



Targeted science, tailored solutions

for people with autoimmune disease



Corporate Presentation
August 2026



Forward-looking statements

This presentation contains forward-looking statements for the purposes of the safe harbor provisions under The Private Securities Litigation Reform Act of 1995 and other federal securities laws. The use of words such as "can," "may," "might," "will," "would," "should," "expect," "believe," "estimate," "design," "plan," "intend," "anticipate," and other similar expressions are intended to identify forward-looking statements. Such forward looking statements include statements regarding Immunovant's expectations regarding the timing, design, and results of clinical trials of IMVT-1402 (imeroprubart); Immunovant's plan to develop IMVT-1402 across a broad range of indications; the registrational nature of Immunovant's clinical trials; and potential benefits of IMVT-1402's unique product attributes and potential best-in-class and first-in-class profile. 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; Immunovant is at various stages of clinical development for IMVT-1402; and Immunovant will require additional capital to fund its operations and advance IMVT-1402 through clinical development. These and other risks and uncertainties are more fully described in Immunovant's periodic and other reports filed with the Securities and Exchange Commission (SEC), including in the section titled "Risk Factors" in Immunovant's Annual Report on Form 10-K filed with the SEC on May 20, 2026, 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.

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Our Focus: Pursue a broad anti-FcRn strategy based on potential best-in-class profile of IMVT-1402 targeting autoantibody-driven diseases

Validated Target



5 US regulatory approvals, 9 positive Phase 3 trials and 17 positive Phase 2 trials

>\$4.3 billion in global anti-FcRn sales in 2025^{1,2}

IMVT-1402: Potential Best-in-Class Product Candidate



Anti-FcRn with deepest, best-in-class IgG reduction delivered by simple autoinjector

On track to be potential first-/best-in-class with potentially registrational* trials in GD, MG, CIDP, SjD, D2T RA, & proof-of-concept trial in CLE

Significant Market Opportunity



Large total addressable market with 20+ indications announced or in development across the anti-FcRn class³

Current IMVT-1402 trials expected to potentially address >600K patients in the US

Financial Strength



Cash balance of ~\$798 million as of June 30, 2026⁴

Provides runway to Graves' disease commercial launch

IMVT-1402 has the potential to be a first- and best-in-class therapy in autoantibody-driven disease

Convenient Administration

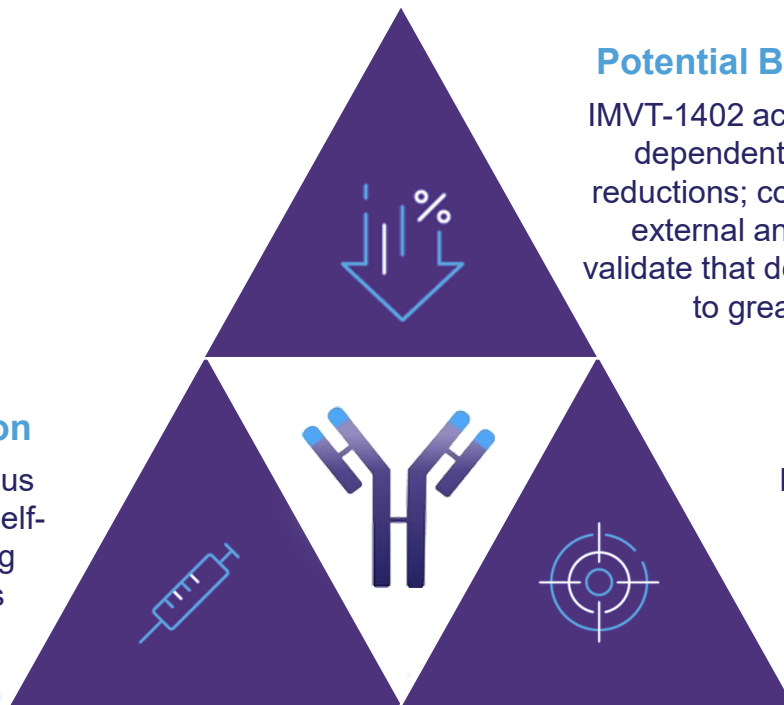
YpsoMate® simple subcutaneous autoinjector with 5-10 second self-administration; currently being tested in all IMVT-1402 trials

Potential Best-in-Class Efficacy

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

Favorable Safety Profile

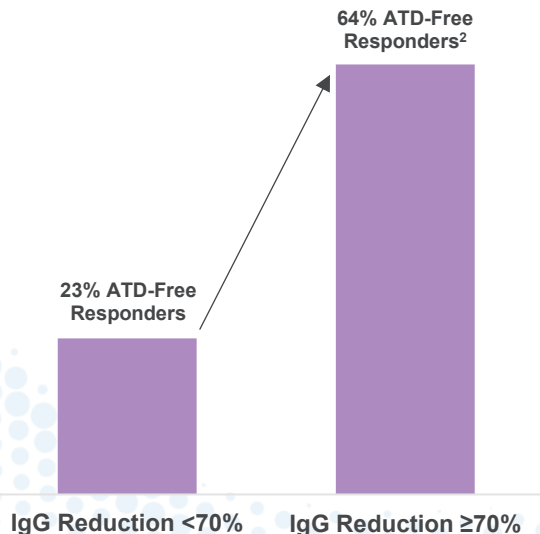
No significant expected safety issues based on data to-date



First generation batoclimab multi-indication clinical data demonstrated that deeper IgG reduction may lead to improved clinical outcomes

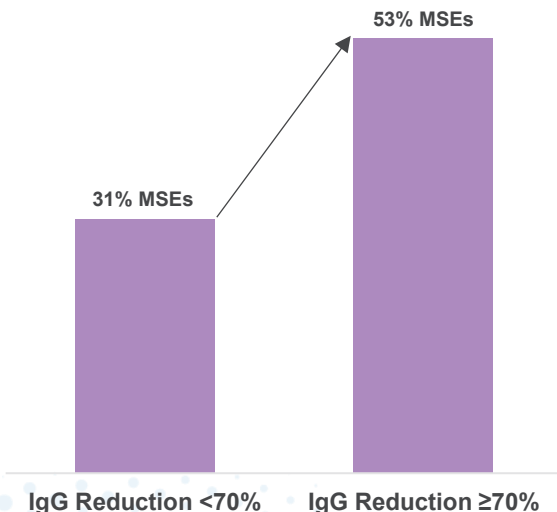
Graves' Phase 2a¹

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



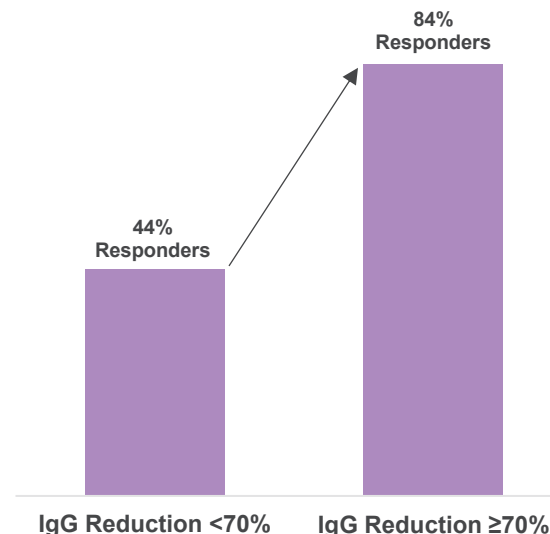
MG Phase 3¹

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



CIDP Phase 2b¹

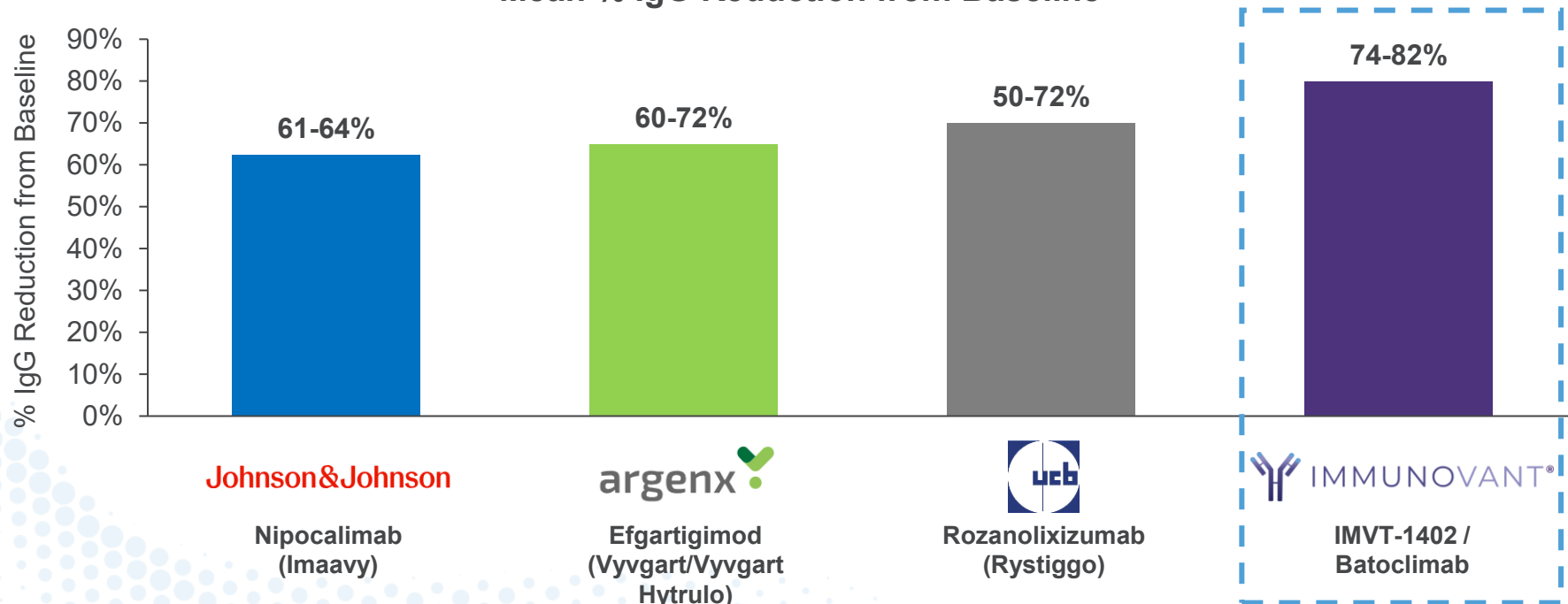
aINCAT Response: % of participants who achieve aINCAT improvement ≥1 at Week 12



Reflects data from multiple clinical trials in multiple indications. Differences exist between trial designs and participant characteristics and caution should be exercised when comparing data across trials.

Best-in-class IgG reductions position Immunovant to drive potential best-in-class efficacy

Mean % IgG Reduction from Baseline



*Figure reflects cross-trial comparisons and not data from head-to-head studies.
Differences exist between trial designs and participant characteristics and caution should be exercised when comparing data across trials.*

Our market: Autoimmune diseases driven by harmful IgG autoantibodies

Anti-FcRn mechanism potentially the leading therapeutic class with 20+ indications announced or in development¹



NEUROLOGY

Chronic inflammatory demyelinating polyneuropathy (CIDP)
Generalized myasthenia gravis (MG)

Myelin oligodendrocyte glycoprotein antibody disorders
Ocular MG
Autoimmune encephalitis



ENDOCRINOLOGY

Graves' disease (GD)



HEMATOLOGY

Fetal neonatal alloimmune thrombocytopenia
Hemolytic disease of the fetus and newborn
Idiopathic thrombocytopenic purpura
Warm autoimmune hemolytic anemia



RHEUMATOLOGY

Rheumatoid arthritis (RA)
Sjögren's disease (SjD)

Myositis
Severe fibromyalgia syndrome
Systemic lupus erythematosus



DERMATOLOGY

Cutaneous lupus erythematosus (CLE)

Bullous pemphigoid
Pemphigus foliaceus/Pemphigus vulgaris
Systemic sclerosis



RENAL

Antibody-mediated rejection
Lupus nephritis
Membranous nephropathy

Indication Strategy: Development strategy designed to maximize commercial potential, with IMVT-1402's potentially best-in-class profile

First-in-Class Best-in-Class

- Expanding use of FcRn blockers to benefit greater number of patients with several new indications, with a potential efficacy advantage driven by deeper IgG reduction
- Example – GD, D2T RA, CLE

Nearly-First Best-in-Class

- Close from a timing perspective to in-class competition, while maintaining potential for a differentiated clinical profile driven by best-in-class IgG reductions
- Example – SjD

Best-in-Class

- Well-established markets with multiple competitors; potential to differentiate on efficacy and convenience
- Example – MG and CIDP

IMVT-1402's potentially differentiated product profile offers wide range of development opportunities

Broad development program for IMVT-1402 with trials underway, expected to potentially address >600K patient population

	Graves' Disease	ACPA+ Difficult-to-Treat RA	Cutaneous Lupus Erythematosus	Sjögren's Disease	Myasthenia Gravis	Chronic Inflammatory Demyelinating Polyneuropathy
Expected US Addressable Population ¹	~330K	~85K	~75K	~90K	~20-35K	~16-58K
Autoantibody Driven Pathology	Driven by autoantibodies to the thyroid-stimulating hormone receptor (TSHR-Ab)	Autoantibodies such as RF and ACPA are present in ~70% of RA patients	IgG autoantibodies (Ro/SSA, La/SSB) observed in majority of CLE patients	Autoantibodies detected in ~50-70% of patients with primary SjD	Driven by AChR autoantibodies disrupting signal transmission in nerve and muscle fibers	Driven by autoantibodies that demyelinate peripheral nerves and nerve roots
In-Class Data	Batoclimab data showed deeper IgG reduction correlated with improved clinical response	Response rate higher for patients with high baseline ACPA & deep IgG reduction	Proof of principle IMVT-1402 case study showed meaningful clinical response	Response rate higher for patients with deeper IgG reduction ²	Batoclimab data showed deeper IgG reduction correlated with improved clinical response	Batoclimab data showed deeper IgG reduction correlated with improved clinical response
Stage of Development	Two Potentially Registrational* Trials Enrolling	Potentially Registrational Trial Fully Enrolled	Proof of Concept Fully Enrolled	Potentially Registrational Trial Enrolling	Potentially Registrational Trial Enrolling	Potentially Registrational Trial Enrolling
Potential Best-in-Class	✓	✓	✓	✓	✓	✓
Potential First-in-Class ³	✓	✓	✓	✓	✓	✓

Clear focus on execution to unlock value both near and long term

Indication	Study	Data Catalyst	2H 2026	2027	2028
ACPA+ D2T RA	Potentially Registrational*	Further Updates			
CLE	POC	Top Line Results			
GD	Potentially Registrational	Top Line Results			
MG	Potentially Registrational	Top Line Results			
SjD	Potentially Registrational	Top Line Results			
CIDP	Potentially Registrational	Top Line Results			



Rheumatology



Dermatology



Endocrinology



Neurology

IMVT-1402: Potentially first anti-FcRn to launch with simple autoinjector device

All current IMVT-1402 trials are being conducted with the Ypsomate® autoinjector – the intended commercial presentation

IMVT-1402

2.25 mL automated
disposable
injection device



Dose: 150 mg/mL
Injection volume: 2 mL

Established, user-friendly autoinjector with multiple approved products

- Automated, simple, subcutaneous injection
- Hidden needle shield
- Provides both visual and audio feedback
- <10 second at home self-administration or HCP administration

Graves' Disease

First-in-Class Opportunity



IMVT-1402: Potentially first- and best-in-class in Graves' disease (GD)

High Unmet Need

~25-30% of Graves' disease patients are challenging to manage on ATD therapy; these patients are either unable to complete initial treatment or unable to stay euthyroid despite treatment

Autoantibody Pathology

Role of TSH-R IgG autoantibodies well-recognized in Graves' disease; anti-FcRn directly targets the underlying disease pathophysiology, while ATDs do not

Lower is Better

Batoclimab POC demonstrated strong correlation between deep IgG lowering, normalization of thyroid hormone levels and reduced dependence on background ATD therapy

Optimized Study Design

IMVT-1402 trial designed to demonstrate thyroid hormone normalization and independence from ATD therapy at rates previously unattainable for challenging-to-manage Graves' patients

Potentially Registrational* Trials Initiated

Two potentially registrational trials are actively enrolling, both with self-administration via market-proven autoinjector

Graves' disease is a classic autoimmune condition driven by the presence of autoantibodies to the thyroid stimulating hormone receptor

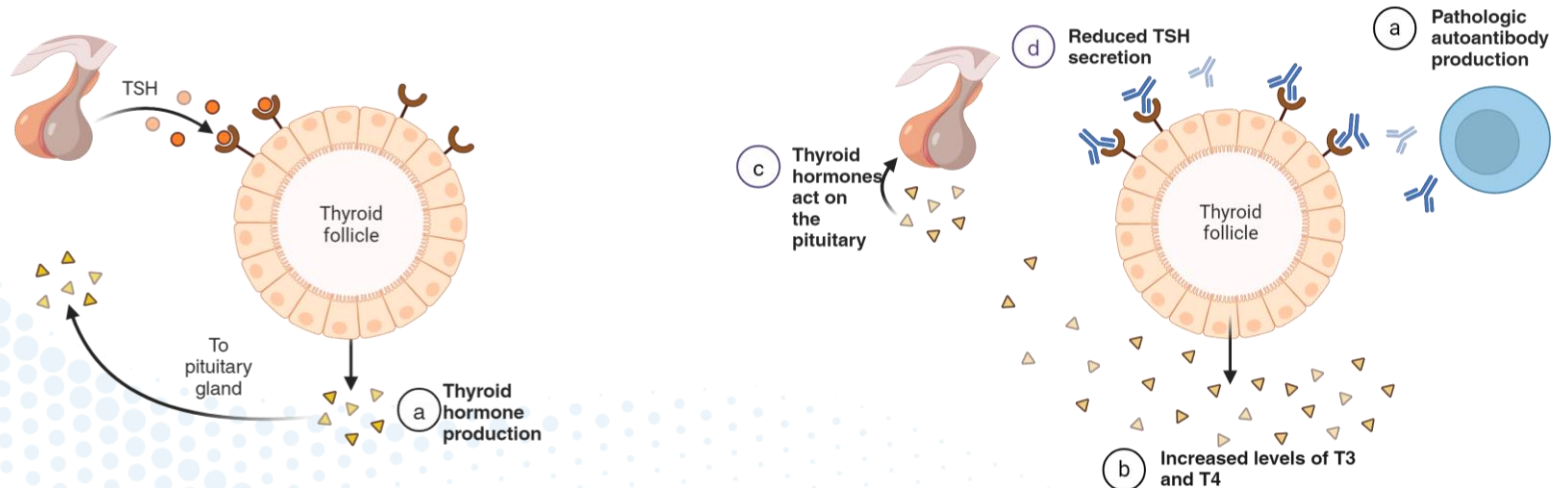
Graves' Disease: Autoantibody-Driven Pathogenesis

Normal Function

TSH produced by the pituitary gland stimulates the thyroid gland to produce and release thyroid hormones (T3 & T4)

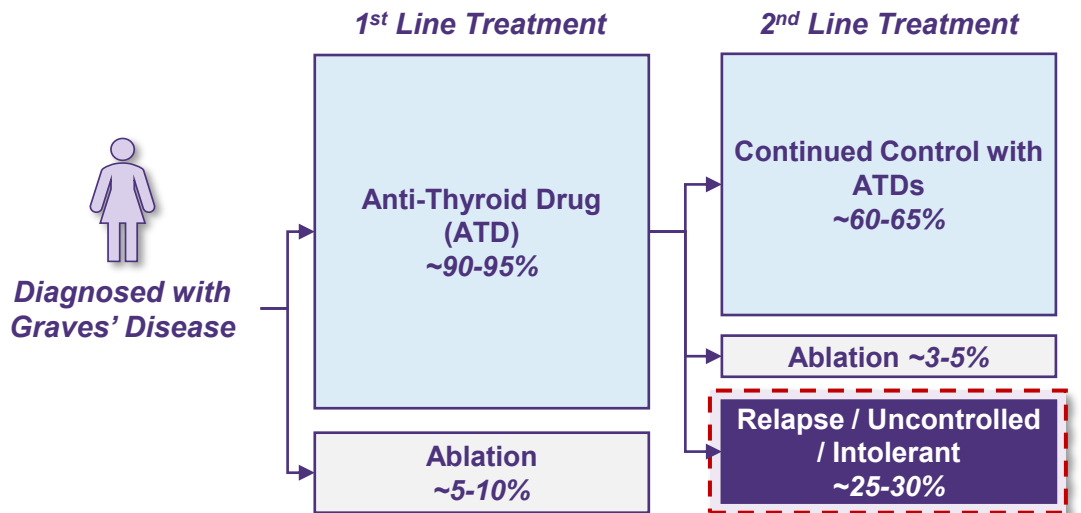
Graves' Disease

Autoantibodies to the thyroid stimulating hormone receptor (TSHR) stimulate thyroid hormone production and lead to excess thyroid hormone production (increased T3, T4)



Shift away from ablation and lack of new medical therapies leaves 25-30% of patients who are relapsed, uncontrolled on, or intolerant to ATDs

Graves' Disease Patient Journey:

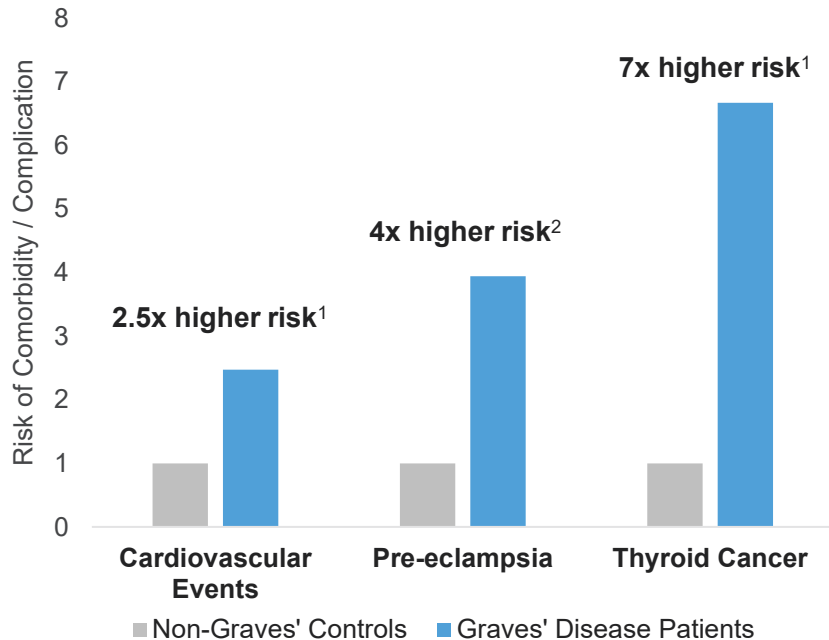


Unmet Need

- 25-30% of patients are relapsed, uncontrolled on or intolerant to ATDs
- US data on ablation rates indicate that patients with ATD-refractory disease are choosing not to undergo ablation
- Patients and healthcare providers seek therapeutic options that address underlying disease pathology

Scientific literature indicates that Graves' disease patients are at a higher risk of a 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' Disease³
 - 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 storm⁵, which has a ~20% mortality rate⁶
- Graves' Disease patients who develop thyroid cancer are at a >3x risk of recurrent disease / progressive distant metastases relative to euthyroid controls⁷

Graves' patients uncontrolled on ATDs experience significant disease burden and risk of adverse events with limited 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**



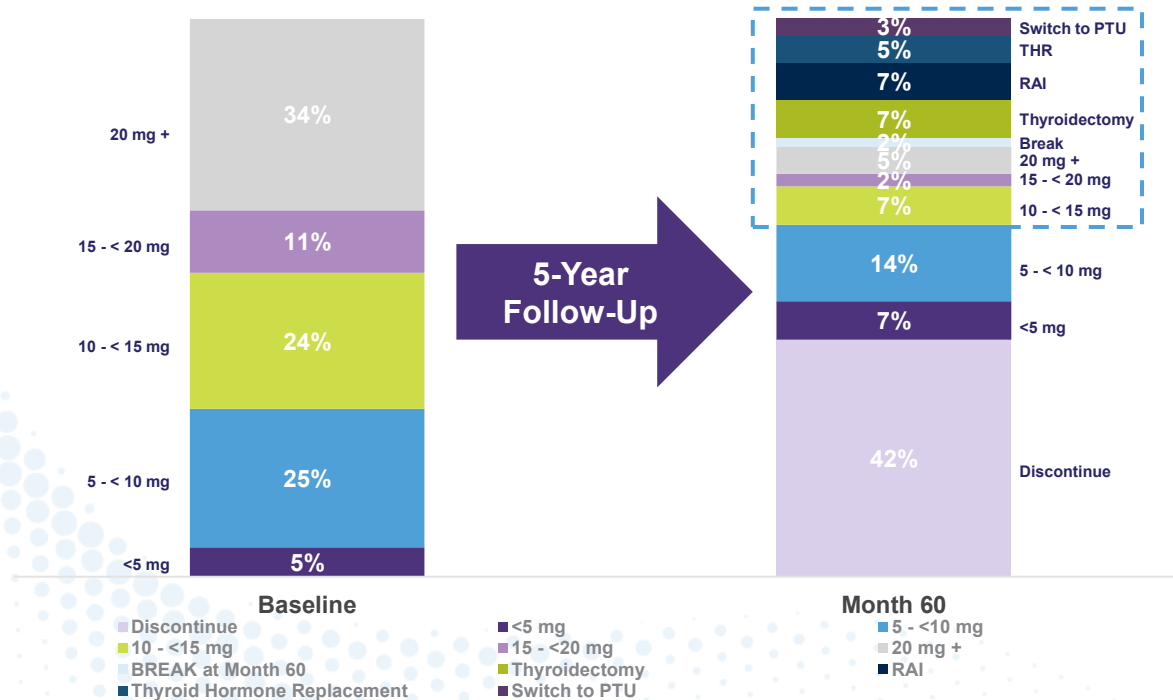
Chronic ATD use can be associated with risk of severe adverse events, such as **hepatotoxicity**, **pancreatitis**, and **agranulocytosis** (loss of white blood cells)



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**

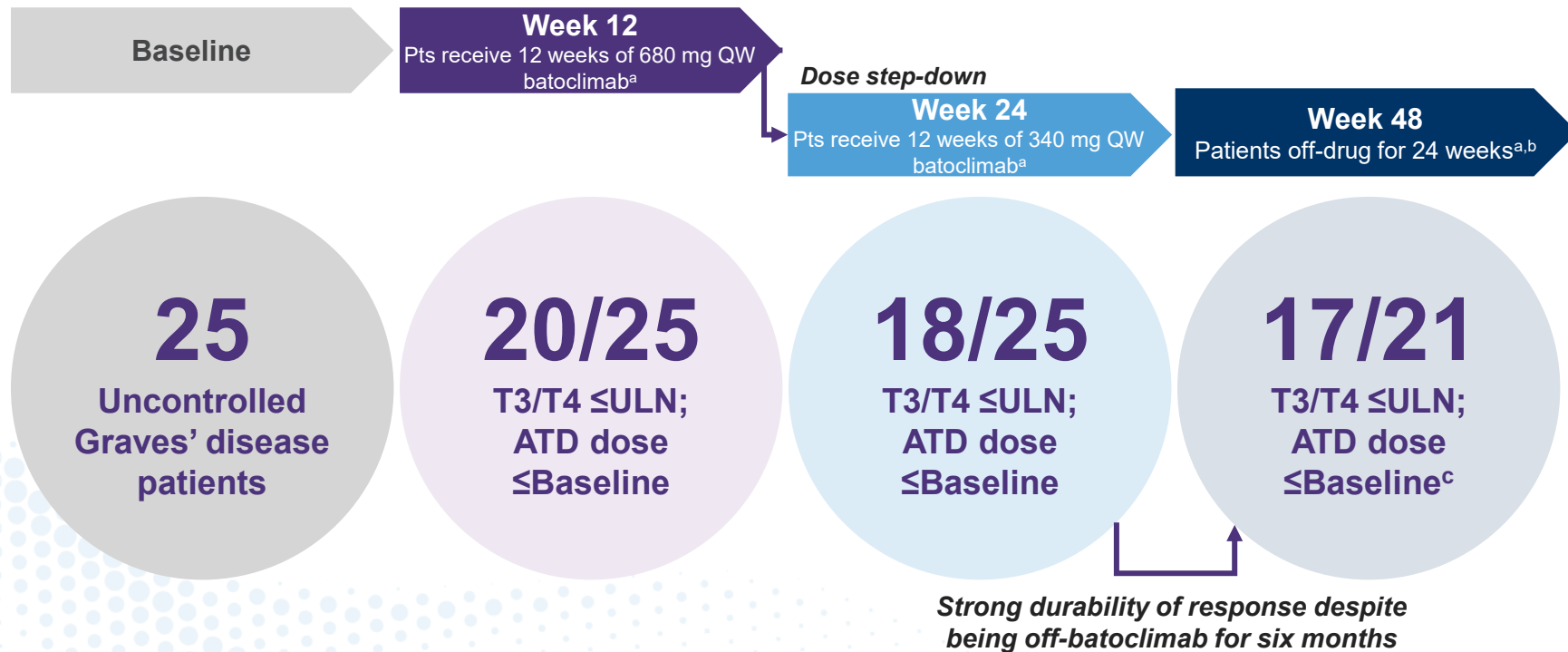
Follow-up of Graves' disease patient methimazole dosing shows significant percent of patients remaining on ATDs after 5-years

5-Year MMI Longitudinal Journey (N = 59,603)

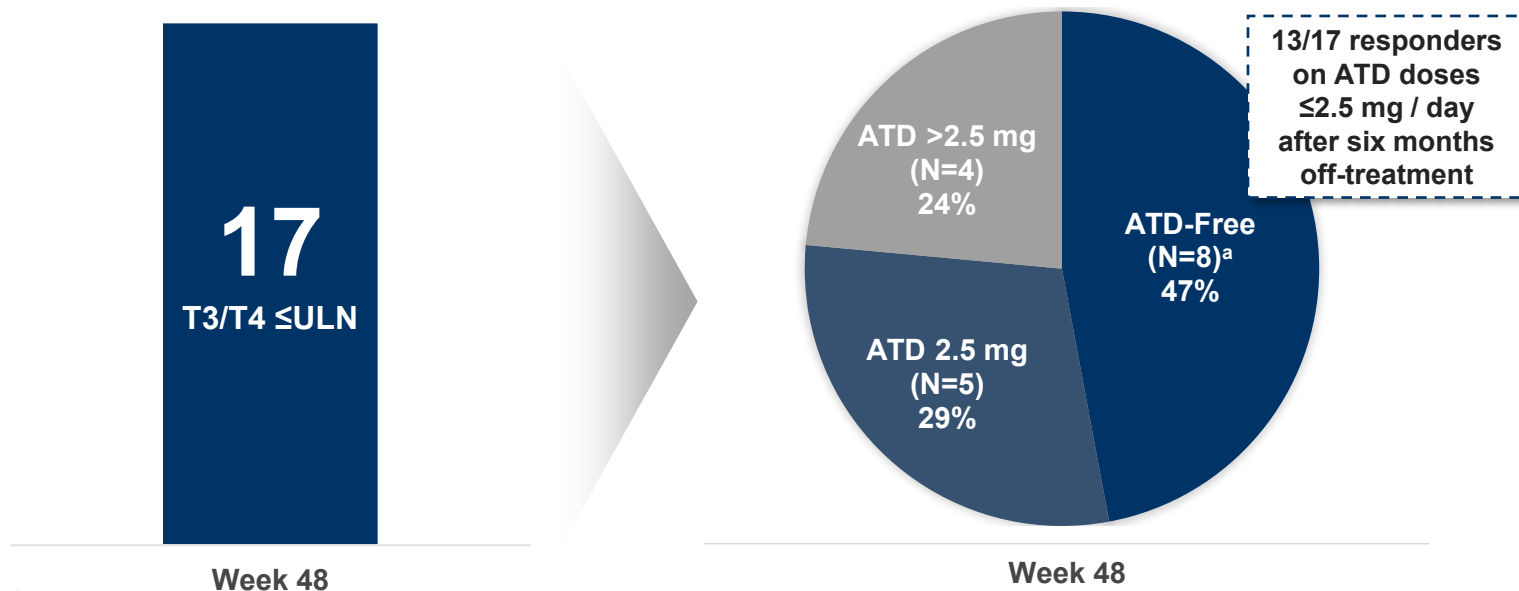


- In a 5-year follow-up period, only 42% of patients were controlled on ATDs alone
- ~37% of patients were on ≥ 10 mg MMIs, break, switched to PTU, received thyroid hormone replacement or ablation

Potential for disease modification with batoclimab responders demonstrating strong durability of response through six months off-treatment at end of follow-up

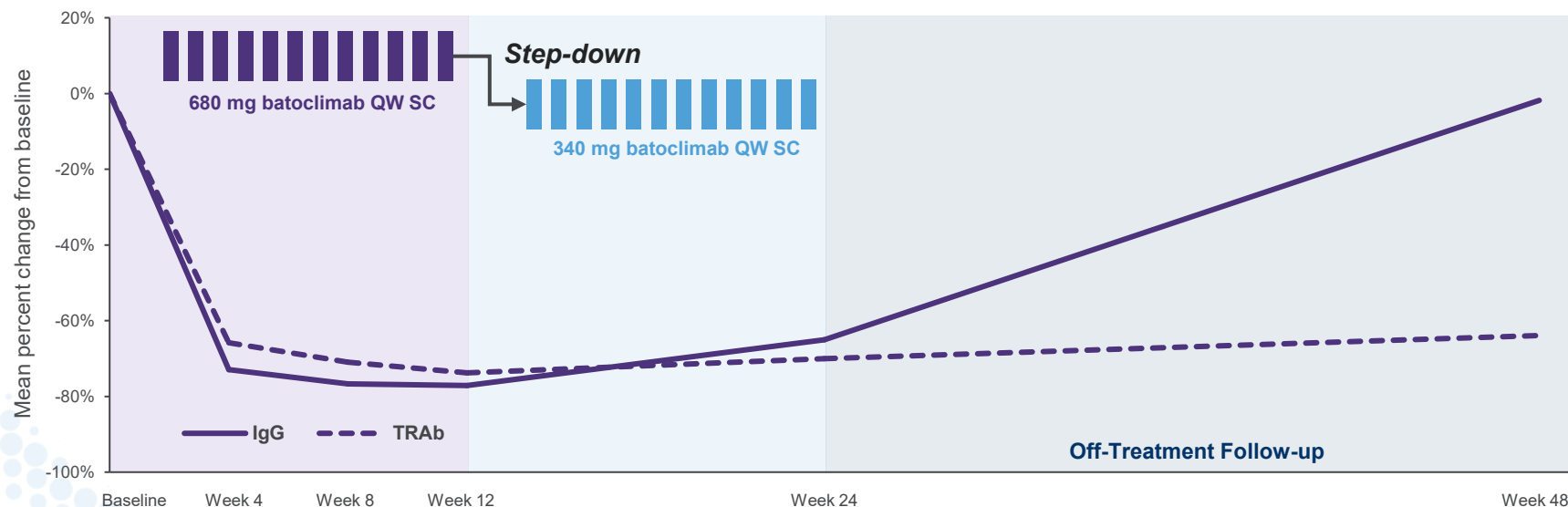


~50% of responders at Week 48 achieved ATD-free remission, demonstrating strong potential for disease modification by a high-dose FcRn



8 of 17 patients with normal T3/T4 at Week 48 were in ATD-free remission

Sustained TRAb reductions post-batoclimab treatment further demonstrate the potential for disease modification



IMVT-1402 could potentially be the first-in-class disease-modifying therapy in Graves' disease

01

Significant effect seen in uncontrolled Graves' disease patients: 18 of 25 patients treated with batoclimab were responders* at Week 24

02

Durable off-drug response observed: Of the 21 patients who entered the off-drug follow-up period, 17 remained responders* six months following batoclimab treatment

03

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

04

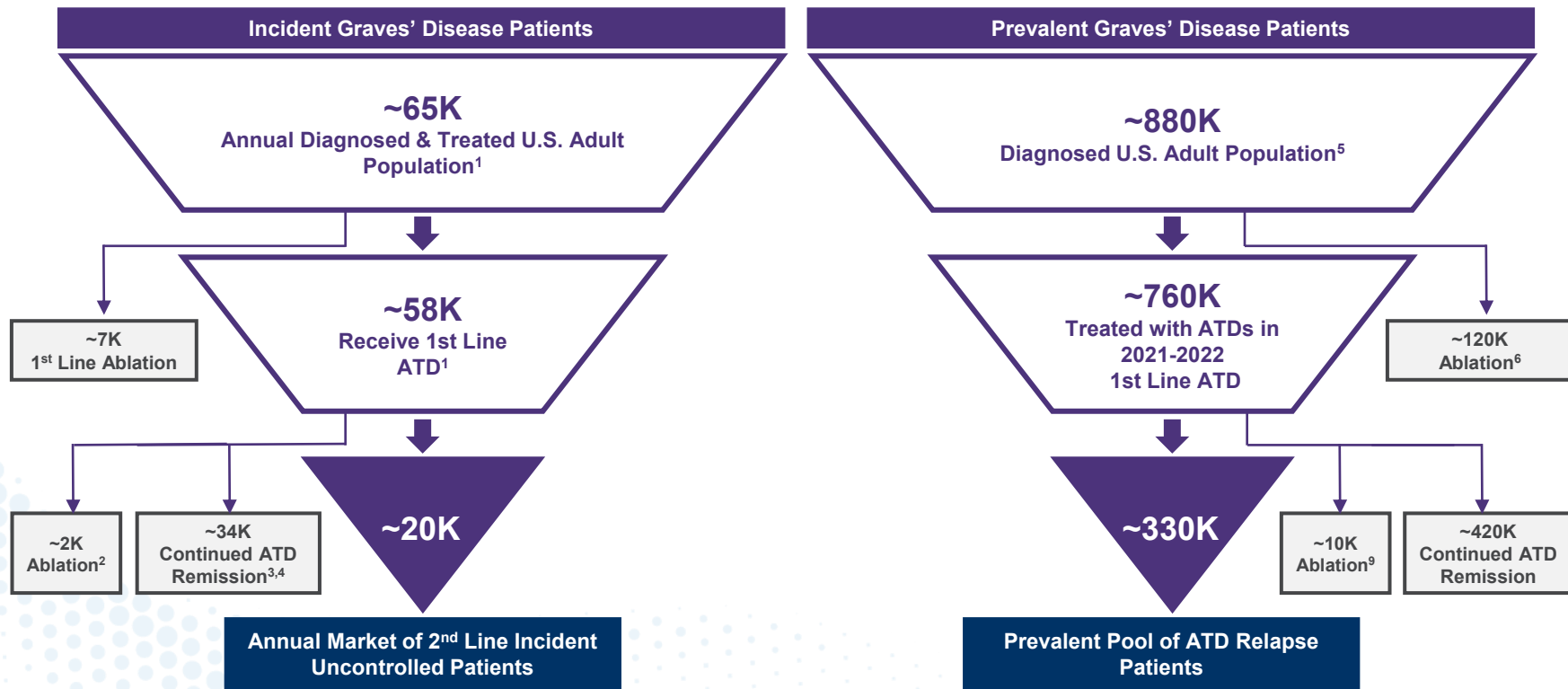
IMVT-1402 pivotal trial design could potentially generate improved efficacy data due to continuous 600 mg QW dosing vs. batoclimab's step-down dosing design

05

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



Graves' disease market opportunity includes annual incident opportunity and a significant untapped prevalent patient pool



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1. Rovi Claims Analysis – 2021 incident patient population, first-line treatment is primary treatment in the first-year post diagnosis, claims review included a five-year lookback to define the incident population.
 2. Grove-Laugesen et al. (2023). Completer rates for combined arms: ATD remission 56.0%, continuing ATD 18.8%, ATD relapse of 21.8%, ablation of 3.4%. Of the 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. Aziz et al. (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. (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).

5. Rovi Claims Analysis – 2022 prevalent patient population based on a two-year lookback for diagnosis.
 6. Of the 120K patients ablated, ~60K were ablated prior to 2021 and ~40K were ablated in 2021/2022.
 7. Aziz et al. (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.
 8. Bandi et al. (2019). Of the ~190K patients previously treated with ATDs and currently monitored off-therapy, ~40% experience relapse, which is 75K.
 9. Grove-Laugesen et al. (2023). 3.4% of ATD relapse patients will pursue ablation. 3.4% applied to the ~340K ATD treatment relapse patients is ~10K.

Myasthenia Gravis

Best-in-Class Opportunity



IMVT-1402 has the potential to improve myasthenia gravis treatment outcomes as a best-in-class therapy, leveraging batoclimab learnings

High Unmet Need	95% of Neurologists agree there is an opportunity for greater disease control (e.g., deeper responses) ¹
Autoantibody Pathology	Classic IgG mediated disease, with proven anti-FcRn mechanistic response ²
Lower is Better	First-gen anti-FcRn batoclimab demonstrated deeper IgG suppression is consistently associated with improved clinical effect ²
Optimized Study Design	Simple parallel continuous dose trial design with two dose options, designed to demonstrate a clear difference of effect between doses
Potentially Registrational* Trial Initiated	Potentially registrational trial enrolling with self-administration via market-proven autoinjector

MG patients and providers indicate a need for deeper and more durable disease control

Deeper Disease Control

95%

Neurologists agree that despite recent advancements with FcRn blockers, there is an opportunity for **greater disease control** (e.g., deeper responses)¹

Durable Response

95%

Neurologists indicate that their existing MG patients could benefit from a new therapy that offers **greater durability**²

Continuous Control

84%

Neurologists report that their patients experience **breakthrough symptoms** with currently available FcRn blockers¹

Dose Flexibility

92%

Neurologists agree a treatment with high-dosage and standard **dosage strength options is attractive** because it allows **flexibility** to address residual disease as needed²

Phase 3 batoclimab MG data¹ positions IMVT-1402 as the potentially best-in-class anti-FcRn

01

680 mg batoclimab outperformed other anti-FcRn, complement, and CD19 inhibitors, demonstrating highest MG-ADL reduction from baseline (-5.6 points) observed in any global Phase 3 MG trial to-date

02

Highest rate of patients with minimal symptom expression (42%) observed in MG patients across any FcRn in a Phase 3 trial

03

93% of patients achieve clinical response (MG-ADL reduction of 2 or more points), representing highest response rate achieved in a global Phase 3 trial

04

75% of patients who achieved Minimal Symptom Expression (MG-ADL = 0 or 1) on 680 mg dose by Week 6 maintained MSE status for ≥6 weeks

Chronic Inflammatory Demyelinating Polyneuropathy

Best-in-Class Opportunity



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 therapies¹

Lower is Better

First-gen anti-FcRn batoclimab demonstrated deeper IgG suppression delivered greatest in-class mean change from baseline in aINCAT score in CIDP patients²

Optimized, Patient-Centric Study Design

Simplified study design leveraging prior batoclimab experience to eliminate need for patient worsening via washout prior to treatment

Potentially Registrational* Trial Initiated

Potentially registrational trial enrolling with self-administration via market-proven autoinjector

Batoclimab CIDP Phase 2b proof-of-concept data¹ positions IMVT-1402 to potentially be best-in-class

Best-in-class efficacy observed across multiple efficacy measures: aINCAT, I-RODS, MRC-SS, and grip strength²



Demonstrated that deeper IgG reductions translate to improved response with 84% aINCAT response rate in patients achieving $\geq 70\%$ IgG reduction



Generated learnings to inform IMVT-1402 trial design optimization



Opportunity to accelerate registrational program for IMVT-1402 in CIDP



MG: IgG-mediated autoimmune disease with growing enthusiasm for the anti-FcRn class

Market Opportunity

59K – 116K

Total MG patients in the US^{1,2}



85%

anti-acetylcholine receptor (AChR) antibody positive³



35%

who are not well-controlled on standard of care^{4,5}



20K – 35K

US addressable population

Despite innovation, patients report residual and breakthrough symptoms on anti-FcRn therapy

70% of patients currently on an anti-FcRn report having very or extremely bothersome symptoms

- **97%** experiencing fatigue and muscle weakness
- **~3 in 4** report drooping eyelids walking/coordination issues, blurred/double vision
- **~1 in 2** report difficulty chewing, speech difficulty, weakness of eye muscles

Note: All estimates are approximate

1. Phillips LH 2nd, et al. (1992) The epidemiology of myasthenia gravis in central and western Virginia. Neurology. 42(10):1888-93
2. Mina-Osorio P, et al. Incidence and prevalence of myasthenia gravis: analysis of a US commercial insurance claims database. Presented at American Association of Neuromuscular and Electrodiagnostic Medicine; 1-4 November 2023. Phoenix, Arizona

3. Lazaridis K, Tzartos SJ. Autoantibody Specificities in Myasthenia Gravis; Implications for Improved Diagnostics and Therapeutics. Front Immunol. 2020
4. Wang L, Zhang Y, He M. Clinical predictors for the prognosis of myasthenia gravis. BMC Neurol. 2017
5. IMVT Market Research HCP Unmet Need 2025

CIDP patients and providers are seeking a new treatment option that reduces symptom and treatment burden¹

75% of HCPs prefer to treat CIDP patients as early and aggressively as possible

Sizable Market Opportunity

58K

Total CIDP Patients in the US²



30%

who are inadequately controlled on treatment⁴



16K

US addressable population

Substantial Unmet Need

Lower Relapse Rates

30-50% of CIDP patients are inadequately controlled with existing therapies⁵

Improved Response and Durability

60% of physicians report a need for better response to treatment and more durable CIDP treatments

More Convenient Dosing Options

~90% of physicians noted a high need for treatments with improved ROA (e.g., at home administration)

Improved safety & tolerability

71% of US physicians report a need for treatment options with fewer side effects⁶

ACPA+ Difficult-to-Treat RA

First- and Best-in-Class Opportunity



IMVT-1402 has the potential to achieve a first- and best-in-class profile for people with ACPA+ D2T RA, who have failed two or more prior advanced mechanisms¹

High Unmet Need Subgroup

5-20% of RA patients have inadequate or loss of response to two or more mechanisms of advanced therapies²

Autoantibody Pathology

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

Lower is Better

Phase 2 FcRn RA data demonstrated that increased IgG reduction led to increased autoantibody reductions, which correlated with improved clinical response³

Potentially Registrational* Trial Fully Enrolled

Clinically meaningful response rates were observed at Week 16 in the open label period of the trial⁴; Immunovant expects to provide further updates in 2H 2026

1. Advanced mechanisms include biologics (e.g., TNF α inhibitors, IL-6R inhibitors, CD80/86 inhibitors, CD20 inhibitors) and targeted synthetic DMARDs (e.g., JAK inhibitors). For patients failing ≥ 2 prior advanced mechanisms in addition to conventional DMARDs, IMVT-1402 would be the fourth line or later line of therapy

2. Takanashi S, et al. Rheumatology, 2021;60:5247-56

3. Taylor PC et al. Efficacy and Safety of Nipocalimab in Patients with Moderate to Severe Active Rheumatoid Arthritis (RA): The Multicenter, Randomized, Double-blinded, Placebo-controlled Phase 2a IRIS-RA Study Presented at ACR, Nov 10-15, 2023

4. Data on file

*Potentially registrational indicates registration is dependent on future alignment with FDA on clinical trial design, endpoints, statistical analysis plans, and overall development strategy

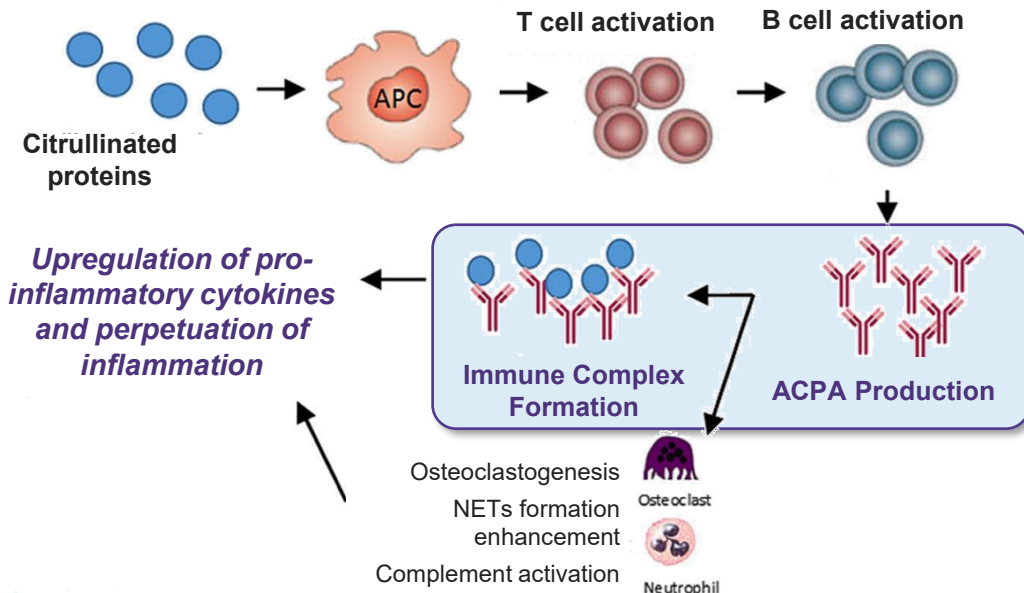
ACPA: anti-citrullinated protein antibody; TNF: tumor necrosis factor; IL-6R: interleukin-6 receptor; DMARD: disease-modifying anti-rheumatic drug; JAK: Janus kinase

In addition to cellular autoimmunity and cytokine dysregulation, autoantibodies like ACPA play a key role in the pathophysiology of RA

Autoantibodies such as Rheumatoid Factor (RF) and ACPA are present in ~75% of RA patients¹

Role of ACPA in RA pathophysiology

- 1 Antigen presenting cells (APCs) process and present citrullinated peptides to T cells
- 2 T cells activate B cells to generate autoantibodies
- 3 Immune complex formation upregulates pro-inflammatory cytokines
- 4 ACPA may bind to osteoclasts and thereby promote bone erosion



Anti-FcRn has the potential to directly target underlying disease biology by lowering pathogenic autoantibodies (i.e., ACPA) and immune complexes

Difficult-to-treat RA is estimated to comprise 5-20% of RA patients whose disease cannot be managed by available therapies

The D2T population of multi-advanced mechanism failures has no proven treatment options

Need for More Options

- Estimated 5-20% of patients remain symptomatic despite multiple treatment rounds with advanced mechanisms^{1,2}
 - These patients need new therapies and approaches, according to a global survey of 410 rheumatologists
- Difficult-to-treat (D2T) RA defined by EULAR as³:
 - Failure on conventional DMARDs and 2 or more advanced therapy mechanisms (i.e., TNF inhibitors, JAK inhibitors and/or other biologics⁴)
 - Signs suggestive of active/progressive disease
 - Symptom management viewed as problematic to doctor and/or patient

D2T RA Criteria

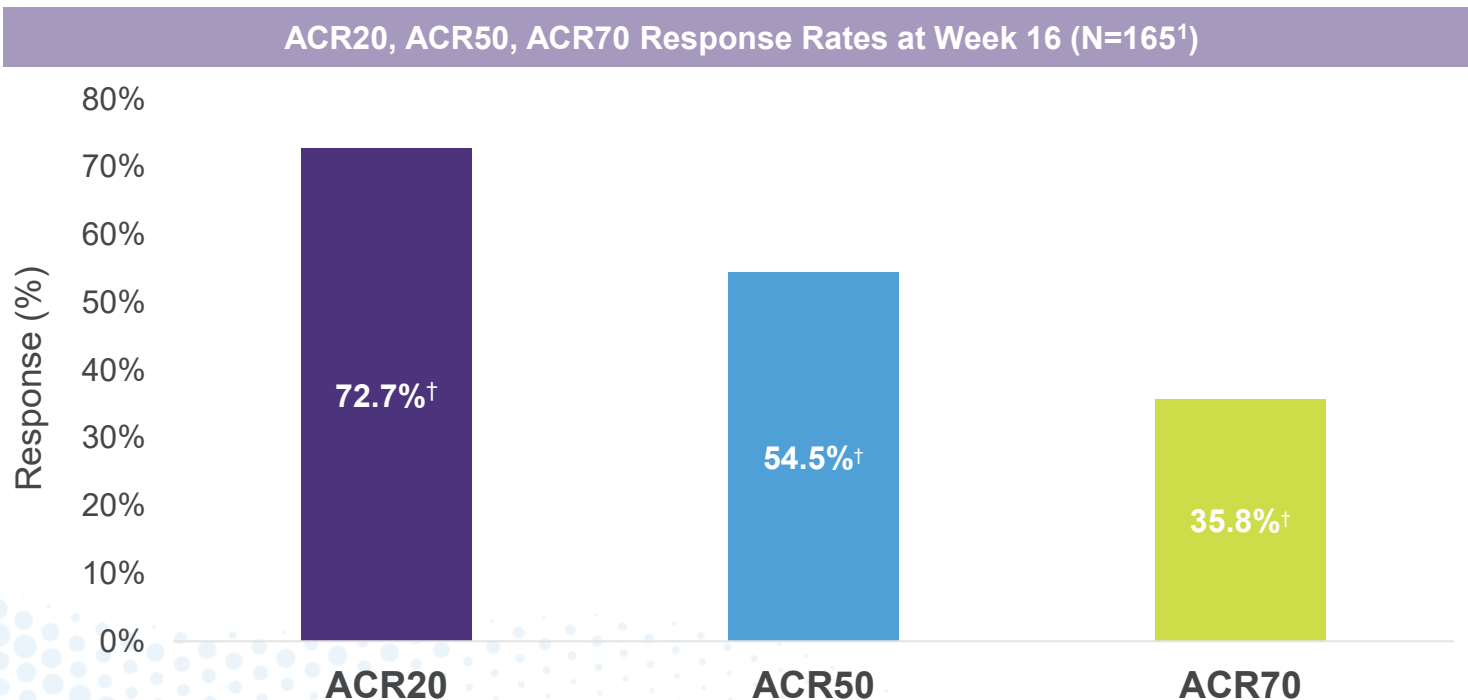
- At least moderate disease activity as defined by composite endpoints which include tender and swollen joint counts
- Progressive joint damage on imaging
- Inability to decrease chronic glucocorticoid therapy below 7.5mg/day
- Ongoing RA symptoms and QoL impact despite therapy

Trial enrolled a difficult-to-treat population: patients were 4L+, having failed conventional therapy and ≥ 2 mechanisms of advanced therapies

Baseline Characteristics <i>Mean unless otherwise noted</i>	IMVT-1402 (Period 1) (N=165²)
Age, years	58.7
Sex, % female, n (%)	116 (70.3%)
Time since RA diagnosis, years	12.8
Tender joint count (0-68)	24.2
Swollen joint count (0-66)	16.7
Clinical Disease Activity Index (CDAI)	44.6
Simplified Disease Activity Index (SDAI)	46.3
DAS28-CRP score	6.1
Number of Prior Advanced Therapy Mechanisms¹	
1 Advanced Therapy Mechanism, n (%)	1 (0.6%)
2 Advanced Therapy Mechanisms, n (%)	143 (86.7%)
≥ 3 Advanced Therapy Mechanisms, n (%)	19 (11.5%)

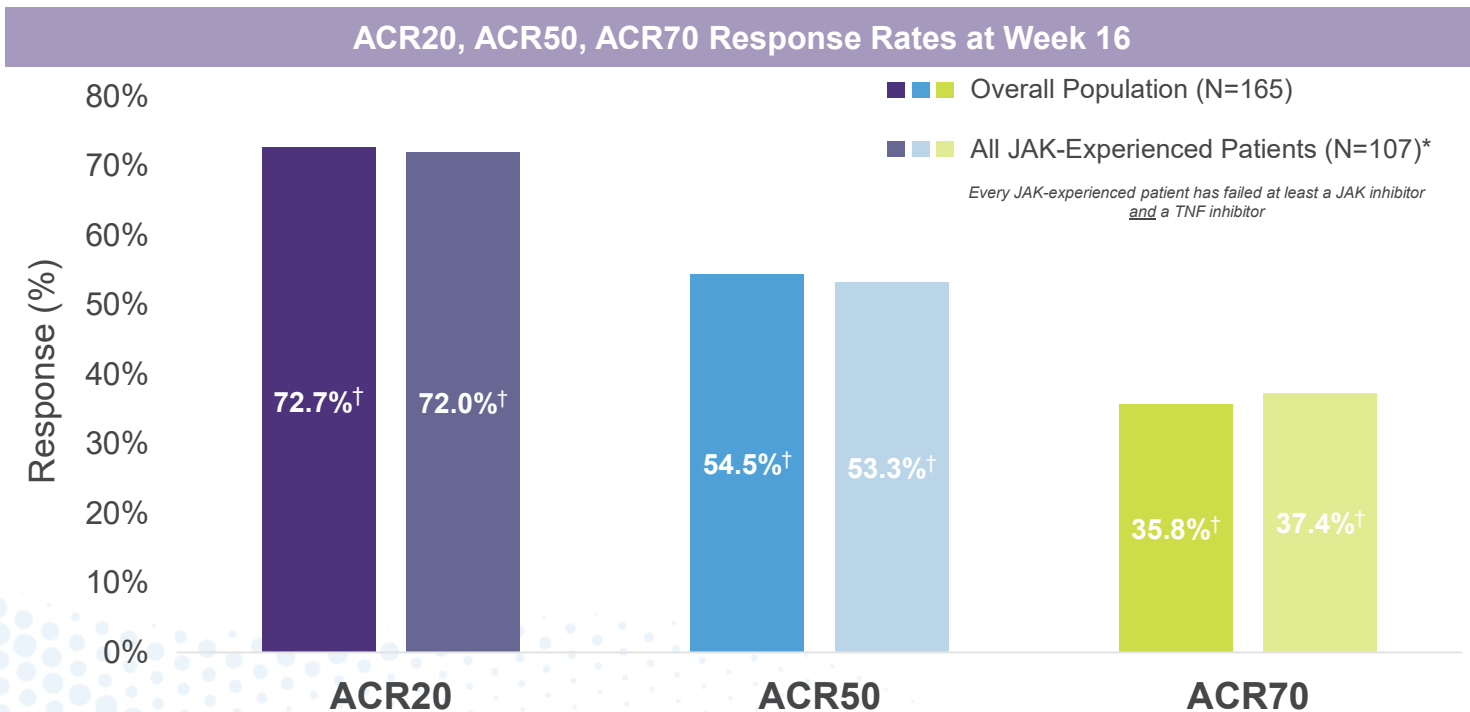
Period 1 preliminary data

Trial enrolled a difficult-to-treat population: patients had to fail at least one conventional DMARD therapy and at least 2 additional mechanisms of advanced therapies (biologic and targeted synthetic DMARDs)



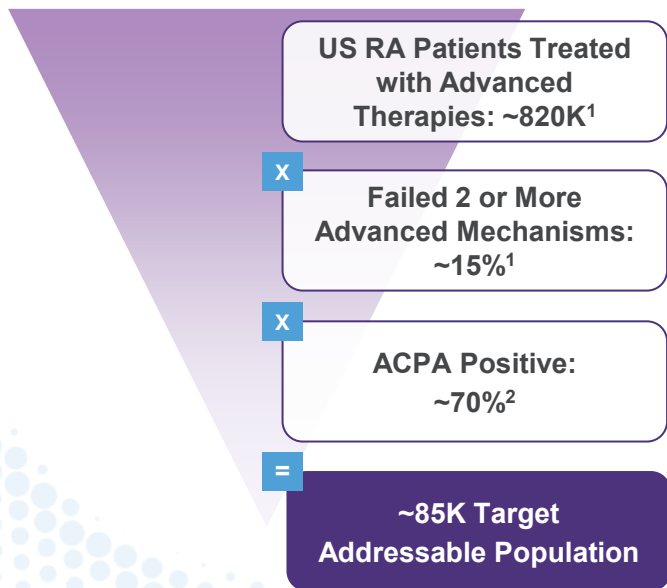
Period 1 preliminary data: consistent & meaningful effect in JAK-class failures

IMVT-1402 response rates were consistent between the overall difficult-to-treat population and patients whose treatment history included failure on at least a TNF inhibitor and a JAK inhibitor



~820K US RA patients are treated with advanced mechanisms: a subset progresses on multiple mechanisms and requires new therapeutic options

Market Opportunity



Unmet Needs in Difficult-to-Treat RA

Fewer than 50% of RA patients remain on first advanced therapy	~50% of patients fail their first advanced therapy within the first year of treatment ^{3,4}
Patients resistant to multiple therapies have more severe disease activity	Multi-drug-resistant patients have significantly higher tender joint count and global evaluator activity scores, despite therapy ⁵
Currently approved advanced mechanisms have significant contraindications	Severe RA patients are highly comorbid, which significantly impacts drug selection given contraindications for approved therapies ⁶

Sjögren's Disease

Best-in-Class Opportunity



Sjögren's disease (SjD) is a potentially best-in-class indication for IMVT-1402

High Unmet Need Disease

No therapies are approved for the treatment of primary SjD

Autoantibody Pathology

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

Lower is Better

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

Potentially Registrational* Trial Initiated

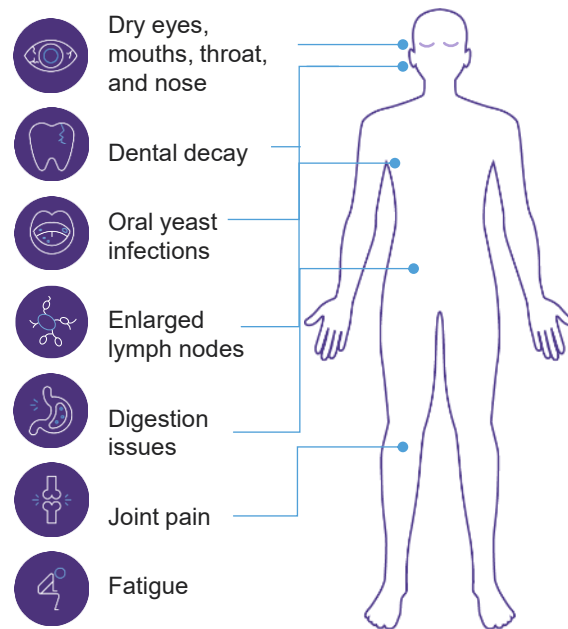
Potentially registrational trial enrolling with self-administration via market-proven autoinjector

SjD is an autoimmune disease associated with a myriad of clinical manifestations

Disease Overview

- SjD is a chronic autoimmune disease characterized by lymphocytic infiltration of the salivary and lacrimal glands
- 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}
- May occur in isolation (primary SjD) or in association with another systemic autoimmune disease such as RA (secondary SjD)
- SjD can be challenging to diagnose due to the heterogeneity of presentation³
- ACR/EULAR classification criteria are now widely endorsed for diagnosing primary SjD

Common symptoms

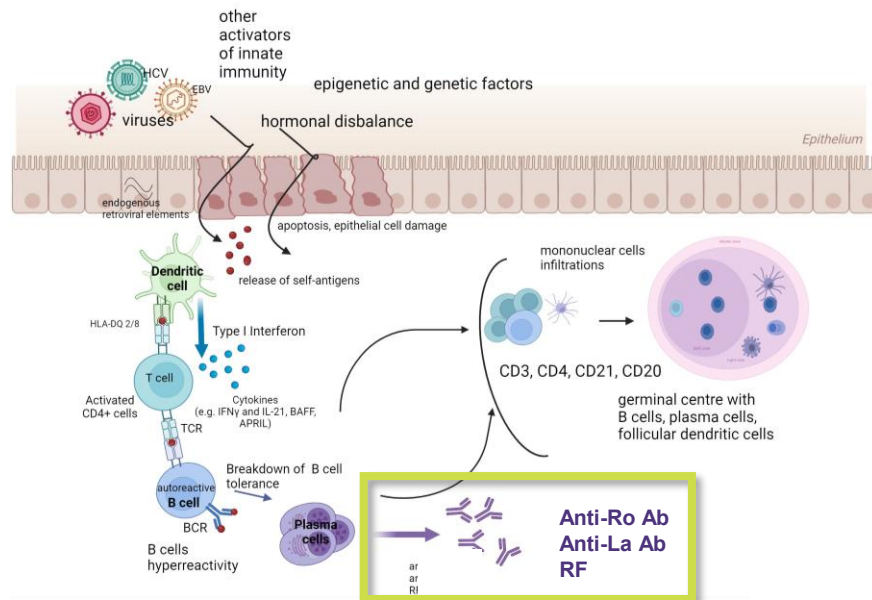


Autoantibodies play crucial roles in both the diagnosis and prognosis of SjD

Autoantibody Involvement

- Serological abnormalities are common in SjD and include autoantibodies, hypergammaglobulinemia, and hypocomplementemia¹
- Identification of disease-precipitating antibodies were discovered back in 1975. Anti-Ro/SSA and anti-La/SSB antibodies were detected in patients with SjD in 1982²
- Present day, autoantibodies are detected in ~50-70% of patients with primary SjD

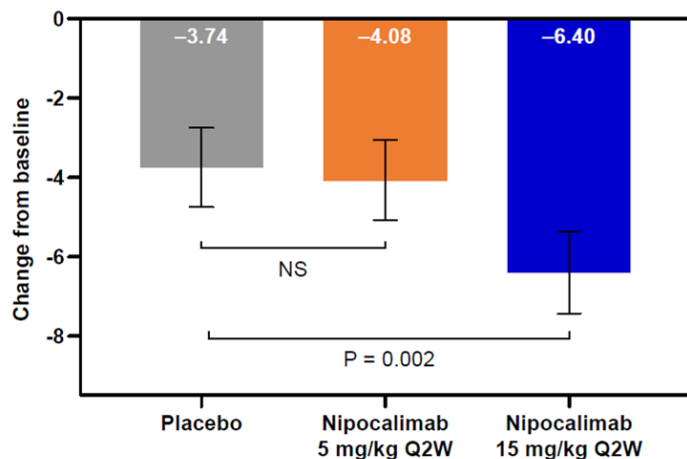
Disease Pathogenesis³



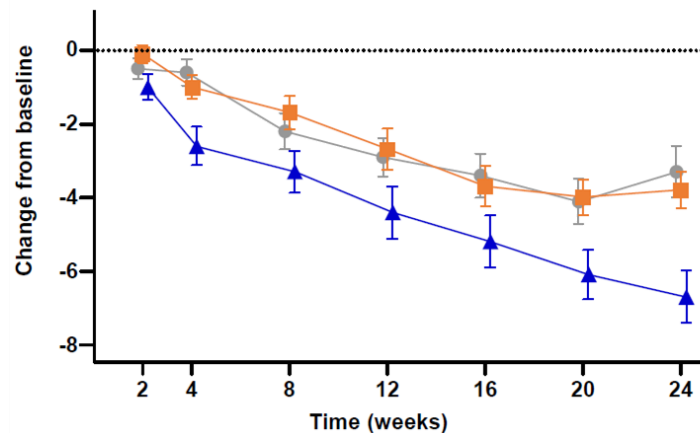
Publicly available nipocalimab data support anti-FcRn proof of mechanism and dose response in SjD

Select results from a study of FcRn blockage vs. placebo in primary SjD

LS mean (90%) change in ClinESSDAI score at Week 24



Mean (SE) change in ClinESSDAI score



● Placebo ■ Nipocalimab 5mg/kg Q2W ▲ Nipocalimab 15mg/kg Q2W

Sizable patient group with unmet need for an approved treatment option in SjD

Market Opportunity

290K

US prevalence of primary Sjögren's disease¹



Up to 30%

moderate-to-severe with anti-Ro/SSA antibodies^{2,3}



90K

US addressable population

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

Cutaneous Lupus Erythematosus

First-in-Class Opportunity



IMVT-1402 is potentially first-/best-in-class in Cutaneous Lupus Erythematosus (CLE)

Untapped Market Opportunity

IMVT-1402 has potential to be the first novel targeted therapy for CLE in >50 years¹

IgG and Immune Complex Driven

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

Upstream Targeting

Disruption of CLE pathology by upstream targeted approach supported by IMVT-1402 patient case studies

IMVT-1402 Trial Fully Enrolled

Proof-of-concept trial fully enrolled with self-administration via market-proven autoinjector; topline results expected in 2H 2026

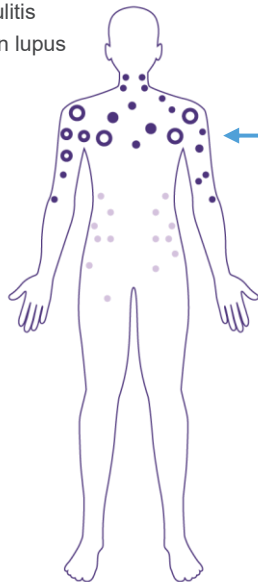


CLE is a rare, chronic autoimmune disease affecting the skin, with limited available treatment options and high unmet need

- CLE is a rare, chronic skin disease characterized by skin-specific disease-activity, inflammation and eventually damage^{1,2}
- Symptoms include painful skin lesions, itching, burning, and alopecia³
- Limited innovation and no novel therapies in >50 years⁴

Subacute Chronic Lupus Erythematosus (SCLE)

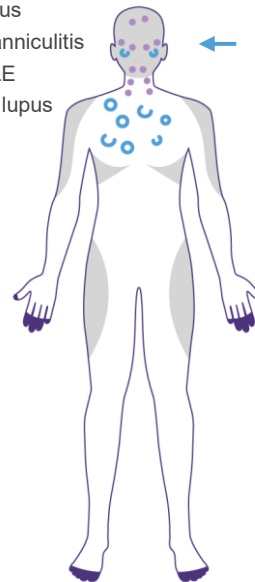
- Panniculitis
- Chilblain lupus



- Annular or papulosquamous, psoriasis-like scaling erythematous plaques
- Estimated 59K prevalence (25%)⁵

Chronic Cutaneous Lupus Erythematosus (CCLE)

- LE tumidus
- Lupus panniculitis
- Discoid LE
- Chilblain lupus



- Scaling, erythematous, typically scarring, disc-shaped plaques, alopecia
- Estimated 94K prevalence (40%)⁵

For the purposes of this presentation, reference to CLE is focused on SCLE and CCLE subtypes.

1. Vale ECSD and Garcia LC. An Bras Dermatol. 2023;98(3):355-372.

2. Presto JK, Werth VP. Cutaneous Lupus Erythematosus: Current Treatment Options. Curr Treat Option Rheumatol. 2016; 2(1): 36–48 Stull, et. al. The Journal of Rheumatology 2023;50:27–35

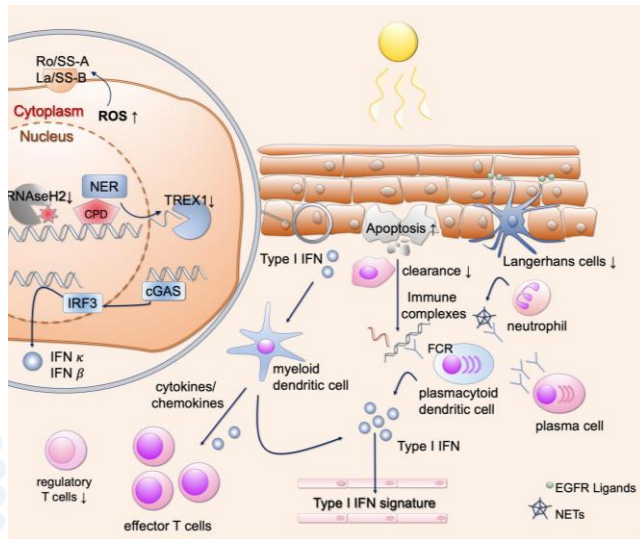
3. Klein R, et al. J Am Acad Dermatol. 2011;64(5):849-858

4. Wahie S, Meggitt SJ. Long-term response to hydroxychloroquine in patients with discoid lupus erythematosus. Br J Dermatol. 2013 Sep;169(3):653-9

5. Internal market research Spherix 2024

CLE: IgG autoantibodies and immune complexes mediate a cycle of self-amplifying skin inflammation and tissue damage in the skin

Pathogenesis of CLE Disease



UV light triggers enhanced cell death, IgG autoantibody immune response, and produces immune complex formation, leading to skin tissue damage and increased inflammation¹

Autoantibody Involvement²

CLE specific IgG autoantibodies produced (i.e., Ro/SSA, La/SSB)

IgG Autoantibodies:

- Induce skin cell death
- Trigger recruitment of inflammatory cells that form immune complexes

Immune Complex Involvement²

Immune complexes can activate receptors of the innate immune system that drive:

- Inflammation
- Tissue damage
- Skin cell death
- Recruit other immune cells

FcRn blockage has the potential to disrupt CLE pathology

IMVT-1402's deep suppression of IgG autoantibodies and immune complexes has the potential to dampen multiple downstream inflammatory cascades by providing upstream inhibition of inflammatory cascade

Case Study: 12-Week Treatment with IMVT-1402 in CLE

Baseline Demographics

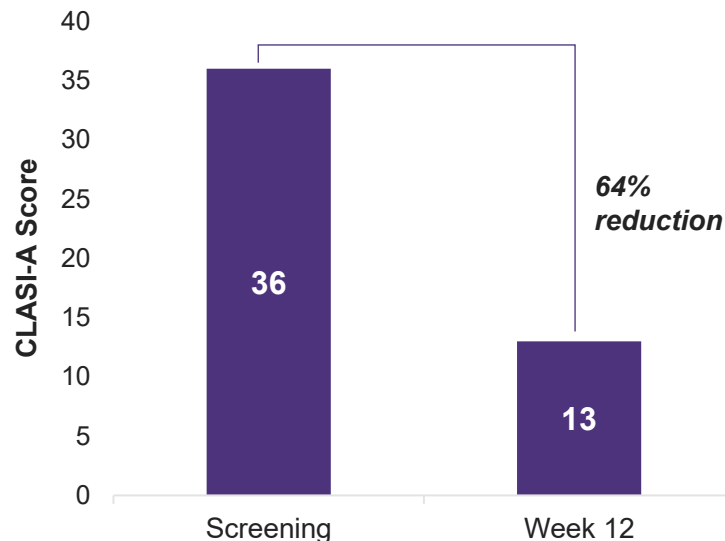
- Female, 57
- Subacute CLE and alopecia
- Multiple skin locations affected
- CLASI-A score at screening = 36
- Background medications: hydroxy-chloroquine, methotrexate, leflunomide

Treatment Outcomes

- **>60% reduction in CLASI-A** score to 13 by week 12
- Significant clinical **improvement in both skin lesions and alopecia**
- **78% total IgG reduction** from baseline achieved by week 12

IMVT-1402 Case Study: Patient 1

Patient treated with 600 mg QW SC open-label for 12 weeks



**Second patient dosed also showed >50% improvement in CLASI-A score by week 12
(CLASI-A at screening of 18 reduced to 8 by week 12)**

Dermatologists desire a skin-focused, targeted biologic that addresses CLE unmet needs¹

IMVT-1402 has potential to be the first novel dermatology therapy for CLE in >50 years²

Considerable Market Opportunity

153K

US prevalence of SCLE and CCLE³



Up to 50%

Non-responders to antimalarials or topicals⁴



75K

Target addressable US population

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 disfigurement¹

Sustained remission

90% of dermatologists cite sustained remission and reduced severity of flares as top unmet needs¹

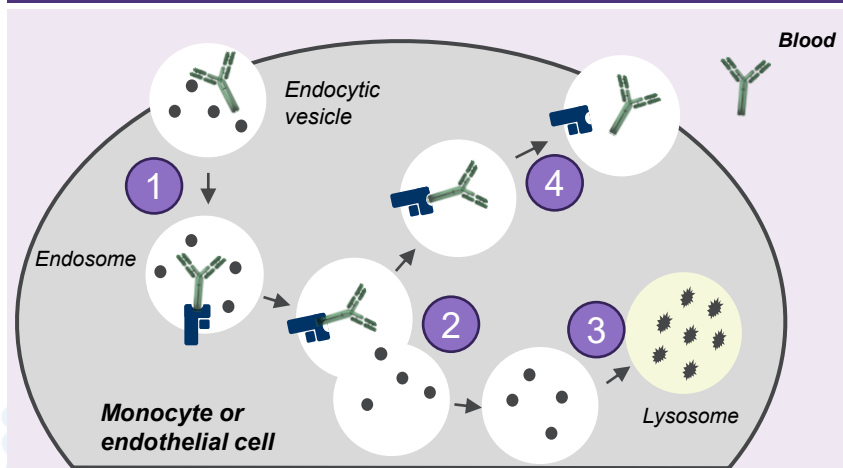
Improved safety & tolerability

80% of HCPs report lack of long-term efficacy, tolerability and toxicity risks with current CLE treatments²

Appendix

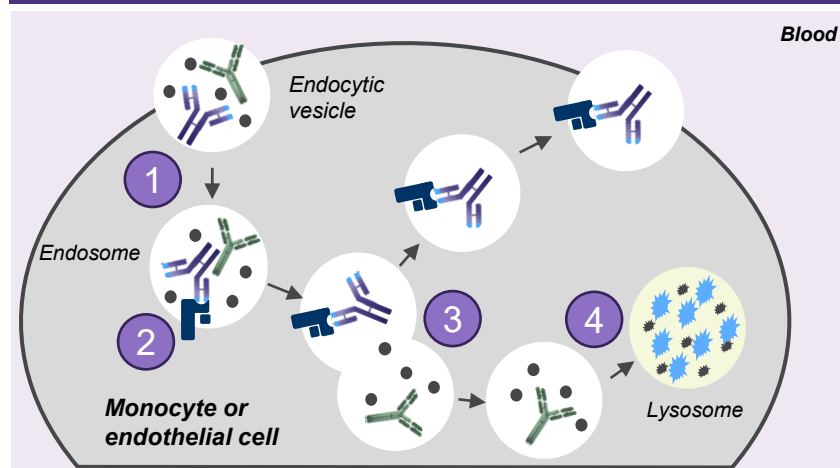
Our target: Neonatal Fc receptor (FcRn)

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



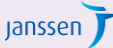
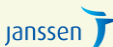
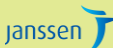
1. IgG is taken up into cells in endocytic vesicle
2. FcRn-IgG complexes are sorted from unbound proteins
3. Unbound proteins are trafficked to lysosome for degradation
4. IgG is recycled back into circulation

Anti-FcRn blocks binding of IgG to FcRn and promotes their removal and degradation



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

Totality of FcRn clinical evidence demonstrates that deeper IgG reductions result in better clinical outcomes across multiple indications

	Company	Evidence of Greater IgG Reductions Translating to Clinical Benefit
GD	 IMMUNOVANT	<u>Phase 2:</u> Greater IgG reduction across treatment cohorts → higher rates of anti-TSHR antibody reduction and numerically higher responses for ATD dose tapering and ATD discontinuation
CIDP	 IMMUNOVANT	<u>Phase 2b:</u> Greater IgG reduction across treatment cohorts → higher aINCAT response rates
MG	 IMMUNOVANT	<u>Phase 2:</u> Deeper IgG across treatment arms → AChR autoantibody reductions and enhanced clinical activity <u>Phase 3:</u> 680 mg dose with greater IgG reduction out-performs 340 mg dose across endpoints
	 janssen	<u>Phase 2:</u> Patient-level scatter plot demonstrating greater IgG declines → greater MG-ADL improvements ¹
	 argenx	<u>Phase 3:</u> Patient-level scatter plot demonstrating greater IgG declines → greater MG-ADL improvements ²
TED	 IMMUNOVANT	<u>Phase 2s:</u> Greater IgG reduction across arms → higher rates of anti-TSHR antibody reduction and greater clinical response rates
SjD	 janssen	<u>Phase 2:</u> Dose-dependent efficacy → deeper IgG reduction (same dose regimen used in RA trial) led to better clinical response ³
RA	 janssen	<u>Phase 2:</u> In those patients with greater IgG reduction → correlation with greater autoAb reduction → correlation with greater clinical response ⁴
ITP	 ucb	<u>Phase 2:</u> Greater IgG reduction across arms → greater platelet responses ⁵
PV/PF	 argenx	<u>Phase 2:</u> More intensive dosing regimens across arms led to deeper IgG lowering → deeper skin responses and lower rates of relapse ⁶

IMVT-1402 first potentially registrational* trial in Graves' disease

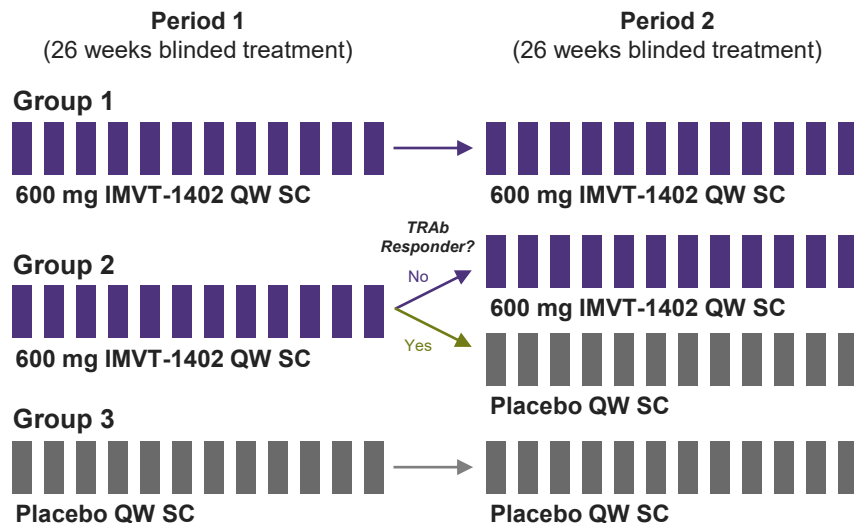
Inclusion^a

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

Randomization (1:1:1)

Treatment Period: 52 weeks

N = 240



Off-Treatment Follow-up (52 weeks)

Primary Endpoint at Week 26:

Proportion of participants who become euthyroid^b and off ATD

Key Secondary Endpoint at Week 52:

Proportion of participants who become euthyroid^b and off ATD

Design enables study of remission

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

IMVT-1402 second potentially registrational* trial in Graves' disease

Inclusion^a

- Adults with active Graves' disease who are hyperthyroid based on suppressed TSH despite ATD treatment

Randomization (1:1:1)

Blinded Treatment Period: 26 weeks

N = 210



600 mg IMVT-1402 QW SC
N=70



300 mg IMVT-1402 QW SC
N=70



Placebo QW SC
N=70

Off-Treatment Follow-up

Primary Endpoint at Week 26:

Proportion of participants who become euthyroid^b and off ATD

Secondary Endpoint at Week 26:

Proportion of participants who have T3 (Total T3 or FT3) and FT4 ≤ ULN and off ATD

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

IMVT-1402 potentially registrational* trial in MG

Global trial with N=231 participants; designed to enable demonstration of deep, durable responses

Inclusion^a

- Mild to severe gMG
- Positive diagnostic autoantibody confirmation (see note^b)

1:1:1 Randomization (N=231)

Period 1: (12 weeks)



600 mg IMVT-1402
QW SC



300 mg IMVT-1402
QW SC



Placebo QW SC

Period 2: (14 weeks)



600 mg IMVT-1402
QW SC



300 mg IMVT-1402
QW SC



600 mg IMVT-1402
QW SC

Period 3: (52 weeks)



600 mg IMVT-1402
QW SC



300 mg IMVT-1402
QW SC



600 mg IMVT-1402
QW SC

Primary
Analysis
(Week 12)

Primary Analysis Population:

anti-AChR+, anti-
MuSK+, anti-LRP4+
(antibody positive)

Primary Endpoint:

Change from
baseline in MG-ADL
to Week 12 for
antibody-positive
participants

IMVT-1402 potentially registrational* trial in CIDP

Trial designed to maximize dose response with IMVT-1402 600 mg

Inclusion^a

- Clinical diagnostic criteria for typical CIDP
- Having evidence of active disease

2:1 Randomization

Blinded Treatment Period^b: 24 Weeks N = 162



600 mg IMVT-1402 QW SC
N = 108



Placebo QW SC
N = 54

Open-label Extension: 52 Weeks



600 mg IMVT-1402 QW SC



600 mg IMVT-1402 QW SC

Primary Endpoint:

Proportion of participants remaining relapse-free (aINCAT) by Week 24

IMVT-1402 potentially registrational* trial in ACPA+ D2T RA¹

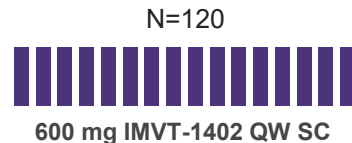
Trial designed as open label lead-in followed by randomized withdrawal in multi-mechanism failure population enriched for higher baseline ACPA levels

Inclusion^a

- hsCRP ≥ upper limit of normal
- Active RA defined as ≥ 6/68 tender/painful joints, ≥ 6/66 swollen joints (SJC), and DAS28-CRP > 4.1
- IgG+ anti-citrullinated protein antibody (ACPA+)
- Inadequate response to 2, but not more than 4, classes of b/tsDMARDs
- On stable treatment with csDMARD

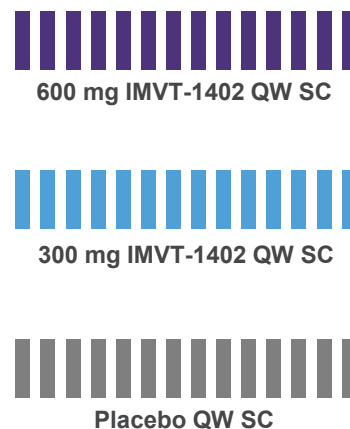
Screening Period (up to 5 weeks)

Period 1: Open-label, active treatment lead-in (16 weeks)



Randomized Treatment Responders** (1:1:1)

Period 2: Blinded randomized withdrawal (12 weeks)



Safety Follow-up Period (4 weeks)

Endpoints

Primary endpoint:

For participants achieving ACR20 response at Weeks 14 and 16, proportion of participants who maintain ACR20 response at Week 28

Secondary endpoint:

Change in CDAI and SDAI from Week 16 to Week 28 for participants in Period 2

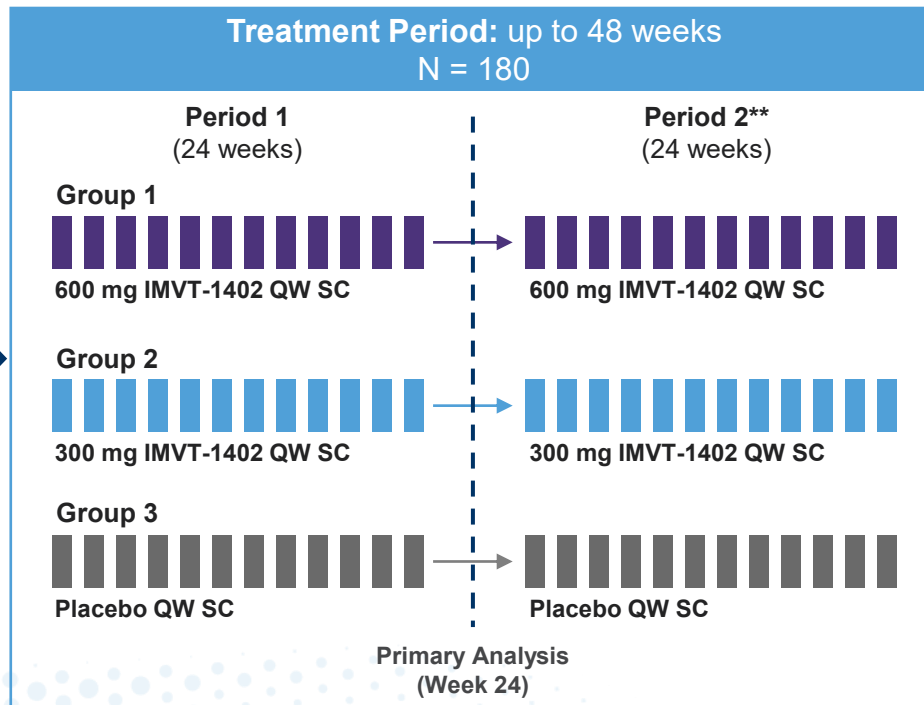
IMVT-1402 potentially registrational* trial in SjD

Trial enables comparison of high dose to low dose FcRn blockage

Inclusion^a

- Primary SjD
- Moderate to severe systemic disease activity (clinESSDAI total score ≥ 5)
- Anti-SSA/Ro antibody positive
- Residual unstimulated salivary flow
- On stable background medication(s) for primary SjD, if applicable

Randomization (1:1:1)



Follow-up (4 weeks)

Endpoints

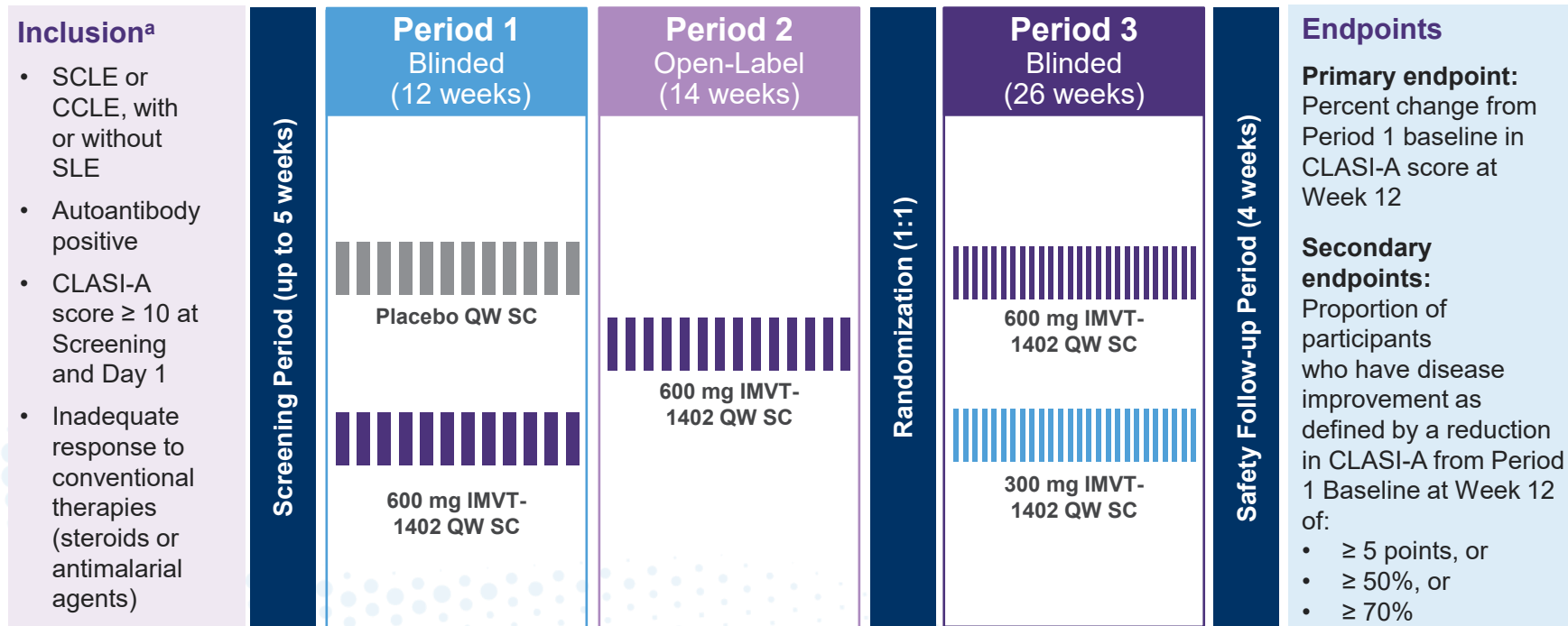
Primary Endpoint at Week 24: Change from baseline in clinESSDAI score

Select Secondary Endpoints:

- Proportion of clinESSDAI responders at Week 24
- Change from baseline in clinESSDAI score at Week 48

IMVT-1402 proof-of-concept study in CLE

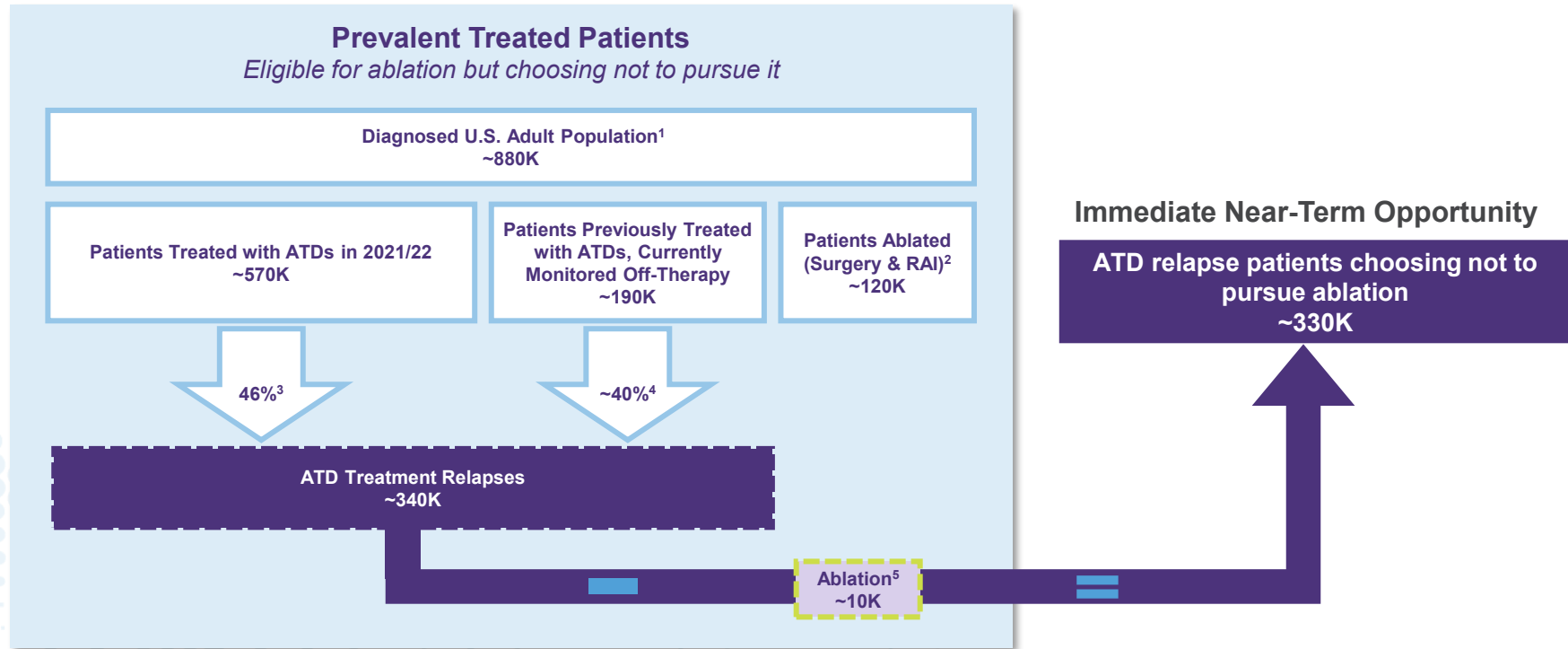
Global trial with N=56 participants; designed to demonstrate short-term and long-term efficacy





Market Opportunity in Graves' Disease

Analysis #1: Real world claims analysis indicates a substantial untapped opportunity in the prevalent treated Graves' Disease market



1. Roivant Claims Analysis – 2022 prevalent patient population based on a two-year lookback for diagnosis

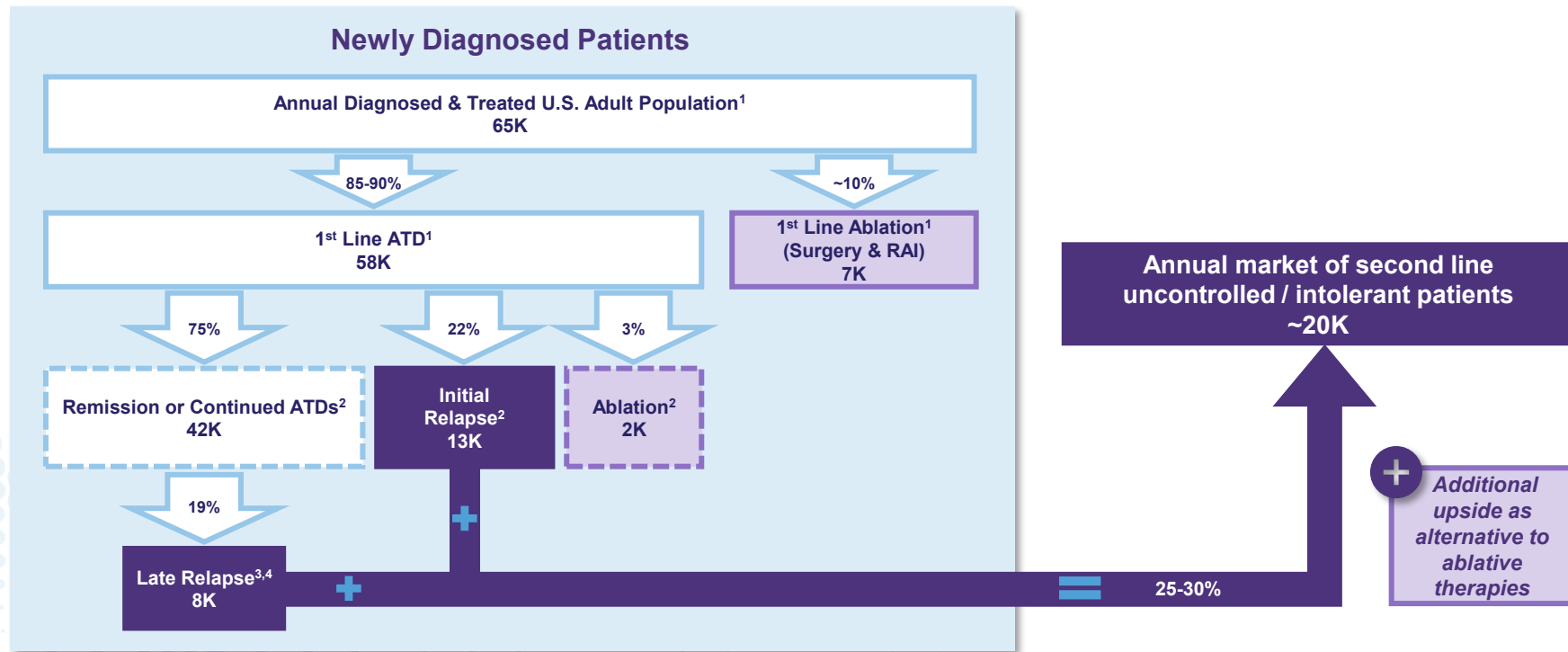
2. Of the 120K patients ablated, ~80K were ablated prior to 2021 and ~40K were ablated in 2021/2022

3. Azizi et al. (2019) Note: the relapse rate was calculated as a weighted average considering relapse rate in patients on ATDs <18months is 53% compared to patients on ATDs >18months is 15%. Of the 570K patients treated with ATDs, ~470K are on ATDs <18months and ~100K are on ATDs for >18months. Rates have been applied proportionally.

4. Bandai et al. (2019): Of the ~190K patients previously treated with ATDs and currently monitored off-therapy, ~40% experience relapse, which is 75K.

5. Grove-Laugesen et al. (2023): 3.4% of ATD relapse patients will pursue ablation. 3.4% applied to the ~340K ATD treatment relapse patients is ~10K.

Analysis #2: Real world claims analysis conservatively estimates an incident US population of ~65K leading to an annual second line market of ~20K patients



1. Rolivant Claims Analysis – 2021 incident patient population, first-line treatment is primary treatment in the first-year post diagnosis, claims review included a five-year lookback to define the incident population

2. Grove-Laugesen et al. (2023): Completer rates for combined arms: ATD remission 56.0%, continuing ATD 18.8%, ATD relapse of 21.8%, ablation of 3.4%. Of the 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. (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. (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)

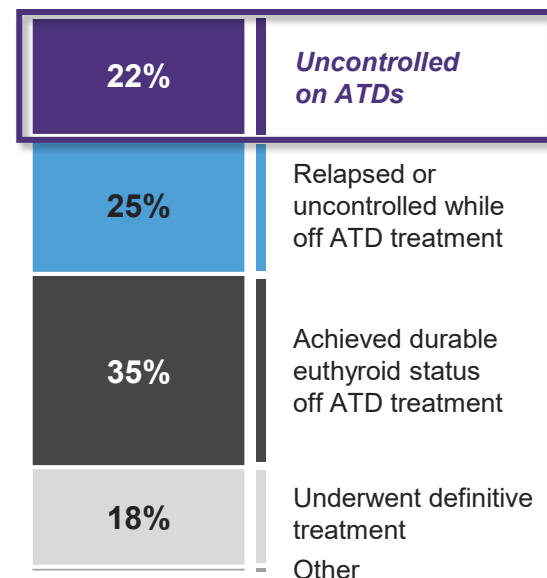
Analysis #3: Surveyed endocrinologists indicate that ~25% of their patients remain uncontrolled on ATDs

Endocrinologist Survey Methodology

1. Board-certified endocrinologists (N=140) were screened based on Graves' disease patient volume (10+ patients in the past 3 months) and time in practice (2-40 years in practice with ≥50% of time spent in direct patient care)
2. The N=140 endocrinologists completed a double-blinded online quantitative survey regarding their treatment experience

Graves' Disease Patient Types: HCP Survey

(n=140 HCPs, % of patients)



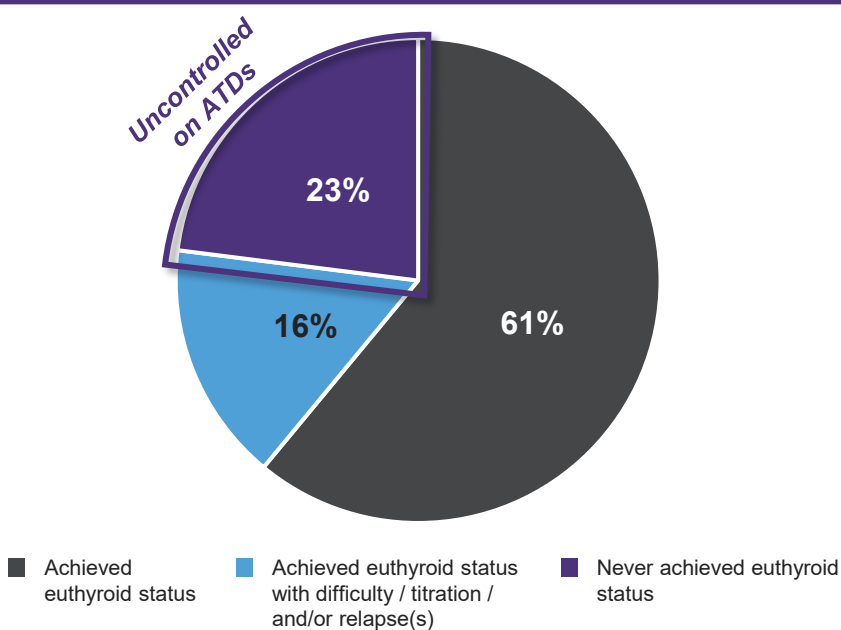
Analysis #4: Real-world in-depth chart review of 1,000+ patient records from 140 endocrinologists indicates ~25% have never achieved euthyroid status on ATDs

Real World Chart Audit Methodology

1. As part of the endocrinologist survey, each healthcare provider was asked to complete N=8 Graves' disease patient charts for a total of 1,120 charts collected via randomized selection to minimize bias
2. Chart selection followed various qualifications:
 1. Diagnosed with Graves' disease
 2. Seen by the healthcare provider in the past 3 months
 3. Under the healthcare provider's care for at least 6 months
 4. First visit in the past 3 years
 5. Either on ATD therapy currently or previously

Characterization of Thyroid Control with ATD Therapy

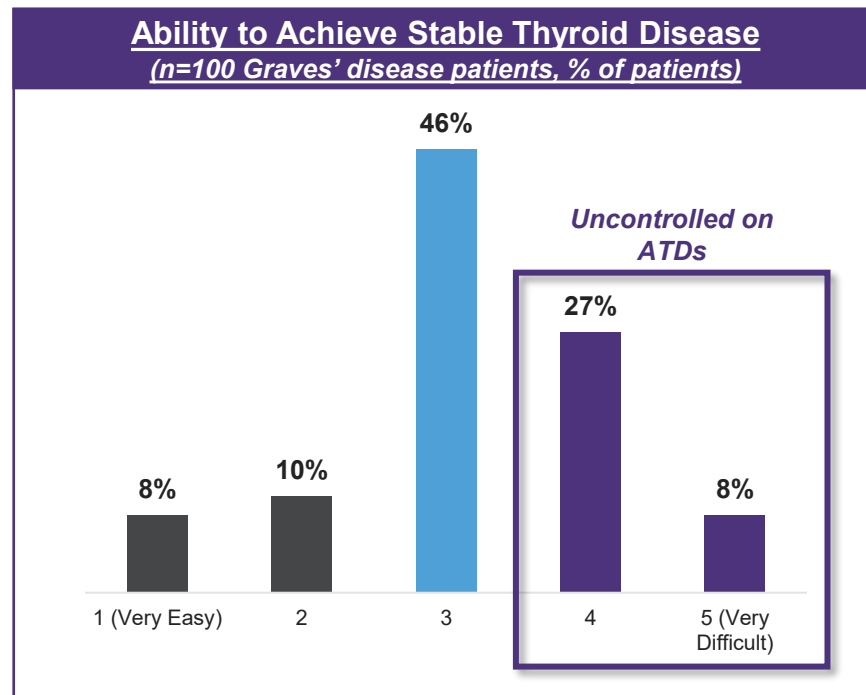
(n=998 Patient Charts*, % of patients)



Analysis #5: ~35% of Graves' disease patients report that they have found it difficult or very difficult to achieve stable thyroid disease while on ATDs

Patient Survey Methodology

1. A double-blinded online survey was conducted with N=100 patients who reported being diagnosed by a healthcare provider with Graves' disease
2. Screening criteria included patients who were diagnosed in the past 3 years OR diagnosed in the past 5 years with a recurrence in the past year
3. Excluded patients who had received radioactive iodine or thyroidectomy



Graves' US market-sizing analyses confirm high unmet need with ~330K prevalent patients relapsed, uncontrolled, or intolerant to ATDs

1

Conservative Inovalon claims analysis¹ yields ~880K prevalent Graves' disease patients, including ~330K prevalent ATD relapsed patients choosing not to pursue ablation

2

Conservative Inovalon claims analysis² yields ~65K annual incident Graves' disease patients, including ~20K annual incident second line uncontrolled / intolerant patients

3

Deep dive endocrinologist survey of 140 healthcare providers treating Graves' disease patients indicates ~25-30% of patients are relapsed, uncontrolled, or intolerant to ATDs

4

Real-world chart audit of 1,120 Graves' disease patients treated by surveyed endocrinologists indicates ~25-30% of patients are relapsed, uncontrolled, or intolerant to ATDs

5

Patient survey of 100 diagnosed Graves' disease patients indicates ~25-30% of patients are relapsed, uncontrolled, or intolerant to ATDs