CRISPR Corporate Update

Q1 Corporate Update

February 12, 2026

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This presentation also contains information regarding our industry, our business and the markets for certain of our product candidates, including data regarding the estimated size of those markets, and the incidence and prevalence of certain medical conditions. Unless otherwise expressly stated, we obtained this industry, business, market and other data from market research firms and other third parties, including medical publications, government data and similar sources. Information that is based on estimates, forecasts, projections, market research or similar methodologies is inherently subject to uncertainties and actual events or circumstances may differ materially from events and circumstances reflected in this information.

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Executing Our Vision Across Four Therapeutic Franchises

Our vision is to develop cures for people suffering from serious diseases through transformative gene-based medicines

	Heme	*In Vivo*	CAR-T	Regen Med
Commercial / Clinical Assets	• **CASGEVY®**, with multi-billion peak revenue potential (40% share for CRISPR) • Addressable population: pediatric expansion and gentler conditioning agents	• Transformative Phase 1 data for **CTX310™** published in NEJM in November 2025 • Best-in-class siRNA **(CTX611™)** targeting FXI achieved >93% peak reduction in FXI activity with Q6M dosing	• Best-in-class allogeneic CAR-T with **zugo-cel™** • 70% CR rate in DLBCL and encouraging data in autoimmune indications (SLE and Myositis)	• Allogeneic beta-cell replacement therapy for diabetes • Proof-of-concept clinical data with CTX211™
Preclinical Assets / Platform	• Best-in-class NHP results for ***in vivo* HSC editing**	• Additional clinical candidates in CV for Lp(a), AGT • Expansion into rare diseases with SyNTase™ editing and leading LNP platform	• Best-in-class NHP results for ***in vivo* CAR-T** (both transient and permanent CAR-Ts)	• Advancing CTX213 as potential best-in-class islet cell therapy for Type 1 diabetes

CV: Cardiovascular; Lp(a): Lipoprotein a; AGT: Angiotensinogen; Zugo-cel: Zugocabtagene geleucel; DLBCL: Diffuse Large B Cell Lymphoma; SLE: Systemic Lupus Erythematosus; Regen Med: Regenerative Medicine

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Broad & Diversified Pipeline

	Program	Disease(s)	Research	IND-Enabling	Clinical	Approved	Partner
Heme	CASGEVY[1]	SCD and TDT	●	●	●	●	VERTEX
Heme	*In Vivo* HSC editing[2]	SCD, TDT, and others	●	○	○	○	VERTEX
CAR-T I/O & Autoimmune	Zugocabtagene geleucel Anti-CD19 allogeneic CAR-T	Autoimmune: SLE, SSc, IIM, ITP, WAIHA Oncology: B cell malignancies	●	●	●	○	
CAR-T I/O & Autoimmune	*In Vivo* CAR-T	Autoimmune and Oncology indications	●	○	○	○	
In Vivo Cardiovascular & Rare Diseases	CTX310: ANGPTL3	sHTG, HeFH, HoFH, Mixed dyslipidemias	●	●	●	○	
In Vivo Cardiovascular & Rare Diseases	CTX611: FXI	Thromboembolic conditions	●	●	●	○	Sirius Therapeutics
In Vivo Cardiovascular & Rare Diseases	CTX321: LPA	ASCVD with elevated Lp(a)	●	●	○	○	
In Vivo Cardiovascular & Rare Diseases	CTX340: AGT	Refractory hypertension	●	●	○	○	
In Vivo Cardiovascular & Rare Diseases	CTX460: SERPINA1	Alpha-1 Antitrypsin Disorder	●	●	○	○	
Regen Med	CTX213	Type I Diabetes Mellitus	●	○	○	○	
Other Disclo-sed	Licensed Programs: DMD, DM1, CF		●	○	○	○	VERTEX

SCD: Severe sickle cell disease; TDT: Transfusion-dependent β-thalassemia; HeFH: Heterozygous familial hypercholesterolemia; HoFH: Homozygous familial hypercholesterolemia; sHTG: Severe hypertriglyceridemia; SLE: Systemic lupus erythematosus; IIM: Idiopathic inflammatory myopathies; ITP: Immune Thrombocytopenic Purpura; WAIHA: Warm Autoimmune Hemolytic Anemia; DMD: Duchenne's muscular dystrophy; DM1: Myotonic dystrophy type I; CF: Cystic Fibrosis; SSc: Systemic sclerosis; RegenMed: Regenerative Medicine

1. Currently approved in some countries for certain eligible patients with SCD or TDT (40-60 cost / profit split); 2. Collaboration with Vertex for applications in SCD and TDT (50-50 cost / profit split)

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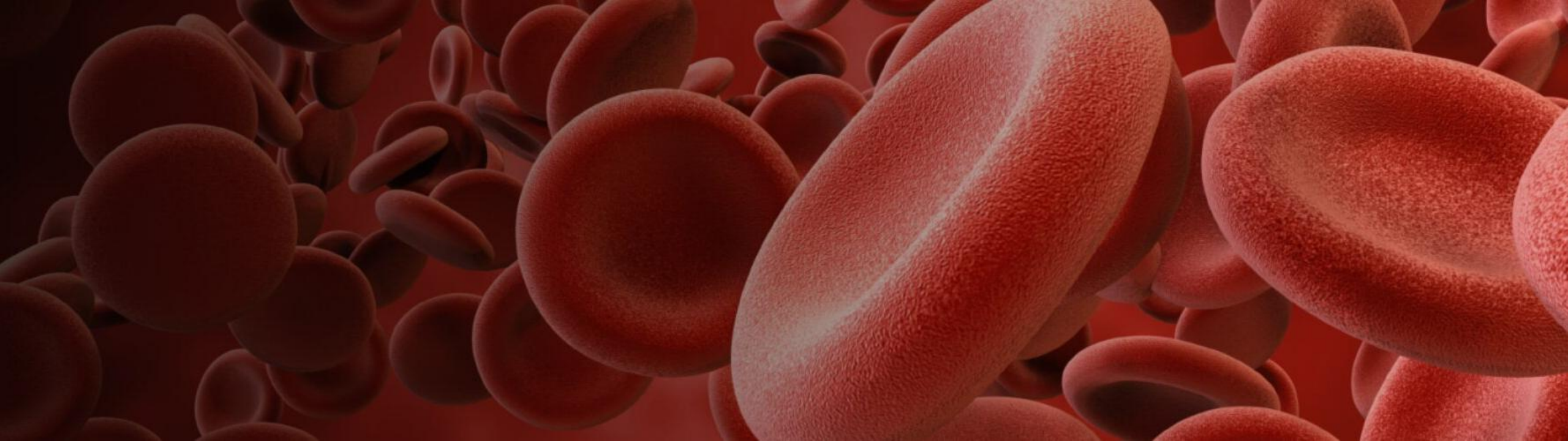


Hemoglobinopathies

CASGEVY: Acceleration Towards Multi-$B Potential

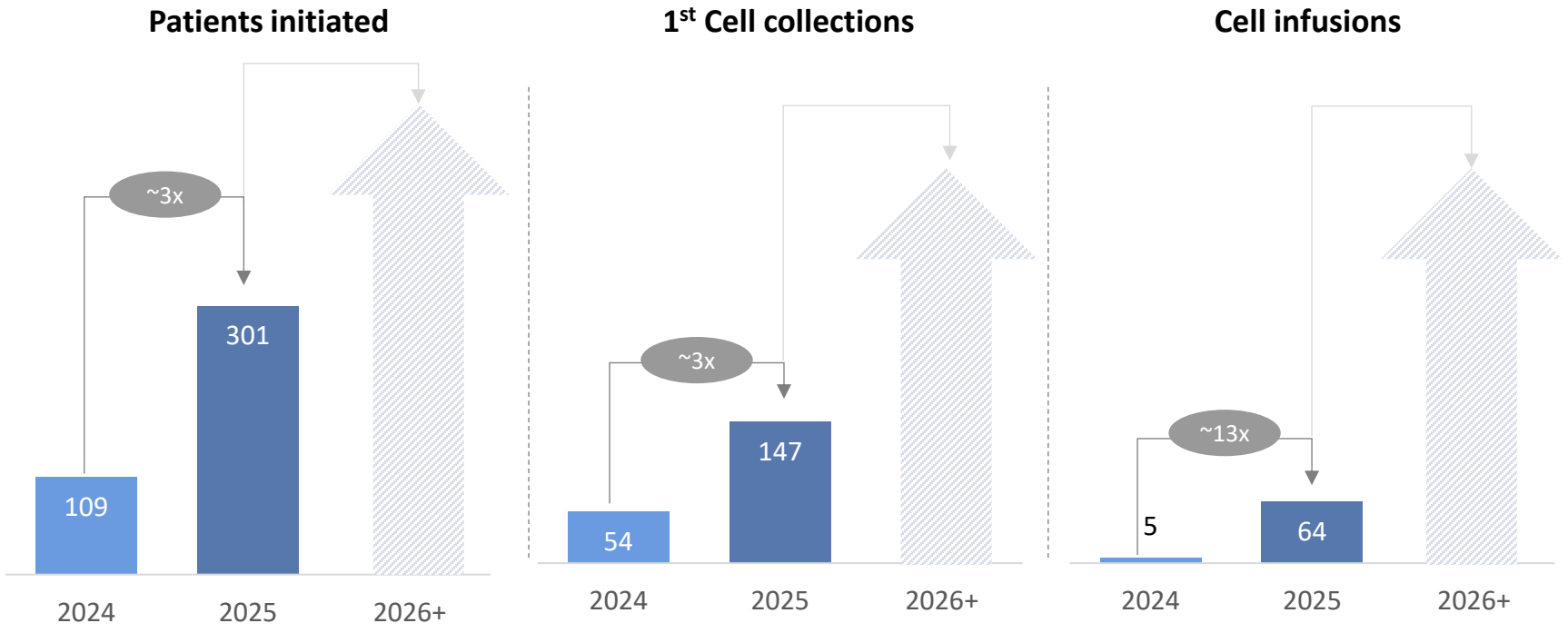
casgevy (exagamglogene autotemcel) suspension for IV infusion

CRISPR THERAPEUTICS

Key Highlights

- Accelerating patient infusions via global ATC network
- Broad coverage:
  - ~90% Medicaid / Commercial in U.S.
  - Access in 12 additional countries
- Transformative outcomes
  - +31 yrs survival in SCD
  - +18 yrs survival in TDT
  - >90% projected reduction in lifetime VOCs and RBCRs

Approved[1] in 10 Countries[2]; At least 1 ATC in each region has initiated 20+ patients



CASGEVY has delivered $116 million in 2025 revenue, with infusions occurring in all regions for both sickle cell and beta thalassemia

1. Approved by the US FDA for treatment of patients aged 12 years and older with sickle cell disease (SCD) with recurrent vaso-occlusive crises (VOCs) and transfusion-dependent ß-thalassemia (TDT) Granted conditional marketing authorization by the UK MHRA and Bahrain NHRA for patients 12 years of age and older with SCD and recurrent VOCs or TDT, for whom hematopoietic stem cell transplantation is appropriate and a human leukocyte antigen–matched related donor is not available. CASGEVY has also been approved in other countries for certain eligible patients with SCD or TDT; 2. Including US, UK, EU, Kingdom of Saudi Arabia (KSA), Bahrain, Qatar, Kuwait, Canada, Switzerland, and United Arab Emirates (UAE)

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Continue to Build on the Momentum for CASGEVY in 2026

Potential expansion into pediatric severe SCD and TDT patients

Data presented at ASH 25, from pivotal studies in children ages 5-11, demonstrated the transformative potential of the therapy in younger patients:

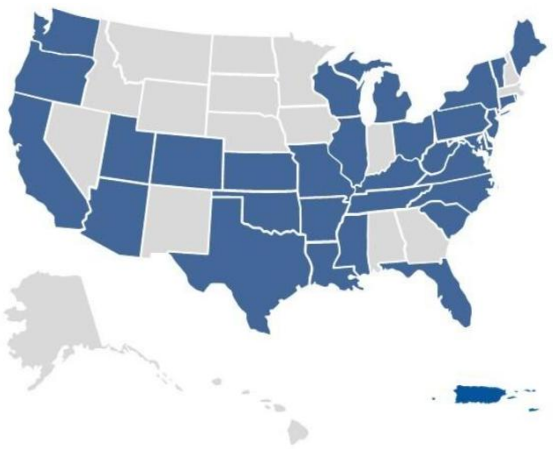
100% *(4/4) SCD children with sufficient follow-up achieved the primary endpoint of being free from vaso-occlusive crises (VOCs) for at least 12 consecutive months (VF12)*

100% *(6/6) patients with sufficient follow-up achieved the primary endpoint of transfusion independence for at least 12 consecutive months while maintaining a weighted average hemoglobin (Hb) of at least 9 g/dL (TI12)*

CASGEVY included on list of programs eligible for FDA's CNPV program

FDA NEWS RELEASE
FDA Awards Second Batch of National Priority Vouchers

CMMI pilot program to include 84% of Medicaid beneficiaries with SCD



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- VT*
- WI
- WV
- VA
- WA

* Participating States also receiving CGT Access Model Cooperative Agreement funding

Source: Centers for Medicare & Medicaid Services

Regulatory submissions for CASGEVY[1] in children 5-11 years old expected in 1H 2026

SCD: Sickle cell Disease; TDT: Transfusion-dependent beta thalassemia; CNPV: Commissioner's National Priority Voucher, CMMI: Center for Medicare and Medicaid Innovation
1. Vertex leads development, regulatory filings, manufacturing, and commercialization

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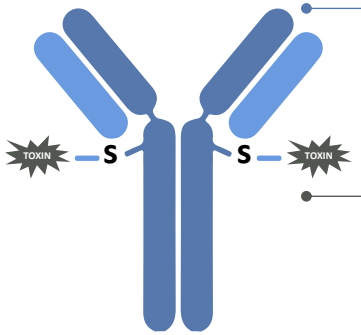
Serial Innovation in Enabling Technologies Will Broaden Access

Targeted Conditioning

Antibody–drug conjugate (ADC) for specific depletion of hematopoietic stem cells (HSCs) with no off-target or bystander toxicity



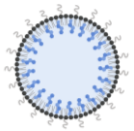
Proprietary **GMP monoclonal antibody** with **short half-life** to enable rapid infusion of edited cells

Validated **GMP toxin** with HSC activity and **reduced hydrophobicity** to limit non-target cell toxicity

Studies in non-human primates (NHP) ongoing

150k+ addressable patients worldwide

In Vivo Editing of HSCs

Delivery	Editing
	

Creating optimized system for *In Vivo* HSC editing with ideal characteristics

- Tolerable doses with no off-target toxicities
- Editing of LT-HSCs for durable effect vs. HSPCs only
- Potential for redosing for enhanced editing

Core research focus in 2026

400k+ addressable patients worldwide

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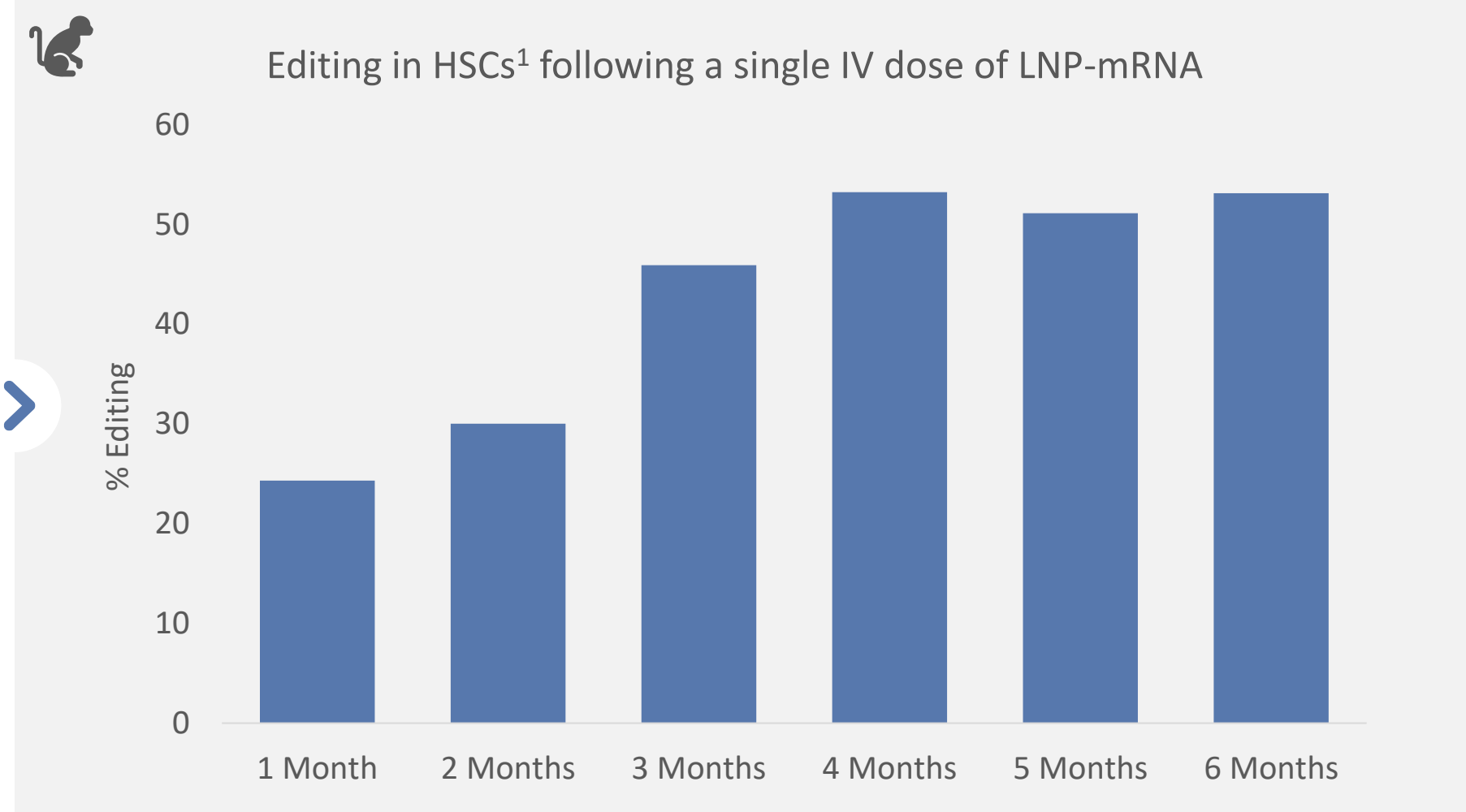
In Vivo Editing: Achieved >50% Editing in HSCs, Durable >6 months After a Single Dose in NHPs

CRISPR THERAPEUTICS

In Vivo HSC Editing Platform

- Proprietary antibody-conjugated LNP delivery systems for *in vivo* HSC editing
- NHP studies provide platform validation
- Potential applications in SCD, TDT and other indications - a core focus for 2026



HSCs: Hematopoietic Stem Cells; IV: Intravenous
1. Sorted as Lineage negative, CD34+ CD90+ HSPCs

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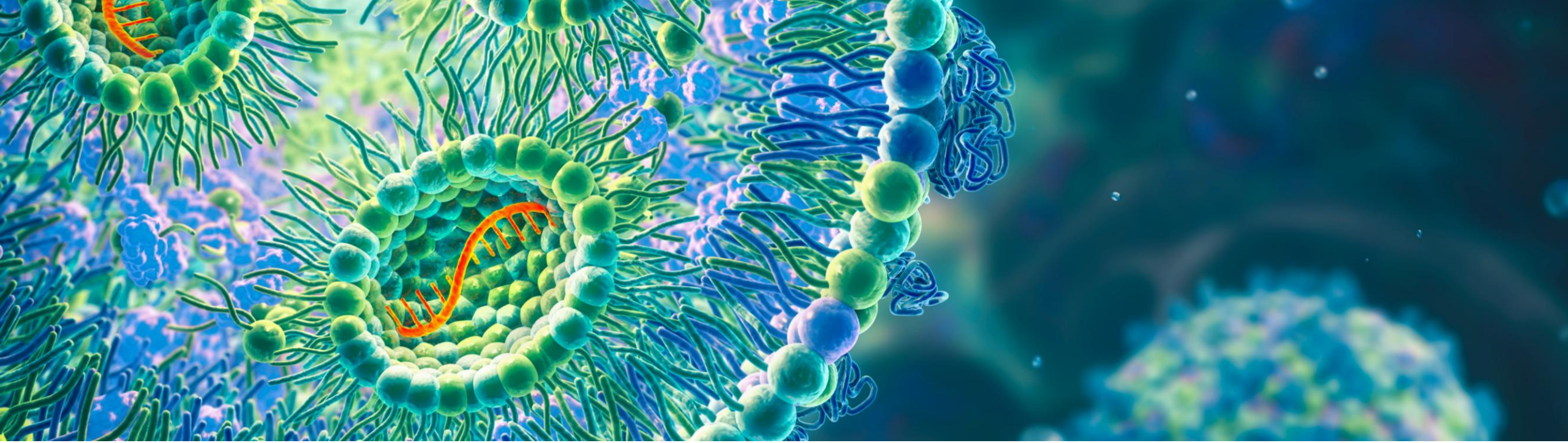

In Vivo

Transformative Data with Our First *In Vivo* Program – CTX310

~50% mean LDL and ~55% mean triglyceride reductions with well-tolerated safety profile in Phase I basket study for CTX310 targeting ANGPTL3

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Phase 1 Trial of CRISPR-Cas9 Gene Editing Targeting ANGPTL3

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NBC NEWS

Harmful cholesterol levels cut in half with one-time gene editing drug in early trial

One dose of an experimental drug cover offer lifetime treatment for people with high cholesterol, but its long-term safety is uncertain.

npr

HEALTH

CRISPR gene-editing works to reduce high cholesterol in a new study

NOVEMBER 8, 2025 · 9:58 AM ET

ENDPOINTS NEWS

CRISPR Therapeutics' gene editing therapy halves cholesterol and triglycerides in early trial

Paradigm changing – Potential to disrupt the chronic care model with a "one and done" solution

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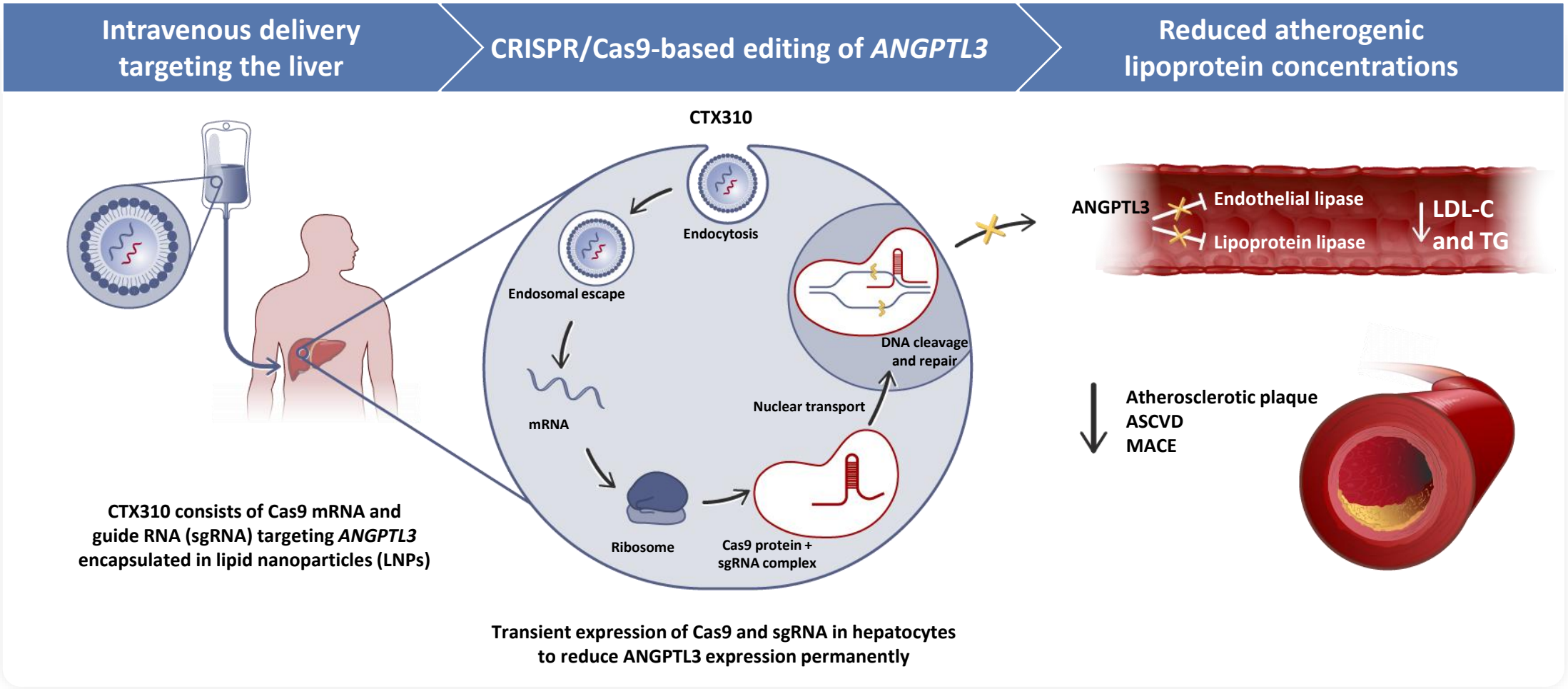
CTX310: CRISPR-Cas9 Editing of ANGPTL3



ANGPTL3 Associated with Low Lipids and Low CV Risk

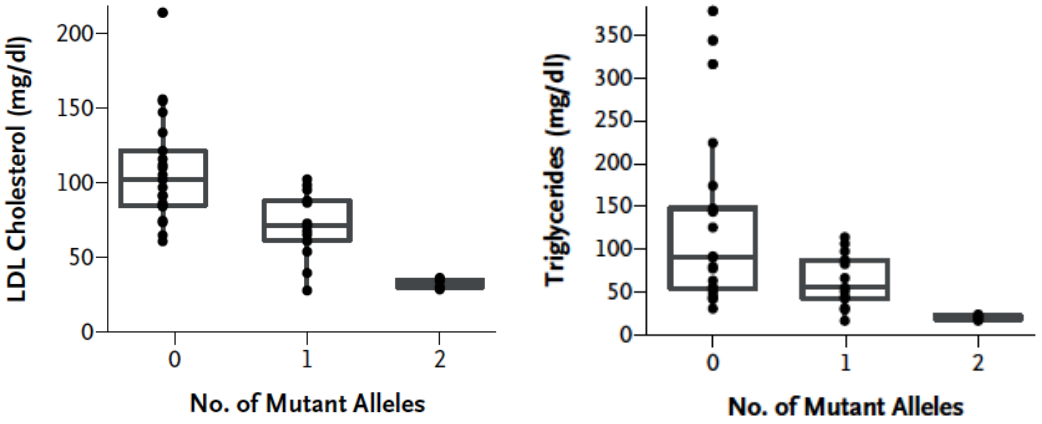
Human Genetic Proof-Of-Concept Demonstrating Protective Effect of ANGPTL3 Loss-of-Function Variants

Study 1: "The Long-Lived Village"

- Residents of Campodimele, Italy are generally known to live past 90 years, prompting exploratory genetic studies
- A significant proportion of people living in Campodimele demonstrated **reduction of serum lipoproteins**, stemming from LoF ANGPTL3 variants[1]

Study 2: Familial Hypolipidemia

- Nonsense mutations in ANGPTL3 gene shown to reduce LDL and TG in separate study[2]
- LoF in both alleles result in greater reduction of LDL and TG compared to mutations in single allele



Note: [1] J. Clin. Endocrinol. Metab. 2012;97(7):E1266–E1275, [2] N Engl J Med 2010;363:2220-7.

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Phase I Study Evaluating the Safety and Efficacy of CTX310

Open-label, multicenter, Phase Ia/Ib study evaluating the safety and efficacy of CTX310 in homozygous familial hypercholesterolemia (HoFH), heterozygous familial hypercholesterolemia (HeFH), severe hypertriglyceridemia (sHTG), or mixed dyslipidemias

Phase Ia: Single ascending dose escalation to identify optimal biological dose

- DL4 – 0.8mg/kg
- DL3 – 0.6mg/kg
- DL2 – 0.3mg/kg
- DL1 – 0.1mg/kg

Key eligibility criteria

- Age ≥18-75 years
- TG (>300 mg/dL) and/or LDL-C (>100 mg/dL); >70 mg/dL for subjects with ASCVD
- No significant comorbidities

Key Objectives/Endpoints

- Safety and Tolerability
- Preliminary efficacy including changes in ANGPTL3, LDL, TG and ApoB compared to baseline
- Pharmacokinetics

Phase Ib

- Patients with refractory hypercholesterolemia and or hypertriglyceridemia
- Phase Ib dose informed by Phase Ia

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CTX310 Baseline Participant Characteristics

	All participants (n=15)
Median Age	53 years
Male	87%
Clinical ASCVD	40%
Familial hypercholesterolemia	40%
Severe hypertriglyceridemia	13%
Mixed dyslipidemia	40%
Mean LDL-C	155 mg/dL
Median triglycerides	192 mg/dL

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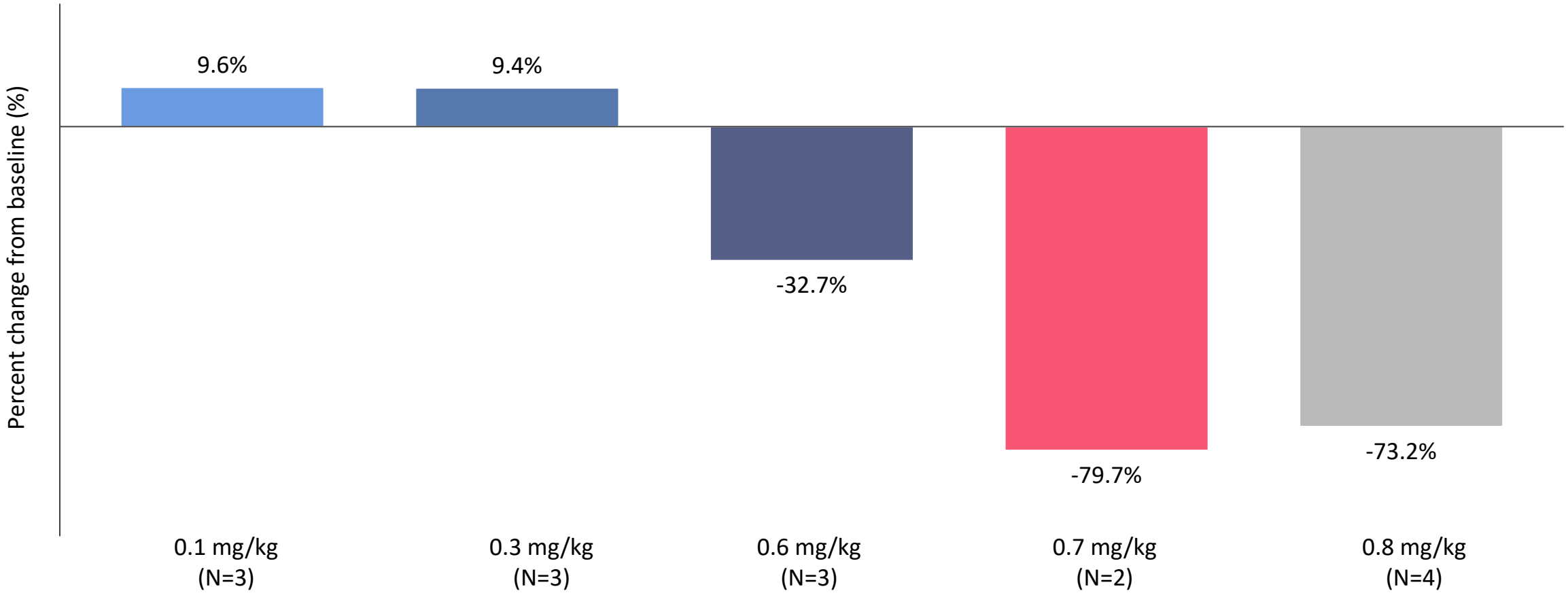
CTX310: Mean Percent Change from Baseline in ANGPTL3

N = 15 patients



Data presented at American Heart Association Meeting in Nov 2025
Note: Mean percent change from baseline are reported at 30 days for all subjects.

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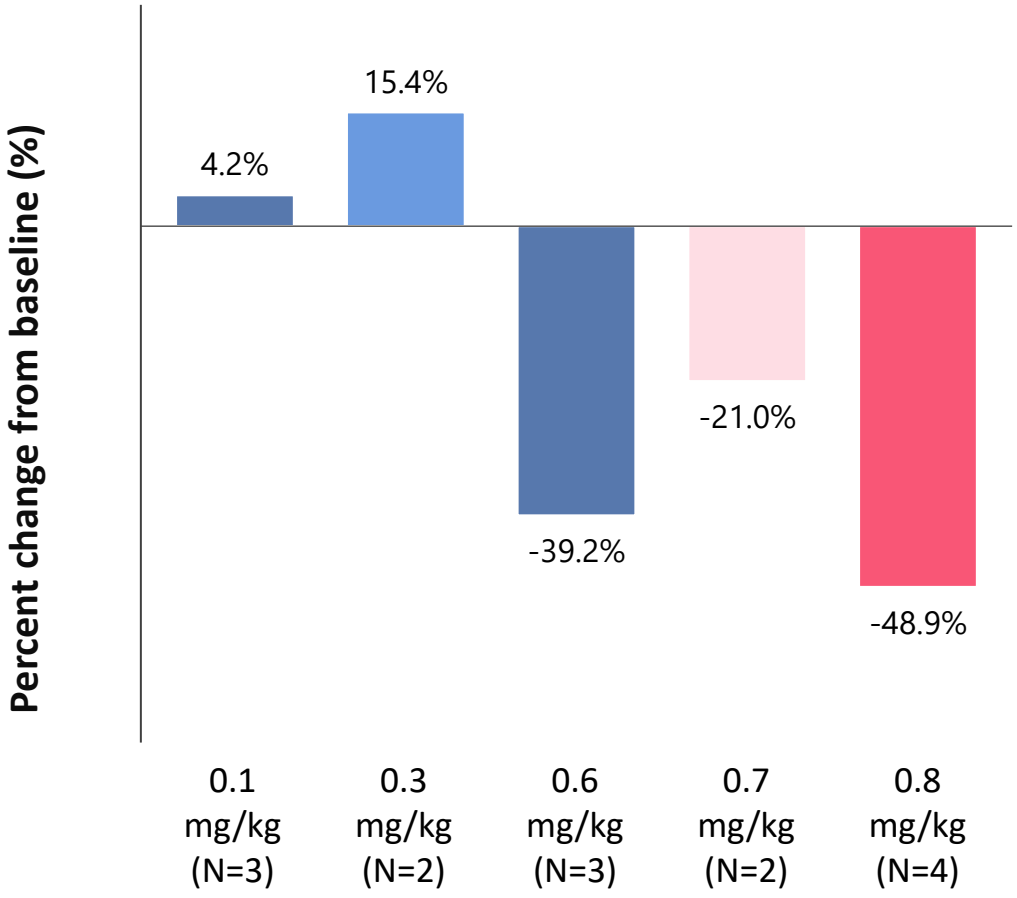
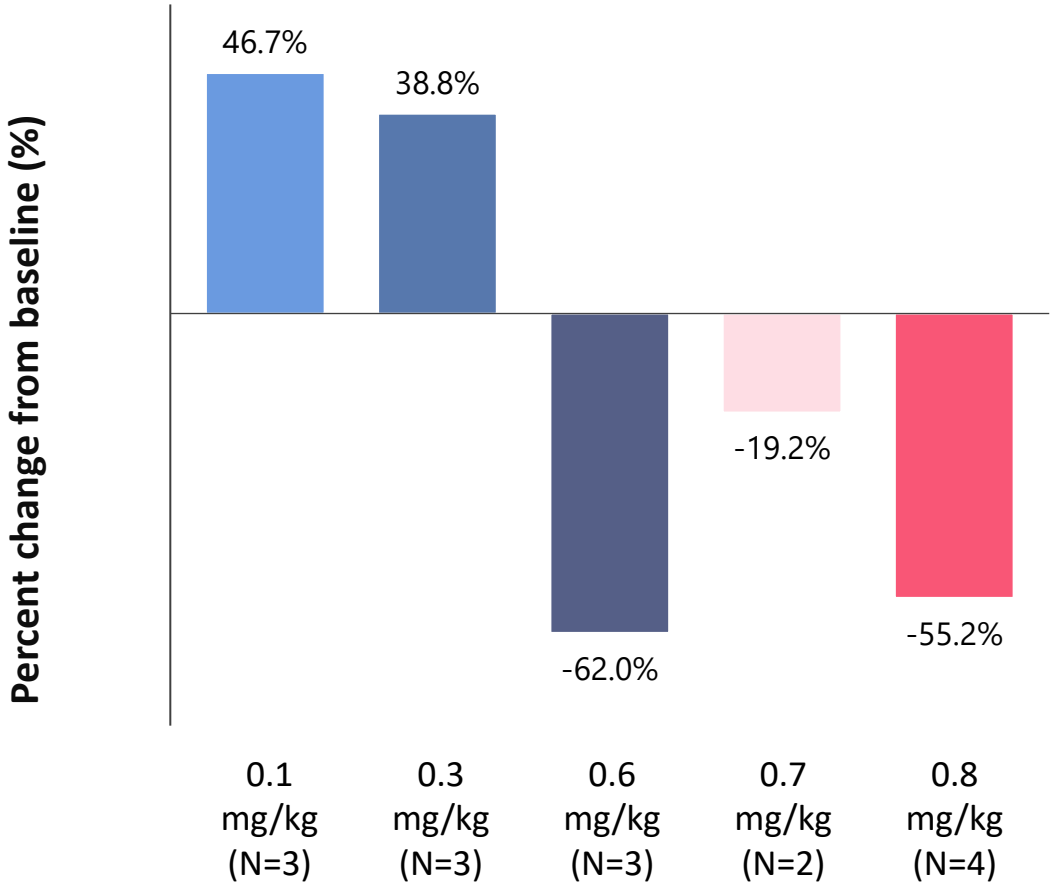
CTX310: Mean Percent Change from Baseline in LDL-C and Triglycerides

LDL Cholesterol



Triglycerides



Mean percent change from baseline are reported at 90 days following 0.1, 0.3, 0.6 mg/kg CTX310 doses and at 60 days following 0.7 and 0.8 mg/kg CTX310 doses.

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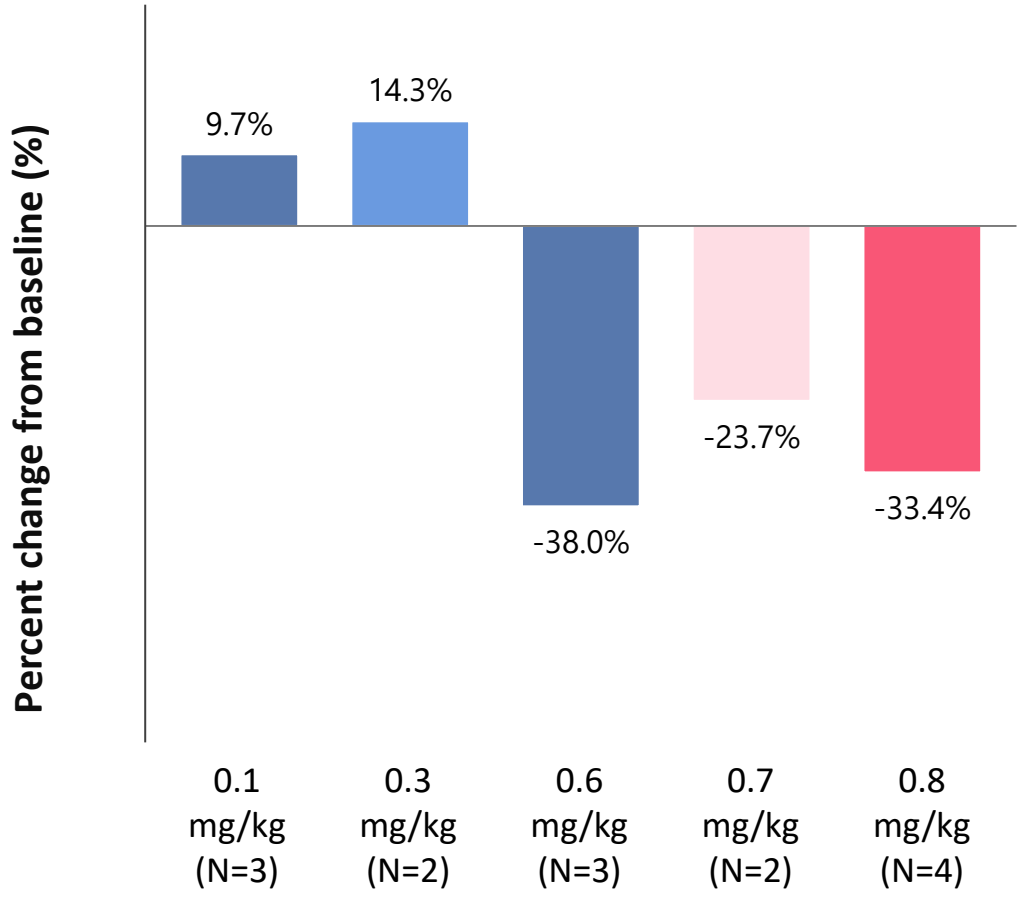
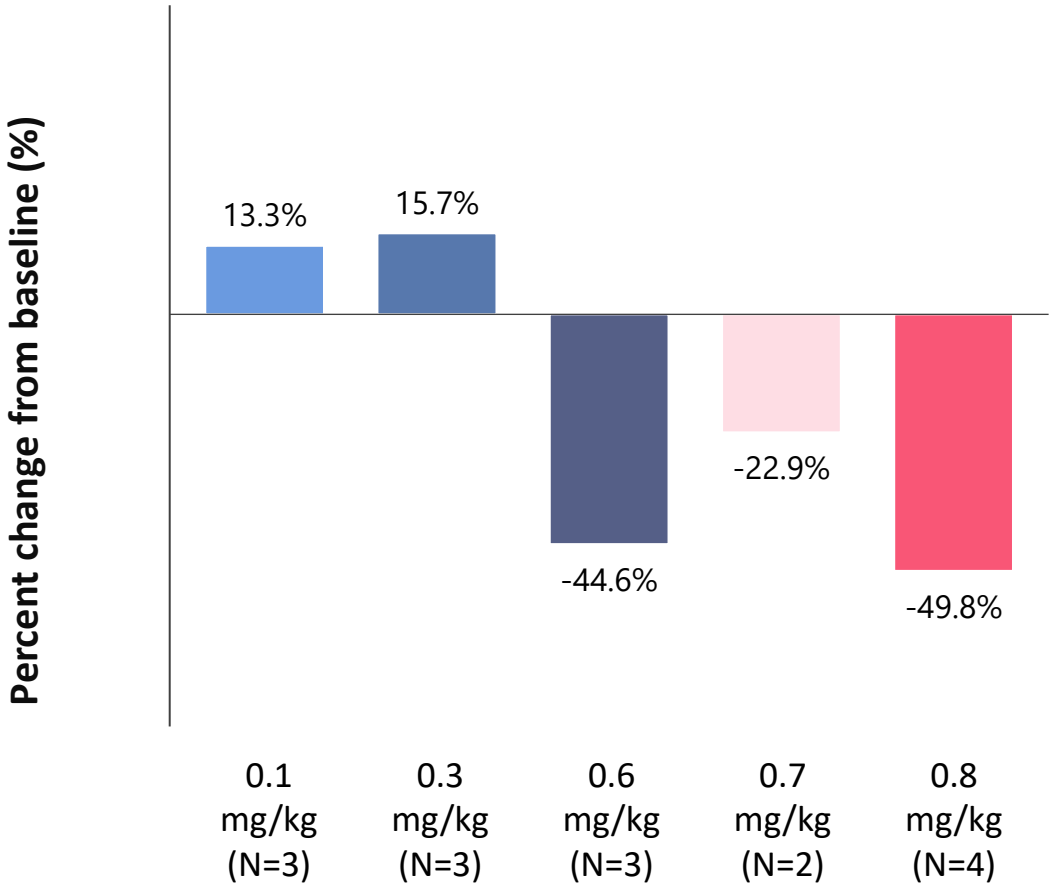
CTX310: Mean Percent Change in ApoB and Non-HDL-C

Apolipoprotein B



Non-HDL Cholesterol



Mean percent change from baseline are reported at 90 days following 0.1, 0.3, 0.6 mg/kg CTX310 doses and at 60 days following 0.7 and 0.8 mg/kg CTX310 doses.

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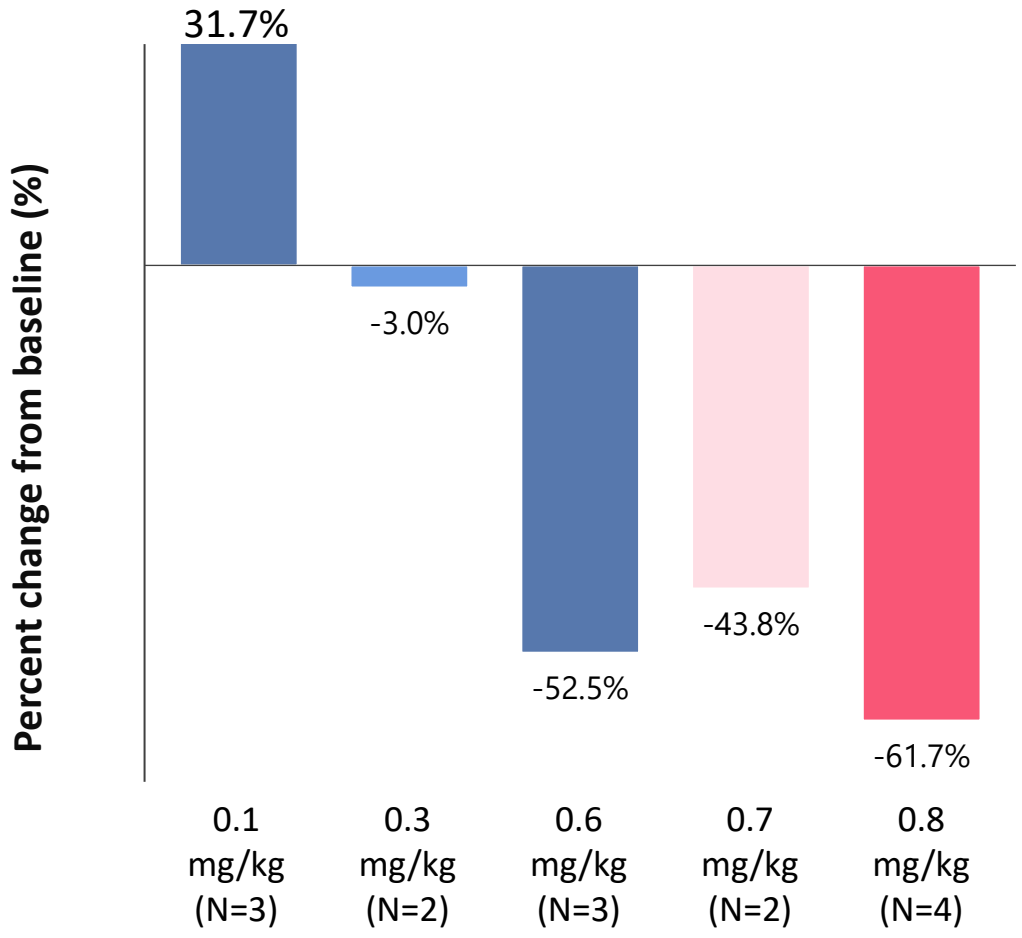
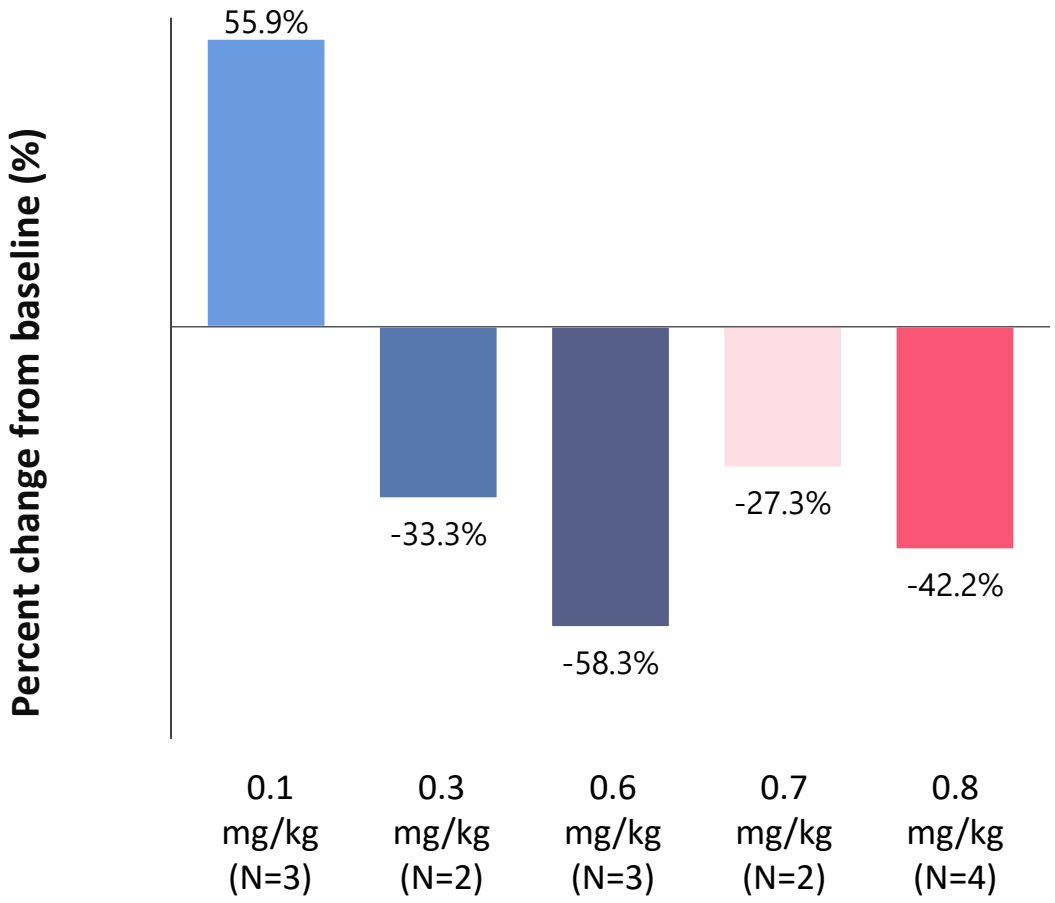
CTX310: Mean Percent Change in Apo CIII and Remnant Cholesterol

Apolipoprotein CIII



Remnant Cholesterol



Mean percent change from baseline are reported at 90 days following 0.1, 0.3, 0.6 mg/kg CTX310 doses and at 60 days following 0.7 and 0.8 mg/kg CTX310 doses.

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CTX310: Adverse Events & Safety Findings

	N (%)
Any serious adverse events	2 (13)
Serious adverse events related to CTX310	0 (0)
Participants with any investigator-reported adverse event	14 (93)
Adverse event deemed related to CTX310	7 (47)
Adverse event of special interest	4 (27)
• Allergic or localized reaction	1 (7)
• Infusion-related reaction	3 (20)
• Elevation in AST or ALT[2]	1 (7)
Death[1]	1 (7)

No clinically significant changes in AST / ALT across patients

1 participant at dose level 4 (0.8mg/kg) with elevated baseline aminotransferases experienced a transient aminotransferase elevation without concurrent bilirubin elevation between 3 and 5 times their baseline peaking on day 4 and returning to baseline by day 14

Data presented at American Heart Association Meeting in Nov 2025

1. Occurred in a participant 179 days after treatment with the 0.1 mg/kg dose, deemed unrelated to CTX310
2. Transient elevation in ALT; peaked at Day 4 and resolved with no increases in bilirubin or ALP

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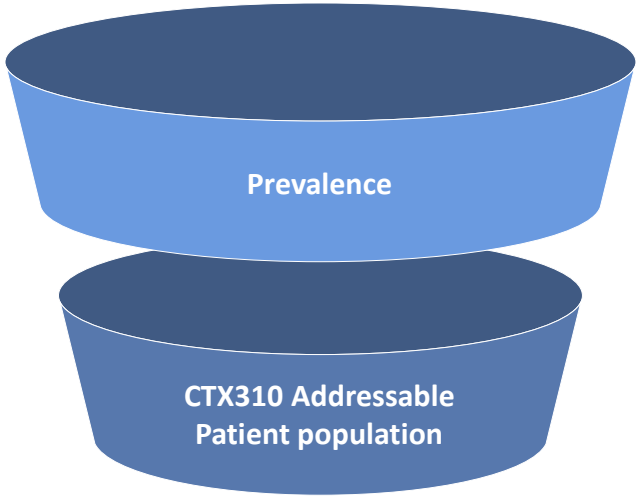
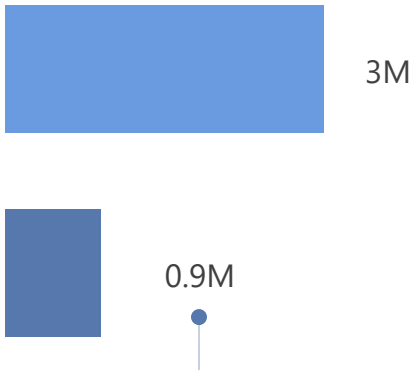
CTX310 Has Multi-Billion Commercial Opportunity

Addressable US Patient Populations Across sHTG, HoFH, HeFH, and non-FH



Potential CTX310 Value Proposition[3]

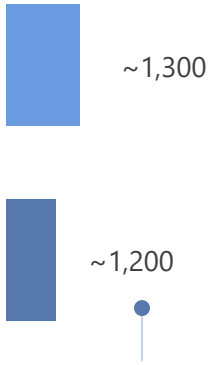
sHTG



~30% High-risk AP[1] patients

- Triglyceride reduction
- Acute pancreatitis reduction

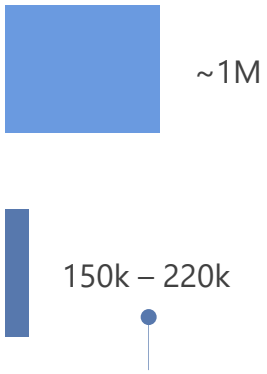
HoFH



~90% Refractory to PCSK9 treatments

- LDL Reduction

HeFH + non-FH[2]



~20% Refractory to PCSK9 treatments

- LDL Reduction

Deep, durable therapeutic effect

CTX310 has >1M addressable patient population in US, representing a potential multi-billion commercial opportunity

sHTG: Severe Hypertriglyceridemia; HoFH: Homozygous Familial Hypercholesterolemia; HeFH: Heterozygous Familial Hypercholesterolemia; FH: Familial Hypercholesterolemia

1. High AP risk defined as patients with TG >880 mg/dL or TG of 500-880 mg/dL with history of AP; 2. Non-FH patients defined as those refractory to SoC therapies on LDL control;
3. Only considering biomarkers-based clinical endpoints; CV outcomes endpoints could further expand the market

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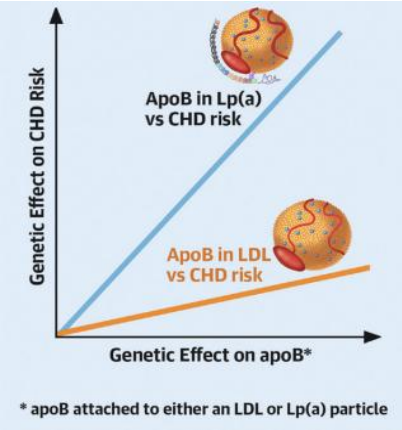
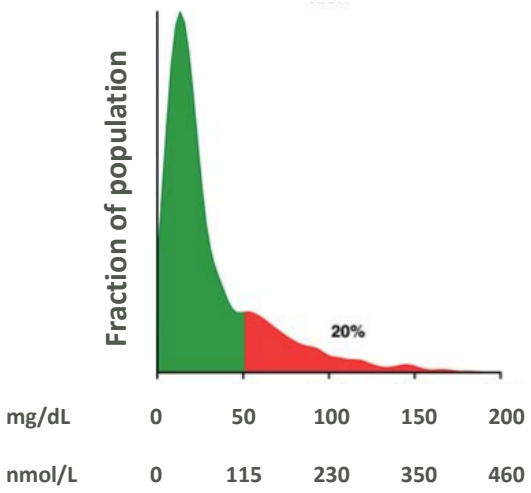
Lp(a) Gene Editing Program is a Key Focus for the Company

Lp(a) is an independent risk factor for atherosclerotic cardiovascular disease (ASCVD), affecting ~ one-fifth of global population

Elevated LP(a) is high risk for ASCVD[1]



Lp(a) levels in general population[4]



- Epidemiologic, Mendelian randomization, and genome-wide association studies have shown that elevated Lp(a) levels increase ASCVD risk[1,2,3]
- Approximately one-fifth of the global population have elevated Lp(a) levels ~3x greater lifetime risk for most elevated Lp(a) population[4]

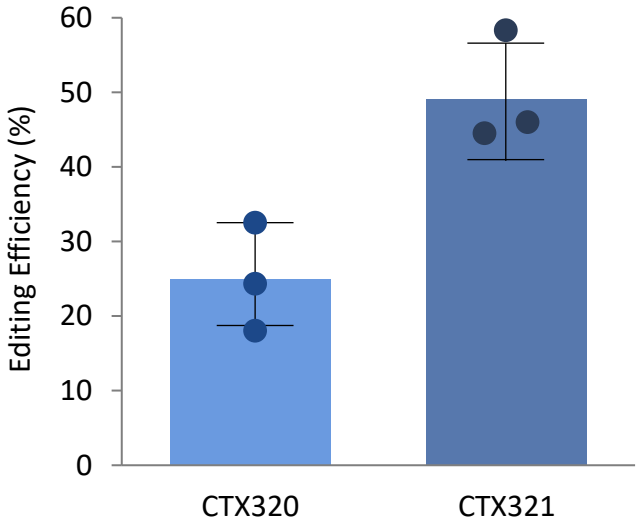
CTX321: New Lp(a) gRNA has potency on par with CTX310

CTX320 demonstrated up to 73% reduction in Lp(a), in dose escalation phase of the clinical trial

CTX310 clinical results provide benchmarks for target potency in humans

The new Lp(a) gRNA is approximately twofold more potent than the current CTX320 guide and is comparable to CTX310 using the same LNP

hLPA mice
Low-dose LNP



CTX321 is in IND-enabling studies, with an Lp(a) program update expected in 2026

1. Enas et al. 2019; 2. Gurdasani et al. 2012; 3. Laschkolnig et al. 2014; 4 Nordestgaard et al. 2010

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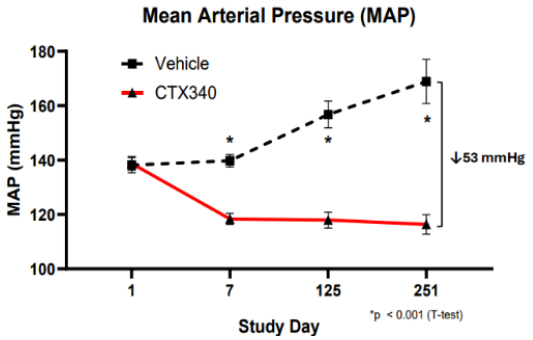
Additional *In Vivo* Programs Advancing Toward Clinical Trials

CTX340 Targeting AGT For Refractory Hypertension (rHTN)

- Hypertension is the leading cause of cardiovascular morbidity and mortality worldwide and adherence is a major limitation[1]
- AGT is upstream of typical therapeutic approaches aiming to significantly impact hypertension and reduce dependence on other antihypertensives

CTX340 Administration Leads to Persistent Pharmacological Benefit in SHR Model

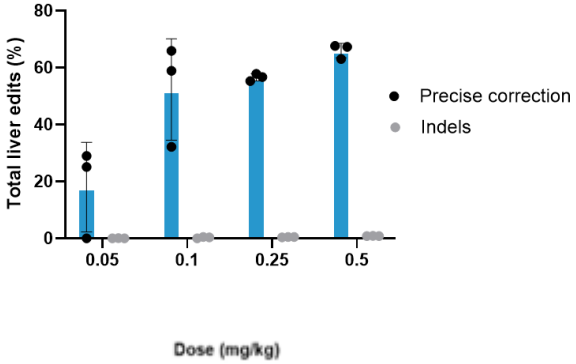


CTX340 durably reduced MAP by Day 7, sustained through the study (~8.5 months)

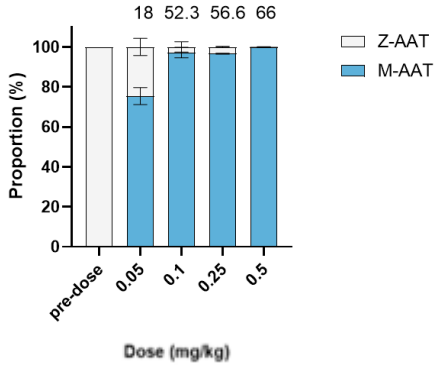
CTX460 Targeting SERPINA1 for AATD

- Alpha-1 antitrypsin deficiency (AATD) is caused by mutations in the SERPINA1 gene which encodes for alpha-1 antitrypsin (AAT)
- The goal of AATD therapy is to normalize levels of AAT
- CTX460, comprising novel SyNTase editing payload, enables highly efficient, durable, and specific SERPINA1-E342K gene correction, without bystander edits

Precise and efficient correction of SERPINA1-E342K (Day 7 post-injection)



Durable, high proportion corrected serum M-AAT (Day 7)



CTX340 Phase 1 trial initiation expected in 1H 2026; CTX460 Phase 1 trial initiation expected in mid-2026

Editing rates reflect whole liver editing; SHR: spontaneous hypertensive rat; MAP: mean arterial pressure

1. Zhou et al. 2021; 2 Danaei et al. 2009

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CTX611 is a Factor XI siRNA with Best-in-Class Potential

FXI: Interrupting thrombosis while maintaining hemostatic clotting

Traditional clotting factors
(e.g., FXa / thrombin)

Extrinsic & Intrinsic Pathway Targeting

Pathological clotting ↓
Less thrombus propagation

Homeostatic clotting ↓
Wound sealing also reduced

Consequence:
Bleeding risk increases

Factor XI
(e.g., FXI / FXIa)

Intrinsic Pathway Targeting

Pathological clotting ↓
Less thrombus propagation

Homeostatic clotting ≈
Largely preserved

Consequence:
Lower bleeding potential

Emerging evidence[1,2,3] suggests Factor XI is important for thrombosis but has a minor role in hemostasis, with potential for FXI targeting anticoagulants to be safer than currently available agents

Unmet Need

- Current anti-coagulation market is ~$20B per year
- Patients with bleeding risk or certain conditions, such as renal impairment or cancer associated thrombosis, continue to have significant unmet needs
- Factor XI targeting agents with potential lower bleeding risk[1] could have attractive profile in multiple indications[2,3]: AFib, Stroke, CAT, VTE, DVT

Best-in-Class Potential

- In clinical data to date, CTX611 has been well tolerated and demonstrated strong, sustained PD effects, including reductions of >93% in FXI activity, along with >2x increase in aPTT relative to baseline, with potential for Q6 months dosing
- CTX611 offers potential for reversibility unique to siRNA platform

AFib: Atrial Fibrillation; CAT: Cancer Associated Thrombosis; VTE: Venous Thromboembolism; DVT: Deep Vein Thrombosis; aPTT: Activated Partial Thromboplastin Time
Note: CTX611 is a collaboration and co-development program with Sirius Therapeutics
1. Lowenberg et. al, Journal of Thrombosis and Hemostasis (2010); 2. Salomon et. al, Blood (2003); 3. Salomon et. al, Journal of Thrombosis and Haemostasis (2011)

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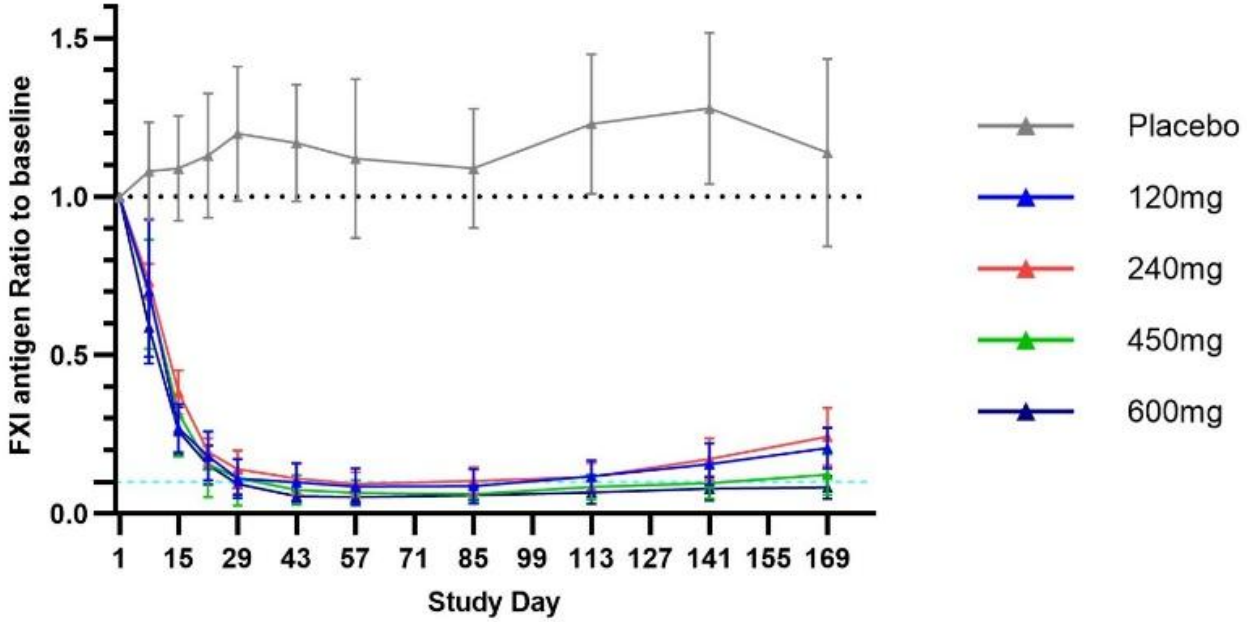
CTX611 Phase 1 Data: Shows Deep, Durable Reductions in FXI Activity

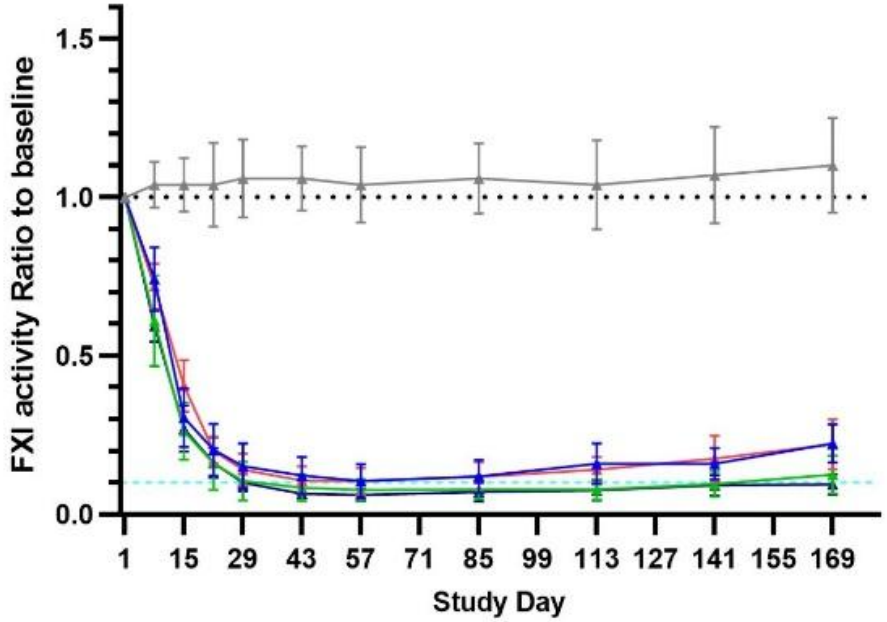
CTX611 Phase I Clinical Results: Dose-dependent pharmacodynamic response to therapy sustained through Month 6

FXI Antigen



95.0% peak reduction in FXI antigen

FXI Activity



93.9% peak reduction in FXI activity

Clinical trials executed and data generated by Sirius Therapeutics

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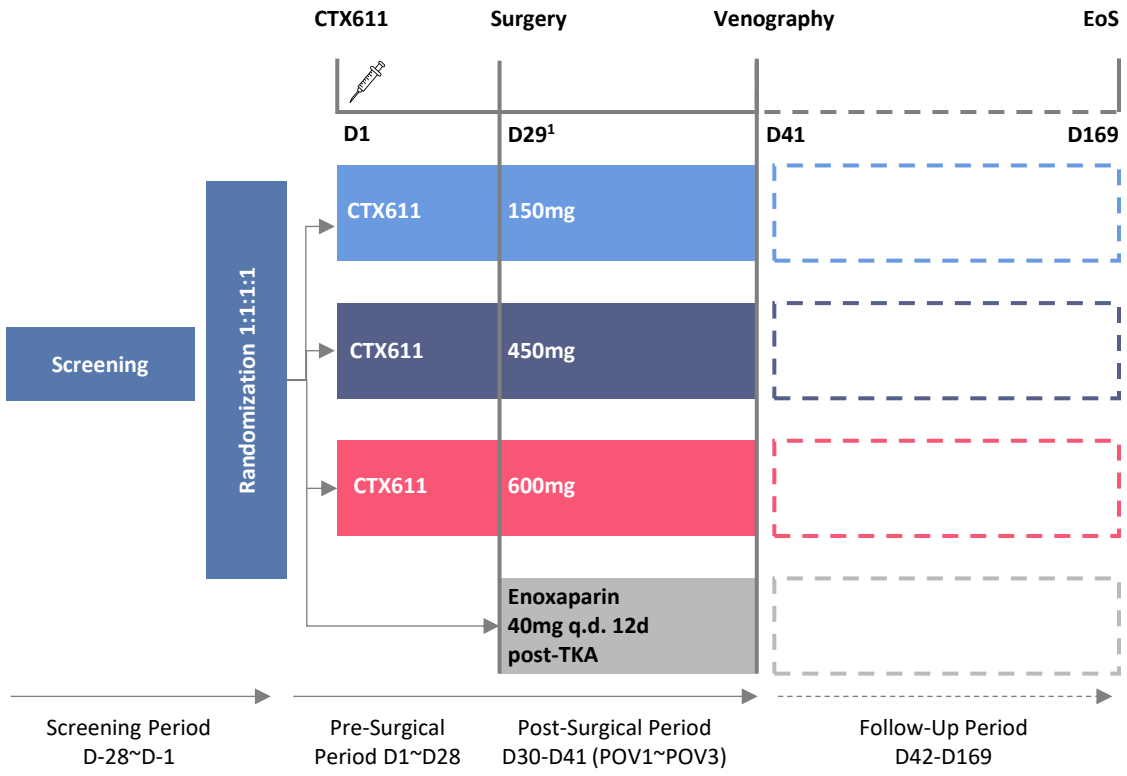
CTX611 Phase II Trials: TKA Top-Line Data Expected in 2H 2026

CTX611-201 Phase II Clinical Program: TKA Top-line Data Expected in 2H 2026

Objective: Establish PoC efficacy in TKA-VTE participant population

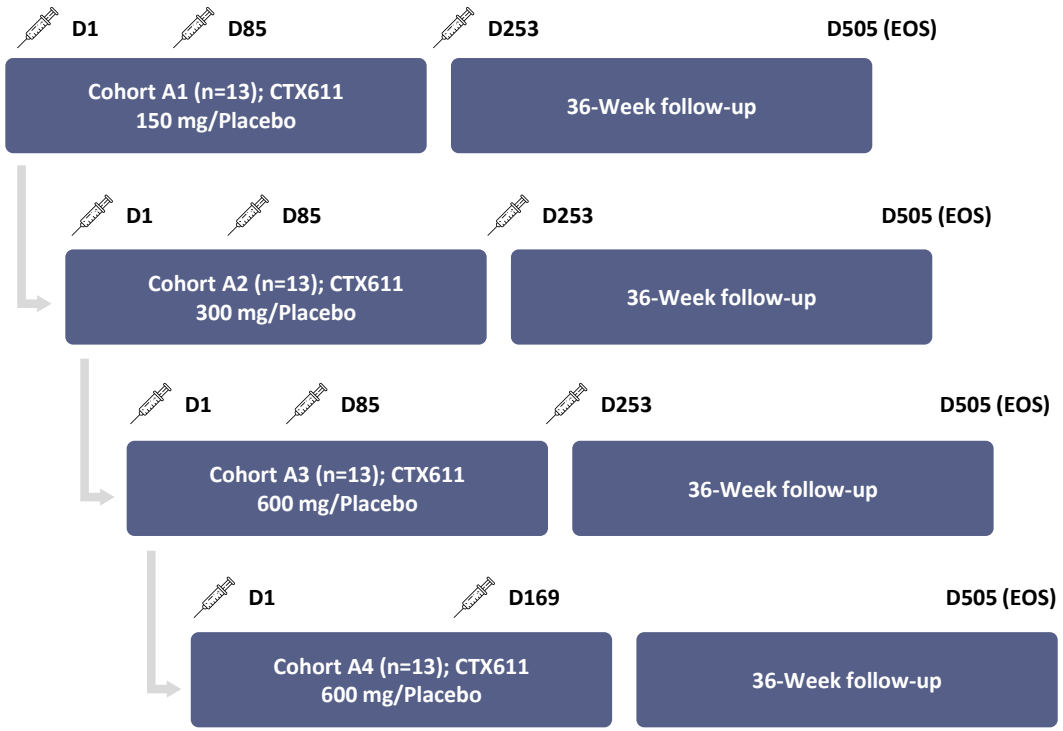


Key Endpoints

- Safety, including bleeding events
- VTE rates post TKA
- PD profile of CTX611

CTX611-202 Phase II CV Study Design

Objective: Establish PK-PD in chronic "arterial" population; evaluate PD profile of CTX611 with ASA



Primary Endpoint

- PD profile of multidose CTX611 with ASA

Secondary Endpoints

- Safety, including bleeding events
- PK profile of CTX611 with ASA

1 TKA surgery will occur on Day 29 (+14 days). Irrespective of the actual study day, the surgery day (POV0) will be regarded as Day 29
TKA: Total Knee Arthroplasty; VTE: Venous Thromboembolism; ASA: Acetylsalicylic Acid

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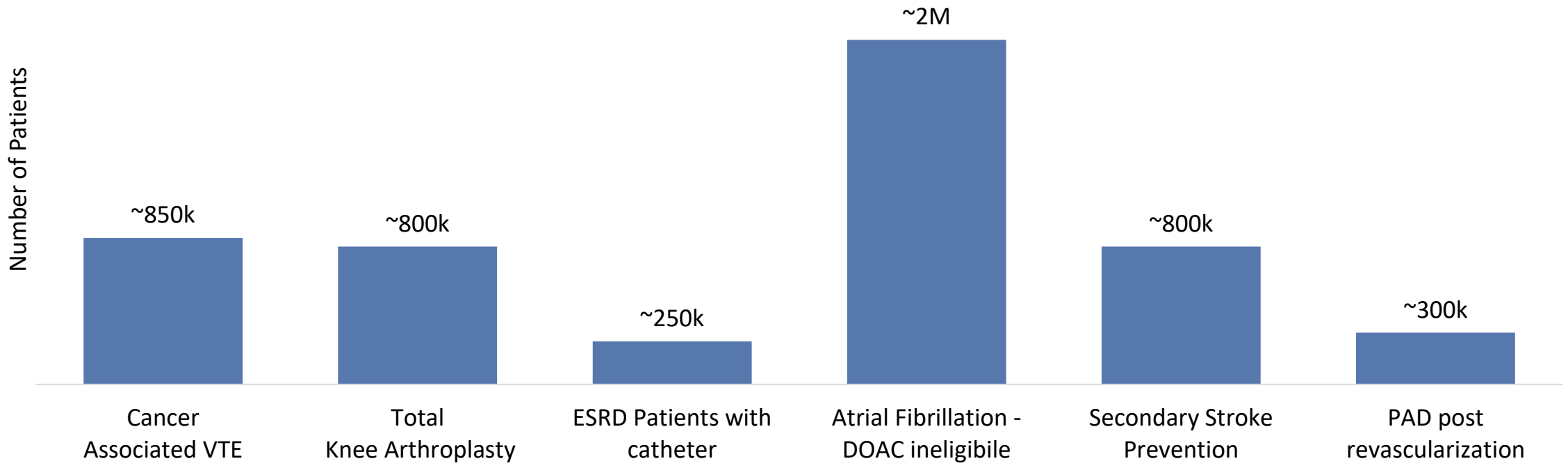
CTX611 Has Significant Potential Across Multiple Indications

US Potential Market Opportunity for FXI Anticoagulation Agent



CRISPR leads Phase III global development of CTX611

VTE: Venous Thromboembolism; ESRD: End Stage Renal Disease; DOAC: Daily Oral Anticoagulant; PAD: Peripheral Artery Disease

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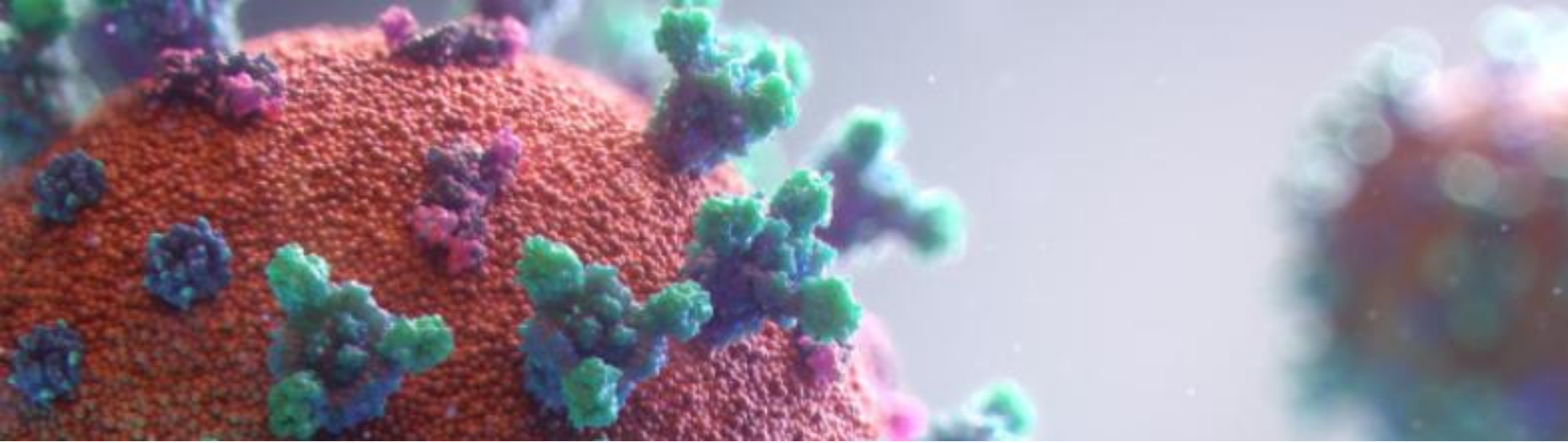

CAR-T

CRISPR Tx Cell Therapy Strategy

CRISPR Focus

CAR-T Landscape

Ex vivo

- Autologous
- **Allogeneic (Healthy donor)**
- Allogeneic (iPSC derived)

In vivo

- *In Vivo* (Viral)
- ***In Vivo* (Non-viral)**

CRISPR *Ex Vivo* Cell Therapy Focus

- CRISPR built **allogeneic cell therapy platform on healthy donor-derived T cells**, to potentially offer autologous-like efficacy with improved cost and accessibility
- CRISPR's allogeneic CAR-Ts have **potentially best-in-class therapeutic profile** with mAbs-like COGS

CRISPR *In Vivo* Cell Therapy Focus

- CRISPR developing **non-viral *In Vivo* CAR-T**, given potential safety concerns associated with viral delivery
- Developing both transient (e.g., mRNA-based) and integrating (e.g., all RNA-based insertion) approaches

CRISPR has potential best-in-class allogeneic CAR-T, plus non-viral *in vivo* CAR-T in preclinical development

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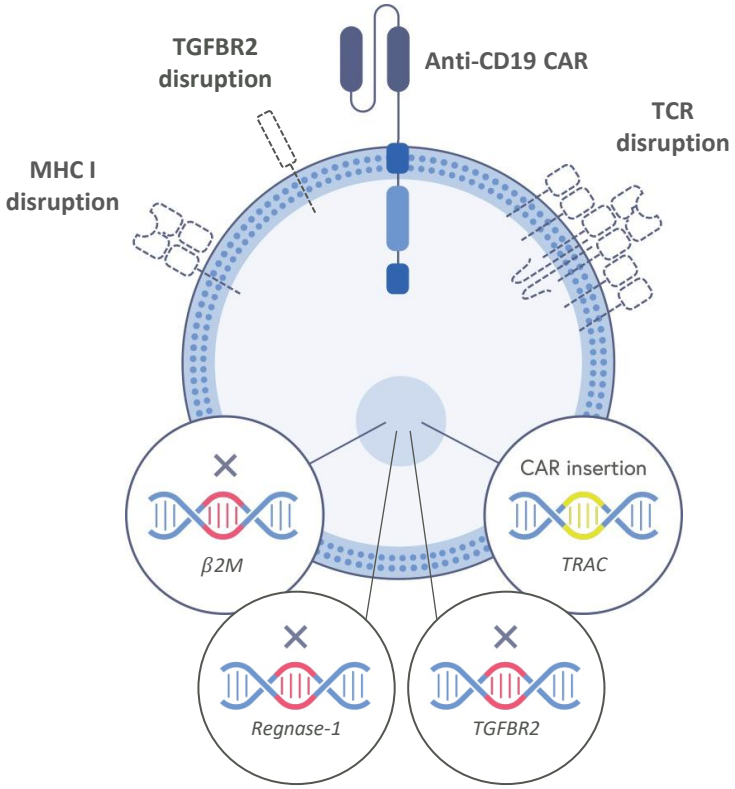
Zugo-cel is an Allogeneic CAR-T Optimized for Potency

Zugo-cel Novel Potency Edits (TGFBR2, Regnase-1)



Regnase-1 and TGFBR2 edits synergistically increase CAR-T potency

Several Competitive Advantages

- Ability to multiplex gene edits precisely and efficiently
- Comprehensive and FDA-validated genomic analysis
- Scalability and low COGS to enable global expansion
- In-house manufacturing enables direct control over process and timelines

COGS projected to be <$10k per patient

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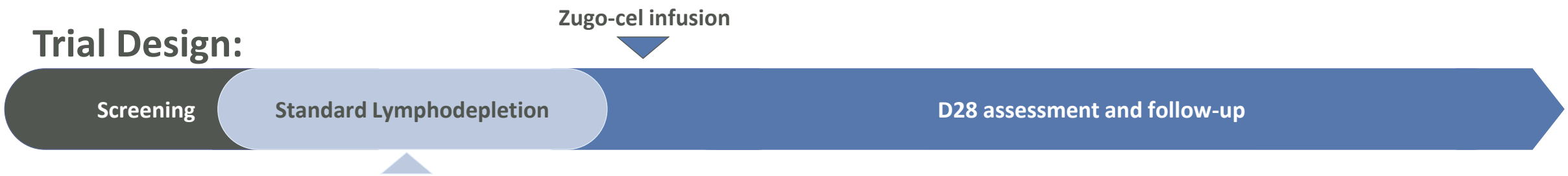
Zugo-cel Phase I Autoimmune Basket Clinical Trial Ongoing

CRISPR THERAPEUTICS

Open-label, Phase 1 clinical trial evaluating the safety and efficacy of zugo-cel in adult subjects with refractory autoimmune disease

Trial Design:



Fludarabine 30 mg/m^2 +
Cyclophosphamide 500 mg/m^2 for 3 days

Dose Level ("DL", no. of CAR+ T cells): DL1 = 100M; DL2 = 300M; DL3 = 600M cells

Benefits of Allogeneic CAR T:

- Site specific CAR insertion
- No apheresis
- Concomitant therapy stays until shortly before LD chemo
- On-site availability of CAR T cell product

Key eligibility criteria:

- Age ≥18 years and ≤70 years
- Participant population: Adult subjects with active SLE (with or without renal involvement), systemic sclerosis (SSc), or idiopathic inflammatory myopathy (IIM) despite use of standard therapies
- No prior anti-CD19 therapy or any gene therapy or genetically modified cell therapy
- No prior solid organ or hematopoietic cell transplant
- Adequate organ function

Primary endpoint

- Incidence of Adverse Events, defined as Dose-limiting toxicities

Secondary endpoints

- Pharmacodynamic (PD) response to zugo-cel (e.g. disease specific autoantibodies, B cell levels)
- Zugo-cel Pharmacokinetics (PK)
- Preliminary efficacy based on disease-specific criteria and assessments

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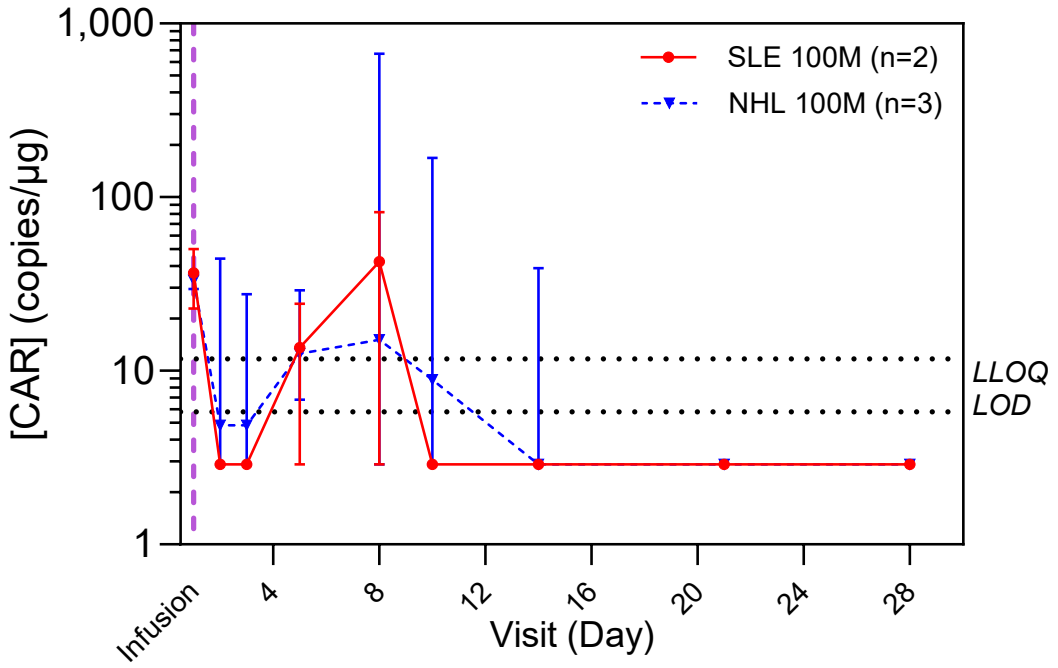
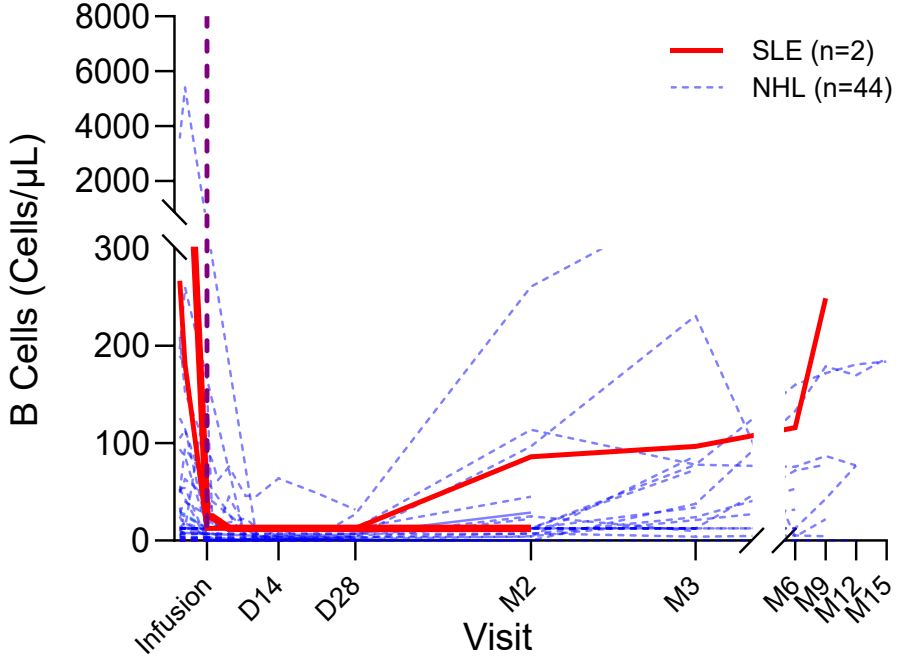
Zugo-cel Clinical Data Shows Comparable PK and PD in AID and NHL

Cell Expansion Summary[1]



Zugo-cel expansion profile in SLE subjects comparable to NHL

B Cell[2] Depletion



~90 day median (range 60 - 360) time to B cell reconstitution

Zugo-cel shows complete B cell depletion in AID patients 28 days post-dosing, in line with NHL profile

1. Data shown as mean + SEM; 2. B cells defined as CD3-CD19+; LLOQ for lymphocytes varies by site, here plotted as ½ <LOQ
AID: Autoimmune Diseases; NHL: Non-Hodgkin's Lymphoma Data Cutoff 07 Jan 2026

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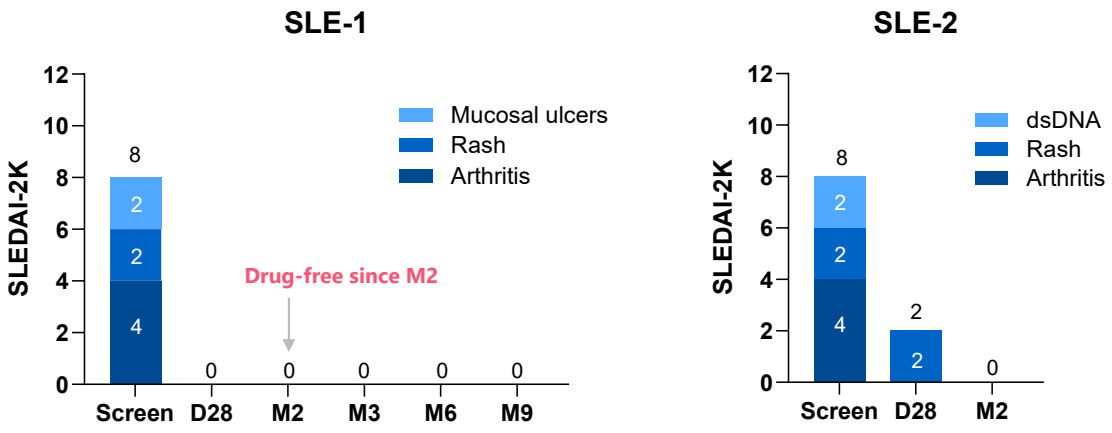
Case Study of SLE Patients Treated with Zugo-cel

2 SLE patients in remission; First SLE participant in drug-free remission maintained at Month 9

Baseline Characteristics	SLE-1	SLE-2
Dose	DL1 (100M cells)	DL1 (100M cells)
Age/Sex	33 yo F	30 yo F
Disease Duration (years)	10	11
Organ Involvement	Skin, mucosal ulcers, joints, pleurisy	Skin, alopecia, joints, pleurisy, Raynaud's
Autoantibodies	ANA	ANA, dsDNA
SLEDAI-2K	8 (rash, oral ulcers, arthritis)	8 (rash, arthritis, dsDNA)
# Prior Therapies	8	10
Most Recent Regimen	HCQ, MTX	HCQ, MMF
Corticosteroid Dose	As needed for flares	As needed for flares

Clinical Efficacy Results



Safety: No CRS, ICANS, or serious infections

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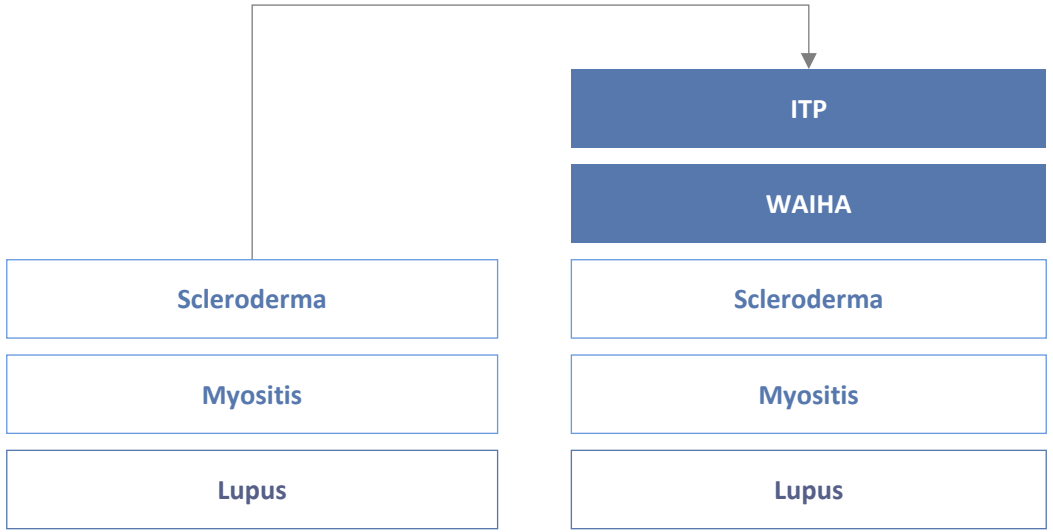
Zugo-cel Autoimmune Program Expansion

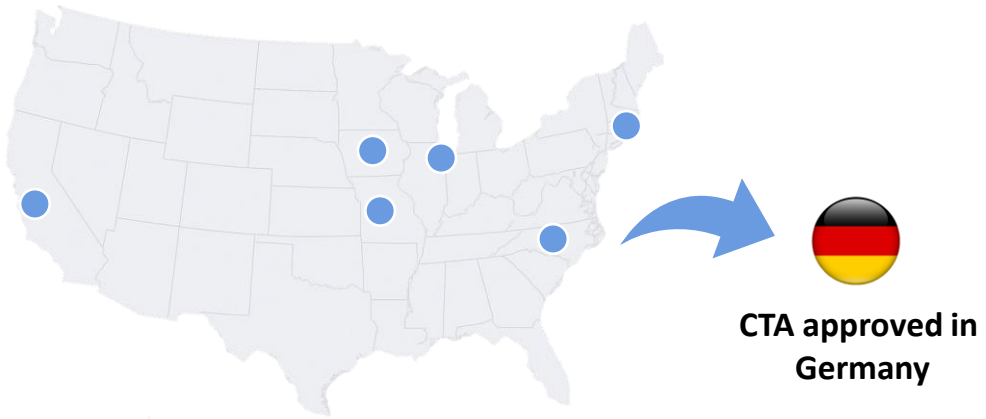
Indication Expansion Summary

Heme AID expansion



IND approved for autoimmune hematologic disorders including ITP and WAIHA

Geographic Expansion Summary



Expanding into the EU with **approval of CTA in Germany**

Zugo-cel clinical update from rheumatology study and topline update from hematological AID study in 2H 2026

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Zugo-cel Phase I Immuno-Oncology Clinical Trial Design

CRISPR THERAPEUTICS

Open-label, multicenter, Phase I/II study evaluating the safety and efficacy of zugo-cel in relapsed or refractory B-cell malignancies

Trial Design:

Zugo-cel infusion

Patients could receive an additional infusion of zugo-cel with LD chemotherapy if they achieved a partial response

Screening → **Standard Lymphodepletion** → **D28 assessment and follow-up**

Fludarabine 30 mg/m^2 +
Cyclophosphamide 500 mg/m^2 for 3 days

Dose Level ("DL", no. of CAR+ T cells): DL1 = 30M; DL2 = 100M; DL3 = 300M cells; DL4 = 600M cells

Benefits of Allogeneic CAR T:

- Short screening timeframe
- No apheresis
- No bridging chemotherapy
- On-site availability of CAR T cell product

Key eligibility criteria:

- Age ≥18 years
- Patient population: R/R FL grade 1-3a, MZL, MCL, DLBCL NOS, DLBCL/high- grade lymphoma with MYC and BCL-2 rearrangement, grade 3b FL, DLBCL arising from FL or MZL or LBCL with prior CAR T
- No prior allogeneic SCT and no history of CNS lymphoma involvement
- Adequate organ function

Primary endpoint

- Incidence of AEs, defined as DLTs
- ORR (per Lugano 2014 criteria or iwCLL 2018 guidelines for CLL/SLL)

Secondary endpoints

- Complete Response rate (CR)
- Duration of response (DOR)
- Progression-free survival (PFS)
- Overall survival (OR)

(NCT05643742); R/R FL: relapsed or refractory follicular lymphoma; MZL: Marginal zone lymphoma; MCL: Mantle cell lymphoma; DLBCL: Diffuse Large B-cell lymphoma; BCL-2: B-cell lymphoma 2; SCT: stem cell therapy; CNS: central nervous system; AE: adverse event; DLT: dose-limiting toxicity; ORR: overall response rate; iwCLL, International Workshop on CLL;

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Zugo-cel Baseline Characteristics (LBCL N=10, DL4)

Baseline Characteristics	Total N = 10
Age ≥ 65, n (%)	7 (70)
Sex (Female), n (%)	6 (60)
Prognostic Score at Baseline[3]	
• Intermediate or High Risk, n (%)	7 (70)
LBCL Subtype, n (%)	
• DLBCL NOS	4 (40)
• Transformed Follicular Lymphoma	3 (30)
• Transformed Marginal Zone Lymphoma	2 (20)
• Follicular Lymphoma 3b	1 (10)
Disease Stage (per Lugano 2014[2])	
• Stage III / IV	6 (60)
Tumor Burden	
• Median SPD (Min-Max)	2011 (561-10492)
• SPD > 2000 mm^2, n (%)	5 (50)
Prior Therapies	
• Median, n (range)	2 (1-5)
• > 3 prior therapies, n (%)	3 (30)
• Prior ASCT / auto-CAR-T / TCE	5 (50)
Primary Refractory Disease[1], n (%)	5 (50)
Early Relapse to Frontline Therapy[2], n (%)	7 (70)

Data cut off 20NOV2025

1. Primary refractory defined as absence of CR after first line of NHL treatment; 2. Early relapse for LBCL defined as progression <12M from end of 1L chemoimmunotherapy; 3. IPI Scoring: Low = 0-1, Intermediate = 2-3, High = 4-5

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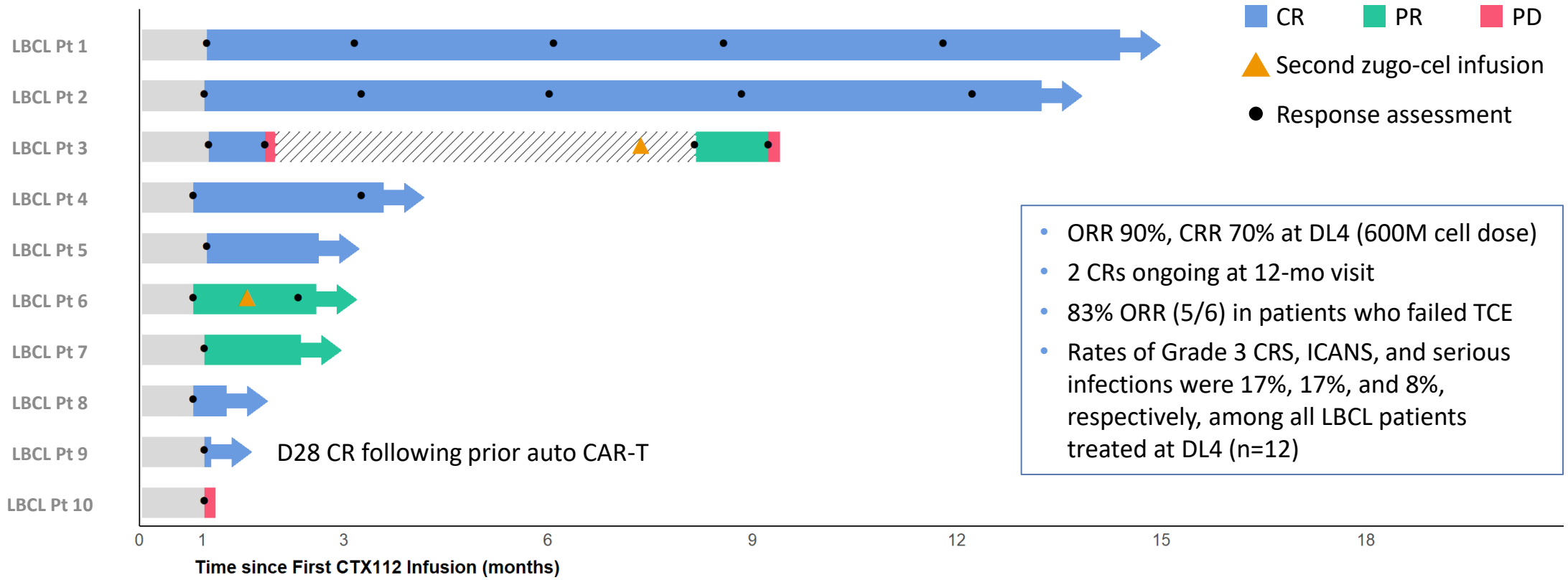
Zugo-cel Ph1 Data Suggest Durability in LBCL at RP2D (600M)

(N=10 with D28 response assessment[1])



- ORR 90%, CRR 70% at DL4 (600M cell dose)
- 2 CRs ongoing at 12-mo visit
- 83% ORR (5/6) in patients who failed TCE
- Rates of Grade 3 CRS, ICANS, and serious infections were 17%, 17%, and 8%, respectively, among all LBCL patients treated at DL4 (n=12)

Additional Phase 1 clinical data update expected in 2H 2026

RP2D: Recommended Phase 2 Dose; TCE: T-cell engagers

1. 006-233-015 (DL4, LBCL) passed away before D28; subject with PTLD (DL4) excluded from analysis; Data cutoff Nov 20, 2025

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Collaboration to Study Zugo-cel Combined with Pirtobrutinib

Zugo-cel
(allogeneic CD19 CAR-T)

+

Pirtobrutinib
(non-covalent BTKi)

=

Potential for deep, durable responses with an off-the-shelf therapy for aggressive B-cell lymphomas

- Zugo-cel has demonstrated overall and complete response rates comparable to autologous CAR-T therapies in LBCL patients with poor prognostic features
- Zugo-cel cell clearance and hematopoietic recovery typically occur within 28 days
- **A study of autologous CD19 CAR-T combined with a BTK inhibitor[1] showed a 93% overall response rate and an 81% complete response rate, with 12-month durability of response of 66%**
- Consolidation or maintenance with an oral, non-covalent BTK inhibitor could deepen responses and improve durability while enabling potential outpatient use in community settings

1. Johnson et al. ICML, June 2025 Presentation

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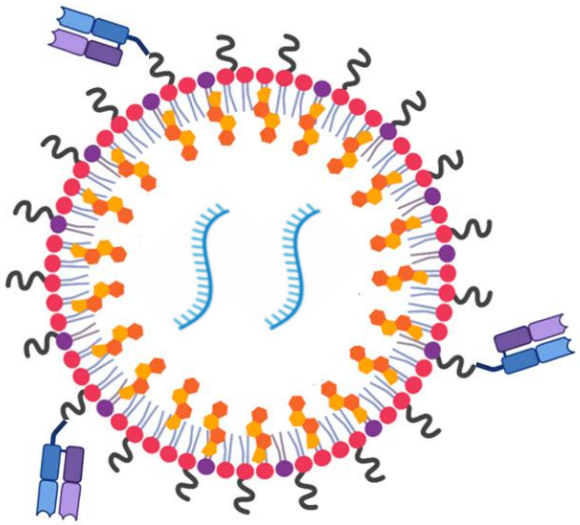
Our *In Vivo* CAR-T Approach

Transient, Re-dosable CAR-T



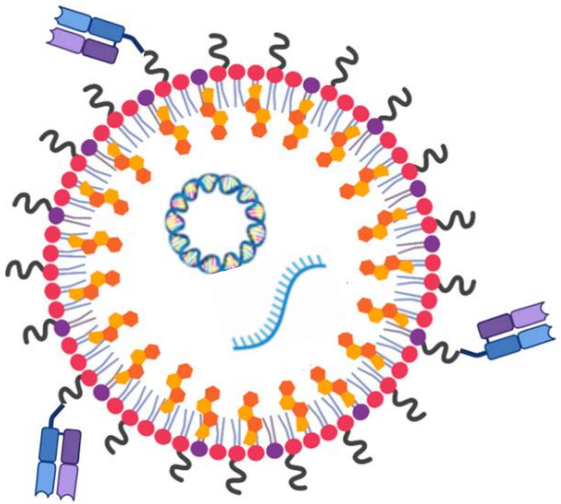
Engineered RNA with extended half life

- RNA format modifications
- Sequence optimization

Proprietary Antibody-LNP Platform

- Targeted delivery to immune cells
- Site-specific conjugation with robust manufacturability
- Long-circulating LNPs minimizes off-target delivery (e.g., liver)
- Proprietary binder formats and LNP components

Non-Viral, Integrating CAR-T



Non-viral delivery, site-specific integration technology using next-generation editing including HDR- and HITI-based integration, retrotransposons

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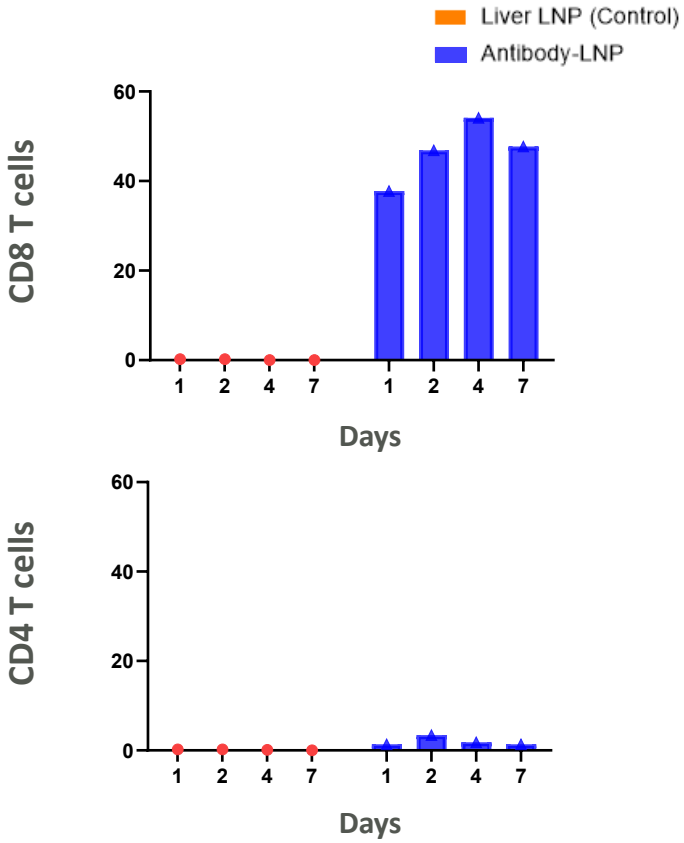
Targeted LNPs Showed Robust Delivery to T-cells with Durable Expression and Minimum Off-Target Expression in the Liver

Cynomolgus Monkey, Peripheral Blood (0.5mg/kg eGFP mRNA-LNP)

% GFP positive cells

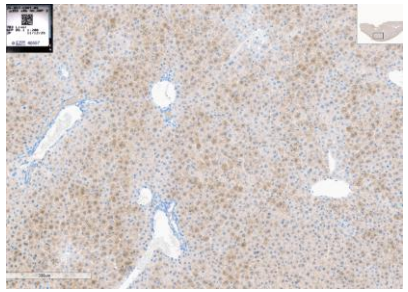
Blood collection:
Days 1, 2, 4



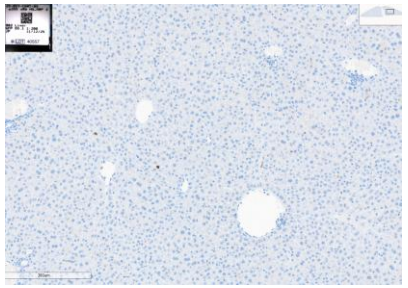
Humanized Mouse (0.5mg/kg eGFP mRNA-LNP, 24hr)

Liver Immunohistochemistry (IHC)

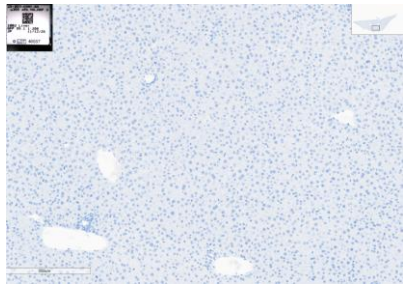
Liver collection:
24hr (day 1)



Liver LNP (control)



Antibody-LNP



PBS (control)

CRISPR's T-cell targeted mRNA-LNPs have extended circulation half-life, enable durable expression, and minimize off-target tissue delivery

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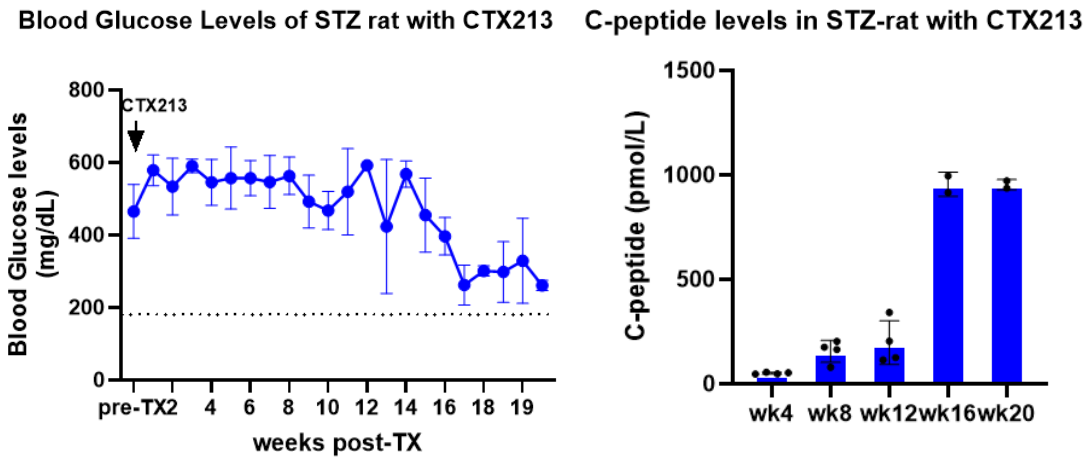
CTX213: Deviceless Hypoimmune Islet Cell Therapy for T1D

CTX211, a gene-edited, stem cell–derived encapsulated cell product for the treatment of type 1 diabetes

- Ph1 completed in n=5 patients
- Well-tolerated with no SAE or AESIs
- Sustained c-peptide production observed 12 months post-implantation
- Histology confirmed survival of transplanted insulin-producing islet cells, despite the fibrosis of encapsulation device and infiltration of immune cells

CTX213, an unencapsulated iPSC-derived islet cell product utilizing the same edits as CTX211



Direct administration of CTX213 leads to improved glycemic control and C-peptide production in STZ rat model

Clinical data validate the hypoimmune edits; CTX213 shows encouraging pre-clinical efficacy, advancing toward the clinic

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Anticipated Key Milestones in 2026

	Program	Timing	Details
Heme	casgevy (exagamglogene autotemcel) suspension for IV infusion	Quarterly	Commercial launch updates
	***In Vivo* HSC**	2H 2026	Preclinical data update
In Vivo	**CTX310**	2H 2026	Phase Ib CV trial clinical data
	CTX611	2H 2026	Phase II TKA study top-line data
	CTX340	1H 2026	Phase I rHTN trial initiation
	CTX460	Mid 2026	Phase I AATD trial initiation
	Lp(a) program	2026	Program update
CAR-T	**Zugo-cel AID**	2H 2026	Phase I Rheumatology trial clinical data
	Zugo-cel AID	2H 2026	Phase I ITP/wAIHA trial top-line data
	Zugo-cel ONC	2H 2026	Phase I Heme malignancies clinical data
	***In Vivo* CAR-T**	1H 2026	Preclinical data update

AID: Auto-immune disease; HSC: hematopoietic stem cells

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