Financial Results and Business Update for the Year Ended March 31, 2026

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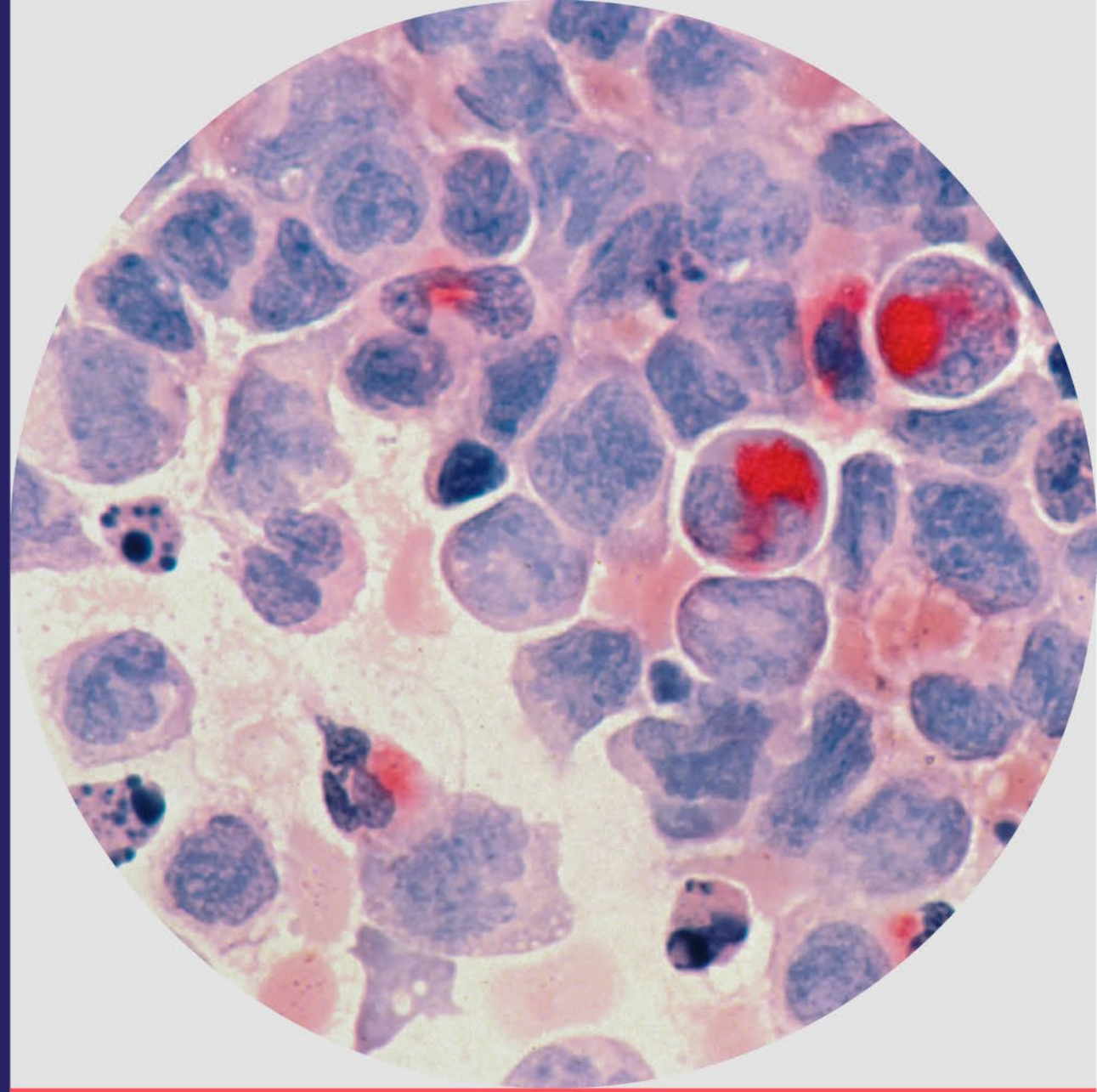


May 20, 2026

Forward-Looking Statements

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

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

These forward-looking statements may be affected by a number of risks and uncertainties, including, but not limited to, those risks set forth in the sections captioned “Risk Factors” and “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 IMVT-1402 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 slide 42 and in our earnings release furnished with our Current Report on Form 8-K dated May 20, 2026. Any non-GAAP financial measures presented are not, and should not be viewed as, substitutes for financial measures required by U.S. GAAP, have no standardized meaning prescribed by U.S. GAAP and may not be comparable to the calculation of similar measures of other companies.

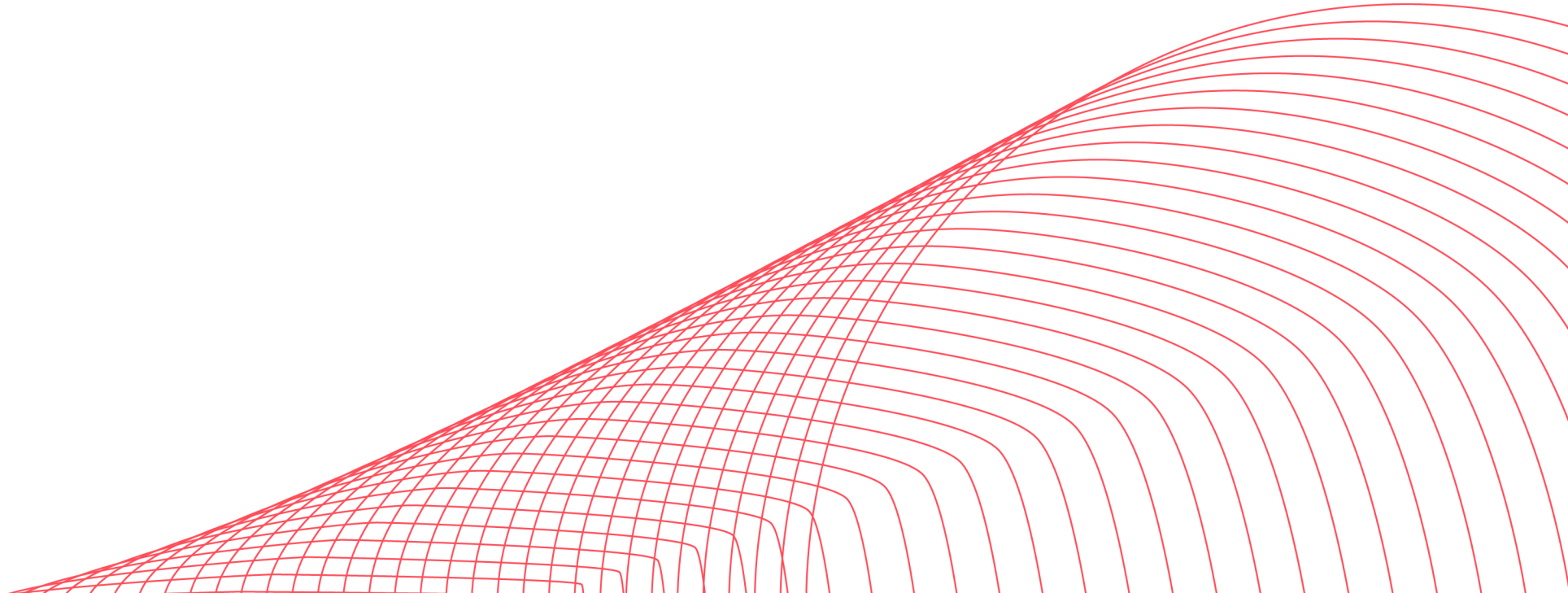
Disclaimer

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

Agenda

- Roivant in 2026
- IMVT-1402 in D2T RA: Preliminary Period 1 Data
- Mosliciguat Spotlight
- Brepocitinib Program Updates
- Financial Update
- Q&A

Roivant in 2026



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Recent Updates Exemplify Continued Momentum in 2026

Brepocitinib

Breakthrough Therapy Designation granted to brepocitinib for the treatment of CS	LPP announced as 4th indication for brepocitinib with subjects already enrolled in registrational study	Commercial preparation underway for brepocitinib launch in DM, expected by end of September 2026

FcRn Franchise

IMVT-1402 showed meaningful response rates in D2T RA patients, including a 36% ACR70 response at Week 16 in open label period of potentially registrational study†	IMVT-1402 proof-of-concept trial in CLE fully enrolled: topline data expected 2H 2026	Phase 3 studies of batoclimab in TED failed, but hyperthyroid patients showed normalization as seen in GD studies

LNP Litigation

$2.25BN settlement reached with Moderna; $950M payment to Genevant and Arbutus expected July 2026[1]

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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.
CS: cutaneous sarcoidosis; DM: dermatomyositis; LPP: lichen planopilaris; D2T RA: difficult-to-treat rheumatoid arthritis; CLE; cutaneous lupus erythematosus; TED: thyroid eye disease; GD: Graves' disease
†Period 1 data is preliminary – minor changes are likely as data is finalized
1. For more information about the settlement with Moderna and related payments, please refer to our Form 10-K filed with the SEC on May 20, 2026. Any references to Genevant in this presentation are to Genevant Sciences GmbH (GSG)

Catalyst-Rich Period Ahead:

DM Launch, 4 Pivotal & 2 PoC Readouts Expected by YE 2027

- Brepocitinib DM commercial launch expected by end of September 2026
- Brepocitinib CS Ph3 trial initiation and NIU Ph3 topline data expected in 2H 2026
- Mosliciguat PH-ILD Ph2b topline data expected in 2H 2026
- IMVT-1402 D2T RA updates and CLE PoC topline data expected in 2H 2026
- IMVT-1402 GD and MG potentially registrational topline data expected in 2027
- $950M payment from MRNA to Genevant/ABUS expected July 2026; PFE/BNTX litigation and MRNA Section 1498 appeal ongoing[1]

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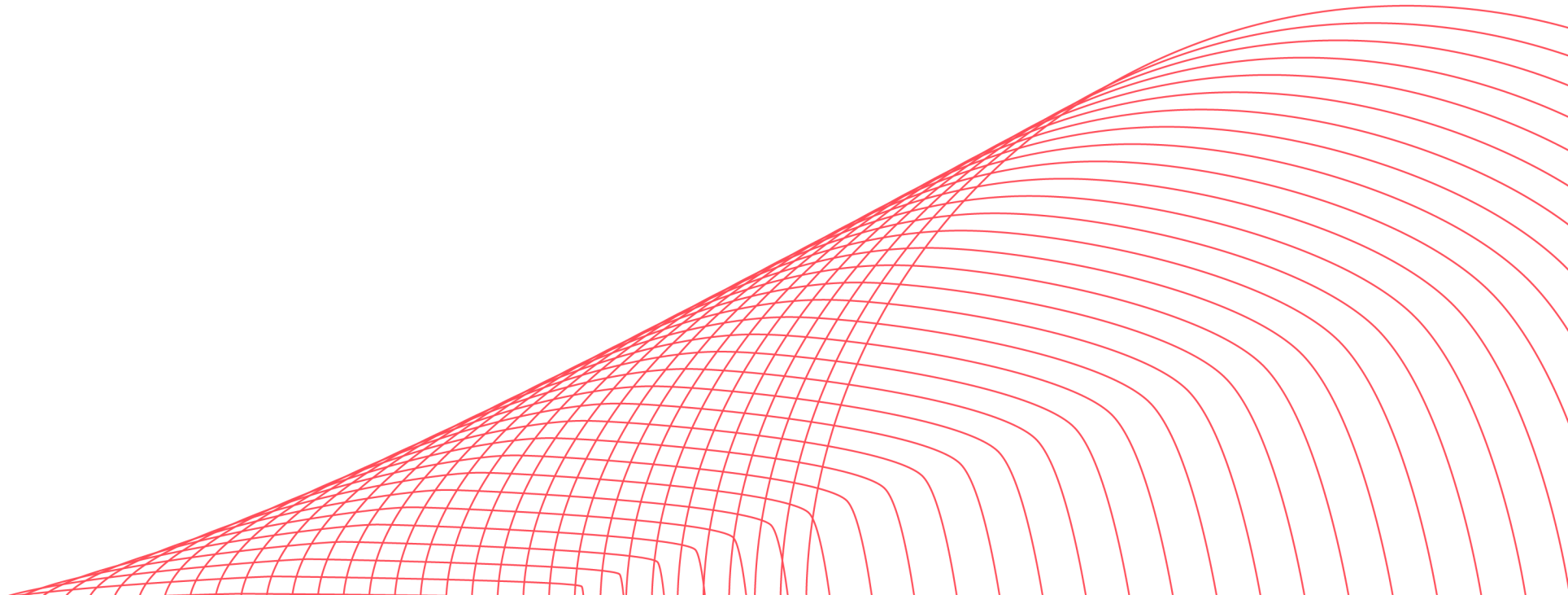
Note: All drugs are investigational and subject to regulatory approvals. All catalyst timings are approximate, based on current expectations and, where applicable, contingent on FDA feedback, and may be subject to change. All references are to calendar years

1. For more information about the settlement with Moderna and related payments and other pending Genevant litigation, please refer to our Form 10-K filed with the SEC on May 20, 2026. Any references to Genevant in this presentation are to Genevant Sciences GmbH (GSG). The timing of the litigation-related events noted above is subject to change, including at the discretion of the court.

IMVT-1402 in D2T RA: Preliminary Period 1 Data



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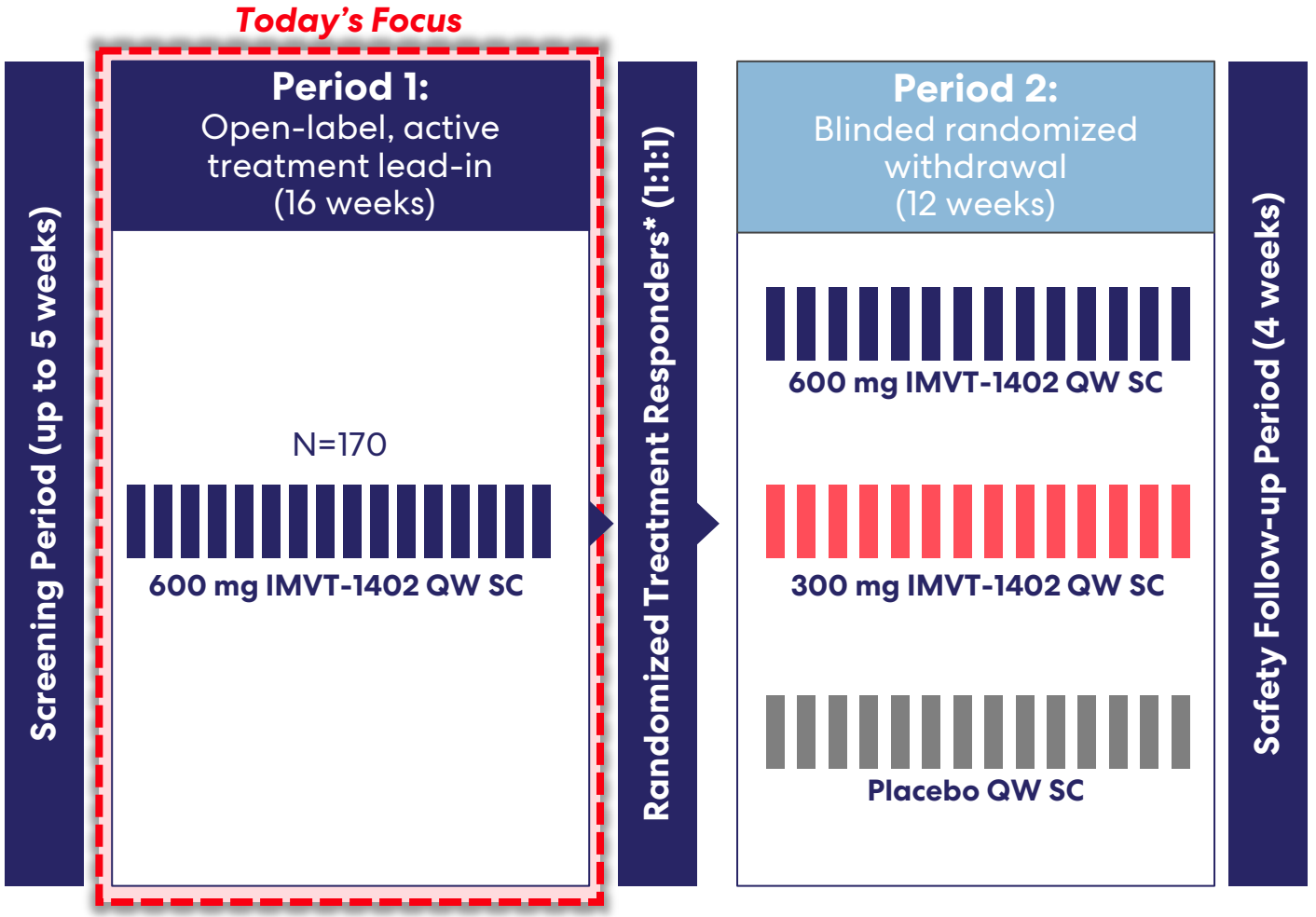
IMVT-1402 Potentially Registrational Trial in ACPA+ Difficult-to-Treat RA

Today's discussion will focus on preliminary data from Period 1 (open-label, active treatment lead-in) with IMVT-1402

Inclusion[a]

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



Endpoints

Primary Endpoint (Period 2):

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

Secondary Endpoint:

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

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

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

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

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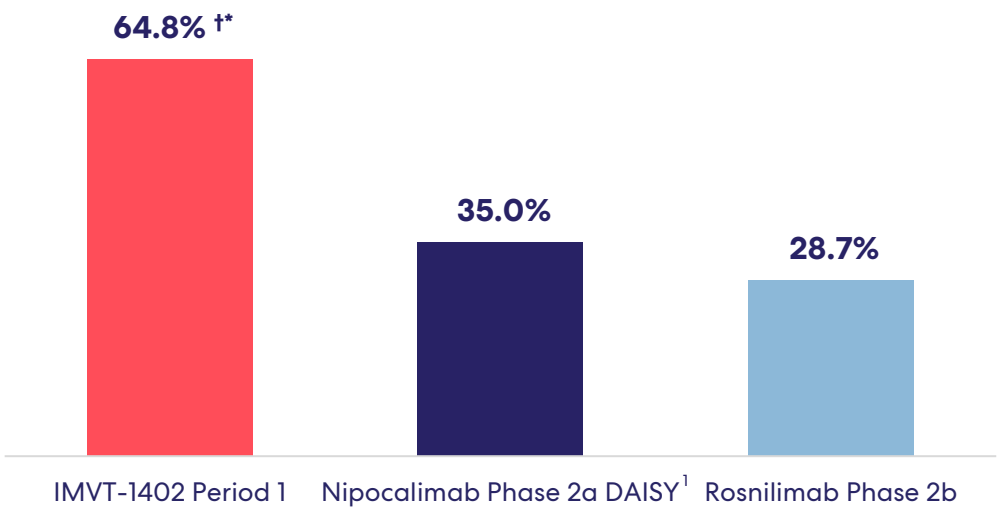
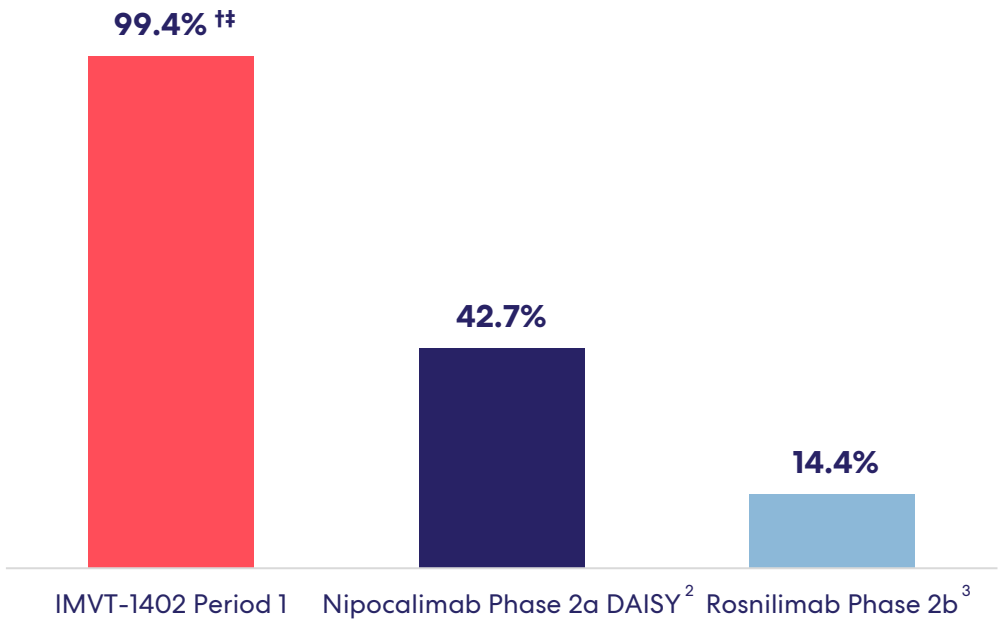
Notes: Period 1 data is preliminary – minor changes are likely as data is finalized. 1. N=2 patients missing information. Advanced therapies include biologic (e.g., anti-TNFs, IL-6R inhibitors, CD80/86 inhibitors, CD20 inhibitors) and targeted synthetic (e.g., JAK inhibitors) DMARDs. 2. Efficacy analysis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

Significantly Higher Rates of Prior Advanced Treatment in IMVT-1402 Trial Versus Precedent Studies

Proportion of JAK-Experienced Patients in Study Population



Proportion of Patients Treated with ≥2 Advanced Therapy Mechanisms



Figures represent cross-study comparisons and not head-to-head studies. Differences exist between study designs and subject characteristics, and caution should be exercised when comparing data across studies.

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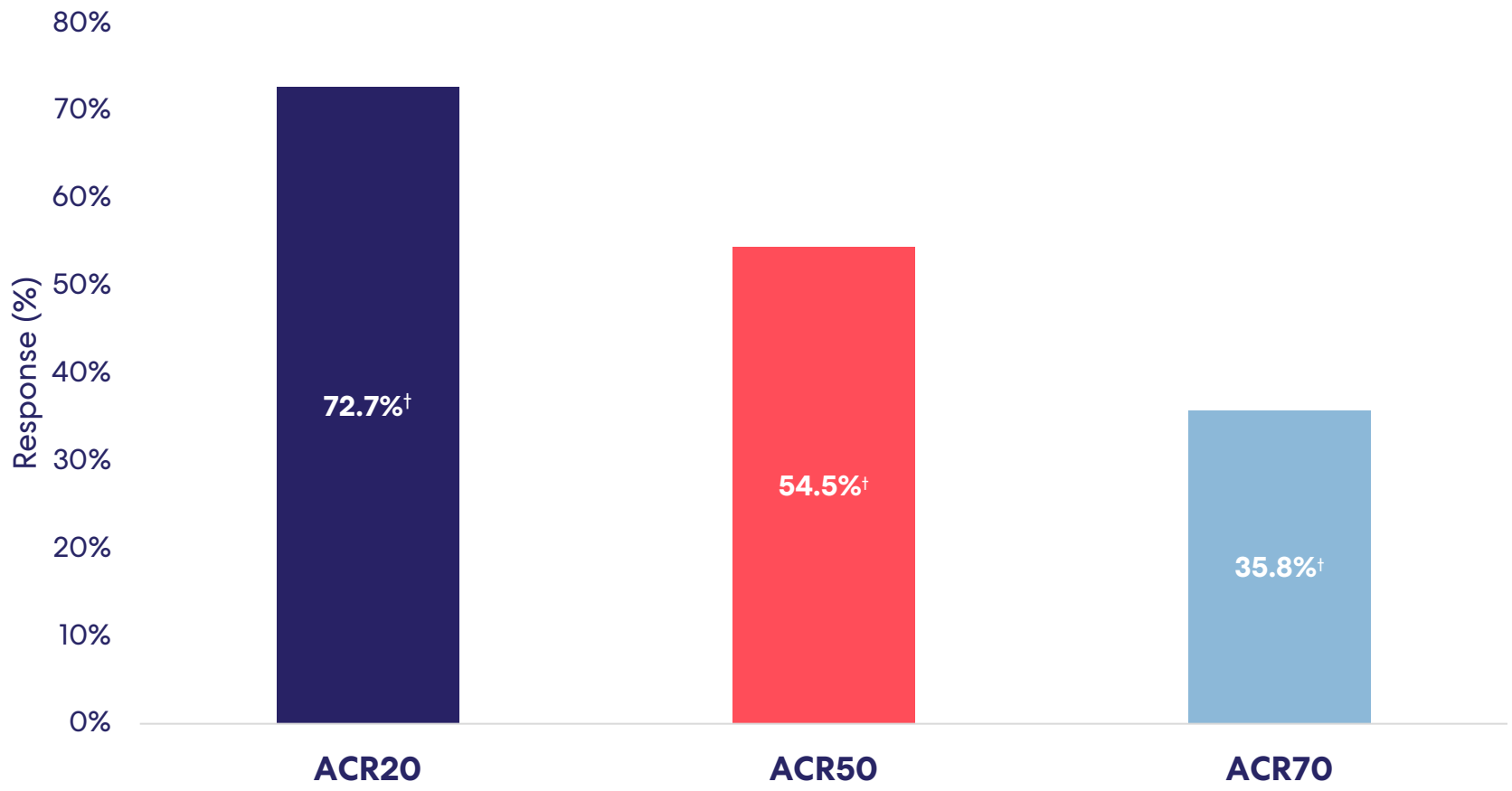
Notes: †Period 1 data is preliminary – minor changes are likely as data is finalized. *Every JAK-experienced patient in the IMVT-1402 trial has failed a JAK inhibitor in addition to a TNF inhibitor +/- other biologics. Advanced therapies include biologic (e.g., anti-TNFs, IL-6R inhibitors, CD80/86 inhibitors, CD20 inhibitors) and targeted synthetic (e.g., JAK inhibitors) DMARDs. ‡N=2 patients with missing data are excluded. 1. Represents percentage of trial participants on any prior tsDMARD (JAK inhibitors). 2. Represents percentage of trial participants who failed 2 or more of any prior b/tsDMARDs. 3. Represents percentage of trial participants on >1 prior b/tsDMARD classes. JAK: Janus Kinase Inhibitor; Sources: Taylor et al., RMD Open (2026); Graf et al., ACR 2025 Oral Presentation.

Period 1 Preliminary Data

Trial enrolled a difficult-to-treat population: patients had to fail at least one conventional DMARD therapy and at least 2 additional mechanisms of advanced therapies (biologic and targeted synthetic DMARDs)

ACR20, ACR50, ACR70 Response Rates at Week 16 (N=165[1])



Notes: †Period 1 data is preliminary – minor changes are likely as data is finalized. 1. Efficacy analysis population (N=165) excludes N=5 patients from one site due to protocol non-compliance. Patients who discontinued treatment during Period 1 are included as non-responders. DMARD: Disease-Modifying Anti-Rheumatic Drug. ACR: American College of Rheumatology. ACR20, ACR50, and ACR70 refer to standardized criteria established by the American College of Rheumatology to measure change in rheumatoid arthritis (RA) symptoms.

Period 1 Preliminary Data: Consistent & Meaningful Effect in JAK-Class Failures

IMVT-1402 response rates were consistent between the overall difficult-to-treat population and patients whose treatment history included failure on at least a TNF inhibitor and a JAK inhibitor

ACR20, ACR50, ACR70 Response Rates at Week 16

Notes: †Period 1 data is preliminary – minor changes are likely as data is finalized. *N=107 includes the entire subset of patients enrolled who had previously failed on a JAK inhibitor in addition to a TNF inhibitor +/- other biologics. Patients who discontinued treatment during Period 1 are included as non-responders. ACR: American College of Rheumatology; DMARD: Disease-Modifying Anti-Rheumatic Drug; JAK: Janus Kinase Inhibitor; TNF: Tumor Necrosis Factor.

Key Takeaways: IMVT-1402 in Difficult-to-Treat RA

Baseline Demographics

- Period 1 enrolled N=170 patients for an open-label 16-week treatment period; N=165 patients were evaluable for efficacy at Week 16[1]
- Trial population is difficult-to-treat: 87% of patients had failed at least one conventional DMARD therapy and two additional mechanisms of advanced therapies (biologic or targeted synthetic DMARDs), and 12% of patients had failed at least one conventional DMARD therapy and three or more additional mechanisms of advanced therapies[2]
- Patients had a mean tender joint count of 24.2 and a mean swollen joint count of 16.7, consistent with moderate-to-severe, active disease activity despite multiple treatment failures

Period 1 Preliminary Data

- At Week 16, IMVT-1402 showed an ACR20 response rate of 73%, ACR50 response rate of 55%, and ACR70 response rate of 36%†
- Response rates were consistent and meaningful in the subpopulation of patients who had failed at least a TNF inhibitor and a JAK inhibitor

Safety Summary

- IMVT-1402 was observed to be safe and well-tolerated in the study, and no new drug-related safety signals were identified

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Notes: †Period 1 data is preliminary – minor changes are likely as data is finalized. 1. Efficacy analysis population (N=165) excludes N=5 patients from one site due to protocol non-compliance. 2. N=2 patients with missing information. ACR20/50/70: American College of Rheumatology response criteria 20/50/70; DMARD: Disease-Modifying Anti-Rheumatic Drug; TNF: Tumor Necrosis Factor; JAK: Janus Kinase; 4L+: Fourth Line or Later.

Path Forward

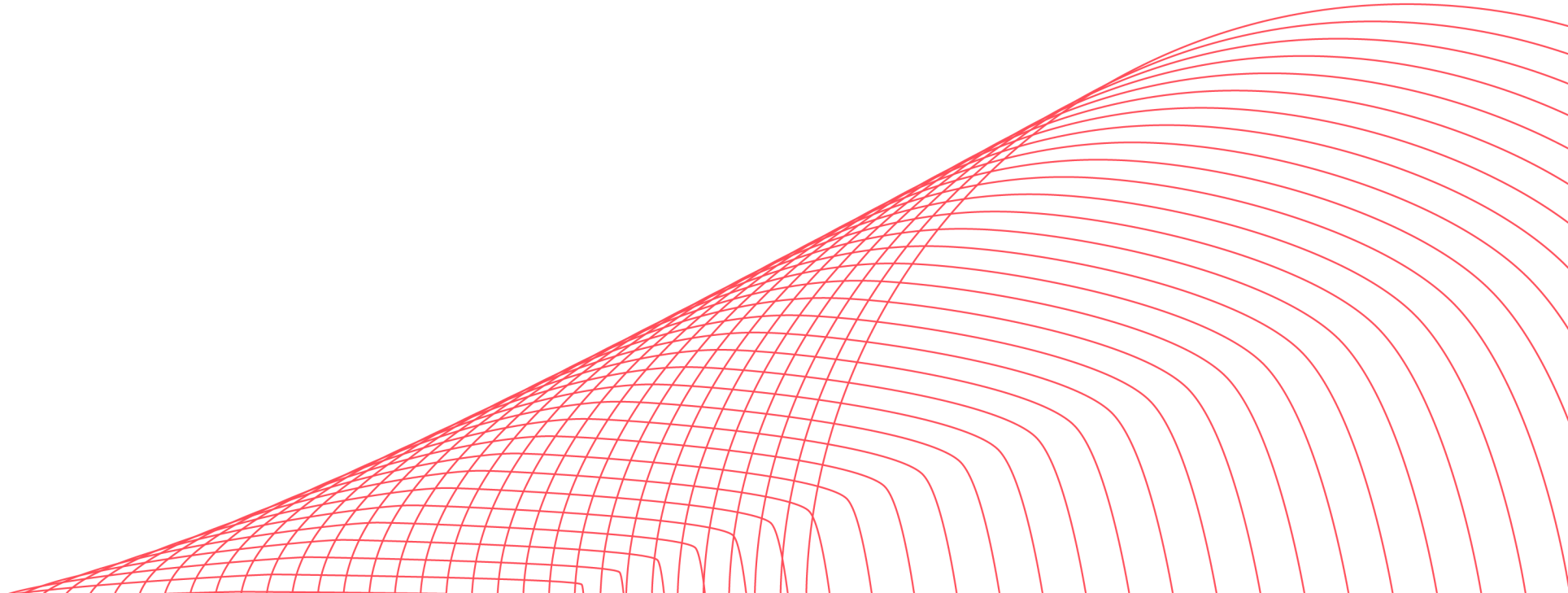
Period 1 preliminary data demonstrates IMVT-1402's clinically meaningful activity and the potential benefits for patients of a new, differentiated mechanism in a difficult-to-treat population with very few treatment options

While encouraging clinically, the deep Period 1 responses could potentially reduce the ability to detect the loss of treatment effect vs. placebo on ACR20 maintenance during the 12-week randomized withdrawal period (Period 2)

The next major program update is expected in 2H 2026 after further analysis of both Periods 1 and 2 as well as FDA interactions regarding the registrational program for IMVT-1402 in RA

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 Spotlight



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Key Takeaways: Mosliciguat

PH-ILD represents an area of **intense unmet medical need** – 23-40% survival at 3 years – 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

Like PAH, **combination therapies** expected to be eventual standard of care in PH-ILD; however, PH-ILD likely to be larger commercial opportunity with competition limited to inhaled mechanisms

Among the best PVR reductions seen to date with convenient once-daily dosing and favorable safety profile across 170 healthy volunteers and PH patients – **~20% reduction in PVR** likely to translate to clinical efficacy[1]

Topline data from ongoing Phase 2 study (PHocus) expected in 2H 2026 – 135 patient study with the potential to define a new standard of care in PH-ILD

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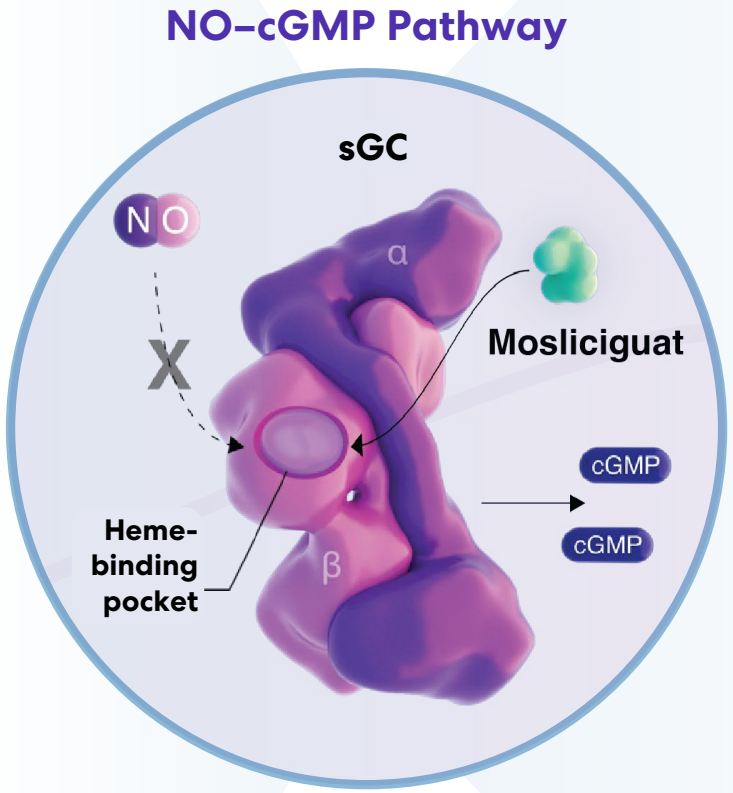
PH-ILD: Pulmonary hypertension associated with interstitial lung disease
Note: All drugs are investigational and subject to regulatory approvals. All catalyst timings are approximate, based on current expectations and, where applicable, contingent on FDA feedback, and may be subject to change. All references are to calendar years.
1. PHocus study is powered for 18% reduction in PVR, which we believe should translate to clinical efficacy.

Mosliciguat is Delivered Directly to the Lungs to Activate Impaired sGC – Potentially the First Non-Treprostinil Treatment Option



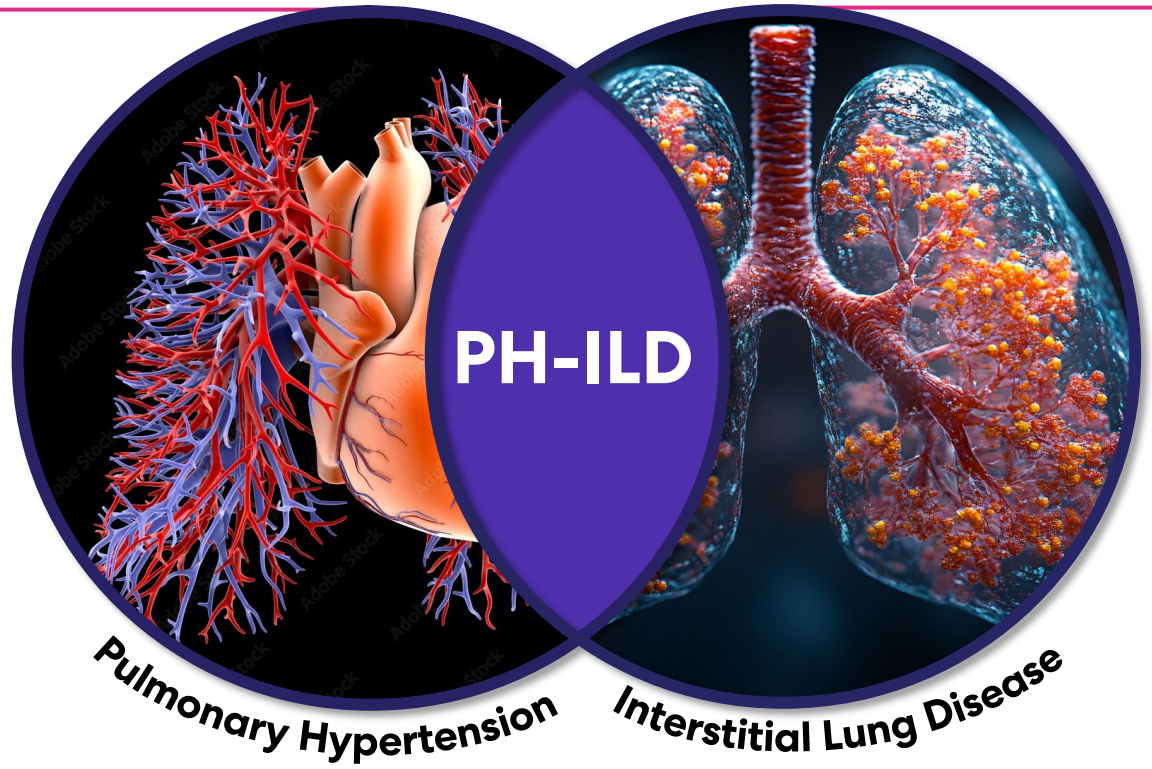
- **sGC is a key enzyme in the NO-cGMP pathway** and its activity is essential for vascular homeostasis[1]
- **Oxidative stress** in pulmonary disease reduces NO production and impairs the sGC binding site, **resulting in sGC dysfunction**[2]
- **Mosliciguat activates** impaired sGC, as well as native 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

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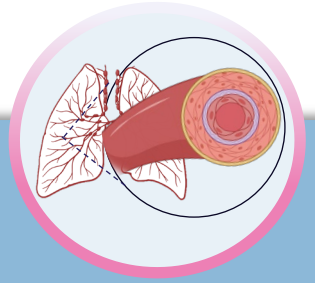
Source: Blanco et al., Curr Opin Pulm Med (2024)

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

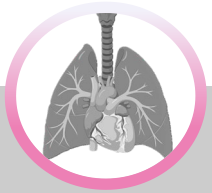


Group 1

Pulmonary Arterial Hypertension

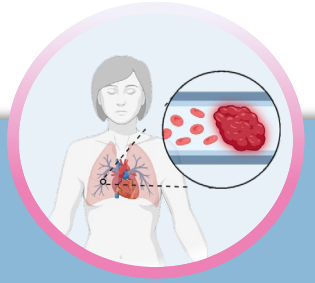
Group 2

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

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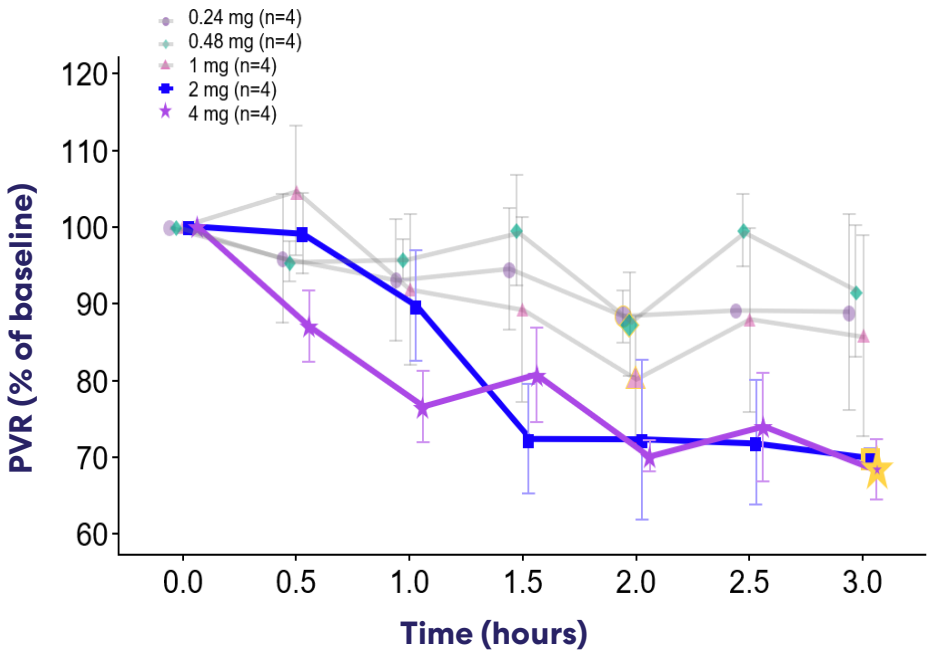
Figure adapted from Humbert et al., Eur Heart J (2022)

Inhaled Mosliciguat Demonstrated Sustained, Clinically Meaningful PVR Reductions of Up to 38%, Among the Highest Seen in PH

>30% Sustained Mean PVR Reductions[1]



Among the Highest PVR Reductions Ever Seen

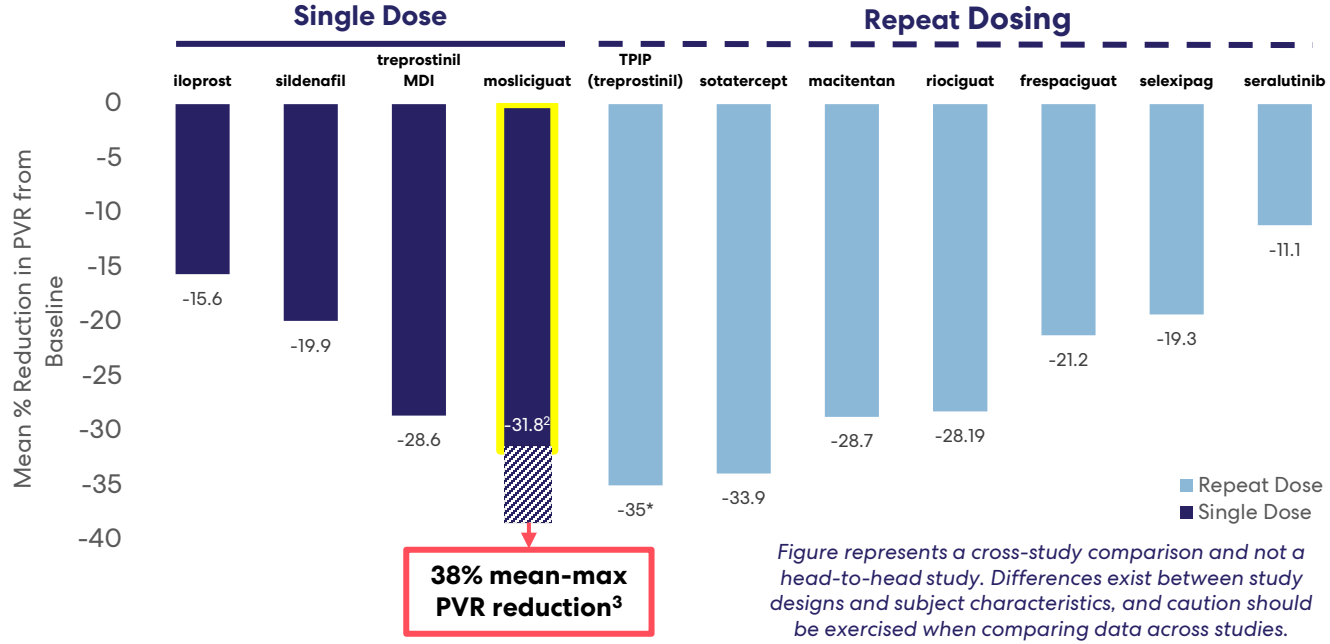


Figure represents a cross-study comparison and not a head-to-head study. Differences exist between study designs and subject characteristics, and caution should be exercised when comparing data across studies.

- Rapid PVR reductions emerged **as early as 30 minutes and persisted** over the observed period
- **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
- Mean reduction in mPAP equivalent to **~20%**, and mean increase in CO equivalent to **~25%**

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* indicates trough PVR observation.
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. 2. Represents average PVR reduction for participants in 4 mg dose group at hour 3 in ATMOS study. 3. Represents average of largest reduction in PVR for each participant in 2 mg dose group in ATMOS study.
PVR reduction sources: iloprost – Richter et al., Pulmn Circ. (2015); sildenafil – Voswinckel et al., Pulm Pharmacol Ther. (2008); treprostinil MDI - Voswinckel et al., Pulm Pharmacol Ther. (2009); mosliciguat – Ghofrani et al., Eur Respir J (2024); TPIP – Grünig et al., Eur Respir J (2025); sotatercept – Humbert et al., N Engl J Med (2021); macitentan – Pulido et al., N Engl J Med (2013); riociguat – Ghofrani et al., N Engl J Med (2013); frespaciguat – Bajwa et al., Int J Chron Obstruct Pulmon Dis (2024); selexipag – Simonneau et al., Eur Respir J (2012); seralutinib – Frantz et al., Lancet Respir Med (2024)

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**		

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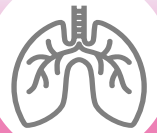
Results from Phase 1 SAD, MAD and ATMOS studies
1. Numbers do not include subjects randomized to placebo

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

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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

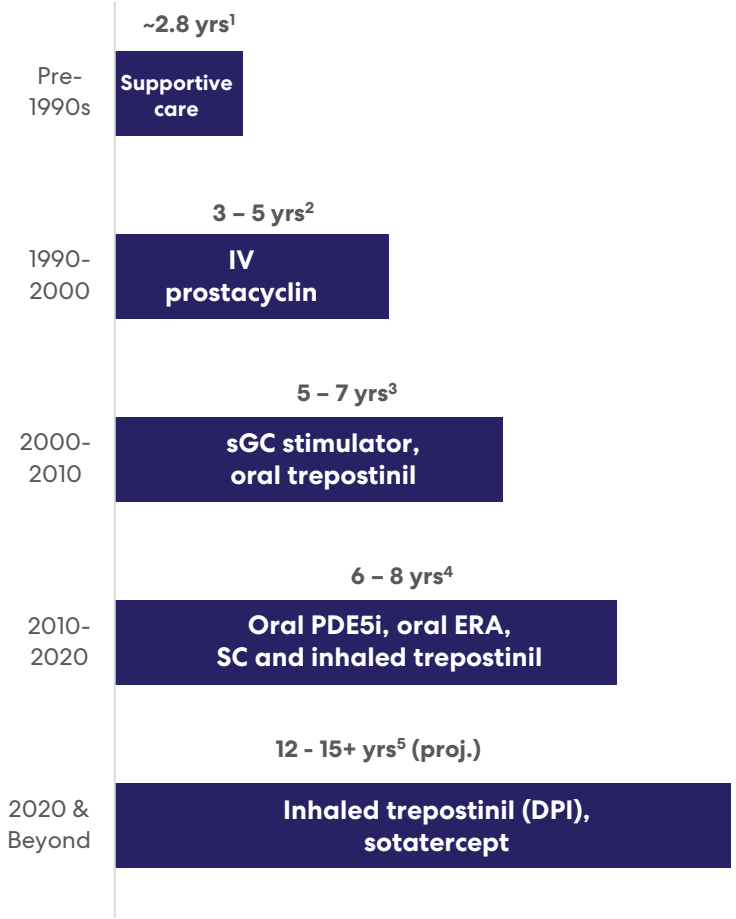
	Mosliciguat	Tyvaso	Yutrepia	TPIP	Seralutinib (PAUSED)
Company	pulmovant	United Therapeutics	Liquidia	insmed	gossamerbio
PH-ILD Stage of Development	Phase 2	Marketed	Marketed	Phase 3	Phase 3
MOA	**sGC activator**	Prostacyclin	Prostacyclin	Prostacyclin	PDGFRα/β, CSF1R and c-KIT inhibitor
# Breath / Day	**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.

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***

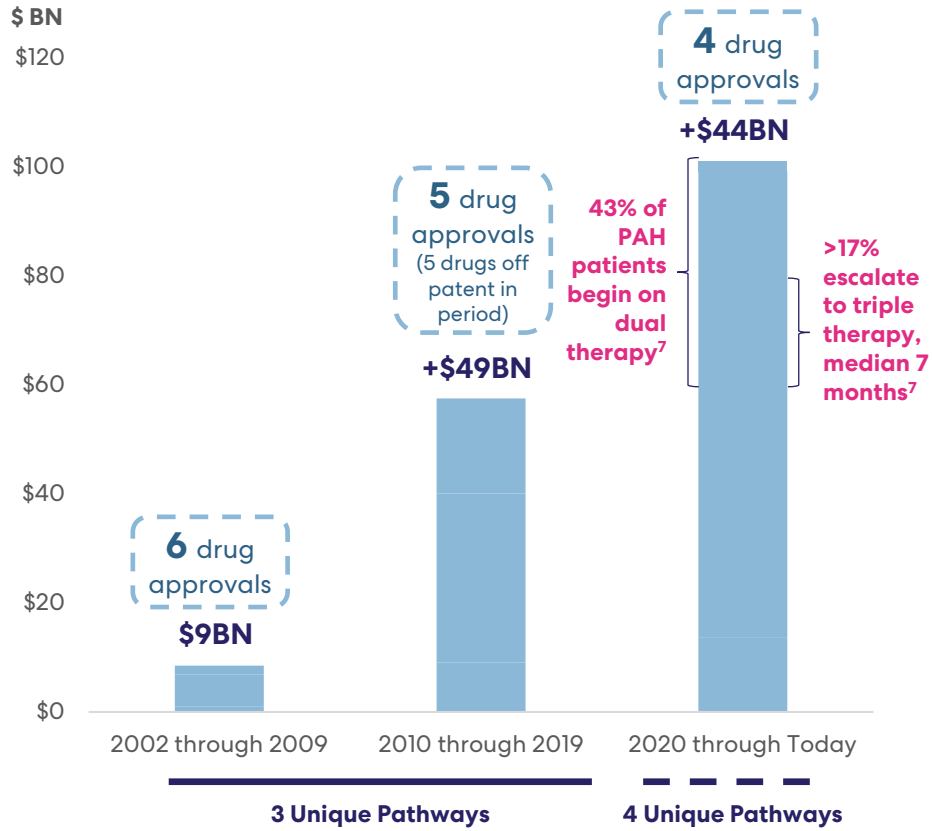
***2009 ESC/ERS:** introduced **sequential combination therapy** for nonresponders*

***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*

Evolution of Total PAH Sales 2002-2025

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



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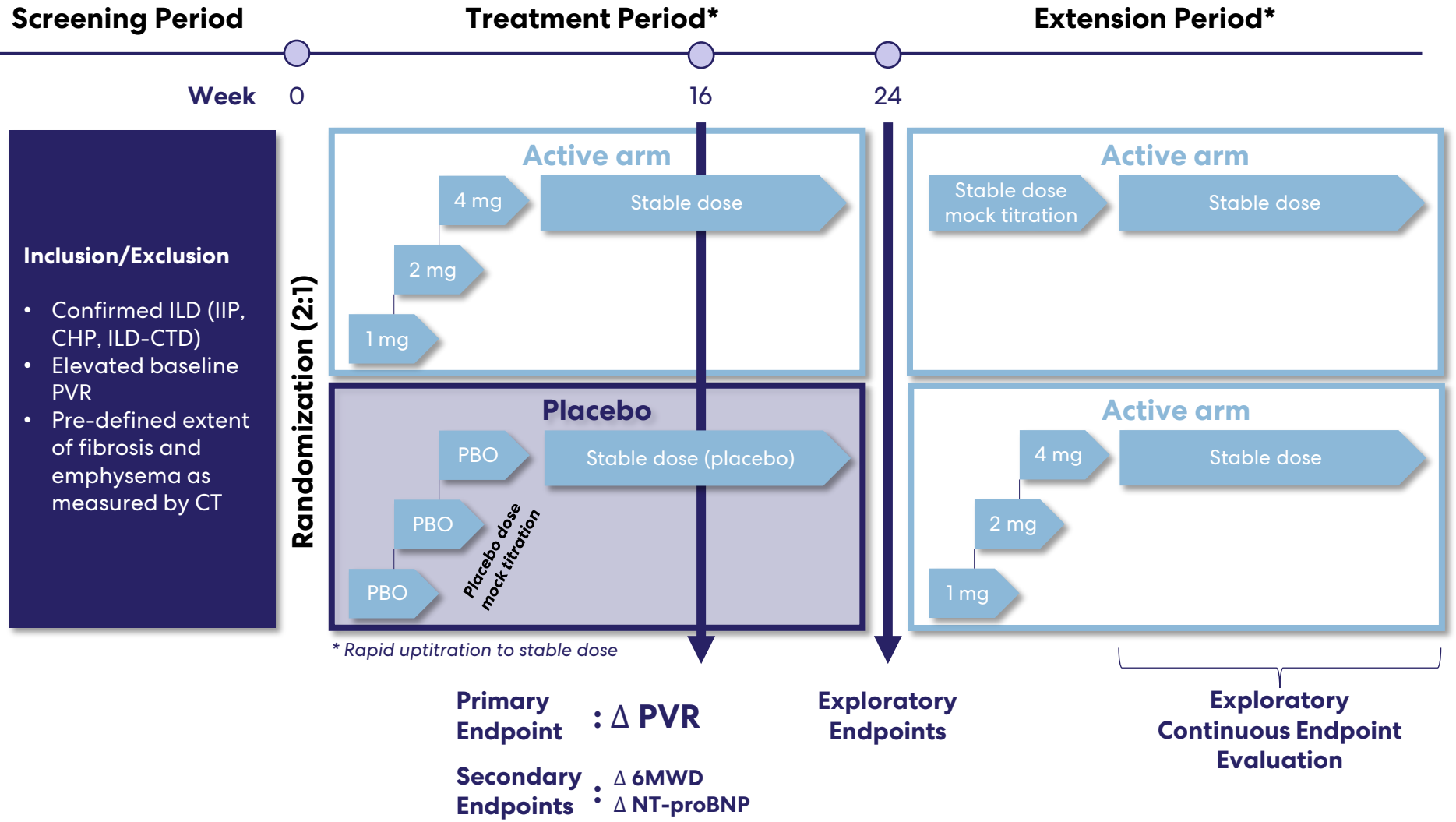
1. Dalonzo et al., Ann Intern Med (1991)
2. Sitbon et al., JACC (2002)
3. Benza et al., Chest (2012)
4. Hendriks et al., Pulm Circ (2022)
5. Alsumali et al., Adv Ther (2025)
6. ESC/ERS Guidelines from 2009 – 2022
7. Muller et al., Adv Ther (2024)

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 (final N=135)

phocus



Study is appropriately powered for primary endpoint of PVR (≥90%)

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.

Patient Selection for PHocus Study Informed by 7th World Symposium on Pulmonary Hypertension (WSPH) Guidelines

7th WSPH Guidelines for Treatment of PH-ILD[1]

- Worsening symptoms due to PH
- Mild-to-moderate restrictive ventilatory defect/vascular limitation to exercise
- **PVR >=4 WU** and **mPAP >=25 mmHg**
- Non-severe fibrotic ILD on CT
- **Emphysema extent < 15%**
- Underlying CTD

PHocus Study – Baseline Characteristics[2]

Mean 6MWD: 277 meters
~78% WHO FC III/IV

Mean Predicted FVC 61.3%
Mean Predicted DLCO 29.5%

Mean PVR: 7.1 WU
mPAP: ~39 mmHg

17% of participants with emphysema, with mean emphysema component: 8.3%
CTD: 36.3%

1. Shlobin et al., Eur Respir J. (2024)
2. Pooled blinded data from PHocus study, extracted prior to database lock and subject to change.

PHocus Study Baseline Characteristics Reflect Purposeful Patient Selection

	Phase 2 PHocus[1]
Study participants	N= 135
Mean Age – no.	67.9
Sex at birth – no. (%)	
Male	70 (51.9)
Female	65 (48.1)
Mean time since diagnosis (yr)	1.75
PVR – WU (mean)	7.1 WU
PAP – mmHg (mean)	39.3
6MWD – m (mean)	277.4
NT-proBNP – pg/mL (mean)	1,381.5
Cause of lung disease – no. (%)	
Idiopathic interstitial pneumonia	57 (42.2)
Chronic hypersensitivity pneumonitis	29 (21.5)
Connective tissue disease	49 (36.3)
Participants with Emphysema Component – no. (%)	23 (17)
Estimated Percentage of Emphysema Component (mean %)	8.3
Background PDE5i – no. (%)	35 (25.9)
Background antifibrotic – no. (%)	
Pirfenidone	12 (8.9)
Nintedanib	55 (40.7)

All PHocus data presented here are blinded (to both sponsor and investigators), aggregated (combined placebo and active drug data), were extracted prior to final database lock, are preliminary and subject to change.

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1. Pooled blinded data from PHocus study, extracted prior to database lock and subject to change
PVR: Pulmonary Vascular Resistance; PAP: Pulmonary Arterial Pressure; 6MWD: 6-Minute Walk Distance; NT-proBNP: N-terminal pro–B-type natriuretic peptide

Mosliciguat Study Endpoints Incorporate Learnings from Precedent Programs

PVR as Phase 2 Primary Endpoint: Consistent with Standards Across PH Studies

phocus

- Direct hemodynamic measure of drug activity based on MOA
- Sensitive signal at Phase 2 sample sizes

Consistent with other PH studies & used as Ph. 2 primary endpoint across multiple recent PAH programs:
PULSAR[3], CADENCE[4], TORREY[5], INSIGNIA-PAH[6], Ralinepag Phase 2[7]

*PVR proof of concept guides **Ph. 3 dose selection***

*Trends in 6MWD & NT-proBNP provide **complementary signal on functional benefit***

Phase 3: 6MWD / Other Clinically Relevant Endpoints

- Widely used, reliable measure of efficacy in PH-ILD
- Only successful Phase 3 study in PH-ILD to date – INCREASE – used 6MWD as primary endpoint

PH-ILD: INCREASE (inhaled treprostinil)[8]
PAH precedent: STELLAR (sotatercept)[9], PROSERA (seralutinib)[10], ADVANCE OUTCOMES (ralinepag)[11]

PHocus Study Addresses Limitations of Earlier PH-ILD Programs via Rigorously Selected, RHC-Confirmed Population with PVR as Appropriate Phase 2 Primary Endpoint

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1. Nathan et al., Chest (2022)
2. Sitbon et al., Adv Pulm Hypertens. (2020)
3. Ghofrani et al., N Engl J Med. (2021)
4. Humbert et al., Circulation. (2025)
5. Frantz et al., Adv Ther. (2025)
6. Bajwa et al, AJRCCM. (2024)
7. Simonneau et al., Eur Respir J. (2019)
8. Waxman et al., N Engl J Med. (2021)
9. Humbert et al., N Engl J Med. (2023)
10. NCT04456998 (PROSERA, seralutinib Phase 3)
11. NCT03626688 (ADVANCE OUTCOMES, ralinepag Phase 3)

Phase 2 PHocus Study: Strong Execution and Safety Review Support Favorable Benefit-Risk Profile

Full study enrollment within 12 months of first patient dosed

Early **discontinuation rates compare favorably** to those observed in previous PH-ILD studies

Over 95% of participants reached maximum dose during titration; all patients who have completed Week 16 remained at highest stable dose[1]

Blinded safety reviews have **not identified need for any study changes**

DMC has consistently reviewed the data and **recommended the study continue as planned**

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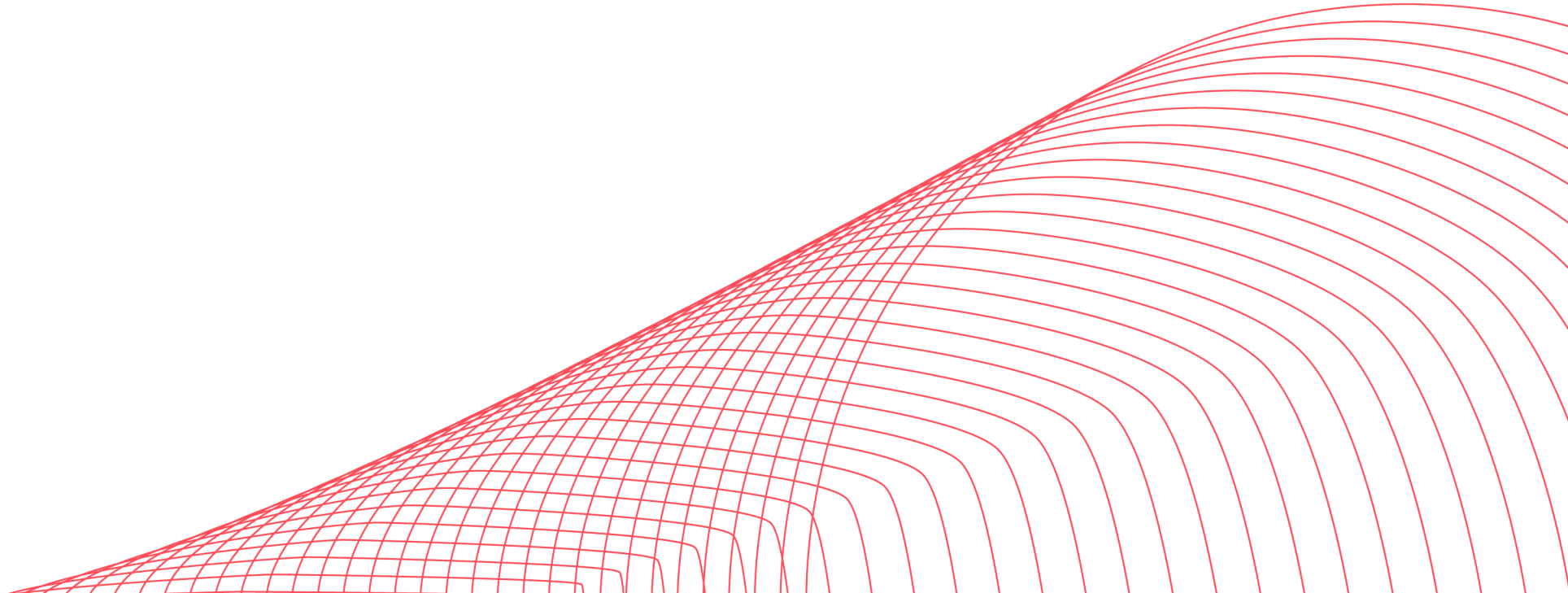
1. Data remain blinded and reflect aggregate data from active and placebo arms extracted prior to final database lock, being preliminary and subject to change

Brepocitinib Program Updates



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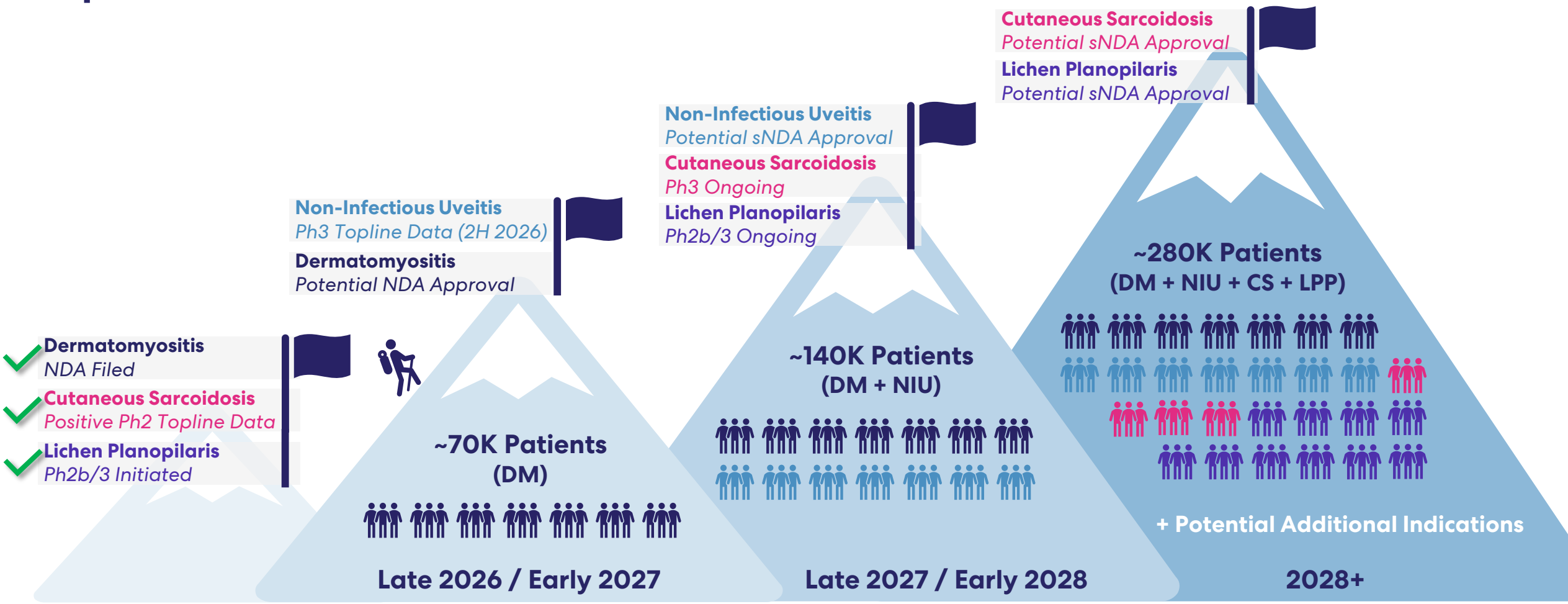
Brepocitinib Poised to Address >280K Patients With Continuous Catalyst Flow Expected Over the Next 12-24 Months



Brepocitinib Received Breakthrough Therapy Designation for the Treatment of CS in May 2026

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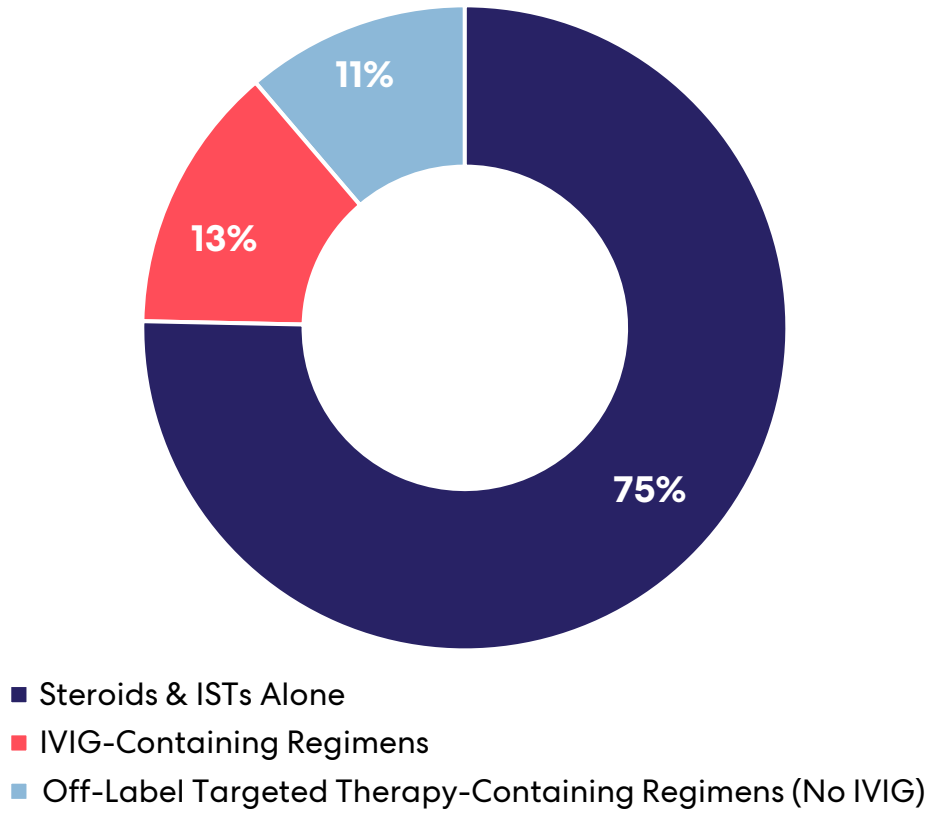
Illustrates ~10K patients.

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.

Standard of Care for DM Patients Is Poor: No New Therapeutic Options and High Treatment Burden

Therapies Received by Treated DM Patients



- **Standard of care in DM is largely unchanged since the 1980s**: combinations of corticosteroids and off-label ISTs
- Patient and physician need for modern, targeted therapies is extraordinarily high given **unapproved targeted therapies with no RCT data (including JAK inhibitors) are used off-label at rates comparable to IVIg**
- Even among patients treated with IVIg or off-label targeted therapies, chronic high-dose steroid use remains high, **with most requiring doses ≥10 mg/day for ≥100 days/year**

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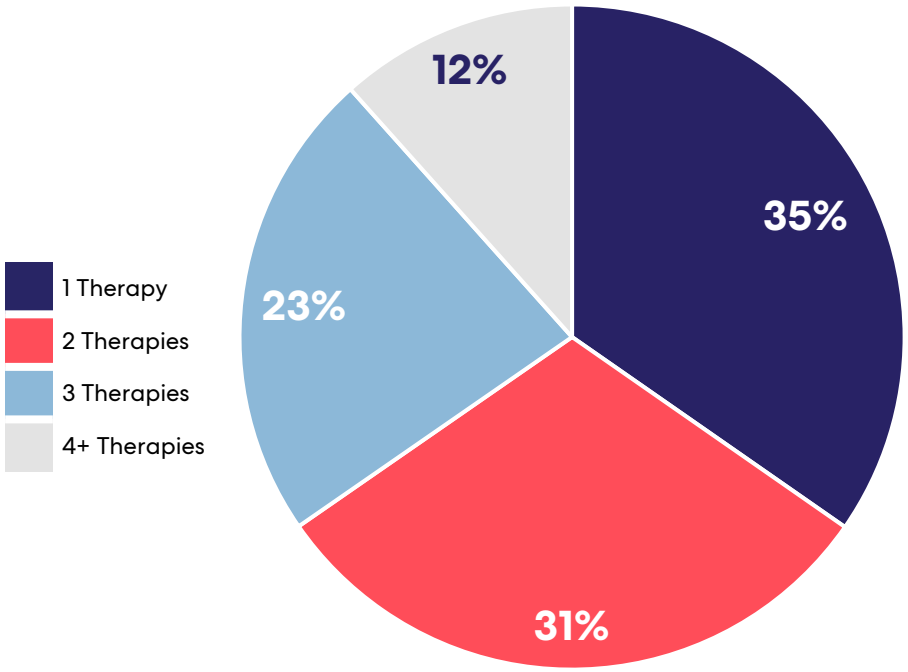
DM: dermatomyositis; IST: immunosuppressive therapy; IVIG: intravenous immunoglobulin; RCT: randomized controlled trial
Data Source: Analysis by Roivant/Priovant using closed claims data from Inovalon. Analysis includes patients with DM with continuous enrollment from 2020-2022. Conclusions corroborated through independent Veeva Compass open claims data through 2024.

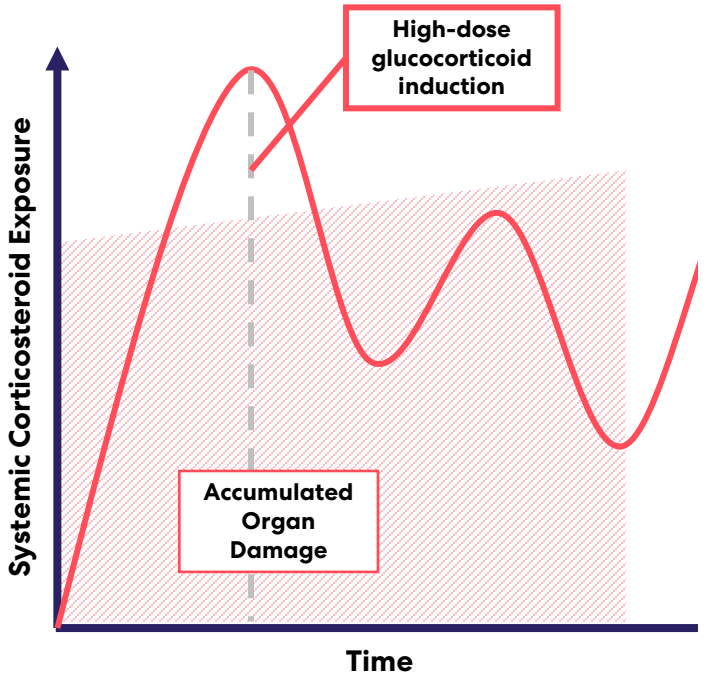
How DM Patients Are Currently Treated: Polypharmacy, With High Risk of AEs

Nearly 2/3 of Treated DM Patients Receive 2 or More Therapies per Year[1]



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

Prolonged Corticosteroid Use (≥3 Months) Markedly Increases Risk of Major Complications[2]



Toxicity is dose-independent; even low-dose (≤5 mg/day) exposure causes cumulative harm[3,4]

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AE: adverse events; ROA: route of administration
1. Analysis by Roivant/Priovant using closed claims data from Inovalon. Analysis includes patients with DM with continuous enrollment from 2019-2024.
2. Aggarwal et al., Clin Rheumatol (2025)
3. Choy et al., Rheumatol (2002)
4. Pujades-Rodriguez et al., PLoS Med (2020)

DM Launch Preparation Ongoing, With Patients at the Heart of Our Commercial Strategy

Engaging with Payers	Educating Physicians	Partnering with Specialty Pharmacies	Hiring a Strong Commercial Team	Unbranded Patient Engagement
				

Brepocitinib VALOR Data in DM Has Been Featured Across a Variety of Major Forums

Notable Conferences & Publications

March 2026 – Online Edition
VALOR Phase 3 Data
NEJM

March 2026
GCOM 2026
6th Global Conference on Myositis

March 2026
MDS ANNUAL MEETING
DENVER COLORADO 2026

March 2026
AAD annual MEETING
MARCH 27–31, 2026
DENVER, COLORADO

May 2026
SOCIETY FOR INVESTIGATIVE DERMATOLOGY SID 1937
83RD SID ANNUAL MEETING
CHICAGO26

June 2026
eular 26
EUROPEAN CONGRESS OF RHEUMATOLOGY
LONDON
3–6 JUNE

Additional Scientific Engagement Around VALOR Data at Dozens of Regional Conferences & Other Forums

Fourth Indication for Brepocitinib, Lichen Planopilaris (LPP), Is a Highly Morbid Disorder With No FDA Approved Therapies

Disease Overview

~100K LPP patients in the US[1-3]

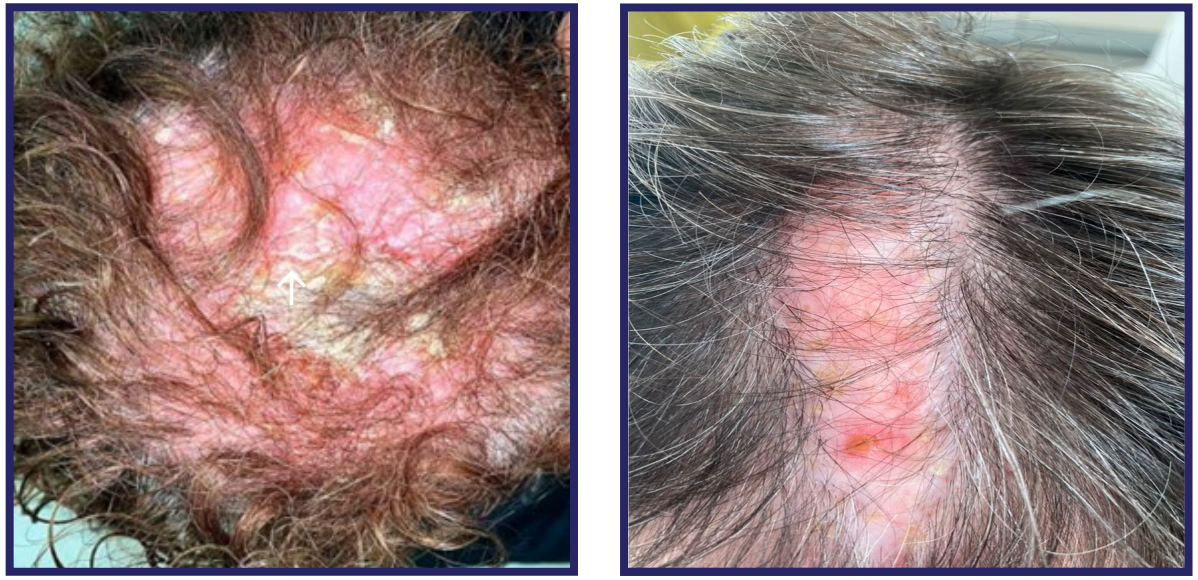
↑ prevalence over time

0 approved modern therapies

LPP patients require aggressive chronic, multi-modal therapy

Nearly all LPP patients are poor responders to steroids/ISTs

Symptoms include: itch, pain, burning, redness, scaling, and scarring, generally irreversible hair loss



LPP scalp scarring and erythema

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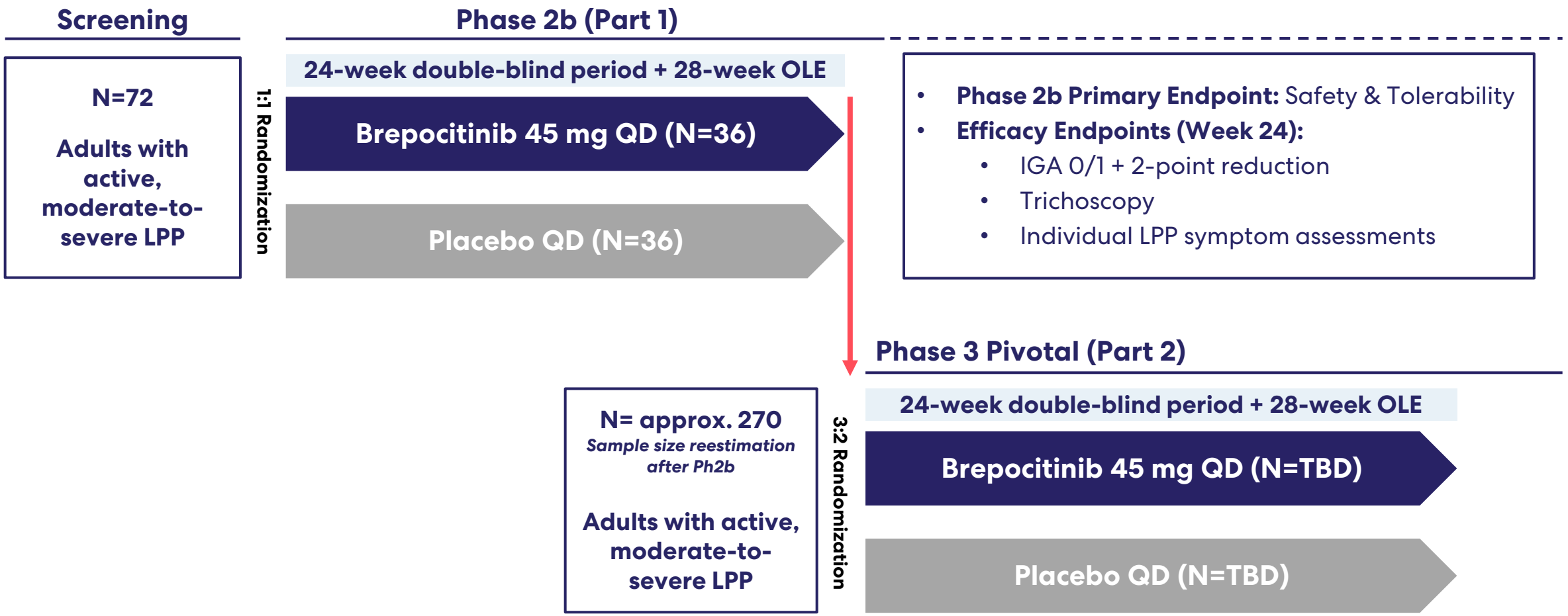
1. Trager et al., JAAD (2021)
2. Joshi et al., JAAD Intl (2022)
3. Chen et al., Intl J Dermatol (2024)

Photos sourced from (left) Lasheras-Pérez et al., Int J Dermatol (2024), (right) Gisondi et al., J Clin Med (2020)

Seamless Phase 2b/3 LPP Pivotal Trial Underway, With First Subjects Enrolled in March 2026



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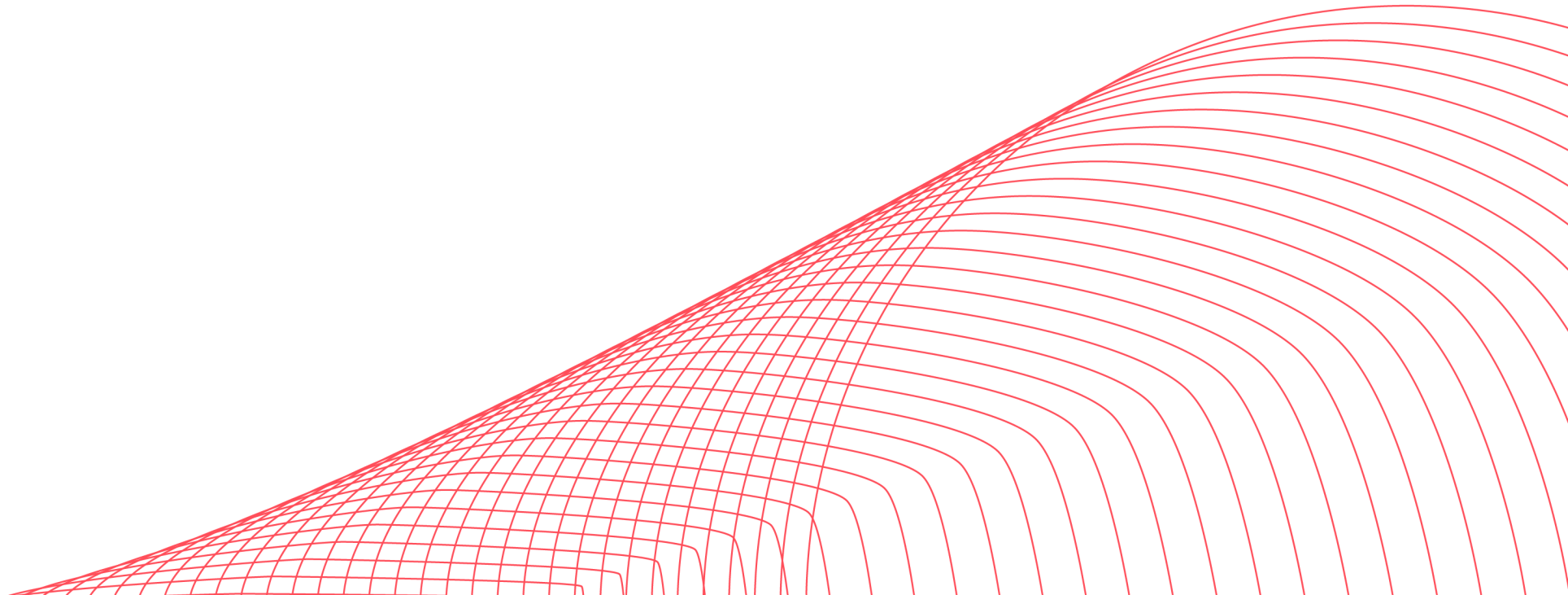
IGA: Investigator's Global Assessment; OLE: Open-Label Extension

Reasons to Be Excited About Brepocitinib in LPP

High Unmet Need	• Zero FDA-approved therapies to treat burdensome, painful, scarring disease with poor response to available off-label treatments
Mechanism Distinctively Suited to LPP	• LPP has a Th1-dominant immunophenotype • Dual JAK1/TYK2 inhibition is well-suited to targeting the Th1 axis, and brepocitinib has generated excellent clinical trial efficacy data in other Th1-driven diseases
Seamless Phase 2b/3 Expedites Path to Registration	• Potentially pivotal, seamless Phase 2b/3 trial underway with first patients enrolled in March 2026
Synergies With DM and CS Indications	• Overlapping KOL and prescriber bases at tertiary medical dermatology centers of excellence

Financial Update



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Key Financial Items

Select Income Statement and Non-GAAP Metrics for the Three Months Ended March 31, 2026

- R&D expense of $199M; adjusted R&D expense of $191M (non-GAAP)
- G&A expense of $158M; adjusted G&A expense of $88M (non-GAAP)
- Income from continuing operations, net of tax of $356M; adjusted loss from continuing operations, net of tax of ($223M) (non-GAAP)

Select Income Statement and Non-GAAP Metrics for the Fiscal Year Ended March 31, 2026

- R&D expense of $682M; adjusted R&D expense of $632M (non-GAAP)
- G&A expense of $610M; adjusted G&A expense of $294M (non-GAAP)
- Loss from continuing operations, net of tax of ($398M); adjusted loss from continuing operations, net of tax of ($748M) (non-GAAP)

Select Balance Sheet Metrics at March 31, 2026

- Cash, cash equivalents and marketable securities of $4.3BN as of March 31, 2026
  - Excludes $770M expected to be received from Moderna in July 2026
- No debt on balance sheet as of March 31, 2026
- 719,270,385 common shares issued and outstanding as of May 12, 2026
  - 3,956,362 common shares repurchased for $110M in the three months ended March 31, 2026

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For a reconciliation of each non-GAAP financial metric to the comparable GAAP financial metric, please see slide 42.

Non-GAAP Disclosures

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

	Note	Three Months Ended March 31, 2026	2025
Income (loss) from continuing operations, net of tax		$ 355,744	$ (252,375)
Adjustments:			
Research and development:			
Share-based compensation	(1)	7,649	9,652
Depreciation and amortization	(2)	373	446
General and administrative:			
Share-based compensation	(1)	69,520	73,835
Depreciation and amortization	(2)	265	937
Gain on litigation settlement	(3)	(770,235)	—
Other:			
Change in fair value of investments	(4)	25,922	(12,899)
Change in fair value of liability instruments	(5)	—	(14,124)
Gain on deconsolidation of subsidiaries		(11,027)	(3,108)
Estimated income tax impact from adjustments	(6)	99,048	43,237
Adjusted loss from continuing operations, net of tax (Non-GAAP)		**$ (222,741)**	**$ (154,399)**

	Note	Three Months Ended March 31, 2026	2025
Research and development expenses		**$ 198,945**	**$ 145,238**
Adjustments:			
Share-based compensation	(1)	7,649	9,652
Depreciation and amortization	(2)	373	446
Adjusted research and development expenses (Non-GAAP)		**$ 190,923**	**$ 135,140**

	Note	Three Months Ended March 31, 2026	2025
General and administrative expenses		**$ 158,250**	**$ 147,092**
Adjustments:			
Share-based compensation	(1)	69,520	73,835
Depreciation and amortization	(2)	265	937
Adjusted general and administrative expenses (Non-GAAP)		**$ 88,465**	**$ 72,320**

Notes to non-GAAP financial measures:

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

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

(3) Represents a gain resulting from the global settlement with Moderna entered in March 2026 and reflects Genevant's expected portion of a non-contingent, non-creditable and non-refundable payment to be made by Moderna to Genevant and Arbutus.

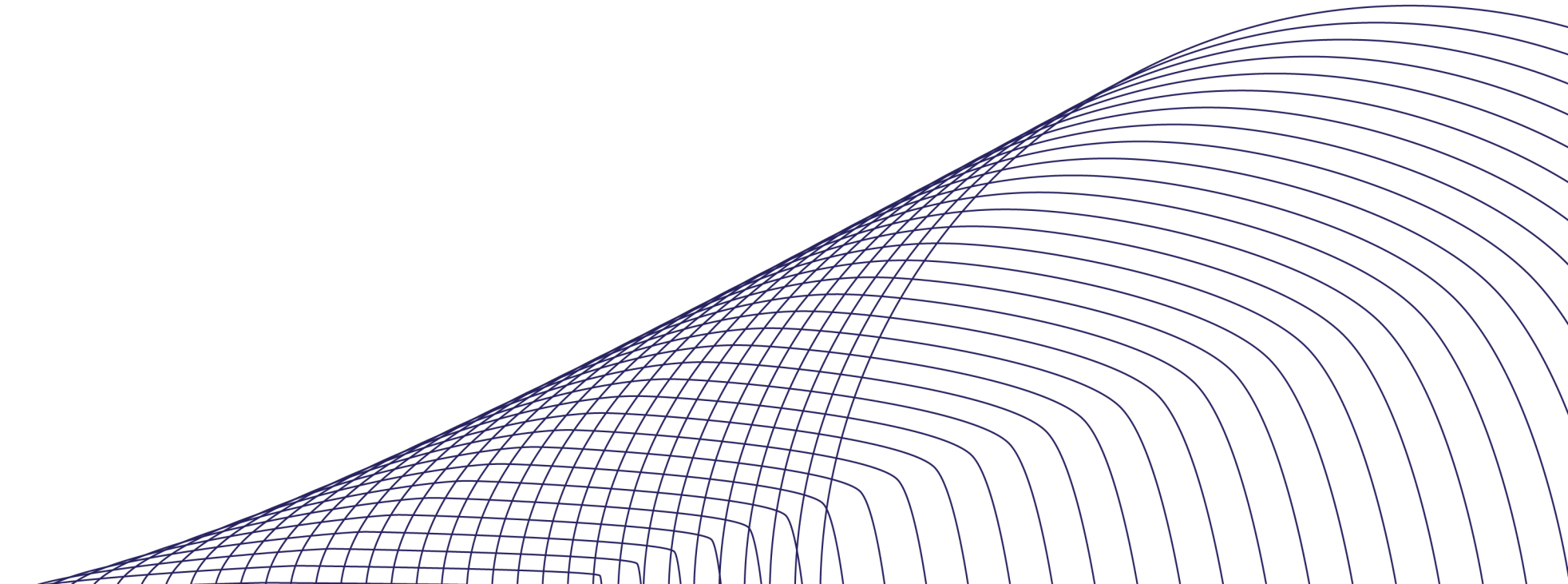
(4) Represents the unrealized loss (gain) on equity investments in unconsolidated entities that are accounted for at fair value with changes in value reported in earnings.

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

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

Illustrative Accounting Treatment

The information contained in these slides is provided for illustrative and educational purposes only. It is not intended to be comprehensive and is not a substitute for reviewing Roivant's consolidated financial statements, including the notes thereto. This should not be relied upon as a complete description of Roivant's accounting policies or financial reporting. Certain items described on this slide are prospective in nature and therefore not reflected in Roivant's Annual Report on Form 10-K for the year ended March 31, 2026.



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Reflecting Consolidated Vants on Roivant Financial Statements

Illustrative Consolidation Accounting Treatment

Roivant consolidates 100% of Priovant, Immunovant & Pulmovant (among others)

100% CONSOLIDATED TO ROIV	
Vant Product Revenue, net	ROIV books 100% of Vant net product revenue, not just ROIV's ownership %
Vant License, Milestone & Other Revenue	ROIV books 100% of Vant milestones and royalties due from partners, recognized when earned / triggered
Vant COGS	ROIV books 100% of Vant product costs; post-approval royalties payable to licensors (e.g. HanAll, Pfizer, Bayer) including amortization of capitalized milestones
Vant R&D / SG&A	ROIV books 100% of Vant cost base
Vant IPR&D	ROIV books 100% of Vant pre-approval milestones payable to licensors (e.g. HanAll, Pfizer, Bayer)
Vant Assets & Liabilities (Balance Sheet)	All Vant assets and liabilities are 100% consolidated onto the ROIV balance sheet

NCI CARVE-OUT (MINORITY SHAREHOLDERS' SHARE) *Only carve-out from full consolidation – removes minority shareholders' share of earnings (P&L) and net assets (balance sheet); appears below net income and as equity component*	
P&L: NCI	Deduct % NCI (minority) ownership of Vant net income – appears below net income to carve out minority shareholders' allocation of earnings based on shareholders' rights
Balance Sheet: NCI	Equity component (not a liability); updated each period for minority shareholders' share of net assets attributable to non-ROIV holders
Cash Flow: Dividends Paid to NCI	Minority ownership % of dividends paid flows to Vant minority shareholders as Financing Outflow[1]

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Note: Includes for illustrative purposes expected P&L components related to a potential commercial launch
1. Dividends are declared at the discretion of the Vant Board of Directors.

Impact of NCI on Roivant EPS

NUMERATOR

Basic EPS	Diluted EPS
Vant consolidated net income	Vant consolidated net income
(-) NCI: allocation reflecting basic ownership[1]	(-) NCI: allocation reflecting basic ownership[1]
	(-) NCI: add'l allocation to potential Vant common shares[2]
Net income attributable to ROIV, basic	Net income attributable to ROIV, diluted (lower)

DENOMINATOR

Basic EPS	Diluted EPS
Basic ROIV weighted average shares outstanding	Diluted ROIV weighted average shares outstanding, including potential ROIV common shares[3]

Vant securities settled in Vant common shares have no effect on the denominator.

= basic EPS	= diluted EPS

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1. Basic ownership refers to percentage ownership of the issued and outstanding Vant shares, including preferred shares in certain instances. Additional allocation to NCI may be required if participating securities exist.
2. Includes allocation to securities issued by Vants, including options and share-based payments that enable holders to obtain Vant common shares. Vant EPS is calculated on a stand-alone basis and then used to determine allocation of Vant's earnings. Vant's diluted EPS is only included when the effect is dilutive (there is net income at the Vant). If Vant has a loss from continuing operations, this adjustment is omitted as the effect of including is anti-dilutive.
3. Potential common shares are only included when dilutive. The dilutive effect is computed using the treasury stock method or application of the if-converted method, as applicable. For periods of loss from continuing operations, these instruments would be excluded as effect of including is anti-dilutive.

Rich Catalyst Calendar

Program	Vant	Catalyst	Expected Timing
Roivant pipeline growth		New mid/late-stage in-licensing announcements	Ongoing
Brepocitinib		FDA decision on brepocitinib in dermatomyositis	3Q 2026
Mosliciguat		Topline data from Phase 2 trial in pulmonary hypertension associated with interstitial lung disease	2H 2026
Brepocitinib		Topline data from Phase 3 trials in non-infectious uveitis	2H 2026
IMVT-1402		Topline data from Phase 2 trial in cutaneous lupus erythematosus	2H 2026
IMVT-1402		Further updates from difficult-to-treat rheumatoid arthritis program	2H 2026
IMVT-1402		Topline data from potentially registrational trials in Graves' disease	2027
IMVT-1402		Topline data from potentially registrational trial in myasthenia gravis	2027
IMVT-1402		Topline data from potentially registrational trial in Sjögren's disease	2028
IMVT-1402		Topline data from potentially registrational trial in chronic inflammatory demyelinating polyneuropathy	2028
Brepocitinib		Topline data from Phase 3 trial in cutaneous sarcoidosis	TBC
Brepocitinib		Topline data from Phase 2b/3 trial in lichen planopilaris	TBC

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

By the 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

9+ Pivotal Study Readouts

Across 7+ Indications

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

3+ POC Study Readouts

Across 3+ Indications

PH-ILD | CLE | CS ✓

brepocitinib | IMVT-1402 | mosliciguat

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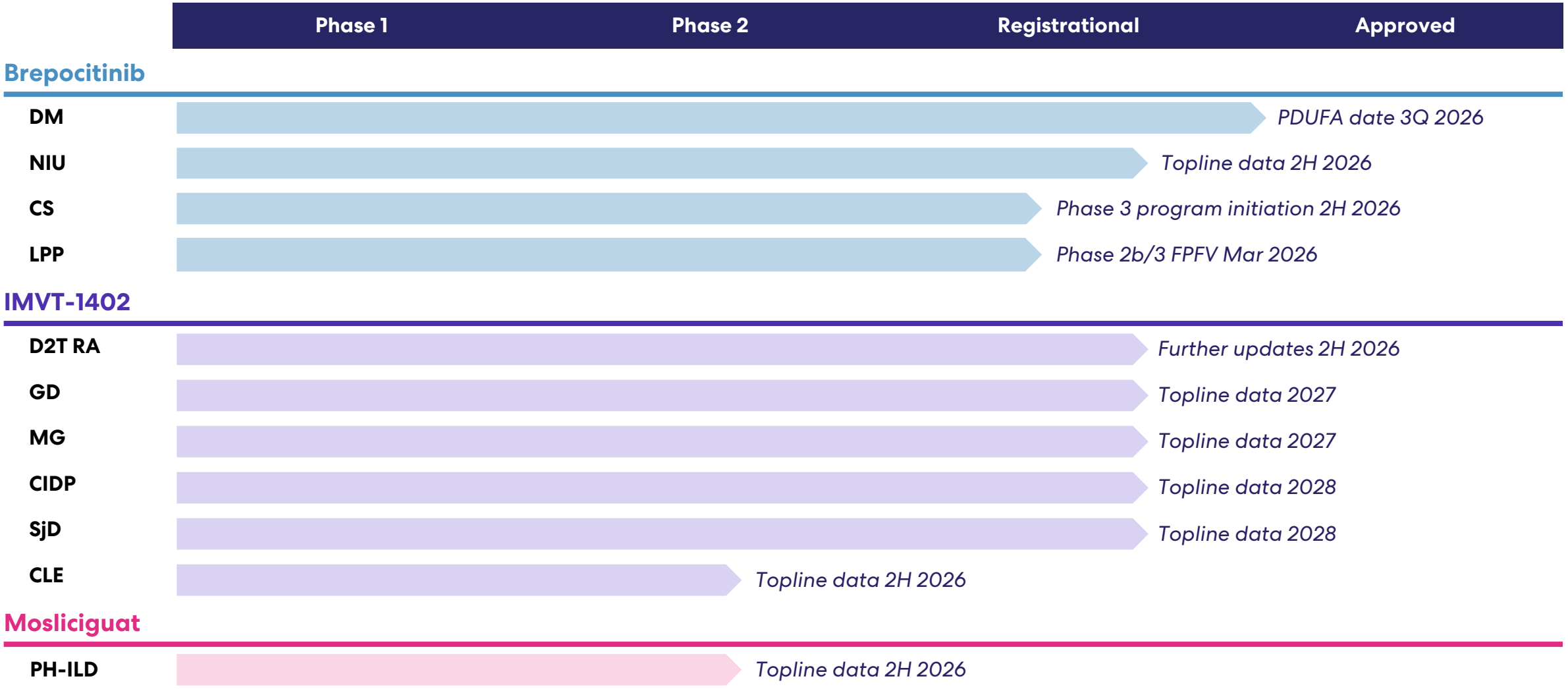
Note: All drugs are investigational and subject to regulatory approvals. All catalyst timings are approximate, based on current expectations and, where applicable, contingent on FDA feedback, and may be subject to change. All references are to calendar years.
Green outline and check indicate successful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

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



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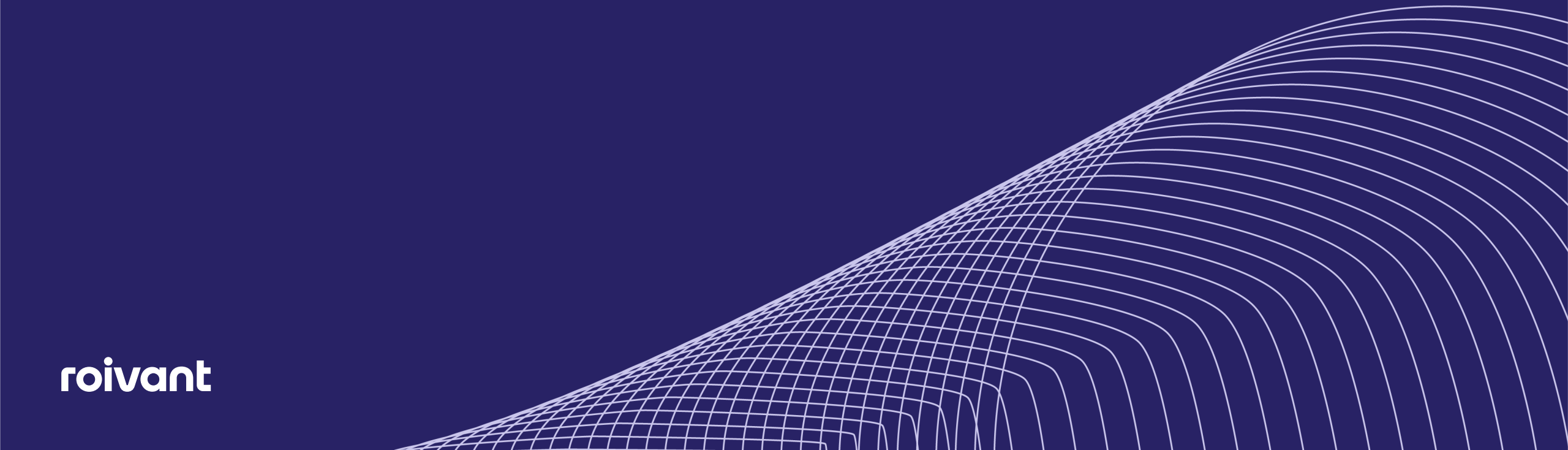
Note: All drugs are investigational and subject to regulatory approvals. All catalyst timings are approximate, based on current expectations and, where applicable, contingent on FDA feedback, and may be subject to change. All references are to calendar years

Thank you.



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