IMMUNOVANT

Targeted science, Tailored solutions

for people with autoimmune disease

Corporate Presentation

August 2023

Forward-looking statements

This presentation contains forward-looking statements for the purposes of the safe harbor provisions under The Private Securities Litigation Reform Act of 1995 and other federal securities laws. The use of words such as "can," “may,” “might,” “will,” “would,” “should,” “expect,” “believe,” “estimate,” “design,” “plan,” "intend," and other similar expressions are intended to identify forward-looking statements. Such forward looking statements include Immunovant’s expectations regarding patient enrollment, timing, design, and results of clinical trials of its product candidates and indication selections; Immunovant's plan to develop batoclimab and IMVT-1402 across a broad range of autoimmune indications; expectations with respect to the safety and monitoring plan and size of the safety database for these planned clinical trials; the timing of discussions with regulatory agencies; the size and growth of the potential markets for Immunovant's product candidates and indication selections; Immunovant’s plan to explore in subsequent study periods follow-on treatment with alternative dosing regimens; Immunovant's expectations regarding its cash runway; Immunovant's beliefs regarding the potential benefits of batoclimab’s and IMVT-1402's unique product attributes; and Immunovant's expectations regarding the issuance and term of any pending patents. All forward-looking statements are based on estimates and assumptions by Immunovant’s management that, although Immunovant believes to be reasonable, are inherently uncertain. All forward-looking statements are subject to risks and uncertainties that may cause actual results to differ materially from those that Immunovant expected. Such risks and uncertainties include, among others: initial results or other preliminary analyses or results of early clinical trials may not be predictive of final trial results or of the results of later clinical trials; results of animal studies may not be predictive of results in humans; the timing and availability of data from clinical trials; the timing of discussions with regulatory agencies, as well as regulatory submissions and potential approvals; the continued development of Immunovant’s product candidates, including the timing of the commencement of additional clinical trials and resumption of current trials; Immunovant’s scientific approach, clinical trial design, indication selection, and general development progress; future clinical trials may not confirm any safety, potency, or other product characteristics described or assumed in this presentation; any product candidate that Immunovant develops may not progress through clinical development or receive required regulatory approvals within expected timelines or at all; Immunovant's pending composition of matter patent for IMVT-1402 may not be issued; Immunovant’s product candidates may not be beneficial to patients, or even if approved by regulatory authorities, successfully commercialized; the effect of global factors such as the ongoing COVID-19 pandemic, geopolitical tensions, and adverse macroeconomic conditions on Immunovant’s business operations and supply chains, including its clinical development plans and timelines; Immunovant’s business is heavily dependent on the successful development, regulatory approval and commercialization of batoclimab and IMVT-1402; Immunovant is at an early stage in development for IMVT-1402 and in various stages of clinical development for batoclimab; and Immunovant will require additional capital to fund its operations and advance batoclimab and IMVT-1402 through clinical development. These and other risks and uncertainties are more fully described in Immunovant’s periodic and other reports filed with the Securities and Exchange Commission (SEC), including in the section titled “Risk Factors” in Immunovant’s most recent Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2023, filed with the SEC on August 10, 2023, and Immunovant’s subsequent filings with the SEC. Any forward-looking statement speaks only as of the date on which it was made. Immunovant undertakes no obligation to publicly update or revise any forward-looking statement, whether as a result of new information, future events or otherwise.

Our vision:
Normal lives for people with autoimmune disease

What we do:

We are developing targeted therapies that are designed to address the complex and variable needs of people with autoimmune diseases.

Love Trailblazing

Bolder, Faster

All Voices

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Our focus:
Build a leading anti-FcRn franchise targeting multiple underserved autoimmune disease indications

Leadership Team	Intellectual Property	Financial Strength	Validated Target	Product Candidates	Market Opportunity
Approximately 100 years of combined experience in drug development and commercialization across C-suite	Composition of matter patent protection for batoclimab to 2035[1] Pending patent protection expected for IMVT-1402 to 2043[1]	Approximately $330M cash balance as of 6/30/2023 Cash runway expected to fund operations into second half of 2025[2]	FcRn is a validated target following the regulatory approval of efgartigimod	Differentiated product candidates may offer patients tailored dosing and ease of administration	22 indications currently announced or in development across the anti-FcRn class[3]

1. Not including any potential patent term extension
2. The assumptions upon which we have based our estimates, including expenditures relating to planned or potential clinical trials, are routinely evaluated and may be subject to change
3. Indications announced or in development with anti-FcRn assets by Immunovant, argenx, Johnson & Johnson, and UCB

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Our leadership team:
A tight-knit group of experienced executives

Peter Salzmann, MD MBA
Chief Executive Officer

Eva Renee Barnett, MBA
Chief Financial Officer

William L. Macias, MD PhD
Chief Medical Officer

Julia G. Butchko, PhD
Chief Development and Technology Officer

Jay S. Stout, PhD
Chief Technology Officer

Mark S. Levine
Chief Legal Officer and Corporate Secretary

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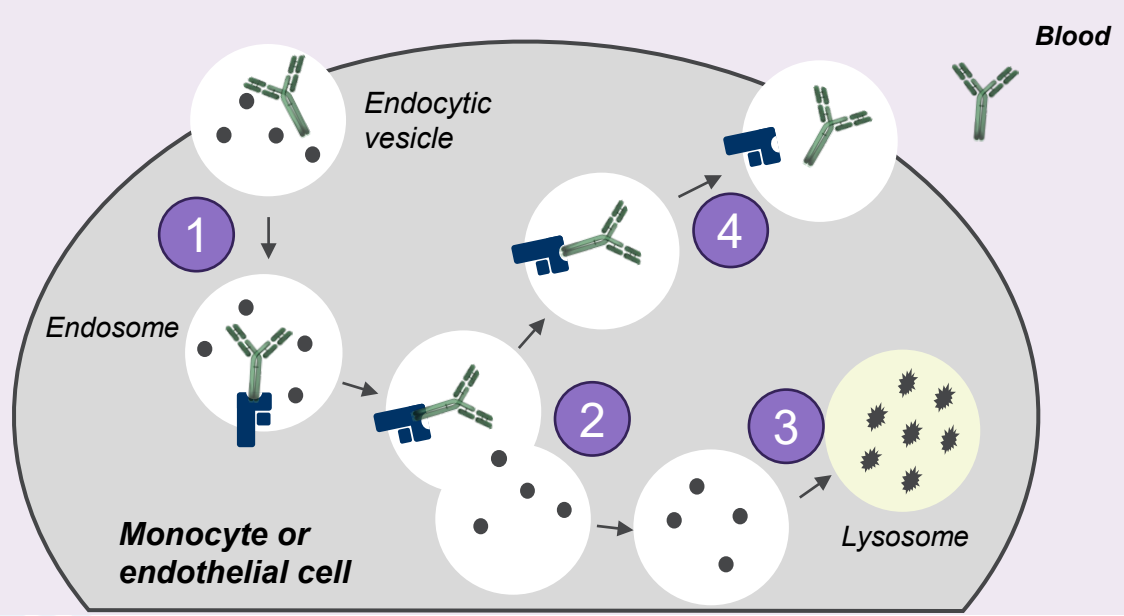
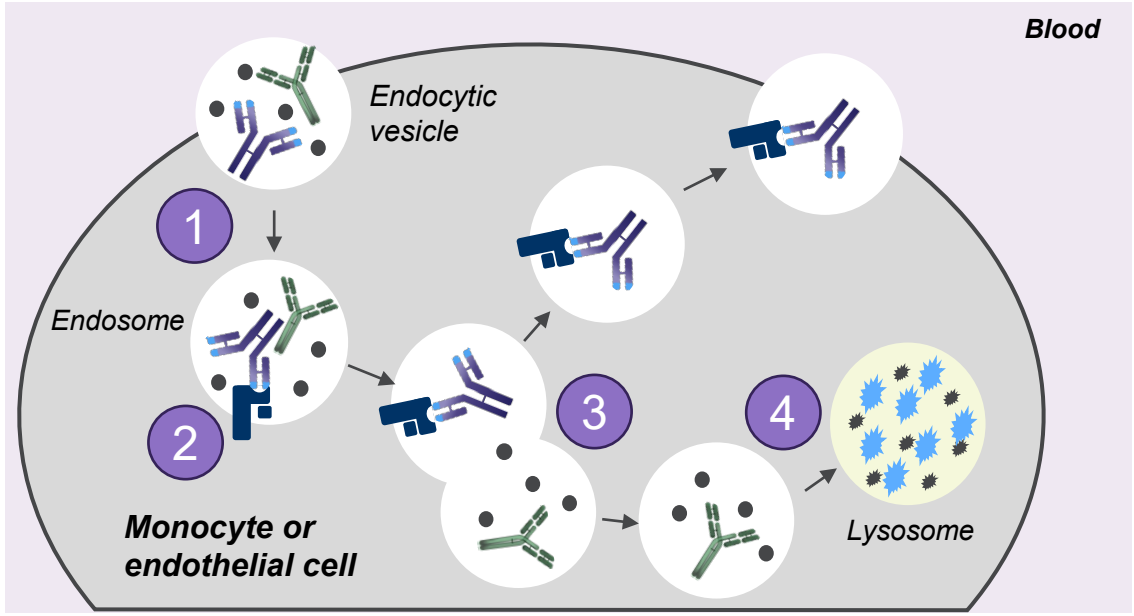
Our target:
Neonatal Fc receptor (FcRn)

FcRn maintains levels of antibodies (IgG) in circulation by preventing their degradation



1. IgG is taken up into cells in endocytic vesicle
2. FcRn-IgG complexes are sorted from unbound proteins
3. Unbound proteins are trafficked to lysosome for degradation
4. IgG is recycled back into circulation

FcRn inhibitor blocks binding of IgG to FcRn and promotes their removal and degradation



1. IgG and FcRn inhibitor are taken up into cells in endocytic vesicles
2. FcRn inhibitor binds to FcRn in endosomes
3. IgGs are blocked from forming complexes with FcRn
4. Non-receptor bound IgGs are degraded in lysosomes

Key: IgG | FcRn | FcRn inhibitor | Serum protein

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Our opportunity:
Autoimmune diseases driven by harmful IgG autoantibodies

22 indications currently announced or in development across the anti-FcRn class[1]

NEUROLOGY

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

HEMATOLOGY

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

ENDOCRINOLOGY

Thyroid eye disease (TED)
Graves' disease

RHEUMATOLOGY

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

DERMATOLOGY

Bullous pemphigoid
Pemphigus foliaceus
Pemphigus vulgaris
Cutaneous lupus erythematosus

RENAL

Membranous nephropathy
Lupus nephritis
Antibody-mediated rejection

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1. Indications announced or in development with anti-FcRn assets by Immunovant, argenx, Johnson & Johnson, and UCB.

Our value proposition:

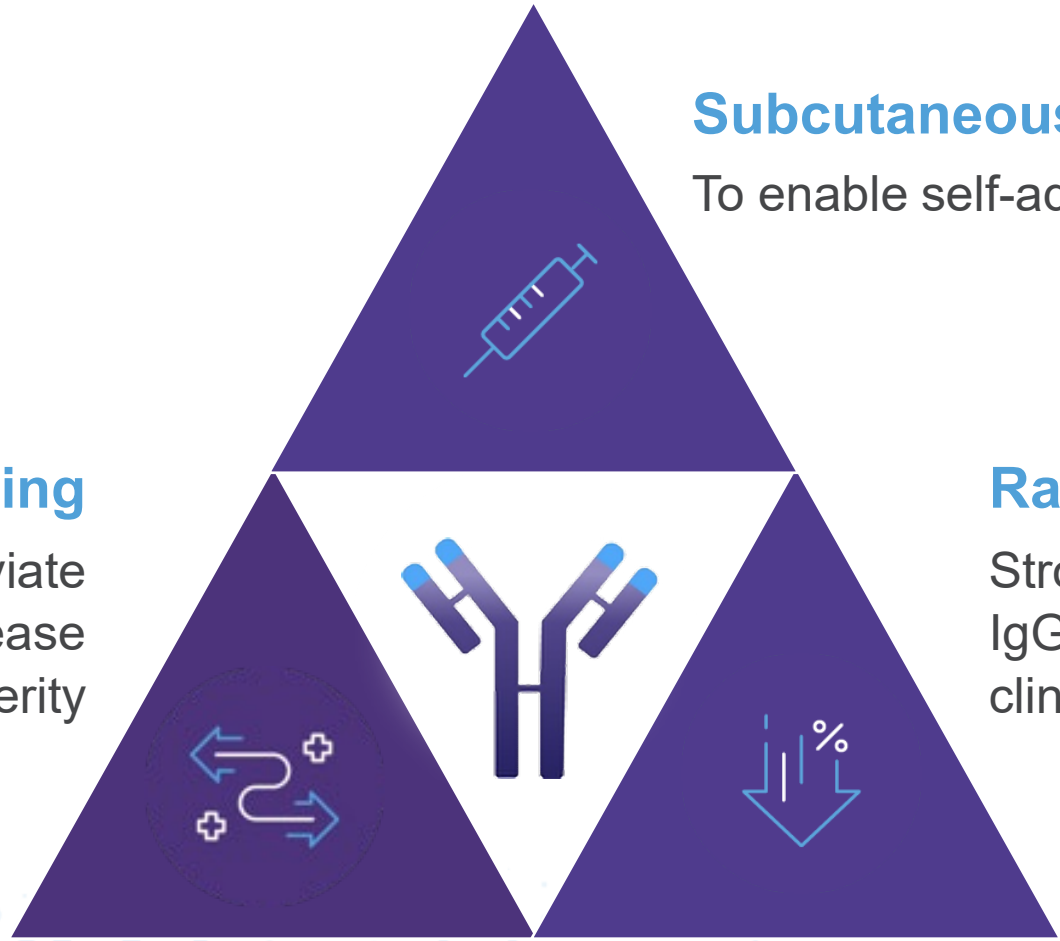
Three potentially unique attributes to address unmet patient needs

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

Our investigational product pipeline

Investigational Compound	Target Indication / Therapeutic Area	Stage of Development
Batoclimab	Myasthenia Gravis (MG)	Pivotal Phase 3
	Thyroid Eye Disease (TED)	Pivotal Phase 3
	Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	Phase 2b
	Graves' Disease	Phase 2
IMVT-1402	Autoimmune Diseases	Phase 1

Myasthenia Gravis

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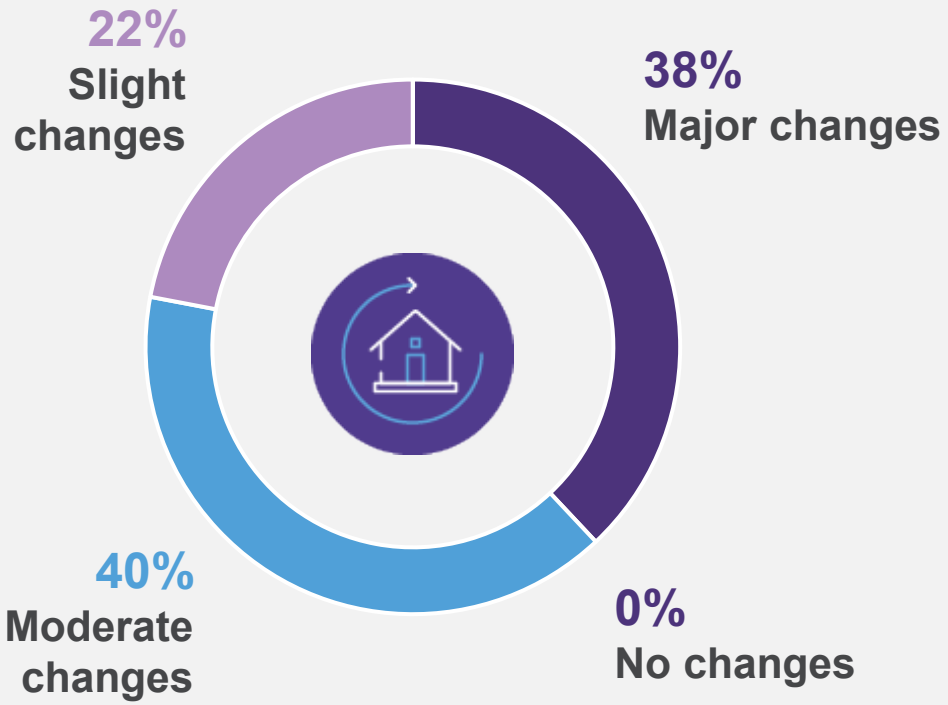
Myasthenia gravis (MG):

IgG-mediated autoimmune disease that typically requires lifestyle changes

Key Takeaways[1]

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

Extent of Lifestyle Modifications[2]



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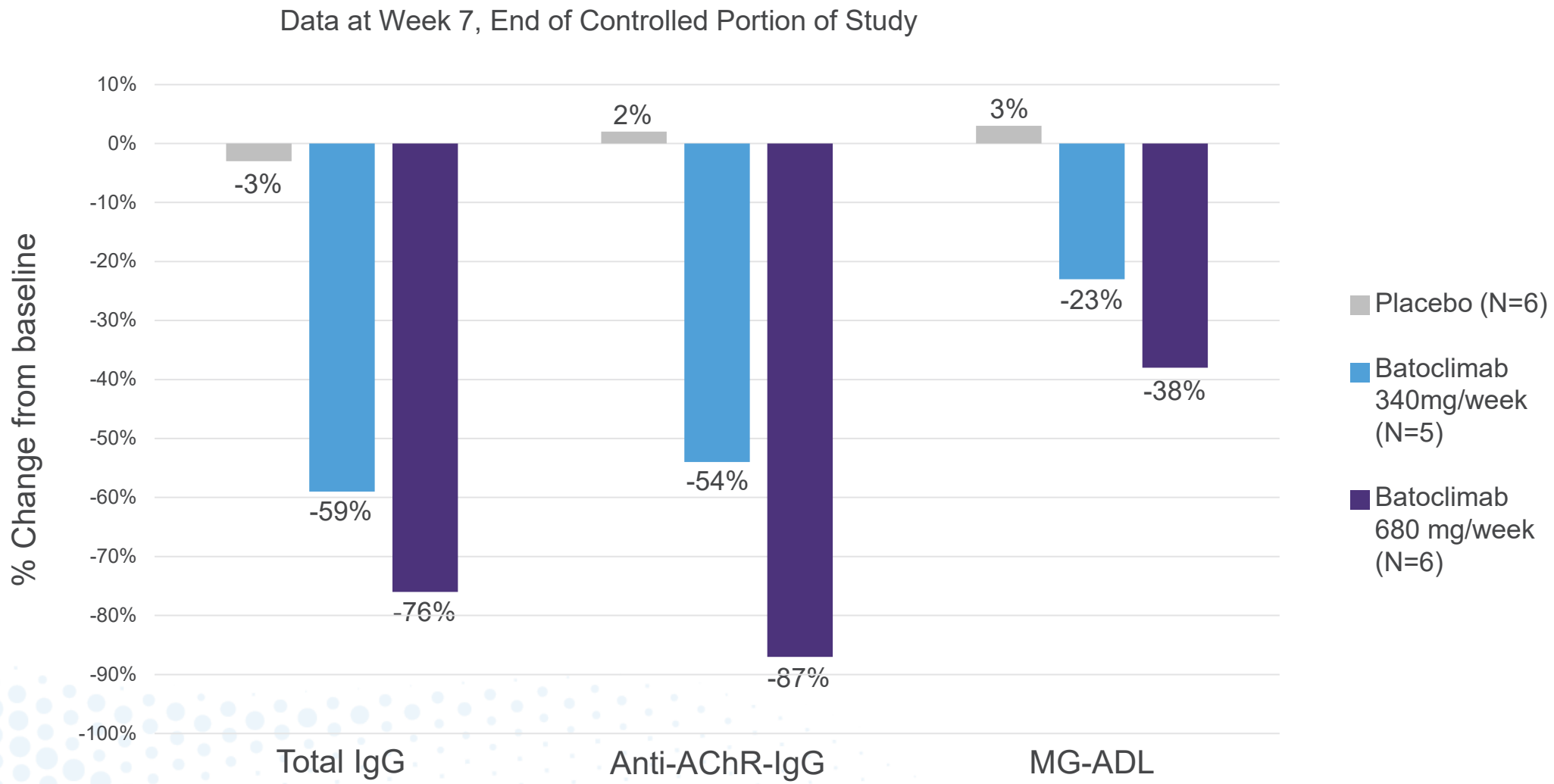
1. KOL Interviews: Data on file at Immunovant. 2. MG Patient Quantitative Survey (n=50). Q: What is the extent of lifestyle modifications you make around your myasthenia gravis?

Encouraging efficacy signals in a Phase 2 trial of batoclimab in MG



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

Batoclimab Phase 3 trial designed to address unmet patient needs

Flexible design first for a MG 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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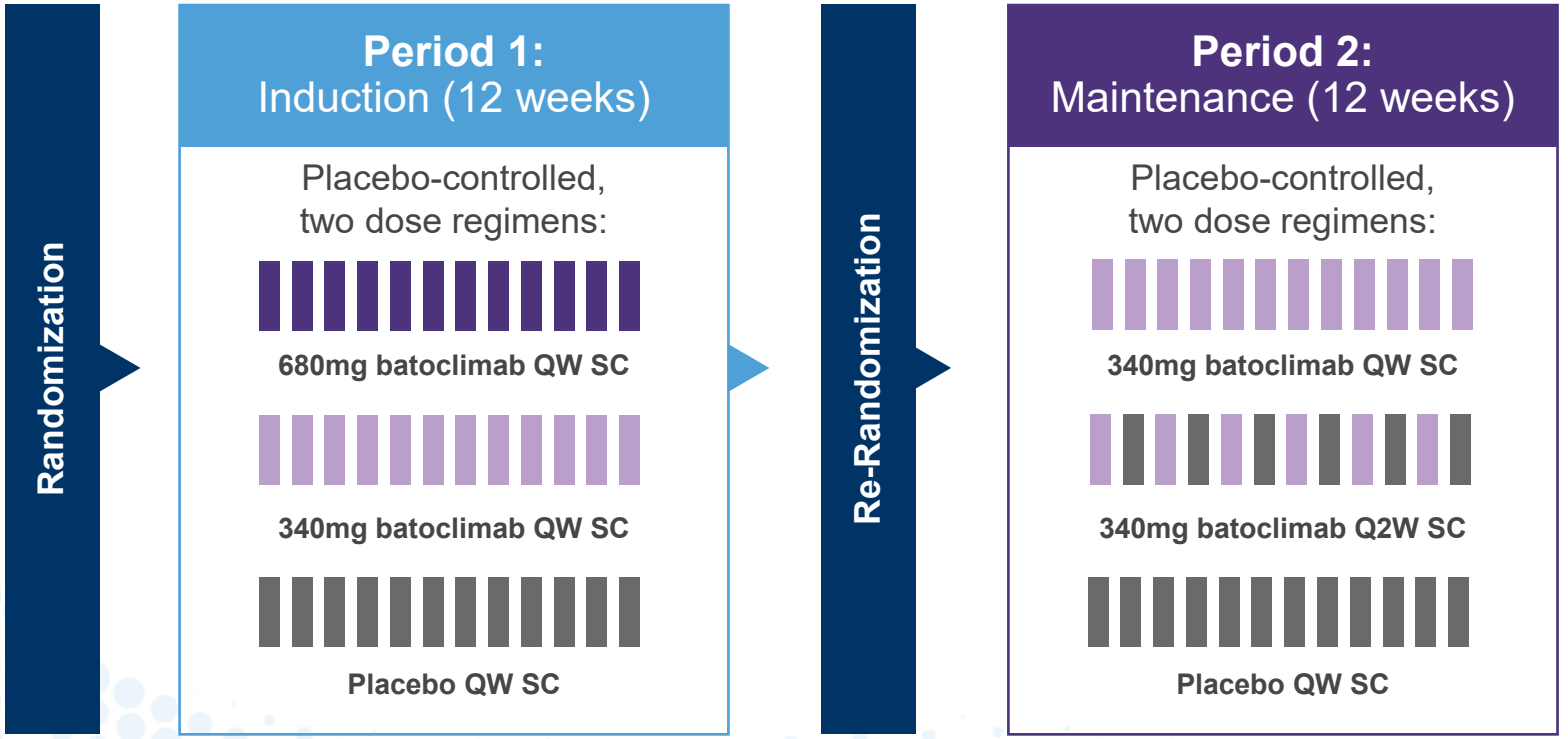
Registrational Phase 3 trial of batoclimab designed to offer MG patients tailored dosing

Top-line data expected in the second half of 2024



Maximize efficacy through primary endpoint*

Maintain efficacy with anchor dose and lower dose

Primary analysis population: AChR Ab+

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

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

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

Batoclimab potentially well positioned to compete in MG market[1,2]

Efgartigimod	Batoclimab	Nipocalimab
IV administration, bridging to Halozyme-enhanced SC administration	Simple SC administration	IV administration
4 infusions, 10 mg/kg QW additional cycles based on loss of response	Continuous dosing via induction, maintenance (3 different doses)	15 mg/kg Q2W for 22 weeks, after single loading dose of 30 mg/kg
Symptomatic exacerbations treated with additional intravenous cycle	Dose increase and dose decrease allowed in LTE based on symptoms	Dose decrease allowed in LTE

IV = Intravenous infusion, LTE = Long-term extension, QW = weekly; SC = subcutaneous injection

1. https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/761195s000lbl.pdf,
2. https://clinicaltrials.gov/ct2/show/NCT04951622

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Thyroid Eye Disease

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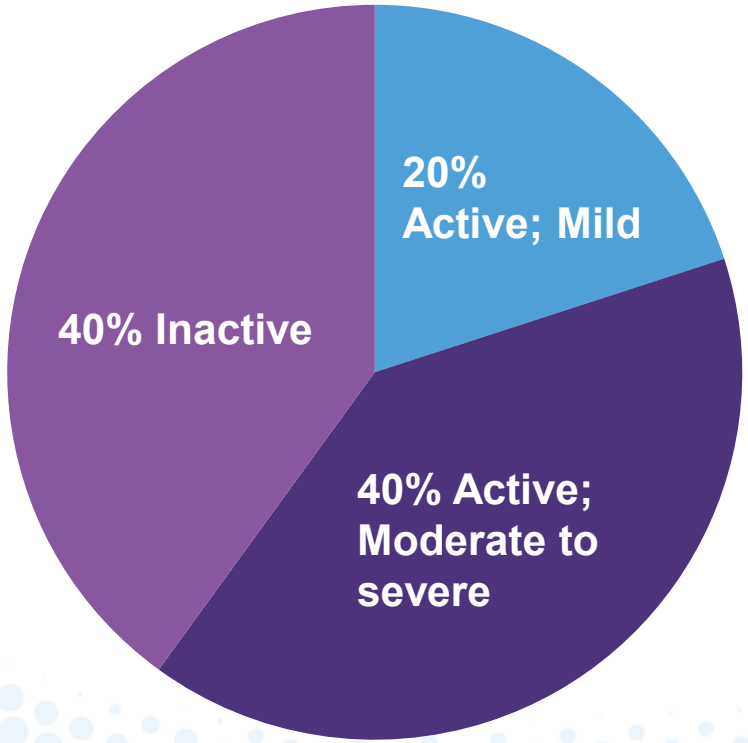
Thyroid eye disease (TED):

Heterogeneous condition that presents with a variety of clinical symptoms

8K-18K Total Addressable U.S. Population



Key Takeaways

- Teprotumumab is the only approved treatment specifically for TED
  - Treatment period is relatively short (~24 weeks) and disease recurrence is common
- 14% of TED patients, and a far higher proportion among active moderate or worse disease, are on teprotumumab and/or immunosuppressants
  - Audiological side effects of teprotumumab could enable greater market share capture by competitor

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Source: KOL Interviews: Data on file at Immunovant

Unique dynamics of TED market create potentially favorable commercial opportunity for new therapeutic approaches

- We believe increased familiarity with the IGF1R mechanism and associated benefit/risk profile may drive HCPs to limit exposure to teprotumumab, especially to any duration beyond controlled period of registrational products
- In the OPTIC 48-week off-treatment follow-up period[1], 44% of teprotumumab patients who were proptosis responders at Week 24 in OPTIC were not proptosis responders at Week 72 illustrating the opportunity for additional treatment
- We anticipate that patients who do not maintain their proptosis response will be candidates for a new mechanism of action
- We believe that a simple subcutaneous route of administration is also important to patients, and perhaps more so during retreatment due to total duration

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1. Horizon Therapeutics, 2020, New Topline TEPEZZA® (teprotumumab-trbw) Data Underscore its Efficacy in Longer Disease Duration, Long-Term Durability and Potential for Retreatment in People Living with Thyroid Eye Disease (TED)

Batoclimab is potentially well positioned to capture significant TED market share

Batoclimab is the first FcRn inhibitor targeting TED[1,2]

Moderate symptoms not yet treated with teprotumumab
(5K-7K)

1/3 of the 15-20K US patients with active, moderate-to-severe TED annually have less severe disease that may benefit from batoclimab[3,4]

Residual symptoms or recurrent symptoms after teprotumumab
(3K-11K)

20%-35% of active TED patients treated with teprotumumab may have residual symptoms warranting treatment[5,6,7]

25%-40% of patients treated with teprotumumab may experience a recurrent symptoms warranting additional TED treatment[8]

1. Based on clinicaltrial.gov database. 2. Lane LC, et al. Endocr Rev. 2020 Dec 1;41(6):873–84. 3. Lazarus JH et al. Best Practice & Research Clinical Endocrinology & Metabolism. v26 (2012) 273-279 . 4. HCP Qualitative Research, Immunovant, 2020. 5. 2021 Cowen Equity Research, March 2022 - surveyed 25 clinicians who treat 3,000+ patients with TED annually 6. Horizon Therapeutics Investor Presentations.
7. Teprotumumab's US Prescribing Information. 8 Douglas R et al. *American Academy of Ophthalmology,* v129, No. 4.

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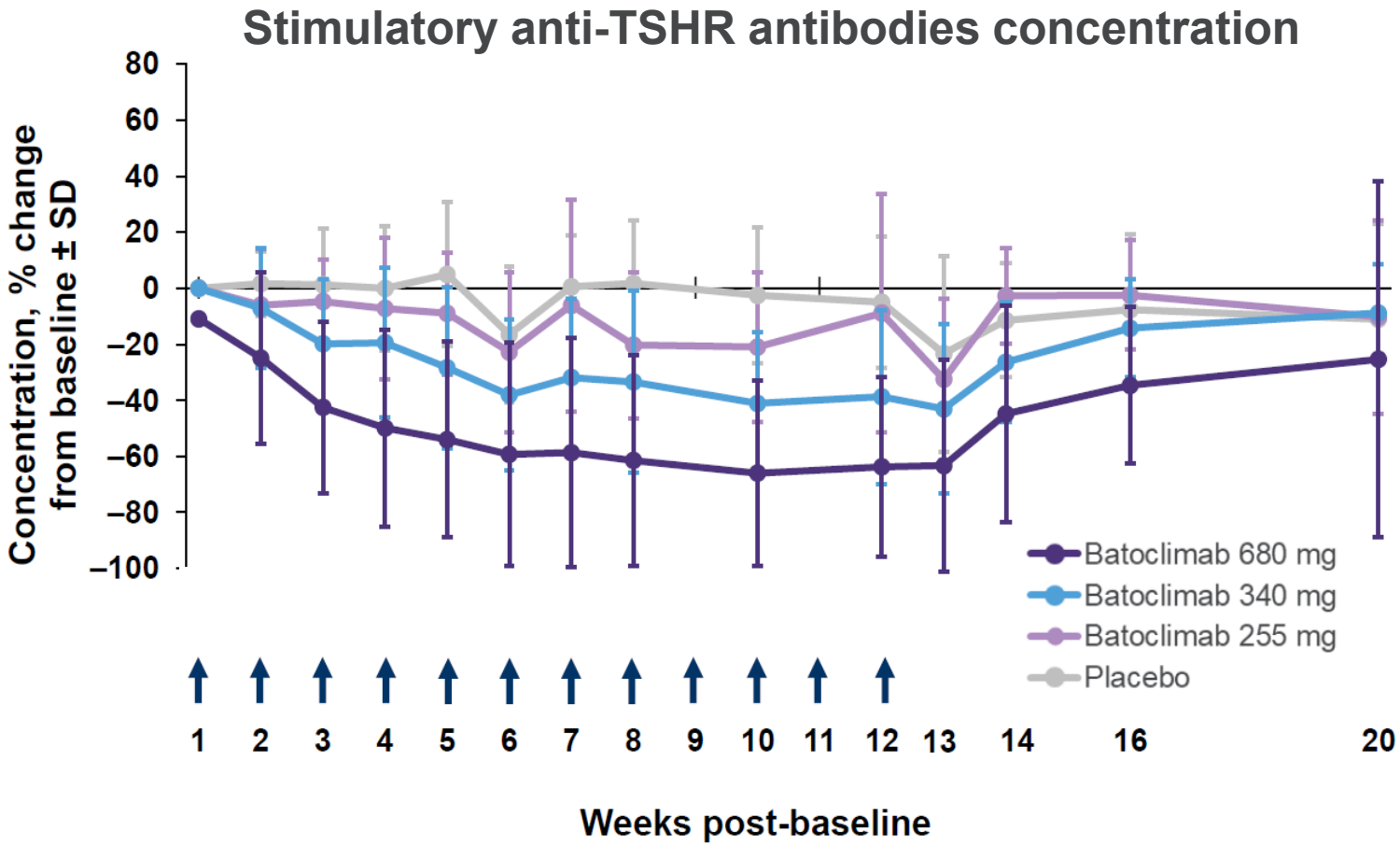
Encouraging pharmacodynamic signals observed from Phase 2b trial of batoclimab in TED



Percentage of subjects with Stimulatory Anti-TSHR antibody below 140 at week 12[1]	
680 mg	50%
340 mg	15%
255 mg	0%
Placebo	0%

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

[1] SRR is the "Sample to Reference Ratio". This cell-based assay readout is the ratio of the sample signal to that of a reference control, expressed as %. A value less than 140 is considered negative for stimulatory antibody; a value greater than or equal, positive for stimulatory antibody.

The efficacy of batoclimab and clinical outcomes were deemed inconclusive, in part, because the study was terminated early.

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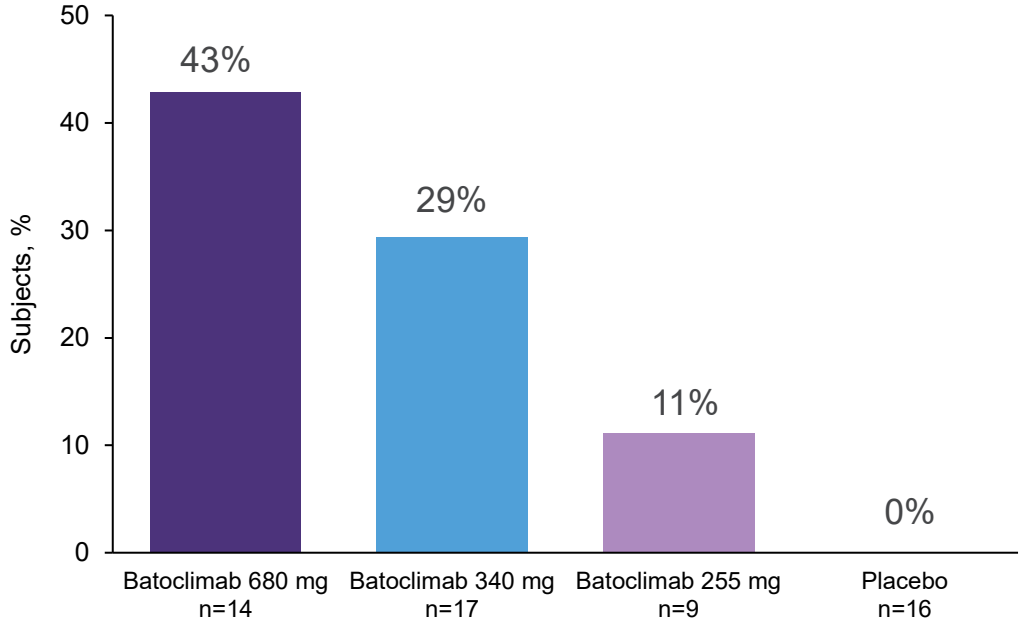
Additional early efficacy signals observed from Phase 2b trial of batoclimab in TED

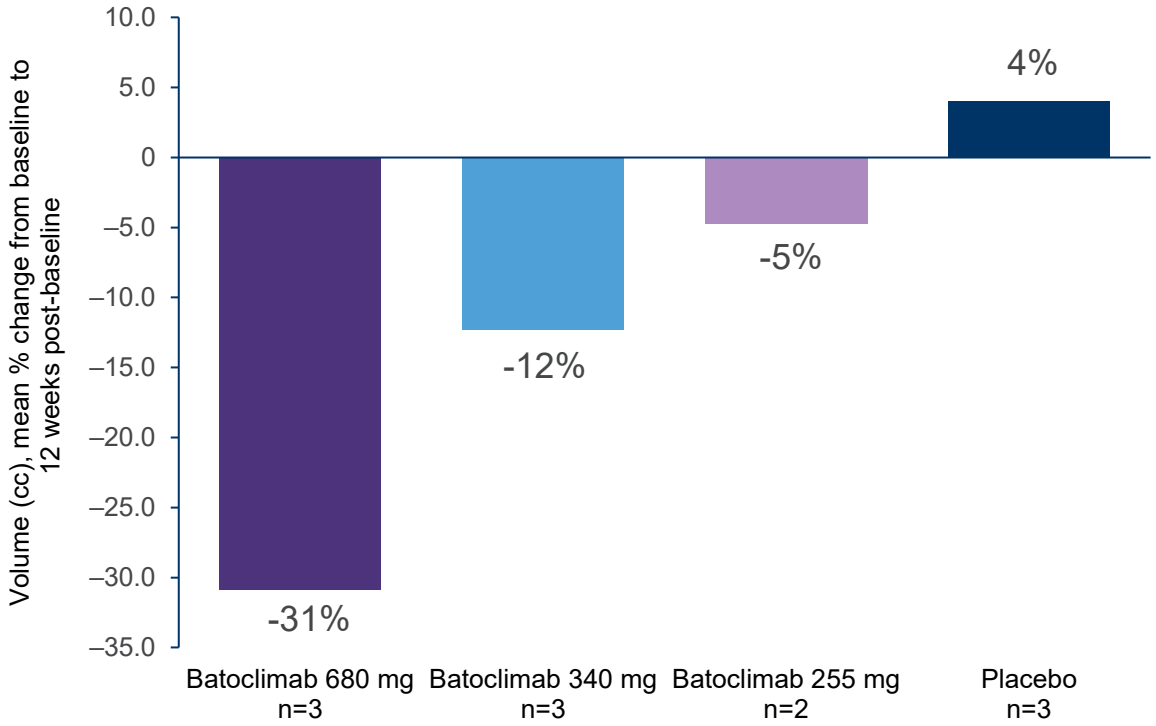
Post-hoc analysis of proptosis response at week 6[1]



Effect size similar at week 12 though confidence intervals wide

1 Proptosis response defined as proptosis reduction ≥2 mm in study eye, without ≥2 mm increase in non-study eye at same visit. Week 6 data selected as it represents the latest time point at which the largest amount of patient data is available prior to the voluntary pause

Total muscle volume at 12 weeks post-baseline in all subjects with baseline and end of treatment CT scans



CT: computed tomography.
Represents all patients who had a baseline and week 12 CT scan, a subset of all study participants.

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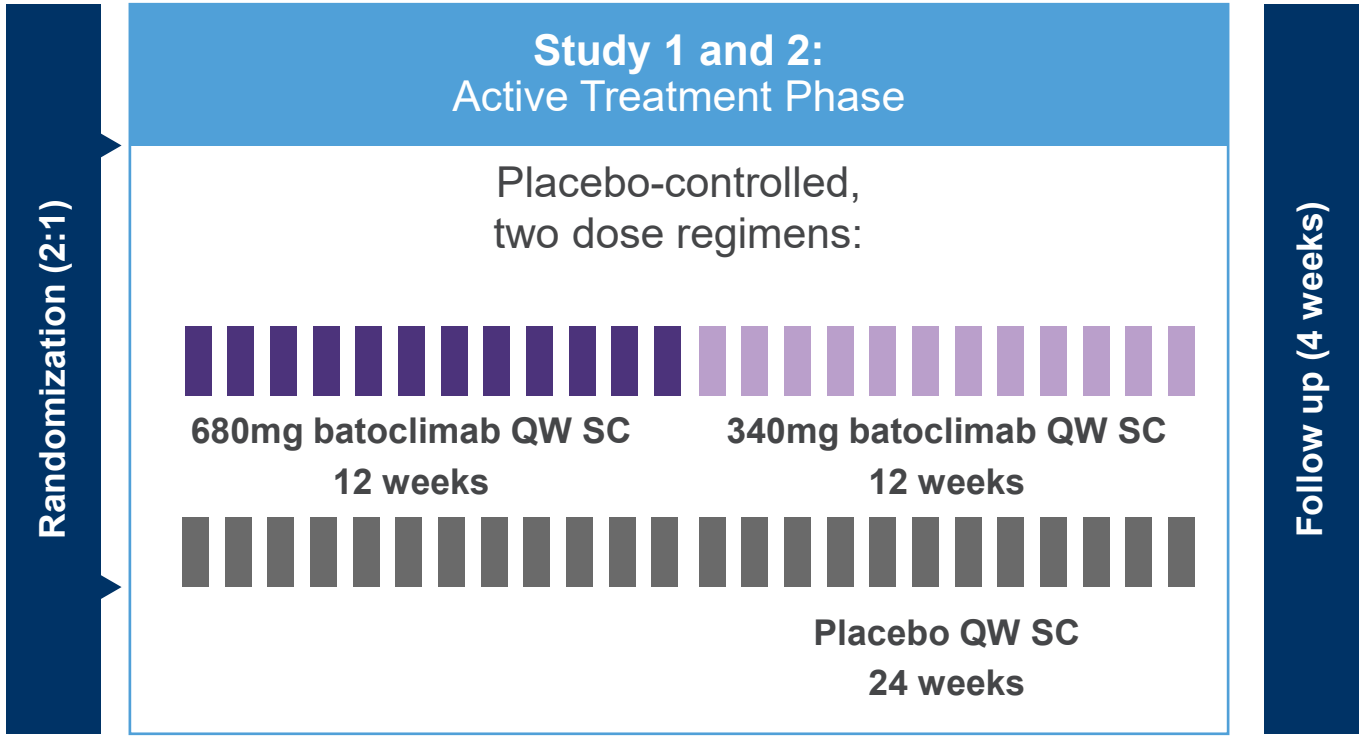
Source: Batoclimab Phase 2b TED trial data on file at Immunovant, Inc.
The efficacy of batoclimab and clinical outcomes were deemed inconclusive, in part, because the study was terminated early.

Two Phase 3 clinical trials of batoclimab in TED initiated

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

Inclusion

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



Primary endpoint:

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

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

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Note: subset of inclusion criteria for TED Phase 3 trial shown on slide

CAS = Clinical Activity Score, anti-TSHR-Ab = anti-TSHR antibody, QW = weekly; SC = subcutaneous injection.

Chronic Inflammatory Demyelinating Polyneuropathy

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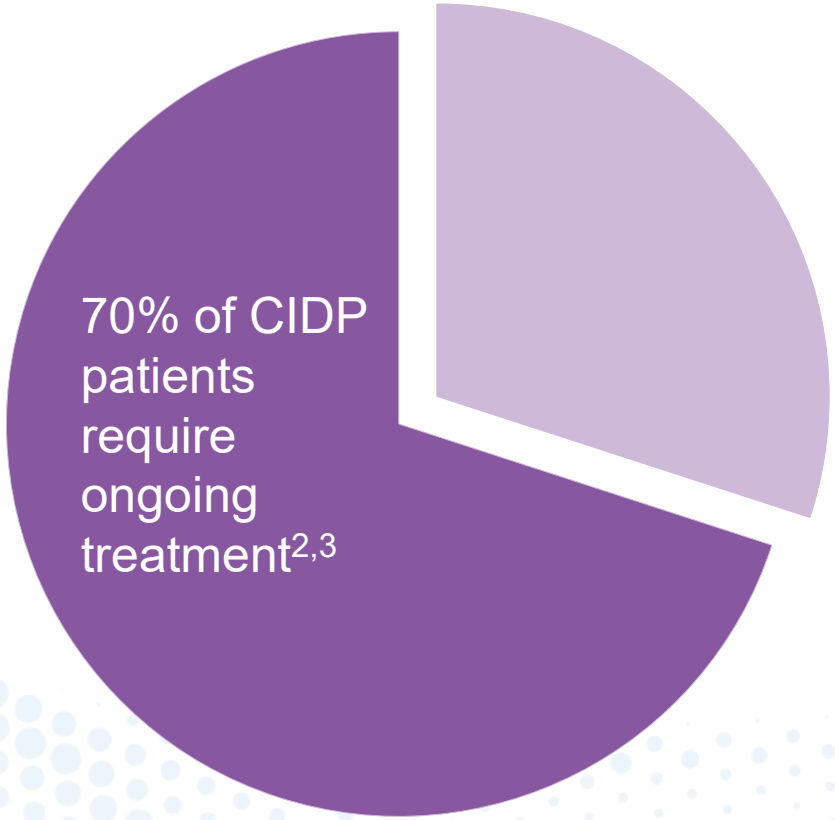
Chronic inflammatory demyelinating polyneuropathy (CIDP):

Important disease in neurology, exciting opportunity for anti-FcRn class

16,000 Total CIDP Patients in the US[1,2]



CIDP – Key Takeaways

- Current therapies (IVIg, plasma exchange, and steroids) are effective, but have significant side effects and logistical limitations (IVIg & plasma exchange).
- CIDP represents 22% of total IVIg market by volume
  - ~$3B in global annual sales for IVIg in CIDP[4]
- Target population – patients with active CIDP

Sources: 1. Broers M, et al (2019) Incidence and prevalence of CIDP: a systematic review and meta-analysis. Neuroepidemiology 52(3–4):161–172; 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. Kuitwaard K, Bos-Eyssen ME, Blomkwist-Markens PH et al (2009) Recurrences, vaccinations and long-term symptoms in GBS and CIDP. J Periph Nerv Syst 14(4):310–315. https://doi. org/10.1111/j.1529-8027.2009.00243.; 4. CSL Behring R&D Investor Briefting, 2021.

A differentiated approach to developing an anti-FcRn as a chronic treatment for CIDP

1

CIDP is an exciting indication that is ripe for disruption

- Given disease complexity, trial design is critical

2

Pivotal study optimized versus historical and current studies

- To improve probability of success and effect size, and include multiple doses for optimal differentiation

3

Potential best-in-class efficacy and simple subcutaneous administration

- Representing meaningful innovation for patients with this chronic disease

Key learnings from historical and ongoing CIDP trials applied to address challenges unique to CIDP

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

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

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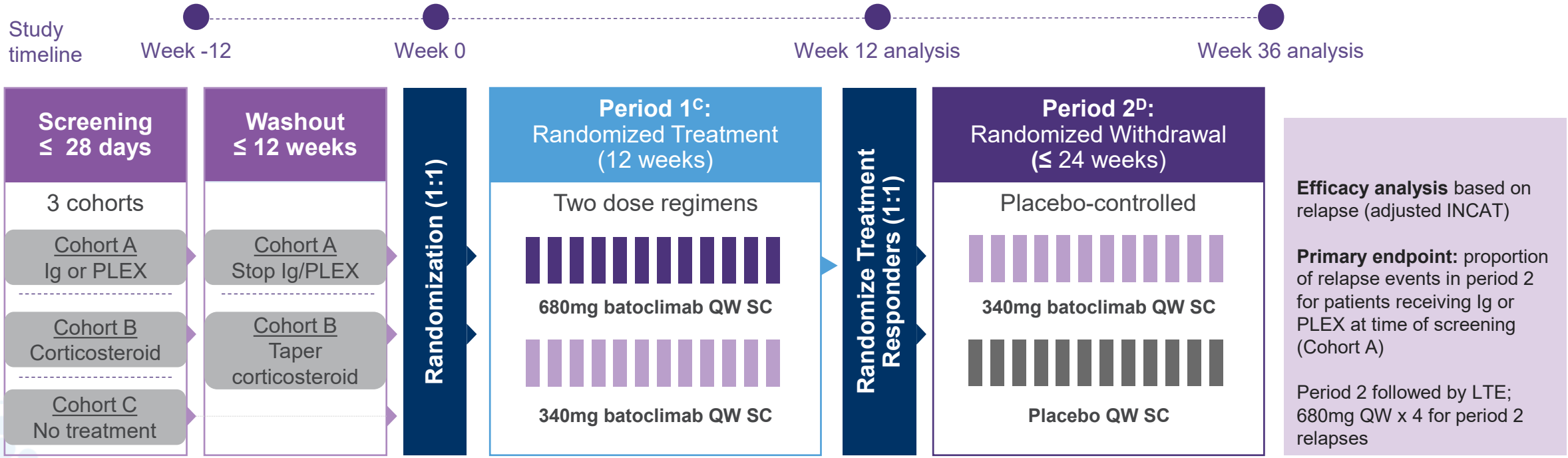
Notes: *Other anti-FcRn trials in CIDP include efgartigimod, nipocalimab, and rozanolixizumab. **clinical trial designs for efgartigimod in CIDP and nipocalimab in CIDP include double enrichment in trial design. Rozanolixizumab ph2 trial in CIDP did not include double enrichment.

Pivotal Phase 2b trial intended to develop potentially best-in-class chronic anti-FcRn therapy in CIDP



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

Cohorts A (n=100): Randomize participants who worsen
Cohort B: Same as A
Cohort C: Randomize all

Period 1 data expected in the first half of 2024

Primary analysis only on Cohort A (IG/PLEX)

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

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Batoclimab and IMVT-1402 provide strategic options in CIDP

Open-label period from batoclimab Phase 2b trial in CIDP to potentially inform IgG reduction and clinical efficacy

+

Phase 1 trial of IMVT-1402 to inform dosage and dosing schedule for IMVT-1402 in future trials

Learnings from both trials combined to determine which asset(s) to develop in CIDP

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Graves’ Disease

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Graves' disease (GD):

Systemic disease that impacts multiple organ systems leaving many patients with substantial symptoms

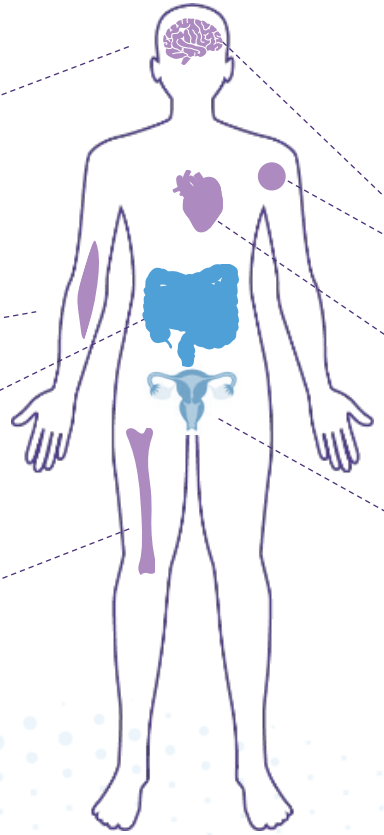
Graves' disease incidence 116K / year [3,4]

Irritability (80%), **anxiety** (76%), **insomnia** (69%), **anger** (60%), **slowed thinking** (49%), **increased crying** (53%), **easily startled** (50%), **sadness** (46%), **decreased sociality** (46%), **hopelessness** (44%), **decreased sexual desire** (43%)[2]

Muscle weakness

Weight loss despite increased appetite (65%)

Brittle bones



Whole body[1]: feeling hot (74%), **fatigue** (69%), **hot or cold flashes** (53%), **sensation of shakiness** (61%), **shortness of breath** (55%), **inability to perform tasks of daily life** (46%)

Change hair or skin texture (60%)

Heart palpitations
Chest pain (39%)

Changes in menstrual cycle/impotence (35%)

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1. Stern RA, et al. J Neuropsychiatry Clin Neurosci. 1996 Spring;8(2):181-5. 2. Arruda et al A survey study of neuropsychiatric complaints in patients with Graves' disease: A reassessment of self-reported symptoms and current practice 20 years later: Graves' Disease and Thyroid Foundation, 2019; 3. Zimmermann MB, Boelaert K. Iodine deficiency and thyroid disorders. Lancet Diabetes Endocrinol. 2015 Apr;3(4):286-95. 4. Furszyfer J, et al. Graves' disease in Olmsted County, Minnesota, 1935 through 1967. Mayo Clin Proc. 1970 Sep;45(9):636-44.]

Current standards-of-care for GD have well-documented, potentially serious safety and tolerability concerns

	Safety			Tolerability		
SoC Treatments	Risk of liver damage	Risk of secondary cancers	Risk of low blood cell counts	Invasive	Rash/Itching	Hypothyroidism risk and fatigue
Anti-Thyroid Medicines	✓	X	✓	X	✓	✓
Radioiodine	X	✓	X	X	X	✓
Surgery	X	X	X	✓*	X	✓

*Surgical risks include laryngeal nerve damage, hypoparathyroidism and bleeding

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Source: Okosieme et al. “Should radioiodine now be first line treatment for Graves’’ disease?” Thyroid Research (2020)

Large population of underserved patients with GD

Total addressable incidence population of 41K – 53K per year (U.S.) beyond anti-thyroid drug (ATD)

Target population

Moderate-severe symptoms not controlled with ATD
(29K–38K)

1/4 to 1/3 of the 116K[1,2] US incident Graves' patients are difficult to control with ATD and remain symptomatic

Persistent need for ATD and wish to avoid thyroid ablation
(12K–15K)

1/4 to 1/3 of 46K[3] patients undergoing ablative procedure (radioactive iodine or surgery) may wish to avoid potential long-term risks
(e.g., increased cancer, complications of thyroidectomy)

1. Zimmermann MB, Boelaert K. Iodine deficiency and thyroid disorders. Lancet Diabetes Endocrinol. 2015 Apr;3(4):286-95. 2. Furszyfer J, et al. Graves' disease in Olmsted County, Minnesota, 1935 through 1967. Mayo Clin Proc. 1970 Sep;45(9):636-44; 3. Brito JP, et al. Antithyroid Drugs-The Most Common Treatment for Graves' Disease in the United States: A Nationwide Population-Based Study. Thyroid. 2016 Aug;26(8):1144-5. doi: 10.1089/thy.2016.0222. Epub 2016 Jul 5. PMID: 27267495.

GD represents potential first-in-class opportunity for anti-FcRns and meaningful expansion in endocrinology

1

Graves' disease represents first-in-class opportunity for anti-FcRns in an indication with substantial need beyond 1L therapy with ATD

2

Poor QOL in Graves' disease patients who do not respond to ATD is primarily related to hyperthyroidism that is directly linked to auto-antibodies

3

Potent FcRn inhibition has the potential to lower stimulating anti-TSHR antibodies and may thereby improve hyperthyroidism in ATD insufficient responders

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Source: KOL Interviews: Data on file at Immunovant.

1L = First Line; ATD = Anti-thyroid Drug; QOL = Quality of Life, TSHR = Thyroid stimulating hormone receptor

The first and only anti-FcRn program targeting GD[1,2]

Inclusion[A]

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

Screening (4 weeks)

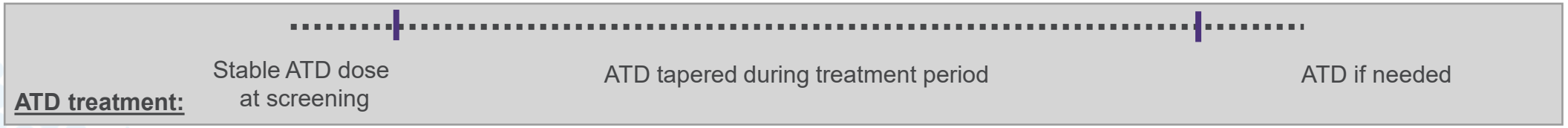
Treatment Period: (24 weeks)
N = up to 40

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



A: Additional inclusion and exclusion criteria not listed on slide
GD = Graves' Disease; ATD = anti-thyroid medications; QW = weekly; SC = subcutaneous.

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1. Based on clinicaltrial.gov database, last accessed on 8/9/2023. 2. Lane LC, et al. Endocr Rev. 2020 Dec 1;41(6):873–84.

A potential targeted therapy for GD

Large unmet need in Graves' disease

Our Phase 2 trial will enroll patients who have elevated thyroid hormone levels despite treatment with ATDs

High scientific rationale and encouraging initial data*

Graves' disease is a classic autoantibody condition and interesting anecdotal data from TED 2b trial

Phase 2 significantly de-risking for development program in Graves' disease

Phase 2 trial designed to further define dose-response and time course to inform potential Phase 3; patient population and trial endpoints likely the same

Initial Phase 2 data expected in the fourth quarter of 2023

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* From TED P2b study, observed reduction in anti-TSHR antibodies and post-hoc, anecdotal observations of patients whose anti-thyroid medication dose was reduced.

IMVT-1402

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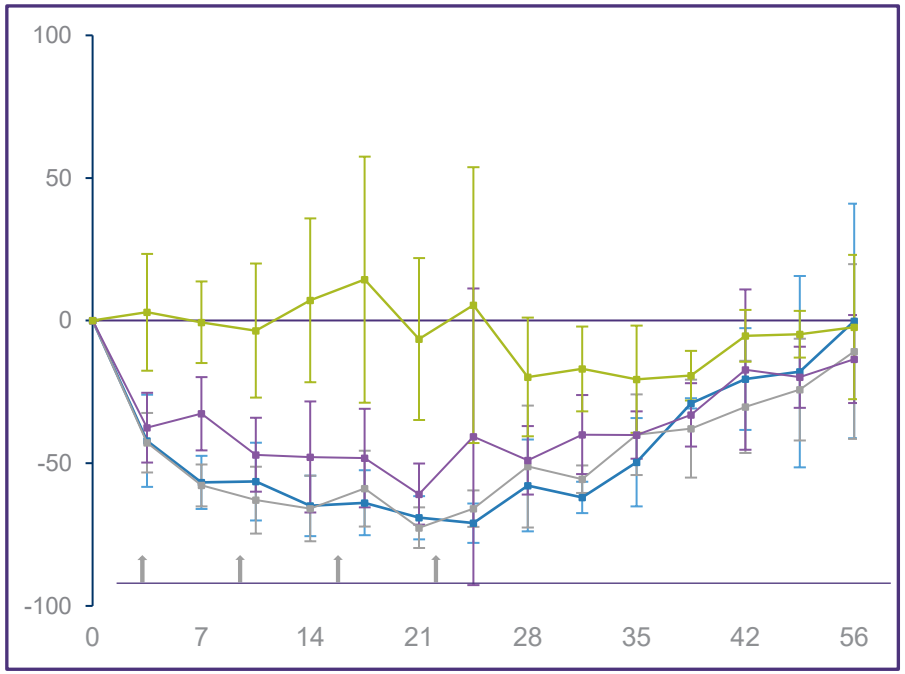
IMVT-1402 demonstrated similarly rapid and deep IgG reduction as batoclimab in a head-to-head monkey study

IgG concentration (mg/mL), mean percent change from baseline ± SD



- Batoclimab 50 mg/kg (n=3)
- IMVT-1402 50 mg/kg (n=7)
- IMVT-1402 5 mg/kg (n=7)
- Placebo (n=3)
- ⬆ Dose administration

- 20 monkeys, dosed IV in head-to-head study across four groups
- At comparable doses, IgG lowering is similar for both batoclimab and IMVT-1402
- Cynomolgus monkeys observed to be reliable pharmacodynamic proxy for anti-FcRn mediated impacts on IgG[1,2]

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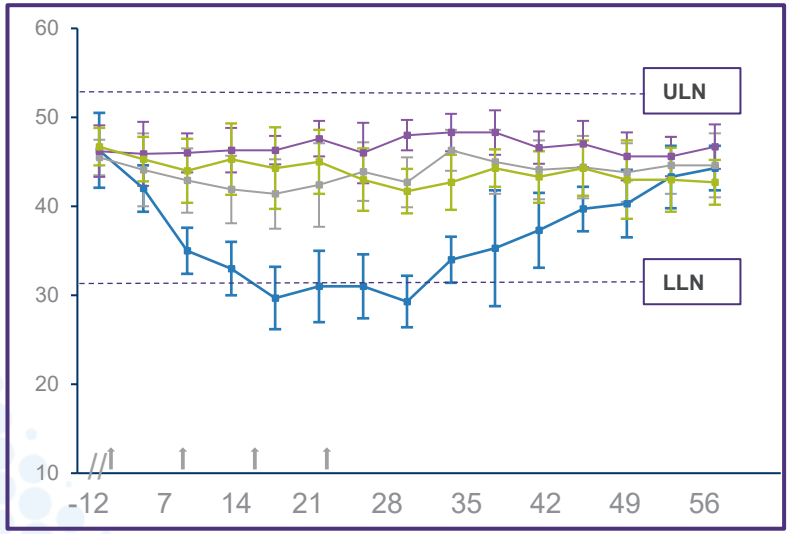
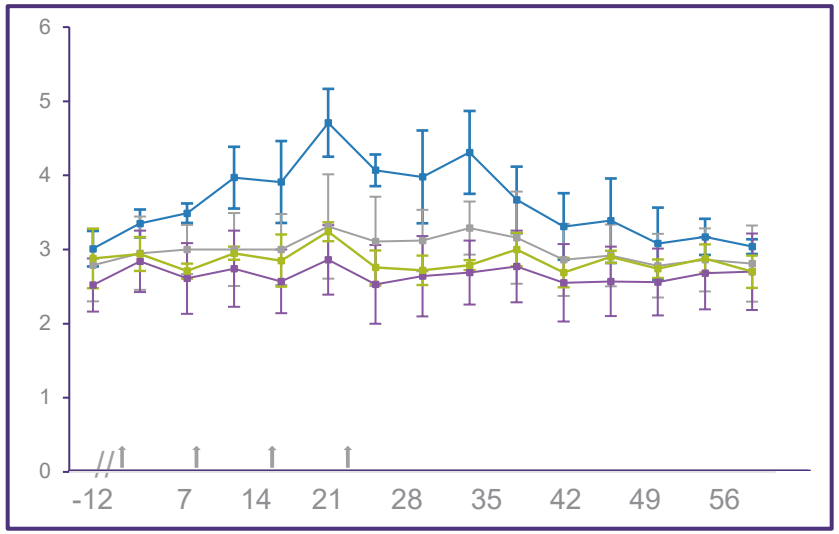
1. Source: Lledo-Garcia, et al, Pharmacokinetic-pharmacodynamic modelling of the anti-FcRn monoclonal antibody rozanolixizumab: Translation from preclinical stages to the clinic, UCB Pharma, 2022.
2. Data on file at Immunovant

IMVT-1402 and placebo produced similar albumin and LDL effects in a head-to-head monkey study

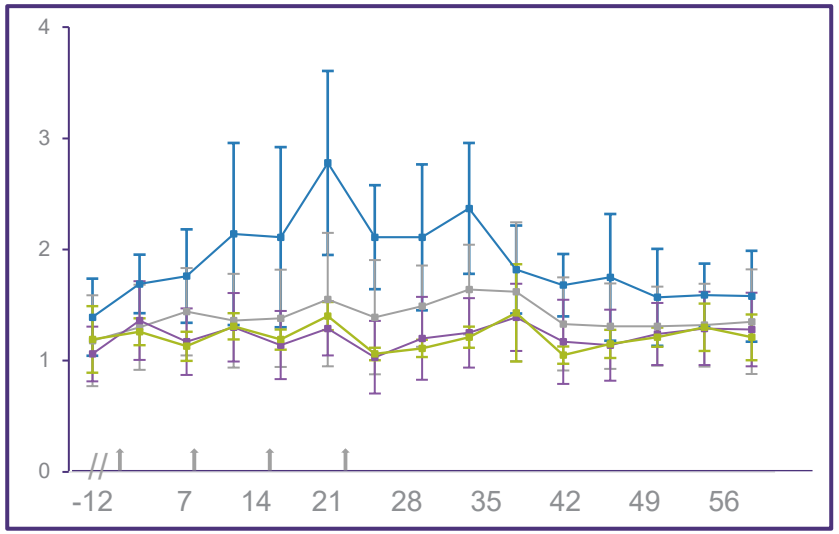
Albumin concentration (g/L), mean ± SD



Cholesterol concentration (mmol/L), mean ± SD



LDL concentration (mmol/L), mean ± SD

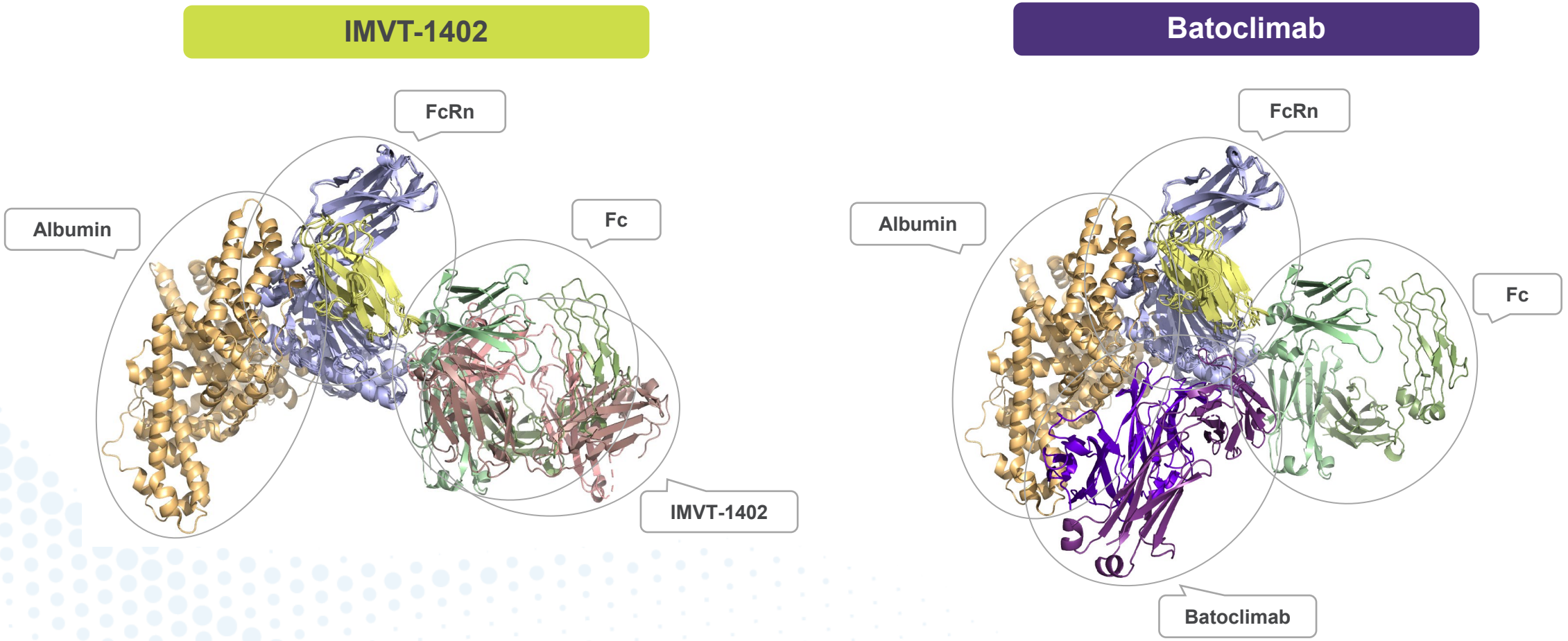


- Batoclimab 50 mg/kg (n=3)
- IMVT-1402 50 mg/kg (n=7)
- IMVT-1402 5 mg/kg (n=7)
- Placebo (n=3)

SD, standard deviation; ULN, upper limit of normal; LLN, lower limit of normal; Arrows indicate time of dosing.
Data on file at Immunovant

Co-crystal structures consistent with non-human primate data

IMVT-1402 orients differently from batoclimab when bound to FcRn



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

IMVT-1402 Phase 1 clinical trial objectives

1

Expeditiously evaluate safety, pharmacokinetic & pharmacodynamic profile

2

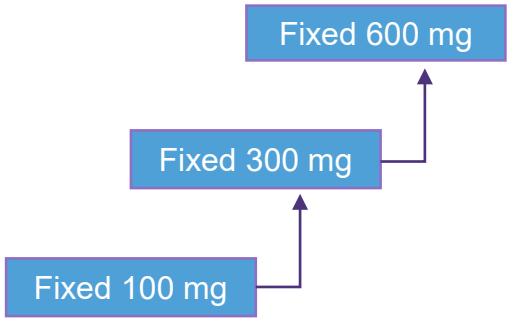
Validate the IMVT-1402 dose that achieves FcRn saturation

3

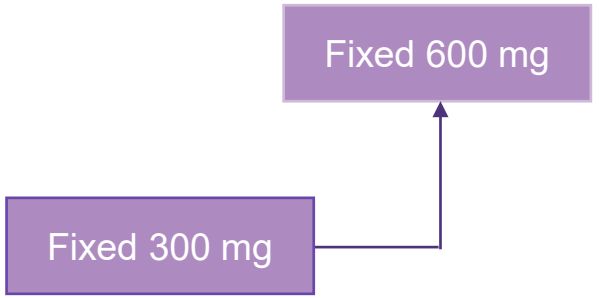
Confirm doses for future studies

IMVT-1402 Phase 1 clinical trial design*

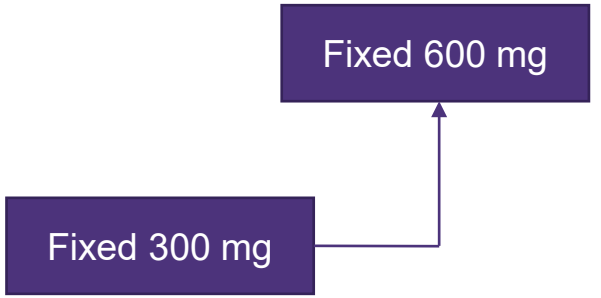
Single-Ascending Intravenous Dose



Single-Ascending Subcutaneous Dose



Multiple-Ascending Subcutaneous Dose



Single Ascending Dose

- 6 IMVT-1402 + 2 placebo participants per dose cohort

Multiple Ascending Dose

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

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

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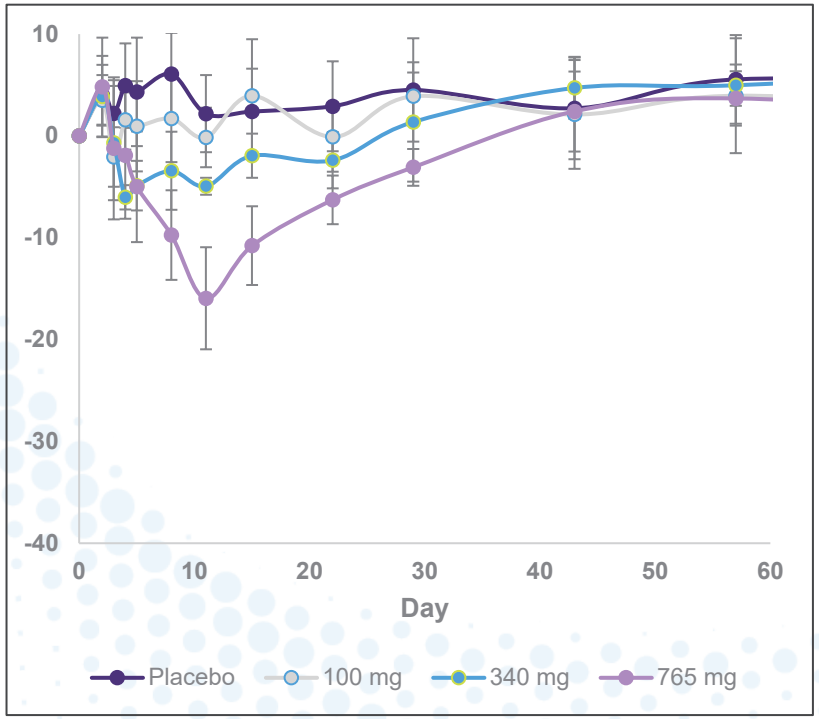
* Additional / optional cohorts may include 1,200 mg IV SAD, 150 mg SC MAD and 450 mg SC MAD. The first MAD cohort will be initiated after review of PK and safety data from SAD cohorts at the same or higher dose levels, with the final dose selection for the first MAD cohort dependent on this PK review.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

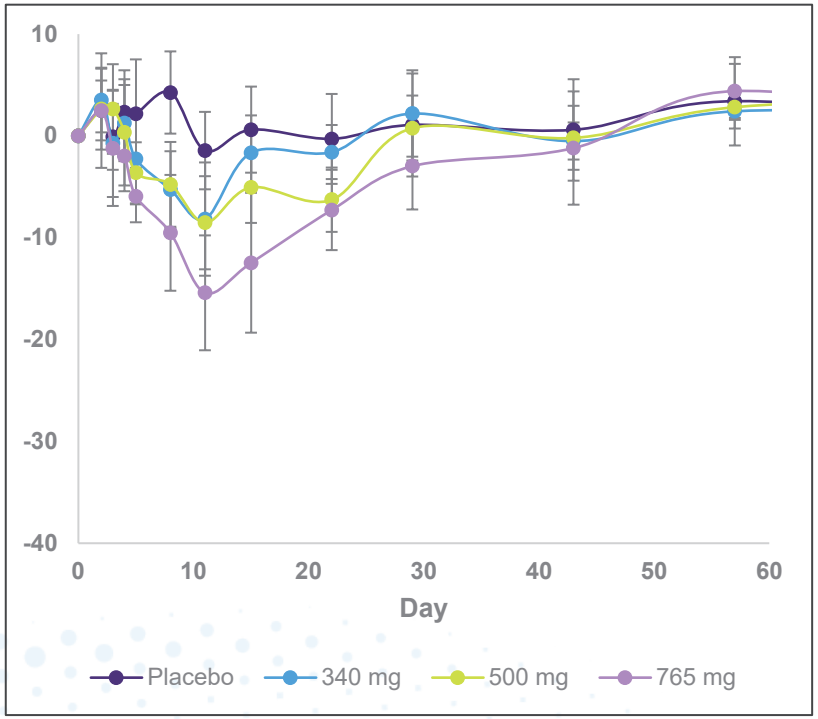
Batoclimab Phase 1 trial suggests SAD data may be predictive of MAD data

Albumin % change from baseline following batoclimab dosing*

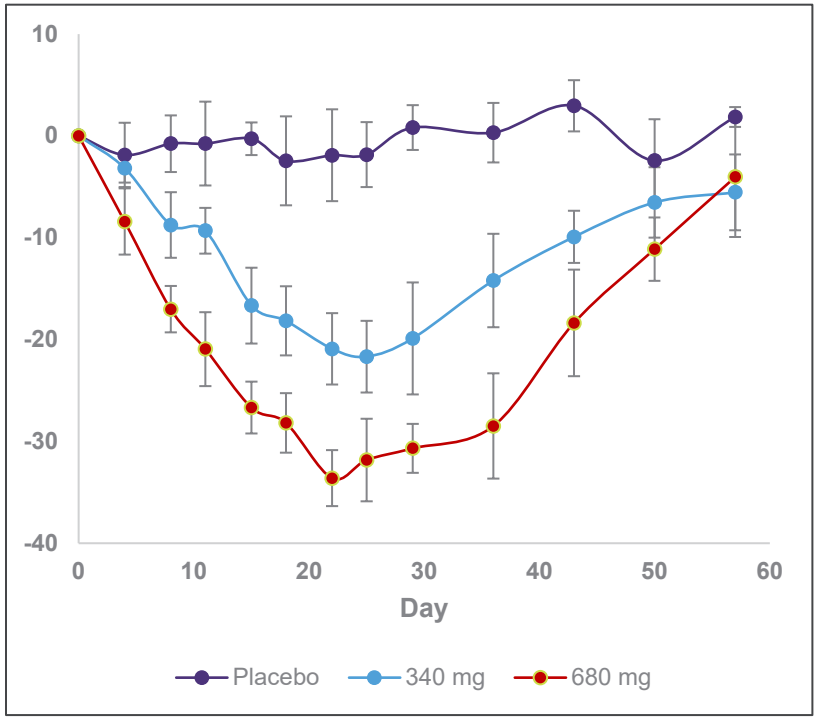
Single-ascending IV dose



Single-ascending SC dose



Multiple-ascending SC dose



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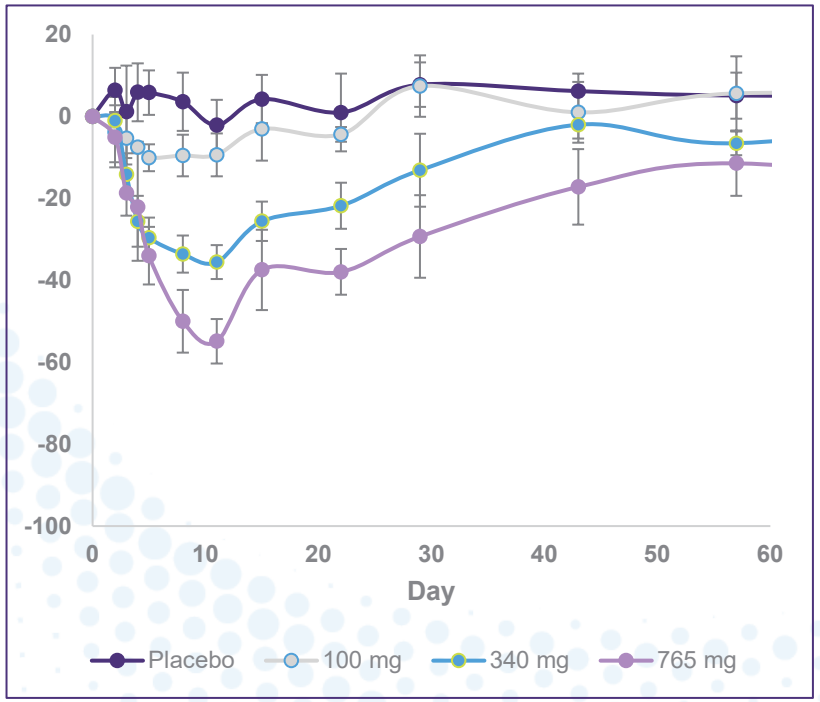
* Data on file

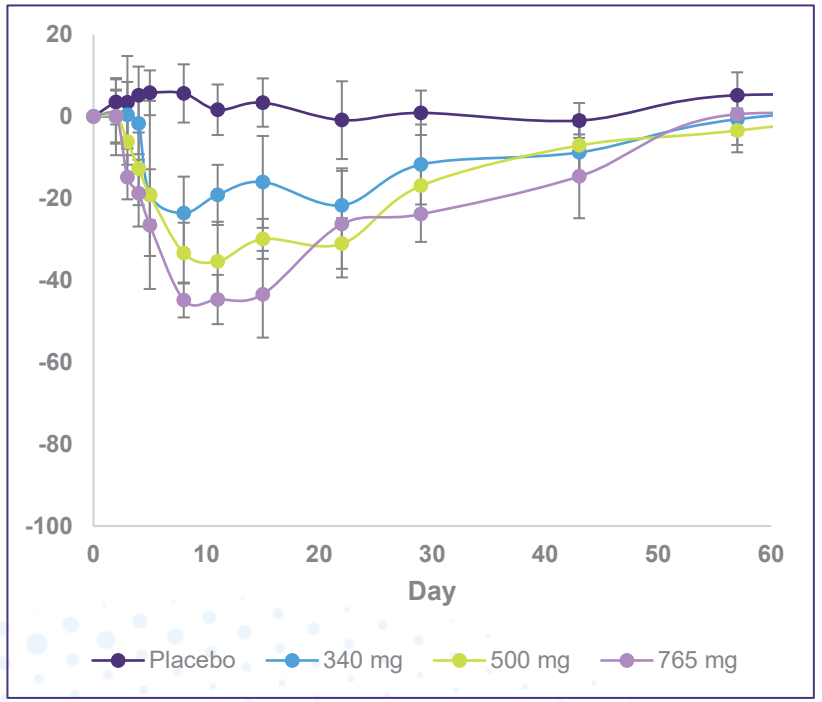
Batoclimab Phase 1 trial suggests SAD data may be predictive of MAD data

Total IgG % change from baseline following batoclimab dosing*

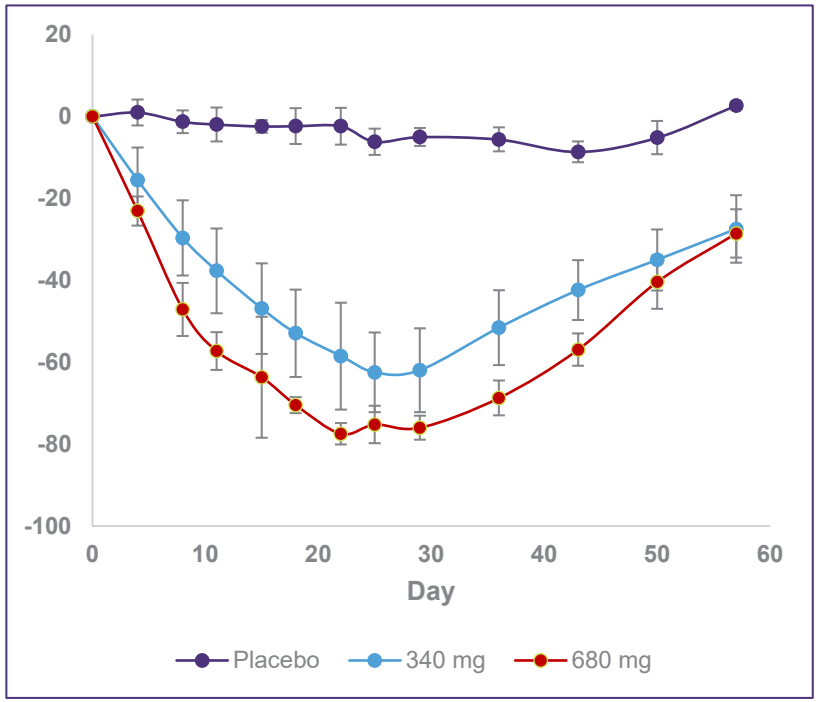
Single-ascending IV dose



Single-ascending SC dose



Multiple-ascending SC dose



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* Data on file

Building a Leading Anti-FcRn Franchise

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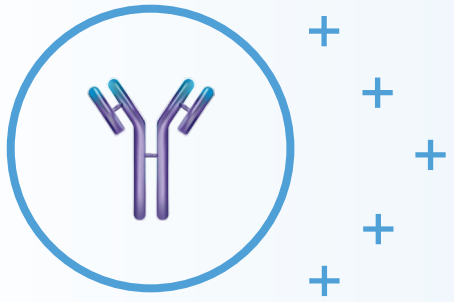
Differentiated assets to address a range of patient needs are the goals of our development

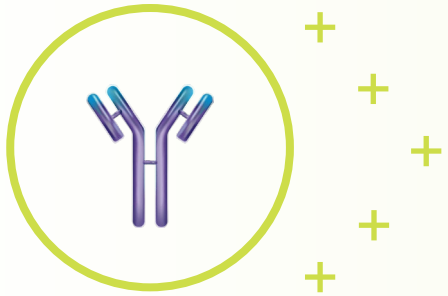
Batoclimab



Tailored dosing to address varying symptom severity across indications and stage of disease

- Short term maximal IgG suppression
- Lower chronic doses where less IgG suppression needed
- Fixed duration dosing in certain conditions

IMVT-1402



Tailored and chronic dosing to address symptom severity and duration for extended periods of time (>12 weeks)[1]

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

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1. Potential outcomes if Phase 1 results are as predicted by pre-clinical studies in cynomolgus monkeys

Potential synergy in clinical development

Learnings from batoclimab potentially leverageable to accelerate IMVT-1402 development

Batoclimab Phase 2 trial in Graves' disease to potentially inform future pivotal trial design and effect size

+

Phase 1 trial of IMVT-1402 to inform dosage and dosing schedule for IMVT-1402 in future trials

Learnings from both trials combined to potentially accelerate IMVT-1402 to pivotal trial in Graves' disease

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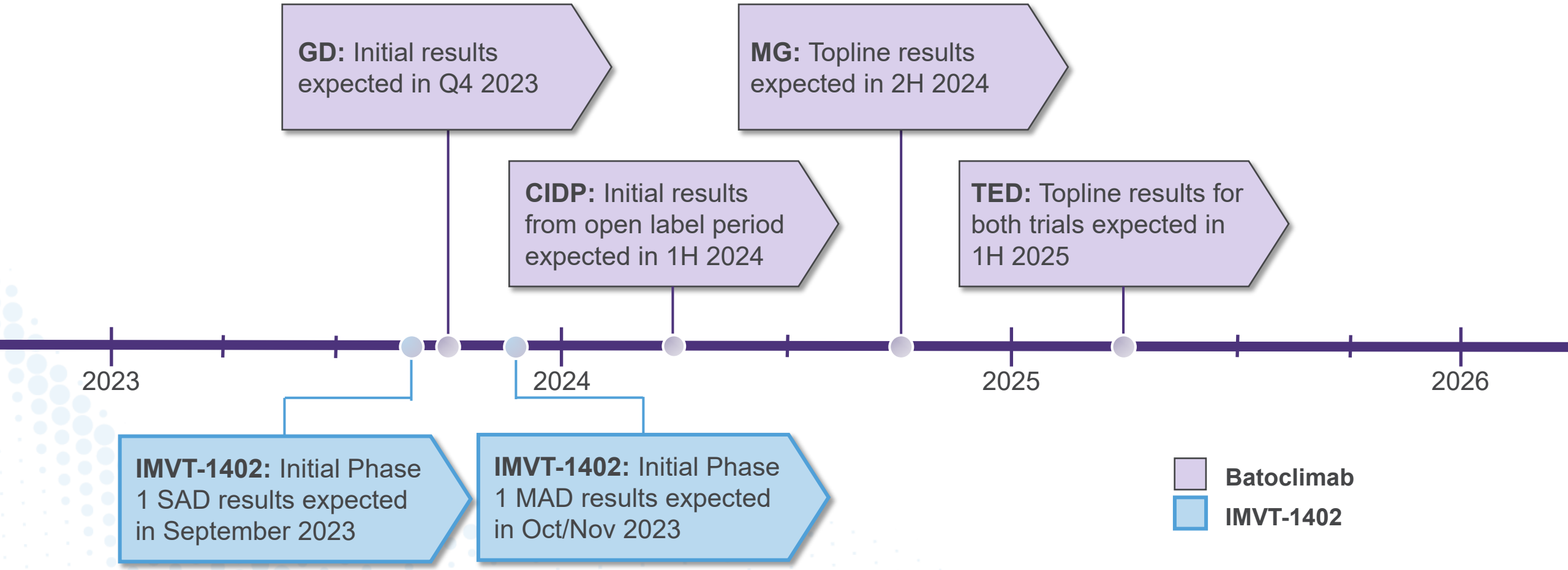
Expected Cadence of Key Catalysts Every 6 Months for Potential Sustained Value Creation



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Trailblazers in anti-FcRn technology: uniquely positioned to meet the complex, variable needs of patients with autoimmune disease

Potentially first to develop subcutaneous anti-FcRn that can be self-administered in seconds

Complementary anti-FcRns potentially enable accelerated development pathways

Cultivating broad network of experts to optimize multi-indication development plans

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Appendix

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Anti-FcRn inhibitors have unique characteristics

		Batoclimab (IMVT-1401)[1]	IMVT-1402[1]	Efgartigimod[2]	Nipocalimab (M281)[3]	Rozanolixizumab (UCB7665)[4]	ALXN1830/ SYNT001[5]
Company		Immunovant	Immunovant	Argenx	Janssen	UCB	Alexion/ AstraZeneca
Structure		Human IgG1	Human IgG1	Human IgG1 frag, Fc mutations	Human IgG1	Humanized IgG4	Humanized IgG4
Fc Effector Potential		No	No	No	No	Low	Low
FcRN-IgG Binding- pH 7.4	Affinity (KD)	3.2 nM +++	0.28 nM +++	320 nM +	0.029 nM ++++	0.023 nM ++++	0.87 nM +++
FcRN-IgG Binding- pH 6.0	Affinity (KD)	1.4 nM +++	0.35 nM +++	14.2 nM ++	0.044 nM ++++	0.034 nM ++++	1.19 nM +++
Human Half-life		10-38 hours	Ph1 study planned for 2023	85-104 hours for 2-50 mg/kg	7.82-33.7 hours		0.636-7.779 hours

No clinical head-to-head comparisons of Immunovant product candidates and third party anti-FcRn assets has been conducted.
Binding affinities are determined by surface plasmon resonance.
Sources: 1. On file at Immunovant; 2. Ulrichts 2018; 3.Ling, 2019 (ASH 2015 poster); 4.Smith, 2018; Kiessling, 2017; 5. Blumberg, 2017 (ASH 2017 poster)

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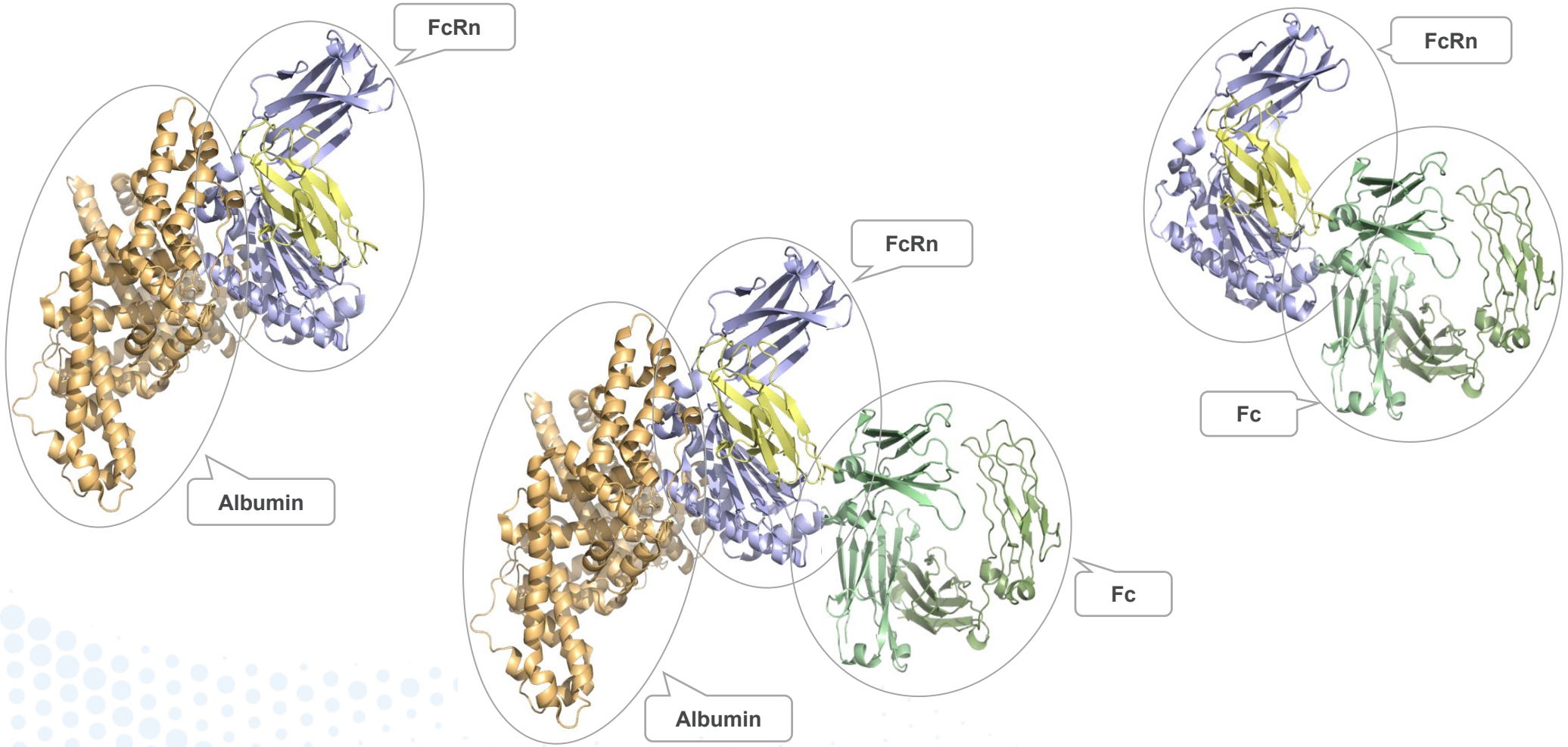
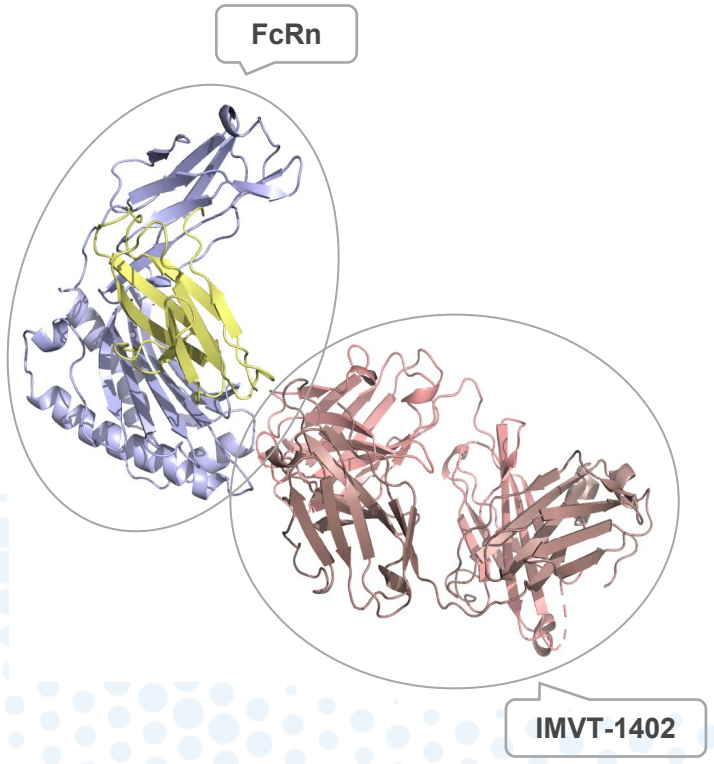
Fc portion of endogenous IgG (Fc) and albumin have different binding sites on FcRn



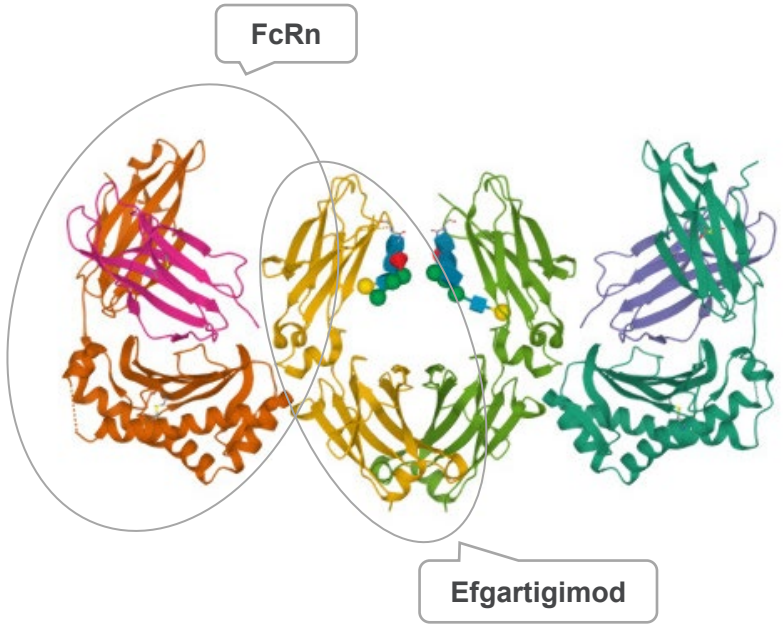
Note: Ribbon representations generated from X-Ray co-crystal structure

Co-crystal structures for FcRn complexes of IMVT-1402, efgartigimod and SYNT001

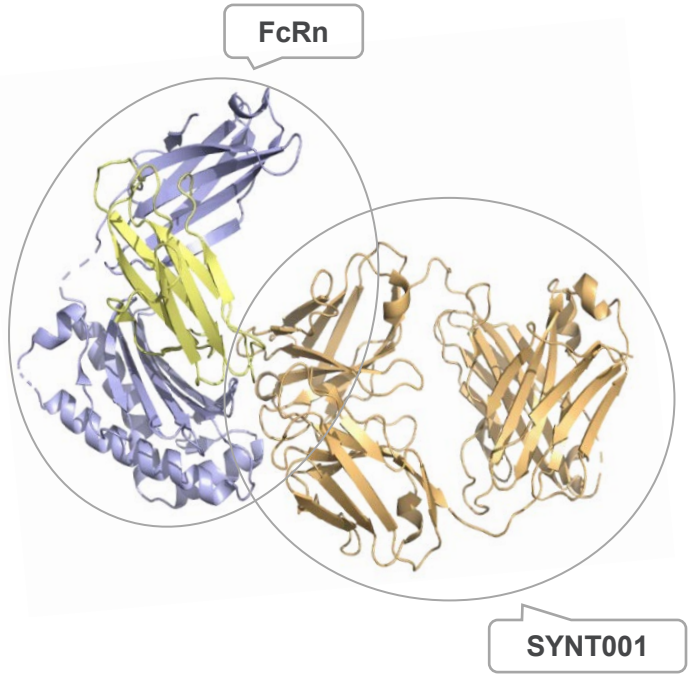
IMVT-1402



Efgartigimod*



SYNT001**



*https://www.rcsb.org/structure/7Q15; **Blumberg et al., Sci. Adv. 2019 Dec 18;5(12):eaax9586
Note: Ribbon representations generated from X-Ray co-crystal structure.
Orientation of FcRn is shown a bit differently (based on publicly available data) for efgartigimod vs 1402 and SYNT001.

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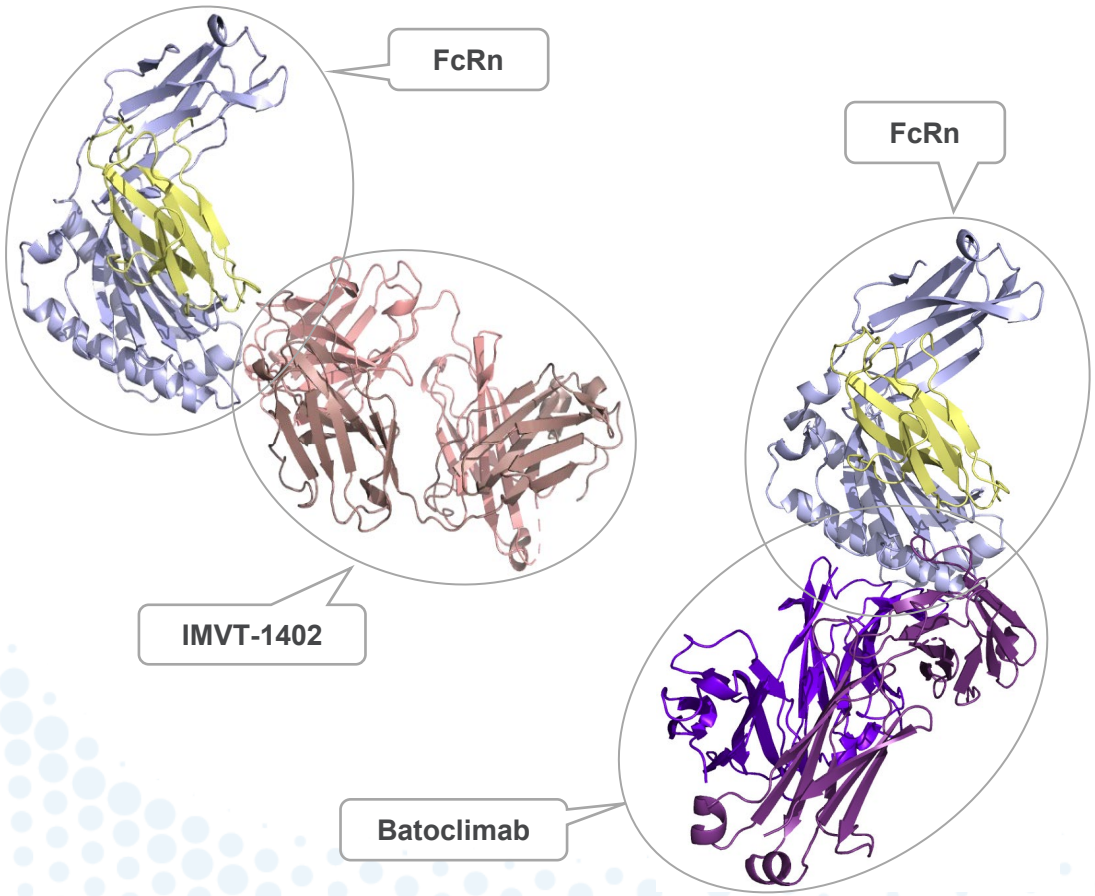
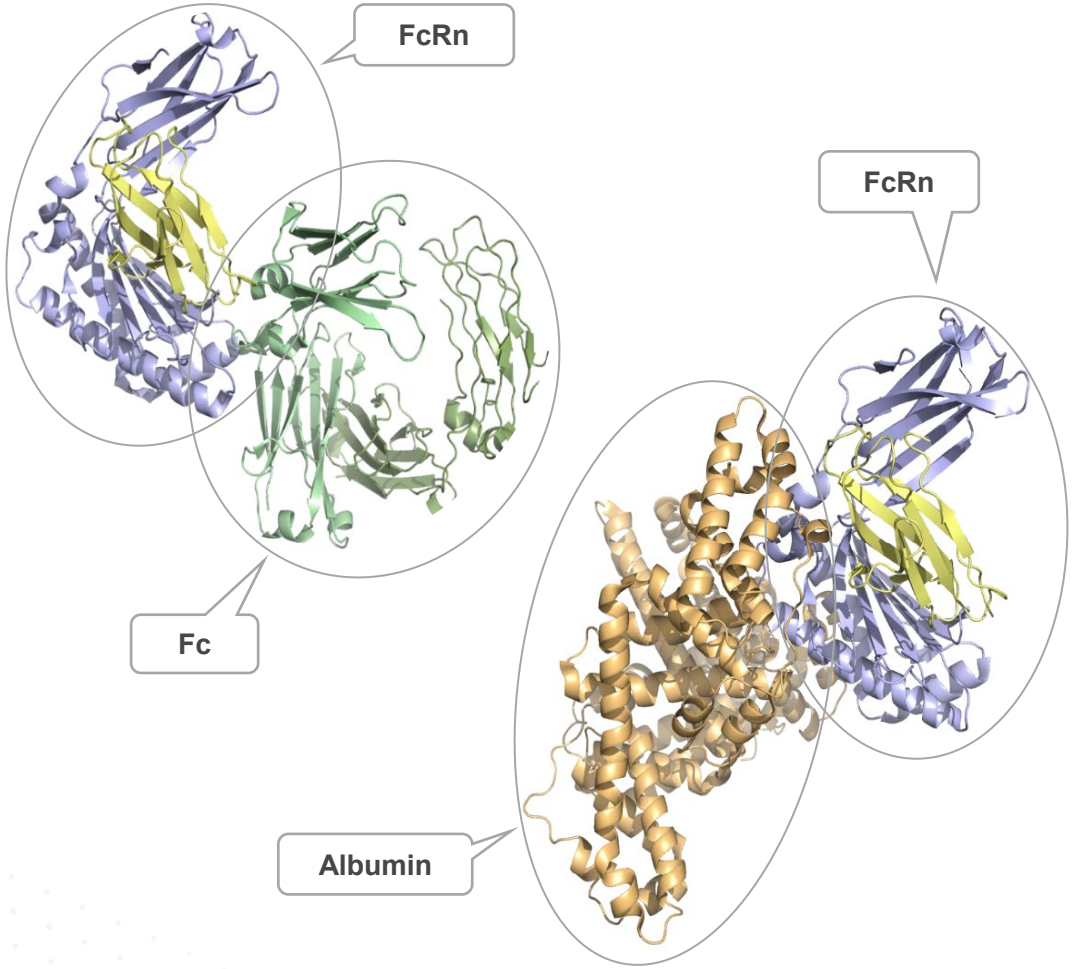
Co-crystallization shows IMVT-1402-FcRn complex orients differently from batoclimab-FcRn complex





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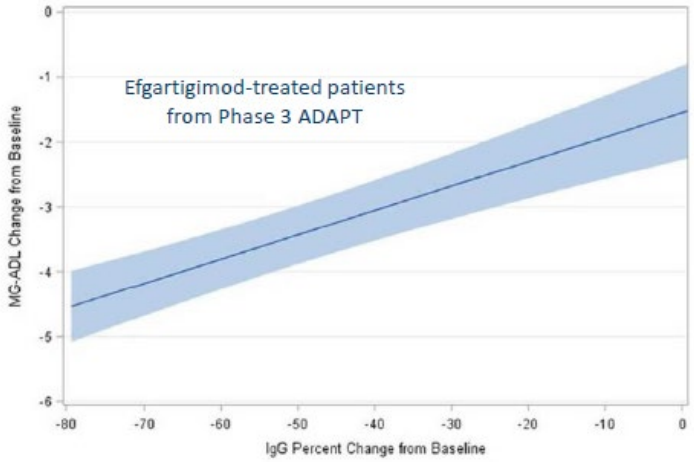
Note: Ribbon representations generated from X-Ray co-crystal structure. Batoclimab solved at 2.4Å resolution. IMVT-1402 solved at 2.6Å resolution.

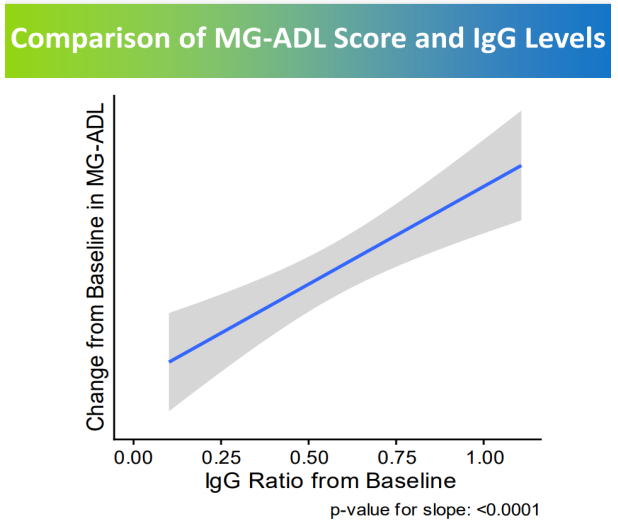
Strong correlation between deep IgG reduction and increased clinical efficacy in MG across anti-FcRn assets

The ADAPT Phase 3 trial of IV efgartigimod demonstrated that patients with deeper IgG reductions saw greater improvements in their disease activity (MG-ADL) compared to patients with lesser IgG suppression



Patient-level data from Efgartigimod (n=84) arm in P3 study

Nipocalimab Phase 2 trial in MG showed a correlation between IgG reductions and clinical activity



Note: No clinical head-to-head comparisons of Immunovant product candidates and third party anti-FcRn assets has been conducted.

In Batoclimab's (IMVT) Phase 2 trial in MG, we observed deeper IgG and AChR autoantibody reductions correlated with bigger MG-ADL changes

Data at week 7	Placebo (N=6)	Batoclimab 340 mg / week (N=5)	Batoclimab 680 mg / week (N=6)
% Change in total IgG from baseline	-3%	-59%	-76%
% Change in Anti-AChR-IgG from baseline	2%	-54%	-87%
% Change in MG-ADL from baseline	3%	-23%	-38%

While a small n, **deeper IgG and anti-AChR autoantibody reductions achieved greater % improvements in MG-ADL**

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Multiple other autoantibody-driven indications also suggest strong correlation between IgG reduction and clinical efficacy

Immunovant's Phase 2 trial in TED indicated that reduction in IgG led to greater restoration of normal levels of pathogenic Abs and greater proptosis response rates

	Placebo	Batoclimab 255 mg	Batoclimab 340 mg	Batoclimab 680 mg
Median Max % IgG Reduction Through Week 6*	3%	54%	63%	79%
% Subjects with Stimulatory anti-TSHR Antibody below 140 at Week 6	0%	0%	**12%**	**57%**
Proptosis Response Rate at week 6**	0%	11%	**29%**	**43%**

*Week 6 data selected as it represents the latest time point at which the largest amount of patient data is available prior to the voluntary pause. **Post-hoc analysis of proptosis response at week 6. Proptosis response defined as proptosis reduction ≥2 mm in study eye, without ≥2 mm increase in non-study eye at same visit.

In UCB's Phase 2 trial in ITP, higher doses and greater IgG reductions were associated with better platelet responses

Single Dose of Rozanolixizumab	Est. IgG Reduction	Mean platelet count (x10⁹/L)	% change platelet count (x10⁹/L)
Day 8			
4 mg/kg	27%*	27	53%
7 mg/kg	27%*	21	53%
10 mg/kg	47%*	41	122%
15 mg/kg	52%	108	409%
20 mg/kg	60%	145	706%

*IgG reduction at day 8 estimated by WebPlotDigitizer for 4mg/kg, 7mg/kg and 10mg/kg doses

In efgartigimod Phase 2 in Pemphigus Vulgaris (PV), more intensive dosing regimens led to deeper skin responses

	Cohort 1	Cohort 2	Cohort 3	Cohort 4
Dosing				
Dose	10mg/kg	10mg/kg	10mg/kg	25mg/kg
Induction Dose Regimen	QW, 4 weeks	QW, 4 weeks	QW, 4 weeks	QW, until EoC
Maintenance Dose Regimen	Week 2, Week 6	Q2W, 8 weeks	Q2W, 12 weeks	Q2W, up to 34 weeks
*IgG Reduction**				
Est. Max IgG Reduction (Day 28)	-56%	-69%	-62%	-67%
Est. IgG Reduction Day 120	11%	-33%	-52%	-54%
Efficacy†				
Complete Response	0%	0%	71%	60%
Relapse	50%	67%	43%	29%

Highest doses → highest sustained IgG reduction → higher CRs & lower relapse rates

Note: No clinical head-to-head comparisons of Immunovant product candidates and third party anti-FcRn assets has been conducted.

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Argenx phase 2 PV/PF publication, Br J Dermatol. 2022 Mar;186(3):429-439; * Estimated by WebPlotDigitizer
† End of Consolidation (EoC): the time at which no new lesions had developed for min. 2 weeks and ~80% of lesions had healed; Disease control (DC): no new lesions and established lesions starting to heal; Complete response (CR): no new lesions and established lesions completely healed; Relapse: Appearance of three or more new lesions per month that do not heal spontaneously in 1 week, or extension of established lesions, evaluated after DC

Consistent evidence across all programs and all indicators that greater IgG reduction leads to greater efficacy

	Company	Evidence of Greater IgG Reductions Translating to Clinical Benefit
MG	IMMUNOVANT	Greater IgG reductions across arms ➔ greater anti-AChR autoantibody reductions and greater MG-ADL improvements
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 higher proptosis response rates
PV	argenx	Greater sustained IgG reduction across arms ➔ higher complete response and lower relapse rates
ITP	ucb	Greater IgG reduction across arms ➔ greater platelet responses

Albumin impact in non-human primates translatable to humans

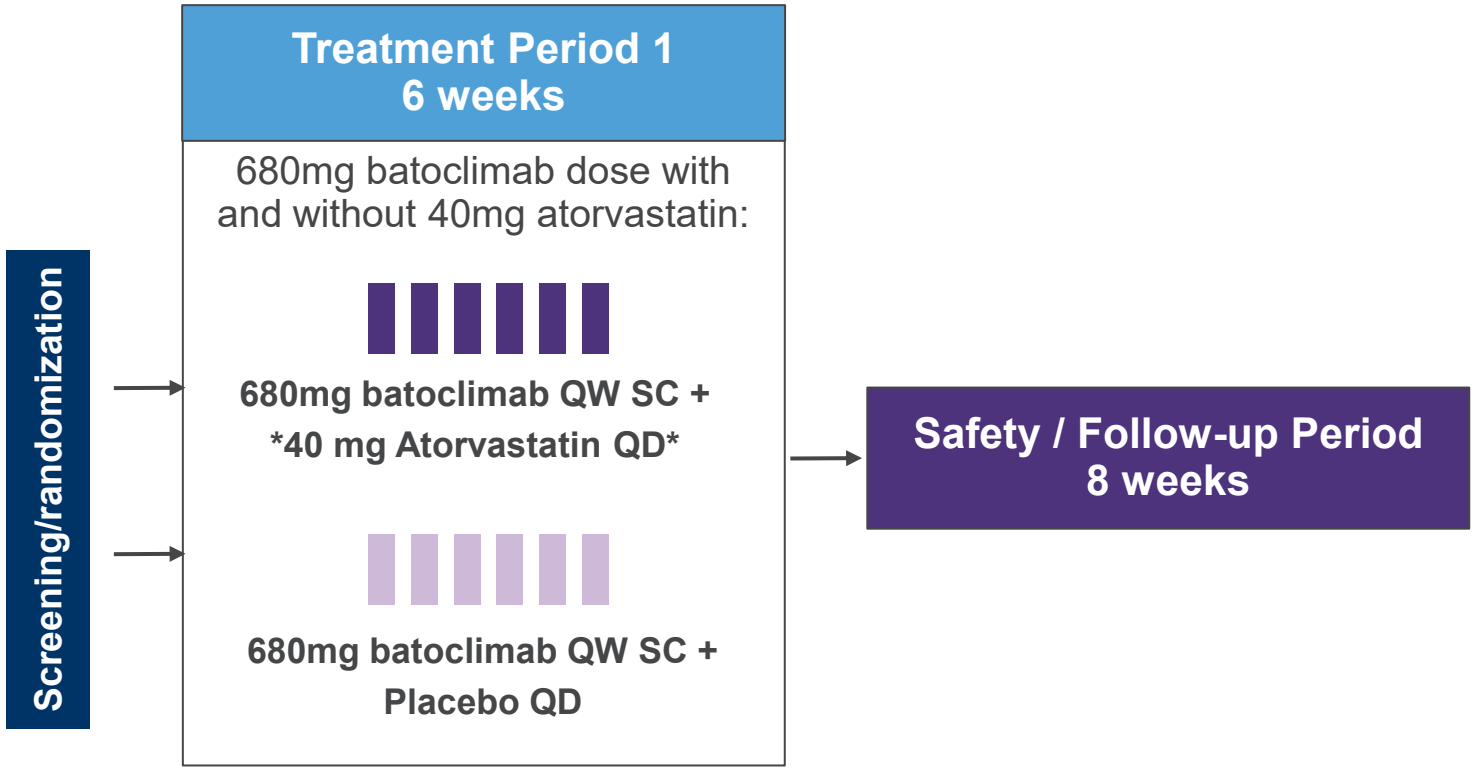
Translatability observed across multiple anti-FcRn inhibitors

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

1. Ulrichts P.J Clin Invest. 2018 Oct 1;128(10):4372-4386
2. Efgartigimod EMA assessment report - EMA/641081/2022
3. Efgartigimod FDA integrated review - 761195Orig1s000
4. Blumberg LJ. Sci Adv. 2019 Dec 18;5(12):eaax9586
5. Stifel research note – Momenta Pharmaceuticals, December 18, 2018
6. Ling L.E. Clin Pharmacol Ther. 2019 Apr;105(4):1031-1039.
7. Momenta Investor Presentation – June 15, 2020
8. Smith B, MAbs. 2018 Oct;10(7):1111-1130
9. Kiessling P. Sci Transl Med. 2017 Nov 1;9(414):eaan1208
10. SAD, single ascending dose; MAD, multiple ascending dose

Cholesterol elevations observed with batoclimab predictable, well-understood, and manageable

Healthy volunteer study initiated to measure LDL impact of concomitant statin therapy with batoclimab

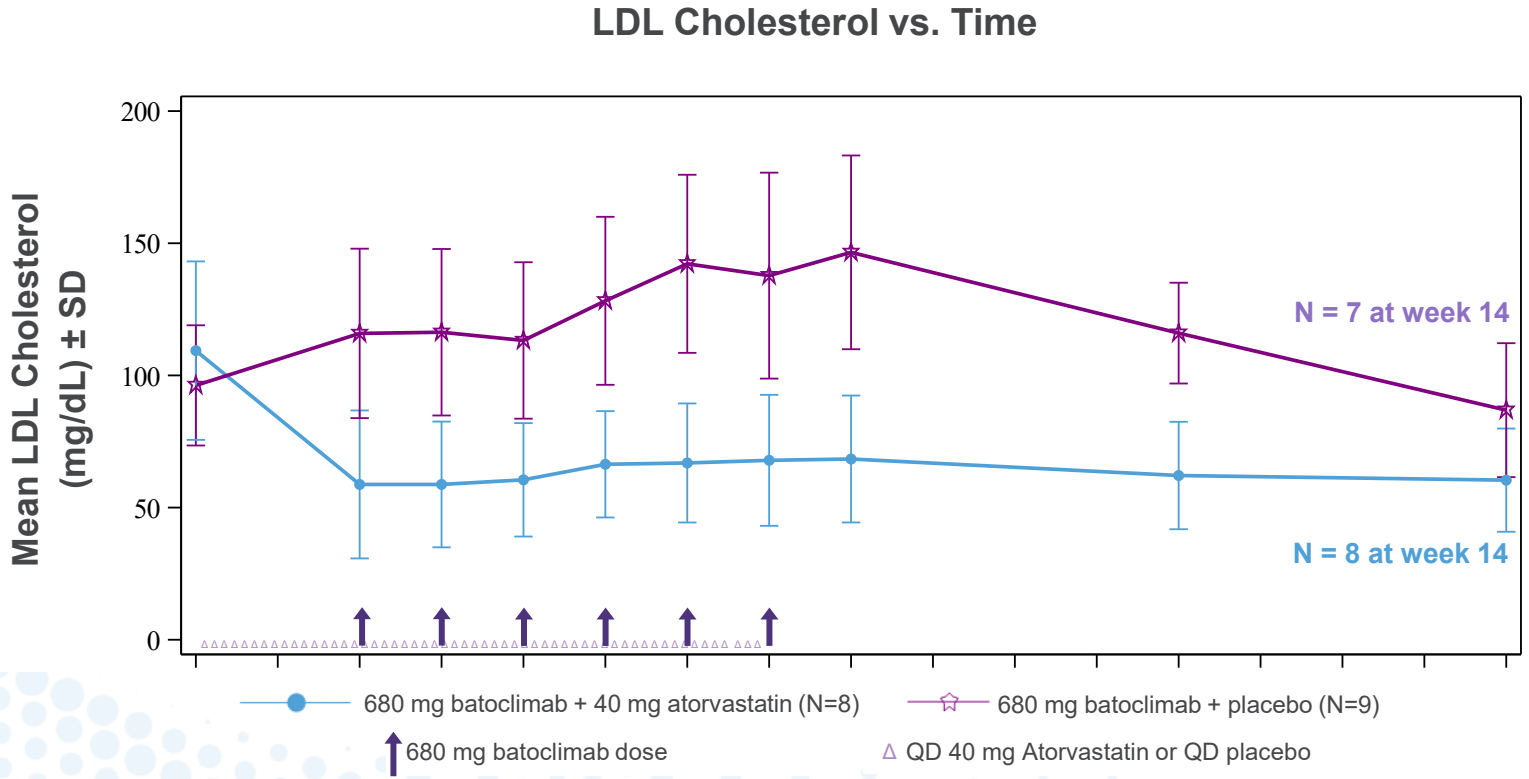


***40mg atorvastatin dosing initiated 14 days prior to initiation of 680mg batoclimab dosing**

QW = weekly; QD = daily, SC = subcutaneous injection

Healthy volunteer study shows robust LDL reduction with co-administration of batoclimab and atorvastatin

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



Distribution of Atorvastatin in US (2019)*

Strength	% of dispensed products
80 mg	13.8
40 mg	36.0
20 mg	29.1
10 mg	20.6
Other, unspecified, or misc.	0.5

*All doses in tablet/capsule form: Data source Medical Expenditure Panel Survey (MEPS) 2013-2019. Agency for Healthcare Research and Quality (AHRQ), Rockville, MD. ClinCalc DrugStats Database version 2021.10

Key takeaways on impact of batoclimab on LDL cholesterol

1

Mechanism is not unique to batoclimab

LDL changes correlated with on target changes in albumin

2

Cholesterol changes are reversible

Dose dependent changes in LDL returned to normal with cessation of dosing

3

Cholesterol changes expected to be manageable

Batoclimab dose titration and use of statins or other cholesterol-lowering therapies provide levers for maximizing benefit-risk

Thank you

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