UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549

FORM 8-K

CURRENT REPORT

Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934

Date of Report (Date of earliest event reported): May 14, 2026

CABALETTA BIO, INC.

(Exact name of Registrant as Specified in Its Charter)

Delaware	**001-39103**	**82-1685768**
(State or Other Jurisdiction of Incorporation)	**(Commission File Number)**	**(IRS Employer Identification No.)**

2929 Arch Street **Suite 600** **Philadelphia, Pennsylvania**	**19104**
(Address of Principal Executive Offices)	**(Zip Code)**

Registrant's Telephone Number, Including Area Code: (267) 759-3100

Not Applicable
(Former Name or Former Address, if Changed Since Last Report)

Check the appropriate box below if the Form 8-K filing is intended to simultaneously satisfy the filing obligation of the registrant under any of the following provisions:

☐ Written communications pursuant to Rule 425 under the Securities Act (17 CFR 230.425)

☐ Soliciting material pursuant to Rule 14a-12 under the Exchange Act (17 CFR 240.14a-12)

☐ Pre-commencement communications pursuant to Rule 14d-2(b) under the Exchange Act (17 CFR 240.14d-2(b))

☐ Pre-commencement communications pursuant to Rule 13e-4(c) under the Exchange Act (17 CFR 240.13e-4(c))

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, par value $0.00001 per share	CABA	The Nasdaq Global Select Market

Indicate by check mark whether the registrant is an emerging growth company as defined in Rule 405 of the Securities Act of 1933 (§ 230.405 of this chapter) or Rule 12b-2 of the Securities Exchange Act of 1934 (§ 240.12b-2 of this chapter).

Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Item 7.01 Regulation FD Disclosure.

On May 14, 2026, Cabaletta Bio, Inc. ("Cabaletta" or the "Company") issued a press release presenting its preconditioning-free clinical data and automated manufacturing translational data for rese-cel (the "Press Release"). A copy of the Press Release is furnished herewith as Exhibit 99.1 to this Current Report on Form 8-K.

The information contained in Item 7.01 of this Current Report on Form 8-K, including Exhibit 99.1 attached hereto, is being furnished and shall not be deemed to be "filed" for the purposes of Section 18 of the Exchange Act, or otherwise subject to the liabilities of that section and shall not be incorporated by reference in any filing under the Securities Act or the Exchange Act, except as shall be expressly set forth by specific reference in such filing.

Item 8.01 Other Events.

On May 14, 2026, the Company posted to the "Investors & Media" section of the Company's website at *www.cabalettabio.com* an updated corporate presentation (the "Corporate Presentation"). A copy of the Corporate Presentation is attached hereto as Exhibit 99.2 to this Current Report on Form 8-K and incorporated herein by reference.

On May 14, 2026, the Company issued the Press Release presenting its preconditioning-free clinical data and automated manufacturing translational data for rese-cel, which are being presented in poster presentations at the American Society of Gene & Cell Therapy ("ASGCT") 2026 Annual Meeting. Highlights of the rese-cel clinical and translational data being presented at the ASGCT 2026 Annual Meeting include:

Lowest Dose Data from RESET-PV Reinforces PC-free Opportunity to Broaden Patient Reach Across Autoimmune Diseases

Cabaletta is presenting clinical and translational data from the first four patients with pemphigus vulgaris treated at the lowest dose of rese-cel without preconditioning. As of April 2, 2026, all four patients had been dosed and completed at least 24 weeks of follow-up. The PDAI Total Activity ("PDAI") scores ranged from 22 to 83 at baseline. Key findings from the poster include:

- **Translational Profile:** PC-free rese-cel demonstrated similar CAR T cell expansion kinetics relative to reported translational data from RESET patients with preconditioning. In all four patients, the magnitude and timing of rese-cel expansion was consistent with RESET patients with preconditioning. Three of the four patients experienced complete peripheral B cell depletion. B cell activating factor serum levels, which may correlate with depth of B cell depletion, were increased and reached the lower end of the range achieved in RESET patients with preconditioning. In the three patients with complete peripheral B cell depletion, repopulated B cells reflected an expected transitional naïve phenotype.
- **Safety Profile:** Rese-cel was generally well tolerated with no dose-limiting toxicities ("DLT") or immune effector cell-associated neurotoxicity syndrome. One patient experienced transient fever, or grade 1 cytokine release syndrome ("CRS").
- **Clinical Profile:** All four patients exhibited initial improvement with clinically meaningful reductions in PDAI total activity scores as early as four weeks. Two of the four patients maintained drug-free compelling clinical responses through 6 months of follow-up. The three patients who exhibited full B cell depletion exhibited the most robust clinical improvements. Serum levels of anti-DSG3 and anti-DSG1 antibodies were reduced with initial improvement in PDAI total activity scores.

The favorable safety observations in all patients and unanticipated, compelling drug-free clinical responses in two of the four patients treated at the lowest PC-free rese-cel dose are supportive of the plan to continue to explore higher doses of PC-free rese-cel in PV and other autoimmune diseases. PC-free rese-cel data at higher doses from RESET-PV are anticipated in 2H26 and initial data at the lowest rese-cel dose from RESET-SLE™ are expected in 1H26 at the European Alliance of Associations for Rheumatology 2026 Congress, being held from June 3-6, 2026, in London, UK.

Automated Manufacturing Replicates Process Consistency and Early Clinical Experience from the First Two Autoimmune Patients to Support Future Scalable Supply with Minimal Capital Investment

Cabaletta is presenting data highlighting the initial manufacturing and translational data from the first two autoimmune patients dosed with rese-cel manufactured using the automated Cellares Cell Shuttle platform, representing the first use of the Cell Shuttle in any clinical program. As of May 6, 2026, both patients had been dosed and completed at least 4 weeks of follow-up. Key findings from the poster include:

- **Manufacturing Profile:** The Cell Shuttle process supported end-to-end, closed and automated manufacturing intended to improve reproducibility, scalability and process control while reducing manual complexity. The first two GMP doses of rese-cel manufactured on the Cell Shuttle met all release specifications with on-time delivery. Critical product quality metrics, including purity, CAR expression, viability, vector copy number, and cytotoxic activity, were within the established quality range based on historical clinical manufacturing runs.

- **Initial Translational Profile:** Rese-cel with automated manufacturing demonstrated similar peak expansion and B cell depletion kinetics, both at similar magnitudes and timeframes, relative to its broader reported translational profile across RESET trials.

Cabaletta believes these initial findings support the continued advancement of the Cell Shuttle automated manufacturing platform as a commercial supplier for rese-cel, if approved, to improve reproducibility and scale over time while maintaining product attributes within established clinical ranges.

Forward-Looking Statements

This 8-K contains “forward-looking statements” of Cabaletta within the meaning of the Private Securities Litigation Reform Act of 1995, as amended, including without limitation, express or implied statements regarding: Cabaletta’s business plans and objectives as a whole; Cabaletta's ability to realize its vision of launching curative targeted cell therapies designed specifically for patients with autoimmune diseases; the clinical significance of the data presented, including clinical and translational data from the RESET-PV preconditioning-free cohort and initial automated manufacturing data from patients treated with the Cellares Cell Shuttle; Cabaletta's expectations regarding the potential of preconditioning-free rese-cel to expand patient access and plans to explore higher doses across autoimmune diseases, including the anticipated timing of data therefrom; Cabaletta's ability to successfully complete research and further development and commercialization of its drug candidates in current or future indications, including the timing and results of its clinical trials; Cabaletta's plans to implement automated manufacturing of rese-cel with Cellares’ Cell Shuttle platform and expectations regarding the potential of such platform to improve reproducibility, scalability and process control, including the potential to supply rese-cel at flexible scale with minimal capital investment and among the lowest cost of goods in the industry for autologous cell therapy production; and Cabaletta's expectations around the potential success and therapeutic benefits of rese-cel, including the potential demand from thousands of patients living with autoimmune diseases.

Any forward-looking statements in this 8-K are based on management’s current expectations and beliefs of future events and are subject to a number of risks and uncertainties that could cause actual results to differ materially and adversely from those set forth in or implied by such forward-looking statements. These risks and uncertainties include, but are not limited to: risks related to regulatory filings and potential clearance; the risk that signs of biologic activity, persistence or clinical response may not inform long-term results or translate across programs; Cabaletta’s ability to demonstrate sufficient evidence of safety, efficacy and tolerability in its preclinical studies and clinical trials of rese-cel; risks that modifications to trial design or approach may not have the intended benefits; risks related to clinical trial site activation, enrollment delays and assessment of clinical trial results; risks related to volatile market and economic conditions and public health crises; Cabaletta’s ability to retain and recognize the intended incentives conferred by Orphan Drug Designation, Fast Track Designation, Regenerative Medicine Advanced Therapy Designation or other designations for its product candidates, as applicable; risks related to Cabaletta’s ability to protect and maintain its intellectual property position; risks related to fostering and maintaining successful relationships with Cabaletta’s collaboration and manufacturing partners; uncertainties related to the initiation and conduct of studies and other development requirements for its product candidates; and the risk that any one or more of Cabaletta’s product candidates will not be successfully developed and/or commercialized. For a discussion of these and other risks and uncertainties, and other important factors, any of which could cause Cabaletta’s actual results to differ from those contained in the forward-looking statements, see the section entitled “Risk Factors” in Cabaletta’s most recent annual report on Form 10-K as well as discussions of potential risks, uncertainties, and other important factors in Cabaletta’s other subsequent filings with the Securities and Exchange Commission. All information in this 8-K is as of the date of this Current Report on Form 8-K, and the Company undertakes no duty to update this information unless required by law.

Item 9.01 Financial Statements and Exhibits.

(d) Exhibits

99.1	Press Release issued by the registrant on May 14, 2026, furnished herewith.
99.2	Cabaletta Bio, Inc. Corporate Presentation, dated May 2026, filed herewith.
104	Cover Page Interactive Data File (embedded within the Inline XBRL Document).

SIGNATURE

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

CABALETTA BIO, INC.

Date: May 14, 2026

By: /s/ Steven Nichtberger

Steven Nichtberger
Chief Executive Officer and President
(Principal Executive Officer)

Exhibit 99.1

Cabaletta Bio®

Cabaletta Bio Presents Preconditioning-free Clinical Data and Automated Manufacturing Translational Data for Rese-cel at ASGCT 2026 Annual Meeting

A single infusion of the lowest dose of rese-cel administered without preconditioning, after discontinuation of all immunomodulators, demonstrated compelling drug-free responses for 6 months in 2 of 4 refractory patients; next dose cohort actively enrolling

Translational data from the first two patients dosed with rese-cel manufactured on the automated Cell Shuttle™ platform showed pharmacokinetic and pharmacodynamic data consistent with other patients dosed in the RESET™ clinical program

ASGCT 2026 presentations reinforce Cabaletta's focus on optimizing the patient and physician experience through simplified treatment regimens and scalable reliable manufacturing

PHILADELPHIA, May 14, 2026 -- Cabaletta Bio, Inc. (Nasdaq: CABA), a late-stage clinical biotechnology company focused on developing and launching targeted cell therapies designed specifically for patients with autoimmune diseases, today announced new clinical and translational data from the first four patients in the lowest dose cohort in RESET-PV® evaluating preconditioning-free (PC-free) rese-cel (resecabtagene autoleucel) and initial manufacturing and translational data from the first two autoimmune patients treated with rese-cel manufactured using the automated Cellares Cell Shuttle platform in the RESET clinical development program. These data are being presented in separate poster presentations today at the American Society of Gene & Cell Therapy (ASGCT) 2026 Annual Meeting in Boston, MA.

"Based on our view that a higher rese-cel dose would be required in the absence of preconditioning, it is encouraging that at the lowest PC-free dose, which is the same dose used across the RESET program with preconditioning, 50% of the patients demonstrated compelling and drug-free responses through 6 months of follow-up. PC-free rese-cel has the potential to substantially expand access for patients in current CAR T centers on an outpatient basis as well as in community-based infusion centers," said David J. Chang, M.D., Chief Medical Officer of Cabaletta. "In addition, the initial automated manufacturing and translational data from patients in the RESET clinical program being presented today move us even closer to realizing a more scalable and reproducible commercial product supply for rese-cel, if approved. We believe this is central to being able to meet the potential demand for rese-cel from thousands of patients living with autoimmune diseases."

Lowest Dose Data from RESET-PV Reinforces PC-free Opportunity to Broaden Patient Reach Across Autoimmune Diseases

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Cabaletta believes these initial findings support the continued advancement of the Cell Shuttle automated manufacturing platform as a commercial supplier for rese-cel, if approved, to improve reproducibility and scale over time while maintaining product attributes within established clinical ranges.

Additional information can be accessed on the website of the ASGCT 2026 Annual Meeting. Presentation materials will be made available on the Posters & Publications section of the Company's website following their presentation.

About rese-cel
Rese-cel (resecabtagene autoleucel) is an investigational, autologous CAR T cell therapy engineered with a fully human CD19 binder and a 4-1BB co-stimulatory domain, designed specifically for the treatment of autoimmune diseases. Administered as a single, weight-based infusion, rese-cel has demonstrated the ability to transiently, reliably and deeply deplete CD19-positive cells, with the goal of resetting the immune system and achieving durable clinical responses without the need for chronic therapy. Cabaletta is evaluating rese-cel in the RESET™ (REstoring SElf-Tolerance) clinical development program, which includes multiple ongoing company-sponsored trials across a broad range of autoimmune diseases in rheumatology, neurology and dermatology.

About Cabaletta Bio
Cabaletta Bio (Nasdaq: CABA) is a late-stage clinical biotechnology company focused on developing and launching curative targeted cell therapies designed specifically for patients with autoimmune diseases. The CABA™ platform encompasses two complementary strategies which aim to advance the discovery and development of engineered T cell therapies with the potential to become deep and durable, perhaps curative, treatments for a broad range of autoimmune diseases. The lead CARTA (Chimeric Antigen Receptor T cells for Autoimmunity) strategy is prioritizing the development of rese-cel, a 4-1BB-containing fully human CD19-CAR T cell investigational therapy. Rese-cel is currently being evaluated in the RESET™ (REstoring SElf-Tolerance) clinical development program spanning multiple therapeutic areas, including rheumatology, neurology and dermatology. Cabaletta Bio's headquarters and labs are located in Philadelphia, PA. For more information, please visit www.cabalettabio.com and connect with us on LinkedIn.

Forward-Looking Statements
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Contacts:

Anup Marda
Chief Financial Officer
investors@cabalettabio.com

Exhibit 99.2

Cabaletta Bio®

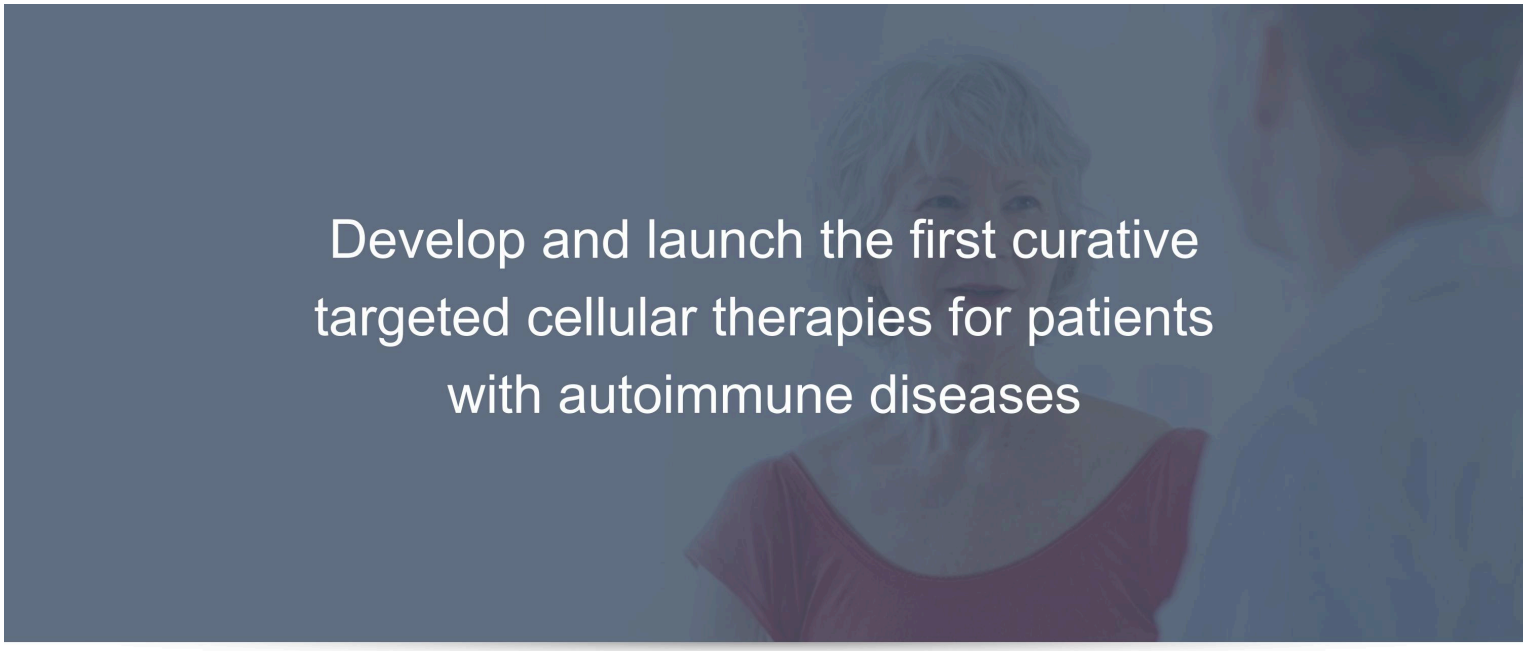
Corporate Presentation

MAY 2026

Disclaimer

This presentation, including any printed or electronic copy of these slides, the talks given by the presenters, the information communicated during any delivery of the presentation and any question and answer session and any document distributed at or in connection with the presentation (collectively, the "Presentation") has been prepared by Cabaletta Bio, Inc. ("we," "us," "our," "Cabaletta" or the "Company") and may contain "forward-looking statements" within the meaning of the Private Securities Litigation Reform Act of 1995 relating to our business, operations, and financial condition, and include, but are not limited to, express or implied statements regarding our current beliefs, expectations and assumptions regarding: our business, future plans and strategies for our technology; our ability to grow our autoimmune-focused pipeline; the ability to capitalize on and potential benefits resulting from our research and translational insights, including those related to any similarly-designed constructs or dosing regimens; the anticipated market opportunities for rese-cel in patients with autoimmune diseases; the Company's business plans and objectives; our expectations around the potential success and therapeutic and clinical benefits of rese-cel, as well as our ability to successfully complete research and further development and commercialization of our drug candidates in current or future indications, including the timing and results of our clinical trials and our ability to conduct and complete clinical trials; expectation that clinical results will support rese-cel's safety and activity profile; our plan to leverage increasing clinical data and a unique development program for rese-cel; the timing, clinical significance and impact of clinical data read-outs, including the progress, results and clinical data from each of the patients dosed with rese-cel in the Phase 1/2 RESET-Myositis, RESET-SLE, RESET-SSc, RESET-MG and RESET-PV trials and our other planned activities with respect to rese-cel; our belief that rese-cel has the potential to provide drug-free, durable transformative clinical responses, through an immune reset; the Company's advancement of separate Phase 1/2 clinical trials of rese-cel and advancement of the RESET-PV and RESET-MS trials, with and without preconditioning, as applicable, including updates related to status, safety data, efficiency of clinical trial design and timing of data read-outs or otherwise; our ability to leverage our experience in autoimmune cell therapy; our ability to enroll the requisite number of patients, dose each dosing cohort in the intended manner and timing thereof, and advance the trial as planned in our Phase 1/2 clinical trials of rese-cel; the timing of any planned regulatory filings for our development programs, including IND applications and interactions with regulatory authorities, including such authorities' review of safety information from our ongoing clinical trials and discussions with regulatory agencies on potential registrational pathway for rese-cel in various indications, and the timing of trial design related thereto; our ability to successfully complete our preclinical and clinical studies for our product candidates, including our ability to progress the trial; our plans and expectations regarding automated scalable manufacturing and no preconditioning and its potential to expand and accelerate access; our expectations that automation and elimination of preconditioning and apheresis will enhance patient experience; our expectation and timing for clinical manufacturing data with Cellares' automated manufacturing process and its ability to confirm GMP readiness, including supply chain logistics, as well as its potential to provide scalability for thousands of patients per year and to facilitate post-approval expansion; our ability to increase enrollment from our rapidly expanding clinical network in the RESET clinical trial program in the US and Europe; our ability to obtain and maintain regulatory approval of our product candidates, including our expectations regarding the intended incentives conferred by and ability to retain regulatory designations and the anticipated initiation of registrational cohorts and potential BLA submission; our expectation and timing for completion of dosing of most disease-specific cohorts; our expectations regarding opportunities based on market research; our ability to accelerate our pipeline to approval and launch and to develop transformative therapies for patients, including in collaboration with academic and industry partners and the ability to optimize such collaborations on, including timing thereof, our development programs; our ability to contract with third-party suppliers and manufacturers; our ability to execute our manufacturing strategy to enable expansion of clinical supply and efficiently scale commercial supply for rese-cel; our potential commercial opportunities, including value and addressable market, for our product candidates; our expectations regarding the potential commercial and economic benefits of preconditioning elimination and automated manufacturing, including its potential to reduce costs of goods, minimize capital investment requirements, and support efficient global expansion of rese-cel. Words such as, but not limited to, "look forward to," "believe," "expect," "anticipate," "estimate," "intend," "plan," "would," "should" and "could," and similar expressions or words, identify forward-looking statements.

Various risks, uncertainties and assumptions could cause actual results to differ materially from those anticipated or implied in our forward-looking statements. Such risks and uncertainties include, but are not limited to, risks related to the success, cost, and timing of our development activities and clinical trials, risks related to our ability to demonstrate sufficient evidence of safety, efficacy and tolerability in our clinical trials, the risk that the results observed with the similarly-designed construct, including, but not limited to, dosing regimen, are not indicative of the results we seek to achieve with rese-cel, the risk that signs of biologic activity or persistence may not inform long-term results, risks related to clinical trial site activation or enrollment rates that are lower than expected, risks that modifications to trial design or approach may not have the intended benefits and that the trial design may need to be further modified; our ability to protect and maintain our intellectual property position, risks related to our relationships with third parties, uncertainties related to regulatory agencies' evaluation of regulatory filings and other information related to our product candidates, our ability to retain and recognize the intended incentives conferred by any regulatory designations, risks related to regulatory filings and potential clearance, the risk that any one or more of our product candidates will not be successfully developed and commercialized, the risk that the results of preclinical studies or clinical studies will not be predictive of future results in connection with future studies, risks related to volatile market and economic conditions and our ability to fund operations and continue as a going concern. New risks and uncertainties may emerge from time to time, and it is not possible to predict all risks and uncertainties. Except as required by applicable law, we do not plan to publicly update or revise any forward-looking statements contained herein, whether as a result of any new information, future events, changed circumstances or otherwise. Although we believe the expectations reflected in such forward-looking statements are reasonable, we can give no assurance that such expectations will prove to be correct. Accordingly, you are cautioned not to place undue reliance on these forward-looking statements. No representations or warranties (expressed or implied) are made about the accuracy of any such forward-looking statements. For a discussion of these and other risks and uncertainties, and other important factors, any of which could cause our actual results to differ materially from those contained in the forward-looking statements, see the section entitled "Risk Factors" in our most recent annual report on Form 10-K and quarterly report on Form 10-Q, as well as discussions of potential risks, uncertainties, and other important factors in our other filings with the Securities and Exchange Commission. Certain information contained in this Presentation relates to or is based on studies, publications, surveys and other data obtained from third-party sources and the Company's own internal estimates and research. While the Company believes these third-party sources to be reliable as of the date of this Presentation, it has not independently verified, and makes no representation as to the adequacy, fairness, accuracy or completeness of, any information obtained from third-party sources. The Company is the owner of various trademarks, trade names and service marks. Certain other trademarks, trade names and service marks appearing in this Presentation are the property of third parties. Solely for convenience, the trademarks and trade names in this Presentation are referred to without the ® and TM symbols, but such references should not be construed as any indicator that their respective owners will not assert, to the fullest extent under applicable law, their rights thereto.



Cabaletta Bio®

Rese-cel[1]: Delivering on the promise of CD19-CAR T in autoimmunity

Preconditioning (PC) free clinical data & automated manufacturing data anticipated throughout 2026

- **Autologous CAR T has delivered reliable, durable, transformative outcomes for autoimmune patients[2]**
  - Rese-cel data: immunomodulator-free efficacy with a favorable safety profile using a single weight-based dose
  - Complete phase 1/2 data in lupus & SSc at EULAR with announcement of 2nd pivotal indication; MG data shared at AAN
- **Myositis: 17 patient single-arm study with planned 2027 BLA submission including potential for outpatient infusion**
  - Primary endpoint: moderate TIS response off immunomodulators & on no or low dose steroids[3] at 16 weeks
  - All phase 1/2 patients with sufficient f/u who would have met inclusion criteria met the registrational primary endpoint[4]
- **Safety profile in first 40 patients dosed with preconditioning (PC) supports outpatient administration[4]**
  - 95% - No CRS (~67%) or Grade 1 CRS (~28% - fever); 95% - No ICANS[5]
- **PC-free lowest dose data: 2 of 4 refractory PV patients off all medicines with compelling responses thru 6 month f/u**
  - Next dose cohort in RESET-PV enrolling; additional data in RESET-PV and RESET-SLE anticipated throughout 2026
- **Automated manufacturing by Cellares offers potential scale to thousands of patients with minimal capital investment**
  - Consistent manufacturing & translational data; commercial supply agreement includes among lowest COGS in industry

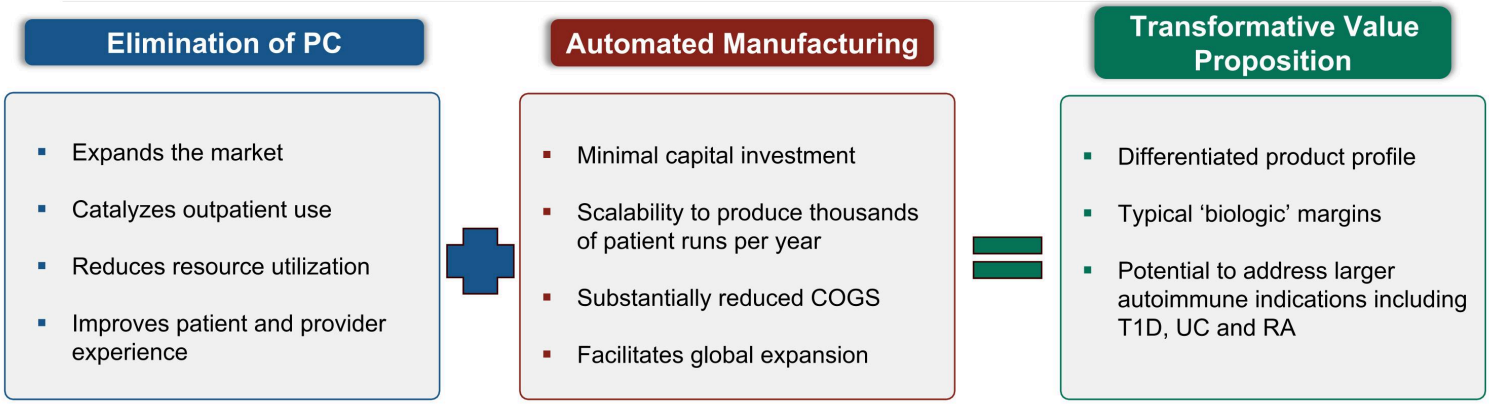
$150mn raise extends runway into mid-27 including 2026 advances in PC-free program, automated scalable manufacturing, progress to BLA submission in myositis next year and initiation of second pivotal indication

BLA – biologics license application; f/u – follow-up; PV – pemphigus vulgaris; SLE – systemic lupus erythematosus; TIS – total improvement score.

1. resecabtagene autoleucel; CABA-201
2. Solimani, Farzan, et al. "Clinical progress of engineered cellular immunotherapies for autoimmunity." Nature Biotechnology (2026): 1-16.
3. Low dose steroids is defined as 50% reduction from baseline or ≤7.5 mg/day.
4. As of data cut-off on September 11, 2025.
5. As of data cut-off on October 30, 2025

Transformative value proposition with PC elimination & automation

Removing PC should expand access while automated manufacturing should reduce COGS & increase scale



1H26

PV: PC-free rese-cel data including longer-term follow up at the initial dose
SLE: PC-free rese-cel data including early data at the initial dose
Initial clinical experience with rese-cel manufactured by Cellares

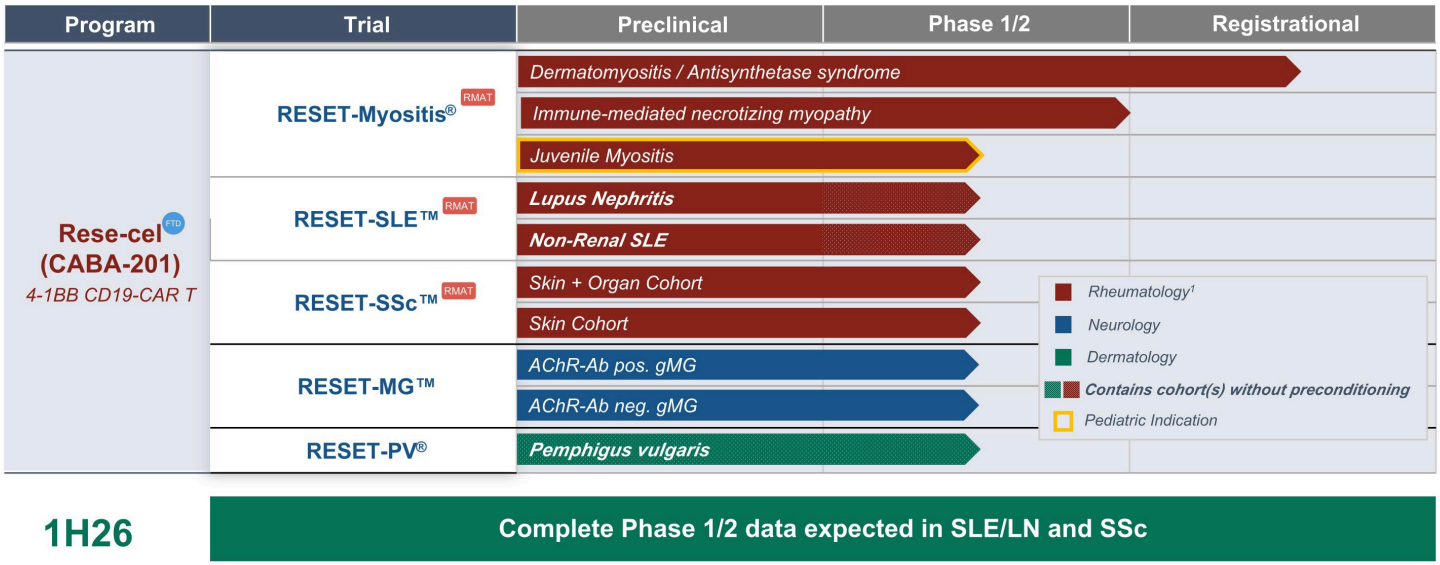
2H26

Longer-term PC-free rese-cel data from the PV & SLE dose cohorts and from patients receiving rese-cel manufactured by Cellares

COGS – Cost of goods sold; PC – Preconditioning; PV – Pemphigus vulgaris; SLE – Systemic lupus erythematosus; RA – Rheumatoid arthritis; T1D – Type 1 diabetes; UC – Ulcerative colitis.

Innovative clinical strategy to support accelerated regulatory path

SLE registrational design in hand; SSc pivotal design anticipated 1H26 and MG anticipated mid-2026



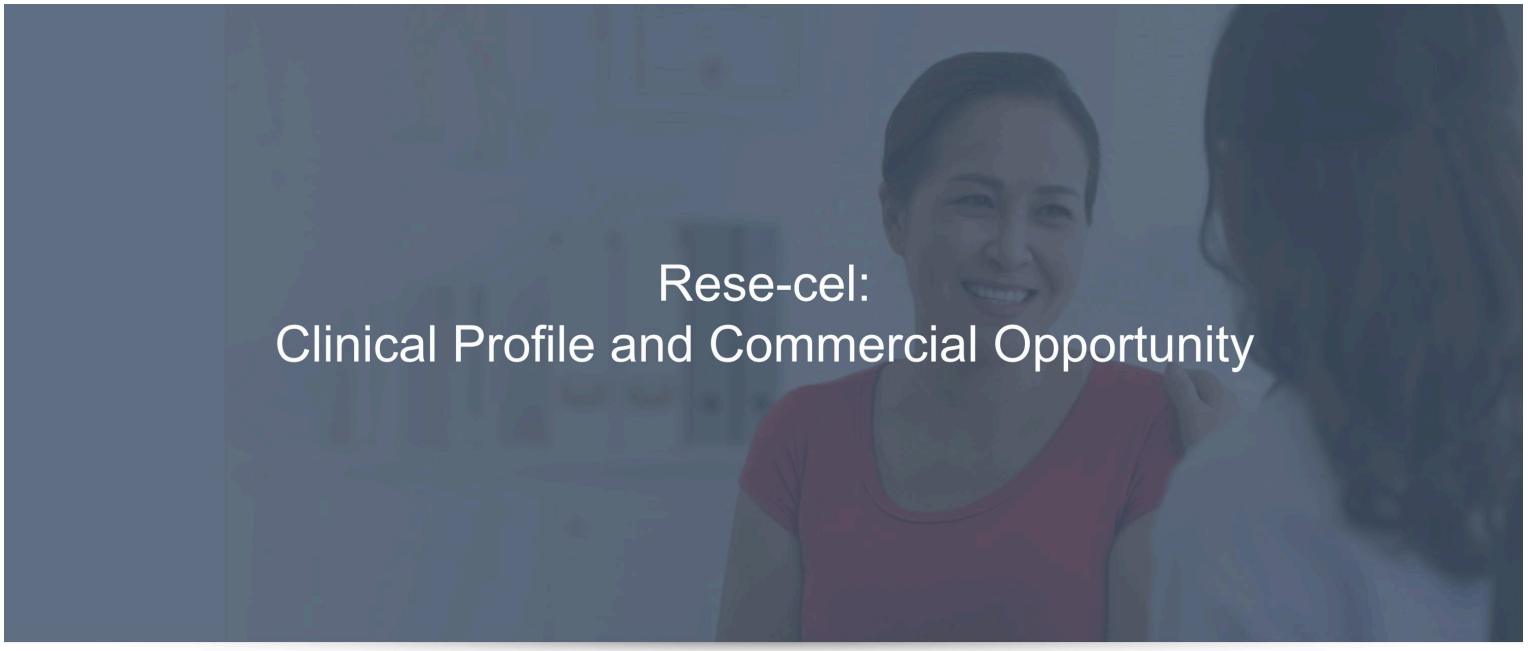
1H26 — **Complete Phase 1/2 data expected in SLE/LN and SSc**

RESET™ – **RE**storing **SE**lf-**T**olerance; Ab – Antibody; AChR – Acetylcholine receptor; gMG – Generalized myasthenia gravis; PV – Pemphigus vulgaris; SLE – Systemic lupus erythematosus; SSc – Systemic sclerosis

1. Myositis patients can also be treated by neurologists or dermatologists; lupus nephritis patients can also be treated by nephrologists.

● FDA Fast Track Designation received in dermatomyositis, SLE and lupus nephritis, systemic sclerosis, generalized myasthenia gravis and multiple sclerosis.

■ FDA Regenerative Medicine Advanced Therapy (RMAT) received in myositis, SLE, LN and systemic sclerosis.



Rese-cel:
Clinical Profile and Commercial Opportunity

Cabaletta Bio®

RESET™ program advancing trials in a broad portfolio of diseases

Broad portfolio of trials designed to address high unmet need and realize the potential of rese-cel

— No PC Cohorts —

— No PC only –

Myositis	SLE/LN	SSc	gMG	PV
				
♀>♂	♀>♂	♀>♂	♀>♂	
Typical onset middle age	Affects young women & people of color	Middle age onset common	Bimodal age of onset	Pure autoantibody & B-cell mediated autoimmune disease
Only FDA-approved therapy is IVIg in DM	~30-40% with lupus nephritis, which carries ~25% risk of death or ESRD within 10y	Progressive skin & organ fibrosis with lung, cardiac, renal damage	Profound weakness that can be disabling	Characterized by painful blisters & erosions
Three-fold increased mortality due to lung & cardiac involvement		Average survival of 12y	Risk for myasthenic crises, with respiratory failure	
U.S. Prevalence				
~80k	~320k	~90k	~100k	~15k

Rheum *Neuro* *Derm*

SLE – Systemic lupus erythematosus; DM – Dermatomyositis; SSc – Systemic sclerosis; gMG – Generalized myasthenia gravis; PC – Preconditioning; ESRD – End-stage renal disease; PV – pemphigus vulgaris

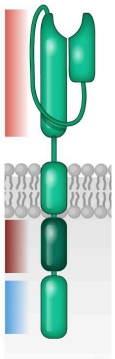
Rese-cel: CD19-CAR T specifically designed for autoimmunity

Rese-cel binder with similar *in vitro* & *in vivo* activity to construct used in academic studies in autoimmunity[1,3]

Fully human anti-CD19 binder

4-1BB costimulatory domain

CD3-ζ signaling domain



Rese-cel[4]

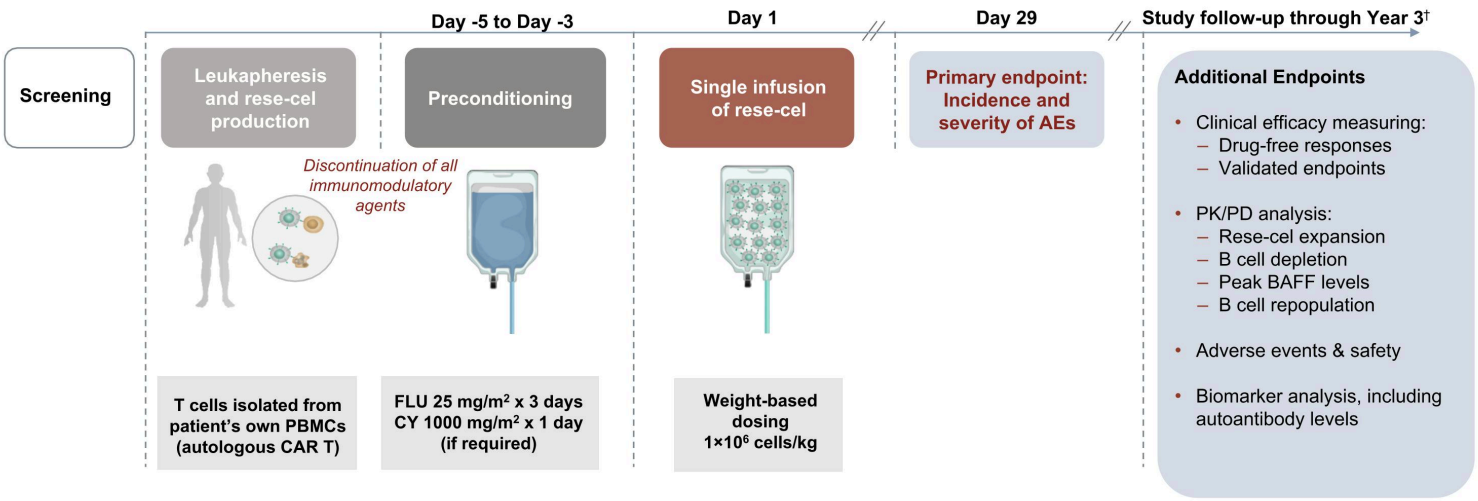
Rese-cel product design & clinical / translational data

- **4-1BB costimulatory domain with fully human binder**
  - **Binder with similar affinity & biologic activity to academic FMC63 binder while binding to the same epitopes[1,2]**
- **Same weight-based dose as in academic studies**
  - **Potential to provide immune reset based on clinical and translational data[5]**
- **Patients treated with rese-cel have shown compelling clinical responses with safety data that supports outpatient use for autoimmune patients[6]**

1. Peng BJ, et al. Mol Ther Methods Clin Dev. 2024;32(2):101267.
2. Dai, Zhenyu, et al. "Development and functional characterization of novel fully human antiCD19 chimeric antigen receptors for T-cell therapy." Journal of Cellular Physiology 236.8 (2021): 5832-5847.
3. Müller, Fabian, et al. "CD19 CAR T-Cell Therapy in Autoimmune Disease—A Case Series with Follow-up." New England Journal of Medicine 390.8 (2024): 687-700.
4. Maschan, Michael, et al. "Multiple site place-of-care manufactured anti-CD19 CAR-T cells induce high remission rates in B-cell malignancy patients." Nature Communications 12, 7200 (2021) Transmembrane domain in rese-cel is CD8α vs. TNFRSF19 (Troy) utilized in the academic construct. The two transmembrane domains have not been shown to have a significant difference in function or IFNγ production in preclinical studies. The CD8α transmembrane domain is employed in tisagenlecleucel.
5. Volkov, Jenell, et al. "Case study of CD19 CAR T therapy in a subject with immune-mediate necrotizing myopathy treated in the RESET-Myositis phase I/II trial." Molecular Therapy 32.11 (2024): 3821-3828.
6. Abstract 1733: Safety and Efficacy of CABA-201, a Fully Human, Autologous 4-1BB Anti-CD19 CAR T Cell Therapy in Patients with Immune-Mediated Necrotizing Myopathy and Systemic Lupus Erythematosus from the RESET-Myositis™ and RESET-SLE™ Clinical Trials. ACR 2024.

RESET™ clinical trials have consistent design principles[1]

Many of the RESET trials share common elements of preconditioning, dose, and study design



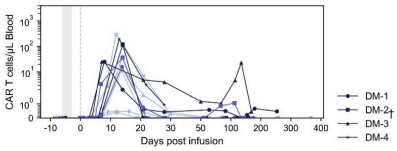
†Follow up period encompasses at least 15 years in total, ed to regulatory guidance for CAR T cell therapies.
AE, adverse event; CABA, Cabaletta Approach to B cell Ablation; FLU, fludarabine; CY, cyclophosphamide; PBMC, peripheral blood mononuclear cell; PD, pharmacodynamics; PK, pharmacokinetics; RESET, REstoring SElf-Tolerance; SLE, systemic lupus erythematosus; SSc, systemic sclerosis.
Cabaletta Bio: Data on file; 1. Peng BJ, et al. Mol Ther Methods Clin Dev. 2024;32(2):101267.

Rese-cel expansion & B cell kinetics across indications*

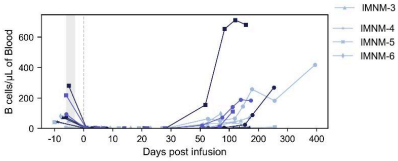
Peak rese-cel expansion and transient peripheral B cell depletion occurred within ~2 weeks post infusion

RESET-Myositis

Rese-cel Pharmacokinetics*

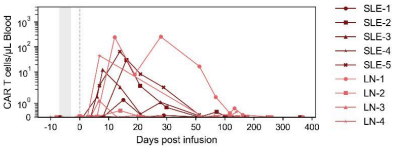


B Cell Kinetics

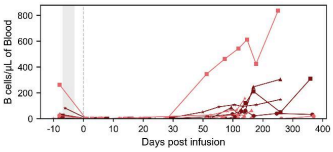


RESET-SLE

Rese-cel Pharmacokinetics**

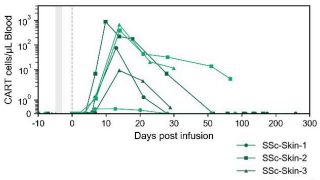


B Cell Kinetics

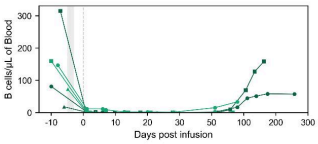


RESET-SSc

Rese-cel Pharmacokinetics

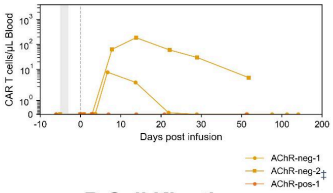


B Cell Kinetics

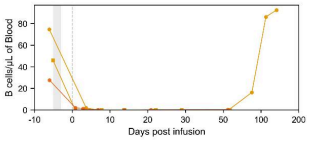


RESET-MG

Rese-cel Pharmacokinetics



B Cell Kinetics



Peripheral B cells begin repopulating ~2 to 3 months after rese-cel in patients with sufficient follow-up*

*All data is as of 11 Sep, 2025, except DM-3 which includes Week 24 data as of 08 Oct 2025.
**LN-1 had prolonged rese-cel detection due to TCR activation that corresponded to longer time to B cell repopulation. LN-4: follow up ongoing
† DM-3 rese-cel PK at Week 20 was artifactually elevated due to low circulating lymphocyte counts.
‡ Reduced rese-cel expansion observed in AChR-pos-1 may be attributed to patient's continued use of azathioprine, a prohibited medication, until day of infusion (Day 1).
ASyS, antisynthetase syndrome; CAR, chimeric antigen receptor; DM, dermatomyositis; IMNM, immune-mediated necrotizing myopathy; LN, lupus nephritis; rese-cel, resecabtagene autoleucel; RESET, REstoring SElf-Tolerance; SLE, systemic lupus erythematosus, SSc, systemic sclerosis, TCR, T cell receptor.
Cabaletta Bio: Data on file.

Demographics & CRS/ICANS in 1st 40 rese-cel patients by indication

Across 4 RESET™ studies, 95% of patients with no CRS or Grade 1 CRS (fever) and 95% with no ICANS[1]

Baseline characteristics of autoimmune disease patients treated with rese-cel

	RESET-Myositis	RESET-SLE	RESET-SSc	RESET-MG
Number of patients	15	10	9	6
Age, years, mean (SD)	51.7 (14.6)	30.4 (7.6)	53.1 (12.3)	57.5 (9.8)
Sex, % female	53.3	80.0	66.7	66.7
Duration of disease, years, mean (SD)	5.4 (3.7)	9.8 (5.0)	2.2 (1.3)	5.1 (5.3)

Incidence, severity and onset of CRS and ICANS in the 1st 28 days in patients treated with rese-cel

	RESET-Myositis	RESET-SLE	RESET-SSc	RESET-MG	Total
CRS‡, n (%)	5 (33.3)	3 (30.0)	4 (44.4)	1 (16.7)	13 (32.5% CRS)
CRS Grade 1, n (%)	5 (33.3)	3 (30.0)	3 (33.3)	0 (0.0)	11 (27.5% G1 CRS)
CRS Grade 2, n (%)	–	–	1 (11.1)	1 (16.7)	2 (5% G2 CRS)
Time to CRS onset, days* (mean)	7.4	7.3	8.5	7.0	7.7 days
CRS duration†, days (mean)	4.6	3.0	3.0	2.0	3.5 days
ICANS‡ n (%) (Grade)	–	1 (10) (G4)	1 (11.1) (G3)	–	2 (5% ICANS)
Time to ICANS onset. days (mean)	–	9.0	8.0	–	8.5 days
ICANS duration, days (mean)	–	3.0	3.0	–	3.0 days

*Days relative to rese-cel infusion.
†Events occurring within 7 days of each other are considered as 1 episode. IMNM-3 CRS duration includes preceding event of fever which was consistent with CRS definition.
‡Graded per ASTCT Consensus Grading Criteria.
1. Presented at ASH 2025 with data cut-off as of October 30, 2025.

CAR T may eliminate active disease & use of expensive medications

Rese-cel safety profile permits outpatient administration which could facilitate favorable reimbursement

Cancer CAR T: Safety profile often requires inpatient infusion, affecting reimbursement

Cancer patients experience early and frequent CRS/ICANS following CAR T therapy, which increases inpatient admissions and shifts Medicare reimbursement to the DRG system.

Majority of oncology patients treated with CAR T therapy experience CRS within first 5 days post-infusion[1]

Many cancer patients are insured under Medicare, which has inpatient **DRG-018** reimbursement

Rese-cel: Safety profile facilitates outpatient infusion, which could favorably impact reimbursement

Commercial

Myositis & SSc patients often commercially insured (60%-75%)[2,3]

CRS less frequent & severe, delayed onset → potential outpatient administration

Outpatient CAR T infrastructure exists at many centers

Medicare

Outpatient administration supports viable Part B Medicare payments

RESET clinical site footprint can be leveraged to generate early adopters

1. Ferreri, Christopher J., and Manisha Bhutani. "Mechanisms and management of CAR T toxicity." Frontiers in Oncology 14 (2024): 1396490.
2. Smoyer-Tomic KE, et al. BMC Musculoskelet. Disord. 2012 Jun 15;13:103. doi: 10.1186/1471-2474-13-103.
3. Gale, Sara L., et al. "Characterizing disease manifestations and treatment patterns among adults with systemic sclerosis: a retrospective analysis of a US healthcare claims population." Rheumatology and therapy 7.1 (2020): 89-99.

RESET™ program designed for outpatient administration at launch

Outpatient administration reduces administrative burden and improves patient and provider accessibility

INPATIENT MODEL

Limited patient beds
and resource infrastructure

- Increases inpatient resource pressure: ↑ total cost of care, human resource and bed space demands
- Reduces eligible patients treated

OUTPATIENT MODEL

More favorable safety profile
reduces need for inpatient admission

- Reduces use of hospital resources; Increases throughput
- Reduces conflicts with cancer patient use of in-patient beds

Rese-cel commercial model – manufacturing and COGM

Health status of patient population and slower disease progression improve manufacturing cost efficiency

In oncology, disease progress & out of specification (OOS) rates increase costs and reduce margins

Late-stage oncology patients have high drop-off rate due to rapid disease progression and compromised T cell fitness, leading to higher manufacturing OOS rates[1,2,3]

- Increased OOS rates; ↑ COGM + ↓ revenue since out of spec products not reimbursed
- Disease progression reduces revenue capture because unused product not reimbursed
- Reduced eligible patients, resulting in economies of scale not being achieved
- Manufacturing capacity constraints → delayed commercial ramp-up

In autoimmunity, less pretreated patients & fully automated rese-cel mfg should support lower COGM

Autoimmune patients are not heavily pretreated with chemotherapy → more fit immune cells that support reliable manufacture, reducing COGM

Autoimmune patients rarely progress as rapidly as cancer patients → more reliable revenue realization for manufactured product

Building manufacturing capacity at CDMOs to support successful launch; Cellares automation has the potential to facilitate post-approval expansion

COGM – Cost of goods manufactured

1. U.S. Food and Drug Administration. Kymriah (tisagenlecleucel) Prescribing Information. Revised 2025, U.S. Food and Drug Administration.https://www.fda.gov/media/107296/download
2. U.S. Food and Drug Administration. Breyanzi (lisocabtagene maraleucel) Prescribing Information. Revised 2025, U.S. Food and Drug Administration.https://www.fda.gov/media/145711/download
3. U.S. Food and Drug Administration. Yescarta (axicabtagene ciloleucel) Prescribing Information. Revised 2025, U.S. Food and Drug Administration.https://www.fda.gov/media/108377/download

Myositis: Unmet Need & Clinical Data

Cabaletta Bio®

Myositis: High rates of disability & increased risk of mortality

Highly concentrated treatment network in the US; dermatomyositis represents ~75% of this market

High disease burden: disability & mortality

- Typical patient is a middle-aged female who experiences muscle weakness, fatigue, pain, shortness of breath and difficulty swallowing
  - Moderate to severe disability (40% to 65%)[1]
  - Assisted walking devices (18% to 38%)[1]
- The **risk of mortality is ~3 times higher** than the general population, primarily due to cancer and lung & cardiac complications[2]
  - ~20% mortality < 5 years with standard immunosuppressive treatment[3]

*"I find it **very difficult to get up from a regular chair**, I need boosters or assistance from somebody else. Walking, my **gait has really suffered**. My stability walking has suffered as well, and I **can't lift anything more than five or eight pounds**. So doing stuff is difficult. Bending down is very difficult. **I can't get up from the floor if I fall.**"*

"John"
61-year-old male with ASyS[4]
~10 yrs since diagnosis

*"It just **affected every aspect of my life. Just work, family, social life, own wellbeing.** It just pours into everything else with that."*

"Erica"
44-year-old female with DM[4]
~2.5 yrs since diagnosis

Subtype prevalence in the U.S.

~60,000 pts[5,6]
Dermatomyositis (DM)

~15,000 pts[7,8]
Anti-synthetase syndrome (ASyS)

~7,500 pts[5,9]
Immune-mediated necrotizing myopathy (IMNM)

1. Opinc AH, Brzezinska OE, Makowska JS. Disability in idiopathic inflammatory myopathies: questionnaire-based study. Rheumatol Int. 2019;39(7):1213-1220.
2. Marie I. Morbidity and mortality in adult polymyositis and dermatomyositis. Curr Rheumatol Rep. 2012;14(3):275-285.
3. Schiopu E, Phillips K, MacDonald PM, Crofford LJ, Somers EC. Predictors of survival in a cohort of patients with polymyositis and dermatomyositis: effect of corticosteroids, methotrexate and azathioprine. Arthritis Res Ther. 2012;14(1):R22.
4. Primary market research conducted via third-party, blinded interviews with myositis patients, conducted in 2024.
5. Khoo 2023 6. Kronzer 2023 7. Coffey 2021 8. Dahal 2022 9. Shelley 2022

Myositis: Limited treatment options for ~80k U.S. patients

IVIg is the only approved therapy (only for patients with the adult dermatomyositis subtype)

Autoimmune disease with B cells component

- Idiopathic inflammatory myopathies (IIMs, or myositis) are a group of autoimmune diseases characterized by inflammation and muscle weakness

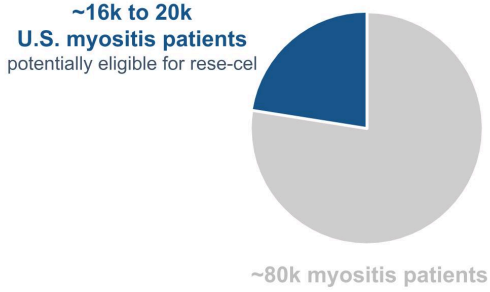
Limited treatment options[1]

- Common therapies: steroids plus an immunomodulator (i.e. methotrexate, azathioprine, mycophenolate, rituximab)
- IVIg (intravenous immunoglobulin), the only FDA-approved therapy, is approved in adult dermatomyositis
- Therapies can carry potential long-term side effects such as serious infections and organ damage
- Despite existing therapies, disease is often refractory
- Two therapies in Phase 3 development, Brepocitinib and Vyvgart®, demonstrated improvement with chronic administration added onto existing immunomodulatory medications

Eligible U.S. myositis patients[2]

Myositis patients with moderate to severe, refractory disease potentially eligible for rese-cel

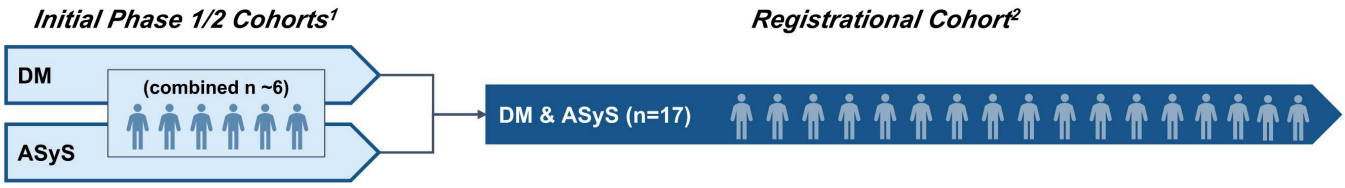
(per analysis of quantitative research with ~240 myositis-treating physicians)



1. Lundberg, Ingrid E., et al. "Idiopathic inflammatory myopathies." Nature Reviews Disease Primers 7.1 (2021): 86.
2. Analysis from quantitative survey of U.S. myositis-treating physicians, conducted 2Q25. N = ~240.

Myositis registrational cohort – Key design elements

Single-arm cohort including DM/ASyS patients with a primary endpoint at 16 weeks



- Expansion of current RESET-Myositis trial to include registrational cohort in DM / ASyS (~60k / ~15k US patients)
- **Primary Endpoint**: Moderate or Major TIS response @ Week 16 off all immunomodulators and off or on low-dose[3] steroids
- Expanded trial to 17 patients to ensure approximately 14 DM patients can enroll based on natural U.S. prevalence estimates
- Confirmed current dose of 1 million cells/kg in a single infusion
- Safety database ~100 autoimmune patients at ≥1-month of follow-up (with at least 35 myositis patients)
  - ~70% of the safety database already enrolled across the RESET clinical development program[4]

Registrational trial initiated with planned 2027 BLA submission

TIS, total improvement score.
1. Pediatric submission based on data available at the time of adult submission from ongoing Ph 1/2 study (no new study) to support pediatric label claim
2. Size of myositis registrational cohort based on key statistical parameters and estimated background remission rate in myositis.
3. Low dose steroids is defined as 50% reduction from baseline or ≤7.5 mg/day.
4. As of October 24, 2025.

Baseline characteristics: First 13 patients in RESET-Myositis*

All patients had active, refractory disease despite multiple immunomodulatory agents, including IVIg

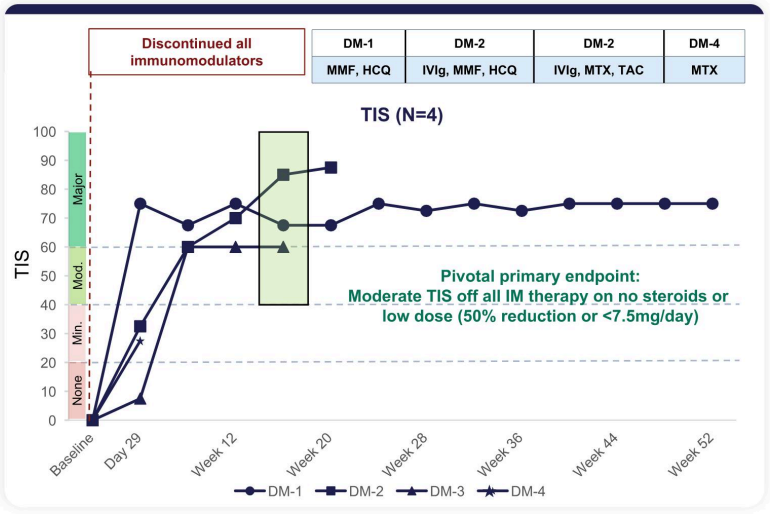
	DM N=4	ASyS N=2	IMNM N=6	JIIM N=1
Mean age, years (min, max)	~58 (45, 72)	~44 (39, 48)	~55 (33, 64)	14
Female, n (%)	3 (75)	1 (50)	1 (17)	1 (100)
Years since diagnosis, mean (min, max)	3.0 (2.0, 3.6)	9.2 (3.6, 14.8)	4.5 (1.4, 8.8)	8.5
Myositis-specific autoantibody	50% TIF1-γ 25% NXP, 25% SAE	100% Jo-1	67% HMGCR 33% SRP	NXP-2
Baseline disease activity†				
Mean MMT-8	109.6	129.5	122.0	134.0
Median CK, U/L	40.0	311.5	2214.5	176.0
Mean CDASI-A	26	N/A	N/A	N/A
Prior RTX‡	75%	100%	50%	100%
Prior IVIg‡	100%	100%	83%	100%
Therapies at Screening				
Systemic GCs	75%	100%	67%	0
≤2 IMs	50%	50%	100%	0
≥3 IMs	50%	50%	0%	100%

*As of 11 Sep, 2025.
†Baseline disease activity = activity before preconditioning.
‡Reflects any exposure to RTX and IVIg prior or at time of study entry. RTX is not allowed within approximately 6 months of Screening.
ASyS, antisynthetase syndrome; CDASI-A, Cutaneous Dermatomyositis Disease Area and Severity Index – Activity;CK, creatine kinase; DM, dermatomyositis; GC, glucocorticoid; HMGCR, 3-hydroxy-3-methylglutaryl-coenzyme A reductase; IM, immunomodulatory medication; IMNM, immune-mediated necrotizing myopathy; IVIg, intravenous immunoglobulin; JIIM, juvenile idiopathic inflammatory myopathy; MMT-8, manual muscle testing 8; NXP, nuclear matrix protein; N/A, not applicable; RESET, REstoring SElf-Tolerance; RTX, rituximab; SAE, small ubiquitin-like modifier activating enzyme; SRP, signal recognition particle; TIF1, transcription intermediary factor 1; U/L, units per liter.
Cabaletta Bio – Data on File.

DM: Efficacy data following rese-cel infusion*

3 of 3 patients with DM with sufficient follow-up achieved major TIS responses at Week 16

Assessment at Week 16	DM Patients (baseline autoantibody)			
	DM-1 (SAE)	DM-2 (None detected†)	DM-3 (TIF1-γ)	DM-4 (TIF1-γ)
IM-free	✓	✓	✓	✓‡
Low dose or no GC	✓	✓	✓	✓‡
TIS Response	Major	Major	Major	N/A§
Complete and transient B cell depletion	✓	✓	✓	✓‡
Antibody trend¶	↓	N/A	↓	N/A§
Meets pivotal primary endpoint	✓	✓	✓	N/A§



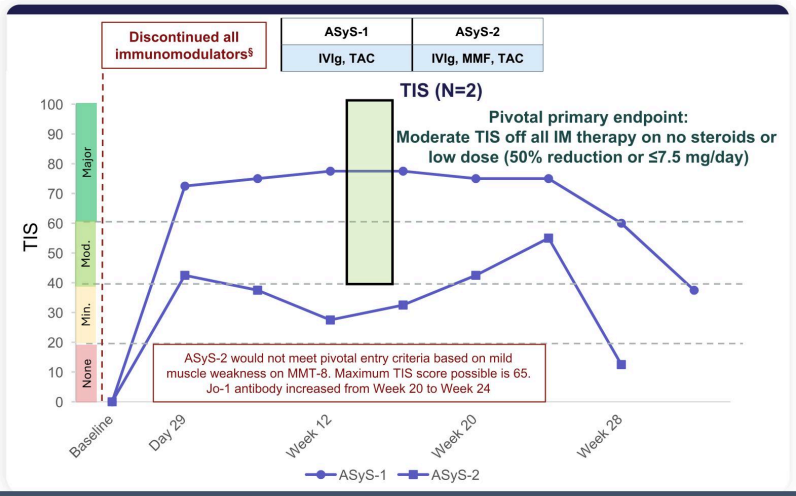
After discontinuation of all IM medications, 3 of 3 DM patients achieved the 16-week primary endpoint for the upcoming pivotal study of at least moderate TIS response

*As of 11 Sep, 2025.
† Historical NXP-2 autoantibody, but none detected at Pre-preconditioning (Baseline) visit). ‡ At latest follow-up (Day 29). § Insufficient follow-up. ¶Reflects trend from baseline to latest timepoint.
DM, dermatomyositis; FDA, Food and Drugs Administration; GC, glucocorticoids; HCQ, hydroxychloroquine; IM, immunomodulatory medication; IVIg, intravenous immunoglobulin; mg, milligrams; MMF, mycophenolate mofetil; MTX, methotrexate; N/A, not available; NXP, nuclear matrix protein; rese-cel, resecabtagene autoleucel; SAE, small ubiquitin-like modifier activating enzyme; TAC, tacrolimus; TIF1-γ, transcription intermediary factor 1 gamma; TIS, total improvement score.
Cabaletta Bio: Data on File.

ASyS: Efficacy data following rese-cel infusion*

Patient who would meet key inclusion criteria in registrational cohort achieved a major TIS response at Week 16

Assessment at Week 16	ASyS (baseline autoantibody)	
	ASyS-1 (Jo-1)	ASyS-2 (Jo-1)
IM-free	✓	✓
Low dose or no GC	✓	✓
TIS response	Major	Minimal
Complete and transient B cells depletion	✓	✓
Antibody trend†	↓‡	↓→‡
Meets pivotal primary endpoint	✓	✗



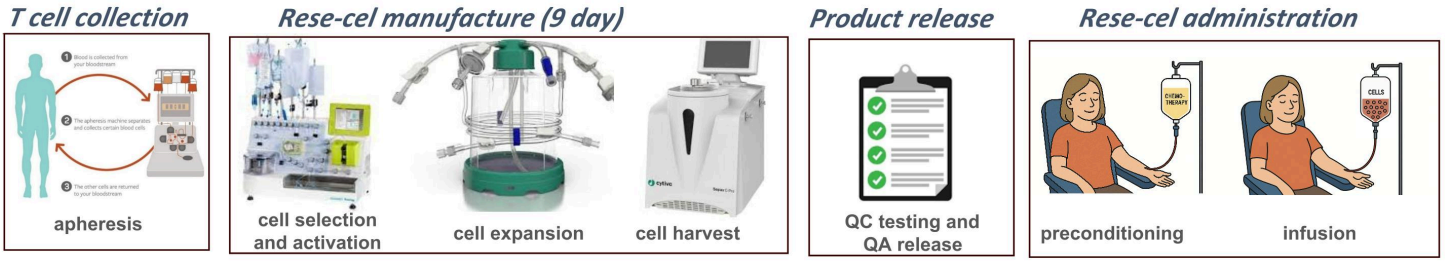
Responses to CD19-CAR T among some ASyS patients may be time-limited by the recurrence or persistence of pathogenic autoantibodies[1–3] from CD19-negative long-lived plasma cells despite complete B cell depletion

*As of 11 Sep, 2025.
†Reflects trend from baseline to latest timepoint antibody results are available (Week 24 for both patients). In ASyS-2, Jo-1 antibody level trended up from Week 20 to Week 24 but was lower than baseline.
‡Based on the research-based, qualified, quantitative Luminex assay.§ASyS-1 to minimal response at latest follow-up (Week 32); treated with GC bursts and obinutuzumab; ASyS-2 to no response at latest follow-up (Week 28); treated with GC burst.
ASyS, antisynthetase syndrome; FDA, Food and Drugs Administration; GC, glucocorticoids; IM, immunomodulatory medication; IVIg, intravenous immunoglobulin; mg, milligrams; MMF, mycophenolate mofetil; N/A, not available; rese-cel, resecabtagene autoleucel; TAC, tacrolimus; TIS, total improvement score.
1. Cabaletta Bio: Data on File. 2. Pinal-Fernandez I, et al. Ann Rheum Dis. 2024;83(11):1549–1560. 3. Galindo-Feria AS, et al. Best Pract Res Clin Rheumatol. 2022;36(2):101767. 4. Müller, F, et al. Nat Med. 2025:31(6):1793–1797.

Cabaletta Bio®

Rese-cel commercial process preliminary comparability established

Reliable process with >90% manufacturing success rate in first ~70 patients[1]

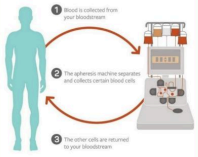
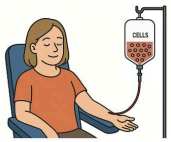
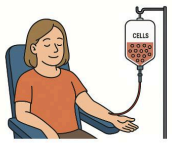


- Process A - Early clinical process
- Process B – Commercial-ready manufacturing process
  - Substantially closed process reducing contamination risk
  - Partially automated manufacturing process improving process consistency
  - 3-fold higher capacity per facility footprint than original Process A
- FDA feedback received on comparability between Process A and Process B
  - Preliminary data enables use of previously dosed patients in safety database

1. Across Process A and Process B; only 1 failure attributed to patient starting material.

Advancing breakthrough innovations to improve scalability and costs

Automation and elimination of preconditioning and apheresis could enhance patient experience

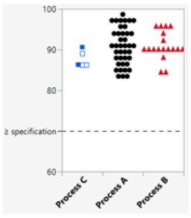
	T cell collection	*Rese-cel manufacture and harvest (9 day)*	*Product release*	*Rese-cel administration*
CURRENT	 apheresis	 cell selection and activation  cell expansion  cell harvest	 post-production testing and QA review	 preconditioning  infusion
INNOVATIONS	***Blood draw to replace apheresis[1,2]***	  ***Cellares Cell Shuttle[3]*** • ***Fully closed, end-to-end automation*** • ***Rapid & global scalability*** • ***Shorter turn-around-time***		 ***One outpatient infusion without preconditioning[4]***

1. Stratton et al, ESGCT 2024. Poster available at https://www.cabalettabio.com/technology/posters-publications
2. (https://d1io3yog0oux5.cloudfront.net/_cdcc45a1b07d9c1e0fc529e815f21ec3/cabalettabio/db/947/8240/pdf/Whole+Blood+Mfg+Poster+ESGCT+2024.pdf)
3. Automation run feasibility completed under TAP program. Video on Cellares technology can be viewed here: https://vimeo.com/947203843/cd59569f16.
4. Under evaluation in an ongoing study in Pemphigus Vulgarus (NCT004422912); presented at ESGCT Conference 2025, presentation is available at https://www.cabalettabio.com/technology/posters-publications.

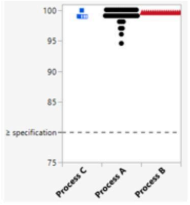
Automated manufacturing initial manufacturing & translational data

Consistent manufacturing and translational rese-cel data in 1st 2 patients vs. traditional CDMOs

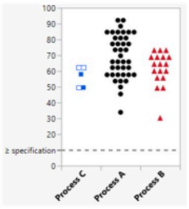
Viability [1]
(accesses T cell health)



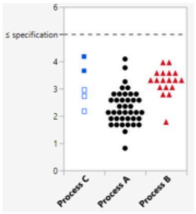
%CD45+ CD3+
(Total T cells produced)



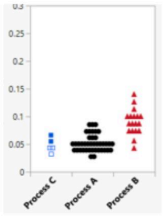
%CD3+ CAR+
(Total CAR-T cells produced)



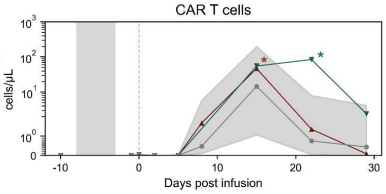
Vector copy number
(Amount of vector/transduced cell)



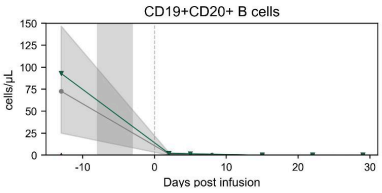
Potency
(Cytotoxicity)



CAR T Cell Expansion[2,3]

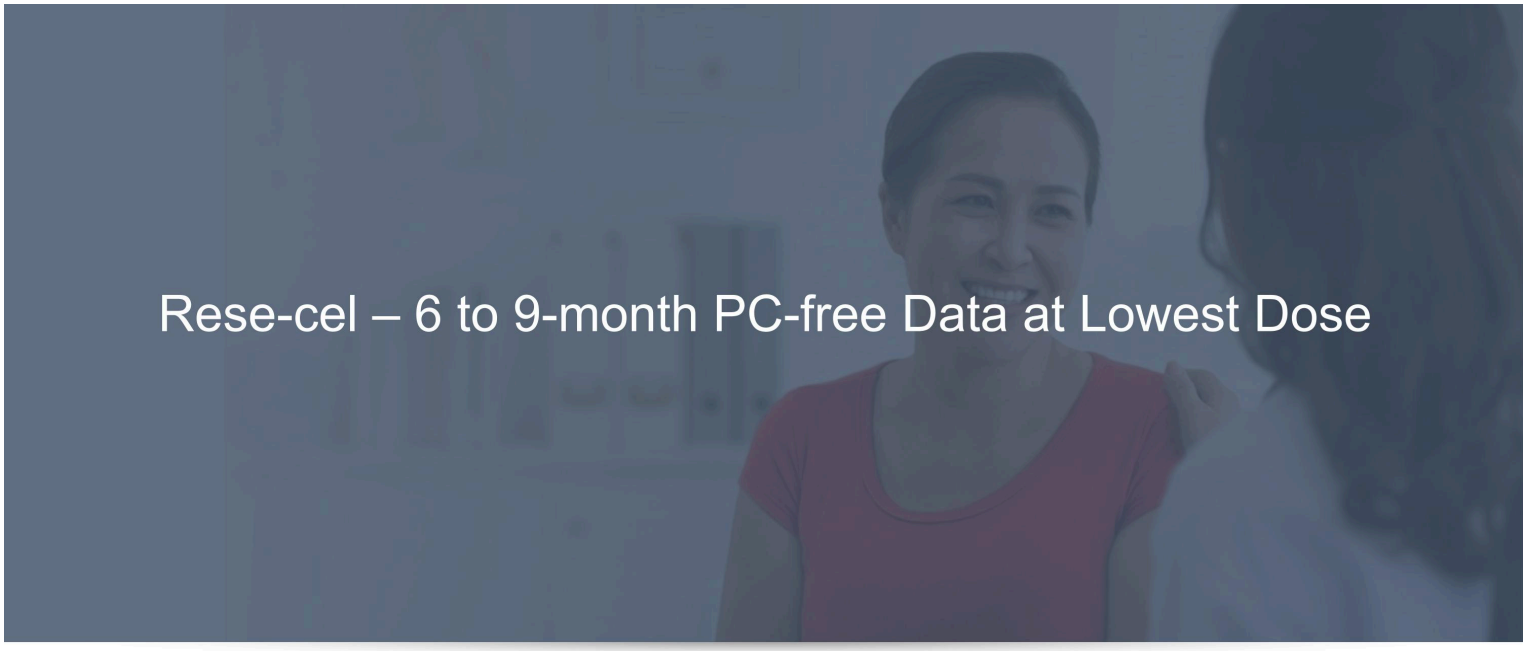


B Cell Depletion[3]



1st 2 rese-cel clinical manufacturing runs met release specifications including product quality attributes within historical ranges; initial data suggest rese-cel manufactured by Cellares exhibited comparable in vivo behavior to rese-cel products manufactured using conventional processes

1. Cellares uses Celleca for viability measurement to enable automated testing. Viability data for Process C shown in this figure were measured using NC200 to enable direct comparison with Process A and Process B, for which NC200 was also used
2. Data points with asterisks had low DNA input per assay recommendation.
3. Median and 50th percentile intervals of values from subjects manufactured with conventional manufacturing (conv) shown in gray.



Cabaletta Bio®

Summary of rese-cel without preconditioning (PC), initial dose cohort[1]

After discontinuing all immunomodulators (IM), clear biologic and clinical activity observed without PC

- In the RESET-PV trial, 4 refractory patients received rese-cel at the lowest dose without preconditioning and had follow-up between 24 and 36 weeks as of the data cut-off
  - 2 of 4 patients demonstrated compelling clinical activity through 6 months follow-up
  - Complete peripheral B cell elimination was observed in 3 of 4 patients
  - CRS was observed in 1 patient (Grade 1); ICANS – none
- Based on the safety profile observed at the lowest dose, multiple additional patients have been enrolled at a higher dose cohort in the RESET-PV trial and longer-term data at the higher dose is anticipated in 2H26
- In the RESET-SLE trial evaluating rese-cel without preconditioning in patients with lupus, the initial dose cohort is fully enrolled with initial data at the first dose anticipated in 1H26

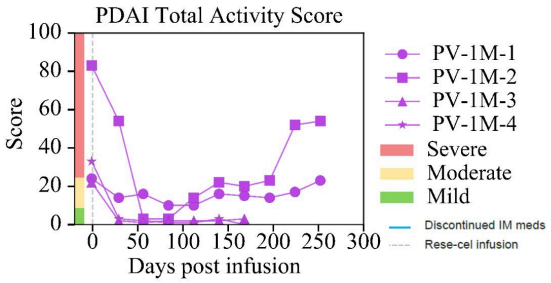
1H26 – PV: PC-free rese-cel data at the initial dose with 6-9 month follow up (ASGCT 2026)
1H26 – SLE: PC-free rese-cel, early data at the initial dose
2H26 – SLE & PV: PC-free rese-cel longer-term data from multiple cohorts

1. Data cut off as of April 2, 2026. Cabaletta Bio: Data on file.

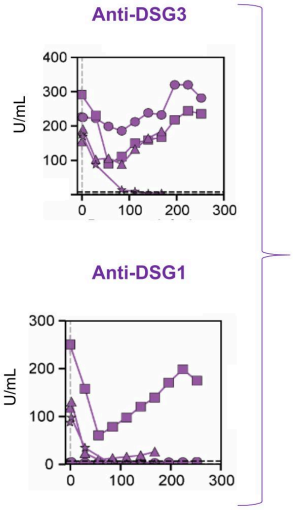
Unanticipated efficacy at lowest PC-free dose supports dose escalation[1]

Near complete resolution of clinical symptoms off all medicines in 2 of 4 patients through 6 months follow-up

PDAI Total Activity Score



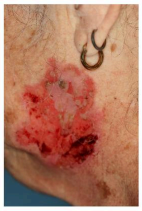
Anti-DSG3 and Anti-DSG1 Titers



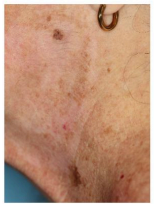
Anti-DSG3 and anti-DSG1 antibodies declined with initial improvement in PDAI total activity scores

Images PV-1M-4

Baseline



Week 12

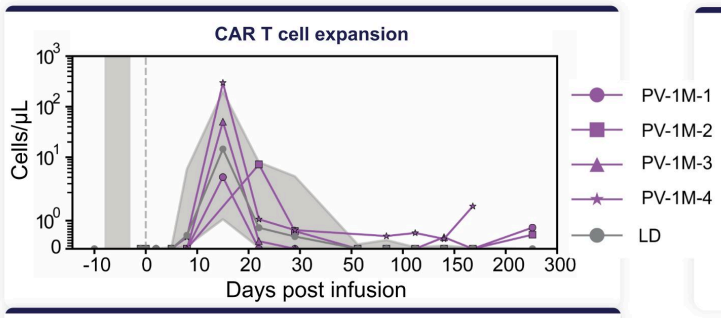


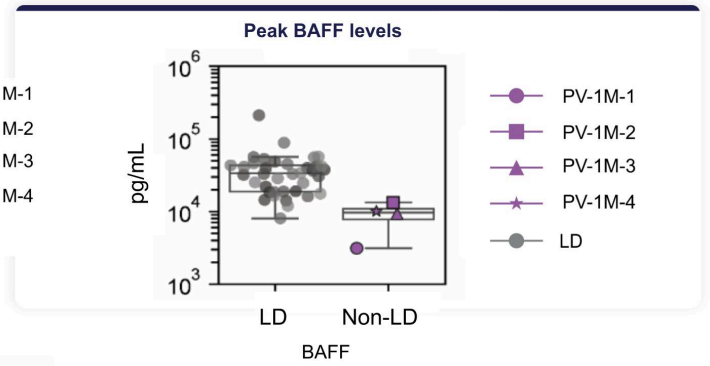
PDAI improvements were the greatest in the three patients who experienced peripheral B cell elimination; Next dose cohort enrolling based on efficacy, translational data and favorable safety profile to date

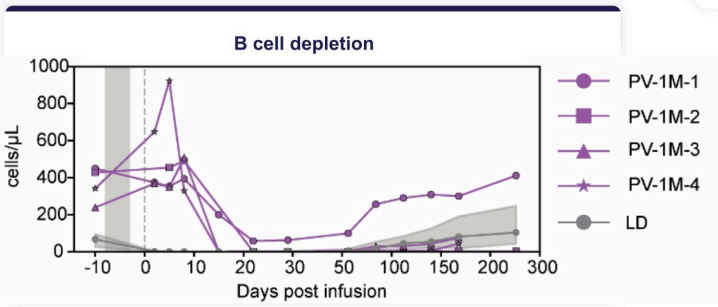
*As of 2 April 2026. Cabaletta Bio: Data on file. Disease severity intervals as defined Krain RL, et al. Br J Dermatol. 2021;184(5): 975–977.
Gray vertical dotted line indicates day of rese-cel infusion (study visit Day 1).

PK / PD for PC-free rese-cel in patients with pemphigus vulgaris[1]

Similar CAR T expansion vs. PC-treated patients with complete B cell depletion in 3 of 4 PC-free patients







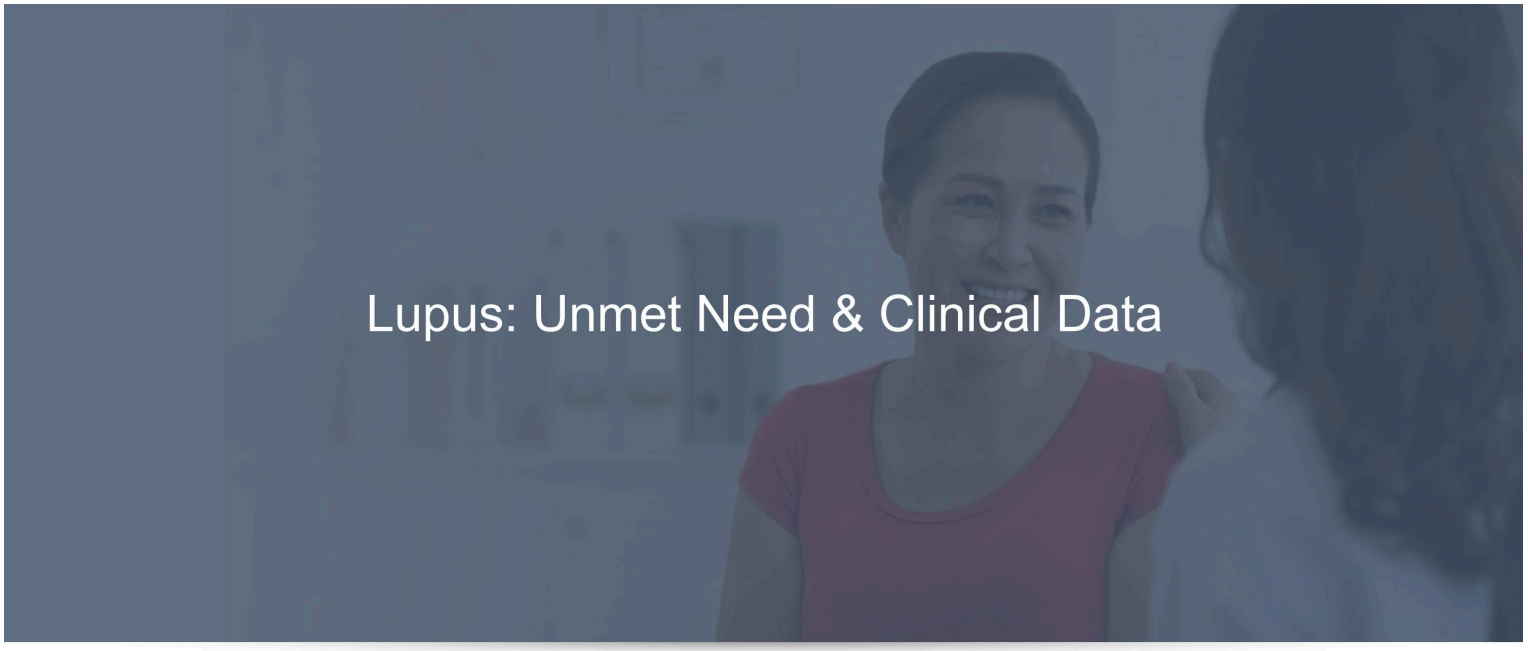
- **PV-1M-2, PV-1M-3 & PV-1M-4 had complete reduction of peripheral B cells at lowest rese-cel dose**
- **BAFF levels in these three patients were at the low end of the range observed with rese-cel with PC**

LD, lymphodepletion

Note: Gray vertical dotted line indicates day of rese-cel infusion (study visit Day 1).Gray shading in BAFF plot is range of median serum BAFF induction observed in PV patients following rituximab (Nagel et. al, 2009 *Journal of Investigative Dermatology* and Hébert et. al, 2021 *Frontiers in Immunology*).

Cabaletta Bio: Data on file.

As of 2 April 2026.



Lupus: Unmet Need & Clinical Data

Cabaletta Bio®

SLE & LN: Represent a high unmet clinical need

Increased mortality risk & negative impact on quality of life for patients with SLE & LN

SLE is a chronic autoimmune condition that can affect nearly every organ system[1]

- Most common in women, with disease onset generally between ages of 20-40 years
- Common symptoms include severe fatigue, joint pain and swelling, skin rashes, ulcers & Raynaud's phenomenon
- >50% of patients develop permanent widespread organ damage, caused by disease & current treatments[2]
- Standardized mortality ratio from 2.4-4.5 for SLE patients[3,4]

~30-40% of SLE patients develop LN, with inflammation & damage within the kidneys

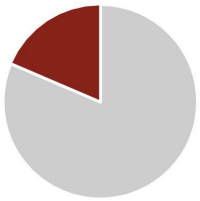
- LN may present silently or with symptoms such as proteinuria, hematuria, swelling & elevated blood pressure
- 10-30% of patients with LN will progress to ESRD, requiring dialysis or transplantation within the first decade of their disease[5,6]

Eligible U.S. Non-Renal SLE & LN patients[7]

SLE patients with moderate to severe, refractory disease & LN patients with refractory disease potentially eligible for rese-cel

(per analysis of quantitative research with ~150 lupus-treating physicians)

~40,000
U.S. non-renal SLE patients
potentially eligible for rese-cel



~210k non-renal SLE patients

~50,000
U.S. LN patients
potentially eligible for rese-cel

~110k LN patients

Market research indicates opportunity to achieve superior penetration and potentially further expand the market through introducing a no preconditioning CAR T alternative for patients

ESRD, end-stage renal disease; LN, lupus nephritis; SLE, systemic lupus erythematosus.

1. Zen M, et al. Eur J Intern Med. 2023;112:45–51. 2. Rahman P, et al. Lupus. 2001;10(2):93-96. 3. Singh, R, et al. Lupus 27.10 (2018): 1577-1581.4. Murimi-Worstell, I., et al. BMJ 10.5 (2020): e031850. 5. Lichtnekert, J. Nature reviews rheumatology 20.11 (2024): 699-711. 6. Tektonidou, M. Arthritis & rheumatology 68.6 (2016): 1432-1441. 7. Results from quantitative survey of U.S. lupus-treating physicians (rheumatologists & nephrologists), conducted 2Q25. N = ~150.

Baseline characteristics: First 9 patients in RESET-SLE*

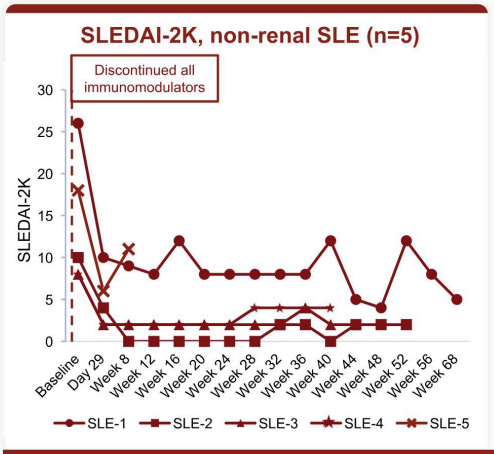
All patients had active, refractory disease and had failed multiple B cell-targeted therapies

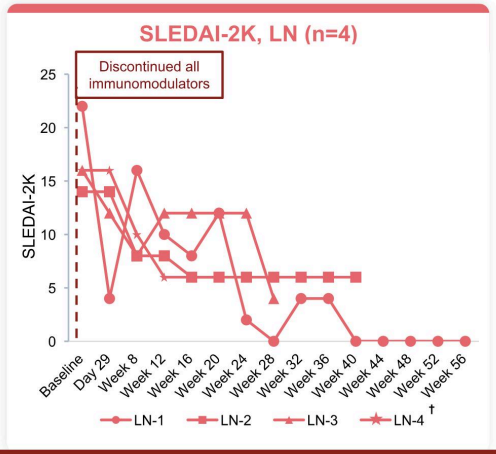
Cohort	**Non-renal SLE (n=5)**	**LN (n=4)**
Age, years, mean (min, max)	~34 (26, 44)	~26 (18, 35)
Female, n (%)	4 (80)	3 (75)
Time from diagnosis to screening, years, mean (min, max)	11.5 (6.1, 17.3)	7.3 (2.2, 15.7)
Autoantibodies (%)	dsDNA: 100% Sm: 60%	dsDNA: 75% Sm: 75%
Baseline disease activity†	**SLEDAI-2K** (median)	
	10	16
	UPCR (mg/mg) (median)	
	1.09§	3.45
Therapies at screening: **Systemic GCs** **≤2 SLE immunomodulators‡** **≥3 SLE immunomodulators‡**	 80% 60% 40%	 50% 50% 50%
GC dose at screening, mg/day, mean (min, max)	13.4 (0, 30)	6.25 (0, 20)

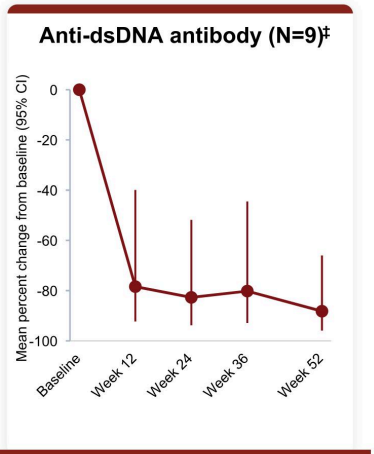
*As of 11 Sep, 2025.
†Baseline disease activity = activity before preconditioning.
‡SLE medications may include biologics, anti-malarials, and immunosuppressants.
§N=2 patients included in UPCR analysis: SLE-1 had pure Class V LN and extra-renal SLE disease activity and SLE-5 had Class II LN with moderate to severe chronicity and extra-renal disease activity that met inclusion criteria for the non-renal cohort.
dsDNA, double-stranded DNA; GC, glucocorticoid; LN, lupus nephritis; RESET, REstoring SElf-Tolerance; SLE, systemic lupus erythematosus; SLEDAI-2K, SLE Disease Activity Index 2000; Sm, Smith; UPCR, urine protein-to-creatinine ratio.
Cabaletta Bio: Data on File.

Efficacy data following rese-cel infusion*

Improvements in SLEDAI-2K over time and significant reduction in anti-dsDNA antibodies after discontinuing immunomodulators

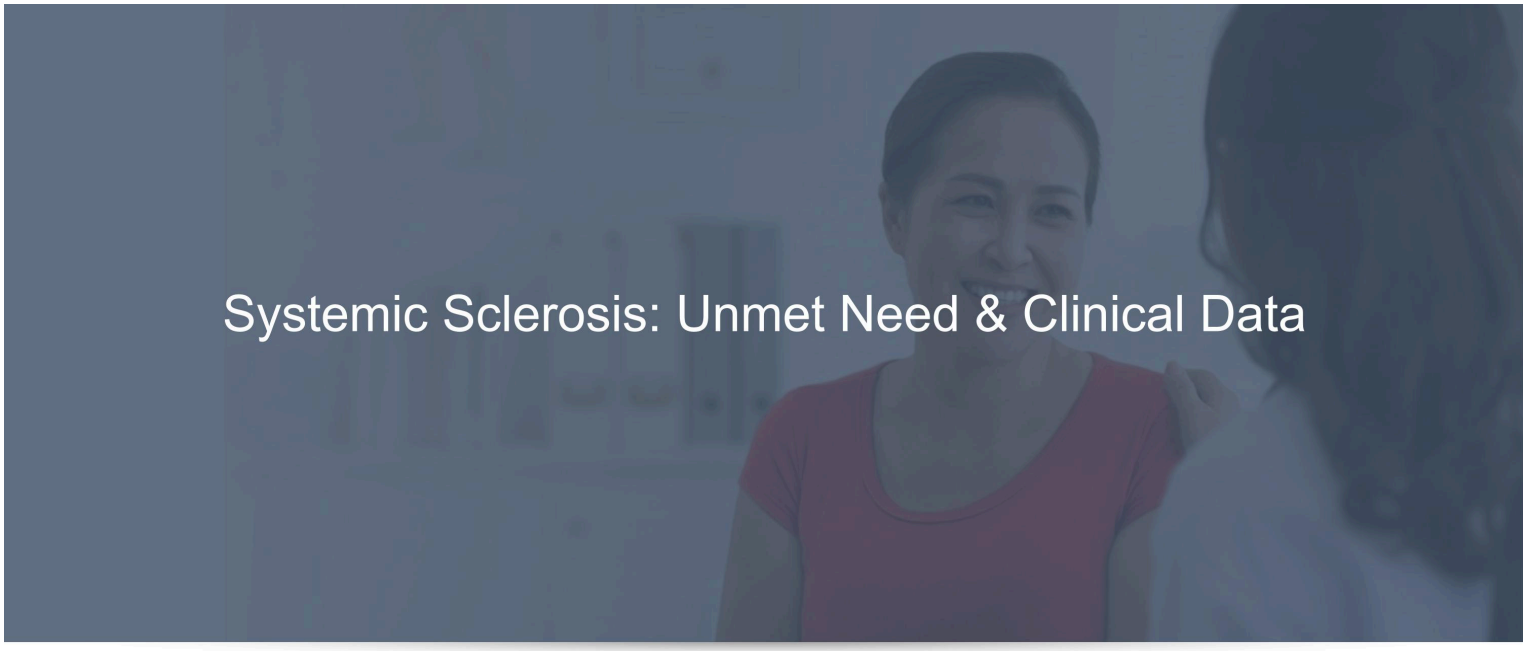






Clinical & translational data in lupus for rese-cel with preconditioning (PC) along with initial PC-free data in PV support expansion of simplified PC-free regimen into lupus; initial data anticipated in 1H26

*As of 11 Sep, 2025.
†Week 20 urinalysis components of the SLEDAI-2K (WBC, RBC and casts) imputed from Week 16 for total SLEDAI-2K score.
‡Assessed by ELISA at a central lab at baseline, weeks 12, 24, 36 and 52.
dsDNA, double-stranded DNA; LN, lupus nephritis; rese-cel, resecabtagene autoleucel; SLE, systemic lupus erythematosus; SLEDAI-2K, Systemic Lupus Erythematosus Disease Activity Index 2000.
Cabaletta Bio: Data on File.



Systemic Sclerosis: Unmet Need & Clinical Data

Cabaletta Bio®

Systemic sclerosis: Profound unmet need & limited options

Associated with progressive morbidity and high mortality[1,2]

Rare, potentially life-threatening autoimmune disease[1]

- Characterized by progressive skin & internal organ fibrosis[1]
- Deep, tissue-level B cell-driven autoimmunity, with activated B cells & autoantibodies, promotes inflammation & organ damage[3]

Patients experience a progressive & often fatal course

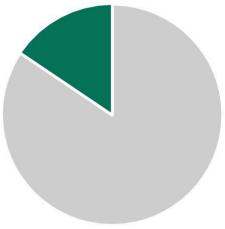
- Typically, middle age onset and more common in females[1]
- Highest mortality of all rheumatological diseases & significant burden from persistent skin & organ manifestations[4,5]
  - Mean survival is ~12 years from diagnosis
- Need for disease-modifying therapies across all SSc subsets[5]
  - FDA-approved agents for SSc-ILD slow but do not stabilize or improve lung progression
    - Approved based on 1-year primary endpoints
  - No existing treatments capable of halting SSc pathology other than AHSCT, which carries high risk

Eligible U.S. SSc patients[6]

SSc patients with early, active disease potentially eligible for rese-cel

(per quantitative research with ~100 SSc-treating physicians)

~12,000-15,000
U.S. SSc patients
potentially eligible for rese-cel



~90k SSc patients
(~40% with clinically significant ILD)

AHSCT, autologous hematopoietic stem cell transplantation; ILD, interstitial lung disease; SSc, systemic sclerosis.

1. Allanore Y, et al. Nat Rev Dis Primers. 2015;1:15002. 2. Denton CP, et al. Lancet. 2017;390(10103):1685–1699. 3. Thoreau B, et al. Front Immunol. 2022;13:933468. 4. Truchetet ME, et al. Clin Rev Allergy Immunol. 2023;64(3):262–283. 5. Pope JE, et al. Nat Rev Rheumatol. 2023;19(4):212–226. 6. Results from quantitative survey of U.S. SSc-treating physicians (rheumatologists), conducted 3Q25. N = ~100.

Baseline characteristics: First 6 Patients in RESET-SSc*

All patients had active, refractory disease and were on 1 to 3 disease-specific therapies at screening

	Severe Skin Cohort			Organ Cohort		
Patient / Cohort	**SSc-Skin-1**	**SSc-Skin-2**	**SSc-Skin-3**	**SSc-Organ-1**	**SSc-Organ-2**	**SSc-Organ-3**
Age, sex	66 F	55 F	59 M	70 M	43 F	60 F
Disease duration (y)	~2	~0.5	~2	~5	~2	~1
Autoantibodies	RNA Pol III	Scl-70	RNA Pol III	□	Scl-70	Scl-70
Baseline† mRSS	**42**	**38**	**45**	**12**	**9**	**24**
Baseline† HAQ-DI	2.25	2.125	2.875	0.75	0.50	2.50
Baseline† PFTs (% predicted)	FVC: 91 DLCO: 70	FVC: 93 DLCO: 58	FVC: 50 DLCO: 89	FVC: 69 DLCO: 58	FVC: 76 DLCO: 66	FVC: 83 DLCO: 78
ILD presence‡	✓	□	□	✓	✓	✓
Therapies at Screening	MMF	GC, MPA	MMF	MMF, TOC, NIN	GC, TOC	MMF, IVIg, HCQ

*As of 11 Sep, 2025; primary endpoint is incidence and severity of adverse events through Day 29
†Baseline disease activity = activity before preconditioning.
‡Per patient history and HRCT.
DLCO, % predicted diffusing capacity for carbon monoxide; FVC, forced vital capacity; GC, glucocorticoid; HAQ-DI, Health Assessment Questionnaire Disability Index; HCQ, hydroxychloroquine; HRCT, high-resolution computed tomography; ILD, interstitial lung disease; IVIg, intravenous immune globulin; MMF, mycophenolate mofetil; MPA, mycophenoloic acid; mRSS, modified Rodnan skin score; NIN, nintedanib; SAE, serious adverse event; PFT, pulmonary function test; RESET, REstoring SElf-Tolerance; RNA Pol III, ribonucleic acid polymerase III; Scl-70, anti–topoisomerase I antibody; SSc, systemic sclerosis; TOC, tocilizumab; y, years.
Cabaletta Bio: Data on File.

SSc: Efficacy data following rese-cel infusion*

As of the data cut-off, 4 of 4 SSc patients with ≥12 weeks follow-up had FVC stabilization or improvement

	Severe Skin Cohort			Organ Cohort		
Patient / Cohort	**SSc-Skin-1**	**SSc-Skin-2**	**SSc-Skin-3**	**SSc-Organ-1**	**SSc-Organ-2**	**SSc-Organ-3**
Latest follow-up	Week 48	Week 24	Day 29	Week 16	Week 12	Day 29
GC-free	✓	✓	✓	✓	✓	–‡‡
IM-free	✓	✓	✓	✓	✓	✓
Antibody and trend†	RNA Pol III ↓	Scl-70 ↓**	RNA Pol III; *too early*	None detected	Scl-70 ↓	Scl-70; *too early*
Revised CRISS-25‡ (time to response)	✓ **Week 12**	✓ **Week 24**	N/A	✓ **Week 12**	✓ **Week 12**	N/A
Revised CRISS-50‡ (time to response)	✓ **Week 12**§	✓ **Week 24**	N/A	–	✓ **Week 12**	N/A
mRSS (baseline to latest follow-up)	42→23	38→27	45→32	12→6	9→4	24→22
FVC¶ [%] (baseline to latest follow-up)	**91→105**	**93→100**	**N/A**	**69→72**	**76→77**	**N/A**
DLCO¶ [%] (baseline to latest follow-up)	70→81	58→75	N/A	58→58	66→75	N/A

SSc patients were able to achieve meaningful clinical responses off all immunomodulators and off or tapering steroids

*As of 11 Sep, 2025; primary endpoint is incidence and severity of adverse events through Day 29.
†Reflects trend from baseline to latest available timepoint.
‡Revised CRISS is evaluated at Weeks 12, 24, 36, and 52. PFTs from Week 24 are carried forward for Week 36 evaluation.
§Revised CRISS-50 met at Weeks 12 and 36. Not met at Week 24.
¶DLCO and FVC are evaluated at Weeks 12 and 24.
**Based on the research-based, qualified, quantitative Luminex assay.
‡‡Tapering GC.
CRISS, Composite Response Index in Systemic Sclerosis; DLCO, % predicted diffusing capacity for carbon monoxide; FVC, forced vital capacity; GC, glucocorticoid; IM, immunomodulatory medication; mRSS, modified Rodnan Skin Score (measure of skin thickness in SSc across 17 body areas, with a maximum score of 51); N/A, not applicable; rese-cel, resecabtagene autoleucel; RNA Pol III/RP11, ribonucleic acid polymerase III; Scl-70, anti–topoisomerase I antibody; SSc, systemic sclerosis.
Cabaletta Bio: Data on File.

Myasthenia Gravis: Unmet Need & Clinical Data

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Myasthenia gravis: Significant disease & treatment burden

High impact of disease due to patient symptoms & cost burden, particularly for refractory patients

Serious, chronic autoimmune neuromuscular disorder[1]

- Characterized by defective transmission at the neuromuscular junction, resulting in weakness of the skeletal muscles
- Typically associated with autoantibodies (e.g. AChR, MuSK, LRP4)
- Symptoms range from ocular involvement, including double vision and ptosis, to severe weakness of the limb, bulbar, trunk, and respiratory muscles, which is worsened with exertion
- Mortality rate estimated to be 5-9%, primarily driven by myasthenic crises, or respiratory crises requiring ventilation[2]

Treatments have transient effect & involve long-term broad immunosuppression[1]

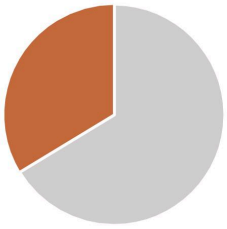
- Available therapeutic options focus on specific symptoms and can be associated with serious long-term side effects
- Mainstays include steroids, immunosuppressants (e.g., mycophenolate), FcRn antagonists, complement inhibitors and rituximab
- MG represents a significant healthcare cost burden in the US, particularly for patients whose disease is inadequately controlled

Eligible U.S. MG patients[3]

Generalized MG patients with refractory disease potentially eligible for rese-cel

(per quantitative research with ~100 MG-treating physicians)

~35,000
U.S. MG patients
potentially eligible for rese-cel



~100k MG patients

1. Gilhus NE, et al. *Eur J Neurol.* 2024 2. Dresser L, et al. *J Clin Med.* May 2021. 3. Results from quantitative survey of U.S. MG-treating physicians (neurologists), conducted 3Q25. N = ~100.

Baseline Characteristics: 13 RESET-MG Patients*

All patients had active, refractory disease despite multiple immunomodulatory agents

	AChR Positive (n=7)	AChR Negative (n=6)
Age, years, mean (min, max)	54.0 (41, 65)	53.3 (37, 70)
Female, n (%)	3 (42.9%)	6 (100.0%)
Time from diagnosis to screening, years, mean (min, max)	7.10 (1.4, 19.1)	6.83 (0.6, 16.2)
Autoantibodies (%)	AChR: 100%	Seronegative: 50% MuSK: 33.3% LRP4: 16.7%
Baseline disease activity†	**MG-ADL (mean)**	
	12.3	12.8
	QMG (mean)	
	14.1	16.8
Prior MG therapies (excluding GCs), mean (min, max)	4.6 (0, 8)	3.5 (1, 6)
Therapies at screening: **Systemic GCs** **≤2 MG therapies‡** **≥3 MG therapies‡**	 57% 71% 29%	 50% 83% 17%
GC dose at screening§, mg/day, mean (min, max)	10 (0, 25)	10.8 (0, 30)

*As of 6 March, 2026.
†Baseline disease activity = activity before preconditioning.
‡MG therapies include acetylcholinesterase inhibitors, FcRn inhibitors, biologics, IVIg, and immunosuppressants.
§GC dose = glucocorticoid dose expressed in equivalent dose of prednisone (mg/day).
AChR, acetylcholine receptor; FcRn, neonatal Fc receptor; GC, glucocorticoid; IVIg, intravenous immunoglobulin; LRP4, low-density lipoprotein receptor-related protein 4; MG, myasthenia gravis; MG-ADL, MG – Activities of Daily Living; MuSK, muscle-specific tyrosine kinase; QMG, Quantitative Myasthenia Gravis Score; RESET, REstoring SElf-Tolerance; rese-cel, resecabtagene autoleucel.
Cabaletta Bio – Data on File.

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Incidence of Relevant and Related Serious Adverse Events*

No CRS was observed in 11 of 13 patients; CRS was mild and resolved with no sequelae; no ICANS observed

Cohort	AChR Positive							AChR Negative					
Patient	AChR-pos-1	AChR-pos-2	AChR-pos-3	AChR-pos-4	AChR-pos-5	AChR-pos-6	AChR-pos-7	AChR-neg-1	AChR-neg-2	AChR-neg-3	AChR-neg-4	AChR-neg-5	AChR-neg-6
CRS†	None	Grade 2‡	None	None	None	None	Grade 1‡	None	None	None	None	None	None
ICANS†	None	None	None	None	None	None	None	None	None	None	None	None	None
Serious infections§	None	None	None	None	None	None	None	None	None	None	None	None	None
Related SAEs¶ **(Grade)** (Excluding CRS/ICANS)	None	Physical deconditioning, anorexia (3)	None	None	None	None	None	None	None	None	None	Neutropenic fever (3)	None

*As of 6 March, 2026; (N=13 dosed); primary endpoint is incidence and severity of adverse events through Day 29.
†Graded per ASTCT Consensus Grading Criteria.
‡The median time to onset of observed CRS was 5 days (range 2–8 days) relative to the rese-cel infusion (events occurring within 7 days of each other were considered a single event).
§Coded in System Organ Class of Infections and Infestations and meets seriousness criteria.
¶As assessed per US Food and Drug Administration guidelines.
AChR, acetylcholine receptor; AE, adverse event; ASTCT, American Society for Transplantation and Cellular Therapy; CRS, cytokine release syndrome; ICANS, immune effector cell-associated neurotoxicity syndrome; SAE, serious adverse event.
Cabaletta Bio – Data on File.

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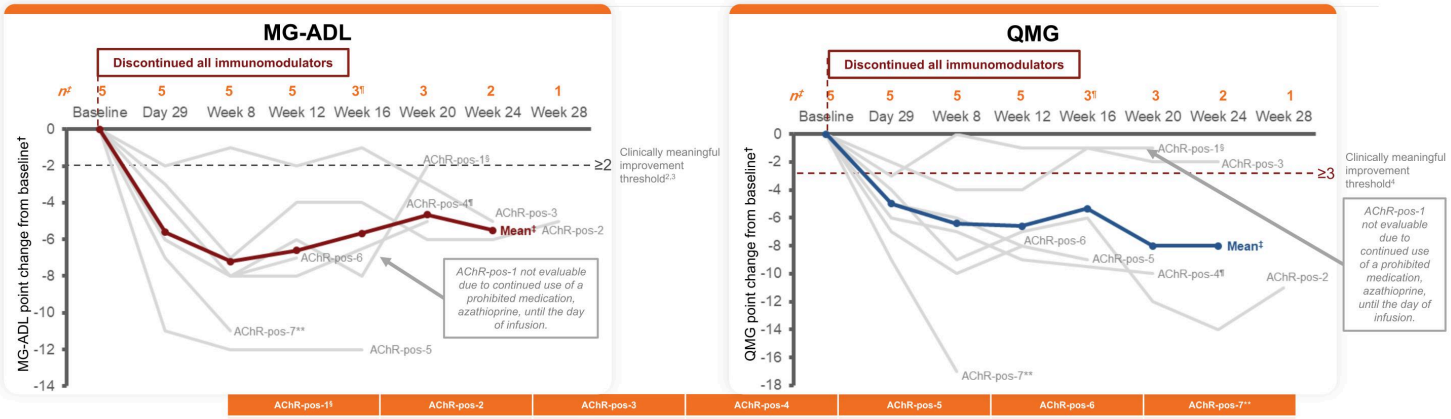
Efficacy data in AChR-positive patients following rese-cel infusion[1]*

After discontinuation of all immunomodulators



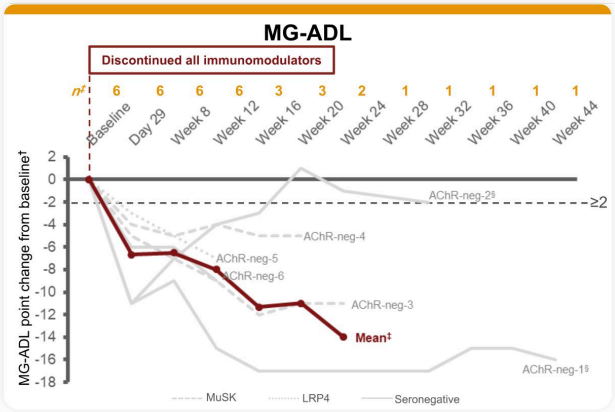
	AChR-pos-1§	AChR-pos-2	AChR-pos-3	AChR-pos-4	AChR-pos-5	AChR-pos-6	AChR-pos-7**
MG medications (screening visit)	AZA, IVIg, GC, PYR	EFG, PYR	EFG, MMF, GC	EFG, MMF, GC, PYR	PYR	GC, PYR	IVIg
GC-free (latest follow-up)	*Taper*	✓	*Taper*	✓	✓	*Taper*	✓
AChEI-free (latest follow-up)	*Ongoing*	✓	✓	✓	*Taper*	✓	✓
MG-ADL response	Received IVIg	✓	✓	✓	✓	✓	Received IVIg

After discontinuation of all immunodulators,
5 of 7 AChR-positive patients showed clinically meaningful improvements on the MG-ADL scale
Cabaletta anticipates announcing registrational plans and trial design in mid-26

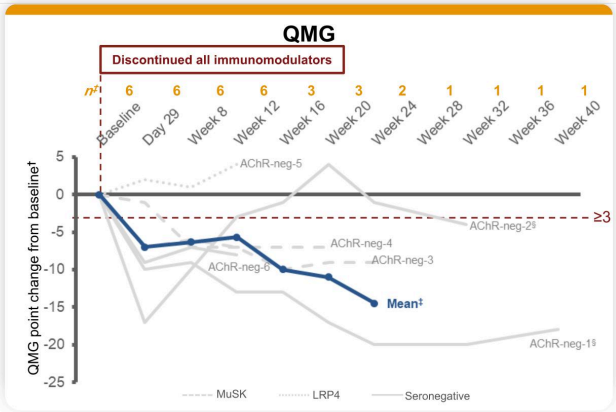
*As of 6 March, 2026.
†Baseline disease activity = activity before preconditioning. ‡Mean and n numbers are based on dosed patients not receiving rescue medication for MG. §AChR-pos-1: AZA, a prohibited medication, was continued until the day of infusion (Day 1). IVIg was stopped prior to rese-cel infusion and restarted 4 weeks after infusion for continued MG symptoms; patient discontinued study at Week 20 due to visit refusal. AChR-pos-1, Day 29 visit data unavailable. ¶AChR-pos-4 missed Week 16 visit. **AChR-pos-7 received rescue IVIg due to MG exacerbation 3 days post rese-cel infusion; IVIg rescue therapy ongoing.
AChEI, acetylcholinesterase inhibitors (i.e PYR); AChR, acetylcholine receptor; AZA, azathioprine; EFG, efgartigimod; GC, glucocorticoid; IM, immunomodulatory medication; IVIg, intravenous immunoglobulin; MG, myasthenia gravis; MG-ADL, MG – Activities of Daily Living; MMF, mycophenolate mofetil; PYR, pyridostigmine; QMG, Quantitative Myasthenia Gravis Score; rese-cel, resecabtagene autoleucel.
1. Cabaletta Bio – Data on File. 2. Muppidi S, et al. Muscle Nerve. 2022;65(6):630–639.
3. EMA. Available at: www.ema.europa.eu/en/documents/overview/soliris-epar-medicine-overview_en.pdf (accessed April 2026). 4. Barnett C, et al. Neurol Clin. 2018;36(2):339–353.

Efficacy data in AChR-negative patients following rese-cel infusion[1]*

After discontinuation of all immunomodulators



Clinically meaningful improvement threshold[2,3]



Clinically meaningful improvement threshold[4]

	AChR-neg-1§ (seronegative)	AChR-neg-2§ (seronegative)	AChR-neg-3 (MuSK)	AChR-neg-4 (MuSK)	AChR-neg-5 (LRP4)	AChR-neg-6 (seronegative)
MG medications (screening visit)	PLA, GC, PYR	MMF, ROZ, PYR	PLA,GC	AZA	EFG	EFG, GC, PYR
GC-free (latest follow-up)	✓	✓	No¶	✓	✓	*Taper*
AChEI-free (latest follow-up)	✓	✓	✓	✓	✓	*Taper*
MG-ADL response	✓	Received EFG and IVIg	✓	✓	✓	✓

After discontinuation of all immunomodulators,
5 of 6 AChR-negative patients showed clinically meaningful improvements on the MG-ADL scale;
Cabaletta anticipates announcing registrational plans and trial design in mid-26

*As of 6 March, 2026.
†Baseline disease activity = activity before preconditioning. ‡Mean and n numbers are based on dosed patients not receiving rescue medication for MG. §AChR-neg-1, no Week 44 QMG performed (unrelated AE prevented assessment being completed); AChR-neg-2, no Week 28 visit data available (missed visit).¶AChR-neg-1 receiving low dose IVIg for ongoing hypogammaglobinemia every 2 months from Week 8; AChR-neg-2 received rescue EFG from Week 13 through Week 16 and IVIg every 3 weeks from Week 24 visit due to MG symptoms; AChR-neg-3 receiving chronic GC for adrenal insufficiency. AChEI, acetylcholinesterase inhibitors (i.e PYR); AChR, acetylcholine receptor; AZA, azathioprine; EFG, efgartigimod; GC, glucocorticoid; IM, immunomodulatory medication; IVIg, intravenous immunoglobulin; LRP4, low-density lipoprotein receptor-related protein 4; MG, myasthenia gravis; MG-ADL, MG – Activities of Daily Living; MMF, mycophenolate mofetil; MuSK, muscle-specific tyrosine kinase; PLA, plasmapheresis; PYR, pyridostigmine; QMG, Quantitative Myasthenia Gravis Score; rese-cel, resecabtagene autoleucel; ROZ, rozanolixizumab.

1. Cabaletta Bio – Data on File. 2. Muppidi S, et al. Muscle Nerve. 2022;65(6):630–639. 3. EMA. Available at: www.ema.europa.eu/en/documents/overview/soliris-epar-medicine-overview_en.pdf (accessed April 2026).
4. Barnett C, et al. Neurol Clin. 2018;36(2):339–353.

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Cabaletta Bio leadership

Track record of operational success evaluating & developing novel cell therapy candidates in autoimmunity

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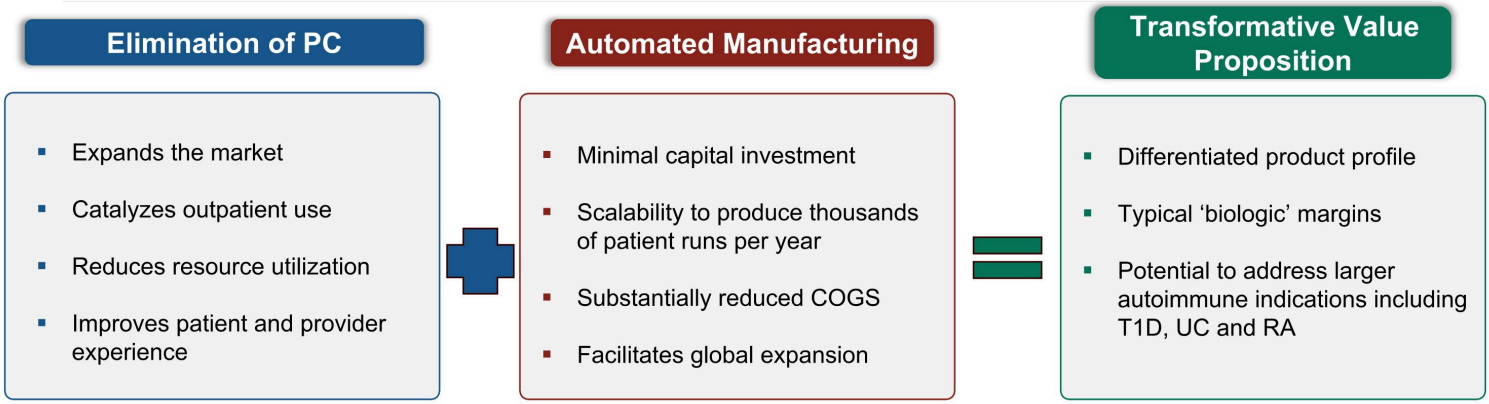
Transformative value proposition with PC elimination & automation

Removing PC should expand access while automated manufacturing should reduce COGS & increase scale



1H26 — *PV: PC-free rese-cel data including longer-term follow up at the initial dose*
SLE: PC-free rese-cel data including early data at the initial dose
Initial clinical experience with rese-cel manufactured by Cellares

2H26 — *Longer-term PC-free rese-cel data from the PV & SLE dose cohorts and from patients receiving rese-cel manufactured by Cellares*

COGS – Cost of goods sold; PC – Preconditioning; PV – Pemphigus vulgaris; SLE – Systemic lupus erythematosus; RA – Rheumatoid arthritis; T1D – Type 1 diabetes; UC – Ulcerative colitis.

Appendix

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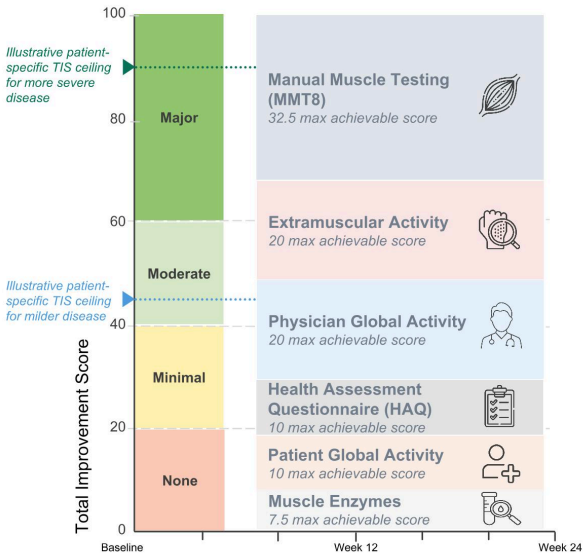
Myositis outcomes captured through validated composite endpoint

TIS is a composite tool measuring a patient's relative improvement from their baseline

Total improvement score (TIS) components



- TIS developed via conjoint analysis based continuous model using **absolute percentage change** in 6 core set measures (CSM): MMT8, Extramuscular Activity, Physician Global Activity, Health Assessment Questionnaire, Patient Global Activity, and Muscle Enzymes
- TIS is the sum of improvement scores in the 6 CSMs, with **ceiling of potential effect likely higher in DM and ASyS than in IMNM given minimal extramuscular involvement**

1. ASyS – antisynthetase syndrome; CSM – core set measure; DM – dermatomyositis; IMNM – immune-mediated necrotizing myopathy; IVIg – intravenous immunoglobulin.
2. Aggarwal R et al. NEJM. 2022;387(14):1264-1278.

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Corporate Presentation

MAY 2026