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): November 9, 2026

Nkarta, Inc.

(Exact name of Registrant as Specified in Its Charter)

Delaware	**001-39370**	**47-4515206**
(State or Other Jurisdiction of Incorporation)	**(Commission File Number)**	**(IRS Employer Identification No.)**
1150 Veterans Boulevard South San Francisco, CA		**94080**
(Address of Principal Executive Offices)		**(Zip Code)**

Registrant's Telephone Number, Including Area Code: (925) 407-1049

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, $0.0001 par value per share	NKTX	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 November 9, 2026, Nkarta, Inc. (the "Company") issued a press release announcing initial clinical data for NKX019 in myositis and systemic sclerosis from its Ntrust clinical trial program, which are being presented at the American College of Rheumatology ("ACR") Convergence 2026. A copy of the press release is furnished as Exhibit 99.1 to this Current Report on Form 8-K.

Also on November 9, 2026, the Company hosted a webcast at 8:00 a.m. Eastern Time to discuss these data. A copy of the presentation used on the webcast, which is available in the Investors section of the Company's website, is furnished as Exhibit 99.2 to this Current Report on Form 8-K.

The information in this Item 7.01, including Exhibits 99.1 and 99.2 attached hereto, is being furnished and shall not be deemed "filed" for purposes of Section 18 of the Exchange Act, or otherwise subject to the liabilities of that section, nor shall it be deemed incorporated by reference in any filing under the Securities Act or the Exchange Act, except as expressly set forth by specific reference in such a filing.

Item 8.01 Other Events.

On November 9, 2026, the Company announced initial clinical data from its ongoing Phase 1/2 Ntrust-2 basket study evaluating NKX019, its allogeneic, off-the-shelf, CD19-directed chimeric antigen receptor natural killer ("CAR NK") cell therapy candidate, in patients with idiopathic inflammatory myopathy ("myositis") and systemic sclerosis. The Company also announced integrated safety data from its Ntrust-1 and Ntrust-2 clinical trials (together, the "Ntrust trials"). All data are as of a data cutoff of September 18, 2026. Patients at the 4 billion cells per dose level received three doses of NKX019 on Days 0, 3 and 7 following lymphodepleting preconditioning, for a total of 12 billion cells.

Myositis. Among 11 patients in the myositis baseline efficacy population across all dose levels, median disease duration was 3.5 years, and nine (82%) had received four or more prior therapies. At the 4 billion cells per dose level:

- Five of six patients (83%) with at least three months of follow-up achieved moderate or major responses, as measured by the Total Improvement Score ("TIS"). These responses spanned three disease subtypes: dermatomyositis, juvenile dermatomyositis and antisynthetase syndrome.
- Five of six patients (83%) with at least three months of follow-up showed improvements in muscle strength, as measured by Manual Muscle Testing 8.
- Four of eight evaluable patients (50%) achieved clinically relevant reductions in skin disease activity, as measured by the Cutaneous Dermatomyositis Disease Area and Severity Index Activity Score. The other four patients had relatively stable scores compared with baseline.

One patient at the 4 billion cells per dose level received a low-dose steroid taper and intravenous immunoglobulin from a community rheumatologist, outside the protocol and without the investigator's knowledge. The additional therapy was not due to worsening disease. The patient had already achieved a moderate response at Day 37, before the additional therapy began at approximately Day 50, and achieved a major response by Day 120. At lower dose levels, two patients had early moderate or major responses that were not sustained. Both later received additional immunomodulatory agents for increased disease activity.

Systemic Sclerosis. Among 14 patients in the systemic sclerosis baseline efficacy population across all dose levels, median disease duration was 4.6 years, and nine (64%) had received at least three prior therapies. Median baseline modified Rodnan skin score ("mRSS") was 26. At the 4 billion cells per dose level, seven of nine patients had reached Day 90 as of the data cutoff. Of those seven patients:

- Six (86%) achieved a revised Composite Response Index in Systemic Sclerosis ("rCRISS")-25 response or greater by Day 90, including five (71%) who achieved an rCRISS-50 response or greater.
- Median improvement in mRSS was 15 points (range, 0 to 29) at Day 90. Six (86%) had a reduction in mRSS, and five (71%) achieved a reduction of at least 50% from baseline.

By comparison, one of five patients treated at 1 billion or 2 billion cells per dose achieved an mRSS reduction of at least 50% by Day 90.

Safety. As of the data cutoff, 40 patients had been treated with NKX019 in the Ntrust trials across five autoimmune indications and three dose levels. There were no deaths and no treatment discontinuations due to adverse events, and no increase in adverse events was observed at higher doses. There were no reported cases of cytokine release syndrome of any grade, immune effector cell-associated neurotoxicity syndrome, immune effector cell-associated hemophagocytic lymphohistiocytosis-like syndrome or graft-versus-host disease. Adverse events were mainly hematologic, attributed to lymphodepleting preconditioning, and generally transient.

Infusion-related reactions occurred in five patients (12.5%), most of them Grade 1. All resolved within 24 to 48 hours with standard supportive care.

Translational Data. Deep peripheral CD19+ B-cell depletion was observed at the 4 billion cells per dose level, with median B-cell counts remaining depleted through Day 27 (n=22).

Development Plans. Pharmacokinetic and T-cell recovery data show that host T cells begin to recover before the Day 7 dose. Based on these data, the Company recently amended the Ntrust protocols to compress dosing to Days 0, 2 and 4, and plans to evaluate 6 billion cells per dose. The Company anticipates upcoming interactions with the U.S. Food and Drug Administration ("FDA") to discuss potential registrational pathways in both myositis and systemic sclerosis. In the first half of 2027, the Company expects to report additional clinical follow-up in myositis and systemic sclerosis, including retreated patients, together with a plan for registrational dose selection.

The data described above are preliminary, are from a small number of patients with limited follow-up and may change as additional data become available. No head-to-head studies have been conducted comparing NKX019 with other therapies. Caution should be exercised in drawing conclusions from comparisons of data across separate trials, which may differ in design, patient populations and other factors.

Forward-Looking Statements

Statements contained in this Current Report on Form 8-K regarding matters that are not historical facts are "forward-looking statements" within the meaning of the Private Securities Litigation Reform Act of 1995, as amended. Words such as "anticipates," "believes," "expects," "intends," "plans," "potential," "projects," "would" and "future" or similar expressions are intended to identify forward-looking statements. Examples of these forward-looking statements include, but are not limited to, statements concerning the Company's expectations regarding any or all of the following: the Company's position, plans, strategies, and timelines for the continued and future clinical development and potential of NKX019 (including the future availability and disclosure of clinical data and other updates from the Company's clinical trials, planned changes to dosing schedules and dose levels, the potential effects of such changes, the potential durability of clinical responses, the safety and efficacy of retreatment, anticipated interactions with the FDA, potential registrational pathways and the timing of registrational dose selection); and the therapeutic potential, accessibility and tolerability of NKX019 for the treatment of autoimmune diseases.

Because such statements are subject to risks and uncertainties, actual results may differ materially from those expressed or implied by such forward-looking statements. These risks and uncertainties include, among others: the Company's limited operating history and historical losses; the Company's lack of any products approved for sale and its ability to achieve profitability; the risk that the results of preclinical studies and early-stage clinical trials may not be predictive of future results; the risk that initial, interim or preliminary data from the Company's clinical trials, including the data presented at ACR Convergence 2026, reflect a limited number of patients with limited follow-up, may change as more patient data become available and may not be predictive of future results; the Company's ability to raise additional funding to complete the development and any commercialization of its product candidates; the Company's dependence on the clinical success of NKX019, including in its leading indications of myositis and systemic sclerosis; risks associated with outpatient administration of NKX019 at community-based sites; the risk that the FDA may not agree with the Company's proposed registrational pathways or dose selection; the risk that changes to dosing schedules or dose levels may not achieve the anticipated results or may result in additional safety or tolerability concerns; that the Company may be delayed in initiating, enrolling patients in or completing its clinical trials; competition from third parties that are developing products for similar uses; the Company's ability to obtain, maintain and protect its intellectual property; the Company's dependence on third parties in connection with manufacturing, clinical trials and pre-clinical studies; and the complexity of the manufacturing process for CAR NK cell therapies. These and other risks and uncertainties are described more fully in the Company's filings with the Securities and Exchange Commission ("SEC"), including the "Risk Factors" section of the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2026, filed with the SEC on November 5, 2026, and the Company's other documents subsequently filed with or furnished to the SEC. All forward-looking statements contained in this Current Report on Form 8-K speak only as of the date on which they were made. Except to the extent required by law, the Company undertakes no obligation to update such statements to reflect events that occur or circumstances that exist after the date on which they were made.

Item 9.01 Financial Statements and Exhibits.

(d) Exhibits.

Exhibit Number	Description
99.1	Press Release dated November 9, 2026 entitled “Nkarta Announces Initial Clinical Data for NKX019 in Myositis and Systemic Sclerosis at ACR Convergence”
99.2	Investor presentation titled “NKX019 in Autoimmune Disease: Initial Clinical Data in Myositis and Systemic Sclerosis,” dated November 9, 2026.

104	Cover Page Interactive Data File (embedded within the Inline XBRL document).

SIGNATURES

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

Nkarta, Inc.

Date: November 9, 2026

By: /s/ Nadir Mahmood

Nadir Mahmood
President

Exhibit 99.1

Nkarta Announces Initial Clinical Data for NKX019 in Myositis and Systemic Sclerosis at ACR Convergence

- *In myositis, 5/6 (83%) patients treated at 4 billion cells per dose with at least three months of follow-up achieved moderate or major responses, as measured by the Total Improvement Score (TIS) in the Ntrust-2 study of NKX019, an investigational, allogeneic CAR NK cell therapy.*
- *In systemic sclerosis, 6/7 (86%) patients treated at 4 billion cells per dose with at least three months of follow-up achieved a* revised Composite Response Index in Systemic Sclerosis *(rCRISS)-25 response or greater, with 5/7 (71%) patients achieving an rCRISS-50 response or greater.*
- *Rapid and deep skin responses observed in systemic sclerosis at 4 billion cells per dose, including a median 15-point reduction in modified Rodnan skin score (mRSS) at Day 90, with 5/7 (71%) patients achieving a reduction of at least 50% from baseline.*
- *No immune effector cell-associated toxicities, including cytokine release syndrome (CRS), immune effector cell-associated neurotoxicity syndrome (ICANS) and immune effector cell-associated hemophagocytic lymphohistiocytosis-like syndrome (IEC-HS), or graft-versus-host disease (GvHD), and no treatment discontinuations due to adverse events, among 40 patients treated across five indications in the Ntrust program.*
- *Webcast scheduled for today, November 9, at 8 a.m. ET*

SOUTH SAN FRANCISCO, Calif., November 9, 2026 — Nkarta (Nasdaq: NKTX), a clinical-stage biotechnology company developing engineered natural killer (NK) cell therapies to treat autoimmune diseases, today announced positive initial clinical data from its Ntrust clinical trial program evaluating NKX019, its allogeneic, off-the-shelf CAR NK cell therapy candidate.

Initial clinical data from the Ntrust program are being presented this week at the American College of Rheumatology (ACR) Convergence 2026 in Orlando in two oral presentations and one poster presentation, highlighting tolerability and early efficacy in Nkarta's lead indications, myositis and systemic sclerosis. Additional translational data will be reviewed today in an investor webcast. All data are as of the September 18, 2026, ACR data cutoff.

Patients at the 4 billion-cell dose level received three doses of NKX019 on Days 0, 3 and 7 following lymphodepleting preconditioning, for a total of 12 billion cells. Efficacy was assessed using disease-specific clinical endpoints.

In myositis, the Total Improvement Score (TIS) combines muscle strength, patient and physician assessments and other disease measures. A TIS of 40 or higher represents a moderate response, reflecting broad improvement in the disease, and a TIS of 60 or higher represents a major response. In systemic sclerosis, the revised Composite Response Index in Systemic Sclerosis (rCRISS) measures skin, lung function, physical function and patient and clinician global assessments. An rCRISS-25 response represents at least 25% improvement across multiple domains of disease.

- In myositis, five of six patients (83%) treated at 4 billion cells per dose with at least three months of follow-up achieved moderate or major TIS responses.

- In systemic sclerosis, six of seven patients (86%) treated at 4 billion cells per dose with at least three months of follow-up achieved an rCRISS-25 response or greater, with five of seven patients (71%) achieving an rCRISS-50 response or greater.

NKX019 has demonstrated a favorable safety and tolerability profile among 40 patients treated across five autoimmune indications and three dose levels at the data cutoff. There were no deaths and no treatment discontinuations due to adverse events, and no increase in adverse events was observed at higher doses.

Additionally, there were no reported cases of cytokine release syndrome (CRS) of any grade, immune effector cell-associated neurotoxicity syndrome (ICANS), immune effector cell-associated hemophagocytic lymphohistiocytosis-like syndrome (IEC-HS) or graft-versus-host disease (GvHD). No cases of leukoencephalopathy, a fludarabine-associated neurotoxicity, have been reported.

Deep peripheral CD19+ B-cell depletion was observed at the 4 billion-cell dose, with median B-cell counts remaining depleted through Day 27 (n=22). In five patients with low to moderate numbers of naïve B cells at baseline, preliminary B-cell profiling showed a predominantly naïve repopulating B-cell compartment, a pattern consistent with B-cell immune reset.

“These initial results represent an important milestone for Nkarta and provide encouraging evidence that NKX019 has the potential to deliver meaningful benefit to patients struggling with advanced forms of myositis and systemic sclerosis,” said Paul J. Hastings, Chief Executive Officer of Nkarta. “Our goal has always been to combine the therapeutic potential of engineered NK cell therapy with a safety profile and ease of administration that make treatment accessible to patients and physicians beyond specialized cell therapy centers. The safety profile of NKX019 observed so far and the evidence of a dose response that we’re seeing as we’ve escalated up to 4 billion cells per dose reinforce our conviction that CAR NK could offer a differentiated approach for patients with autoimmune disease.”

“Patients with refractory myositis and systemic sclerosis often endure years of progressive disease despite multiple lines of treatment, with few effective options remaining,” said Guillermo Valenzuela, M.D., principal investigator and founding medical director of Integral Rheumatology and Immunology Specialists (IRIS). “These are diseases in which preserving muscle strength, physical function and organ health can profoundly affect both the quality of a patient’s life and its duration. As a clinician who has cared for patients living with these debilitating conditions, I am encouraged by both the proportion of patients experiencing meaningful clinical improvement and the depth of responses observed. I’ve been participating in the Ntrust clinical trials in my community clinic, IRIS, based in Plantation, Florida, where we are treating patients with NKX019 on an outpatient basis followed by a two-hour post-infusion observation period and subsequent discharge home, similar to a biologic infusion.”

Initial Clinical Results in Myositis

The Ntrust-2 basket study enrolled patients with active, treatment-refractory myositis (idiopathic inflammatory myopathy), including dermatomyositis, juvenile dermatomyositis, antisynthetase syndrome and immune-mediated necrotizing myopathy. Among 11 patients in the baseline efficacy population across all dose levels, median disease duration was 3.5 years and nine (82%) had received four or more prior therapies. Clinical activity in myositis was assessed using TIS, described above.

At the 4 billion-cell dose level:

- Five of six patients (83%) with at least three months of follow-up achieved moderate or major TIS responses spanning three disease subtypes: dermatomyositis, juvenile dermatomyositis and antisynthetase syndrome. The patient with the longest available follow-up, six months, has maintained a major response of TIS 90.
- Five of six patients (83%) with at least three months of follow-up demonstrated improvements in muscle strength, as measured by Manual Muscle Testing 8 (MMT-8). Improvements generally emerged early following treatment and were maintained through available follow-up.
- Four of eight evaluable patients (50%) achieved clinically relevant reductions in skin disease activity, as measured by the Cutaneous Dermatomyositis Disease Area and Severity Index Activity Score (CDASI-A). The remaining four patients had relatively stable scores compared with baseline.

Early evidence of a dose response was observed. NKX019 exposure increased with dose, and clinical responses at 4 billion cells per dose were more consistent than at lower dose levels, where two patients treated (one at 1 billion and one at 2 billion cells per dose) had early moderate or major responses that were not sustained.

One patient at the 4 billion-cell dose level received a low-dose steroid taper and intravenous immunoglobulin from a community rheumatologist, outside the protocol and without the investigator's knowledge. This was not due to worsening disease. The patient had already achieved a moderate response (TIS of 40 or higher) at Day 37, before additional therapy began at approximately Day 50, and went on to achieve a major response by Day 120. Both patients treated at the lower dose levels received additional immunomodulatory agents at later timepoints for increased disease activity.

These findings provide early evidence of clinical activity across multiple manifestations of myositis, including muscle weakness and inflammatory skin disease. Continued follow-up will further characterize durability of response.

Initial Clinical Results in Systemic Sclerosis

Systemic sclerosis patients enrolled in the Ntrust-2 study had active disease despite extensive prior treatment. Among 14 patients included in the baseline efficacy population across all dose levels, median disease duration was 4.6 years and nine (64%) had received at least three prior therapies. Median baseline mRSS was 26, reflecting substantial skin involvement.

Clinical activity was evaluated using the modified Rodnan skin score (mRSS), a measure of skin thickening, and rCRISS, described above, which measures improvement across skin, lung function, physical function and patient and clinician global assessments.

At the 4 billion-cell dose level, seven of nine patients had reached Day 90 as of the data cutoff. Among these patients, NKX019 demonstrated rapid and deep clinical responses through Day 90:

- Six of seven patients (86%) achieved an rCRISS-25 response or greater by Day 90, including five of seven patients (71%) who achieved an rCRISS-50 response or greater.
- Skin responses were rapid and deep, with a median improvement in mRSS of 15 points (range, 0 to 29) at Day 90. Six of seven patients (86%) had a reduction in mRSS, and five of seven patients (71%) achieved a reduction of at least 50% from baseline.

A dose response was also observed in skin. One of five patients treated at 1 billion or 2 billion cells per dose achieved an mRSS reduction of at least 50% by Day 90, compared with five of seven patients at 4 billion cells per dose.

Among patients treated at lower dose levels, one patient in the 2 billion-cell dose cohort, with nine months of follow-up, has maintained an rCRISS-70 response through Day 270.

Safety

Adverse events were mainly hematologic and attributed to lymphodepleting preconditioning, and were generally transient, typically recovering within one to two months. Across all indications and dose levels, no cases of CRS of any grade, ICANS, IEC-HS or GvHD were observed. Infusion-related reactions, the main events associated with NKX019 administration, occurred in five patients (12.5%), most of them grade 1. All resolved within 24 to 48 hours with standard supportive care, without the use of tocilizumab.

The Ntrust protocols have included a safety standard for patients with compromised kidney function since fludarabine was added to the lymphodepletion regimen, requiring either a reduced dose of fludarabine or exclusion from the trial. No cases of leukoencephalopathy, a fludarabine-associated neurotoxicity, have been reported to date.

Additional integrated safety data from the Ntrust program will be presented by Dr. Valenzuela in an oral presentation at ACR Convergence 2026 on Wednesday, November 11.

Registrational Preparations Underway

Based on pharmacokinetic and T-cell recovery data showing that host T cells begin to recover before the Day 7 dose, Nkarta recently amended the Ntrust protocols to compress dosing to Days 0, 2 and 4, and plans to evaluate 6 billion cells per dose.

Nkarta anticipates upcoming interactions with the U.S. Food and Drug Administration to discuss potential registrational pathways in both indications. The company also expects to report additional clinical follow-up in myositis and systemic sclerosis, as well as retreated patients, together with a plan for registrational dose selection, in the first half of 2027.

About the Ntrust℠ Clinical Trials in Autoimmune Disease
Ntrust-1 (NCT06557265) and Ntrust-2 (NCT06733935) are multi-center, open-label, dose-escalation clinical trials in patients with autoimmune disease receiving lymphodepletion followed by CD19-targeted CAR NK cell therapy. Both trials assess the safety of NKX019 in people living with autoimmune diseases as well as its potential to achieve durable remission via a “reset” of the immune system through the elimination of pathogenic B cells.

The Ntrust trials are enrolling up to 12 patients per dose level per disease indication. Additional patients may be enrolled if needed to refine patient populations for further study.

In both studies, patients receive a three-dose cycle of NKX019 following lymphodepleting preconditioning with fludarabine and cyclophosphamide or cyclophosphamide alone, if they have significant cytopenia at baseline. This approach is designed to evaluate the single-agent activity of NKX019 and facilitate a more rapid path to regulatory approval. Patients in both trials may also receive additional cycles, if needed, to restore response or enable a deeper response.

About NKX019

NKX019 is an allogeneic, cryopreserved, off-the-shelf immunotherapy candidate that uses natural killer (NK) cells derived from the peripheral blood of healthy adult donors. It is engineered with a humanized CD19-directed chimeric antigen receptor (CAR) for enhanced cell targeting and a proprietary, membrane-bound form of interleukin-15 (IL-15) for greater persistence and activity without exogenous cytokine support. CD19 is a biomarker for normal B cells as well as those implicated in autoimmune disease. Nkarta is evaluating NKX019 in multiple autoimmune conditions.

About Nkarta
Nkarta is a clinical-stage biotechnology company advancing the development of allogeneic, off-the-shelf natural killer (NK) cell therapies for people living with autoimmune diseases. By harnessing the power of the innate immune system to eliminate pathogenic B cells driving the autoimmune response, Nkarta is advancing novel cell therapies engineered for deep therapeutic impact. The on-demand availability and outpatient dosing of our CAR NK cells enable a broad population of patients with different autoimmune conditions to conveniently access NK cell therapy in community health settings. For more information, please visit the company's website at www.nkartatx.com.

Cautionary Note on Forward-Looking Statements
Statements contained in this press release regarding matters that are not historical facts are "forward-looking statements" within the meaning of the Private Securities Litigation Reform Act of 1995, as amended. Words such as "anticipates," "believes," "expects," "intends," "plans," "potential," "projects," "would" and "future" or similar expressions are intended to identify forward-looking statements. Examples of these forward-looking statements include, but are not limited to, statements concerning Nkarta's expectations regarding any or all of the following: Nkarta's position, plans, strategies and timelines for the continued and future clinical development and potential of NKX019 (including the future availability and disclosure of clinical data and other updates from Nkarta's clinical trials, planned changes to dosing schedules and dose levels, the potential effects of such changes, the potential durability of clinical responses, the safety and efficacy of retreatment, anticipated interactions with the U.S. Food and Drug Administration, potential registrational pathways and the timing of registrational dose selection); and the therapeutic potential, accessibility and tolerability of NKX019 for the treatment of autoimmune diseases, including as a result of advancing Nkarta's dose escalation and expansion of outpatient dosing in community-based settings.

Because such statements are subject to risks and uncertainties, actual results may differ materially from those expressed or implied by such forward-looking statements. These risks and uncertainties include, among others: Nkarta's limited operating history and historical losses; Nkarta's lack of any products approved for sale and its ability to achieve profitability; the risk that the results of preclinical studies and early-stage clinical trials may not be predictive of future results; the risk that initial, interim or preliminary data from Nkarta's clinical trials, including the data presented at ACR Convergence 2026, reflect a limited number of patients with limited follow-up, may change as more patient data become available and may not be

predictive of future results; Nkarta's ability to raise additional funding to complete the development and any commercialization of its product candidates; Nkarta's dependence on the clinical success of NKX019, including in its lead indications of myositis and systemic sclerosis; risks associated with outpatient administration of NKX019 at community-based sites; the risk that the U.S. Food and Drug Administration may not agree with Nkarta's proposed registrational pathways or dose selection; the risk that changes to dosing schedules or dose levels may not achieve the anticipated results or may result in additional safety or tolerability concerns; that Nkarta may be delayed in initiating, enrolling patients in or completing its clinical trials; competition from third parties that are developing products for similar uses; Nkarta's ability to obtain, maintain and protect its intellectual property; Nkarta's dependence on third parties in connection with manufacturing, clinical trials and preclinical studies; and the complexity of the manufacturing process for CAR NK cell therapies.

The data described in this press release are preliminary, are from a small number of patients with limited follow-up and may change as additional data become available. No head-to-head studies have been conducted comparing NKX019 with other therapies, and caution should be exercised in drawing conclusions from comparisons of data across separate trials, which may differ in design, patient populations and other factors.

These and other risks and uncertainties are described more fully in Nkarta's filings with the Securities and Exchange Commission ("SEC"), including the "Risk Factors" section of Nkarta's Quarterly Report on Form 10-Q for the quarter ended September 30, 2026, filed with the SEC on November 5, 2026, and Nkarta's other documents subsequently filed with or furnished to the SEC. All forward-looking statements contained in this press release speak only as of the date on which they were made. Except to the extent required by law, Nkarta undertakes no obligation to update such statements to reflect events that occur or circumstances that exist after the date on which they were made.

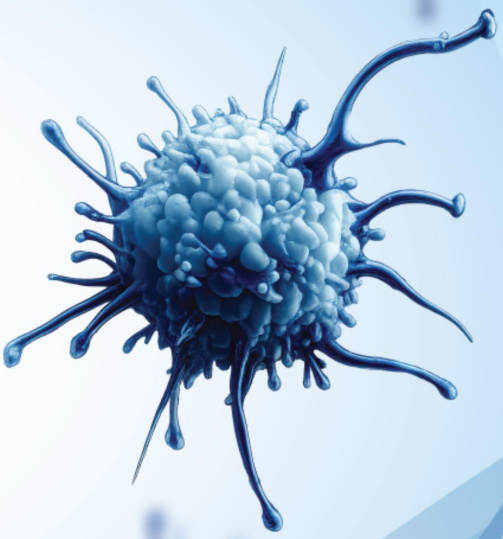
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nkarta

NKX019 in Autoimmune Disease

Initial Clinical Data in Myositis and Systemic Sclerosis

ACR Convergence | November 9, 2026



Forward-Looking Statements

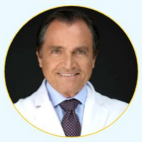
This presentation contains forward-looking statements, within the meaning of the Private Securities Litigation Reform Act of 1995, regarding future events and the future results of the company that are based on current expectations, estimates, forecasts, and projections about the industry in which the company operates and the future of our business, future plans and strategies, projections, anticipated trends and events, the economy, and other future conditions, and the beliefs and assumptions of the management of the company. These forward-looking statements include, without limitation, statements regarding the potential therapeutic benefits, safety profile, and differentiation of NKX019; the company's clinical development plans for NKX019, including the expected timing of additional follow-up data, the selection of a registrational dose, planned changes to dosing schedules and dose levels, the potential effects of such changes, the potential durability of clinical responses, and the safety and efficacy of retreatment; the company's planned interactions with the FDA and the potential registrational path for NKX019 in myositis and systemic sclerosis; the potential market opportunity for NKX019, including estimated patient populations and estimated refractory patient populations; the potential approval of NKX019 in any indication; and the company's expected cash runway. Words such as "address," "anticipate," "believe," "consider," "continue," "could," "develop," "estimate," "expect," "forecast," "further," "goal," "intend," "may," "opportunity," "plan," "potential," "project," "seek," "should," "target," "will," "would," variations of such words, and similar expressions are intended to identify such forward-looking statements. Such statements reflect the current views of the company and its management with respect to future events and are subject to inherent risks, uncertainties, and changes in circumstances that are difficult to predict and may be outside our control. Important factors that could cause actual results to differ materially include, among others: the results of ongoing and future clinical trials of NKX019; whether the FDA agrees with the company's proposed registrational path and dose; the risk that changes to dosing schedules or dose levels may not achieve the anticipated results or may result in additional safety or tolerability concerns; whether and when NKX019 receives regulatory approval in any indication; the size of the addressable patient populations, including refractory populations, which are based on published estimates and limited primary market research and may be smaller than estimated; pricing, coverage, and reimbursement; market acceptance by physicians and patients; competition; the company's ability to manufacture and commercialize NKX019; and the risk that the company uses its capital resources sooner than expected. Therefore, you should not rely on any of these forward-looking statements. Should one or more of these risks or uncertainties materialize, or should underlying assumptions prove incorrect, the company's actual results, performance, or achievements could differ materially from the results expressed in, or implied by, these forward-looking statements. Please see section entitled "Risk Factors" in our annual, quarterly and other filings with the Securities and Exchange Commission for a description of these risks and uncertainties.

This presentation has been prepared by the company based on information it has obtained from sources it believes to be reliable. Summaries of documents contained in this presentation may not be complete. The company does not represent that the information herein is complete. Estimates of patient populations and market opportunity in this presentation are based on the company's internal estimates and research, including third-party publications and primary market research, which the company has not independently verified. These estimates involve assumptions and limitations, are unrisked, and assume regulatory approval, which may not occur. The information in this presentation is current only as of the date on the cover, and the company's business or financial condition and other information in this presentation may change after that date. The company undertakes no obligation to update any forward-looking statements in order to reflect any event or circumstance occurring after the date of this presentation or currently unknown facts or conditions, except as required by law.

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Three Nkarta Scientific Presentations at ACR Convergence 2026



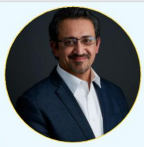
Guillermo Valenzuela, MD, FACR
Medical Director, Integral Rheumatology and Immunology Specialists

- Preliminary Safety, PK/PD, and Clinical Activity of NKX019, an Allogeneic, CD19-Targeted, CAR NK Cell Therapy, in **Idiopathic Inflammatory Myopathy**: Results From an Ongoing, Phase 1/2, Open-Label, Multicenter, Dose-Escalation/Optimization, Basket Study

Sunday, Nov. 8, 1:15–1:30 pm ET

- Overall, Immune-Mediated, and Hematologic **Safety** Outcomes Following Fludarabine/Cyclophosphamide Lymphodepletion and NKX019, an Allogeneic CD19-Targeted CAR NK Cell Therapy, in B-Cell–Mediated Autoimmune Diseases

Wednesday, Nov. 11, 10:15–10:30 am ET



Dinesh Khanna, MBBS, MSc
Professor of Medicine and Director, University of Michigan Scleroderma Program

- Preliminary Safety, PK/PD, and Clinical Activity of NKX019, an Allogeneic, CD19-Targeted, CAR NK Cell Therapy, in **Systemic Sclerosis**: Results From an Ongoing, Phase 1/2, Open-Label, Multicenter, Dose-Escalation/Optimization, Basket Study

Monday, Nov. 9, 10:30 am–12:30 pm ET

Agenda

Introduction & Overview

Paul Hastings, **CEO**

Clinical & Translational Data

Shawn Rose, MD, PhD, **CMO and Head of R&D**

Opportunity & Next Steps

Nadir Mahmood, PhD, **President**

Summary and Q&A

Paul Hastings, **CEO**

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Advantages of NKX019

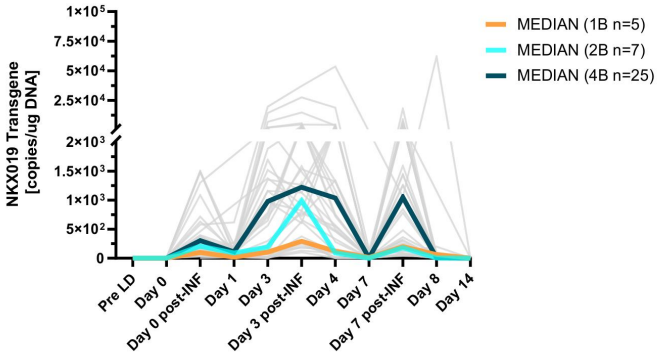
An Off-the-Shelf, On-Demand, Allogeneic, CD19-Targeting CAR NK Cell Therapy

- On demand using healthy donor-derived NK cells
- Outpatient administration in community setting
- No need for hospitalization or overnight monitoring
- Rheumatologist directs care, not a cancer specialist
- Ability to retreat a patient with CAR NK cells, if needed
- Engineered for persistence to enhance B cell killing

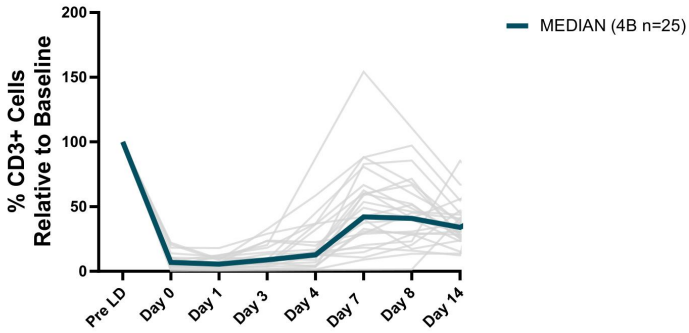
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Dose-dependent exposure, plus an opportunity to enhance activity with a compressed schedule

NKX019 exposure rises with dose and peaks at Days 3–4



Host T cells begin to recover after LD preconditioning, before the Day 7 dose



NKX019 exposure and host T-cell kinetics support dosing on Days 0, 2, and 4

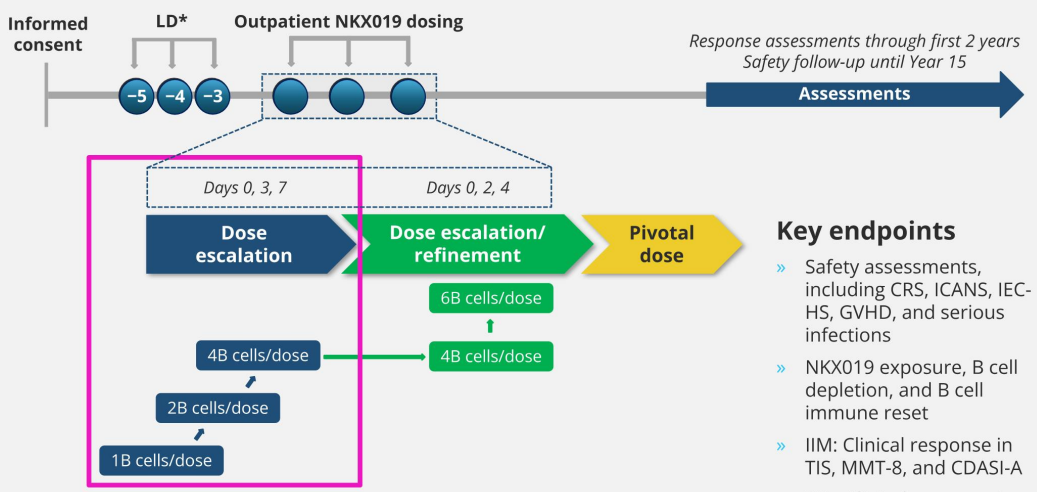
Data as of September 18, 2026. All patients received lymphodepletion (LD) preconditioning with fludarabine/cyclophosphamide (Flu/Cy) and NKX019 infusions on Days 0, 3, and 7. Gray lines show individual patients; colored and dark lines show medians for the 3 dose cohorts. Left: NKX019 transgene in peripheral blood by droplet digital polymerase chain reaction (ddPCR); the y-axis is broken at 2×10^3. Right: CD3+ T cells relative to baseline before LD preconditioning (n = 25) and from the 4 billion (4B) cells/dose cohort only.

Clinical & Translational Data



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NKX019 for autoimmune disease: dose response, delivered outpatient



Key endpoints

- Safety assessments, including CRS, ICANS, IEC-HS, GVHD, and serious infections
- NKX019 exposure, B cell depletion, and B cell immune reset
- IIM: Clinical response in TIS, MMT-8, and CDASI-A
- SSc: Clinical response in mRSS and rCRISS

Myositis endpoints

TIS Total Improvement Score

TIS40 Moderate | **TIS60** Major

Response target: **TIS40 and up**

MMT-8 Muscle strength

CDASI-A Skin disease activity

SSc endpoints

rCRISS 5-measure composite

Response target: **rCRISS-25 and up**

mRSS Skin thickness

*LD preconditioning = a total of 90 mg/m² Flu as 30 mg/m²/day on Days −5, −4, and −3 and 1 g/m²/day Cy on Day −3. Patients with cytopenia may receive Cy alone as 1 g/m² Cy on Day −3. LD preconditioning is performed in an outpatient setting for both treatments.

B, billion; CDASI-A, Cutaneous Dermatomyositis Disease Area and Severity Index Activity Score; CRS, cytokine release syndrome; Cy, cyclophosphamide; Flu, fludarabine; GVHD, graft-versus-host disease; ICANS, immune effector cell–associated neurotoxicity syndrome; IEC-HS, immune effector cell–associated hemophagocytic lymphohistiocytosis-like syndrome; IIM, idiopathic inflammatory myopathy; LD, lymphodepletion preconditioning; MMT-8, Manual Muscle Testing 8; mRSS, modified Rodnan skin score; rCRISS, revised Composite Response Index in Systemic Sclerosis; SSc, systemic sclerosis; TIS, Total Improvement Score.

Overall Ntrust Safety



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NKX019 caused no treatment discontinuations or deaths in 40 patients

Measure, n (%)	Overall N = 40	Disease Indications				
		SSc n = 15	IIM n = 13	LN n = 6	AAV n = 1	RA n = 5
Any TEAEs*,	**34 (85.0)**	**13 (86.7)**	**10 (76.9)**	**6 (100)**	**1 (100)**	**4 (80.0)**
Grade 3 events	14 (35.0)	5 (33.3)	4 (30.8)	5 (83.3)	0	0
Anemia	5 (12.5)	1 (6.7)	1 (7.7)	3 (50.0)	0	0
Neutropenia	5 (12.5)	2 (13.3)	0	3 (50.0)	0	0
Febrile neutropenia	4 (10.0)	2 (13.3)	1 (7.7)	1 (16.7)	0	0
Leukopenia	6 (15.0)	3 (20.0)	1 (7.7)	2 (33.3)	0	0
Serious TEAEs	7 (17.5)	4 (26.7)	2 (15.4)	1 (16.7)	0	0
Serious infections	2 (5.0)	1 (6.7)	1 (7.7)	0	0	0
TEAEs leading to treatment discontinuation	0	0	0	0	0	0
Deaths	0	0	0	0	0	0
Any TRAEs (related to LD or NKX019)*	**30 (75.0)**	**11 (73.3)**	**9 (69.2)**	**6 (100)**	**1 (100)**	**3 (60.0)**
Grade 3 events	12 (30.0)	4 (26.7)	3 (23.1)	5 (83.3)	0	0
Serious TRAEs	3 (7.5)	2 (13.3)	1 (7.7)	0	0	0
Infections (any grade)	4 (10.0)	1 (6.7)	1 (7.7)	2 (33.3)	0	0

Adverse events were mainly hematologic and attributed to LD preconditioning

Data as of September 18, 2026. *AEs within 30 days of last NKX019 dose. Events were included regardless of causality (including those assessed as not related to LD preconditioning and/or NKX019). All hematologic events shown are captured using AE terms (vs laboratory values). Twenty-eight, 7, and 5 patients in this analysis were enrolled, received LD preconditioning, and received at least 1 dose of NKX019 at 4B, 2B, and 1B cells, respectively.

AAV, antineutrophil cytoplasmic antibody-associated vasculitis; AE, adverse event; B, billion; IIM, idiopathic inflammatory myopathy; LD, lymphodepletion preconditioning; LN, lupus nephritis; RA, rheumatoid arthritis; SSc, systemic sclerosis; TEAE, treatment-emergent adverse event; TRAE, treatment-related adverse event.

NKX019: a differentiated safety profile built for autoimmune disease

Measure, n (%)	Overall N = 40	Disease Indications				
		SSc n = 15	IIM n = 13	LN n = 6	AAV n = 1	RA n = 5
NKX019-related IRRs	5 (12.5)	1 (6.7)	1 (7.7)	2 (33.3)	0	1 (20.0)
IEC-associated AEs						
CRS	0	0	0	0	0	0
ICANS	0	0	0	0	0	0
IEC-HS	0	0	0	0	0	0
GVHD	0	0	0	0	0	0

NKX019 caused no cases of CRS, ICANS, IEC-HS, or GVHD across all indications

Data as of September 18, 2026. 28, 7, and 5 patients in this analysis were enrolled, received LD preconditioning, and received at least 1 dose of NKX019 at 4B, 2B, and 1B cells, respectively.

AAV, antineutrophil cytoplasmic antibody-associated vasculitis; AE, adverse event; B, billion; CRS, cytokine release syndrome; GVHD, graft-versus-host disease; ICANS, immune effector cell–associated neurotoxicity syndrome; IEC, immune effector cell; IEC-HS, IEC-associated hemophagocytic lymphohistiocytosis-like syndrome; IIM, idiopathic inflammatory myopathy; IRR, infusion-related reaction; LD, lymphodepletion preconditioning; LN, lupus nephritis; RA, rheumatoid arthritis; SSc, systemic sclerosis.

Myositis Results



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Myositis patients had active, treatment-refractory disease at baseline

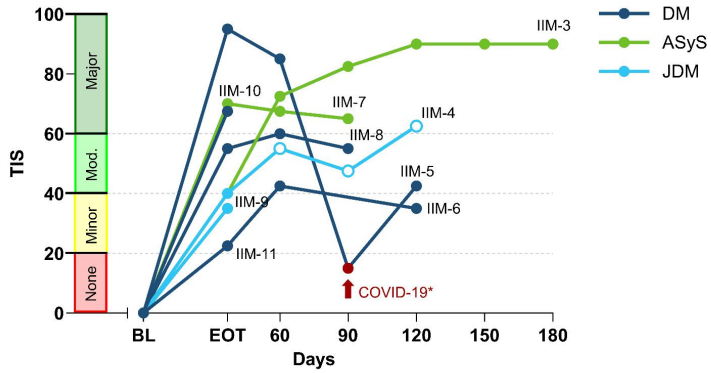
Measure	Overall N = 11	Disease Subtype		
		DM / JDM n = 6 / n = 2	ASyS n = 2	IMNM n = 1
Age, median (range), years	46.0 (19–63)	47.5 (19–63)	40.5 (22–59)	28
Female, n (%)	11 (100)	8 (100)	2 (100)	1 (100)
Disease duration, median (range), years	3.5 (0.3–30.3)	4.1 (1.3–30.3)	1.1 (0.3–1.9)	8.7
Baseline disease activity, median (range)				
MMT-8	117.0 (85.0–135.0)	118.5 (85.0–135.0)	99.0 (86.0–112.0)	122.0
CDASI-A	17.0 (0–32.0)	19.0 (7.0–32.0)	3.5 (0–7.0)	–
Number of prior treatments, n (%)				
1–3	2 (18.2)	2 (25.0)	0	0
≥4	9 (81.8)	6 (75.0)	2 (100)	1 (100)
Prior treatments,* n (%)				
Systemic GCs	7 (63.6)	4 (50.0)	2 (100)	1 (100)
cDMARDs	10 (90.9)	7 (87.5)	2 (100)	1 (100)
Rituximab	4 (36.4)	3 (37.5)	0	1 (100)
IVIG	5 (45.5)	3 (37.5)	1 (50.0)	1 (100)
Other	6 (54.5)	4 (50.0)	1 (50.0)	1 (100)

Data as of September 18, 2026. Includes patients who received Fludarabine/Cyclophosphamide LD preconditioning and 3 doses of NKX019 and had at least 1 post-baseline efficacy-evaluable assessment. *At screening prior to LD preconditioning. Other treatments included antimalarials, calcineurin inhibitors, Janus kinase inhibitors, and biologics.

ASyS, antisynthetase syndrome; CDASI-A, Cutaneous Dermatomyositis Disease Area and Severity Index Activity Score; cDMARD, conventional disease-modifying antirheumatic drug; DM, dermatomyositis; GC, glucocorticoid; IIM, idiopathic inflammatory myopathy; IMNM, immune-mediated necrotizing myopathy; IVIG, intravenous immunoglobulin; JDM, juvenile dermatomyositis; LD, lymphodepletion preconditioning; MMT-8, Manual Muscle Testing 8.

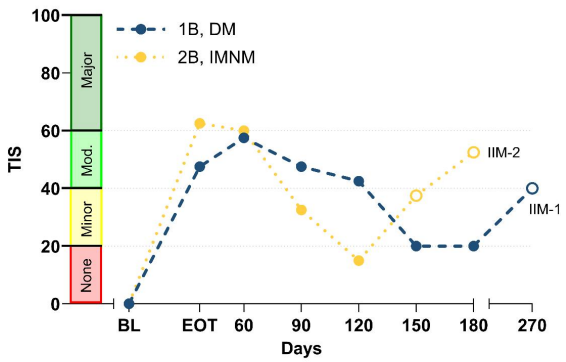
At 4B cells/dose, 5 of 6 IIM patients (83.3%) with ≥3 months of follow-up achieved a moderate-to-major TIS response

NKX019 4B Cells/Dose



4B cells/dose, n =	9	9	6	5	4	1	1

NKX019 1B and 2B Cells/Dose



1B cells/dose, n =	1	1	1	1	1	1	1	1
2B cells/dose, n =	1	1	1	1	1	1	1	0

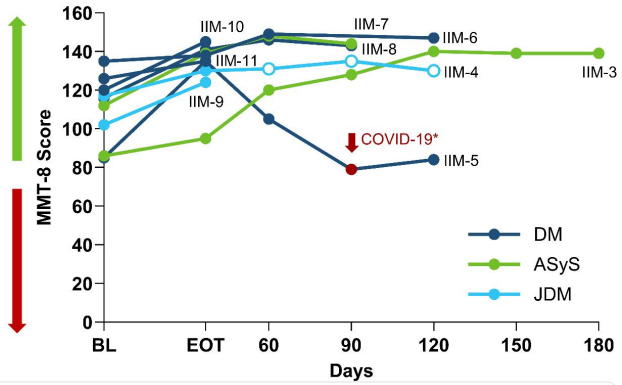
4B responses spanned three subtypes and were more consistent relative to lower doses

Data as of September 18, 2026. TIS was evaluated in patients who received LD preconditioning and 3 doses of NKX019 and had at least 1 post-baseline efficacy-evaluable assessment. Open circles indicate visits where administration of additional immunomodulatory agents (cDMARDs, IVIG, and/or rituximab) may have contributed to clinical efficacy. *IIM-5 diagnosed with COVID-19 infection, followed by a DM flare.

ASyS, antisynthetase syndrome; B, billion; BL, baseline; cDMARD, conventional disease-modifying antirheumatic drug; DM, dermatomyositis; EOT, end of treatment; IIM, idiopathic inflammatory myopathy; IMNM, immune-mediated necrotizing myopathy; IVIG, intravenous immunoglobulin; JDM, juvenile dermatomyositis; LD, lymphodepletion preconditioning; mod, moderate; TIS, Total Improvement Score.

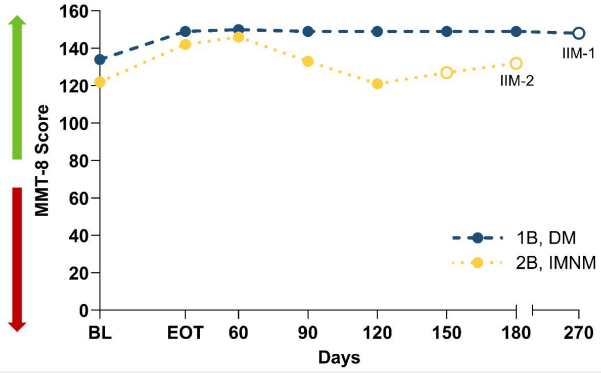
At 4B cells/dose, 5 of 6 IIM patients (83.3%) with ≥3 months of follow-up achieved increases in their MMT-8 score

NKX019 4B Cells/Dose



4B cells/dose, n =	9	9	6	5	4	1	1

NKX019 1B and 2B Cells/Dose



1B cells/dose, n =	1	1	1	1	1	1	1	1
2B cells/dose, n =	1	1	1	1	1	1	1	0

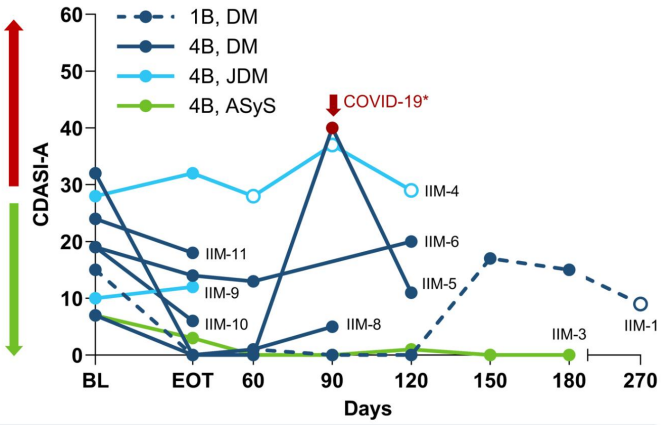
At 4B, strength gains generally appeared early and were maintained across IIM subtypes

Data as of September 18, 2026. MMT-8 was evaluated in patients who received LD preconditioning and 3 doses of NKX019 and had at least 1 post-baseline efficacy-evaluable assessment. Open circles indicate visits where administration of additional immunomodulatory agents (cDMARDs, IVIG, and/or rituximab) may have contributed to clinical efficacy. *IIM-5 diagnosed with COVID-19 infection, followed by a DM flare.

ASyS, antisynthetase syndrome; B, billion; BL, baseline; cDMARD, conventional disease-modifying antirheumatic drug; DM, dermatomyositis; EOT, end of treatment; IIM, idiopathic inflammatory myopathy; IMNM, immune-mediated necrotizing myopathy; IVIG, intravenous immunoglobulin; JDM, juvenile dermatomyositis; LD, lymphodepletion preconditioning; mod, moderate; TIS, Total Improvement Score.

Treatment with NKX019 in myositis led to reductions in CDASI-A

NKX019 1B and 4B Cells/Dose



1B cells/dose, n =	1	1	1	1	1	1	1	1
4B cells/dose, n =	8	8	5	4	4	1	1	0

4 of 8 (50.0%) patients receiving 4B cells/dose achieved clinically relevant reductions in CDASI-A, with 4 patients remaining relatively stable compared to baseline

Data as of September 18, 2026. CDASI-A was evaluated in patients who received LD preconditioning and 3 doses of NKX019 and had at least 1 post-baseline efficacy-evaluable assessment. Open circles indicate visits where administration of additional immunomodulatory agents (cDMARDs, IVIG, and/or rituximab) may have contributed to clinical efficacy. *IIM-5 diagnosed with COVID-19 infection, followed by a DM flare.

ASyS, antisynthetase syndrome; B, billion; BL, baseline; CDASI-A, Cutaneous Dermatomyositis Disease Area and Severity Index Activity Score; cDMARD, conventional disease-modifying antirheumatic drug; DM, dermatomyositis; EOT, end of treatment; IIM, idiopathic inflammatory myopathy; IVIG, intravenous immunoglobulin; JDM, juvenile dermatomyositis; LD, lymphodepletion preconditioning.

Systemic Sclerosis Results



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SSc patients treated with NKX019 had long-standing disease and extensive prior therapy at baseline

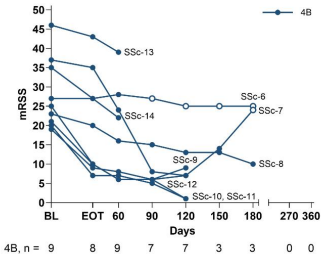
Measure	Overall N = 14	Dose 4B n = 9	2B n = 3	1B n = 2
Age, median (range), years	51.5 (30–66)	52.0 (30–66)	55.0 (51–61)	38.5 (31–46)
Female, n (%)	10 (71.4)	7 (77.8)	1 (33.3)	2 (100.0)
Disease duration,* median (range), years	4.6 (0.5–8.1)	5.3 (0.5–8.1)	2.9 (1.3–2.9)	4.1 (1.8–6.4)
Baseline disease activity, median (range)				
mRSS	26.0 (12.0–46.0)	25.0 (19.0–46.0)	27.0 (18.0–32.0)	23.5 (12.0–35.0)
Number of prior treatments, n (%)				
1–2	5 (35.7)	3 (33.3)	1 (33.3)	1 (50.0)
≥3	9 (64.3)	6 (66.7)	2 (66.7)	1 (50.0)
Prior treatments, n (%)				
Systemic GCs	5 (35.7)	4 (44.4)	1 (33.3)	0
cDMARDs	12 (85.7)	8 (88.9)	3 (100.0)	1 (50.0)
MMF (and derivatives)	9 (64.3)	7 (77.8)	2 (66.7)	0
Rituximab	2 (14.3)	2 (22.2)	0	0
Anti-fibrotics	1 (7.1)	1 (11.1)	0	0
Other	10 (71.4)	6 (66.7)	2 (66.7)	2 (100.0)

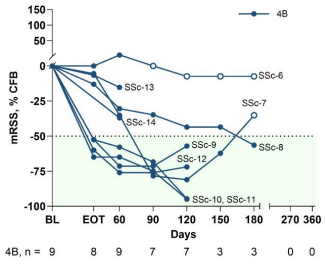
Data as of September 18, 2026. Includes patients who received Fludarabine/Cyclophosphamide LD preconditioning and 3 doses of NKX019 and had at least 1 post-baseline efficacy-evaluable assessment. *From occurrence of the first non–Raynaud phenomenon symptom. At screening prior to LD preconditioning. Other treatments included antimalarials, calcineurin inhibitors, Janus kinase inhibitors, biologics.

B, billion; cDMARD, conventional disease-modifying antirheumatic drug; GC, glucocorticoid; LD, lymphodepletion preconditioning; MMF, mycophenolate mofetil; mRSS, modified Rodnan skin score; SSc, systemic sclerosis.

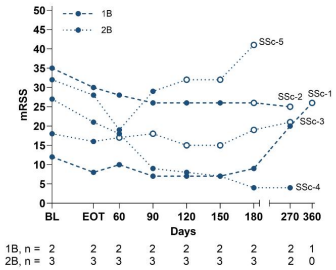
Rapid and deep responses in skin were observed through Day 90 in patients receiving 4B cells/dose

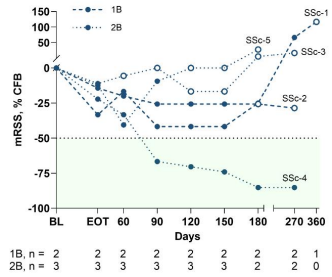
4B Cells/Dose:





1B and 2B Cells/Dose:





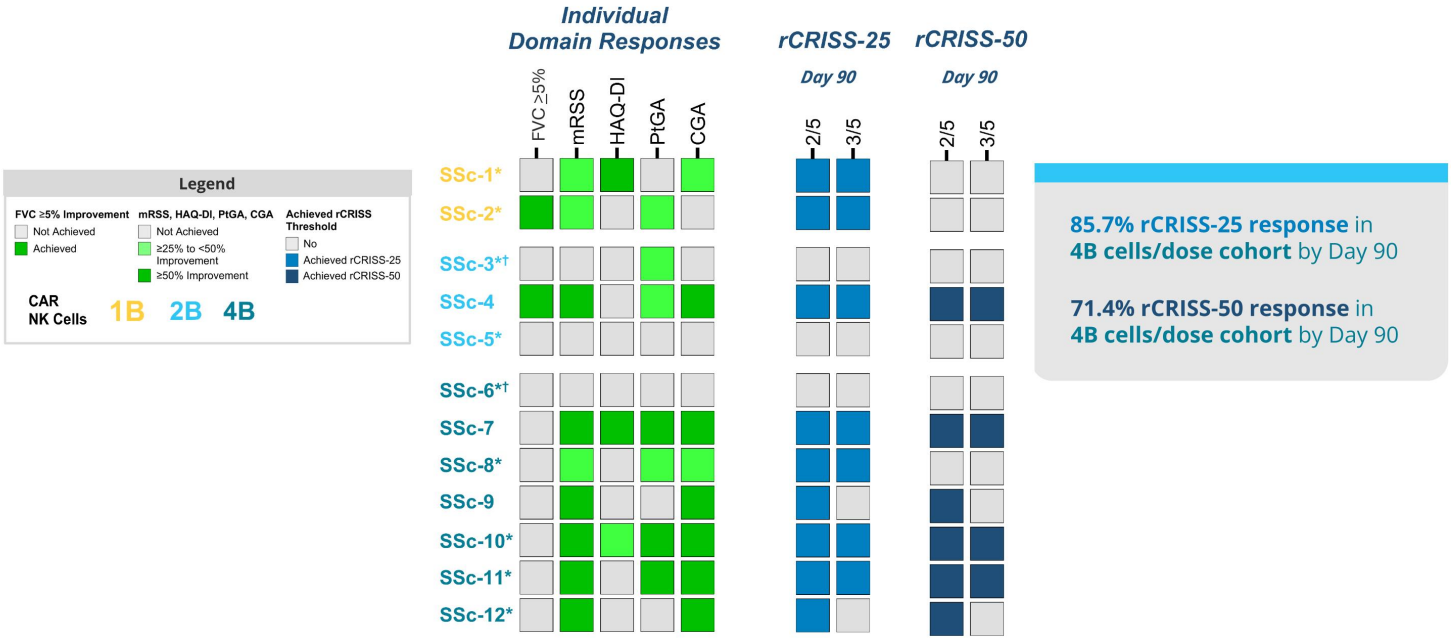
4B cells/dose cohort at Day 90:

- Median reduction in mRSS of 15 points (range, 0–29)
- 6 of 7 (85.7%) patients had a decrease in mRSS
- 5 of 7 (71.4%) patients achieved mRSS-50

Data as of September 18, 2026. Axis breaks were applied as needed for visualization purposes; no data points were excluded. Open circles indicate visits where administration of additional immunomodulatory agents (cDMARDs, IVIG, and/or rituximab) may have contributed to clinical efficacy.

B, billion; BL, baseline; cDMARD, conventional disease-modifying antirheumatic drug; CFB, change from baseline; EOT, end of treatment; IVIG, intravenous immunoglobulin; mRSS, modified Rodnan skin score; SSc, systemic sclerosis.

5 of 7 (71.4%) SSc patients at 4B cells/dose achieved rCRISS-50 by Day 90



85.7% rCRISS-25 response in **4B cells/dose cohort** by Day 90

71.4% rCRISS-50 response in **4B cells/dose cohort** by Day 90

Data as of September 18, 2026. An rCRISS response required improvement in 2 of 5 (2/5) or 3 of 5 (3/5) measures. *Denotes patients with ILD. Indicates visits where administration of additional immunomodulatory agents (cDMARDs, IVIG, and/or rituximab) may have contributed to clinical efficacy.

B, billion; CAR, chimeric antigen receptor; cDMARD, conventional disease-modifying antirheumatic drug; CGA, Clinician Global Assessment; FVC, forced vital capacity; HAQ-DI, Health Assessment Questionnaire Disability Index; ILD, interstitial lung disease; IVIG, intravenous immunoglobulin; mRSS, modified Rodnan skin score; NK, natural killer; PtGA, Patient Global Assessment; rCRISS, revised Composite Response Index in Systemic Sclerosis; SSc, systemic sclerosis.

Translational Data

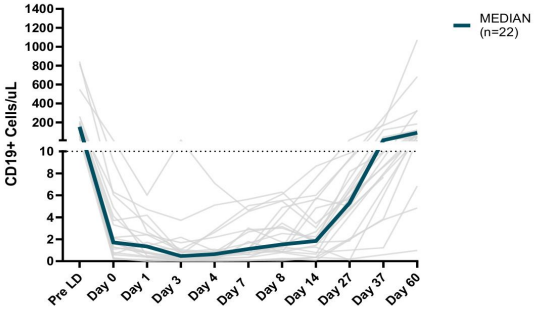


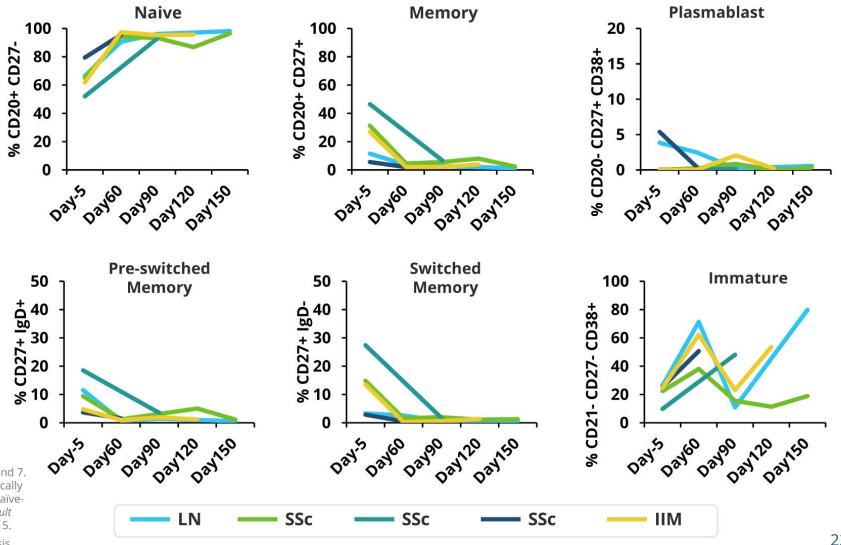
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NKX019 achieved deep B cell depletion at 4B cells/dose, with early evidence of B cell immune reset

B cell nadir reached by Days 3–4, with median B cell counts remaining depleted through Day 27

Early B cell reset in patients with naïve-low baseline in 5 patients





Data as of September 18, 2026. All patients dosed at 4 billion cells per dose on Days 0, 3, and 7. Left panel: gray lines, individual patients; dark line, median (n = 22). Ten cells/μL is the clinically reliable threshold for peripheral B cell depletion and is represented with a dotted line.[1,2] Naïve-low defined as naïve B cells comprising <80% of total B cells at baseline. 1. Revie L, et al. *Mult Scler*. 2025;31(7):813–820; 2. Rodriguez-Mogeda C, et al. *J Neuroinflammation*. 2023;20(1):215.

B, billion; IIM, idiopathic inflammatory myopathy; LN, lupus nephritis; SSc, systemic sclerosis.

Key Takeaways – Clinical and Translational Data

Safety

- NKX019 was well tolerated in 40 patients, with no cases of CRS, ICANS, IEC-HS, or GVHD
- No increase in adverse events at higher doses

Myositis

- 5 of 6 (83.3%) patients receiving 4B cells/dose with ≥3 months of follow-up achieved a moderate-to-major TIS response

Systemic Sclerosis

- 6 of 7 (85.7%) patients receiving 4B cells/dose achieved rCRISS-25 or higher by Day 90
- 5 of 7 (71.4%) patients receiving 4B cells/dose achieved rCRISS-50 or higher by Day 90

Dose Response

- PK exposure increased with dose
- Most consistent clinical responses seen at 4B cells/dose

Translational Data

- Deep B cell depletion, followed by reconstitution with a predominantly naïve B cell profile

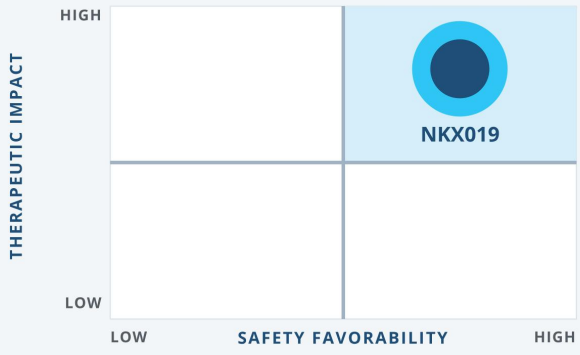
Opportunity & Next Steps



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NKX019: Efficacy and Safety, Made Accessible for Patients and Physicians

ASSESSMENT



OPERATIONAL EASE — Lower · Moderate · High

Therapeutic impact — efficacy, depth of response and durability
Safety — rate and severity of treatment-related toxicity
Operational ease — patient preparation, site of care and follow-up burden

ATTRIBUTES

MEANINGFUL ENDPOINT IMPROVEMENT

Myositis	Systemic Sclerosis
5/6	**5/7**
Moderate-to-major TIS	rCRISS-50 response

In patients with 3 months of follow-up

FAVORABLE SAFETY

No CRS · No ICANS · No IEC-HS · No GVHD

OFF-THE-SHELF

Allogeneic · No apheresis

No wait time — made ahead, ready to ship

CONVENIENT SITE OF CARE

Outpatient

Academic to community

Data as of September 18, 2026. Response, safety and endpoint data at the 4 billion cell dose level, in patients with 3 months of follow-up.

CRS, cytokine release syndrome; GVHD, graft-versus-host disease; ICANS, immune effector cell–associated neurotoxicity syndrome; IEC, immune effector cell; IEC-HS, IEC-associated hemophagocytic lymphohistiocytosis-like syndrome; rCRISS, revised Composite Response Index in Systemic Sclerosis; TIS, Total Improvement Score.

U.S. market opportunity: patient population



Preliminary and unrisked market sizing for discussion, assuming approval in both indications; not guidance or a revenue forecast. Prevalence, US: myositis 70,000–85,000 (Smoyer-Tomic, BMC Musculoskelet Disord 2012;13:103); SSc ~88,000 (Fan, J Manag Care Spec Pharm 2020;26(12):1539–1547). Refractory counts (a subset of prevalence) apply primary research shares (10 US rheumatologists, September 2026): 70% of myositis and 60% of SSc prevalence in pursued subtypes; 25–35% fail glucocorticoids, then 30–60% fail the next advanced therapy.

ILD, interstitial lung disease; SSc, systemic sclerosis.

Key near-term catalysts and financial position

Focus on advancing NKX019 in myositis and systemic sclerosis

Expected Key Catalysts

- **Upcoming FDA interactions** to discuss the registrational path in myositis and systemic sclerosis
- **1H 2027:** Additional follow-up in myositis and systemic sclerosis
- **1H 2027:** Plan for registrational dose (4B vs 6B cell dose)

Financial Position

- **$216 million** cash, cash equivalents and investments as of Sep. 30, 2026
- **Expected cash runway into 2029** based on the current operating plan

Summary and Q&A



Paul Hastings
Chief Executive Officer



Nadir Mahmood, PhD
President



Shawn Rose, MD, PhD
Chief Medical Officer and Head of R&D



Guillermo Valenzuela, MD, FACR
Medical Director, Integral Rheumatology and Immunology Specialists

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