IMMUNOVANT®

Targeted science, tailored solutions

for people with autoimmune disease

Corporate Presentation

March 2025

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 Immunovant's expectations regarding patient enrollment, timing, design, and results of clinical trials of its product candidates and indication selections; Immunovant's plan to develop IMVT-1402 and batoclimab across a broad range of autoimmune indications; expectations with respect to these planned clinical trials including the number and timing of (a) trials Immunovant expects to initiate, (b) FDA clearance with respect to IND applications, and (c) potential pivotal or registrational programs and clinical trials of IMVT-1402; the size and growth of the potential markets for Immunovant's product candidates and indication selections, including any estimated market opportunities; Immunovant's plan to explore in subsequent study periods follow-on treatment with alternative dosing regimens; Immunovant's beliefs regarding the potential benefits of IMVT-1402's and batoclimab's unique product attributes and first-in-class or best-in-class potential, as applicable; Immunovant's anticipated strategic reprioritization from batoclimab to IMVT-1402; and whether, if approved, IMVT-1402 or batcolimab will be successfully distributed, marketed or commercialized. All forward-looking statements are based on estimates and assumptions by Immunovant's management that, although Immunovant believes to be reasonable, are inherently uncertain. All forward-looking statements are subject to risks and uncertainties that may cause actual results to differ materially from those that Immunovant expected. Such risks and uncertainties include, among others: initial results or other preliminary analyses or results of early clinical trials may not be predictive of final trial results or of the results of later clinical trials; results of animal studies may not be predictive of results in humans; the timing and availability of data from clinical trials; the timing of discussions with regulatory agencies, as well as regulatory submissions and potential approvals; the continued development of Immunovant's product candidates, including the timing of the commencement of additional clinical trials; Immunovant's scientific approach, clinical trial design, indication selection, and general development progress; future clinical trials may not confirm any safety, potency, or other product characteristics described or assumed in this presentation; any product candidate that Immunovant develops may not progress through clinical development or receive required regulatory approvals within expected timelines or at all; Immunovant's product candidates may not be beneficial to patients, or even if approved by regulatory authorities, successfully commercialized; the effect of global factors such as geopolitical tensions and adverse macroeconomic conditions on Immunovant's business operations and supply chains, including its clinical development plans and timelines; Immunovant's business is heavily dependent on the successful development, regulatory approval and commercialization of batoclimab and IMVT-1402; Immunovant is in 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 most recent Quarterly Report on Form 10-Q for the quarter ended December 31, 2024, filed with the SEC on February 6, 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.

Our vision:
Normal lives for people with autoimmune disease

What we do:

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

Love Trailblazing

Bolder, Faster

All Voices

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Our focus:

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

Leadership Team	Intellectual Property	Financial Strength	Validated Target	Product Candidates	Market Opportunity
					
Deep drug development and commercialization experience across the C-suite and senior leaders	Strong patent protection for IMVT-1402 to 2043[1] Issued U.S. claims cover composition of matter, method of use, and methods for manufacturing	Pro forma cash balance of approximately $825 million as of December 31, 2024, including approximately $450M gross proceeds from PIPE January 2025	FcRn is a validated target following the regulatory approval of efgartigimod and rozanolixizumab	Lead asset, IMVT-1402, has potential best-in-class profile 6 INDs cleared including GD, ACPA+ D2T RA, MG and CIDP[2]	Large total addressable market with 23 indications announced or in development across the anti-FcRn class[3]

1. Not including any potential patent term extension
2. Anti-citrullinated protein autoantibody positive (ACPA+), Difficult-to-Treat Rheumatoid Arthritis (D2T RA), Myasthenia Gravis (MG), Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
3. Indications announced or in development with anti-FcRn assets by Immunovant, argenx, Johnson & Johnson, and UCB

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

Pete Salzmann, MD MBA
Chief Executive Officer

Eva Renee Barnett, MBA
Chief Financial Officer

Michael Geffner, MD MBA
Chief Medical Officer

Melanie Gloria, BMS
Chief Operating Officer

Chris Van Tuyl
Chief Legal Officer

William L. Macias, MD PhD
Chief Medical Officer Emeritus

Jay S. Stout, PhD
Chief Technology Officer

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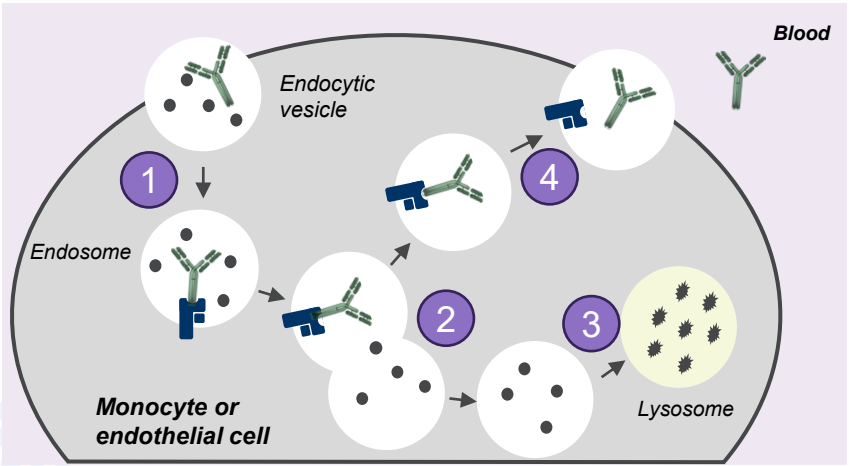
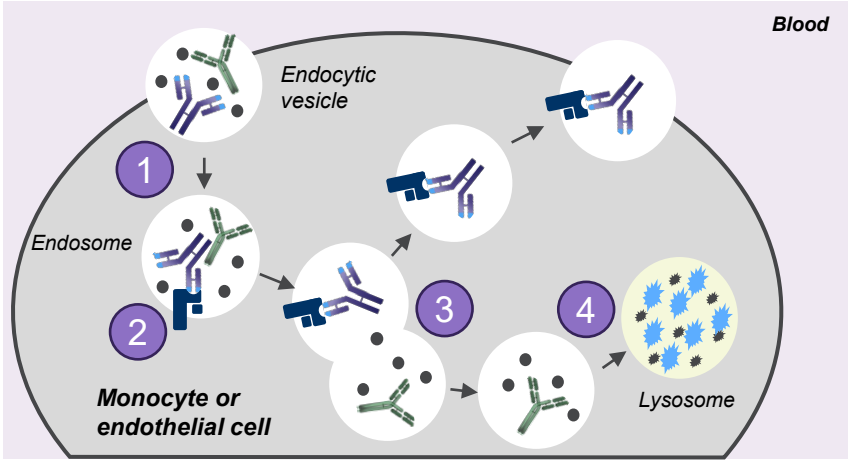
Our target:
Neonatal Fc receptor (FcRn)

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



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

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



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

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Key: IgG | FcRn | FcRn inhibitor | Serum protein

Our market:

Autoimmune diseases driven by harmful IgG autoantibodies

Anti-FcRn mechanism potentially the leading therapeutic class with 23 indications announced or in development[1]

NEUROLOGY

Chronic inflammatory demyelinating polyneuropathy (CIDP)
Generalized myasthenia gravis (MG)
Ocular MG
Pediatric MG
Myelin oligodendrocyte glycoprotein antibody disorders (MOG-antibody disorder)

ENDOCRINOLOGY

Graves' disease (GD)
Thyroid eye disease (TED)

HEMATOLOGY

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

RHEUMATOLOGY

Myositis
Primary Sjögren's syndrome
Rheumatoid arthritis (RA)
Severe fibromyalgia syndrome
Systemic lupus erythematosus

DERMATOLOGY

Bullous pemphigoid
Pemphigus foliaceus
Pemphigus vulgaris
Systemic sclerosis

RENAL

Antibody-mediated rejection
Lupus nephritis
Membranous nephropathy

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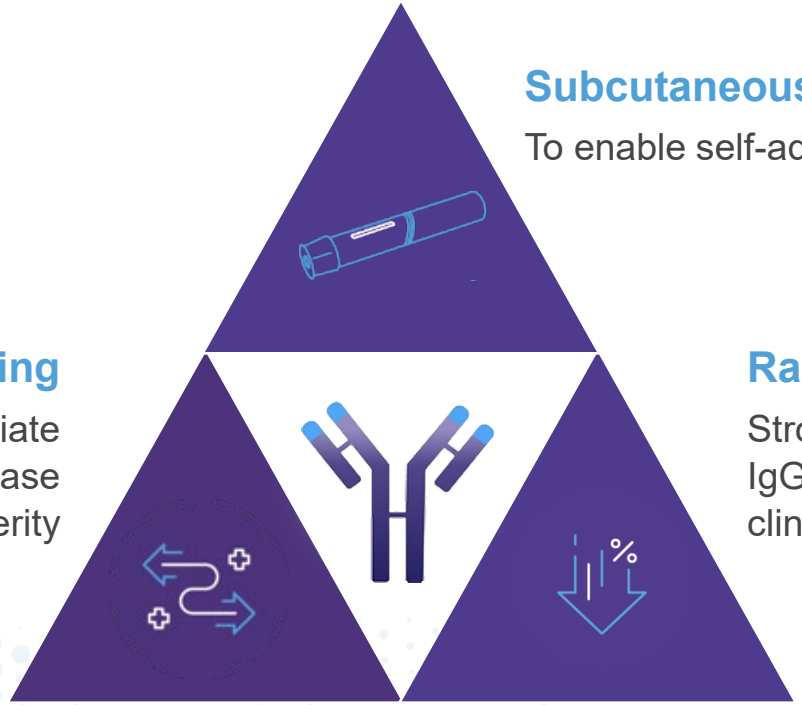
1. Indications announced or in development with anti-FcRn assets by Immunovant, argenx, Johnson & Johnson, and UCB.

Our differentiated value proposition:
Three potentially unique attributes to address unmet patient needs



Subcutaneous injection

To enable self-administration at home

Tailored dosing

To help alleviate symptoms across disease stage and severity

Rapid & deep IgG reduction

Strong correlation between deep IgG reduction and increased clinical efficacy

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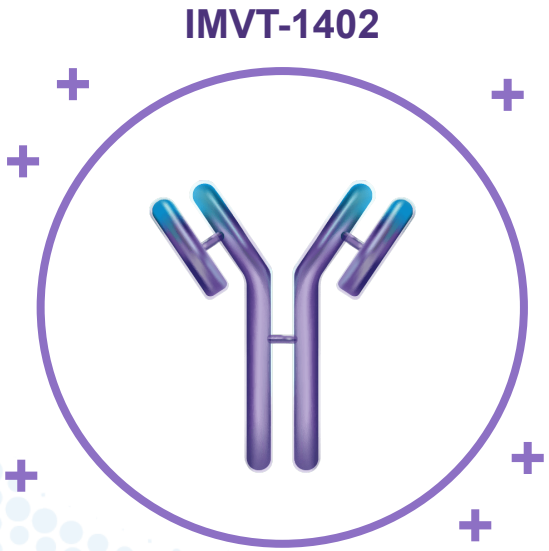
Our lead asset:
IMVT-1402 has a combination of potentially best-in-class attributes not seen with other anti-FcRns



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

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

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

Convenient Administration Delivered via market-proven, user-friendly autoinjector

Compelling Patent Protection Issued U.S. patent covers composition of matter, method of use and methods for manufacturing to 2043[1]

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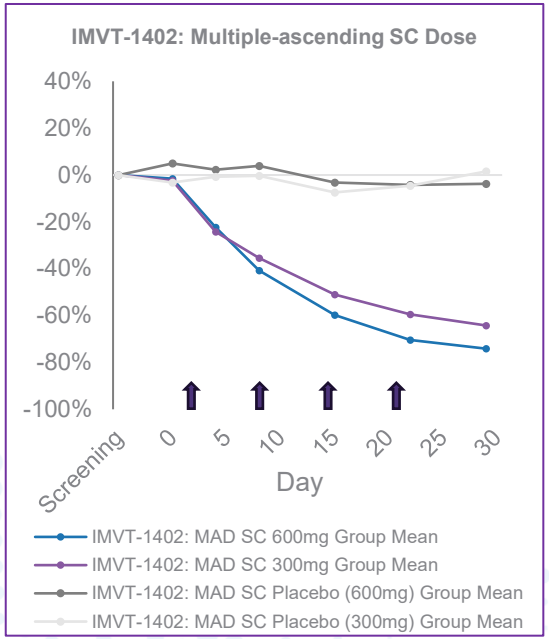
1. Not including any potential patent term extension

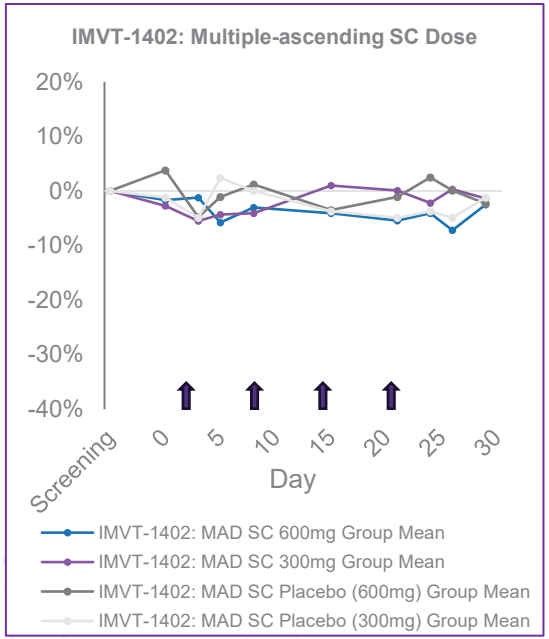
IMVT-1402 demonstrated potentially best-in-class profile in initial Phase 1 clinical trial data in healthy adults

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

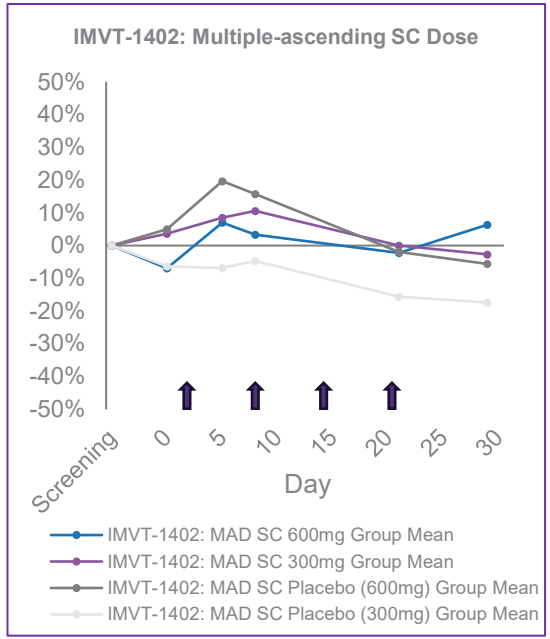
IgG % change over time



Albumin % change over time



LDL % change over time



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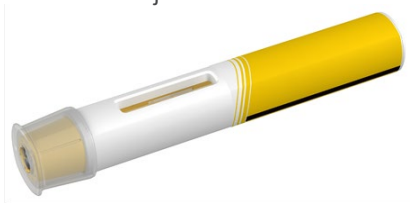
⬆ Dose administration

IMVT-1402 starting pivotal trials with intended commercial formulation and device: YpsoMate® autoinjector

Leveraging market-proven, user-friendly technology to meet patient needs

IMVT-1402

2.25 mL automated disposable injection device



Dose: 150 mg/mL
Injection volume: 2 mL

Established autoinjector with multiple approved products

- Automated, simple, subcutaneous injection
- Hidden needle shield
- Provides both visual and audio feedback

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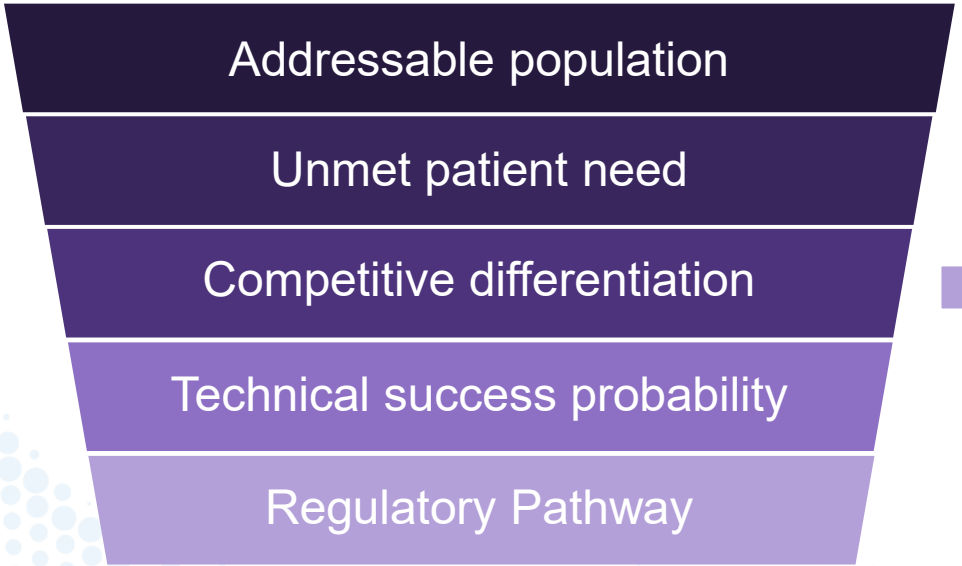
*Ypsomate® autoinjector used in ADBRY®, COSENTYX®, AJOVY®, NUCALA®, FASENRA®, TEZSPIRE®
*Ypsomate® is a registered trademark of Ypsomed AG.

Creating the best portfolio of indications for IMVT-1402

Guided by IgG biomarker in a proven mechanism with well-characterized safety profile



Potential to address multiple indications in an exciting class

Potential best-in-class product profile opens broad range of indication opportunities for IMVT-1402

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

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SC: subcutaneous; PTS: Probability of technical success

2025: Exciting year ahead

01 MG and CIDP data (CYQ1) and TED data (CYH2) designed to reinforce correlation of greater efficacy with deeper IgG reduction

02 Additional data from Graves' POC including 6-month remission data designed to further articulate potential for IMVT-1402 in Graves' disease

03 Potentially registrational trials enrolling in GD, ACPA+ D2T RA, MG, CIDP and soon to be unveiled 5th indication

04 Additional studies (including POCs) to be announced for IMVT-1402, all with autoinjector

05 Studies initiated in 10 indications by March 31, 2026

Graves' Disease

First-in-class Potential

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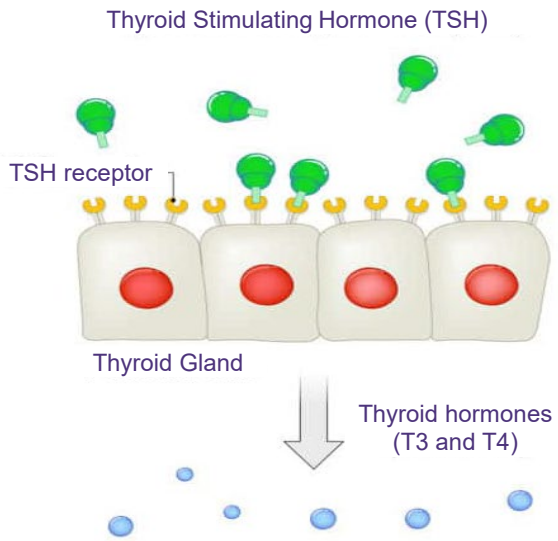
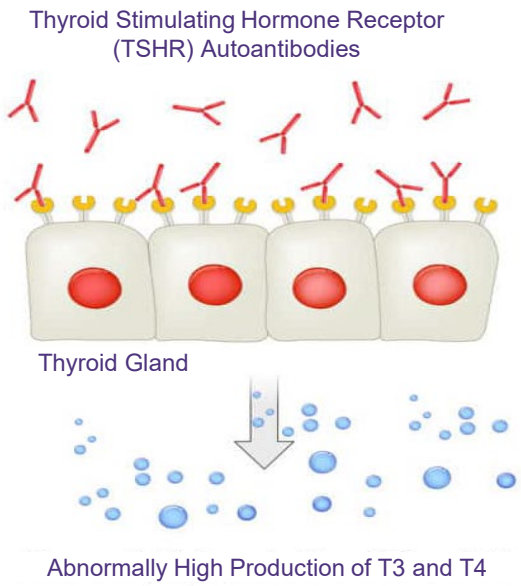
Graves' disease is a classic autoimmune condition driven by the presence of thyroid stimulating antibodies

Pathogenesis of Graves' Disease

Normal Function



Graves' Disease



1 **Normally, TSH produced by the pituitary gland stimulates the thyroid gland to produce and release thyroid hormones (T3 and T4)**

2 **Graves' disease is caused by autoantibodies to the thyroid stimulating hormone receptor (TSHR), leading to excess thyroid hormone production**

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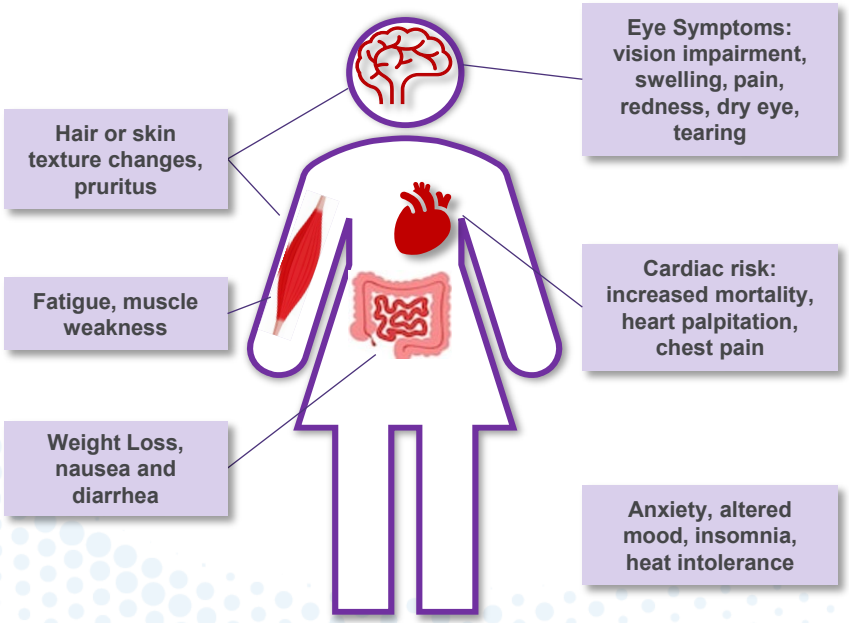
Sources: McIver, Bryan and Morris, John C. The Pathogenesis of Graves' Disease. Endocrinology and Metabolism Clinics of North America, 1998, https://doi.org/10.1016/S0889-8529(05)70299-1., Davies, T.F., Andersen, S., Latif, R. et al. Graves' disease. Nat Rev Dis Primers, 2020. https://doi.org/10.1038/s41572-020-0184-y

Graves' disease: high patient burden and significant morbidity

Symptoms impact many organ systems and leave many patients with substantial burden[1,2]



Substantial morbidity and loss of quality of life if untreated or insufficiently treated

Cardiovascular Complications

Graves' disease patients have a 23% increase in all cause mortality and more than double the risk of a major CV event[3]

Thyroid Eye Disease (TED)

TED affects ~40% of patients diagnosed with Graves' disease[4]

- ~10% of TED patients on novel therapies experience hearing-related events including hearing loss[5]

Pregnancy Complications[6]

Miscarriage, stillbirth, neuro-intellectual impairment in offspring, fetal thyroid disease

Other Significant Complications

Thyroid storm (~20% mortality rate[7]), thyroid cancer, psychiatric issues

Sources: 1. Smith et al. (2016), 2. Burch et al. (2015), 3. Okosieme et al. (2019), 4. Chin et al. (2020), 5. Smith et al. (2023), 6. Okosieme et al. (2020), 7. Bourcier et al. (2020)

Minimal innovation in Graves' disease treatment options over the past 70+ years

No existing pharmacologic therapy addresses underlying disease pathology

Standard-of-Care Treatments	Associated Challenges
Anti-Thyroid Drugs (ATDs) (e.g., Methimazole, Propylthiouracil)	• ~25-30% of patients are relapsed, uncontrolled or intolerant to ATDs[1] • Potential for serious adverse events, including hepatotoxicity (liver injury ~3%) and agranulocytosis (loss of white blood cells ~0.3%)[2,3]
Radioactive Iodine	• TED development and/or exacerbation in 15-33% of patients4 • Dose dependent, long-term increased risk of death (5-12% increased risk per 100-mGy dose) from solid cancers5 • Necessitates life-long thyroid replacement therapy
Thyroidectomy	• Recurrent laryngeal nerve damage risk in 1-4% of patients leading to dysphonia3 • Permanent hypoparathyroidism observed in 2.6% of patients4 • Necessitates life-long thyroid replacement therapy

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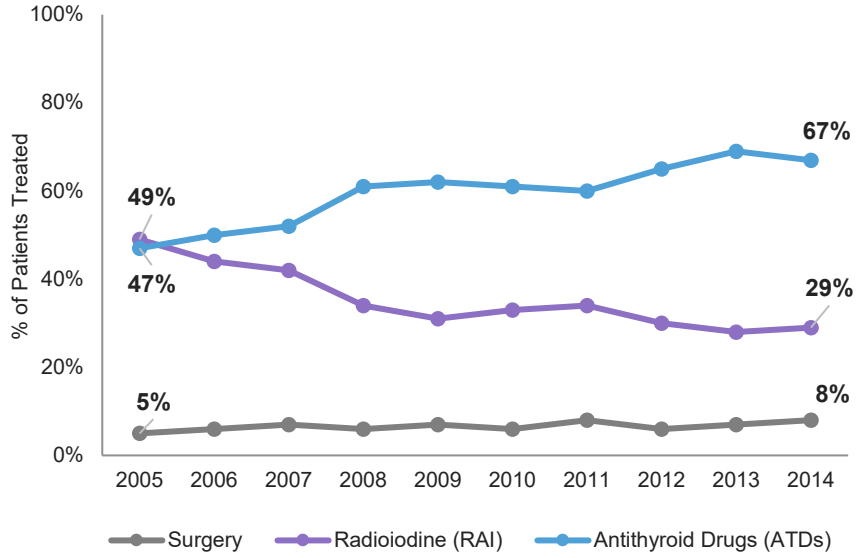
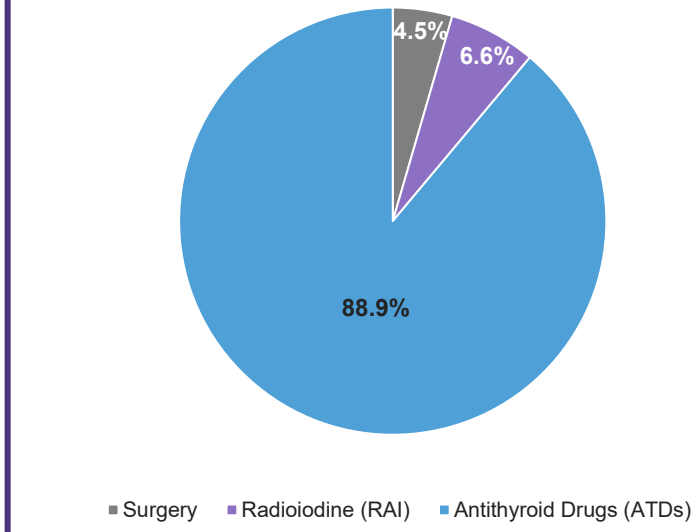
Sources: 1. Roivant / Inovalon Claims Analysis – 2021 incident patient population, first-line treatment is primary treatment in the first-year post diagnosis, claims review included a five-year lookback to define the incident population, IMVT Market Research 2020-2023; 2. Suzuki, N., et al. (2019), 3. Smith, T., & Hegedüs, L. (2016). 4. Sundaresh, V., et al. (2013). 5. Kitahara, C., et al. (2019).

In North America, the treatment paradigm for Graves' disease continues to shift away from radioactive iodine and surgery

US Claims Data (2005-2014)[1]



Real-World US Claims Analysis (2021-2022)[2]



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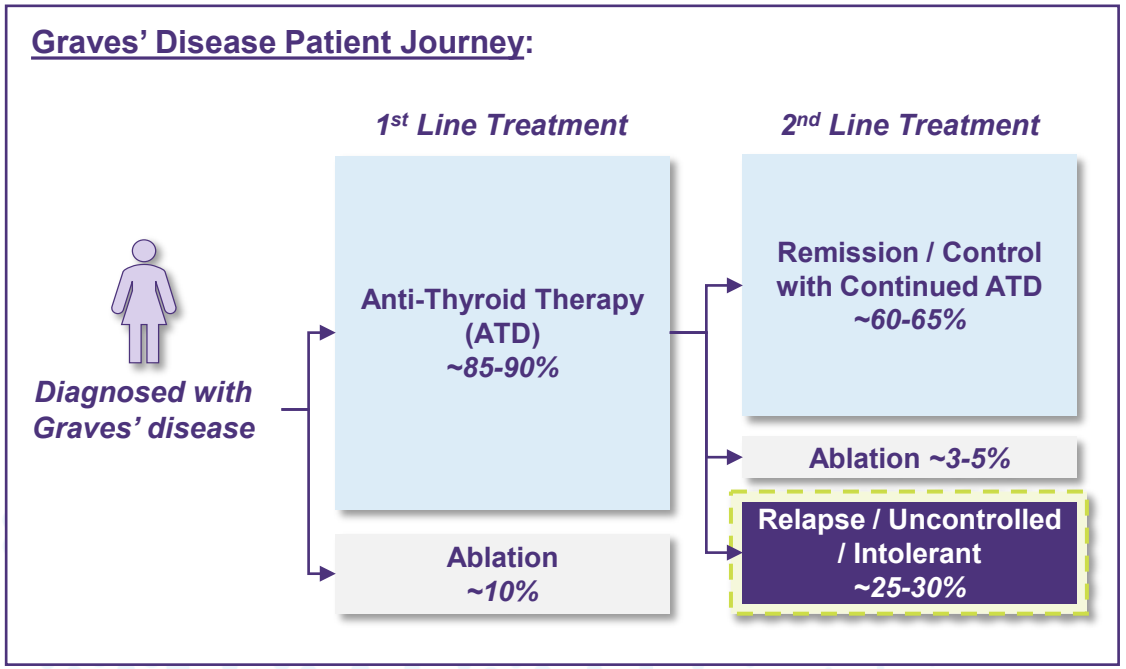
Sources: 1. Brito et al. (2016), 2. Roivant Claims Analysis – 2021 incident patient population, first-line treatment is primary treatment in the first-year post diagnosis, claims review included a five-year lookback to define the incident population.

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



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

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

Graves' disease Phase 2 study design tests two doses of batoclimab

12 weeks of 680mg followed by 12 weeks of 340mg in Graves' disease patients uncontrolled on ATDs

Inclusion[a]

- Subjects with active Graves' Disease as documented by presence of elevated stimulatory TSH-R-Ab
- Subjects hyperthyroid despite ATD

Treatment Period: 24 weeks
N = 25

680mg batoclimab QW SC
(Week 0-12)

340mg batoclimab QW SC
(Week 12-24)

Key Endpoint:

Proportion of participants who:

- Achieve normalization of T3 and T4 or have T3 / T4 below LLN, and
- Do not increase in ATD

ATD Treatment:

Stable ATD dose at screening

Goal to taper ATD during treatment period

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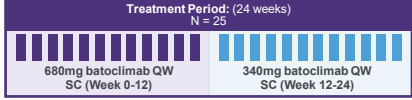
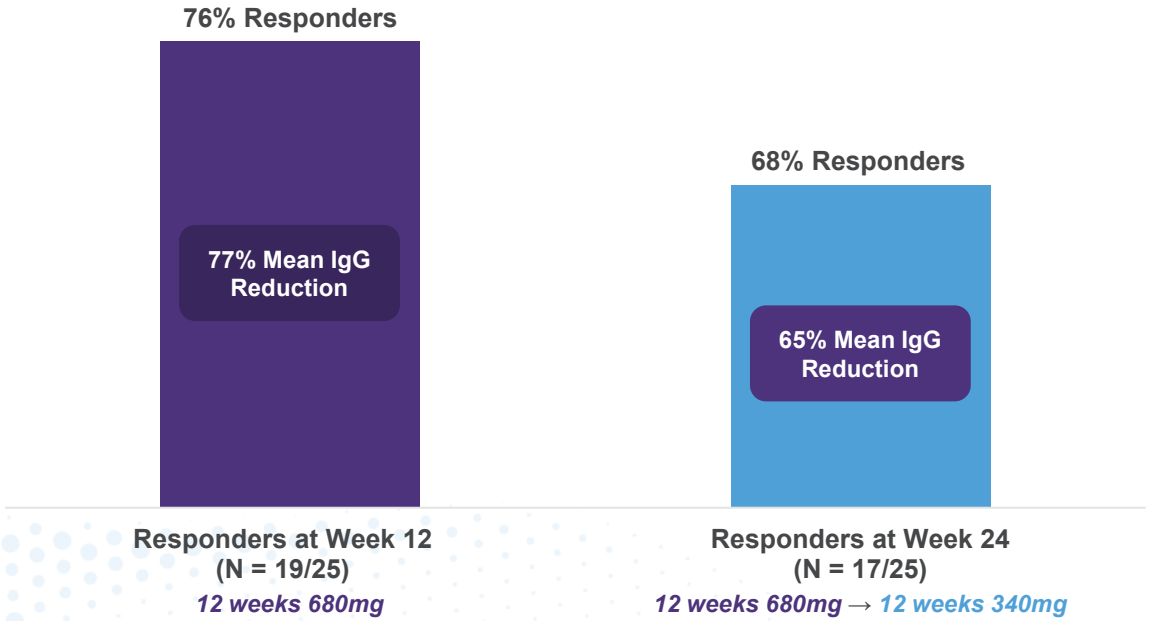
a: Additional inclusion and exclusion criteria not listed on slide
ATD: Anti-thyroid medications; QW: Weekly; SC: Subcutaneous; LLN: Lower limit of normal

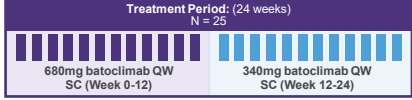


Batoclimab demonstrated potentially transformational results in ATD uncontrolled patients with greater response driven by higher IgG lowering

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

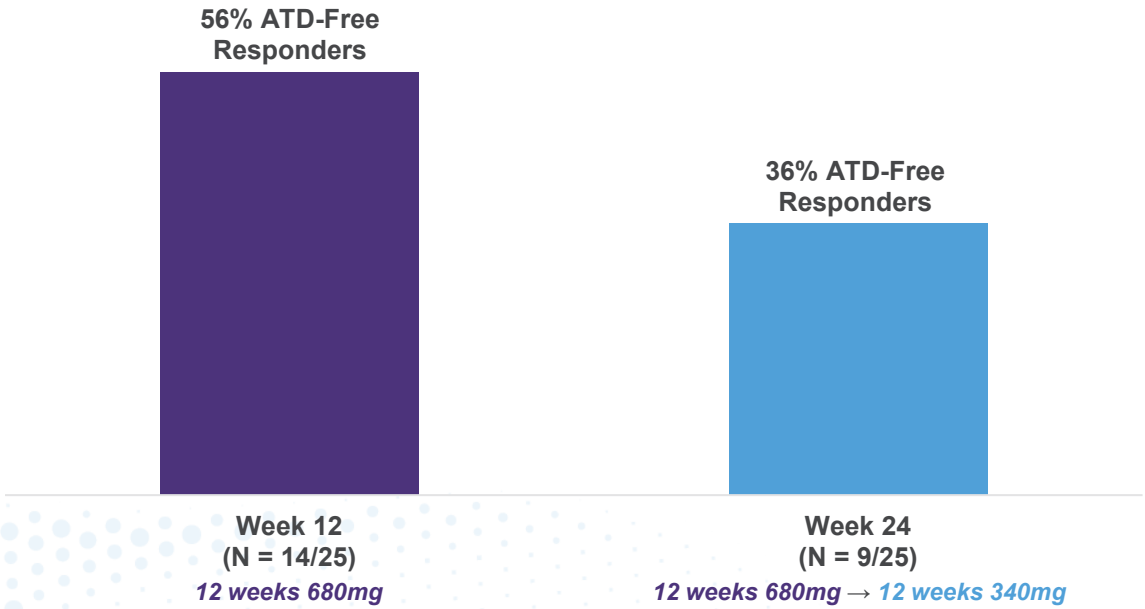


Note: Includes two patient discontinuations. One patient did not complete Week 12 due to pre-existing gallstones and is counted as a non-responder at Week 12 and Week 24. The second patient did not complete Week 24 and is counted as a non-responder at Week 24. This patient was lost to follow-up due to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



>50% of patients receiving high-dose batoclimab not only achieved normal T3 and T4 levels but also ceased ATD entirely by 12 weeks

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



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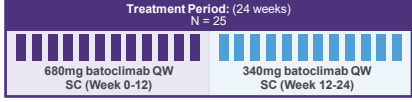
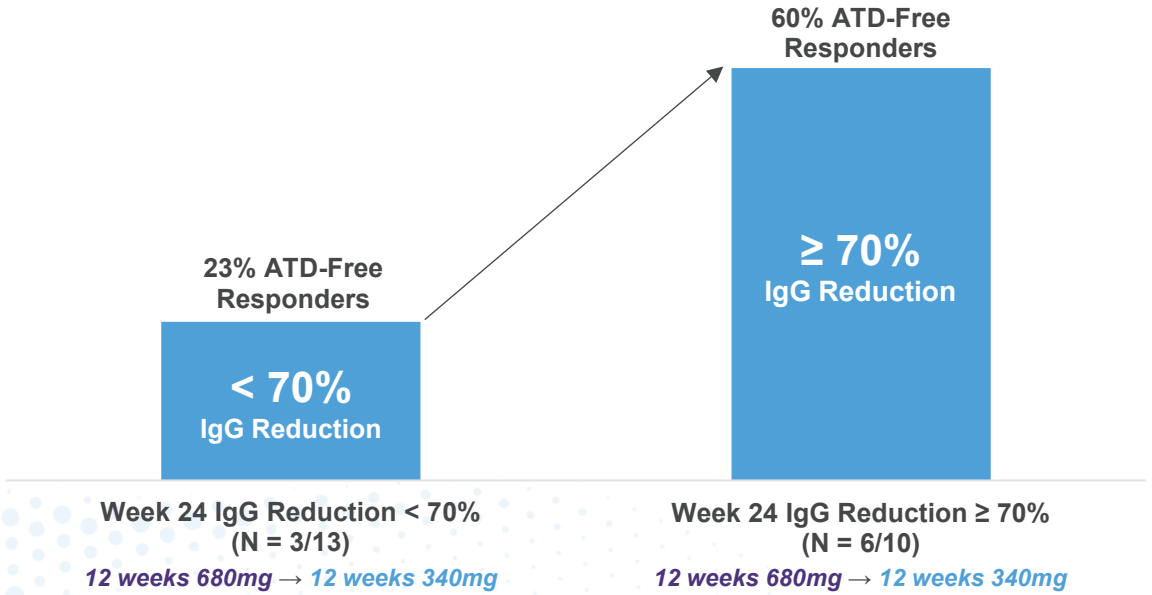
Note: Includes two patient discontinuations. One patient did not complete Week 12 due to pre-existing gallstones and is counted as a non-responder at Week 12 and Week 24. The second patient did not complete Week 24 and is counted as a non-responder at Week 24. This patient was lost to follow-up due to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

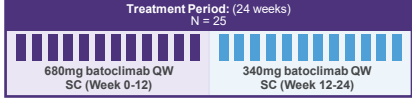


Deeper IgG reduction at 24 weeks was associated with a meaningfully higher ATD-free responder rate

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

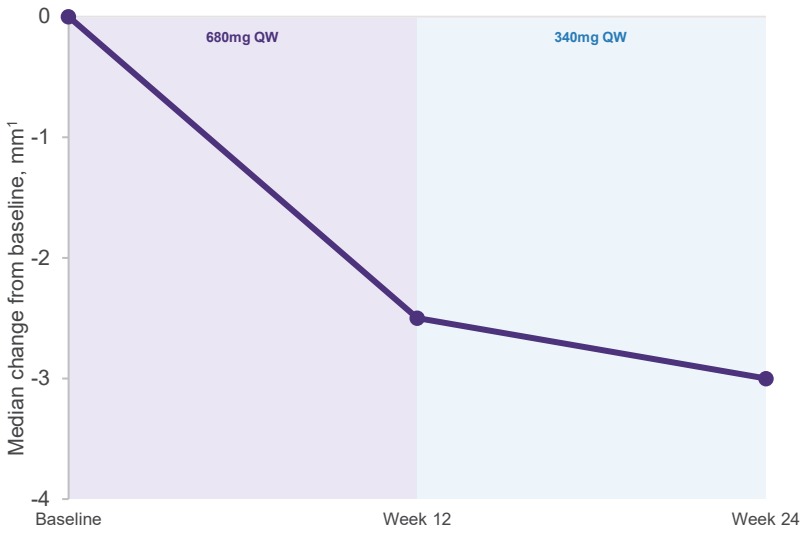


Note: Excludes two patient discontinuations given no IgG data available for these patients at this time point.

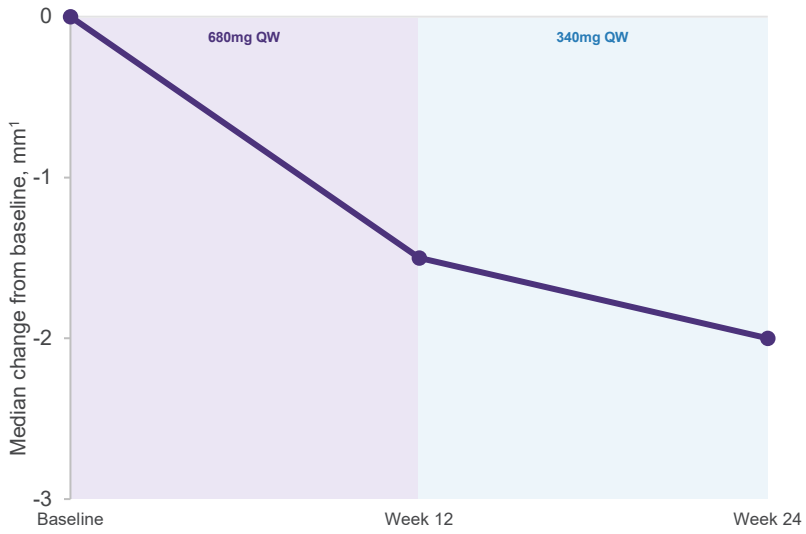


Meaningful improvements observed in proptosis and lid aperture in Graves' disease patients treated with batoclimab

Change from Baseline in Proptosis (N=25)



Change from Baseline in Lid Aperture (N=25)



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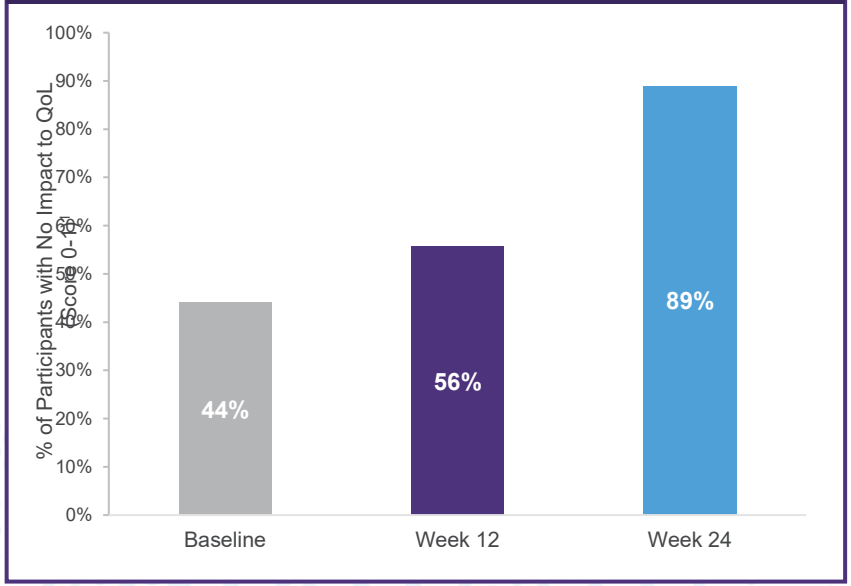
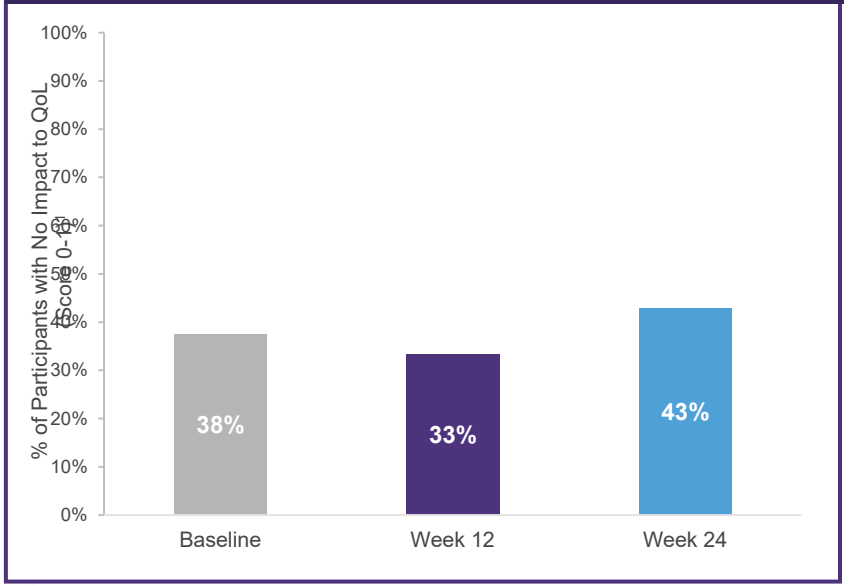
Note: Excludes one patient discontinuation at Week 12 (N=24) and two patient discontinuations at Week 24 (N=23) given no data available for these patients at these timepoints.

ATD-free responders reported more pronounced improvements to quality of life, with ~90% experiencing normal quality of life by Week 24

Week 24 ATD-Free Responders (N=9)
QoL Impact Scale: *% of Responders with Normal QoL*[2]



All Other Patients (On ATDs at Week 24) (N=14)[1]
QoL Impact Scale: *% of Patients with Normal QoL*[2]



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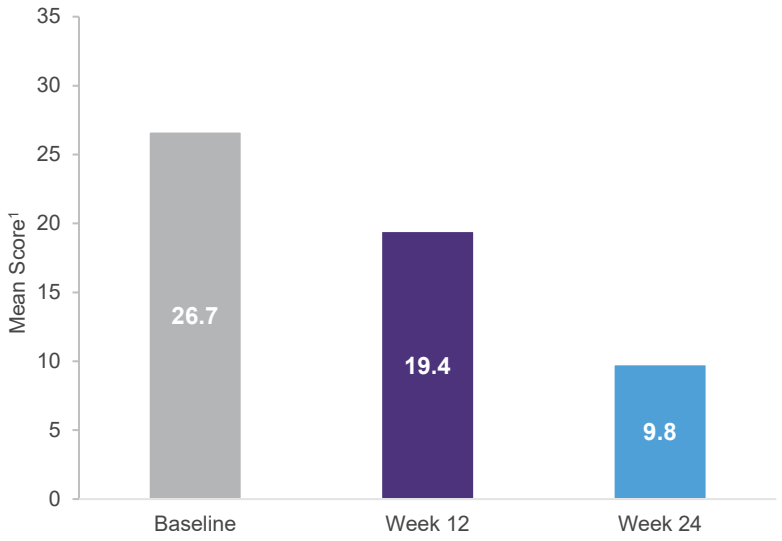
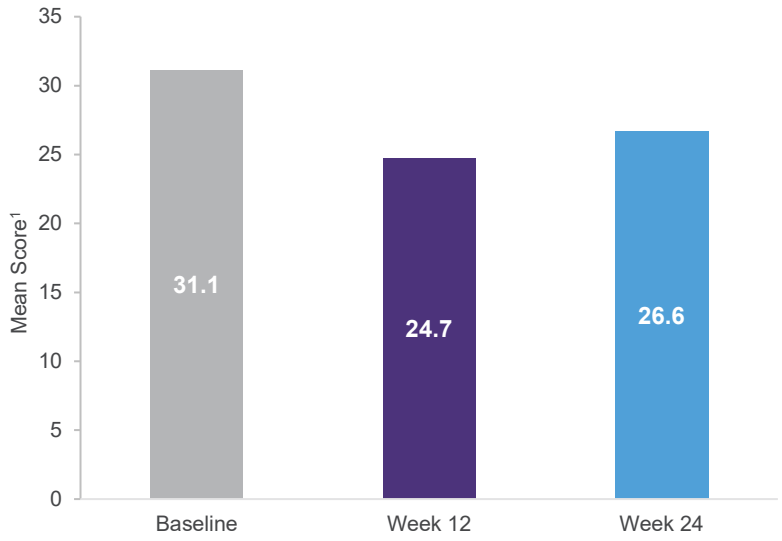
Notes: ThyPRO-39: Thyroid-Related Patient-Reported Outcome; 1) Includes N=14 patients who were not ATD-free responders at Week 24; 2) Patients represented if selected 0 or 1 = "No Impact at All" to Question: *In the past 4 weeks, has your thyroid disease had a negative effect on your quality of life?*

ATD-free responders reported greater improvements in daily functioning versus patients remaining on ATDs at Week 24

Week 24 ATD-Free Responders (N=9)
ThyPRO-39 Daily Life Scale



All Other Patients (On ATDs at Week 24) (N=14)[1]
ThyPRO-39 Daily Life Scale



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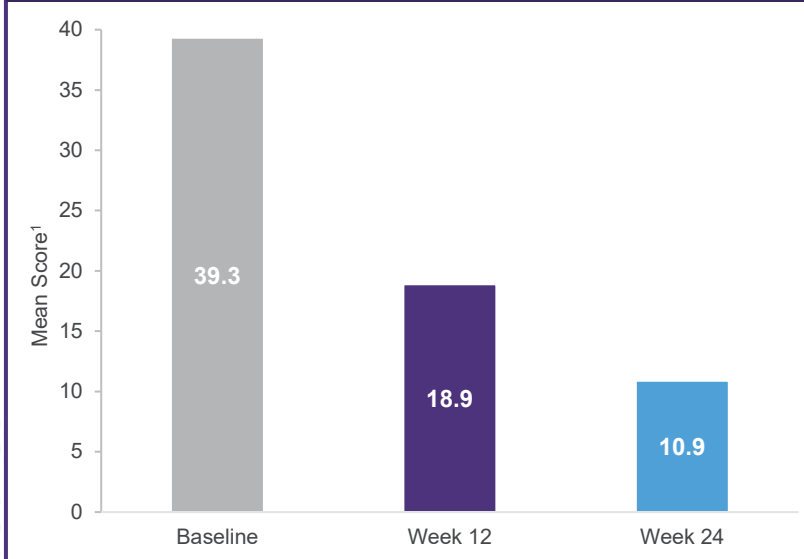
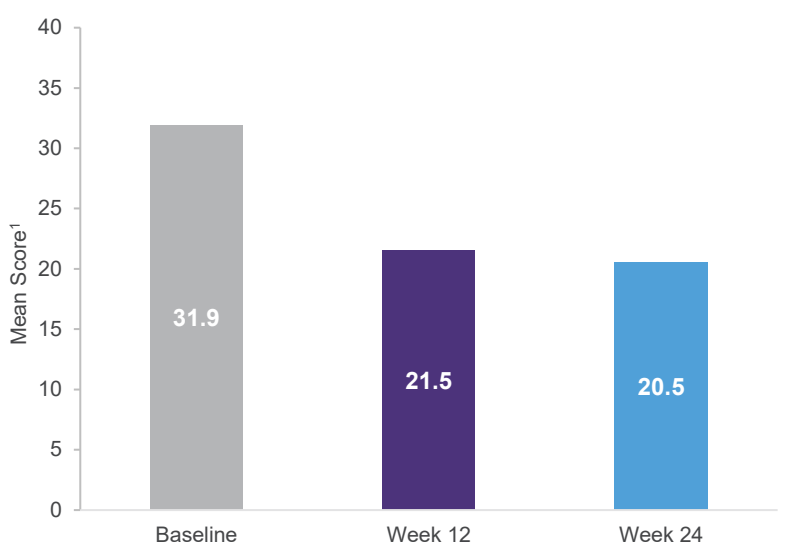
Notes: Higher scores on Anxiety and Daily Life Impairment scales correspond to poorer quality of life in these domains. ThyPRO-39: Thyroid-Related Patient-Reported Outcome; 1) Includes N=14 patients who were not ATD-free responders at Week 24

ATD-free responders reported greater improvements in anxiety versus patients remaining on ATDs at Week 24

Week 24 ATD-Free Responders (N=9)
ThyPRO-39 Anxiety Scale



All Other Patients (On ATDs at Week 24) (N=14)[1]
ThyPRO-39 Anxiety Scale



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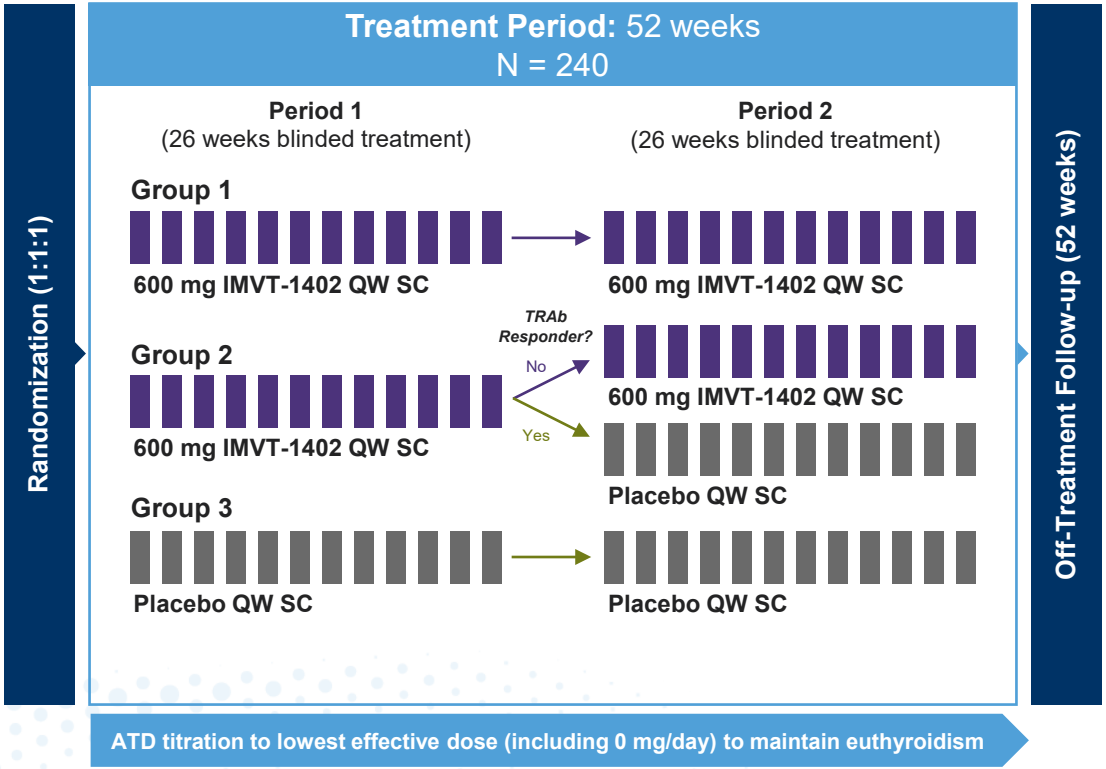
Notes: Higher scores on Anxiety and Daily Life Impairment scales correspond to poorer quality of life in these domains. ThyPRO-39: Thyroid-Related Patient-Reported Outcome; 1) Includes N=14 patients who were not ATD-free responders at Week 24;

IMVT-1402 Path Forward in Graves' Disease

First pivotal trial for IMVT-1402 in Graves' disease enrolling

Inclusion[a]

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



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

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

Design enables study of remission as upside

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a: Additional inclusion and exclusion criteria not listed on slide
b: Euthyroid = T3/T4 and TSH within normal limits
QW: Weekly; SC: Subcutaneous

Market Opportunity in Graves' Disease

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

1. Conservative Inovalon claims analysis[1] yields ~880K prevalent Graves' disease patients, including ~330K prevalent ATD relapsed patients choosing not to pursue ablation
2. Conservative Inovalon claims analysis[2] 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

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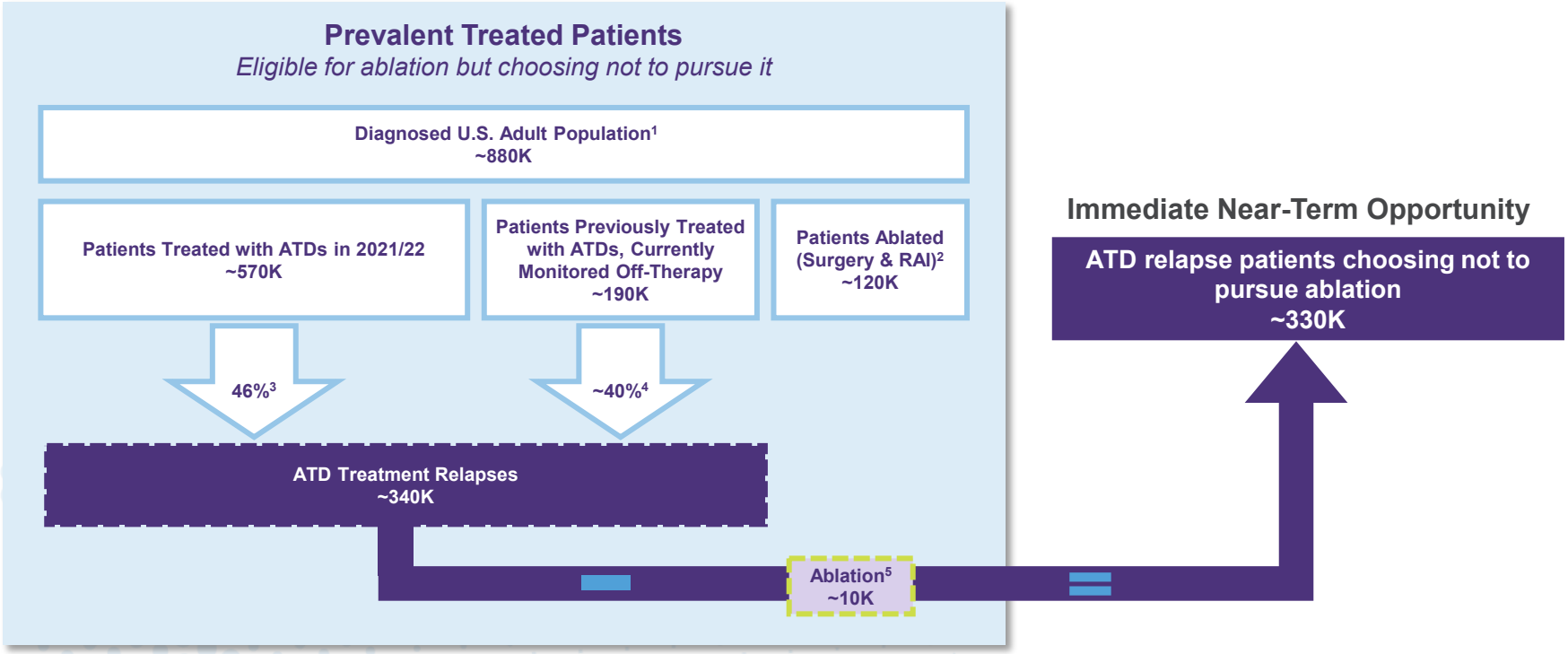
1. Roivant Claims Analysis – 2022 prevalent patient population based on a two-year lookback for diagnosis
2. Roivant Claims Analysis – 2021 incident patient population based on a five-year lookback to define the incident population

Note: See Immunovant, Inc. Graves' Disease Program Update Deck dated September 9, 2024, available at Immunovant.com

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



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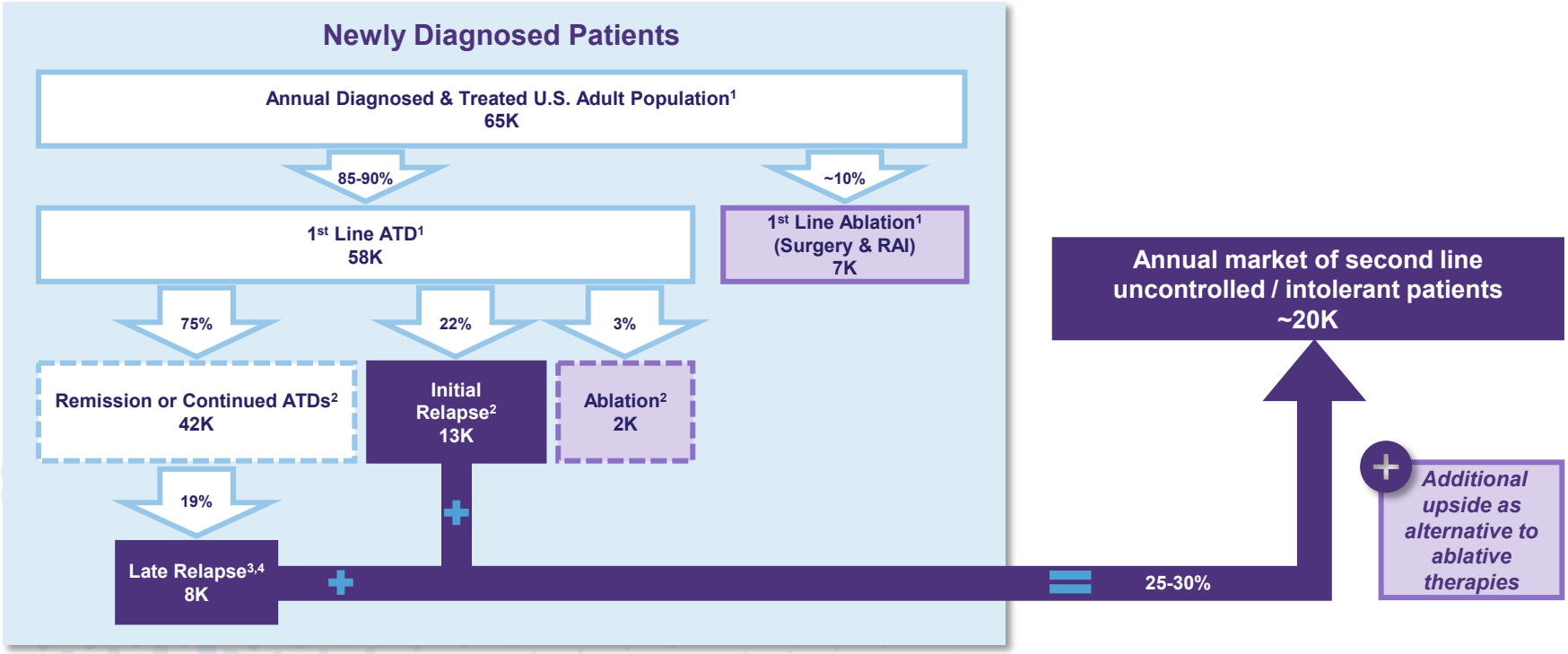
Sources: 1. Roivant Claims Analysis – 2022 prevalent patient population based on a two-year lookback for diagnosis, 2. Of the 120K patients ablated, ~80K were ablated prior to 2021 and ~40K were ablated in 2021/2022. 3. Azizi et al. (2019): Note, the relapse rate was calculated as a weighted average 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



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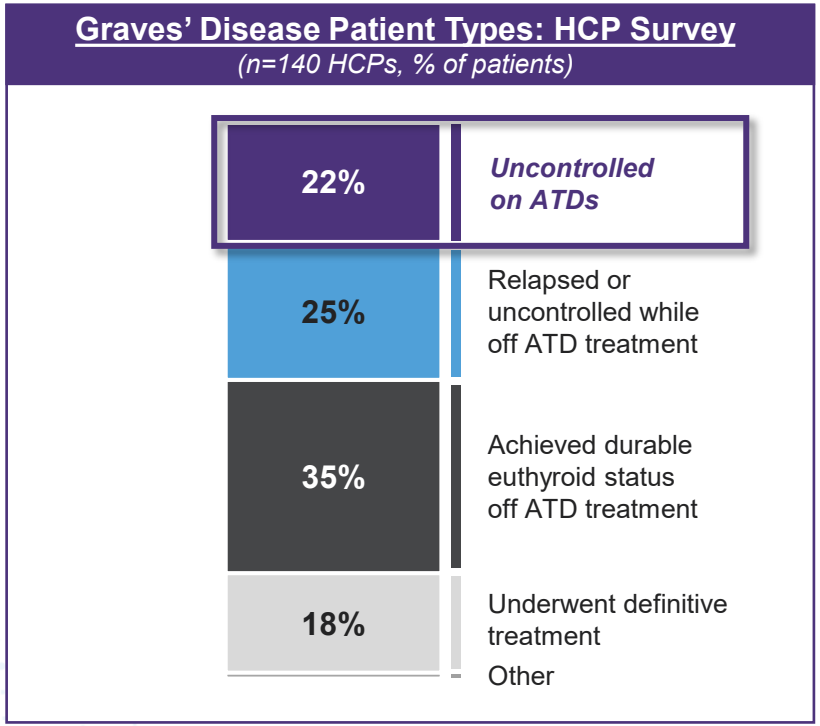
Sources: 1. Roivant Claims Analysis – 2021 incident patient population, first-line treatment is primary treatment in the first-year post diagnosis, claims review included a five-year lookback to define the incident population, 2. Grove-Laugesen et al. (2023): Completer rates for combined arms: ATD remission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



Sources: 1) Graves' Disease Physician Survey (n=140) by Immunovant

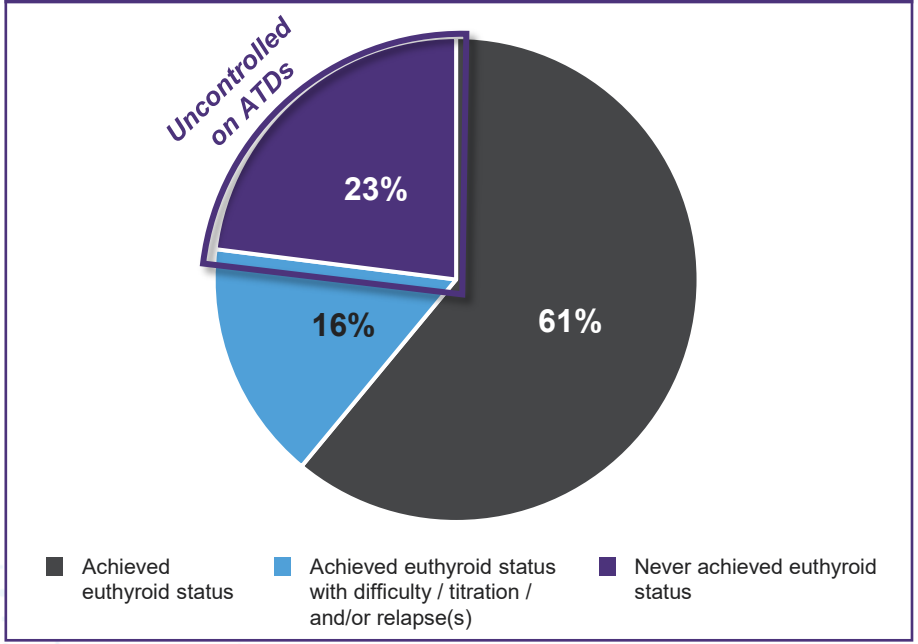
Analysis #4: Real-world in-depth chart review of 1,000+ patient records from 140 endocrinologists indicates ~25% have never achieved euthyroid status on ATDs

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)*



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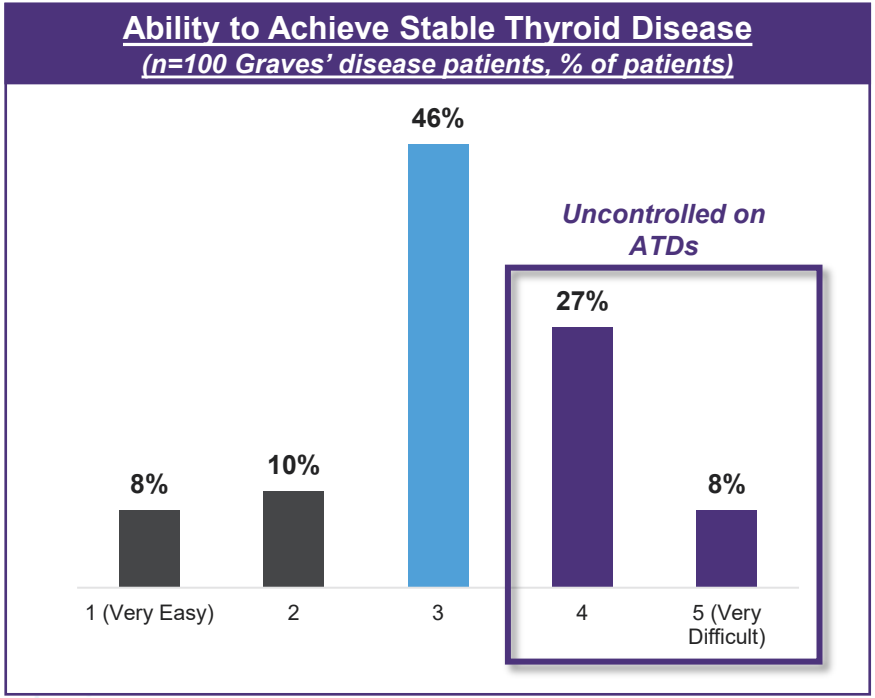
*Excludes patients who have received definitive treatment; Sources: Patient Chart Audit analysis (n=988 on ATD, n=1120 total) by Immunovant

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



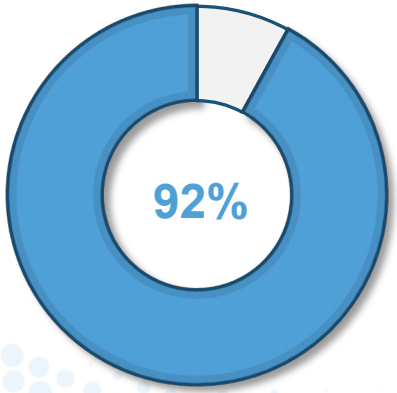
Sources: Graves' Disease Patient Quantitative Survey (n=100) by Immunovant

Survey data, chart review, and literature all point to a clear shift in the US Graves' disease treatment paradigm away from surgery and radioiodine treatment

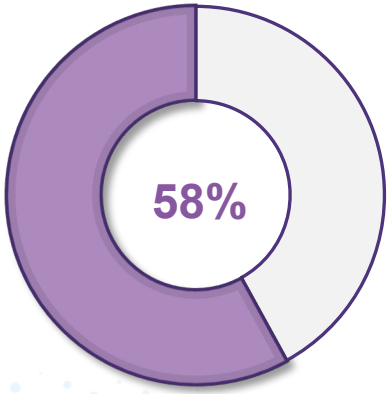
Endocrinologists strongly prefer ATDs over definitive treatment options…

…Even when they recommend ablation, ~60% of patients do not undergo definitive treatment

Endocrinologists who prefer ATDs as their primary treatment option for Graves' disease[1]



Patients who have not yet undergone definitive treatment despite it being recommended[2]



Primary Reasons for Preferring ATDs over Ablative Options:

- Desire to avoid hypothyroidism
- Avoid exposure to radiation
- Avoid worsening TED

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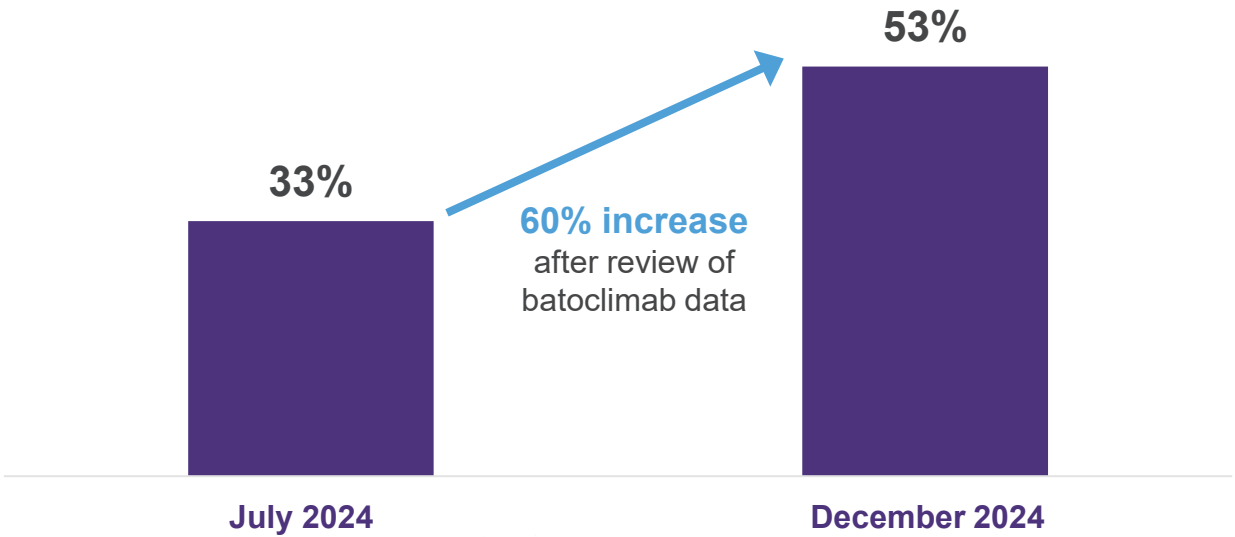
1. Villagelin D. et al., *Journal of Clincial Endocrinology & Metabolism*, 2024; 00, 1-11; North American Respondents – n=263 Endocrinologist
2. IQVIA / Immunovant Graves' Disease Chart Study Analysis, n=1,120 total charts

Unmet medical need in Graves' disease was rated higher by thyroid specialists after exposure to batoclimab data

Percent of ATD-treated GD patients needing alternative medical therapy



Source: Graves' Disease HCP Quantitative Survey (n=152 Endocrinologists) by Immunovant, July 2024
Graves' Disease HCP Quantitative Survey (n=74 Endocrinologists) by Immunovant, December 2024

IMVT-1402 is potentially best and first-in-class in Graves' disease

01	High dose batoclimab rapidly achieved a 76% response rate in patients uncontrolled on ATDs, meaningfully exceeding 50% response rate bar
02	High dose batoclimab rapidly achieved a 56% ATD-free response rate in patients uncontrolled on ATDs, meaningfully exceeding 30% ATD-free response rate bar
03	Strong correlation observed between degree of IgG lowering and clinical outcomes yields potential best-in-class and first-in-class opportunity for IMVT-1402; Additional POC results including 6-month remission data expected Summer 2025
04	IMVT-1402 Graves' disease IND cleared and study enrolling with autoinjector
05	Real world claims data indicates 25-30% of Graves' disease patients per year are relapsed, uncontrolled on or intolerant to ATDs with no existing pharmacologic options representing an attractive commercial opportunity with limited competition

ACPA+ Difficult-to-Treat Rheumatoid Arthritis

Best-in-Class Potential

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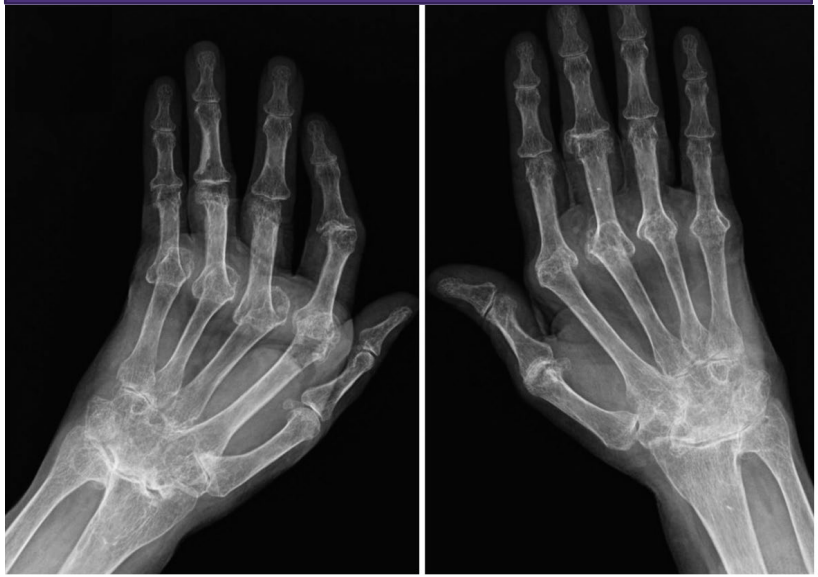
Despite tremendous progress in the treatment of rheumatoid arthritis (RA), a subset of patients do not respond well to available therapies

Key Takeaways[1]

- RA is a chronic, progressive disease that causes joint inflammation and pain
- Most common systemic autoimmune disease, affecting 18M globally and 1.5M in the US
- Medical therapy is used to help control joint inflammation; treatment options include a variety of conventional oral, targeted synthetic and biologic DMARDs
- Inadequate disease control can result in irreversible joint erosions

Significant Impact



PA view of the hands shows joint space narrowing, erosions, and diffused osteoporosis

Source: Nakshabandi N al. et al. Radiology in Rheumatology, 2021.

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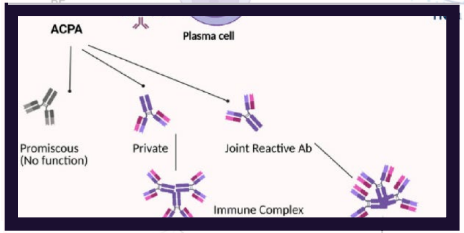
1. Aletaha D, Smolen JS. *JAMA*. 2018;320(13):1360.
DMARDs: disease-modifying antirheumatic drugs

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

Rheumatoid factor (RF) and ACPA autoantibodies are present in ~75% of RA patients[1]

Anti-FcRn mechanism may lower pathogenic IgG autoantibodies and immune complexes



1. Okada et al. Ann Rheum Dis 2019;78; 446-453
2. Image: Mueller A-L et al. *Cells, 2021;* 10(11), 3017

RF: rheumatoid factor, ACPA: anti-citrullinated protein autoantibodies

What is difficult-to-treat RA and why is innovation needed?

Need for More Options

- Estimated 5-20% of patients remain symptomatic despite multiple treatment rounds[1]
  - These patients need new therapies and approaches, according to a global survey of 410 rheumatologists
- Difficult-to-treat (D2T) RA defined by EULAR as:[2]
  - Multiple DMARD failures
  - 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

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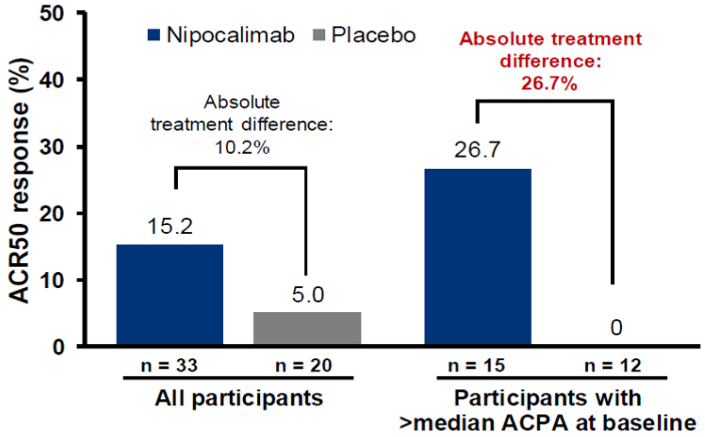
1. Roodenrijs NMT et al. *Ann Rheum Dis* 2018;1705 -09, 2. Nagy G, et al. *Ann Rheum Dis* 2021; 80: 31-35
EULAR: European League Against Rheumatism Collaborative Initiative; DMARD: disease-modifying antirheumatic drug; QoL: Quality of Life

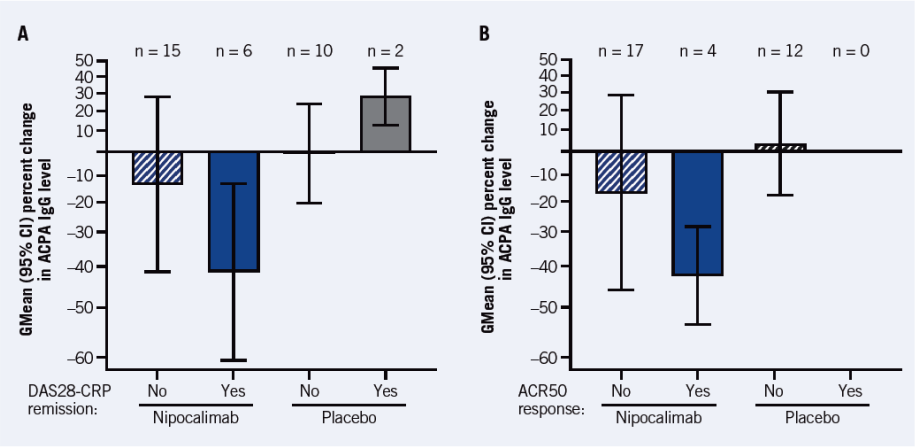
Publicly available nipocalimab data in RA demonstrated proof of mechanism and showed that deeper ACPA IgG reduction correlated with clinical response[1]

Select results from a study of FcRn inhibition vs placebo in biologic experienced RA patients

Proportions of Participants Who Achieved ACR50 Response at Week 12 by ACPA



Percent Changes from Baseline at Trough in ACPA IgG Levels versus (A) DAS-28 CRP Remission and (B) ACR50 Response at Week 12

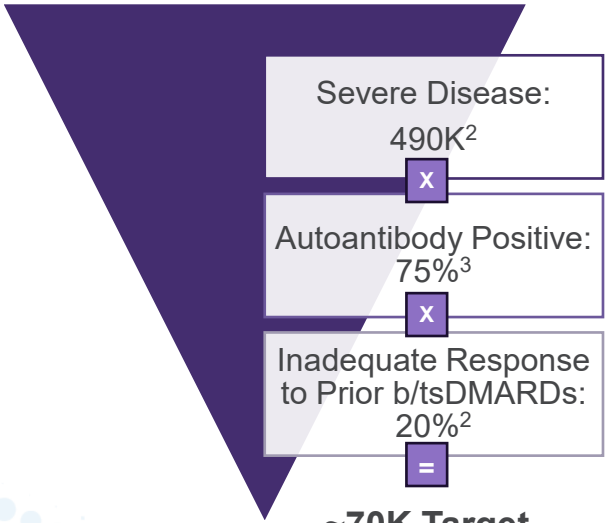


ACPA, anti-citrullinated protein autoantibody; ACR50, ≥50% response in American College of Rheumatology response criteria; anti-CCP2, anti-cyclic citrullinated peptide 2 antibody; CI, confidence interval; DAS28-CRP, Disease Activity Score 28 using C-reactive protein; GMean, geometric mean; IgG, immunoglobulin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

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

Of the 1.5M US RA patients[1], a subset progresses to D2T status in a relatively short period of time and require new therapeutic options

Epidemiology



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]

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1. Aletaha D, Smolen JS. *JAMA*. 2018;320(13):1360. 2. GlobalData Analysis and Forecast, 2023. 3. Okada et al. Ann Rheum Dis 2019;78; 446-453.
4. Murray K et al. *Arthritis Res Ther* 2021; 23(1):25. 5. Rosenberg V et al. *Adv Ther* 2023; 40(10):4504-4522. 6. Paudel ML. *Rheumatology (Oxford)* 2024: 318
b/tsDMARD: biologic (b) or targeted synthetic (ts) disease-modifying antirheumatic drug

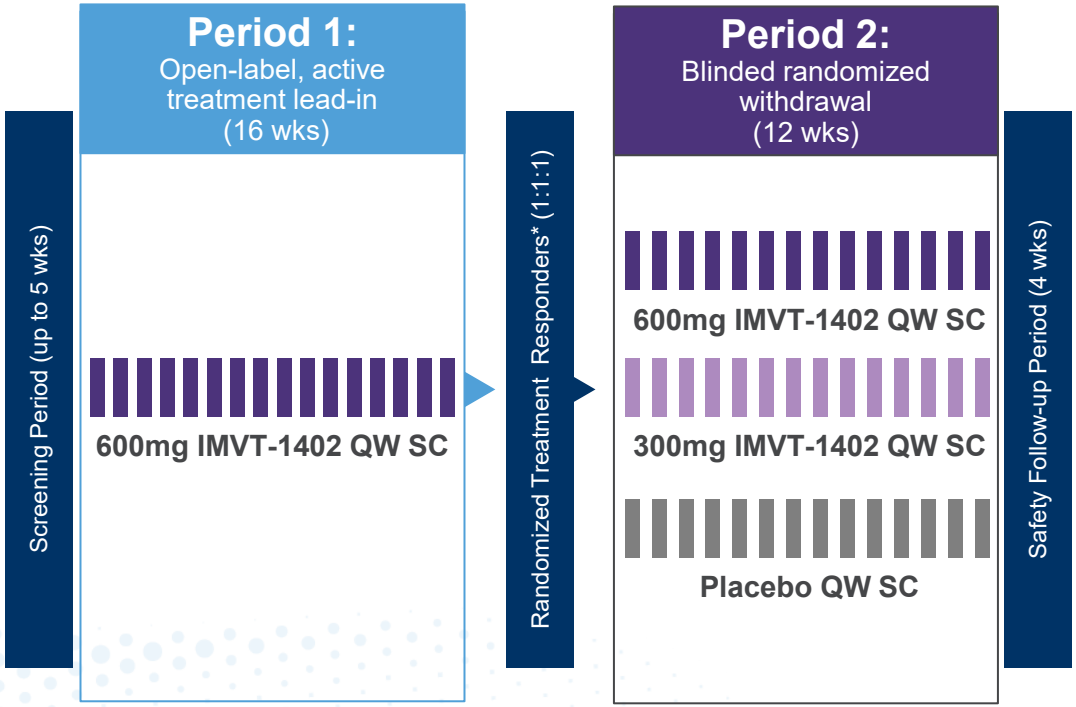
IMVT-1402 Path Forward in ACPA+ Difficult-to-Treat Rheumatoid Arthritis

Pivotal study design in ACPA+ D2T rheumatoid arthritis enrolling

Global Trial with N=120 Participants

Inclusion

- CRP > upper limit of normal (ULN)
- Active RA defined as ≥ 6/68 tender/painful joints (TJC), ≥ 6/66 swollen joints (SJC), and DAS28-CRP > 4.1
- Anti-citrullinated protein antibody positive (ACPA+)
- Inadequate response to 2 or 3, but not more than 3, classes of b/tsDMARDs
- On stable treatment with csDMARD



Endpoints

Primary endpoint:

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

Secondary endpoint:

Change from baseline in CDAI and SDAI at Weeks 16 to Week 28

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*Meets ACR20 criteria at Week 14 & Week 16

With pivotal program in RA, IMVT-1402 has the potential to achieve a best-in-class profile for people with ACPA+ D2T rheumatoid arthritis

High Unmet Need Subgroup	5-20% of RA patients are difficult-to-treat (D2T) (failed at least 3 therapies)[1]
Autoantibody Pathology	ACPA positive RA is associated with severe disease and poor outcomes; publicly disclosed, in-class data from another FcRn inhibitor encouraging[2]
Enhanced Study Design	Open label lead-in with randomized withdrawal attractive for D2T population that is enriched for higher baseline ACPA levels
Lower is Better	We believe deeper ACPA antibody reduction expected to correlate with improved clinical efficacy within the anti-FcRn class
IMVT-1402 IND Active	Received FDA IND clearance, study enrolling

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ACPA: anticitrullinated protein autoantibodies

1. Paudel ML. *Rheumatology (Oxford)* 2024: 318. 2. 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.*

Myasthenia Gravis

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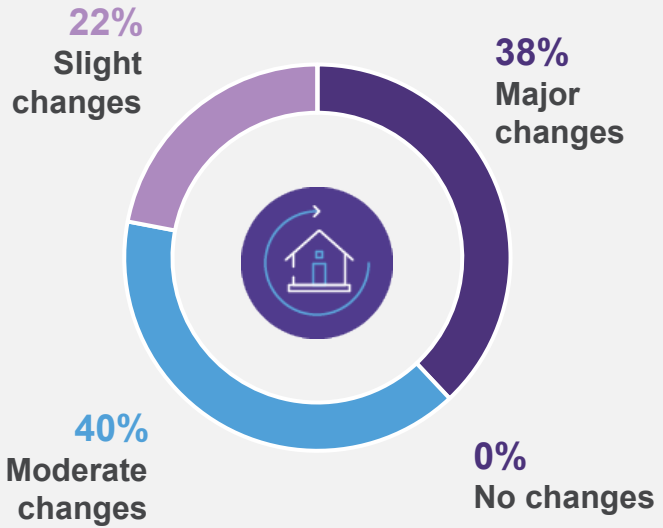
Myasthenia gravis (MG): IgG-mediated autoimmune disease that typically requires lifestyle changes

Key Takeaways

- One of the larger IgG-mediated autoimmune diseases
  - ~59,000 to 116,000 estimated in the US[1,2]
- ~80% of patients require lifelong therapy
- Substantial share of population on steroids and first-line immunosuppressants
- Shift towards immunosuppressants and immunoglobulin therapy as disease severity increases

Extent of Lifestyle Modifications[3]



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. MG Patient Quantitative Survey (n=50). Q: What is the extent of lifestyle modifications you make around your myasthenia gravis?

Batoclimab Phase 3 trial designed to address unmet patient needs

Flexible design first for a MG trial but common in immunology

1 INDUCTION PHASE

Gain control
High doses included, designed to achieve maximum efficacy at beginning of treatment

2 MAINTENANCE PHASE

Keep control
Lower dose designed to maintain efficacy with potentially fewer side effects

3 LONG-TERM EXTENSION

Optimize control
Rescue therapy available

Unmet Patient Needs

- Ease of administration
- Quick, deep response to gain initial control
- Sustainable long-term disease control
- Flexible dosing in chronic phase for disease fluctuations

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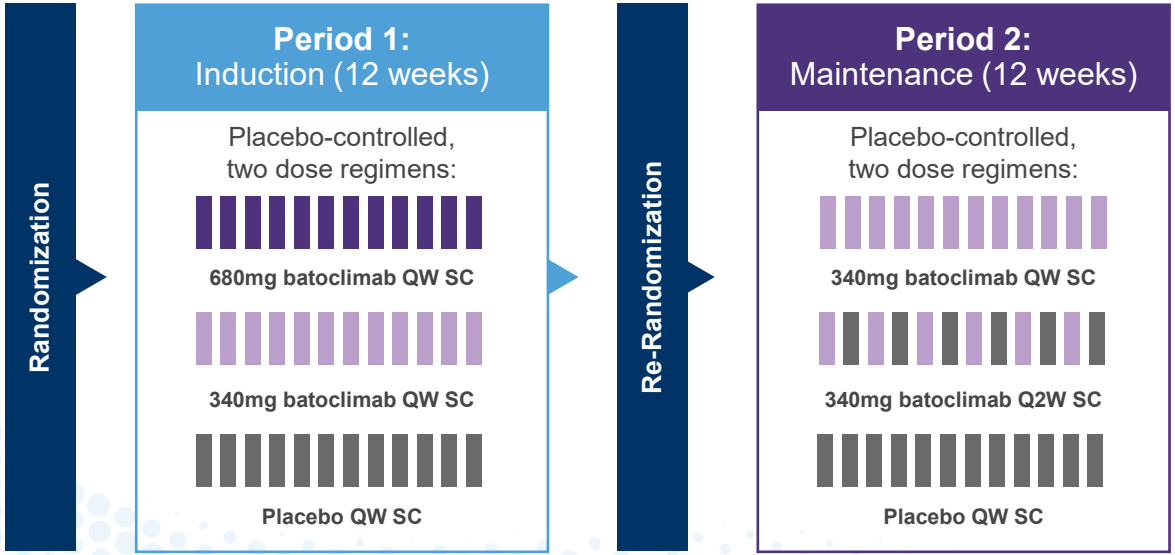
Registrational Phase 3 trial of batoclimab designed to offer MG patients tailored dosing[1]

Completed enrollment, top-line results to be reported and initiation of a potentially registrational program for IMVT-1402 expected by March 31, 2025



Maximize efficacy through primary endpoint*

Maintain efficacy with anchor dose and lower dose

Primary analysis population: AChR Ab+

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

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

1. Enrollment expanded to increase the AChR- patient group.

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

Chronic Inflammatory Demyelinating Polyneuropathy

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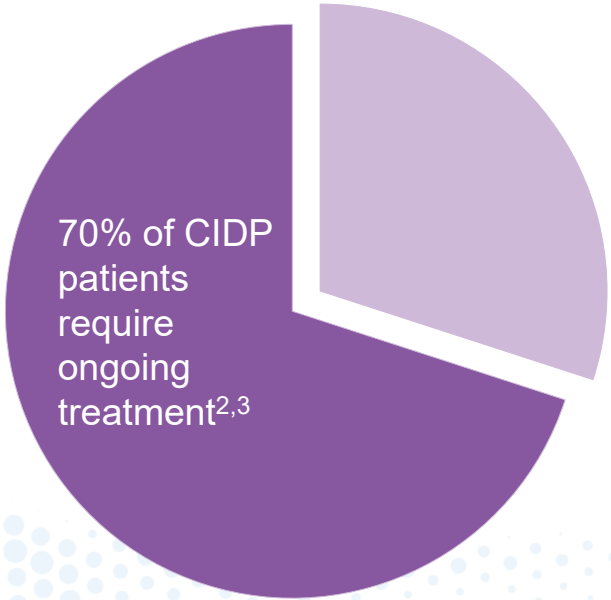
Chronic inflammatory demyelinating polyneuropathy (CIDP): Important disease in neurology, an exciting opportunity for anti-FcRn class

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

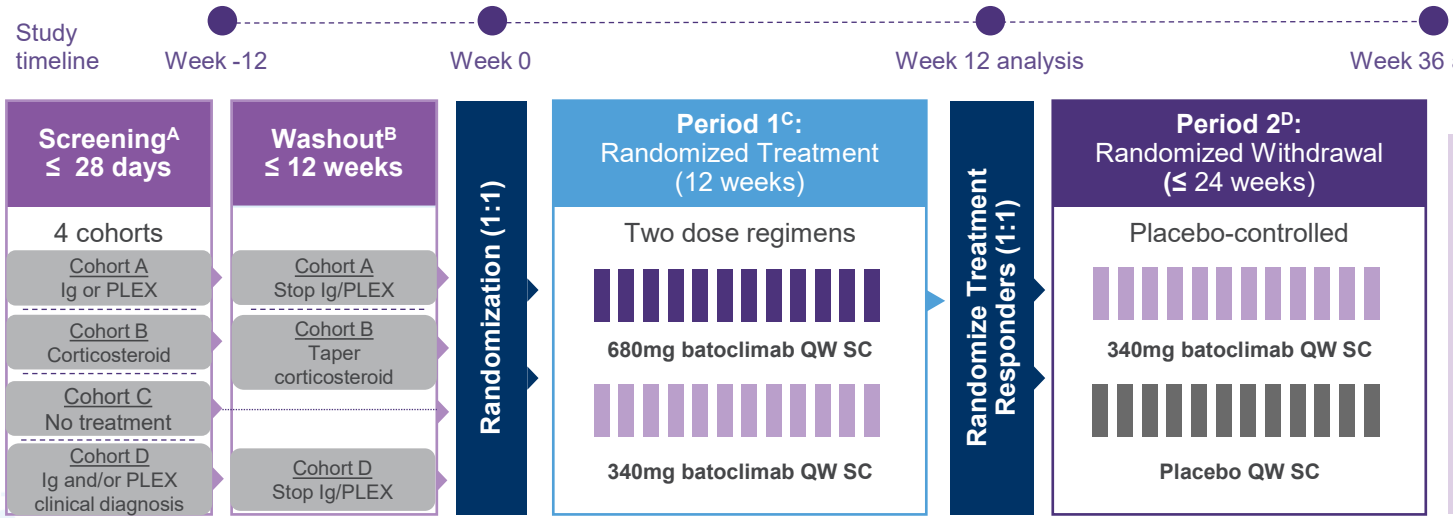


CIDP – Key Takeaways

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

Sources: 1. Broers M, et al (2019) Incidence and prevalence of CIDP: a systematic review and meta-analysis. Neuroepidemiology 52(3–4):161–172; 2. Querol, L., et al. Systematic literature review of burden of illness in chronic inflammatory demyelinating polyneuropathy (CIDP). J Neurol 268, 3706–3716 (2021).; 3. Kuitwaard K, Bos-Eyssen ME, Blomkwist-Markens PH et al (2009) Recurrences, vaccinations and long-term symptoms in GBS and CIDP. J Periph Nerv Syst 14(4):310–315. https://doi. org/10.1111/j.1529-8027.2009.00243.; 4. CSL Behring R&D Investor Briefing, 2021.

Pivotal Phase 2b trial intended to develop potentially best-in-class chronic anti-FcRn therapy in CIDP[1]



Efficacy analysis based on relapse (adjusted INCAT)

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

Period 2 followed by LTE; two dose regimens studied in LTE

Key selection criteria:
Adults diagnosed with CIDP based on EAN/PNS 2021 guidelines (Cohorts A, B, and C) or clinical diagnosis (Cohort D, not required to have evidence of demyelination)

Cohorts A/B/D: Randomize participants who worsen

Cohort C: Randomize all

Primary analysis only on Cohort A (IG/PLEX)

Enrollment completed for patients included in the Period 1 data expected by March 31, 2025.
No further patients will be enrolled until after such Period 1 data is disclosed.

1. Two-stage approach, to accommodate additional registration trial, if necessary, has the potential to deliver a differentiated product label with a larger effect size
A: Cohorts are defined by CIDP treatment at Screening. B: Participants who fail to worsen by Week 0 will be withdrawn from the study at Week 0. C: Period 1 Non-Responders who complete Period 1 will be withdrawn from the study after completing Week 12 and the subsequent 4-week Follow-Up visit. Period 1 Non-Responders who require protocol-prohibited rescue therapy prior to Week 12 will discontinue IMP and may return to standard of care; these participants will be encouraged to remain in the study for Safety Follow-Up through Week 12 and the Follow-Up Visit. D: Participants that relapse in Period 2 or complete Period 2 without relapse will be eligible for participation in the Long-Term Extension study.
CIDP = Chronic Inflammatory Demyelinating Polyneuropathy; EAN/PNS = European Academy of Neurology/Peripheral Nerve Society; Ig = immunoglobulin (IVIG and SCIG) therapy; IMP = investigational medicinal product; LTE = Long-term Extension; PLEX = plasma exchange; QW = every week; Wk = weekly; SC = subcutaneously; INCAT = Inflammatory Neuropathy Cause and Treatment

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Thyroid Eye Disease

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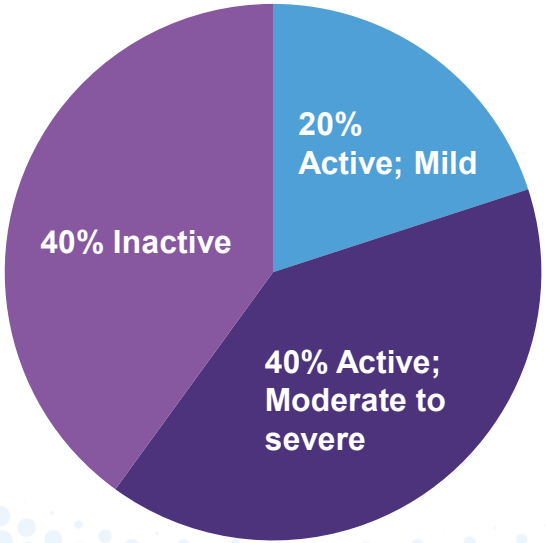
Thyroid eye disease (TED): Heterogeneous condition that presents with a variety of clinical symptoms

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



Key Takeaways

- Teprotumumab is the only approved treatment specifically for TED
  - Treatment period is relatively short (~24 weeks) and disease recurrence is common
- 14% of TED patients, and a far higher proportion among active moderate or worse disease, are on teprotumumab and/or immunosuppressants
  - Warning added to FDA label for teprotumumab on severe hearing impairment including hearing loss, which in some cases may be permanent,[1] could enable greater market share capture by competitor

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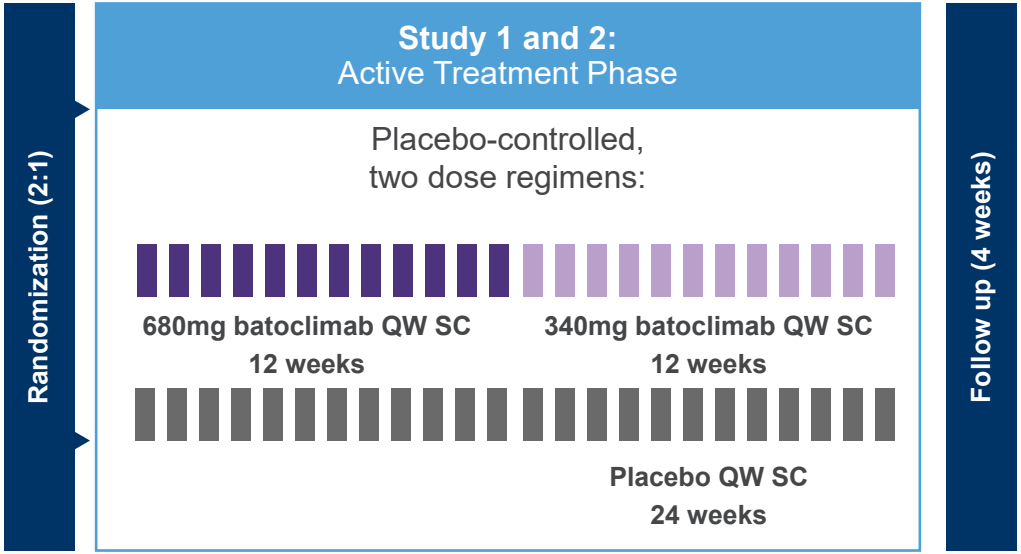
Source: KOL Interviews: Data on file at Immunovant
1.https://www.accessdata.fda.gov/scripts/cder/safetylabelingchanges/index.cfm?event=searchdetail.page&DrugNameID=2544

Two Phase 3 clinical trials of batoclimab in TED ongoing

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

Inclusion

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



Primary endpoint:

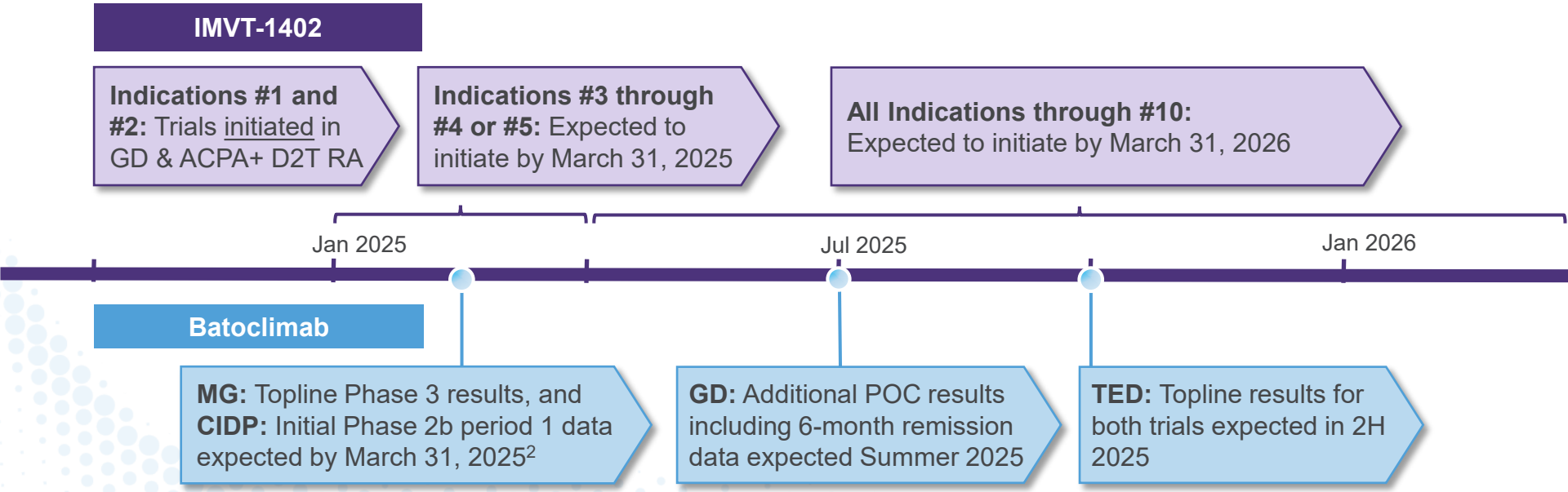
proptosis responders at Week 24 vs placebo where responders defined as ≥ 2 mm reduction from baseline in proptosis in the study eye without deterioration (≥ 2 mm increase) in the fellow eye

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

Note: subset of inclusion criteria for TED Phase 3 trial shown on slide
CAS = Clinical Activity Score, anti-TSHR-Ab = anti-TSHR antibody, QW = weekly; SC = subcutaneous injection.

Multiple near-term milestones for enhanced value creation

On track to initiate 4-5 potentially registrational programs for IMVT-1402 by March 31, 2025 and trials in a total of 10 indications by March 31, 2026[1]



1. Indications #1 through #5 will be potentially registrational programs, Indications #6 through #10 may be proof-of-concept or potentially registrational programs 2. Enrollment completed for MG. For CIDP, enrollment completed for patients included in the period 1 data expected by March 31, 2025. No further patients will be enrolled until after such period 1 data is disclosed.

Appendix

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Tailored dosing: Strong commercial product precedent for multiple dosing regimens within and across immunology indications

The top 10 highest selling immunology medications generally have multiple doses and dose regimens

Initial Dosing		Subsequent Dosing
Higher dose or dosing regimen designed to achieve **rapid** clinical response	Patient Opportunity	**Optionality** in maintenance dose and frequency allows for **tailored** treatment regimens
Among the 10 highest selling immunology drugs globally, **majority** of labeled indications included a loading or induction dose[1,2]	Commercial Product Precedent	10 highest selling immunology drugs globally had a **median of 3 unique**, labeled maintenance dosing regimens[1]

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1. Immunovant analysis of adult indications and dosing regimens in FDA prescribing information; additional details provided in the appendix
2. Loading and induction doses = initial doses in the first 12 weeks that are higher and / or more frequent than the steady state doses

Initial and subsequent dosing regimens for highlighted immunology drugs: Strong commercial product precedent for multiple dosing regimens within and across immunology indications[1,2]

Initial dosing: Almost 70% of labeled indications among the highlighted immunology drugs have a loading and / or induction dose[1,2,4]

Subsequent (maintenance) dosing: 7 of the highlighted 10 drugs have multiple unique maintenance dosing regimens[1,2,3]

Highlighted immunology drug[2]	# of adult indications[1]	Initial dosing: Indications with loading and / or induction doses[1,4]	Subsequent dosing: # of unique maintenance doses[1,3]
Humira (adalimumab)	8	5 of 8 indications	3
Stelara (ustekinumab)	4	4 of 4 indications	3
Dupixent (dupilumab)	5	3 of 5 indications	3
Ocrevus (ocrelizumab)	2	2 of 2 indications	1
Skyrizi (risankizumab)	3	3 of 3 indications	3
Cosentyx (secukinumab)	5	5 of 5 indications	4
Enbrel (etanercept)	4	1 of 4 indications	1
Orencia (abatacept)	3	3 of 3 indications	4
Tremfya (guselkumab)[5]	2	2 of 2 indications	1
Actemra/RoActemra (tocilizumab)	5	0 of 5 indications	5
	Total of 41 indications	**28 / 41 of labeled indications have a loading and / or induction dose**	**Median of 3 unique maintenance doses per product**

1. Based on adult indications and dosing regimens in FDA prescribing information for each product (pulled in December 2023); excluding pediatric dosing regimens
2. 10 highlighted immunology drugs selected and ordered based on publicly available global 2022 net sales
3. Subsequent (i.e., maintenance) doses = all continuous dosing options, by dosage or frequency, listed in product's FDA prescribing information
4. Loading and induction doses = initial dose(s) in the first 12 weeks that are higher and / or more frequent than the subsequent doses
5. For Tremfya (guselkumab), studies are ongoing in Ulcerative Colitis and Crohn's disease with doses different than the labeled Plaque Psoriasis and Psoriatic Arthritis dose

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Deep IgG reduction: Consistent evidence across programs and indications that greater IgG reduction leads to greater efficacy[1]

	Company	Evidence of Greater IgG Reductions Translating to Clinical Benefit
GD	IMMUNOVANT	Deeper IgG reductions ➔ meaningfully higher responder and ATD-free responder rate
MG	IMMUNOVANT	Deeper IgG reductions across treatment arms ➔ AChR autoantibody reductions and enhanced clinical activity
	argenx / janssen	Patient-level scatter plot showed that greater IgG declines ➔ greater MG-ADL improvements[2,3]
RA	janssen	In those patients with greater IgG reduction ➔ correlation with greater autoAb reduction ➔ correlation with greater clinical response[4]
SjD	janssen	Dose-dependent IgG reduction across arms ➔ dose-dependent autoantibody reductions ➔ dose-dependent clinical response
TED	IMMUNOVANT	Greater IgG reduction across arms ➔ higher rates of anti-TSHR antibody reduction and greater clinical response rates
ITP	ucb	Greater IgG reduction across arms ➔ greater platelet responses[6]

1. Many of the analyses above were post-hoc and not all were statistically significant. Cross trial and post-hoc analyses are inherently limited and are presented for hypothesis generating purposes only, nevertheless consistent and numerically positive increases in efficacy were observed as noted above; 2. argenx JP Morgan Healthcare Conference Presentation January 2021; 3. Momenta Vivacity-MG Interim Phase 2 Investor Presentation, 2020; 4. Janssen Research & Development, ACR poster, November 2023.. 5 Gottenberg JE et al. Efficacy and Safety of Nipocalimab, an Anti-FcRn Monoclonal Antibody, in Primary Sjogren's Disease: Results from a Phase 2, Multicenter, Randomized, Placebo-Controlled, Double-Blind Study (DAHLIAS). ACR Convergence 2024, November 16-19, 2024 6. IgG reduction at day 8 estimated by WebPlotDigitizer for 4mg/kg, 7mg/kg and 10mg/kg doses;

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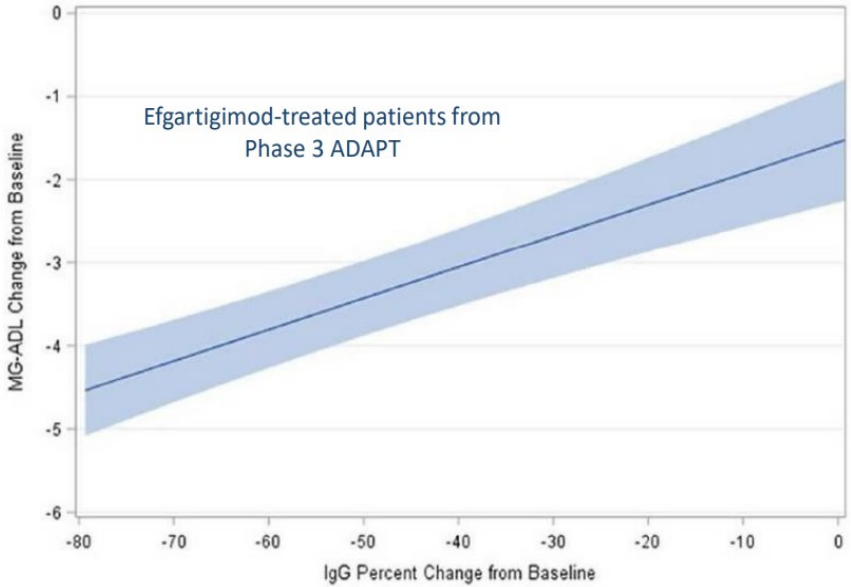
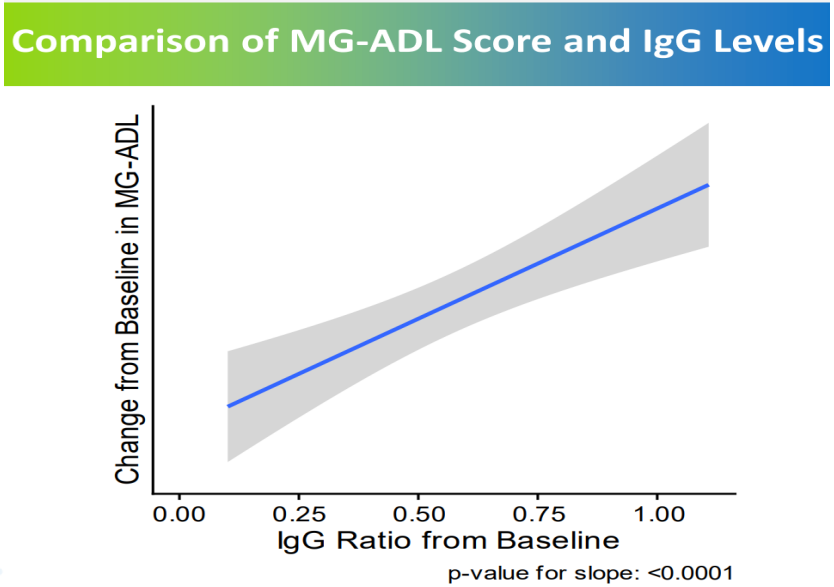
Efgartigimod and nipocalimab MG data showed higher clinical response with deeper IgG reduction

ADAPT Phase 3 trial of IV efgartigimod in MG showed a correlation between IgG reductions and clinical response



Source: argenx JP Morgan Healthcare Conference Presentation January 2021

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



Source: Momenta Vivacity-MG Interim Phase 2 Investor Presentation, 2020

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

Batoclimab TED data and nipocalimab RA data showed higher clinical response with deeper IgG reduction

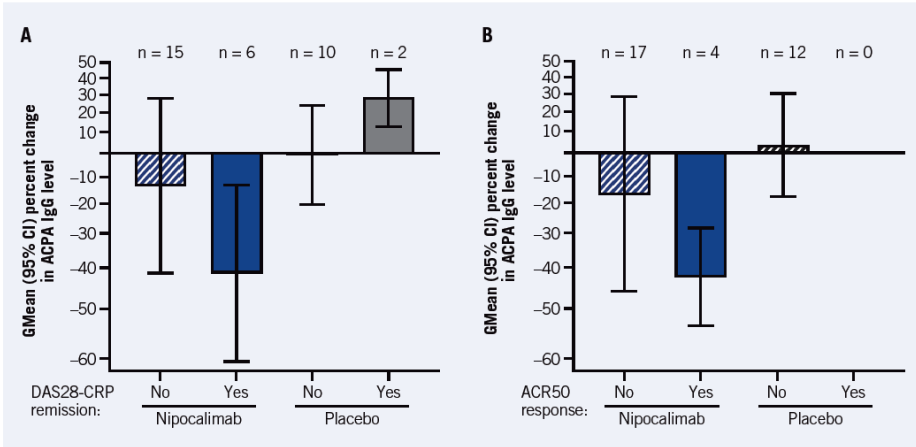
Deeper IgG reduction led to greater restoration of normal levels of pathogenic antibodies and greater proptosis response in Phase 2 trial in TED

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

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

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

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



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

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

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

Rozanolixizumab ITP data showed higher clinical response with deeper IgG reduction

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

Single Dose of Rozanolixizumab	Data at Day 8		
	Estimated IgG Reduction	Mean platelet count (x109/L)	% change platelet count (x109/L)
4 mg/kg	27%[1]	27	53%
7 mg/kg	27%[1]	21	53%
10 mg/kg	47%[1]	41	122%
15 mg/kg	52%	108	409%
20 mg/kg	60%	145	706%

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

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Source: Robak T et al. Phase 2 multiple-dose study of an FcRn inhibitor, rozanolixizumab, in patients with primary immune thrombocytopenia. Blood Adv. 2020 Sep 8;4(17):4136-4146. No clinical head-to-head comparisons of Immunovant product candidates and third party anti-FcRn assets has been conducted.