Priovant Overview

October 2025

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Priovant Is an Emerging Leader in Specialty I&I

Brepocitinib, an oral once daily dual TYK2/JAK1 inhibitor, is in late-stage development for multiple highly morbid orphan autoimmune diseases with few or no approved targeted therapies; brepocitinib has generated compelling Phase 2 and Phase 3 clinical results in these indications

Successful Phase 3 VALOR study in dermatomyositis (DM) positions brepocitinib to potentially be the first approved targeted therapy in indication with tremendous unmet need

VALOR results confirm brepocitinib's potential to meaningfully improve DM patients' lives

- Rapid, sustained, clinically and statistically significant improvement across key disease domains
- Substantial reduction in steroid exposure, a major cause of morbidity in DM patients

Phase 3 ongoing in second orphan indication with high unmet need (non-infectious uveitis)

- 52-week Phase 2 data suggest potential best-in-indication profile for brepocitinib

Additional studies in orphan/specialty I&I indications underway

- Ongoing Phase 2 study in cutaneous sarcoidosis
- Initiation of additional studies planned for 2026

Brepocitinib Is a Potential First-In-Class Dual Selective TYK2/JAK1 Inhibitor, Representing Next Generation of JAK Inhibition

Evolution of JAK inhibitor field highlights market demand for efficacy in treating patients with the most debilitating conditions

Nonspecific/pan-JAK inhibitors

XELJANZ® [tofacitinib]

olumiant® (baricitinib) tablets

First targeted oral agents for inflammatory diseases

Non-specificity limited ability to dose to maximal efficacy and led to class-wide black box warning

Modest commercial success, but uptake impaired by less-than-biologic efficacy

Single JAK Isoform Inhibitors

RINVOQ® upadacitinib

SOTYKTU™ (deucravacitinib) 6 mg tablets

Rinvoq (JAK1) has generated often best-in-indication efficacy and is a multi-blockbuster drug despite black box warnings

Sotyktu (TYK2), which avoided a black box warning, has underperformed commercially due to less-than-biologic efficacy

Selective, Dual Inhibitor of TYK2 and JAK1

Brepocitinib

Brepocitinib combines the attributes of selective TYK2 and JAK1 inhibition with the potential **to provide greater efficacy** for patients with highly morbid, heterogeneous autoimmune diseases

Dermatomyositis

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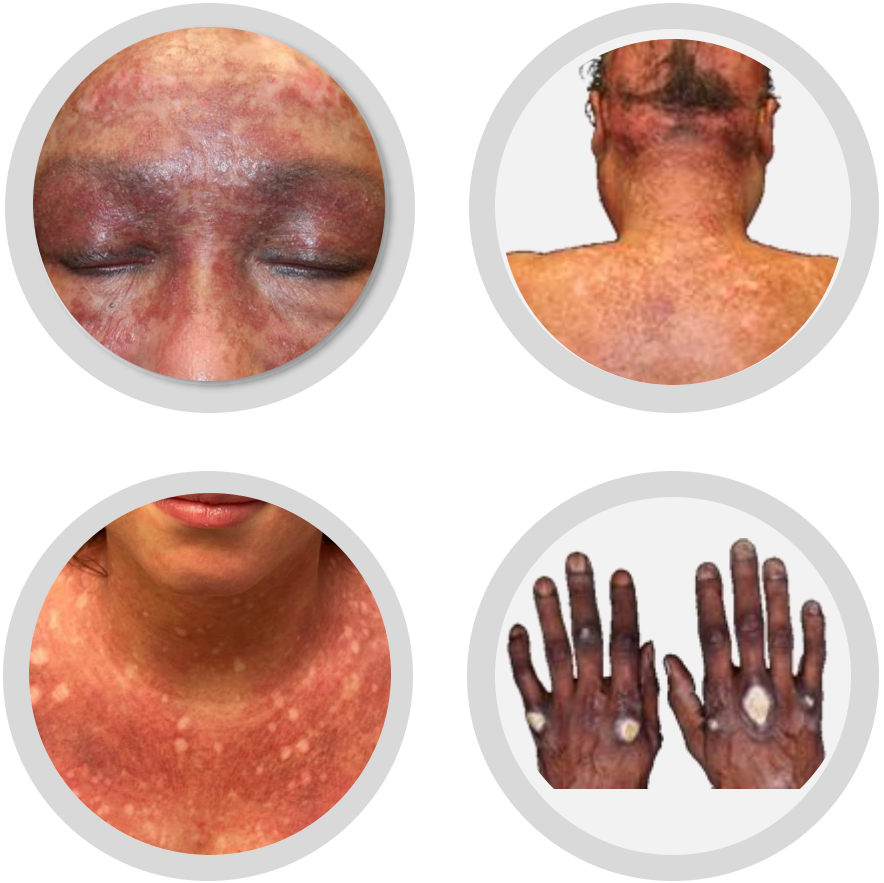
Dermatomyositis: Key Features in Common with Recent Orphan I&I Launches that Rapidly Achieved Blockbuster Revenue



Mid-tens-of-thousands prevalence

Prevalence of approximately 40,000-50,000 adults in US with approximately 35,000 patients receiving advanced chronic therapy[1]

High morbidity with poor/no modern treatment options

Skin and muscle disease lead to pain, disfigurement, highly impaired mobility, and extensive comorbidities (e.g., cardiometabolic, GI, depression)

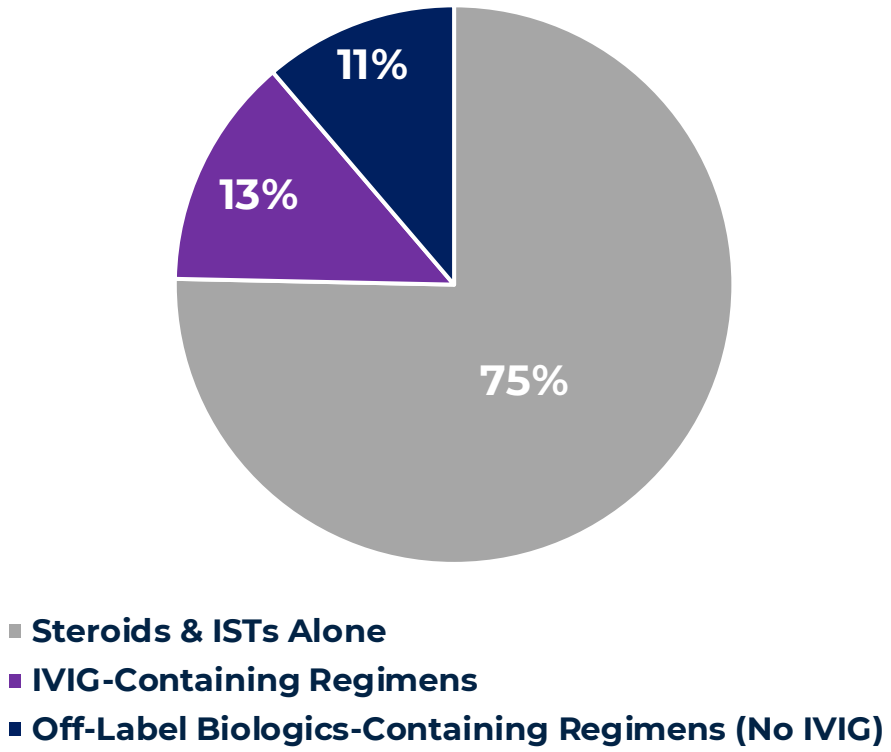
Orphan price point and concentrated prescriber base

Patients concentrated at tertiary centers of excellence

All disease photos courtesy of Priovant.
1) PriovantTx estimates based on Reeder 2010, Smoyer-Tomic 2012, and claims analysis

Dermatomyositis Patients Have Significant Unmet Medical Needs

Therapies Received by Treated DM Patients



- **Standard-of-care in DM is largely unchanged since the 1980s**: combinations of corticosteroids and off-label ISTs
- Patient and physician need for modern, targeted therapies is extraordinarily high given that **unapproved therapies with no RCT data (including JAK inhibitors) are used off-label at rates comparable to IVIg**
- Even among patients treated with IVIg or off-label targeted therapies, chronic high-dose steroid use remains high, **with most requiring doses ≥10 mg/day for ≥100 days/year**

DM: Dermatomyositis
IST: Immunosuppressive therapy
IVIG: Intravenous immunoglobulin
RCT: Randomized controlled trial

Data Source: Analysis by Roivant/Priovant using closed claims data from Inovalon. Analysis includes patients with DM with continuous enrollment from 2020-2022. Conclusions corroborated through independent Veeva Compass open claims data through 2024.

Brepocitinib Delivered First Ever Positive 52-Week Placebo Controlled Trial in DM (VALOR Study)

- **Highly significant, robust, and consistent data across primary and all key secondary endpoints**
- **Consistent dose response seen between 15 mg and 30 mg, establishing 30 mg dose as optimal in this setting**
- **Responses were rapid, deep, and broad, and showed clinically meaningful benefit to both muscle and skin symptoms**
    - **Robust, steroid-sparing benefit:** Brepocitinib 30 mg showed a mean TIS of 46.5, a delta of >15 points (p=0.0006) relative to placebo at week 52 (TIS of 31.2), even with twice as many patients coming off background steroids on brepocitinib compared to placebo
    - **Depth of response:** >2/3 of brepocitinib 30 mg patients experienced at least a moderate response (TIS40), and nearly half experienced a major response (TIS60)
    - **Rapidity of response:** Onset was rapid with median time to a TIS40 response of ~2 months; TIS and CDASI responses significant as early as week 4
    - **Breadth of response:** Positive data on all 10 pre-specified endpoints demonstrating improvement in both skin and muscle symptoms
- **Brepocitinib 30 mg safety profile in VALOR was consistent with prior clinical studies**
    - Adverse Events of Special Interest (including malignancy, thromboembolic events, and cardiovascular events) did not occur with greater frequency in brepocitinib 30 mg arm compared to placebo + SOC therapies in VALOR over 52 weeks of double-blind treatment
    - Brepocitinib safety database across all evaluated indications and patient populations includes over 1,500 patients and subjects, with a safety profile that appears consistent with approved JAK and TYK2 inhibitors

TIS: Total Improvement Score
CDASI-A: Cutaneous Dermatomyositis Activity and Severity Index - Activity Subscore
SOC: Standard of care
Product candidate is investigational and subject to regulatory approval. Timing is based on current expectations and subject to FDA feedback

Strong Clinical Data Supported by Distinctive Alignment of Brepocitinib Mechanism (TYK2/JAK1 Inhibition) to DM Pathogenesis

Pathogenic Cytokine	Role in DM Pathogenesis		Brepocitinib	Selective JAK1 Inhibitor	Selective TYK2 Inhibitor	Type I IFN Antibody
Type I IFN (IFNα/β)	**Lymphocyte Activation**		✓✓	✓	✓	✓✓
Type II IFN (IFNγ)	**Th1** Lymphocyte Polarization		✓	✓	✗	✗
IL-12			✓	✗	✓	✗
IL-6	**Th17** Lymphocyte Polarization	**B Cell Activation**	✓✓	✓	Partial	✗
IL-23			✓	✗	✓	✗

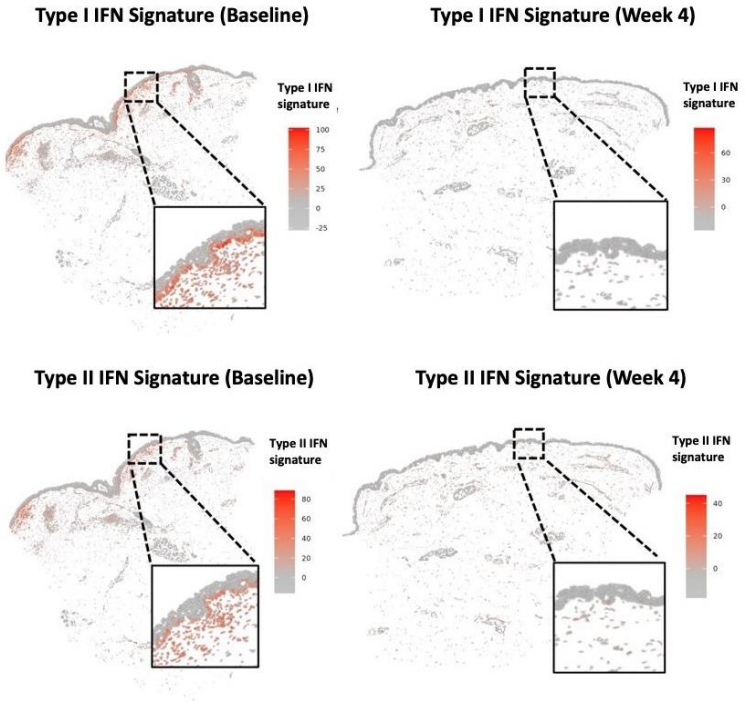
DM: Dermatomyositis
INF: Interferon

Paik et al., *Clin Exp Rheumatol* (2025)
Arshanapalli et al., *Cytokine* (2015)
Castellini et al., *Autoimmunity Reviews* (2024)
Thuner et al., *Autoimmunity Reviews* (2023)

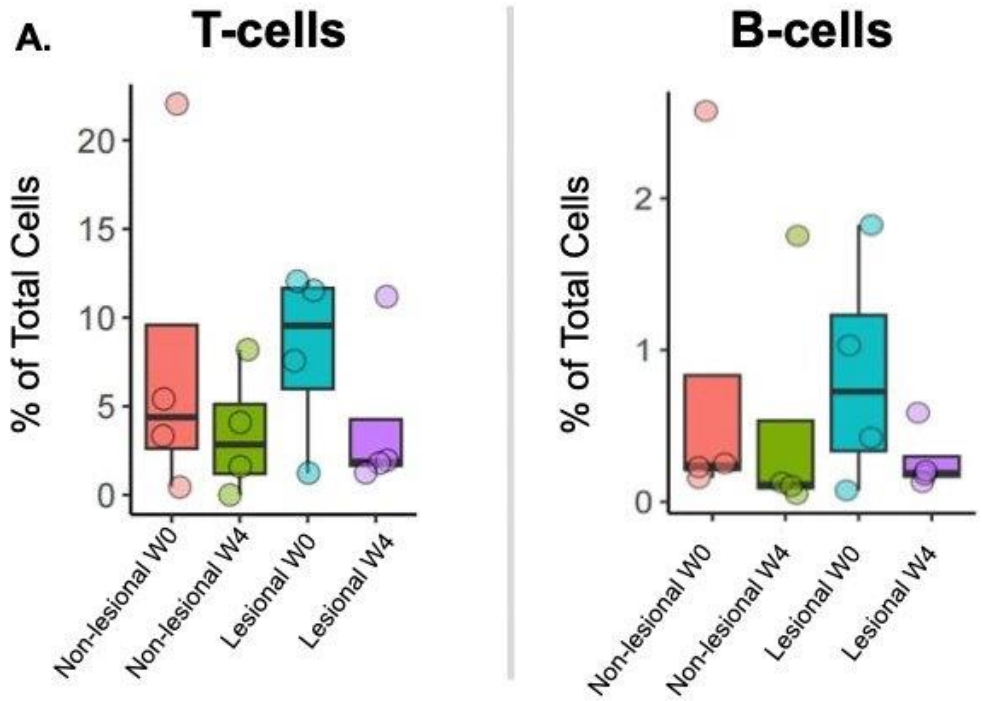
Mechanistic Data from DM Patients Confirm Potential Disease-Modifying Effects of Dual TYK2 and JAK1 Inhibition with Brepocitinib

In an open-label study of five DM patients with highly active skin disease[1], treatment with brepocitinib resulted in marked reduction in Type I and Type II IFN signaling and reduced infiltration of immune cells at the dermal-epidermal junction at Week 4

Normalization of Type I and Type II IFN Signaling[2]



Reduced Infiltration of Pathogenic Lymphocytes

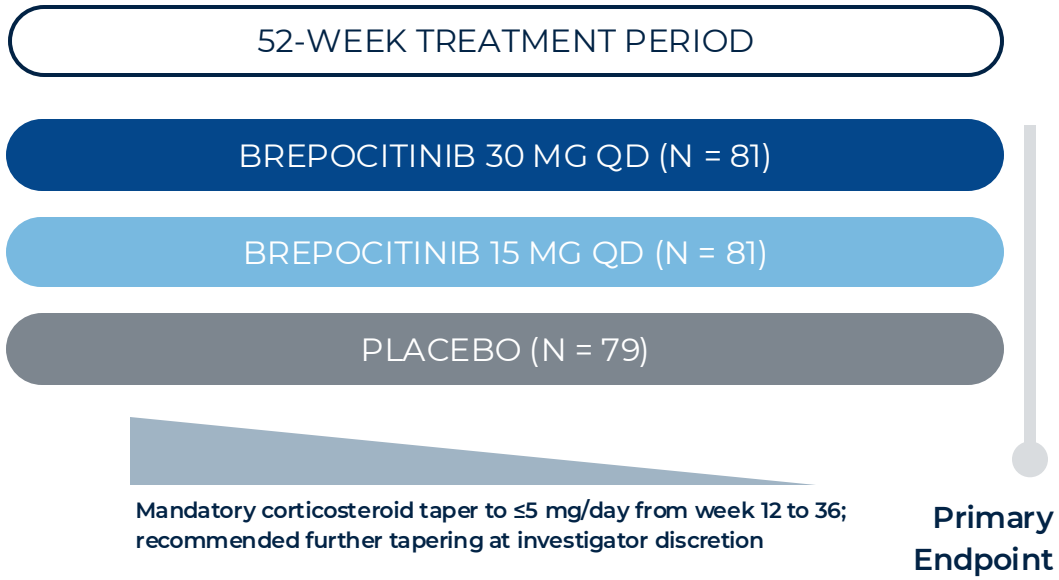


1) NCT06433999
2) Representative spatial RNA transcriptomics image of type I and type II IFN signature scores at Week 0 and Week 4 in lesional skin (single patient shown)

VALOR: Global Phase 3 Placebo-Controlled Study Evaluating Brepocitinib In Dermatomyositis

N=241 adults with dermatomyositis

Randomized 1:1:1
by PhGA-VAS



Eligible Patients

- Definite or probable dermatomyositis (2017 EULAR/ACR criteria)
- Skin activity: CDASI-A ≥6
- Muscle activity: MMT-8 ≤142
- Refractory or intolerant to SOC therapy

Permitted Background Therapy

Oral IST, antimalarial, and/or OCS

Primary Endpoint

30 mg vs. placebo mean Total Improvement Score at Week 52

IST: Immunosuppressive therapy
OCS: Oral corticosteroids
CDASI-A: Cutaneous Dermatomyositis Activity and Severity Index - Activity Subscore

MMT-8: Manual testing of 8 muscle groups
SOC: Standard of care
PhGA-VAS: Physician's Global Assessment – Visual Analog Scale

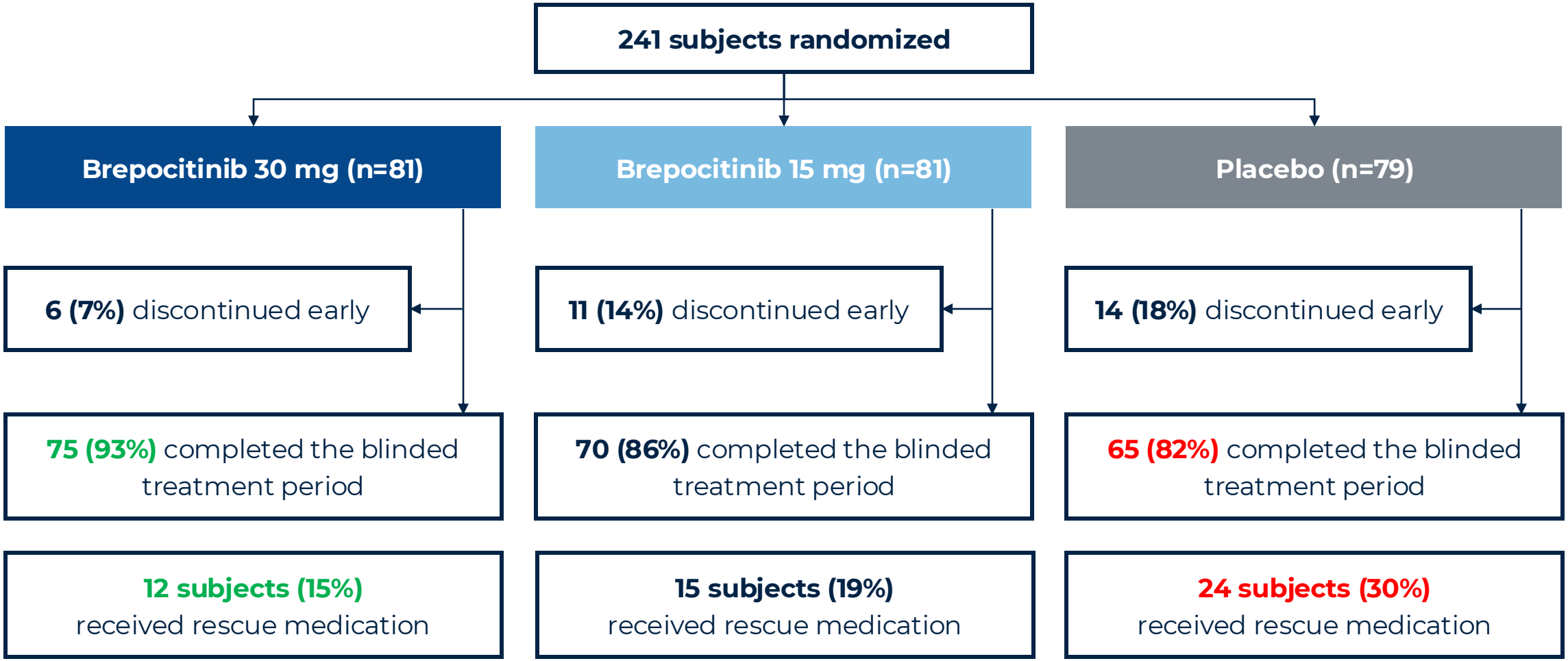
Enrolled Population Had Highly Active, Multisystem Disease

Arms were well-balanced across demographics, baseline disease activity, and background medications

	Brepocitinib 30 mg (n = 81)	Brepocitinib 15 mg (n = 81)	Placebo (n = 79)
Mean Age (years) (± SD)	50.4 (14.5)	50.7 (12.1)	50.7 (13.5)
Sex (Female) – no. (%)	65 (80%)	67 (83%)	55 (70%)
Region: US/Canada – no. (%)	32 (40%)	34 (42%)	30 (38%)
Disease Activity – no. (%)			
Mild	13 (16%)	19 (24%)	13 (16%)
Moderate	54 (67%)	40 (49%)	48 (61%)
Severe	14 (17%)	22 (27%)	18 (23%)
Mean MMT-8 Score (± SD)	121.7 (16.4)	124.5 (14.2)	121.6 (17.0)
Mean CDASI-A Score (± SD)	19.5 (11.3)	18.7 (11.3)	21.1 (12.0)
History of ILD – no. (%)	19 (24%)	17 (21%)	11 (14%)
Medications at Baseline – no. (%)			
Immunosuppressant	55 (68%)	57 (70%)	61 (77%)
Antimalarial	24 (30%)	22 (27%)	19 (24%)
Corticosteroids	60 (74%)	58 (72%)	64 (81%)
Mean dose (mg/day) (± SD)	12.2 (5.7)	10.7 (6.2)	11.3 (5.9)
Corticosteroids > 5 mg/day	47 (58%)	38 (47%)	47 (59%)

MMT-8: Manual muscle testing of 8 muscles
CDASI-A: Cutaneous Dermatomyositis Activity and Severity Index - Activity Subscore
ILD: Interstitial lung disease

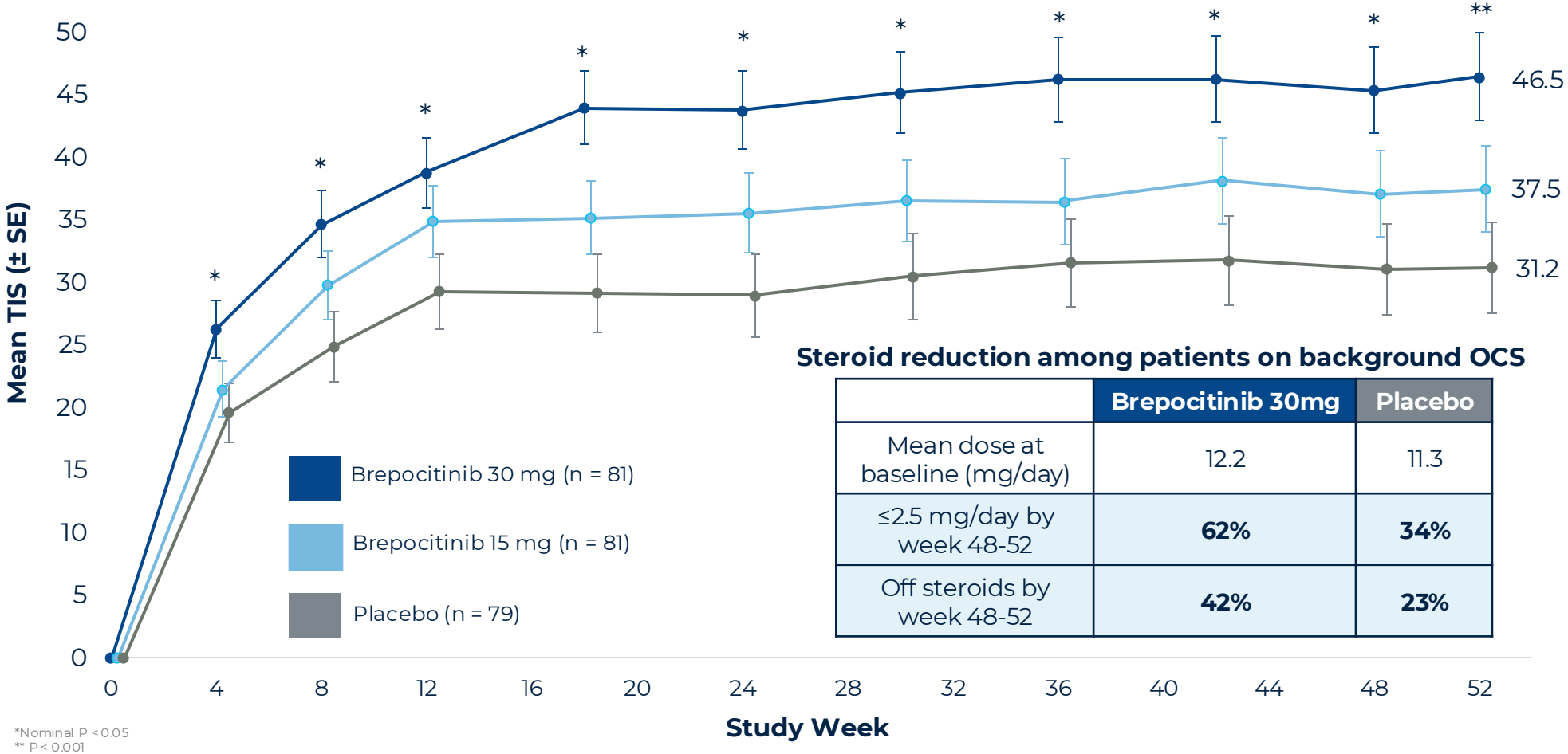
Disposition: Brepocitinib Had Substantially Higher Completion Rate and Substantially Lower Rescue Rate Than Placebo



The definition of rescue medication was prespecified. This included initiation or clinically-meaningful increase in intensity of one or more systemic therapies given for treatment of DM.

Brepocitinib Showed Statistically Significant and Clinically Meaningful Improvement on Primary Endpoint of TIS

Separation between brepocitinib 30 mg and placebo at all time points, starting as early as week 4, achieved together with substantially greater steroid reduction in brepocitinib 30 mg arm



Steroid reduction among patients on background OCS

	Brepocitinib 30mg	Placebo
Mean dose at baseline (mg/day)	12.2	11.3
≤2.5 mg/day by week 48-52	**62%**	**34%**
Off steroids by week 48-52	**42%**	**23%**

Primary Endpoint

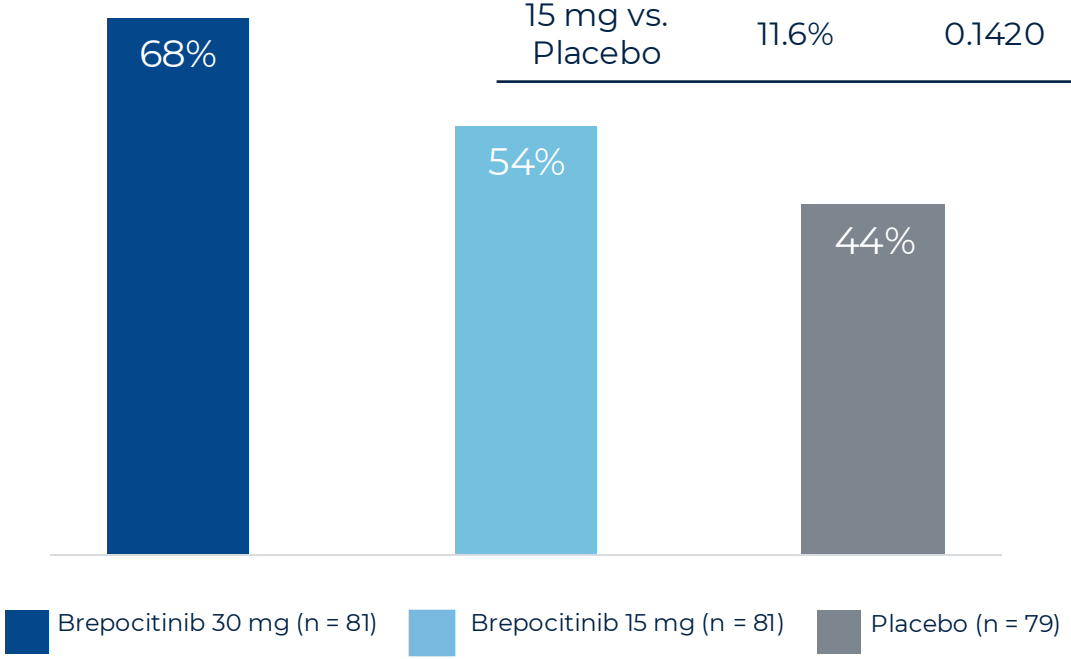
30 mg vs. Placebo
At Week 52
TISΔ 15.3
P = 0.0006

*Nominal P < 0.05
** P < 0.001

>2/3 of Patients on 30 mg Achieved Moderate TIS Response (TIS40) & Nearly Half Achieved Major TIS Response (TIS60)

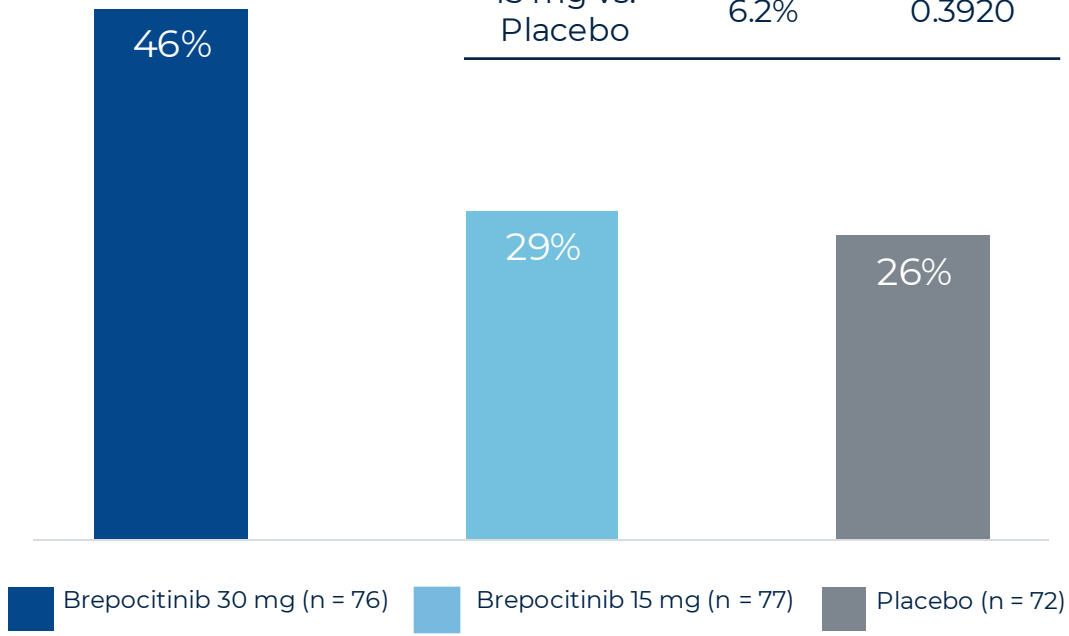
Patients Achieving Moderate TIS Response (TIS40) at Week 52

	Δ	P
30 mg vs. Placebo	**22.2%**	**0.0040**
15 mg vs. Placebo	11.6%	0.1420



Patients Achieving Major TIS Response (TIS60) at Week 52

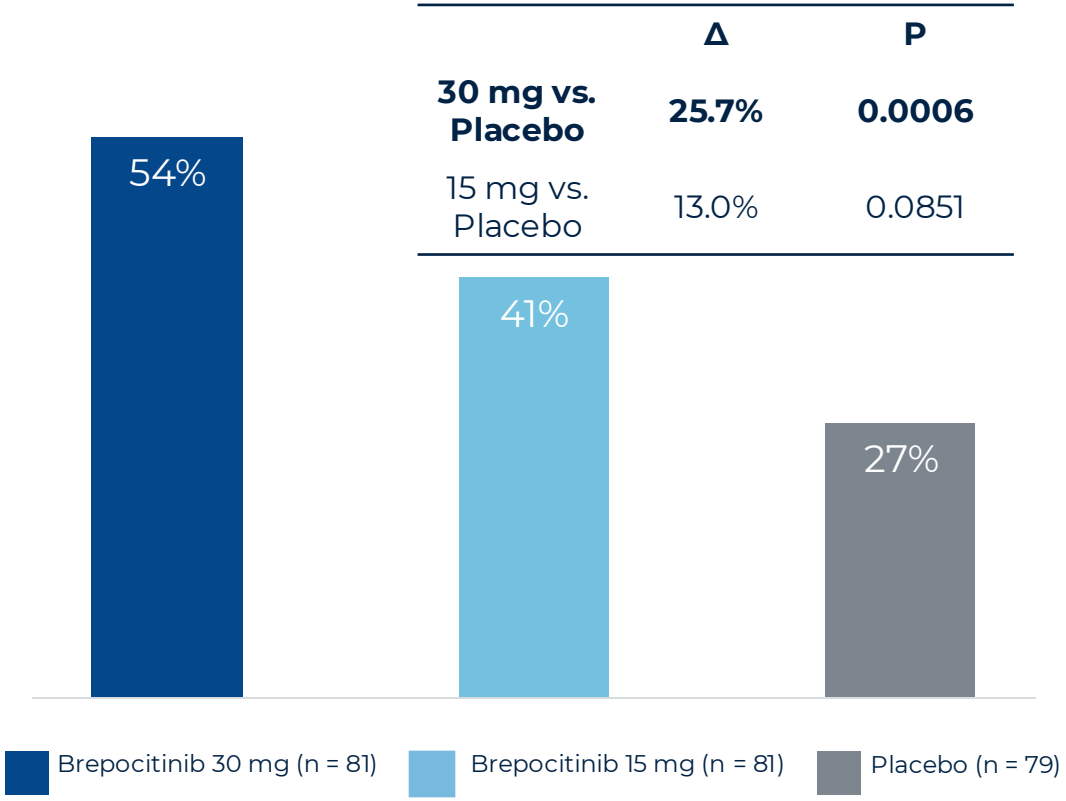
	Δ	P
30 mg vs. Placebo	**19.5%**	**0.0126**
15 mg vs. Placebo	6.2%	0.3920



Adjusted response rate (risk) differences calculated using the Mantel-Haenszel method.

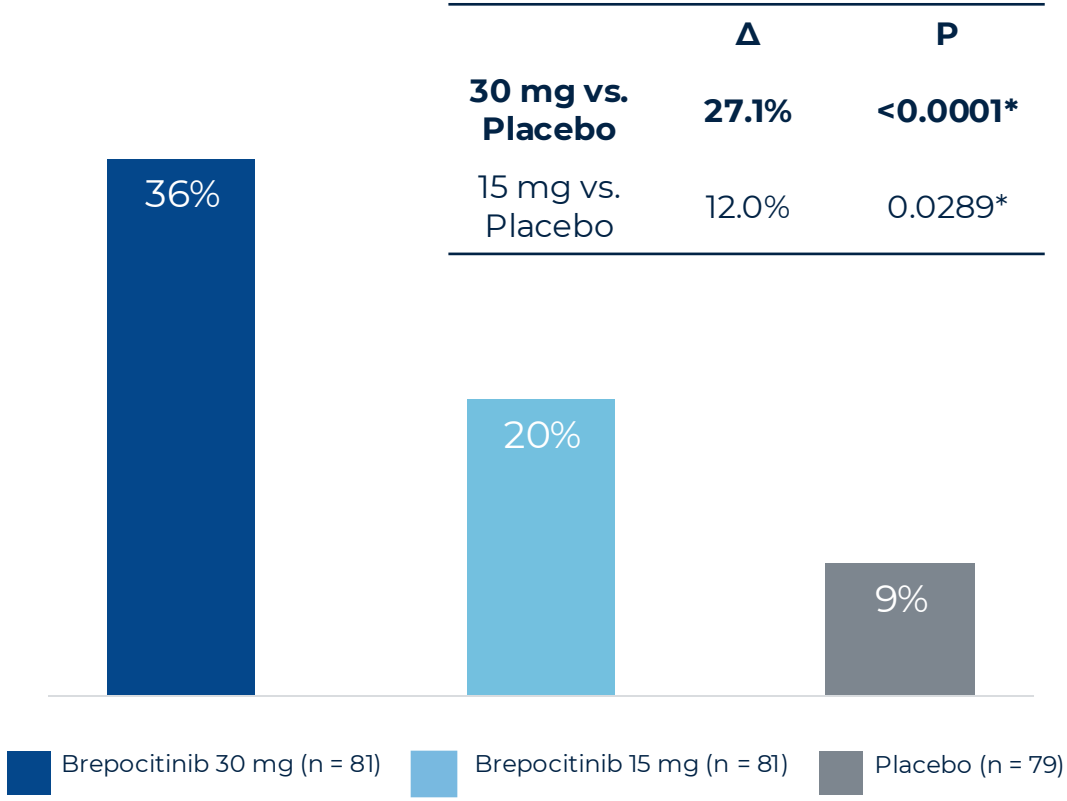
More Than a Third of Brepocitinib 30 mg Patients Achieved Both Major TIS Response and Minimal or No Steroid Burden at Week 52

Patients Achieving Moderate TIS Response (TIS40) with Oral Steroids ≤2.5 mg/day at Week 52



	Δ	P
30 mg vs. Placebo	**25.7%**	**0.0006**
15 mg vs. Placebo	13.0%	0.0851

Patients Achieving Major TIS Response (TIS60) with Oral Steroids ≤2.5 mg/day at Week 52



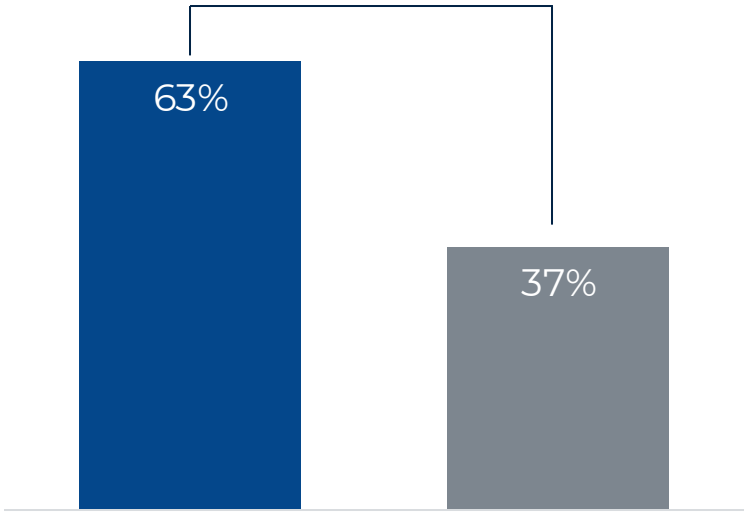
	Δ	P
30 mg vs. Placebo	**27.1%**	**<0.0001***
15 mg vs. Placebo	12.0%	0.0289*

*Nominal p-value
Adjusted response rate (risk) differences calculated using the Mantel-Haenszel method.

Brepocitinib 30 mg Achieved Meaningful Cutaneous Improvement in Subjects with Moderate-to-Severe Skin Disease at Baseline

Highly morbid, often treatment-resistant population representing significant share of DM patients

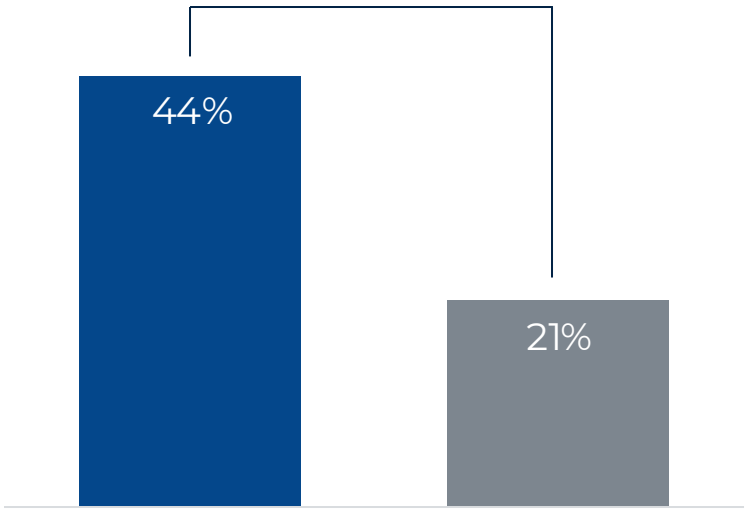
30 mg vs. Placebo: **Δ 25.7%; P=0.0016***



Mean Percent Reduction in CDASI-A by Week 52

Subjects with baseline CDASI-A > 14

30 mg vs. Placebo: **Δ 26.6%; P=0.0060***



Patients Achieving Cutaneous Clinical Remission by Week 52 (CDASI-A ≤ 5)

Subjects with baseline CDASI-A > 14

Ns for subjects with moderate-to-severe skin disease at baseline: brepocitinib 30 mg n = 46; placebo n = 53
*Nominal p-value calculated as part of post-hoc analysis

CDASI-A: Cutaneous Dermatomyositis Activity and Severity Index - Activity Subscore

Brepocitinib 30 mg Demonstrated Substantial Evidence of Improvement on Muscle Disease Across Multiple Endpoints

Global Myositis Benefit

Substantial Improvement on TIS in Patients with Moderate-to-Severe Muscle Disease at Baseline

+17 points

vs. Placebo in patients with MMT-8 < 136 at baseline[1]

72% on brepocitinib 30 mg achieved TIS40 in this subgroup, versus 46% on placebo

Motor Strength

Confirmed Benefit on MMT-8 with Brepocitinib 30 mg vs. Placebo

13.5 vs. 8.7

Δ 4.8, P=0.04[2]

72% on brepocitinib 30 mg achieved 7-point increase[3], compared to 54% on placebo

Functional Muscle Improvement

HAQ-Disability Index Achieved Clinical and Statistical Significance

-.30 points

vs. Placebo, P = 0.0035

49% on brepocitinib 30 mg achieved the MCID of at least -0.3, compared to 29% on placebo

1. Based on a post-hoc analysis
2. Nominal P value
3. 7-point change on the MMT-8 score represents 1 category of muscle disease activity (i.e., moderate vs. mild disease).

MCID: Minimum clinically important difference

Brepocitinib 30 mg Achieved Statistically Significant Benefit on All Ten Ranked Endpoints

Measurements of skin disease, muscle disease, rapidity of onset, and steroid sparing; consistent dose response was also seen across endpoints

Key Endpoint	Important Features	Brepocitinib 30mg (n=81)	Placebo (n=79)	P-Value
Mean TIS (Primary)	Composite endpoint, focus on **muscle disease** and **global** benefit	46.5	31.2	**0.0006**
CDASI-A change from baseline at Week 52	Improvement in **skin disease** activity	-11.7	-7.0	**0.0006**
DMOMS at Week 52	DM-specific **muscle and skin** composite measure of benefit	57.9	40.5	**0.0014**
TIS40 Response at Week 52	Moderate TIS response (focus on **global benefit / muscle**)	67.9%	44.3%	**0.0040**
Time to Consecutive TIS40 Response by Week 52	**Time to onset of sustained benefit** (particularly high bar)	85 days	168 days	**0.0155**
Patients achieving TIS40 Response + ≤2.5 mg OCS at Week 52	Achievement of clinical response and **steroid reduction**	54.3%	26.6%	**0.0006**
CDASI-A 40% Response with ≥4-point improvement at Week 52	Clinically meaningful **skin response**	61.7%	44.3%	**0.0357**
TIS60 Response at Week 52	Major TIS response – **Highest TIS response threshold**	46.1%	26.4%	**0.0126**
Change from baseline in HAQ-DI at Week 52	Improvement in physical and functional disability and daily living activities related to **muscle** strength	-0.337	-0.042	**0.0035**
Change from baseline in CDASI-A at Week 4	**Rapid onset** of skin response	-6.4	-3.5	**0.0003**

Overview of Safety Events

	Brepocitinib 30 mg QD (N=81)	Brepocitinib 15 mg QD (N=81)	Placebo (N=79)
Participants with:			
AEs	73 (90%)	70 (86%)	72 (91%)
Death	0	0	0
SAEs	13 (16%)	7 (9%)	10 (13%)
AEs leading to treatment discontinuation	5 (6%)	6 (7%)	9 (11%)
AEs leading to study discontinuation	3 (4%)	4 (5%)	3 (4%)
Adverse Events of Special Interest:			
Cardiovascular events	1 (1%)	0	2 (3%)
Thromboembolic events	0	0	1 (1%)
Viral reactivation	4 (5%)	2 (2%)	4 (5%)
Opportunistic infections	0	0	0
New or recurrent diagnoses of malignancy	0	0	2 (3%)
Increase in ALT or AST	1 (1%)	2 (2%)	1 (1%)

- Adverse events of special interest balanced across treatment arms; no new safety signals for brepocitinib
- Brepocitinib safety database includes over 1,500 patients and subjects, with a safety profile that appears consistent with approved JAK and TYK2 inhibitors

Abbreviations: AE=adverse event, ALT=alanine aminotransferase, AST=aspartate aminotransferase, SAE=serious adverse event.
Note: Percentages are based on the number of unique participants with an event out of the column total. Treatment-emergent AEs are reported.

VALOR Results Confirm Brepocitinib's Potential to Meaningfully Improve the Lives of Patients with DM

	Breadth of Response	Depth of Response	Speed of Response	Safety
Observed Results in VALOR	✓ Statistically and clinically significant improvement in skin disease ✓ Statistically and clinically significant improvement in muscle disease	✓ High TIS response rates even while aggressively tapering steroids ✓ Functional remission of skin disease achieved in nearly half of subjects with moderate-to-severe disease at baseline	✓ Confirmed benefit on TIS and CDASI as early as week 4 ✓ Median Time to TIS40 of 8 weeks	✓ Safety database of >1,500 patients ✓ Adverse events of special interest balanced across treatment arms; no new safety signals for brepocitinib
Implication for Patients	**Nearly all DM patients can potentially benefit from brepocitinib**	Significant fraction of patients can potentially achieve **deep, clinically meaningful responses**	Patients can potentially achieve **rapid improvement in symptoms** in as few as 4 weeks	Potentially **favorable benefit:risk** profile for patients

Results achieved with a convenient once-daily oral therapy

TIS: Total Improvement Score
CDASI-A: Cutaneous Dermatomyositis Activity and Severity Index - Activity Subscore

Non-Infectious Uveitis

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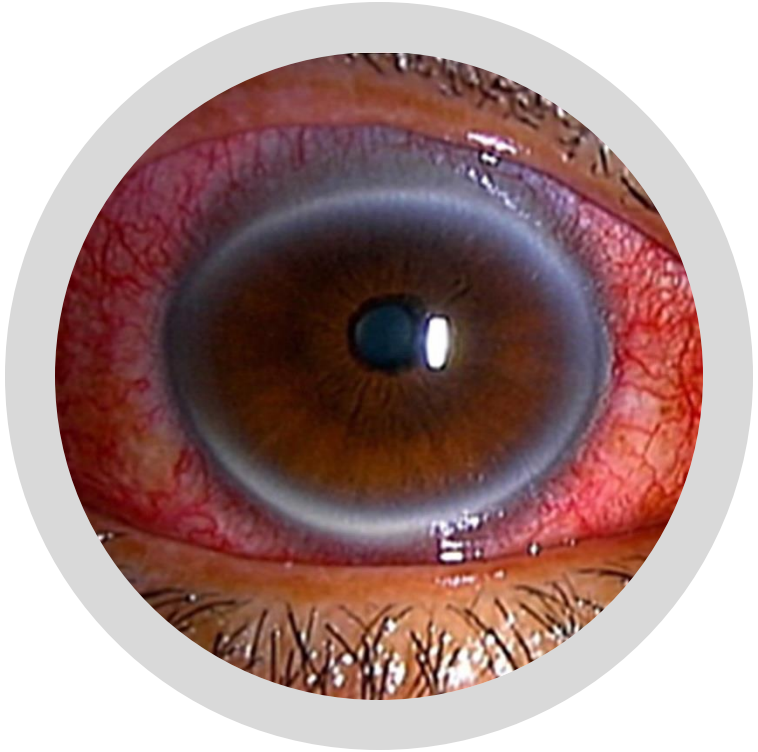
Non-Infectious Uveitis: Key Features in Common with Recent Orphan I&I Launches that Rapidly Achieved Blockbuster Revenue



High tens-of-thousands prevalence

Approximately 70,000-100,000 prevalent patients in the US, with >40,000 patients receiving biologic therapy[1]

High morbidity and few treatment options

Fourth-leading cause of blindness among working-age population in developed world[2]

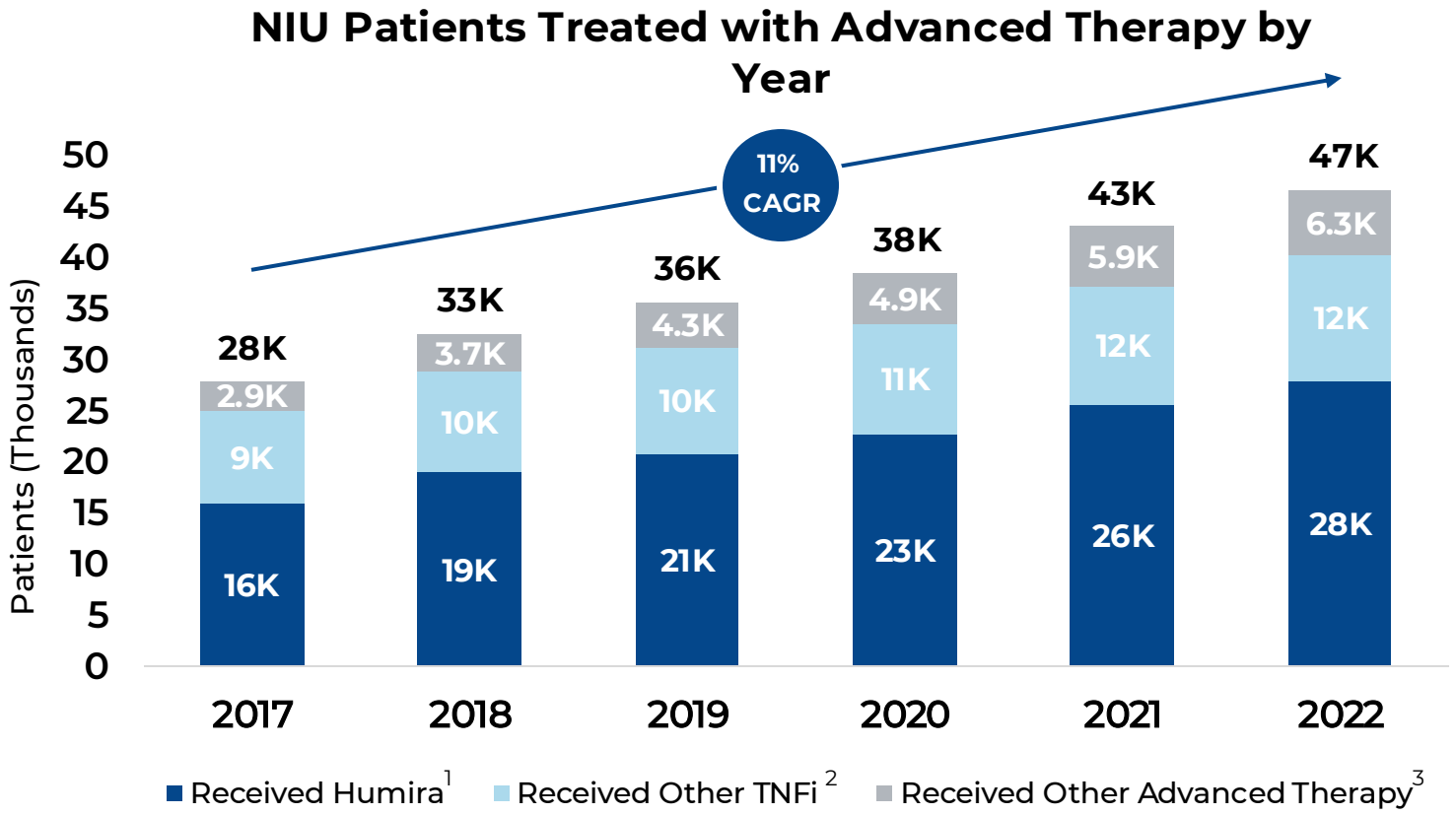
Only approved modern therapy (Humira) has limited efficacy, with >50% ultimately experiencing treatment failure[3]

Orphan price point and concentrated prescriber base

High concentration of patients treated at dedicated uveitis specialty centers; most of remainder treated by retina specialists

1) Thorne et al, JAMA Ophthalmol. (2016) and IQVIA analysis of pharmacy claims of patients with NIU
2) Barisani-Asenbauer, T., Maca, S.M., Mejdoubi, L. et al. Orphanet J Rare Dis 7, 57 (2012)
3) Jaffe et al, NEJM (2016)
4) Photo sourced from Masuda et al, Am J Ophthalmol Case Rep (2018)

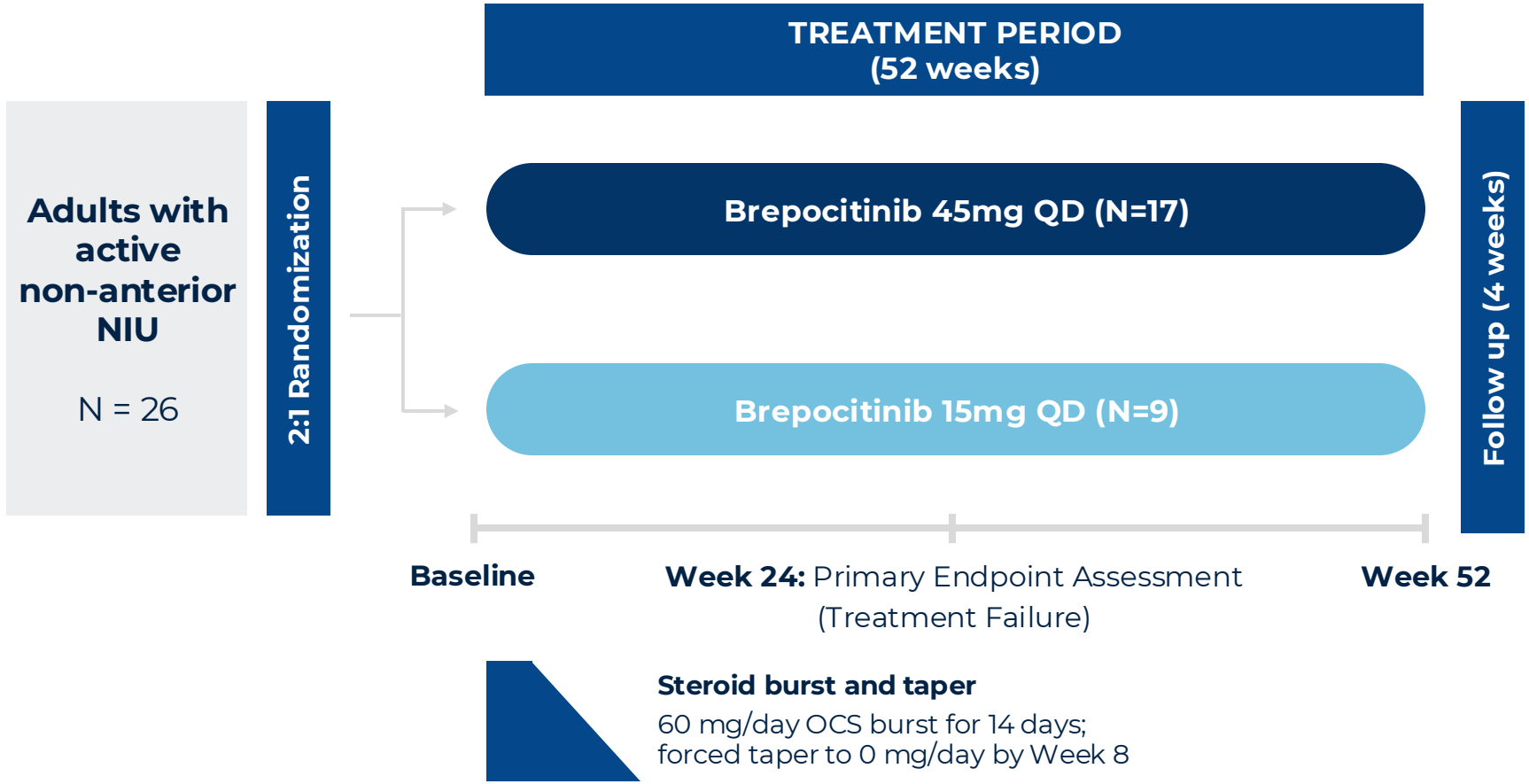
IQVIA Analysis of the NIU Market Confirms >40,000 Patients Receiving TNFi for NIU, with >10% CAGR for Advanced Therapies



- Widespread use of advanced systemic medication for NIU treatment
- Large commercial opportunity in TNF-refractory population alone, given high TNFi failure rate (>50% in clinical studies)
- Additional potential blockbuster opportunity in broader non-anterior NIU population

1) Analysis includes patients with at least 2 NIU Dx claims at least 30 days in or before 2022 (patients had to have continuous pharmacy and medical benefit enrollment in 2021 - 2023) and medication utilization within one year of index NIU diagnosis in 2022. Includes NIU of any etiology or anatomic area.
2) Includes any patient who received Humira during calendar year, whether or not they received any additional advanced therapy (including other TNFi)
3) Includes any patient who did not receive Humira during calendar year, but did receive a different TNFi. Includes originator molecules (e.g., Remicade, Enbrel) and biosimilars (e.g., Inflectra, Renflexis, Avsola) targeting TNF-α
4) Other advanced therapies used include JAK inhibitors and biologic agents/monoclonal antibodies targeting IL-6, IL-12/23, IL-17, IL-1β, IL-1Ra, CD-20, and CD-28
5) The statements, findings, conclusions, views, and opinions contained and expressed on this page are based in part on data obtained under license from IQVIA PharMetrics Plus, January 2018 – December 2023, Iqvia, Inc. All Rights Reserved. The statements, findings, conclusions, views, and opinions contained and expressed herein are not those of IQVIA Inc. or any of its affiliated or subsidiary entities.

Design Of Phase 2 NEPTUNE Study of Brepocitinib in Non-Infectious Uveitis

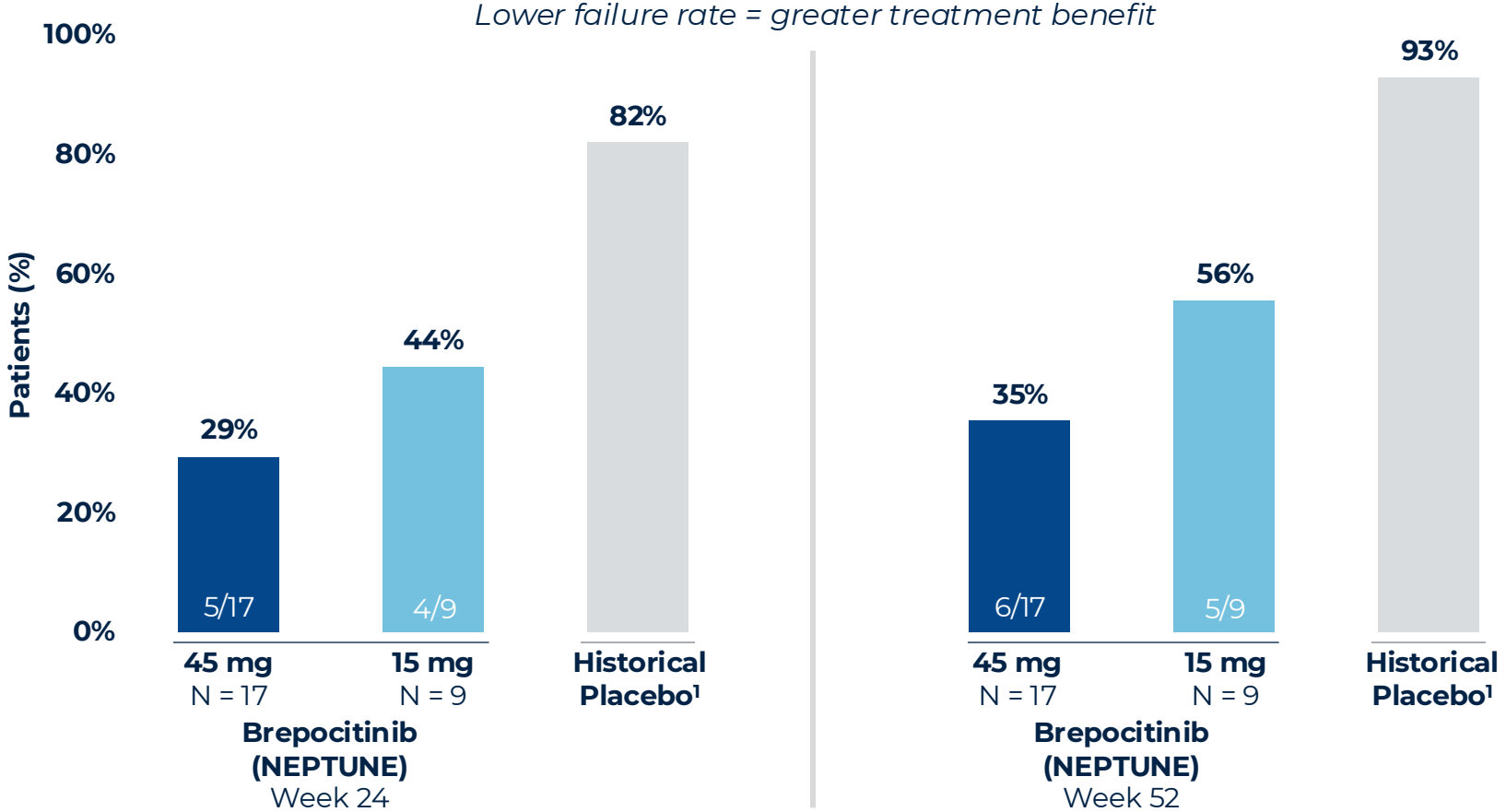


ACC: anterior chamber cell; BCVA: best-corrected visual acuity; IST: immunosuppressive therapy; VH: vitreous haze

52-Week Data from the Phase 2 NEPTUNE Study of Brepocitinib in NIU Showed Potential Best-in-Indication Efficacy Sustained to One Year

Treatment Failure at Week 24 and 52, compared to historical placebo*

Lower failure rate = greater treatment benefit



Reminder:

Better Treatment Failure results for brepocitinib in NEPTUNE achieved despite 6-week steroid taper in NEPTUNE compared to 13-week taper in precedent studies, in both cases following two-week steroid burst

- Requires that brepocitinib act more quickly
- Increases difficulty of maintaining best state achieved
- Reduces steroid burden

Disclaimer: Figure reflects cross-trial comparison and not results from a head-to-head study. Differences exist between trial designs and subject characteristics, and caution should be exercised when comparing data across studies.

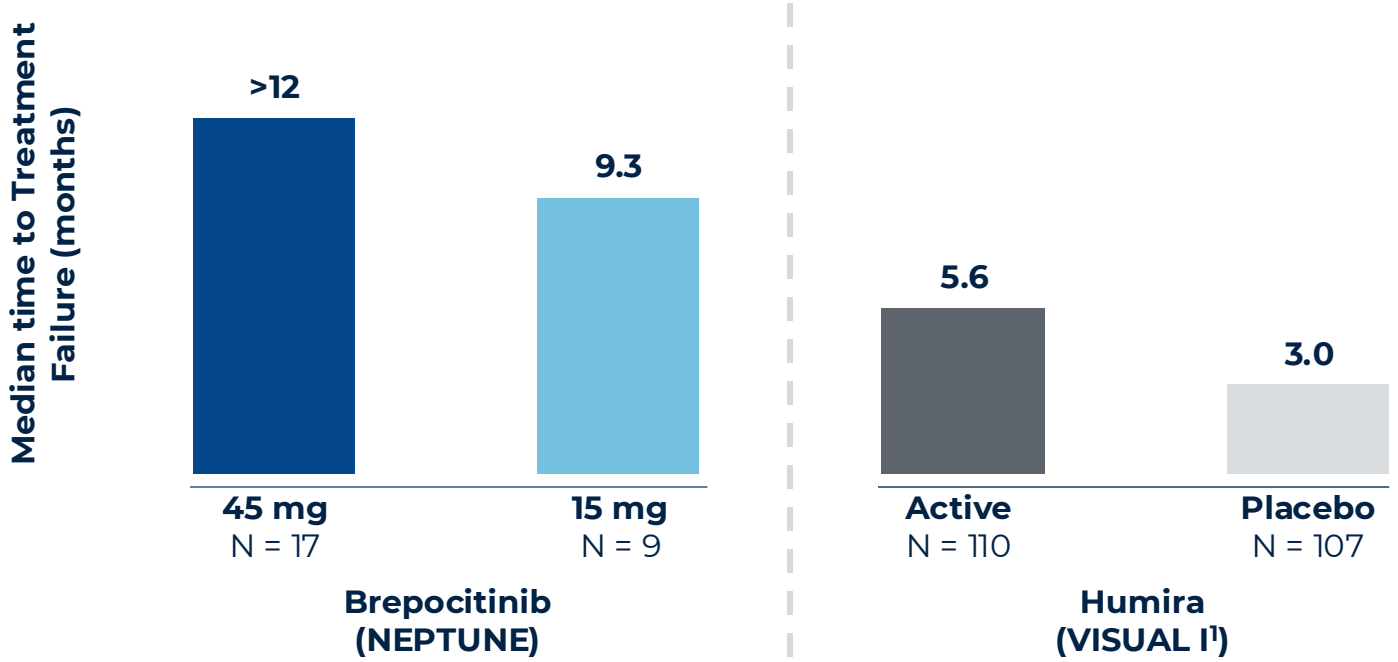
*Treatment Failure calculations include all discontinuations as failures, per pre-specified endpoint definition in NEPTUNE study

1) Historical placebo data from Humira VISUAL 1 study - Jaffe et al, NEJM, 2016. Placebo failure rate was calculated by subtracting the reported No. of patients remaining over the total initial placebo population from 1 at weeks 25 and 55 (N=107)

Brepocitinib Potential Best-in-Indication Efficacy Profile Also Seen on Median Time-to-Treatment Failure

Time To Treatment Failure, compared to VISUAL I Study*

Higher time-to-treatment failure = greater treatment benefit



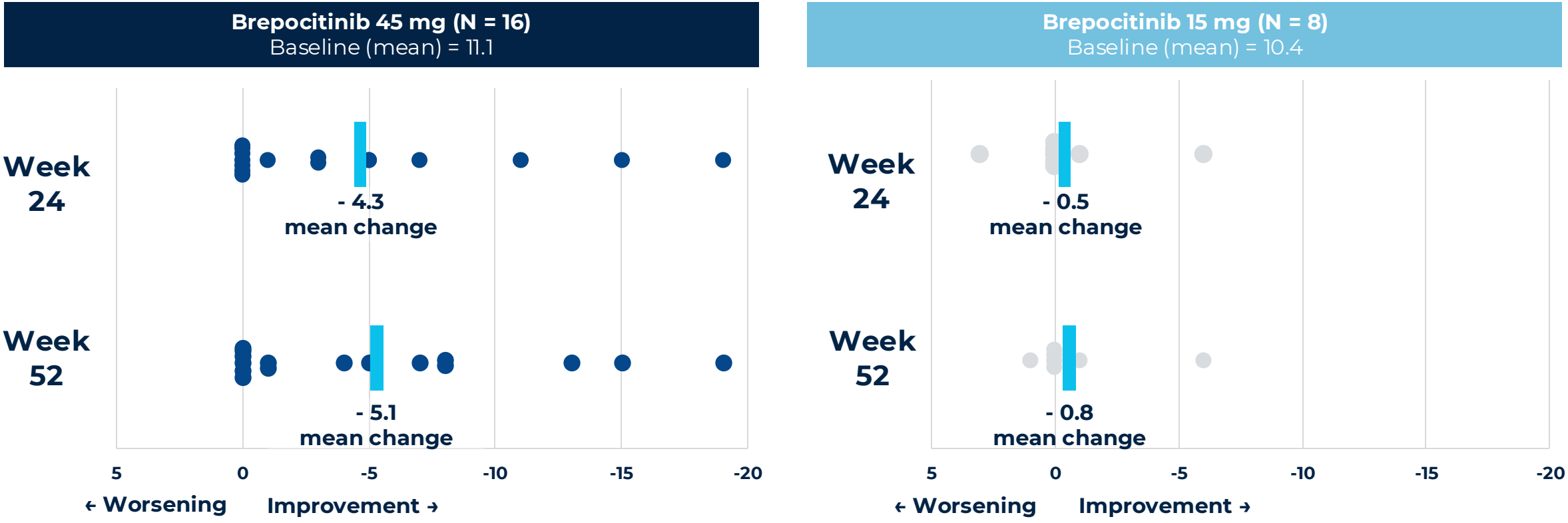
Disclaimer: Figures reflect cross-trial comparison and not results from a head-to-head study. Differences exist between trial designs and subject characteristics, and caution should be exercised when comparing data across studies.

*Time-To-Treatment Failure was primary endpoint in VISUAL I study. VISUAL I calculations do not include discontinuations as treatment failures, per pre-specified definition in VISUAL I. NEPTUNE calculations include discontinuations as treatment failures.

1) As reported at https://www.humirapro.com/uveitis

Dose Dependent Benefit on Posterior Segment Inflammation Seen, with Sustained Improvement at 52 Weeks

Measurement of retinal vascular leakage by wide-field fluorescein angiography (FA) score change from baseline at Week 24 and Week 52; centrally assessed using ASUWOG, a multi-domain, semi-quantitative scoring system[1]



No patients on brepocitinib 45 mg worsened from baseline

Last observation carried forward used for participants with treatment failure or intercurrent event.

1) Tugal-Tutkun et al., Int Ophthalmol (2010)

Potential Brepocitinib Benefit on Prevention and Treatment of Macular Edema Also Sustained to 52 Weeks

45 mg at Baseline	45 mg at Week 24	45 mg at Week 52
10 patients did *not* have macular edema (CST < 300 µm[1])	**0 patients** *developed* macular edema **(0% occurrence rate)**	**0 patients** *developed* macular edema **(0% occurrence rate)**
7 patients had macular edema (CST ≥ 300 µm)	**3 of 7 patients** had *resolution* of macular edema **(43% resolution rate)**	**3 of 7 patients** had *resolution* of macular edema **(43% resolution rate)**

By comparison:

In the Humira VISUAL I study, among patients who did not have macular edema at baseline, **50% of placebo patients developed macular edema after 6.2 months**[1]

- 50% of Humira patients developed macular edema after 11.1 months[2]

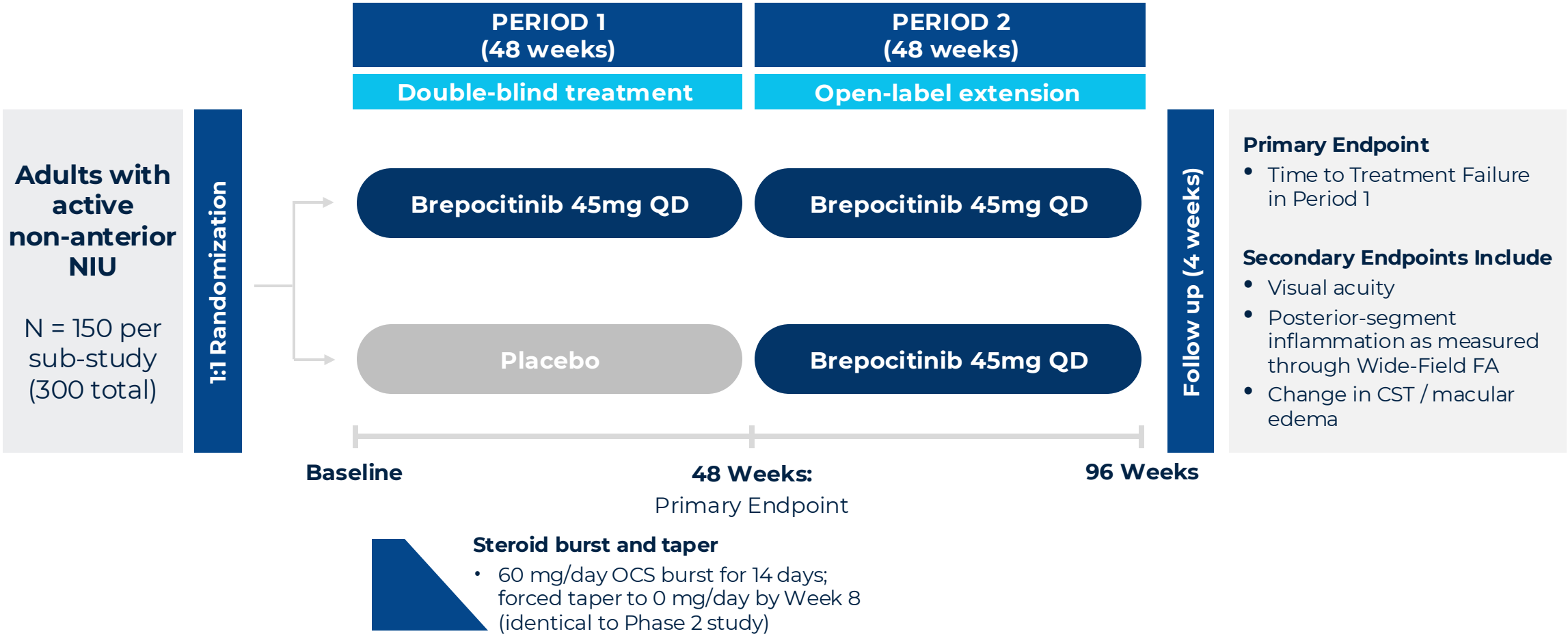
In a different study of patients with uveitic macular edema at baseline, **Humira resolution rates at Month 6 were 22%**[3]

Disclaimer: Figures reflect cross-trial comparison and not results from a head-to-head study. Differences exist between trial designs and subject characteristics, and caution should be exercised when comparing data across studies.

CST: central subfield thickness
1) Definition of macular edema in NEPTUNE was CST ≥ 300 µm, normalized by central reader across instrument types
2) Jaffe et al, NEJM 2016
3) Leclerq et al, Ophthalmology 2021

CLARITY: A Phase 3 Study of Brepocitinib in Adults with Active, Non-Infectious, Non-Anterior Uveitis

Two identical sub-studies, CLARITY-1 and CLARITY-2, actively enrolling under a single protocol; topline results expected in 1H 2027



Cutaneous Sarcoidosis

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Cutaneous Sarcoidosis: Next Proof-of-Concept Indication for Brepocitinib

Mid tens-of-thousands prevalence

30,000-50,000 affected US cutaneous sarcoidosis patients[1] with no approved therapies; uncontrolled disease can result in severe disfigurement[2]

Proof-of-concept data from ~20 JAK-treated patients

Dual TYK2/JAK1 inhibition well-suited to Th1 immunophenotype of sarcoidosis; case reports and investigator-initiated trial with JAKi agents have shown clinically meaningful responses

Alignment with DM and NIU

Orphan price point; concentrated prescriber base overlapping with DM

1) Grunewald et al, Nat Rev Dis Primers 2019
2) Culver, Curr Clin Med 2010
Image adapted from Patel et al, 2011

Yale IIT Provides Proof-of-Concept for JAK Inhibition in Cutaneous Sarcoidosis

Open label study of tofacitinib in 10 patients with longstanding cutaneous sarcoidosis[1]

Cutaneous Sarcoidosis Activity and Morphology Instrument (CSAMI) is an established, reproducible endpoint to assess sarcoidosis skin disease symptoms[2]

Baseline Characteristics

10 Patients with cutaneous sarcoidosis

37 Mean CSAMI score at baseline, indicating severe disease

Tofacitinib 5 mg BID for 6 months

Results

10 (100%) Patients achieved clinically meaningful reduction in CSAMI from baseline (>5 point improvement)[3]

6 (60%) Patients achieved complete resolution of disease (CSAMI = 0)

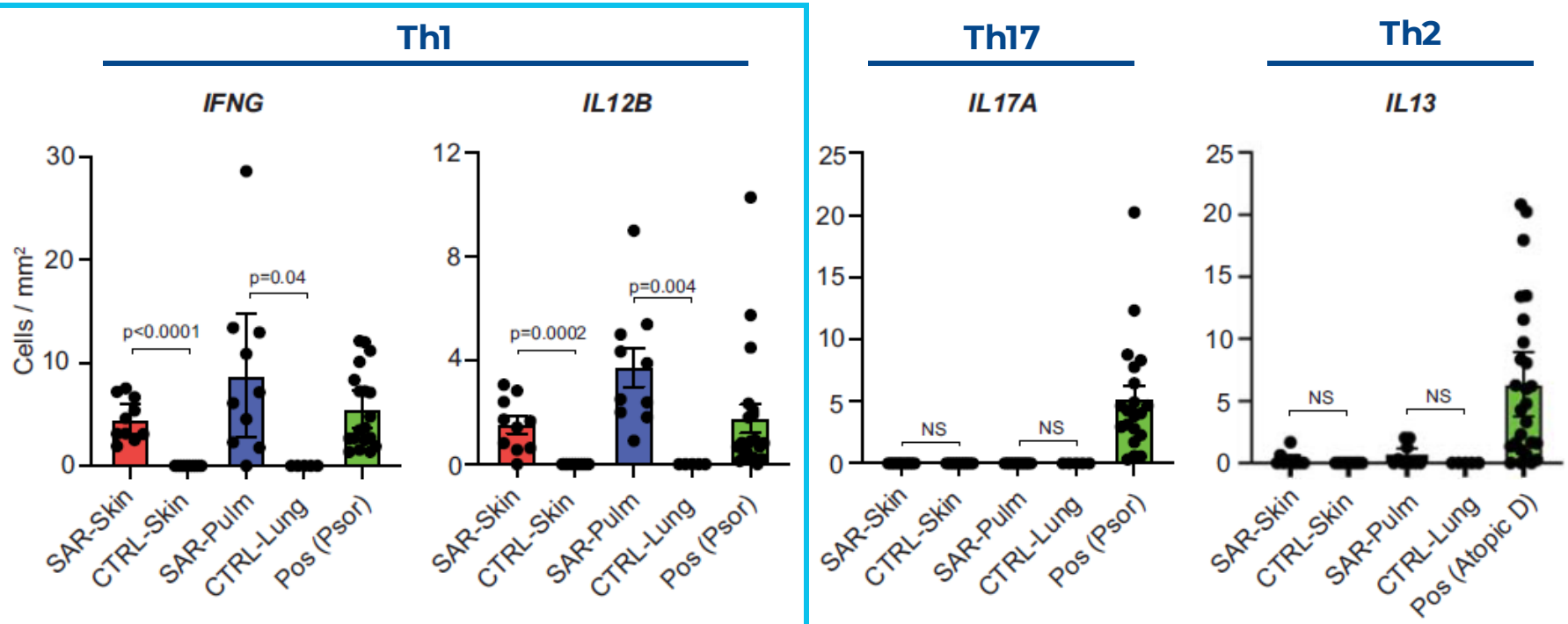
Results supported by multiple case reports indicating complete or near-complete resolution of longstanding, recalcitrant disease in JAK-treated patients[4,5,6,7,8,9]

1) Damsky et al, Nat Comm 2022
2) Noe et al, JAMA Dermtol 2019
3) MCID = 5 point reduction from baseline
4) Damsky et al, N Engl J Med. (2018)
5) Damsky et al, J Am Acad Dermatol. (2020)
6) Damsky et al, ACR Open Rheumatol. (2020)
7) Kerkemeyer et al, J Am Acad Dermatol. (2021)
8) Rotenberg et al, Eur Respir J. (2018)
9) Wei et al, JAAD Case Rep. (2019)

Pronounced Th1-type Immunity Is the Predominant Polarization in Sarcoidosis Skin and Lung Tissue

Marked upregulation of key Th1 cytokines, including Type II IFN and IL-12, suggests potential best-in-indication selectivity profile for brepocitinib's dual inhibition of TYK2 and JAK1

Quantitation of RNA In-Situ Hybridization for Key Immunoregulatory Cytokines



JAK Signaling Pairs:

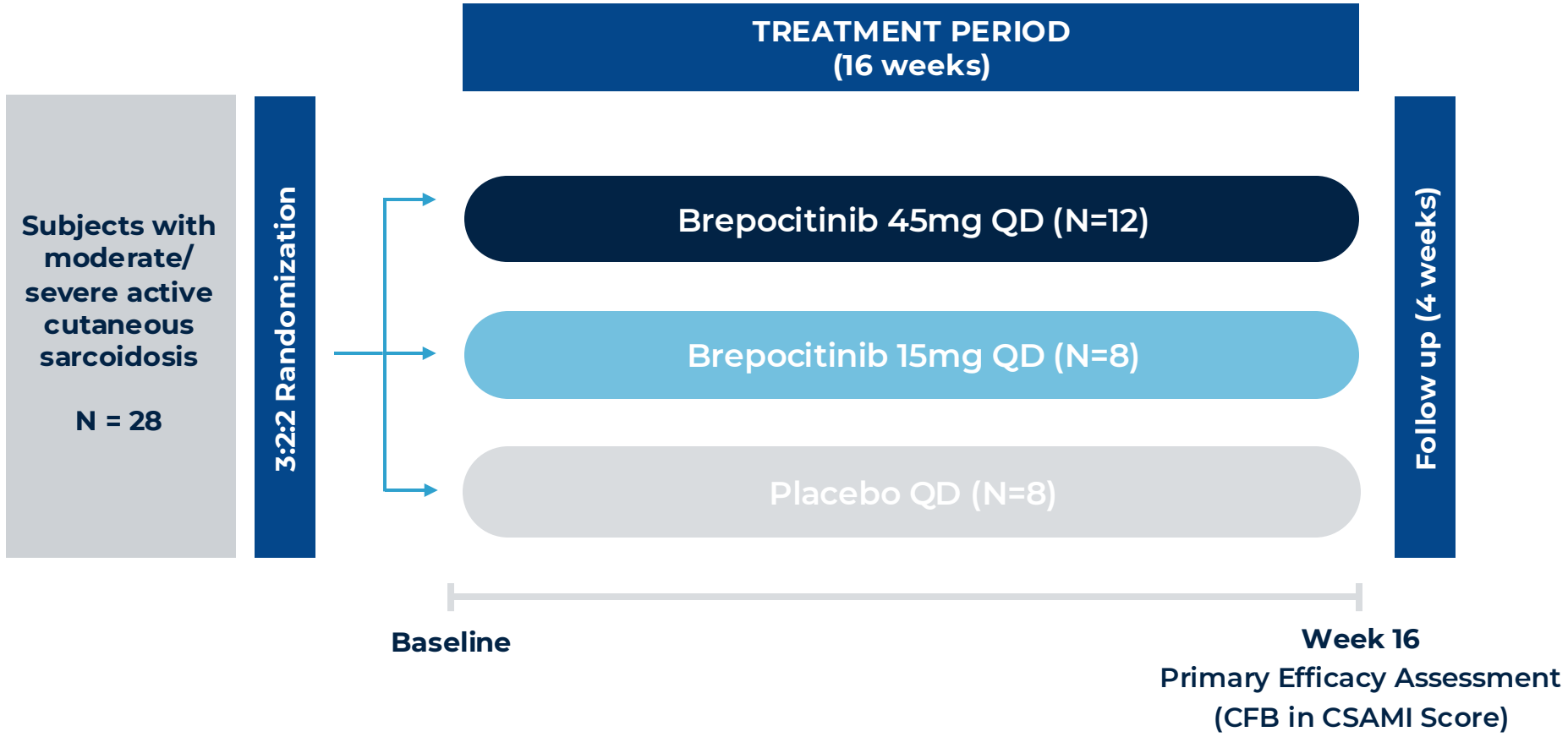
JAK1/JAK2

JAK2/**TYK2**

Adapted from Damsky et al, Nat Comm 2022. RNA in situ hybridization quantitation in control skin (n = 10), control lung (n = 5), cutaneous sarcoidosis (n = 10), and pulmonary sarcoidosis (n = 10). Data presented as means ± 95% CI.

BEACON: A Phase 2 Study of the Safety and Efficacy of Brepocitinib in Adults with Cutaneous Sarcoidosis

Study actively enrolling; topline results expected in 2H 2026



CFB: Change from baseline
CSAMI: Cutaneous sarcoidosis activity and morphology instrument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Total Improvement Score (TIS): A Validated Assessment Tool for Use in Myositis Clinical Studies

The TIS reflects improvement from baseline in 6 core set measures (CSMs), including 3 global measures that capture disease activity across organ systems, 2 muscle-specific measures, and a commonly used measure for ADLs

Global Activity Measures

Physician Global Activity	Assessed by investigator on a Visual Analog Scale (VAS) **20 points**
Patient Global Activity	Reported by patient on a Visual Analog Scale (VAS) **10 points**
Extramuscular Global Activity	All non-muscle organs (e.g., skin, lungs) assessed by investigator on a Visual Analog Scale (VAS) **20 points**

Muscle Disease Activity

Manual Muscle Testing	Assessment of muscle/muscle group strength against examiner's resistance **32.5 points**
Muscle Enzymes	Most abnormal serum muscle enzyme (includes creatinine kinase, aldolase, ALT, AST, and LDH) **7.5 points**

Activities of Daily Living

Heath Assessment Questionnaire	Questionnaire completed by the patient **10 points**