roivant

investor day 2025

December 11, 2025
New York City

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, profitability, the anticipated timing, costs, design, conduct and results of our ongoing and planned preclinical studies and clinical trials for our products and product candidates, and any commercial potential of our products and product candidates 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, uncertainties and assumptions, including, but not limited to, those risks set forth in the sections captioned "Risk Factors" and "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 each of batoclimab, IMVT-1402, brepocitinib, and mosliciguat as compared to certain other potential competitor products generated from separate, independent studies and that do not come from head-to-head analyses.

Differences exist between study or trial designs and subject characteristics and caution should be exercised when comparing data across studies. Data regarding other products is based on publicly available information.

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 slides 166-167. 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 candidates referenced herein or otherwise influence healthcare prescribing decisions.

Today's Agenda

8:00 – 8:15	**Introduction**
8:15 – 9:00	**Brepocitinib**
9:00 – 9:15	Q&A
9:15 – 9:25	*Break*
9:25 – 10:20	**IMVT-1402**
10:20 – 10:30	Q&A
10:30 – 10:50	**Mosliciguat**
10:50 - 11:00	Q&A
11:00 – 11:10	*Break*
11:10 – 11:25	**LNP Litigation**
11:25 – 11:30	**Financial Outlook**
11:30 – 11:40	**Closing Remarks**
11:40 – 12:00	Q&A
12:00	Lunch

Today's Speakers

CEO, Roivant

Matt Gline

President & Vant Chair, Roivant

Frank Torti

CFO, Roivant

Richard Pulik

CEO, Priovant

Ben Zimmer

CEO, Immunovant
President, Roivant

Eric Venker

CEO, Pulmovant

Drew Fromkin

Special Counsel, Genevant
CEO, Arbutus

Lindsay Androski

Introduction

Matt Gline

CEO, Roivant

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Key Takeaways From Today

Roivant's next decade will look materially different from its last: now simplified to a "traditional development and commercialization" company with a near-term commercial launch

Successful clinical execution has accelerated
3 topline readouts

Multiple "pipeline-in-a-product" opportunities uniquely position us to shape our own destiny

Executing on our existing portfolio is the highest priority for us

All while maintaining our unique culture, dynamism, and focus on shareholder value creation

Combination of Capital, Expertise and Track Record Maximizes Value for Patients, Partners and Shareholders

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Significant Financial Strength

$4.4BN cash & equivalents[1]; funded into profitability

Proven Performance & Strong Pipeline

12
Positive Phase 3 Studies[2]

3
Commercial Launches Over the Next 3 Years

8
FDA Approvals[2]

>$10BN
in Exits to Pharma

Focus on Capital Efficiency

Repurchased $1.5BN at ~$10[3]; additional $500M authorized

1. Consolidated cash, cash equivalents, marketable securities, and other current assets as of September 30, 2025. Does not include $200M in non-ROIV gross proceeds from Immunovant's December 2025 offering.
2. FDA approval and trial figures include Vants transferred to Sumitomo Pharma in December 2019, as well as Dermavant, which was acquired by Organon in October 2024
3. 148.6M shares were purchased for $1.5BN at an average price of $10.09
Note: All drugs are investigational and subject to regulatory approvals. 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

What Makes Roivant Unique

Talent, Organization & Culture

- **Homegrown leadership – unique mix of expertise**
- **Lean, dynamic and agile organization**
- **Entrepreneurial mindset with aligned incentives**

Creative Product Development

Brepocitinib
Identifying rare I&I as our opportunity

IMVT-1402
Identifying and pioneering Graves' disease development

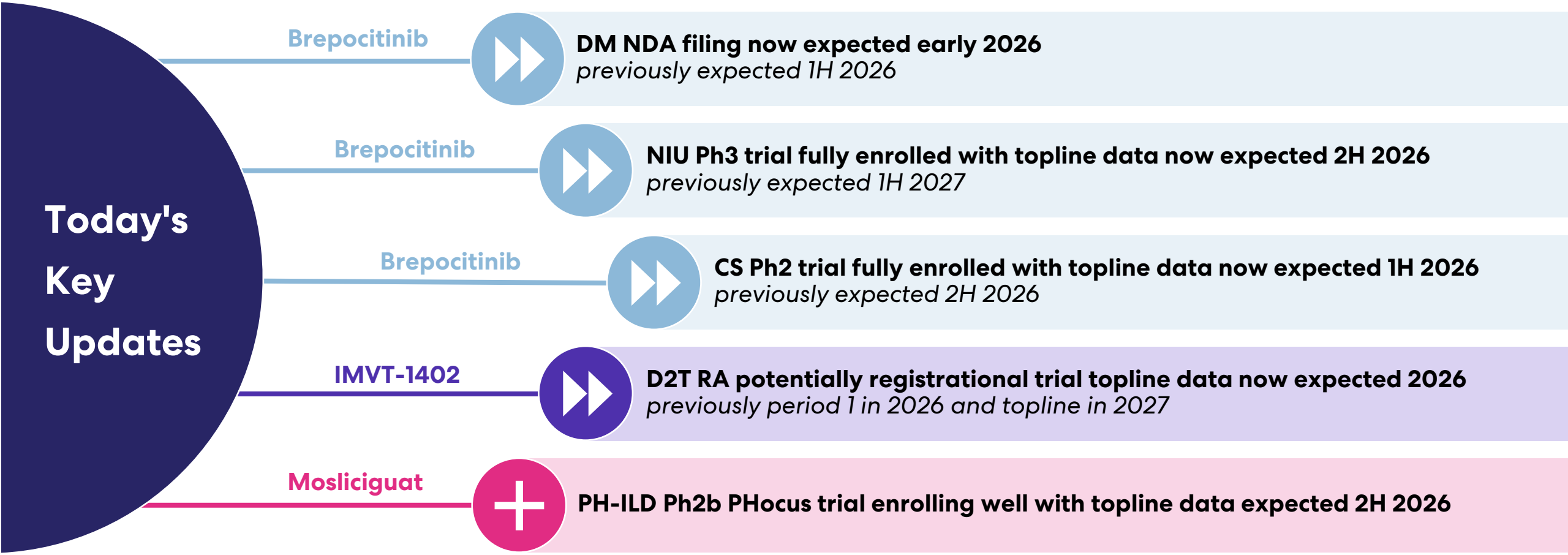
Mosliciguat
Pivoting initial program to PH-ILD from PAH

Focus on Execution

Executed the longest and biggest DM study in just ~3 years in a challenging-to-enroll indication

Execution of multiple other studies including CS, NIU, D2T RA, all expected to report ahead of schedule

Strong Execution With Multiple Positive Updates to Timing Guidance



Note: All drugs are investigational and subject to regulatory approvals. 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

Over the Next 36 Months (by End of CY 2028), Roivant Will Execute on...

3+ Commercial Launches

- **brepocitinib**: DM, NIU
- **IMVT-1402**: GD

4+ NDA/BLA Filings*

- **brepocitinib**: DM, NIU
- **IMVT-1402**: GD, MG

8+ Pivotal Study Readouts

Across 6+ Indications

NIU | GD | MG | CIDP | SjD | D2T RA

3+ POC Study Readouts

Across 3+ Indications

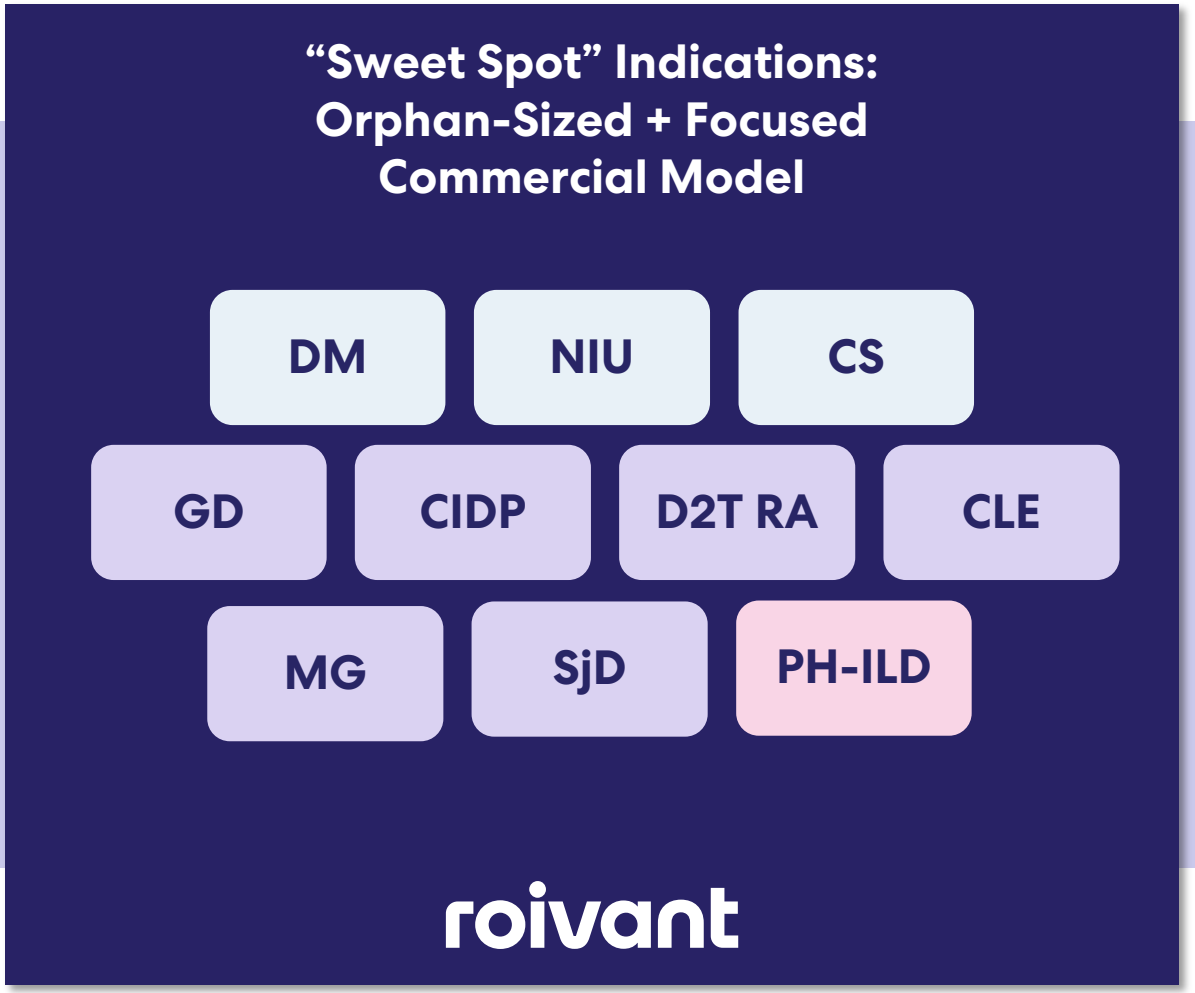
PH-ILD | CLE | CS

brepocitinib | IMVT-1402 | mosliciguat

Note: All drugs are investigational and subject to regulatory approvals. 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
NDA: new drug application; BLA: biologics license application; DM: dermatomyositis; NIU: non-infectious uveitis; GD: Graves' disease; MG: myasthenia gravis; CIDP: chronic inflammatory demyelinating polyneuropathy; SjD: Sjögren's disease; D2T RA: difficult-to-treat rheumatoid arthritis; PH-ILD: pulmonary hypertension with interstitial lung disease; CLE: cutaneous lupus erythematosus; CS: cutaneous sarcoidosis
*May be supplementary filings, depending on drug/indication

Roivant's Commercial Opportunity Is Rooted in High-Value, Tractable Indications

Ultra-Orphan Indications



"Large Pharma" Indications

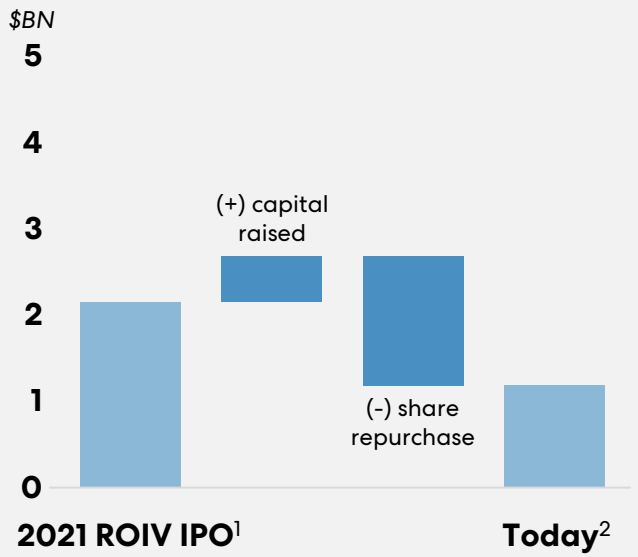
Note: All drugs are investigational and subject to regulatory approvals.
DM: dermatomyositis; NIU: non-infectious uveitis; CS: cutaneous sarcoidosis; GD: Graves' disease; CIDP: chronic inflammatory demyelinating polyneuropathy; D2T RA: difficult-to-treat rheumatoid arthritis; CLE: cutaneous lupus erythematosus; MG: myasthenia gravis; SjD: Sjögren's disease; PH-ILD: pulmonary hypertension with interstitial lung disease

Capital Efficiency & Value Creation With Minimal Dilution

Multiple value-generating late-stage programs fully-funded to launch with cushion to selectively invest in other promising opportunities

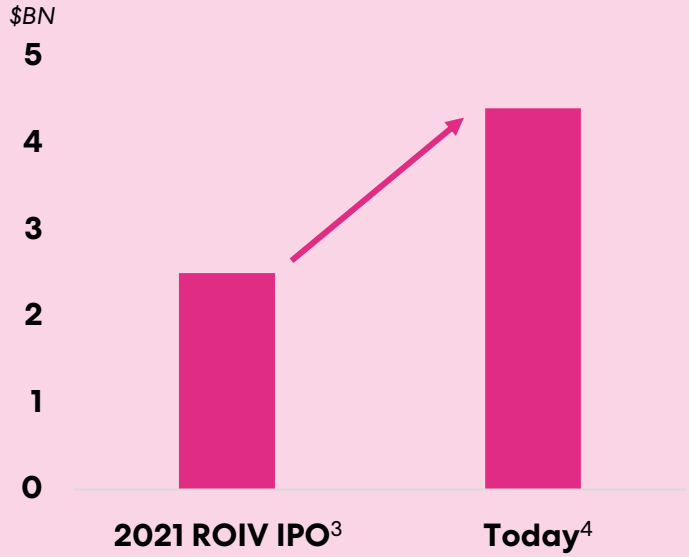
Net Equity Capital

Since IPO, we have returned significant capital to shareholders...



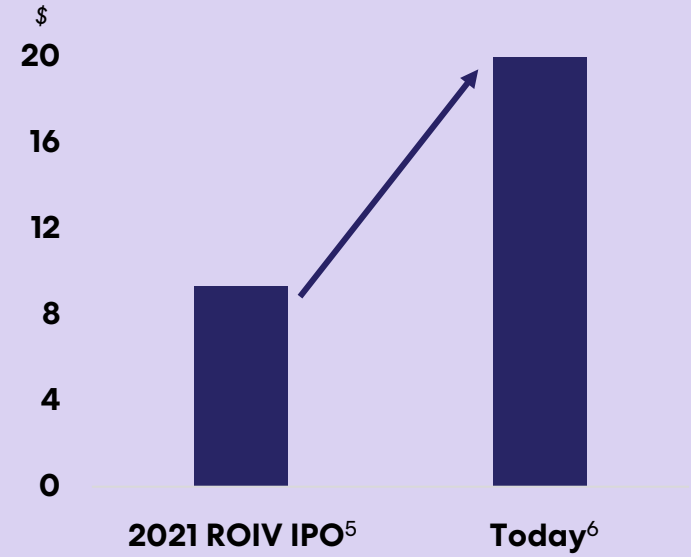
Cash

...increased our cash balance...



Share Price

...and generated substantial shareholder returns



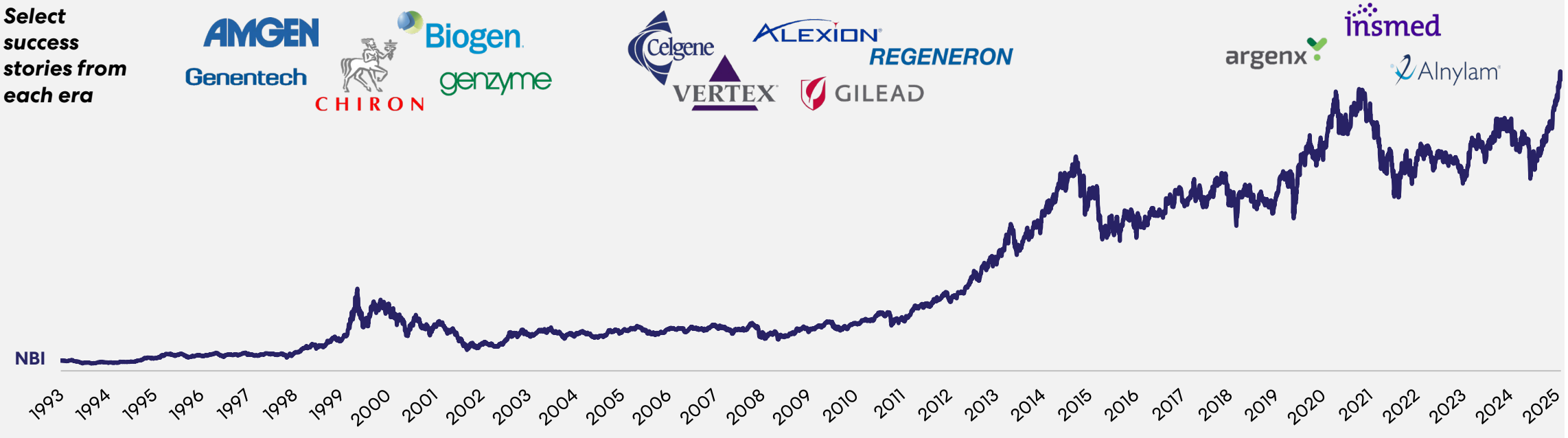
1. 2021 ROIV IPO includes cumulative capital raised by ROIV as private company and via IPO
2. Today's equity capital raised reflects gross proceeds from parent company equity issuances, net of share repurchases
3. Consolidated cash, cash equivalents, and restricted cash as of September 30, 2021; includes $559M at Immunovant
4. Consolidated cash, cash equivalents, restricted cash, and marketable securities as of September 30, 2025; includes $522M at Immunovant
5. As of October 1, 2021, close
6. As of December 5, 2025, close

We Are at a Unique Time in the Evolution of the Biotech Industry

	Genesis: <2000	Discovery Phase: 2000 - 2020	Execution Phase: 2020+
Select milestones and themes driving industry fundamentals and value creation	• **Industry Birth:** Creation of modern biotech • **Disruption:** Shift away from chemical-based pharma • **Early Consolidation:** The first wave of M&A	• **Science Boom:** Genomic sequencing, mRNA, & cell therapy • **Launch Struggles:** ~40% of launch stocks underperformed by >50% ("Short the Launch") • **M&A Reliance:** Investors relied on buyouts for returns	• **Strategic Partnering:** Licensing replaces pure acquisition • **Launch Success:** ~40% of launch stocks outperformed by 25% ("Own the Launch") • **New Leaders:** A "graduating class" of standalone biopharmas

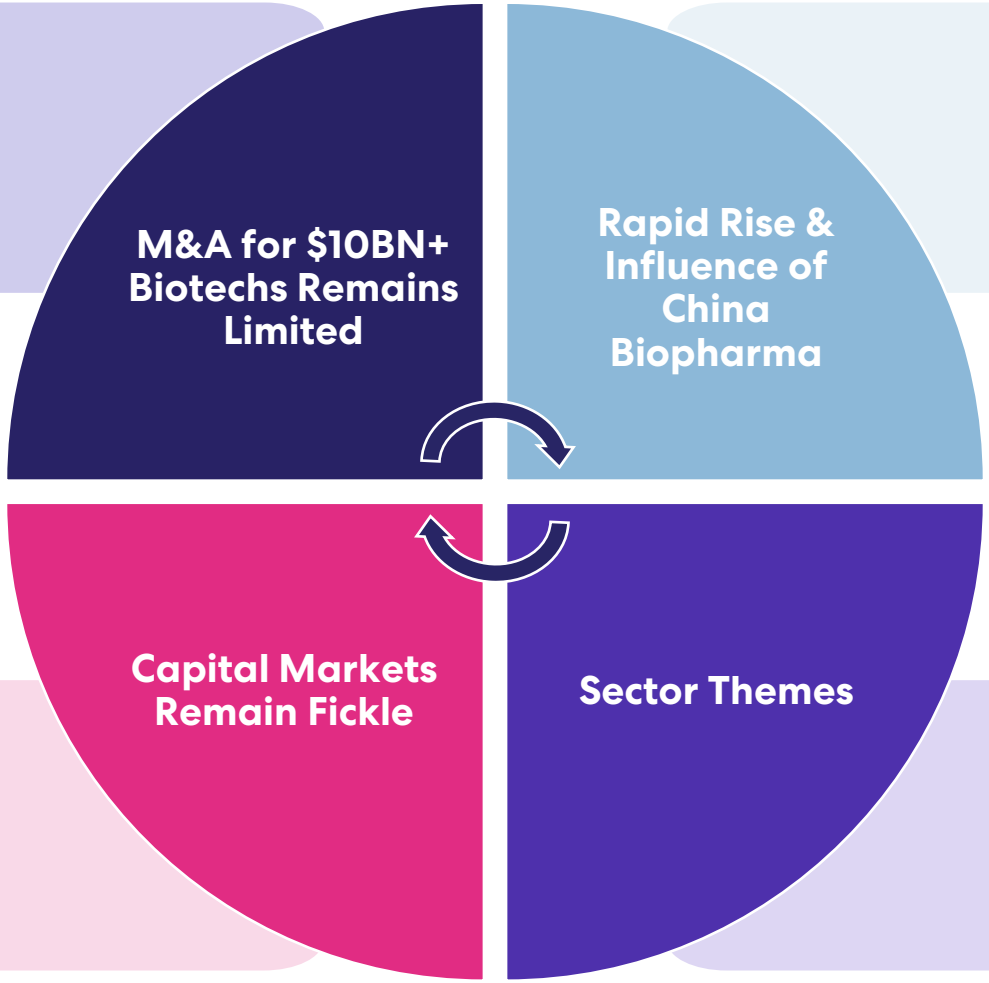
Select success stories from each era

AMGEN Biogen Genentech CHIRON genzyme Celgene ALEXION REGENERON VERTEX GILEAD argenx insmed Alnylam



Confluence of Intrinsic and External Factors Creates Opportunity for Roivant's Differential Value Creation in Biopharma Ecosystem

Roivant's multiple near-term launches and pivotal readouts support value inflection opportunities



Roivant differentiates via creative development strategies with late-stage trials underway

Roivant's cash balance supports runway into profitability

Roivant's portfolio of unique, differentiated products provides insulation against regulatory & reimbursement dynamics

Significant Upside and Value Creation Across Recent Launches

Post readout, pre-approval to today[1]

	Selected Paradigm-Shifting Pivotal Readouts	Δ in 2029 Consensus Rev. Estimate[2]	Δ in Share Price	Δ in Market Cap
ARGX	Efgartigimod in gMG *ADAPT study*	+90%	+204%	$14BN → $55BN
ALNY	Vutrisiran in ATTR-CM *HELIOS-B study*	+87%	+75%	$30BN → $55BN
INSM	Brensocatib in NCFB *ASPEN study*	+ 88%	+190%	$11BN → $42BN

New therapeutic options + better diagnostics grows identified prevalence

Significant unmet medical need supports market access

Rapid adoption

1. Table represents change from post readout/pre-approval relative to today, as of December 9, 2025
2. Historical and current consensus revenue estimates sourced from Bloomberg

Common Themes Among the Recent Biotech Graduating Class

Successful Precedent Launches Provide Well-Trodden Path for Roivant's Pipeline

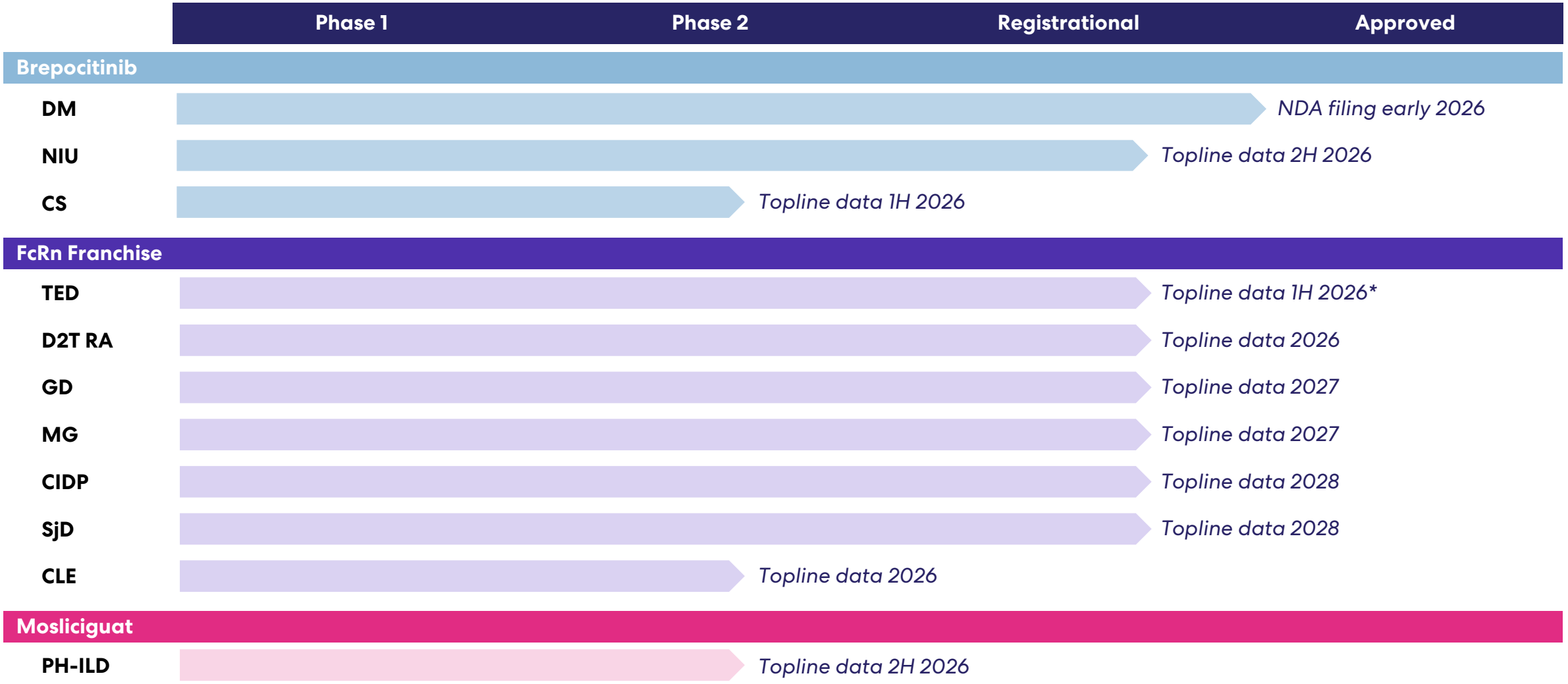
Key Takeaways from Selected Success Stories

- High unmet medical need
- Tractable commercial execution
- Prevalence in thousands, not millions
- Specialty centers / doctors
- Dedicated patient access support and organizations
- Limited competition at launch

Common Themes Among the Recent Biotech Graduating Class

Successful Precedent Launches Provide Well-Trodden Path for Roivant's Pipeline	
Key Takeaways from Selected Success Stories	**roivant**
High unmet medical need	✓
Tractable commercial execution	✓
Prevalence in thousands, not millions	✓
Specialty centers / doctors	✓
Dedicated patient access support and organizations	✓
Limited competition at launch	✓

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



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Note: All drugs are investigational and subject to regulatory approvals. 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
*Immunovant continues to expect the first of the two batoclimab Phase 3 TED studies to read out before the end of calendar year 2025. However, due to evolving competitive dynamics, Immunovant anticipates sharing topline results from both TED studies concurrently in the first half of calendar year 2026.

Brepocitinib

Matt Gline
CEO, Roivant

Ben Zimmer
CEO, Priovant

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Key Takeaways: Brepocitinib

Brepocitinib program is focused on indications with **biology suited for dual JAK1/TYK2 inhibition** and **significant unmet need**

NIU treatment paradigm enables potential for new therapeutic **uptake across market segments;** topline data from Phase 3 CLARITY study expected to **read out 2H 2026 ahead of prior guidance (1H 2027)**

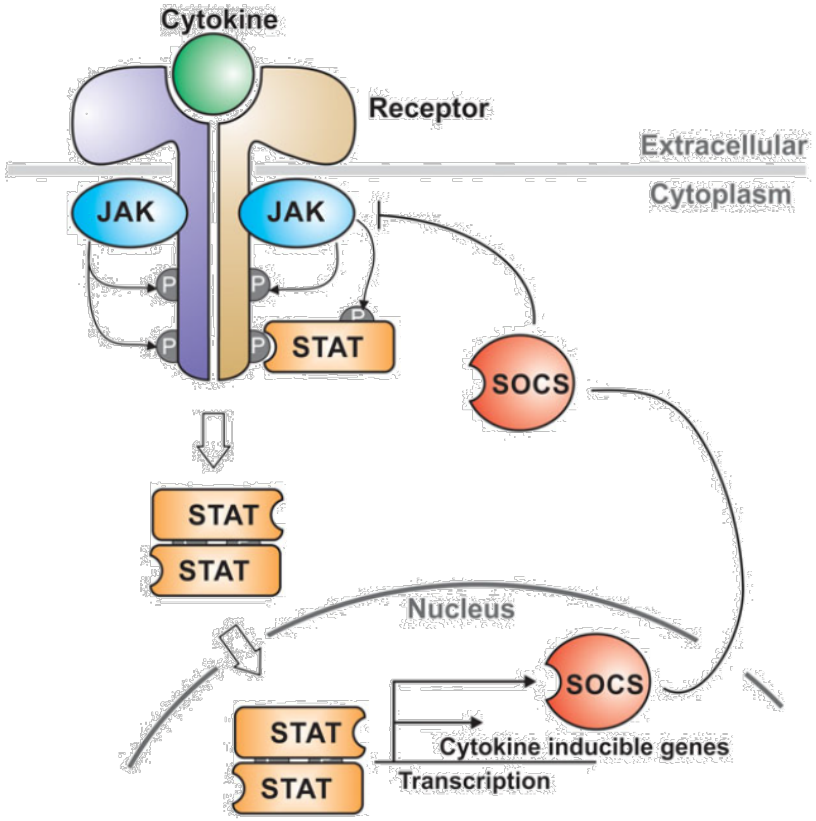
No approved therapies and risk of permanent cutaneous damage highlight unmet need in **CS**; topline data from Phase 2 BEACON study expected to **read out 1H 2026 ahead of prior guidance (2H 2026)**

DM standard of care leaves patients **poorly controlled, dissatisfied, and exposed to high steroid burden, underscoring the need for new treatments**

NDA filing for brepocitinib in DM expected in **early 2026**; preparations underway for potential **commercial launch in DM in early 2027**

NIU: non-infectious uveitis; CS: cutaneous sarcoidosis; DM: dermatomyositis
Note: All drugs are investigational and subject to regulatory approvals. 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.

JAK-STAT Signaling Pathway Reminder

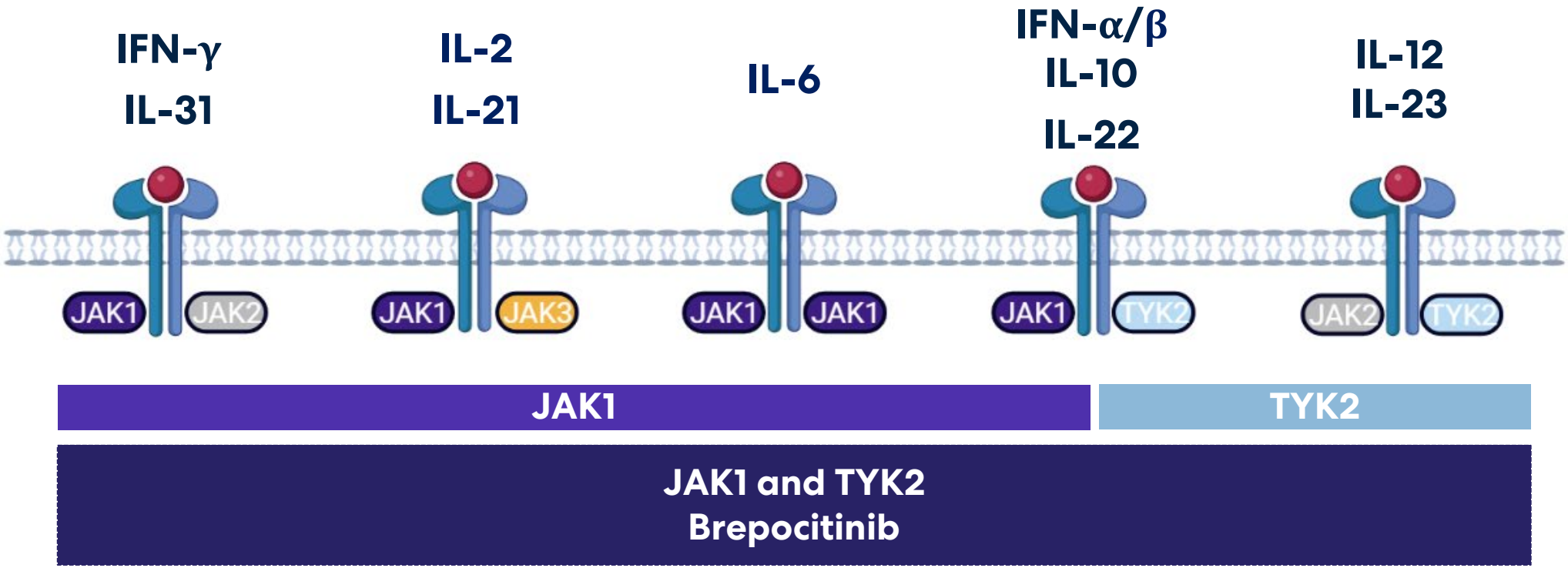


There are 4 human JAK isoforms (JAK1, JAK2, JAK3, and TYK2) and distinct combinations of each are required for specific cytokine signaling pathways

Inhibiting different JAK isoforms has a distinct pharmacologic effect in terms of which cytokine signaling pathways are suppressed

Figure adapted from Morris et al., 2018

Dual JAK1/TYK2 Inhibition Is a Novel Mechanism of Action, With Potential for Greater Efficacy Than Earlier Generation JAK Inhibitors

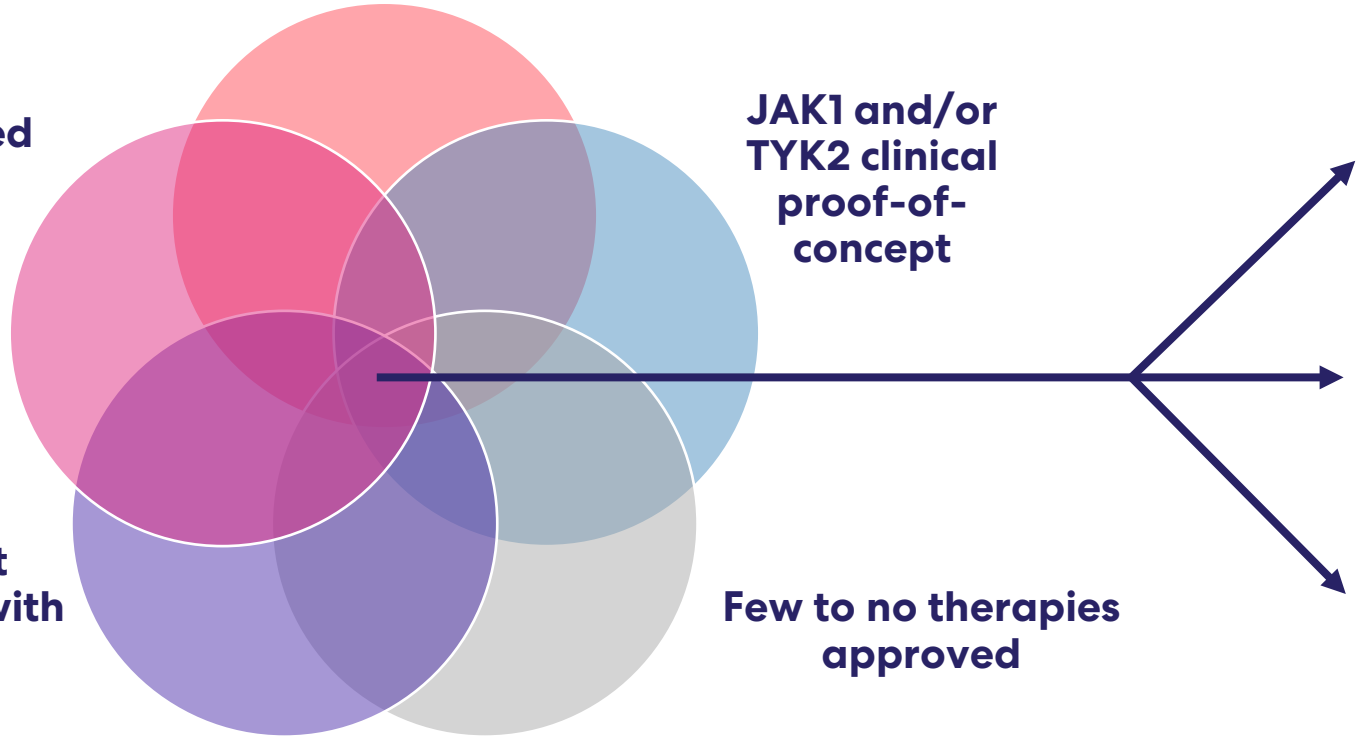


Brepocitinib: Pursuing Indications at the Intersection of Dual JAK1/TYK2 Biology and High Unmet Medical Need

Mid-high tens-of-thousands prevalence

Biologically exquisitely suited for dual JAK1/TYK2 inhibition

JAK1 and/or TYK2 clinical proof-of-concept



Large unmet medical need with favorable benefit/risk

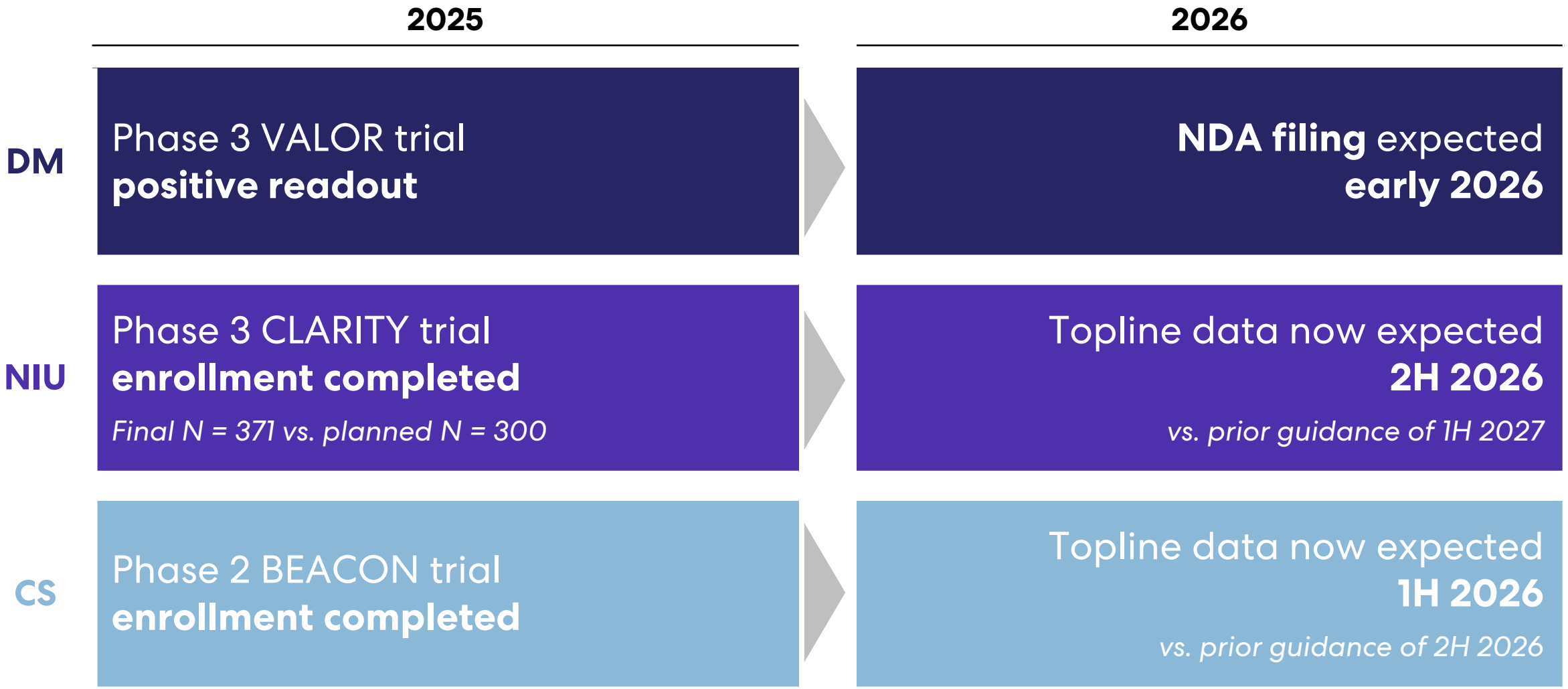
Few to no therapies approved

Current Brepocitinib Indications

- **Dermatomyositis (DM)**
- **Non-Infectious Uveitis (NIU)**
- **Cutaneous Sarcoidosis (CS)**

Note: All drugs are investigational and subject to regulatory approvals. 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.

Successful Clinical Execution Has Set Up the Brepocitinib Program for a Catalyst-Rich 2026



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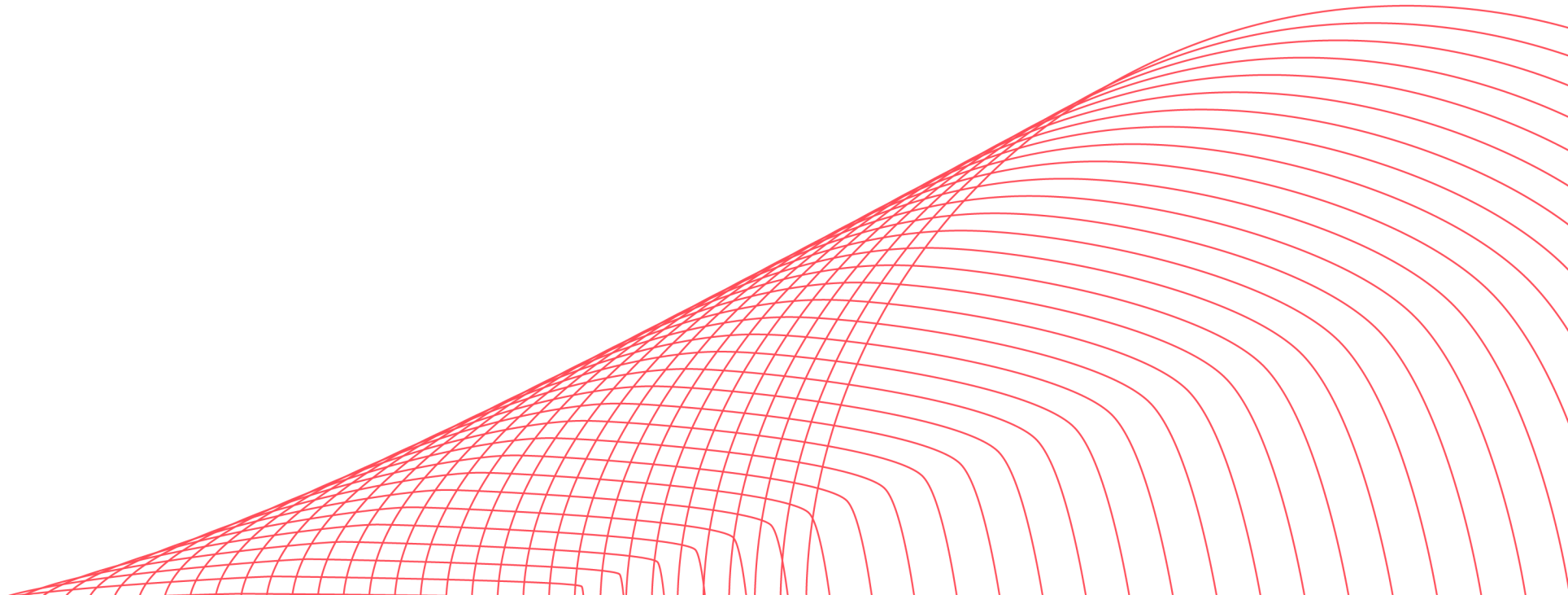
Non-Infectious Uveitis



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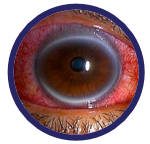
Non-Infectious Uveitis (NIU): Highly Morbid, Poorly Served Indication With Large Unmet Need

Disease Overview

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

1 approved modern 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

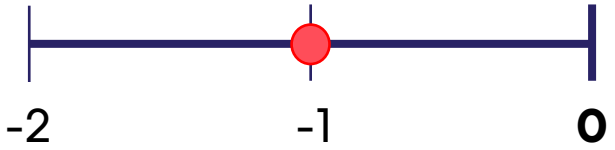
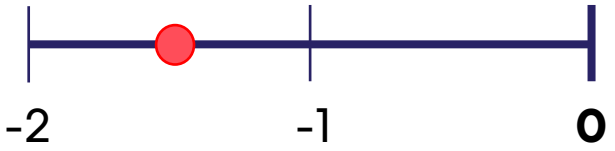
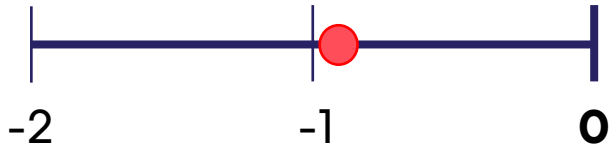
50% in combo with other autoimmune diseases

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

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)

Inadequate Control of Uveitic Inflammation Leads to Vision Loss

The results of the SITE study[1] – covering nearly 9,000 eyes – demonstrated that any ocular inflammation contributes to worsened visual outcomes, with greater inflammation resulting in greater expected vision loss

Uveitis Disease Characteristic	Mean Modeled Visual Acuity Loss[2] (ETDRS Lines)
Anterior Chamber Cells (Grade 2+) *Inflammation of front of eye*	
Vitreous Haze (Grade 2+) *Inflammation of middle eye*	
Macular edema *Swelling of macula (back of eye) caused by inflammation*	

Potential for More Severe, Debilitating Visual Outcomes[3,4]

Blindness
Cataracts
Floaters
Blurred Vision
Intermittent Vision
Ocular Pain

Vision Loss Is Episodic and Accumulates Over Time With Recurrent Inflammation, Reinforcing Need for Aggressive Treatment[3]

1. Plstilli et al., Ocul Inflam Immunol (2021)
2. Mean predicted outcome shown for each category
3. Durrani et al., Br J Ophthalmol (2004)
4. Rothova et al., Br J Ophthalmol (1996)

Two Distinct Prescriber Bases for Novel Systemic Therapy for NIU

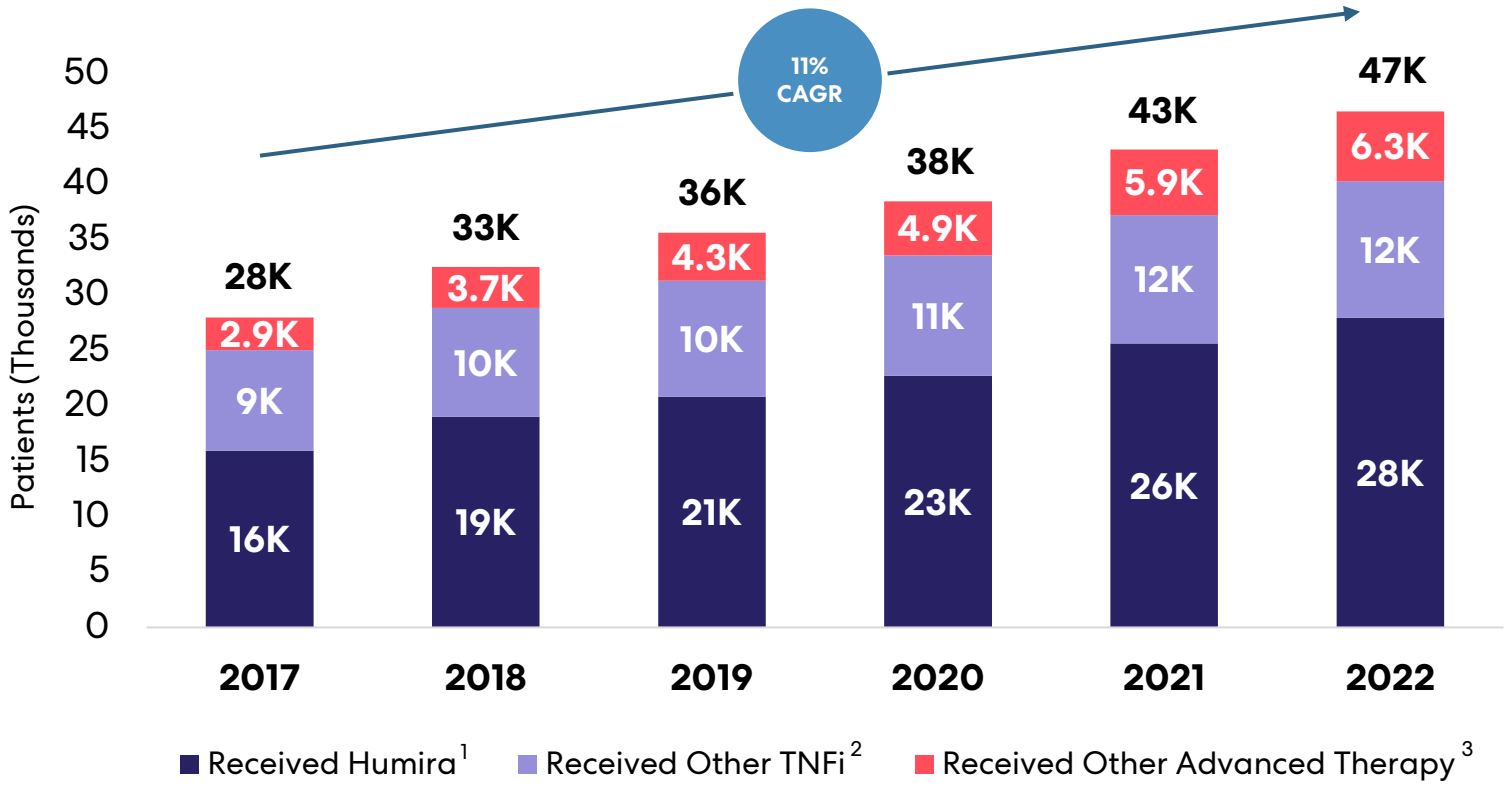
	Uveitis Specialists	Community Retina Doctors / Partnered Rheumatologists
Approach To Systemic Medication	Quickly move to systemic medications; uveitis specialist leads medication selection	Start with short-term local intervention; partnered rheumatologist leads systemic medication selection
Treatment Paradigm	Treat aggressively, with "zero tolerance" for ocular inflammation[1]	Local treatments → Systemic steroids → →DMARDs → TNFi → Other
Potential Early Adopters	All uveitis specialists	Rheumatologists prescribing TNFi for NIU (and partnered retina doctor)
Potential for Rapid Adoption	All patients under uveitis specialists' care	TNFi-refractory population
Patients Reached at Launch	Tens of thousands of eligible patients treated at specialist centers	Tens of thousands of TNF refractory patients

Potential to Impact Tens of Thousands of Patients at Launch, With Additional Expansion Over Time

1. Nguyen, Am Acad Ophthamol (2007)

2023 IQVIA Analysis of the NIU Market Confirms >40,000 Patients Receiving TNFi for NIU, with >10% CAGR for Advanced Therapies

NIU Patients Treated with Advanced Therapy by Year



- Widespread use of advanced systemic medication for NIU treatment
- Large commercial opportunity in TNF-refractory population alone, given high TNFi failure rate (>50% in clinical studies)
- Additional potential blockbuster opportunity in broader non-anterior NIU population

Analysis includes patients with at least 2 NIU Dx claims at least 30 days in or before 2022 (patients had to have continuous pharmacy and medical benefit enrollment in 2021 - 2023) and medication utilization within one year of index NIU diagnosis in 2022. Includes NIU of any etiology or anatomic area

1. Includes any patient who received Humira during calendar year, whether or not they received any additional advanced therapy (including other TNFi)
2. Includes any patient who did not receive Humira during calendar year, but did receive a different TNFi. Includes originator molecules (e.g., Remicade, Enbrel) and biosimilars (e.g., Inflectra, Renflexis, Avsola) targeting TNF-α
3. Other advanced therapies used include JAK inhibitors and biologic agents/monoclonal antibodies targeting IL-6, IL-12/23, IL-17, IL-1β, IL-1Ra, CD-20, and CD-28

In Both Placebo-Controlled and Open-Label Settings, Humira Successfully Treats Only Half of Patients With Active Uveitis

VISUAL 1: Placebo-Controlled Trial in Active Uveitis[1]

50%

of 110 Humira-treated patients experienced treatment failure at 6 months[2]

Patients experiencing treatment failure in VISUAL 1 or VISUAL 2 (Inactive Uveitis Trial) were enrolled in VISUAL 3 and were defined as patients with active uveitis

VISUAL 3: Open-Label Extension Study in Active and Inactive Uveitis[3]

51%

of 189 Humira-treated patients with active uveitis at baseline achieved steroid-free quiescence at 1 year

1. Jaffe et al., NEJM (2016)
2. Data as reported on HumiraPro.com/Uveitis; DCs are censored. Analysis population for Humira unknown
3. Suhler et al., Ophthalmology (2018)

Brepocitinib's Dual Inhibition of TYK2 and JAK1 Distinctively Addresses Th1-Mediated and Th17-Mediated Autoimmunity in NIU

Only mechanism that can simultaneously suppress IL-6, IFNγ, IL-12, and IL-23 with single targeted agent

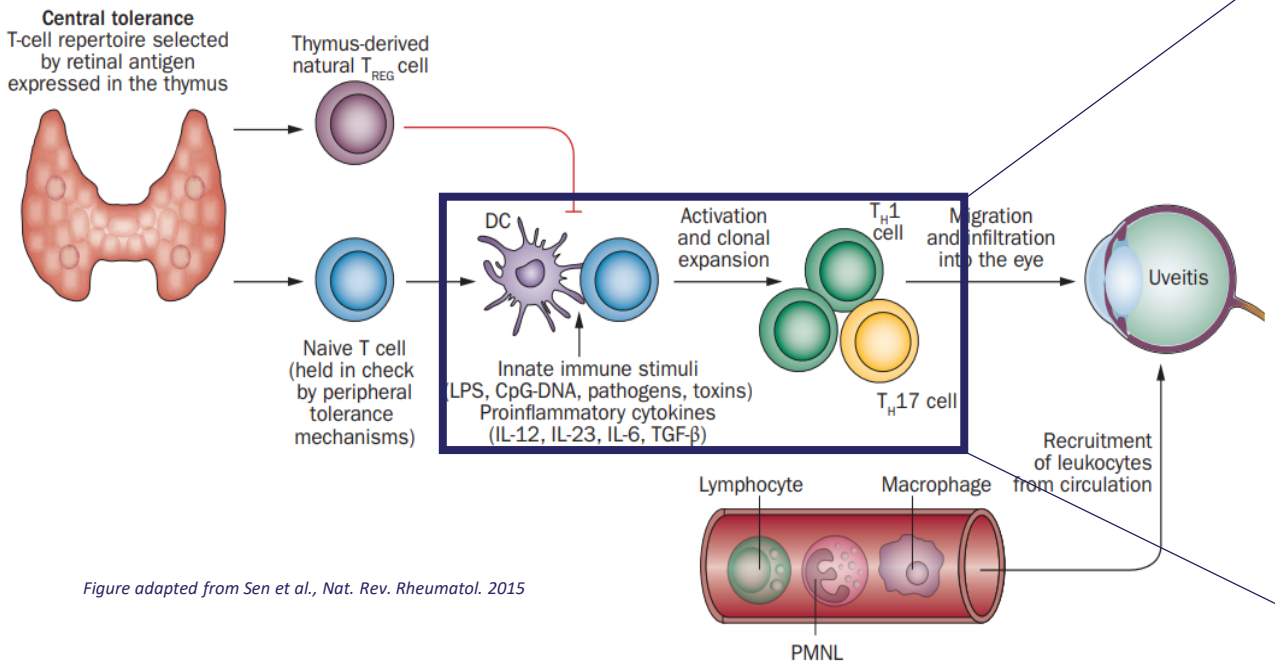
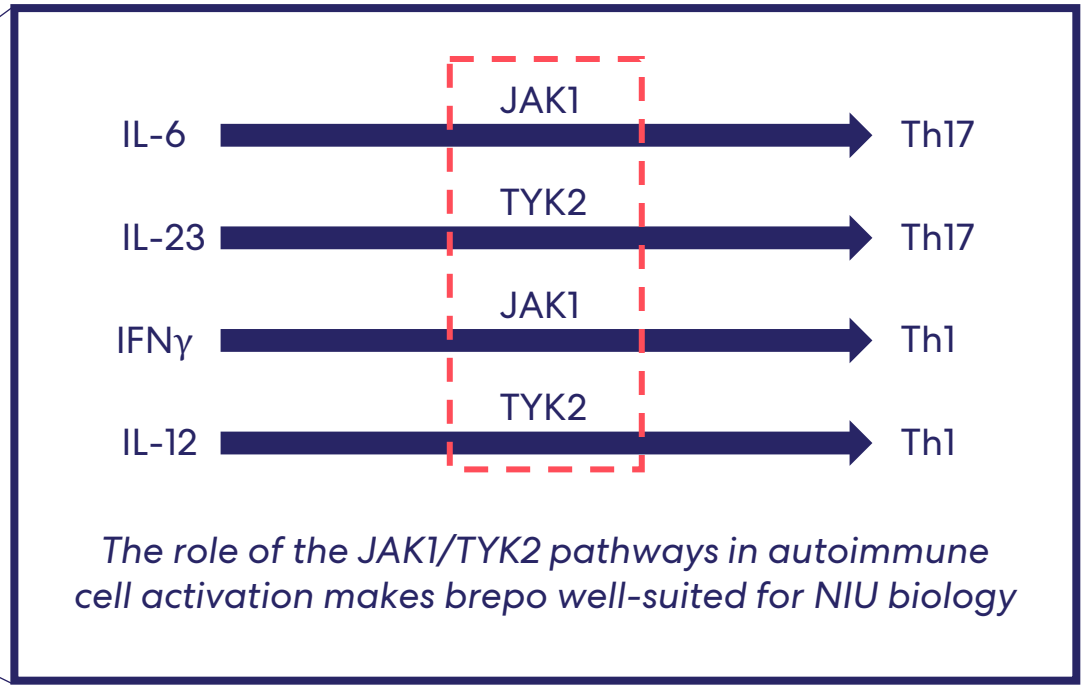


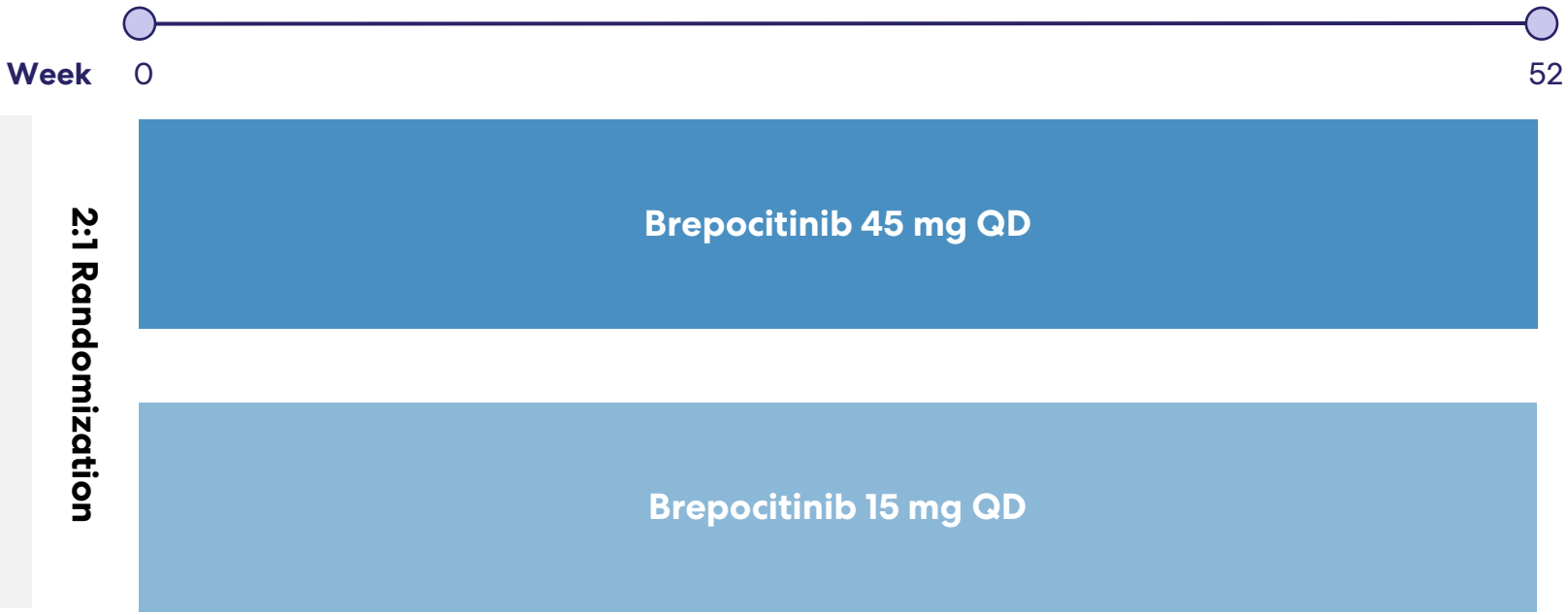
Figure adapted from Sen et al., Nat. Rev. Rheumatol. 2015



The role of the JAK1/TYK2 pathways in autoimmune cell activation makes brepo well-suited for NIU biology

NEPTUNE: Phase 2 Study of Brepocitinib in NIU

Positive readout in 2024



Steroid burst and taper: 60 mg/day OCS burst for 14 days; forced taper to 0 mg/day over 6 weeks

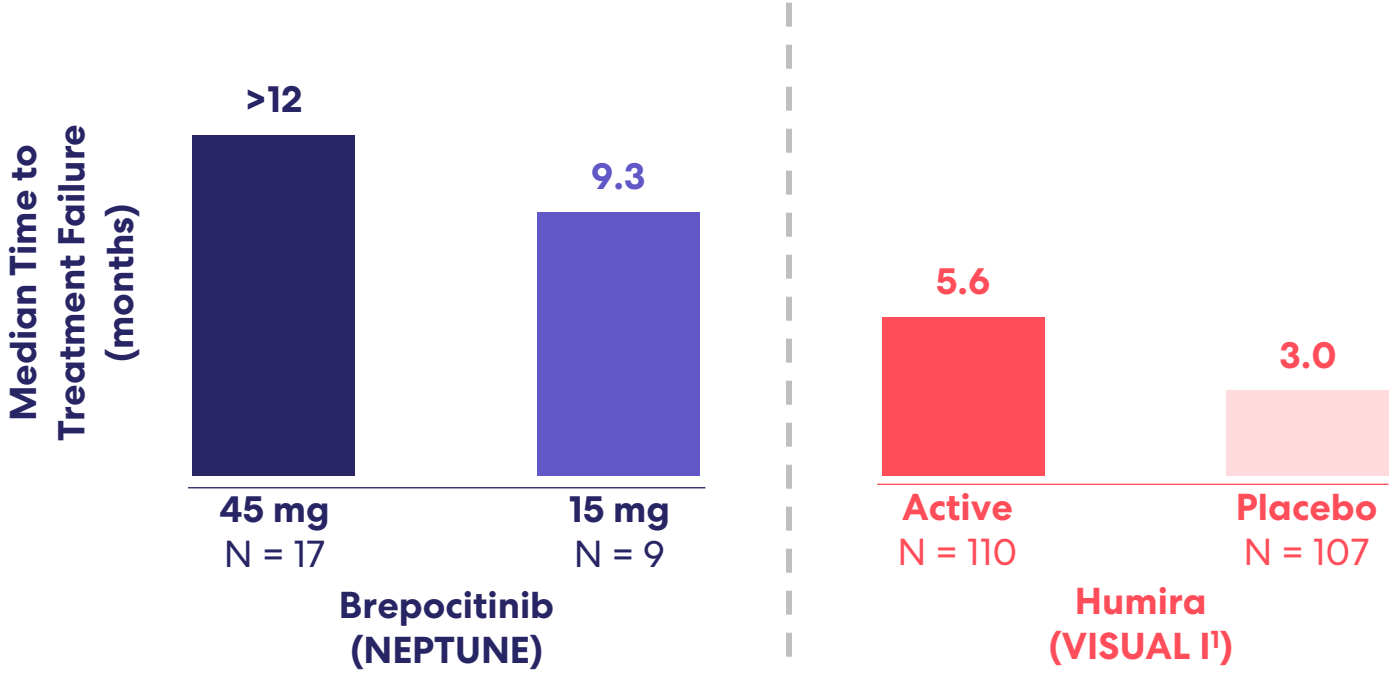
Note: Additional inclusion and exclusion criteria not listed on slide
Note: Additional primary and secondary endpoint details not listed on slide
QD: daily; OCS: oral corticosteroids; ACC: anterior chamber cell; VH: vitreous haze; BCVA: Best Corrected Visual Acuity
References are to calendar years

Phase 2 NEPTUNE Median Time to Treatment Failure Data Suggests Potential For Best-In-Indication Efficacy Profile

6-week taper in NEPTUNE trial following two-week steroid burst, compared to 13-week taper in VISUAL 1

Time to Treatment Failure, compared to VISUAL I Study*

Higher Time to Treatment Failure = greater treatment benefit



Disclaimer: 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.

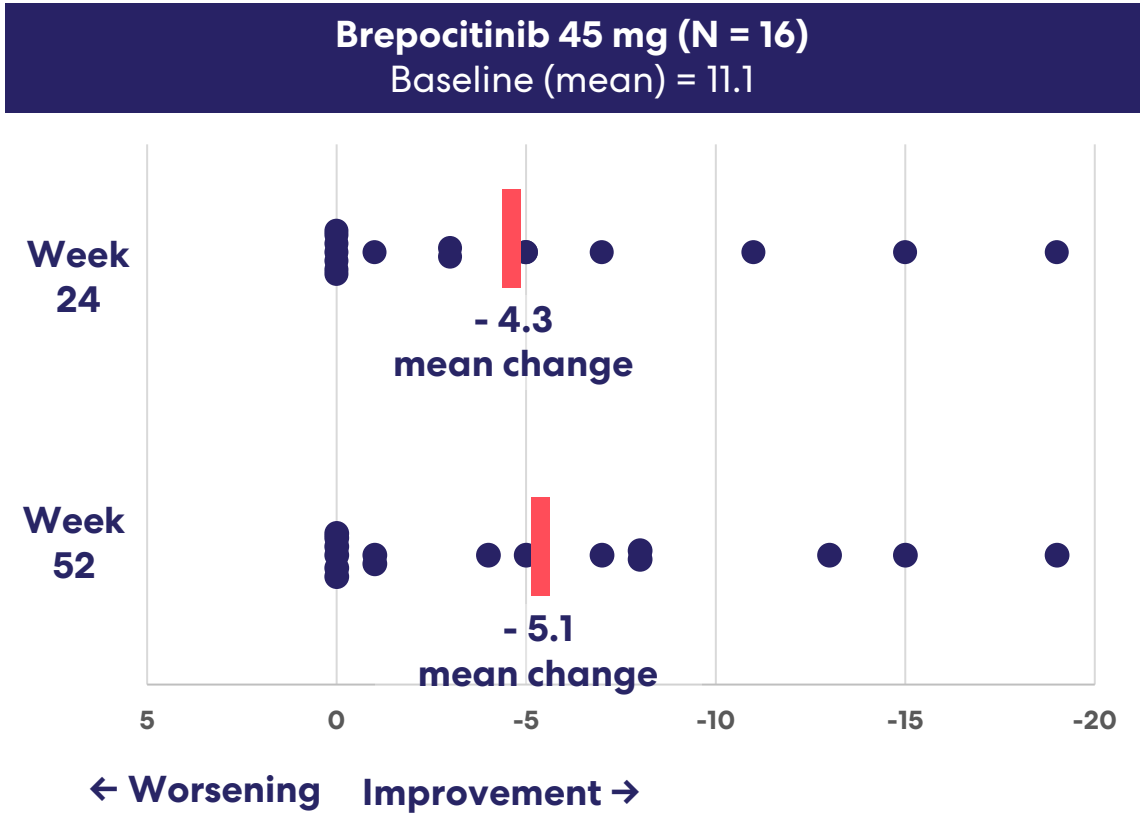
Phase 3 CLARITY Study Evaluates Brepocitinib 45 mg Against Placebo

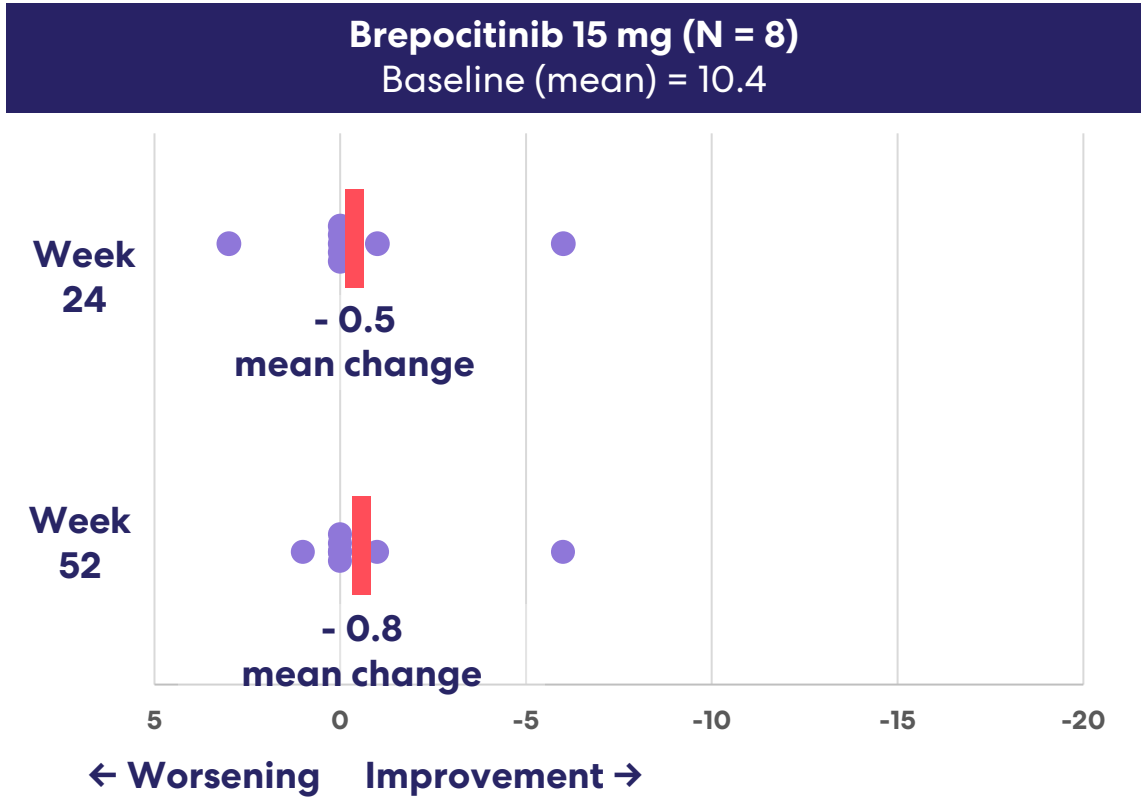
*Time to Treatment Failure was primary endpoint in VISUAL I study. VISUAL I calculations do not include discontinuations as treatment failures, per pre-specified definition in VISUAL I. NEPTUNE calculations include discontinuations as treatment failures

1. As reported at https://www.humirapro.com/uveitis

Dose Dependent Benefit on Posterior Segment Inflammation Seen, With Sustained Improvement at 52 Weeks

Measurement of retinal vascular leakage by wide-field fluorescein angiography (FA) score change from baseline at Week 24 and Week 52; centrally assessed using ASUWOG, a multi-domain, semi-quantitative scoring system[1]



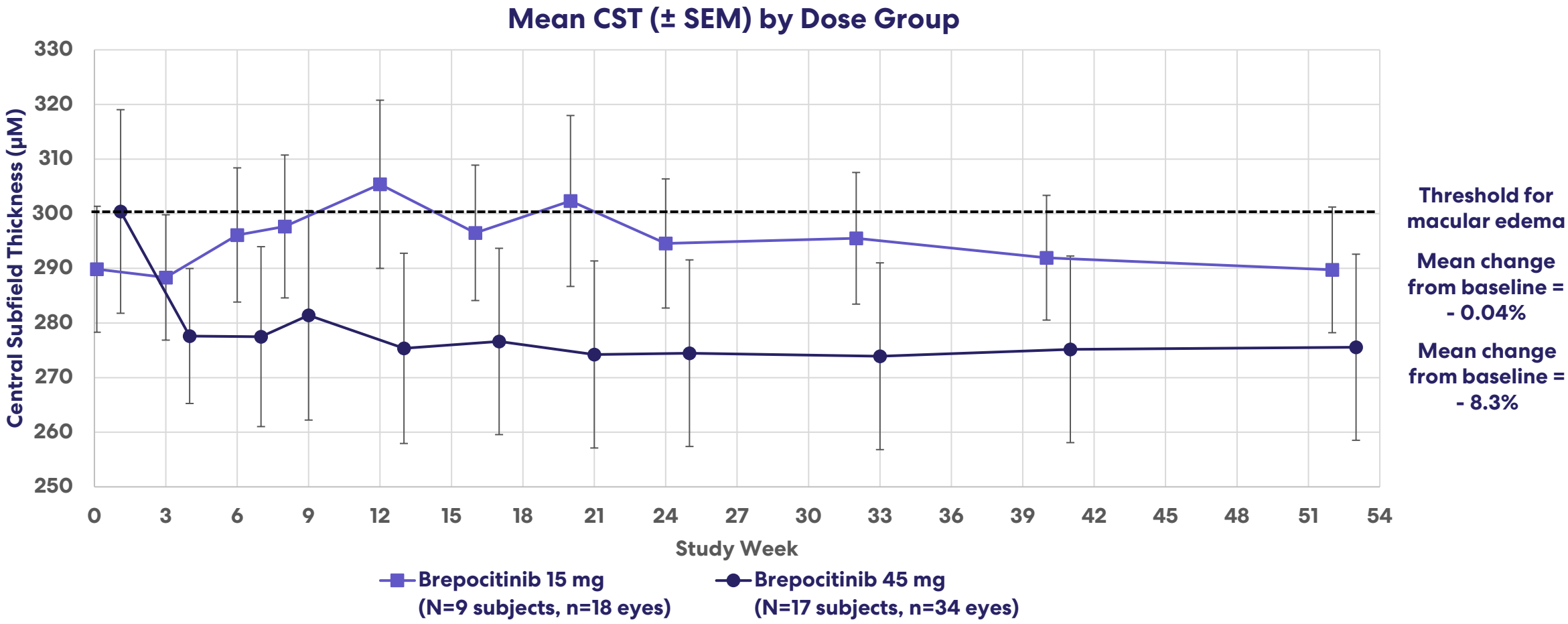


Phase 3 CLARITY Study Evaluates Brepocitinib 45 mg Against Placebo

Last observation carried forward used for participants with treatment failure or intercurrent event.

1. Tugal-Tutkun et al., Int Ophthalmol (2010)

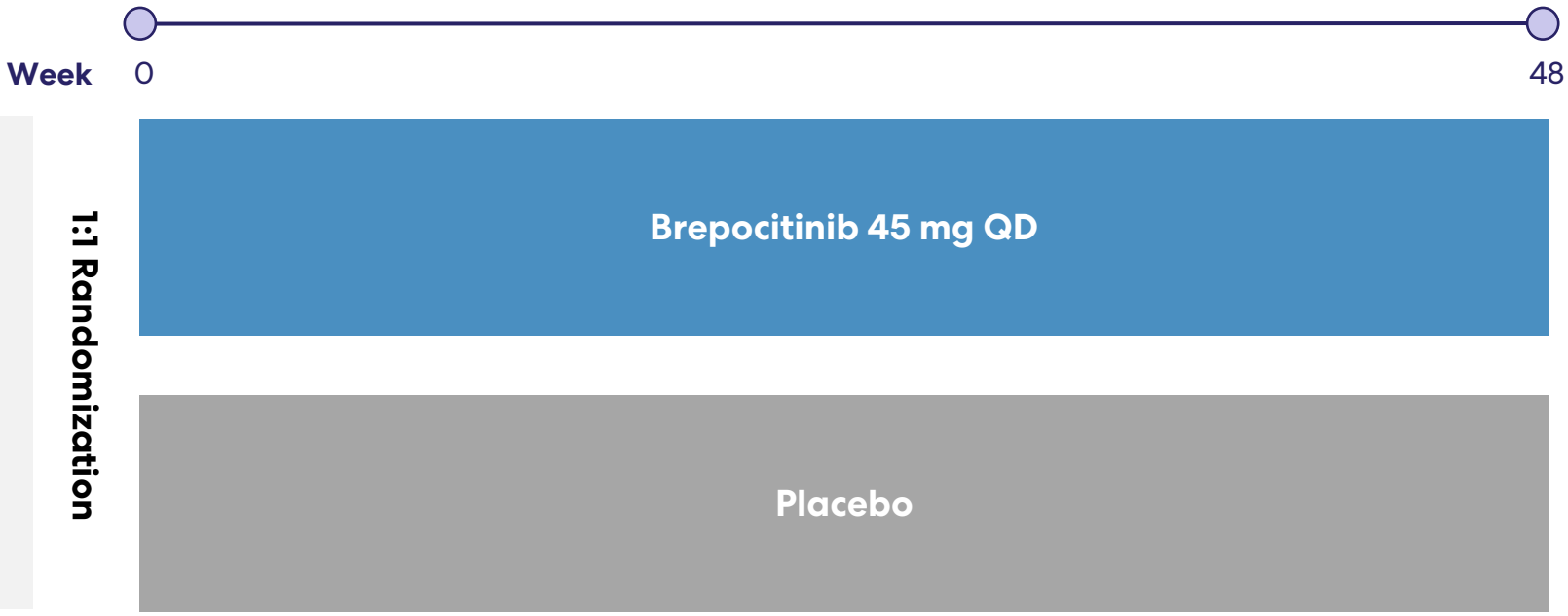
Brepocitinib 45 mg Associated With Sustained Improvement in Central Subfield Thickness Through Week 52



Phase 3 CLARITY Study Evaluates Brepocitinib 45 mg Against Placebo

CLARITY: Phase 3 Study of Brepocitinib in NIU

Two identical sub-studies, CLARITY-1 and CLARITY-2, under a single protocol; study is now fully enrolled and topline results are expected 2H 2026



Global N=371
CLARITY-1 N=180
CLARITY-2 N=191

Adults with active non-infectious intermediate-, posterior-, or panuveitis

1:1 Randomization

Primary Endpoint:
Time to Treatment Failure

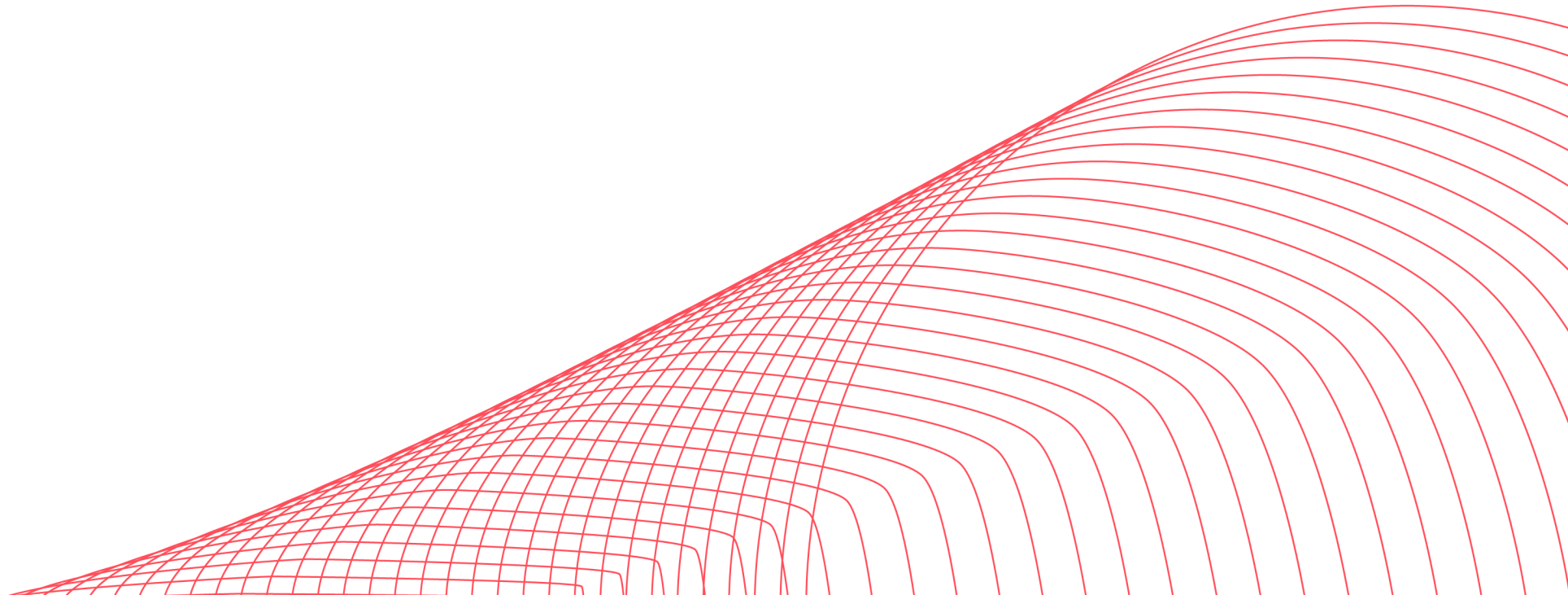
Secondary Endpoints:
Include measurements related to

- Macular edema/CST
- Retinal vascular leakage as measured through WFFA
- Functional vision

Steroid burst and taper: 60 mg/day OCS burst for 14 days; forced taper to 0 mg/day over 6 weeks

Note: Additional inclusion and exclusion criteria not listed on slide.
Note: Additional primary and secondary endpoint details not listed on slide
QD: daily; OCS: oral corticosteroids; CST: central subfield thickness; WFFA: wide-field fluorescein angiography
References are to calendar years

Cutaneous Sarcoidosis



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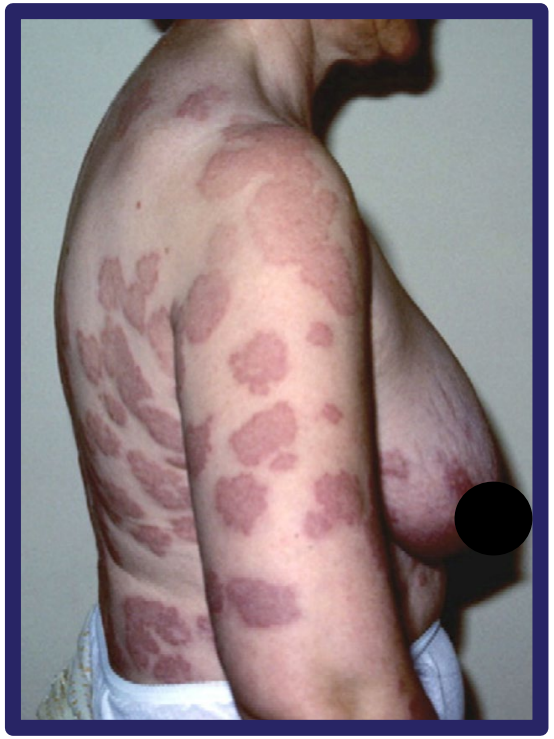
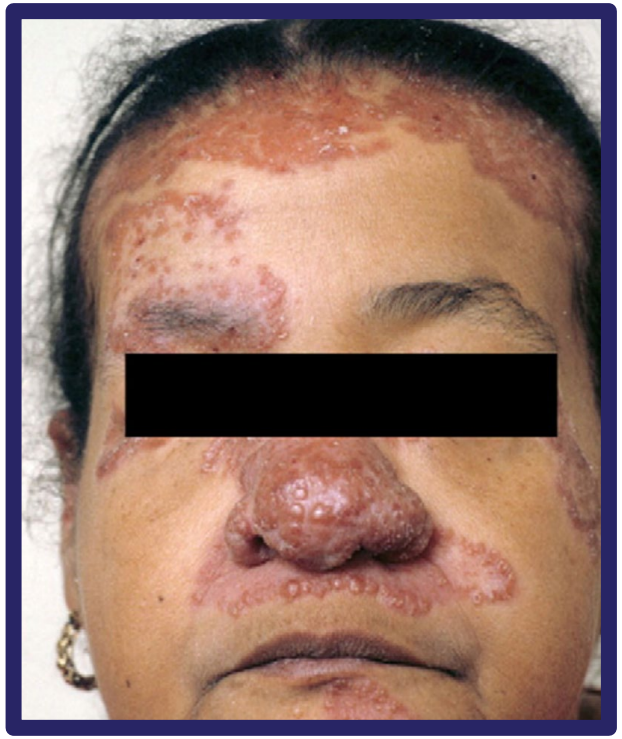
High Urgency to Treat Given Poor Cosmesis and Potential to Cause Irreversible Damage

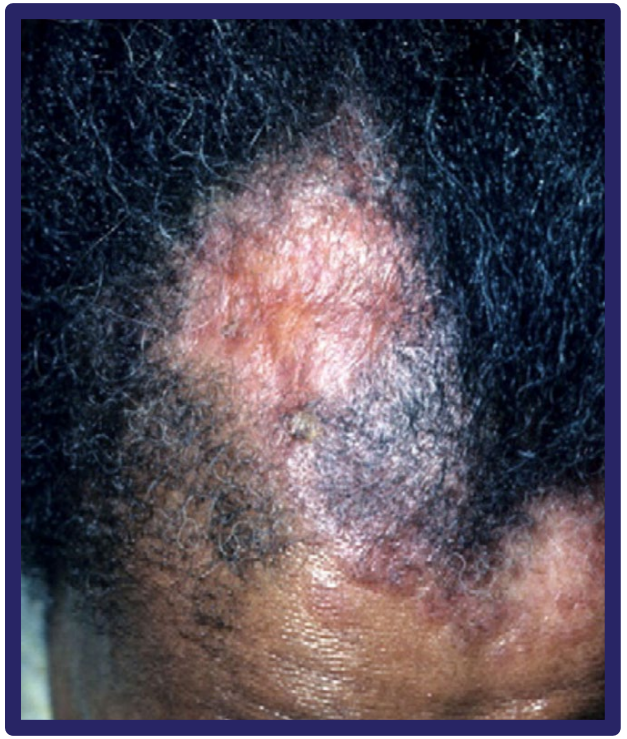
Unlike many inflammatory skin diseases (e.g., plaque psoriasis, eczema, alopecia areata), inadequately treated cutaneous sarcoidosis can rapidly cause permanent scarring or even cartilage destruction



Plaque cutaneous sarcoidosis affecting significant body surface area



Lupus pernio (papular and plaque cutaneous sarcoidosis)



Plaque cutaneous sarcoidosis resulting in scarring alopecia

Images adapted from Fernandez-Faith and McDonnell, Clinics in Dermatol (2007)

Ongoing Programs in Ocular (Uveitis) and Cutaneous Sarcoidosis Could Collectively Address Large Segment of Overall Sarcoidosis Population

After the lungs, skin and eyes are the organs most commonly affected by sarcoidosis

Affected Organ	Reported Prevalence[1] (%) *Total number of sarcoidosis patients is approximately 200,00 US adults[2]*	High Morbidity	Approved Non-Steroidal Therapies	Strong Clinical Endpoints To Assess Benefit In RCT
Lung	>90%	Yes	0	No
Skin	**16-32%**	**Yes**	**0**	**Yes**
Eyes (uveitis)	**5-23%**	**Yes**	**1**	**Yes**
Others	Varies, but lower	Varies	0	Varies

Potential for 20-50% of the Prevalent Sarcoidosis Population to Be On-Label for Brepocitinib

1. Grunewald et al., Nat Rev Primers (2019)
2. Assumes 200,000 overall prevalent sarcoidosis patients, adapted from Baughman et al., Ann Am Thorac Soc (2016)

Cutaneous Sarcoidosis Alone Includes Eligible Population of ~40,000 Patients

~40K

CS patients in the US[1,2]

~16K

have minimal to no activity in other organs

~24K

have other organ involvement affecting treatment decisions (principally lung and/or eye)[3]

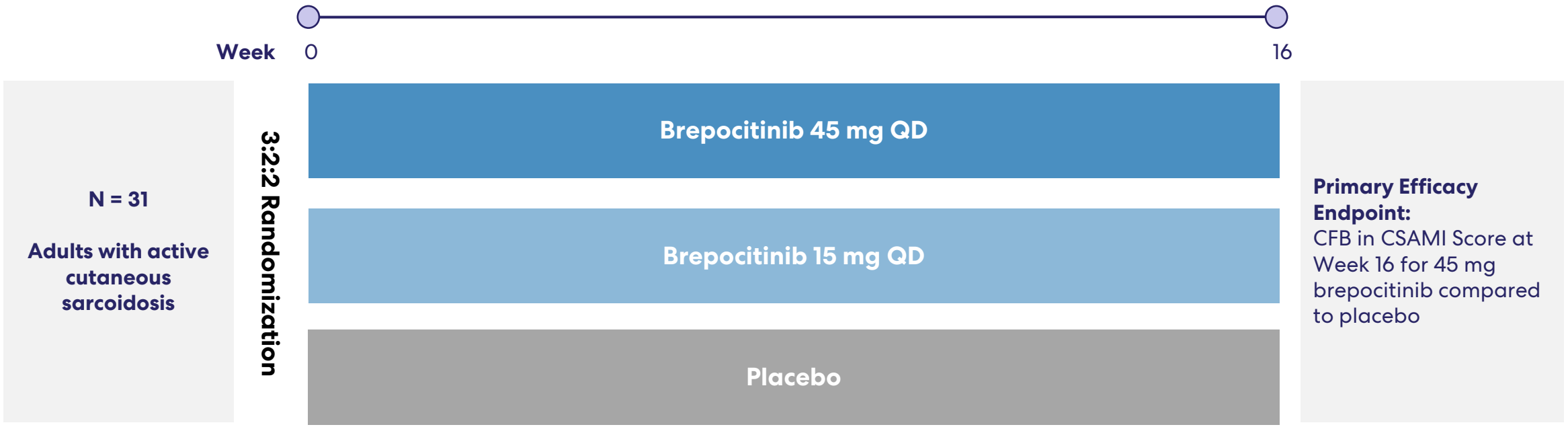
No approved therapies for pulmonary sarcoidosis, and none in late-stage clinical development

Brepocitinib Has the Potential to Become the On-Label Therapy of Choice for All Sarcoidosis Patients With Any Cutaneous Disease

1. Foundation for Sarcoidosis Research
2. Haimovic, et al., J Am Acad Dermatol (2012)
3. Altmeyer et al., Altmeyers Encycl (2025)

BEACON: Phase 2 Study of Brepocitinib in Cutaneous Sarcoidosis

Study is now fully enrolled and topline results are expected 1H 2026



Note: Additional inclusion and exclusion criteria not listed on slide
Note: Additional primary and secondary endpoint details not listed on slide
CS: cutaneous sarcoidosis; QD: daily; CFB: change from baseline; CSAMI: Cutaneous Sarcoidosis Activity and Morphology Instrument
References are to calendar years

BEACON's Primary Efficacy Endpoint: Change from Baseline in Cutaneous Sarcoidosis Activity & Morphology Index (CSAMI)

Select the score in each anatomical area that describes the most severely affected sarcoidosis lesion in that site

	ACTIVITY				DAMAGE	
	Inflammation	Induration or Depression	Surface Change	Area	Post-inflammatory result	
Anatomical Location	0 = absent 1 = flesh-colored to brown (active) 2 = faint erythema (pink) 3 = bright erythema (red) or violaceous (purple)	0 = flat 1 = <1mm 2 = 1-2mm 3 = >2mm	0 = no surface change 1 = scaling 2 = thick / extensive scale (>1mm) 3 = ulcerated	1 = single lesion 2 = <25% of site 4 = 25-50% of site 6 = >50% of site	0 = no residual 1 = hyper-/hypo-pigmentation 2 = scarring	Anatomical Location
Scalp						Scalp
Ears						Ears
Periorificial (eyes, mouth)						Periorificial (eyes, mouth)
Nose (including nares)						Nose (including nares)
Rest of face						Rest of face
Neck						Neck
Chest						Chest
Abdomen						Abdomen
Back (incl. buttocks)						Back (incl. buttocks)
Arms (incl. hands)						Arms (incl. hands)
Legs (incl. feet)						Legs (incl. feet)

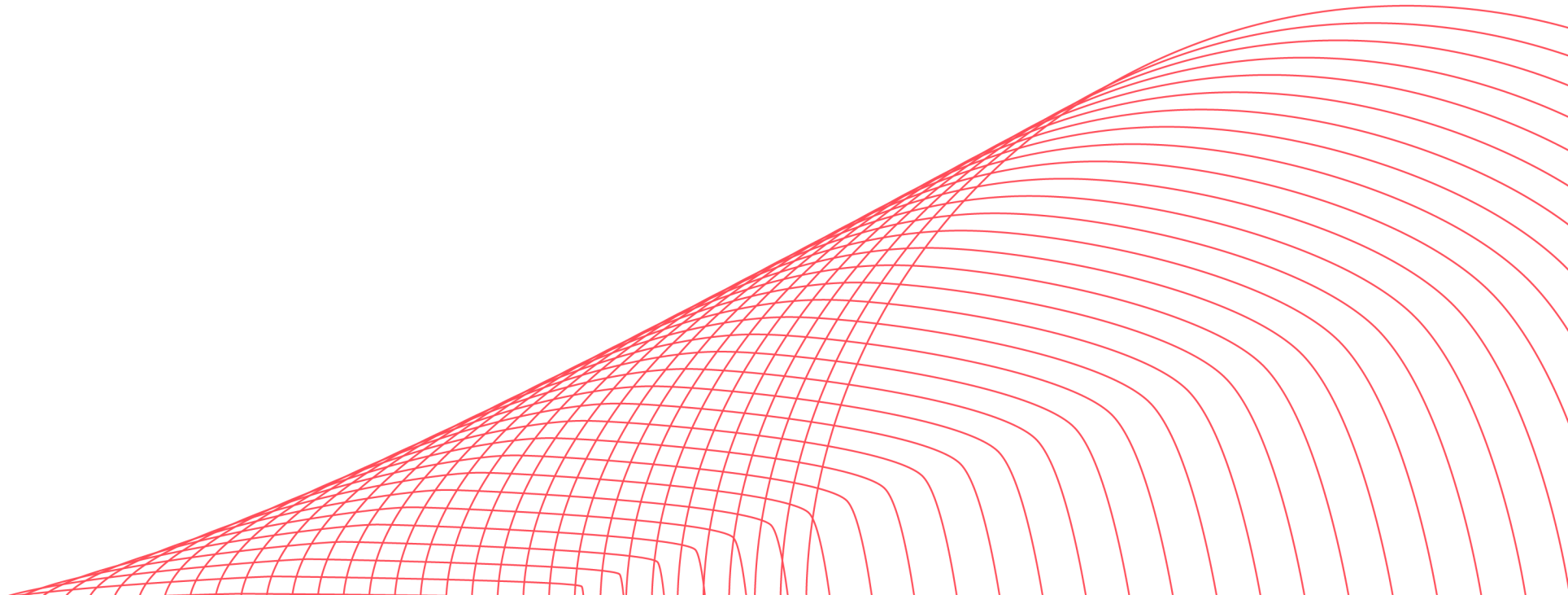
Total activity score_____ Total damage score _____

- **CSAMI is analogous to other area-and-severity instruments**
- **CSAMI Activity (CSAMI-A) scores range from 0 – 165**
  - **Minimal clinically important difference (MCID) = 5 pts[1]**

Bar for Success in BEACON: At Least 5-Point Difference in Mean CSAMI-A CFB Between Brepocitinib 45 mg and Placebo, Supported by Totality of Patient-Level Data Across Endpoints

1. Noe et al., JAMA Dermatol (2020)

Dermatomyositis



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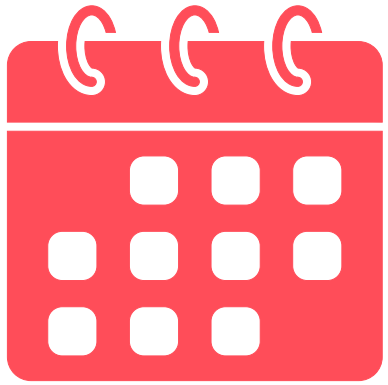
Dermatomyositis Patient Video

Within the First Year of Diagnosis, DM Patients Experience a High Steroid Burden



128

Average number of days/year on steroids

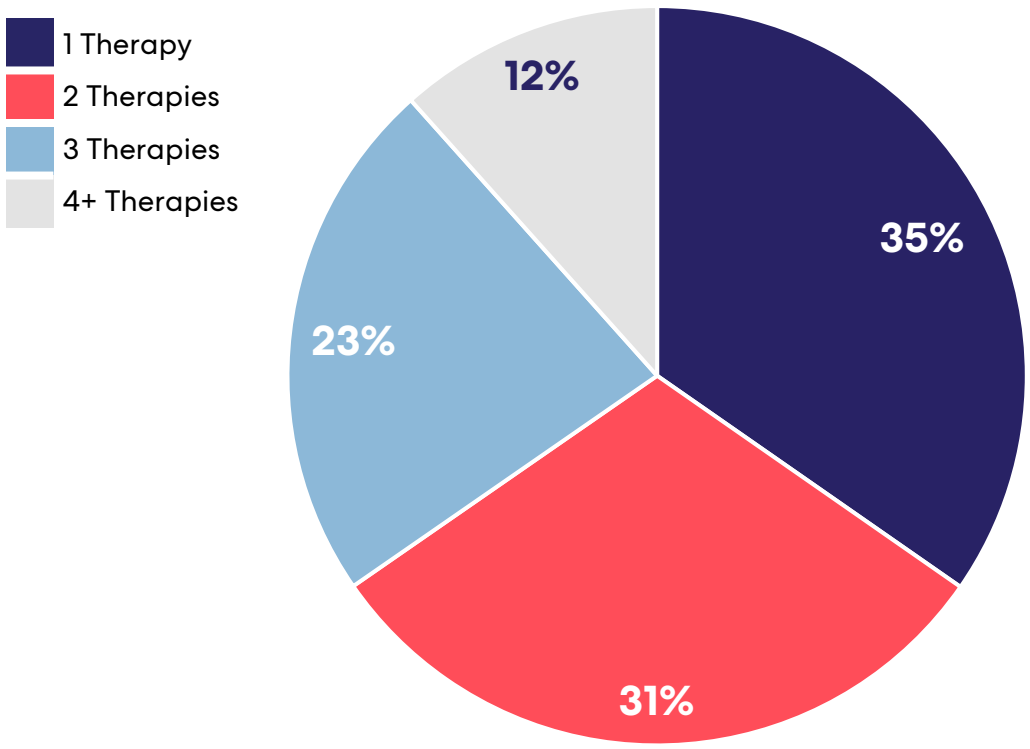
18.6 mg

Average oral steroid daily dose

Note: Analysis by Roivant/Priovant using closed claims data from Inovalon. Analysis includes patients with DM, continuous enrollment from 2019-2024, and steroids use in first year post index

High Rates of Polypharmacy Treatment Reflect Limited Efficacy of Existing DM Treatment Options

Number of Drugs Received by DM Patients



Note: all glucocorticoids considered as 1 therapy for each patient, regardless of formulation or ROA

Nearly 2/3 of treated DM patients receive **2 or more** therapies a year

Note: Analysis by Roivant/Priovant using closed claims data from Inovalon. Analysis includes patients with DM with continuous enrollment from 2019-2024.

Steroid Use is High Among DM Patients, Even for Those Who Receive Concomitant Steroid Sparing Therapy

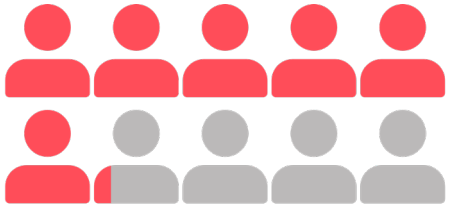
	Among Patients Receiving:		
	ISTs	**Off-Label Biologics**	**IVIG**
Percent receiving concomitant systemic steroids	**69%**	**91%**	**77%**
Average number of days on oral steroids	*139*	*146*	*150*
Among patients receiving concomitant systemic steroids, percent receiving oral steroids ≥ 10 mg/day	**63%**	**59%**	**65%**
Average number of days on oral steroids ≥ 10 mg/day	*73*	*86*	*90*

Note: Analysis by Roivant/Priovant using closed claims data from Inovalon from 2019-2024.
IST: immunosuppressive therapy; DMARD: disease-modifying antirheumatic drug; IVIG: intravenous immunoglobulin

DM Patients Report Persistent Dissatisfaction with Current Standard-of-Care

62%

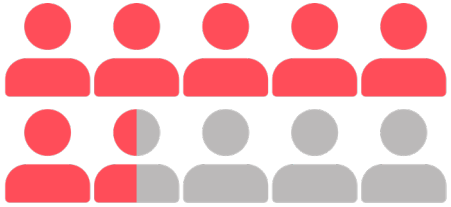
(N=195)



Dissatisfied with Current Treatment Options[1]

65%

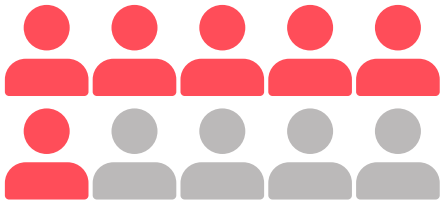
(N=34)



Only Partially Controlled with Current Regimens[2]

60%

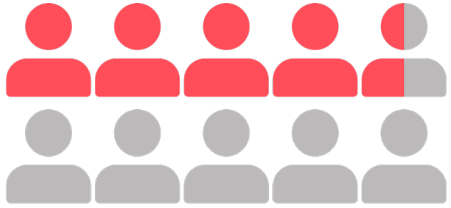
(N=195)



Discontinue Treatment Due to Side Effects and Lack of Efficacy[1]

57%

(N=195)



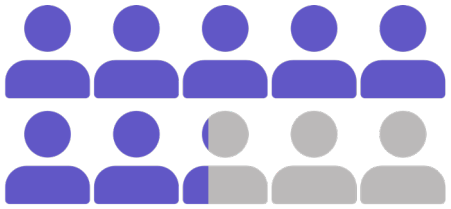
Are Usually or Always Worried About Worsening Disease[1]

1. Christopher-Stine et al., BMC Rheumatology (2025)
2. TMA/MSU EL-PFDD Meeting (2025)

Despite Widespread Use of Standard Therapies, DM Patients Face High Rates of Disease Flare, Hospitalizations, and Pain, Often Requiring Opioids

73%

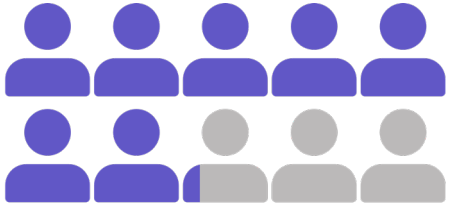
(N=524)



Experienced ≥ 1 Disease Flare in the Past Year[1]

72%

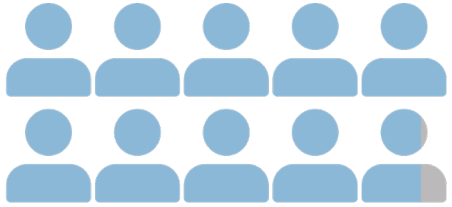
(N=378)



Hospitalization Rate Among Patients Who Experienced ≥ 1 Disease Flare[1]

97%

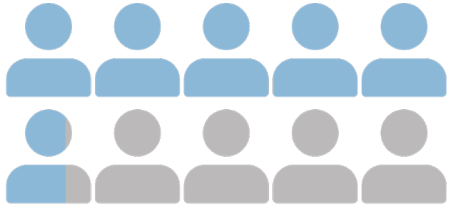
(N=183)



Experienced Pain Attributed to Their Myositis[2]

57%

(N=195)



Used Opioids to Manage DM-Associated Pain[2]

1. Christopher-Stine, et al., J Manag Care Spec Pharm (2020)
2. Bhashyam et al., Rheumatology (2023)

Patient Advocacy Group Surveys (TMA, MSU) Report Significant Muscle Disease Burden and Impact on Patients' ADLs

63%[1]

Unable to climb one flight of stairs

Unable to do chores (e.g., vacuuming, yard work)

40%[2]

53%[2]

Unable to walk more than 1 mile

Unable to lift or carry groceries

36%[2]

50%[2]

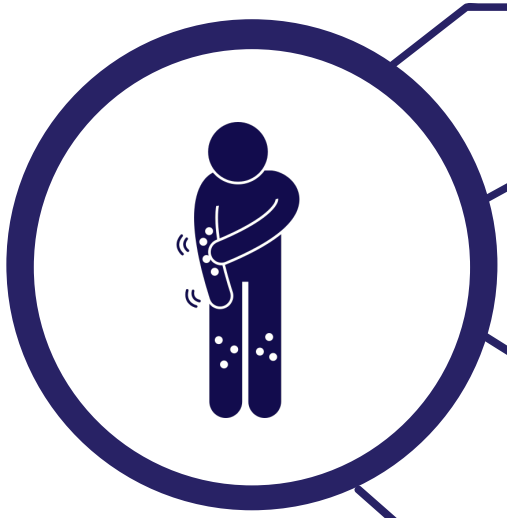
Unable to bend, kneel, or stoop

Report use of mobility aids (e.g., canes/crutches, rollators, walkers, and wheelchairs)

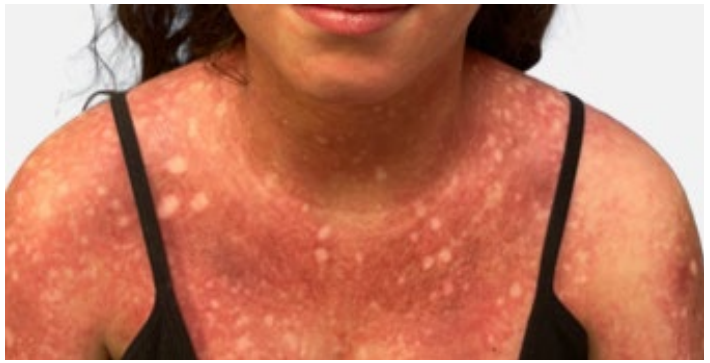
35%[2]

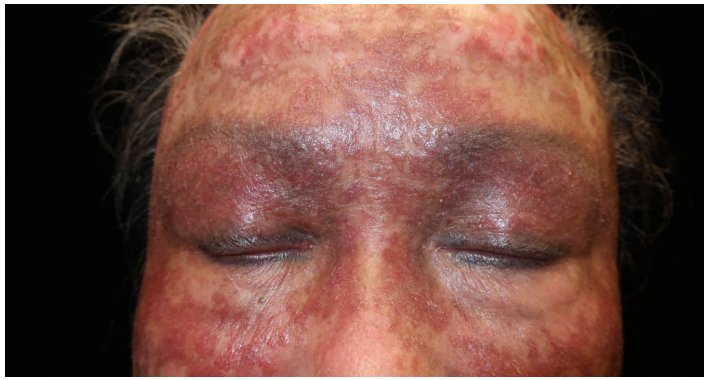
1. Priovant/TMA Patient Survey
2. Myositis Journey and Burden of Disease Survey, MSU (2022)

DM Skin Disease Activity Contributes to Major Quality of Life Disruption and Is Associated With Poor Emotional and Social Health



- **82%** Reported that their cutaneous disease caused disruption of daily life
- **65%** Reported emotional symptoms caused by their disease including fear, anxiety, frustration, worry, guilt, discontent, and longing
- **58%** Reported itchiness; many patients experience disruption in their sleep due to itchiness
- **53%** Reported social impacts of their disease; patients feel self-conscious about how they look and experience social restrictions because of it



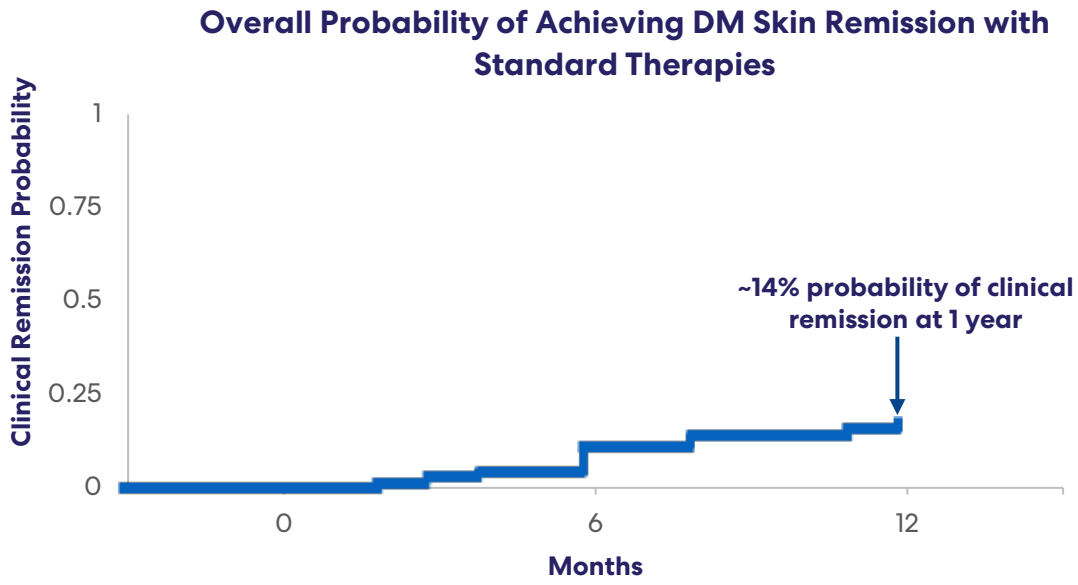


In a Separate Analysis of DM Skin Disease's Impact on QoL, DM Had Higher (Worse) Skindex-29 Emotional Subscores Than Any Other Inflammatory Skin Disease[1]

ADL: Activities of Daily Living
Survey data adapted from Kleitsch et al, Arch Dermatol Res (2023)
1. Goreshi et al., J AM Acad Dermatol (2011)

Even in Specialized Myositis Centers, Durable Skin Remission Remains Rare, Underscoring the Limitations of Standard Therapies

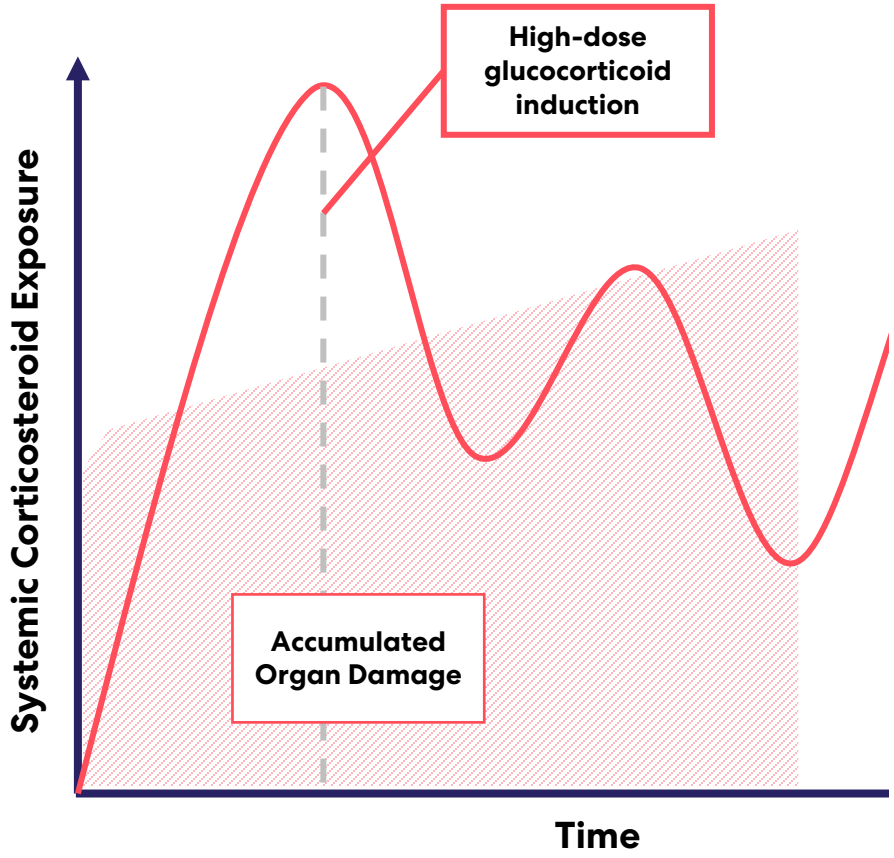
Treatment	Study Cohort (n = 74)
Mycophenolate mofetil	27 (36%)
Antimalarials	28 (38%)
Methotrexate	29 (39%)
IVIg	19 (26%)



- **Only 14% of DM patients in a tertiary myositis clinic achieved remission at 1 year[1,2]**
- **Protracted time to remission underscores slow and incomplete cutaneous responses with standard therapies**
- **IVIg showed no association with clinical remission**

1. Wolstencroft and Fiorentino et al., JAMA Derm 2018
2. Ahmed et al., Semin Arthritis Rheum (2020)

Systemic Steroid Use Drives Much of the Adverse Event Burden in DM



- **Prolonged corticosteroid use (≥3 months) markedly increases risk of major complications[1]**
- **Patient-reported AEs highlight poor tolerability of systemic steroids[2,3]**
- **Toxicity is dose-independent; even low-dose (≤5 mg/day) exposure causes cumulative harm[4,5]**

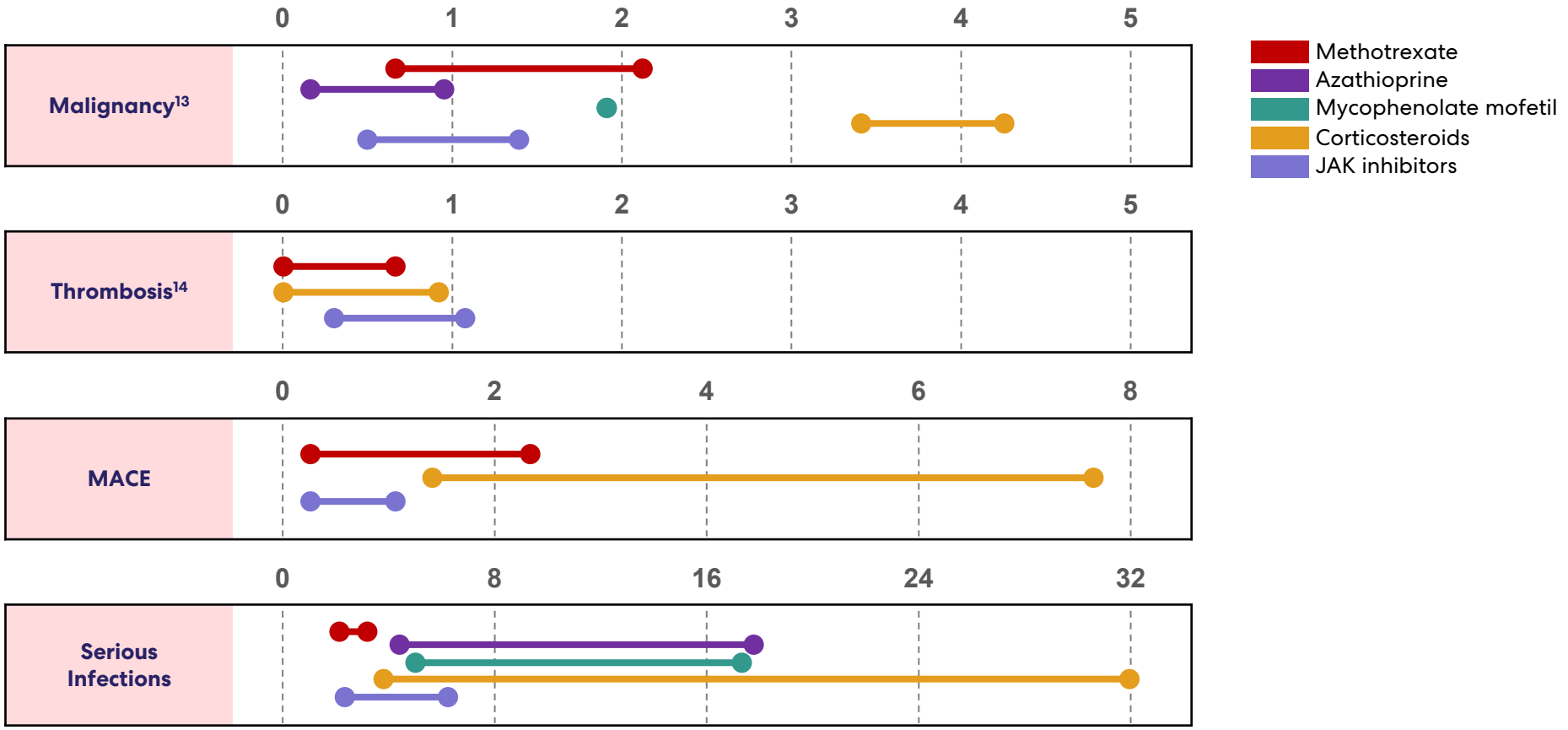
1. Aggarwal et al., Clin Rheumatol (2025)
2. Loarce-Martos et al., Clin Rheumatol (2021)
3. Mirza et al., Clin Rheumatol (2021)
4. Choy et al., Rheumatol (2002)
5. Pujades-Rodriguez et al., PLoS Med (2020)

Pooled Safety Data From Multiple Sources Suggest Significantly Higher Risk From Corticosteroids Versus Other Medication Categories for Most AESIs

Comparative ranges are based on an internal systematic review of published incidence rates for AESIs across corticosteroids, DMARDs, and JAK inhibitors

Brepocitinib event rates consistent with other JAK inhibitors

Incidence Rate of Events per 100 Patient-Years[1-12]

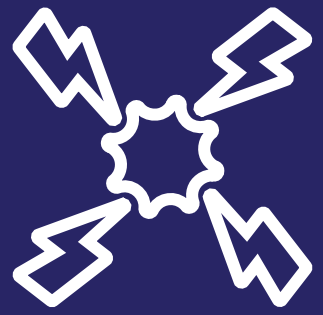


1. Khan et al., Adv Ther (2021)
2. Lane et al., Ophthalmology (1995)
3. Wei et al., Ann Intern Med (2004)
4. George et al., Ann Intern Med (2020)
5. George et al., Epidemiology (2022)
6. Bloechliger et al., Respir Res (2018)
7. Feldman et al., Arthritis Rheumatol (2018)
8. Cohen et al., RMD Open (2020)
9. Smolen et al., J Rheumatol (2019)
10. Pfizer ORAL Surveillance Study
11. Baricitinib FDA Risk Review (2018)
12. Upadacitinib FDA Risk Review (2019)
13. Methotrexate malignancy incidence rate upper bound provided as Subjects with Event per 100 Patient-Years.
14. Methotrexate thrombosis incidence rate lower bound provided as Subjects with Event per 100 Patient-Years.

DM Patient Experience Shows Need for New Treatments That Can Meaningfully Impact Patients' Quality of Life

Patients are heavily treated with **polypharmacy**, including high dose OCS administered chronically[1]

Patient are **unhappy with the current treatment** options and are **frequently switching their treatment**[2]



Patients report continued **symptoms, flares, and pain despite treatment**[3,4]

Continued symptoms are leading to **significant burden** on **ADLs, QoL**, and overall **health outcomes**[5,6]

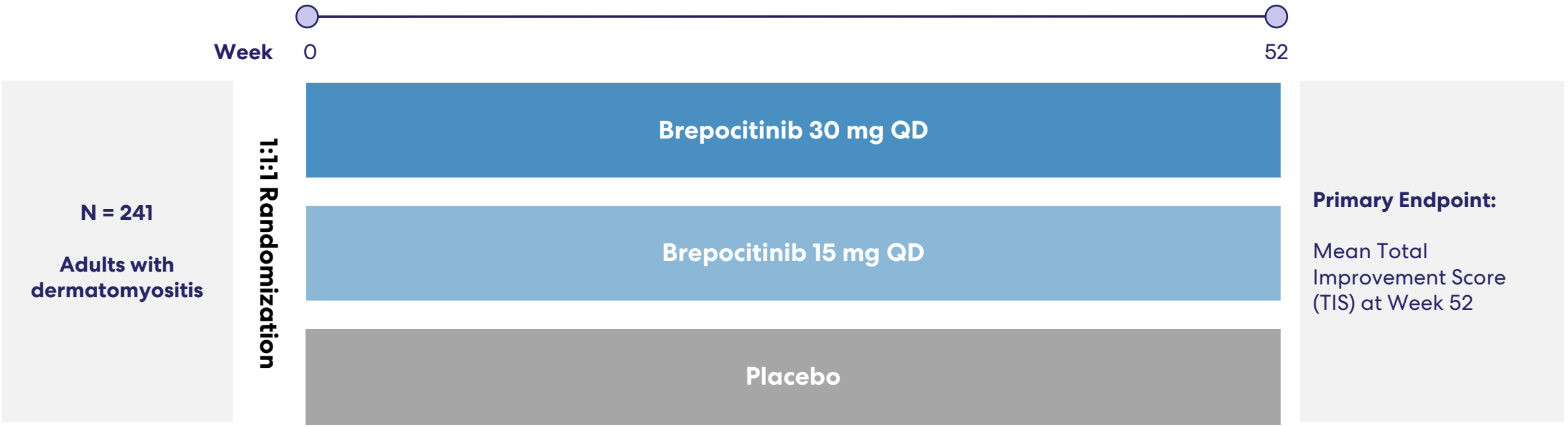
These adverse health outcomes are compounded by the **toxicities of high-dose chronic steroids**[7-9]

High unmet need for novel, targeted therapy that can provide sustained clinical benefit while allowing patients to get to minimal or no steroid burden

1. Analysis by Roivant/Priovant using closed claims data from Inovalon from 2019-2024
2. Christopher-Stine et al., BMC Rheumatology (2025)
3. Christopher-Stine, et al., J Manag Care Spec Pharm (2020)
4. Bhashyam et al., Rheumatology (2023)
5. Kleitsch et al., Arch Dermatol Res (2023)
6. Goreshi et al., J AM Acad Dermatol (2011)
7. Aggarwal et al., Clin Rheumatol (2025)
8. Choy et al., Rheumatol (2002)
9. Pujades-Rodriguez et al., PLoS Med (2020)

VALOR: Phase 3 Study Design

Positive topline results announced in September 2025



Steroid taper: Mandatory OCS taper to ≤5 mg/day from week 12 to 36; recommended further tapering at investigator discretion

Note: Additional inclusion and exclusion criteria not listed on slide
Note: Additional primary and secondary endpoint details not listed on slide
DM: dermatomyositis; QD: daily; OCS: oral corticosteroids

VALOR Baseline Disease and Treatment Characteristics Reflect Real-World Patient Population: Active, Multisystem Disease Requiring Multiple Therapies

	Brepocitinib 30 mg (n = 81)	Brepocitinib 15 mg (n = 81)	Placebo (n = 79)
Disease Activity (PhGA) – no. (%)			
Mild (0 to < 4 cm)	13 (16%)	19 (24%)	13 (16%)
Moderate (4 to < 7 cm)	54 (67%)	40 (49%)	48 (61%)
Severe (7 to 10 cm)	14 (17%)	22 (27%)	18 (23%)
Mean MMT-8 Score (± SD)	121.7 (16.4)	124.5 (14.2)	121.6 (17.0)
Mean CDASI-A Score (± SD)	19.5 (11.3)	18.7 (11.3)	21.1 (12.0)
Mean HAQ-DI Score (± SD)	1.28 (0.68)	1.17 (0.68)	1.20 (0.71)
Medications at Baseline – no. (%)			
Non-steroidal Immunosuppressant	55 (68%)	57 (70%)	61 (77%)
Antimalarial	24 (30%)	22 (27%)	19 (24%)
Corticosteroids	60 (74%)	58 (72%)	64 (81%)
Prednisone > 5 mg/day	47 (58%)	38 (47%)	47 (60%)
Mean dose (mg/day) (± SD)	12.2 (5.7)	10.7 (6.2)	11.3 (5.9)
2 or More DM Medications	64 (79%)	66 (81%)	66 (84%)
Prior Treatment with IVIg – no. (%)	19 (24%)	23 (28%)	19 (24%)
Prior Neoplasm (Benign or Malignant)	14 (17.3%)	9 (11.1%)	11 (13.9%)

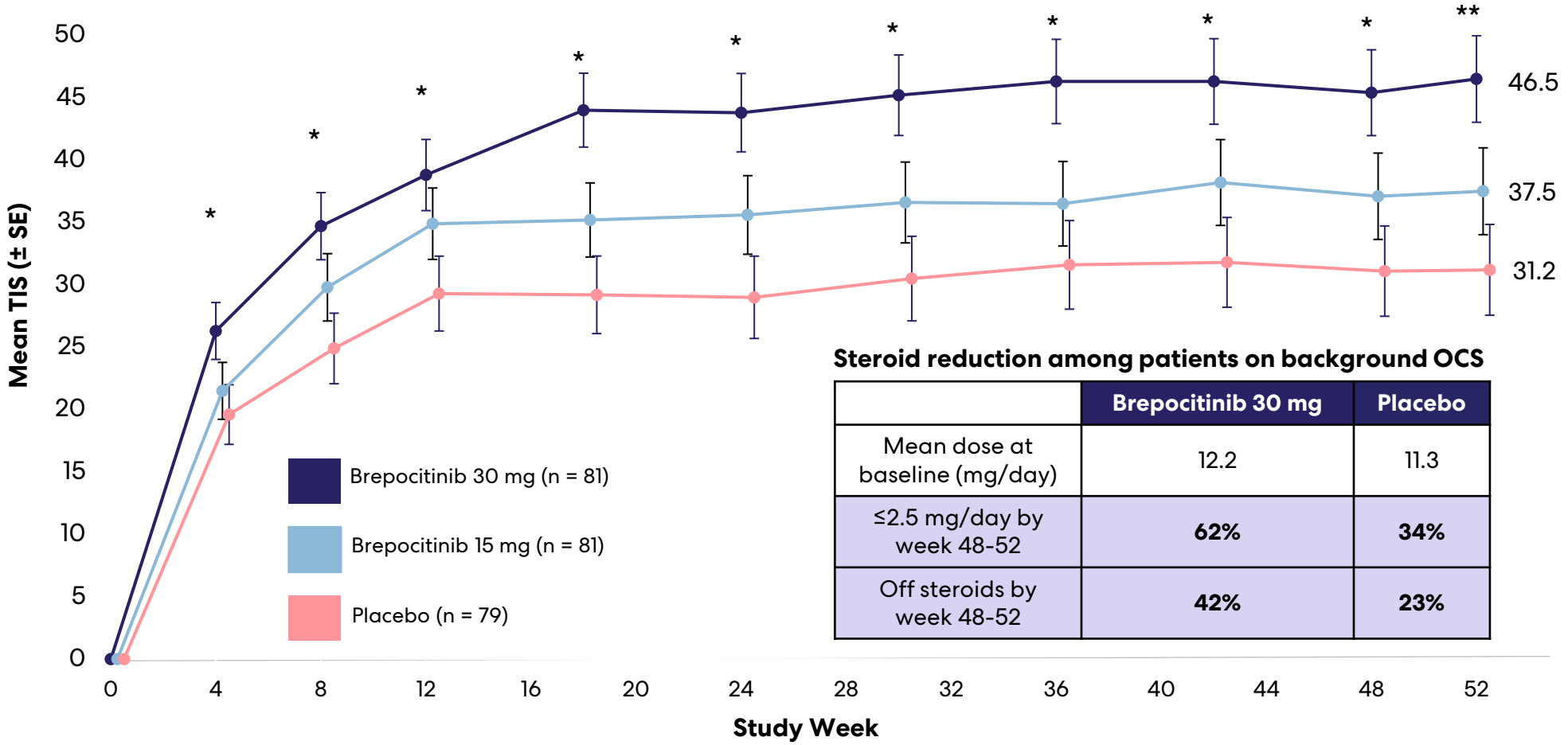
Brepocitinib 30 mg Achieved Statistically Significant Benefit On All Ten Ranked Endpoints in the VALOR Study

Measurements of skin disease, muscle disease, rapidity of onset, and steroid sparing; consistent dose response was also seen across endpoints

Key Endpoint	Important Features	Brepocitinib 30mg (n=81)	Placebo (n=79)	P-Value
Mean TIS (Primary)	Composite endpoint, focus on **muscle disease** and **global** benefit	46.5	31.2	**0.0006**
CDASI-A change from baseline at Week 52	Improvement in **skin disease** activity	-11.7	-7.0	**0.0006**
DMOMS at Week 52	DM-specific **muscle and skin** composite measure of benefit	57.9	40.5	**0.0014**
TIS40 Response at Week 52	Moderate TIS response (focus on **global benefit / muscle**)	67.9%	44.3%	**0.0040**
Time to Consecutive TIS40 Response by Week 52	**Time to onset of sustained benefit** (particularly high bar)	85 days	168 days	**0.0155**
Patients achieving TIS40 Response + ≤2.5 mg OCS at Week 52	Achievement of clinical response and **steroid reduction**	54.3%	26.6%	**0.0006**
CDASI-A 40% Response with ≥4-point improvement at Week 52	Clinically meaningful **skin response**	61.7%	44.3%	**0.0357**
TIS60 Response at Week 52	Major TIS response – **Highest TIS response threshold**	46.1%	26.4%	**0.0126**
Change from baseline in HAQ-DI at Week 52	Improvement in physical and functional disability and daily living activities related to **muscle** strength	-0.337	-0.042	**0.0035**
Change from baseline in CDASI-A at Week 4	**Rapid onset** of skin response	-6.4	-3.5	**0.0003**

Brepocitinib Showed Significant and Clinically Meaningful Improvement on Primary Endpoint of TIS

Separation between brepocitinib 30 mg and placebo at all time points, starting as early as week 4, achieved together with substantially greater steroid reduction in brepocitinib 30 mg arm



Steroid reduction among patients on background OCS

	Brepocitinib 30 mg	Placebo
Mean dose at baseline (mg/day)	12.2	11.3
≤2.5 mg/day by week 48-52	**62%**	**34%**
Off steroids by week 48-52	**42%**	**23%**

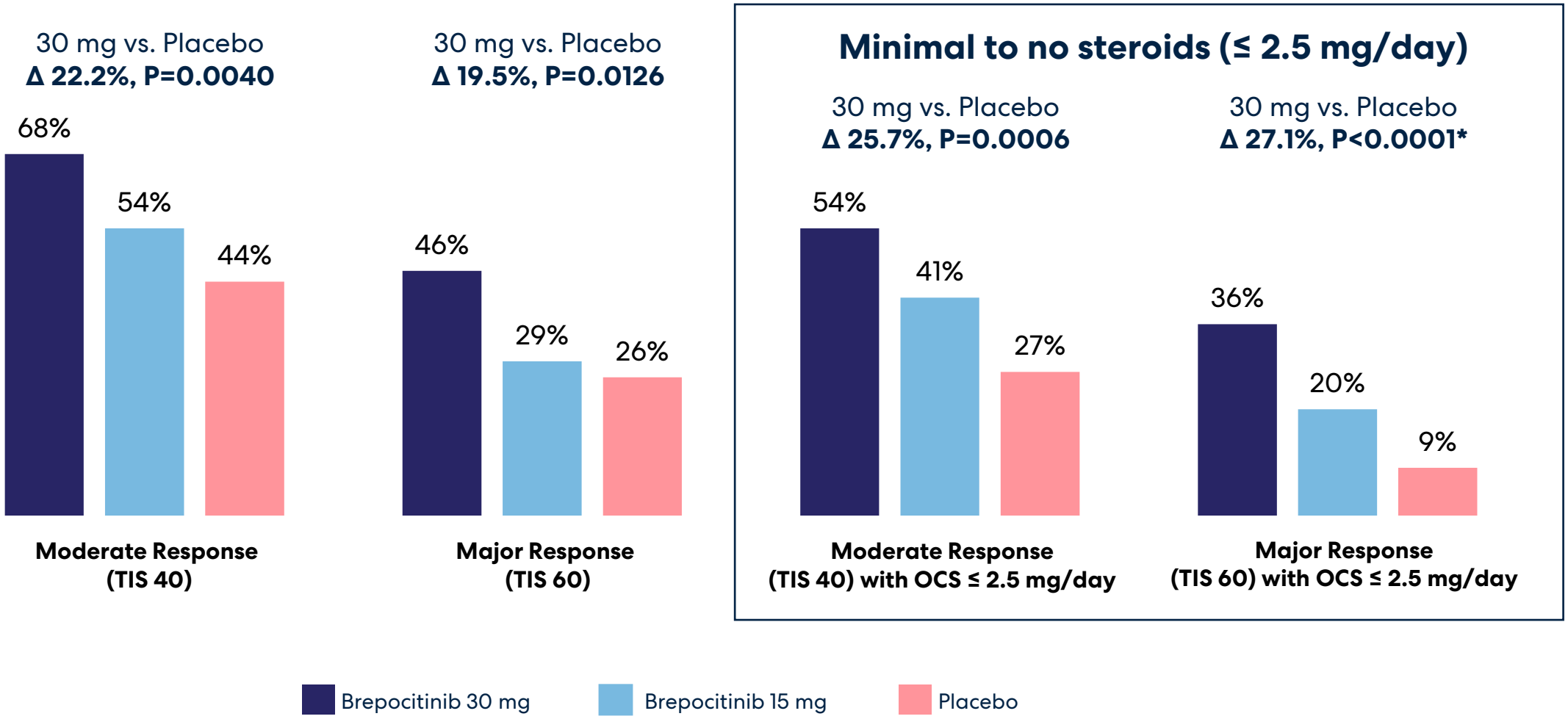
Primary Endpoint

30 mg vs. Placebo
At Week 52
TISΔ 15.3
P = 0.0006

*Nominal P < 0.05
** P < 0.001

TIS 40 (Moderate) and TIS 60 (Major) Responses at Week 52

Greater achievement of TIS 40 and TIS 60 responses including with minimal or no steroids



Adjusted response rate (risk) differences calculated using the Mantel-Haenszel method. OCS dose assessed at weeks 48 and 52.

Percentages are calculated using the number of participants within the ITT analysis set who can achieve a maximum possible TIS ≥ 60 points at post-baseline given the baseline CSMs as a denominator.
* Exploratory endpoint; nominal P value

Overview of Safety Events

	Brepocitinib 30 mg QD (N=81)	Brepocitinib 15 mg QD (N=81)	Placebo (N=79)
Participants with:			
AEs	73 (90%)	70 (86%)	72 (91%)
Death	0	0	0
SAEs	13 (16%)	7 (9%)	10 (13%)
AEs leading to treatment discontinuation	5 (6%)	6 (7%)	9 (11%)
AEs leading to study discontinuation	3 (4%)	4 (5%)	3 (4%)
Adverse Events of Special Interest:			
Cardiovascular events	1 (1%)	0	2 (3%)
Thromboembolic events	0	0	1 (1%)
Viral reactivation	4 (5%)	2 (2%)	4 (5%)
Opportunistic infections	0	0	0
New or recurrent diagnoses of malignancy	0	0	2 (3%)
Increase in ALT or AST	1 (1%)	2 (2%)	1 (1%)

- Adverse events of special interest balanced across treatment arms; no new safety signals for brepocitinib
- Brepocitinib safety database includes over 1,500 patients and subjects, with a safety profile that appears consistent with approved JAK inhibitors

Abbreviations: AE=adverse event, ALT=alanine aminotransferase, AST=aspartate aminotransferase, SAE=serious adverse event.
Note: Percentages are based on the number of unique participants with an event out of the column total. Treatment-emergent AEs are reported.

Key Regulatory and Launch Planning Activities

NDA Submission Expected in Early 2026

Robust field medical team in place driving scientific engagement with key DM-treating physicians

- Foundational relationships from before VALOR TLR with at least one key physician at all top DM centers of excellence in US
- Post-TLR engagement has expanded to include additional relevant HCPs at centers of excellence, as well as longer tail of community specialists

Strong engagement with patient community

- Patient advocacy group collaborations and events
- Dermatomyositis.com disease website and associated social media ecosystem

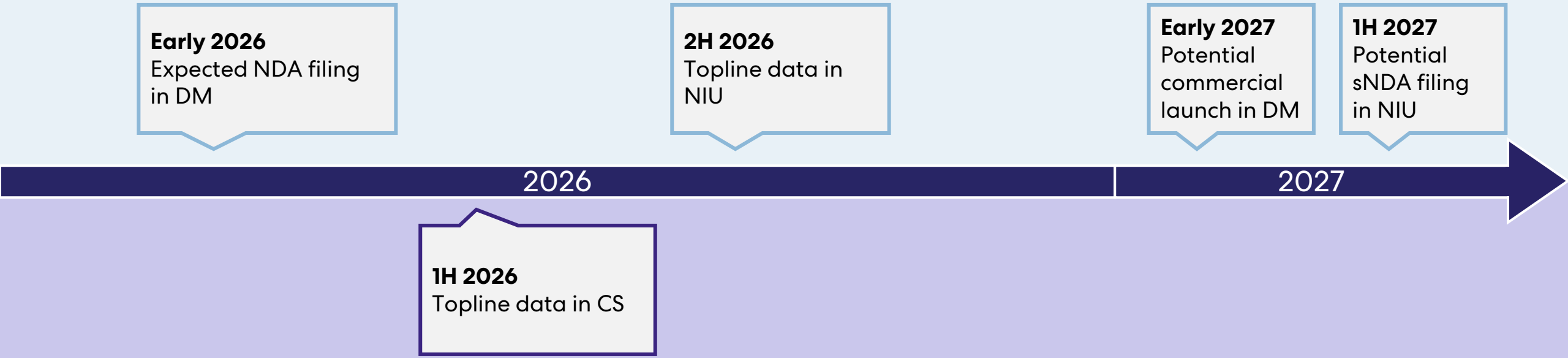
Limited distribution network and in-house Priovant Hub

- Strategy consistent with prior successful rare disease launches
- Partner selection and operational buildout well underway

Note: All drugs are investigational and subject to regulatory approvals. 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.

Upcoming Brepocitinib Catalysts Over the Next 18 Months

Pivotal / Potentially Registrational



Proof of Concept / Other

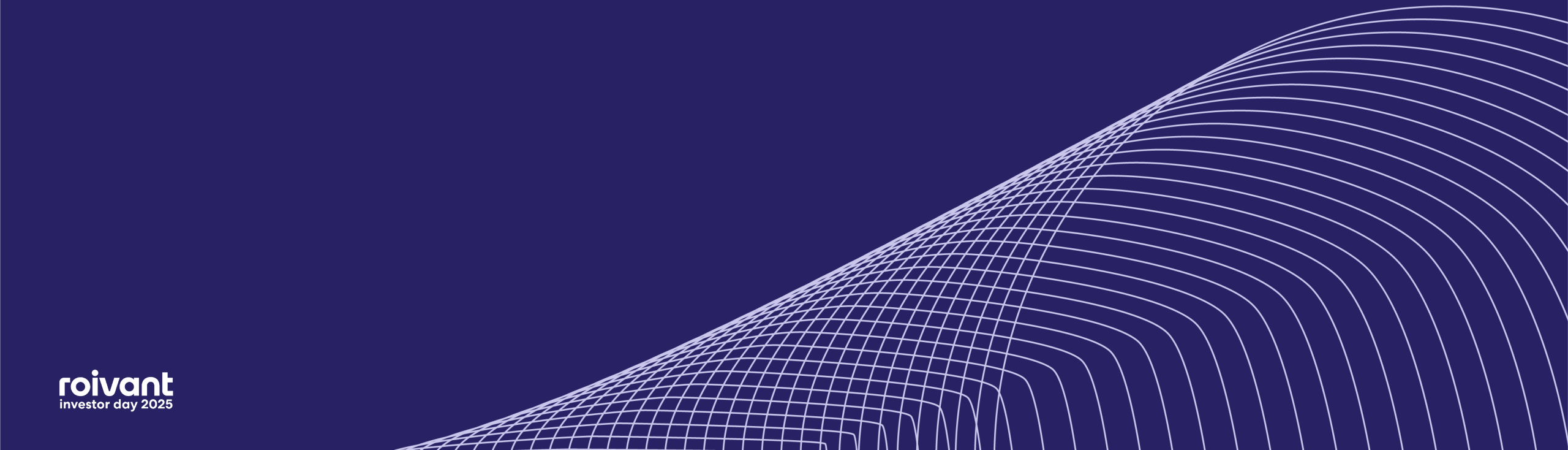
Note: All drugs are investigational and subject to regulatory approvals. All catalyst timings are approximate, based on current expectations and, where applicable, contingent on FDA feedback, and may be subject to change. All references are to calendar years.

In Summary: Brepocitinib

- **Following positive VALOR readout, planning for commercial launch of brepocitinib in DM is underway, with launch expected early 2027**
- **Phase 3 CLARITY study for brepocitinib in NIU expected to read out 2H 2026; NIU has significant unmet medical need**
- **Phase 2 BEACON study for brepocitinib in CS expected to read out 1H 2026; CS has high unmet medical need**

Note: All drugs are investigational and subject to regulatory approvals. 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.

Q&A



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IMVT-1402

Matt Gline
CEO, Roivant

Eric Venker
CEO, Immunovant

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Key Takeaways: IMVT-1402

IMVT-1402 drives **deep dose-dependent reductions** of pathogenic IgG autoantibodies; expected to reach **best-in-class IgG reductions of ~80%**, unmatched by current anti-FcRn competitors

Significant evidence across late-stage clinical trials shows **deeper IgG reductions are correlated with better efficacy** across 8 different indications to date

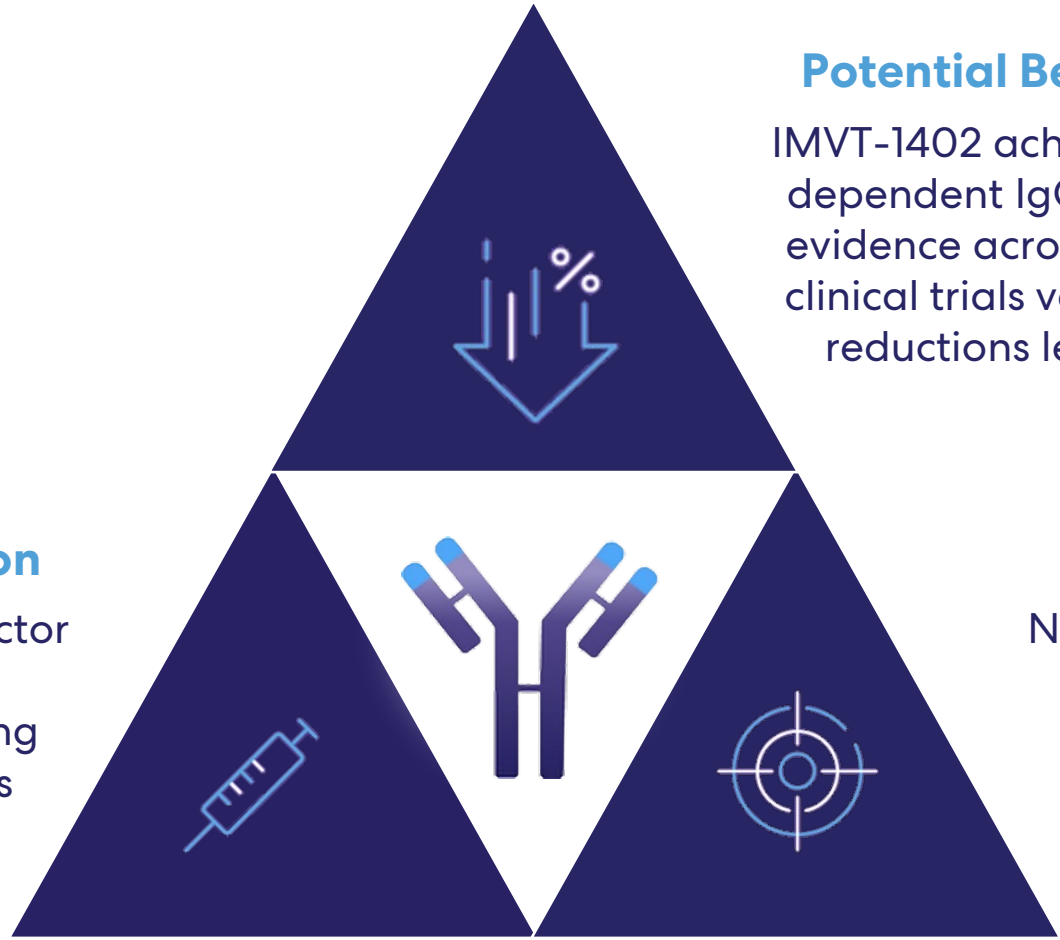
Massive opportunity in uncontrolled Graves' disease; generated disease-modifying PoC data and expect potentially registrational data in 2027 with multi-year lead and best-in-class efficacy

IMVT-1402 is expected to be **first- and best-in-class in GD, D2T RA, and CLE; best-in-class in MG, CIDP, and SjD; D2T RA topline readout now expected in 2026** as well as initial results in CLE

Pipeline-in-a-product potential; approved anti-FcRns antibodies have generated **~$7BN in cumulative revenue in MG and CIDP within 4 years of launch** with additional indications expected[1]

Note: GD: Graves' disease; SjD: Sjogren's disease; D2T RA: difficult-to-treat rheumatoid arthritis; CIDP: Chronic inflammatory demyelinating polyneuropathy; MG: Myasthenia gravis; CLE: Cutaneous lupus erythematosus
Note: All drugs are investigational and subject to regulatory approvals. 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.
1. Data from Evaluate and company filings

IMVT-1402 Has the Potential to Be a First- and Best-in-Class Therapy in Autoantibody-Driven Disease



Potential Best-in-Class Efficacy

IMVT-1402 achieves deep, rapid, dose-dependent IgG reductions; consistent evidence across external and internal clinical trials validate that deeper IgG reductions lead to greater clinical benefit

Convenient Administration

Simple subcutaneous autoinjector with 5-10 second self-administration; currently being tested in all IMVT-1402 trials

Favorable Safety Profile

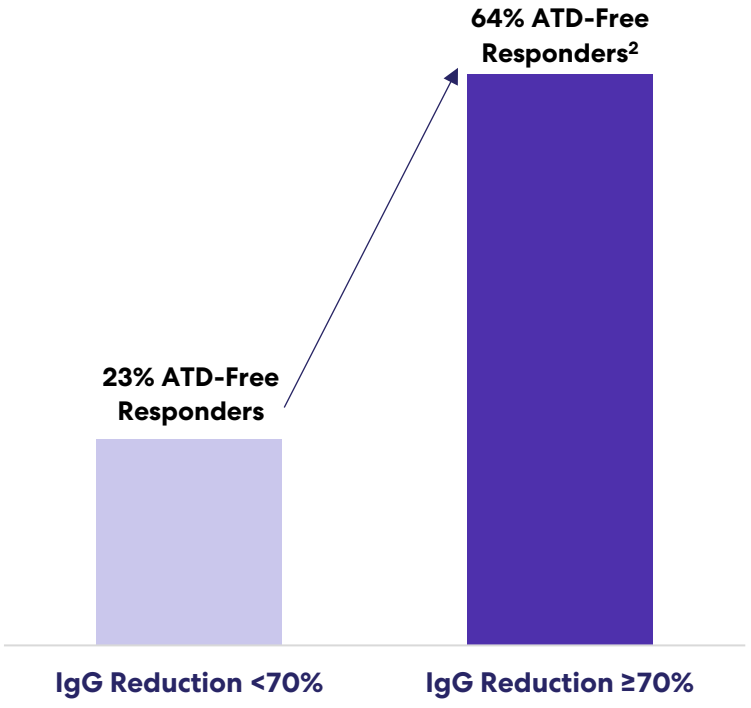
No significant expected safety issues based on data to-date

Settling the "Deeper Is Better" Debate With Batoclimab Proof-of-Concept Trials

Our clinical data generated across multiple indications consistently shows that deeper IgG reduction leads to improved clinical outcomes for patients

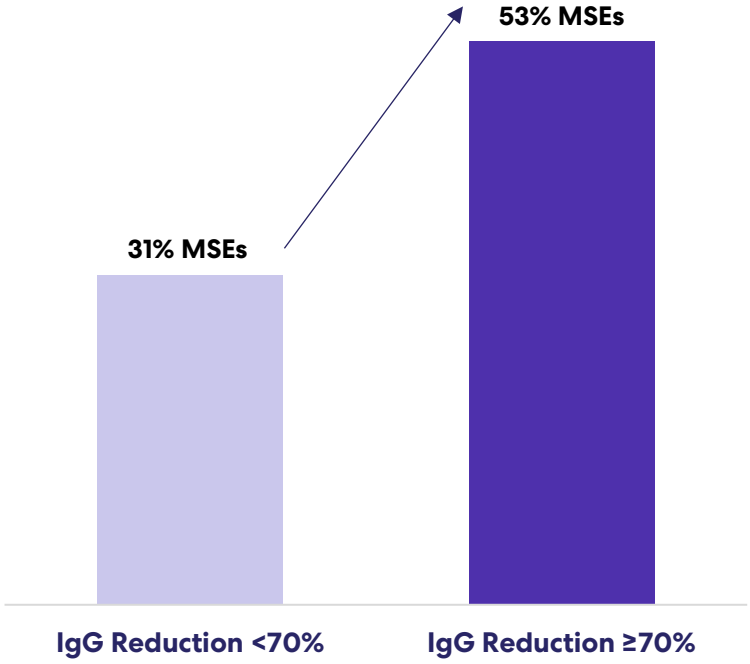
Graves' Phase 2a[1]

ATD-Free Response: % of participants who achieve normal T3 and T4 or have T3 or T4 below LLN, and ceased all ATD medications



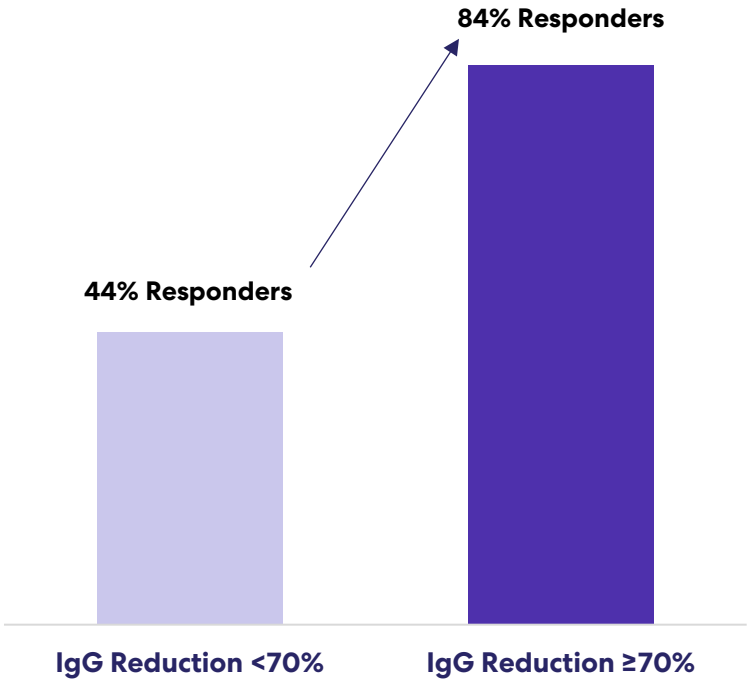
MG Phase 3[1]

Minimal Symptom Expression: % of participants who achieve MG-ADL score of 0 or 1 at Week 12



CIDP Phase 2b[1,3]

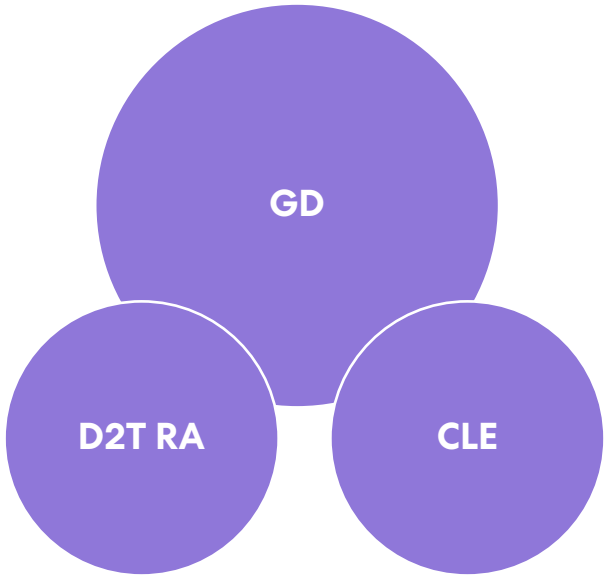
aINCAT Response: % of participants who achieve aINCAT improvement ≥1 at Week 12

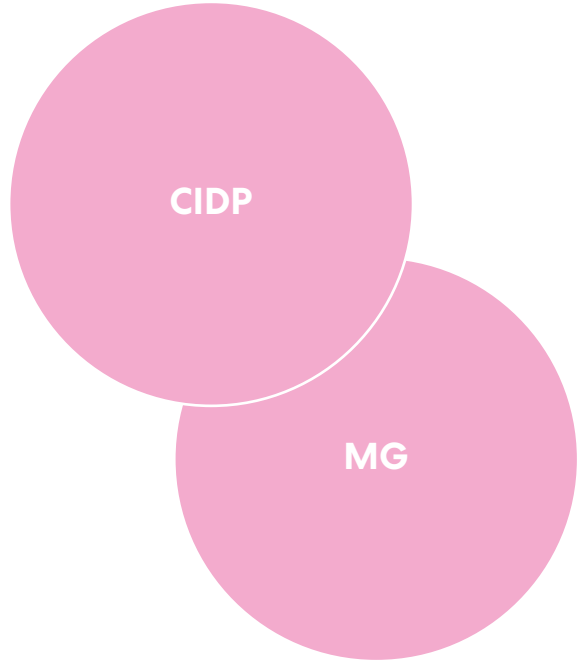


Reflects data from multiple clinical trials in multiple indications. Differences exist between study designs and subject characteristics, and caution should be exercised when comparing data across studies.

Notes: MG data presented for acetylcholine receptor antibody-positive patients; ATD: Antithyroid drug; aINCAT: Adjusted Inflammatory Neuropathy Cause and Treatment; IgG: Immunoglobulin G; MSE: Minimal Symptom Expression; LLN: Lower limit of normal.
1. Batoclimab clinical data. 2. Includes N=1 additional responder vs. September 2024 disclosure. Patient discontinued prior to Week 12 and was counted as a non-responder per protocol but was included by the PI in the ATA 2025 poster presentation, given they were a responder at time of discontinuation and continued through 6 month off-treatment follow-up period. 3. The data referenced here includes data from the ongoing batoclimab Phase 2 study in CIDP and is based on a preliminary analysis of key efficacy and safety data, and such data may change following completion of the clinical trial and may not accurately reflect the complete results of the study

IMVT-1402 Development Well Underway With 5 Potentially Registrational Datasets Expected in Next 36 Months





First-in-Class / Best-in-Class
Multi-year head-start with key clinical catalysts in 2026 and 2027

Best-in-Class
Potential best-in-class product in untapped market;
close timing to in-class competition

Best-in-Class / "Upside"
Well-established markets; potential to gain market share as clear best-in-class

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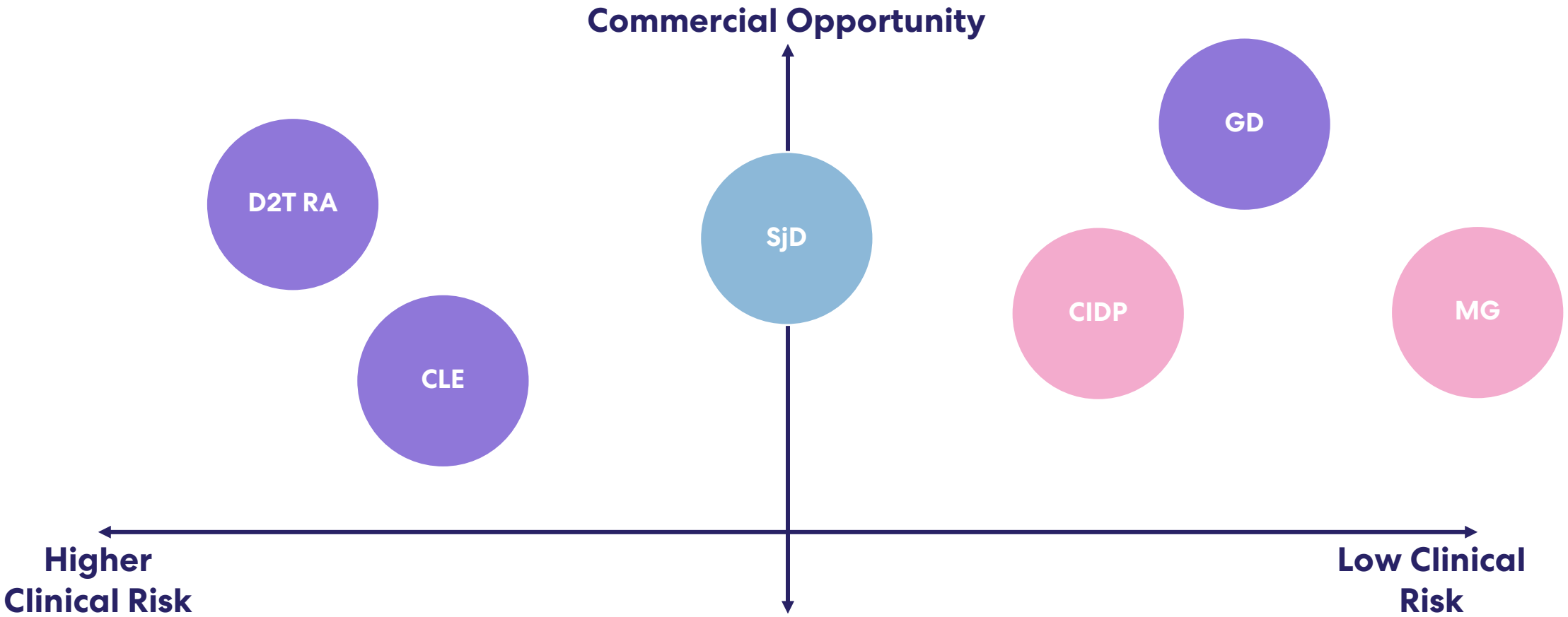
Note: GD: Graves' disease; SjD: Sjogren's disease; ACPA+ D2T RA: anti-citrullinated protein antibody positive (ACPA+), difficult-to-treat rheumatoid arthritis; CIDP: chronic inflammatory demyelinating polyneuropathy; MG: myasthenia gravis; CLE: cutaneous lupus erythematosus
Note: All drugs are investigational and subject to regulatory approvals. 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.

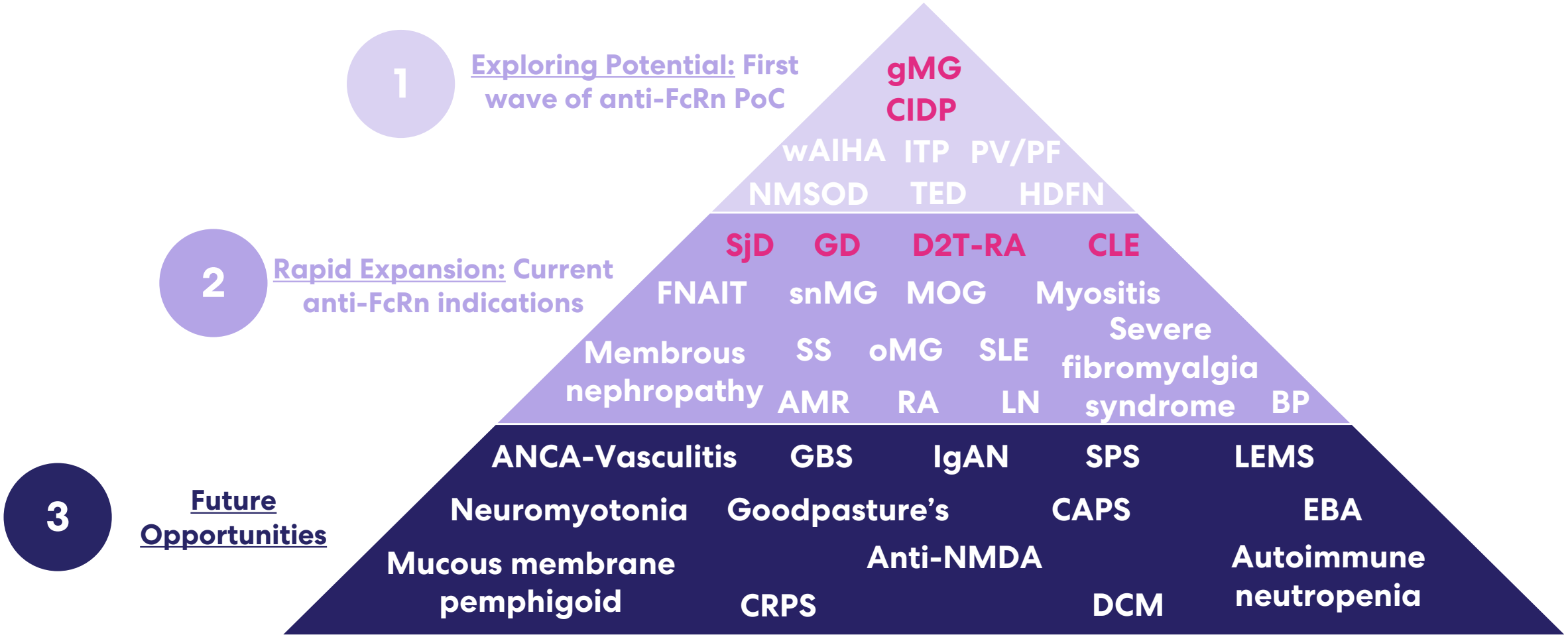
IMVT-1402 Indication Selection Optimizes Across Both Clinical Validation and Commercial Potential



Exploring Other Potential Opportunities for IMVT-1402 Across the Spectrum

Note: Bubble placement is illustrative and not representative of expected clinical risk and commercial opportunity. Size of bubbles is not indicative of market size

Anti-FcRns Have Pipeline-in-a-Product Potential Across Autoimmune Diseases Driven by Harmful IgG Autoantibodies With Continued Room for Growth



Current IMVT-1402 indications

Note: Indications listed include possible indications where anti-FcRn may have mechanistic rationale to pursue

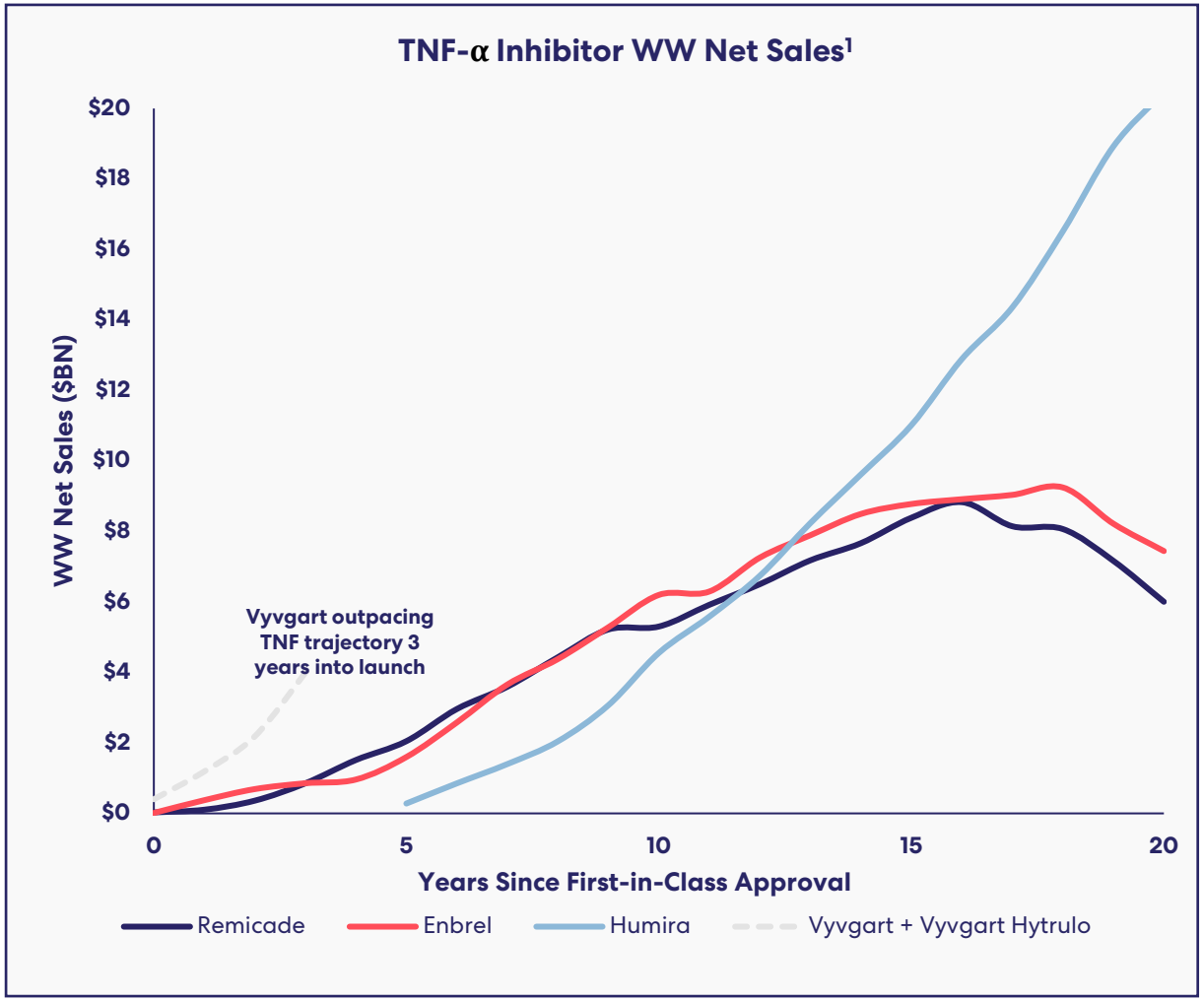
Anti-FcRn Antibody Development Has Seen Explosive Growth Since 2020

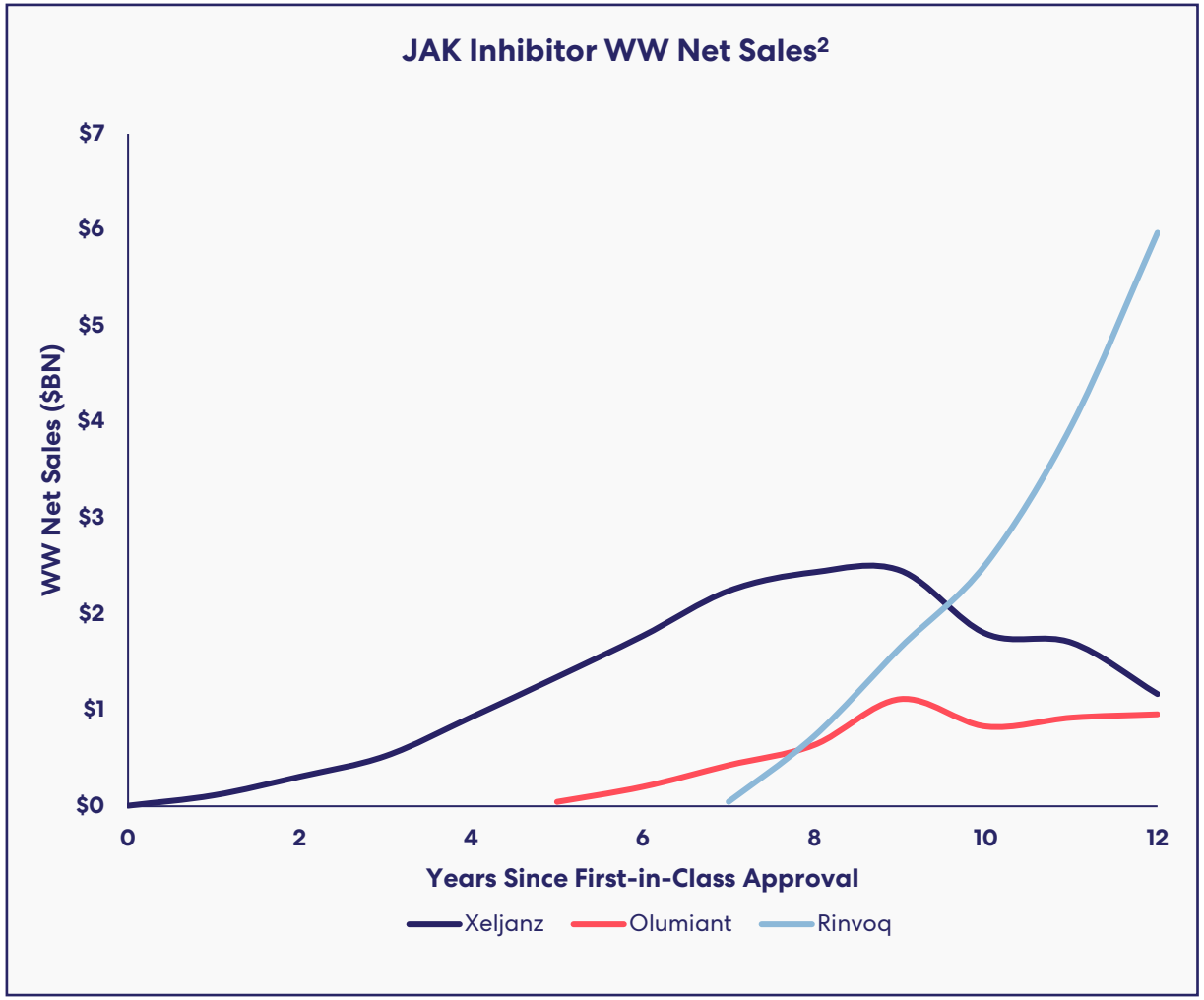
2020		2025		
8	**~700K**	**20+**	**~4M**	**~$7BN**
Total Indications in Development	Total Addressable Patient Population	Total Indications in Development	Total Addressable Patient Population	Cumulative Anti-FcRn Sales in MG & CIDP[1]

NEUROLOGY | HEMATOLOGY | ENDOCRINOLOGY | RHEUMATOLOGY | RENAL | DERMATOLOGY

Note: Indications in development cover anti-FcRn antibodies in development by Immunovant, argenx, JNJ and UCB
1. Includes disclosed sales from argenx and UCB

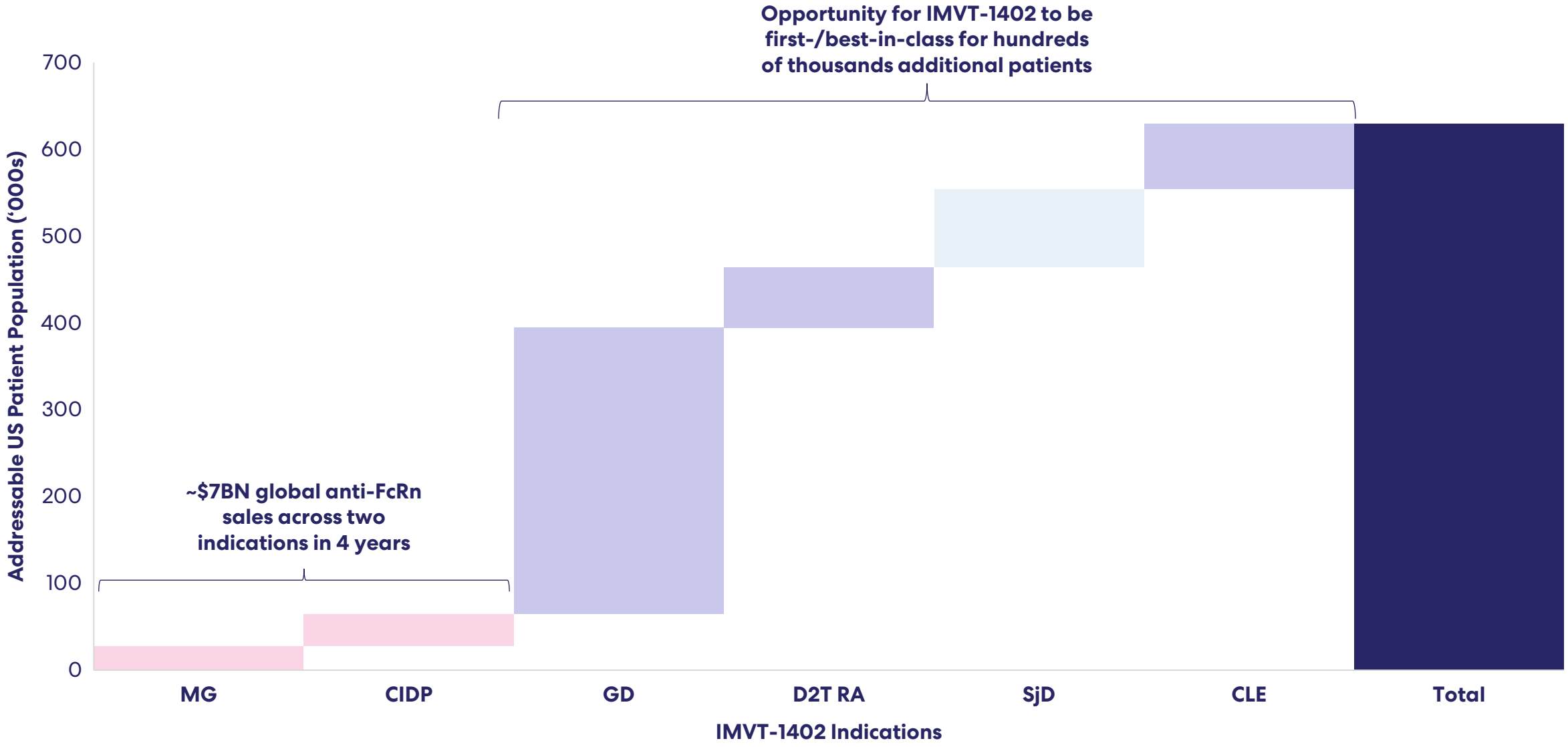
In Both TNF-α and JAKi Classes, a Later Product Launch With a Better Profile Rapidly Captured Dominant Market Share in Autoimmune Disease





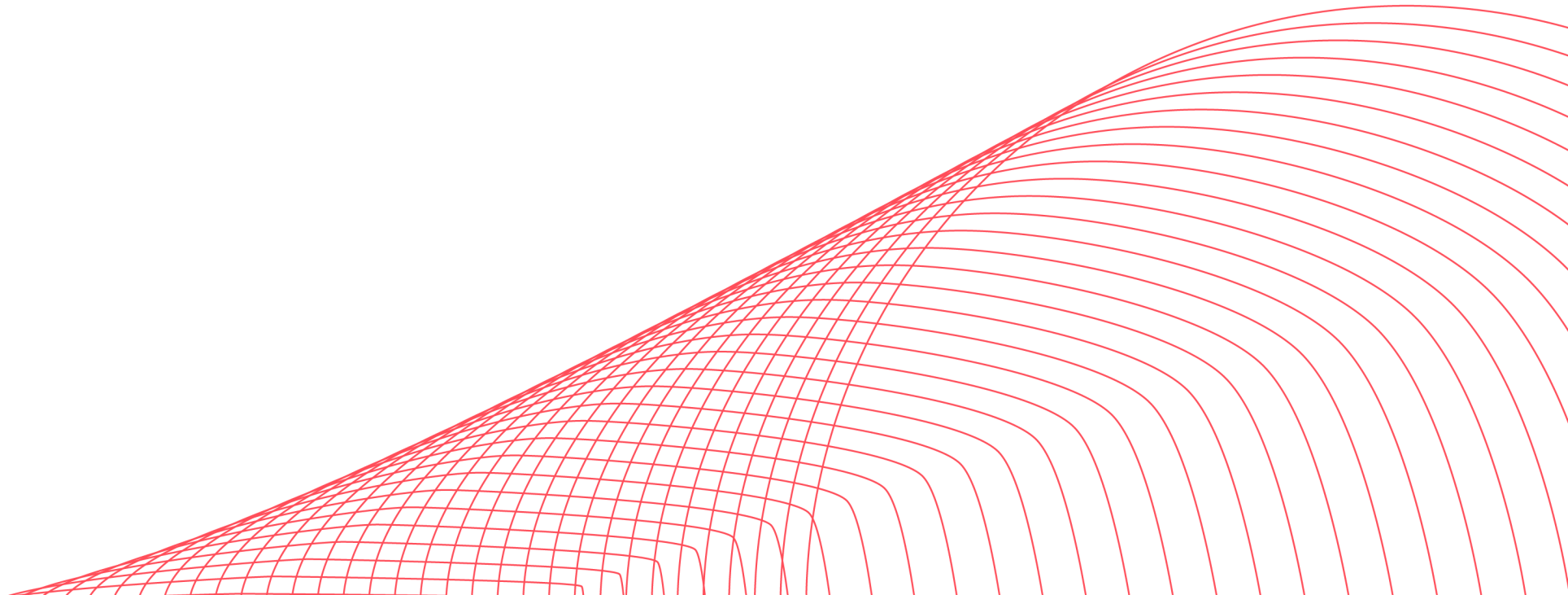
1. Data from Evaluate. 4Q2025 net sales for Vyvgart held constant based on sales in 3Q2025. Remicade and Enbrel launch in 1998, Humira in 2003. Vyvgart launch in 2022.
2. Data from Evaluate. Xeljanz launch in 2012, Olumiant launch in 2017, Rinvoq launch in 2019
Note: Net sales from company filings and Evaluate Pharma

IMVT-1402 Is Expected to Potentially Address >600K US Patients



Note: Addressable populations as listed in IMVT Pipeline in IMVT Corporate Overview deck

Near-Term Upside Catalysts for IMVT-1402



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IMVT-1402 Is Leading in 3 First-/Best-in-Class Indications With Key Catalysts Expected in D2T RA and CLE in 2026

Difficult-to-Treat Rheumatoid Arthritis

Rapidly enrolling trial; topline results now expected in 2026 (formerly 2027)

Cutaneous Lupus Erythematosus

Strong PoC data from IMVT-1402 basket study; initial results from PoC expected in 2026

Graves' Disease

Multi-year lead with remarkable PoC data; topline results from both potentially registrational trials expected in 2027

Note: All drugs are investigational and subject to regulatory approvals. 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.

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

D2T RA Patients Have Failed on Multiple Lines of Therapy

- **5-20%** of RA patients are difficult-to-treat (D2T), with inadequate or loss of response to multiple classes of advanced therapies[1]

Up to ~70k 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**

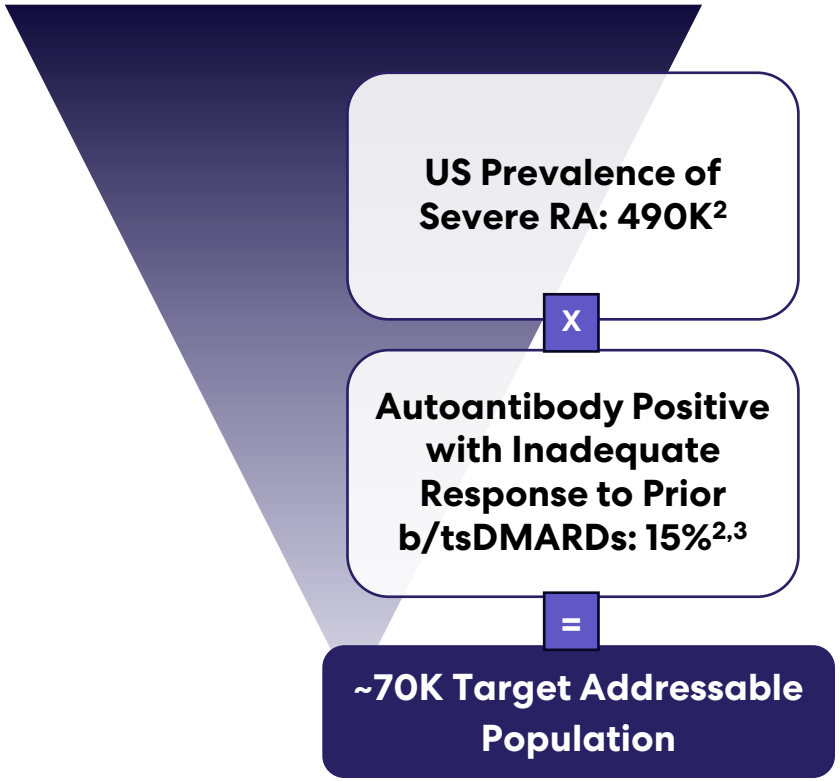
Deeper Is Better

- Phase 2 anti-FcRn RA data demonstrated that **greater IgG reduction led to greater autoantibody reductions**, which correlated with greater clinical response[3]

ACPA: anticitrullinated protein autoantibodies
1. Takanashi et al., Rheumatology (2021)
2. Aletaha and Smolen, JAMA (2018)
3. Taylor et al., ACR (2023)

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[1]

Market Opportunity



Patient Journey Learnings

Fewer than 50% of RA patients remain on first therapy	~50% of patients fail their first b/tsDMARD therapy within the first year of treatment [4,5]
D2T emerges for some in ~4 years	In a large US registry, the median time to meeting D2T criteria was 4 years, in those who were D2T[6]
5% - 20% of RA patients are D2T	5% – 20% of all RA patients meet the criteria for D2T in the US[6]

Note: All estimates are approximate; b/tsDMARD: biologic (b) or targeted synthetic (ts) disease-modifying antirheumatic drug

1. Aletaha and Smolen, JAMA (2018)
2. GlobalData Analysis and Forecast, 2023
3. Okada et al., Ann Rheum Dis (2019)
4. Murray et al., Arthritis Res Ther (2021)
5. Rosenberg et al., Adv Ther (2023)
6. Takanashi et al., Rheumatology (2021)

Cutaneous Lupus Erythematosus (CLE) Is a Debilitating Skin Condition With Minimal Current Treatment Options

Limited Treatment Options for CLE

- CLE is a rare, **chronic autoimmune disease affecting the skin, with limited available treatment options and high unmet need**
- No novel targeted treatment option in >50 years[1]

Up to ~75k Patients in the US

- Of the **~150K systemic and chronic CLE patients in the US,** ~50% are non-responders to anti-malarials and topicals

Autoantibody Pathology

- Biologic, translational and mechanistic evidence support the **critical role of IgG autoantibodies** and immune complexes in the pathogenesis of CLE

Early Proof of Concept Data

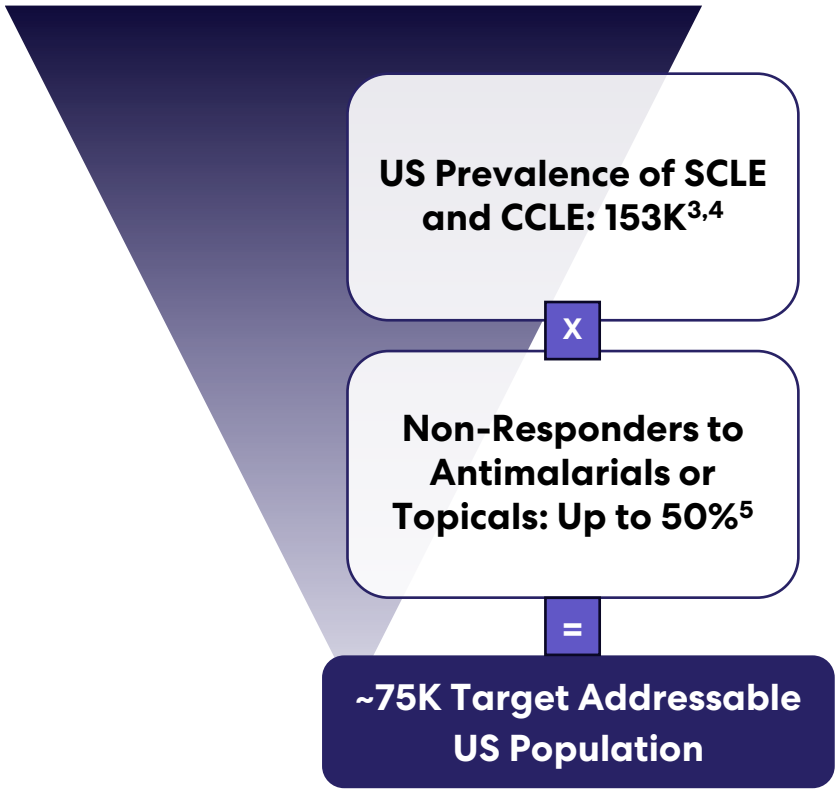
- Disruption of CLE pathology by upstream targeted approach supported by IMVT-1402 patient case studies
- **12-week treatment with IMVT-1402 in CLE demonstrated meaningful clinical benefit**

1. Presto and Werth, Curr Treat Opt Rheum (2016)

Dermatologists Desire a Skin-Focused, Targeted Biologic That Addresses Unmet Needs in CLE[1]

IMVT-1402 has potential to be the first novel dermatology therapy for CLE in >50 years[2]

Market Opportunity



Potential Differentiated Profile

Targeted Biologic	Dermatologists are frustrated by the skin-specific therapies currently available
Quick Control	Speed of action is critical to disease control and QoL- prevention of scarring and potential disfigurement[1]
Sustained Remission	90% of dermatologists cite sustained remission and reduced severity of flares as top unmet needs[1]
Improved Safety and Tolerability	80% of HCPs report lack of long-term efficacy, tolerability and toxicity risks with current CLE treatments[2]

1. Internal Market Research CLE Dermatologist Unmet Need (2023), Internal Market Research CLE Patient Journey (2024)
2. Presto and Werth, Curr Treat Opt Rheum (2016)
3. Jarukitsopa et al., Arthritis Care Res (2015)
4. IMVT Spherix Internal Market Research
5. Wahie and Meggitt, Br J Dermatol (2013)

Introducing Dr. Mark Lupo

Graves' Disease Thought Leader

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Why Are We Still Treating Graves' Disease Like It's 1950?

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Disclosures

Mark A. Lupo, MD

- Speaking, research, and/or consulting: AbbVie, Amgen, argenx, Eisai, Immunovant, Interpace Diagnostics, Lycia Therapeutics, QuidelOrtho, Takeda, Viridian

My Practice

- Established in 2002
- Independent center focused on thyroid and parathyroid disease
- 3 Endocrinologists
- We see/follow hundreds of Graves' disease patients
  - About half still on long-term antithyroid drug treatment

Patient Phenotypes

MILD (~50%)
- Small goiter
- +/- Slightly high T4/T3
- No TED/mild TED
- Modest TRAb elevation
- Predictable ATD response

MODERATE (~35-40%)
- +/- Goiter
- Overt hyper (T4/T3 elevation)
- +/- TED mild-moderate
- TRAb elevation >3-5x normal
- Multiple ATD dose changes

SEVERE (~10-15%)
- Large Goiter
- T4/T3 levels >4-5x normal
- TED present, often severe
- TRAb elevation >5x normal
- High ATD dose with unpredictable responses

Factors decreasing remission rates:
AGE <40
SEX – male
TOBACCO USE

TRAb Levels Are Associated With Medical Treatment Relapse Rates, Indicating an Autoimmune Pathology

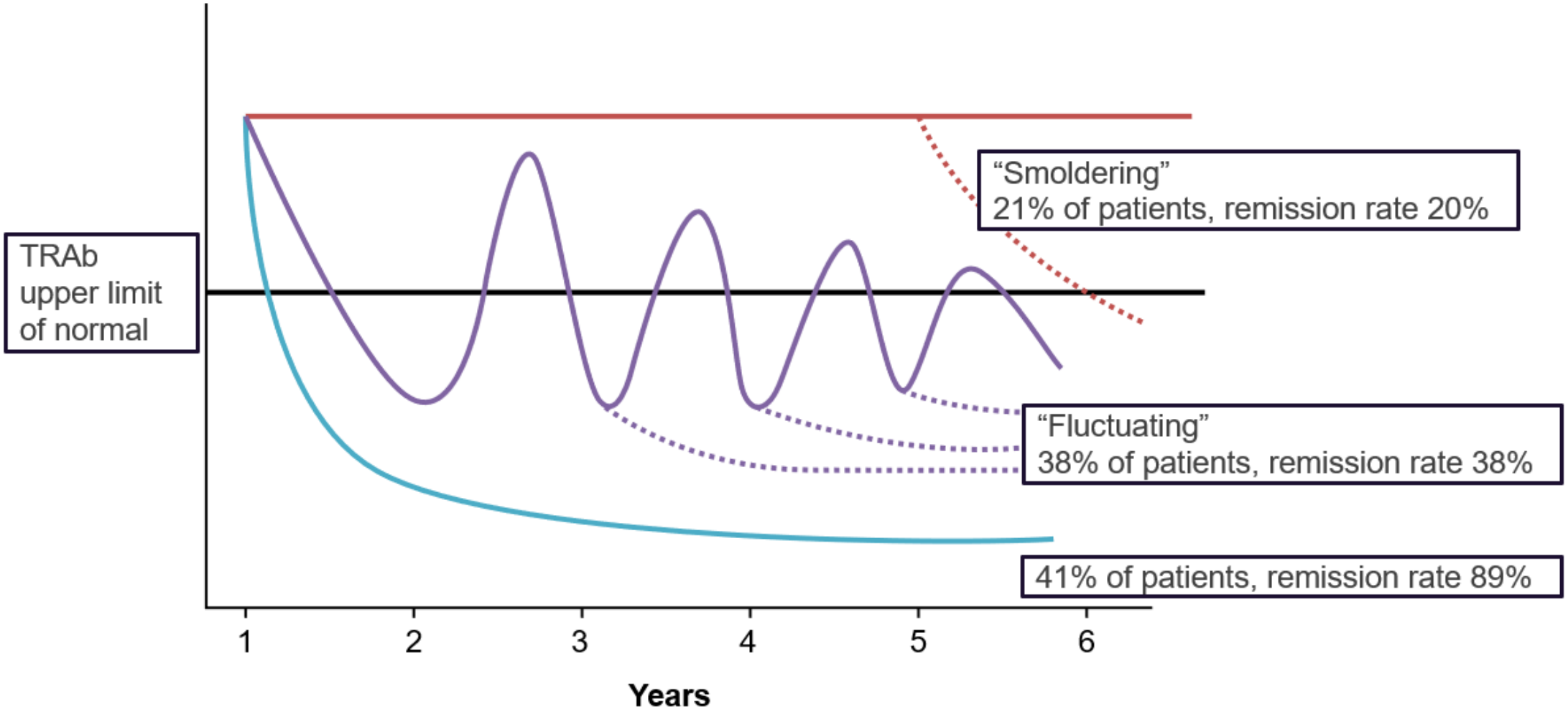
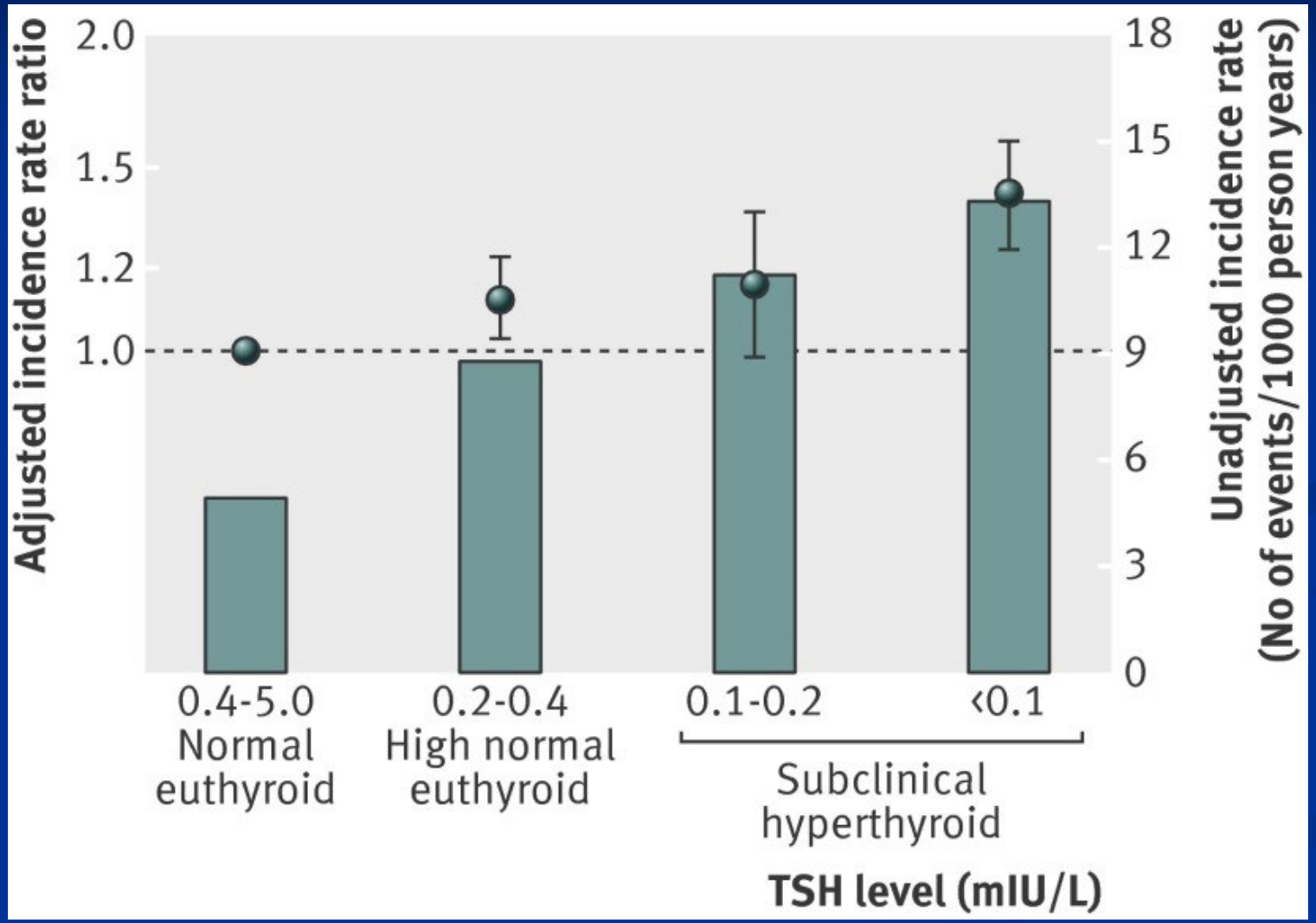


Figure adapted from Cooper D. *Curr Opin Endocrinol Diabetes Obes*. 2021;28(5):510-6. Used with permission of Wolters Kluwer Health, Inc.

Consequences of Uncontrolled Graves'

- Cardiovascular
  - Atrial Fibrillation → Stroke/Death
  - High Output Heart Failure → Morbidity/Death
  - Increased Clotting Risks → Stroke/Blood Clots
- Bone Loss → Osteoporosis/Fracture
- Thyroid Eye Disease → Vision Threatening
- Quality of Life Impact
  - Anxiety, Insomnia, Muscle Weakness, Tremor, Infertility

Atrial Fibrillation Risk with Hyperthyroidism



Registry Data of 586,460 Adults

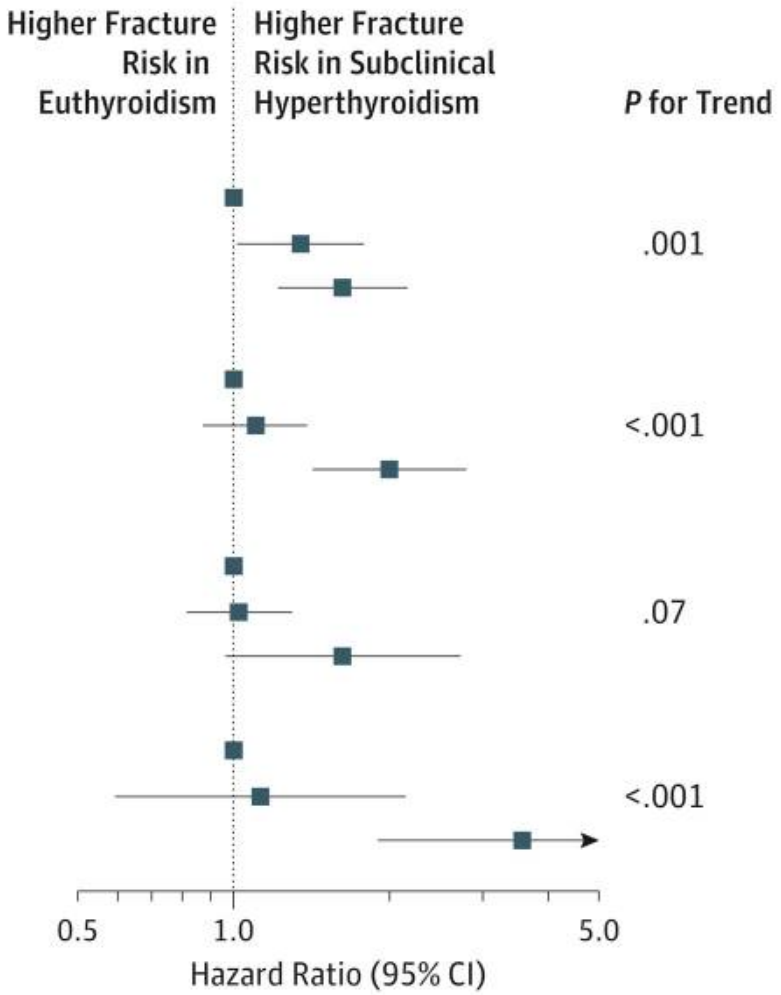
No Prior Atrial Fibrillation or Recorded Thyroid Disease

16,170 Atrial Fibrillation Events

Selmer C et al. BMJ 2012.

Fracture Risk by TSH

Fracture Outcome by Thyroid-Stimulating Hormone Levels, mIU/L	Euthyroidism		Subclinical Hyperthyroidism		Hazard Ratio (95% CI)	*P* for Trend
	No. With Fracture	Total No. of Participants	No. With Fracture	Total No. of Participants		
Hip fracture[a]						
0.45-4.49	2534	56471			1 [Reference]	
0.10-0.44			99	1568	1.34 (1.01-1.77)	.001
<0.10			47	510	1.61 (1.21-2.15)	
Any fracture[b]						
0.45-4.49	2203	25901			1 [Reference]	
0.10-0.44			77	676	1.10 (0.87-1.38)	<.001
<0.10			44	212	1.98 (1.41-2.78)	
Nonspine fracture[c]						
0.45-4.49	1745	21722			1 [Reference]	
0.10-0.44			74	757	1.02 (0.81-1.29)	.07
<0.10			32	185	1.61 (0.96-2.71)	
Spine fracture[d]						
0.45-4.49	255	20328			1 [Reference]	
0.10-0.44			9	566	1.12 (0.59-2.13)	<.001
<0.10			8	162	3.57 (1.88-6.78)	



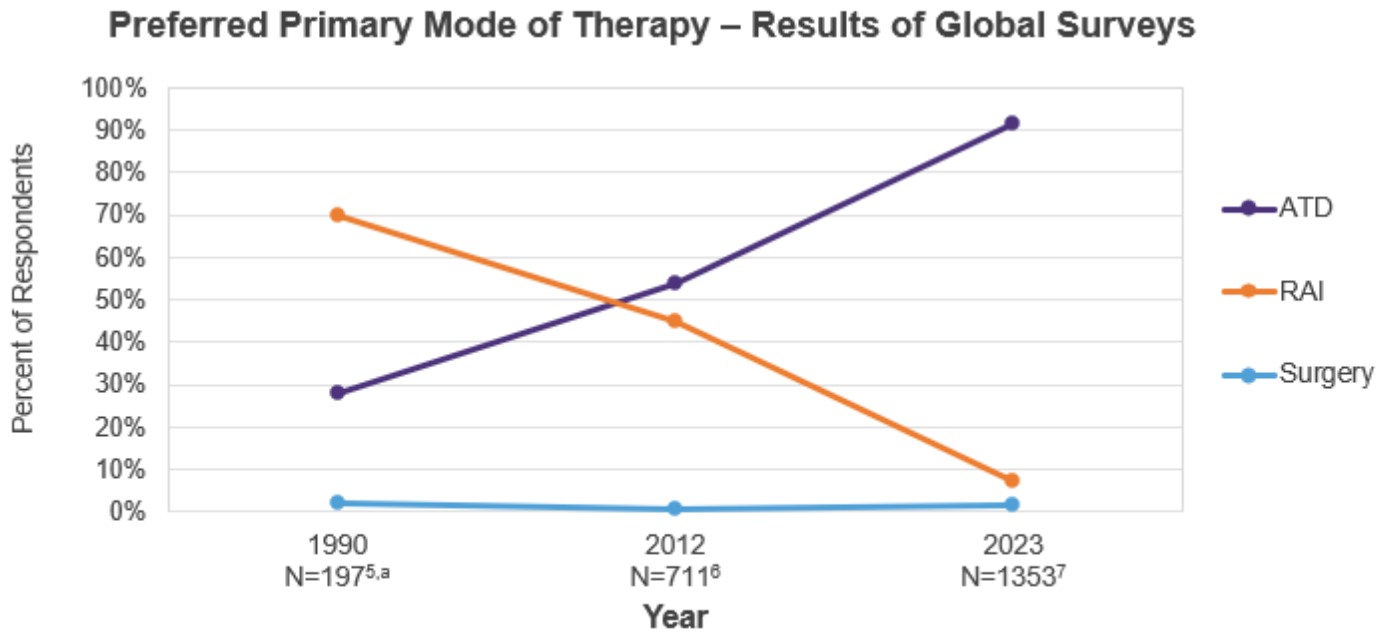
Blum M et al. JAMA 2015

Current Therapies for Graves' Disease Target the Thyroid Gland and Have Remained Largely Unchanged for 75 Years…

Treatment	MOA
ATDs	Inhibit thyroid hormone synthesis[1-3]
RAI	RAI-induced thyrocyte destruction[1,4]
Thyroidectomy	Removal of thyroid gland[1]

… but Practice Patterns for Graves' disease Are Evolving

ATDs are the Preferred First Line Therapy



[a]All respondents were residing in the US. GD, Graves' disease; MOA, mechanism of action.

References: 1. Kahaly GJ. *J Clin Endocrinol Metab.* 2020;105(12):3704-20. 2. [Pr]PROPYL-THYRACIL (propylthiouracil tablets USP) [prescribing information]. Paladin Labs Inc.; 2020. 3. Methimazole tablet [prescribing information]. AvKARE; 2025. 4. SODIUM IODIDE I 131 CAPSULES THERAPEUTIC [prescribing information]. Mallinckrodt Nuclear Medicine LLC; 2018. 5. Solomon B, et al. *J Clin Endocrinol Metab.*1990;70(6):1518-1524. 6. Burch HB, et al. *J Clin Endocrinol Metab.* 2012;97(12):4549-4558. 7. Villagelin D, et al. *J Clin Endocrinol Metab.* 2024:dgae222.

Definitive Treatment Discussion

- Radioactive Iodine
  - Increased risk TED
  - TRAb elevation
  - Radiation exposure
  - **Permanent hypothyroidism**
- Thyroidectomy
  - Indicated if concern for cancer or large obstructive goiter
  - Higher risk*
    - Hypoparathyroidism
    - Post-operative bleeding
    - Tracheostomy
  - Scar
  - **Permanent Hypothyroidism**

*relative to thyroid surgery for other indications

Quality of Life after Definitive Treatment

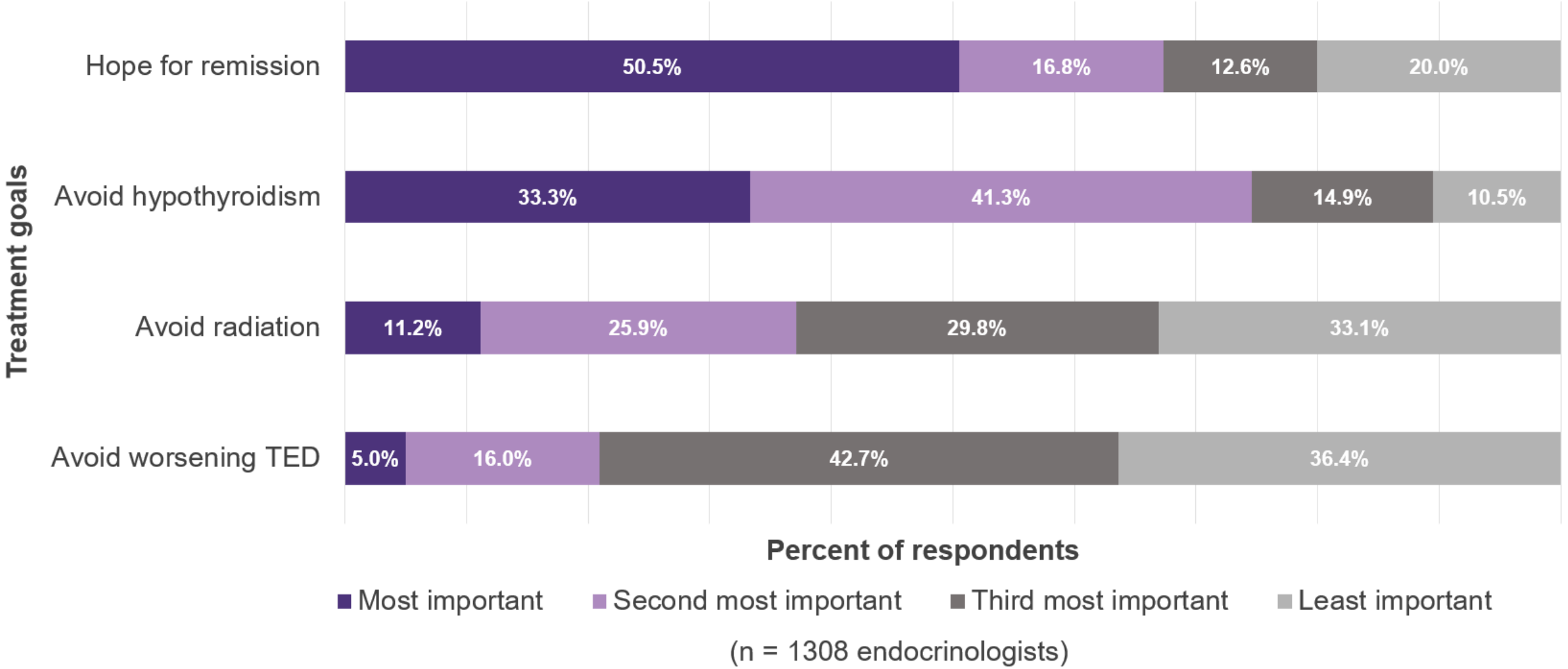
- Hypothyroid patients consistently report lower scores on QOL scales compared to general population
- Treatment specific complications
- 1 in 4 patients still feel "unwell" but often told they are fine due to normal thyroid labs

Long-term Outcomes

- 2430 GD patients diagnosed 2003-2005
- 60% had follow-up data mean 8 years
- Remission rates: ATD-45%, RAI-82%, Surgery-96%
  - ATD, second course 29% remission rate
- Patients receiving ATD had 50% chance of avoiding definitive treatment and 40% chance of achieving euthyroid state
- Overall, 25% patients did not feel "fully recovered" long-term

Sjolin et al. Thyroid 2019

Remission and Avoiding Hypothyroidism Are the Primary Treatment Goals



TED, thyroid eye disease.

Reference: Villagelin D, et al. *J Clin Endocrinol Metab*. 2024;109(11):2956-2966.

Approximately 50% of Patients with Graves' Disease Relapse After Stopping Medical Therapy

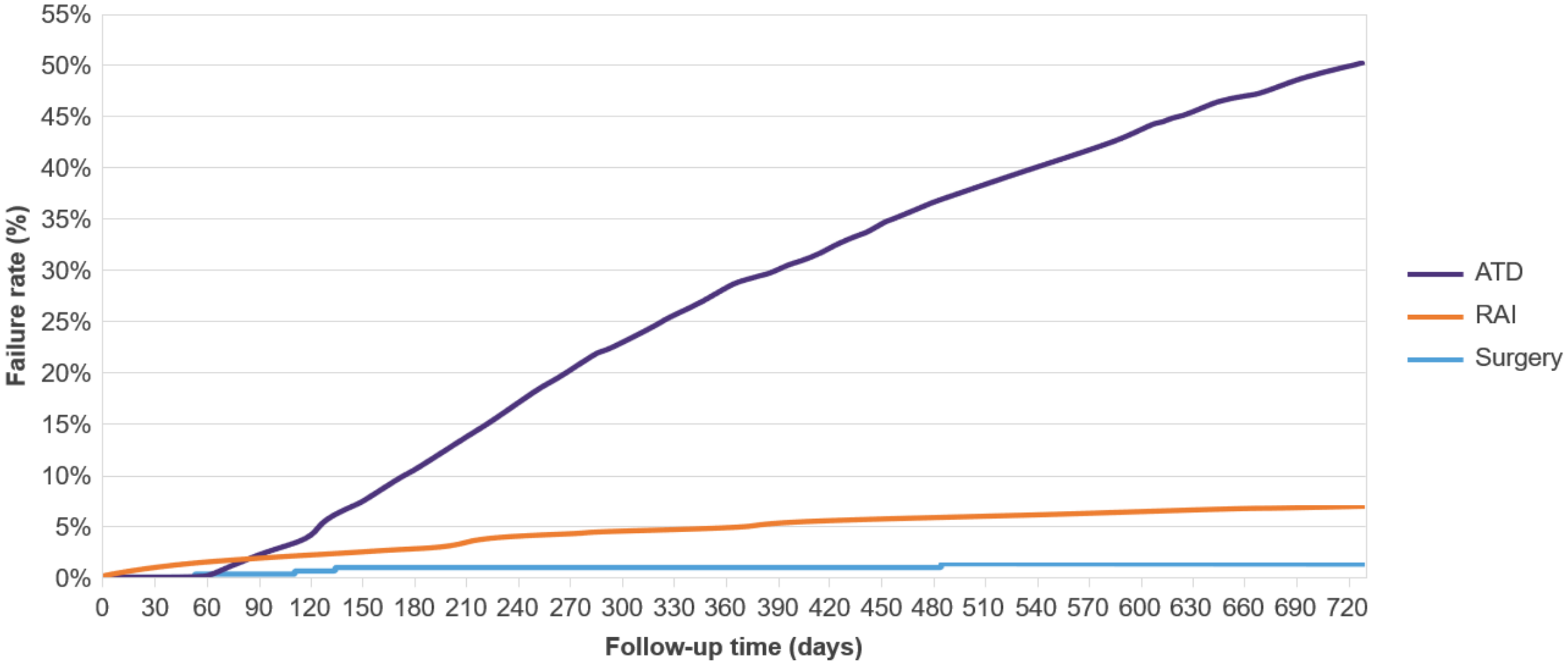


Figure adapted from Brito JP, et al. *Thyroid*. 2020;30(3):357-64. Used with permission of Mary Ann Liebert, Inc.

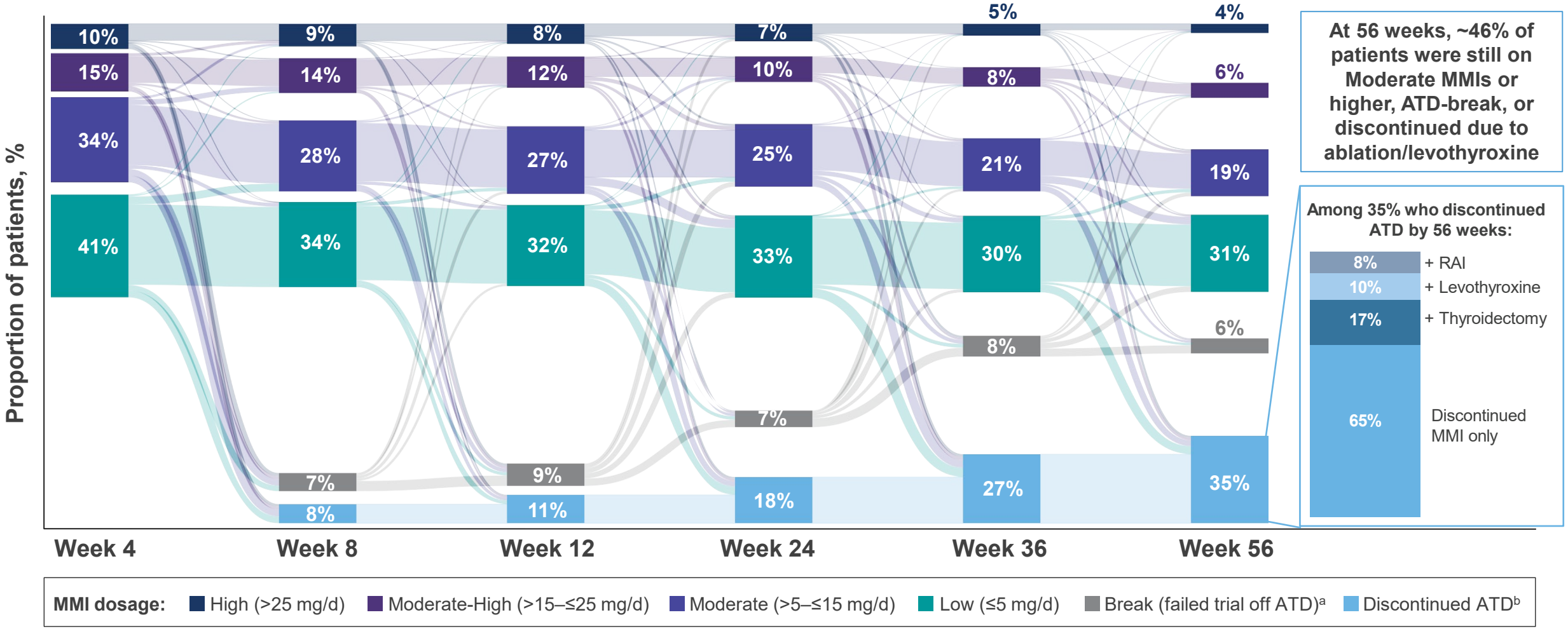
Real-World Treatment Patterns of Methimazole (MMI) Use in the United States

Study Objective
To evaluate dosage and treatment patterns following MMI initiation among patients with Graves' disease in the US

Study Methods	
Data Source	IQVIA Open Claims and PharMetrics Plus databases
Time Period Analyzed	November 2017 to October 2023
Inclusion Criteria	Patients with a GD diagnosis within 3 years prior to or 2 years after an MMI prescription
Index Date	Date of the first MMI prescription claim from November 2020 through October 2021
Follow-Up Assessment	Patients were followed for 104 weeks from their first MMI prescription to evaluate treatment patterns

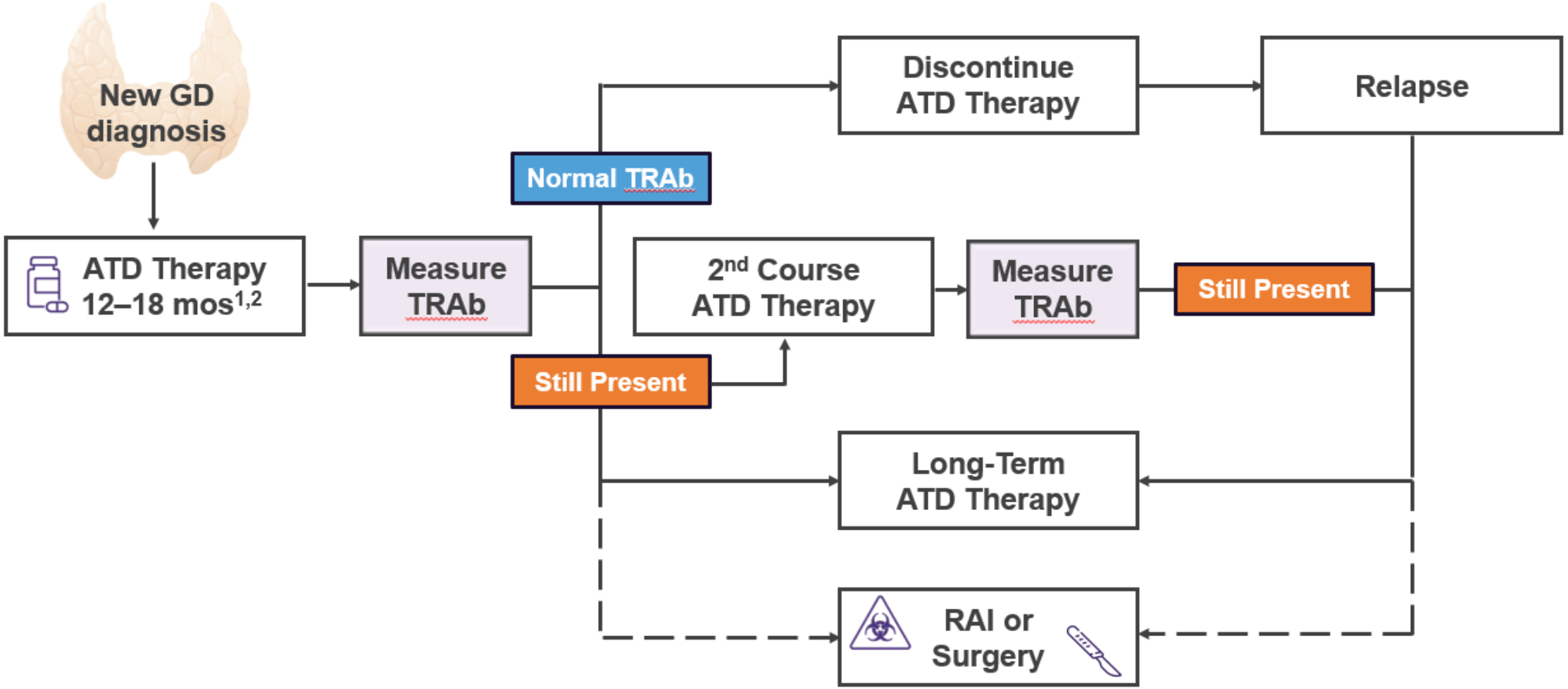
GD, Graves' disease; MMI, methimazole. Lupo m et al. Treatment Patterns Among Methimazole-Treated Patients With Graves' Disease. Poster #1112323 Presented at 17th International Thyroid Congress (ITC), June 21, 2025, Rio de Janeiro, Brazil.

Longitudinal Patient Dose Journey After First MMI Dose, by Starting Dose (N = 46,373)



ATD, antithyroid drug; d, day; MMI, methimazole. [a] Failed trial off ATD: Patient was off therapy for the period but later returned to ATD during the study. [b]Discontinued therapy: Patient remained off therapy for the remainder of the study (up to 104 weeks). Lupo m et al. Treatment Patterns Among Methimazole-Treated Patients With Graves' Disease. Poster #1112323 Presented at 17th International Thyroid Congress (ITC), June 21, 2025, Rio de Janeiro, Brazil.

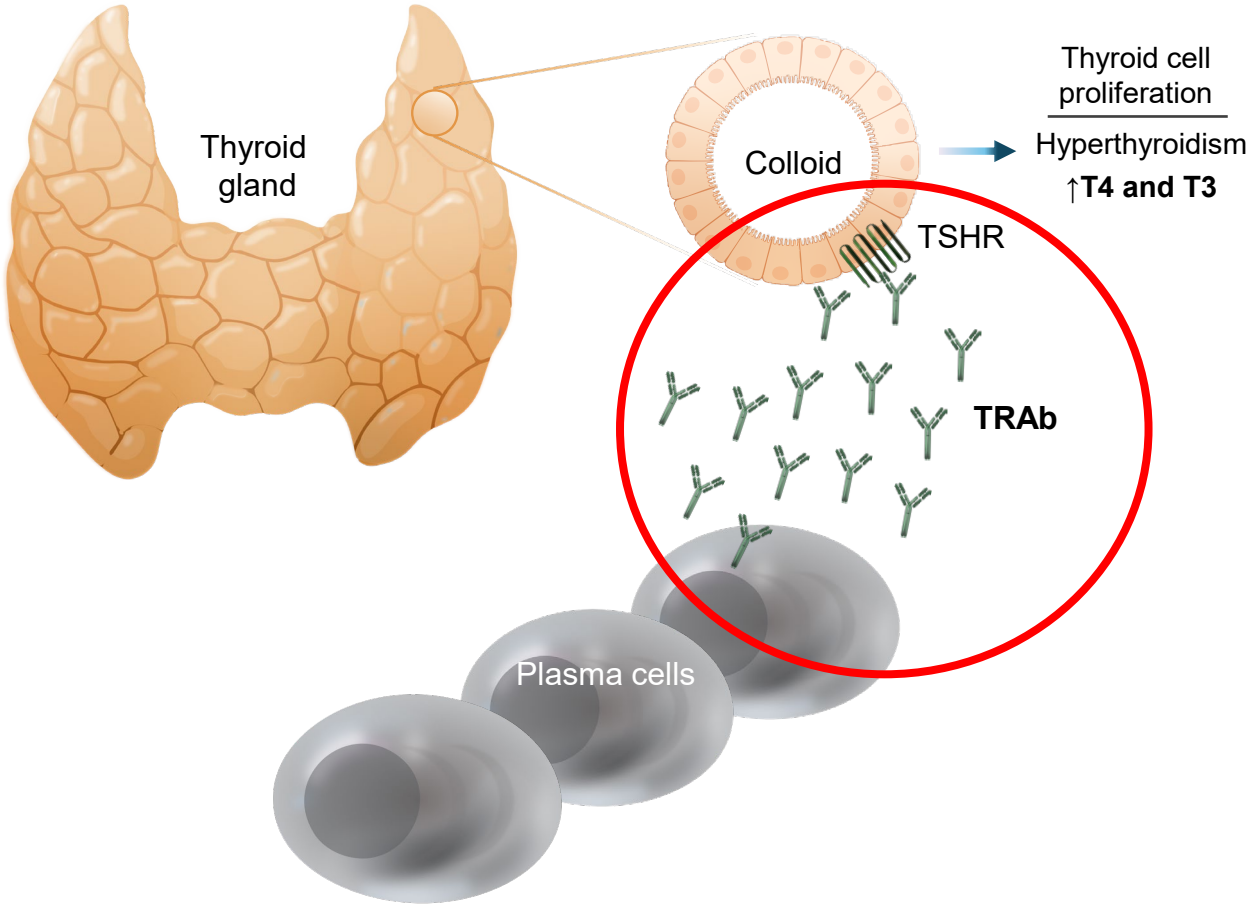
Current Recommendations for the Management of Graves' Disease



ATD, antithyroid drug; GD, Graves' disease; RAI, radioactive iodine; TRAb, thyroid-stimulating hormone receptor antibodies.

References: 1. Kahaly GJ, et al. *Eur Thyroid J*. 2018;7:167-86. 2. Ross DS, et al. *Thyroid*. 2016;26(10):1343-421.
3. Cooper DS. *Curr Opin Endocrinol Diabetes Obes*. 2021;28:510-6

Unmet Needs in Graves' Disease



Standard of Care

- Current therapies do **not target** the underlying autoimmune response[1]
- While a significant proportion of patients respond to ATD therapy, up to **~25%** are unable to complete their initial course[2]
- **~50% remission** rate after stopping ATD therapy[3,4]
- Positive **TRAb** levels are associated with markedly increased **relapse** rates[5]

ATD, antithyroid drug; T3, triiodothyronine; T4, thyroxine; TRAb, thyroid-stimulating hormone receptor-binding autoantibodies.

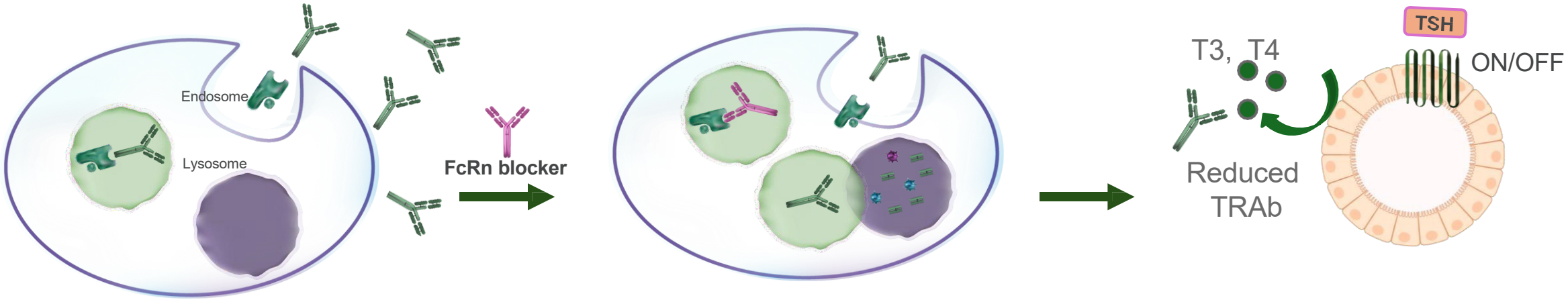
1. Bartalena L. *Nat Rev Endocrinol*. 2013;9(12):724-34. 2. Sjolin G, et al. *Thyroid*. 2019;29(110):1545-67. 3. Liu L, et al. *Exp Ther Med*. 2016;11(4):1453-58. 4. Chung *J. Endocrinol Metab*. 2021;36(3):491-99. 5. Da Silva Santos T, et al. *Cureus*. 2022;14(2):e22190.

Rationale for Treatment of GD With an FcRn Blocker

Endothelial cell recycles anti-TSHR autoantibodies (TRAb)

FcRn blocker blocks FcRn-mediated IgG recycling in circulation

Thyroid follicles activated by natural ligand, TSH



In the absence of FcRn blocker, FcRn binds to the anti-TSHR Ab, inhibiting their degradation and returning them into the circulation

In the presence of FcRn blocker, FcRn is blocked from binding to anti-TSHR Ab, which are then transported to the lysosome for degradation, decreasing their levels in the circulation

Potential for reduced stimulation of TSHR by pathogenic TRAb which may potentially alleviate systemic symptoms

Legend: FcRn; Thyrotropin Receptor (TSHR); Anti-TR autoantibodies; FcRn blocker; T3, T4 Thyroid hormones; TSH; Thyroid stimulating hormone; Thyroid follicle

Ab, antibodies; FcRn, neonatal fragment crystallizable receptor; GD, Graves' disease; T3, triiodothyronine; T4, thyroxine; TRAb, thyroid-stimulating hormone receptor antibodies; TSH, thyroid-stimulating hormone; TSHR, thyroid-stimulating hormone receptor.

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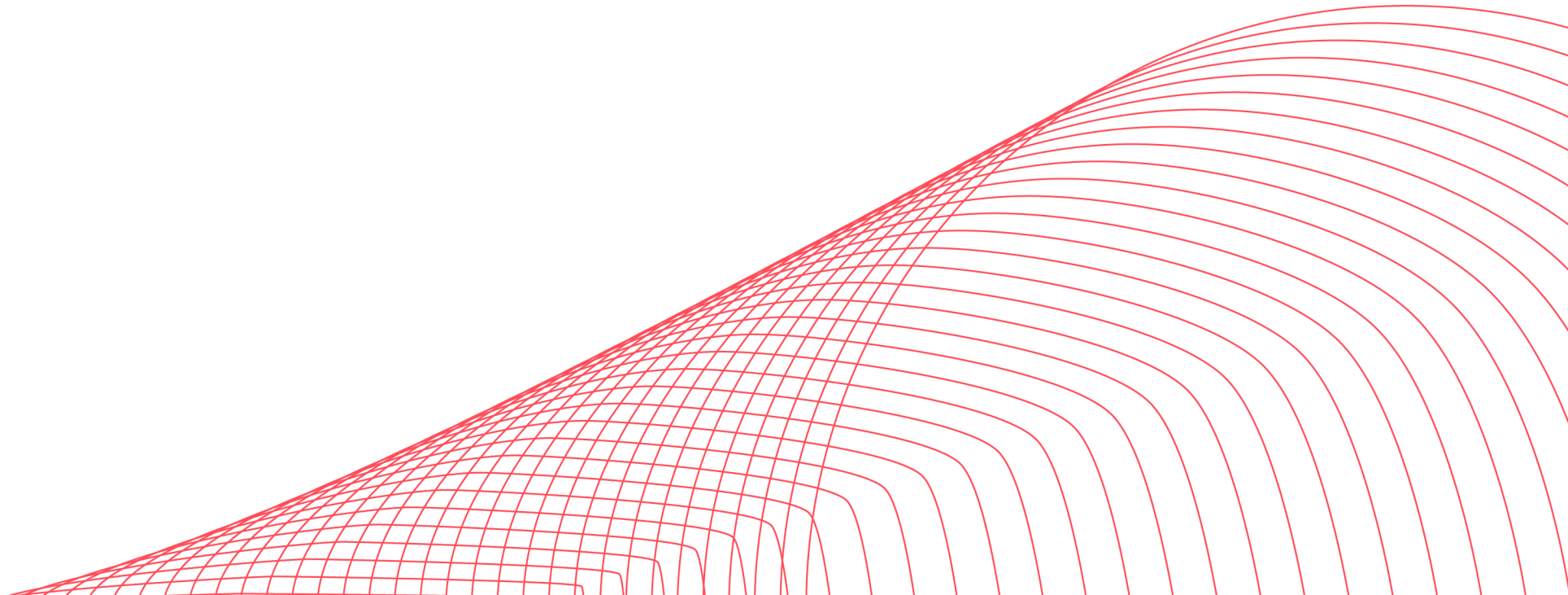
Paving the Path Forward in Graves' Disease



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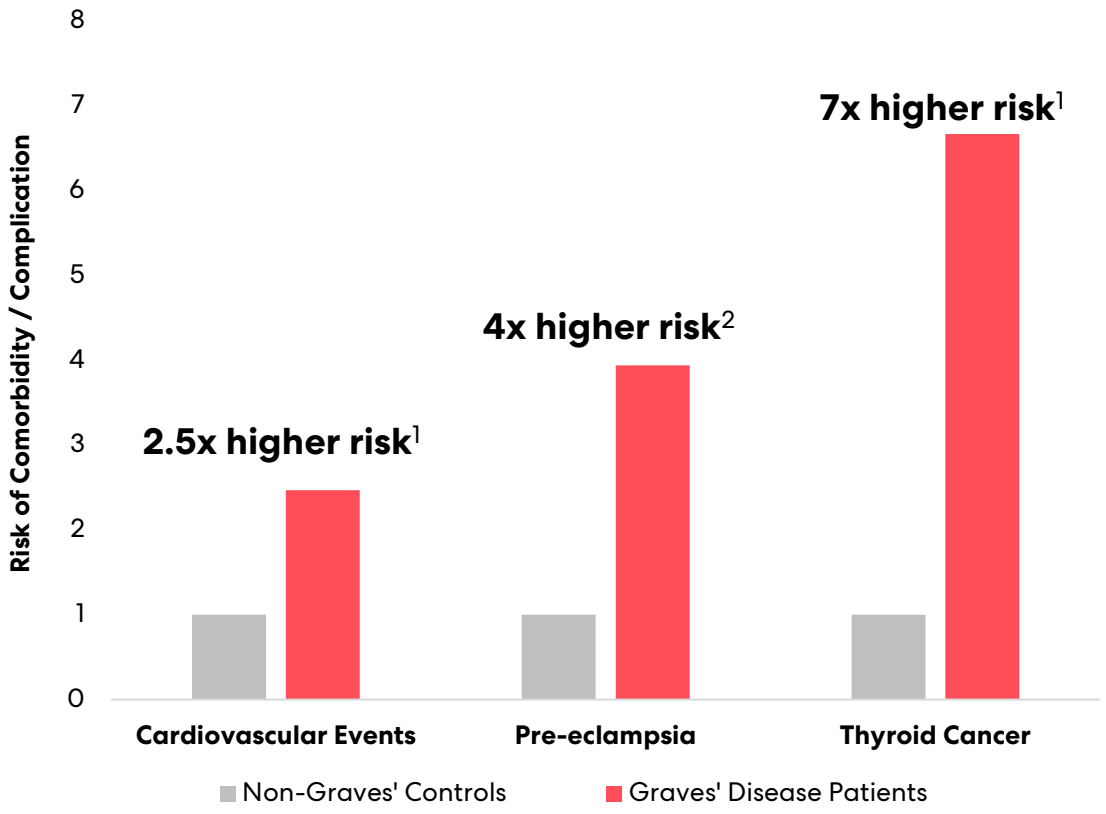
Graves' Disease Patients Have Higher Risk of Sequelae of Severe Comorbidities

Relative to Healthy Controls, Graves' Patients Are at Increased Risk of Developing Several Severe Comorbidities



Untreated or Insufficiently Treated Graves' Patients Experience Substantial Morbidity and Loss of Quality of Life

Thyroid Eye Disease (TED)

- TED affects ~40% of patients diagnosed with Graves' disease[3]
  - Up to 8% of TED patients experience dysthyroid optic neuropathy (impairment of visual function, leading to permanent sight loss)[4]

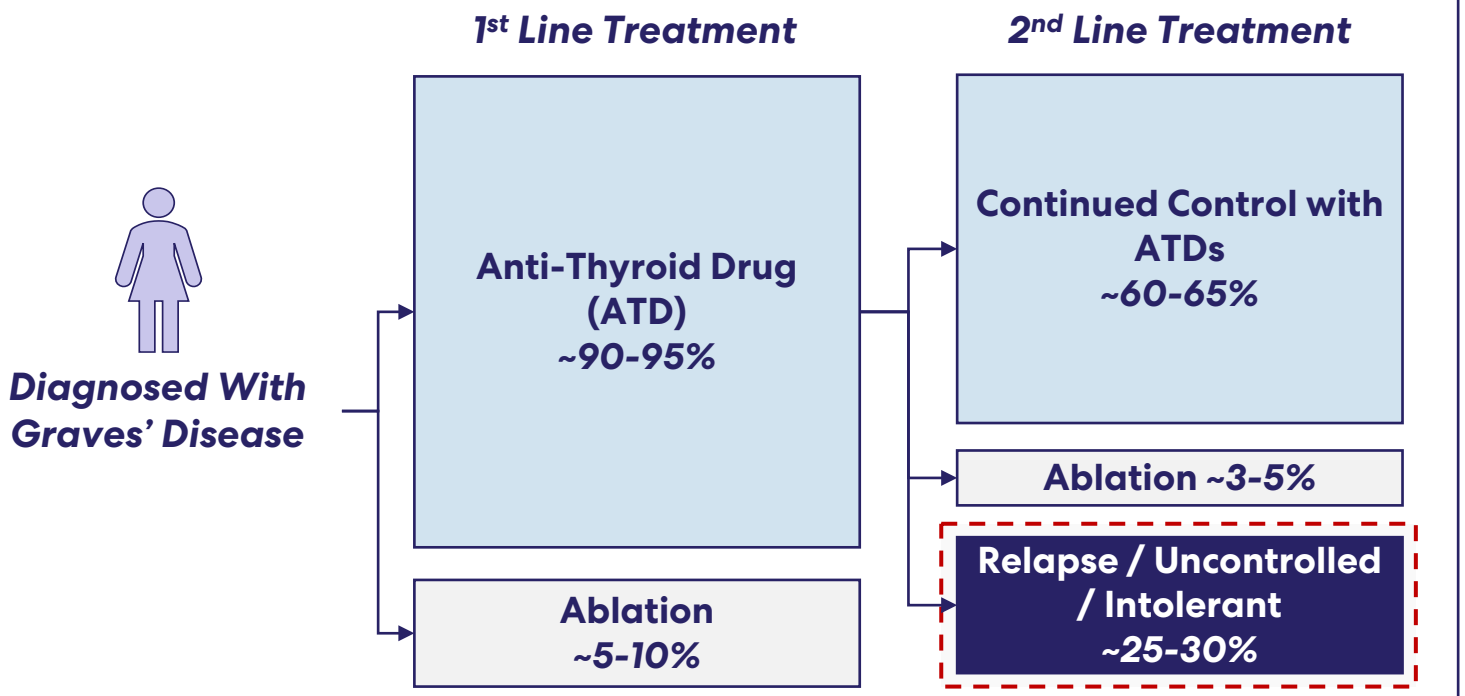
Other Significant Complications

- In patients hospitalized for Graves' disease, ~16% are diagnosed with thyroid storm[5], which has a ~20% mortality rate[6]
- Graves' disease patients who develop thyroid cancer are at a >3x risk of recurrent disease / progressive distant metastases relative to euthyroid controls[7]

1. Okosieme et al., Lancet Diabetes Endocrinol (2019)
2. Aggarwal et al., Gynecol Obstet Invest (2014)
3. Chin et al., Clin Endocrinol (Oxf.) (2020)
4. Potvin et al., Ophthalmic Plast Reconstr Surg (2023)
5. Galindo et al., Thyroid (2019)
6. Bourcier et al., Crit Care Med (2020)
7. Pellegriti et al., J Clin Endocrinol Metab (1998)

Shift Away From Ablation and Lack of New Medical Therapies Leaves 25-30% of Patients Who Are Relapsed, Uncontrolled, or Intolerant to ATDs

Graves' Disease Patient Journey:



Unmet Need

- 25-30% of patients are relapsed, uncontrolled on or intolerant to ATDs
- Ablation rates in the US indicate that despite lack of disease control on ATDs, patients are choosing not to pursue ablation
- Patients and healthcare providers seek therapeutic options that address underlying disease pathology

1. Values presented have been triangulated based on primary research (Immunovant Physician Primary Research (N=140 endocrinologists)) and claims analysis

Graves' Patients Uncontrolled on ATDs Experience Significant Disease Burden and Risk of Adverse Events With Limited Alternative Treatment Options

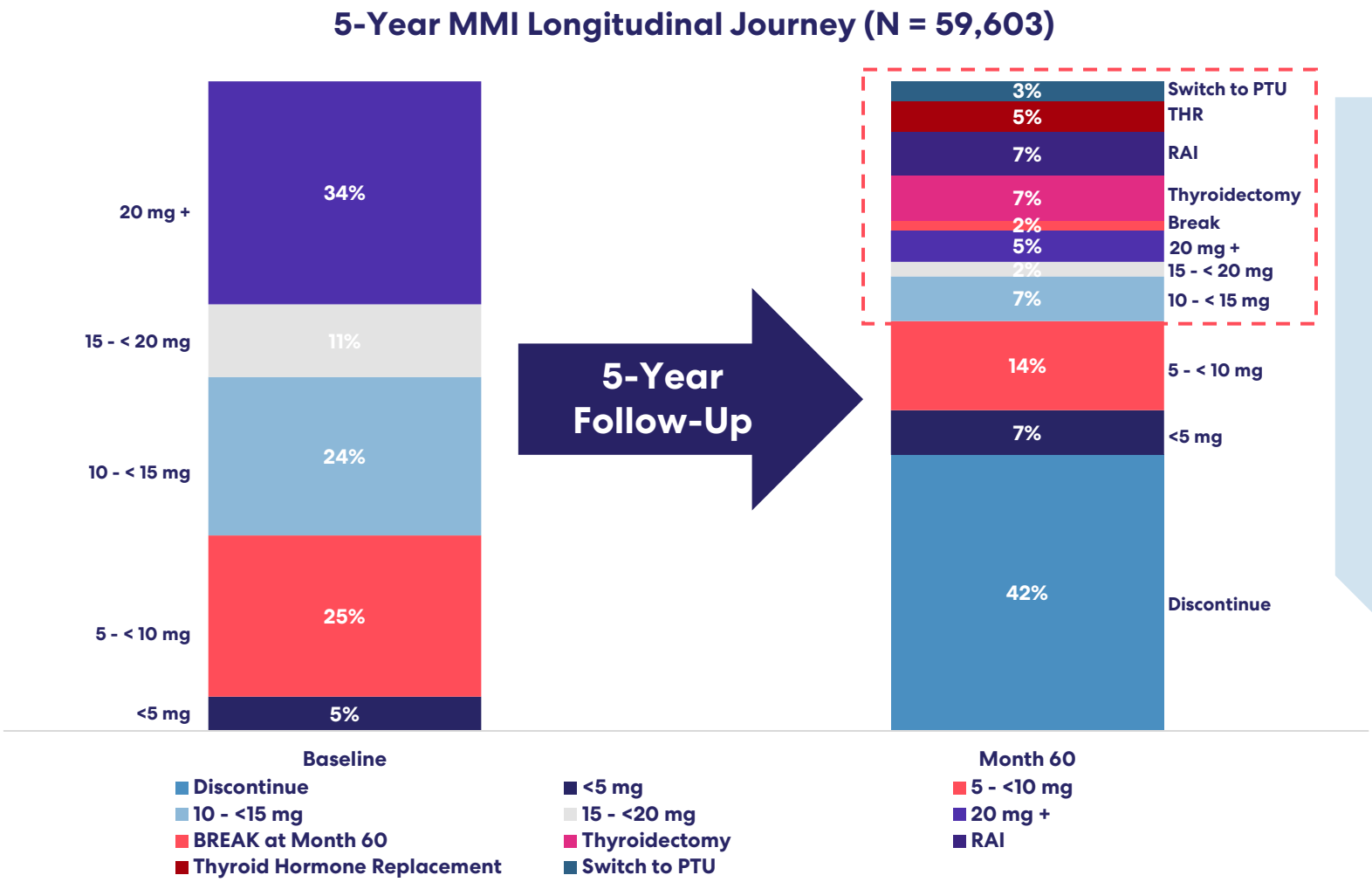
RAI and surgery are associated with **significant complications** including increased risk of death from solid cancers; patients are often hypothyroid and require **lifelong thyroid hormone replacement**[1,2]

Chronic ATD use can be associated with risk of severe adverse events, such as **hepatotoxicity**, **pancreatitis**, and **agranulocytosis** (loss of white blood cells)[4-6]

Uncontrolled Graves' patients are at risk for a sequelae of **severe comorbidities** (e.g., **cardiovascular events**, **thyroid cancer**) and experience significant **anxiety** and **impact to quality of life**[7-8]

1. Sundaresh et al., J Clin Endocrinol Metab (2013)
2. Kitahara, et al., JAMA Intern Med (2019)
3. Suzuki et al., Thyroid (2019)
4. Smith and Hegedüs, N Engl J Med (2016)
5. Brix et al., ETA 2019
6. Okosieme et al., Lancet Diabetes Endocrinol (2019)
7. Cramon et al., Thyroid (2016)

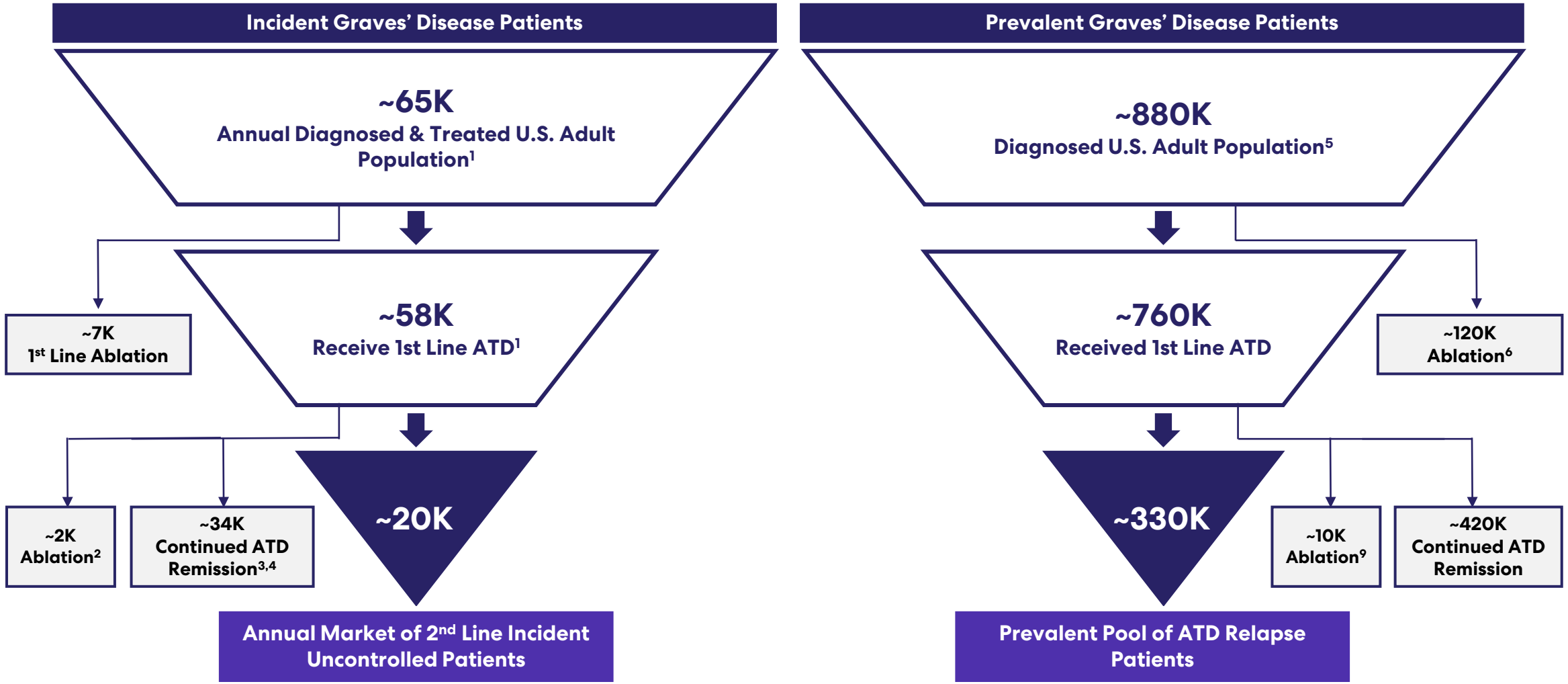
Follow-Up of Graves' Disease Patient Methimazole Dosing Shows Significant Percent of Patients Remaining on ATDs After 5-Years



- In a 5-year follow-up period, only 42% of patients were controlled on ATDs alone
- ~37% of patients were on ≥10 mg MMIs, break, switched to PTU, received thyroid hormone replacement or ablation

Source: Roivant claims analysis
Patients continuously enrolled from 2016 - 2024, newly diagnosed in 2019, 5 years of follow up data from initial MMI script

Graves' Disease Market Opportunity Includes Annual Incident Population and a Significant Untapped Prevalent Patient Pool



1. Roivant Claims Analysis – 2021 incident patient population, first-line treatment is primary treatment in the first-year post diagnosis, claims review included a five-year lookback to define the incident population 2. Grove-Laugesen et al., Thyroid (2023): Completer rates for combined arms: ATD remission 56.0%, continuing ATD 18.8%, ATD relapse of 21.8%, ablation of 3.4%. Of the 58K 1st line ATD patients, a total of ~75% are either in remission (56.0%: 32.5K) or continued ATDs (18.8%: 10.9K) 3. Azizi et al., Thyroid (2019): ATD remission for patients on long-term ATDs is 85%. Of the 10.9K patients who continued ATDs, 15% relapse (1.6K) and 85% go into remission (9.3K). These 9.3K patients in remission will have a 15% rate of relapse resulting in 1.4K relapses. From the original 10.9K patients who continued on ATDs, there will be a total of 3K (1.4K +1.6K) relapses, 4. Stokland et al., J Clin Endocrinol Metab. (2023): Relapse post remission 15%. Of the 42K patients who are in remission, 15% will relapse (6.3K). In total, the late relapses from remission and continued ATDs will be ~9.3K, resulting in a weighted average relapse rate of ~19% (6.3K relapses from the 32.5K patients in remission averaged with the 3K relapses from the 10.5K patients who continued on ATDs). 5.Roivant Claims Analysis – 2022 prevalent patient population based on a two-year lookback for diagnosis. Of the 120K patients ablated, ~80K were ablated prior to 2021 and ~40K were ablated in 2021/2022 6.Azizi et al., Thyroid (2019): Relapse rate was calculated as a weighted average considering relapse rate in patients on ATDs <18months is 53% compared to patients on ATDs >18months is 15%. Of the 570K patients treated with ATDs, ~470K are on ATDs <18months and ~100K are on ATDs for >18months. Rates have been applied proportionally. 7.Bandai et al., Endocr J (2019): Of the ~190K patients previously treated with ATDs and currently monitored off-therapy, ~40% experience relapse, which is 75K. 8.Grove-Laugesen et al., Thyroid (2023): 3.4% of ATD relapse patients will pursue ablation. 3.4% applied to the ~340K ATD treatment relapse patients is ~10K

Potential for Disease Modification With Responders Demonstrating Strong Durability of Response Through Six Months Off-Treatment

Treatment Period: 24 weeks		Follow-up: 24 weeks
680 mg batoclimab QW SC (Week 0-12)	340 mg batoclimab QW SC (Week 12-24)	Off-Treatment (Week 24-48)

Baseline

Week 12
Pts receive 12 weeks of 680 mg QW batoclimab[1]

Dose step-down

Week 24
Pts receive 12 weeks of 340 mg QW batoclimab[1]

Week 48
Patients off-drug for 24 weeks[1,2]

25
Uncontrolled Graves' disease patients

20/25
T3/T4 ≤ULN; ATD dose ≤Baseline

18/25
T3/T4 ≤ULN; ATD dose ≤Baseline

17/21
T3/T4 ≤ULN; ATD dose ≤Baseline[3]

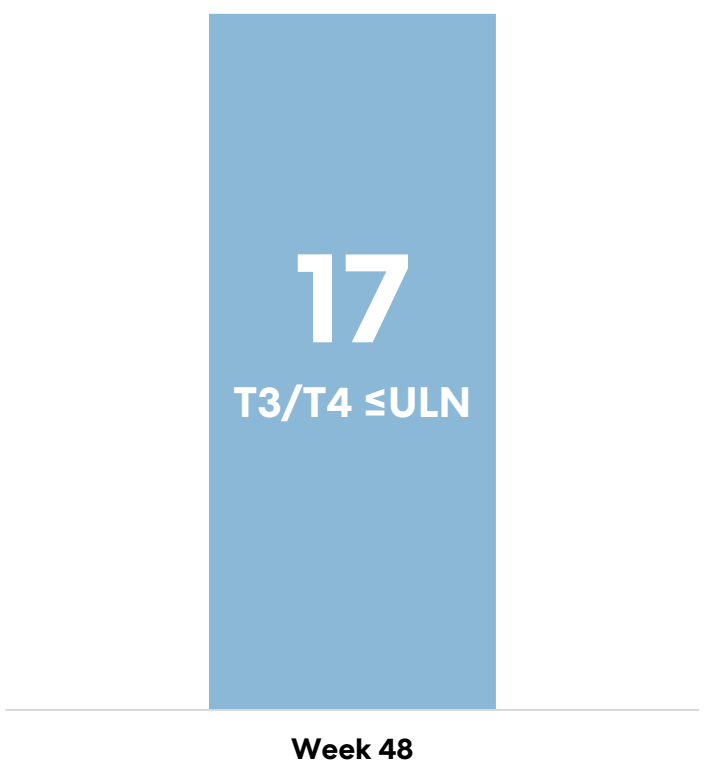
Strong durability of response despite being off-batoclimab for six months

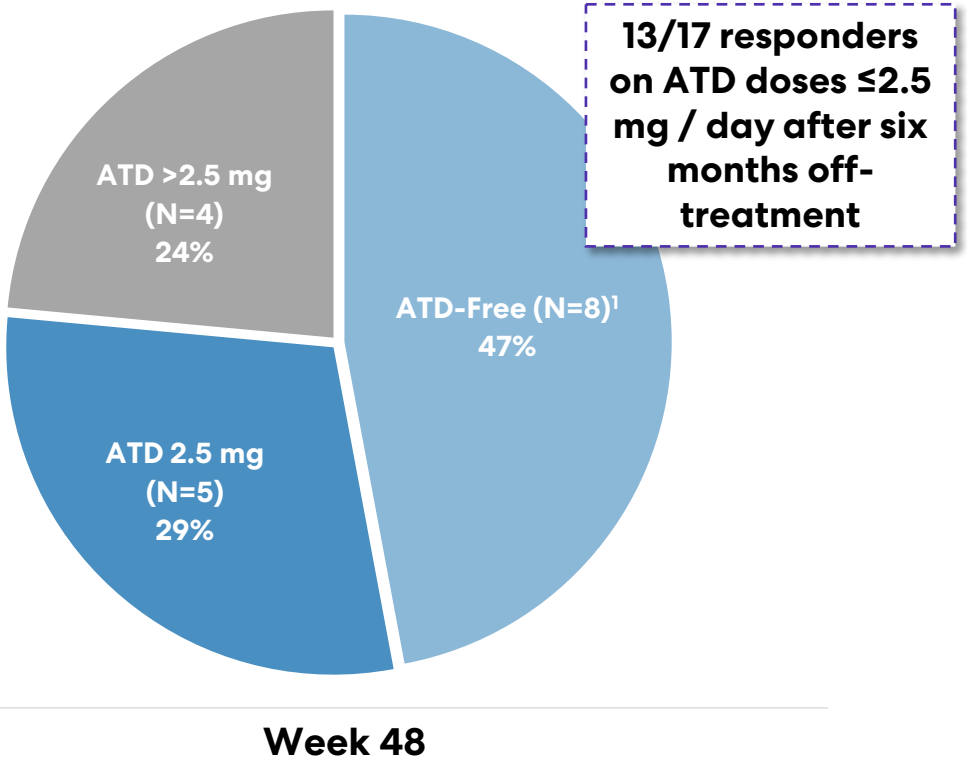
1. Includes N=1 patient who discontinued prior to Week 12 but remained in off-drug follow-up.
2. Includes N=21 patients who entered follow-up period and could be assessed for remission.
3. N=1 patient had T3/T4 ≤ULN, and one day following Week 48 visit had ATD dose equivalent to baseline.

Responders: Patients who have T3 and T4 values ≤ULN and no increase in ATD dose from baseline. Pts: Patients; T3: Triiodothyronine; T4: Thyroxine; ULN: Upper limit of normal; ATD: Anti-thyroid drug.

~50% of Responders at Week 48 Achieved ATD-Free Remission, Demonstrating Strong Potential for Disease Modification by a High-Dose FcRn

Treatment Period: 24 weeks		Follow-up: 24 weeks
680 mg batoclimab QW SC (Week 0-12)	340 mg batoclimab QW SC (Week 12-24)	Off-Treatment (Week 24-48)





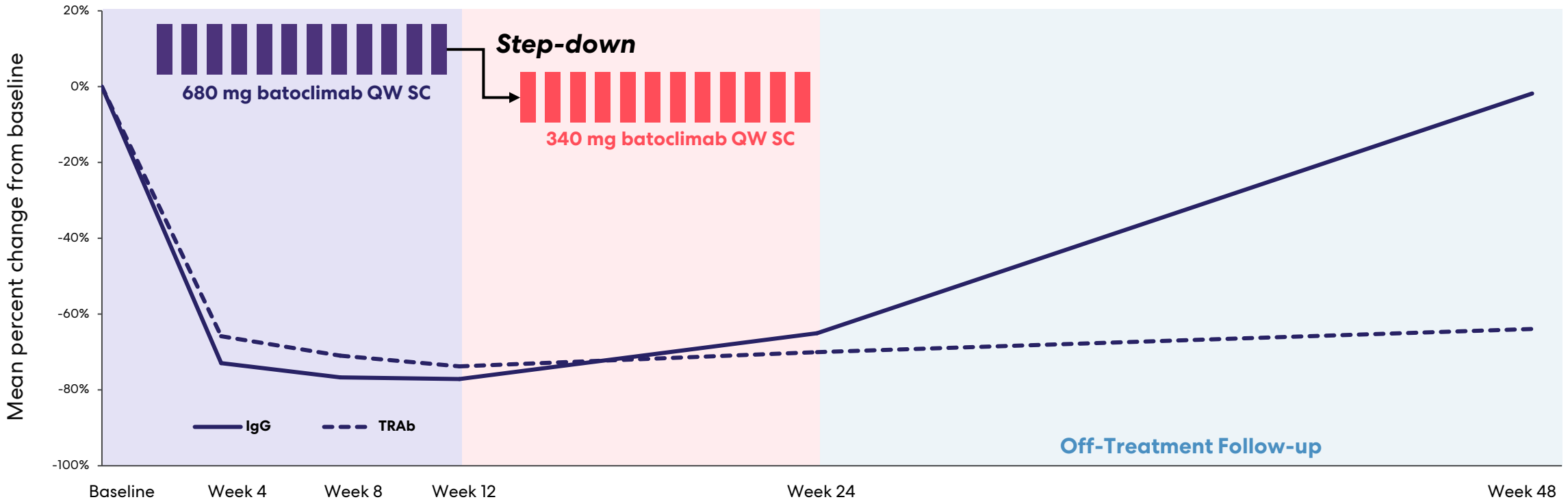
13/17 responders on ATD doses ≤2.5 mg / day after six months off-treatment

8 of 17 Patients With Normal T3/T4 at Week 48 Were in ATD-Free Remission

1. Includes N=1 patient who discontinued prior to Week 12 but remained in off-drug follow-up.
Responders: Patients who have T3 and T4 values ≤ULN and no increase in ATD dose from baseline. T3: Triiodothyronine; T4: Thyroxine; ULN: Upper limit of normal; ATD: Anti-thyroid drug; FcRn: Neonatal fragment crystallizable receptor inhibitor.

Sustained TRAb Reductions Post-Batoclimab Treatment Further Demonstrate Potential for Disease Modification

Treatment Period: 24 weeks		Follow-up: 24 weeks
680 mg batoclimab QW SC (Week 0-12)	340 mg batoclimab QW SC (Week 12-24)	Off-Treatment (Week 24-48)



Notes: Data includes up to last measurement available for patients who discontinued.
IgG: Immunoglobulin G; TRAb: Thyroid Stimulating Hormone Receptor Antibody; QW: Once weekly; SC: Subcutaneous. Patient counts at each time include Baseline (N=25), Week 12 (N=24), Week 24 (N=23), Week 48 (N=19).

IMVT-1402 Could Potentially Be the First-in-Class Disease-Modifying Therapy in Graves' Disease

01 Remarkable effect seen in uncontrolled Graves' disease patients: 18 of 25 patients treated with batoclimab are responders at Week 24

02 Durable off-drug response: of the 21 patients who entered the off-drug follow-up period, 17 remain responders six months following batoclimab treatment

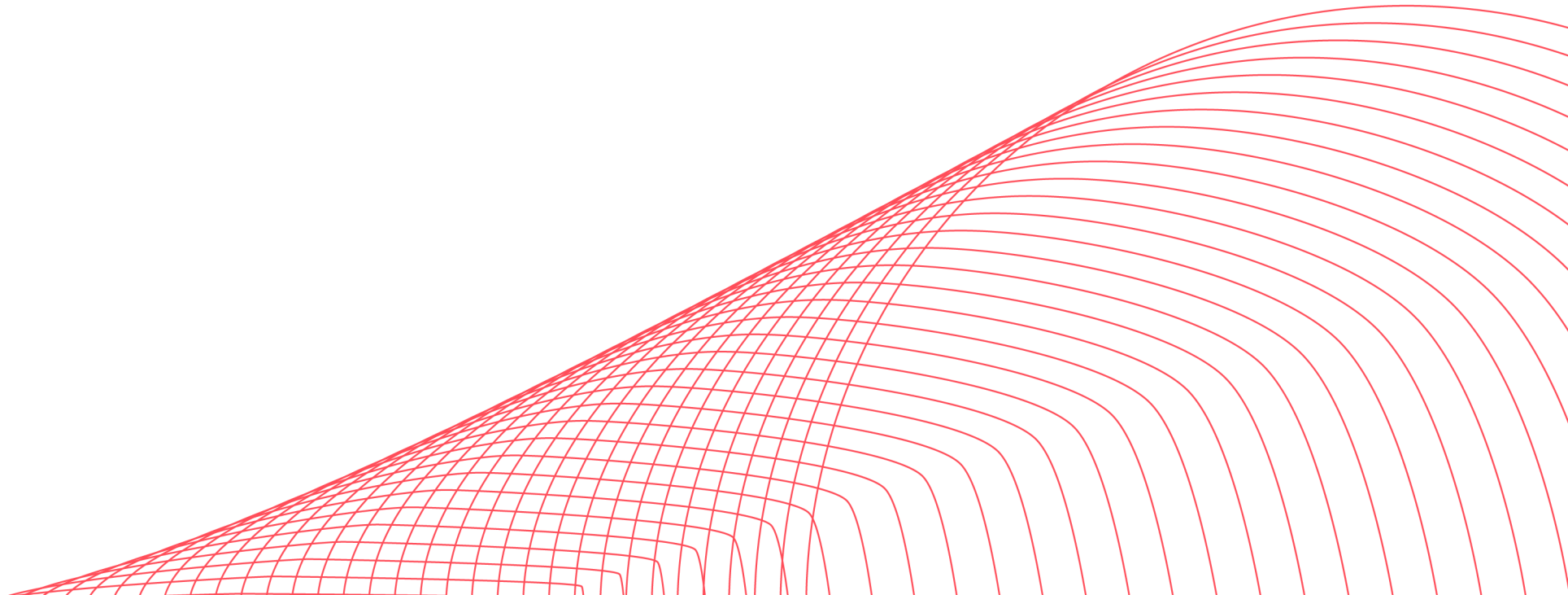
03 First-ever observed ATD-free remission in uncontrolled patients: 8 of 17 responders remain off all medications six months following batoclimab treatment demonstrating potential for disease modification

04 IMVT-1402 pivotal trial design could potentially generate improved efficacy data due to continuous 600 mg QW dosing vs. batoclimab's step-down dosing design

05 Two potentially registrational trials for IMVT-1402 in Graves' disease currently enrolling

Notes: Data includes N=1 patient who discontinued prior to Week 12 but remained in off-drug follow-up.
ATD: Anti-thyroid drug; QW: Once weekly; responders: patients who have T3 and T4 values ≤ULN and no increase in ATD dose from baseline.

Opportunities for IMVT-1402 to Win on Efficacy



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IMVT-1402 Has the Potential to Be Best-in-Class in MG, SjD and CIDP, With Room to Penetrate Large, Well-Validated Markets

Myasthenia Gravis

Market rapidly expanding with space for multiple blockbuster agents; topline results expected in 2027

Sjögren's Disease

Expected to be best-in-class with limited entrenched competition; topline results expected in 2028

Chronic Inflammatory Demyelinating Polyneuropathy

Market quickly growing with 1 approved agent; topline results expected in 2028

Note: All drugs are investigational and subject to regulatory approvals. 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.

Sjögren's Disease (SjD) Is a Chronic Autoimmune Disease Characterized by Lymphocytic Infiltration of the Salivary and Lacrimal Glands

Limited Treatment Options for SjD

- SjD symptoms include severe dryness of the eyes and mouth; the latter frequently associated with difficulty swallowing or speaking, tooth decay, gum disease, and impaired QoL[1,2]
- No therapies approved for the treatment of primary Sjogren's disease

Up to ~90k Addressable Patients in the US

- Of the **~290K primary SjD patients in the US,** ~30% are moderate-severe with anti-Ro/SSA antibodies[3]

Autoantibody Pathology

- Autoantibodies detected in ~50-70% of patients with primary SjD; anti-FcRn proof of mechanism established

Deeper Is Better

- Nipocalimab data demonstrated that deeper IgG reduction leads to better clinical response across all primary and secondary endpoints[4]

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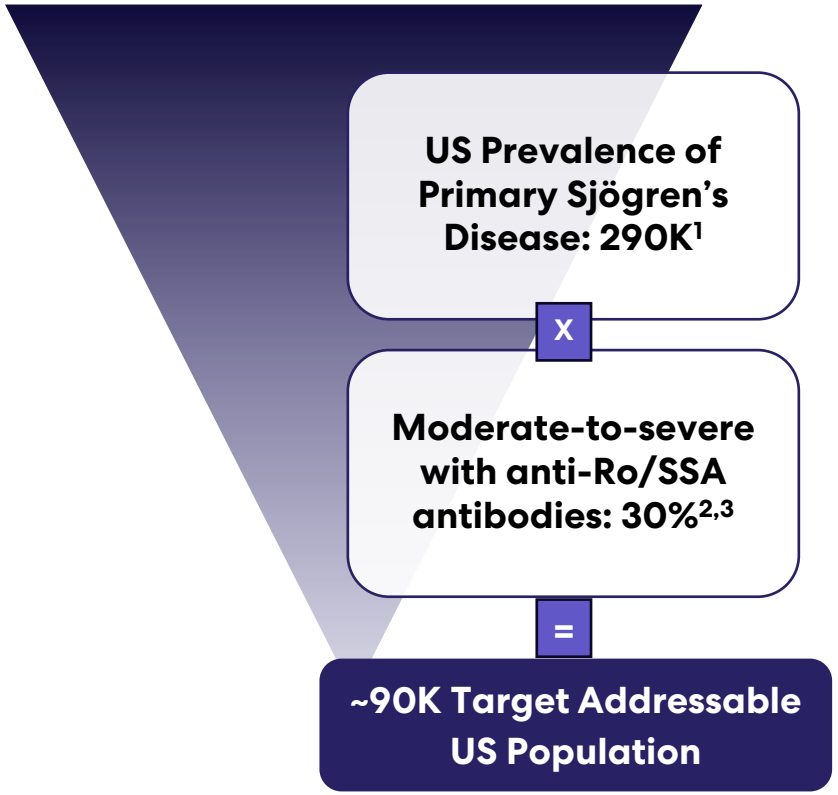
1. Mariette et al., N. Engl J Med (2018)
2. Brito-Zeron et al., Nat Rev Dis Primers (2016)
3. GlobalData Analysis and Forecast, January 2025
4. Gottenberg et al., ACR (2024)

Sizable SjD Patient Group With Unmet Need for an Approved Treatment Option

Sizable Unmet Need



Expansion Opportunities

Secondary Sjögren's	Potential to impact conditions with shared autoimmune pathology
Glandular Disease	Unmet need to improve glandular manifestations beyond symptom relief
Less Severe Disease	Disease impact on patient QoL varies widely; so-called "nuisance" symptoms can become debilitating if inadequately managed

Note: All estimates are approximate
1. GlobalData Analysis and Forecast, January 2025
2. Brito-Zeron P et al., Nat Rev Dis Primers (2016)
3. Decision Resources Group

IMVT-1402 Has the Potential to Improve Myasthenia Gravis (MG) Treatment Outcomes as a Best-in-Class Therapy

High Unmet Need

- 95% of neurologists agree there is opportunity for greater disease control (e.g., deeper responses)[1]

Up to ~35k Addressable Patients in the US

- Of the **~60-120K MG patients in the US,** ~30% are AChR autoantibody positive and not well-controlled on standard of care[2,3,4,5,6]

Autoantibody Pathology

- Classic IgG mediated disease with proven anti-FcRn mechanistic response; 3 approved in-mechanism products

Deeper Is Better

- External and batoclimab data demonstrated that deeper IgG reduction consistently leads to better clinical effect
- Batoclimab data showed highest MG-ADL reductions from baseline observed in any global Phase 3 MG trial to date[7]

AChR: anti-acetylcholine receptor
1. IMVT Market Research HCP Unmet Need
2. Phillips et al., Neurology (1992)
3. Mina-Osorio et al., AANEM (2023)
4. Lazaridis and Tzartos, Front Immunol (2020)
5. Wang et al., BMC Neurol (2017)
6. IMVT Investor Presentation March 19, 2025

IMVT-1402 Has the Potential to Deliver Best-in-Class Efficacy in Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)

High Unmet Need

- 30-50% of CIDP patients are inadequately controlled with existing therapies[1]

Up to ~16k Addressable Patients in the US

- Of the **~58K CIDP patients in the US,** ~30% are inadequately controlled on treatment[2,3]

Autoantibody Pathology

- IgG mediated disease with proven anti-FcRn mechanistic response; 1 approved in-mechanism product

Deeper Is Better

- First-gen anti-FcRn batoclimab demonstrated deeper IgG suppression delivered greatest in-class mean change from baseline in aINCAT score in CIDP patients[4]

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1. Internal Market Research Market Dynamics 2024
2. Broers et al., Neuroepidemiology (2019)
3. Querol et al., J Neurol (2021)
4. IMVT batoclimab initial Period 1 Data Investor Presentation March 19, 2025

Rich Catalyst Calendar Over the Next 36 Months

Pivotal / Potentially Registrational

1H 2026
Topline data in TED*

2026
Topline data in D2T RA
(formerly expected in 2027)

2027
Topline data in GD
Topline data in MG

2028
Topline data in SjD
Topline data in CIDP

2026 | 2027 | 2028

2026
Initial Results in CLE

2027+
Future PoC study readouts in undisclosed indications and future BD

Proof of Concept

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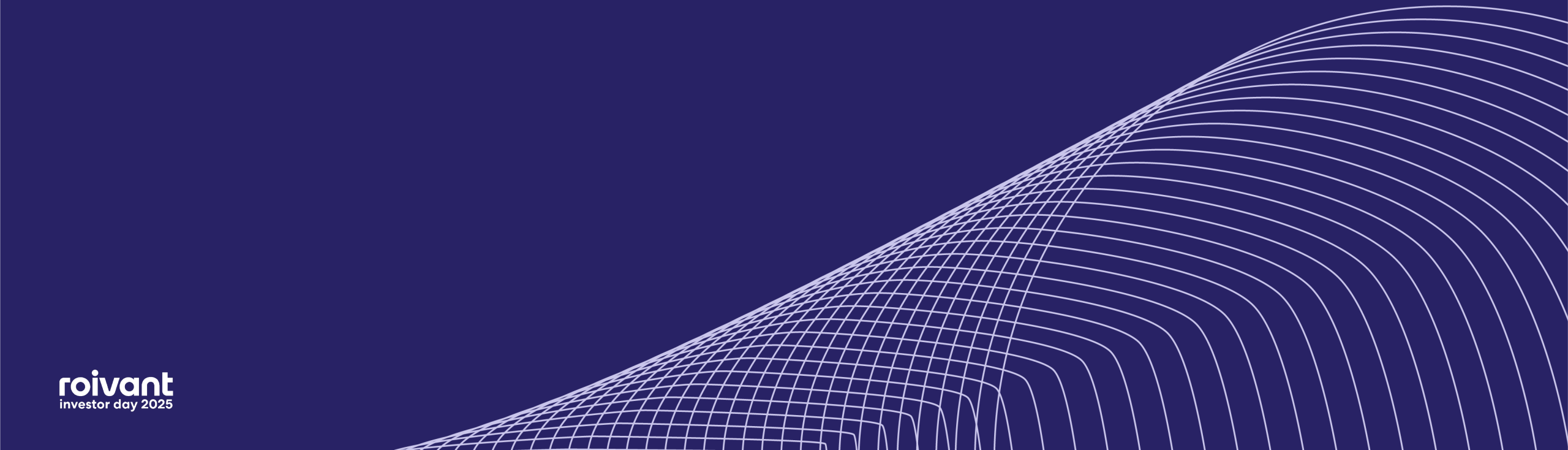
Note: All drugs are investigational and subject to regulatory approvals. All catalyst timings are approximate, based on current expectations and, where applicable, contingent on FDA feedback, and may be subject to change. All references are to calendar years
*Immunovant continues to expect the first of the two batoclimab Phase 3 TED studies to read out before the end of calendar year 2025. However, due to evolving competitive dynamics, Immunovant anticipates sharing topline results from both TED studies concurrently in the first half of calendar year 2026.

In Summary: IMVT-1402

- **Multiple shots on goal: IMVT-1402 offers best-in-class profile in 5 late-stage indications and 1 PoC**
- **The anti-FcRn class is rapidly growing; precedent best-in-class products have won significant market share in I&I indications**
- **Graves' disease has extraordinary unmet need; we have demonstrated best-in-class potential with a multi-year lead**
- **Focused clinical execution: topline data in D2T RA now expected in 2026; readouts in 3 potentially registrational trials and 1 PoC expected in next 24 months**

Note: All drugs are investigational and subject to regulatory approvals. 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.

Q&A



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Mosliciguat

Frank Torti
President &
Vant Chair, Roivant

Drew Fromkin
CEO, Pulmovant

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Key Takeaways: Mosliciguat

PH-ILD represents an area of **intense unmet medical need** with only one approved mechanism (two therapies) and an estimated 200,000 patients across the US and Europe

Mosliciguat with a **differentiated mechanism of action** – inhaled soluble guanylate cyclase (sGC) activator – is potentially the **first non-treprostinil treatment** option for PH-ILD patients

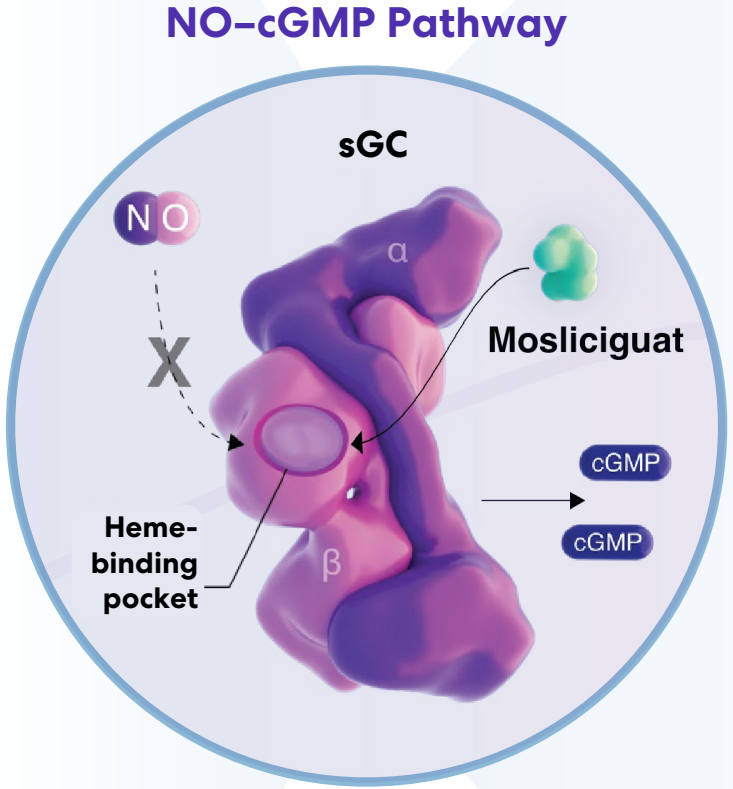
Among the best PVR reductions seen to date with convenient once-daily dosing and favorable safety profile across 170 healthy volunteers and PH patients – approved drugs have shown PVR reductions translate to clinical efficacy

Parallels to PAH market with **combination therapies** present across the disease spectrum; however, PH-ILD expected to be larger commercial opportunity with competition limited to inhaled mechanisms

Topline data from ongoing Phase 2 study (PHocus) is expected in 2H 2026 – 120 patient study with the potential to define a new standard of care in PH-ILD

PH-ILD: Pulmonary hypertension associated with interstitial lung disease
Note: All drugs are investigational and subject to regulatory approvals. 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.

Mosliciguat is Delivered Directly to the Lungs to Activate Impaired sGC



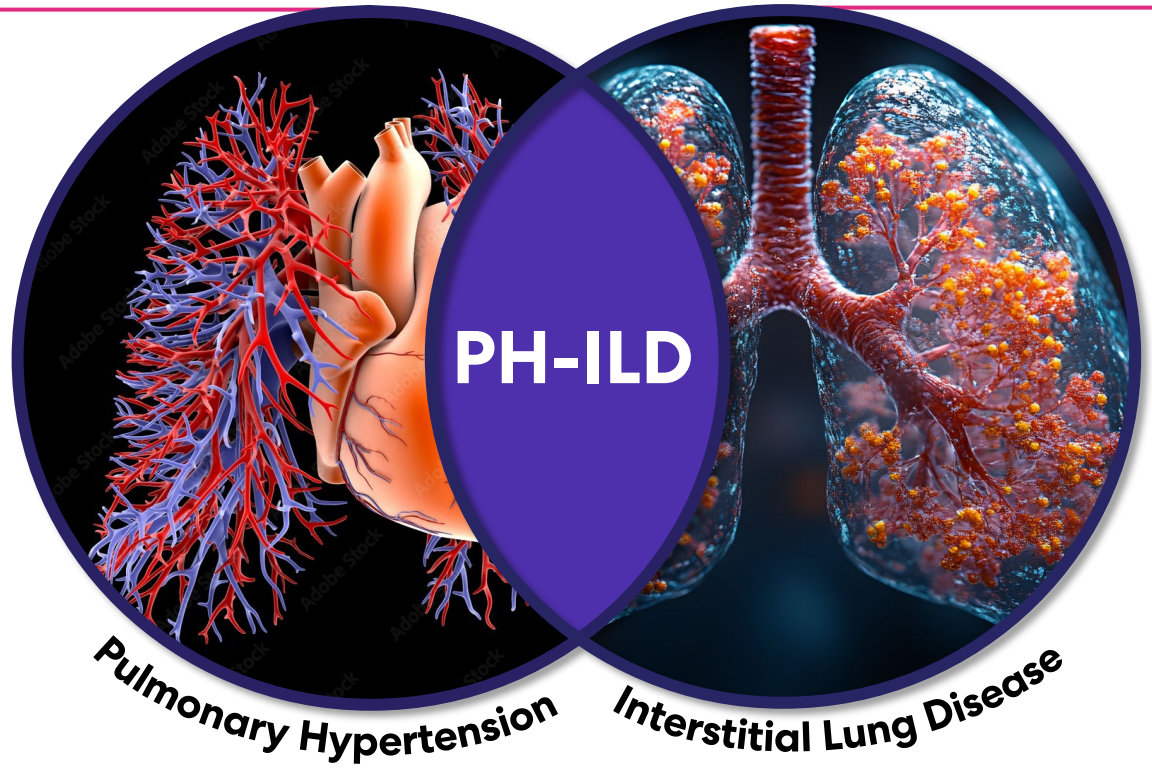
- **sGC is a key enzyme in the NO-cGMP pathway** and its activity is essential for vascular homeostasis[1]
- **Oxidative stress** in pulmonary disease reduces NO production and impairs the sGC binding site, **resulting in sGC dysfunction**[2]
- **Mosliciguat activates** impaired sGC, as well as native sGC, **restoring cGMP production,** resulting in vasodilation and potential reduction of fibrosis and inflammation[1,3]
- Optimized particle size ensures **distal lung deposition** for targeted delivery[4]

1. Sandner et al., Respir Med (2017)
2. Thoonen et al., Nat Commun (2015)
3. Becker-Pelster et al., Respir Res (2022)
4. Saleh et al., Clin Pharmacokinet (2025)

Pulmonary Diseases Are Highly Comorbid and Create Complexities for Patient Treatment

Pulmonary Vasculature Disease

- Narrowing, remodeling, or obstruction of pulmonary vessels
- Increased pressure in the pulmonary arteries
- Right heart strain or failure



Lung Parenchyma Disease

- Inflammation, scarring/fibrosis, stiffening
- Impaired gas exchange, reduced lung compliance
- Progressive respiratory dysfunction

Mosliciguat Offers a Differentiated Profile With Potential to Address Complex Nature of Pulmonary Diseases

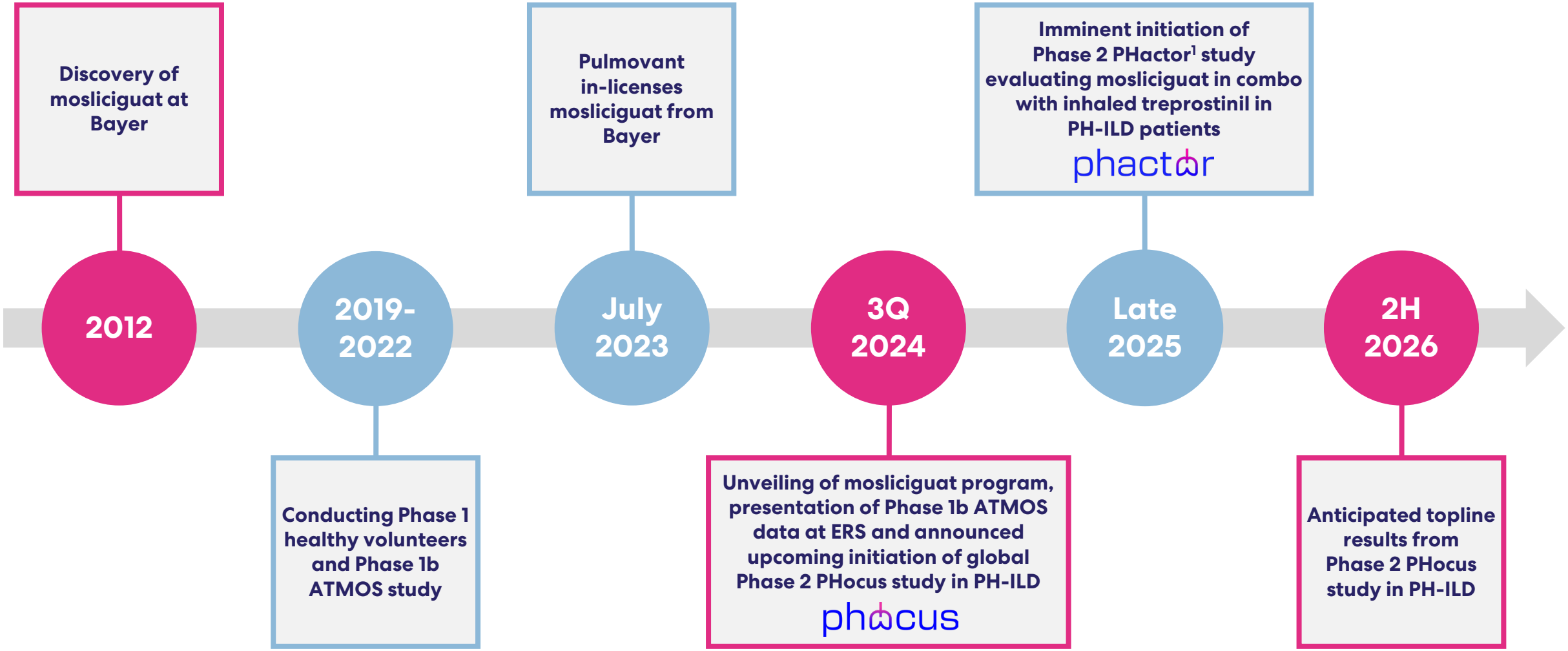
Blanco et al., Curr Opin Pulm Med (2024)

Mosliciguat Mechanism Video

Pulmovant is committed to transforming the lives of patients with pulmonary diseases

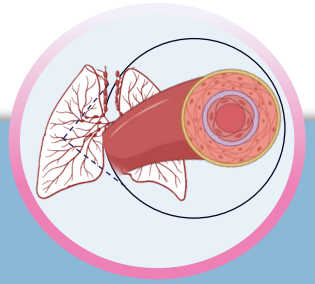
For investor audiences only

A Brief Reminder of How We Got Here and What's Next...



1. A separate, open-label Phase 2 study (PHactor), is planned to evaluate the tolerability and safety of inhaled mosliciguat in combination with inhaled treprostinil in participants with PH-ILD (n=20).
Note: All drugs are investigational and subject to regulatory approvals. 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.

Mosliciguat's MoA and Molecular Properties Prompted Phase 1 Investigations in Healthy Volunteers and PH Patients (N=170)

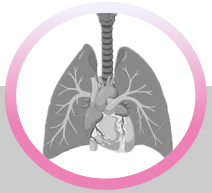


Group 1

Pulmonary Arterial Hypertension

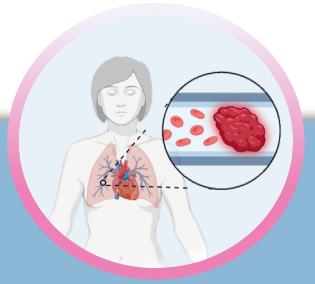
Group 2

PH associated with left heart disease



Group 3

PH associated with lung diseases and/or hypoxia



Group 4

PH associated with pulmonary artery obstructions

Group 5

PH with unclear / multifactorial mechanisms

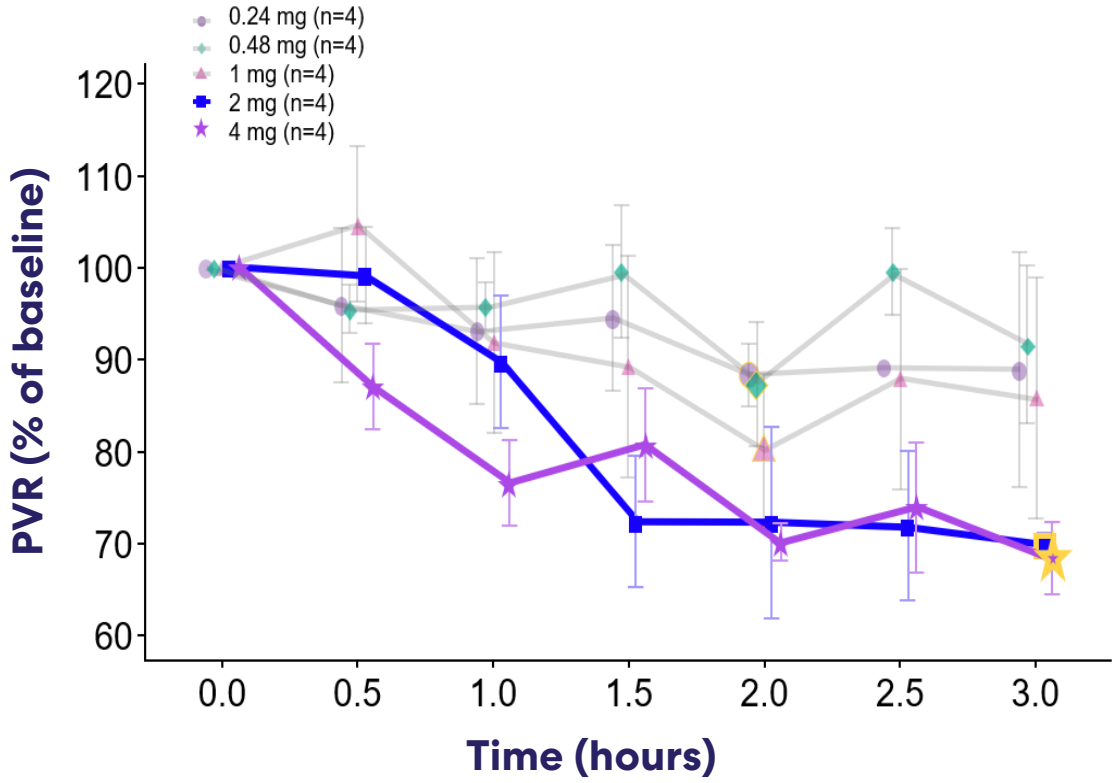
Phase 1a	Phase 1b
N=132, Healthy Volunteers ▪ SAD, MAD, Bioavailability ▪ Single and multiple ascending dose ▪ ~40-hour half-life	**ATMOS Study: N=38, PH Patients** ▪ Group 1 and 4 patients ▪ Single ascending dose ▪ Significant activity and well tolerated

Adapted from Humbert et al., Eur Heart J (2022)

Single Dose of Inhaled Mosliciguat Led to Sustained, Clinically Meaningful Mean-Max Reductions in Pulmonary Vascular Resistance (PVR) of Up to ~38%

(Single Dose - Group 1 and Group 4 Patients)

>30% Sustained Mean PVR Reductions[1]



- Rapid PVR reductions emerged as **early as 30 minutes and persisted** over the observed period
- **PVR reductions among the largest ever seen** in the single or repeat dose setting

1. Based on data seen in open-label, single-dose escalation multicenter trial in patients with untreated pulmonary arterial hypertension (PAH) or chronic thromboembolic pulmonary hypertension (CTEPH). PVR measured in dyn*sec*cm-5. Symbols with yellow outline indicate time points with greatest observed mean percent PVR reduction for each dose group.

Mosliciguat Has Shown Among the Highest PVR Reductions Ever Seen in the Single or Repeat Dose Setting

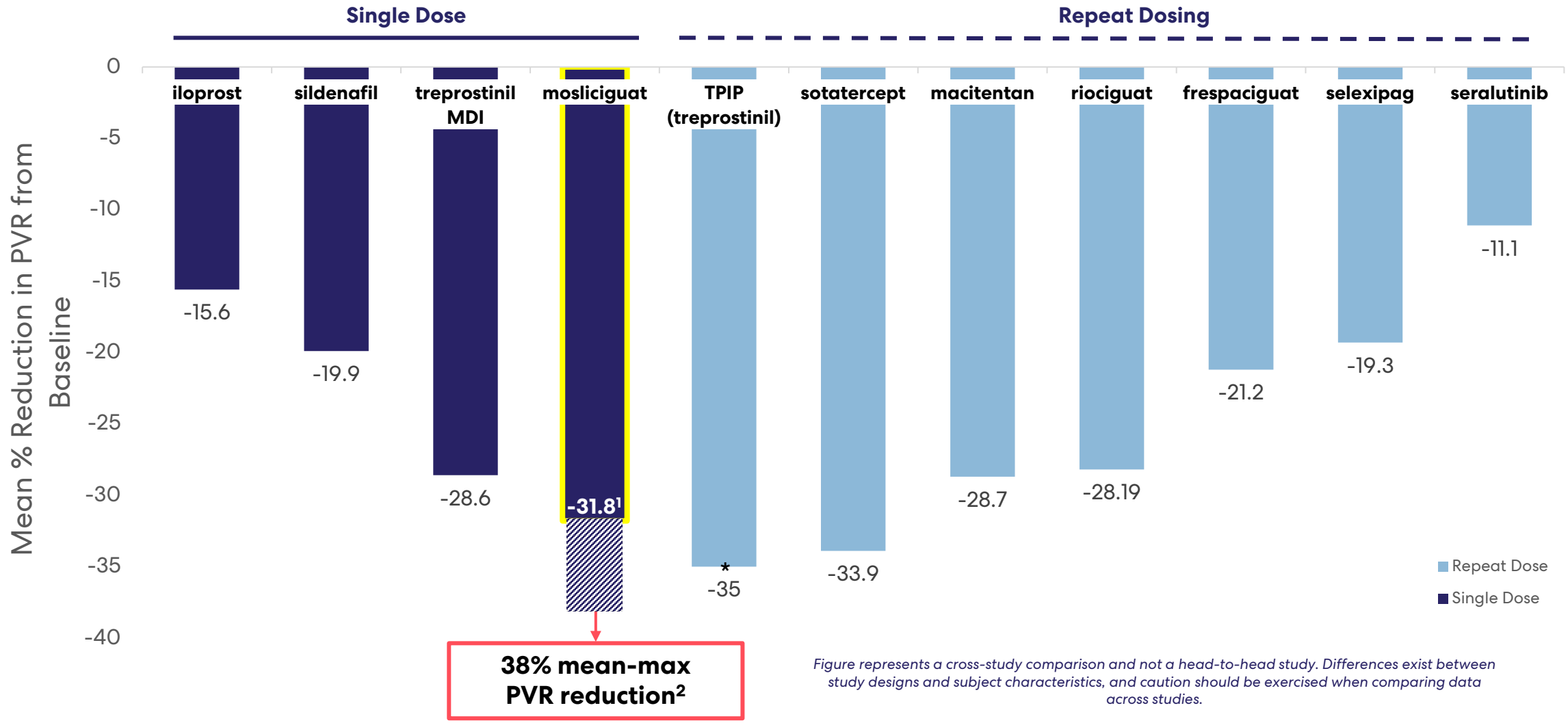


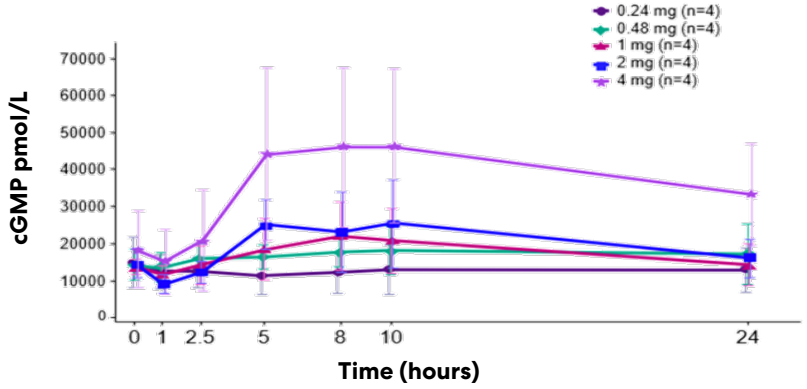
Figure represents a cross-study comparison and not a head-to-head study. Differences exist between study designs and subject characteristics, and caution should be exercised when comparing data across studies.

* indicates trough PVR observation.
1. Represents average PVR reduction for participants in 4 mg dose group at hour 3 in ATMOS study.
2. Represents average of largest reduction in PVR for each participant in 2 mg dose group in ATMOS study.
SOURCES: iloprost – Richter et al., 2015; sildenafil – Voswinckel et al., 2008; treprostinil MDI - Voswinckel et al., 2009; mosliciguat – Ghofrani et al., 2024; TPIP – Grünig et al., 2025; sotatercept – Humbert et al., 2021; macitentan – Pulido et al., 2013; riociguat – Ghofrani et al., 2013; frespaciguat – Bajwa et al., 2024; selexipag – Simonneau et al., 2012; seralutinib – Frantz et al., 2024.

cGMP Concentrations Increased With Limited Systemic Effects and Correlated With Reductions in Mean Pulmonary Arterial Pressure and Increases in Cardiac Output[1]

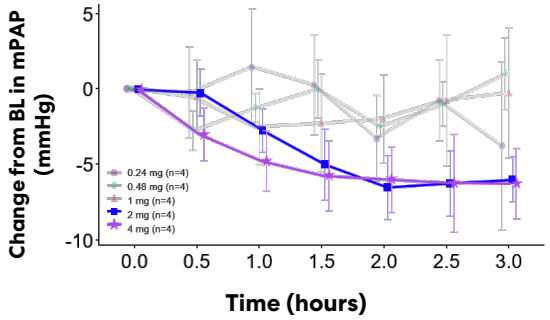
(Single Dose - Group 1 and Group 4 Patients)

Elevated Plasma cGMP Maintained Over 24 Hours



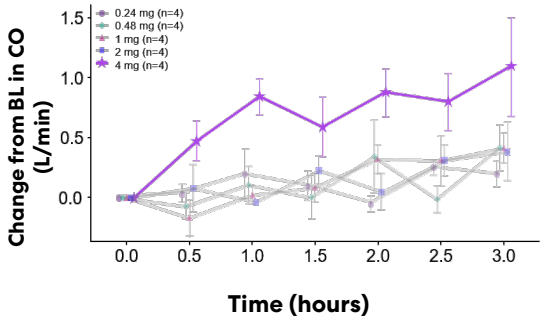
- **Plasma cGMP levels rose rapidly**, peaking at 8 hours post single dose
- **No clinically meaningful systemic effects** in systolic blood pressure or heart rate observed

Reduction in Mean Pulmonary Arterial Pressure (mPAP)



- Mean reduction in mPAP of up to **6.5mmHg**, equivalent to **~20%**

Increase in Cardiac Output (CO)



- Mean increase in CO of up to **1.1L/min** from baseline, equivalent to **~25%**

1. Based on data seen in open-label, single-dose escalation multicenter trial in patients with untreated pulmonary arterial hypertension (PAH) or chronic thromboembolic pulmonary hypertension (CTEPH)

Mosliciguat Was Well Tolerated Across Doses and Study Participants

Reported TEAEs were of mild/moderate intensity and consistent across healthy volunteers (HVs) and PH participants

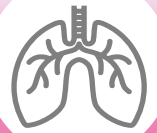
All inhaled doses were well tolerated and without significant cough

There is limited systemic exposure or bioavailability

Trial (Population)	N[1]	Duration	Findings
SAD (HVs)	62	Single dose	• Inhaled dose range of 0.06-4.0 mg well-tolerated • Dose-dependent increase in cGMP
MAD (HVs)	27	7-day	• Inhaled dose range of 0.48-2.0 mg well-tolerated • Accumulation and dose-dependent increases in cGMP confirms **effective once-daily dosing**
Bioavailability (HVs)	26	Single dose	• **Determined inhaled bioavailability** • Inhaled, oral and intravenous dosing well-tolerated
MAD (HVs)	17	14-day	• Well-tolerated over 14 days • Steady state of cGMP production **achieved in <14 days**
ATMOS (Group 1/4 PH)	38	Single dose	• Data presented at ERS 2024 • Primary endpoint: PVR reduction
Total	**170**		

Results from Phase 1 SAD, MAD and ATMOS studies.
1. Numbers do not include subjects randomized to placebo.

Phase 1 and ATMOS Demonstrated Mosliciguat Has the Attributes to Potentially Address Complex, Heterogeneous Pulmonary Disorders Like PH-ILD

PH-ILD		MOSLICIGUAT
Lung is the primary site of the disease		Target delivery to the lungs with deep lung deposition[1]
High dosing burden with multiple daily inhalations	1x day	Convenient once-daily dosing
Current therapies are poorly tolerated and can increase cough		Well-tolerated, with limited cough and systemic side effects[1]
Interplay of vascular remodeling and parenchymal scarring	cGMP	Promotes vasodilation[1,2] and may exert antifibrotic and anti-inflammatory effects[2]

1. Evidenced by data demonstrated in ATMOS and Phase 1 studies conducted in healthy volunteers
2. Becker-Peslster et al., Respir Res (2022)

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

Up to ~200k patients in US and Europe

- **Prevalence likely underreported** due to limited treatment options, diagnostic barriers and evolving disease awareness[1-9]

< 5-year median survival[4]

- **PH-ILD is a particularly severe subgroup of PH**
- **Poorer prognosis and higher mortality** than other forms of pulmonary hypertension[10-13]
- Elevations in PVR are associated with worse mortality in PH-ILD patients[14,15] – **reducing PVR should improve outcomes**

Limited or no approved treatment options

- **Only 2 FDA approved therapies in PH-ILD** (both inhaled treprostinil) requiring **as many as 5x daily doses, with even more inhalations and leading to unwanted cough**

"Even if progression of ILD seems to be slowing with the antifibrotics, I am pretty aggressive with treatment given how fast they can decline when PH is present."
- Physician

"My medical problems are consuming my everyday life."
– PH-ILD patient

"Efficacy [of approved therapy] is not amazing … it's all we have, but there is definitely room to improve."
- Physician

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

Potential for Robust PVR Reductions, Favorable Tolerability, and Simple, Inhaled, Once-per-Day Dosing Regimen Differentiate Mosliciguat from Other, Potential PH-ILD Therapies

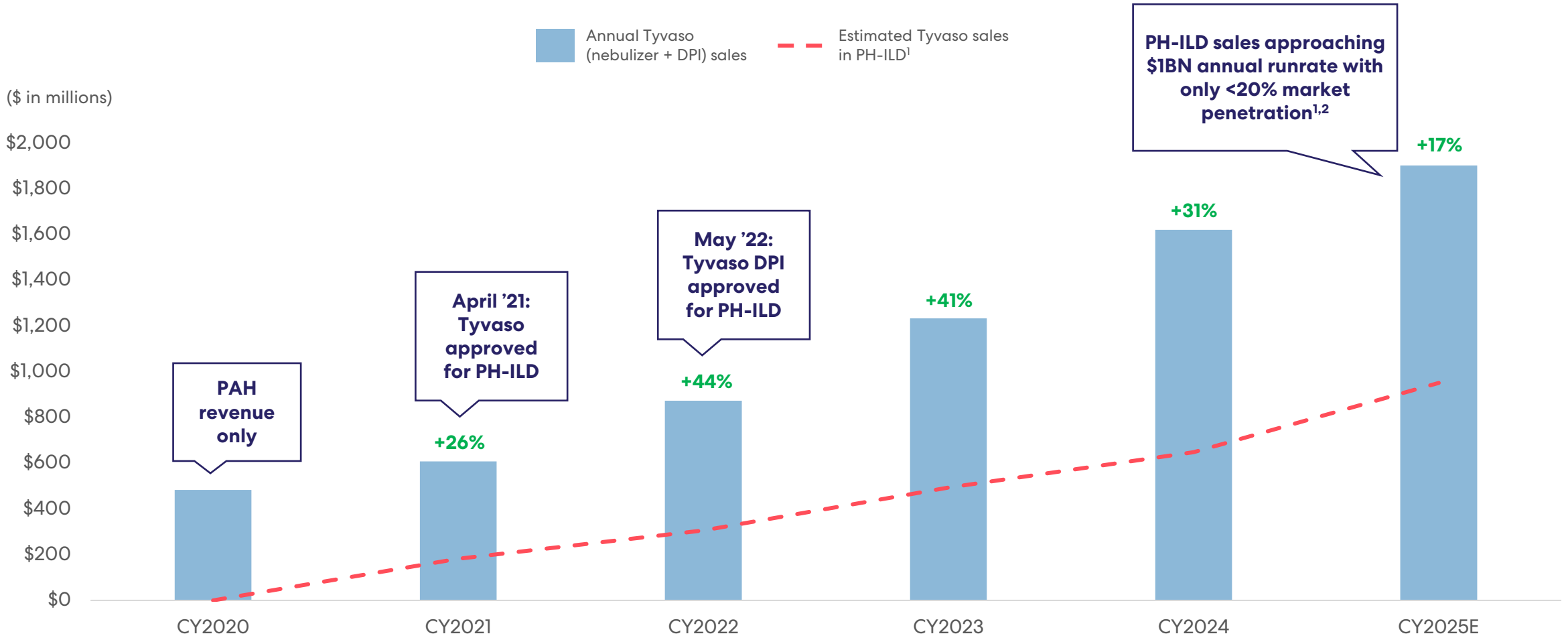
	Mosliciguat	Tyvaso	Yutrepia	TPIP	Seralutinib
Company	pulmovant	United Therapeutics	Liquidia	insmed	gossamerbio
PH-ILD Stage of Development	Phase 2	Marketed	Marketed	Phase 3	Phase 3
MOA	**sGC activator**	Prostacyclin	Prostacyclin	Prostacyclin	PDGFRα/β, CSF1R and c-KIT inhibitor
# Breath / Day	**1**	**4 - 48**	**6 - 20**	**1 - 4**	**12**
>30% PVR Reductions	✓	✗	✗	✓	✗
Half-life	**~40+ hours**	**~0.5 / 4 hours (DPI/Nebulized)**	**~0.5 hour**	**~9 hours**	**~3–6 hours**
Tolerability[1] (limited cough)	✓	✗	✗	✗	✓

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.

1. Based upon placebo-adjusted cough rates, except for mosliciguat which did not have placebo group in Phase 1 trial.

Rapid Growth in Tyvaso Sales Since PH-ILD Approval Illustrates Clear Unmet Need Yet PH-ILD Treatment Domain Remains in Its Infancy

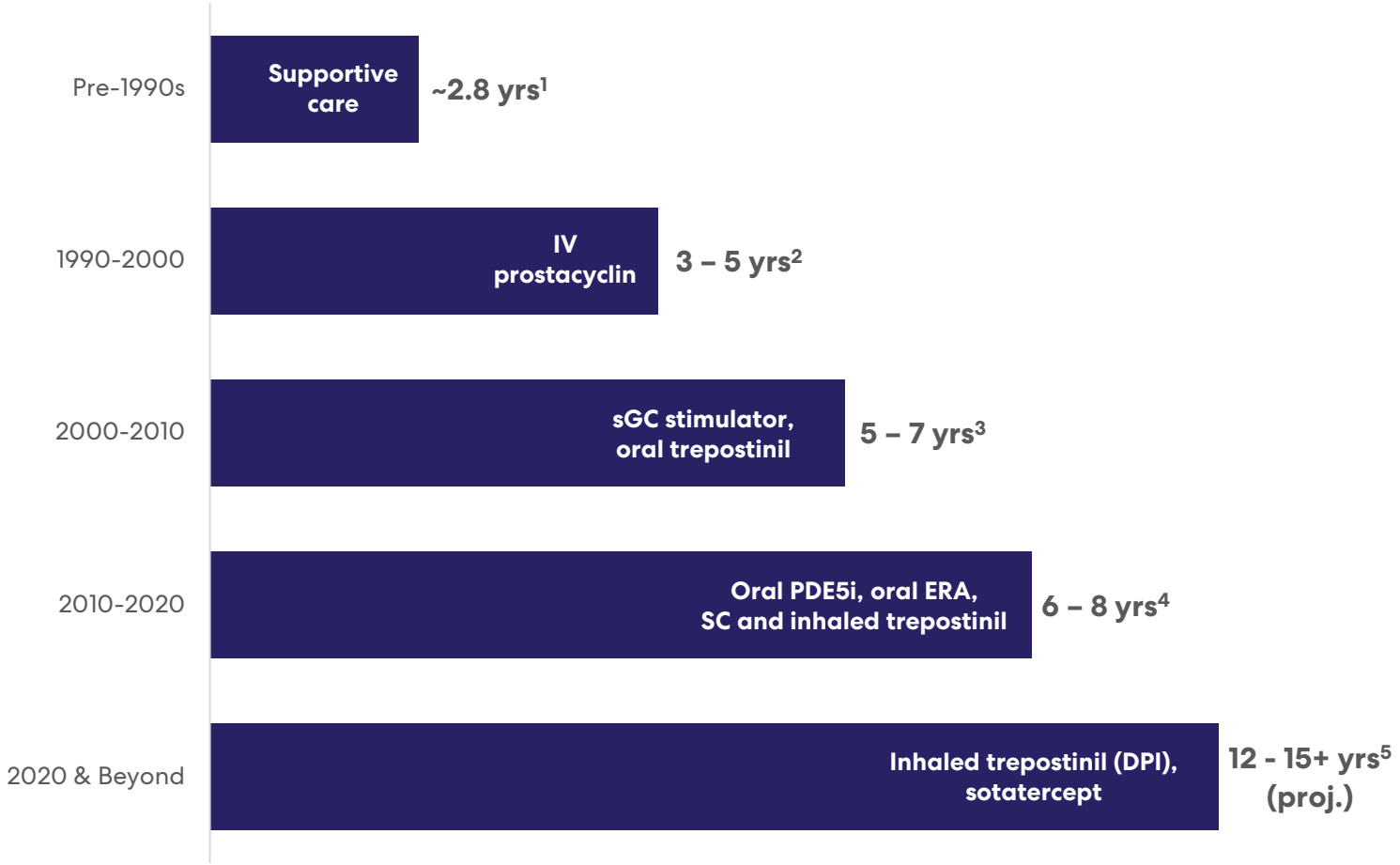
Blockbuster sales in PH-ILD achieved ~3 years into launch[1]



1. Company estimate for breakdown of Tyvaso sales in PAH / PH-ILD.
2. Per UTHR management guidance.

Evolution of Pulmonary Arterial Hypertension (PAH) Treatment Paradigm Represents a Likely Path for PH-ILD Market Development

Key Treatment Pathway(s) | Median Survival Progression



PAH Guideline Evolution[6]

No targeted therapy – only symptom management

*Guidelines based on **functional class**; **monotherapy only***

***2009 ESC/ERS:** introduced **sequential combination therapy** for nonresponders*

***2015 ESC/ERS: initial combination therapy** (ERA + PDE5i) endorsed; **risk-based approach** formalized*

***2022 ESC/ERS:** 4-strata **risk model**, earlier diagnosis, support for **early triple therapy** in select patients*

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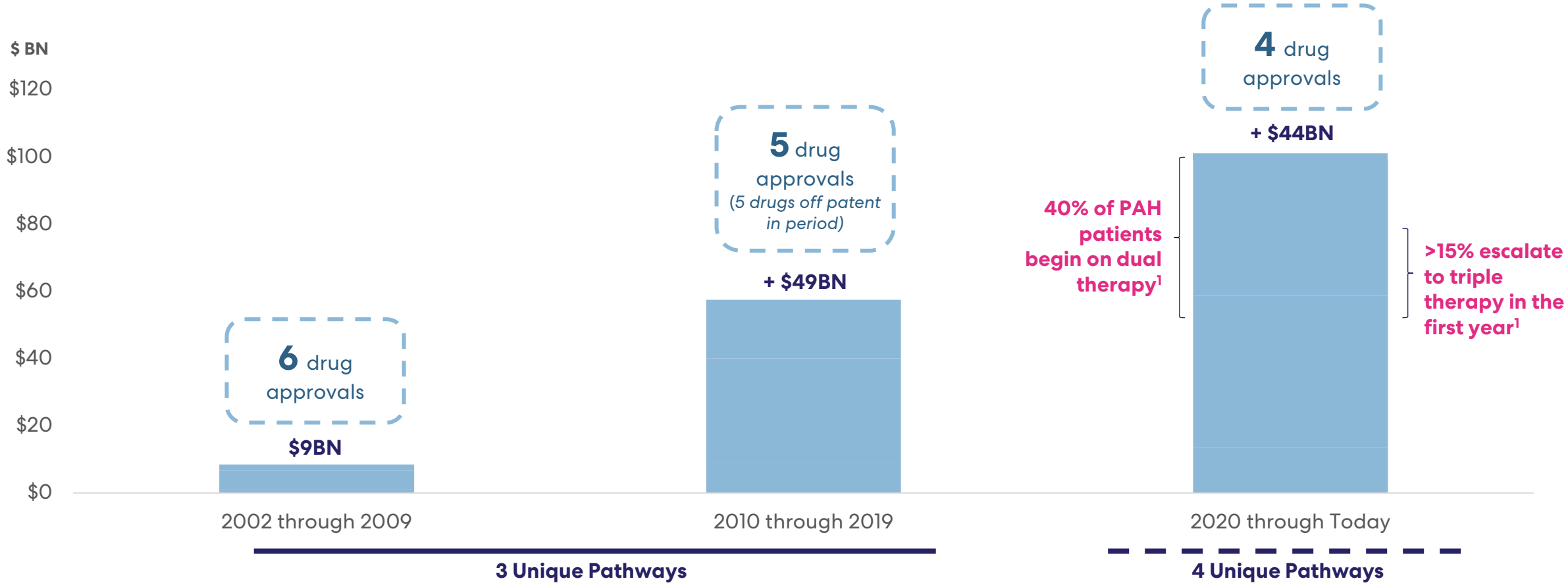
1. Dalonzo et al., Ann Intern Med (1991)
2. Sitbon et al., JACC (2002)
3. Benza et al., Chest (2012)
4. Hendriks et al., Pulm Circ (2022)
5. Alsumali et al., Adv Ther (2025)
6. ESC/ERS Guidelines from 2009 – 2022

PAH Disease Severity Supports Multiple Modalities With Increased Preference for Combination Therapy

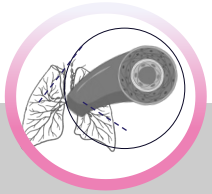
15+ approved drugs to date have yielded >$100BN in sales

Evolution of Total PAH Sales: 2002 – 2025



1. Muller et al., Adv Ther (2024)

Phase 2 Development of Mosliciguat Focuses on the Urgent and Complex Needs of Patients With PH-ILD

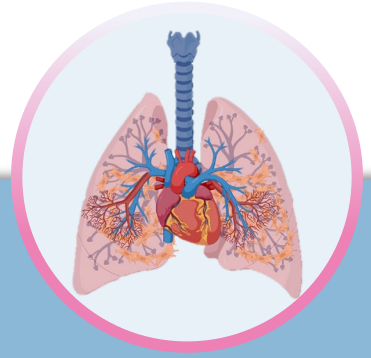


Group 1

Pulmonary Arterial Hypertension

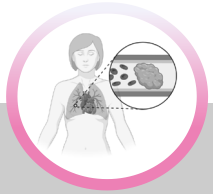
Group 2

PH associated with left heart disease



Group 3

PH associated with lung diseases and/or hypoxia



Group 4

PH associated with pulmonary artery obstructions

Group 5

PH with unclear / multifactorial mechanisms

Phase 2

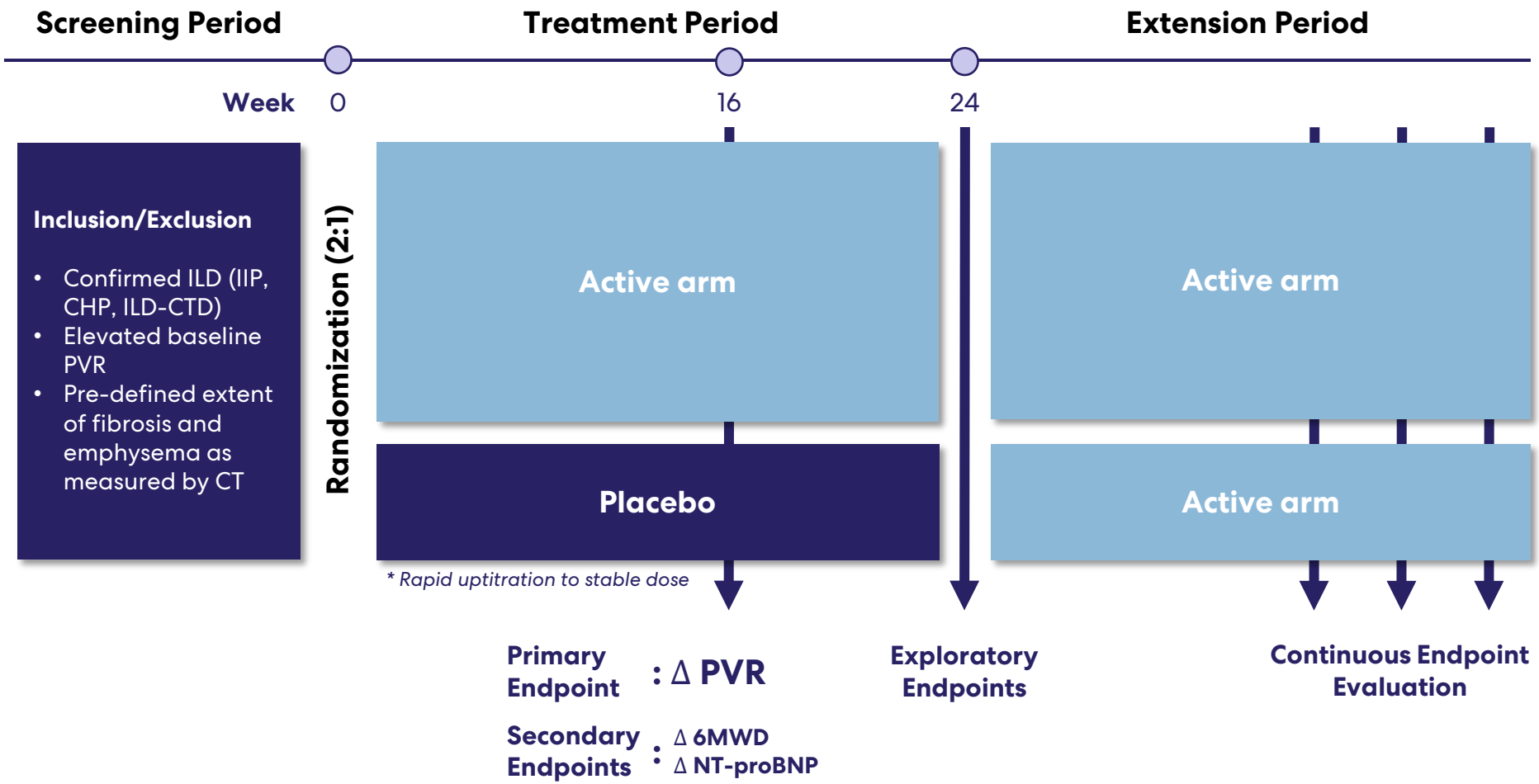
PHocus Study of Mosliciguat in Adult Patients with PH-ILD

Adapted from Humbert et al., Eur Heart J (2022)

Phase 2 PHocus Study of Mosliciguat in Adult Patients With PH-ILD

Double-blinded, multi-center, global trial in ~120 PH-ILD patients with topline readout expected in 2H 2026

phocus



Note: All drugs are investigational and subject to regulatory approvals. 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.

Phase 2 PHactor Study of Mosliciguat in Combination with Inhaled Trepostinil

A separate, open-label Phase 2 study is planned to evaluate the tolerability and safety of inhaled mosliciguat in combination with inhaled treprostinil in participants with PH-ILD (n=20). This study is expected to initiate imminently.

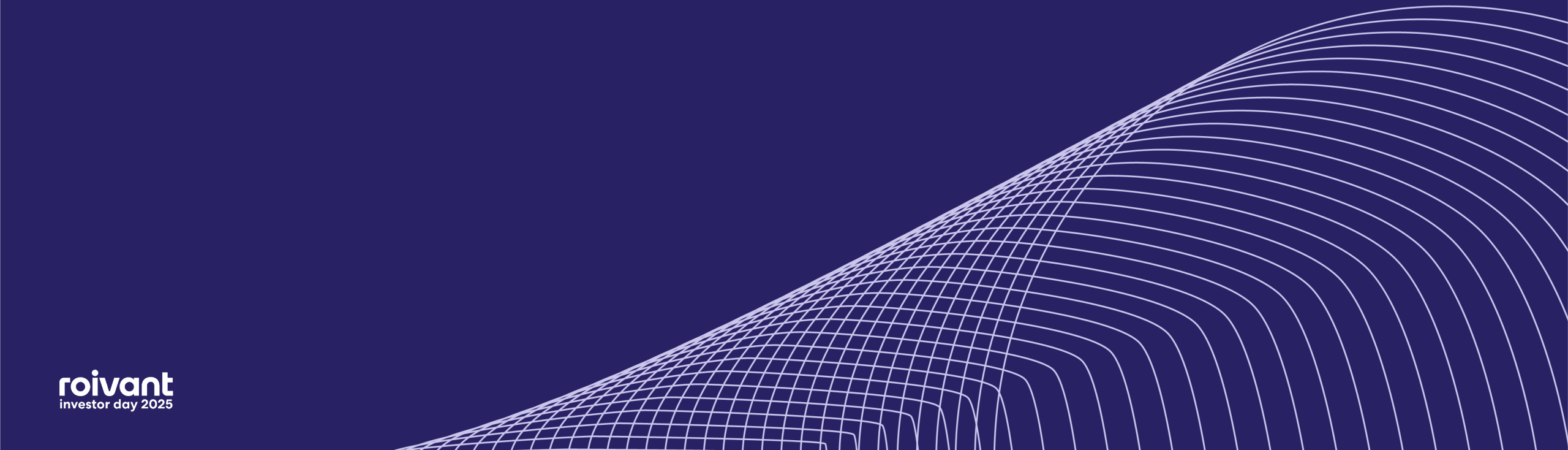
Note: All drugs are investigational and subject to regulatory approvals. All catalyst timings are approximate, based on current expectations and, where applicable, contingent on FDA feedback, and may be subject to change. All references are to calendar years.

In Summary: Mosliciguat

- PH-ILD is an area of unmet medical need – tractable market with only one approved mechanism
- Mosliciguat will potentially represent the first non-treprostinil treatment option for PH-ILD patients
- Among the best PVR reductions seen to date with differentiated MoA, convenient once-daily dosing and favorable safety profile
- Topline data from ongoing Phase 2 study (PHocus) expected in 2H 2026; if successful, has potential to define standard of care in PH-ILD

Note: All drugs are investigational and subject to regulatory approvals. 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.

Q&A



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Genevant & Arbutus LNP Litigation

Matt Gline
CEO, Roivant

Lindsay Androski
Special Counsel, Genevant
CEO, Arbutus

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Key Takeaways: LNP Litigation

We believe that **both the Moderna COVID-19 vaccine (SPIKEVAX) and Pfizer/BioNTech's COVID-19 vaccine (COMIRNATY) infringe multiple Genevant/Arbutus LNP patents**

Global COVID-19 vaccine sales since launch have been **~$145BN between Moderna and Pfizer/BioNTech**

Markman rulings (claim construction) have been issued in both US cases – viewed by Genevant generally to be **favorable**

In the US Moderna litigation, a **jury trial has been scheduled for March 2026**. Awaiting court scheduling in the Pfizer/BioNTech litigation

In the ex-US Moderna litigation, initial court hearings and rulings are expected **in 2026**

Note: All references are to calendar years and are approximate and subject to change. The timing of the litigation-related events noted above is subject to change, including at the discretion of the court. See Slide 2 for further information on these forward-looking statements

Genevant and Arbutus Corporate History

2000

Ian MacLachlan co-founded Protiva, which became a pioneer in LNP technology

2006

Protiva and Alnylam (an RNAi developer) published a landmark study in Nature demonstrating the first effective gene silencing in monkeys, using Protiva's LNP technology

2008

Protiva acquired Tekmira, another company working on LNP technology

2015

Roivant set out to assemble a leading global HBV company by merging OnCore Biopharma with Protiva/Tekmira to form Arbutus Biopharma

2018

Roivant and Arbutus launched Genevant as a joint venture to focus on Arbutus' LNP and ligand conjugate delivery technologies, with Arbutus' focus remaining on HBV therapeutics

A Leading Nucleic Acid Delivery Company

GENEVANT

- **Industry-leading LNP delivery capabilities and IP portfolio**
- **Selective collaboration business model, partnering with payload companies to develop innovative nucleic acid medicines**
- **The first LNP technology to be part of an FDA-approved RNA product, Alnylam's Onpattro® developed under LNP license from Arbutus**

Genevant/Arbutus IP Portfolio and Pending Litigation

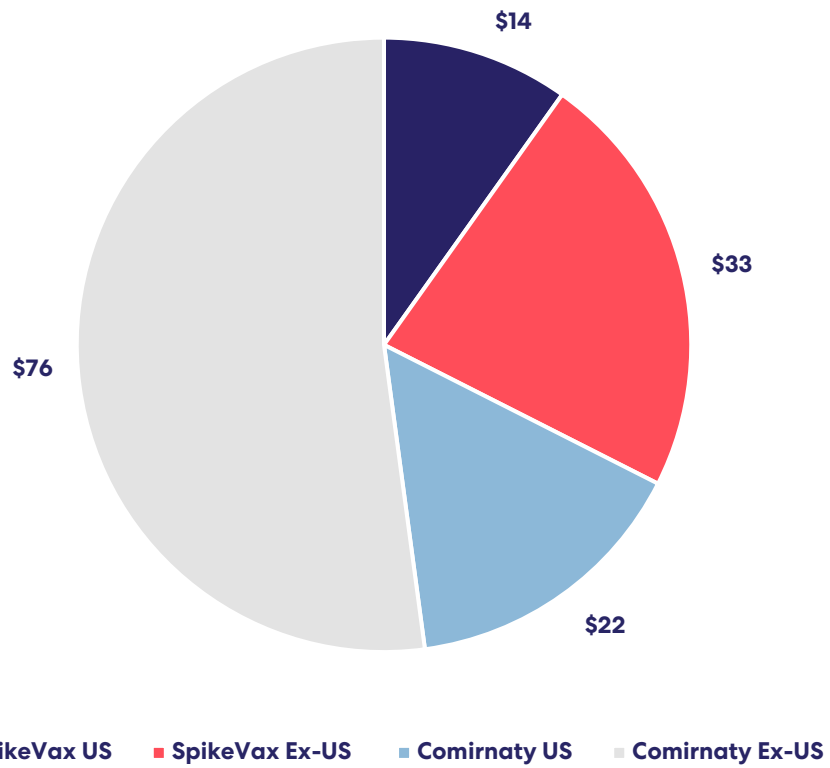
- Some of the US patents licensed by Genevant from Arbutus include:

Subject Matter	US Patent No.	Expiration Date
Particle Composition	8,058,069	April 2029
	8,492,359	April 2029
	8,822,668	April 2029
	9,364,435	April 2029
	11,141,378	April 2029
mRNA-LNP Compositions	9,504,651	July 2023
Manufacturing Methods	11,298,320	June 2023
	11,318,098	June 2023

- Moderna previously sought to invalidate two of the particle composition patents referenced above with IPR challenges but was largely unsuccessful
- Litigation is ongoing against Moderna in the US and certain other jurisdictions and against Pfizer/BioNTech in the US to seek appropriate compensation for the unauthorized use of Genevant's/Arbutus's patented technology

mRNA COVID-19 Vaccines from Moderna and Pfizer/BioNTech Have Generated Over $145BN in Revenue

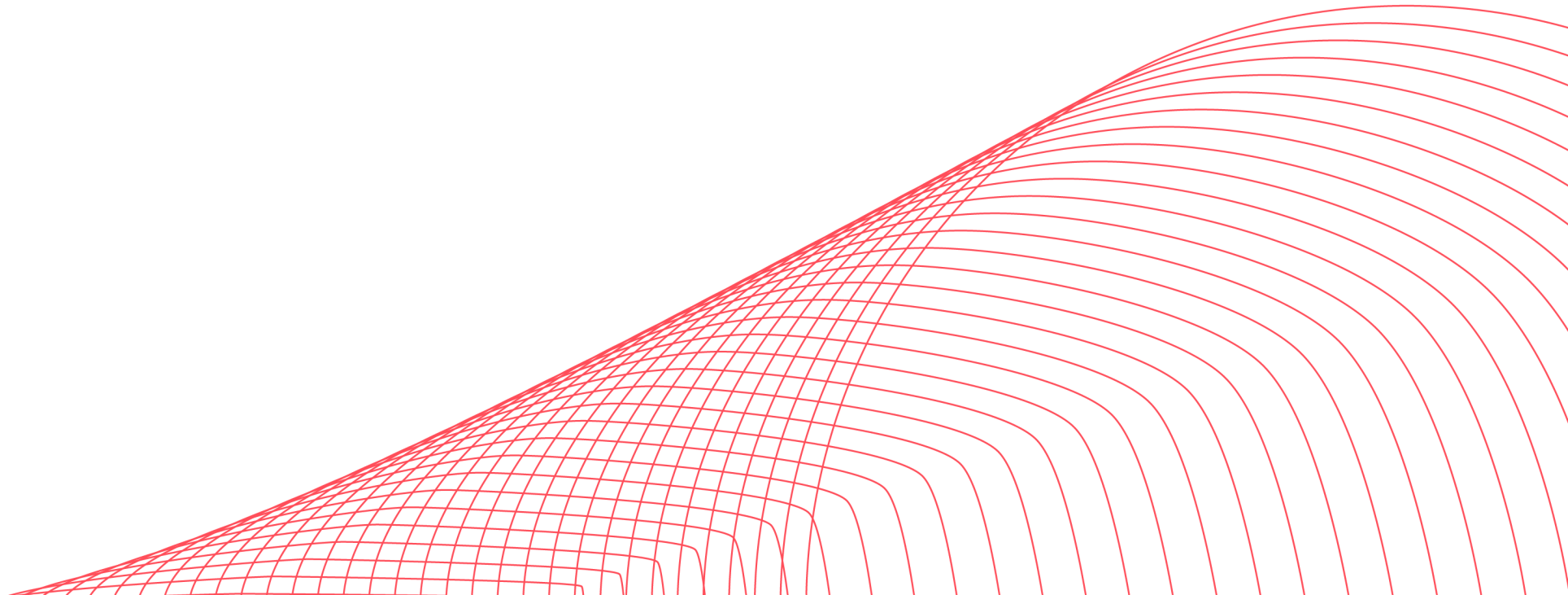
MRNA and PFE/BNTX COVID-19 Vaccine Sales ($ BNs)



- Total SpikeVax Sales account for ~1/3 of mRNA vaccine sales to date; Comirnaty sales account for remaining ~2/3
- US SpikeVax Sales make up ~10% of global COVID-mRNA vaccine sales to date
- Genevant/ABUS continue to pursue recovery against Pfizer and BioNTech in the US, as well as against Moderna in the US and in several other major markets

Revenue as of 9/30/2025
Data and sales calculated from Evaluate and company docs from MRNA, PFE, and BNTX

Moderna Case



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In February 2022, Genevant and Arbutus Jointly Filed a Complaint Against Moderna Asserting Patent Infringement on Patents Related to LNP Technology

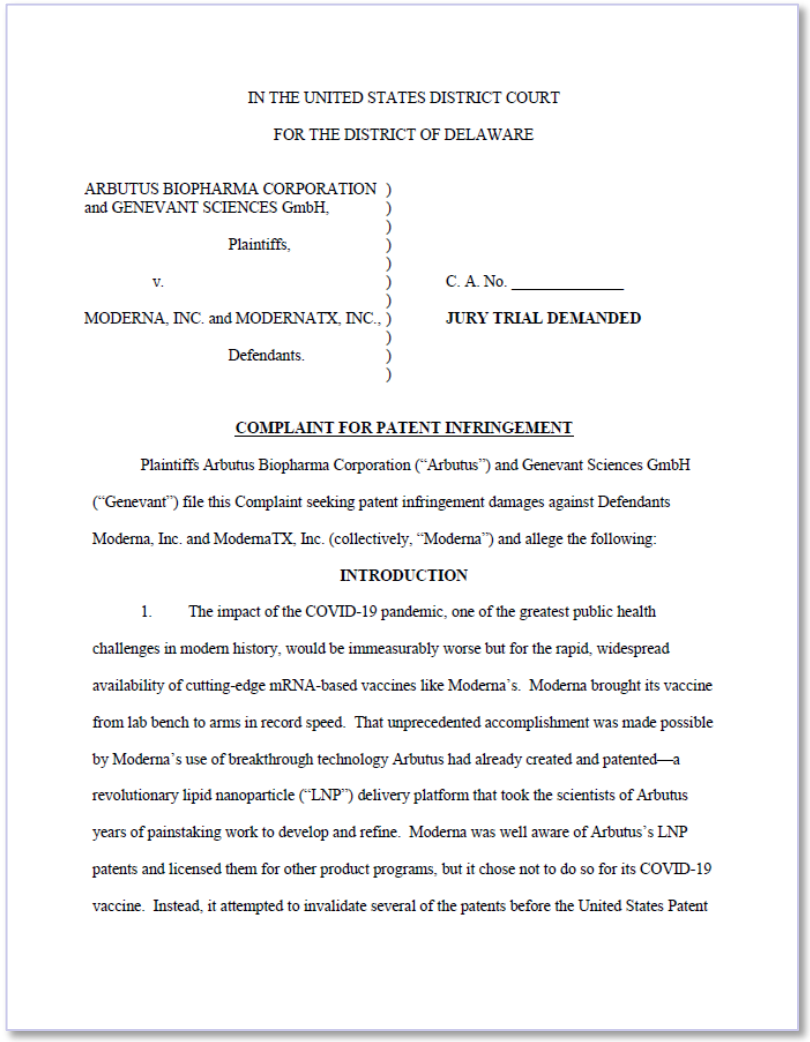
Case filed in the US District Court for the District of Delaware asserting infringement of six patents

Genevant and Arbutus did not seek an injunction or otherwise to impede the sale, manufacture, or distribution of Moderna's COVID-19 vaccine, given the unprecedented global emergency

We recognize the important work of Moderna that helped lead to a lifesaving vaccine in record time

That success was built on, and made possible by, the substantial advances and contributions of Arbutus and Genevant scientists, which Moderna utilized extensively well before COVID-19

The filing of this lawsuit was necessary because Moderna did not pursue and obtain a license to Genevant's LNP technology for COVID-19



IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF DELAWARE

ARBUTUS BIOPHARMA CORPORATION and GENEVANT SCIENCES GmbH,

Plaintiffs,

v.

MODERNA, INC. and MODERNATX, INC.,

Defendants.

C. A. No. _____

JURY TRIAL DEMANDED

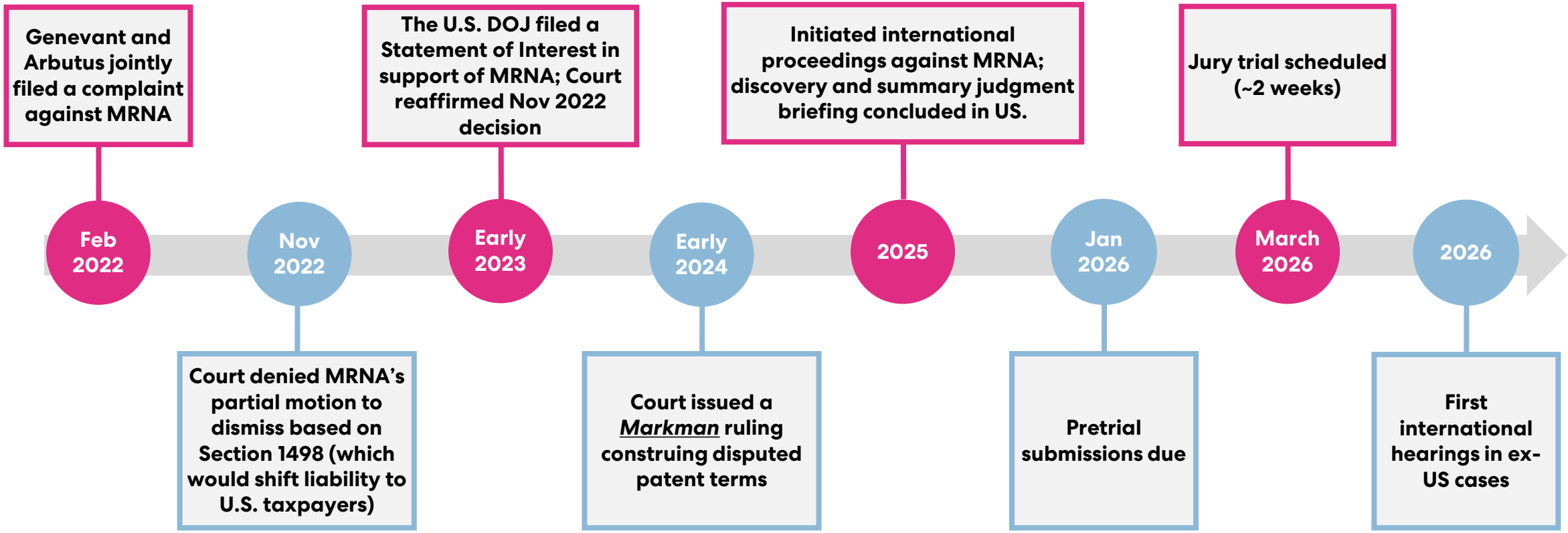
COMPLAINT FOR PATENT INFRINGEMENT

Plaintiffs Arbutus Biopharma Corporation ("Arbutus") and Genevant Sciences GmbH ("Genevant") file this Complaint seeking patent infringement damages against Defendants Moderna, Inc. and ModernaTX, Inc. (collectively, "Moderna") and allege the following:

INTRODUCTION

1. The impact of the COVID-19 pandemic, one of the greatest public health challenges in modern history, would be immeasurably worse but for the rapid, widespread availability of cutting-edge mRNA-based vaccines like Moderna's. Moderna brought its vaccine from lab bench to arms in record speed. That unprecedented accomplishment was made possible by Moderna's use of breakthrough technology Arbutus had already created and patented—a revolutionary lipid nanoparticle ("LNP") delivery platform that took the scientists of Arbutus years of painstaking work to develop and refine. Moderna was well aware of Arbutus's LNP patents and licensed them for other product programs, but it chose not to do so for its COVID-19 vaccine. Instead, it attempted to invalidate several of the patents before the United States Patent

Moderna Patent Litigation Timeline: Years in the Making



Note: All references are to calendar years and are approximate and subject to change. The timing of the litigation-related events noted above is subject to change, including at the discretion of the court. See Slide 2 for further information on these forward-looking statements

Summary Judgment Motions Filed in US Moderna Case

Genevant and Arbutus Filed 5 Motions for Summary Judgment

1. Moderna cannot relitigate obviousness arguments against the Lipid Composition Patents (the '359, '435, and '378 patents) already raised in its unsuccessful IPRs and appeals.
2. Moderna cannot argue at trial that the Asserted Patents are invalid because they do not enable someone in the art to practice the inventions without undue experimentation.
3. Arbutus and Genevant did not derive the invention disclosed in the '651 patent from a much later Moderna invention.
4. 28 U.S.C. § 1498 does not apply (cross motion).
5. Moderna's indefiniteness arguments fail as a matter of law (cross motion).

Moderna Filed 3 Motions for Summary Judgment

1. 28 U.S.C. § 1498 requires Arbutus and Genevant to recover damages for infringement under one government contract from the U.S. government, not Moderna.
2. Plaintiffs' claims under the doctrine of equivalents are barred by amendments and arguments made to the PTO during patent prosecution, and Arbutus and Genevant should be able to recover for literal infringement only.
3. The asserted claims of the '651 patent are invalid for indefiniteness with respect to the Court's construction of the term "fully encapsulated."

Patents Remaining to Be Litigated at Trial (Following Judge's Order on Claim Narrowing)

Subject Matter	US Patent No.
Particle Composition	8,492,359
	9,364,435
	11,141,378
mRNA-LNP Compositions	9,504,651

Note: All references are to calendar years and are approximate and subject to change. The timing of the litigation-related events noted above is subject to change, including at the discretion of the court. See Slide 2 for further information on these forward-looking statements

Daubert Motions: Judge to Decide Admissibility of Certain Expert Testimony

Genevant/Arbutus' Motions to Exclude Moderna's Expert Testimony

1) Damages methodologies

2) Certain opinions regarding Infringement, Doctrine of Equivalents, Written Description and Enablement

3) Opinions regarding obviousness

Moderna's Motions to Exclude Genevant/Arbutus' Expert Testimony

1) Damages methodologies

2) Opinions regarding willful infringement

3) Fractionation testing

4) Opinions regarding infringement

5) Opinions regarding applicability of Section 1498

Key Upcoming Milestones in US Litigation

Summary Judgement/Daubert Motions

- Judge to rule on summary judgment motions, including decision on § 1498, before the jury trial in March
- Judge will rule on *Daubert* motions, which could narrow the expert testimony allowed to be presented on both sides or impact presentations on damages, infringement, willful infringement, and invalidity

Jury Trial

- A jury trial is currently scheduled to start on March 9, 2026, in the U.S. District Court of Delaware. Jury selection will occur that day
- Genevant and Arbutus first, and Moderna second, will present their cases over the course of ~2 weeks
- Jury will deliberate, and parties will remain in Delaware until the jury issues their verdict

After the Trial

- Any jury verdict is expected to be appealed
  - Post-trial motions entertained by trial court in period after trial
  - An appeal could take an additional 18-24 months
- If the jury rules favorably for Genevant/Arbutus, to obtain a stay of execution of judgment pending appeal, Moderna would likely need to obtain a bond or post cash collateral with the court within 30 days

Note: All references are to calendar years and are approximate and subject to change. The timing of the litigation-related events noted above is subject to change, including at the discretion of the court. See Slide 2 for further information on these forward-looking statements

Overview of International Infringement Litigation; Accounts for Significant Portion of Ex-US SpikeVax Revenue

All ex-US jurisdictions with cases pending bifurcate liability from damages and, with success in liability phase, typically issue injunction preventing future sales; many award damages based on profits rather than reasonable royalty

Initial Hearings Expected in 2026

UPC

Japan

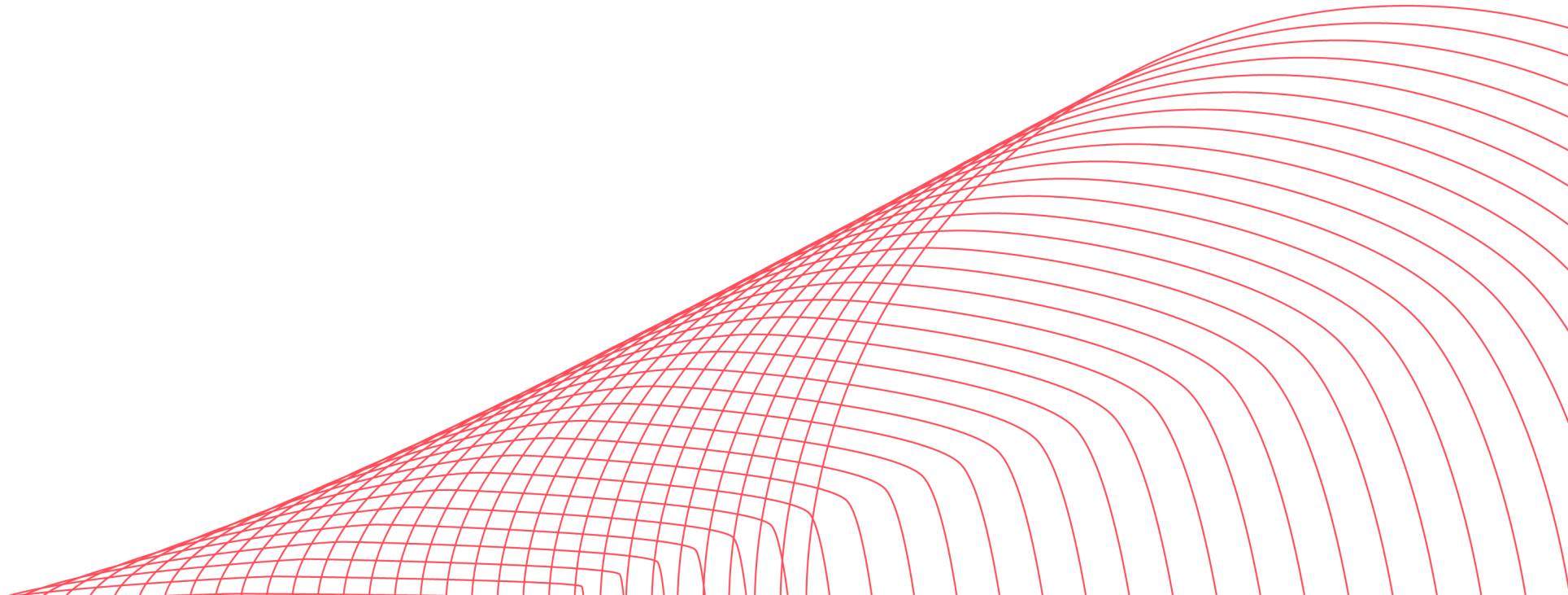
Switzerland

Initial Hearings Expected in 2027

Canada

Note: All references are to calendar years and are approximate and subject to change. The timing of the litigation-related events noted above is subject to change, including at the discretion of the court. See Slide 2 for further information on these forward-looking statements

Pfizer Case



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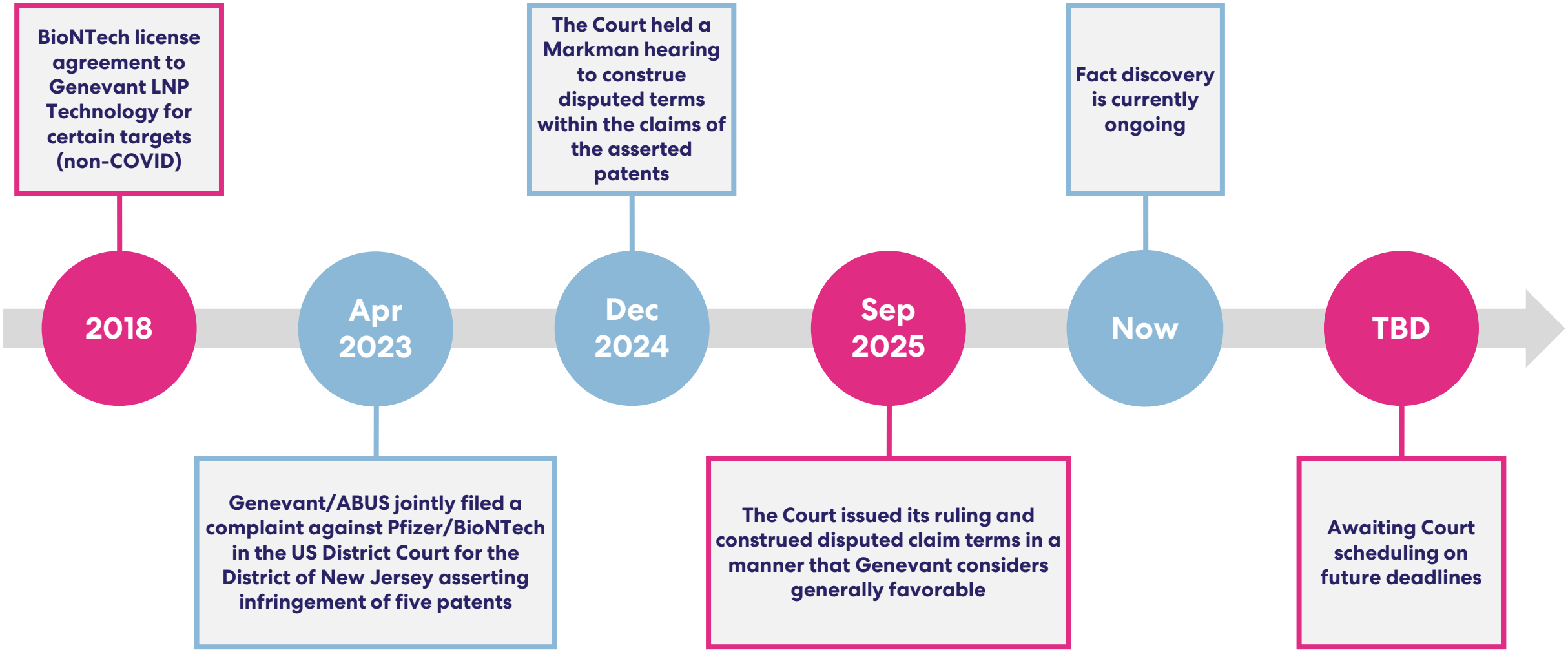
Pfizer/BioNTech Litigation Timeline to Date



Note: All references are to calendar years and are approximate and subject to change. The timing of the litigation-related events noted above is subject to change, including at the discretion of the court. See Slide 2 for further information on these forward-looking statements

Publicly Available Evidence Supports the Initial Filing of Our Case

Publicly Available Evidence Supporting the Case[1]

- BioNTech had license to Genevant LNP Technology for use for specific cancer and rare liver disease targets dating back to 2018; contract described Genevant's platform as "the best lipid nanoparticle technology"
- FDA EUA filing indicated that Pfizer/BioNTech's mRNA-vaccine infringes on Genevant and Arbutus lipid composition patents '651, '359 and '378
- CNN report covering Pfizer's manufacturing process confirmed infringement of Genevant and Arbutus manufacturing patents '320 and '098

"T-Mixer" used to create LNP; Arbutus/Genevant '320 patent

Note: Case 3:23-cv-01876-ZNQ-TJB, Document 1; COMPLAINT FOR PATENT INFRINGEMENT (2022)

In Summary: LNP Litigation

- We believe both Moderna's and Pfizer/BioNTech's COVID-19 vaccines infringe multiple Genevant/Arbutus patents
- Markman decisions in both cases viewed by Genevant generally to be favorable
- Trial/hearings in both the US and the ex-US litigation against Moderna expected in 2026
- Awaiting court scheduling in the Pfizer/BioNTech litigation

Note: All references are to calendar years and are approximate and subject to change. The timing of the litigation-related events noted above is subject to change, including at the discretion of the court. See Slide 2 for further information on these forward-looking statements

Financial Outlook

Richard Pulik

CFO, Roivant

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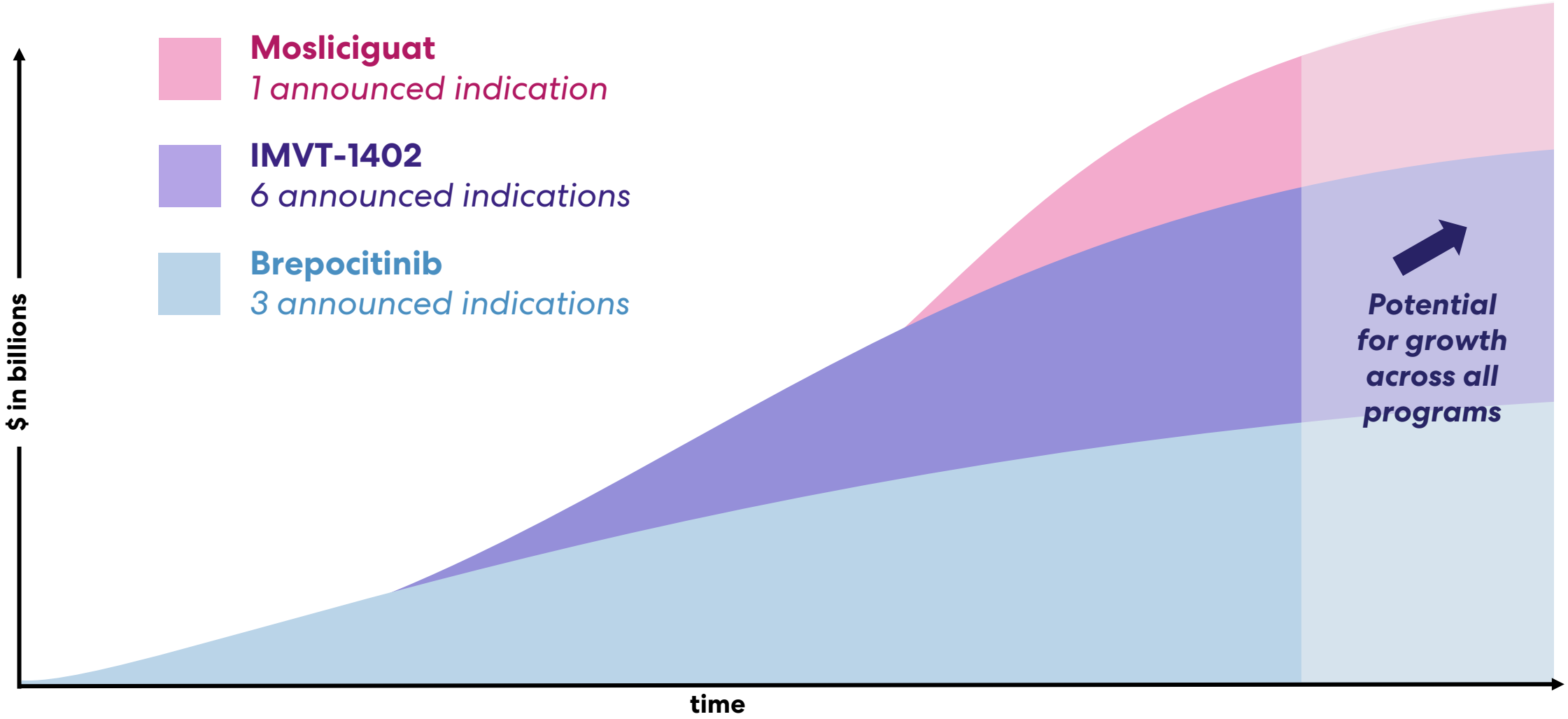
Our Portfolio Supports Wave of Approvals in Untapped High-Value Growth Markets With $15BN+ Peak Revenue Potential

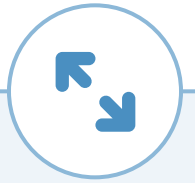


Represents non-probability adjusted peak sales across all announced indications. Graph is an approximate illustration of peak sales opportunity and is not drawn to scale

Roivant Capitalized to Profitability With $4.4BN Cash Balance to Advance Current Priorities and Fund Selective Capital Allocation Opportunities[1]

Invest in Current Pipeline & Launches

10+ disclosed indications in mid-late-stage development



Invest in New Opportunities

~$2BN available for late-stage development and high value creation opportunities

Return Excess Capital to Shareholders

$1.5BN buyback completed and additional $500M authorized

Roivant-Led Immunovant Financing Generated Gross Proceeds to Immunovant of Approximately $550M, Extending Immunovant's Cash Runway to the Launch of IMVT-1402 in Graves' Disease

1. Cash, cash equivalents, restricted cash, and marketable securities as of September 30, 2025

Selected Financial Metrics and Non-GAAP Modeling Assumptions

in $ millions, unaudited	*Last 12 months, ending September 30, 2025* GAAP[1]	Non-GAAP[1]
Roivant Consolidated		
Net Revenue	**$20**	**$20**
R&D	$604	$560
G&A	$566	$278
Total OpEx	**$1,171**	**$839**
Interest Income	$210	$210
Immunovant		
R&D	$404	$375
G&A	$83	$56
Total OpEx	**$487**	**$431**
Interest Income	$23	$23

Modeling Assumptions[2]

	Fiscal year ending March 31, 2026	2027	2028
R&D (non-GAAP)	low-mid $600M range		
SG&A (non-GAAP)	Low-mid $300M range		Low-mid $400M range

- Brepocitinib DM launch expected early CY 2027 and NIU launch early CY 2028
- First IMVT-1402 launch expected in CY 2028
- Non-GAAP R&D guidance assumes upcoming proof-of-concept study readouts support investment in registrational studies
- Non-GAAP SG&A guidance assumes ramp for brepocitinib launch costs
- Interest income expected to decline over time
- $4BN+[3] consolidated cash balance supports current pipeline to profitability

Notes :

(1) 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 pages 166-167. 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. Roivant consolidated figures include 100% of IMVT results below.

(2) This forward-looking analysis is based on non-GAAP metrics. Roivant does not provide a reconciliation of forward-looking non-GAAP financial measures to the most directly comparable GAAP measure due to the inherent difficulty in accurately forecasting certain amounts, particularly share-based compensation expense, that are necessary to develop meaningful comparable GAAP financial measures. These amounts could have a material impact on GAAP reported results for the guidance period. Please see page 2 for further information regarding forward-looking statements and non-GAAP financial information.

(3) Consolidated cash, cash equivalents, restricted cash, and marketable securities as of September 30, 2025. Does not include non-ROIV gross proceeds from Immunovant's December 2025 offering.

Non-GAAP Disclosures

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

	Note	Last 12 Months Actual September 30, 2025
Total Roivant		
Total operating expenses		**$ 1,171**
Adjustments:		
Research and development:		
Share-based compensation	(1)	41
Depreciation and amortization	(2)	3
General and administrative:		
Share-based compensation	(1)	285
Depreciation and amortization	(2)	3
Adjusted total operating expenses (Non-GAAP)		**$ 839**

	Note	Last 12 Months Actual September 30, 2025
Total Immunovant		
Total operating expenses		**$ 487**
Adjustments:		
Research and development:		
Share-based compensation	(1)	29
General and administrative:		
Share-based compensation	(1)	27
Adjusted total operating expenses (Non-GAAP)		**$ 431**

Notes to non-GAAP financial measures:

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

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

Non-GAAP Disclosures

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

	Note	Last 12 Months Actual September 30, 2025
Total Roivant		
Research and development expenses		**$ 604**
Adjustments		
Share-based compensation	(1)	41
Depreciation and amortization	(2)	3
Adjusted research and development expenses (Non-GAAP)		**$ 560**

	Note	Last 12 Months Actual September 30, 2025
Total Roivant		
General and administrative expenses		**$ 566**
Adjustments		
Share-based compensation	(1)	285
Depreciation and amortization	(2)	3
Adjusted research and development expenses (Non-GAAP)		**$ 278**

	Note	Last 12 Months Actual September 30, 2025
Immunovant		
Research and development expenses		**$ 404**
Adjustments		
Share-based compensation	(1)	29
Adjusted research and development expenses (Non-GAAP)		**$ 375**

	Note	Last 12 Months Actual September 30, 2025
Immunovant		
General and administrative expenses		**$ 83**
Adjustments		
Share-based compensation	(1)	27
Adjusted research and development expenses (Non-GAAP)		**$ 56**

Notes to non-GAAP financial measures:

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

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

Closing Remarks

Matt Gline

CEO, Roivant

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Keys to Our Success in 2026 and Beyond

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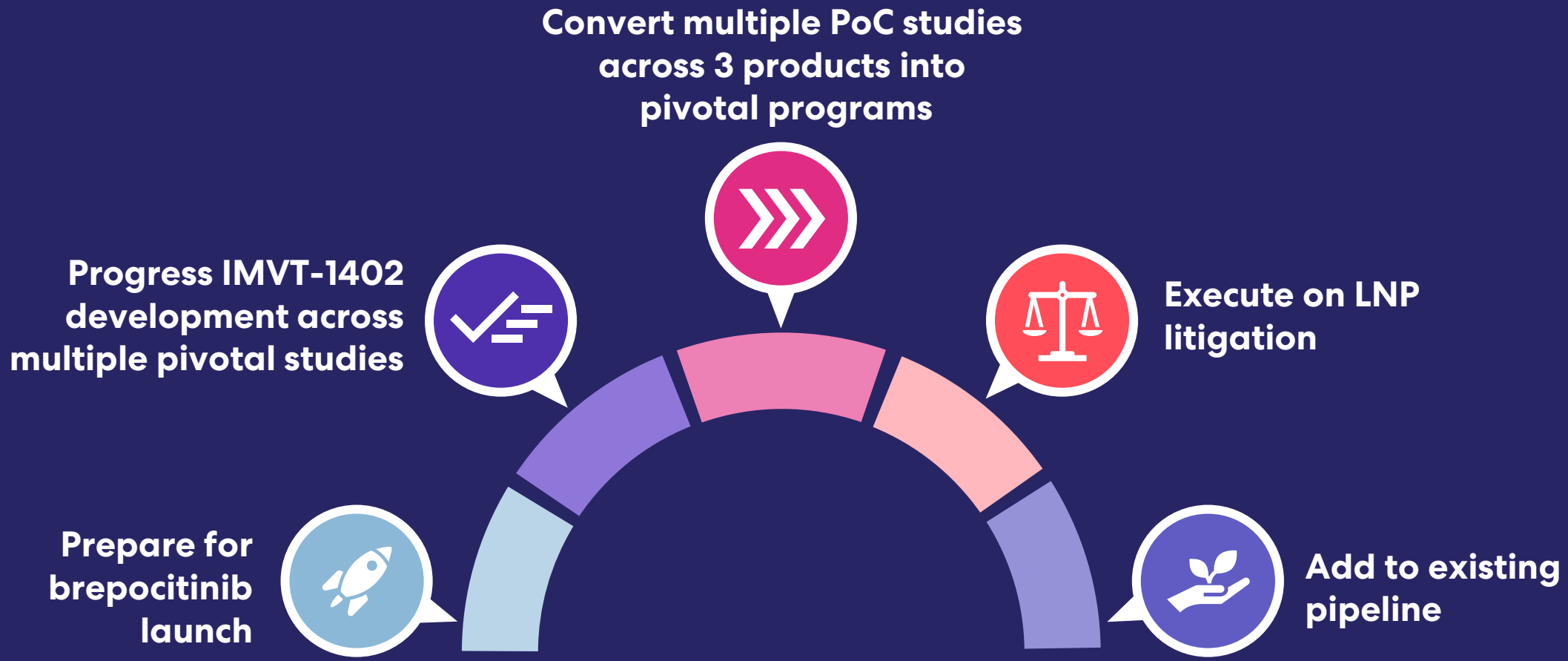
Unique and creative development programs for high quality molecules		Purposeful indication selection across pipeline programs
Well-capitalized		Funded through profitability
Ability to successfully commercialize drugs in non-mass-market indications		Preparing for brepocitinib launch in DM, and others to follow
Reinvesting capital into next generation of pipeline		~$2BN reserved for opportunistic pipeline expansion

2026: Another Catalyst-Rich Year for Roivant

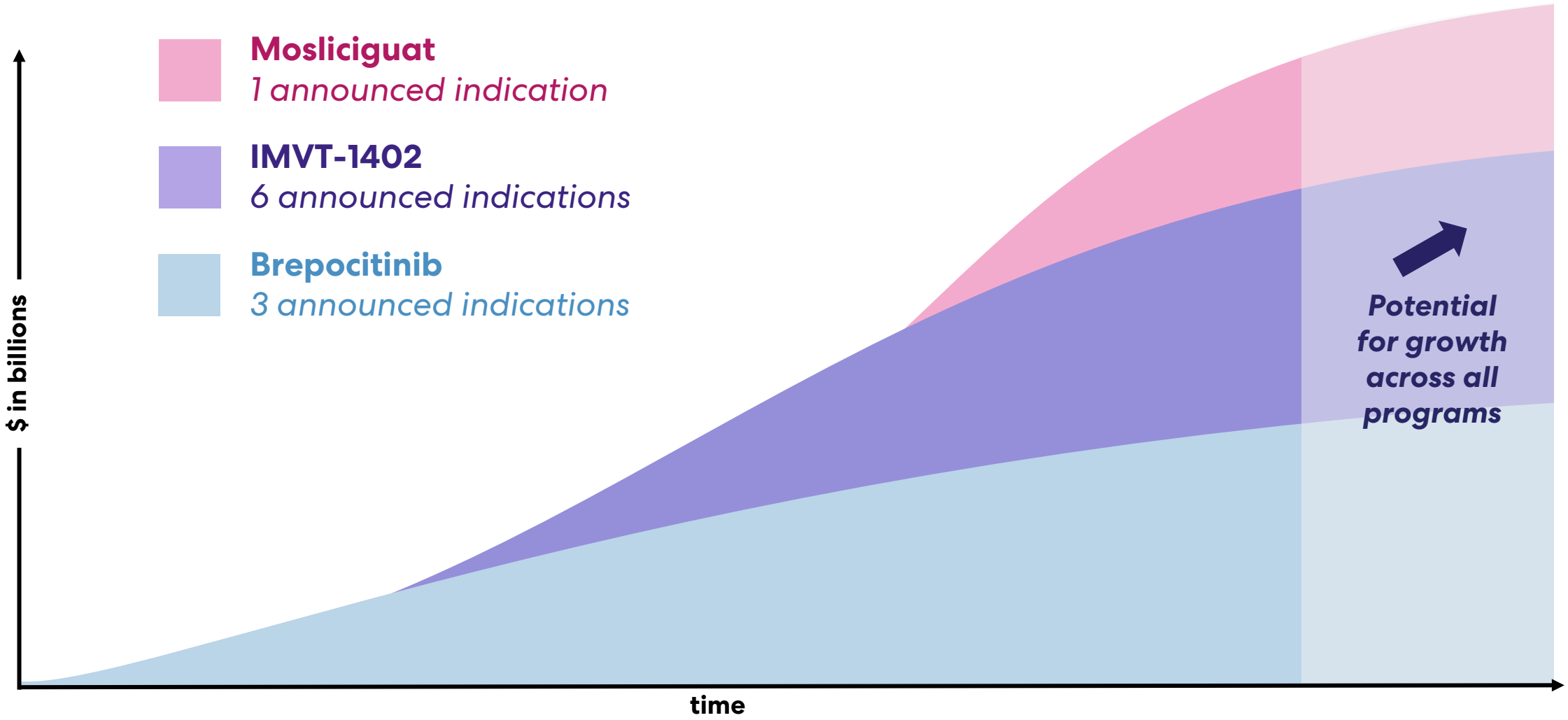
- Brepocitinib DM NDA filing planned for early 2026
- Brepocitinib NIU Ph3 topline data in 2H 2026
- Mosliciguat PH-ILD Ph2b topline data in 2H 2026
- IMVT-1402 D2T RA potentially registrational topline data in 2026
- Topline data in PoC studies for brepocitinib in CS in 1H 2026 and IMVT-1402 in CLE in 2026
- LNP litigation jury trial in US Moderna case in 1Q 2026

Note: All drugs are investigational and subject to regulatory approvals. 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

Roivant's Priorities for the Next 12 Months...



... To Fully Capitalize on an Exciting Next Decade



Represents non-probability adjusted peak sales across all announced indications. Graph is an approximate illustration of peak sales opportunity and is not drawn to scale

Rich Catalyst Calendar Over the Next 36 Months

Pivotal / Potentially Registrational / Launch

Early 2026 NDA filing in DM

1H 2026 Topline data in TED*

2H 2026 Topline data in NIU

2026 Topline data in D2T RA

Early 2027 **DM Launch**

2027 Topline data in GD
Topline data in MG

Early 2028 **NIU Launch**

2028 Topline data in SjD
Topline data in CIDP
GD Launch

2026 | 2027 | 2028

Proof of Concept / Other

1Q 2026 Jury trial in US MRNA case

1H 2026 Topline data in CS

2H 2026 Topline data in PH-ILD

2026 Initial results in CLE
First hearings in ex-US MRNA cases

2027+
Future POC study readouts in undisclosed indications and future BD

KEY

FcRn franchise | mosliciguat
brepocitinib | LNP litigation

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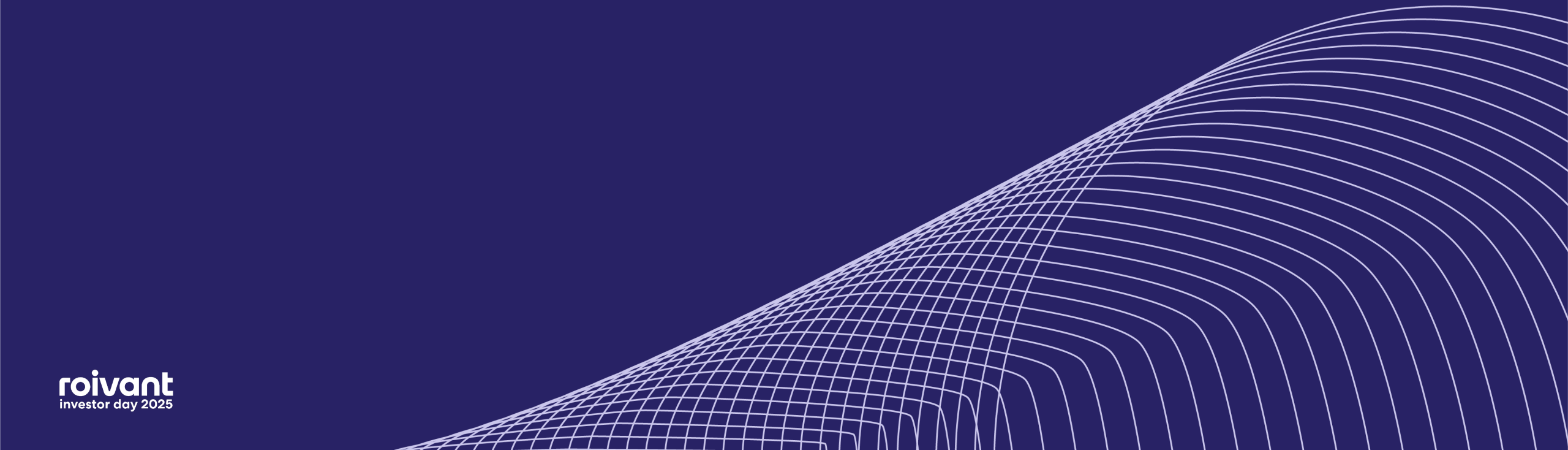
Note: All drugs are investigational and subject to regulatory approvals. All catalyst timings are approximate, based on current expectations and, where applicable, contingent on FDA feedback, and may be subject to change. All references are to calendar years.
*Immunovant continues to expect the first of the two batoclimab Phase 3 TED studies to read out before the end of calendar year 2025. However, due to evolving competitive dynamics, Immunovant anticipates sharing topline results from both TED studies concurrently in the first half of calendar year 2026

Q&A



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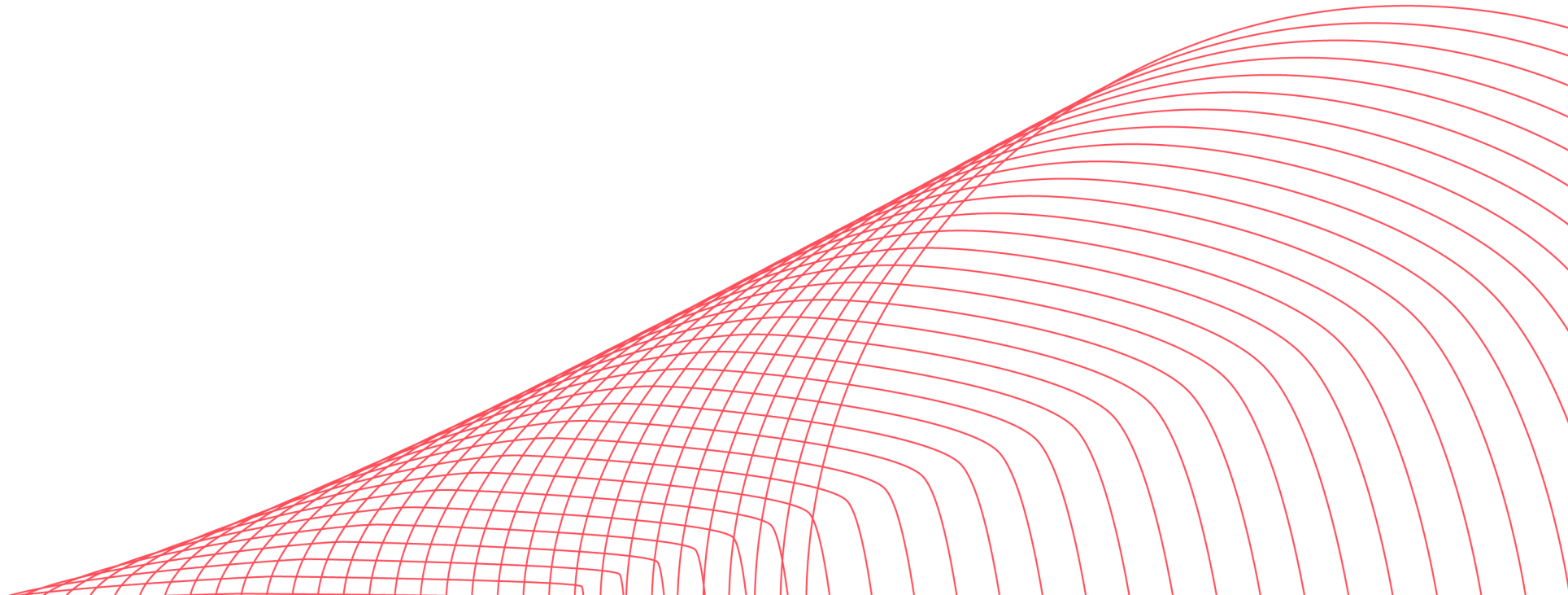
Appendix

Selected Study Designs



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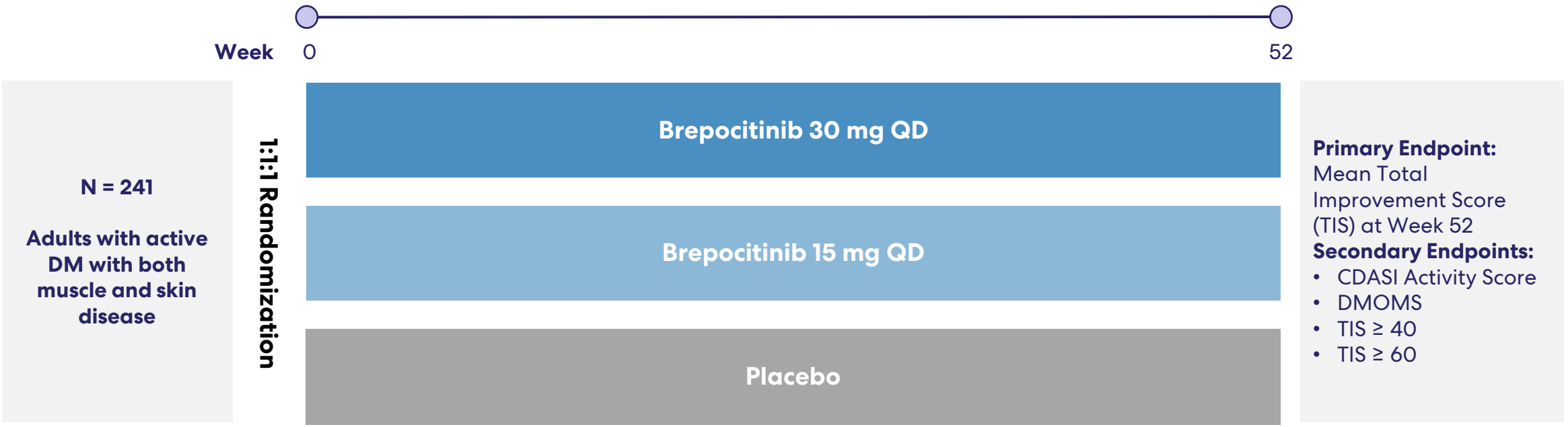
valor: Single Phase 3 Study for Brepocitinib in Dermatomyositis

Positive topline results announced in September 2025

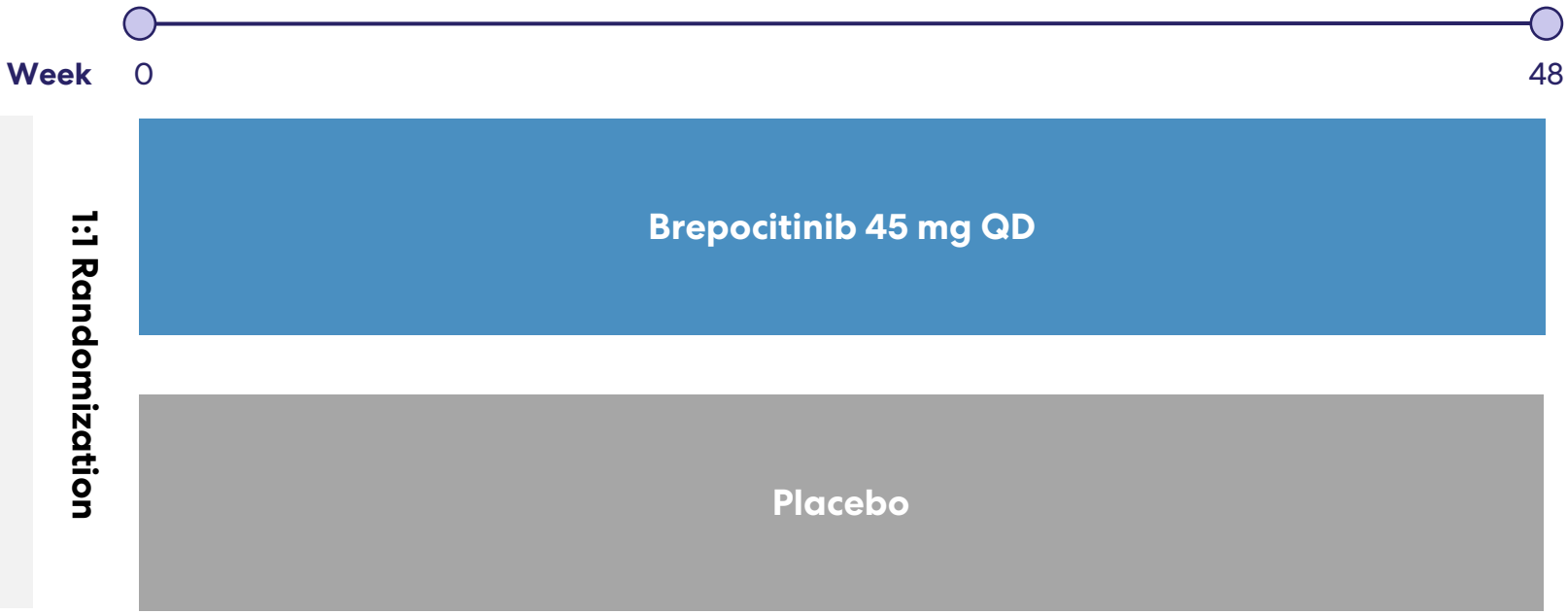


Steroid taper: Mandatory OCS taper to ≤5 mg/day from week 12 to 36; recommended further tapering at investigator discretion

Note: Additional inclusion and exclusion criteria not listed on slide
Note: Additional primary and secondary endpoint details not listed on slide
DM: dermatomyositis; QD: daily; OCS: oral corticosteroids; CDASI: Cutaneous Dermatomyositis Disease Area and Severity Index; DMOMS: Dermatomyositis Outcomes for Muscle and Skin

CLARITY: Phase 3 Study for Brepocitinib in Non-Infectious Uveitis

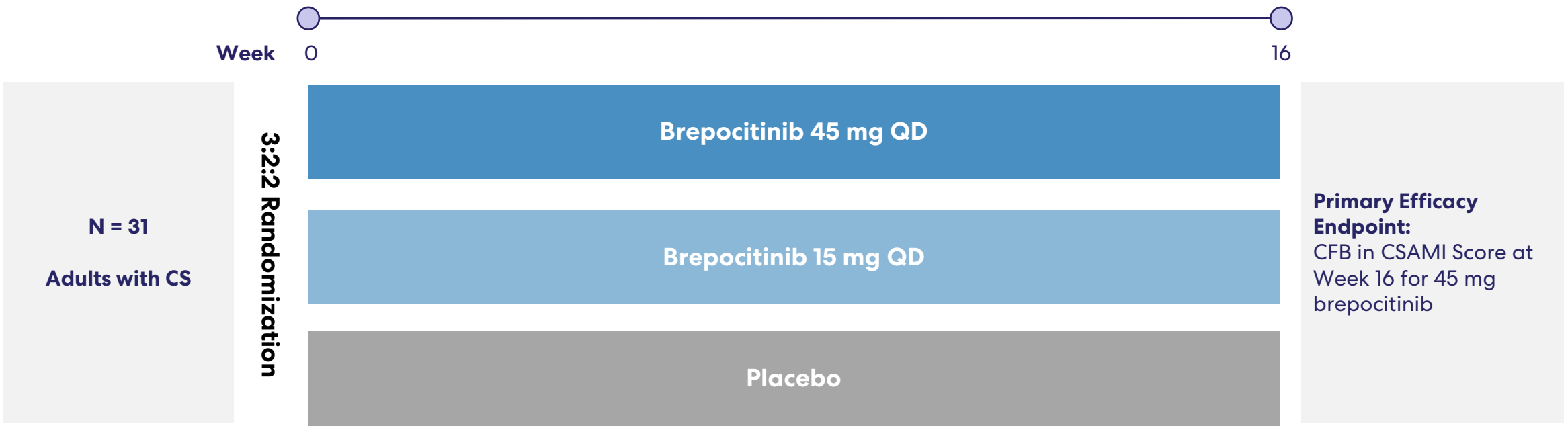
Two identical sub-studies, CLARITY-1 and CLARITY-2, under a single protocol



Steroid burst and taper: 60 mg/day OCS burst for 14 days; forced taper to 0 mg/day by Week 8 (identical to Phase 2 study)

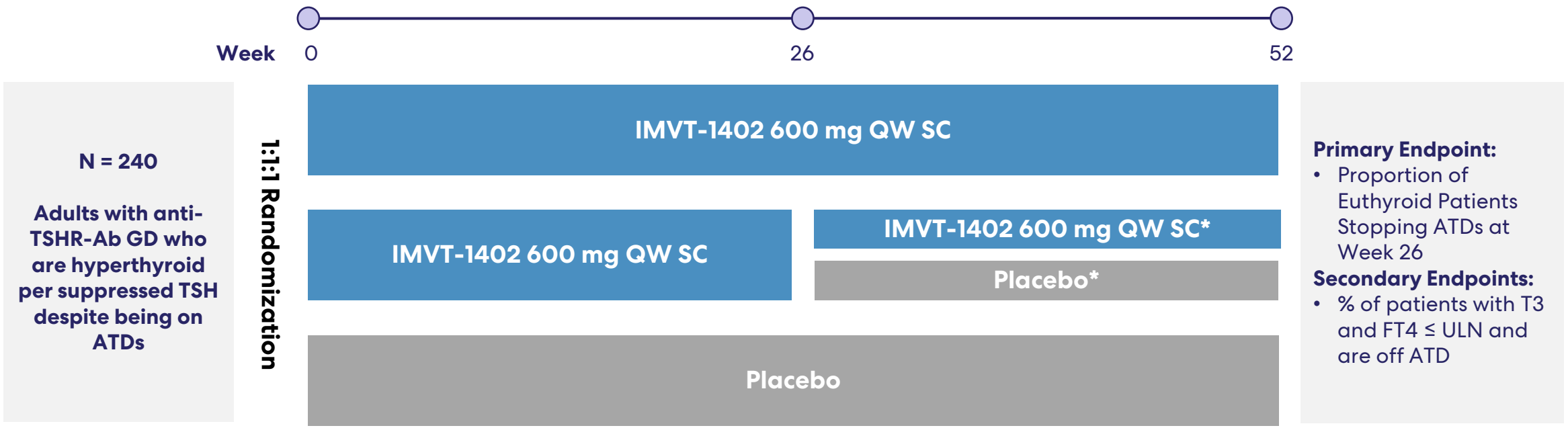
Note: Additional inclusion and exclusion criteria not listed on slide
Note: Additional primary and secondary endpoint details not listed on slide
QD: daily; OCS: oral corticosteroids; CST: central subfield thickness; WFFA: wide-field fluorescein angiography
References are to calendar years

BEACON: Phase 2 Study for Brepocitinib in Cutaneous Sarcoidosis



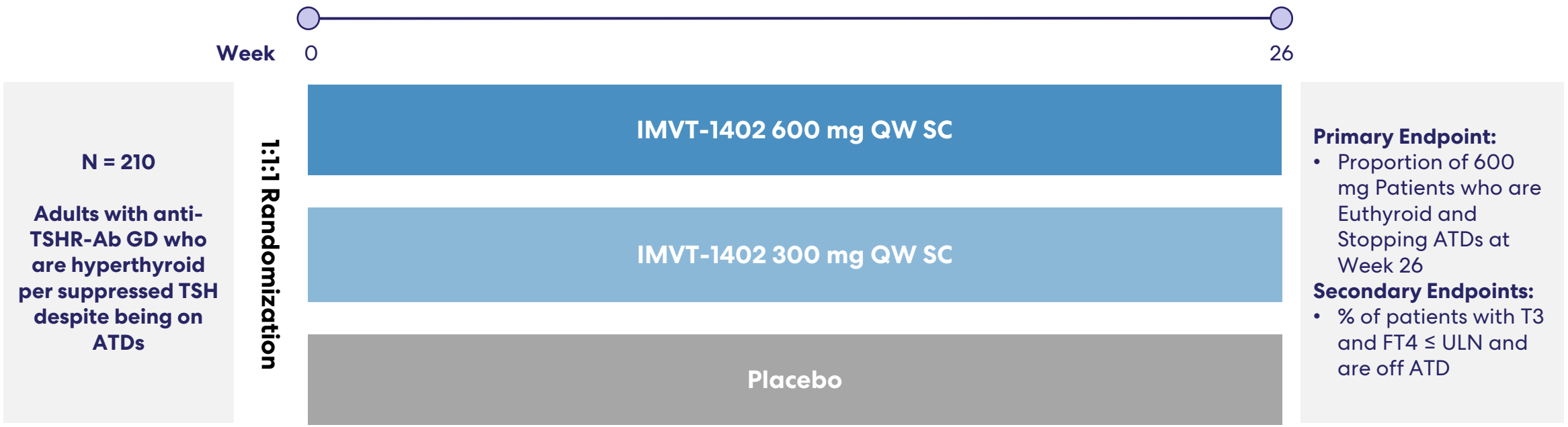
Note: Additional inclusion and exclusion criteria not listed on slide
Note: Additional primary and secondary endpoint details not listed on slide
CS: cutaneous sarcoidosis; QD: daily; CFB: change from baseline; CSAMI: Cutaneous Sarcoidosis Activity and Morphology Instrument
References are to calendar years

FORWARD : Potentially Registrational Study for IMVT-1402 in Graves' Disease



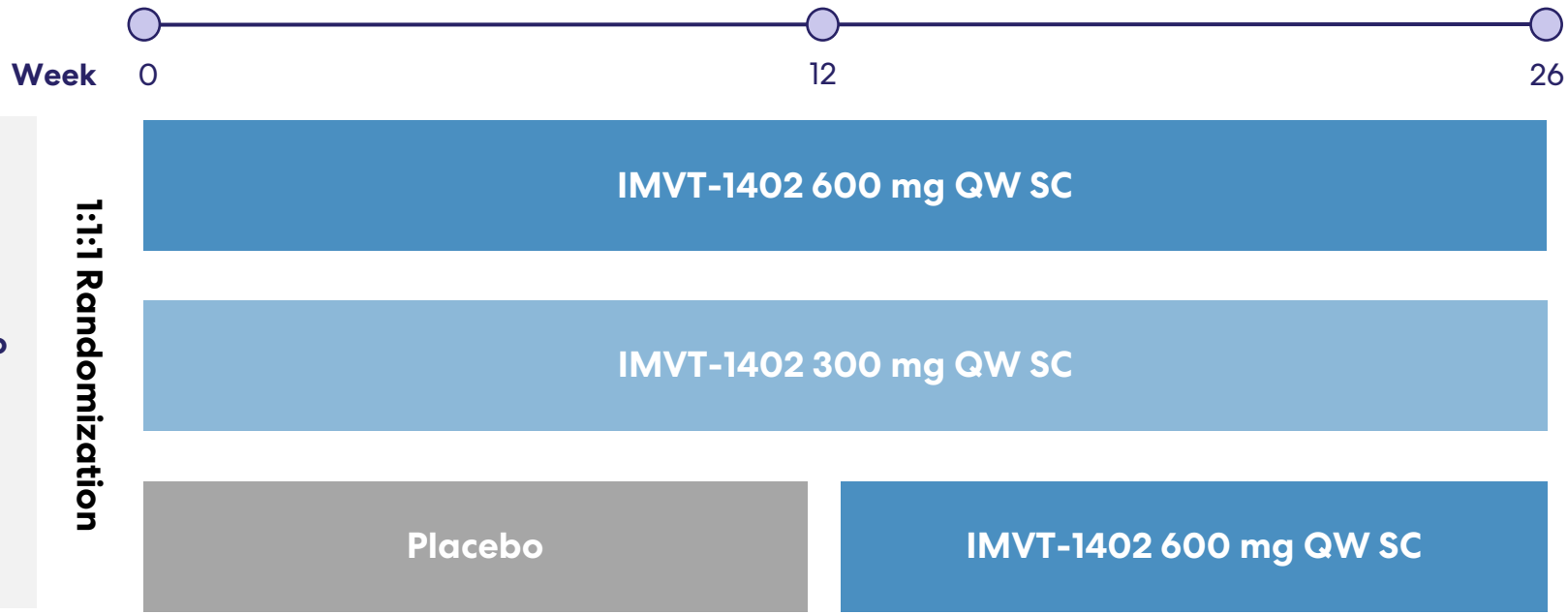
Note: Additional inclusion and exclusion criteria not listed on slide
Note: Additional primary and secondary endpoint details not listed on slide
Note: Throughout the study, ATD titration occurs to lowest effective dose (including 0 mg/day) to maintain euthyroidism
*Dosage split for the middle group at Week 26 is determined by TRAb response: TRAb responders switch from 600 mg of IMVT-1402 to placebo, while non-responders stay on the 600 mg regimen
1. Euthyroid = T3/T4 and TSH within normal limits
Anti-TSHR-Ab: anti-TSHR antibody; GD: Graves' disease; TSH: thyroid-stimulating hormone; ATD: antithyroid drugs; QW: weekly; SC: subcutaneous; T3: triiodothyronine; FT4: free thyroxine; ULN: upper limit of normal

FORWARD II: Potentially Registrational Study for IMVT-1402 in Graves' Disease



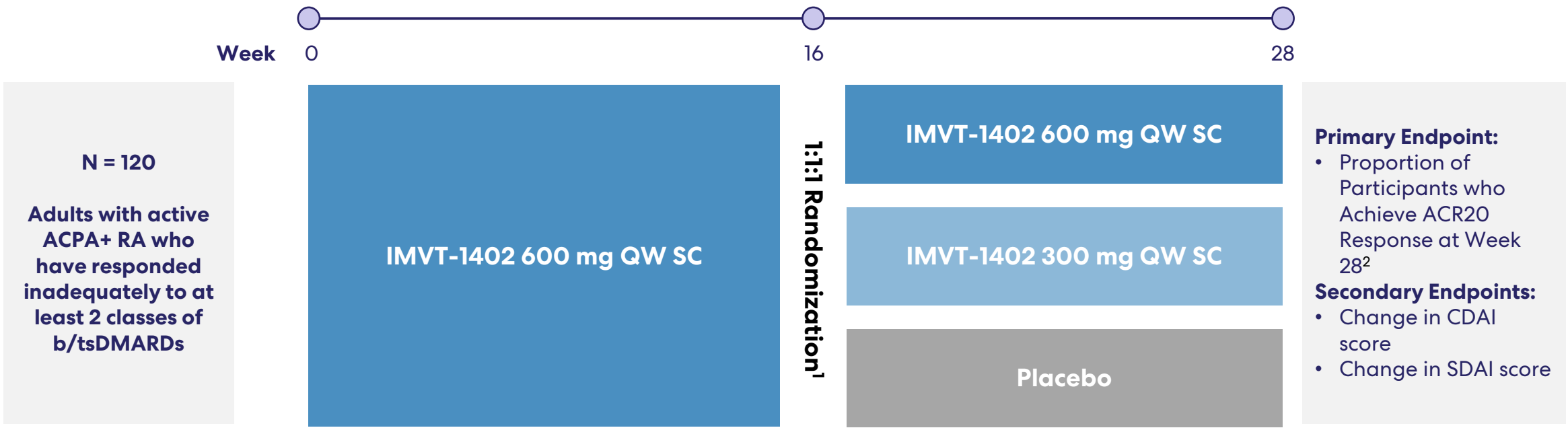
Note: Additional inclusion and exclusion criteria not listed on slide
Note: Additional primary and secondary endpoint details not listed on slide
Note: Throughout the study, ATD titration occurs to lowest effective dose (including 0 mg/day) to maintain euthyroidism
1. Euthyroid = T3/T4 and TSH within normal limits
Anti-TSHR-Ab: anti-TSHR antibody; GD: Graves' disease; TSH: thyroid-stimulating hormone; ATD: antithyroid drugs; QW: weekly; SC: subcutaneous; T3: triiodothyronine; FT4: free thyroxine; ULN: upper limit of normal

Propel: Potentially Registrational Study for IMVT-1402 in Myasthenia Gravis



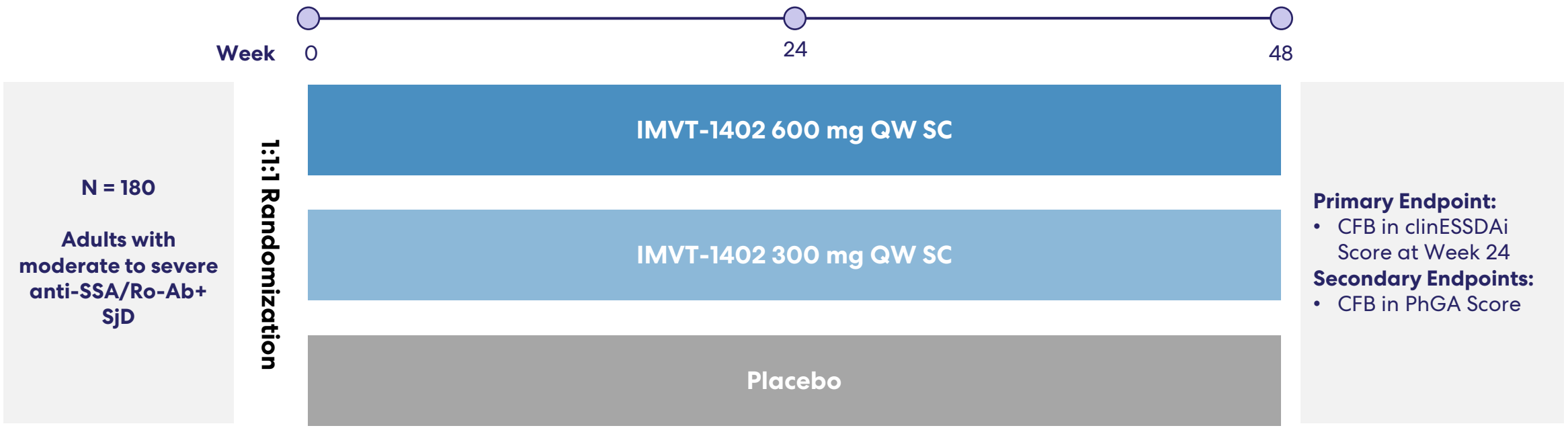
Note: Additional inclusion and exclusion criteria not listed on slide
Note: Additional primary and secondary endpoint details not listed on slide
Note: Long-Term Extension (LTE) study starts at Week 26
AChR Ab+: acetylcholine receptor antibody-positive; MuSK+: muscle-specific tyrosine kinase antibody-positive; LRP4+: low-density lipoprotein receptor-related protein 4 antibody-positive; MG: myasthenia gravis; QW: weekly; SC: subcutaneous injection; MG-ADL: Myasthenia Gravis Activities of Daily Living scale; QMG: Quantitative Myasthenia Gravis Score

Explore: Potentially Registrational Study for IMVT-1402 in Difficult-to-Treat Rheumatoid Arthritis



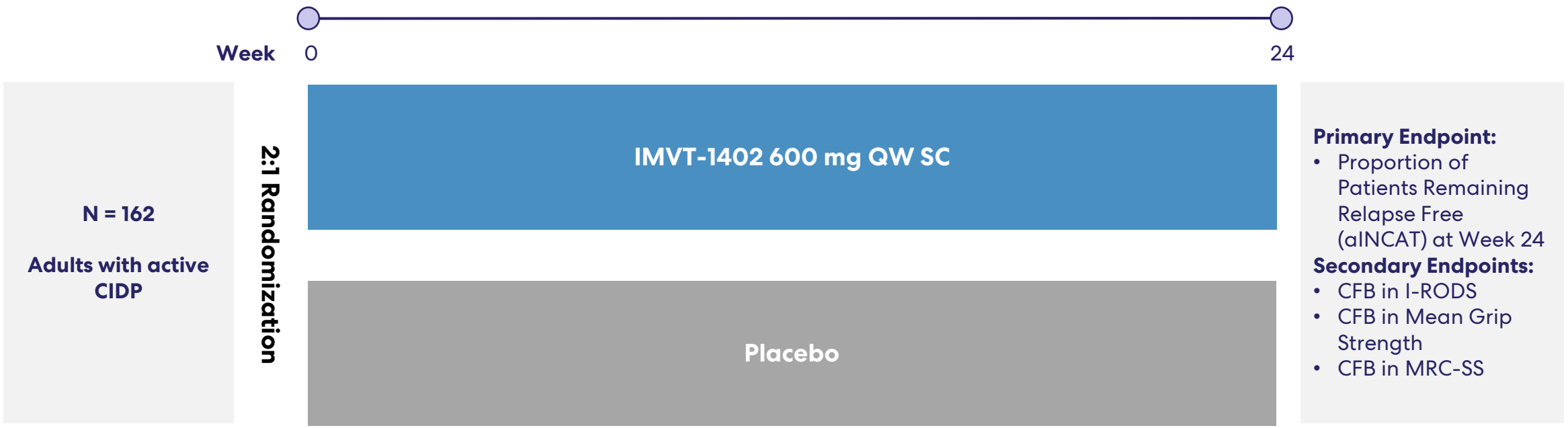
Note: Additional inclusion and exclusion criteria not listed on slide
Note: Additional primary and secondary endpoint details not listed on slide
1. 1:1:1 randomization of patients meeting ACR20 criteria at Week 14 & Week 16
2. Only includes participants who achieve ACR20 response at Week 14 & Week 16
APCA: anti-citrullinated protein antibody; RA: rheumatoid arthritis; bDMARDs: biologic disease-modifying anti-rheumatic drugs; tsDMARDs: targeted synthetic disease-modifying anti-rheumatic drugs; QW: Weekly; SC: Subcutaneous; ACR20: American College of Rheumatology 20; CDAI: Clinical Disease Activity Index; SDAI: Simplified Disease Activity Index

Bloom: First Potentially Registrational Study for IMVT-1402 in Sjögren's Disease



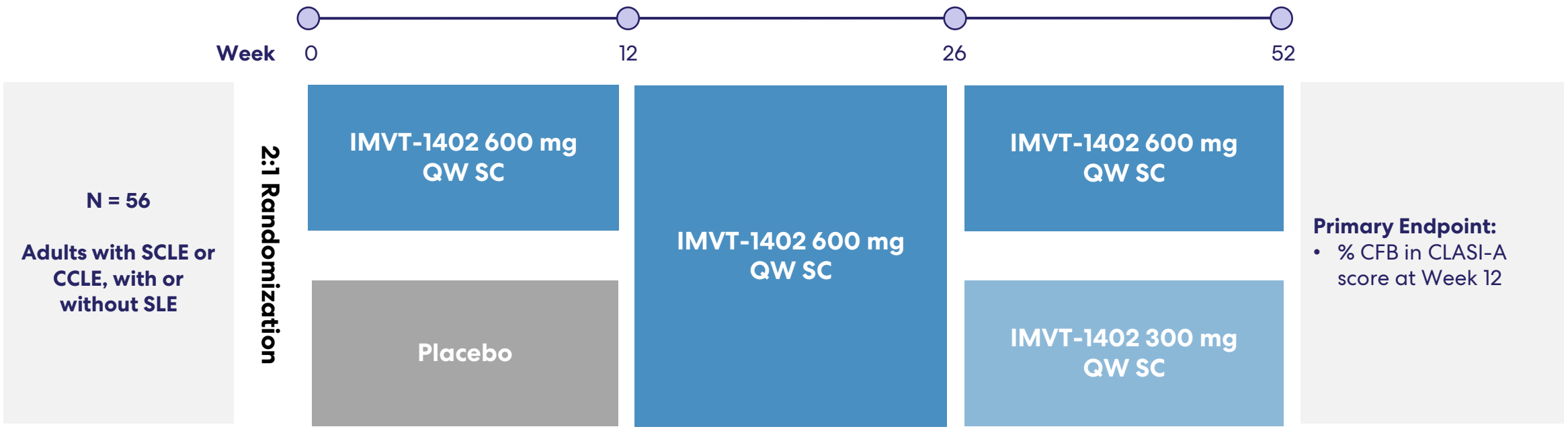
Note: Additional inclusion and exclusion criteria not listed on slide
Note: Additional primary and secondary endpoint details not listed on slide
*Only clinESSDAI responders (improvement of ≥ 4 points from baseline) continue through period 2
anti-SSA: anti-Sjögren's-syndrome-related antigen A antibody; SjD: Sjögren's disease; QW: weekly; SC: subcutaneous; CFB: change from baseline; clinESSDAI: clinical European League Against Rheumatism Sjögren's Syndrome Disease Activity Index; PhGA: Physician General Assessment of Disease Activity

Amplifi: Potentially Registrational Study for IMVT-1402 in Chronic Inflammatory Demyelinating Polyneuropathy



Note: Additional inclusion and exclusion criteria not listed on slide
Note: Additional primary and secondary endpoint details not listed on slide
Note: Simplified study design without washout period and flare requirement prior to randomization based on experience in the batoclimab CIDP study in identifying patients with active disease
CIDP: chronic inflammatory demyelinating polyneuropathy; QW, once weekly; SC subcutaneous; aINCAT: Adjusted Inflammatory Neuropathy Cause and Treatment disability score; CFB: change from baseline; I-RODS: Inflammatory Rash-Built Overall Disability Scale; MRC-SS: Medical Research Council Sum Score

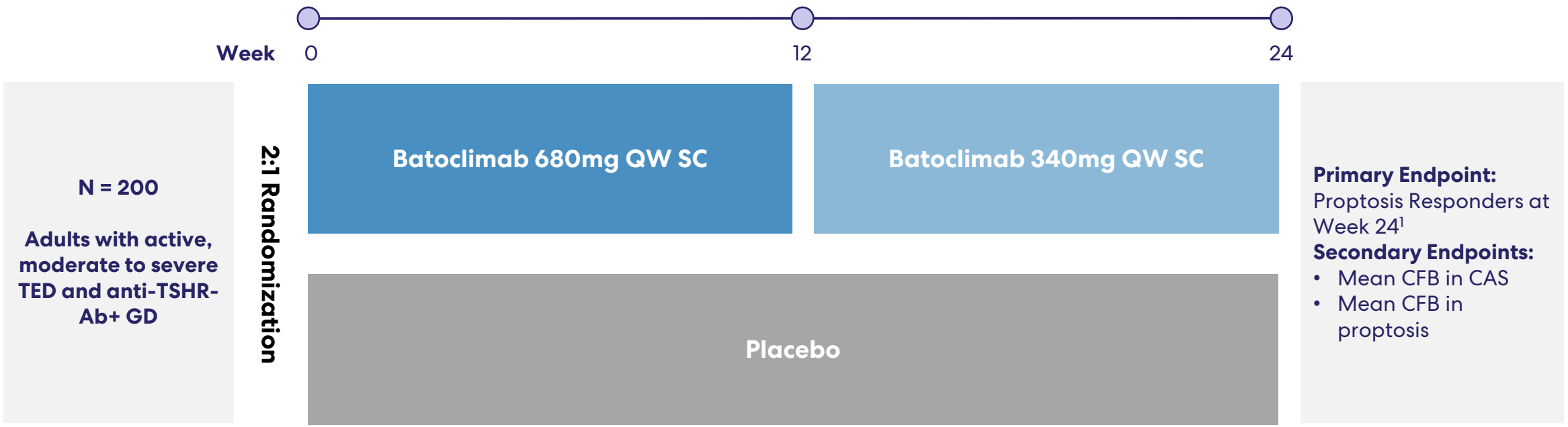
Proof-of-Concept Study for IMVT-1402 in Cutaneous Lupus Erythematosus



Note: Additional inclusion and exclusion criteria not listed on slide
Note: Additional primary and secondary endpoint details not listed on slide
Note: Simplified study design without washout period and flare requirement prior to randomization based on experience in the batoclimab CIDP study in identifying patients with active disease
SCLE: subacute cutaneous lupus erythematosus; CCLE: chronic cutaneous lupus erythematosus; SLE: systemic lupus erythematosus; QW: once weekly; SC: subcutaneous; CFB: change from baseline; CLASI-A: Cutaneous Lupus Area and Severity Score Index – Activity

GO and GO-2: Phase 3 Studies for Batoclimab in Thyroid Eye Disease

Anticipate sharing topline data from both trials in 1H 2026*



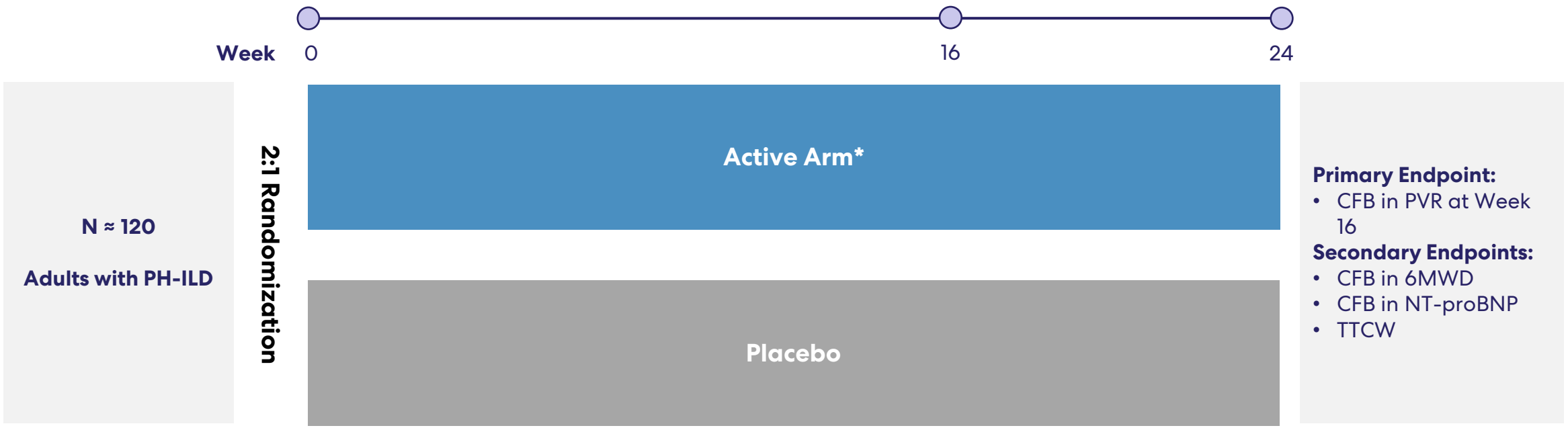
Note: Additional inclusion and exclusion criteria not listed on slide; additional primary and secondary endpoint details not listed on slide; participants that complete the active treatment phase may enter an open-label extension study, which will evaluate the response rate and durability of response over time

*Immunovant continues to expect the first of the two batoclimab Phase 3 TED studies to read out before the end of calendar year 2025. However, due to evolving competitive dynamics, Immunovant anticipates sharing topline results from both TED studies concurrently in the first half of calendar year 2026.

1. Responders defined as ≥ 2 mm reduction from baseline in proptosis in the study eye without deterioration (≥ 2 mm increase) in the fellow eye

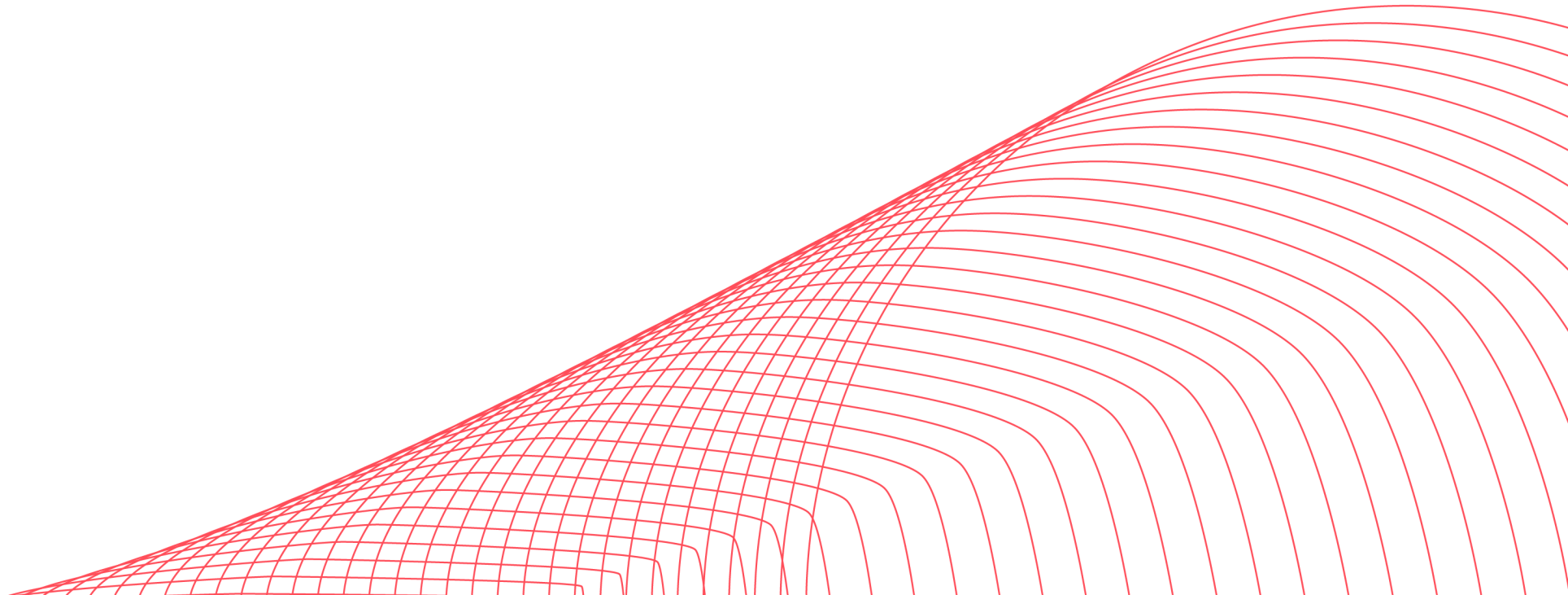
TED: thyroid eye disease; anti-TSHR-Ab: anti-TSHR antibody; GD: Graves' disease; QW: weekly; SC: subcutaneous injection; CFB: change from baseline; CAS: Clinical Activity Score

phocus: Phase 2 Study of Mosliciguat in Pulmonary Hypertension Associated With Interstitial Lung Disease



Note: Additional inclusion and exclusion criteria not listed on slide
Note: Additional primary and secondary endpoint details not listed on slide
*Rapid uptitration to stable dose
PH-ILD: pulmonary hypertension associated with interstitial lung disease; CFB: change from baseline; PVR: pulmonary vascular resistance; 6MWD: Six-Minute Walk Distance; NT-proBNP: N-terminal pro-B-type natriuretic peptide; TTCW: time to clinical worsening

Vant Financials Overview



roivant
investor day 2025

Priovant: Other Details

Ownership	ROIV owns 73%[1] of Priovant, with Pfizer owning 24%.
Geographic Rights	Priovant has commercial rights to brepocitinib in US and Japan.
Intellectual Property	We expect brepocitinib to have US exclusivity at least until 2039[2].
Milestones	Priovant is obligated to pay Pfizer mid tens-of-millions if sales exceed a mid hundreds-of-millions amount in Priovant territories. Pfizer is obligated to pay Priovant low tens-of-millions if sales exceed a mid hundreds-of-millions amount in non-Priovant territories.
Royalties	Priovant is obligated to pay Pfizer tiered sub-teens royalties on annual sales in Priovant territories. Pfizer is obligated to pay Priovant tiered high single digits to sub-teens royalties on annual sales in non-Priovant territories.

1. As of September 30, 2025. 65% on a fully diluted basis.
2. Includes potential patent term extension

Immunovant: Other Details

Ownership	Immunovant is publicly traded, with ROIV owning 55%[1]
Geographic Rights	Immunovant has global rights to batoclimab and IMVT-1402 outside of APAC[2]
Intellectual Property	We expect IMVT-1402 to have US exclusivity at least until 2043[3]
Milestones	Immunovant is obligated to pay HanAll future development and commercial milestone payments up to an aggregate $420M (of which $32.5M has been paid)
Royalties	Immunovant is obligated to pay HanAll tiered mid-single-digits to mid-teens royalty on net sales of batoclimab and IMVT-1402

1. As of September 30, 2025, 50% on a diluted basis
2. Immunovant has commercialization rights in U.S., Canada, Mexico, the E.U., the U.K., Switzerland, the Middle East, North Africa and Latin America
3. Not including any potential patent term extension

Pulmovant: Other Details

Ownership	ROIV owns 98%[1] of Pulmovant.
Geographic Rights	Pulmovant holds worldwide commercial rights to mosliciguat.
Intellectual Property	We expect mosliciguat to have US exclusivity until the mid-2040s[2].
Milestones	Pulmovant is obligated to pay Bayer development, regulatory and net sales milestones, up to an aggregate $280M
Royalties	Pulmovant is obligated to pay Bayer tiered high-single-digit royalties on annual net sales

1. As of September 30, 2025. 91% on a fully diluted basis.
2. Includes potential patent term extension