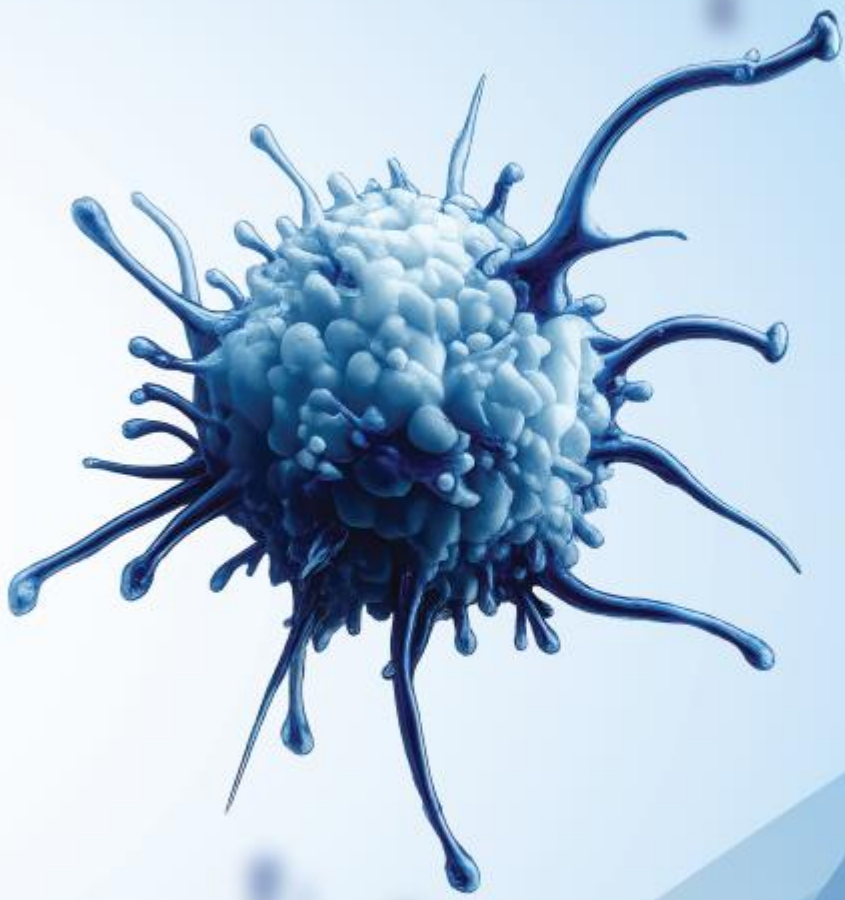
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NKX019 in Autoimmune Disease

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.

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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**

Advantages of NKX019

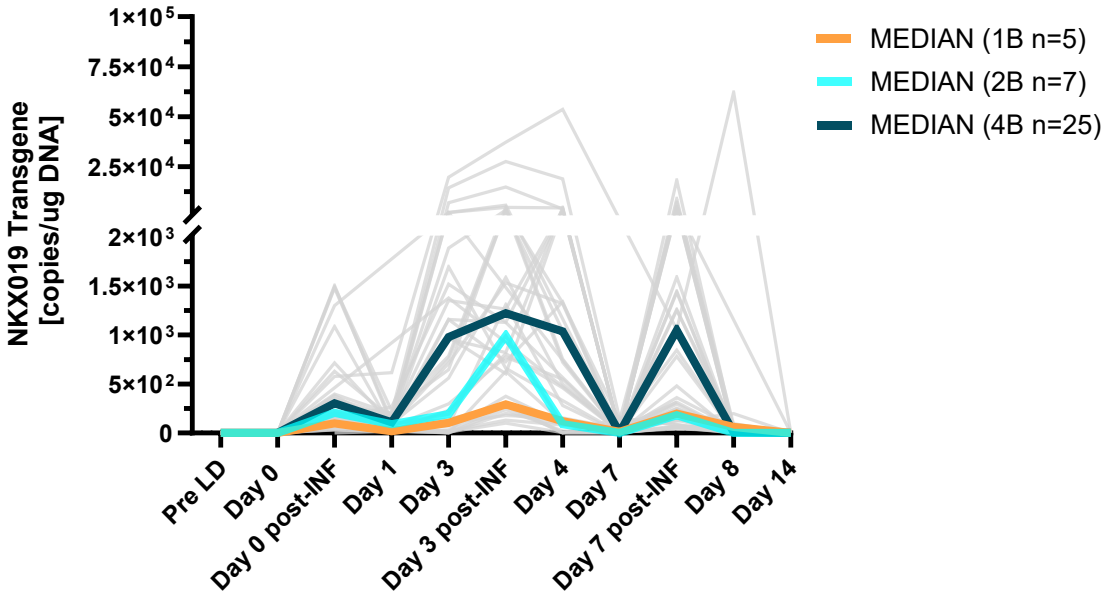
An Off-the-Shelf, On-Demand, Allogeneic, CD19-Targeting CAR NK Cell Therapy

- 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

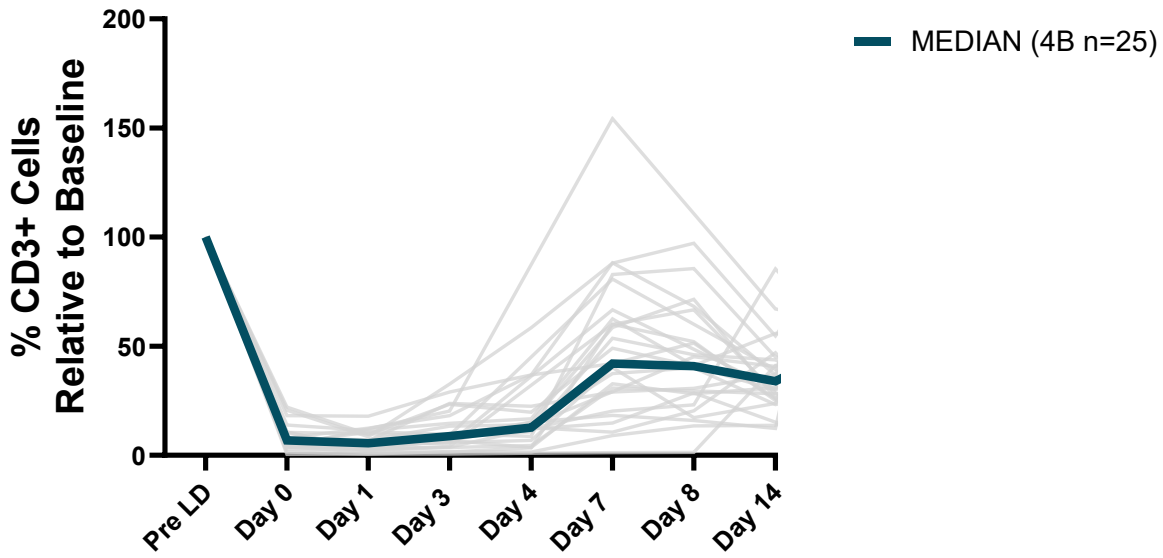
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Dose-dependent exposure, plus an opportunity to enhance activity with a compressed schedule

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

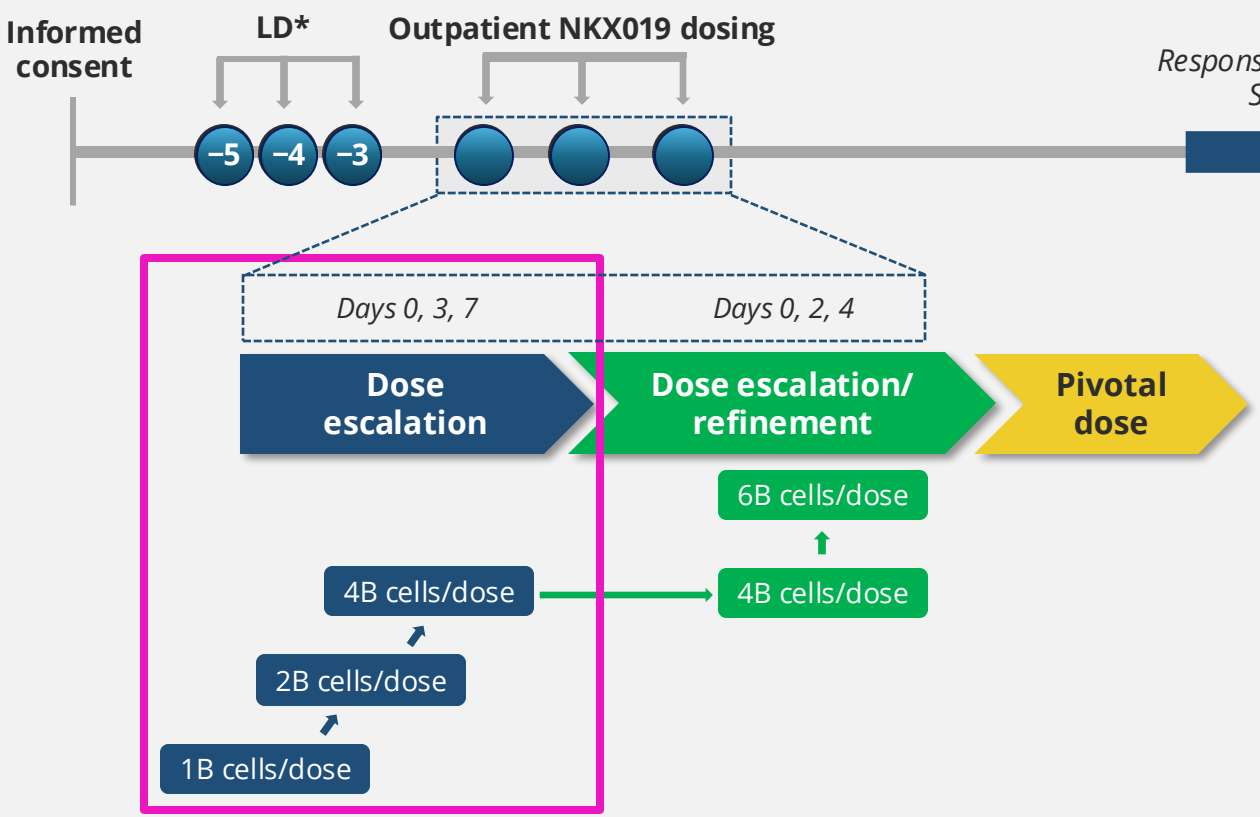
Data as of September 18, 2026. All patients received lymphodepletion (LD) preconditioning with fludarabine/cyclophosphamide (Flu/Cy) and NKX019 infusions on Days 0, 3, and 7. Gray lines show individual patients; colored and dark lines show medians for the 3 dose cohorts. Left: NKX019 transgene in peripheral blood by droplet digital polymerase chain reaction (ddPCR); the y-axis is broken at 2×10³. 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/m^2 Flu as 30 mg/m^2/day on Days –5, –4, and –3 and 1 g/m^2/day Cy on Day –3. Patients with cytopenia may receive Cy alone as 1 g/m^2 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

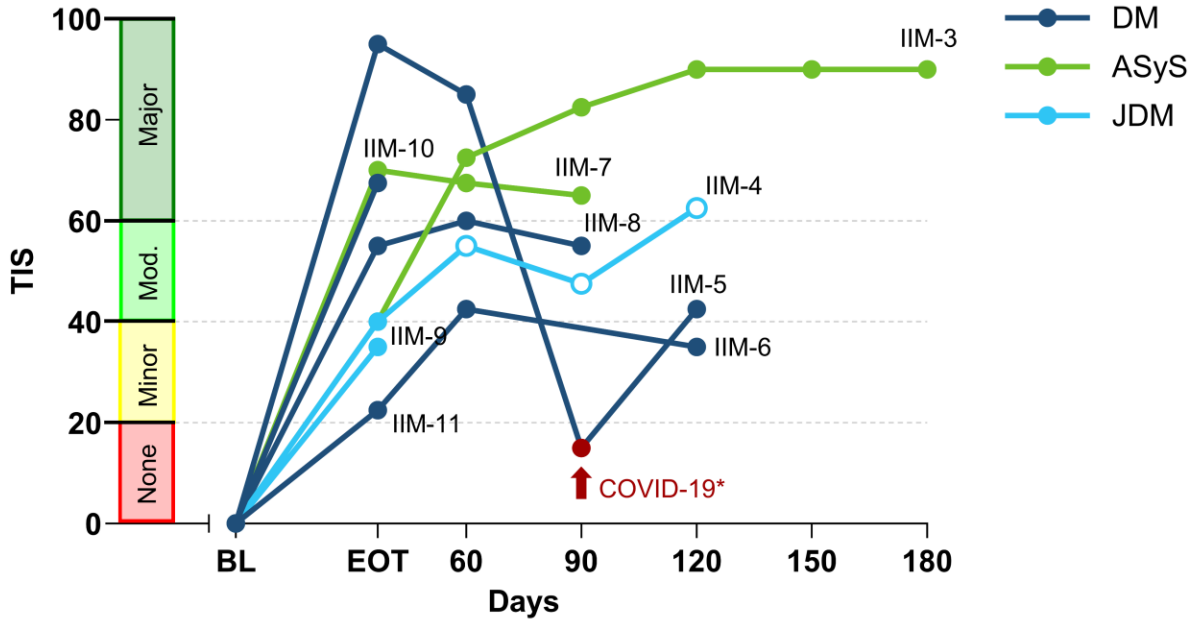
Measure	Overall N = 11	Disease Subtype		
		DM / JDM n = 6 / n = 2	ASyS n = 2	IMNM n = 1
Age, median (range), years	46.0 (19–63)	47.5 (19–63)	40.5 (22–59)	28
Female, n (%)	11 (100)	8 (100)	2 (100)	1 (100)
Disease duration, median (range), years	3.5 (0.3–30.3)	4.1 (1.3–30.3)	1.1 (0.3–1.9)	8.7
Baseline 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.

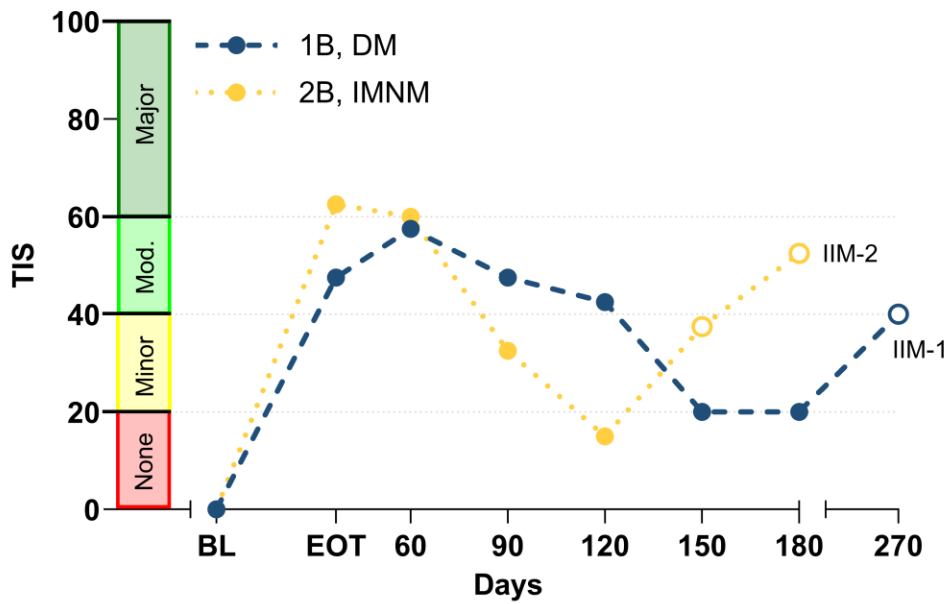
At 4B cells/dose, 5 of 6 IIM patients (83.3%) with ≥3 months of follow-up achieved a moderate-to-major TIS response

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

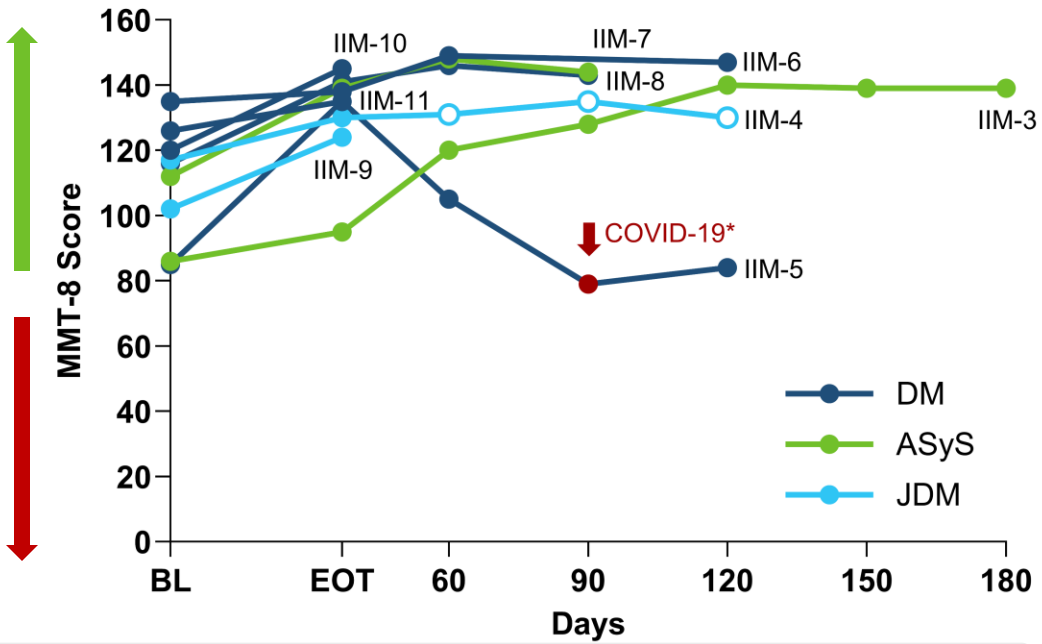
Data as of September 18, 2026. TIS was evaluated in patients who received LD preconditioning and 3 doses of NKX019 and had at least 1 post-baseline efficacy-evaluable assessment. Open circles indicate visits where administration of additional immunomodulatory agents (cDMARDs, IVIG, and/or rituximab) 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.

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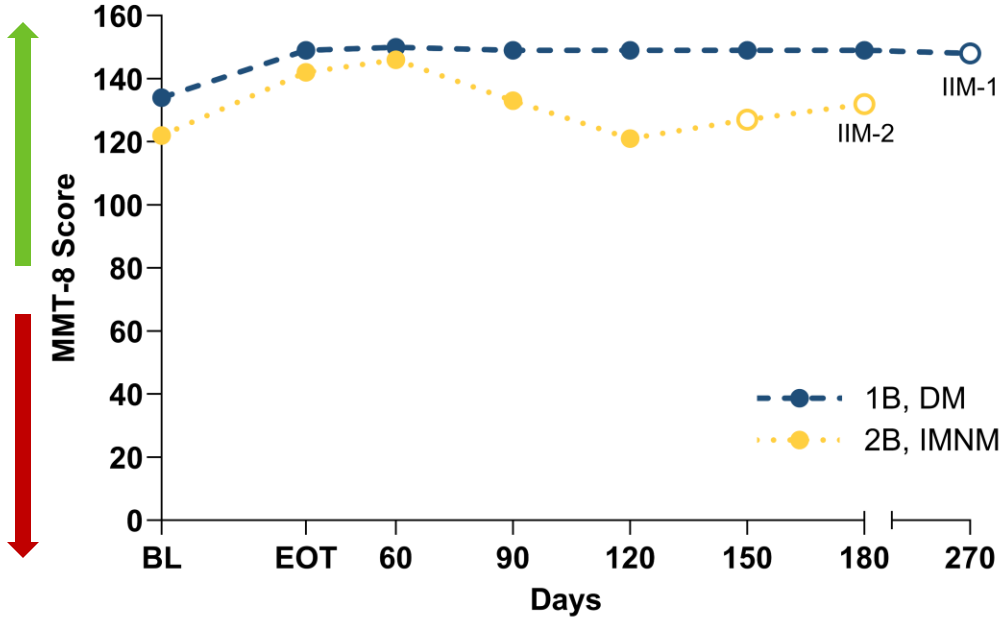
At 4B cells/dose, 5 of 6 IIM patients (83.3%) with ≥3 months of follow-up achieved increases in their MMT-8 score

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

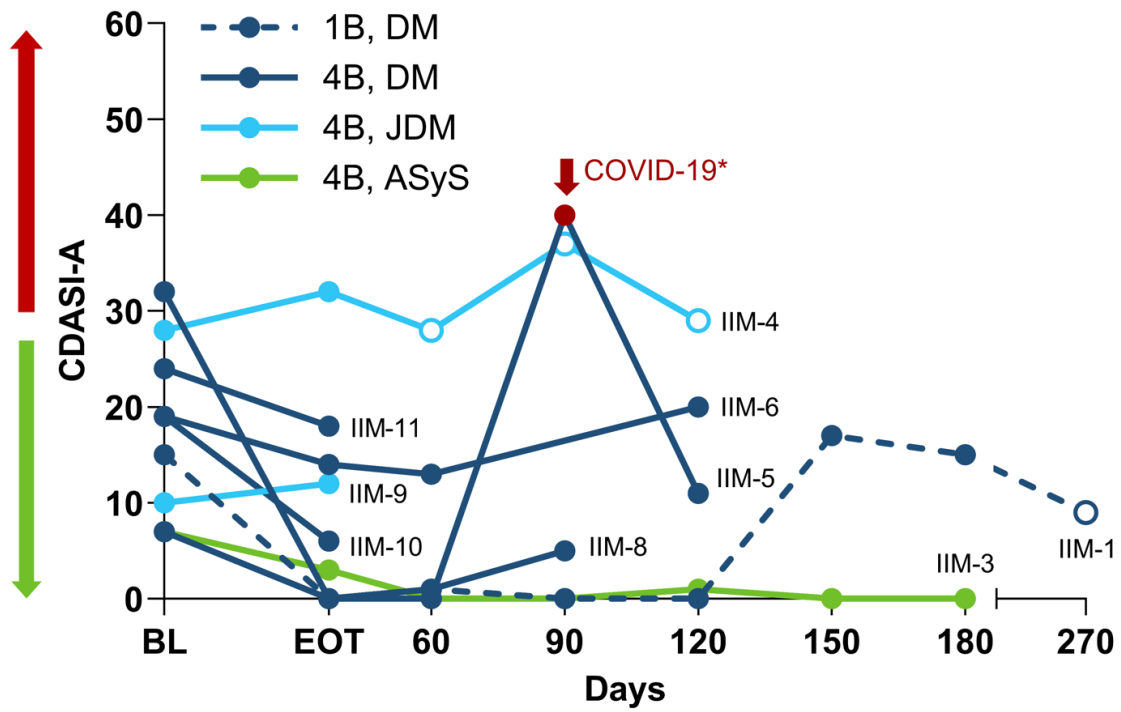
At 4B, strength gains generally appeared early and were maintained across IIM subtypes

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

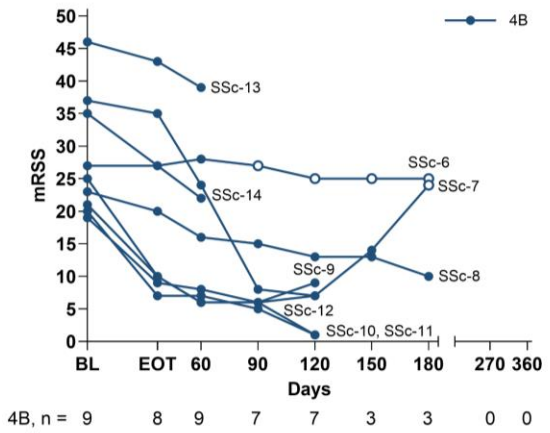
Measure	Overall N = 14	Dose 4B n = 9	Dose 2B n = 3	Dose 1B n = 2
Age, median (range), years	51.5 (30–66)	52.0 (30–66)	55.0 (51–61)	38.5 (31–46)
Female, n (%)	10 (71.4)	7 (77.8)	1 (33.3)	2 (100.0)
Disease duration,* median (range), years	4.6 (0.5–8.1)	5.3 (0.5–8.1)	2.9 (1.3–2.9)	4.1 (1.8–6.4)
Baseline 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)

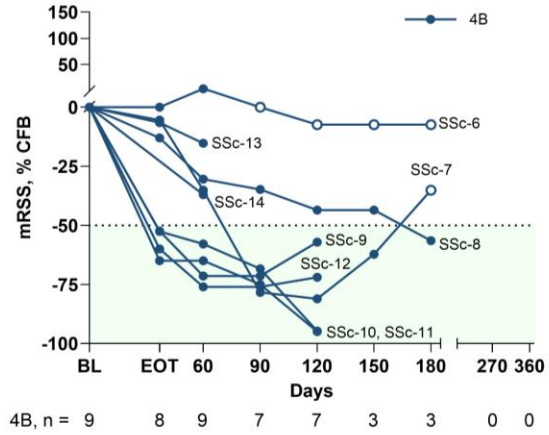
Data as of September 18, 2026. Includes patients who received Fludarabine/Cyclophosphamide LD preconditioning and 3 doses of NKX019 and had at least 1 post-baseline efficacy-evaluable assessment. *From occurrence of the first non–Raynaud phenomenon symptom. †At screening prior to LD preconditioning.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

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

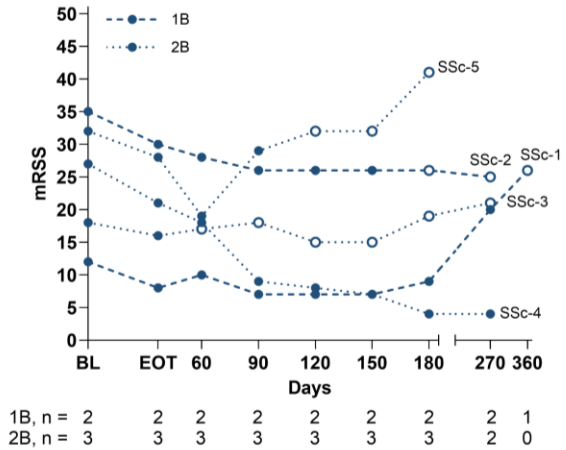
Rapid and deep responses in skin were observed through Day 90 in patients receiving 4B cells/dose

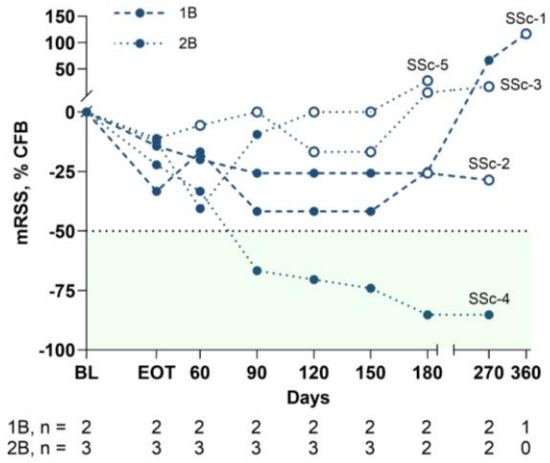
4B Cells/Dose:





1B and 2B Cells/Dose:





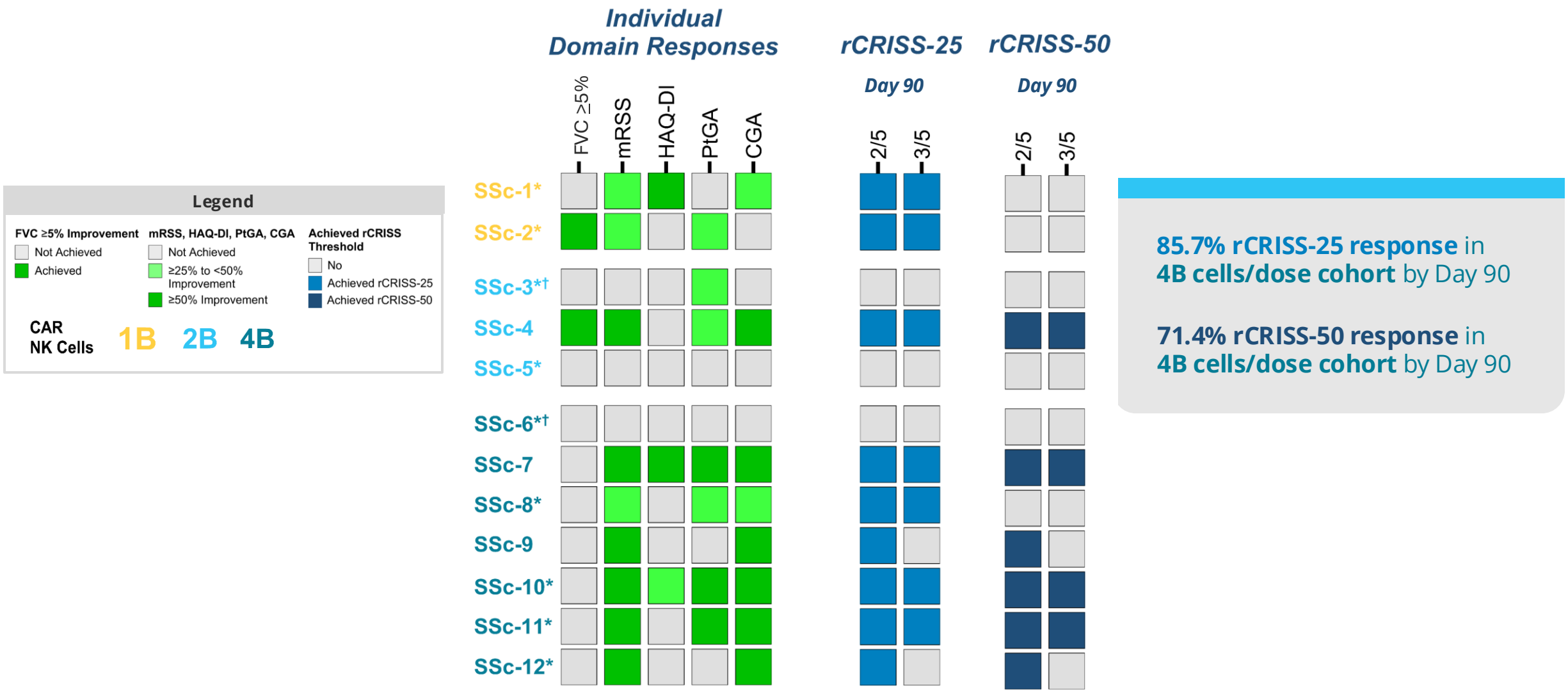
4B cells/dose cohort at Day 90:

- 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.

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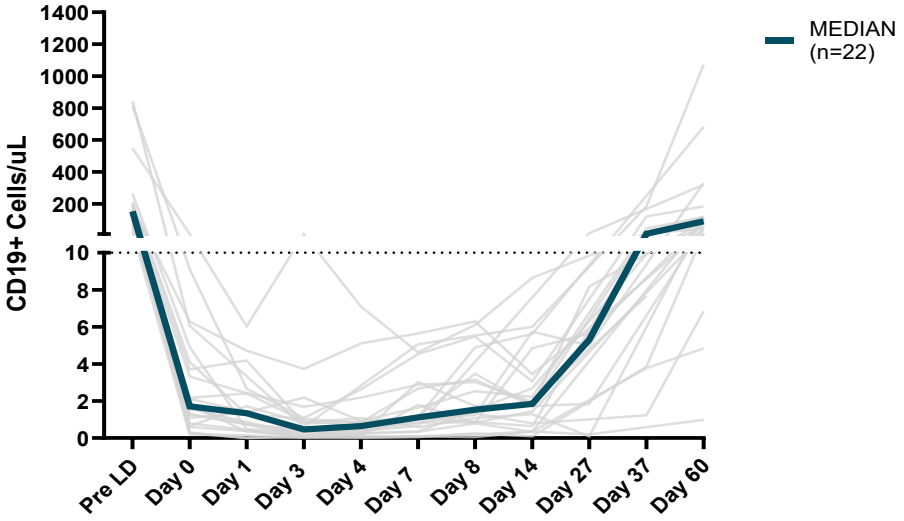
Translational Data



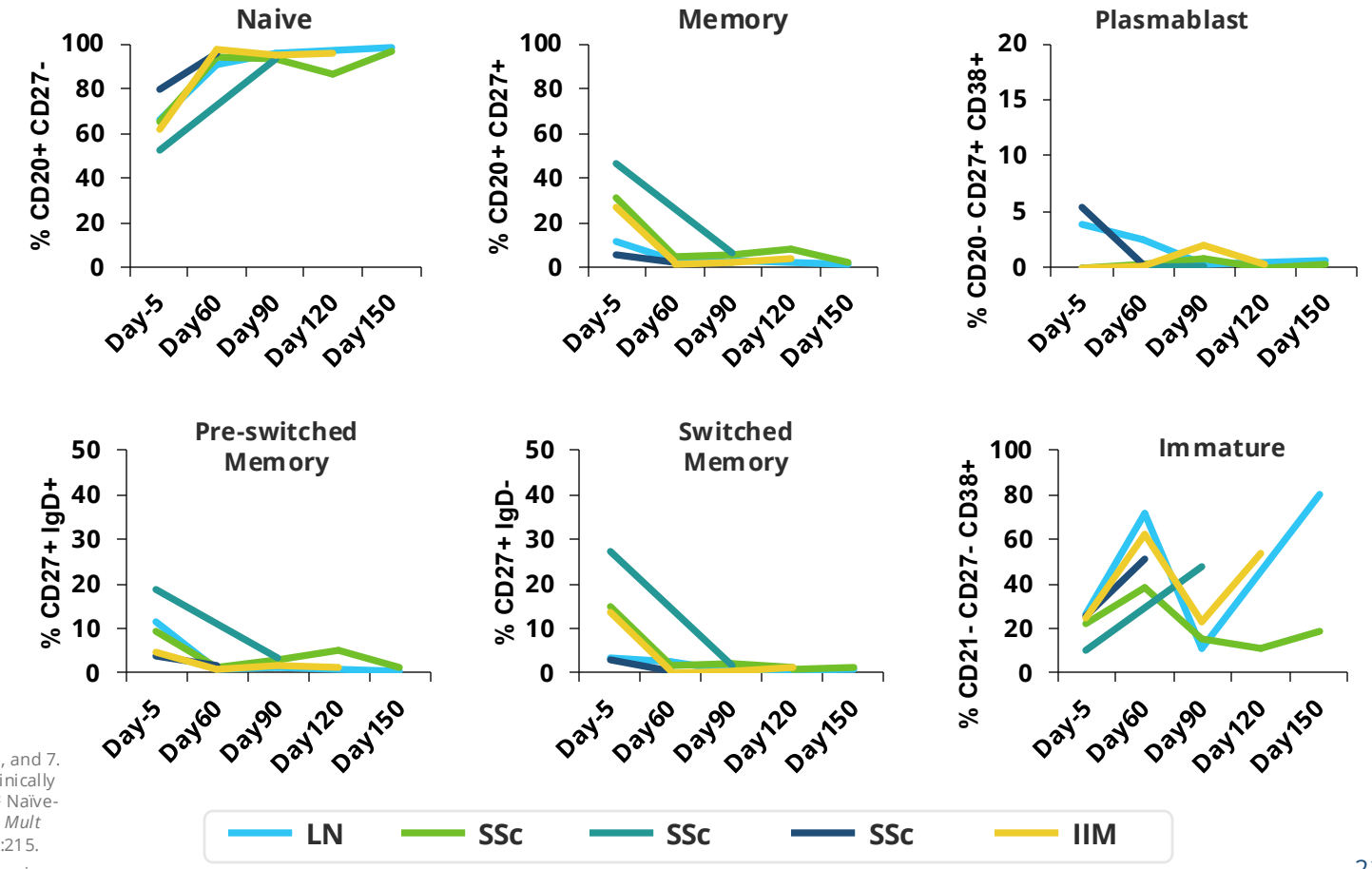
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NKX019 achieved deep B cell depletion at 4B cells/dose, with early evidence of B cell immune reset

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

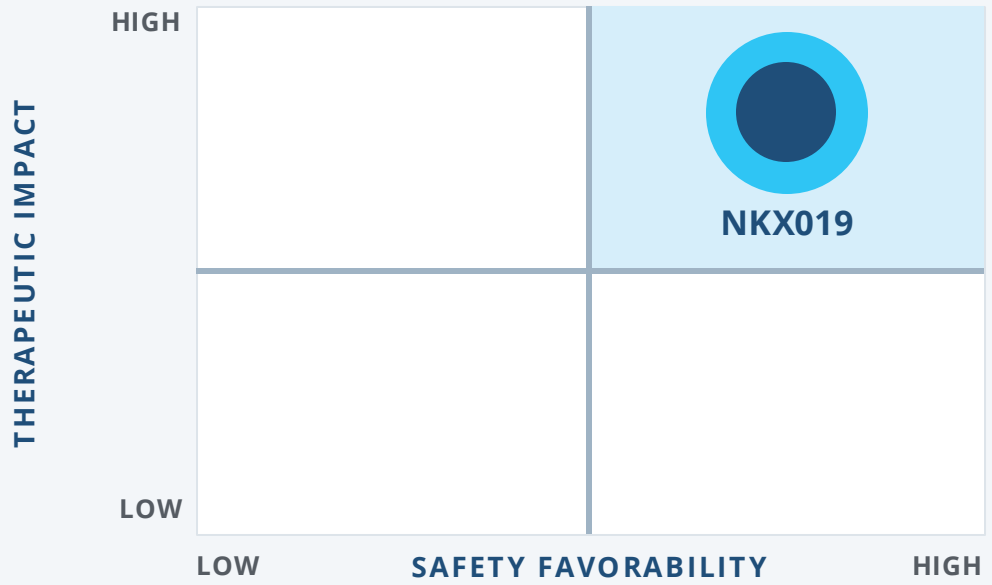
Opportunity & Next Steps



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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

5/6
Moderate-to-major TIS

Systemic Sclerosis

5/7
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

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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