Forward-Looking Statements

This presentation includes forward-looking statements that are subject to substantial risks and uncertainties that could cause actual results to differ materially from those expressed or implied by such statements. All statements other than statements of historical facts contained in this presentation, including statements regarding our future results of operations and financial position, business strategy, 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 and (ii) the ADORING 1 and ADORING 2 topline study results, 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 interim data presented here from the induction period of the TUSCANY-2 study are based on an interim 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.

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, results and attributes for each of RVT-3101 and 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 age 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: Redefining “Big Pharma” from End to End

Roivant Edge

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

➢ Technology boosts all aspects of commercialization, development, and discovery

Clinical and Regulatory Achievements

VTAMA (tapinarof) approved May 2022 – our first wholly-owned commercial launch

6 FDA approvals from Vants launched by Roivant

10 consecutive positive Phase 3 trials

1. FDA approval and trial figures include Vants transferred to Sumitomo Pharma in December 2019.
Roivant’s Potential Blockbuster Launch Ongoing and Further Growth Supported by Broad Pipeline, Discovery Engine, and Strong Capital Position

1. VTAMA has only received FDA approval for psoriasis, not atopic dermatitis.
2. As of December 31, 2022, we had cash, cash equivalents and restricted cash of approximately $1.5 billion. Giving effect to Roivant’s February 2023 follow-on offering for $250 million in gross proceeds and $114.6 million in proceeds received from the sale of the Myovant top-up shares in connection with the acquisition of Myovant by Sumitomo Pharma, Roivant’s consolidated cash, cash equivalents and restricted cash would have been approximately $1.9 billion. Runway includes proceeds from Roivant follow-on, proceeds received from the sale of Myovant top-up shares, and the continuation of our cost optimization and pipeline reprioritization initiatives initially announced in June 2022.
2023: Roivant’s Biggest Year Yet

Expanded VTAMA Coverage and Reach
Ongoing

ADORING 1 and 2 - Positive VTAMA Phase 3 Readouts in AD
sNDA Submission Expected 1Q 2024

RVT-3101 (Anti-TL1A) UC Phase 2b Data
1H 2023

IMVT-1402 (Next-Gen Anti-FcRn) Human Data
Initial Phase 1 Results Expected Aug/Sep 2023

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

Ongoing coverage expansion expected to increase net yield and add revenue

Positive results pave the way to atopic dermatitis market, which is ~4x the size of psoriasis market

Positive final data from global Phase 2b would validate best-in-class potential

Two potentially best-in-class anti-FcRn antibodies with deeper IgG reduction and simple subQ dosing give flexibility to maximize value across indications

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

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Indication</th>
<th>Modality</th>
<th>Preclinical</th>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
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<td>Topical</td>
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<td>BREPOCITINIB</td>
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<td>BATOCILIMAB</td>
<td>Myasthenia Gravis</td>
<td>Immunovant</td>
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<td>Sarcoidosis</td>
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<td>RVT-2001</td>
<td>Transfusion-Dependent Anemia in Patients with Lower-Risk MDS</td>
<td>Hemavant</td>
<td>Small Molecule</td>
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</tbody>
</table>

*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.*

► Represents registrational or potentially registrational trials
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
# Rich Catalyst Calendar Through 2025

<table>
<thead>
<tr>
<th>Program</th>
<th>Vant</th>
<th>Catalyst</th>
<th>Expected Timing</th>
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<tr>
<td>VTAMA (tapinarof) cream</td>
<td></td>
<td>Updates on commercial launch of VTAMA in psoriasis</td>
<td>Ongoing</td>
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<tr>
<td>Roivant pipeline growth</td>
<td></td>
<td>New mid/late-stage in-licensing announcements</td>
<td>Ongoing</td>
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<td>LNP platform</td>
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<td>Updates to LNP patent litigation</td>
<td>Ongoing</td>
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<td>Roivant Discovery</td>
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<td>Updates on discovery programs and technology</td>
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<td>RVT-3101</td>
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<td>Final data from Phase 2B trial in ulcerative colitis</td>
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<td>IMVT-1402</td>
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<td>Initial data from Phase 1 trial (SAD results)</td>
<td>Aug/Sep 2023</td>
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<td>IMVT-1402</td>
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<td>Initial data from Phase 1 trial (MAD results)</td>
<td>Oct/Nov 2023</td>
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<td>Brepocitinib</td>
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<td>Topline data from potentially registrational Phase 2B trial in systemic lupus erythematosus</td>
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<td>Batoclimab</td>
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<td>Initial data from Phase 2 trial in Graves’ disease</td>
<td>4Q 2023</td>
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<td>Data from RVT-2001 Phase 1/2 trial in lower-risk myelodysplastic syndrome</td>
<td>2H 2023</td>
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<tr>
<td>VTAMA (tapinarof) cream</td>
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<td>Expected sNDA filing for VTAMA in atopic dermatitis</td>
<td>1Q 2023</td>
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<td>Batoclimab</td>
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<td>Initial data from pivotal Phase 2B trial in chronic inflammatory demyelinating polyneuropathy</td>
<td>1H 2024</td>
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<td>Batoclimab</td>
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<td>Topline data from Phase 3 trial in myasthenia gravis</td>
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<td>Batoclimab</td>
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<td>Topline data from Phase 3 trials in thyroid eye disease</td>
<td>1H 2025</td>
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<tr>
<td>Brepocitinib</td>
<td></td>
<td>Topline data from Phase 3 trial in dermatomyositis</td>
<td>2025</td>
</tr>
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</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.
Commercial Launch of VTAMA® Cream
VTAMA is Charting a Path to Become a Potential Blockbuster Topical in Both Psoriasis and Atopic Dermatitis

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.

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 Leads the Other Branded Topicals in Weekly TRx

Over 145,000 VTAMA prescriptions written by approximately 10,000 unique prescribers since launch

PsO Branded Topical Market – Weekly TRxs

Weekly TRx

Source: IQVIA National Prescription Audit (NPA). March 2023 weekly TRx numbers reflect IMS restatement.
VTAMA’s Growth Continues to Progress with GTN Yield Closely Tracking Precedent Launch

- 18% net yield for quarter ended Dec. 31, 2022, up from 12% in prior quarter
- $9.2M net product revenue for quarter ended Dec. 31, 2022, up from $5.0M in prior quarter
- Patient demand has continued to be impressive; demand has a positive impact on ongoing conversations with payers

Near doubling of revenue shows strong patient demand and good payer progress
60%+ Commercial Coverage Achieved Within 9 Months of Launch

Innovation and TRx performance driving accelerated coverage

✓ 1 National PBM Formulary Addition
✓ 2 National Health Plan Formulary Additions
✓ 1 Regional PBM Formulary Addition
✓ 8 Blue Cross Blue Shield Plan Formulary Additions
✓ 1 National PBM lifts NTMB Ahead of Review

>100M

Commercial Lives Covered
(>60% of Total)

Sources: MMIT and Clarivate | DRG March 9, 2023
VTAMA Payer Update – A Premium Product Driving Quality Access

Multiple factors have driven market access progress including strong patient and physician demand, payer judgment regarding fundamental clinical value, and overall prescription volume

• Representative coverage details include:
  • One major PBM lifted the NTMB and requires a single step edit through a topical steroid or topical vitamin D analog
  • One major PBM added VTAMA to formulary and requires a step edit through two of the following: a topical steroid, vitamin D, or combination topical steroid/vitamin D
  • One regional PBM added VTAMA to formulary with no restrictions/edits/steps
  • Two national health plans cover VTAMA with a step through any two of the four most common topical therapies
  • Multiple regional plans cover VTAMA as either unrestricted or with a simple topical steroid look back
  • Coverage at parity or better than topical competitors

Update as of 2/13/2023
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

<table>
<thead>
<tr>
<th></th>
<th>Psoriasis</th>
<th>Atopic Dermatitis</th>
<th>Total</th>
<th>Total</th>
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<tr>
<td></td>
<td>VTAMA approved indication2</td>
<td>Positive Phase 3 Readouts</td>
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<tr>
<td>Topicals</td>
<td>VTAMA</td>
<td>Systemics</td>
<td>Total</td>
<td>Topicals</td>
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<td></td>
<td>4,956</td>
<td>56,220</td>
<td>151,290</td>
<td>313,586</td>
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<tr>
<td>Systemics</td>
<td>90,114</td>
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<tr>
<td>Total</td>
<td>100,000</td>
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</table>

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)

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

**Broad Target Population and Use Cases**
- Mild, moderate & severe plaque psoriasis
-May be applied to all affected skin areas

**Differentiated Clinical Efficacy**
- 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>
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<tr>
<th>Remittive Off-Treatment Benefit Data</th>
<th>Non-Steroidal Topicals</th>
<th>Systemics</th>
<th>Topical Steroids</th>
<th>Steroid Combinations</th>
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<tr>
<td>VTAMA (EpsilonRt cream %)</td>
<td>VTAMA® (Topical)</td>
<td>OTEZLA® (Oral)</td>
<td>HUMIRA® (Subcutaneous)</td>
<td>SOTYKTU® (Oral)</td>
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<td>Remittive Off-Treatment Benefit Data</td>
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<td>×</td>
<td>∼</td>
<td>✓</td>
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<tr>
<td>No Duration Limitations</td>
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<tr>
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</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 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.

For investor audiences only
6x Treatment Success Rate vs. Vehicle at Week 12, With Significant Efficacy Seen as Early as Week 4

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

PATOING 1
- VTAMA cream (n=340)
- Vehicle QD (n=170)

PATOING 2
- VTAMA cream (n=343)
- Vehicle QD (n=172)

~40% of VTAMA cream patients achieved PGA treatment success vs ~ 6% of vehicle patients at week 12

~80% of VTAMA cream patients achieved a ≥1-grade PGA improvement at week 12 vs ~35% of patients on vehicle

*P=0.0012; †P<0.0001
*P=0.0014; †P<0.0001

PGAs: Physician Global Assessment; QD, once daily
2. Dermavant DOF [DMVT-505-3001 CSR; October 2020].
3. Dermavant DOF [DMVT-505-3002 CSR; October 2020].

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

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.

**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

For investor audiences only.

PGAD and PASI are global efficacy assessments. Example of one representative target lesion of a patient treated with tapinarof cream 1% OD 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; OD, once daily.

$1,325 Launch WAC Designed To Optimize Launch Velocity and Life-Cycle Asset Value

**Topical WAC Price Landscape**

- **Opzelura** (ruxolitinib) cream 1.5%
  - $1,500 - $2,000

- **VTAMA** (tapinarof) cream 1%
  - $1,300 - $1,500
  - ($1,325)

- **Enstilar**
  - $900 - $1,300

- **eucrisa**
  - $500 - $900

- **BRYHALI**
  - $100 - $500

- **Generic Tier**

---

**Rationale for VTAMA Cream WAC Price**

- **VTAMA** is 1st topical NCE approved in PsO in 25 years
- Reflects novel mechanism and differentiated profile with **strongest on-label remittive effect** for a topical
- Positions VTAMA as valuable to both rebate- and WAC-sensitive health plans
- May delay the path to expensive systemic therapies

---

**Accelerates Launch Velocity & Enables Broad Adoption**

All trademarks are property of their respective owners. Based on RedBook drug pricing database, extracted May 2022. WAC prices based on 60g tubes, except for Duobrii, which is based on 100g tube. * WAC price for Atopic Dermatitis

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

---

* *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>
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</thead>
<tbody>
<tr>
<td></td>
<td>VTAMA 1% QD (n=270)</td>
<td>Vehicle QD (n=137)</td>
</tr>
<tr>
<td>Age, mean (SD)</td>
<td>15.6 (16.62)</td>
<td>15.6 (16.49)</td>
</tr>
<tr>
<td>Age group, n (%)</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>Male, n (%)</td>
<td>130 (48.1)</td>
<td>66 (48.2)</td>
</tr>
<tr>
<td>Weight, kg, mean (SD)</td>
<td>46.69 (27.25)</td>
<td>47.69 (27.725)</td>
</tr>
<tr>
<td>BMI, kg/m², mean (SD)</td>
<td>21.38 (6.307)</td>
<td>22.06 (6.557)</td>
</tr>
<tr>
<td>vIGA-ADTM, n (%)</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>EASI, mean (SD)</td>
<td>12.24 (5.007)</td>
<td>12.86 (5.633)</td>
</tr>
<tr>
<td>BSA affected (%), mean (SD)</td>
<td>16.45 (8.666)</td>
<td>17.71 (9.500)</td>
</tr>
<tr>
<td>PP-NRS (all), mean (SD)</td>
<td>6.8 (2.33)</td>
<td>6.5 (2.39)</td>
</tr>
<tr>
<td>PP-NRS (≥12 years), mean (SD)</td>
<td>6.5 (2.40)</td>
<td>6.3 (2.31)</td>
</tr>
<tr>
<td>PP-NRS (&lt;12 years), mean (SD)</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
ADORING 1 and 2 vIGA-AD™ Score of 0 or 1 and at Least a ≥2-grade Improvement from Baseline at Week 8 (ITT)

ADORING 1

vIGA-AD™ Score of 0 or 1 and at Least a ≥2-grade Improvement from Baseline at Week 8 (ITT)

Δ 31.5%

P<0.0001

45.4%

13.9%

VTAMA 1% QD (n=270)

Vehicle QD (n=137)

MEAN TREATMENT SUCCESS, % (SE)

Δ 28.5%

P<0.0001

46.4%

18.0%

VTAMA 1% QD (n=271)

Vehicle QD (n=135)

MEAN TREATMENT SUCCESS, % (SE)

Robust efficacy demonstrated by magnitude of vIGA-AD™ treatment success*

vIGA-AD™ score of 0 or 1 and at least a ≥2-grade improvement from baseline. P-value based upon Cochran-Mantel-Haenszel analysis stratified by baseline vIGA-AD™ score and age group. ITT, intention-to-treat; QD, once daily; SE, standard error; vIGA-AD™, Validated Investigator Global Assessment for Atopic Dermatitis™. Source: 14.2.1.1.
ADORING 1 and 2 EASI75 From Baseline at Week 8 (ITT)

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).
ADORING 1 and 2 Improvement in PP-NRS of ≥4 Points* at Week 8 (Patients ≥12 Years) (ITT)

**ADORING 1**

Improvement in PP-NRS of ≥4 Points* at Week 8 (Patients ≥12 Years) (ITT)

![Graph showing mean PP-NRS response rate](image)

Δ 21.6%

P = 0.0366

55.8%

34.2%

VTAMA 1% QD (n=103)  
Vehicle QD (n=54)

**ADORING 2**

Improvement in PP-NRS of ≥4 Points* at Week 8 (Patients ≥12 Years) (ITT)

![Graph showing mean PP-NRS response rate](image)

Δ 28.7%

P = 0.0015

52.8%

24.1%

VTAMA 1% QD (n=126)  
Vehicle QD (n=64)

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)

*Patients with baseline PP-NRS score ≥4 who achieve ≥4-point reduction in the PP-NRS from baseline. P-value based upon Cochran-Mantel-Haenszel analysis stratified by baseline vIGA-AD™ score and age group, ITT, intention-to-treat; PP-NRS, Peak Pruritus Numeric Rating Scale; QD, once daily; SE, standard error; vIGA-AD™, Validated Investigator Global Assessment for Atopic Dermatitis™. Source: 14.2.2.4.1.
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

- 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

<table>
<thead>
<tr>
<th>Patients, n (%)</th>
<th>VTAMA 1% QD (n=270)</th>
<th>Vehicle QD (n=137)</th>
<th>VTAMA 1% QD (n=271)</th>
<th>Vehicle QD (n=133)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adverse events of special interest (treatment emergent)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact dermatitis</td>
<td>4 (1.5)</td>
<td>3 (2.2)</td>
<td>3 (1.1)</td>
<td>2 (1.5)</td>
</tr>
<tr>
<td>Follicular event</td>
<td>27 (10.0)</td>
<td>1 (0.7)</td>
<td>24 (8.9)</td>
<td>2 (1.5)</td>
</tr>
<tr>
<td>Headache</td>
<td>19 (7.0)</td>
<td>3 (2.2)</td>
<td>4 (1.5)</td>
<td>0</td>
</tr>
<tr>
<td>TEAE leading to treatment discontinuation</td>
<td>6 (2.2)</td>
<td>6 (4.4)</td>
<td>4 (1.5)</td>
<td>5 (3.8)</td>
</tr>
<tr>
<td>TEAE leading to study discontinuation</td>
<td>5 (1.9)</td>
<td>5 (3.6)</td>
<td>4 (1.5)</td>
<td>4 (3.0)</td>
</tr>
</tbody>
</table>

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

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>Study Characteristics</th>
<th>VTAMA (tapinarof)</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>
<td>Dupixent®</td>
</tr>
<tr>
<td>Studied in Subjects with AD Down to 2 Years Old</td>
<td>✔️</td>
<td>✗</td>
<td>✗</td>
<td>✔️</td>
</tr>
<tr>
<td>Studied in Moderate to Severe AD</td>
<td>✔️</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Once Daily Dosing</td>
<td>✔️</td>
<td>✗</td>
<td>✔️</td>
<td>✗</td>
</tr>
<tr>
<td>Little to No Systemic Absorption</td>
<td>✔️</td>
<td>✗</td>
<td>✔️</td>
<td>✗</td>
</tr>
<tr>
<td>&gt;45% of Patients Achieved vIGA-AD™ Success</td>
<td>✔️</td>
<td>✔️</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>&gt;55% of Patients Achieved EASI75†</td>
<td>✔️</td>
<td>✔️</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>&gt;50% 4-point Reduction in Itch†</td>
<td>✔️</td>
<td>✔️</td>
<td>✗</td>
<td>✗</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.

RVT-3101: A Phase 3-Ready Anti-TL1A Antibody for Ulcerative Colitis, Crohn’s Disease and Other Indications

Statistically Significant and Clinically Meaningful Effects Seen in UC Phase 2b

- High-end efficacy in all-comers population, statistically significant and clinically meaningful benefit at all doses tested
- Response rates enriched in patients positive for a prospectively defined biomarker (~60% of UC patients)
- Favorable safety and tolerability profile

Large and Well-Validated Market Opportunity

- Both ulcerative colitis and Crohn’s disease are large, well-validated commercial markets
- Additional value creation potential expected outside of IBD

RVT-3101 is First-in-class with Large Data Set in Hand

- Robust dose ranging work to date: ~300 patients across four dose arms and two studies (including with SQ formulation)
- Efficient Phase 3 program planned with clearly defined path to approval

Additional Near-Term Catalyst

- Final UC Phase 2b data (TUSCANY-2) expected 1H 2023

Strong Intellectual Property Position

- Composition of matter IP protection until 2039+ (including extensions)
- Biologic confers 12 years of regulatory exclusivity following approval
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

2021 US Sales in IBD ($B)

- Entyvio (Integrin Inhibitor)
- Humira (Anti-TNF)
- Stelara (Anti-IL-12/23)

Recently approved in UC (Oct 2019)
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, Asthma, AS, PsO, SLE
- 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
- ↓ IL-12Rβ
- ↑ IL-13
- ↓ IL-13
- ↓ IL-5
- ↑ IL-6
- ↓ MMP7 & MMP10
- Fibroblast # reduction

Figure adapted from Aiba et al., Mediators of Inflammation (2013); Hassan-Zahraee et al, Inflammatory Bowel Disease (2022)
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 (2021)

For investor audiences only
TUSCANY-2 Phase 2b Study Design (N = 245)

Screening Period

Induction Period
(12 weeks of dosing, no loading dose)
- Placebo
- 50mg, SQ, Monthly
- 150mg, SQ, Monthly
- 450mg, SQ, Monthly

Chronic Period
(40 additional weeks of dosing)
- 50mg, 150mg, and 450mg dose levels
  SQ, Monthly

Study Outcomes

Primary Endpoints
- Clinical Remission (Induction Period, at Week 14)
- Safety

Secondary Endpoints
- Clinical Remission (Chronic Period, at Week 56)
- Endoscopic Assessments

Key Additional Efficacy Analyses
- Biomarker Status
- Prior Biologic Experience

For investor audiences only
Subject Disposition in Induction Period

Randomized
N = 246

Randomized and Treated (ITT)
N = 245

Placebo, N = 45

Discontinued treatment, N = 5 (11.1%)
Primary Reason:
  - Adverse Event, N = 3 (6.7%)
  - Lack of Efficacy, N = 0 (0%)
  - Physician Decision, N = 0 (0%)
  - Protocol Deviation, N = 0 (0%)
  - Withdrawal by Subject, N = 2 (4.4%)

Completed, N = 40 (88.9%)

RVT-3101, N = 200*

Discontinued treatment, N = 11 (5.5%)
Primary Reason:
  - Adverse Event, N = 2 (1.0%)
  - Lack of Efficacy, N = 2 (1.0%)
  - Physician Decision, N = 2 (1.0%)
  - Protocol Deviation, N = 1 (0.5%)
  - Withdrawal by Subject, N = 4 (2.0%)

Completed, N = 188 (94.0%)

* All RVT-3101 dose arms arm are comprised of patient populations larger than the placebo group
Baseline Demographics and Disease Characteristics

Baseline characteristics are consistent with a refractory and difficult-to-treat patient population (42% were previously treated with ≥1 advanced therapy and 14% with ≥3 advanced therapies)

<table>
<thead>
<tr>
<th></th>
<th>Placebo N = 45</th>
<th>Pooled Drug N = 200</th>
<th>Expected Ph3 Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years, mean)</td>
<td>39.9</td>
<td>40.9</td>
<td>41.6</td>
</tr>
<tr>
<td>Female</td>
<td>47%</td>
<td>39%</td>
<td>40%</td>
</tr>
<tr>
<td>Weight (kg, mean)</td>
<td>70.0</td>
<td>71.5</td>
<td>72.3</td>
</tr>
<tr>
<td>Geographic Region</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>US / Canada / Australia</td>
<td>11%</td>
<td>12%</td>
<td>16%</td>
</tr>
<tr>
<td>EU</td>
<td>56%</td>
<td>66%</td>
<td>59%</td>
</tr>
<tr>
<td>Asia</td>
<td>29%</td>
<td>18%</td>
<td>19%</td>
</tr>
<tr>
<td>Other</td>
<td>4%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Duration of disease (years, mean)</td>
<td>7.6</td>
<td>7.3</td>
<td>7.5</td>
</tr>
<tr>
<td>Extent of Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proctosigmoiditis</td>
<td>24%</td>
<td>27%</td>
<td>23%</td>
</tr>
<tr>
<td>Left-sided colitis</td>
<td>33%</td>
<td>46%</td>
<td>38%</td>
</tr>
<tr>
<td>Pancolitis</td>
<td>42%</td>
<td>39%</td>
<td>42%</td>
</tr>
<tr>
<td>Partial Mayo Score (mean)</td>
<td>6.4</td>
<td>6.5</td>
<td>6.8</td>
</tr>
<tr>
<td>Endoscopy Score</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>49%</td>
<td>48%</td>
<td>48%</td>
</tr>
<tr>
<td>3</td>
<td>51%</td>
<td>53%</td>
<td>52%</td>
</tr>
<tr>
<td>Concomitant corticosteroid use</td>
<td>20%</td>
<td>39%</td>
<td>41%</td>
</tr>
<tr>
<td>Number of prior advanced therapies exposed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Naive</td>
<td>58%</td>
<td>58%</td>
<td>55%</td>
</tr>
<tr>
<td>1 prior advanced therapy</td>
<td>18%</td>
<td>17%</td>
<td>15%</td>
</tr>
<tr>
<td>2 prior advanced therapies</td>
<td>9%</td>
<td>12%</td>
<td>18%</td>
</tr>
<tr>
<td>≥3 prior advanced therapies</td>
<td>16%</td>
<td>14%</td>
<td>12%</td>
</tr>
</tbody>
</table>

Baseline characteristics are consistent with a refractory and difficult-to-treat patient population (42% were previously treated with ≥1 advanced therapy and 14% with ≥3 advanced therapies).
RVT-3101 Shows Consistent Effect Across Endpoints and Patient Populations

Results were statistically significant for pooled drug and at each individual dose tested

Clinical Remission (Modified Mayo)

- **Pbo-adj Δ = 21%**
  - p = 0.01

- **Pbo-adj Δ = 27%**
  - p = 0.02

Endoscopic Improvement

- **Pbo-adj Δ = 41%**
  - p = 0.002

- In ~20% of patients across the study, biomarker was not analyzed due to lack of consent at specific sites
- Among patients for whom biomarker status was analyzed, biomarker positive or negative status was determined in 100% of patients
- One-sided p-value of difference of proportions were computed using Chan And Zhang (1999) method, in accordance with Pfizer prespecified statistical analysis plan. Statistical significance considered to be a p-value ≤ 0.025. Values that are not significant are marked “NS”
- Placebo-adjusted delta values may not exactly match the difference between gross and placebo values due to rounding.

For investor audiences only
Expected Phase 3 Dose Shows Clinically Meaningful Improvements in Biomarker Positive Patients Beyond Those Seen in the Overall Population

Clinical Remission (Modified Mayo)

- **All-Comers Expected P3 Dose**
  - RVT-3101: 31%
  - Placebo: 12%
  - Pbo-adj Δ = 20%
  - p = 0.01

- **Biomarker Positive Expected P3 Dose**
  - RVT-3101: 40%
  - Placebo: 10%
  - Pbo-adj Δ = 30%
  - p = 0.02

Endoscopic Improvement

- **All-Comers Expected P3 Dose**
  - RVT-3101: 40%
  - Placebo: 19%
  - Pbo-adj Δ = 22%
  - p = 0.01

- **Biomarker Positive Expected P3 Dose**
  - RVT-3101: 56%
  - Placebo: 10%
  - Pbo-adj Δ = 46%
  - p = 0.0005

For investor audiences only
Consistent Data Supports Highly Compelling Clinical Activity for TL1A Class

Clinical Remission (Modified Mayo)

- **All-Comers Expected P3 Dose**
  - RVT-3101: 31%
  - Placebo: 12%
  - Comparator: 10%
  - Placebo: 5%

- **Biomarker Positive Expected P3 Dose**
  - RVT-3101: 26%
  - Placebo: 19%
  - Comparator: 10%
  - Placebo: 6%

- **PRA023**
  - RVT-3101: 7%
  - Placebo: 1%

- Pbo-adj Δ = 30%
  - P = 0.02

- Pbo-adj Δ = 25%
  - P = 0.01

- Pbo-adj Δ = 20%
  - P = 0.01

Endoscopic Improvement

- **All-Comers Expected P3 Dose**
  - RVT-3101: 40%
  - Placebo: 30%
  - Comparator: 22%
  - Placebo: 46%

- **Biomarker Positive Expected P3 Dose**
  - RVT-3101: 40%
  - Placebo: 19%
  - Comparator: 19%
  - Placebo: 6%

- **PRA023**
  - RVT-3101: 56%
  - Placebo: 37%
  - Comparator: 37%
  - Placebo: 37%

- Pbo-adj Δ = 46%
  - P = 0.0005

- Pbo-adj Δ = 31%

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.

- Clinical Remission for RVT-3101 requires stool frequency ≤ 1 and ≥1 point reduction from baseline, rectal bleeding frequency = 0, and endoscopic score ≤ 1
- Clinical Remission for PRA023 requires stool frequency ≤ 1 and ≥0 point reduction from baseline, rectal bleeding frequency = 0, and endoscopic score ≤ 1

For investor audiences only
RVT-3101 Offers Transformative Potential in Biologic-Experienced Patients who are Biomarker Positive

Clinical Remission (Modified Mayo) in Biologic-Experienced Patients

- Biomarker Positive
- RVT-3101
- Stelara
- Zeposia
- mirikizumab
- Placebo

Pbo-adj Δ = 41%

- 41% Pbo-adj Δ = 41%
p = 0.03, NS

45%
40%
35%
30%
25%
20%
15%
10%
5%
0%

RVT-3101
Stelara
Zeposia
mirikizumab

Endoscopic Improvement in Biologic-Experienced Patients

- Biomarker Positive
- RVT-3101
- Stelara
- Zeposia
- mirikizumab
- Placebo

Pbo-adj Δ = 56%

- 56% Pbo-adj Δ = 56%
p = 0.005

65%
60%
55%
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%

RVT-3101
Stelara
Zeposia
mirikizumab

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.

For investor audiences only
RVT-3101 Shows Rapid Reduction in Symptoms at Earliest Time Point Measured

Change in Partial Mayo Score

- Placebo
- RVT-3101 (Expected P3 Dose)

- Partial Mayo Score (mean +/− SE)

- Baseline
- Week 4
- Week 8
- Week 12

P-value ≤ 0.0003 at all post-baseline time points
RVT-3101 Was Well-Tolerated With No Safety Signals Identified in Ongoing Phase 2b Study

Reflects interim results from induction period of study (through week 14). If a given patient had more than one occurrence in the same event category, only the most severe occurrence was counted. Patients were only counted once per treatment per event.

• The most common treatment emergent AEs were infections, anemia and injection site reactions, which were balanced across arms
• There were no dose-related trends for AEs; severe and serious AEs were sporadic and generally considered not related to drug
• No impact of immunogenicity on clinical efficacy or safety results
  o ADA rate of 46% and neutralizing antibody rate of 8% at expected Phase 3 dose
  o Immunogenicity results in-line with approved biologics*
    — Humira showed ADA rates of 32 – 46% and neutralizing antibody rates of 11 – 23% at week 24¹
    — Skyrizi showed ADA rates of 19% and neutralizing antibody rates of 8% at week 16²

<table>
<thead>
<tr>
<th></th>
<th>Pbo N = 45</th>
<th>Pooled N = 200</th>
<th>Expected Ph3 Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants with AEs</td>
<td>56%</td>
<td>45%</td>
<td>53%</td>
</tr>
<tr>
<td>Participants with severe AEs</td>
<td>7%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Participants with serious AEs</td>
<td>7%</td>
<td>4%</td>
<td>3%</td>
</tr>
<tr>
<td>Participants discontinued study due to AEs</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Participants discontinued study drug due to AEs</td>
<td>4%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Participants with dose reduced or temporary discontinuation due to AEs</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>

*Based on published data. No head-to-head studies were performed with approved biologics.

2. Skyrizi (risankizumab) FDA Summary Basis of Approval

For investor audiences only
RVT-3101 Shows High-End Efficacy Results in TUSCANY-2

Statistically significant and clinically meaningful efficacy results observed at every dose tested and in both overall and biomarker positive populations.

<table>
<thead>
<tr>
<th></th>
<th>Overall Population</th>
<th>Biomarker Positive Population*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>At Expected P3 Dose</td>
<td>At Expected P3 Dose</td>
</tr>
<tr>
<td>Clinical Remission</td>
<td>31%</td>
<td>40%</td>
</tr>
<tr>
<td>Endoscopic Improvement</td>
<td>40%</td>
<td>56%</td>
</tr>
</tbody>
</table>

Well-tolerated with no dose-related trends in AEs and no impact of immunogenicity on clinical efficacy or safety results.

*A single, prospectively defined biomarker was used in the study and was the same biomarker used in the Phase 2a study.
### Pbo-adj. Efficacy

| TNF | Remicade | Not Reported | X | X | ✓ 
| Integrin | Entyvio | Not Reported | X | ✓ | X 
| IL-12 | Stelara | 11% | X | ✓ | X 
| IL-12/23 | Skyrizi | UC Trial in Progress | N/A | N/A | ✓ 
| JAK | Rinvoq | 22% | ✓ | X | ✓ 
| Xeljanz | 12% | X | X | ✓ | ✓ 
| S1P1 | Zeposia | 5% | X | ✓ | ✓ 
| Etrasimod | 15% | Not Reported | X | ✓ | ✓ 

### OVERALL PROFILE

<table>
<thead>
<tr>
<th>Efficacy</th>
<th>Safety Profile</th>
<th>Convenience</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>X</td>
<td>✓</td>
</tr>
<tr>
<td>X</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>X</td>
<td>✓</td>
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<td>X</td>
<td>✓</td>
</tr>
<tr>
<td>X</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

#### RVT-3101 Has Compelling Efficacy Overall, Even Stronger Data in Biomarker Positive Patients, and The Strongest Data Seen in Biologics Experienced Patients

RVT-3101 has the potential to be the first therapy offering both high-end efficacy and safety.

- Table reflects 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. RVT-3101 data and overall profile reflect results from expected P3 dose in the induction period of the Phase 2b TUSCANY-2 study.
- Efficacy defined as clinical remission rate. Remicade, Humira and Xeljanz report total Mayo, while Rinvoq, Stelara and RVT-3101 report definitions as previously described.
- Safety assessment reflect presence or absence of black box warnings. Convenience assessment based on route of administration and dosing regimen.

For investor audiences only
Key Highlights

**First-in-class anti-TL1A Antibody**
- Large ~300 patient Phase 2 data set in UC in hand, with final data, including chronic period, expected H1 2023
- SQ efficacy *already demonstrated*
- Efficacy across broad dose range *already demonstrated*
- Unprecedented efficacy in biomarker positive, biologics-experienced population *already demonstrated*
- Favorable safety and tolerability profile

**Well-validated path to approval into a large, growing and well-validated commercial market**
- Dose ranging study in hand, removing need for dose ranging in Phase 3 program
- Leading IBD therapies have generated multi-billion annual revenues despite low response rates

**Precision immunology approach creates significant upside potential**
- High-end efficacy results shown in all-comer population
- A simple diagnostic test identifies the ~60% of patients who could see significantly improved benefit as “2nd line agent of choice”

**Multiple avenues for additional growth**
- Unique targeting of both inflammatory and fibrotic pathways leads to unique proposed indication set
- High likelihood of successful expansion into Crohn’s disease, given robust data in ulcerative colitis
- Additional indications to be announced
Brepocitinib
**Brepocitinib Overview**

First-in-class **dual TYK2/JAK1** inhibitor being developed for specialty autoimmune diseases with high morbidity/mortality and limited treatment options

<table>
<thead>
<tr>
<th>Unique, Dual-Targeting Mechanism</th>
<th>Robust Clinical Data</th>
<th>Distinctive Strategy Tailored to Novel Mechanism</th>
<th>Two Ongoing Registrational Programs</th>
<th>Strong Intellectual Property Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dual inhibition of TYK2 and JAK1 is expected to potentially provide <strong>greater efficacy</strong> than agents that inhibit either alone in multiple highly inflammatory autoimmune diseases.</td>
<td><strong>Statistically significant</strong> and clinically meaningful benefit in <strong>all five placebo-controlled studies completed to date</strong> (oral, once-daily) Exposure in &gt;1,400 subjects and patients to date; safety profile consistent with approved JAK inhibitors</td>
<td>Rather than standard set of highly competitive broad market JAK indications, <strong>pursue series of uncrowded, orphan and specialty autoimmune diseases</strong> with highest morbidity/mortality and where we expect that both TYK2 and JAK1 inhibition will contribute to efficacy</td>
<td><strong>Single registrational phase 3 study in dermatomyositis initiated</strong> Large, global phase 2B study in lupus with enrollment complete; data anticipated in 4Q 2023 (designed to serve as one of two registrational studies) Additional indications to be announced</td>
<td>Patent protection expected through ~2039</td>
</tr>
</tbody>
</table>

**For investor audiences only**
Dual Inhibition of TYK2 and JAK1: Novel Mechanism To Address Highly Inflammatory, Severe Autoimmune Diseases

**Dual TYK2/JAK1 inhibition: Distinctive benefits for suppression of key cytokines linked to autoimmunity**

1. Optimized for suppression of type I IFN signaling
2. Ability to suppress each of IFNα/β, IFNγ, IL-6, IL-12, IL-23 through a single agent

**Key JAK Dimerization Combinations and Associated Cytokine Signaling Pathways**

**Brepocitinib is the only dual inhibitor of TYK2 and JAK1 in late-stage development; none are approved**

<table>
<thead>
<tr>
<th>Molecule</th>
<th>Isoform Selectivity</th>
<th>Latest Development Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brepocitinib</td>
<td>TYK2/JAK1</td>
<td>Phase 3</td>
</tr>
<tr>
<td>XELJANZ (tofacitinib)</td>
<td>JAK1/JAK3</td>
<td>Approved</td>
</tr>
<tr>
<td>JAKAFI/OPZELURA</td>
<td>JAK1/JAK2</td>
<td>Approved</td>
</tr>
<tr>
<td>OLUMIANT (baricitinib)</td>
<td>JAK1/JAK2</td>
<td>Approved</td>
</tr>
<tr>
<td>RINVOQ (upadacitinib)</td>
<td>JAK1</td>
<td>Approved</td>
</tr>
<tr>
<td>CIBINQO (abrocitinib)</td>
<td>JAK1</td>
<td>Approved</td>
</tr>
<tr>
<td>SOTYKTVU (deucravacitinib)</td>
<td>TYK2**</td>
<td>Approved</td>
</tr>
<tr>
<td>Ritlecitinib</td>
<td>JAK3/TEC</td>
<td>NDA submitted</td>
</tr>
</tbody>
</table>

2. Adapted from Murray et al, 2007 and Morris et al, 2018
3. Allosteric
4. JAK1 is dominant, but these receptor also bind JAK2 and TYK2
5. **Type II
Oral Brepocitinib: Statistically Significant and Clinically Meaningful Results Across Every Completed Placebo-Controlled Phase 2 Study

Consistent, reproducible clinical benefit observed across wide range of autoimmune indications
Exposure in >1,400 subjects and patients suggests safety profile consistent with approved JAK inhibitors

<table>
<thead>
<tr>
<th>Study Population</th>
<th>N</th>
<th>Brepocitinib Dose</th>
<th>Primary Endpoint Result</th>
<th>Statistical Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psoriatic Arthritis</td>
<td>218</td>
<td>30 mg once daily</td>
<td>23.4% placebo-adjusted ACR20 RR at week 16</td>
<td>P = 0.0197</td>
</tr>
<tr>
<td>Patients with active PsA</td>
<td></td>
<td></td>
<td></td>
<td></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</td>
<td>P &lt; 0.0001</td>
</tr>
<tr>
<td>Patients with moderate-to-severe PsO</td>
<td></td>
<td></td>
<td></td>
<td></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</td>
<td>P = 0.0005</td>
</tr>
<tr>
<td>Patients with moderate-to-severe UC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alopecia Areata</td>
<td>94</td>
<td>30 mg once daily³</td>
<td>49.18 placebo-adjusted CFB in SALT Score at week 24</td>
<td>P &lt; 0.0001⁴</td>
</tr>
<tr>
<td>Patients with moderate-to-severe AA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hidradenitis Suppurativa</td>
<td>100</td>
<td>45 mg once daily⁴</td>
<td>18.7% placebo-adjusted HiSCR Rate at week 16</td>
<td>P = 0.0298⁴</td>
</tr>
<tr>
<td>Patients with moderate-to-severe HS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In an August 2022 poster abstract presented at the EADV congress, initial results from Pfizer’s phase 2 umbrella study in HS showed that brepocitinib was the only molecule that achieved statistical significance on the primary endpoint of HiSCR at Week 16 (18.7% placebo-adjusted, P = 0.0298)

CFB: change from baseline; RR: response rate
1. Overall study N represents patients randomized to all brepocitinib dose levels or placebo and excludes patients randomized to other agents
2. Includes patients from initial 24-week study period only
3. 60 mg QD for 4 weeks followed by 30 mg QD for 20 weeks
4. One-sided p-value (pre-specified statistical analysis)
5. Brepocitinib 45 mg once daily was the only brepocitinib dose evaluated in this study

For investor audiences only
Priovant Strategy: Indications with High Unmet Need and Tailored to Novel Mechanism of dual TYK2 / JAK1 Inhibition

**Priorvant Focus:** Indications with high unmet need and tailored to novel mechanism of dual TYK2 / JAK1 inhibition

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

- **High morbidity and mortality:** need for novel therapies that provide meaningful efficacy benefit
- **Few available treatments,** including no approved oral therapies
- **Expect inhibition of both TYK2 and JAK1** to contribute to potential efficacy

### Table: Priovant Focus

<table>
<thead>
<tr>
<th></th>
<th>DM</th>
<th>SLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>TYK2 and/or JAK1 Clinical Proof-of-concept</td>
<td>Open-Label</td>
<td>Yes</td>
</tr>
<tr>
<td>Drugs approved in the past 60 years*</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Approved Branded Oral Drugs*</td>
<td>0</td>
<td>0</td>
</tr>
<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><strong>OVERALL OPPORTUNITY</strong></td>
<td><strong>HIGH</strong></td>
<td><strong>HIGH</strong></td>
</tr>
</tbody>
</table>

*Excluding biosimilars and branded generics
Dermatomyositis: A Debilitating Inflammatory Myopathy

Dermatomyositis (DM) is a rare, chronic, immune-mediated disease of the muscles and skin affecting approximately 37,0001 adults in the United States

Clinical Presentation and Unmet Need

Hallmark symptoms include painful skin rashes and muscle weakness, often leading to disfigurement and disability

Cycle of inflammation, damaged muscle and damaged vascular endothelium leads to damage in multiple organ systems including pulmonary and cardiovascular

Significant mortality, estimated to be 10–40% at 5 years2

>60% of DM patients experience chronic disease3, and ~30% of patients are unable to discontinue long-term steroid-based treatment due to refractory disease4

Only approved therapy (other than glucocorticoids and corticotropin) is IVIg – difficult, cumbersome administration, associated with severe side effects

- IV; dosed for 2-5 consecutive days (3-9 hours each) every 4 weeks
- Thrombotic events are estimated to occur in 1-17% of patients receiving IVIg therapy5

High need for novel, targeted therapies that address underlying DM pathobiology in chronic, refractory patients

1. ProviantTx estimates based on Reeder 2010, Smoyer-Tomic 2012, and claims analysis; Syneos Health Research
4. Syneos Health Research
JAK1 Inhibition Is Clinically Validated In DM: Investigator-Initiated Study and Off-Label Case Reports

STIR Study in Refractory Dermatomyositis

- Open-label study evaluating a JAK1 inhibitor in adults with refractory dermatomyositis
- Primary endpoint: Total Improvement Score, a validated composite endpoint of six measures of disease activity (regulatory approval endpoint)
- All ten subjects demonstrated clinically meaningful response: **TIS20 Response Rate at Week 12 of 100%**
- Secondary endpoints included robust improvement in CDASI and steroid-sparing ability for steroid-dependent patients

Dermatomyositis Case Reports

- Systematic literature review identified 145 total cases of DM (n=84) and juvenile dermatomyositis (JDM) (n=61) treated with JAK inhibitors
  - Most patients were initiated on JAK inhibitors for refractory disease and had failed SOC treatment
  - Key Results:
    - Of 145 profiled subjects, 137 were considered clinical successes or responders by their respective investigators
    - Objective and subjective improvements noted in muscle disease, skin disease, and in DM-ILD
  - Where available, cross-trial comparison of clinical data in other indications for brepocitinib 30 mg QD compared with JAK inhibitors used in DM case reports suggests brepocitinib 30 mg QD may generate clinically meaningful efficacy in DM
Dual Inhibition Of TYK2 and JAK1 Provides Optimized Suppression of Type 1 IFN and Other Pathogenic Cytokines in Dermatomyositis

Type I IFN is the key pathogenic cytokine in dermatomyositis; its signaling is mediated by the dual activity of TYK2 and JAK1.

IFNα, IL-12, and IL-23 also contribute to dermatomyositis; their signaling is mediated by JAKs inhibited by brepocitinib.

Percent Cytokine Inhibition at Modeled Exposures

- Brepocitinib 30 mg QD
- Tofacitinib 5 mg BID
- Baricitinib 4 mg QD
- Upadacitinib 15 mg QD
- Deucravacitinib 6 mg QD

Cross-study comparisons with different assay conditions.

For investor audiences only

Single Phase 3 Study in Dermatomyositis

Phase 3 program is evaluating 15 mg and 30 mg brepocitinib once daily vs. placebo using the Total Improvement Score (TIS), a validated myositis improvement index

52-week treatment period

Subjects with dermatomyositis (N = 225)

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

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 subjects achieving TIS ≥ 40 points
- Manual Muscle Testing (MMT-8)

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

Week 52: Primary Efficacy Assessment (Total Improvement Score)

Brepocitinib is the Only Late-Stage Oral Therapy in Industry-Sponsored Development for DM

For investor audiences only
SLE: A Heterogeneous Connective Tissue Disease

SLE is a chronic autoimmune disease characterized by elevated levels of proinflammatory cytokines, autoantibodies, and autoreactive cell types that affects up to 300,000 people in the United States

Clinical Presentation and Unmet Need

SLE affects predominantly women and can result in symptoms in nearly all major organ systems; skin and musculoskeletal manifestations are most common.

10- and 15-year mortality is estimated to be 9 and 15%, respectively.

Urgent need for new therapies is widely recognized by patients, physicians, and regulators

- Benlysta (belimumab) 2021 net revenue >$1B, despite modest efficacy (SRI-4 PBO adjusted delta of 10-14%)
- Saphnelo (anifrolumab) was approved by FDA despite outright failure of one of two Phase 3 trials

Despite two approved biologics, many treated patients will fail to achieve response/remission (particularly those with moderate/severe disease)

Many patients will continue to experience recalcitrant organ domain-specific symptoms, and new treatments that effectively treat these manifestations are urgently needed.

Images adapted from Kaul et al (2016)
1. Centers for Disease Control
5. GSK Annual Report FY 2021
7. Saphnelo Package Insert
8. Strand et al, Abstract 1077; ACR 2014
JAK1 or TYK2 Inhibition in SLE: Each with Signs of Efficacy, but With Meaningful Room for Improvement

Baricitinib and deucravacitinib PoC studies established therapeutic relevance of JAK1 and TYK2 inhibition, while also highlighting need for more potent agents; deucravacitinib and upadacitinib progressing to Phase 3.\(^1\)\(^2\)

---

**Phase 2 and Phase 3 Studies of Baricitinib in SLE\(^3\)^4**

<table>
<thead>
<tr>
<th>Dose</th>
<th>Week 24 (Phase 2)</th>
<th>Week 52 (Phase 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 mg QD</td>
<td>P = 0.016 16.8%</td>
<td>NS 3.8%</td>
</tr>
<tr>
<td>4 mg QD</td>
<td>10.8%</td>
<td>NS 0.7%</td>
</tr>
</tbody>
</table>

**Phase 2 Study of Upadacitinib in SLE\(^5\)**

<table>
<thead>
<tr>
<th>Dose</th>
<th>Week 48</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 mg QD</td>
<td>P = 0.1 13.2%</td>
</tr>
</tbody>
</table>

**Phase 2 Study of Deucravacitinib in SLE\(^6\)**

<table>
<thead>
<tr>
<th>Dose</th>
<th>Week 32</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 mg BID</td>
<td>P = 0.0006 23.8%</td>
</tr>
<tr>
<td>6 mg BID</td>
<td>15.1%</td>
</tr>
<tr>
<td>12 mg QD</td>
<td>NS 10.5%</td>
</tr>
</tbody>
</table>

Note: 3 mg BID arm had ~50% more subjects receiving triple combo SOC therapy at baseline compared to all other arms, and the 12 mg QD arm had significantly higher dropout rates compared to the other two active arms, which could explain the inverse dose response.\(^7\)
Brepocitinib Potential For Greater Efficacy: Clinical And Biological Rationale

Clinical: cross-study comparisons of brepocitinib, deucravacitinib, baricitinib, and upadacitinib in other indications on registration endpoints

No direct head-to-head data available – cross-trial comparison of studies with different inclusion-exclusion criteria and design elements

**Clinical:**
- **Psoriatic Arthritis:**
  - Brepocitinib 60 mg QD (Phase 2B – 16W) vs. Deucravacitinib 12 mg QD (Phase 2 – 16W, NCT03881059) vs. Upadacitinib 30 mg QD (Phase 3 – 16W, NCT03104400, "Trial of Upadacitinib and Adalimumab for Psoriatic Arthritis," McInnes et al., NEJM, value extracted from charts)
- **Plaque Psoriasis:**
  - Brepocitinib 30 mg QD (Phase 2 – 12W) vs. Baricitinib 4 mg QD (Phase 2B – 12W, NCT01490632) vs. Deucravacitinib 6 mg QD (Pooled Phase 3 POETYK-PSO-1 and POETYK-PSO-2 – 12W, NCT03624127 & NCT0361175, value extracted from charts)
- **Alopecia Areata:**
  - Brepocitinib 60 mg QD→30 mg QD (Phase 2 – 24W) vs. Baricitinib 4 mg QD (Pooled Brave-AA1 and AA2, NCT03570749 & NCT03899259)
- **Hidradenitis Suppurativa:**
  - Brepocitinib 45 mg QD (Phase 2 – 16W) vs. Upadacitinib 30 mg QD (Phase 2 – 12W, NCT04430855)
- **Ulcerative Colitis:**
  - Brepocitinib 30 mg QD (Phase 2B – 8W) vs. Deucravacitinib 6 mg BID (Phase 2 LATITUDE-UC – 12W, NCT03934252) vs. Upadacitinib 45 mg QD (Pooled U-ACHIEVE and U-ACCOMPUSH – 8W, NCT02819635 & NCT03653026)

**Biological:**
- Dual inhibition of TYK2 and JAK1 distinctively suppresses multiple key cytokines implicated in SLE pathobiology, including type I IFN, type II IFN, IL-6, IL-12, and IL-23

---

**Note:** where more than one value is available for a competitor molecule (e.g., in the case of two identical Phase 3 studies), a weighted average value is used.

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**For investor audiences only**
Ongoing Global Phase 2B Study in SLE – Designed To Serve As One Of Two Registrational Studies

Enrollment complete; expected top-line data in 2H 2023

52-week treatment period

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

Subjects with active, moderate/severe SLE (N = 350)\textsuperscript{1}

- 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
  - 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

---

1. Final sample size is subject to an ongoing protocol amendment.
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)\(^1\)

- Sustained maximal IgG suppression where needed
- Chronic delivery with simple subcutaneous delivery in seconds
- No or minimal impact to albumin / LDL

**Pivotal-enabling catalyst in 2023:** IMVT-1402 initial Phase 1 data expected in mid-2023 (Aug/Sep)

1. Potential outcomes if Phase 1 results are as predicted by pre-clinical studies in cynomolgus monkeys
IMVT-1402 and Batoclimab Each Demonstrated Rapid and Deep IgG Reduction in a Head-to-Head Monkey Study

We believe that deeper IgG suppression correlates with the clinical benefits across several anti-FcRn data sets

2. Data on file at Immunovant
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</td>
</tr>
<tr>
<td></td>
<td>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
In a Head-to-Head Monkey Study, We Observed That IMVT-1402 and Placebo Produced Similar Albumin and LDL Effects

Albumin concentration (g/L), mean ± SD

Cholesterol concentration (mmol/L), mean ± SD

LDL concentration (mmol/L), mean ± SD

SD, standard deviation; ULN, upper limit of normal; LLN, lower limit of normal; Arrows indicate time of dosing.

Data on file at Immunovant

Batoclimab 50 mg/kg (n=3)
IMVT-1402 50 mg/kg (n=7)
IMVT-1402 5 mg/kg (n=7)
Placebo (n=3)
† Dose administration
Healthy Volunteer Study Shows Robust LDL Reduction with Co-Administration of Batoclimab and Atorvastatin

Mean LDL cholesterol for first two cohorts of patients reflects impact of statin treatment on LDL cholesterol when co-administered with 680mg batoclimab

![Graph showing LDL Cholesterol vs. Time](image)

**Distribution of Atorvastatin in US (2019)**

<table>
<thead>
<tr>
<th>Strength</th>
<th>% of dispensed products</th>
</tr>
</thead>
<tbody>
<tr>
<td>80 mg</td>
<td>13.8</td>
</tr>
<tr>
<td>40 mg</td>
<td>36.0</td>
</tr>
<tr>
<td>20 mg</td>
<td>29.1</td>
</tr>
<tr>
<td>10 mg</td>
<td>20.6</td>
</tr>
<tr>
<td>Other, unspecified, or misc.</td>
<td>0.5</td>
</tr>
</tbody>
</table>

Key Takeaways on Impact of Batoclimab on LDL Cholesterol

1. Mechanism is not unique to batoclimab
   LDL changes correlated with on target changes in albumin

2. Cholesterol changes are reversible
   Dose dependent changes in LDL returned to normal with cessation of dosing

3. Cholesterol changes expected to be manageable
   Batoclimab dose titration and use of statins or other cholesterol-lowering therapies provide levers for maximizing benefit-risk
IMVT-1402 Selected to Deliver Maximum IgG Reduction While Minimizing Interference with Albumin Recycling

Note: Ribbon representations generated from X-Ray crystal structure. Batoclimab solved at 2.4Å resolution. IMVT-1402 solved at 2.6Å resolution.

For investor audiences only
**Albumin Impact in Non-human Primates Translatable to Humans**

Translatability observed across multiple anti-FcRn inhibitors

<table>
<thead>
<tr>
<th>Product (Company)</th>
<th>Impact on Albumin Levels from Baseline</th>
<th>Clinical Data</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cynomolgus Monkeys</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Efgartigimod (Argenx) | • Reported no impact on albumin homeostasis<sup>1</sup>  
• EMA public assessment report indicates that there was no impact on albumin levels across doses<sup>2</sup> | • Phase 1 reported multiple doses had no impact on albumin levels in humans<sup>1</sup>  
• Phase 3 pivotal trials did not identify a safety signal of hypoalbuminemia<sup>3</sup> |
| SYNT-001 (Syntimmune) | • Reported no difference in albumin levels from baseline for vehicle, 10, 30, or 100mg/kg<sup>4</sup> | • Phase 1 data showed no difference in albumin levels from baseline following a single dose of vehicle, 1, 3, 10, or 30mg/kg<sup>4</sup> |
| Nipocalimab (J&J) | • Data not published  
• Momenta management’s public commentary has indicated that albumin reductions were seen in MAD studies in cynomolgus monkeys<sup>5</sup> | • Phase 1 reported reductions in albumin levels from baseline at 15 and 30mg/kg doses<sup>6</sup>  
• Phase 2 showed reductions in albumin levels from baseline at 30 and 60mg/kg<sup>7</sup> |
| Rozanolixizumab (UCB) | • Reported small reductions (1-13%) in albumin levels from baseline<sup>8</sup> | • Phase 1 reported a small decrease in albumin levels from baseline for both IV and SC (1-5%)<sup>9</sup> |
| Batoclimab (Immunovant) | • Observed consistent reduction in albumin levels from baseline | • Observed dose dependent decreases in albumin levels from baseline |
| IMVT-1402 (Immunovant) | • No or minimal impact on albumin levels observed from baseline (variability like placebo) | • Initial Phase 1 data (SAD) expected in mid-2023 (Aug/Sept), MAD data expected in Oct/Nov 2023<sup>10</sup> |

---

2. Efgartigimod EMA assessment report - EMA/540681/2022  
3. Efgartigimod FDA integrated review - 76/195/606/300  
5. Stifel research note – Momenta Pharmaceuticals, December 18, 2018  
10. SAF, single ascending dose; MAD, multiple ascending dose

For investor audiences only
Autoimmune Diseases Driven by Pathogenic IgG

22 indications currently announced or in development across the anti-FcRn class¹

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

**RHEUMATOLOGY**
- Primary Sjögren 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

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

---

¹ Indications announced or in development with anti-FcRn assets by Immunovant, Argenx, JNJ, and UCB.
² If approved by regulatory authorities.
Significant Progress in Developing IMVT-1402 as Next-Generation FcRn Inhibitor for Autoimmune Disease Therapy

- Phase 1 clinical trial in healthy volunteers initiated in New Zealand
- Investigational New Drug (IND) application cleared by the FDA
- Initial data readout for single-ascending dose cohorts expected in August/September 2023, and for multiple-ascending dose cohorts expected in October/November 2023
**IMVT-1402 Phase 1 Clinical Trial Design**

**Single-Ascending Intravenous Dose**
- Fixed 100 mg
- Fixed 300 mg
- Fixed 600 mg

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

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

IMVT-1402 is delivered as a 2 mL simple subcutaneous injection with a 27-gauge needle at a concentration of 150 mg/mL in the Subcutaneous Dose cohorts

* Additional / optional cohorts may include 1,200 mg IV SAD, 150 mg SC MAD and 450 mg SC MAD. The first MAD cohort will be initiated after review of PK and safety data from SAD cohorts at the same or higher dose levels, with the final dose selection for the first MAD cohort dependent on this PK review. SAD and MAD cohorts will be initiated following review of safety data and PK data from all previously dosed cohorts.
Batoclimab Phase 1 Trial Suggests SAD Data May be Predictive of MAD Data

Albumin % change from baseline following batoclimab dosing*

* Data on file
Batoclimab Phase 1 Trial Suggests SAD Data May be Predictive of MAD Data

Total IgG % change from baseline following batoclimab dosing*

* Data on file
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
Encouraging Efficacy Signals in a Phase 2 Trial of Batoclimab in Myasthenia Gravis

Data at Week 7, End of Controlled Portion of Study

<table>
<thead>
<tr>
<th>% Change from baseline</th>
<th>Total IgG</th>
<th>Anti-AChR-IgG</th>
<th>MG-ADL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placebo (N=6)</td>
<td>-59%</td>
<td>-54%</td>
<td>-23%</td>
</tr>
<tr>
<td>Batoclimab 340mg/week (N=5)</td>
<td>-76%</td>
<td>-87%</td>
<td>-38%</td>
</tr>
<tr>
<td>Batoclimab 680 mg/week (N=6)</td>
<td>-3%</td>
<td>2%</td>
<td>3%</td>
</tr>
</tbody>
</table>

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

For investor audiences only
Registrational Phase 3 Trial of Batoclimab Designed to Offer Myasthenia Gravis 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 Autoimmune Condition

TED is a rare autoantibody mediated inflammatory disease that affects between 15,000 and 20,0001 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 sensitivity3

Progressive disease marked by inflammation that can lead to fibrosis and may become sight-threatening if untreated4

Caused by IgG autoantibodies that activate cell types present in tissues surrounding the eye4

While Tepezza shows a validated US market opportunity (2021 net sales of $1.7 billion and expected annual peak net sales over $3 billion)5, 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 treatment6

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)5,7-11

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

It was observed in batroclimab's Phase 2b trial in TED that reductions in IgG resulted in greater proptosis response rates\(^1\,\text{3}\).

<table>
<thead>
<tr>
<th></th>
<th>Placebo</th>
<th>Batroclimab 255 mg</th>
<th>Batroclimab 340 mg</th>
<th>Batroclimab 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 batroclimab 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 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 Thyroid Eye Disease Initiated

### Inclusion criteria:
- 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

N = 100 per study

### Study 1 and 2: Active Treatment Phase
- Placebo-controlled, two dose regimens:
  - Placebo QW SC: 24 wks
  - 680mg batoclimab QW SC: 12 wks
  - 340mg batoclimab QW SC: 12 wks
  - Placebo QW SC: 24 wks

### 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

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

Note: subset of inclusion criteria for TED Ph3 trial shown on slide
CAS = Clinical Activity Score, anti-TSHR-Ab = anti-TSHR antibody, QW = weekly; SC = subcutaneous injection
CIDP: A Complex Chronic Neurological Disease

CIDP is an autoimmune associated with pathogenic, complement-activating IgG and IgM autoantibodies that target myelin and other neuronal proteins that affects up to 16,000 people in the United States.

Clinical Presentation and Unmet Need

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, PLEX and steroids) are effective, but have significant side effects and logistical limitations (IVIG & PLEX).

- 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>X</td>
<td>✓</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 |                                                                      | Not All**                                                                   | ✓                                |
| 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 | X                                             | ✓                                |
| 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                                             | ✓                                |

Notes: *Other anti-FcRn trials in CIDP include efgartigimod, nipocalimab, and rozanolizumab. **Clinical trial designs for efgartigimod in CIDP and nipocalimab in CIDP include double enrichment in trial design. Rozanolizumab ph2 trial in CIDP did not include double enrichment.
Pivotal Phase 2b Trial Intended to Develop Potentially Best-in-Class Chronic Anti-FcRn Therapy in CIDP

**Study timeline**
- Week -12
- Week 0
- Week 12 analysis
- Week 36 analysis

**Screening**
- **A**: ≤ 28 days
  - 3 cohorts
  - Cohort A: Ig or PLEX
  - Cohort B: Corticosteroid
  - Cohort C: No treatment

**Washout**
- **B**: ≤ 12 weeks
  - Cohort A: Stop Ig/PLEX
  - Cohort B: Taper corticosteroid

**Period 1C**
- **C**: Randomized Treatment (12 weeks)
  - Two dose regimens
  - 680mg batoclimab QW SC
  - 340mg batoclimab QW SC

**Period 2D**
- **D**: Randomized Withdrawal (≤ 24 weeks)
  - Placebo-controlled
  - 340mg batoclimab QW SC
  - Placebo QW SC

**Key selection criteria:**
- Adult participants diagnosed per EAN/PNS CIDP guidelines, 2021 revision
- Cohort A (N=100): Randomize participants who worsen
  - Cohort B: Same as A
  - Cohort C: Randomize all

**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

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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 fail 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
Graves’ Disease: a Systemic Condition with High Unmet Need

Graves’ Disease is an immune disorder characterized by hyperthyroidism and has an incidence of about 116,000 cases per year in the U.S.1,2

Clinical Presentation and Unmet Need

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 patient3-9

• 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 116K1,2 US incident Graves’ patients are difficult to control with ATD and remain symptomatic

• 1/4 to 1/3 of 46K10 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

7. Dhawan DK. Thyroid disorders and bone mineral metabolism. Indian J Endocrinol Metab. 2011 Jul

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

\textbf{Inclusion\textsuperscript{A}}

- Subjects with active GD as documented by presence of elevated stimulatory TSH-R-Ab
- Subjects on an ATD for ≥12 weeks before the Screening Visit
- Subjects hyperthyroid despite ATD

\textbf{Treatment Period: (24 weeks)}

\begin{itemize}
  \item N = up to 40
  \item Two doses tested over 24 weeks
  \item 680mg batoclimab QW SC
  \item 340mg batoclimab QW SC
\end{itemize}

\textbf{Screening (4 weeks)}

\textbf{Follow-up Period}

\textbf{Primary endpoint:} Proportion of participants who achieve normalization of T3 and T4 at Week 24 with ATD dose < baseline ATD dose

\textbf{ATD treatment:}

- Stable ATD dose at screening
- ATD tapered during treatment period
- ATD if needed

A: Additional inclusion and exclusion criteria not listed on slide.
GD = Graves’ Disease; ATD = anti-thyroid medications; QW = weekly; SC = subcutaneous injection
RVT-2001: Potential First-in-Class Small Molecule SF3B1 Modulator for the Treatment of Transfusion-Dependent Anemia in Patients with Lower-Risk MDS

<table>
<thead>
<tr>
<th>Lower-Risk MDS is a Commercially Validated Market</th>
<th>Encouraging Proof-of-Concept Data</th>
<th>Multipronged Strategy to Optimize RVT-2001’s Clinical Impact</th>
<th>Expect Fast, Well-Established Path to Potential Approval</th>
<th>Strong Intellectual Property Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfusion-dependent anemia in MDS has limited treatment options</td>
<td>First-in-class potential as the only known SF3B1 modulator currently in clinical development</td>
<td>Development strategy optimizing dosing, utilizing precision medicine enrollment, and excluding certain refractory patients</td>
<td>Conducting a robust open-label expansion of an ongoing Phase 1/2 trial</td>
<td>Composition of matter IP protection expected until 2035, before any potential patent term extensions</td>
</tr>
<tr>
<td>Luspatercept (Reblozyl), approved for RS+ MDS in 2020, with current run rate sales &gt;$600M; BMS potential projected peak &gt;$4B(^1)</td>
<td>Compelling data in a highly refractory population</td>
<td>Compelling data in a highly refractory population</td>
<td>Precedent suggests minimal data decay between Phase 2 and Phase 3(^3)</td>
<td>Precedent suggests minimal data decay between Phase 2 and Phase 3(^3)</td>
</tr>
<tr>
<td>80+ subjects treated in Phase 1/2 study; generally well-tolerated(^2)</td>
<td>80+ subjects treated in Phase 1/2 study; generally well-tolerated(^2)</td>
<td>80+ subjects treated in Phase 1/2 study; generally well-tolerated(^2)</td>
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<td>80+ subjects treated in Phase 1/2 study; generally well-tolerated(^2)</td>
</tr>
</tbody>
</table>

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\(^{1}\) Bristol Myers Squibb filings, November 16, 2021 Investor Event.

\(^{2}\) Steensma et al., 2021. Data as of January 10, 2022.

\(^{3}\) Platzbecker et al., 2017; Fenaux et al., 2020; Lot et al., 2006; Fenaux et al., 2011

\(^{4}\) Fenaux et al., 2021; Fenaux et al. 2011; Santini et al. 2016

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All product candidates are investigational and subject to regulatory approval.

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High Unmet Need for an Oral Therapy in Transfusion-Dependent Anemia in Lower-Risk MDS

Current treatment options fail in multiple segments of the patient population

- Lower-risk MDS is a chronic condition; therapy is focused on management of symptoms
- Erythropoiesis-stimulating agents (ESA) used in 1L
  - Ineffective in >50% of patients, primarily used in patients with low transfusion burden and EPO levels
- Luspatercept and lenalidomide are only approved for specific subsets of MDS patients and can have challenging toxicity profiles
  - Luspatercept is also ineffective in >50% of patients
  - Lenalidomide is only approved patients with del(5q) lower-risk MDS, who only make up 10-15% of the population

Initial plan to target second line in SF3B1-mutated patients, with potential to expand to other spliceosome mutations and first line

All product candidates are investigational and subject to regulatory approval.

1. Cogle et al., 2015, prevalence based on midpoint, incidence based on lower end of range using 2021 US population.
2. Carraway et al., 2020, overall response rates of 20% to 40% and an 18- to 24-month duration of response.
3. Cazzola et al., 2020
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), Mupo 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 Date¹

- **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 HMAš
  - Median duration of treatment for responders of approximately 2 years¹²
  - **Luspatercept**: 13% RBC-TI among patients with prior lenalidomide exposure in Phase 2 trial³
  - **Lenalidomide**: 12% HI-E among patients with prior HMA exposure in investigator-sponsored trial⁴
  - 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 1³

**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 2³
    - In luspatercept’s Phase 2 trial, 44% RBC-TI in patients without prior lenalidomide exposure vs. 13% with prior lenalidomide exposure³
    - In a lenalidomide investigator-sponsored trial of patients with lower-risk, non-del(5q) MDS, HI-E of 38% prior to HMAs vs. 12% post-HMAs⁵

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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

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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)\(^1\)
- 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)\(^2\)
  - High ratios of aberrantly spliced TMEM14C transcripts were associated with SF3B1 mutations\(^2\)

Improve Dosing

- Strengthen pharmacodynamic effect by optimizing dosage 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

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\(^1\) Malcovati et al., 2015
Phase 1/2 Ongoing with Recently Added Dose-Optimization Cohort

**Study Objectives:** Determine the recommended P3 dose and frequency, assess safety and tolerability, inform patient selection

**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

**Primary Efficacy Data:** RBC transfusion independence

**N = up to 64**

**Primary endpoint assessed at 25 weeks**

**Oral capsule**

All product candidates are investigational and subject to regulatory approval.
RVT-2001 Key Highlights

✅ Significant market opportunity for RVT-2001
  • Potentially first-in-class (only clinical stage) oral agent in a commercially established multibillion dollar market with limited effective treatment options

✅ Compelling RVT-2001 data to date in a highly refractory population, where luspatercept and lenalidomide have shown weaker responses
  • ~2x better RBC-TI response than luspatercept in a similar patient population

✅ Multiple paths to “win” given robust signal-refining Phase 2 design
  • High response rates / long duration in the overall population
  • High response rates / long duration in genetically defined subsets (e.g., high TMEM14C AJ / CJ ratio)

✅ Potential for an extremely fast path to market
  • Robust open-label, dose exploration study ongoing
  • Precedent in the space is a single pivotal study, n~200-250 patients

1. No head-to-head studies of RVT-2001 have been conducted. Based on interim results which may change following completion of the trial and may not accurately reflect the complete results of the trial.
Namilumab
Namilumab: Potential First Novel Therapy for Pulmonary Sarcoidosis, a Large, Untapped Orphan Market

---

### Pulmonary Sarcoidosis Is A Large, Untapped Orphan Market

- ~180,000 patients in the US alone\(^1\)
- Characterized by the accumulation of granulomas in the lung, which cause injury and scarring
- Leads to declining pulmonary function, dyspnea, fatigue, cough, pain, and death
- No modern approved agents; systemic corticosteroids are the mainstay, and other immunosuppressives are used off-label

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### GM-CSF Inhibition Uniquely Stops the “Bad Actor” Cell Type

- Pulmonary sarcoidosis is driven by alveolar macrophages, which form the granulomas\(^2\)
- Alveolar macrophages are uniquely driven by GM-CSF\(^3\)

---

### Compelling Drug Properties

- Extremely potent (sub-nanomolar IC50)
- Fully human monoclonal antibody
- Dosed subcutaneously, designed for high patient convenience*
- Existing safety database of over 300 patients to date\(^4\)

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### Robust RESOLVE-LUNG Study Underway

- Robust Phase 2 is underway
- Could count as a registrational study if successful
- Clinical study design incorporates lessons learned from previous trials

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* 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 ever four weeks after an initial loading period.
* All product candidates are investigational and subject to regulatory approval.

---

Pulmonary Sarcoidosis is a Large, Untapped Orphan Market

A well-tolerated and effective, steroid-sparing therapy for sarcoidosis has blockbuster commercial potential\(^1\)

\(~180,000\) patients in the US alone\(^2\)

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\(^3\)

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

1. Market research
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 sarcoidosis

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

**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)
- Steroid Taper
  - Goal (≤ 5mg/day, 0 mg if possible)

**Open-label Extension Period**
- Namilumab 150 mg
- Steroid Taper
  - Goal (≤ 5mg/day, 0 mg if possible)

**Follow up**
- 14 weeks after EOT, 18 weeks after last dose

**Primary Endpoint**
Proportion of subjects requiring rescue\(^1\) 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

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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

### Collaboration Partner

<table>
<thead>
<tr>
<th>LNP Collaborations Outside of COVID-19</th>
<th>Publicly Disclosed Financials*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gene editing therapeutics for specified neuromuscular diseases, including DMD¹</td>
<td>Royalty rate: mid-single to low-double digits†</td>
</tr>
<tr>
<td></td>
<td>Near-term: $50M + significant milestones</td>
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<tr>
<td>Nucleic acid therapeutics directed to specified targets in HSCs to treat liver fibrosis²</td>
<td>Royalty rate: undisclosed</td>
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<tr>
<td></td>
<td>Upfront and milestones: $600M</td>
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<tr>
<td>Nonviral gene therapies for up to two rare liver diseases³</td>
<td>Royalty rate: undisclosed</td>
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<tr>
<td></td>
<td>Upfront and milestones: $303M</td>
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<tr>
<td>Gene editing therapies for hemophilia A⁴</td>
<td>Royalty rate: mid-single digits†</td>
</tr>
<tr>
<td></td>
<td>Upfront and near-term option: $10M + milestones</td>
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<tr>
<td>Self-amplifying RNA for an unspecified indication⁵</td>
<td>Low to mid-single digits†</td>
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<tr>
<td></td>
<td>Initial payment and milestones: $73M</td>
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<tr>
<td>Nucleic acid therapeutics directed to specified targets in HSCs to treat liver fibrosis</td>
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<tr>
<td>mRNA for a specified number of oncology targets; co-dev in up to five rare diseases⁶</td>
<td>Milesstones and royalties (amounts undisclosed);</td>
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<td></td>
<td>50:50 on co-development programs</td>
</tr>
</tbody>
</table>

### Collaboration Partner

<table>
<thead>
<tr>
<th>LNP Collaborations for COVID-19</th>
<th>Publicly Disclosed Financials*</th>
</tr>
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<tbody>
<tr>
<td>Self-amplifying RNA COVID-19 vaccine program⁷</td>
<td>Royalty rate: mid-single to mid-double digits†</td>
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<tr>
<td></td>
<td>Upfront + milestones: $192M/product</td>
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<tr>
<td>mRNA COVID-19 vaccine program in specified Asian countries⁸</td>
<td>Royalty rate: 8%</td>
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<tr>
<td></td>
<td>Upfront + milestones: $133.75M</td>
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<tr>
<td>mRNA COVID-19 vaccine program</td>
<td>Undisclosed</td>
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<tr>
<td>mRNA COVID-19 vaccine program in specified Asian countries</td>
<td>Undisclosed</td>
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</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.
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
Discovery Updates
ER Degrader Demonstrates Equal or Better Tumor Volume Reduction Compared to Most Advanced Degrader In-Class

*In vitro and in vivo* data supportive of equal or better potency than ARV-471 in head-to-head studies

**Potent Antagonism Demonstrated in In Vitro Assay**

**Potent Degradation Demonstrated in In Vitro Assay**

<table>
<thead>
<tr>
<th>Concentration (nM)</th>
<th>% Inhibition</th>
<th>ARV-471</th>
<th>PVT-4206</th>
<th>4-Hydroxytamoxifen</th>
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<tbody>
<tr>
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<td>10000</td>
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</tbody>
</table>

Note: ARV-471 10 mpk:ARV-471 30 mpk * = P value <0.05; ARV-471 10 mpk:PVT-4206 10 mpk * = P value <0.05; ARV-471 10 mpk:PVT-4206 30 mpk ** = P value <0.005.
Multiple Strategic Partnerships Validating the Quality of Discovery Pipeline

Partnership with Janssen focused on VantAI’s deep learning platform to potentially generate novel molecular-glue and hetero-bifunctional protein degrader drug candidates

Strategic collaboration between Proteovant and Blueprint to advance novel targeted protein degrader therapies to address important areas of medical need

Early discovery research collaboration between Boehringer Ingelheim and VantAI focused on developing degraders for traditionally “undruggable” targets

Research collaboration and licensing agreement between Boehringer Ingelheim and Covant focused on developing a novel small molecule immunotherapy targeting ADAR1

Collaborations with Blueprint Medicines, Janssen, and Boehringer Ingelheim include aggregate contingent milestone payments of over $1.5 billion as well as product royalties
Thank you.