IMVT-1402

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Forward-Looking Statements

Roivant Forward-Looking Statements

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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.

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

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All forward-looking statements are based on estimates and assumptions by Immunovant’s management that, although Immunovant believes to be reasonable, are inherently uncertain. All forward-looking statements are subject to risks and uncertainties that may cause actual results to differ materially from those that Immunovant expected. Such risks and uncertainties include, among others: Immunovant may not be able to protect or enforce its intellectual property rights; initial results or other preliminary analyses or results of early clinical trials may not be predictive final trial results or of the results of later clinical trials; the timing and availability of data from clinical trials; the timing of discussions with regulatory agencies, as well as regulatory submissions and potential approvals; the continued development of Immunovant’s product candidates, including the number and timing of the commencement of additional clinical trials; Immunovant’s scientific approach, clinical trial design, indication selection, and general development progress; future clinical trials may not confirm any safety, potency, or other product characteristics described or assumed in this press release; any product candidate that Immunovant develops may not progress through clinical development or receive required regulatory approvals within expected timelines or at all; Immunovant’s product candidates may not be beneficial to patients, or even if approved by regulatory authorities, successfully commercialized; the potential impact of global factors, such as international trade tariffs, geopolitical tensions, and adverse macroeconomic conditions on Immunovant’s business operations and supply chain, including its clinical development plans and timelines; Immunovant’s business is heavily dependent on the successful development, regulatory approval, and commercialization of IMVT-1402 or batoclimab; Immunovant is at various stages of clinical development for IMVT-1402 and batoclimab; and Immunovant will require additional capital to fund its operations and advance IMVT-1402 and batoclimab through clinical development. These and other risks and uncertainties are more fully described in Immunovant’s periodic and other reports filed with the Securities and Exchange Commission (SEC), including in the section titled “Risk Factors” in Immunovant’s Annual Report on Form 10-K filed with the SEC on May 29, 2025, and Immunovant’s subsequent filings with the SEC. Any forward-looking statement speaks only as of the date on which it was made. Immunovant undertakes no obligation to publicly update or revise any forward-looking statement, whether as a result of new information, future events or otherwise.

Disclaimer

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

Key Takeaways: IMVT-1402

IMVT-1402 drives **deep dose-dependent reductions** of pathogenic IgG autoantibodies; expected to reach **best-in-class IgG reductions of ~80%**, unmatched by current anti-FcRn competitors

Significant evidence across late-stage clinical trials shows **deeper IgG reductions are correlated with better efficacy** across 8 different indications to date

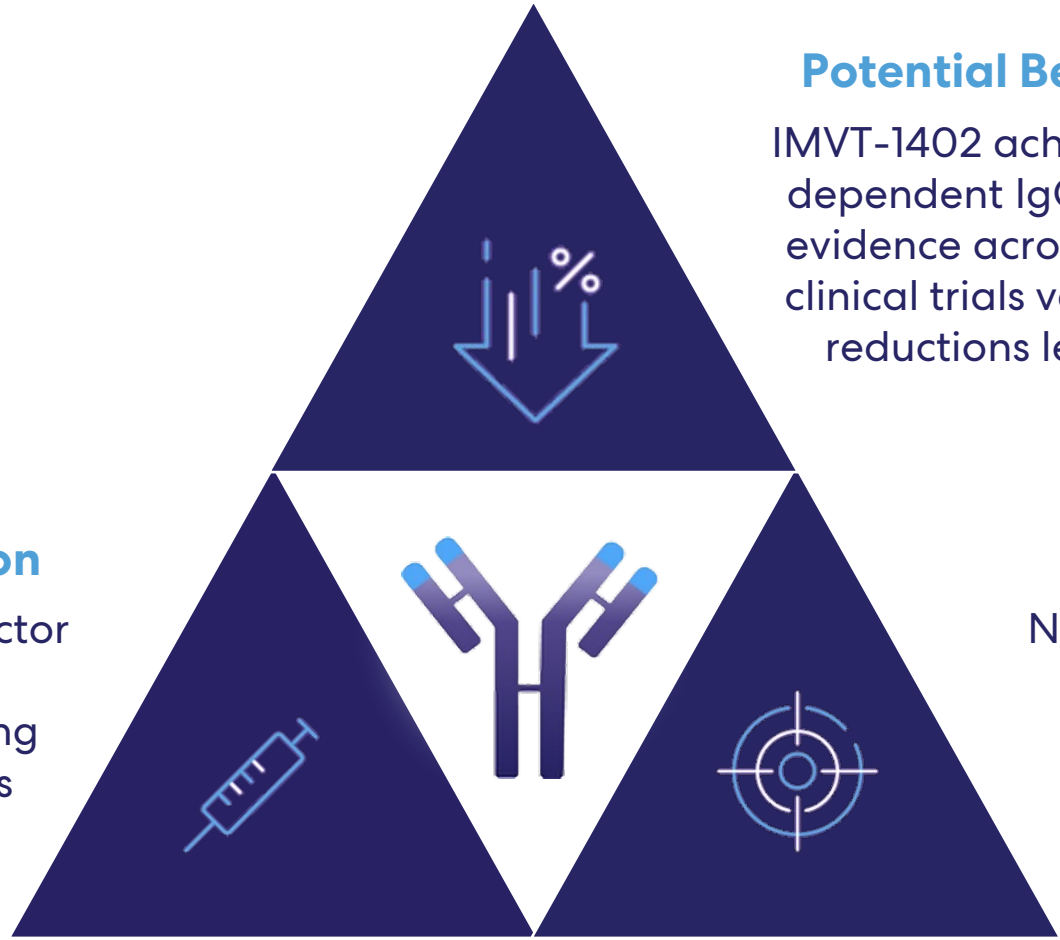
Massive opportunity in uncontrolled Graves' disease; generated disease-modifying PoC data and expect potentially registrational data in 2027 with multi-year lead and best-in-class efficacy

IMVT-1402 is expected to be **first- and best-in-class in GD, D2T RA, and CLE; best-in-class in MG, CIDP, and SjD; D2T RA topline readout now expected in 2026** as well as initial results in CLE

Pipeline-in-a-product potential; approved anti-FcRns antibodies have generated **~$7BN in cumulative revenue in MG and CIDP within 4 years of launch** with additional indications expected[1]

Note: GD: Graves' disease; SjD: Sjogren's disease; D2T RA: difficult-to-treat rheumatoid arthritis; CIDP: Chronic inflammatory demyelinating polyneuropathy; MG: Myasthenia gravis; CLE: Cutaneous lupus erythematosus
Note: All drugs are investigational and subject to regulatory approvals. All catalyst timings are approximate, based on current expectations and, where applicable, contingent on FDA feedback, and may be subject to change. All references are to calendar years.
1. Data from Evaluate and company filings

IMVT-1402 Has the Potential to Be a First- and Best-in-Class Therapy in Autoantibody-Driven Disease



Potential Best-in-Class Efficacy

IMVT-1402 achieves deep, rapid, dose-dependent IgG reductions; consistent evidence across external and internal clinical trials validate that deeper IgG reductions lead to greater clinical benefit

Convenient Administration

Simple subcutaneous autoinjector with 5-10 second self-administration; currently being tested in all IMVT-1402 trials

Favorable Safety Profile

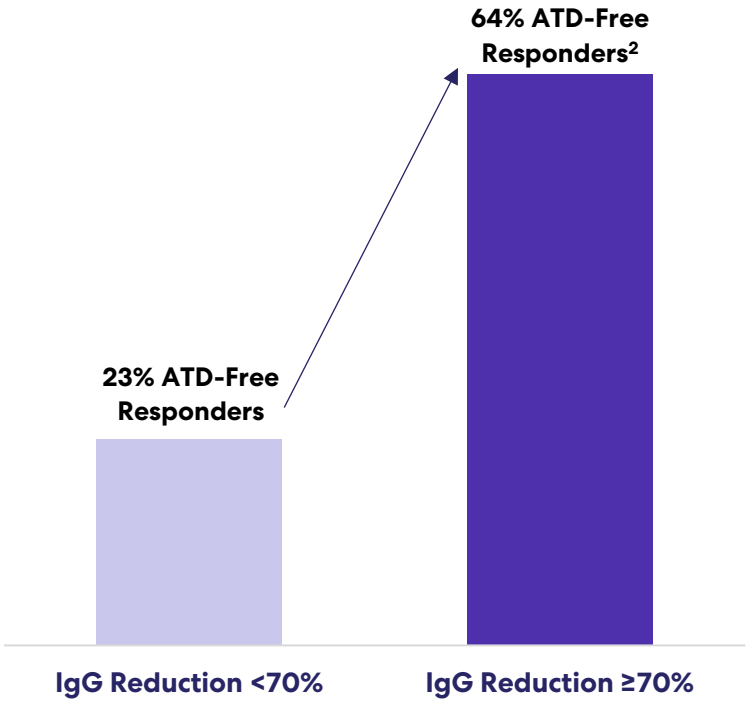
No significant expected safety issues based on data to-date

Settling the "Deeper Is Better" Debate With Batoclimab Proof-of-Concept Trials

Our clinical data generated across multiple indications consistently shows that deeper IgG reduction leads to improved clinical outcomes for patients

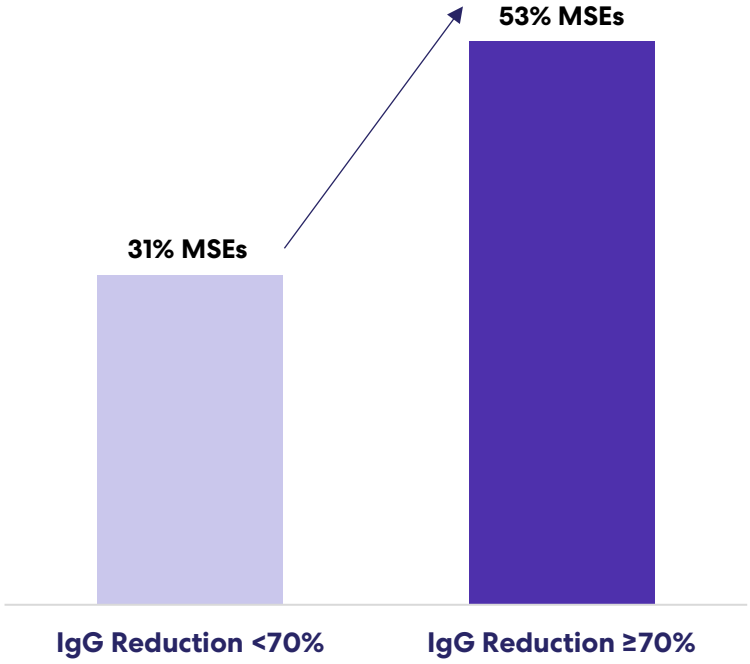
Graves' Phase 2a[1]

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



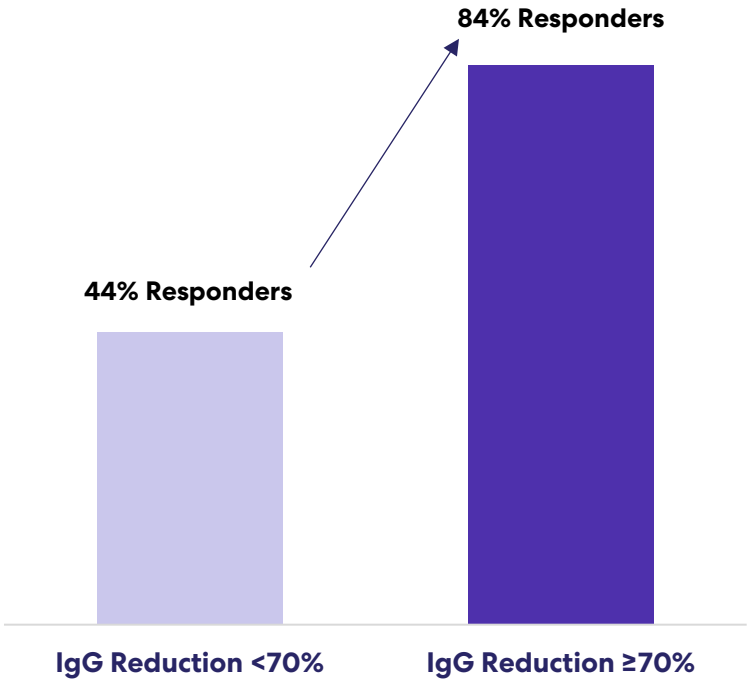
MG Phase 3[1]

Minimal Symptom Expression: % of participants who achieve MG-ADL score of 0 or 1 at Week 12



CIDP Phase 2b[1,3]

aINCAT Response: % of participants who achieve aINCAT improvement ≥1 at Week 12



Reflects data from multiple clinical trials in multiple indications. Differences exist between study designs and subject characteristics, and caution should be exercised when comparing data across studies.

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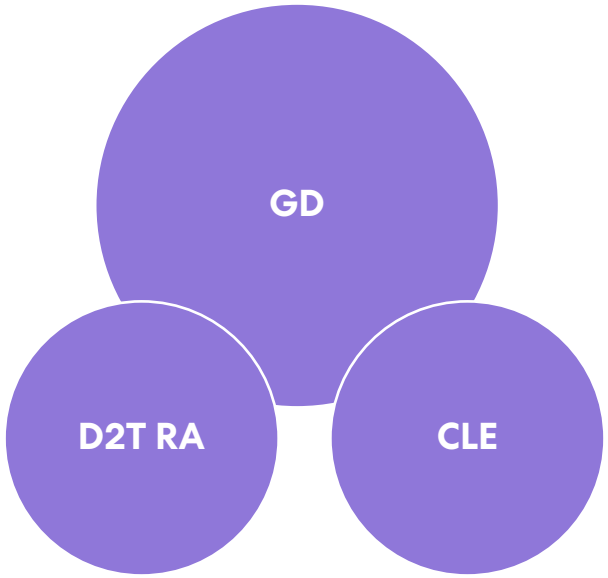
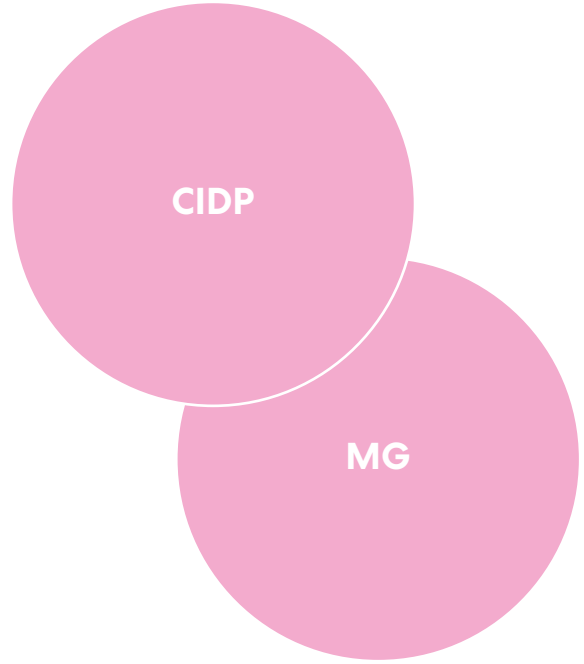
Notes: MG data presented for acetylcholine receptor antibody-positive patients; ATD: Antithyroid drug; aINCAT: Adjusted Inflammatory Neuropathy Cause and Treatment; IgG: Immunoglobulin G; MSE: Minimal Symptom Expression; LLN: Lower limit of normal.
1. Batoclimab clinical data. 2. Includes N=1 additional responder vs. September 2024 disclosure. Patient discontinued prior to Week 12 and was counted as a non-responder per protocol but was included by the PI in the ATA 2025 poster presentation, given they were a responder at time of discontinuation and continued through 6 month off-treatment follow-up period. 3. The data referenced here includes data from the ongoing batoclimab Phase 2 study in CIDP and is based on a preliminary analysis of key efficacy and safety data, and such data may change following completion of the clinical trial and may not accurately reflect the complete results of the study

IMVT-1402 Development Well Underway With 5 Potentially Registrational Datasets Expected in Next 36 Months





First-in-Class / Best-in-Class
Multi-year head-start with key clinical catalysts in 2026 and 2027

Best-in-Class
Potential best-in-class product in untapped market;
close timing to in-class competition

Best-in-Class / "Upside"
Well-established markets; potential to gain market share as clear best-in-class

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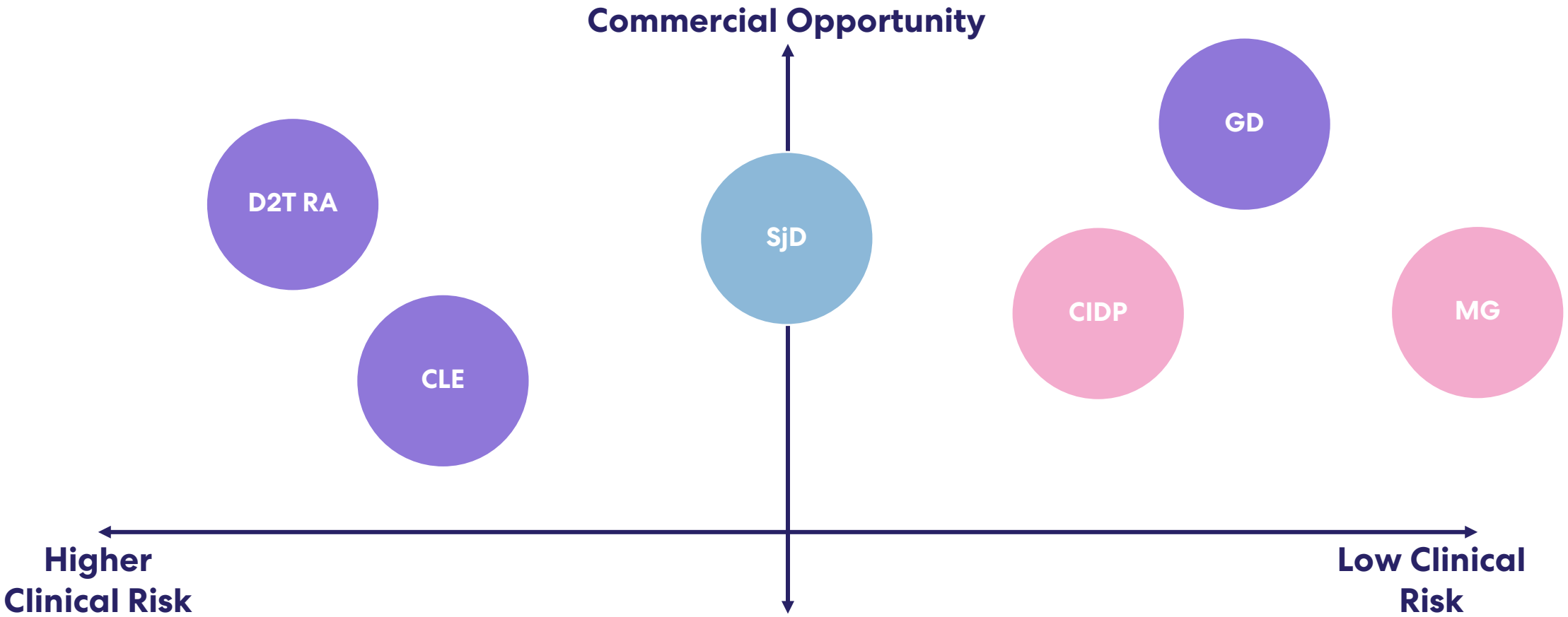
Note: GD: Graves' disease; SjD: Sjogren's disease; ACPA+ D2T RA: anti-citrullinated protein antibody positive (ACPA+), difficult-to-treat rheumatoid arthritis; CIDP: chronic inflammatory demyelinating polyneuropathy; MG: myasthenia gravis; CLE: cutaneous lupus erythematosus
Note: All drugs are investigational and subject to regulatory approvals. All catalyst timings are approximate, based on current expectations and, where applicable, contingent on FDA feedback, and may be subject to change. All references are to calendar years.

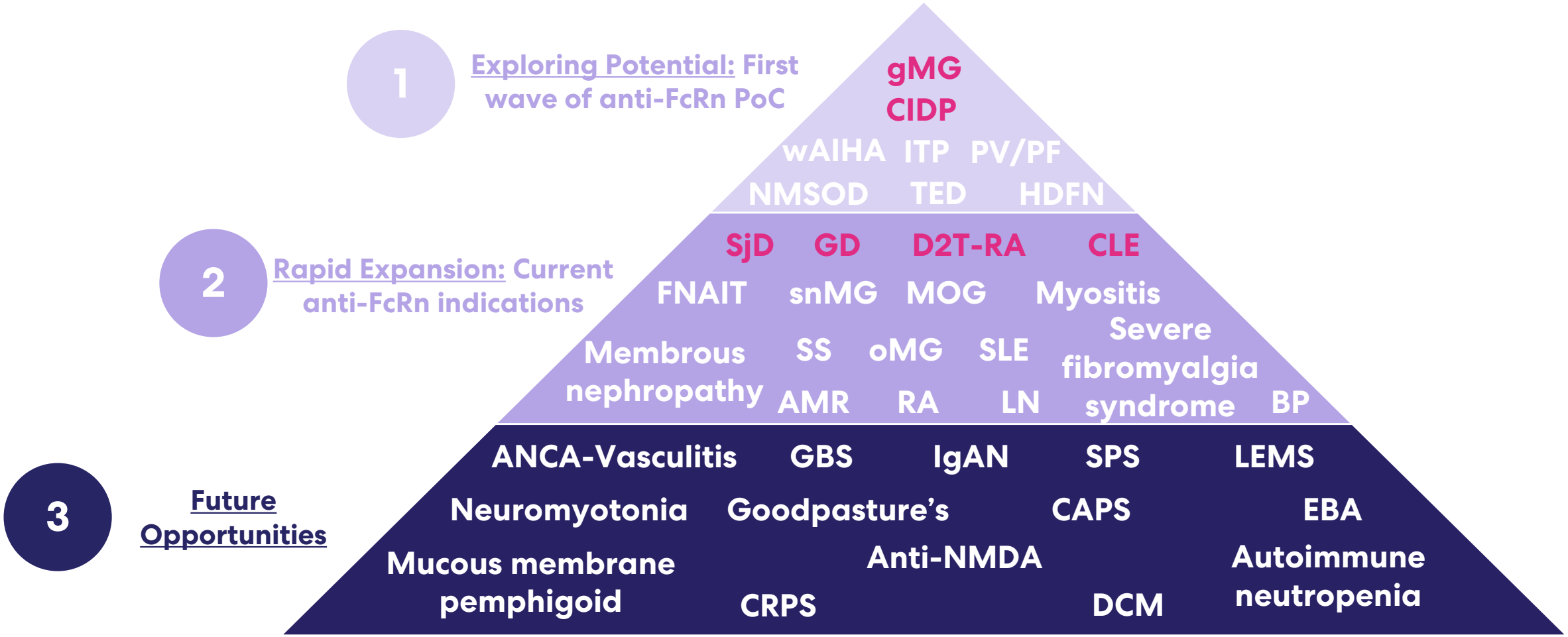
IMVT-1402 Indication Selection Optimizes Across Both Clinical Validation and Commercial Potential



Exploring Other Potential Opportunities for IMVT-1402 Across the Spectrum

Note: Bubble placement is illustrative and not representative of expected clinical risk and commercial opportunity. Size of bubbles is not indicative of market size

Anti-FcRns Have Pipeline-in-a-Product Potential Across Autoimmune Diseases Driven by Harmful IgG Autoantibodies With Continued Room for Growth



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Current IMVT-1402 indications

Note: Indications listed include possible indications where anti-FcRn may have mechanistic rationale to pursue

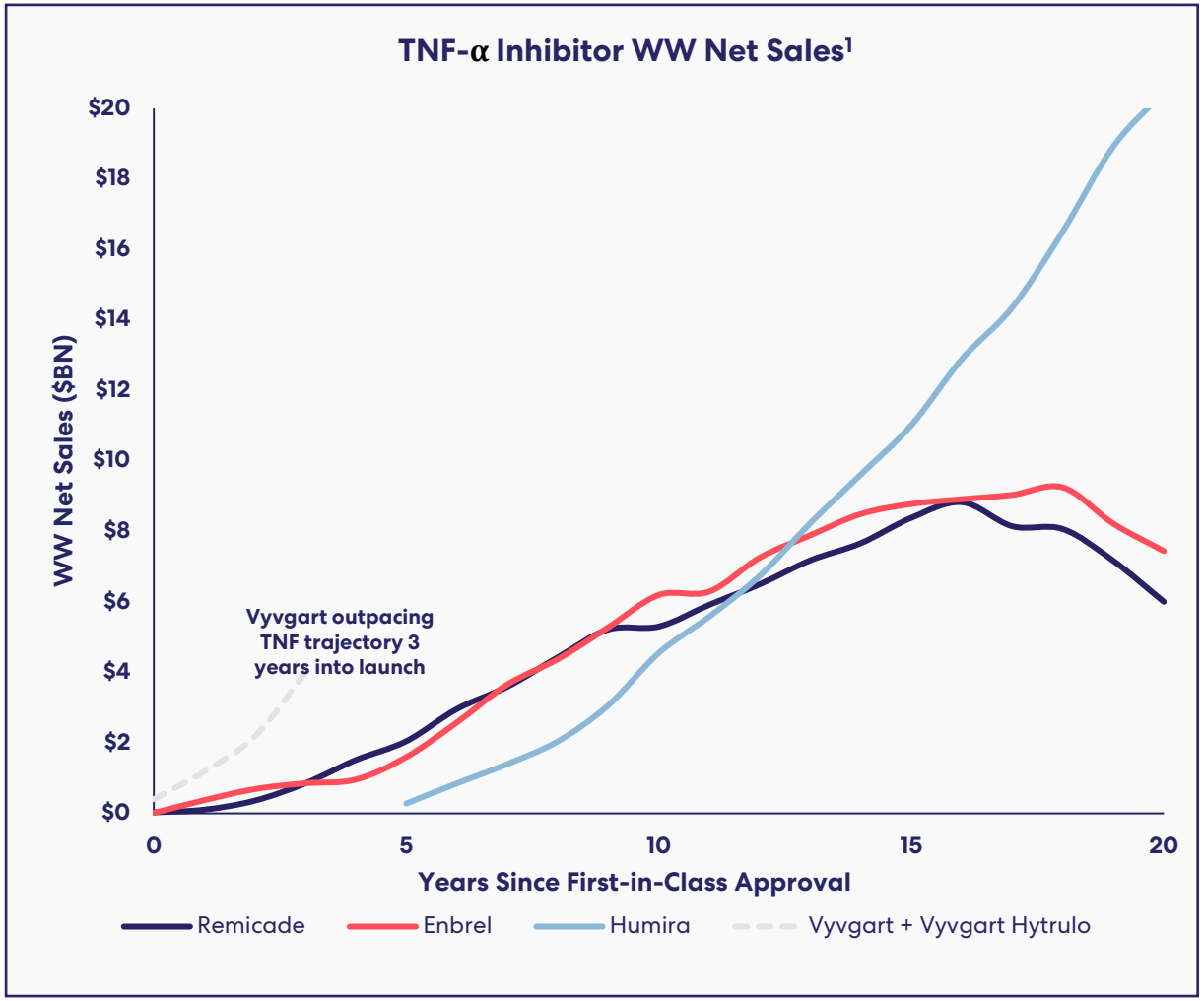
Anti-FcRn Antibody Development Has Seen Explosive Growth Since 2020

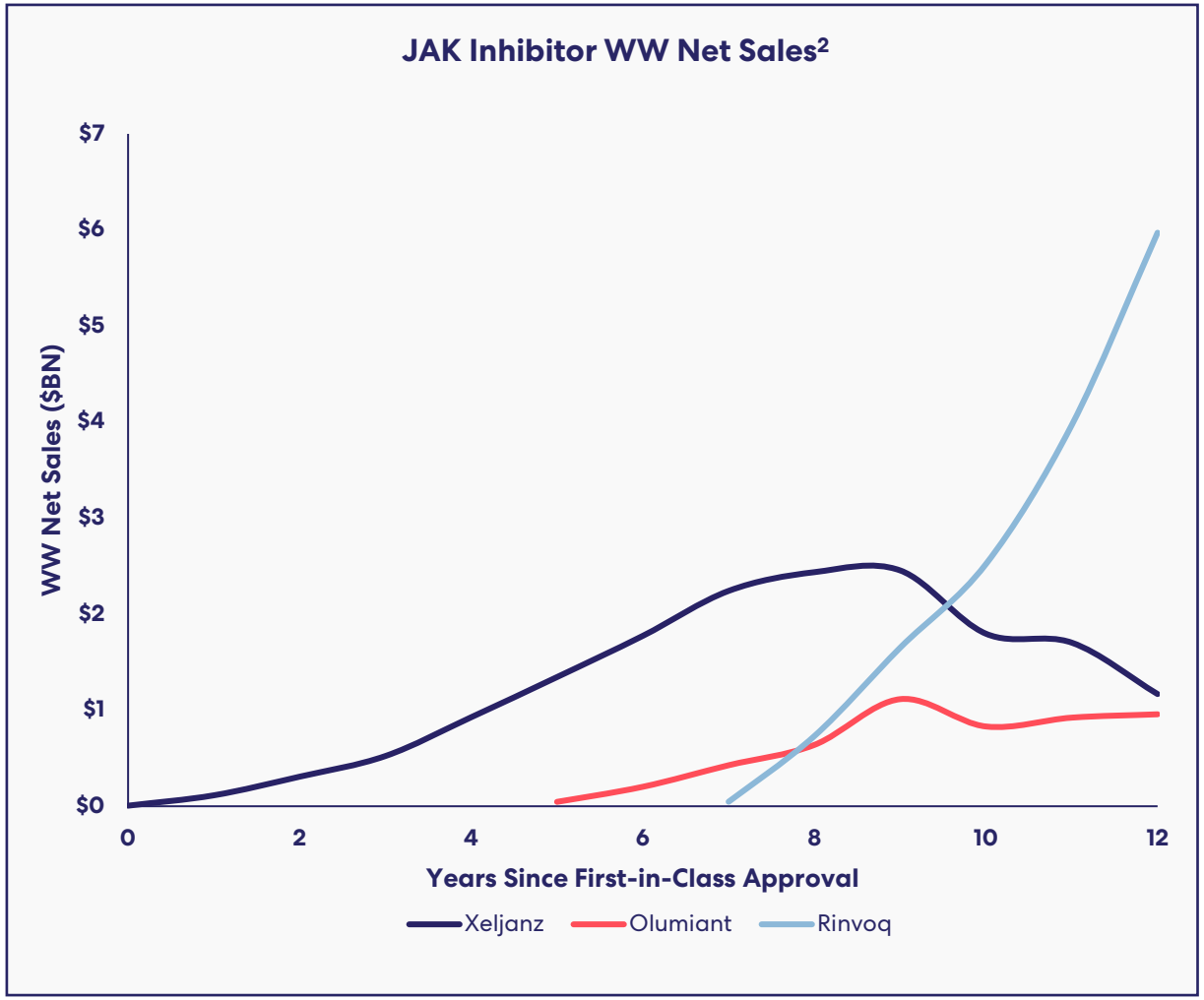
2020		2025		
8	**~700K**	**20+**	**~4M**	**~$7BN**
Total Indications in Development	Total Addressable Patient Population	Total Indications in Development	Total Addressable Patient Population	Cumulative Anti-FcRn Sales in MG & CIDP[1]

NEUROLOGY | HEMATOLOGY | ENDOCRINOLOGY | RHEUMATOLOGY | RENAL | DERMATOLOGY

Note: Indications in development cover anti-FcRn antibodies in development by Immunovant, argenx, JNJ and UCB
1. Includes disclosed sales from argenx and UCB

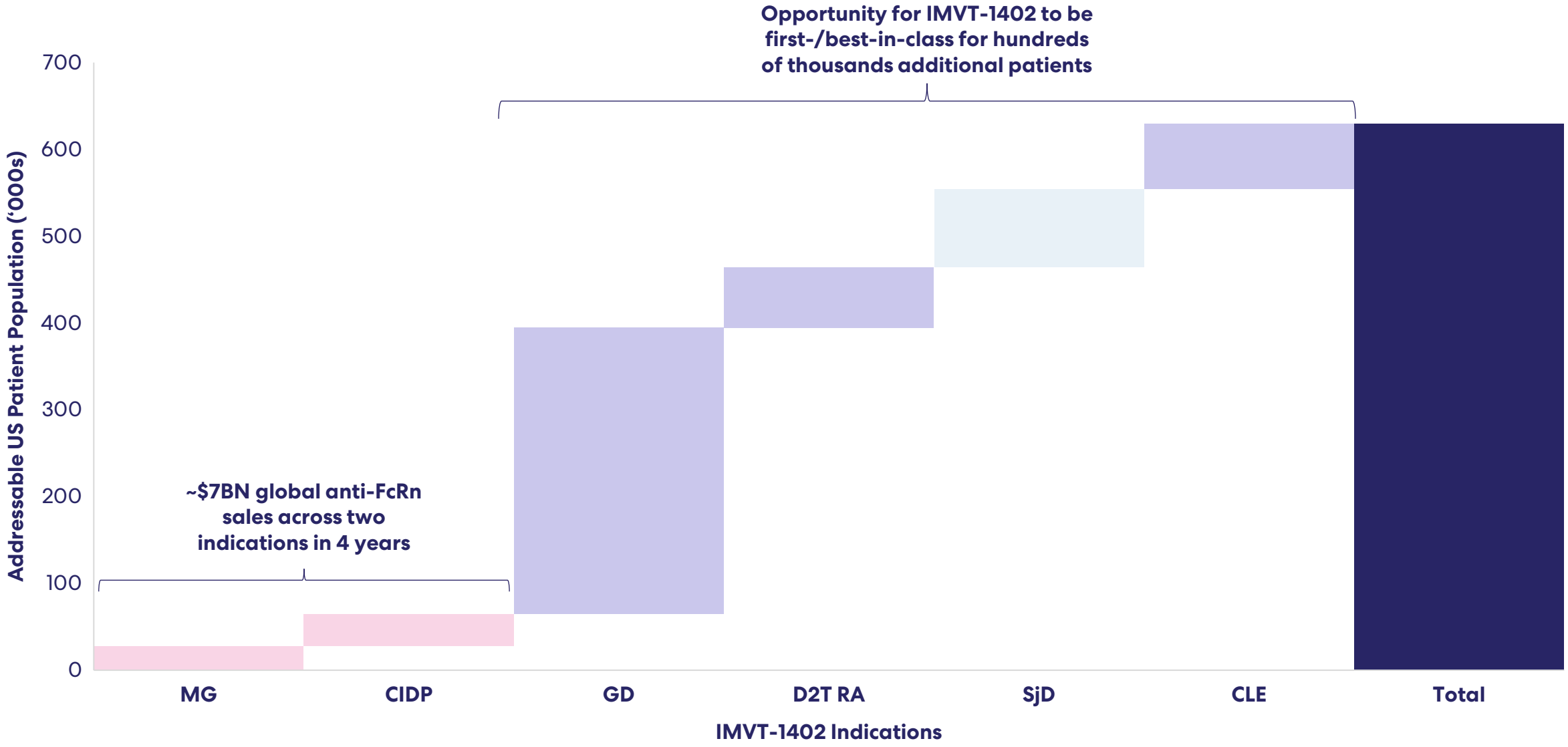
In Both TNF-α and JAKi Classes, a Later Product Launch With a Better Profile Rapidly Captured Dominant Market Share in Autoimmune Disease





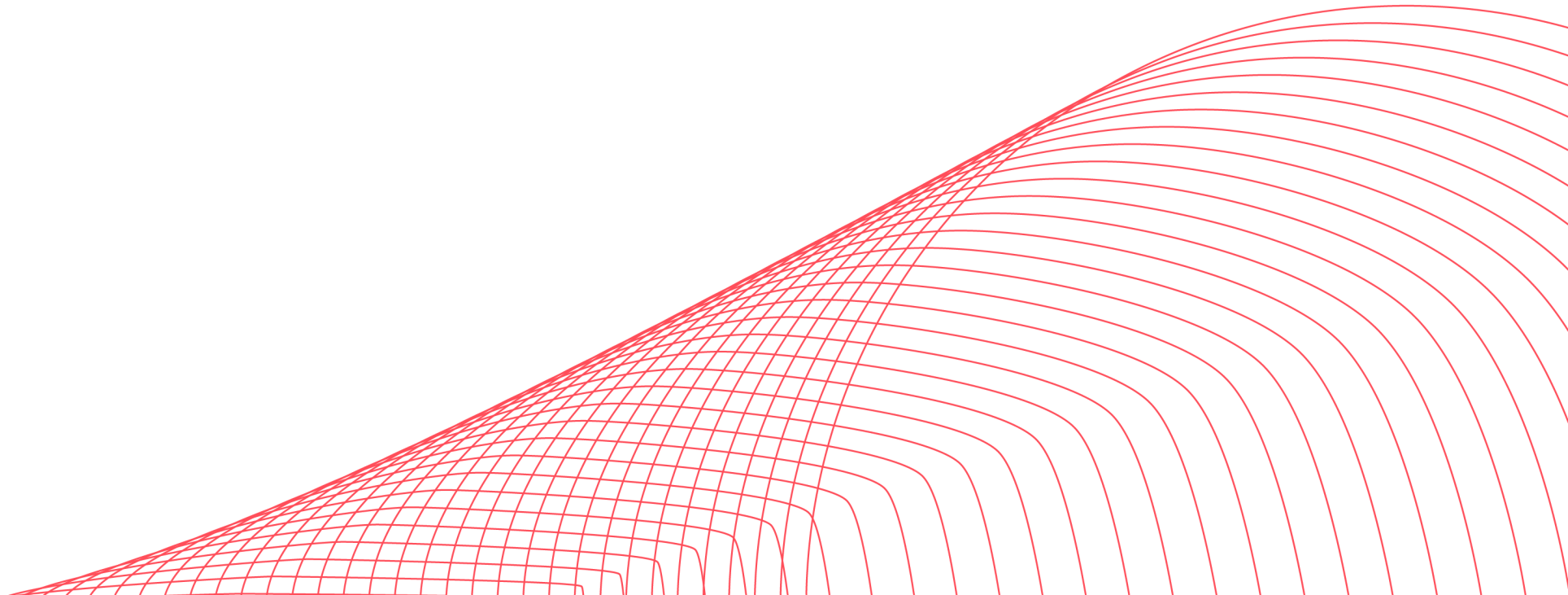
1. Data from Evaluate. 4Q2025 net sales for Vyvgart held constant based on sales in 3Q2025. Remicade and Enbrel launch in 1998, Humira in 2003. Vyvgart launch in 2022.
2. Data from Evaluate. Xeljanz launch in 2012, Olumiant launch in 2017, Rinvoq launch in 2019
Note: Net sales from company filings and Evaluate Pharma

IMVT-1402 Is Expected to Potentially Address >600K US Patients



Note: Addressable populations as listed in IMVT Pipeline in IMVT Corporate Overview deck

Near-Term Upside Catalysts for IMVT-1402



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IMVT-1402 Is Leading in 3 First-/Best-in-Class Indications With Key Catalysts Expected in D2T RA and CLE in 2026

Difficult-to-Treat Rheumatoid Arthritis

Rapidly enrolling trial; topline results now expected in 2026 (formerly 2027)

Cutaneous Lupus Erythematosus

Strong PoC data from IMVT-1402 basket study; initial results from PoC expected in 2026

Graves' Disease

Multi-year lead with remarkable PoC data; topline results from both potentially registrational trials expected in 2027

Note: All drugs are investigational and subject to regulatory approvals. All catalyst timings are approximate, based on current expectations and, where applicable, contingent on FDA feedback, and may be subject to change. All references are to calendar years.

Difficult-to-Treat Rheumatoid Arthritis (D2T RA) Represents an Unmet Medical Need With Few Current Treatment Options

D2T RA Patients Have Failed on Multiple Lines of Therapy

- **5-20%** of RA patients are difficult-to-treat (D2T), with inadequate or loss of response to multiple classes of advanced therapies[1]

Up to ~70k Patients in the US

- Of the **1.5M US RA patients**, a subset progresses to D2T status in a relatively short period of time and requires new therapeutic options[2]

Autoantibody Pathology

- **Autoantibodies such as ACPA** play a key role in pathophysiology, and **ACPA-positive RA is associated with severe disease and poor outcomes**

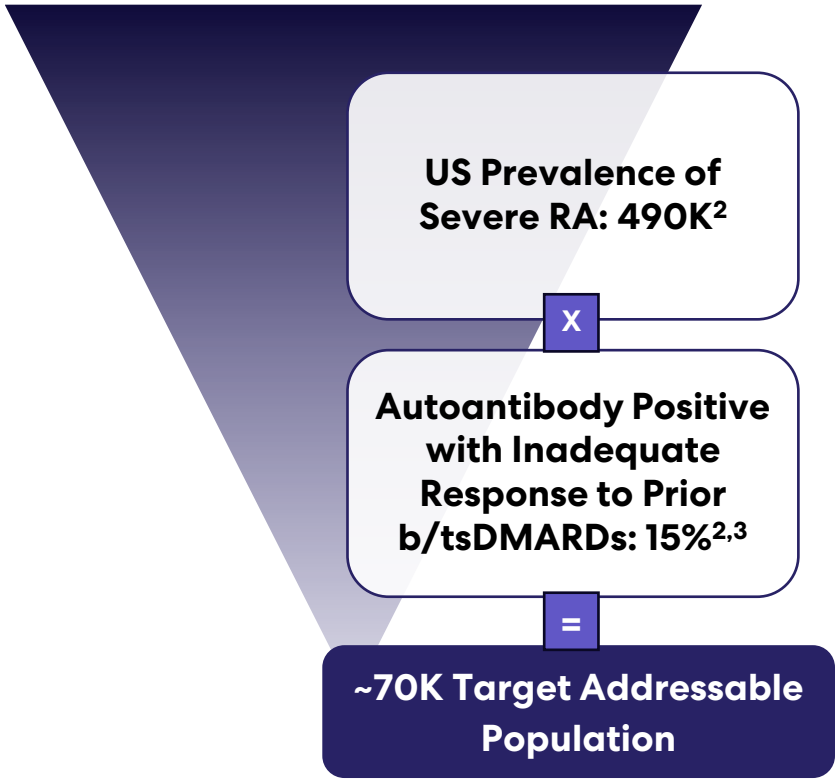
Deeper Is Better

- Phase 2 anti-FcRn RA data demonstrated that **greater IgG reduction led to greater autoantibody reductions**, which correlated with greater clinical response[3]

ACPA: anticitrullinated protein autoantibodies
1. Takanashi et al., Rheumatology (2021)
2. Aletaha and Smolen, JAMA (2018)
3. Taylor et al., ACR (2023)

Of the 1.5M US RA Patients, a Subset Progresses to D2T Status in a Relatively Short Period of Time and Requires New Therapeutic Options[1]

Market Opportunity



Patient Journey Learnings

Fewer than 50% of RA patients remain on first therapy	~50% of patients fail their first b/tsDMARD therapy within the first year of treatment [4,5]
D2T emerges for some in ~4 years	In a large US registry, the median time to meeting D2T criteria was 4 years, in those who were D2T[6]
5% - 20% of RA patients are D2T	5% – 20% of all RA patients meet the criteria for D2T in the US[6]

Note: All estimates are approximate; b/tsDMARD: biologic (b) or targeted synthetic (ts) disease-modifying antirheumatic drug

1. Aletaha and Smolen, JAMA (2018)
2. GlobalData Analysis and Forecast, 2023
3. Okada et al., Ann Rheum Dis (2019)
4. Murray et al., Arthritis Res Ther (2021)
5. Rosenberg et al., Adv Ther (2023)
6. Takanashi et al., Rheumatology (2021)

Cutaneous Lupus Erythematosus (CLE) Is a Debilitating Skin Condition With Minimal Current Treatment Options

Limited Treatment Options for CLE

- CLE is a rare, **chronic autoimmune disease affecting the skin, with limited available treatment options and high unmet need**
- No novel targeted treatment option in >50 years[1]

Up to ~75k Patients in the US

- Of the **~150K systemic and chronic CLE patients in the US,** ~50% are non-responders to anti-malarials and topicals

Autoantibody Pathology

- Biologic, translational and mechanistic evidence support the **critical role of IgG autoantibodies** and immune complexes in the pathogenesis of CLE

Early Proof of Concept Data

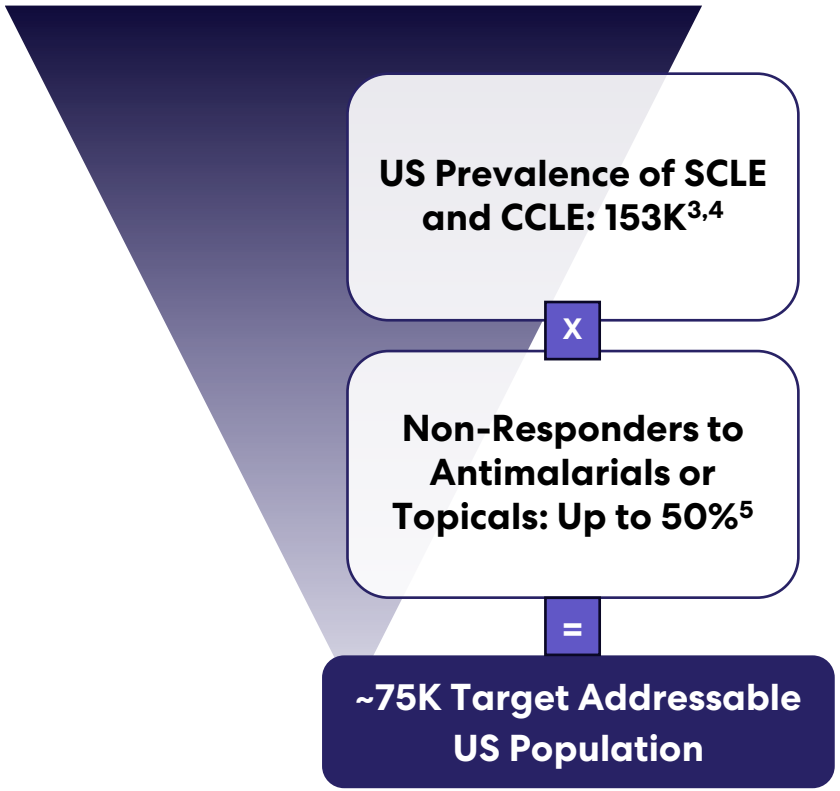
- Disruption of CLE pathology by upstream targeted approach supported by IMVT-1402 patient case studies
- **12-week treatment with IMVT-1402 in CLE demonstrated meaningful clinical benefit**

1. Presto and Werth, Curr Treat Opt Rheum (2016)

Dermatologists Desire a Skin-Focused, Targeted Biologic That Addresses Unmet Needs in CLE[1]

IMVT-1402 has potential to be the first novel dermatology therapy for CLE in >50 years[2]

Market Opportunity



Potential Differentiated Profile

Targeted Biologic	Dermatologists are frustrated by the skin-specific therapies currently available
Quick Control	Speed of action is critical to disease control and QoL- prevention of scarring and potential disfigurement[1]
Sustained Remission	90% of dermatologists cite sustained remission and reduced severity of flares as top unmet needs[1]
Improved Safety and Tolerability	80% of HCPs report lack of long-term efficacy, tolerability and toxicity risks with current CLE treatments[2]

1. Internal Market Research CLE Dermatologist Unmet Need (2023), Internal Market Research CLE Patient Journey (2024)
2. Presto and Werth, Curr Treat Opt Rheum (2016)
3. Jarukitsopa et al., Arthritis Care Res (2015)
4. IMVT Spherix Internal Market Research
5. Wahie and Meggitt, Br J Dermatol (2013)

Introducing Dr. Mark Lupo

Graves' Disease Thought Leader

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Florida State University, College of Medicine
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Why Are We Still Treating Graves' Disease Like It's 1950?

Mark A. Lupo, MD, FACE, ECNU
Thyroid & Endocrine Center of Florida
Assistant Clinical Professor of Medicine
Florida State University, College of Medicine
Sarasota, Florida

Disclosures

Mark A. Lupo, MD

- Speaking, research, and/or consulting: AbbVie, Amgen, argenx, Eisai, Immunovant, Interpace Diagnostics, Lycia Therapeutics, QuidelOrtho, Takeda, Viridian

My Practice

- Established in 2002
- Independent center focused on thyroid and parathyroid disease
- 3 Endocrinologists
- We see/follow hundreds of Graves' disease patients
  - About half still on long-term antithyroid drug treatment

Patient Phenotypes

MILD (~50%)
- Small goiter
- +/- Slightly high T4/T3
- No TED/mild TED
- Modest TRAb elevation
- Predictable ATD response

MODERATE (~35-40%)
- +/- Goiter
- Overt hyper (T4/T3 elevation)
- +/- TED mild-moderate
- TRAb elevation >3-5x normal
- Multiple ATD dose changes

SEVERE (~10-15%)
- Large Goiter
- T4/T3 levels >4-5x normal
- TED present, often severe
- TRAb elevation >5x normal
- High ATD dose with unpredictable responses

Factors decreasing remission rates:
AGE <40
SEX – male
TOBACCO USE

TRAb Levels Are Associated With Medical Treatment Relapse Rates, Indicating an Autoimmune Pathology

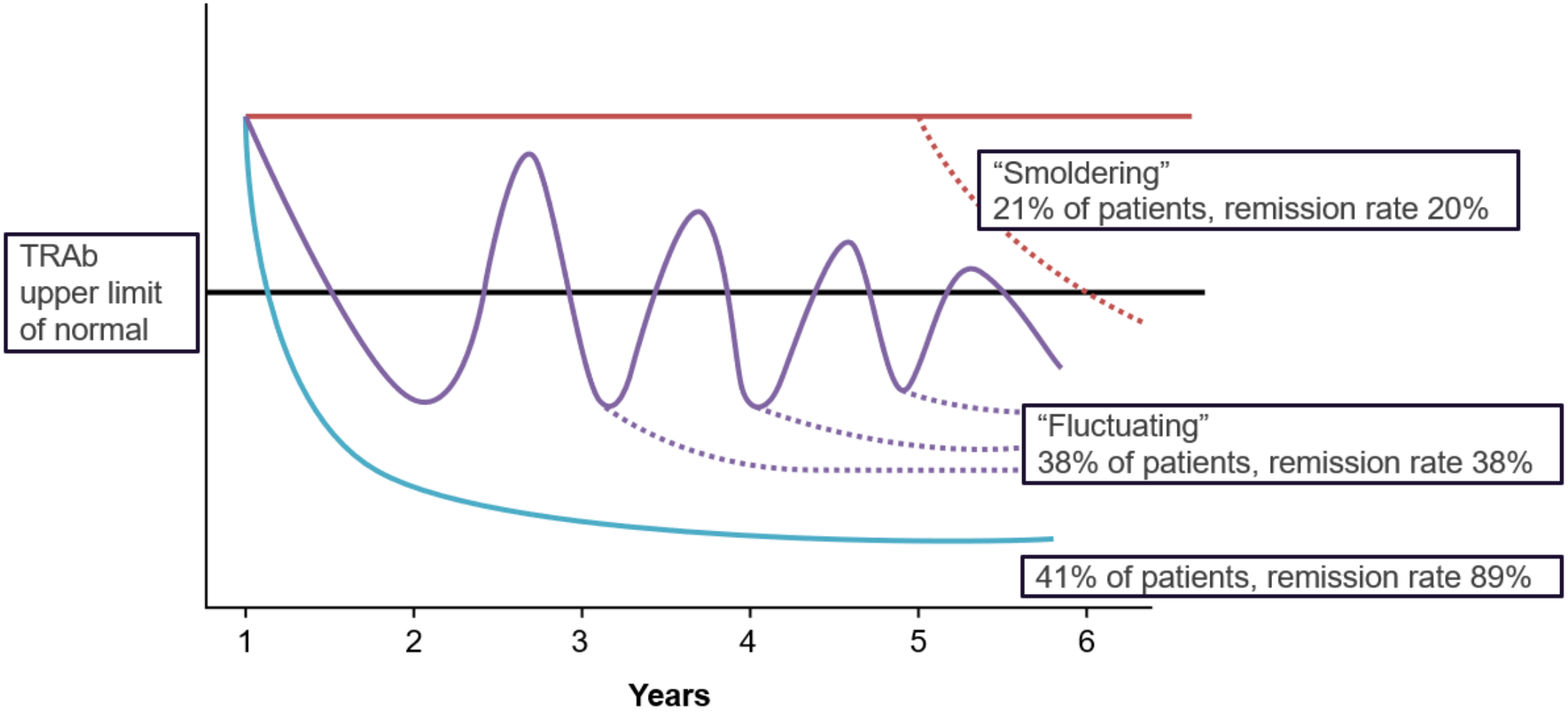
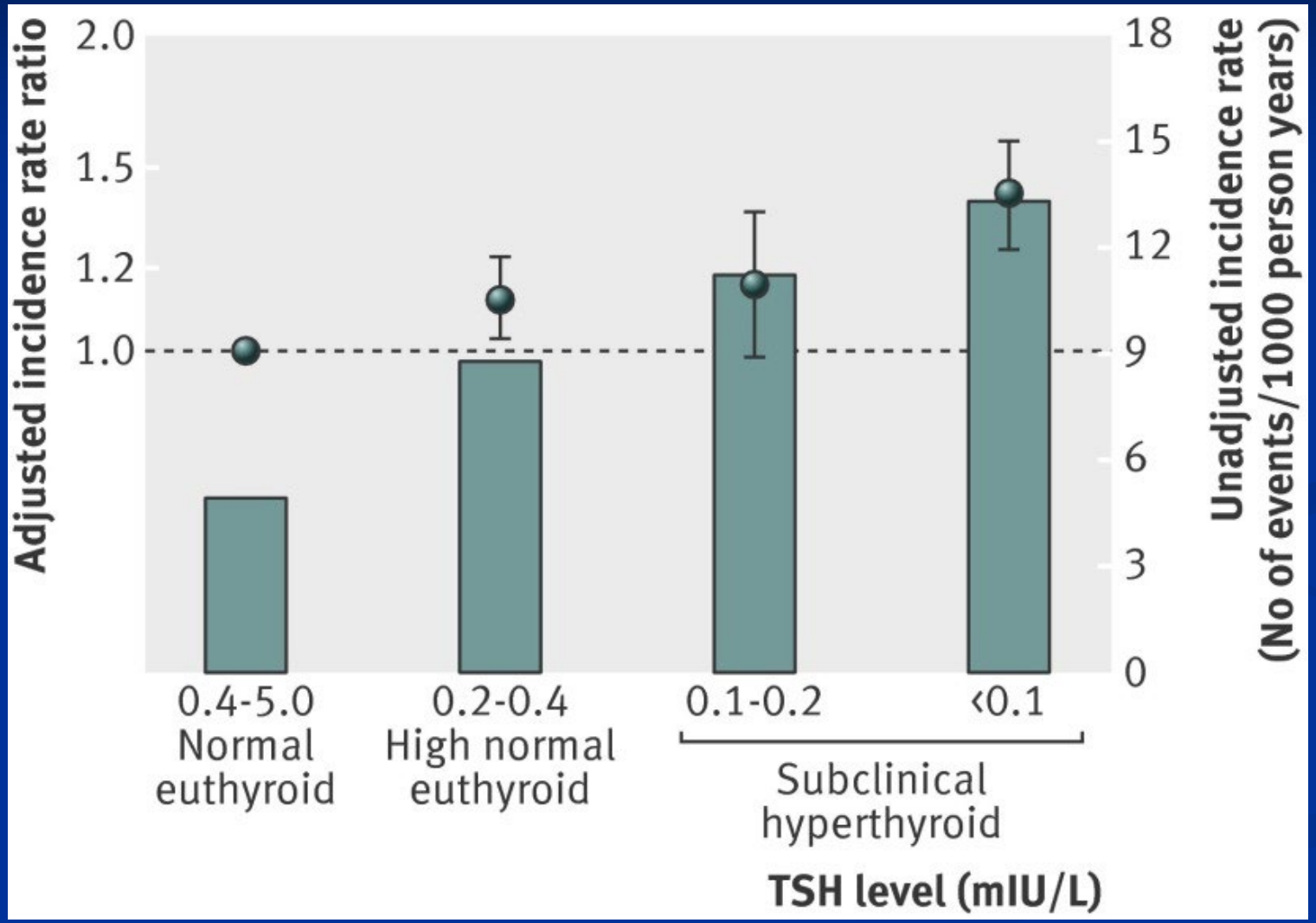


Figure adapted from Cooper D. *Curr Opin Endocrinol Diabetes Obes*. 2021;28(5):510-6. Used with permission of Wolters Kluwer Health, Inc.

Consequences of Uncontrolled Graves'

- Cardiovascular
  - Atrial Fibrillation → Stroke/Death
  - High Output Heart Failure → Morbidity/Death
  - Increased Clotting Risks → Stroke/Blood Clots
- Bone Loss → Osteoporosis/Fracture
- Thyroid Eye Disease → Vision Threatening
- Quality of Life Impact
  - Anxiety, Insomnia, Muscle Weakness, Tremor, Infertility

Atrial Fibrillation Risk with Hyperthyroidism



Registry Data of 586,460 Adults

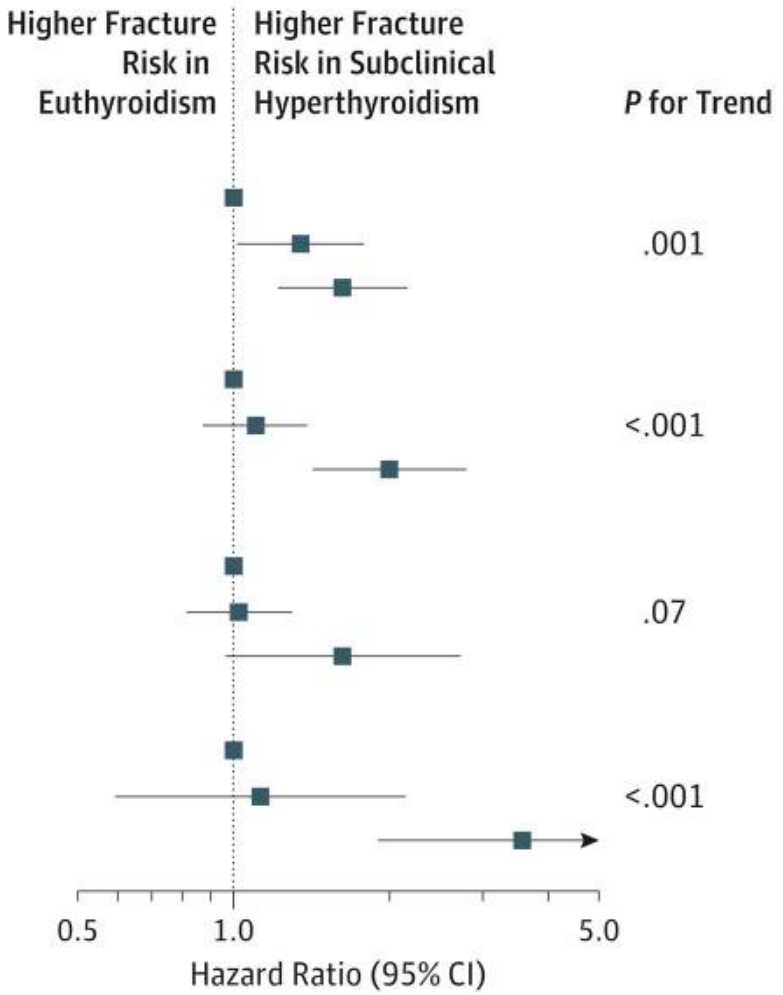
No Prior Atrial Fibrillation or Recorded Thyroid Disease

16,170 Atrial Fibrillation Events

Selmer C et al. BMJ 2012.

Fracture Risk by TSH

Fracture Outcome by Thyroid-Stimulating Hormone Levels, mIU/L	Euthyroidism		Subclinical Hyperthyroidism		Hazard Ratio (95% CI)	*P* for Trend
	No. With Fracture	Total No. of Participants	No. With Fracture	Total No. of Participants		
Hip fracture[a]						
0.45-4.49	2534	56471			1 [Reference]	
0.10-0.44			99	1568	1.34 (1.01-1.77)	.001
<0.10			47	510	1.61 (1.21-2.15)	
Any fracture[b]						
0.45-4.49	2203	25901			1 [Reference]	
0.10-0.44			77	676	1.10 (0.87-1.38)	<.001
<0.10			44	212	1.98 (1.41-2.78)	
Nonspine fracture[c]						
0.45-4.49	1745	21722			1 [Reference]	
0.10-0.44			74	757	1.02 (0.81-1.29)	.07
<0.10			32	185	1.61 (0.96-2.71)	
Spine fracture[d]						
0.45-4.49	255	20328			1 [Reference]	
0.10-0.44			9	566	1.12 (0.59-2.13)	<.001
<0.10			8	162	3.57 (1.88-6.78)	



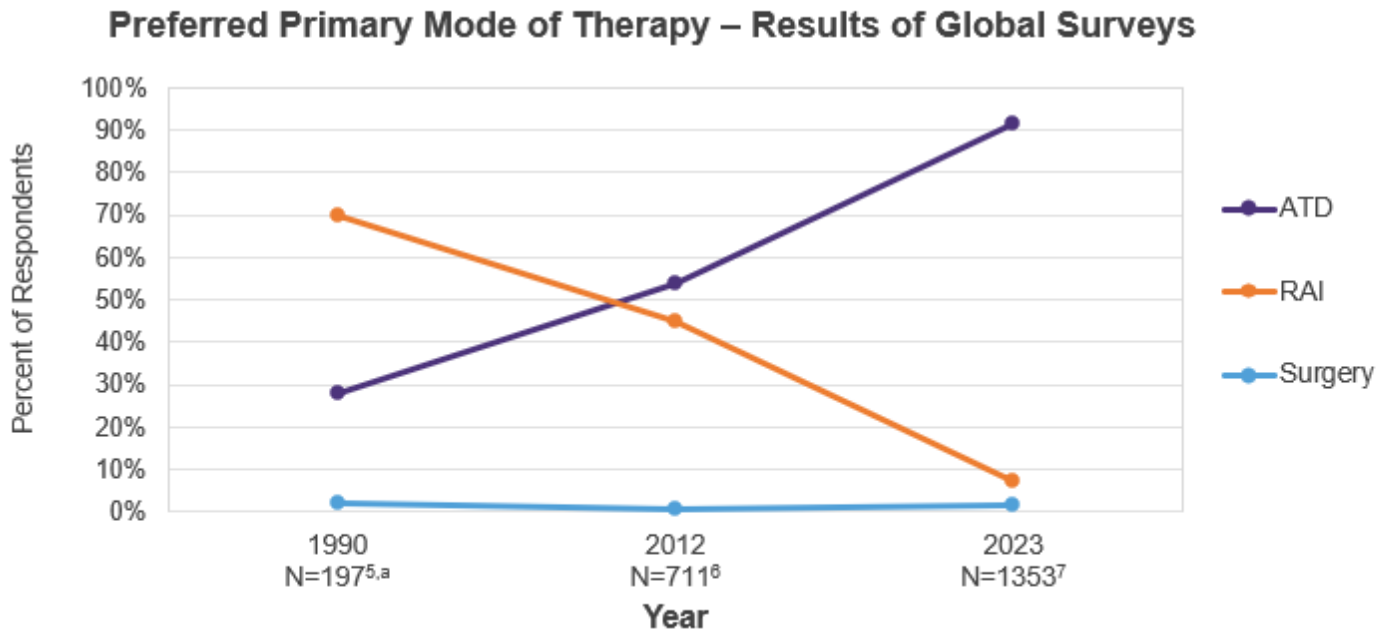
Blum M et al. JAMA 2015

Current Therapies for Graves' Disease Target the Thyroid Gland and Have Remained Largely Unchanged for 75 Years…

Treatment	MOA
ATDs	Inhibit thyroid hormone synthesis[1-3]
RAI	RAI-induced thyrocyte destruction[1,4]
Thyroidectomy	Removal of thyroid gland[1]

… but Practice Patterns for Graves' disease Are Evolving

ATDs are the Preferred First Line Therapy



[a]All respondents were residing in the US. GD, Graves' disease; MOA, mechanism of action.

References: 1. Kahaly GJ. *J Clin Endocrinol Metab.* 2020;105(12):3704-20. 2. [Pr]PROPYL-THYRACIL (propylthiouracil tablets USP) [prescribing information]. Paladin Labs Inc.; 2020. 3. Methimazole tablet [prescribing information]. AvKARE; 2025. 4. SODIUM IODIDE I 131 CAPSULES THERAPEUTIC [prescribing information]. Mallinckrodt Nuclear Medicine LLC; 2018. 5. Solomon B, et al. *J Clin Endocrinol Metab.*1990;70(6):1518-1524. 6. Burch HB, et al. *J Clin Endocrinol Metab.* 2012;97(12):4549-4558. 7. Villagelin D, et al. *J Clin Endocrinol Metab.* 2024:dgae222.

Definitive Treatment Discussion

- Radioactive Iodine
  - Increased risk TED
  - TRAb elevation
  - Radiation exposure
  - **Permanent hypothyroidism**
- Thyroidectomy
  - Indicated if concern for cancer or large obstructive goiter
  - Higher risk*
    - Hypoparathyroidism
    - Post-operative bleeding
    - Tracheostomy
  - Scar
  - **Permanent Hypothyroidism**

*relative to thyroid surgery for other indications

Quality of Life after Definitive Treatment

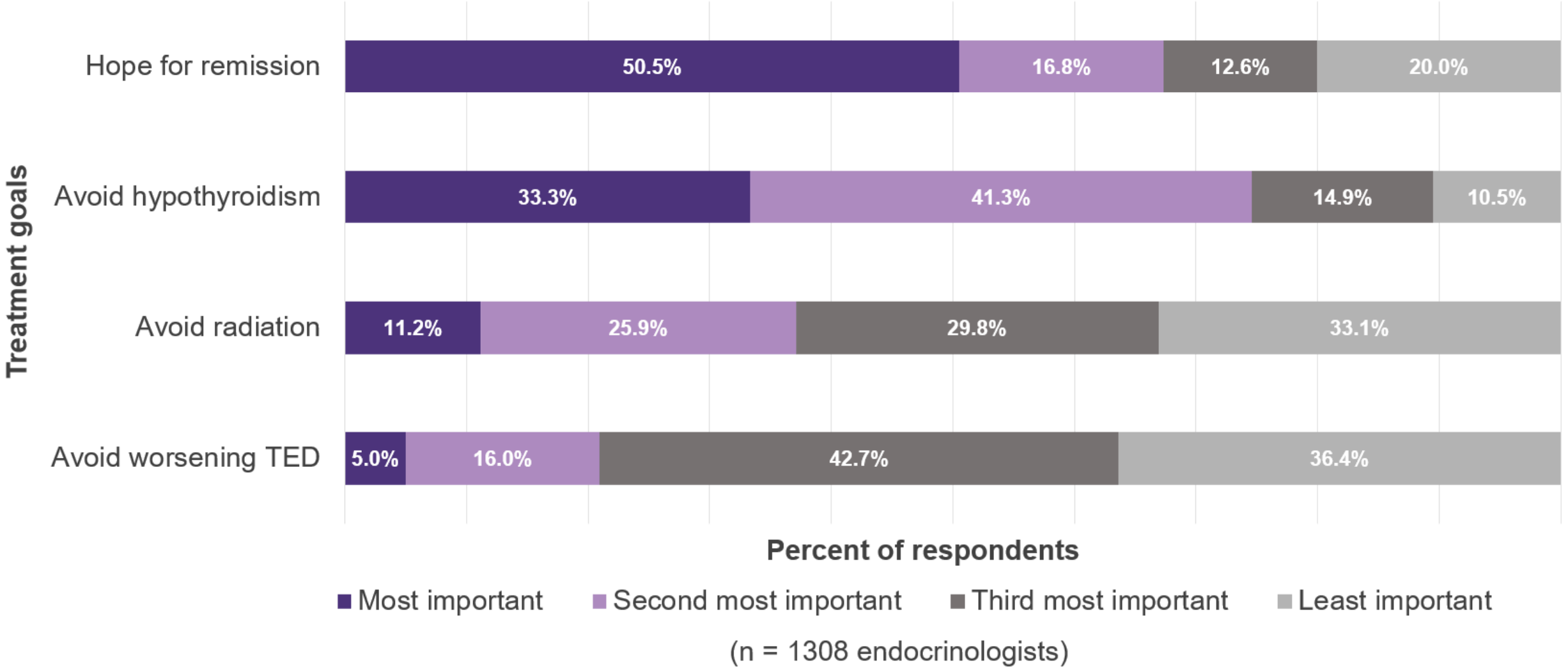
- Hypothyroid patients consistently report lower scores on QOL scales compared to general population
- Treatment specific complications
- 1 in 4 patients still feel "unwell" but often told they are fine due to normal thyroid labs

Long-term Outcomes

- 2430 GD patients diagnosed 2003-2005
- 60% had follow-up data mean 8 years
- Remission rates: ATD-45%, RAI-82%, Surgery-96%
  - ATD, second course 29% remission rate
- Patients receiving ATD had 50% chance of avoiding definitive treatment and 40% chance of achieving euthyroid state
- Overall, 25% patients did not feel "fully recovered" long-term

Sjolin et al. Thyroid 2019

Remission and Avoiding Hypothyroidism Are the Primary Treatment Goals



TED, thyroid eye disease.

Reference: Villagelin D, et al. *J Clin Endocrinol Metab*. 2024;109(11):2956-2966.

Approximately 50% of Patients with Graves' Disease Relapse After Stopping Medical Therapy

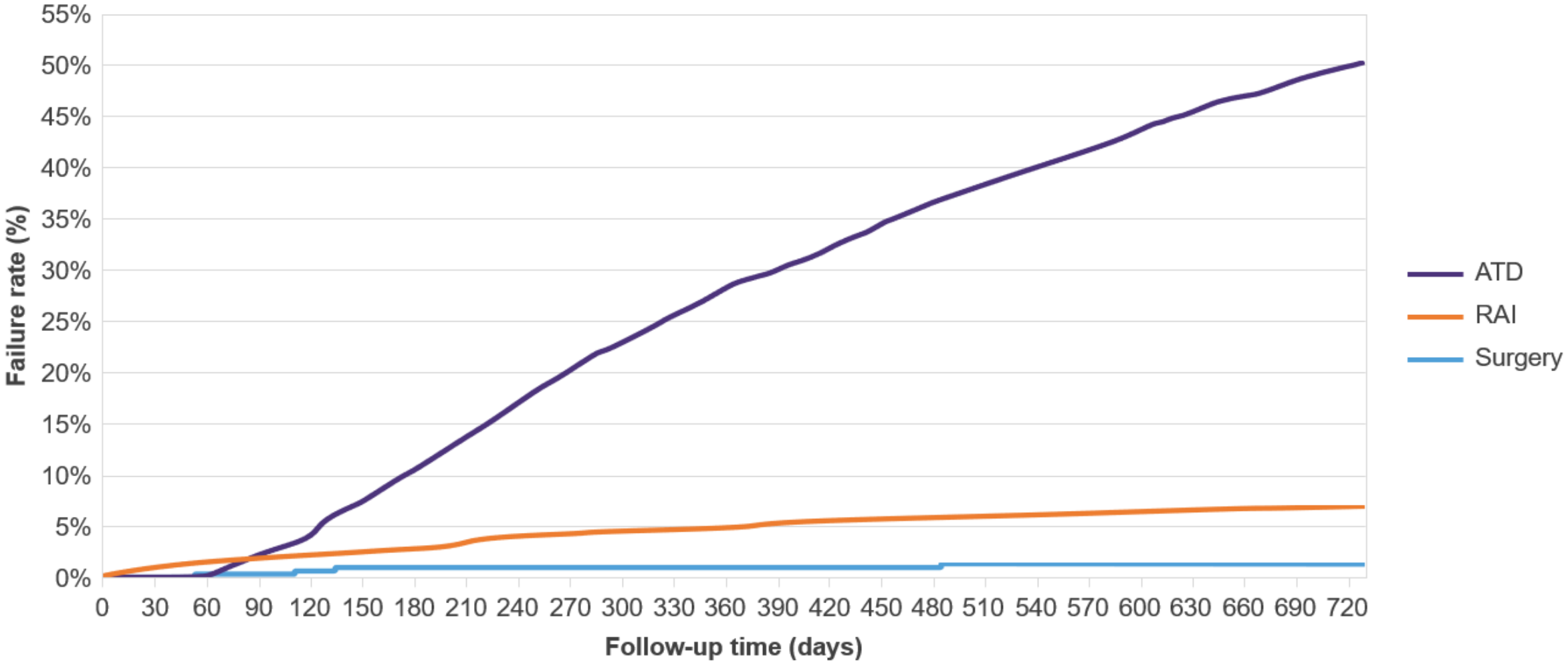


Figure adapted from Brito JP, et al. *Thyroid*. 2020;30(3):357-64. Used with permission of Mary Ann Liebert, Inc.

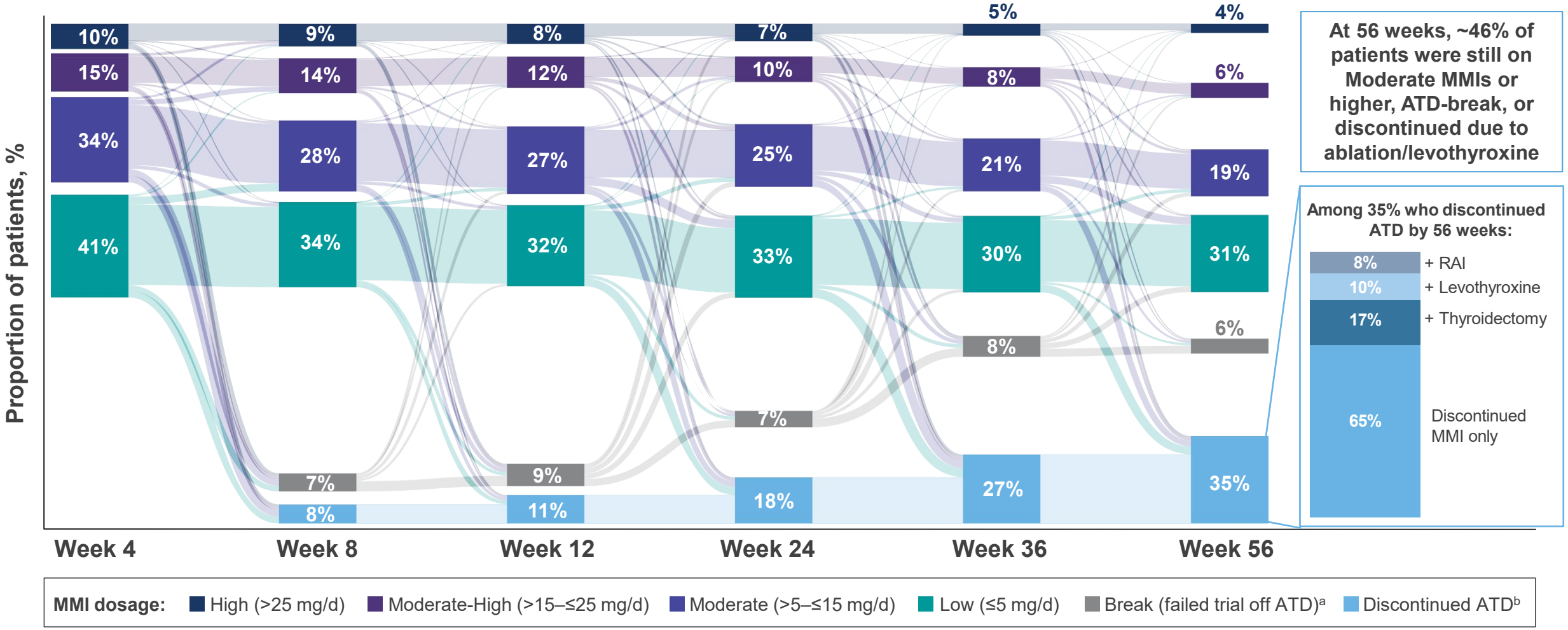
Real-World Treatment Patterns of Methimazole (MMI) Use in the United States

Study Objective
To evaluate dosage and treatment patterns following MMI initiation among patients with Graves' disease in the US

Study Methods	
Data Source	IQVIA Open Claims and PharMetrics Plus databases
Time Period Analyzed	November 2017 to October 2023
Inclusion Criteria	Patients with a GD diagnosis within 3 years prior to or 2 years after an MMI prescription
Index Date	Date of the first MMI prescription claim from November 2020 through October 2021
Follow-Up Assessment	Patients were followed for 104 weeks from their first MMI prescription to evaluate treatment patterns

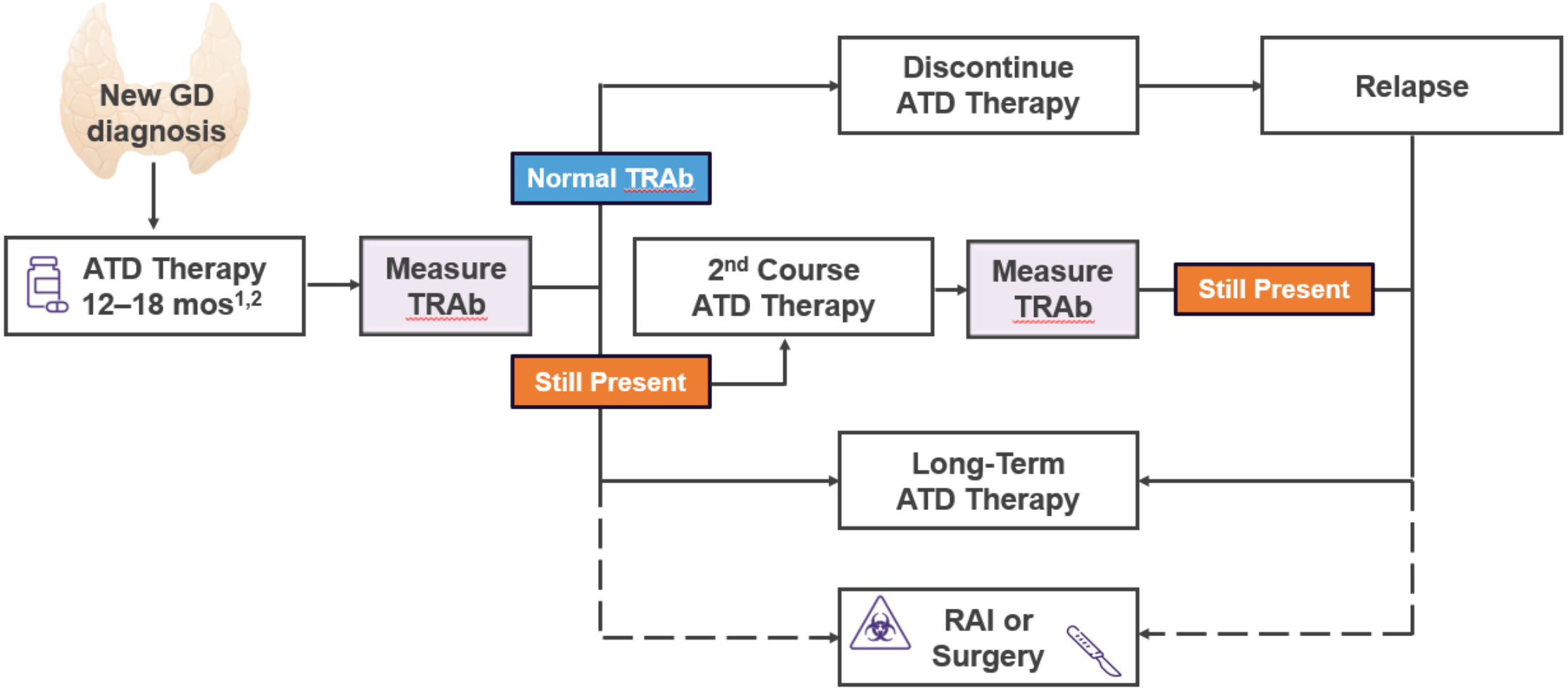
GD, Graves' disease; MMI, methimazole. Lupo m et al. Treatment Patterns Among Methimazole-Treated Patients With Graves' Disease. Poster #1112323 Presented at 17th International Thyroid Congress (ITC), June 21, 2025, Rio de Janeiro, Brazil.

Longitudinal Patient Dose Journey After First MMI Dose, by Starting Dose (N = 46,373)



ATD, antithyroid drug; d, day; MMI, methimazole. [a] Failed trial off ATD: Patient was off therapy for the period but later returned to ATD during the study. [b]Discontinued therapy: Patient remained off therapy for the remainder of the study (up to 104 weeks). Lupo m et al. Treatment Patterns Among Methimazole-Treated Patients With Graves' Disease. Poster #1112323 Presented at 17th International Thyroid Congress (ITC), June 21, 2025, Rio de Janeiro, Brazil.

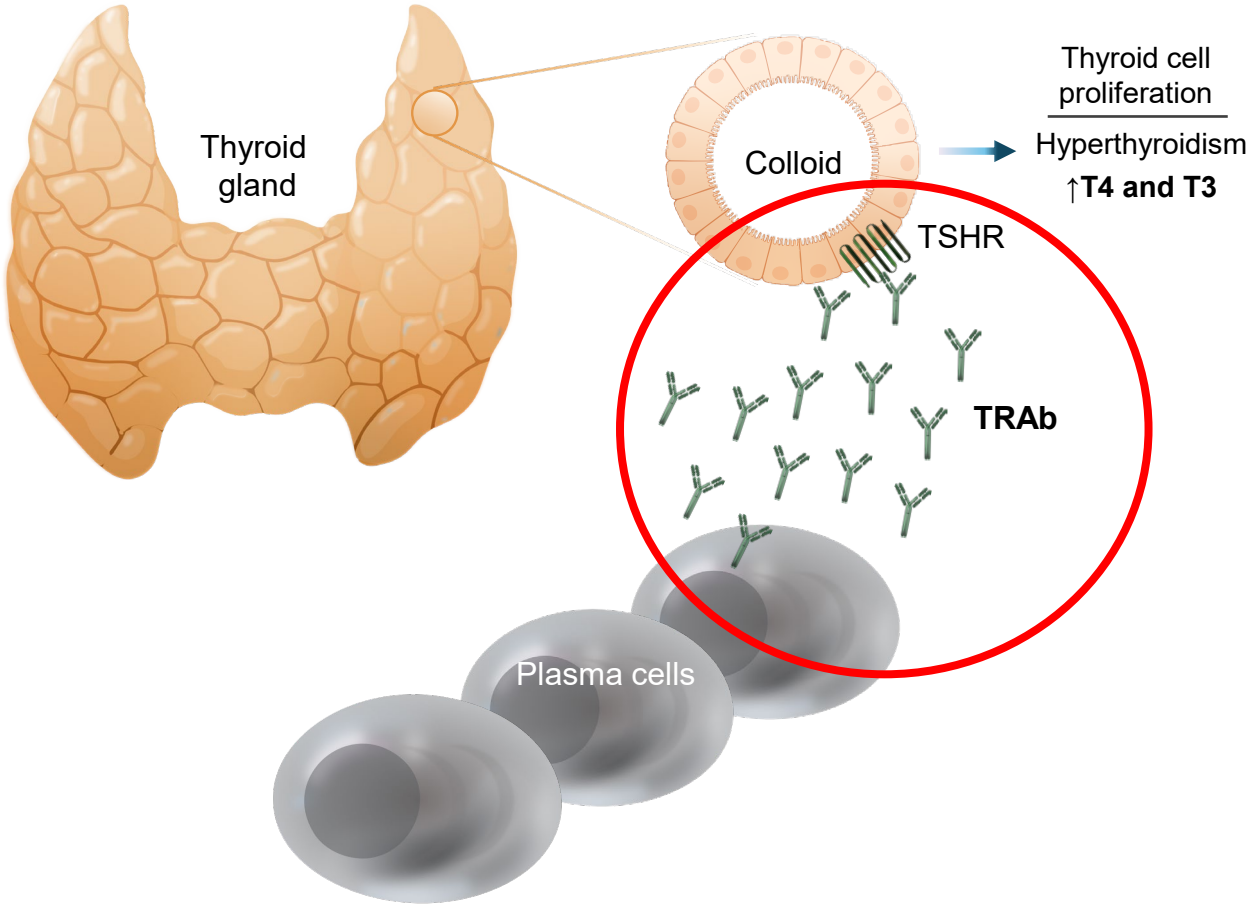
Current Recommendations for the Management of Graves' Disease



ATD, antithyroid drug; GD, Graves' disease; RAI, radioactive iodine; TRAb, thyroid-stimulating hormone receptor antibodies.

References: 1. Kahaly GJ, et al. *Eur Thyroid J*. 2018;7:167-86. 2. Ross DS, et al. *Thyroid*. 2016;26(10):1343-421.
3. Cooper DS. *Curr Opin Endocrinol Diabetes Obes*. 2021;28:510-6

Unmet Needs in Graves' Disease



Standard of Care

- Current therapies do **not target** the underlying autoimmune response[1]
- While a significant proportion of patients respond to ATD therapy, up to **~25%** are unable to complete their initial course[2]
- **~50% remission** rate after stopping ATD therapy[3,4]
- Positive **TRAb** levels are associated with markedly increased **relapse** rates[5]

ATD, antithyroid drug; T3, triiodothyronine; T4, thyroxine; TRAb, thyroid-stimulating hormone receptor-binding autoantibodies.

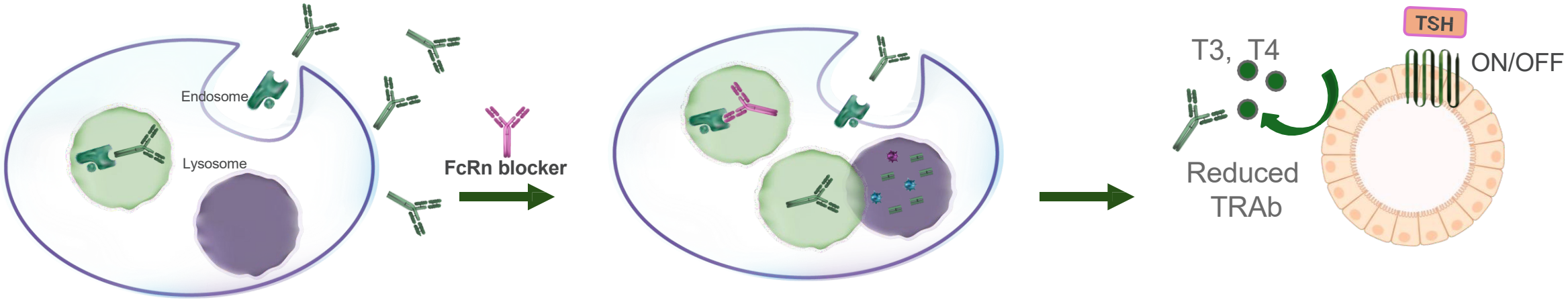
1. Bartalena L. *Nat Rev Endocrinol*. 2013;9(12):724-34. 2. Sjolin G, et al. *Thyroid*. 2019;29(110):1545-67. 3. Liu L, et al. *Exp Ther Med*. 2016;11(4):1453-58. 4. Chung *J. Endocrinol Metab*. 2021;36(3):491-99. 5. Da Silva Santos T, et al. *Cureus*. 2022;14(2):e22190.

Rationale for Treatment of GD With an FcRn Blocker

Endothelial cell recycles anti-TSHR autoantibodies (TRAb)

FcRn blocker blocks FcRn-mediated IgG recycling in circulation

Thyroid follicles activated by natural ligand, TSH



In the absence of FcRn blocker, FcRn binds to the anti-TSHR Ab, inhibiting their degradation and returning them into the circulation

In the presence of FcRn blocker, FcRn is blocked from binding to anti-TSHR Ab, which are then transported to the lysosome for degradation, decreasing their levels in the circulation

Potential for reduced stimulation of TSHR by pathogenic TRAb which may potentially alleviate systemic symptoms

Legend: FcRn; Thyrotropin Receptor (TSHR); Anti-TR autoantibodies; FcRn blocker; T3, T4 Thyroid hormones; TSH; Thyroid stimulating hormone; Thyroid follicle

Ab, antibodies; FcRn, neonatal fragment crystallizable receptor; GD, Graves' disease; T3, triiodothyronine; T4, thyroxine; TRAb, thyroid-stimulating hormone receptor antibodies; TSH, thyroid-stimulating hormone; TSHR, thyroid-stimulating hormone receptor.

Dr. Mark Lupo

Graves' Disease Thought Leader

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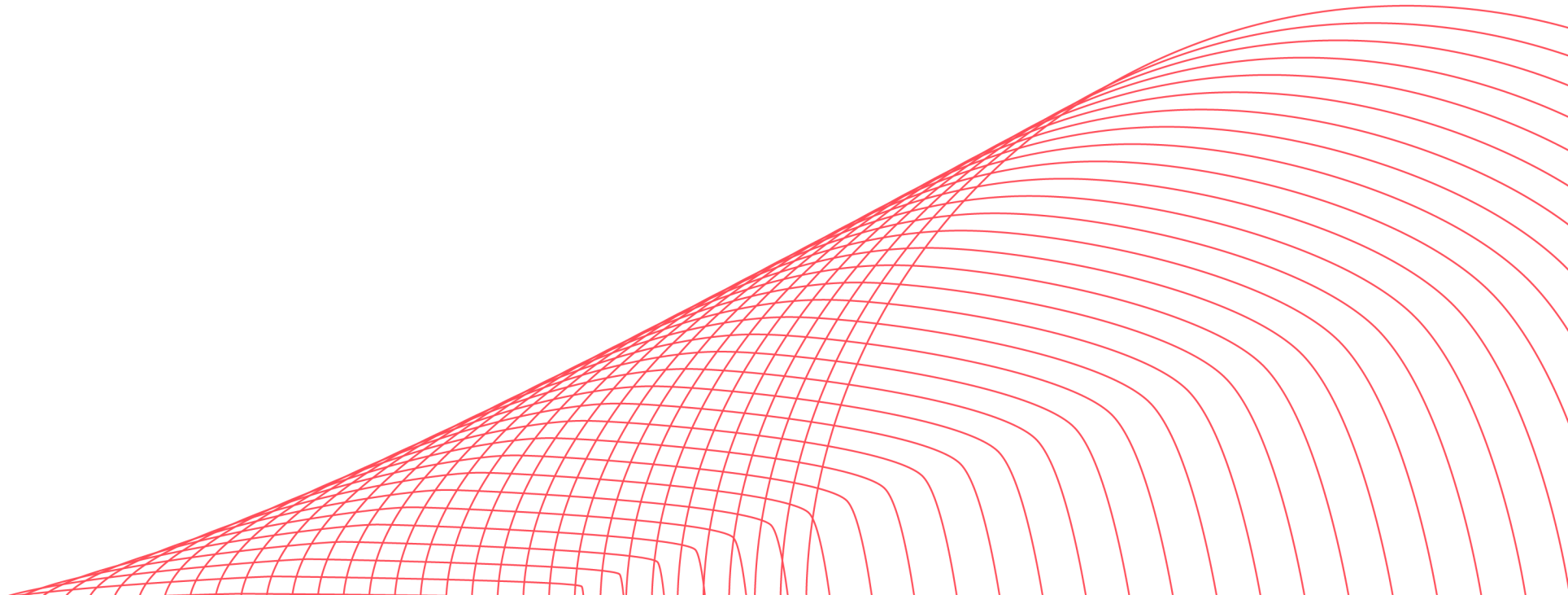
Paving the Path Forward in Graves' Disease



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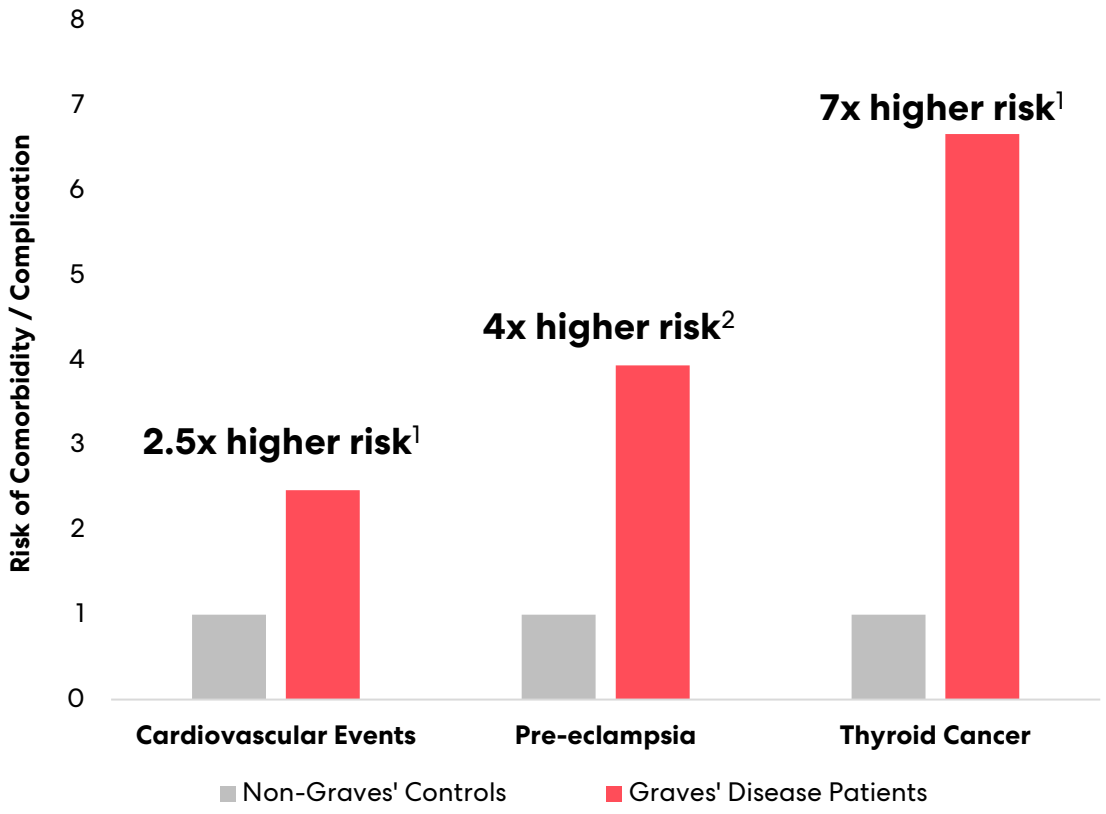
Graves' Disease Patients Have Higher Risk of Sequelae of Severe Comorbidities

Relative to Healthy Controls, Graves' Patients Are at Increased Risk of Developing Several Severe Comorbidities



Untreated or Insufficiently Treated Graves' Patients Experience Substantial Morbidity and Loss of Quality of Life

Thyroid Eye Disease (TED)

- TED affects ~40% of patients diagnosed with Graves' disease[3]
  - Up to 8% of TED patients experience dysthyroid optic neuropathy (impairment of visual function, leading to permanent sight loss)[4]

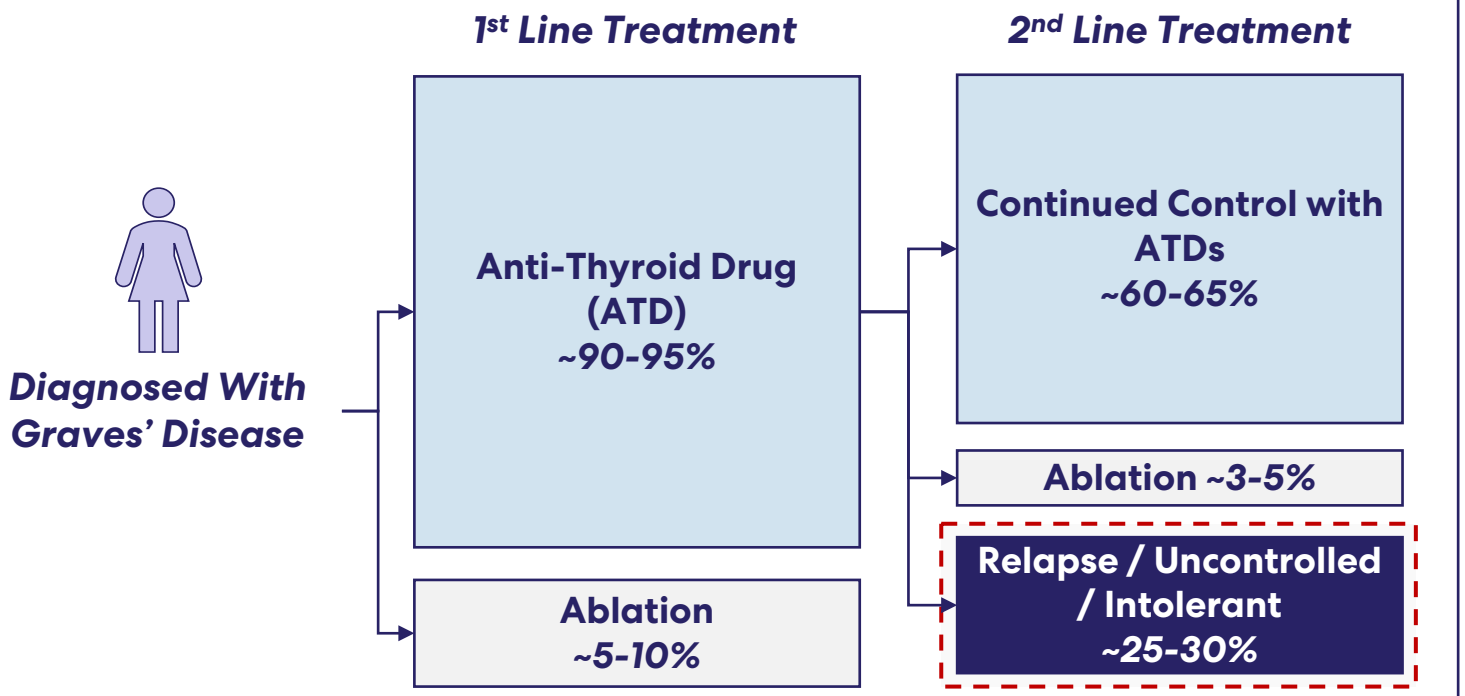
Other Significant Complications

- In patients hospitalized for Graves' disease, ~16% are diagnosed with thyroid storm[5], which has a ~20% mortality rate[6]
- Graves' disease patients who develop thyroid cancer are at a >3x risk of recurrent disease / progressive distant metastases relative to euthyroid controls[7]

1. Okosieme et al., Lancet Diabetes Endocrinol (2019)
2. Aggarwal et al., Gynecol Obstet Invest (2014)
3. Chin et al., Clin Endocrinol (Oxf.) (2020)
4. Potvin et al., Ophthalmic Plast Reconstr Surg (2023)
5. Galindo et al., Thyroid (2019)
6. Bourcier et al., Crit Care Med (2020)
7. Pellegriti et al., J Clin Endocrinol Metab (1998)

Shift Away From Ablation and Lack of New Medical Therapies Leaves 25-30% of Patients Who Are Relapsed, Uncontrolled, or Intolerant to ATDs

Graves' Disease Patient Journey:



Unmet Need

- 25-30% of patients are relapsed, uncontrolled on or intolerant to ATDs
- Ablation rates in the US indicate that despite lack of disease control on ATDs, patients are choosing not to pursue ablation
- Patients and healthcare providers seek therapeutic options that address underlying disease pathology

1. Values presented have been triangulated based on primary research (Immunovant Physician Primary Research (N=140 endocrinologists)) and claims analysis

Graves' Patients Uncontrolled on ATDs Experience Significant Disease Burden and Risk of Adverse Events With Limited Alternative Treatment Options

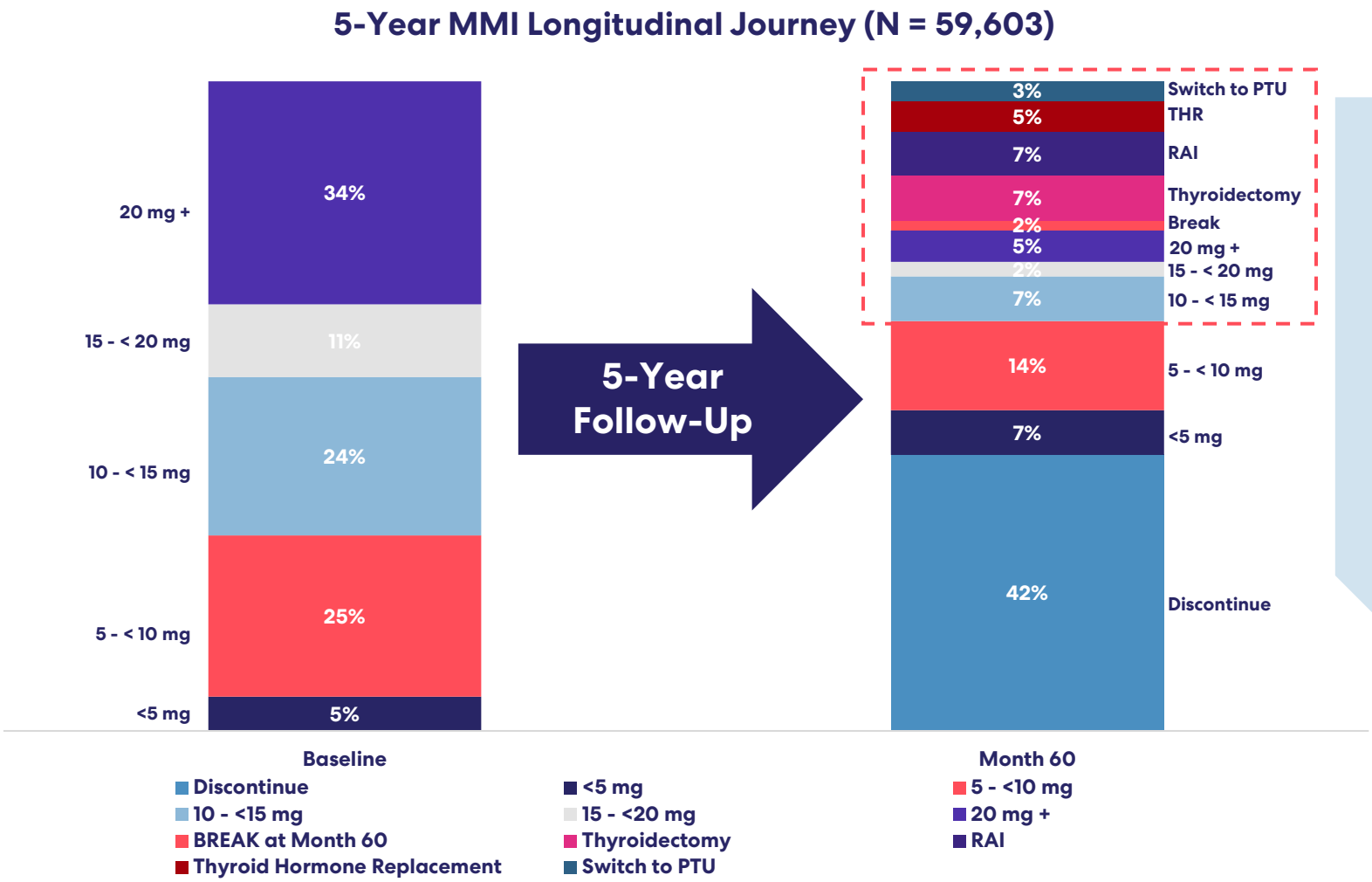
RAI and surgery are associated with **significant complications** including increased risk of death from solid cancers; patients are often hypothyroid and require **lifelong thyroid hormone replacement**[1,2]

Chronic ATD use can be associated with risk of severe adverse events, such as **hepatotoxicity**, **pancreatitis**, and **agranulocytosis** (loss of white blood cells)[4-6]

Uncontrolled Graves' patients are at risk for a sequelae of **severe comorbidities** (e.g., **cardiovascular events**, **thyroid cancer**) and experience significant **anxiety** and **impact to quality of life**[7-8]

1. Sundaresh et al., J Clin Endocrinol Metab (2013)
2. Kitahara, et al., JAMA Intern Med (2019)
3. Suzuki et al., Thyroid (2019)
4. Smith and Hegedüs, N Engl J Med (2016)
5. Brix et al., ETA 2019
6. Okosieme et al., Lancet Diabetes Endocrinol (2019)
7. Cramon et al., Thyroid (2016)

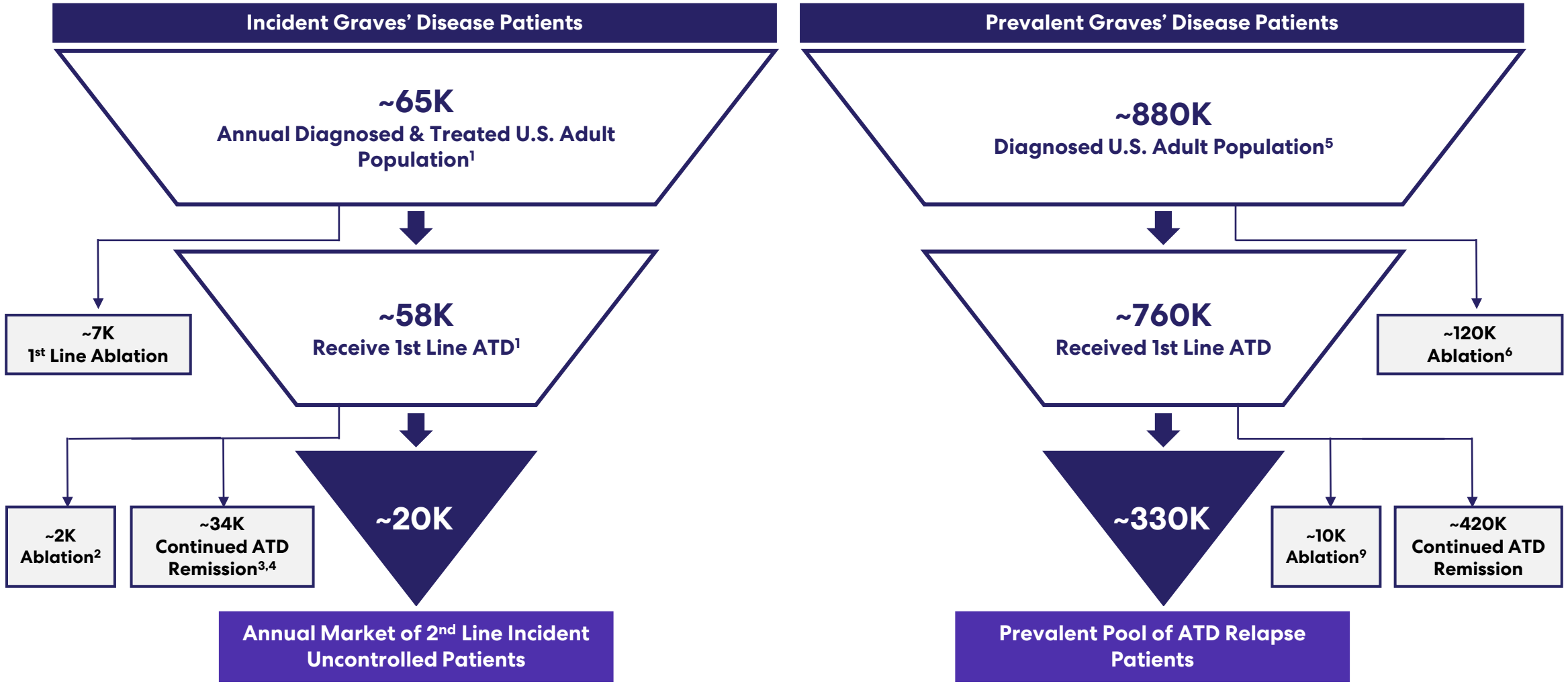
Follow-Up of Graves' Disease Patient Methimazole Dosing Shows Significant Percent of Patients Remaining on ATDs After 5-Years



- In a 5-year follow-up period, only 42% of patients were controlled on ATDs alone
- ~37% of patients were on ≥10 mg MMIs, break, switched to PTU, received thyroid hormone replacement or ablation

Source: Roivant claims analysis
Patients continuously enrolled from 2016 - 2024, newly diagnosed in 2019, 5 years of follow up data from initial MMI script

Graves' Disease Market Opportunity Includes Annual Incident Population and a Significant Untapped Prevalent Patient Pool



1. Roivant Claims Analysis – 2021 incident patient population, first-line treatment is primary treatment in the first-year post diagnosis, claims review included a five-year lookback to define the incident population 2. Grove-Laugesen et al., Thyroid (2023): Completer rates for combined arms: ATD remission 56.0%, continuing ATD 18.8%, ATD relapse of 21.8%, ablation of 3.4%. Of the 58K 1st line ATD patients, a total of ~75% are either in remission (56.0%: 32.5K) or continued ATDs (18.8%: 10.9K) 3. Azizi et al., Thyroid (2019): ATD remission for patients on long-term ATDs is 85%. Of the 10.9K patients who continued ATDs, 15% relapse (1.6K) and 85% go into remission (9.3K). These 9.3K patients in remission will have a 15% rate of relapse resulting in 1.4K relapses. From the original 10.9K patients who continued on ATDs, there will be a total of 3K (1.4K +1.6K) relapses, 4. Stokland et al., J Clin Endocrinol Metab. (2023): Relapse post remission 15%. Of the 42K patients who are in remission, 15% will relapse (6.3K). In total, the late relapses from remission and continued ATDs will be ~9.3K, resulting in a weighted average relapse rate of ~19% (6.3K relapses from the 32.5K patients in remission averaged with the 3K relapses from the 10.5K patients who continued on ATDs). 5.Roivant Claims Analysis – 2022 prevalent patient population based on a two-year lookback for diagnosis. Of the 120K patients ablated, ~80K were ablated prior to 2021 and ~40K were ablated in 2021/2022 6.Azizi et al., Thyroid (2019): Relapse rate was calculated as a weighted average considering relapse rate in patients on ATDs <18months is 53% compared to patients on ATDs >18months is 15%. Of the 570K patients treated with ATDs, ~470K are on ATDs <18months and ~100K are on ATDs for >18months. Rates have been applied proportionally. 7.Bandai et al., Endocr J (2019): Of the ~190K patients previously treated with ATDs and currently monitored off-therapy, ~40% experience relapse, which is 75K. 8.Grove-Laugesen et al., Thyroid (2023): 3.4% of ATD relapse patients will pursue ablation. 3.4% applied to the ~340K ATD treatment relapse patients is ~10K

Potential for Disease Modification With Responders Demonstrating Strong Durability of Response Through Six Months Off-Treatment

Treatment Period: 24 weeks		Follow-up: 24 weeks
680 mg batoclimab QW SC (Week 0-12)	340 mg batoclimab QW SC (Week 12-24)	Off-Treatment (Week 24-48)

Baseline

Week 12
Pts receive 12 weeks of 680 mg QW batoclimab[1]

Dose step-down

Week 24
Pts receive 12 weeks of 340 mg QW batoclimab[1]

Week 48
Patients off-drug for 24 weeks[1,2]

25
Uncontrolled Graves' disease patients

20/25
T3/T4 ≤ULN; ATD dose ≤Baseline

18/25
T3/T4 ≤ULN; ATD dose ≤Baseline

17/21
T3/T4 ≤ULN; ATD dose ≤Baseline[3]

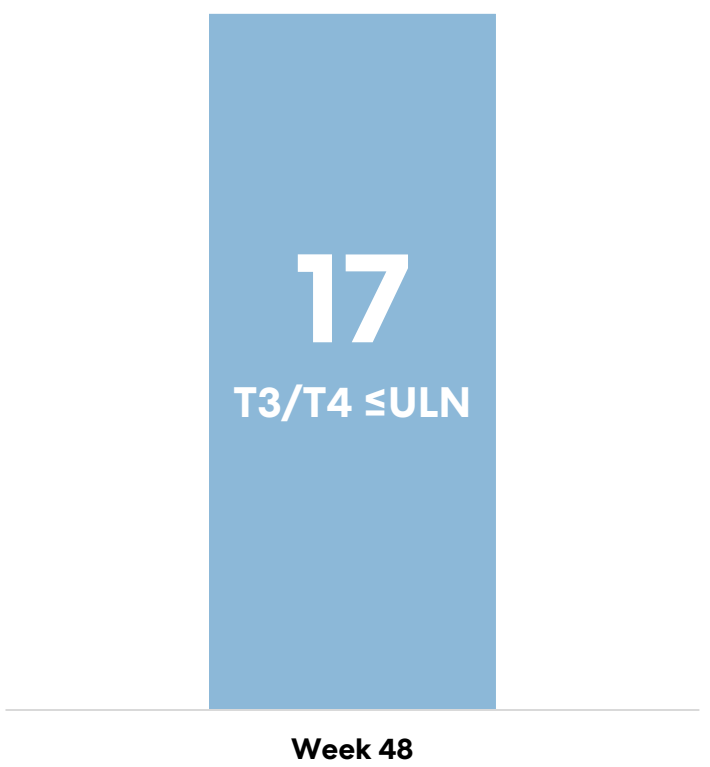
Strong durability of response despite being off-batoclimab for six months

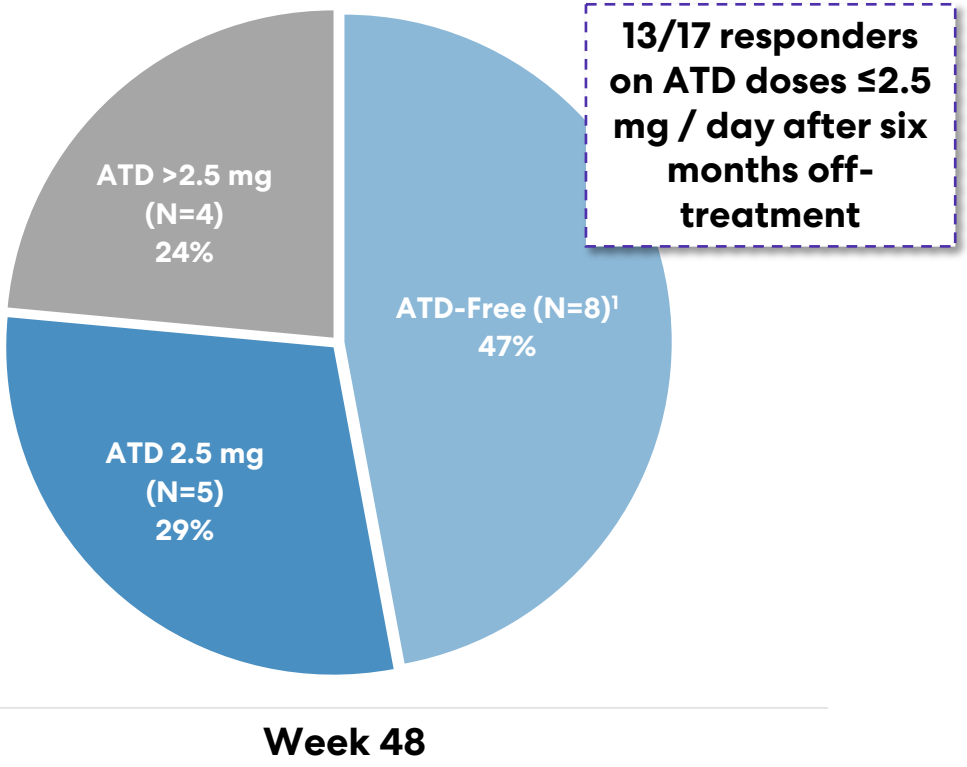
1. Includes N=1 patient who discontinued prior to Week 12 but remained in off-drug follow-up.
2. Includes N=21 patients who entered follow-up period and could be assessed for remission.
3. N=1 patient had T3/T4 ≤ULN, and one day following Week 48 visit had ATD dose equivalent to baseline.

Responders: Patients who have T3 and T4 values ≤ULN and no increase in ATD dose from baseline. Pts: Patients; T3: Triiodothyronine; T4: Thyroxine; ULN: Upper limit of normal; ATD: Anti-thyroid drug.

~50% of Responders at Week 48 Achieved ATD-Free Remission, Demonstrating Strong Potential for Disease Modification by a High-Dose FcRn

Treatment Period: 24 weeks		Follow-up: 24 weeks
680 mg batoclimab QW SC (Week 0-12)	340 mg batoclimab QW SC (Week 12-24)	Off-Treatment (Week 24-48)





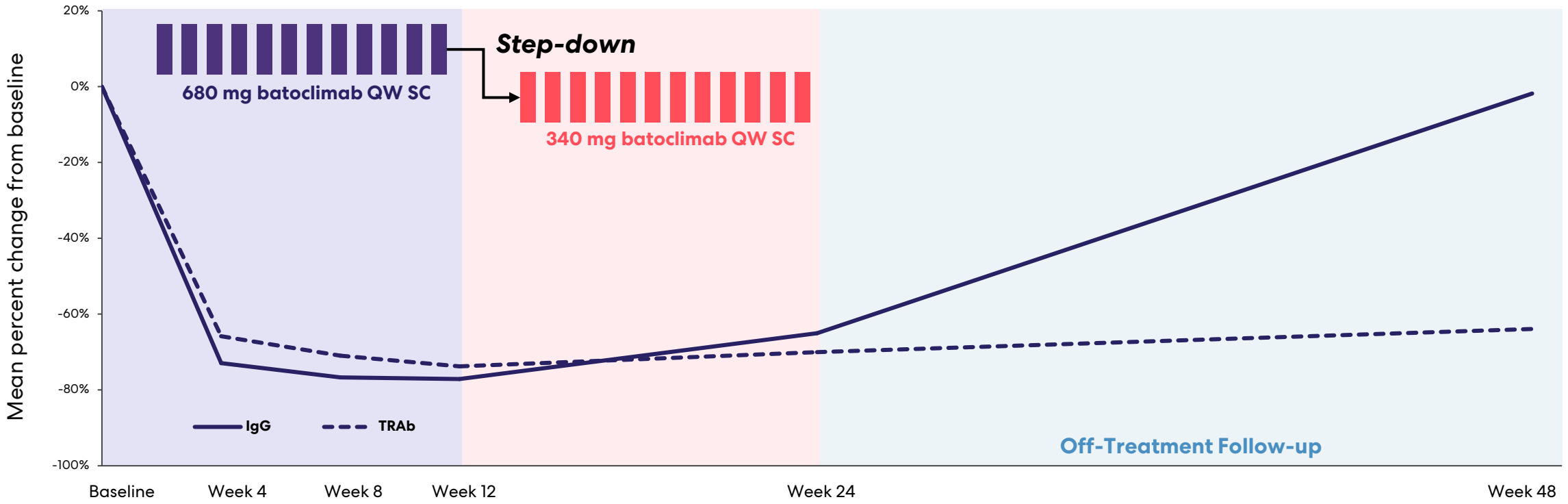
13/17 responders on ATD doses ≤2.5 mg / day after six months off-treatment

8 of 17 Patients With Normal T3/T4 at Week 48 Were in ATD-Free Remission

1. Includes N=1 patient who discontinued prior to Week 12 but remained in off-drug follow-up.
Responders: Patients who have T3 and T4 values ≤ULN and no increase in ATD dose from baseline. T3: Triiodothyronine; T4: Thyroxine; ULN: Upper limit of normal; ATD: Anti-thyroid drug; FcRn: Neonatal fragment crystallizable receptor inhibitor.

Sustained TRAb Reductions Post-Batoclimab Treatment Further Demonstrate Potential for Disease Modification

Treatment Period: 24 weeks		Follow-up: 24 weeks
680 mg batoclimab QW SC (Week 0-12)	340 mg batoclimab QW SC (Week 12-24)	Off-Treatment (Week 24-48)



Notes: Data includes up to last measurement available for patients who discontinued.
IgG: Immunoglobulin G; TRAb: Thyroid Stimulating Hormone Receptor Antibody; QW: Once weekly; SC: Subcutaneous. Patient counts at each time include Baseline (N=25), Week 12 (N=24), Week 24 (N=23), Week 48 (N=19).

IMVT-1402 Could Potentially Be the First-in-Class Disease-Modifying Therapy in Graves' Disease

01 Remarkable effect seen in uncontrolled Graves' disease patients: 18 of 25 patients treated with batoclimab are responders at Week 24

02 Durable off-drug response: of the 21 patients who entered the off-drug follow-up period, 17 remain responders six months following batoclimab treatment

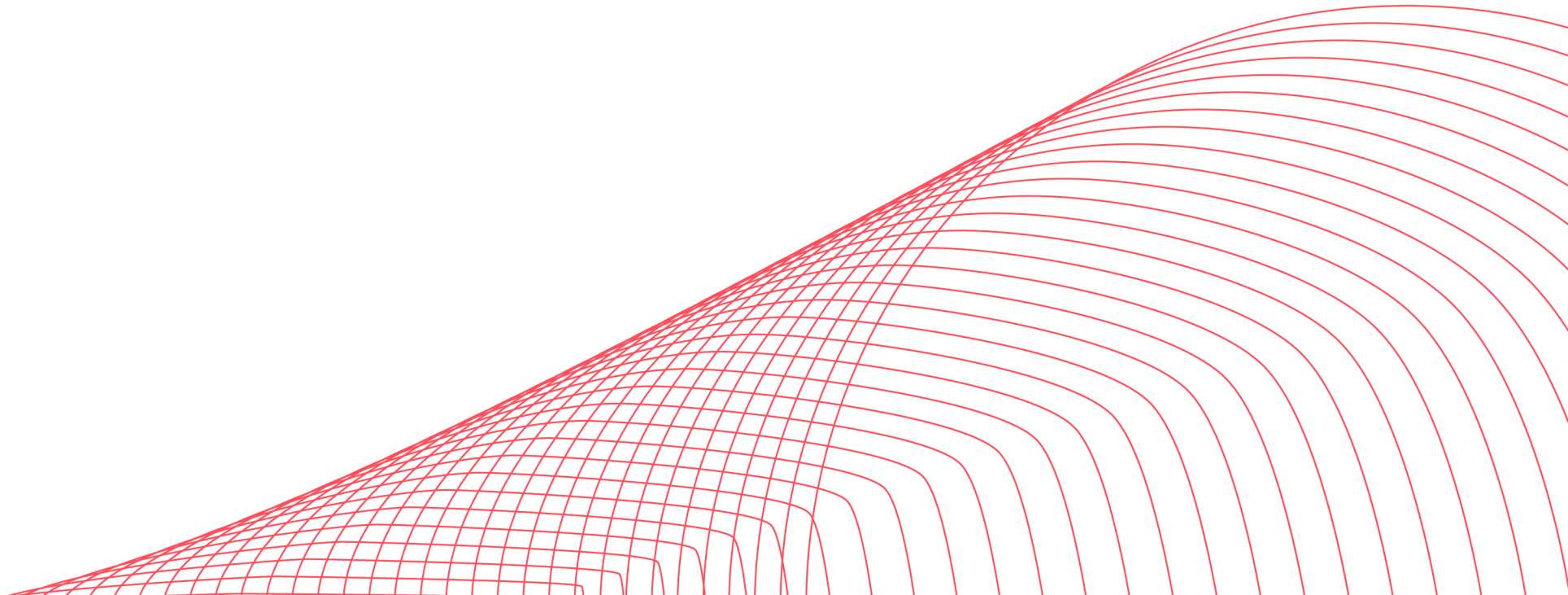
03 First-ever observed ATD-free remission in uncontrolled patients: 8 of 17 responders remain off all medications six months following batoclimab treatment demonstrating potential for disease modification

04 IMVT-1402 pivotal trial design could potentially generate improved efficacy data due to continuous 600 mg QW dosing vs. batoclimab's step-down dosing design

05 Two potentially registrational trials for IMVT-1402 in Graves' disease currently enrolling

Notes: Data includes N=1 patient who discontinued prior to Week 12 but remained in off-drug follow-up.
ATD: Anti-thyroid drug; QW: Once weekly; responders: patients who have T3 and T4 values ≤ULN and no increase in ATD dose from baseline.

Opportunities for IMVT-1402 to Win on Efficacy



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IMVT-1402 Has the Potential to Be Best-in-Class in MG, SjD and CIDP, With Room to Penetrate Large, Well-Validated Markets

Myasthenia Gravis

Market rapidly expanding with space for multiple blockbuster agents; topline results expected in 2027

Sjögren's Disease

Expected to be best-in-class with limited entrenched competition; topline results expected in 2028

Chronic Inflammatory Demyelinating Polyneuropathy

Market quickly growing with 1 approved agent; topline results expected in 2028

Note: All drugs are investigational and subject to regulatory approvals. All catalyst timings are approximate, based on current expectations and, where applicable, contingent on FDA feedback, and may be subject to change. All references are to calendar years.

Sjögren's Disease (SjD) Is a Chronic Autoimmune Disease Characterized by Lymphocytic Infiltration of the Salivary and Lacrimal Glands

Limited Treatment Options for SjD

- SjD symptoms include severe dryness of the eyes and mouth; the latter frequently associated with difficulty swallowing or speaking, tooth decay, gum disease, and impaired QoL[1,2]
- No therapies approved for the treatment of primary Sjogren's disease

Up to ~90k Addressable Patients in the US

- Of the **~290K primary SjD patients in the US,** ~30% are moderate-severe with anti-Ro/SSA antibodies[3]

Autoantibody Pathology

- Autoantibodies detected in ~50-70% of patients with primary SjD; anti-FcRn proof of mechanism established

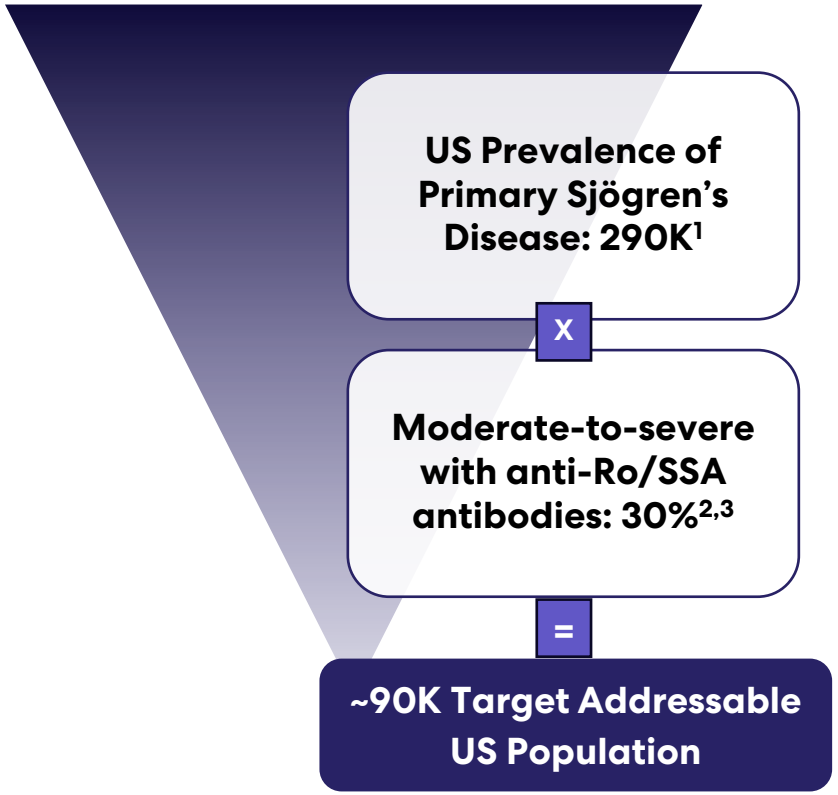
Deeper Is Better

- Nipocalimab data demonstrated that deeper IgG reduction leads to better clinical response across all primary and secondary endpoints[4]

1. Mariette et al., N. Engl J Med (2018)
2. Brito-Zeron et al., Nat Rev Dis Primers (2016)
3. GlobalData Analysis and Forecast, January 2025
4. Gottenberg et al., ACR (2024)

Sizable SjD Patient Group With Unmet Need for an Approved Treatment Option

Sizable Unmet Need



Expansion Opportunities

Secondary Sjögren's	Potential to impact conditions with shared autoimmune pathology
Glandular Disease	Unmet need to improve glandular manifestations beyond symptom relief
Less Severe Disease	Disease impact on patient QoL varies widely; so-called "nuisance" symptoms can become debilitating if inadequately managed

Note: All estimates are approximate
1. GlobalData Analysis and Forecast, January 2025
2. Brito-Zeron P et al., Nat Rev Dis Primers (2016)
3. Decision Resources Group

IMVT-1402 Has the Potential to Improve Myasthenia Gravis (MG) Treatment Outcomes as a Best-in-Class Therapy

High Unmet Need

- 95% of neurologists agree there is opportunity for greater disease control (e.g., deeper responses)[1]

Up to ~35k Addressable Patients in the US

- Of the **~60-120K MG patients in the US,** ~30% are AChR autoantibody positive and not well-controlled on standard of care[2,3,4,5,6]

Autoantibody Pathology

- Classic IgG mediated disease with proven anti-FcRn mechanistic response; 3 approved in-mechanism products

Deeper Is Better

- External and batoclimab data demonstrated that deeper IgG reduction consistently leads to better clinical effect
- Batoclimab data showed highest MG-ADL reductions from baseline observed in any global Phase 3 MG trial to date[7]

AChR: anti-acetylcholine receptor
1. IMVT Market Research HCP Unmet Need
2. Phillips et al., Neurology (1992)
3. Mina-Osorio et al., AANEM (2023)
4. Lazaridis and Tzartos, Front Immunol (2020)
5. Wang et al., BMC Neurol (2017)
6. IMVT Investor Presentation March 19, 2025

IMVT-1402 Has the Potential to Deliver Best-in-Class Efficacy in Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)

High Unmet Need

- 30-50% of CIDP patients are inadequately controlled with existing therapies[1]

Up to ~16k Addressable Patients in the US

- Of the **~58K CIDP patients in the US,** ~30% are inadequately controlled on treatment[2,3]

Autoantibody Pathology

- IgG mediated disease with proven anti-FcRn mechanistic response; 1 approved in-mechanism product

Deeper Is Better

- First-gen anti-FcRn batoclimab demonstrated deeper IgG suppression delivered greatest in-class mean change from baseline in aINCAT score in CIDP patients[4]

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1. Internal Market Research Market Dynamics 2024
2. Broers et al., Neuroepidemiology (2019)
3. Querol et al., J Neurol (2021)
4. IMVT batoclimab initial Period 1 Data Investor Presentation March 19, 2025

Rich Catalyst Calendar Over the Next 36 Months

Pivotal / Potentially Registrational

1H 2026
Topline data in TED*

2026
Topline data in D2T RA
(formerly expected in 2027)

2027
Topline data in GD
Topline data in MG

2028
Topline data in SjD
Topline data in CIDP

2026 | 2027 | 2028

2026
Initial Results in CLE

2027+
Future PoC study readouts in undisclosed indications and future BD

Proof of Concept

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Note: All drugs are investigational and subject to regulatory approvals. All catalyst timings are approximate, based on current expectations and, where applicable, contingent on FDA feedback, and may be subject to change. All references are to calendar years
*Immunovant continues to expect the first of the two batoclimab Phase 3 TED studies to read out before the end of calendar year 2025. However, due to evolving competitive dynamics, Immunovant anticipates sharing topline results from both TED studies concurrently in the first half of calendar year 2026.

In Summary: IMVT-1402

- **Multiple shots on goal: IMVT-1402 offers best-in-class profile in 5 late-stage indications and 1 PoC**
- **The anti-FcRn class is rapidly growing; precedent best-in-class products have won significant market share in I&I indications**
- **Graves' disease has extraordinary unmet need; we have demonstrated best-in-class potential with a multi-year lead**
- **Focused clinical execution: topline data in D2T RA now expected in 2026; readouts in 3 potentially registrational trials and 1 PoC expected in next 24 months**

Note: All drugs are investigational and subject to regulatory approvals. All catalyst timings are approximate, based on current expectations and, where applicable, contingent on FDA feedback, and may be subject to change. All references are to calendar years.