Brepocitinib: Investor Event

Seeking to improve the lives of patients with DM and other serious autoimmune conditions

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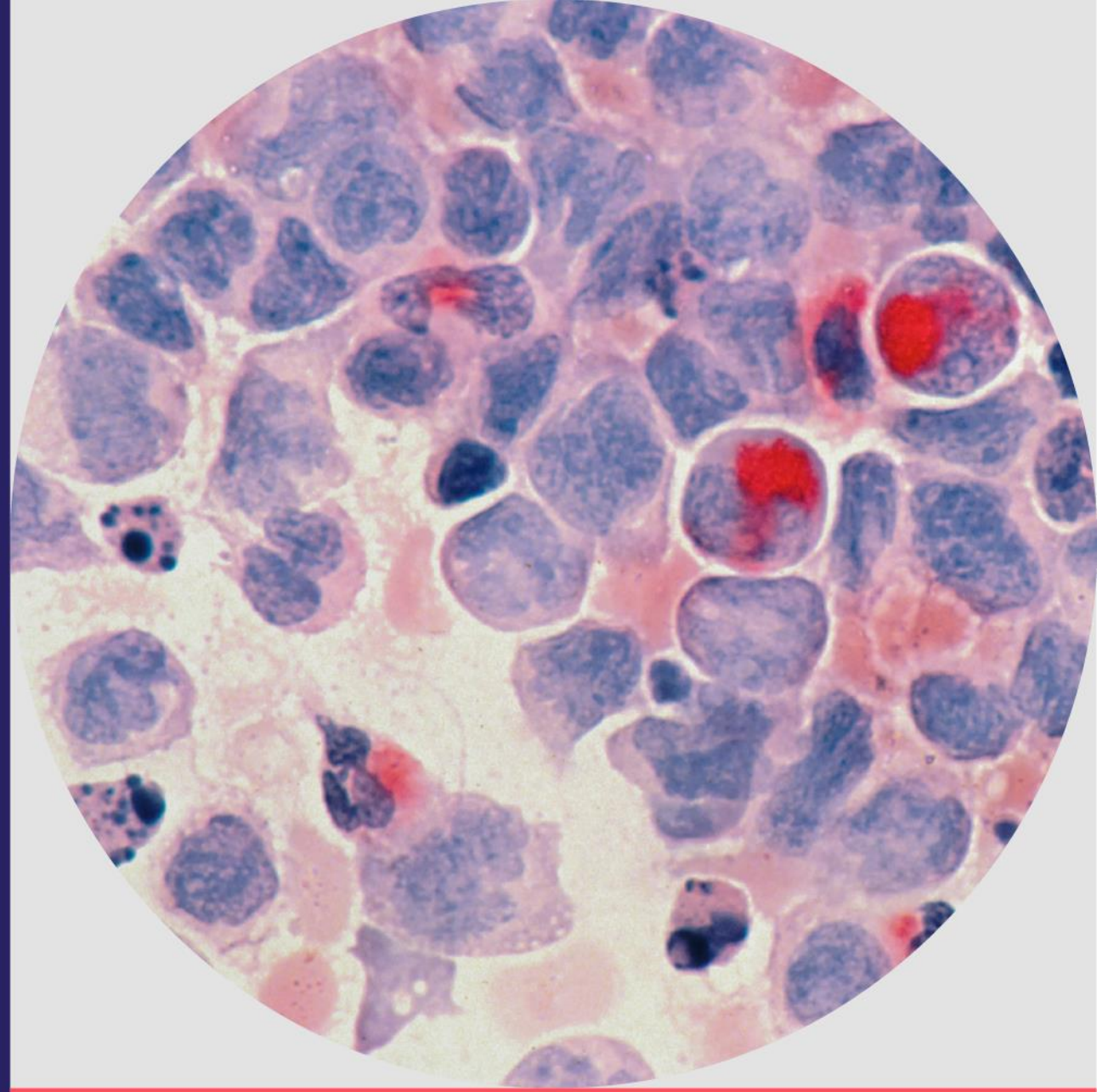

June 17, 2025

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 brepocitinib 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.

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

1. Brepocitinib program overview
2. Focus on dermatomyositis (DM)
3. Brepocitinib in the context of Roivant
4. Q&A

Matthew Gline

Chief Executive Officer, Roivant

Benjamin Zimmer

Chief Executive Officer, Priovant

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Aiming to Set New SoC for Patients Across Multiple Areas of High Unmet Medical Need

Brepocitinib's VALOR study, if positive, could significantly improve the standard of care for >40K patients currently living with dermatomyositis (DM) and potentially set a new clinical bar for other therapies

Across multiple ongoing studies, if successful, brepocitinib could help >200K patients. ROIV's enthusiasm and confidence drives the speed, depth and breadth of brepocitinib's ongoing & planned late-stage development program (with Phase 3 studies ongoing for NIU and PoC study ongoing in CS)

VALOR's expected readout in 2H25 is the first of several upcoming clinical and regulatory catalysts expected for brepo over the next 24 months

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.
SoC = Standard of Care
PoC = Proof of Concept
NIU = Non-Infectious Uveitis
CS = Cutaneous Sarcoidosis

Brepocitinib is a Potential First-In-Class Dual Selective TYK2/JAK1 Inhibitor, Represening Next Generation of Treatment for Inflammatory Diseases

Evolution of JAK inhibitor field highlights demand for efficacy in treating patients with the most debilitating symptoms

Nonspecific/pan-JAK inhibitors

XELJANZ® (tofacitinib)

olumiant® (baricitinib) tablets

First targeted oral agents for inflammatory diseases

Non-specificity limited ability to dose to maximal efficacy and led to class-wide black box warning

Modest commercial success, uptake impaired by less-than-biologic efficacy

Single JAK Isoform Inhibitors

RINVOQ® upadacitinib

SOTYKTU™ (deucravacitinib) 6 mg tablets

Rinvoq (JAK1) is a multi-blockbuster drug (despite a black box warning) on the back of often best-in-indication efficacy

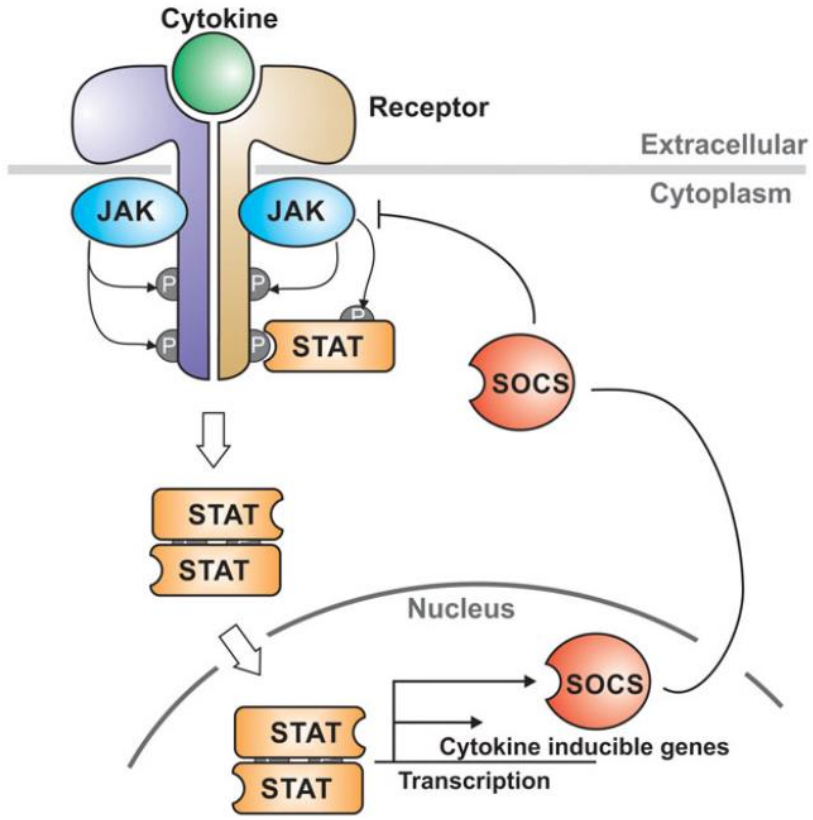
Sotyktu (TYK2), designed specifically to avoid black box liability, has underperformed commercially due to less-than-biologic efficacy

Selective, Dual Inhibitor of TYK2 and JAK1

Brepo

Brepo combines the best attributes of selective TYK2 and JAK1 inhibition with potential **to provide very robust efficacy** for patients across highly morbid, heterogeneous autoimmune diseases

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

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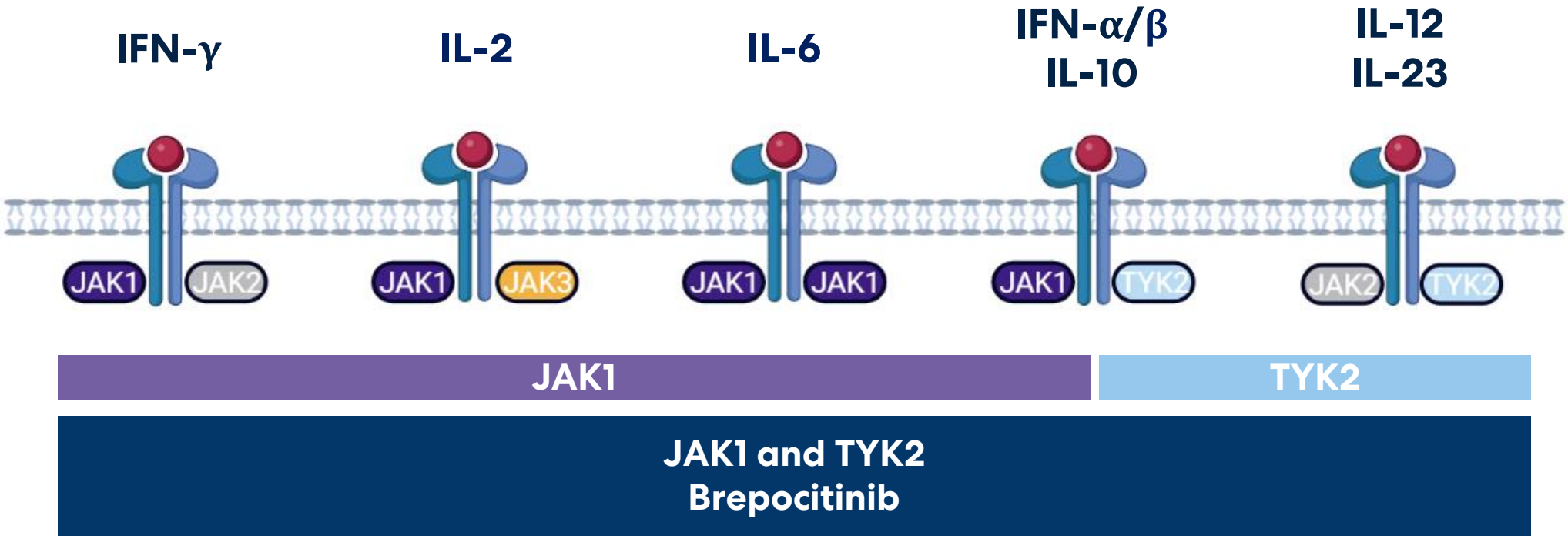
Figure adapted from Morris et al, 2018

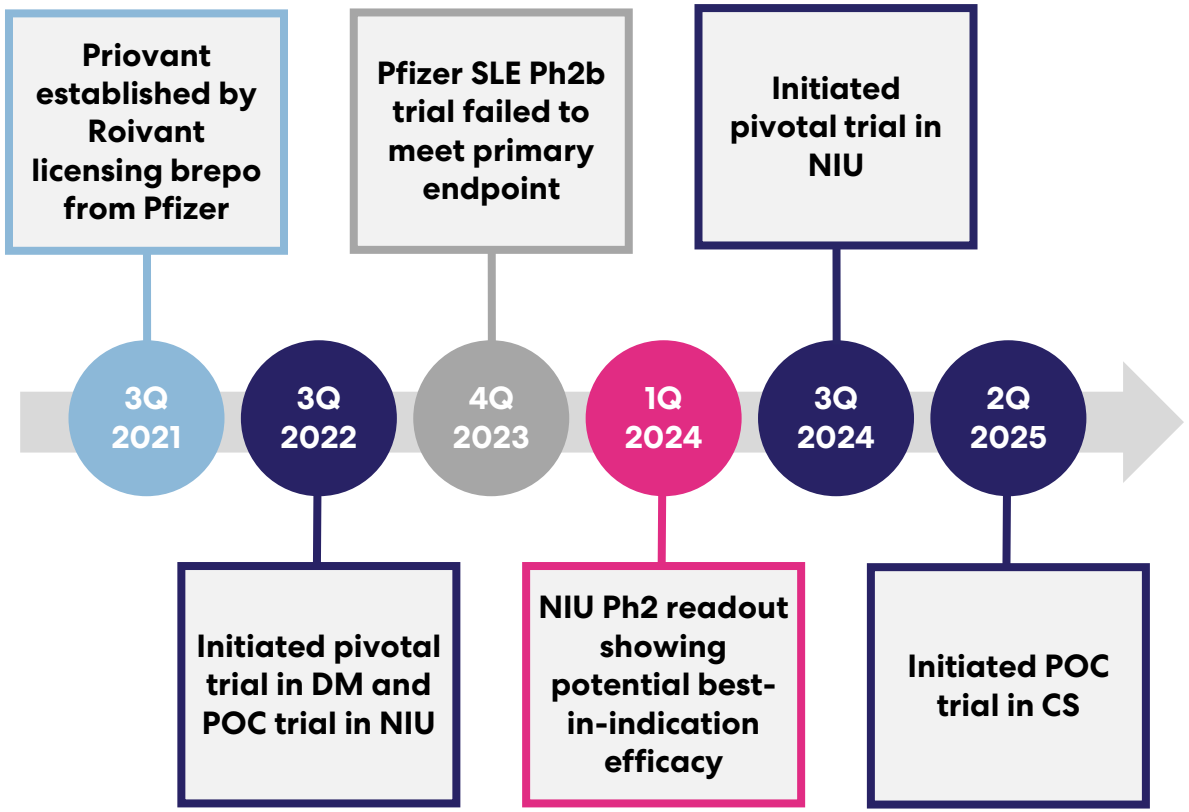
Dual TYK2/JAK1 Inhibition is a Novel Mechanism of Action, With Potential for Greater Efficacy Than Earlier Generation JAK Inhibitors

Unlike any approved molecule, brepo inhibits both TYK2 and JAK1, suppressing signaling pathways for a distinctive set of cytokines linked to autoimmunity



Rapid Expansion of Brepocitinib Program into Multiple Orphan Immunological Conditions with Well Established Safety Profile Across >1,500 Patients

Roivant's Rapid Expansion of Brepocitinib



Seven Positive Phase 2 Studies

Study Population	N[1]	Brepocitinib Dose
Alopecia Areata *Patients with moderate-to-severe AA*	94[2]	30 mg once daily[3]
Psoriatic Arthritis *Patients with active PsA*	218	30 mg once daily
Ulcerative Colitis *Patients with moderate-to-severe UC*	167	30 mg once daily
Plaque Psoriasis *Patients with moderate-to-severe PsO*	212	30 mg once daily
Hidradenitis Suppurativa *Patients with moderate-to-severe HS*	100	45 mg once daily[4]
Crohn's Disease *Patients with moderate-to-severe CD*	151	60 mg once daily[5]
Non-infectious Uveitis *Patients with active non-infectious intermediate-, posterior-, and panuveitis*	26	45 mg once daily

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1. Overall study N represents patients randomized to all brepocitinib dose levels or placebo and excludes patients randomized to other agents
2. Includes patients from initial 24-week study period only
3. 60 mg QD for 4 weeks followed by 30 mg QD for 20 weeks
4. Brepocitinib 45 mg once daily was the only brepocitinib dose evaluated in this study
5. Brepocitinib 60 mg once daily was the only brepocitinib dose evaluated in the induction period of this study

Note: The failed SLE study was conducted by Pfizer. All other studies on the left-hand side timeline were conducted by Priovant. Out of the seven positive phase 2 studies on the right-hand side table, the non-infectious uveitis study was conducted by Priovant, and all others were conducted by Pfizer.

Brepocitinib Could Redefine SoC for Patients with Dermatomyositis (DM)

DM is a debilitating disease with significant unmet medical need

- DM skin and muscle disease is debilitating to patients' quality of life
- Patients are heavily treated with high-dose chronic steroids and immunosuppressive therapies, with limited efficacy
- Brepo is only oral therapy in late-stage development and could be first advanced novel approved therapy of any modality for patients with DM

VALOR Study is designed to potentially establish brepocitinib as a new SoC in DM

- Strong clinical and pharmacologic rationale for TYK2/JAK1 inhibition in DM
- VALOR is largest interventional DM trial ever conducted, with clinically relevant endpoints and enrolled patient population representative of real-world DM population
- Strong success seen with steroid taper during study (blinded/pooled)

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SoC = Standard of Care

Dermatomyositis is a Chronic Inflammatory Disease of the Skin and Muscles That Affects Approximately 40-50K US Adults

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, wheelchairs, and walkers)	35%[2]

KEY SYMPTOMS		
	100%	Red, Painful Skin Rash
	~90%	Proximal Muscle Weakness

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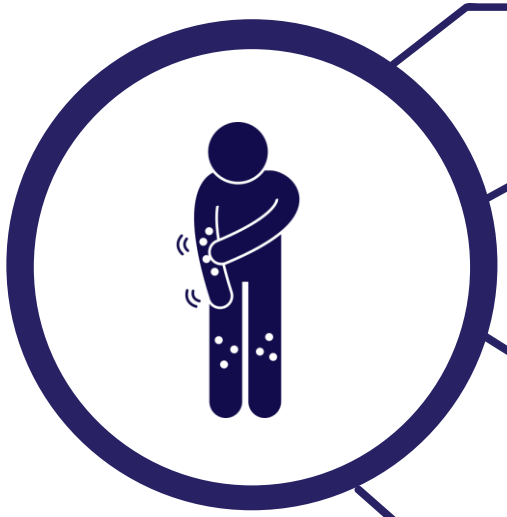
1. Priovant/TMA Patient Survey
2. Myositis Journey and Burden of Disease Survey, MSU (2022)

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

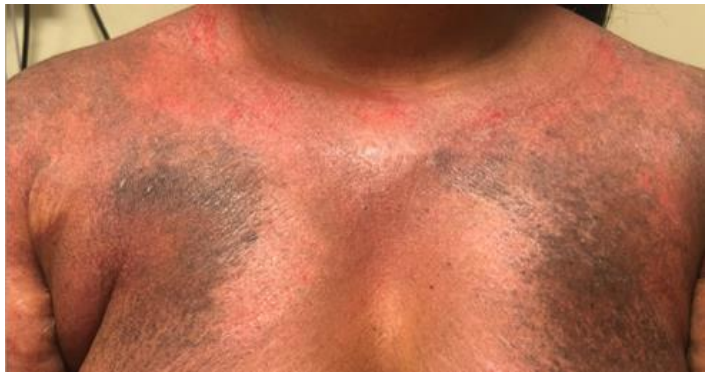


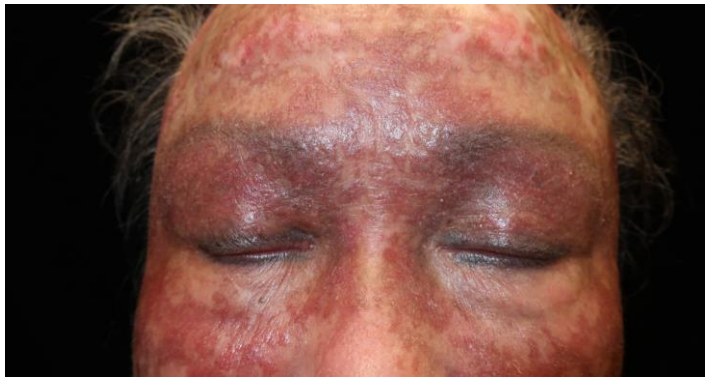
82% Reported that their cutaneous disease caused disruption of daily life

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].

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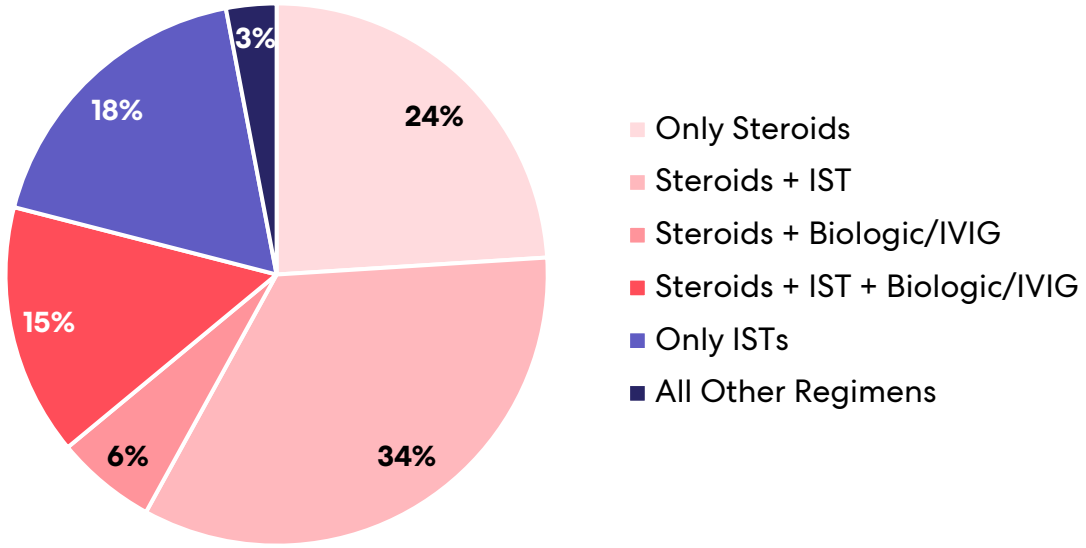
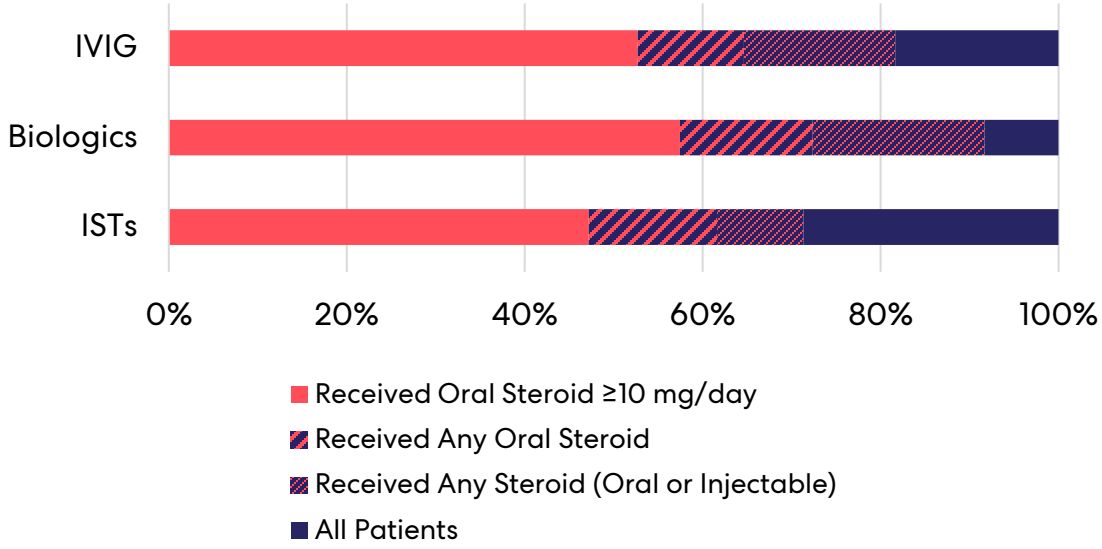
ADL: Activities of Daily Living
Survey data adapted from Kleitsch et al, Arch Dermatol Res (2023)
1. Goreshi et al, J AM Acad Dermatol (2011)

High Treatment Rates, with >60% Receiving Multiple Therapies and ~80% Receiving Steroids, Often High Doses Administered Chronically

Therapies Received by ~34K Treated Dermatomyositis Patients



Steroid Use Among Patients Receiving Steroid-Sparing Therapy



Despite widespread use of multi-drug steroid-sparing therapy combinations, 62-72% of patients receiving steroid-sparing therapy still use oral corticosteroids, with most requiring doses ≥10 mg/day for ≥100 days/year

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Note: Analysis by Roivant/Priovant using closed claims data from Inovalon. Analysis includes patients with DM with continuous enrollment from 2020-2022.

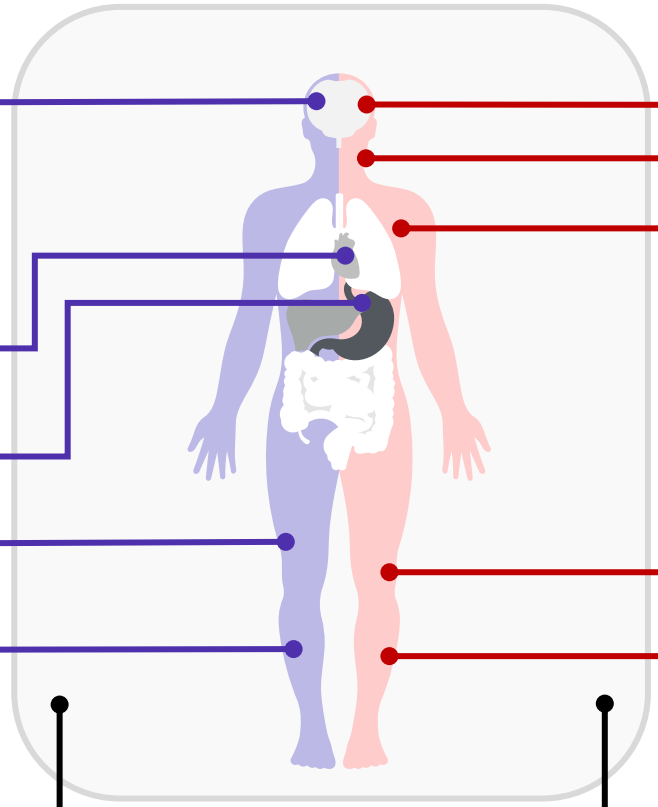
High Rates of Glucocorticoid (Steroid) Use in DM Patients are Associated with Major Adverse Effects Across Multiple Organ Systems

Ability to reduce or discontinue chronic corticosteroids would likely have significant positive impact on patient health

Short-Term Adverse Events

(Reported Frequency in DM/IIM)

- **Skin Thinning**[1] *(47%)*
- **Hair Loss**[1] *(37%)*
- **Euphoria and Hypomania**
- **Hypertension**[1,3] *(13-17%)*
- **Gastric Symptoms**[1,2] *(43%)*
- **Cutaneous Striae**
- **Impaired Wound Healing**[1] *(40%)*



- **Infections**[1,3,4] *(22-29%)*

Long-Term Adverse Events

(Reported Frequency in DM/IIM)

- **Cataracts**[1,4] *(11-13%)*
- **Mood Swings**[1,2] *(67-86%)*
- **Glaucoma**[1,4] *(11-13%)*
- **Cushingoid State**[1] *(57%)*
- **Adrenal Insufficiency**
- **Steroid Myopathy**[7,8]
- **Diabetes/Hyperglycemia**[1,3] *(33-36%)*
- **Osteoporosis**[4,5,6] *(18-42%)*
- **Osteonecrosis** *(18-42%)*

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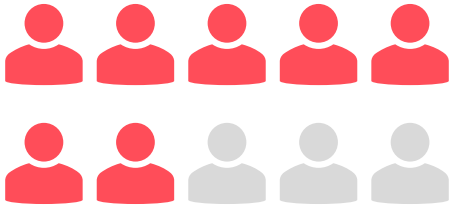
1. Vlekkert J., et al., Neuromuscul Dis (2010)
2. Loarce-Martos J., et al., Clin Rheumatol (2021)
3. Uchino M., et al., Eur Neurol (2012)
4. Ng K.P., et al., Clin Rheumatol (2009)
5. de Andrade D.C.O., et al., Rheumatol Int (2012)
6. Choy E.H.S., et al., Rheumatol (2002)
7. Naim M.Y., et al., J Rheumatol (2006)
8. Akter T., et al., J Dhaka Med Coll (2015)

Despite Widespread Use of SoC Therapies, Patients with DM Experience High Rates of Disease Flare and Pain, Often Requiring Opioid Painkillers

73%

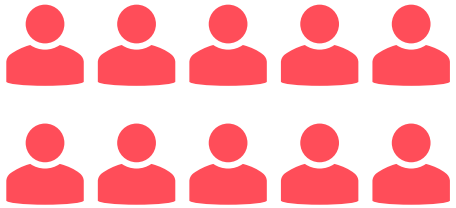
(N=524)



Despite existing therapies, most adults with DM and PM experienced at least one disease flare in the past year[1]

97%

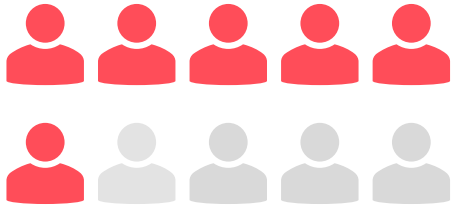
(N=183)



Nearly all DM patients report experiencing current or prior pain[2]

57%

(N=183)



% of DM patients who use opioids to manage DM-associated pain[2]

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

PM = polymyositis

Growing Evidence of Effectiveness of JAK Pathway for DM Patients

2021

STIR Study (Tofacitinib)[1] *(N = 10 skin-predominant patients)*	Marked improvement in skin disease
SLR: Case Reports in Adult and Juvenile Myositis[2] *(N = 145)*	Consistent improvements in skin and muscle disease

1 IIT, ~150 published cases

2025

STIR Study (Tofacitinib)[1] *(N = 10 skin-predominant patients)*	Marked improvement in skin disease
MYOJAK Study (Baricitinib)[3] *(N = 15 patients with PM or DM, n = 13 with DM)*	Marked improvement in skin and muscle disease
Pilot Study of Barictinib or Ruxolitinib in Adult DM[4] (N = 16 patients)	Marked improvement in skin and muscle disease
SLR: Case Reports in Adult and Juvenile Myositis[5] *(N = 601)*	Consistent improvement in skin and muscle disease

3 IITs, >600 published cases

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1. Paik et al, Arth Rheum 2021
2. Paik et al, Clin Exp Rheum 2022
3. Chinoy et al, ACR 2024 Abstract #1731
4. Landon-Cardinal et al, JAAD 2023
5. Wallwork et al, Exp Opin Pharmacother 2024

Note: IIT = investigator initiated trial

Dual TYK2/JAK1 Inhibition is Particularly Well-Suited to Address Underlying DM Pathobiology

Pathogenic Cytokine	Role in DM Pathogenesis		Brepocitinib	Selective JAK1 Inhibitor	Selective TYK2 Inhibitor	Type I IFN Antibody
Type I IFN (IFNα/β)	**Direct Cellular Damage & Lymphocyte Activation**		✓✓	✓	✓	✓✓
Type II IFN (IFNγ)	**Th1** Lymphocyte Polarization		✓	✓	✗	✗
IL-12			✓	✗	✓	✗
IL-6	**Th17** Lymphocyte Polarization	**B Cell Activation**	✓✓	✓	**Partial**	✗
IL-23			✓	✗	✓	✗

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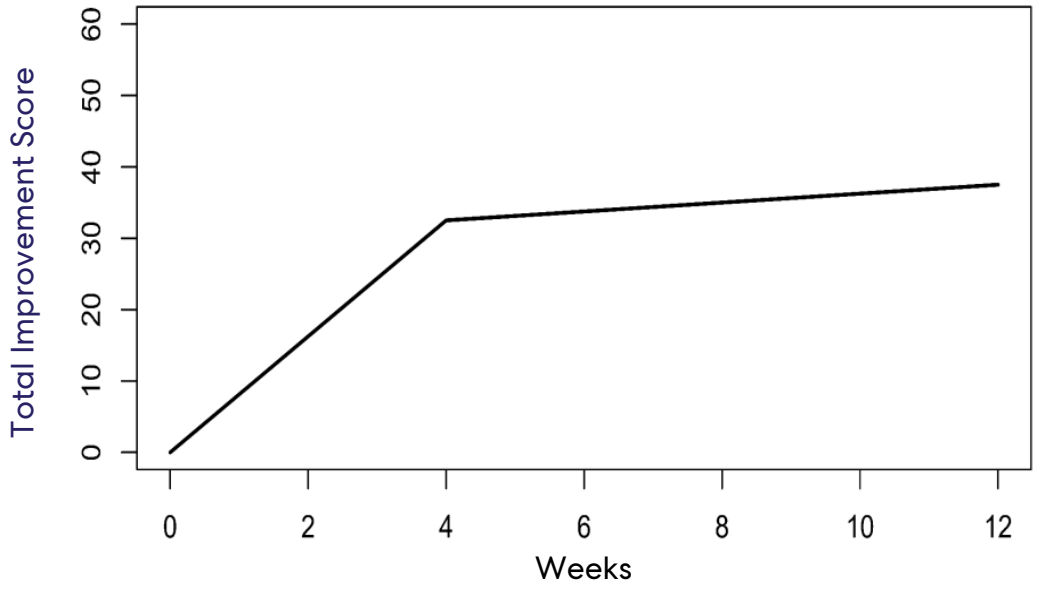
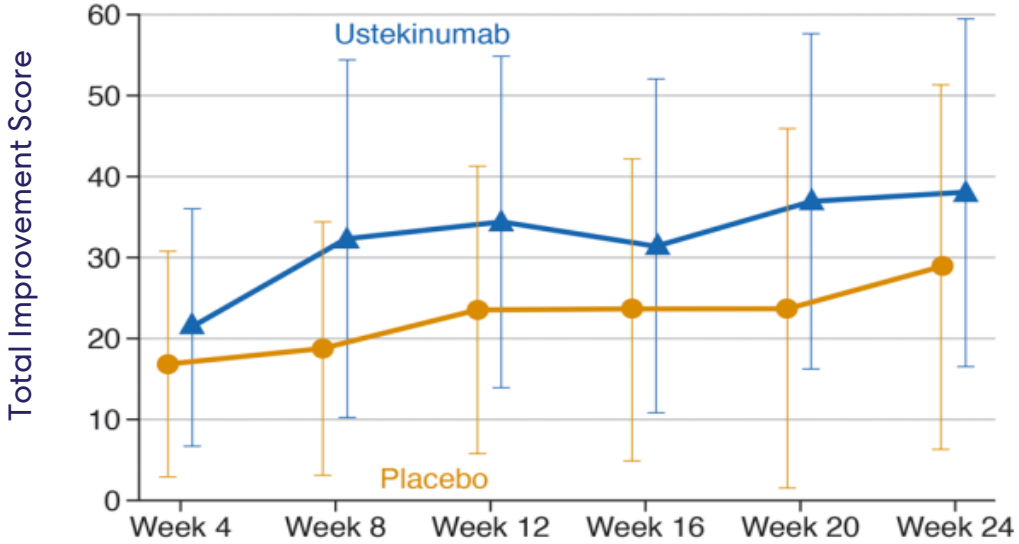
Independent Clinical Evidence for Each of JAK1 and TYK2 Axes in DM

Phase 2 trial of tofacitinib in refractory DM (STIR)[1]
(Proxy for JAK1 inhibition)



Phase 3 trial of anti-IL-12/23 ustekinumab in refractory DM[2]
(Proxy for TYK2 inhibition)



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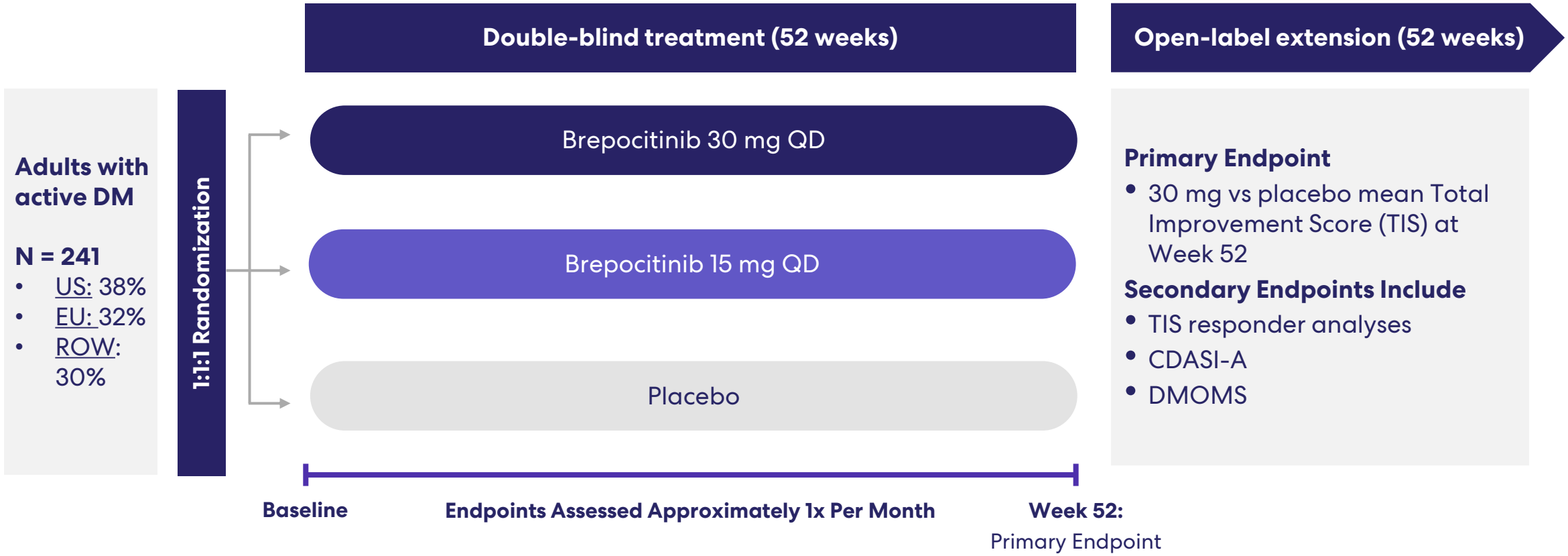
1. Paik et al, Arth Rheum (2021)
2. Kawahata et al, RMD Open (2023)

VALOR: A Single Phase 3 Study of Brepocitinib in Adults with Dermatomyositis

Pivotal study fully enrolled with topline data expected 2H 2025



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.

VALOR Required Both Active Muscle and Skin Disease at Baseline

Baseline Muscle Disease Requirement

Active muscle disease, with MMT8 ≥80 and ≤142

Clinical interpretation: at least mild muscle weakness at baseline, but without end-stage/irreversible muscle damage

Baseline Skin Disease Requirement

Active skin disease, with CDASI-A ≥6

Clinical interpretation: at least mild skin disease activity at baseline

Concomitant Medication Protocol Requirements/Allowances

Allowed Background Medications
Oral corticosteroids (OCS) ≤ 20 mg/day prednisone equivalent, with mandatory taper
Antimalarials (e.g., hydroxychloroquine)
Non-steroidal immunosuppressant (IST) (e.g., azathioprine, methotrexate, mycophenolate mofetil)
Subjects could be on any combination of these medications, with dose stability requirements prior to baseline

Prohibited Background Medications
IVIg
Biologic therapies
Other JAK inhibitors
Prior use of these therapies with washout at trial start was allowed

History of inadequate response to at least one current or prior DM medication required for enrollment, but no active background medication was required

Total Improvement Score (TIS): A Validated Assessment Tool for Use in Myositis Clinical Studies

The TIS reflects improvement from baseline in 6 core set measures (CSMs), including 3 global measures that capture disease activity across organ systems, 2 muscle-specific measures, and a commonly used measure for ADLs

Global Activity Measures

Physician Global Activity	Assessed by investigator on a Visual Analog Scale (VAS)
Patient Global Activity	Reported by patient on a Visual Analog Scale (VAS)
Extramuscular Global Activity	All non-muscle organs (e.g., skin, lungs) assessed by investigator on a Visual Analog Scale (VAS)

Muscle Disease Activity

Manual Muscle Testing	Assessment of muscle/muscle group strength against examiner's resistance
Muscle Enzymes	Most abnormal serum muscle enzyme (includes creatinine kinase, aldolase, ALT, AST, and LDH)

Activities of Daily Living

Heath Assessment Questionnaire	Questionnaire completed by the patient

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Total Improvement Score (TIS): A Validated Assessment Tool for Use in Myositis Clinical Studies

Absolute changes in each CSM are assigned a level score, and all six level scores are summed to obtain a value from 0-100 – this is a patient's Total Improvement Score

Physician Global Activity	
Worsening to 5% improvement	0
>5% to 15% improvement	7.5
>15% to 25% improvement	15
>25% to 40% improvement	17.5
>40% improvement	20

Patient Global Activity	
Worsening to 5% improvement	0
>5% to 15% improvement	2.5
>15% to 25% improvement	5
>25% to 40% improvement	7.5
>40% improvement	10

Extramuscular Global Activity	
Worsening to 2% improvement	0
>2% to 10% improvement	7.5
>10% to 20% improvement	12.5
>20% to 30% improvement	15
>30% improvement	20

Manual Muscle Testing	
Worsening to 2% improvement	0
>2% to 10% improvement	10
>10% to 20% improvement	20
>20% to 30% improvement	27.5
>30% improvement	32.5

Muscle Enzymes	
Worsening to 5% improvement	0
>5% to 15% improvement	2.5
>15% to 25% improvement	5
>25% to 40% improvement	7.5
>40% improvement	7.5

Health Assessment Questionnaire	
Worsening to 5% improvement	0
>5% to 15% improvement	5
>15% to 25% improvement	7.5
>25% to 40% improvement	7.5
>40% improvement	10

Total Improvement Score

Sum of all 6 CSM Level Scores

Range: 0-100

TIS Responder Categories	
Minimal Responder	≥20
Moderate Responder	≥40
Major Responder	≥60

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The VALOR Study Will Evaluate the TIS as Both a Continuous Variable (Primary Endpoint) and as Response Rates for Given Improvement Thresholds

Mean TIS is the VALOR primary endpoint

- Mean TIS is a continuous variable that ranges from 0 to 100
- Primary endpoint is the difference in means at week 52 between the 30mg arm and the placebo arm
- VALOR is 90% powered to detect a difference of 12 points between 30mg arm and placebo on mean TIS, and to result in a statistically significant outcome for differences as low as 8 points

Response rates for TIS improvement thresholds are secondary endpoints

- The percentage of patients achieving a 40-point improvement on TIS (TIS40) and a 60-point improvement on TIS (TIS60) will be assessed as secondary endpoints
  - TIS40 and TIS60 are responder endpoints evaluated as “double deltas” (i.e., difference between drug and placebo in percentage of patients achieving the given response threshold)
- Focusing on higher-threshold measures most relevant to patients (akin to those in other inflammatory diseases, like PASI-90 or HiSCR-90)
- We will also evaluate time-to-TIS-response and percentage of patients achieving TIS response while also meeting certain steroid reduction benchmarks

Placebo Response Behavior in TIS is Still in the Process of Being Understood, Particularly Across a 52-Week Study

- **TIS only goes up** → some placebo response inevitable
- Only completed 52-week study using TIS was Corbus's lenabasum trial: mean TIS at 52 weeks in placebo group was 39.3[1]
  - Lenabasum failed in Phase 3 studies in scleroderma and dermatomyositis
- Placebo mean TIS in shorter studies has varied significantly:

Octagam P3 placebo	Week 16	21.6[2]
Dazukibart P2 placebo	Week 12	36.9[3]
Efgartigimod P2 placebo	Week 24	35.7[4]

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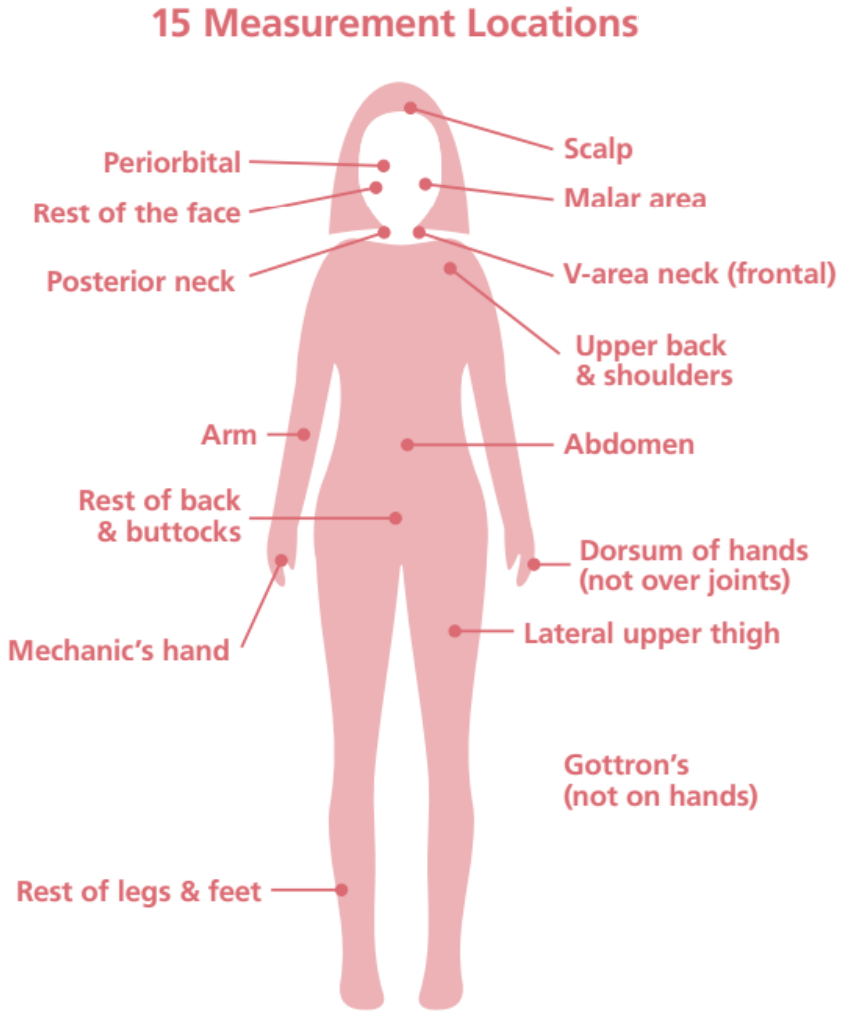
1. Among patients with MMT-8<142 at baseline
2. Aggarwal et al, NEJM (2022)
3. Fiorentino et al., Lancet (2025)
4. Argenx ALKIVIA poster, EULAR OP0002 (2025)

CDASI: Cutaneous Dermatomyositis Disease Area and Severity Index

CDASI is a validated, widely used measure of skin disease activity in patients with dermatomyositis

- CDASI is scored by a clinician at 15 distinct anatomic sites based on the extent of erythema, scale, and erosion/ulceration
- Activity scores **(CDASI-A)** range from 0 – 100; a higher score indicates more severe disease
- CDASI-A scores of 14 or greater indicate moderate-to-severe skin disease activity
- A 4-point change is the minimum clinically important difference
- Historically less susceptible to placebo response than TIS



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DMOMS – Recently Developed DM-Specific Composite Endpoint

The Dermatomyositis Outcomes for Muscle and Skin (DMOMS) endpoint was developed to more precisely reflect the clinical manifestations of dermatomyositis specifically, rather than myositis in general

Physician Global Activity

≤ 0.5 point improvement	**0**
0.6 – 1.5 point improvement	**7.5**
1.6 – 2.5 point improvement	**15**
2.6 – 4.0 point improvement	**17.5**
≥ 4.1 point improvement	**20**

Patient Global Activity

≤ 0.5 point improvement	**0**
0.6 – 1.5 point improvement	**4**
1.6 – 2.5 point improvement	**7.5**
2.6 – 4.0 point improvement	**11**
≥ 4.1 point improvement	**15**

Global Activity Measures

CDASI-A

≤ 4 point improvement	**0**
5 – 7 point improvement	**10**
8 – 12 point improvement	**20**
13 – 19 point improvement	**27.5**
≥ 20 point improvement	**32.5**

Skin Disease Activity

Manual Muscle Testing

≤ 3 point improvement	**0**
4 – 7 point improvement	**10**
8 – 12 point improvement	**20**
13 – 19 point improvement	**27.5**
≥ 20 point improvement	**32.5**

Muscle Disease Activity

Total DMOMS Score	**Sum of all 4 Level Scores** Range: 0-100

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VALOR Pooled/Blinded Baseline Characteristics, Compared to ProDERM (IVIg Phase 3 Trial) Pooled

VALOR enrolled similar patient population, with modestly higher proportion of patients having severe disease

	VALOR (N = 241)	ProDERM[1] (N = 95)
Disease Activity (by Physician Global Activity)		
Mild	45 (19%)	26 (27%)
Moderate	142 (59%)	56 (59%)
Severe	54 (22%)	13 (14%)
Median Time Since Diagnosis (years)	3.0	2.6
Mean MMT-8 (Max score = 150, lower scores indicate more weakness)	122.6	120.9
Mean CDASI-A (Max score = 100, higher scores indicate more severe disease)	19.8	18.9
CDASI-A > 14	146 (61%)	51 (54%)

All VALOR data are pooled and blinded to sponsor and investigators. Data extracted prior to final database lock are preliminary and subject to change.

1. Aggarwal et al, NEJM (2022)

Nearly All Patients Entered Study on Background OCS and/or IST, Consistent with Real-World Population

			Proportion of subjects within each medication group receiving stable dose for given duration prior to baseline			
	N (overall study N = 241)	**Protocol dose stability requirement** (prior to baseline)	**4+ Weeks**	**12+ Weeks**	**18+ Weeks**	**24+ Weeks**
Oral corticosteroids	N = 181 Mean dose ~12 mg/day	4 weeks (must have initiated OCS ≥12 weeks prior)	99%	75%	59%	47%
Immunosuppressive therapy (azathioprine, methotrexate, mycophenolate mofetil)	N = 166	12 weeks	100%	99%	84%	80%
Antimalarial	N = 65	12 weeks	100%	98%	88%	83%

All VALOR data are pooled and blinded to sponsor and investigators. Data extracted prior to final database lock are preliminary and subject to change.

Steroid Tapering Was A Key Focus of VALOR Study

All clinical improvement demonstrated in VALOR results will be against the backdrop of significant reductions in harmful steroid exposure

Protocol Requirements

- Mandatory taper to ≤5 mg/day for any subjects on >5 mg/day at baseline (N = 133)
- Encouraged taper off steroids altogether for all subjects on background OCS (N = 181)

Among Subjects Taking OCS at Baseline Without ICE		
Mean OCS Dose	**Baseline**	**End of Study[1]**
	~12 mg/day	~2.5 mg/day
Proportion Achieving OCS Dose Reduction >50% from BL	>85%	
Proportion Achieving OCS Dose Reduction >75% from BL	>60%	
Proportion Eliminating OCS Entirely	>40%	
Success Rate of Mandatory Taper	>98%	

All VALOR data are pooled and blinded to sponsor and investigators. Data extracted prior to final database lock are preliminary and subject to change.

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ICE = Intercurrent Event
1. Observed patients to date

VALOR Study: Concluding Thoughts

Any positive result (i.e., statistical significance on primary endpoint) for the VALOR trial would represent a breakthrough for DM research and treatment

Steroid burden is significant in DM; ability to demonstrate improvement on disease symptoms while also reducing steroid exposure would be highly impactful for patients and clinicians

Active engagement with FDA around potential NDA submission if study successful; received Orphan Drug Designation in May

Increasing Pharma Recognition of Commercial Opportunity in DM with Brepocitinib Well Ahead of the Pack and Only Oral Option in Phase 3

	Brepocitinib (priovant therapeutics)	Dazukibart (Pfizer)	Efgartigimod (argenx)	Anifrolumab (AstraZeneca)
Phase 3 Top Line Readout*	⊕ **2H 2025**	⊖ 2H 2026	⊖ 2H 2026	⊖ 1H 2027
Route of Administration	⊕ **Oral**	⊖ IV	⊖ SC	⊖ SC

Phase 2 DM Clinical Program Initiations Since VALOR Study Start

Galápagos · argenx · MERCK · Cabaletta Bio™ · AMGEN / HORIZON · immunoforge · kyverna

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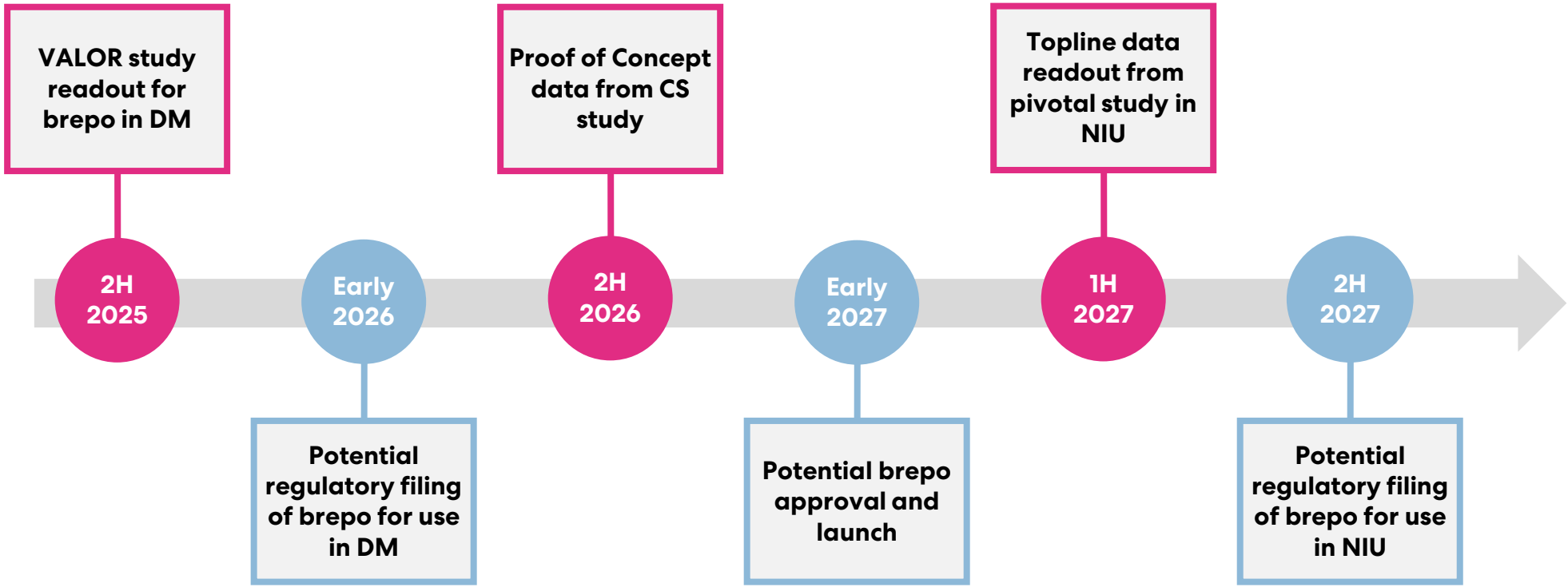
Note: All drugs are investigational and subject to regulatory approvals. All timings are based on current expectations and, where applicable, contingent on FDA feedback, and may be subject to change. All references are to calendar years.
Note: All trademarks are property of their respective owners
*Phase 3 top line readouts per ClinicalTrials.gov

The Brepocitinib Program is a Good Case Study of ROIV's Broader Strategy

Roivant's Strengths	**Identify high value programs with differentiated mechanisms of action**	**Focus on creative development plans in indications with significant unmet medical need**	**Execute efficiently on focused clinical execution**
How Brepocitinib Exemplifies These Objectives	Dual TYK2/JAK1 inhibition is a novel mechanism, with broad and differentiated therapeutic impact. If successful, Brepo will represent a next generation treatment for hard to treat autoimmune conditions.	Chose to focus on rare autoimmune conditions vs. more 'obvious' areas like PsA, UC, CD, AA, HS etc. Driven by quantum of unmet medical need, clear commercial 'swim lane,' and deep understanding of disease biology for interested indications.	VALOR is the largest interventional DM trial ever conducted and has enrolled patients significantly faster than several other DM studies. Beyond VALOR, decision to expand into other indications and speed of execution (e.g., rapid transition from PoC trial start to expected Ph 3 readout for NIU) showcases strong clinical execution.

Brepocitinib: Expected Upcoming Events



Additional opportunities evaluation and pivotal study progression based on PoC data

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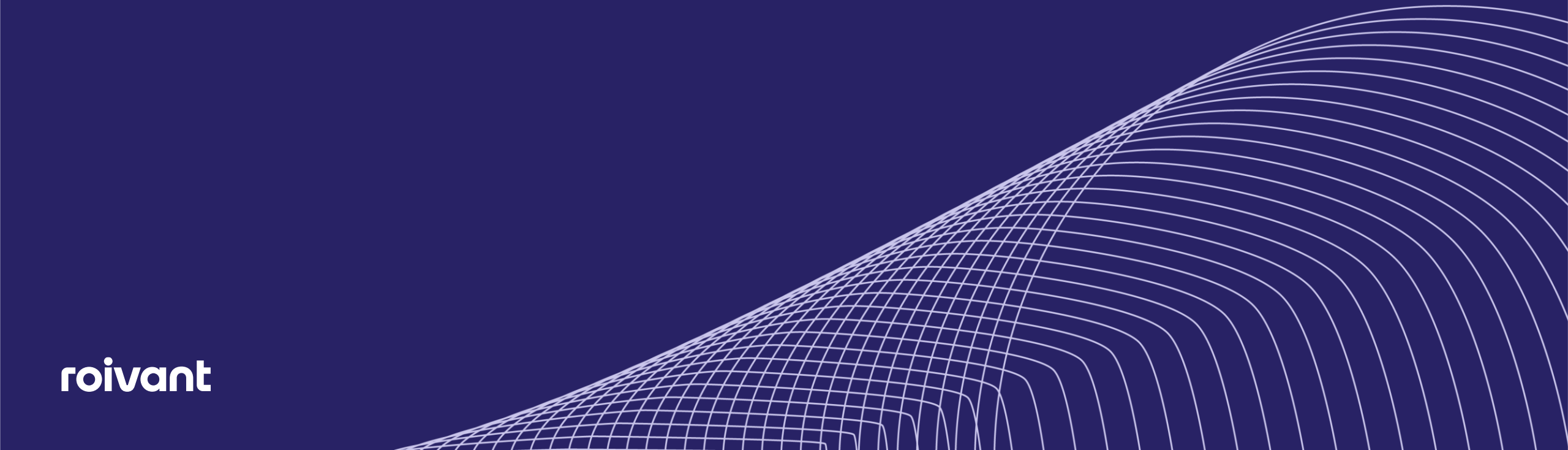
Note: All drugs are investigational and subject to regulatory approvals. All catalyst timings are based on current expectations and, where applicable, contingent on FDA feedback, and may be subject to change. All references are to calendar years.

Q&A



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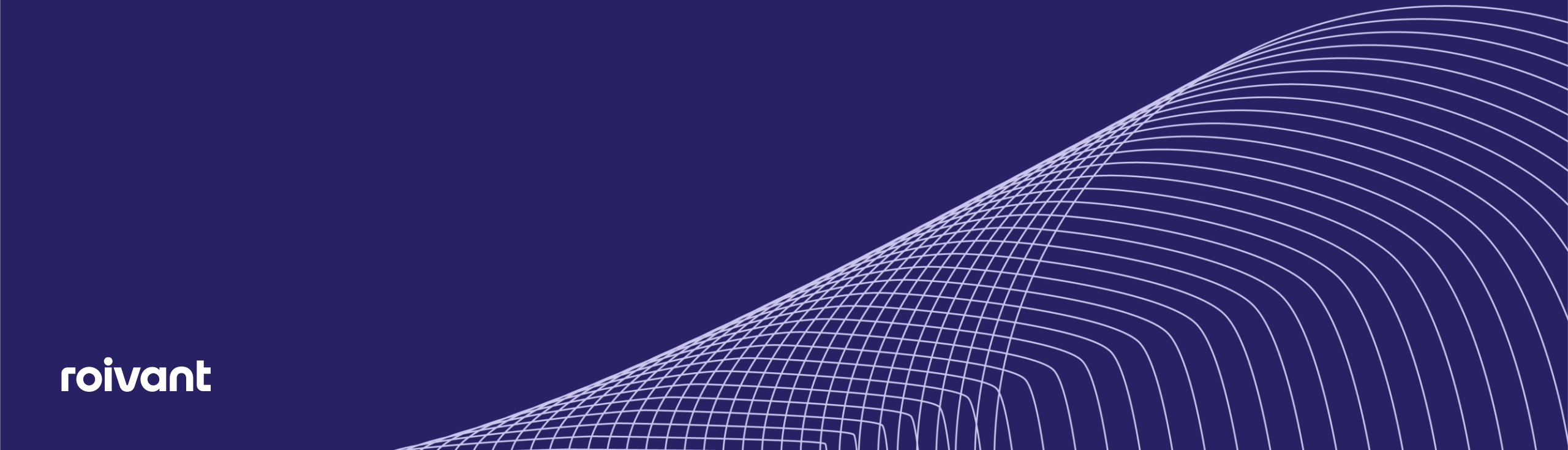
Thank you.



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Appendix

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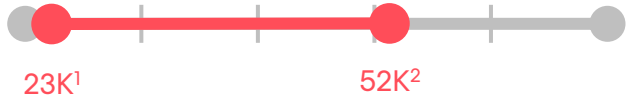
Dermatomyositis: Disease Overview

Dermatomyositis is a chronic inflammatory disease of the skin and muscles that affects approximately 40-50K US adults

US ADULT PREVALENCE

Literature-Based Estimates



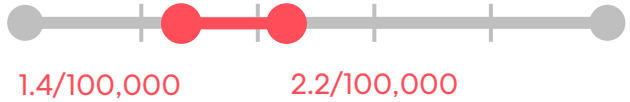
Priovant Claims Analysis

Other Companies Developing DM Therapies

INCIDENCE

Literature-Based Estimates

Priovant Claims Analysis



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1. Smoyer-Tomic et al, BMC Musculoskeletal Disorders (2012)
2. Reeder et al, Arch Dermatol (2010)
3. Kronzer et al, Arth Care Res (2021)
4. Osman et al, Sci Reports (2023)

Brepocitinib: Other Details

Ownership	ROIV owns 75%* of Priovant, with Pfizer owning the remainder.
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.
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.

*As of March 31, 2025. 68% on a fully diluted basis.

Speaker Biographies

Matthew Gline

Matt Gline serves as Chief Executive Officer of Roivant Sciences. Mr. Gline joined Roivant in March 2016 and previously served as Chief Financial Officer. From April 2014 to March 2016, he was a Vice President at Goldman Sachs, Fixed Income Digital Structuring, where he focused on technology and data strategy. Prior to Goldman Sachs, Mr. Gline was a co-founder of Fourthree, a risk analytics technology and consulting company. From 2008 to 2012, he served as Vice President at Barclays, Enterprise Risk Management Advisory, where he provided analysis for corporate clients related to capital markets access for financing and risk management. Mr. Gline earned his A.B. in Physics from Harvard College.

Benjamin Zimmer

Ben Zimmer has been CEO of Priovant since the company's creation in 2021. Prior to joining Priovant he served on the leadership team of Roivant as acting COO (2018-2019) and President, Roivant Health (2018-2021). In this role, Ben led the incubation, launch, and board oversight of Datavant (majority stake acquired by New Mountain Capital), Sinovant (included in Roivant-DSP transaction), and VantAI. From 2015-2018, Ben worked at Roivant in a variety of roles across business operations, clinical operations, and public affairs. Before Roivant, Ben founded and ran a public policy-focused non-profit and worked as a consultant at McKinsey. He holds an A.B. in History from Harvard College and a J.D. from Yale Law School.