





Roche Pharma Day 2025
London, 22 September 2025



This presentation contains certain forward-looking statements. These forward-looking statements may be identified by words such as 'believes', 'expects', 'anticipates', 'projects', 'intends', 'should', 'seeks', 'estimates', 'future' or similar expressions or by discussion of, among other things, strategy, goals, plans or intentions. Various factors may cause actual results to differ materially in the future from those reflected in forward-looking statements contained in this presentation, among others:

- 1 pricing and product initiatives of competitors;
- 2 legislative and regulatory developments and economic conditions;
- 3 delay or inability in obtaining regulatory approvals or bringing products to market;
- 4 fluctuations in currency exchange rates and general financial market conditions;
- 5 uncertainties in the discovery, development or marketing of new products or new uses of existing products, including without limitation negative results of clinical trials or research projects, unexpected side-effects of pipeline or marketed products;
- 6 increased government pricing pressures;
- 7 interruptions in production;
- 8 loss of or inability to obtain adequate protection for intellectual property rights;
- 9 litigation;
- 10 loss of key executives or other employees; and
- 11 adverse publicity and news coverage.

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Welcome

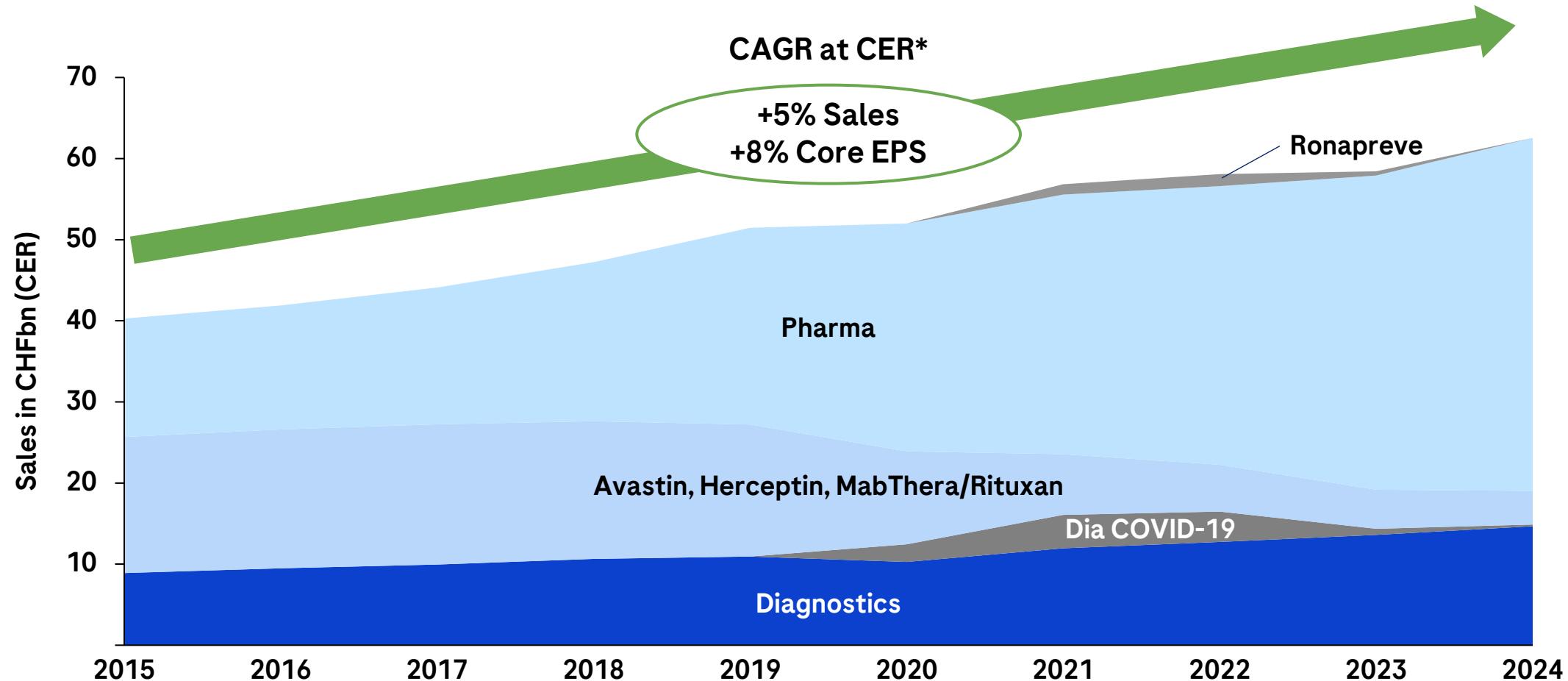
Bruno Eschli
Head of Investor Relations

Agenda: Pharma Day 2025

Strategy	Introduction 09:30 BST Bruno Eschli, Head of Investor Relations Pharma Strategy and Commercial Growth Drivers Teresa Graham, CEO Roche Pharmaceuticals R&D Excellence Levi Garraway, CMO and Global Head of Product Development
	<hr/>
	Q&A - Strategy
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	Lunch Break
	<hr/>
Pipeline	Oncology/Hematology 12:20 BST Charles Fuchs, SVP and Global Head of Oncology and Hematology Product Development Neurology Hideki Garren, SVP and Global Head of Neurology Product Development Immunology Larry Tsai, SVP and Global Head of Immunology Product Development Ophthalmology Christopher Brittain, SVP and Global Head of Ophthalmology Product Development Cardiovascular, Renal and Metabolism Manu Chakravarthy, SVP and Global Head of Cardiovascular, Renal and Metabolism Product Development
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	Q&A - Pipeline
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	Buffet reception

Roche delivered consistent growth throughout the last decade

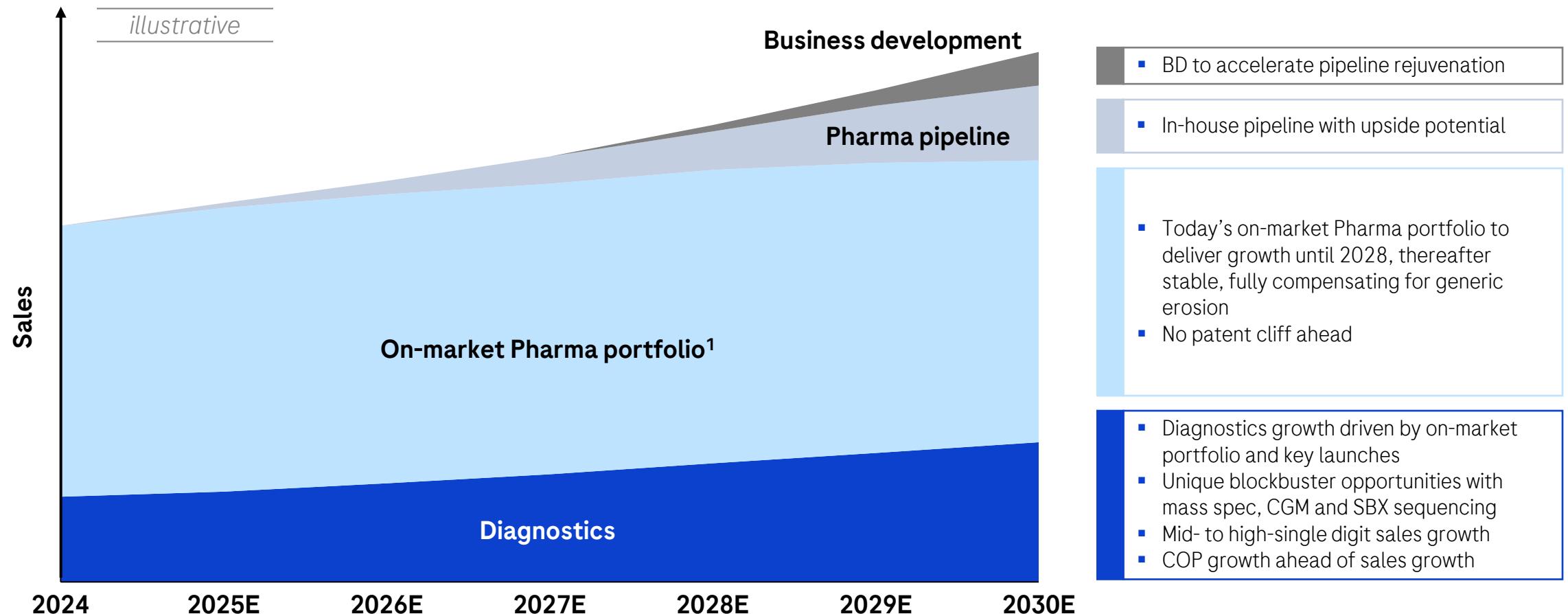
Increased diversification with 17 blockbusters in Pharma



*CAGR based on CER growth rates of each year; CAGR: Compound annual growth rate; CER: Constant exchange rates (avg full year 2023);
Note: Blockbusters based on FY 2024 global sales, including Venclexta (sales are booked by partner AbbVie)

A solid base to deliver long-lasting future growth

Emerging pipeline complemented by business development to add significant upside potential



Note: Graph is purely conceptual to outline portfolio trends; 1. Pharma: On-market portfolio including young portfolio (products launched since end of 2015); COP: Core operating profit



Pharma Strategy and Commercial Growth Drivers

Teresa Graham

CEO Roche Pharmaceuticals

Progress since Pharma Day 2024

Pharma strategy and on-market portfolio update

Obesity strategy

Future growth opportunities

Our Ten-Year Pharma Ambition

Focus on delivering transformative medicines, enabled by R&D and business objectives



Pharma Ambition 2020-2029

Deliver 20 transformative medicines¹ addressing diseases with the highest societal burden²



Value

+40%
in avg. pipeline peak sales



Innovation

80%
of pipeline has best-in-disease potential

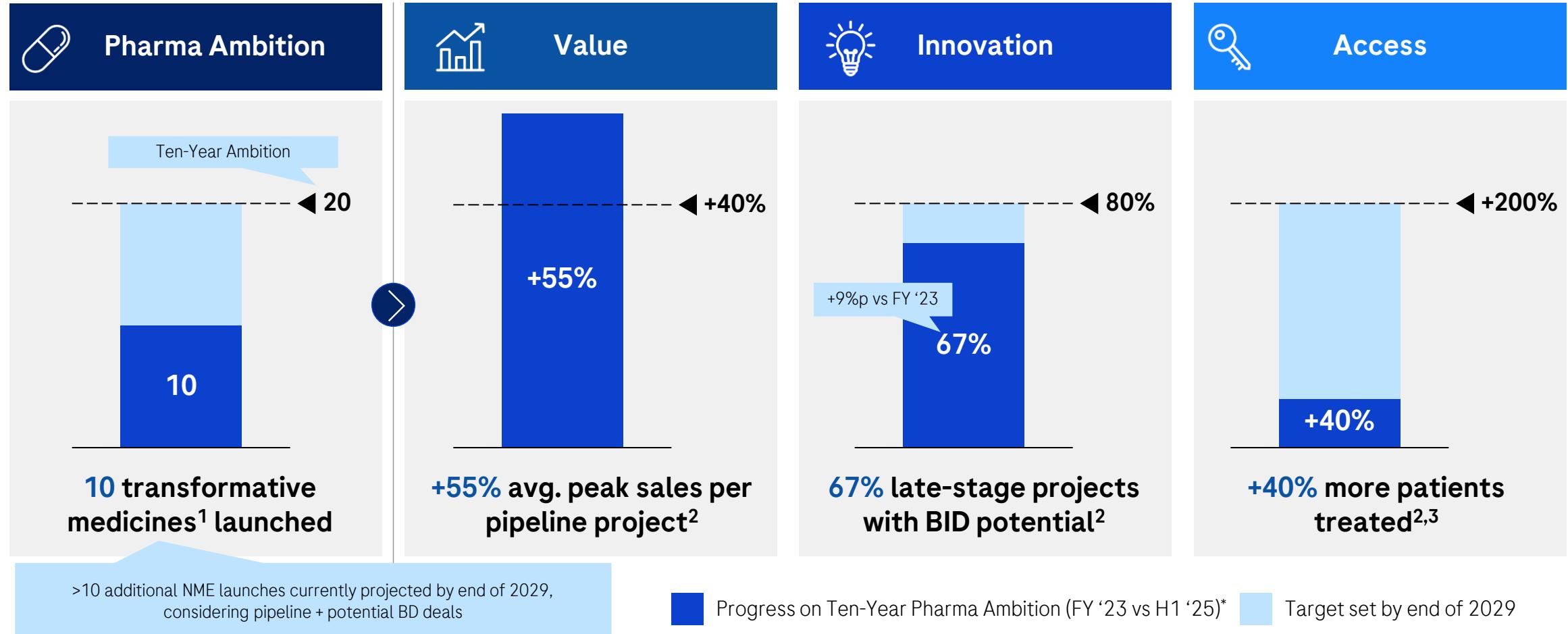


Access

3x
more patients treated³

1. Transformative medicines: Medicines that deliver significant or transformative clinical benefit in at least one indication or bring a significant benefit to the healthcare system; 2. Addressing the highest societal burden: high burden in terms of patient unmet need and the population affected; 3. Excludes LOE products and pandemic stockpiling

Significant progress made on Ten-Year Pharma Ambition



1. Transformative medicines: Medicines that deliver significant or transformative clinical benefit in at least one indication or bring a significant benefit to the healthcare system; 2. Source: Internal data; 3. Excludes LOE products and pandemic stockpiling; *Access shown with FY'23 vs FY '24 values for patients treated; BID: Best-in-disease

Significant progress made since Pharma Day 2024

Milestones reached for operational efficiency, R&D Excellence and Pharma strategy implementation



Financials¹

+10% HY 25 sales growth

+13% HY 25 COP growth

+1.7%p HY 25 COP margin growth



R&D Excellence

+26% total portfolio value²

55% of NMEs are post “the Bar”³

3 key assets “fast-tracked”



Strategy

5 TA strategies aligned to overall Pharma strategy

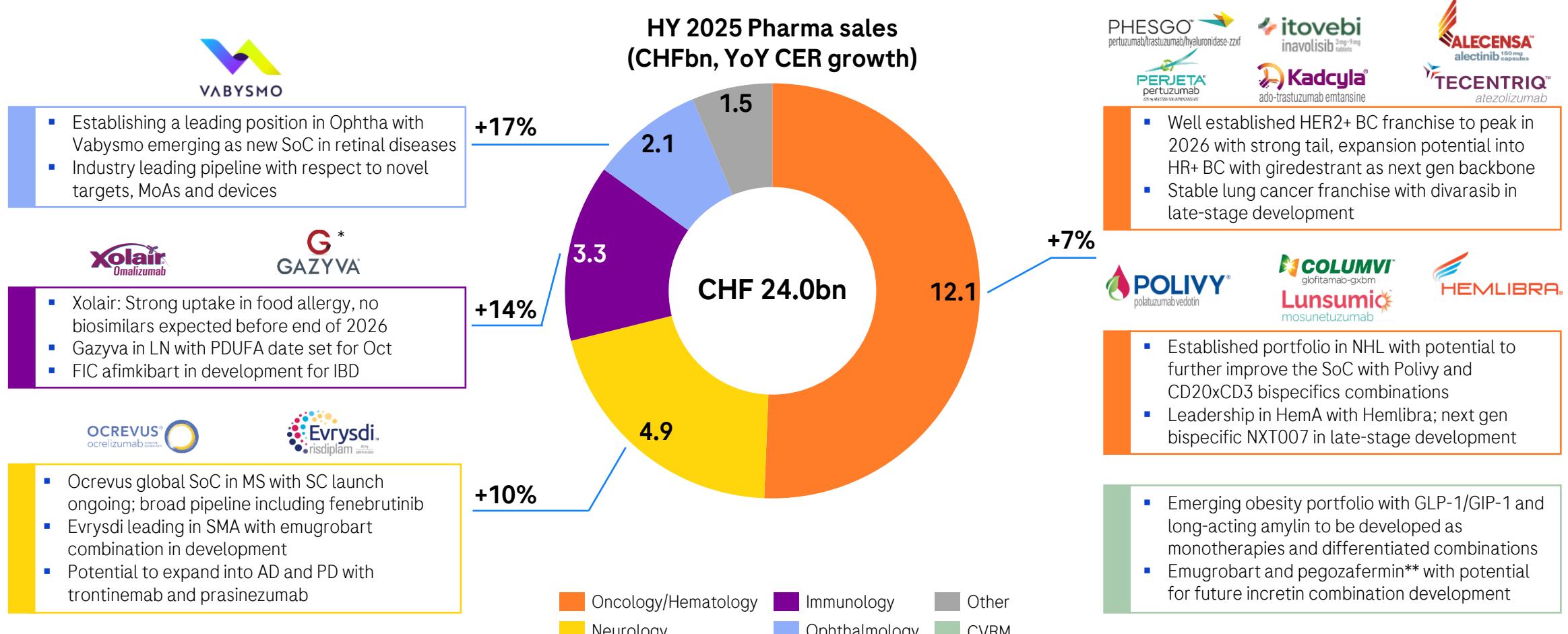
11 E2E disease areas currently in focus of R&D investment

Obesity strategy defined and supported by BD

1. At CER: Constant exchange rates (avg. full year 2024); 2. Change from YE23 to HY25; 3. Post “the Bar” defined as NMEs entering the portfolio after YE2023 or advancing to the next clinical phase after YE2023 (including PivGo decisions); CER: Constant exchange rates (avg. full year 2024); E2E: End-to-end; TA: Therapeutic area

On-market portfolio with strong growth in the midterm

Portfolio increasingly diversified with 17 blockbusters today

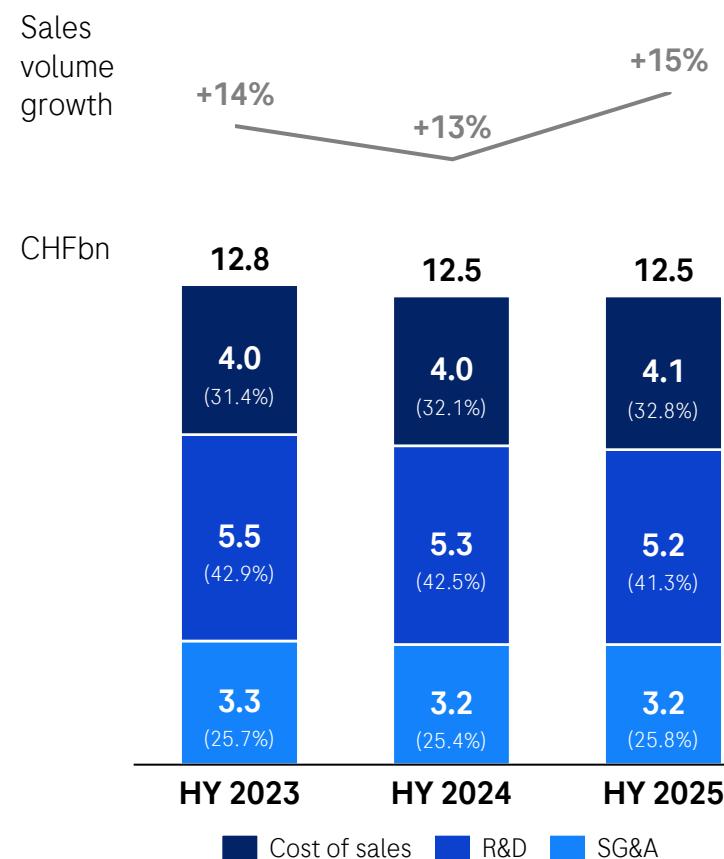


Note: Differences may occur due to rounding; *pending approval of Gazyva in LN; ** pending deal closure; AD: Alzheimer's disease; BC: Breast cancer; CER: Constant exchange rates (avg. full year 2024); DED: Dry eye disease; FIC: First-in-class; HER2: Human epidermal growth factor receptor; IBD: Inflammatory bowel disease; LN: Lupus nephritis; MoA: Mechanism of action; MS: Multiple sclerosis; NHL: Non-Hodgkins lymphoma; PD: Parkinson's disease; SC: Subcutaneous; SMA: Spinal muscular atrophy; SoC: Standard of care

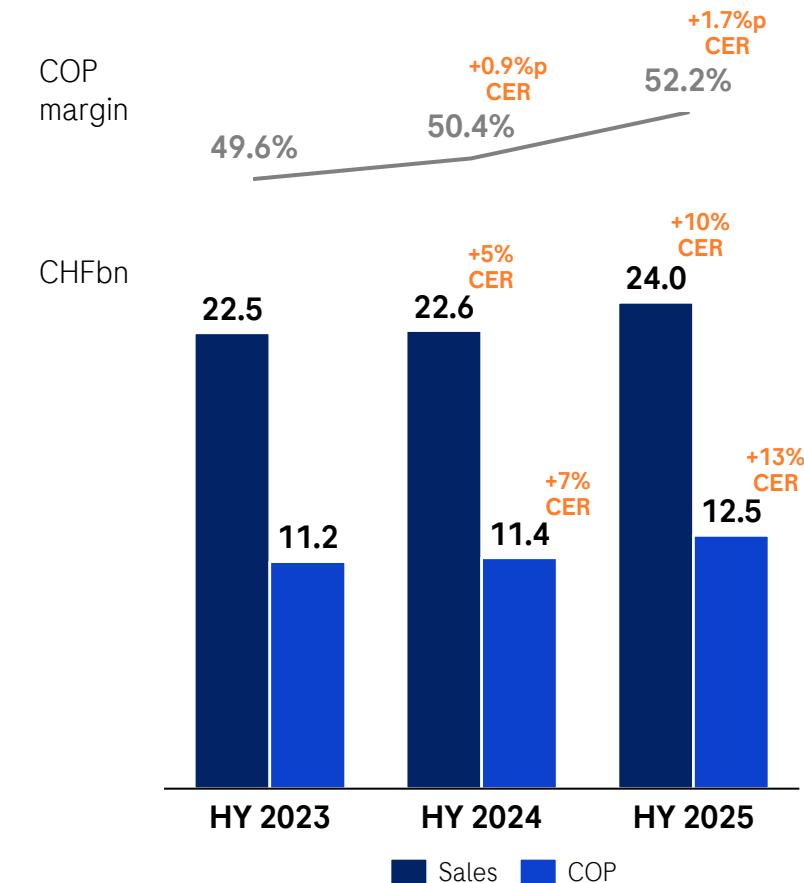
Operational excellence in Pharma since 2023

Efficiency gains & cost control driving steady COP Pharma margin improvement

HY Pharma OPEX development (% of OPEX)



HY Pharma sales & profit development



Note: Totals & subtotals may not add up due to rounding; CER: Constant exchange rates of given year; COP: Core operating profit; OPEX: Operating expenditure; SG&A: Selling, general and administrative expenses

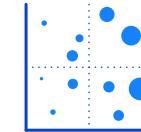
Defining our portfolio focus and implementing the Bar

Purposeful balance between exploration and focus



Follow the science

with emphasis on breakthrough innovation and patient value



Intentional focus

in end-to-end disease areas where we develop depth of experience and operational scale to deliver transformative medicines



The Bar

defines transformative medicines and is applied rigorously to each asset entering and progressing in the portfolio, across all stages of R&D (including Partnering and M&A)



Answers a clear & addressable unmet need



Engages a “foundational target”



Possess worthy pharmacologic & developability characteristics



Achieves meaningful therapeutic differentiation



Unlocks a path to value

R&D progress made: First wave of “post Bar NMEs” entering Ph III

55% of clinical pipeline now consists of post Bar assets

“Post Bar” assets moved into Ph III development

TA	Asset	Indication	Peak sales potential
Oncology/ Hematology	NXT007	Hem A	
	cevostamab	R/R MM	
Neurology	trontinemab	AD	
	prasinezumab	PD	
Immunology	afimkibart	UC/CD	
CVRM	CT-388	Obesity	
	zilebesiran	Hypertension	
	pegozafermin**	MASH	

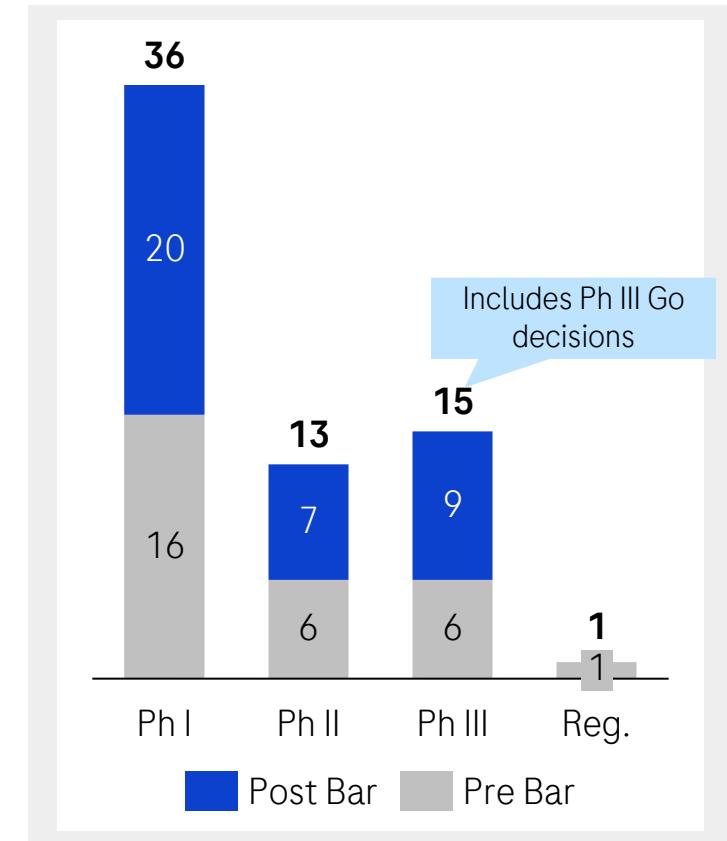
 0.5-1bn peak sales

 1-2bn peak sales

 2-3bn peak sales

 >3bn peak sales

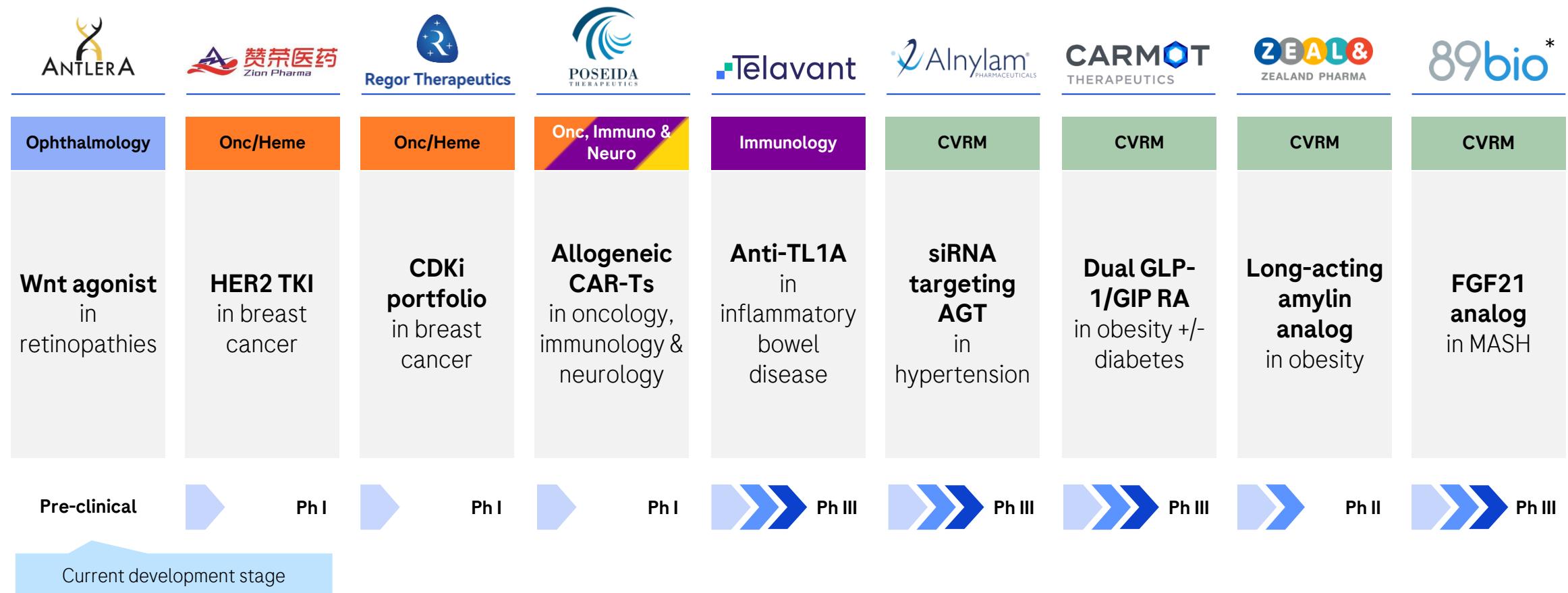
Portfolio composition (# of NMEs)*



*Post Bar defined as NMEs entering the portfolio after YE2023 or advancing to the next clinical phase after YE2023 (including Ph III Go decisions); ** pending deal closure; Peak sales shown unadjusted in CHF bn; For an overview of the full pipeline and asset classification, please see slides 163-164

Pipeline acceleration through partnering and acquisitions

Stringent R&D budget control in combination with BD to catalyze portfolio rejuvenation



* Pending deal closure; ADC: Antibody-drug conjugate; AGT: Angiotensinogen; CAR-T: Chimeric antigen receptor T-cell; CDKi: Cyclin dependent kinase inhibitor; CVRM: Cardiovascular, renal & metabolism; siRNA: Small interfering RNA; TKI: Tyrosine kinase inhibitor; TL1A: Tumor necrosis factor-like cytokine 1A; WNT: Wingless-related integration site

Progress since Pharma Day 2024

Pharma strategy and on-market portfolio update

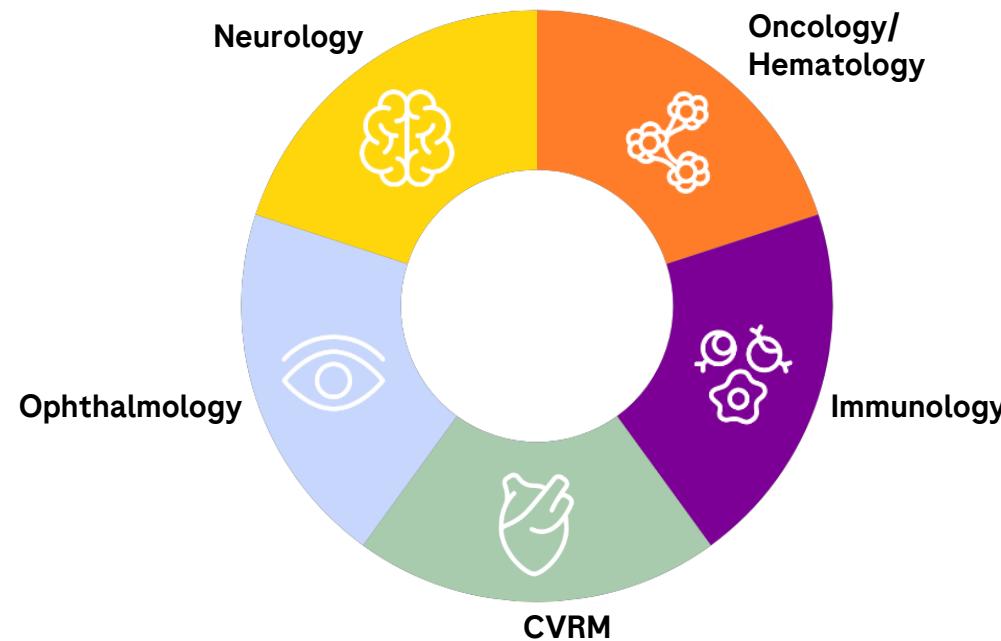
Obesity strategy

Future growth opportunities

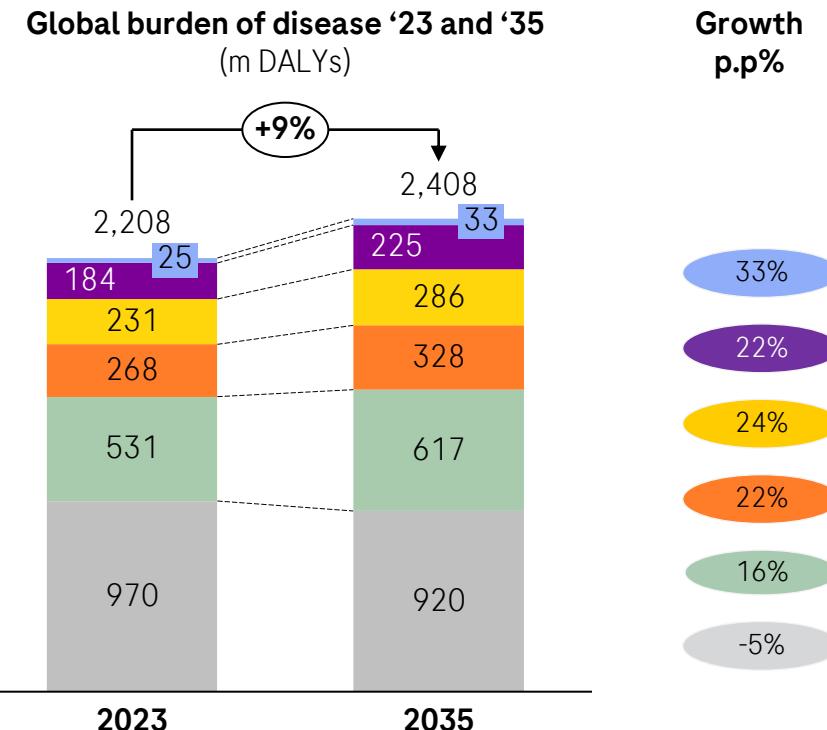
Our Pharma Strategy introduced in 2024

Providing clarity and intentional focus to leverage our scientific strengths and impact patients globally

Our five Therapeutic Areas



Covering 60% of total global burden of disease

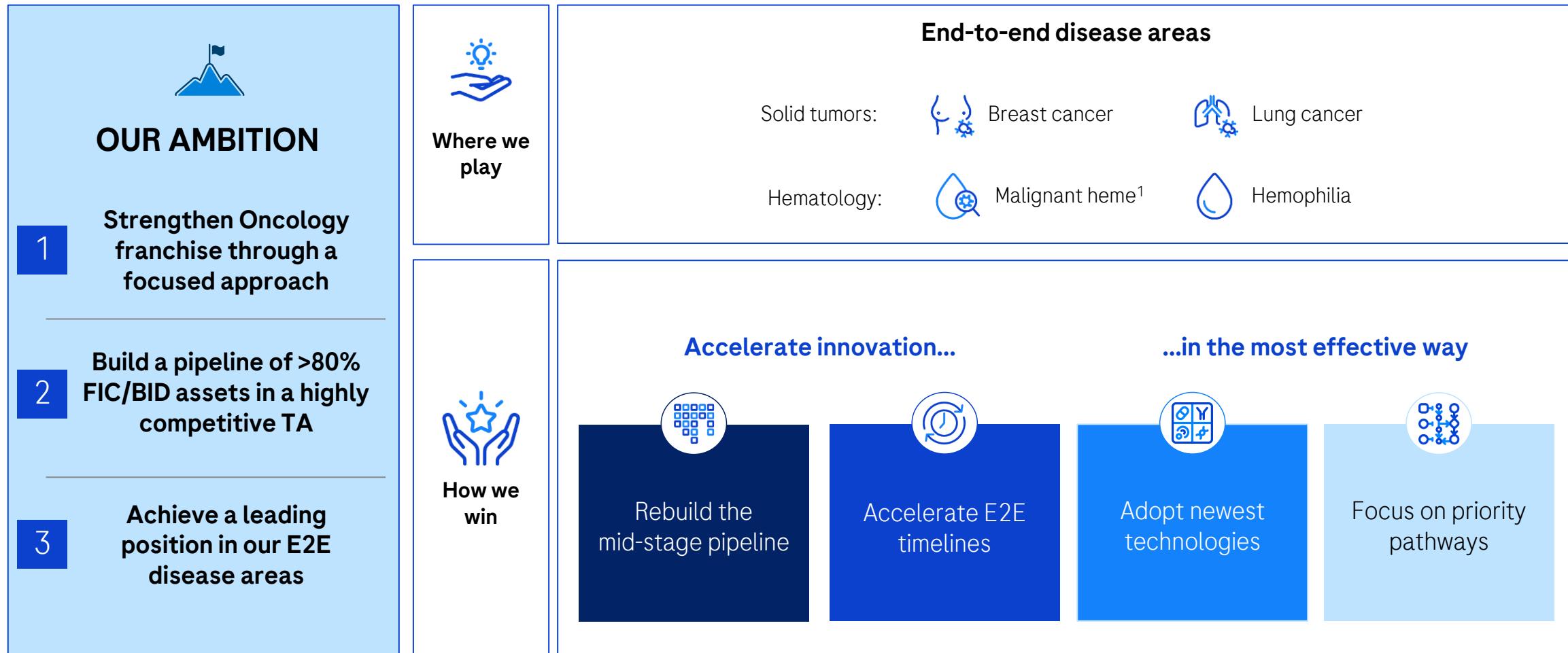


Currently 11 disease areas where we invest E2E from discovery to commercial



Oncology strategy highlights

Clear focus on our E2E disease areas to accelerate innovation and strengthen our key franchises

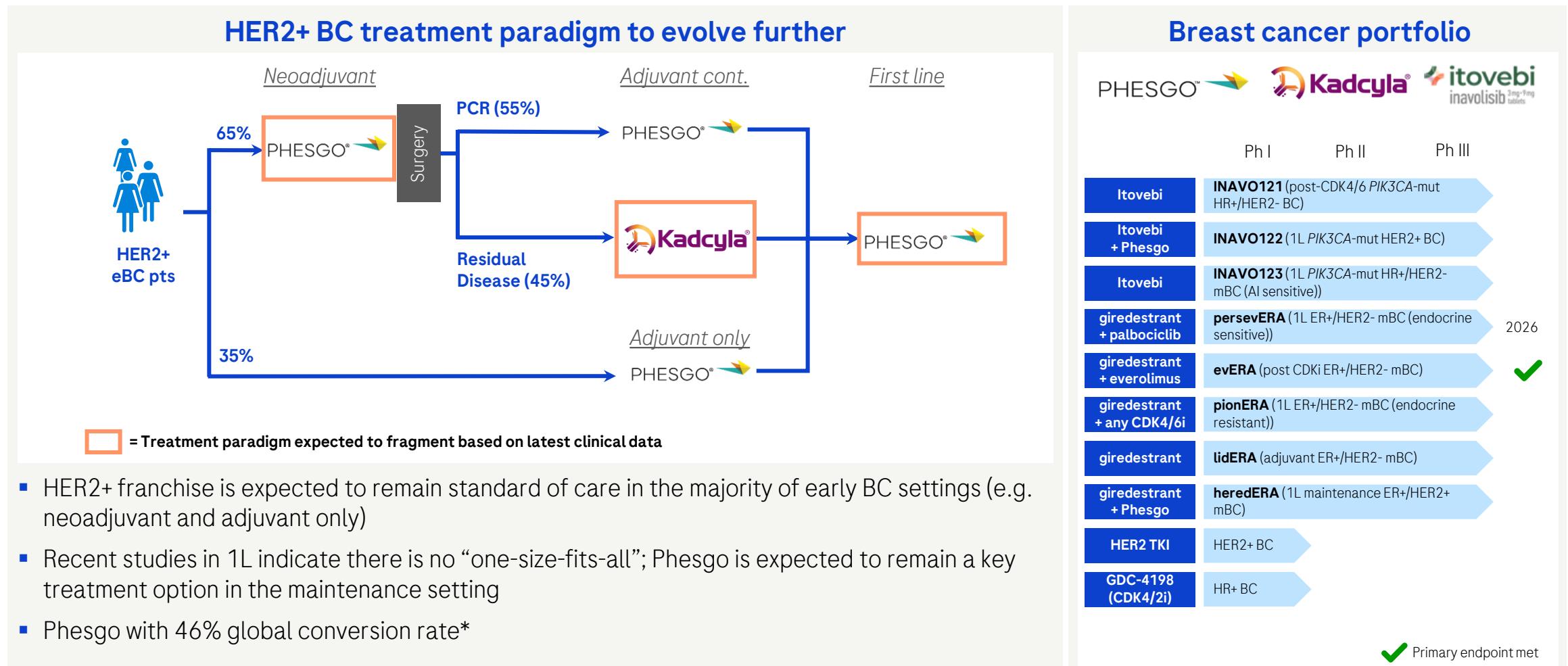


1. Includes B-cell malignancies, AML, MM; BID: Best-in-disease; E2E: End-to-end; FIC: First-in-class



Breast Cancer: A key focus area for future innovation

Positive Ph III (evERA) results for giredestrant enable expansion into HR+ BC

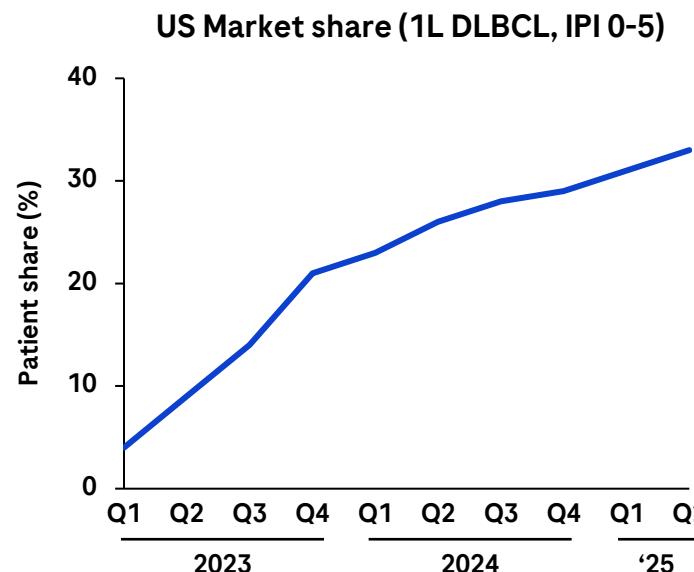




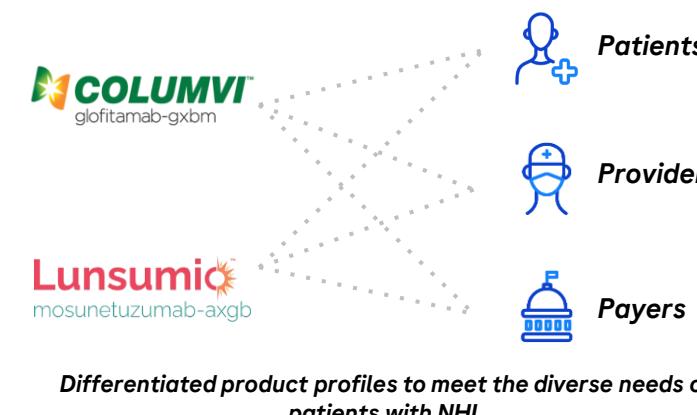
Malignant heme: Established portfolio with strong pipeline

Bispecifics expanding into earlier lines; cevostamab to move into Ph III in R/R multiple myeloma

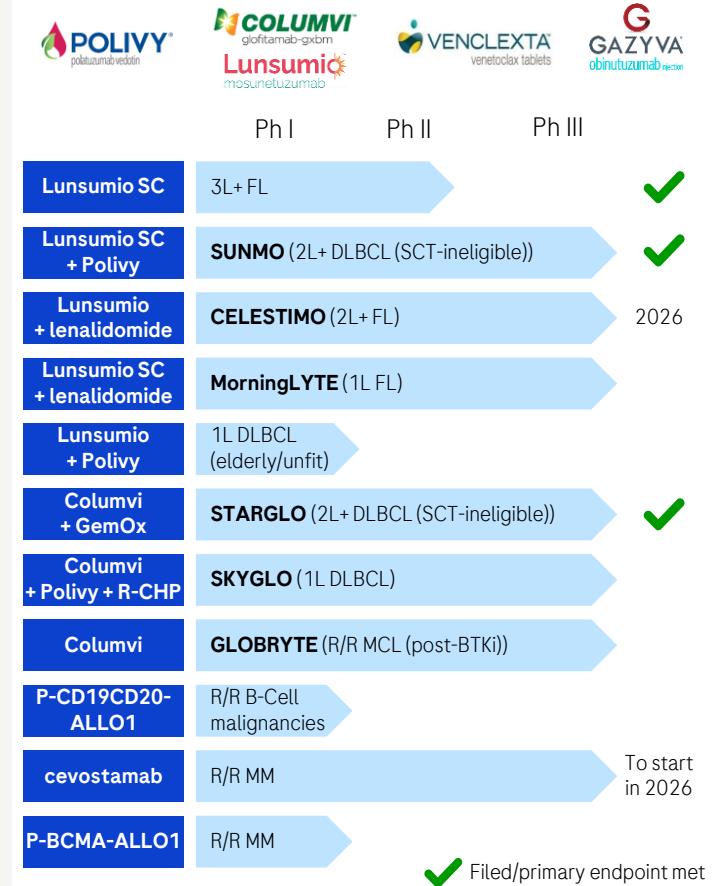
Polivy in 1L DLBCL



Columvi/Lunsumio in 2L+ NHL



Malignant hematology portfolio



- Polivy establishing a new SoC in 1L DLBCL
- 2L DLBCL: Columvi launched successfully in the EU based on Ph III (STARGLO); Lunsumio to be filed in the US based on positive Ph III (SUNMO)
- Emerging multiple myeloma pipeline with cevostamab and allogeneic CAR-Ts

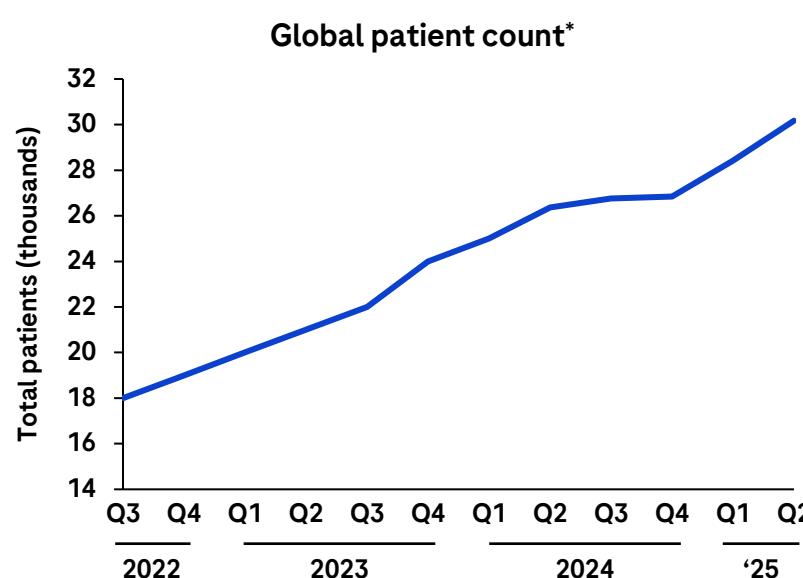
Note: Venclexta sales booked by AbbVie; CAR: Chimeric antigen receptor; FL: Follicular lymphoma; DLBCL: Diffuse large B-cell lymphoma; MCL: Mantle cell lymphoma; MM: Multiple myeloma; NHL: Non-Hodgkin's lymphoma; IPI: International prognostic index; R/R: Relapsed/refractory; SoC: Standard of care



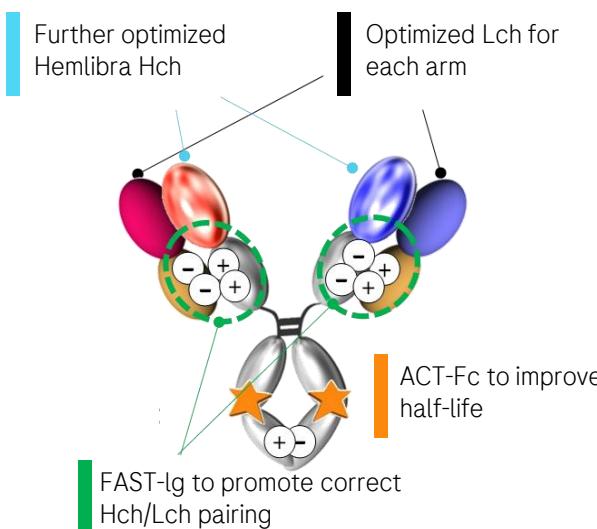
Hemophilia A: Building on Hemlibra success with NXT007

Hemlibra with >30,000 patients on treatment globally consolidating it as the SoC

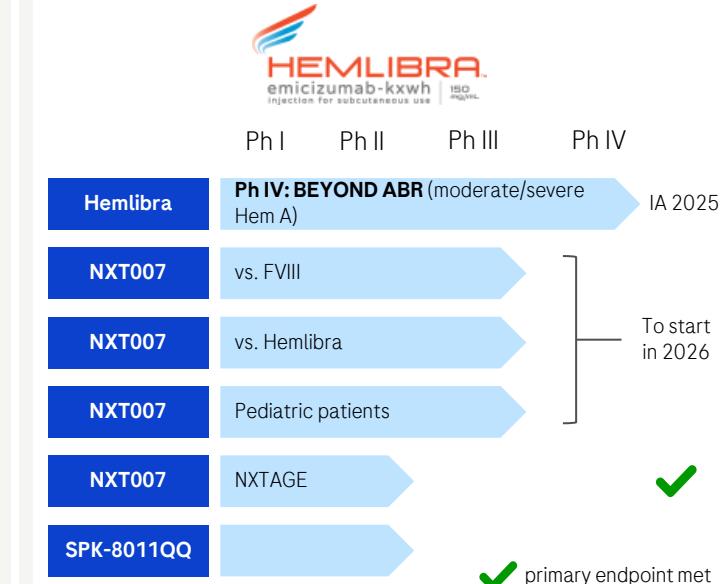
Hemlibra in Hemophilia A



NXT007: Structure & function



Hemophilia A portfolio



- Hemlibra with strong growth driven by non-inhibitor patients in all regions
- Sustained protection with >2/3 pts on Q2W or Q4W SC dosing
- Around 80% of pts with zero treated bleeds** and without inducing FVIII inhibitors, supported by RWD collected over >10 years in diverse pts populations and severities
- Autoinjectors in development to further improve convenience for Hemlibra and NXT007

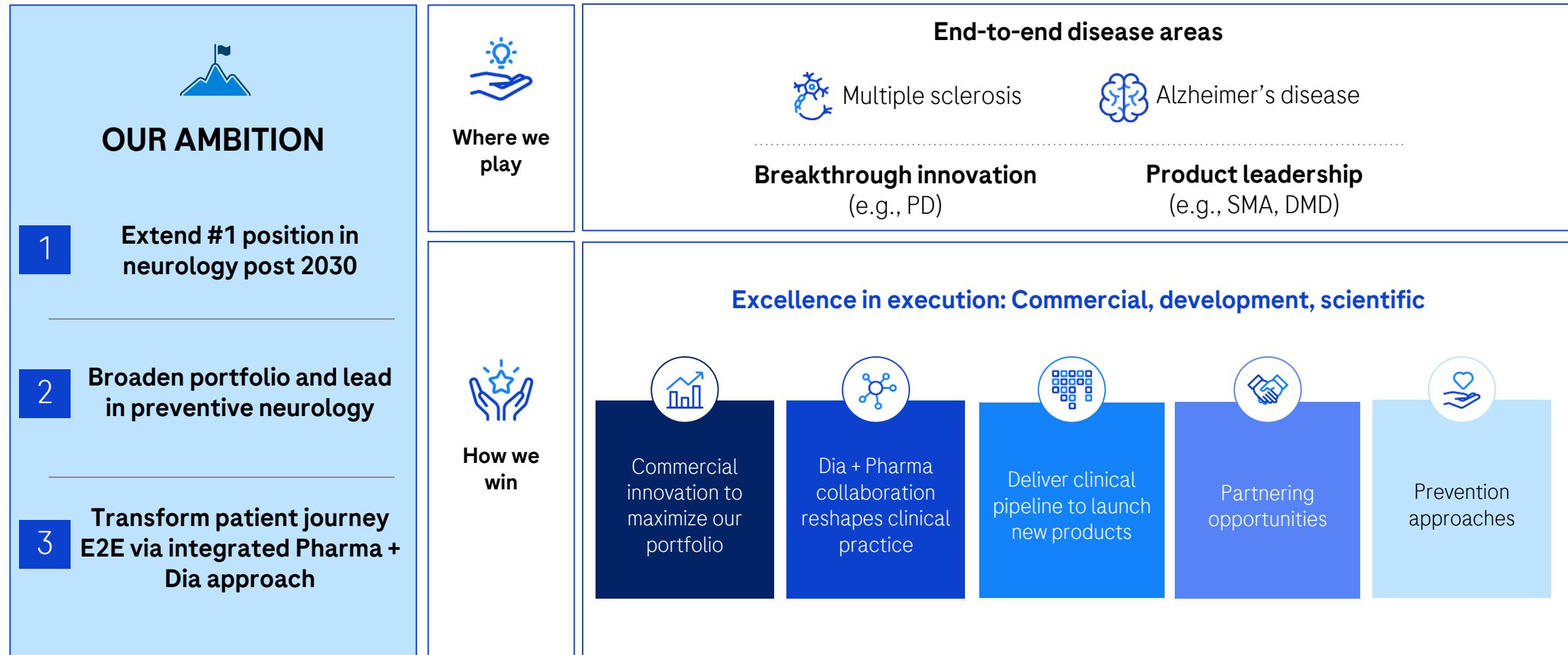
- Three NXT007 Ph III trials, incl. H2H vs. Hemlibra, planned to start 2026
- NXT007 with potential for zero treated bleeds without need for FVIII
- New Ph II data to be shared in H2 2025

*Commercial and WFH HA program; **Based RWD from McCary I, et al. Haemophilia 2020; Wall C, et al. ISTH 2020; Poon M-C, et al. ASH 2022 and Khairnar R, et al. ASH 2021; ACT-Fc: Activating fragment, crystalline; FAST-Ig: Four-chain assembly by electrostatic steering technology – immunoglobulin; Hch: Heavy chain; IA: Interim analysis; Lch: Light chain; Q2W/Q4W: Once every 2/4 weeks; RWD: Real-world data; SC: Subcutaneous; SoC: Standard of care



Neurology strategy highlights

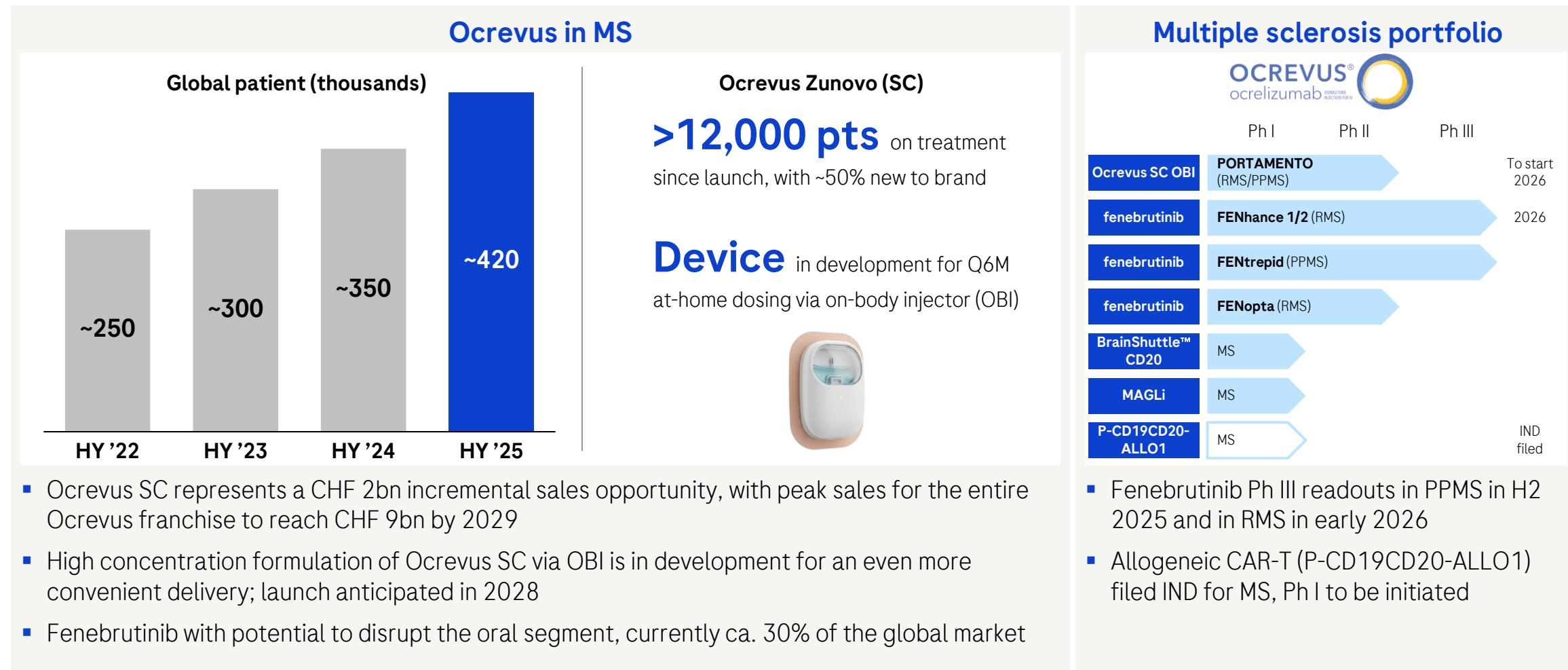
Maintain and grow our leadership through the next wave of transformative medicines and diagnostics





Multiple sclerosis: Ocrevus firmly established as global SoC

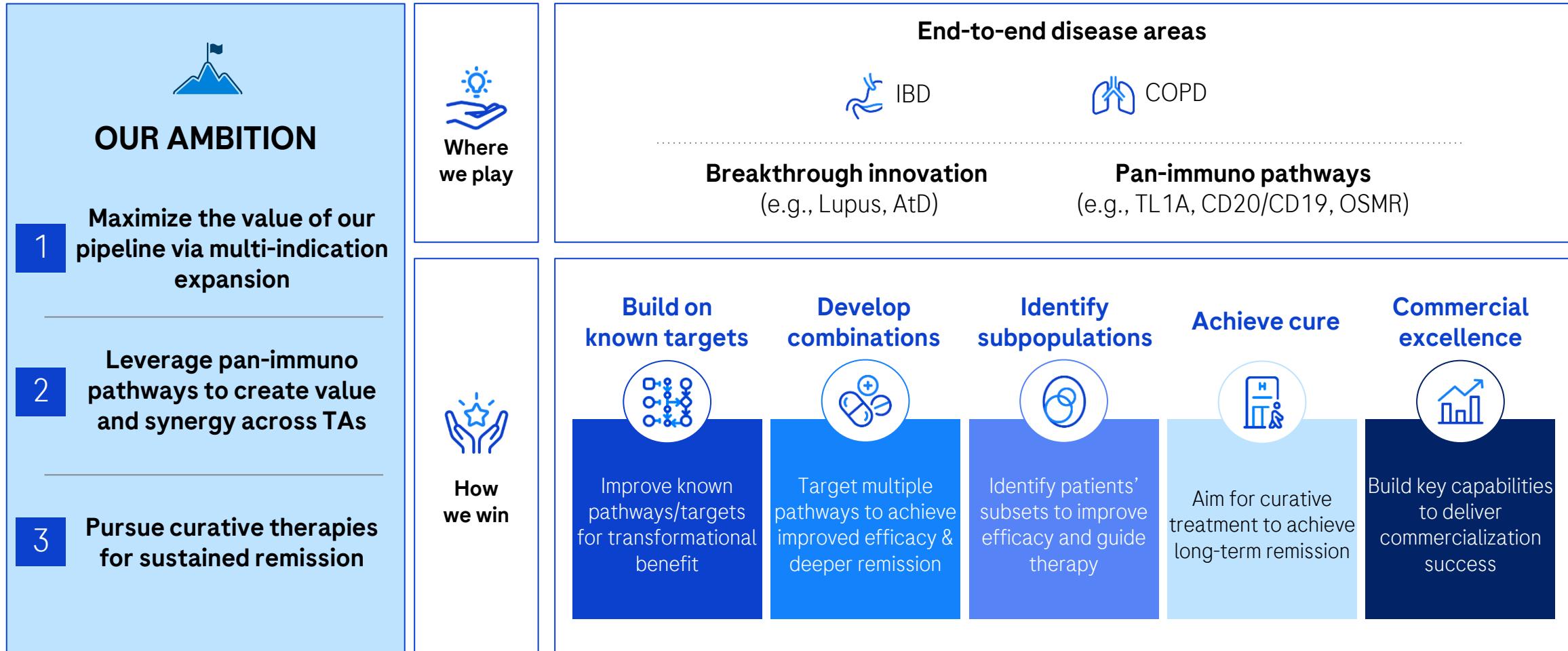
420,000 patients treated with Ocrevus globally; broad pipeline in MS, including allogeneic CAR-T





Immunology strategy highlights

Roche is well positioned to capture future innovation

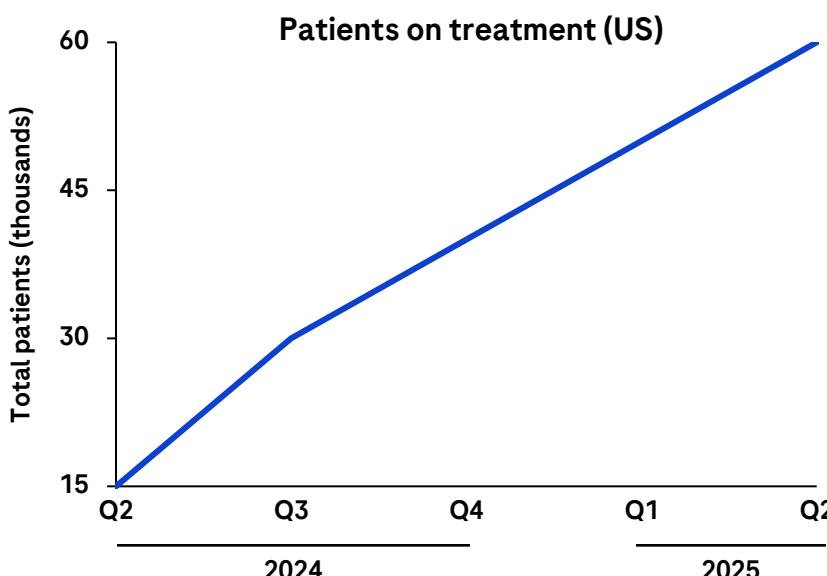




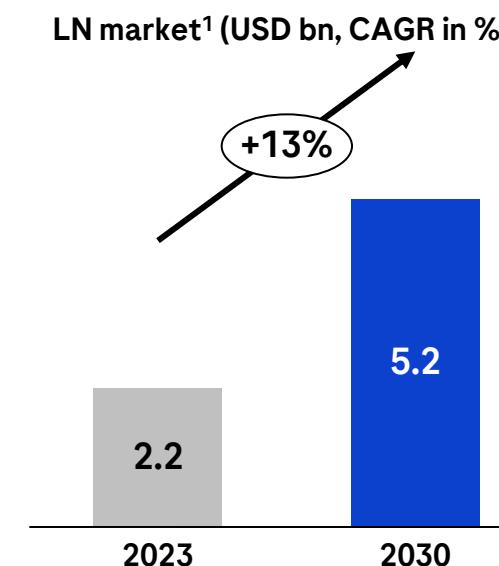
Immunology: Strong Xolair uptake in food allergy, Gazyva filed in LN

B-cell-depleting bispecifics and allogeneic CAR-T moving into chronic autoimmune diseases

Xolair in food allergy



Gazyva in LN



Immunology portfolio



- Xolair: Strong food allergy launch with no biosimilar expected before end of 2026
- Ph III (REGENCY) of Gazyva in LN met its primary endpoint of CRR, showing superiority over SoC
- Filed in US/EU with US PDUFA set for Oct
- Global LN market is expected to grow at a CAGR 2023-30 of 13%

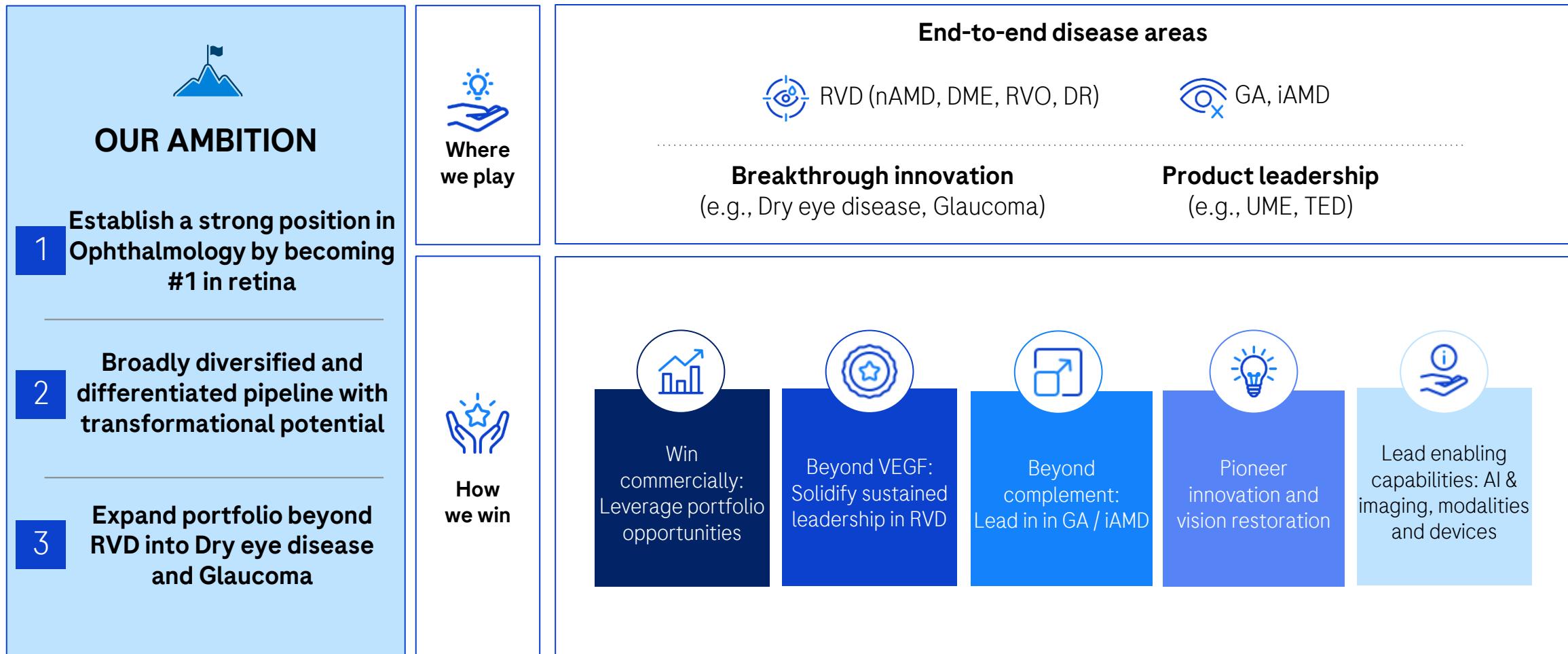
- MN, SLE and INS: Complementary indications of the Gazyva program
- Allogeneic CAR-T (P-CD19CD20-ALLO1) filed IND for SLE, Ph I to be initiated

1. Evaluate Pharma; *pending approval of Gazyva in LN; sefaxersen in partnership with Ionis Pharmaceuticals; BID: Best-in-disease; CRR: Complete renal response; IgAN: IgA nephropathy; INS: Idiopathic nephrotic syndrome (Childhood onset INS also known as PNS: Pediatric nephrotic syndrome); LN: Lupus nephritis; MN: Membranous nephropathy; SLE: Systemic lupus erythematosus; SoC: Standard of care



Ophthalmology strategy highlights

Amplify leading position in retina through next generation innovation and expand to Glaucoma and Dry eye



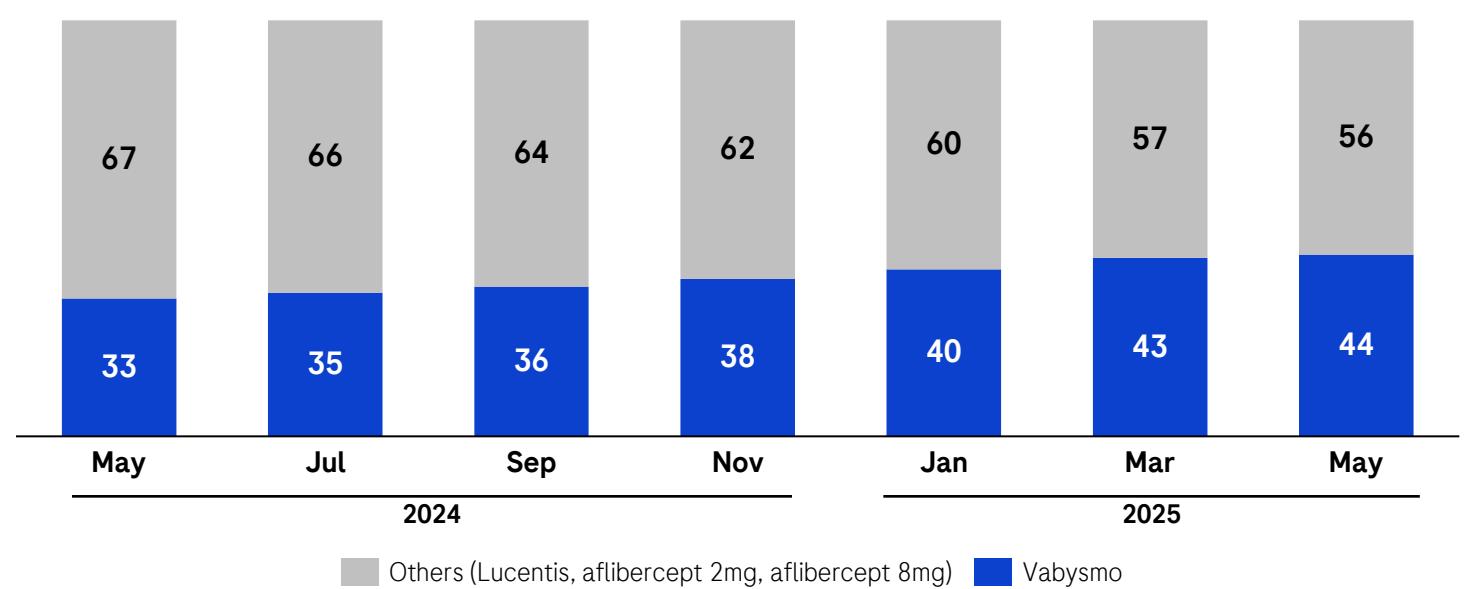


Retinal vascular disorders: Vabysmo with strong global growth

Continued market share gains in the branded IVT market, despite US market contraction*

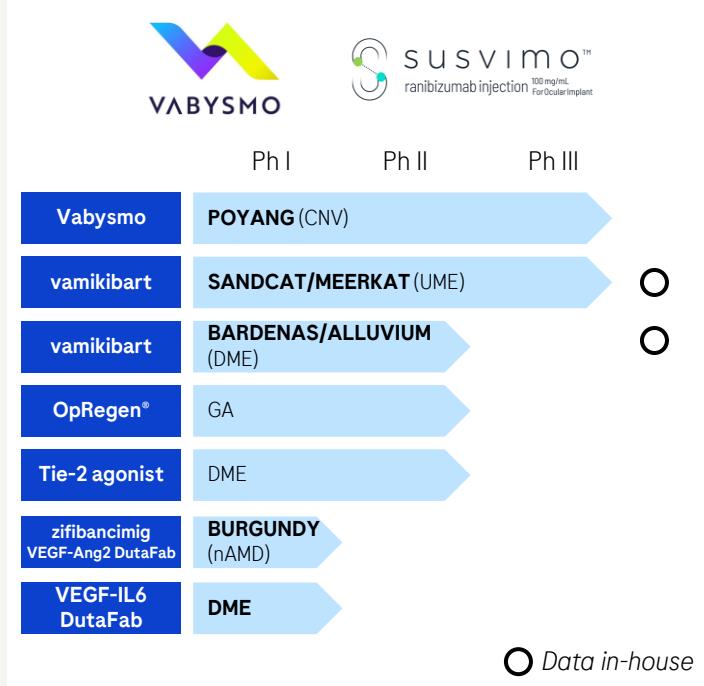
IR Ophtha Update @ ASOPRS/AAO Oct 21st

Vabysmo: US branded IVT total patient share (R3M, all indications)*



- Vabysmo with continued market share gains and increasing penetration in naive patients; continued market share gains in key markets including EU5 and China
- New positive clinical data (AVONELLE-X & SALWEEN) in nAMD and PCV reinforce strong efficacy, safety and durability profile with treatment intervals up to 5 months; presented at EURETINA
- Susvimo filed in the EU in nAMD

Retinal vascular disorder portfolio



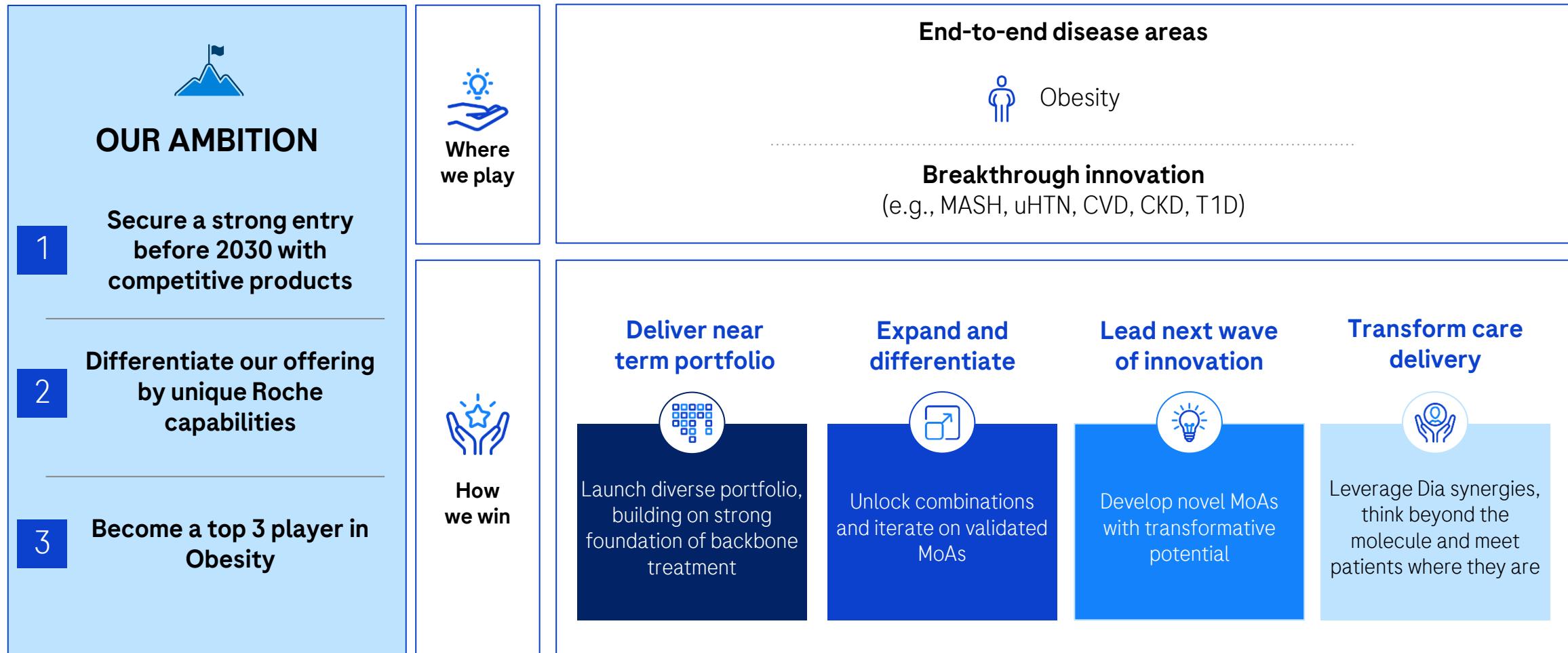
- Vamikibart Ph III data in UME to be shared with regulators and to be presented at AAO
- Vamikibart Ph II data in DME to be presented in 2026; development paused

*Based on Verana patient claims data, May 2025. Includes Vabysmo, Lucentis, aflibercept 2mg and aflibercept 8mg, excludes Avastin and biosimilars; CNV: Choroidal neovascularization; DME: Diabetic macular edema; DR: Diabetic retinopathy; GA: Geographic atrophy; nAMD: Neovascular age-related macular degeneration; PCV: Polypoidal choroidal vasculopathy; R3M: Rolling 3-months; RVO: Retinal vein occlusion; UME: Uveitic macular edema; OpRegen® cell therapy in collaboration with Lineage Cell Therapeutics



CVRM strategy highlights

Deliver current portfolio in the near term, focus on innovation, transformative solutions for patients





Entry into new disease areas

Resource prioritization required to excel in diversified portfolio

2015

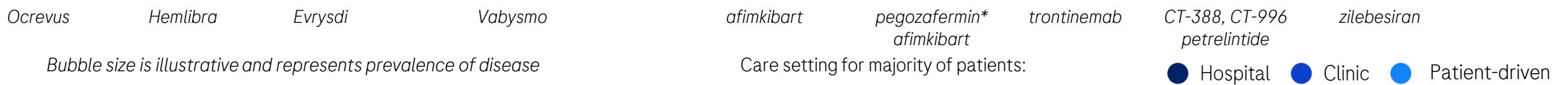
2025

2035

Over the past 10 years, Roche has successfully entered new Disease Areas, primarily within targeted patient populations and specialty care settings



In the next 10 years, Roche will enter broad-scale Disease Areas like Obesity and Hypertension, necessitating different approaches and significant investment



*pending deal closure; AD: Alzheimer's disease; AtD: Atopic dermatitis; DME: Diabetic macular edema; IBD: Inflammatory bowel disease, MASH: Metabolic dysfunction-associated steatohepatitis; MS: Multiple sclerosis; nAMD: Neovascular age-related macular degeneration; RA: Rheumatoid arthritis; RVO: Retinal vein occlusion; SMA: Spinal muscular atrophy;

How we succeed: Our Core Capabilities

Modalities & technologies



Focus on approaches with breakthrough potential in focus TAs & diseases

Devices



Making devices an integral part of our assets, from R&D to commercialization

Manufacturing



Optimizing and future-proofing our manufacturing network

Customer experience & access



Providing a holistic customer experience & enabling rapid, broad & sustainable access

Data & AI



Leveraging data and generative AI to improve process efficiency

Our People



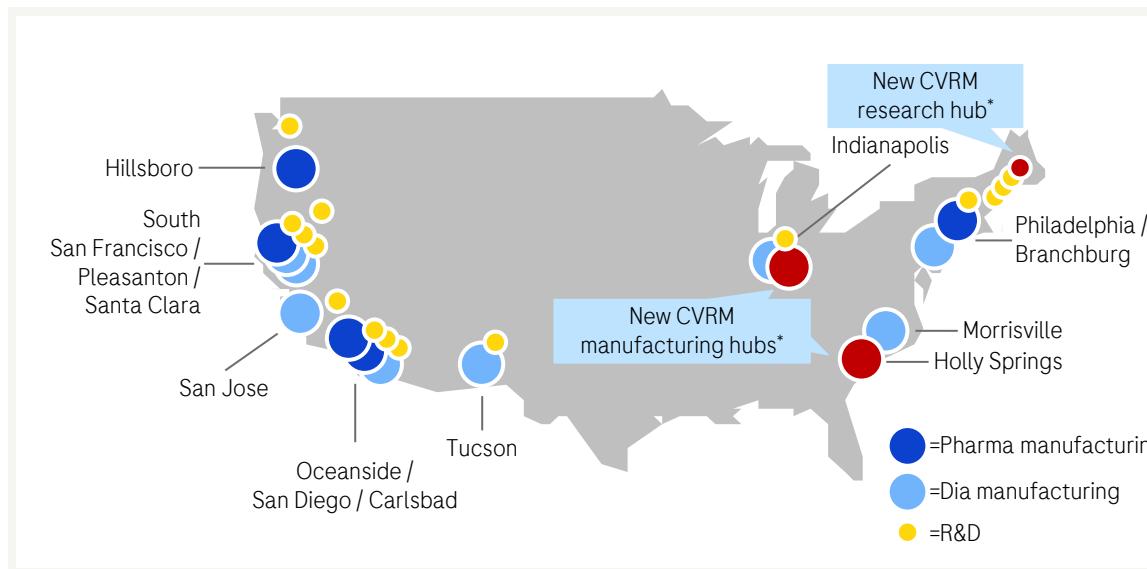
Creating a culture that allows our people to thrive in our Pharma division



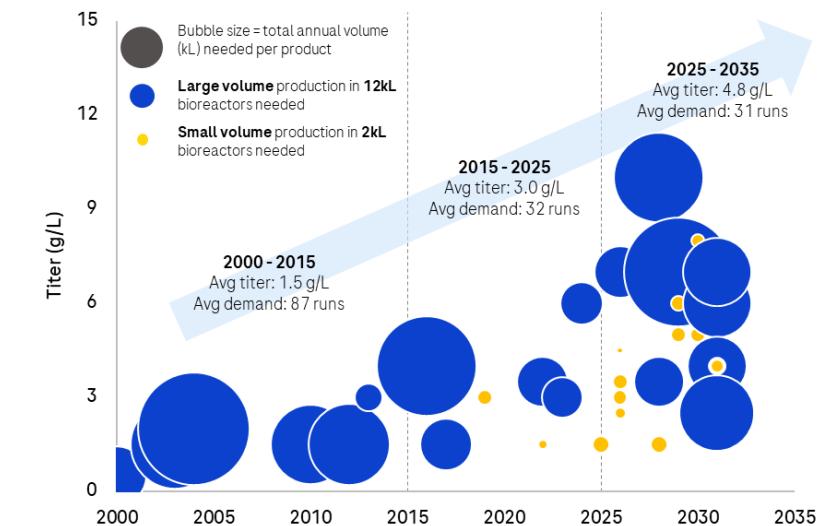
Roche with full Pharma and Diagnostics value chains in the US

Serving key geographies out of local manufacturing sites

13+1* manufacturing and 15+1* R&D sites in the US



Biologics productivity evolution 2000 to 2030

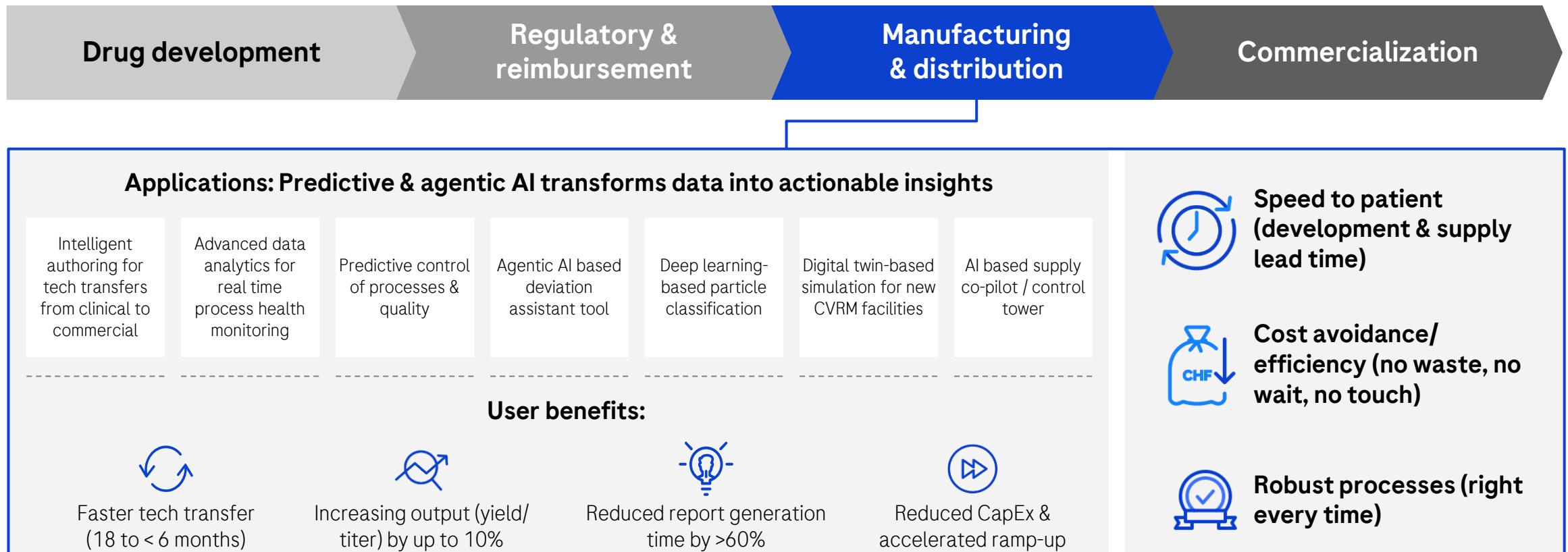


- Commitment to invest USD 50bn into R&D and PP&E in the US until the end of the decade (incl. one new R&D site and one new manufacturing site focusing on CVRM and AI/ML)
- All key medicines already produced already today in the US, with tech transfer for one remaining key product to be finalized by 2026
- New biologics manufacturing site under construction in Shanghai to serve Chinese market
- High level of flexibility in our global manufacturing network due to sufficient free US API capacity
- IP for medicines invented in the US always held in the US

*One new Pharma CVRM manufacturing site (Holly Springs, groundbreaking in Aug. '25), one new Dia CGM manufacturing expansion (Indianapolis, to be constructed) and one CVRM focused R&D center (Boston, to be constructed); AI/ML: Artificial intelligence/machine learning; API: Active pharmaceutical ingredient; CVRM: Cardiovascular, renal and metabolism; PP&E: Property, plant and equipment; Small volume: less than 10 runs at 12kL scale

Leveraging AI to supply faster, ensure robust & compliant processes

Rethinking the end-to-end process for Pharma Technical Operations



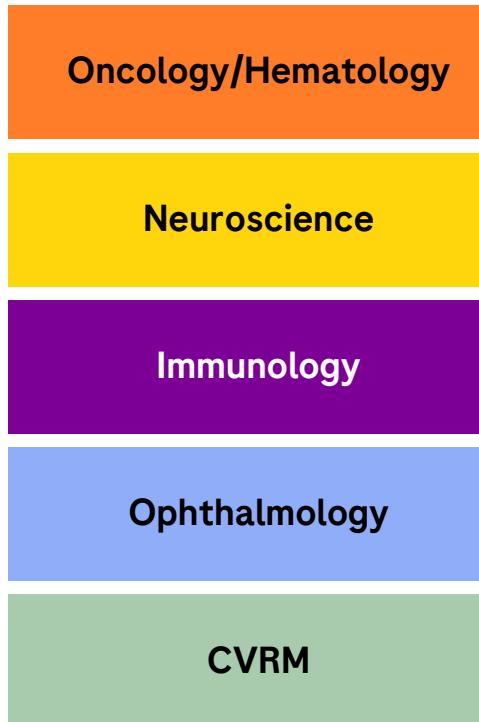
AI-enabled solutions transforming the way we work in Pharma Technical Operations



Streamlining our drug delivery approach

Significant investments in device development excellence will be critical to support our future portfolio

Therapeutic areas



Currently four device platforms



~60% of current pipeline NMEs and LEs will launch with a device

Investing for the future

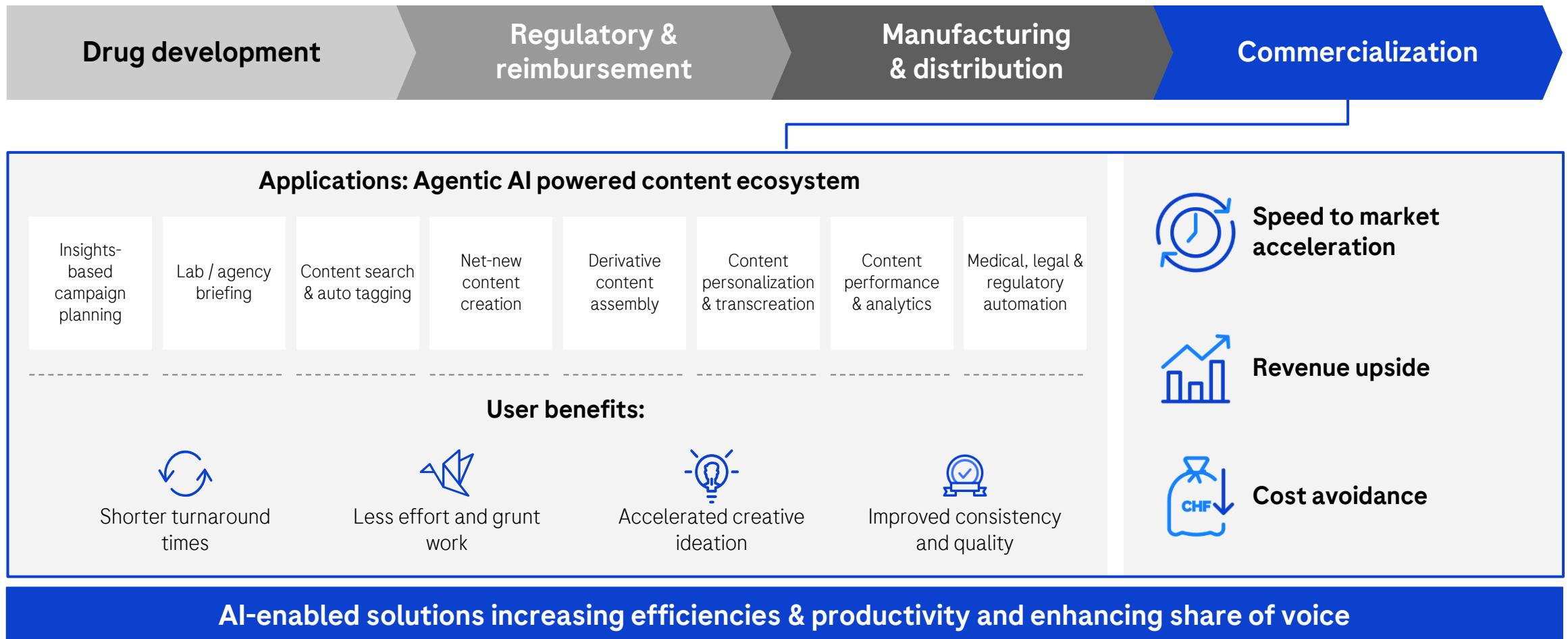
- Planned device pilot facility in Basel for medical devices and drug-device combinations
- Addresses critical bottlenecks in scaling to commercial production and will optimize manufacturing
- Ensures readiness for future launches involving devices



Site for planned device pilot facility in Basel

Leveraging AI to increase overall productivity along the value chain

Rethinking the end-to-end process for Pharma commercial & medical content creation





Our people: Critical enablers for our Pharma Strategy

We commit to creating a culture where our people can thrive across the Pharma Division

An attractive employer

We strive to hire, develop and retain the best people in the industry; providing an environment for talent to thrive across their career

High performing organization

We purposefully commit to the five conditions of a High Performing Organisation - elevating our performance and delivery

People Strategy pull through

We deliver the People Strategy - a simplified and focused approach ensuring current and future activities have the greatest collective impact

Ways of working

We elevate our ways of working¹ across the Pharma Division

1. Put patients first, follow the science, act as one team, embrace differences, accelerate learning, simplify radically, make impact now, think long term

Progress since Pharma Day 2024

Pharma strategy and on-market portfolio update

Obesity strategy

Future growth opportunities



Our capabilities strongly position us to deliver in Obesity





Obesity is quite different from other disease areas at Roche

Scale and complexity, with prominent patients and primary care role, make obesity like no other disease area

Unprecedented size
and scale

Heterogeneity and fragmentation

Patient as key
decision driver*

Two-track system: primary and
specialty settings

Not an established disease





Physical, emotional and social needs driving patient decisions

Patients view obesity as a medical condition and take the initiative to seek treatment

Patients driving treatment decision¹

~55%

of patients self-refer



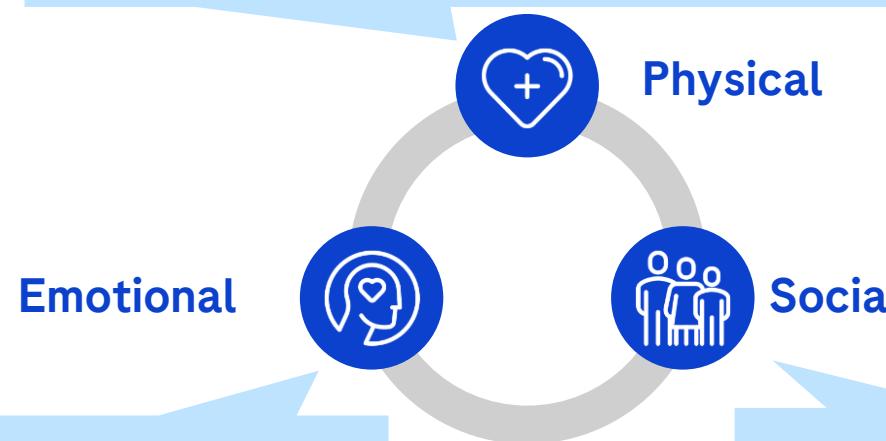
~28%

of consumers with BMI >30
would consider a GLP-1



Key patient needs²

- Preserve health & prevent disease
- Physical well-being (sleep quality, pain management, etc.)



- Appearance & self-confidence (aesthetics)
- Psychological & emotional well-being

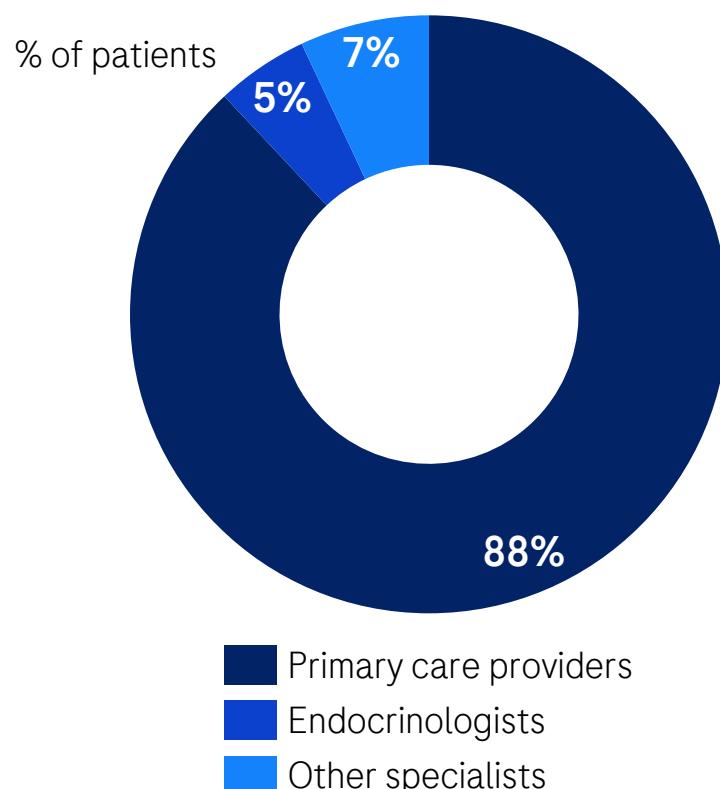
- Family and social drivers
- Lifestyle events and goals



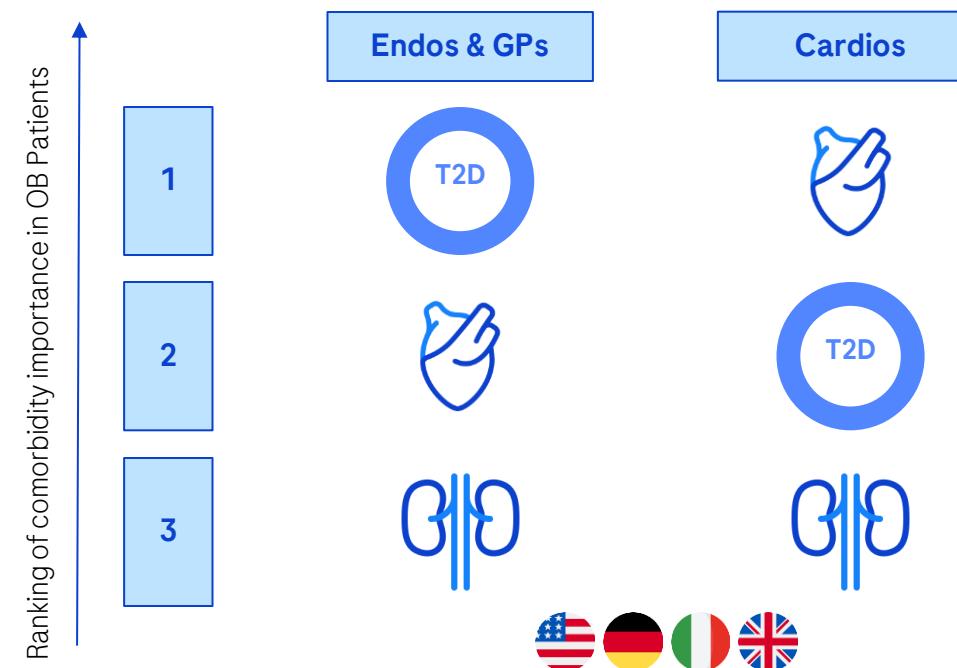
Both primary and specialty care providers are key in Obesity

>50% of US GLP-1 prescribers are primary care providers, with different priorities than specialists

Distribution of US GLP-1 prescribers by setting¹



Current ranking of comorbidity importance²



Comorbidity importance varies by specialties:

- Cardiac comorbidities have the largest impact on mortality
- The knock-on impact of T2D on the heart, liver and kidney makes it also a treatment priority, even more in the context of Incretins



Reimbursement and out-of-pocket market

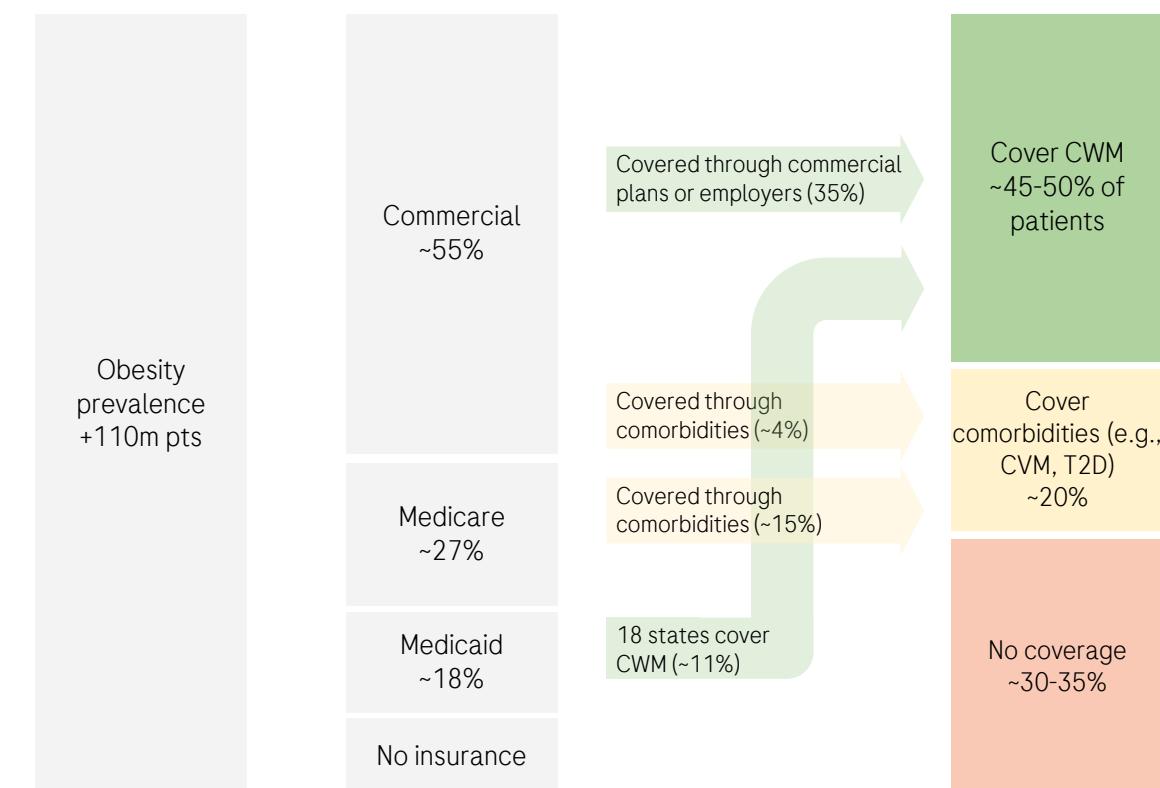
Obesity is not an established disease for reimbursement across countries

AOM coverage status in key countries

Chronic disease	Reimbursement
	✓ ✓ ²
	X X
	X Restricted
	✓ X
	✓ X
	X Restricted
	✓ X



US AOM coverage, % of patients¹



1. IQVIA and market research; 2. Medicare is legally blocked from reimbursing AOMs; AOM: Anti-obesity medication; CVM: Cardiovascular, metabolism; CWM: Chronic weight management; T2D: Type-2 diabetes

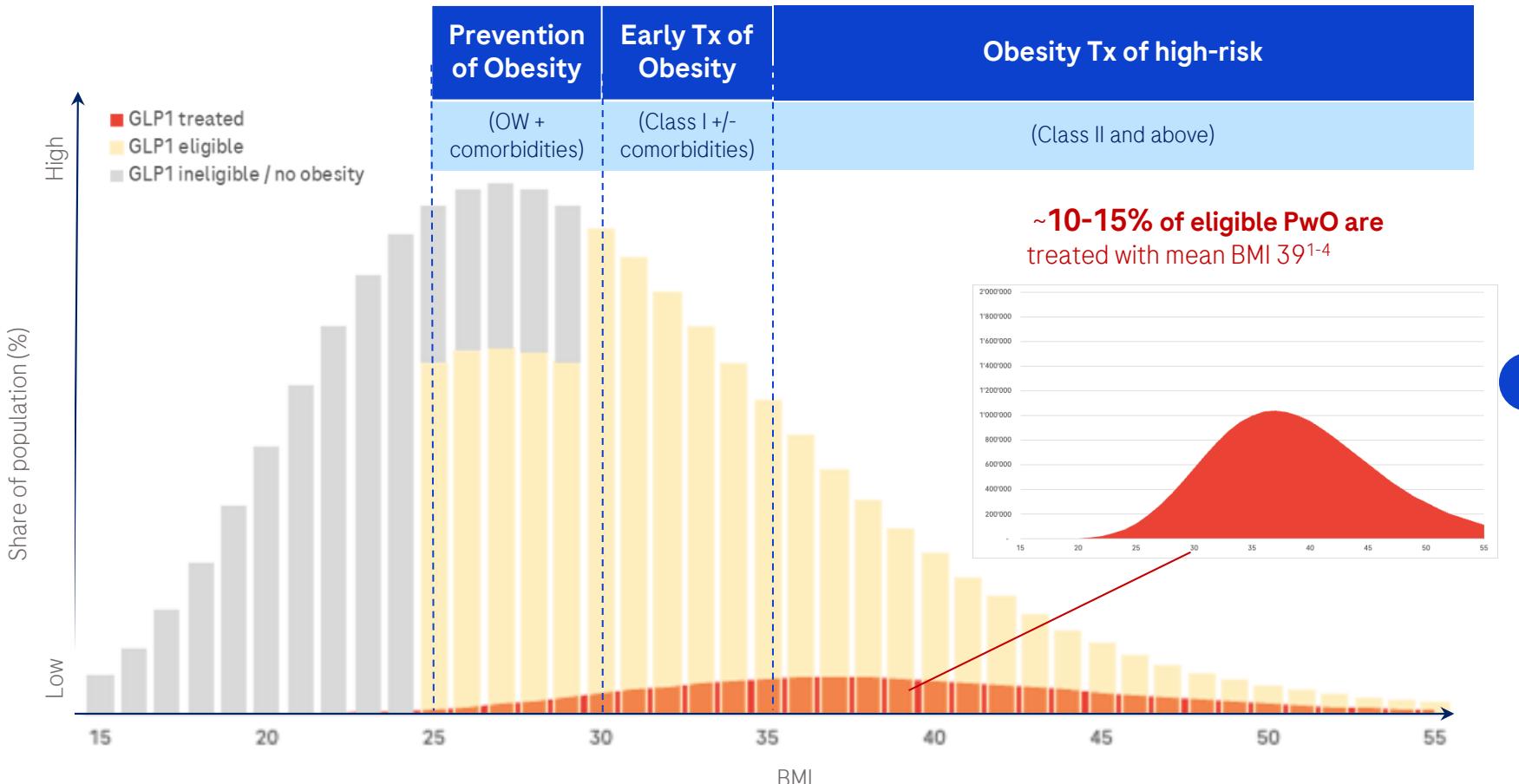


The global Obesity epidemic presents a monumental challenge

Only small population currently served, with expected expansion towards preventative treatment

BMI distribution, AOM eligibility and GLP-1 usage¹

[Illustrative]



51%

The **majority of the global population** will be living with either overweight or obesity by 2035 if current trends continue²

\$4.3 Trillion

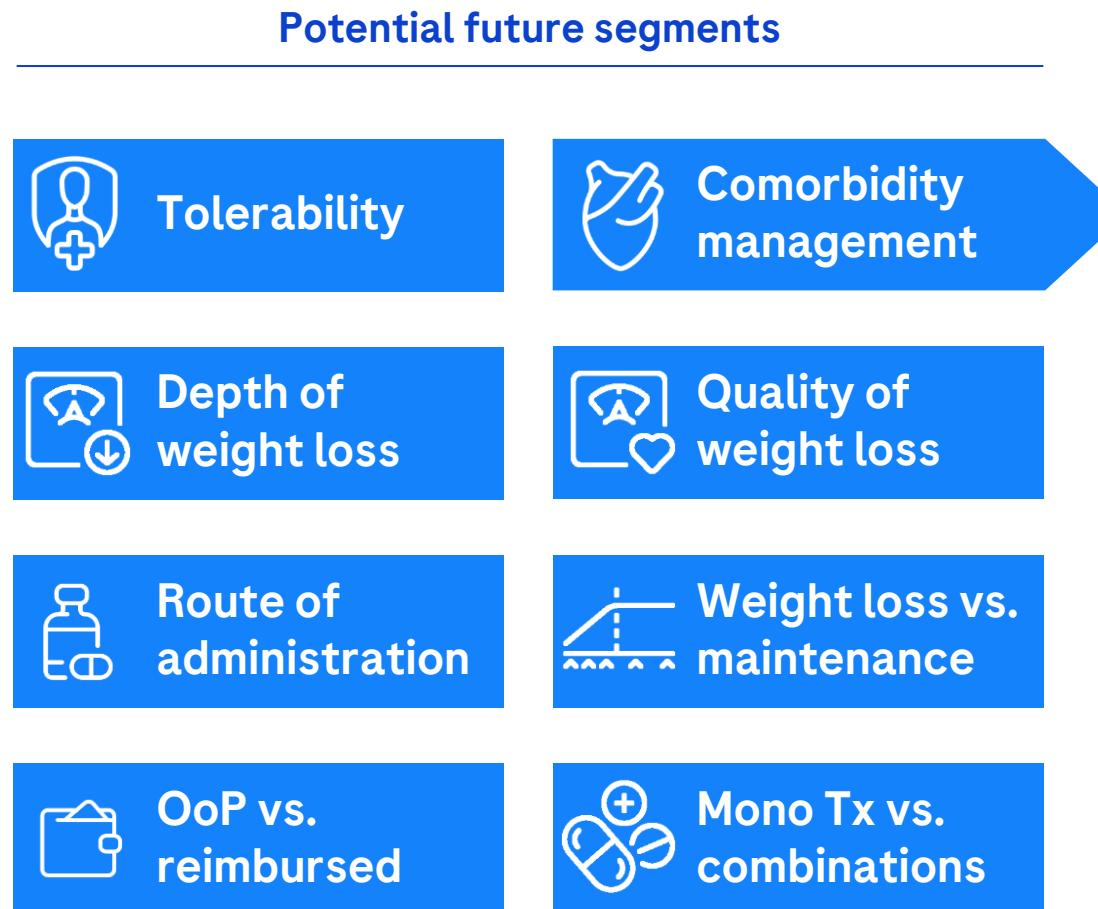
The global **economic impact of obesity** could reach \$4.3 trillion annually by 2035, if prevention and treatment measures do not improve²

*Note: Graph is illustrative. The general population BMI is modeled on national public health statistics from a large, developed market. AOM eligibility is assumed based on large-scale real-world data analysis and corroborated by findings on co-morbidity prevalence in overweight populations (Yao et al., Lancet 2025). Current GLP-1 treatment rates are estimated from published data in a developed market (Yeo et al. 2024). The treated population's higher BMI profile is modeled on findings from a recent large-scale study in a leading medical journal (Kim et al. 2025). Tx rate excludes compounding. References: 1. FAIR Health. Obesity and GLP-1 Drugs: A FAIR Health White Paper, 2024 2.RAND Corporation. The Rise of GLP-1s: The Truth About the New "Ozempic" Drugs for Weight Loss, 2024. 3. KFF Health Tracking Poll May 2024: The Public's Use and Views of GLP-1 Drugs, 2024 4. Cartwright, C. et al. A Systematic Literature Review of Utility Values for Health States Related to Overweight and Obesity, ISPOR Europe, 2023 5. World obesity atlas 2023. March 2023.

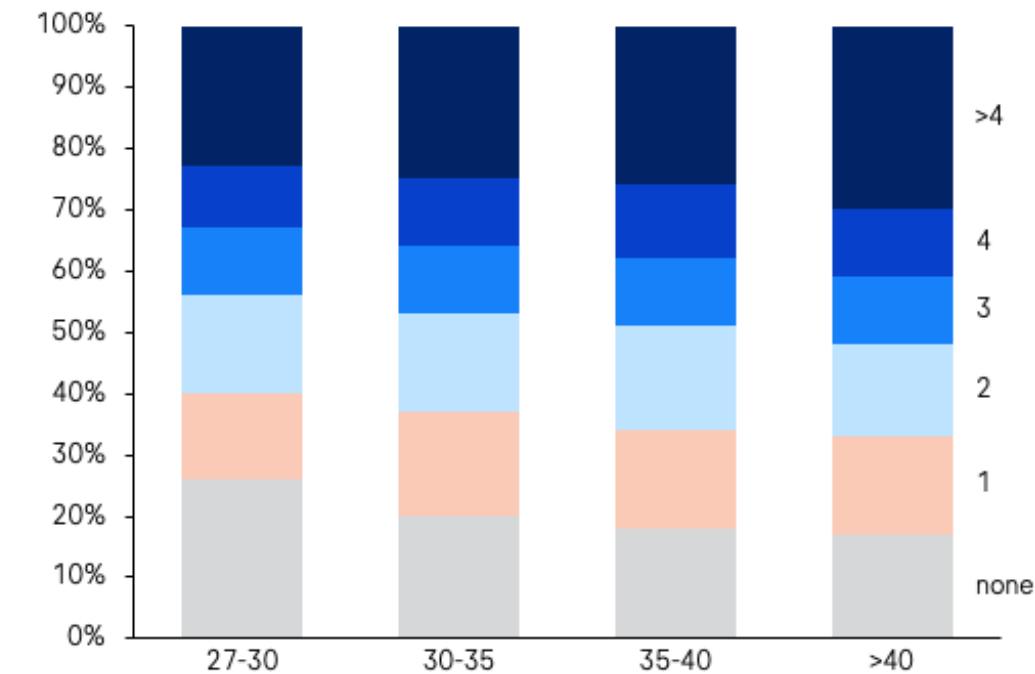


Significant market fragmentation is expected

>70% of PwO have at least one comorbidity which may impact treatment choice



Number of comorbidities by BMI cohort (US population), #¹



Higher BMI is associated with a larger number of comorbidities (generally also of higher severity) - only a modest percentage of PwO have no comorbidities



Obesity is a major risk factor for a range of diseases

>220 complications and comorbidities are associated with Obesity¹

Metabolic disease

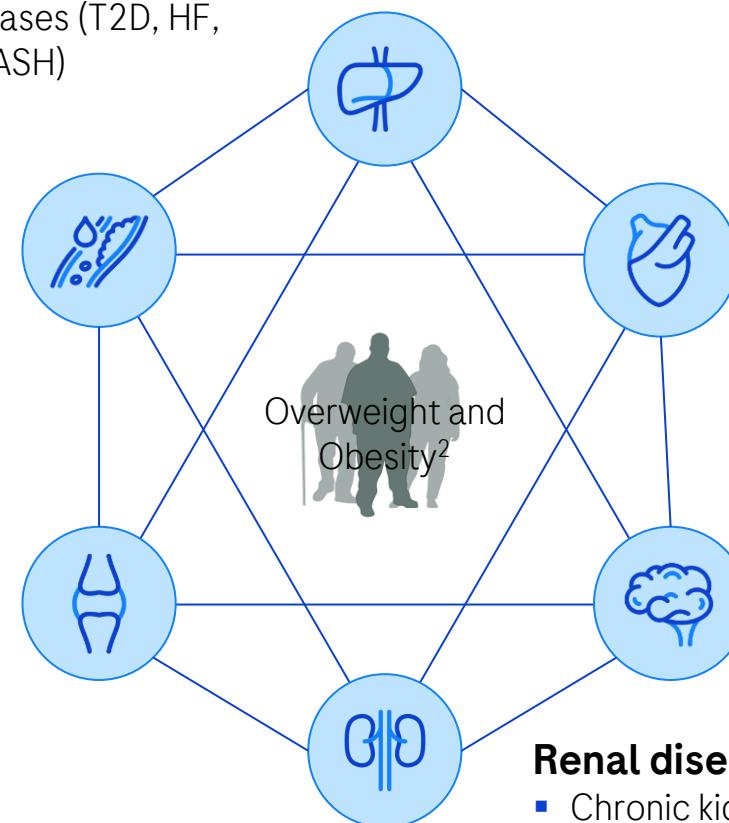
- Metabolic syndrome
- Associated diseases (T2D, HF, dyslipidemia, MASH)

Atherosclerosis

- Systemic atherosclerosis
- Intracranial atherosclerosis
- Stroke

Mechanical & Musculoskeletal

- Osteoarthritis
- Degenerative joint disease
- Reduced mobility and chronic pain
- Sleep apnea (OSA)



Cardiovascular disease*

- Hypertension
- Myocardial infarction
- Ischemic cardiomyopathy
- Heart failure

Neurodegeneration* and mental health

- Parkinson's disease
- Alzheimer's disease
- Depression

Renal disease

- Chronic kidney disease

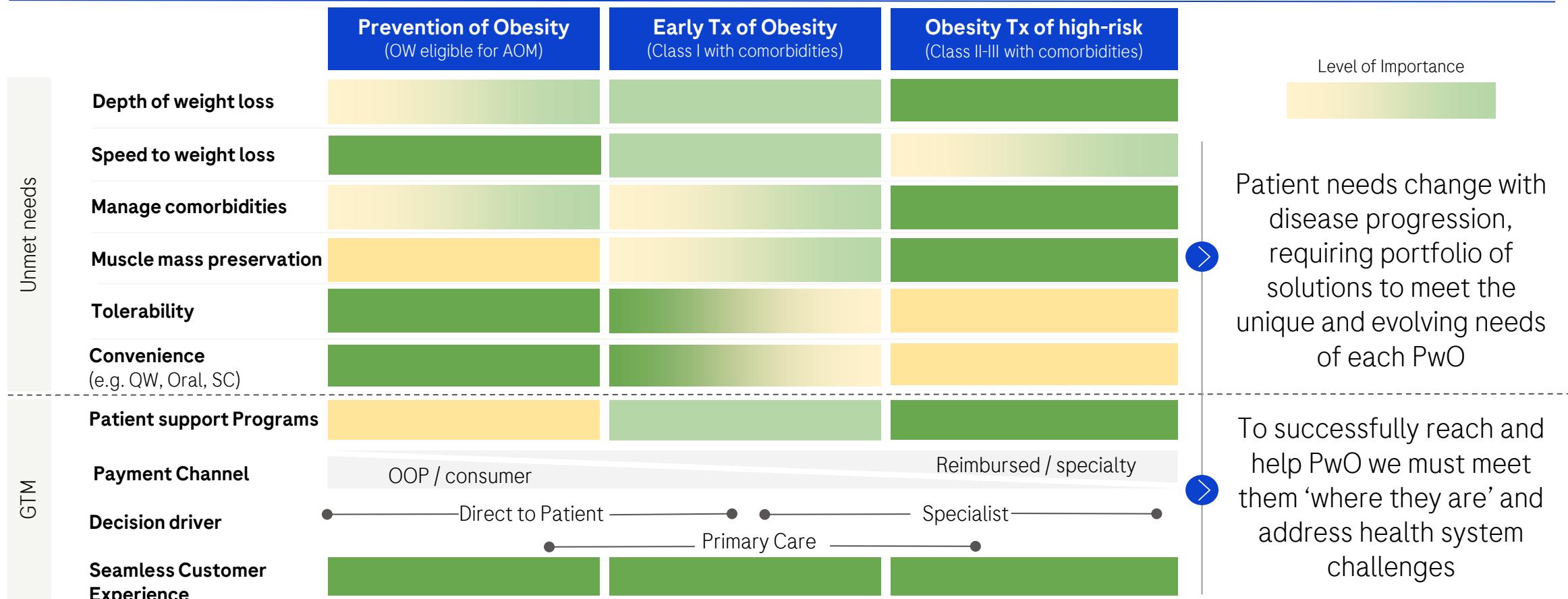
1. American Medical Association 2024: <https://www.amaassn.org/topics/obesity>; 2. Modified from Yusuf S, et al.. Lancet, 2020; * Does not apply to hereditary diseases. HF: Heart failure; MASH: Metabolic dysfunction-associated steatohepatitis; OSA: Obstructive sleep apnea; T2D: Type-2 diabetes



A patient-centric approach is key to meet the evolving needs of PwO

Shifting from “one-size-fits-all” to tailored solutions for diverse patient needs

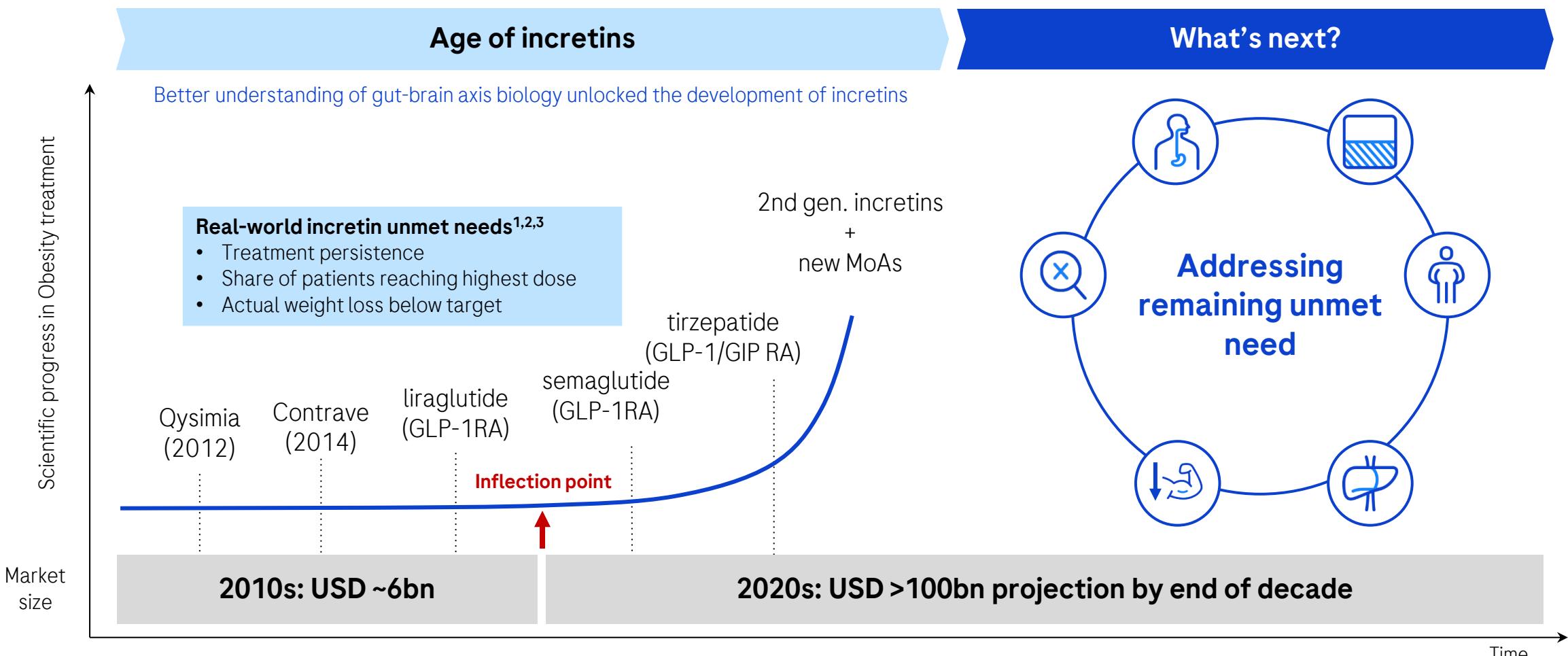
Patient profiles based on point in AOM journey, unmet needs & GTM considerations





Incretins have unlocked a new era in Obesity treatment

Significant unmet need remains, requiring new treatment options, modalities and combinations



1. Blue Health Intelligence, 2024, Real-world Trends in GLP-1 Persistence and Prescribing for Weight Management, May 2024; 2. LifeSci Capital Survey, May 2024; 3. IQVIA, June 2025; MoA: Mechanism of action



Incretins offer many benefits, but come with some limitations

Unmet need for next-gen incretins, combination therapies, and novel mechanisms of action

Tolerability

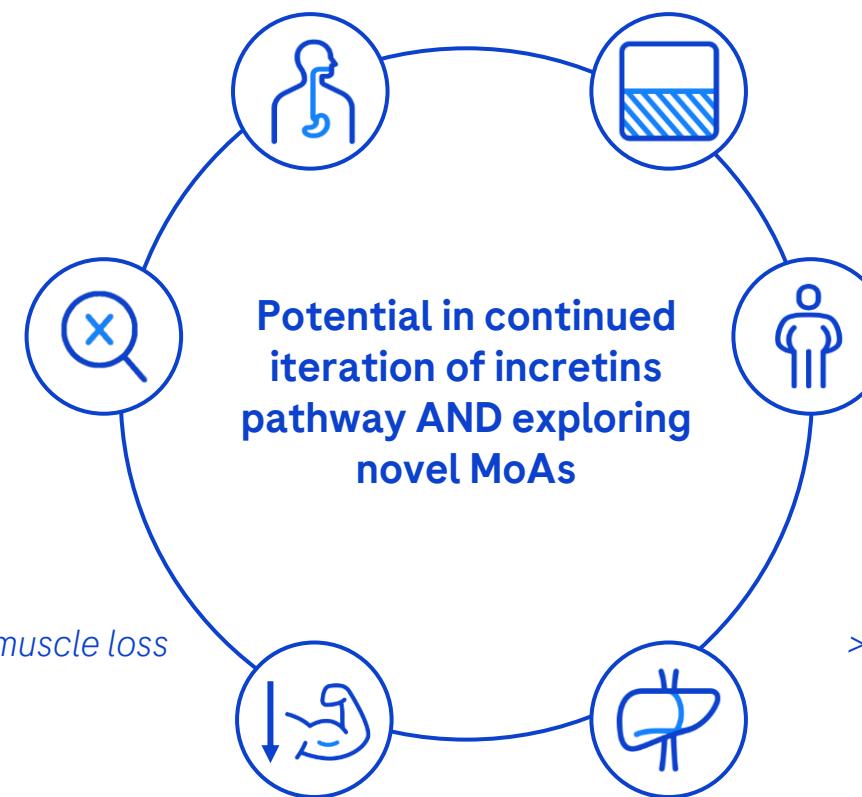
e.g. nausea/emesis is a main driver for discontinuation

No or suboptimal response

to incretins in up to 20%¹ of patients

Lean muscle loss

Up to 40% of weight loss comes from muscle loss



Ceiling effect on weight loss

e.g., weight loss plateaus after 12–18 months

Weight maintenance

Majority of patients regain weight after stopping treatment



Our near-term portfolio offers a strong foundation

Our differentiation potential relies on the breadth of options to address patient needs

Tolerability

e.g. nausea/emetisis is a main driver for discontinuation

petrelintide	CT-388
CT-388 + petrelintide	

No or suboptimal response

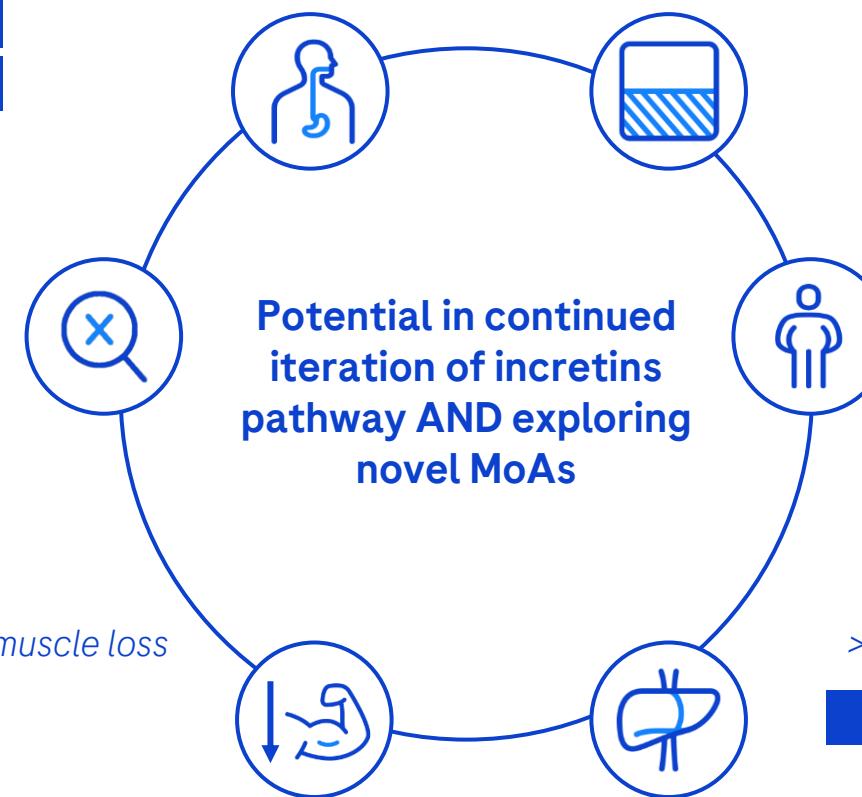
to incretins in up to 20%¹ of patients

petrelintide	CT-388 + petrelintide
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Lean muscle loss

Up to 40% of weight loss comes from muscle loss

incretin + emugrobart



Ceiling effect on weight loss

e.g., weight loss plateaus after 12–18 months

petrelintide	CT-388
CT-388 + petrelintide	

Weight maintenance

Majority of patients regain weight after stopping treatment

petrelintide	CT-388	CT-996
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Comorbidities

>70% of PwO have at least one comorbidity

CT-388	petrelintide	CT-388 + petrelintide
pegozafermin*		incretin + pegozafermin*

*pending deal closure; Source: Market research (2025); 1. SURMOUNT-1 study shows there are up to 20% of incretin inadequate responders (at week 12); MASH: Metabolic dysfunction-associated steatohepatitis; MoA: Mechanism of action; PwO: People with obesity



Our capabilities strongly position us to deliver in Obesity



Best-in-disease potential



Synergies across TAs



Manufacturing and supply chain



Global commercial footprint



End-to-end patient journey

Multiple pipeline assets with BIC and BID potential as monotherapy and/or combinations

Leverage potential of combinations with in-house assets, including future commercialization

Robust manufacturing and supply network with additional capacity build up to ensure future-readiness

Commercial presence and digital footprint in >150 countries with strong relationships with key local stakeholders

Utilize our unique combination of Pharma and Diagnostics divisions to create differentiated value

Roche committed to become a top 3 player in Obesity

Progress since Pharma Day 2024

Pharma strategy and on-market portfolio update

Obesity strategy

Future growth opportunities

8 NMEs new to Ph III in 2025 YTD

Increased value potential of post Bar NMEs entering Ph III

NXT007 in hemophilia A	cevostamab in R/R MM	trontinemab in AD	prasinezumab in PD	zosurabalin in MDR bacterial inf.	zilebesiran in hypertension	CT-388 in obesity	pegozafermin in MASH*
Onc/Heme	Onc/Heme	Neurology	Neurology	Immunology	CVRM	CVRM	CVRM
Potential for BID and to achieve zero treated bleeds	Novel FcRH5xCD3 bispecific with potential for FIC	Rapid and robust amyloid lowering with low ARIA E risk	First potential disease modifying therapy in PD	Potentially first new class of antibiotics against gram neg. bacteria in 50 years	Novel therapy targeting AGT for continuous control of BP	Clinical data support development in T2D and Obesity, including as backbone Tx	FGF21 analog engineered to balance efficacy and extended dosing
Ph III to initiate 2026	Ph III to initiate 2026	Ph III initiated in Sep 2025	Ph III to initiate Q4 2025	Ph III to initiate 2026	Ph III to initiate Q4 2025	Ph III to initiate H1 2026	Ph III ongoing

*pending deal closure; AD: Alzheimer's disease; AGT: Angiotensin; BP: Blood pressure; BID: Best-in-disease; FIC: First- in-class; T2D: Type-2 diabetes; MDR: Multidrug-resistant; MM: Multiple myeloma; NME: New molecular entity; PD: Parkinson's disease; R/R: Relapsing/Remitting; Tx: Treatment

Consensus outlook 2024-29*

Growth driven by our young on-market portfolio; potential pipeline up-side



*All estimates are based on Post HY 2025 consensus collected by FTI Consulting on behalf of Roche (n=17) differences may occur due to rounding;

1. Elevidys consensus sales growth ex-US; 2. Activase/TnKase, Pulmozyme, CellCept, Xofluza, Rozlytrek, Mircera; 3. included in >50% of sell-side models; 4. pending deal closure

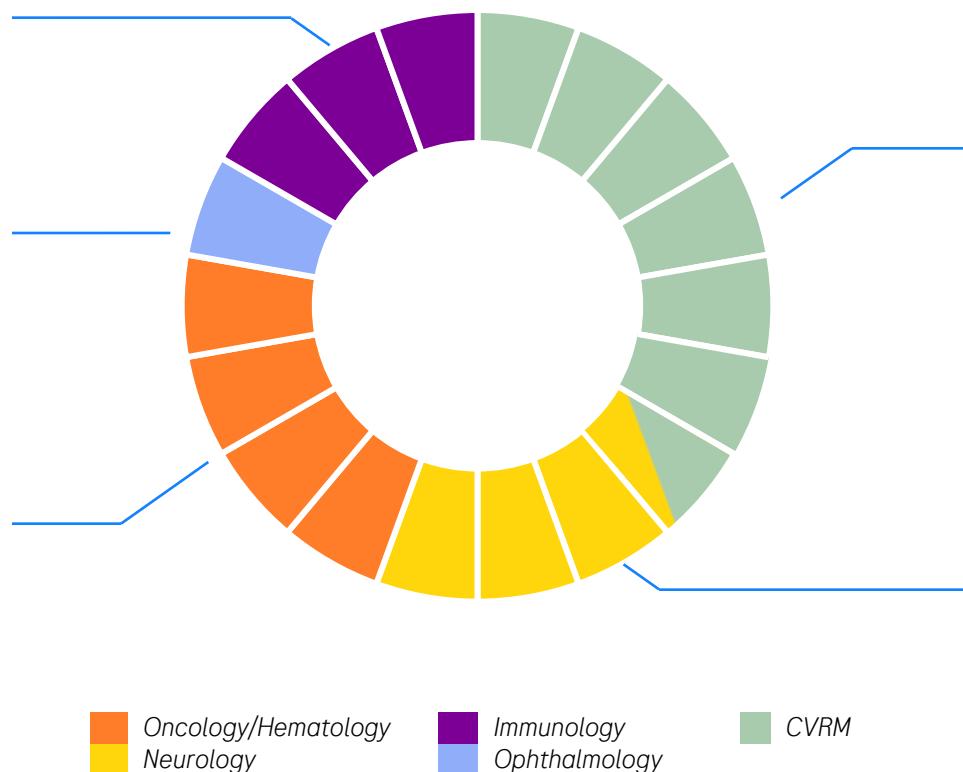
Up to 18 NMEs with launch potential by 2030

Including 15 NMEs with blockbuster potential

afimkibart IBD, AtD, AD, MASH	
sefaxersen IgAN	
zosurabalin Bacterial infections	
vamikibart UME	
giredestrant HR+ BC	
NXT007 Hemophilia A	
divarasib KRAS+ NSCLC, CRC	
cevostamab R/R MM	

0.5-1bn peak sales
2-3bn peak sales

1-2bn peak sales
>3bn peak sales



CT-388 Obesity +/- T2D	
CT-868 T1D with BMI ≥25	
CT-996 Obesity +/- T2D	
petrelintide* Obesity +/- T2D	
zilebesiran Hypertension	
pegozafermin** MASH	
trontinemab Alzheimer's disease	
prasinezumab Parkinson's disease	
fenebrutinib RMS, PPMS	
emugrobart SMA, FSHD, obesity	



R&D Excellence

Levi Garraway

EVP, Global Head of Product Development and Chief Medical Officer

Recap: Our 2030 ambition

R&D Excellence is accelerating our path to a more productive R&D engine



Consistently deliver many of the world's **most impactful medicines** (20 transformative medicines¹ by end 2029)



Reach **top-quartile performance** in R&D productivity across the biopharma industry

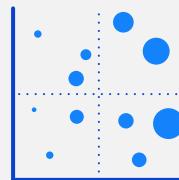


1. Reaching 'Bar' criteria: Future medicines that can have high impact for patients, high revenue potential, and optimized risk

R&D Excellence: Our solutions

All seven solutions are now being actively implemented across the enterprise

Adopt a unified portfolio framework



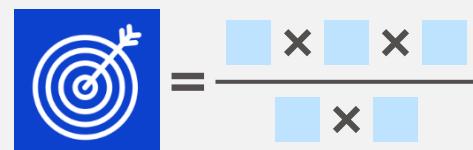
Transform our portfolio management & governance



Access the best external innovation



Embrace ambitious R&D objectives



Evolve our R&D engine and invest in its excellence



Align our incentives with the new R&D strategy



New vs. 2024

Build a simplified system landscape and data foundation



Implemented and moving into business as usual

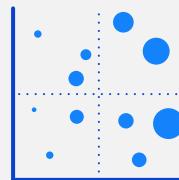


Implementation in progress

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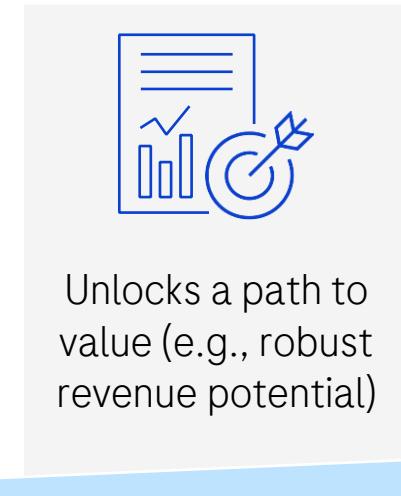
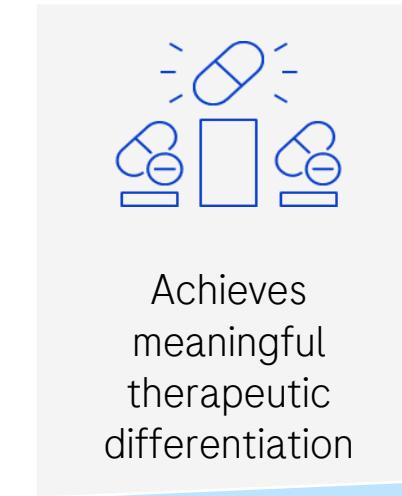
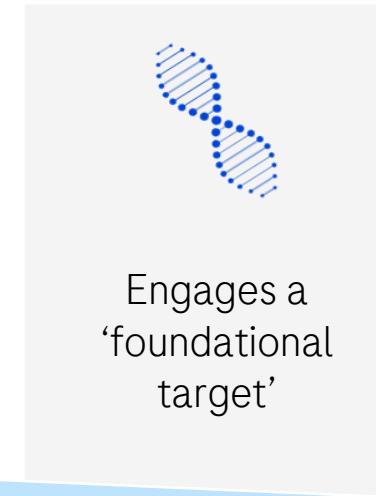
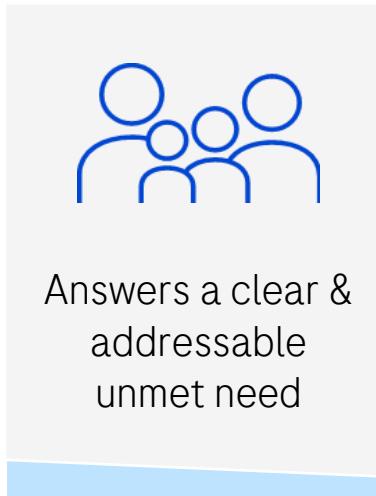


Implementation in progress



Prioritizing transformative assets with the Bar

The merits of the Bar are driving alignment and focus



Full adoption and early impact seen

100% adoption in Research and Development, enforced via Governance Boards

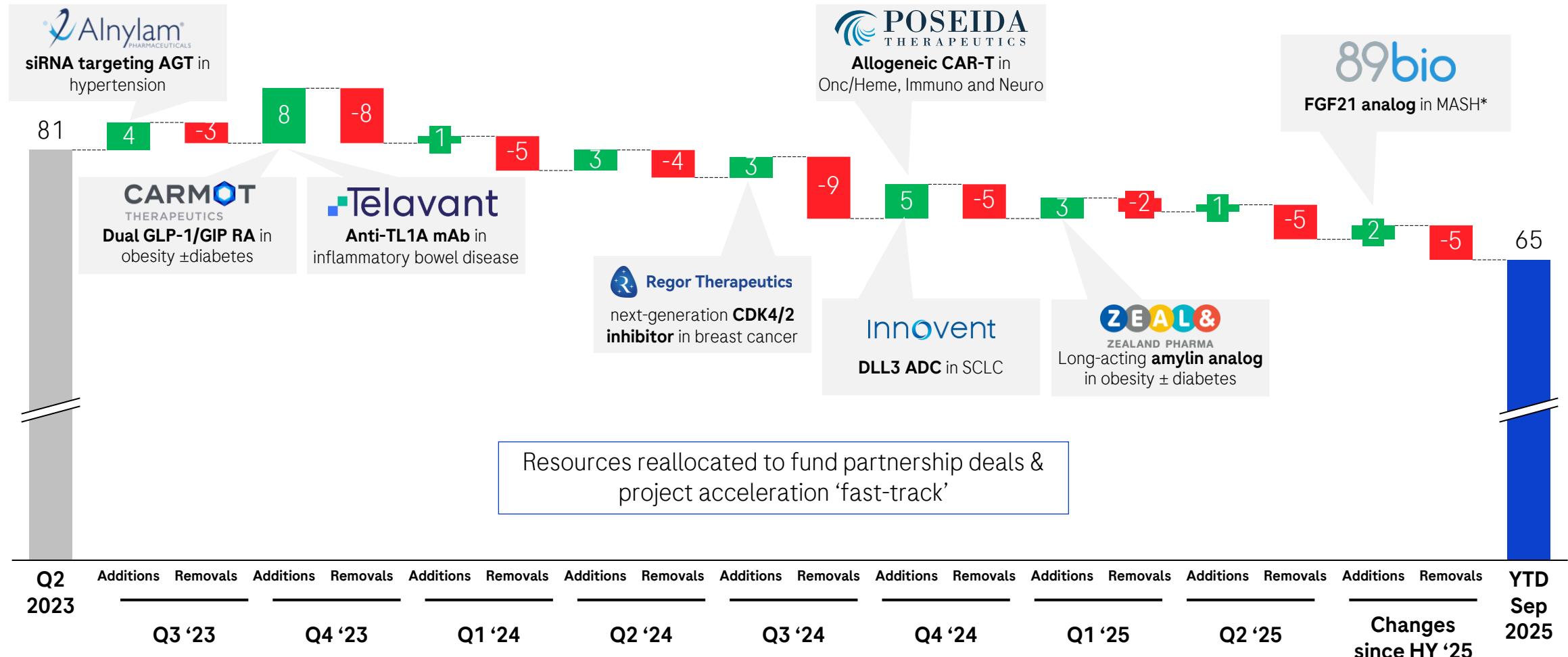
Sharper focus on critical aspects

Recent updates sharpen the focus on the 'crux' (single most important risk of program), path to value, and therapeutic differentiation



Pipeline prioritization since start of R&D Excellence

Focus on high-impact projects and resource allocation to partnerships and fast-track initiatives



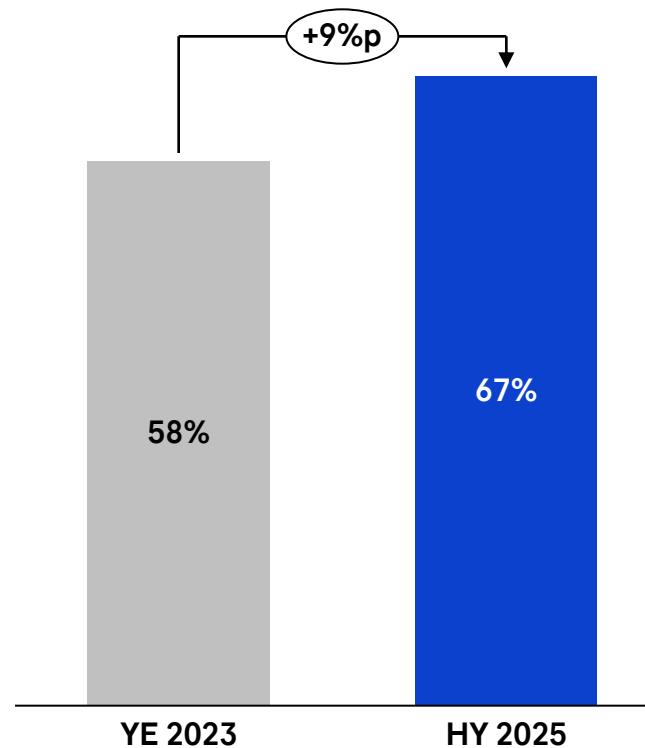
*pending deal closure; ADC: Antibody-drug conjugate; AGT: Angiotensinogen; CDK4/2: Cyclin dependent kinase-4/2; GIP: Glucose-dependent insulinotropic polypeptide; GLP-1: Glucagon-like peptide-1; mAb: Monoclonal antibody; NME: New molecular entity; RA: Receptor agonist; SCLC: Small-cell lung cancer; siRNA: Small interfering RNA; TL1A: Tumor necrosis factor-like cytokine 1A; Note: Chart Includes all assets from Ph I to Registration



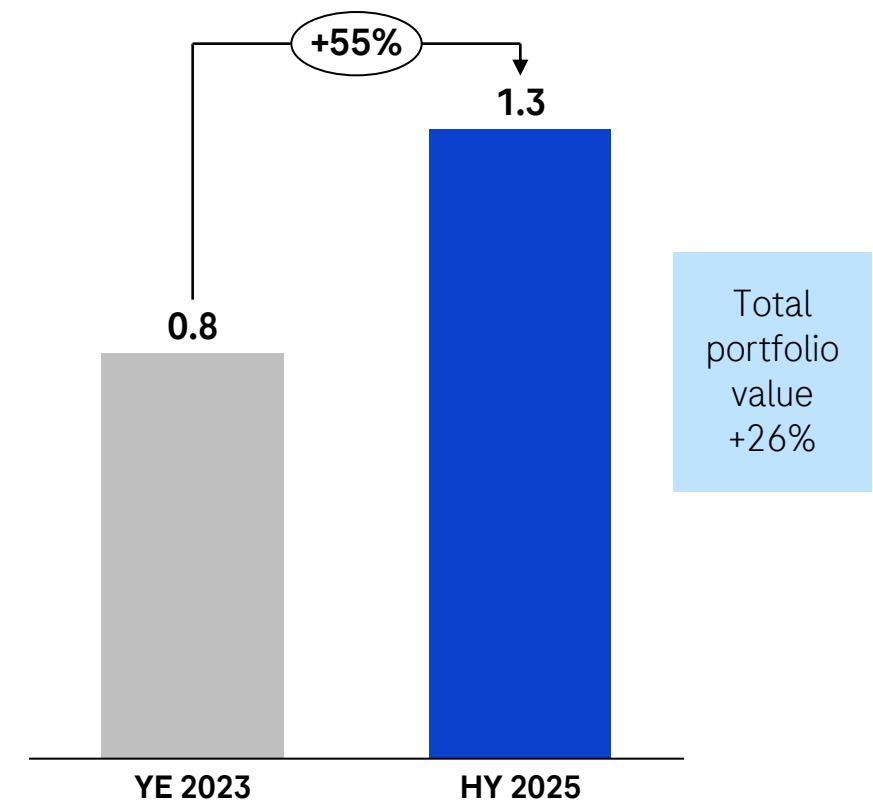
Pipeline evolution since YE 2023

Growing share of potential best in disease assets and increasing peak sales for pipeline projects

Share of late-stage projects with BID potential¹



Average peak sales per pipeline project, CHFbn²

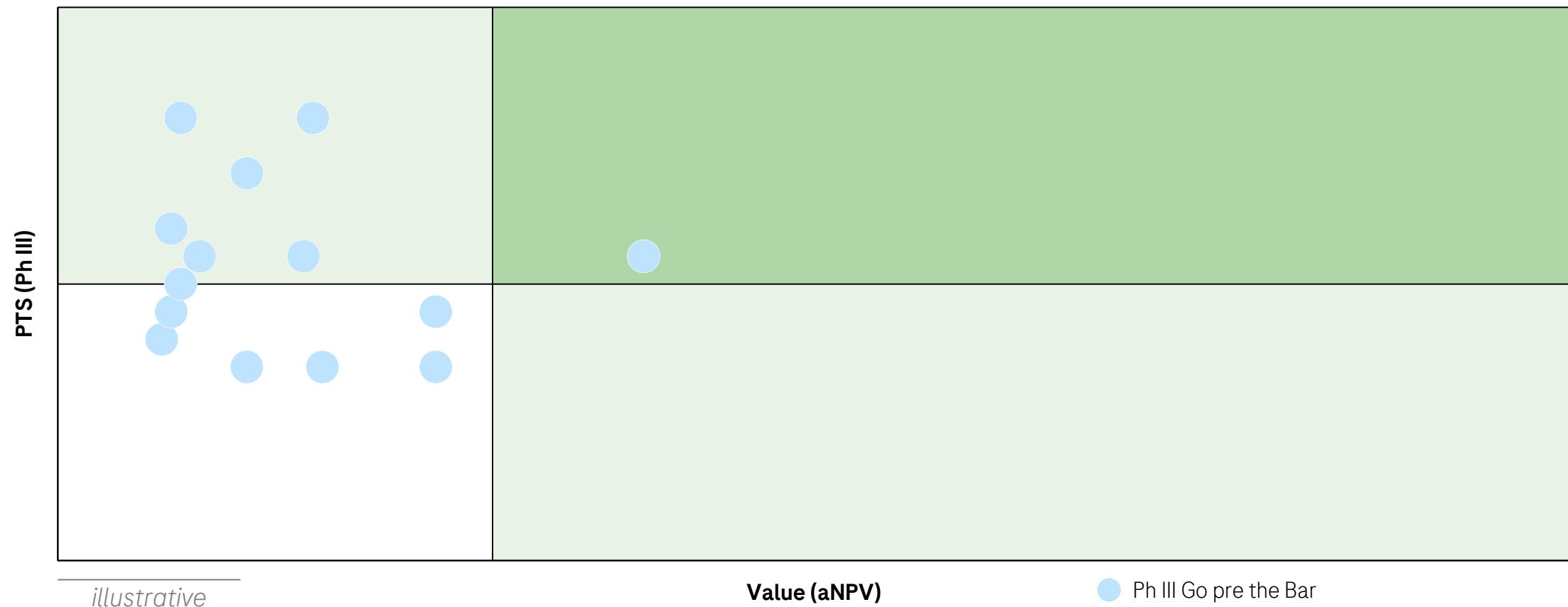




Overall portfolio shift - before introduction of the Bar

Shifting portfolio to higher value and more balanced risk as a result of these combined solutions

Risk-reward profile of assets with Ph III Go decisions pre introduction of the Bar¹, NMEs only



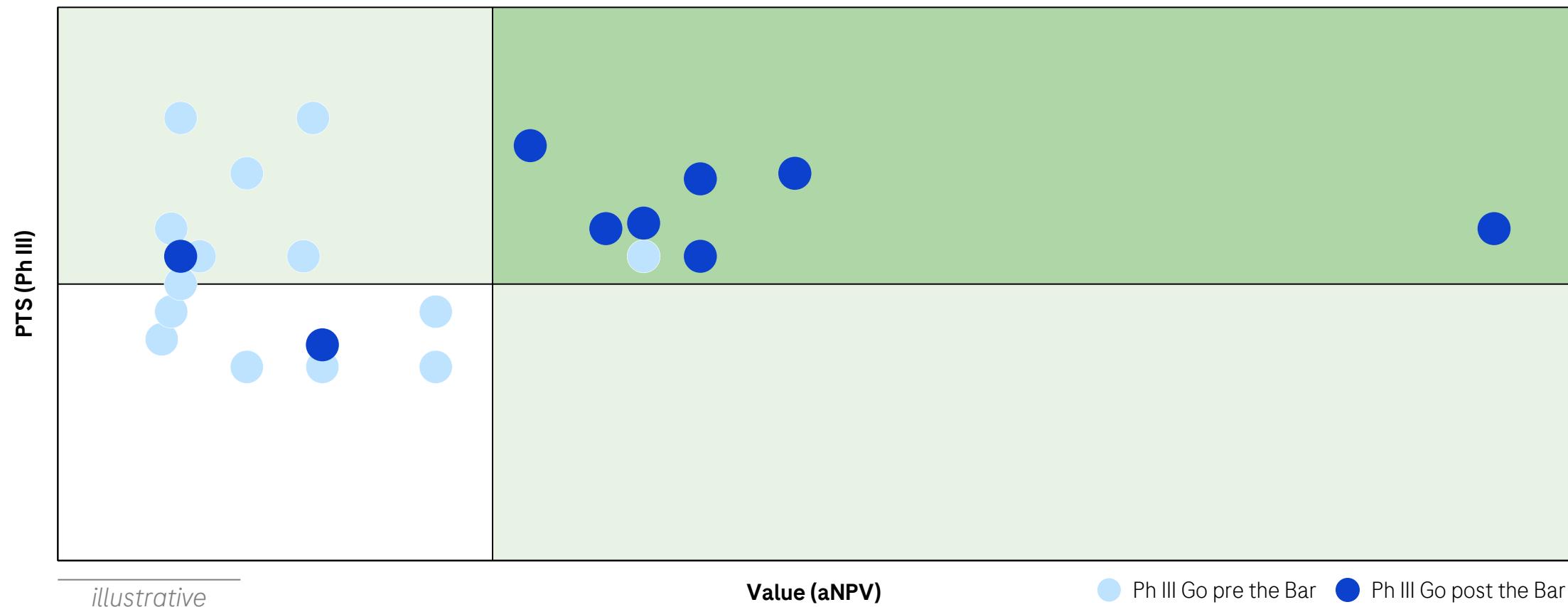
1. Based on all NMEs with Ph III Go decision since 2019, cut-off for pre the Bar at start of 2024; aNPV: Risk-adjusted net present value (accounting for probability of launch); NME: New molecular entity; PTS: Probability of technical success



Overall portfolio shift - after introduction of the Bar

Shifting portfolio to higher value and more balanced risk as a result of these combined solutions

Risk-reward profile of assets with Ph III Go decisions post introduction of the Bar vs pre the Bar¹, NMEs only

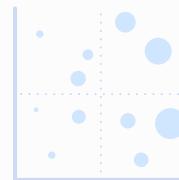


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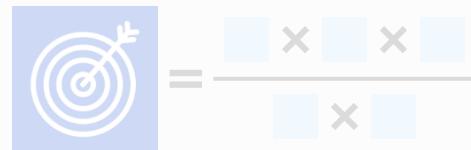
Transform our portfolio management & governance



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Evolve our R&D engine and invest in its excellence



Align our incentives with the new R&D strategy



New vs. 2024

Build a simplified system landscape and data foundation



Implemented and moving into business as usual



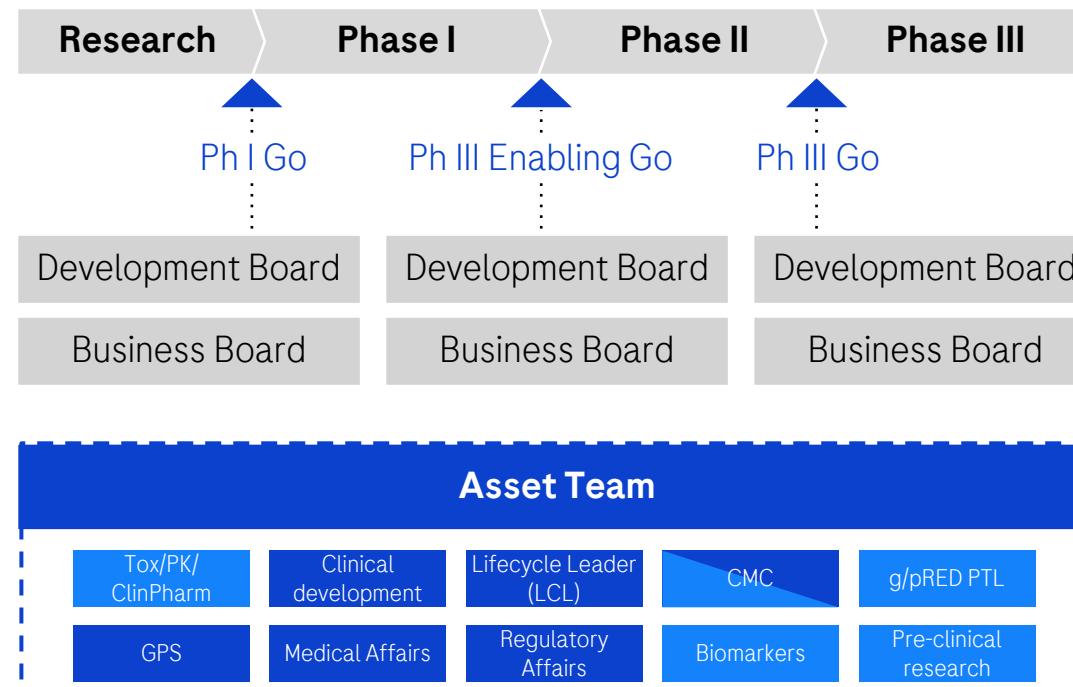
Implementation in progress



New governance and E2E portfolio management implemented

Development & Business Boards shape our portfolio with broad adoption across R&D

Portfolio Governance



Disease area specific boards assess E2E alignment

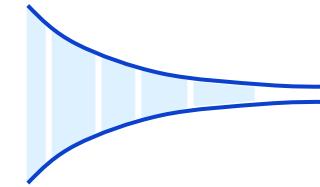
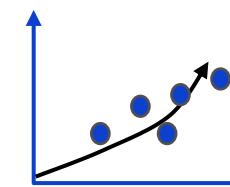
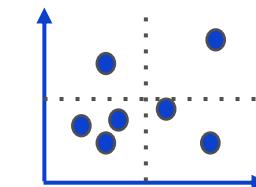
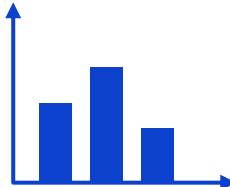
- Asset teams have a fluid, fit-for-purpose, membership spanning early to late-stage development roles strengthening E2E thinking
- Development Boards rigorously assess E2E asset strategies and clinical development plans
- Business Boards provide expertise on commercial value drivers, barriers and risks



Assessing the health of our overall portfolio

Ensure long term portfolio health to reach our ambitions and drive sustainable value creation

Portfolio health framework

Components	Volume and value	Transformative potential	Risk / reward	Strategic fit
Key success factor				



Zilebesiran Ph III Go decision based on meeting the Bar criteria

Ph III trial informed by comprehensive KARDIA data set from 3 Ph II studies: KARDIA-1, KARDIA-2 and KARDIA-3

The Bar	Zilebesiran
	Answers a clear & addressable unmet need <ul style="list-style-type: none">HTN is the #1 modifiable risk factor for CV diseases. Up to 80% of patients have uncontrolled HTN. Treatment durability and adherence is a major gap
	Engages a ‘foundational target’ <ul style="list-style-type: none">Angiotensinogen targets upstream of RAAS cascade, a major blood pressure control pathway (supported by KARDIA-1/2/3)
	Possesses worthy pharmacologic & developability characteristics <ul style="list-style-type: none">Twice-yearly subcutaneous dosing, encouraging safety profile, profound AGT silencing (supported by KARDIA-1/2/3)
	Achieves meaningful therapeutic differentiation <ul style="list-style-type: none">Uncontrolled HTN patients (KARDIA-3) with established CVD and high risk of future events; combination with diuretics (KARDIA-3)
	Unlocks a path to value <ul style="list-style-type: none">Peak sales potential CHF >3bn (unadjusted)



Prasinezumab Ph III Go decision based on meeting the Bar criteria

Multiple endpoints from Ph II studies (PASADENA & PADOVA) and OLE suggest potential to delay motor progression

The Bar



Prasinezumab



Answers a clear & addressable unmet need

- >10m Parkinson's disease patients globally; no approved disease modifying therapy to slow/stop progression



Engages a 'foundational target'

- α -synuclein is a known biological driver of PD progression, as supported by preclinical data and Ph II clinical studies (e.g., PADOVA and PASADENA)



Possesses worthy pharmacologic & developability characteristics

- Potentially first in class anti- α -synuclein antibody
- Favorable safety and tolerability profile (PADOVA and PASADENA)



Achieves meaningful therapeutic differentiation

- Evidence of delayed motor progression
- Effect on top of effective symptomatics, i.e. L-DOPA (PADOVA)



Unlocks a path to value

- Peak sales potential CHF >3bn (unadjusted)



Trontinemab Ph III Go decision based on meeting the Bar criteria

Ph III in early symptomatic AD initiation planned in 2025 based on totality of data

The Bar



Trontinemab



Answers a clear & addressable unmet need

- >55m living with dementia, Alzheimer's disease accounts for ~70%. Recent treatment advances only offer moderate slowing of clinical decline



Engages a 'foundational target'

- A β as target and MoA has been validated in research and several Ph III programs of anti-amyloid monoclonal antibodies



Possesses worthy pharmacologic & developability characteristics

- Rapid, deep clearance of amyloid plaques; 91% become amyloid PET negative
- ARIA-E <5% at 28 weeks (trontinemab Ph I/Ila results)



Achieves meaningful therapeutic differentiation

- Speed and depth of amyloid reduction is unprecedented in the field
- Earlier amyloid negativity correlates with greater efficacy in a meta-analysis of Ph II/III trials



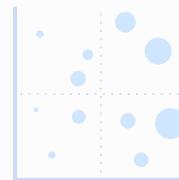
Unlocks a path to value

- Peak sales potential CHF >3bn (unadjusted)

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All seven solutions are now being actively implemented across the enterprise

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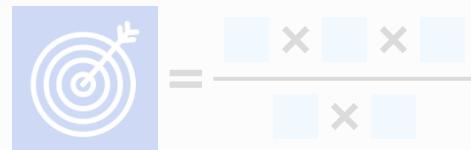
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Implemented and moving into business as usual



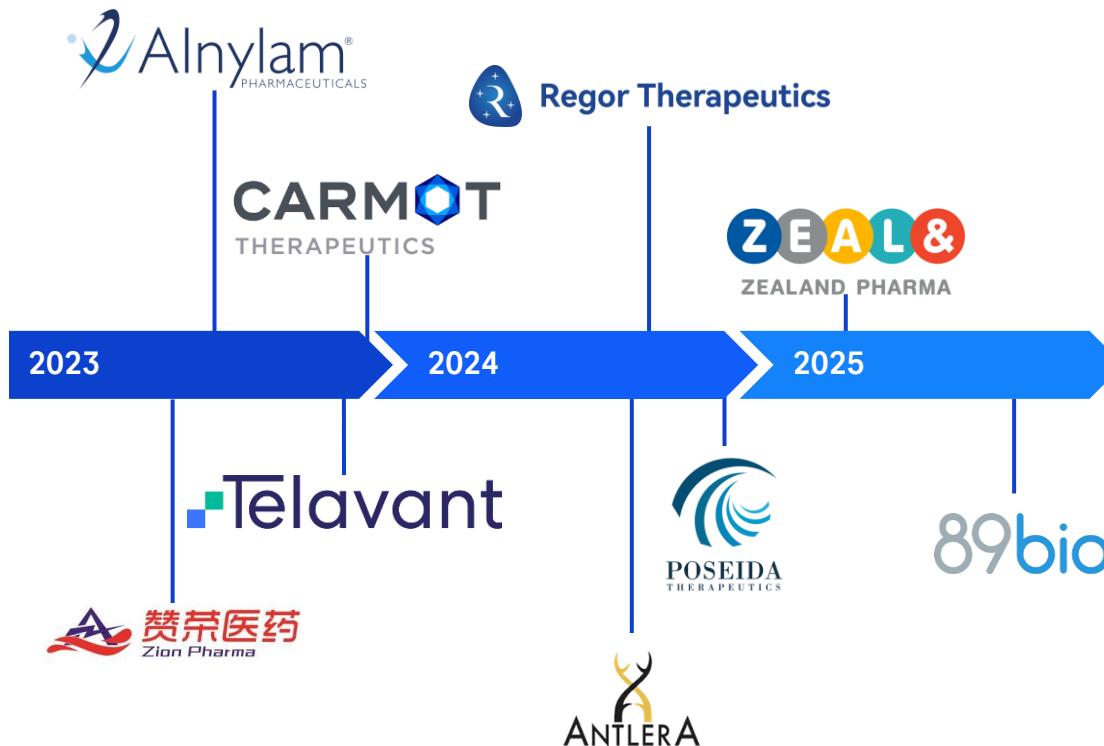
Implementation in progress



Pipeline acceleration through partnering and acquisitions

Key deals completed to complement our pipeline across our five therapeutic areas

Key deals completed since start of R&D Excellence



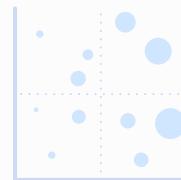
External innovation to catalyze portfolio rejuvenation

- Prioritization of assets that meet the Bar and align with Pharma Strategy, to foster a consistent approach and efficient decision making
- Strengthening of our integration process and capabilities as the 'Partner of choice' for biotech
- Stringent R&D budget control in combination with business development to catalyze portfolio rejuvenation

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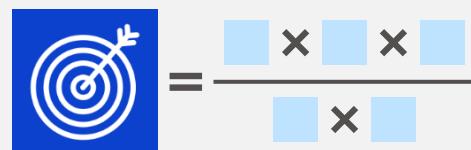
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New vs. 2024

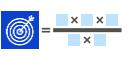
Build a simplified system landscape and data foundation



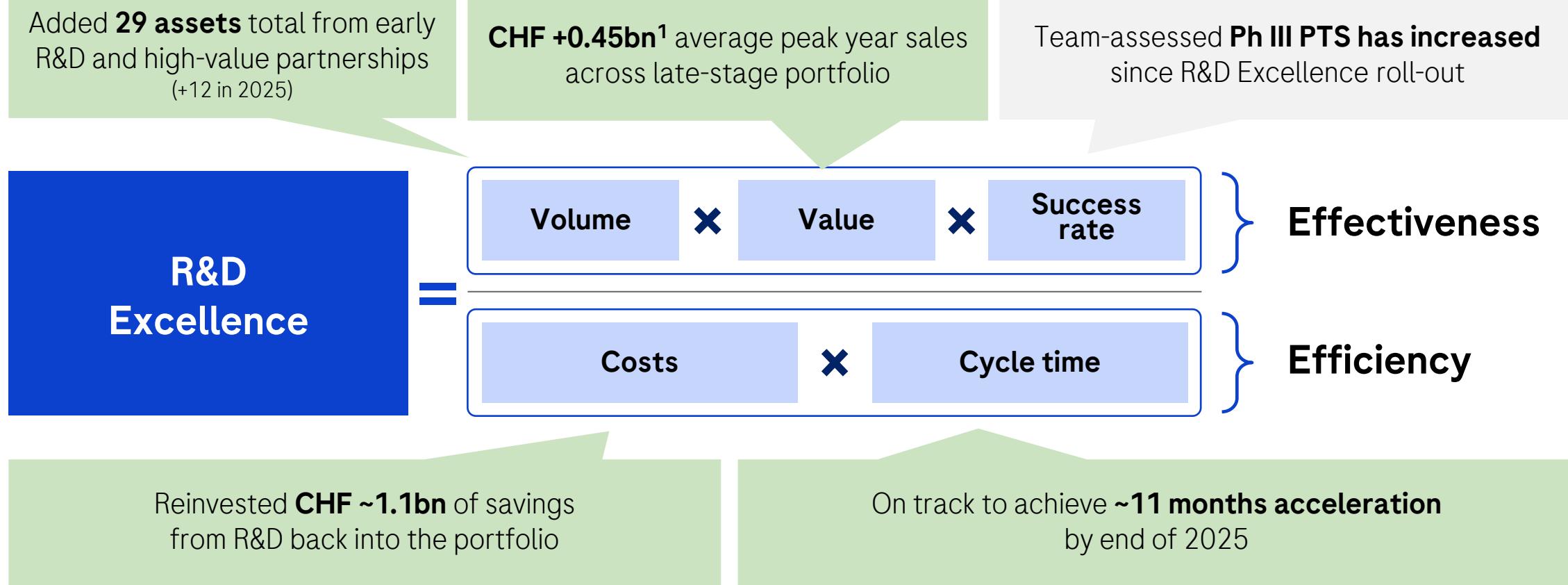
Implemented and moving into business as usual



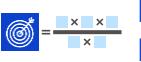
Implementation in progress



Our cumulative impact (2024 - YTD 2025)



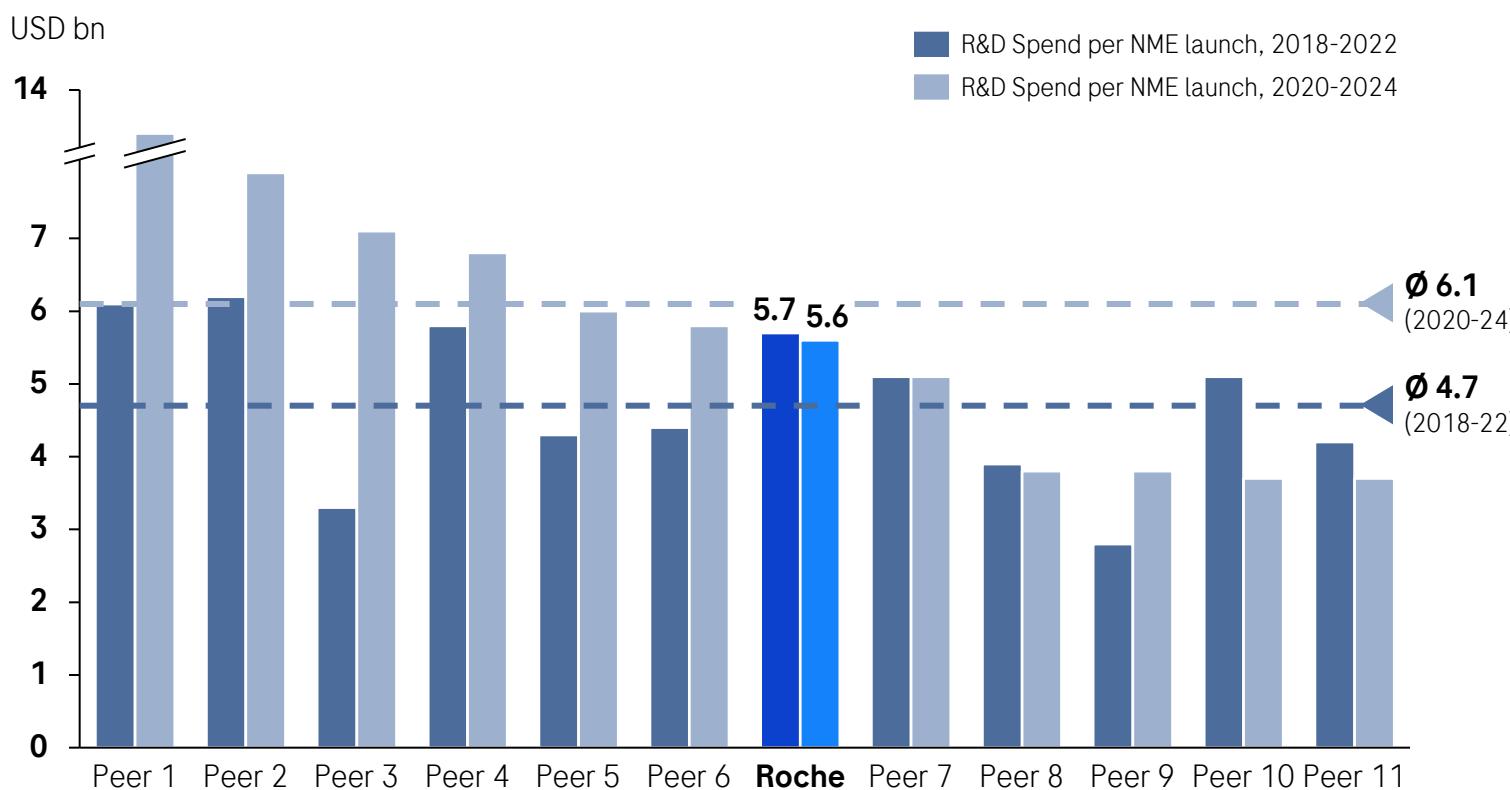
1. From CHF 0.8 bn CHF to nearly CHF 1.3 bn; PTS: Probability of technical success; PYS: Peak year sales



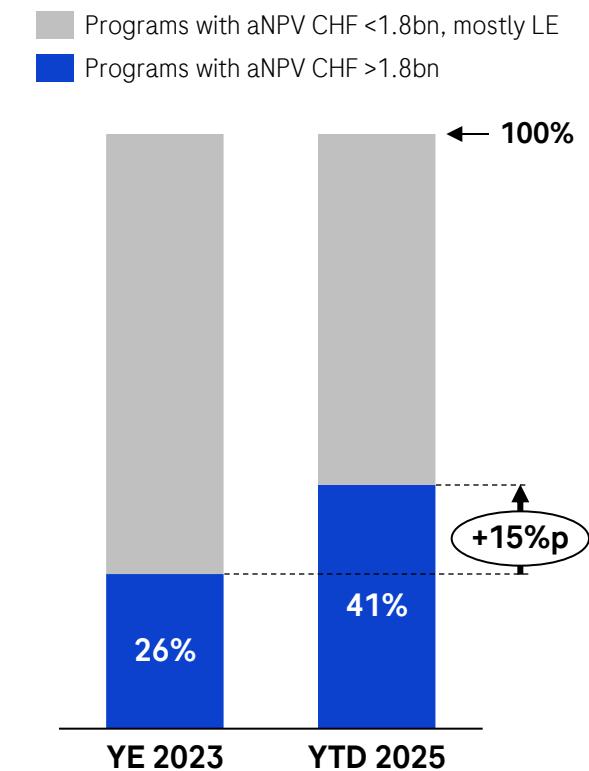
Roche beginning to reduce R&D spend per NME launch

Increasing share of R&D budget spent on high value programs since start of R&D Excellence

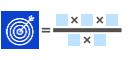
R&D spend per NME launch¹(USD bn²)



Roche: Share of Ph II/III R&D costs for high value programs (%)⁴



1. Restricted to NMEs launched 2018-23 & 2020-24 with visible revenues for that company (any year in visible forecast data). Partnered launches can be assigned to multiple companies if there are revenues associated with several player; 2. Average annual pharmaceutical R&D Spend from 2018-2022 & 2020-2024 (device and generics R&D spend excluded whenever reported separately). Pre-acquisition R&D spend for mega-merged entities (M&A USD >10bn) is included to account for NME pipeline continuity; only asset products sales included; Sources: Evaluate Pharma March 2023 / Evaluate Pharma April 2025; 3. Average of USD 5.4bn excluding outlier; 4. Analysis includes total investment in Ph II and Ph III assets based on adjusted present value of R&D investment and excludes programs without an assessed aNPV (e.g. projects with pending valuations) Source: Roche internal data; aNPV: Adjusted net present value; LE: line extension; NME: New molecular entity



Material progress achieved across all “fast-track” programs

R&D Excellence initiatives and “fast-track” jointly enable acceleration of selected assets

trontinemab

21 months

faster to filing

- Accelerated decision making for Ph III based on biomarker PoC
- Frontloaded activities to start Ph III in Q4 2025
- Pre-screen cohort through TRAVELLER (by ptau217) - ready to be recruited into Ph III

CT-388

9 months

faster to filing

- Completed Ph II recruitment within four months
- Frontloading activities to start Ph III, with Ph II interim data informing final trial design
- Ph III to be initiated in 2026

afimkibart

up to 6 months

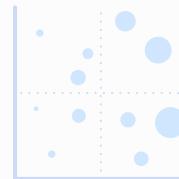
faster to filing

- Optimized study design
- Implemented a "high-touch" site engagement model with accelerated site contracting
- Fast Go decisions to explore additional indications, e.g. Ph II in rheumatoid arthritis

R&D Excellence: Our solutions

All seven solutions are now being actively implemented across the enterprise

Adopt a unified portfolio framework



Transform our portfolio management & governance



Access the best external innovation



Embrace ambitious R&D objectives



Evolve our R&D engine and invest in its excellence



Align our incentives with the new R&D strategy



New vs. 2024

Build a simplified system landscape and data foundation



Implemented and moving into business as usual



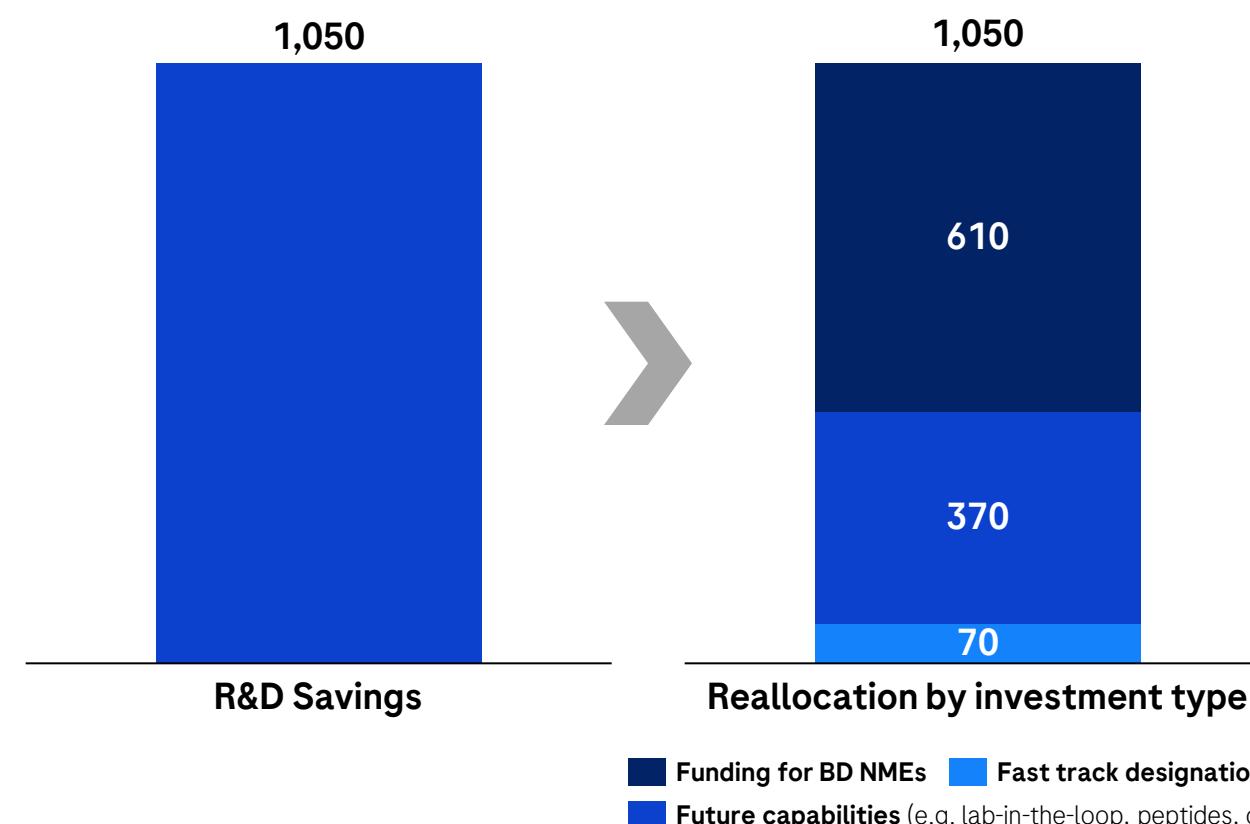
Implementation in progress



Efficiency: Resource reallocation

CHF ~1.1bn spend reallocated to transformative programs and productivity initiatives

Reallocation of the R&D budget in 2024+2025¹ (CHFm)



Reinvestment into the portfolio

- Increased the number of high value assets
- Reallocated funds to programs with transformational potential
- Cycle time²: 11 mos. acceleration since start of R&D Excellence³ (ambition 2030: ca. 50 months)
- Invested into key productivity initiatives, including new systems, automation and AI

1. Source: Internal data; Including Spark, Flatiron, RMCS, PHC; 2. Refers to cycle time from Lead Identification and Lead Optimization to end of Phase 3; 3. Estimate for FY 2025 based on currently achieved cycle acceleration; AI: Artificial intelligence; BD: Business development; NME: New molecular entity



New CRO model delivers on speed, site experience, efficiency & quality

Increased efficiency expected to deliver CHF ~300m in annual savings by 2030



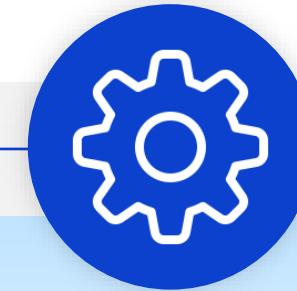
Speed

On track to deliver 20% acceleration of study startup timelines, anticipating to reach top quartile industry performance by 2028



Site experience

Enabling industry-leading site experience with OneRoche approach to site interactions



Efficiency

Achieving efficiency gains leading to annual cost reductions; already achieved CHF ~100m savings since 2024



Quality

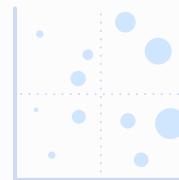
Delivering high quality trials through increased oversight, process consistency, and automation

**Delivering on the promise of consolidated CROs:
Reducing cycle times and costs while improving site experience and delivering high quality trials**

R&D Excellence: Our solutions

All seven solutions are now being actively implemented across the enterprise

Adopt a unified portfolio framework



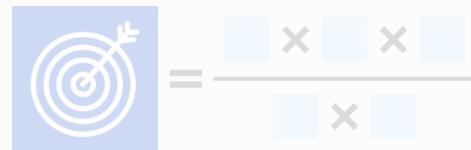
Transform our portfolio management & governance



Access the best external innovation



Embrace ambitious R&D objectives



Evolve our R&D engine and invest in its excellence



Align our incentives with the new R&D strategy



New vs. 2024

Build a simplified system landscape and data foundation



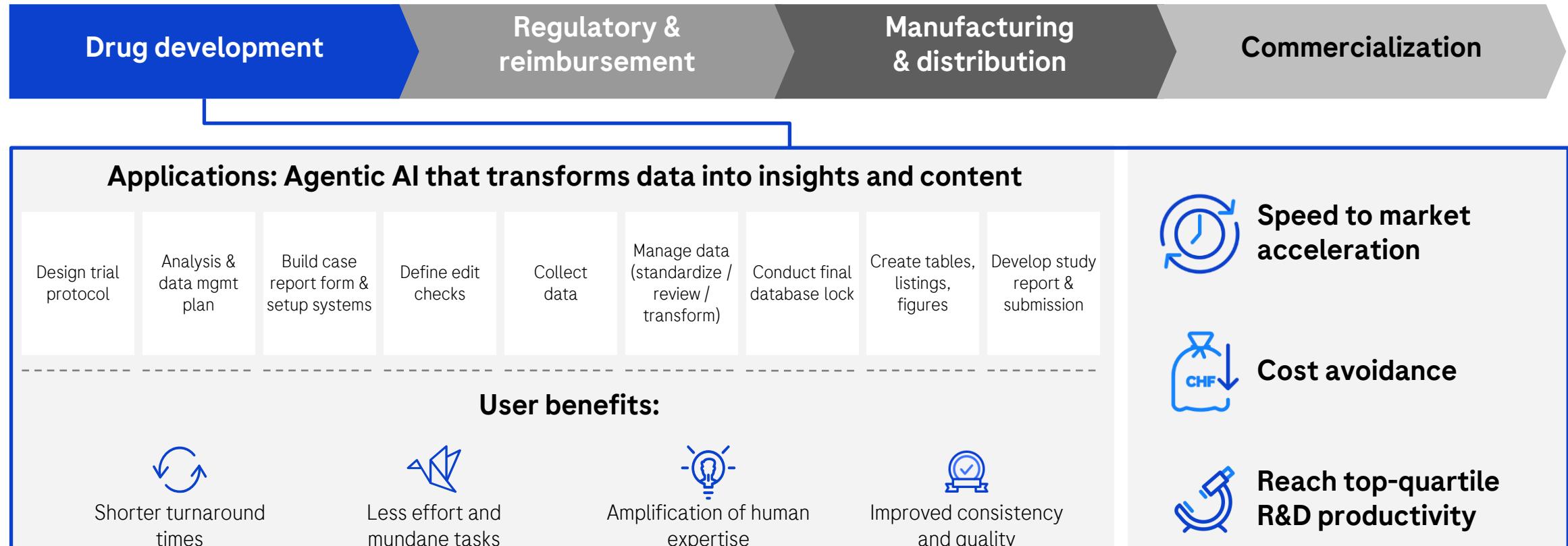
Implemented and moving into business as usual



Implementation in progress

Leveraging AI to increase overall productivity along the value chain

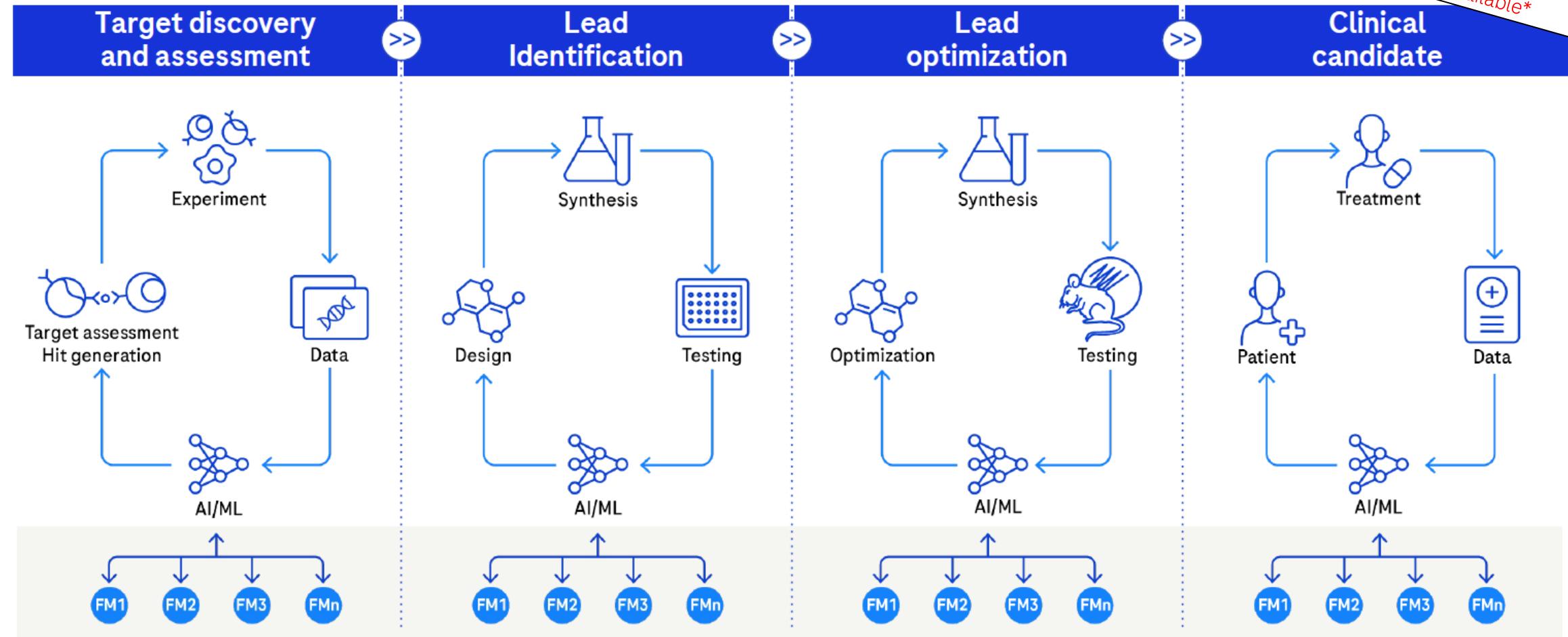
Rethinking the end-to-end process for clinical development AI-driven data and content generation



AI-enabled solutions increasing efficiencies and productivity

Leveraging AI in drug discovery

Lab-in-the-Loop: Embedding AI from target discovery to the clinic



By 2030, with our ongoing efforts in R&D excellence, we will...



Adopt a unified portfolio framework



Transform our portfolio management & governance



Access the best external innovation



Embrace ambitious R&D objectives



Evolve our R&D engine and invest in its excellence



Align our incentives with the new R&D strategy



Build a simplified system landscape and data



Delivered many of the world's most impactful medicines (20 transformative medicines¹ by 2029)



Reached top-quartile performance in R&D productivity across the biopharma industry



Implemented and moving into business as usual



Implementation in progress



1. Reaching 'Bar' criteria: Future medicines that can have high impact for patients, high revenue potential, and optimized risk



Oncology/Hematology

Charles Fuchs

*SVP and Global Head of Oncology and Hematology
Product Development*



Oncology/Hematology R&D focus areas

Critical Capabilities



Precision medicine

Right medicines for the right patient



Combinations

Leverage breadth of oncology and hematology portfolio to explore new combinations



Novel modalities

Investing in key technologies to engage unique set of targets



E2E investment

Discovery, R&D and commercialization resources concentrated on our end-to-end disease areas

Examples

Itovebi: BIC PI3Ki being developed in HR+ BC and beyond

Divarasib: BIC KRAS G12Ci with a comprehensive Phase III program across NSCLC lines of treatment

Columvi + Polivy-R-CHP: Bringing Columvi and Polivy to 1L DLBCL

Giredestrant: Potential to replace current ET backbone in HR+ BC

Allogeneic CAR-Ts: Investigating off-the-shelf cell therapies for NHL and MM

Molecular glue degraders: Investing in therapies to address well-established but undruggable targets

Breast cancer: Development program targeting key signaling pathways (ER, CDK, PI3K, HER2)

Malignant heme: Comprehensive clinical development program across NHL; expanding into MM



A diversified portfolio by drug modalities and targets

Strengthening our portfolio through external innovation

Oncology/ hematology pipeline

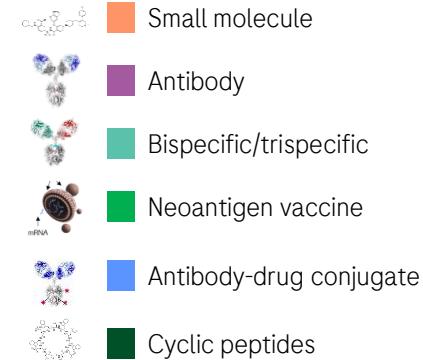
Small molecules	Antibodies	Bispecifics/ trispecifics	Antibody-drug conjugates	Fusion proteins	Gene therapy	Neoantigen vaccines	Allogenic CAR-Ts	Cyclic peptides
<ul style="list-style-type: none"> inavolisib divarasib giredestrant HER2 TKI¹ CDK4/2 inh. mosperafenib KRAS G12D inh. Pan-RAS inh. MINT91 	<ul style="list-style-type: none"> anti-CTLA-4 switch codrituzumab 	<ul style="list-style-type: none"> cevostamab LTBR agonist DLL3 x CD3 x CD137 FIXa x FX (NXT007) 	<ul style="list-style-type: none"> cMET ADC² DLL3 x CD3 x CD137 	<ul style="list-style-type: none"> englumafusp alfa 	<ul style="list-style-type: none"> SPK-8011QQ 	<ul style="list-style-type: none"> autogene cevumeran 	<ul style="list-style-type: none"> P-BCMA-ALLO¹⁴ P-CD19 x CD20-ALLO¹⁴ 	<ul style="list-style-type: none"> Pan-KRAS inh.
<ul style="list-style-type: none"> fenebrutinib selnolast alogabat GLP-1 RA (CT-996) TMEM16A potentiator MAGL inh. nivegacetor zosurabalpin LepB inh. REVN24 	<ul style="list-style-type: none"> emugrobart prasinezumab vamikibart afimkibart vixarelimab satalizumab anti-HLA-DQ2.5 x gluten peptides anti-C1s recycling astegolimab Tie-2 agonist BRY10 	<ul style="list-style-type: none"> p40 x TL1A CD19 x CD3 VEGF x IL6 DutaFab zifibancimig 	<ul style="list-style-type: none"> trontinemab Brain shuttle CD20 	<ul style="list-style-type: none"> HTT miRNA GT 	<ul style="list-style-type: none"> zilebesiran⁵ sefaxersen tominersen 	<ul style="list-style-type: none"> GLP-1/GIP RA (CT-868) GLP-1/GIP RA (CT-388) petrelintide⁶ OpRegen 	<ul style="list-style-type: none"> AR degrader⁷ Pre-clinical^{8,9} 	

1. Zion Pharma managed; 2. MediLink Therapeutics managed; 3. Innovent managed; 4. Poseida led studies undergoing integration into Roche portfolio; 5. Alnylam Pharmaceuticals managed; 6. In collaboration with Zealand Pharma; 7. In collaboration with Jemincare; 8. Orionis Biosciences managed; 9. Monte Rosa Therapeutics managed



Oncology solid tumor pipeline

Focus on breast and lung as end-to-end investment areas

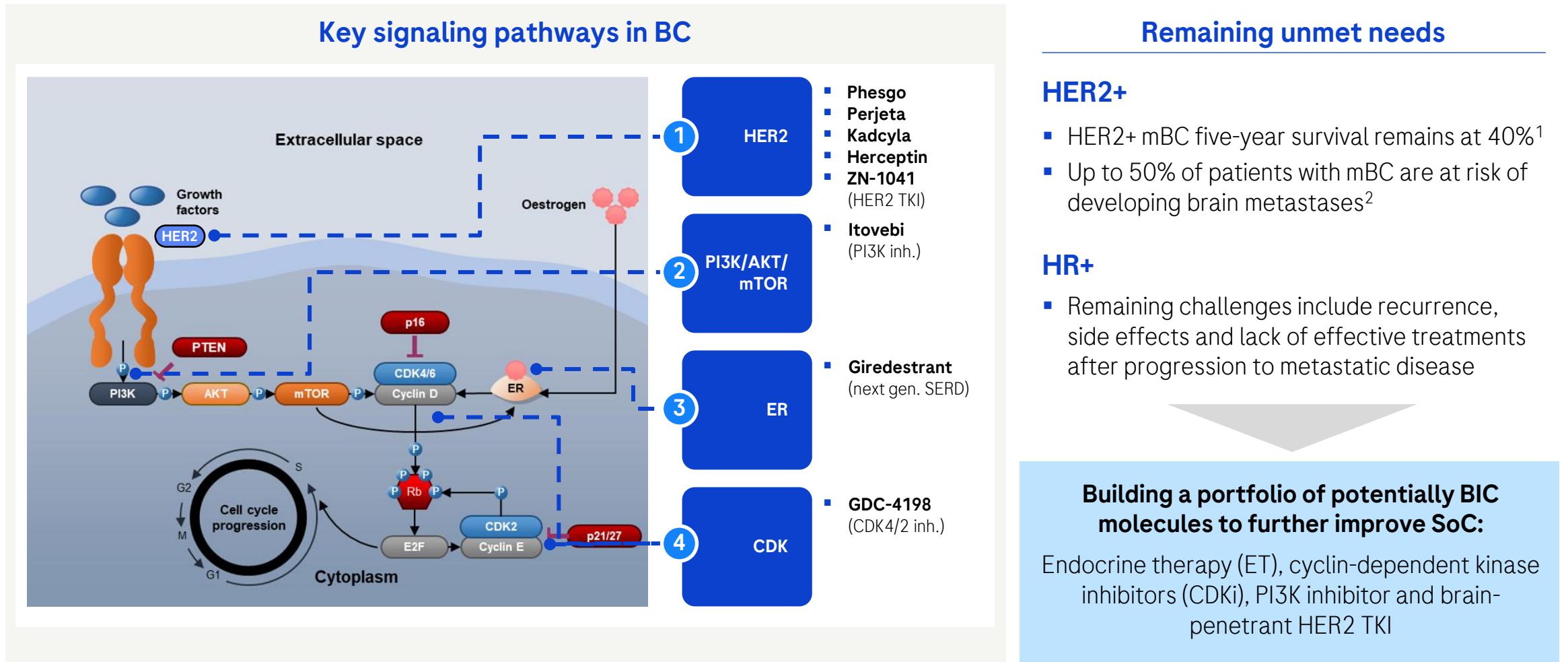
Phase I		Phase II		Phase III		Registration	
RG6114	inavolisib						
RG6171	giredestrant						
RG6221	LTBR agonist						
RG6330	divarasib						
RG6344	mosperafenib (BRAF inhibitor)						
RG6411	undisclosed						
RG6468	undisclosed						
RG6505	Pan-RAS inhibitor						
RG6537	AR Degrader						
RG6561	undisclosed						
RG6596 ¹	HER2 TKI ¹						
RG6620	KRAS G12D inhibitor						
RG6648	cMET ADC ²						
RG66794	CDK4/2 inhibitor						
RG6810	DLL3 ADC ³						
CHU	codrituzumab						
CHU	ROSE12 (anti-CTLA-4 switch Ab)						
CHU	MINT91						
CHU	AUBE00 (Pan-KRAS inhibitor)						
CHU	DLL3 trispecific						
		 RG6180	autogene cevumeran multiple indications	 RG6171	giredestrant multiple HR+ BC indications	 RG7446	Tecentriq 1L maintenance SCLC
		 RG6171	giredestrant endometrial cancer	 RG6330	divarasib NSCLC		
		 RG6114	Itovebi eBC HR+	 RG3502	Kadcyla HER2+ eBC high risk		
				 RG7446	Tecentriq multiple indications		
				 RG6114	Itovebi multiple BC indications		
							

RG-No: Roche/Genentech; CHU: Chugai managed; 1. Zion Pharma managed; 2. MediLink managed; 3. Innovent managed; AR: Androgen receptor; (e)BC: CDK: cyclin-dependent kinase; (Early)breast cancer; HER2: Human epidermal growth factor receptor 2; HR: Hormone receptor; (N)SCLC: (Non)small cell lung cancer; TKI: tyrosine kinase inhibitor



Building a portfolio to address unmet needs in BC

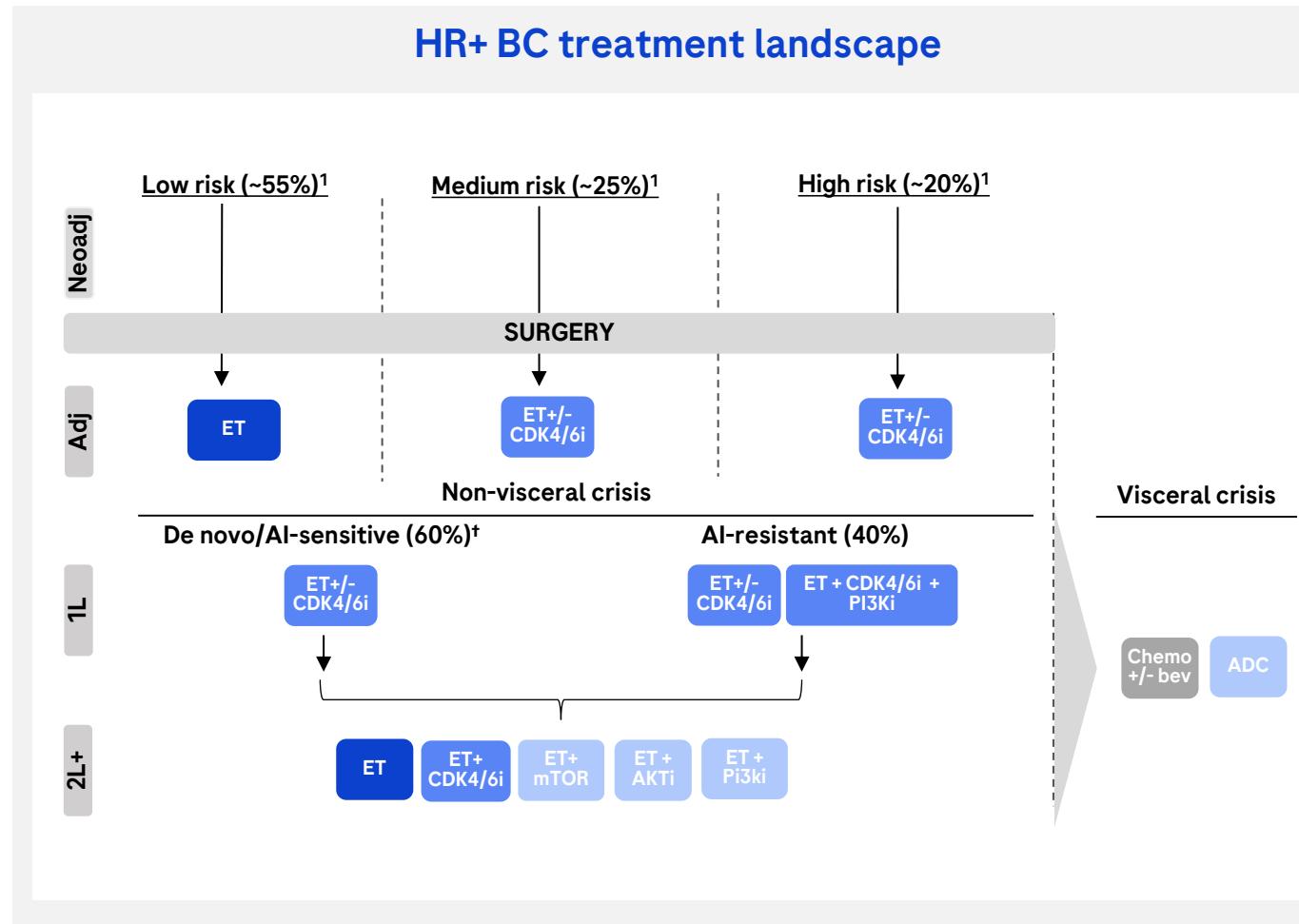
Targeting key signaling nodes contributing to etiology and progression of BC





HR+/HER2- BC treatment paradigm

Targeting three critical signaling pathways that drive underlying disease and resistance



1. Risk definitions vary according to guidelines and tools used: stage at diagnosis based on internal estimates using SEER data [†]AI sensitive defined as patients who relapse >1yr after completion of adjuvant therapy; ADC: Antibody-drug conjugate; Adj: Adjuvant; AI: Aromatase inhibitor; BC: Breast cancer; CDK: Cyclin-dependent kinase; eBC: Early breast cancer; ET: Endocrine therapy; HR: Hormone receptor; mBC: Metastatic breast cancer; Neoadj: Neoadjuvant; PI3K: Phosphatidylinositol 3-kinase; SERD: Selective estrogen receptor degrader

ET Endocrine Therapy (ET)

ET is backbone treatment for ER+ BC; however, there are limitations with current ET options

ET + CDK4/6i CDKi

ET+CDK4/6i established as backbone in HR+ mBC, and emerging in eBC, however resistance and tolerability issues remain

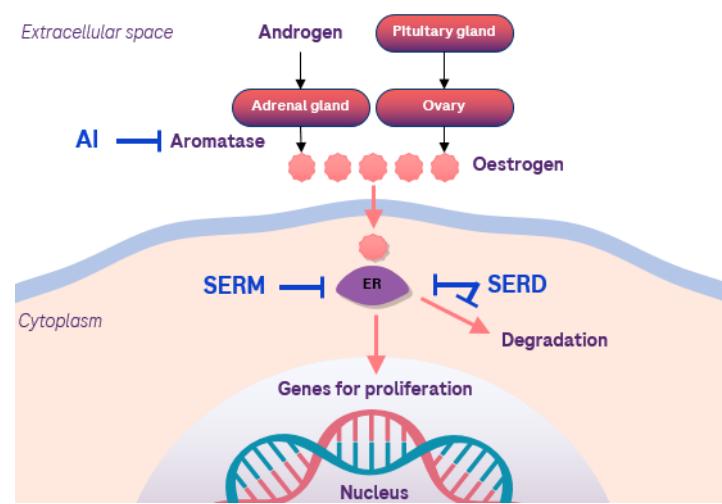
ET + tgt Targeted therapies

Limited to metastatic breast cancer (1L+)



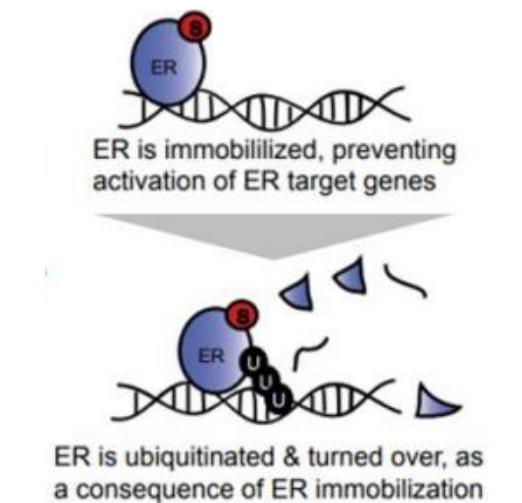
Giredestrant: A next-gen SERD with BIC potential

Selective ER degrader (SERD)¹



- Current SoC* endocrine therapies limited by AEs leading to low adherence and mechanisms of resistance (including ESR1m)
- High unmet need for patients who have developed resistance following ET + CDK4/6 inhibitor treatment in later line settings

Novel two-step MoA²



- Giredestrant is a full ER antagonist that suppresses ER signaling through 1) ER immobilization and 2) subsequent degradation

More potent than competitor SERDs³

Endocrine therapy	Potency (IC_{50}) across three ER-positive BC cell lines (nM)
giredestrant	4.5-8.7
camizestrant	11.5-27.2
fulvestrant	19.1-34.1
4-hydroxy tamoxifen	24.5-80.7
elacestrant	86.3-334.8

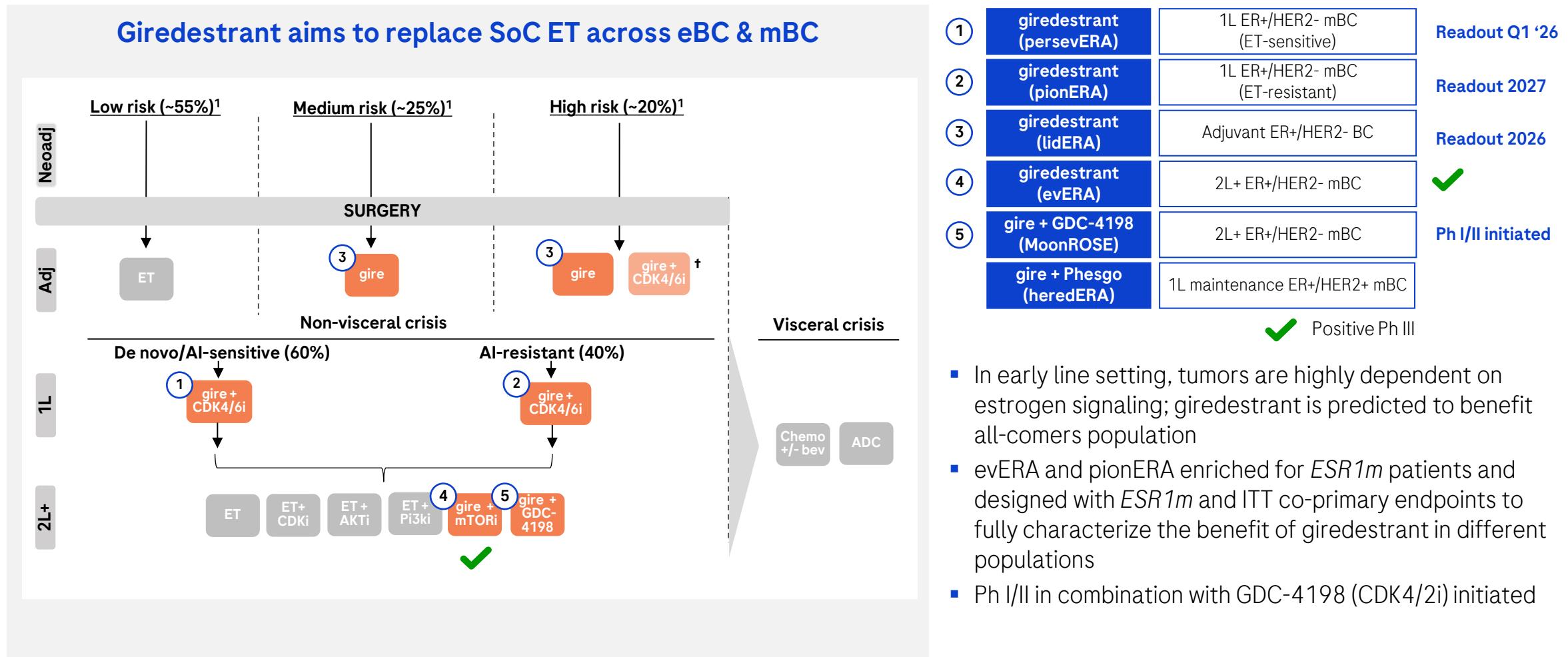
- Highest preclinical potency vs. other oral SERDs
- Combinable with all CDKis including palbociclib, abemaciclib, ribociclib
- Well tolerated at all doses, with no dose-limiting toxicities

1. Adapted from: Brufsky AM & Dickler MN, Oncologist 2018. 2. Guan J & Zhou W, et al., Cell 2019; 3. Liang J, et al. J Med Chem 2021; *Standard of care defined as aromatase inhibitors, tamoxifen and fulvestrant; AE: Adverse event; BC: Breast Cancer; CDKi: Cyclin dependent kinase inhibitor; ER: Estrogen receptor; ESR1: Estrogen receptor 1; ESR1m: ESR1 mutation; ET: Endocrine therapy; MoA: Mechanism of action; SERD: Selective estrogen receptor degrader



Giredestrant: Comprehensive clinical program across patient populations

Potential to become the ET backbone of choice throughout lines of treatment



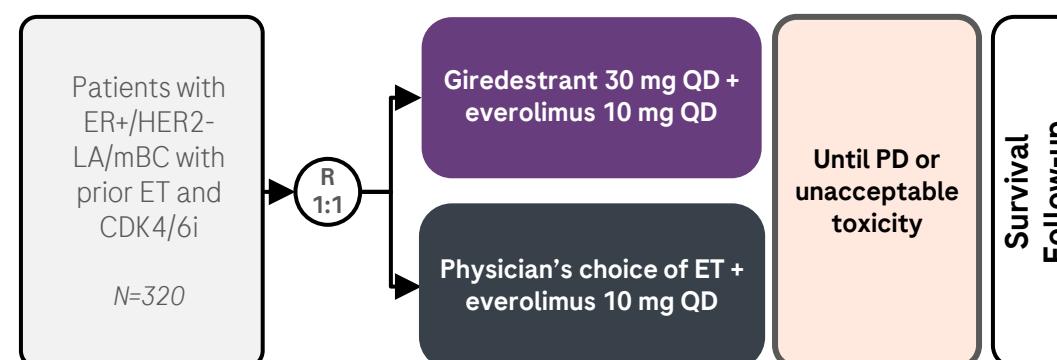
1. Risk definitions vary according to guidelines and tools used: stage at diagnosis based on internal estimates using SEER data †giredestrant + CDK4/6i in adjuvant HR+ BC being evaluated as single arm substudy as part of Ph III lidERA; Adj: Adjuvant; AI: Aromatase inhibitor; eBC: Early breast cancer; ET: Endocrine therapy; gire: Giredestrant; mBC: Metastatic breast cancer; Neoadj: Neoadjuvant; SERD: Selective estrogen receptor degrader



Giredestrant: Positive Ph III (evERA) in *ESR1m* and ITT post-CDKi ER+ mBC

First positive H2H Ph III trial investigating an all-oral SERD-containing regimen vs. SoC

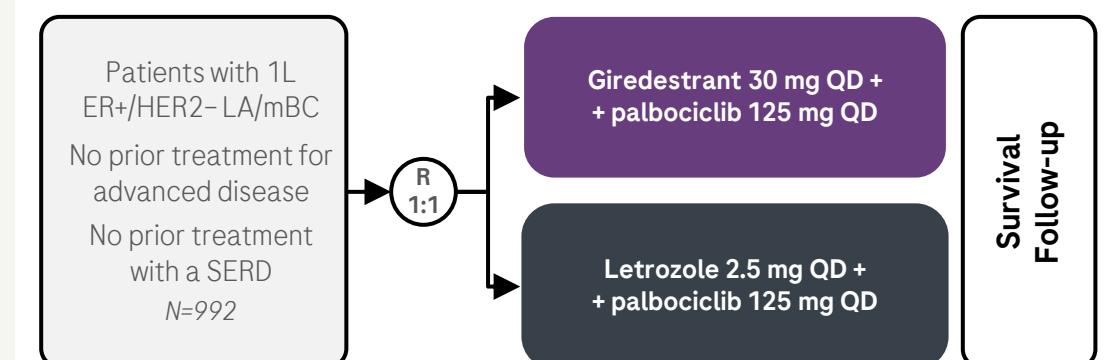
Ph III (evERA): Gire + everolimus in ER+ mBC post-CDKi



Study enriched for *ESR1m* pts (>40%)

- Statistically significant and clinically meaningful PFS benefit in ER+ mBC in *ESR1m* and ITT populations
- OS immature but with a positive trend in both *ESR1m* and ITT
- Well-tolerated and safety profile aligned with individual drug profile
- Data to be presented at an upcoming medical conference and to be filed with regulators

Ph III (persevERA): Gire + palbociclib in 1L ER+ mBC



***ESR1* mutations are rare in this study population**

- Ph III (persevERA) results expected Q1 2026
- Ph III (pionERA) giredestrant + CDK4/6i in ET-resistant* ER+/HER2- mBC results expected 2027; study enriched for *ESR1m* pts, an *ESR1m* and ITT co-primary endpoint
- Ph III (lidERA) adjuvant giredestrant in patients with ER+/HER2- eBC expected in 2026

*Adjuvant ET resistance in pionERA defined as relapse on ET ± CDK4/6i after 1 year, or relapse off ET ± CDK4/6i within 1 year; CDKi: Cyclin dependent kinase inhibitor; eBC: Early breast cancer; ER: Estrogen receptor; ESR1: Estrogen receptor 1; ESR1m: ESR1 mutation; ET: Endocrine therapy; Gire: Giredestrant; mBC: Metastatic breast cancer, ITT: Intention-to-treat; PD: Disease progression; QD: Once a day; SERD: Selective estrogen receptor degrader

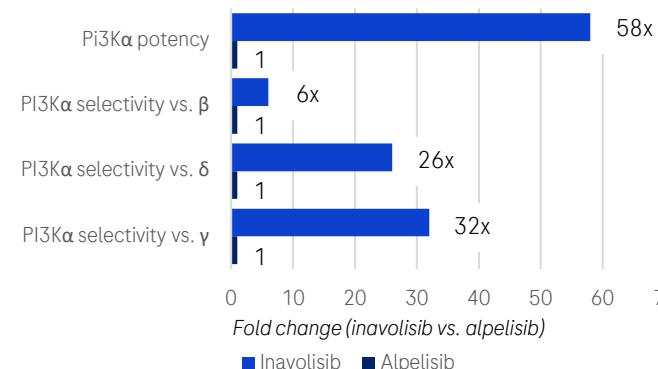


Itovebi in PIK3CAm HR+ BC to define new SoC

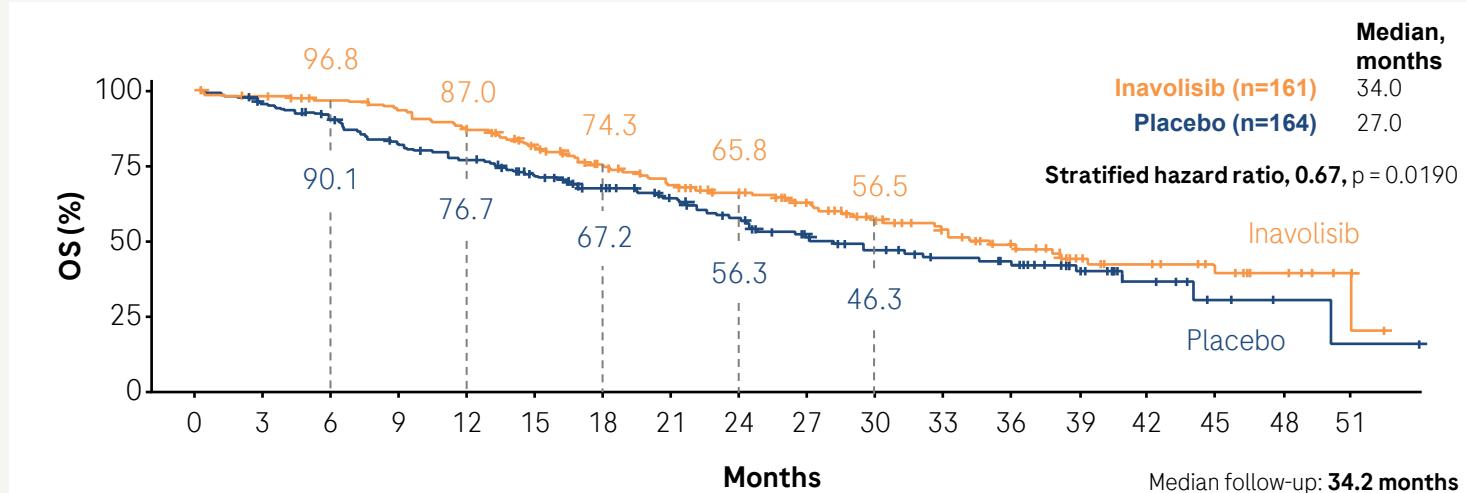
Approved in US, EU and China, additional launches ongoing

BIC PI3K α inhibitor

Potency/selectivity (inavolisib vs. alpelisib)¹



Ph III (INAHO120): First PI3K-targeted therapy to significantly extend OS²



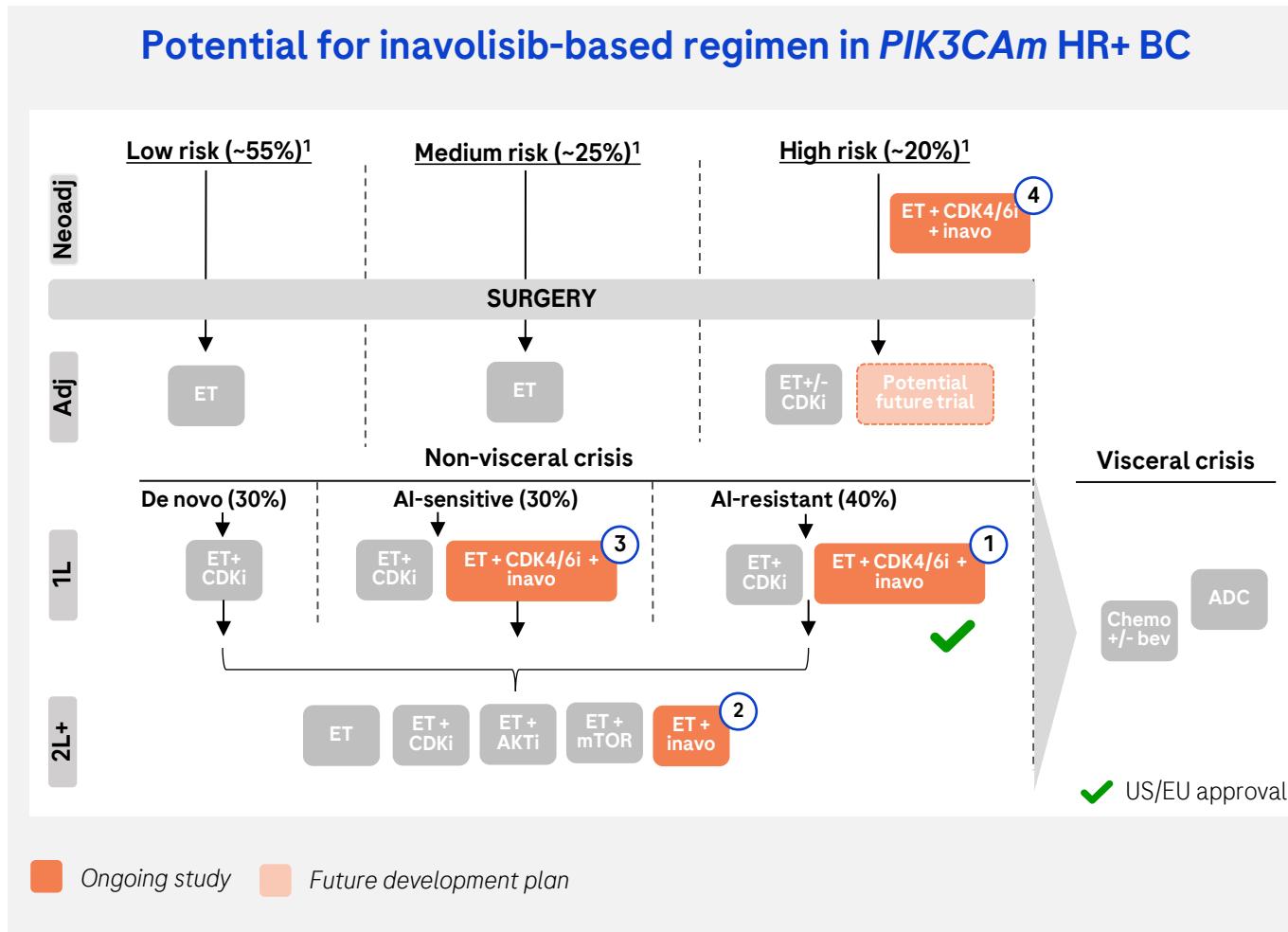
- More potent and selective for PI3K α isoform
- Better *in vivo* efficacy
- Greater safety margins allow for combination with ET and CDK4/6i at standard doses

- Ph III (INAHO120) Itovebi + palbociclib + fulvestrant reduced risk of death >30% compared with palbociclib + fulvestrant alone (mOS 34.0m vs. 27.0m, HR=0.67; p=0.0190)
- PFS benefit was maintained during longer follow-up (17.2m vs. 7.3m; HR=0.42; p<0.0001)
- Median time to subsequent chemotherapy was delayed by ~2 years (35.6m vs. 12.6m, HR=0.43)
- Low discontinuation rates due to AEs (6.8%), confirming manageable tolerability

1. Jhaveri KL et al., SABCS 2023; 2. Turner N et al., ASCO 2025; BIC: Best-in-class; CDK: Cyclin-dependent kinase; ER+: Estrogen receptor positive; ET: Endocrine therapy; HR: Hazard ratio; HR+: Hormone-receptor positive; HER2: Human epidermal growth factor receptor 2; (m)BC: (Metastatic) breast cancer; PIK3CA-mut: Phosphatidylinositol 3-kinase, catalytic, alpha polypeptide mutated; PFS: Progression-free survival; ORR: Objective response rate; OS: Overall survival; SoC: Standard of care



Itovebi: Potential to expand broadly in PIK3CAm BC



①	inavolisib (INAVO120)	1L PIK3CAm HR+/HER2- mBC (AI resistant)	
②	inavolisib (INAVO121)	Post-CDK4/6i PIK3CAm HR+/HER2- BC	Readout 2026
③	inavolisib (INAVO123)	1L PIK3CAm HR+/HER2- mBC (ET sensitive)	Ph III initiated
④	inavolisib (neoTOV)	untreated, PIK3CAm, stage II-III, HR+/HER2- BC	Ph II initiated
	inavo + Phesgo (INAVO122)	1L PIK3CAm HER2+ BC	

US/EU approval

- Ph III (INAVO123) initiated in 1L ET sensitive pts
- Ph II (neoTOV) open label neoadjuvant study of Itovebi + ribociclib + letrozole initiated; additional adjuvant study considered
- Itovebi + GDC-4198 (CDK4/2i) combination to be initiated
- Potential to expand into other PIK3CAm tumors: Ph Ib/II signal seeking studies ongoing across multiple tumors

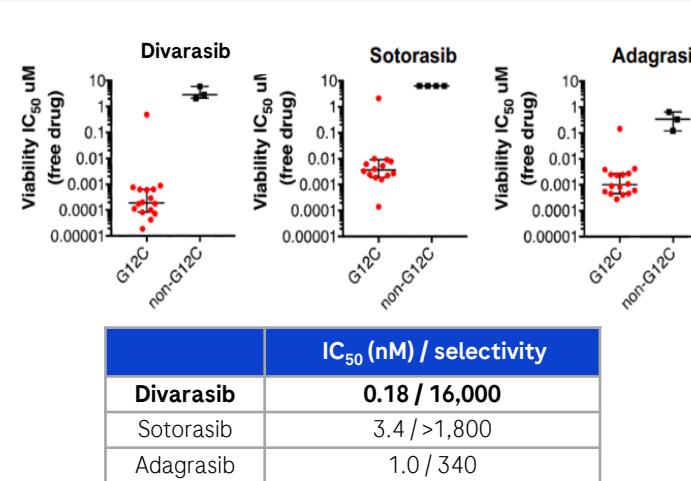
1. Risk definitions vary according to guidelines and tools used: stage at diagnosis based on internal estimates using SEER data; adj: adjuvant; AI: Aromatase inhibitor; BC: Early breast cancer; CDK: Cyclin-dependent kinase; ET: Endocrine therapy; HER2: Human epidermal growth factor receptor 2; mBC: Metastatic breast cancer; Neoadj: Neoadjuvant; PIK3CA-mut: Phosphatidylinositol 3-kinase, catalytic, alpha polypeptide mutated



Divarasib: Best-in-class potential in KRAS G12C-mutated tumors

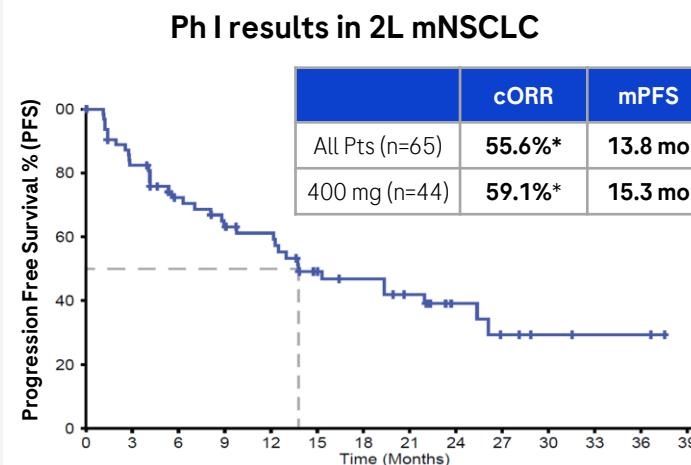
Comprehensive Ph III development program in NSCLC

Higher potency and selectivity¹



- Divarasib is an irreversible covalent inhibitor of mutant KRAS G12C resulting in a locked inactive conformation
- 5 to 25 times more potent and 10 to 50 times more selective *in vitro* than sotorasib and adagrasib¹
- ~12–14% NSCLC cases have G12C mut

Durable clinical activity²



- Divarasib monotherapy induced durable clinical benefit with confirmed ORR of 59.1% and mPFS of 15.3 months at 400 mg dose
- Tolerable safety profile with low rates of Grade ≥ 3 LFT abnormalities for monotherapy and in combination with PD-L1

Expanding the program into eNSCLC

FDA BTD Readout 2026

divarasib (KRASCENDO-1)	2L mNSCLC H2H vs. sotorasib/adagrasib
divarasib + pembro (KRASCENDO-2)	1L mNSCLC
divarasib (KRASCENDO-3)	eNSCLC (adjuvant)

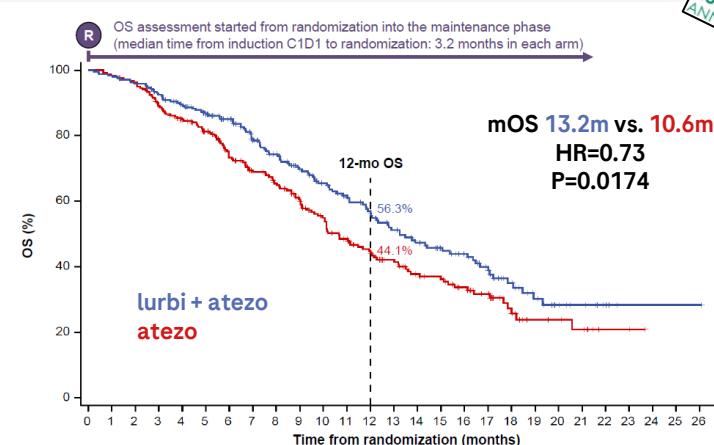
- Ph III (KRASCENDO-1): H2H trial vs. sotorasib/adagrasib in 2L expected to read out in 2026; granted FDA BTD in 2L
- Ph III (KRASCENDO-2): Chemo-free regimen 1L mNSCLC initiated
- Ph III (KRASCENDO-3): Decision to initiate study in adjuvant eNSCLC



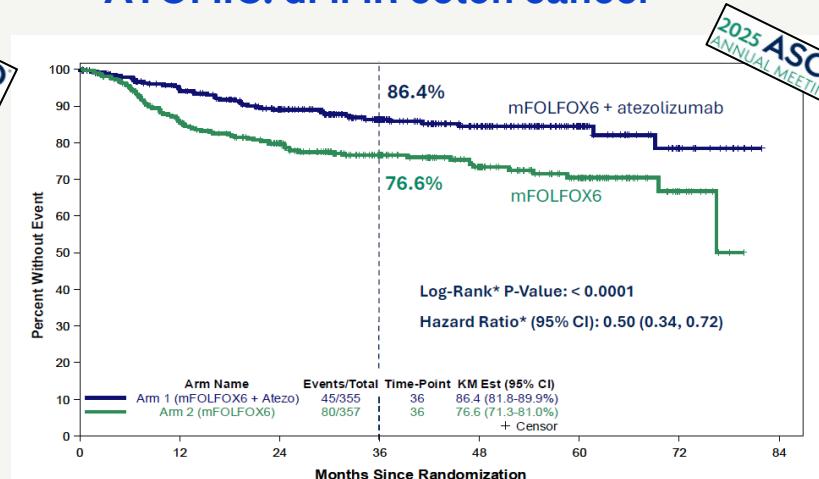
Tecentriq: Positive Ph III results in SCLC, colon cancer and MIBC

Overall Tecentriq sales expected to remain stable in the long term

IMforte: 1L maintenance in SCLC¹



ATOMIC: dMMR colon cancer²



IMvigor011: MIBC



BERLIN GERMANY
17-21 OCTOBER 2025

- Tecentriq + lurbinectedin with statistically significant mOS (13.2m vs. 10.6m, HR=0.73) and PFS benefit (5.4m vs. 2.1m, HR=0.54) vs. Tecentriq alone
- Potential to become the new SoC for 1L ES-SCLC maintenance treatment
- Filed in US; PDUFA date set for October

- Adding Tecentriq to mFOLFOX6 significantly improved DFS in dMMR stage III colon cancer (HR=0.50)
- Practice-changing and potential new SoC for dMMR stage III colon cancer
- Incorporated in NCCN guidelines

- Tecentriq showed a statistically significant and clinically meaningful DFS and OS benefit
- First prospective Ph III in MIBC using a personalized ctDNA MRD-guided approach

1. Lancet. 2025 Jun 14;405(10495):2129-2143, 2. JCO.2025.43.17_suppl.LBA1; atezo: atezolizumab; ctDNA: Circulating tumor DNA, DFS: Disease-free survival, dMMR: Deficient DNA mismatch repair, (m)FOLFOX6: (Modified) folinic acid+fluorouracil+oxaliplatin; lurbi: lurbinectedin; MIBC: Muscle-invasive bladder cancer, MRD: Minimal residual disease; OS: Overall survival; PFS: Progression-free survival; (ES)-SCLC: (Extensive stage) small cell lung cancer; SoC: Standard of care



Hematology pipeline

Cevostamab moving into Phase III in r/r MM

Ph I	Ph II	Ph III	Registration
RG6076 englumafusp alfa combos heme tumors	RG6512 NXT007 hemophilia A	RG6026 Columvi 1L DLBCL, r/r MCL	RG7828 Lunsumio SC 3L FL
RG6538 ¹ P-BCMA-ALLO1 r/r MM	RG6797 SPK-8011QQ hemophilia A	RG7828 Lunsumio 2L FL, 2L DLBCL	
RG6540 ¹ P-CD19xCD20-ALLO1 heme tumors		RG6107 PiSky aHUS	
RG7828 Lunsumio SC 3L CLL		RG6013 Hemlibra Type 3 VWD	
RG6026 Columvi monotherapy + combos heme tumors		RG6160 cevostamab r/r MM	

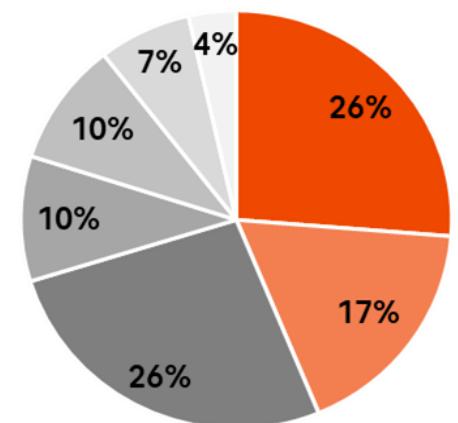
- Antibody
- Bispecifics
- Gene therapy
- Allogeneic CAR-T cells
- Fusion protein

1.Poseida led studies undergoing integration into Roche portfolio; aHUS: Atypical hemolytic uremic syndrome; CLL: Chronic lymphocytic leukemia; DLBCL: Diffuse large B-cell lymphoma; FL: Follicular lymphoma; MCL: Mantle cell lymphoma; MDS: Myelodysplastic syndrome; MM: Multiple myeloma; R/r: Relapsed/refractory; VWD: Von Willebrand disease



Moving CD20xCD3 bispecifics (Lunsumio/Columvi) into earlier lines

NHL accounts for almost 50% of hematological malignancies¹



- aNHL (incl. DLBCL, MCL) ■ iNHL (incl. FL)
- Leukemia (incl. CLL) ■ Hodgkin Lymphoma
- Myeloma ■ MPNs
- MDS

Comprehensive development program across NHL subtypes

Regimen	Indication	Ph I	Ph II	Ph III	
Polivy + R-GemOx	2L DLBCL	POLARGO			✓ PEP of OS met
Polivy + R-CHP	1L DLBCL	POLARIX			✓ US/EU approved
Lunsumio	3L FL				✓ US/EU approved
Lunsumio + POLIVY	2L DLBCL (SCT-ineligible)	SUNMO			✓ Dual PEPs met
Lunsumio + lenalidomide	2L FL	CELESTIMO			Readout 1Q '26
Lunsumio + lenalidomide	1L FL	MorningLYTE			
COLUMVI	3L DLBCL				✓ US/EU approved
COLUMVI + GemOx	2L DLBCL (SCT-ineligible)	STARGLO			✓ EU approved
COLUMVI + Polivy + R-CHP	1L DLBCL	SKYGLO			
COLUMVI	R/R MCL (post-BTKi)	GLOBRYTE			
COLUMVI + englumafusp alfa	r/r NHL				
P-CD19xCD20-ALLO1	r/r B-cell malignancies				

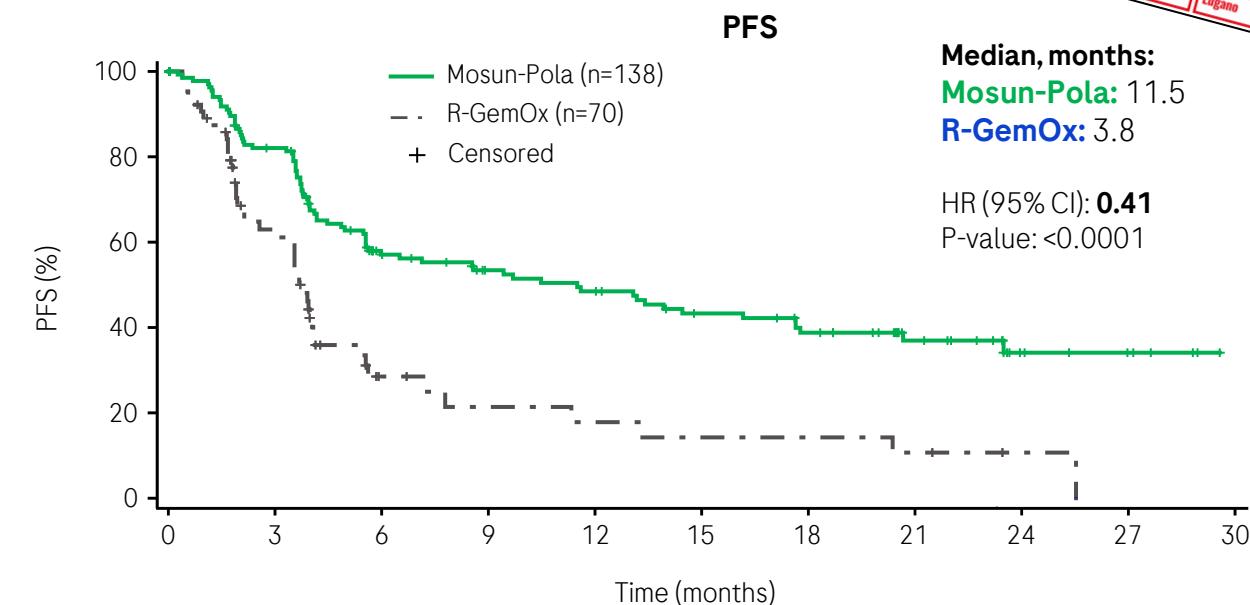
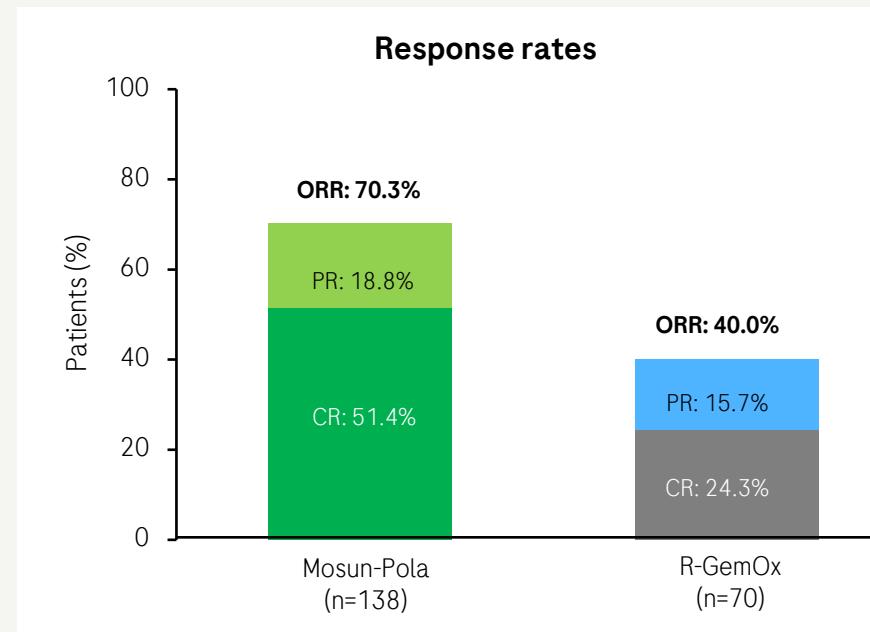
1. The Leukemia & Lymphoma Society. Facts 2022-2023. Updated Data on Blood Cancers <https://www.lls.org/booklet/facts-updated-data-blood-cancers>; CAR: chimeric antigen receptor; CLL: Chronic lymphocytic leukemia; DLBCL: Diffuse large B-cell lymphoma; FL: Follicular lymphoma; MCL: Mantle cell lymphoma; NHL: Non-hodgkin lymphoma; PEP: Primary endpoint; SCT: Stem cell transplant; P-CD19CD20-ALLO1 and PBCMA-ALLO1 in collaboration with Poseida Therapeutics



Ph III (SUNMO): Chemo-free combo of two unique MoAs in 2L DLBCL

High activity and durable responses with low CRS potentially suitable for outpatient community care

Ph III (SUNMO) results for Lunsumio+Polivy in 2L R/R aggressive LBCL¹



- Lunsumio+Polivy demonstrated a 59% risk reduction for progression or death (11.5 vs. 3.8 months), doubled the CR rate (51.4% vs. 24.3%) and improved the ORR by 30% compared with R-GemOx (70.3% vs. 40.0%)
- SUNMO is the first positive Phase III trial combining a bispecific antibody and ADC without conventional chemotherapy in DLBCL
- Lunsumio+Polivy has the lowest CRS incidence and severity among T-cell directed therapies to date and thus may be suitable for outpatient use

1. Westin et al. ICML 2025 Refractory was defined as SD, PD, PR, or CR with relapse <3 months after first-line therapy. Relapse was defined as CR with relapse ≥ 3 and ≤ 12 months after 1L therapy; CR: Complete response; DLBCL: Diffuse large B-cell lymphoma; GemOx: Gemcitabine + oxaliplatin; HGBCL: High grade B-cell lymphoma; LBCL: Large B-cell lymphomas; ORR: Overall response rate; PFS: Progression-free survival; R/R: relapsed/refractory



Ph III (SKYGLO): Columvi + Polivy-R-CHP in 1L DLBCL

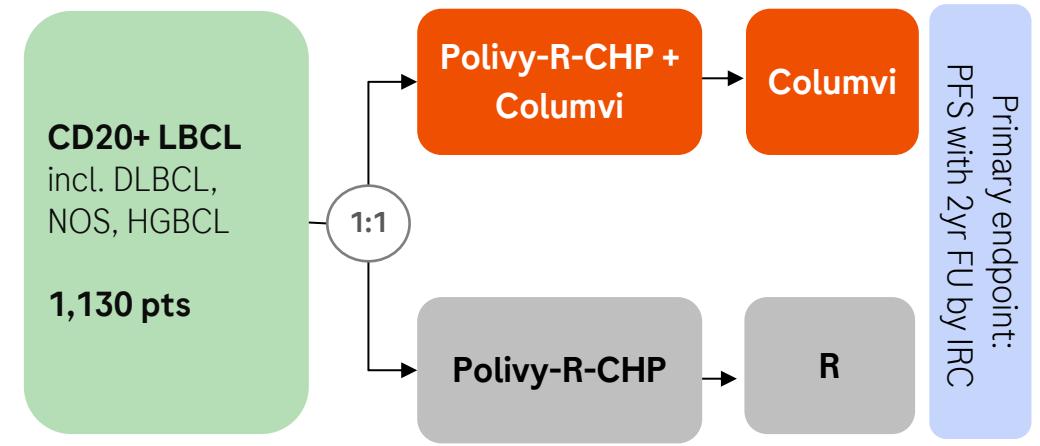
Early data support Columvi's combinability with current SoC, with high response rates and low CRS rates

Ph Ib: High response rates and durable remissions¹

Glofit + Pola-R-CHP (n=24)	
ORR n (%)	24 (100%)
CMR n (%)	23 (95.8%)



Ph III (SKYGLO): Columvi + Polivy-R-CHP in 1L DLBCL



- Columvi + Pola-R-CHP demonstrates high and durable ORR (100%) and CMR (96%) with manageable safety profiles, consistent with multiple independent data sets
- Median PFS, and duration of response were not reached
- Manageable safety profile with CRS Grade 1: 12.5%, Grade 2: 0.0%, Grade 3+: 0.0%

- Multi-regional Phase III study combining the efficacy of Columvi and Polivy-R-CHP in the outpatient setting
- Recruitment nearly completed
- Results expected in 2027

1. Topp M et al, ICML 2025; CMR: Complete metabolic response; DLBCL: Diffuse large B cell lymphoma; FU: Follow-up; HGBCL: High grade B-cell lymphoma; IRC: Independent review committee; NOS: Not otherwise specified; ORR: Overall response rate; PFS: Progression-free survival; Pola-R-CHP: Polivy + Rituxan + cyclophosphamide + hydroxydaunorubicin + prednisone; R-CHOP: Rituxan + cyclophosphamide + doxorubicin + vincristine + prednisone; SoC: Standard of care; Yr: Year

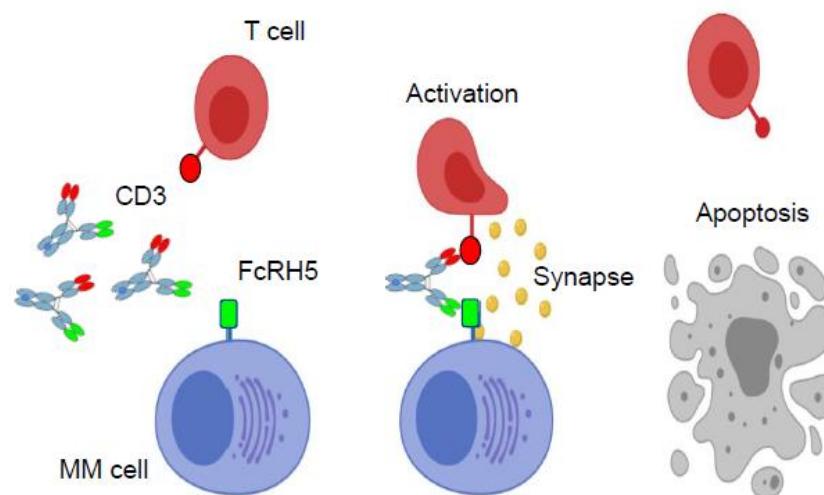


Cevostamab: Potential to become FIC FcRH5xCD3 bispecific

Ph III (CEVOLUTION) Go decision in 2L+ r/r MM to create treatment optionality for patients

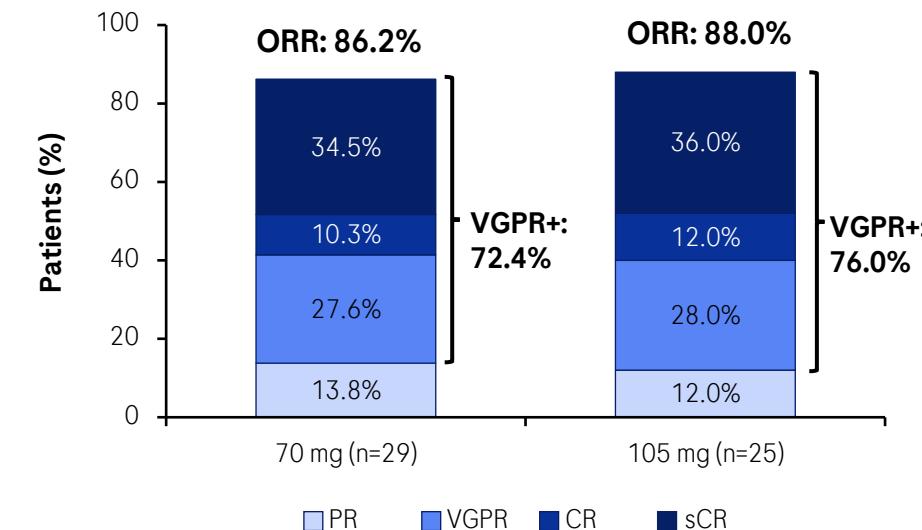


Unique MoA to address unmet need in r/r MM



- FcRH5 prevalently expressed on MM cells
- With quadruplet therapies (incl. 3 standard classes: IMiDs, aCD38 Abs, proteasome inhibitors) being increasingly used in 1L, there is a high unmet need for novel therapies in the r/r MM setting

Ph I (CAMMA 1): Cevostamab + Pd in r/r MM¹



- A pooled 74.1% VGPR+ across the two dose levels
- Gr3 infection rate of <30% and substantiated by extensive safety data across >700 pts in monotherapy and combination therapy
- Decision to initiate a Ph III (CEVOLUTION) of cevostamab + Pd in 2L+ r/r MM
- Potential to become the future combination partner of choice



CAR-Ts to further complement our NHL and MM pipeline

Rapid, accessible, and “off-the-shelf” investigational allogeneic CAR-T to treat patients without waiting

Roche allogeneic CAR-Ts key features

FDA ODD + RMAT

- Non-viral gene insertion and gene editing **customized for T_{SCM} cells**
- Robust healthy **donor screening system**
- Proprietary **Booster Molecule** improves manufacturing yield
- Safety “switch” to eliminate CAR-T cells if needed
- “On-demand” delivery from inventory
- Selectable marker for purification so nearly all cells are CAR-carrying
- Unit operations optimization across process development and quality

P-BCMA-ALLO1 highly clinically active¹

Group	PR (%)	VGPR (%)	CR (%)	sCR (%)	Total (%)
All Patients Arm C (N=32)	88%	8%	2%	0%	100%
Patients With EMD (n=13)	85%	5%	2%	0%	100%
BCMA Naïve (n=16)	100%	0%	0%	0%	100%
BCMA Naïve With EMD (n=6)	100%	0%	0%	0%	100%
BCMA Exposed (n=16)	75%	5%	5%	5%	100%
BCMA Exposed With EMD (n=7)	71%	5%	5%	5%	100%

- Strong clinical activity in heavily pretreated population, including in BCMA-exposed patients
- Full ITT population received lymphodepletion and P-BCMA-ALLO1; several pts received treatment in outpatient setting
- Well tolerated, with no GvHD and low rates of CRS

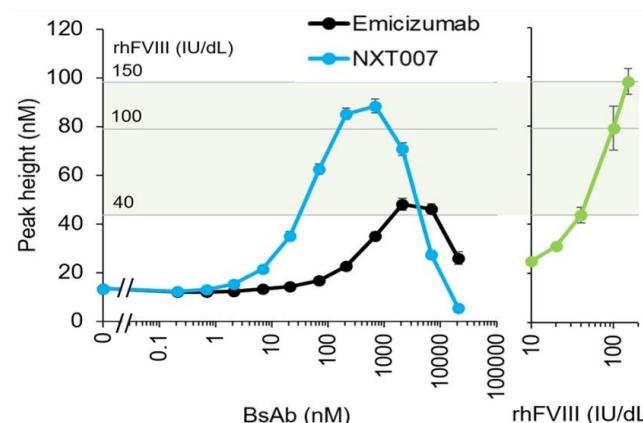
1. Ganguly et al. Presented at TANDEM February 2025; BCMA: B-cell maturation antigen; CAR-T: Chimeric antigen receptor T-cell; CR: Complete response; CRS: Cytokine release syndrome; EMD: Extramedullary disease; GvHD: Graft versus host disease; ITT: Intent-to-treat; MM: Multiple myeloma; NHL: Non-hodgkin lymphoma; ODD: Orphan drug designation; RMAT: Regenerative medicine advanced therapy designation; R/r: Relapsed/refractory; VGPR: Very good partial response



NXT007: Next-gen Factor VIIIa mimetic bispecific with BID potential

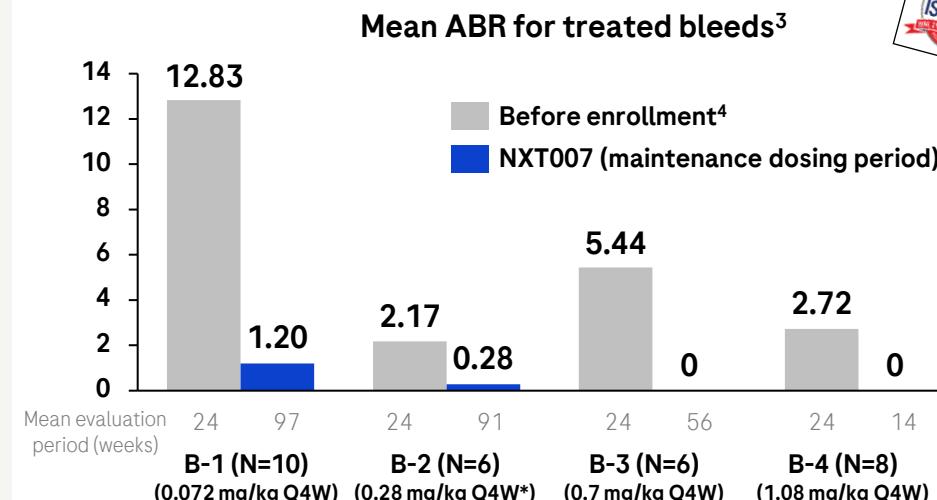
No treated bleeds in cohorts B-3 and B-4 during NXT007 prophylaxis; Ph III program to initiate in 2026

Thrombin generation activity¹



- NXT007 is intended to achieve zero treated bleeds; ~30-fold more potent than Hemlibra
- *In vitro* assay indicates that thrombin generation is well into the normal range of people without Hem A

Ph I/II (NXTAGE Part B) in Hemophilia A²



- NXT007 prophylaxis led to a decrease in ABR compared to baseline in all cohorts, with zero treated bleeds achieved in cohorts B-3 and B-4
- No safety concerns observed up to the highest dose cohort (B-4); one patient (out of 30) with clinically significant ADA

Ph III clinical development

Start 2026	
NXT007	Hem A vs. FVIII
NXT007	Hem A vs. Hemlibra
NXT007	Hem A pediatric patients

- Three Ph III trials, including H2H vs. Hemlibra
- Additional Ph II data to be shared at an upcoming medical conference in 2025

1. Teranishi-Ikawa et al. Journal of Thrombosis and Haemostasis 2024;22(2):430-440; 2. Shima et al. ISTH 2025; 3. Bleeding information before study was collected from 24 weeks before the study in a retrospective manner. Calculated ABR is displayed.; 4. 96.7% of participants received prophylactic therapy with FVIII agents; *Dosing regimen was switched from 0.14 mg/kg Q2W to 0.28 mg/kg Q4W to reflect study protocol amendment; NXT007 developed in collaboration with Chugai; ABR: Annual bleed rate; ADA: Anti-drug antibodies; BID: Best-in-disease; (Bs)Ab: (Bispecific) antibody; FVIIIa: Factor 8a; H2H: Head-to-head; Q4W: Once every 4 weeks; rhFVIII: recombinant human FVIII



Neurology

Hideki Garren

SVP and Global Head of Product Development Neurology



Neurology R&D focus areas

End-to-end investment in MS and AD

Critical Capabilities



Therapeutic modalities



Pharma + Dia partnership



Prevention approaches



E2E investment

Examples

Brainshuttle™ in AD (trontinemab) and MS (RG6035)

Allo-CAR-T (P-CD19 CD20-ALLO1) to enter Ph I in MS

TRAVELLER prescreening program in AD uses blood-based biomarkers to reduce diagnostic burden (CSF/PET)

Elecsys® NfL blood-test detects disease activity

Initiating Ph III trial of trontinemab in Preclinical AD

Invest end-to-end in Alzheimer's disease and Multiple sclerosis from discovery, R&D, to commercialization

Invest into breakthrough innovation in Parkinson's disease



Neurology pipeline

Trontinemab in AD and prasinezumab in PD moving into Ph III development

Phase I	Phase II	Phase III	Registration
RG6035 Brainshuttle™ CD20 Multiple Sclerosis	RG1594 Ocrevus SC OBI MS	RG6168 Enspryng MOG-AD RD	RG6356 Elevidys ¹ DMD ² RD
RG6540 P-CD19 CD20-ALLO1* Multiple Sclerosis	RG6289 nivegacetor (GSM) Alzheimer's	RG6168 Enspryng AIE RD	
RG6182 MAGLi Multiple Sclerosis	RG6042 tominersen Huntington's	RG7845 fenebrutinib RMS	
RG6662 HTT miRNA GT (SPK-10001) Huntington's RD	RG6237 + emugrobart (GYM329) + Evrysdi SMA RD	RG7845 fenebrutinib PPMS	
RG6434 undisclosed Neurodegenerative disorders	RG6237 emugrobart (GYM 329) FSHD RD	RG6356 Elevidys ¹ DMD (>8 y.o. ³) RD	
RG6418 selnoflast Parkinson's	RG6356 Elevidys ¹ DMD (0-4 y.o.) RD	RG7935 prasinezumab Parkinson's	
	RG6168 Enspryng DMD RD	RG6102 trontinemab Alzheimer's	
	RG7816 alogabat Angelman Syndrome		

- Neuroimmunologic disorders
- Neurodegenerative diseases
- Neurodevelopmental disorders
- Neuromuscular disorders
- RD = Rare disease

- Small molecule
- Antibody
- Gene therapy
- Brainshuttle™
- Locked nucleic acid/antisense
- Allogeneic CAR-T

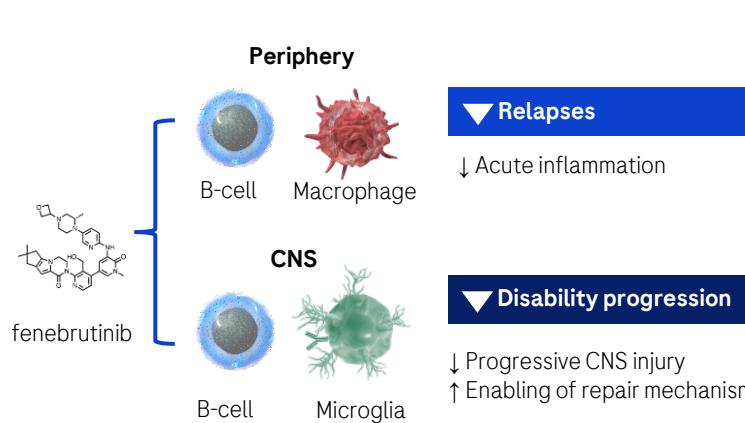
* IND filed; 1. Elevidys in partnership with Sarepta Therapeutics; 2. Elevidys approved in US, filed in EU; 3. Ambulatory, 8- $<$ 18 yrs; non-ambulatory, all ages; AIE: Autoimmune encephalitis; DMD: Duchenne muscular dystrophy; FSHD: Facioscapulohumeral muscular dystrophy; GSM: Gamma-secretase modulator; MAGL: Monoacylglycerol lipase; MOG-AD: Myelin oligodendrocyte glycoprotein antibody-associated disease; NMOSD: Neuromyelitis optica spectrum disorders; PPMS: Primary progressive multiple sclerosis; RMS: Relapsing multiple sclerosis; SMA: Spinal muscular atrophy; y.o.: year old



Fenebrutinib: Potentially BIC BTKi different by design

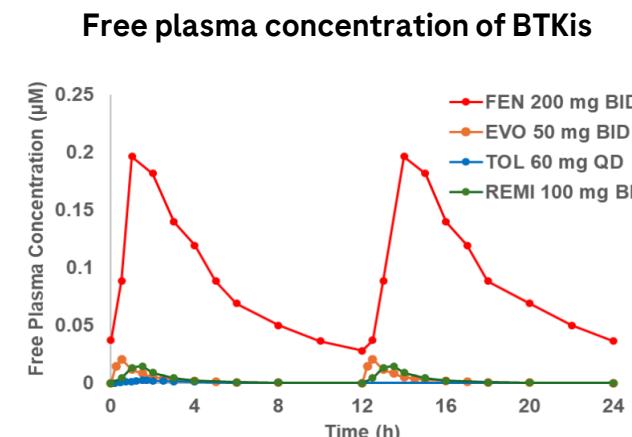
The only BTKi that achieves CSF concentrations $>IC_{90}$ for B-cells and microglia for 24h¹

Dual mechanism of action



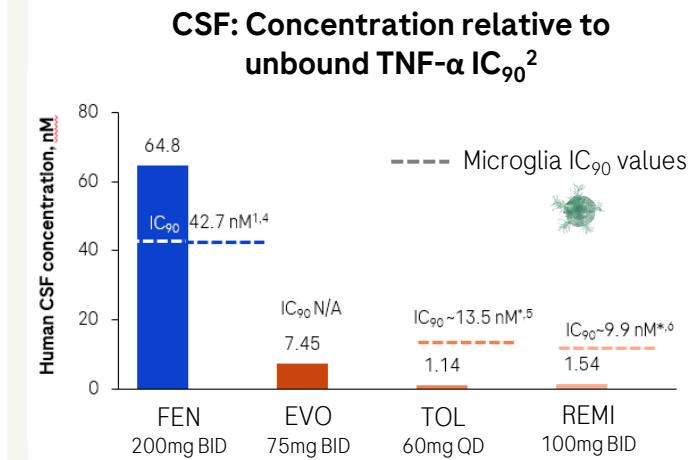
- BTKi dual mechanism of action, inhibiting both B-cells and myeloid-lineage cells (macrophages, microglia), has the potential to impact both relapsing and progressive disease biology in MS
- Orals continue to make up around 30% of MS market, but currently offer modest efficacy

Optimized PK profile¹



- Fenebrutinib with high bioavailability, long half-life and large free fraction in plasma
- Free plasma AUC significantly higher vs. other BTKi
- Free plasma AUC defines the drug's availability to enter the brain and drives brain concentration

CNS Penetration¹



- Optimized PK profile allows for plasma and CSF concentrations at biologically relevant levels ($>IC_{90}$ for B cells and microglia) for a 24-hour dosing cycle
- Fenebrutinib is the only BTKi that achieves near-maximal inhibition of microglia in the CNS

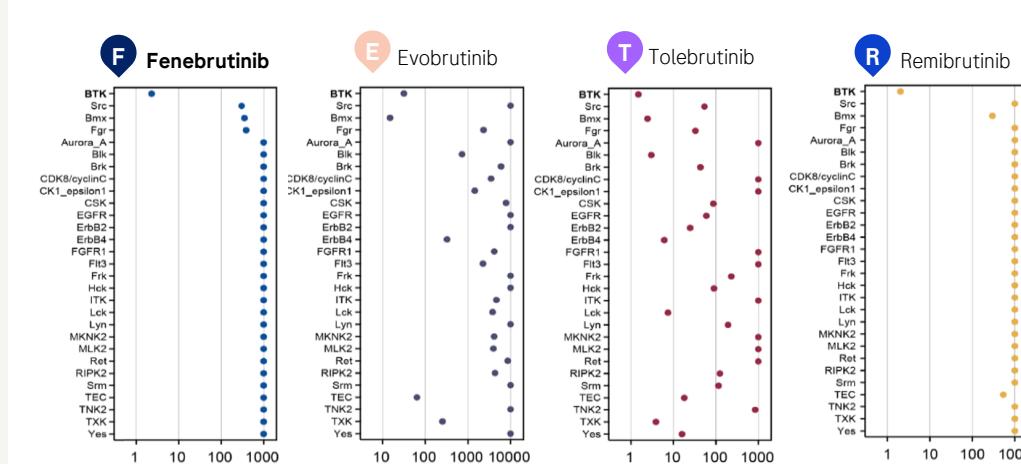
1. Roche data on File; 2. Johnson A, et al. Presented at ACTRIMS 2025 (Poster P146); 3. Langlois J, et al. J Neuroinflammation 2024;21:276; 4. Gruber RC, et al. Nat Commun 2024;15:10116; 5. Nuesslein-Hildesheim B, et al. J Neuroinflammation; 2023;20:194; Cross-trial comparisons which are not based on head-to-head data are inherently limited due to differences in study populations, study design, endpoints and statistical methods. No direct comparisons can be made. Any interpretations regarding relative efficacy or safety should be interpreted with caution and are not statistically supported. See individual study publications for complete data and context; AUC: Area under the curve; MS: Multiple sclerosis; nM: Nanomolar; PPMS: Primary progressive multiple sclerosis; RMS: Relapsing multiple sclerosis; WB: Whole blood



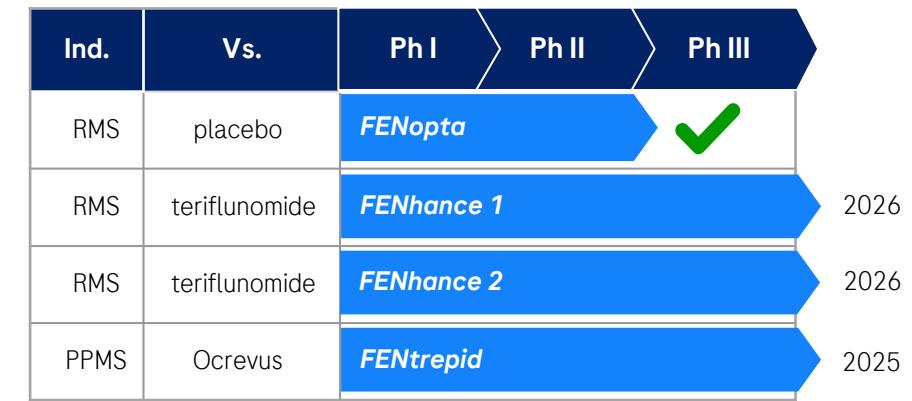
Fenebrutinib: The only non-covalent, reversible BTKi in Ph III MS studies

Highly selective BTKi, potentially contributing to long-term safety

BTKi selectivity¹



Fenebrutinib development program



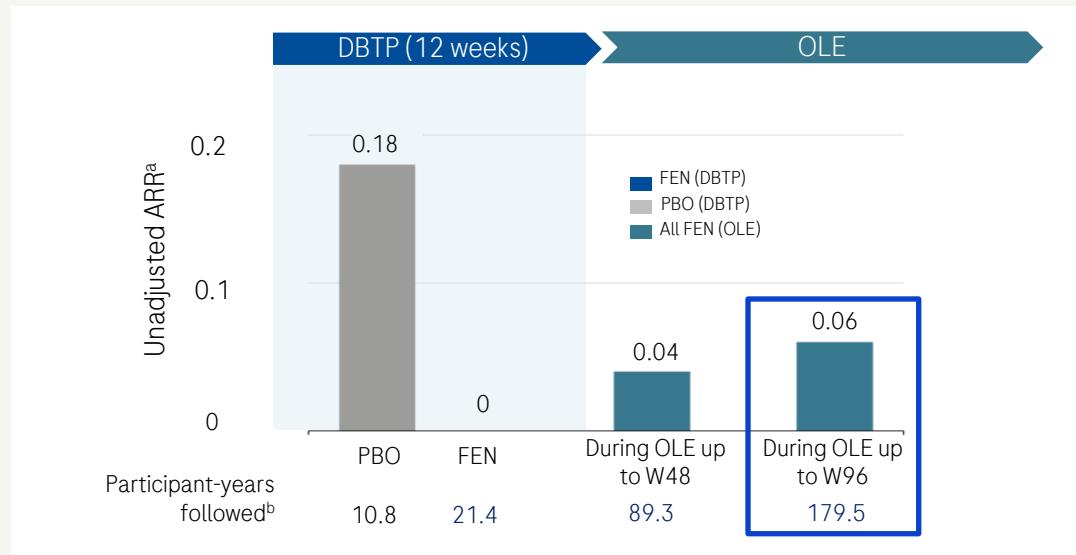
- Fenebrutinib is highly selective for BTK and binds non-covalently, which may limit off-target effects and potentially contribute to better long-term safety

- Ph III (FENTrepid) in PPMS results expected in Q4 2025; FENTrepid is the only H2H study vs Ocrevus
- FENhance 1/2 results in RMS expected in early 2026

Ph II (FENopta) data add to confidence of fenebrutinib in RMS

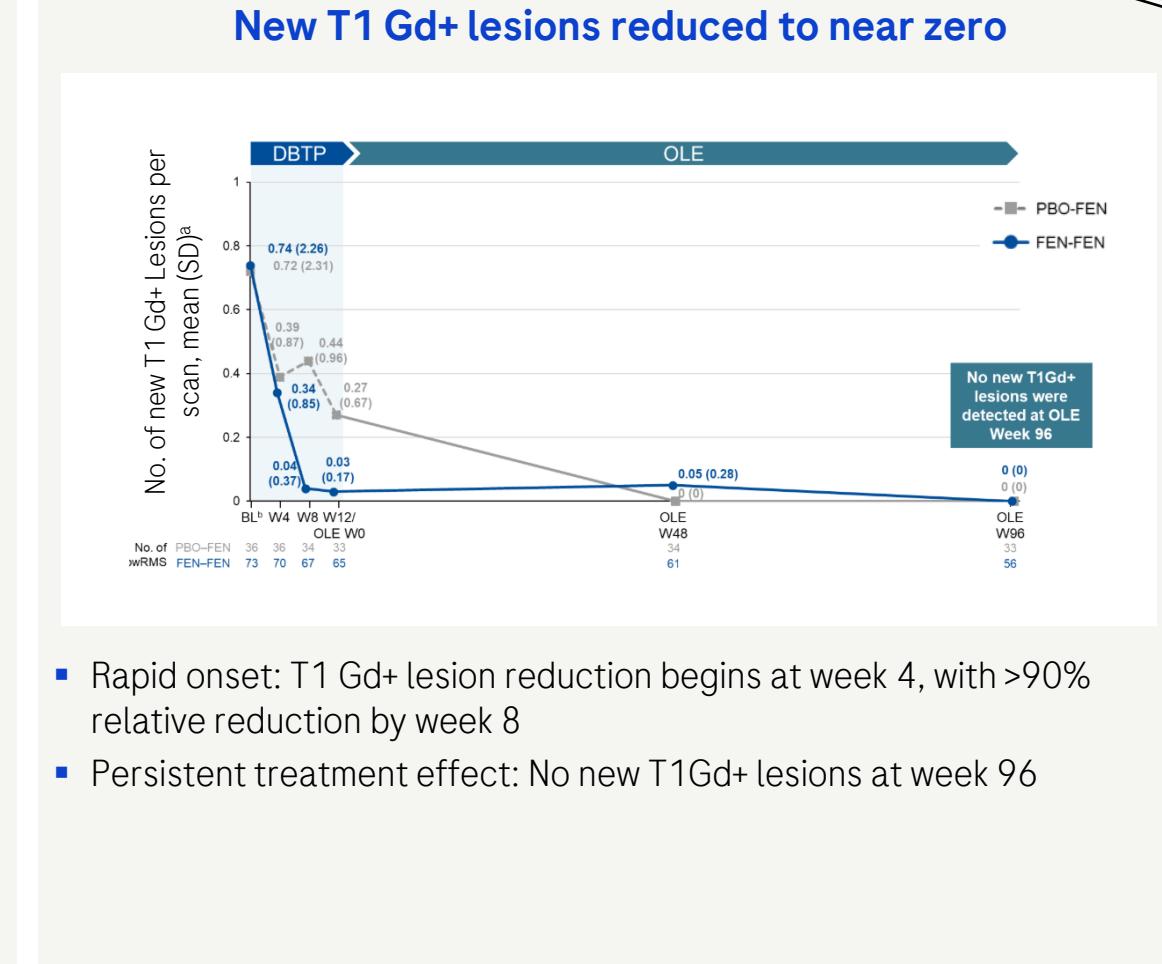
Participants treated with fenebrutinib had low clinical disease activity through week 96

ARR was low in participants receiving fenebrutinib



- ARR of 0.06 translates to approximately 1 relapse every 17 years
- 94% of patients relapse free
- 97% of patients remained in the OLE until week 48

New T1 Gd+ lesions reduced to near zero

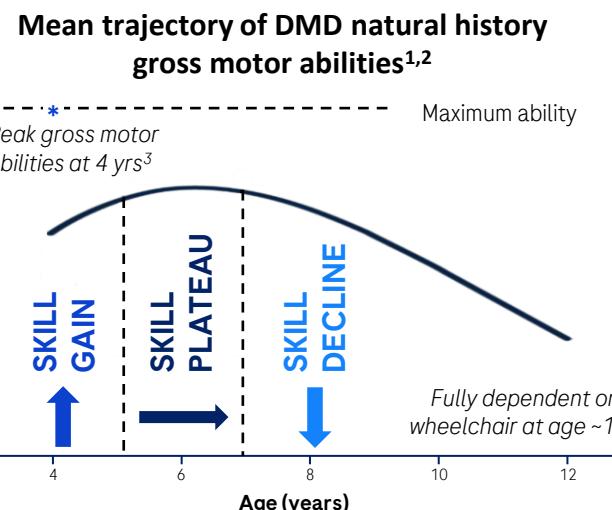


- Rapid onset: T1 Gd+ lesion reduction begins at week 4, with >90% relative reduction by week 8
- Persistent treatment effect: No new T1Gd+ lesions at week 96

Elevidys benefit/risk profile in ambulatory DMD remains positive

Continuing to engage with global health authorities to resume shipping and advance approvals

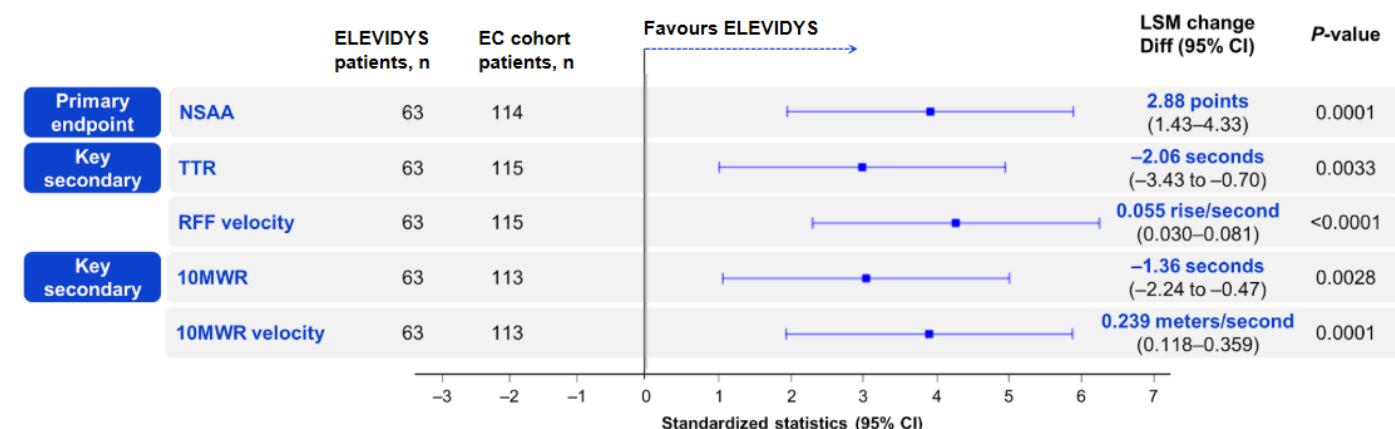
High unmet need in DMD



- Patients on standard of care experience persistent loss of function and have an urgent need for a disease-modifying treatment targeting the underlying disease before irreversible muscle loss^{1,2}

Positive-benefit risk profile in ambulatory DMD

EMBARK Part 1: Functional outcomes at 2 years vs. matched external control³



- Elevidys has demonstrated stabilizing/slowing of disease progression with durable effects on functional muscle; consistent and manageable safety profile in ambulatory DMD¹
- Regulatory status: Plan to engage with EMA following negative CHMP opinion; approved in JP in ambulatory pts 3-7 and insurance coverage discussions in planning; shipping has resumed for ambulatory patients in most other countries referencing FDA approval⁴
- >850 pts with ambulatory DMD treated with Elevidys across clinical and real-world settings

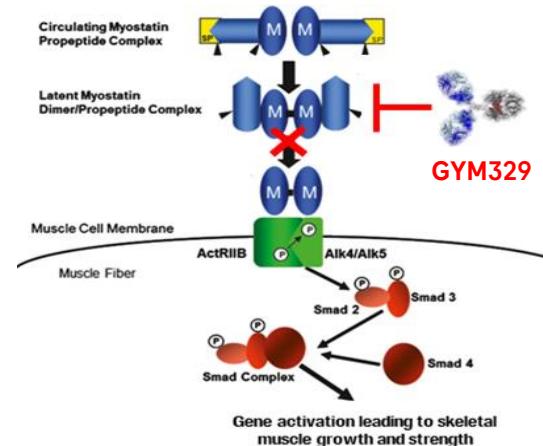
1. Mercuri E, et al. PLoS One. 2016; 11:e0160195; 2. Muntoni F, et al. PLoS One. 2019; 14:e0221097; 3. Mendell et al. MDA 2025; 4. Qatar license suspended; Brazil (health authority safety evaluation ongoing); US approval by partner Sarepta, Roche approval 8 countries ex-US; *LSMs (of change from baseline) and CIs were standardized by dividing by the SE. Negative values for timed function tests (TTR and 10MWR) show an improvement in the time taken to achieve these endpoints. LSMS difference are on original scale (without SE adjustment). Signs of timed function tests were reversed in the forest plot to align favorable directions among endpoints. Numerical results of LSM difference kept the original signs. All P-values reported are nominal and have not been adjusted for multiple comparisons; Ascend 4: Time to ascend 4 steps; CI: Confidence interval; LSM: Least-squares mean; SV95C: Stride velocity 95th centile; 10MWR/100MWR: 10/100-m walk/run velocity; Elevidys in collaboration with Sarepta



Emugrobart (GYM329) Ph II results in SMA, FSHD expected 2025

Emugrobart has best-in-class potential among anti-myostatin mAbs

Anti-latent myostatin mAb



- Emugrobart inhibits latent myostatin, a key negative regulator of skeletal muscle growth and strength
- Unique sweeping¹ and recycling technology allows Q4W SC dosing and highly specific myostatin inhibition; no inhibition of GDF11 (related muscle hormone)²
- Preclinical studies show that GYM 329 has superior muscle strength-improvement effects in mice vs other anti-myostatin therapies²

SMA/FSHD development program

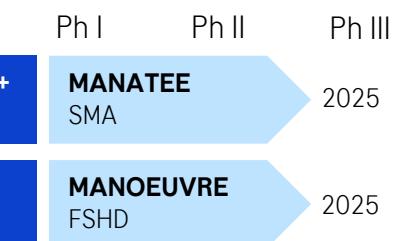
SMA combination rationale



Evrysdi treats the underlying disease, SMA, throughout the CNS and in peripheral tissues



GYM 329 targets skeletal muscles to increase their size and strength



- SMA: Emugrobart has opportunity to be first SC administered anti-myostatin, with potential for differentiated efficacy
- FSHD: Progressive muscle wasting disease with no approved DMTs
- Potential to develop emugrobart in other neuromuscular diseases

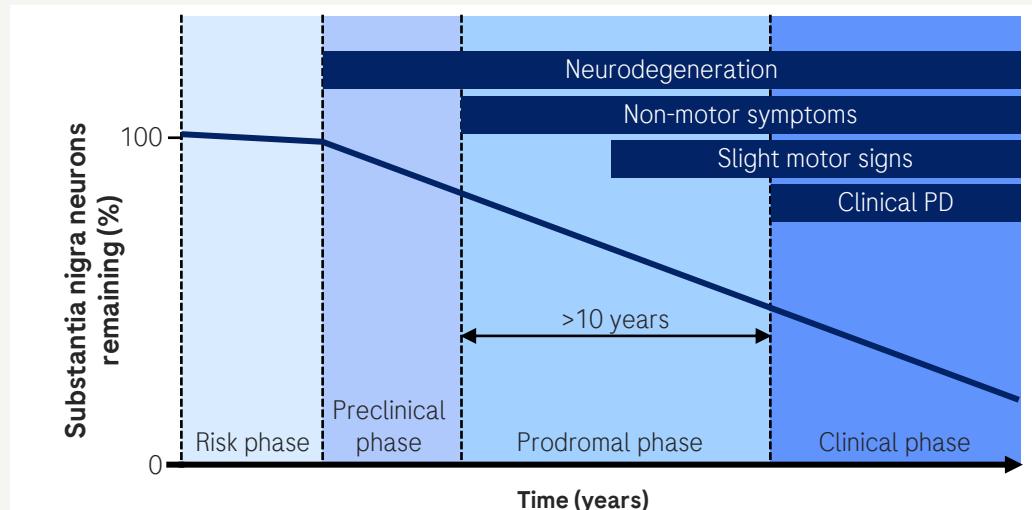
1. Igawa et al. Immunol. Rev. 2016;270:132–151; 2. Muramatsu H. et al., Nature Scientific Reports 2021; 3. Feng et al. Human Molecular Genetic. 2016: 255: 964–975; BL: Baseline; FSHD: Facioscapulohumeral muscular dystrophy; mAb: Monoclonal antibody; PD: Pharmacodynamics; PK: Pharmacokinetics; RHS: Revised Hammersmith Scale; SC: Subcutaneous; SMA: Spinal muscular atrophy; emugrobart in collaboration with Chugai



Parkinson's: Progressive neurodegenerative disease

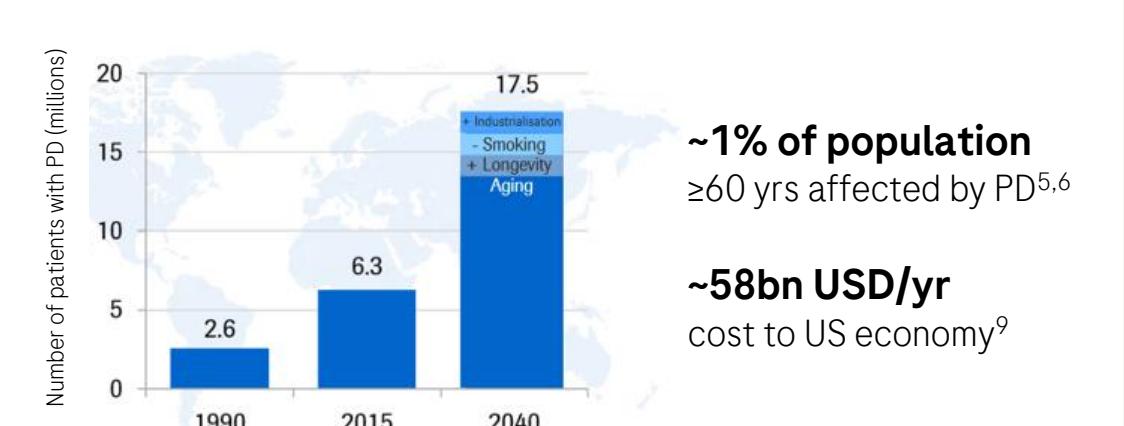
Current symptomatic treatments only address motor symptoms, but do not affect PD progression

Loss of dopaminergic neurons starts many years before onset of symptoms¹



- Neurodegeneration starts long before onset of motor symptoms²
- At time of diagnosis, ~40–60% of dopamine-producing cells in the substantia nigra have already been degenerated³
- The dopaminergic pathway is involved in controlling movement, anticipating rewards, learning from mistakes, and adapting to new situations⁴

Significant economic burden to people and HC systems with no therapies to slow progression



~1% of population
≥60 yrs affected by PD^{5,6}

~58bn USD/yr
cost to US economy⁹

- In early PD the goal of therapy is to improve function and quality of life by enhancing dopamine levels in the brain (i.e. L-DOPA, MAO-B inh.)¹⁰
- After several years, the response to dopamine replacement reduces (“wearing off”) with an increase in motor and non-motor complications¹⁰

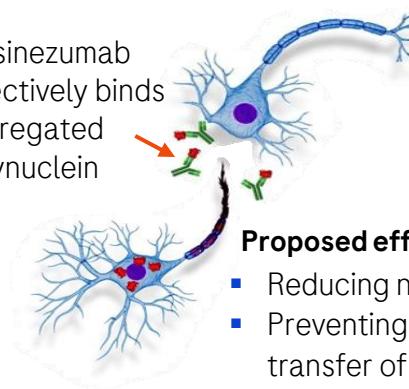
1. Postuma RB & Berg D. Nat Rev Neurol. 2016; 12:622–634; 2. Kalia LV & Lang AE. Lancet. 2015; 386:896–9125; 3. Giguère N, et al. Front Neurol. 2018; 9:455; 4. Meder D, et al. Neuroimage. 2019N 190:79–93; 5. Rizek P et al. CMAJ 2016: 188:1157–1165; 6. Abik A et al. Brain Pathol 2016; 26:410–418; 7. Dorsey ER et al. J Parkinsons Dis 2018; 8: 3–8 8Rossi A et al. Mov Disord 2018; 33:156–159; 9. The Michael J Fox Foundation. Available at <https://www.michaeljfox.org/news/study-finds-parkinsons-52-billion-economic-burden-double-previous-estimates>, updated Jan 13 2022 to 58bn/yr; 10. Stocchi F et al. Nat Rev Neurol 2024 20:695–707; HC: Healthcare; MAO-B inh: Monoamine oxidase type B inhibitor; PD: Parkinson's disease; prasinezumab in collaboration with Prothena



Prasinezumab: Totality of evidence supports Ph III Go decision

Multiple endpoints from Ph II PASADENA and PADOVA suggest potential to delay motor progression

**Prasinezumab
(anti- α -synuclein mAb)**



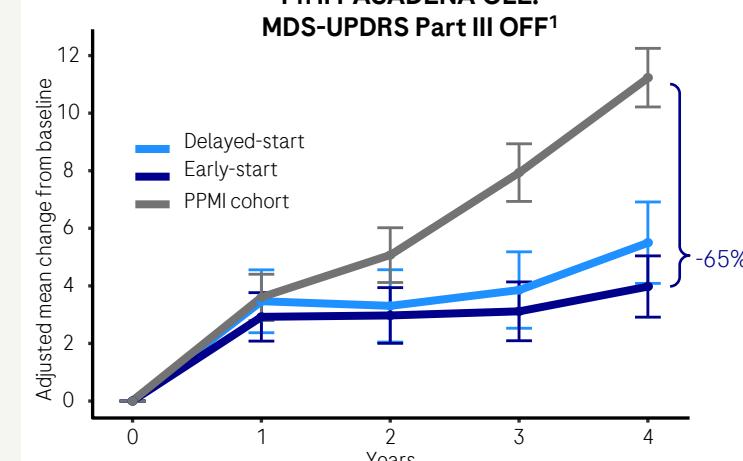
Prasinezumab selectively binds aggregated α -synuclein

Proposed effects:

- Reducing neuronal toxicity
- Preventing cell-to-cell transfer of pathogenic α -synuclein aggregates
- Slowing disease progression

Ph II PASADENA/PADOVA results inform Ph III trial design

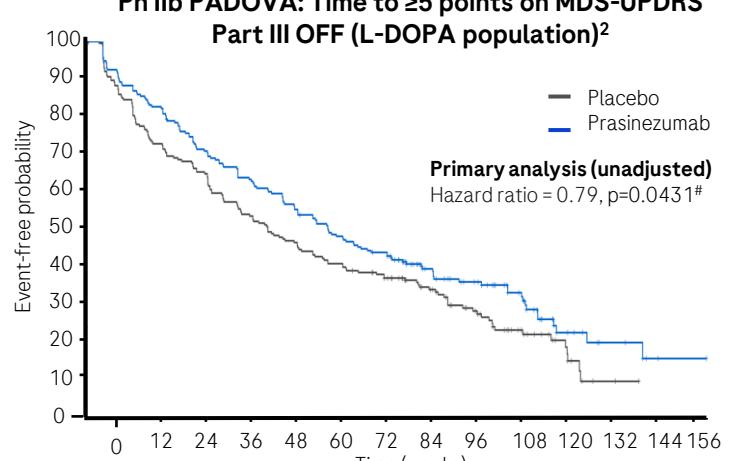
**Ph II PASADENA OLE:
MDS-UPDRS Part III OFF¹**



Year	Delayed-start	Early-start	PPMI cohort
0	0	0	0
1	~3.5	~3.0	~4.5
2	~4.0	~3.5	~5.5
3	~4.5	~3.5	~7.5
4	~5.5	~4.0	~11.0

65% reduction in adjusted mean change from baseline at year 4.

**Ph IIb PADOVA: Time to ≥ 5 points on MDS-UPDRS
Part III OFF (L-DOPA population)²**



Primary analysis (unadjusted) Hazard ratio = 0.79, p=0.0431#

- Prasinezumab has the potential to be the first disease modifying therapy
- Favorable safety profile
- Ph II studies continuing with high retention (~750 pts in OLE)
- Ph III (PARAISO) initiated

- Ph II (PASADENA) results suggest potential benefit and inform Ph III endpoint selection: MDS-UPDRS Part III scale (clinical examination) and novel time-to-event endpoint enhance feasibility of assessing disease progression
- Ph IIb (PADOVA) results add to clinical evidence and inform patient selection: In a pre-specified analysis, the effect of prasinezumab was more pronounced in L-DOPA treated pts (75% of participants) with a HR=0.79, p=0.0431 (nominal)

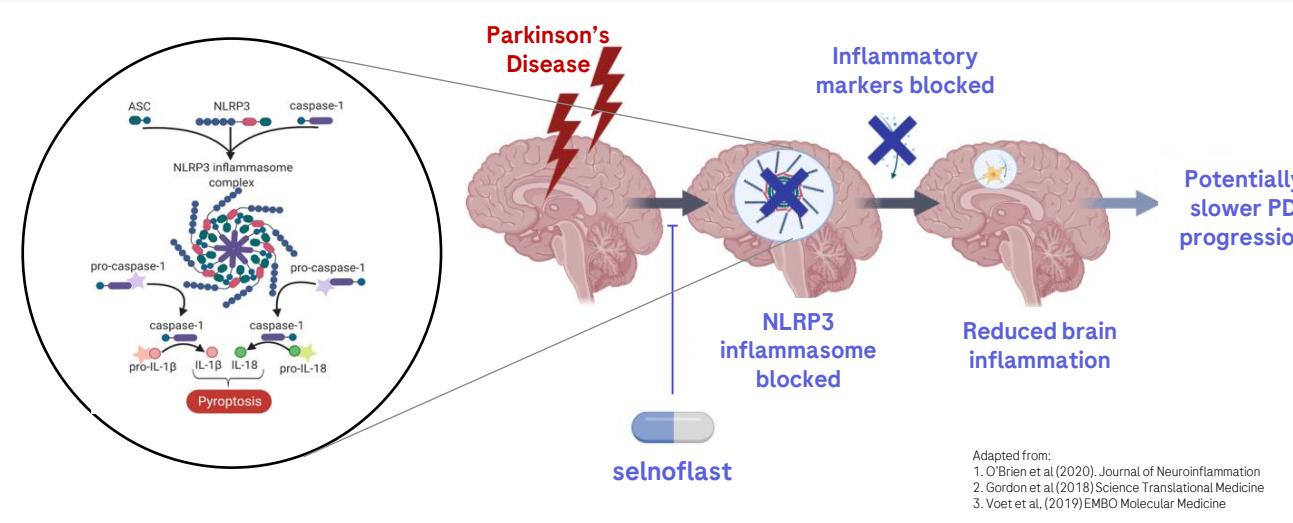
1. Pagano et al. Presented at ADPD 2024; 2. Nikolcheva et al. Presented at ADPD 2025; MDS-UPDRS: Movement disorder society-sponsored revision of the unified Parkinson's disease rating scale; OFF: practically defined OFF state; PD: Parkinson's disease; PPMI: Parkinson progression marker initiative; TTE= time-to-event; prasinezumab in collaboration with Prothena



NLRP3 inhibition in Parkinson's disease

Potential to reduce pro-inflammatory responses in Parkinson's and other diseases

NLRP3 inflammasome inhibition



- The NLRP3 inflammasome is a multi-protein complex implicated in inflammation-related disorders across multiple therapeutic areas
- Inhibition of NLRP3 reduces inflammatory response and may prevent pyroptotic cell death
- Selnolast is an active, potent, selective and reversible oral NLRP3 inhibitor

Selnolast development program

TA	Indication	Ph I	Ph II	Ph III	Status
Neurology	Parkinson's disease				Data in-house
CVRM	Coronary artery disease				Data in-house
Immunology	Asthma				Data exp 2026

- Ph Ib in Parkinson's: Potentially slowing progression by reducing brain inflammation and modulating microglia activation
- Ph Ic in coronary artery disease: Prevention of pro-inflammatory signaling activities in heart that cause MACE
- Ph Ib in moderate-severe asthma: Reduction of airway inflammation and hyper-responsiveness in steroid-resistant asthma

Considerations for successful drug development in AD

Limitations of current AD therapies



Blood-brain barrier penetration

Ensuring drug is reaching site of disease



Rapid and deep reduction in amyloid load

To deliver the potential for maximum clinical benefit



Overall safety profile

To detect and effectively manage risk

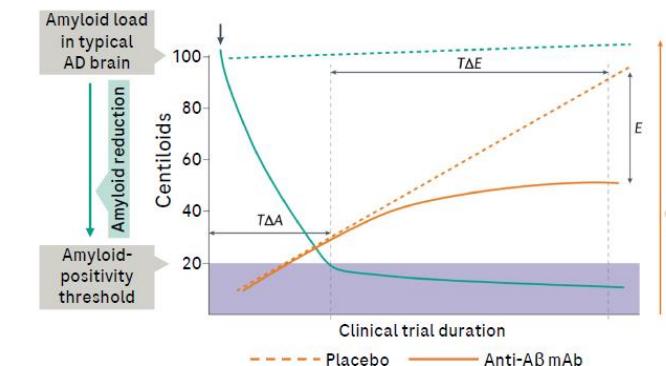


Changes in established fluid biomarkers of disease

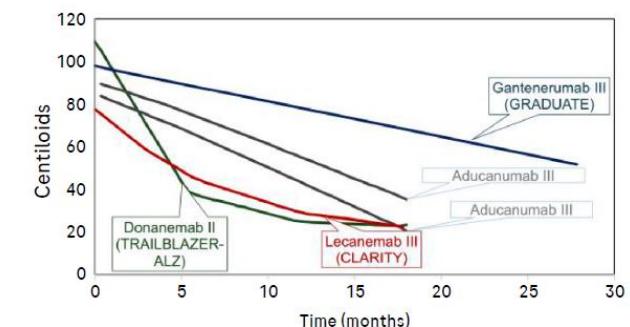
To demonstrate effect on AD pathology downstream of amyloid

Amyloid removal associated with clinical response

Predicted relationship between amyloid removal and clinical response¹



Actual relationship between amyloid removal and clinical response in trials²



- Converging evidence from anti-amyloid immunotherapy trials suggests the rate and amount of clearance of amyloid is important¹
- An amyloid-negative threshold of approximately 24 CL appears to be critical for clinical response¹



Trontinemab has best-in-disease potential in Alzheimer's disease

Updated interim data continue to support differentiated profile on safety and efficacy

**Trontinemab
(Brainshuttle™ anti-A β mAb)**

The diagram illustrates the blood-brain barrier (BBB) as a grey vertical wall between 'Blood' on the left and 'Brain tissue' on the right. A protein complex on the blood side, labeled 'Transferrin receptor 1' (TfR1) and 'A β binder', binds to 'Aggregated A β ' (represented by purple spheres). This triggers the 'Brain shuttle module' (a blue and grey structure) to move across the BBB, carrying the aggregated A β into the brain tissue.

Active TfR1 transport at the capillary level

Recent interim data confirm rapid and deep amyloid lowering with a favorable safety profile

Ph Ib/IIa trontinemab: Dose-dependent amyloid reduction

The graph plots 'Adj. change from BL (CL)' on the y-axis (ranging from -120 to 20) against time points on the x-axis: BL, D50, D78, D106, and D196. Three lines represent different doses: Placebo (black circles), Trontinemab 1.8 mg/kg (blue circles), and Trontinemab 3.6 mg/kg (purple circles). Error bars indicate standard error of the mean.

Time Point	Placebo (n)	1.8 mg/kg (n)	3.6 mg/kg (n)
BL	29	61	59
D50	6	13	13
D78	13	29	30
D106	8	15	14
D196	25	51	54

Key data points from the graph:

Time Point	1.8 mg/kg CL Change	3.6 mg/kg CL Change
D50	-45 CL	-71 CL
D78	-60 CL	-84 CL
D106	-66 CL	-91 CL
D196	-78 CL	-99 CL

Ph Ib/IIa trontinemab ARIA rates

Total number of participants (%)	Part 1 + 2 (combined) (n = 149)	
	Cohort 3 1.8 mg/kg or Pbo (n = 76)	Cohort 4 3.6 mg/kg or Pbo (n = 73)
ARIA-E	3 (3.9%)	1 (1.4%)
ARIA-H	5 (6.6%)	2 (2.7%)
Microhemorrhage	2 (2.6%)	2 (2.7%)
Superficial siderosis	3 (3.9%)	0
ARIA-E with concurrent ARIA-H	0	0

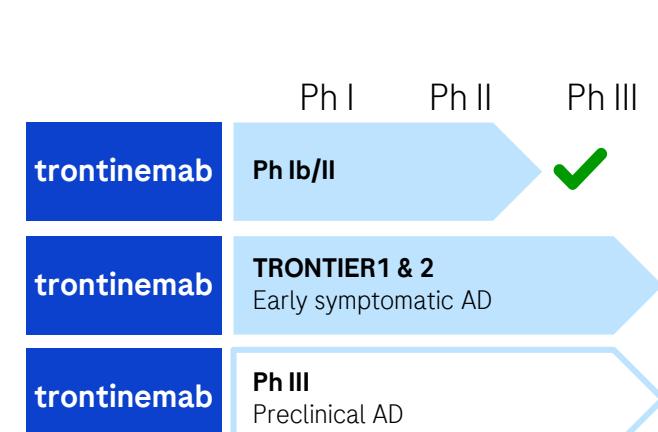
- A β -targeting mAb specifically engineered for efficient TfR-1-mediated transport across the BBB²
- 8-fold increase in CSF/plasma ratio was observed with trontinemab vs. standard antibody²
- 91% of participants were below the amyloid positivity threshold at 28w¹
- Substantial amyloid reduction in all patients (minimum -47 CL change from baseline)
- Pronounced effect on fluid biomarkers: CSF pTau181 decreased 27% at 25w
- <5% incidence of ARIA-E: All events were mild/mild+ in radiologic severity, resolution (MRI) after 4–8 weeks



Trontinemab: First patient in Ph III TRONTIER 1&2 studies in early AD

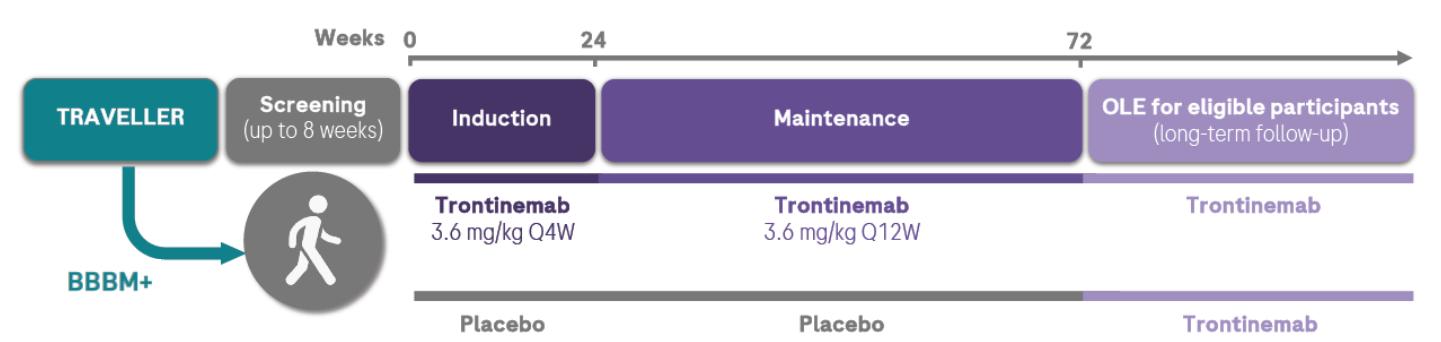
Ph III trial in preclinical AD to be initiated

Trontinemab development program



- TRONTIER 1&2 trials in early symptomatic AD achieved FPI
- Announced intent to initiate Ph III trial in preclinical AD

TRONTIER 1 & 2 trials in early symptomatic AD supported by TRAVELLER pre-screener study



- TRAVELLER: Pre-screener study utilizing blood-based biomarkers, to support recruitment of TRONTIER 1&2; in the first 60 days, >3,000 patients have been enrolled in TRAVELLER
- TRONTIER 1 & 2 dosing regimen:
 - Induction Phase: Q4W for 24 weeks achieving rapid and robust amyloid removal
 - Maintenance Phase: Q12W maintenance dosing to reduce participant burden and further control AD pathology



Identifying amyloid pathology is critical for early AD diagnosis

Blood-based tests drive access to therapies and support disease management

Diagnosis plays a crucial role in AD



>55m people

with dementia, with AD being the most common cause



75% of pts undiagnosed

Despite showing symptoms²

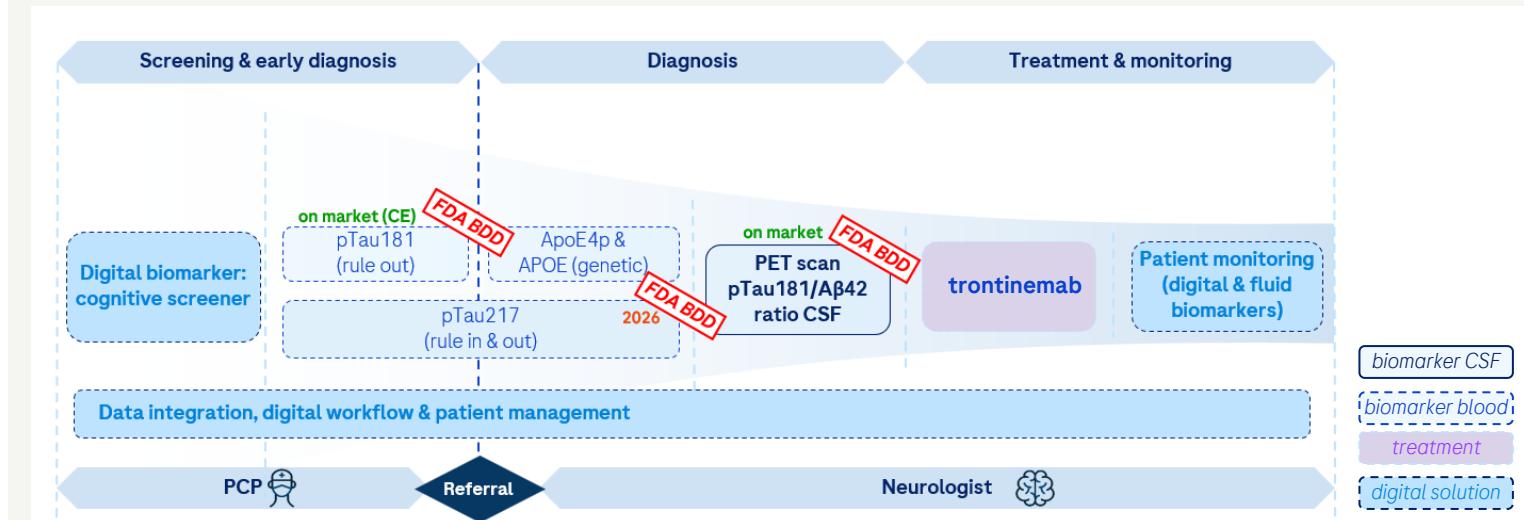


2.8 years to diagnosis

On average post symptom onset³

- Access issues for amyloid PET and invasive nature of CSF draws has limited AD diagnosis

Clinically validated, commercially available blood-based biomarkers are key for differential diagnosis and early triage

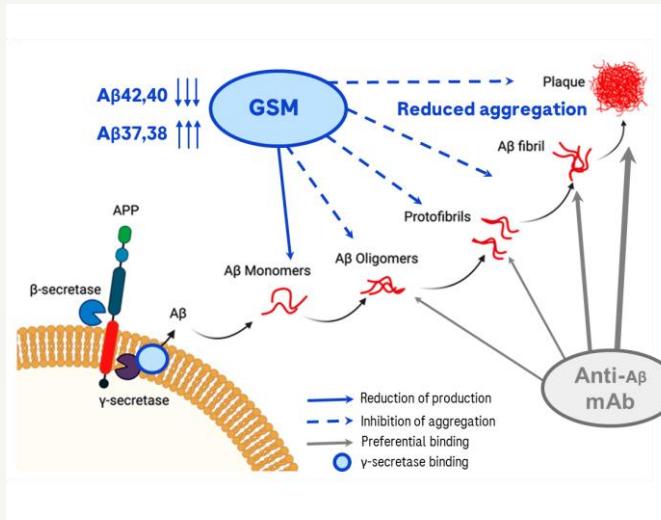


- Elecsys® pTau217 blood-based biomarker test provides comparable results to PET scan and CSF diagnostics for rule-in and rule-out diagnosis of amyloid pathology (launch in 2026)
- Development of blood-based biomarkers enables early screening, including of preclinical population
- Elecsys® pTau217 test is used in trontinemab TRAVELLER study to optimize recruitment into Ph III trials (TRONTIER 1 & 2 and preclinical AD)

Nivegacetor: Potential first-in-class GSM in Alzheimer's disease

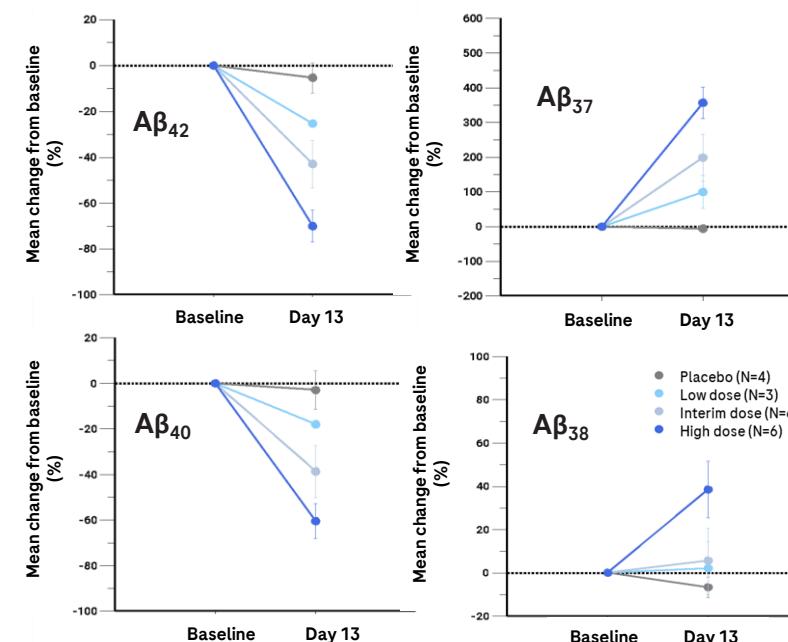
Targeting amyloid precursor protein processing to prevent A β -aggregation

GSM to reduce A β aggregation¹



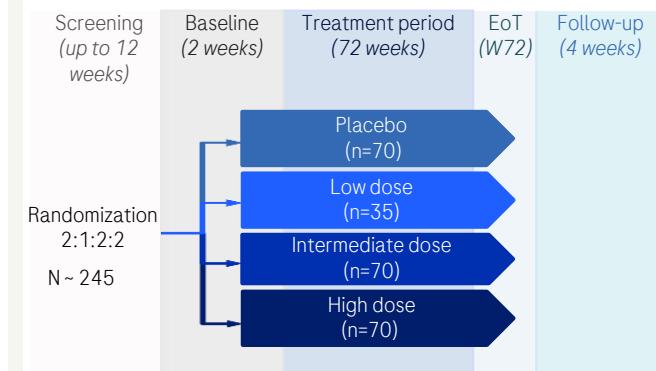
- Nivegacetor is a highly potent and selective oral GSM
- GSMS alter APP processing: less A β 42/40 and increase of A β 38/37
- GSMS prevent amyloid accumulation and halt plaque formation in animal models of AD

Ph I dose escalation results²



- Once daily intake of nivegacetor decreased A β 42/40 and increased A β 37/38 in CSF dose-dependently (HV)

Ph IIa (GABriella) study design³



- Ph IIa (GABriella) in individuals at risk for or at prodromal stage of AD
- Endpoints are safety, tolerability and AD-biomarkers
- Interim data expected in 2026

1. Figure adapted from Vogt et al., Int. J. Mol. Sci. 2023; 2. Sturm et al; presented at CTAD 2023; 3. Tortelli et al. presented at ADPD 2024; A β : Amyloid β ; AD: Alzheimer's disease; APP: Amyloid precursor protein; GSM: Gamma-secretase modulator; mAb: Monoclonal antibody; HV: Healthy volunteers



Immunology

Larry Tsai

*SVP and Global Head of Product Development
Immunology*



Immunology R&D focus areas

Addressing immunology challenges in efficacy, durability, and heterogeneous patient responses

Critical Capabilities

 Optimize pathways	<i>Improve known pathways/targets for transformational benefit</i>	Examples
 Combinations	<i>Target multiple pathways to achieve improved efficacy and deeper remission</i>	p40xTL1A combines orthogonal, validated targets to raise efficacy
 Endotypes	<i>Identify patients' subsets to improve efficacy and guide therapy</i>	Afimkibart IBD trials explore biomarkers to predict better response to treatment
 Cure	<i>Aim for curative treatment to achieve long-term remission</i>	P-CD19CD20-ALLO1 CAR-T has potential to achieve durable B-cell depletion and immune reset
 E2E investment	<i>Invest end-to-end in select disease areas from discovery, R&D, to commercialization</i>	Inflammatory bowel disease (IBD) and chronic obstructive pulmonary disease (COPD)



Immunology pipeline

Broad development portfolio across several disease areas

Phase I		Phase II		Phase III		Registration	
	RG6382 CD19 x CD3 SLE		RG6536 vixarelimab IPF/SSc-ILD		RG7159 Gazyva Membranous nephropathy		RG7159 Gazyva Lupus nephritis
	RG6418 selnolast Asthma		RG7828 Lunsumio SLE		RG7159 Gazyva SLE		RG7159 Gazyva Lupus nephritis
	RG6421 TMEM16A potentiator COPD		RG6631 afimkibart Atopic dermatitis		RG7159 Gazyva Childhood onset INS		RG7159 Gazyva Lupus nephritis
	RG6631 afimkibart MASH		RG6631 afimkibart Rheumatoid arthritis		RG6149 astegolimab COPD		RG7159 Gazyva Lupus nephritis
	RG6377 undisclosed IBD		RG6730 p40 x TL1A Ulcerative colitis		RG6299 sefaxersen IgAN		RG7159 Gazyva Lupus nephritis
	RG6540 P-CD19CD20-ALLO1* SLE		RG6287 flizasertib CS-AKI		RG6631 afimkibart Ulcerative colitis		RG7159 Gazyva Lupus nephritis
	CHU anti-HLA-DQ2.5 x gluten peptides Celiac disease				RG6631 afimkibart Crohn's disease		
	CHU RAY121 (anti-C1s recycling Ab) Immunology						
Data in-house and to be discussed with regulators and shared at an upcoming medical meeting							
Small molecule Antibody Locked nucleic acid / antisense Bispecifics Allogeneic CAR-T Primary endpoint met							
<ul style="list-style-type: none"> Immune-mediated kidney diseases Respiratory & allergy Gastroenterology Others/undisclosed 							

*IND filed; Ab: Antibody; COPD: Chronic obstructive pulmonary disease; CS-AKI: cardiac surgery-associated acute kidney injury; IBD: Inflammatory bowel disease; IgAN: IgA nephropathy; INS: Idiopathic nephrotic syndrome; IPF: Idiopathic pulmonary fibrosis; MASH: Metabolic dysfunction-associated steatohepatitis; SLE: Systemic lupus erythematosus; SSc-ILD: Systemic sclerosis-interstitial lung disease



Well positioned for a strong future in immune-mediated kidney diseases

Chronic kidney disease is predicted to become the 5th leading cause of death globally by 2040¹

Years of life loss due to CKD predicted to continue to increase⁵



- Chronic kidney disease (CKD) is a common and debilitating condition that affects around 1 in 10 people worldwide¹
- CKD is among the most expensive diseases for health systems, with a cost estimated at 24% of annual US Medicare budget² and EUR 140bn annually in Europe³
- Up to 25% of lupus and IgAN patients develop ESKD despite treatment with current available therapies⁴

Development program

Molecule	Indication	Ph I	Ph II	Ph III	Status
Gazyva	LN	REGENCY			✓ Filed US/EU
	SLE/LN	ALLEGORY			2025
	MN	MAJESTY			2026
	INS	INShore			2025
PiaSky	aHUS	COMMUTE*			2025
sefaxersen	IgAN	IMAGINATION			2026
Lunsumio	SLE/LN				Initiated Ph II
CD19xCD3	SLE/LN				Ongoing
P-CD19CD20-ALLO1	SLE/LN				IND filed

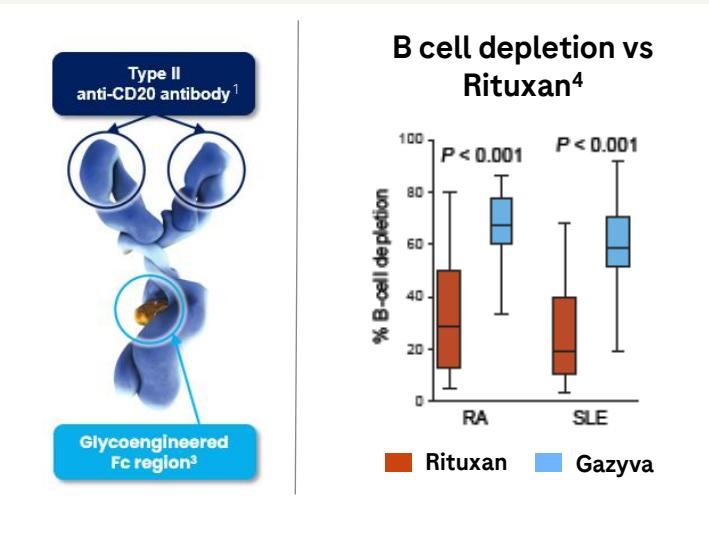
✓ Primary endpoint met



Gazyva: Deeper B-cell depletion key to improved clinical response

Ph III (REGENCY) in lupus nephritis US/EU filing completed; US PDUFA set for October 2025

Gazyva (anti-CD20 mAb)

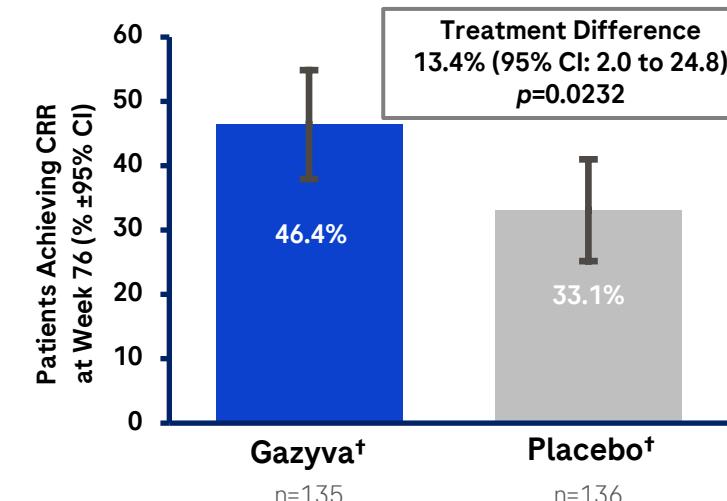


- Type II anti-CD20 region with increased direct cell death, decreased CDC and reduced internalization
- Glycoengineered Fc region with higher FcYR affinity and increased ADCC/ADCP^{2,3}
- Greater potency than Rituxan in depleting peripheral and tissue B-cells

Ph III (REGENCY) results in lupus nephritis

Primary Endpoint: CRR at Week 76

- Includes all of the following:
- UPCR <0.5 g/g
 - eGFR ≥85% of baseline
 - No intercurrent events of rescue therapy, treatment failure, death and/or early study withdrawal



- Primary endpoint of CRR at week 76 achieved with statistically significant and clinically meaningful treatment difference of 13% (95% CI: 2.0 to 24.8)
- International and national Lupus Nephritis Guidelines have already been updated with 1L positioning of Gazyva, including Gazyva as a combination therapy (EULAR, BSR, GLADEL); others expected to be updated upon revision
- Ph III data in SLE (ALLEGORY) and INS (INShore) expected 2025; Ph III (MAJESTY) in MN data expected 2026

1. Yurkovich M, et al. Arthritis Care Res. 2014;66:608. 2. Rahman A and Isenberg DA. N Engl J Med. 2008;358:929 938; 3. Gomez Mendez LM, et al. Clin J Am Soc Nephrol. 2018;13:1502 1509; 4. Adapted from Reddy V, et al. Rheumatology (Oxford).2017;56:1227 1237; 5. Rovin BH, et al. WCN 2025; †Plus ST of mycophenolate mofetil plus glucocorticoids; ADCC: Antibody-dependent cell-mediated cytotoxicity; ADCP: Antibody-dependent cellular phagocytosis; CDC: Complement-dependent cytotoxicity; CI: Confidence interval; CRR: Complete renal response; eGFR: Estimated glomerular filtration rate; INS: Idiopathic nephrotic syndrome; MN: Membranous nephropathy; SLE: Systemic lupus erythematosus; UPCR: Urine protein creatinine ratio; EULAR: European League Against Rheumatism; BSR: British Society for Rheumatology; GLADEL: Grupo Latino Americano de Estudio del Lupus



Multiple B cell depletion approaches for SLE/LN in development

Initiated Ph II study for Lunsumio and Ph I study for P-CD19CD20-ALL01

Bispecifics: Lunsumio (CD20xCD3) & CD19xCD3

Activation, proliferation

Cell death

B-Cell Depletion in pts with SLE treated with Lunsumio¹

Day	5 + 15 mg (n=3)	5 + 45 mg (n=3)	5 + 60 mg (n=3)
0	~400	~400	~400
100	~10	~10	~10
200	~10	~10	~10
300	~10	~10	~10
400	~10	~10	~10

eular 2025

- Lunsumio in SLE/LN preliminary Ph I data shows deep B-cell depletion, with patients depleting to below 0.4 cells/uL in the 3 highest dose cohorts
- Lunsumio exhibits an acceptable safety profile and PK profile consistent with that observed in R/R NHL population
- Lunsumio Ph II study in SLE/LN initiated in 2025
- CD19xCD3 Ph I study in SLE/LN ongoing

Allogeneic CAR-T: P-CD19CD20-ALLO1 CAR-T

- Transposon-based CAR insertion
- Cas-CLOVER gene editing technology
- Two full-length CARs with novel human VH binders
- “Off-the-shelf” therapy with high manufacturing yields with Poseida’s proprietary Booster molecule

- Preclinical data shows complete B-cell depletion in samples from patients with RA, SLE, and MS²
- FDA IND filed for P-CD19CD20-ALLO1 CAR-T in SLE/LN; Ph I to start in 2025

1. Chindalore V, et al. EULAR 2025; 2. Poseida Cell Therapy R&D Day, Nov 2024; IND: Investigational new drug; SC: Subcutaneous; R/R: Release refractory; NHL: Non-Hodgkins lymphoma; PK: Pharmacokinetics; CAR-T: Chimeric antigen receptor T cells; KO: Knock out; LN: Lupus nephritis; MHC: Major histocompatibility complex; MS: Multiple sclerosis; RA: Rheumatoid arthritis; SLE: Systemic lupus erythematosus; TCR: T cell receptor

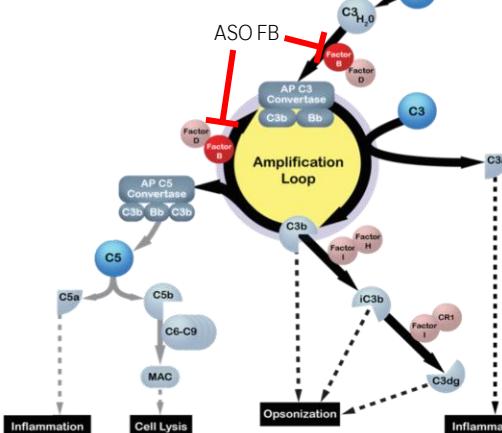


Sefaxersen: First ASO for selective complement suppression in IgAN

Convenient monthly dosing with robust Ph II clinical outcomes; Ph III (IMAGINATION) results expected 2026

Sefaxersen (ASO Factor B)

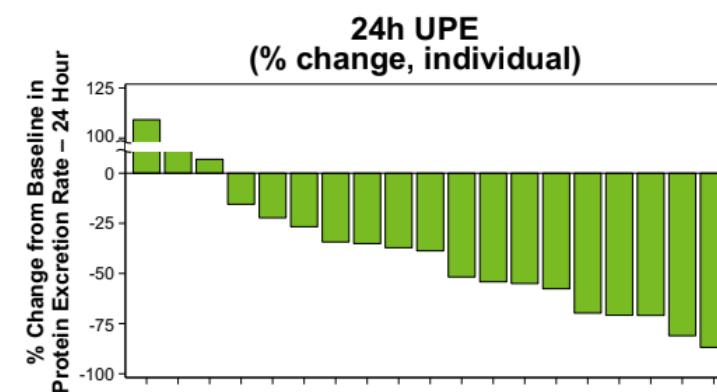
Alternative complement pathway



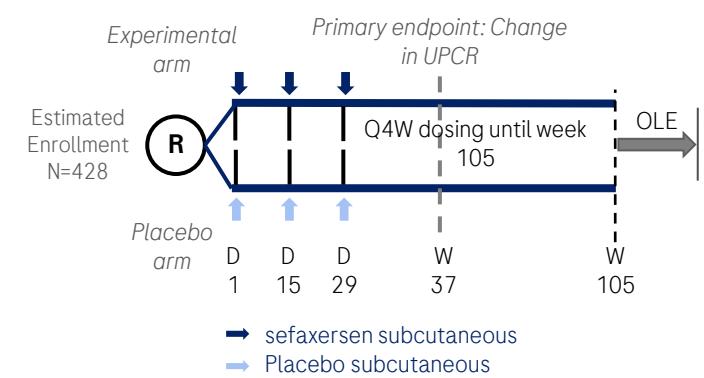
- Globally, IgAN is the most common primary GN that can progress to renal failure
- High levels of CFB are associated with IgAN^{1,2}
- Sefaxersen downregulates CFB production by inhibiting mRNA translation

Clinical development program in IgAN

Early Ph II results³



Ph III (IMAGINATION) trial design

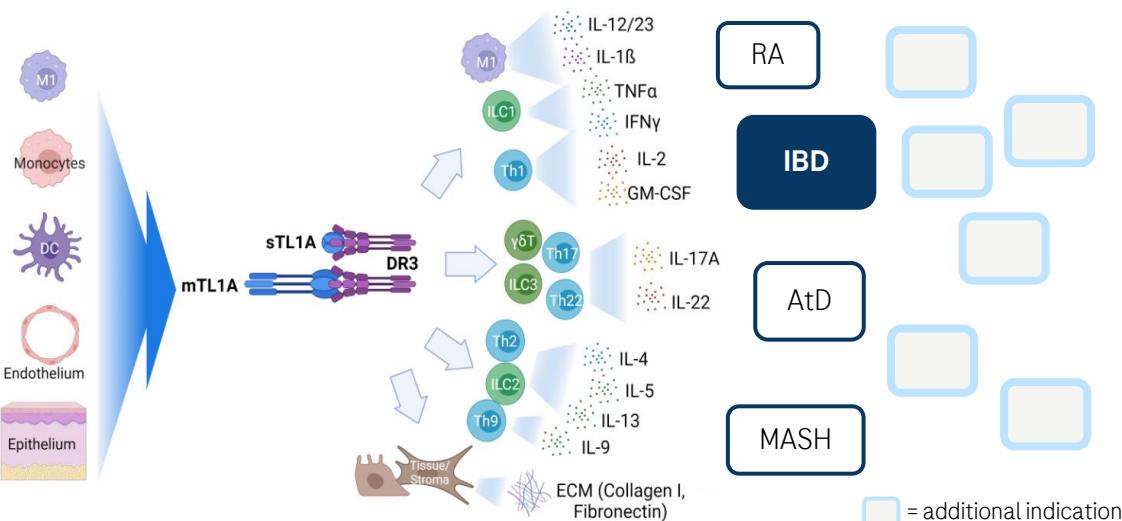


- Ph II study met its primary endpoint of change in 24-hour urinary protein, with 43% mean reduction in proteinuria at week 29^{3,4}
- Improvement also seen in secondary outcomes of change in UPCR from baseline to week 29; kidney function stable during the study³
- Ph III (IMAGINATION) results expected 2026

Afimkibart: Broad anti-TL1A development program

TL1A is linked to multiple immunological diseases: IBD, AtD, MASH trials ongoing, initiated RA & pediatric IBD

TL1A is upstream of multiple immunological cytokine & cellular pathways, presenting pan-immunological potentia



- TL1A/DR3 binding acts as a key amplifier of inflammatory pathways and tissue remodeling in immune-mediated diseases¹
 - TL1A- and DR3-expressing cells are known drivers of different immune-mediated and fibrotic diseases
 - Non-clinical and translational studies demonstrated its involvement in pathogenesis of fibrotic conditions

Development program

Indication	Ph I	Ph II	Ph III	FPI status
Ulcerative colitis	AMETRINE 1 & 2			Q3'24
Crohn's disease	SIBERITE 1 & 2			Q1'25
Atopic dermatitis				Q1'25
Rheumatoid arthritis				Q4'25
MASH				Q1'25

- Initiated Ph II in rheumatoid arthritis
 - Initiated pediatric UC and CD registrational studies
 - CD, AtD, and MASH recruitment on track
 - Continuing to explore additional indications

1. Ref: Solitano V, et al. Med. 2024;5(5):386-400; Hassan-Zahraee M, et al. Inflamm Bowel Dis. 2022;28(3):434-446; Bamias G, et al. Gut. 2025;74(4):652-668; Xu WD, et al. Front Immunol. 2022, 13:891328; AtD: Atopic dermatitis; CD: Crohn's disease; DR3: Death receptor 3; IBD: Inflammatory bowel disease; MASH: Metabolic dysfunction-associated steatohepatitis; RA: Rheumatoid arthritis; AtD: Atopic dermatitis; TL1A: Tumor necrosis factor-like cytokine 1A; UC: Ulcerative colitis; ECM: Extracellular matrix; FPI: First patient in

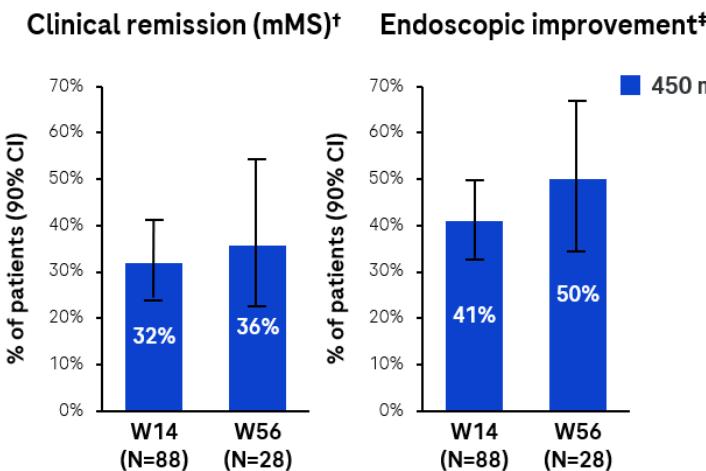


Afimkibart in UC: Significant recruitment acceleration

Fast-Track designation enabled expedited trial enrollment and execution

Ph IIb (TUSCANY-2) in UC¹

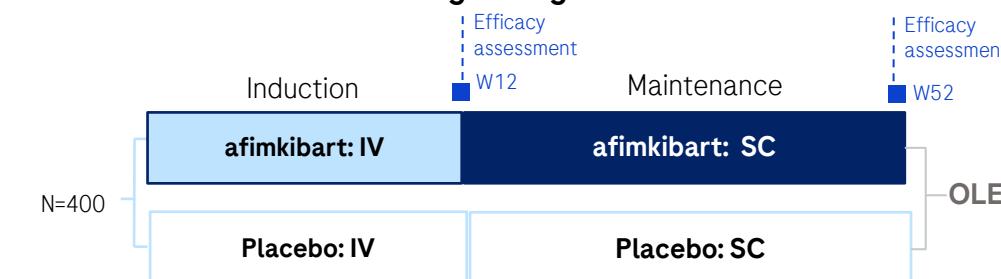
THE LANCET
Gastroenterology & Hepatology



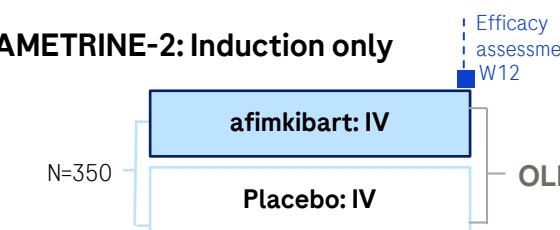
- Ph IIb (TUSCANY-2) in UC demonstrated strong efficacy and safety in a large group of pts (n=245)
- Sustained clinical remission and endoscopic improvement from induction to chronic phase

Ph III (AMETRINE-1&2) study design in UC

AMETRINE-1: With treat-through design



AMETRINE-2: Induction only



- Ph III (AMETRINE-1&2) accelerated recruitment by up to 6 months; Ph III results expected 2027
- Ph III (SIBERITE1&2) in CD, Ph II in AtD, and Ph I in MASH recruitment on track
- Exploring biomarker test which may predict better response to treatment

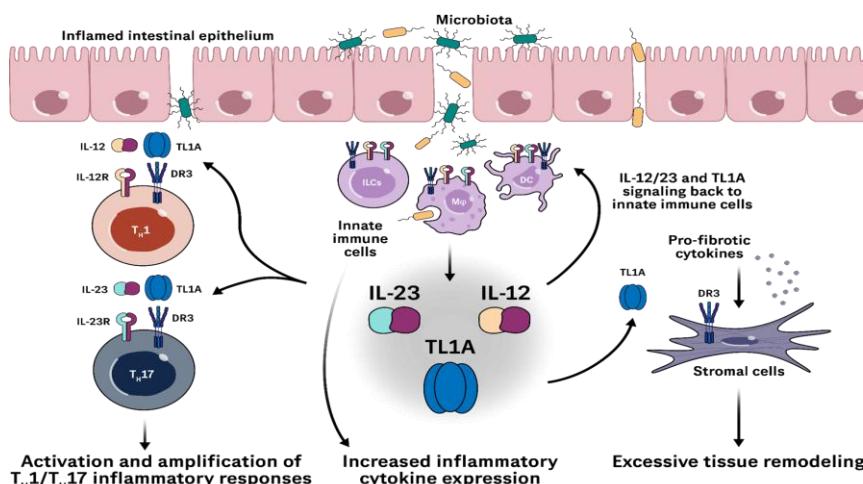
1. Danese S. et al. The Lancet Gastroenterology & Hepatology 2025, ISSN 2468-1253, [https://doi.org/10.1016/S2468-1253\(25\)00129-3](https://doi.org/10.1016/S2468-1253(25)00129-3); [†]Defined per FDA definition with an mMS 0-2 (endoscopic subscore=0 or 1, ≥1 point decrease from baseline to achieve a stool frequency subscore=0 or 1, and rectal bleeding subscore=0). [‡]Defined as endoscopic subscore=0 or 1; *Biomarker not yet disclosed; mMS=modified Mayo score; aTL1A: Anti-tumor necrosis factor-like cytokine 1A; CD: Crohn's Disease; Cl: Confidence interval; FPI: First-patient-in; IV: Intravenous; MASH: Metabolic dysfunction-associated steatohepatitis; mMS: Modified Mayo score; OLE: Open label extension; SC: Subcutaneous; UC: Ulcerative colitis; W: Week



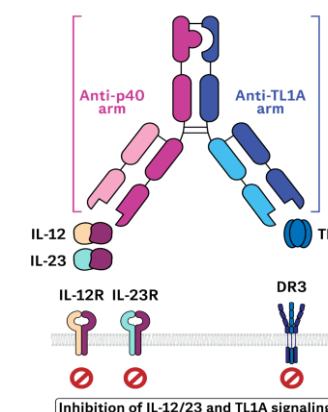
p40xTL1A bispecific: Simultaneously targeting two pathways in IBD

Bispecifics inhibiting TL1A and other validated targets may break the IBD efficacy ceiling

p40xTL1A inhibits two key targets central to IBD pathology: IL-12/IL-23 and TL1A



p40xTL1A bispecific*⁹⁻¹⁰



Development program

Indication	Ph I	Ph II	Ph III	FPI status
Ulcerative colitis		SUNCREST		Q3'25

- IL-12 and IL-23 are proinflammatory cytokines that both contain the p40 subunit, promote intestinal inflammation, and are strongly associated with IBD pathology⁶⁻⁸
- The TL1A cytokine is an amplifier of immune responses that plays a key role in chronic inflammation and tissue damage
- Due to the diverse mechanisms driving IBD, simultaneously inhibiting multiple targets may overcome the therapeutic efficacy ceiling¹⁻⁵

- Ph IIb (SUNCREST) in UC initiated, with FPI expected Q3'25
- Additional bispecifics in preclinical development

*Global collaboration with Pfizer; 1. Selin KA, et al. J Crohns Colitis. 2021;15(11):1959-1973.; 2. Schmitt H, et al. Gut. 2019;68(5):814-828.; 3. Valatas V, et al. Front Immunol. 2019;10:583. 4. Strober W, Fuss IJ. Gastroenterology. 2011;140(6):1756-1767.; 5. Li L, et al. Arch Dermatol Res. 2014;306(10):927-932.; 6. Verstockt B, et al. Nat Rev Gastroenterol Hepatol. 2023;20(7):433-446.; 7. Xu WD, et al. Front Immunol. 2022;13:891328.; 8. Bamias G, et al. J Immunol. 2003;171(9):4868-4874.; 9. ClinicalTrials.gov Identifier, NCT05536440; 10. ClinicalTrials.gov Identifier, NCT06979336.; DR3: Death receptor 3; FPI: First patient in; IBD: Inflammatory bowel disease; IL: Interleukin; TH: T helper; TL1A: Tumor necrosis factor-like ligand 1A; UC: Ulcerative colitis

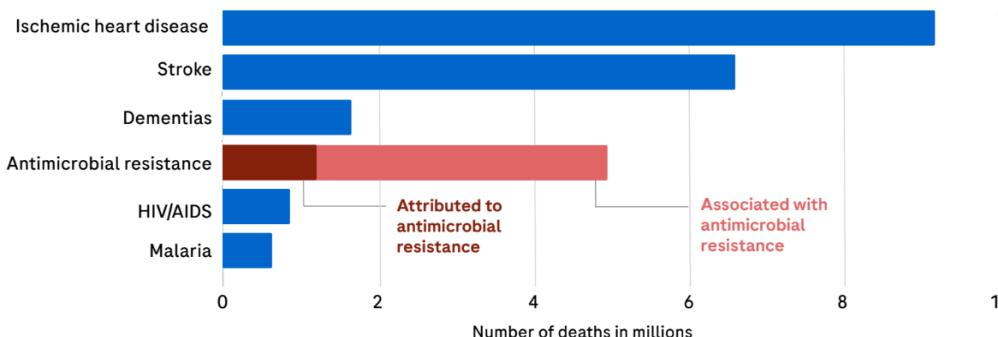


Zosurabalin in antimicrobial resistance

Zosurabalin represent the first new class of antibiotics against gram negative bacteria in 50 years

Antimicrobial resistance (AMR)

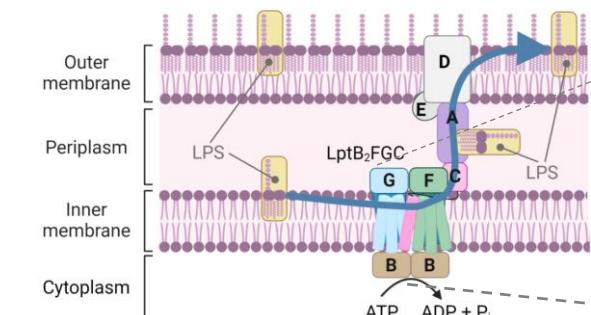
The global burden of AMR is a present and growing danger³



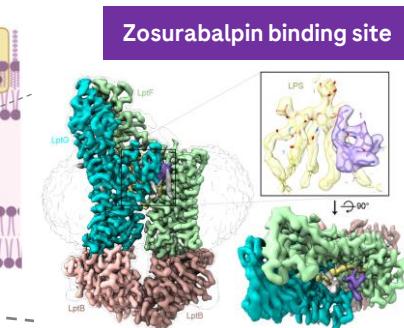
- AMR is a 'silent pandemic' expected to claim more lives over the next 30 years than cancer today
- Despite the need for antibiotics and the rise of antibiotic resistance, no novel class of antibiotics effective against gram-negative bacteria has been discovered since 1968

Zosurabalin (Abx macrocyclic peptide)

Localization of the LPS transport system in gram-negative cell envelope¹



Cryo-EM structure of zosurabalin bound to the LptB₂FBG transporter and LPS²



- Zosurabalin blocks transport of lipopolysaccharide (LPS) by inhibition of LptB2FG complex
- This novel MoA prevents carbapenem-resistant *A. baumannii* (the highest threat pathogen according to WHO and CDC) from properly constructing its protective membrane
- Ph III to initiate in 2026

1. Picture created with BioRender.com. Adapted from Owens et al., Nature 2019, 567, 550; 2 Cryo-EM structure derived from Roche pRED / Dan Kahne Laboratory, Harvard University, collaboration; 3.Lancet 2022; 399: 629-55; CDC: Centers for Disease Control and Prevention; LPS: Lipopolysaccharide; MoA: Mechanism of action; WHO: World Health Organization



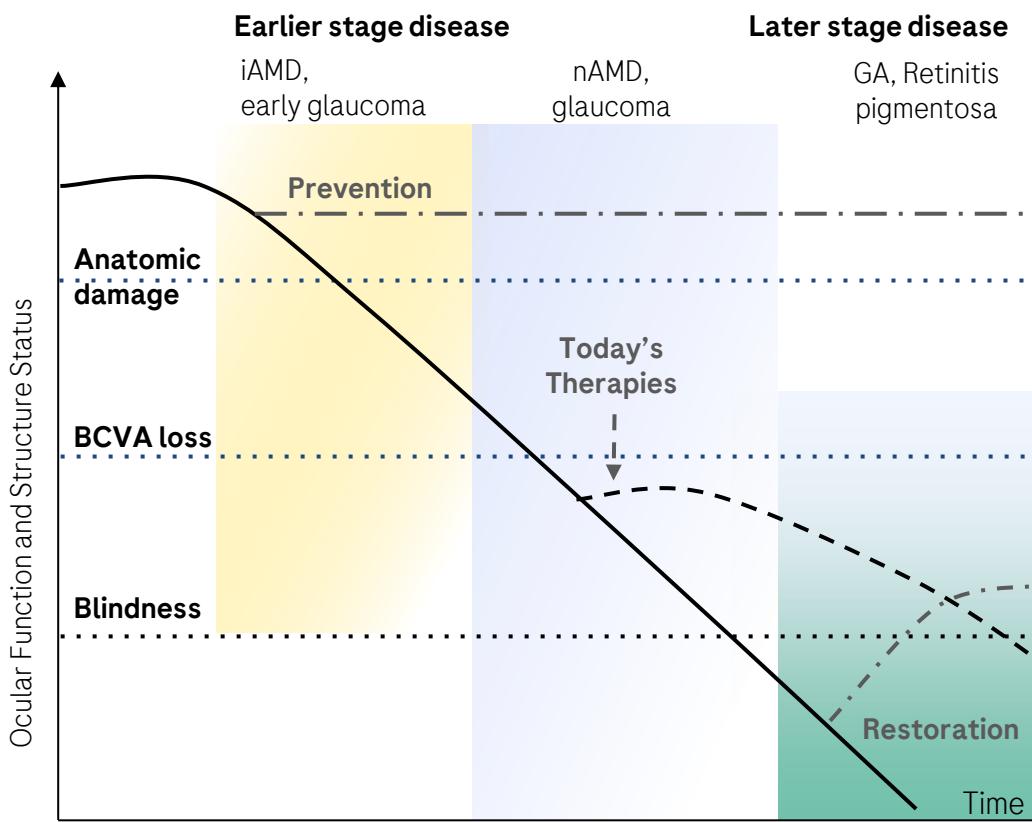
Ophthalmology

Christopher Brittain

*SVP and Global Head of Product Development
Ophthalmology*



Ophthalmology: Aiming to alter the trajectory of vision loss



Improve outcome across all stages of ocular diseases

Earlier stage disease: Vision preservation

- Supplement current target approaches: Inhibit inflammation & neo-angiogenesis
- Explore clinically useful biomarkers predicting rapid vision loss
- Protect key retinal lineages

Later stage disease: Vision restoration

- Replace photosensitive cells once vision is lost
- Continue investment in new therapeutic modalities e.g., cell therapy and gene therapy/optogenetics



Ophthalmology R&D focus areas

Improving patient outcomes and reducing treatment burden

Critical Capabilities



**Novel MoAs & new indications,
addressing multiple disease
pathways**



**Extended durability & future
technologies**



Digital capabilities



E2E investment

Examples

New MoAs to target a broader range of disease pathways and address additional indications

Multiple approaches for long-acting delivery, intravitreal targets, and potential for vision restoration

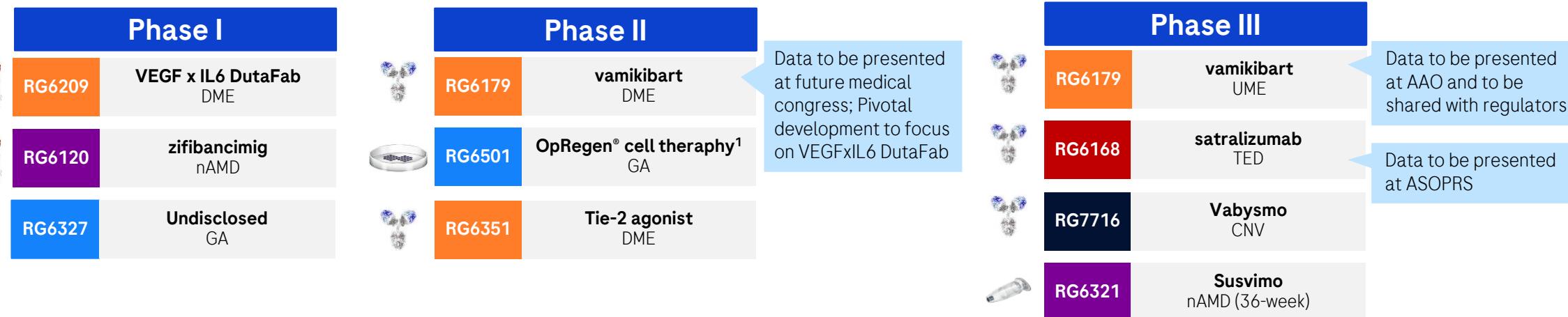
Expanded capabilities that apply biomarkers and data analytics, remote vision monitoring, and AI-supported clinical decision-making

Invest end-to-end in retinal vascular disease (RVD), geographic atrophy (GA) and iAMD from discovery, R&D, to commercialization



Ophthalmology pipeline

Further improving the standard of care and expanding in new indications



- Antibody
 - DutaFab
 - Port Delivery Platform
 - Stem cell therapy
- nAMD
 - DME/UME
 - GA
 - TED
 - CNV

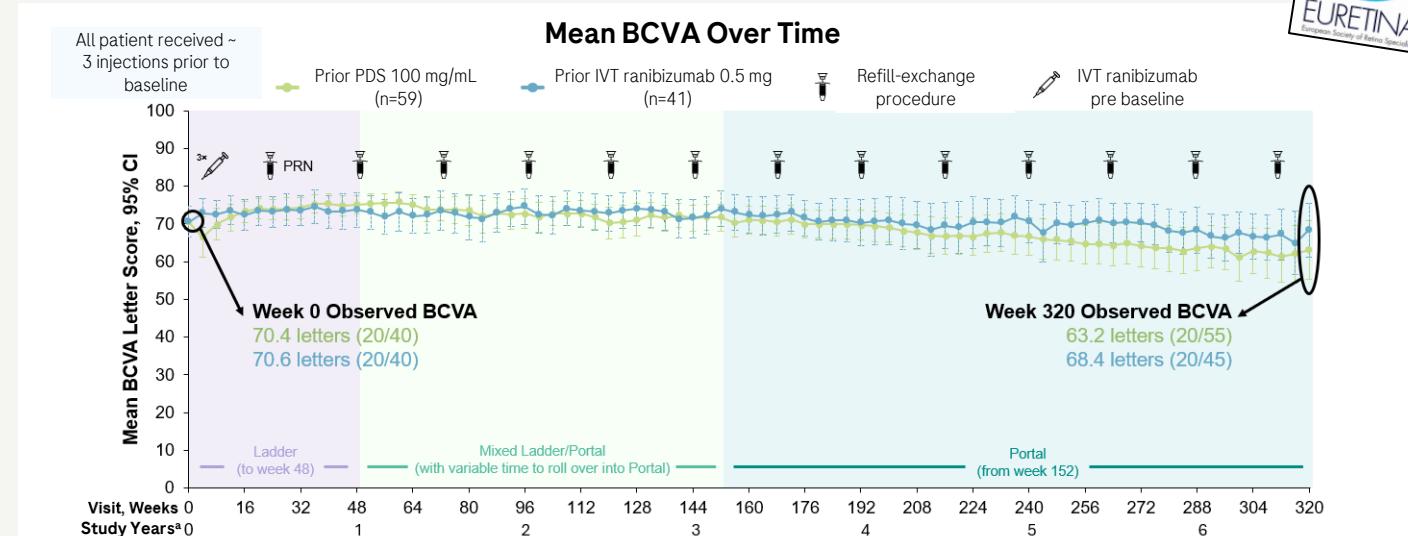
1. In collaboration with Lineage Cell Therapeutics (LCTX); CNV: Corneal neovascularization; DME: Diabetic macular edema; DutaFab: Dual targeting fragment antigen-binding; GA: Geographic atrophy; nAMD: Neovascular age-related macular degeneration; NME: New molecular entity; TED: Thyroid eye disease; UME: Uveitic macular edema



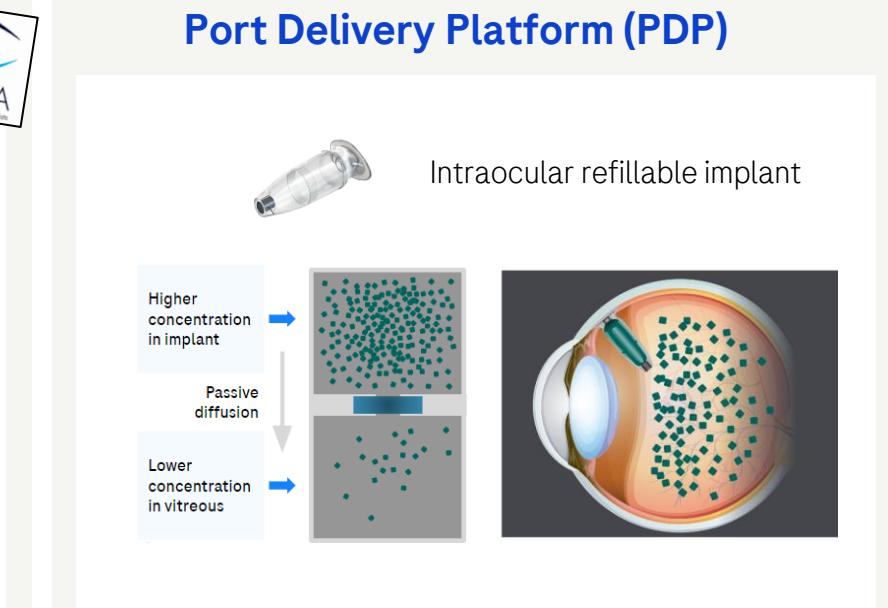
Susvimo in nAMD: Maintained vision over 7 yrs with x2 refills/yr

Continuing to innovate on Port Delivery Platform with multiple assets in development

Ph III (Ladder) / OLE (Portal): 7 yrs outcomes in nAMD



Port Delivery Platform (PDP)



- Q24W dosing maintained vision and retinal anatomy, with 50% of patients maintaining ~20/40 vision for up to 7 years^a
- Sustained durability of the PDP was maintained across each refill-exchange interval in ~95% of patients throughout OLE
- Received CE mark; EU approval in nAMD expected in 2026

- PDP is designed for continuous delivery of customized molecules through passive diffusion and addresses the key challenge of frequent IVT injections
- Two DutaFabs and multiple preclinical molecules in development with PDP

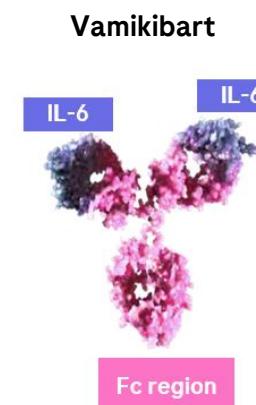
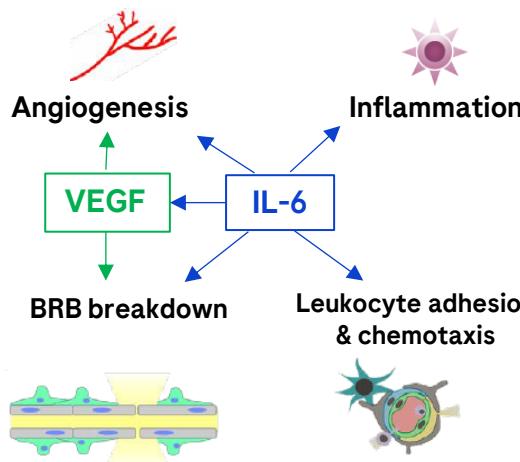
1. Khanani A et al, EURETINA 2025; a. Study year = 48 weeks, based on 12 months comprising 4 weeks; DutaFab: Dual targeting fragment antigen-binding; BCVA: Best corrected-visual acuity; CI: Confidence interval; IVT: Intravitreal; nAMD: Neovascular age-related macular degeneration; OLE: Open label extension; PDP: Port Delivery Platform; PRN: Pro re nata; Q24W: Every 24 weeks



Vamikibart: Targeting IL-6 to achieve better visual outcomes

Ph III (SANDCAT/MEERKAT) results in UME with favorable benefit-risk profile to be shared with regulators

IL-6 is a key pro-inflammatory cytokine in the pathogenesis of uveitis and retinal diseases



Development plan

IR Ophtha Update @ ASOPRS/AAO Oct 21st

Molecule	Indication	Ph I	Ph II	Ph III	Status
Vamikibart	UME	SANDCAT/MEERKAT			Data in-house and to be shared with regulators
Vamikibart	DME	BARDENAS / ALLUVIUM			Data in-house; Pause development
VEGFxIL6 DutaFab	DME				Prioritize over vamikibart; Accelerate development

- Inflammation is a currently sub-optimally treated pathway in a number of ocular diseases
- IL-6 is upregulated in uveitis and retinal diseases
- Vamikibart inhibits major IL-6 signaling pathways and is specifically designed for intraocular use and optimized for a rapid systemic clearance

- Ph III (SANDCAT/MEERKAT) trials in UME completed; data in-house and to be presented AAO 2025
- VEGF x IL6 DutaFab Ph I (IVT) trial ongoing
- Ph II (BARDENAS/ALLUVIUM) results for vamikibart + ranibizumab in DME in-house and will be presented at a future medical congress

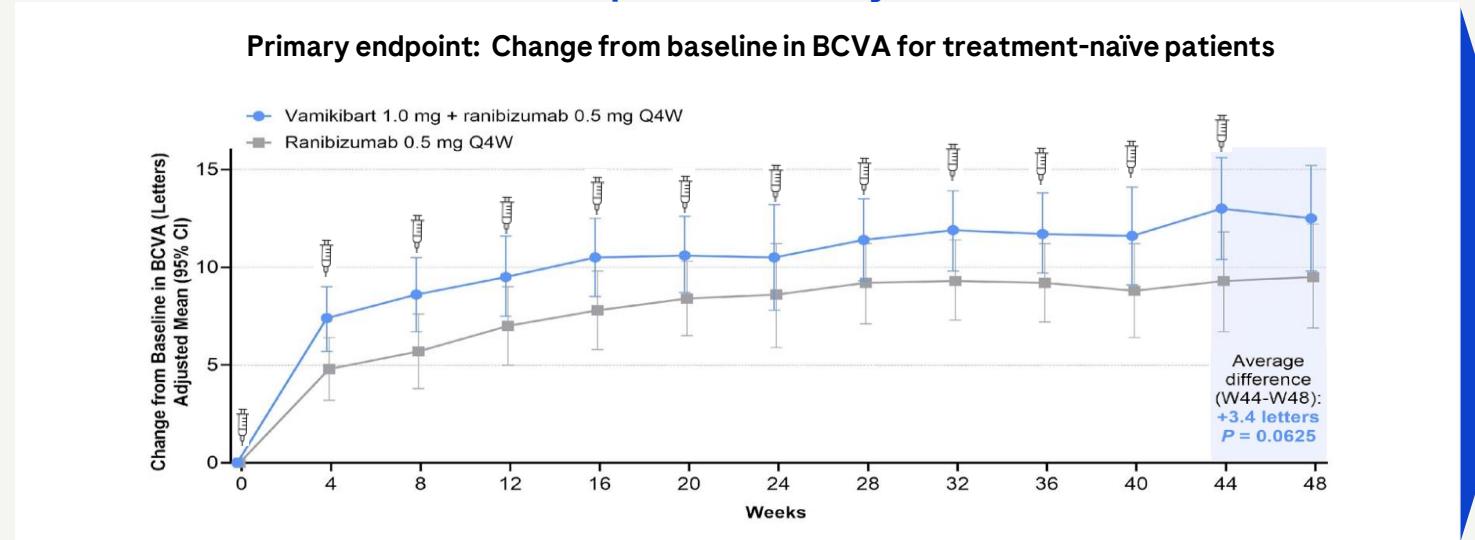


VEGFxIL6 DutaFab: A next generation bispecific for DME

Ph II (BARDENAS) establishes role of IL-6 inhibition in DME

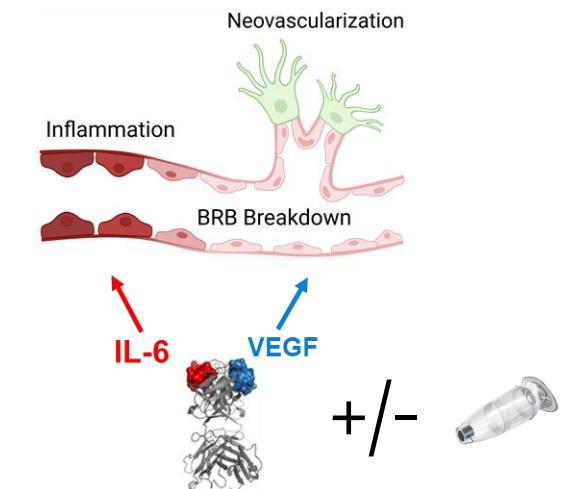
IR Ophtha Update @ ASOPRS/AAO Oct 21st

Ph II (BARDENAS): Anti-IL-6 (vamikibart) + anti-VEGF (ranibizumab) showed superior efficacy in DME^a



- In a treatment-naïve population, results show 44.7% of patients receiving vamikibart + ranibizumab gained ≥ 15 BCVA letters vs. 28.6% with ranibizumab alone
- Vamikibart 1.0 mg + ranibizumab Q4W was associated with adverse events of intraocular inflammation (IOI) including two cases of occlusive retinal vasculitis (ORV)^b
- Following proof of concept data, future development now focusing on next generation VEGFxIL6 DutaFab bispecific

Accelerating development of VEGFxIL6 DutaFab



- Intended to inhibit angiogenesis, vascular permeability and inflammation by binding and blocking VEGF and IL-6
- Single IVT administration
- Ph I (IVT) trial ongoing
- Compatible with Port Delivery Platform

a. Primary endpoint: Change from baseline in BCVA in the BARDENAS treatment-naïve population; b. vamikibart + ranibizumab arm enrolled 93 patients; DutaFab: Dual targeting fragment antigen-binding; IL-6: Interleukin-6; VEGF: Vascular endothelial growth factor; DME: Diabetic macular edema; BRB: Blood-retinal barrier; IVT: Intravitreal; BCVA: Best-corrected visual acuity; Q4W: Every 4 weeks

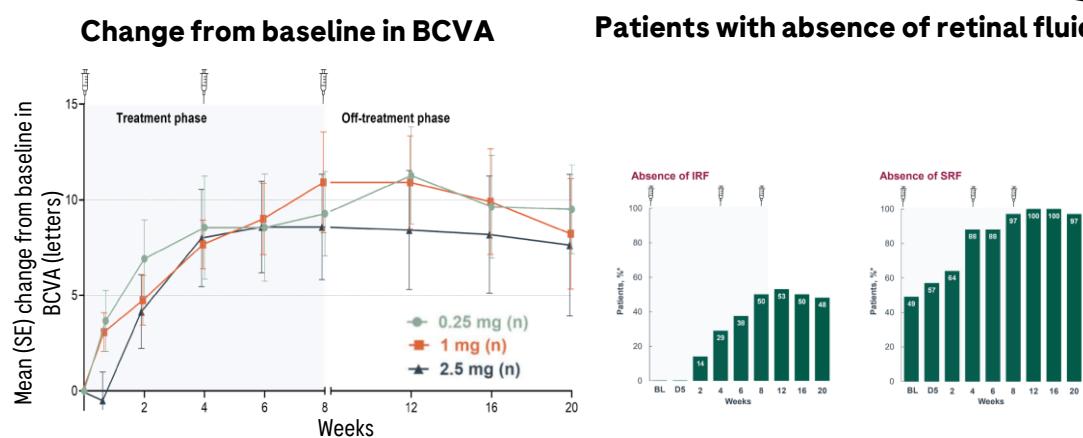


Vamikibart in UME: Potential FIC non-steroid IVT treatment

Ph III (SANDCAT/MEERKAT) data in-house demonstrating improvements in vision and anatomy

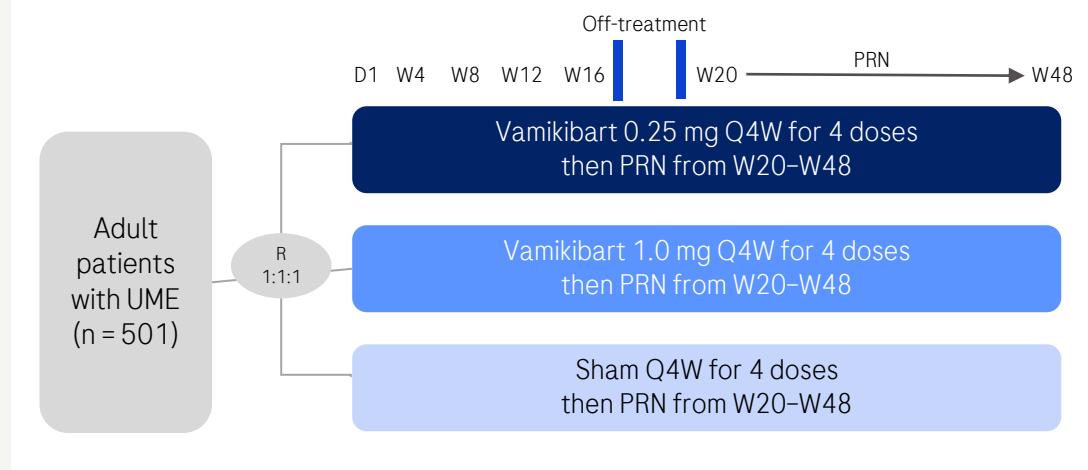
*IR Ophtha Update
ASOPRS/AAO
Oct 21st*

Ph I (DOVETAIL) results for vamikibart in UME¹



- UME is the leading cause of vision loss², affecting around one-third of patients with NIU³
- Despite immunomodulatory therapies, UME persists in 40% of eyes^{4,5} and corticosteroids, the mainstay of treatment, are associated with undesirable ocular and systemic side effects^{6,7}
- Ph I (DOVETAIL) results show improved vision and retinal thickness in all dosing cohort with all doses being well tolerated

Ph III (SANDCAT/MEERKAT) in UME



- Ph III (SANDCAT/MEERKAT) in UME completed; data in-house and to be presented at AAO 2025
- Data demonstrate improvements in vision and anatomy with no serious safety concerns identified
- Data support a favorable benefit-risk profile and will be shared with regulators

1. Sharma et al. ARVO 2023; 2. Massa H et al. Clin Ophthalmol. 2019;13:1761-1777. 3. Lardenoye CWTA et al. Ophthalmology. 2006;113:1446-1449. 4. Kempen JH et al. Ophthalmology. 2011;118:1916-1926. 5. Tomkins-Netzer O et al. Ophthalmology. 2015;122:2351-2359. 6. Pleyer U et al. Ophthalmol Ther. 2013;2:55-72. 7. Jobling AI and Augusteyn RC. Clin Exp Optom. 2002;85:61-75; FIC: First-in-class; UME: Uveitic macular edema; PRN: Pro re nata; NIU: Noninfectious uveitis; IRF=Intraretinal fluid; SRF: Subretinal fluid; BCVA: Best-corrected visual acuity; SE: Standard error; Q4W: Every 4 weeks; W: Week



Zifibancimig in nAMD: Potential for once-yearly dosing

Combining dual VEGF/Ang-2 inhibition & continuous delivery through Port Delivery Platform

Zifibancimig (VEGFxAng-2 DutaFab)

Anti-VEGF-A
Reduces vascular leakage
Inhibits neovascularization

Anti-Ang2
Stabilizes vessels:
Reduces vascular leakage
and inflammation

Single antigen-binding fragment
binding two targets independently
with high potency and selectivity

Molecule Binding Affinity for VEGF-A1 and Ang-2 via KinExA K_D (Fold Relative Difference)			
Target	Zifibancimig	Faricimab-Analog	Ranibizumab-Analog
VEGF-A121	~4 pM (ref)	169 pM (~40x weaker)	229 pM (~60x weaker)
VEGF-A165	~2 pM (ref)	224 pM (~100x weaker)	160 pM (~80x weaker)
Ang-2-RBD	~2 pM (ref)	7000 pM (~3500x weaker)	NA

- Zifibancimig is a bispecific DutaFab binding VEGF and Ang-2 and designed for continuous delivery via Port Delivery Platform
- Preclinical data shows high-affinity target binding and inhibition for VEGF-A and Ang-2, more potent than reference molecules¹
- Potential to offer optimized disease control and outcome certainty with the potential for extended dosing intervals

PhI/II (BURGUNDY) trial design

PhI

Part 1 → Zifibancimig IVT

Part 2

Port delivery with zifibancimig low dose

Port delivery with zifibancimig high dose

Ph II

Part 3

Port delivery with zifibancimig low dose

Port delivery with zifibancimig high dose

Susvimo 100mg/ml

- PhI/II (BURGUNDY) Part 1 and Part 2 fully enrolled, Part 3 recruitment ongoing
- Full data expected in 2027

1. Moelleken, J., et. al. Association for Research in Vision and Ophthalmology 2025; Ang-2: Angiopoietin-2; DutaFabs: Dual targeting fragment antigen-binding; IVT: Intravitreal; nAMD: Neovascular age-related macular degeneration; Q6M: Every six months; VEGF: Vascular endothelial growth factor

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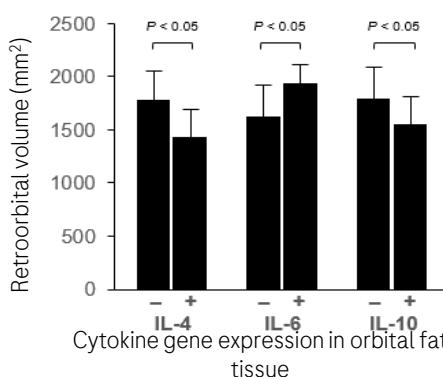
Satralizumab: Potential to be the first SC therapy in TED

Designed to enable maximal IL-6 suppression with a well-established safety profile

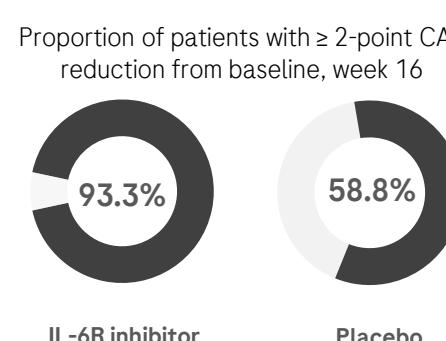
*IR Ophtha Update @
ASOPRS/AAO
Oct 21st*

IL-6 pathway plays a key role in TED¹ and clinical evidence supports IL-6R inhibition

IL-6 expression correlates with orbital tissue expansion²



CAS reduction of ≥ 2 points achieved with IL-6 inhibition

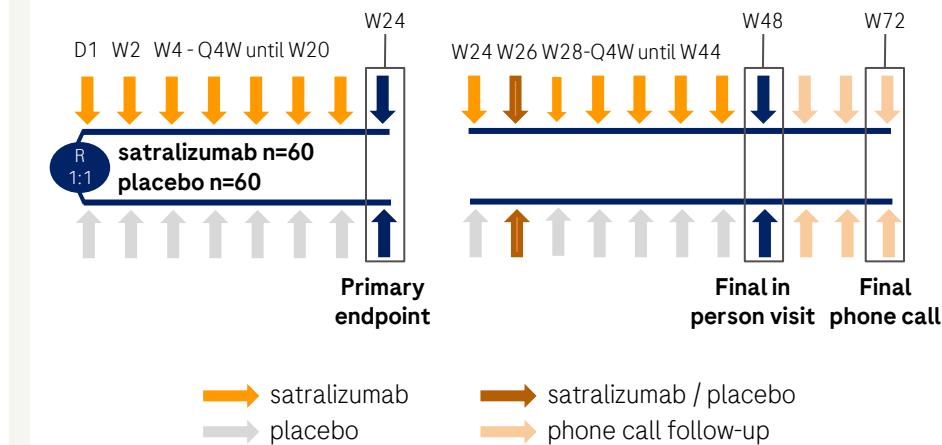


- IL-6 is a key mediator of inflammation and drives fibrosis in TED; blocking IL-6R signaling has the potential to reverse the manifestation of the disease
- In a placebo-controlled randomized trial, CAS reduction of ≥2 point and proptosis reduction were achieved
- Satralizumab is designed to enable maximal sustained suppression of IL-6 signaling and allow practical Q4W SC dosing with an established safety profile

Ph III (SatraGo-1/SatraGo-2) trial design

Key Inclusion criteria

- Active, moderate to severe and chronic inactive TED pts
- Systemic or local steroid treatment naïve pts



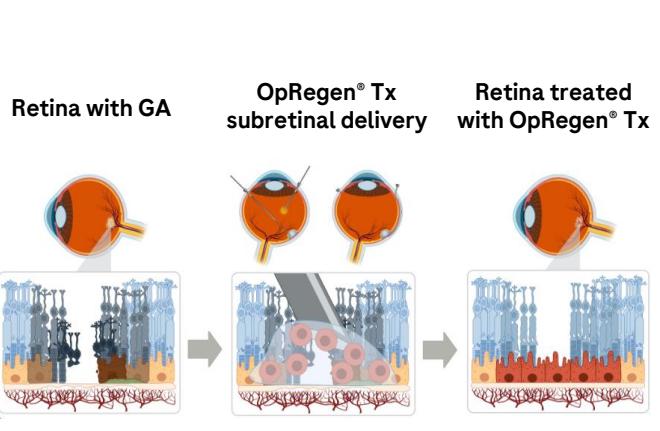
- Ph III (SatraGO-1/SatraGO-2) trials in TED data in-house and to be presented at ASOPRS



OpRegen® Tx in GA: Replenishing the retinal pigment epithelium

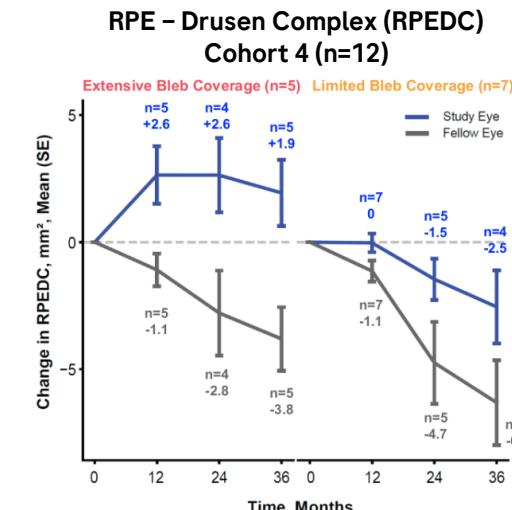
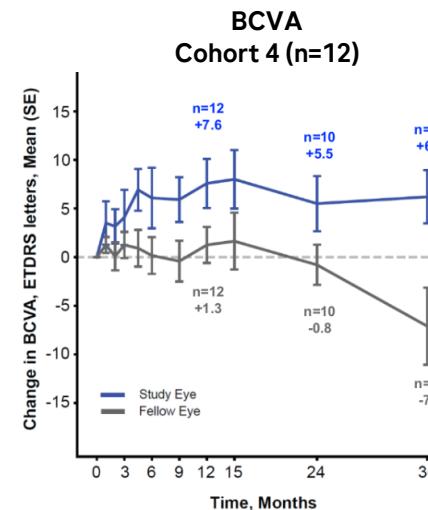
Ph IIa GAlette surgical development study ongoing

Potential to treat RPE loss in GA



- OpRegen® Tx is a suspension of human allogeneic RPE cells delivered as a single injection to the subretinal space in the area of the GA lesion
- Subretinal delivery is performed with different devices through a transvitreal or transchoroidal route

Ph I/IIa results: Visual function and retinal structure improvements sustained through month 36¹



FDARMAT



- Gains in BCVA in patients in Cohort 4 (less advanced GA) measured at month 12 remain evident through month 36 following subretinal administration of OpRegen® Tx
- Improvement in BCVA and outer retinal structure in patients with extensive OpRegen® Tx bleb coverage of their GA area was greater than in patients with limited coverage and persistent through month 36
- With extended follow-up, OpRegen® Tx continues to show an acceptable safety profile



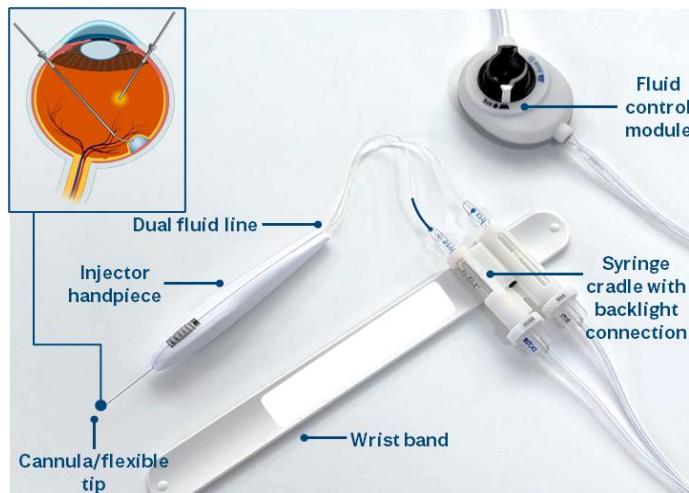
Acquired proprietary surgical devices for OpRegen® Tx development

Potential for broader application in the delivery of other pipeline assets across different modalities

Advanced subretinal delivery devices under development in Ph IIa GAlette in GA

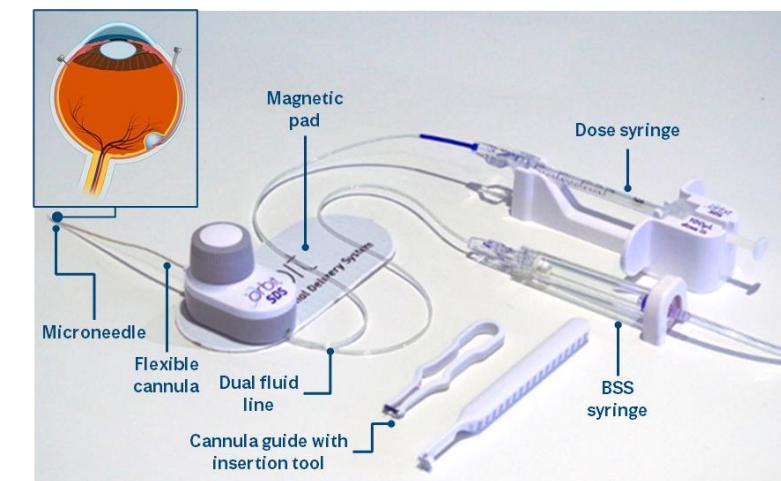
Transvitreal Subretinal Injector with Dual Lumen:

Allows delivery of two infusates via a single insertion/retinotomy



Orbit SDS® Subretinal Delivery System:

Subretinal delivery via transchoroidal approach removes the need for vitrectomy and retinotomy



- Ph IIa GAlette surgical development currently enrolling; designed to optimize lesion targeting while maintaining safety profile
- The study will test two new proprietary surgical devices and its potential advantages over currently available devices and procedures

Cardiovascular, Renal and Metabolism

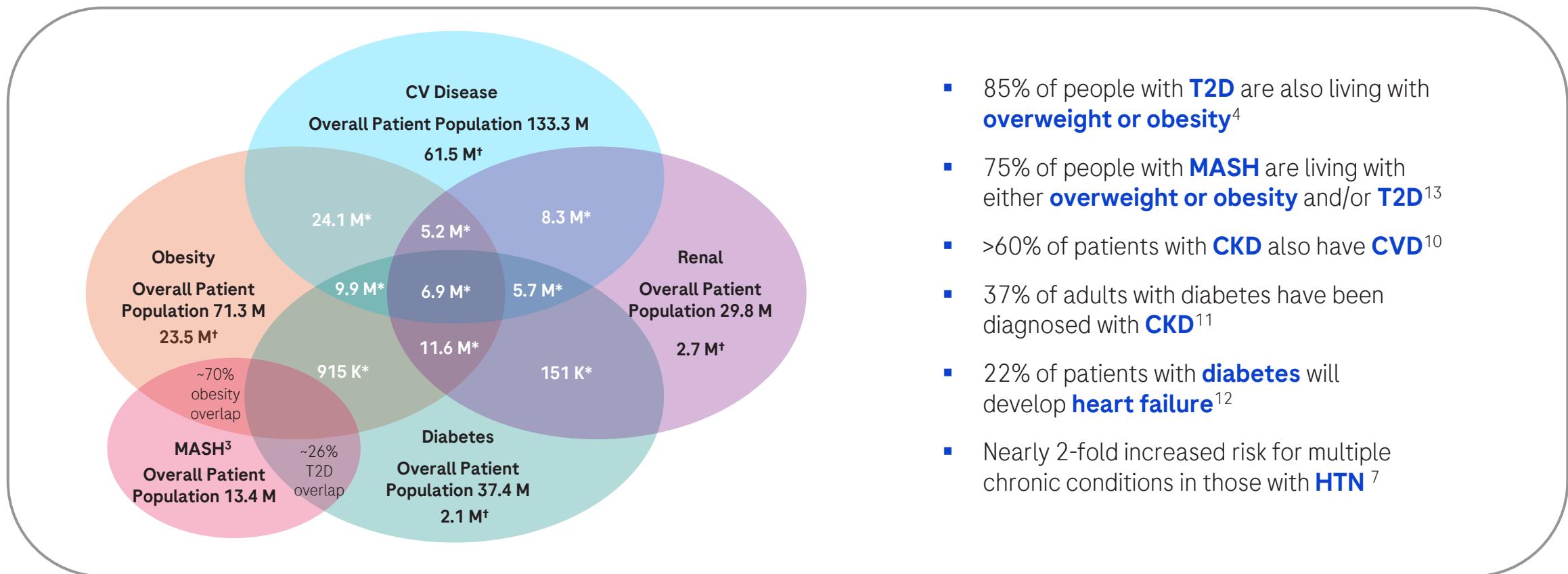
Manu Chakravarthy

*SVP and Global Head of Cardiovascular, Renal and
Metabolism (CVRM) Product Development*



Roche views CVRM diseases as a continuous interdependent spectrum¹

1 in 4 US adults have a CVRM condition and 1 in 10 have more than one²



Numbers refer to US rather than global population, not drawn to scale

Not shown owing to diagram spacing: Obesity and Renal ONLY overlap; Obesity, Diabetes, and Renal ONLY overlap

*Represents number of patients in each Venn diagram overlap. †Represents number of patients with a single condition (no comorbidity overlap). Numbers refer to US rather than global population. Diabetes numbers shown for type 1 and type 2 diabetes combined. 1. IQVIA .White Paper; Achieving Excellence in Commercialising Cardiometabolic Innovation. Available at: Achieving Excellence in Commercialising Cardiometabolic Innovation - IQVIA. Accessed: August 2025; 2. Islam ANMS. Prev Med Rep. 2024;46:102882; 3. IDF Diabetes Atlas 2021. Available at: IDF Diabetes Atlas 2025 | Global Diabetes Data & Insights. Accessed: August 2025; 4. Bhupathiraju SN, Hu FB. Circ Res. 2016;118:1723–35; 5. Lindstrom M, et al. J Am Coll Cardiol. 2022;80:2372–25; 6. Vaduganathan M, et al. J Am Coll Cardiol. 2022;80:2361–71; 7. Alanaeme, Chibueke J, et al., American journal of hypertension vol. 37, 7 (2024): 493–502. 8. GBD Chronic Kidney Disease Collaboration. Lancet. 2020;395:709–33; 9. Chen TK, et al. JAMA. 2019;322:1294–1304; 10. Colombijn JMT, et al. JAMA Netw Open. 2024;7:e240427; 11. Murphy D, et al. Ann Intern Med. 2016;165:473–81; 12. Pop-Busui R, et al. Diabetes Care. 2022;45:1670–90.; 13. Front Cell Dev Biol. 2024 Jul 16;12:1433857; CAD: coronary artery disease, CVD: cardiovascular disease, CKD: chronic kidney disease, CVRM: cardiovascular, renal, and metabolism, HTN: hypertension, K: thousand, M: million, MASH: metabolic dysfunction-associated steatohepatitis, T2D: type 2 diabetes



Roche is well positioned to capture future innovation

Drivers of innovation in Cardiovascular, Renal & Metabolism

Critical Capabilities

	Incretins and beyond	<i>Combat obesity as a driver for metabolic diseases</i>	CT-388: Obesity ± T2D CT-996: Obesity ± T2D Petrelintide: Obesity ± T2D
	Combinations	<i>Establish a portfolio of combination therapies</i>	Add-on and/or Fixed-dose combination: e.g., CT-388 + petrelintide, incretin + emugrobart
	Comorbidities	<i>Address additional causal factors of metabolic disease</i>	HTN: Zilebesiran + SoC in people with established/high risk of CVD MASH: Pegozafermin* and afimkibart CKD, HF, AD: Combinations within portfolio
	Holistic patient solutions	<i>Synergies with Roche Diagnostics and Digital Health solutions</i>	Diagnosis: MI (TropC), HF (NT-proBNP), fibrosis (ProC3), dementia (Tau), CV risk (Lp(a)) Monitoring: CGMs and other point of care devices Empowerment: Mobile apps to enable self-management

*Pending deal closure; AD: Alzheimer's disease ; CV: cardiovascular; CVD: cardiovascular disease; CKD: chronic kidney disease; CGM: continuous glucose monitoring; HF: heart failure; MASH: metabolic dysfunction-associated steatohepatitis; MI: myocardial infarction



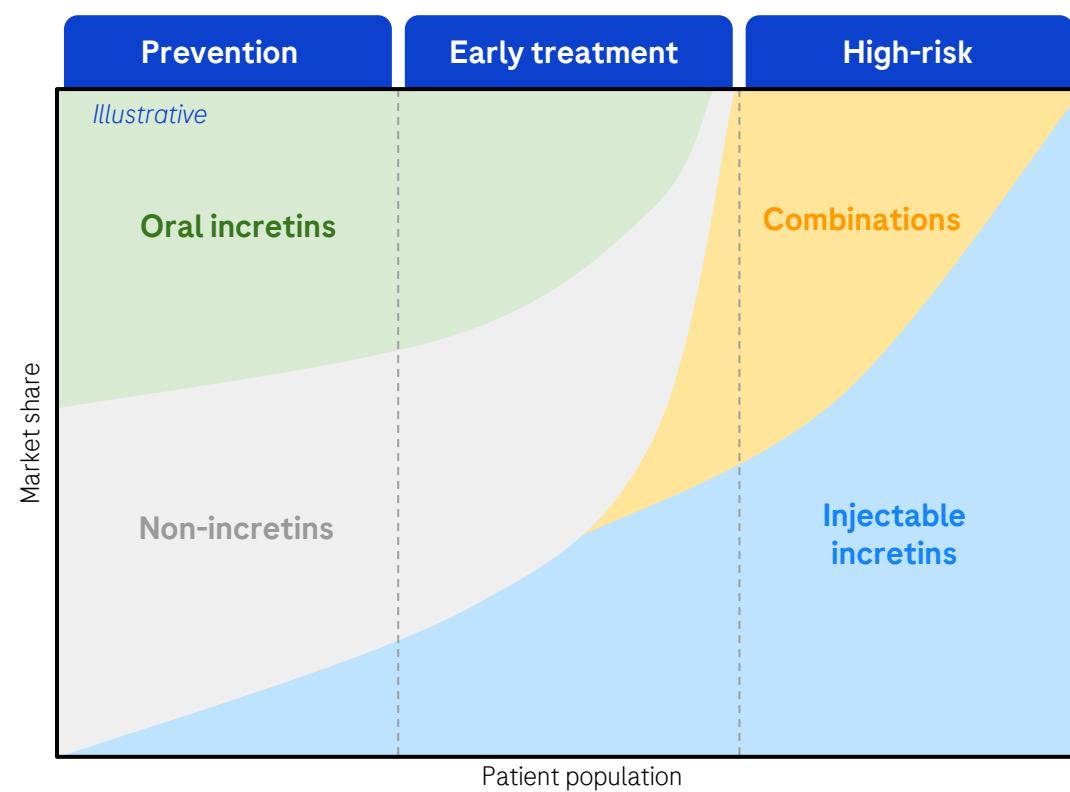
Diverse patient needs will lead to increased market segmentation

Physicians expect new therapies to improve weight-related comorbidities

Roche internal KOL survey results

Expectation for upcoming treatments by frequency of mention	
	KOLs
Superior control in weight-related comorbidities, particularly those posing a higher mortality / morbidity risk	
Improvement in cardiometabolic outcomes, ideally enabling the reduction of other medications from the patient regimen	
Greater tolerability (lower discontinuation rates due to AEs, especially GI-related)	
Better maintenance of weight-loss through reduced dosing or inherent treatment MoA	
Greater body weight loss , incl. achieving higher mean BWL for pts with BMI ≥40 and / or enabling a higher share of pts to achieve weight loss targets	
Better quality of weight loss	

Obesity market outlook by segment and drug class





2024: Starting to build an innovative CVRM portfolio

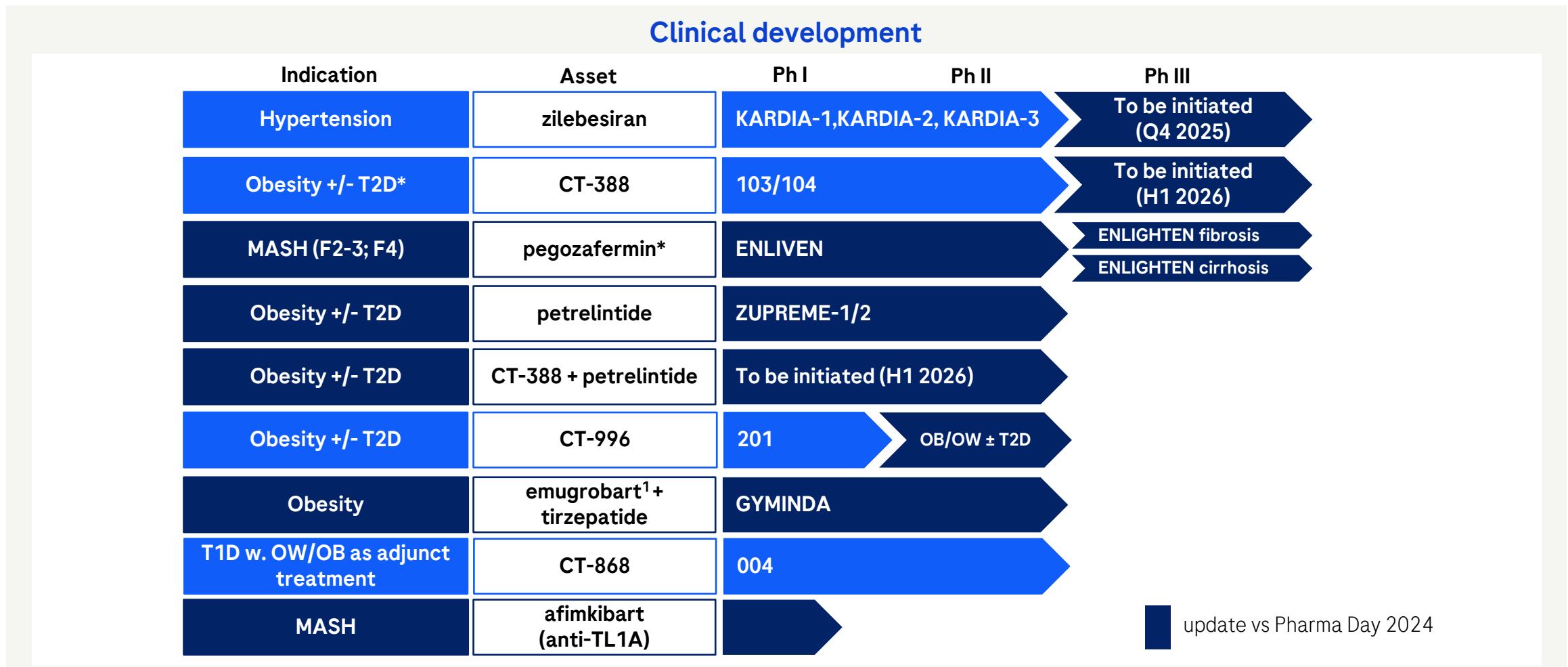
Clinical development

Indication	Asset	Ph I	Ph II	Ph III
Hypertension	zilebesiran	KARDIA-1,KARDIA-2, KARDIA-3		
Obesity +/- T2D*	CT-388	103/104		
Obesity +/- T2D	CT-996	201		
T1D w. OW/OB as adjunct treatment	CT-868	004		
Obesity	emugrobart ¹			
Obesity	CT-173 (PYY analogue)			

1. GYM 329; OB: Obesity; OW: Overweight; T1D/T2D: Type-1/2 diabetes; * Patients with obesity or overweight with at least one weight-related comorbidity including type 2 diabetes; zilebesiran in partnership with Alnylam



2025: On the path to a leading CVRM portfolio creating optionality



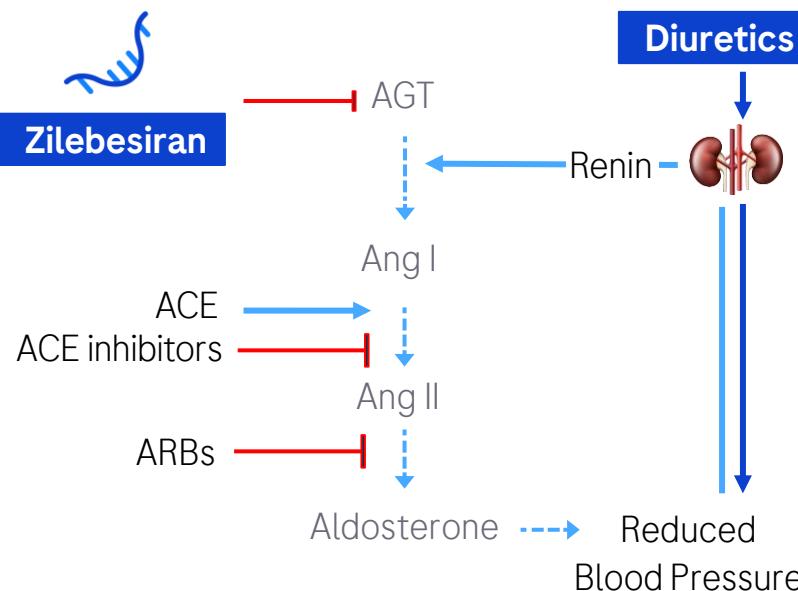
*Pending deal closure; 1. GYM 329; OB: Obesity; OW: Overweight; T1D/T2D: Type-1/2 diabetes; MASH: metabolic dysfunction-associated steatohepatitis; *Patients with obesity or overweight with at least one weight-related comorbidity including type 2 diabetes; petrelintide in partnership with Zealand Pharma, zilebesiran in partnership with Alnylam



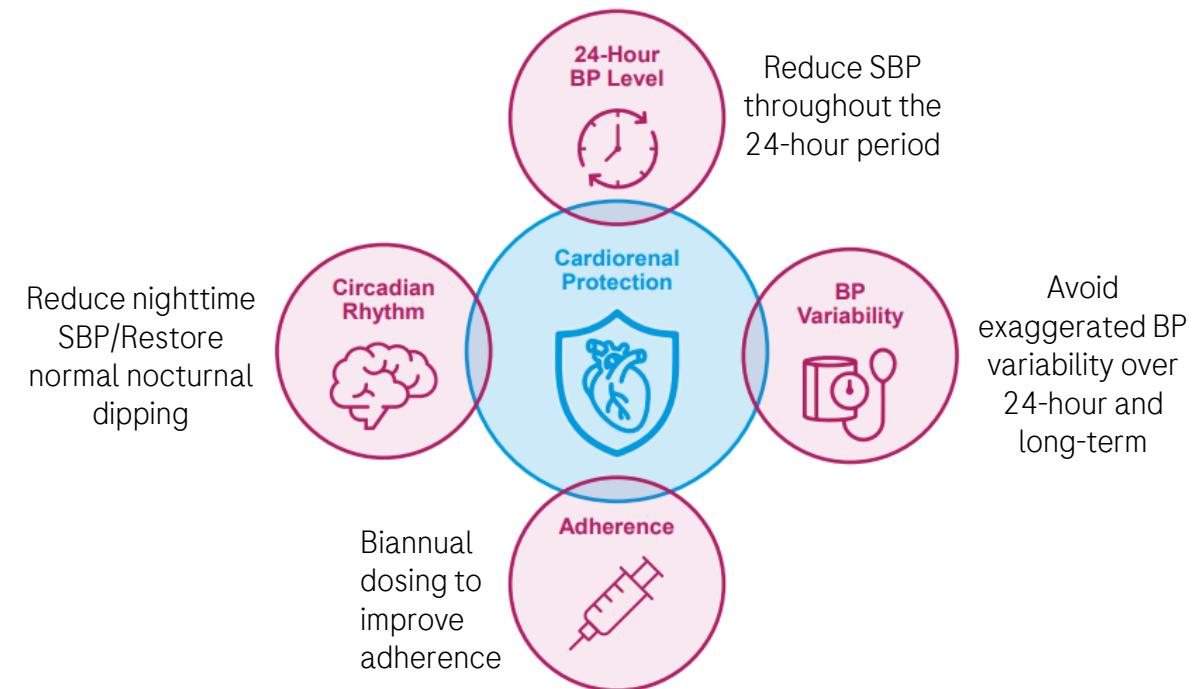
Zilebesiran, a novel therapy targeting AGT for uncontrolled HTN

Continuous control of blood pressure aiming to reduce cardiovascular and renal risk

Potential for tightest control of BP by blocking upstream of the RAAS pathway¹



Biannual dosing offers a unique value proposition in uHTN leading to continuous control of BP up to 6 months²



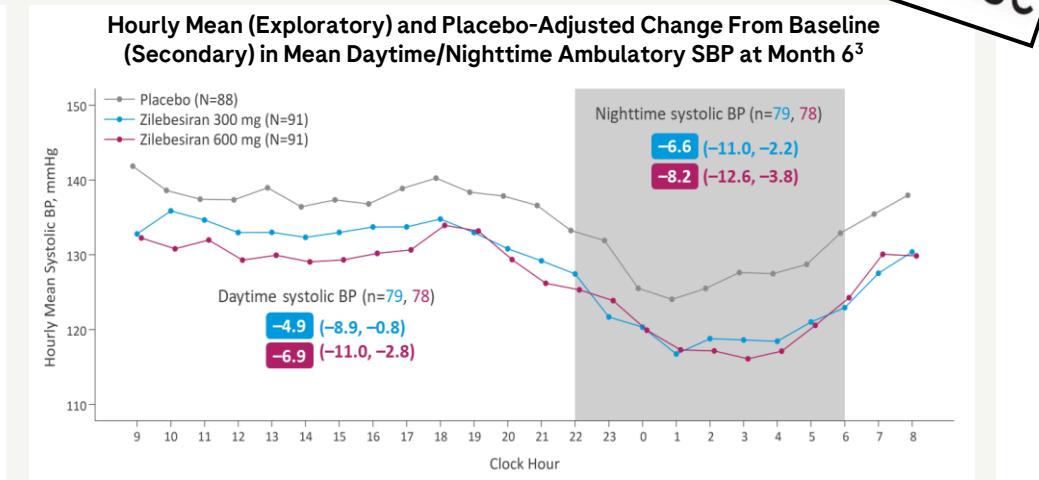
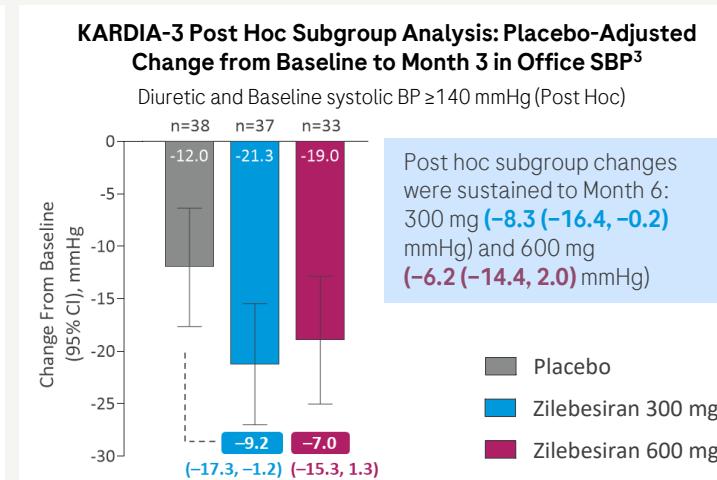
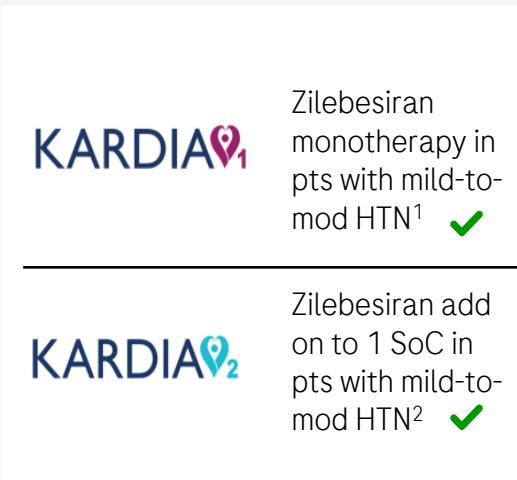
1. Pagidipati et al. ESC 2025; 2. Figure adapted from Kario K. Prog Cardiovasc Dis. 2016;9:262–81; ACE: Angiotensin-converting enzyme; ARB: Angiotensin receptor blockers; uHTN: Uncontrolled hypertension; SBP: Systolic blood pressure, zilebesiran in partnership with Alnylam Pharmaceuticals



Zilebesiran shows enhanced effect in pts at risk, nocturnal BP control

Zilebesiran investigated in three Ph II studies in more than 1,300 patients

Ph II (KARDIA-3) results



- In patients with uncontrolled hypertension with a baseline office SBP of ≥ 140 , despite treatment with a diuretic and at least one other antihypertensive (90% of ACE or ARB), zilebesiran produced an enhanced effect with observed SBP reductions of 7-9mmHg sustained out to six months
- Clinically meaningful reduction in nocturnal BP
- Improved markers of cardiac and renal risk with the potential to improve BP variability over the long-term has the potential to reduce cardiovascular risk

1. Bakris GL, et al. JAMA. 2024;331(9):740–749; 2. Bakris et al. ACC Scientific Sessions 2024, 3. Pagidipati et al. ESC 2025, HTN: Hypertension; SoC: Standard of care; SBP: Systolic blood pressure; Q3M: Every 3 months; Q6M: Every 6 months; zilebesiran in partnership with Alnylam Pharmaceuticals



Zilebesiran moving into global Ph III cardiovascular outcomes trial

Potential new SoC with tighter pathway control, synergistic effect with diuretics and improved Tx adherence

Ph III (ZENITH) will evaluate CV outcomes in pts with HTN and high CV risk or established CV disease



Phase III CVOT design (N = 11,000)

Adult patients with established CV disease or at high risk
Office SBP >140 mmHg on stable treatment (≥ 2 antihypertensive medications, one of which being a diuretic)



Zilebesiran 300 mg Q6M + SOC

Placebo Q6M + SOC

Primary Outcome:
Composite endpoint of CV death, nonfatal MI, nonfatal stroke, or HF event

Select Secondary and Exploratory Outcomes:
Death, other individual components

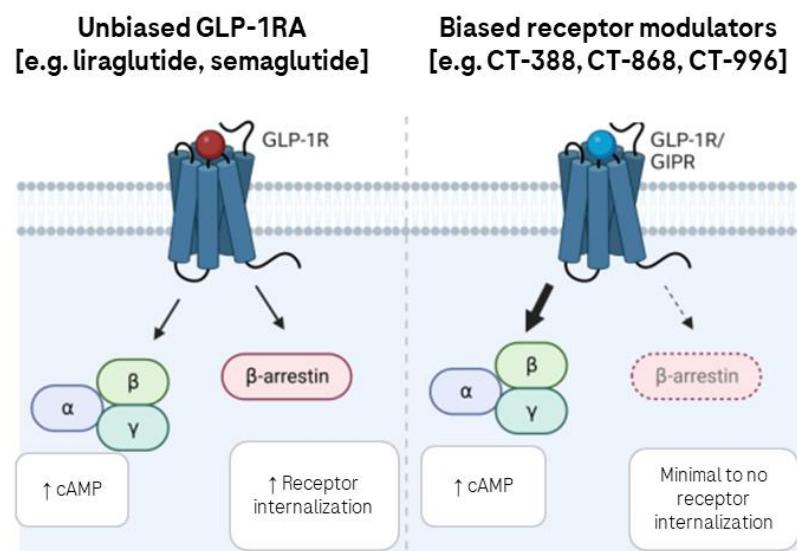
- Ph III (ZENITH) will be a 11,000-patient CVOT study evaluating zilebesiran (300 mg) every six months compared to placebo in patients with uncontrolled hypertension at high CV risk on two or more antihypertensives, one being a diuretic
- Data expected to enable a launch around 2030



Expanding CVRM portfolio, creating optionality with differentiated MoAs

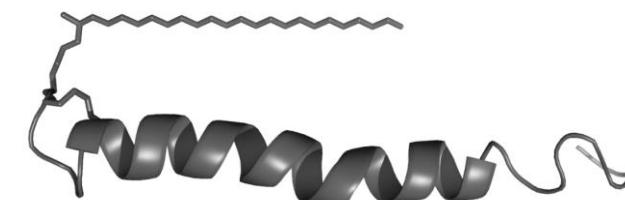
Leveraging biased GLP-1/GIP and amylin agonism for potentially greater efficacy and tolerability

CT-388, CT-868 and CT-996 are biased agonists¹



- CT-388, CT-868 and CT-996 are G protein-biased with robust cAMP potency and minimal to no β-arrestin recruitment
- GLP-1R/ GIPR biased agonism enhances glucose lowering and weight loss, potential for greater efficacy¹

Petrelintide is a long-acting amylin analog



Petrelintide is a 36-amino-acid acylated peptide, based on the peptide sequence of human amylin. Native amylin is a non-incretin peptide that increases satiety in contrast to GLP-1, which reduces appetite

- Long-acting amylin analog, suitable for Q1W dosing^{2,3}
- Potent balanced agonist effect on amylin and calcitonin receptors^{2,4}
- Favorable physicochemical properties, allow for co-formulation and co-administration with other peptides^{5,6}

1. Based on preclinical data, Rodriguez et al, Cell Rep Med. 2025 Jun 2; 2. Data on file; 3. Brændholt Olsen et al. Poster 92-LB. Presented at ADA 83rd Scientific Sessions, June 23–26, 2023, San Diego, CA; 4. Eriksson et al. Presentation at ObesityWeek, November 1–4, 2022, San Diego, CA.; 5. Skarbalienė et al. Poster 1406-P. Presented at ADA 82nd Scientific Sessions, June 3–7, 2022, New Orleans, LA; 6. Eriksson et al. Poster 532. Presented at ObesityWeek, November 1–4, 2022, San Diego, CA; GLP-1R: Glucagon-like peptide 1 receptor; GIPR: glucose-dependent insulinotropic polypeptide receptor

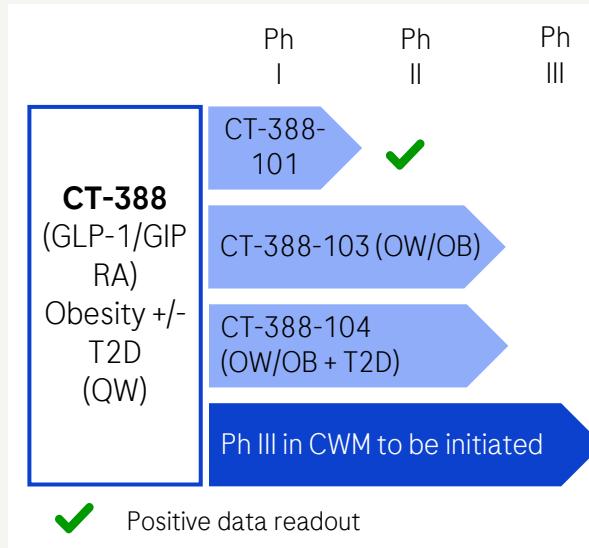


CT-388 showed a competitive profile with robust efficacy in Ph I

CT-388 is a biased, dual GLP-1/GIP receptor agonist for people living with OW/OB with or without T2D



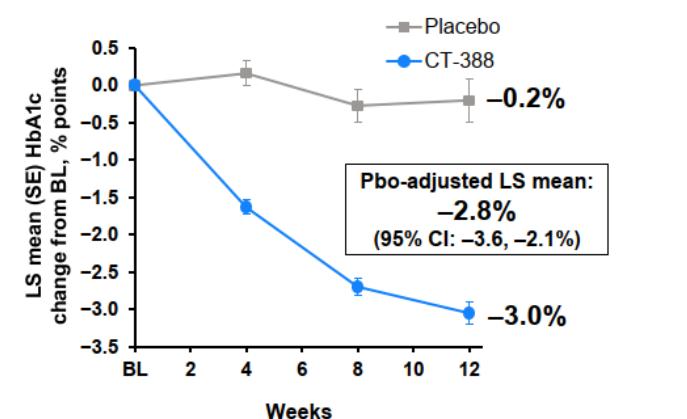
Development program



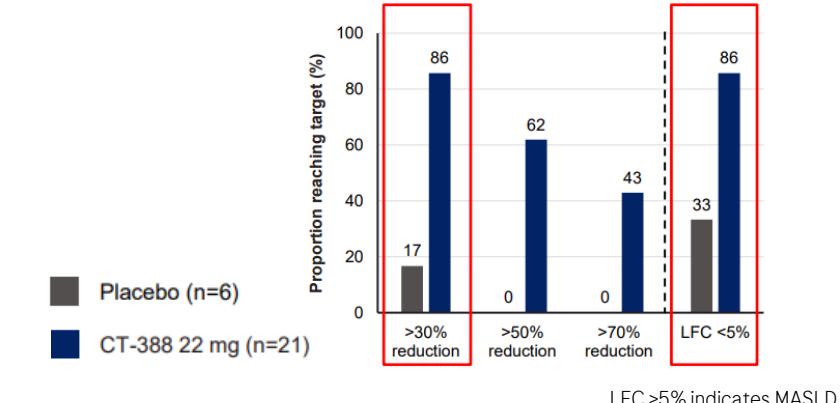
- Ph II trials in OW/OB ± T2D ongoing
- Ph III trial in chronic weight management to be initiated (H1 2026)

Ph I data show glycemic control (OB+T2D) and robust LFC reduction (OW/OB)

Ph I CT-388-101 (cohort 13)² Glycemic control



Ph I CT-388-101 (cohort 12)¹: LFC target achievement at w24¹



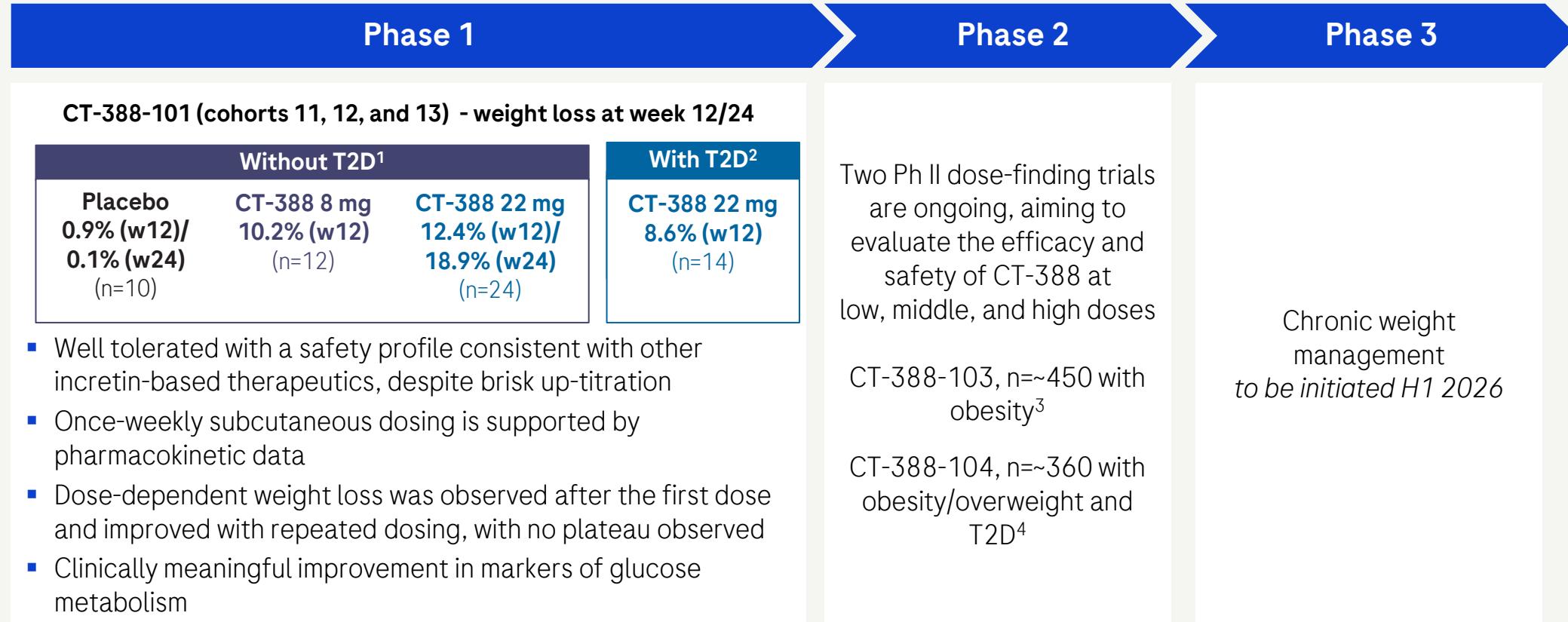
- CT-388 treatment in people living with obesity and T2D over 12 weeks led to a robust improvement in glycemic control, including normalizing dysglycemia as well as clinically meaningful WL, consistent with that observed in the non-T2D cohort (Ph I 101, cohort 13)
- CT-388 treatment in people living with OW/OB over 24 weeks led to a robust decrease in liver fat content; 86% of participants receiving CT-388 had LFC reduction of >30% (Ph I 101, cohort 12)
- Safety/tolerability were in line with incretin-based therapies at early stages of development

1. Steinberg et al, ADA 2025 2. Chakravarthy et al, ADA 2025; CWM: Chronic weight management; LFC: Liver fat content; MASLD: Metabolic dysfunction-associated steatotic liver disease; OB: Obesity; OW: Overweight; T2D: type-2 diabetes; WL: Weight loss



CT-388: Ph I completed, Ph II trials ongoing, Ph III to be initiated

Clinical data support the potential for development in T2D and chronic weight management



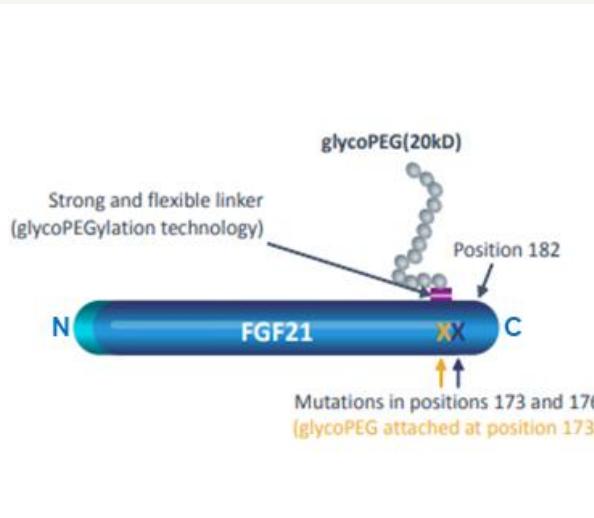
1. Chakravarthy MV, et al. EASD, 2024; 2. Steinberg A, et al. Presentation ADA 2025; 3. NCT06525935; 4. NCT06628362; 4. NCT06628362; FPI: First patient in; GIP: Glucose-dependent insulinotropic polypeptide; GLP-1: Glucagon-like peptide-1; SC: Subcutaneous; T2D: Type-2 diabetes



Pegozafermin: Potential best-in-disease therapy in MASH

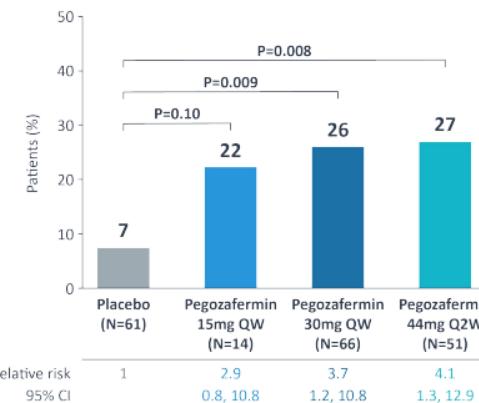
Further strengthens CVRM portfolio and offers optionality for future combination development

Pegozafermin¹

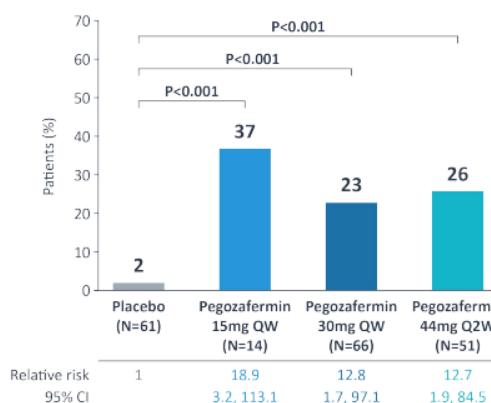


Ph II (ENLIVEN) week 24 results in pts with MASH and fibrosis (F2-F4)^{2*}

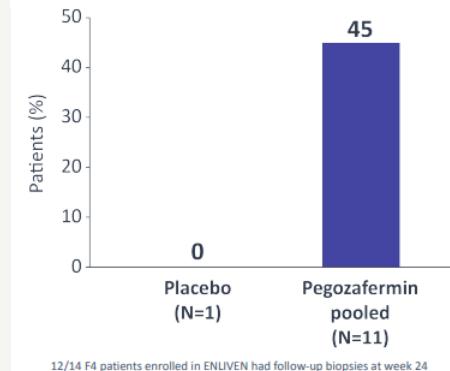
Fibrosis improvement ≥ 1 stage without worsening of MASH



MASH resolution without worsening of fibrosis



Pts with F4 at baseline: Fibrosis improvement ≥ 1 stage without worsening of MASH



- Pegozafermin is an FGF21 analog engineered to balance efficacy and extended dosing
- Anti-fibrotic and anti-inflammatory downstream effects improve insulin resistance and reduce oxidative stress

- Ph II study of pegozafermin showed fibrosis improvement and MASH at week 24
- Ph II showed fibrosis improvement at w24 in pts with well-compensated cirrhosis (F4) at baseline*
- Sustained benefits on fibrosis markers were observed vs. placebo in patients on background GLP-1 therapy at week 48 (ENLIVEN 48-week extension data¹)
- Pegozafermin was well tolerated across all patients
- Ph III (ENLIGHTEN) fibrosis (F2-F3); topline histology data expected in 1H 2027
- Ph III (ENLIGHTEN) cirrhosis (F4); topline histology data in 2028

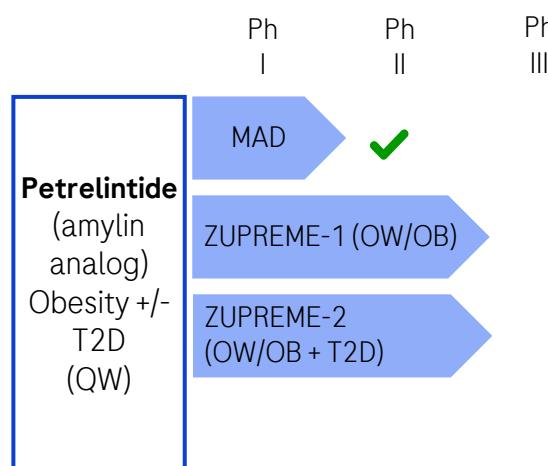
The transaction is expected to close in the fourth quarter of 2025. It is subject to customary closing conditions, including the tender of at least a majority of the outstanding shares of 89bio's common stock and the expiration or termination of the waiting period under the Hart-Scott-Rodino Antitrust Improvements Act of 1976.; *Fourteen ENLIVEN F2/F3 subjects were reclassified as F4 by 3-panel read; 1.Loomba et al EASL 2024; 2. Loomba et al EASL 2023; MASH: metabolic dysfunction-associated steatohepatitis



Petrelintide: Potential to be a foundational therapy in obesity

Strengthening our growing CVRM portfolio with a long-acting amylin analog

Development program

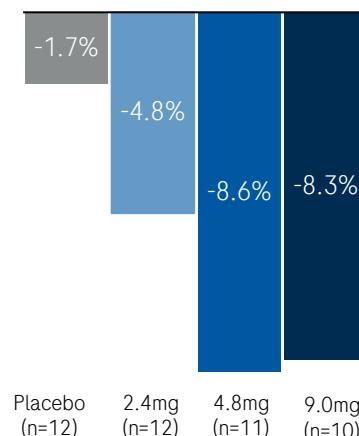


✓ Positive data readout

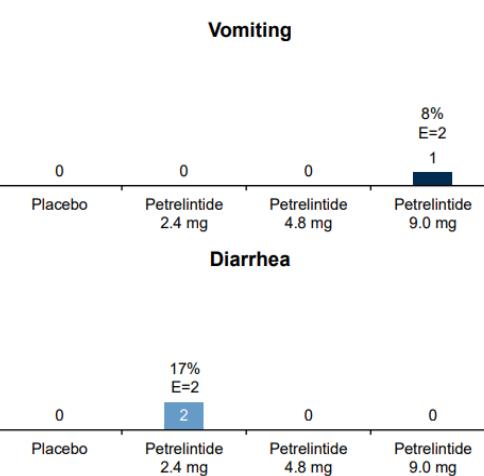
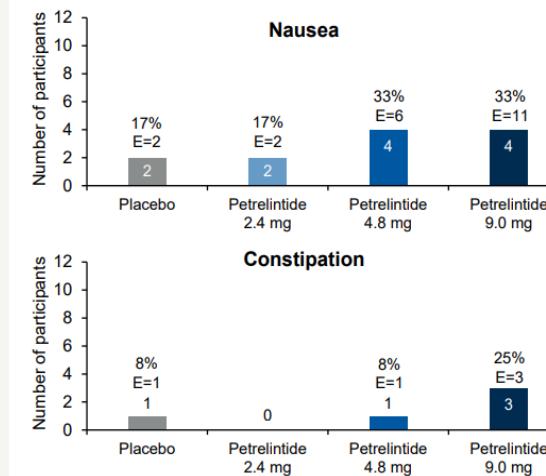
- Two Ph II studies (ZUPREME-1/2) in obesity +/- T2D ongoing, with topline results expected from ZUPREME-1 in H1 2026 and anticipated Ph III initiation in H2 2026

Ph I results: Change in body weight from baseline and selected GI TEAEs

MAD trial – Part 2¹
(% change, Week 16)



MAD trial – Part 2⁶ (Selected Gastrointestinal TEAEs)



- After 16 weeks of treatment, mean weight loss was up to 8.6% with petrelintide vs 1.7% with placebo
- Petrelintide was well tolerated: All GI AEs mild, except two moderate events in one patient who discontinued
- Combined Ph I data suggest a potential for weight loss comparable to mono GLP-1, but with improved tolerability for a better patient experience and high-quality weight loss

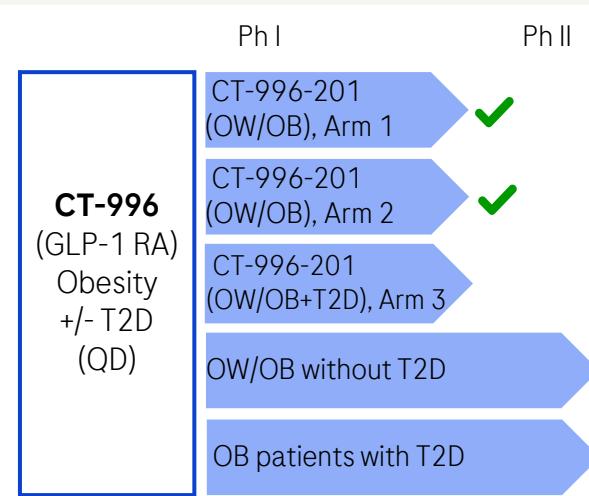
1. Data presented at ObesityWeek 2024 in San Antonio, Texas; FDC: Fixed dose combination; SAD/MAD: Single/multiple ascending dose; (TE)AE: (Treatment emergent) adverse event; AE: Adverse event; Petrelintide in collaboration with Zealand Pharma



CT-996: Ph II trials of CT-996 in people with OW/OB ± T2D ongoing

Oral small molecule with high bioavailability and no food restrictions

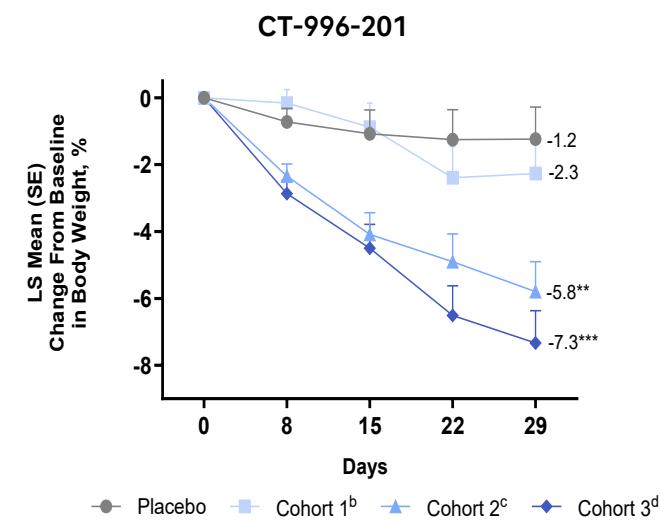
Development program



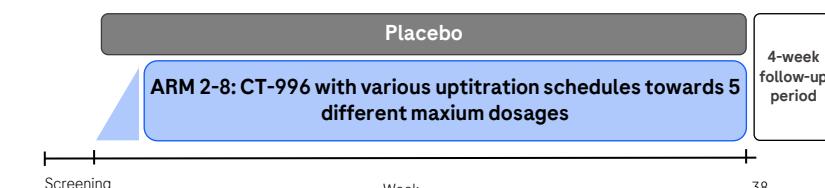
✓ Positive data readout

- Ph I in OW/OB + T2D (Arm 3) ongoing
- Ph II in OW/OB +/- T2D patients started in 2025

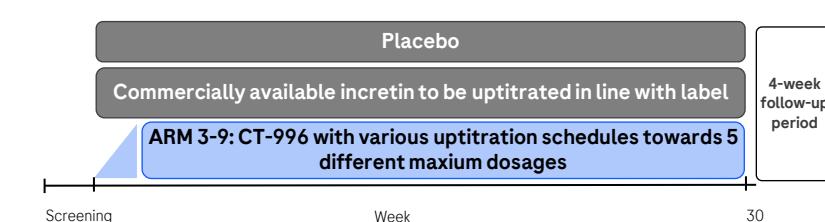
Once-daily oral dosing of CT-996 over 4 wks shows WL of up to 7.3%; Ph II studies ongoing



CT-996 Ph II obesity trial without T2D participants; N=340²



CT-996 Ph II glycaemic control trial with T2D participants; N=240³



- Once daily oral dosing of CT-996 showed clinically meaningful placebo-adjusted weight loss up to 7.3% within 4 weeks in Ph I trial; GI-Related TEAEs were mostly mild and none were severe¹
- Plasma half-life (17-22 hrs) supports once-daily dosing

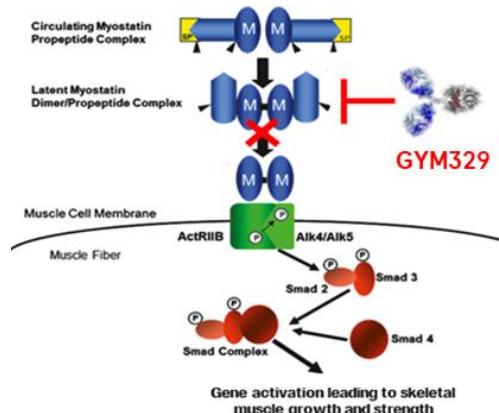
*1. Chakravarthy MV, et al. EASD 2024; 2. NCT07081958 3. NCT07112872; T2D: type-2 diabetes; OW: overweight; OB: obesity; d: day; LS: least squares; a. P values are nominal and have not been adjusted for multiplicity; b. Cohort 1 (CT-996 10/30/60/90): planned 10/30/60/90 mg; each dose for 7 days (actual: all participants followed planned titration path); c. Cohort 2 (CT-996 10/30/60/90/120): planned 10 mg × 3d, 30 mg × 4d, 60 mg × 7d, 90 mg × 7d, 120 mg × 7d (actual: 2 participants needed 3 additional days at 90 mg before escalating to 120 mg; 1 participant remained at 60 mg); d. Cohort 3 (CT-996 10/30/50/80/120): planned 10 mg × 3d, 30 mg × 4d, 50 mg × 7d, 80 mg × 7d, 120 mg × 7d (actual: all except 1 participant followed the planned path; 1 participant decreased their dose from 50 mg to 30 mg to 10 mg and completed the study at 10 mg).



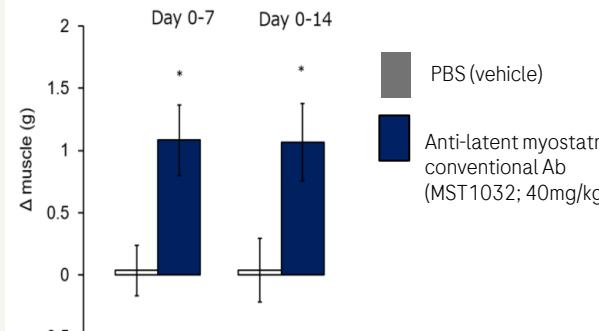
Emugrobart + tirzepatide Ph II (GYMINDA) results expected in 2026

Combination has potential to improve weight loss and preserve muscle mass

Emugrobart (GYM329, anti-latent myostatin mAb)

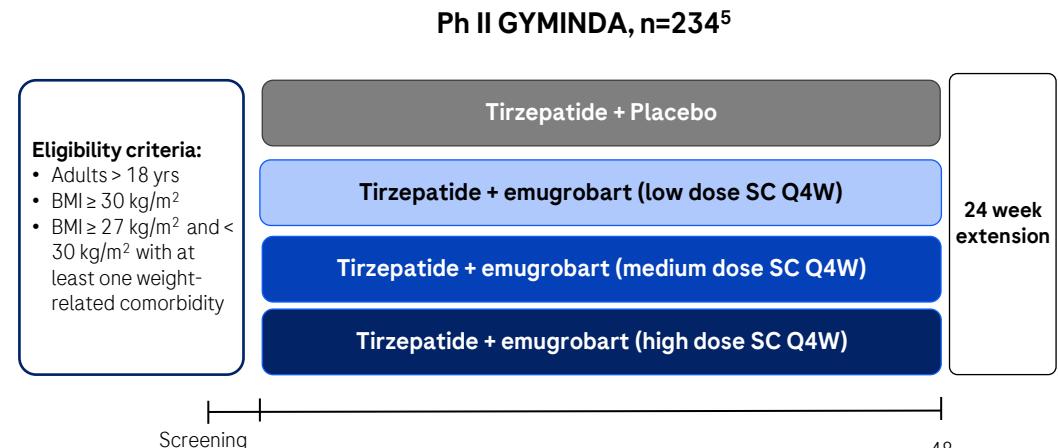


Whole-body muscle change (g)^b in 2-week treated, diet-induced obese mice



- Myostatin and its receptor ActRIIb are negative regulators of muscle mass^{1,2}
- Emugrobart is an anti-latent myostatin sweeping antibody^a designed to increase muscle mass. Unlike many other myostatin antibodies, it does not block GDF11², giving it greater selectivity
- Anti-myostatin antibodies significantly increased muscle mass in a diet-induced obese mouse model^b

Ph II GYMINDA (tirzepatide + emugrobart) OB/OW pts



- Current anti-obesity therapies cause loss of lean mass; preservation of lean muscle mass during WL is a therapeutic goal^{3,4}
- Emugrobart in combination with incretin-based therapies has the potential to improve weight loss, preserve muscle mass, and improve weight maintenance via increased metabolic rate
- Ph II trial recruitment completed, data in 2026

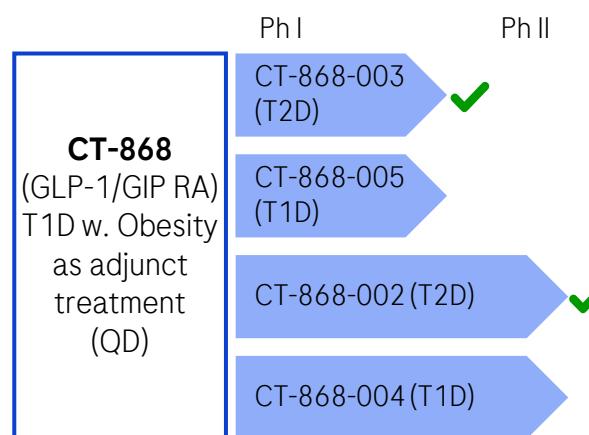
a. A sweeping antibody is a recycling antibody that has been further engineered to bind to FcRn at neutral pH. binternal non-clinical data in Chugai, not published (figure illustrative), whole-body muscle was measured with TD-NMR. 1. Pistilli EE, et al. Am J Pathol. 2011;178:1287-97; 2. Muramatsu H, et al. Sci Rep. 2021;11:2160; 3. Bikou A, other. 2024;25:611-19; 4. Song J-E, et al. Drug Des Devel Ther. 2024;18:845-58. 5. NCT06965413; ActRIIB: activin A receptor type 2B.;FcRn: Neonatal R_c receptor, GDF11: Growth differentiation factor 11; PBS: Phosphate-buffered saline; SE: Standard error; TDNMR: Time-domain nuclear magnetic resonance.; WL: Weight loss; emugrobart in collaboration with Chugai



CT-868: Ph II results in T1D expected in Q4 2025

Flexible and easy integration into standard insulin regimens for patients with T1D through once-daily dosing

Development program

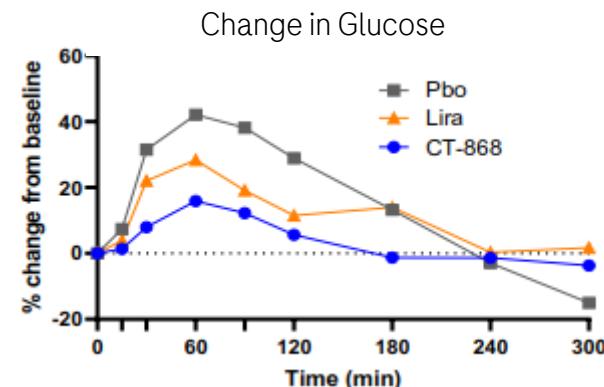


✓ Positive data readout

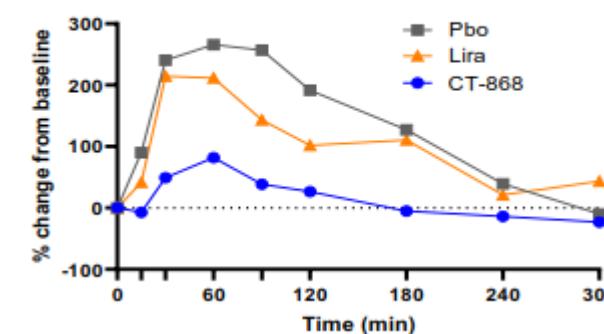
- Ph II PoC trial in T2D completed
- Ph I study in T1D ongoing
- Ph II PoC trial in T1D ongoing, results Q4 2025

CT-868 concomitantly reduces plasma glucose and insulin excursion¹

Mixed Meal Tolerance Test (Ph I CT-868-003 T2D)



Change in Insulin



- Clinical data in people living with OW/OB and T2D show CT-868 lowers glucose with less insulin excursions vs. liraglutide during mixed meal tolerance test
- This suggests enhanced insulin sensitivity and/or enhanced insulin independent glucose disposal induced by CT-868, independent of weight loss



Our near-term portfolio offers a strong foundation

Our differentiation potential relies on the breadth of options to address patient needs

Tolerability

e.g. nausea/emesis is a main *driver for discontinuation*

petrelintide	CT-388
CT-388 + petrelintide	

No or suboptimal response

to incretins in up to 20%¹ of patients

petrelintide	CT-388 + petrelintide
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Lean muscle loss

Up to 40% of weight loss comes from *muscle loss*

incretin + emugrobart

Cardiovascular and renal (CVR)

Improvement in cardiometabolic outcomes

zilebesiran

Ceiling effect on weight loss

e.g., weight loss *plateaus* after 12–18 months

petrelintide	CT-388
CT-388 + petrelintide	

Weight maintenance

Majority of patients *regain weight* after stopping treatment

petrelintide	CT-388	CT-996
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Comorbidities

>70% of PwO have at least one comorbidity

CT-388	petrelintide	CT-388 + petrelintide
pegozafermin* incretin + pegozafermin*		

* Pending deal closure; Source: Market research (2025); 1. SURMOUNT-1 study shows there are up to 20% of incretin inadequate responders (at week 12); 2. Based on pre-clinical data; MASH: Metabolic dysfunction-associated steatohepatitis; MoA: Mechanism of action

Doing now what patients need next

Driving performance and strategy implementation



Strategy

- Finalized five TA strategies for implementation
- Strengthening capabilities along the value chain via advanced technologies, including AI



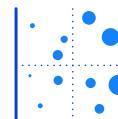
Commercial excellence

- Optimizing commercialization and life-cycle management of on-market portfolio
- Investing in capabilities to seize emerging opportunities, including CVRM



Financial discipline

- Maintaining stringent cost discipline to allow agile resource reallocation and fund future innovation



Portfolio

- 2 key readouts (giredestrant, fenebrutinib) in '25/26
- 8 NMEs new to Ph III in '25, first readouts from '27
- Establishing leading obesity portfolio with further combination optionality



R&D Excellence

- Applied the Bar E2E for long-term portfolio health: Already 55% of NMEs passed the Bar and 67% of late-stage projects with BID potential
- Boosting R&D productivity e.g., shorter development times or Lab-in-a-loop



Partnering

- Disciplined BD approach combined with in-house R&D Excellence to drive further portfolio rejuvenation

Preparing for future growth

Thank you for your attention and we are happy to answer your questions



Appendix

2025: Significant key newsflow ahead*

	Compound	Indication	Milestone	
Regulatory	Itovebi + palbociclib + fulvestrant	1L PIK3CA-mut HR+ BC	EU approval	✓
	Columvi + GemOx	2L+ DLBCL	US/EU approval	✗ / ✓ (US/EU)
	Lunsumio SC	3L+ FL	US approval/EU filing	✓ (EU filing)
	Elevidys	DMD	EU approval	
	Gazyva	Lupus nephritis	US/EU filing; US approval	✓ (US/EU filing)
	Susvimo	DME/DR	US approval	✓
	Susvimo	nAMD	EU filing	✓
Clinical results	giredestrant + palbociclib	1L ER+/HER2- mBC	Ph III persevERA	2026
	giredestrant + everolimus	post CDKi ER+/HER2- mBC	Ph III evERA	✓
	Lunsumio + Polivy	2L+ DLBCL	Ph III SUNMO	✓
	Lunsumio + lenalidomide	2L+ FL	Ph III CELESTIMO	2026
	Venclexta + azacitidine	1L MDS	Ph III VERONA	✗
	PiaSky	aHUS	Ph III COMMUTE-a	
	Ocrevus HD	RMS/PPMS	Ph III MUSETTE/GAVOTTE	✗
	fenebrutinib	RMS	Ph III FENhance 1/2	2026
	fenebrutinib	PPMS	Ph III FENTrepid	
	astegolimab	COPD	Ph II/III ALIENTO/ARNASA	✗ (Mixed results)
	Gazyva	SLE	Ph III ALLEGORY	
	vamikibart	UME	Ph III SANDCAT/MEERKAT	○ (To be filed)
	NXT007	Hemophilia A	Ph I/II	✓
	trontinemab	AD	Ph I/II Brainshuttle™ AD	✓
	Evrysdi + emugrobart	SMA	Ph II MANATEE	
	emugrobart	FSHD	Ph II MANOEUVRE	
	zilebesiran	Hypertension	Ph II KARDIA-3	✗ (Moving to Ph III)
	CT-868 (QD SC)	T1D with Obesity	Ph II	
	CT-996 (QD oral)	Obesity with T2D	Ph I (Arm 3)	

Additional 2025 newsflow: ✓ TNKase US approval in acute ischemic stroke
 ✓ Zosurabipin in MDR bacterial infections moving to Ph III

✓ Tecentriq positive Ph III (IMforte) in 1L SCLC
 ✓ Tecentriq positive Ph III (ATOMIC) in adj. dMMR CC

✓ Tecentriq positive Ph III (IMvigor011) in MIBC

*Outcome studies are event-driven: timelines may change

2026: Key newsflow outlook*

	Compound	Indication	Milestone
 Regulatory	Lunsumio + Polivy	2L+ DLBCL	US approval
	giredestrant + everolimus	post CDKi ER+/HER2- mBC	US/EU filing/ US approval
	Susvimo	nAMD	EU approval
	Susvimo	DME	EU filing
	vamikibart	UME	US/EU filing
 Clinical results	divarasib	2L KRASG12C+ NSCLC	Ph III KRASCENDO 1
	giredestrant + palbociclib	1L ER+/HER2- mBC	Ph III persevERA
	giredestrant	Adjuvant ER+/HER2- BC	Ph III lidERA
	Itovobi + fulvestrant	post CDKi HR+ mBC	Ph III INAVO121
	Itovobi + Phesgo	PIK3CA-mut HER2+ mBC	Ph III INAVO122
	Lunsumio + lenalidomide	2L+ FL	Ph III CELESTIMO
	Enspryng	MOG-AD	Ph III METEOROID
	Enspryng	AIE	Ph III CIELO
	fenebrutinib	RMS	Ph III FENhance 1/2
	Gazyva	MN	Ph III MAJESTY
	sefaxersen	IgAN	Ph III IMAGINATION
	Vabysmo	CNV	Ph III POYANG
	CT-388	Obesity	Ph II
	CT-996	Obesity	Ph II
	petrelintide	Obesity	Ph II ZUPREME-1/2
	emugrobart + tirzepatide	Obesity	Ph II GYMINDA

Changes to the development pipeline

Pharma Day update

New to phase I	New to phase II	New to phase III	New to registration
1 NME: CHU pan-KRAS inhibitor (AUBE00) – solid tumors	1 NME: RG6652 GLP-1 RA (CT-996) - obesity +/- T2D 1 AI: RG6114 Itovebi - early-stage, PIK3CA-mut. BC	1 NME: RXXXX* pegozafermin* - MASH (F2-3; F4) RG6102 trontinemab - Alzheimer's 1 AI: RG6013 Hemlibra - Type 3 VWD Phase III to be initiated: RG6006 zosurabalin - bacterial infections RG6615 zilebesiran - hypertension RG6640 GLP-1/GIP RA (CT-388) - obesity +/- T2D RG7935 prasinezumab - Parkinson's RG6160 cevostamab - r/r multiple myeloma RG6330 divarasib – 1L mNSCLC/eNSCLC	
Removed from phase I	Removed from phase II	Removed from phase III	Approvals
4 NMEs: CHU anti-latent TGF-β1 (SOF10) - solid tumors CHU CD137 switch - solid tumors CHU paluratide (RAS inhibitor) - solid tumors CHU anti-CLDN6 trispecific - CLDN6+ solid tumors	1 NME: CHU anti-IL-8 – endometriosis 1 AI: RG6107 PiaSky - sickle cell disease	1 AI: RG1594 Ocrevus higher dose - PPMS	

Roche Group development pipeline

Phase I (38 NMEs + 7 Als)			Phase II (17 NMEs + 8 Als)		
RG6026	Columvi monotherapy + combos	heme tumors	RG6382	CD19 x CD3	SLE
RG6076	englumafusp alfa combos	heme tumors	RG6377	-	IBD
RG6114	Itovebi	solid tumors	RG6418*	selnolast	inflammation
RG6160	cevostamab	r/r multiple myeloma	RG6421	TMEM16A potentiator	Muco-obstructive respiratory disease
RG6171	giredestrant monotherapy + combos	solid tumors	RG6631	afimkibart (anti-TL 1A)	MASH
RG6221	LTBR agonist	solid tumors	RG7828	Lunsumio	SLE
RG6330	divarasib monotherapy + combos	solid tumors	CHU	anti-HLA-DQ2.5 x gluten peptides	celiac disease
RG6344	mosperafenib (BRAF inhibitor (3))	solid tumors	CHU	anti-C1s recycling antibody	immunology
RG6411	-	solid tumors	RG6035	Brainshuttle™ CD20	multiple sclerosis
RG6468	-	solid tumors	RG6182	MAGL inhibitor	multiple sclerosis
RG6505	PanRAS inhibitor	solid tumors	RG6434	-	neurodegenerative disorders
RG6537	AR degrader	mCRPC	RG6662	HTT miRNA GT (SPK-10001)	Huntington's disease
RG65381	P-BCMA-ALLO1	r/r multiple myeloma	RG6120	zifibancimig	nAMD
RG65401	P-CD19 x CD20 - ALLO1	heme tumors	RG6209	VEGF-IL-6 DutaFab	DME
RG6561	-	solid tumors	RG6327	-	geographic atrophy
RG65962	HER2 TKI	HER2+ BC	RG6006	zosurabalin	bacterial infections
RG6620	KRAS G12D inhibitor	solid tumors	RG6436	LepB inhibitor	complicated urinary tract infection
RG66483	cMET ADC	solid tumors	CHU	REVN24	acute diseases
RG7828	Lunsumio monotherapy + combos	heme tumors	CHU	BRY10	chronic diseases
RG6794	CDK4/2i	HR+ HER2- BC	Post Bar projects (entered or progressed in the pipeline after YE 2023)		
RG68104	DLL3 ADC	SCLC	Pre Bar projects		
CHU	DLL3 trispecific	solid tumors	Oncology / Hematology		
CHU	codrituzumab	HCC	Immunology		
CHU	MINT91	solid tumors	Cardiovascular, Renal & Metabolism		
CHU	anti-CTLA-4 switch antibody	solid tumors	Neurology		
CHU	pan-KRAS inhibitor (AUBE00)	solid tumors	Ophthalmology		

RG-No - Roche/Genentech; CHU - Chugai managed; ¹Poseida led studies undergoing integration into Roche portfolio; ²Zion Pharma managed; ³MediLink managed; ⁴Innovent managed; ⁵Anlylam Pharmaceuticals managed; ⁶Zealand Pharma managed *also developed in neurology; T: Tecentriq; RA: Receptor agonist

Status as of September 22, 2025; Note: Development stage shown here based on FPI achieved, additionally the following Ph III Go decisions have been made: CT-388, cevostamab, NXT007, prasinezumab, zilebesiran, zosurabalin

Post Bar projects
Pre Bar projects
Oncology / Hematology
Immunology

Cardiovascular, Renal & Metabolism
Neurology
Ophthalmology
Other

Roche Group development pipeline

Phase III (9 NMEs + 28 AIs)			Registration US & EU (1 NME + 4 AIs)		
RG3502	Kadcyla + T	HER-2+ eBC high-risk	RG6149	astegolimab	COPD
RG6013	Hemlibra	Type 3 VWD	RG6299	sefaxersen (ASO factor B)	IgA nephropathy
RG6026	Columvi + Polivy + R-CHP	1L DLBCL	RG6631	afimkibart (anti-TL1A)	ulcerative colitis
	Columvi	r/r MCL		afimkibart (anti-TL1A)	Crohn's disease
RG6107	PiaSky	aHUS		Gazyva	membranous nephropathy
	Itovebi + fulvestrant	post CDKi HR+ PIK3CA-mut. BC		Gazyva	systemic lupus erythematosus
RG6114	Itovebi + Phesgo	1L HER2+ PIK3CA-mut. mBC	RG7159	Gazyva	childhood onset idiopathic nephrotic syndrome*
	Itovebi + CDK4/6i + letrozole	1L ES PIK3CA-mut. HR+ HER2- advanced BC			
	giredestrant + everolimus	post-CDK4/6 ER+/HER2- BC	RGXXXX*	pegozafermin*	MASH (F2-3; F4)
RG6171	giredestrant + palbociclib	1L ET sensitive ER+/HER2-mBC	RG6102	trontinemab	Alzheimer's
	giredestrant	ER+ BC adj	RG6168	Enspryng	MOG-AD
	giredestrant + Phesgo	1L ER+/HER2+ BC		Enspryng	autoimmune encephalitis
	giredestrant + CDK4/6i	1L ET resistant ER+/HER2- BC	RG6356	Elevidys	amb. 8 to <18y & non amb. DMD
RG6330	divarasib	2L NSCLC	RG7845	fenebrutinib	RMS
	Tecentriq + platinum chemo	NSCLC periadj		fenebrutinib	PPMS
RG7446	Tecentriq + BCG	NMIBC, high-risk	RG6168	Enspryng	TED
	Tecentriq	ctDNA+ high-risk MIBC	RG6179	vamikibart	UME
RG7828	Lunsumio + lenalidomide	2L+ FL	RG6321	Susvimo	wAMD, 36-week
	Lunsumio + Polivy	2L+ DLBCL	RG7716	Vabysmo	CNV

■ Post Bar projects (entered or progressed in the pipeline after YE 2023)

■ Post Bar projects
■ Pre Bar projects
■ Oncology / Hematology
■ Immunology

■ Cardiovascular, Renal & Metabolism
■ Neurology
■ Ophthalmology
■ Other

* Pending deal closure; Status as of September 22, 2025; Note: Development stage shown here based on FPI achieved, additionally the following Ph III Go decisions have been made: CT-388, cevostamab, NXT007, prasinezumab, zilebesiran, zosurabalin

Doing now what patients need next