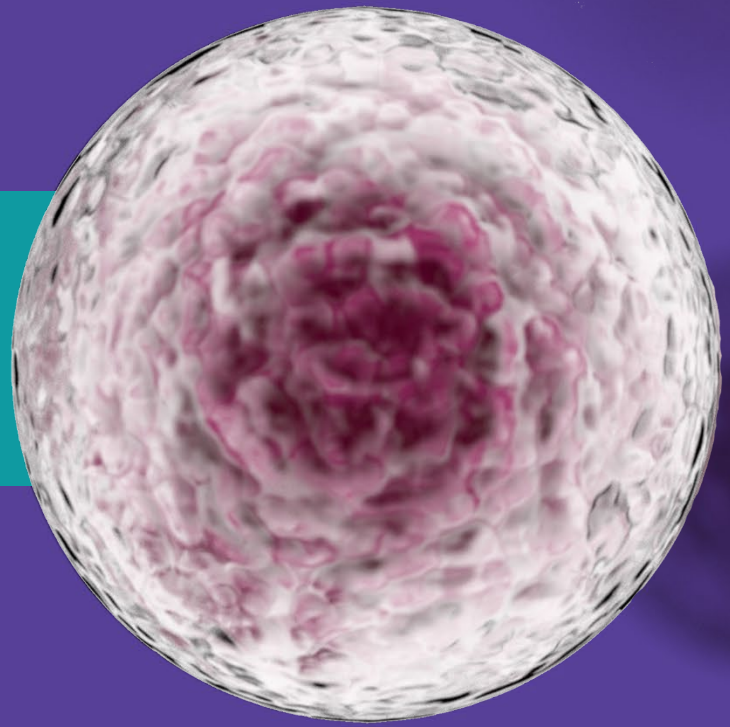
celularity



# THE NEXT **EVOLUTION** IN **CELLULAR MEDICINE**

June 2022

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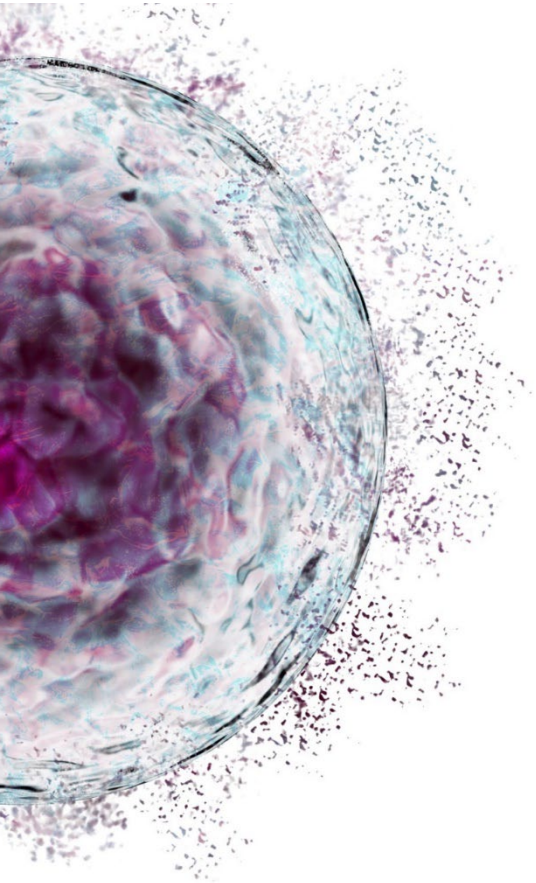
# CELULARITY'S VISION

**To deliver innovative off-the-shelf allogeneic cellular medicines for patients with high unmet need at unparalleled scale, quality and cost.**



**Lead the evolution in placental-derived therapeutics:**
advance the discovery of the placenta as a limitless, renewable source of neonatal cells, which are biologically preferred to cells from adult bone marrow or peripheral blood.

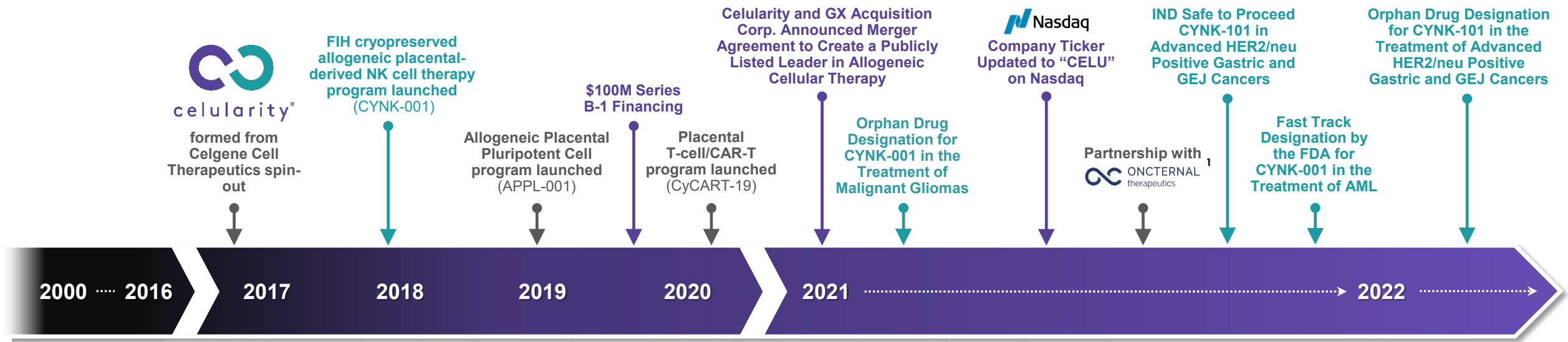
**Target large markets with high unmet need**:
broad therapeutic application including cancer, infectious, and degenerative diseases.

**Develop safe and effective therapies**:
leverage inherent advantages of placental-derived cells to produce uniform, scalable and optimized cellular medicines.

**Deliver off-the-shelf, affordable therapies**:
cryopreserved allogeneic cellular medicines and biomaterial products that clinicians can access on demand and off-the-shelf, enabling repeat dosing/multiple cycles as required in an outpatient setting.

# CELULARITY: COMPANY HISTORY

## Celgene Spin-out (2017) Leveraging 20+ Years of Cellular Therapeutics Innovation




**2000** – Anthrogenesis Corporation – Founded by Dr. Robert Hariri

**2002** – Anthrogenesis acquired by Celgene, becomes Celgene Cellular Therapeutics

**2005** – Allogeneic Placental Mesenchymal-like Stromal Cells in Crohn's, DFU

**2014** – Celgene & Bluebird Bio Autologous CAR-T Collaboration

**2015** – Celgene & Juno Therapeutics Autologous CAR-T collaboration

**2016** – FIH allogeneic placental-derived NK cell therapy product (Placental NK-007)

***KEY:*** *CORPORATE MILESTONE* *CLINICAL MILESTONE* *FINANCIAL MILESTONE*

**1, 2** Celularity continues to work with collaboration partners and may elect to provide updates at upcoming conferences.

# CELULARITY PLACENTAL-DERIVED PRODUCT PLATFORM

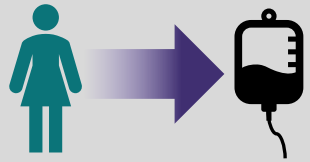
## Capitalizing on the Benefits of Placental-Derived Cells to Target Multiple Diseases

**PLACENTA**

- T-Cell Isolation + Genetic Modification
- NK CD 34+ Cell Isolation
- NK CD34+ Cell Isolation + Genetic Modification
- Mesenchymal-like Stromal Cell Isolation

**CELL THERAPY PRODUCTS**

**One Placenta → Many Patients**
- Universal donor material
- No requirement for matching between a patient and donor



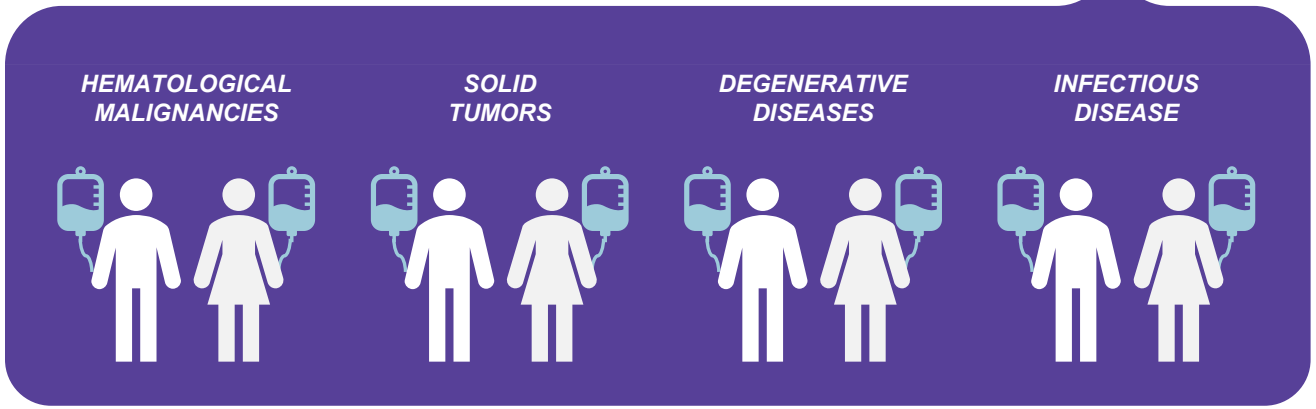
1 Donor

**Cryopreserved - On Demand & Off-The-Shelf**
- No immunogenicity or toxicity
- Re-dose\fine tune treatments
- Absence of allo-antibodies

### Postpartum Placenta
- Abundant, reliable, renewable and biologically consistent raw material
- *Nature's 'professional'* ***universal donor tissue***
- +140 Million Worldwide

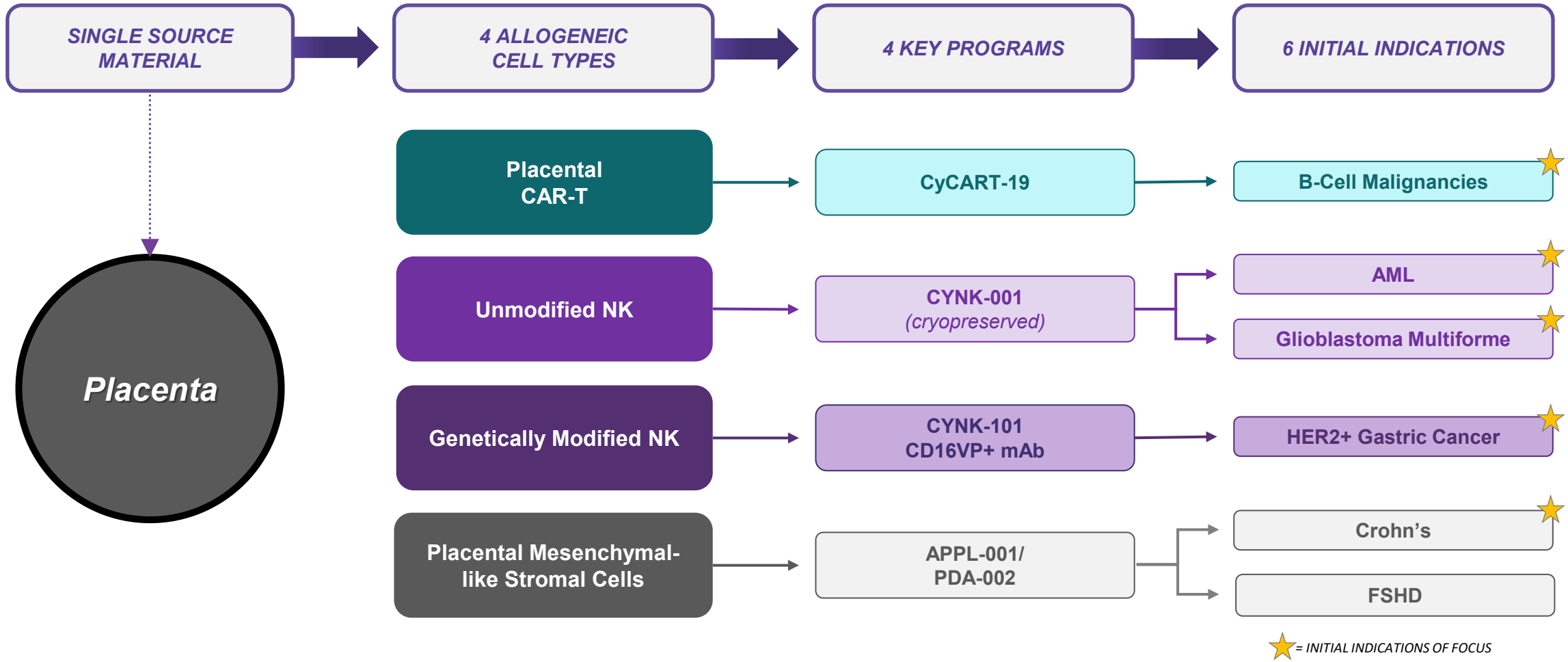
### Greatest Degree of Natural Stemness
- Greater proliferative performance (Cmax), and persistence
- Greater natural immune tolerance

### 100-100K Doses/Placenta
- High scalability



# SINGLE-SOURCE, PLACENTA-BASED PLATFORM DRIVING BROAD PIPELINE

## 4 Key Cell Types Driving 6 Clinical Indications and Potential for Broad Expansion




***MANUFACTURING*** >> Purpose-built, fully integrated manufacturing facility; rapidly scalable, end-to-end supply chain

# MANUFACTURING OVERVIEW

## Fully Integrated, Purpose-Built Commercial Scale Manufacturing Site Including Translational Research & Biorepository



### *PURPOSE BUILT FACILITY FOR COMMERCIAL-SCALE CELLULAR THERAPEUTIC MANUFACTURING*

- $80M investment in cGMP/cGTP manufacturing
- Enables greater control, efficiency and optimization than is achievable by outsourcing to contract manufacturing organizations (CMOs) alone

### *STAFFED BY OVER 100 HIGHLY SPECIALIZED SCIENTISTS, ENGINEERS & TECHNICIANS*

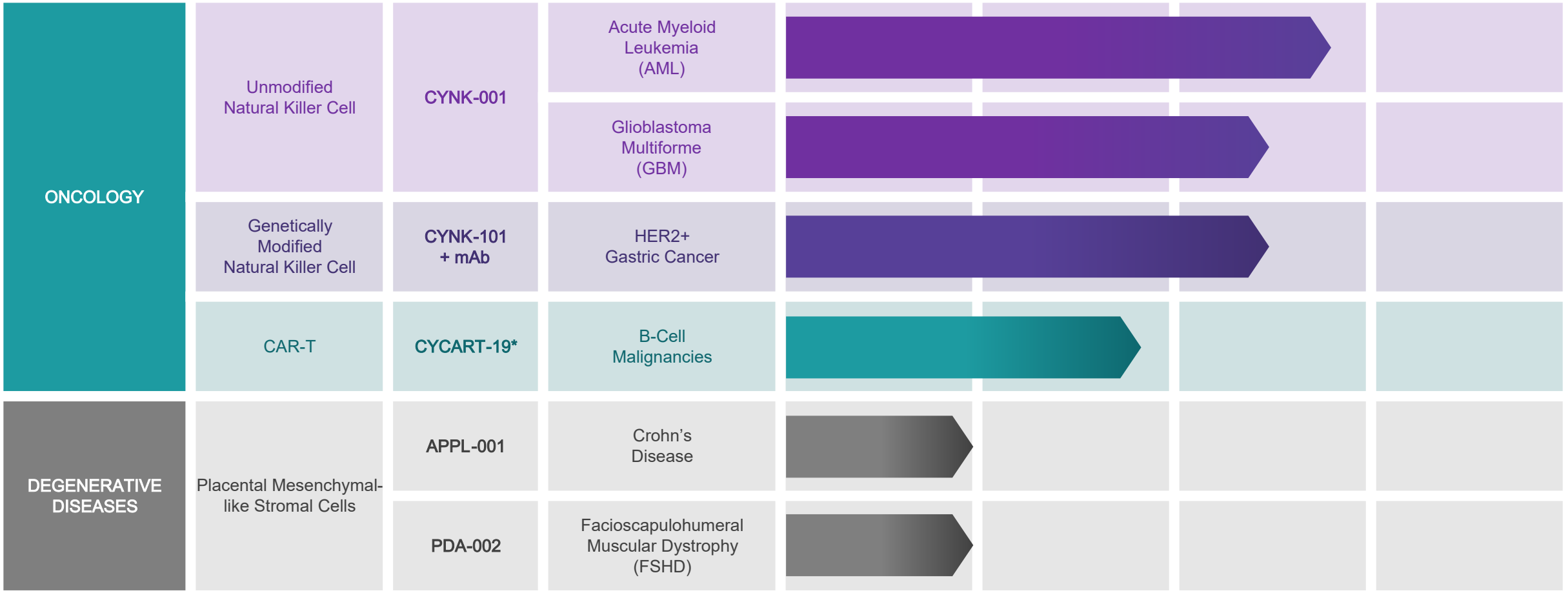
- Optimized, product-specific CMC, QA/QC and manufacturing processes accelerate product development, production and commercialization
- Over 2 decades of experience with source material procurement

### *COMMERCIAL SCALE, GMP-READY*

- 9 Grade C/ISO 7 suites
- 6 Grade D/ISO 8 labs
- Dedicated translational research labs

**Celularity benefits from Celgene's 20 year+ investment in developing the technologies and capabilities required to manufacture cellular products at scale with consistent and reliable quality**

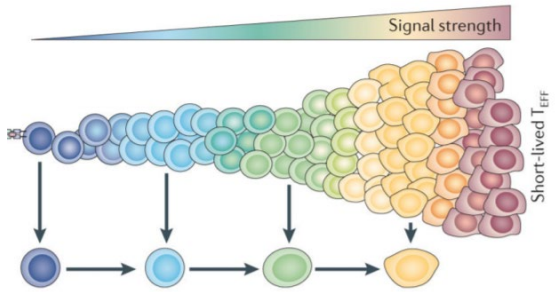
# CLINICAL PIPELINE
## Overview




*includes technology in-licensed from Sorrento Therapeutics, Inc.

# Cell Characterization

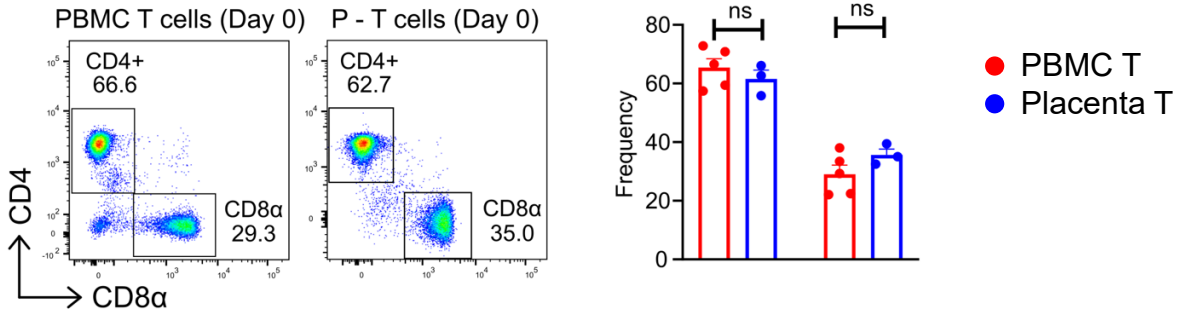
# THE PLACENTA IS ENRICHED FOR NAÏVE/SCM T CELLS COMPARED TO HEALTHY DONOR PERIHPERAL BLOOD ENABLING PRODUCTION OF CAR-T CELLS WITH GREATER ACTIVITY IN ANIMAL MODELS



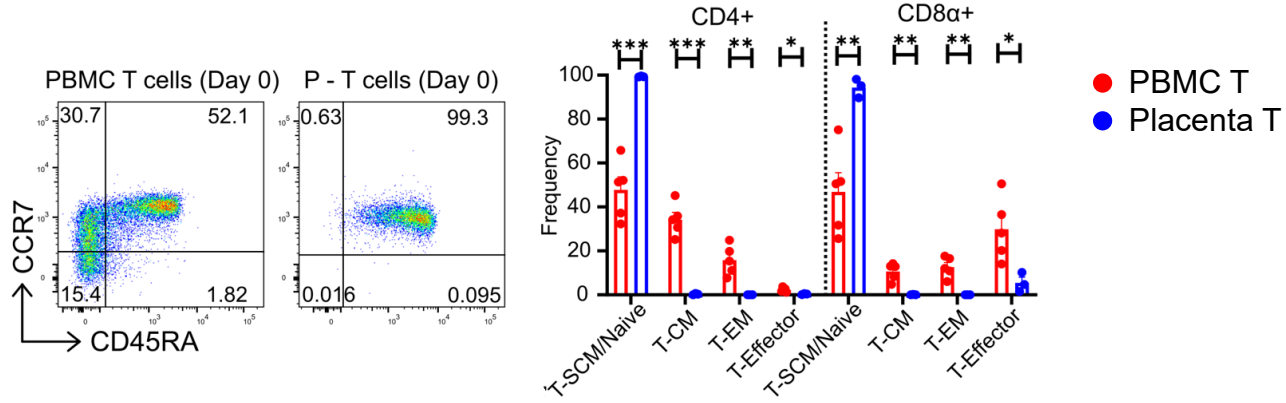

| | Marker | Naïve | Stem Cell Memory | Central Memory | Effector Memory |
|---|---|---|---|---|---|
| Phenotype | CD45RA | + | + | - | +/- |
| | CD27 | +++ | +++ | ++ | +/- |
| | CCR7 | +++ | +++ | ++ | - |
| | CD28 | ++ | +++ | +++ | +/- |
| Function | Telomere | +++ | +++ | ++ | + |
| | Self-renewal | + | +++ | ++ | + |
| | IFN-γ | - | + | ++ | +++ |
| | IL-2 | - | ++ | +++ | +/- |
| | Cytotoxicity | - | +/- | + | +++ |

Adopted from Gattinoni *et al.* Nature Reviews Cancer 2012

**Placenta T cell starting material contains similar CD4/CD8 ratio as healthy adult blood T cells**

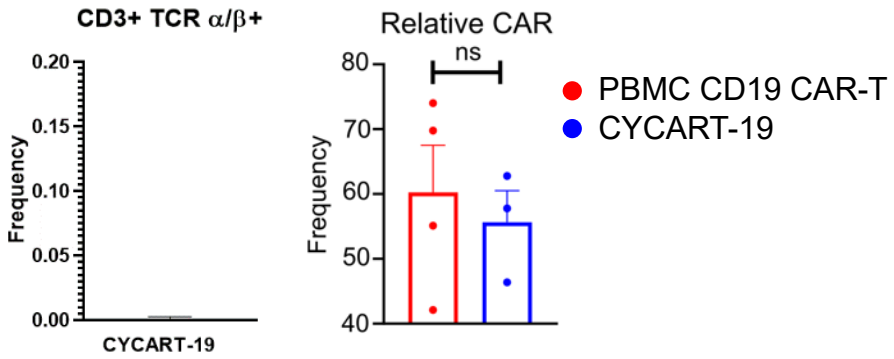



**The primary T cell population in placenta are $T_N$ and $T_{SCM}$ which retain the greatest proliferative potential**

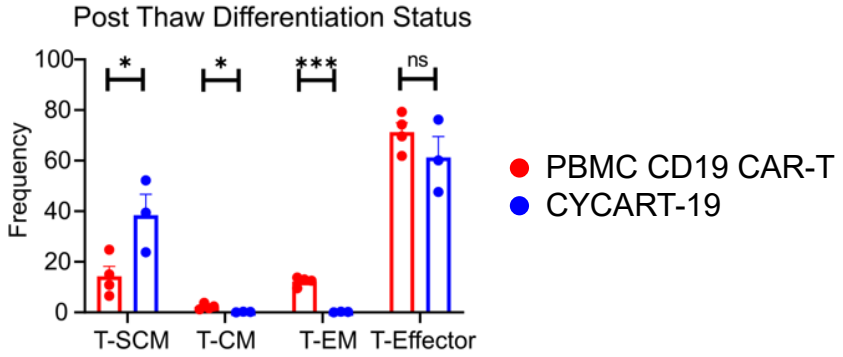


# CYCART-19 (PLACENTAL CAR-T) RETAINED STEMNESS VS PBMC CD19 CAR-T POST MANUFACTURING

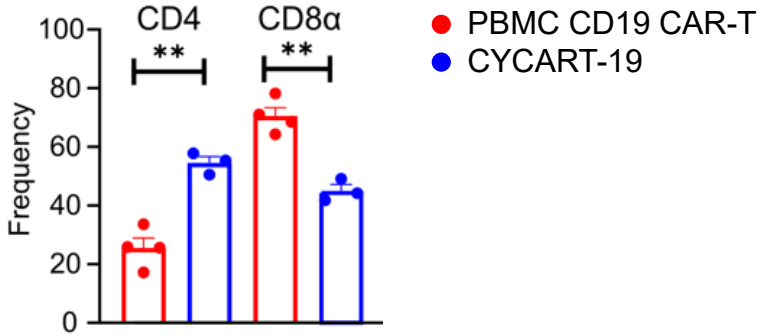
**Our process uses CRISPR to knockout TRAC and transduction of CD19-CAR**



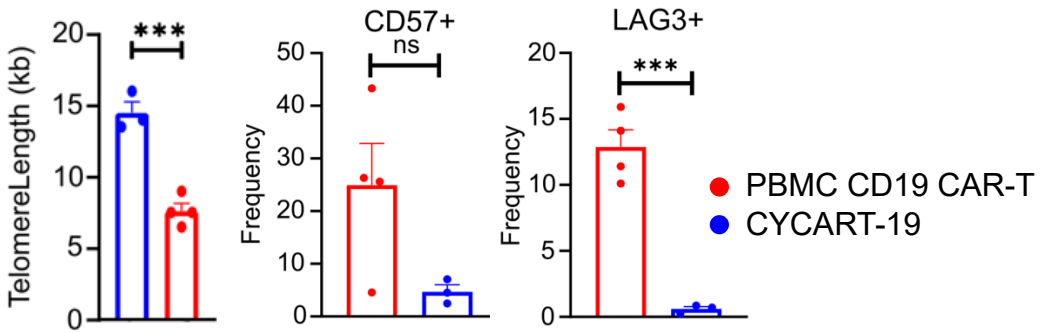

**CYCART-19 cells had better retention of the $T_{SCM}$ population following manufacturing**




**CYCART-19 cells yielded a preferable CD4/CD8 CAR-T cell ratio closer to 1:1**

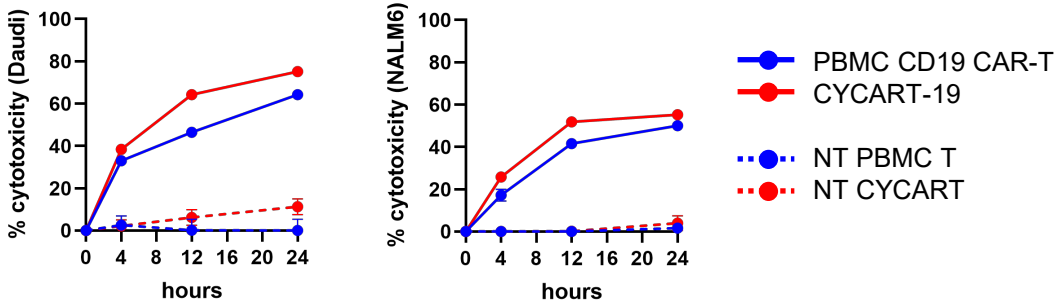



**CYCART-19 had longer telomeres, resisted expression of senescence marker CD57 and checkpoint inhibitor LAG3**

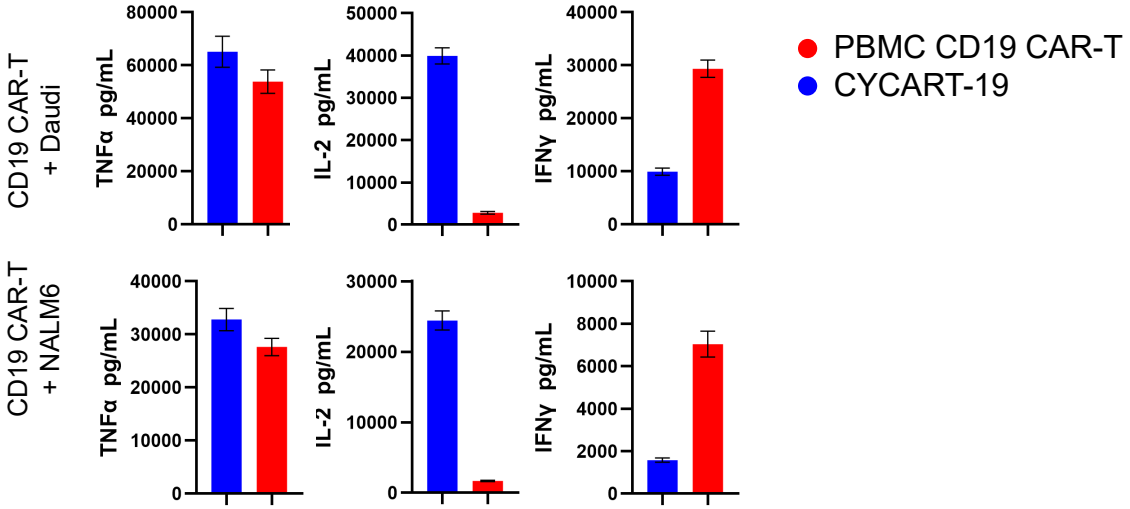


# CYCART-19 SECRETED HIGH LEVELS OF IL-2 AS COMPARED TO PBMC DERIVED CAR-T, CONFERRING A POTENTIAL CAR-T CELL SURVIVAL AND PROLIFERATION BENEFIT

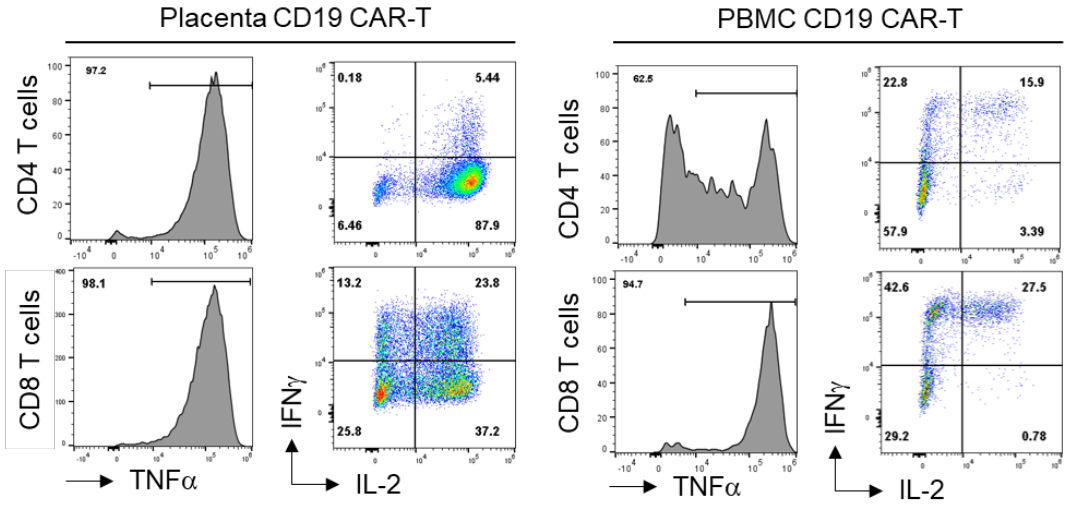
## CYCART-19 and PBMC CD19-CART were similarly cytotoxic




## CYCART-19 secreted high levels of IL-2 and low levels of IFNγ following stimulation by CD19+ lymphomas




## CD4 and CD8 CYCART-19 cells strongly expressed IL-2




- Enhanced Intrinsic IL-2 production is expected to help sustain CYCART-19 survival, proliferation, resist exhaustion, and maintain persistence in vivo
  - M. Kahan et al, Science Immunology 2022
- Reduced IFNγ production by CYCART-19, is expected to limit local PD-L1 upregulation, which may mitigate severity of CRS

# CYNK-001

AML and GBM

# **CYNK-001**(unmodified NK cellular therapy)
## Overview

### *RATIONALE*

- NK cells are natural immune cells that eradicate both cancer and virus-infected cells
  - Key mediators of antibody-dependent cellular cytotoxicity (ADCC)
- Placental-derived NK cells exhibit:
  - distinct, maturation and activation states
  - an immature phenotype
  - longer telomere length in comparison to PB NK cells, which suggests **high in vivo proliferation and persistence**

### *KEY HIGHLIGHTS*

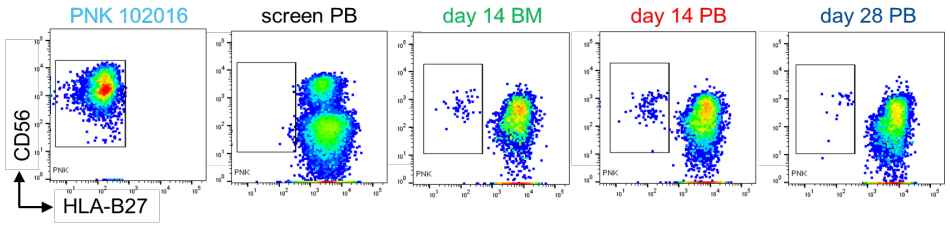
CYNK-001 (unmodified NK cellular therapy)

- Preclinical data support anticancer activity against a range of hematological malignancies and solid tumors
- Phase 1 trial in relapsed/refractory (r/r) AML showed early signs of clinical benefit and a generally positive safety profile
- Estimated trial completion in 2023
- Anticipated BLA in 2025 for AML
- Anticipated BLA To Be Determined for GBM

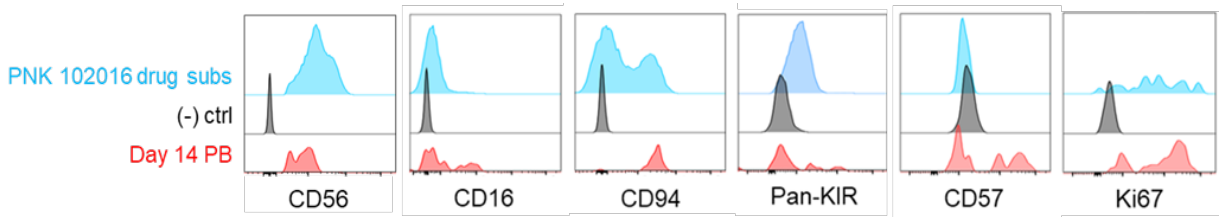
| | | NK CELL THERAPIES | |
|---|---|---|---|
| | **Cell Therapy Technology Scorecard** | **ADULT DONOR DERIVED** | **CELULARITY CYNK-001 & CYNK-101** |
| **MANUFACTURING COMPLEXITY** | **Source Procurement** Non-invasive Collection / Reliable Procurement | ✓ | ✓ |
| | **Lower COGs** Standardized, Scalable Manufacturing | ✓ | ✓ |
| | **Starting Material** Consistent Quality and Phenotype | ✓ | ✓ |
| | **Ability to Readily Expand** While Maintaining a Less Differentiated Phenotype | ✗ | ✓ |
| | **"Off-the-Shelf" Treatment** | ✓ | ✓+ |
| | **Ability to Re-dose Patients** (if Necessary) | ✗ | ✓+ |

# PERSISTENCE, MATURATION AND PROLIFERATION WITH ABSENCE OF ALLO-HLA ANTIBODIES

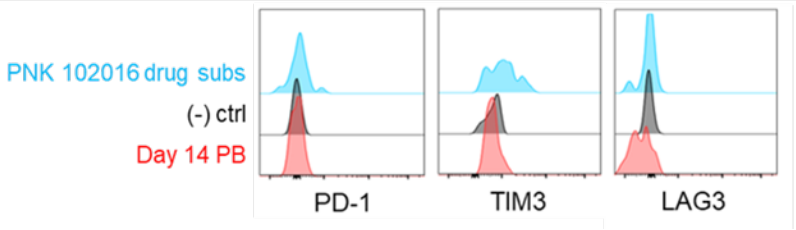
PNK-007 demonstrated **persistence up to 28 days** (mean=11days)



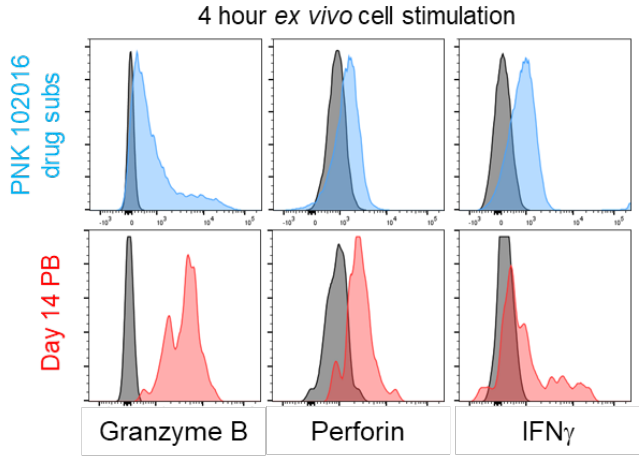

Persistent PNK-007 cells **matured and proliferated**



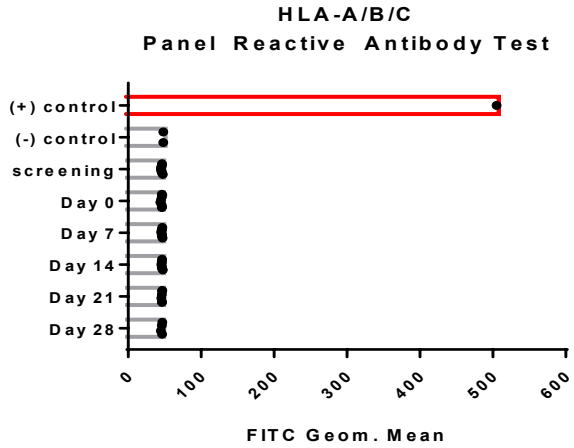

**No detectable exhaustion** on PNK-007 cells




PNK-007 **demonstrated effector function** post infusion




**Absence of allo-HLA antibodies** in all subjects



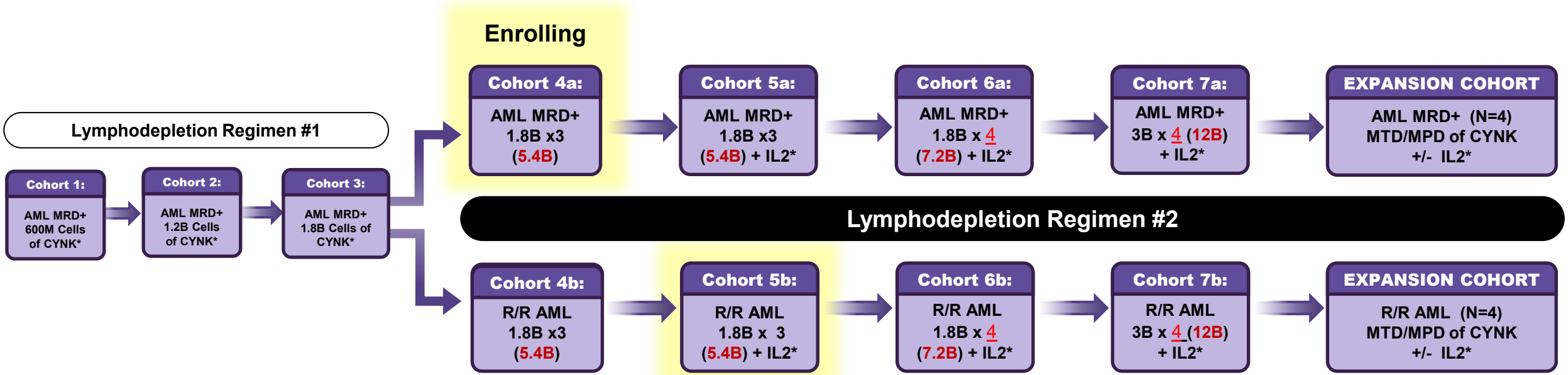

Source: AACR 2019 poster: Immune monitoring of CYNK-001, an allogeneic, off the shelf NK cell in a Phase I study of acute myeloid leukemia", Celularity data; *CYNK-001 is a comparable cryopreserved formulation of PNK-007, the product used in this study

# CYNK-001

AML

# CYNK-001-AML-001 (MRD+ AND RELAPSED REFRACTORY AML)

## Phase 1 Study Schema – Trial in progress




**LD Regimen #1**

Lymphodepletion
for Cohorts 1 to 3
(Days -5, -4, -3)

Cyclophosphamide
300 mg/m2/day

& Fludarabine
25 mg/m2/day

**LD Regimen #2**

Lymphodepletion
for Cohorts 4 to 6
(Days -6, -5, -4, -3)

Cyclophosphamide
900 mg/m2/day

& Fludarabine
30 mg/m2/day

MESNA

** CYNK-currently given on Days 0, 7,14 and D21 (for cohorts 6 & 7)*
*For Cohorts with IL-2 – Dose 6M IU on Days 0,2,4,7,9,11,14 & D21 (cohorts 6 & 7)*

- Developed an enhanced Lymphodepletion Regimen implemented in cohort 4, which enables safe outpatient administration and results in adequate IL-15 serum levels and maximum suppression of T regulatory cells. This enables co-administration of IL-2 to promote CYNK-001 expansion, persistence and potency for over 21 days.
- CYNK-001 is generally well-tolerated with evidence of a dose effect and biologic activity as demonstrated with CR's in some patients.
- From cohort 6, we plan to add IL-2, add a 4$^{th}$ dose of cells on day 21 and potentially increase the dose to 3 Billion CYNK-001 cells/infusion given the window of dosing opportunity observed in our translational studies.

# AML PATIENT OUTCOMES DATA SUMMARY – RELAPSED REFRACTORY AML

## Evidence of a dose effect of CYNK-001

| Patient ID | Risk Group / Age (yrs) | LD Doses: Cytoxan/ Fludarabine | Cell Dose / IL2 | Blast Pre-LD | Day 28 | Day 60 | Day 120 | Day 180 | Day 300 |
|---|---|---|---|---|---|---|---|---|---|
| **002-1001** | **Poor/adverse / 70** | 8400 mg / 230 mg | 70 Million | 82.2% | > 82.2% | Died | | | |
| **006-1002** | **Poor/adverse / 61** | 8400 mg / 230 mg | 70 Million | > 10% | > 10% | | | | Died |
| **002-1003** | **Intermediate / 67** | 8400 mg / 230 mg | 70 Million | 89% | 49% | | Died | | |
| **007-1001** | **Poor/adverse / 30** | 8400 mg / 230 mg | 240 Million | 52% | > 52% | | Died | | |
| **001-1002** | **Poor/adverse / 59** | 8400 mg / 230 mg | 240 Million | 2% | 25% | | | Died | |
| **007-1002** | **Poor/adverse / 65** | 8400 mg / 230 mg | 240 Million | 15% | > 15% | Died | | | |
| **001-1003** | **Poor/adverse / 70** | 8400 mg / 230 mg | 700 Million | 9.7% | 12% | Died | | | |
| **002-1004** | **Poor/adverse / 69** | 8400 mg / 230 mg | 700 Million | 6% | 1% (CRp) | Died | | | |
| **006-1004** | **Intermediate / 63** | 8400 mg / 230 mg | 700 Million | 30% | Died Day 18 | | | | |
| **008-1001** | **Poor/adverse / 66** | 8400 mg / 230 mg | 700 Million | 7% | 0% (MLFS) | | | Died | |
| **106-0005** | **Poor/adverse / 71** | 6624 mg / 221 mg | 5.4 Billion | 8.4% | 0.8% (MLFS) | | CR – post allo-HSCT | | |
| **103-0006** | **Poor/adverse / 67** | 6624 mg / 221 mg | 5.4 Billion | 21% | Died Day 15 | | | | |
| **101-0009** | **Intermediate / 62** | 6624 mg / 221 mg | 5.4 Billion | 11% | 0.096% (MLFS) | 0.57% | | | |

**CR= Complete remission, CRp = Complete remission with incomplete platelet recovery, MLFS: Morphologic Leukemia Free State**

# AML PATIENT OUTCOMES DATA SUMMARY – MRD AML

## Evidence of a dose effect of CYNK-001

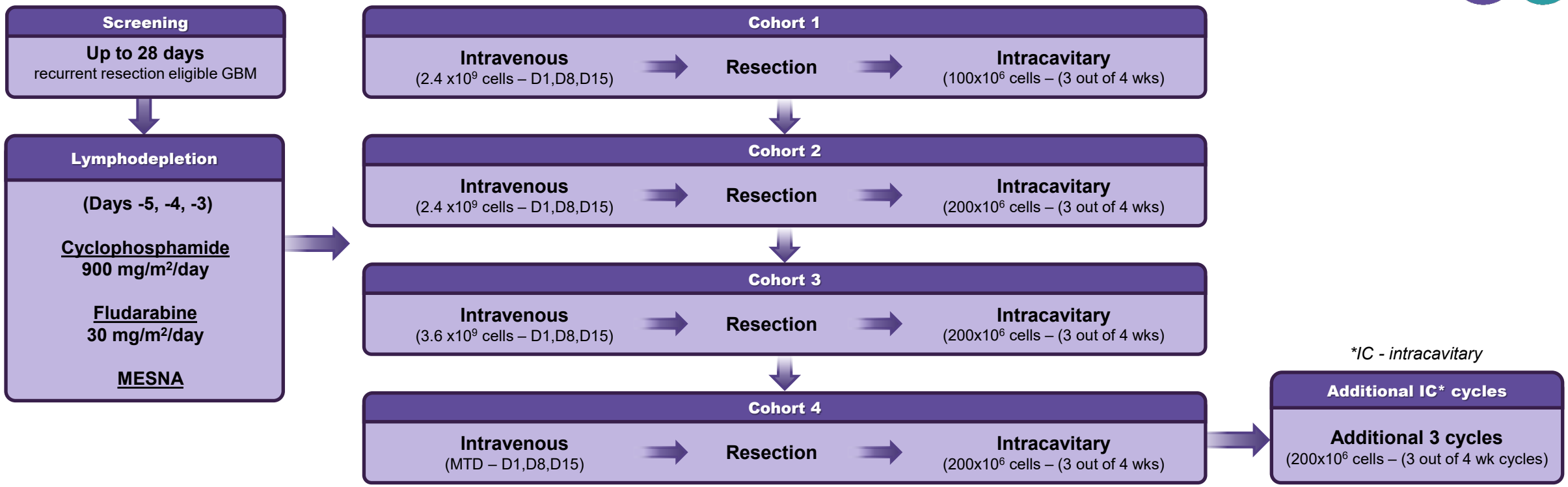
| Patient ID | Risk Group/ Age (yrs) | LD Doses: Cytoxan/ Fludarabine | Cell Dose / IL2 | Blast Pre-LD | Day 28 | Day 60 | Day 120 | Day 180 | Day 300 |
|---|---|---|---|---|---|---|---|---|---|
| **102-0001** | **Intermediate / 75** | 1656 mg / 138 mg | 1.8 Billion | 0.87% | 0.54% | 0.42% | 0.18% | 1.6% | 1.9% |
| **101-0001** | **Intermediate / 51** | 1656 mg / 138 mg | 3.6 Billion | 0.007% | 2.8% | 30.9% | Died | | |
| **101-0002** | **Intermediate / 58** | 1656 mg / 138 mg | 3.6 Billion | 0.78% | 0.19% | 29.3% | | | |
| **101-0003** | **Intermediate/ 66** | 1656 mg / 138 mg | 3.6 Billion | 2.6% | 1.7% | 12.2% | | | |
| **106-0003** | **Intermediate / 62** | 1656 mg / 138 mg | 5.4 Billion | 0.52% | 0.72% | | | | |
| **106-0004** | **Intermediate / 62** | 1656 mg / 138 mg | 5.4 Billion | 1.2% | 0.013% | | 0.47% | 8.2% | |
| **101-0007** | **Intermediate /76** | 1656 mg / 138 mg | 5.4 Billion | 4.3% | 23.1% | | | | |
| **101-0008** | **Intermediate / 69** | 6624 mg / 221 mg | 5.4 Billion | 3.4% | 0.53% | 6.8% | | | |

# CYNK-001

GBM

# CYNK-001-GBM-002 (GLIOBLASTOMA PROGRAM)

## Planned Phase 1 Dose Escalation / Phase 2 Proof of Concept




### Phase 1 Dose Escalation

- N = ~ 21 patients
- North American sites (~5 sites)
- **Primary Endpoints**: Safety, Feasibility and Tolerability (42 Day DLT period)
- **Secondary Endpoints:** Progression Free Survival (PFS)

### Phase 2 Proof of Concept

- N = ~ 45 patients (80% Power - Target 35% 6-month PFS)
- North American sites (5 - 10 sites)
- **Primary Endpoints**: Overall Survival (OS)
- **Secondary Endpoints:** PFS, ORR post resection
- **Exploratory Endpoints:** NK cell persistence and trafficking

# CYNK-101

## HER2+ Advanced Esophageal / Gastric Adenocarcinoma

# **CYNK-101** (modified NK cellular therapy) **IN HER2+ GASTRIC CANCER**

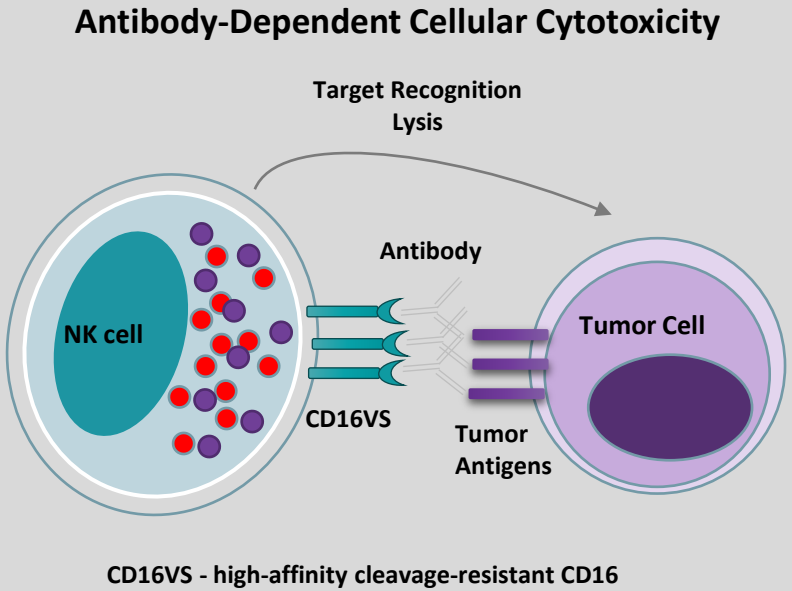
## Overview

### *RATIONALE*

- Engineering CYNK cells with high affinity and cleavage resistant (CD16VS) expected to improve affinity for IgG1 therapeutic antibodies, resist activation induced cleavage and improve overall ADCC potential

### *KEY HIGHLIGHTS*

- CYNK-101 adds “punching power” to the CYNK-001 platform via genetic modification
- Enable combination therapy with ADCC mediating therapeutic monoclonal antibody (mAb) therapies
  - When combined with Trastuzumab demonstrates ADCC activity against HER2+ Gastric Cancer cells
  - Joint impact of modified NK cells + mAb shows improved immunologic response with added NK cell killing
- Anticipated BLA To Be Determined for HER2+ Gastric Cancer

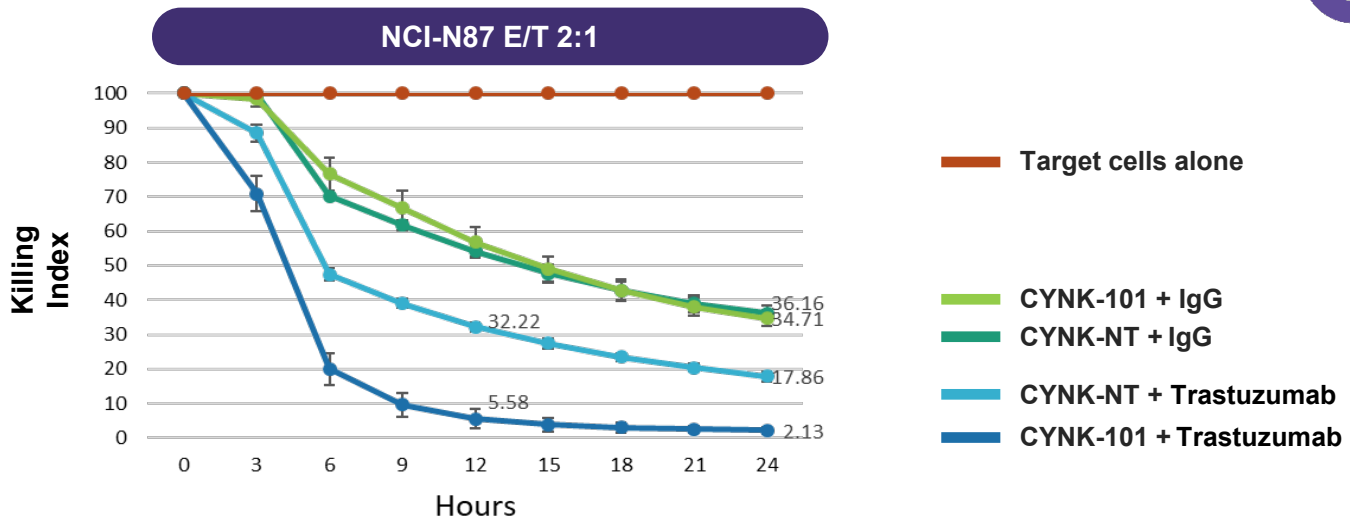


# CYNK-101 DEMONSTRATED ANTITUMOR ACTIVITY

## Against Gastric Cancer Cell Lines in Conjunction with Anti-HER2 Monoclonal Antibody

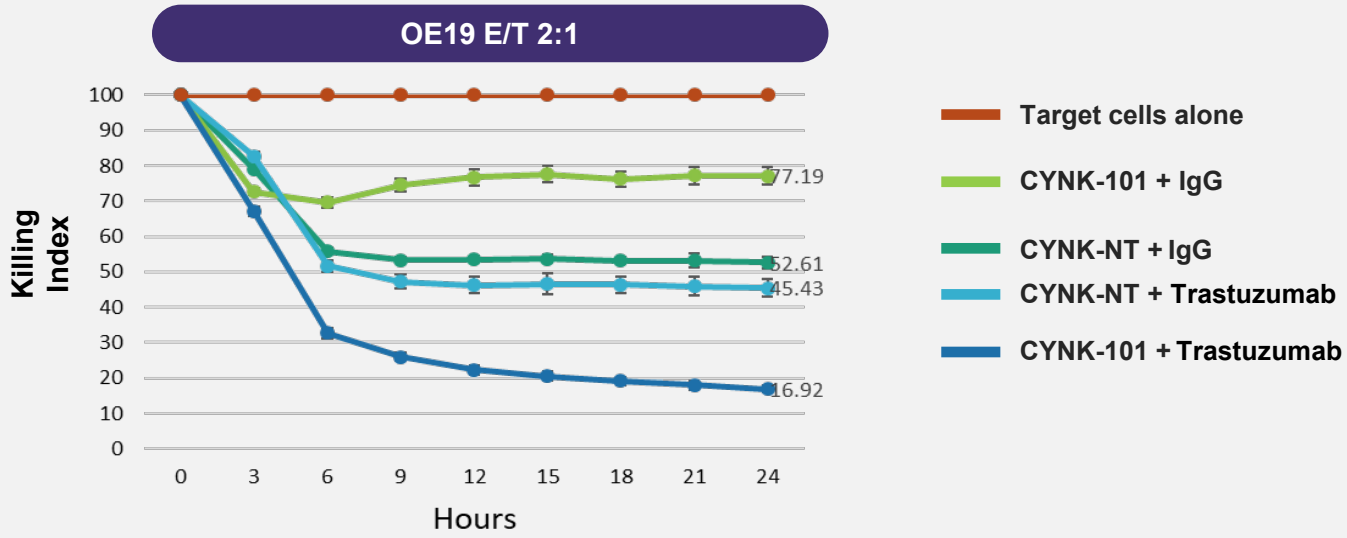
### *RESULTS*

- Significant ADCC activity of CYNK-101 in combination with Trastuzumab against both gastric cancer cell lines was shown at E:T ratio of 2:1 over 24h in comparison with that of CYNK Non-Transduced (NT) or IgG control




### *CONCLUSION*

- Demonstrated ADCC activity of CYNK-101 in combination with Trastuzumab against HER2+ gastric cancer cells
  - HER2+ Gastric demonstrated to be an immunologically susceptible tumor type with evidence of strong NK cell infiltration

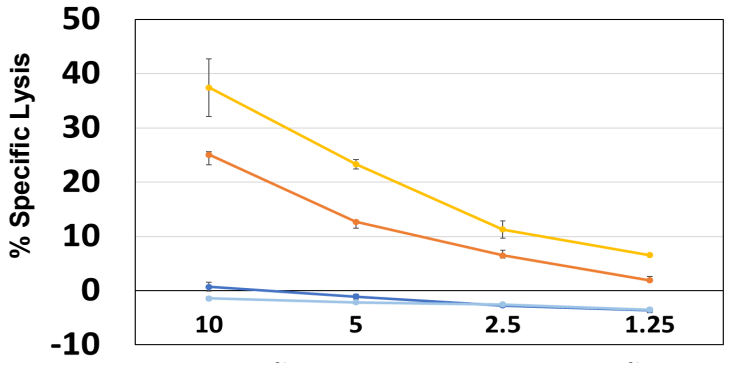



Source: Celularity Data

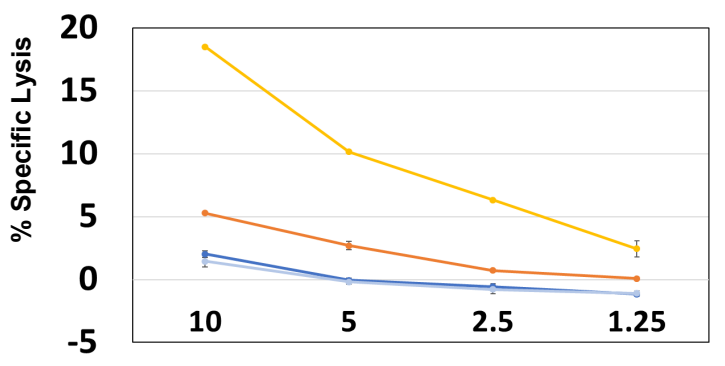
# CYNK-101 PROVIDES A BACKBONE FOR COMBINATION THERAPIES

## Enhanced ADCC with Multiple Antibodies Forms the Basis of Potential Combination Therapies

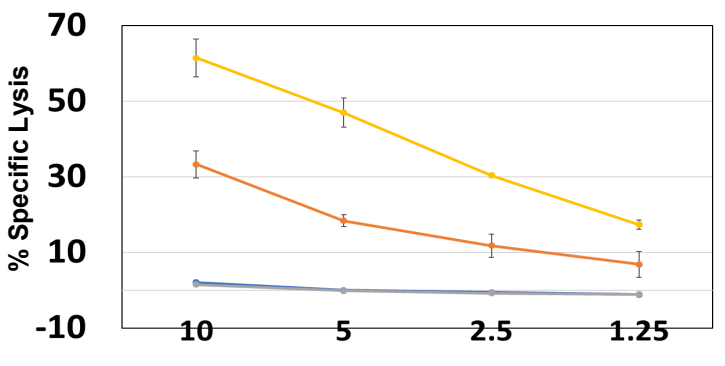
### *ADCC WITH RITUXIMAB*




### *ADCC WITH ELOTUZUMAB*




### *ADCC WITH DARATUMUMAB*



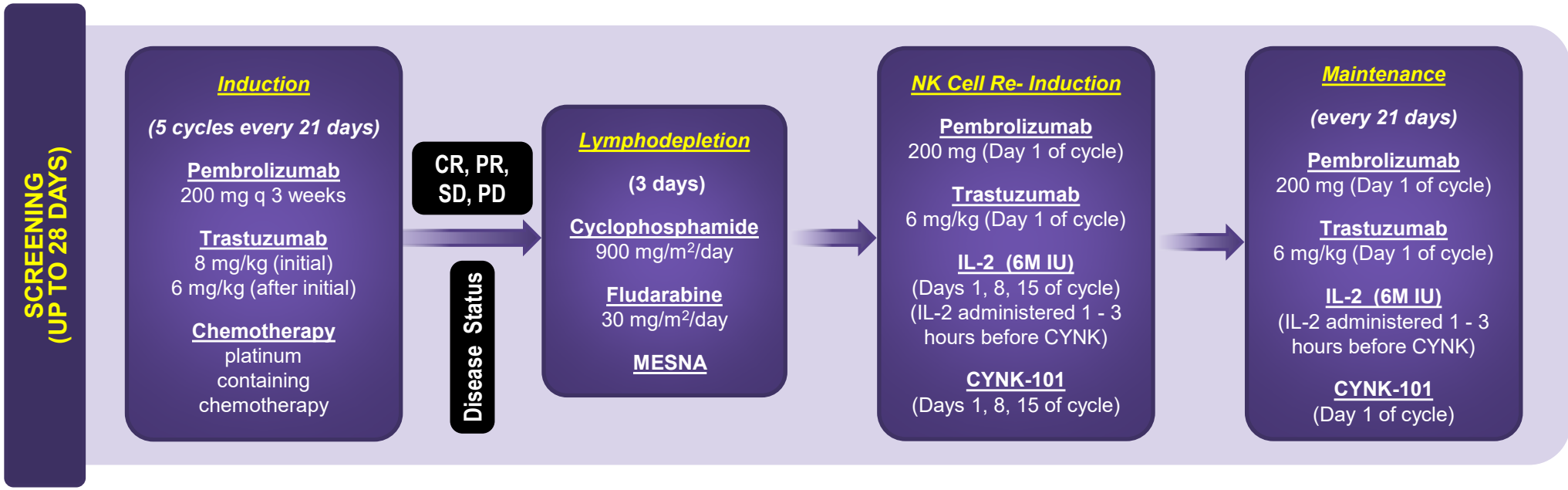

E:T Ratio (Against Daudi)

CYNK-101 + mAb  CYNK + mAb  CYNK-101 + IgG  CYNK + IgG

- Improved ADCC response observed from CYNK-101 compared to unmodified CYNK cells against lymphoma cell lines in combination with: Rituximab, Daratumumab and Elotuzumab antibodies
- IND-enabling studies on-going to evaluate CYNK-101 + mAbs in subcutaneous and orthotopic tumor models

# CYNK-101-HER2-001 (HER2+ GASTRIC/GEJ CANCER)

## Planned Phase 1 - Dose Escalation / Phase 2a Expansion/Proof of Concept




### Phase 1: Dose Escalation (n = up to 15 patients)

- **Primary Endpoints**: Determine safety and maximum tolerated dose
- **Secondary Endpoints**: Various Efficacy measures

**Dosing Cohorts**

| *CYNK-101 Re-Induction Dosing* | *CYNK-101 Maintenance Dosing* |
|---|---|
| **Cohort -1: 1.8 x $10^9$ cells** | **Cohort -1: 1.8 x $10^9$ cells** |
| **Cohort 1: 3.6 x $10^9$ cells** | **Cohort 1: 3.6 x $10^9$ cells** |
| **Cohort 2: 7.2 x $10^9$ cells** | **Cohort 2: 3.6 x $10^9$ cells** |

### Phase 2a: Expansion/Proof of Concept (n = ~40 patients)

- **Primary Endpoints**: ORR (CR+PR) (>65%-80%)
- **Secondary Endpoints**: (For patients that are CR, PR and SD)
  - Landmark PFS at 6 months & 12 months (CR, PR and SD)
  - Duration of Response (CR and PR)
  - Incidence of response conversion (PR and SD)
  - ORR for patients after initial induction are PD
  - Safety
- **Maintenance Dosing**
  - Patients in CR after CYNK-101 to dose an additional 2 cycles of NK cells combination
  - Patients in PR/SD after CYNK-101 to dose until CR or Progression
  - Patients in PD after CYNK-101 to discontinue to from study

# CyCART-19

## B-Cell Malignancies

# CYCART-19 OVERVIEW

## Celularity Approach and Advantages

### *RATIONALE*

- Rationale for greater stemness, expandability, persistence
- Abundant renewable starting cell source for allogeneic therapies
- Potential for improved safety profile due to immunological naivety

### *KEY HIGHLIGHTS*

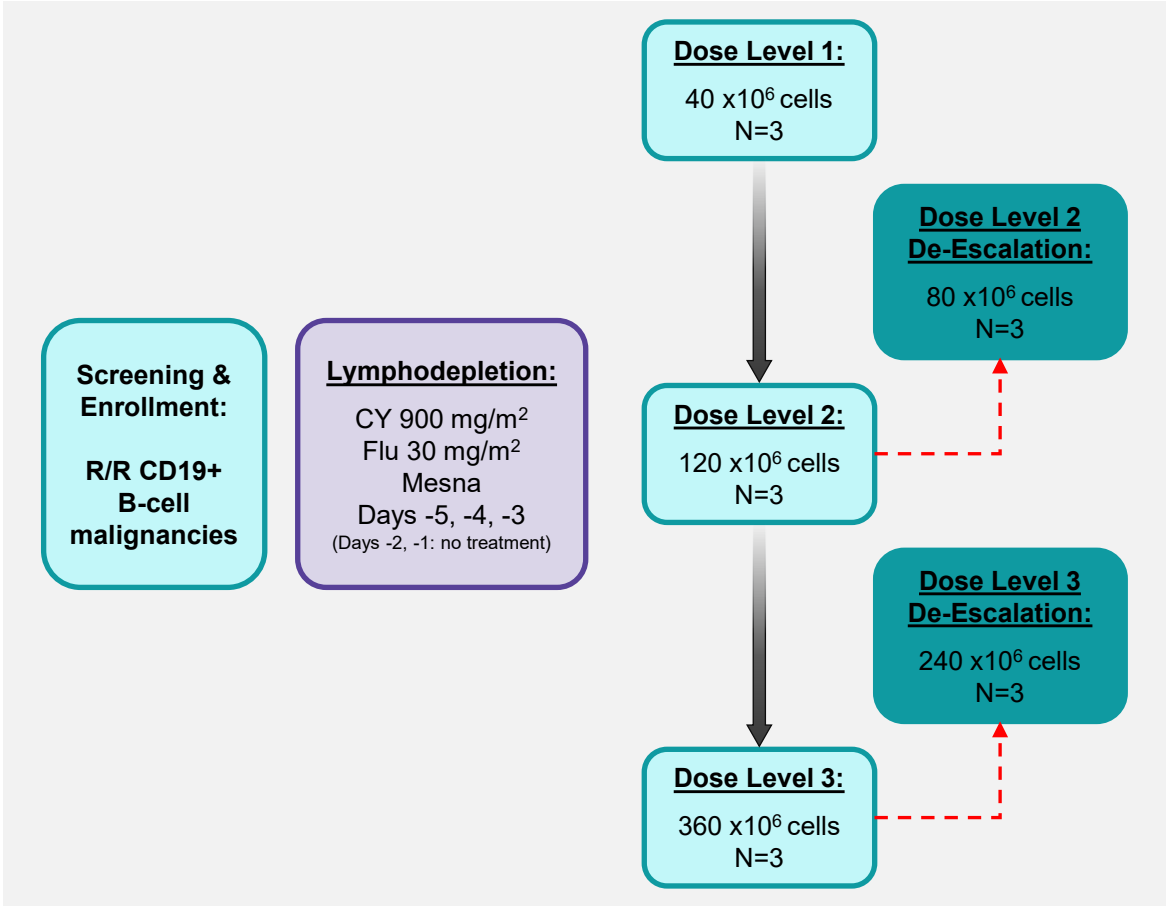
- Celularity has established a robust process to obtain placental T naive/scm population as source materials to produce off-the-shelf, highly scalable CYCART-19 cells
- CYCART-19 has shown stem cell memory characteristics as evidenced by greater in vivo persistence and durable antitumor activity in preclinical models
- Strong pre-clinical evidence of anti-tumor activity
  - CYCART-19 cells outperformed adult blood-derived CAR-T cells by showing significantly greater persistence and longer survival in preclinical studies
- Early data have not shown signs of GvHD
- IND submitted in first quarter of 2022 and pending resolution of additional questions from FDA, expect to commence Phase 1/2 clinical trial in second half of 2022
- Note: If Phase 1 successful, Celularity plans to pursue a Phase 2 basket trial across major B-cell malignancies (subject to FDA discussions)
- Anticipated BLA To Be Determined for CYCART-19

| | | CAR-T THERAPIES | | |
|---|---|---|---|---|
| | CELL THERAPY TECHNOLOGY SCORECARD | AUTOLOGOUS | OTHER ALLOGENEIC | CELULARITY CYCART-19 |
| MANUFACTURING COMPLEXITY | **Source Procurement** Non-invasive Collection / Reliable Procurement | ✗ | ✗ | ✓ |
| | **Lower COGs** Standardized, Scalable Manufacturing | ✗ | ✓ | ✓ |
| | **Starting Material** Consistent Quality and Phenotype | ✗ | ✗ | ✓ |
| | **Ability to Readily Expand** While Maintaining a Less Differentiated Phenotype | ✗ | ✗ | ✓ |
| | **"Off-the-Shelf" Treatment** | ✗ | ✓ | ✓+ |
| | **Ability to Re-dose Patients** (if Necessary) | ✗ | ✓ | ✓+ |

# CYCART-19-BCM-001 (RELAPSED/REFRACTORY B-CELL MALIGNANCIES)

## Planned Phase 1 / Phase 2

### Phase 1
### Safety and Dose Finding




### Phase 2:
### Cohorts

***Cohort A: High Grade NHL***
***CD-19 targeted therapy naïve (n= ~66)***

- DLBCL
- High Grade B-Cell lymphoma
- Primary mediastinal B-Cell lymphoma
- Transformed follicular lymphoma
- Mantle cell
- Burkitt lymphoma/leukemia
- Any B-Cell malignancy with Secondary CNS involvement

***Cohort B: Low Grade NHL***
***CD-19 targeted therapy naïve (n= ~66)***

- Follicular
- Marginal Cell
- CLL/SLL
- Waldenström's macroglobulinemia
- Any other low grade NHL subtypes

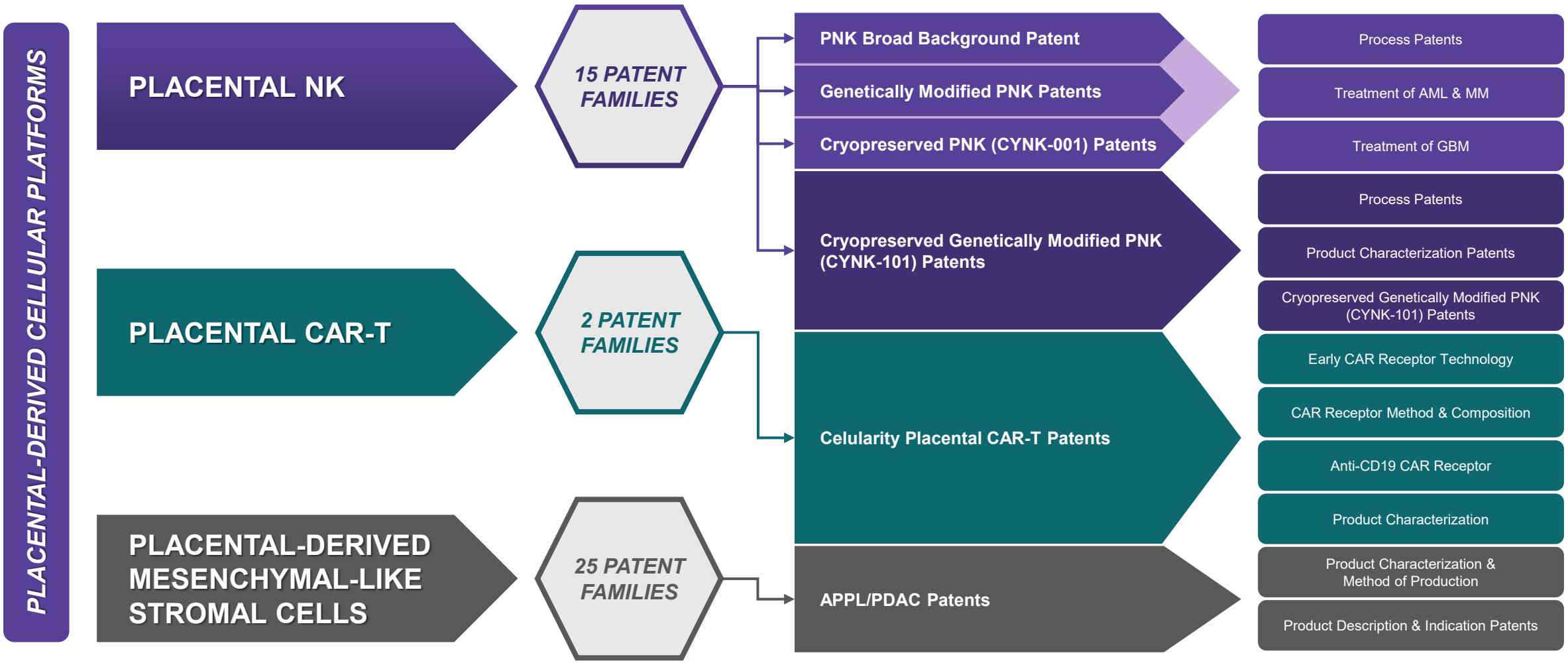
***Cohort C: Any Grade NHL***
***CD-19 targeted therapy exposed***
***(n= ~66)***

***Cohort D: Primary Central Nervous System Lymphoma***
***(n= ~74)***

# Appendix
## Additional Detail

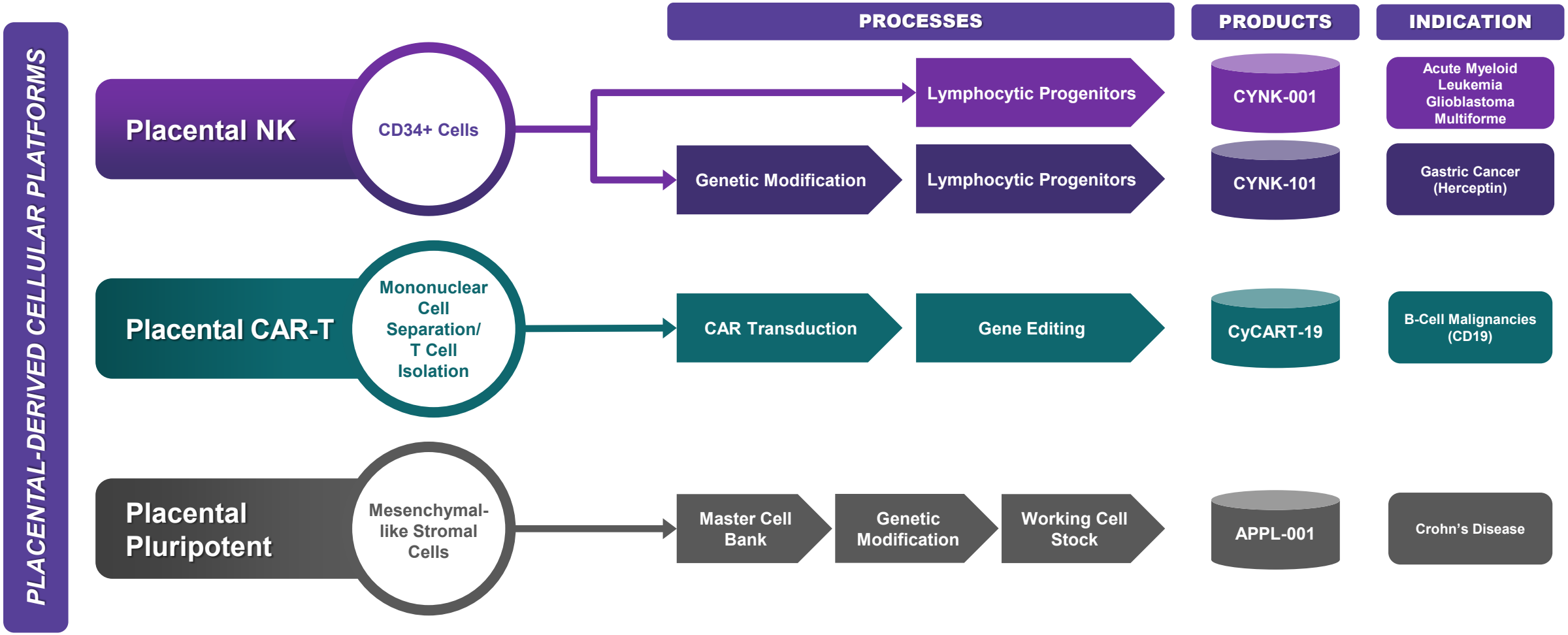
# CELULARITY IMPACT™ PLATFORM

## Broad IP Protection Across All Lead Programs



# CELULARITY IMPACT™ PLATFORM

## The Placenta as a Renewable Allogeneic Source, with Purpose-Built Commercial Scale Manufacturing



# MANUFACTURING PROCESS

## Celularity Purpose-built Commercial Scale 150,000 sq. ft. Manufacturing Facility

**Network of Longstanding Partnerships**

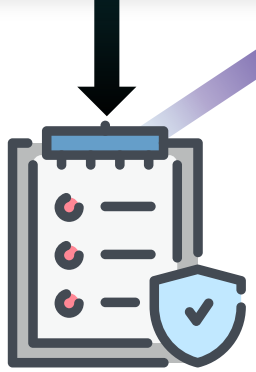
- Birthing Centers
- Obstetricians
- Academic Hospitals
  - Controllable and scalable on-demand birthing material
  - Supports multiple products/programs

**Controlled Courier System**

- Procurement Kits
- Temperature tracking
- Unique barcoding/labeling
- Traceability from birthing center to Celularity through manufacturing & distribution

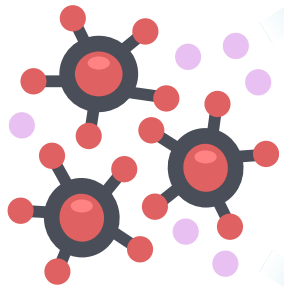
**Collection & Documentation of Donor Information**

- Qualified donors/Donor eligibility
- Informed consent
- Detailed maternal and family health questionnaire
- Completed delivery information
- Comprehensive data set on donor and cell source



**Cell Isolation and Selection**

- Proprietary perfusion methodology
- Removal of vascular/ circulatory blood
- Cell suspension/separation
- Cell selection/sorting for hematopoietic, progenitor, and T-cells.
- Cryopreserved donor stock

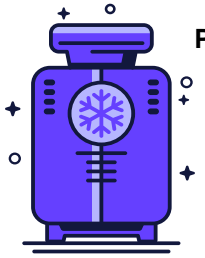


**Cell Manufacturing**

- Controllable and flexible manufacturing
- Cell seeding, expansion and differentiation
- Cell harvesting & formulation
- Use of automation (i.e., bioreactors, etc.)
- Highly scalable

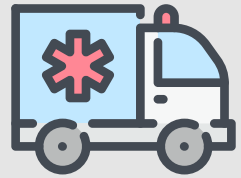
**Tissue Manufacturing**

- Multiple commercial products with (30+ SKUs)
- Multiple suite allocation allows for rapid increase in product manufacturing
- Multiple shift manufacturing
- In house packaging capability
- Ambient product storage
- Long product shelf life/expiry



**Product Cryopreservation**

- In-process cooling/cryopreservation of drug product
- In-house cryostorage facility with 24/7 monitoring
- Long term storage readiness
- Cold-chain logistics and distribution expertise
- Cold-chain monitoring and traceability



**Delivery to Patients**