



Pierre Fabre

Pharmaceuticals Inc.

New ways to care



Tabelecleucel: An Investigational Therapy Proposed for Use Within Epstein-Barr–Positive Post-Transplant Lymphoproliferative Disease (EBV+ PTLD)

Medical Affairs

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Regulatory Status and Use of Slides by Medical Affairs

- Tabelecleucel is not approved by the FDA and the safety or effectiveness of the product, or its use has not been established
- The use of these slides is in compliance with FDA Guidance titled “Responding to Unsolicited Requests for Off-Label Information About Prescription Drugs and Medical Devices” and “Drug and Device Manufacturer Communications With Payors, Formulary Committees, and Similar Entities — Questions and Answers”

FDA, US Food and Drug Administration.

Pierre Fabre Pharmaceuticals is the new **US pharmaceutical subsidiary** of a truly **global** healthcare company, established in **43** countries, with products distributed in **119** territories across the globe.



Pierre Fabre Laboratories Worldwide

10,000 employees

The company has 2 divisions: **Medical Care**, a global player in oncology and dermatology, and **Dermo-Cosmetics**, the world's second-largest dermo-cosmetics lab.

Medical Care focuses on **oncology, rare diseases, dermatology**, primary care and family health.

The company is **foundation-owned**, with an emphasis on creating long-term value for patients.

Product/ Investigational Asset ¹⁻³	Partner/ Originator	Therapeutic Class	Disease Area	Indication	Discovery	Preclinical	Phase 1	Phase 2	Phase 3	Approval ^{1,4,5}	
 Hemangeol [®] (propranolol hydrochloride) oral solution 4.20 mg/mL	 CHU BDX CENTRE HOSPITALIER UNIVERSITAIRE BORDEAUX	Beta-blocker	Dermatology	Proliferating infantile hemangioma	●	●	●	●	●		
• Blocks beta-adrenergic receptors											
Tabelecleucel	 ATARA BIO [®]	Allogeneic T-cell therapy	Malignant hematology	R/R EBV ⁺ PTLD	●	●	●	●	●	CRL and BLA Resubmission ^a	
• Allogeneic T-cell therapy											
ER004	 espeRare	Protein replacement therapy	Genetic disorder	X-linked hypohidrotic ectodermal dysplasia	●	●	●				
• In-utero therapy designed to replace the function of endogenous ectodysplasin A1 (EDA1), which is a protein key to the normal development of ectodermal structures in fetuses											
Exarafenib	 KINNATE BIOPHARMA	Targeted therapy	Solid tumor	NRAS melanoma	●	●					
• Pan-RAF small molecule inhibitor											
PFL-002/VERT-002		Targeted therapy	Solid tumor	NSCLC with mutation or amplification of <i>MET</i>	●	●					
• Monoclonal antibody acting as a degrader of c-MET											

This chart includes investigational compounds and/or investigational uses of approved products, for which efficacy and safety have not been established. Approved products should be used in accordance with their respective approved label.

Information about the trials can be found at: www.ClinicalTrials.gov.

^aIn January 2025, the tabelecleucel program was placed on clinical hold due to GMP compliance issues identified during the pre-license inspection of the third-party manufacturing facility.

BLA, biological license application; CRL, complete response letter; EBV, Epstein-Barr virus; EDA1, ectodysplasin A1; GMP, good manufacturing practice; NSCLC, non-small cell lung cancer; PTLD, post-transplant lymphoproliferative disease; R/R, relapsed/refractory.

1. Pierre Fabre Pharmaceuticals Inc. Accessed April 22, 2024. <https://www.pierrefabrepharmaceuticals.com/> 2. Oncology portfolio - approved products & pipeline. Pierre Fabre. Accessed April 22, 2025. https://static.pierre-fabre.com/corpo/sites/pierre-fabre.com/files/2024-10/RD_OncoPipeline%20des%20Laboratoires%20Pierre%20Fabre_29102024.pdf 3. Intraamniotic administrations of ER004 to male subjects with X-linked hypohidrotic ectodermal dysplasia (EDELIFE). Clinicaltrials.gov identifier: NCT04980638. Updated June 27, 2024. Accessed August 27, 2024. <https://clinicaltrials.gov/study/NCT04980638> 4. Pierre Fabre Laboratories announces the submission by Atara Biotherapeutics of Tabelecleucel (Tab-cel[®]) Biologics License Application for treatment of Epstein-Barr virus positive post transplant lymphoproliferative disease with U.S FDA. Pierre Fabre Pharmaceuticals. Accessed April 22, 2025. https://www.pierrefabrepharmaceuticals.com/press/20240520_PR_BLA_Filing_EBVALLO.pdf 5. Atara Biotherapeutics Provides Regulatory Updates on EBVALLO[™] (tabelecleucel). Accessed May 14, 2025. <https://investors.atarabio.com/news-events/press-releases/detail/371/atarabio-biotherapeutics-provides-regulatory-updates-on>



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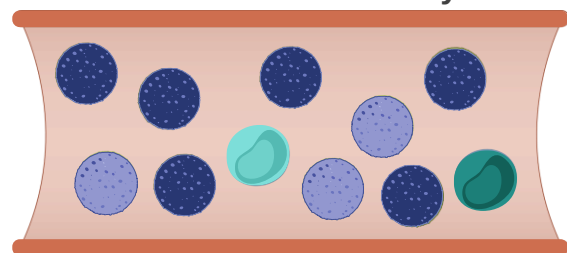
Disease State and Unmet Need: EBV+ PTLD

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EBV+ PTLD Is an Ultra-Rare and Potentially Under-Reported Condition That Occurs in HCT and SOT Patients^{1,2}

Epstein-Barr Virus–Positive (EBV+) Post-Transplant Lymphoproliferative Disorder (PTLD) occurs when EBV infection or reactivation triggers uncontrolled growth of B cells in immunosuppressed patients (eg, post-transplant)³⁻⁵

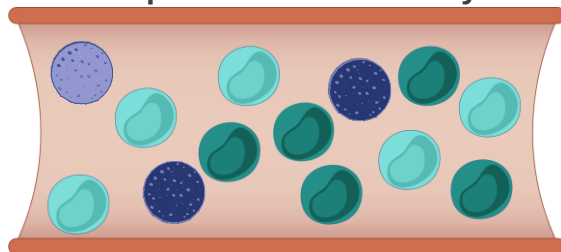
Intact T-cell immunity



Immunocompetent individual

T cells keep the EBV infection under control by killing infected B cells^{3,4}

Impaired T-cell immunity

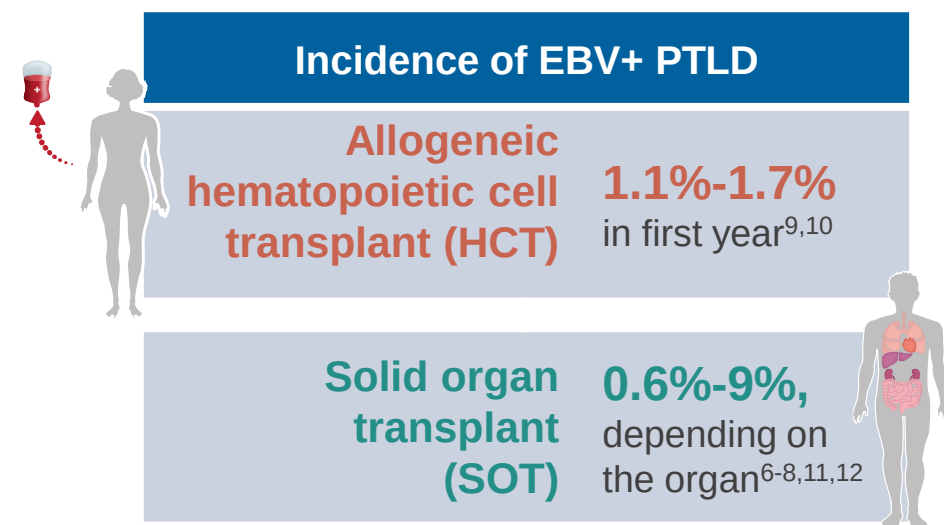


Transplant patients

With impaired T-cell immunity, reactivated EBV can cause B cells to transform and rapidly proliferate, causing a range of malignancies, such as PTLD³⁻⁵



EBV+ PTLD is rare, and the incidence is generally higher in pediatric patients than adult patients, regardless of organ transplanted.⁶⁻⁹



CD, clusters of differentiation; CTL, cytotoxic lymphocyte; EBV, Epstein-Barr virus; HCT, hematopoietic cell transplant; PTLD, post-transplant lymphoproliferative disorder; SOT, solid organ transplant.

1. Chaganti S et al. *Adv Ther*. 2023;40(3):1267-1281. 2. Sun ZJ et al. *World J Clin Cases*. 2019;7(24):4334-4341. 3. Nijland ML et al. *Transplant Direct*. 2015;2(1):e48. 4. Cohen JL. *N Engl J Med*. 2000;343(7):481-492. 5. Crombie JL, LaCasce AS. *Front Oncol*. 2019;9:109. 6. Hart A et al. *Am J Transplant*. 2021;21(suppl 2):21-137. 7. Kwong AJ et al. *Am J Transplant*. 2021;21(suppl 2):208-315. 8. Colvin M et al. *Am J Transplant*. 2021;21(suppl 2):356-440. 9. Valapour M et al. *Am J Transplant*. 2021;21(suppl 2):441-520. 10. Dierickx D et al. *Leuk Lymphoma*. 2013;54(11):2433-2440. 11. García-Cadenas I et al. *Eur J Haematol*. 2019;102(6):465-471. 12. Kandaswamy R et al. *Am J Transplant*. 2021;21(suppl 2):138-207. 13. Horslen SP et al. *Am J Transplant*. 2021;21(suppl 2):316-355.

EBV+ PTLD Differs From EBV- PTLD in Regard to Clinical Presentation, Onset, and Treatment



Clinical presentation

EBV+ PTLD

- Clinical presentation of EBV+ PTLD is **heterogeneous**, with a median time to diagnosis of 2.06 years^{1,2}

EBV- PTLD

- Clinical presentation of EBV- PTLD typically develops later in the post-transplant period with a median time to diagnosis of 4.79 years²



Treatment and prognosis

- Reduction in immunosuppression is generally the initial step for treatment PTLD, followed by first-line anti-CD20 antibody treatment or chemoimmunotherapy³
- Approximately 50% of patients with EBV+ PTLD following hematopoietic cell transplant (HCT) and 60% of patients with EBV+ PTLD following solid organ transplant (SOT) respond to first-line therapy⁴
- Novel therapies, such as EBV-targeted cell therapy, may be a treatment option for patients with relapsed or refractory EBV+ PTLD³

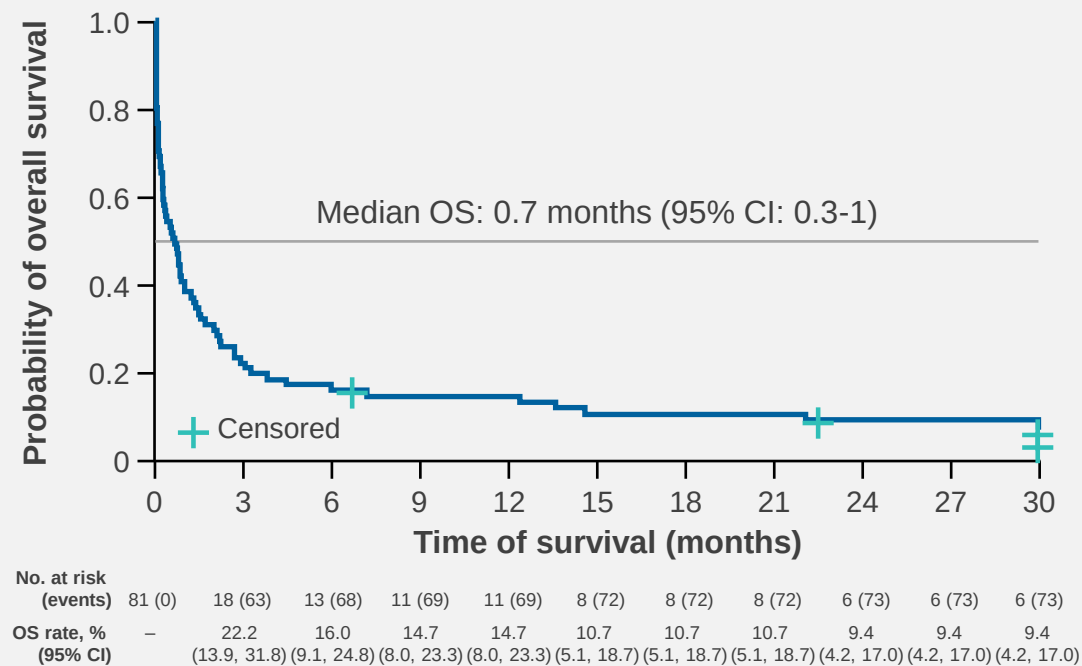
CD, Clusters of Differentiation; EBV, Epstein-Barr virus; HCT, hematopoietic cell transplant; PTLD, post-transplant lymphoproliferative disorder.

1. Fujimoto A, Suzuki R. *Cancers (Basel)*. 2020;12(2):328. 2. Luskin MR et al *Am J Transplant*. 2015;15(10):2665-2673. 3. Amengual JE, Pro B. *Blood*. 2023;142(17):1426-1437. 4. Mahadeo KM et al. *Lancet Oncol*. 2024;25(3):376-387.



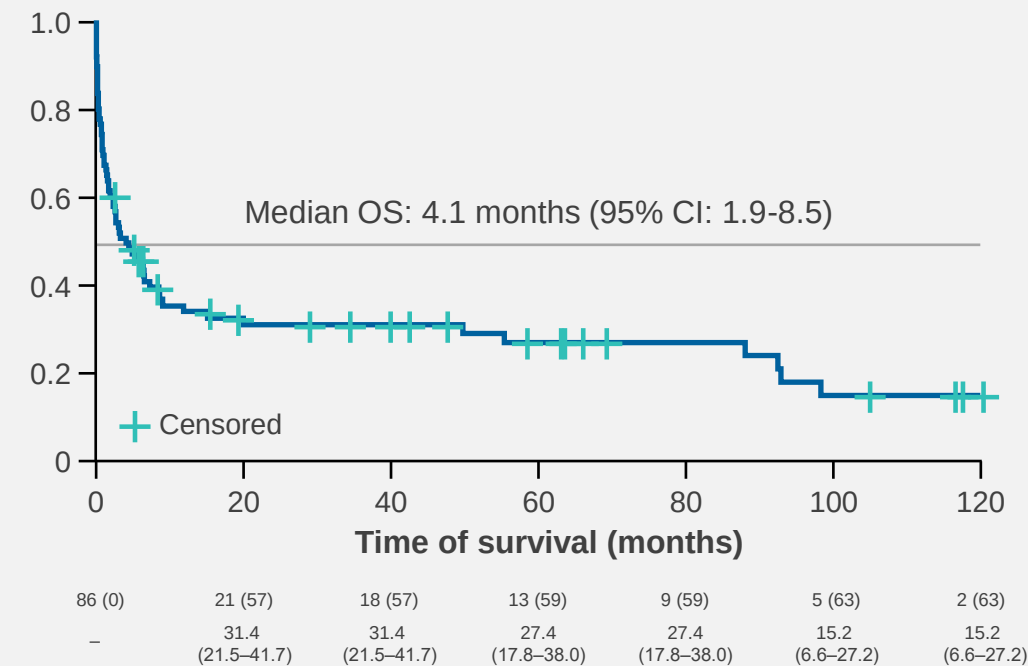
OS Is Poor in Patients With EBV+ PTLD That Do Not Respond to Standard Treatment Options

OS in Patients with R/R EBV+ PTLD Following HCT Who Failed Anti-CD20 Antibody ± CT^a (N=81)¹



Survival was measured from the earliest date when patients became refractory or relapsed to rituximab ±CT.

OS in Patients with R/R EBV+ PTLD Following SOT Who Failed Anti-CD20 Antibody + CT^a (N=86)²



Survival was estimated from the earliest date when patients became refractory or relapsed after rituximab + CT.

^aThese therapies are not approved for the treatment of PTLD.

CT, chemotherapy; EBV, Epstein-Barr Virus; HCT, hematopoietic cell transplant; OS, overall survival; PTLD, post-transplant lymphoproliferative disease; R/R, relapsed or refractory; SOT, solid organ transplant.

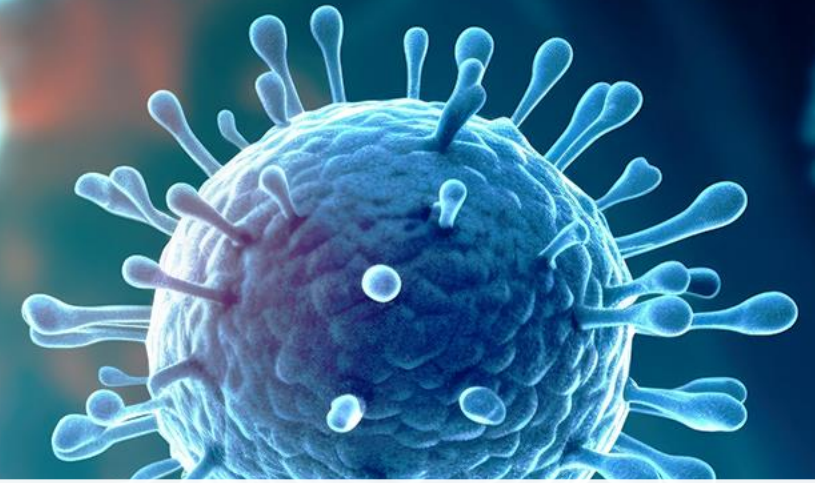
1. Sanz J et al. Poster presented at: 63rd ASH Annual Meeting and Exposition, December 11-14, 2021, Atlanta, GA. 2. Dharnidharka V et al. Poster presented at: 63rd ASH Annual Meeting and Exposition, December 11-14, 2021, Atlanta, GA.



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Tabelecleucel Mechanism and Production

Tabelecleucel is an investigational therapy that has not been cleared by the FDA for any indication at this time. This investigational agent is not approved by the FDA, and the safety or effectiveness of the product or its use has not been established.

This information is provided exclusively for scientific exchange (and formulary committee evaluation) purposes only.

For reactive medical scientific exchange with Healthcare Professionals and non-promotional use only.

Tabelecleucel Is an Individualized Allogeneic T-Cell Immunotherapy That Targets EBV-Infected Cells



Tabelecleucel is being investigated for the potential treatment of Epstein-Barr virus (EBV)–associated malignancies and diseases¹



Tabelecleucel is being developed to target and eliminate EBV-expressing cells in a human leukocyte antigen (HLA)-restricted manner¹



Cells are typically matched within 24 hours and received within a few days²



Cells are injected over 5-10 minutes via a slow IV push²

From clinical trial protocols, treatment with tabelecleucel¹:

- Did not require lymphodepletion
- Included a one-hour monitoring period following IV injection
- Occurred in both inpatient and outpatient settings

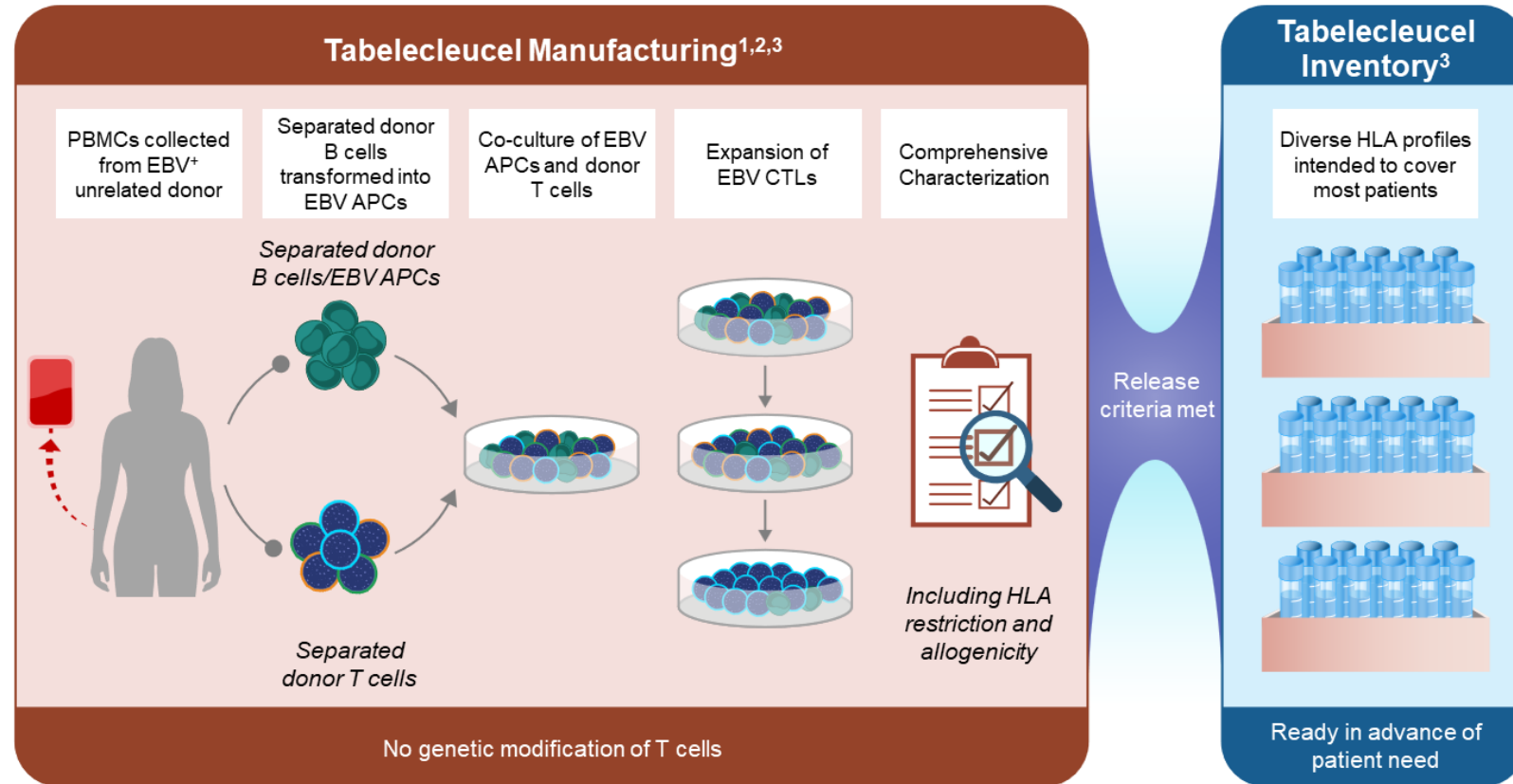
EBV, Epstein-Barr virus; HLA, human leukocyte antigen; IV, intravenous.

1. Ghobadi A et al. Presented at ASTCT and CIBMTR Tandem Meeting 2025. [abstract 742]. 2. Data on file. Pierre Fabre Pharmaceuticals Inc.



Tabelecleucel Is Manufactured Using a Highly Specialized Process That Uses CTLs From a Healthy Donor

Overview of Tabelecleucel Manufacturing



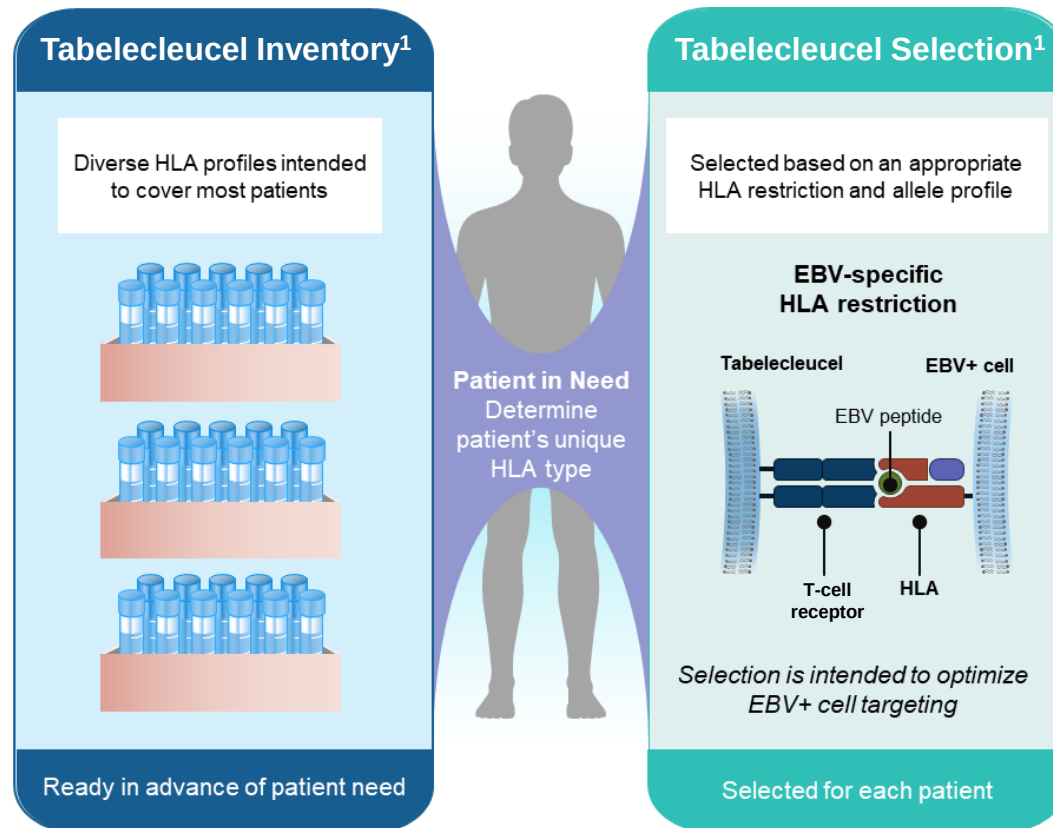
Donor cells are expanded and tested to target EBV, creating a bank of patient-ready preprepared lots

APC, antigen-presenting cells; CTL, cytotoxic T lymphocyte; EBV, Epstein-Barr virus; PBMC, peripheral blood mononuclear cell; HLA, human leukocyte antigen.

1. Koehne G et al. *Blood*. 2002;99(5):1730-1740. 2. Barker JN et al. *Blood*. 2010;116(23):5045-5049. 3. Prockop S et al. *J Clin Invest*. 2020;130(2):733-747.

Patients Receive Appropriately Matched Tabelecleucel Lot Based on Their HLA Type

Overview of Selection of Tabelecleucel for a Specific Patient



- 1 Human leukocyte antigen (HLA) restriction determined in tabelecleucel²
- 2 **High-resolution** HLA typing provided by treating physician^{2,3}
- 3 Tabelecleucel selection based on the following criteria²:
≥1 shared HLA restriction + ≥1 additional HLA match
- 4 Matched tabelecleucel proposed and shipped to the treating physician¹
- 5 Patients may be switched to tabelecleucel with a different HLA restriction up to 4 times if response is not adequate²

EBV, Epstein-Barr virus; HLA, human leukocyte antigen.

1. Prockop S et al. *J Clin Invest*. 2020;130(2):733-747. 2. Koehne G et al. *Blood*. 2002;99(5):1730-1740. 3. Barker JN et al. *Blood*. 2010;116(23):5045-5049.



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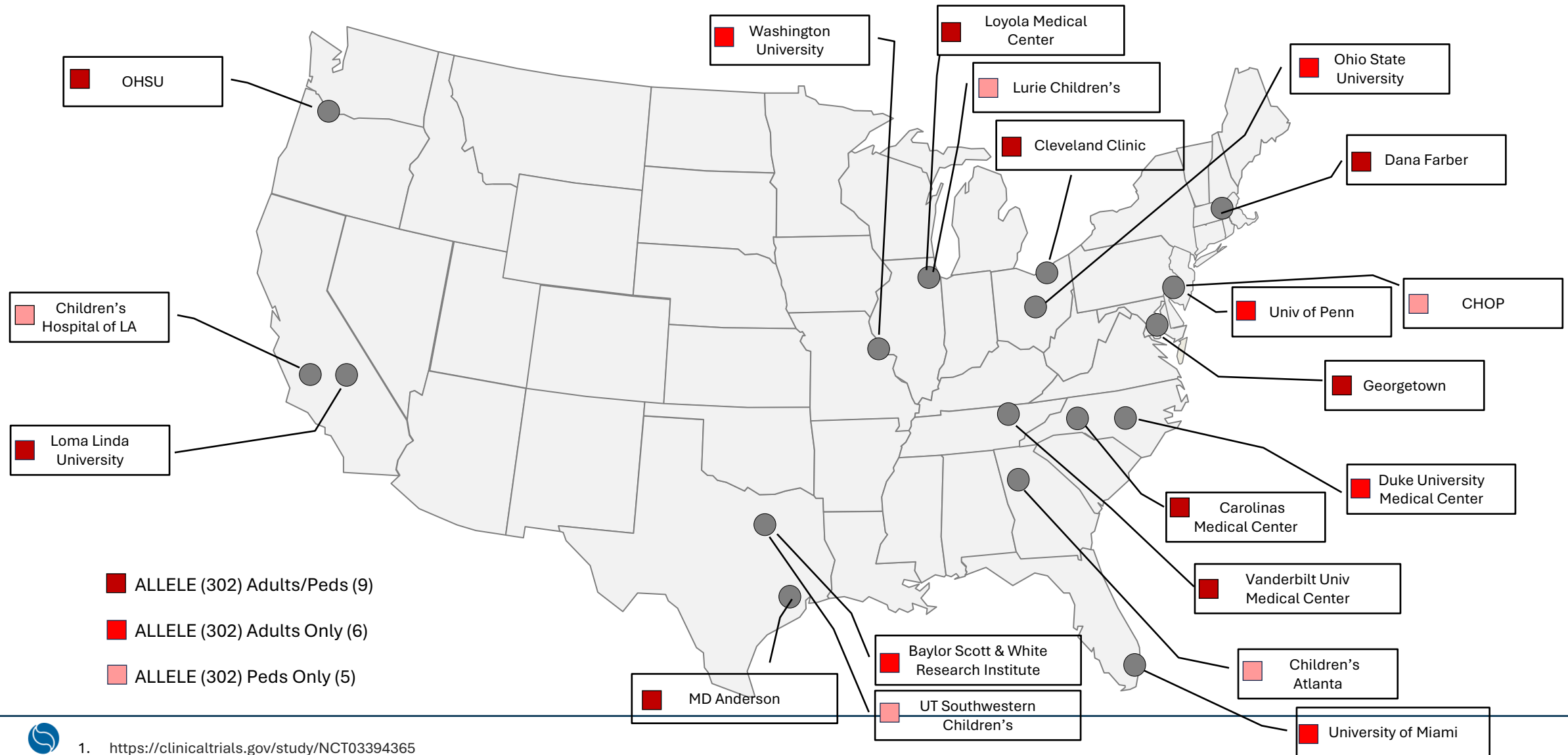
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Efficacy and Safety of Tabelecleucel in EBV+ PTLD After Rituximab Failure: ALLELE Study

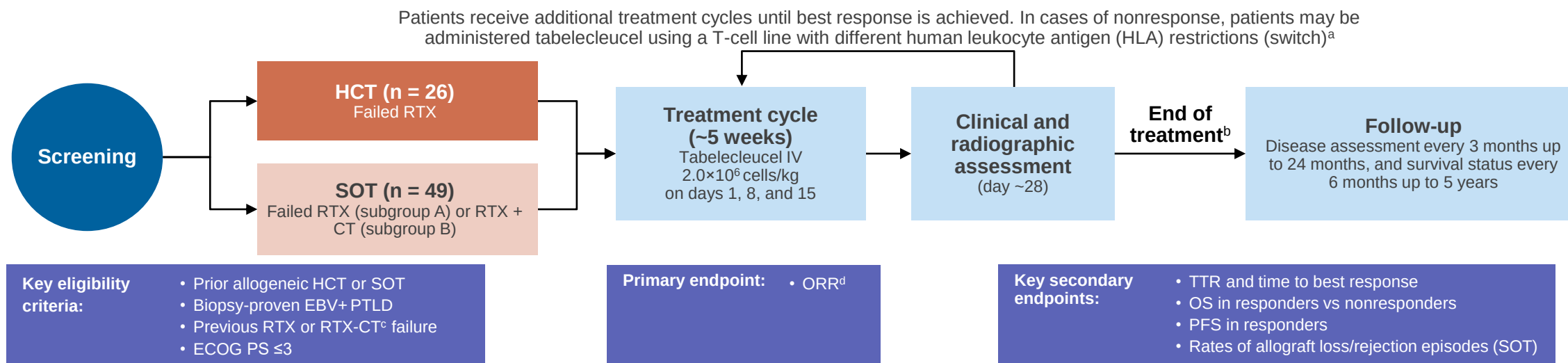
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ALLELE Clinical Trial Sites in the US¹



The Phase 3 ALLELE Study Investigating Tabelecleucel in EBV+ PTLD After Rituximab Failure^{1,2}

The ALLELE study (NCT03394365) is an ongoing, global, multicenter, open-label, phase 3 study of tabelecleucel after failure of rituximab (RTX) ± chemotherapy (CT) in patients with EBV+ PTLD following hematopoietic cell transplant (HCT) or solid organ transplant (SOT).



Data cut off date: Oct 9, 2023.

^aPatients may receive up to 4 (in HCT group) or 2 (in SOT group) different HLA restrictions. ^bDefined as any of the following: maximal response achieved; unacceptable toxicity; initiation of nonprotocol therapy; or failure of up to 4 (in HCT group) or 2 (in SOT group) different HLA restrictions. ^cIncluding R-CHOP. ^dEvaluated by independent review.

CT, chemotherapy; EBV, Epstein-Barr virus; ECOG PS, Eastern Cooperative Oncology Group performance status; HCT, hematopoietic cell transplant; HLA, human leukocyte antigen; IV, intravenous; ORR, objective response rate; OS, overall survival; PFS, progression free survival; PTLD, post-transplant lymphoproliferative disorder; R-CHOP, rituximab, cyclophosphamide, doxorubicin, vincristine, and prednisolone; RTX, rituximab; SOT, solid organ transplant; TTR, time to response.

1. Mahadeo KM et al. *Lancet Oncol.* 2024;25(3):376-387. 2. Ghobadi A et al. ASTCT and CIBMTR Tandem Meetings; February 12-15, 2025; Honolulu, HI. Abstract 742.

ALLELE Study: Baseline Demographics and Disease Characteristics

Demographics	HCT (n = 26)	SOT (n = 49)	All (N = 75)
Age, median (range), years	49.3 (3.2-73.2)	42.8 (2.7-81.5)	44.4 (2.7-81.5)
Male sex, n (%)	15 (57.7)	29 (59.2)	44 (58.7)
ECOG PS score, median (range) ^a	1 (0-3)	1 (0-3)	1 (0-3)
ECOG PS score ≥2, n (%) ^b	6 (24)	12 (27.9)	18 (26.5)
Disease characteristics			
Extranodal disease at screening, n (%)	16 (61.5)	40 (81.6)	56 (74.7)
PTLD-adapted prognostic index, n (%) ^c	n = 25	n = 43	N = 68
High risk	12 (48.0)	17 (39.5)	29 (42.6)
Intermediate risk	13 (52.0)	21 (48.8)	34 (50.0)
Low risk	0	4 (9.3)	4 (5.9)
Unknown	0	1 (2.3)	1 (1.5)
PTLD morphology, n (%)	n = 26	n = 49	N = 75
Diffuse large B-cell lymphoma	18 (69.2)	34 (69.4)	52 (69.3)
Plasmablastic lymphoma	1 (3.8)	2 (4.1)	3 (4.0)
Other ^d	7 (26.9)	12 (24.5)	19 (25.3)
Median (range) time, months			
From transplant to EBV ⁺ PTLD diagnosis	3.9 (0.6-66.0)	10.8 (2.4-314.4)	-
From EBV ⁺ PTLD diagnosis to first tabellecleucel administration	2.1 (0.6-28.1)	6.9 (1.3-190.5)	4.6 (0.6-190.5)

^aData are shown for patients aged ≥16 years and having a baseline ECOG measurement (n = 67; n = 25 for HCT and n = 42 for SOT). ^bData are shown for patients aged ≥16 years (n = 68; n = 25 for HCT and n = 43 for SOT). ^cPTLD-adapted prognostic index at study entry: low risk (no high-risk factors among age, ECOG, and LDH) vs intermediate risk (1 high-risk factor) vs high risk (2 or 3 high risk factors); data are shown for patients aged ≥16 years. ^dMorphologies not clearly diffuse large B-cell lymphoma or plasmablastic lymphoma were categorized as "Other."

EBV⁺, Epstein-Barr virus positive; ECOG PS, Eastern Cooperative Oncology Group performance status; HCT, hematopoietic cell transplant; LDH, lactate dehydrogenase; PTLD, posttransplant lymphoproliferative disease; SOT, solid organ transplant.

1. Ghobadi A et al. ASTCT and CIBMTR Tandem Meetings; February 12-15, 2025; Honolulu, HI. Abstract 742.

Patients in the ALLELE Study Received a Median of 1 Line (Range: 1-5) of Prior Systemic Treatment

Treatment and prior therapies	HCT (n = 26)	SOT (n = 49)	All (N = 75)
Median lines of prior systemic treatment, n (range)	1 (1-4)	1 (1-5)	1 (1-5)
Prior rituximab monotherapy, n (%)	26 (100.0)	39 (79.6)	65 (86.7)
Prior chemotherapy, n (%)	4 (15.4)	31 (63.3)	35 (46.7)
Prior chemotherapy in combination with rituximab, n (%)	0	28 (57.1)	28 (37.3)
Prior immunotherapy, n (%)	1 (3.8)	2 (4.1)	3 (4.0)
Transplant type, n (%)			
Kidney	-	14 (28.6)	-
Heart	-	12 (24.5)	-
Lung	-	9 (18.4)	-
Liver	-	4 (8.2)	-
Multivisceral	-	10 (20.4)	-

HCT, hematopoietic cell transplant; SOT, solid organ transplant.

1. Ghobadi A et al. ASTCT and CIBMTR Tandem Meetings; February 12-15, 2025; Honolulu, HI. Abstract 742.

Patients in the ALLELE Study Received a Median of 2 (Range: 1-6) Cycles of Tabelecleucel

Tabelecleucel exposure	HCT (n = 26)	SOT (n = 49)	All (N = 75)
Number of tabelecleucel cycles, median (range)	2 (1-5)	2 (1-6)	2 (1-6)
Number of tabelecleucel infusions, median (range)	6 (2-15)	6 (1-18)	6 (1-18)
Tabelecleucel treatment duration, median (range), months	2.0 (0.2-5.8)	1.8 (0.03-6.5)	1.9 (0.03-6.5)
Location of infusion administration, n (%) ^a			
Inpatient, number of infusions (%)	72 (36.0)	103 (31.4)	175 (33.1)
Outpatient, number of infusions (%)	128 (64.0)	225 (68.6)	353 (66.9)
Number of unique lots received, n (%)			
1	15 (57.7)	34 (69.4)	49 (65.3)
2	8 (30.8)	15 (30.6)	23 (30.7)
3	3 (11.5)	0	3 (4.0)

- Regarding the change of lot with different HLA restrictions, 65% of patients received only 1 lot, 31% received 2, and 4% received 3 different lots

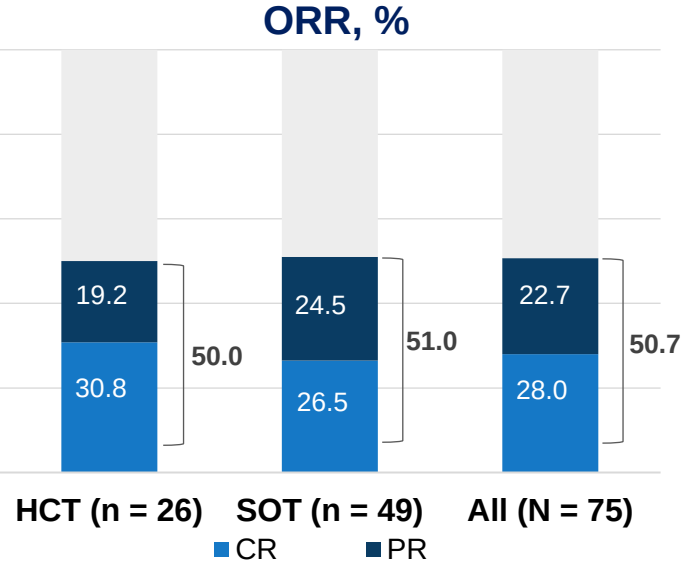
^aDenominator is total number of tabelecleucel infusions.

HCT, hematopoietic cell transplant; HLA, human leukocyte antigen; SOT, solid organ transplant.

1. Ghobadi A et al. ASTCT and CIBMTR Tandem Meetings; February 12-15, 2025; Honolulu, HI. Abstract 742.

In the ALLELE Study, the Primary Endpoint Analysis Revealed an ORR of 50.7% (n = 38/75) in All Patients¹

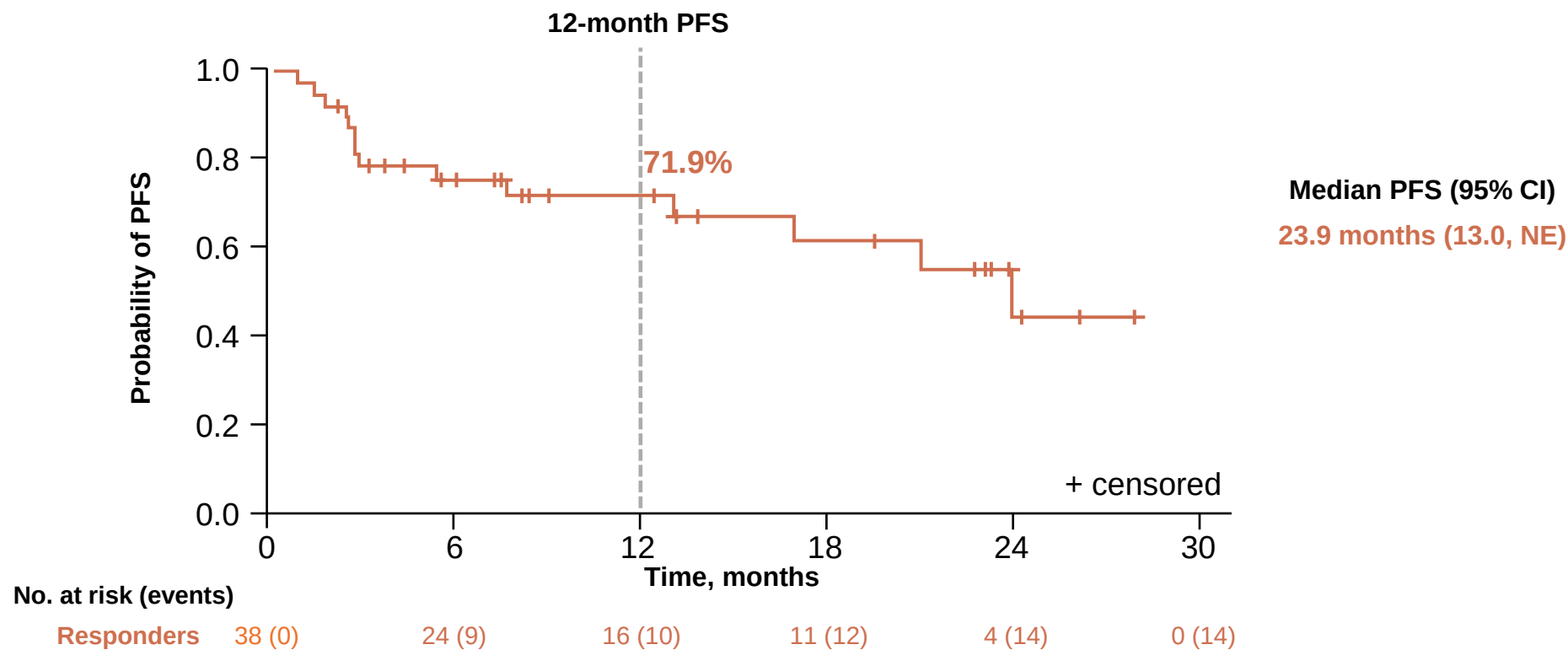
- Most patients treated with tabellecleucel achieved a clinical benefit, with a clinical benefit rate of **71%** for **hematopoietic cell transplant (HCT)** and **59%** for **solid organ transplant (SOT)**²
- Over 25% of patients showed a complete response (CR) (21 patients [**28.0%**] achieved CR, and 17 patients [**22.7%**] achieved partial response [PR])¹
 - Median time to response in all patients was **1.1 months**
 - Estimated median duration of response was **23 months**



	HCT (n = 26)	SOT (n = 49)	All (N = 75)
Responders, n (%) ^a	13 (50.0)	25 (51.0)	38 (50.7)
(95% CI)	(29.9, 70.1)	(36.3, 65.6)	(38.9, 62.4)
Response before 1st restriction switch, n (%)	12 (46.2)	20 (40.8)	32 (42.7)
(95% CI)	(26.6, 66.6)	(27.0, 55.8)	(31.3, 54.6)
Time, median (range), months	n = 13	n = 25	n = 38
Time to response	1.0 (0.6-9.0)	2.0 (0.7-4.7)	1.1 (0.6-9.0)
Time to best response	1.0 (0.6-9.0)	2.1 (0.7-7.3)	1.6 (0.6-9.0)
Estimated duration of response, median (95% CI), months ^b	19.0 (1.5, NE)	NE (6.8, NE)	23.0 (12.1, NE)

^aResponse assessed per Lugano classification with LYRIC modification by IORA. ^bEstimated by the Kaplan-Meier method.
CR, complete response; HCT, hematopoietic cell transplant; IORA, independent oncologic response adjudication; LYRIC, Lymphoma Response to Immunomodulatory Therapy Criteria; NE, not estimable; ORR, objective response rate; PR, partial response; SOT, solid organ transplant.
1. Ghobadi A et al. ASTCT and CIBMTR Tandem Meetings; February 12-15, 2025; Honolulu, HI. Abstract 742. 2. Mahadeo KM et al. Lancet Oncol. 2024;25(3):376-387.

In the ALLELE Study, PFS Was Assessed in Responders



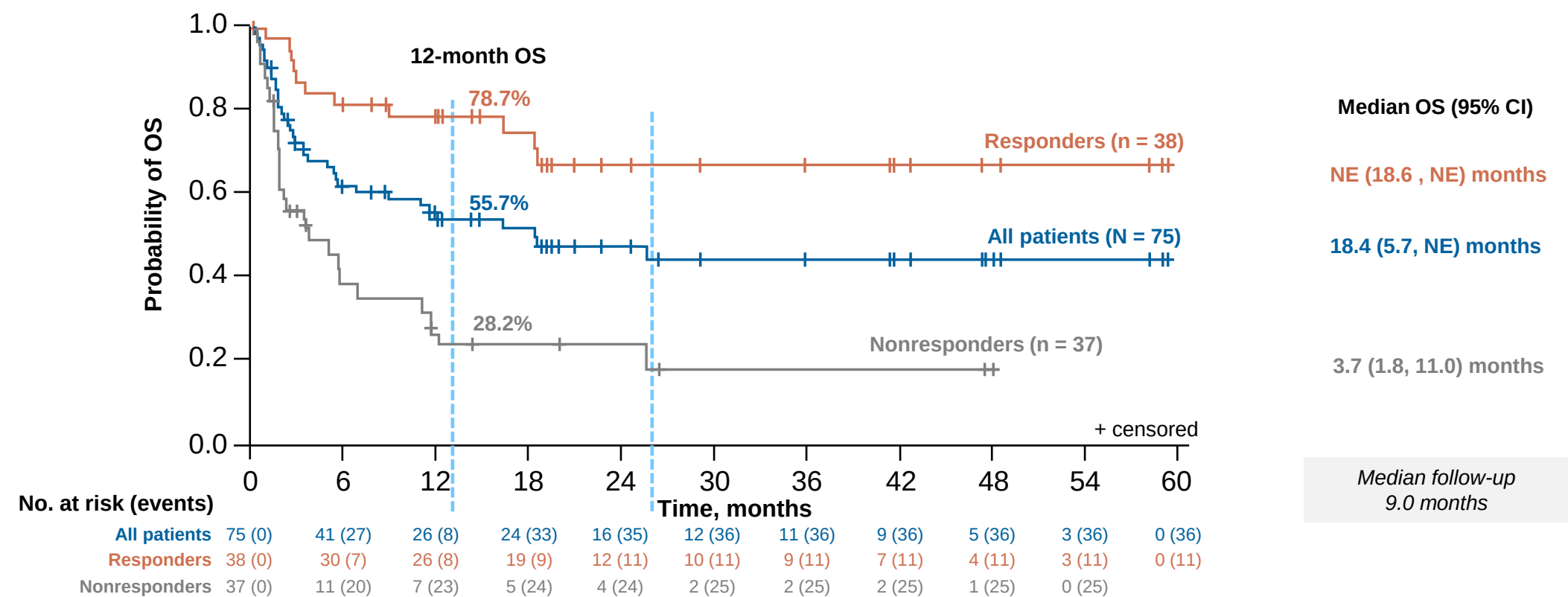
Responders to tabellecleucel had a 12-month progression-free survival (PFS) rate^a of **71.9%**

^aPFS was estimated by the Kaplan-Meier method.

NE, not estimable; PFS, progression-free survival.

1. Ghobadi A et al. ASTCT and CIBMTR Tandem Meetings; February 12-15, 2025; Honolulu, HI. Abstract 742.

In the ALLELE Study, Patients With a Clinical Response Had a One-Year Survival Rate Above 75%^{1,2}



- The 1-year overall survival (OS) rate was **78.7%** for **responders** compared to **28.2%** for **nonresponders**.
- For **complete responders**, 4-year survival reached **95%**



Click to view additional OS data by response

OS was estimated by the Kaplan-Meier method.
NE, not estimable; OS, overall survival.
1. Ghobadi A et al. ASTCT and CIBMTR Tandem Meetings; February 12-15, 2025; Honolulu, HI. Abstract 742. 2. Data on file. Pierre Fabre Pharmaceuticals Inc.

The Phase 3 ALLELE Study Has Shown That Tabelecleucel Has a Well-Characterized Safety Profile¹

	HCT (n = 26)	SOT (n = 49)	All (N = 75)
TESAEs, n (%)			
Any	17 (65.4)	30 (61.2)	47 (62.7)
Treatment-related ^a	2 (7.7)	4 (8.2)	6 (8.0)
Treatment-related fatal	0	0	0
Treatment-emergent identified and potential risks, including AESI by SOC, n (%)			
Tumor flare reaction	0	0	0
Infusion-related reaction	0	0	0
Cytokine release syndrome	0	0	0
Transmission of infectious disease	0	0	0
Graft-vs-host disease	3 (11.5)	0	3 (4.0)
Bone marrow/organ rejection	0	3 (6.1)	3 (4.0)
ICANS	0	0	0
Immunogenicity ^b	0	0	0

Tabelecleucel is not approved by the U.S. FDA and the safety or effectiveness of the product has not been established.

Fatal TESAEs were disease progression (n = 7), multiple organ dysfunction syndrome (n = 2), respiratory failure (n = 1), COVID-19 (n = 1), acute respiratory distress (n = 1), pneumococcal sepsis (n = 1), and shock (n = 1).

^aTreatment-related TESAEs were pyrexia, diarrhea, hypoxia, hypotension, rash, rash erythematous, and tachycardia. ^b47 participants had pan anti-HLA antibody testing completed, 18 of which were evaluable (18 in target population) for anti-HLA antibody assessment.

AESI, adverse event of special interest; HCT, hematopoietic cell transplant; HLA, human leukocyte antigen; ICANS, immune effector cell–associated neurotoxicity syndrome; SOC, system organ class; SOT, solid organ transplant; TESAE, treatment-emergent serious adverse event.

1. Ghobadi A et al. ASTCT and CIBMTR Tandem Meetings; February 12-15, 2025; Honolulu, HI. Abstract 742.

- 8% of treatment-emergent serious adverse events (TESAEs) were found by Investigators to be treatment related
- None of the fatal TESAEs were identified by Investigators to be related to tabelecleucel
- **No reports of**
 - Tumor flare reactions
 - Cytokine release syndrome
 - Immune effector cell–associated neurotoxicity syndrome (ICANS)
- **No cases of tabelecleucel-related graft-vs-host disease or organ rejection were reported by Investigators**



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