Roivant Overview

February 2023

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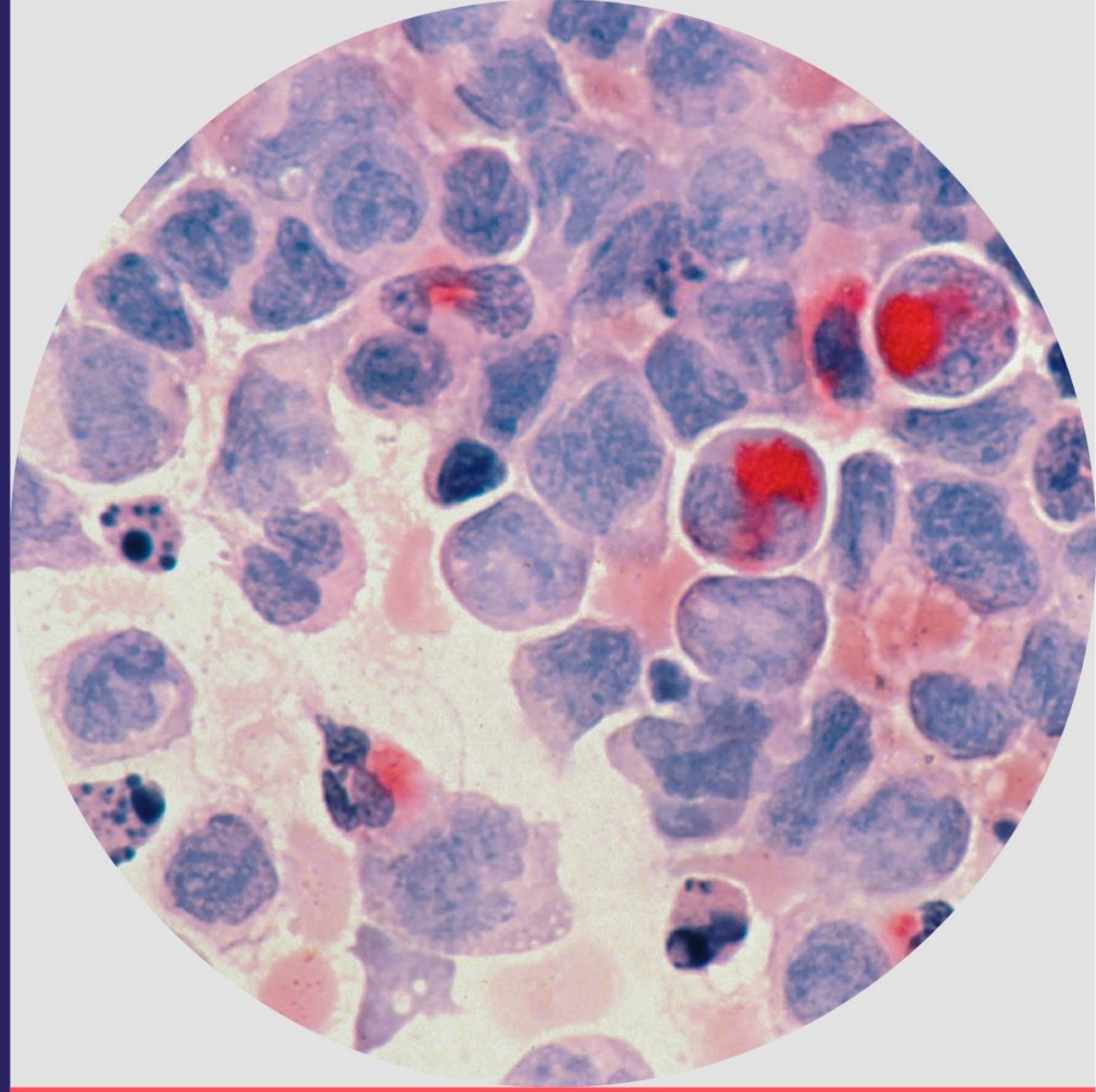


Forward-Looking Statements

Forward–Looking Statements

This presentation includes forward-looking statements that are subject to substantial risks and uncertainties that could cause actual results to differ materially from those expressed or implied by such statements. All statements other than statements of historical facts contained in this presentation, including statements regarding our future results of operations and financial position, business strategy, research and development plans, the anticipated timing, costs, design and conduct of our ongoing and planned preclinical studies and clinical trials for our products and product candidates, including the information presented in this presentation with respect to RVT-3101 and the potential for RVT-3101 to improve the treatment of Ulcerative Colitis (UC) and Crohn's Disease (CD) and to be a first-in-class agent, any commercial potential of our product candidates and the receipt of proceeds from the expected sale of the Myovant top-up shares to Sumitomo Pharma, are forward-looking statements.

These forward-looking statements are based upon the current expectations and beliefs of our management as of the date of this presentation, and are subject to certain risks and uncertainties that could cause actual results to differ materially from those described in the forward-looking statements. Although we believe that our plans, intentions, expectations and strategies as reflected in or suggested by those forward-looking statements are reasonable, we can give no assurance that the plans, intentions, expectations or strategies will be attained or achieved. Furthermore, actual results may differ materially from those described in the forward-looking statements. The interim data presented here for RVT-3101 is from the induction period of the TUSCANY-2 study and is based on an interim analysis of key efficacy and safety data, and such data may change following completion of the clinical trial and may not accurately reflect the complete results of the TUSCANY-2 study.

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

This presentation includes data, results and attributes for RVT-3101 and certain other products and product candidates generated from separate, independent studies and that do not come from head-to-head analysis. Differences exist between study or trial designs and subject characteristics and caution should be exercised when comparing data across studies. Data regarding other products and product candidates is based on publicly available information.

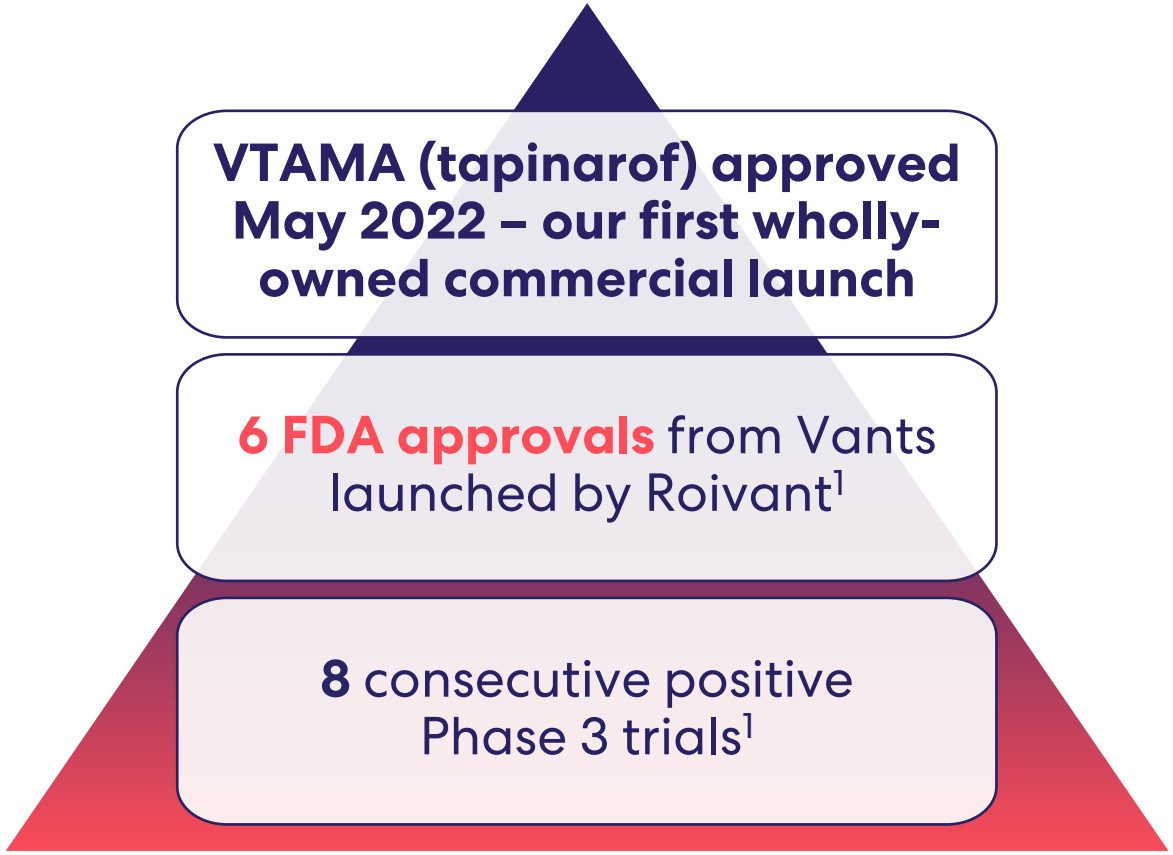
Roivant: Redefining “Big Pharma” from End to End

Roivant Edge

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

- **Technology** boosts all aspects of commercialization, development, and discovery

Clinical and Regulatory Achievements



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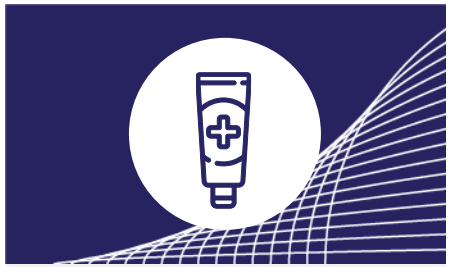
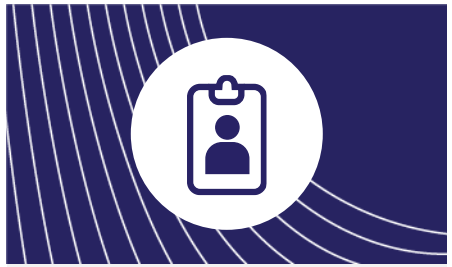
1. FDA approval and trial figures include Vants transferred to Sumitomo Pharma in December 2019.

Roivant's Potential Blockbuster Launch Ongoing and Further Growth Supported by Broad Pipeline, Discovery Engine, and Strong Capital Position



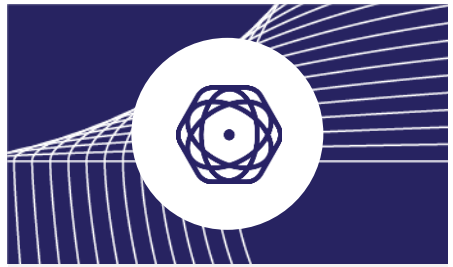
Commercial launch of VTAMA

Potential blockbuster in psoriasis with additional blockbuster upside potential in atopic dermatitis[1]



Broad clinical-stage pipeline

Differentiated pipeline programs across multiple therapeutic areas; 8 ongoing registrational trials in multi-billion-dollar markets



Chip-to-clinic discovery platform

Focused on targeted protein degraders, covalency, and using our computational physics platform for de-risked biological targets

Asymmetric upside potential

Genevant IP portfolio and deep scientific expertise in nucleic acid delivery; early-stage pipeline with promising pre-clinical data

Strong capital position

$1.5BN cash at Dec. 31; $1.9BN giving effect to subsequent Roivant follow-on offering and anticipated proceeds from sale of Myovant minority to Sumitomo[3]

Runway expected into the second half of calendar year 2025[3]

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1. VTAMA has only received FDA approval for psoriasis, not atopic dermatitis.
3. As of December 31, 2022, we had cash, cash equivalents and restricted cash of approximately $1.5 billion. Giving effect to Roivant's February 2023 follow-on offering for $230 million in gross proceeds and $115 million in expected proceeds from the planned sale of the Myovant top-up shares in connection with the pending acquisition of Myovant by Sumitomo Pharma, Roivant's consolidated cash, cash equivalents and restricted cash would have been approximately $1.9 billion. The Myovant transaction is expected to close in the first calendar quarter of 2023, subject to customary closing conditions. Runway includes proceeds from Roivant follow-on, planned sale of Myovant top-up shares, and the continuation of our cost optimization and pipeline reprioritization initiatives initially announced in June 2022.

Robust Late-Stage Pipeline

	Modality	Preclinical	Phase 1	Phase 2	Phase 3	Approved
VTAMA (tapinarof) cream 1% Psoriasis | *Dermavant*	*Topical*					▶
VTAMA (tapinarof) cream 1% Atopic Dermatitis | *Dermavant*	*Topical*				▶	
RVT-3101 Ulcerative Colitis | New Vant	*Biologic*			▶		
RVT-3101 Crohn's Disease | New Vant	*Biologic*			▶		
BREPOCITINIB Dermatomyositis | *Priovant*	*Small Molecule*				▶	
BREPOCITINIB Systemic Lupus Erythematosus | *Priovant*	*Small Molecule*			▶		
BREPOCITINIB Other Indications | *Priovant*	*Small Molecule*			▶		
BATOCLIMAB Myasthenia Gravis | *Immunovant*	*Biologic*				▶	
BATOCLIMAB Thyroid Eye Disease | *Immunovant*	*Biologic*				▶	
BATOCLIMAB Chronic Inflammatory Demyelinating Polyneuropathy | *Immunovant*	*Biologic*			▶		
BATOCLIMAB Graves' Disease | *Immunovant*	*Biologic*			▶		
IMVT-1402 Numerous Indications | *Immunovant*	*Biologic*		▶			
NAMILUMAB Sarcoidosis | *Kinevant*	*Biologic*			▶		
RVT-2001 Transfusion-Dependent Anemia in Patients with Lower-Risk MDS | *Hemavant*	*Small Molecule*		▶			

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Pipeline reflects both ongoing clinical trials and expected upcoming trials. VTAMA has only received FDA approval for psoriasis, not atopic dermatitis.

▶ Represents registrational or potentially registrational trials

2023: Roivant's Biggest Year Yet

Expanded VTAMA Coverage and Reach

Ongoing

Ongoing coverage expansion expected to increase net yield and add revenue

VTAMA Phase 3 Readout in AD

ADORING 2 – March 2023
ADORING 1 – May 2023

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

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

1H 2023

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

IMVT-1402 (Next-Gen Anti-FcRn) Human Data

Mid-2023

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

Brepocitinib (TYK2/JAK1) Pivotal Trial Readout in SLE

4Q 2023

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

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References are to calendar years. Other than VTAMA in psoriasis, all drugs are investigational and subject to regulatory approval.

Charting a Path to a $15BN+ Inflammation & Immunology Franchise

2023-2025

2025+

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

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

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

Key Catalysts

Program	Vant	Catalyst	Expected Timing
VTAMA (tapinarof) cream		Updates on commercial launch of VTAMA in psoriasis	Ongoing
Roivant pipeline growth		New mid/late-stage in-licensing announcements	Ongoing
LNP platform		Updates to LNP patent litigation	Ongoing
Roivant Discovery		Updates on discovery programs and technology	Ongoing
VTAMA (tapinarof) cream		Topline data from Phase 3 trials in atopic dermatitis	March 2023 & May 2023
RVT-3101		Final data from Phase 2B trial in ulcerative colitis	1H 2023
IMVT-1402		Initial data from Phase 1 trial	Mid-2023
Brepocitinib		Topline data from potentially registrational Phase 2B trial in systemic lupus erythematosus	4Q 2023
Batoclimab		Initial data from Phase 2 trial in Graves' disease	2H 2023
RVT-2001		Data from RVT-2001 Phase 1/2 trial in lower-risk myelodysplastic syndrome	2H 2023
Batoclimab		Initial data from pivotal Phase 2B trial in chronic inflammatory demyelinating polyneuropathy	1H 2024
Namilumab		Topline data from Phase 2 trial in sarcoidosis	1H 2024
Batoclimab		Topline data from Phase 3 trial in myasthenia gravis	2H 2024
Batoclimab		Topline data from Phase 3 trials in thyroid eye disease	1H 2025
Brepocitinib		Topline data from Phase 3 trial in dermatomyositis	2025

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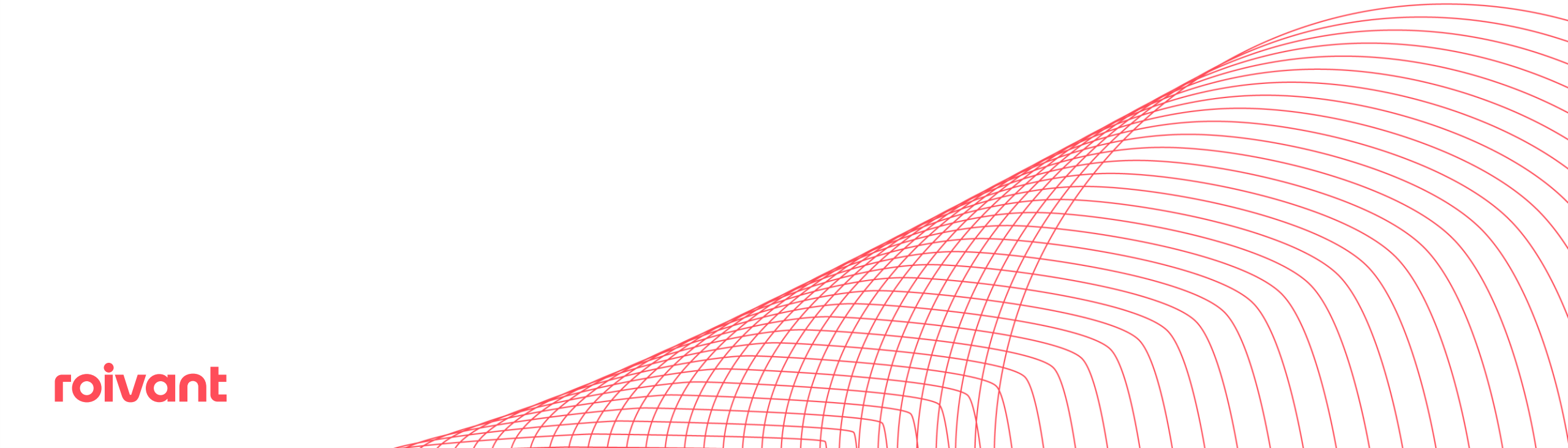
All catalyst timings are based on current expectations and, where applicable, contingent on FDA feedback, and may be subject to change. All timelines reference calendar years.

Commercial Launch of VTAMA® Cream



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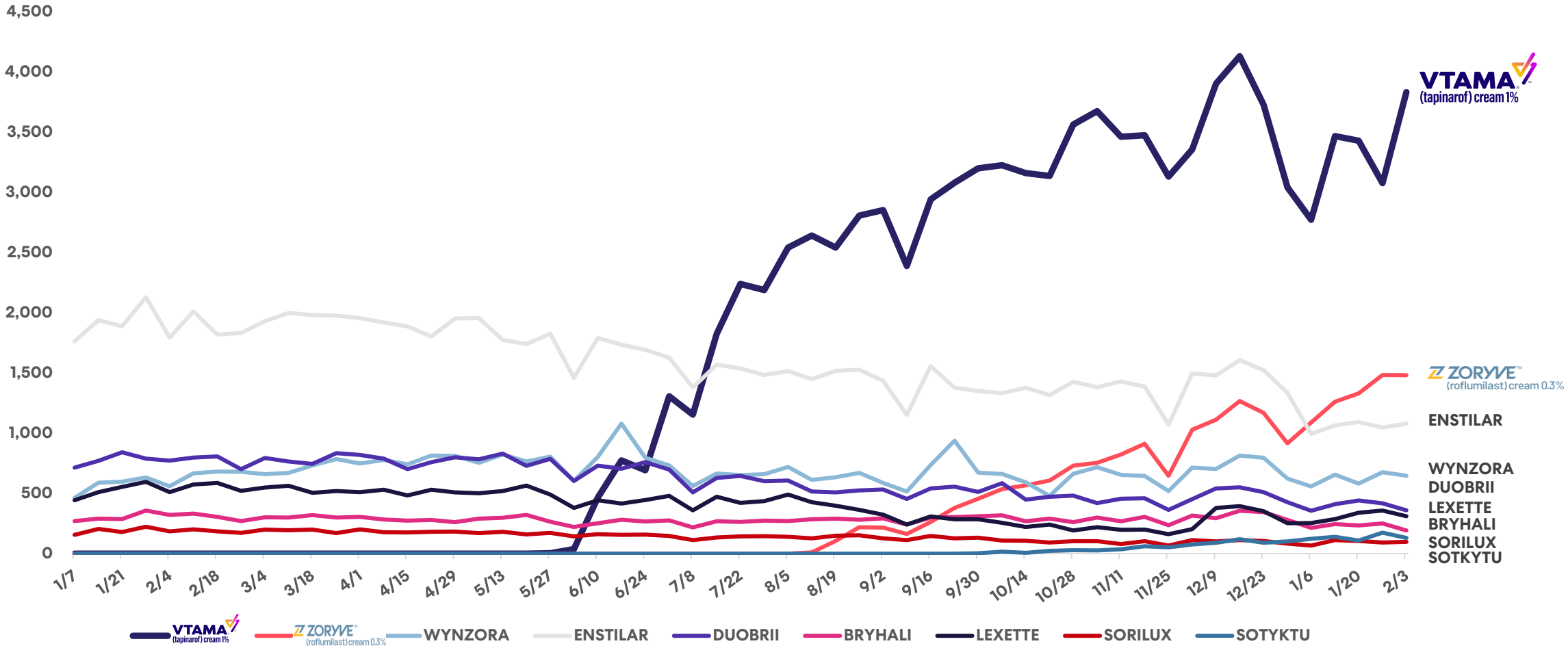
VTAMA Leads the Other Branded Topicals in Weekly TRx

Nearly 100,000 VTAMA prescriptions written by approximately 8,600 unique prescribers since launch

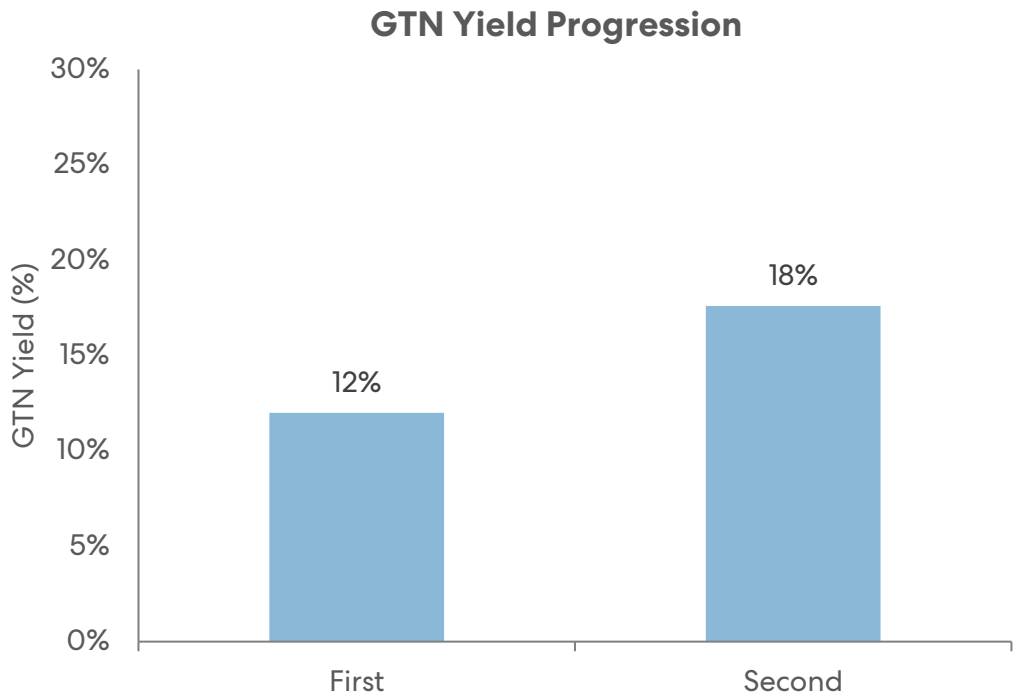
PsO Branded Topical Market – Weekly TRxs[1]



Source: IQVIA National Prescription Audit (NPA).

VTAMA's Growth Continues to Progress with GTN Yield Closely Tracking Precedent Launch

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



Near doubling of revenue shows strong patient demand and good payer progress

57% Commercial Coverage Achieved Within 9 Months of Launch

Innovation and TRx performance driving accelerated coverage

94.9M

Commercial Lives Covered (57% of Total)

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

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Sources: MMIT and Clarivate|DRG January 27, 2023

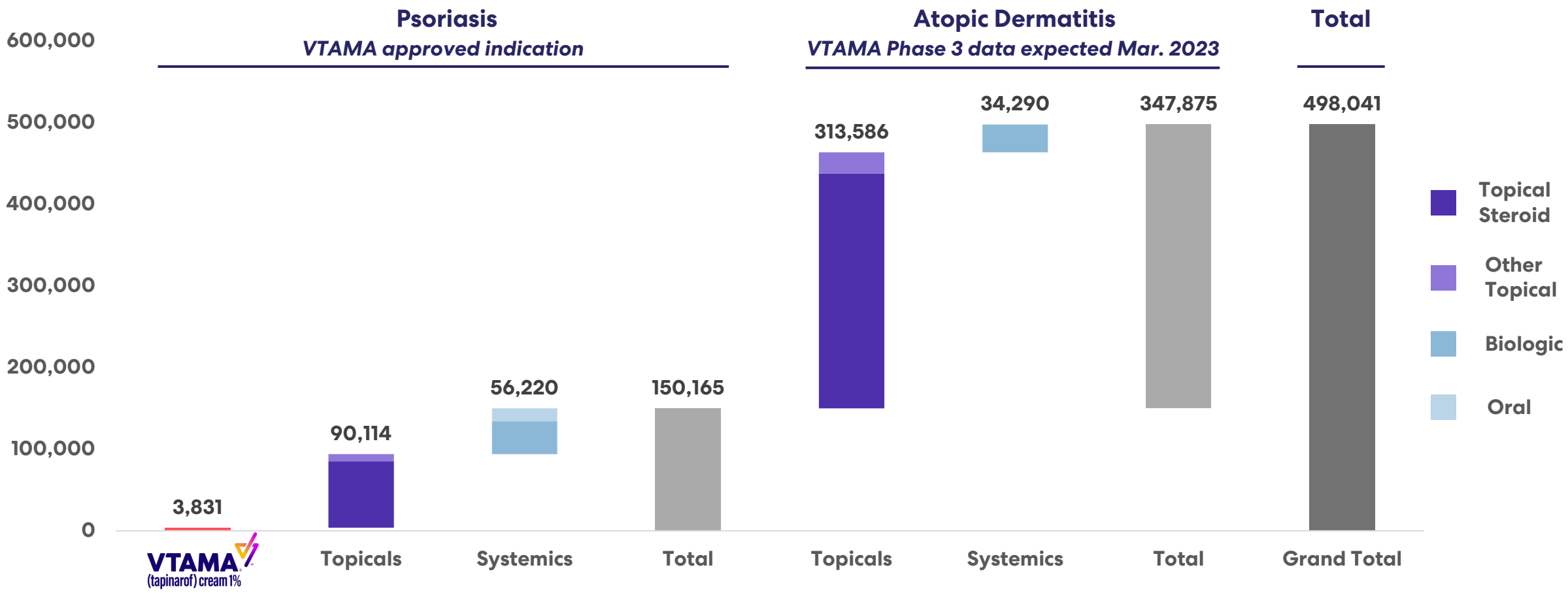
VTAMA Payer Update – A Premium Product Driving Quality Access

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

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

VTAMA Is Just Getting Started Penetrating 400,000+ TRx Weekly Topical Market[1]

Psoriasis and Atopic Dermatitis Total Market – Weekly TRx[2]



1. VTAMA has only received FDA approval for psoriasis, not atopic dermatitis.
2. Source: IQVIA National Prescription Audit (NPA). Market data as of week ending 1/20/2023. VTAMA TRx as of 2/3/2023. Market weekly TRx factored at the product level using ICD-10 code claim analytics.

VTAMA: A Paradigm Shift In Everyday Psoriasis Care

Physician Quotes from Investor Day KOL Panel:

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

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

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

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

*"[One patient of mine] cleared 100% on this medication. She showed me pictures of herself in shorts, and she told me she never thought she could wear shorts again. She got teary-eyed, I got teary-eyed. But that moment just showed me that **this drug is not only impacting the disease itself. It's changing people lives**"*

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VTAMA Cream Broad and Differentiated FDA-Approved Label

VTAMA® (tapinarof) cream 1%

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

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

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

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

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

Broad Target Population and Use Cases	**Mild, moderate & severe plaque psoriasis**
	May be applied to all affected skin areas
Differentiated Clinical Efficacy	**Unlimited duration of treatment as demonstrated in clinical studies over 52 weeks**
	Demonstrated median REMITTIVE OFF-TREATMENT EFFECT of ~4 months
Safe and Well-Tolerated	**No label safety warnings or precautions**
	2,200+ patients treated in clinical trials

VTAMA Cream's FDA Label is Differentiated Among Competitors

On Label	Non-Steroidal Topicals		Systemics			Topical Steroids			Steroid Combinations	
	VTAMA (tapinarof) cream 1%	ZORYVE™	OTEZLA® (Oral)	HUMIRA® (Subcutaneous)	SOTYKTU™ (Oral)	Clobetasol	Halobetasol	Betamethasone	DUOBRII™ (Corticosteroid/ Vitamin A)	ENSTILAR® (Corticosteroid/ Vitamin D)
Remittive Off-Treatment Benefit Data[1]	✓	✗	~	✓	~	✗	✗	✗	✗	~
No Duration Limitations	✓	✓	✓	✓	✓	≤ 4 weeks	≤ 2 weeks	≤ 4 weeks	✓	≤ 4 weeks
No Body Surface Limitations (incl. Intertriginous Areas)	✓	✓	✓	✓	✓	Avoid face, groin and underarm	Avoid face, groin and underarm	Avoid face, groin and underarm	Avoid face, groin and underarm	Avoid face, groin and underarm
No Label Safety Warnings	✓	✓	GI issues, hypersensitivity weight loss, depression	Black box warning of serious infections	Hypersensitivity, serious infections, TB, malignancy, rhabdomyolysis	HPA axis suppression, Cushing's syndrome, hyperglycemia	HPA axis suppression, Cushing's syndrome, hyperglycemia	HPA axis suppression, Cushing's syndrome, hyperglycemia	Embryofetal risk, HPA axis suppression, Cushing's syndrome	HPA axis suppression, Cushing's syndrome, hyperglycemia
No Drug Interactions	✓	CYP3A4 or CYP3A4/CYP1A2 dual inhibitors, or oral contraceptives with gestodene and ethinyl estradiol	Strong cytochrome P450 enzyme inducers	Anakinra, live vaccines	Live vaccines, other immuno-suppressants	✓	✓	✓	✓	✓
No Contraindications	✓	Moderate/severe liver impairment	Known hypersensitivity to apremilast	✓	Known hypersensitivity to deucravacitinib	✓	✓	Known hypersensitivity to betamethasone or any other corticosteroids	Pregnancy	✓

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

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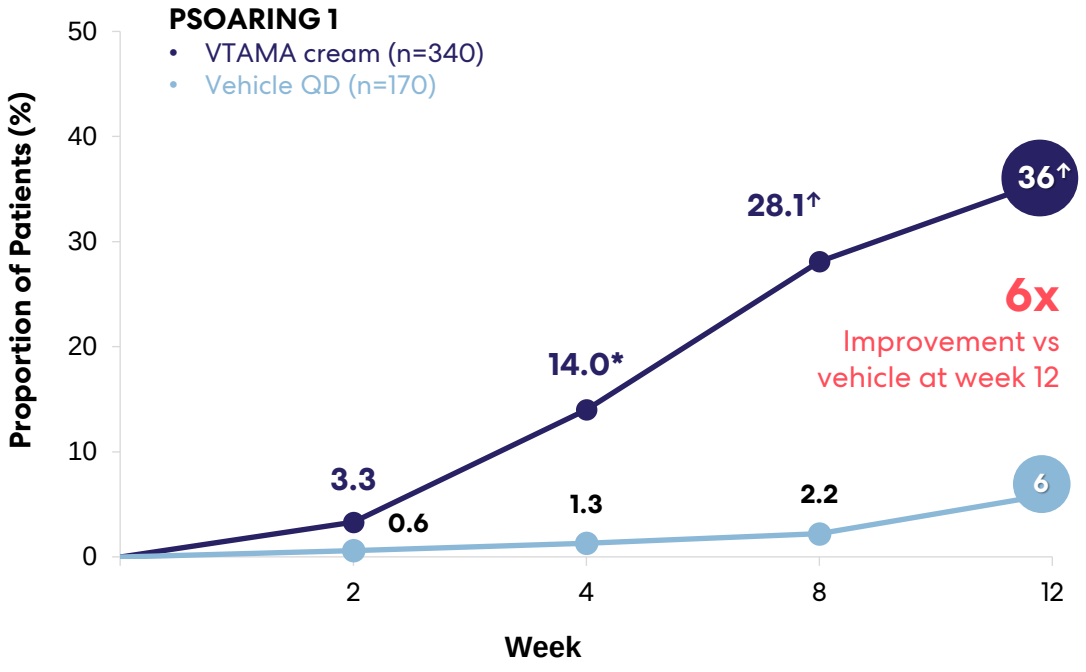
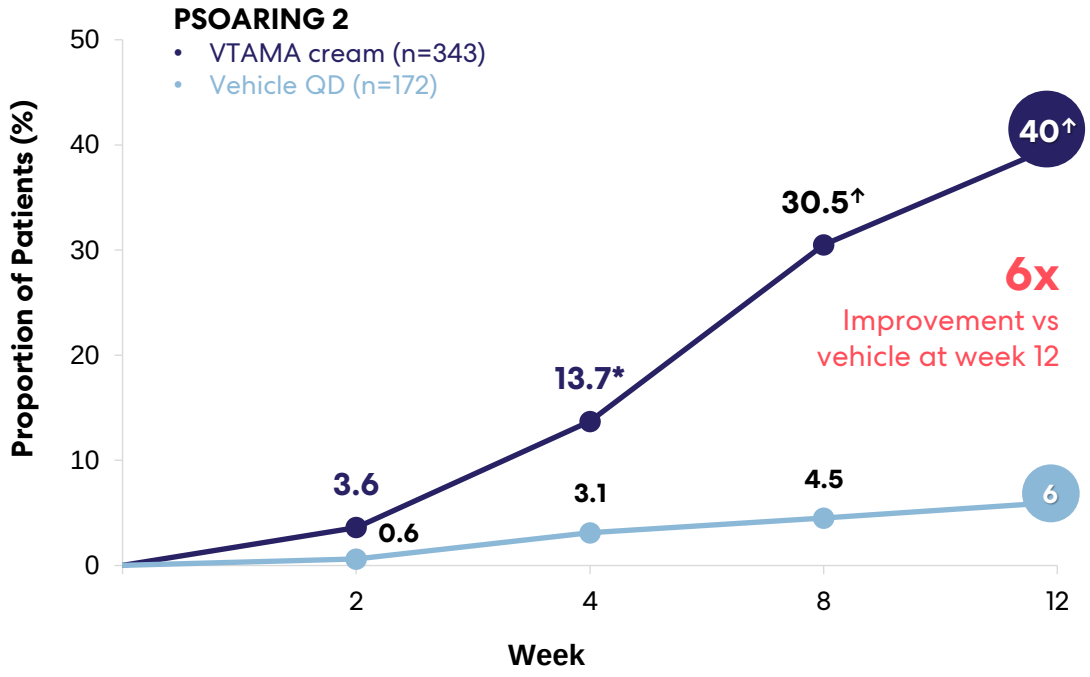
1. VTAMA cream demonstrated a median time of ~4 months off treatment to PGA ≥ 2. Patients on OTEZLA lost PASI-75 response after a median of ~5-weeks off treatment. Patients on SOTYKTU lost sPGA 0/1 after a median of ~8 weeks off treatment and lost PASI-75 response after a median of ~12 weeks off treatment. Patients on ENSTILAR showed a median of ~4-weeks off treatment to IGA ≥ 1.

6x Treatment Success Rate vs. Vehicle at Week 12, With Significant Efficacy Seen as Early as Week 4[1-3]

PGA treatment success: PGA score of 0 or 1 & a ≥2-grade improvement from baseline to week 12[1-3]



*P=0.0012; ↑P<0.0001



*P=0.0014; ↑P<0.0001

- **~40%** of VTAMA cream patients achieved PGA treatment success vs ~ 6% of vehicle patients at week 12[1-3]
- **~80%** of VTAMA cream patients achieved a ≥1-grade PGA improvement at week 12 vs ~35% of patients on vehicle[1-3]

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PGA, Physician Global Assessment; QD, once daily

1. Lebwohl M, et al. N Engl J Med. 2021;385:2219–2229.
2. Dermavant DOF. [DMVT-505-3001 CSR; October 2020].
3. Dermavant DOF. [DMVT-505-3002 CSR; October 2020].

Remittive Effect is Unprecedented, and The Hallmark of VTAMA

PSOARING 1

12 Weeks on treatment

PSOARING 3 LTE

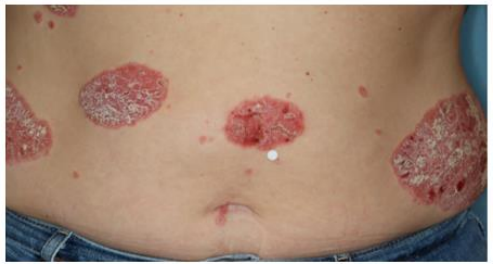
12 Weeks on treatment

24 Weeks off treatment

Month 1 | Month 2 | Month 3 | Month 4 | Month 5 | Month 6 | Month 7 | Month 8 | Month 9 | Month 10 | Month 11 | Month 12

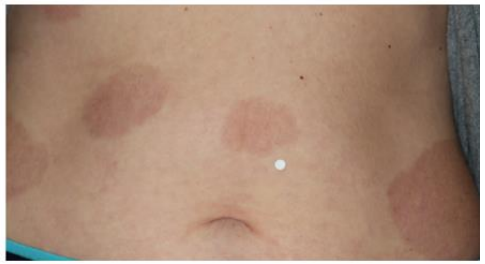
Patient achieved PGA=0 on treatment and subsequently went off therapy

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



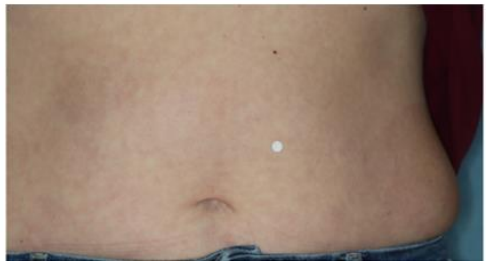
Baseline

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



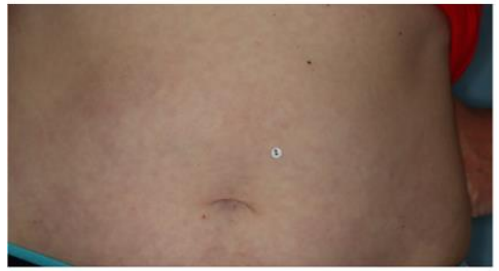
On treatment for 12 weeks

- PGA=1
- DLQI=0
- PASI=3.8
- PP-NRS=0



Off treatment for 12 weeks*

- PGA=1
- DLQI=0
- PASI=1.2



Off treatment for 24 weeks†

- PGA=2
- DLQI=2
- PASI=5.4

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

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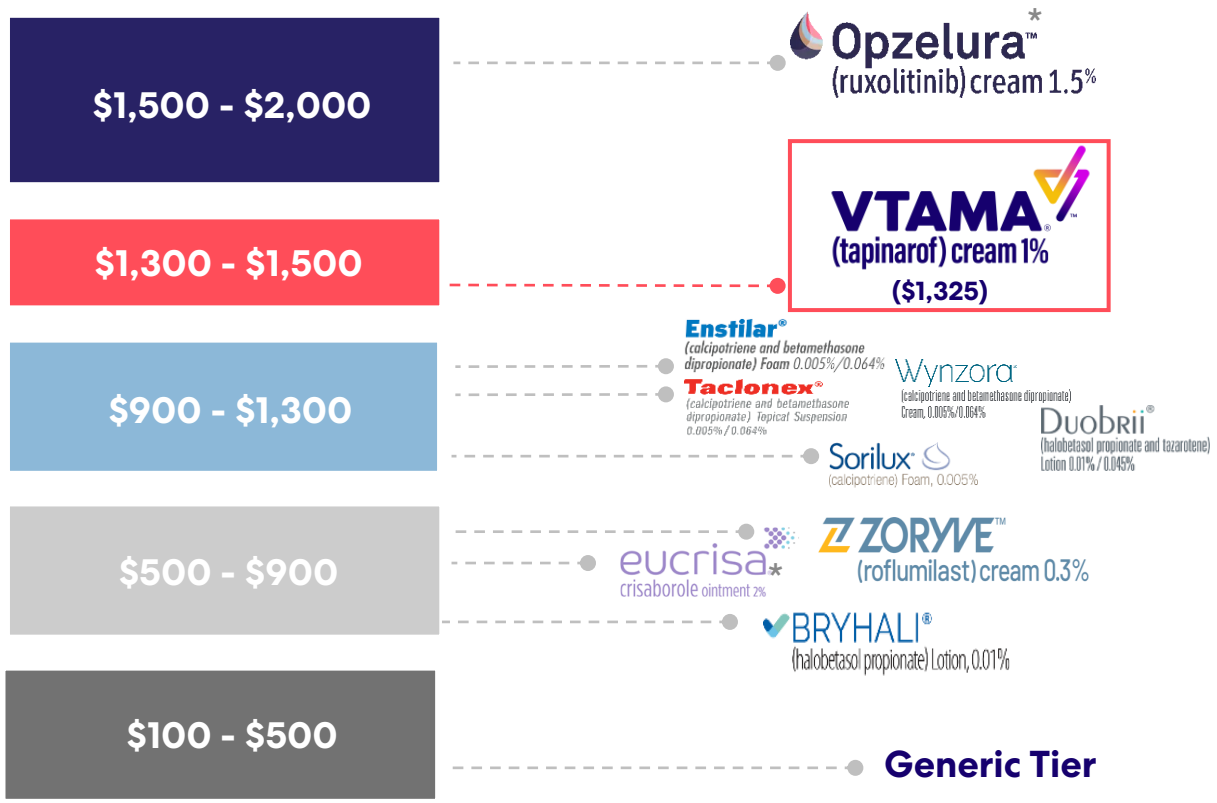
PGA and PASI are global efficacy assessments. Example of one representative target lesion of a patient treated with tapinarof cream 1% QD in the PSOARING 1 and 3 trials. *LTE Week 24: Off treatment for 12 weeks (after achieving PGA=0 at LTE Week 12). †LTE Week 36: Off treatment for 24 weeks, with re-treatment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

1. Stein Gold L, et al. Poster presented at American Academy of Dermatology Annual Meeting, Boston, MA, March 25–29, 2022; 2. Dermavant DOF [PSOARING Patient Images].

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

Topical WAC Price Landscape



Rationale for VTAMA Cream WAC Price

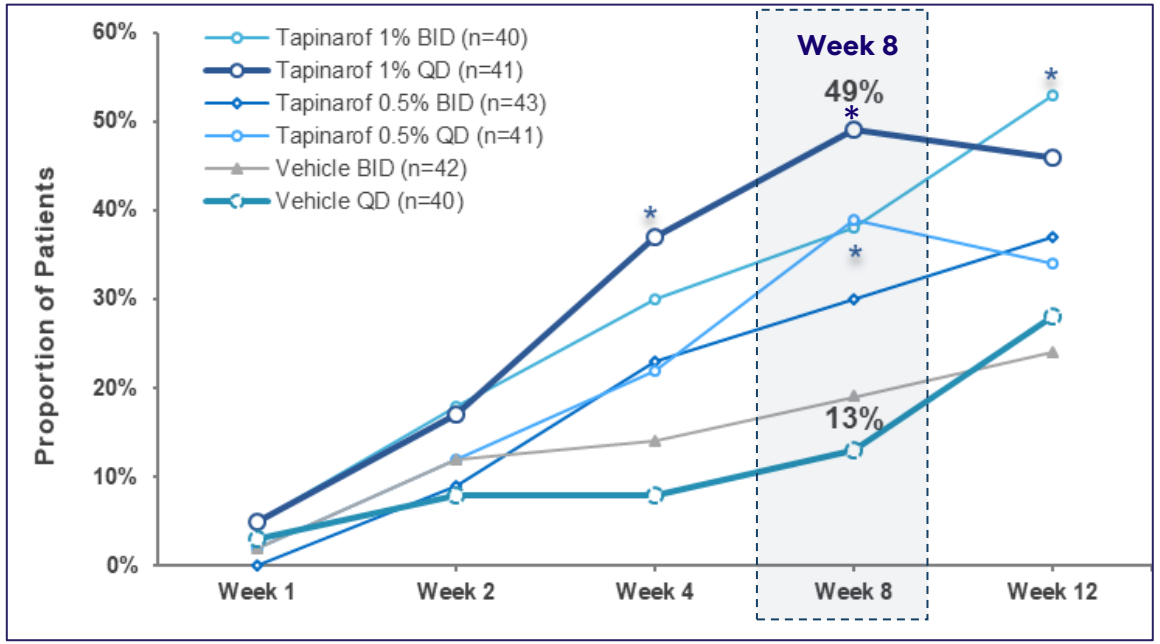
- **VTAMA** is 1st topical NCE approved in PsO in 25 years
- Reflects novel mechanism and differentiated profile with **strongest on-label remittive effect for a topical**
- Positions VTAMA as **valuable to both rebate- and WAC-sensitive health plans**
- May delay **the path to expensive systemic therapies**

Accelerates Launch Velocity & Enables Broad Adoption

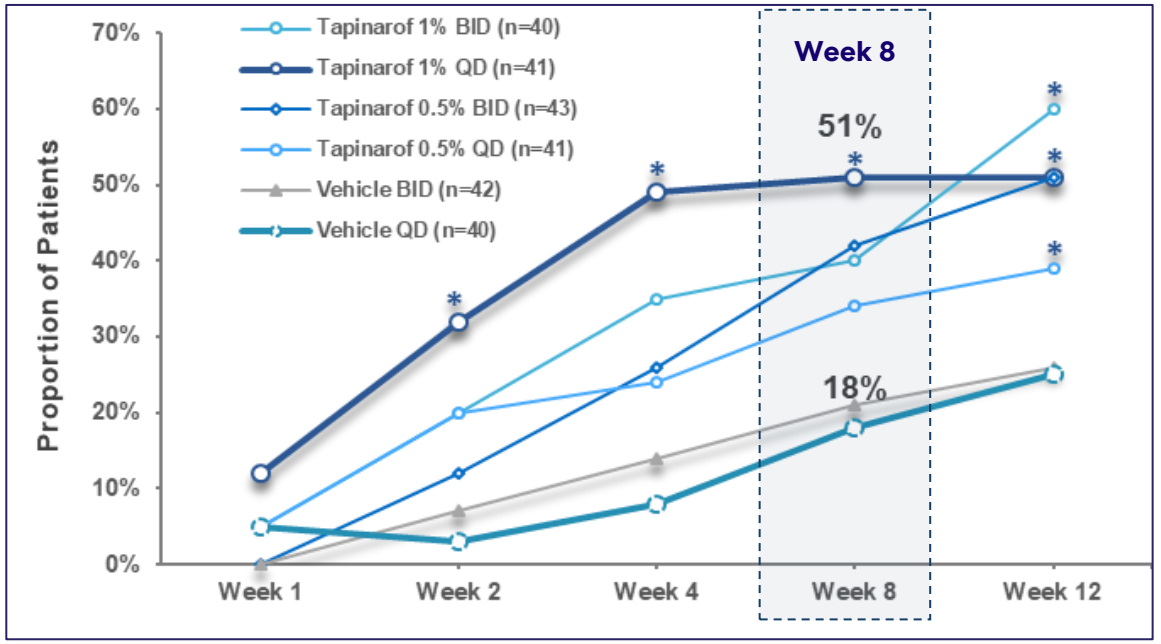
Efficacy Data from a Phase 2b, Randomized Clinical Trial of Tapinarof Cream for the Treatment of Atopic Dermatitis

Response rates: 49% of patients achieved IGA response and 51% of patients achieved EASI75 response at week 8

IGA Score 0 or 1 and ≥2-Grade Improvement at Week 8
Primary Endpoint was at 12 Weeks: Assessed in ITT Population (NRI Analysis)



EASI75 at Week 8
Secondary Endpoint was at 12 Weeks: Assessed in ITT Population (NRI Analysis)



Japanese partner has also reported positive topline IGA and EASI75 results in Phase 3 trial for tapinarof in AD

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For Investor Audiences Only.
*Difference vs vehicle is statistically significant at p-value of 0.05 or lower. NRI analysis to account for higher dropout rates in vehicle group. BID, twice daily; IGA, Investigator Global Assessment; EASI, Eczema Area and Severity Index; ITT, intention to treat; NRI, non-responder imputation; QD, once daily.

Highly Favorable Results for VTAMA in Pediatric Maximal Use AD Study

Study demonstrated minimal-to-no systemic exposure despite maximal use

Study Overview

- Objective to **characterize pharmacokinetics (PK) and safety of VTAMA cream under maximal usage conditions in pediatric subjects with atopic dermatitis**
  - VTAMA cream utilized the **same dose and frequency** (1% cream, applied QD) that is **currently FDA approved**[1] for adult plaque psoriasis as well as in pivotal trials for atopic dermatitis (ADORING 1 and ADORING 2)
- The study **enrolled 36 patients aged 2-17 years old** with extensive disease
  - **Subjects had up to 90% body surface area (BSA)** affected and a mean BSA of 43%

Topline Data

- VTAMA cream demonstrated **favorable safety and PK** in children 2 years of age and above
  - **Minimal to no systemic exposure** was confirmed under maximal use conditions in subjects with up to 90% body surface area (BSA) affected
  - There was a **low incidence of adverse events (AEs)** with no SAEs
  - **PK profile consistent with adult psoriasis population** with no relationship observed between plasma exposure and % BSA involvement

Simplicity of a single dose form will be a differentiator versus other topicals that have multiple doses for different age groups and disease states (e.g., roflumilast 0.05% and 0.15% in AD as well as 0.3% dose in plaque psoriasis)[2]

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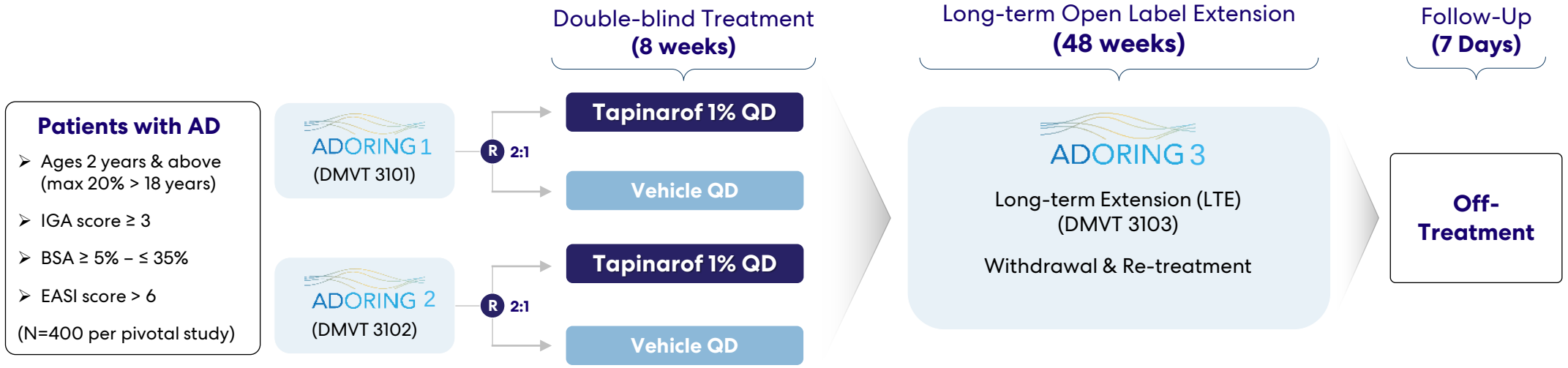
1. VTAMA has only received FDA approval for psoriasis, not atopic dermatitis.
2. Based on approved adult plaque psoriasis dose and current clinical trials in atopic dermatitis

Phase 3 Atopic Dermatitis ADORING Program – Study Design

Two identically-designed pivotal trials followed by long-term, open-label extension

Study Objective: To demonstrate statistically significant treatment effect of tapinarof as compared with vehicle and an acceptable safety profile in moderate to severe atopic dermatitis patients

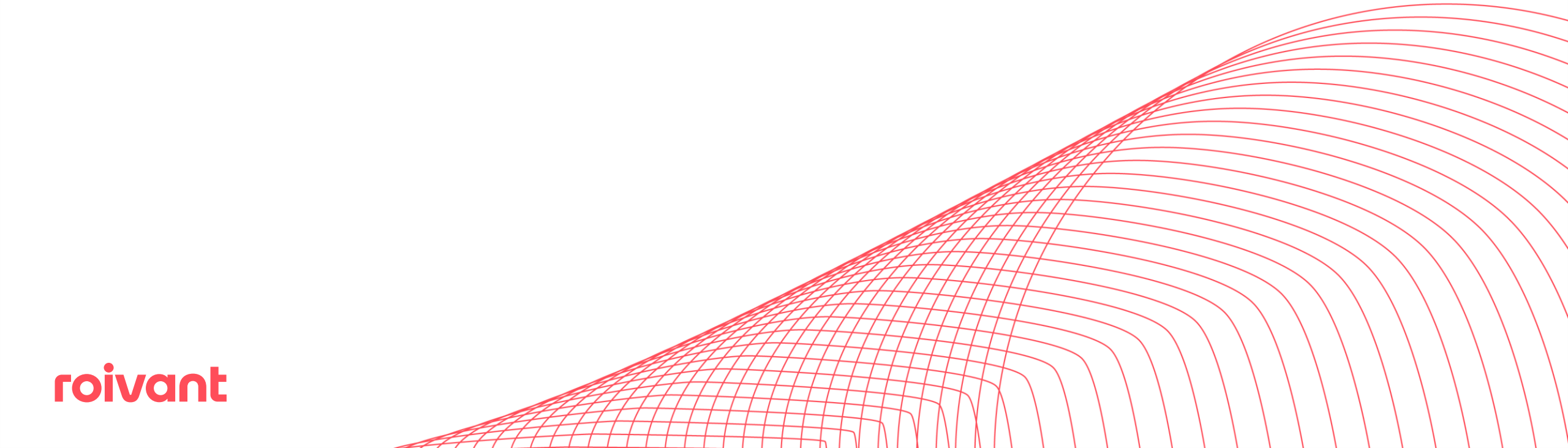


Primary endpoint:
› Proportion of subjects who have a vIGA-AD™ 0 or 1 Baseline at Week 8

Secondary endpoints:
› Proportion of subjects with EASI 75 @ week 8
› Mean change in %BSA from Baseline at Week 8
› Proportion of subjects with EASI 90 @ Week 8
› Proportion of subjects with > 4-pt reduction in PP-NRS @ Week 8

PROs:
› LTE
› DLQI/CLDQI/IDQOL
› EQ-5D-5L/EQ-5D-Y
› POEM
› DFI
› PP-NRS

RVT-3101



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

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

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

Large and Well-Validated Market Opportunity

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

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

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

Additional Near-Term Catalyst

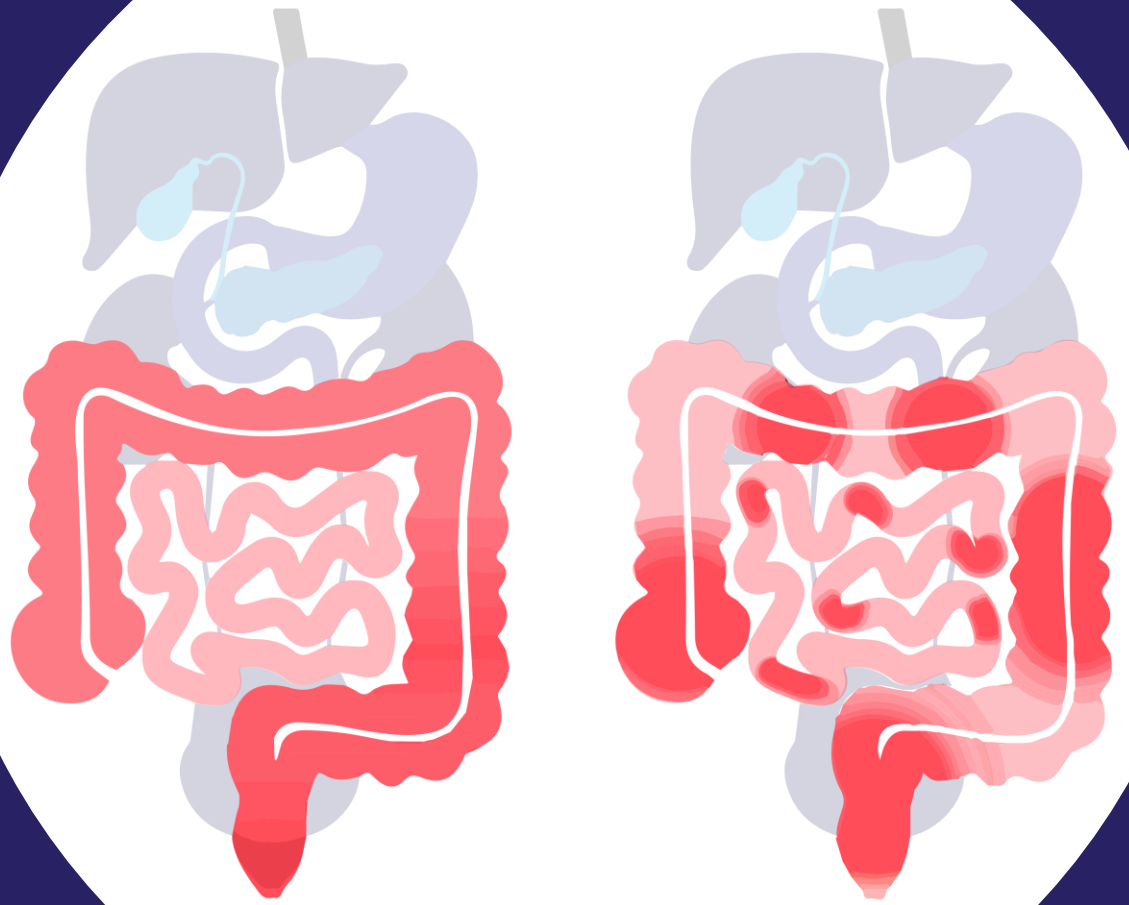
- Final UC Phase 2b data (TUSCANY-2) expected 1H 2023

Strong Intellectual Property Position

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

Significant Unmet Medical Need Persists for Patients with IBD

- Affects ~2M people in the US – two most common forms are ulcerative colitis (UC) and Crohn's disease (CD)
- Abdominal pain, bleeding, frequent bathroom visits or constipation, obstruction, and surgery
- Constitutional symptoms of weight loss, fever, and fatigue; significant mental health burden
- Poor prognostic indicators and lack of biomarkers lead to a "trial and error" treatment paradigm or eventual removal of the colon for more severe patients
- Even the best advanced therapies typically result in **10-15%** remission of disease, leaving frequent flare-ups or continued worsening of disease



Adapted from https://www.hopkinsmedicine.org/

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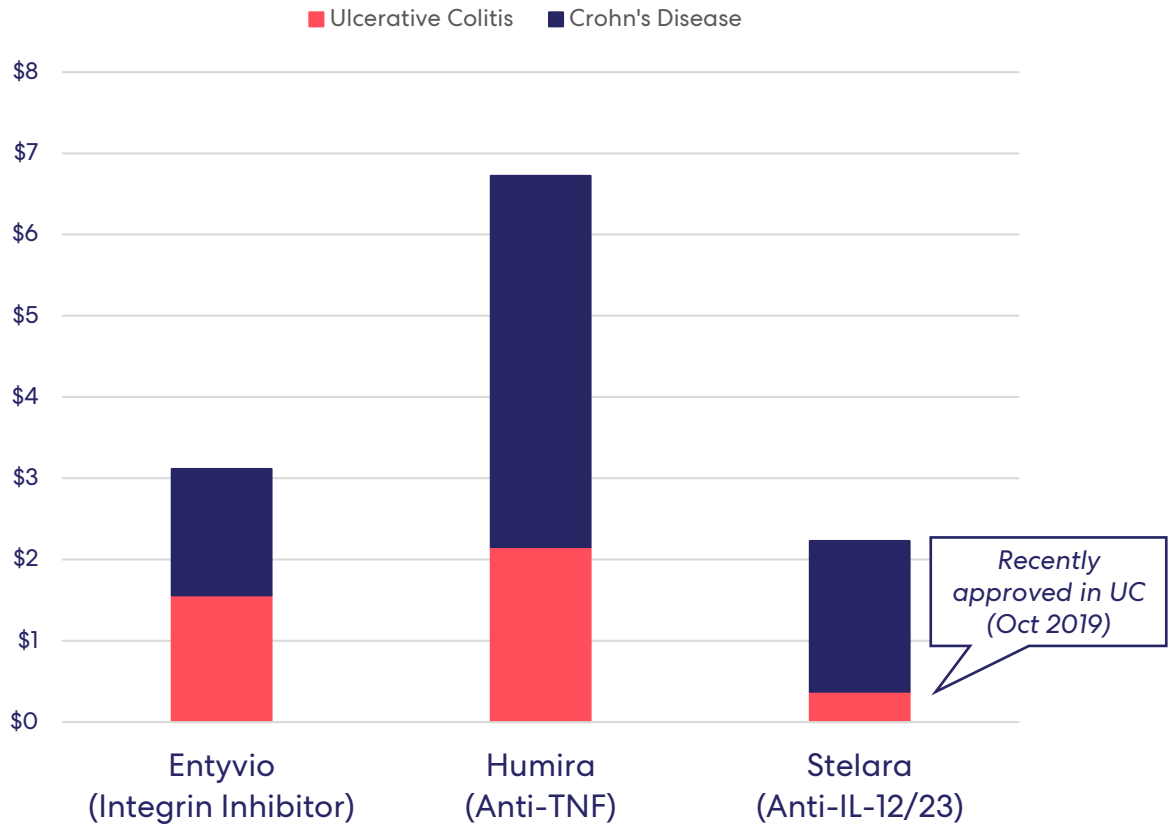
Source: 2014 Crohn's and Colitis Foundation of America Guidebook; 2019 IBD Global Disease Burden from The Lancet; 2012 Molodecky et al., Gastroenterology

IBD Has Consistently Yielded Blockbuster Revenues for Therapies in Multiple Classes

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

- IBD has consistently yielded blockbuster revenues for drugs from multiple asset classes
- To date, the leading therapy for each novel mechanism has achieved ≥$2B in US sales
- In 2021, leading therapies in each of the three mechanisms generated a combined **$12B** in US sales in IBD

2021 US Sales in IBD ($B)



Source: Evaluate Pharma

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

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

- Multiple Inflammatory Diseases: RA, Asthma, AS, PsO, SLE
- Intestinal Fibrosis
- Pulmonary Fibrosis
- Liver Fibrosis

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

Additional indications to be announced

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

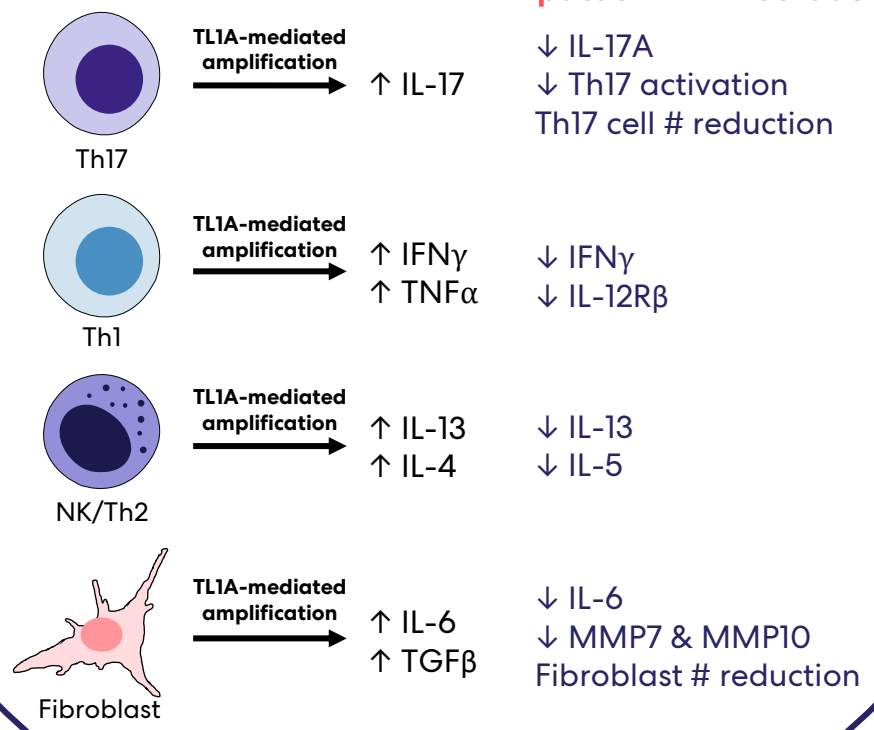


Figure adapted from Aiba et al., Mediators of Inflammation (2013); Hassan-Zahraee et al, Inflammatory Bowel Disease (2022)

Two Robust, Positive Studies Conducted By Pfizer To Date

TUSCANY (Phase 2a)

- 14-week induction study
- IV, single-arm study
- Biologic experienced and naïve
- Exploratory biomarkers; biomarker of interest identified
- Global study
- N = 50

TUSCANY-2 (Phase 2b)

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

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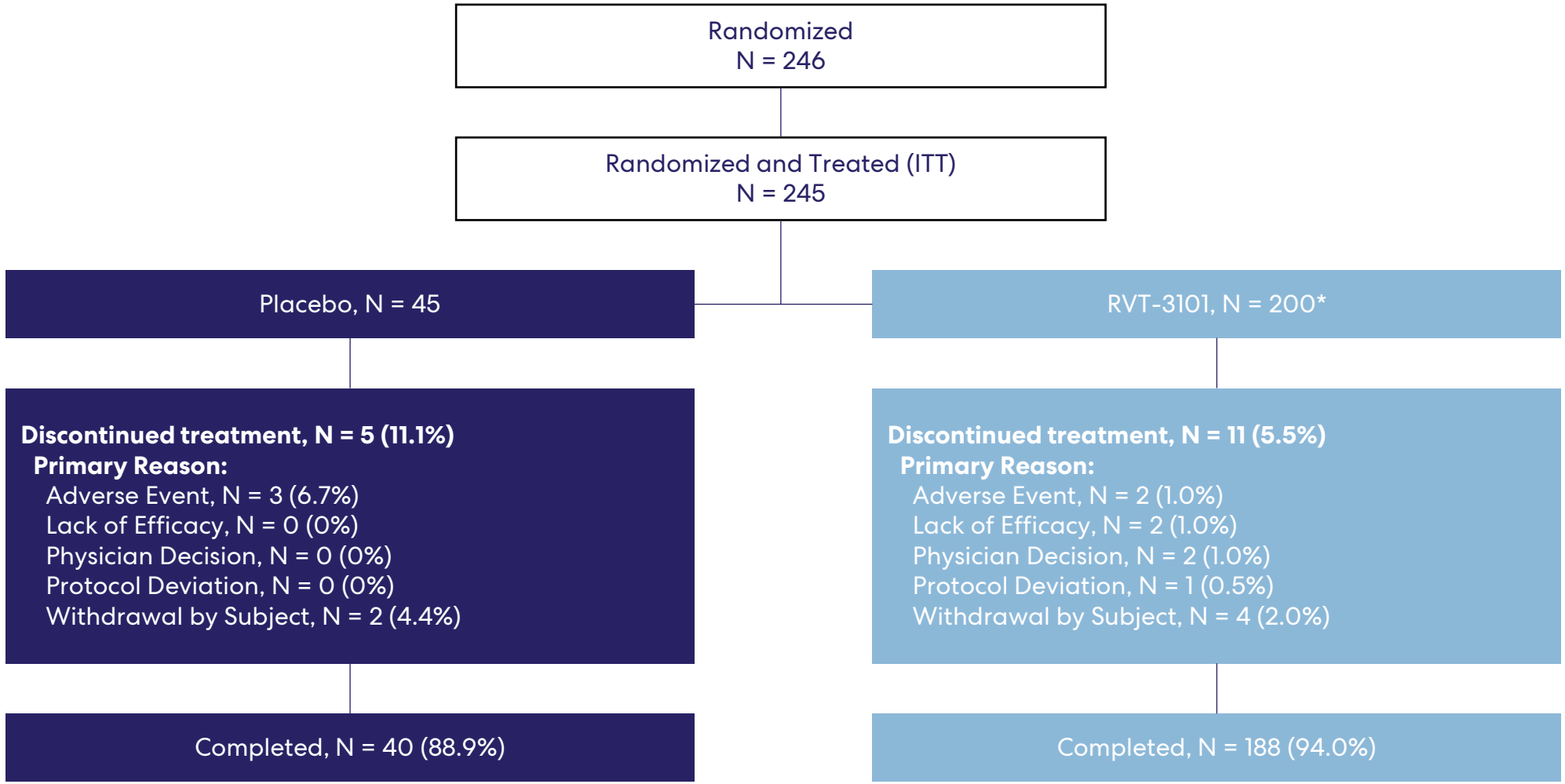
For TUSCANY results, see *Danese, Silvio, et al., Clinical Gastroenterology and Hepatology (2021)*

TUSCANY-2 Phase 2b Study Design (N = 245)

Study Outcomes

Primary Endpoints	Clinical Remission (Induction Period, at Week 14)	Safety
Secondary Endpoints	Clinical Remission (Chronic Period, at Week 56)	Endoscopic Assessments
Key Additional Efficacy Analyses	Biomarker Status	Prior Biologic Experience

Subject Disposition in Induction Period



* All RVT-3101 dose arms arm are comprised of patient populations larger than the placebo group

Baseline Disease Characteristics and Demographics

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

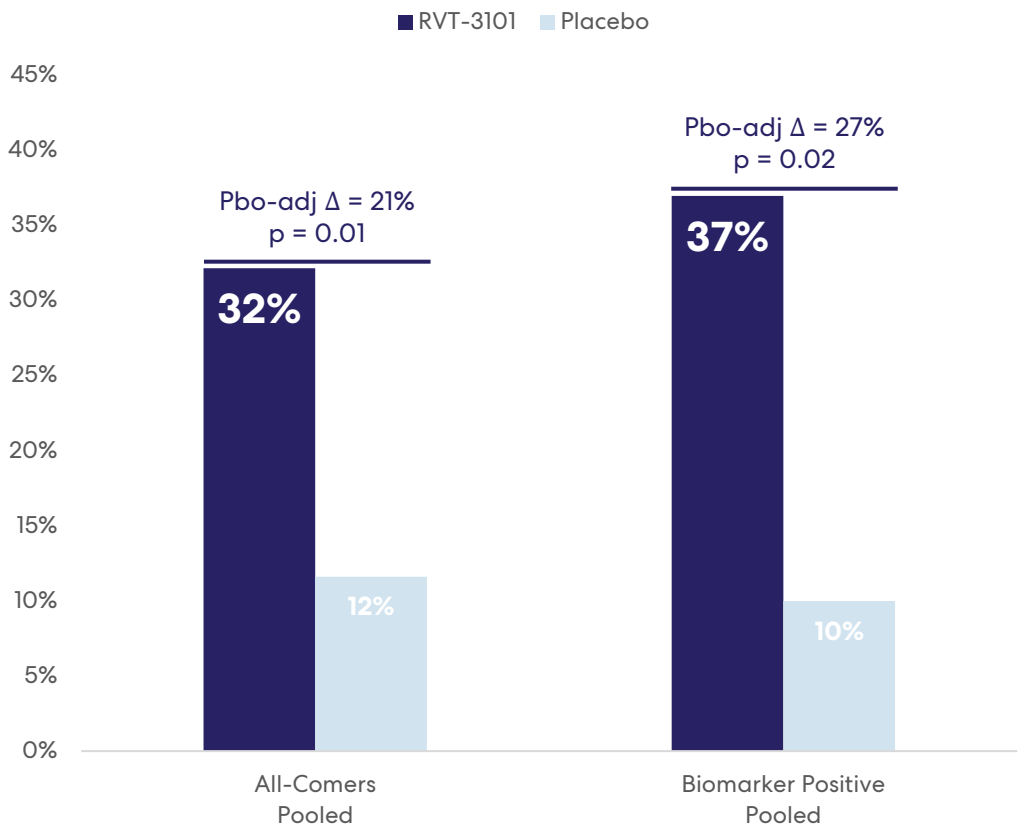
	Placebo N = 45	Pooled Drug N = 200	Expected Ph3 Dose
Age (years, mean)	39.9	40.9	41.6
Female	47%	39%	40%
Weight (kg, mean)	70.0	71.5	72.3
Geographic Region			
US / Canada / Australia	11%	12%	16%
EU	56%	66%	59%
Asia	29%	18%	19%
Other	4%	5%	5%
Duration of disease (years, mean)	7.6	7.3	7.5
Extent of Disease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

Advanced therapy includes approved biologics and JAKs

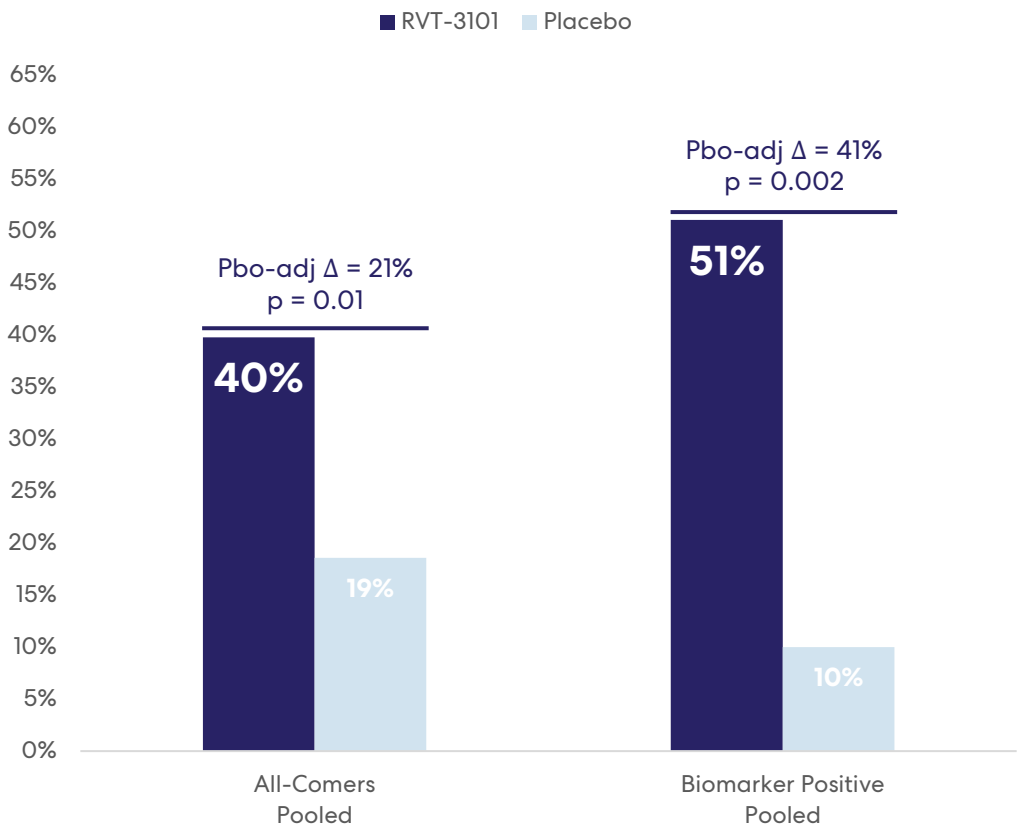
RVT-3101 Shows Consistent Effect Across Endpoints and Patient Populations

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

Clinical Remission (Modified Mayo)



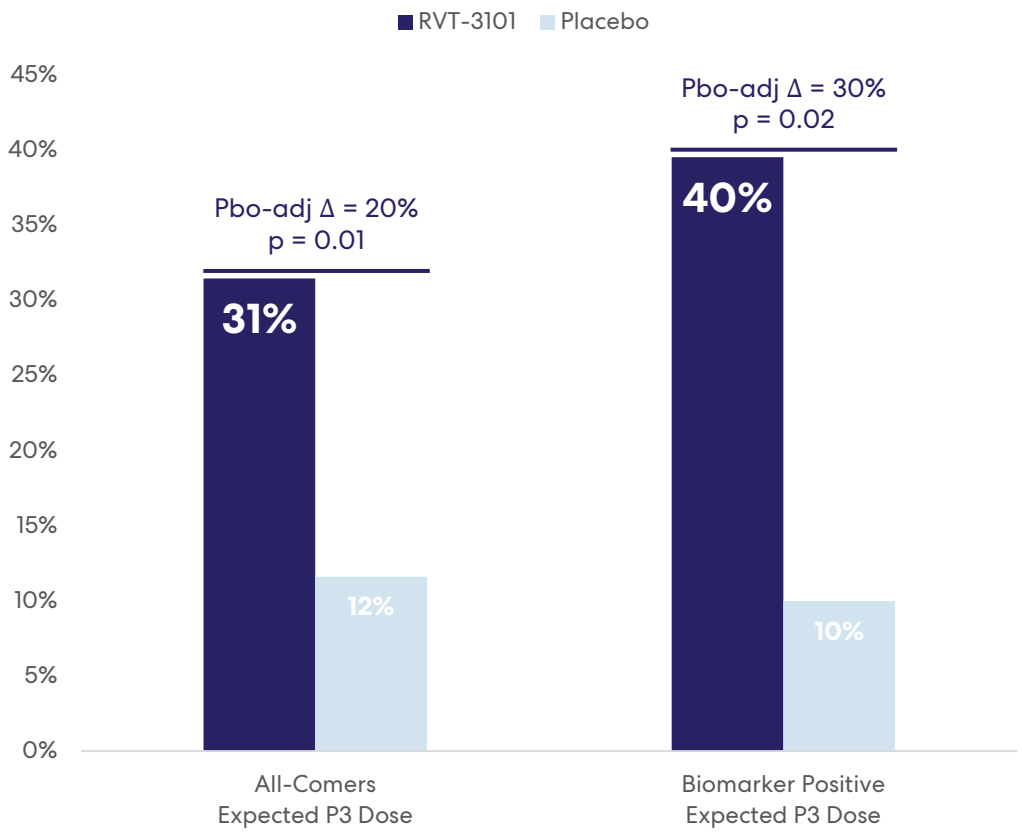
Endoscopic Improvement



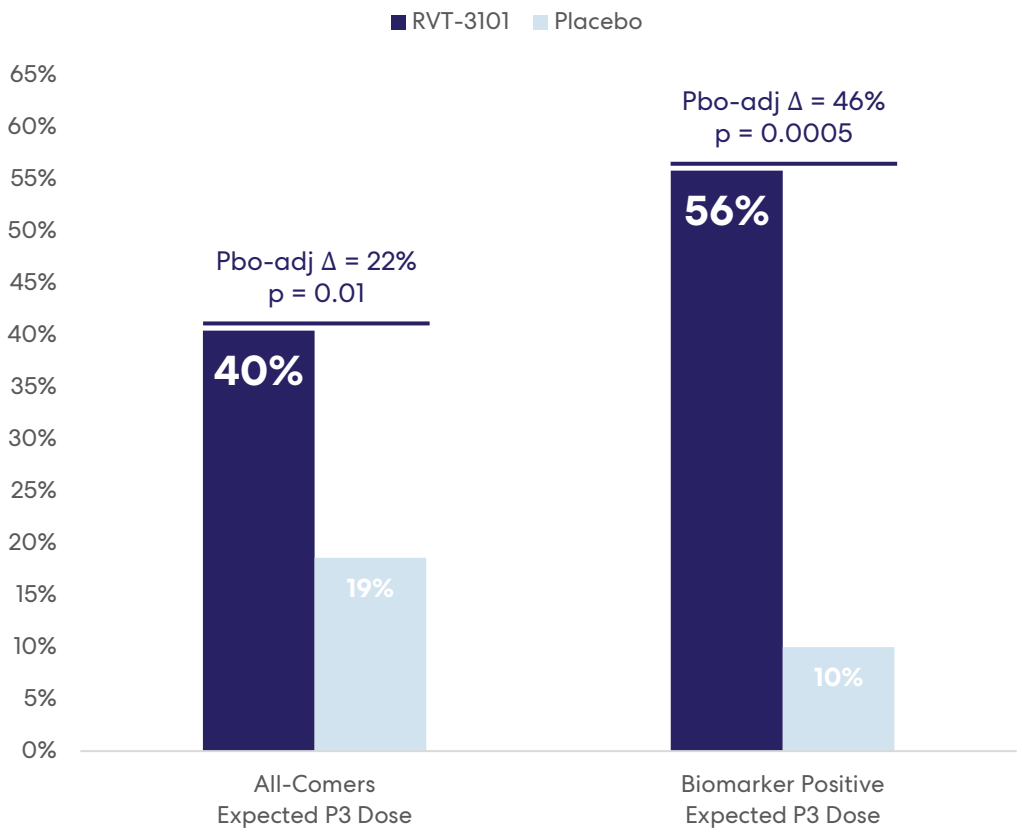
- In ~20% of patients across the study, biomarker was not analyzed due to lack of consent at specific sites
- Among patients for whom biomarker status was analyzed, biomarker positive or negative status was determined in 100% of patients
- One-sided p-value of difference of proportions were computed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

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

Clinical Remission (Modified Mayo)

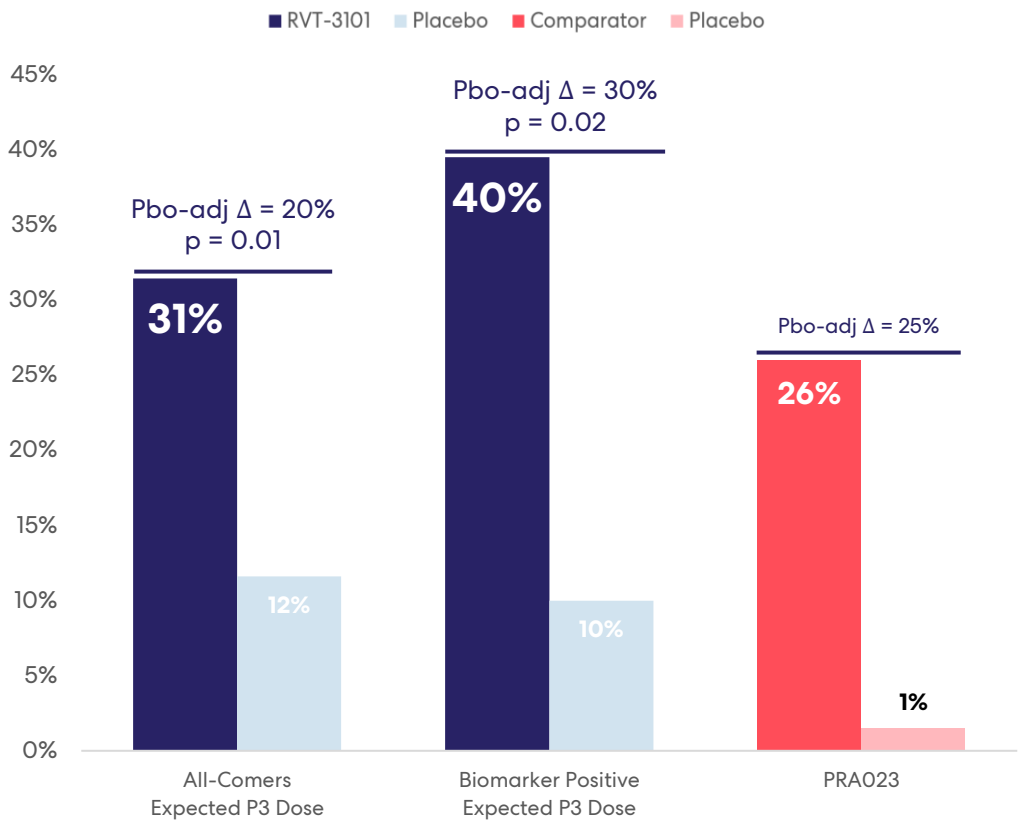


Endoscopic Improvement

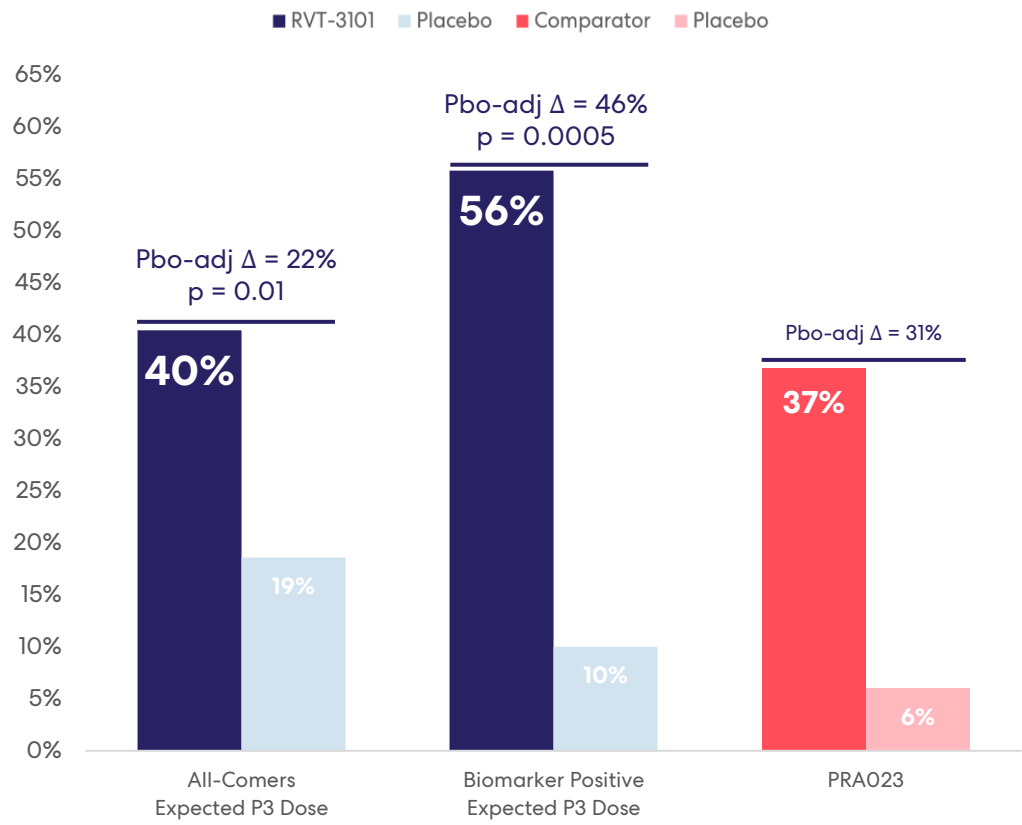


Consistent Data Supports Highly Compelling Clinical Activity for TL1A Class

Clinical Remission (Modified Mayo)



Endoscopic Improvement



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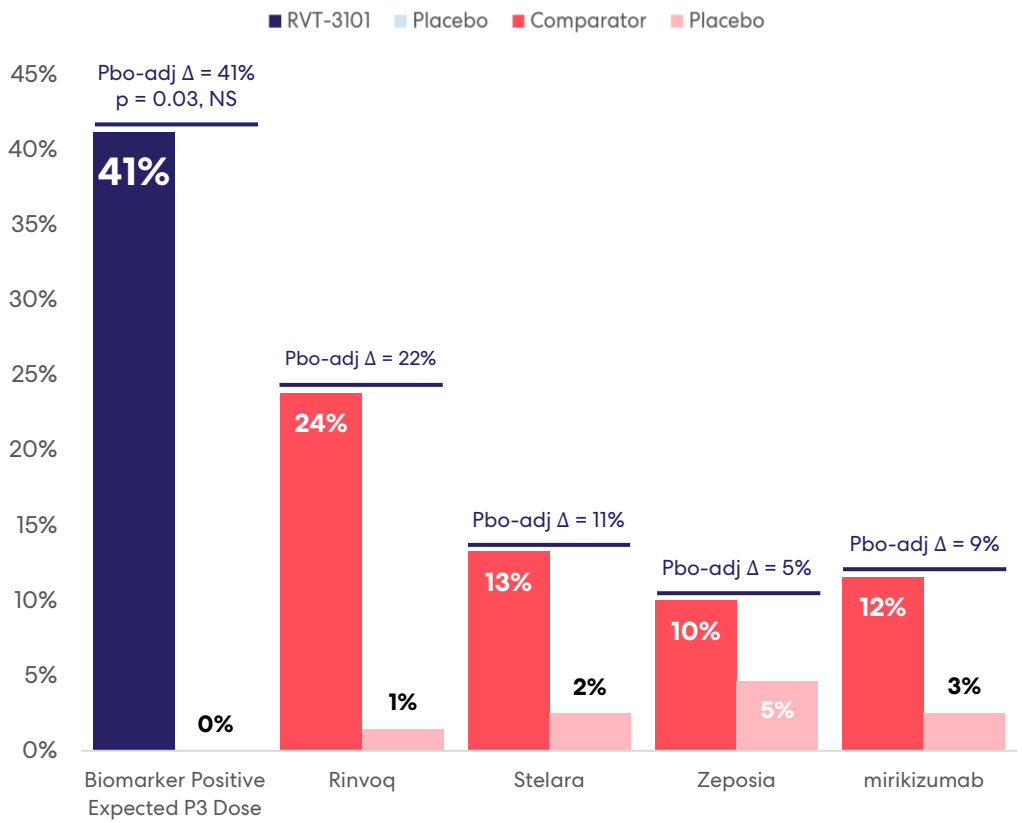
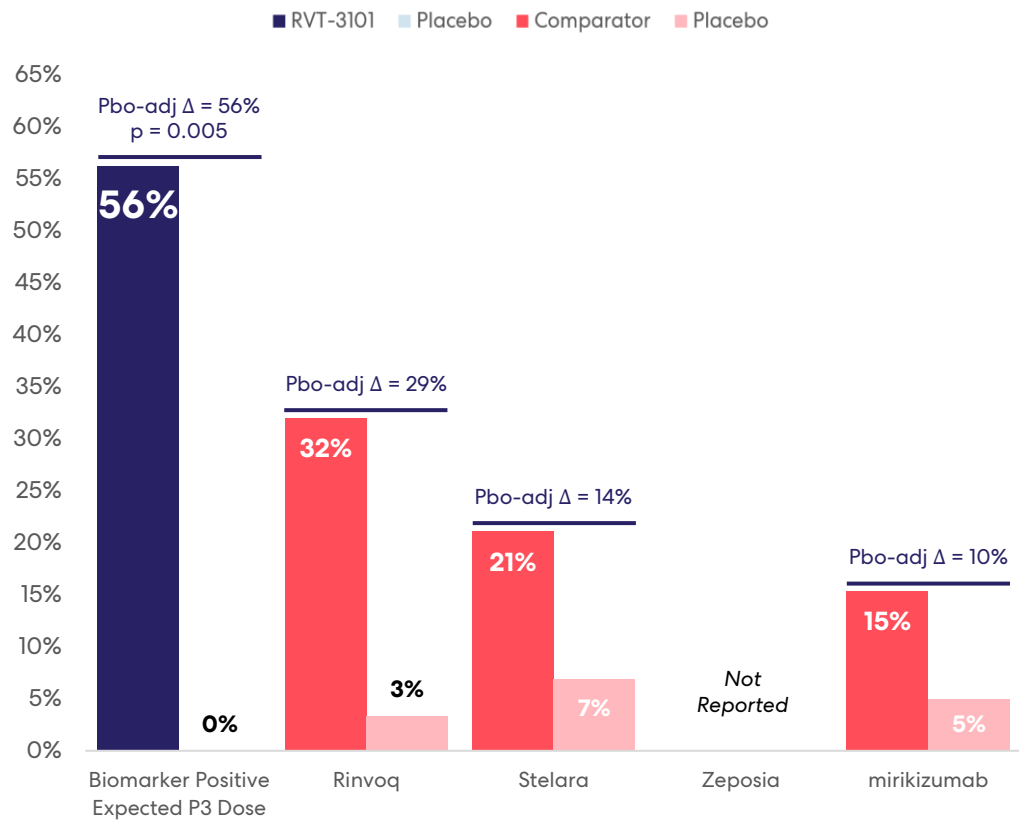
- Clinical Remission reported for RVT-3101 requires stool frequency ≤ 1 and ≥1 point reduction from baseline, rectal bleeding frequency = 0, and endoscopic score ≤ 1
- Clinical Remission reported for PRA023 requires stool frequency ≤ 1 and ≥0 point reduction from baseline, rectal bleeding frequency =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

RVT-3101 Offers Transformative Potential in Biologic-Experienced Patients who are Biomarker Positive

Clinical Remission (Modified Mayo) in Biologic-Experienced Patients



Endoscopic Improvement in Biologic-Experienced Patients



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. Data for comparators come from respective Phase 3 studies except for mirikizumab where Phase 2 data are presented (biologic-experienced subset not reported in Phase 3)

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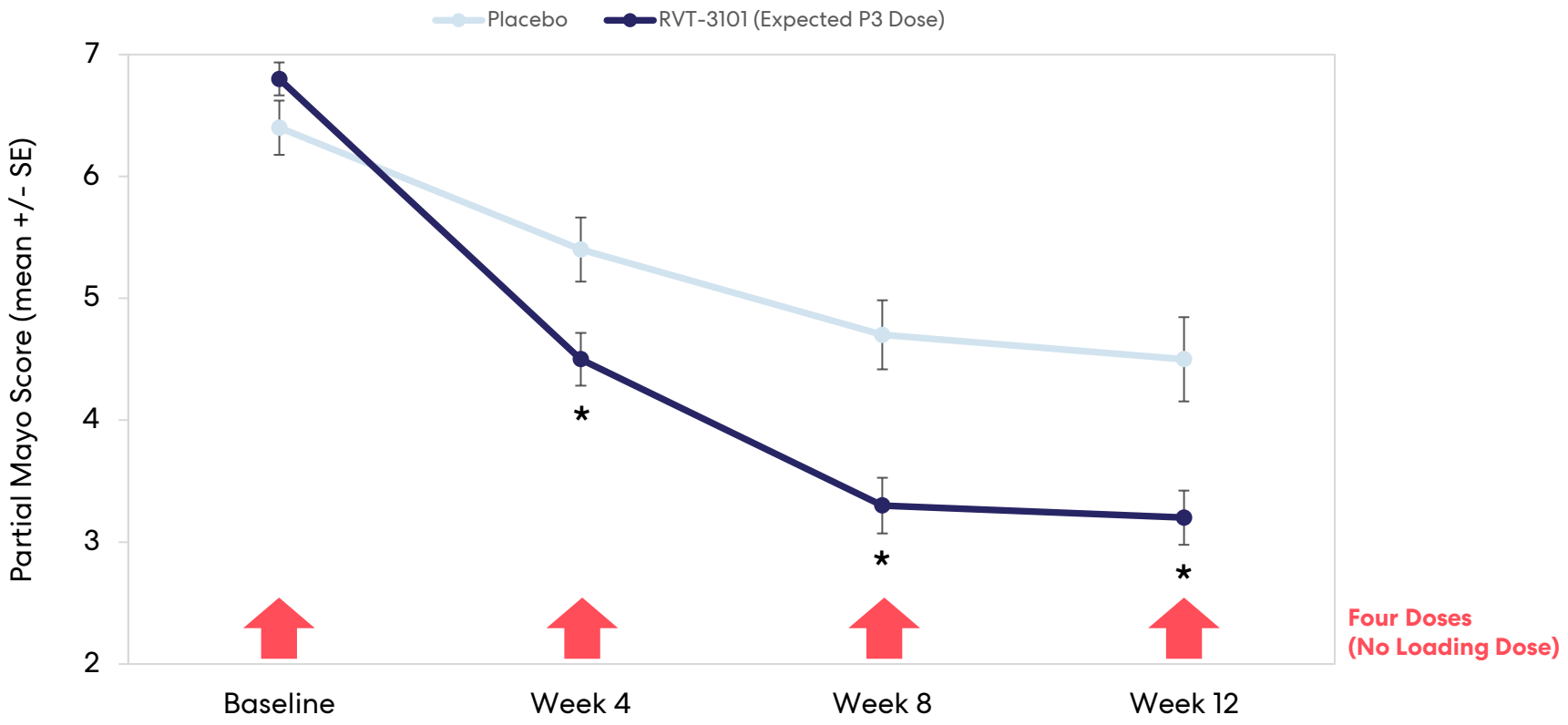
- Clinical Remission reported for RVT-3101 requires stool frequency ≤ 1 and ≥1 point reduction from baseline, rectal bleeding frequency = 0, and endoscopic score ≤ 1
- Clinical Remission reported for Rinvoq requires stool frequency ≤ 1 and ≥0 point reduction from baseline, rectal bleeding frequency = 0, and endoscopic score ≤ 1
- Clinical Remission reported for Stelara requires stool frequency ≤ 3, rectal bleeding frequency = 0, and endoscopic score ≤ 1
- For RVT-3101, some biologic experienced patients had also received a JAK inhibitor. Rinvoq data exclude patients with prior JAK exposure and reflect weighted average across the two Phase 3 studies. Mirikizumab data reflect weighted average of 200mg/600mg dose groups in their Phase 2 study.

RVT-3101 Shows Rapid Reduction in Symptoms at Earliest Time Point Measured

Change in Partial Mayo Score



P-value ≤ 0.0003 at all post-baseline time points

RVT-3101 Was Well-Tolerated With No Safety Signals Identified in Ongoing Phase 2b Study

	Pbo N = 45	Pooled N = 200	Expected Ph3 Dose
Participants with AEs	56%	45%	53%
Participants with severe AEs	7%	2%	2%
Participants with serious AEs	7%	4%	3%
Participants discontinued study due to AEs	0%	0%	0%
Participants discontinued study drug due to AEs	4%	1%	1%
Participants with dose reduced or temporary discontinuation due to AEs	0%	0%	0%
Deaths	0%	0%	0%
Most Common AEs / AEs of Interest			
Infection and Infestations	9%	10%	9%
Anemia	9%	4%	2%
Injection Site Reaction	2%	5%	5%
COVID-19	2%	1%	1%

- The most common treatment emergent AEs were infections, anemia and injection site reactions, which were balanced across arms
- There were no dose-related trends for AEs; severe and serious AEs were sporadic and generally considered not related to drug
- No impact of immunogenicity on clinical efficacy or safety results
  - ADA rate of 46% and neutralizing antibody rate of 8% at expected Phase 3 dose
  - Immunogenicity results in-line with approved biologics*
    - Humira showed ADA rates of 32 – 46% and neutralizing antibody rates of 11 – 23% at week 24[1]
    - Skyrizi showed ADA rates of 19% and neutralizing antibody rates of 8% at week 16[2]

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Reflects interim results from induction period of study (through week 14). If a given patient had more than one occurrence in the same event category, only the most severe occurrence was counted. Patients were only counted once per treatment per event.
* Based on published data. No head-to-head studies were performed with approved biologics.
1. Hanauer et al 2021; Weinblatt et al 2017; Cohen et al 2019
2. Skyrizi (risankizumab) FDA Summary Basis of Approval

RVT-3101 Shows High-End Efficacy Results in TUSCANY-2

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

	Overall Population At Expected P3 Dose	Biomarker Positive Population* At Expected P3 Dose
Clinical Remission	**31%**	**40%** **41%** for biologic-experienced
Endoscopic Improvement	**40%**	**56%** **56%** for biologic-experienced

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

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* A single, prospectively defined biomarker was used in the study and was the same biomarker used in the Phase 2a study

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

		Pbo-adj. Efficacy ALL PATIENTS	Pbo-adj. Efficacy 2nd LINE AND BEYOND	OVERALL PROFILE		
				Efficacy	Safety Profile	Convenience
TNF	Humira	8%	*Not Reported*	X	X	✓
	Remicade	26%	*Not Reported*	✓	X	X
Integrin	Entyvio	12%	*Not Reported*	X	✓	X
IL-12	Stelara	13%	11%	X	✓	X
IL-12/23	Skyrizi	*UC Trial in Progress*	*N/A*	*N/A*	✓	X
JAK	Rinvoq	25%	22%	✓	X	✓
	Xeljanz	12%	12%	X	X	✓
S1P1	Zeposia	12%	5%	X	✓	✓
	Etrasimod	15%	*Not Reported*	X	✓	✓
RVT-3101 (Expected P3 dose)		All-Comers **20%** Biomarker Positive **30%**	Biomarker Positive **41%**	✓	✓	✓

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

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- Table reflects cross-trial comparison and not results from a head-to-head study. Differences exist between trial designs and subject characteristics, and caution should be exercised when comparing data across studies. RVT-3101 data and overall profile reflect results from expected P3 dose in the induction period of the Phase 2b TUSCANY-2 study
- Efficacy defined as clinical remission rate. Remicade, Humira and Xeljanz report total Mayo, while Rinvoq, Stelara and RVT-3101 report definitions as previously described
- Safety assessment reflect presence or absence of black box warnings. Convenience assessment based on route of administration and dosing regimen.

Key Highlights

First-in-class anti-TL1A Antibody

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

Well-validated path to approval into a large, growing and well-validated commercial market

- Dose ranging study in hand, removing need for dose ranging in Phase 3 program
- Leading IBD therapies have generated multi-billion annual revenues despite low response rates

Precision immunology approach creates significant upside potential

- High-end efficacy results shown in all-comer population
- A simple diagnostic test identifies the ~60% of patients who could see significantly improved benefit as "2nd line agent of choice"

Multiple avenues for additional growth

- Unique targeting of both inflammatory and fibrotic pathways leads to unique proposed indication set
- High likelihood of successful expansion into Crohn's disease, given robust data in ulcerative colitis
- Additional indications to be announced

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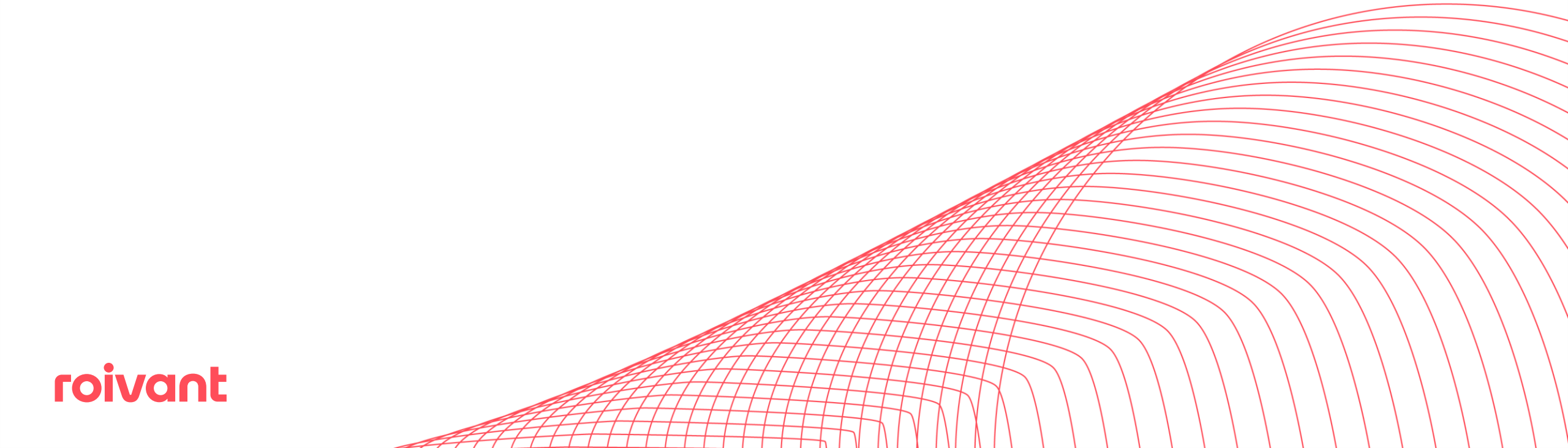
Brepocitinib



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Brepocitinib Overview

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

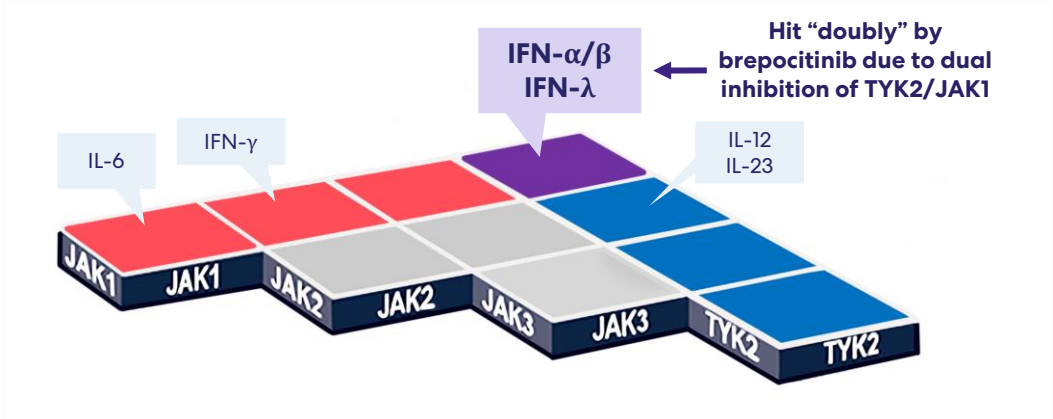
Unique, Dual-Targeting Mechanism	Robust Clinical Data	Distinctive Strategy Tailored to Novel Mechanism	Two Ongoing Registrational Programs	Strong Intellectual Property Position
Dual inhibition of TYK2 and JAK1 is expected to potentially provide **greater efficacy** than agents that inhibit either alone in multiple highly inflammatory autoimmune diseases	**Statistically significant** and clinically meaningful benefit in **all five placebo-controlled studies completed to date** (oral, once-daily) **Exposure in >1,000 subjects and patients to date**; safety profile consistent with approved JAK inhibitors	Rather than standard set of highly competitive broad market JAK indications, **pursue series of uncrowded, orphan and specialty autoimmune diseases** with highest morbidity/mortality and where we expect that **both TYK2 and JAK1 inhibition will contribute to efficacy**	**Single registrational phase 3 study in dermatomyositis initiated** **Large, global phase 2B study in lupus with enrollment complete; data anticipated in 4Q 2023** (designed to serve as one of two registrational studies) Additional indications to be announced	**Patent protection expected through ~2039**

Dual Inhibition of TYK2 and JAK1: Novel Mechanism To Address Highly Inflammatory, Severe Autoimmune Diseases

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

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

Key JAK Dimerization Combinations and Associated Cytokine Signaling Pathways[2]



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

Molecule	Isoform Selectivity	Latest Development Phase
Brepocitinib	**TYK2/JAK1**	**Phase 3**
XELJANZ (tofacitinib)	JAK1/JAK3	Approved
JAKAFI/OPZELURA (ruxolitinib)	JAK1/JAK2	Approved
OLUMIANT (baricitinib)	JAK1/JAK2	Approved
RINVOQ (upadacitinib)	JAK1	Approved
CIBINQO (abrocitinib)	JAK1	Approved
SOTYKTYU (deucravacitinib)	TYK2[3]	Approved
Ritlecitinib	JAK3/TEC	Phase 3

1. Traves et al, Ann Rheum Dis (2020)
2. Adapted from Murray et al, 2007 and Morris et al, 2018
3. Allosteric

* JAK1 is dominant, but these receptor also bind JAK2 and TYK2

** Type II

Oral Brepocitinib: Statistically Significant and Clinically Meaningful Results Across Every Completed Placebo-Controlled Phase 2 Study

Consistent, reproducible clinical benefit observed across wide range of autoimmune indications
Exposure in >1,000 subjects and patients suggests safety profile consistent with approved JAK inhibitors

Study Population	N[1]	Brepocitinib Dose	Primary Endpoint Result	Statistical Significance
Psoriatic Arthritis *Patients with active PsA*	**218**	**30 mg once daily**	**23.4% placebo-adjusted ACR20 RR at week 16**	**P = 0.0197**
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**
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**
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]**
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]**

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

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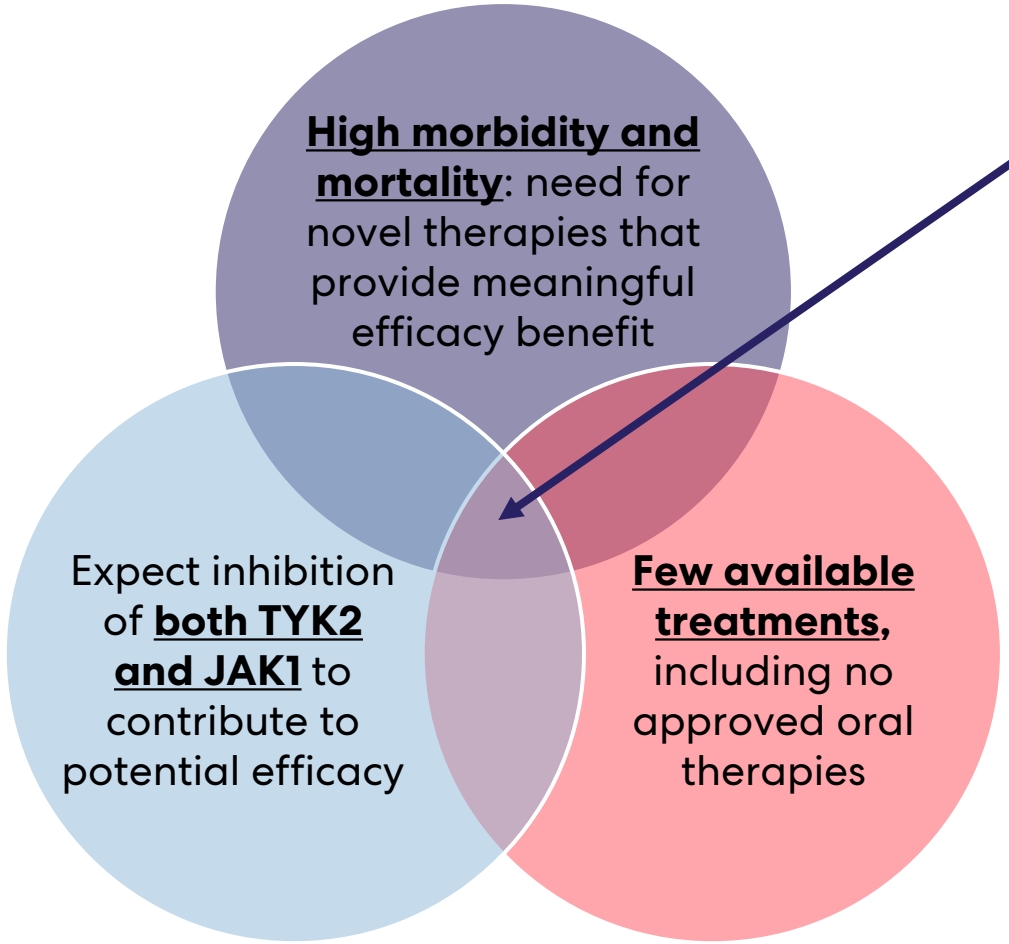
CFB: change from baseline; RR: response rate
1. Overall study N represents patients randomized to all brepocitinib dose levels or placebo and excludes patients randomized to other agents
2. Includes patients from initial 24-week study period only
3. 60 mg QD for 4 weeks followed by 30 mg QD for 20 weeks
4. One-sided p-value (pre-specified statistical analysis)
5. Brepocitinib 45 mg once daily was the only brepocitinib dose evaluated in this study
6. Jacob Pleith. Evaluate Vantage. 8/30/22

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



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

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

	DM	SLE
TYK2 and/or JAK1 Clinical Proof-of-concept	**Open-Label**	**Yes**
Drugs approved in the past 60 years*	**1**	**2**
Approved Branded Oral Drugs*	**0**	**0**
No TYK2s or JAK1s in registrational programs	✓	**Deucravacitinib only**
Biologically exquisitely suited for dual TYK2/JAK1 inhibition	✓	✓
Large unmet medical need with favorable benefit/risk	✓	✓
OVERALL OPPORTUNITY	***HIGH***	***HIGH***

*Excluding biosimilars and branded generics

Dermatomyositis: A Debilitating Inflammatory Myopathy

Dermatomyositis (DM) is a rare, chronic, immune-mediated disease of the muscles and skin affecting approximately 37,000[1] adults in the United States

Clinical Presentation and Unmet Need

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

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

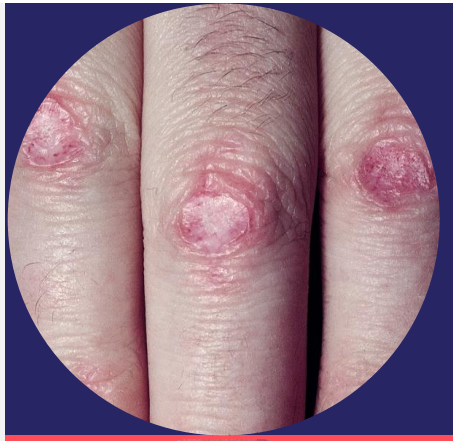
Significant mortality, estimated to be 10-40% at 5 years[2]

>60% of DM patients experience chronic disease[3], and ~30% of patients are unable to discontinue long-term steroid-based treatment due to refractory disease[4]

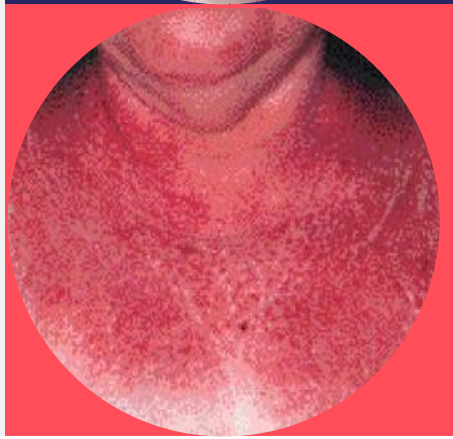
Only approved therapy (other than glucocorticoids and corticotropin) is IVIg – difficult, cumbersome administration, associated with severe side effects

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

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



Gottron's papules
Red to violaceous papules overlying the knuckles



V-sign rash
Irregular, patchy erythema on the chest

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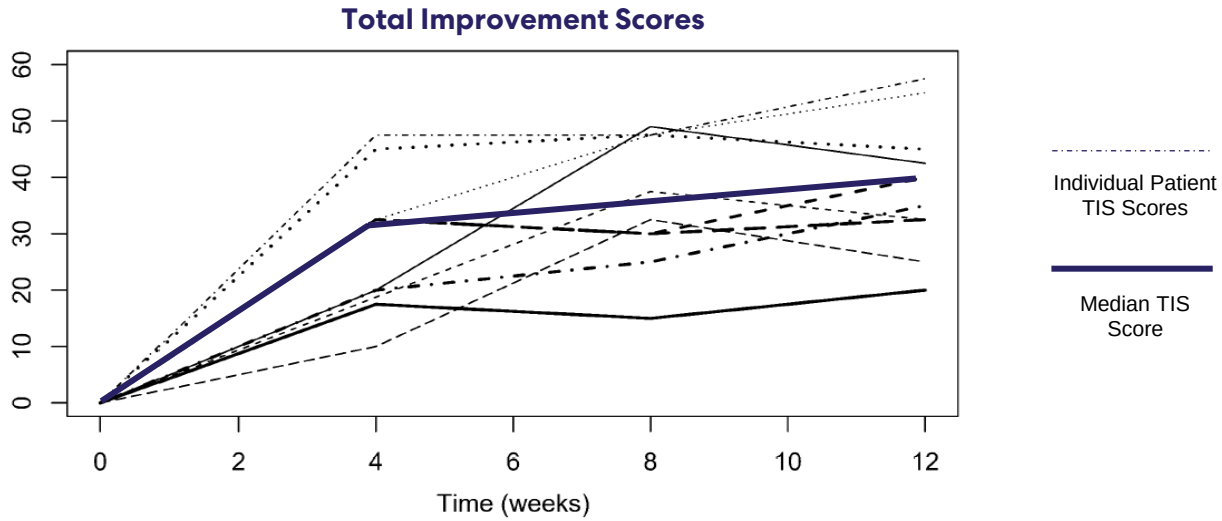
1. PriovantTx estimates based on Reeder 2010, Smoyer-Tomic 2012, and claims analysis; Syneos Health Research
2. Liu et al, *Oncol Letters* (2018)
3. Robinson et al, *Nature Reviews Rheumatology* (2011)
4. Syneos Health Research
5. Guo et al, Front Immunol (2018)

JAK1 Inhibition Is Clinically Validated In DM: Investigator-Initiated Study and Off-Label Case Reports

STIR Study in Refractory Dermatomyositis[1]

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



Dermatomyositis Case Reports

- Systematic literature review[2] identified 145 total cases of DM (n=84) and juvenile dermatomyositis (JDM) (n=61) treated with JAK inhibitors
  - Most patients were initiated on JAK inhibitors for refractory disease and had failed SOC treatment
- Key Results:
  - **Of 145 profiled subjects, 137 were considered clinical successes or responders by their respective investigators**
  - Objective and subjective improvements noted in muscle disease, skin disease, and in DM-ILD
- Where available, cross-trial comparison of clinical data in other indications for brepocitinib 30 mg QD compared with JAK inhibitors used in DM case reports suggests brepocitinib 30 mg QD may generate clinically meaningful efficacy in DM

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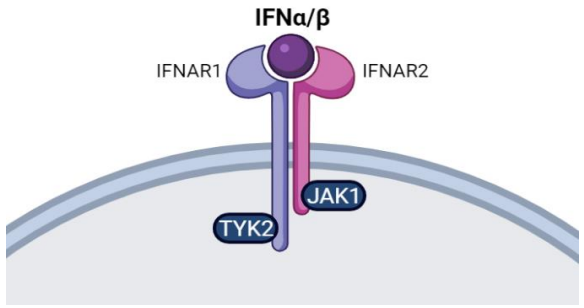
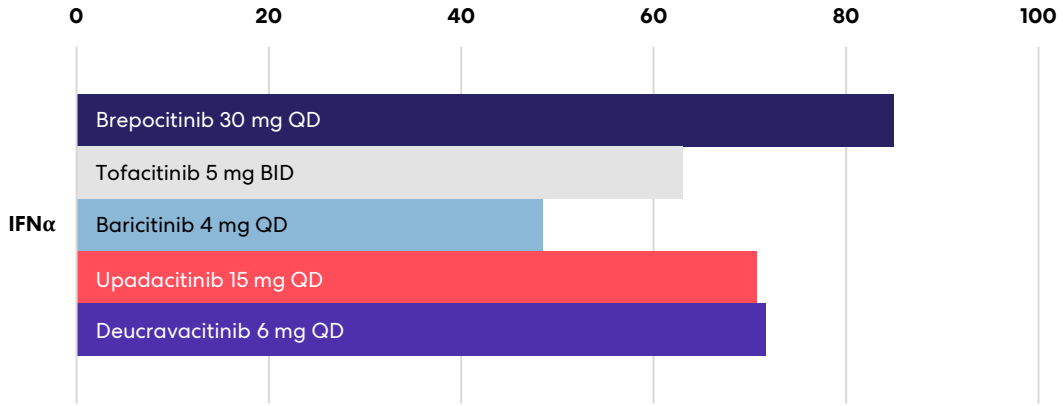
1. Paik et al 2020
2. Paik et al, Clin Exp Rheum 2022 (in press)

Dual Inhibition Of TYK2 and JAK1 Provides Optimized Suppression of Type 1 IFN and Other Pathogenic Cytokines in Dermatomyositis

Type I IFN is the key pathogenic cytokine in dermatomyositis[1]; its signaling is mediated by the dual activity of TYK2 and JAK1[2]

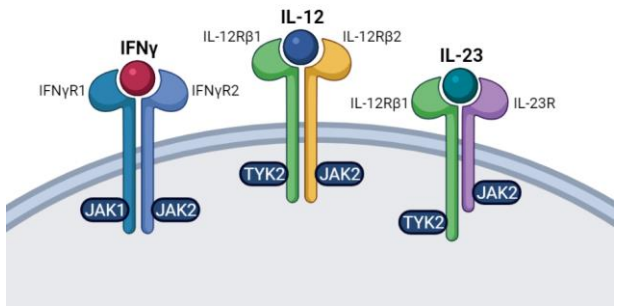


Percent Cytokine Inhibition at Modeled Exposures[3]

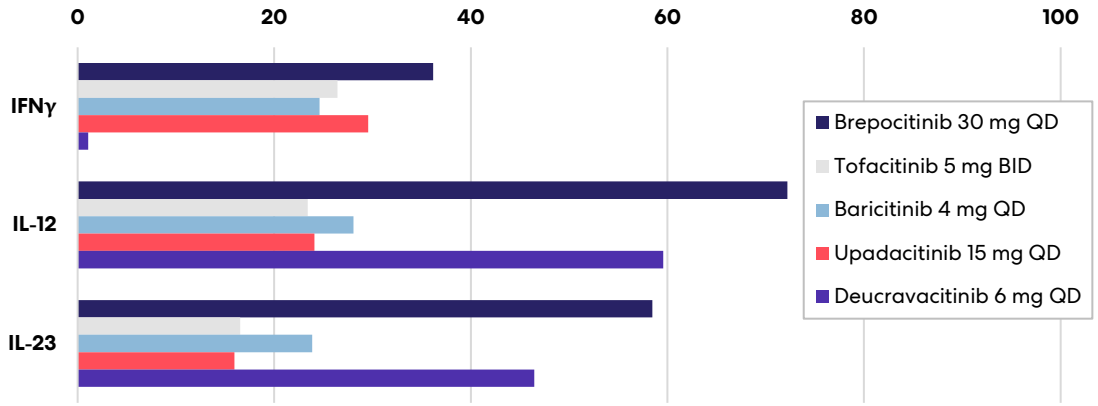


Cross-study comparisons with different assay conditions.

IFNγ, IL-12, and IL-23 also contribute to dermatomyositis[4]; their signaling is mediated by JAKs inhibited by brepocitinib



Percent Cytokine Inhibition at Modeled Exposures[3]



Cross-study comparisons with different assay conditions.

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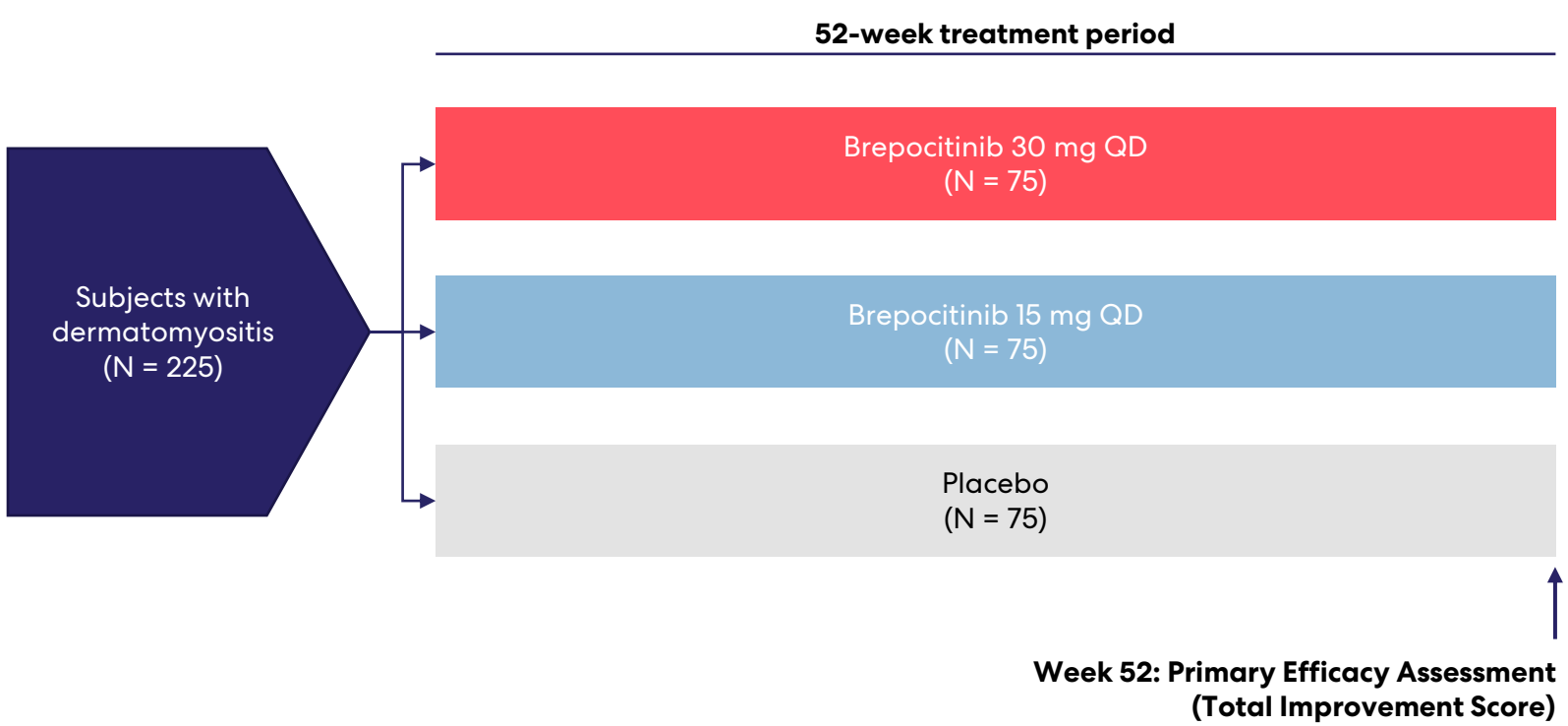
1. Pathogenic role of type I IFN in DM: Wong et al, 2012, Greenberg, *Curr Opin Rheum* 2010, Greenberg et al, *Genes Immun* 2012, Huard et al, *Br J Dermatol* 2017, Ladislau et al, *Brain* 2018, Li et al, *J Immunol* 2013; 2. Li et al, *J Immunol* 2013. 3. Calculations based on modeling approach described in Dowty et al, Pharmacol Res Perspect (2019), estimated ICxx (% levels of cytokine inhibition), calculated at various therapeutic dose levels. Brepocitinib source data: Brepocitinib Investigator's Brochure; Priovant data on file. Tofacitinib source data: Dowty et al, *Pharmacol Res Perspect* 2019; Dowty et al, *J Pharmacol Exp Ther* 2013. Baricitinib source data: Dowty et al, *Pharmacol Res Perspect* 2019. Upadacitinib source data: Dowty et al, *Pharmacol Res Perspect* 2019; EMA Risk Assessment Report – RINVOQ (June 2021). Deucravacitinib source data: Priovant data on file; Chimalakonda et al, *Dermatol Ther* 2021; Wrobleski et al, *J Med Chem* 2019; 4.Pathogenic role of IFNγ in DM: Giris et al, *In Vivo* 2017, Ishikawa et al, *Arth Res Ther* 2018; Pathogenic role of IL-12 and IL-23 in DM: Ishikawa et al, Arth Res Ther 2018, Shen et al, Scand J Rheum 2011, Tournadre et al, Arth Rheum 2012, Umezawa et al, Sci Reports 2018

Single Phase 3 Study in Dermatomyositis

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



Eligible Patients

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

Primary Endpoint

- Mean Total Improvement Score (TIS) at Week 52

Secondary Endpoints

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

Safety Endpoints

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

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

SLE: A Heterogeneous Connective Tissue Disease

SLE is a chronic autoimmune disease characterized by elevated levels of proinflammatory cytokines, autoantibodies, and autoreactive cell types that affects up to 300,000[1] people in the United States

Clinical Presentation and Unmet Need

SLE affects predominantly women[2] and can result in symptoms in nearly all major organ systems; skin and musculoskeletal manifestations are most common[3]

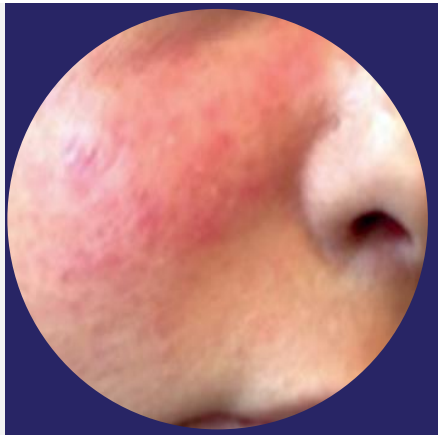
10- and 15-year mortality is estimated to be 9 and 15%, respectively[4]

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

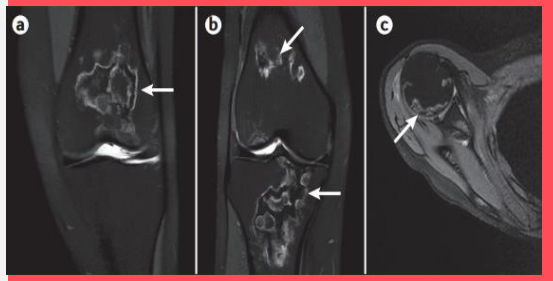
- Benlysta (belimumab) 2021 net revenue >$1B, despite modest efficacy (SRI-4 PBO adjusted delta of 10-14%)[6]
- Saphnelo (anifrolumab) was approved by FDA despite outright failure of one of two Phase 3 trials[7]

Despite two approved biologics, many treated patients will fail to achieve response/remission (particularly those with moderate/severe disease)[8]

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



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



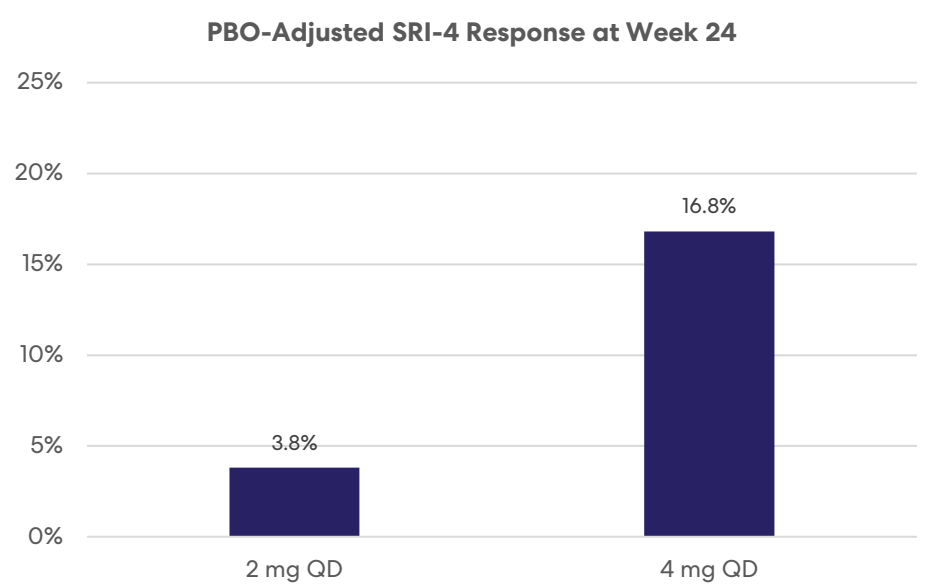
Osteonecrosis of knees and shoulder
Complication of long-term OCS use in SLE

Images adapted from Kaul et al (2016)
1. Centers for Disease Control
2. Weckerle et al, Clin Rev Allergy Immunol (2011)
3. Kaul et al, Nat Rev Dis Primers (2016)
4. Kasitanon et al, Medicine (2006)
5. GSK Annual Report FY 2021
6. Wise and Stohl, Exp Opin Drug Safety 2019
7. Saphnelo Package Insert
8. Strand et al, Abstract 1077; ACR 2014

JAK1 or TYK2 inhibition in SLE: Each with Signs of Efficacy, but With Meaningful Room for Improvement

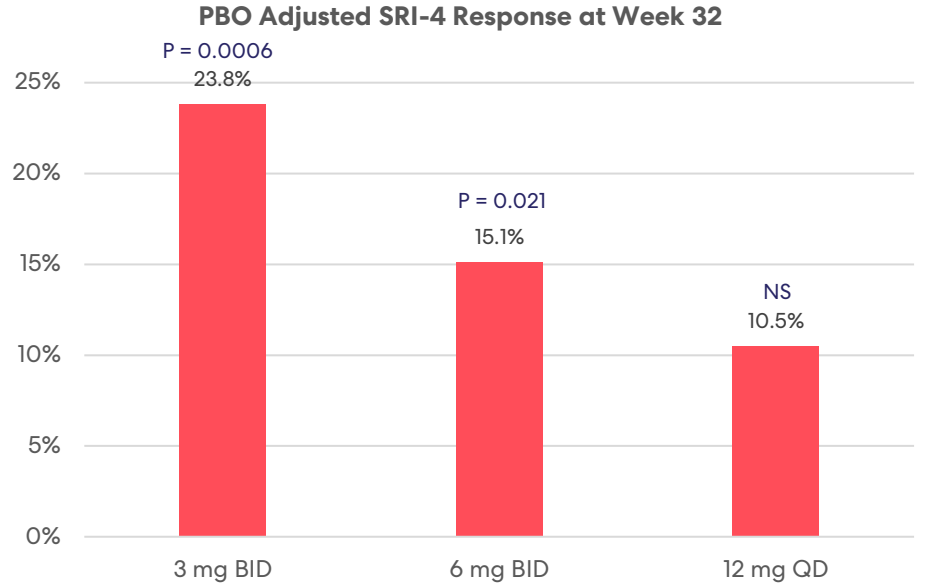
Baricitinib and deucravacitinib PoC studies established therapeutic relevance of JAK1 and TYK2 inhibition, respectively, while also highlighting need for more potent agents

Phase 2 Study of Baricitinib in SLE[1]



One of two phase 3 confirmatory studies achieved statistically significant efficacy on primary endpoint of SRI-4 at Week 52, with 10.8% (PBO-adjusted, p = 0.016) of patients who received 4 mg QD achieving response[2]

Phase 2 Study of Deucravacitinib in SLE[3]



Primary endpoint of SRI-4 response at Week 32 was met at 3 mg BID (p = 0.0006) and 6 mg BID (p = 0.021) dose levels; 12 mg QD did not achieve significance (p = 0.078)

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1) Wallace et al, The Lancet (2018)
2) EULAR 2022 Poster POS0190
3) EULAR 2022 Abstract LB0004

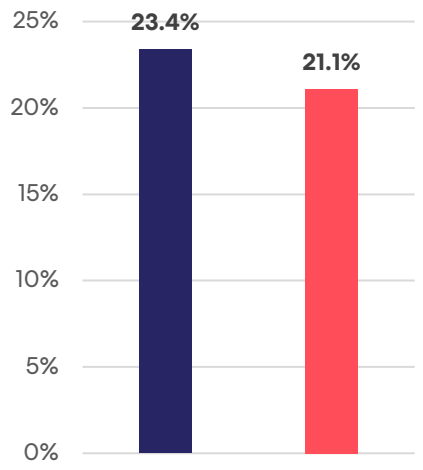
Brepocitinib Potential For Greater Efficacy: Clinical And Biological Rationale

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

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

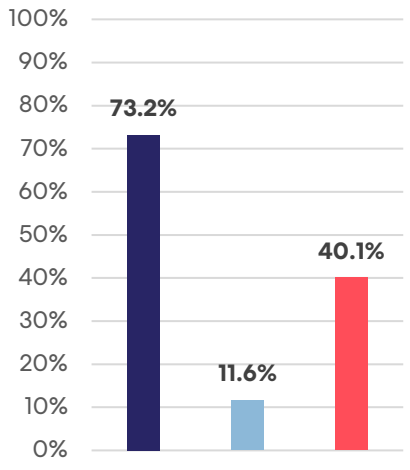
Psoriatic Arthritis

Placebo-Adjusted ACR20 Response Rate at 16W



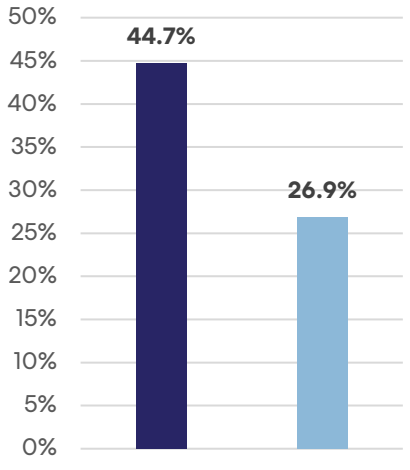
Plaque Psoriasis

Placebo-Adjusted PASI75 Response Rate at 12W



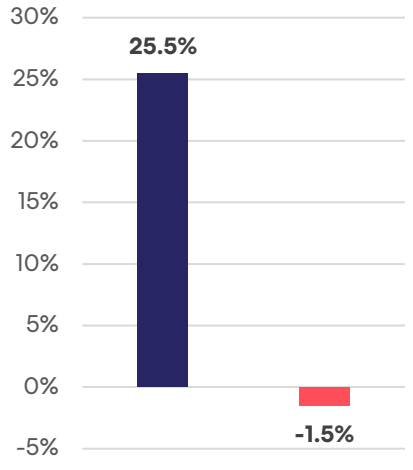
Alopecia Areata

Placebo-Adjusted SALT ≤ 20 Response Rate at 24W



Ulcerative Colitis

Placebo-Adjusted Modified Remission Rate



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

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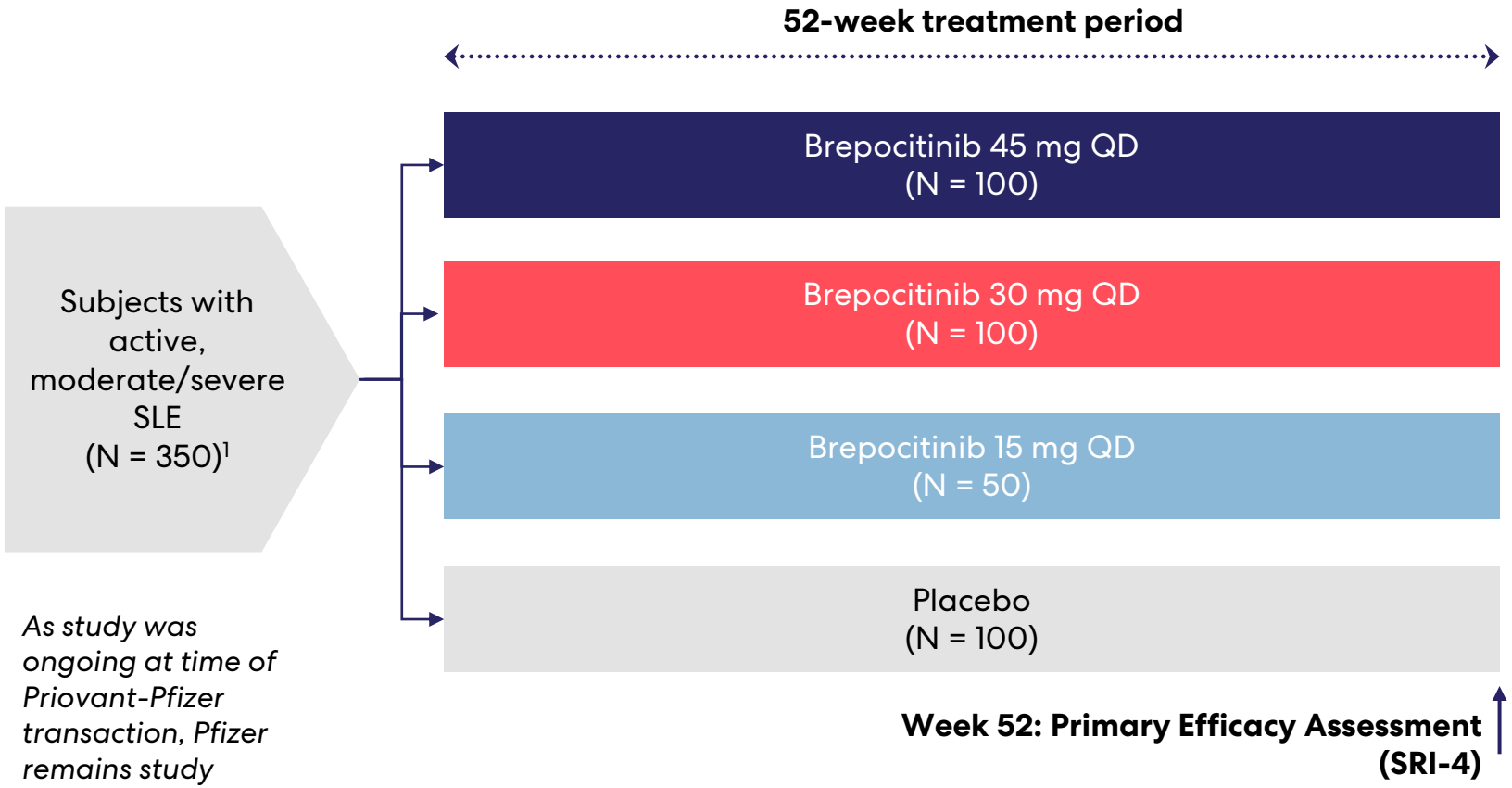
Psoriatic Arthritis: brepocitinib 30 mg QD (Phase 2B – 16W) vs. deucravacitinib 6 mg QD (Phase 2 – 16W, NCT03881059)
Plaque Psoriasis: brepocitinib 30 mg QD (Phase 2 – 12W) vs. baricitinib 4 mg QD (Phase 2B – 12W, NCT01490632) vs. deucravacitinib 6 mg QD (Phase 3 POETYK-PSO-2 – 12W, NCT03611751)
Alopecia Areata: brepocitinib 60 mg QD→30 mg QD (Phase 2 – 24W) vs. baricitinib 4 mg QD (Phase 3 BRAVE-AA2 – 24W, NCT03899259)
Ulcerative Colitis: brepocitinib 30 mg QD (Phase 2B – 8W) vs. deucravacitinib 6 mg BID (Phase 2 LATTICE-UC – 12W, NCT03934216)

Note: where more than one value is available for a competitor molecule (e.g., in the case of two Phase 3 studies), the higher value was selected for comparison to brepocitinib

Ongoing Global Phase 2B Study in SLE – Designed To Serve As One Of Two Registrational Studies

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



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

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

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

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

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

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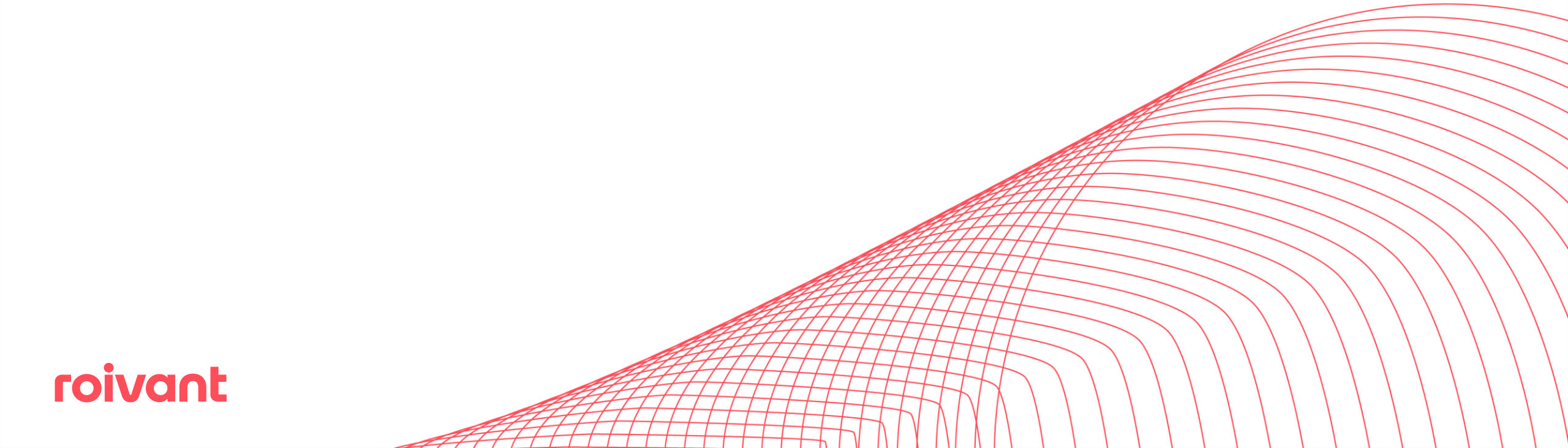
1. Final sample size is subject to an ongoing protocol amendment.

Anti-FcRn Franchise: Batoclimab and IMVT-1402



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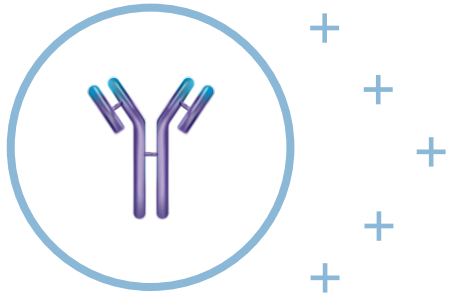
Anti-FcRn Franchise Overview

Batoclimab

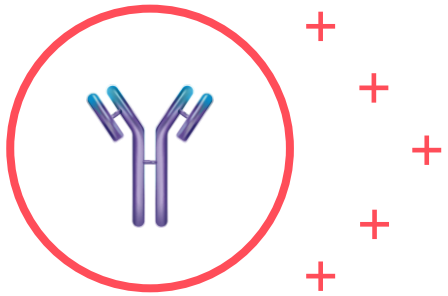


Tailored dosing to address varying symptom severity across indications and stage of disease

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

Multiple pivotal trials ongoing in MG, TED and CIDP

IMVT-1402



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

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

Pivotal-enabling catalyst in 2023: IMVT-1402 initial Phase 1 data expected in mid-2023

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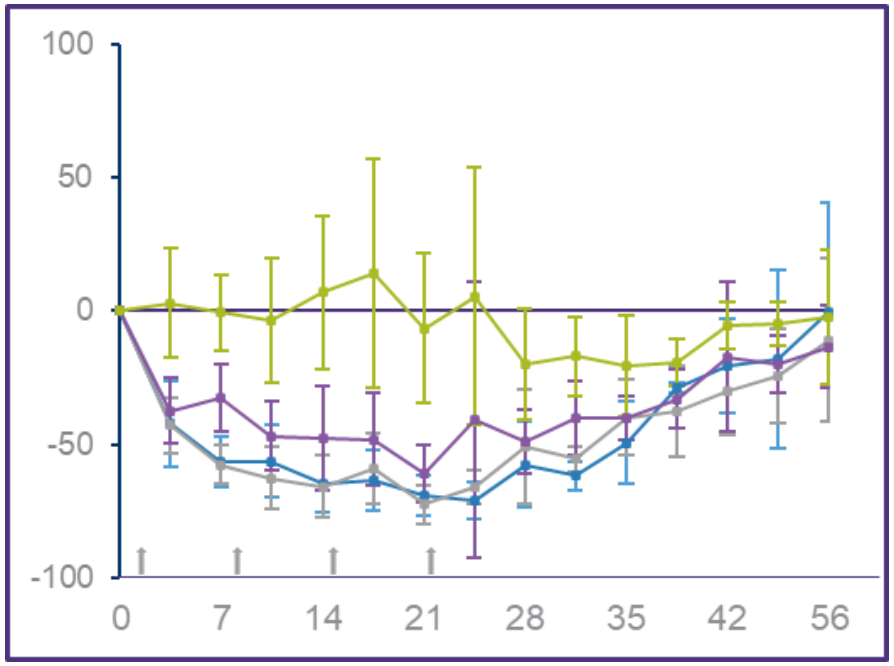
1. Potential outcomes if Phase 1 results are as predicted by pre-clinical studies in cynomolgus monkeys

IMVT-1402 and Batoclimab Each Demonstrated Rapid and Deep IgG Reduction

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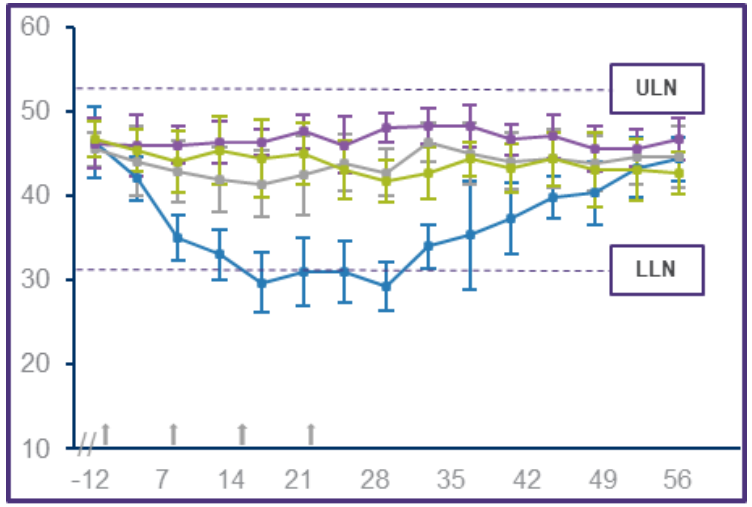
1. Lledo-Garcia, et al, Pharmacokinetic-pharmacodynamic modelling of the anti-FcRn monoclonal antibody rozanolixizumab: Translation from preclinical stages to the clinic, UCB Pharma, 2022.
2. Data on file at Immunovant

IMVT-1402 and Placebo Demonstrated Similar Albumin and LDL

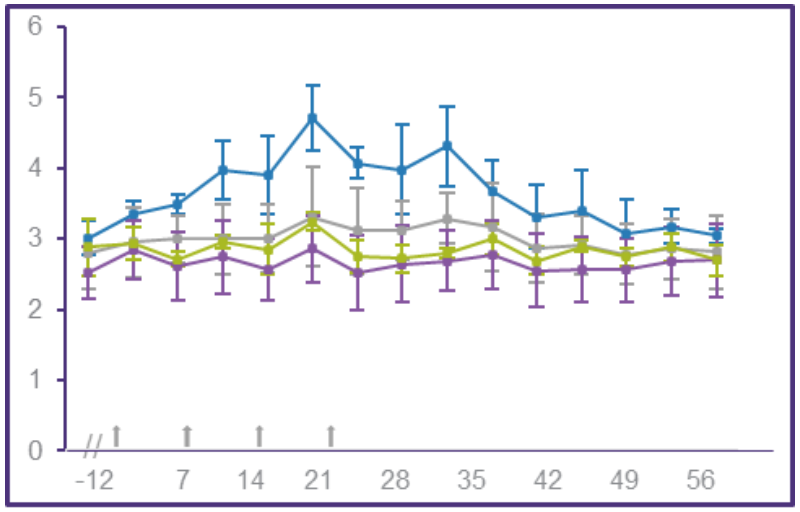
Head-to-Head Monkey Study

Albumin concentration (g/L), mean ± SD



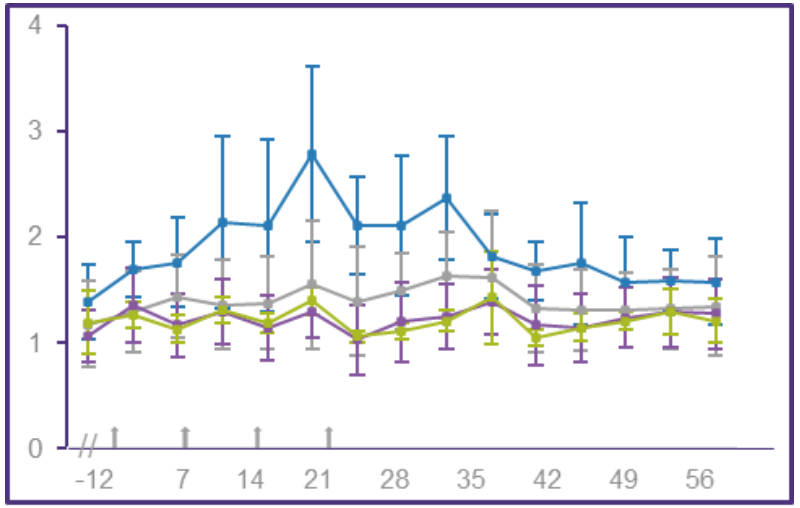
Day

Cholesterol concentration (mmol/L), mean ± SD



Day

LDL concentration (mmol/L), mean ± SD



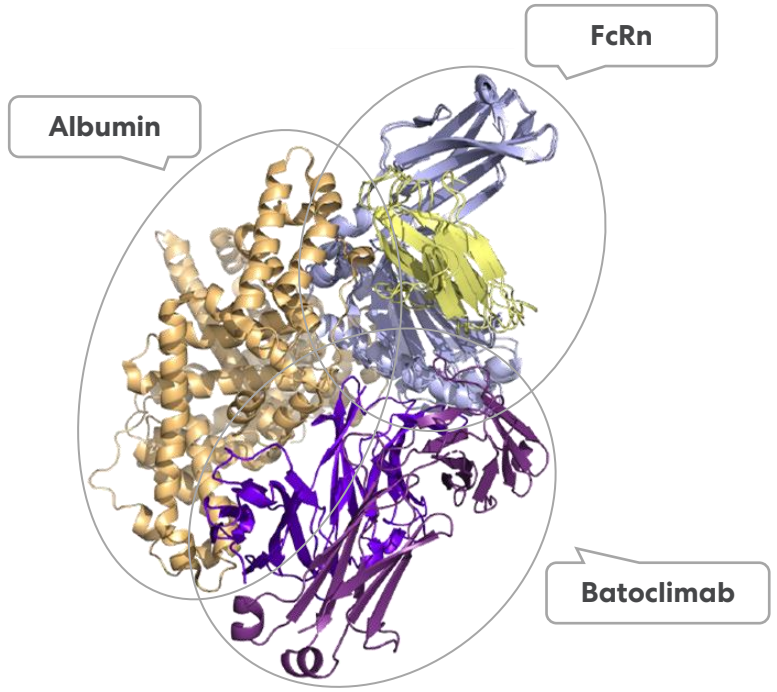
Day

- 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

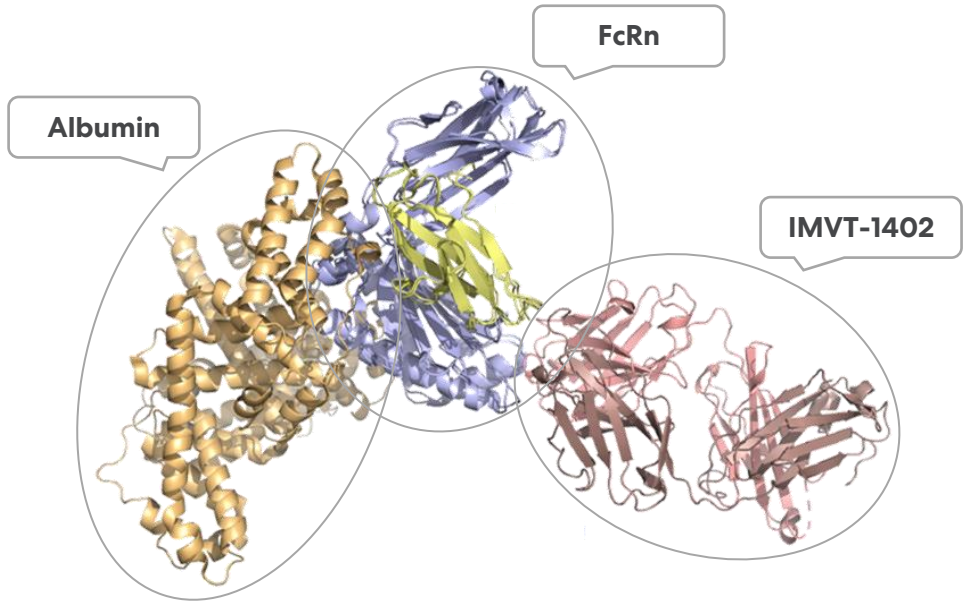
SD, standard deviation; ULN, upper limit of normal; LLN, lower limit of normal; Arrows indicate time of dosing.
Data on file at Immunovant

IMVT-1402 Is Designed to Deliver Maximum IgG Reduction While Minimizing Interference with the Albumin Binding Site

Batoclimab



IMVT-1402



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

Impact on Albumin Observed in Non-Human Primates Has Been Highly Translatable to Humans

Strong evidence observed across multiple anti-FcRn agents

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 *(J&J)*	• Data not published • Management's public commentary has 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 modest / minor reductions in albumin levels from baseline[8]	• Phase 1 reported a modest decrease in albumin levels from baseline for both IV and SC[9]
Batoclimab *(Immunovant)*	• Reported reduction in albumin levels from baseline	• Phase 2 reported a decrease in albumin levels from baseline
IMVT-1402 *(Immunovant)*	• No impact on albumin levels observed from baseline (same as placebo)	• Phase 1 data readout in mid-2023

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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 et.al, 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

Batoclimab and IMVT-1402 Have the Potential to Offer Multiple Differentiated Product Features, if Approved

		Immunovant Franchise	
Product and program attributes	**efgartigimod[1]**	**batoclimab**	**IMVT-1402[2]**
IgG reduction ~65%	X	X	X
IgG reduction ~80%		X	X
Albumin/LDL changes: none or minimal	X		X
Subcutaneous (SC) formulation delivered in seconds		X	X
Chronic dosing to achieve ~65%	X	X	X
Chronic dosing to achieve ~65% with SC in seconds		X	X
Chronic dosing to achieve ~80% with SC in seconds			X
Induction and maintenance dosing[3]	N/A, requires high dose	**MG Ph 3, CIDP**	**Possible**
Fixed duration dosing	**Possible**	**TED Ph 3**	**Possible**
Chronic higher dosing (with saturating dose)	N/A, requires high dose	Not planned	**Possible**
As needed cyclic dosing	X	Not planned	Not planned

Key product candidate advantages favor batoclimab and IMVT-1402	**efgartigimod[1]**	**batoclimab**	**IMVT-1402[2]**
	1. No Albumin/LDL changes 2. Exclusive Halozyme partnership	1. Deeper IgG reduction with 680 mg 2. SC delivery in seconds	1. 680 mg-like IgG reduction 2. SC delivery in seconds 3. Minimal Albumin/LDL change

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1. Source: Argenx Corporate Presentation, June 2022
2. Potential outcomes if Phase 1 results are as predicted by pre-clinical studies in cynomolgus monkeys
3. Induction refers to starting with saturating dose that can achieve ~80% IgG reduction

FcRn Inhibition has Broad Potential in Autoimmune Diseases

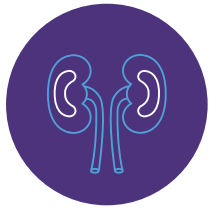
19 Announced Indications[1] Across Multiple Therapeutic Areas Create Clinical and Commercial[2] Opportunity for a Franchise Approach

NEUROLOGY

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

ENDOCRINOLOGY

Thyroid eye disease (TED)
Graves' disease



RENAL

Membranous nephropathy
Lupus nephritis

HEMATOLOGY

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

RHEUMATOLOGY

Primary Sjogrens syndrome
Systemic lupus erythematosus
Rheumatoid arthritis

DERMATOLOGY

Bullous pemphigoid
Pemphigus foliaceus
Pemphigus vulgaris
Cutaneous lupus erythematosus

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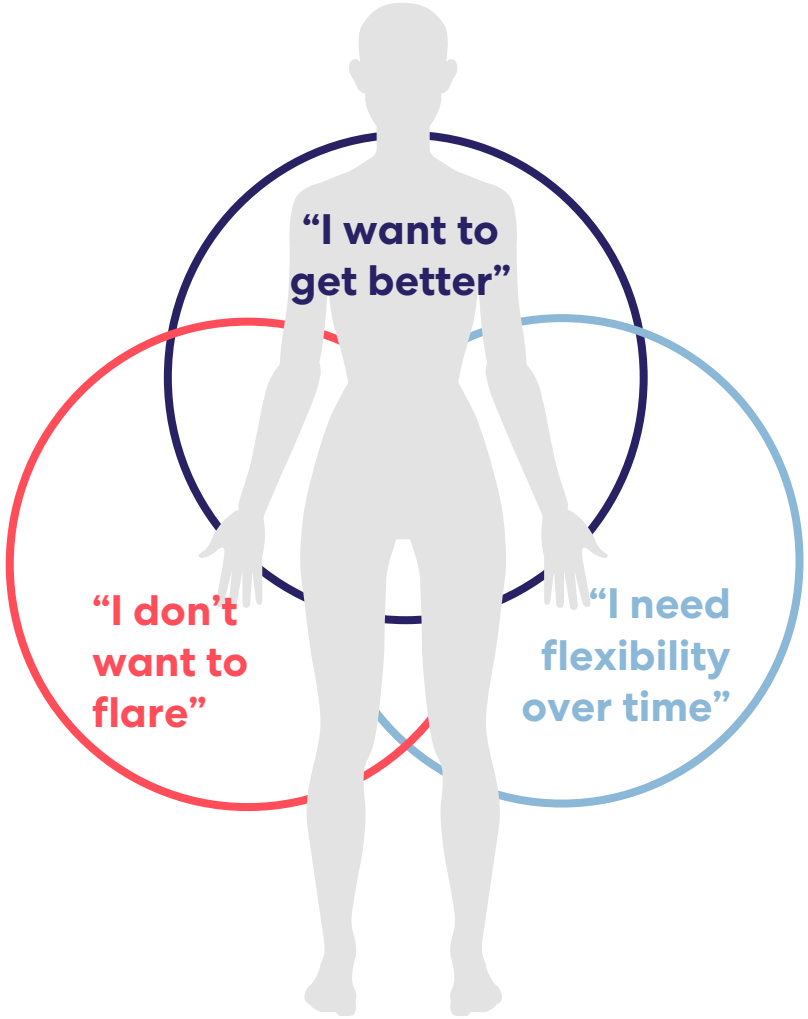
1. Indications announced or in development with anti-FcRn assets by Immunovant, Argenx, JNJ, and UCB
2. If approved by regulatory authorities

Phase 3 trial in MG is Designed to Address Unmet Patient Needs and Differentiate Batoclimab

Need for significant improvement initially:
High doses included in the induction period to achieve maximum efficacy at the beginning of treatment

Peace of mind over time:
Chronic treatment to provide consistent symptom relief while lowering the dose to maintain efficacy with potentially fewer side effects

Flexible dosing to match disease fluctuations:
Myasthenia gravis waxes and wanes over time; clinicians and patients desire a data-driven approach to optimize care over time



MG Phase 3 Trial Design

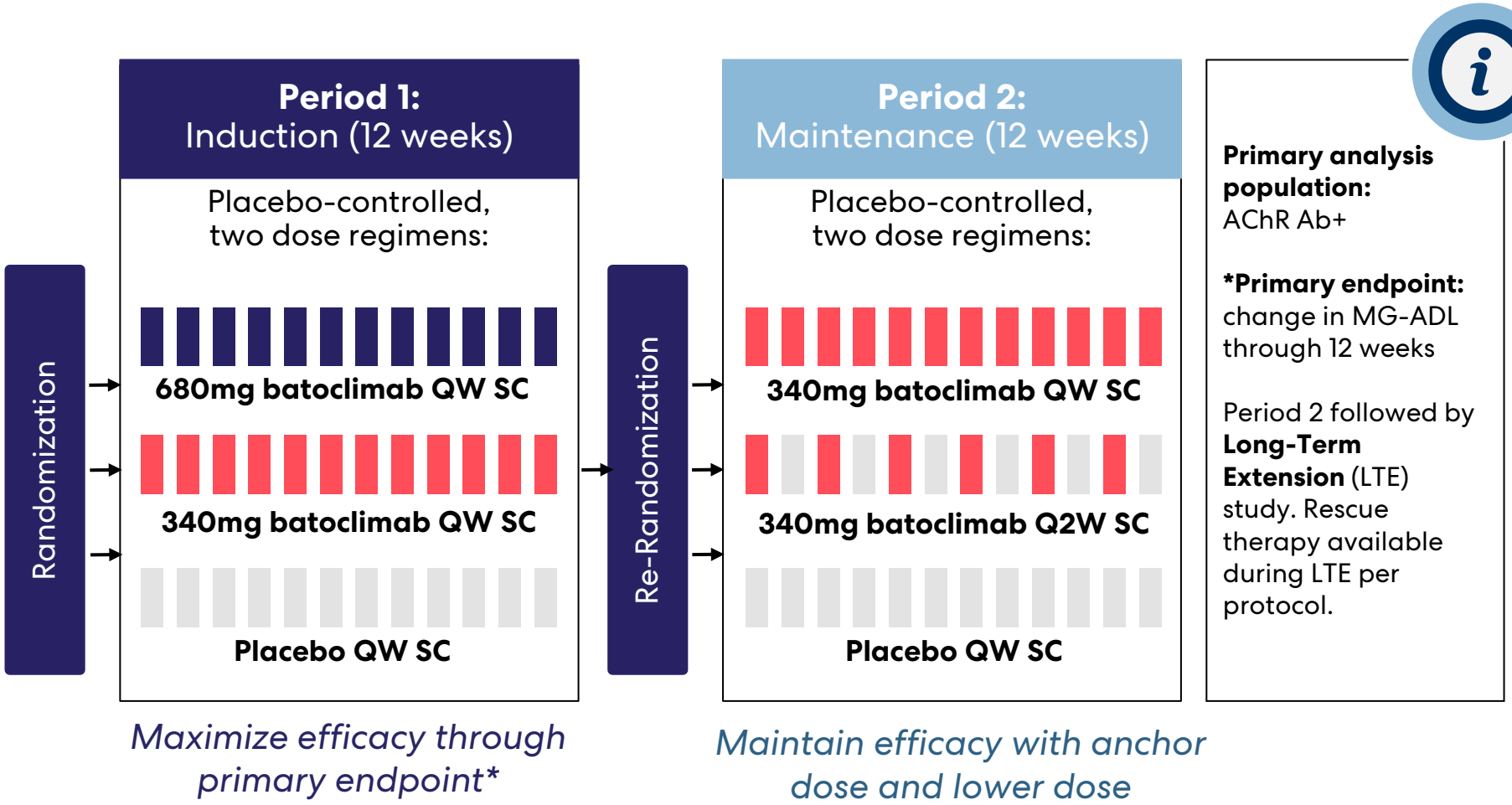
Inclusion criteria:

- Subjects with **MGFA class** II-IVA MG
- Subjects with wide range of severity (baseline **MG-ADL** score of 5 or more)
- **AChR Ab+ and AChR Ab-** patients
    - *Primary endpoint analysis excludes AChR Ab- patients*

Exclusion criteria:

- Subjects with baseline LDLs greater than 190
- Subjects with a history of cardiovascular disease that have an LDL greater than 160
- Subjects with a cardiovascular event within the prior 6 months

N = 210



QW = weekly; Q2W = bi-weekly; SC = subcutaneous injection; AChR Ab+/- = acetylcholine receptor antibody-positive or negative; MG-ADL = Myasthenia Gravis Activities of Daily Living scale; MGFA = Myasthenia Gravis Foundation of America
Note: All drugs in current pipeline are investigational and subject to regulatory approval.

TED: A Heterogeneous Autoimmune Condition

TED is a rare autoantibody mediated inflammatory disease that affects between 15,000 and 20,000[1] 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[3]

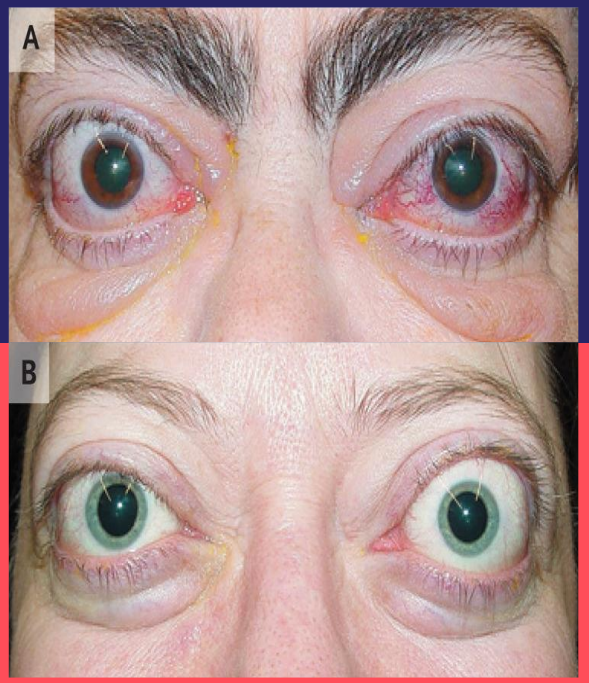
Progressive disease marked by inflammation that can lead to fibrosis and may become sight-threatening if untreated[4]

Caused by IgG autoantibodies that activate cell types present in tissues surrounding the eye[4]

While Tepezza shows a validated US market opportunity (2021 net sales of $1.7 billion and expected annual peak net sales over $3 billion)[5], many TED patients can benefit from a new therapy

- In a Phase 3 extension study, 44% of patients who were proptosis responders following 24 weeks of treatment were no longer responders after 48 weeks off treatment[6]

Patients with less severe disease not yet treated with Tepezza and those with recurrent or residual symptoms may benefit from new therapies



Proptosis, eye edema and chemosis[2]
Typical complications in TED patients

1. 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
2. Bahn R. Graves' ophthalmopathy. New England Journal of Medicine, 2010.
3. Davies T. and Burch H.B. Clinical features and diagnosis of Graves' orbitopathy (ophthalmopathy), UpToDate, 2018.
4. McAlinden C. An overview of thyroid eye disease. Eye and Vision, 2014.
5. Horizon Therapeutics Investor Presentations.
6. Horizon Therapeutics press release, 2020,

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

It was observed in batoclimab's Phase 2b trial in TED that reductions in IgG resulted in greater proptosis response rates[1,3]

	Placebo	Batoclimab 255 mg	Batoclimab 340 mg	Batoclimab 680 mg
Median Max % IgG Reduction Through Week 12	No significant change	62%	69%	80%
% Subjects with Stimulatory anti-TSHR Antibody below 140 at Week 12[2]	0%	0%	**15%**	**50%**
Proptosis Response Rates[3]	0%	11%	**29%**	**43%**

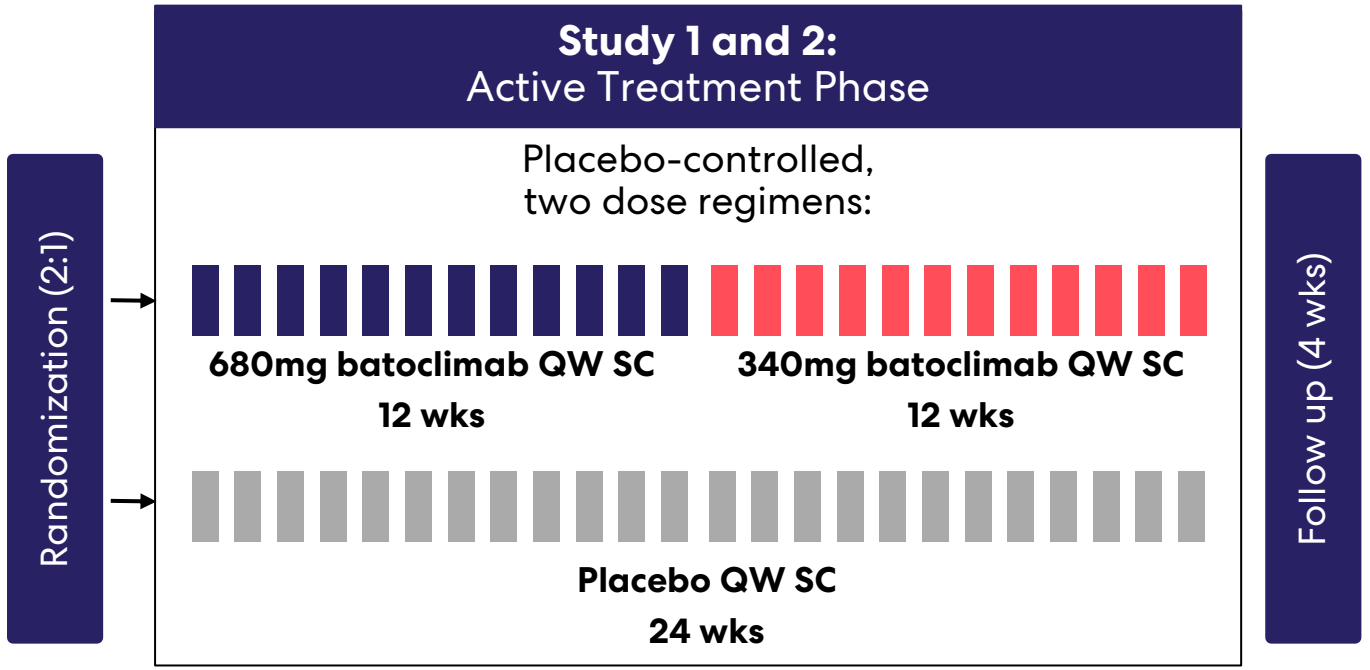
1. The efficacy of batoclimab and clinical outcomes were deemed inconclusive, in part, because the study was terminated early
2. This cell-based assay readout is the ratio of the sample signal to that of a reference control, expressed as %. A value less than 140 is considered negative for stimulatory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

TED Pivotal Clinical Trial Design – Two Studies to be Run in Parallel

Inclusion criteria:

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

N = 100 per study



Planning for two studies to run in parallel that follow trial design outlined above

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

CIDP: A Complex Chronic Neurological Disease

CIDP is an autoimmune associated with pathogenic, complement-activating IgG and IgM autoantibodies that target myelin and other neuronal proteins that affects up to 16,000[1,2] people in the United States

Clinical Presentation and Unmet Need

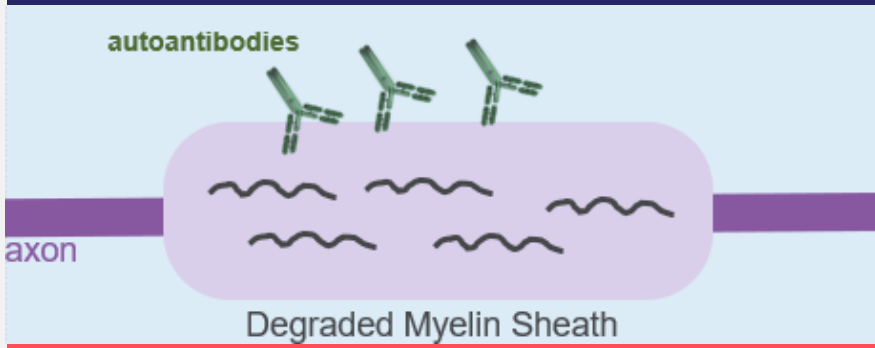
CIDP is characterized by predominant demyelination of motor and sensory nerves. Although the root cause of CIDP is unknown, significant evidence suggests that the disorder(s) are immunologically mediated[3]

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

- 70% of CIDP patients require ongoing treatment[4]
- $3B in global annual sales for IVIG in CIDP[5]

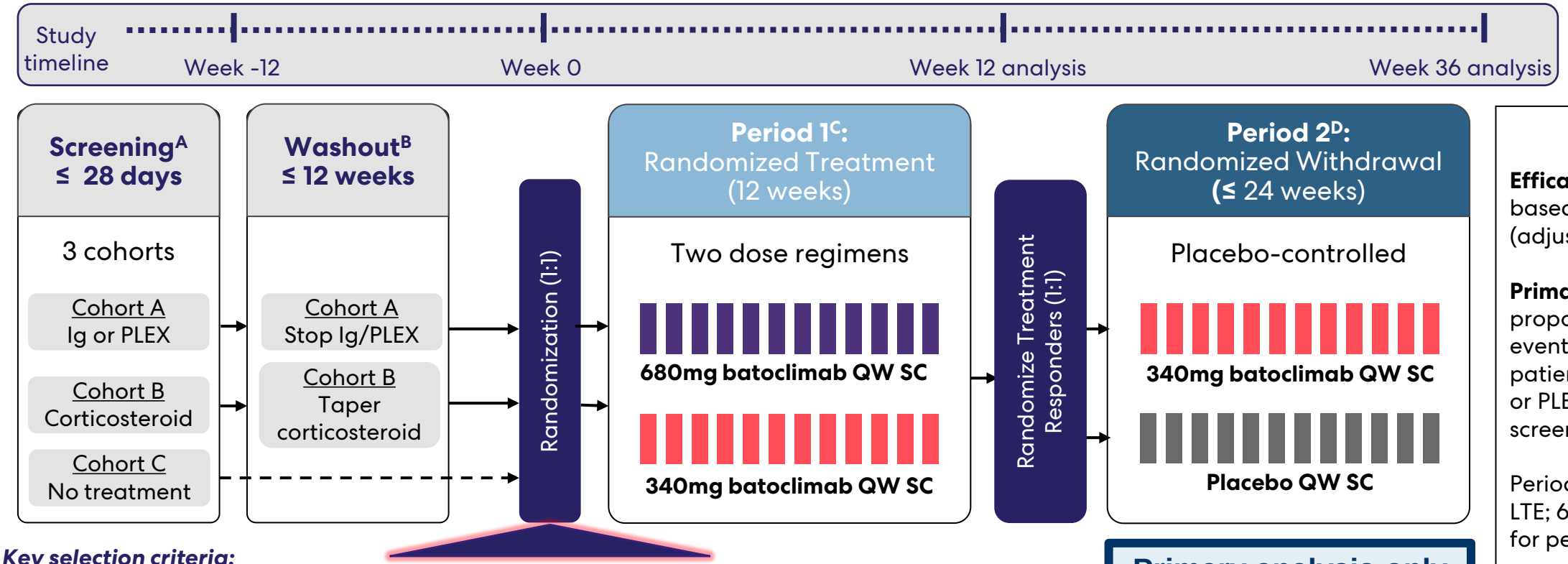
An effective treatment that could be administered via a simple subcutaneous injection would represent a meaningful improvement for patients with CIDP



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

CIDP Pivotal Phase 2b Trial Design Intended to Enable Development of Potentially Best-in-Anti-FcRn-Class Chronic Therapy for CIDP



Key selection criteria:

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

***Cohort A (N=100)**: Randomize participants who worsen*

***Cohort B**: Same as A*

***Cohort C**: Randomize all*

Primary analysis only on Cohort A (IG/PLEX)

Efficacy analysis based on relapse (adjusted INCAT)

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

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

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

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

Graves' Disease: a Systemic Condition with High Unmet Need

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

Clinical Presentation and Unmet Need

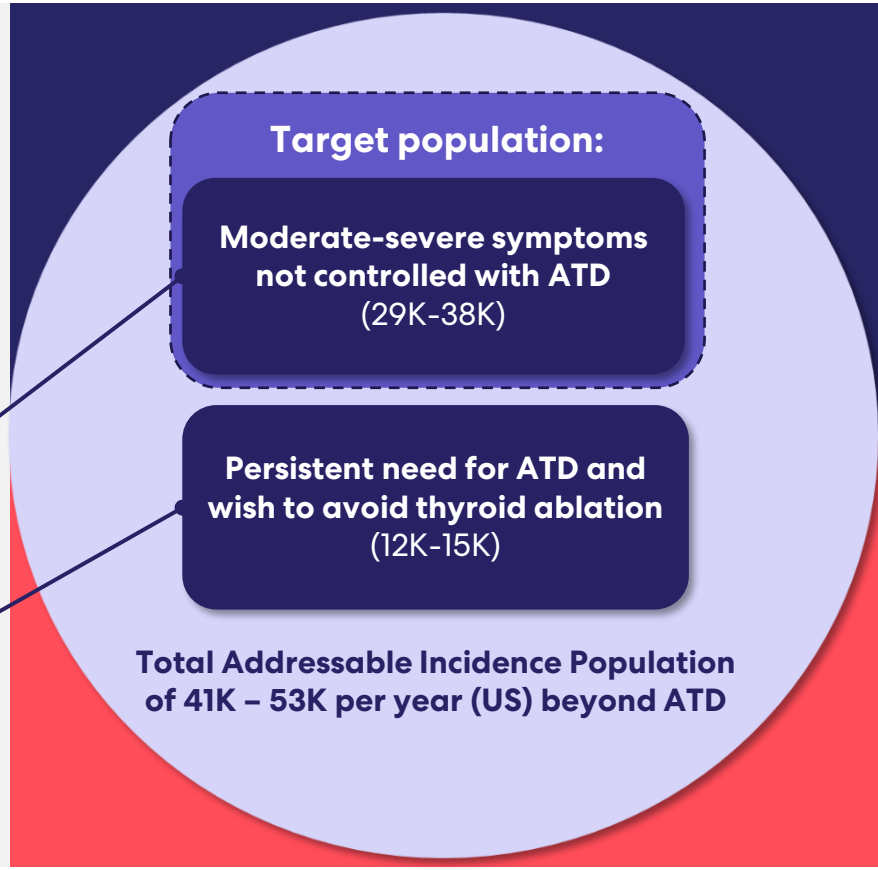
Caused by anti-TSHr autoantibodies which overstimulate the thyroid gland and cause hyperthyroidism; FcRn inhibition could foster degradation of those autoantibodies

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

- 1/4 to 1/3 of the 116K[1,2] US incident Graves' patients are difficult to control with ATD and remain symptomatic
- 1/4 to 1/3 of 46K[10] patients undergoing ablative procedure (radioactive iodine or surgery) may wish to avoid potential long-term risks (e.g. increased cancer, complications of thyroidectomy)

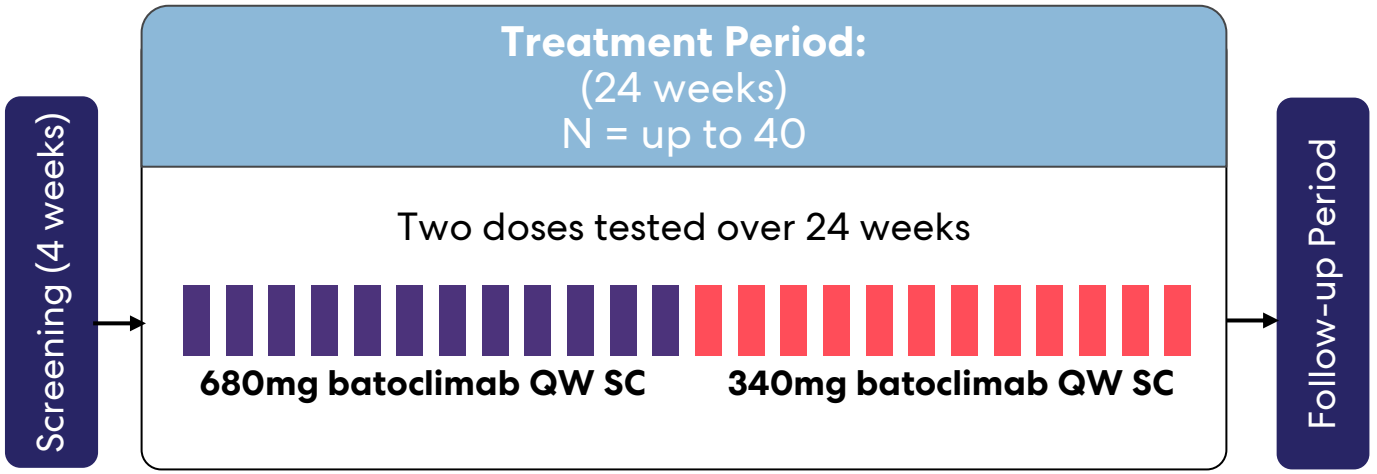


1. Zimmermann MB, Boelaert K. Iodine deficiency and thyroid disorders. Lancet Diabetes Endocrinol. 2015 Apr;3(4):286-95
2. Furszyfer J, et al. Graves' disease in Olmsted County, Minnesota, 1935 through 1967. Mayo Clin Proc. 1970 Sep;45(9):636-44
3. Girgis CM, Champion BL, Wall JR. Current concepts in 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
10. 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

Graves' Disease Phase 2 Trial Measures Clinically Relevant Biomarkers / Hormone Levels to Assess Efficacy and to Inform a Phase 3 Development Strategy

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



***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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A: Additional inclusion and exclusion criteria not listed on slide

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

RVT-2001

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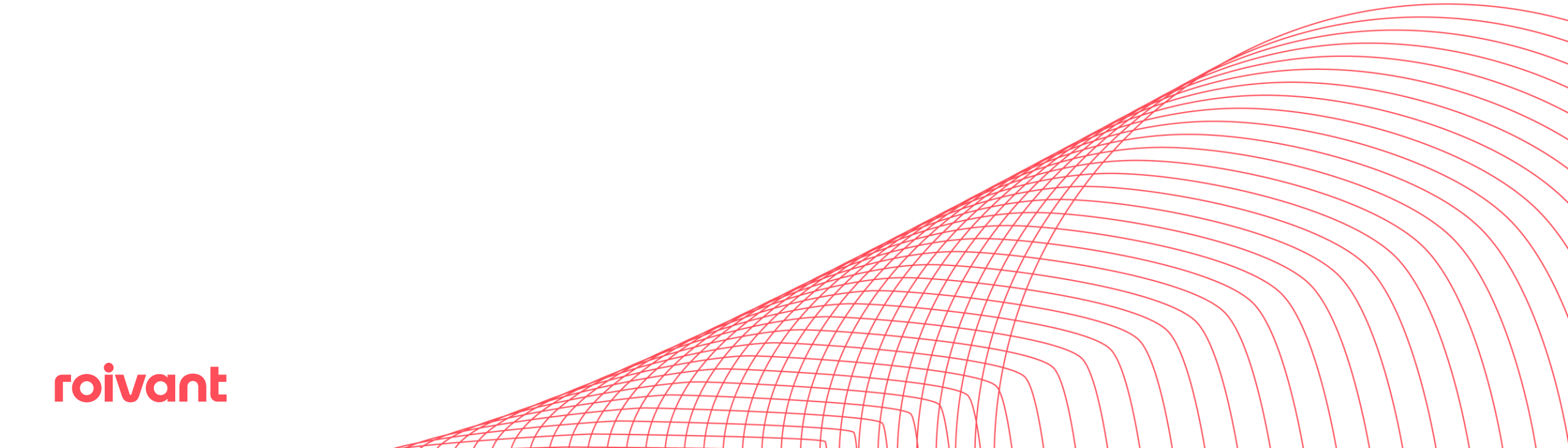

RVT-2001: Potential First-in-Class Small Molecule SF3B1 Modulator for the Treatment of Transfusion-Dependent Anemia in Patients with Lower-Risk MDS

Lower-Risk MDS is a Commercially Validated Market	Encouraging Proof-of-Concept Data	Multipronged Strategy to Optimize RVT-2001's Clinical Impact	Expect Fast, Well-Established Path to Potential Approval	Strong Intellectual Property Position
Transfusion-dependent anemia in MDS has limited treatment options Luspatercept (Reblozyl), approved for RS+ MDS in 2020, with current run rate sales >$600M; BMS potential projected peak >$4B[1]	First-in-class potential as the only known SF3B1 modulator currently in clinical development Compelling data in a highly refractory population 80+ subjects treated in Phase 1/2 study; generally well-tolerated[2]	Development strategy optimizing dosing, utilizing precision medicine enrollment, and excluding certain refractory patients Precedent suggests minimal data decay between Phase 2 and Phase 3[3]	Conducting a robust open-label expansion of an ongoing Phase 1/2 trial Precedent in the space is a single pivotal study with approximately 200-250 patients[4]	Composition of matter IP protection expected until 2035, before any potential patent term extensions

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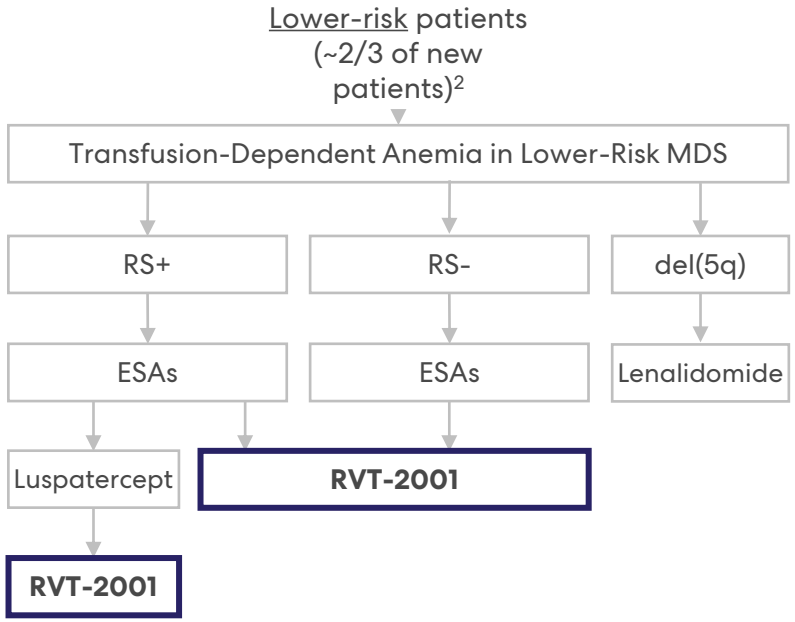
All product candidates are investigational and subject to regulatory approval.
1. Bristol Myers Squibb filings, November 16, 2021 Investor Event.
2. Steensma et al., 2021. Data as of January 10, 2022.
3. Platzbecker et al., 2017; Fenaux et al., 2020; List et al., 2006; Fenaux et al., 2011
4. Fenaux et al., 2021; Fenaux et al. 2011; Santini et al. 2016

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

Current treatment options fail in multiple segments of the patient population

~17K new MDS cases/year, ~115K MDS patients total in US[1]



- Lower-risk MDS is a chronic condition; therapy is focused on management of symptoms
- Erythropoiesis-stimulating agents (ESA) used in 1L
  - Ineffective in >50% of patients, primarily used in patients with low transfusion burden and EPO levels[2]
- Luspatercept and lenalidomide are only approved for specific subsets of MDS patients and can have challenging toxicity profiles
  - Luspatercept is also ineffective in >50% of patients[3]
  - Lenalidomide is only approved patients with del(5q) lower-risk MDS, who only make up 10-15%[4] of the population

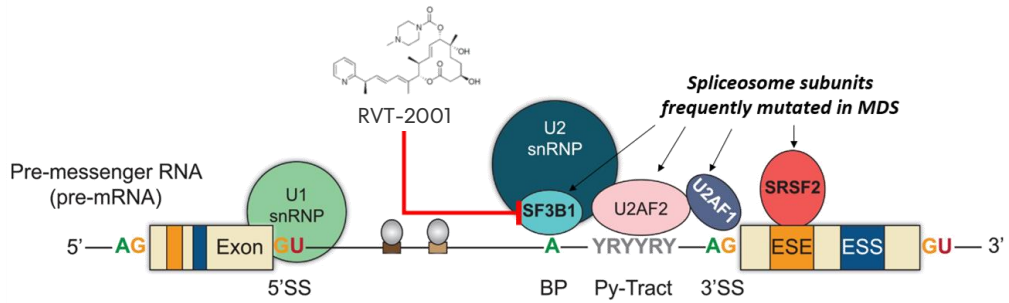
Initial plan to target second line in SF3B1-mutated patients, with potential to expand to other spliceosome mutations and first line

All product candidates are investigational and subject to regulatory approval.
1. Cogle et al., 2015, prevalence based on midpoint, incidence based on lower end of range using 2021 US population.
2. Carraway et al., 2020, overall response rates of 20% to 40% and an 18- to 24-month duration of response.
3. Cazzola et al. 2020
4. Solé F, Espinet B, Sanz GF, et al. Incidence, characterization and prognostic significance of chromosomal abnormalities in 640 patients with primary myelodysplastic syndromes. 2000

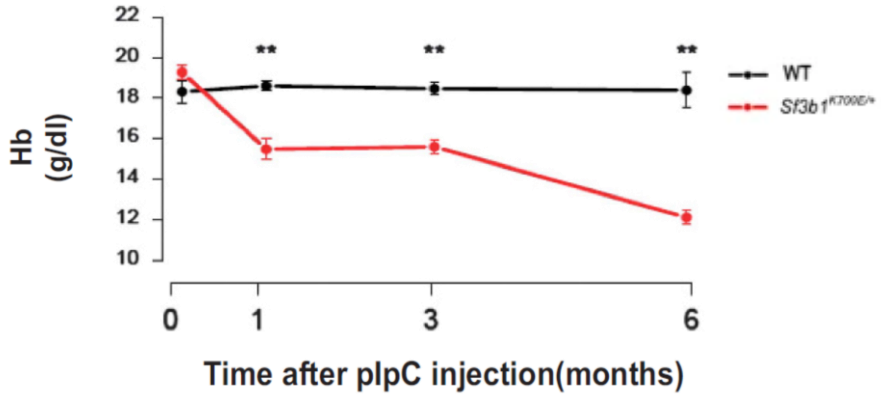
SF3B1: A Target Uniquely Suited to Improving Anemia in MDS

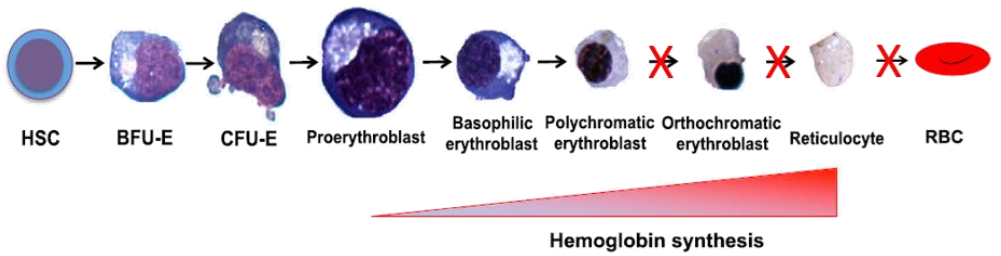
RVT-2001 is an oral therapy for the treatment of anemia associated with lower-risk MDS that utilizes a novel mechanism to correct aberrant splicing caused by SF3B1 mutations

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



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





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Source: Figures adopted from Xu et al., Experimental Hematology (2019), Mupo et al., Leukemia (2017) and Zivot et al., Molecular Medicine (2017)

Encouraging Early Data Demonstrate RVT-2001's Clinical Potential

Meaningful Clinical Impact in Refractory Patient Population to Date[1]

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

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

Potential for Improved Therapeutic Effect in Earlier-Line Patients

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

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All product candidates are investigational and subject to regulatory approval.
RBC-TI: Red blood cell-transfusion independence.
HMA: Hypomethylating agents.
AML: Acute myeloid leukemia.
CMML: Chronic myelomonocytic leukemia.
Hi-E: Erythroid hematologic improvement

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

Trial Design Intended to Target Improved and Extended Responses

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

Target Genetically Defined Subpopulations

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

Improve Dosing

- Strengthen pharmacodynamic effect by optimizing dosage of RVT-2001

Minimal Data Decay

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

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All product candidates are investigational and subject to regulatory approval.
AJ/CJ: Ratio of aberrant splicing junction to canonical splicing junction.
1. Malcovati et al., 2015
2. Steensma et al., 2021. Data as of January 10, 2022.

Phase 1/2 Ongoing with Recently Added Dose-Optimization Cohort

N = up to 64

Primary endpoint assessed at 25 weeks

Oral capsule

Key Exclusion/Inclusion Criteria:

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

Enrolling only lower-risk MDS patients with SF3B1 mutations

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

Primary Efficacy Data: RBC transfusion independence

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

RVT-2001 Key Highlights

Significant market opportunity for RVT-2001

- Potentially first-in-class (only clinical stage) oral agent in a commercially established multibillion dollar market with limited effective treatment options

Compelling RVT-2001 data to date in a highly refractory population, where luspatercept and lenalidomide have shown weaker responses

- ~2x better RBC-TI response than luspatercept in a similar patient population[1]

Multiple paths to "win" given robust signal-refining Phase 2 design

- High response rates / long duration in the overall population
- High response rates / long duration in genetically defined subsets (e.g., high TMEM14C AJ / CJ ratio)

Potential for an extremely fast path to market

- Robust open-label, dose exploration study ongoing
- Precedent in the space is a single pivotal study, n~200-250 patients

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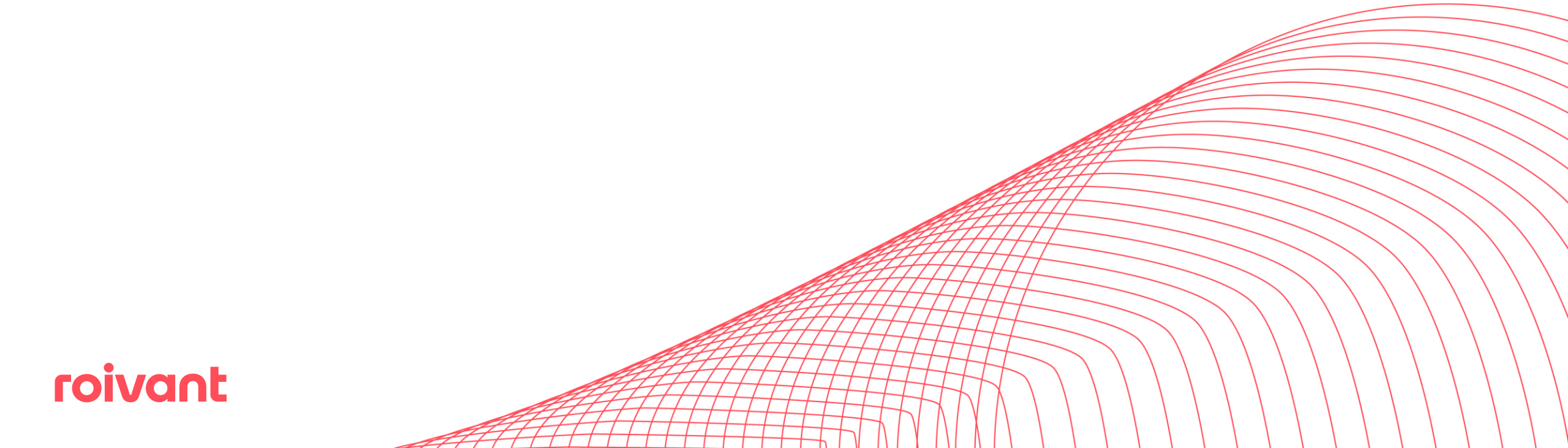
1. No head-to-head studies of RVT-2001 have been conducted. Based on interim results which may change following completion of the trial and may not accurately reflect the complete results of the trial.

Namilumab



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Namilumab: Potential First Novel Therapy for Pulmonary Sarcoidosis, a Large, Untapped Orphan Market

Pulmonary Sarcoidosis Is A Large, Untapped Orphan Market

~180,000 patients in the US alone[1]

Characterized by the accumulation of granulomas in the lung, which cause injury and scarring

Leads to declining pulmonary function, dyspnea, fatigue, cough, pain, and death

No modern approved agents; systemic corticosteroids are the mainstay, and other immunosuppressives are used off-label

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

Robust Phase 2 is underway

Could count as a registrational study if successful

Clinical study design incorporates lessons learned from previous trials

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

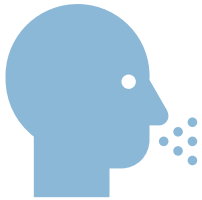
1. Denning, et al. European Respiratory Journal 2013
2. Ishioka S, et al. Sarcoidosis, Vasculitis, and Diffuse Lung Diseases 1996.
3. Itoh A, et al. Respirology 1998
4. Taylor P, et al. Arthritis Res Therapy 2019; Tanaka S et al. International J Pharmacol Therapy 2018; Papp KA et al. J Dermatol 2019; 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]

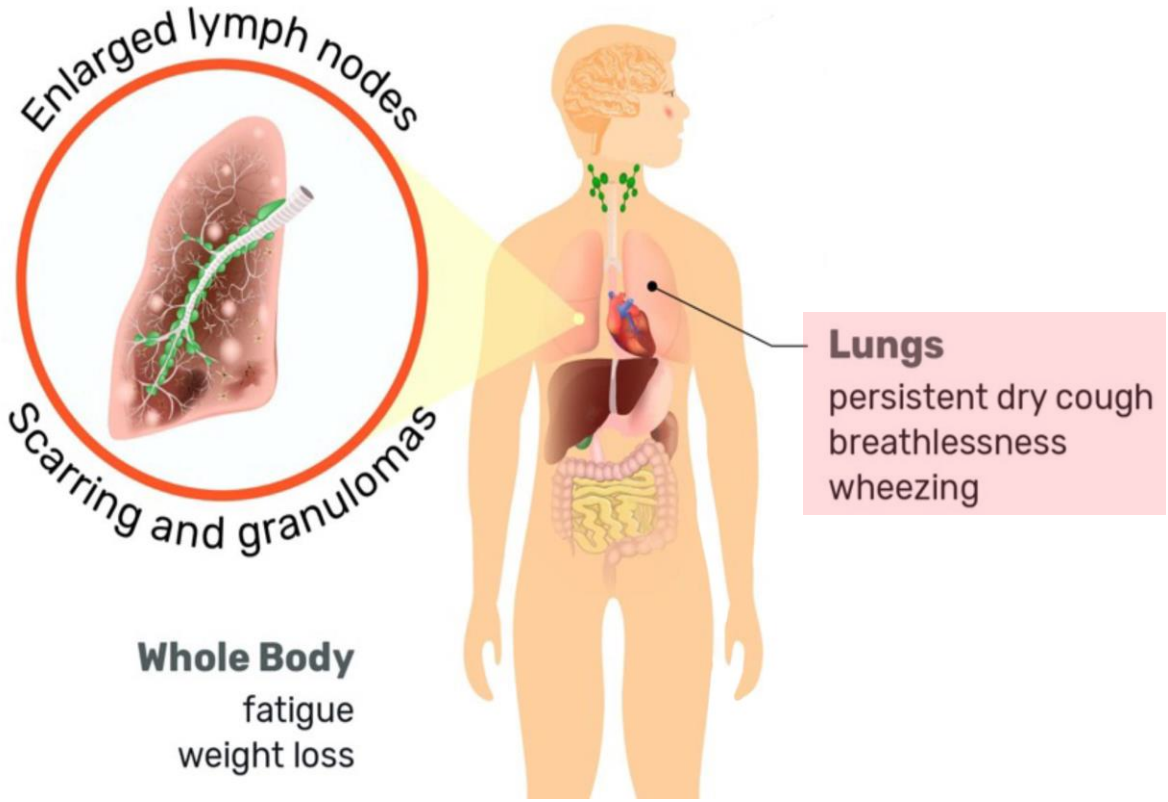


Clinical consequences:

Declining pulmonary function

Dyspnea, fatigue, cough, and pain

Death



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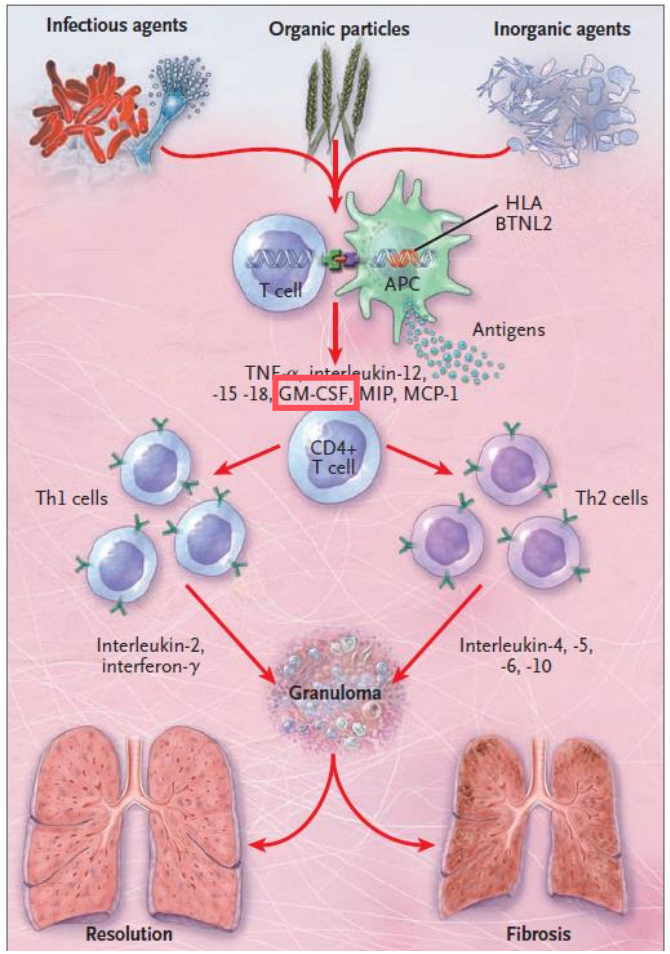
1. .Market research
2. Denning, et al. European Respiratory Journal 2013
3. Baughman, et al. Annals ATS 2016

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

Pulmonary Sarcoidosis Phase 2 Study Design

RESOLVE LUNG

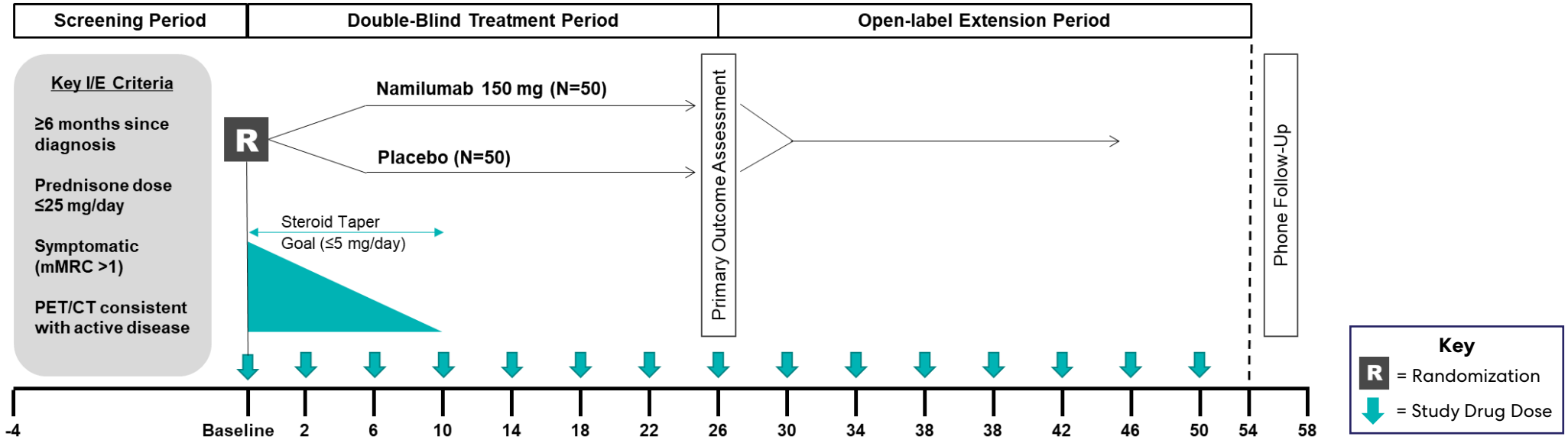
Phase 2 study design incorporates lessons learned from previous trials and could count as a registrational study if successful

Primary Endpoint

Mean change from baseline in percent predicted forced vital capacity (ppFVC)

Key Secondary Endpoint

Proportion of subjects successfully achieving OCS taper without rescue



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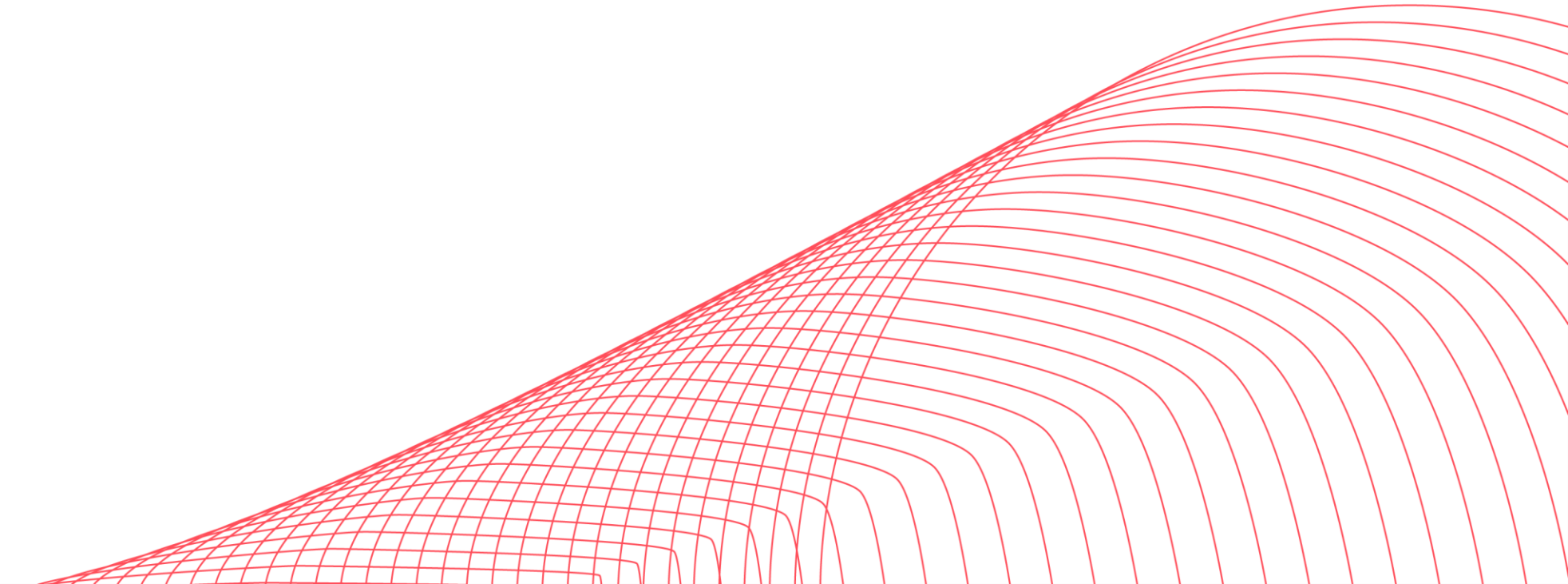
LNP Patent Litigation



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Genevant and Arbutus have Jointly Filed a Complaint against Moderna Asserting Patent Infringement

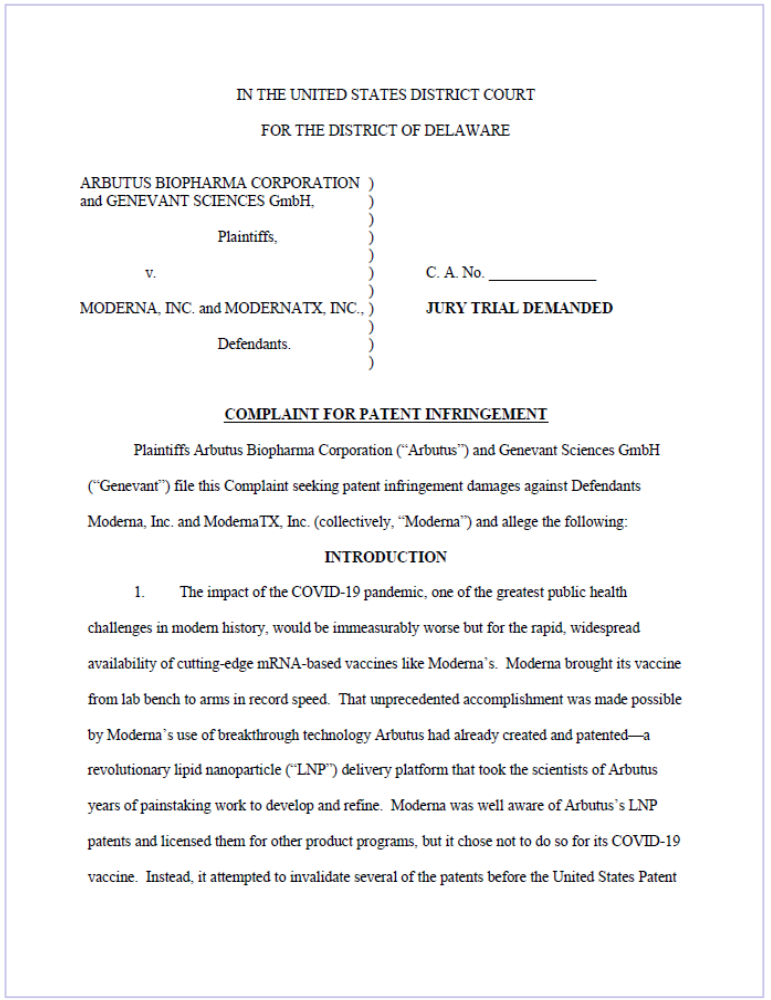
In February, Genevant and Arbutus jointly filed a complaint against Moderna in the US District Court for the District of Delaware asserting infringement of six patents

Genevant and Arbutus do not seek an injunction or otherwise to impede the sale, manufacture, or distribution of Moderna's COVID-19 vaccine

We recognize the important work of Moderna that helped lead to a lifesaving vaccine in record time

That success was built on, and made possible by, the substantial advances and contributions of Arbutus and Genevant scientists

Genevant has out-licensed its LNP technology on multiple occasions; the filing of this lawsuit was necessary because Moderna has not meaningfully engaged in licensing discussions



IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF DELAWARE

ARBUTUS BIOPHARMA CORPORATION and GENEVANT SCIENCES GmbH,

Plaintiffs,

v.

MODERNA, INC. and MODERNATX, INC.,

Defendants.

C. A. No. _____

JURY TRIAL DEMANDED

COMPLAINT FOR PATENT INFRINGEMENT

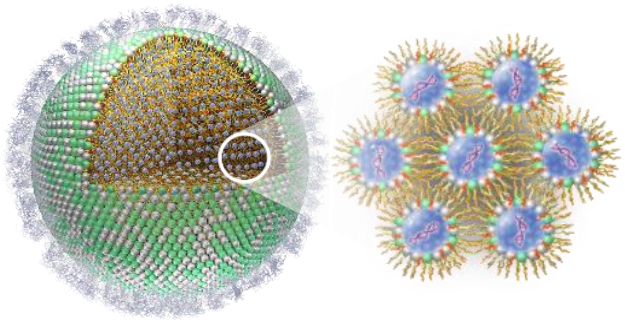
Plaintiffs Arbutus Biopharma Corporation ("Arbutus") and Genevant Sciences GmbH ("Genevant") file this Complaint seeking patent infringement damages against Defendants Moderna, Inc. and ModernaTX, Inc. (collectively, "Moderna") and allege the following:

INTRODUCTION

1. The impact of the COVID-19 pandemic, one of the greatest public health challenges in modern history, would be immeasurably worse but for the rapid, widespread availability of cutting-edge mRNA-based vaccines like Moderna's. Moderna brought its vaccine from lab bench to arms in record speed. That unprecedented accomplishment was made possible by Moderna's use of breakthrough technology Arbutus had already created and patented—a revolutionary lipid nanoparticle ("LNP") delivery platform that took the scientists of Arbutus years of painstaking work to develop and refine. Moderna was well aware of Arbutus's LNP patents and licensed them for other product programs, but it chose not to do so for its COVID-19 vaccine. Instead, it attempted to invalidate several of the patents before the United States Patent

Genevant is a Leading Nucleic Acid Delivery Solutions Company

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



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

Collaboration Partner	LNP Collaborations Outside of COVID-19	Publicly Disclosed Financials*
SAREPTA THERAPEUTICS	Gene editing therapeutics for specified neuromuscular diseases, including DMD[1]	Royalty rate: mid-single to low-double digits† Near-term: $50M + significant milestones
Takeda	Nucleic acid therapeutics directed to specified targets in HSCs to treat liver fibrosis[2]	Royalty rate: undisclosed Upfront and milestones: $600M
Takeda	Nonviral gene therapies for up to two rare liver diseases[3]	Royalty rate: undisclosed Upfront and milestones: $303M
2seventybio	Gene editing therapies for hemophilia A[4]	Royalty rate: mid-single digits† Upfront and near-term option: $10M + milestones
gritstone bio	Self-amplifying RNA for an unspecified indication[5]	Low to mid-single digits† Initial payment and milestones: $73M
BIONTECH	mRNA for a specified number of oncology targets; co-dev in up to five rare diseases[6]	Milestones and royalties (amounts undisclosed); 50:50 on co-development programs

Collaboration Partner	LNP Collaborations for COVID-19	Publicly Disclosed Financials*
gritstone bio	Self-amplifying RNA COVID-19 vaccine program[7]	Royalty rate: mid-single to mid-double digits† Upfront + milestones: $192M/product
ST PHARM	mRNA COVID-19 vaccine program in specified Asian countries[8]	Royalty rate: 8% Upfront + milestones: $133.75M
PROVIDENCE THERAPEUTICS	mRNA COVID-19 vaccine program	Undisclosed
Chula Chulalongkorn University	mRNA COVID-19 vaccine program in specified Asian countries	Undisclosed

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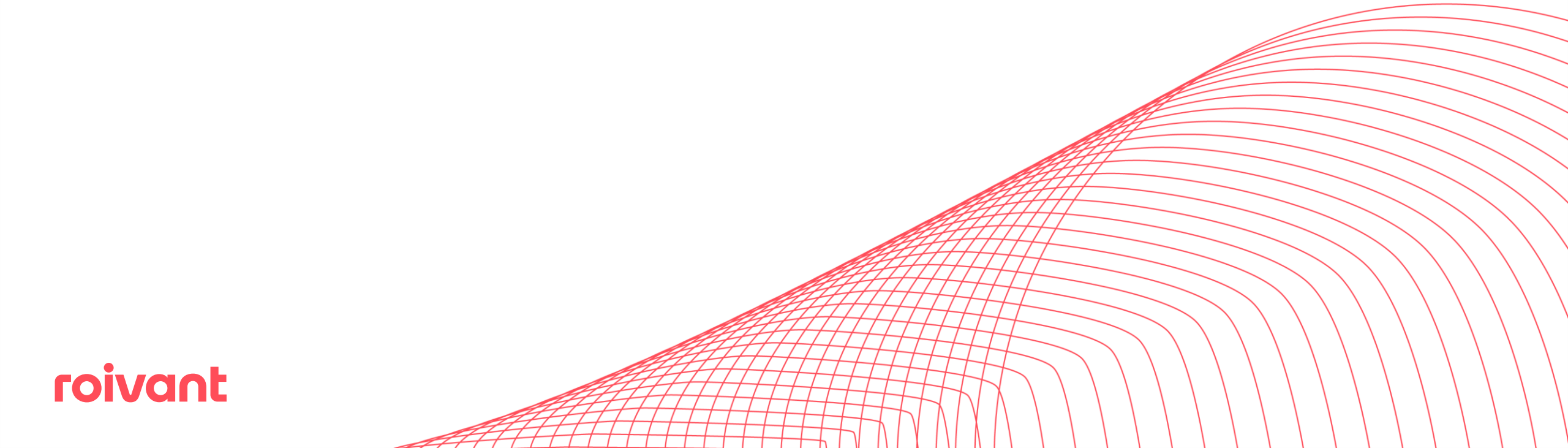
*Includes publicly disclosed terms only and therefore does not reflect all payments that may be applicable and received by Genevant (e.g., reimbursements for FTE support, field expansion fees, etc.). All potential payments are contingent upon achievement of specified milestones. †Depending on the circumstances.

 1. Genevant and Sarepta joint press release, January 13, 2021. 2. Genevant press release, March 15, 2021. 3. Genevant press release, August 23, 2021. 4. 2seventy bio press release, January 6, 2022. 5. Gritstone Oncology 8-K, October 20, 2020. 6. BioNTech Form F-1, July 21, 2020. 7. Genevant and Gritstone joint press release, January 20, 2021. 8. ST Pharm Korean disclosure document, April 8, 2021.

Updates on Genevant IP Litigation

- On November 2, the federal district court in Delaware issued an opinion and order in the patent infringement suit brought by Genevant and Arbutus against Moderna
- The court denied Moderna's partial motion to dismiss the suit based on the government-contractor defense under 28 U.S.C. Section 1498, which was an attempt by Moderna to shift liability for an unspecified portion its alleged infringement to the US government and taxpayers
- We expect that the case will now proceed to the pre-trial discovery phase

Discovery Updates



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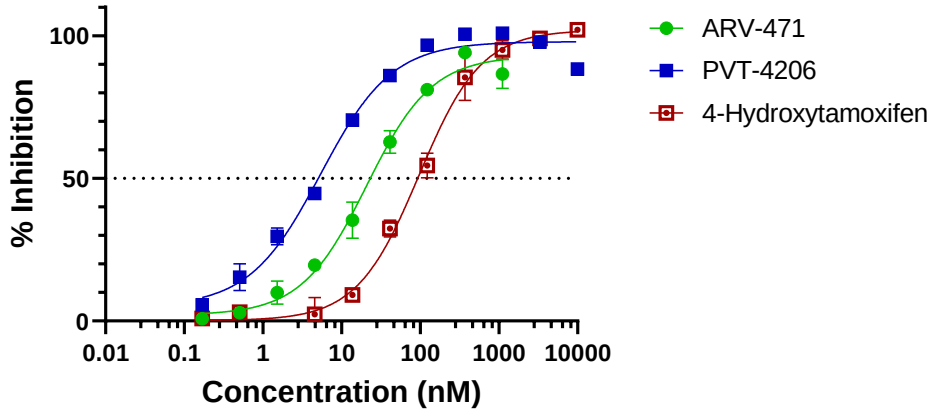
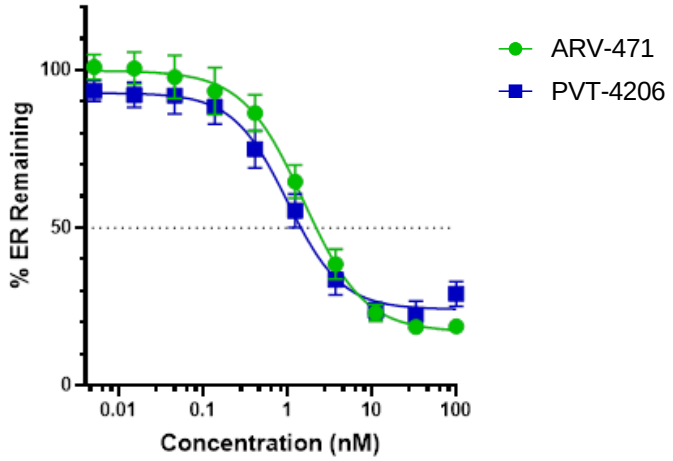
ER Degrader Demonstrates Equal or Better Tumor Volume Reduction Compared to Most Advanced Degrader In-Class

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

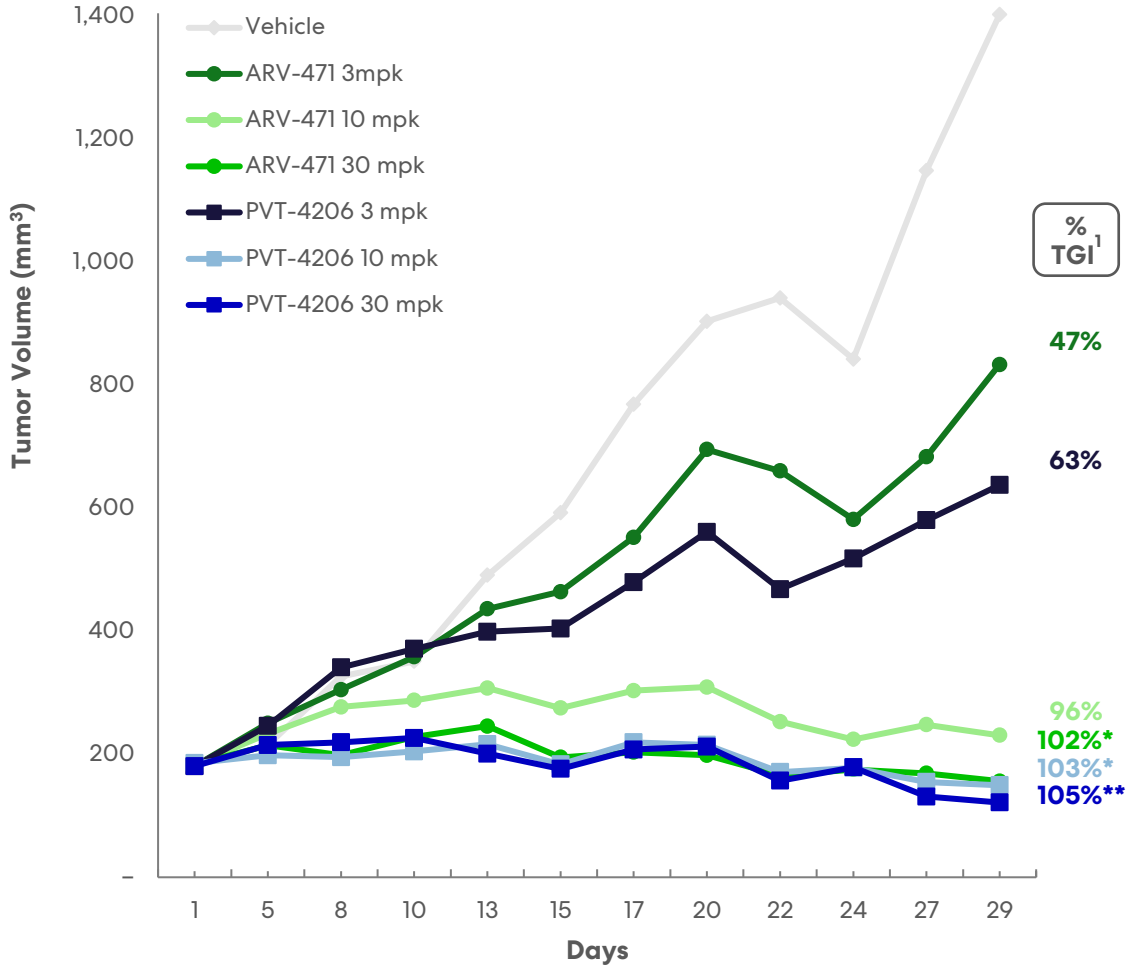
Potent Antagonism Demonstrated in *In Vitro* Assay



Potent Degradation Demonstrated in *In Vitro* Assay



In Vivo Tumor Growth Inhibition Demonstrated in MCF-7 Model



1. TGI = Tumor Growth Inhibition. % TGI calculated as 1-(tumor volume treated/tumor volume control).
Note: ARV-471 10 mpk:ARV-471 30 mpk * = P value <0.05; ARV-471 10 mpk:PVT-4206 10 mpk * = P value <0.05; ARV-471 10 mpk:PVT-4206 30 mpk ** = P value <0.005.

Multiple Strategic Partnerships Validating the Quality of Discovery Pipeline

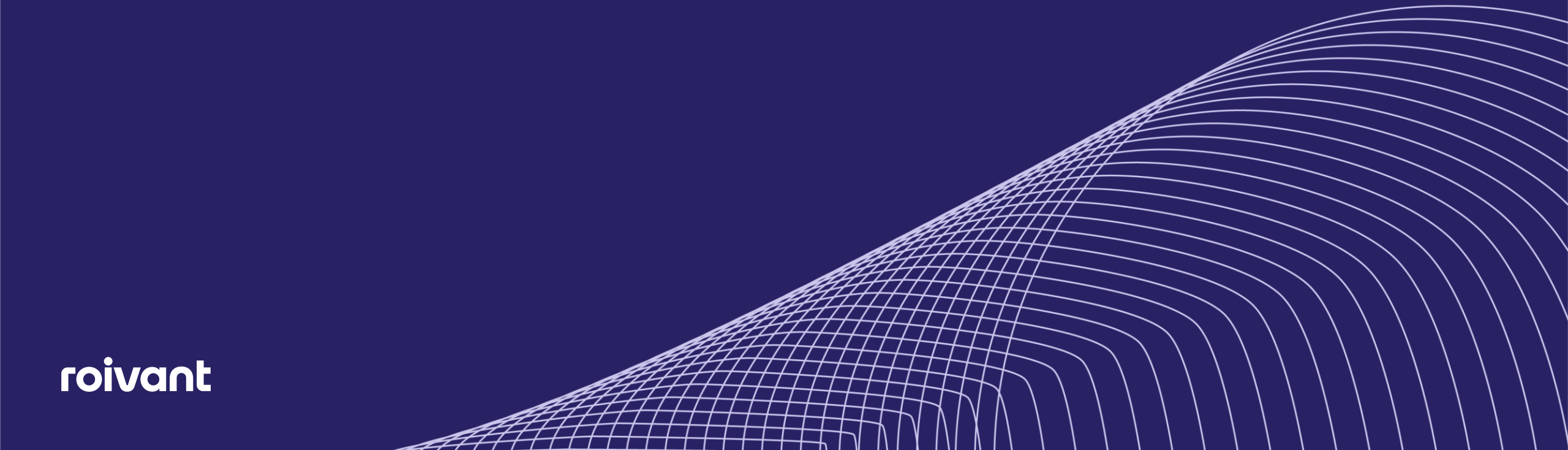
Partnership with Janssen focused on VantAI's deep learning platform to potentially generate novel molecular-glue and hetero-bifunctional protein degrader drug candidates

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

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

Collaborations with Blueprint Medicines, Janssen, and Boehringer Ingelheim include aggregate contingent milestone payments of **over $1 billion as well as product royalties**

Thank you.



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