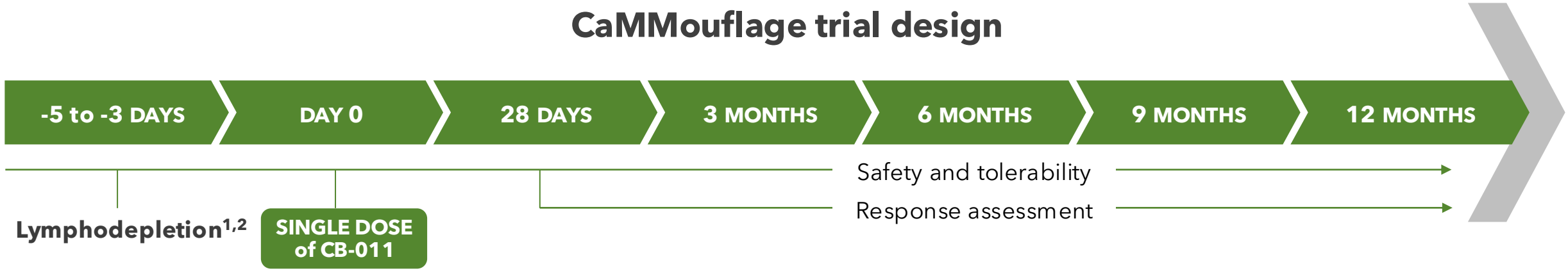
## Dose escalation

- LD: 300 mg/m$^2$ cy or 500 mg/m$^2$ cy with 30 mg/m$^2$ flu x 3 days
- CB-011: 50M,150M, 300M, 450M, 800M CAR-T cells
- **RDE: 500 mg/m$^2$ cy + 30 mg/m$^2$ flu x 3d; 450M CAR-T cells**

## Dose expansion

- BCMA-naïve and BCMA-exposed cohorts

## CaMMouflage trial design




**Off-the-shelf product, no manufacturing wait time, promising deep and durable responses observed with CB-011** are key reasons why investigators enrolled patients in CaMMouflage trial[3]



[1]300 mg/m$^2$ cy and 30 mg/m$^2$ flu daily x 3 days
[2]500 mg/m$^2$ cy and 30 mg/m$^2$ flu daily x 3 days
[3]Based on survey results from CaMMouflage investigators asking why patients were treated with CB-011 vs other treatment options
cy: cyclophosphamide; flu: fludarabine; LD; lymphodepletion; IMiD: immunomodulatory drug; PI: proteasome inhibitor; RDE: recommended dose for expansion

# High-risk, heavily pretreated patients enrolled in CaMMouflage

| Patient and disease characteristics | All patients[1] (N=48) |
|---|---|
| **Age, years, median (range)** | 68.5 (49-84) |
| ≥ 65 years old | 32 (67) |
| **Male, n (%)** | 33 (69) |
| **ECOG performance status, n (%)** | |
| 0 | 13 (27) |
| 1 | 35 (73) |
| **R-ISS disease stage, n (%) at diagnosis** | |
| I | 6 (13) |
| II | 17 (35) |
| III | 12 (25) |
| Unknown | 13 (27) |
| **High-risk cytogenetics[2], n (%)** | 27 (56) |
| **Extramedullary disease (EMD)[3], n (%)** | 16 (33) |
| **Prior lines of therapy, median (range)** | 4 (3-11) |
| **Median time since diagnosis (years)** | 5.3 (1-15) |
| **Prior stem cell transplant, n (%)** | 30 (63) |
| **Prior exposure to BCMA therapy, n (%)** | 8 (17)[4] |

[1]All patients treated with a single dose of CB-011 and a lymphodepletion regimen of either 500 mg/m$^2$ cy or 300 mg/m$^2$ cy with 30 mg/m$^2$ flu daily x 3 days
[2]High-risk cytogenetics include t(4;14), del(17/17p), t(14;16), t(14;20), and amplification/gain (1q)
[3]EMD defined as: soft tissue plasmacytoma noncontiguous with bone or lytic lesion with paramedullary extension
[4]4 patients received belantamab (ADC) one of whom also received elranatamab (bispecific), 3 patients received teclistamab (bispecific), and 1 patient received NK trispecific (CC-92329 (BCMAXNKG2D/CD16))
cy: cyclophosphamide; ECOG: Eastern Cooperative Oncology Group; flu: fludarabine; NK: natural killer; R-ISS: revised international staging system
Data cutoff 20Apr2026

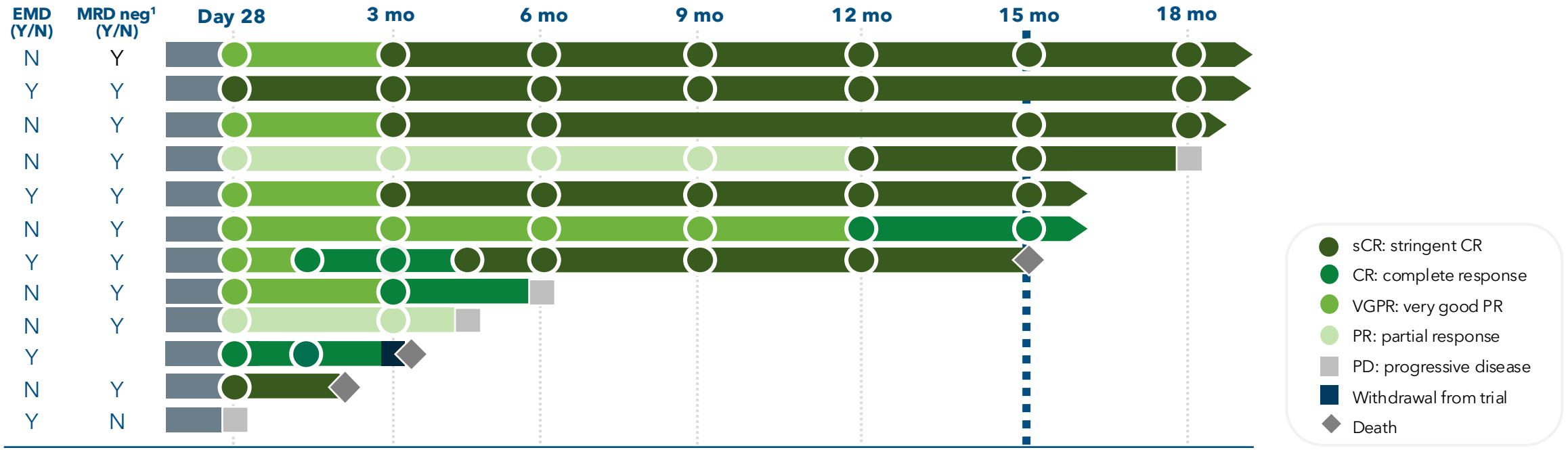
# CB-011 induces deep, durable responses in high-risk patients

Heavily pretreated BCMA-naïve patients treated with a single dose of 450M CB-011 CAR-T cells

**92% ORR**
(11/12)

**83% ≥CR rate**
(10/12)

**91% MRD neg**
(10/11 evaluable patients)




One patient who had previously withdrawn from the trial died on day 90 of treatment-related ICAHT; one patient died of pneumonia on day 50 (not treatment-related); one patient developed respiratory acidosis on Day 466 (not treatment-related)

Data shown are from BCMA-naïve patients dosed at 450M cell dose with LD regimen of 500 mg/m$^2$ cy and 30 mg/m$^2$ flu daily x 3 days

[1]MRD negative at ≤$10^{-5}$

ICAHT: immune effector cell-associated hematotoxicity; M: million; mo: month; MRD: minimal residual disease; ORR: overall response rate

Data cutoff 26May2026

# No GvHD, IEC-EC, parkinsonism, or cranial nerve palsies observed

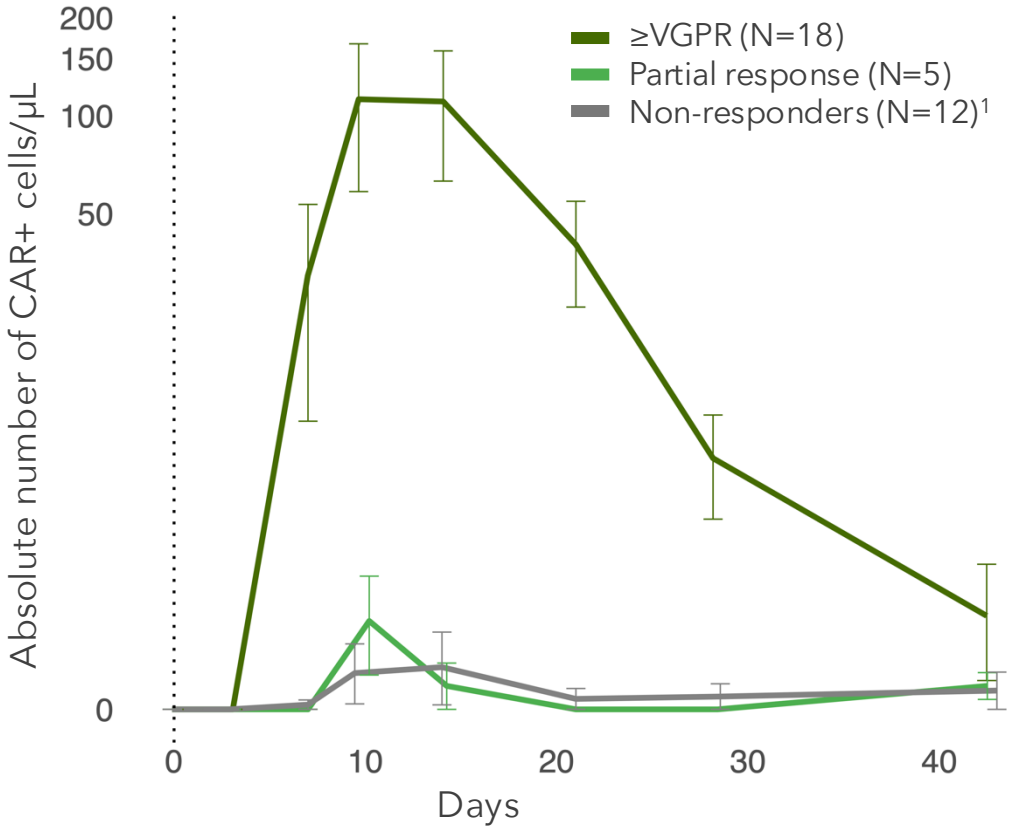
| | All at selected LD[1] (N=35) | | BCMA-naïve 450M at selected LD[1] (N=12) | |
|---|---|---|---|---|
| **Adverse events of special interest** | Any grade n (%) | Grade ≥3 n (%) | Any grade n (%) | Grade ≥3 n (%) |
| **Infections**, n (%) | 17 (49) | 6 (17) | 8 (67) | 3 (25) |
| **CRS**, n (%) | 12 (34) | 1 (3) | 4 (33) | 1 (8) |
| **ICANS**, n (%) | 3 (9) | -- | 3 (25) | -- |
| **IEC-HS**, n (%) | 3 (9) | 1 (3) | 1 (8) | 1 (8) |
| **IEC-EC**, n (%) | -- | -- | -- | -- |
| **GvHD**, n (%) | -- | -- | -- | -- |
| **Prolonged cytopenias[2]** | NA | 12/34 (35) | NA | 5/12 (42) |

- Three grade 5 AEs occurred at 450M cell dose (ICAHT on day 90 [related], pneumonia on day 50 [unrelated], respiratory acidosis on day 466 [unrelated]) and one grade 5 AE occurred at the 300M dose (respiratory syncytial virus on day 73 [unrelated])
- 1 grade 4 Guillain-Barré Syndrome (related) at the 450M cell dose on day 129, resolving

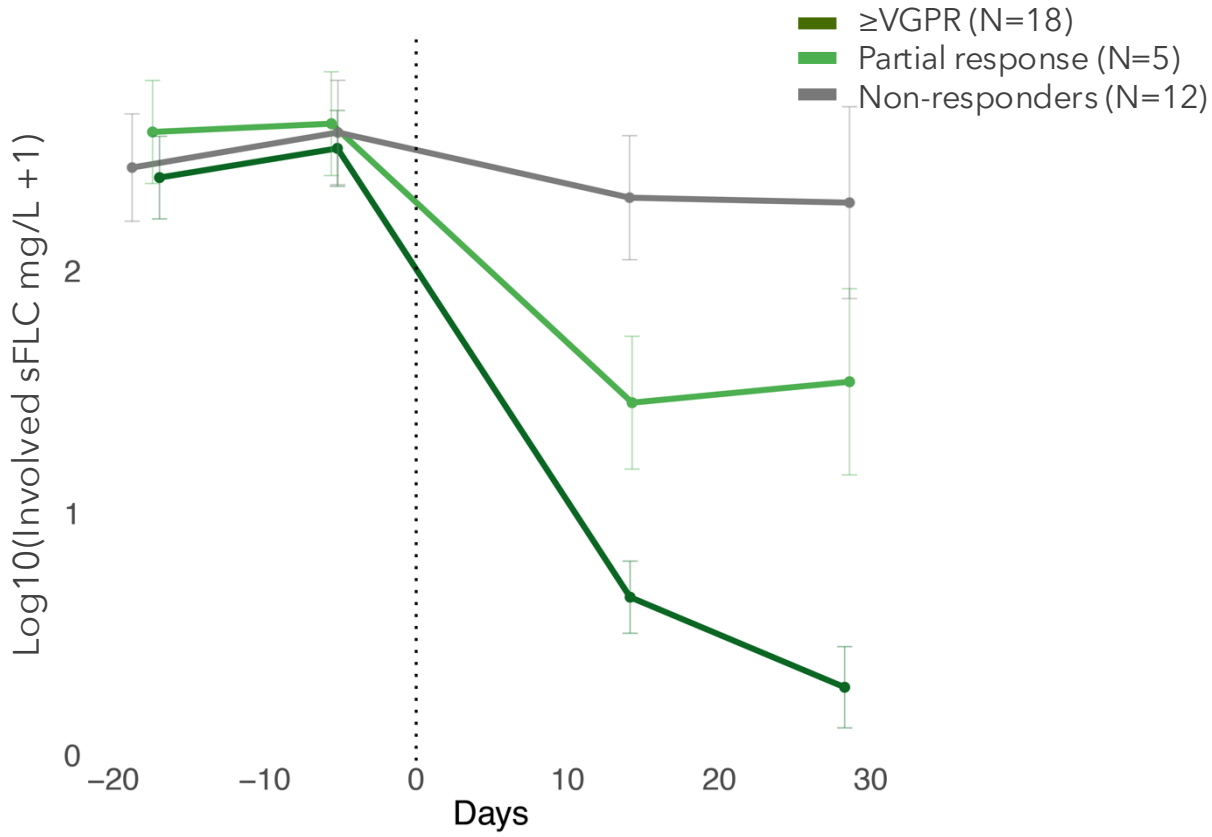
[1]LD regimen of 500 mg/m$^2$ cy and 30 mg/m$^2$ flu daily x 3 days
[2]Any continued ≥ grade 3 cytopenia based on laboratory data at day 30 (+/-5 days). The denominator represents those with data at day 30 (+/- 5 days)
AE: adverse event; CRS: cytokine release syndrome; cy: cyclophosphamide; flu: fludarabine; GvHD: graft-versus-host disease; ICANS: immune effector cell-associated neurotoxicity syndrome; ICAHT: immune effector cell-associated hematotoxicity; IEC-HS: immune effector cell-associated hemophagocytic lymphohistiocytosis-like syndrome; IEC-EC: immune effector cell-associated enterocolitis;
LD: lymphodepletion; NA: not applicable
Data cutoff 20Apr2026

# Robust CAR-T cell expansion and rapid sFLC decrease strongly correlate with clinical responses

**PK at selected LD**

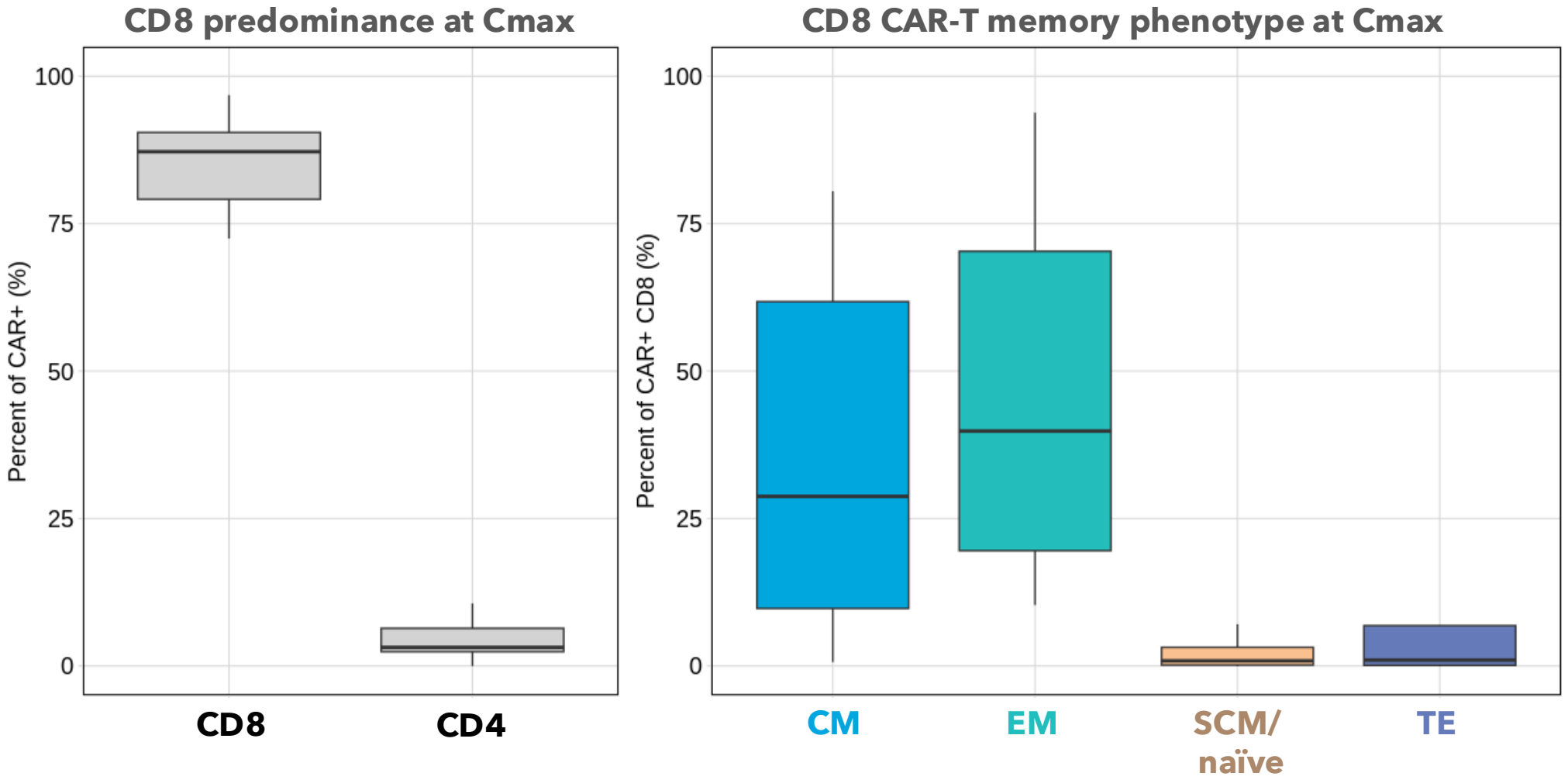



**Rapid sFLC decrease in responders**



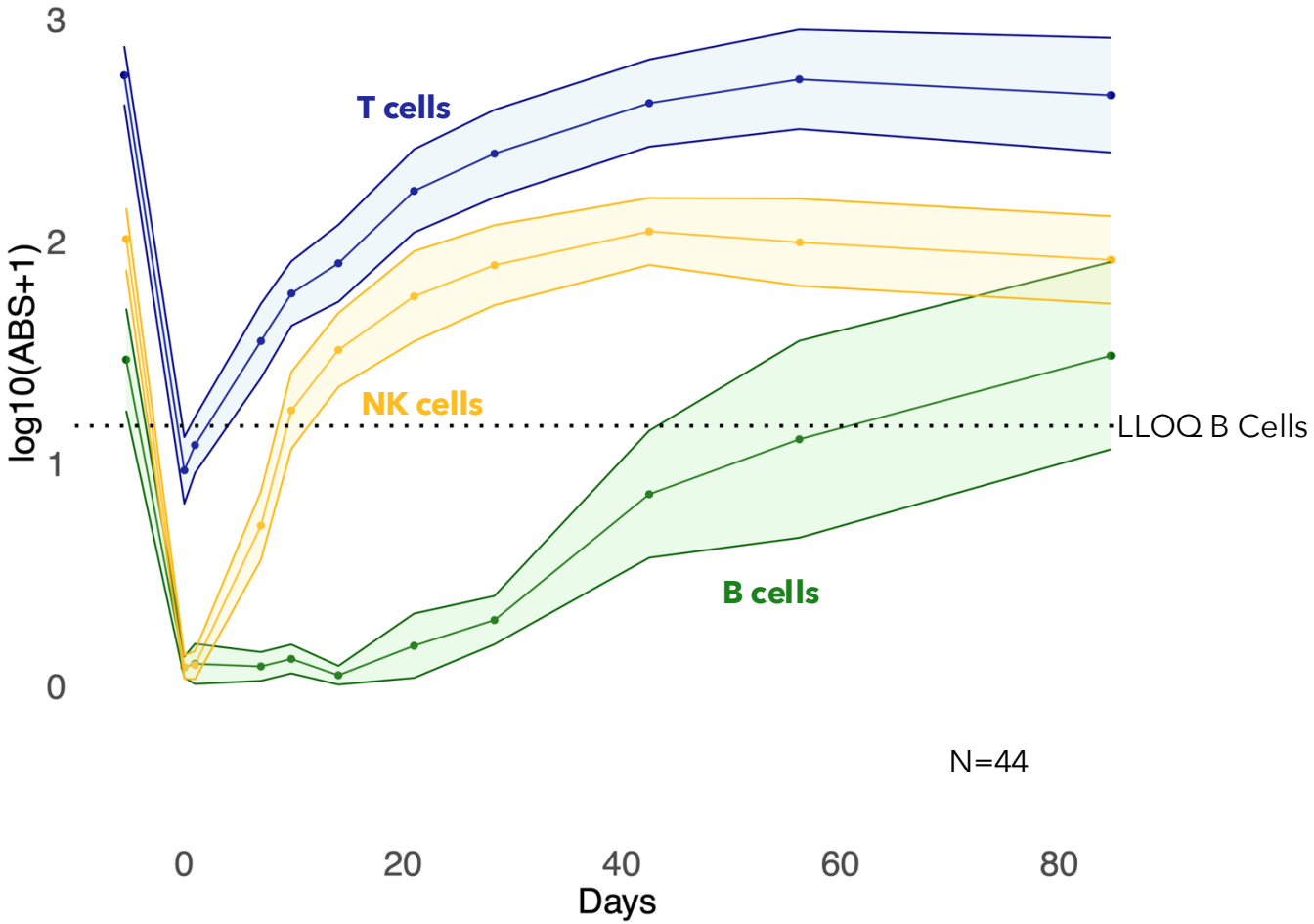

[1]One patient non-evaluable; flow PK data up to Week 6 visit with 34 of 35 patients evaluable. Mean values with SE shown.
sFLC data in all 35 patients to Day 28 visit; mean of log transformed values with SE shown.
AUC: area under the curve; Cmax: maximum concentration; MR: minimal response; PD: progressive disease; PK: pharmacokinetic; SD: stable disease; SE: standard error average; sFLC: serum free light chains; Tmax: time to maximum concentration; ≥VGPR: very good partial response or better
Data cutoff 20Apr2026 for biomarker data for 35 patients treated in dose escalation with the selected LD

# Balanced central and effector memory CAR+ CD8 T cells support potent antitumor activity and functional persistence




Data shown for patients treated with 500mg/m² cy and 30 mg/m² flu daily x 3 days at 450M dose.
CD4/8 ratio data represents patients with at least 100 CAR+ T cell events by flow cytometry at Tmax (D14, n=13).
Memory data represents patients with at least 100 CAR+ CD8 T cell events by flow cytometry at individual subject Tmax (n=16).
CM: central memory (CD45RA-CCR7+); EM: effector memory (CD45RA-CCR7-); SCM/naïve : stem cell memory/naïve (CD45RA+CCR7+); TE: terminal effector (CD45RA+CCR7-).
Data cutoff 20Apr2026

# Rapid recovery of endogenous T and NK cells contributes to the manageable safety profile




- Patient T cell depletion enables CAR-T cell expansion
- Fast recovery of T and NK cells quickly reinstates the patient's natural immunity, likely contributing to the favorable safety profile [1,2]
- Balancing CAR-T cell activity and recovery of natural immune activity is a key differentiator for Caribou's allogeneic CAR-T programs

Average of log transformed values shown with ribbons reflecting standard error; dotted line is lower limit of quantification (LLOQ) for B cells
Data through week 6 for 36 patients who received CB-011 with LD regimen of 500 mg/m² cy and 30 mg/m² flu daily x 3 days
[1]van de Donk N et al. 21st IMS (Annual Meeting, Brazil), 2024, P-090
[2]Tabbara N, et al. Hematology Am Soc Hematol Educ Program. 2024;(1):116-125
NK: natural killer
Data cutoff 20Apr2026

# Next steps for CB-011 in r/r MM patients

**Enrollment ongoing in dose expansion at selected LD with 450M CAR-T cells (RDE)**

→ **BCMA-naïve**

→ **BCMA-exposed**

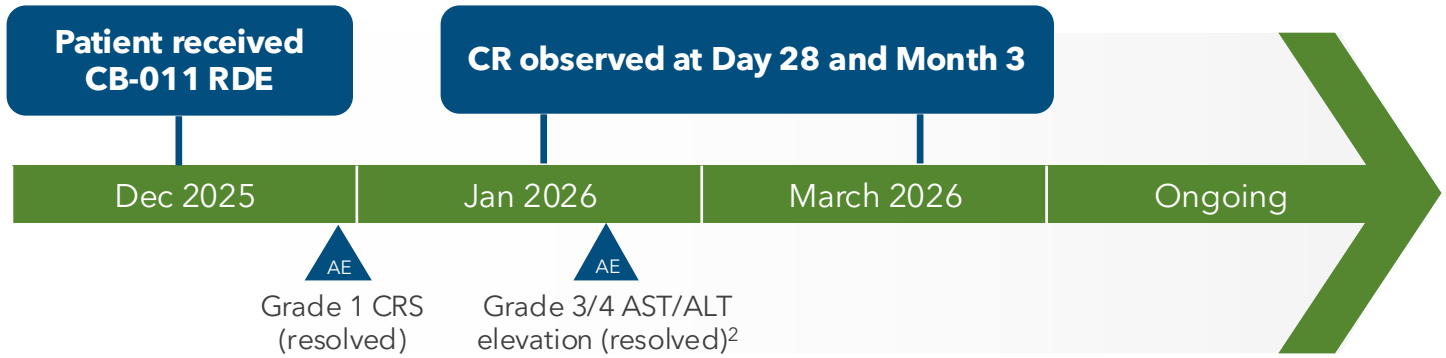


RDE: recommended dose for expansion

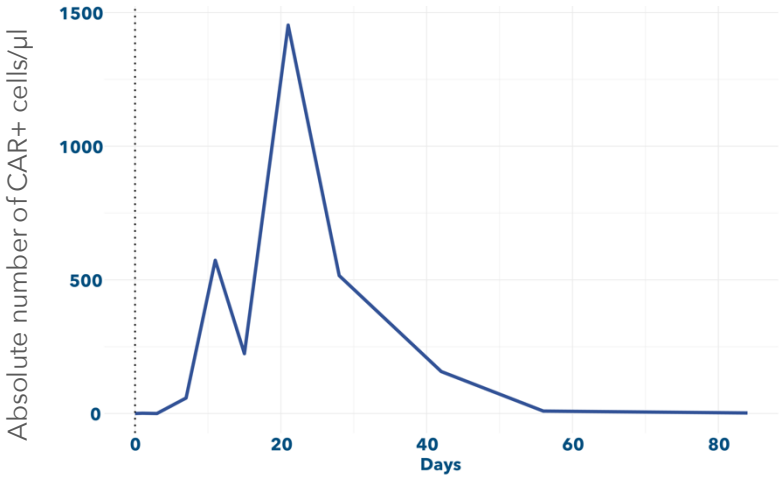
# BCMA-exposed patient case from dose expansion:

## Ongoing CR following CB-011 in heavily pretreated MM patient who previously received cilta-cel

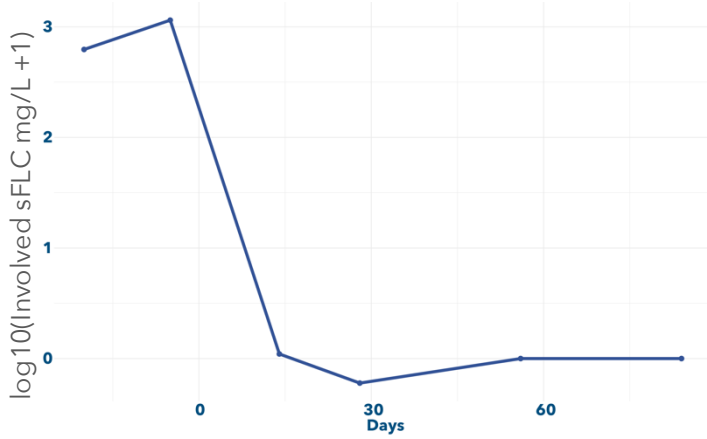
Sex: male
Age: 71
Prior lines of therapy: 8
No CR following any post-1L therapy
Cilta-cel[1] best response: VGPR




### Robust CB-011 CAR-T cell expansion




### Rapid decrease of serum free light chains (sFLC) correlated with CR




[1]Patient received cilta-cel and achieved a response for 20 mo followed by KPd for 6 mo as last line of therapy prior to enrollment
[2]Patient had medical history of intermittent ALT elevation starting in June 2024
1L: frontline; ALT: alanine transaminase; AST: aspartate transferase; Kpd: carfilzomib, pomalidomide, and dexamethasone; RDE: recommended dose for expansion (450M CB-011 CAR-T cells); VGPR: very good partial response.

# Conclusions and next steps for CB-011 in r/r MM patients

- Deep and durable responses observed with CB-011 in heavily pre-treated r/r MM patients
  - ✓ **92% ORR, 83% ≥ CR rate, 91% MRD negativity, 50% in ≥CR at 15 months** in BCMA-naïve patients treated with the recommended dose for expansion of 450M cells
- **Manageable safety profile** with no GvHD, colitis, parkinsonism, or cranial nerve palsies
- Initial proof-of-concept with CB-011 demonstrated in patient treated with prior BCMA CAR-T
- RMAT designation granted for CB-011 by FDA in March 2026
- Next steps:
  - ✓ Continue enrollment in dose expansion for BCMA-naïve and -exposed patients


RMAT: Regenerative Medicine Advanced Therapy

# Gratitude for our patients, caregivers, investigators, and site staff