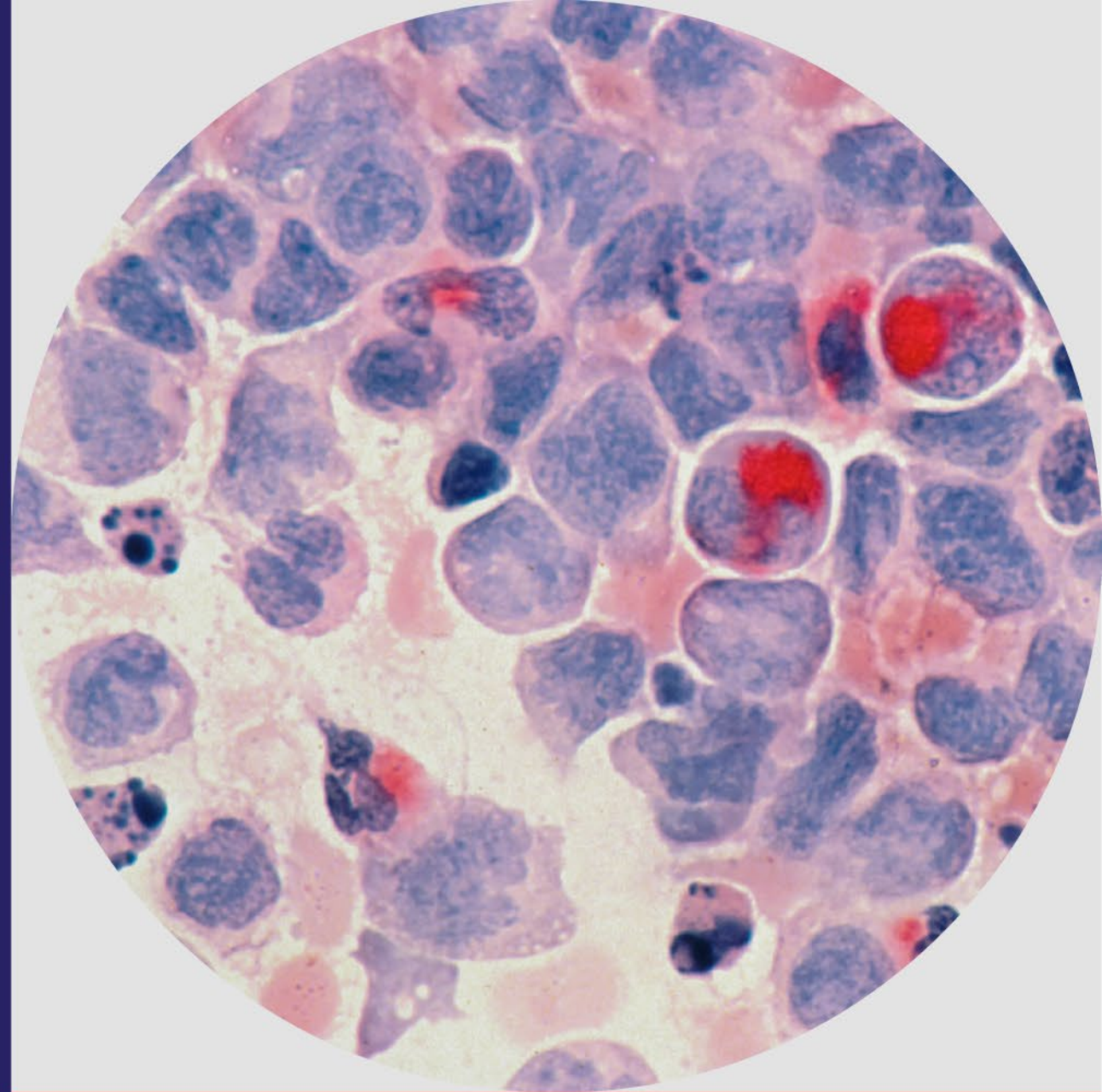


Brepocitinib in NIU: CLARITY Topline Results

roivant



October 21, 2026

Forward-Looking Statements

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

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

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

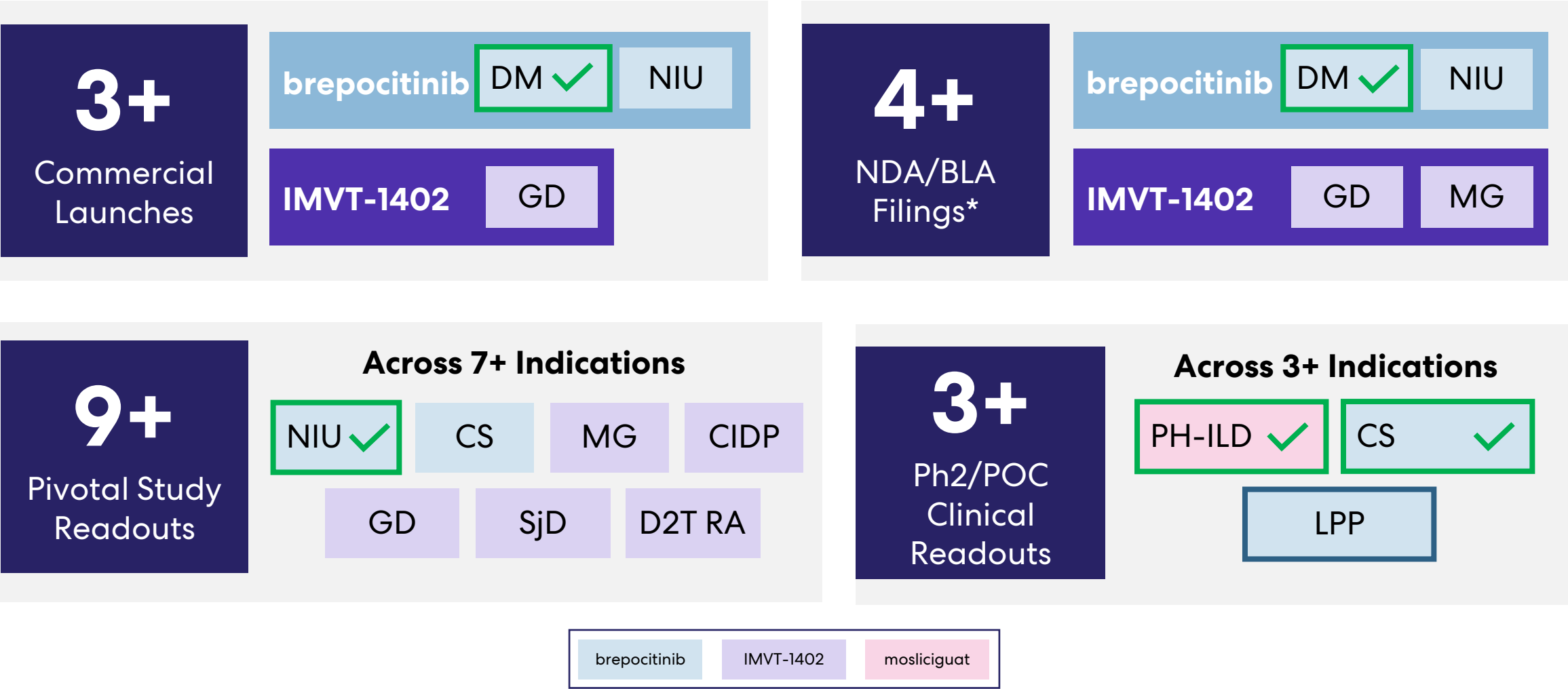
This presentation includes data for brepocitinib as compared to another product generated from separate, independent studies, not from head-to-head analysis. Differences exist between study or trial designs and subject characteristics and caution should be exercised when comparing data across studies.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

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

Disclaimer

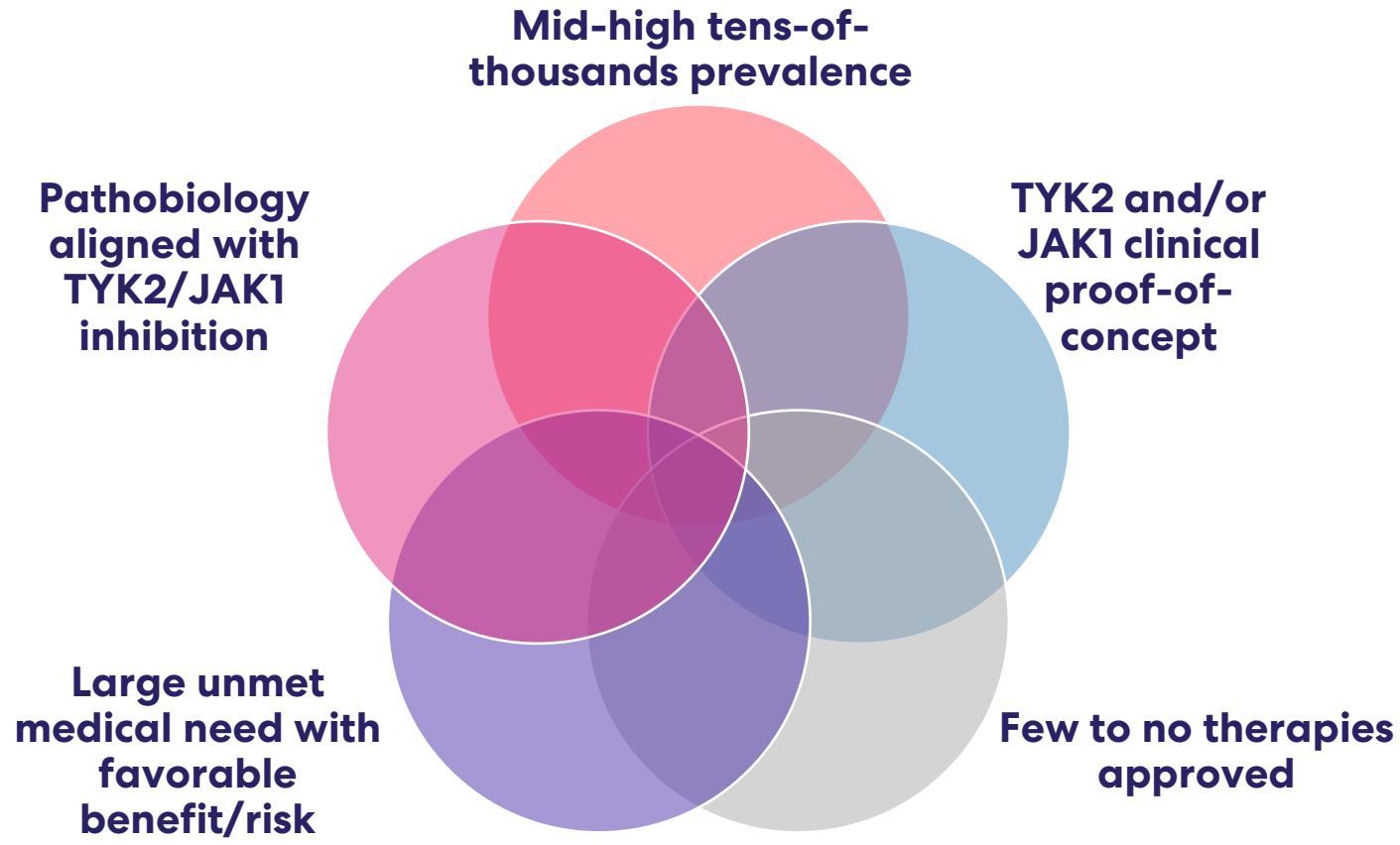
This presentation is intended for the investor community only; it is not intended to promote the product candidates referenced herein or otherwise influence healthcare prescribing decisions.

By the End of CY 2028, Roivant Will Execute on...



Note: LISRAYA (brepocitinib) is FDA-approved only for the treatment of dermatomyositis in adults. Its use in NIU remains investigational and subject to approval by the FDA. 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. **Blue outline** denotes addition since 2025 Investor Day.
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; CS: cutaneous sarcoidosis; LPP: Lichen Planopilaris; POC: proof-of-concept
*May be supplementary filings, depending on drug/indication

Brepocitinib: ROIV's Clinical Development Strategy Focuses on Indications at the Intersection of Dual TYK2/JAK1 Biology and High Unmet Medical Need



Current Brepocitinib Indications

Dermatomyositis (DM)

Approved August 2026

Positive Ph3 Data Announced Today

Non-Infectious Uveitis (NIU)

sNDA Filing 1H 2027

Cutaneous Sarcoidosis (CS)

Ph3 Ongoing

Lichen Planopilaris (LPP)

Ph2b/3 Ongoing

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

Disease Overview

3rd leading cause of blindness in the US¹

1 approved non-steroid therapy (Humira)²

50% of NIU patients fail within 6 months on Humira²



Symptoms include: eye pain, eye redness, distorted vision, floaters, headache, and fatigue³

Anatomic Location

May present as anterior, intermediate, posterior or panuveitis⁴

300-860K

US adults with anterior uveitis – generally treatable with local therapy^{4,5}



70-190K

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

Etiology

Across etiologies, pathobiology is driven by T-cell infiltration into the eye⁷

50%
idiopathic

50%
in combo with other autoimmune diseases

Common comorbidities: sarcoidosis, Behcet's disease, Crohn's disease, rheumatoid arthritis, ankylosing spondylitis, VKH, birdshot chorioretinopathy⁸

1. Dayani, Modern Retina (2020)

2. Jaffe et al., NEJM (2016)

3. Tallouzi et al., BMJ Open Ophth (2020)

4. Thorne et al., JAMA Ophthalmol (2016)

5. Analysis by Roivant/Priorant using closed claims data from Inovalon from 2016-2024

6. Pate and Cleghorn, Rev Opt (2024)

7. Sen et al., Nat Rev Rheumatol (2015)

8. Rosenbaum, Rev Opt (2024)

Two Distinct Prescriber Bases for Novel Systemic Therapy for NIU

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

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

Brepocitinib CLARITY Topline Results



Brepocitinib’s Groundbreaking Efficacy Results In CLARITY Reflect Distinctive Features Of TYK2/JAK1 Mechanism Of Action

Dual TYK2/JAK1 inhibition is a novel mechanism with a distinctive pharmacologic effect that TYK2 or JAK inhibitors alone cannot match

NIU Inflammatory Cascade

Pathogenic Cytokine	Role in NIU Pathogenesis	JAK1 Alone	TYK2 Alone	Brepocitinib
IL-23	Polarization of Th17 effector cells, which cause breakdown of the blood-retinal barrier ¹	X	✓	✓
IFN γ	Recruit, activate, and sustain proinflammatory cells in the eye ^{2,3}	✓	X	✓
IL-12		X	✓	✓
IL-6	Increases vascular permeability, causing fluid leakage and retention in the retina ⁴	✓	Partial	✓✓

Sources: 1. Oh et al, J Immunol (2011); 2. Egwuagu et al, J Immunol (1995); 3. Meng et al, Clin Exp Med (2025); 4. Yang et al, Intl J Mol Sci (2023)

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



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



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



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

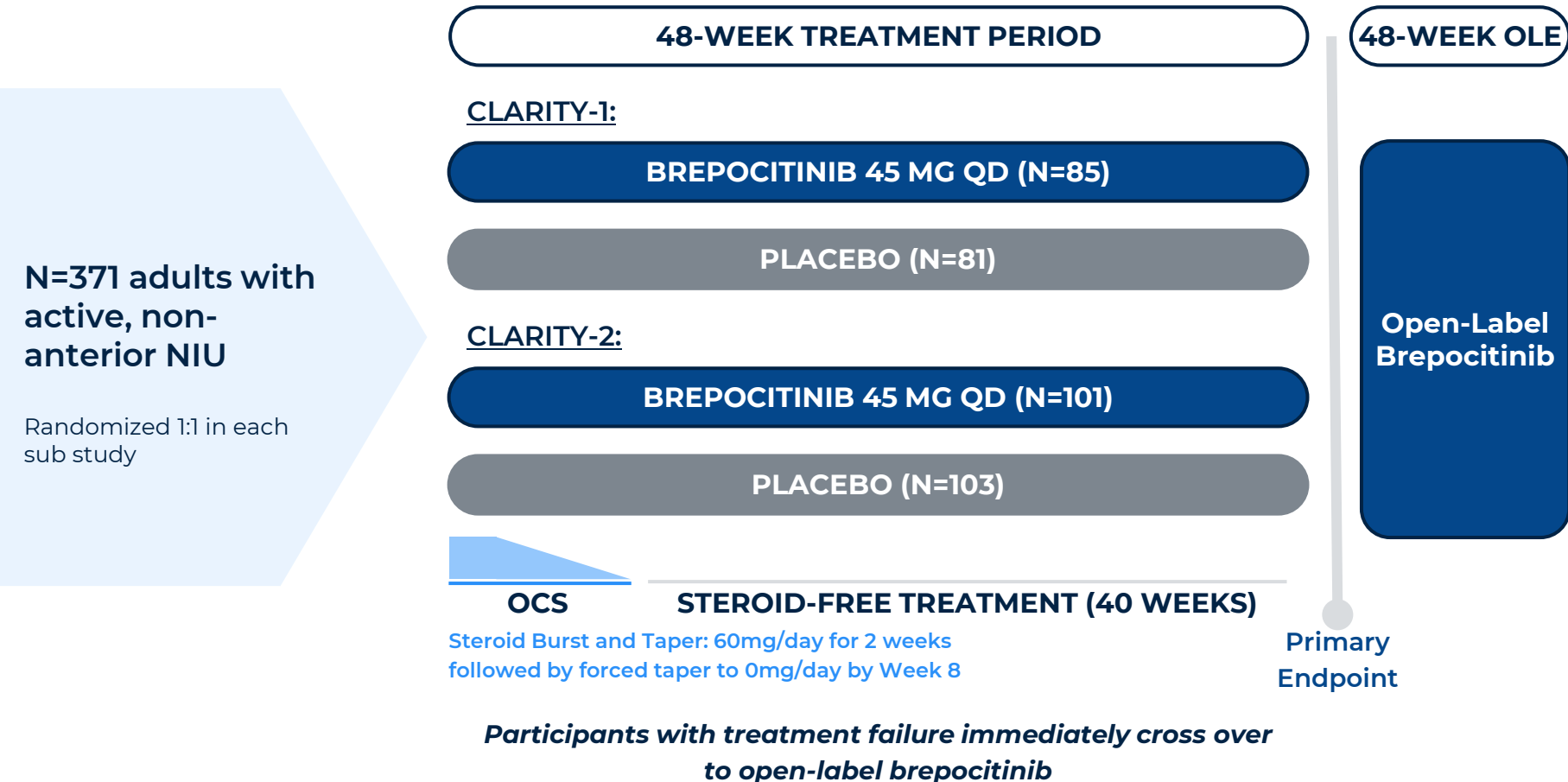


Efficacy was consistent across all patient subgroups with statistically and clinically meaningful improvements in vision-related endpoints and strong structural and functional benefit (including posterior inflammation measured with fluorescein angiography and macular edema resolution)



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

CLARITY: Two Identical Global Phase 3 Studies of Brepocitinib in Patients with Non-Infectious Uveitis



Eligible Patients

- Active, non-infectious intermediate uveitis, posterior uveitis, or panuveitis
- Active disease defined by the presence of at least one of the following:
 - Active inflammation, such as inflammatory chorioretinal and/or retinal vascular lesion
 - $\geq 2+$ vitreous haze grade presumed due to active inflammation

Primary Endpoint

Time to treatment failure from Week 6 through Week 48

CLARITY Enrolled a Representative NIU Population

Population represents a broad NIU population including patients with varying levels of visual acuity impairment and those with and without macular edema

CLARITY-1

	Brepocitinib 45 mg (N=85)	Placebo (N=81)
Mean Age (years) (± SD)	45.0 (±14.8)	47.3 (±14.9)
Sex (Female) – no. (%)	53 (62%)	55 (68%)
Region: US/Canada – no. (%)	55 (65%)	51 (63%)
Uveitis Type – no. (%)		
Intermediate	19 (22%)	16 (20%)
Posterior	29 (34%)	27 (33%)
Panuveitis	37 (44%)	38 (47%)
Bilateral uveitis (%) – no. (%)	73 (86%)	76 (94%)
BCVA ETDRS letters (± SD)	77.9 (±12.4)	76.5 (±12.5)
Macular edema – no. eyes (%)	52 (32%)	48 (30%)
CST¹ (± SD), µm	433 (±123)	465 (±161)
FA total score (± SD)	13.2 (±6.7)	13.2 (±7.0)
Medications at Baseline – no. (%)		
Immunosuppressive therapy	23 (27%)	27 (33%)
Topical corticosteroid drops	21 (25%)	24 (30%)
Prior TNFi use – no. (%)	28 (33%)	25 (31%)

CLARITY-2

	Brepocitinib 45 mg (N=101)	Placebo (N=103)
Mean Age (years) (± SD)	45.7 (±16.0)	46.6 (±14.8)
Sex (Female) – no. (%)	74 (73%)	69 (67%)
Region: US/Canada – no. (%)	56 (55%)	59 (57%)
Uveitis Type – no. (%)		
Intermediate	19 (19%)	26 (25%)
Posterior	30 (30%)	38 (37%)
Panuveitis	52 (51%)	39 (38%)
Bilateral uveitis (%) – no. (%)	89 (88%)	89 (86%)
BCVA ETDRS letters (± SD)	77.0 (±12.7)	79.1 (±11.5)
Macular edema – no. eyes (%)	61 (31%)	57 (28%)
CST¹ (± SD), µm	420 (±108)	424 (±123)
FA total score (± SD)	12.5 (±6.2)	12.6 (±6.8)
Medications at Baseline – no. (%)		
Immunosuppressive therapy	20 (20%)	24 (23%)
Topical corticosteroid drops	17 (17%)	23 (22%)
Prior TNFi use – no. (%)	30 (30%)	29 (28%)

Notes: 1. Among subjects with macular edema at baseline. Excludes subjects with lamellar or full thickness macular hole.

All slides reflect the modified ITT (mITT) population, which excludes one subject who was randomized but did not receive any doses of masked study drug.

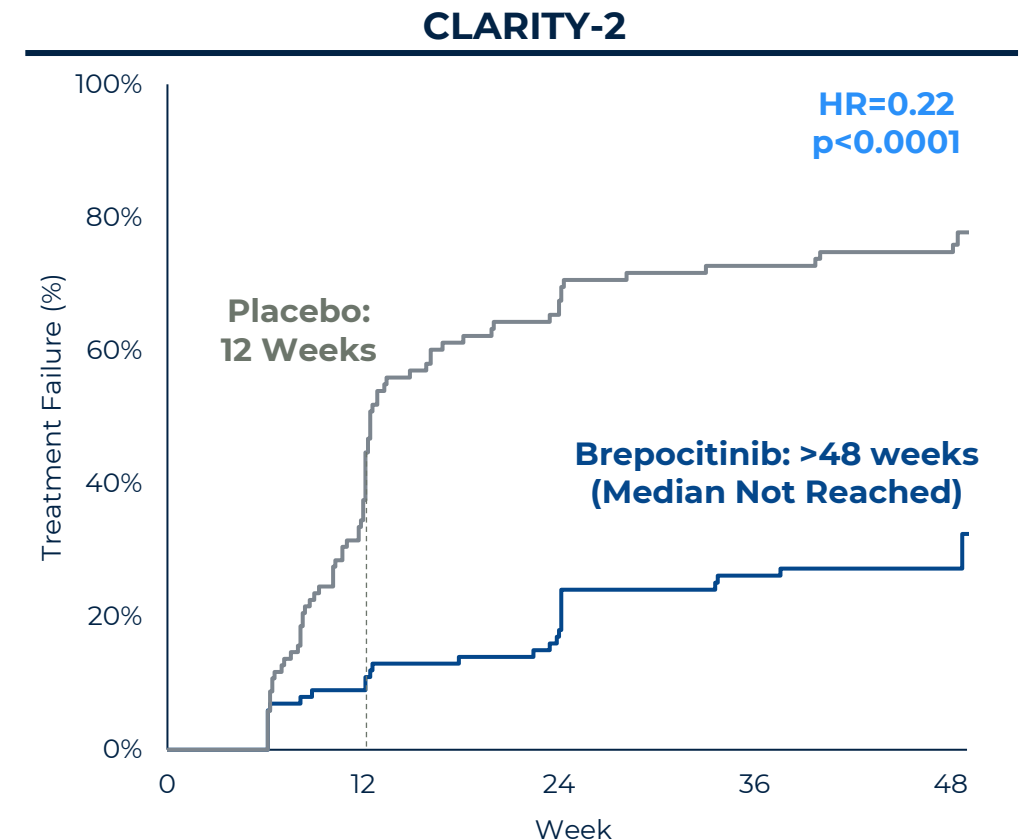
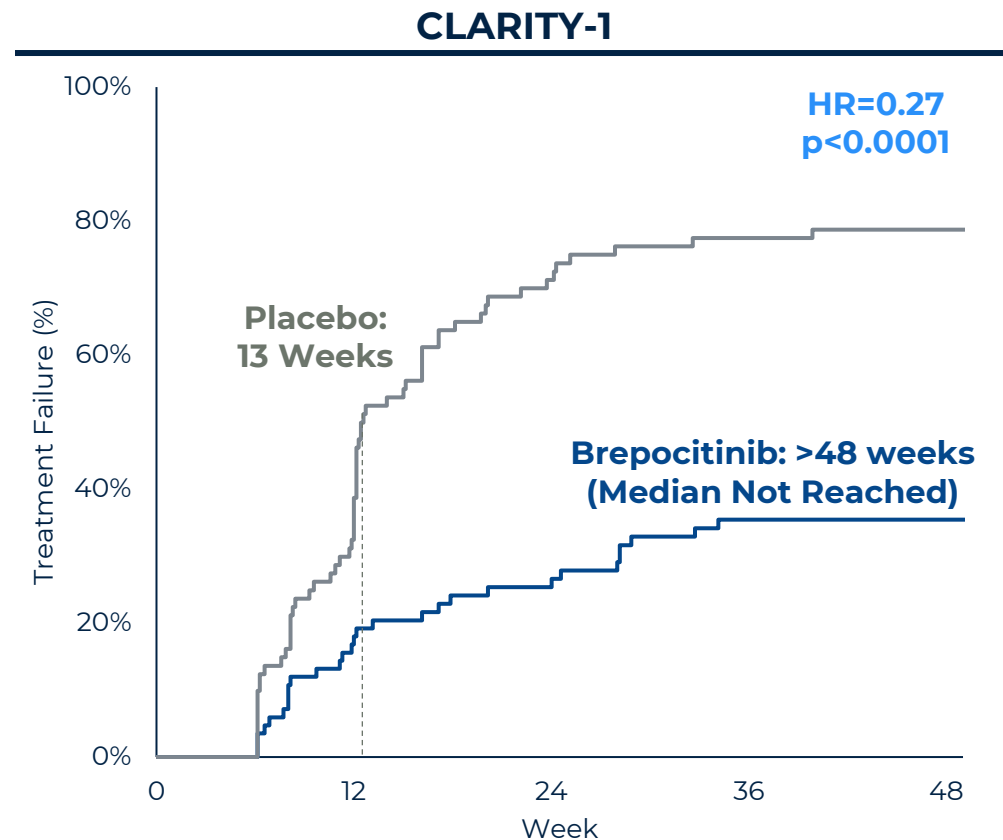
NIU: Non-infectious uveitis; BCVA: Best corrected visual acuity; ETDRS: Early Treatment Diabetic Retinopathy Study; CST: Central subfield thickness; FA: Fluorescein angiography; TNFi: Tumor necrosis factor inhibitor; SD: Standard deviation.

Brepocitinib Achieved Statistical Significance On The Primary Endpoint And All Secondary Endpoints Across Both Trials

Key Endpoint	Key Features	CLARITY-1 P-Value	CLARITY-2 P-Value
Time to Treatment Failure <i>Primary Endpoint</i>	Time to first occurrence of treatment failure, including new vascular lesions, ACC grade worsening, vitreous haze worsening, or visual acuity worsening	<0.0001	<0.0001
Patients Achieving Steroid-Free Quiescence in Both Eyes	Both eyes with no new active vascular inflammatory lesions; ACC and VH grades $\leq 0.5+$; and no current use of systemic or ophthalmic corticosteroids for uveitis at Week 48	<0.0001	<0.0001
Eyes Achieving $\geq 30\%$ Reduction in Total Fluorescein Angiography Score	Proportion of eyes achieving clinically meaningful reduction in total FA score (ASUWOG) from baseline at Week 48	<0.0001	<0.0001
Resolution of Macular Edema	Proportion of eyes achieving macular edema resolution (CST $< 325 \mu\text{m}$) at Week 48, among eyes with macular edema (CST $\geq 325 \mu\text{m}$) at baseline	0.0041	0.0002
≥ 5-point improvement in NEI VFQ-25 Overall Composite Score	Clinically meaningful improvement in patient-reported vision-related quality of life and how vision affects daily functioning	0.0013	0.0003

Primary Endpoint: Time to Treatment Failure Over 48 Weeks

Primary endpoints in both studies were met with high statistical significance with median time to treatment failure >48 weeks (median not reached) for brepocitinib vs. ~12 weeks for placebo during the 48-week trial



The primary endpoint compared time to treatment failure from Week 6 to Week 48. Treatment failure defined as: New chorioretinal and/or retinal vascular lesions, ACC grade (inability to achieve $\leq 0.5+$ at Week 6 or ≥ 2 -step increase), VH grade (inability to achieve $\leq 0.5+$ at Week 6 or ≥ 2 -step increase), BCVA ≥ 15 -letter worsening from best state achieved. Participants who received rescue therapies prior to treatment failure were handled as if treatment failure had occurred at the time of rescue medication; all other intercurrent events used observed data, with censoring at the time of Period 1 exit. The primary inference was made via a Gehan-Wilcoxon test. Hazard ratio and Wald 95% CI are for brepocitinib vs placebo and are estimated using a Cox-proportional hazards model that includes treatment and randomization stratification factors as covariates. ACC: Anterior chamber cell; VH: Vitreous haze; BCVA: Best correct visual acuity; HR: Hazard Ratio.

Cross-Trial Comparison Suggests Brepocitinib May Provide >2x Longer Timeline For Prevention of Treatment Failure vs. Standard of Care

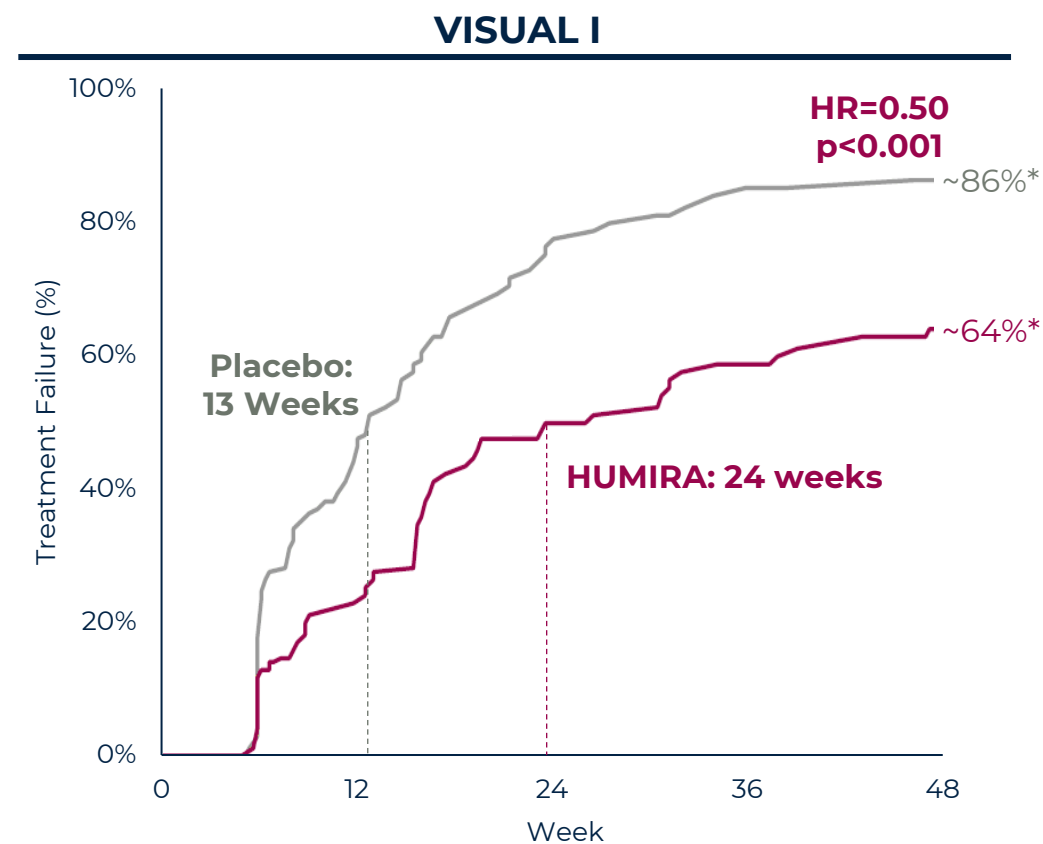
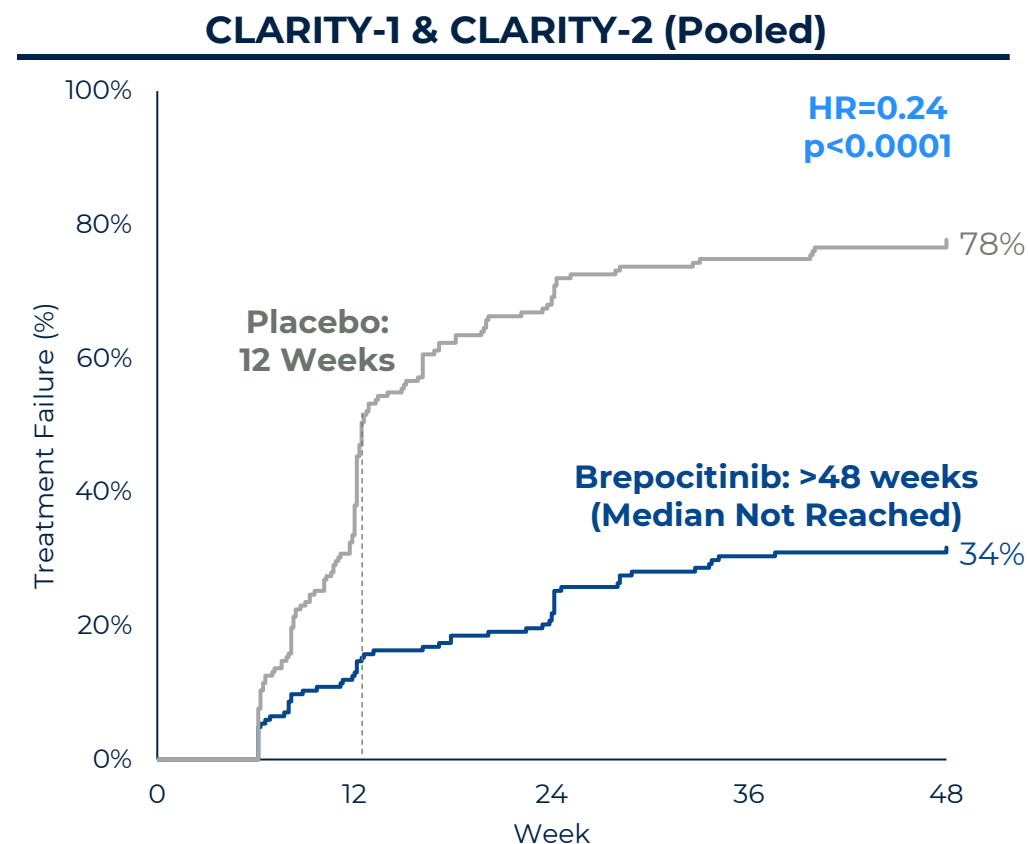


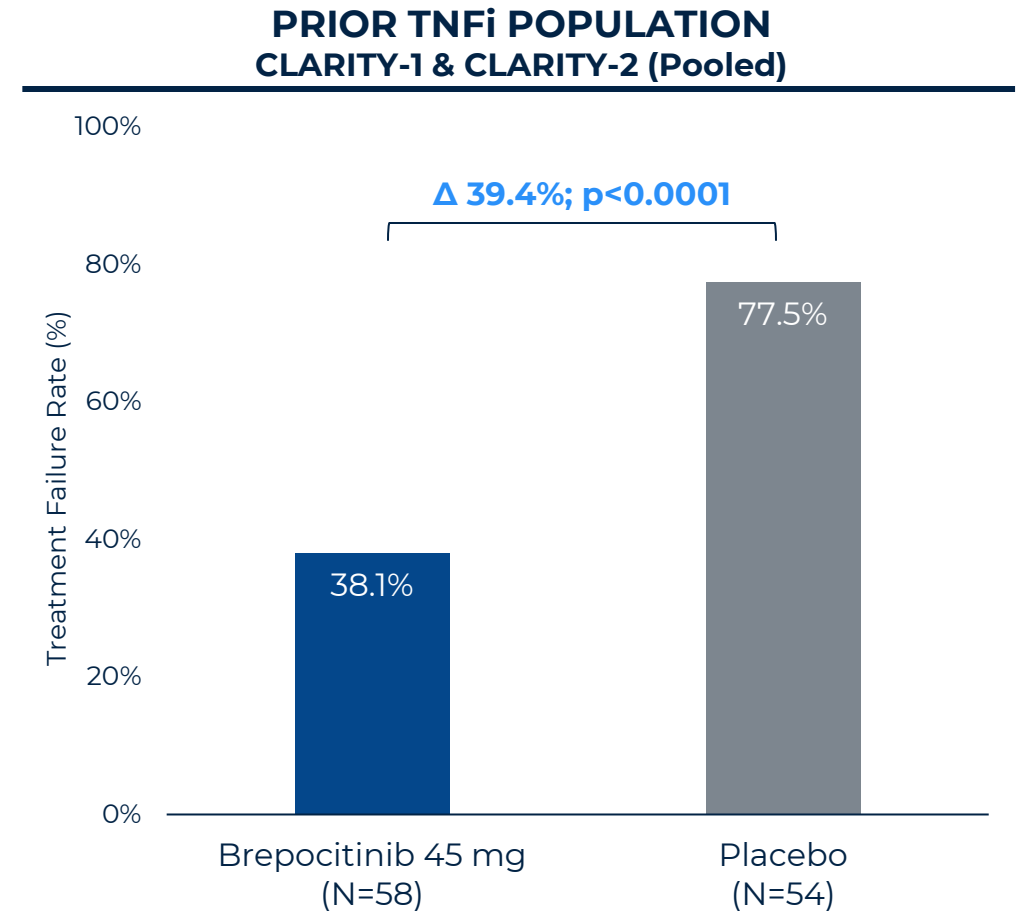
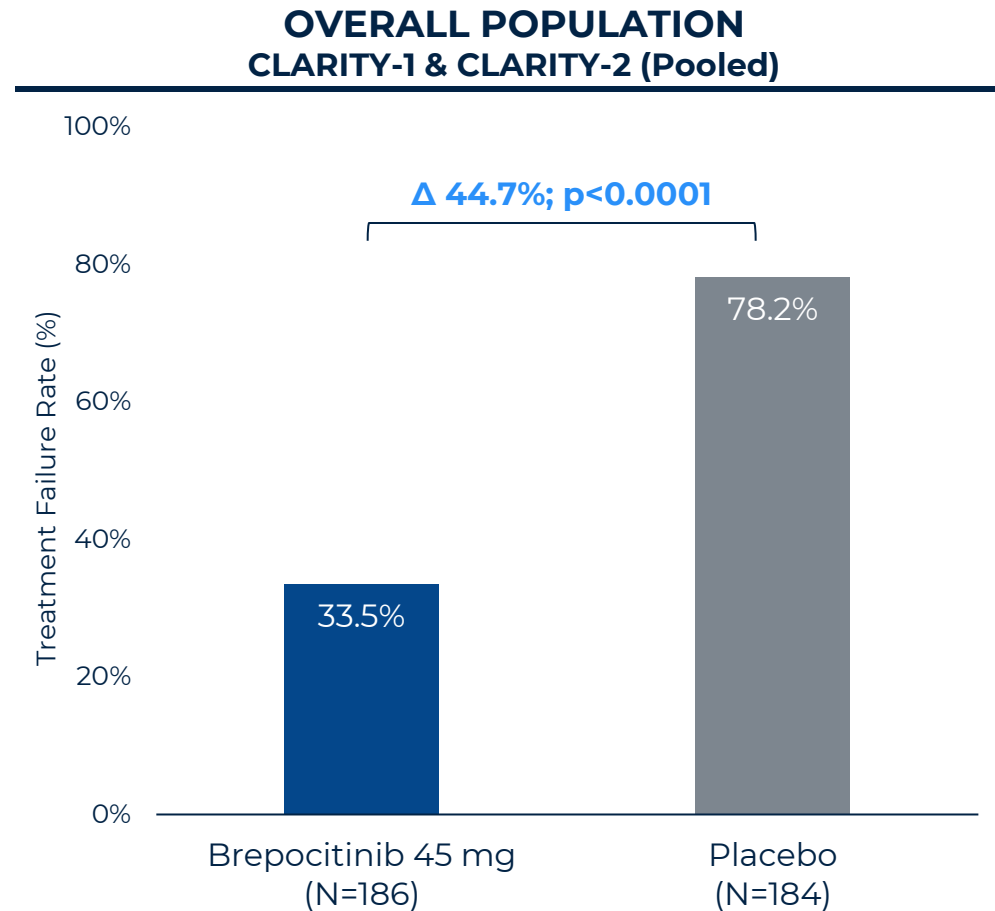
Figure represents a cross-study comparison and not a head-to-head study. Differences exist between study designs and subject characteristics, and caution should be exercised when comparing data across studies.

Cross-Trial Comparison Suggests Brepocitinib May Provide Even Greater Benefit vs. SoC Given Rapid Steroid Taper in CLARITY

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

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

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



Evolving Treatment Goals in NIU Extend Beyond Flare Management to Early, Sustained Disease Control

Emerging Standards for NIU Treatment

Sustained steroid-free quiescence

Sustained disease control without the cumulative local and systemic toxicities of steroids

Early, aggressive treatment supported by key imaging biomarkers

Treat-to-target approach with early normalization of wide-field FA and CST

Preservation of visual acuity and function

Protection of visual acuity, rather than treating vision loss *after* it occurs, with improvements in vision-related quality of life and functioning

“

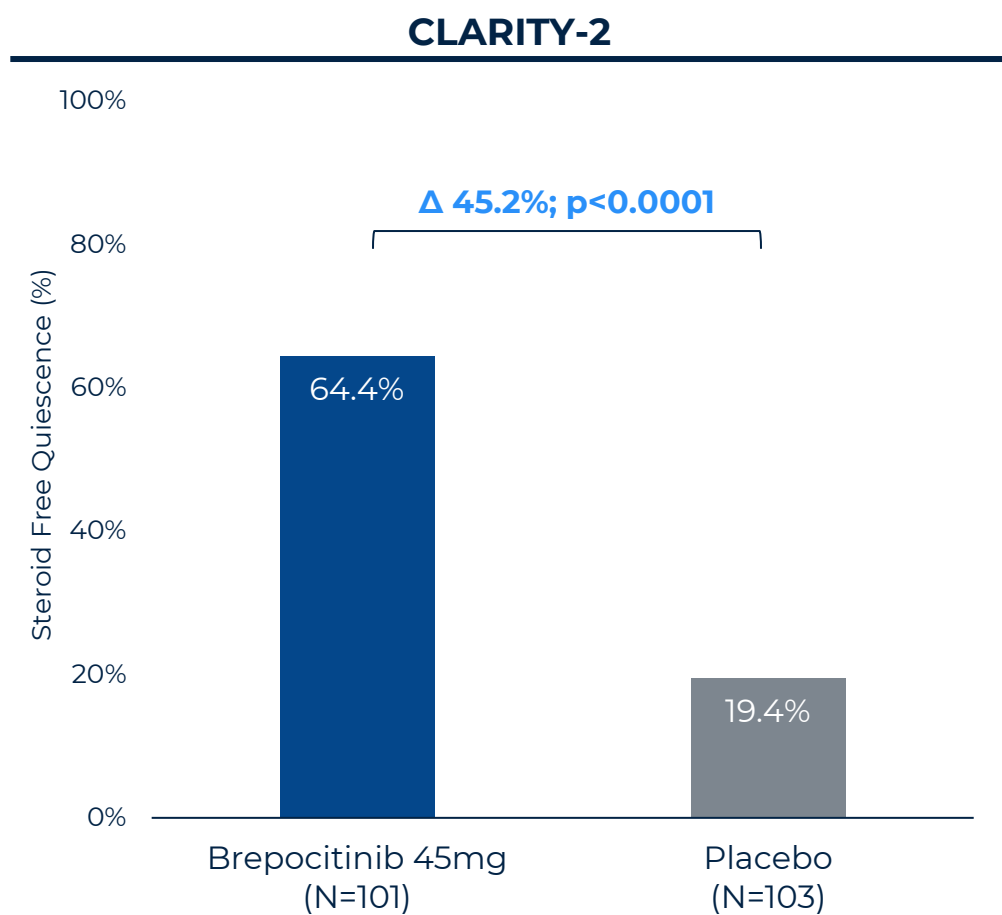
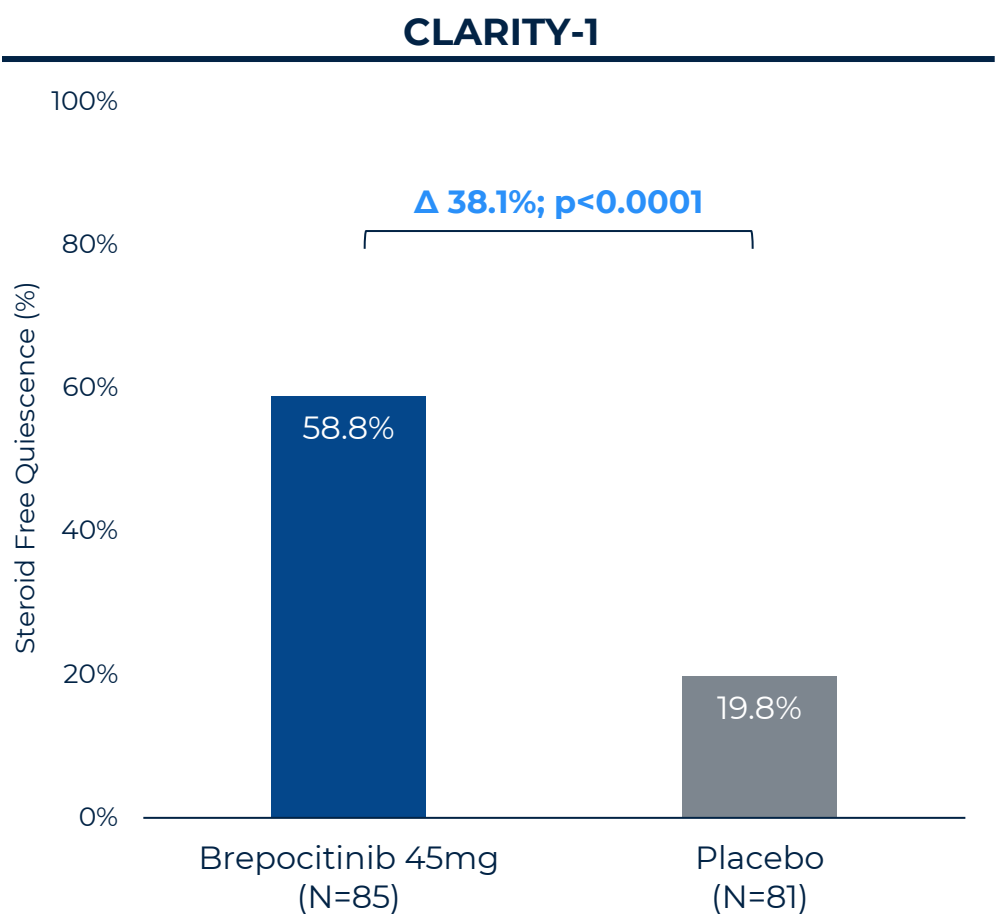
Maintaining quiescence in chronic uveitis is critical as inflammation tends to cause cumulative damage with each recurrent episode. Even if vision partially recovers with treatment of a flare, repeated episodes tend to result in a stepwise, ‘saw-tooth’ decline in visual function over time.”

— Zhang et al., *J Ophthalmic Inflamm Infect* (May 2026)

Prior to CLARITY, no systemic therapy demonstrated the ability to deliver substantial benefits across all these domains

Steroid Free Quiescence (Week 48): Brepocitinib Delivers Significant Improvement

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



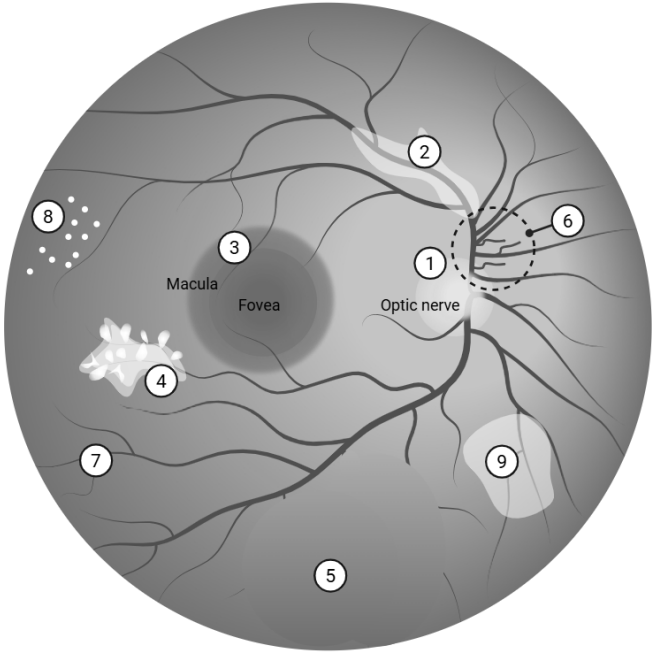
The risk difference and relative risk and their corresponding p-values are for brepocitinib vs. placebo and are based on the non-linear estimates from generalized estimating equations with logit link function adjusted for treatment and randomization stratification factors. ACC: Anterior chamber cell;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

Wide-Field Fluorescein Angiography Now Enables More Rigorous, Quantitative Assessment of Inflammatory Disease Control in NIU

Brepocitinib is the first therapy to be rigorously evaluated using wide-field fluorescein angiography (FA), the gold standard biomarker for chorioretinal inflammation, in a uveitis registrational trial; centrally scored at Duke Reading Center

Registrational Program (NIU or UME/MESI)	Therapy	Wide-field FA assessed as efficacy endpoint?
RETISERT	Fluocinolone 0.59 mg implant	No
HURON / OZURDEX	Dexamethasone intravitreal implant	No
VISUAL I / II	Adalimumab	No
YUTIQ / ILUVIEN	Fluocinolone 0.18 mg implant	No
PEACHTREE	Suprachoroidal triamcinolone	No
MEERKAT / SANDCAT	Vamikibart	No
PEAK / PINNACLE	KSI-101	No
CLARITY-I/II	Brepocitinib	Yes

Schematic Fluorescein Angiogram (right eye)



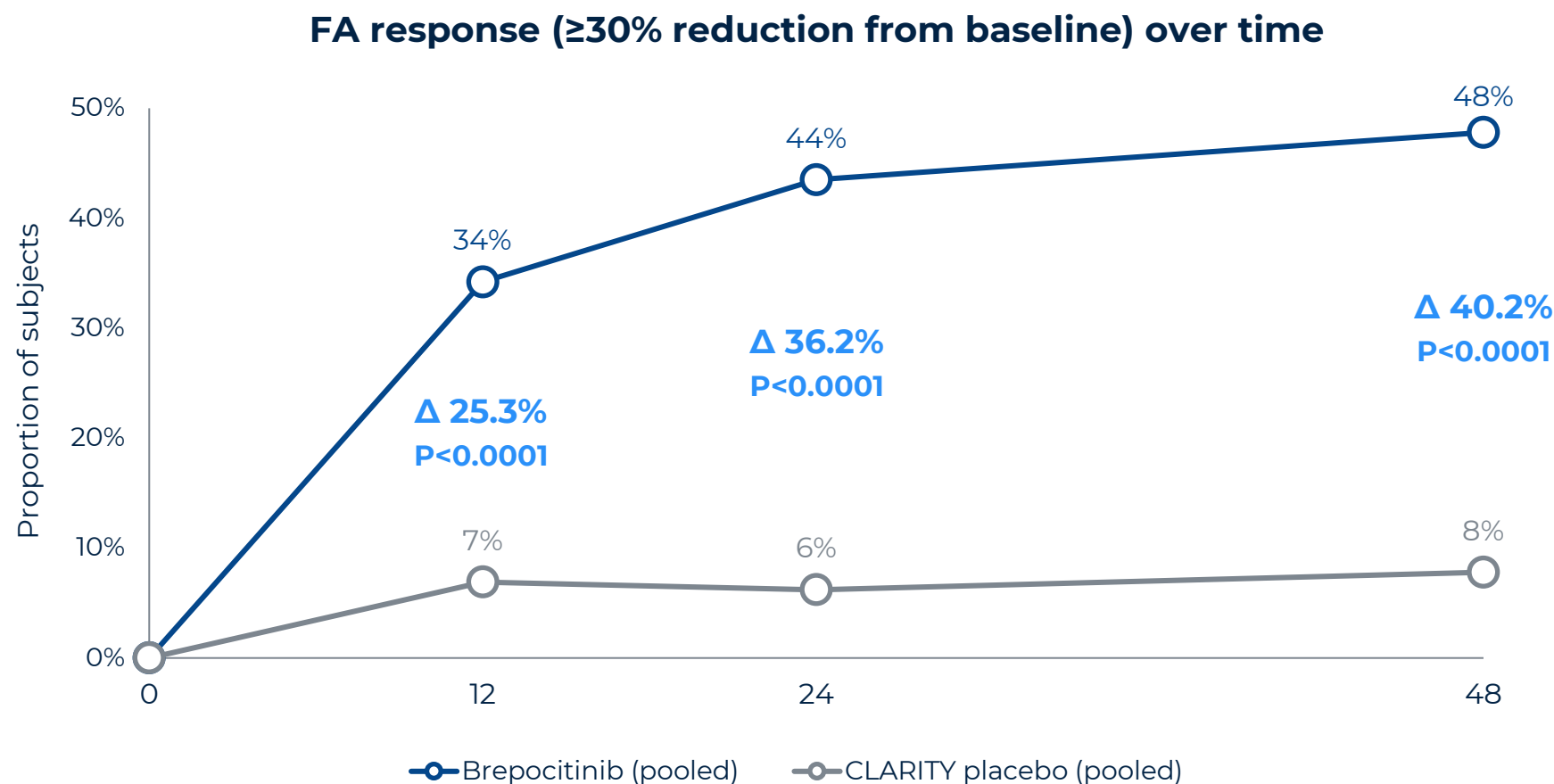
ASUWOG FA scoring domains

Semiquantitative fluorescein angiography
40-point scale

Domain	Max points
1 Disc hyperfluorescence	3
2 Retinal vascular leakage	7
3 Macular edema	4
4 Capillary leakage	10
5 Capillary nonperfusion	6
6 Neovascularization of disc	2
7 Neovascularization elsewhere	2
8 Pinpoint leaks	2
9 Retinal staining / subretinal pooling	4
Total maximum FA score	40

Fluorescein Angiography (FA) Response Was Rapid, With Increasing Benefit Over Time

Results suggest brepocitinib can provide durable control of posterior segment inflammation and potentially prevent uveitis flares



Among eyes with baseline FA total score > 5

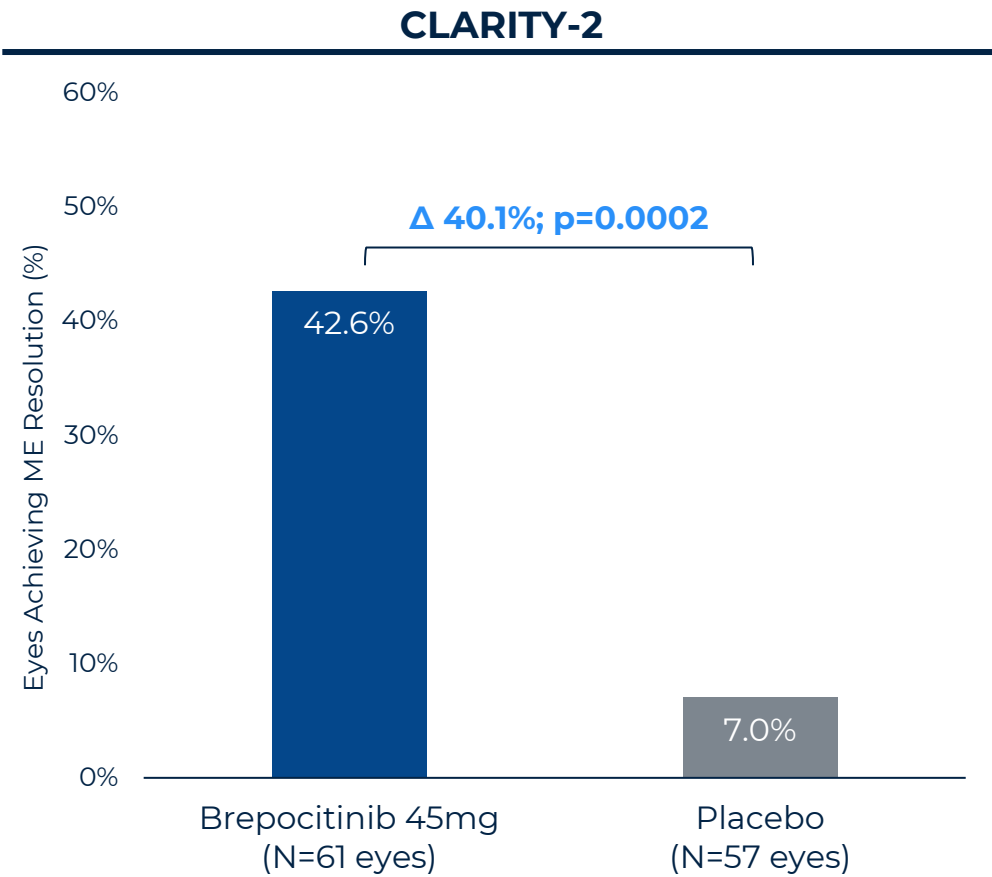
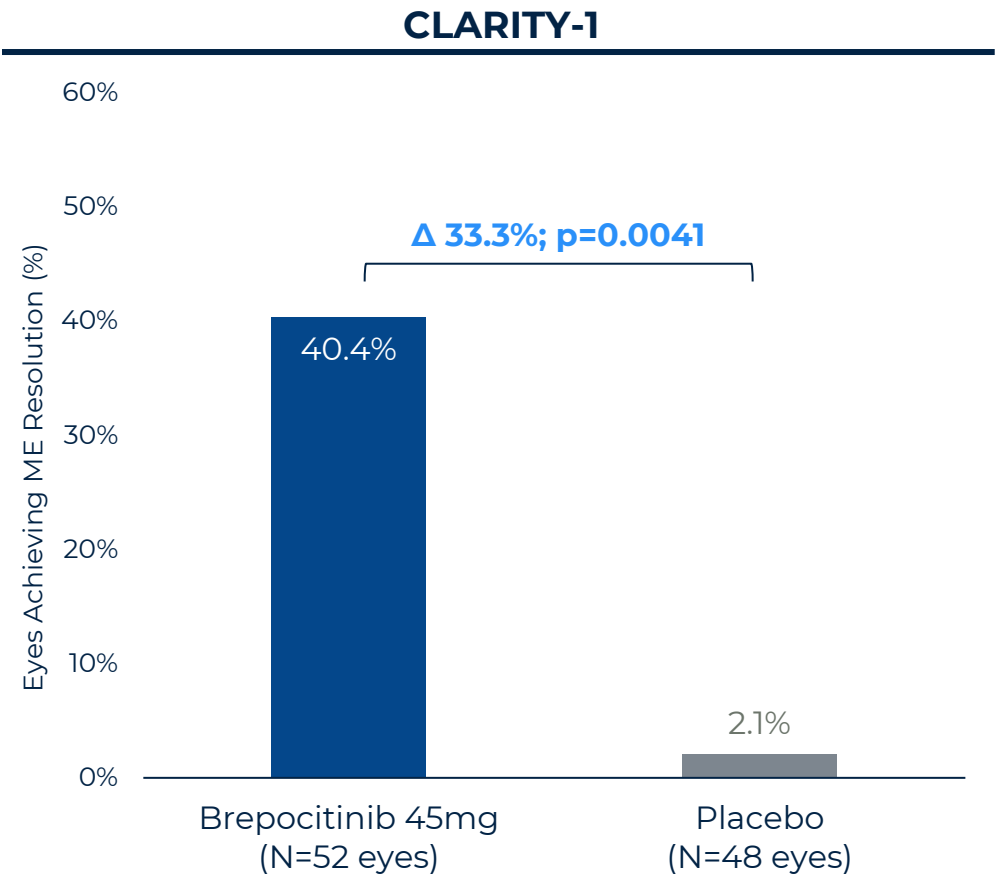
Fluorescein angiography total score was assessed by the Angiography Scoring for Uveitis Working Group (ASUWOG) scoring system. Analysis is limited to eyes with baseline FA total score > 5 . The risk difference and the corresponding p-value are based on the non-linear estimates from generalized estimating equations with logit link function adjusted for clustered eyes within participants and adjusting for treatment and randomization stratification factors. Nominal P-values are reported. FA: Fluorescein angiography

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Macular Edema (Week 48): Brepocitinib Delivers Statistically and Clinically Meaningful Resolution

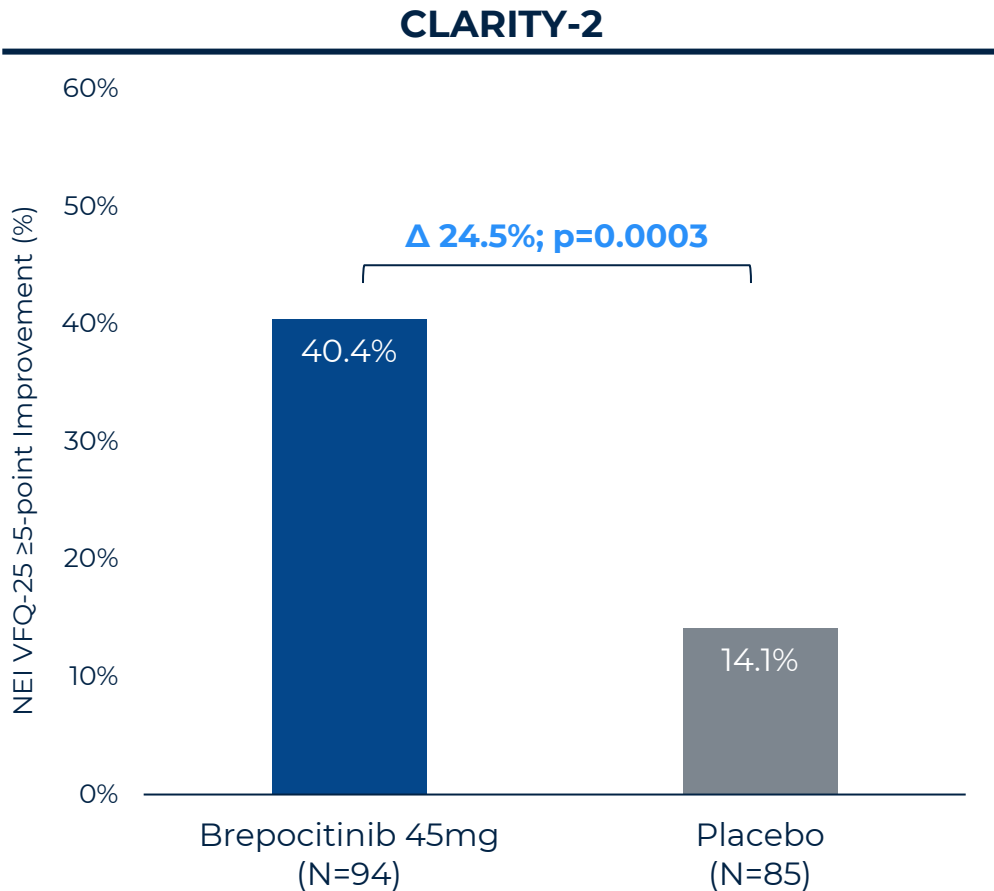
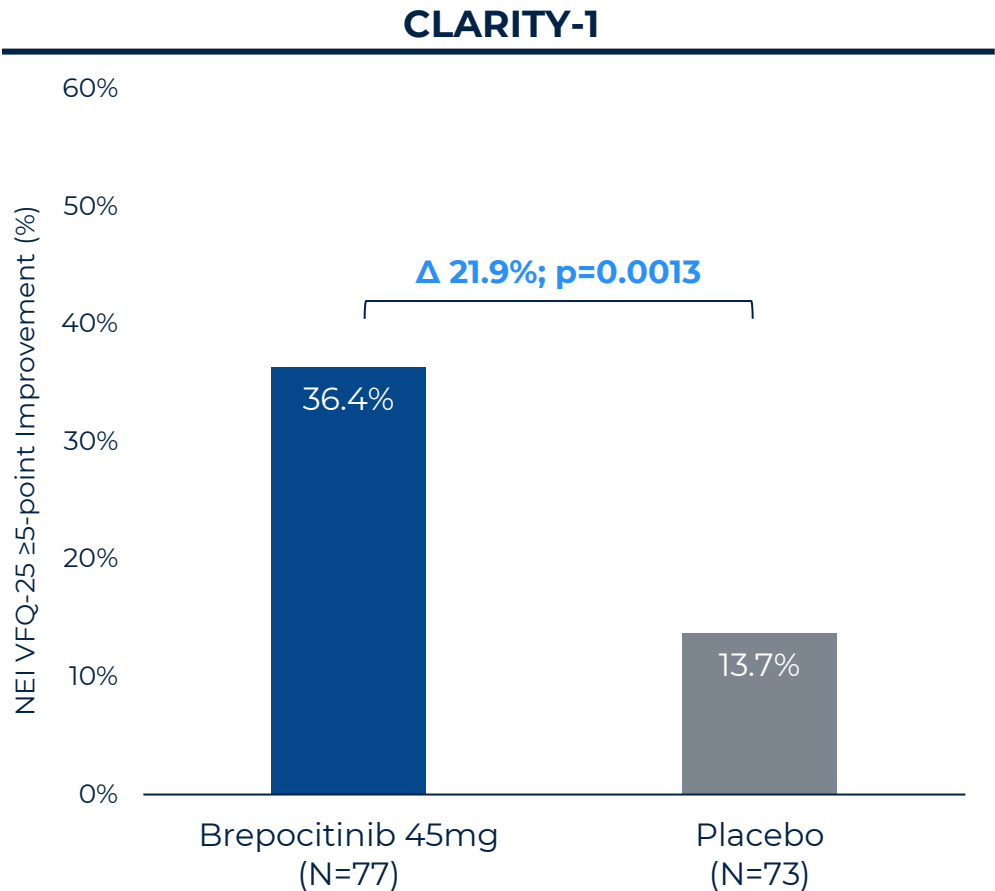
Macular Edema affects roughly one-third of uveitic eyes: persistent edema damages photoreceptors, which could lead to permanent vision loss and have a major impact on vision-related quality of life



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

NEI Visual Function Questionnaire-25: Brepocitinib Achieved Clinically and Statistically Significant Improvement in Visual Function

Benefits observed across VFQ-25 subscales, including general vision, ocular pain, near activities, distance activities, mental health, role difficulties, dependency, and driving, with onset beginning at Week 6



Overall Summary of Safety: Double-Masked Treatment Period

Safety consistent with prior brepocitinib studies and JAK drug class

	CLARITY-1 & CLARITY-2 (Pooled)	
<i>Reported as n (%)</i>	Brepocitinib 45mg N=186 130.1 Patient Years ¹	Placebo N=184 77.0 Patient Years ¹
Treatment-Emergent Adverse Events	153 (82%)	120 (65%)
Mild	82 (44%)	81 (44%)
Moderate	62 (33%)	34 (18%)
Severe	9 (5%)	5 (3%)
Serious Adverse Events	14 (8%)	5 (3%)
Infections and infestations	3 (2%)	2 (<1%)
Adverse events leading to permanent discontinuation	6 (3%)	5 (3%)
Fatal Events	1 (1%)*	0

*62-year-old with sarcoidosis and ILD requiring supplemental O2 at baseline. After one month of treatment, brepocitinib and steroids were discontinued. Death occurred on Day 49, approximately 20 days off brepocitinib, due to complications of end-stage ILD secondary to fibrotic sarcoidosis (autopsy confirmed).

AESIs and Laboratory Changes

CLARITY-1 & CLARITY-2 (Pooled)		
	Brepocitinib 45mg N=186 130.1 Patient Years ¹	Placebo N=184 77.0 Patient Years ¹
Cardiovascular events		
Chest discomfort	0	1 (<1%)
MACE	0	0
Thromboembolic events		
Peripheral artery thrombosis	0	1 (<1%)
Pulmonary embolism	1 (<1%)	0
Malignancy (NMSC)		
Basosquamous carcinoma <i>Onset Day 53; resected and brepocitinib was continued</i>	1 (<1%)	0
Malignancy (excluding NMSC)		
CNS lymphoma <i>Onset Day 36; onset of CNS symptoms was documented prior to the study and overlapped with the onset of uveitis</i>	1 (<1%)	0
Thyroid cancer recurrent <i>Onset Day 182; Recurrent from 3 years prior to study</i>	1 (<1%)	0
Viral reactivation		
Herpes zoster	11 (6%)	1 (<1%)
CK elevation > 5x ULN		
With rhabdomyolysis	0	1 (<1%)
Without rhabdomyolysis	8 (4%)	0
Liver enzyme elevation		
ALT or AST elevation ≥ 3x ULN or baseline	6 (3%)	0
Probable or confirmed drug-induced liver injury	0	0
Reductions in lymphocytes, neutrophils, or hemoglobin		
Grade 3	4 (2%)	6 (3%)
Grade 4	0	0

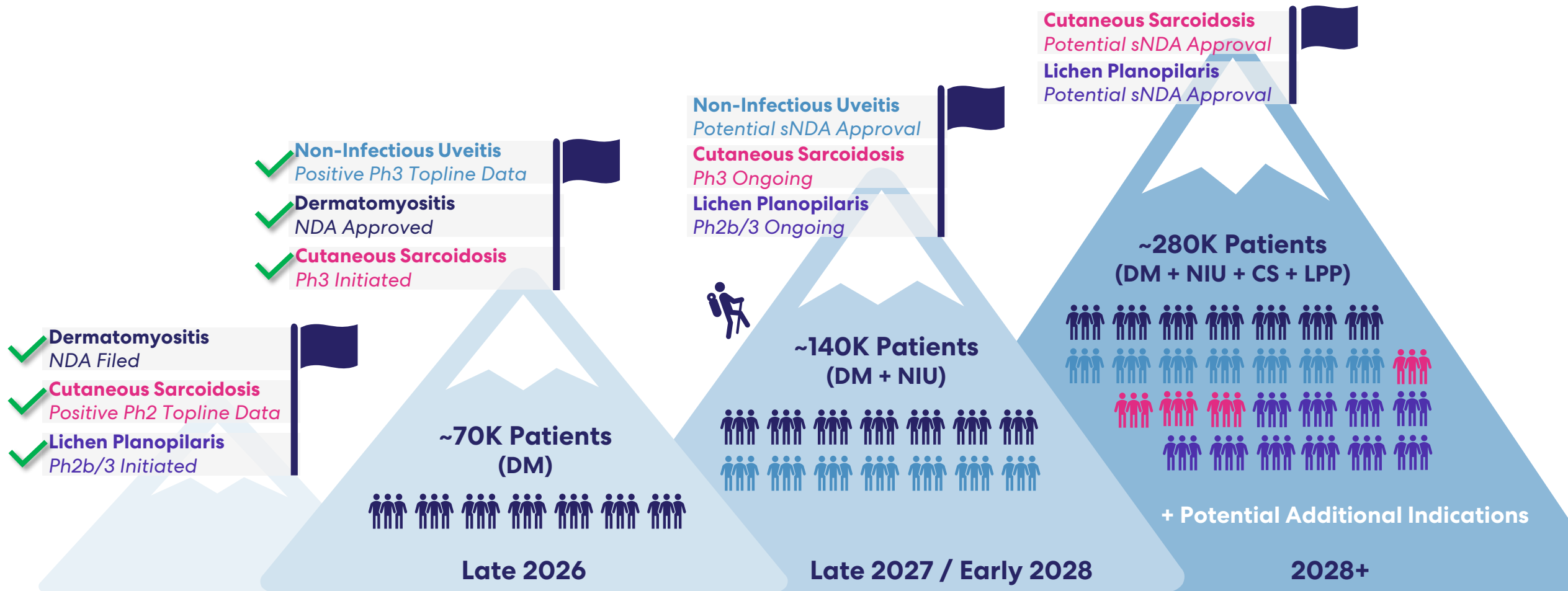
Notes: 1. Because of the study design, which crossed patients over to open-label treatment immediately when treatment failure occurred, brepocitinib exposure was about 2x that of the placebo group during the masked treatment period. AEsI: adverse events of special interest. MACE: major adverse cardiovascular events. NMSC: non-melanoma skin cancer. CK: creatine kinase. ULN: upper limit of normal. ALT: alanine transaminase. AST: aspartate transaminase.

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

 Sustained steroid-free quiescence	 Improving imaging biomarkers	 Preserved acuity and function	 Safety
✓ Best-in-disease treatment failure prevention (HR 0.24, Δ45%, p<0.0001) ✓ High rates of steroid-free quiescence at one year (62%, Δ41%, p<0.0001)	✓ Significant increase in FA responses (48%, Δ40%, p<0.0001) ✓ Resolution of macular edema (42%, Δ34%, p<0.0001) with rapid improvement in CST	✓ Preserved visual acuity vs. progressive worsening on placebo (p<0.0001) ✓ Improvement in visual function and HRQoL (VFQ-25 response 39%, Δ23%, p<0.0001) ✓ Once-daily oral therapy that avoids injections	✓ Brepocitinib was generally well-tolerated ✓ Most adverse events were mild or moderate in severity ✓ Safety profile was consistent with prior brepocitinib studies
Data suggests brepocitinib may be the most effective therapy for preventing treatment failure and achieving steroid-free quiescence	Data suggests brepocitinib can control the underlying inflammatory and structural processes that contribute to poor outcomes in uveitis	Data suggests brepocitinib can preserve & restore visual function with less steroids and with once-daily oral administration	Potentially favorable benefit:risk profile for patients with NIU

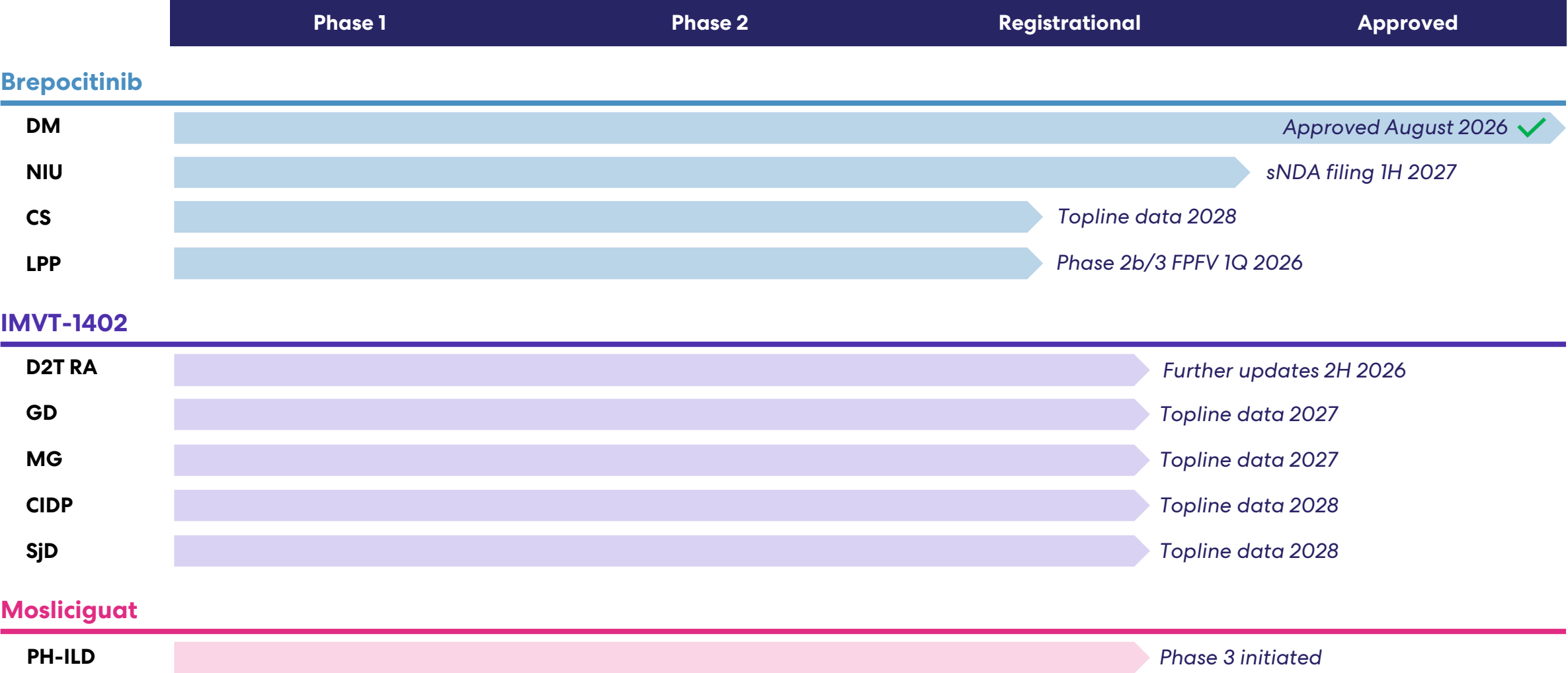
Brepocitinib sNDA filing in NIU expected in 1H 2027

Positive CLARITY Data Marks the Next Step in Brepocitinib's Multi-Indication Journey, With Two Additional Pivotal Programs Underway



Positive CLARITY data de-risks the opportunity in NIU, a DM-scale indication with significant unmet need

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





Investor Day 2026

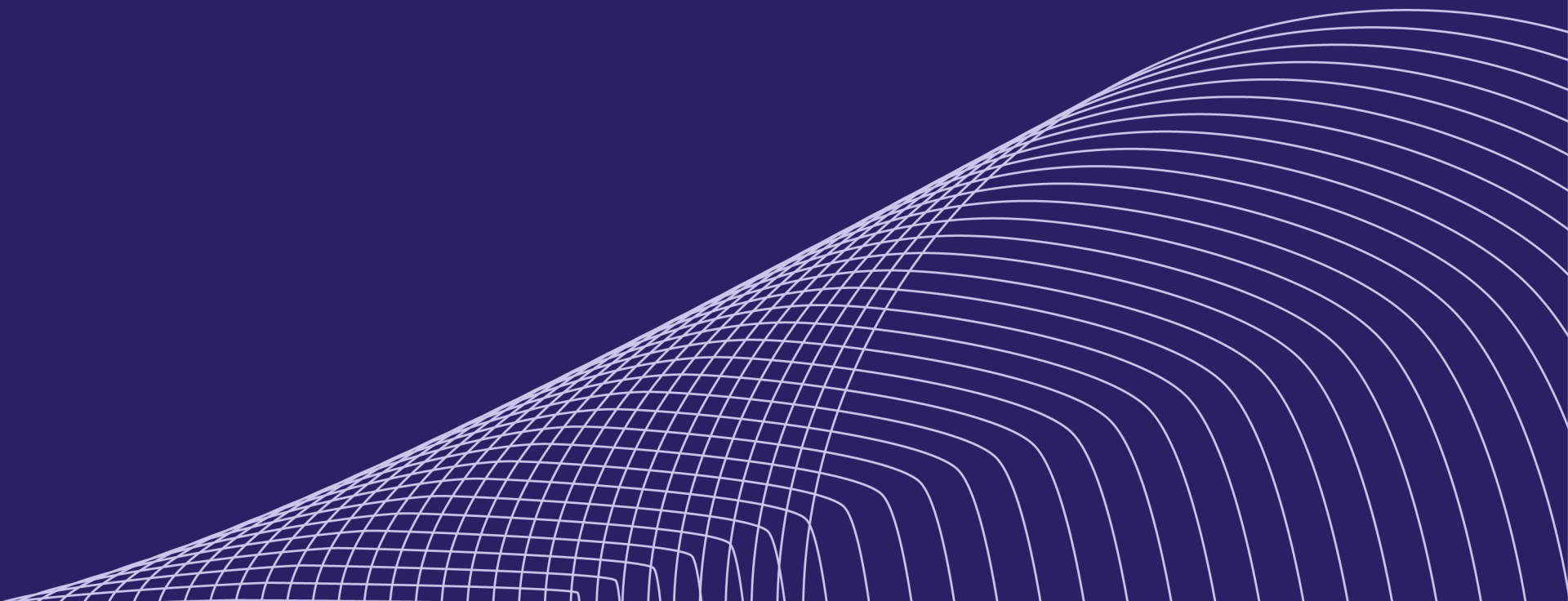
Morning sessions followed by lunch
Further details to come

December 9, 2026 | New York City

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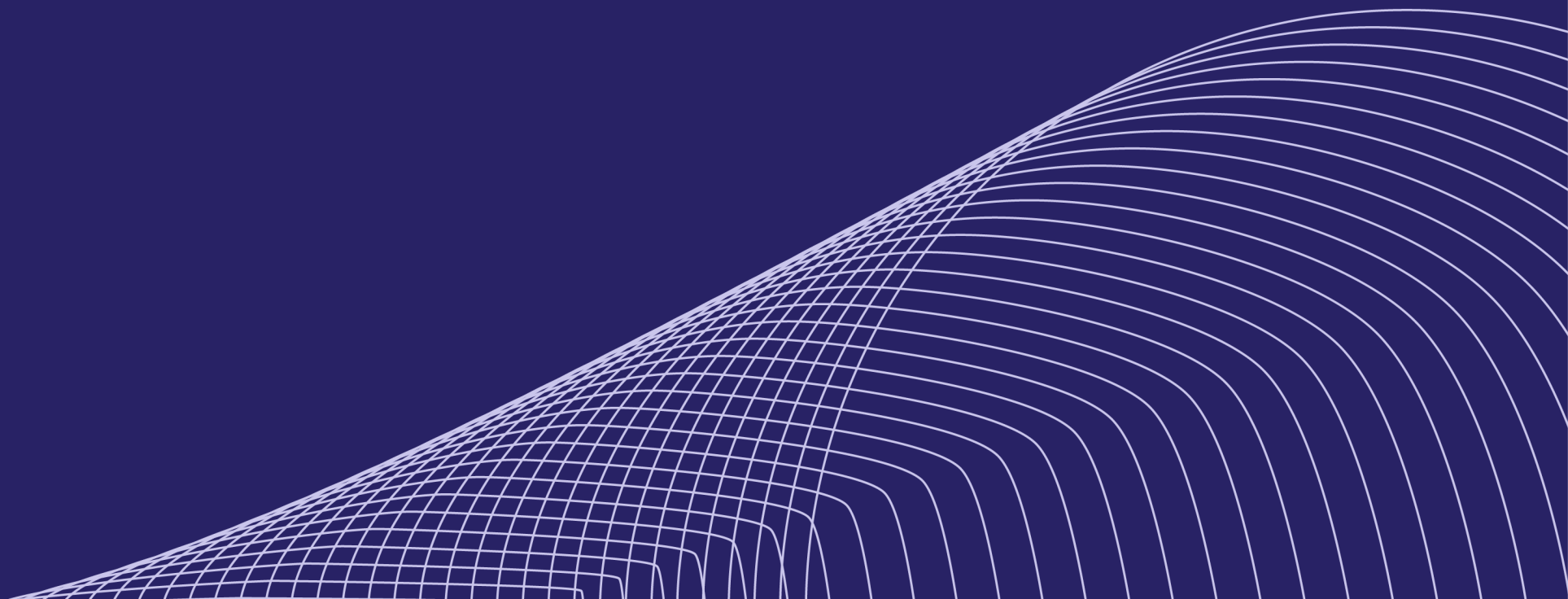
Q&A

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Appendix

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NEI VFQ-25 Measures Vision-Targeted Health-Related Quality of Life and Visual Functioning

NEI VFQ-25 combines 11 vision-related subscales to generate an overall composite score, from 0 to 100 (best)

General Vision Overall assessment of eyesight		Ocular pain Discomfort in or around the eyes	
Near Vision Reading the newspaper, cooking, finding objects on a shelf		Distance Vision Reading street signs, going to the movies	
Peripheral Vision Seeing objects off to the side		Color Vision Matching clothes or finding objects by color	
Driving Driving in daylight, driving at night, in difficult conditions		Mental Health Worrying about eyesight, frustration, embarrassment	
Social Functioning Difficulty visiting with friends, neighbors, or relatives		Role Difficulties Accomplishing less because of vision, being limited in work	
Dependency Staying home, relying on others, needing help from others		Scored from 0 to 100 (best) MCID is <u>3-4 points</u>	

Priovant: Other Details

Ownership

ROIV owns 71%¹ of Priovant, with Pfizer owning 24%.

Geographic Rights

Priovant has commercial rights to brepocitinib in US and Japan.

Intellectual Property

We expect brepocitinib to have US exclusivity at least until 2039².

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.