Roivant Overview

September 2024

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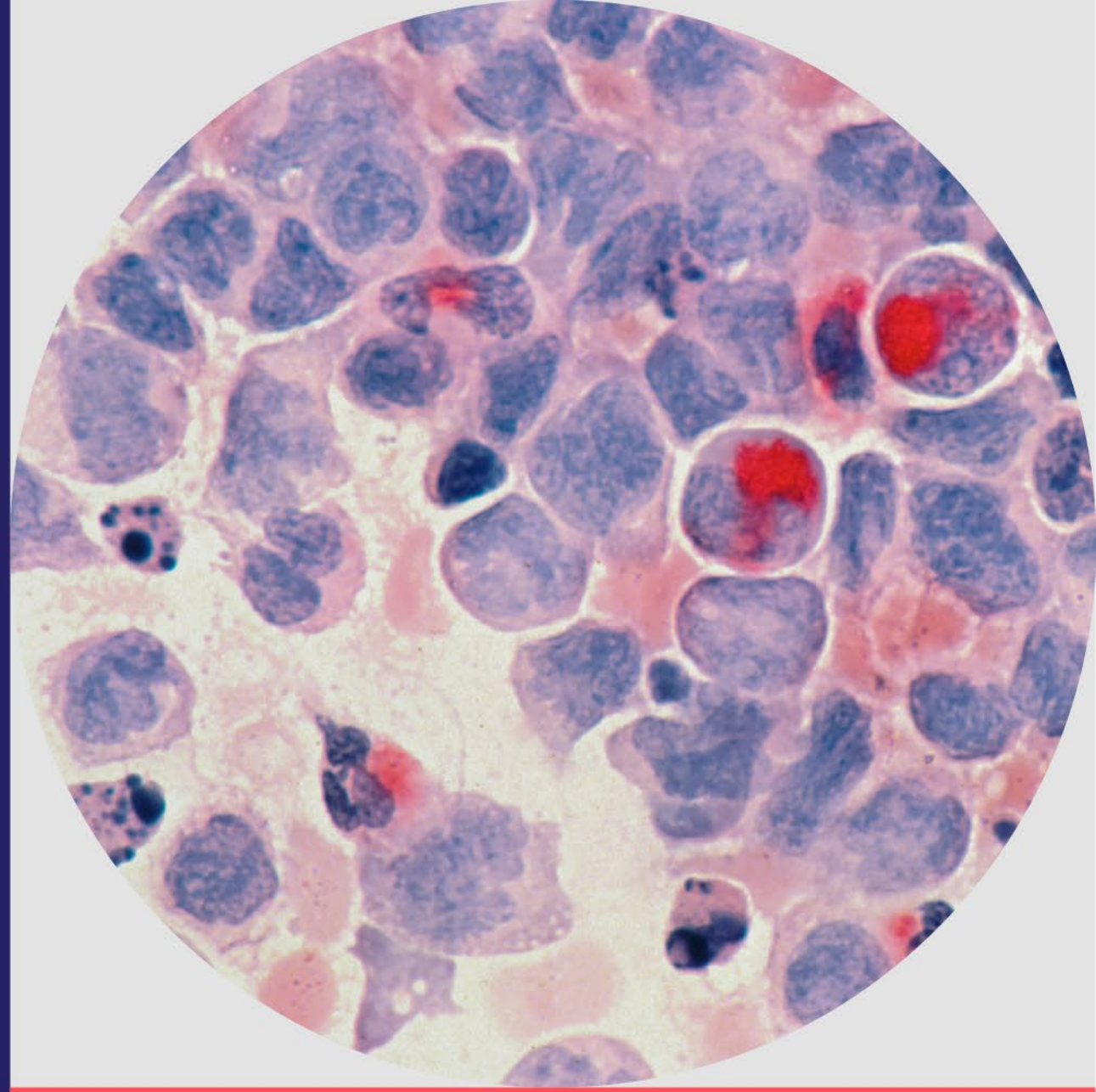


Forward-Looking Statements

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

These forward-looking statements are based upon the current expectations and beliefs of our management as of the date of this presentation and are subject to certain risks and uncertainties that could cause actual results to differ materially from those described in the forward-looking statements. Although we believe that our plans, intentions, expectations and strategies as reflected in or suggested by those forward-looking statements are reasonable, we can give no assurance that the plans, intentions, expectations or strategies will be attained or achieved. Furthermore, actual results may differ materially from those described in the forward-looking statements. The initial or topline study results presented here for brepocitinib in non-infectious uveitis are based on initial analyses of key efficacy and safety data and such data may not accurately reflect the complete results of those 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.

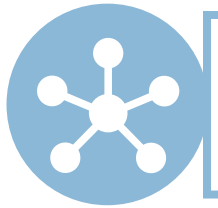
This presentation includes data for each of brepocitinib and mosliciguat as compared to certain other potential competitor products generated from separate, independent studies and that do not come from head-to-head analyses. Differences exist between study or trial designs and subject characteristics and caution should be exercised when comparing data across studies. Data regarding other products is based on publicly available information.

The closing of the Dermavant transaction described in this Presentation, currently expected in 4Q 2024, is subject to the satisfaction or waiver certain customary closing conditions, including the expiration of the waiting period under the Hart-Scott-Rodino Antitrust Improvements Act. Final upfront, milestone and royalty payments under the agreement and plan of merger and referenced in this Presentation are subject to certain customary purchase price adjustments, including adjustments for repayment of certain obligations, and net sales calculations are subject to standard limitations and adjustments. A copy of the agreement and plan of merger related to the Dermavant transaction will be filed with the Securities and Exchange Commission (“SEC”) and will be publicly available.

Disclaimer

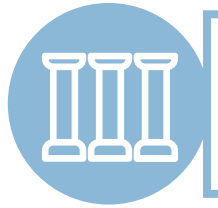
This presentation is intended for the investor community only; it is not intended to promote the product candidates referenced herein or otherwise influence healthcare prescribing decisions.

Roivant: Developing and Commercializing Transformative Medicines

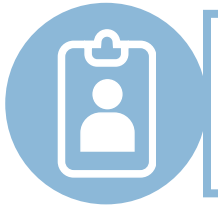


Vant model aligns incentives to drive fast, high-quality execution and rigorous capital allocation

Proven track record with **10 consecutive positive Phase 3 trials** and 6 FDA approvals[1]



Consolidated cash, cash equivalents and restricted cash of $5.7BN as of June 30, 2024



Capital infusion leaves company in position of strength to **expand our pipeline, as well as pursue additional investments and potentially return additional capital to shareholders**

1. FDA approval and trial figures include Vants transferred to Sumitomo Pharma in December 2019, as well as Dermavant, whose acquisition by Organon is pending

2024 Is a Year of Expansion for Roivant

Deliver Clinical Data for Leading Anti-FcRn Franchise and Announce Development Plans for 1402

Anticipate that deeper IgG suppression may lead to greater efficacy across multiple indications with data from batoclimab to inform IMVT-1402 trial design

Advance Clinical Development In a Range of Underappreciated Pipeline Opportunities

Initiate brepocitinib Phase 3 program in NIU and mosliciguat Phase 2 program in PH-ILD; namilumab Phase 2 readout to inform portfolio prioritization

Expand VTAMA Label with AD & Accelerate PsO Revenue Growth

Deal Expected to Maximize Growth Potential

sNDA filed with FDA PDUFA action expected 4Q 2024; accelerate PsO revenue growth through script expansion and GTN yield accretion

Expand Pipeline Through Mid-Late-Stage Business Development

Bolster pipeline through creative, win-win deals with partners, enabled by execution track record and strong balance sheet

Prioritize Capital Allocation Towards Best Value Creation Opportunities

Plan to be prudent and thoughtful deploying capital; will prioritize optimizing shareholder base for next era of Roivant growth

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Note: All timelines reference calendar years

Our Next Chapter is Anchored by Our Robust Late-Stage Pipeline

Exciting late-stage pipeline with 6 ongoing registrational trials in multi-billion dollar markets and 4-5 additional potentially registrational programs with IMVT-1402 expected by March 31, 2025

	Modality	Preclinical	Phase 1	Phase 2	Phase 3	Approved
BATOCLIMAB Myasthenia Gravis | *Immunovant*	*Biologic*				▶	
BATOCLIMAB Thyroid Eye Disease | *Immunovant*	*Biologic*				▶	
BATOCLIMAB Chronic Inflammatory Demyelinating Polyneuropathy | *Immunovant*	*Biologic*			▶		
IMVT-1402 Graves' Disease | *Immunovant*	*Biologic*				▶	
IMVT-1402 Numerous Additional Indications | *Immunovant*	*Biologic*			▶		
BREPOCITINIB Dermatomyositis | *Priovant*	*Small Molecule*				▶	
BREPOCITINIB Non-Infectious Uveitis | *Priovant*	*Small Molecule*				▶	
BREPOCITINIB Other Indications | *Priovant*	*Small Molecule*			▶		
NAMILUMAB Sarcoidosis | *Kinevant*	*Biologic*			▶		
MOSLICIGUAT Pulmonary Hypertension associated with Interstitial Lung Disease | *Pulmovant*	*Inhaled*			▶		
ONGOING BD Pipeline Expansion Opportunities | *Roivant*						

▶ Represents potentially registrational trials

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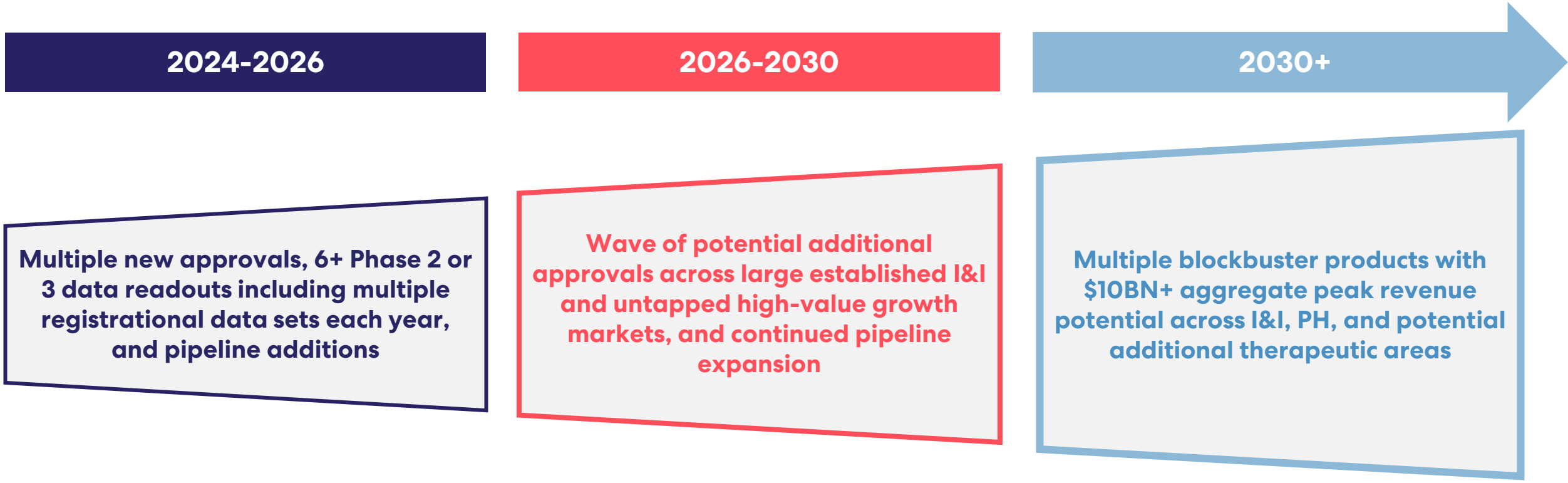
Note: Pipeline reflects both ongoing clinical trials and expected upcoming trials

Charting a Path to a $10BN+ Portfolio Spanning Multiple Therapeutic Areas

Continuing to focus on patients suffering from diseases with high mortality, low quality of life and limited treatment options



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Note: Revenue potential based on internal company estimates
I&I = Inflammation & Immunology
PH = Pulmonary Hypertension

Pipeline Expansion Enabled By Roivant's Track Record and Balance Sheet

Our partners come from all over the pharmaceutical landscape

We build win-win deals for us and our partners

- 10-Year track record of finding, securing and developing high-conviction promising drug candidates
- Creative deal structures have led to win-win outcomes for our partners and Roivant
- Shared financial successes with partners has increased collaboration interest with Roivant
- Our balance sheet and execution capabilities make us a uniquely valuable partner

Rich Catalyst Calendar

Program	Vant	Catalyst	Expected Timing
Roivant pipeline growth		New mid/late-stage in-licensing announcements	Ongoing
LNP platform		Updates to LNP patent litigation	Ongoing
Namilumab		Topline data from Phase 2 trial in sarcoidosis	4Q 2024
Batoclimab		Topline data from Phase 3 trial in myasthenia gravis	By FY End
Batoclimab		Initial data from period 1 of Phase 2B trial in chronic inflammatory demyelinating polyneuropathy	By FY End
Batoclimab		Topline data from Phase 3 trials in thyroid eye disease	1H 2025
Brepocitinib		Topline data from Phase 3 trial in dermatomyositis	2H 2025
Mosliciguat		Topline data from Phase 2 trial in pulmonary hypertension associated with interstitial lung disease	2H 2026

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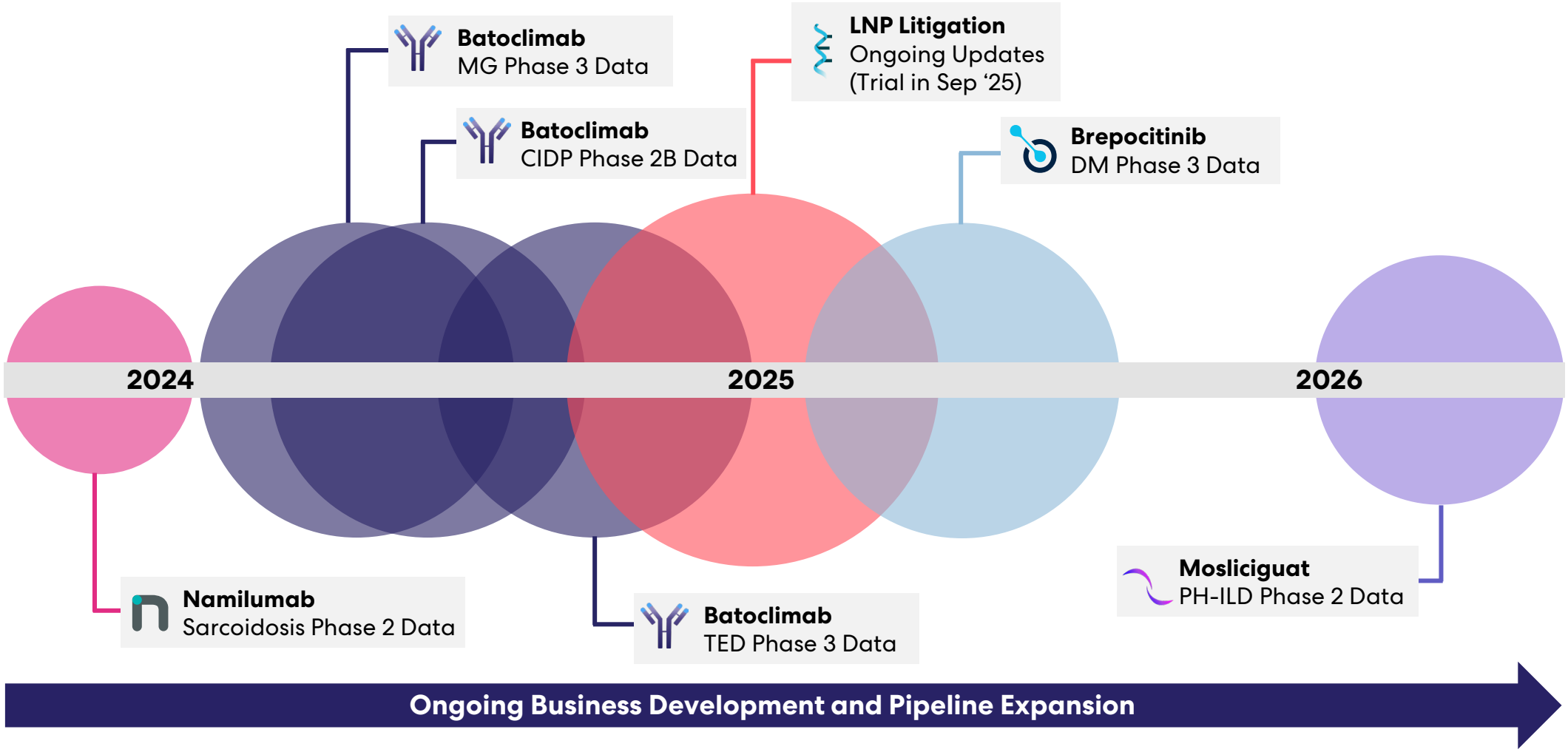
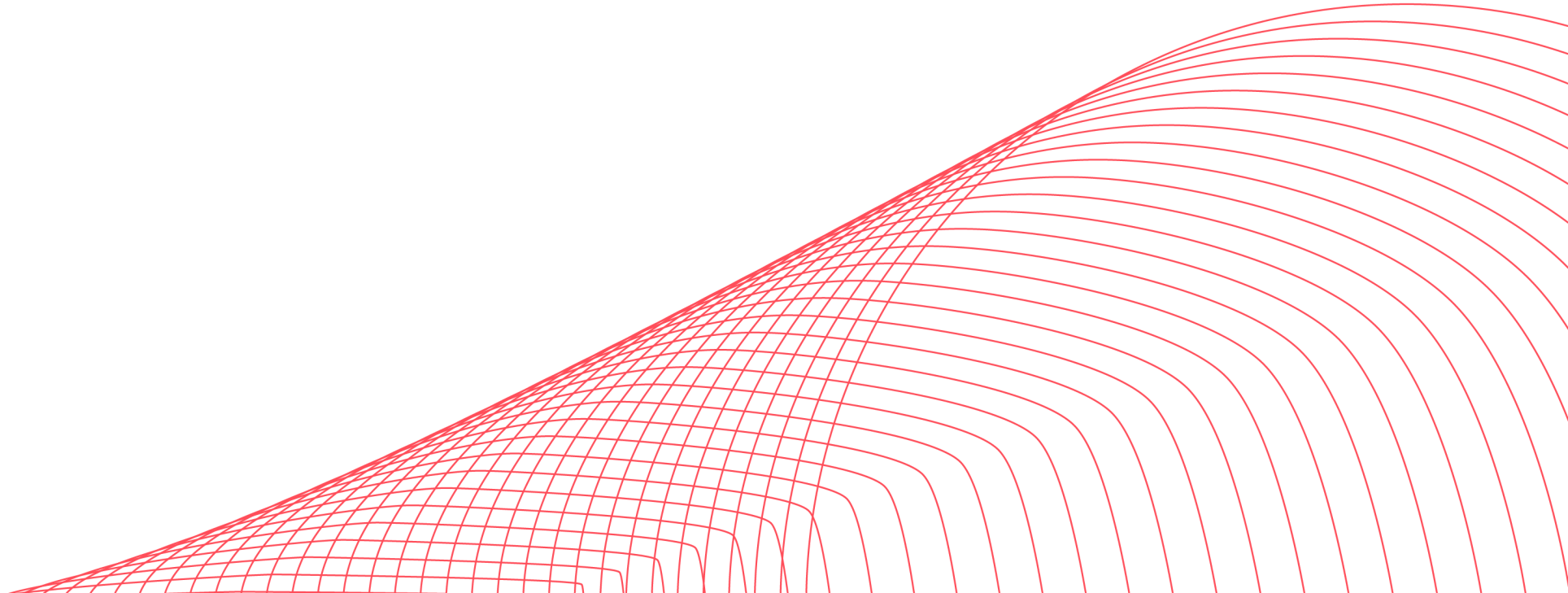
Note: All catalyst timings are based on current expectations and, where applicable, contingent on FDA feedback, and may be subject to change. All timelines reference calendar years unless otherwise noted. FY= Fiscal Year

Multi-Billion $ Value Creation Opportunities Over the Next 2 Years



Note: Figure is illustrative of potential near-term value creation opportunities and is not intended to be representative of specific dollar values or relative amounts associated with the events noted. All references are to calendar years and are approximate and subject to change. See Slide 2 for further information on these forward-looking statements

Pending Dermavant Deal with Organon



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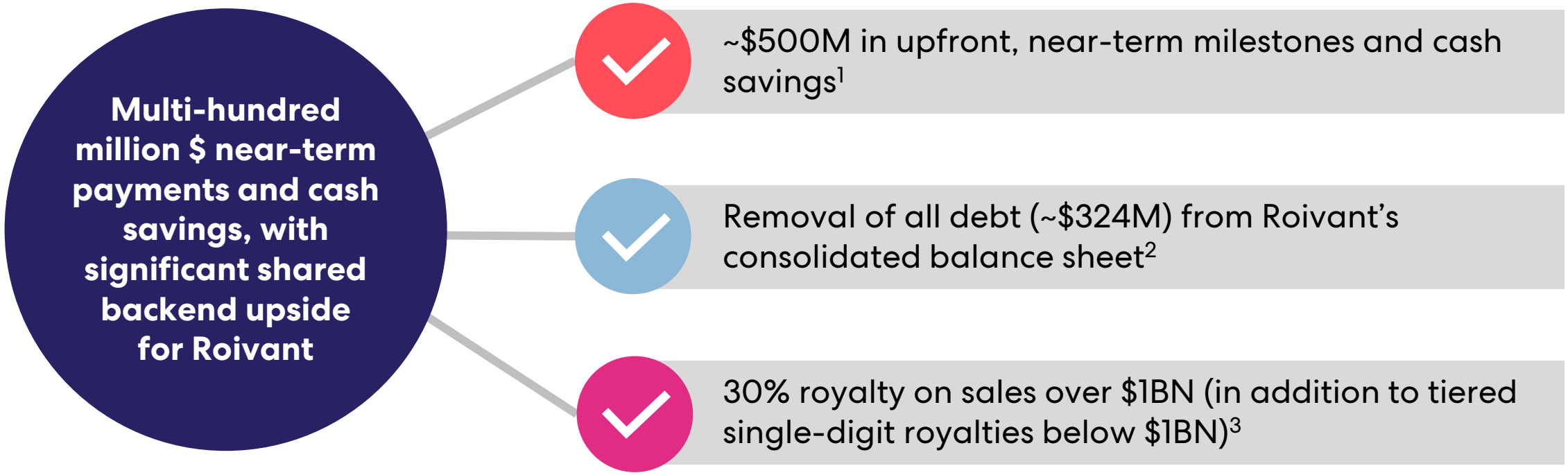
Dermavant Deal Generates Meaningful Additional Capital for Roivant with the Potential for Additional Shareholder Return While Maintaining a Large Share in Potential VTAMA Upside



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1. Near-term defined as within the next 3 years. Net of repayment of credit facility which will occur at or before closing
2. Organon to assume Novaquest payments and RIPSA royalties. Credit facility will be repaid at or before closing. Value of debt based on June 30, 2024 balance sheet net carrying value
3. Royalties begin in 2027

$1.2BN in Potential Payments Across Upfront and Milestones, Plus Additional Upside from Assumed Debt, Cost Savings and Royalties

Deal will maximize VTAMA patient reach and value potential as AD launch approaches

Upfront Payment	$175M on closing[1]
Regulatory Milestone	$75M upon US AD approval (expected by CYE 2024)
Sales Milestones	**Up to $950M aggregate, all at ≤$1BN net sales**
Sales Royalties	Tiered low-to-mid single-digit royalties on net sales below $1BN; 30% royalty on net sales over $1BN[2]
Debt	Organon to assume NovaQuest payments and RIPSA royalties with ~$286M carrying value[3]
Scope	Organon to acquire Dermavant, which owns rights to VTAMA cream globally (excluding China) and has out-licensed Japan rights; Roivant will not retain any Dermavant liabilities/obligations post-closing

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Note: Under the Merger Agreement, Roivant will receive 100% of payments to equity holders up to the liquidation preference of its preferred shares (currently $187.5M) and will participate proportionally in any future payments based on its common stock ownership. As reported in its 10-Q filing for the quarter ended June 30, 2024, Roivant held 87% of issued and outstanding common and preferred shares and 82% of Dermavant's equity interests on a fully-diluted basis. Royalties begin in 2027.

1. Credit facility will be repaid at or before closing
2. Royalties begin in 2027
3. Value of debt based on June 30, 2024 balance sheet net carrying value

Anti-FcRn Franchise: IMVT-1402 and Batoclimab

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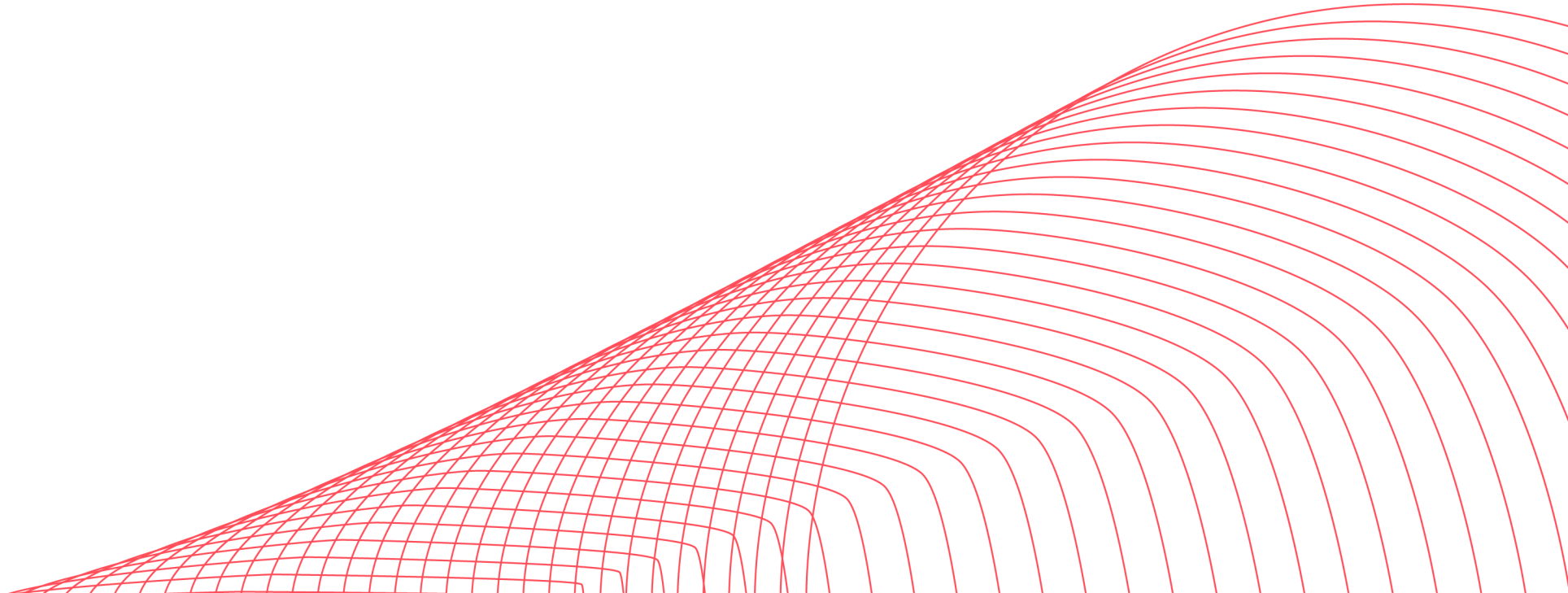
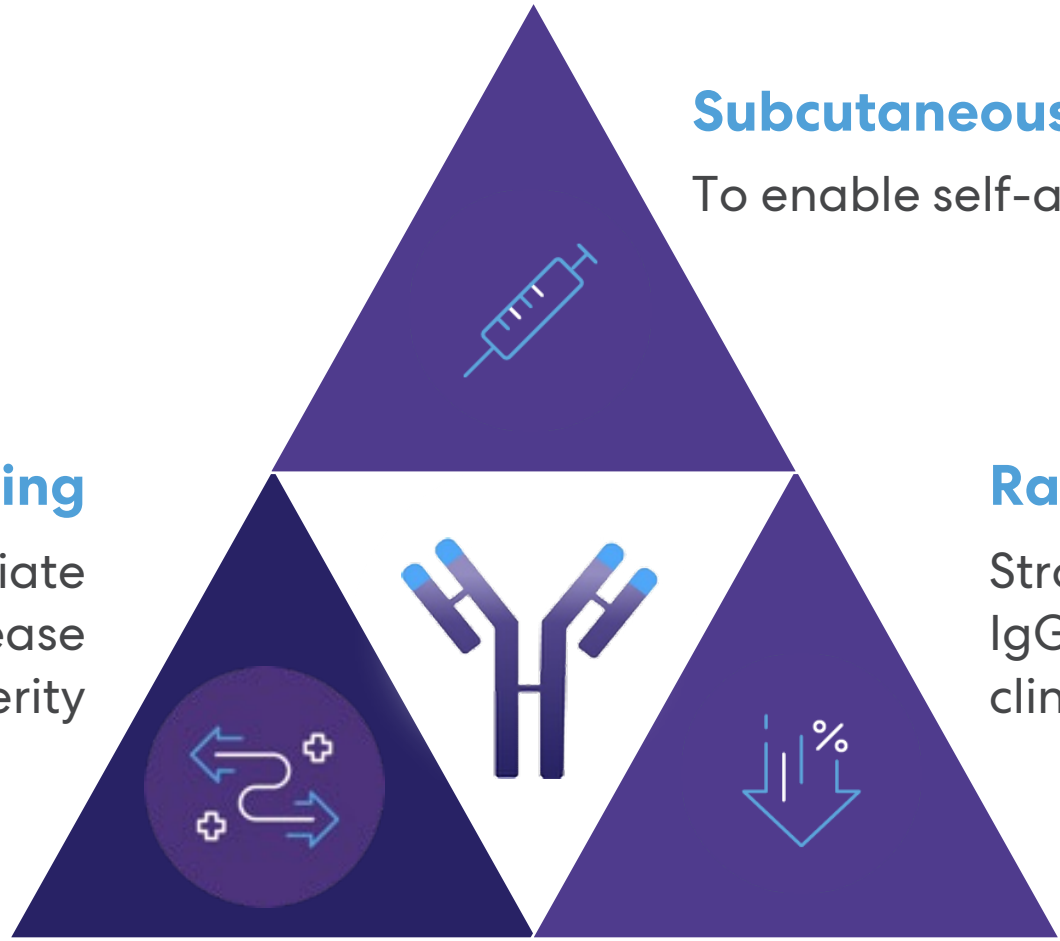


FcRn Franchise Offers Three Potentially Unique Attributes to Address Unmet Patient Needs

Subcutaneous injection

To enable self-administration at home



Tailored dosing

To help alleviate symptoms across disease stage and severity

Rapid & deep IgG reduction

Strong correlation between deep IgG reduction and increased clinical efficacy

Anti-FcRn Antibody Development has Seen Explosive Growth from 2020 to 2024

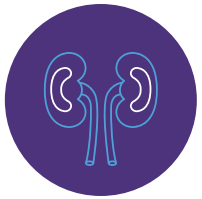
2020		2024	
8	**~700K**	**23**	**~4M**
Total Indications in Development	Total Addressable Patient Population	Total Indications in Development	Total Addressable Patient Population

NEUROLOGY

HEMATOLOGY

ENDOCRINOLOGY

RHEUMATOLOGY



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DERMATOLOGY

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Note: Indications announced cover anti-FcRn antibodies in development by Immunovant, Argenx, JNJ and UCB

Substantial Increase in Clinical Validation of FcRn Antibody Biology: Now with ~2,000 Patients Studied in 22 Positive Late-stage Trials

4 compounds across 9 indications have demonstrated success in 7 Phase 3 (N = ~1,300) and 15 Phase 2 (N = ~700) trials, with only 3 failed trials

Indication	FcRn	Phase	N
Myasthenia Gravis	Efgartigimod (SC)	Phase 3	110
	Efgartigimod (IV)	Phase 3	167
	Efgartigimod (IV)	Phase 2	24
	Rozanolixizumab (SC Infusion)	Phase 3	200
	Rozanolixizumab (SC Infusion)	Phase 2	43
	Nipocalimab (IV)	Phase 3	199
	Nipocalimab (IV)	Phase 2	68
	Batoclimab (SC) – Immunovant	Phase 2	17
	Batoclimab (SC) – Harbour	Phase 3	132
	Batoclimab (SC) – Harbour	Phase 2	30
Primary Immune Thrombocytopenia	Efgartigimod (IV)	Phase 3	131
	Efgartigimod (IV)	Phase 2	38
	Rozanolixizumab (SC Infusion)	Phase 2	66
Sjogren's Syndrome	Efgartigimod (IV)	Phase 2	31
	Nipocalimab (IV)	Phase 2	163
Thyroid Eye Disease	Batoclimab (SC)	Phase 2b	65
	Batoclimab (SC)	Phase 2a	7
Pemphigus Vulgaris / Pemphigus Foliaceus	Efgartigimod (IV)	Phase 2	34
Chronic Inflammatory Demyelinating Polyneuropathy	Efgartigimod (SC)	Phase 2/3	322
Graves' Disease	Batoclimab (SC)	Phase 2a	25
Hemolytic Disease of the Fetus and Newborn	Nipocalimab (IV)	Phase 2	13
Rheumatoid Arthritis	Nipocalimab (IV)	Phase 2	53
Total Indications = 9	**Total Compounds = 4**	**Total Trials = 22**	**Total N = ~2,000**

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Sources: public presentations, press releases, clinicaltrials.gov

Anti-FcRn Antibodies Have Significantly Discharged Development and Commercial Risks Versus Other Emerging Mechanisms in Autoimmune Disease

	Anti-FcRn Antibodies	IgG Degraders[1]	CAR-T[2]	T-Cell Engagers[3]
Approvals	2	0	0	0
Positive Phase 3 Trials	7	0	0	0
Positive Phase 2 Trials	15	0	2[4]	0
No. of Patients and Healthy Subjects with Released Data[5]	>2,300	<32	<70	<10

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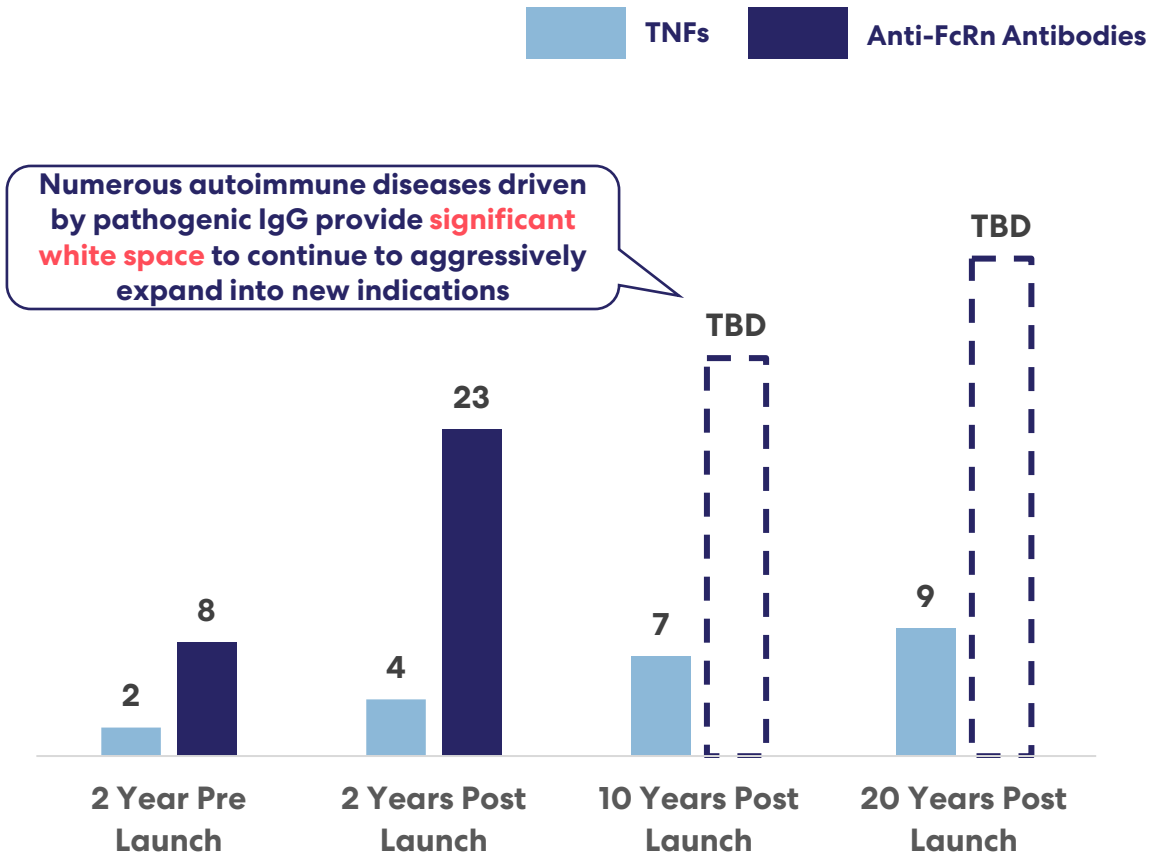
Note: Table summarizes approvals and trials for compounds treating only auto-immune indications

1. Biohaven has released Phase 1 SAD data in four cohorts of 6-8 patients. No patients with auto-immune diseases have been dosed to-date
2. Number of patients with released data comes from studies from Schett German Academic Group, Novartis (YTB323), Cabaletta (CABA-201), Kyverna (KYV-101), iCell (BCMA-CD-19 CAR), Cartesian (Descartes-08), IASO (CT103A)
3. Number of patients with released data comes from pilot studies of blinatumomab in RA and SSc
4. Cartesian Therapeutics Phase 2 Study in MG (N=14) with Descartes-08, an RNA CAR-T (rCAR-T) therapy. Company PR – June 22, 2023. Cartesian Therapeutics Phase 2b Study in MG (N=36) with Descartes-08. Company PR – July 2, 2024
5. Patients in autoimmune diseases or healthy subjects

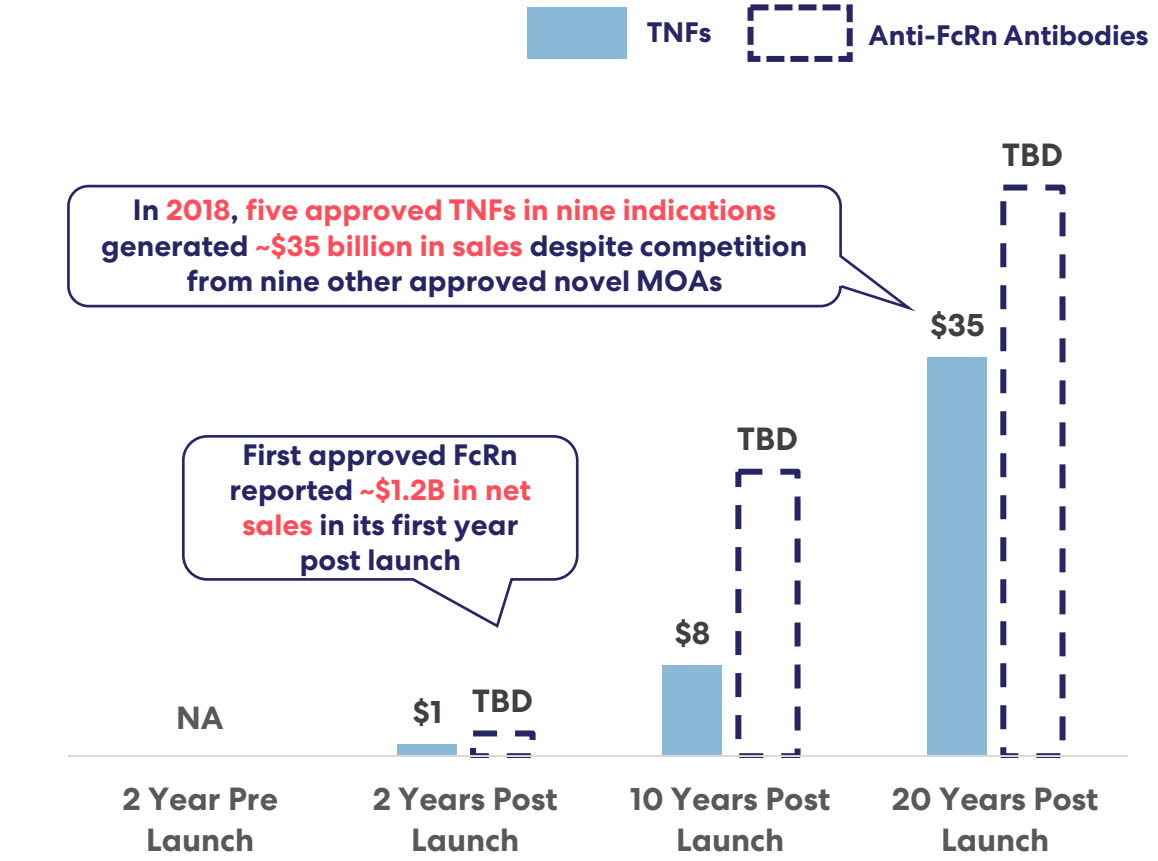
Evolution of the Anti-FcRn Antibody Class is Analogous to the TNF Class

Anti-FcRn antibodies, at the beginning of their development cycle, are already outpacing indication expansion timeline of TNF agents at a similar timepoint

Indications Approved/In Development



Sales ($ in Billions)



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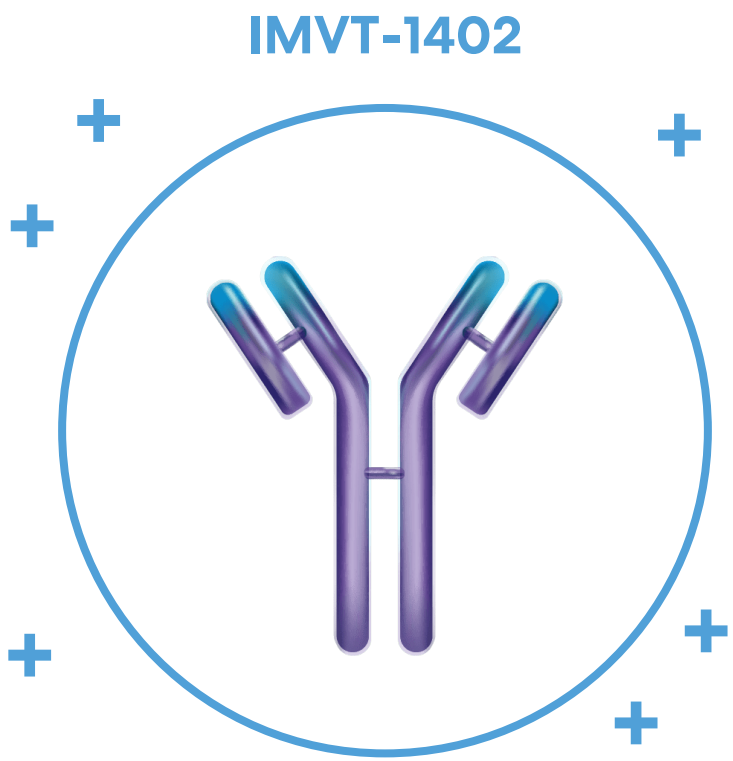
Note: TNF Sales Source: IQVIA (IMS). FcRn Sales Source: ARGX Investor Presentation
Note: Launch year for first TNF – 1998, Launch year for first FcRn – 2022
Note: Other approved mechanisms approved in the US in TNF-approved indications as of 2018 were integrin, JAK, IL-1, IL-6, IL-12/23, IL-17, IL-23, CD20,and CD80/86

IMVT-1402 Has a Combination of Potentially Best-In-Class Attributes Not Seen with Other Anti-FcRns



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

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

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

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

Compelling Patent Protection Issued patent covers composition of matter, method of use and methods for manufacturing to 2043*

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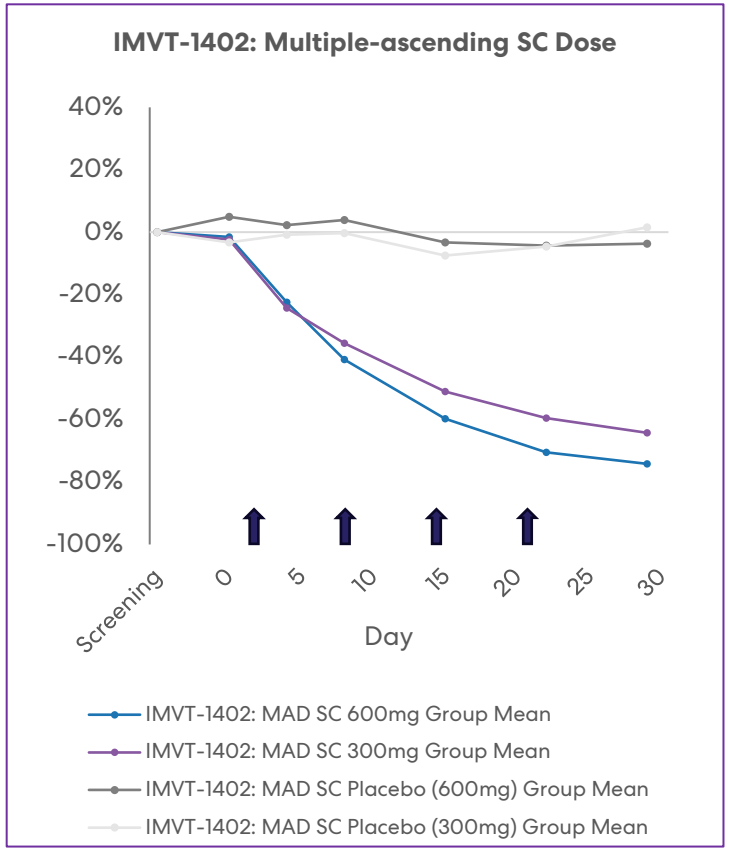
* Not including any potential patent term extension

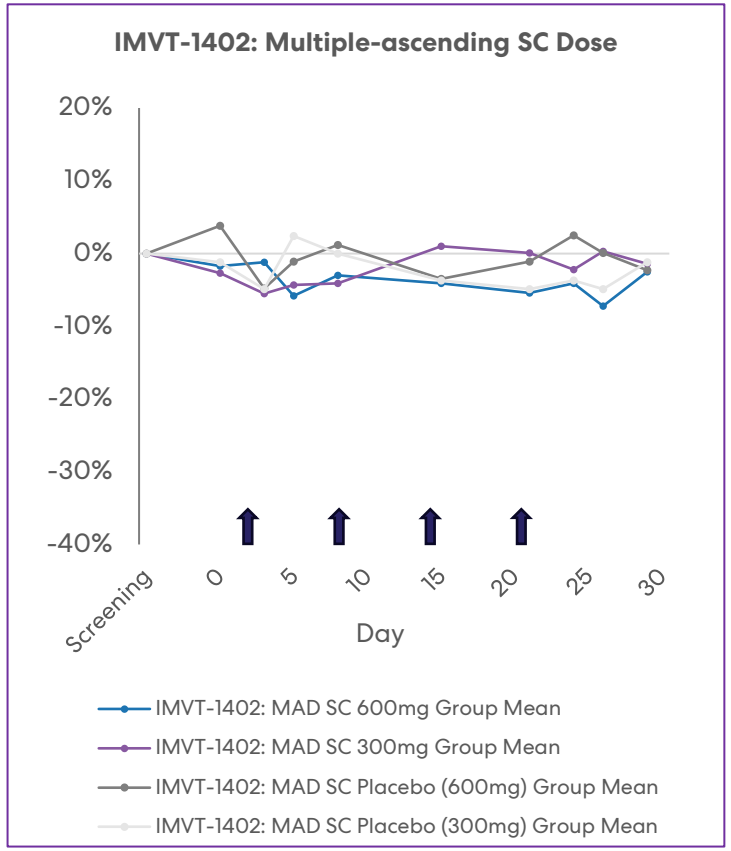
IMVT-1402 Demonstrated Potentially Best-in-Class Profile in Initial Phase 1 Clinical Trial Data in Healthy Adults

Deep IgG reduction with minimal to no impact on albumin and LDL

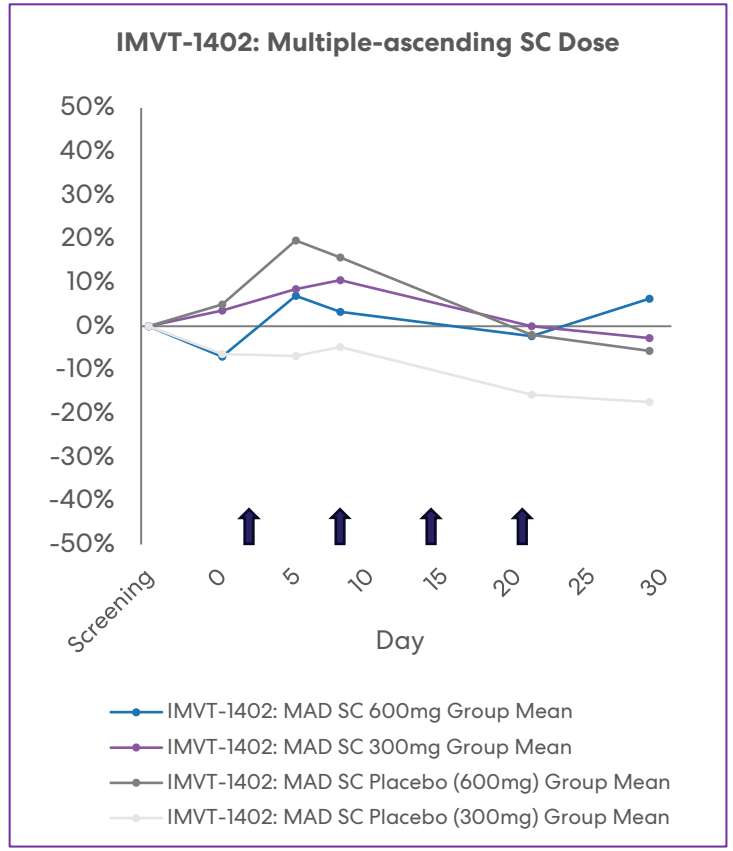
IgG % change over time



Albumin % change over time



LDL % change over time



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Consistent Evidence Across Programs and Indications that Greater IgG Reduction Leads to Greater Efficacy*

	Company	Evidence of Greater IgG Reductions Translating to Clinical Benefit
MG	argenx / janssen	Patient-level scatter plot showed that greater IgG declines ➔ greater MG-ADL improvements
TED	IMMUNOVANT	Greater IgG reduction across arms ➔ higher rates of anti-TSHR antibody reduction and greater clinical response rates
GD	IMMUNOVANT	Greater IgG reduction across treatment cohorts ➔ higher rates of anti-TSHR autoantibody reduction and numerically higher responses for ATD dose tapering and ATD discontinuation observed
ITP	ucb	Greater IgG reduction across arms ➔ greater platelet responses
RA	janssen	In those patients with greater IgG reduction ➔ correlation with greater autoAb reduction ➔ correlation with greater clinical response

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*Many of the analyses above were post-hoc and not all were statistically significant. Cross trial and post-hoc analyses are inherently limited and are presented for hypothesis generating purposes only, nevertheless consistent and numerically positive increases in efficacy were observed as noted above
Note: MG: Myasthenia gravis, TED: Thyroid eye disease, PV: Pemphigus vulgaris, ITP: Immune thrombocytopenic purpura, RA: Rheumatoid arthritis, GD: Graves' disease

Batoclimab TED Data and Nipocalimab RA Data Showed Higher Clinical Response with Deeper IgG Reduction

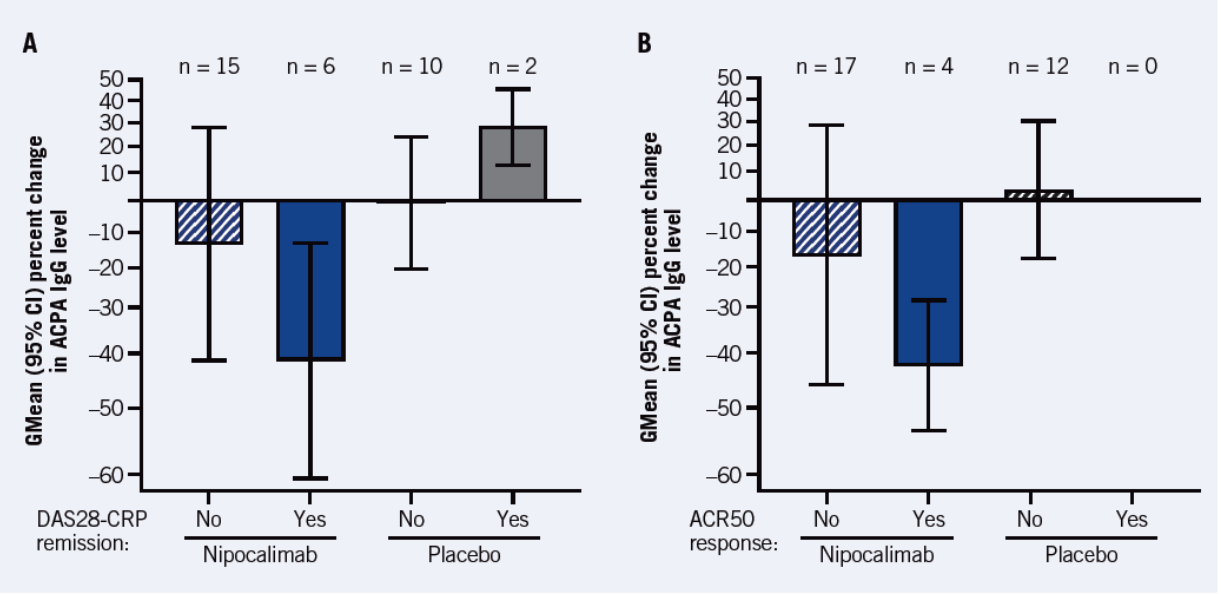
Deeper IgG reduction led to greater restoration of normal levels of pathogenic antibodies and greater proptosis response in Phase 2 trial in TED

	Placebo	Batoclimab 255 mg	Batoclimab 340 mg	Batoclimab 680 mg
Median Max % IgG Reduction at Week 5[1]	3%	54%	63%	79%
% Subjects with Stimulatory anti-TSHR Antibody below 140 at Week 5	0%	0%	12%	57%
Proptosis Response Rate at Week 5[2]	0%	11%	29%	43%

1. Week 5 data (study day 36) selected as it represents the latest time point at which the largest amount of patient data is available prior to the voluntary pause of the study. 2. Post-hoc analysis of proptosis response at week 5. Proptosis response defined as proptosis reduction ≥2 mm in study eye, without ≥2 mm increase in non-study eye at same visit.

Nipocalimab Phase 2 trial in RA showed a correlation between auto-Ab reductions and clinical response

Figure 4. Percent Changes From Baseline at Trough in ACPA IgG (Anti-CCP2) Levels Versus (A) DAS28-CRP Remission and (B) ACR50 Response at Week 12



ACPA, anti-citrullinated protein autoantibody; ACR50, ≥50% response in American College of Rheumatology response criteria; anti-CCP2, anti-cyclic citrullinated peptide 2 antibody; CI, confidence interval; DAS28-CRP, Disease Activity Score 28 using C-reactive protein; GMean, geometric mean; IgG, immunoglobulin G.

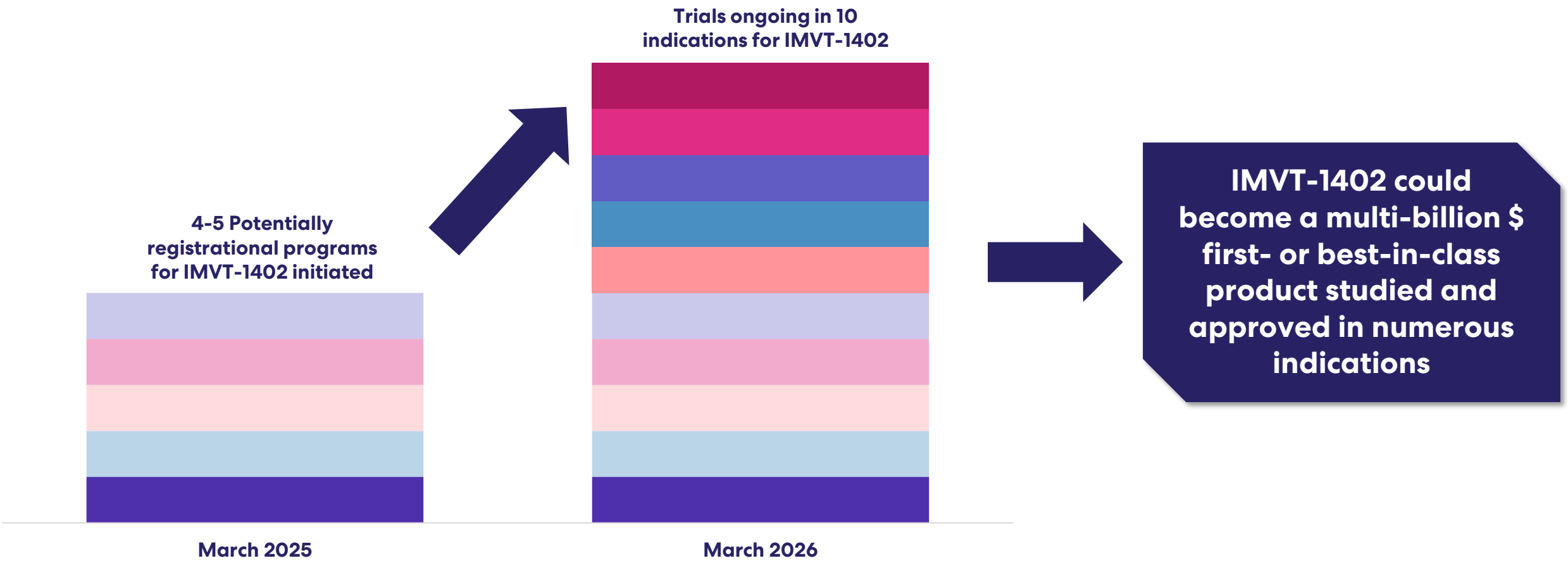
Source: Pharmacodynamic effects of nipocalimab in patients with moderate to severe active rheumatoid arthritis (RA): Results from the multicenter, randomized, double-blinded, placebo-controlled Phase 2A IRIS-RA study. Janssen Research & Development, ACR poster, November 2023.

Potential Best-in-Class Product Profile Opens Broad Range of Indication Opportunities for IMVT-1402

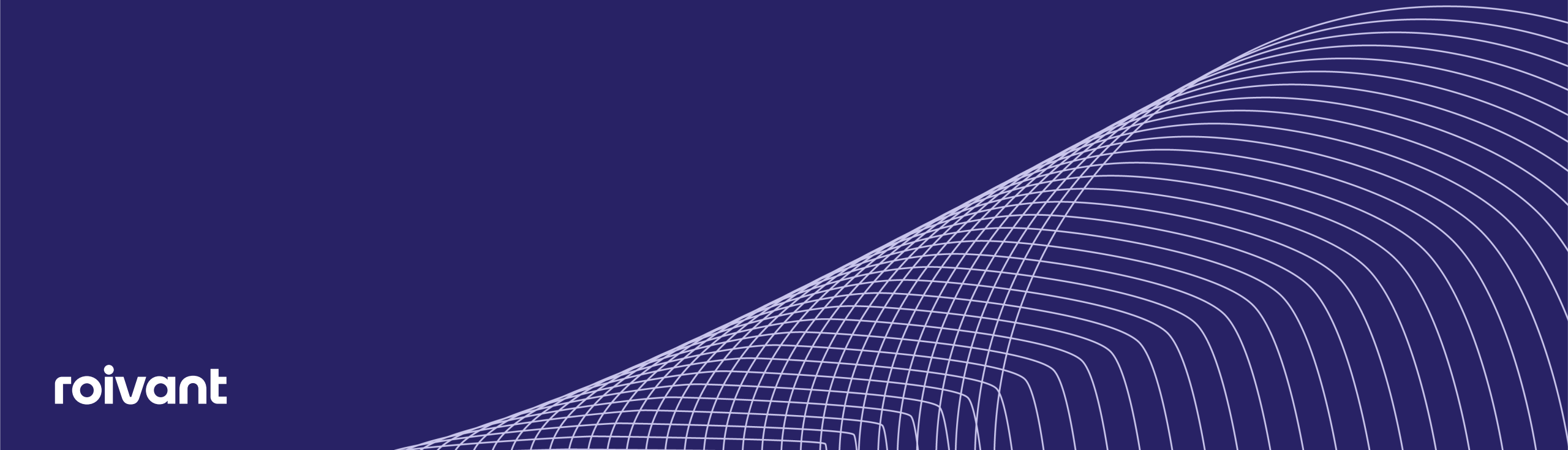
First-in-Class	• Assuming differentiated benefit/risk and simple SC delivery, opportunity to leverage potency of 1402 to further expand applicable patient types for anti-FcRn development • Example – Graves' disease	**High unmet need, biologic plausibility**
Best-in-Class	• IgG autoantibodies part of disease pathophysiology • Insights from later-stage anti-FcRn programs may be leveraged together with 1402 potency to optimize development approach for IMVT-1402 • Example – MG	**Classic autoAb, class data positive**
Best-in-Class	• Other underserved patient populations • Potential to enhance PTS via focus on subset of patients with autoantibodies of interest and leverage 1402 potency • Example – Refractory rheumatoid arthritis	**Other auto-immune, class data suggestive**

Immunovant is Aggressively Developing IMVT-1402 with Plans to Initiate Trials in a Total of 10 Indications by March 31, 2026

3 INDs for IMVT-1402 expected to be active by December 31, 2024



Indications



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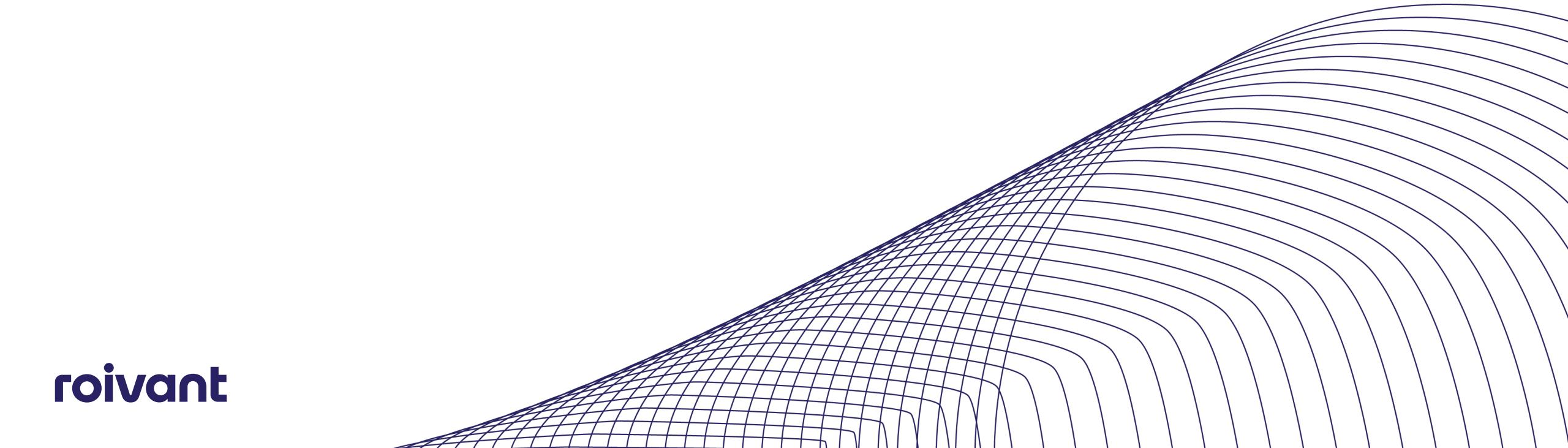
Graves' Disease



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Graves' Disease: a Systemic Disease that Impacts Multiple Organ Systems Leaving Many Patients with Substantial Symptoms

Graves' Disease is an immune disorder characterized by hyperthyroidism and has an incidence of ~65K[1] cases per year and prevalence of ~880K[2] patients in the US

Clinical Presentation and Unmet Need

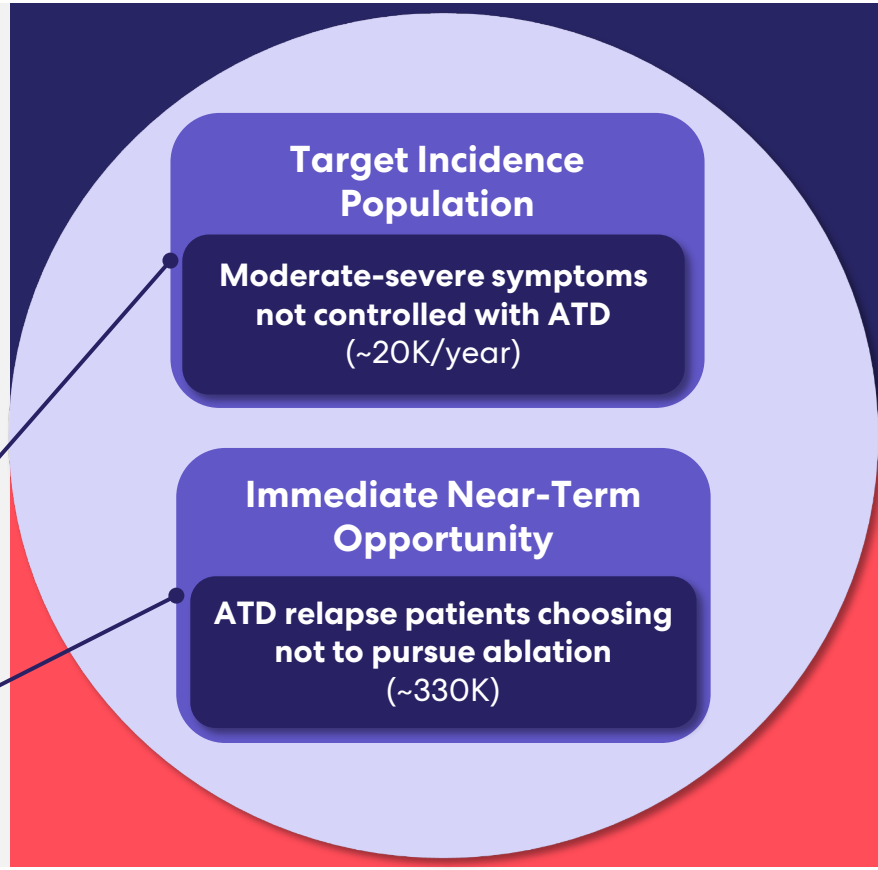
Caused by anti-TSHr autoantibodies which overstimulate the thyroid gland and cause hyperthyroidism; FcRn inhibition could foster degradation of those autoantibodies

Because thyroid hormones affect many body systems, Graves' Disease can impact many organ systems with variable symptoms per patient[3-9]

- 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

- 25-30% of the ~65K[1] US incident Graves' patients are difficult to control with ATD and remain symptomatic
  - Additional upside as alternative to ablative therapies
- 35-40% of the ~880K[2] US prevalent population are ATD relapse patients choosing not to pursue ablation

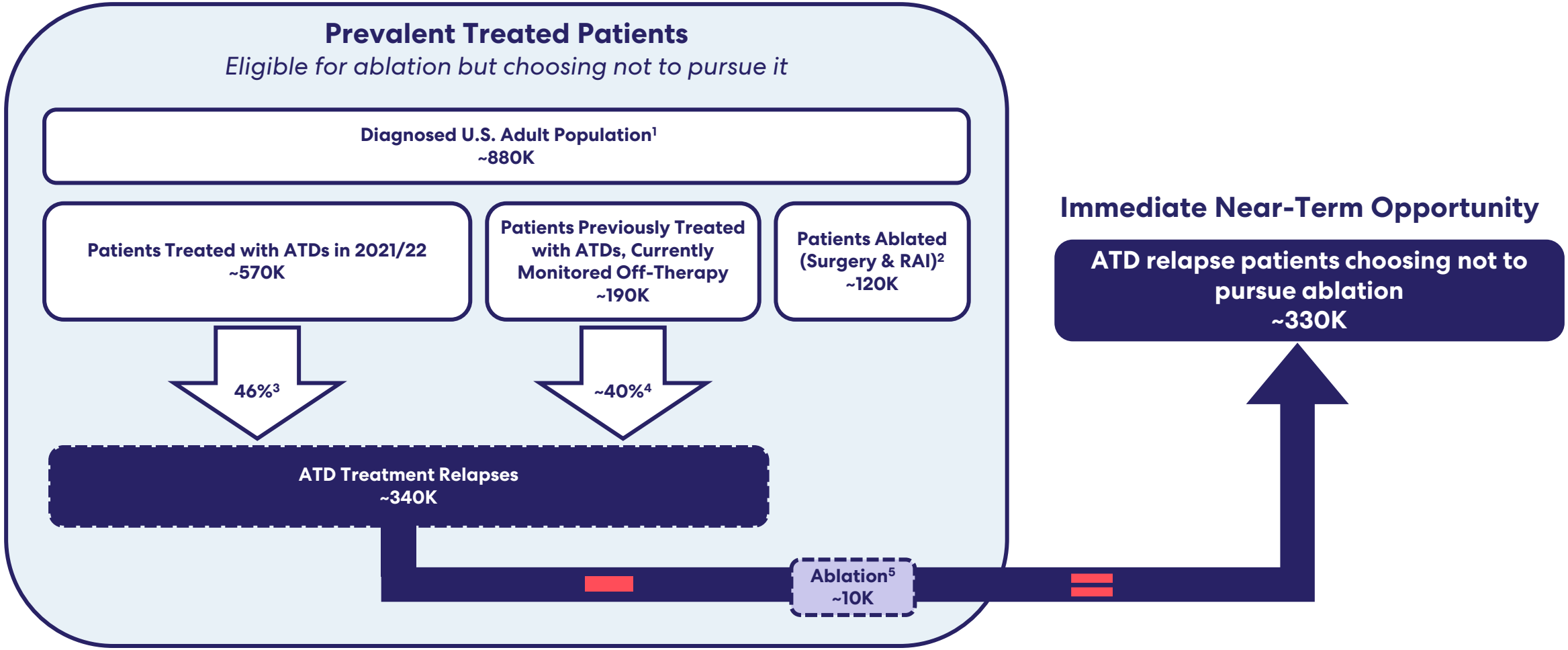


1. Roivant Claims Analysis: 2021 incident patient population
2. Roivant Claims Analysis: 2022 prevalent patient population based on a two-year lookback for diagnosis
3. Girgis CM, Champion BL, Wall JR. Current concepts in Graves" disease. Ther Adv Endocrinol Metab. 2011 Jun;2(3):135-44
4. Gawałko M, Balsam P, Lodziński P, Grabowski M, Krzowski B, Opolski G, Kosiuk J. Cardiac Arrhythmias in Autoimmune Diseases. Circ J. 2020 Apr 24
5. Fukao A, Takamatsu J, Arishima T, Tanaka M, Kawai T, Okamoto Y, Miyauchi A, Imagawa A. Graves" disease and mental disorders. J Clin Transl Endocrinol. 2019 Oct 11
6. Kubota S., Amino N., Matsumoto Y., Ikeda N., Morita S., Kudo T., et al. (2008) Serial changes in liver function tests in patients with thyrotoxicosis induced by Graves" disease and painless thyroiditis. Thyroid 18: 283–287
7. Maser C, Toset A, Roman S. Gastrointestinal manifestations of endocrine disease. World J Gastroenterol. 2006 May 28
8. Dhanwal DK. Thyroid disorders and bone mineral metabolism. Indian J Endocrinol Metab. 2011 Jul
9. Sethi PP, Parchani A, Pathania M. Respiratory Muscle Weakness in Thyrotoxic Periodic Palsy: A Lesson to Remember. Ann Neurosci. 2021 Jul

Multiple Market-Sizing Analyses Confirm High Unmet Need in Graves' Disease with at Least 25-30% of Patients Relapsed, Uncontrolled, or Intolerant to ATDs

1. Conservative Inovalon claims analysis yields ~880K prevalent Graves' Disease patients
2. Conservative Inovalon claims analysis yields ~65K incident Graves' Disease patients
3. Deep dive endocrinologist survey of 140 healthcare providers treating Graves' Disease patients indicates ~25-30% of patients are relapsed, uncontrolled, or intolerant to ATDs
4. Real-world chart audit of 1,120 Graves' Disease patients treated by surveyed endocrinologists indicates ~25-30% of patients are relapsed, uncontrolled, or intolerant to ATDs
5. Patient survey of 100 diagnosed Graves' Disease patients indicates ~25-30% of patients are relapsed, uncontrolled, or intolerant to ATDs

Real World Claims Analysis Indicates a Substantial Untapped Opportunity in the Prevalent Treated Graves' Disease Market



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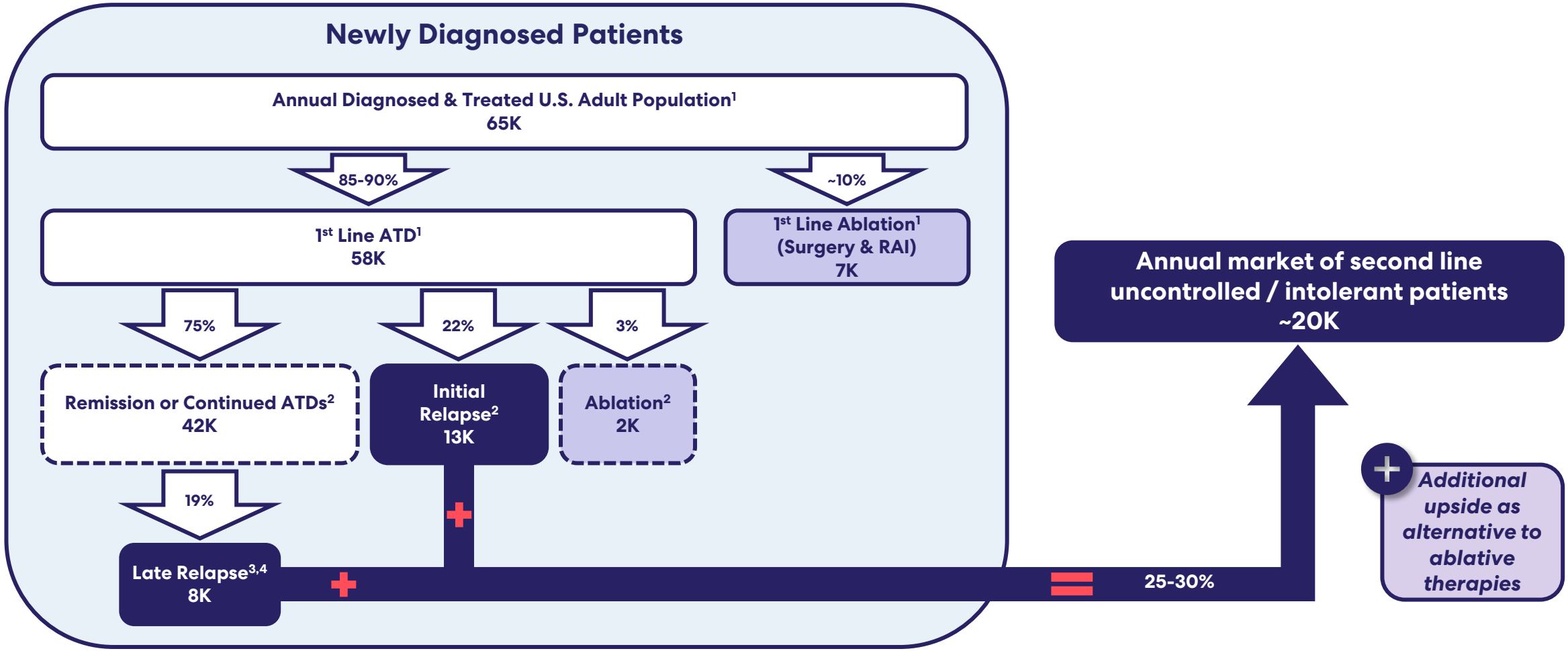
1. Roivant Claims Analysis – 2022 prevalent patient population based on a two-year lookback for diagnosis
2. Of the 121K patients ablated, 77.4K were ablated prior to 2021 and 43.4K were ablated in 2021/2022
3. Azizi et al. (2019): Note, the relapse rate was calculated as a weighted average considering relapse rate in patients on ATDs <18months is 53% compared to patients on ATDs >18months is 15%. Of the 571K patients treated with ATDs, 467K are on ATDs <18months and 104K are on ATDs for >18months. Rates have been applied proportionally
4. Bandai et al. (2019): Of the 188K patients previously treated with ATDs and currently monitored off-therapy, ~40% experience relapse, which is 75K
5. Grove-Laugesen et al. (2023): 3.4% of ATD relapse patients will pursue ablation. 3.4% applied to the 338K ATD treatment relapse patients is 11K

Real World Claims Analysis Conservatively Estimates an Incident US Population of ~65K Leading to an Annual Second Line Market of ~20K Patients



1. Roivant Claims Analysis – 2021 incident patient population, first-line treatment is primary treatment in the first-year post diagnosis, claims review included a five-year lookback to define the incident population
2. Grove-Laugesen et al. (2023): Completer rates for combined arms: ATD remission 56.0%, continuing ATD 18.8%, ATD relapse of 21.8%, ablation of 3.4%. Of the 55.9K 1st line ATD patients, a total of ~75% are either in remission (56.0%: 31.3K) or continued ATDs (18.8%: 10.5K)
3. Azizi et al. (2019): ATD remission for patients on long-term ATDs is 85%. Of the 10.5K patients who continued ATDs, 15% relapse (1.6K) and 85% go into remission (8.9K). These 8.9K patients in remission will have a 15% rate of relapse resulting in 1.3K relapses. From the original 10.5K patients who continued on ATDs, there will be a total of 3K (1.3K +1.6K) relapses
4. Stokland et al. (2023): Relapse post remission 15%. Of the 31.3K patients who are in remission, 15% will relapse (4.7K). In total, the late relapses from remission and continued ATDs will be ~7.6K, resulting in a weighted average relapse rate of ~18% (4.7K relapses from the 31.3K patients in remission averaged with the 2.9K relapses from the 10.5K patients who continued on ATDs)

Batoclimab Phase 2 Proof-of-Concept Trial: The First and Only Anti-FcRn Program Targeting Graves' Disease[1,2]

Inclusion[3]

- 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

Screening (4 weeks)

Treatment Period: (24 weeks)
N = up to 40

Two doses tested over 24 weeks

680mg batoclimab QW SC | **340mg batoclimab QW SC**

Follow-up Period

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

ATD treatment:

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

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1. Based on clinicaltrial.gov database, last accessed on 2/8/2024
2. Lane LC, et al. Endocr Rev. 2020 Dec 1;41(6):873-84
3. Additional inclusion and exclusion criteria not listed on slide

Note: GD = Graves' Disease; ATD = anti-thyroid medications; QW = weekly; SC = subcutaneous injection

Proof of Concept Achieved in Graves' Disease, Positioning IMVT-1402 to Potentially be Best-in-Class and First-in-Class

>75% Response Rate in Patients Uncontrolled on Anti-Thyroid Drugs (ATDs): T3 and T4 rapidly normalized by Week 12 without an increase in ATDs in 76% of patients

>50% of Patients are ATD-Free Responders: 56% of patients not only achieved normal T3 and T4 levels but also ceased ATD therapy entirely by 12 weeks

Lower is Better: Deeper IgG reductions drove meaningfully higher response rates, positioning IMVT-1402 to potentially be best-in-class

High Unmet Need Yields Attractive Commercial Opportunity: 25-30% of Graves' Disease patients per year are uncontrolled on / intolerant to ATDs with no pharmacologic options

IMVT-1402 IND Cleared: Received FDA greenlight, enabling straight to pivotal transition

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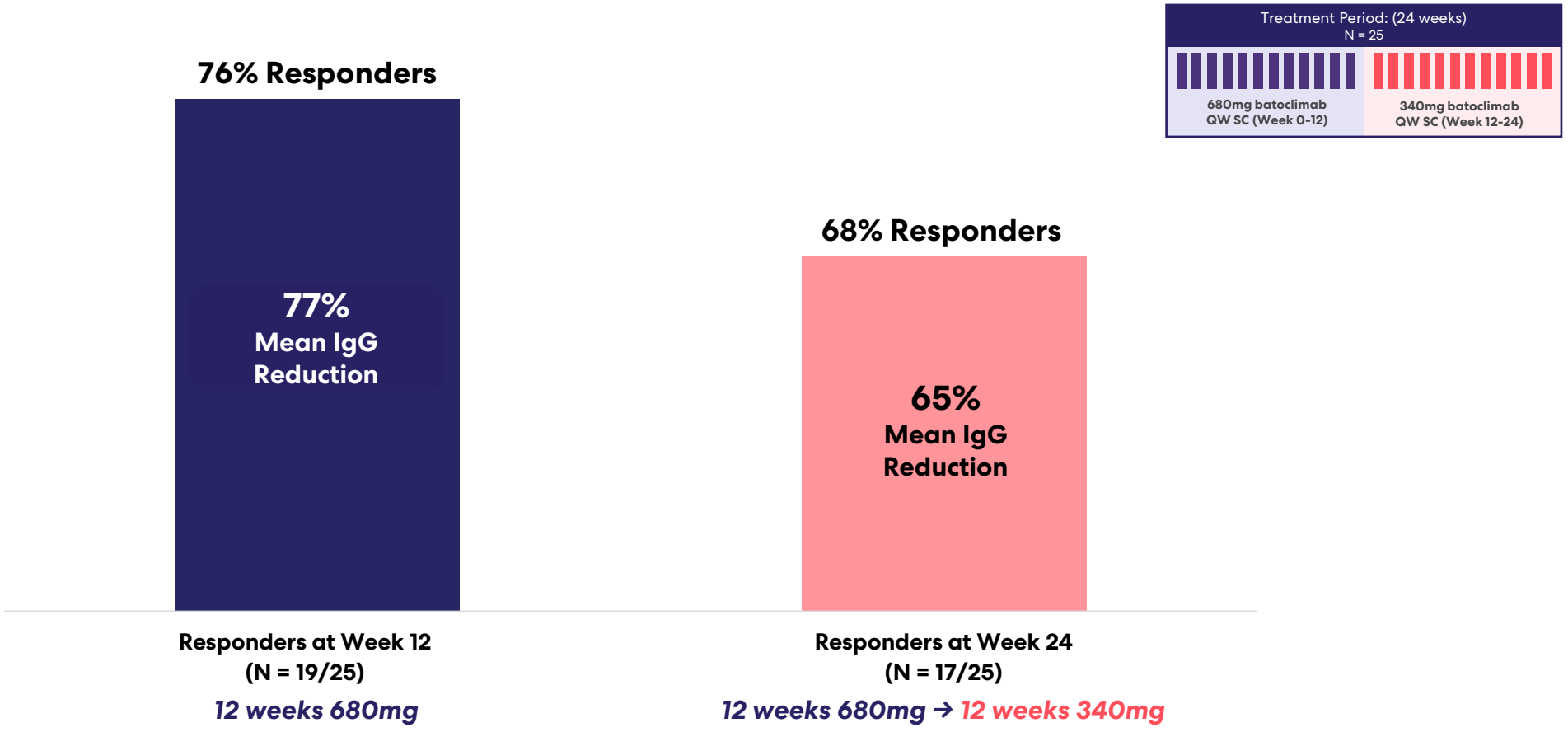
Batoclimab Demonstrated Potentially Transformational Results in ATD-Uncontrolled Patients with Greater Response Driven by Higher IgG Lowering

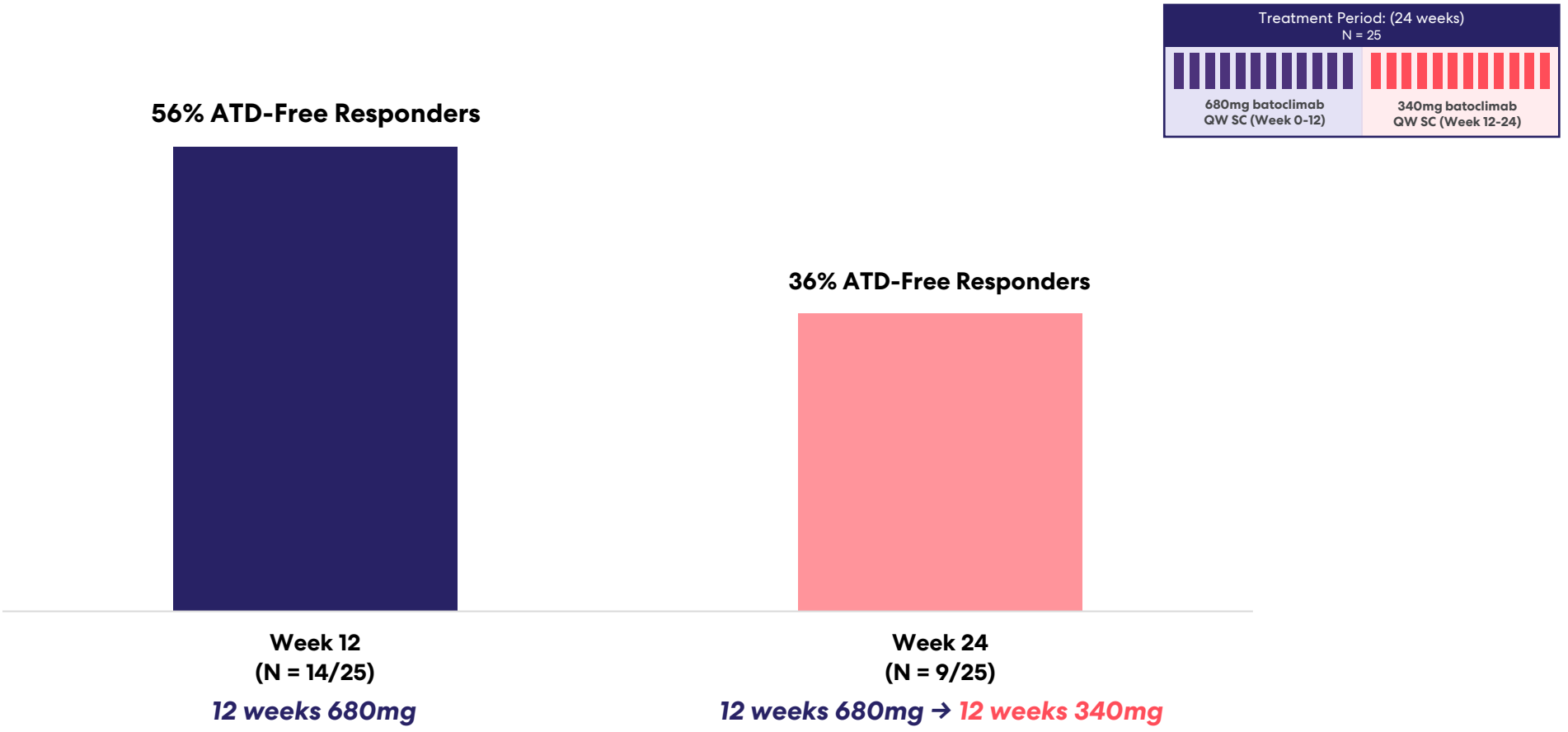
% of participants who achieve normal T3 and T4 or have T3 or T4 below LLN, without increase in ATD



Note: Includes two patient discontinuations. One patient did not complete Week 12 due to pre-existing gallstones and is counted as a non-responder at Week 12 and Week 24. The second patient did not complete Week 24 and is counted as a non-responder at Week 24. This patient was lost to follow-up due to substance abuse unrelated to treatment

>50% of Patients Receiving High-Dose Batoclimab Not Only Achieved Normal T3 and T4 Levels but Also Ceased ATD Entirely by 12 weeks

% of participants who achieve normal T3 and T4 or have T3 or T4 below LLN, and ceased all ATD medications



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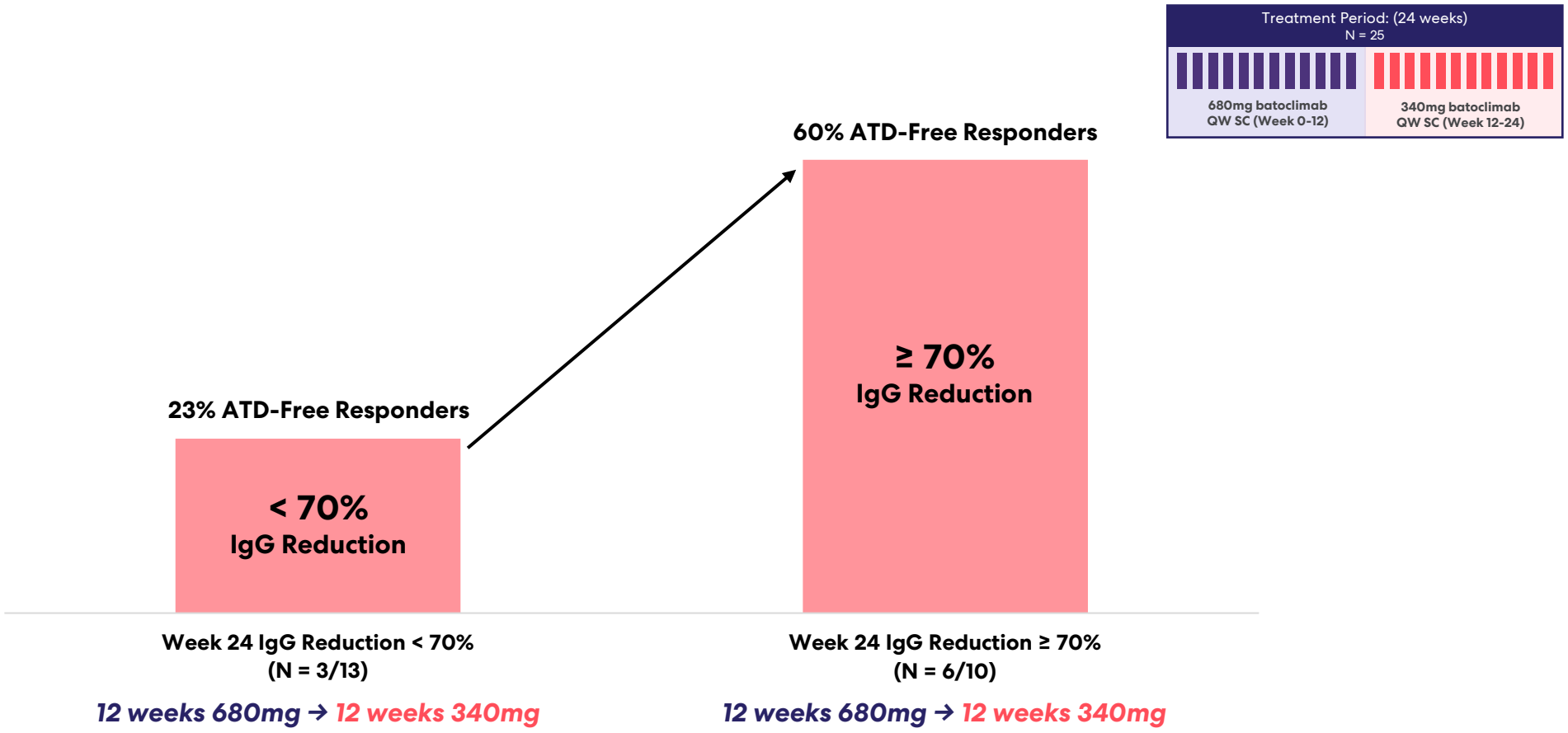
Deeper IgG Reduction at 24 Weeks Was Associated with a Meaningfully Higher ATD-Free Responder Rate

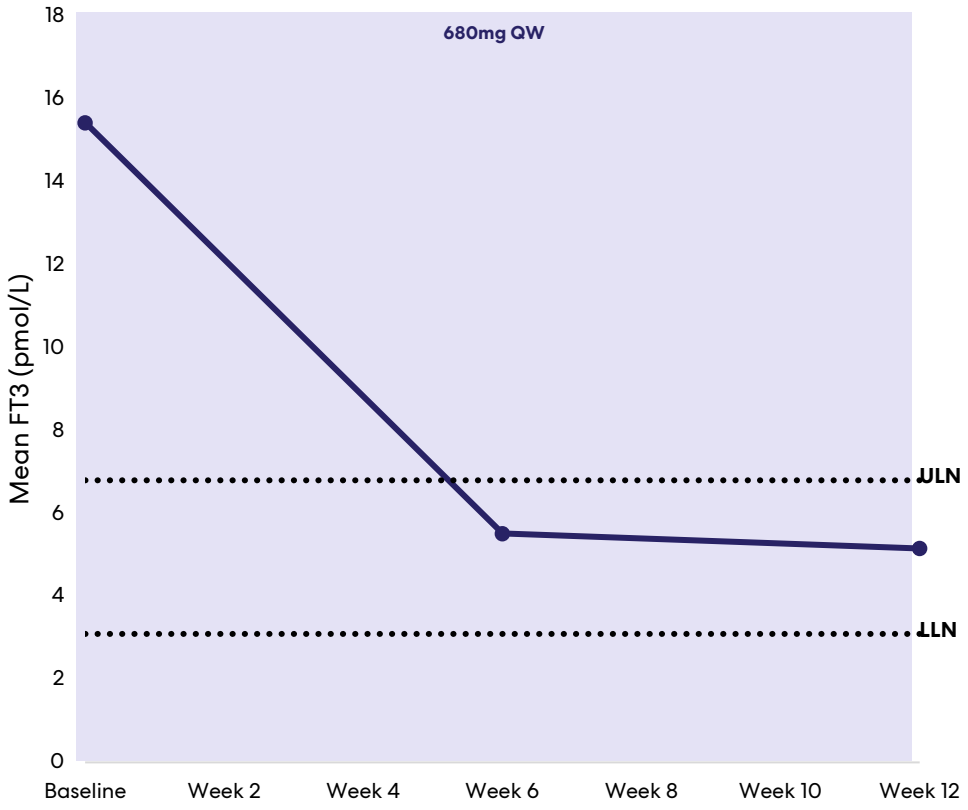
% of participants who achieve normal T3 and T4 or have T3 or T4 below LLN, and ceased all ATD medications



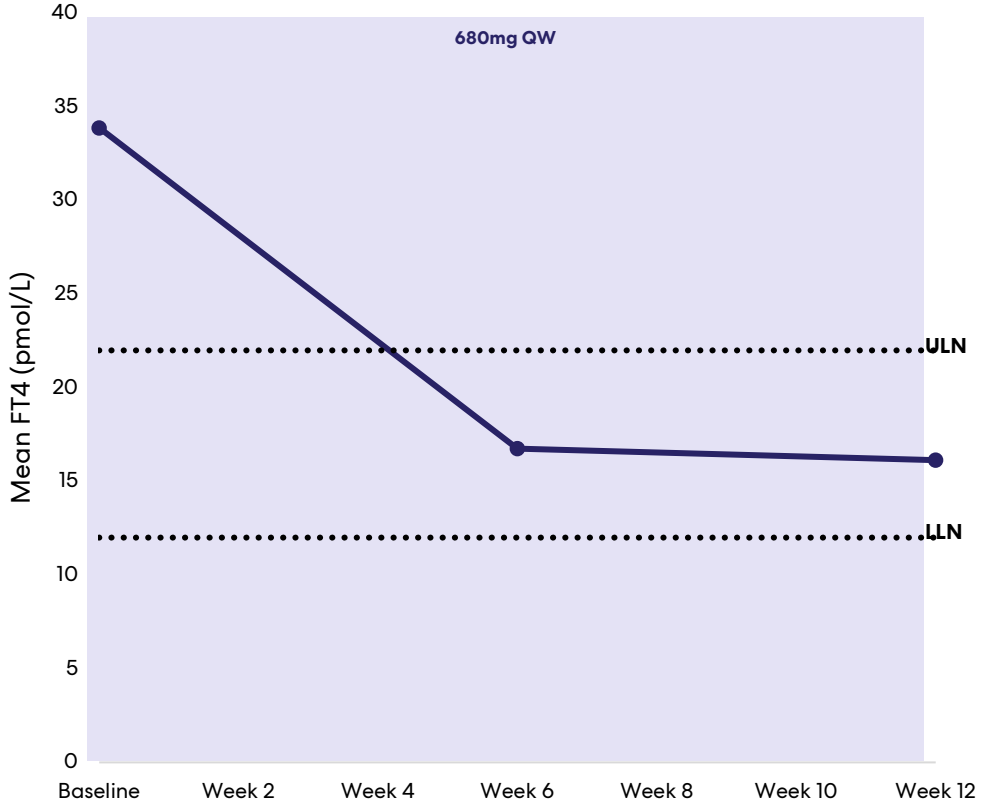
Note: Excludes two patient discontinuations given no IgG data available for these patients at this time point

High-Dose Batoclimab Drives Rapid Normalization of T3 and T4 and ATD Tapering

T3



T4



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Note: T3 / T4 data includes up to last measurement available for two patient discontinuations
Note: T3 LLN=3.1 pmol/L and ULN=6.8 pmol/L; T4 LLN=12 pmol/L and ULN=22 pmol/L

Batoclimab was Well-Tolerated with no New Safety Signals Identified

	Batoclimab SC QW N = 25
Patients with any TEAE, n (%)	25 (100)
Patients with any Serious TEAE	1 (4)
Patients with any Treatment-related Serious TEAE	0
Patients with any Treatment-related TEAE Leading to Study Drug Withdrawal	0
Patients with any TEAE Leading to Study Drug Dose Reduction or Interruption[1]	1 (4)
Patients with any TEAE Leading to Study Discontinuation[2]	1 (4)
Deaths	0

All treatment-related TEAEs were mild or moderate with no serious treatment-related TEAEs reported

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1. Patient experienced moderate menstrual disorder that led to a missed dose. Patient resumed treatment the following week and completed 24 weeks of batoclimab treatment
2. Patient underwent cholecystectomy due to pre-existing gallstones. Event was not related to study treatment

First Pivotal Trial for IMVT-1402 in Graves' Disease

Inclusion[1]

- Adults with active Graves' Disease as documented by presence of TSH-R binding autoantibodies
- Subjects on an ATD for ≥12 weeks before the Screening Visit
- Subjects who are hyperthyroid based on suppressed TSH despite ATD

Randomization (1:1:1)

Treatment Period: 52 Weeks
N = 240

Period 1 (26 weeks blinded treatment)	Period 2 (26 weeks blinded treatment)
Group 1	
600 mg IMVT-1402 QW SC	→ 600 mg IMVT-1402 QW SC
Group 2	
600 mg IMVT-1402 QW SC	*TRAb Responder?* No → 600 mg IMVT-1402 QW SC; Yes → Placebo QW SC
Group 3	
Placebo QW SC	→ Placebo QW SC

Off-Treatment Follow-Up (52 Weeks)

Primary Endpoint: Proportion of participants who become euthyroid[2] and stop ATD at week 26

Key Secondary Endpoint: Proportion of participants who become euthyroid[2] and stop ATD at week 52

Design enables study of remission as upside

ATD titration to lowest effective dose (including 0 mg/day) to maintain euthyroidism

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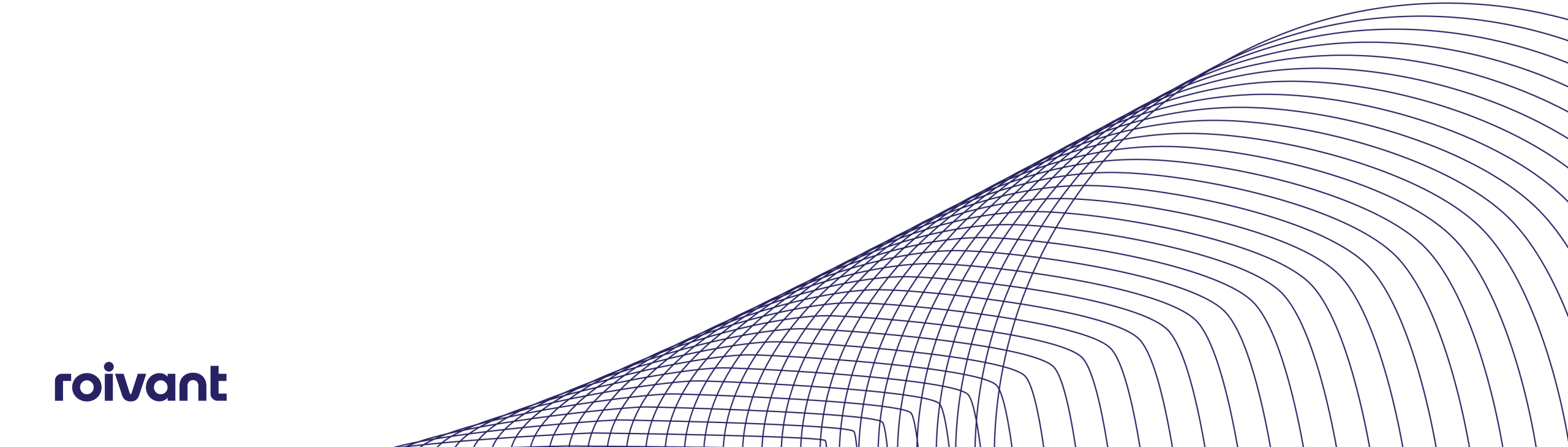
1. Additional inclusion and exclusion criteria not listed on slide
2. Euthyroid = T3/T4 and TSH within normal limits

Note: QW: Weekly; SC: Subcutaneous

Myasthenia Gravis



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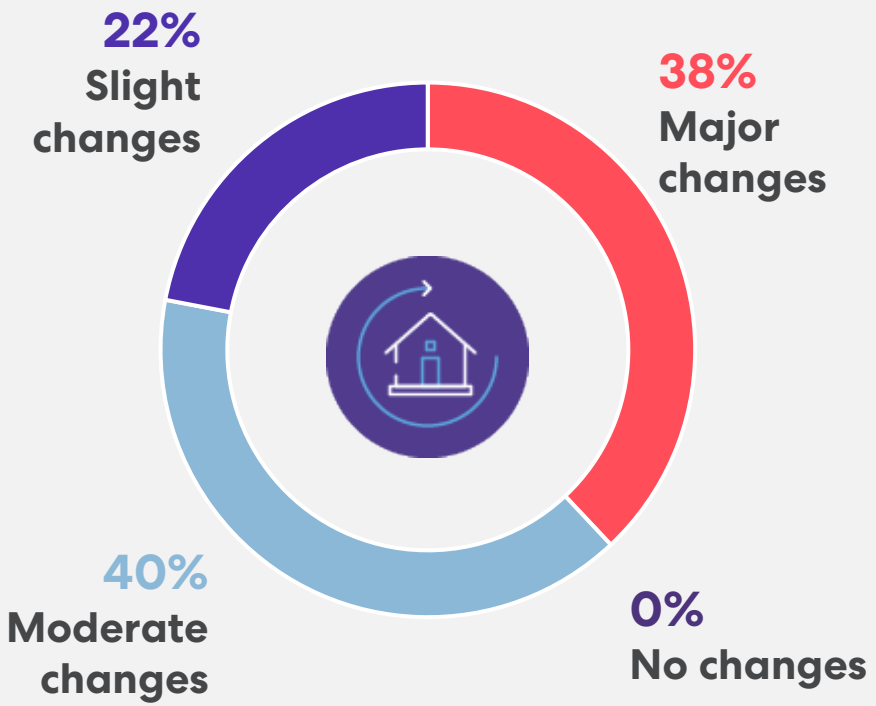
Myasthenia Gravis (MG): IgG-Mediated Autoimmune Disease that Typically Requires Lifestyle Changes

Key Takeaways[1]

- One of the larger IgG-mediated autoimmune diseases
  - ~59,000 to 116,000 patients estimated in the US
- ~80% of patients require lifelong therapy
- Substantial share of population on steroids and first-line immunosuppressants
- Shift towards immunosuppressants and immunoglobulin therapy as disease severity increases

Extent of Lifestyle Modifications[2]



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

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

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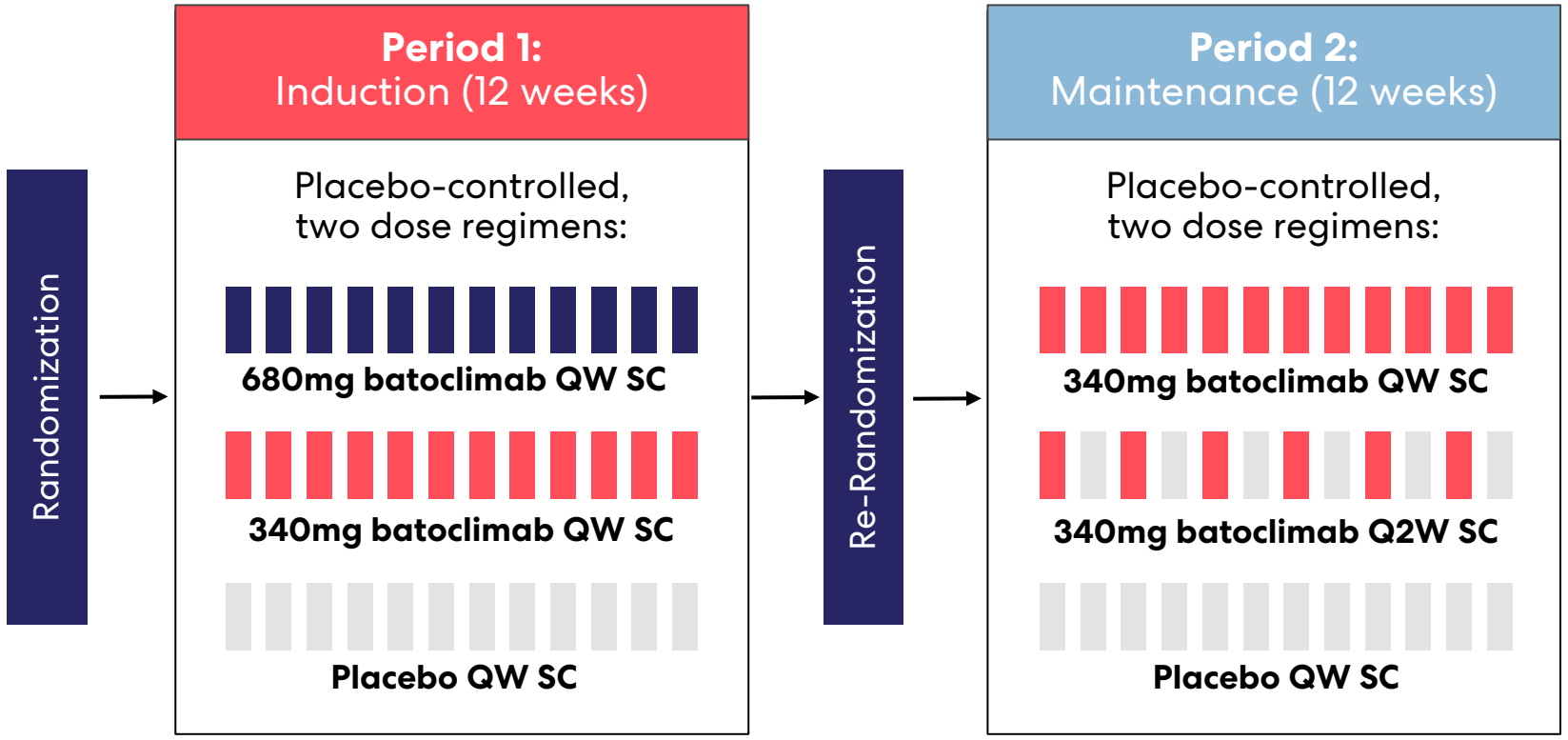
Registrational Phase 3 Trial of Batoclimab Designed to Offer MG Patients Tailored Dosing[1]

Batoclimab MG pivotal trial enrollment is complete; topline data and initiation of a potentially registrational program for IMVT-1402 in MG are on track for March 31, 2025



*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

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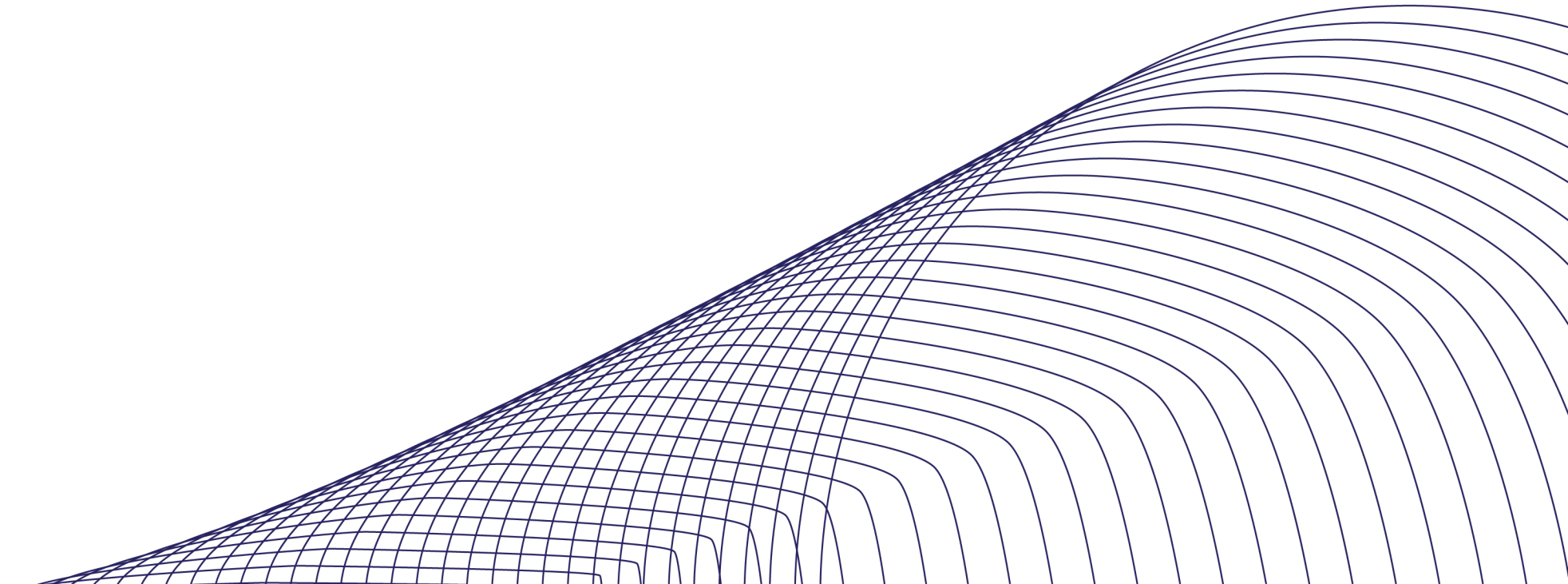
1. Enrollment expanded to increase the AChR- patient group

Note: QW = weekly; Q2W = bi-weekly; SC = subcutaneous injection; AChR Ab+ = acetylcholine receptor antibody-positive; MG-ADL = Myasthenia Gravis Activities of Daily Living scale

Chronic Inflammatory Demyelinating Polyneuropathy



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CIDP: A Complex Chronic Neurological Disease & Exciting Opportunity for Anti-FcRn Class

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[1,2] people in the United States

Clinical Presentation and Unmet Need

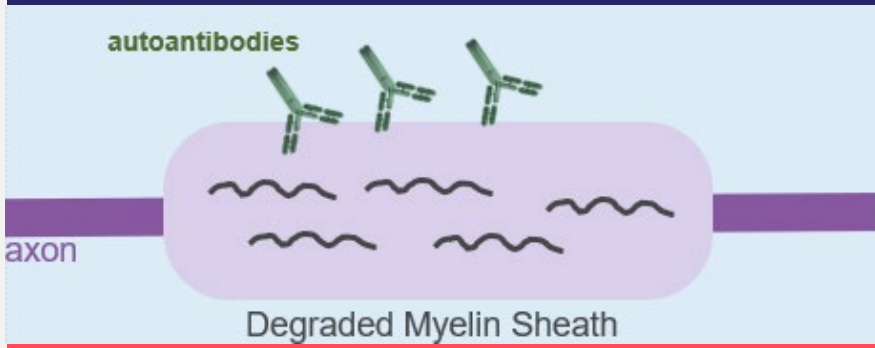
CIDP is characterized by predominant demyelination of motor and sensory nerves. Although the root cause of CIDP is unknown, significant evidence suggests that the disorder(s) are immunologically mediated[3]

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

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

- 70% of CIDP patients require ongoing treatment[4]
- CIDP represents 22% of total IVIg market by volume
    - $3B in global annual sales for IVIG in CIDP[5]

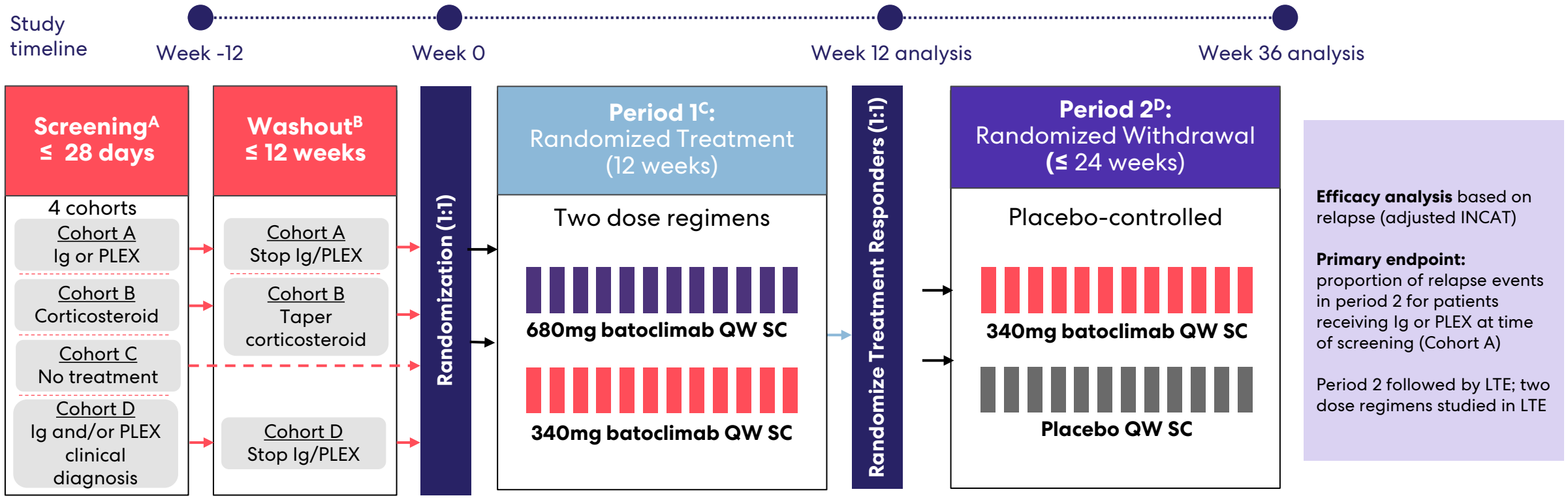
An effective treatment that could be administered via a simple subcutaneous injection would represent a meaningful improvement for patients with CIDP



FcRn binds to the IgG autoantibodies, inhibiting their degradation and returning them into circulation. IgGs may attack the myelin resulting in myelin degradation and neuropathy[6]

1. Broers M, et al. Incidence and prevalence of CIDP: a systematic review and meta-analysis. Neuroepidemiology 52(3–4):161–172 2019
2. Querol, L., et al. Systematic literature review of burden of illness in chronic inflammatory demyelinating polyneuropathy (CIDP). J Neurol 268, 3706–3716 2021
3. Mathey EK, Park SB, Hughes RAC, et al Chronic inflammatory demyelinating polyradiculoneuropathy: from pathology to phenotype Journal of Neurology, Neurosurgery & Psychiatry 2015
4. Kuitwaard K, Bos-Eyssen ME, Blomkwist-Markens PH et al. Recurrences, vaccinations and long-term symptoms in GBS and CIDP. J Periph Nerv Syst 14(4):310–315 2009
5. CSL Behring R&D Investor Briefting, 2021
6. Koike H, Katsuno M. Pathophysiology of Chronic Inflammatory Demyelinating Polyneuropathy: Insights into Classification and Therapeutic Strategy. Neurol Ther. 2020 Dec;9(2):213-227. doi: 10.1007/s40120-020-00190-8. Epub 2020 May 14

Pivotal Phase 2b Trial Intended to Develop Potentially Best-in-Class Chronic Anti-FcRn Therapy in CIDP



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; two dose regimens studied in LTE

Key selection criteria:

Adult participants diagnosed per EAN/PNS CIDP guidelines, 2021 revision

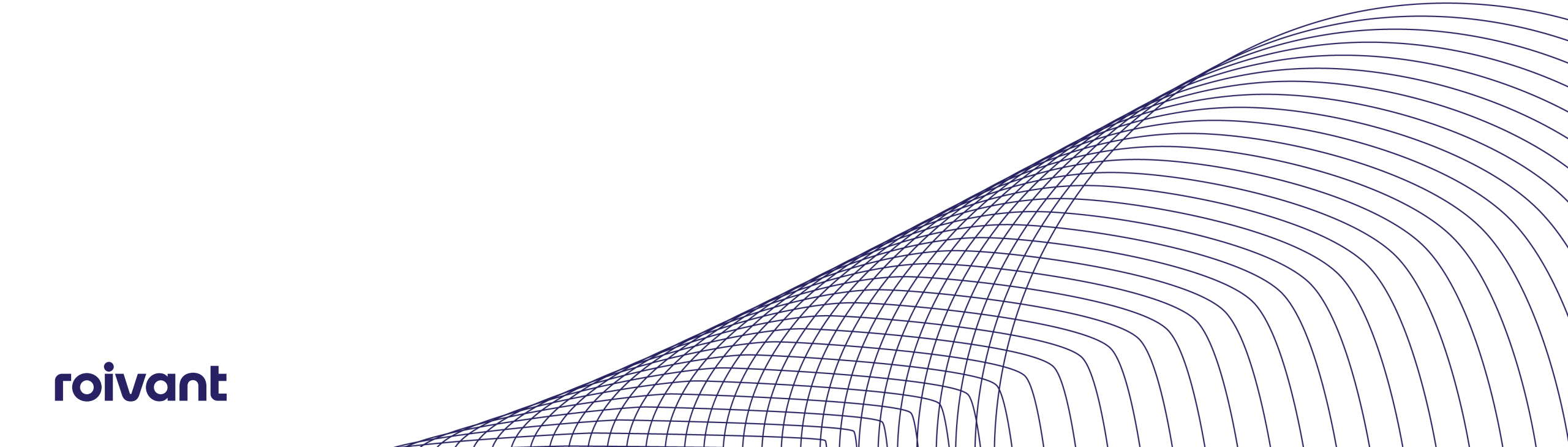
Cohorts A/B/D: Randomize participants who worsen

Cohort C: Randomize all

Primary analysis only on Cohort A (IG/PLEX)

Note: Two-stage approach, to accommodate additional registration trial, if necessary, has the potential to deliver a differentiated product label with a larger effect size
A: Cohorts are defined by CIDP treatment at Screening
B: Participants who fail to worsen by Week 0 will be withdrawn from the study at Week 0
C: Period 1 Non-Responders who complete Period 1 will be withdrawn from the study after completing Week 12 and the subsequent 4-week Follow-Up visit. Period 1 Non-Responders who require protocol-prohibited rescue therapy prior to Week 12 will discontinue IMP and may return to standard of care; these participants will be encouraged to remain in the study for Safety Follow-Up through Week 12 and the Follow-Up Visit
D: Participants that relapse in Period 2 or complete Period 2 without relapse will be eligible for participation in the Long-Term Extension study. 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

Thyroid Eye Disease



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TED: A Heterogeneous Condition that Presents with a Variety of Clinical Symptoms

TED is a rare autoantibody mediated inflammatory disease that affects between 15,000 and 20,000[1,2] new patients each year in the United States

Clinical Presentation and Unmet Need

Clinical features include eye bulging ("proptosis"), eye pain, double vision ("diplopia") and light sensitivity[4]

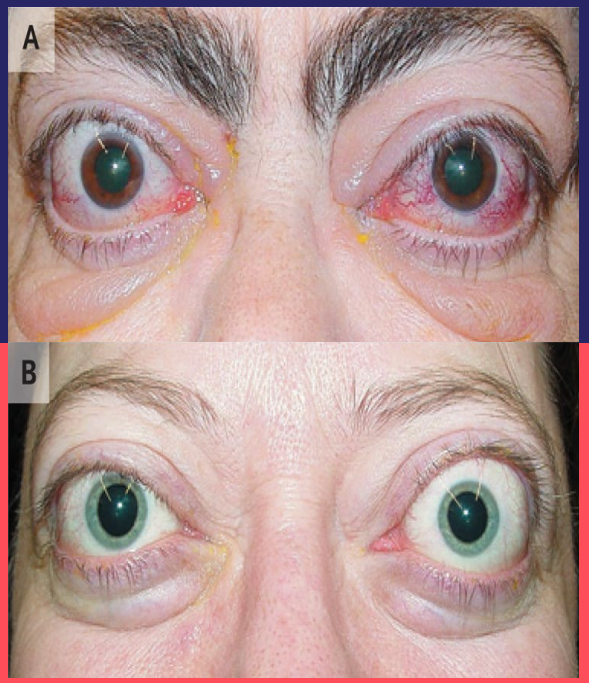
Progressive disease marked by inflammation that can lead to fibrosis and may become sight-threatening if untreated[5]

Caused by IgG autoantibodies that activate cell types present in tissues surrounding the eye[5]

While Tepezza shows a validated US market opportunity (2021 net sales of $1.7 billion and expected annual peak net sales over $3 billion)[6], many TED patients can benefit from a new therapy

- In a Phase 3 extension study, 44% of patients who were proptosis responders following 24 weeks of treatment were no longer responders after 48 weeks off treatment[7]
- Warning added to FDA label for teprotumumab on severe hearing impairment including hearing loss, which in some cases may be permanent, could enable greater market share capture by competitor[8]

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)[6,9-12]



Proptosis, eye edema and chemosis[3]
Typical complications in TED patients

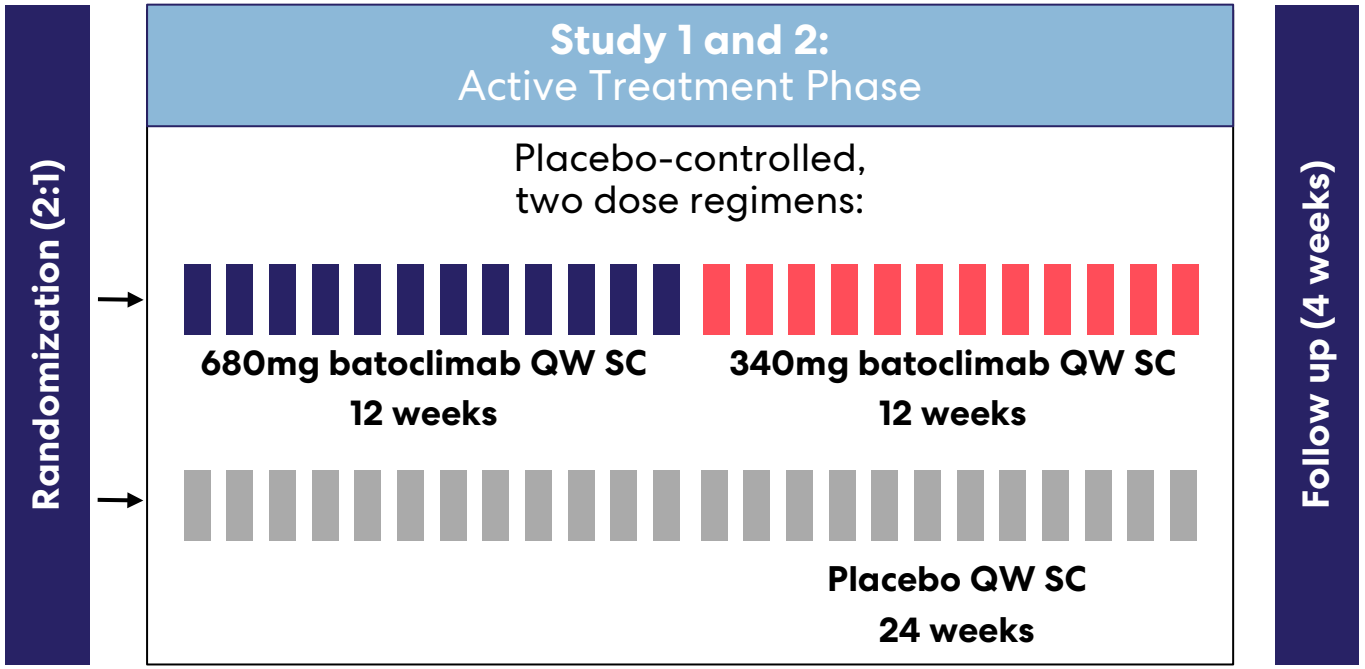
1. Lazarus JH et al. Best Practice & Research Clinical Endocrinology & Metabolism. v26 (2012) 273-279
2. HCP Qualitative Research, Immunovant, 2020
3. Bahn R. Graves' ophthalmopathy. New England Journal of Medicine, 2010
4. Davies T. and Burch H.B. Clinical features and diagnosis of Graves' orbitopathy (ophthalmopathy), UpToDate, 2018
5. McAlinden C. An overview of thyroid eye disease. Eye and Vision, 2014
6. Horizon Therapeutics Investor Presentations
7. Horizon Therapeutics press release, 2020
8. Teprotumumab's US Prescribing Information https://www.accessdata.fda.gov/scripts/cder/safetylabelingchanges/index.cfm?event=searchdetail.page&DrugNameID=2544
9. Horizon Therapeutics estimate on moderate-to-severe TED population based on triangulating data from clinician interactions, surgical procedures, epidemiological publications and U.S. steroid utilization claims data.
10. HCP Qualitative Research, Immunovant, 2020
11. 2021 Cowen equity Research, March 2022 – surveyed 25 clinicians who treat 3,000+ patients with TED annually
12. Douglas R et al. American Academy of Ophthalmology, v129, No. 4

Two Phase 3 Clinical Trials of Batoclimab in TED Ongoing

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

Inclusion

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



Primary endpoint:

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

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

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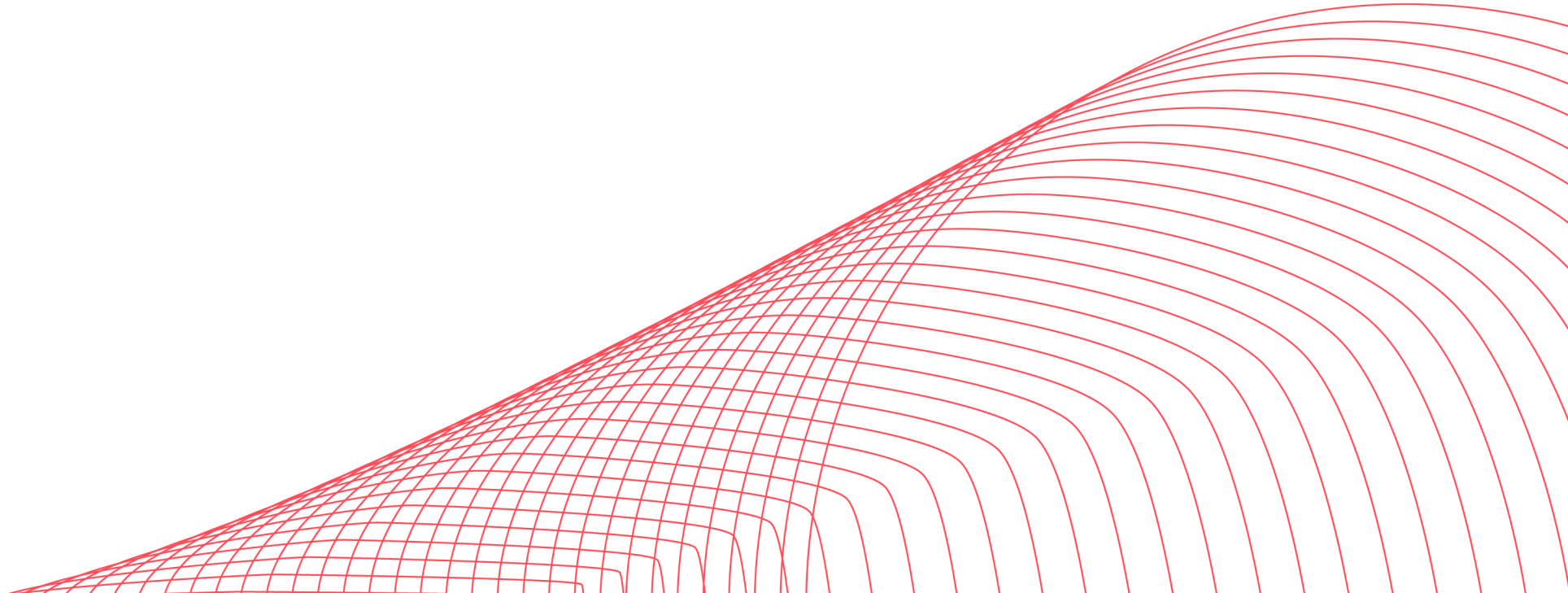
Note: Subset of inclusion criteria for TED Ph3 trial shown on slide
Note: CAS = Clinical Activity Score, anti-TSHR-Ab = anti-TSHR antibody, QW = weekly; SC = subcutaneous injection

Brepocitinib



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Oral Brepocitinib Overview

Potential multi-billion dollar rare and orphan autoimmune disease franchise with upcoming catalysts in 2024 and 2025

Six Positive Placebo-Controlled Phase 2 Studies Conducted

- Clinically meaningful efficacy demonstrated in Psoriasis, Alopecia, Psoriatic Arthritis, Ulcerative Colitis, Hidradenitis Suppurativa and Crohn's disease
- Did not meet primary endpoint in Systemic Lupus Erythematosus
- Safety in line with other JAKs

Registrational Data in DM Expected in 2025

- **Dermatomyositis:** Large orphan indication with no NCEs approved in past 60 years and no other oral therapies in late-stage development
- Phase 3 VALOR enrollment complete, making it the largest interventional DM trial conducted to date; data expected to read out in 2H2025 and be sufficient for NDA filing

Initiation of Phase 3 Program in NIU Expected in 2024

- **Non-infectious uveitis:** Large orphan indication with only one approved therapy and no other oral therapies in late-stage development
- Initiation of Phase 3 program in non-infectious uveitis expected by end of 2024; end of Phase 2 FDA meeting complete

Potential for Multiple Additional Large Market Orphan Indications with Rapid Path to Market

- NEPTUNE results in NIU reinforce relevance of TYK2/JAK1 inhibition for highly inflammatory indications with high morbidity
- **Hidradenitis Suppurativa:** Phase 2 results suggest potential for better efficacy than selective JAK1 inhibitors and comparable to leading biologics

Strong Intellectual Property Position

- IP protection expected until at least 2039*

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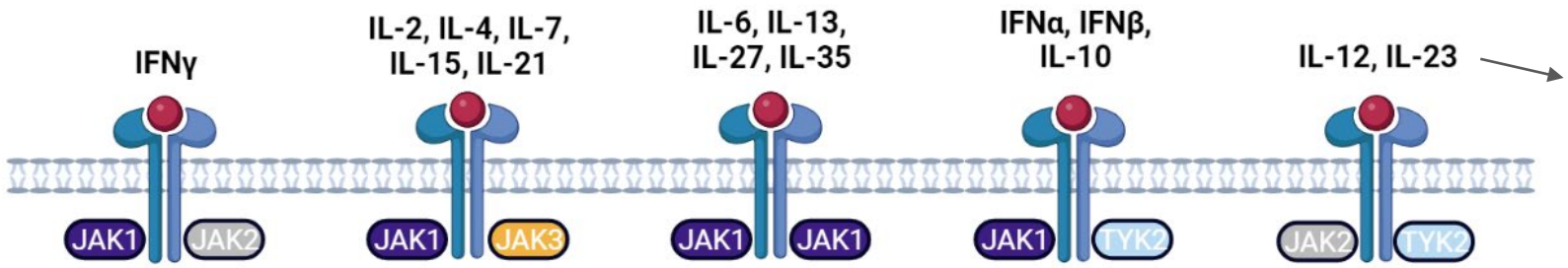
* Includes potential patent term extension

Dual TYK2/JAK1 Inhibition is Optimized For Highly Inflammatory Heterogeneous Autoimmune Diseases With Multiple Pathogenic Cytokines

JAK inhibitors have been approved in...

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

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



IL-23 drives the differentiation and activation of Th17 cells and downstream IL-17 production

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

JAK1 coverage – *Rinvoq (upadacitib), Cibinqo (abrocitinib)*

TYK2 coverage – *Sotyktu (deucravacitinib)*

Brepocitinib was **designed** to target **both** TYK2 and JAK1

Greater coverage vs. TYK2s | **Dual Hit** | **Greater coverage vs. JAK1s**

Hypothesis: *brepocitinib can provide best-in-class efficacy in indications mediated by the TYK2/JAK1 dimer and in diseases requiring broad cytokine coverage*

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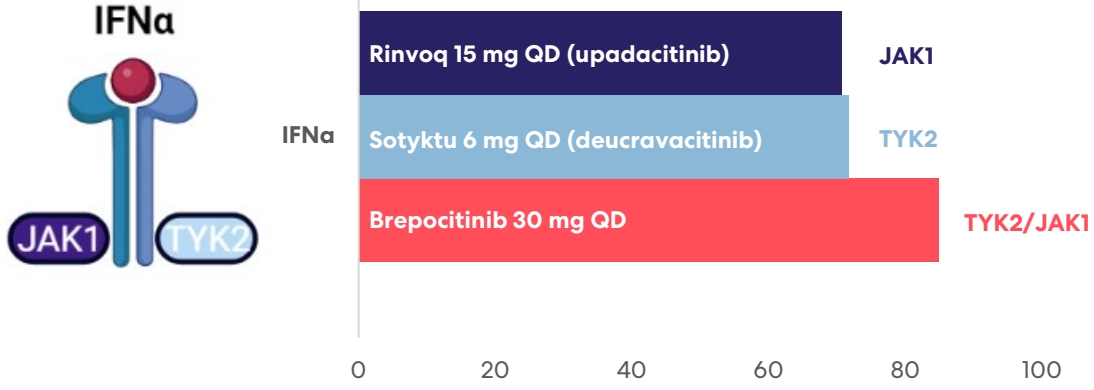
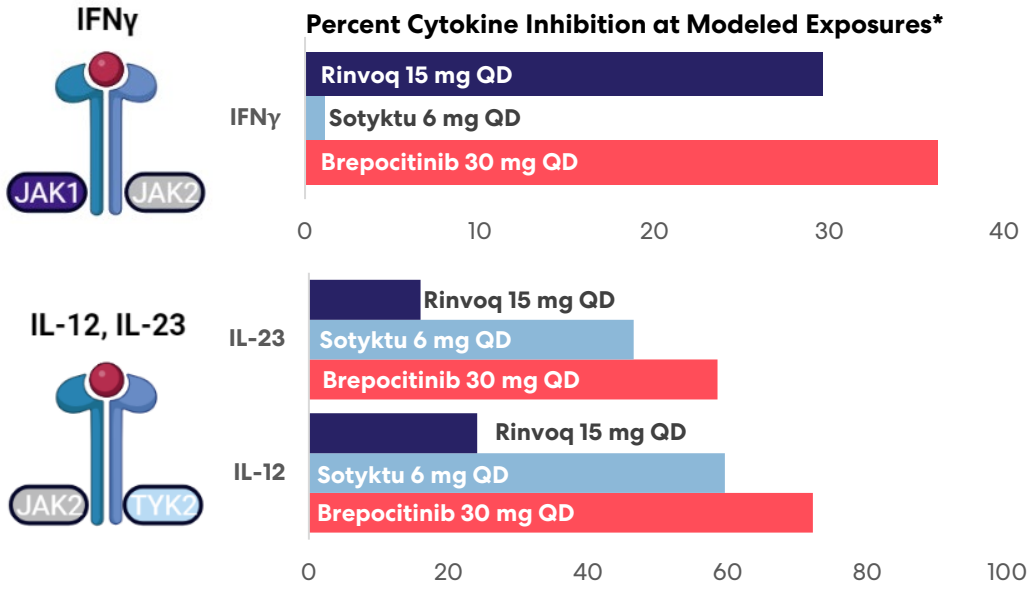
In Vitro Data Support Mechanistic Benefits of Dual Inhibition of TYK2 and JAK1

Dual Hit



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

Greater Coverage



Brepocitinib may recapitulate <u>in a single molecule</u> the cytokine suppression profiles of both the leading TYK2 and JAK1 agents

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

Clinical Experience Suggests Oral Brepocitinib is Highly Active and Able to Generate Clinical Benefit in TYK2- and JAK1-Driven Indications

Seven Positive Phase 2 Studies

Study Population	N[1]	Brepocitinib Dose	Brepocitinib Primary Endpoint Result	
Alopecia Areata *Patients with moderate-to-severe AA*	94[2]	30 mg once daily[3]	49.18 placebo-adjusted CFB in SALT Score at week 24	P < 0.0001[4]
Psoriatic Arthritis *Patients with active PsA*	218	30 mg once daily	23.4% placebo-adjusted ACR20 RR at week 16	P = 0.0197
Ulcerative Colitis *Patients with moderate-to-severe UC*	167	30 mg once daily	-2.28 placebo-adjusted CFB in Mayo Score at week 8	P = 0.0005
Plaque Psoriasis *Patients with moderate-to-severe PsO*	212	30 mg once daily	-10.1 placebo-adjusted CFB in PASI Score at week 12	P < 0.0001
Hidradenitis Suppurativa *Patients with moderate-to-severe HS*	100	45 mg once daily[5]	18.7% placebo-adjusted HiSCR Rate at week 16	P = 0.0298[4]
Crohn's Disease *Patients with moderate-to-severe CD*	151	60 mg once daily[6]	21.4% placebo-adjusted SES-CD 50 Rate at week 12	P = 0.0012[4]
Non-infectious Uveitis *Patients with active non-infectious intermediate-, posterior-, and panuveitis*	26	45 mg once daily	29.4% Treatment Failure Rate at week 24	

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

Note: CFB: change from baseline; RR: response rate
Note: The non-infectious uveitis study was conducted by Priovant; all other studies shown here were conducted by Pfizer

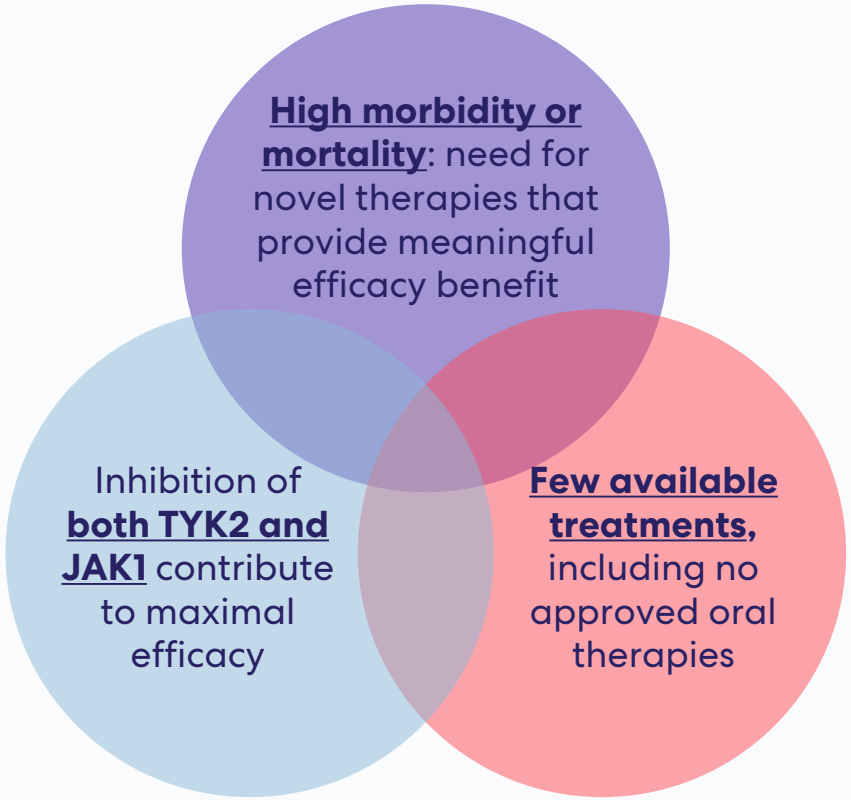
Brepocitinib: Potential Large Orphan Franchise

First Phase 3 readout expected in 2025 (dermatomyositis), with NDA submission to follow

Brepocitinib Background

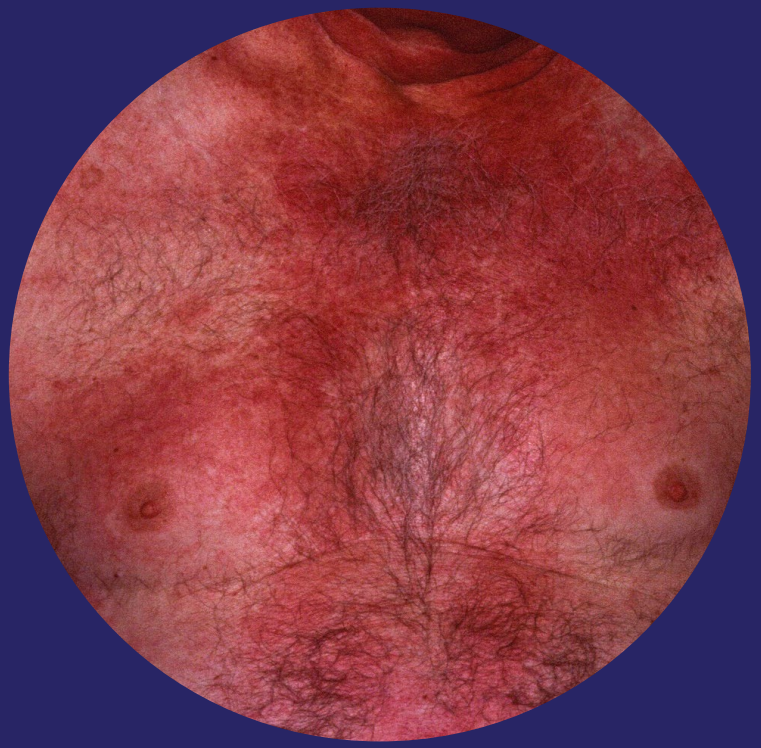
- **Dual inhibitor of TYK2 and JAK1**, optimized for highly inflammatory indications
- **Clinically meaningful benefit in seven phase 2 studies** (once-daily oral administration)
- **Exposure in >1,400 subjects and patients** suggests safety profile consistent with approved JAK inhibitors
- **IP protection expected to at least 2039**

Indication Strategy



Dermatomyositis: Large Orphan Indication With Blockbuster Opportunity For An Efficacious Oral Therapy

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



Characteristic V-sign rash on the chest

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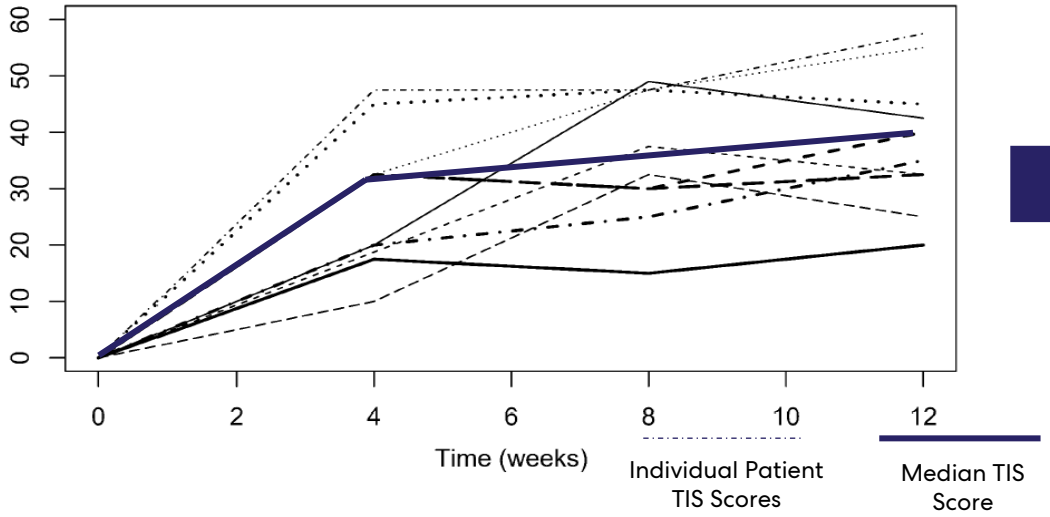
1. PriovantTx estimates based on Reeder 2010, Smoyer-Tomic 2012, and claims analysis
2. Liu et al, Oncol Letters 2018
3. Fardet et al, Medicine 2009
4. Sun et al, Sem Arth Rheum 2021
5. Phase 3 trials or adaptive Phase 2/3 trials

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

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

Study of Tofacitinib in Refractory Dermatomyositis (STIR)[1]
Total Improvement Scores



STIR Study TIS Outcomes	ProDERM Phase 3 Study (IVIg)[2] TIS Outcomes
Open-label, single-arm	*Double-blind, placebo-controlled*
100% TIS20 Response Rate at Week 12	**79%** TIS20 Response Rate at Week 16
40 Median TIS Score at Week 12[3]	**43** Mean TIS Score at Week 12[3]

Cross-study comparison; no head-to-head data available

Clinical PoC further validated by extensive case report literature[3]

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

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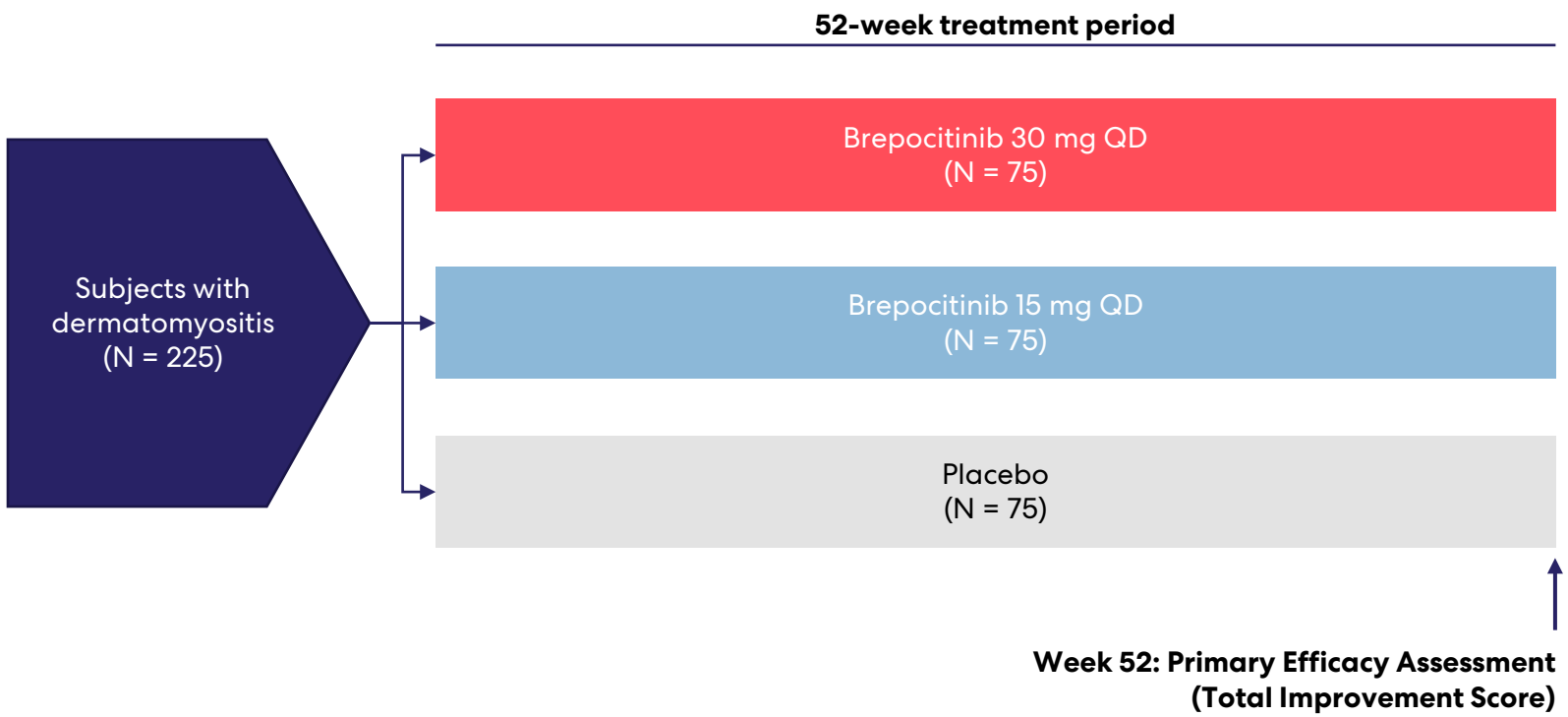
1. Paik et al, Arth Rheum 2020
2. Aggarwal et al, NEJM 2022
3. STIR study: median is the only statistical analysis provided; ProDERM study: mean is the only statistical analysis provided
4. Paik et al, Clin Exp Rheum 2022

Single Phase 3 Study Enrollment Complete; Expected To Generate Registrational Data Required for Approval

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



Eligible Patients

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

Primary Endpoint

Mean Total Improvement Score (TIS) at Week 52

Secondary Endpoints

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

Safety Endpoints

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

Data expected 2025 → potentially next approved drug of any modality

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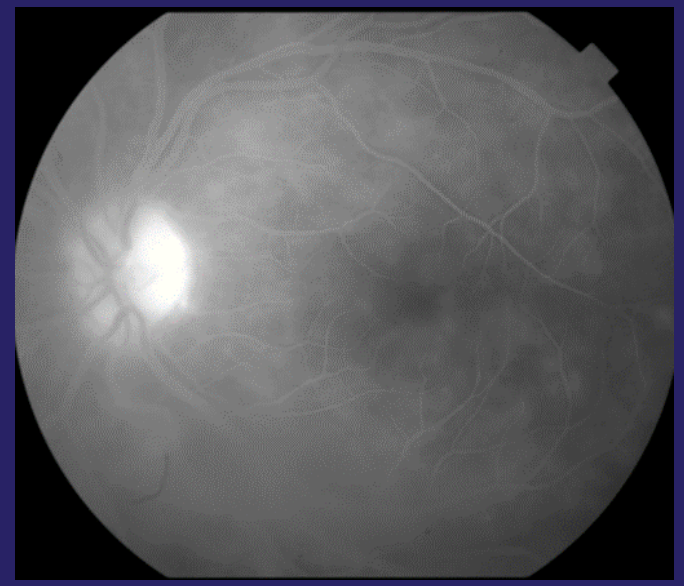
Non-Infectious Uveitis: A Sight-Threatening Ocular Disease

Orphan indication with potential blockbuster opportunity for brepocitinib to become the first approved oral therapy

Tens of Thousands	New instances of legal blindness attributable to NIU in the United States each year[1]
>70,000	Patients living with non-anterior NIU in the United States[1]
Most Common Symptoms	Light sensitivity, pain, redness and floaters
Etiology	Approximately half idiopathic, half in context of other systemic autoimmune disease[2]
1	Approved targeted therapy (Humira)
0	Competitors in Phase 3 development[3]



Posterior Segment Inflammation
Diffuse areas of capillary leakage and disc hyperfluorescence

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1. Thorne et al, JAMA Ophthalmol. 2016
2. Lopalco et al, Clin Exp Rheum 2018
3. One therapy in Phase 3 for uveitic macular edema, which comprises a subset of non-anterior NIU patients

Significant Unmet Need & Commercial Opportunity in NIU

Uveitis is the fourth-leading cause of blindness among working-age population in the developed world[1]

- Accounts for approximately 10% of cases of blindness in U.S.[2,3]
- Tens of thousands of new instances of legal blindness per year[2]

Etiology: Approximately half idiopathic, half in context of other systemic autoimmune disease[4]

Approximately 40,000 patients with non-anterior NIU on biologics in 2023, including adalimumab (only approved therapy) and off-label therapies[5]

- Rapid growth rate from 2019-2023

No competitors in Phase 3[6], limited competition in Phase 2

At an orphan price point with differentiated data, multi-$B peak sales potential in post-biologic population alone

- Additional potential blockbuster opportunity in broader non-anterior NIU population

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1. Barisani-Asenbauer, T., Maca, S.M., Mejdoubi, L. et al. Uveitis- a rare disease often associated with systemic diseases and infections- a systematic review of 2619 patients. Orphanet J Rare Dis 7, 57 2012
2. Thorne et al, JAMA Ophthalmol. 2016
3. Emmett T. E.Cunningham & Manfred Zierhut 2021; Vision Loss in Uveitis, Ocular Immunology and Inflammation, 29:6, 1037-1039
4. Lopalco et al, Clin Exp Rheum 2018
5. Roivant/Priovant analysis of closed claims data from Inovalon. Includes idiopathic NIU and NIU as a sequela of other autoimmune disease. Includes adalimumab and adalimumab biosimilars, infliximab and infliximab biosimilars and tocilizumab
6. One therapy in Phase 3 for uveitic macular edema, which comprises a subset of non-anterior NIU patients

Positive Results from Phase 2 NEPTUNE Study of Brepocitinib in NIU

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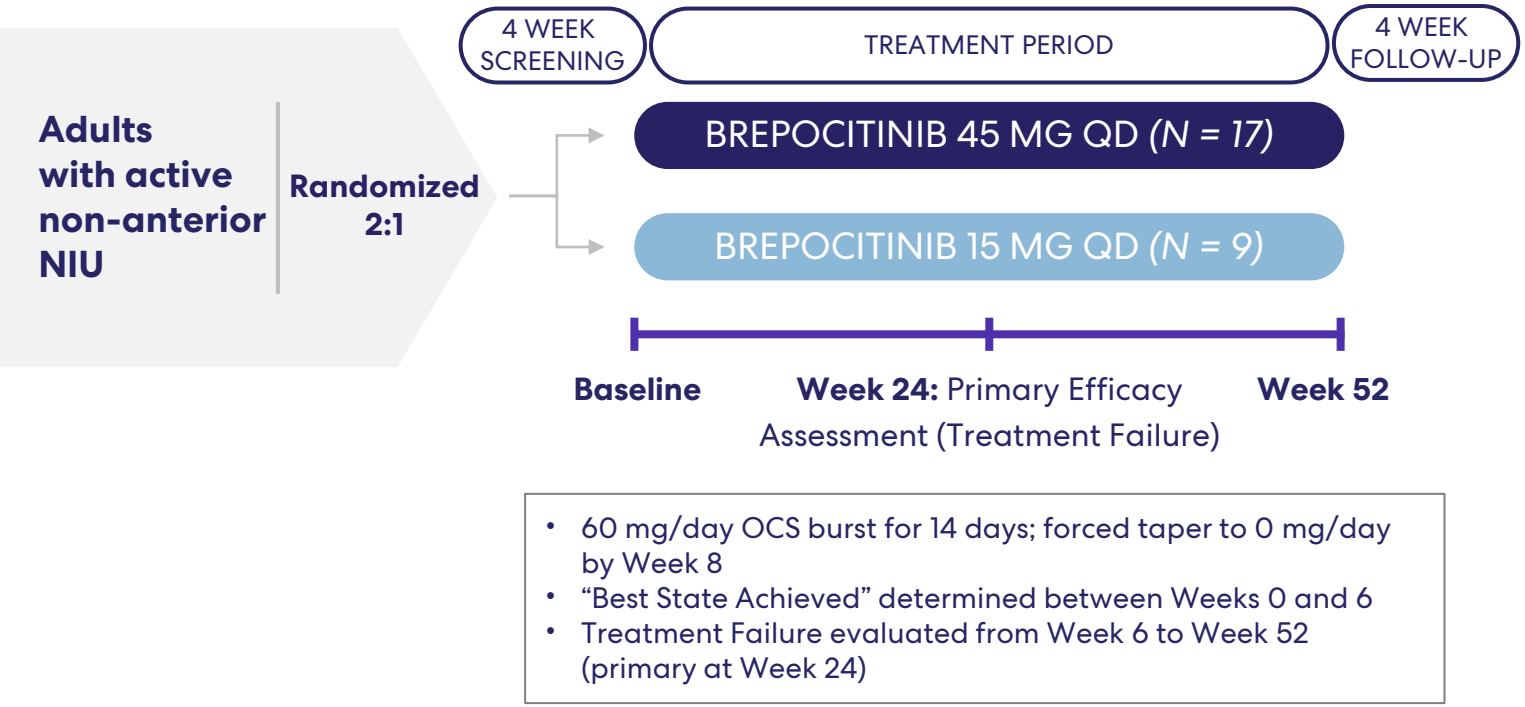
NEPTUNE Study Design

A Phase 2 Randomized, Double-Masked, Dose-Ranging Study to Investigate the Safety and Efficacy of Oral Brepocitinib in Adults with Active Non-Infectious Intermediate-, Posterior-, and Panuveitis



- 60 mg/day OCS burst for 14 days; forced taper to 0 mg/day by Week 8
- "Best State Achieved" determined between Weeks 0 and 6
- Treatment Failure evaluated from Week 6 to Week 52 (primary at Week 24)

Key Efficacy Endpoints

- Treatment Failure rate at Week 24 (primary)
- Treatment Failure Sub-Components: Change on ACC grade, VH grade, inflammatory lesions and BCVA*
- Change in central subfield thickness

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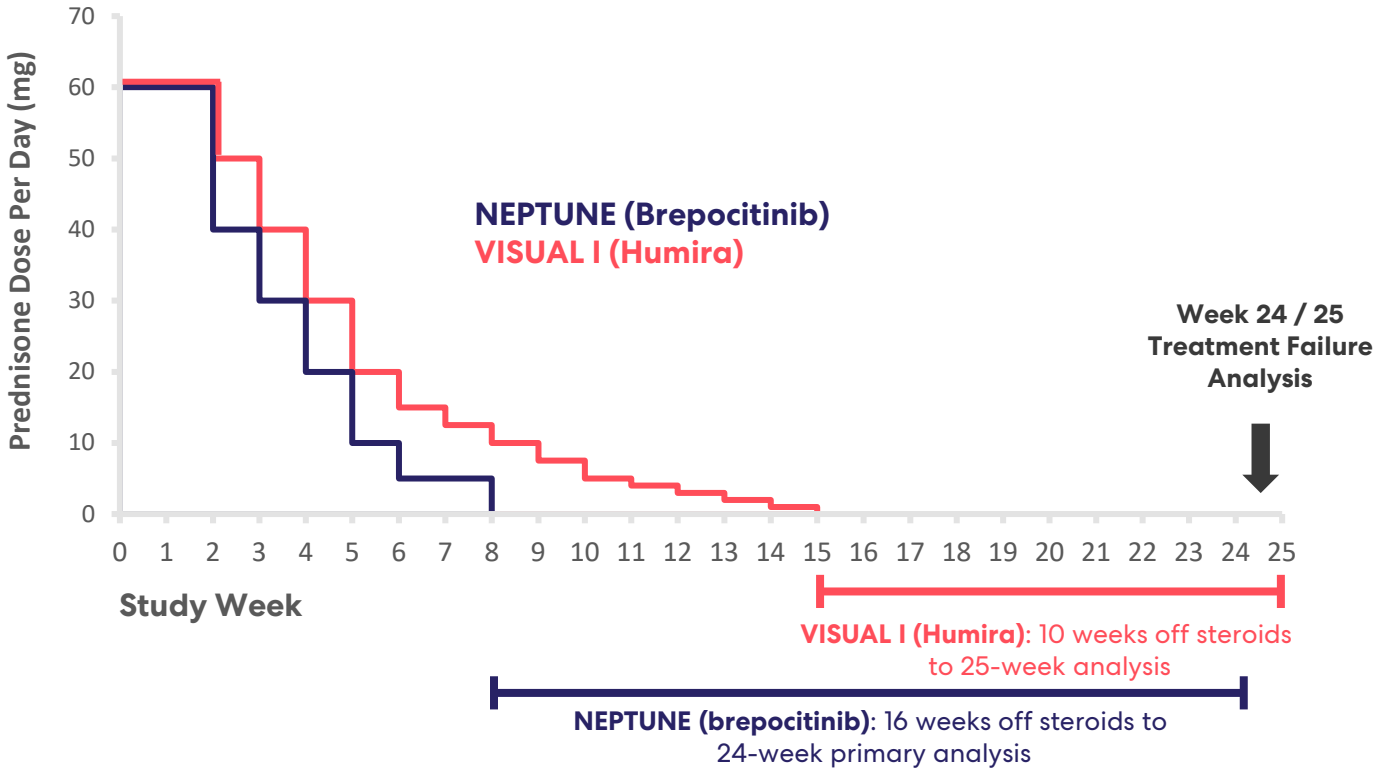
*ACC: anterior chamber cell; BCVA: best-corrected visual acuity; IST: immunosuppressive therapy; VH: vitreous haze

Steroid Taper Sets Higher Bar for Brepocitinib Compared to Precedent Studies

NEPTUNE (brepocitinib) study is modeled on VISUAL I (active uveitis registrational study for Humira) with one key exception – brepocitinib steroid taper was more than twice as fast



KEY IMPLICATIONS OF DIFFERENT TAPERS

Brepocitinib patients tapered from 60 mg/day to 0 mg/day more than twice as quickly as Humira/placebo patients in VISUAL I (6 weeks compared to 13 weeks) → ***much higher risk of flares***

- **Requires that brepocitinib act more quickly**
- **Requires brepocitinib meet higher efficacy bar to prevent flares**

Brepocitinib had to provide steroid-free benefit for >50% longer to prevent treatment failure by week 24

- **Requires that brepocitinib demonstrate more durable steroid-sparing benefit**

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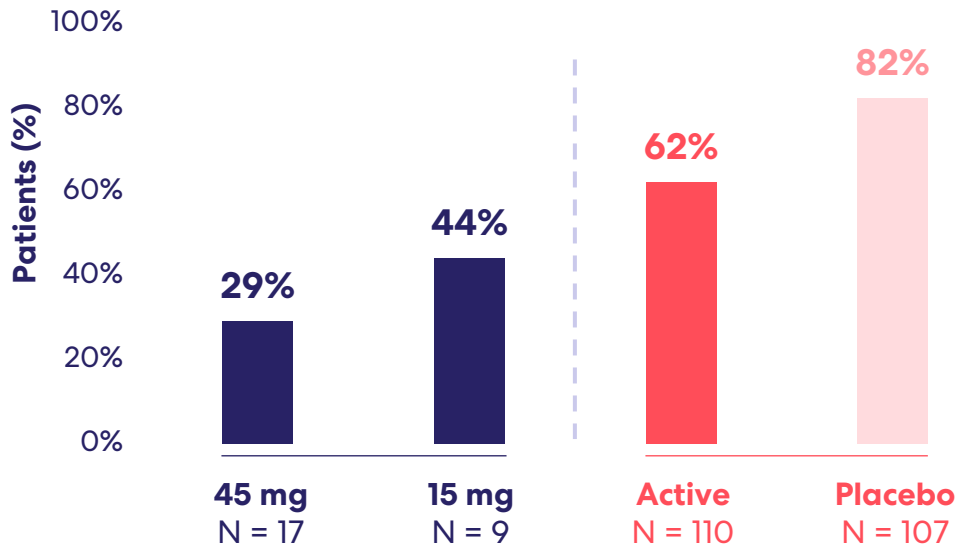
Treatment Failure Rate at Week 24 *(lower rate = greater treatment benefit)*

Including Cross-Study Comparison to VISUAL I

Treatment Failure

(ITT; ICEs Imputed as Treatment Failure; Pre-Specified)



Brepocitinib (NEPTUNE)
Week 24

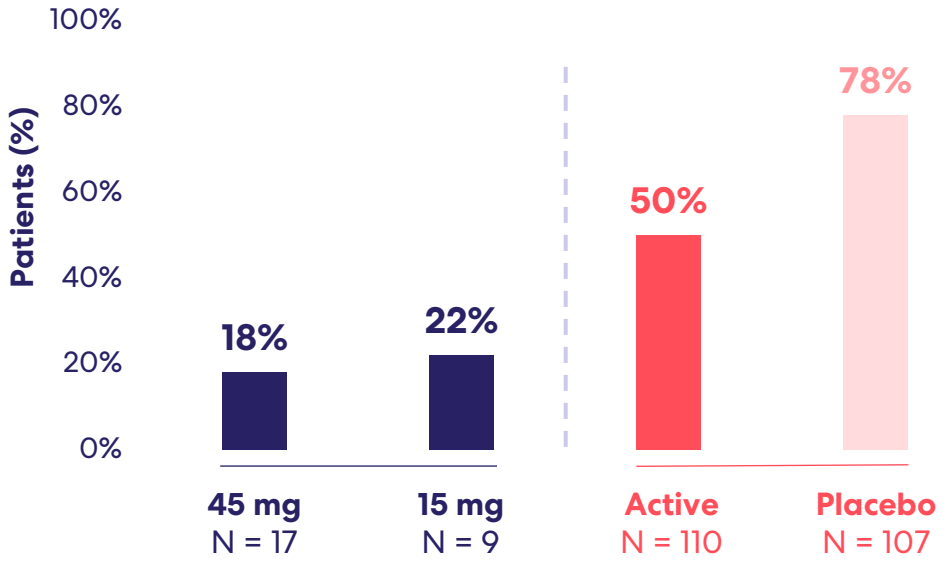
Humira (VISUAL I)[1]
Week 25

Brepocitinib Treatment Failure Rate Analysis:

$$\frac{\text{Treatment Failures + Discontinuations/ICEs}^{3}}{\text{Subjects Randomized}}$$

Treatment Failure

(DCs Censored)



Brepocitinib (NEPTUNE)
Week 24

Humira (VISUAL I)[2]
Month 6

Brepocitinib Treatment Failure Rate Analysis:

$$\frac{\text{Treatment Failures}}{\text{Subjects Randomized}}$$

<u>Disclaimer:</u> 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.

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1. Jaffe et al, NEJM 2016
2. Data as reported on HumiraPro.com/Uveitis; DCs are censored. Analysis population for Humira unknown
3. Intercurrent Event (ICE) = Treatment discontinuation or use of rescue medication prior to Week 24

Brepocitinib Proof-of-Concept in Potentially Resolving and Preventing Macular Edema

Data suggests potential to resolve macular edema and potential to prevent or reverse swelling before threshold for macular edema is reached and patient is formally diagnosed with UME

In the 45 mg arm, at Baseline:	In the 45 mg arm, by Wk 24:	By comparison:
10 patients did *not* have macular edema (CST < 300 µm[1])	**0 patients** *developed* macular edema **(0% occurrence rate)**	In the VISUAL I study, among patients who did not have macular edema at baseline, **50% of placebo patients developed macular edema after 6.2 months**[1] • 50% of Humira patients developed macular edema after 11.1 months[2]
7 patients had macular edema (CST ≥ 300 µm)	**3 of 7 patients** had *resolution* of macular edema **(43% resolution rate)**	In a different study of patients with uveitic macular edema at baseline, **Humira resolution rates at Month 6 were 22%**[3]

Disclaimer: 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.

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Note: CST: central subfield thickness

1. Definition of macular edema in NEPTUNE was CST ≥ 300 µm, normalized by central reader across instrument types
2. Jaffe et al, NEJM 2016
3. Leclerq et al, Ophthalmology 2021

Overview of Safety Data

	Brepocitinib 45 mg N = 17	Brepocitinib 15 mg N = 9
Any TEAEs, n (%)	13 (76.5%)	9 (100%)
Any Treatment-Emergent SAEs	0	1 (11.1%)
Any Treatment-Related TEAEs	8 (47.1%)	2 (22.2%)
Any TEAEs Leading to Discontinuation of study drug	2 (11.8%)	2 (22.2%)

Brepocitinib was generally safe and well tolerated in NEPTUNE; no new safety or tolerability signals were identified

- No deaths, MACE, malignancy, or thromboembolic events in either treatment arm
- 1 SAE of Grade 2 hypersensitivity in 15 mg arm resolved following discontinuation of study drug and administration of oral diphenhydramine (Benadryl)
- TEAE severity
    - Two Grade 3 events – one uveitis flare in 15 mg arm reported as an AE, one case of costochondritis (benign sternum pain) in 45 mg arm
    - All other TEAEs were mild-to-moderate in severity

Brepocitinib's safety database comprises >1,400 exposed subjects and patients

- Safety profile appears consistent with safety profile of approved and widely prescribed JAK inhibitors

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Note: TEAE: Treatment-Emergent Adverse Event; SAE: Serious Adverse Event

NEPTUNE Data Supports Potentially Differentiated Product Profile for Brepocitinib: Potential Early Treatment Option for Physicians Looking to Intervene Aggressively to Prevent Vision Loss

NIU treatment paradigm places premium on efficacy, given particularly high morbidity

Aggressive Early Treatment Following Diagnosis Given Risks of Blindness

60+ mg/day steroid burst; transition patients as quickly as possible onto chronic therapies, without causing treatment failure

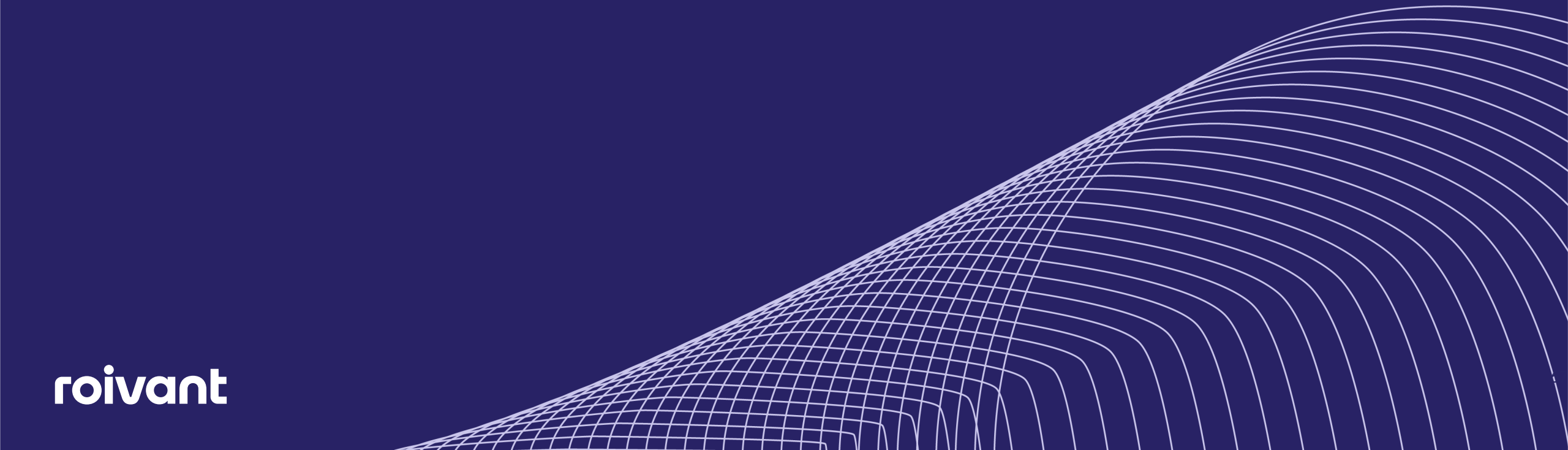
Large number of biologic-treated patients (~40,000) with high failure/relapse rate (~50%)

NEPTUNE Data Supports Potential Brepocitinib Use Early In Treatment Paradigm And In Refractory Population

- Low treatment failure rates, even with rapid steroid taper
- Potential benefit across multiple disease manifestations: inflammation and preventing onset of macular edema
- Observed steroid-free benefit sustained over time: potential long-term quiescence

Expansion Opportunities

Hidradenitis Suppurativa



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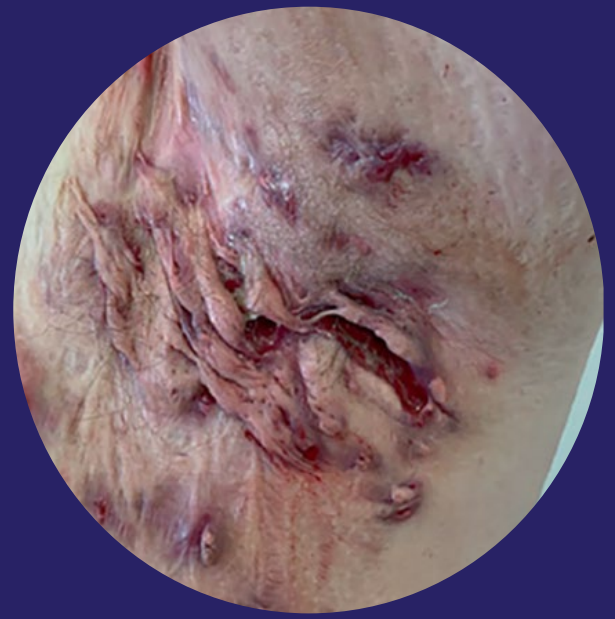
Hidradenitis Suppurativa: A Severe and Disfiguring Skin Disease

Opportunity for brepocitinib to become leading oral therapy for treatment of exceptionally debilitating inflammatory skin disease

170,000	Patients living with HS in the United States[1]
Key Symptoms	Nodule, abscess and tunnel formation in intertriginous zones (skin folds)
Comorbidities	Metabolic syndrome[2], spondylarthritis[3], inflammatory bowel disease[4]
>2x	Increased suicide risk for patients living with HS compared to the general population[5]



Extensive skin involvement with tunnel formation and scarring in a Hurley Stage III (severe) patient

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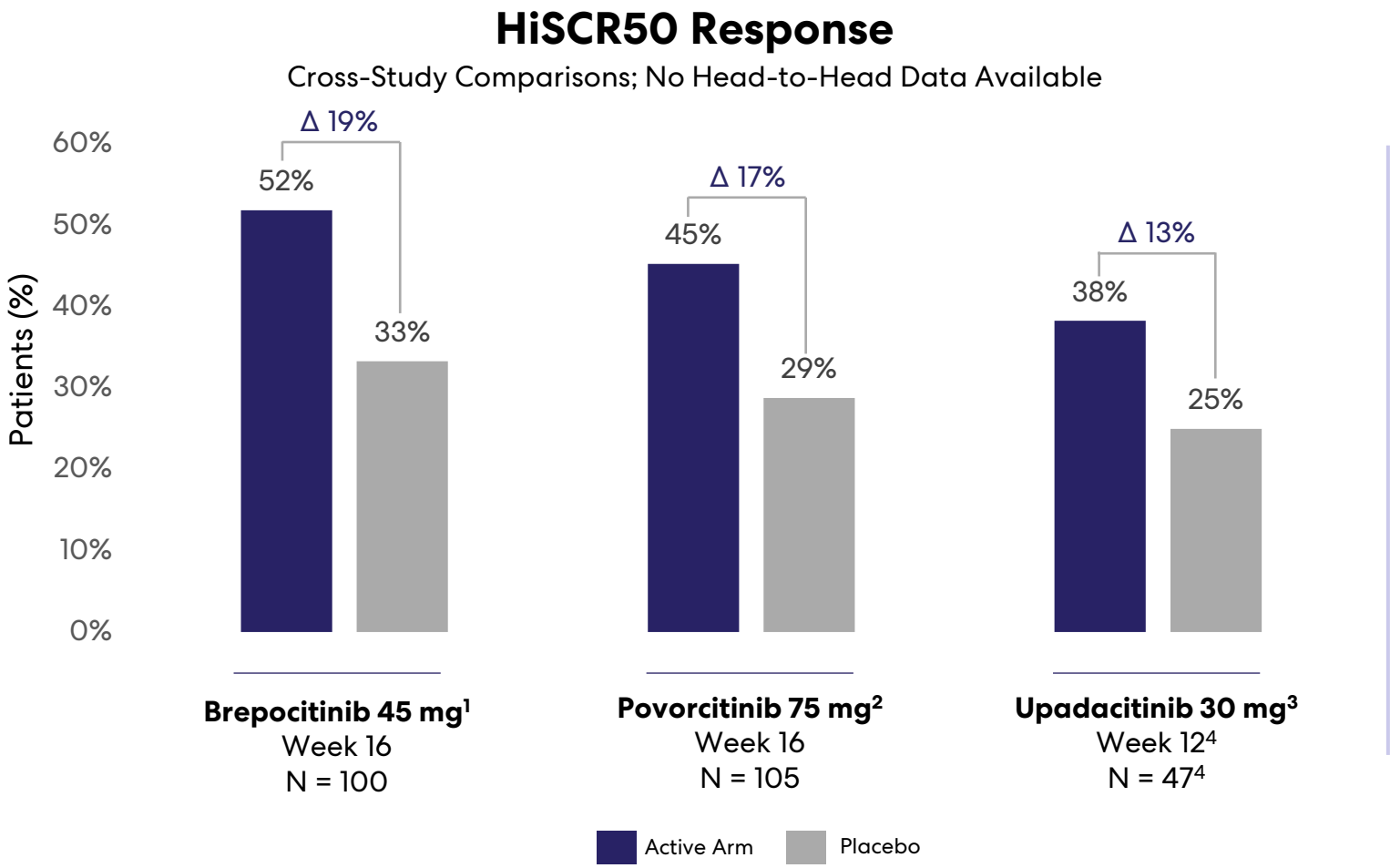
1. Estimates for moderate/severe HS only; based on Phan et al, Biomed Derm 2020
2. Sabat et al, PLoS One 2012
3. Shlyankevich et al, J Am Acad Derm 2014
4. Deckers et al, J Am Acad Derm 2017
5. Thorlacious et al, J Invest Dermatol 2018

Dual TYK2/JAK1 Inhibition May Generate Greater Efficacy than Inhibition of JAK1 Alone



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

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

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1. Kimball et al, EADV 2022
2. Kirby et al, EADV 2022 Poster P0004
3. Kimball et al, AAD 2023 Poster 43799
4. Primary endpoint of upadacitinib Phase 2 study was HiSCR at 12 weeks. N represents active arm only as primary statistical analyses were performed in reference to prespecified historical placebo control (N = 259). Active arm performance at Week 16 for UPA30 was 40%

Namilumab

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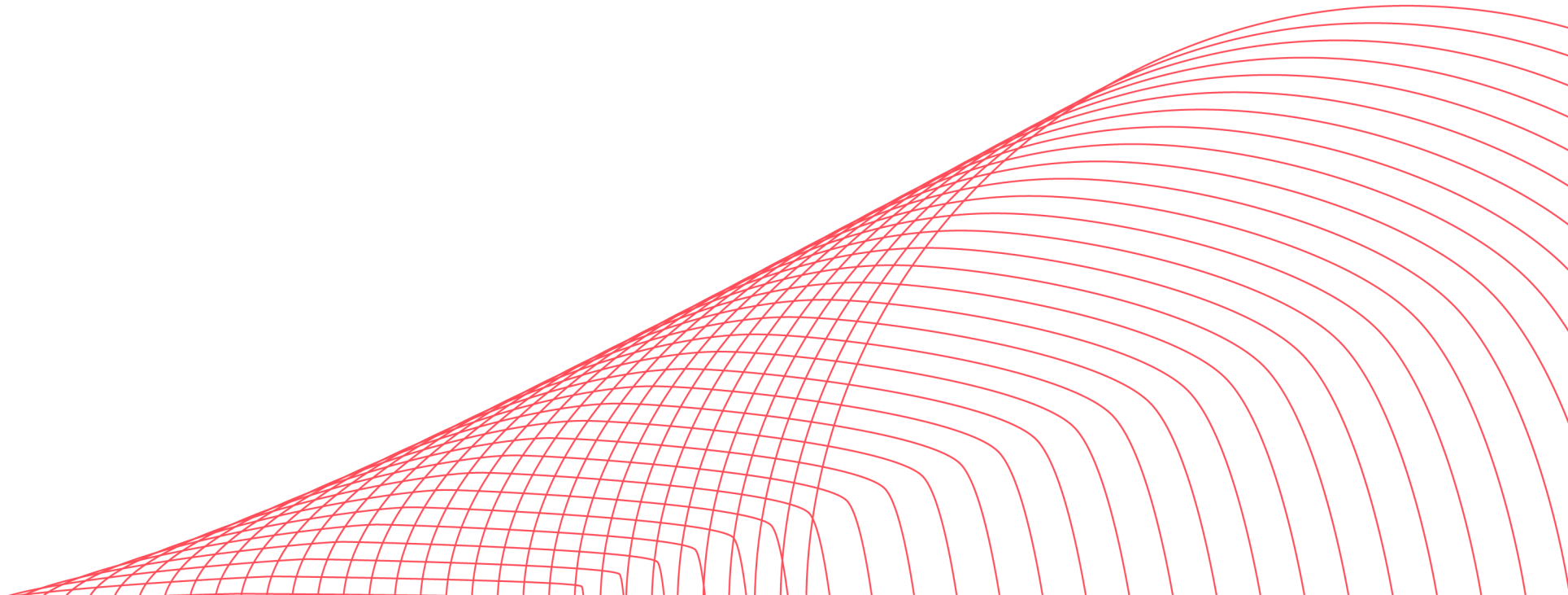

Namilumab Overview

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

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]

Robust RESOLVE-LUNG Study Underway

- Enrollment has been completed in the Phase 2 potentially registrational RESOLVE-LUNG study
- Clinical study design incorporates lessons learned from previous trials
- On track to read out in 4Q 2024

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Note: All product candidates are investigational and subject to regulatory approval

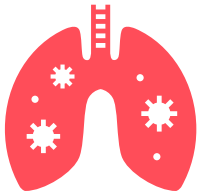
* Namilumab is being developed with potentially the least frequent dosing schedule among subcutaneous anti-GM-CSFs in Phase 2 clinical trials, with a single dose every four weeks after an initial loading period

1. Denning, et al. European Respiratory Journal 2013
2. Ishioka S, et al. Sarcoidosis, Vasculitis, and Diffuse Lung Diseases 1996
3. Itoh A, et al. Respirology 1998
4. Taylor P, et al. Arthritis Res Therapy 2019; Tanaka S et al. International J Pharmacol Therapy 2018; Papp KA et al. J Dermatol 2019; Huizinga TW et al. Arthritis Res Ther. 2017; Unpublished Ph 2 results ankylosing spondylitis; Fisher et al. The Lancet Respiratory Medicine 2021

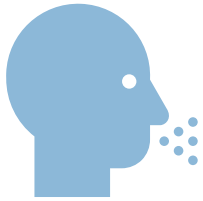
Pulmonary Sarcoidosis is a Large, Untapped Orphan Market

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]

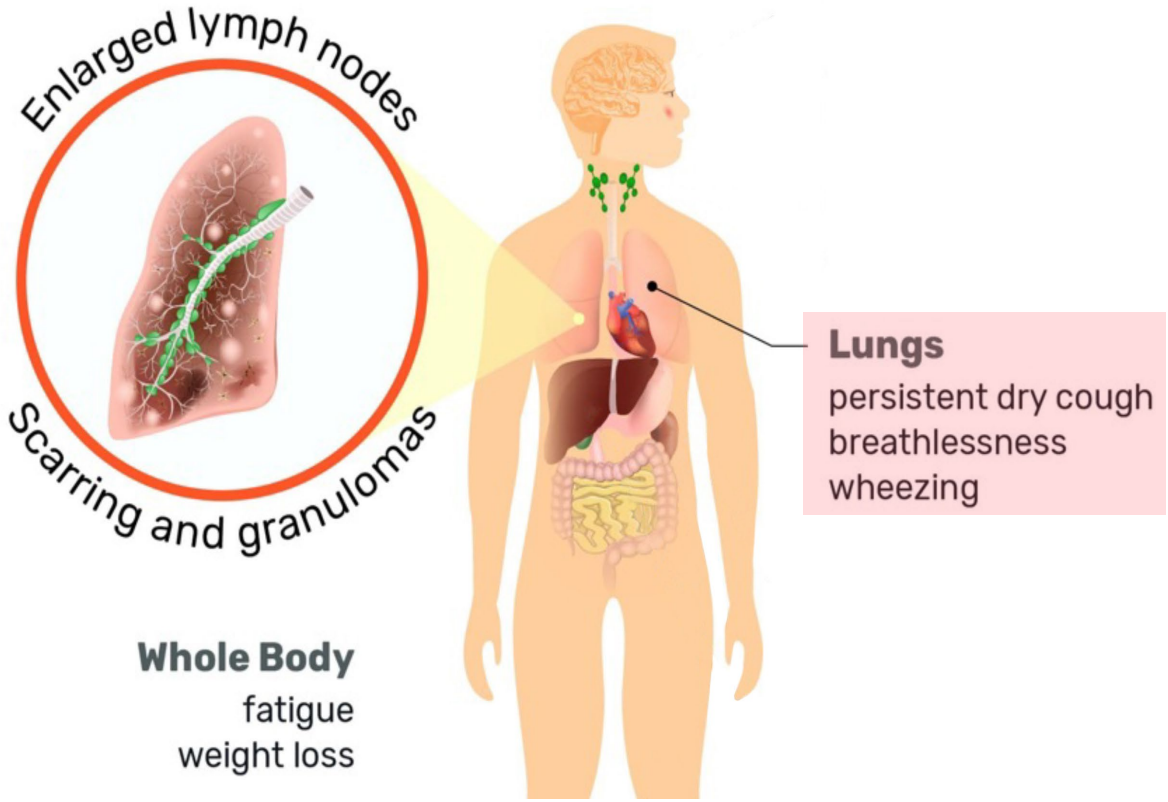


Clinical consequences:

Declining pulmonary function

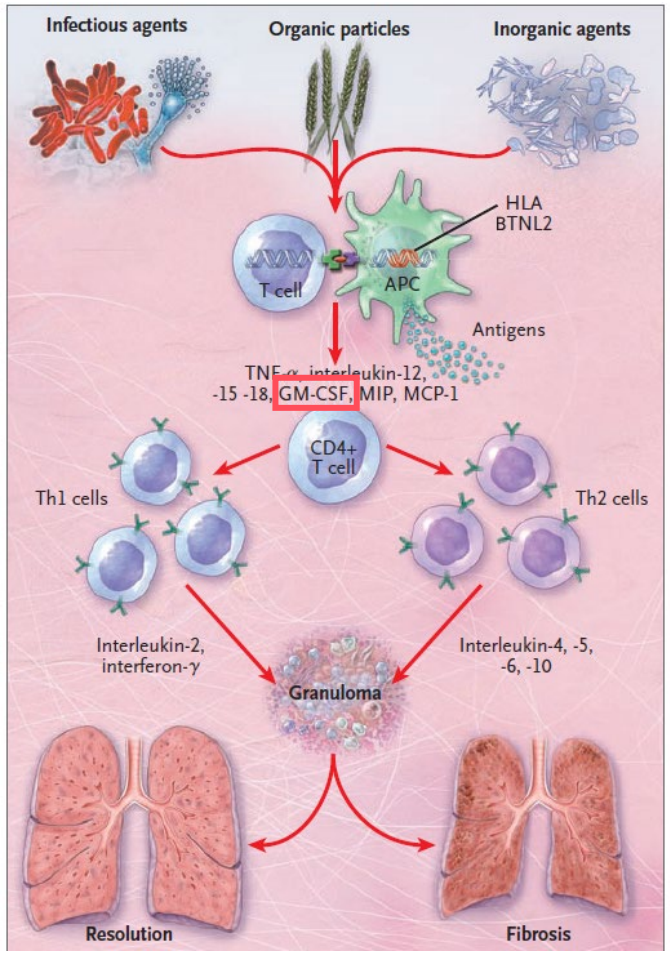
Dyspnea, fatigue, cough and pain

Death



1. Market research
2. Denning, et al. European Respiratory Journal 2013
3. Baughman, et al. Annals ATS 2016

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**

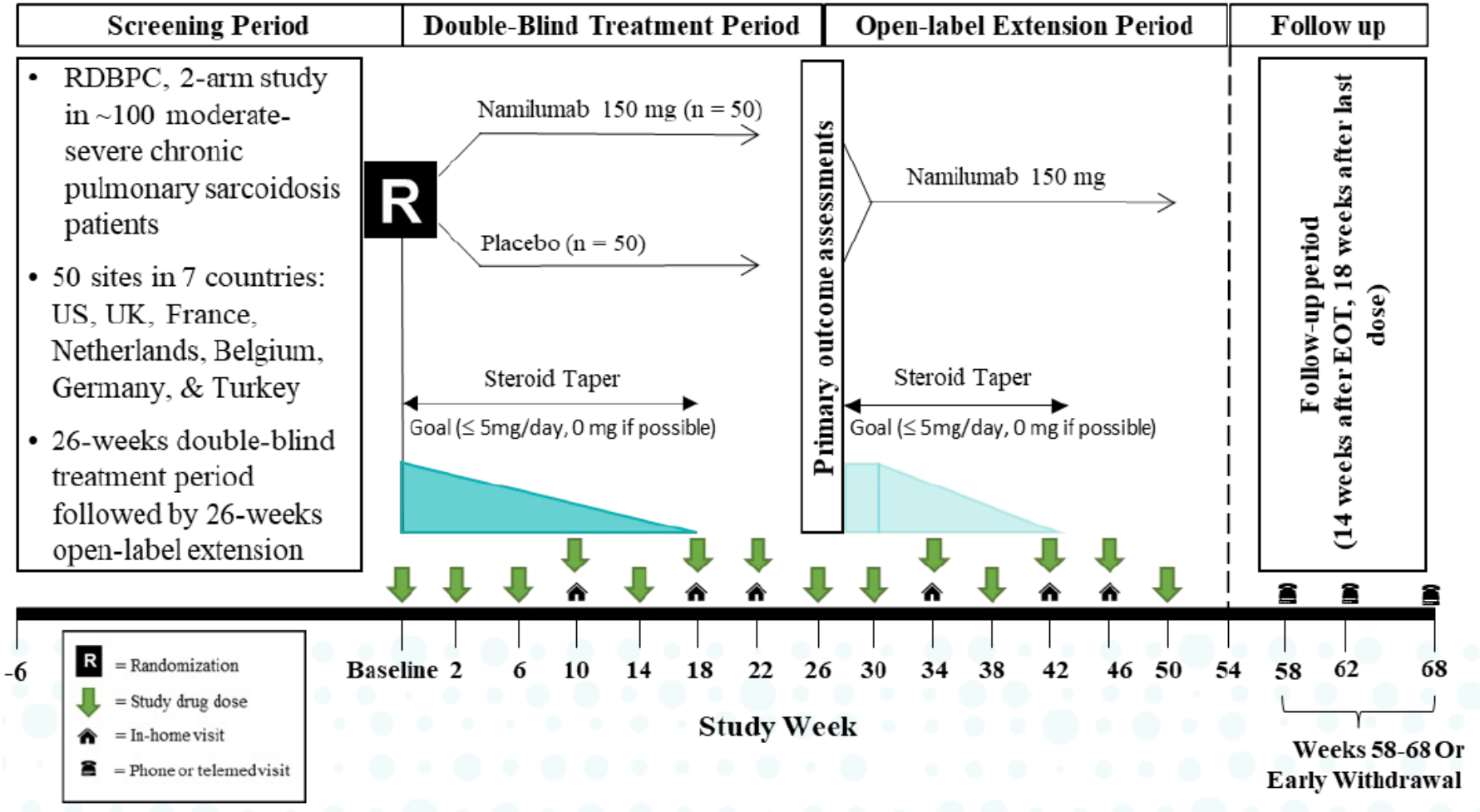
Alveolar macrophages contribute to a **cytokine feedback loop with other myeloid and lymphoid cells** secreting additional GM-CSF and other inflammatory cytokines

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[1]

1. Baughman, et al. Annals ATS 2016

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



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

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

Mosliciguat

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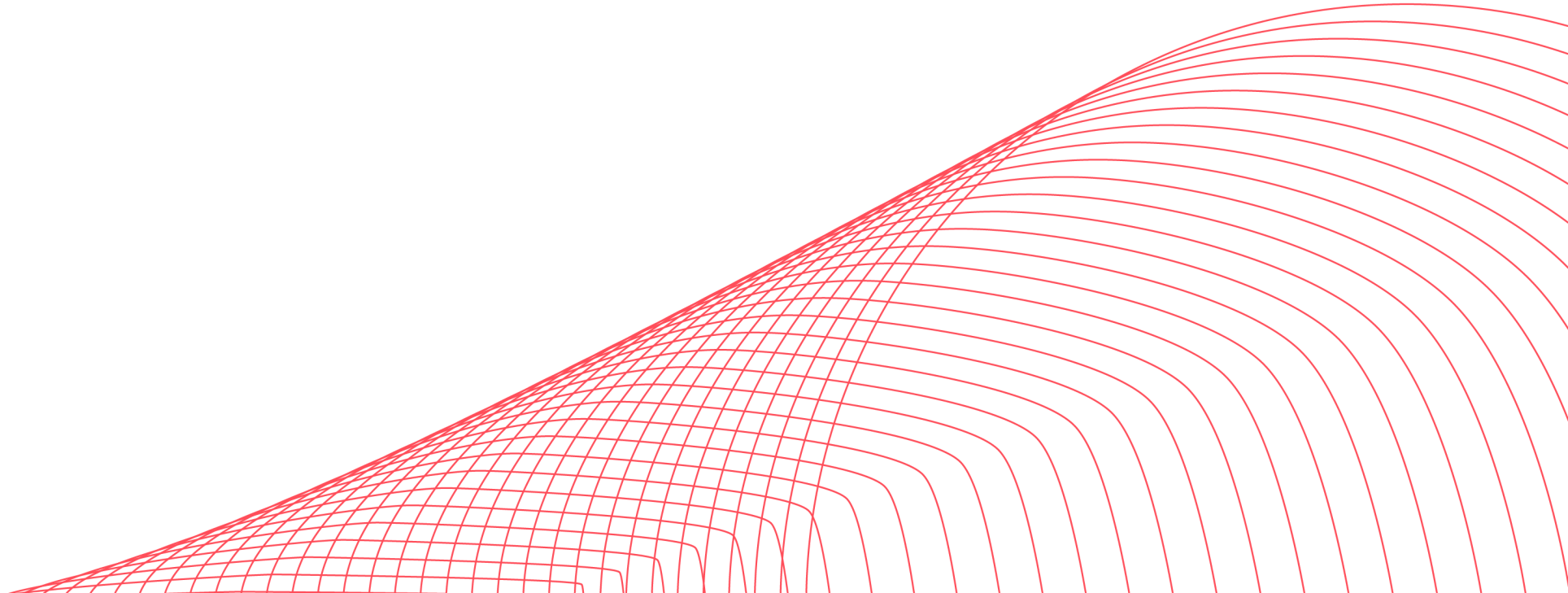

Mosliciguat: Phase 2-Ready Inhaled, Once-Daily, Soluble Guanylate Cyclase (sGC) Activator with Potential to Transform Pulmonary Hypertension (PH)

Mosliciguat has Potential to be First-in-Class

- Mosliciguat is an inhaled sGC activator specifically designed for lung-targeted effects
- sGC pathway activation results in vasodilatory, anti-inflammatory and anti-fibrotic effects
- Unlike sGC stimulators, mosliciguat does not require heme or NO to work and retains efficacy even in conditions associated with oxidative stress

Large and Well-Validated Market Opportunity

- Focusing initially on high unmet need in pulmonary hypertension associated with interstitial lung disease (PH-ILD), a large population with limited or no treatment options
- Imminently initiating a Phase 2 study in PH-ILD – optimized trial design/ patient population maximizes POS

Compelling Clinical Data in Phase 1b ATMOS study

- Some of the highest reductions to date in pulmonary vascular resistance (PVR)[1]
- Favorable safety profile with no clinically relevant changes seen in systemic vascular resistance or blood pressure
- Phase 1b (n=38) data, including PVR reductions, were presented at European Respiratory Society (ERS) Congress
- Robust and well-characterized program, with safety database of 170 subjects to date

Differentiated Dosing Profile

- ~40-hour half-life allows convenient, one puff per day dosing with a dry powder inhaler (DPI)
- Targeted delivery directly to lungs reduces risk of systemic side effects

Favorable Transaction Structure with Strong IP

- Global rights licensed from Bayer for $14M upfront and up to $280M in development, regulatory, and commercial milestones, and tiered high-single digit royalties
- Granted patents and pending applications, if issued, provide protection out to 2042, before potential PTE

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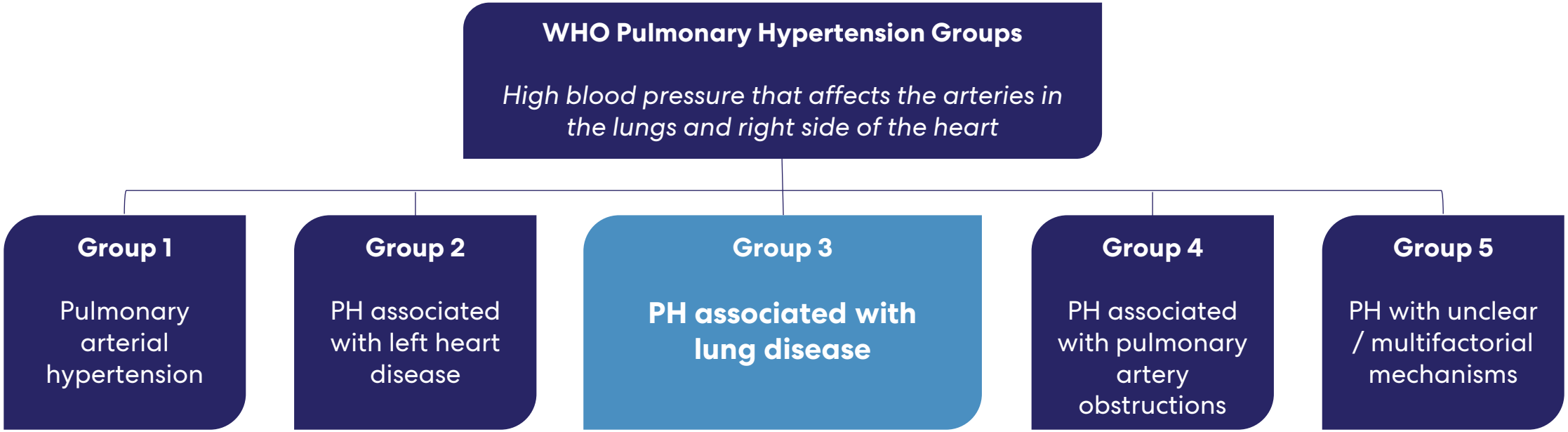
1. Based on ATMOS PH trial with Group 1 and 4 patients

Initially Focusing on Group 3, PH Associated with Lung Disease; Potential for Multiple Other PH Expansion Opportunities



- **PH-ILD:** PH associated with interstitial lung disease
- **PH-COPD:** PH associated with chronic obstructive pulmonary disease
- *Additional lung diseases*

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Adapted from European Heart Journal, Volume 43, Issue 38, 7 October 2022, Pages 3618–3731

PH-ILD Patients Have Limited Treatment Options with Reduced Quality of Life and Less Than 5-Year Median Survival

PH-ILD is a particularly severe subgroup of PH[1]

- Lung disease is the second most common cause of PH[1]
- Structural lung changes and chronic hypoxia lead to pulmonary vascular remodeling and PH in ILDs[2]

"Even if progression of ILD seems to be slowing with the antifibrotics, I am pretty aggressive with treatment given how fast they can decline when PH is present." - Physician

< 5-year median survival[3]

- Compared to patients with PAH, PH-ILD patients have[3]:
  - Increased risk of mortality & morbidity
  - Reduced functional capacity and health related QoL
- Elevations in PVR are associated with worse mortality in PH-ILD patients[4] – reducing PVR should improve outcomes

"My medical problems are consuming my everyday life." – PH-ILD patient

Limited or no approved treatment options

- No approved therapies in major ex-US markets
- Only 1 approved therapy in the US, which requires 4x daily dosing and causes cough in patients whose lungs are already compromised
- Other than inhaled treprostinil, Group 1 PH drugs have generally not shown clinical benefit in patients with Group 3 PH[5]

"Efficacy [of approved therapy] is not amazing … it's all we have, but there is definitely room to improve." - Physician

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1. Humbert et al., European Heart Journal, 2022
2. Kacprzak et al., Diagnostics, 2023
3. Nikkho et al., Pulm Circulation, 2022; Klinger et al., Cardiol Clin., 2016; Hoeper et al., PLoS One, 2015; Gall et al., J. Heart and Lung Transplantation, 2017
4. Olsson et al., Eur Respir. J., 2021; Alhamad et al., J Clin Med., 2020
5. Humbert et al., Eur Respir J., 2023; Dhont et al., ERJ Open Res., 2022

PH-ILD is Even More Prevalent than PAH (~$6BN Market) but Has Only One Approved Therapy in US and None Ex-US

	PAH *Group 1* *Idiopathic PAH or Connective-Tissue Disease Associated PAH*	**PH-ILD** *Group 3* *PH associated with interstitial lung disease*
US & EU Patient Population	70 – 100k patients[1]	Up to ~200k patients[2]
Competitive Landscape	15+ approved therapies, across five drug classes	**High unmet need** Only 1 approval in PH-ILD (US only, among major markets)
Commercial Validation[4]	Generated multiple blockbuster products	Only approved therapy approaching $1BN in annual US PH-ILD sales just ~3 years into launch
Market Size	~$6BN[3]	**Potentially >$6BN[4]**

1. Humbert et al., Respiratory Medicine, 2020; Leber et al., Pulm Circ., 2021; Delcroix et al., Eur Resp Review, 2015
2. Sathananthan et al., Chest, 2023; Kacprzak et al., Diagnostics, 2023; Hilberg et al., ERJ Open Res., 2022; Raghu et al., Eur Respir J., 2015
3. Analysis of global Group 1 PH 2023 revenues including Tyvaso, Adempas, Remodulin, Orenitram, Uptravi, Opsumit and Letairis
4. Company estimate based on US and EU patient population size for PH-ILD and Tyvaso pricing (~$300K/pt/year) for treatment

Mosliciguat has an Ideal Target Product Profile, with Potential to Differentiate Across All Three Key Domains – Efficacy, Convenience and Safety/Tolerability

Efficacy

"Big Gun"

- Group 1 PH experience shows that the ability to reduce PVR is a predictor of success
- Tyvaso Phase 3 INCREASE study in PH-ILD confirms this principle translates to Group 3 PH for inhaled therapies[1]
- Mosliciguat is able to generate greater PVR reductions than any product to date in a single-dose setting (exceeding what many can do even with repeat dosing)

Convenience

One Puff per Day

- A single dose of mosliciguat is able to drive sustained cGMP elevation through 24 hours, while every other approved inhaled product requires between one and twelve breaths given 4x per day
- Mosliciguat is delivered via DPI, preferable to cumbersome nebulizers

Safety / Tolerability

Safe and Well Tolerated

- Inhaled prostacyclins carry class AEs that preclude many patients from reaching maximally effective doses and lead to significant rates of discontinuation
- sGC modulation has been shown to be safe and well tolerated when delivered as an inhaled therapy (minimizing systemic exposure)

Mosliciguat well-positioned for front-line use in PH-ILD;
Tyvaso's consensus ~$1.5-$2BN peak sales for PH-ILD sets floor for opportunity

No head to head studies have been conducted. Differences exist between study designs and subject characteristics, and caution should be exercised when comparing data across studies.

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1. In INCREASE, 6MWD benefit was driven entirely by patients with baseline PVR ≥ 4WU

Robust Phase 1 Program Demonstrates that Mosliciguat is a Potent sGC Activator with a Favorable Safety Profile

Given to 170 healthy volunteers and patients with PH[1]

Trial (Population)	N[1]	Duration	Findings
SAD (HVs)	62	Single dose	• Inhaled dose range of 0.06-4.0 mg well tolerated • Dose-dependent increase in cGMP
MAD (HVs)	27	7-day	• Inhaled dose range of 0.48-2.0 mg well tolerated • Accumulation and dose-dependent increases in cGMP confirms **effective once-daily dosing**
Bioavailability (HVs)	26	Single dose	• **Determined inhaled bioavailability** • Inhaled, oral and intravenous dosing well tolerated
MAD (HVs)	17	14-day	• Well tolerated over 14 days • Steady state of cGMP production **achieved in <14 days**
ATMOS (Group 1 / 4 PH)	38	Single dose	• Data presented at ERS • Primary endpoint: PVR reduction
Total	**170**		

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1. Numbers do not include subjects randomized to placebo

sGC Modulation is Ideally Suited for Disease Modification in Pulmonary Hypertension

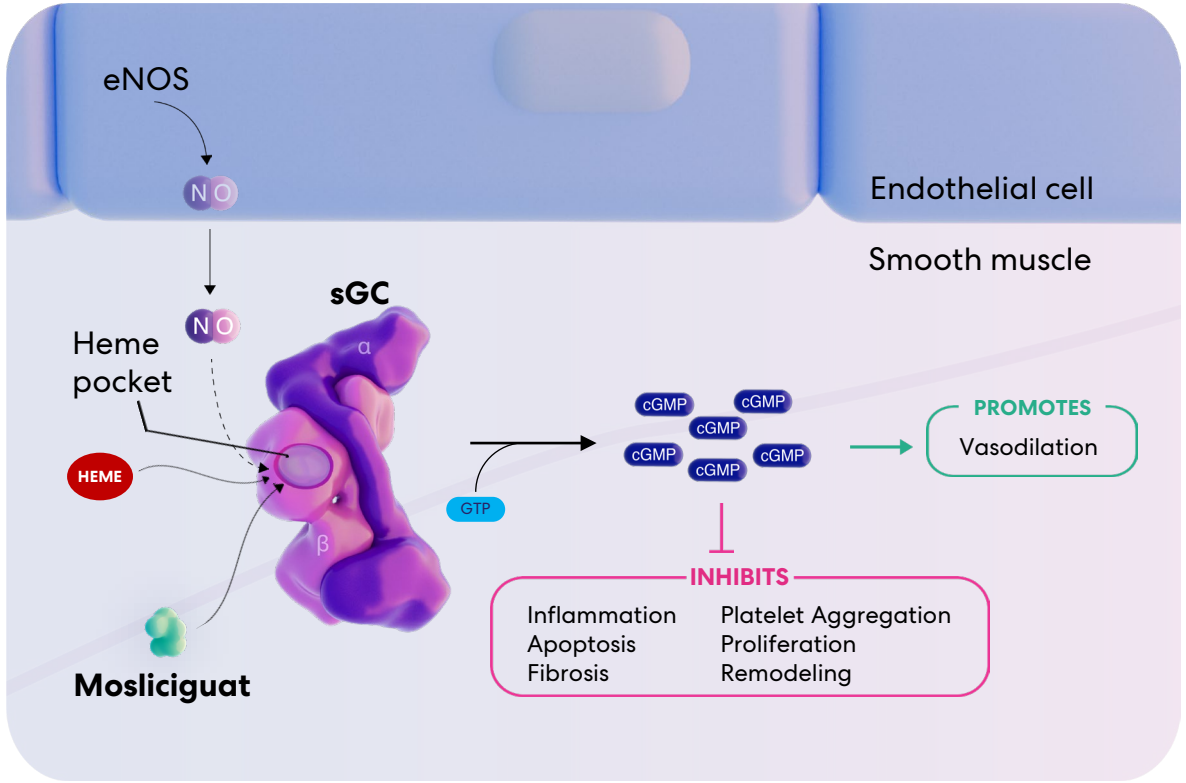
sGC is a key enzyme in the nitric oxide (NO) and cyclic guanosine monophosphate (cGMP) signaling pathway that helps maintain vascular homeostasis

sGC catalyzes conversion of GTP to cGMP, a key messenger molecule responsible for a wide variety of desirable outcomes[1]

Both reduced heme and NO are required for maximal sGC activity

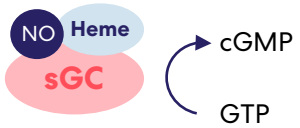
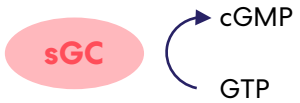
PH and lung disease are often associated with high oxidative stress, leading to impaired sGC activity and insufficient levels of cGMP

sGC modulation restores impaired sGC activity and recovers cGMP levels



1. Stasch et al., Circulation, 2011; Mauersberger et al., Nature Cardiovascular Research, 2022; Dumitrascu et al., Circulation, 2006; Sandner et al., Respir Med., 2017

Mosliciguat, an sGC Activator, Should Outperform an sGC Stimulator in the Oxidative Environment of PH-ILD

	Target	Requirements	In a Highly Oxidized Environment (eg PH-ILD) where reduced heme and NO are depleted
Stimulator →		Requires both reduced heme and NO for optimal activity	**LOSES** activity
Activator →		Works independently of heme and NO	**RETAINS** activity

Broad applicability makes mosliciguat the "go to" sGC modulator

Mosliciguat has Shown Among the Highest PVR Reductions Ever Seen in the Single or Repeat Dose Setting

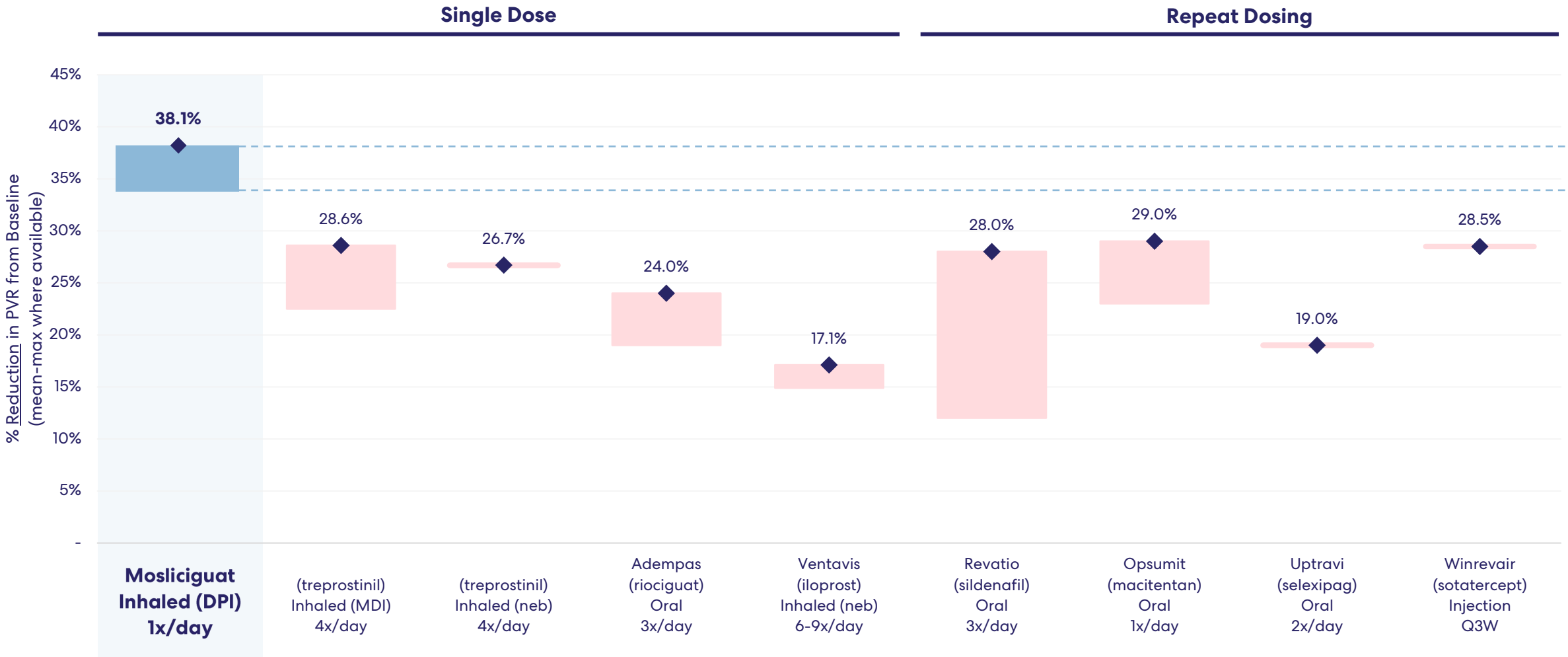


Figure represents a cross-study comparison and not a head-to-head study. Differences exist between study designs and subject characteristics, and caution should be exercised when comparing data across studies.

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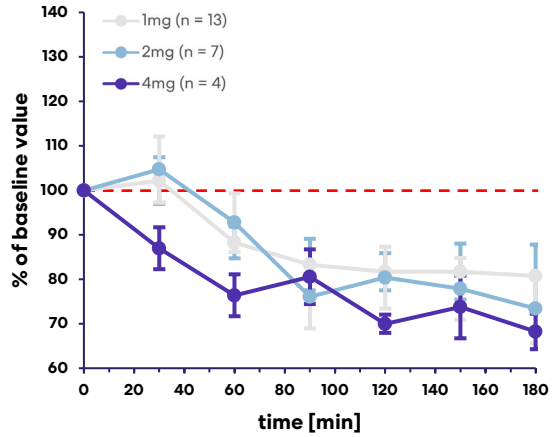
NOTES: Where PVR reductions not published for labeled dose, ranges estimated based on P2 or academic studies with active ingredient. Treprostinil MDI for 45 mcg (28.6%) and 60 mcg (22.5%) shown. In clinical practice, dose depends on what the specific patient can tolerate. Frequency of administration refers to that of approved dose, rather than how compound was used in given study. Single dose data reflects mean-max PVR change from baseline. Repeat dosing data reflects minor variations in how PVR reductions were defined across studies.
SOURCES: Treprostinil (MDI) - Voswinckel 2008; Treprostinil (neb) - Voswinckel 2006; Adempas - Grimminger 2009; Ventavis - Richter 2015; Revatio - Galie 2005; Opsumit - Pulido 2013; Uptravi – Simmoneau 2012; Winrevair – Hoeper 2023

Mosliciguat Pairs Best-In-Category PVR Reductions with a Superior Dosing Profile and Formulation

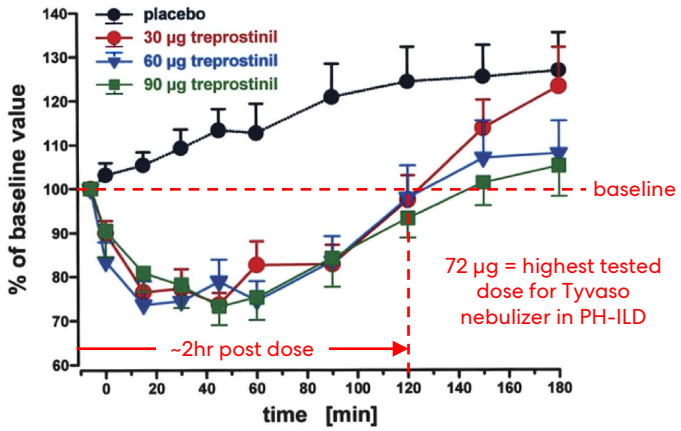
Single dose of mosliciguat has shown...



- >30% PVR reductions continue to deepen as of last time point measured (3 hours post-dose)
- C_{max} at ~2-2.5 hours with extended half-life in blood of ~40+hr
- cGMP levels peak 8 hours post-dose, are sustained through 24 hours and rise with repeat dosing

Highly convenient
"One Puff per Day" dosing

Single dose of inhaled treprostinil has shown...



- A short half-life, leading to small window of effect: PVR back to baseline in as little as 2 hours[1]
- 6MWT effects are reduced at trough exposures[2]

Tyvaso has 4x daily dosing, with majority of day and entire night still spent with suboptimal PVR reductions

No head to head studies have been conducted. Differences exist between study designs and subject characteristics, and caution should be exercised when comparing data across studies.

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1. PVR reduction data in Group 1 PH patients with nebulized treprostinil: Voswinckel et al., Journal of the American College of Cardiology, 2006
2. Results from Tyvaso Phase 3 INCREASE study (per FDA label)

Safety Data Indicate All Dose Levels of Mosliciguat Were Well-Tolerated in Both Healthy Volunteers and Patients with PH

Mosliciguat SAD/MAD and ATMOS Phase 1b Data Show Clean Safety and Tolerability Profile

- Majority of treatment emergent adverse events were mild
- Continuous dosing in healthy volunteers (HV) for 7-14 days did not reveal relevant additional events compared to single-dose experience in HV and PH patients
- No clinically significant changes to blood pressure or heart rate suggest successful minimization of systemic side effects
- All doses tolerated as inhaled dry powder without significant cough
- “One Puff per Day” dosing further mitigates risk of cough

Tolerability Concerns for Inhaled Prostacyclins as a Class

- Inhaled prostacyclin-related AEs include high rates of cough, throat irritation, oropharyngeal pain and headache
- These AEs are likely to occur with any inhaled prostacyclin, regardless of frequency of administration or formulation
- In Tyvaso’s Phase 3 PH-ILD study (INCREASE) with 4x/day nebulizer:[1]
  - ~45% of Tyvaso patients had cough
  - less than half reached the top dose level (72 µg), likely due to poor tolerability
- In the INCREASE OLE, AEs led to 22% of patients discontinuing drug[2]

No head to head studies have been conducted. Differences exist between study designs and subject characteristics, and caution should be exercised when comparing data across studies.

1. Results from Tyvaso Phase 3 INCREASE study (per FDA label)
2. Waxman et al., European Respiratory Journal, 2023

Potential for Best-in-Category Profile with Robust Efficacy, Favorable Tolerability and Safety, and a Convenient, One Puff per Day Dosing Regimen

	Mosliciguat	Tyvaso + Other Inhaled Prostacyclins[1]	Seralutinib[2]	MK-5475[3]
Company	pulmovant	United Therapeutics, Inspire, Liquidia	gossamerbio	MERCK
Group 3 PH Stage of Development	Phase 2	Marketed or Pending Phase 3	Pending Phase 3	Phase 2 (*in PH-COPD only*)
MOA	**sGC activator**	Prostacyclin	PDGFRα/β, CSF1R and c-KIT inhibitor	sGC stimulator
Administration	**Inhaled**	**Inhaled**	**Inhaled**	**Inhaled**
>30% PVR Reductions with Once Daily Dosing	✓	✗	✗	✗
# Inhalations / Day	**1**	**Up to 48**	**Up to 12**	**TBD**
Half-life	**~40+ hours**	**~0.5–9 hours**	**~3–6 hours**	**~2–3 hours**
Tolerability	✓	✗	~	✓

No head to head studies have been conducted. Differences exist between study designs and subject characteristics, and caution should be exercised when comparing data across studies.

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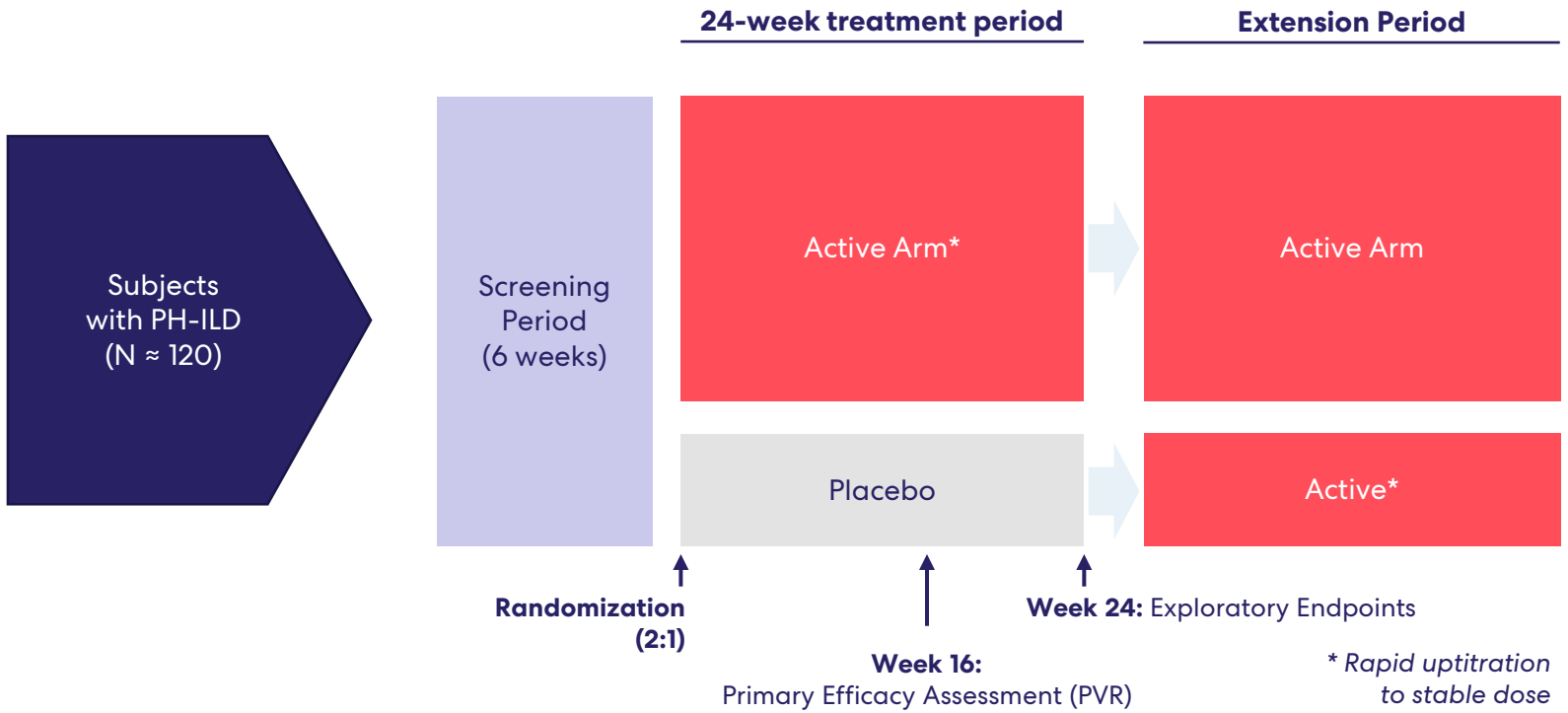
1. Tyvaso INCREASE trial results: Nathan et al., N Engl J Med, 2021; Tyvaso showed high cough AE rate (43.6%) and 20-25% of patients had a clinical event within 16 weeks in the INCREASE trial. Tyvaso PVR reduction data obtained from Phase 1 study (N=28) in Group 1, Group 3 and Group 4 PH
2. Seralutinib Phase 2 TORREY trial results: Frantz et al., Lancet Resp Med, 2024; Seralutinib showed high cough AE rate (43%) in the TORREY study
3. Bajwa et al., Am J Respir Crit Care Med, 2023, Bajwa et al., Int J Chron Obstruct Pulmon Dis., 2024

Phase 2 PHocus Study of Mosliciguat to Begin Imminently

Multi-center, global trial in ~120 PH-ILD patients



phocus

Eligible Patients

Eligible participants diagnosed with PH-ILD

Inclusion/Exclusion Criteria

- Confirmed ILD (IIP, CHP, ILD-CTD)
- Elevated baseline PVR
- Pre-defined extent of fibrosis and emphysema as measured by CT

Primary Endpoint

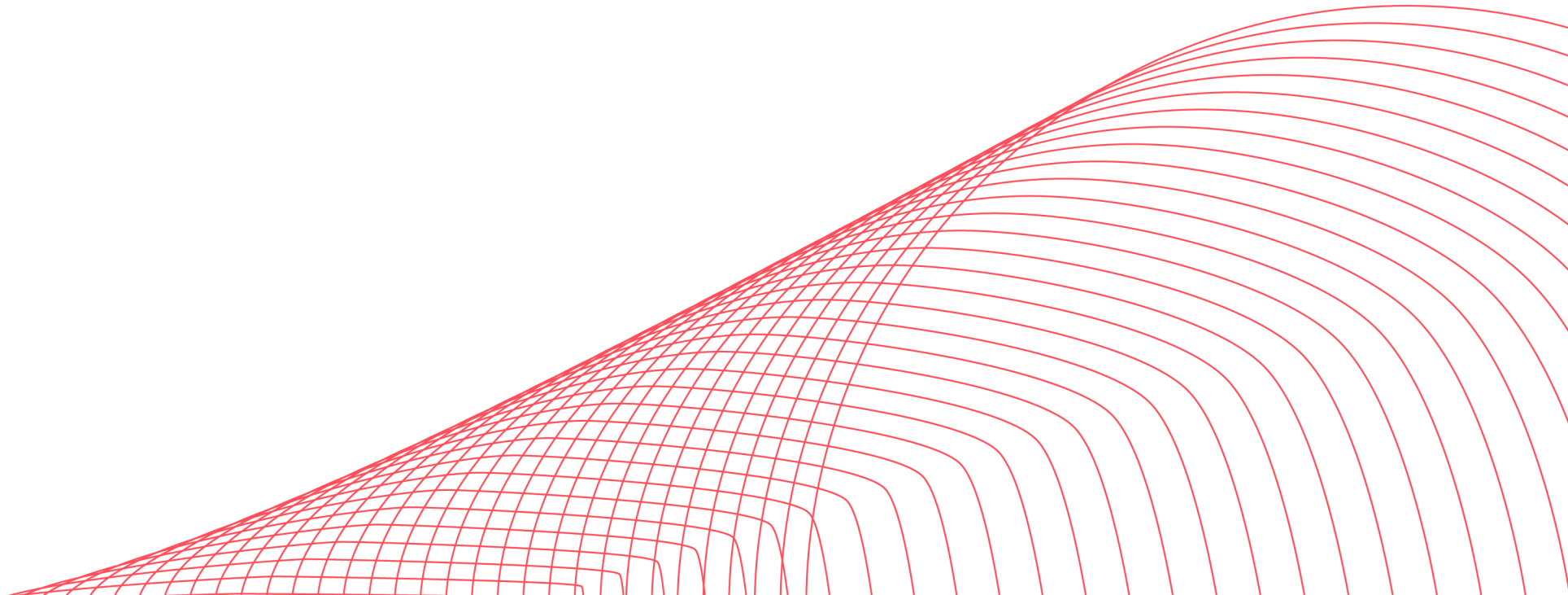
Change from Baseline PVR

Secondary / Exploratory Endpoints

- Change from baseline 6MWD
- Change from baseline NT-proBNP
- Time-to-clinical-worsening (TTCW) at W24
- QoL

If Phase 2 is positive, we believe a single registrational study will be sufficient for approval

Genevant/LNP Patent Litigation



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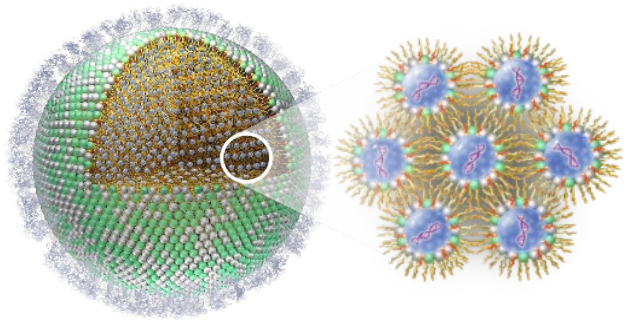
Genevant is a Leading Nucleic Acid Delivery Solutions Company

- 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
- LNPs are now 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



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Genevant Collaborates with Leading Companies for Access to its LNP Technology to Develop Medicines for a Variety of Diseases and Disorders, Including COVID-19

Partner	LNP Collaborations Outside of COVID-19	Publicly Disclosed Financials*
Takeda	Nucleic acid therapeutics directed to specified targets in HSCs to treat liver fibrosis[1]	Royalty rate: undisclosed Upfront & milestones: $600M
gritstone bio	Self-amplifying RNA (samRNA) for an unspecified indication[2]	Royalty rate: low to mid-single digits† Upfront & milestones: $73M
gritstone bio	Self-amplifying RNA (samRNA) for various infectious disease vaccines[3]	Royality rate: mid to high-single digits† Option exercise fee: single-digit millions Milestones: $136M/product
BIONTECH	mRNA for a specified number of oncology targets; co-dev in up to five rare diseases[4]	Milestones and royalties (amounts undisclosed); 50:50 on co-development programs
KORRO BIO	RNA editing therapy for Alpha-1 Antitrypsin Deficiency (AATD)[5]	Royalty rate: mid-single digits[6] Upfront & milestones: $100M
novo nordisk®	Gene editing therapy for hemophilia A[7]	Royalty rate: mid-single digits† Upfront & near-term option: $10M + milestones
Tome BIOSCIENCES	Gene editing therapy for an undisclosed rare monogenic liver disorder[8]	Total deal value: $114.3M Royalty rate: undisclosed

Partner	LNP Collaborations for COVID-19	Publicly Disclosed Financials*
gritstone bio	Self-amplifying RNA (samRNA) COVID-19 vaccine program[9]	Royalty rate: mid-single to mid-double digits† Upfront & milestones: $192M/product
Chula Chulalongkorn University	mRNA COVID-19 vaccine program in specified Asian countries	Undisclosed

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*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
Note: All trademarks are property of their respective owners

1. Genevant press release, March 15, 2021
2. Gritstone Oncology 8-K, October 20, 2020
3. Gritstone press release, August 15, 2023.
4. BioNTech Form F-1, July 21, 2020
5. Genevant and Korro Bio joint press release, March 7, 2023
6. Korro Bio S-1/A SEC Filing, December 20, 2023
7. Genevant press release, November 6, 2023. Agreement arose from the exercise of an option under agreement between Genevant and 2seventy bio and later assigned by 2seventy bio to Novo Nordisk.
8. Genevant press release, January 16, 2024
9. Genevant and Gritstone joint press release, January 20, 2021.

Updates on Genevant IP Litigation

Moderna

- In February 2022, Genevant and Arbutus jointly filed a complaint against Moderna in the U.S. District Court for the District of Delaware asserting infringement of six patents
- In November 2022, the Court 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 (Section 1498), which was an attempt by Moderna to shift liability for an unspecified portion of its alleged infringement to the US government and taxpayers
- In February 2023, the United States Government filed a Statement of Interest urging the Court to rule that Section 1498 does apply to Moderna's first vaccine contract with the Government to shield Moderna from liability for patent infringement related to that contract and require that infringement claims based on that contract be brought against the Government in the Federal Court of Claims
- In March 2023, the Court reaffirmed the analysis and conclusions in its November 2022 opinion and order and its denial of Moderna's partial motion to dismiss
- In February 2024, the Court in the Moderna case held a Markman hearing to construe four disputed terms within the claims of the asserted patents
- On April 3, 2024, the Court issued its Markman ruling, in which it agreed with Genevant and Arbutus' proposed constructions for three of the four disputed terms
- In August 2024, the parties requested an amended case schedule in order for Moderna to accommodate certain outstanding discovery requests; the trial is now scheduled for September 2025

Pfizer

- In April 2023, 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 is ongoing
- The Court in the Pfizer case has scheduled a Markman hearing for December 2024

VantAI

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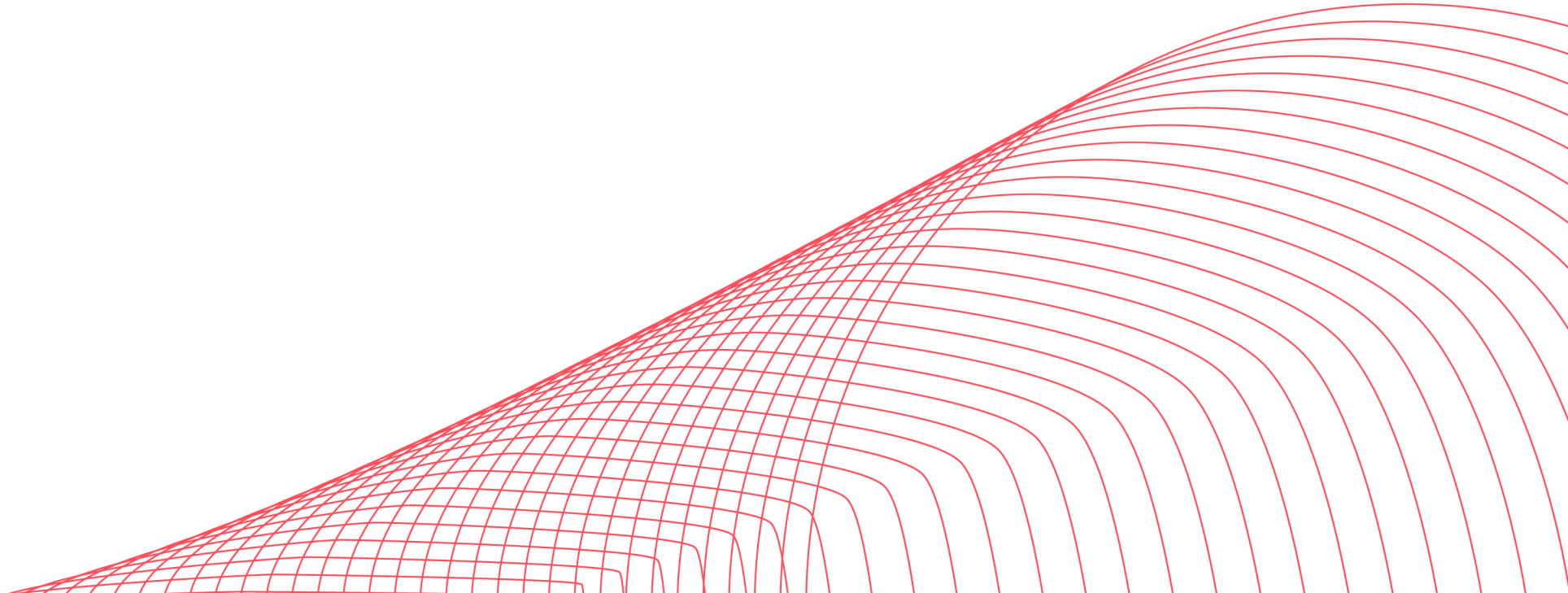
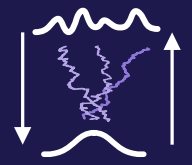


VantAI | Continued Progress at VantAI Underscores Unique Opportunity

Proximity Modulators

Pre-clinical milestones hit **on every major collaboration** with $3.6B+ in total potential upside[1]



Generative AI

Predict and engineer protein surfaces to modify **protein-protein interactions** with proprietary data and world-class AI team

Enable development of **proximity modulators**, with focus on **rational molecular glue design**

Structural Proteomics

Unprecedented **proprietary data moat**, perfectly matched to unlock Proximity Modulation at scale with AI

Select recent milestones

Bristol Myers Squibb

Entered into collaboration to **accelerate molecular glue drug discovery with generative AI. Eligible to receive up to $674M** in discovery, development, clinical, regulatory, and sales milestone payments plus tiered royalties from BMS

blueprint MEDICINES

Expanded partnership on **heterobifunctionals and molecular glues with $1.25B potential upside**

World-leading SAB with Ian Churcher, Bradley Pentelute, Fan Liu, Bruno Correia and Philippe Schwaller

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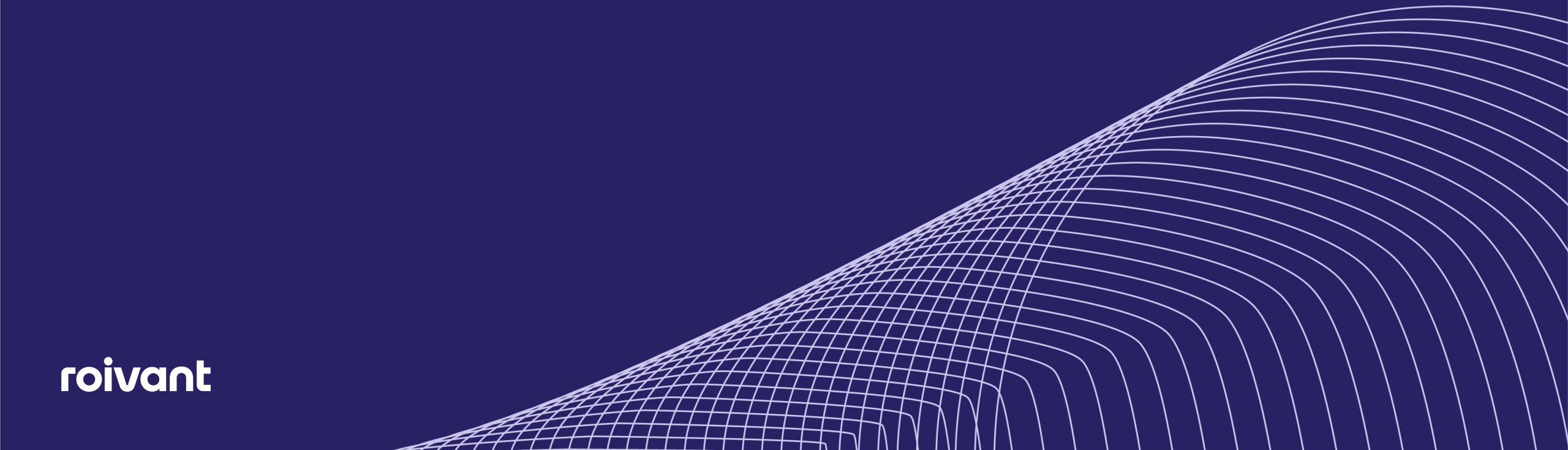
1. All partnerships where work began prior to February 2024

Thank you.



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