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, research and development plans, the anticipated timing, costs, design and conduct of our ongoing and planned preclinical studies and clinical trials for our products and product candidates, including the information presented in this presentation with respect to (i) RVT-3101 and the potential for RVT-3101 to improve the treatment of Ulcerative Colitis (UC) and Crohn’s Disease (CD) and to be a first-in-class agent, (ii) the ADORING 1 and ADORING 2 topline study results, (iii) initial data from a Phase 1 trial of IMVT-1402 and the potential for IMVT-1402 to be best-in-class with respect to IgG lowering and with respect to albumin and LDL impact, and any commercial potential of our 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. The data presented here is from the induction and chronic periods of the TUSCANY-2 study and is based on a preliminary analysis of key efficacy and safety data, and such data may change following completion of the clinical trial and may not accurately reflect the complete results of the TUSCANY-2 study. The ADORING 1 and ADORING 2 topline study results presented here are based on an initial analysis of key efficacy and safety data and such data may not accurately reflect the complete results of the ADORING 1 and ADORING 2 studies. The initial IMVT-1402 Phase 1 results presented here may not reflect the complete results of the MAD study.

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 VTAMA as compared to certain other products and product candidates generated from separate, independent studies and that do not come 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 products and product candidates is based on publicly available information.

VTAMA cream is only FDA-approved for the topical treatment of plaque psoriasis in adults but is under clinical investigation for the treatment of atopic dermatitis in adults and children aged two (2) years old and above.

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.
Roivant: Developing and Commercializing Transformative Medicines

Vant model aligns incentives to drive fast, high-quality execution and rigorous capital allocation

Proven track record with **10 consecutive positive Phase 3 trials** and 6 FDA approvals\(^1\)

**$1.4BN cash** at June 30, 2023, supporting cash runway into the second half of calendar year 2025\(^2\)

Industry-leading I&I pipeline with **$15BN+ sales potential** supported by commercial launch of novel topical VTAMA and multiple potential best- or first-in-class programs

---

1. FDA approval and trial figures include Vanta transferred to Sumitomo Pharma in December 2019.
2. As of June 30, 2023, we had consolidated cash, cash equivalents and restricted cash of approximately $1.4 billion.
2023: Roivant’s Biggest Year Yet

- **Expanded VTAMA Coverage and Reach**
  - Coverage expanded to 79% of commercial lives in August with further coverage expansion expected to increase net yield and add revenue

- **ADORING 1 and 2 - VTAMA Phase 3 Readouts in AD**
  - Positive results pave the way to atopic dermatitis market, which is ~4x the size of psoriasis market

- **RVT-3101 (Anti-TL1A) UC Phase 2b Data**
  - Positive final data from global Phase 2b validates best-in-class potential

- **IMVT-1402 (Next-Gen Anti-FcRn) Initial Human Data**
  - Two potentially best-in-class anti-FcRn antibodies with deeper IgG reduction and simple subQ dosing give flexibility to maximize value across indications

- **Brepocitinib (TYK2/JAK1) Pivotal Trial Readout in SLE**
  - 4Q 2023

If positive could serve as one of two registrational trials in a large market with high unmet need

References are to calendar years. Other than VTAMA in psoriasis, all drugs are investigational and subject to regulatory approval.
## Robust Late-Stage Pipeline

### Seven ongoing registrational trials in multi-billion dollar markets

<table>
<thead>
<tr>
<th>Drug</th>
<th>Indication</th>
<th>Modality</th>
<th>Preclinical</th>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
<th>Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>VTAMA</td>
<td>Psoriasis</td>
<td>Dermavant</td>
<td>Topical</td>
<td></td>
<td></td>
<td></td>
<td>▶️</td>
</tr>
<tr>
<td>VTAMA</td>
<td>Atopic Dermatitis</td>
<td>Dermavant</td>
<td>Topical</td>
<td></td>
<td></td>
<td></td>
<td>Completed</td>
</tr>
<tr>
<td>RVT-3101</td>
<td>Ulcerative Colitis</td>
<td>Telavant</td>
<td>Biologic</td>
<td></td>
<td></td>
<td></td>
<td>▶️</td>
</tr>
<tr>
<td>RVT-3101</td>
<td>Crohn’s Disease</td>
<td>Telavant</td>
<td>Biologic</td>
<td></td>
<td></td>
<td></td>
<td>▶️</td>
</tr>
<tr>
<td>BREPOCITINIB</td>
<td>Dermatomyositis</td>
<td>Priovant</td>
<td>Small Molecule</td>
<td></td>
<td></td>
<td></td>
<td>▶️</td>
</tr>
<tr>
<td>BREPOCITINIB</td>
<td>Systemic Lupus Erythematosus</td>
<td>Priovant</td>
<td>Small Molecule</td>
<td></td>
<td></td>
<td></td>
<td>▶️</td>
</tr>
<tr>
<td>BREPOCITINIB</td>
<td>Other Indications</td>
<td>Priovant</td>
<td>Small Molecule</td>
<td></td>
<td></td>
<td></td>
<td>▶️</td>
</tr>
<tr>
<td>BATOCILMAB</td>
<td>Myasthenia Gravis</td>
<td>Immunovant</td>
<td>Biologic</td>
<td></td>
<td></td>
<td></td>
<td>▶️</td>
</tr>
<tr>
<td>BATOCILMAB</td>
<td>Thyroid Eye Disease</td>
<td>Immunovant</td>
<td>Biologic</td>
<td></td>
<td></td>
<td></td>
<td>▶️</td>
</tr>
<tr>
<td>BATOCILMAB</td>
<td>Chronic Inflammatory Demyelinating Polyneuropathy</td>
<td>Immunovant</td>
<td>Biologic</td>
<td></td>
<td></td>
<td></td>
<td>▶️</td>
</tr>
<tr>
<td>BATOCILMAB</td>
<td>Graves’ Disease</td>
<td>Immunovant</td>
<td>Biologic</td>
<td></td>
<td></td>
<td></td>
<td>▶️</td>
</tr>
<tr>
<td>IMVT-1402</td>
<td>Numerous Indications</td>
<td>Immunovant</td>
<td>Biologic</td>
<td></td>
<td></td>
<td></td>
<td>▶️</td>
</tr>
<tr>
<td>NAMILUMAB</td>
<td>Sarcoidosis</td>
<td>Kinevant</td>
<td>Biologic</td>
<td></td>
<td></td>
<td></td>
<td>▶️</td>
</tr>
<tr>
<td>RVT-2001</td>
<td>Transfusion-Dependent Anemia in Patients with Lower-Risk MDS</td>
<td>Hemavant</td>
<td>Small Molecule</td>
<td></td>
<td></td>
<td></td>
<td>▶️</td>
</tr>
</tbody>
</table>

▶️ Represents registrational or potentially registrational trials

Pipeline reflects both ongoing clinical trials and expected upcoming trials. VTAMA has only received FDA approval for psoriasis, not atopic dermatitis. Other than VTAMA in psoriasis, all drugs are investigational and subject to regulatory approval.

For investor audiences only.
Charting a Path to a $15BN+ Inflammation & Immunology Franchise

2023-2025

Multiple new approvals and 10+ Phase 2 or 3 data readouts including multiple registrational data sets each year

2025+

Wave of potential additional approvals across large I&I indications with high unmet need

Major I&I franchise on market with $15BN+ aggregate peak revenue potential

For investor audiences only
## Rich Catalyst Calendar Through 2025

<table>
<thead>
<tr>
<th>Program</th>
<th>Vant</th>
<th>Catalyst</th>
<th>Expected Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>VTAMA (tapinarof) cream</td>
<td></td>
<td>Updates on commercial launch of VTAMA in psoriasis</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Roivant pipeline growth</td>
<td></td>
<td>New mid/late-stage in-licensing announcements</td>
<td>Ongoing</td>
</tr>
<tr>
<td>LNP platform</td>
<td></td>
<td>Updates to LNP patent litigation</td>
<td>Ongoing</td>
</tr>
<tr>
<td>IMVT-1402</td>
<td></td>
<td>Data from IMVT-1402 MAD 600mg SC cohort</td>
<td>Nov. 2023</td>
</tr>
<tr>
<td>Brepocitinib</td>
<td></td>
<td>Topline data from potentially registrational Phase 2B trial in SLE</td>
<td>4Q 2023</td>
</tr>
<tr>
<td>Batoclimab</td>
<td></td>
<td>Initial data from Phase 2 trial in Graves’ disease</td>
<td>4Q 2023</td>
</tr>
<tr>
<td>RVT-2001</td>
<td></td>
<td>Data from RVT-2001 Phase 1/2 trial in lower-risk myelodysplastic syndrome</td>
<td>2H 2023</td>
</tr>
<tr>
<td>VTAMA (tapinarof) cream</td>
<td></td>
<td>Expected sNDA filing for VTAMA in atopic dermatitis</td>
<td>1Q 2024</td>
</tr>
<tr>
<td>Brepocitinib</td>
<td></td>
<td>Topline data from proof-of-concept trial in non-infectious uveitis</td>
<td>1Q 2024</td>
</tr>
<tr>
<td>Batoclimab</td>
<td></td>
<td>Initial data from period 1 of Phase 2B trial in CIDP</td>
<td>1H 2024</td>
</tr>
<tr>
<td>Namilumab</td>
<td></td>
<td>Topline data from Phase 2 trial in sarciodosis</td>
<td>2H 2024</td>
</tr>
<tr>
<td>Batoclimab</td>
<td></td>
<td>Topline data from Phase 3 trial in myastenia gravis</td>
<td>2H 2024</td>
</tr>
<tr>
<td>RVT-3101</td>
<td></td>
<td>Topline data from induction portion of Phase 2 trial in Crohn’s disease</td>
<td>4Q 2024</td>
</tr>
<tr>
<td>Batoclimab</td>
<td></td>
<td>Topline data from Phase 3 trials in thyroid eye disease</td>
<td>1H 2025</td>
</tr>
<tr>
<td>Brepocitinib</td>
<td></td>
<td>Topline data from Phase 3 trial in dermatomyositis</td>
<td>2025</td>
</tr>
</tbody>
</table>

All catalyst timings are based on current expectations and, where applicable, contingent on FDA feedback, and may be subject to change. All timelines reference calendar years. SAD, single ascending dose; MAD, multiple ascending dose.

For investor audiences only.
Commercial Launch of VTAMA® Cream
VTAMA is Charting a Path to Become a Potential Blockbuster Topical in Both Psoriasis and Atopic Dermatitis

1. Powerful efficacy and rapid onset in plaque psoriasis with remittive data on label and remarkable efficacy in atopic dermatitis

2. Favorable safety and tolerability profile that enables long term use anywhere on the body

3. Convenient, once-daily product with expected single tube for psoriasis and atopic dermatitis, including for pediatric patients

VTAMA cream is only FDA-approved for the topical treatment of plaque psoriasis in adults but is under clinical investigation for the treatment of atopic dermatitis in adults and children age two (2) years old and above.
VTAMA Leads the Other Branded Topicals in Weekly TRx

Over 220,000 VTAMA prescriptions written by over 11,500 unique prescribers since launch

PsO Branded Topical Market – Weekly TRxs

Weekly TRx

Another Quarter of VTAMA Launch Execution & Strong Demand

$16.7M net product revenue for quarter ended June 30, 2023, up from $13.7M in prior quarter

26% net yield for quarter ended June 30, 2023, up from 25% in prior quarter

VTAMA is bringing patients back into the doctor’s office - 33% of VTAMA NBRx are from patients who have not had an Rx in the previous 12 months

Continued growth in product revenue shows strong patient demand and good payer progress
Commercial and Government Coverage Progressing Ahead of Plan

Innovation and TRx performance driving VTAMA accelerated coverage

- **129M** Commercial Lives Covered
  - (79% of Total)

- **86M** Government Lives Covered

- 3 National PBM Formulary Additions
- 4 National Health Plan Formulary Additions
- 1 Regional PBM Formulary Addition
- 14 Regional Health Plan Formulary Additions
- 22 Blue Cross Blue Shield Plan Formulary Additions

Sources: MMIT Aug 2023
AD Data Supports Potential Market Expansion from ~90K Weekly Topical TRx in Psoriasis to >400K Combined Weekly Topical TRx Market

Psoriasis and Atopic Dermatitis Total Market – Weekly TRx¹

2. VTAMA cream is only FDA-approved for the topical treatment of plaque psoriasis in adults but is under clinical investigation for the treatment of atopic dermatitis in adults and children age two (2) years old and above.
VTAMA: A Paradigm Shift In Everyday Psoriasis Care

Physician Quotes from Investor Day KOL Panel:

“What has really struck me using this post approval in the real world is really the fast onset of action. I am seeing some of my patients come back into the office or message me through the portal telling me they’re clearing as early as 1 to 2 weeks into therapy”

“In the eyes of my own patients and the rapidity of the improvement, [VTAMA] has really positioned itself as a first-line monotherapy topical treatment for our patients with plaque psoriasis. And that really is a very significant change in the way we treat this disease”

“This is really a paradigm shift of how we’re managing [psoriasis] patients. I think that the cornerstone of topical therapy for me has radically shifted in a matter of months to using [VTAMA] as a primary treatment and thinking about the other therapies as adjuvant therapies to combine with VTAMA, if necessary”

“Patients tell me that the feel of the cream is very elegant. They’re not having any tolerability issues. I’ve been privileged that over the last 3 months of prescribing it, I haven’t seen any side effects yet”

“[One patient of mine] cleared 100% on this medication. She showed me pictures of herself in shorts, and she told me she never thought she could wear shorts again. She got teary-eyed, I got teary-eyed. But that moment just showed me that this drug is not only impacting the disease itself. It’s changing people lives”
VTAMA Cream Broad and Differentiated FDA-Approved Label

**HIGHLIGHTS OF PRESCRIBING INFORMATION**
These highlights do not include all the information needed to use VTAMA® cream safely and effectively. See full prescribing information for VTAMA.

VTAMA (tapinarof) cream, for topical use
Initial U.S. Approval: 2022

**INDICATIONS AND USAGE**
VTAMA cream, 1% is an aryl hydrocarbon receptor agonist indicated for the topical treatment of plaque psoriasis in adults. (1)

**DOSAGE AND ADMINISTRATION**
• Apply a thin layer of VTAMA cream to affected areas once daily. (2)
• VTAMA cream is not for oral, ophthalmic, or intravaginal use. (2)

**DOSEAGE FORMS AND STRENGTHS**
Cream, 1% (3)
Each gram of VTAMA cream contains 10 mg of tapinarof. (3)

**Mild, moderate & severe plaque psoriasis**

**May be applied to all affected skin areas**

**Unlimited duration of treatment as demonstrated in clinical studies over 52 weeks**

**Demonstrated median REMITTIVE OFF-TREATMENT EFFECT of ~4 months**

**Safe and Well-Tolerated**

**No label safety warnings or precautions**

**2,200+ patients treated in clinical trials**
VTAMA Cream’s FDA Label is Differentiated Among Competitors

<table>
<thead>
<tr>
<th>On Label</th>
<th>Non-Steroidal Topicals</th>
<th>Systemics</th>
<th>Topical Steroids</th>
<th>Steroid Combinations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remittive Off-Treatment Benefit Data</td>
<td>VTAMA® (Topical)</td>
<td>ZORYVE™ (Oral)</td>
<td>OTEZLA® (Oral)</td>
<td>HUMIRA® (Subcutaneous)</td>
</tr>
<tr>
<td>No Duration Limitations</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Body Surface Limitations (incl. Intertriginous Areas)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Label Safety Warnings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Drug Interactions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Contraindications</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comparison above is based on a review of the FDA-approved labels for the referenced products. No head-to-head studies or comparisons between the products have been conducted against other psoriasis treatments.

1. VTAMA cream demonstrated a median time of ~4 months off treatment to PGA ≥ 2. Patients on OTEZLA lost PASI-75 response after a median of ~5-6 weeks off treatment. Patients on SOTYKTU lost PASI-75 response after a median of ~12 weeks off treatment. Patients on ENSTILAR showed a median of ~4 weeks off treatment to PGA ≥ 1.
6x Treatment Success Rate vs. Vehicle at Week 12, With Significant Efficacy Seen as Early as Week 4\textsuperscript{1-3}

PGA treatment success: PGA score of 0 or 1 & a ≥2-grade improvement from baseline to week 12\textsuperscript{1-3}

- ~40% of VTAMA cream patients achieved PGA treatment success vs ~ 6% of vehicle patients at week 12\textsuperscript{1-3}
- ~80% of VTAMA cream patients achieved a ≥1-grade PGA improvement at week 12 vs ~35% of patients on vehicle\textsuperscript{1-3}

For investor audiences only
Remittive Effect is Unprecedented, and The Hallmark of VTAMA

**PSOARING 1**

<table>
<thead>
<tr>
<th>Month 1</th>
<th>Month 2</th>
<th>Month 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>12 Weeks on treatment</strong></td>
<td><strong>12 Weeks on treatment</strong></td>
<td><strong>12 Weeks on treatment</strong></td>
</tr>
</tbody>
</table>

Patient achieved PGA=0 on treatment and subsequently went off therapy

Baseline
- PGA=4
- DLQI=6
- PASI=19.8
- PP-NRS=10

On treatment for 12 weeks
- PGA=1
- DLQI=0
- PASI=3.8
- PP-NRS=0

Off treatment for 12 weeks
- PGA=1
- DLQI=0
- PASI=1.2
- PP-NRS=0

Off treatment for 24 weeks
- PGA=2
- DLQI=2
- PASI=5.4

**PSOARING 3 LTE**

<table>
<thead>
<tr>
<th>Month 7</th>
<th>Month 8</th>
<th>Month 9</th>
<th>Month 10</th>
<th>Month 11</th>
<th>Month 12</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>24 Weeks off treatment</strong></td>
<td><strong>24 Weeks off treatment</strong></td>
<td><strong>24 Weeks off treatment</strong></td>
<td><strong>24 Weeks off treatment</strong></td>
<td><strong>24 Weeks off treatment</strong></td>
<td><strong>24 Weeks off treatment</strong></td>
</tr>
</tbody>
</table>

Patient maintained clear or almost clear skin for 24 weeks after the removal of therapy

For investor audiences only

VTAMA cream demonstrated strong clinical efficacy and remittive OFF-treatment effect in a patient with baseline characteristics (severe disease [PGA=4]) well suited for a biologic

PGA and PASI are global efficacy assessments. Example of one representative target lesion of a patient treated with tapinarof cream 1% QD in the PSOARING 1 and 3 trials. "LTE: Week 24: Off treatment for 12 weeks (after achieving PGA=0 at LTE Week 12); "LTE Week 36: Off treatment for 24 weeks, with re-treatment at Week 36 due to disease worsening (PGA=2). LTE: long-term extension; PASI, Psoriasis Area and Severity Index; PGA, Physician Global Assessment; QD, once daily.


For investor audiences only
VTAMA Cream Phase 3 ADORING Program – Trial Design

813 patients down to two years of age with atopic dermatitis in two identical pivotal trials followed by long-term, open-label extension

Patients with moderate to severe atopic dermatitis (N=813)
• Aged 2 years and above (max 20% ≥18 years old)*
• vIGA-AD™ score ≥3†
• EASI score ≥6
• BSA ≥5% to ≤35%

Primary Endpoint:
• Proportion of patients with a vIGA-AD™ score of 0 (clear) or 1 (almost clear) and ≥2-grade improvement from baseline at Week 8

Secondary Endpoints:
• EASI75 from baseline at Week 8
• %BSA affected from baseline at Week 8
• EASI90 from baseline at Week 8
• Achievement of a ≥4-point PP-NRS reduction at Week 8¶

Safety:
• TEAEs, SAEs

PROs:
• LTS
• DLQI/CDLQI/IDQOL
• EQ-5D-5L/ EQ-5D-Y
• POEM
• DFI
• PP-NRS

ADORING 1
N=407
VTAMA 1% QD
Vehicle QD
Double-blind Treatment
(8 weeks)

ADORING 2
N=406
VTAMA 1% QD
Vehicle QD

Follow-up
(1 week)

ADORING 3
VTAMA 1% QD
Withdrawal and re-treatment

Long-term, Open-label Extension‡
(48 weeks)

VTAMA Cream Phase 3 ADORING Program

For investor audiences only.

*A minimum of ~15% of patients will be enrolled into the following age groups: 2–6 years, 7–11 years, 12–17 years, and ≥18 years. Adults (≥18 years) will comprise a maximum of approximately 20% of enrolled patients. (Patients with a vIGA-AD™ score of 4 (severe) will represent a minimum of ~10% of the total randomized population; the remainder will have a vIGA-AD™ score of 3 (moderate). (Patients electing not to participate in ADORING 3 will attend a follow-up visit 1 week after completion of the treatment period in ADORING 1 or 2. (In patients ≥12 years with a baseline PP-NRS score ≥4, vIGA-AD™ is the trademark of Eli Lilly and Co.
**ADORING 1 & 2: Baseline Demographics and Disease Characteristics**

80% pediatric patients and well balanced across pediatric age cohorts

<table>
<thead>
<tr>
<th>Patients, n (%)</th>
<th>ADORING 1</th>
<th>ADORING 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>VTAMA 1% QD (n=270)</td>
<td>Vehicle QD (n=137)</td>
</tr>
<tr>
<td><strong>Age, mean (SD)</strong></td>
<td>15.6 (16.62)</td>
<td>15.6 (16.49)</td>
</tr>
<tr>
<td><strong>Age group, n (%)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2–6 years</td>
<td>76 (28.1)</td>
<td>39 (28.5)</td>
</tr>
<tr>
<td>7–11 years</td>
<td>75 (27.8)</td>
<td>37 (27.0)</td>
</tr>
<tr>
<td>12–17 years</td>
<td>67 (24.8)</td>
<td>34 (24.8)</td>
</tr>
<tr>
<td>≥18 years</td>
<td>52 (19.3)</td>
<td>27 (19.7)</td>
</tr>
<tr>
<td><strong>Male, n (%)</strong></td>
<td>130 (48.1)</td>
<td>66 (48.2)</td>
</tr>
<tr>
<td><strong>Weight, kg, mean (SD)</strong></td>
<td>46.69 (27.251)</td>
<td>47.69 (27.725)</td>
</tr>
<tr>
<td><strong>BMI, kg/m², mean (SD)</strong></td>
<td>21.38 (6.307)</td>
<td>22.06 (6.557)</td>
</tr>
<tr>
<td><strong>vIGA-ADTM, n (%)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 – Moderate</td>
<td>244 (90.4)</td>
<td>122 (89.1)</td>
</tr>
<tr>
<td>4 – Severe</td>
<td>26 (9.6)</td>
<td>15 (10.9)</td>
</tr>
<tr>
<td><strong>EASI, mean (SD)</strong></td>
<td>12.24 (5.007)</td>
<td>12.86 (5.633)</td>
</tr>
<tr>
<td><strong>BSA affected (%), mean (SD)</strong></td>
<td>16.45 (8.666)</td>
<td>17.71 (9.500)</td>
</tr>
<tr>
<td><strong>PP-NRS (all), mean (SD)</strong></td>
<td>6.8 (2.33)</td>
<td>6.5 (2.39)</td>
</tr>
<tr>
<td><strong>PP-NRS (≥12 years), mean (SD)</strong></td>
<td>6.5 (2.40)</td>
<td>6.3 (2.31)</td>
</tr>
<tr>
<td><strong>PP-NRS (&lt;12 years), mean (SD)</strong></td>
<td>7.0 (2.25)</td>
<td>6.6 (2.46)</td>
</tr>
</tbody>
</table>

Baseline disease characteristics reflect moderate to severe patient population; age 2–81 years and mean PP-NRS of 6.7–6.8
Robust efficacy demonstrated by magnitude of vIGA-AD™ treatment success*.

Nearly 60% of patients treated with VTAMA cream achieved at least 75% improvement in eczema severity by Week 8 (mean baseline EASI 12.45 in ADORING 1 and EASI 13.33 in ADORING 2).

Majority of patients treated with VTAMA cream achieved clinically meaningful ≥4-point reduction in itch at Week 8 (patients aged ≥12 years, mean baseline PP-NRS 6.4 in ADORING 1 and 6.4 in ADORING 2).
ADORING 1 & 2: Summary of TEAEs – Safety Population

VTAMA 1% QD demonstrates highly favorable safety profile in AD patients down to age 2 years old

<table>
<thead>
<tr>
<th>Patients, n (%)</th>
<th>ADORING 1</th>
<th>ADORING 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>VTAMA 1% QD (n=270)</td>
<td>Vehicle QD (n=137)</td>
<td>VTAMA 1% QD (n=271)</td>
</tr>
<tr>
<td>Adverse events of special interest (treatment emergent)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact dermatitis</td>
<td>4 (1.5)</td>
<td>3 (2.2)</td>
</tr>
<tr>
<td>Follicular event</td>
<td>27 (10.0)</td>
<td>1 (0.7)</td>
</tr>
<tr>
<td>Headache</td>
<td>19 (7.0)</td>
<td>3 (2.2)</td>
</tr>
<tr>
<td>TEAE leading to treatment discontinuation</td>
<td>6 (2.2)</td>
<td>6 (4.4)</td>
</tr>
<tr>
<td>TEAE leading to study discontinuation</td>
<td>5 (1.9)</td>
<td>5 (3.6)</td>
</tr>
</tbody>
</table>

- Low rates of treatment and trial discontinuation due to adverse events
- Study and treatment discontinuation rate due to AEs greater in vehicle-treated group than VTAMA-treated group
- 91% rollover rate from ADORING 1 and 2 into the 48-week open-label, long-term extension study
- AEs in general were balanced between vehicle and treatment arms

AE, adverse event; QD, once daily; TEAE, treatment-emergent adverse event. Source: 14.3.1.1
ADORING 2: Primary Efficacy Endpoint – VTAMA Cream Regulatory Success

Rapid response to treatment with VTAMA cream in pediatric patient achieving regulatory endpoint by Week 2

<table>
<thead>
<tr>
<th></th>
<th>BASELINE</th>
<th>WEEK 2</th>
<th>WEEK 4</th>
<th>WEEK 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>vIGA-AD™</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>EASI</td>
<td>6.5</td>
<td>3.0</td>
<td>0.3</td>
<td>0.9</td>
</tr>
<tr>
<td>CDLQI</td>
<td>6</td>
<td>5</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>PP-NRS</td>
<td>9</td>
<td>4.6</td>
<td>3.7</td>
<td>0.3</td>
</tr>
</tbody>
</table>

Example of a representative target lesion of a patient treated with VTAMA cream, 1% once daily in ADORING 2 clinical trial. Individual results may vary.
EASI-75 Responder Rate vs Existing Topical and Systemic Therapies

VTAMA (tapinarof) cream 1%
(ADORING 1 & 2 Phase 3; Topical QD)

DUPIXENT (dupilumab)
(Phase 3; Injection Q2W)

Adbry
(tralokinumab-tdfm)
(Phase 3; Injection EOW)

Opzelura (ruxolitinib) cream 1.5%
(Phase 3; Topical BID)

ZORYVE (roflumilast) cream 0.3%
(Phase 3; Topical QD)

eucrisa (crisaborole) ointment 2%
(Phase 3; Topical BID)

Proportion of Patients

Week 8

VTAMA

Tapinarof Cream 1%
Vehicle

59%
21%
23%

Week 16

DUPIXENT

Dupixent
Placebo

51%
15%
25%

Adbry

Adbry
Placebo

44%
12%
25%

Opzelura

Opzelura
Placebo

62%
13%
33%

Roflumilast Cream 0.15%

Vehicle

25%
10%
25%

Eucrisa

Eucrisa
Vehicle

29%
14%
22%

Week 4

VTAMA

Tapinarof Cream 1%
Vehicle

56%
12%
10%

ZORYVE

Roflumilast Cream 0.15%
Vehicle

43%
14%
22%

Eucrisa

Eucrisa
Vehicle

42%
20%
15%

Figures reflect cross-trial comparison and not results from a head-to-head study. Differences exist between trial designs and subject characteristics, and caution should be exercised when comparing data across studies.

EASI-75 response rates shown above based on published data, company presentations, and FDA approval labels.

For investor audiences only
Systemic-Like Efficacy Alongside Exceptional Product Profile as a Non-Steroidal Once Daily Topical

<table>
<thead>
<tr>
<th>VTAMA (tapinarof) cream</th>
<th>Topical JAK</th>
<th>Topical PDE4</th>
<th>Biologics</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Opzelura®</td>
<td>ZORYVE®</td>
<td>Eucrisa®</td>
</tr>
<tr>
<td>Studied in Subjects with AD Down to 2 Years Old</td>
<td>✔</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Studied in Moderate to Severe AD</td>
<td>✔</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Once Daily Dosing</td>
<td>✔</td>
<td>X</td>
<td>✔</td>
</tr>
<tr>
<td>Little to No Systemic Absorption</td>
<td>✔</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>&gt;45% of Patients Achieved vIGA-AD™* Success</td>
<td>✔</td>
<td>✔</td>
<td>X</td>
</tr>
<tr>
<td>&gt;55% of Patients Achieved EASI75†</td>
<td>✔</td>
<td>✔</td>
<td>X</td>
</tr>
<tr>
<td>&gt;50% 4-point Reduction in Itch†</td>
<td>✔</td>
<td>✔</td>
<td>X</td>
</tr>
</tbody>
</table>

Comparison above is based on USPI or available public information for the referenced products. Differences exist between trial designs and subject characteristics, and caution should be exercised when comparing data across studies.

*Primary endpoint in ADORING 2 and INTEGUMENT-1 and 2 measured using the vIGA-ADTM; primary endpoints in other trials measured using IGA or ISGA. 1As monotherapy. AD, atopic dermatitis; EASI75, ≥75% improvement in Eczema Area and Severity Index score; IGA, Investigator Global Assessment; ISGA, Investigator’s Static Global Assessment; vIGA-ADTM, Validated Investigator Global Assessment for Atopic DermatitisTM.

Significant Unmet Medical Need Persists for Patients with IBD

- Affects ~2M people in the US – two most common forms are ulcerative colitis (UC) and Crohn’s disease (CD)

- Abdominal pain, bleeding, frequent bathroom visits or constipation, obstruction, and surgery

- Constitutional symptoms of weight loss, fever, and fatigue; significant mental health burden

- Poor prognostic indicators and lack of biomarkers lead to a “trial and error” treatment paradigm or eventual removal of the colon for more severe patients

- Even the best advanced therapies typically result in 10-15% remission of disease, leaving frequent flare-ups or continued worsening of disease

Source: 2014 Crohn’s and Colitis Foundation of America Guidebook; 2019 IBD Global Disease Burden from The Lancet; 2012 Molodecky et al., Gastroenterology

Adapted from https://www.hopkinsmedicine.org/
IBD Has Consistently Yielded Blockbuster Revenues for Therapies in Multiple Classes

IBD is a ~$15B market in the US alone and growing

- IBD has consistently yielded blockbuster revenues for drugs from multiple asset classes

- To date, the leading therapy for each novel mechanism has achieved ≥$2B in US sales

- In 2021, leading therapies in each of the three mechanisms generated a combined $12B in US sales in IBD

Source: Evaluate Pharma
TL1A Blockade is a Unique Mechanism with Broad Potential Application in Both Inflammatory and Fibrotic Diseases

TL1A independently mediates both inflammation and fibrosis. TL1A is linked to numerous immune and fibrotic diseases:

- Multiple Inflammatory Diseases: RA, Atopic Dermatitis, SLE, Asthma, Psoriasis
- Intestinal Fibrosis
- Pulmonary Fibrosis
- Liver Fibrosis

Clinical validation in ulcerative colitis and Crohn’s disease in hand, with SSc-ILD also being studied

Additional indications to be announced

Analyses of patient samples from Ph2a TUSCANY study demonstrate impact of RVT-3101 treatment across a broad range of inflammatory and fibrotic biomarkers

Impact of TL1A Blockade

- ↓ IL-17A
- ↓ Th17 activation
- Th17 cell # reduction
- ↑ IFNγ
- ↓ IFNγ
- ↓ IL-12Rβ
- ↑ IL-13
- ↓ IL-13
- ↓ IL-5
- ↑ IL-6
- ↓ IL-6
- ↓ MMP7 & MMP10
- Fibroblast # reduction

For investor audiences only

Figure adapted from Aiba et al., Mediators of Inflammation (2013); Hassan-Zahraee et al, Inflammatory Bowel Disease (2022)
Continued Treatment with RVT-3101 Improves Upon High-End Efficacy Results Observed During the Induction Period in TUSCANY-2

Safety and efficacy observed through 56 weeks confirms RVT-3101 potential for best-in-category profile

<table>
<thead>
<tr>
<th></th>
<th>Clinical Remission</th>
<th>Endoscopic Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Week 14 → Week 56)</td>
<td>(Week 14 → Week 56)</td>
</tr>
<tr>
<td><strong>Overall Population</strong></td>
<td>29% → 36%</td>
<td>36% → 50%</td>
</tr>
<tr>
<td>(At Expected Phase 3 Dose)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Biomarker Positive</strong></td>
<td>33% → 43%</td>
<td>47% → 64%</td>
</tr>
<tr>
<td>(At Expected Phase 3 Dose)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Well-tolerated through 56 weeks across all doses;
No impact of immunogenicity on clinical efficacy or safety results
Two Robust, Positive Studies Conducted By Pfizer To Date

**TUSCANY (Phase 2a)**
- 14-week induction study
- IV, single-arm study
- Biologic experienced and naïve
- Exploratory biomarkers; biomarker of interest identified
- Global study
- N = 50

**TUSCANY-2 (Phase 2b)**
- 52-week induction and chronic study
- SQ, placebo-controlled dose ranging study
- Biologic experienced and naïve
- Single, prospectively-defined biomarker used
- Global study
- N = 245
- *Among the largest Phase 2b studies conducted in ulcerative colitis*

For TUSCANY results, see Danese, Silvio, et al., *Clinical Gastroenterology and Hepatology* (2020)
### Induction Period

<table>
<thead>
<tr>
<th>Arm</th>
<th>Dosing</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Placebo, SQ, Q4W</td>
</tr>
<tr>
<td>B</td>
<td>Placebo, SQ, Q4W</td>
</tr>
<tr>
<td>C</td>
<td>Placebo, SQ, Q4W</td>
</tr>
<tr>
<td>D</td>
<td>RVT-3101 50 mg, SQ, Q4W</td>
</tr>
<tr>
<td>E</td>
<td>RVT-3101 150 mg, SQ, Q4W</td>
</tr>
<tr>
<td>F</td>
<td>RVT-3101 150 mg, SQ, Q4W</td>
</tr>
<tr>
<td>G</td>
<td>RVT-3101 450 mg, SQ, Q4W</td>
</tr>
<tr>
<td>H</td>
<td>RVT-3101 450 mg, SQ, Q4W</td>
</tr>
<tr>
<td>I</td>
<td>RVT-3101 450 mg, SQ, Q4W</td>
</tr>
</tbody>
</table>

### Chronic Period

- **Arm D**
  - Dosing: RVT-3101 50 mg, SQ, Q4W
  - **CONSTANT DOSE**

- **Arms E, F, G, H, I**
  - Dosing: RVT-3101 150 mg, SQ, Q4W or RVT-3101 50 mg, SQ, Q4W
  - **CONSTANT DOSE**

### Screening (up to 6 weeks) and Randomization

<table>
<thead>
<tr>
<th>Arm</th>
<th>Dosing</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Placebo, SQ, Q4W</td>
</tr>
<tr>
<td>B</td>
<td>Placebo, SQ, Q4W</td>
</tr>
<tr>
<td>C</td>
<td>Placebo, SQ, Q4W</td>
</tr>
<tr>
<td>D</td>
<td>RVT-3101 50 mg, SQ, Q4W</td>
</tr>
<tr>
<td>E</td>
<td>RVT-3101 150 mg, SQ, Q4W</td>
</tr>
<tr>
<td>F</td>
<td>RVT-3101 150 mg, SQ, Q4W</td>
</tr>
<tr>
<td>G</td>
<td>RVT-3101 450 mg, SQ, Q4W</td>
</tr>
<tr>
<td>H</td>
<td>RVT-3101 450 mg, SQ, Q4W</td>
</tr>
<tr>
<td>I</td>
<td>RVT-3101 450 mg, SQ, Q4W</td>
</tr>
</tbody>
</table>

### Follow-up Period (12 weeks)

- **Arm D**
  - Week 56 endpoints
  - Chronic Period (mITT = modified intention-to-treat, N = 224)
  - Key endpoints at weeks 14 and 56: clinical remission and endoscopic assessments
Patient Disposition in Chronic Period of TUSCANY-2 Phase 2b Study

Entered Chronic Period (mITT)  
N = 224

Discontinued treatment, N = 46 (20.5%)  
Primary reason:  
Adverse event, N = 11 (4.9%)  
Lack of efficacy, N = 14 (6.3%)  
Physician decision, N = 4 (1.8%)  
Protocol deviation, N = 1 (0.4%)  
Withdrawal by patient, N = 15 (6.7%)  
Other, N = 1 (0.4%)

Completed, N = 178 (79.5%)

mITT is defined as patients who received at least one dose of RVT-3101 during the Chronic Period.

Efficacy data presented here reflect Induction and Chronic Period data for this group of patients.

mITT analysis is as prespecified in the Pfizer SAP.

For investor audiences only
Baseline Disease Characteristics and Demographics

Baseline characteristics are consistent with the Induction Period and reflective of a refractory and difficult-to-treat patient population.

<table>
<thead>
<tr>
<th></th>
<th>All Arms N = 224</th>
<th>Constant Expected Ph3 Dose Arm</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (years, mean)</strong></td>
<td>40.8</td>
<td>46.0</td>
</tr>
<tr>
<td><strong>Female</strong></td>
<td>40%</td>
<td>28%</td>
</tr>
<tr>
<td><strong>Weight (kg, mean)</strong></td>
<td>71.4</td>
<td>74.8</td>
</tr>
<tr>
<td><strong>Geographic Region</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>US / Canada / Australia</td>
<td>12%</td>
<td>17%</td>
</tr>
<tr>
<td>EU</td>
<td>64%</td>
<td>52%</td>
</tr>
<tr>
<td>Asia</td>
<td>19%</td>
<td>24%</td>
</tr>
<tr>
<td>Other</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td><strong>Extent of Disease</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proctosigmoiditis</td>
<td>26%</td>
<td>7%</td>
</tr>
<tr>
<td>Left-sided colitis</td>
<td>44%</td>
<td>48%</td>
</tr>
<tr>
<td>Pancolitis</td>
<td>40%</td>
<td>41%</td>
</tr>
<tr>
<td><strong>Modified Mayo Score (mean)</strong></td>
<td>6.7</td>
<td>6.9</td>
</tr>
<tr>
<td><strong>Endoscopy Score</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>46%</td>
<td>34%</td>
</tr>
<tr>
<td>3</td>
<td>54%</td>
<td>66%</td>
</tr>
<tr>
<td><strong>Concomitant corticosteroid use</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Number of prior advanced therapies exposed</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Naive</td>
<td>57%</td>
<td>55%</td>
</tr>
<tr>
<td>1 prior advanced therapy</td>
<td>18%</td>
<td>14%</td>
</tr>
<tr>
<td>2 prior advanced therapies</td>
<td>11%</td>
<td>24%</td>
</tr>
<tr>
<td>≥3 prior advanced therapies</td>
<td>14%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Advanced therapy includes approved biologics and JAKs.

For investor audiences only.
At the Expected Phase 3 Dose, Substantial Improvements Were Observed Across All Key Efficacy Metrics with Chronic Dosing

Efficacy data from patients assigned Expected P3 Dose throughout study

Clinical Remission (Modified Mayo)

- Induction (Week 14): 29%
- Chronic (Week 56): 36%

Endoscopic Improvement

- Induction (Week 14): 36%
- Chronic (Week 56): 50%

Endoscopic Remission

- Induction (Week 14): 11%
- Chronic (Week 56): 21%

• Induction and Chronic Period data shown here and on future slides refer to mITT population at Week 14 and Week 56, where mITT is defined as patients who received at least one dose of RVT-3101 in the Chronic Period.
• Delta values may not exactly match the difference between Week 14 and Week 56 values due to rounding.
At the Expected P3 Dose, Even Greater Improvements Were Observed with Chronic Dosing in Biomarker Positive Patients

Efficacy data from biomarker positive patients assigned Expected P3 Dose throughout study

Clinical Remission (Modified Mayo)

- Induction (Week 14): 33%
- Chronic (Week 56): 43% (+10%)

Endoscopic Improvement

- Induction (Week 14): 47%
- Chronic (Week 56): 64% (+18%)

Endoscopic Remission

- Induction (Week 14): 13%
- Chronic (Week 56): 36% (+22%)

Delta values may not exactly match the difference between Week 14 and Week 56 values due to rounding.
At the Expected Phase 3 Dose, Sustained Efficacy Rates Were Among the Highest Observed in Ulcerative Colitis

Efficacy data from patients assigned Expected P3 Dose throughout study

**Sustained Clinical Remission:**
Proportion of Patients With Clinical Remission at Week 14 Who Maintain Clinical Remission at Week 56

75%

**Sustained Endoscopic Improvement:**
Proportion of Patients With Endoscopic Improvement at Week 14 Who Maintain Endoscopic Improvement at Week 56

80%

Comparison based on a survey of publicly available and reported Phase 2 and Phase 3 sustained clinical remission and endoscopic improvement rates
RVT-3101 Showed Strong Results in All Comer Population that Were Maintained in the Chronic Period Across Endpoints

Efficacy data pooled across all nine arms

**Clinical Remission (Modified Mayo)**

- **Induction (Week 14):** 31%
- **Chronic (Week 56):** 34%

**Endoscopic Improvement**

- **Induction (Week 14):** 38%
- **Chronic (Week 56):** 41%

Delta values may not exactly match the difference between Week 14 and Week 56 values due to rounding.
Biologic-Experienced Patients Who Are Biomarker Positive Saw Transformative Outcomes at Completion of Chronic Period

Efficacy data pooled across all nine arms

Clinical Remission (Modified Mayo)

- Induction (Week 14): 29%
- Chronic (Week 56): 34%
  
Delta values may not exactly match the difference between Week 14 and Week 56 values due to rounding.

Endoscopic Improvement

- Induction (Week 14): 41%
  
- Chronic (Week 56): 45%
  
+3%
RVT-3101 Remained Well Tolerated in the Chronic Period

Topline Safety data: no safety signals; favorable safety profile in Induction Period was maintained in Chronic Period

<table>
<thead>
<tr>
<th>Treatment-Emergent AEs at ≥5% in Chronic Period</th>
<th>Placebo</th>
<th>All Drug Arms</th>
<th>Exp P3 Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colitis ulcerative</td>
<td>2%</td>
<td>5%</td>
<td>4%</td>
</tr>
<tr>
<td>SARS-CoV-2 test positive</td>
<td>2%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Anemia</td>
<td>9%</td>
<td>5%</td>
<td>2%</td>
</tr>
<tr>
<td>Pyrexia</td>
<td>2%</td>
<td>3%</td>
<td>5%</td>
</tr>
<tr>
<td>Headache</td>
<td>2%</td>
<td>6%</td>
<td>10%</td>
</tr>
</tbody>
</table>

| Injection site reactions                        | 2%      | 3%            | 2%          |

In the Chronic Period

- Well tolerated through 56 weeks at all doses
- Serious AEs were sporadic and determined not to be related to drug
- No severe infections observed; no infections observed at ≥5%
- No dose response observed for injection site reactions; all cases but one were mild

<table>
<thead>
<tr>
<th>Induction Period (Prior to Week 16)</th>
<th>Chronic Period (Weeks 16 to 56)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placebo</td>
<td>All Drug Arms</td>
</tr>
<tr>
<td>---------</td>
<td>---------------</td>
</tr>
<tr>
<td>Participants with adverse events (AEs)</td>
<td>56%</td>
</tr>
<tr>
<td>Participants with severe AEs</td>
<td>9%</td>
</tr>
<tr>
<td>Participants with serious AEs</td>
<td>9%</td>
</tr>
<tr>
<td>Participants who discontinued study due to AEs</td>
<td>0%</td>
</tr>
<tr>
<td>Participants who discontinued study drug due to AEs</td>
<td>7%</td>
</tr>
<tr>
<td>Participants with dose reduced or temporary discontinuation due to AEs</td>
<td>0%</td>
</tr>
<tr>
<td>Deaths</td>
<td>0%</td>
</tr>
</tbody>
</table>

For investor audiences only
No Negative Impact of ADAs or NAbs on Either Short-Term or Long-Term Efficacy Results of RVT-3101

Efficacy data pooled across all nine arms

Week 56 Clinical Remission Rate by ADA levels

NAb rate was 0% at Week 56 at the Constant Expected Phase 3 Dose
RVT-3101 Results Surpass Data Recently Seen in a Treat-Through Design

Recent UC studies have employed a treat-through design, which lacks the selection bias of a “re-randomization design” that serves to artificially increase Week 52 or Week 56 response rates

Efficacy data from patients assigned the Expected P3 Dose throughout the study

<table>
<thead>
<tr>
<th>Clinical Remission (Modified Mayo)</th>
<th>Endoscopic Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RVT-3101</strong></td>
<td><strong>Comparator</strong></td>
</tr>
<tr>
<td>All Comers</td>
<td>Biomarker Positive</td>
</tr>
<tr>
<td>36%</td>
<td>43%</td>
</tr>
</tbody>
</table>

Figures reflect cross-trial comparison and not results from a head-to-head study. Differences exist between trial designs and patient characteristics, caution should be exercised when comparing data across studies

- Entyvio (anti-integrin) and Humira (anti-TNF) data from VARSITY P3 study, SIP receptor modulator data from ELEVATE S2 P3 study
- Clinical Remission for Humira/Entyvio used different definition than RVT-3101 (Total Mayo vs Modified Mayo) and so cannot be directly compared
RVT-3101 Breaks Through the Monotherapy Barrier

Results at Week 56 exceed that seen in recent VEGA combination study which intensively combined an anti-TNF and an anti-IL23 in biologics-naïve patients

Efficacy data from biologics-naïve patients assigned Expected P3 Dose throughout study

Clinical Remission (Modified Mayo) and Endoscopic Improvement

Clinical Remission for RVT-3101 requires stool frequency score ≤ 1 and ≥1 point reduction from baseline, rectal bleeding score = 0, and endoscopic score ≤ 1

Clinical Remission in VEGA study requires stool frequency score ≤ 1 and ≥0 point reduction from baseline, rectal bleeding score = 0, and endoscopic score ≤ 1

VEGA was a partially IV regimen; signs of broad immunosuppression were observed, such as the appearance of opportunistic infections

Figures reflect cross-trial comparison and not results from a head-to-head study. Differences exist between trial designs and patient characteristics, caution should be exercised when comparing data across studies.

- Gusekumab (IL-23) and golimumab (TNF) combination data from VEGA P2 study (VEGA P2 trial combines gusekumab + golimumab in induction, with only gusekumab continued into maintenance)
- RVT-3101 data reflect bio-naïve patient population to allow direct comparison to VEGA study (which was bio-naïve patients only)
- Clinical Remission for RVT-3101 requires stool frequency score ≤ 1 and ≥ 1 point reduction from baseline, rectal bleeding score = 0, and endoscopic score ≤ 1
- Clinical Remission in VEGA study requires stool frequency score ≤ 1 and ≥ 0 point reduction from baseline, rectal bleeding score = 0, and endoscopic score ≤ 1

For investor audiences only
## RVT-3101: Potentially First-in-Class and Best-in-Class

<table>
<thead>
<tr>
<th></th>
<th>RVT-3101</th>
<th>PRA-023</th>
<th>TEV-48574</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Generated to Date</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Subjects Dosed</td>
<td>&gt;400</td>
<td>~225</td>
<td>&lt;100</td>
</tr>
<tr>
<td>Induction Data</td>
<td>~250 patients across one IV and three SQ doses</td>
<td>~70 patients at a single IV dose</td>
<td>X</td>
</tr>
<tr>
<td>Maintenance Data</td>
<td>&gt;200 patients across three SQ doses out to one year</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>SQ Injection Efficacy Data</td>
<td>&gt;200 patients across three SQ doses</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Dose Ranging Data</td>
<td>&gt;250 patients across one IV and three SQ doses</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Biomarker Strategy Locked Data</td>
<td>&gt;200 patients prospectively defined &gt;250 patients total</td>
<td>X</td>
<td>No Biomarker Data</td>
</tr>
<tr>
<td><strong>Phase 3 Readiness</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Expected Commercial Form Factor</strong></td>
<td>QM SQ autoinjector</td>
<td>Likely an IV loading dose → SQ injection</td>
<td>Likely a large volume SQ infusion loading dose → Q2W SQ infusion</td>
</tr>
</tbody>
</table>

- Based on publicly available data for referenced product candidates; patient counts reference trials publicly listed on clinicaltrials.gov and that have completed enrollment
- Differences exist between trial designs and caution should be exercised when comparing studies
Intestinal Fibrosis
Pulmonary Fibrosis
Liver Fibrosis

RVT-3101 Leads the Emergence of TL1A Blockade as a New Potential “Superclass” of Therapeutics

~$15B

Starts with the transformation of the US IBD market
High-end efficacy combined with a very favorable safety profile
Positioned for all patients, regardless of line of therapy
More patients stay on drug for longer duration
Bring promise of precision immunology to IBD

Expand To

Large Market
Inflammation-Driven
Indications
Rheumatoid Arthritis
Atopic Dermatitis
SLE
Asthma
Psoriasis

High Unmet Need
Fibrosis-Driven Indications
Intestinal Fibrosis
Pulmonary Fibrosis
Liver Fibrosis

Largely Untapped

For investor audiences only
Phase 2 Study Initiated in Crohn’s Disease (N ~ 105)

**Induction Period**
(12 weeks of dosing, no loading dose)

- Screening Period
  - Dose #1, SQ, Q4W
  - Dose #2, SQ, Q4W

**Chronic Period**
(40 additional weeks of dosing)

- Maintenance Dose
  - SQ, Q4W

**Study Outcomes**

- *Primary Endpoints*
  - Clinical Remission
    - (CDAI < 150)
  - Safety

- *Secondary Endpoints*
  - Endoscopic Response
    - (SES-CD)
  - Clinical Remission
    - (PRO2)

- *Key Additional Efficacy Analyses*
  - By Biomarker Status
  - PK/PD

Evaluated after induction and chronic periods
Key Highlights

First-in-class anti-TL1A Antibody, with an efficient, well-validated path to approval
- Most comprehensive data set in the class enables deep understanding of dose response and molecule behavior
- De-risked and ready for Phase 3 – single dose selected, no IV to SQ translation risk, biomarker locked

Uniquely positioned to overcome traditional limitations of IBD therapies
- Outstanding efficacy results regardless of line of therapy, which meaningfully improve with long-term dosing
- Sustained clinical remission and endoscopic improvement rates among the highest ever reported
- Favorable safety and tolerability profile, with no impact of immunogenicity on short- or long-term efficacy results

Precision immunology approach creates significant upside potential
- A simple diagnostic test identifies the ~60% of patients who could see significantly improved benefit
- High-end efficacy results shown in all comer population allow optionality for where and how to position biomarker

Multiple avenues for additional growth
- Dose-ranging Phase 2 in Crohn’s disease initiated with fast path to Phase 3, in line with competition
- Dual targeting of both inflammatory and fibrotic pathways uniquely enables access to a broad range of large market and high unmet need indications
Anti-FcRn Franchise: Batoclimab and IMVT-1402
Differentiated Assets to Address a Range of Patient Needs Are the Goals of Our Development

**Tailored dosing** to address varying symptom severity across indications and stage of disease
- Short term maximal IgG suppression
- Lower chronic doses where less IgG suppression needed
- Fixed duration dosing in certain conditions

*Multiple pivotal trials ongoing in MG, TED and CIDP*

**Tailored and chronic dosing** to address symptom severity and duration for extended periods of time (>12 weeks)
- Sustained maximal IgG suppression where needed
- Chronic delivery with simple subcutaneous delivery in seconds
- Initial SAD and 300 mg MAD data show no impact to albumin / LDL

*Next pivotal-enabling catalyst in 2023: Data from MAD 600 mg SC cohort expected in November 2023*

Additional data from other FcRn studied in CIDP further validates the breadth of FcRn opportunity
Our Opportunity: Autoimmune Diseases Driven by Harmful IgG Autoantibodies

22 indications currently announced or in development across the anti-FcRn class

1. Indications announced or in development with anti-FcRn assets by Immunovant, Argenx, JNJ, and UCB
2. If approved by regulatory authorities

**NEUROLOGY**
- Myasthenia gravis (MG)
- Chronic inflammatory demyelinating polyneuropathy (CIDP)
- Myositis
- Autoimmune encephalitis
- Myelin oligodendrocyte glycoprotein antibody disorders (MOG-antibody disorder)

**RHEUMATOLOGY**
- Primary Sjogrens syndrome
- Systemic lupus erythematosus
- Rheumatoid arthritis
- Antineutrophil cytoplasmic antibody (ANCA)-associated vasculitis
- Severe fibromyalgia syndrome

**HEMATOLOGY**
- Warm autoimmune hemolytic anemia (WAIHA)
- Hemolytic disease of the fetus and newborn
- Idiopathic thrombocytopenic purpura

**DERMATOLOGY**
- Bullous pemphigoid
- Pemphigus foliaceus
- Pemphigus vulgaris
- Cutaneous lupus erythematosus

**ENDOCRINOLOGY**
- Thyroid eye disease (TED)
- Graves’ disease

**RENAZL**
- Membranous nephropathy
- Lupus nephritis
- Antibody-mediated rejection

For investor audiences only
**Consistent Evidence Across All Programs and All Indicators that Greater IgG Reduction Leads to Greater Efficacy**

<table>
<thead>
<tr>
<th>Company</th>
<th>Evidence of Greater IgG Reductions Translating to Clinical Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>MG</td>
<td>Greater IgG reductions across arms ➔ greater anti-AChR autoantibody reductions and greater MG-ADL improvements. Patient-level scatter plot showed that greater IgG declines ➔ greater MG-ADL improvements.</td>
</tr>
<tr>
<td>TED</td>
<td>Greater IgG reduction across arms ➔ higher rates of anti-TSHR antibody reduction and higher proptosis response rates.</td>
</tr>
<tr>
<td>PV</td>
<td>Greater sustained IgG reduction across arms ➔ higher complete response and lower relapse rates.</td>
</tr>
<tr>
<td>ITP</td>
<td>Greater IgG reduction across arms ➔ greater platelet responses.</td>
</tr>
</tbody>
</table>

For investor audiences only.
IMVT-1402 was Selected to Deliver Maximum IgG Reduction While Minimizing Interference with Albumin Recycling

IMVT-1402: overlay with albumin and Fc

Batoclimab: overlay with albumin and Fc

Note: Ribbon representations generated from X-Ray crystal structure. Batoclimab solved at 2.4Å resolution. IMVT-1402 solved at 2.6Å resolution.
Best-in-Class Potential for IMVT-1402 as FcRn Inhibitor Highlighted by Initial Phase 1 Safety and Pharmacodynamic Data

Initial SAD and 300 mg MAD data demonstrated deep and rapid IgG reduction, similar to batoclimab, with 63% mean IgG reduction in the 300 mg MAD cohort after four doses.

Initial 300 mg MAD data after four doses showed a favorable analyte profile of no decrease in albumin and no increase in LDL relative to baseline levels.

Simple subcutaneous formulation designed to enable patient self-administration and provide additional differentiation beyond depth of IgG reduction.
Study Design for IMVT-1402 Phase 1 Clinical Trial in Healthy Volunteers*

**Single-Ascending Intravenous Dose**
- Fixed 1,200 mg
- Fixed 600 mg
- Fixed 300 mg
- Fixed 100 mg

**Single-Ascending Subcutaneous Dose**
- Fixed 600 mg
- Fixed 300 mg

**Multiple-Ascending Subcutaneous Dose**
- Fixed 600 mg
- Fixed 300 mg

**Single Ascending Dose**
- 6 IMVT-1402 + 2 placebo participants per dose cohort

**Multiple Ascending Dose**
- 10 IMVT-1402 + 2 placebo participants per dose cohort
- Once weekly dosing x 4 weeks

300 mg of IMVT-1402 is delivered as a 2 mL simple subcutaneous injection with a 27-gauge needle in the Subcutaneous Dose cohorts

*1,200 mg IV SAD cohort and 600 mg SC MAD cohort remain to be completed
Single-Ascending Subcutaneous Doses
IMVT-1402 SAD Data Suggests Potential Best-in-Class IgG Reduction Similar to Batoclimab

**IgG % change from baseline**

**IMVT-1402: Single-ascending SC Dose**

**Batoclimab: Single-ascending SC Dose**

All IgG values in the IMVT-1402 arms showed a significant decrease from baseline (all p-values < 0.05)

Dose administration * Data presented are from separate clinical trials, not a head-to-head study, conducted by Immunovant.
IMVT-1402 SAD Data Suggests Potential Best-in-Class IgG Reduction Similar to Batoclimab

IgG % change from baseline*

Single-ascending SC Dose

-100% -80% -60% -40% -20% 0% 20% 40%

0 10 20 30

Day

IMVT-1402: 600mg Group Mean
IMVT-1402: 300mg Group Mean
IMVT-1402: Placebo (Pooled) Group Mean
Batoclimab: 765mg Group Mean
Batoclimab: 340mg Group Mean
Batoclimab: Placebo (Pooled) Group Mean

Data presented are from separate clinical trials, not a head-to-head study, conducted by Immunovant.
**IMVT-1402 Produced a Similar Effect on Albumin as Placebo**

**Albumin % change from baseline***

---

**IMVT-1402: Single-ascending SC Dose**

- IMVT-1402: 600mg Group Mean
- IMVT-1402: 300mg Group Mean
- IMVT-1402: Placebo (Pooled) Group Mean

**Batoclimab: Single-ascending SC Dose**

- Batoclimab: 765mg Group Mean
- Batoclimab: 340mg Group Mean
- Batoclimab: Placebo (Pooled) Group Mean

---

No albumin values in the IMVT-1402 arms showed a significant decrease from baseline (all p-values > 0.05)

---

Dose administration

* Data presented are from separate clinical trials, not a head-to-head study, conducted by Immunovant.
IMVT-1402 Produced a Similar Effect on LDL as Placebo

LDL % change from baseline*

**No LDL values in the IMVT-1402 arms showed a significant increase from baseline (all p-values > 0.05)**

* Batoclimab phase 1 study did not measure LDL, so no comparison provided

Dose administration
Multiple-Ascending Subcutaneous Doses
(Once-weekly dosing x 4 weeks)
IMVT-1402 300 mg MAD Data Suggests Potential Best-in-Class IgG Reduction Similar to Batoclimab

IgG % change from baseline*

IMVT-1402: Multiple-ascending SC Dose

Batoclimab: Multiple-ascending SC Dose

All IgG values in the IMVT-1402 arms showed a significant decrease from baseline (all p-values < 0.05)

IMVT-1402 MAD 600 mg data on track for November 2023

Data presented are from separate clinical trials, not a head-to-head study, conducted by Immunovant.
IMVT-1402 300 mg MAD Data Suggests Potential Best-in-Class IgG Reduction Similar to Batoclimab

IgG % change from baseline*

Multiple-ascending SC Dose

IMVT-1402 MAD 600 mg data on track for November 2023

Dose administration  * Data presented are from separate clinical trials, not a head-to-head study, conducted by Immunovant.
**IMVT-1402 300 mg MAD Data: No Albumin Reduction Compared to Baseline After Four Weeks of Dosing**

*Albumin % change from baseline*

---

**IMVT-1402: Multiple-ascending SC Dose**

No albumin values in the IMVT-1402 arms showed a significant decrease from baseline (all p-values > 0.05)

**Batoclimab: Multiple-ascending SC Dose**

---

**IMVT-1402 MAD 600 mg data on track for November 2023**

Dose administration

* Data presented are from separate clinical trials, not a head-to-head study, conducted by Immunovant.
IMVT-1402 300 mg MAD Data: No LDL Increase Compared to Baseline After Four Weeks of Dosing

**LDL % change from baseline**

No LDL values in the IMVT-1402 arms showed a significant increase from baseline (all p-values > 0.05)

IMVT-1402 MAD 600 mg data on track for November 2023
IMVT-1402 Showed a Favorable Safety Profile in SAD / MAD Initial Data Set

<table>
<thead>
<tr>
<th></th>
<th>IV SAD</th>
<th>SC SAD</th>
<th>SC MAD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Placebo</td>
<td>100mg</td>
<td>300mg</td>
</tr>
<tr>
<td>N = 6</td>
<td>N = 6</td>
<td>N = 6</td>
<td>N = 6</td>
</tr>
<tr>
<td>Participants with at least one TEAE</td>
<td>4 (67)</td>
<td>4 (67)</td>
<td>3 (50)</td>
</tr>
<tr>
<td>Participants with at least one TESAE</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Participants discontinued study due to TEAEs</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Participants with dose reduced or temporary discontinuation due to TEAEs**</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Deaths</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**TEAE (≥ 2 Instances)**

<table>
<thead>
<tr>
<th></th>
<th>IV SAD</th>
<th>SC SAD</th>
<th>SC MAD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper Respiratory Tract Infections</td>
<td>2 (33)</td>
<td>3 (50)</td>
<td>0</td>
</tr>
<tr>
<td>Headache</td>
<td>3 (50)</td>
<td>1 (17)</td>
<td>1 (17)</td>
</tr>
<tr>
<td>Catheter Site Pain***</td>
<td>1 (17)</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

All TEAEs were either mild or moderate with no severe TEAEs reported across any arm to date.

* Participant who discontinued experienced a Mild TEAE. The event was considered not related to study treatment.
** Participant in the 1200 mg IV SAD had an infusion reaction without change in vital signs. The event resolved and the subject remained on-study.
*** Catheter site pain refers to pain at the site of the catheter used for blood draws.
TEAE = treatment emergent adverse event; TESAE = treatment emergent serious adverse event.
Summary of IMVT-1402 SAD/MAD Data Reviewed

IMVT-1402 SAD/MAD data to date suggest potential for best-in-class IgG lowering with IMVT-1402

IMVT-1402 data appeared similarly potent as batoclimab in both the SAD and 300 mg MAD data with robust, predictable, dose-dependent IgG lowering

IMVT-1402 SAD/MAD data to date suggest potential best-case profile with respect to albumin and LDL impact

No reduction in albumin and no increase in LDL compared to baseline observed, including after the full four weeks of dosing in the MAD 300 mg cohort
IMVT-1402 Has Potentially Best-In-Class Attributes to Address Large Unmet Need in Autoimmune Disease

IMVT-1402

Deep IgG Lowering Initial Phase 1 data suggests deep dose-dependent IgG lowering similar to batoclimab

Favorable Analyte Profile Initial Phase 1 data supports a favorable analyte profile with no or minimal effect on albumin and LDL

Convenient Administration Formulated for simple subcutaneous injection that may enable self-administration at home

Compelling Patent Protection Pending composition of matter patent expected for IMVT-1402 to 2043*

Novel, fully human, monoclonal antibody inhibiting FcRn-mediated recycling of IgG

* Not including any potential patent term extension
Indications
Myasthenia Gravis (MG): IgG-Mediated Autoimmune Disease that Typically Requires Lifestyle Changes

Key Takeaways¹

- One of the larger IgG-mediated autoimmune diseases
  - ~65,000 patients estimated in the US and ~100,000 in Europe
- ~80% of patients require lifelong therapy
- Substantial share of population on steroids and first-line immunosuppressants
- Shift towards immunosuppressants and immunoglobulin therapy as disease severity increases

Extent of Lifestyle Modifications²

- 22% Slight changes
- 38% Major changes
- 40% Moderate changes
- 0% No changes

---

¹ KOL Interviews. Data on file at Immunovant. ² MG Patient Quantitative Survey (n=50). Q: What is the extent of lifestyle modifications you make around your myasthenia gravis?
Encouraging Efficacy Signals in a Phase 2 Trial of Batoclimab in MG

Data at Week 7, End of Controlled Portion of Study

- Total IgG: -59% (Placebo), -76% (340mg/week), -87% (680mg/week)
- Anti-AChR-IgG: -3% (Placebo), -23% (340mg/week), -38% (680mg/week)
- MG-ADL: 2% (Placebo), 3% (340mg/week), 76% (680mg/week)

Source: Batoclimab Phase 2 MG trial data on file at Immunovant, Inc.

For investor audiences only
Batoclimab Phase 3 Trial Designed to Address Unmet Patient Needs

Flexible Design First for a Myasthenia Gravis Trial but Common in Immunology

1. **INDUCTION PHASE**
   - **Gain control**
     - High doses included, designed to achieve maximum efficacy at beginning of treatment

2. **MAINTENANCE PHASE**
   - **Keep control**
     - Lower dose designed to maintain efficacy with potentially fewer side effects

3. **LONG-TERM EXTENSION**
   - **Optimize control**
     - Rescue therapy available

**Unmet Patient Needs**
- Ease of administration
- Quick, deep response to gain initial control
- Sustainable long-term disease control
- Flexible dosing in chronic phase for disease fluctuations
Registrational Phase 3 Trial of Batoclimab Designed to Offer MG Patients Tailored Dosing

Top-line data expected in the second half of 2024

**Period 1:** Induction (12 weeks)
- Placebo-controlled, two dose regimens:
  - 680mg batoclimab QW SC
  - 340mg batoclimab QW SC
  - Placebo QW SC

**Period 2:** Maintenance (12 weeks)
- Placebo-controlled, two dose regimens:
  - 340mg batoclimab QW SC
  - 340mg batoclimab Q2W SC
  - Placebo QW SC

Maximize efficacy through primary endpoint*

Maintain efficacy with anchor dose and lower dose

**Primary analysis population:**
AChR Ab+

*Primary endpoint: change in MG-ADL through 12 weeks

Period 2 followed by Long-Term Extension (LTE) study. Rescue therapy available during LTE per protocol

QW = weekly; Q2W = bi-weekly; SC = subcutaneous injection; AChR Ab+ = acetylcholine receptor antibody-positive; MG-ADL = Myasthenia Gravis Activities of Daily Living scale
TED: A Heterogeneous Condition that Presents with a Variety of Clinical Symptoms

TED is a rare autoantibody mediated inflammatory disease that affects between 15,000 and 20,000 new patients each year in the United States.

Clinical Presentation and Unmet Need

Clinical features include eye bulging (“proptosis”), eye pain, double vision (“diplopia”), and light sensitivity.

Progressive disease marked by inflammation that can lead to fibrosis and may become sight-threatening if untreated.

Caused by IgG autoantibodies that activate cell types present in tissues surrounding the eye.

While Tepezza shows a validated US market opportunity (2021 net sales of $1.7 billion and expected annual peak net sales over $3 billion), many TED patients can benefit from a new therapy.

- In a Phase 3 extension study, 44% of patients who were proptosis responders following 24 weeks of treatment were no longer responders after 48 weeks off treatment.

- Audiological side effects of teprotumumab could enable greater market share capture by competitor.

Patients with less severe disease not yet treated with Tepezza and those with recurrent or residual symptoms may benefit from new therapies (8K-18K addressable patient population).

Batoclimab’s Phase 2b in TED Indicated that Greater Knockdown of IgG Led to Greater Proptosis Response Rates

It was observed in batoclimab’s Phase 2b trial in TED that reductions in IgG resulted in greater proptosis response rates\(^1,3\). Batoclimab’s Phase 2b in TED Indicated that Greater Knockdown of IgG Led to Greater Proptosis Response Rates

<table>
<thead>
<tr>
<th></th>
<th>Placebo</th>
<th>Batoclimab 255 mg</th>
<th>Batoclimab 340 mg</th>
<th>Batoclimab 680 mg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Max % IgG Reduction Through Week 12</td>
<td>No significant change</td>
<td>62%</td>
<td>69%</td>
<td>80%</td>
</tr>
<tr>
<td>% Subjects with Stimulatory anti-TSHR Antibody below 140 at Week 12(^2)</td>
<td>0%</td>
<td>0%</td>
<td>15%</td>
<td>50%</td>
</tr>
<tr>
<td>Proptosis Response Rates(^3)</td>
<td>0%</td>
<td>11%</td>
<td>29%</td>
<td>43%</td>
</tr>
</tbody>
</table>

1. The efficacy of batoclimab and clinical outcomes were deemed inconclusive, in part, because the study was terminated early.
2. This cell-based assay readout is the ratio of the sample signal to that of a reference control, expressed as % A value less than 140 is considered negative for stimulatory antibody; a value greater than or equal, positive for stimulatory antibody.
3. Post-hoc analysis of proptosis response at week 6. Proptosis response defined as proptosis reduction ≥2 mm in study eye, without ≥2 mm increase in non-study eye at same visit. Week 6 data selected as it represents the latest time point at which the largest amount of patient data is available prior to the voluntary pause.
Two Phase 3 Clinical Trials of Batoclimab in TED Initiated

Top-line data from both trials expected in the first half of 2025

Inclusion

- Subjects with clinical diagnosis of TED (active, moderate to severe TED with a CAS ≥ 4)
- Moderate to severe active TED (not sight-threatening but has an appreciable impact on daily life)
- Graves’ disease as evidenced by positive anti-TSHR-Ab titers

Primary endpoint:
Proptosis responders at Week 24 vs placebo where responders defined as ≥ 2 mm reduction from baseline in proptosis in the study eye without deterioration (≥ 2 mm increase) in the fellow eye

Participants that complete the active treatment phase may enter an open-label extension study, which will evaluate the response rate and durability of response over time

Study 1 and 2: Active Treatment Phase

<table>
<thead>
<tr>
<th>Placebo-controlled, two dose regimens:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Placebo QW SC 24 weeks</td>
<td></td>
</tr>
<tr>
<td>680mg batoclimab QW SC 12 weeks</td>
<td></td>
</tr>
<tr>
<td>340mg batoclimab QW SC 12 weeks</td>
<td></td>
</tr>
</tbody>
</table>

Randomization (2:1)

Follow up (4 weeks)

For investor audiences only
CIDP is characterized by predominant demyelination of motor and sensory nerves. Although the root cause of CIDP is unknown, significant evidence suggests that the disorder(s) are immunologically mediated.

CIDP is a progressive degenerative disease if left untreated; patients experience worsening motor weakness and sensory loss in arms and legs; some patients need walking canes or wheelchairs.

Current therapies (IVIG, plasma exchange, and steroids) are effective, but have significant side effects and logistical limitations (IVIG & plasma exchange):

• 70% of CIDP patients require ongoing treatment
• $3B in global annual sales for IVIG in CIDP

An effective treatment that could be administered via a simple subcutaneous injection would represent a meaningful improvement for patients with CIDP.
### Key Learnings from Historical and Ongoing CIDP Trials Applied to Address Challenges Unique to CIDP

Two-stage approach, to accommodate additional registration trial, if necessary, has the potential to deliver a differentiated product label with a larger effect size

<table>
<thead>
<tr>
<th>Trial risks</th>
<th>Mitigations</th>
<th>Mitigation included in other anti-FcRn Trials*</th>
<th>Mitigation included in IMVT trial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease heterogeneity and challenging diagnosis</td>
<td>Diagnostic algorithm</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
| Mix of active and inactive disease among those enrolled creates risk of low relapse rate in the placebo arm, thereby shrinking potential effect size for the investigational product | Double enrichment:  
1. Subjects must worsen after withdrawal / taper of standard of care (e.g. IVIG/SCIG, PLEX, or steroids) on study entry, AND  
2. Subjects must then improve on open label investigational product | Not All**                                                                   | ✓                                |
| Patients enrolled in placebo arm of trial may not have demonstrated initial response to investigational product | Third enrichment:  
Primary endpoint on IVIG/SCIG/Plex cohort only to maximize the potential effect size |                                               | X                                |
| Steroids are a common standard of care outside the US and often can’t be fully tapered, weakening double enrichment | Third enrichment:  
Primary endpoint on IVIG/SCIG/Plex cohort only to maximize the potential effect size |                                               | ✓                                |
| Lack of dose exploration                                                   | Data on multiple doses in “Period 1” of trial will inform future development strategy                                                      |                                               | X                                |
| Single large trial limits flexibility to optimize product label and differentiation | Smaller, initial pivotal trial that can be adjusted or complemented with a second smaller pivotal trial to optimize product label and differentiation based on new data |                                               | X                                |
Pivotal Phase 2b Trial Intended to Develop Potentially Best-in-Class Chronic Anti-FcRn Therapy in CIDP

A: Cohorts are defined by CIDP treatment at Screening.
B: Participants who fail to worsen by Week 0 will be withdrawn from the study at Week 0.
C: Period 1 Non-Responders who complete Period 1 will be withdrawn from the study after completing Week 12 and the subsequent 4-week Follow-Up visit. Period 1 Non-Responders who require protocol-prohibited rescue therapy prior to Week 12 will discontinue IMP and may return to standard of care; these participants will be encouraged to remain in the study for Safety Follow-Up through Week 12 and the Follow-Up Visit. D: Participants that relapse in Period 2 or complete Period 2 without relapse will be eligible for participation in the Long-Term Extension study.

Key selection criteria:
Adult participants diagnosed per EAN/PNS CIDP guidelines, 2021 revision

Cohort A: Randomize participants who worsen
Cohort B: Same as A
Cohort C: Randomize all

Period 1 data expected in the first half of 2024

Primary analysis only on Cohort A (IG/PLEX)

Efficacy analysis based on relapse (adjusted INCAT)

Primary endpoint: proportion of relapse events in period 2 for patients receiving Ig or PLEX at time of screening (Cohort A)

Period 2 followed by LTE; 680mg QW x 4 for period 2 relapsers

For investor audiences only

Period 1C: Randomized Treatment (12 weeks)

Two dose regimens

680mg batoclimab QW SC
340mg batoclimab QW SC

Randomization (1:1)

Randomized Treatment Responders

Placebo-controlled

340mg batoclimab QW SC
Placebo QW SC

Period 2D: Randomized Withdrawal (≤ 24 weeks)

Screening^A ≤ 28 days

Washout^B ≤ 12 weeks

Cohort A: Ig or PLEX
Cohort B: Corticosteroid
Cohort C: No treatment

Placebo QW SC

Study timeline

Week -12

Week 0

Week 12 analysis

Week 36 analysis

A: Cohorts are defined by CIDP treatment at Screening. B: Participants who fail to worsen by Week 0 will be withdrawn from the study at Week 0. C: Period 1 Non-Responders who complete Period 1 will be withdrawn from the study after completing Week 12 and the subsequent 4-week Follow-Up visit. Period 1 Non-Responders who require protocol-prohibited rescue therapy prior to Week 12 will discontinue IMP and may return to standard of care; these participants will be encouraged to remain in the study for Safety Follow-Up through Week 12 and the Follow-Up Visit. D: Participants that relapse in Period 2 or complete Period 2 without relapse will be eligible for participation in the Long-Term Extension study.

Acronyms: CIDP = Chronic Inflammatory Demyelinating Polyneuropathy; EAN/PNS = European Academy of Neurology/Peripheral Nerve Society; Ig = immunoglobulin (IVIG and SCIG) therapy; IMP = investigational medicinal product; LTE = Long-term Extension; PLEX = plasma exchange; QW = every week; Wk = weekly; SC = subcutaneously; INCAT = Inflammatory Neuropathy Cause and Treatment

For investor audiences only

78
**Caused by anti-TSHr autoantibodies which overstimulate the thyroid gland and cause hyperthyroidism; FcRn inhibition could foster degradation of those autoantibodies**

Because thyroid hormones affect many body systems, Graves’ Disease can impact many organ systems with variable symptoms per patient.

- Heart, skeletal muscle, skin, bones, eyes, liver, brain, reproductive, and GI systems may be affected.

Many patients with Graves’ Disease remain symptomatic despite maximally tolerated anti-thyroid medications; others would avoid ablation if possible.

- 1/4 to 1/3 of the 116K US incident
- Graves’ patients are difficult to control with ATD and remain symptomatic.
- 1/4 to 1/3 of 46K patients undergoing ablative procedure (radioactive iodine or surgery) may wish to avoid potential long-term risks (e.g. increased cancer, complications of thyroidectomy).

**Target population:**
- Moderate-severe symptoms not controlled with ATD (29K–38K)
- Persistent need for ATD and wish to avoid thyroid ablation (12K–15K)

**Total Addressable Incidence Population of 41K – 53K per year (US) beyond ATD**

---

The First and Only Anti-FcRn Program Targeting Graves’ Disease\textsuperscript{1,2}

<table>
<thead>
<tr>
<th>Inclusion\textsuperscript{A}</th>
<th>Treatment Period: (24 weeks)</th>
<th>Primary endpoint:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subjects with active GD as documented by presence of elevated stimulatory TSH-R-Ab</td>
<td>N = up to 40</td>
<td>Proportion of participants who achieve normalization of T3 and T4 at Week 24 with ATD dose &lt; baseline ATD dose</td>
</tr>
<tr>
<td>Subjects on an ATD for ≥12 weeks before the Screening Visit</td>
<td>Two doses tested over 24 weeks</td>
<td></td>
</tr>
<tr>
<td>Subjects hyperthyroid despite ATD</td>
<td>680mg batoclimab QW SC</td>
<td>340mg batoclimab QW SC</td>
</tr>
</tbody>
</table>

\textsuperscript{1} Based on clinicaltrial.gov database, last accessed on 3/24/2023. 2. Lane LC, et al. Endocr Rev. 2020 Dec 1;41(6):873-84

\textsuperscript{A} Additional inclusion and exclusion criteria not listed on slide

GD = Graves’ Disease; ATD = anti-thyroid medications; QW = weekly; SC = subcutaneous injection


For investor audiences only
Brepocitinib
Oral Brepocitinib Updates Since In-Licensing in 2021

Potential multi-billion dollar specialty autoimmune franchise with upcoming catalysts in 2023, 2024, and 2025

- Clinically meaningful efficacy demonstrated in Psoriasis, Alopecia, Psoriatic Arthritis, Ulcerative Colitis, Hidradenitis Suppurativa, and Crohn’s disease (new today)
- Safety in line with other JAKs

- Potential to become the leading oral therapy in SLE; dual TYK2/JAK1 inhibition to provide greater efficacy than inhibition of either alone
- Large global study designed as one of two registrational studies

- Dermatomyositis: Large orphan indication with no NCEs approved in past 60 years and no other oral therapies in late-stage development
- P3 study ongoing – data expected to read out in 2025 and be sufficient for NDA filing

- Hidradenitis Suppurativa: Phase 2 results suggest potential for better efficacy than selective JAK1 inhibitors and comparable to leading biologics
- Non-infectious uveitis: PoC data expected Q1 2024
- Potential 2024 initiation of a registrational study (eg in NIU or HS) and additional POC studies

- IP protection expected until at least 2039*
Dual TYK2/JAK1 Inhibition is Optimized For Highly Inflammatory Heterogeneous Autoimmune Diseases With Multiple Pathogenic Cytokines

JAK inhibitors have been approved in...

- **Rheumatology**: RA, PsA, AS, JIA, axSpA
- **Immuno-Dermatology**: PsO, AD, Vitiligo, Alopecia
- **IBD**: Ulcerative Colitis, Crohn’s

Disease states are driven by different combinations of cytokines, requiring inhibition of specific JAK isoforms to treat distinct indications most effectively.

Field is currently focused on single isoform inhibitors (specifically TYK2 or JAK1).

Brepocitinib was designed to target both TYK2 and JAK1.

Hypothesis: brepocitinib can provide best-in-class efficacy in indications mediated by the TYK2/JAK1 dimer and in diseases requiring broad cytokine coverage.
In Vitro Data Support Mechanistic Benefits of Dual Inhibition of TYK2 and JAK1

**Dual Hit**

Brepocitinib may be able to achieve deeper Type I IFN suppression than is possible by targeting either TYK2 or JAK1 alone.

*Figures reflect data generated from separate in vitro assays performed by Pfizer*

**Greater Coverage**

Brepocitinib may recapitulate in a single molecule the cytokine suppression profiles of both the leading TYK2 and JAK1 agents.
Clinical Experience Confirms Oral Brepocitinib is Highly Active and Able to Generate Consistent, Reproducible Clinical Benefit in TYK2- and JAK1-Driven Indications

Statistically Significant and Clinically Meaningful Results Across Every Placebo-Controlled Phase 2 Study Completed To Date

<table>
<thead>
<tr>
<th>Study Population</th>
<th>N</th>
<th>Brepocitinib Dose</th>
<th>Brepocitinib Primary Endpoint Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alopecia Areata</td>
<td>94</td>
<td>30 mg once daily</td>
<td>49.18 placebo-adjusted CFB in SALT Score at week 24 P &lt; 0.0001</td>
</tr>
<tr>
<td>Psoriatic Arthritis</td>
<td>218</td>
<td>30 mg once daily</td>
<td>23.4% placebo-adjusted ACR20 RR at week 16 P = 0.0197</td>
</tr>
<tr>
<td>Ulcerative Colitis</td>
<td>167</td>
<td>30 mg once daily</td>
<td>-2.28 placebo-adjusted CFB in Mayo Score at week 8 P = 0.0005</td>
</tr>
<tr>
<td>Plaque Psoriasis</td>
<td>212</td>
<td>30 mg once daily</td>
<td>-10.1 placebo-adjusted CFB in PASI Score at week 12 P &lt; 0.0001</td>
</tr>
<tr>
<td>Hidradenitis Suppurativa</td>
<td>100</td>
<td>45 mg once daily</td>
<td>18.7% placebo-adjusted HiSCR Rate at week 16 P = 0.0298</td>
</tr>
<tr>
<td>Crohn’s Disease</td>
<td>151</td>
<td>60 mg once daily</td>
<td>21.4% placebo-adjusted SES-CD 50 Rate at week 12 P = 0.0012</td>
</tr>
</tbody>
</table>

New: results from induction period of Phase 2 study in Crohn’s disease

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) 30 mg OD for 4 weeks followed by 30 mg OD for 20 weeks
4) One-sided p-value (pre-specified statistical analysis)
5) Brepocitinib 45 mg once daily was the only brepocitinib dose evaluated in this study
6) Brepocitinib 60 mg OD was the only brepocitinib dose evaluated in the induction period of this study

CFB: change from baseline; RR: response rate
All studies shown here were conducted by Pfizer
Brepocitinib Demonstrated Strong, Statistically Significant Results in a Phase 2 Study in Moderate-to-Severe Crohn’s Disease

Results from 12-week induction period suggest robust activity in CD

12-week Induction Period

<table>
<thead>
<tr>
<th>Screening Period</th>
<th>Brepocitinib 60 mg QD (N = 72)</th>
<th>Placebo (N = 79)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Endpoint: Endoscopic Response Rate at Week 12 (SES-CD 50)</td>
<td>33.8%</td>
<td>12.8%</td>
</tr>
<tr>
<td>Key Secondary Endpoint: Clinical Remission Rate at Week 12 (CDAI &lt;150)</td>
<td>54.3%</td>
<td>20.5%</td>
</tr>
</tbody>
</table>

Difference from placebo:

- 21.4% \(P=0.0012^2\)
- 33.5% \(P=0.0007^2\)

Inclusion Criteria

- Adults with Crohn’s disease duration of at least 3 months
- Endoscopically confirmed active disease, with SES-CD total score of ≥7 (≥4 for isolated ileal disease)
- Inadequate response or loss of response to conventional CD therapy, including corticosteroids, immunosuppressants, or biologics

Best observed clinical remission data of any drug to date in Crohn’s disease

Safety and tolerability generally consistent with prior brepocitinib studies

1) Analysis conducted only in patients with baseline CDAI ≥ 220 (N = 56/72), consistent with inclusion criteria for recent moderate-to-severe Crohn’s disease clinical trials
2) One-sided p-value (pre-specified statistical analysis)
Priovant Strategy: Indications with High Unmet Need and Tailored to Novel Mechanism of dual TYK2 / JAK1 Inhibition

Focus on indications with high unmet need and tailored to novel mechanism of dual TYK2 / JAK1 inhibition

- High morbidity or mortality: need for novel therapies that provide meaningful efficacy benefit
- Few available treatments, including no approved oral therapies
- Inhibition of both TYK2 and JAK1 required for maximal efficacy

Opportunity for brepocitinib to become a leading treatment option in large, uncrowded markets

<table>
<thead>
<tr>
<th>Lead Indications</th>
<th>DM</th>
<th>SLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biologically exquisitely suited for dual TYK2/JAK1 inhibition</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Large unmet medical need with favorable benefit/risk</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>TYK2 and/or JAK1 Clinical Proof-of-concept</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>NCEs approved in the last 60 years*</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Approved Branded Oral Drugs*</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>OVERALL OPPORTUNITY</td>
<td>HIGH</td>
<td>HIGH</td>
</tr>
</tbody>
</table>

* Excluding biosimilars and branded generics

For investor audiences only
**Dermatomyositis: Large Orphan Indication With Blockbuster Opportunity For An Efficacious Oral Therapy**

| 37,000 | Affected adult patients in the United States alone\(^1\) |
| 10-40% | Mortality at five years\(^2\) |
| 100% | Red, painful, itchy skin rash often disseminated across substantial body surface area |
| 88% | Proximal muscle weakness\(^3\), limiting activities of daily living (ADL) |
| 42% | Interstitial lung disease\(^4\), contributing to substantial morbidity |
| 0 | Other oral therapies in industry-sponsored late-stage development\(^5\) |
| 0 | NCEs approved in last 60 years |

---

1. PriovantTx estimates based on Reeder 2010, Smoyer-Tomic 2012, and claims analysis
2. Liu et al., Oncol Letters (2018)
5. Phase 3 trials or adaptive Phase 2/3 trials

---

For investor audiences only
Clinical Proof-of-Concept with Tofacitinib Suggests High Probability of Success For Brepocitinib in Ongoing Phase 3 Study

Investigator-initiated open-label study of tofacitinib in refractory dermatomyositis demonstrated activity comparable to that of IVIg, the only approved non-corticosteroid/corticotropin therapy for dermatomyositis

Clinical PoC further validated by extensive case report literature

DM pathobiology driven by both TYK2 and JAK1-mediated cytokines → expect brepocitinib to potentially demonstrate greater benefit

---

1) Paik et al. Arth Rheum (2020)
2) Aggarwal et al. NEJM (2022)
3) STIR study: median is the only statistical analysis provided; ProDERM study: mean is the only statistical analysis provided
Single Phase 3 Study Ongoing; Expected To Generate Registrational Data Required for Approval

Primary Endpoint: Total Improvement Score (TIS), a recognized myositis improvement index that served as basis of approval for IVIg in dermatomyositis

Eligible Patients
Adult subjects with active dermatomyositis who are refractory or intolerant to at least one standard-of-care therapy

Primary Endpoint
Mean Total Improvement Score (TIS) at Week 52

Secondary Endpoints
- Proportion of patients achieving moderate response (TIS40)
- Manual Muscle Testing (MMT-8)

Safety Endpoints
Incidence of treatment-emergent AEs, SAEs, AEs of special interest, clinically significant vital signs or lab abnormalities

52-week treatment period

- Brepocitinib 30 mg QD (N = 75)
- Brepocitinib 15 mg QD (N = 75)
- Placebo (N = 75)

Week 52: Primary Efficacy Assessment (Total Improvement Score)

Data expected 2025 → potentially next approved drug of any modality

For investor audiences only
SLE: Opportunity For Brepocitinib To Potentially Become Leading Oral Therapy

Need for therapy that suppresses multiple inflammatory axes underscored by heterogeneity of symptoms and large pool of refractory patients

300,000 Affected patients in the United States

50-60% Patients with moderate or severe disease

Most Common Symptoms Rash, arthritis, fatigue, hematologic abnormalities, cardiorespiratory involvement

2 New approved drugs in >20 years

Benlysta and Saphnelo have combined annual revenue >$1.5B despite modest efficacy (low teens pbo-adj delta on SRI-4)

Malar (butterfly) rash
Typical skin complication found in up to 50% of patients with SLE

Osteonecrosis of knees and shoulder
Complication of long-term OCS use in SLE

Images adapted from Kaul et al (2016)
1) Centers for Disease Control
2) Priovant SLE claims analysis
Dual TYK2/JAK1 Inhibition May Overcome Single-Agent Limitations to Treating Lupus

Multiple interconnected pathways drive SLE biology: T-cells, B-cells, and IFN signaling

- Selective TYK2s and JAK1s address certain of these pathways, but not all three

Brepocitinib is uniquely suited to address all three axes simultaneously:

- Modulate T-cell activity via IL-12/IL-23 (TYK2)
- Modulate B-cell activity via IL-6, IL-7, and IL-21 (JAK1)
- Directly suppress type I IFN signaling (TYK2 & JAK1)

Potential for brepocitinib superiority in lupus further supported by cross-trial comparisons vs. selective TYK2s and JAK1s in other indications

Figure adapted from Ganguly et al, Trends in Immunology (2017)
Both TYK2 and JAK1 Inhibition Have Been Clinically Validated in SLE, Though Room Exists for Meaningful Improvement in Efficacy

Through its novel dual TYK2/JAK1 mechanism of action, brepocitinib may be able to improve upon the efficacy shown by TYK2 or JAK1 inhibition alone, potentially stacking efficacy by combining independent axes of effect.

### Placebo-Adjusted SRI-4 Response Rate

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Phase</th>
<th>Dose</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Olumiant</td>
<td>3</td>
<td>4mg QD</td>
<td>11%</td>
</tr>
<tr>
<td>Rinvoq</td>
<td>2</td>
<td>4mg QD</td>
<td>2% (NS)</td>
</tr>
<tr>
<td>Sotyktu</td>
<td>3</td>
<td>30mg QD</td>
<td>13%</td>
</tr>
<tr>
<td>Olumiant</td>
<td></td>
<td>3mg BID</td>
<td>24%</td>
</tr>
<tr>
<td>Rinvoq</td>
<td></td>
<td>6mg BID</td>
<td>15%</td>
</tr>
<tr>
<td>Sotyktu</td>
<td></td>
<td>12mg QD</td>
<td>11%</td>
</tr>
</tbody>
</table>

Figures reflect cross-trial comparison and not results from a head-to-head study. Differences exist between trial designs and subject characteristics, and caution should be exercised when comparing data across studies.

1) Olumiant P3 data at Week 52: Morand et al, EULAR 2022 Abstract PO3079G. Results for BRAVE-II P3 study were not statistically significant
2) Rinvoq P2 data at Week 48: Merrill et al, EULAR Abstract OP0139 (2023)
3) Sotyktu P2 data at Week 32: EULAR 2022 Abstract LB0004
4) EULAR 2022 Presentation LB0004
Registrational Study in SLE: Top-Line Data Expected Q4 2023

Eligible Patients
Adult subjects with moderate to severe active lupus who are receiving a stable regimen of SOC immunosuppressive agents

Primary Endpoint
Systemic Lupus Erythematosus Responder Index change of 4 (SRI-4) at Week 52

Secondary Endpoints
- BICLA (British Isles Lupus Assessment Group Composite Lupus Assessment)
- Time to first severe flare
- Lupus Low Disease Activity State (LLDAS)
- Reduction in steroid usage
- Cutaneous Lupus Erythematosus Disease Area and Severity Index activity (CLASI-A) response

Safety Endpoints
Incidence of treatment-emergent AEs, SAEs, AEs of special interest, clinically significant vital signs or lab abnormalities

Subjects with active, moderate/severe SLE (N = 350)

- Brepocitinib 45 mg QD (N = 100)
- Brepocitinib 30 mg QD (N = 100)
- Brepocitinib 15 mg QD (N = 50)
- Placebo (N = 100)

52-week treatment period

Week 52: Primary Efficacy Assessment (SRI-4)

As study was ongoing at time of Priovant-Pfizer transaction, Pfizer remains study sponsor
Expansion Opportunities

Non-Infectious Uveitis

Hidradenitis Suppurativa
Opportunity for brepocitinib to become the first approved oral therapy for the treatment of a leading cause of blindness

Non-Infectious Uveitis: A Sight-Threatening Ocular Disease

30,000
New cases of legal blindness attributable to NIU in the US each year¹

>75,000
Patients living with non-anterior NIU in the United States¹

Most Common Symptoms
Light sensitivity, pain, redness and floaters

Etiology
Idiopathic, or secondary to systemic autoimmune diseases²

1
Approved targeted therapy (Humira)

Posterior Segment Inflammation
Diffuse areas of capillary leakage and disc hyperfluorescence

¹ Thorne et al, JAMA Ophthalmol (2016)
² De Smet et al, Prog in Ret and Eye Res (2011)
Phase 2 POC Study Designed to Provide Rapid Validation of TYK2/JAK1 Approach in NIU

Enrollment complete; topline data expected in Q1 2024

Eligible Patients
Adult subjects with active intermediate, posterior, or panuveitis

Primary Efficacy Endpoint
Proportion of subjects meeting treatment failure criteria on or after Week 6 up to Week 24

Other Endpoints
• Treatment failure rate at Week 52
• Change in best corrected visual acuity

Subjects with Active Non-Anterior NIU (N = 24)

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Duration</th>
<th>Subjects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brepocitinib 45 mg QD (N = 16)</td>
<td>24-week main treatment period</td>
<td>28-week extension period</td>
</tr>
<tr>
<td>Brepocitinib 15 mg QD (N = 8)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Week 24: Primary Efficacy Assessment (Treatment Failure)

- Phase 2 study of filgotinib confirmed therapeutic relevance of JAK1 inhibition in NIU; TYK2-mediated cytokines (IL-12/23) are also involved in pathobiology
- Success criteria for brepocitinib study: 45mg treatment failure rate of no greater than 70%*

* Assumed synthetic placebo rate of 80-90%, based on historical placebo rates, adjusted for more aggressive mandatory corticosteroid taper in brepocitinib study

For investor audiences only
Opportunity for brepocitinib to become leading oral therapy for treatment of exceptionally debilitating inflammatory skin disease

Hidradenitis Suppurativa: A Severe and Disfiguring Skin Disease

1) Estimates for moderate/severe HS only; based on Phan et al, Biomed Derm 2020
5) Thorlacius et al, J Invest Dermatol 2018

170,000
Patients living with HS in the United States

Key Symptoms
Nodule, abscess, and tunnel formation in intertriginous zones (skin folds)

Comorbidities
Metabolic syndrome, spondylarthritids, inflammatory bowel disease

>2x
Increased suicide risk for patients living with HS compared to the general population

Extensive skin involvement with tunnel formation and scarring in a Hurley Stage III (severe) patient
Dual TYK2/JAK1 Inhibition May Generate Greater Efficacy than Inhibition of JAK1 Alone

HiSCR50 Response
Cross-Study Comparisons; No Head-to-Head Data Available

Absolute and placebo-adjusted results numerically better than other oral agents and comparable to leading biologics

Results suggest that addition of TYK2 inhibition may contribute to better efficacy in HS; inhibition of Th17 (IL-23) axis in HS extensively validated by IL-17-targeting biologics (eg Cosentyx)

1) Kimball et al, EADV 2022
2) Kirby et al, EADV 2022 Poster P0004
3) Kimball et al, AAD 2023 Poster 43799
4) Primary endpoint of upadacitinib Phase 2 study was HiSCR at 12 weeks. N represents active arm only as primary statistical analyses were performed in reference to pre-specified historical placebo control (N = 259). Active arm performance at Week 16 for UPA30 was 40%.
Clear Path To Multi-Billion Dollar Specialty Autoimmune Franchise, Even Beyond SLE
Multiple Catalysts Over the Near, Intermediate and Long Term

<table>
<thead>
<tr>
<th></th>
<th>2023</th>
<th>2024</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SLE</strong></td>
<td>1st Registrational Study</td>
<td>Confirmatory Study</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Data <strong>Read Out</strong> (Q4)</td>
<td><strong>Initiated</strong></td>
<td></td>
</tr>
<tr>
<td><strong>DM</strong></td>
<td>Phase 3 Study</td>
<td>Phase 3 Data <strong>Read Out</strong> (expected to be sufficient for registration)</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Fully Enrolled</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Additional</strong></td>
<td>NIU POC Data</td>
<td>Identify additional indications uniquely suited to dual TYK2/JAK1 inhibition</td>
<td></td>
</tr>
<tr>
<td><strong>Indications</strong></td>
<td><strong>Read Out</strong> (Q1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Potential Registrational Study (eg NIU, HS) and POC Studies <strong>Initiated</strong></td>
<td>Run additional POC studies and develop new registrational data sets</td>
<td></td>
</tr>
</tbody>
</table>
RVT-2001: Potential First-in-Class Small Molecule SF3B1 Modulator for the Treatment of Transfusion-Dependent Anemia in Patients with Lower-Risk MDS

**Lower-Risk MDS is a Commercially Validated Market**
Transfusion-dependent anemia in MDS has limited treatment options

Luspatercept (Reblozyl), approved for RS+ MDS in 2020, with current run rate sales >$800M; BMS projected potential peak >$4B

**Encouraging Proof-of-Concept Data**
First-in-class potential as the only known SF3B1 modulator currently in clinical development

Compelling data in a highly refractory population

80+ subjects treated in Phase 1/2 study; generally well-tolerated

**Multipronged Strategy to Optimize RVT-2001’s Clinical Impact**
Development strategy optimizing dosing, utilizing precision medicine enrollment, and excluding certain refractory patients

Precedent suggests minimal data decay between Phase 2 and Phase 3

**Expect Fast, Well-Established Path to Potential Approval**
Conducting a robust open-label expansion of an ongoing Phase 1/2 trial

Precedent in the space is a single pivotal study with approximately 200-250 patients

**Strong Intellectual Property Position**
Composition of matter IP protection expected until 2035, before any potential patent term extensions

---

All product candidates are investigational and subject to regulatory approval.

3. Platzbecker et al., 2017; Fenaux et al., 2020; List et al., 2006; Fenaux et al., 2011
High Unmet Need for an Oral Therapy in Transfusion-Dependent Anemia in Lower-Risk MDS

Current treatment options leave significant unmet need in multiple treatment segments

- Lower-risk MDS is a chronic condition; therapy is focused on management of symptoms
- Erythropoiesis-stimulating agents (ESA) used in first line
  - Ineffective in >50% of patients, primarily used in patients with low transfusion burden and EPO levels
- Luspatercept and lenalidomide are currently approved for specific subsets of MDS patients and can have challenging toxicity profiles
  - Luspatercept is ineffective in >50% of second line patients
  - Lenalidomide is approved in patients with del(5q) lower-risk MDS, who make up roughly 10% of the population

Initial plan to target second line in SF3B1-mutated patients, with potential to expand to other spliceosome mutations and first line
SF3B1: A Target Uniquely Suited to Improving Anemia in MDS

RVT-2001 is an oral therapy for the treatment of anemia associated with lower-risk MDS that utilizes a novel mechanism to correct aberrant splicing caused by SF3B1 mutations.

Mutations in SF3B1 cause alterations in splicing of hundreds of genes and is thought to be an initiating event in MDS.

Genetic knock-in of mutant SF3B1 in mice show progressive anemia (left figure), and recapitulates the impaired erythroid differentiation observed in humans with SF3B1-mutant MDS (right figure).

Source: Figures adopted from Xu et al., Experimental Hematology (2019); Mupa et al., Leukemia (2017) and Zivot et al., Molecular Medicine (2017).
Encouraging Early Data Demonstrate RVT-2001’s Clinical Potential

Meaningful Clinical Impact in Refractory Patient Population to Date

- **RVT-2001: RBC-TI rate of >30%** in Phase 1/2 study in subset of 19 patients with lower-risk, transfusion-dependent MDS, 15 of whom had documented prior treatment with lenalidomide and/or HMAAs
  - Median duration of treatment for responders of approximately 2 years$^{1,2}$
  - **Luspatercept: 13% RBC-TI** among patients with prior lenalidomide exposure in Phase 2 trial$^{3}$
  - **Lenalidomide: 12% HI-E** among patients with prior HMA exposure in investigator-sponsored trial$^{4}$
  - RVT-2001 was generally well-tolerated in Phase 1/2 study (n=84 in patients with MDS, AML, and CMML), with the majority of events classified as Grade 1$^{1}$

Note: No head-to-head studies of RVT-2001 have been conducted

Potential for Improved Therapeutic Effect in Earlier-Line Patients

- Hemavant enrolling earlier-line patients in RVT-2001 trials, who have been more responsive in trials for other therapies to treat anemia associated with lower-risk MDS
  - Luspatercept Phase 3 trial excluded prior lenalidomide exposure following reduced RBC-TI responses in Phase 2$^{3}$
    - In a Phase 2 trial, luspatercept showed 44% RBC-TI in patients without prior lenalidomide exposure vs. 13% with prior lenalidomide exposure$^{3}$
    - In an investigator-sponsored trial of patients with lower-risk, non-del(5q) MDS, lenalidomide showed HI-E of 38% prior to HMAs vs. 12% post-HMAs$^{5}$

All product candidates are investigational and subject to regulatory approval.

RBC-TI: Red blood cell transfusion independence.

HMA: Hypomethylating agents.

AML: Acute myeloid leukemia.

CMML: Chronic myelomonocytic leukemia.

HI-E: Erythroid hematologic improvement

1. Internal unpublished interim results. Note that interim results may change following completion of the trial and may not accurately reflect the complete results of the trial
2. Steensma et al., 2021
3. Platzbecker et al., 2017
4. Zeidan et al., 2015
5. Luspatercept Phase 3 Protocol, NEJM

For investor audiences only
Trial Design Intended to Target Improved and Extended Responses

Robust signal-enhancing design can provide multiple paths to demonstrate value through potential high response rates and/or long duration either in the overall population or in genetically defined subsets

Target Genetically Defined Subpopulations

- Selectively enrolling lower-risk MDS patients with SF3B1 mutations (~30% of MDS patients)
- Expand dataset in high TMEM14C ratio subset
  - RBC-TI of 71% (5/7) among patients in RVT-2001 Phase 1/2 study with the highest levels of aberrant TMEM14C transcripts (as measured by elevated AJ/CJ ratios)
  - High ratios of aberrantly spliced TMEM14C transcripts were associated with SF3B1 mutations

Improve Dosing

- Strengthen pharmacodynamic effect by optimizing dose and schedule of RVT-2001

Minimal Data Decay

- Minimal data decay observed historically from Phase 2 to Phase 3 in precedent trials for other therapies in MDS

All product candidates are investigational and subject to regulatory approval.
AJ/CJ: Ratio of aberrant splicing junction to canonical splicing junction.
1. Malcovati et al., 2015
Phase 1/2 Ongoing with Recently Added Dose-Optimization Cohort

Key Exclusion/Inclusion Criteria:

Excluding lower-risk MDS patients with prior HMA or lenalidomide exposure

Enrolling only lower-risk MDS patients with SF3B1 mutations

Evaluating baseline expression of TMEM14C transcripts as potential biomarker predictive of response to RVT-2001

N = up to 64

Primary endpoint at 24 weeks

Oral capsule

Primary Efficacy Data: RBC transfusion independence

Study Objectives: Determine the recommended Phase 3 dose and frequency, assess safety and tolerability, inform patient selection

All product candidates are investigational and subject to regulatory approval.
Namilumab
## Namilmub: Potential First Novel Therapy for Pulmonary Sarcoidosis, a Large, Untapped Orphan Market

<table>
<thead>
<tr>
<th><strong>Pulmonary Sarcoidosis Is A Large, Untapped Orphan Market</strong></th>
<th><strong>GM-CSF Inhibition Uniquely Stops the “Bad Actor” Cell Type</strong></th>
<th><strong>Compelling Drug Properties</strong></th>
<th><strong>Robust RESOLVE-LUNG Study Underway</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>~180,000 patients in the US alone(^1)</td>
<td>Pulmonary sarcoidosis is driven by alveolar macrophages, which form the granulomas(^2)</td>
<td>Extremely potent (sub-nanomolar IC50)</td>
<td>Robust Phase 2 is underway</td>
</tr>
<tr>
<td>Characterized by the accumulation of granulomas in the lung, which cause injury and scarring</td>
<td>Alveolar macrophages are uniquely driven by GM-CSF(^3)</td>
<td>Fully human monoclonal antibody</td>
<td>Could count as a registrational study if successful</td>
</tr>
<tr>
<td>Leads to declining pulmonary function, dyspnea, fatigue, cough, pain, and death</td>
<td></td>
<td>Dosed subcutaneously, designed for high patient convenience*</td>
<td>Clinical study design incorporates lessons learned from previous trials</td>
</tr>
<tr>
<td><strong>No modern approved agents; systemic corticosteroids are the mainstay, and other immunosuppressives are used off-label</strong></td>
<td></td>
<td>Existing safety database of over 300 patients to date(^4)</td>
<td></td>
</tr>
</tbody>
</table>

---


All product candidates are investigational and subject to regulatory approval. *Namilumab is being developed with potentially the least frequent dosing schedule among subcutaneous anti-GM-CSFs in Phase 2 clinical trials, with a single dose every four weeks after an initial loading period.*
Pulmonary Sarcoidosis is a Large, Untapped Orphan Market

A well-tolerated and effective, steroid-sparing therapy for sarcoidosis has blockbuster commercial potential

\[ \sim 180,000 \text{ patients in the US alone} \]

Characterized by the accumulation of granulomas – compact, centrally organized collections of macrophages and epithelioid cells encircled by lymphocytes – in the lungs, which causes injury and scarring.

Clinical consequences:
- Declining pulmonary function
- Dyspnea, fatigue, cough, and pain
- Death

For investor audiences only
GM-CSF Inhibition Uniquely Stops the “Bad Actor” Cell Type: Alveolar Macrophages

Pulmonary sarcoidosis is an autoimmune condition driven by alveolar macrophages

Alveolar macrophages are uniquely driven by GM-CSF signaling

Alveolar macrophages contribute to a cytokine feedback loop with other myeloid and lymphoid cells secreting additional GM-CSF and other inflammatory cytokines

Alveolar macrophages then form noncaseating granulomas in the lungs

Granulomas and related tissue injury (e.g., lung fibrosis) are features of – and cause the disease consequences of – pulmonary sarcoidosis¹

RESOLVE-Lung: Phase 2 Pulmonary Sarcoidosis Study Could Serve as a Registrational Study if Successful

Primary Endpoint
Proportion of subjects requiring rescue for worsening of sarcoidosis

Key Secondary Endpoints
- Change from baseline in ppFVC
- Time to rescue treatment
- Proportion of subjects successfully achieving OCS taper without rescue
- Change from baseline in the KSQ Lung domain score

Screening Period
- RDBPC, 2-arm study in ~100 moderate-severe chronic pulmonary sarcoidosis patients
- 50 sites in 7 countries: US, UK, France, Netherlands, Belgium, Germany, & Turkey
- 26-weeks double-blind treatment period followed by 26-weeks open-label extension

Double-Blind Treatment Period
- Namilumab 150 mg (n = 50)
- Placebo (n = 50)

Open-label Extension Period
- Namilumab 150 mg

Follow-up
- Follow-up period (14 weeks after EOT, 18 weeks after last dose)

Study Week
- Baseline 2  6  10  14  18  22  26  30  34  38  42  46  50  54  58  62  68

1. Rescue defined as inability to adhere to taper protocol or need to increase/add OCS and/or add IST

For investor audiences only
LNP Patent Litigation
Genevant is a Leading Nucleic Acid Delivery Solutions Company

- Genevant was formed in 2018 by Roivant and Arbutus and licensed Arbutus’s LNP technology and patent portfolio
- Deep expertise in delivery systems for mRNA and other nucleic acids
- Without adequate protection, nucleic acids degrade quickly in the body before accessing their target cells – long known to be a significant obstacle to accessing their therapeutic potential
- Many years ago, a team of research scientists at an Arbutus predecessor company began to take on this challenge
  - Years of effort led to the innovative solution — tiny particles made of four carefully selected lipid types, now commonly known as lipid nanoparticles or LNP
  - Genevant’s technology became the first LNP to be included in an FDA-approved RNA product in 2018, Alnylam’s Onpattro® developed under LNP license from Arbutus
- Today, LNPs have emerged as the primary means for delivering the industry’s mRNA pipeline, as well as a key delivery approach for gene editing
- Core members of the team behind the early LNPs now lead Genevant’s R&D efforts, collaborating with leading companies to develop innovative nucleic acid medicines
Genevant Collaborates with Leading Companies for Access to its LNP Technology to Develop Medicines for a Variety of Diseases and Disorders, Including COVID-19

<table>
<thead>
<tr>
<th>Collaboration Partner</th>
<th>LNP Collaborations Outside of COVID-19</th>
<th>Publicly Disclosed Financials*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-amplifying RNA (samRNA) COVID-19 vaccine program</strong> ⁸</td>
<td>Royalty rate: mid-single to mid-double digits †</td>
<td>Near-term: $50M + significant milestones</td>
</tr>
<tr>
<td><strong>mRNA COVID-19 vaccine program in specified Asian countries</strong> ⁹</td>
<td>Royalty rate: 8%</td>
<td>Upfront and milestones: $133.75M</td>
</tr>
<tr>
<td><strong>mRNA COVID-19 vaccine program</strong></td>
<td>Undisclosed</td>
<td></td>
</tr>
<tr>
<td><strong>mRNA COVID-19 vaccine program in specified Asian countries</strong></td>
<td>Undisclosed</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Collaboration Partner</th>
<th>LNP Collaborations for COVID-19</th>
<th>Publicly Disclosed Financials*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-amplifying RNA (samRNA) COVID-19 vaccine program</strong> ⁸</td>
<td>Royalty rate: mid-single to mid-double digits †</td>
<td>Upfront and milestones: $192M/product</td>
</tr>
</tbody>
</table>

*Includes publicly disclosed terms only and therefore does not reflect all payments that may be applicable and received by Genevant (e.g., reimbursements for FTE support, field expansion fees, etc.). All potential payments are contingent upon achievement of specified milestones. †Depending on the circumstances.

Self-amplifying RNA (samRNA) COVID-19 vaccine program
Royalty rate: mid-single to mid-double digits
Near-term: $50M + significant milestones
Upfront and milestones: $600M
Upfront and milestones: $303M
Royalty rate: mid-single digits†
Upfront and near-term option: $10M + milestones
Royalty rate: mid to high-single digits†
Option exercise fee: single-digit millions
Milestones: $136M/product
Milestones and royalties (amounts undisclosed); 50:50 on co-development programs
Royalty rate: low to mid-single digits†
Upfront and milestones: $73M
Royalty rate: mid-single digits†
Upfront and milestones: $50M + significant milestones
Royalty rate: mid-single digits†
Upfront and milestones: $600M
Royalty rate: undisclosed
Upfront and milestones: $303M
Royalty rate: undisclosed
Upfront and milestones: $303M
Royalty rate: mid-single digits†
Upfront and near-term option: $10M + milestones
Royalty rate: mid to high-single digits†
Option exercise fee: single-digit millions
Milestones: $136M/product
Milestones and royalties (amounts undisclosed); 50:50 on co-development programs
Royalty rate: low to mid-single digits†
Upfront and milestones: $73M
Royalty rate: mid-single digits†
Upfront and near-term option: $10M + milestones
Royalty rate: mid to high-single digits†
Option exercise fee: single-digit millions
Milestones: $136M/product
Milestones and royalties (amounts undisclosed); 50:50 on co-development programs
Royalty rate: mid-single to mid-double digits †
Upfront and milestones: $192M/product
Royalty rate: 8%
Upfront and milestones: $133.75M
Undisclosed
Undisclosed

Updates on Genevant IP Litigation

• In February 2022, Genevant and Arbutus jointly filed a complaint against Moderna in the US District Court for the District of Delaware asserting infringement of six patents

• On November 2, the federal district court in Delaware issued an opinion and order denying Moderna’s partial motion to dismiss the suit based on the government-contractor defense under 28 U.S.C 1498, which was an attempt by Moderna to shift liability for an unspecified portion of its alleged infringement to the US government and taxpayers

• On February 14, the United States Government filed a Statement of Interest in which it urged the court to rule that the government-contractor defense applied to shield Moderna from liability for patent infringement related to the first vaccine contract with the Government and force Genevant and Arbutus to assert infringement claims based on that contract against the Government in the Court of Claims

• On March 10, the court issued a memorandum opinion in which it reaffirmed the analysis and conclusions in its November 2 opinion and order and refused to grant Moderna’s partial motion to dismiss

• On March 21, the court entered a formal scheduling order for pre-trial activities but did not set a trial date and discovery is now ongoing

• On April 4, Genevant and Arbutus jointly filed a complaint against Pfizer and BioNTech in the U.S. District Court for the District of New Jersey asserting infringement of five patents
VantAI Positioned to Unlock the Potential of Induced Proximity

Targeted protein degradation is just the beginning...

• Many more fields to come beyond degradation (e.g., induced phosphorylation, induced glycosylation, etc.)

• All induced proximity (current and future) relies on protein-protein interaction

• AI is well-suited to solve the combinatorial challenges presented by three-body problems (protein-molecule-protein)

• Challenging disease targets necessitate approaches beyond inhibition

VantAI has positioned itself at the intersection of three transformative technologies...

Unique proprietary data

Largest known protein interface structure database

Interface structure data generation at unprecedented speed & scale

All star team & scientific leadership

Including Michael Bronstein, VantAI Chief Scientist

Trusted

>15 partnerships

Validated

Multiple preclinical milestones hit

Multiple biopharma deal expansions

VantAI has positioned itself at the intersection of three transformative technologies...
Thank you.