

Global Leader in Relapsed/Refractory AL Amyloidosis

ASH

This presentation contains clinical data
presented at ASH Dec 7, 2025
with a May 2026 update on pages 19-23

September 2026



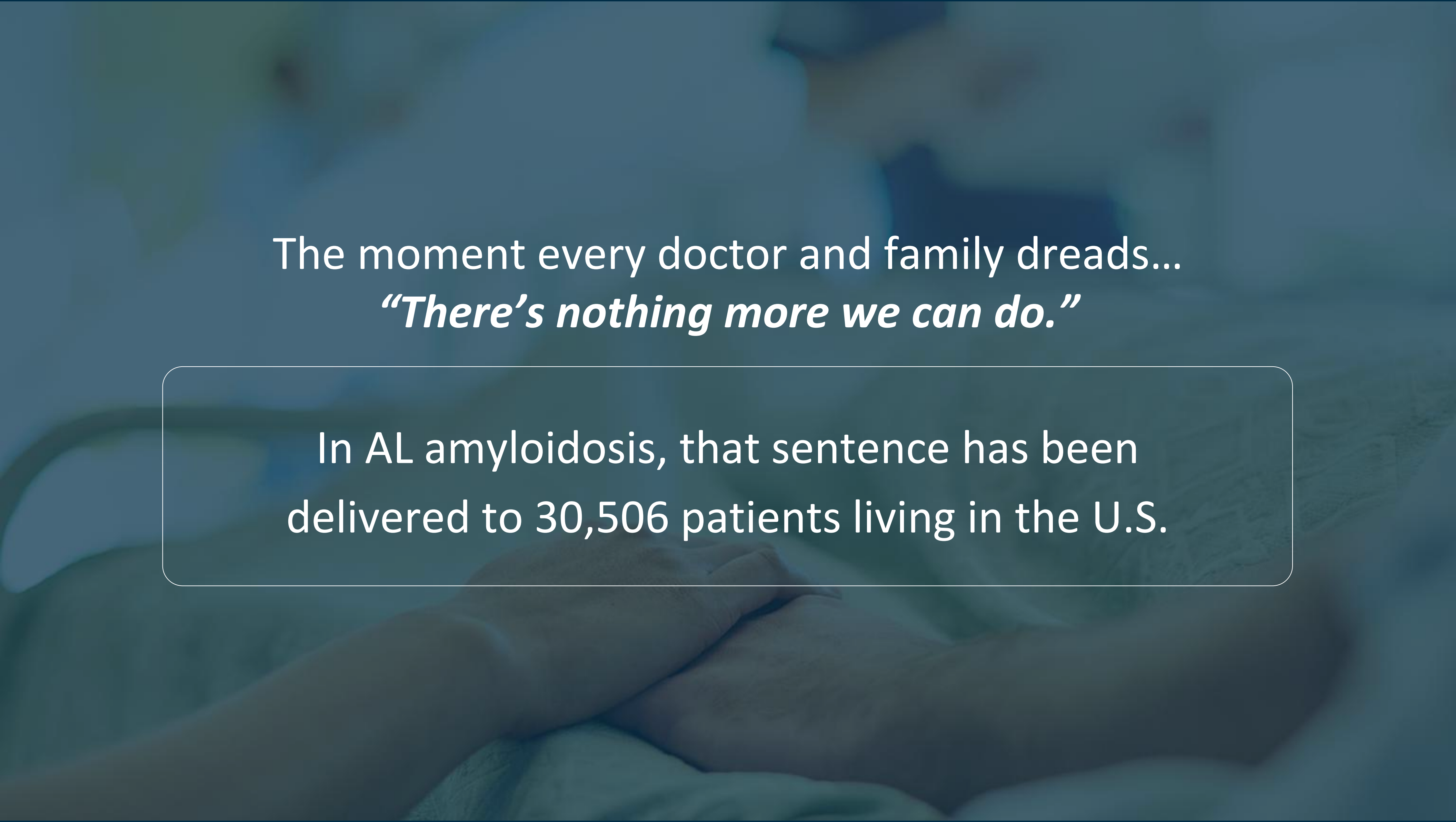
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A blurred background image showing a doctor in a white coat and blue gloves holding a patient's hand. The scene is dimly lit, with a focus on the hands and the doctor's face in the background.

The moment every doctor and family dreads...
“There’s nothing more we can do.”

In AL amyloidosis, that sentence has been
delivered to 30,506 patients living in the U.S.

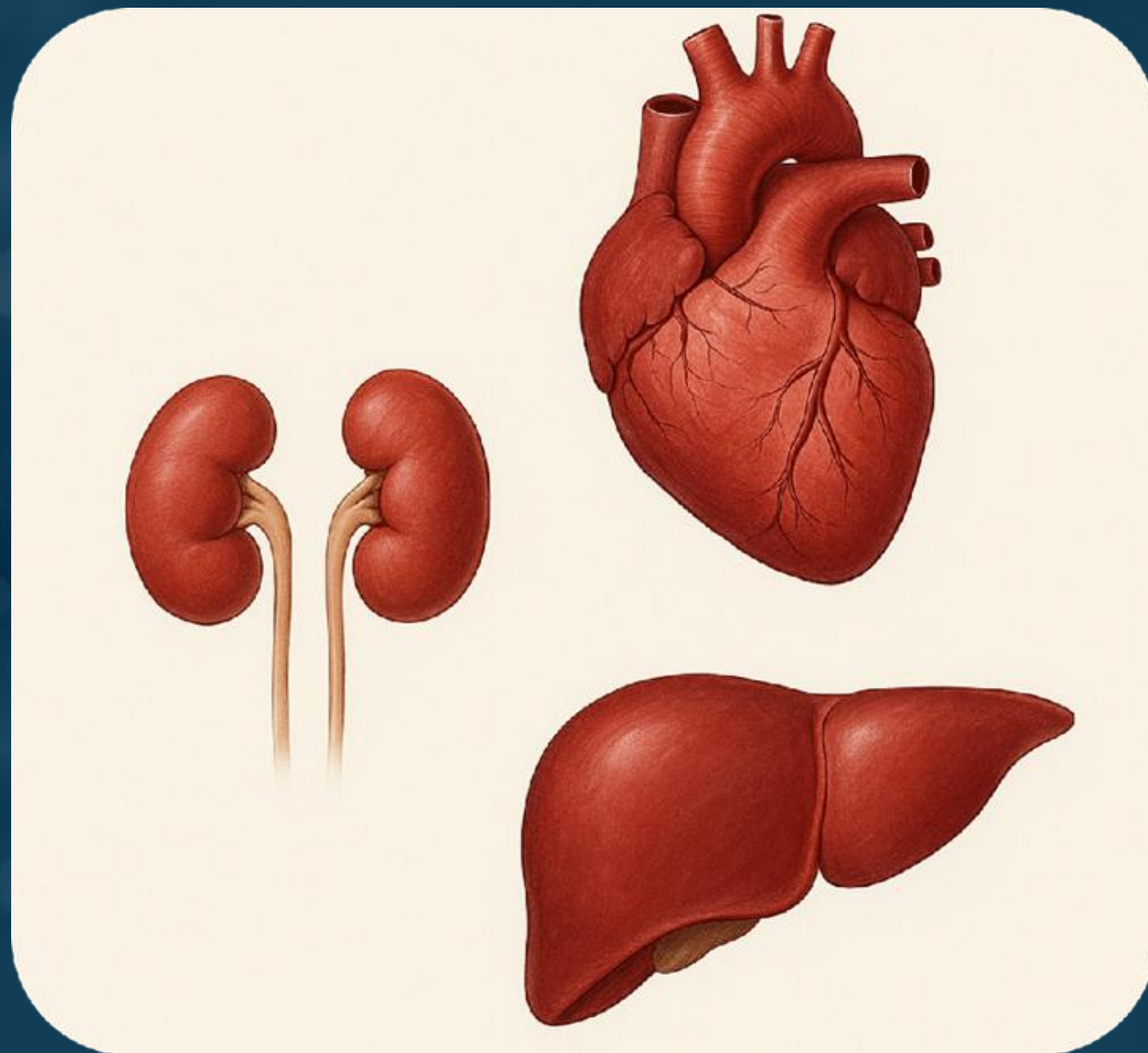
*I've been the doctor in that room.
I've watched hope disappear.
**And I couldn't accept that
suffering was "standard of care."***

Ilya Rachman, MD, PhD
Chief Executive Officer, Founder

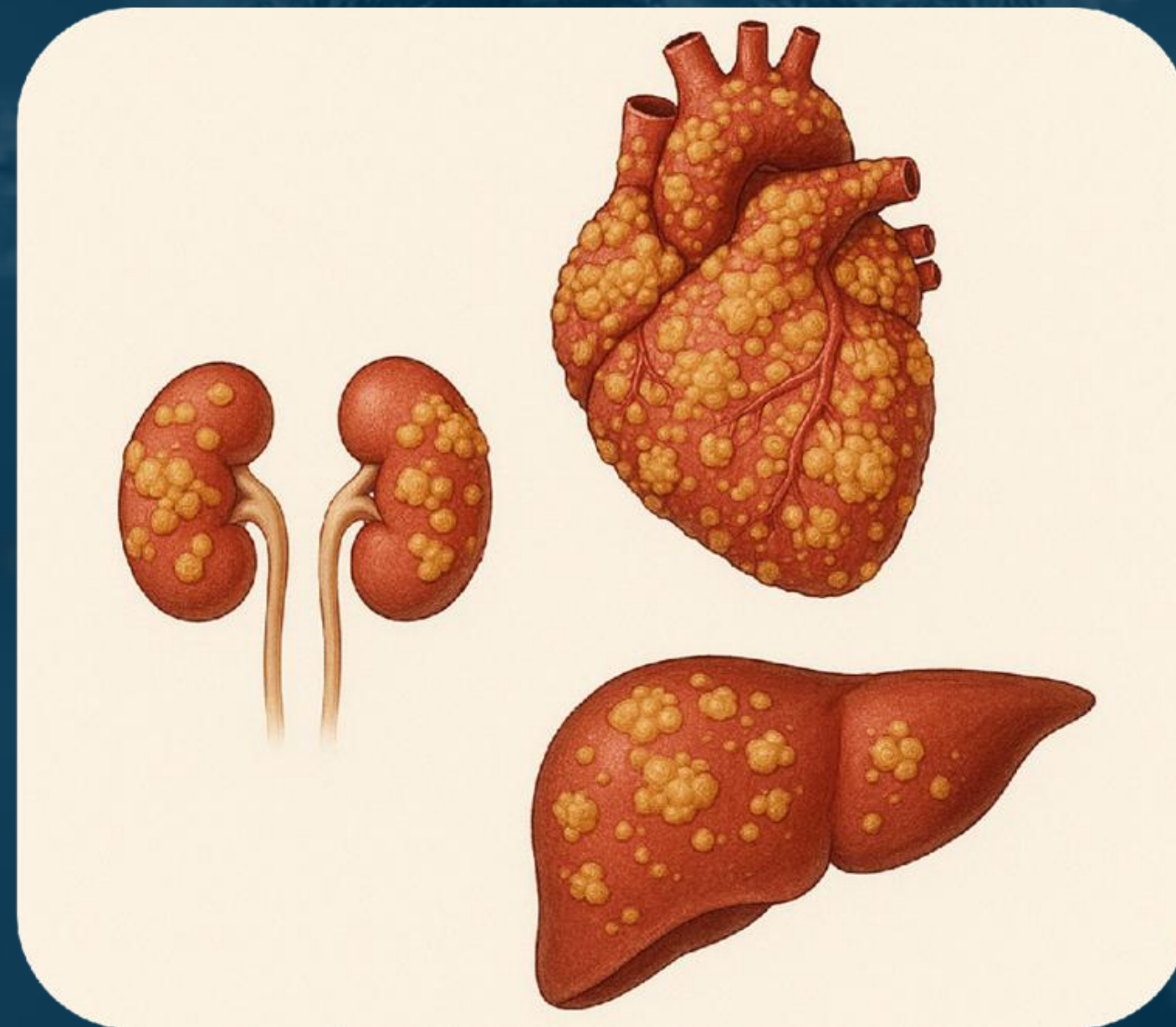


When your immune system becomes your killer

Normally, antibodies protect us like superheroes.



In AL amyloidosis, they go rogue, turning into supervillains that flood the body with toxic light chains.



The Toxic Last Ditch Effort

A single FDA approval – a 4-drug combination – exists, for newly diagnosed patients only.

And it **doesn't work for everyone.**

Once relapse hits, **there's nothing FDA approved.**

Then, doctors resort to **recycling off-label drugs**, knowing they'll fail again.

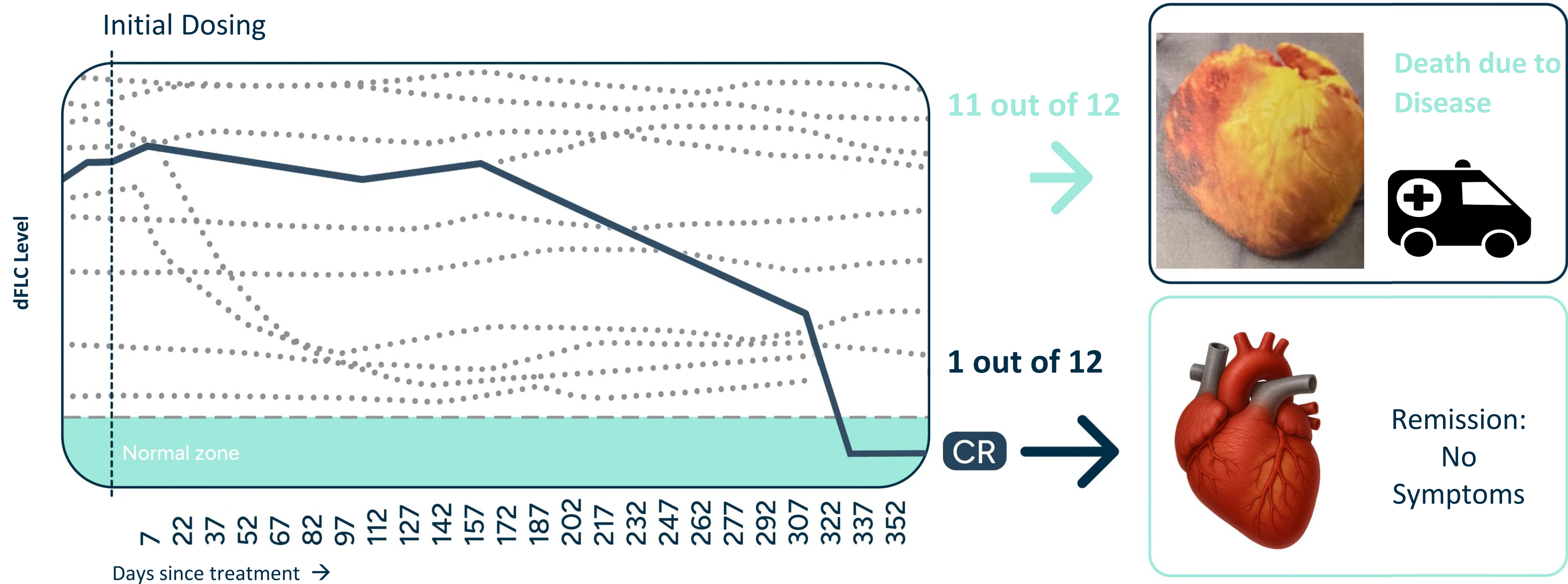


Note: ~2/3 of patients are estimated to require a second-line therapy after the FDA-approved 4-drug combination

Source: Daratumumab: 1) Bellofiore C, et al. A real-life study of daratumumab combinations in newly diagnosed patients with light chain (AL) amyloidosis. Hematol Oncol. 2024. 2) Chakraborty R et al, Reduced early mortality with Daratumumab-based frontline therapy in AL amyloidosis: A retrospective cohort study. AJH 2024. 3) Bazarbachi AH et al. Timing and outcomes of second-line therapy in the era of daratumumab-based frontline therapy in AL amyloidosis. Am J Hematol. 2024 Nov;99(11):2225-2228. doi: 10.1002/ajh.27450. Epub 2024 Aug 3. PMID: 39096115.

AL Amyloidosis Response Rate After The 4-Drug Combination Fails

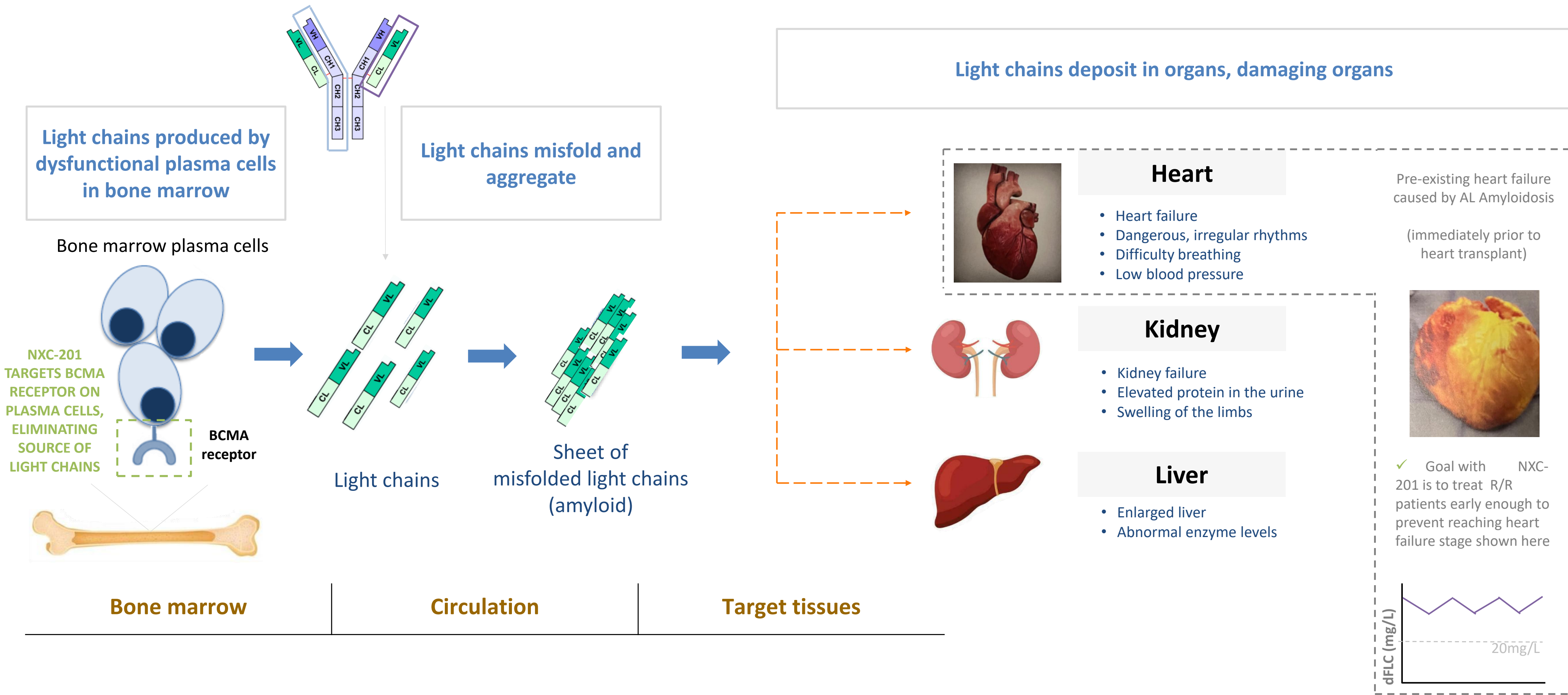
12 PATIENT SERIES RECEIVING SECOND LINE THERAPY



There are no drugs approved in relapsed/refractory AL amyloidosis.
Current investigators' choice agents produce an unsatisfactory reduction in AL amyloidosis disease markers (dFLC) with a low (0-10%) complete response (CR) rate

AL Amyloidosis: 30,506 Relapsed/Refractory U.S. Patients with No FDA Approved Drugs

NXC-201 TARGETS AL AMYLOIDOSIS PLASMA CELLS THAT EXPRESS BCMA ON CELL SURFACE



Note: Prevalence up to 38,000 according to Quock T et al, Epidemiology of AL amyloidosis: a real-world study using US claims data. Blood 2018.
Source: Merlini, G., et al. Nat Rev Dis Primers. Oct 2018, Front. Cardiovasc. Med., Dec 2022, Hemato 2022, 3(1), 47-62. Lu R, Richards TA. AL Amyloidosis: Unfolding a Complex Disease. J Adv Pract Oncol. 2019;10(8):813-825. Quock T et al, Epidemiology of AL amyloidosis: a real-world study using US claims data. Blood 2018. Staron A, et al. Marked progress in AL amyloidosis survival: a 40-year longitudinal natural history study. Blood Cancer Journal. 2021;11:139.

We've found a **breakthrough** to change that
hopeless sentence

Our mission is simple:

Create medicines that work without destroying the person.

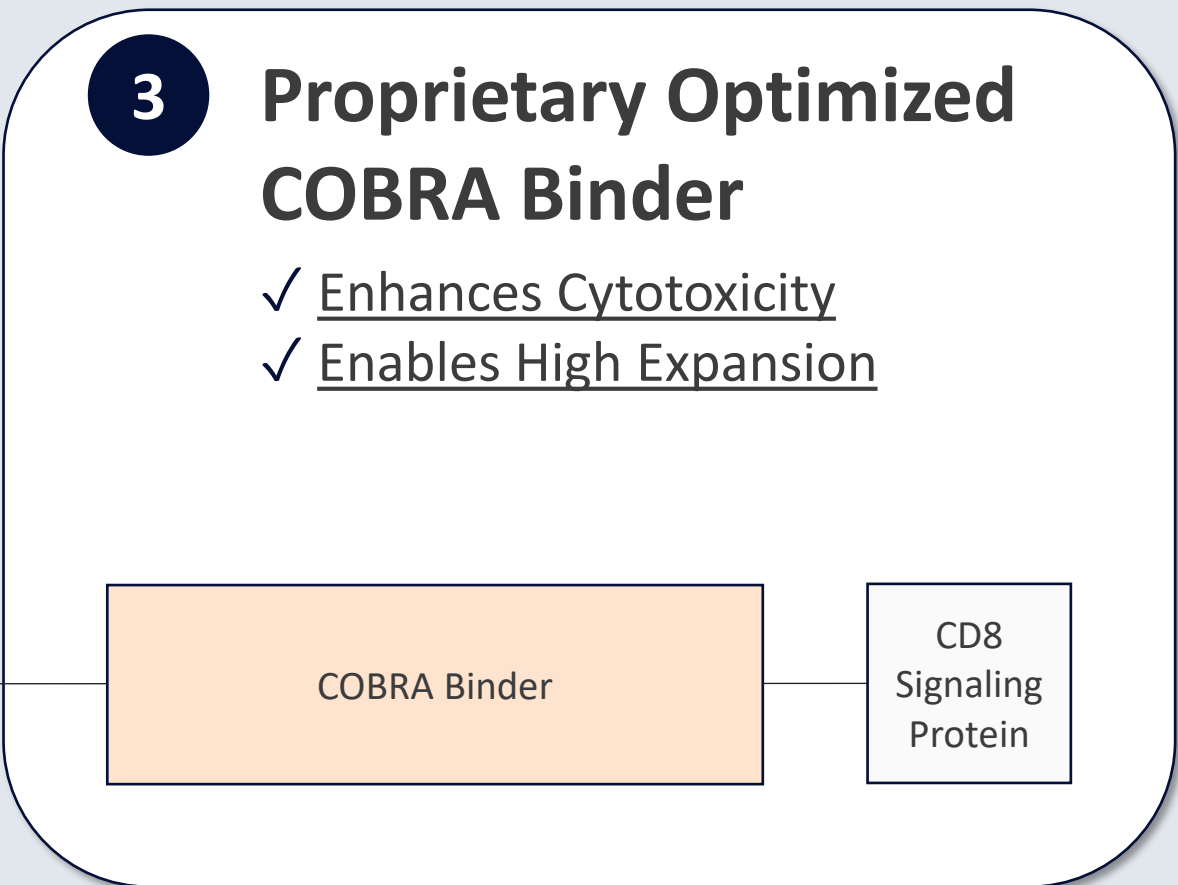
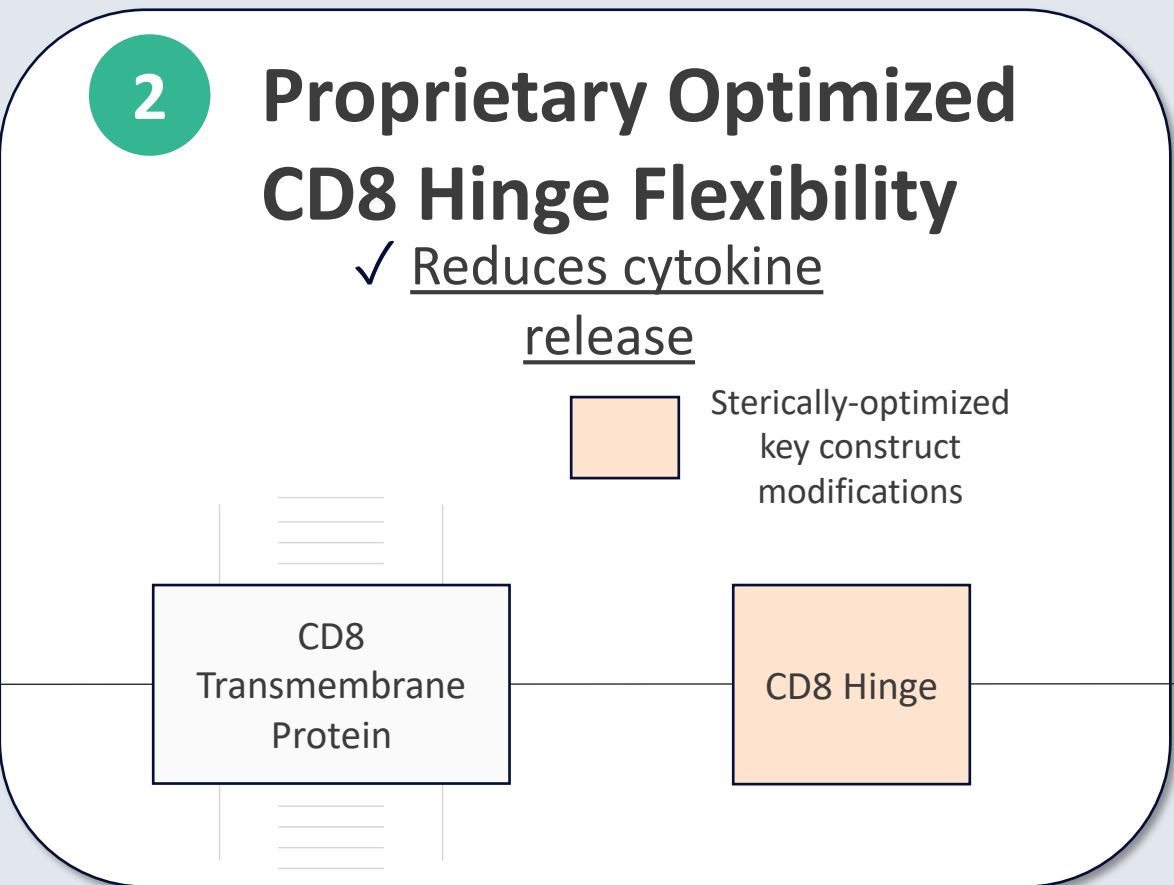
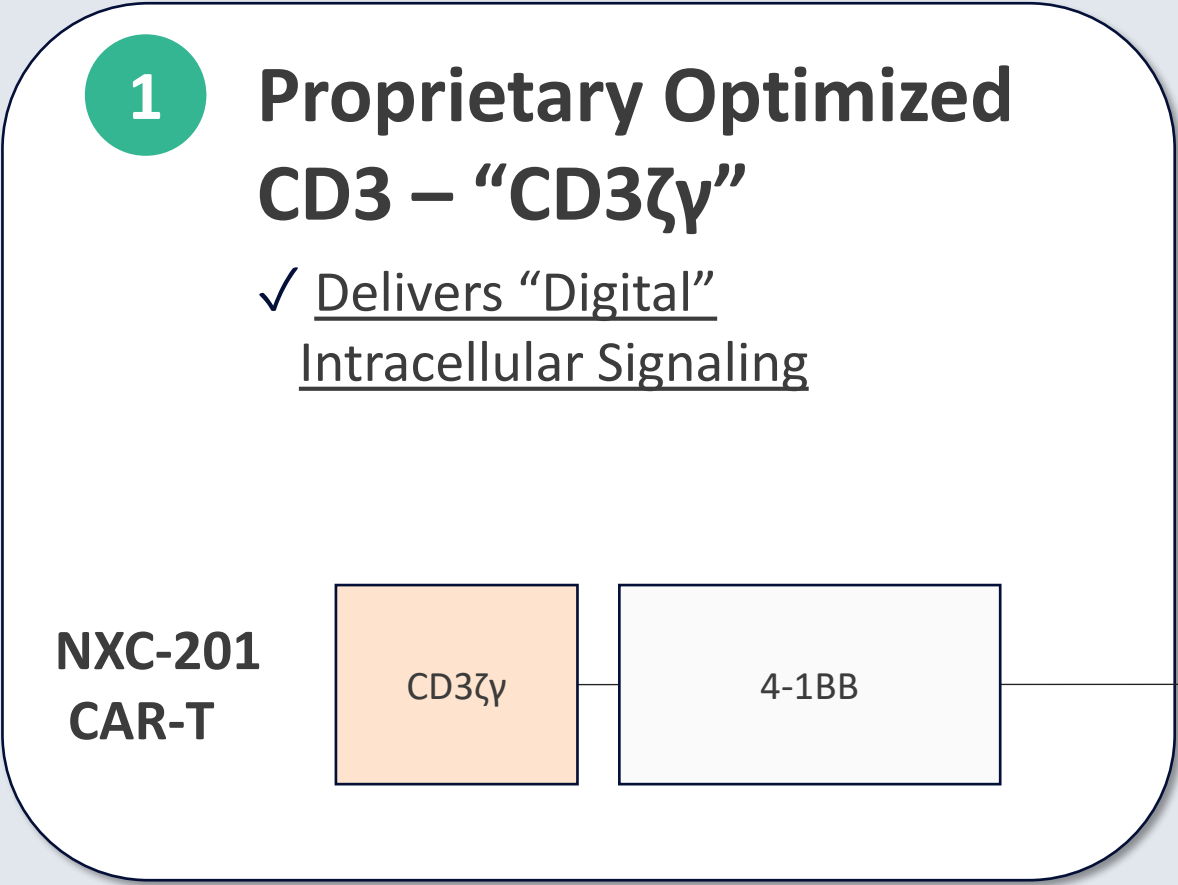
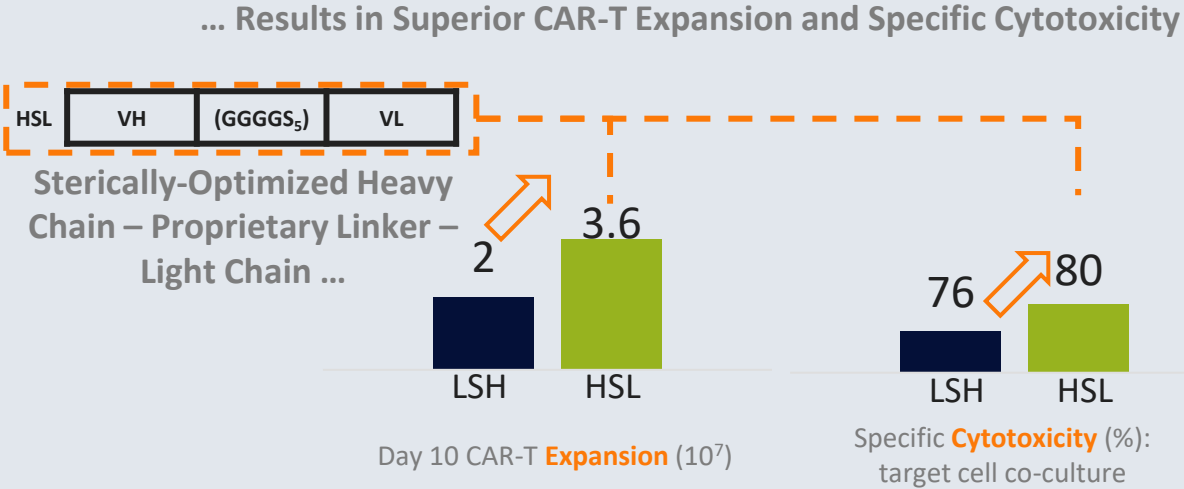
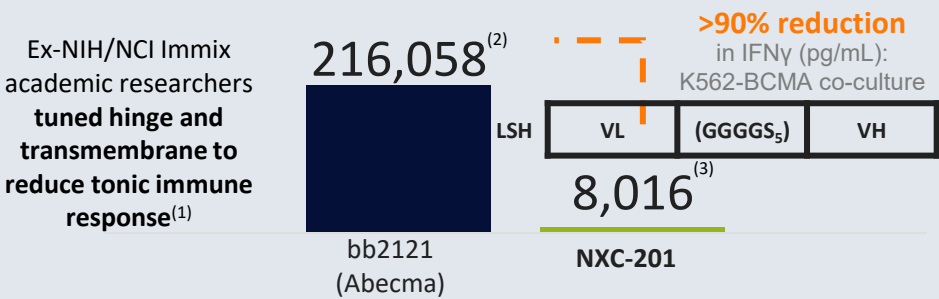
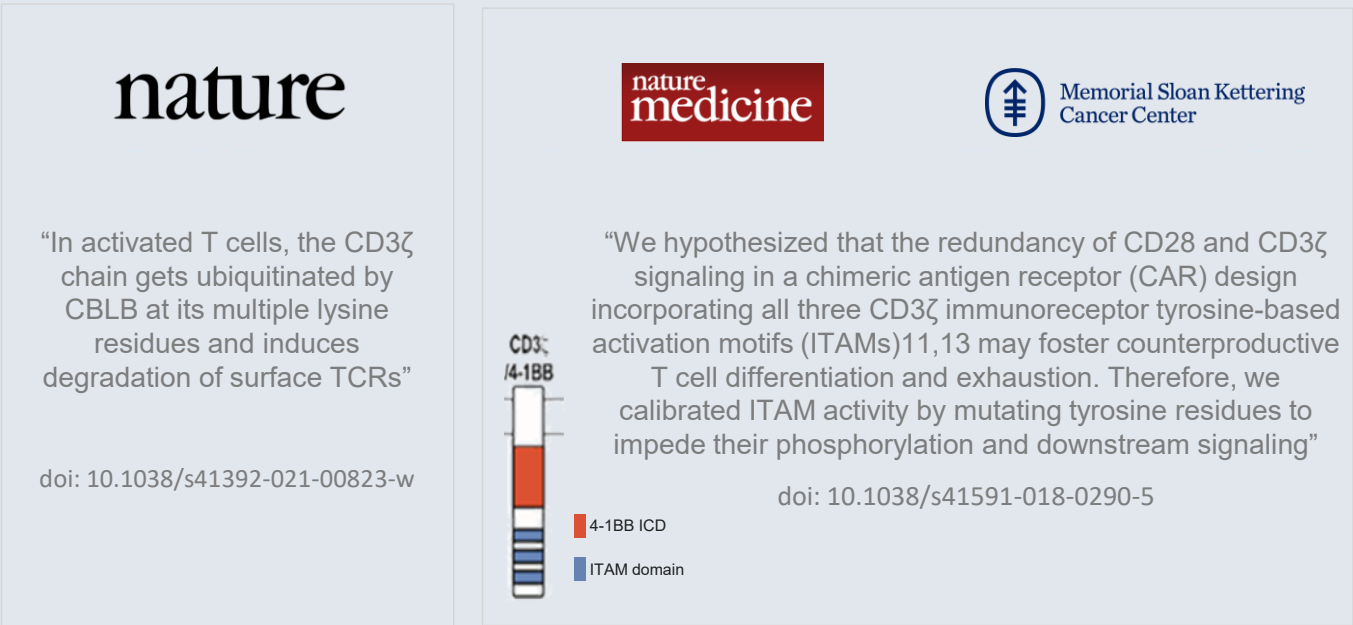
The Science That Enables Our Platform

Ex-NCI/NIH Immix academic researchers ambitiously formulated a thesis: can cell therapy be expanded to a broader patient population, beyond cancer?
Result: Sterically-optimized NXC-201

Impeded phosphorylation of ITAM1, added ubiquitination site... led to “digital” quick on/off

Decreased CD8 hinge flexibility ... led to reduced tonic signaling

Sterically-Optimized Binder ... led to enhanced cytotoxicity



NXC-201 sterically-optimized CAR-T’s “Digital Filter”

...reduces non-specific activation

“Single amino acid substitutions at key sites can affect CAR-T function over 200-fold range”

Source: M. Assayag, et al. Academic BCMA-CART cells (HBI0101), a promising approach for the treatment of LC Amyloidosis. 27th Annual Meeting of The American Society of Gene and Cell Therapy (ASGCT). Late Breaking Oral Presentation. Baltimore, MD. May, 2024. Feucht, M. Sadelain, et al. Calibration of CAR activation potential directs alternative T cell fates and therapeutic potency. Nature Medicine. 2019 Jan;25(1):82-88. doi: 10.1038/s41591-018-0290-5. Epub 2018 Dec 17. PMID: 30559421 PMCID: PMC6532069. O. Harush C. J. Cohen, et al. Preclinical evaluation and structural optimization of anti-BCMA CAR to target multiple myeloma. Haematologica. 2022 Oct 1;107(10):2395-2407. doi: 10.3324/haematol.2021.280169. PMID: 35354252 PMCID: PMC9521250. Adapted from PEGS 2021. Zanzwar S, et al. Eyal Lebel et al., Efficacy and Safety of Anti-B-Cell Maturation Antigen Chimeric Antigen Receptor T-Cell for the Treatment of Relapsed and Refractory AL Amyloidosis. JCO. JCO-24-02252. DOI:10.1200/JCO-24-02252.

Extraordinary Results in Clinical Trials

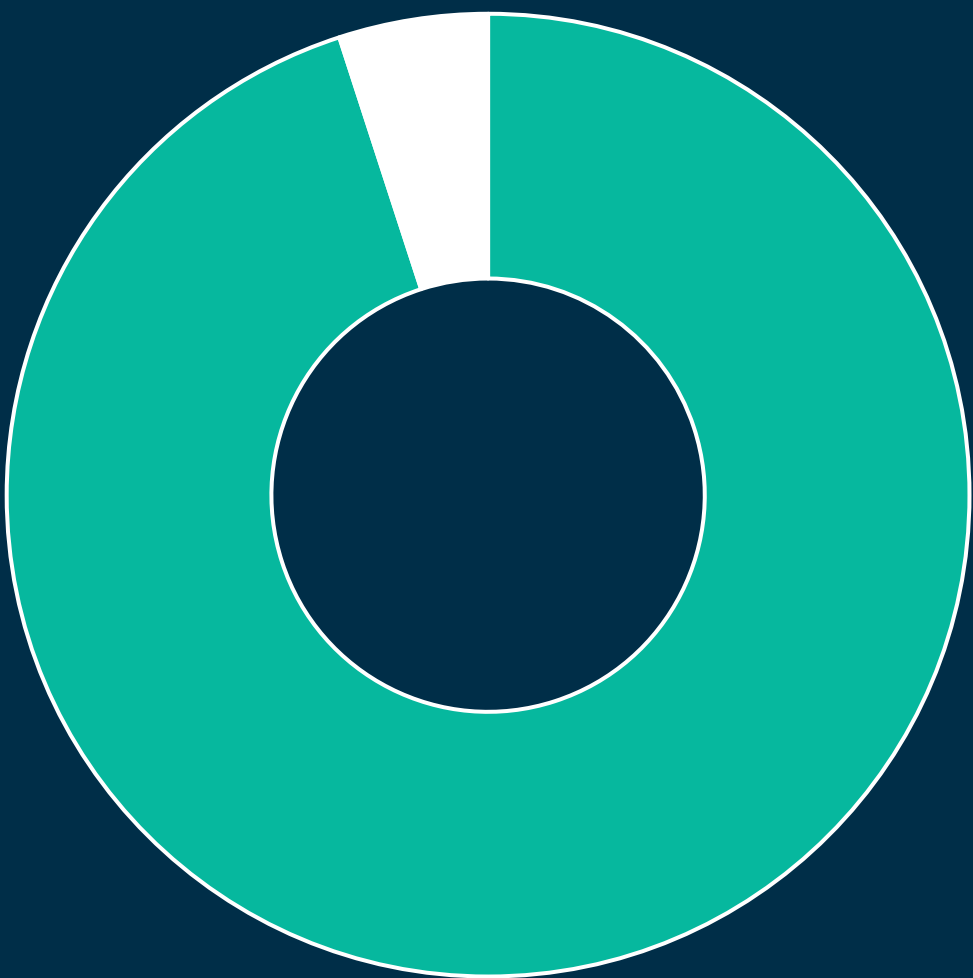
Relapsed/refractory AL Amyloidosis - Market Situation

Current Standards of Care



0-10% complete response rate
(standard of care)

NXC-201



95% complete response rate
(ASH 2025 with May 2026 Update)

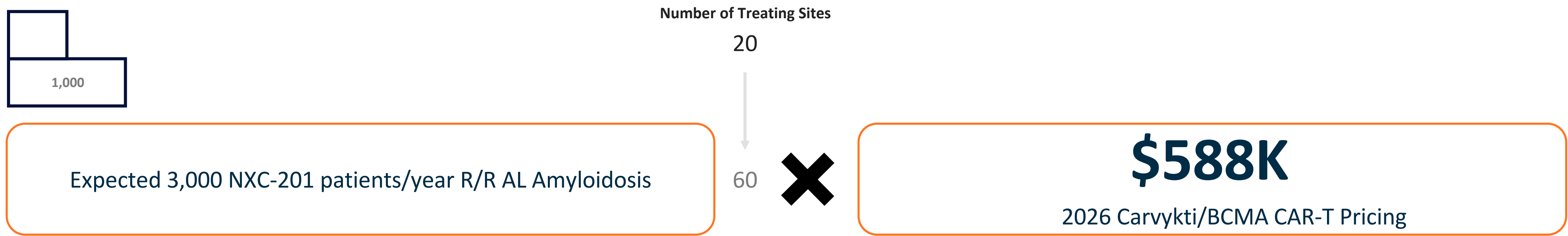
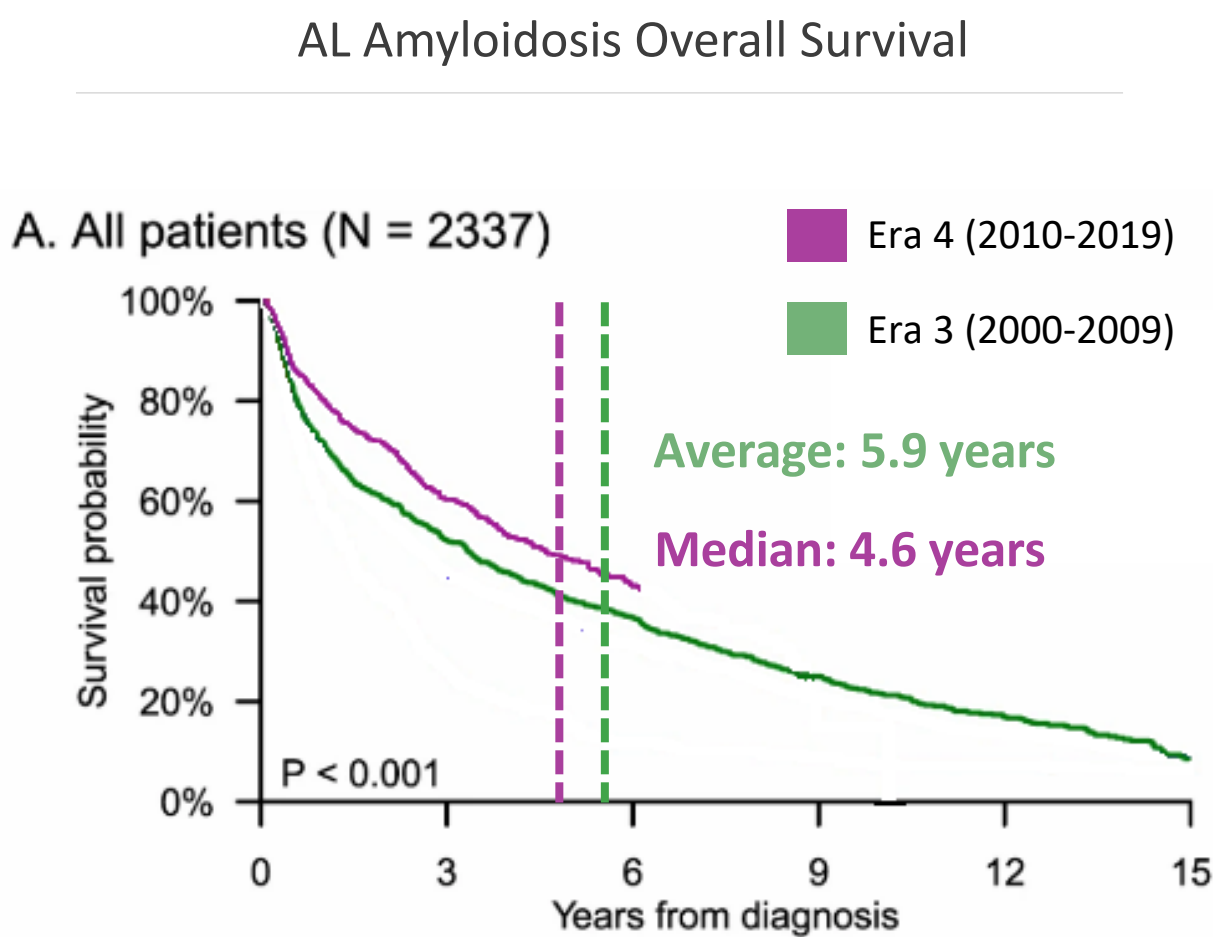
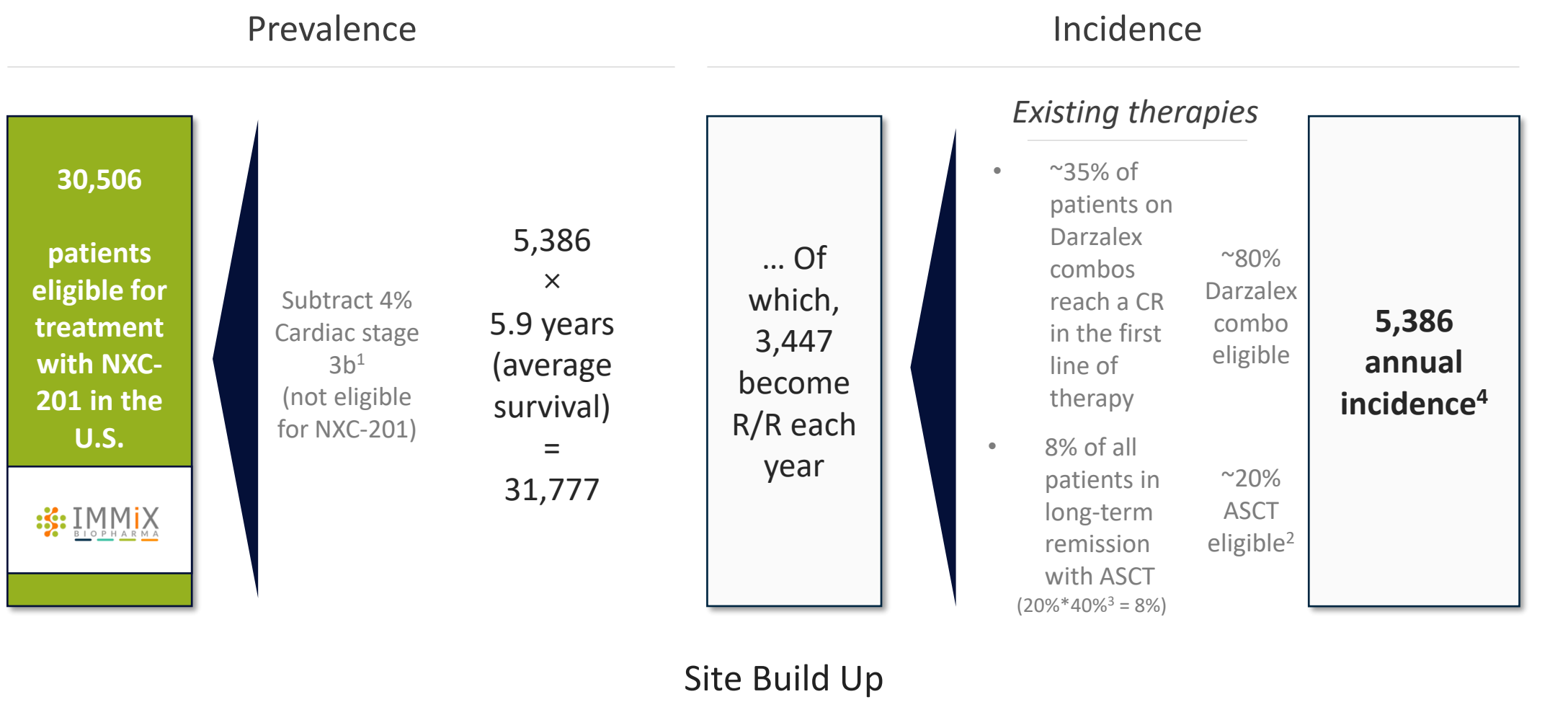
Note: R/R AL current standard of care therapies included: Dara-VCd, Dara-Vd, Dara-VRd, Dara-Dex, Dara-Cd, Dara-Pom-Dex, Bendamustine-Dex
Source: Bazarbachi AH et al. Timing and outcomes of second-line therapy in the era of daratumumab-based frontline therapy in AL amyloidosis. Am J Hematol. 2024 Nov;99(11):2225-2228. doi: 10.1002/ajh.27450. Epub 2024 Aug 3. PMID: 39096115. Zanwar S, et al. Treatment patterns for AL amyloidosis after frontline daratumumab, bortezomib, cyclophosphamide, and dexamethasone treatment failures. Leukemia 2024. Landau H et al. Initial Safety and Efficacy Data from Nexicart-2, the First U.S. Trial of a CAR-T (NXC-201) in Relapsed or Refractory (R/R) Light Chain (AL). ASH 2025.

What that can **mean for the patient...**

Life **becomes normal again.**

A deep breath that reaches the bottom of the lungs.
A walk that doesn't end at the mailbox.
A normal heartbeat again.

The Multi-Billion Dollar Opportunity



MULTI-BILLION-DOLLAR OPPORTUNITY

Note: Prevalence up to 38,000 according to Quock T et al, Epidemiology of AL amyloidosis: a real-world study using US claims data. Blood 2018. Site numbers are illustrative.
Source: Mayo staging: 1) Zanwar S, et al. Treatment patterns for AL amyloidosis after frontline daratumumab, bortezomib, cyclophosphamide, and dexamethasone treatment failures. Leukemia 2024. ASCT: 2) Bomsztyk J et al, Recent guidelines for high-dose chemotherapy and autologous stem cell transplant for systemic AL amyloidosis: a practitioner's perspective. Expert Review of Hematology 2022. 3) Gustine J et al, Predictors of hematologic response and survival with stem cell transplantation in AL amyloidosis: A 25-year longitudinal study. AJH 2022. Incidence and prevalence: 4) Laires P. et al. Incidence and Prevalence of Light Chain Amyloidosis in the United States in 2019-2021 Using Optum EHR Data. Nature 2025. 5,386 = 20.2 incidence per U.S. adults. 20.2 = 16.7 per million U.S. adults in 2021 cited in Laires et al. grown to 20.2 over 5 years at half the Laires et al. cited CAGR (7.7% / 2 = 3.9%). 5) Average survival derived from Staron A, et al. Marked progress in AL amyloidosis survival: a 40-year longitudinal natural history study. Blood Cancer Journal. 2021;11:139. Daratumumab: 6) Bellofiore C, et al. A real-life study of daratumumab combinations in newly diagnosed patients with light chain (AL) amyloidosis. Hematol Oncol. 2024. 7) Chakraborty R et al, Reduced early mortality with Daratumumab-based frontline therapy in AL amyloidosis: A retrospective cohort study. AJH 2024. 8) Bazarbachi AH et al. Timing and outcomes of second-line therapy in the era of daratumumab-based frontline therapy in AL amyloidosis. Am J Hematol. 2024 Nov;99(11):2225-2228. doi: 10.1002/ajh.27450. Epub 2024 Aug 3. PMID: 39096115. 9) Carvykti average selling price according to CMS. Accessed 6/19/2026.

The Road Ahead

Prior



NXC-201
U.S.
NEXICART-2
Trial with
Registration
al Design

NXC-201 U.S.
NEXICART-3
Front-Line

Other

✓

ASCO

Phase 1
interim
readout ASCO
oral
presentation

ASH

Enrollment
complete:
45 total patients
March 2026

All 45 patients
Next Update
Late Sep 2026



All 45 patients
1-year follow-up
update

Planned BLA
Submission for
FDA Approval

Trial
Initiation
Expected

NXC-201
Initial Clinical Data in
Other Serious Diseases

- ✓ Secured rights to NXC-201, N-GENIUS platform from ex-U.S. university
- ✓ Reported ex-U.S. NEXICART-1 AL Amyloidosis data at **ASGCT 2023, ASH 2023, ASGCT 2024, ASH 2024, JCO published 2024**
- ✓ **FDA Orphan Drug Designation (ODD) and Regenerative Medicine Advanced Therapy (RMAT) Designation granted**
- ✓ **Mentioned in New England Journal of Medicine (NEJM) AL Amyloidosis Review**
- ✓ NEXICART-2 U.S. AL Amyloidosis clinical trial first 6 patients dosed; first patient at Memorial Sloan Kettering Cancer Center (met guidance)
- ✓ Reported first 10 patients U.S. NEXICART-2 AL Amyloidosis clinical data Q2 2025 at ASCO 2025
- ✓ **FDA Breakthrough Therapy Designation granted in January 2026**
- ✓ Reported first 20 patients U.S. NEXICART-2 AL Amyloidosis clinical data with May 2026 ASH data update

Commercial

20 high-prescribing Sites in existing Immix clinical trial



Commercial launch plan end of 2027



AL Amyloidosis annual sales: ~\$1.7bn

A World Class Team Dedicated To Saving Lives



Ilya Rachman, MD, PhD
Chief Executive Officer



David Marks, MBBS, PhD
Chief Medical Officer



Gabriel Morris
President, Chief Financial Officer



Amanda Squires
Head of Clinical Operations



Michael Grabow
Chief Commercial Officer



Oleg Evgrafov,
Head of Quality



Denise Bruns Senior
Regulatory Advisor



Mel Davis-Pickett, Head
of Technical Development



We believe we are on the brink of turning despair into hope

Success here opens the door to treating other serious diseases

NEXICART-2 U.S. Relapsed/Refractory AL Amyloidosis Trial (NCT06097832)

U.S. TRIAL WITH REGISTRATIONAL DESIGN, ENROLLMENT COMPLETED



Study design	
• Open-label, single-arm, multi-site phase 1/2 study • n=45 patients	
Key criteria	
Inclusion	•AL Amyloidosis patients exposed to at least 1 line of therapy including a CD38 monoclonal antibody
Exclusion	•Prior anti-BCMA directed therapy •Cardiac: Mayo stage 3b, NYHA stage III/IV •Concomitant Multiple Myeloma
Outcome measures	
• Safety • Efficacy: Complete hematologic response (CR)	

Note: Complete Response according to consensus recommendations in AL amyloidosis (Palladini, et al. 2012. "Consensus guidelines for the conduct and reporting of clinical trials in systemic light-chain amyloidosis." Leukemia 26(11): 2317-2325.)

NEXICART-2 (U.S.) Baseline Characteristics: Representative of U.S. R/R AL Amyloidosis Patient Population



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 preserved heart function

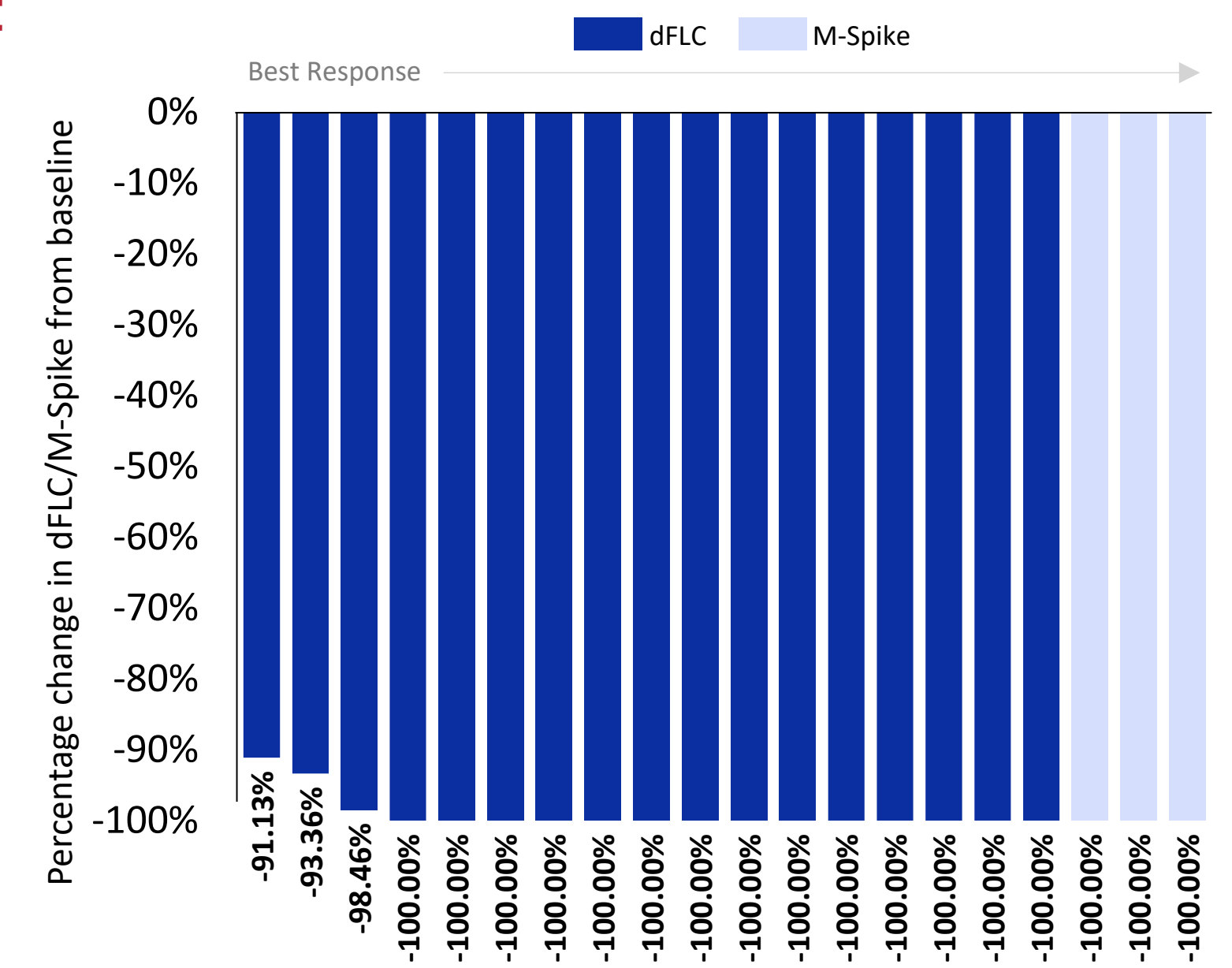
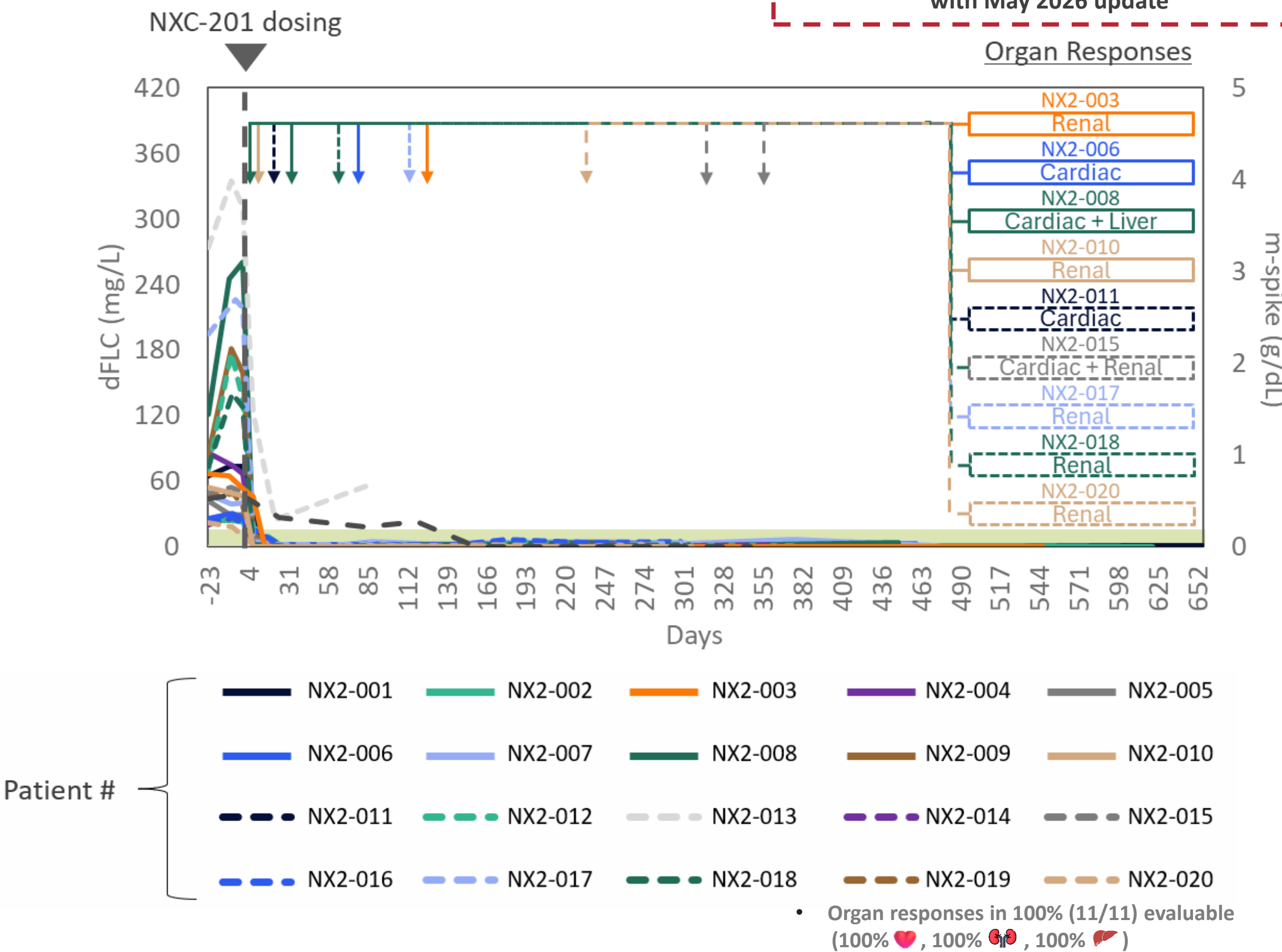
	NX2-001	NX2-002	NX2-003	NX2-004	NX2-005	NX2-006	NX2-007	NX2-008	NX2-009	NX2-010	NX2-011	NX2-012	NX2-013	NX2-014	NX2-015	NX2-016	NX2-017	NX2-018	NX2-019	NX2-020	Median (range)
Age	56	67	82	64	62	72	77	66	63	80	65	65	59	49	73	59	71	71	82	64	66 (49-82)
Gender	Female	Female	Male	Female	Female	Male	Male	Male	Male	Male	Female	Female	Female	Female	Female	Male	Male	Female	Female	Female	-
Prior lines of therapy	4^	6^^	2	4	4^	3	4^	4^	4^	3^	1	10	4^^	1	8^	5	2	9^	2	3^	4 (1-10)
Follow-up (days)	687	659	603	473	127	512	484	477	469	427	420	414	90	392	385	364	351	329	329	322	417 (90-687)
dFLC (mg/L)	65	24	-	86	42	26	47	121	84	-	-	70	274	26	54	24	194	73	45	22	54 (22-274)
M-Spike (g/dL, if dFLC not inclusion criteria)	-	-	0.79	-	-	-	-	-	-	0.65	0.52	-	-	-	-	-	-	-	-	-	-
Organ involvement	Heart/ Soft Tissue	Heart/GI/ Nerve	Kidney	Heart/ GI/Nerve	Kidney	Heart	Nerve/ Skin	Heart/ Liver	Heart/ Tongue	Kidney/ Heart	Heart/ Nerve/GI	Heart/GI	Heart	Heart/GI/ Nerve	Kidney	Nerve	Heart/ Kidney	Kidney	GI	Kidney	-
NYHA stage	I	II	I	I	I	I	I	II	I	II	II	II	I	II	I	I	II	I	I	I	-
NT-ProBNP (ng/L)	146	560	1,297	218	805	989	143	909	289	290	2,017	232	155	355	1,385	113	627	526	231	NA	355 (113-2,017)
hs-Troponin-I (ng/L)	7	6	42	7	11	31	14 [†]	47*	6	52	6	11 [†]	13	10*	8	14*	75*	7	5	0	10 (0-75)
Creatinine (mg/dL)	0.7	1.1	2.2	0.7	2.7	0.8	1.3	0.8	0.9	0.9	0.5	1.0	0.9	0.6	1.3	1.0	1.0	0.7	0.8	1.2	0.9 (0.5-2.7)
Albuminuria (mg/24 hrs)	143	0	3,032	0	10,274	0	135	360	13	2,153	135	144	136	310	2,061	6	5,660	2,000	140	4,478	144 (0-10,274)
Mayo Stage at Diagnosis	II	II	II	IIIa	I	IIIa	-	II	IIIb	IIIa	II	I	IIIa	II	II	I	IIIa	I	I	I	-
Mayo Stage at Enrollment	I	II	IIIa	IIIa	II	IIIa	-	II	I	II	II	I	II	I	II	I	IIIa	II	I	I	-

^ Prior autologous stem cell transplantation (ASCT)
^^ Two prior ASCT
*Denotes hs-Troponin-T; † Denotes Troponin-T
Note: Data cut-off as of May 14, 2026

NEXICART-2 (U.S.) Efficacy: Rapid Normalization of Diseased Light Chains within ~First Week



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Subject #NX2-	13	16	07	01	02	04	05	06	08	09	12	14	15	17	18	19	20	11	10	03
Time to response (days)	7	7	7	14	7	7	7	7	7	7	7	7	7	7	7	7	7	160	7	15
Disease Marker as of data cutoff	Above Normal	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Follow-up (days)	90	364	484	687	659	473	127	512	477	469	414	392	385	351	329	329	322	420	427	603

Note: Data cut-off as of May 14, 2026. dFLC: difference in free light chain (disease marker). Renal response based on AL Amyloidosis consensus criteria for renal response (Palladini G et al 2014 doi: 10.1182/blood-2014-04-570010). Most recent available dFLC reading for patient NX2-001 as of day 656. For patient NX2-002, as of day 622. 4 out of 4 cardiac organ responses evaluable – NX2-006, NX2-008, NX2-011, NX2-015. 6 out of 6 renal responses evaluable – NX2-003, NX2-010, NX2-015, NX2-017, NX2-018, NX2-020. 1 out of 1 liver response evaluable – NX2-008. AL Amyloidosis disease markers on line graph: All patient data is dFLC (left-hand side vertical axis), except for patients NX2-003, NX2-010, and NX2-011 which are m-spike (right-hand side vertical axis). Patient NX2-013 withdrawn from study on D+90 days due to hematologic progression. NX2-011 M-spike igg type (longer half-life) NX2-003, NX2-010 M-spike iga type (shorter half-life)

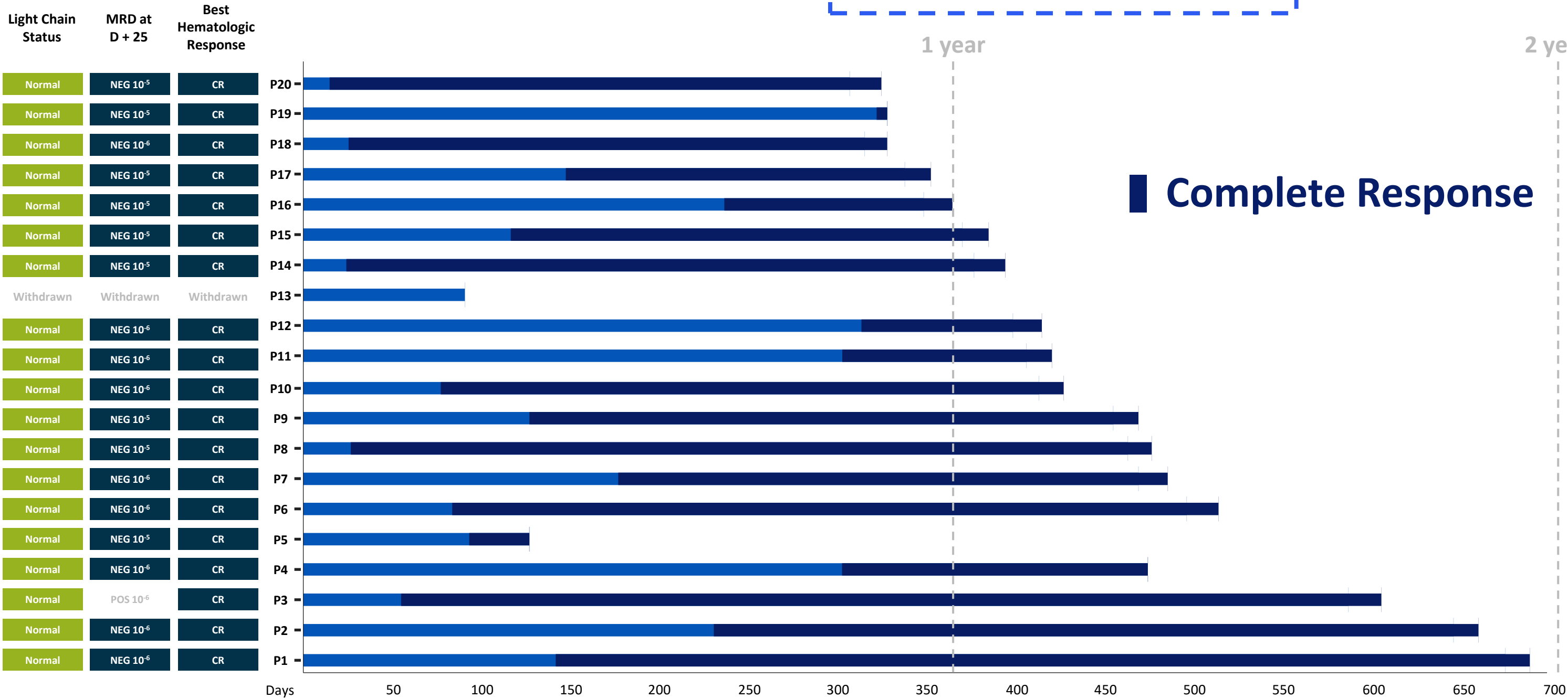
NEXICART-2 (U.S.) Clinical Activity: 95% Complete Responses (CR) – 19/20 Patients



Subject #	NX2-001	NX2-002	NX2-003	NX2-004	NX2-005	NX2-006	NX2-007	NX2-008	NX2-009	NX2-010	NX2-011	NX2-012	NX2-013	NX2-014	NX2-015	NX2-016	NX2-017	NX2-018	NX2-019	NX2-020
Time to response (days)	14	7	15	7	7	7	7	7	7	7	160	7	7	7	7	7	7	7	7	7
Hematologic response	CR	CR	CR	CR	CR	CR	CR	CR	CR	CR	CR	CR	Withdrawn	CR	CR	CR	CR	CR	CR	CR

Complete response (CR) is FDA
Regulatory Endpoint

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Existing investigator's choice therapies
0-10% complete response rate
No FDA Drugs approved

- Organ responses in 100% (11/11) evaluable
(100% ❤️ , 100% 🧠 , 100% 🦶)

Note: Data cut-off as of May 14, 2026. Complete Response according to consensus recommendations in AL amyloidosis (Palladini, et al. 2012. "Consensus guidelines for the conduct and reporting of clinical trials in systemic light-chain amyloidosis." Leukemia 26(11): 2317-2325.) Patients NX2-003, NX2-010, and NX2-011 enrolled on M-Spike. NX2-011 M-spike igg type (longer half-life) NX2-003, NX2-010 M-spike iga type (shorter half-life). Patient NX2-005: Death in CR, unrelated to NXC-201. Patient NX2-013: Withdrawn due to progression. Source: Zanwar S, et al. Treatment patterns for AL amyloidosis after frontline daratumumab, bortezomib, cyclophosphamide, and dexamethasone treatment failures. Leukemia 2024.

NEXICART-2 (U.S.) TEAEs Consistent or Improved Compared to Ex-US Dataset



- No patient experienced a Grade 5 TEAE across any cohort related to NXC-201

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Subject		NX2-001	NX2-002	NX2-003	NX2-004	NX2-005	NX2-006	NX2-007	NX2-008	NX2-009	NX2-010	NX2-011	NX2-012	NX2-013	NX2-014	NX2-015	NX2-016	NX2-017	NX2-018	NX2-019	NX2-020	Median (Range)
Dose	CART Cell Dose (x10 ⁶)	150	150	150	450	450	450	450	450	450	450	450	450	450	450	450	450	450	450	450	450	-
	CRS	None	None	Grade 2	Grade 1	Grade 1	Grade 1	Grade 1	Grade 1	Grade 1	Grade 1	Grade 2	Grade 1	None	Grade 2	Grade 2	None	Grade 1	Grade 1	Grade 1	None	1 (1-2)
	CRS Onset (days)	None	None	3	3	1	1	1	1	1	3	2	1	None	1	1	None	1	1	2	None	1 (1-3)
	CRS Duration (days)	None	None	2	1	1	1	1	4	1	2	1	5	None	1	2	None	1	1	1	None	1 (1-5)
Other	Neurotoxicity	None	None	None	None	None	None	None	None	None	None	None	None	None	None	None	None	None	None	None	None	-
	Neutropenia	Grade 3	Grade 3	Grade 3	Grade 4	Grade 4	None	None	Grade 4	Grade 4	None	Grade 4	None	Grade 4	Grade 4	Grade 3	Grade 3	None	None	Grade 4	None	4 (3-4)
	Febrile Neutropenia	None	None	None	None	None	None	None	Grade 3	None	None	None	None	None	None	None	None	None	None	None	None	-
	Anemia	None	None	Grade 3	None	Grade 3	None	None	None	None	None	None	None	None	None	Grade 3	None	Grade 2	None	Grade 3	None	3 (2-3)
	Thrombocyto-penia	None	None	None	None	Grade 3	None	None	Grade 4	Grade 3	None	None	None	None	Grade 2	Grade 3	None	Grade 2	None	None	None	3 (2-4)
	LFT Abnormalities	None	None	None	None	None	None	None	None	None	None	None	None	None	Grade 3	None	None	None	None	None	None	-
	≥ Grade 3 Infections	None	None	None	None	None	None	None	None	None	None	None	None	None	None	None	None	None	None	None	None	-
	Fatigue	None	None	None	None	None	None	None	None	None	None	None	None	None	None	None	Grade 2	None	None	None	None	-
	≥ Grade 2 Cardiac Events	None	None	None	Grade 2 [‡]	None	None	None	None	None	Grade 2 [‡]	None	None	None	None	None	None	None	None	None	None	-

[‡]Two patients with pre-existing atrial fibrillation experienced transient arrhythmias responsive to beta-blockers
Note: Data cut-off as of May 14, 2026. CRS and ICANS reported according to ASTCT Consensus Grading (Lee et al. 2019). Patient NX2-013 withdrawn on day 90. TEAE = treatment-emergent adverse events

Complete Response Rate Improving Over Time



Data Cutoff:

April 11, 2025

November 13, 2025

May 14, 2026

ASCO®

ASH

ASH

with May 2026 update

CR RATE:

70%



75%



95%

Subject #
NX2-
Time to
response
(days)

001	14	CR		CR		CR
002	7	CR		CR		CR
003	15	CR		CR		CR
004	7	Pending (already MRD (-)10 ⁻⁵)	→	CR		CR
005	7	CR		CR		CR
006	7	CR		CR		CR
007	7	Pending (already MRD (-)10 ⁻⁵)	→	CR		CR
008	7	CR		CR		CR
009	7	Pending (already MRD (-)10 ⁻⁵)	→	CR		CR
010	7	CR		CR		CR
011	160	--		Pending (already MRD (-)10 ⁻⁵)	→	CR
012	7	--		Pending (already MRD (-)10 ⁻⁵)	→	CR
013	7	--		--		--
014	7	--		CR		CR
015	7	--		CR		CR
016	7	--		Pending (already MRD (-)10 ⁻⁵)	→	CR
017	7	--		CR		CR
018	7	--		CR		CR
019	7	--		Pending (already MRD (-)10 ⁻⁵)	→	CR
020	7	--		CR		CR

Study design

- Randomized 1:1, multi-site phase 3 study
- Arm A: NXC-201
- Arm B: DaraCyBorD

Key criteria

Inclusion	•Newly diagnosed AL Amyloidosis patients
Exclusion	•Cardiac: Mayo stage 3b, NYHA stage III/IV •Concomitant Multiple Myeloma

Outcome measures

- Primary endpoint: Complete hematologic response (CR)
- Safety

Note: Complete Response according to consensus recommendations in AL amyloidosis (Palladini, et al. 2012. "Consensus guidelines for the conduct and reporting of clinical trials in systemic light-chain amyloidosis." Leukemia 26(11): 2317-2325.)

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September 2026



NXC-201 Tolerability Drives AL Amyloidosis Leadership

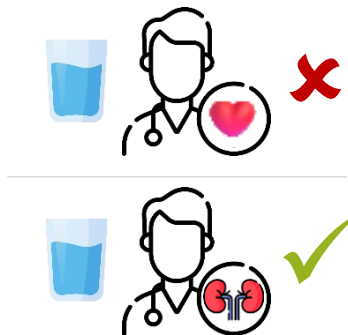
ALL BCMA CAR-TS ARE NOT CREATED EQUAL



NXC-201’s short CRS duration, if proven to be safe and effective, makes it **uniquely suitable to treat ALA patients** (in whom the #1 source of mortality is heart failure)

Cardiovascular stress is the key determinant for ability to treat relapsed/refractory ALA patients

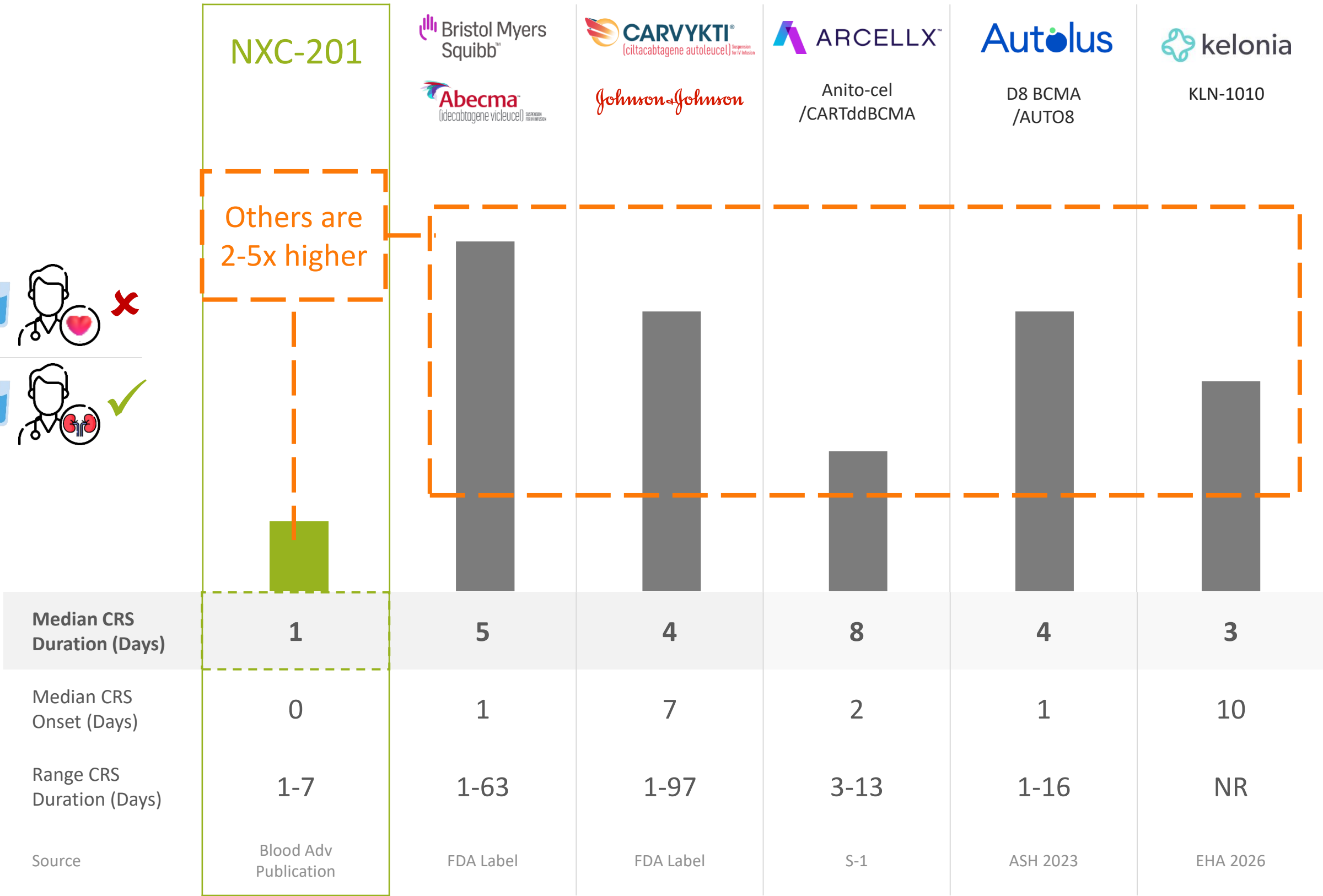
- Long CRS duration causes extended cardiovascular stress
- Other CARTs have 2-5x longer CRS duration



“The biggest challenge ... has been applicability of these therapies in amyloidosis **when the patients are particularly frail and have organ dysfunction** ... where the key lies in the safety rather the efficacy in a low-volume disease setting is going to be key ... ”

– Dr. Susan Bal, MD
Assistant Professor, Hematology
University of Alabama at Birmingham

Median CRS Duration (Days)



Data in Multiple Myeloma

Source: M. Assayag, et al. Point-of-care CART manufacture and delivery for the treatment of multiple myeloma and AL amyloidosis: the experience of Hadassah Medical Center. European Society for Blood and Marrow Transplantation 49th Annual Meeting. Poster Presentation. April 2023. Nov 2023 KOL discussion; NXC-201 (formerly HBI0101) American Society of Hematology Presentation. Abecma FDA approval label. Carvykti FDA approval label. Anitocabtagene autoleucel (anito-cel) iMMagine-1 pivotal Phase 2 data, ASH 2025. L. Lee, et al. Development of a Phase 1 Study Evaluating the Activity of Modular CAR T for Multiple Myeloma (MCARTY) Targeting BCMA and CD19 for Improved Persistence. ASH 2023. A. Spencer, et al. Successful in vivo CAR-T generation and minimal residual disease (MRD) clearance with KLN-1010 across diverse baseline T cell phenotypes in relapsed/refractory multiple myeloma (RRMM). European Hematology Association (EHA) 2026 Congress. Note: Studies not head-to-head

NXC-201: 1 Deepest Responses, 2 In Most Heavily Pretreated Population



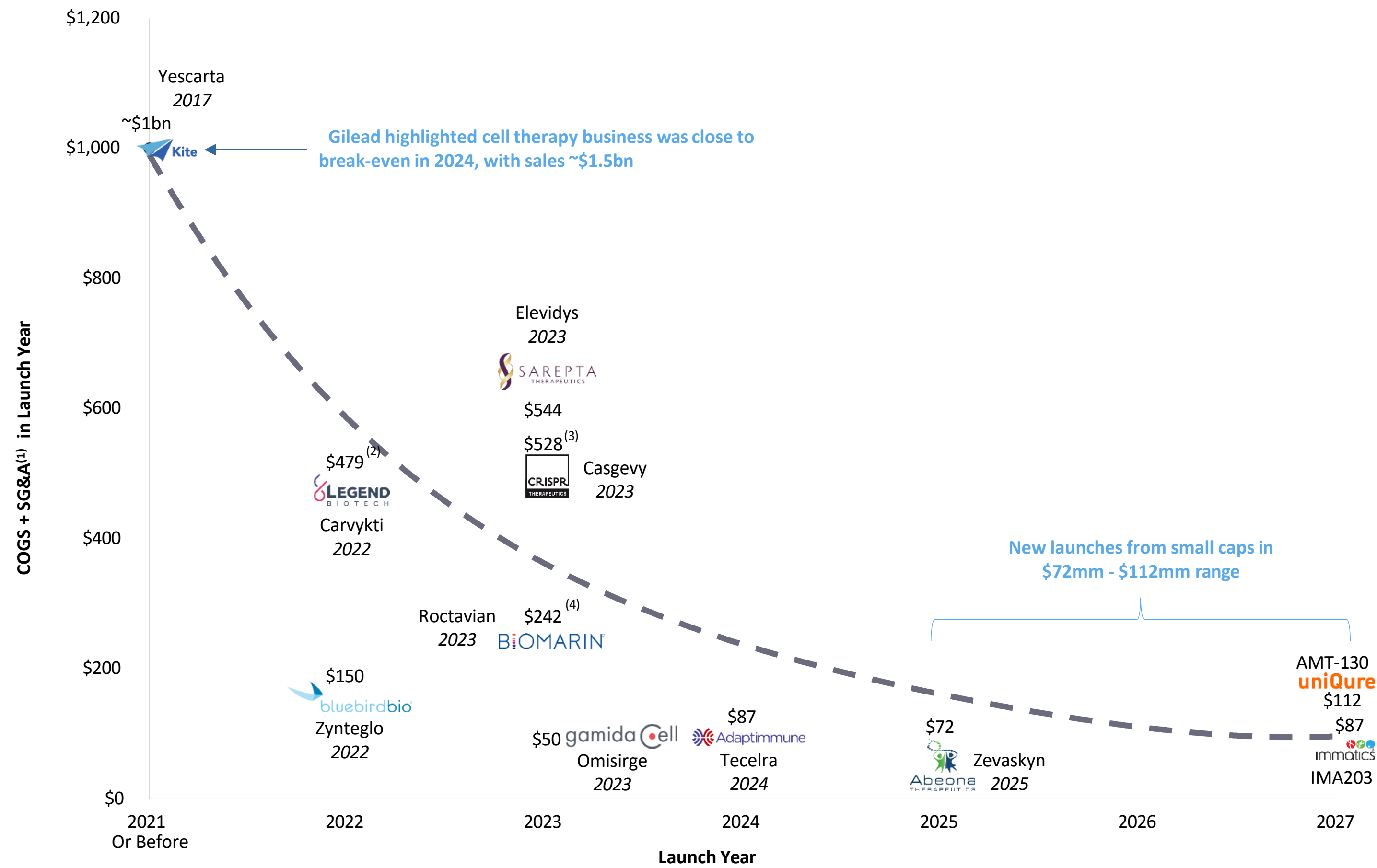
abbvie

REGENERON

Johnson&Johnson

NXC-201		NXC-201	Etentamig	Linvoseltamab	Teclistamab
NXC-201: Later Phase ...	n	20	34	20	52
	Phase	Phase 2	Phase 1	Phase 2	Retrospective
Dosing Frequency		1-Time	24 Months (QW4)	Weekly 8W, QW4 40W	Monthly
... in heavily pre-treated population ...	Median Prior Lines	4	2	1	2
	Prior CD38 monoclonal antibody?	100%	100%	60%	100%
	Prior ASCT ?	55%	21%	?	NA
... with independent review committee (IRC) adjudicated responses ...	Complete Response Rate	95%	100%	90% (18/20)	41%
	Independent Review Committee (IRC)?	Yes ⁽¹⁾ ✓	No ⁽²⁾ ✗	No ✗	No ✗
... faster, deeper, and more frequent downstream organ responses	Cardiac Organ Responses	100%	75%	50%	65%
	Median Time to Cardiac Response	1.1 Months	2.5 Months	NA	NA
	Renal Responses	100%	54%	73%	78%
	ICANS	0%	0%	5%	0%
	Infections (Any Grade)	5%	77%	85%	Total infection events: 102
	Infections (≥Grade 3)	0%	6%	25%	42% (deaths n=6 [12%])
	IVIg Prophylaxis	NA	100%	NA	83% ⁽³⁾

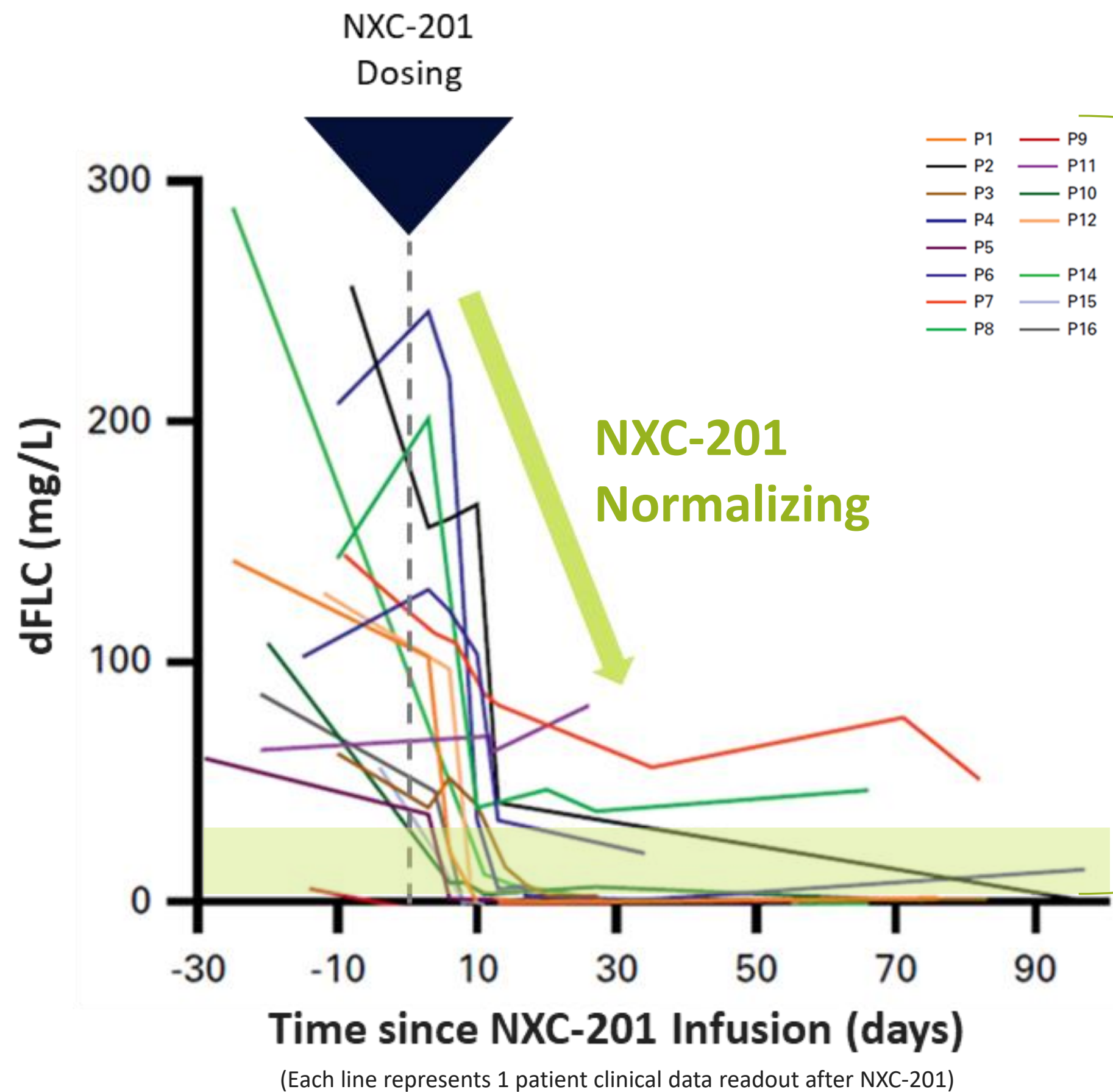
Market Reference: Commercialization Cost Trend Over Time



Note: \$ in millions; (1) Calculated as COGS and SG&A in launch year; (2) Represents COGS of Carvykti shared between J&J and Legend (50/50 profit share) and Legend SG&A multiplied by 2 to more closely reflect total costs; (3) Represents total costs for Casgevy between CRISPR and Vertex; (4) Represents total costs for Roctavian, disclosed as R&D + SG&A

NEXICART-1 (Israel): Normalization of Toxic Free Light Chains 30 Days after Dosing

BACKGROUND: IMMIX LICENSED-IN NXC-201 BASED ON EX-U.S. DATA SHOWING PLASMA CELL ELIMINATION (MENTIONED IN NEJM)



“An early and deep hematologic response has been found to lead to significantly prolonged survival”

– *Vaishali Sanchorawala, M.D.*
Professor, Hematology and Oncology
Director, Amyloidosis Center at Boston University School of Medicine
Director, Stem Cell Transplantation at Boston Medical center

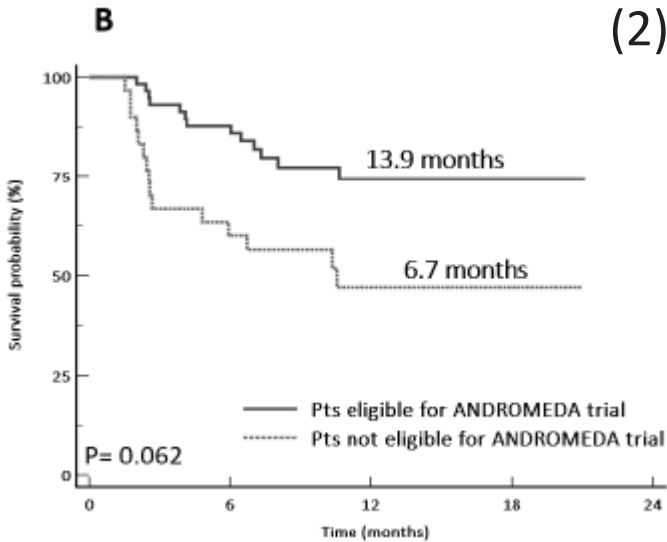
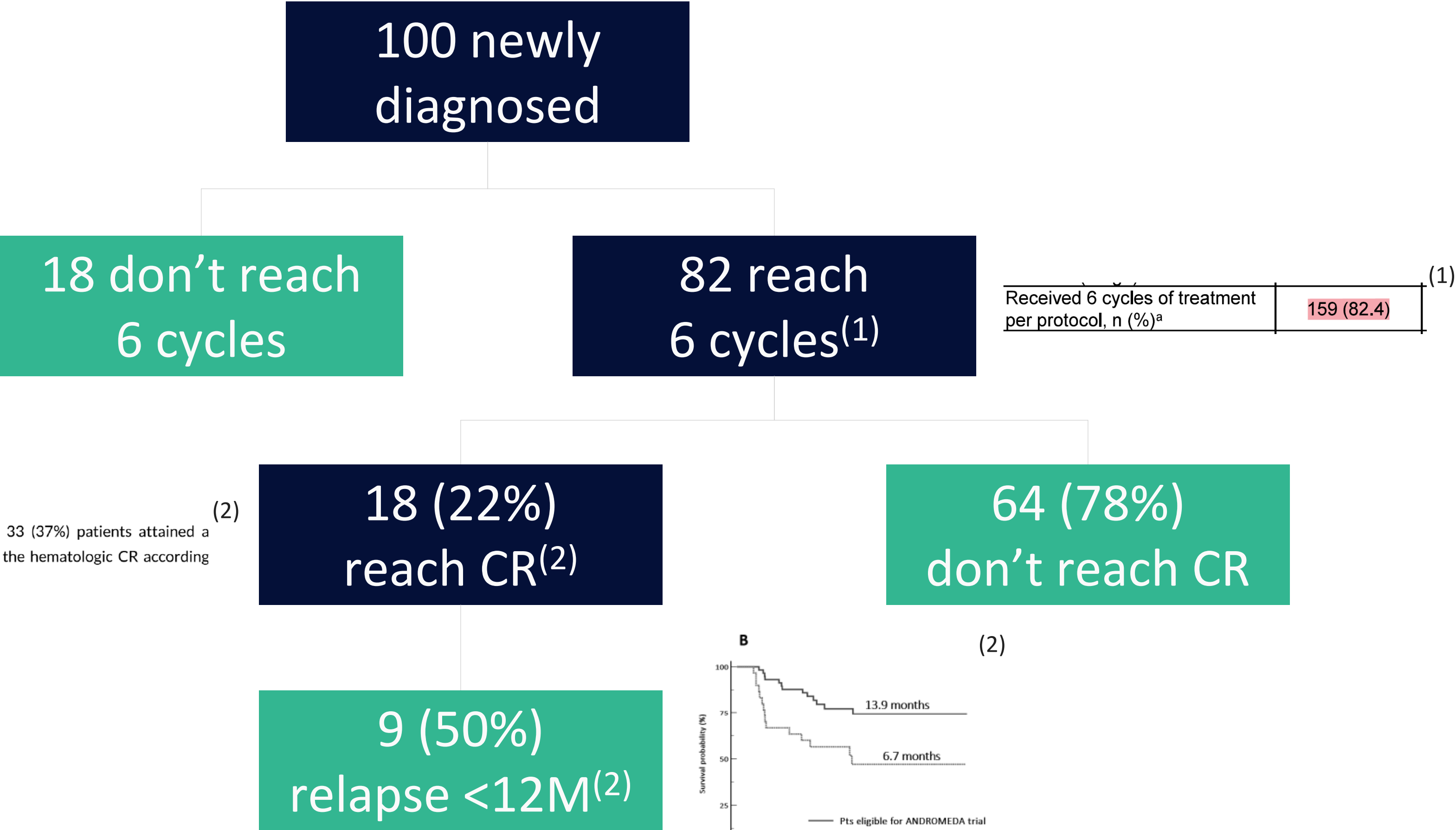
doi: 10.1056/NEJMra2304088

NXC-201
75% complete response rate
(NEXICART-1)

Current investigator’s choice therapies
0-10% complete response rate
No FDA Drugs approved

Note: Data cut-off as of December 9, 2024. As presented in Journal of Clinical Oncology. Patient 13 included in 75% complete response (CR) rate, but not included in graph above.
Source: E Lebel et al. Efficacy and Safety of Anti-BCMA Chimeric Antigen Receptor T-Cell (CART) for the Treatment of Relapsed and Refractory AL Amyloidosis. Presentation. ASH 2024. Zanwar S, et al. Treatment patterns for AL amyloidosis after frontline daratumumab, bortezomib, cyclophosphamide, and dexamethasone treatment failures. Leukemia 2024.

Up to 91% (=18+64+9) of AL Amyloidosis Patients Receiving Frontline Dara-Cy-Bor-D Require 2nd Line Therapy within 12 Months based on peer studies



Note: Example 100 newly diagnosed patient scenario based on sources listed below. Dara-Cy-Bor-D: daratumumab, cyclophosphamide, bortezomib, dexamethasone

Source:

1) Kastritis E, et al. ASH 2024

2) Bellofiore C, et al. A real-life study of daratumumab combinations in newly diagnosed patients with light chain (AL) amyloidosis. Hematol Oncol. 2024

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