Financial Results and Business Update for the Quarter Ended September 30, 2026

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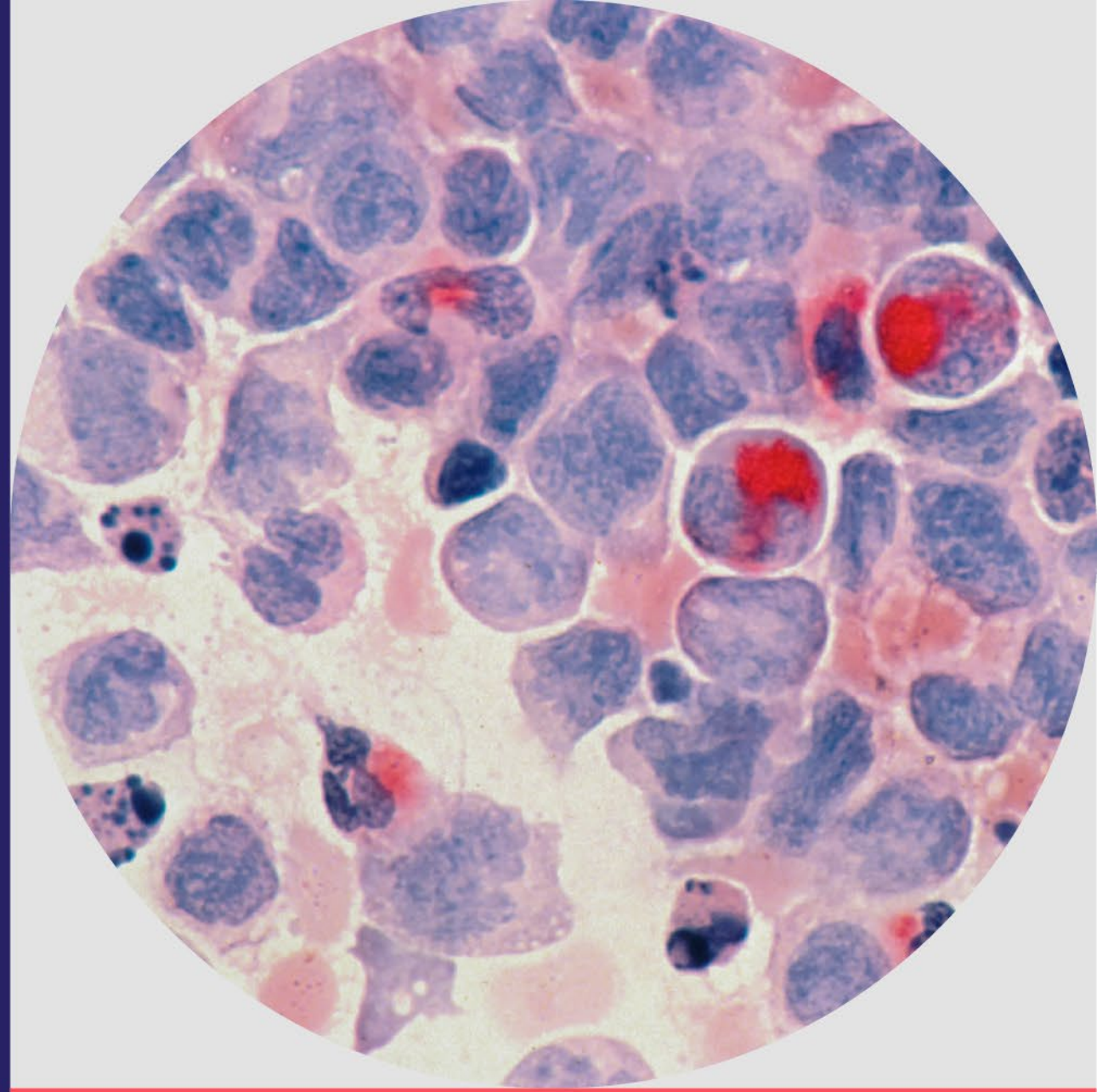

November 9, 2026

Forward-Looking Statements

This presentation includes forward-looking statements that are subject to substantial risks and uncertainties that could cause actual results to differ materially from those expressed or implied by such statements. All statements other than statements of historical facts contained in this presentation, including statements regarding our future results of operations and financial position, business strategy, potential uses of cash and capital allocation, research and development plans, the anticipated timing, costs, design, conduct and results of our ongoing and planned preclinical studies and clinical trials for our product and product candidates, the timing of potential regulatory approvals for our product and product candidates, any commercial potential of our product and product candidates following applicable regulatory approvals and the outcome of any pending litigation are forward-looking statements.

These forward-looking statements are based upon the current expectations and beliefs of our management as of the date of this presentation and are subject to certain risks and uncertainties that could cause actual results to differ materially from those described in the forward-looking statements. Although we believe that our plans, intentions, expectations and strategies as reflected in or suggested by those forward-looking statements are reasonable, we can give no assurance that the plans, intentions, expectations or strategies will be attained or achieved. Furthermore, actual results may differ materially from those described in the forward-looking statements.

These forward-looking statements may be affected by a number of risks and uncertainties, including, but not limited to, those risks set forth in the sections captioned “Risk Factors” and “Cautionary Note Regarding Forward-Looking Statements” of our filings with the U.S. Securities and Exchange Commission, available at www.sec.gov and investor.roivant.com. We operate in a very competitive and rapidly changing environment in which new risks emerge from time to time. These forward-looking statements are based upon the current expectations and beliefs of our management as of the date of this presentation, and are subject to certain risks and uncertainties that could cause actual results to differ materially from those described in the forward-looking statements. Except as required by applicable law, we assume no obligation to update publicly any forward-looking statements, whether as a result of new information, future events or otherwise.

This presentation includes data for brepocitinib as compared to another product generated from separate, independent studies, not from head-to-head analysis. Differences exist between study or trial designs and subject characteristics and caution should be exercised when comparing data across studies. Data regarding other product is based on publicly available information.

LISRAYA (brepocitinib) is FDA-approved only for treatment of dermatomyositis in adult patients. All other indications remain investigational and subject to regulatory approval. See important LISRAYA safety information, including boxed warning, at lisrayahcp.com/pi

Non-GAAP Financial Information

This presentation includes certain financial measures that were not prepared in accordance with U.S. generally accepted accounting principles (GAAP). Additional information regarding non-GAAP financial measures can be found on slide 40 and in our earnings release furnished with our Current Report on Form 8-K dated November 9, 2026. Any non-GAAP financial measures presented are not, and should not be viewed as, substitutes for financial measures required by U.S. GAAP, have no standardized meaning prescribed by U.S. GAAP and may not be comparable to the calculation of similar measures of other companies.

Disclaimer

This presentation is intended for the investor community only; it is not intended to promote the product or product candidates referenced herein or otherwise influence healthcare prescribing decisions.

Agenda

- LISRAYA Launch Update
- IMVT-1402 in D2T RA: Period 2 Data
- Brepocitinib in NIU: Review of Phase 3 Data
- Mosliciguat in PH-ILD: Review of Phase 2 Data
- Financial Update
- Q&A

Strong Execution Across The Pipeline in 2026

Brepocitinib

Positive Ph2 results for brepocitinib in CS *Announced February 2026*	**Initiated Ph2b/3 trial for brepocitinib in LPP** *Announced April 2026*	**Initiated Ph3 trial for brepocitinib in CS** *Announced August 2026*	**LISRAYA approved and launched in DM** *Announced August 2026*	**Positive Ph3 results for brepocitinib in NIU** *Announced October 2026*

IMVT-1402

Positive Ph2 Period 1 data for IMVT-1402 in D2T RA *Announced May 2026*	**PoC study of IMVT-1402 in CLE did not meet primary endpoint** *Announced September 2026*	**Positive Ph2 Period 2 data for IMVT-1402 in D2T RA** *Announced Today*	**Unlikely to advance IMVT-1402 in SjD beyond ongoing Ph2** *Announced Today*

Mosliciguat

Positive Ph2 results for mosliciguat in PH-ILD *Announced September 2026*	**Initiated Ph3 PHrontier study for mosliciguat in PH-ILD** *Announced September 2026*

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Note: LISRAYA (brepocitinib) is FDA-approved only for treatment of dermatomyositis in adult patients. All other drugs and indications remain investigational and subject to regulatory approval.
CS: cutaneous sarcoidosis; LPP: lichen planopilaris; DM: dermatomyositis; NIU: non-infectious uveitis; D2T RA: difficult-to-treat rheumatoid arthritis; CLE: cutaneous lupus erythematosus; PH-ILD: pulmonary hypertension with interstitial lung disease

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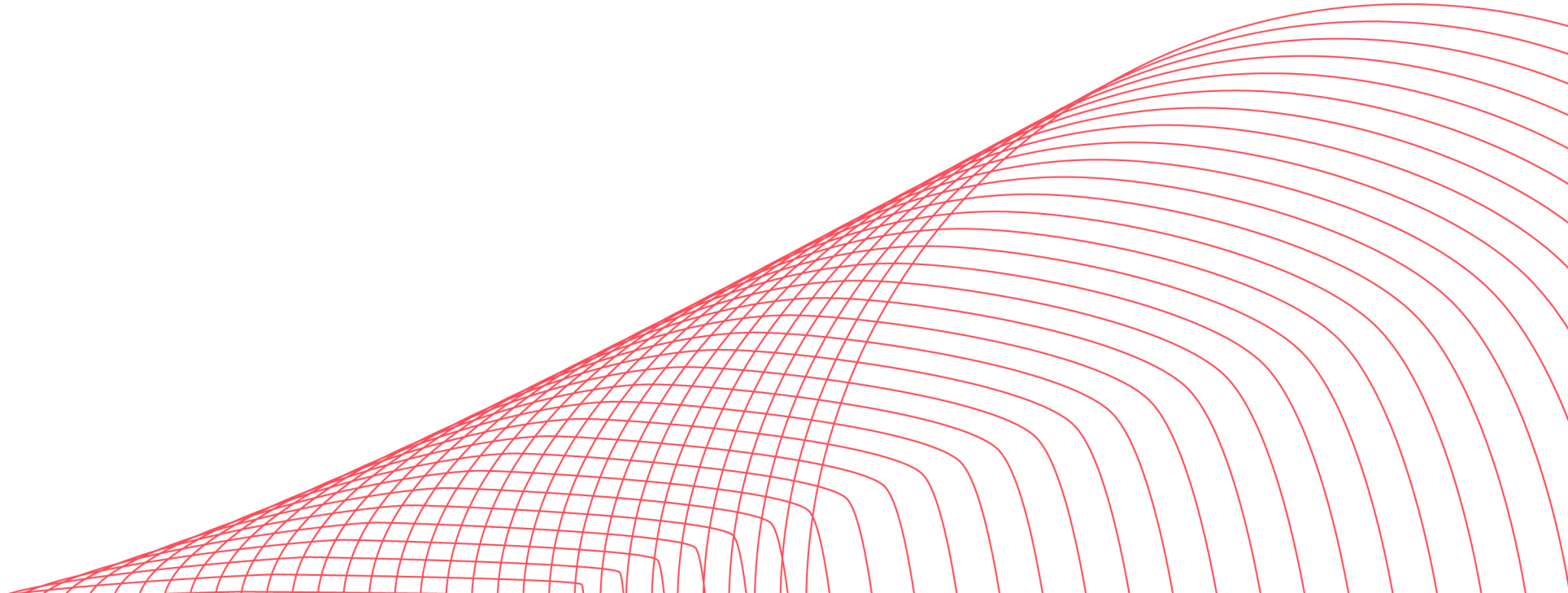
LISRAYA Launch Update



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APPROVED AUGUST 2026

LISRAYA™ (brepocitinib)

LISRAYA is a tyrosine kinase 2 (TYK2) and Janus kinase (JAK) inhibitor indicated for the treatment of dermatomyositis in adult patients

See important LISRAYA safety information, including boxed warning, at lisrayahcp.com/pi

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LISRAYA™ (brepocitinib) Launch Update: CQ3 2026

$31M

U.S. Net Product Revenue Quarter Ending September 30, 2026

- **Strong initial demand,** driven by unmet medical need, physician and patient enthusiasm and launch readiness, despite only ~5 weeks of sales in the quarter
- **Hundreds of patients on paid drug as of September 30,** many hundreds on paid drug today
- **Broad initial prescriber base** and early payer dynamics have supported rapid uptake, though still too early to extrapolate from here

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Note: LISRAYA (brepocitinib) is FDA-approved only for treatment of dermatomyositis in adult patients. See important LISRAYA safety information, including boxed warning, at lisrayahcp.com/pi

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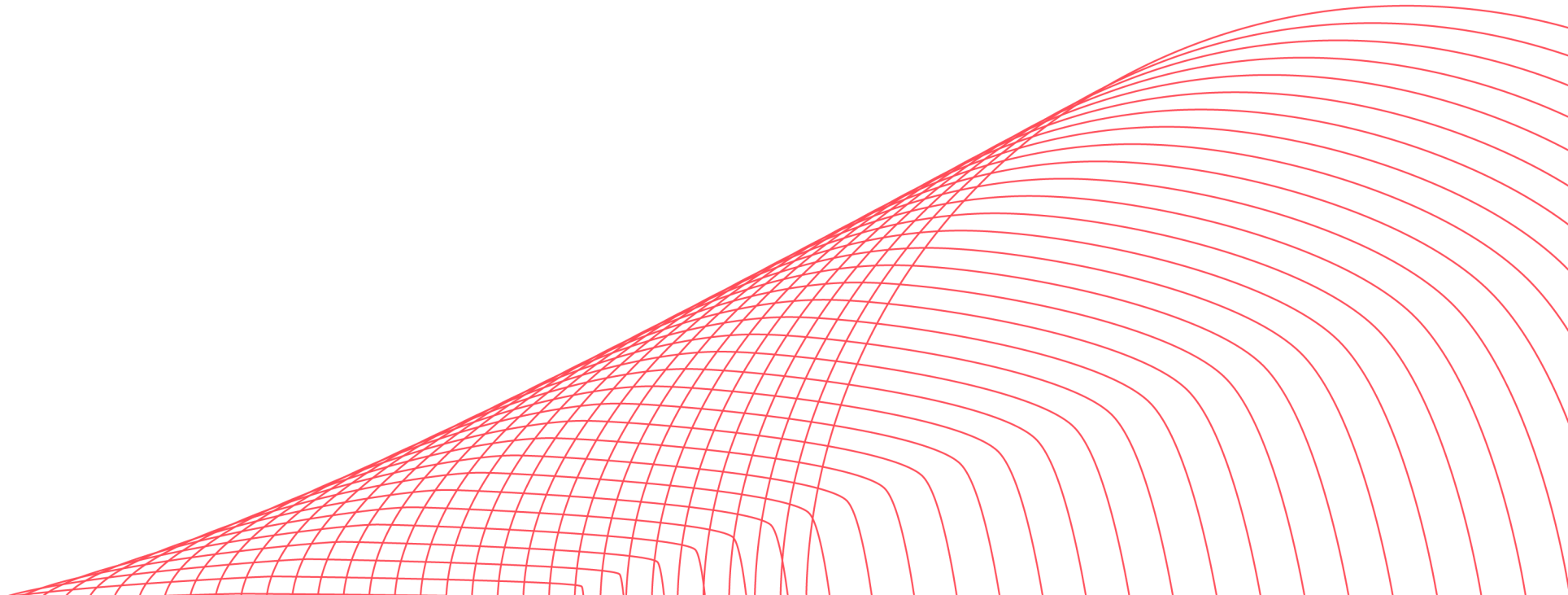
IMVT-1402 in D2T RA: Period 2 Data



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IMVT-1402 Potentially Registrational Trial in ACPA+ Difficult-to-Treat RA

Today's discussion will focus on the IMVT-1402 randomized withdrawal period (Period 2)

Inclusion[a]

- hsCRP ≥ upper limit of normal
- Active RA defined as ≥ 6/68 tender/painful joints, ≥ 6/66 swollen joints (SJC), and DAS28-CRP > 4.1
- IgG+ Anti-citrullinated protein antibody (ACPA+)
- Inadequate response at least 2, but not more than 4, mechanisms of advanced therapies (biologics and targeted synthetic DMARDs)[1]
- On stable treatment with conventional DMARDs

Screening Period (up to 5 weeks)

Presented May '26

Period 1:
Open-label, active treatment lead-in
(16 weeks)

N=165[2]

600mg IMVT-1402 QW SC

Randomized Treatment Responders* (1:1:1)

Today's Focus

Period 2:
Blinded randomized withdrawal
(12 weeks)

600mg IMVT-1402 QW SC

300mg IMVT-1402 QW SC

Placebo QW SC

Safety Follow-up Period (4 weeks)

Endpoints

Primary Endpoint (Period 2):

For participants achieving ACR20 response at Weeks 14 and 16, proportion of participants who maintain ACR20 response at Week 28

Secondary Endpoint:

Change in CDAI and SDAI from Week 16 to Week 28 for participants in Period 2

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Notes: *Meets ACR20 criteria at Week 14 & Week 16. a. Additional inclusion and exclusion criteria not listed on slide. 1. Advanced therapies defined as biologics and targeted synthetic therapies; patients had to have had insufficient efficacy/loss of efficacy/intolerance to TNFi and insufficient efficacy/loss of efficacy to at least one other class of biologics and/or targeted synthetic therapies (e.g., JAK inhibitor, IL-6R inhibitor, CD80/86 inhibitor). 2. Efficacy analysis population (N=165) excludes N=5 patients from one site in Period 1 due to protocol non-compliance. hsCRP: high-sensitivity C-reactive protein; DAS28: Disease Activity Score-28; CDAI: Clinical Disease Activity Index; SDAI: Simplified Disease Activity Index; Registrational nature of the study is dependent on future alignment with FDA on clinical trial design, endpoints, statistical analysis plans, and overall development strategy.

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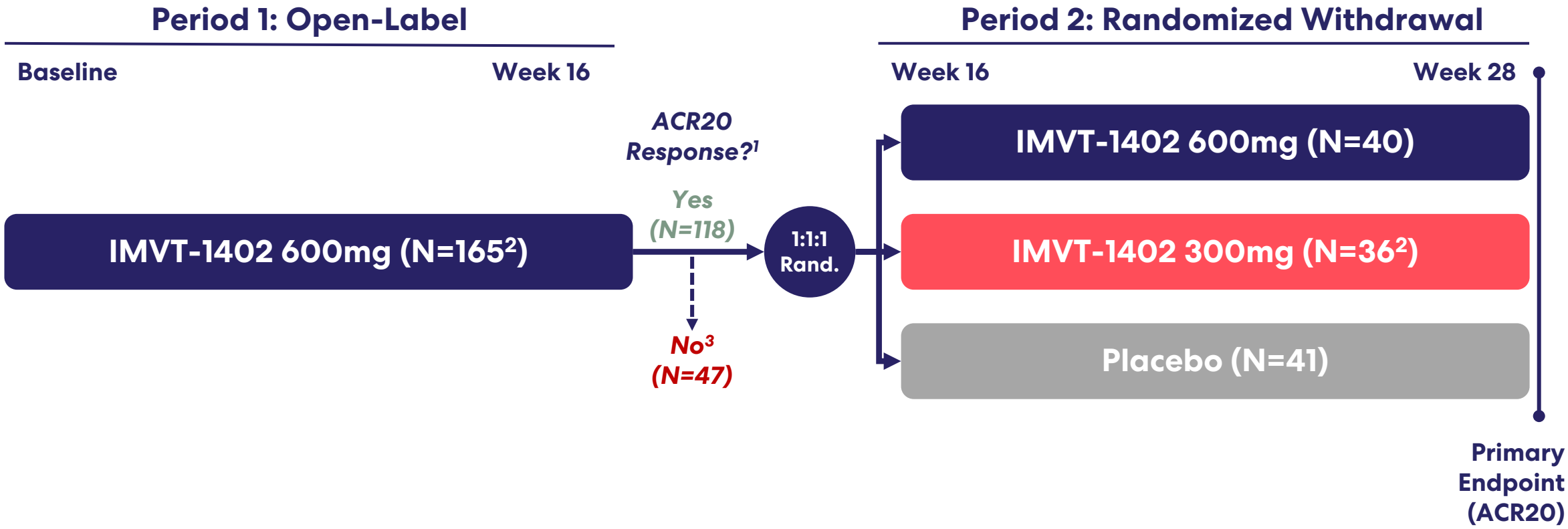
Trial Schematic & Participant Disposition



Notes: 1. Meets ACR20 criteria at Week 14 & Week 16. 2. Efficacy analysis population excludes (i) N=5 patients from one site in Period 1 and (ii) N=1 patient from one site in Period 2, in each case due to protocol non-compliance. 3. Includes patients who discontinued prior to Week 16. Rand: Randomization

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Difficult-to-Treat Rheumatoid Arthritis (D2T RA) Represents an Unmet Medical Need With Few Current Treatment Options

D2T RA Patients Have Failed Multiple Lines of Therapy

- Difficult-to-treat (D2T) RA patients experience inadequate or loss of response to multiple classes of advanced therapies, including conventional DMARDs and two or more advanced therapy mechanisms (i.e., TNF inhibitor, JAK inhibitor)[1]



Up to ~85k Patients in the US

- Of the **1.5M US RA patients**, a subset progresses to D2T status in a relatively short period of time and requires new therapeutic options[2]

Autoantibody Pathology

- **Autoantibodies such as ACPA** play a key role in pathophysiology, and **ACPA-positive RA is associated with severe disease and poor outcomes**

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ACPA: anticitrullinated protein autoantibodies
1. Takanashi et al., Rheumatology (2021)
2. Aletaha and Smolen, JAMA (2018)

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Patients With Difficult-to-Treat RA Have Substantial Morbidity and Quality of Life Impairment Due to Disease Severity and Complications



43%

Fully work disabled for 10-15 years[1]



46

Consultations per year with HCPs[1]



>50%

Dependent on external help to live independently[2]



63%

Require joint surgeries[3]



45%

Report walking disability[4]

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Sources: 1. Roodenrijs et al. Rheumatology 2021;60:4681–4690; 2. Westhoff et al., Arthritis Care & Research 2000; 3. Roodenrijs et al. Rheumatology 2021;60:3778–3788; 4. Tuominen et al., Rheumatol Int, 2010.
Notes: Includes studies of patients with difficult-to-treat RA as well as refractory RA. Work disabled proportion based on patients who are of working age; HCPs include rheumatologists, rheumatology nurses, general practitioners, other medical specialists, other paramedics, and psychosocial support – annual rate = mean 3-month rate * 4. HCP: Healthcare professional.

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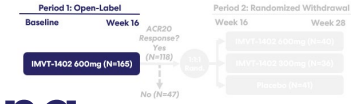

Trial Enrolled a Difficult-to-Treat Population: Patients Were 4L+, Having Failed Conventional Therapy and ≥2 Mechanisms of Advanced Therapies

Baseline Characteristics *Mean unless otherwise noted*	**IMVT-1402 (Period 1) (N=165[2])**
Age, years	58.7
Sex, % female, n (%)	116 (70.3%)
Time since RA diagnosis, years	12.8
Tender joint count (0-68)	24.2
Swollen joint count (0-66)	16.7
Clinical Disease Activity Index (CDAI)	44.6
Simplified Disease Activity Index (SDAI)	46.3
DAS28-CRP score	6.1
Number of Prior Advanced Therapy Mechanisms[1]	
1 Advanced Therapy Mechanism, n (%)	1 (0.6%)
2 Advanced Therapy Mechanisms, n (%)	143 (86.7%)
≥3 Advanced Therapy Mechanisms, n (%)	19 (11.5%)

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Notes: Data reflects preliminary figures as reported in May 2026 disclosure. 1. N=2 patients missing information. Advanced therapies include biologic (e.g., anti-TNFs, IL-6R inhibitors, CD80/86 inhibitors, CD20 inhibitors) and targeted synthetic (e.g., JAK inhibitors) DMARDs. 2. Efficacy analysis population (N=165) excludes N=5 patients from one site in Period 1 due to protocol non-compliance. DAS28-CRP: Disease Activity Score 28 with C reactive protein; 4L+: Fourth line or later; DMARD: Disease-modifying anti-rheumatic drug.

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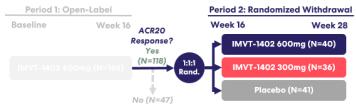

Period 2 (Weeks 16-28): Following 16 Weeks of 600mg Treatment, Distribution Across Treatment Arms at Week 16 Generally Well-Balanced

	IMVT-1402 600mg	IMVT-1402 300mg[2]	Placebo
N (Period 2)	**40**	**36**	**41**
Age, years	60.1	57.5	57.8
Sex, % female	30 (75.0%)	25 (69.4%)	31 (75.6%)
Time since RA diagnosis, years	11.3	11.2	14.2
Tender joint count (0-68)	4.2	4.6	5.5
Swollen joint count (0-66)	2.3	3.2	3.3
Clinical Disease Activity Index (CDAI)	9.9	11.6	11.9
Simplified Disease Activity Index (SDAI)	11.2	12.7	13.4
DAS28-CRP score	3.2	3.3	3.5
Number of Prior Advanced Therapy Mechanisms[1]			
1 Advanced Therapy Mechanism, n (%)	1 (2.5%)	0 (0%)	0 (0%)
2 Advanced Therapy Mechanisms, n (%)	32 (80.0%)	34 (94.4%)	37 (90.2%)
≥3 Advanced Therapy Mechanisms, n (%)	7 (17.5%)	2 (5.6%)	4 (9.8%)

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Notes: Baseline characteristics represent Period 2 baseline (Week 16) values excluding age, sex, time since diagnosis, and prior mechanism failures, which represent Period 1 baseline. 1. Advanced therapies defined as biologics and targeted synthetic therapies; patients had to have had insufficient efficacy/loss of efficacy/intolerance to TNFi and insufficient efficacy/loss of efficacy to at least one other class of biologics and/or targeted synthetic therapies (e.g., JAK inhibitor, IL-6R inhibitor, CD80/86 inhibitor). 2. Efficacy analysis population (N=36) excludes N=1 patient from one site in Period 2 due to protocol non-compliance. SC: Subcutaneous; QW: Once Weekly; DAS28: Disease Activity Score-28; CDAI: Clinical Disease Activity Index; SDAI: Simplified Disease Activity Index; Registrational nature of the study is dependent on future alignment with FDA on clinical trial design, endpoints, statistical analysis plans, and overall development strategy.

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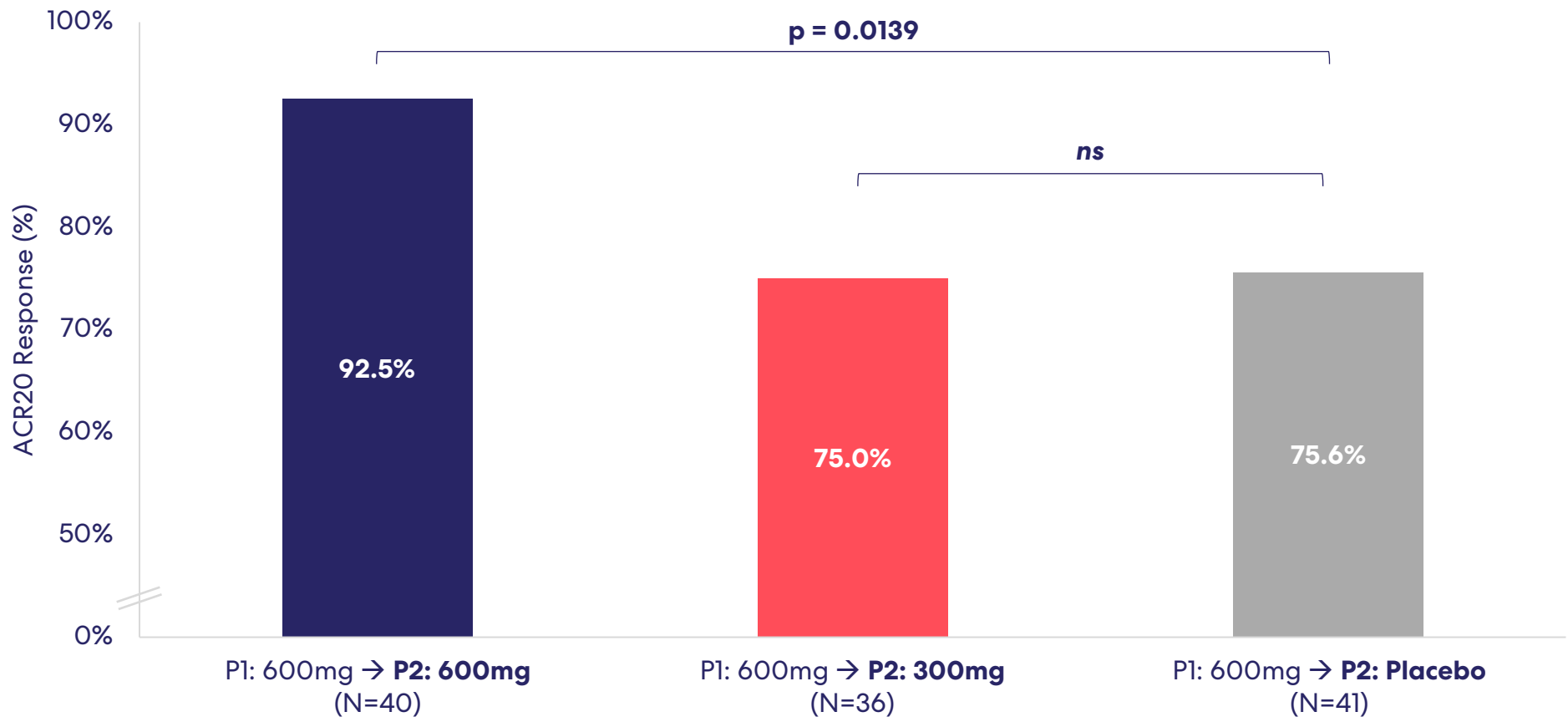
Period 2 (Weeks 16-28) Primary Endpoint: IMVT-1402 600mg Met the Primary Endpoint of ACR20 Response at Week 28



Period 2 ACR20 Response Rates at Week 28



Notes: ACR: American College of Rheumatology. ACR20 refers to standardized criteria established by the American College of Rheumatology to measure change in rheumatoid arthritis (RA) symptoms.
ns: not statistically significant; P1: Period 1 (Baseline-Week 16); P2: Period 2 (Week 16-Week 28).

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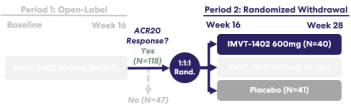
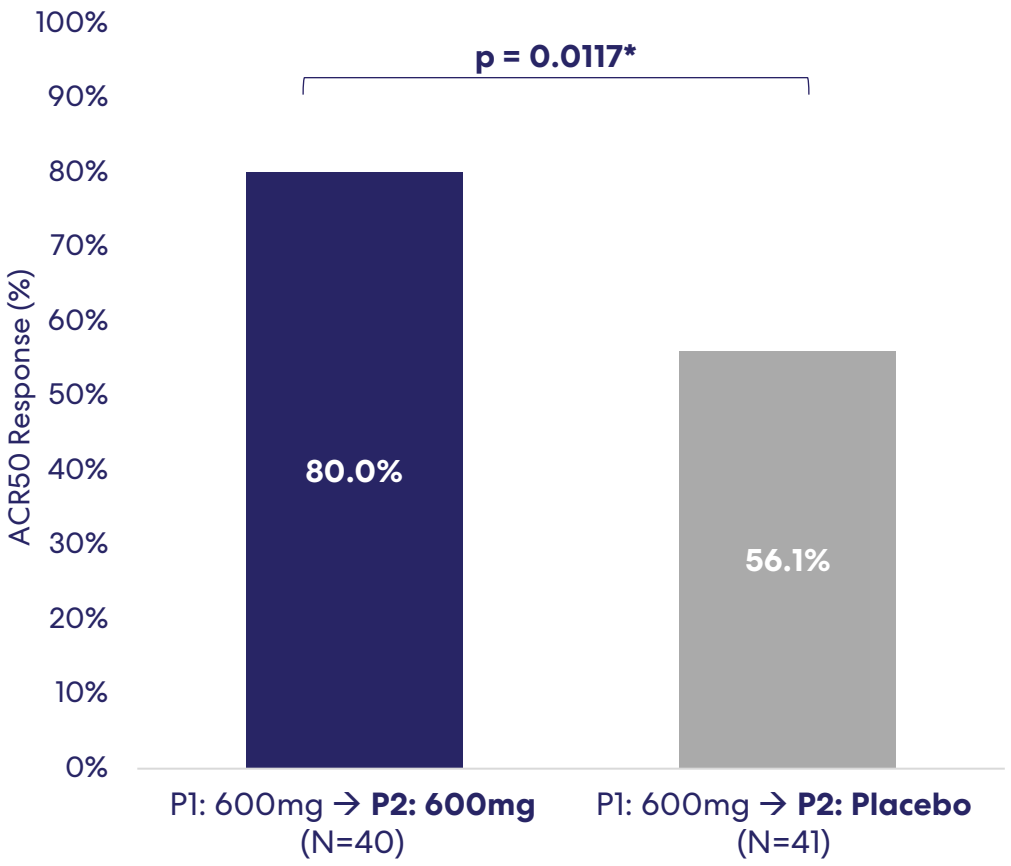
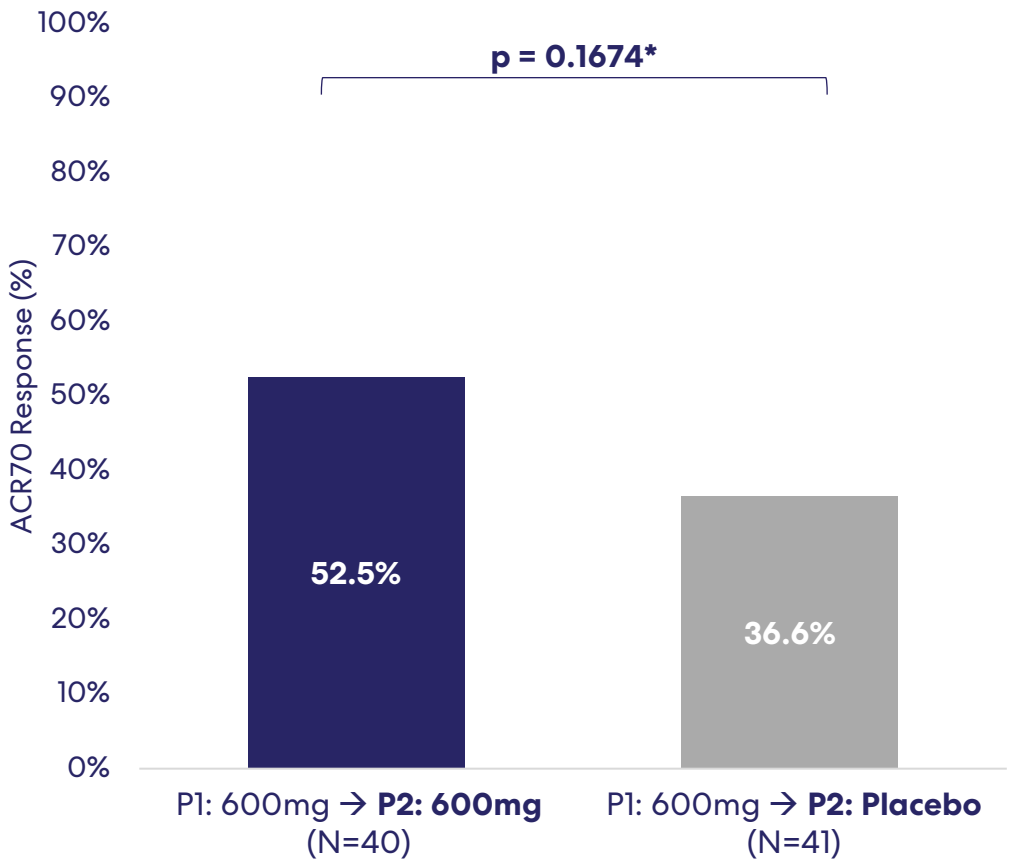


Period 2 (Weeks 16-28): IMVT-1402 600mg Continued to Demonstrate Meaningful Improvements in ACR50 and ACR70 at Week 28

Period 2 ACR50 Response Rates at Week 28



Period 2 ACR70 Response Rates at Week 28



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Notes: *Nominal p-value; trial was not powered to detect difference in ACR50 or ACR70. ACR: American College of Rheumatology. ACR50/70 refers to standardized criteria established by the American College of Rheumatology to measure change in rheumatoid arthritis (RA) symptoms.

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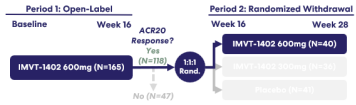
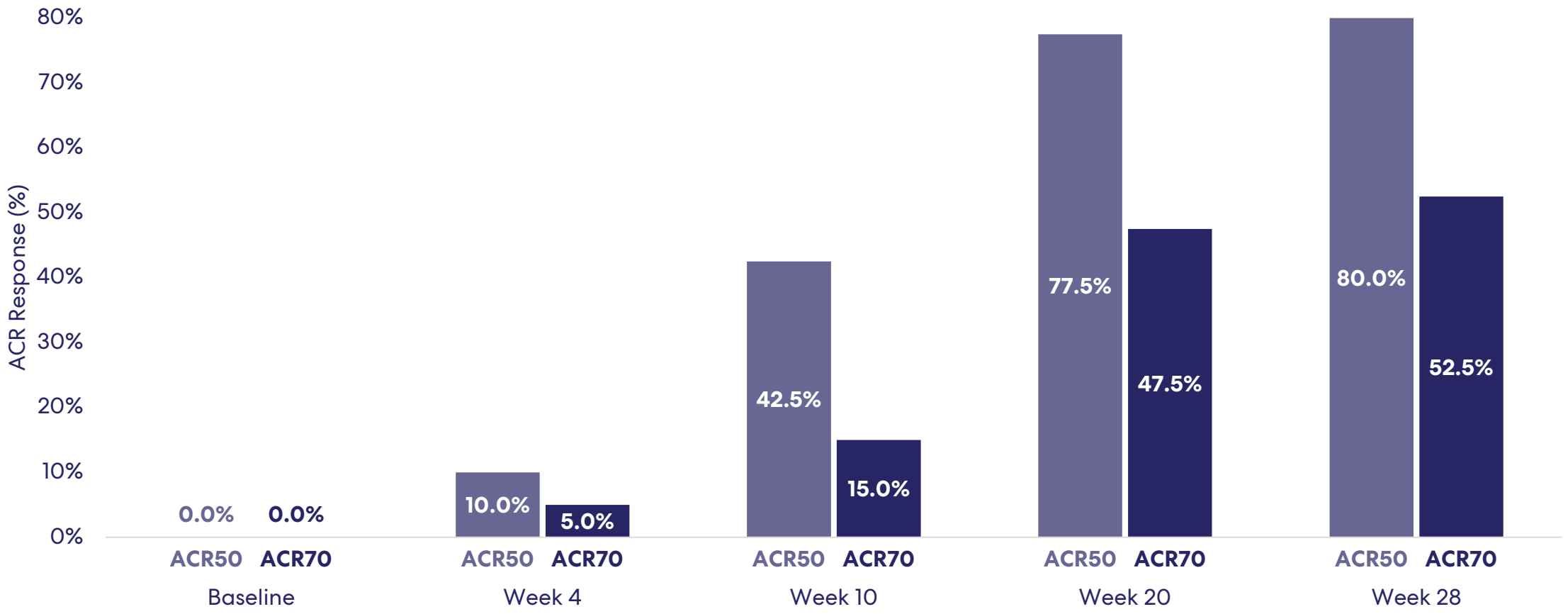


ACR50/70 Rates Increased From Baseline to Week 28 in Patients Who Received IMVT-1402 600mg for the Full 28-Week Treatment Period

ACR50 & ACR70 for Patients Randomized to IMVT-1402 600mg for the Full 28-Week Period (N=40)



Notes: ACR: American College of Rheumatology. ACR50/70 refers to standardized criteria established by the American College of Rheumatology to measure change in rheumatoid arthritis (RA) symptoms. Chart represents patients on IMVT-1402 600mg QW for both Period 1 and Period 2.

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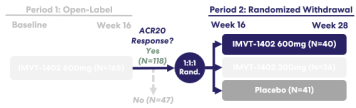
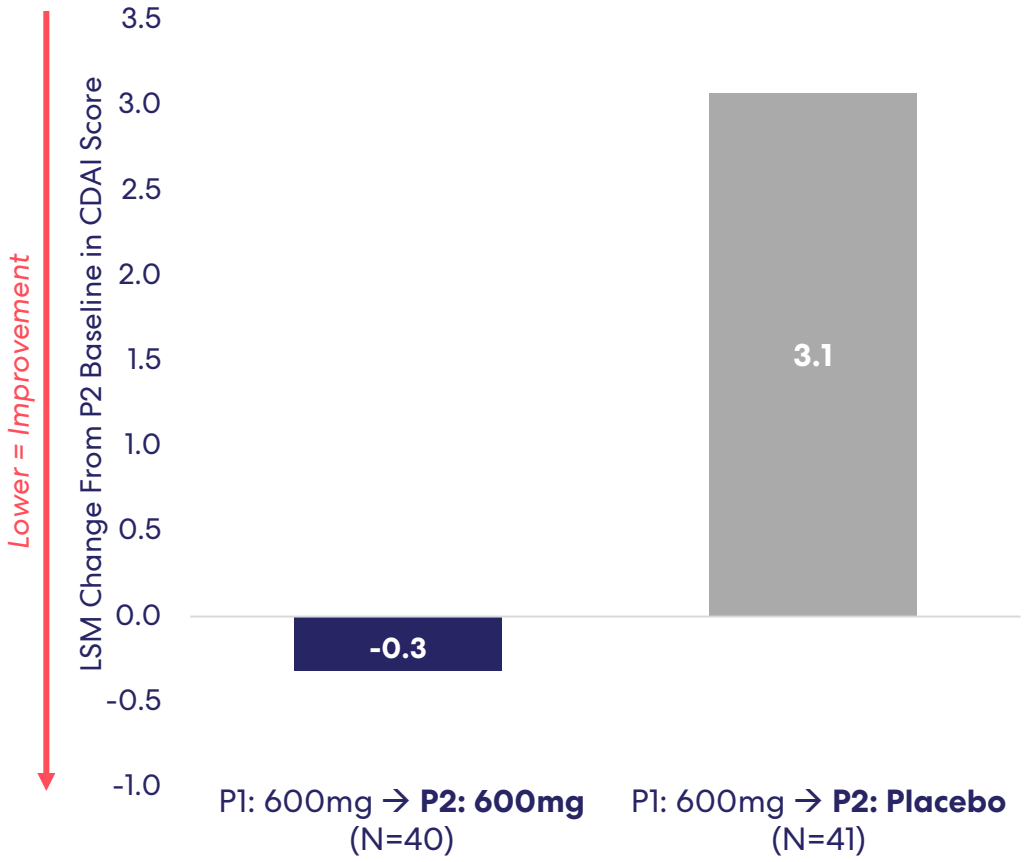


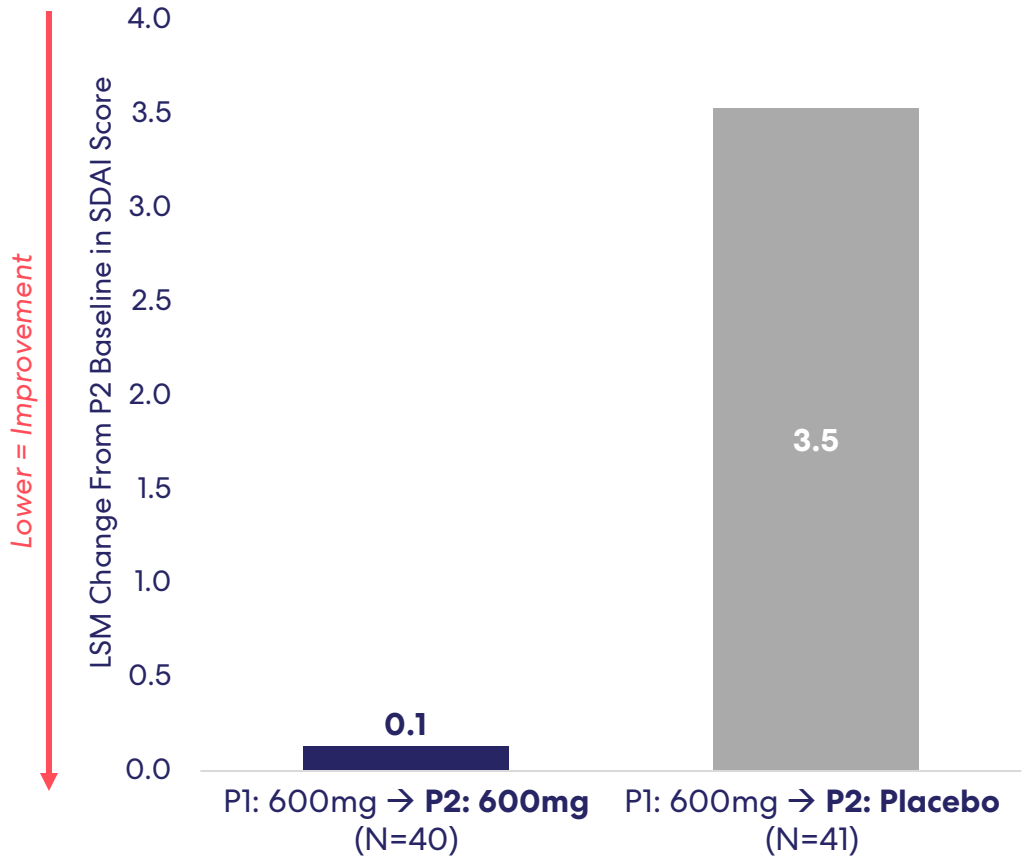
Period 2 (Weeks 16-28) Secondary Endpoints: Patients on IMVT-1402 600mg Maintained CDAI & SDAI Scores vs. Placebo Patients Who Worsened

CDAI and SDAI endpoints reflect widely used scales in clinical practice for assessing sustained response

CDAI Change from Period 2 Baseline at Week 28



SDAI Change from Period 2 Baseline at Week 28



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Notes: Period 2 Baseline represents Week 16. LSM: Least squares mean; CDAI: Clinical Disease Activity Index; SDAI: Simplified Disease Activity Index; P2: Period 2. Change represents change in score from Period 2 baseline.
P-value for 600mg vs. placebo: p=0.1096 (CDAI) and p=0.1299 (SDAI)

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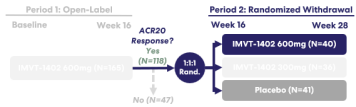
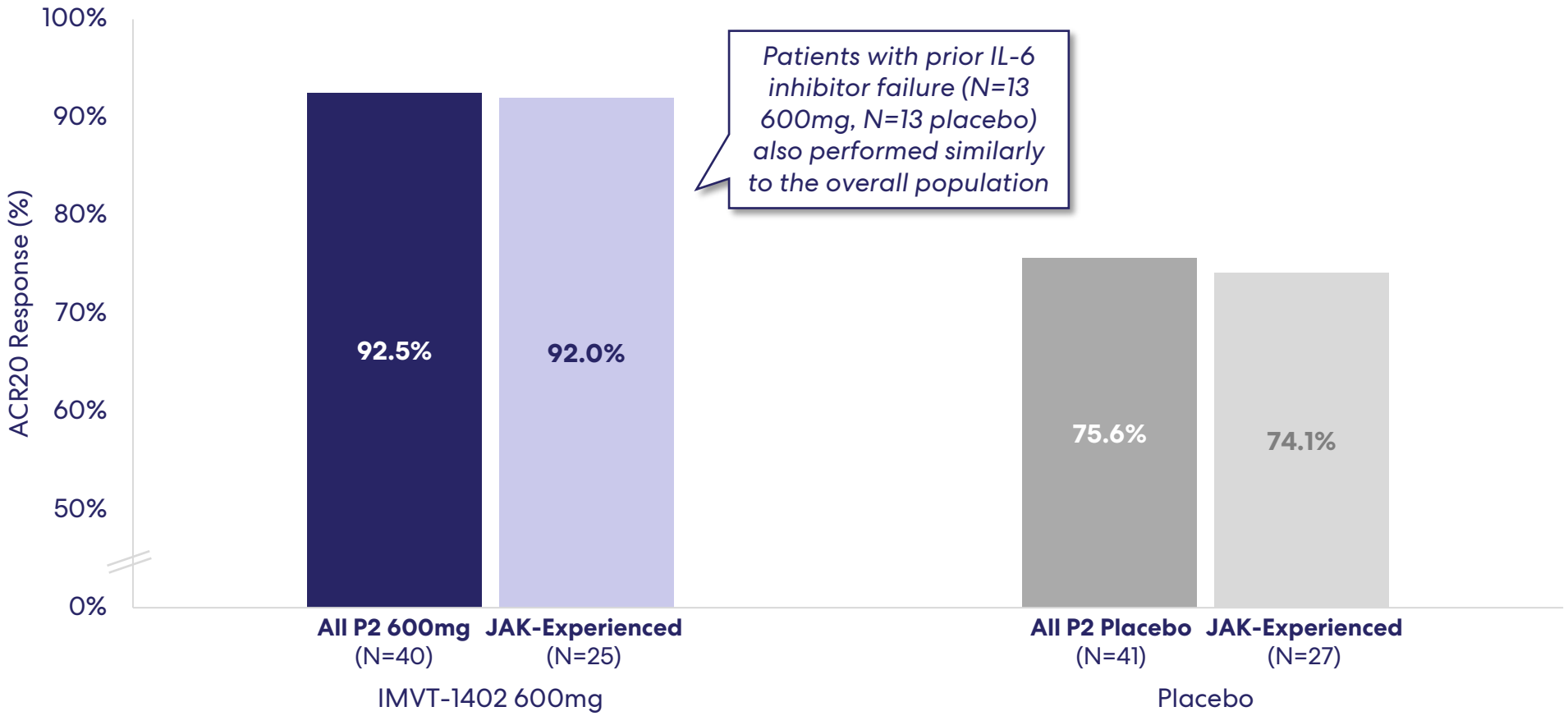


Period 2 (Weeks 16-28): Patients Maintained ACR20 Response on IMVT-1402 600mg at Week 28 Regardless of Prior JAK Inhibitor Failure

Period 2 ACR20 Response Rates at Week 28 by Prior JAK Inhibitor Failure



Every JAK-experienced patient has failed at least a JAK inhibitor and a TNF inhibitor

Notes: ACR: American College of Rheumatology. ACR20 refers to standardized criteria established by the American College of Rheumatology to measure change in rheumatoid arthritis (RA) symptoms. P2: Period 2

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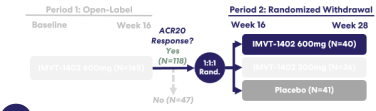
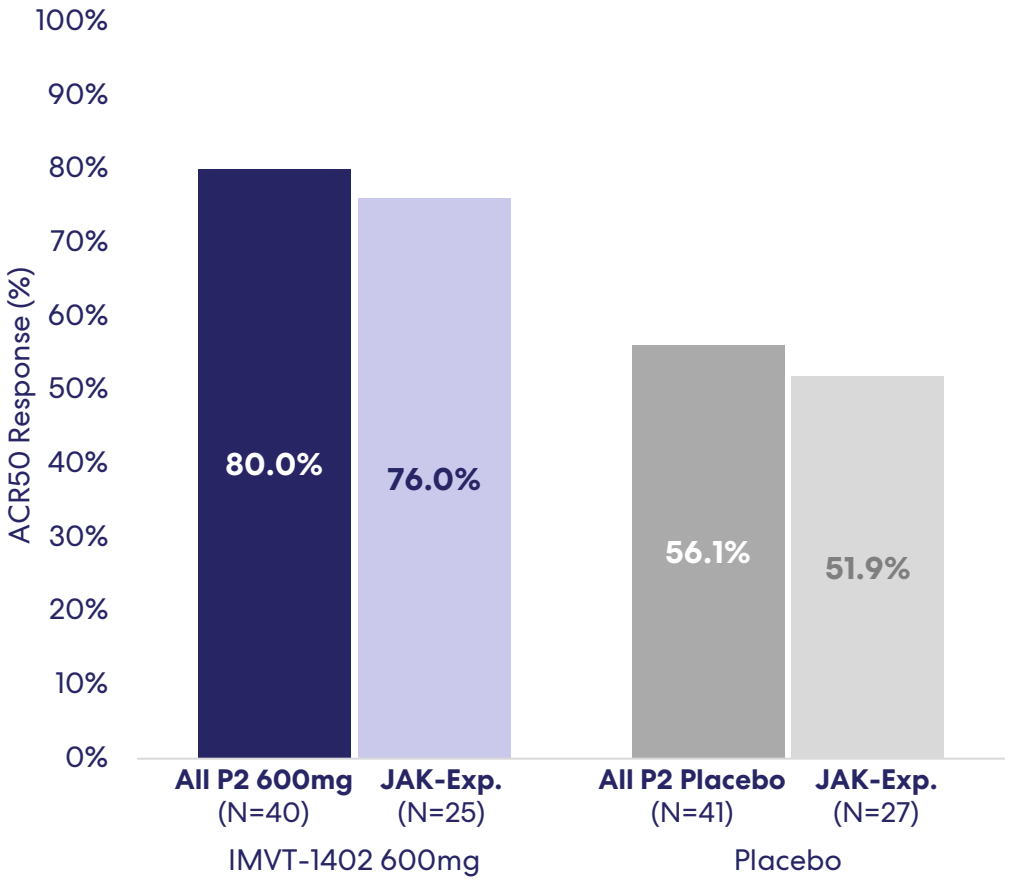
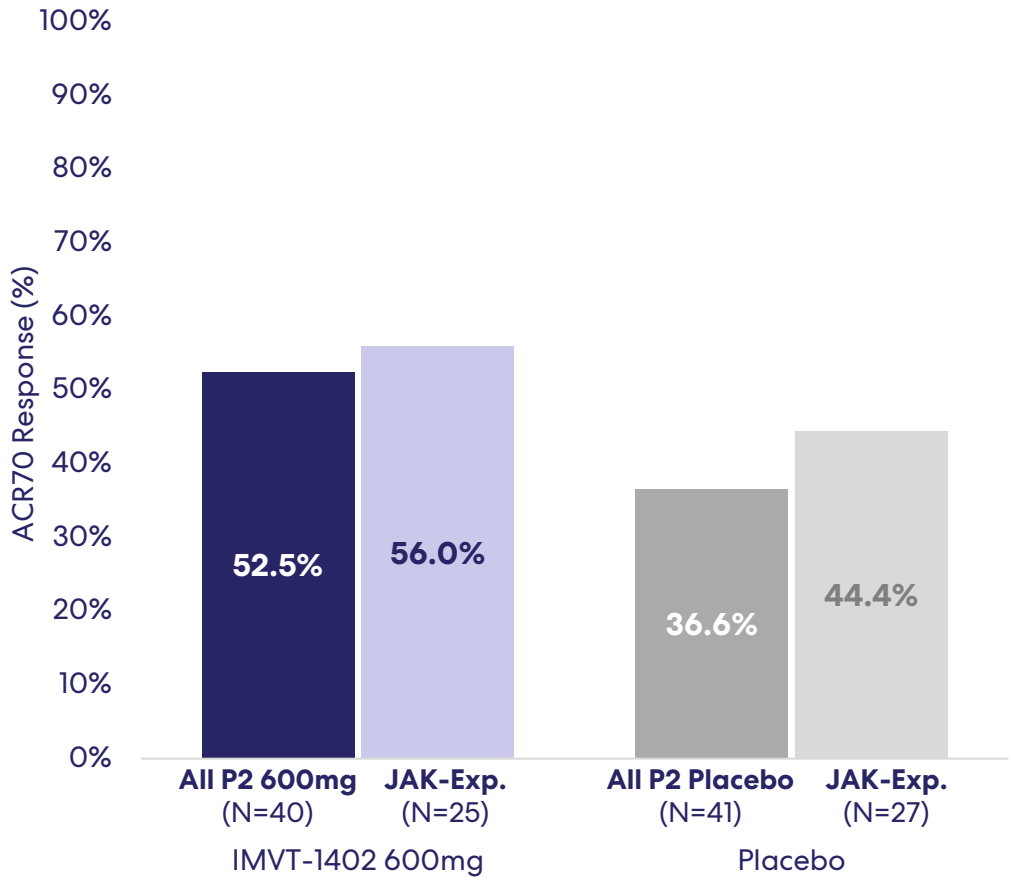


Period 2 (Weeks 16-28): Patients Also Maintained ACR50/70 Response On IMVT-1402 600mg at Week 28 Regardless of Prior JAK Inhibitor Failure

Period 2 ACR50 Response Rates at Week 28 by Prior JAK Inhibitor Failure



Period 2 ACR70 Response Rates at Week 28 by Prior JAK Inhibitor Failure



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Every JAK-experienced patient has failed at least a JAK inhibitor and a TNF inhibitor

Notes: ACR: American College of Rheumatology. ACR50/70 refers to standardized criteria established by the American College of Rheumatology to measure change in rheumatoid arthritis (RA) symptoms. P2: Period 2; Exp.: Experienced

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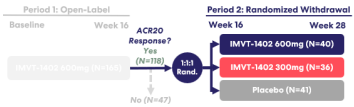

Period 2 (Weeks 16-28) Safety: IMVT-1402 Demonstrated a Favorable Safety Profile With Adverse Event Rates Comparable to Placebo

n (%)	IMVT-1402 600mg	IMVT-1402 300mg	Placebo
N (Period 2)	**40**	**35**	**39**
Any Treatment-Emergent Adverse Event (TEAE)	9 (22.5%)	10 (28.6%)	12 (30.8%)
Grade ≥3 TEAE	0	0	0
Any Serious Adverse Event	0	0	0
Any TEAE Leading to Treatment Discontinuation	0	0	0
Any Adverse Event of Special Interest	6 (15.0%)	9 (25.7%)	8 (20.5%)

Safety data in Period 1 were generally comparable to Period 2 and prior IMVT-1402 studies

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Notes: Safety represents observed rates during Period 2; N's represent safety population: 3 patients included in the ITT efficacy analysis dataset are excluded from the safety analysis population because they never received study drug following randomization in Period 2. AESIs include infections, injection site reactions, and hypersensitivity reactions.

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Period 2 Key Takeaways & Path Forward

Period 2 data further support the potential for IMVT-1402 to not only induce but to maintain deep therapeutic responses in a population that has failed multiple advanced therapies

FDA interaction is planned for later this year to determine the path forward regarding the registrational program for IMVT-1402 in difficult-to-treat RA

Period 1 and 2 data support the opportunity for IMVT-1402 as a differentiated, novel mechanism in a difficult-to-treat population of ~85K US patients readily accessible in the healthcare system, with high unmet need and very few treatment options

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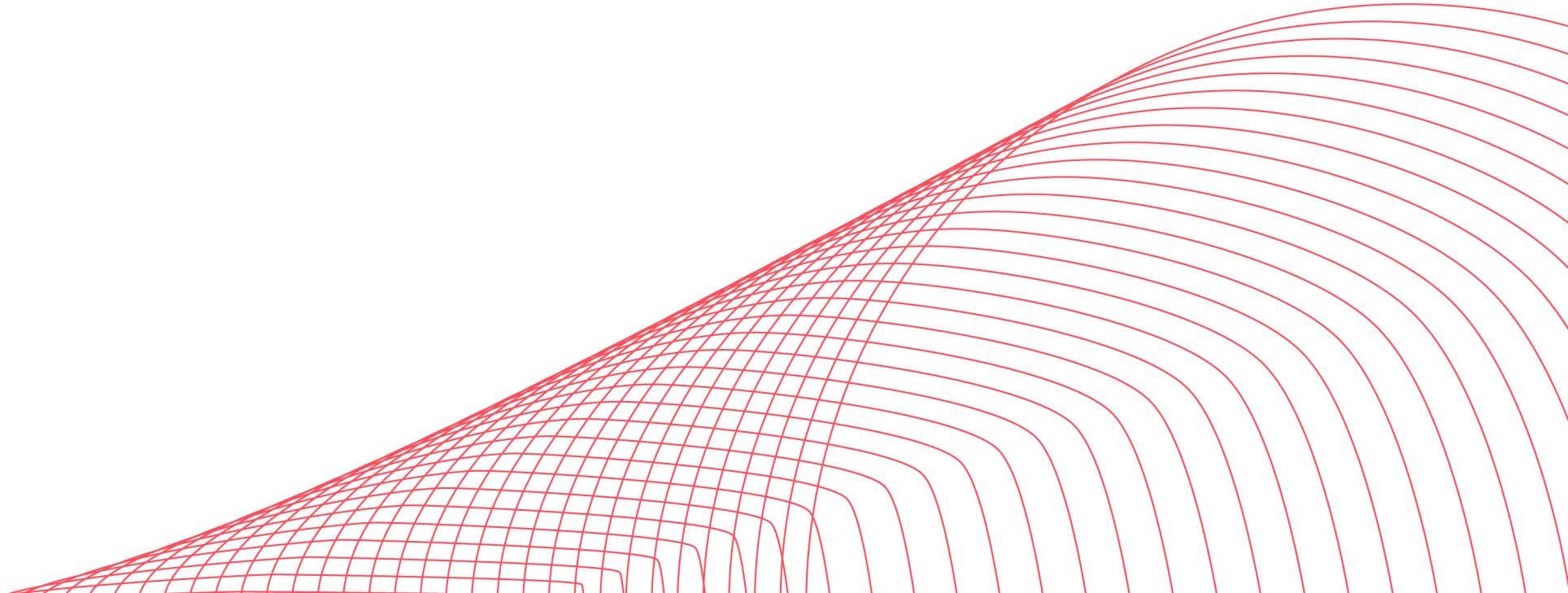
Brepocitinib in NIU: Review of Phase 3 Data



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Non-Infectious Uveitis (NIU): Highly Morbid, Poorly Served Indication With Large Unmet Need

Disease Overview

3rd leading cause of blindness in the US[1]

1 approved non-steroid therapy (Humira)[2]

50% of NIU patients fail within 6 months on Humira[2]



Symptoms include: eye pain, eye redness, distorted vision, floaters, headache, and fatigue[3]

Anatomic Location

May present as anterior, intermediate, posterior or panuveitis[4]

300-860K US adults with anterior uveitis – generally treatable with local therapy[4,5]

70-190K US adults with posterior, intermediate, or panuveitis, generally requiring systemic therapy → **many patients with panuveitis but particularly notable anterior inflammation may be initially diagnosed with anterior disease[4-6]**

Etiology

Across etiologies, pathobiology is driven by T-cell infiltration into the eye[7]

50% idiopathic

50% in combo with other autoimmune diseases

Common comorbidities: sarcoidosis, Behcet's disease, Crohn's disease, rheumatoid arthritis, ankylosing spondylitis, VKH, birdshot chorioretinopathy[8]

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1. Dayani, Modern Retina (2020)
2. Jaffe et al., NEJM (2016)
3. Tallouzi et al., BMJ Open Ophth (2020)
4. Thorne et al., JAMA Opthalmol (2016)
5. Analysis by Roivant/Priovant using closed claims data from Inovalon from 2016-2024
6. Pate and Cleghorn, Rev Opt (2024)
7. Sen et al., Nat Rev Rheumatol (2015)
8. Rosenbaum, Rev Opt (2024)

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CLARITY Data Suggests Brepocitinib Can Potentially Achieve a New Standard for NIU Treatment Outcomes



Brepocitinib achieved the largest efficacy benefit ever seen for a non-steroidal therapy in NIU (time to treatment failure >48 weeks [median not reached] vs. ~12 weeks for placebo, p<0.0001), suggesting potential for improvement even beyond what was observable in the trial



Brepocitinib met the primary endpoint and all secondary endpoints for each of CLARITY-1 and CLARITY-2 studies



62% of patients achieved steroid-free quiescence at one year (placebo-adjusted Δ 41%, p<0.0001), a key treatment goal for physicians



Efficacy was consistent across all patient subgroups with statistically and clinically meaningful improvements in vision-related endpoints and strong structural and functional benefit (including posterior inflammation measured with fluorescein angiography and macular edema resolution)



Brepocitinib was generally well-tolerated with a safety profile consistent with prior studies

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Reminder: Brepocitinib is not FDA-approved for treatment of NIU, and FDA has not yet deemed brepocitinib to be safe & effective for treatment of NIU

Notes: Efficacy results are presented for brepocitinib vs. placebo in CLARITY (pooled). TNF: Tumor necrosis factor; NIU: Non-infectious uveitis

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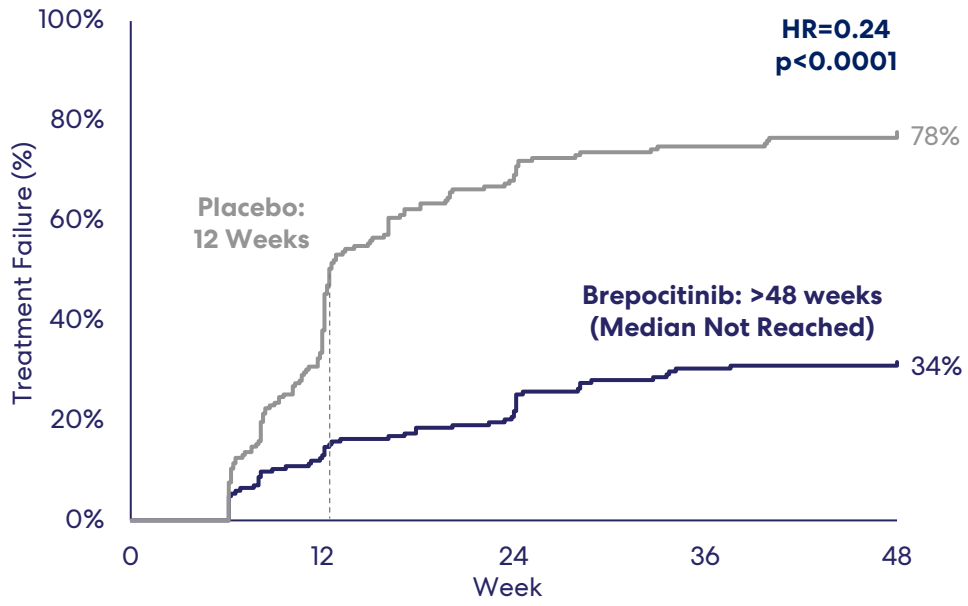
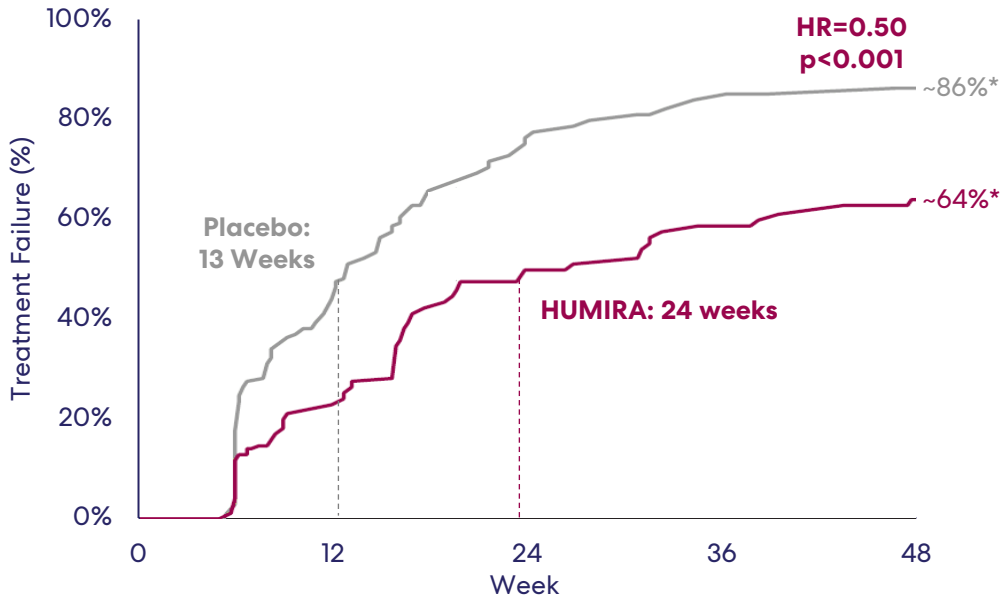
Cross-Trial Comparison Suggests Brepocitinib May Provide >2x Longer Timeline for Prevention of Treatment Failure vs. Standard of Care, With Rapid Steroid Taper

CLARITY-1 & CLARITY-2 (Pooled)



VISUAL I



	Brepocitinib (CLARITY-1 & CLARITY-2 Pooled)	HUMIRA (VISUAL I)
OCS burst and taper period	8 weeks	15 weeks
Median time to treatment failure	>48 weeks	24 weeks
Time from end of steroids to median treatment failure	**>40 weeks**	**9 weeks**

Figure represents a cross-study comparison and not a head-to-head study. Differences exist between study designs and subject characteristics, and caution should be exercised when comparing data across studies.

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Note: Kaplan-Meier estimates for treatment failure from CLARITY (pooled) and VISUAL-I are presented. *Approximate values for the Week 48 visit window for VISUAL-I were measured from Kaplan-Meier figures included in HUMIRA product labeling. Source: Jaffe et al., NEJM (2016), Figure 1A..HR: Hazard Ratio.

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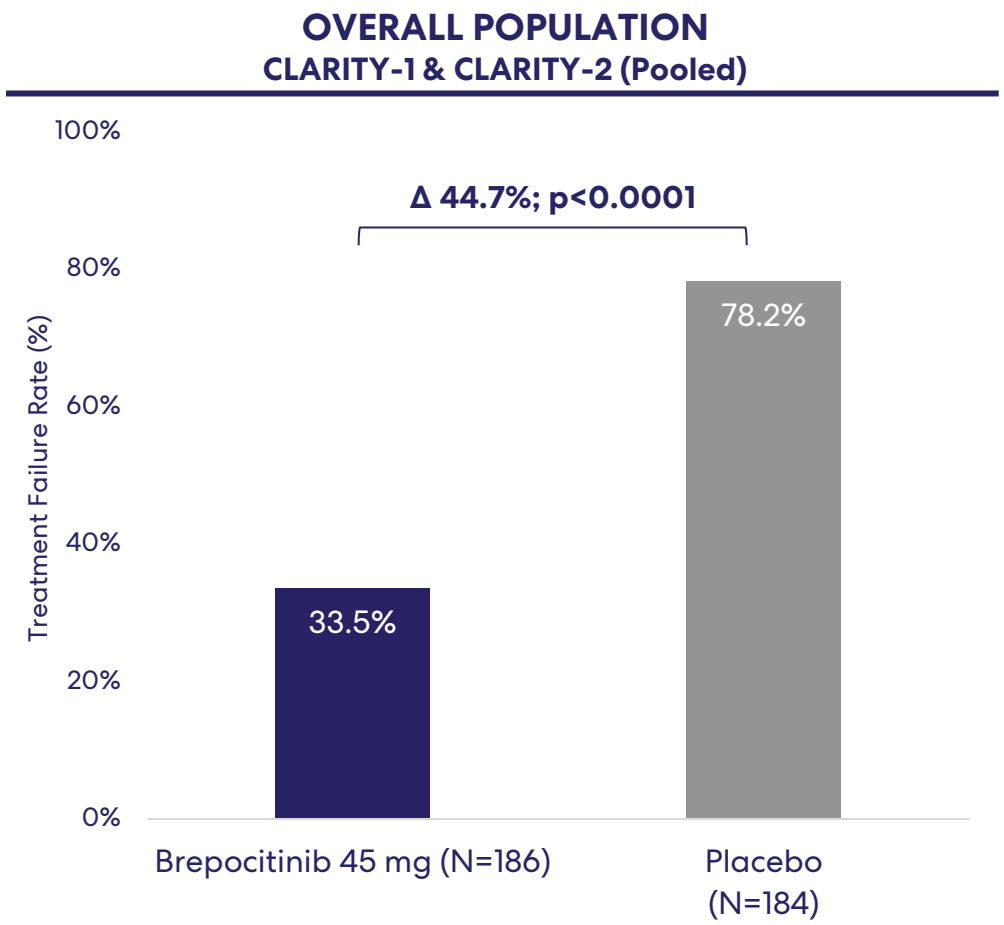
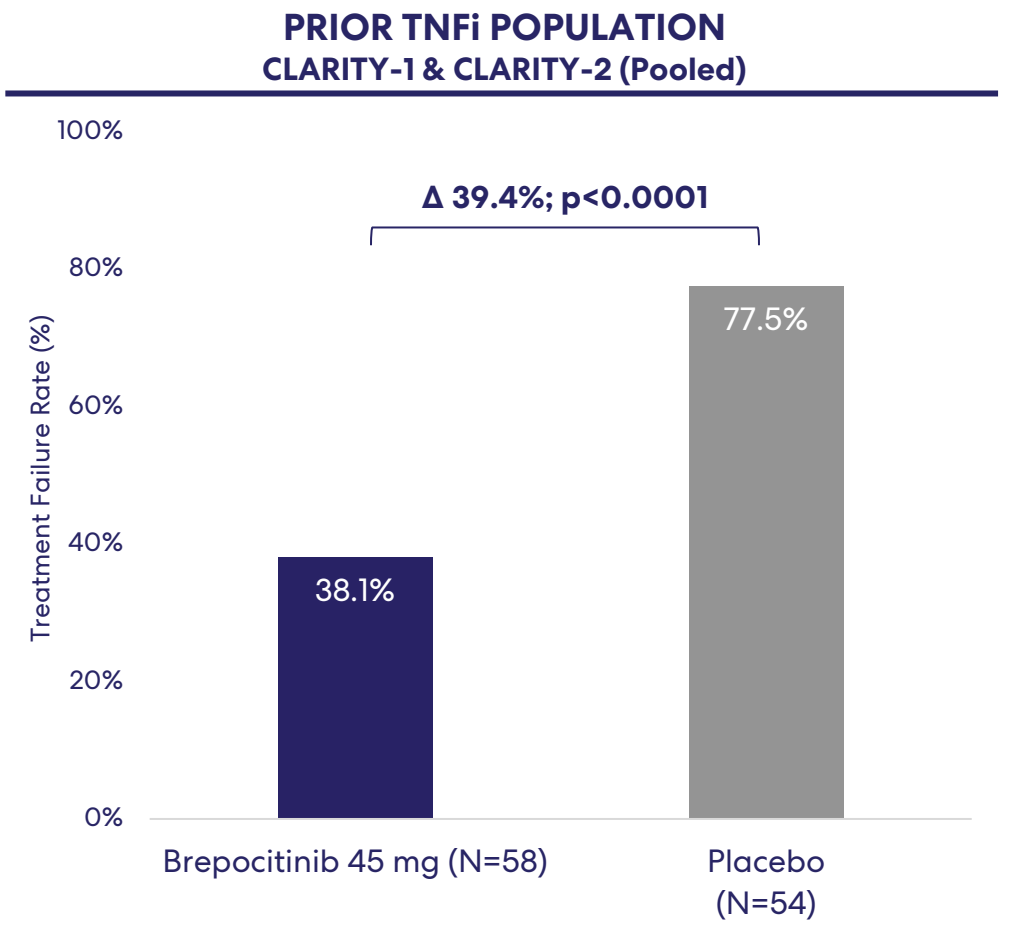
Brepocitinib Shows Low Treatment Failure Rates In Overall Population As Well As For Patients With Prior TNFi Treatment





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Notes: Kaplan-Meier estimates for cumulative incidence of treatment failure by Week 48 are presented. P-value is based on Gehan-Wilcoxon test for brepocitinib vs placebo. P values are nominal.
TNFi: Tumor necrosis factor inhibitor

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Brepocitinib Delivers Statistically and Clinically Significant Improvement on Key Secondary Endpoints by Week 48

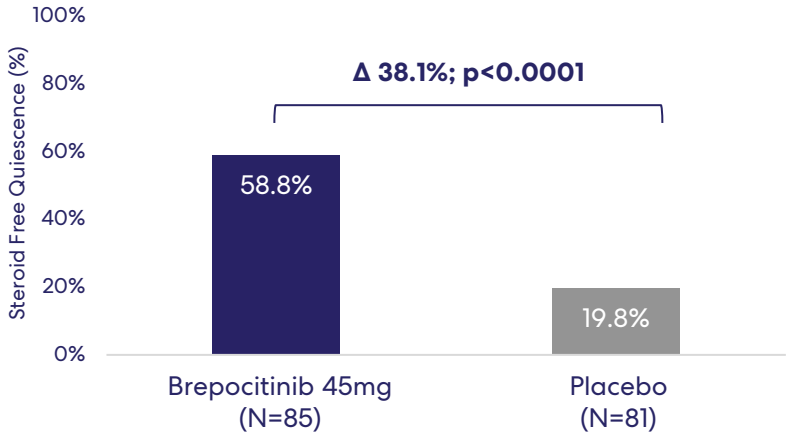
Steroid Free Quiescence

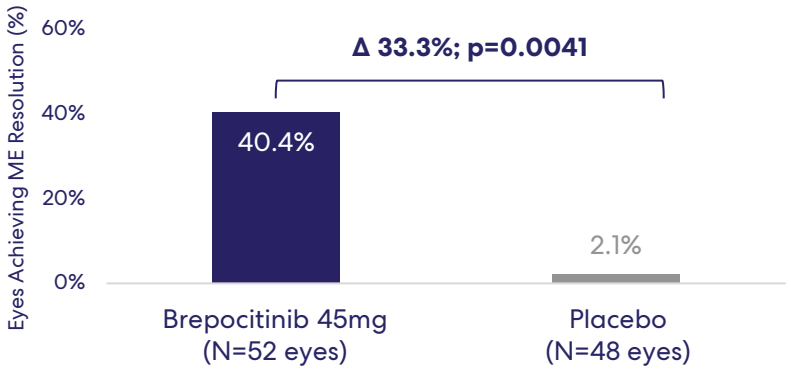
Quiescence requires both eyes with no new active chorioretinal and/or retinal vascular inflammatory lesions; ACC and VH grades ≤ 0.5+; and no current use of systemic or ophthalmic corticosteroids for uveitis

Macular Edema

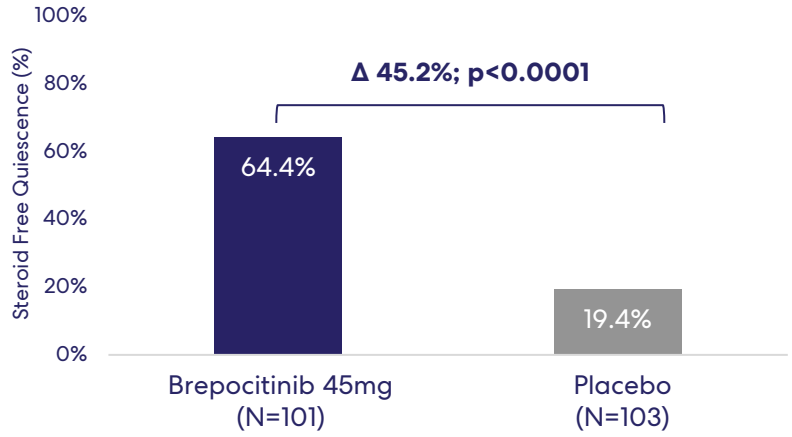
Includes eyes with macular edema (CST ≥ 325 µm) and without lamellar or full thickness macular holes at baseline. Eyes with a lamellar or full thickness macular hole at Week 48 are considered non-responders. Central subfield thickness was assessed by a central reader

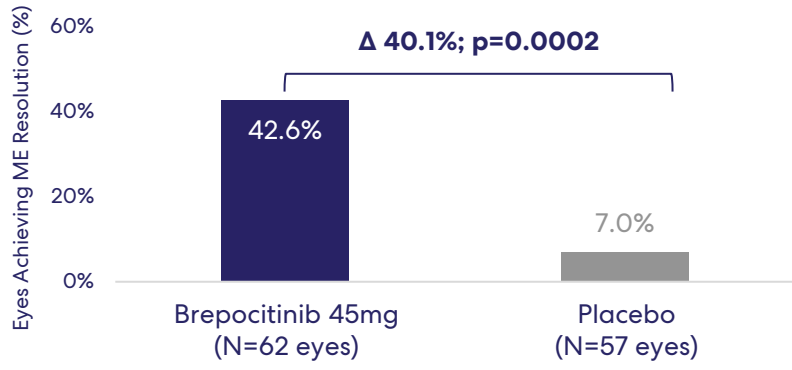
CLARITY-1





CLARITY-2





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Notes on steroid free quiescence: The risk difference and relative risk and their corresponding p-values are for brepocitinib vs. placebo and are based on the non-linear estimates from generalized estimating equations with logit link function adjusted for treatment and randomization stratification factors. ACC: Anterior chamber cell; VH: Vitreous haze

Notes on macular edema (ME): Includes eyes with macular edema (CST ≥ 325 µm) and without lamellar or full thickness macular holes at baseline. Eyes with a lamellar or full thickness macular hole at Week 48 are considered non-responders. Central subfield thickness was assessed by a central reader. The risk difference and the corresponding p-value for brepocitinib vs placebo are based on non-linear estimates from generalized estimating equations with logit link function adjusted for clustered eyes within participants and adjusting for treatment and randomization stratification factors.

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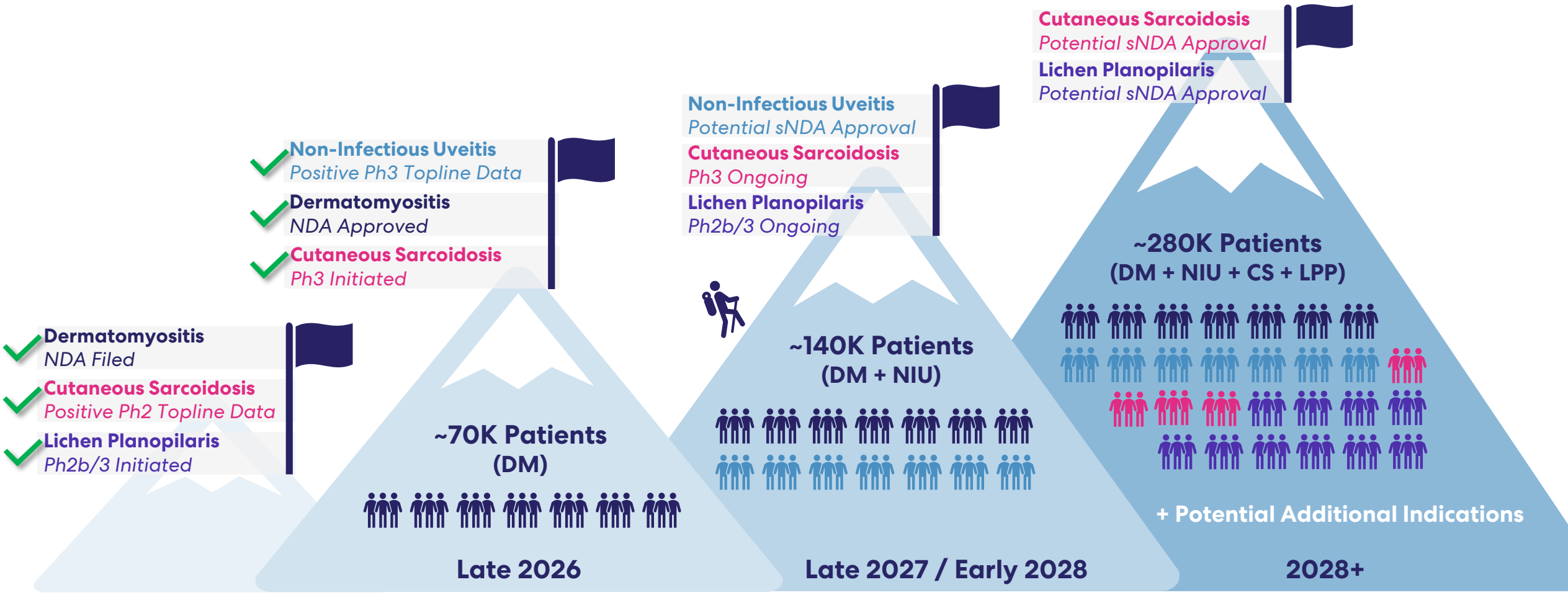
Continued Momentum Across Brepocitinib Franchise, With LISRAYA Launch, Positive CLARITY Data and Two Additional Pivotal Programs Underway



Brepocitinib sNDA filing in NIU expected in 1H 2027

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Illustrates ~10K patients.

Note: LISRAYA (brepocitinib) is FDA-approved only for treatment of dermatomyositis in adult patients. All other indications remain investigational and subject to regulatory approval. All catalyst timings are approximate, based on current expectations and, where applicable, contingent on FDA feedback, and may be subject to change. All references are to calendar years.

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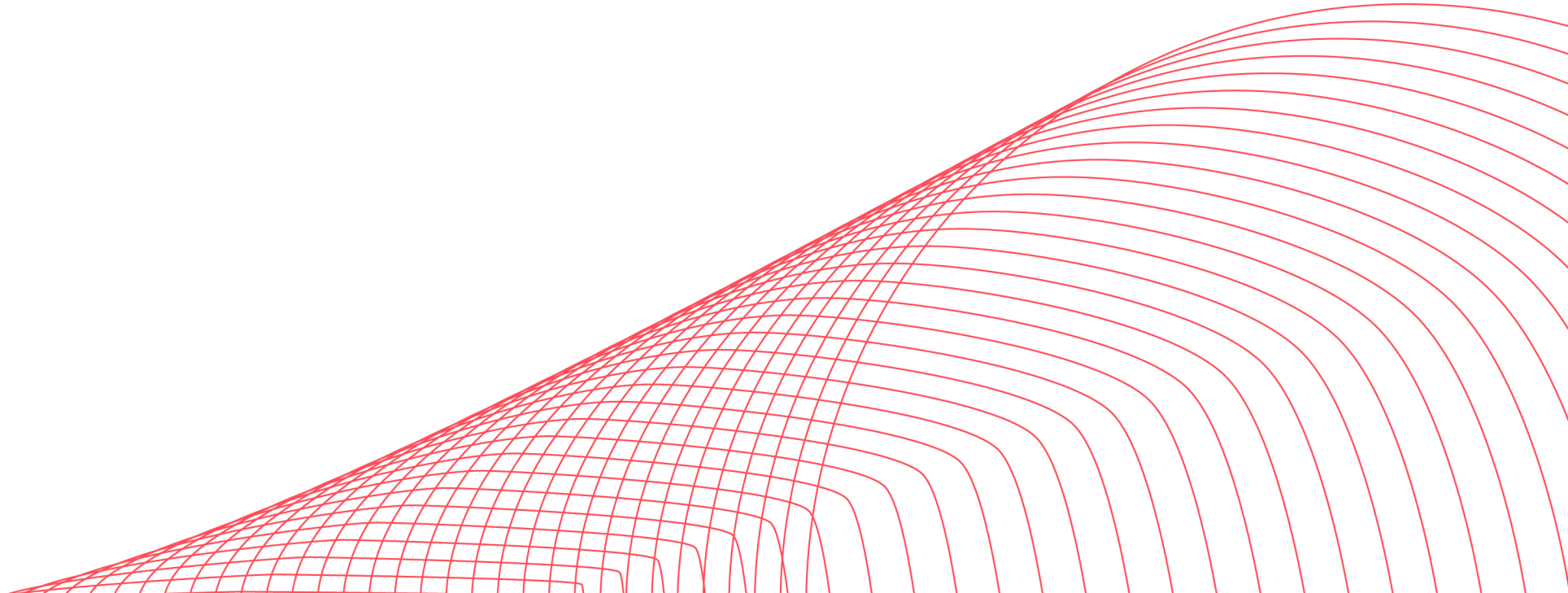
Mosliciguat in PH-ILD: Review of Phase 2 Data



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PH-ILD Represents a Significant Unmet Medical Need With Few Current Treatment Options



1.5-2 Years Median Survival Despite Best-Available SoC[1]

- Patients with PH-ILD have a median survival of only 1.5-2 years from diagnosis[1]
- **PH-ILD is a particularly severe subgroup of pulmonary hypertension with poorer prognosis and higher mortality** than other forms of PH[2-5]
- Elevations in PVR are associated with worse mortality in PH-ILD patients[6,7]



Up to ~200k Patients in US and Europe

- **Prevalence likely underreported** due to limited treatment options, diagnostic barriers and evolving disease awareness[8-16]
- Despite potentially being a larger population, **PH-ILD remains comparatively underserved** relative to PAH



No Non-Treprostinil Approved Therapies

- Approved treprostinil therapies require **as many as 5x daily doses (up to 48 breaths/day),** with unwanted cough and other side effects
- Unmet needs with approved PH-ILD therapies necessitate novel therapies with **improved efficacy, tolerability, and convenience**

1. El-Kersh et al., JHLT Open (2025)
2. Klinger et al., Cardiol Clin (2016)
3. Hoeper et al., PLoS One (2015)
4. Gall et al., J Heart Lung Transplant (2017)
5. Olsson et al., Eur Respir J (2021)
6. Kimura et al., Arthritis Care Res (2013)
7. Nikkho et al., Pulm Circulation (2022)
8. Alhamad et al., J Clin Med (2020)
9. Sathananthan et al., Chest (2023)
10. Kacprzak et al., Diagnostics (2023)
11. Hilberg et al., ERJ Open Res (2022)
12. Raghu et al., Eur Respir J (2015)
13. King et al., Chest (2020)
14. Collard et al., J Am Geriatr Soc (2012)
15. Shorr et al., Eur Respir J (2007)
16. Mathai et al., Am J Respir Crit Care Med (2010)

Abbreviations: SoC: Standard of Care; PH: Pulmonary hypertension; ILD: Interstitial lung disease; PVR: Pulmonary vascular resistance

Key Highlights: Mosliciguat PHocus Trial in PH-ILD

All results achieved with convenient, one breath-per-day dosing

Key Clinical Endpoints

Primary Endpoint

-56.3%

Placebo-adjusted PVR reduction at Week 16 (p<0.0001)

Key Secondary Endpoint

+35.2m

Placebo-adjusted increase in **6MWD at Week 16** (p=0.0027)

Week 24 Exploratory Analyses

-75.9%

Placebo-adjusted reduction in **NT-proBNP at Week 24** (p<0.0001)

+52.7m

Placebo-adjusted increase in **6MWD at Week 24** (p<0.0001)

Cardiac Measures

-22.8%

Reduction in **mean pulmonary arterial pressure** (p<0.0001)

+26.2%

Increase in **cardiac output** (p<0.0001)

Safety & Tolerability

98%[1]

Of patients reached highest (4 mg) dose and remained on 4 mg through Week 24

Well-tolerated with **cough rates lower than placebo (12.1% mosliciguat vs. 18.2% placebo)**

Phase 3 PHrontier program in PH-ILD initiated

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Mosliciguat is an investigational drug and subject to regulatory approval
Note: P-values except primary and key secondary endpoints are nominal given they are exploratory endpoints.
1. Excludes patients who discontinued during titration period; 87% with discontinuations included
PVR: Pulmonary Vascular Resistance; 6MWD: 6-minute walk distance; PH: Pulmonary Hypertension; ILD: Interstitial Lung Disease

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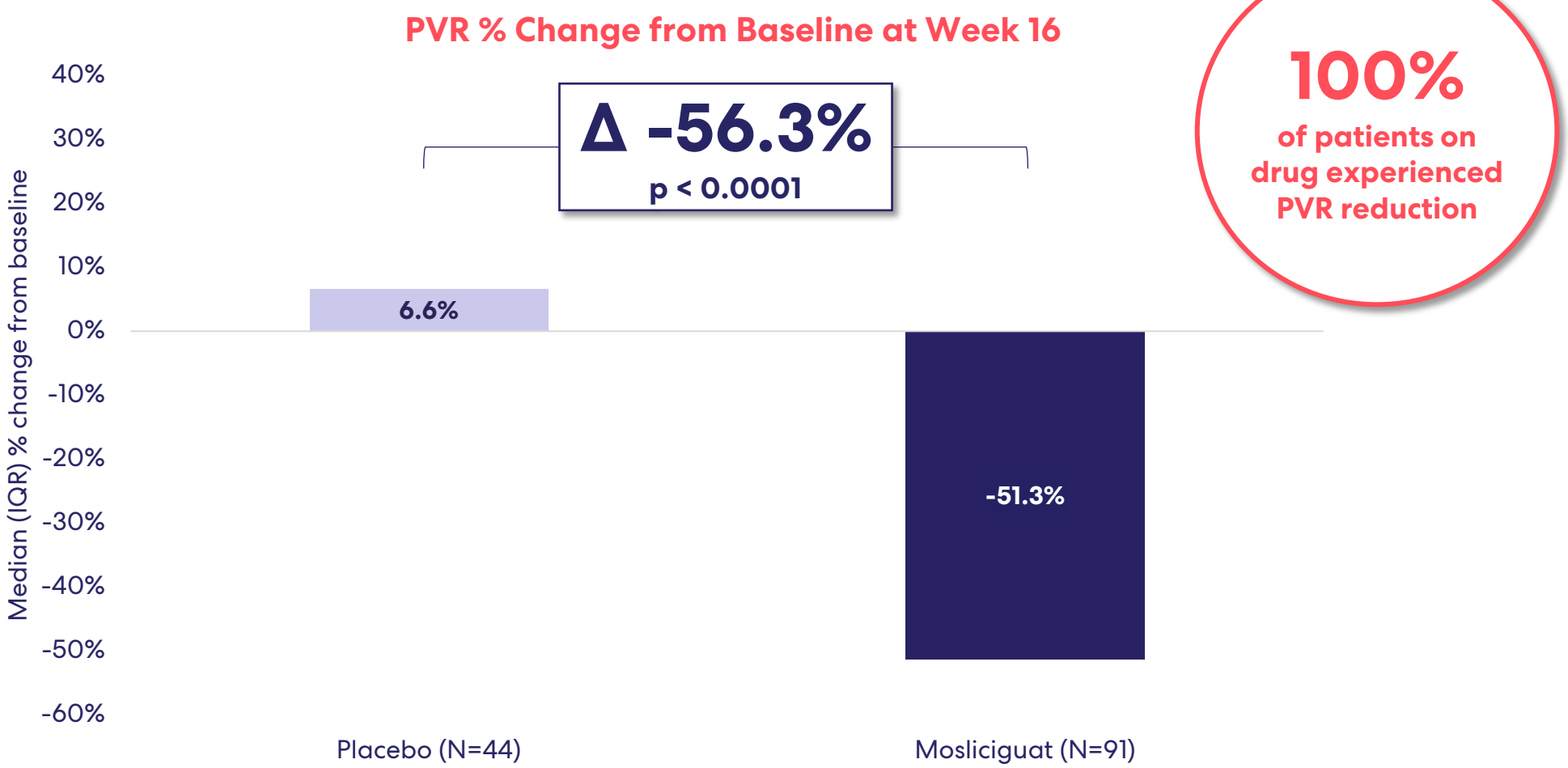
Mosliciguat Met the Primary Endpoint Of Pulmonary Vascular Resistance % Change From Baseline at Week 16 With a 56.3% Placebo-Adjusted Reduction

Highest-ever reported PVR % reduction in any randomized, controlled trial in PH



100%
of patients on drug experienced PVR reduction

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Mosliciguat is an investigational drug and subject to regulatory approval
PVR percent change from baseline at Week 16 was analyzed using a nonparametric ANCOVA model (stratified Wilcoxon test)
Abbreviations: IQR: interquartile range; PVR: pulmonary vascular resistance. Source data on file.

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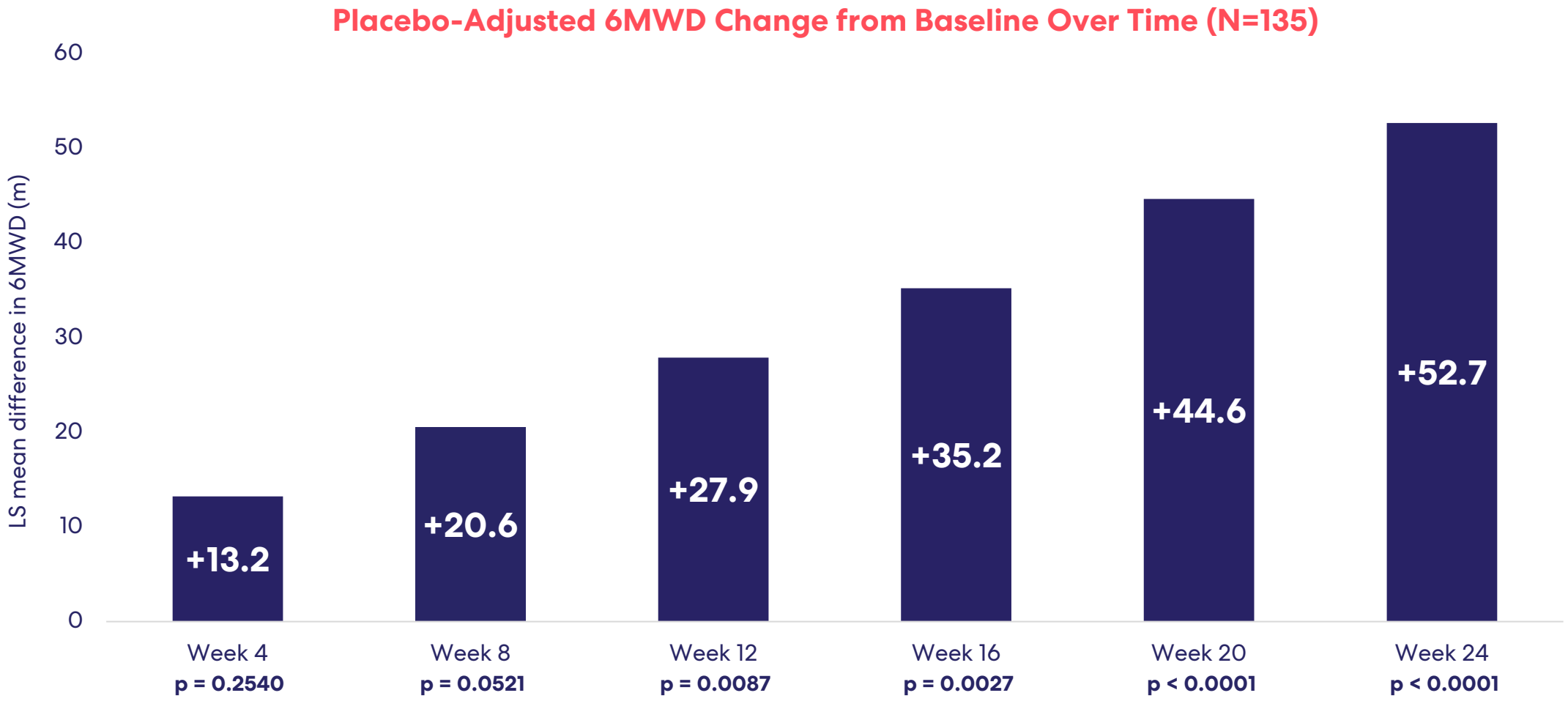
Improvement In 6MWD Observed Early and Continued To Improve Through Week 24, Reaching More Than 52 Meters



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Mosliciguat is an investigational drug and subject to regulatory approval
P-values except Week 16 are nominal given they are exploratory endpoints. Change from baseline in 6MWD was analyzed using an MMRM model. For the primary analysis, the model includes data through Week 16 and for the exploratory analysis, the model includes data through Week 24. Abbreviations: 6MWD: six-minute walk distance. Source data on file.

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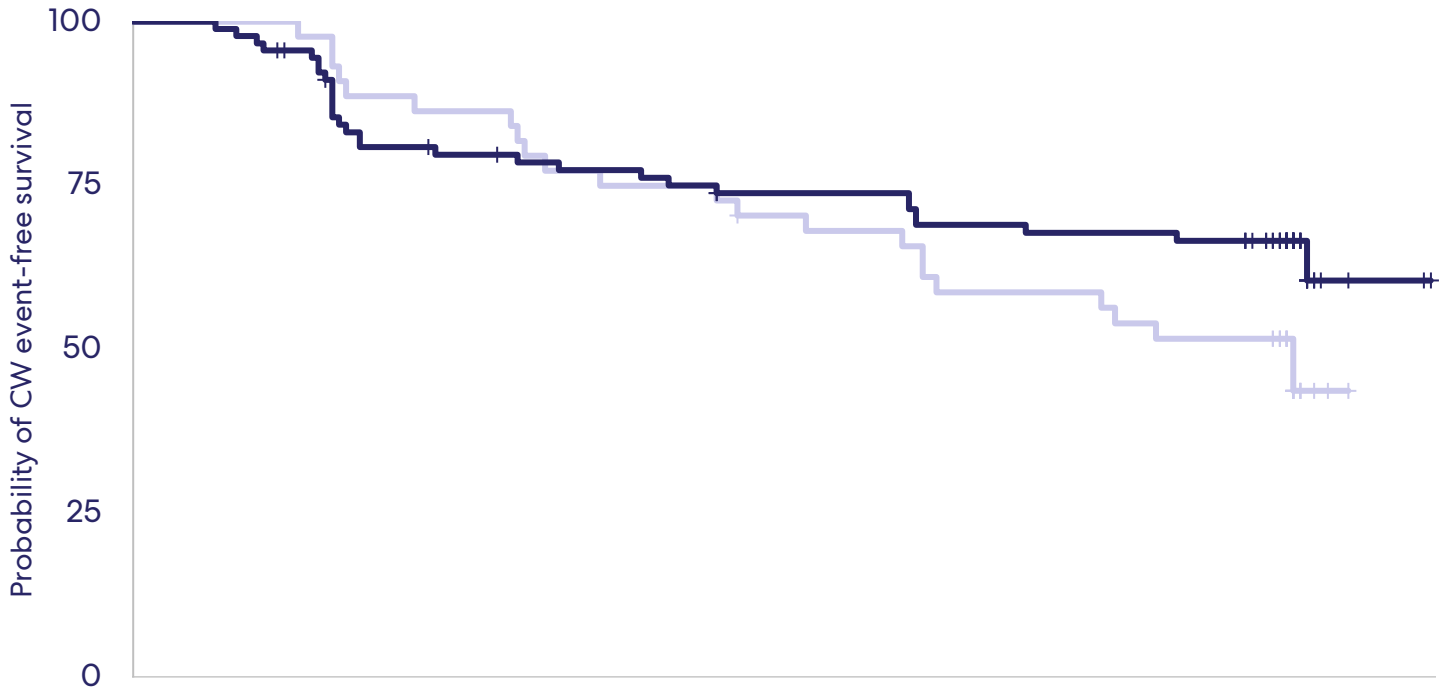
Exploratory Analysis of Time To Clinical Worsening Suggests Mosliciguat Reduced Risk of Worsening By 37%

Time to First Clinical Worsening



Week	0	4	8	12	16	20	24
N at risk							
Placebo (N=44)	44	43	37	33	29	25	17
Mosliciguat (N=91)	91	82	68	64	61	56	43

37%

Risk Reduction

HR: 0.63

p = 0.0955

Time to Clinical Worsening (TTCW) defined as the first occurrence of one or more of:

- Hospitalization for cardiopulmonary indication
- Decrease in 6MWD >15% from baseline
- Lung transplantation for worsening PH
- Rescue therapy for PH
- Death (all causes)

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Mosliciguat is an investigational drug and subject to regulatory approval
P-value was calculated based on log-rank test. Hazard ratio was calculated using a Cox proportional hazard model. Abbreviations: CW: clinical worsening; PH: Pulmonary hypertension; 6MWD: Six-minute walk distance. Source data on file.

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Mosliciguat

Mosliciguat: In A League Of Its Own



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Mosliciguat is an investigational drug and subject to regulatory approval; PVR: Pulmonary Vascular Resistance; 6MWD: 6-minute walk distance; m = Meters; NT-proBNP: N-terminal pro b-type natriuretic peptide. Notes: Mosliciguat and competitor efficacy data represent placebo-adjusted improvements on efficacy measures at Week 16 for PVR and at Week 24 for 6MWD and NT-proBNP. Competitor data is approximate – ranges represented by data from Tyvaso, Yutrepia, TPIP, L606.

Figure represents a cross-study comparison and not a head-to-head study. Differences exist between study designs and subject characteristics, and caution should be exercised when comparing data across studies.

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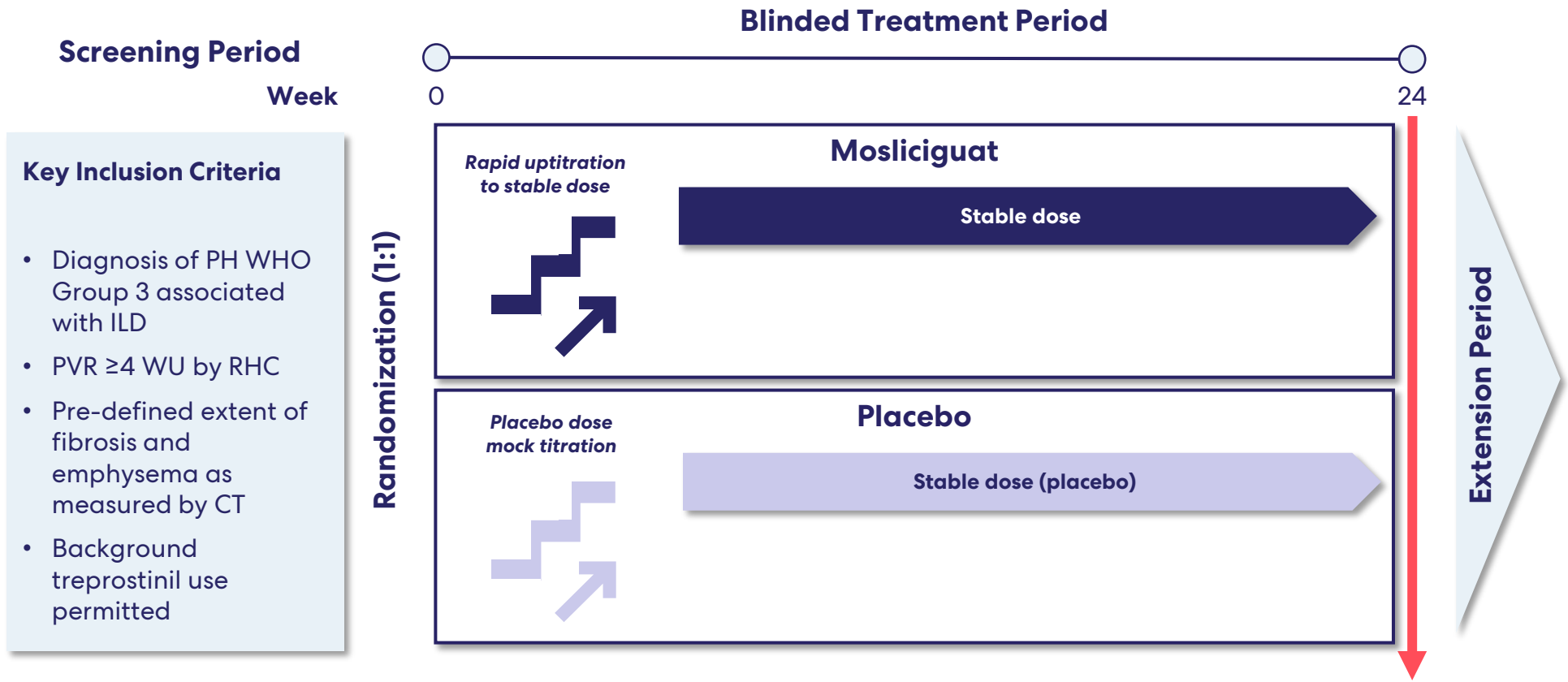
Phase 3 PHrontier Study Is Underway And Actively Screening

Double-blinded, multi-center, global trial in N = ~375 PH-ILD patients



Primary Endpoint: Δ 6MWD

Key Secondary Endpoints:

- Time to Clinical Worsening
- Δ PVR
- Δ NT-proBNP

Mosliciguat is an investigational drug and subject to regulatory approval

Notes: All endpoints assessed at estimated peak exposure. Abbreviations: PH: pulmonary hypertension; ILD: interstitial lung disease; PVR: pulmonary vascular resistance; 6MWD: six-minute walk distance; NT-proBNP: N-terminal pro-B-type natriuretic peptide; WHO: World Health Organization; RHC: Right Heart Catheterization; CT: computed tomography.

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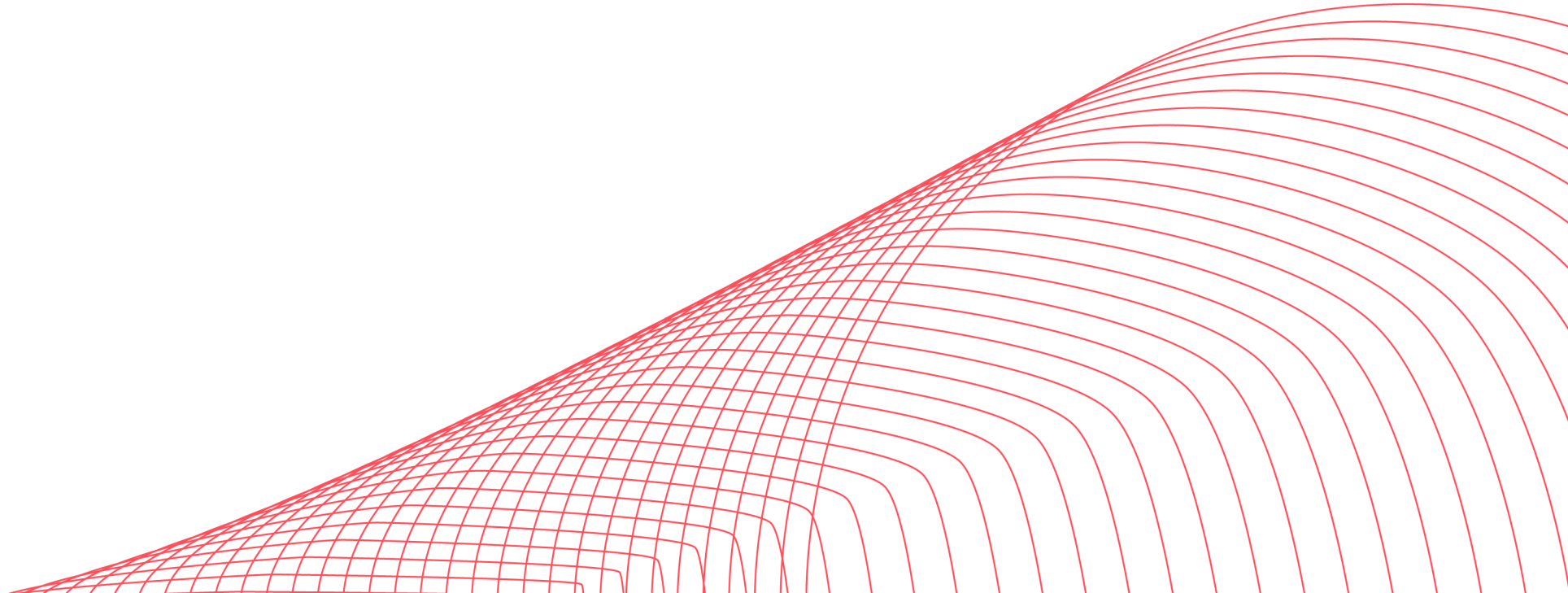
Financial Update



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Key Financial Items

Select Income Statement and Non-GAAP Metrics for the Three Months Ended September 30, 2026

- R&D expenses of $146M; adjusted R&D expenses of $137M (non-GAAP)
- SG&A expenses of $154M; adjusted SG&A expenses of $82M (non-GAAP)
- Loss from continuing operations, net of tax of $153M; adjusted loss from continuing operations, net of tax of $133M (non-GAAP)

Select Balance Sheet Metrics as of September 30, 2026

- Cash, cash equivalents and marketable securities of $4.2BN as of September 30, 2026
- 724,561,460 common shares issued and outstanding as of November 3, 2026
    - 9,359,498 common shares repurchased for $281M in the 6 months ended September 30, 2026

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For a reconciliation of each non-GAAP financial metric to the comparable GAAP financial metric, please see slide 40.

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Non-GAAP Disclosures

Reconciliation of GAAP to Non-GAAP Financial Measures *(unaudited, in thousands)*

	Note	Three Months Ended September 30, 2026	2025
Loss from continuing operations, net of tax		$ (152,974)	$ (166,039)
Adjustments:			
Research and development:			
Share-based compensation	(1)	7,965	10,996
Depreciation and amortization	(2)	347	676
Selling, general and administrative:			
Share-based compensation	(1)	71,332	70,825
Depreciation and amortization	(2)	257	246
Other:			
Change in fair value of investments	(3)	(60,292)	(128,501)
Change in fair value of liability instruments	(4)	—	20,959
Estimated income tax impact from adjustments	(5)	—	3,059
Adjusted loss from continuing operations, net of tax (Non-GAAP)		**$ (133,365)**	**$ (187,779)**

	Note	Three Months Ended September 30, 2026	2025
Research and development expenses		**$ 145,747**	**$ 164,568**
Adjustments:			
Share-based compensation	(1)	7,965	10,996
Depreciation and amortization	(2)	347	676
Adjusted research and development expenses (Non-GAAP)		**$ 137,435**	**$ 152,896**

	Note	Three Months Ended September 30, 2026	2025
Selling, general and administrative expenses		**$ 154,076**	**$ 143,125**
Adjustments:			
Share-based compensation	(1)	71,332	70,825
Depreciation and amortization	(2)	257	246
Adjusted selling, general and administrative expenses (Non-GAAP)		**$ 82,487**	**$ 72,054**

Notes to non-GAAP financial measures:

(1) Represents non-cash share-based compensation expense.

(2) Represents non-cash depreciation and amortization expense.

(3) Represents the unrealized gains on equity investments in unconsolidated entities that are accounted for at fair value with changes in value reported in earnings.

(4) Represents the change in fair value of liability instruments, which is non-cash and primarily includes the loss relating to the measurement and recognition of fair value on a recurring basis of certain liabilities.

(5) Represents the estimated tax effect of the adjustments.

Rich Catalyst Calendar

Program	Vant	Catalyst	Expected Timing
Roivant pipeline growth		New mid/late-stage in-licensing announcements	Ongoing
Brepocitinib		sNDA filing for non-infectious uveitis	1H 2027
IMVT-1402		Topline data from potentially registrational trials in Graves' disease	2027
IMVT-1402		Topline data from potentially registrational trial in myasthenia gravis	2027
Multiple Programs		Additional indication expansion	2027
IMVT-1402		Topline data from potentially registrational trial in chronic inflammatory demyelinating polyneuropathy	2028
Brepocitinib		Topline data from Phase 3 trial in cutaneous sarcoidosis	2028
Brepocitinib		Topline data from Phase 2b/3 trial in lichen planopilaris	TBC
Mosliciguat		Topline data from Phase 3 trial in pulmonary hypertension associated with interstitial lung disease	TBC

Note: LISRAYA (brepocitinib) is FDA-approved only for treatment of dermatomyositis in adult patients. All other drugs are investigational and subject to regulatory approvals. All catalyst timings are based on current expectations and, where applicable, contingent on FDA feedback, and may be subject to change. All references are to calendar years

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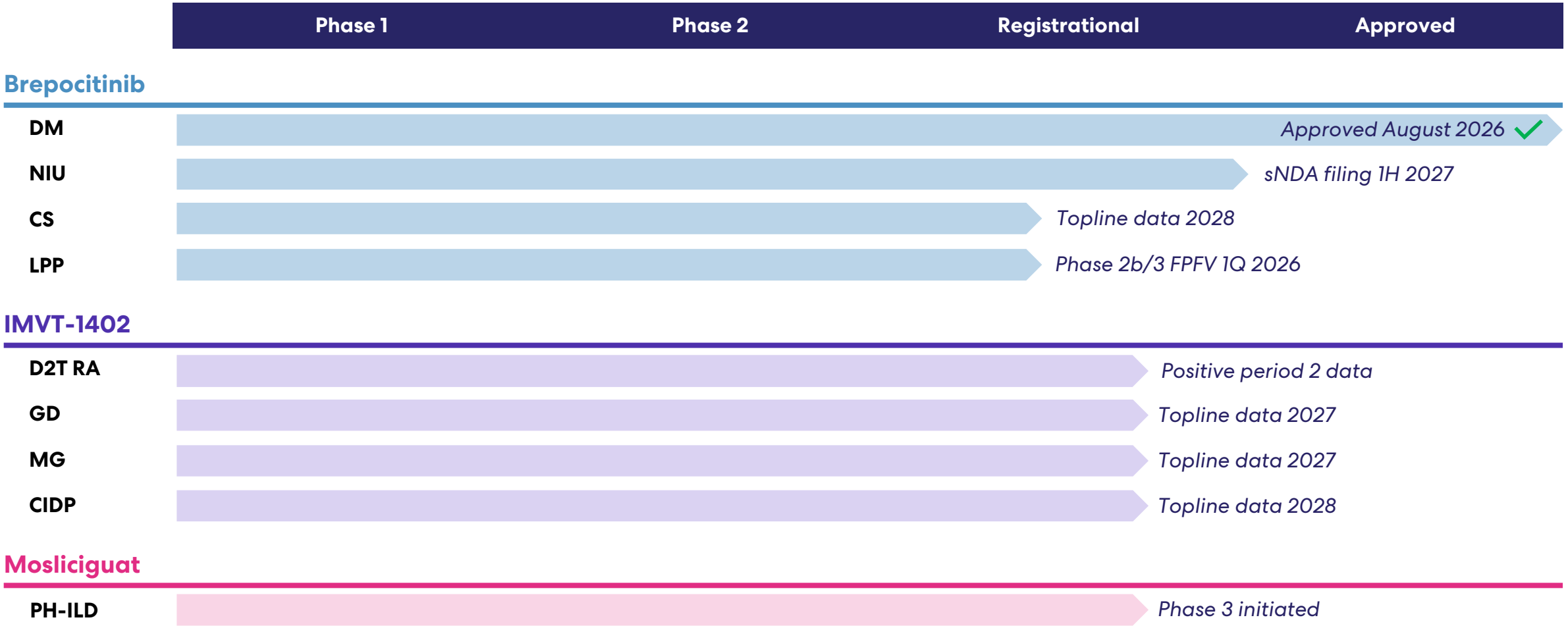
High-Value Pipeline, Delivering Series of Near-Term Catalysts



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Note: LISRAYA (brepocitinib) is FDA-approved only for treatment of dermatomyositis in adult patients. All other drugs and indications remain investigational and subject to regulatory approval. All catalyst timings are approximate, based on current expectations and, where applicable, contingent on FDA feedback, and may be subject to change. All references are to calendar years.

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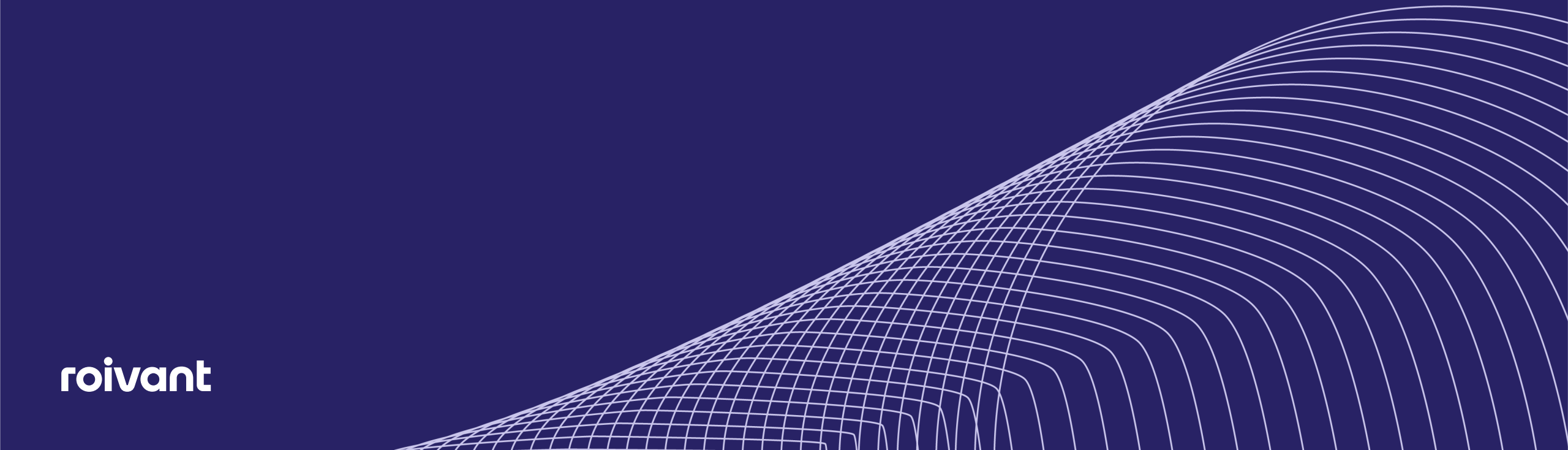
Investor Day 2026

Wednesday, December 9, 2026
8:00 AM–1:00 PM ET
New York City + Virtual

Register

https://roivant-investor-day-2026.open-exchange.net/registration

Thank you.



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