
Roche

Roche Pharma Day 2025

London, 22 September 2025

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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;
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6 increased government pricing pressures;
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Welcome

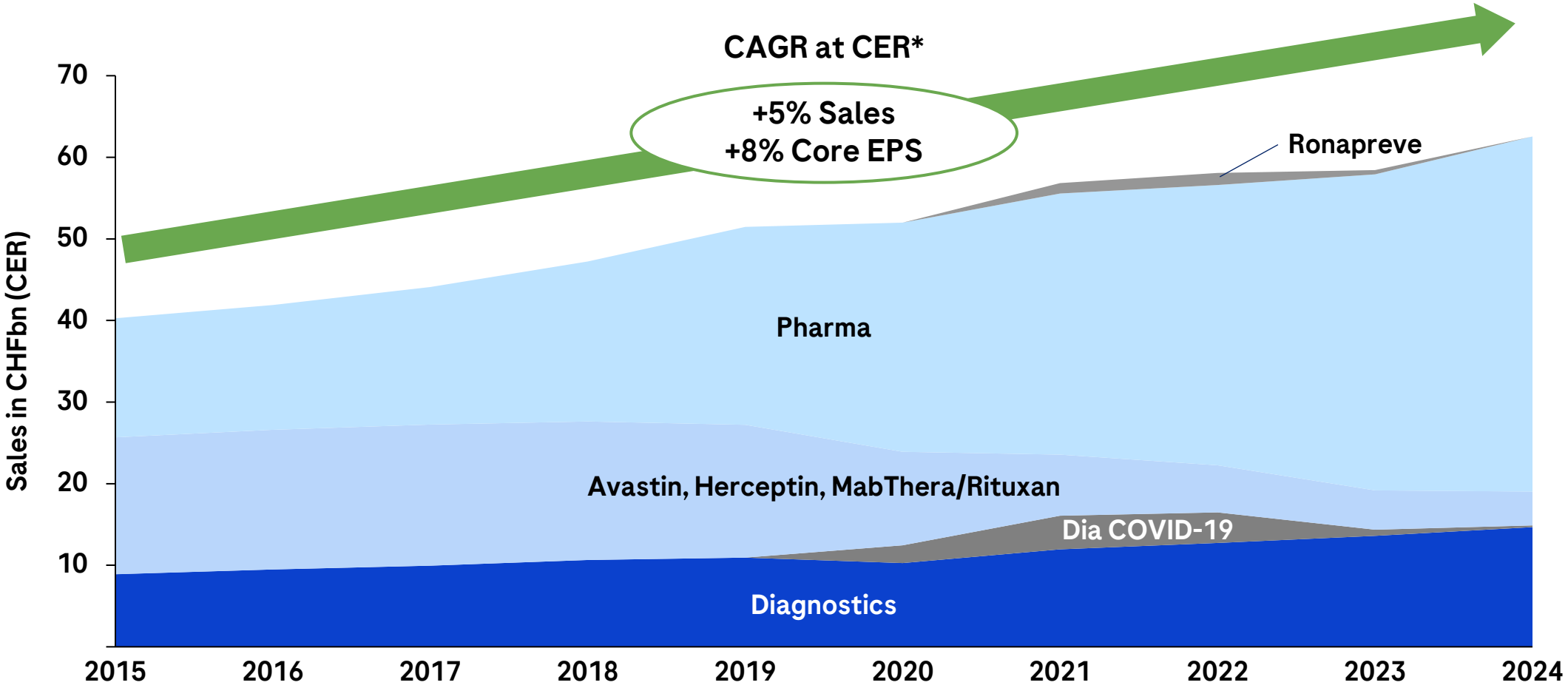
Bruno Eschli
Head of Investor Relations

Agenda: Pharma Day 2025

	Introduction	
	09:30 BST	Bruno Eschli, Head of Investor Relations
Strategy	**Pharma Strategy and Commercial Growth Drivers**	
		Teresa Graham, CEO Roche Pharmaceuticals
	R&D Excellence	
		Levi Garraway, CMO and Global Head of Product Development
	11:00-11:30	**Q&A – Strategy**
	11:30-12:20	**Lunch Break**
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
	14:00-14:30	**Q&A - Pipeline**
	14:30-15:00	**Buffet reception**

Roche delivered consistent growth throughout the last decade

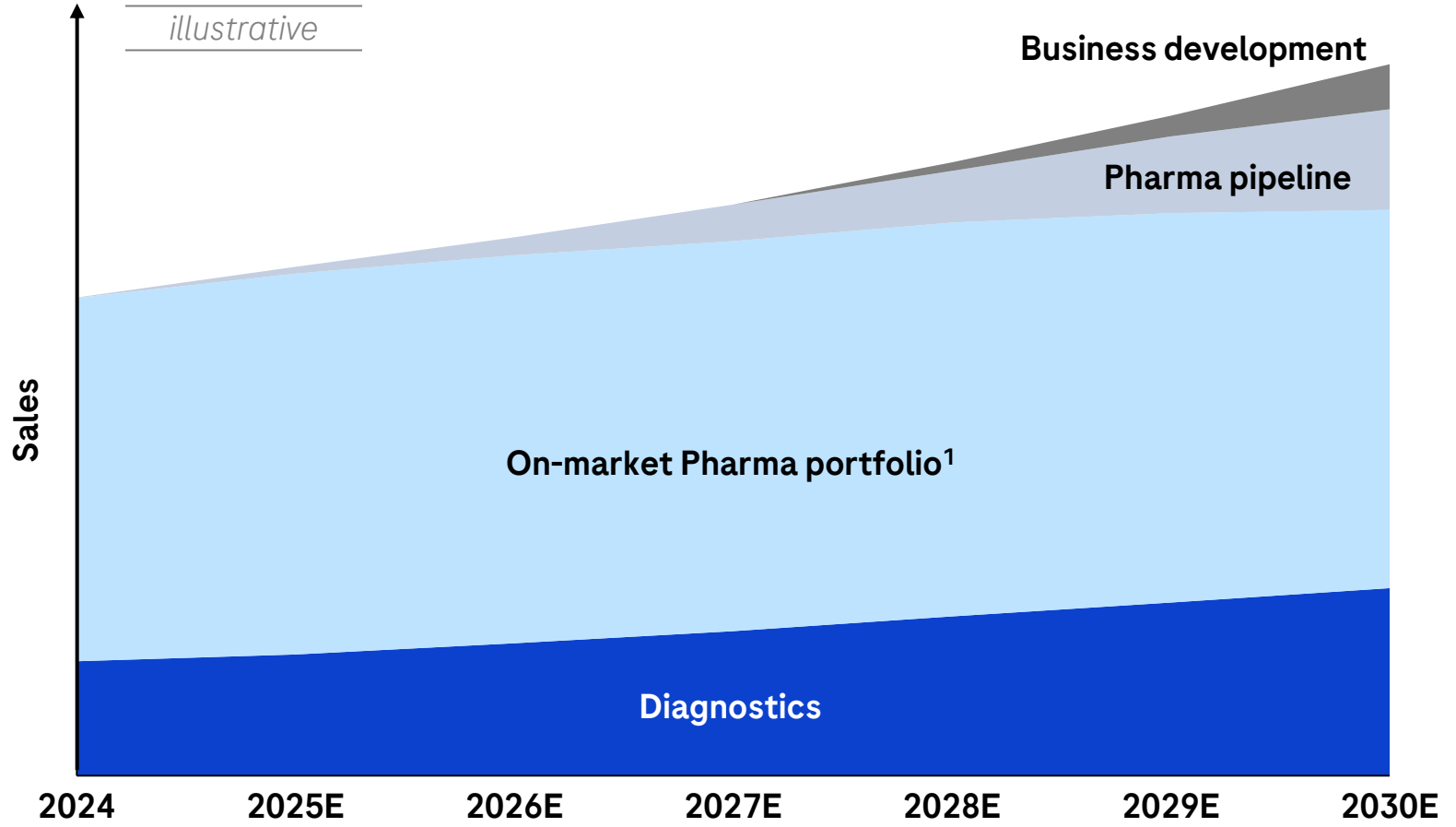
Increased diversification with 17 blockbusters in Pharma



*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



- BD to accelerate pipeline rejuvenation
- In-house pipeline with upside potential
- Today's on-market Pharma portfolio to deliver growth until 2028, thereafter stable, fully compensating for generic erosion
- No patent cliff ahead
- Diagnostics growth driven by on-market portfolio and key launches
- Unique blockbuster opportunities with mass spec, CGM and SBX sequencing
- Mid- to high-single digit sales growth
- COP growth ahead of sales growth

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 medicines[1] addressing diseases with the highest societal burden[2]

Value

+40%

in avg. pipeline peak sales

Innovation

80%

of pipeline has best-in-disease potential

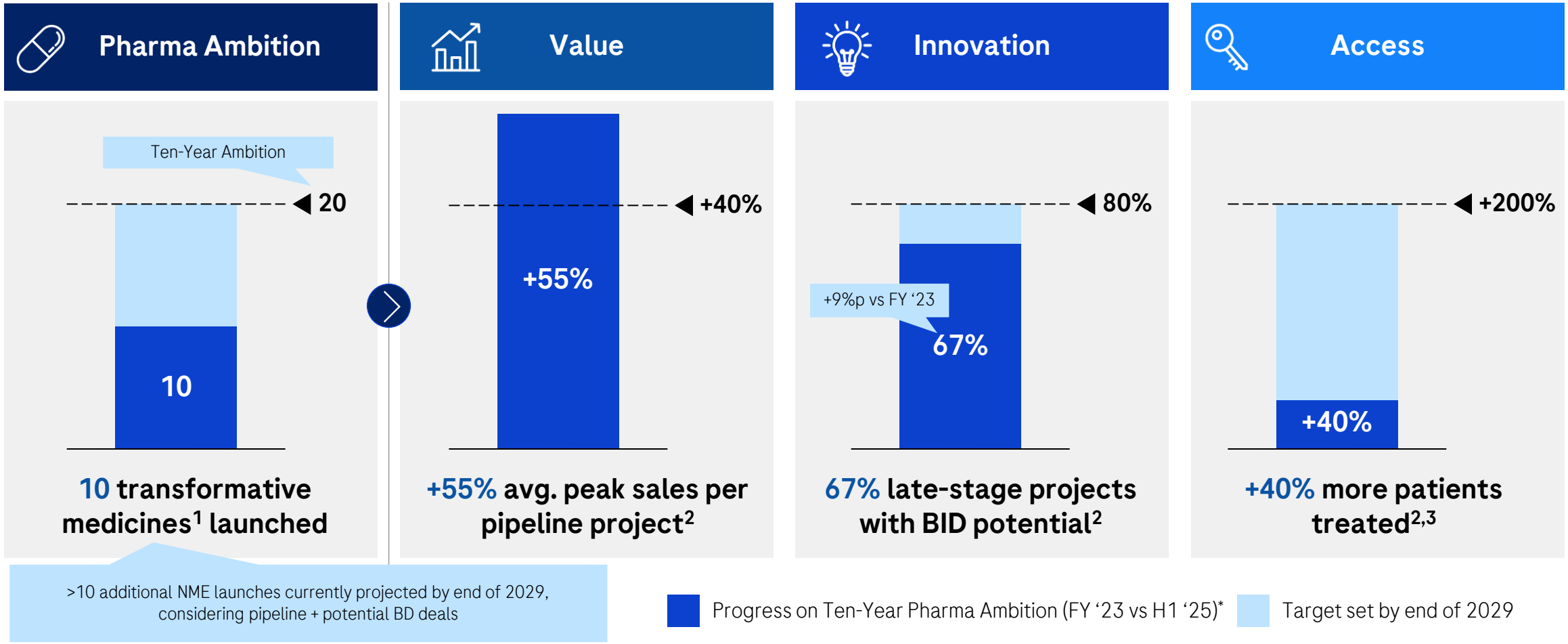
Access

3x

more patients treated[3]

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

Financials[1]

+10% HY 25 sales growth

+13% HY 25 COP growth

+1.7%p HY 25 COP margin growth

R&D Excellence

+26% total portfolio value[2]

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

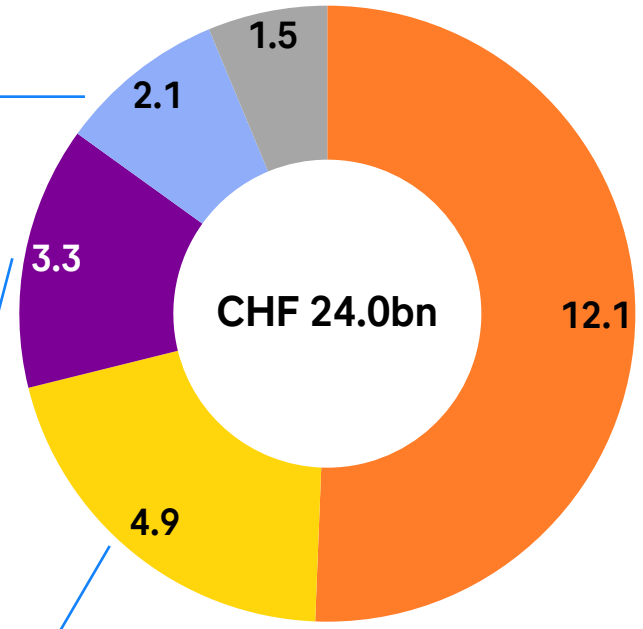
Obesity strategy defined and supported by BD

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

HY 2025 Pharma sales (CHFbn, YoY CER growth)



VABYSMO

- Establishing a leading position in Ophtha with Vabysmo emerging as new SoC in retinal diseases
- Industry leading pipeline with respect to novel targets, MoAs and devices

Xolair Omalizumab · GAZYVA*

- Xolair: Strong uptake in food allergy, no biosimilars expected before end of 2026
- Gazyva in LN with PDUFA date set for Oct
- FIC afimkibart in development for IBD

OCREVUS ocrelizumab · Evrysdi risdiplam

- Ocrevus global SoC in MS with SC launch ongoing; broad pipeline including fenebrutinib
- Evrysdi leading in SMA with emugrobart combination in development
- Potential to expand into AD and PD with trontinemab and prasinezumab

PHESGO pertuzumab/trastuzumab/hyaluronidase-zzxf · itovebi inavolisib · ALECENSA alectinib · PERJETA pertuzumab · Kadcyla ado-trastuzumab emtansine · TECENTRIQ atezolizumab

- Well established HER2+ BC franchise to peak in 2026 with strong tail, expansion potential into HR+ BC with giredestrant as next gen backbone
- Stable lung cancer franchise with divarasib in late-stage development

POLIVY polatuzumab vedotin · COLUMVI glofitamab-gxbm · Lunsumio mosunetuzumab · HEMLIBRA

- Established portfolio in NHL with potential to further improve the SoC with Polivy and CD20xCD3 bispecifics combinations
- Leadership in HemA with Hemlibra; next gen bispecific NXT007 in late-stage development

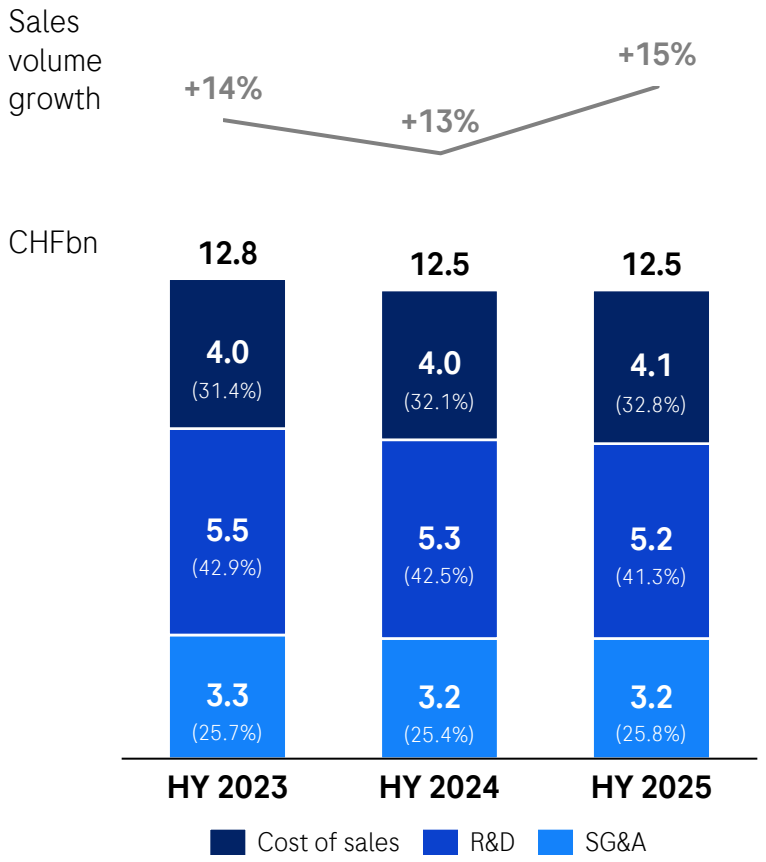
- Emerging obesity portfolio with GLP-1/GIP-1 and long-acting amylin to be developed as monotherapies and differentiated combinations
- Emugrobart and pegozafermin** with potential for future incretin combination development

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

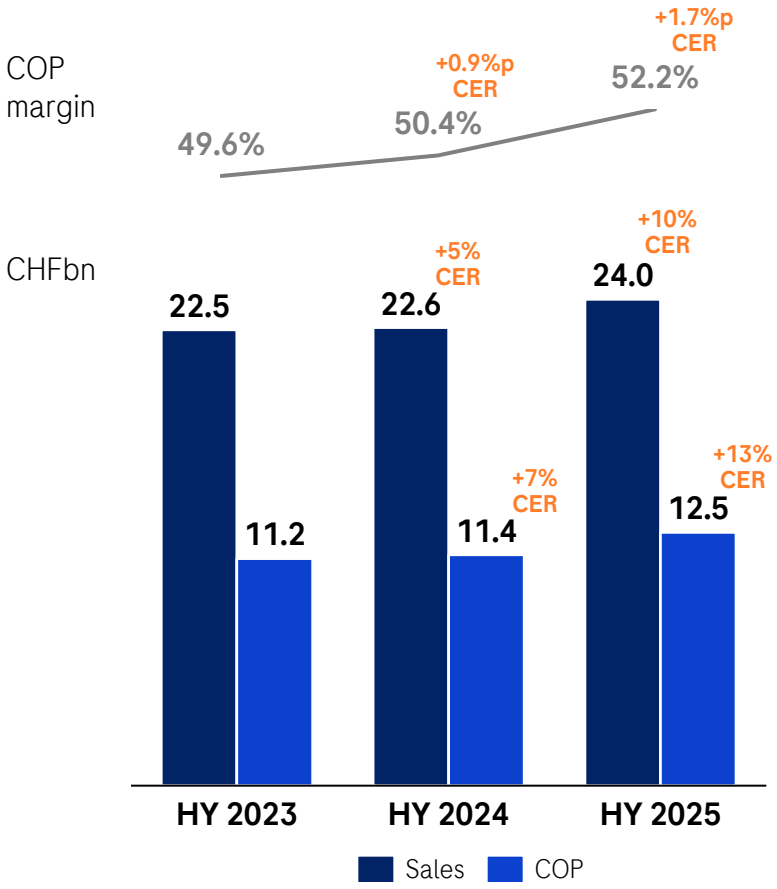
Operational excellence in Pharma since 2023

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

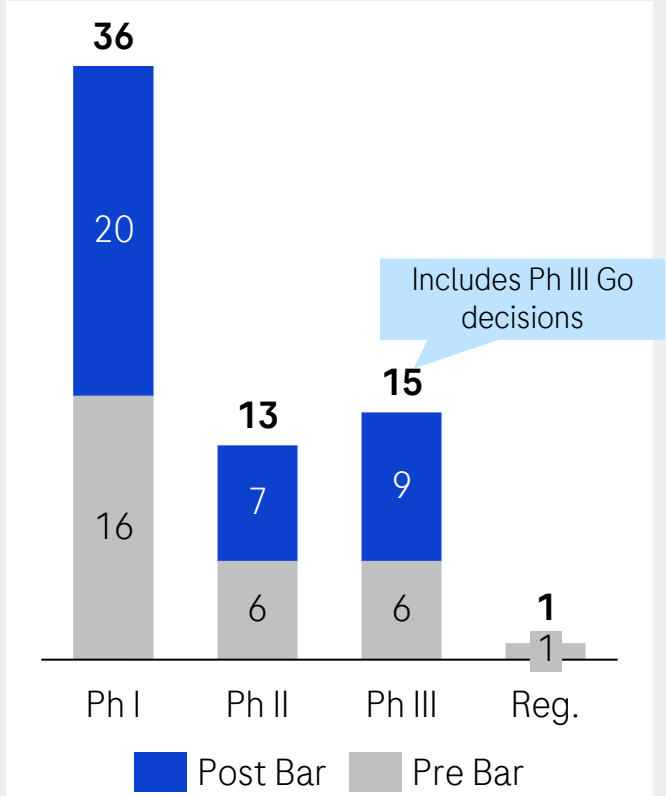
“Post Bar” assets moved into Ph III development

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

ANTLERA	赞荣医药 Zion Pharma	Regor Therapeutics	POSEIDA THERAPEUTICS	Telavant	Alnylam PHARMACEUTICALS	CARMOT THERAPEUTICS	ZEALAND PHARMA	89bio*
Ophthalmology	**Onc/Heme**	**Onc/Heme**	**Onc, Immuno & Neuro**	**Immunology**	**CVRM**	**CVRM**	**CVRM**	**CVRM**
Wnt agonist in retinopathies	**HER2 TKI** in breast cancer	**CDKi portfolio** in breast cancer	**Allogeneic CAR-Ts** in oncology, immunology & neurology	**Anti-TL1A** in inflammatory bowel disease	**siRNA targeting AGT** in hypertension	**Dual GLP-1/GIP RA** in obesity +/- diabetes	**Long-acting amylin analog** in obesity	**FGF21 analog** in MASH
Pre-clinical	**Ph I**	**Ph I**	**Ph I**	**Ph III**	**Ph III**	**Ph III**	**Ph II**	**Ph III**

Current development stage

* 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

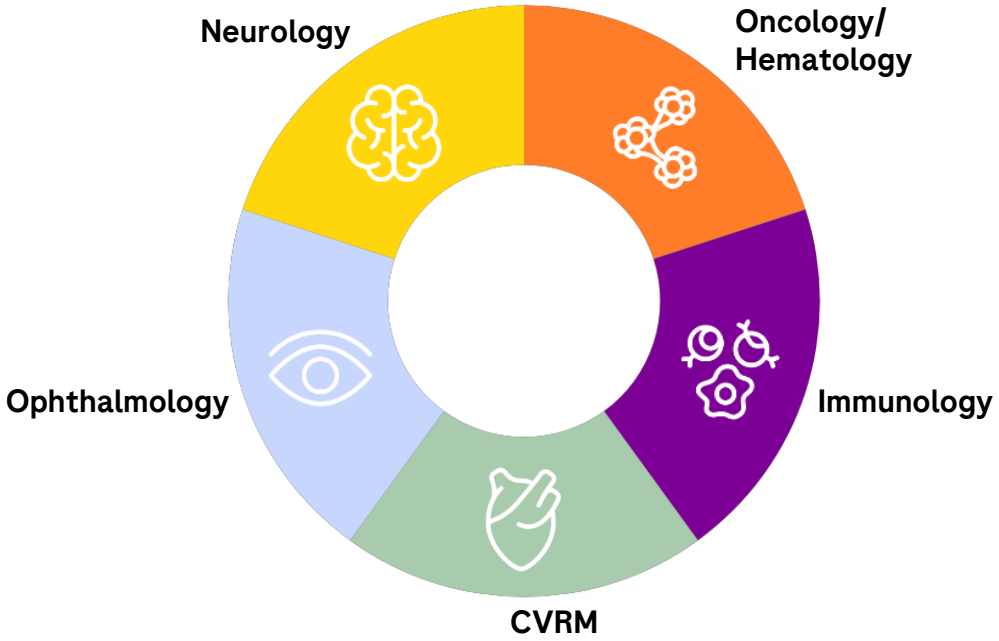
Obesity strategy

Future growth opportunities

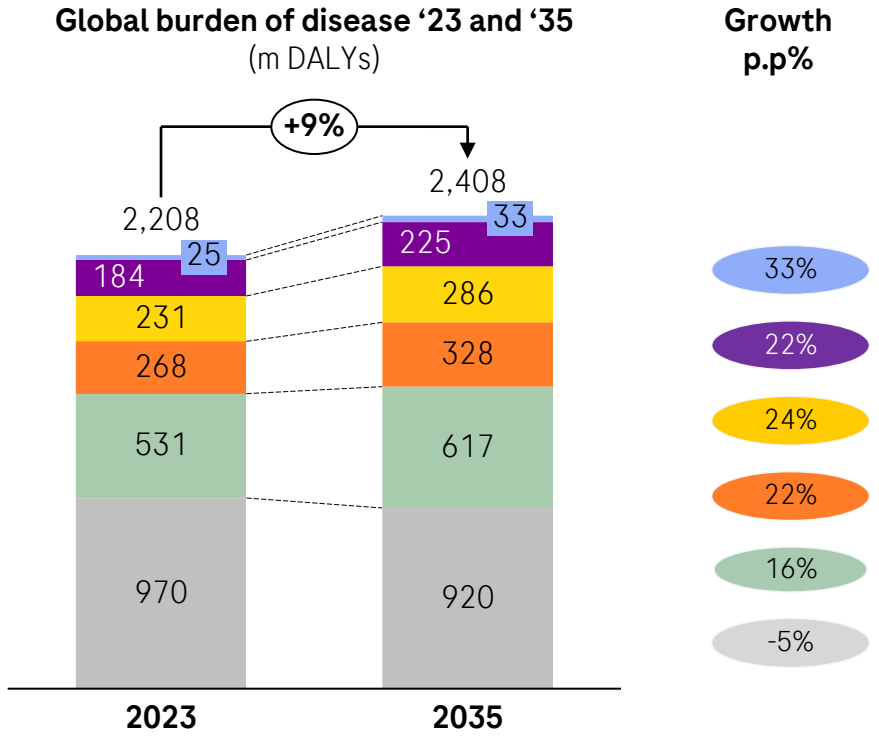
Our Pharma Strategy introduced in 2024

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

CVRM: Cardiovascular, renal and metabolism; DALY: Disability-adjusted life years; E2E: End-to-end

Oncology strategy highlights

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

OUR AMBITION

1. **Strengthen Oncology franchise through a focused approach**
2. **Build a pipeline of >80% FIC/BID assets in a highly competitive TA**
3. **Achieve a leading position in our E2E disease areas**

Where we play

End-to-end disease areas

Solid tumors:	Breast cancer	Lung cancer
Hematology:	Malignant heme[1]	Hemophilia

How we win

Accelerate innovation...

- Rebuild the mid-stage pipeline
- Accelerate E2E timelines

...in the most effective way

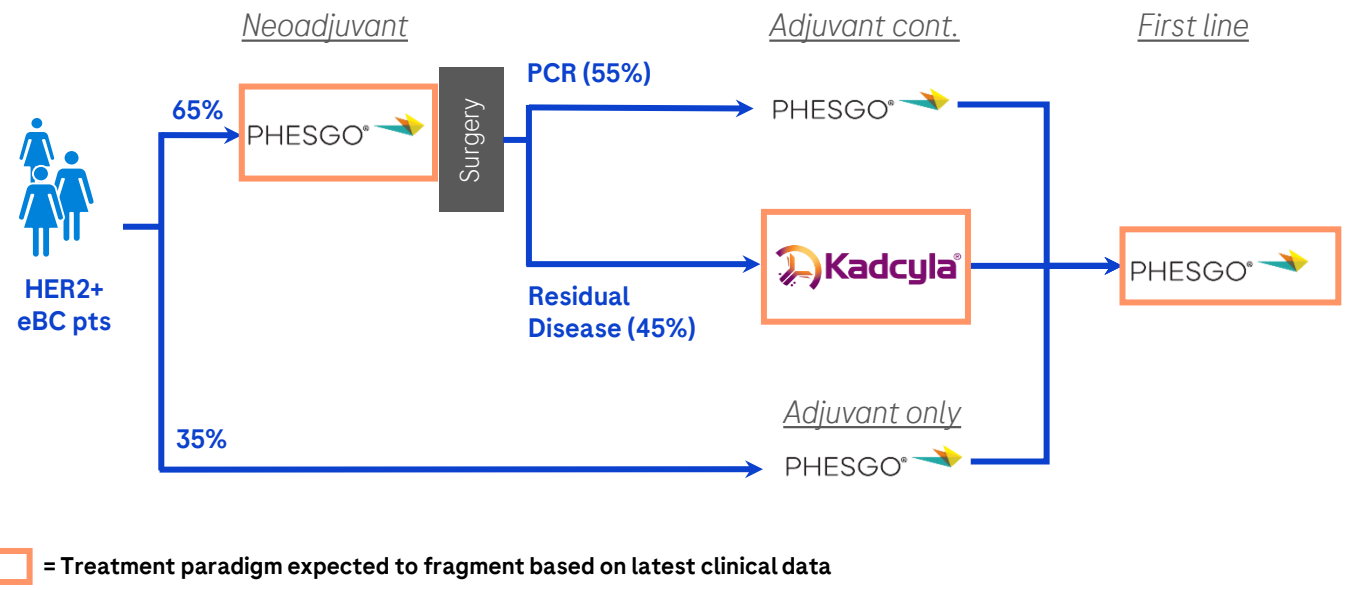
- Adopt newest technologies
- Focus on priority pathways

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

HER2+ BC treatment paradigm to evolve further



- HER2+ franchise is expected to remain standard of care in the majority of early BC settings (e.g. neoadjuvant and adjuvant only)
- Recent studies in 1L indicate there is no "one-size-fits-all"; Phesgo is expected to remain a key treatment option in the maintenance setting
- Phesgo with 46% global conversion rate*

Breast cancer portfolio

PHESGO · Kadcyla · itovebi inavolisib

	Ph I	Ph II	Ph III	
Itovebi			**INAVO121** (post-CDK4/6 *PIK3CA*-mut HR+/HER2- BC)	
Itovebi + Phesgo			**INAVO122** (1L *PIK3CA*-mut HER2+ BC)	
Itovebi			**INAVO123** (1L *PIK3CA*-mut HR+/HER2- mBC (AI sensitive))	
giredestrant + palbociclib			**persevERA** (1L ER+/HER2- mBC (endocrine sensitive))	2026
giredestrant + everolimus			**evERA** (post CDKi ER+/HER2- mBC)	✓
giredestrant + any CDK4/6i			**pionERA** (1L ER+/HER2- mBC (endocrine resistant))	
giredestrant			**lidERA** (adjuvant ER+/HER2- mBC)	
giredestrant + Phesgo			**heredERA** (1L maintenance ER+/HER2+ mBC)	
HER2 TKI			HER2+ BC	
GDC-4198 (CDK4/2i)			HR+ BC	

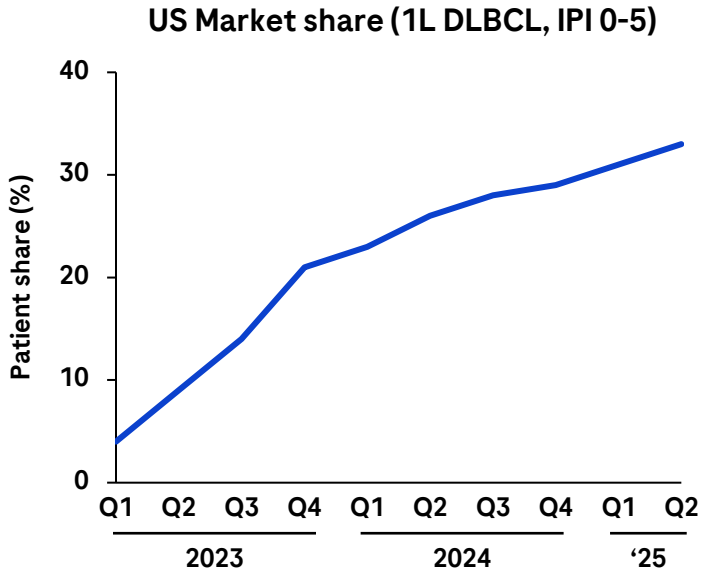
✓ Primary endpoint met

*Perjeta/Phesgo conversion rate calculated using volumes, currently taking 78 launch countries into account; AI: Aromatase inhibitor; CDKi: Cyclin dependent kinase inhibitor; e/mBC: Early/metastatic breast cancer; ER+: Estrogen receptor positive; HER2: Human epidermal growth factor receptor 2; HR+: Hormone receptor positive; PCR: Pathological complete response; PIK3CA-mut: Phosphatidylinositol 3-kinase, catalytic, alpha polypeptide mutated; TKI: Tyrosine kinase inhibitor

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

Differentiated product profiles to meet the diverse needs of patients with NHL

Malignant hematology portfolio

	Ph I	Ph II	Ph III	
Lunsumio SC	3L+ FL			✓
Lunsumio SC + Polivy	**SUNMO** (2L+ DLBCL (SCT-ineligible))			✓
Lunsumio + lenalidomide	**CELESTIMO** (2L+ FL)			2026
Lunsumio SC + lenalidomide	**MorningLYTE** (1L FL)			
Lunsumio + Polivy	1L DLBCL (elderly/unfit)			
Columvi + GemOx	**STARGLO** (2L+ DLBCL (SCT-ineligible))			✓
Columvi + Polivy + R-CHP	**SKYGLO** (1L DLBCL)			
Columvi	**GLOBRYTE** (R/R MCL (post-BTKi))			
P-CD19CD20-ALLO1	R/R B-Cell malignancies			
cevostamab	R/R MM			To start in 2026
P-BCMA-ALLO1	R/R MM			

✓ Filed/primary endpoint met

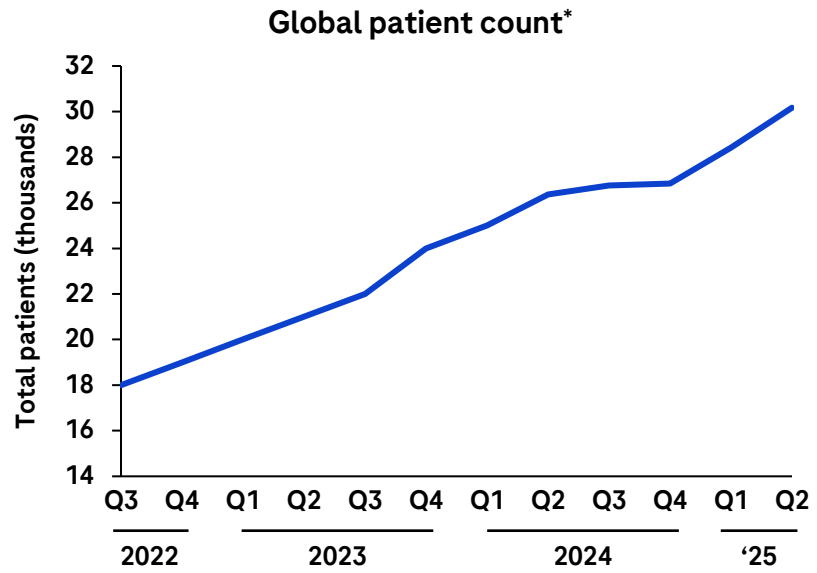
- Polivy establishing a new SoC in 1L DLBCL
- 2L DLBCL: Columvi launched successfully in the EU based on Ph III (STARGLO); Lunsumio to be filed in the US based on positive Ph III (SUNMO)
- Emerging multiple myeloma pipeline with cevostamab and allogeneic CAR-Ts

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

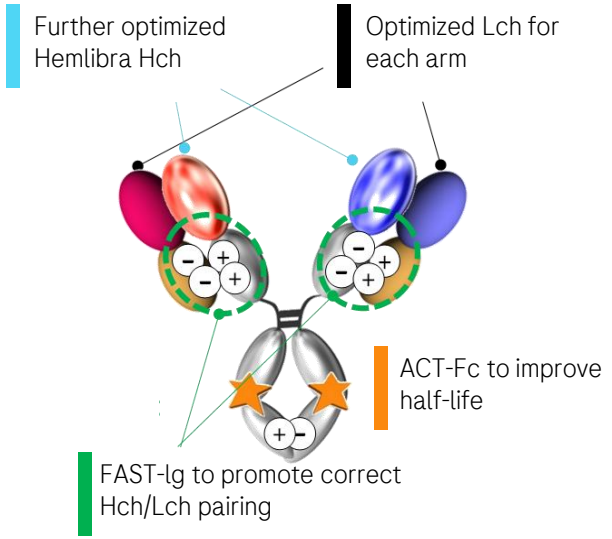
Hemophilia A: Building on Hemlibra success with NXT007

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

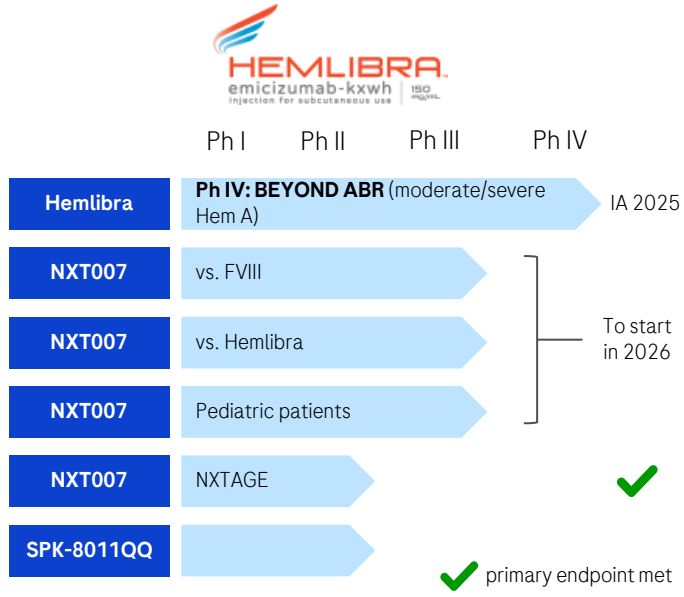
Hemlibra in Hemophilia A



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

OUR AMBITION

1. **Extend #1 position in neurology post 2030**
2. **Broaden portfolio and lead in preventive neurology**
3. **Transform patient journey E2E via integrated Pharma + Dia approach**

Where we play

End-to-end disease areas

- Multiple sclerosis
- Alzheimer's disease

Breakthrough innovation (e.g., PD)

Product leadership (e.g., SMA, DMD)

How we win

Excellence in execution: Commercial, development, scientific

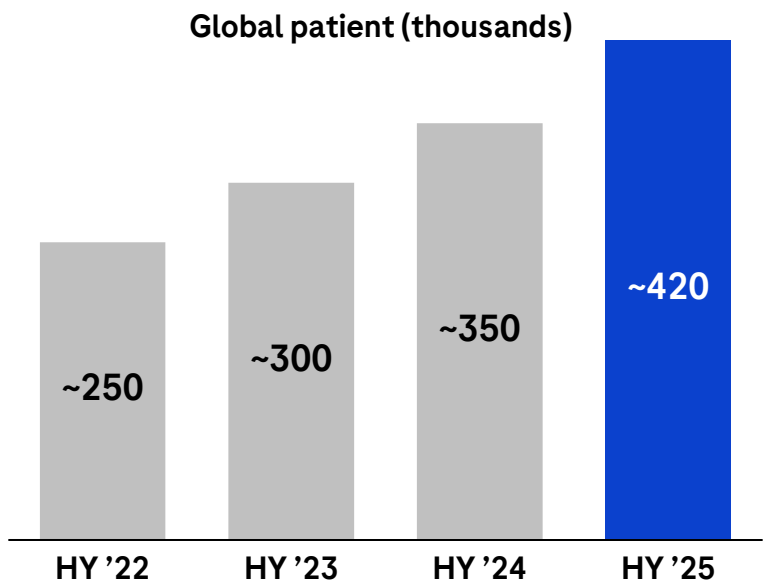
- Commercial innovation to maximize our portfolio
- Dia + Pharma collaboration reshapes clinical practice
- Deliver clinical pipeline to launch new products
- Partnering opportunities
- Prevention approaches

DMD: Duchenne muscular dystrophy; E2E-End-to-end; PD: Parkinson's disease; SMA: Spinal muscular atrophy

Multiple sclerosis: Ocrevus firmly established as global SoC

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

Ocrevus in MS



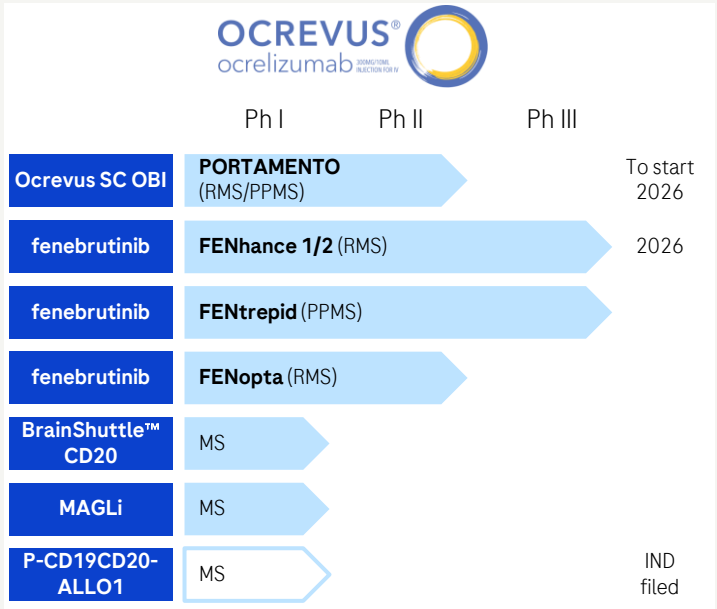
Ocrevus Zunovo (SC)

>12,000 pts on treatment since launch, with ~50% new to brand

Device in development for Q6M at-home dosing via on-body injector (OBI)

- Ocrevus SC represents a CHF 2bn incremental sales opportunity, with peak sales for the entire Ocrevus franchise to reach CHF 9bn by 2029
- High concentration formulation of Ocrevus SC via OBI is in development for an even more convenient delivery; launch anticipated in 2028
- Fenebrutinib with potential to disrupt the oral segment, currently ca. 30% of the global market

Multiple sclerosis portfolio



- Fenebrutinib Ph III readouts in PPMS in H2 2025 and in RMS in early 2026
- Allogeneic CAR-T (P-CD19CD20-ALLO1) filed IND for MS, Ph I to be initiated

CAR-T: Chimeric antigen receptor T- cell; IND: Investigational new drug; MS: Multiple sclerosis; OBI: On-body injector; PPMS: Primary progressive MS; Q6M: Every 6 months; RMS: Relapsing MS; SC: Subcutaneous; Ocrevus Zunovo with Halozyme's rHuPH20/ Halozyme's human hyaluronidase

Immunology strategy highlights

Roche is well positioned to capture future innovation

OUR AMBITION

1. **Maximize the value of our pipeline via multi-indication expansion**
2. **Leverage pan-immuno pathways to create value and synergy across TAs**
3. **Pursue curative therapies for sustained remission**

Where we play

End-to-end disease areas

IBD

COPD

Breakthrough innovation
(e.g., Lupus, AtD)

Pan-immuno pathways
(e.g., TL1A, CD20/CD19, OSMR)

How we win

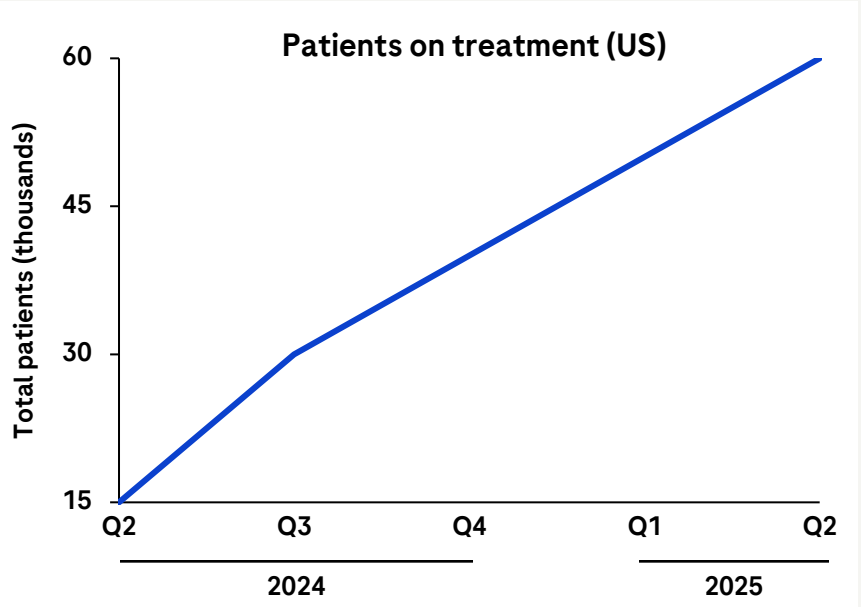
Build on known targets	Develop combinations	Identify subpopulations	Achieve cure	Commercial excellence
Improve known pathways/targets for transformational benefit	Target multiple pathways to achieve improved efficacy & deeper remission	Identify patients' subsets to improve efficacy and guide therapy	Aim for curative treatment to achieve long-term remission	Build key capabilities to deliver commercialization success

AtD: Atopic dermatitis; COPD: Chronic obstructive pulmonary disease; IBD: Inflammatory bowel disease; OSMR: Oncostatin M receptor; TL1A: TNF-like molecule 1A

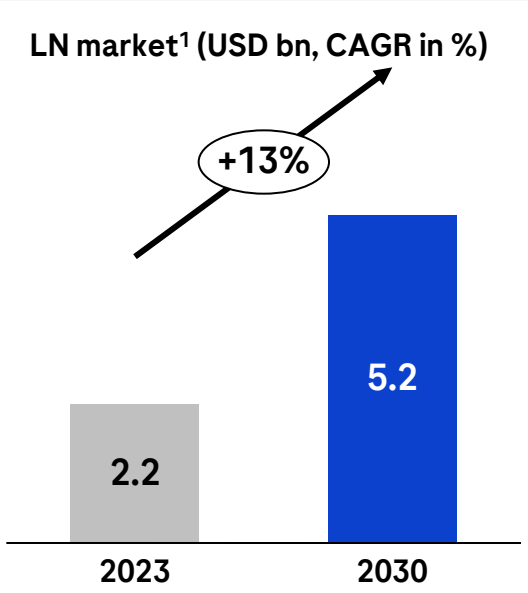
Immunology: Strong Xolair uptake in food allergy, Gazyva filed in LN

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

Xolair in food allergy

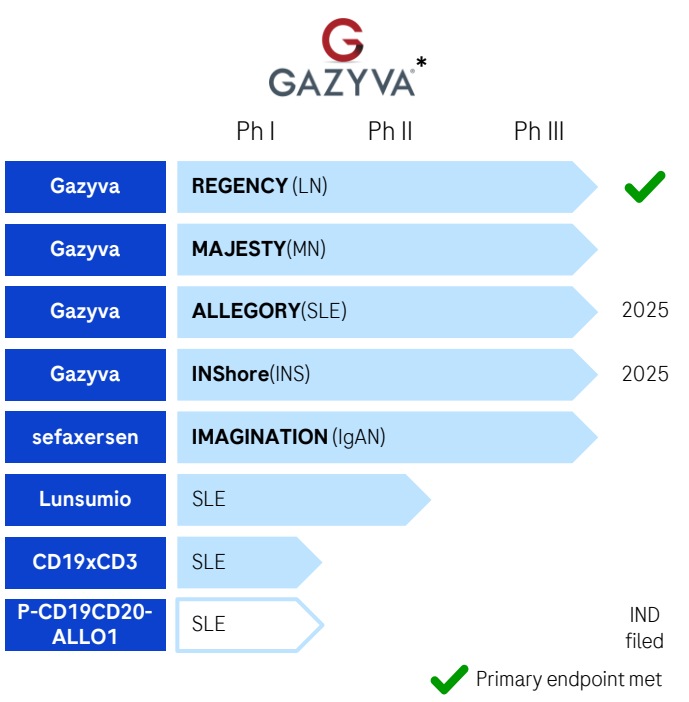


Gazyva in LN



- 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%

Immunology portfolio



- 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

OUR AMBITION

1. **Establish a strong position in Ophthalmology by becoming #1 in retina**
2. **Broadly diversified and differentiated pipeline with transformational potential**
3. **Expand portfolio beyond RVD into Dry eye disease and Glaucoma**

Where we play

End-to-end disease areas

- RVD (nAMD, DME, RVO, DR)
- GA, iAMD

Breakthrough innovation
(e.g., Dry eye disease, Glaucoma)

Product leadership
(e.g., UME, TED)

How we win

- Win commercially: Leverage portfolio opportunities
- Beyond VEGF: Solidify sustained leadership in RVD
- Beyond complement: Lead in in GA / iAMD
- Pioneer innovation and vision restoration
- Lead enabling capabilities: AI & imaging, modalities and devices

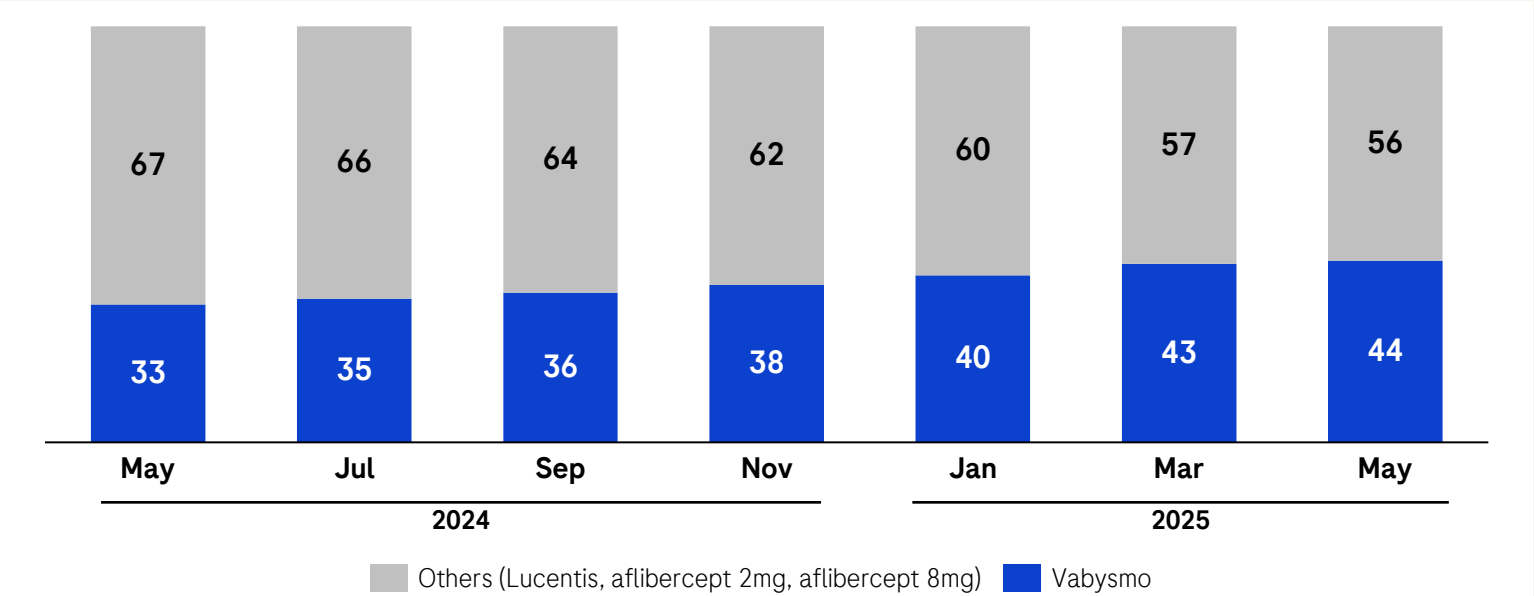
DME: Diabetic macular edema; DR: Diabetic retinopathy; iAMD: Intermediate age-related macular degeneration; GA: Geographic atrophy; nAMD: Neovascular age-related macular degeneration; RVD: Retinal vascular disease; RVO: Retinal vein occlusion; TED: Thyroid eye disease; UME: Uveitic macular edema; VEGF: Vascular endothelial growth factor

Retinal vascular disorders: Vabysmo with strong global growth

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

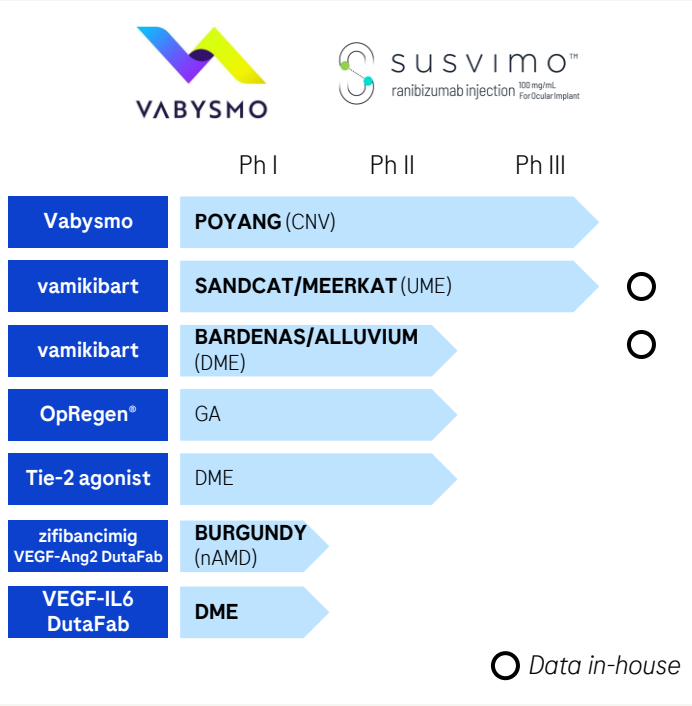
IR Ophtha Update @ ASOPRS/AAO Oct 21st

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

OUR AMBITION

1. **Secure a strong entry before 2030 with competitive products**
2. **Differentiate our offering by unique Roche capabilities**
3. **Become a top 3 player in Obesity**

Where we play

End-to-end disease areas

- Obesity

Breakthrough innovation
(e.g., MASH, uHTN, CVD, CKD, T1D)

How we win

Deliver near term portfolio	Expand and differentiate	Lead next wave of innovation	Transform care delivery
Launch diverse portfolio, building on strong foundation of backbone treatment	Unlock combinations and iterate on validated MoAs	Develop novel MoAs with transformative potential	Leverage Dia synergies, think beyond the molecule and meet patients where they are

CKD: Chronic kidney disease; CVD: Cardiovascular disease; MASH: Metabolic dysfunction-associated steatohepatitis; MoA: Mechanism of action; NME: New molecular entity; T1D; Type-1 diabetes; uHTN: Uncontrolled hypertension

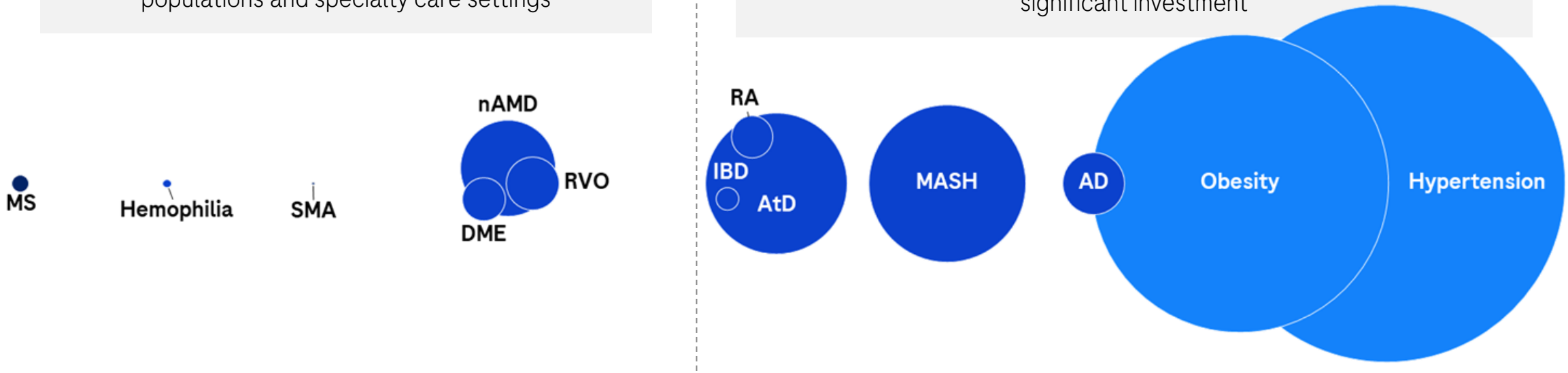
Entry into new disease areas

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



Ocrevus | *Hemlibra* | *Evrysdi* | *Vabysmo* | *afimkibart* | *pegozafermin* afimkibart* | *trontinemab* | *CT-388, CT-996 petrelintide* | *zilebesiran*

Bubble size is illustrative and represents prevalence of disease

Care setting for majority of patients: Hospital, Clinic, Patient-driven

*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

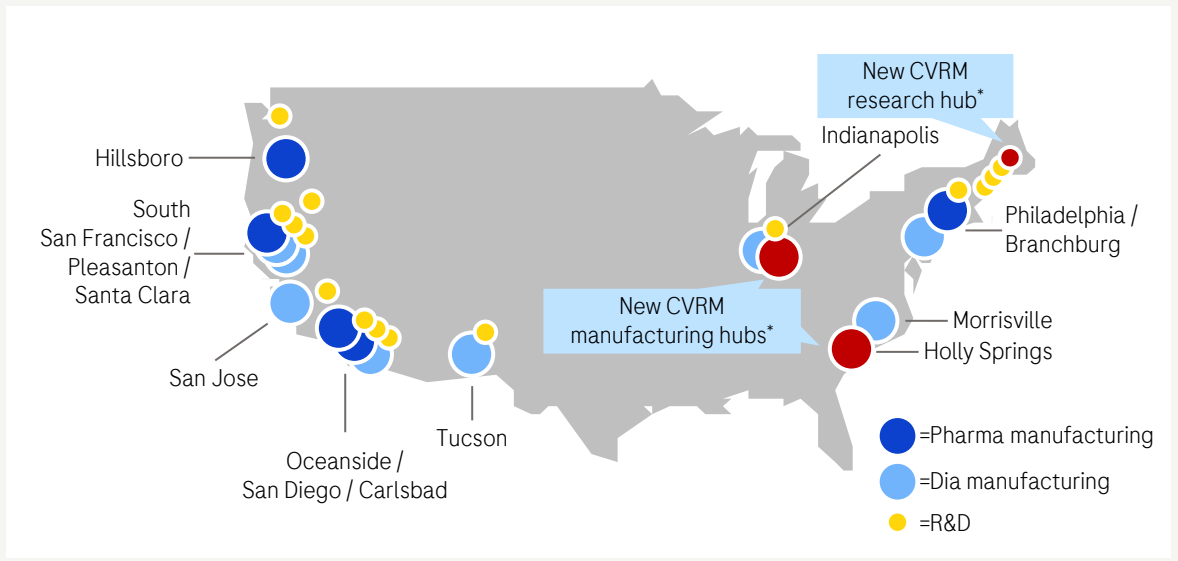
Creating a culture that allows our people to thrive in our Pharma division

AI: Artificial intelligence

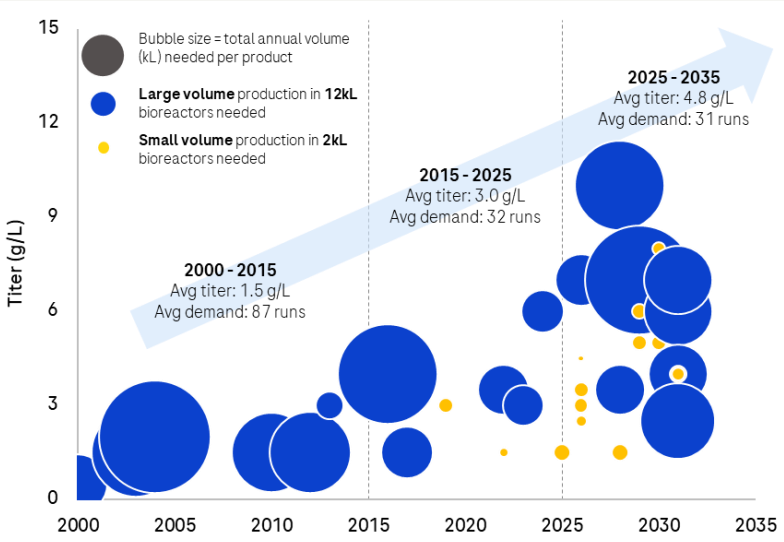
Roche with full Pharma and Diagnostics value chains in the US

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

Drug development | **Regulatory & reimbursement** | **Manufacturing & distribution** | **Commercialization**

Applications: Predictive & agentic AI transforms data into actionable insights

- Intelligent authoring for tech transfers from clinical to commercial
- Advanced data analytics for real time process health monitoring
- Predictive control of processes & quality
- Agentic AI based deviation assistant tool
- Deep learning-based particle classification
- Digital twin-based simulation for new CVRM facilities
- AI based supply co-pilot / control tower

User benefits:

- Faster tech transfer (18 to < 6 months)
- Increasing output (yield/ titer) by up to 10%
- Reduced report generation time by >60%
- Reduced CapEx & accelerated ramp-up

- **Speed to patient (development & supply lead time)**
- **Cost avoidance/ efficiency (no waste, no wait, no touch)**
- **Robust processes (right every time)**

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

AI: Artificial intelligence; CapEx: Capital expenditure; CVRM: Cardiovascular, renal and metabolism

Streamlining our drug delivery approach

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

Therapeutic areas

- Oncology/Hematology
- Neuroscience
- Immunology
- Ophthalmology
- CVRM

Currently four device platforms

Auto-injector	Needle safety device
	
Ophthalmic pre-filled syringe	**Intravitreal drug delivery implant**
	

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

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

Current device platforms are illustrative and not comprehensive; CVRM: Cardiovascular, renal and metabolism; LE: Line extension; NME: New molecular entity

Leveraging AI to increase overall productivity along the value chain

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

Drug development → **Regulatory & reimbursement** → **Manufacturing & distribution** → **Commercialization**

Applications: Agentic AI powered content ecosystem

Insights-based campaign planning	Lab / agency briefing	Content search & auto tagging	Net-new content creation	Derivative content assembly	Content personalization & transcreation	Content performance & analytics	Medical, legal & regulatory automation

User benefits:

- Shorter turnaround times
- Less effort and grunt work
- Accelerated creative ideation
- Improved consistency and quality

Speed to market acceleration

Revenue upside

Cost avoidance

AI-enabled solutions increasing efficiencies & productivity and enhancing share of voice

AI: Artificial intelligence

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 working[1] 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

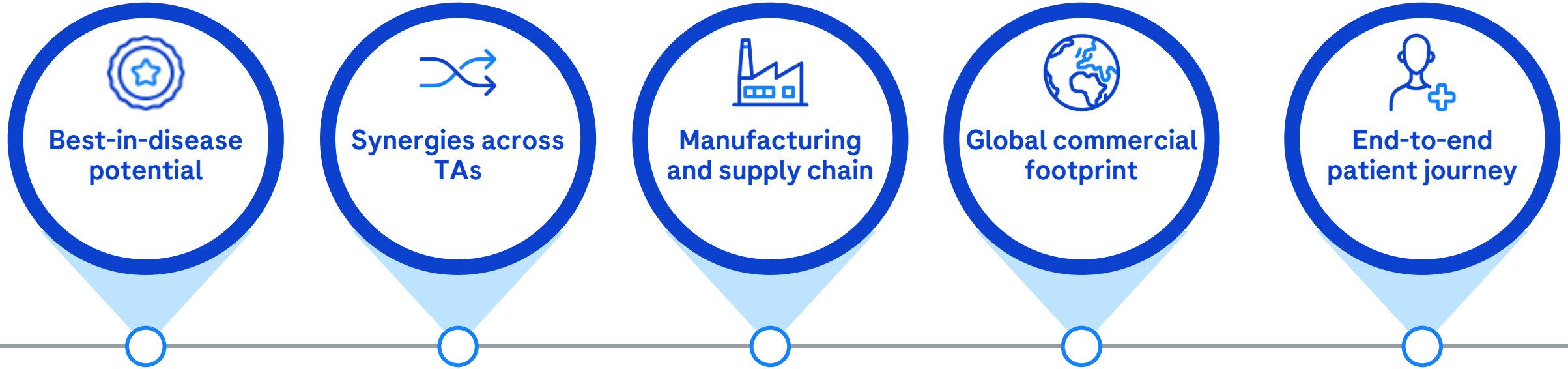
Progress since Pharma Day 2024

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

Patient as key decision driver*

Unprecedented size and scale

Two-track system: primary and specialty settings

Heterogeneity and fragmentation

Not an established disease

*Medicinal products remain prescription only. Ultimate decision-maker remains the treating physician

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 decision[1]

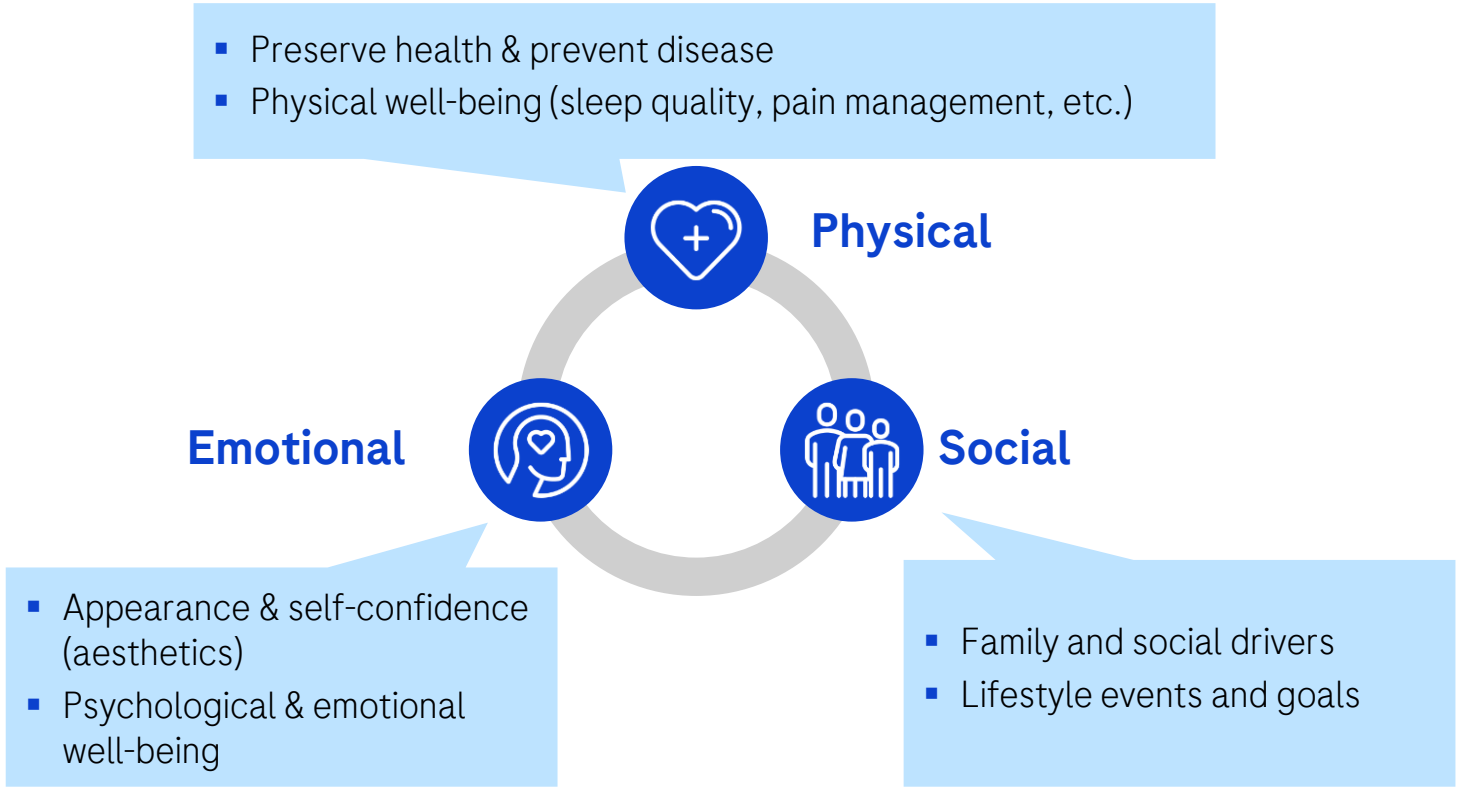
~55%

of patients self-refer

~28%

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

Key patient needs[2]

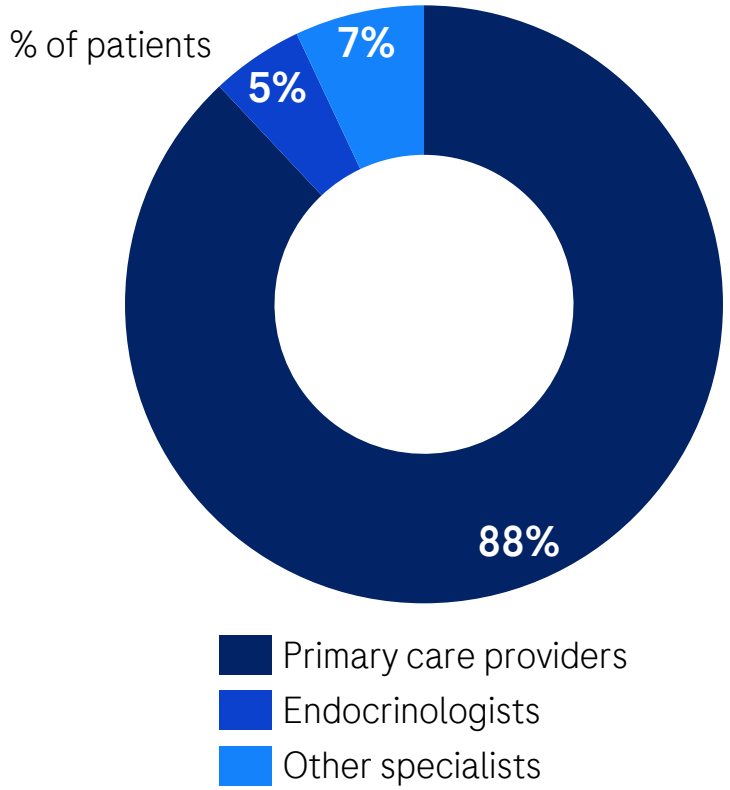


1. Ipsos, 2024; 2. Market research (2025); BMI: Body mass index

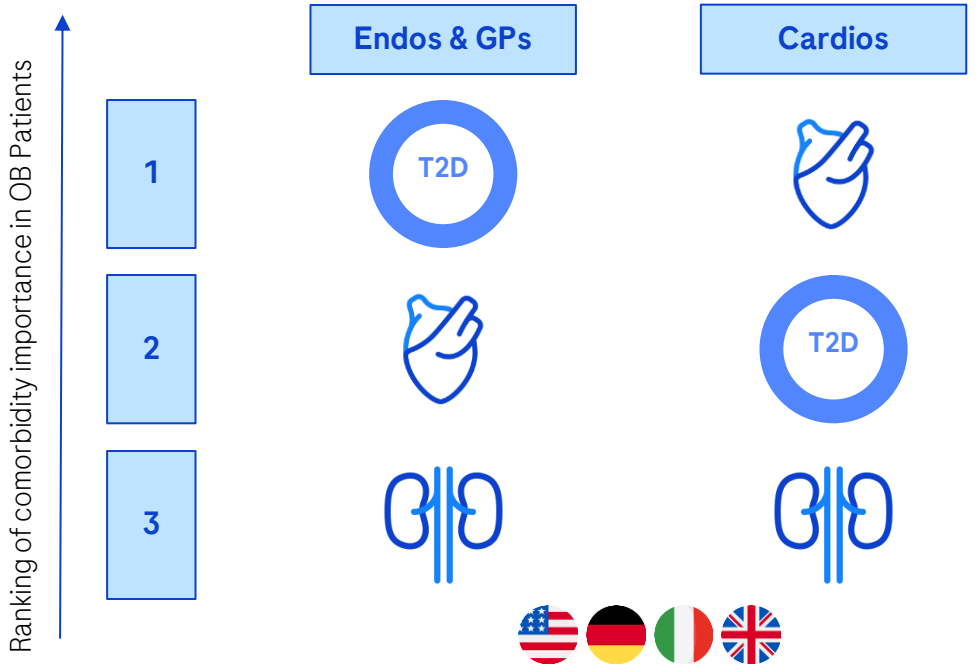
Both primary and specialty care providers are key in Obesity

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

Distribution of US GLP-1 prescriptions by setting[1]



Current ranking of comorbidity importance[2]



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

1IQVIA, July 2025; Primary care providers includes family nurse practitioners and family medicine, internal medicine, pediatric, prevention specialist physicians. Other specialists includes Ob/Gyns, cardiologists, nutritionists and physicians at non-office locations like hospitals, emergency rooms, and managed care settings; Note: Excludes compounding market; 2. Simon Kucher Market Research (n=221; April 2025), data on file; GP: General practitioner; T2D: Type-2 diabetes

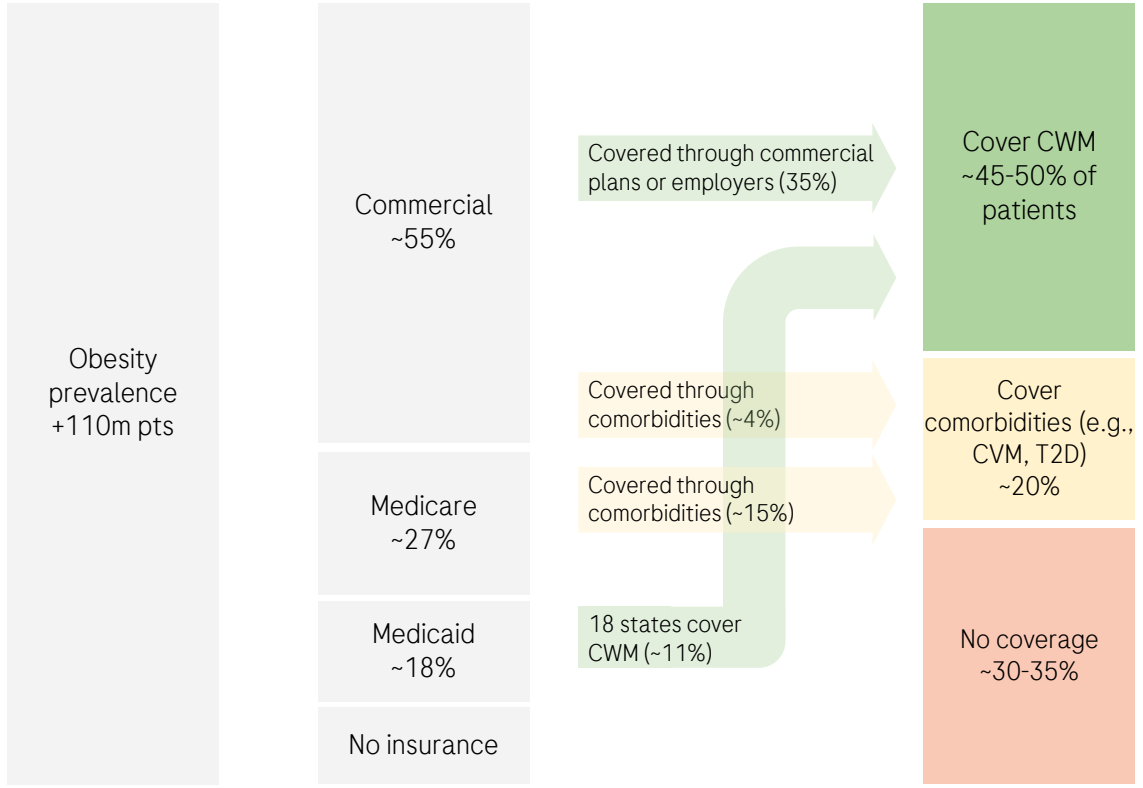
Reimbursement and out-of-pocket market

Obesity is not an established disease for reimbursement across countries

AOM coverage status in key countries

	Chronic disease	Reimbursement
US	✓	✓[2]
Germany	X	X
France	X	Restricted
Italy	✓	X
Spain	✓	X
UK	X	Restricted
China	✓	X

US AOM coverage, % of patients[1]



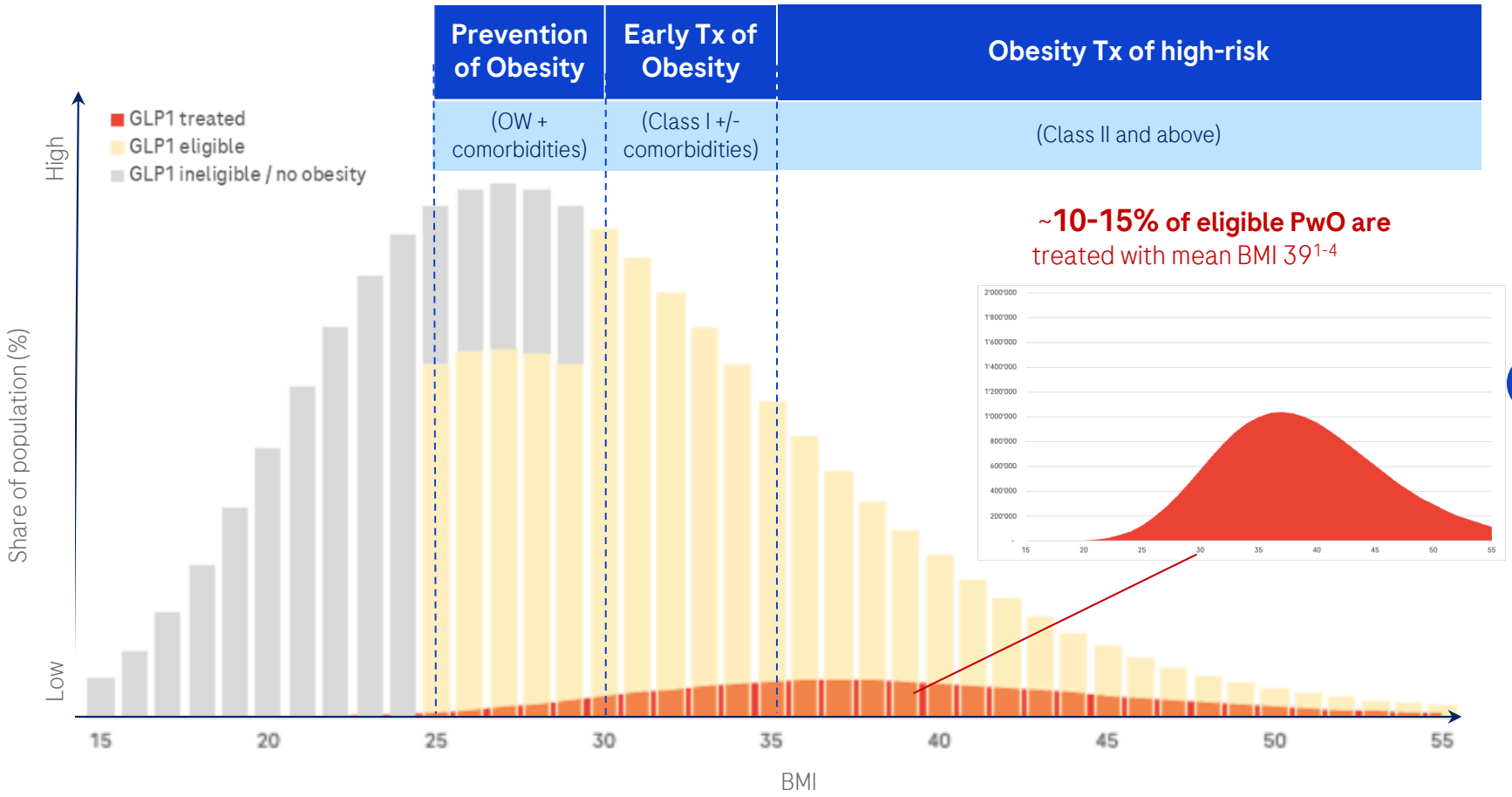
1. IQVIA and market research; 2. Medicare is legally blocked from reimbursing AOMs; AOM: Anti-obesity medication; CVM: Cardiovascular, metabolism; CWM: Chronic weight management; T2D: Type-2 diabetes

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 usage[1]

[Illustrative]



51%

The **majority of the global population** will be living with either overweight or obesity by 2035 if current trends continue[2]

$4.3 Trillion

The global **economic impact of obesity** could reach $4.3 trillion annually by 2035, if prevention and treatment measures do not improve[2]

*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. 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.

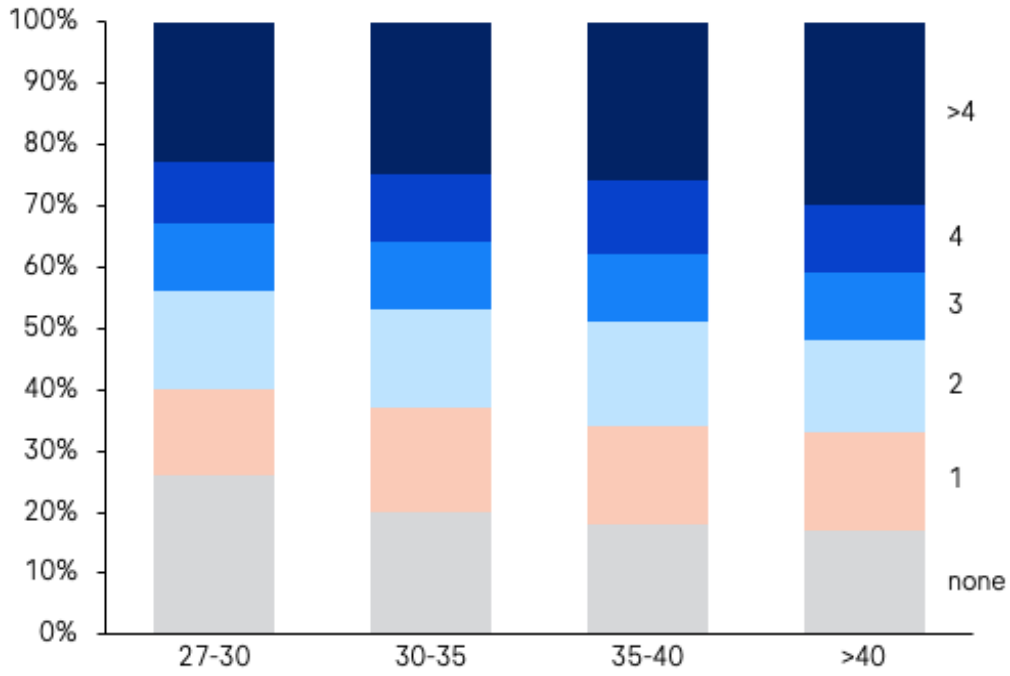
Significant market fragmentation is expected

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

Potential future segments

- Tolerability
- Comorbidity management
- Depth of weight loss
- Quality of weight loss
- Route of administration
- Weight loss vs. maintenance
- OoP vs. reimbursed
- Mono Tx vs. combinations

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

1 When the dust settles: The future shape of the obesity market, IQVIA, 2024; BMI: Body mass index; OoP: Out-of-pocket; PwO: People with obesity; Tx: treatment

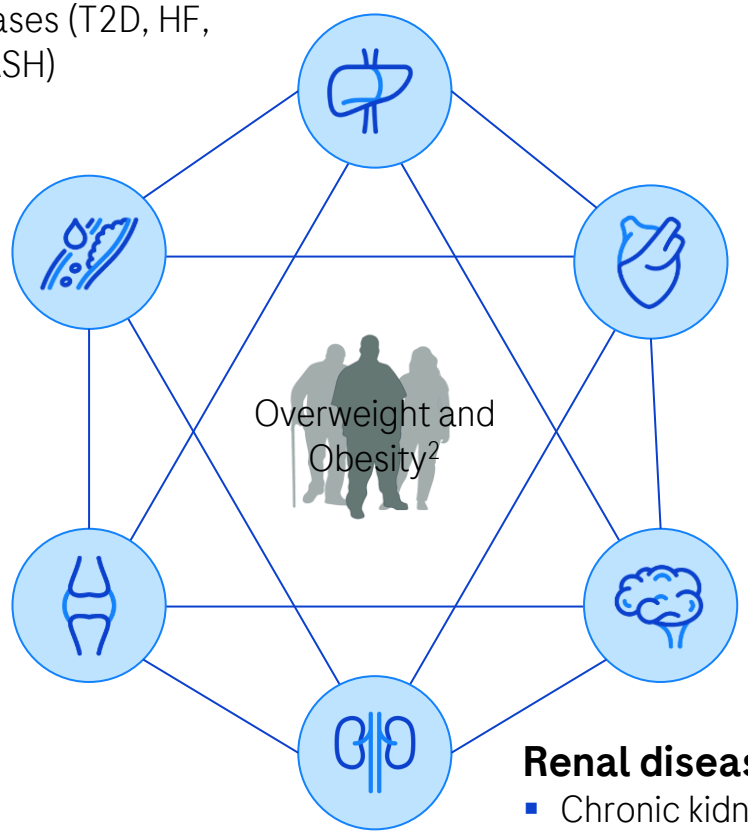
Obesity is a major risk factor for a range of diseases

>220 complications and comorbidities are associated with Obesity[1]

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

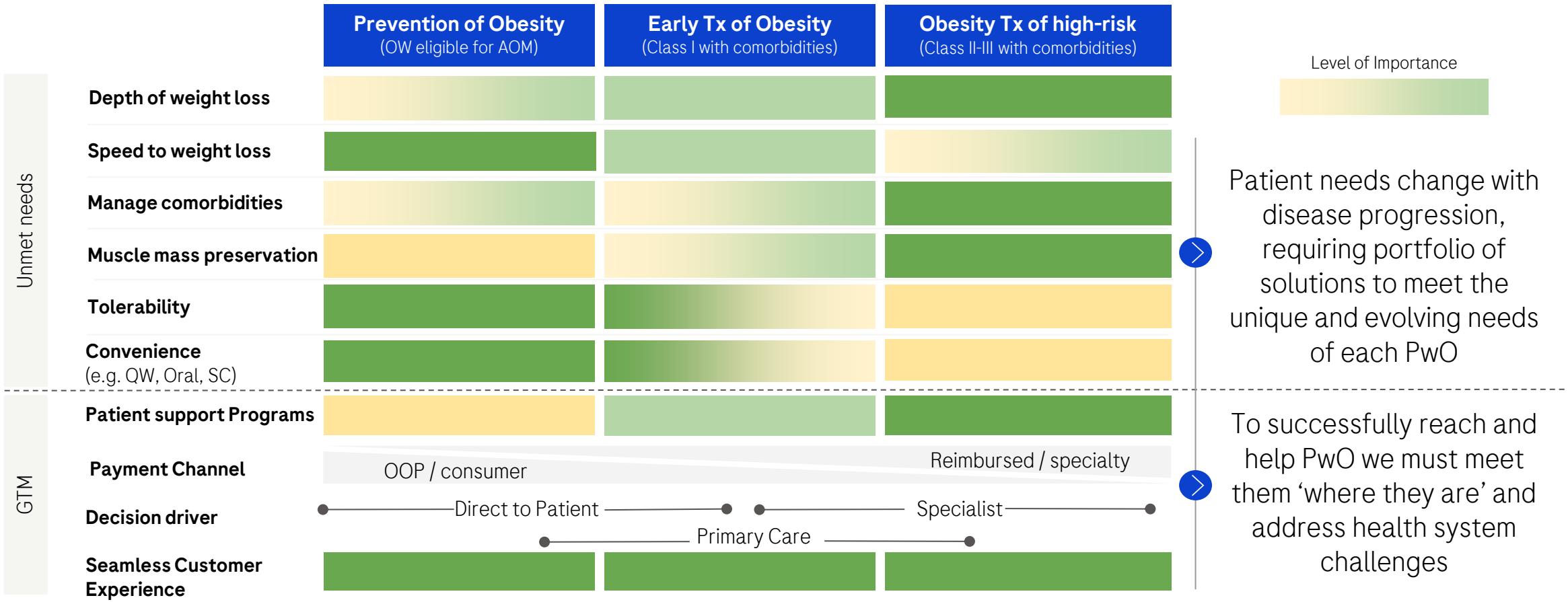
Renal disease
- Chronic kidney disease

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



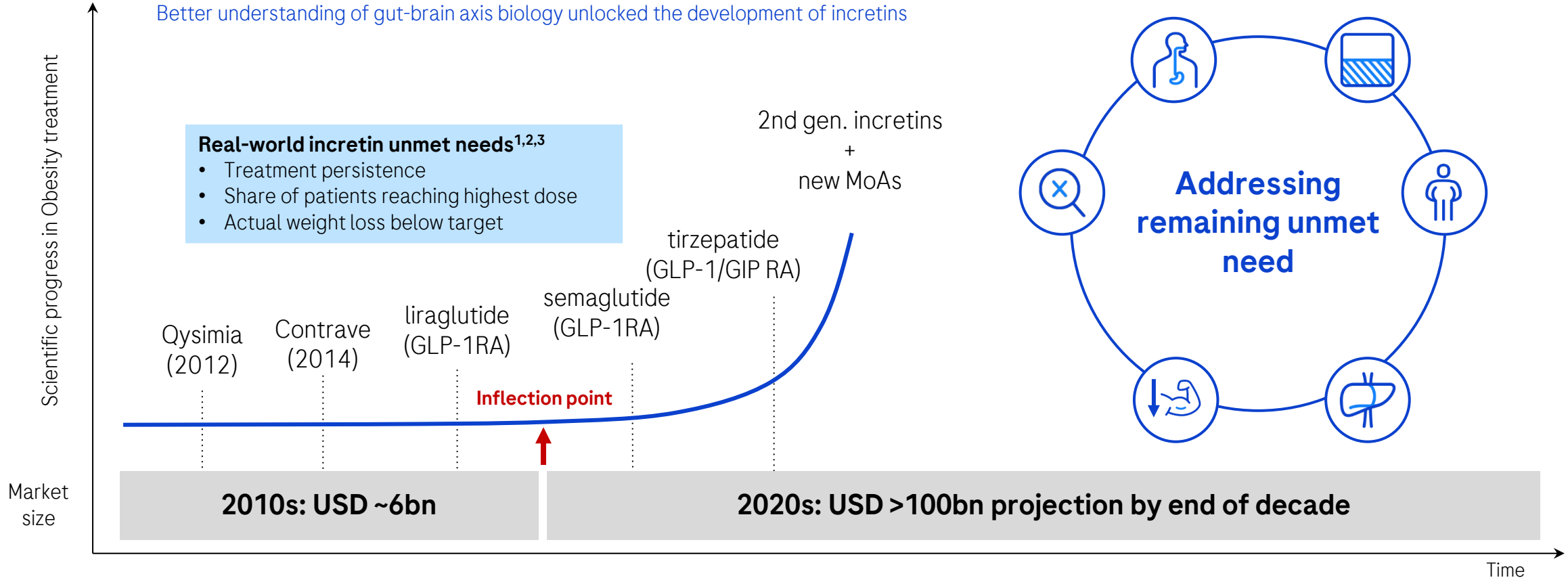
Class I: BMI 30-35, Class II: BMI 35-40, Class III: BMI >40; AOM: Anti-obesity medication; GTM: Go-to-market; OOP: Out-of-pocket; OW: Overweight; PwO: People with Obesity; QW: Once weekly; SC: Subcutaneous; Tx: Treatment

Incretins have unlocked a new era in Obesity treatment

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

Age of incretins | **What's next?**

Better understanding of gut-brain axis biology unlocked the development of incretins



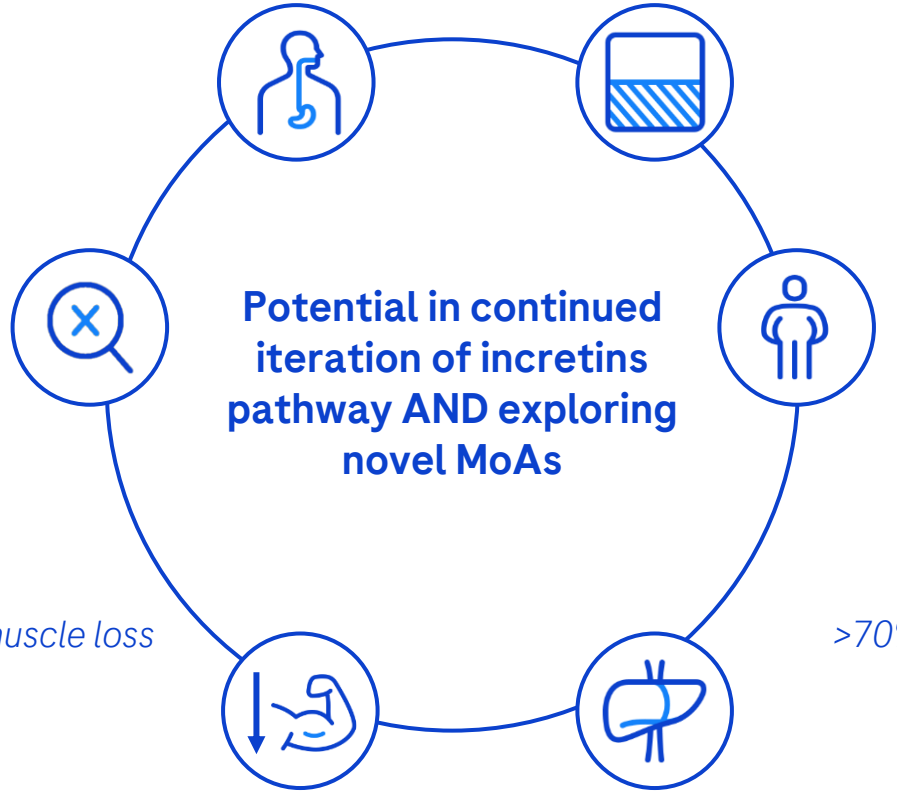
1. Blue Health Intelligence, 2024, Real-world Trends in GLP-1 Persistence and Prescribing for Weight Management, May 2024; 2. LifeSci Capital Survey, May 2024; 3. IQVIA, June 2025; MoA: Mechanism of action

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

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



No or suboptimal response
to incretins in up to 20%[1] of patients

Weight maintenance
Majority of patients regain weight after stopping treatment

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

Comorbidities
>70% of PwO have at least one comorbidity

*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 near-term portfolio offers a strong foundation

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

Tolerability

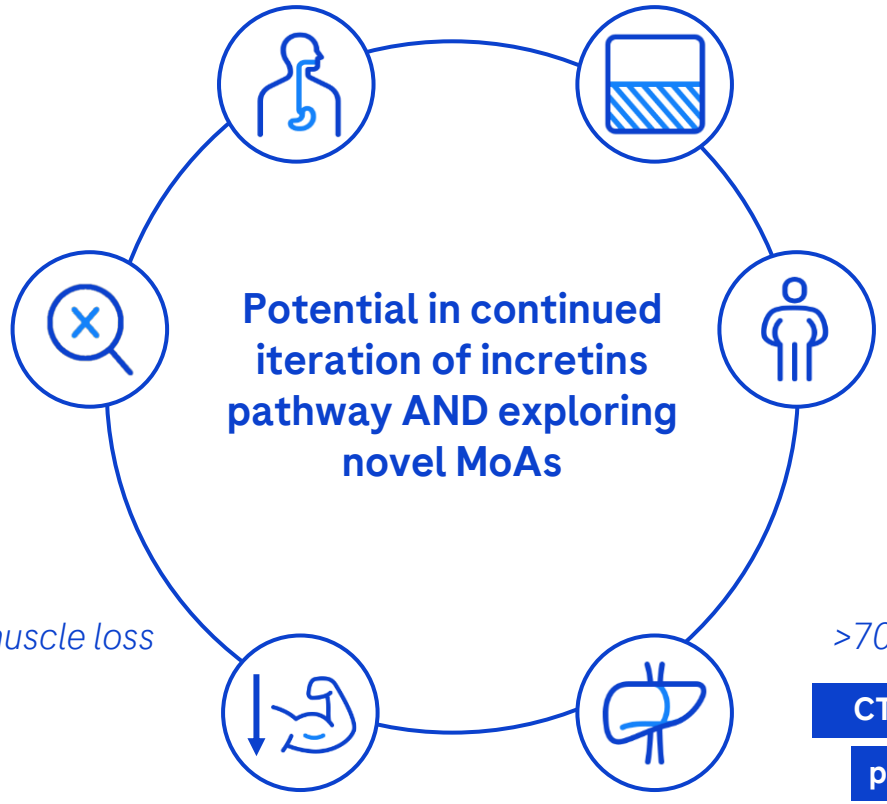
e.g. nausea/emesis is a main driver for discontinuation

petrelintide | CT-388 | CT-388 + petrelintide

Ceiling effect on weight loss

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

petrelintide | CT-388 | CT-388 + petrelintide



No or suboptimal response

to incretins in up to 20%[1] of patients

petrelintide | CT-388 + petrelintide

Weight maintenance

Majority of patients regain weight after stopping treatment

petrelintide | CT-388 | CT-996

Lean muscle loss

Up to 40% of weight loss comes from muscle loss

incretin + emugrobart

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

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

Synergies across TAs

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

Manufacturing and supply chain

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

Global commercial footprint

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

End-to-end patient journey

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

Roche committed to become a top 3 player in Obesity

BIC: Best-in-class; BID: Best-in-disease

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

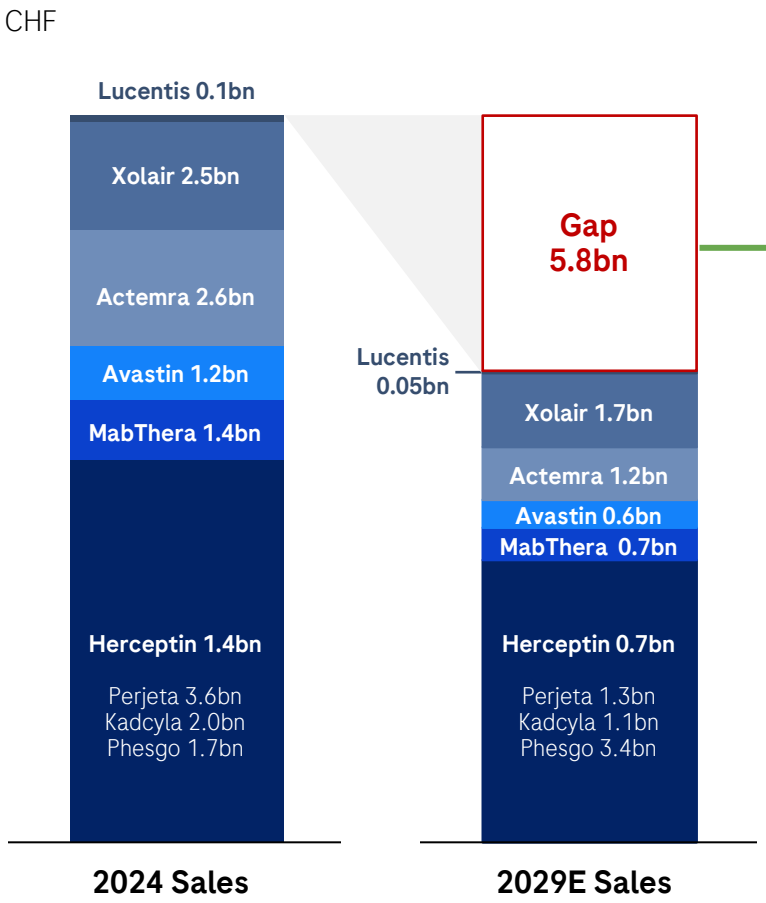
NXT007 in hemophilia A	cevostamab in R/R MM	trontinemab in AD	prasinezumab in PD	zosurabalpin in MDR bacterial inf.	zilebesiran in hypertension	CT-388 in obesity	pegozafermin in MASH*
Onc/Heme	**Onc/Heme**	**Neurology**	**Neurology**	**Immunology**	**CVRM**	**CVRM**	**CVRM**
Potential for BID and to 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

Biosimilar gap (24-29)



Consensus sales growth (24-29)

Vabysmo	2.5bn
Itovebi	1.1bn
Polivy	1.0bn
Columvi	0.9bn
Ocrevus	0.7bn
Hemlibra	0.7bn
Gazyva	0.7bn
Evrysdi	0.6bn
Lunsumio	0.6bn
PiaSky	0.4bn
Alecensa	0.2bn
Enspryng	0.2bn
Susvimo	0.2bn
Elevidys[1]	0.2bn
Tecentriq	-0.1bn
Other in-market[2]	-0.1bn
Pipeline Ph III[3]	**3.1bn**
thereof giredestrant	*0.9bn*
thereof fenebrutinib	*0.7bn*
thereof afimkibart (TL1A)	*0.4bn*
thereof divarasib	*0.3bn*
thereof prasinezumab	*0.3bn*
thereof trontinemab	*0.3bn*
thereof vamikibart	*0.3bn*
Total	**12.9bn**

Potential up-side

Assets with low to no coverage in current sell side models:

Cardiovascular & Metabolism: pegozafermin in MASH[4]; CT-388 in Obesity +/- T2D; CT-868 in T1D; CT-996 in Obesity +/- T2D; petrelintide in Obesity +/- T2D; emugrobart in Obesity; zilebesiran in uncontrolled Hypertension

Oncology/Hematology: NXT007 in HemA; cevostamab in r/r MM; CDK4/2i in BC; HER2 TKI in HER2+ BC; allogeneic CAR-Ts in r/r MM and NHL

Neurology: emugrobart in SMA & FSHD; nivegacetor in AD; P-CD19 x CD20 - ALLO1 in MS

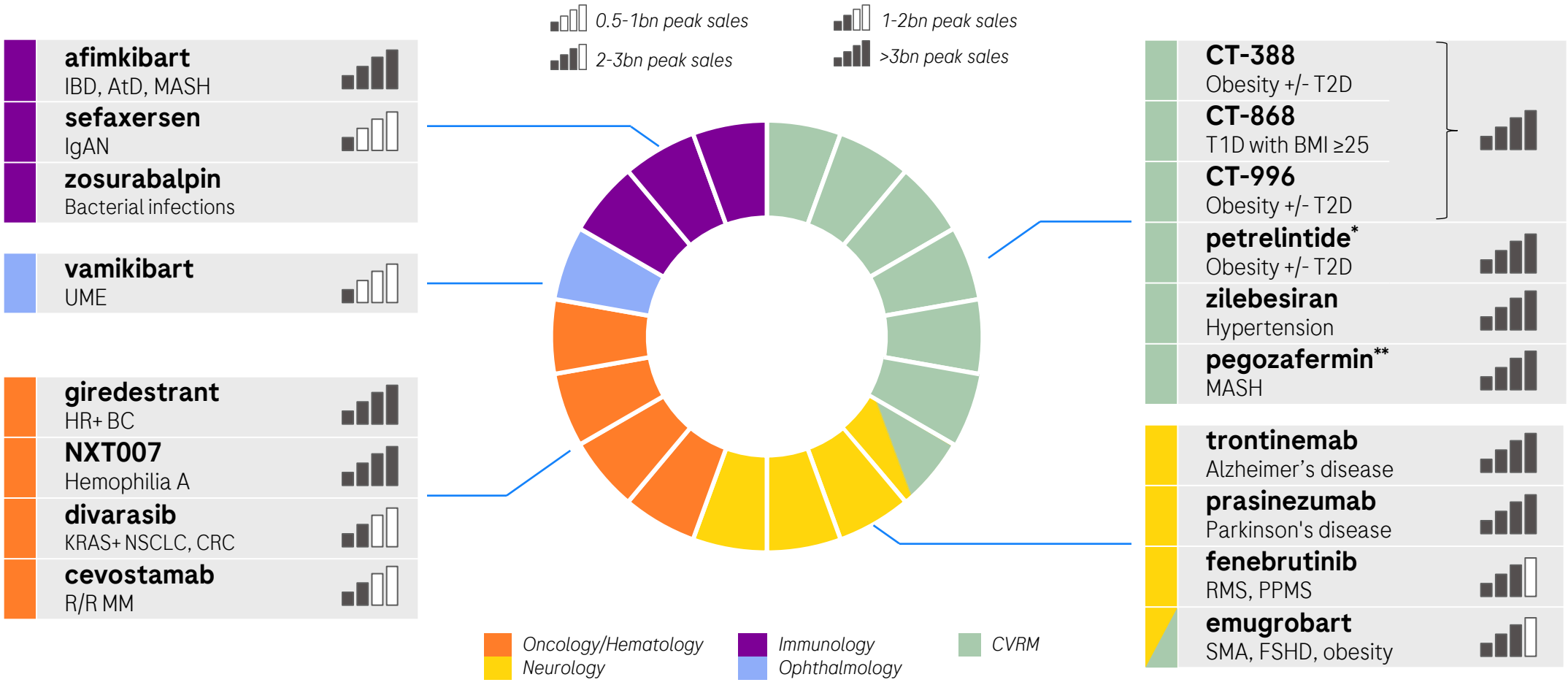
Immunology: Gazyva in SLE, sefaxersen in IgAN; B-cell depleting bispecifics and allogeneic CAR-Ts on autoimmune diseases

Ophthalmology: satralizumab in TED; VEGF-IL-6 DutaFab in DME; OpRegen® cell therapy in GA

*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



Peak sales shown unadjusted; * Zealand Pharma and Roche entered collaboration in 2025; **Pending deal closure; CVRM: Cardiovascular, renal and metabolism

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 medicines[1] by end 2029)

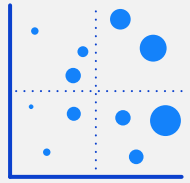
Reach **top-quartile performance** in R&D productivity across the biopharma industry

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

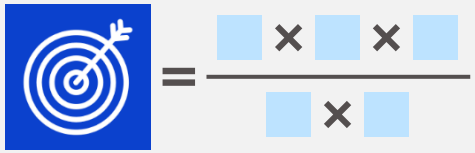
Adopt a unified portfolio framework ✓



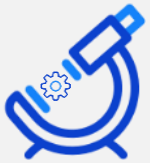
Transform our portfolio management & governance ✓

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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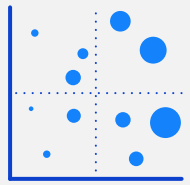

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Evolve our R&D engine and invest in its excellence ✓

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

Prioritizing transformative assets with the Bar

The merits of the Bar are driving alignment and focus

Answers a clear & addressable unmet need

Engages a ‘foundational target’

Possesses worthy pharmacologic & developability characteristics

Achieves meaningful therapeutic differentiation

Unlocks a path to value (e.g., robust revenue potential)

Full adoption and early impact seen

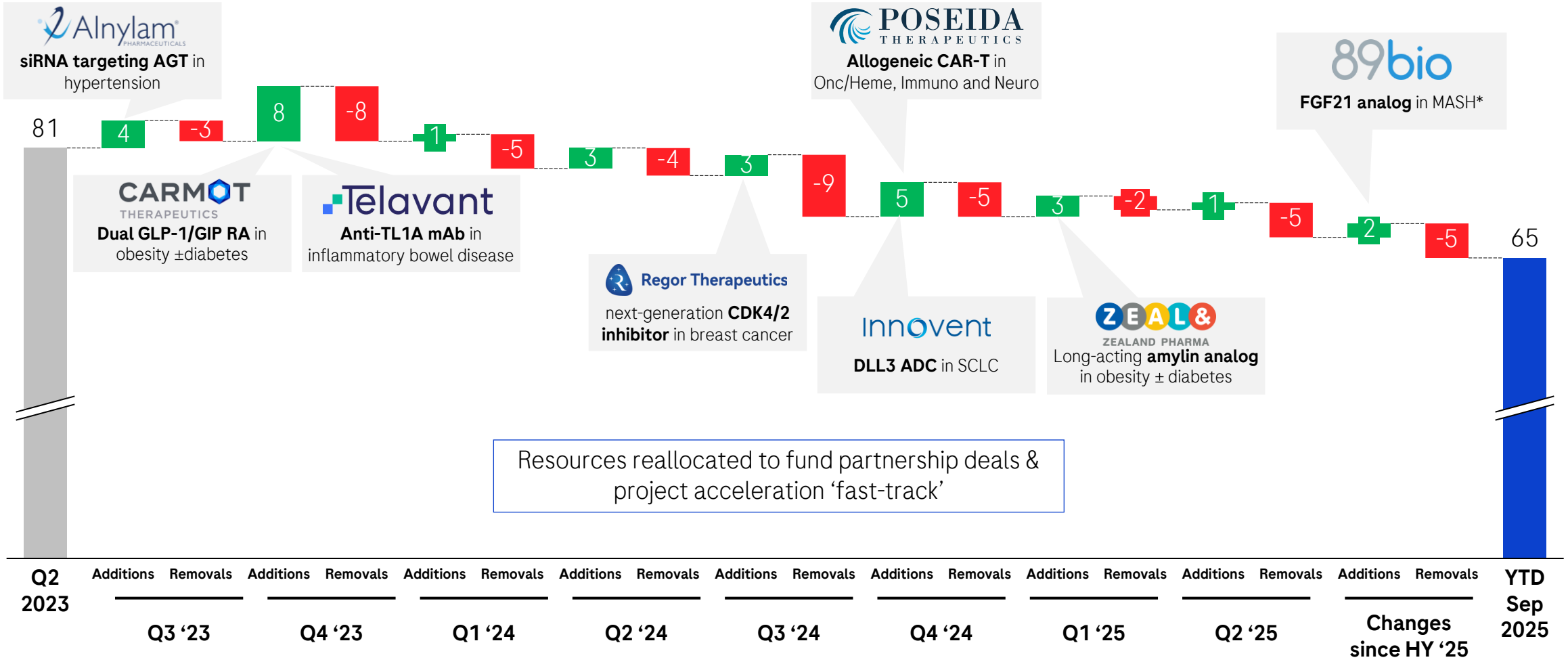
100% adoption in Research and Development, enforced via Governance Boards

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

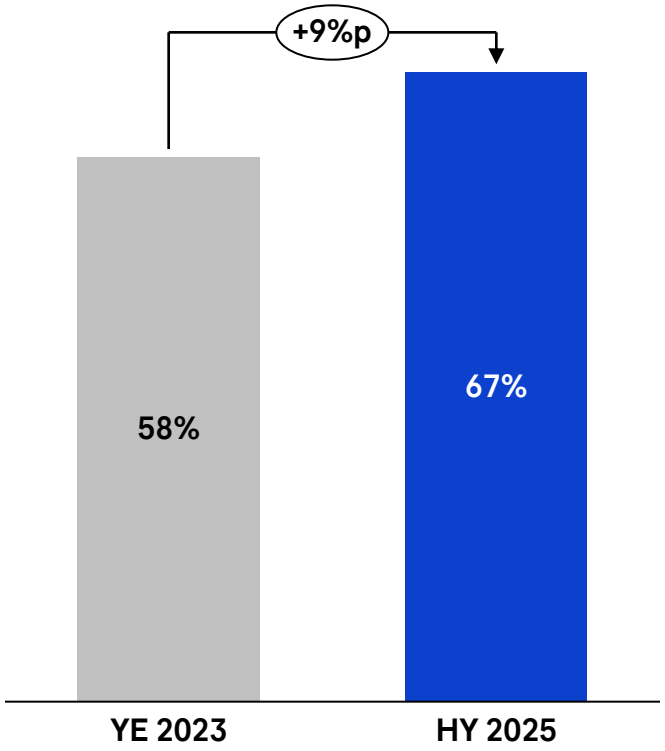


*pending deal closure; ADC: Antibody-drug conjugate; AGT: Angiotensinogen; CDK4/2: Cyclin dependent kinase-4/2; GIP: Glucose-dependent insulinotropic polypeptide; GLP-1: Glucagon-like peptide-1; mAb: Monoclonal antibody; NME: New molecular entity; RA: Receptor agonist; SCLC: Small-cell lung cancer; siRNA: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

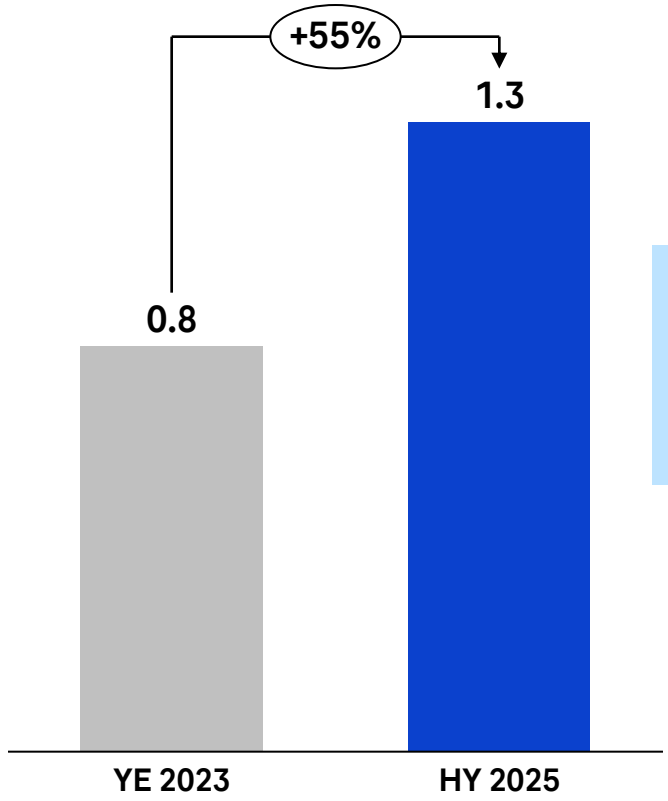
Pipeline evolution since YE 2023

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

Share of late-stage projects with BID potential[1]



Average peak sales per pipeline project, CHFbn[2]



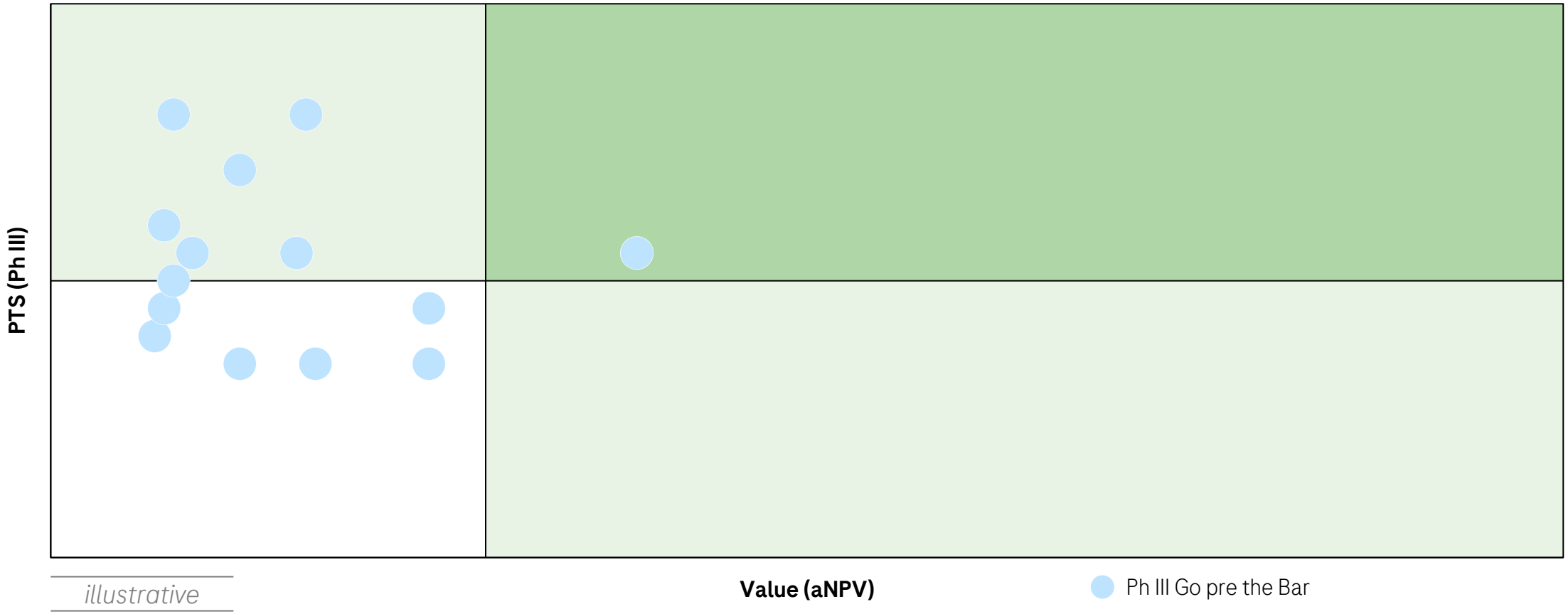
Total portfolio value +26%

1. Source: Internal data; 2. Source: Internal data. BID: Best-in-disease; YE: Year end

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 Bar[1], NMEs only

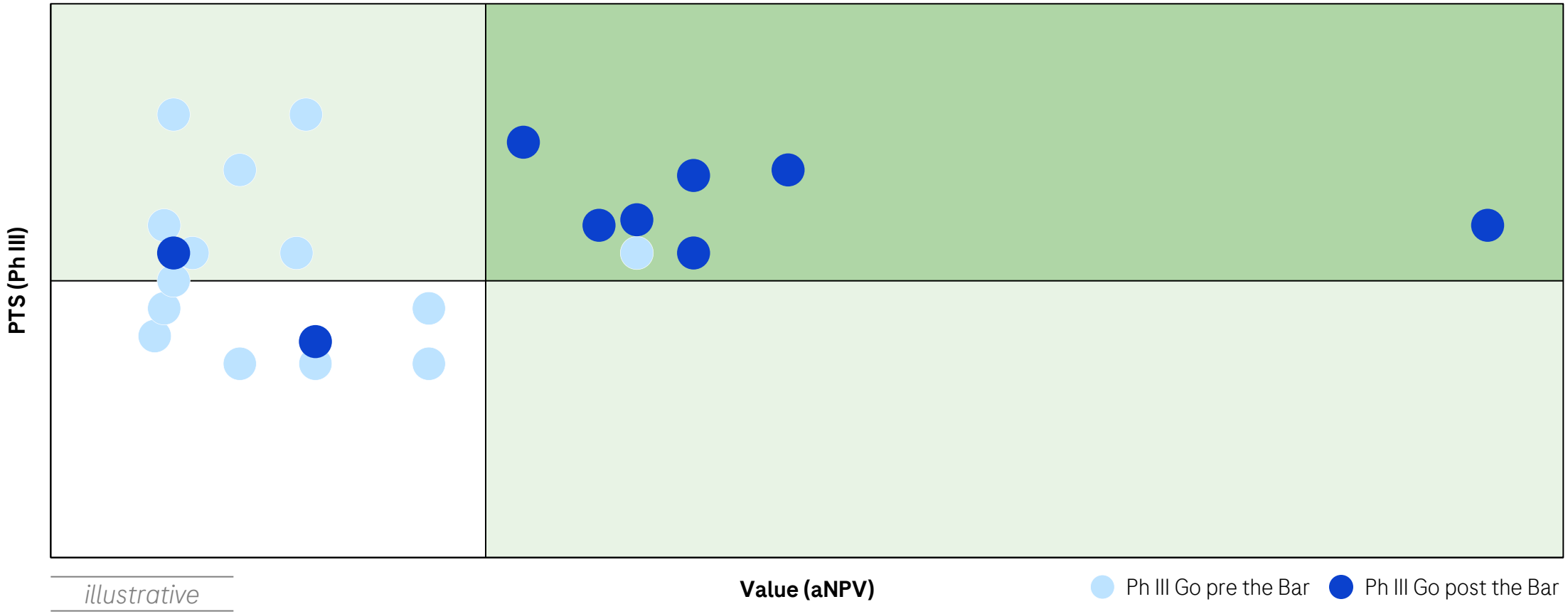


1. Based on all NMEs with Ph III Go decision since 2019, cut-off for pre the Bar at start of 2024; aNPV: Risk-adjusted net present value (accounting for probability of launch); NME: New molecular entity; PTS: Probability of technical success

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 Bar[1], NMEs only



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New vs. 2024

Build a simplified system landscape and data foundation

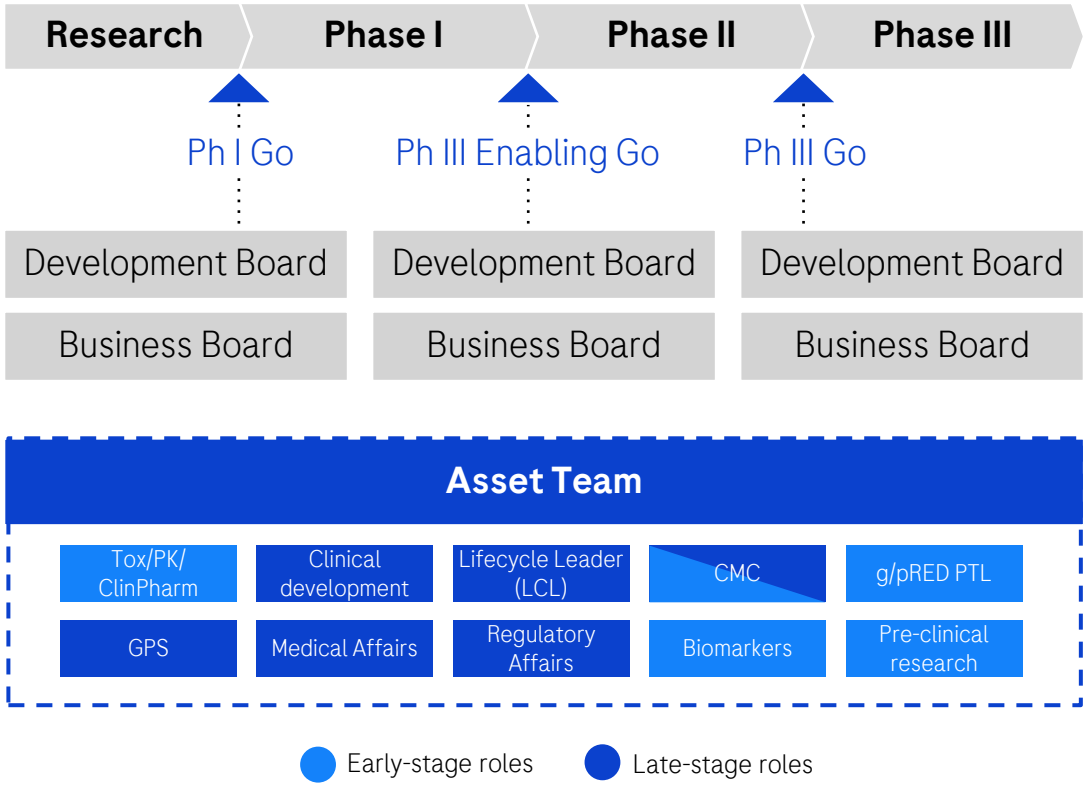
Implemented and moving into business as usual

Implementation in progress

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

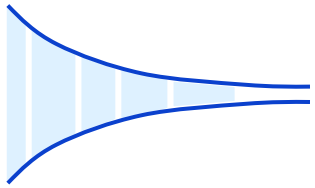
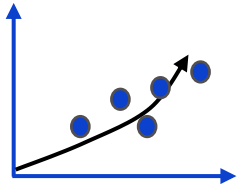
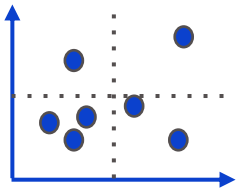
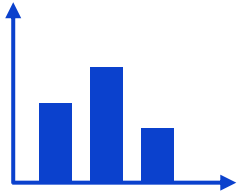
- Asset teams have a fluid, fit-for-purpose, membership spanning early to late-stage development roles strengthening E2E thinking
- Development Boards rigorously assess E2E asset strategies and clinical development plans
- Business Boards provide expertise on commercial value drivers, barriers and risks

ClinPharm: Clinical pharmacology; CMC: Chemistry, manufacturing and controls; Tox: Toxicology; E2E: End-to-end; PK: Pharmacokinetics; PD: Product development; PTL: Project team leader; RED: Research and early development

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	Consistent and sustainable launches of NMEs and steady revenue growth	Pursuing science that can revolutionize patient care	Balancing risk with sufficient high-value project focus	Monitoring TA productivity and contributions to overall ambitions

NME: New molecular entity; TA: Therapeutic area

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	▪ 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'	▪ Angiotensinogen targets upstream of RAAS cascade, a major blood pressure control pathway (supported by KARDIA-1/2/3)
Possesses worthy pharmacologic & developability characteristics	▪ Twice-yearly subcutaneous dosing, encouraging safety profile, profound AGT silencing (supported by KARDIA-1/2/3)
Achieves meaningful therapeutic differentiation	▪ Uncontrolled HTN patients (KARDIA-3) with established CVD and high risk of future events; combination with diuretics (KARDIA-3)
Unlocks a path to value	▪ Peak sales potential CHF >3bn (unadjusted)

AGT: Angiotensinogen; CVD: Cardiovascular disease; RAAS: Renin–angiotensin–aldosterone system; HTN: Hypertension

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)

OLE: Open label extension; PD: Parkinson's disease

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'	▪ Aβ 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/IIa 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)

Aβ: Amyloid β; AD: Alzheimer's disease; ARIA-E: Amyloid-related imaging abnormalities-edema/effusion; MoA: Mechanism of action; PET: Positron-emission tomography

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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

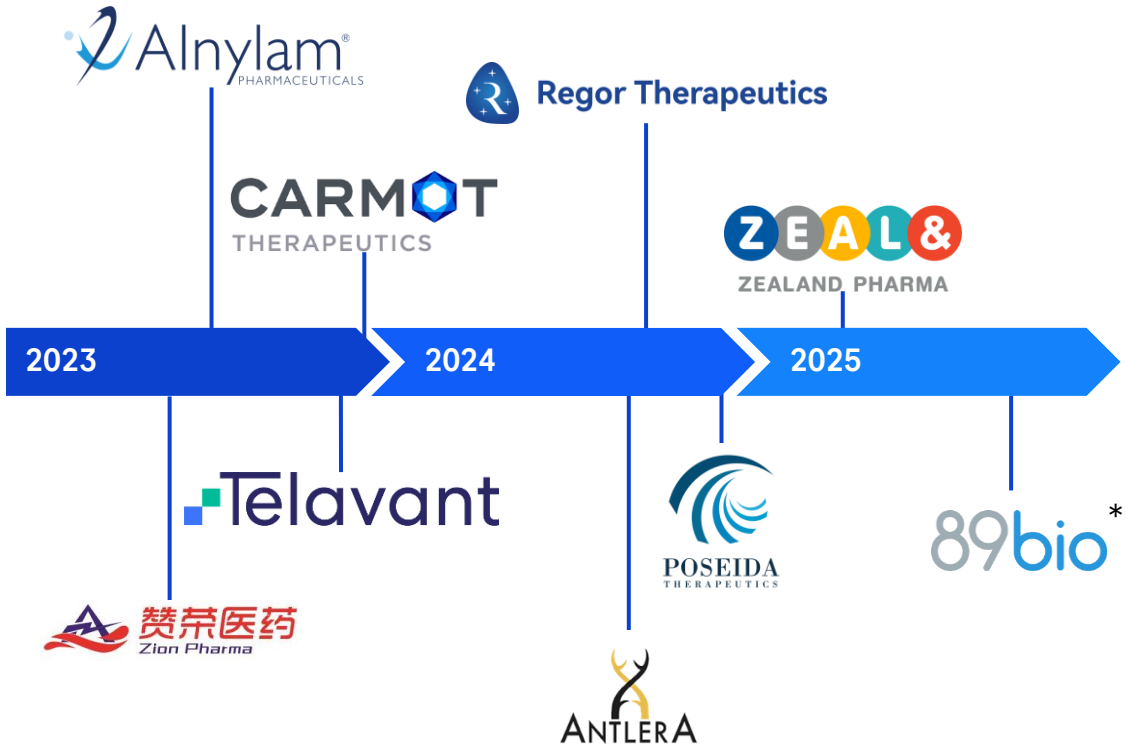
Implemented and moving into business as usual

Implementation in progress

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

*Pending deal closure

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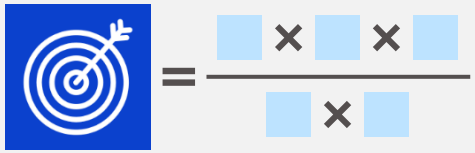

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Implementation in progress

Our cumulative impact (2024 - YTD 2025)

Added **29 assets** total from early R&D and high-value partnerships (+12 in 2025)

CHF +0.45bn[1] average peak year sales across late-stage portfolio

Team-assessed **Ph III PTS has increased** since R&D Excellence roll-out

R&D Excellence =

Volume × **Value** × **Success rate** } **Effectiveness**

Costs × **Cycle time** } **Efficiency**

Reinvested **CHF ~1.1bn** of savings from R&D back into the portfolio

On track to achieve **~11 months acceleration** by end of 2025

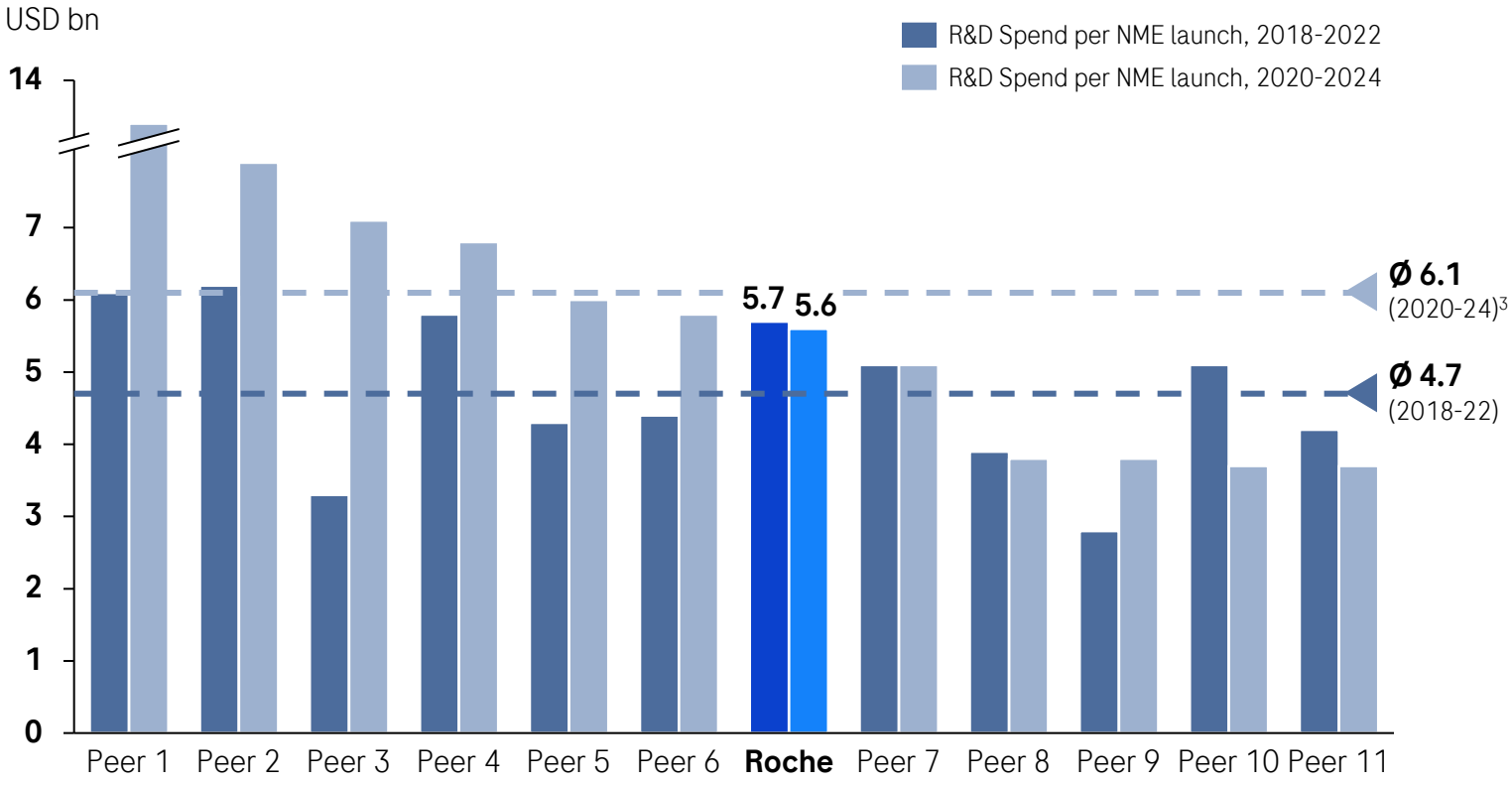
On track | Longer follow-up needed

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

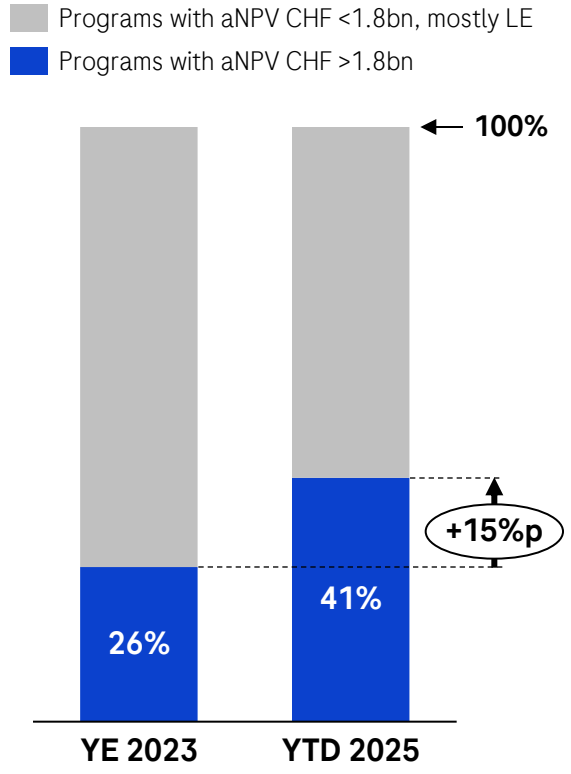
Roche beginning to reduce R&D spend per NME launch

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

R&D spend per NME launch[1] (USD bn[2])



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

PoC: Proof of concept

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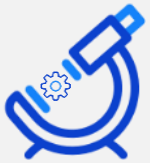

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New vs. 2024

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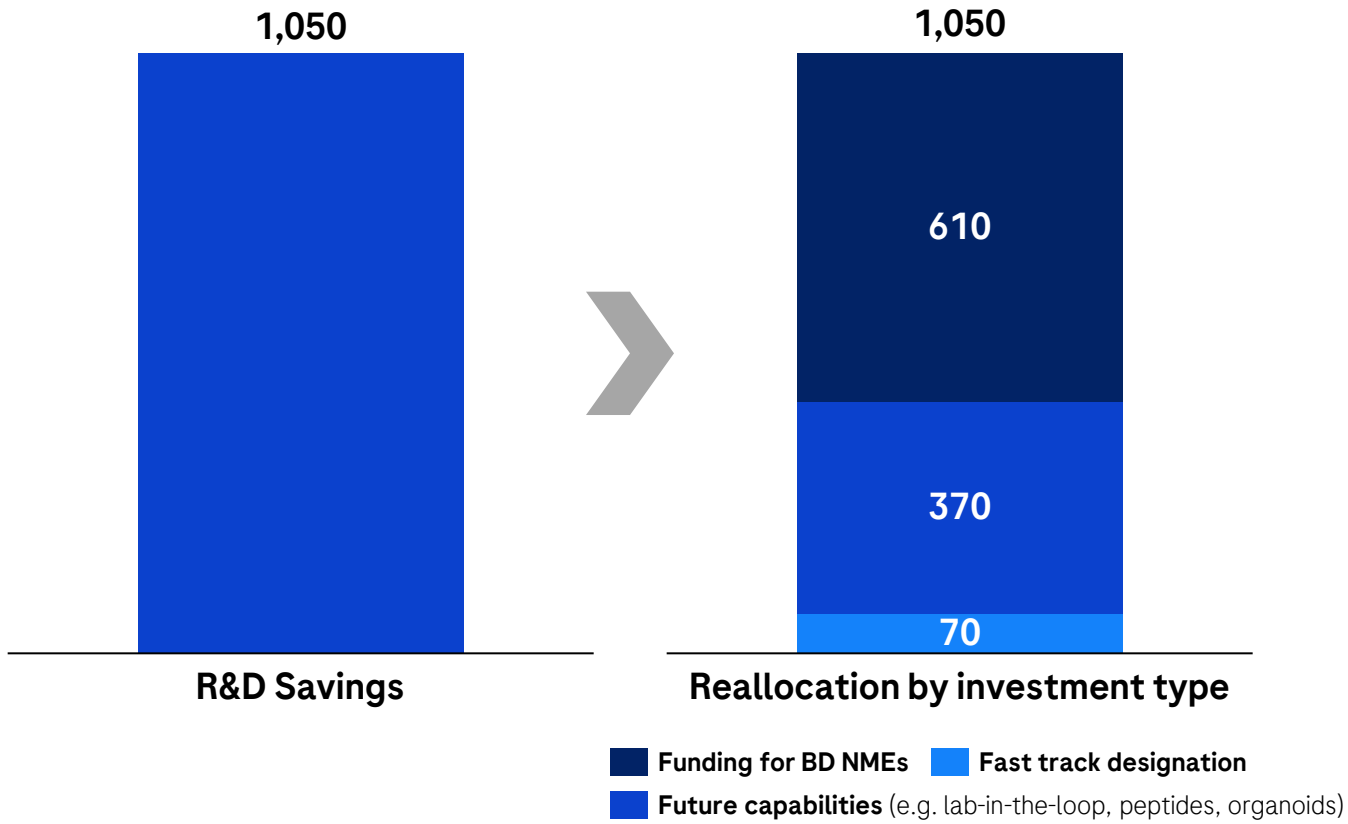
✓ Implemented and moving into business as usual

✓ 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+2025[1] (CHFm)



Reinvestment into the portfolio

- Increased the number of high value assets
- Reallocated funds to programs with transformational potential
- Cycle time[2]: 11 mos. acceleration since start of R&D Excellence[3] (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

CRO: Contract research organization; ClinOps: Clinical operations

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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

Drug development | **Regulatory & reimbursement** | **Manufacturing & distribution** | **Commercialization**

Applications: Agentic AI that transforms data into insights and content

Design trial protocol	Analysis & data mgmt plan	Build case report form & setup systems	Define edit checks	Collect data	Manage data (standardize / review / transform)	Conduct final database lock	Create tables, listings, figures	Develop study report & submission

User benefits:

- Shorter turnaround times
- Less effort and mundane tasks
- Amplification of human expertise
- Improved consistency and quality

- **Speed to market acceleration**
- **Cost avoidance**
- **Reach top-quartile R&D productivity**

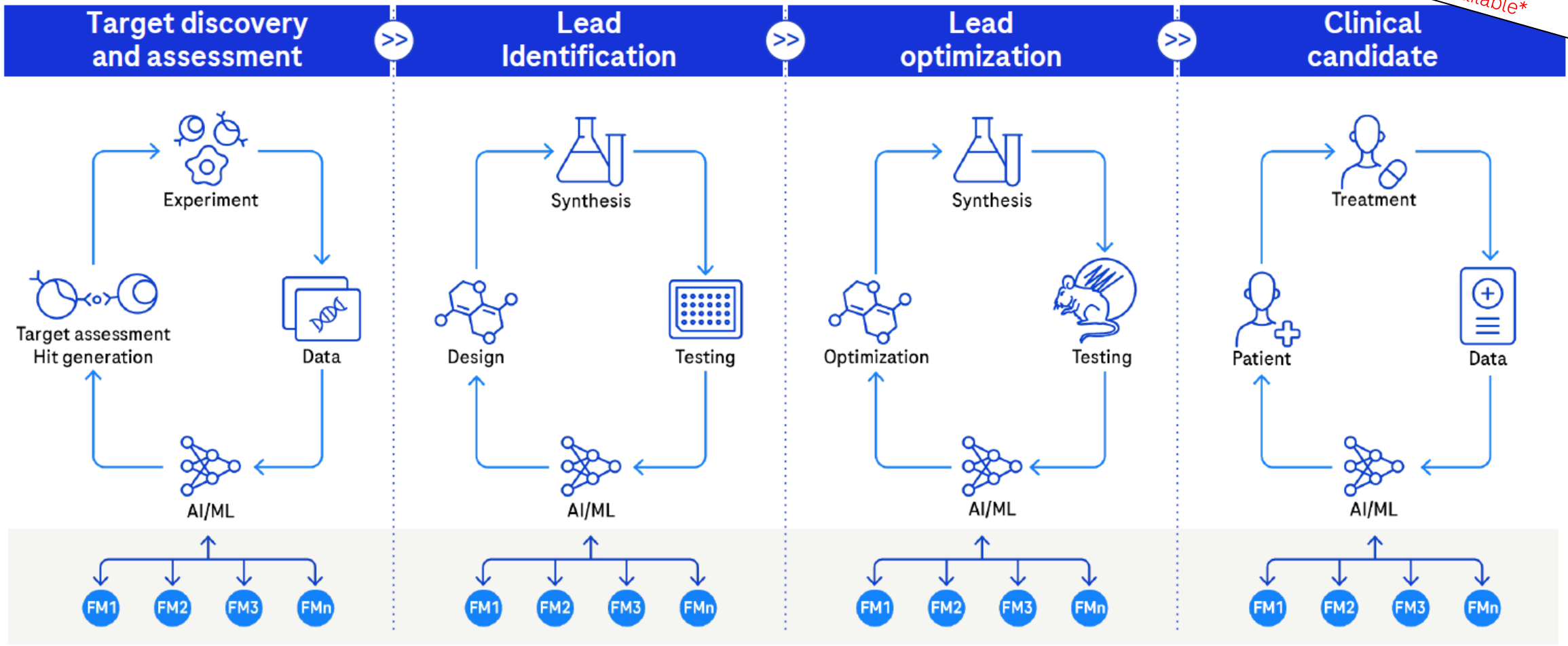
AI-enabled solutions increasing efficiencies and productivity

Roche

Leveraging AI in drug discovery

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

IR Digitalization Day 2024
"Lab-in-the-Loop"
replay available*



* Replay and slides available on the IR homepage: https://www.roche.com/investors/events/roche-virtual-ir-digitalization-day; FM: Foundation model

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 medicines[1] 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		Examples
Precision medicine	*Right medicines for the right patient*	**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
Combinations	*Leverage breadth of oncology and hematology portfolio to explore new combinations*	**Columvi + Polivy-R-CHP:** Bringing Columvi and Polivy to 1L DLBCL **Giredestrant:** Potential to replace current ET backbone in HR+ BC
Novel modalities	*Investing in key technologies to engage unique set of targets*	**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
E2E investment	*Discovery, R&D and commercialization resources concentrated on our end-to-end disease areas*	**Breast cancer:** Development program targeting key signaling pathways (ER, CDK, PI3K, HER2) **Malignant heme:** Comprehensive clinical development program across NHL; expanding into MM

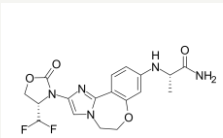
ADC: Antibody-drug conjugate; BIC: Best-in-class; CAR-Ts: Chimeric antigen receptor T-cells; DLBCL: Diffuse large B-cell lymphoma; eBC: Early breast cancer; ET: Endocrine therapy; H2H: Head-to-head; NHL: Non-hodgkins lymphoma; HR: Hormone receptor; NSCLC: Non-small cell lung cancer; MM: Multiple myeloma; SoC: Standard of care

A diversified portfolio by drug modalities and targets

Strengthening our portfolio through external innovation

Oncology/ hematology pipeline

Small molecules



- inavolisib
- divarasib
- giredestrant
- HER2 TKI[1]
- CDK4/2 inh.
- mosperafenib
- KRAS G12D inh.
- Pan-RAS inh.
- MINT91

- fenebrutinib
- selnoflast
- alogabat
- GLP-1 RA (CT-996)
- TMEM16A potentiator
- MAGL inh.
- nivegacetor
- zosurabalpin
- LepB inh.
- REVN24

Antibodies

- anti-CTLA-4 switch
- codrituzumab

- emugrobart
- prasinezumab
- vamikibart
- afimkibart
- vixarelimab
- satralizumab
- anti-HLA-DQ2.5 x gluten peptides
- anti-C1s recycling
- astegolimab
- Tie-2 agonist
- BRY10

Bispecifics/ trispecifics

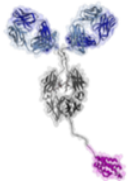
- cevostamab
- LTBR agonist
- DLL3 x CD3 x CD137
- FIXa x FX (NXT007)

- p40 x TL1A
- CD19 x CD3
- VEGF x IL6 DutaFab
- zifibancimig

Antibody-drug conjugates

- cMET ADC[2]
- DLL3 ADC[3]

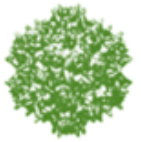
Fusion proteins



- englumafusp alfa

- trontinemab
- Brain shuttle CD20

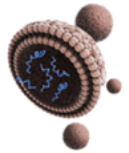
Gene therapy



- SPK-8011QQ

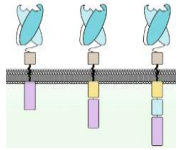
- HTT miRNA GT

Neoantigen vaccines



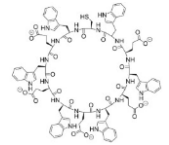
- autogene cevumeran

Allogenic CAR-Ts



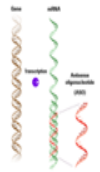
- P-BCMA-ALLO1[4]
- P-CD19 x CD20-ALLO1[4]

Cyclic peptides



- Pan-KRAS inh.

RNA modifiers

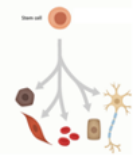


- zilebesiran[5]
- sefaxersen
- tominersen

Peptides

- GLP-1/GIP RA (CT-868)
- GLP-1/GIP RA (CT-388)
- petrelintide[6]

Stem cell therapy



- OpRegen

Molecular degraders

- AR degrader[7]
- 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

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]
RG6794	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

Phase II

RG6180	**autogene cevumeran** multiple indications
RG6171	**giredestrant** endometrial cancer
RG6114	**Itovebi** eBC HR+

Phase III

RG6171	**giredestrant** multiple HR+ BC indications
RG6330	**divarasib** NSCLC
RG3502	**Kadcyla** HER2+ eBC high risk
RG7446	**Tecentriq** multiple indications
RG6114	**Itovebi** multiple BC indications

Registration

RG7446	**Tecentriq** 1L maintenance SCLC

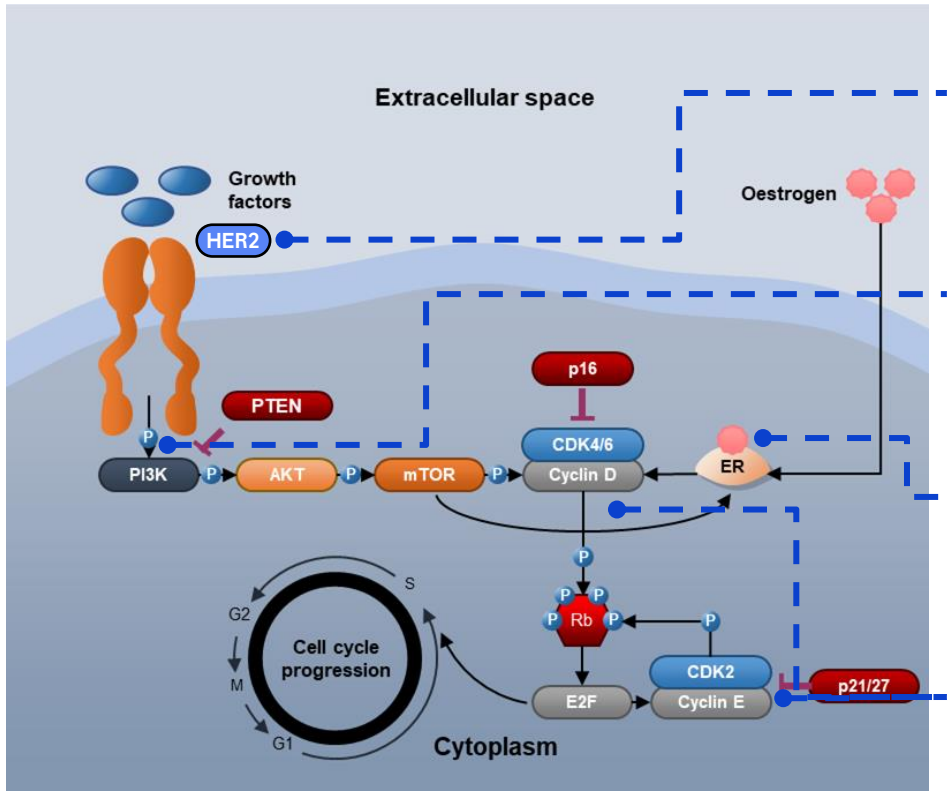
Small molecule
Antibody
Bispecific/trispecific
Neoantigen vaccine
Antibody-drug conjugate
Cyclic peptides

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

Key signaling pathways in BC



1. **HER2**
   - **Phesgo**
   - **Perjeta**
   - **Kadcyla**
   - **Herceptin**
   - **ZN-1041** (HER2 TKI)
2. **PI3K/AKT/mTOR**
   - **Itovebi** (PI3K inh.)
3. **ER**
   - **Giredestrant** (next gen. SERD)
4. **CDK**
   - **GDC-4198** (CDK4/2 inh.)

Remaining unmet needs

HER2+

- HER2+ mBC five-year survival remains at 40%[1]
- Up to 50% of patients with mBC are at risk of developing brain metastases[2]

HR+

- Remaining challenges include recurrence, side effects and lack of effective treatments after progression to metastatic disease

Building a portfolio of potentially BIC molecules to further improve SoC:

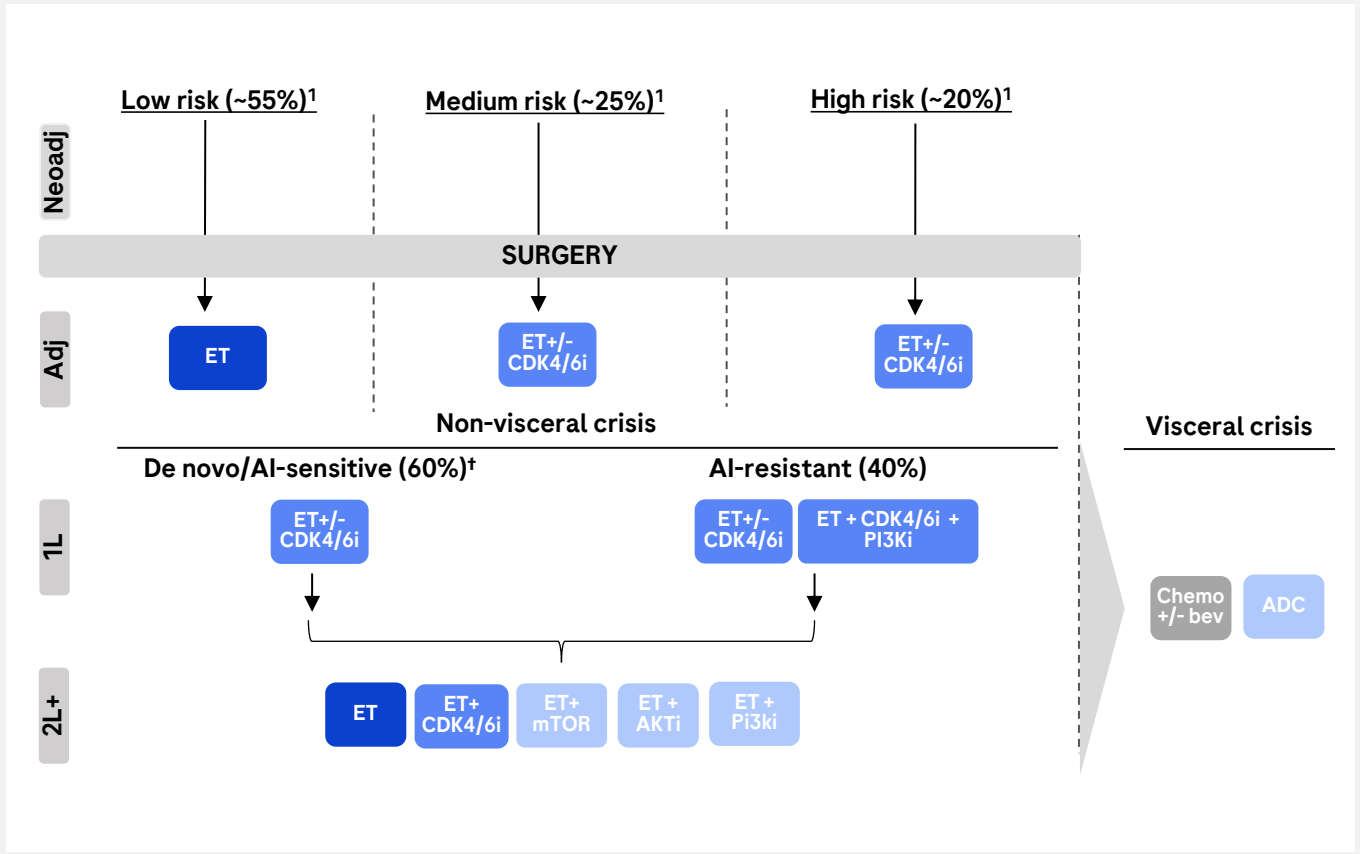
Endocrine therapy (ET), cyclin-dependent kinase inhibitors (CDKi), PI3K inhibitor and brain-penetrant HER2 TKI

Adapted from: Brufsky AM & Dickler MN. Oncologist 2018; 23:528. 1. National Cancer Institute: Surveillance, Epidemiology and Ends Result Program. Cancer Stat Facts: Female Breast Cancer Subtypes [accessed 2024 September], available from: https://seer.cancer.gov/statfacts/html/breast-subtypes.html; 2. Giordano G, et al. Critical Reviews in Oncology/Hematology. 2023;192:104185; BC: Breast cancer; BIC: Best-in-class; CDK: Cyclin-dependent kinase; ET: Endocrine therapy; HER2: Human epidermal growth factor receptor 2; HR: Hormone receptor; mBC: Metastatic breast cancer; PI3K: Phosphatidylinositol 3-kinase; SERD: Selective estrogen receptor degrader; TKI: tyrosine kinase inhibitor

HR+/HER2- BC treatment paradigm

Targeting three critical signaling pathways that drive underlying disease and resistance

HR+ BC treatment landscape



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

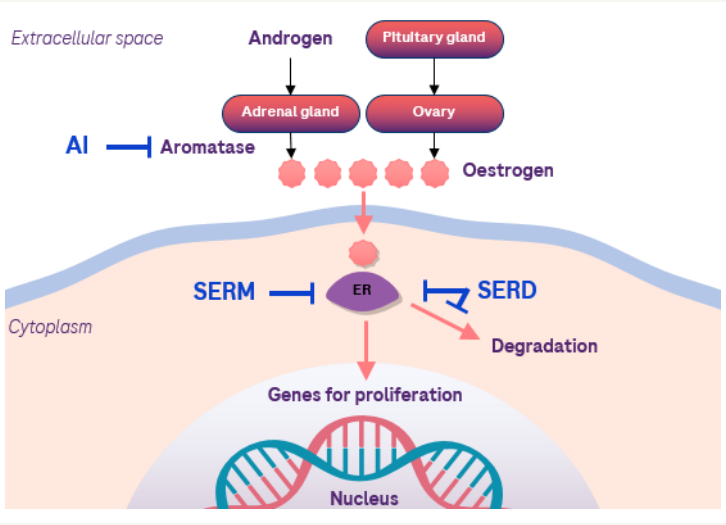
ET + tgt **Targeted therapies**

Limited to metastatic breast cancer (1L+)

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

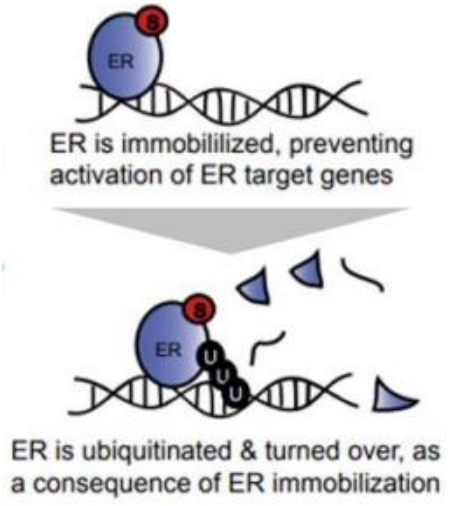
Giredestrant: A next-gen SERD with BIC potential

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 MoA[2]



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

More potent than competitor SERDs[3]

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

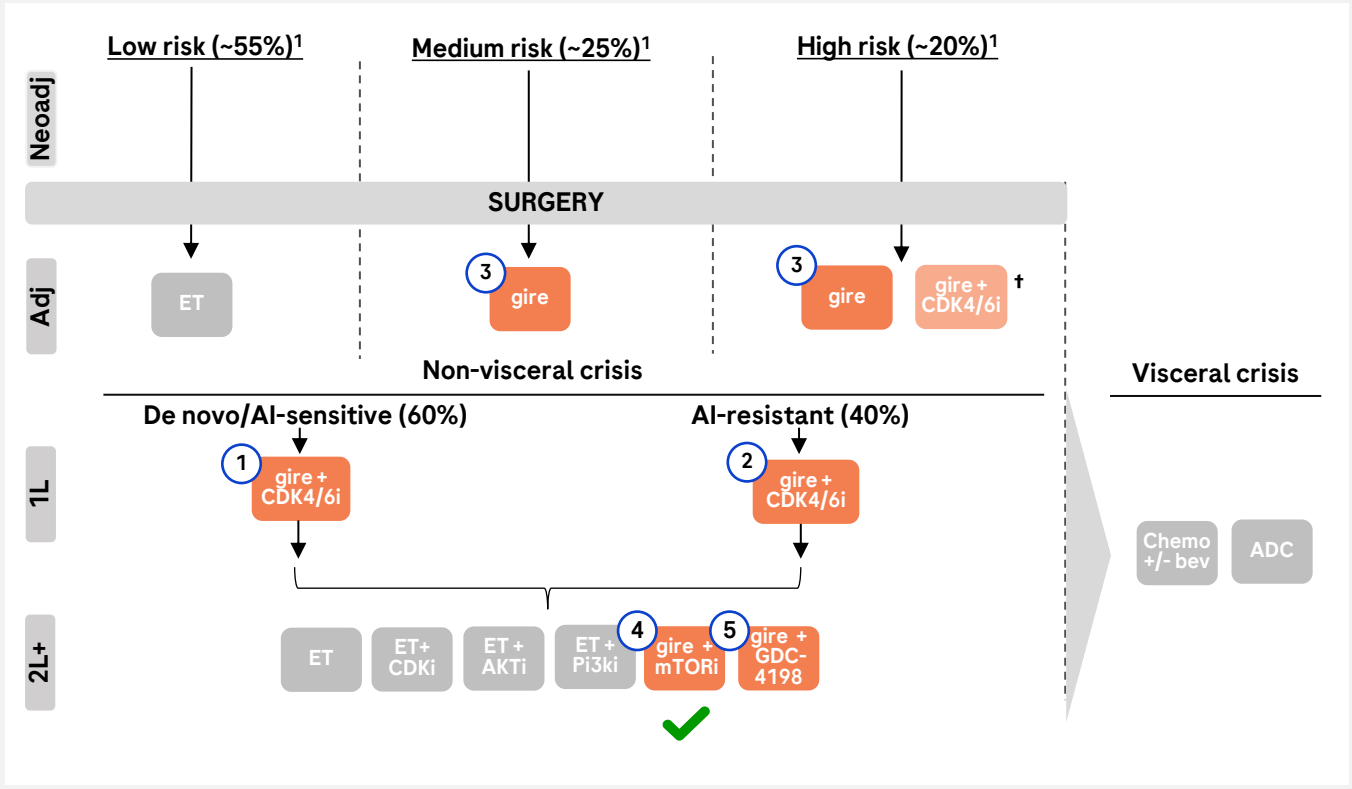
- Highest preclinical potency vs. other oral SERDs
- Combinable with all CDKis including palbociclib, abemaciclib, ribociclib
- Well tolerated at all doses, with no dose-limiting toxicities

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

Giredestrant aims to replace SoC ET across eBC & mBC



1	giredestrant (persevERA)	1L ER+/HER2- mBC (ET-sensitive)	Readout Q1 '26
2	giredestrant (pionERA)	1L ER+/HER2- mBC (ET-resistant)	Readout 2027
3	giredestrant (lidERA)	Adjuvant ER+/HER2- BC	Readout 2026
4	giredestrant (evERA)	2L+ ER+/HER2- mBC	✓
5	gire + GDC-4198 (MoonROSE)	2L+ ER+/HER2- mBC	Ph I/II initiated
	gire + Phesgo (heredERA)	1L maintenance ER+/HER2+ mBC	

✓ Positive Ph III

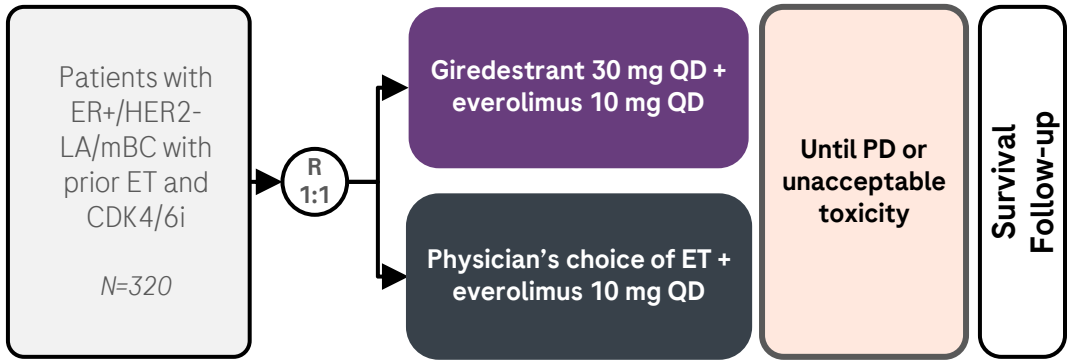
- In early line setting, tumors are highly dependent on estrogen signaling; giredestrant is predicted to benefit all-comers population
- evERA and pionERA enriched for *ESR1m* patients and designed with *ESR1m* and ITT co-primary endpoints to fully characterize the benefit of giredestrant in different populations
- Ph I/II in combination with GDC-4198 (CDK4/2i) initiated

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

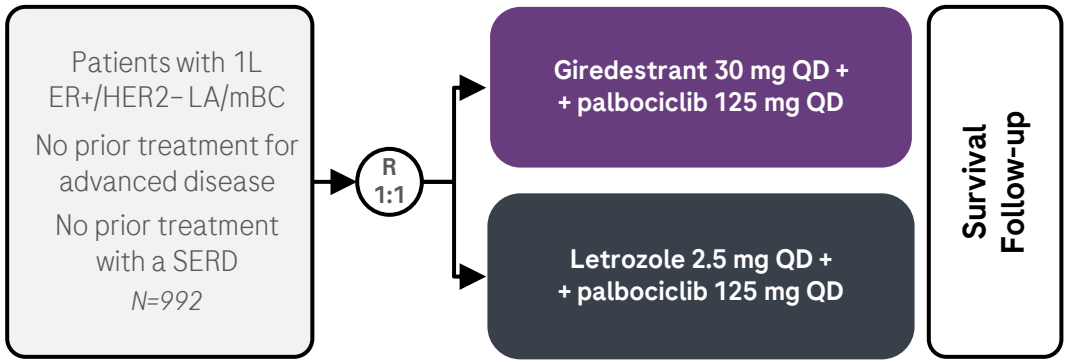
Ph III (evERA): Gire + everolimus in ER+ mBC post-CDKi



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**

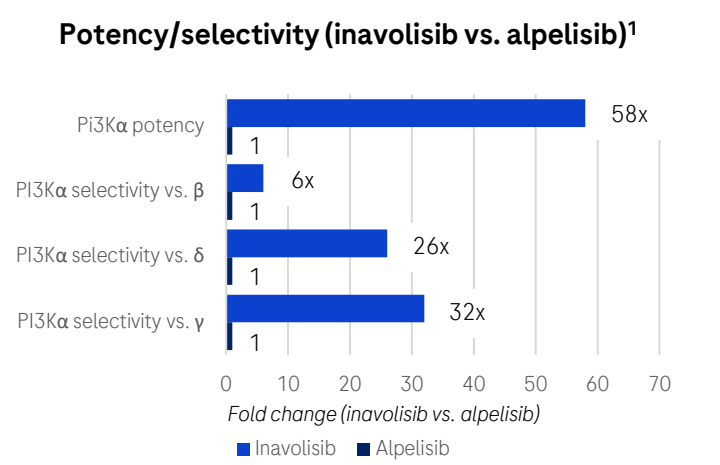
- Ph III (persevERA) results expected Q1 2026
- Ph III (pionERA) giredestrant + CDK4/6i in ET-resitant* ER+/HER2- mBC results expected 2027; study enriched for *ESR1m* pts, an *ESR1m* and ITT co-primary endpoint
- Ph III (lidERA) adjuvant giredestrant in patients with ER+/HER2- eBC expected in 2026

*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 *PIK3CA*m HR+ BC to define new SoC

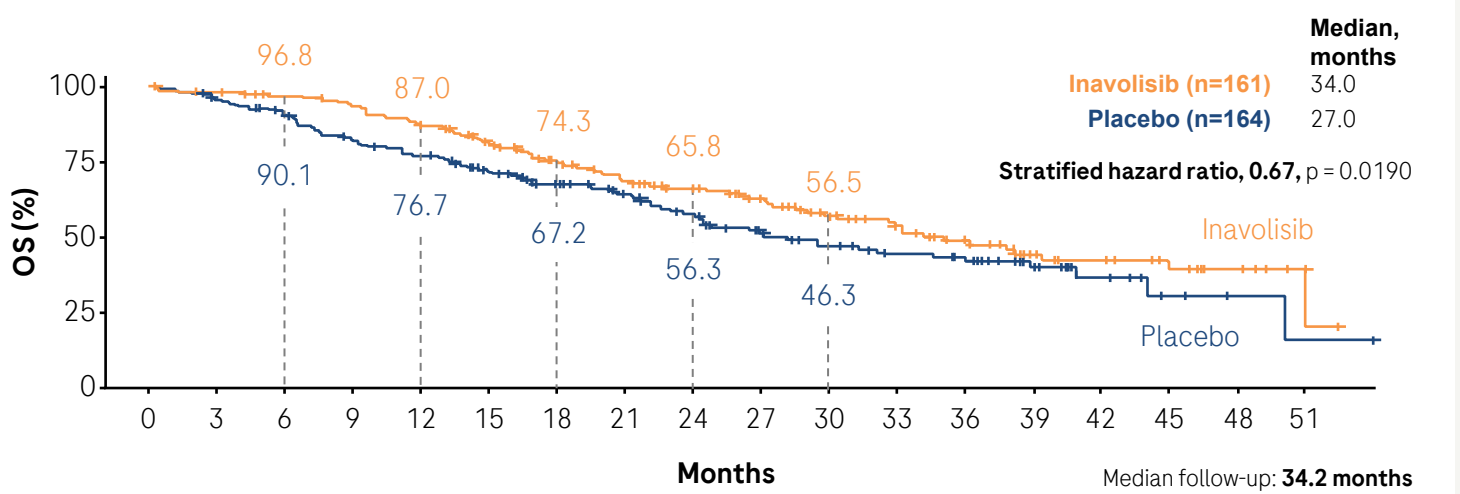
Approved in US, EU and China, additional launches ongoing

BIC PI3Kα inhibitor



- More potent and selective for PI3Kα isoform
- Better *in vivo* efficacy
- Greater safety margins allow for combination with ET and CDK4/6i at standard doses

Ph III (INAVO120): First PI3K-targeted therapy to significantly extend OS[2]

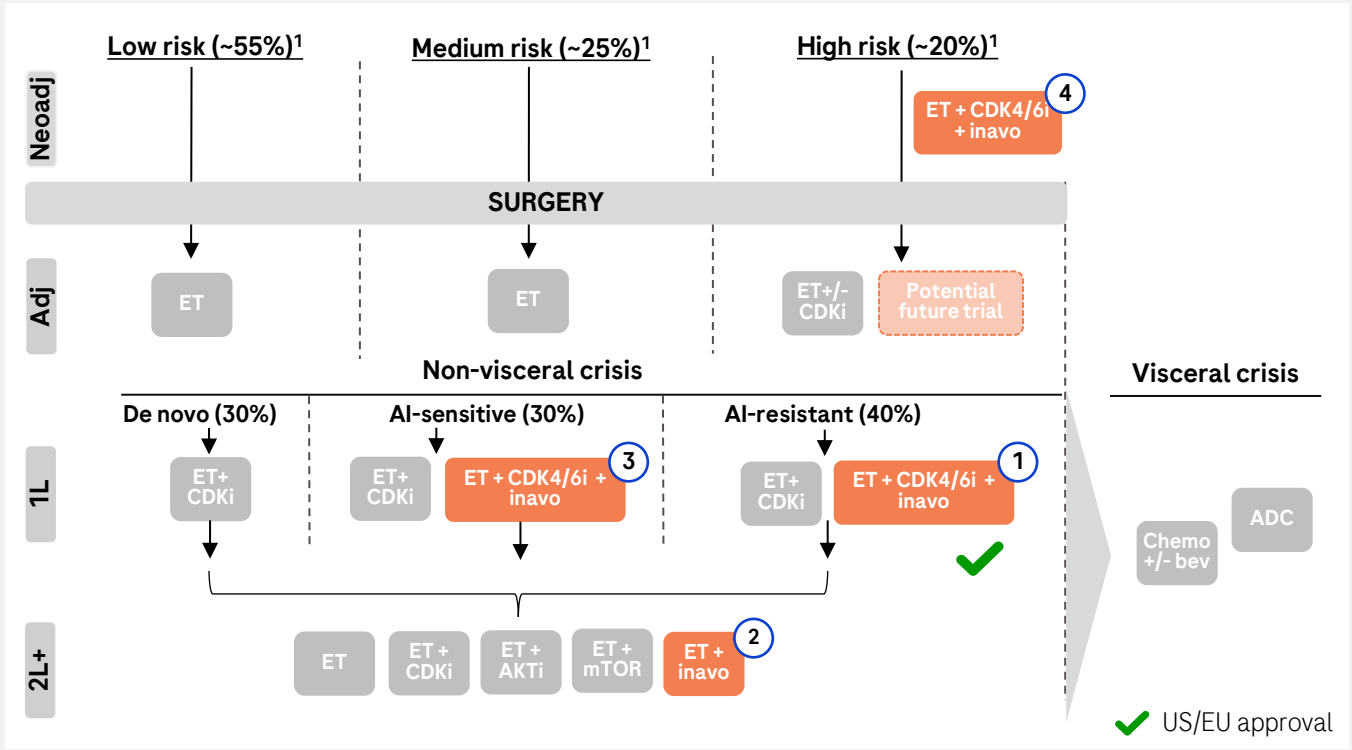


- Ph III (INAVO120) Itovebi + palbociclib + fulvestrant reduced risk of death >30% compared with palbociclib + fulvestrant alone (mOS 34.0m vs. 27.0m, HR=0.67; p=0.0190)
- PFS benefit was maintained during longer follow-up (17.2m vs. 7.3m; HR=0.42; p<0.0001)
- Median time to subsequent chemotherapy was 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 *PIK3CA*m BC

Potential for inavolisib-based regimen in *PIK3CA*m HR+ BC



1	inavolisib (INAVO120)	1L *PIK3CA*m HR+/HER2- mBC (AI resistant)	✓
2	inavolisib (INAVO121)	Post-CDK4/6i *PIK3CA*m HR+/HER2- BC	Readout 2026
3	inavolisib (INAVO123)	1L *PIK3CA*m HR+/HER2- mBC (ET sensitive)	Ph III initiated
4	inavolisib (neoTOV)	untreated, *PIK3CA*m, stage II–III, HR+/HER2- BC	Ph II initiated
	inavo + Phesgo (INAVO122)	1L *PIK3CA*m HER2+ BC	

✓ US/EU approval

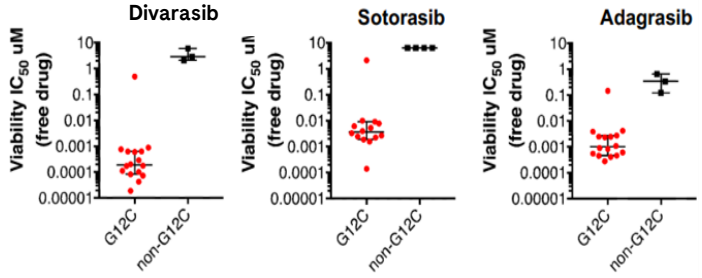
- Ph III (INAVO123) initiated in 1L ET sensitive pts
- Ph II (neoTOV) open label neoadjuvant study of Itovebi + ribociclib + letrozole initiated; additional adjuvant study considered
- Itovebi + GDC-4198 (CDK4/2i) combination to be initiated
- Potential to expand into other PIK3CAm tumors: Ph Ib/II signal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



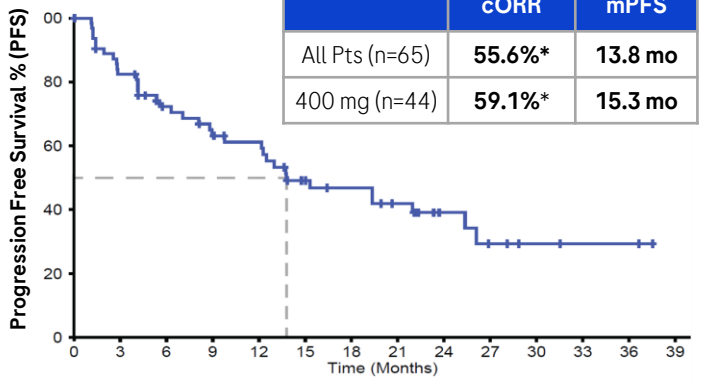
	IC_{50} (nM) / selectivity
Divarasib	**0.18 / 16,000**
Sotorasib	3.4 / >1,800
Adagrasib	1.0 / 340

- 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 adagrasib[1]
- ~12–14% NSCLC cases have G12C mut

Durable clinical activity[2]

Ph I results in 2L mNSCLC

	cORR	mPFS
All Pts (n=65)	**55.6%***	**13.8 mo**
400 mg (n=44)	**59.1%***	**15.3 mo**



- Divarasib monotherapy induced durable clinical benefit with confirmed ORR of 59.1% and mPFS of15.3 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

divarasib (KRASCENDO-1)	2L mNSCLC H2H vs. sotorasib/adagrasib	**Readout 2026**
divarasib + pembro (KRASCENDO-2)	1L mNSCLC	
divarasib (KRASCENDO-3)	eNSCLC (adjuvant)	

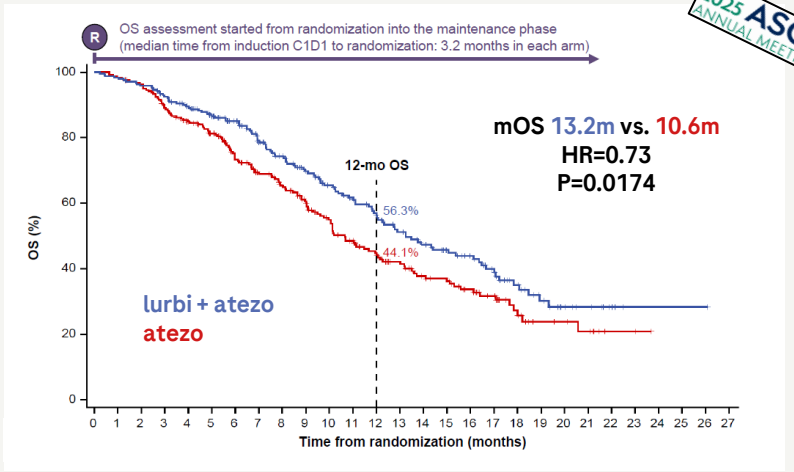
- Ph III (KRASCENDO-1): H2H trial vs. sotarasib/adagrasib in 2L expected to read out in 2026; granted FDA BTD in 2L
- Ph III (KRASCENDO-2): Chemo-free regimen 1L mNSCLC initiated
- Ph III (KRASCENDO-3): Decision to initiate study in adjuvant eNSCLC

1. Purkey H. et al., AACR 2022; 2. Sacher et al., WCLC 2024; *Patients with measurable disease (all patients n: 63, 400mg n: 44); BTD: Breakthrough therapy designation; LFT: Liver functional test; (m)NSCLC: (Metastatic) non-small cell lung cancer; (m)PFS: (Median) progression free survival; (c)ORR: (Confirmed) objective response rate

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

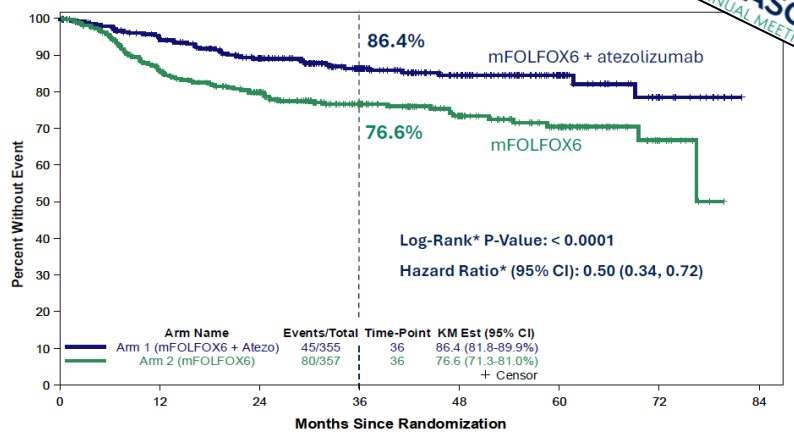
Overall Tecentriq sales expected to remain stable in the long term

IMforte: 1L maintenance in SCLC[1]



- 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

ATOMIC: dMMR colon cancer[2]



- 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

IMvigor011: MIBC

BERLIN 2025 ESMO congress

BERLIN GERMANY
17-21 OCTOBER 2025

- 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

RG6076	**englumafusp alfa combos** heme tumors
RG6538[1]	**P-BCMA-ALLO1** r/r MM
RG6540[1]	**P-CD19xCD20-ALLO1** heme tumors
RG7828	**Lunsumio SC** 3L CLL
RG6026	**Columvi monotherapy + combos** heme tumors

Ph II

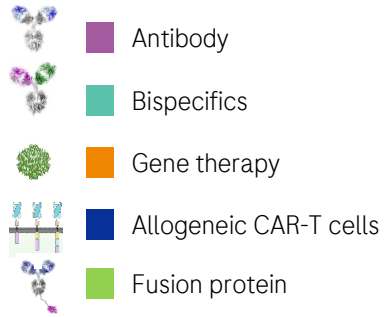
RG6512	**NXT007** hemophilia A
RG6797	**SPK-8011QQ** hemophilia A

Ph III

RG6026	**Columvi** 1L DLBCL, r/r MCL
RG7828	**Lunsumio** 2L FL, 2L DLBCL
RG6107	**PiaSky** aHUS
RG6013	**Hemlibra** Type 3 VWD
RG6160	**cevostamab** r/r MM

Registration

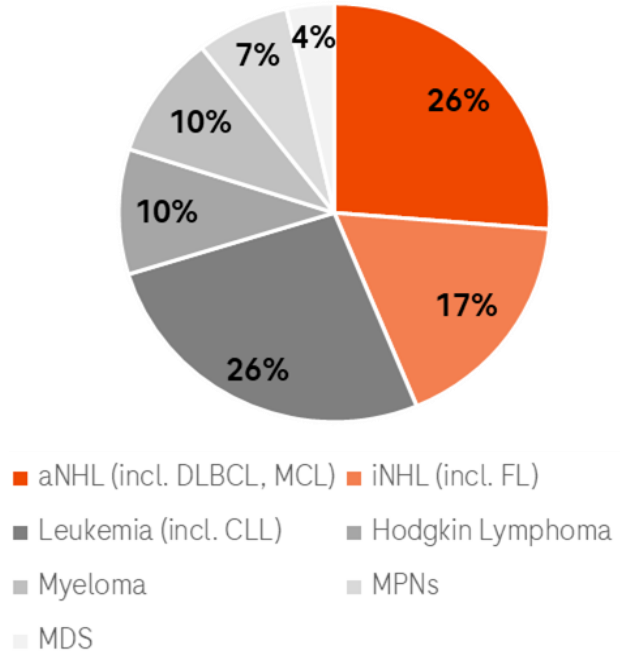
RG7828	**Lunsumio SC** 3L FL



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 malignancies[1]



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		

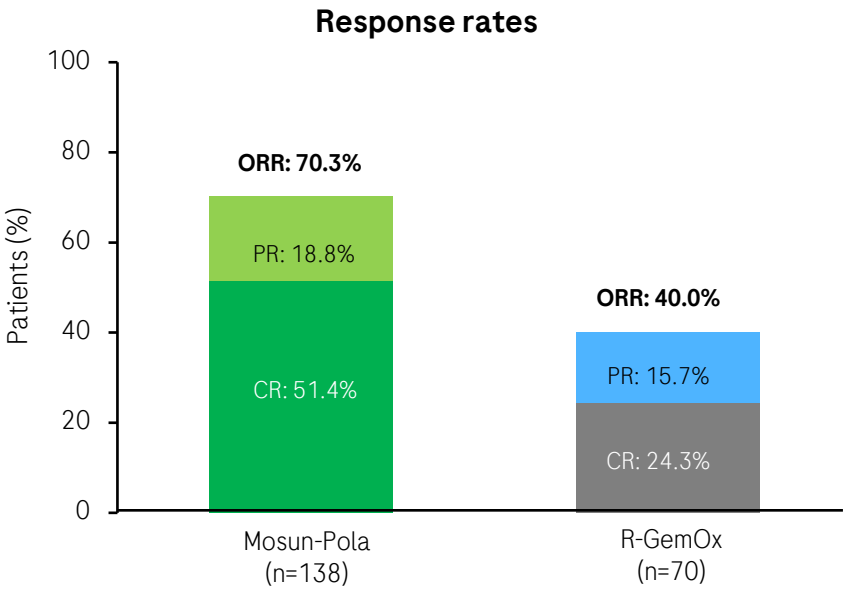
1. The Leukemia & Lymphoma Society. Facts 2022-2023. Updated Data on Blood Cancers https://www.lls.org/ booklet/facts-updated-data-blood-cancers;
CAR: chimeric antigen receptor; CLL: Chronic lymphocytic leukemia; DLBCL: Diffuse large B-cell lymphoma; FL: Follicular lymphoma; MCL: Mantle cell lymphoma;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

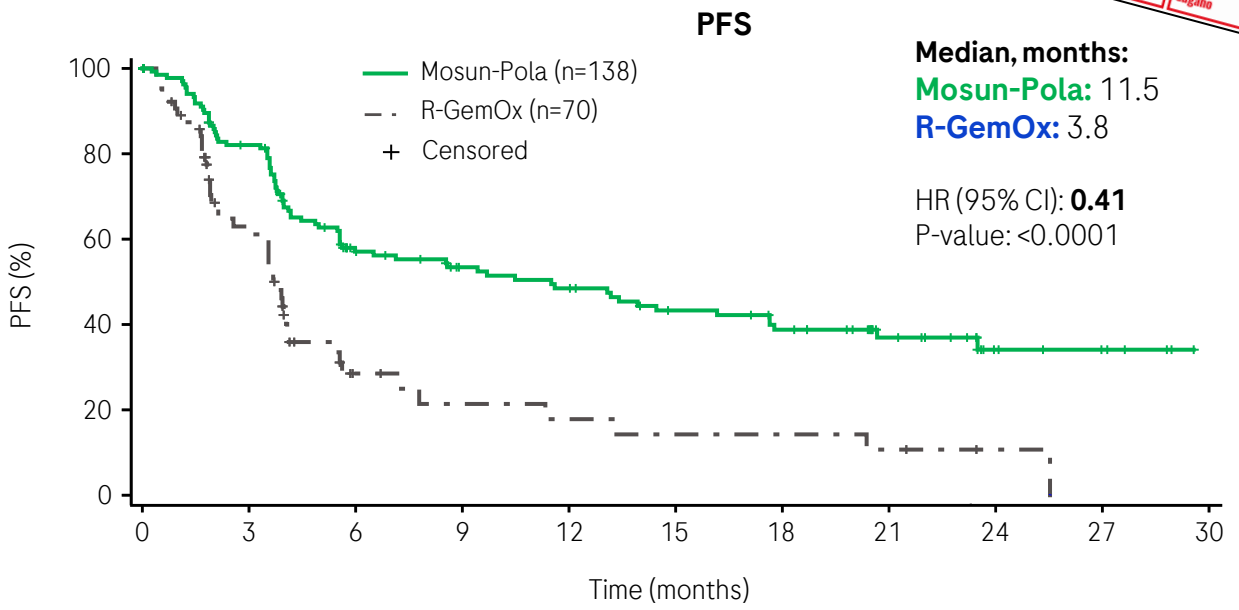
Ph III (SUNMO): Chemo-free combo of two unique MoAs in 2L DLBCL

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

Roche
Lunsumio mosunetuzumab
POLIVY polatuzumab vedotin

Ph III (SUNMO) results for Lunsumio+Polivy in 2L R/R aggressive LBCL[1]





- 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 DLBLC
- 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

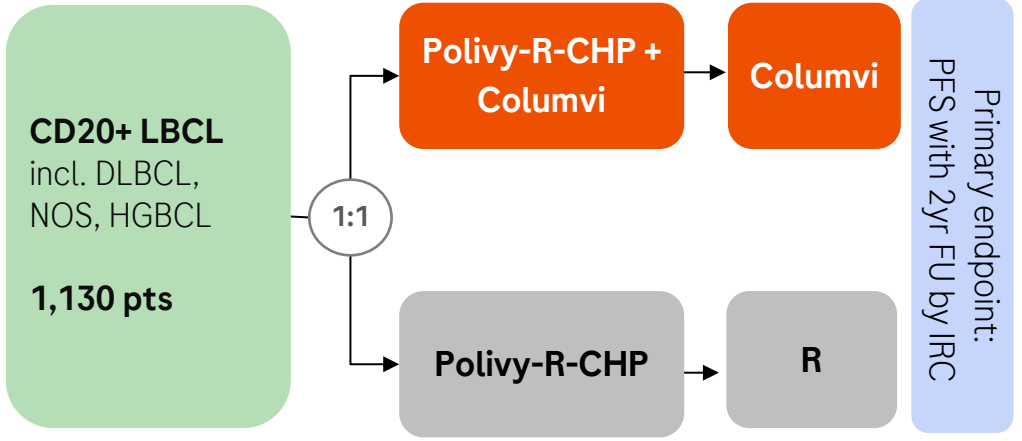
Early data support Columvi's combinability with current SoC, with high response rates and low CRS rates

Ph Ib: High response rates and durable remissions[1]

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

- 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%

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



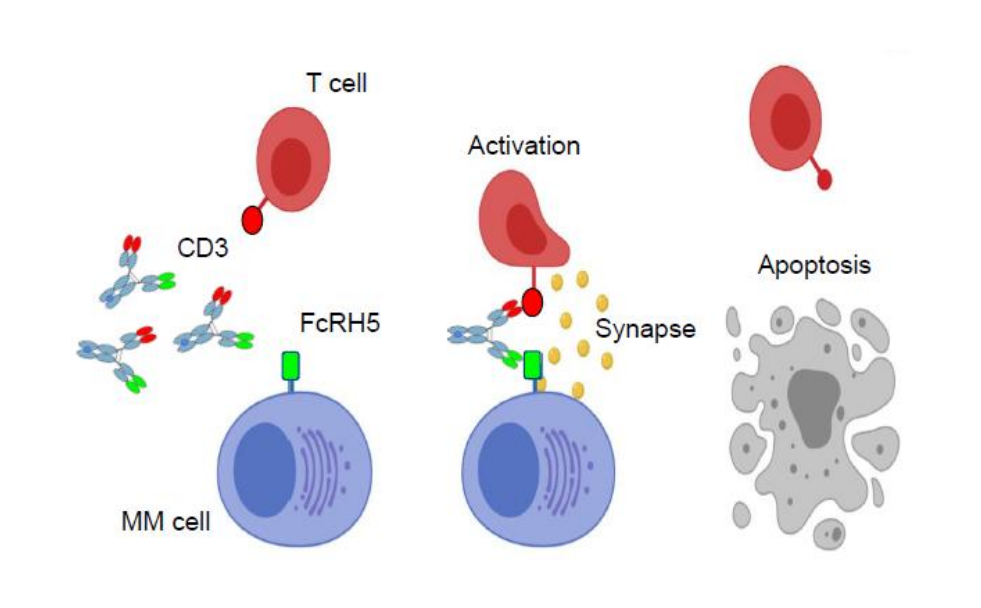
- Multi-regional Phase III study combining the efficacy of Columvi and Polivy-R-CHP in the outpatient setting
- Recruitment nearly completed
- Results expected in 2027

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

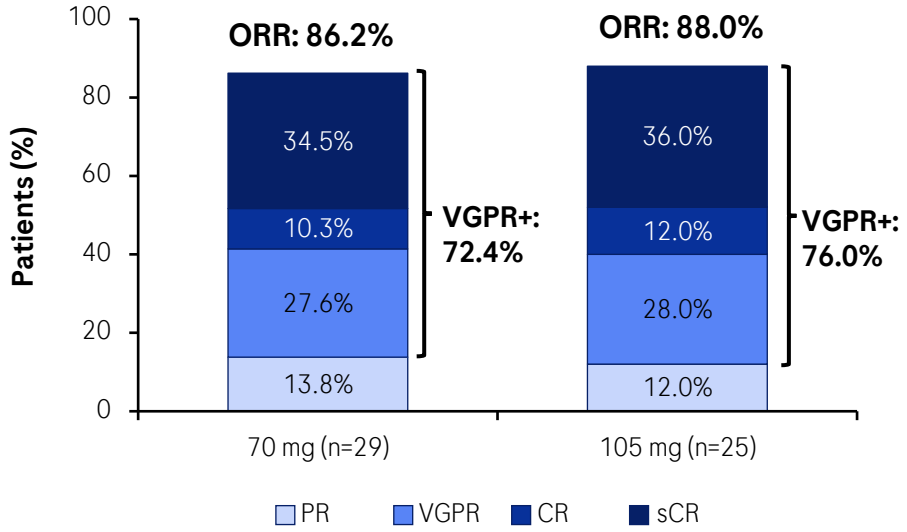
Ph III (CEVOLUTION) Go decision in 2L+ r/r MM to create treatment optionality for patients

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 MM[1]



- 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

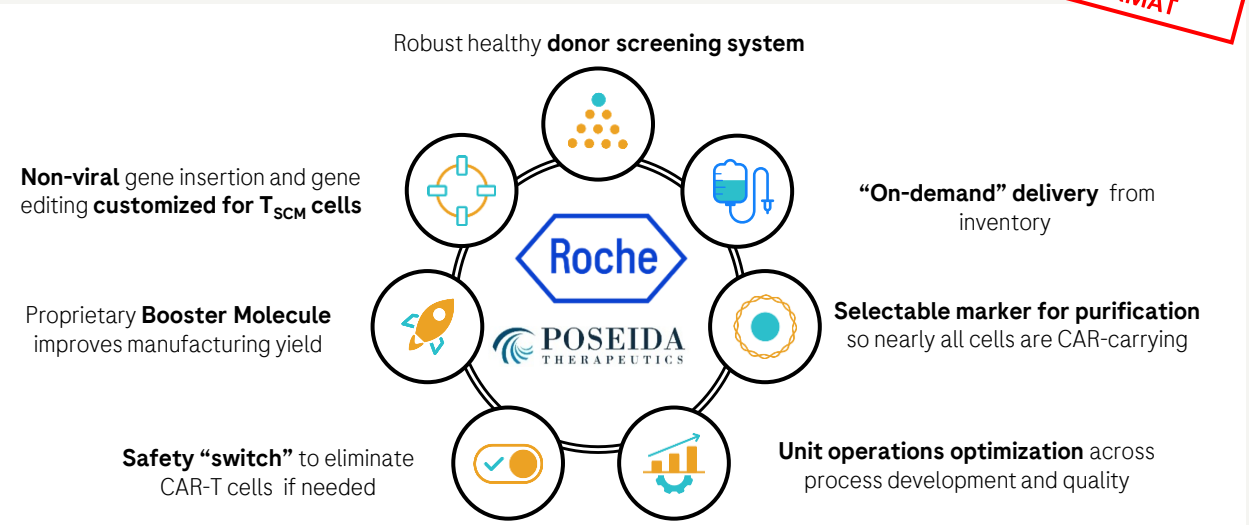
Source: Li et al., Cancer Cell 2017; 1. Mian H et al., IMS 2025; BCMA: B cell maturation antigen; FcRH5: Fc receptor-homolog 5; FIC: First-in-class; IMiD: immunomodulatory imide drugs; LoT: Line of treatment; MM: Multiple myeloma; MoA: Mechnism of action; ORR: Overall response rate; Pd: Pomalidomide and dexamethasone; PoC: Proof of concept; r/r: Relapsed/refractory; VGPR: Very good partial response

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

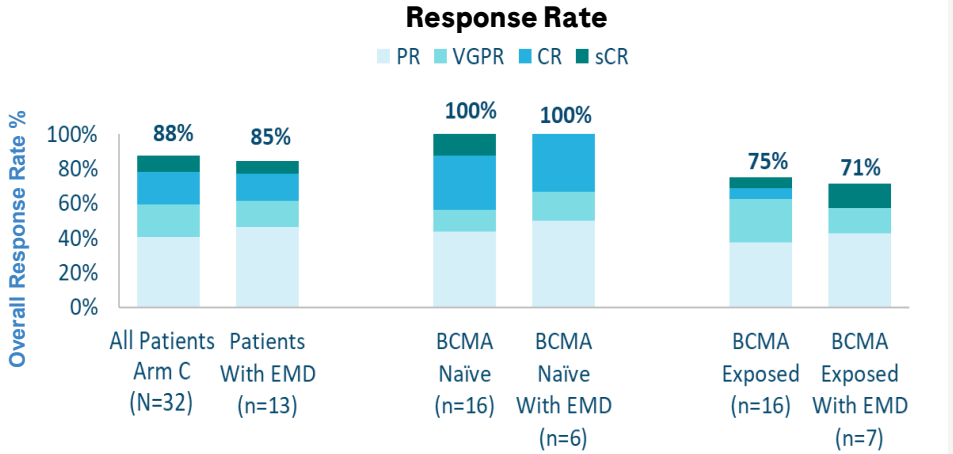
Roche allogeneic CAR-Ts key features

FDA ODD + RMAT



- Technology features set Roche ALLO-CARTs apart as potentially best-in-class
- FDA awarded P-BCMA-ALLO1 ODD for treatment of MM and RMAT for r/r MM
- P-CD19CD20-ALLO1 currently in Ph I for NHL

P-BCMA-ALLO1 highly clinically active[1]



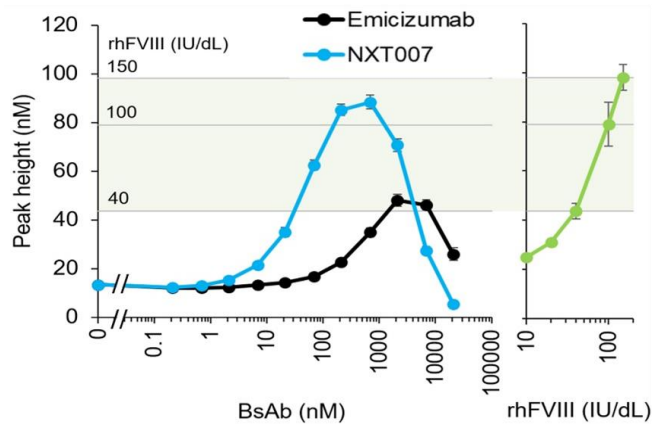
- Strong clinical activity in heavily pretreated population, including in BCMA-exposed patients
- Full ITT population received lymphodepletion and P-BCMA-ALLO1; several pts received treatment in outpatient setting
- Well tolerated, with no GvHD and low rates of CRS

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

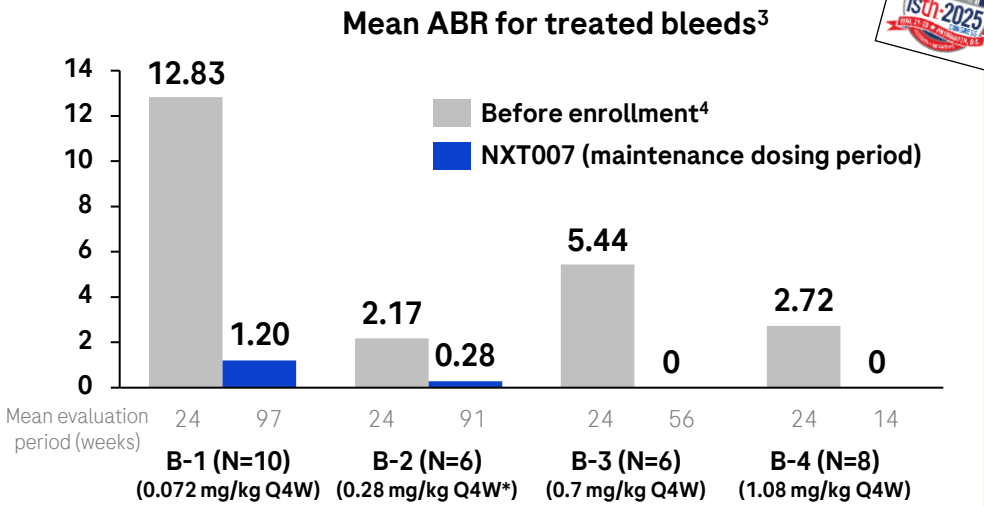
No treated bleeds in cohorts B-3 and B-4 during NXT007 prophylaxis; Ph III program to initiate in 2026

Thrombin generation activity[1]



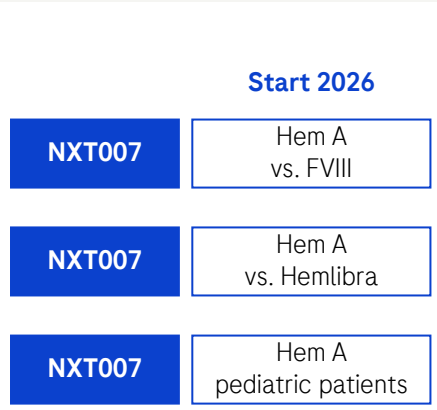
- NXT007 is intended to achieve zero treated bleeds; ~30-fold more potent than Hemlibra
- *In vitro* assay indicates that thrombin generation is well into the normal range of people without Hem A

Ph I/II (NXTAGE Part B) in Hemophilia A[2]



- 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



- 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

Roche

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	Examples
Therapeutic modalities	Brainshuttle™ in AD (trontinemab) and MS (RG6035) Allo-CAR-T (P-CD19 CD20-ALLO1) to enter Ph I in MS
Pharma + Dia partnership	TRAVELLER prescreening program in AD uses blood-based biomarkers to reduce diagnostic burden (CSF/PET) Elecsys® NfL blood-test detects disease activity
Prevention approaches	Initiating Ph III trial of trontinemab in Preclinical AD
E2E investment	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

AD: Alzheimer's Disease; CSF: Cerebrospinal fluid; MS: Multiple Sclerosis; NfL: Neurofilament light chain; PD: Parkinson's Disease; PET: Positron emission tomography

Neurology pipeline

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

Phase I

RG6035	**Brainshuttle™ CD20** Multiple Sclerosis	
RG6540	**P-CD19 CD20-ALLO1*** Multiple Sclerosis	
RG6182	**MAGLi** Multiple Sclerosis	
RG6662	**HTT miRNA GT (SPK-10001)** Huntington's	RD
RG6434	**undisclosed** Neurodegenerative disorders	
RG6418	**selnoflast** Parkinson's	

Phase II

RG1594	**Ocrevus SC OBI** MS	
RG6289	**nivegacetor (GSM)** Alzheimer's	
RG6042	**tominersen** Huntington's	
RG6237 + RG7916	**emugrobart (GYM329) + Evrysdi** SMA	RD
RG6237	**emugrobart (GYM 329)** FSHD	RD
RG6356	**Elevidys[1]** DMD (0-<4 y.o.)	RD
RG6168	**Enspryng** DMD	RD
RG7816	**alogabat** Angelman Syndrome	

Phase III

RG6168	**Enspryng** MOG-AD	RD
RG6168	**Enspryng** AIE	RD
RG7845	**fenebrutinib** RMS	
RG7845	**fenebrutinib** PPMS	
RG6356	**Elevidys[1]** DMD (>8 y.o.[3])	RD
RG7935	**prasinezumab** Parkinson's	
RG6102	**trontinemab** Alzheimer's	

Registration

RG6356	**Elevidys[1]** DMD[2]	RD

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

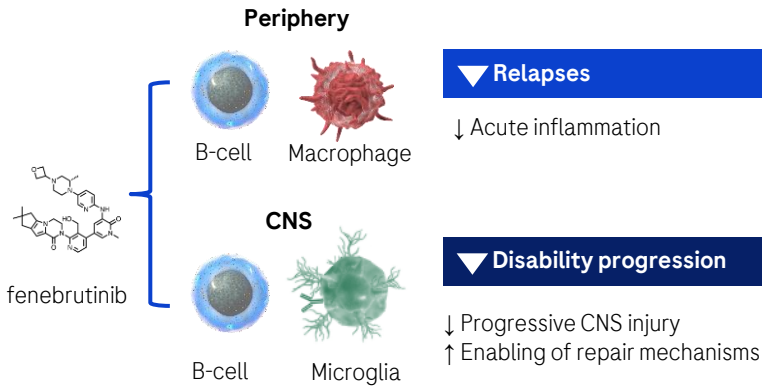
Small molecule
Antibody
Gene therapy
Brainshuttle™
Locked nucleic acid/antisense
Allogeneic CAR-T

* 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

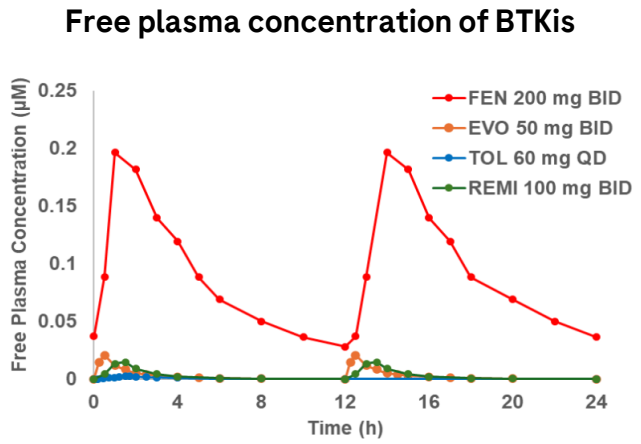
The only BTKi that achieves CSF concentrations >IC90 for B-cells and microglia for 24h[1]

Dual mechanism of action



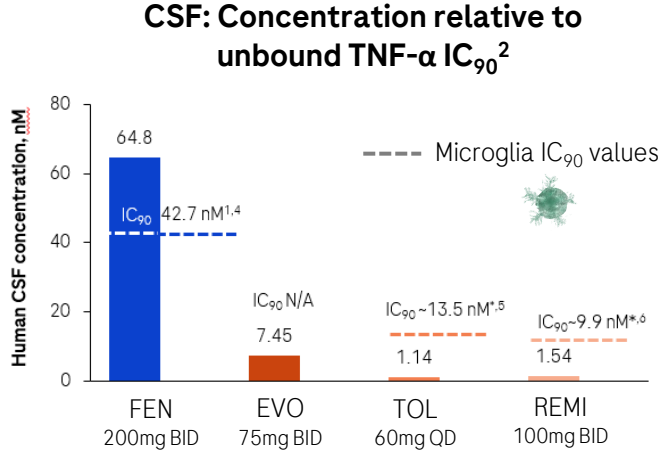
- BTKi dual mechanism of action, inhibiting both B-cells and myeloid-lineage cells (macrophages, microglia), has the potential to impact both relapsing and progressive disease biology in MS
- Orals continue to make up around 30% of MS market, but currently offer modest efficacy

Optimized PK profile[1]



- 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 Penetration[1]



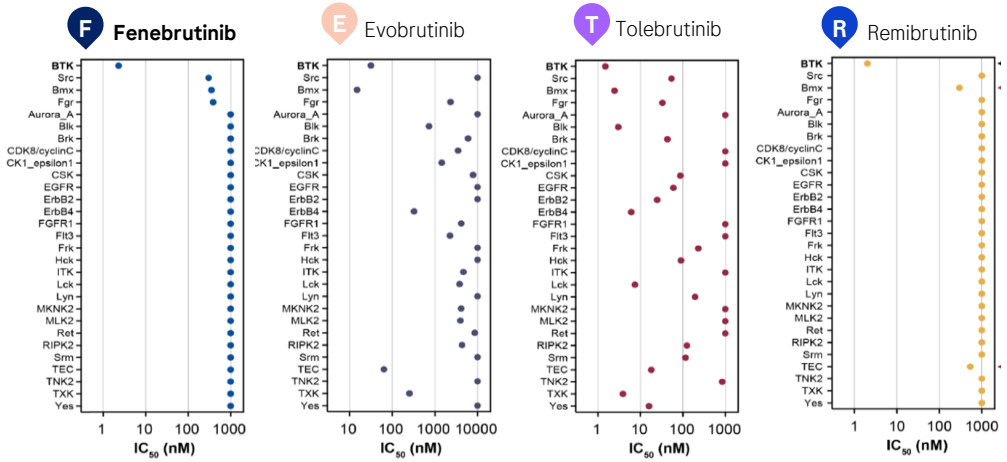
- Optimized PK profile allows for plasma and CSF concentrations at biologically relevant levels (> IC_{90} for B cells and microglia) for a 24-hour dosing cycle
- Fenebrutinib is the only BTKi that achieves near-maximal inhibition of microglia in the CNS

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 selectivity[1]



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

Fenebrutinib development program

Ind.	Vs.	Ph I / Ph II / Ph III	
RMS	placebo	*FENopta* ✓	
RMS	teriflunomide	*FENhance 1*	2026
RMS	teriflunomide	*FENhance 2*	2026
PPMS	Ocrevus	*FENtrepid*	2025

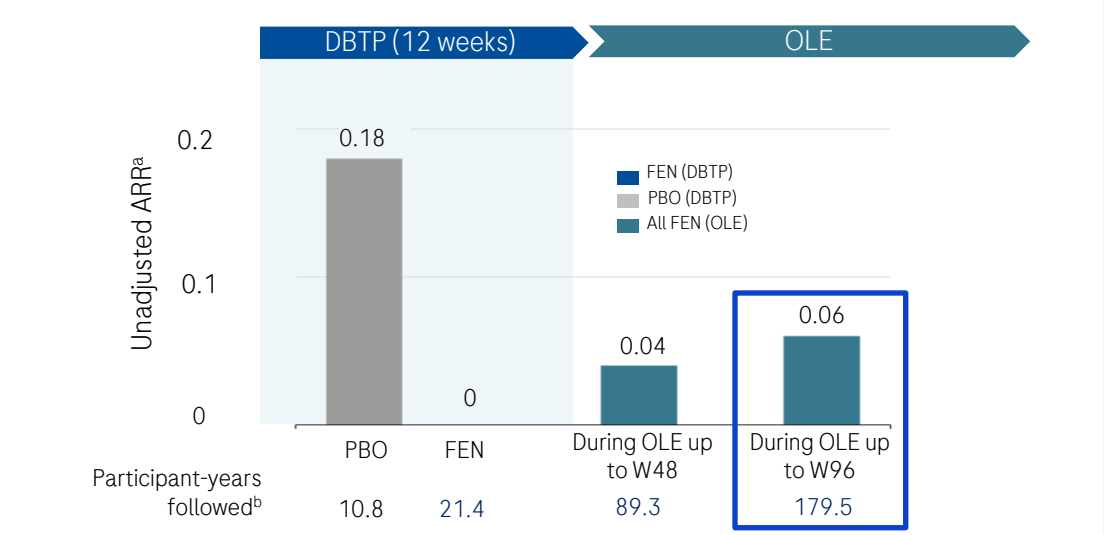
- Ph III (FENtrepid) in PPMS results expected in Q4 2025; FENtrepid is the only H2H study vs Ocrevus
- FENhance1/2 results in RMS expected in early 2026

1. Johnson et al. MSVirtual 2020; PPMS: Primary progressive multiple sclerosis; RMS: Relapsing multiple sclerosis

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

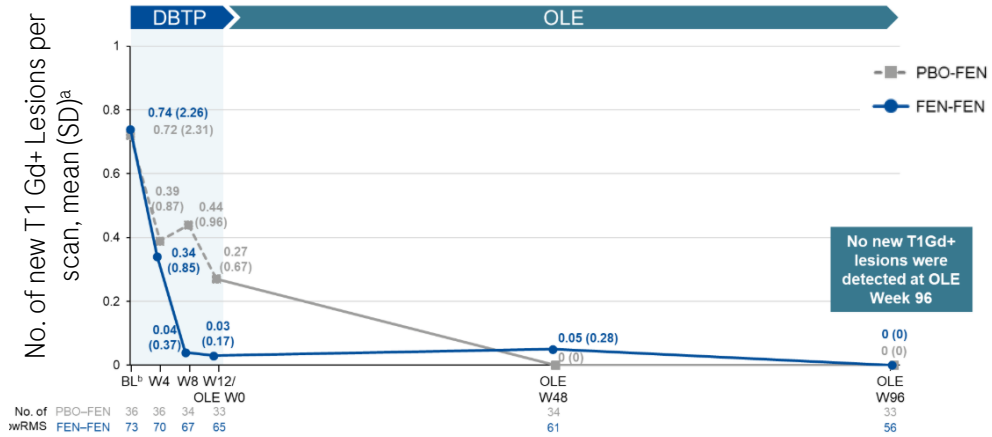
Participants treated with fenebrutinib had low clinical disease activity through week 96

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

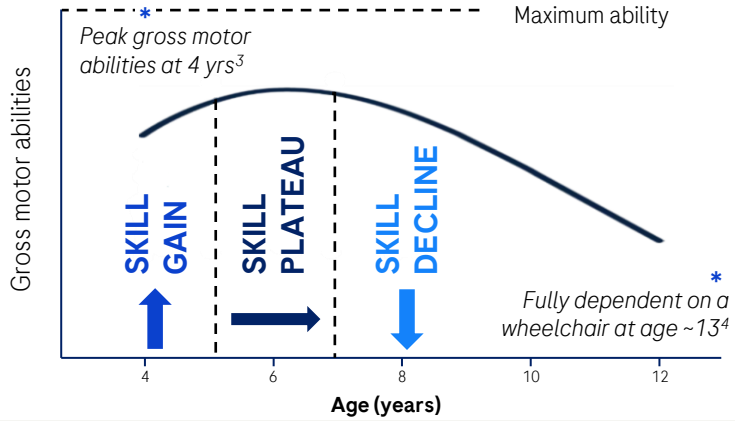
ARR: Annualized relapse rate; BL: Baseline; DBTP: Double-blind treatment period; FEN: Fenebrutinib; OLE: Open-label extension; PBO: Placebo, pwRMS: Patients with relapsing multiple sclerosis; Bar-Or et al. (2025) CMSC a. Unadjusted annualized relapse rate calculated as total number of protocol-defined relapses divided by total participant-years followed; b. Participant-years followed during treatment. A participant is assumed to be receiving treatment from their initiation of any study drug through study drug discontinuation, end of their double-blind treatment or by OLE Week 96 visit, the last participant contact date or the clinical cutoff date, whichever is earliest. Clinical cutoff date: Jan 29, 2025

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

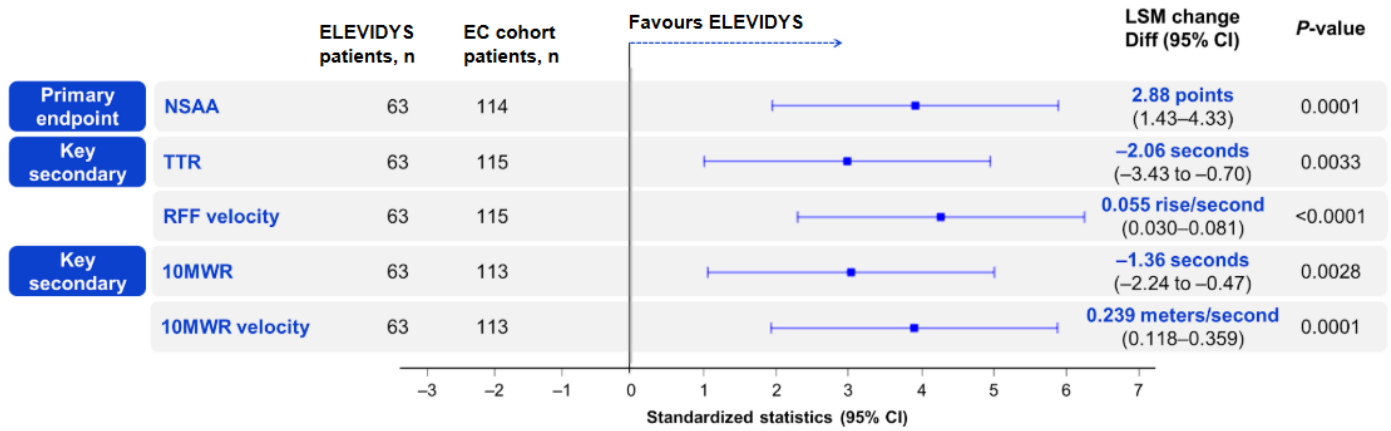
Mean trajectory of DMD natural history gross motor abilities[1,2]



- 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 control[3]



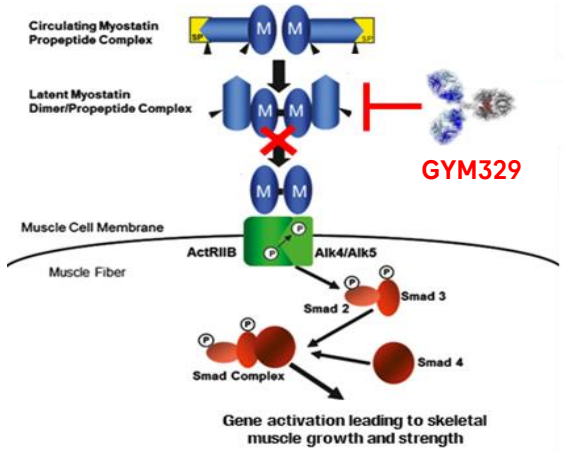
- Elevidys has demonstrated stabilizing/slowing of disease progression with durable effects on functional muscle; consistent and manageable safety profile in ambulatory DMD[1]
- Regulatory status: Plan to engage with EMA following negative CHMP opinion; approved in JP in ambulatory pts 3-7 and insurance coverage discussions in planning; shipping has resumed for ambulatory patients in most other countries referencing FDA approval[4]
- >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 (TTRand 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 sweeping[1] 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 therapies[2]

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

	Ph I	Ph II	Ph III
Emugrobart + Evrysdi		MANATEE SMA	2025
Emugrobart		MANOEUVRE FSHD	2025

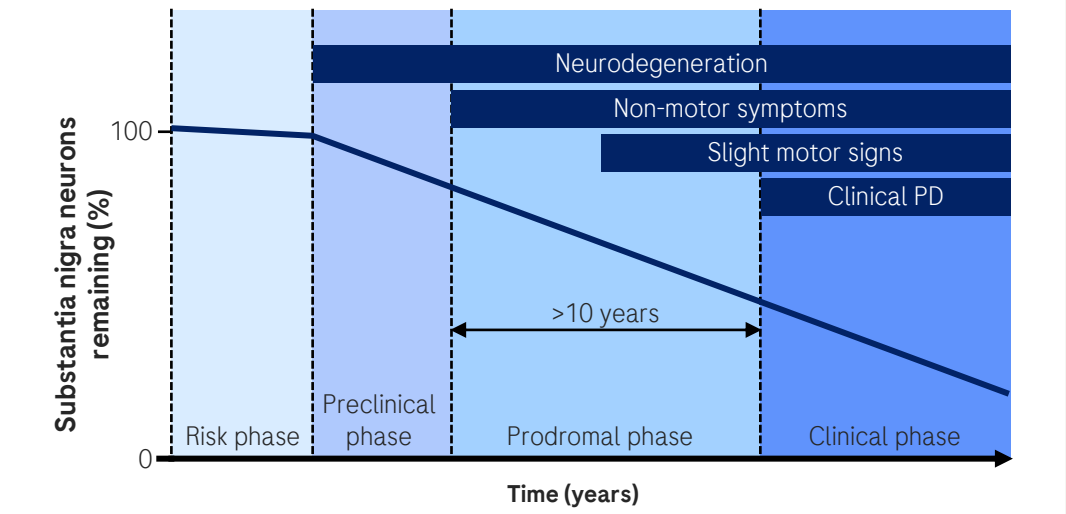
- SMA: Emugrobart has opportunity to be first SC administered anti-myostatin, with potential for differentiated efficacy
- FSHD: Progressive muscle wasting disease with no approved DMTs
- Potential to develop emugrobart in other neuromuscular diseases

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

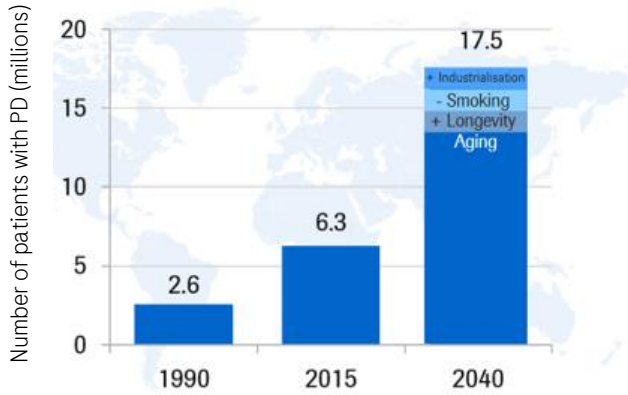
Current symptomatic treatments only address motor symptoms, but do not affect PD progression

Loss of dopaminergic neurons starts many years before onset of symptoms[1]



- Neurodegeneration starts long before onset of motor symptoms[2]
- At time of diagnosis, ~40–60% of dopamine-producing cells in the substantia nigra have already been degenerated[3]
- The dopaminergic pathway is involved in controlling movement, anticipating rewards, learning from mistakes, and adapting to new situations[4]

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 economy[9]

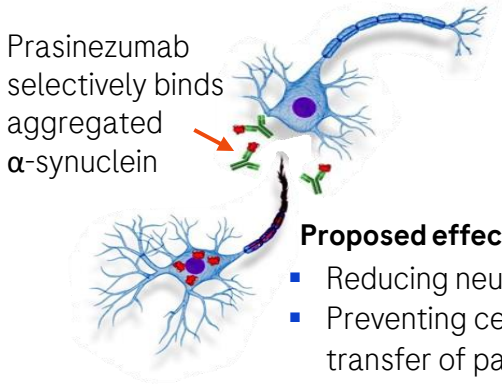
- In early PD the goal of therapy is to improve function and quality of life by enhancing dopamine levels in the brain (i.e. L-DOPA, MAO-B inh.)[10]
- After several years, the response to dopamine replacement reduces ("wearing off") with an increase in motor and non-motor complications[10]

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

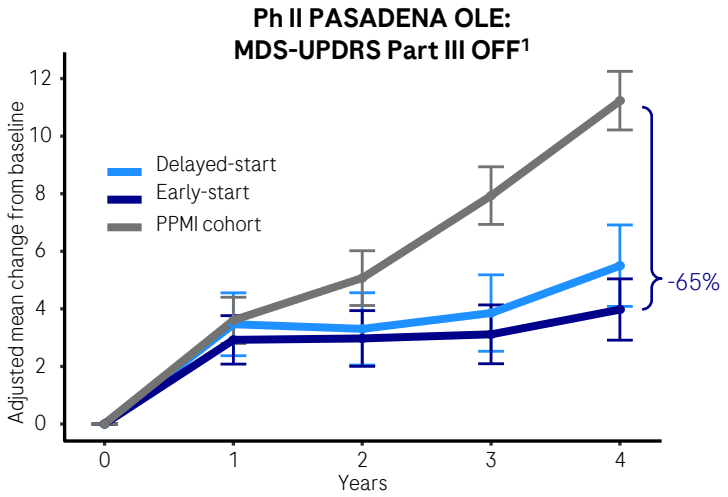
Prasinezumab (anti-α-synuclein mAb)

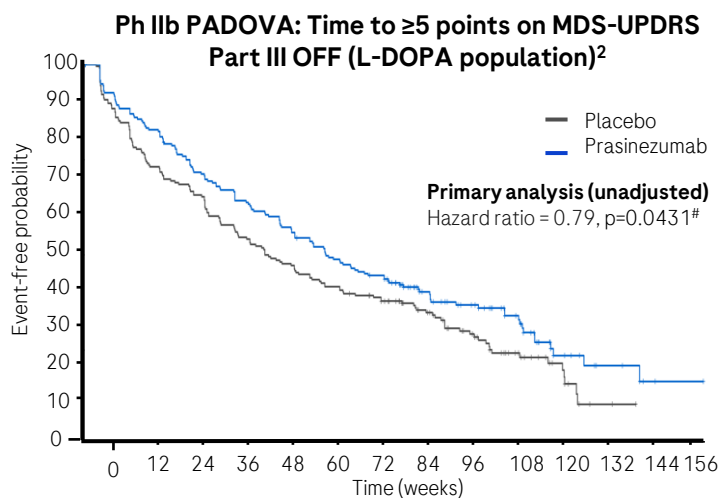


Proposed effects:

- 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





- 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

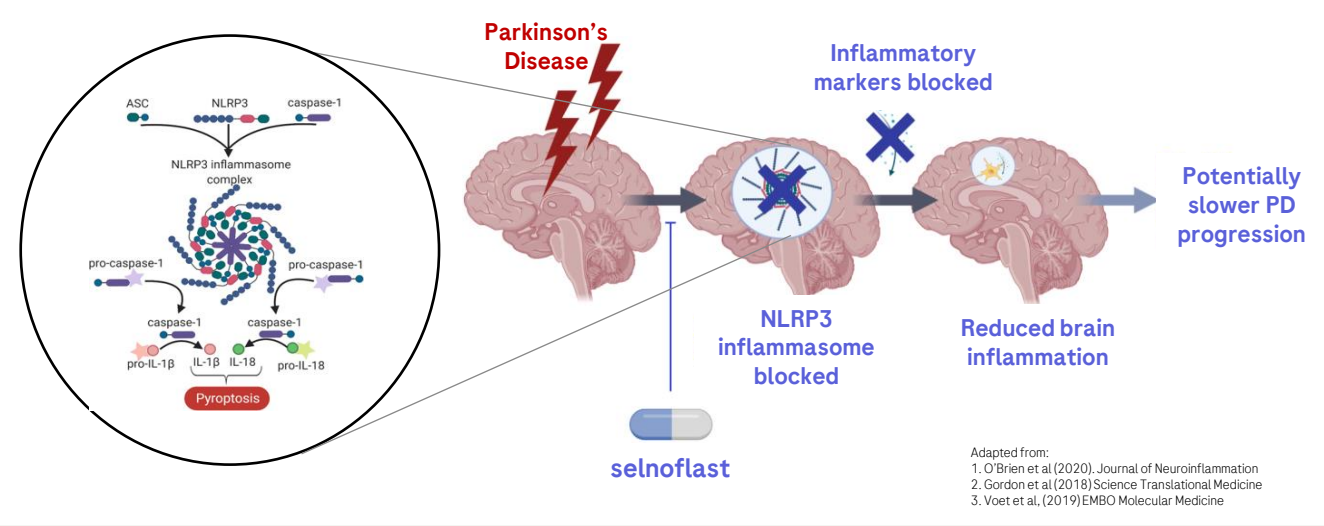
- Ph II (PASADENA) results suggest potential benefit and inform Ph III endpoint selection: MDS-UPDRS Part III scale (clinical examination) and novel time-to-event endpoint enhance feasibility of assessing disease progression
- Ph IIb (PADOVA) results add to clinical evidence and inform patient selection: 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
- Selnoflast is an active, potent, selective and reversible oral NLRP3 inhibitor

Selnoflast 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

Figure adapted from O'Brien et al (2020). Journal of Neuroinflammation. 17. 10.1186/s12974-020-01778-5; Gordon et al (2018) Science Translational Medicine.10(465); Voet et al, (2019) EMBO Mol Med.11(6):e10248; CVRM: Cardiovascular, renal and metabolism; MACE: Major adverse cardiovascular events; NLRP3: NOD-, LRR- and pyrin domain-containing protein 3

Considerations for successful drug development in AD

Limitations of current AD therapies

Blood–brain barrier penetration
Ensuring drug is reaching site of disease

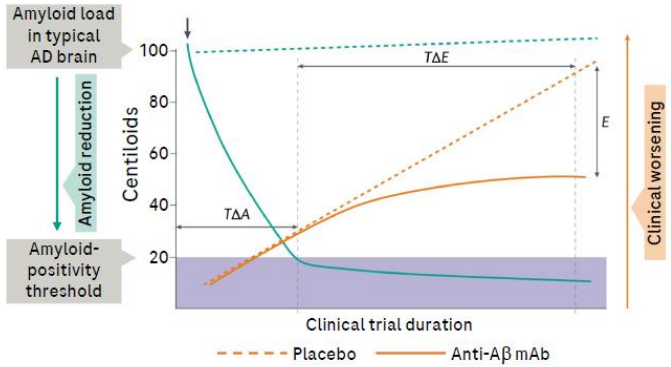
Rapid and deep reduction in amyloid load
To deliver the potential for maximum clinical benefit

Overall safety profile
To detect and effectively manage risk

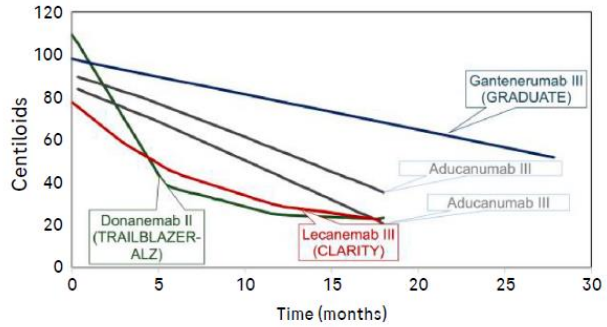
Changes in established fluid biomarkers of disease
To demonstrate effect on AD pathology downstream of amyloid

Amyloid removal associated with clinical response

Predicted relationship between amyloid removal and clinical response[1]



Actual relationship between amyloid removal and clinical response in trials[2]



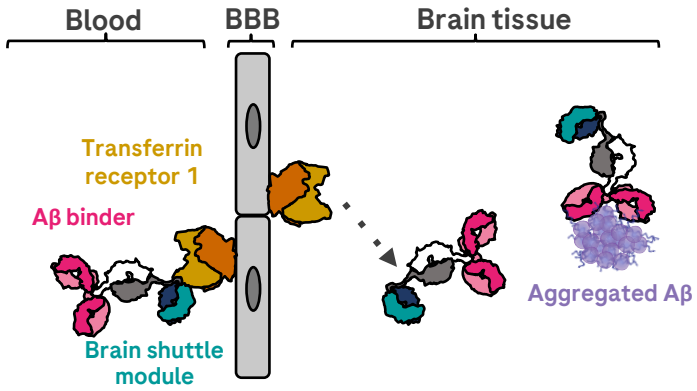
- Converging evidence from anti-amyloid immunotherapy trials suggests the rate and amount of clearance of amyloid is important[1]
- An amyloid-negative threshold of approximately 24 CL appears to be critical for clinical response[1]

In the context of a clinical trial, the shorter the duration required to reach low amyloid levels (TΔA), the longer the period available to reveal statistically significant clinical efficacy between treatment and placebo groups (TΔE); 1. Karran E & De Strooper B. Nat Rev Drug Discov. 2022;21:306-318; 2. Hardy J & Mummery C. Brain 2023;146:1240–1242; AD: Alzheimer's Disease; CL: centiloid

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-Aβ mAb)

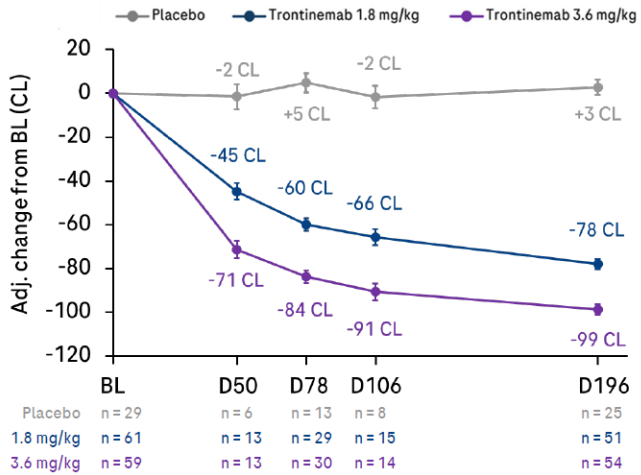


Active TfR1 transport at the capillary level

- Aß-targeting mAb specifically engineered for efficient TfR-1-mediated transport across the BBB[2]
- 8-fold increase in CSF/plasma ratio was observed with trontinemab vs. standard antibody[2]

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

Ph Ib/IIa trontinemab: Dose-dependent amyloid reduction



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

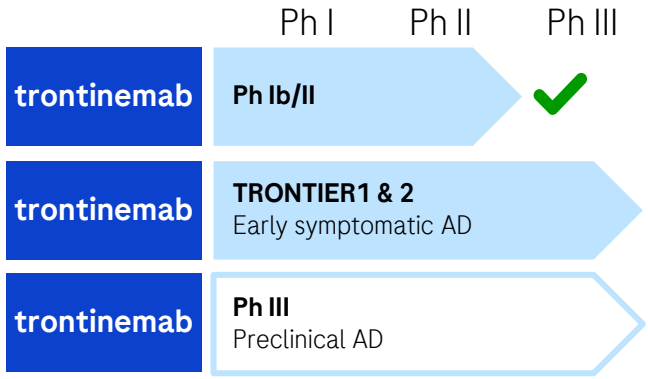
- 91% of participants were below the amyloid positivity threshold at 28w[1]
- Substantial amyloid reduction in all patients (minimum -47 CL change from baseline)
- Pronounced effect on fluid biomarkers: CSF pTau181 decreased 27% at 25w
- <5% incidence of ARIA-E: All events were mild/mild+ in radiologic severity, resolution (MRI) after 4–8 weeks

Kulic L et al., AAIC 2025, 1. Amyloid positivity threshold defined as values = 24 CL.; 2. Kerchner G, et al. Presented at AAIC 2024; Aβ: Amyloid β; AD: Alzheimer's disease; AE: Adverse event; ARIA: Amyloid-related imaging abnormalities; BBB: Blood-brain barrier; C: Cohort; CL: Centiloid unit; mAb: Monoclonal antibody; Pbo: Placebo; Pt: Patient; q4w: Every 4 weeks

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

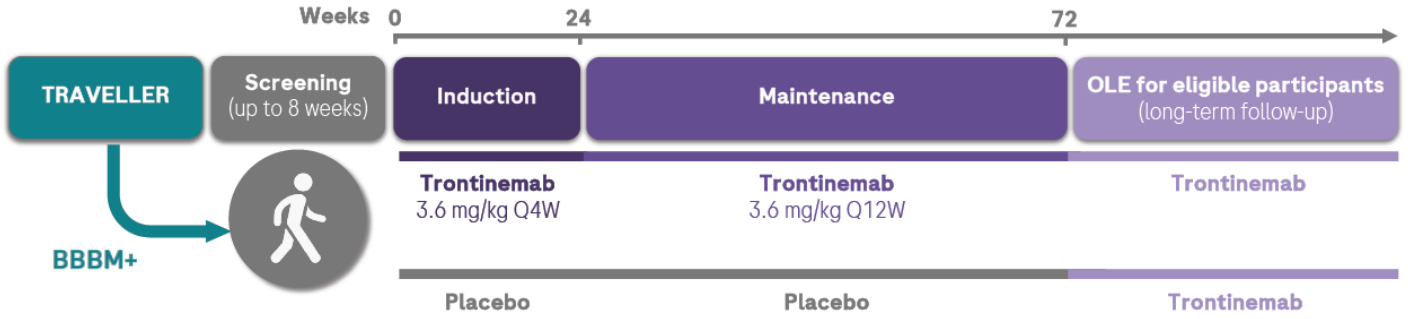
Ph III trial in preclinical AD to be initiated

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

Kulic L et al., AAIC 2025; AD: Alzheimer's disease; q4w: Every 4 weeks; q12w: Every 12 weeks

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

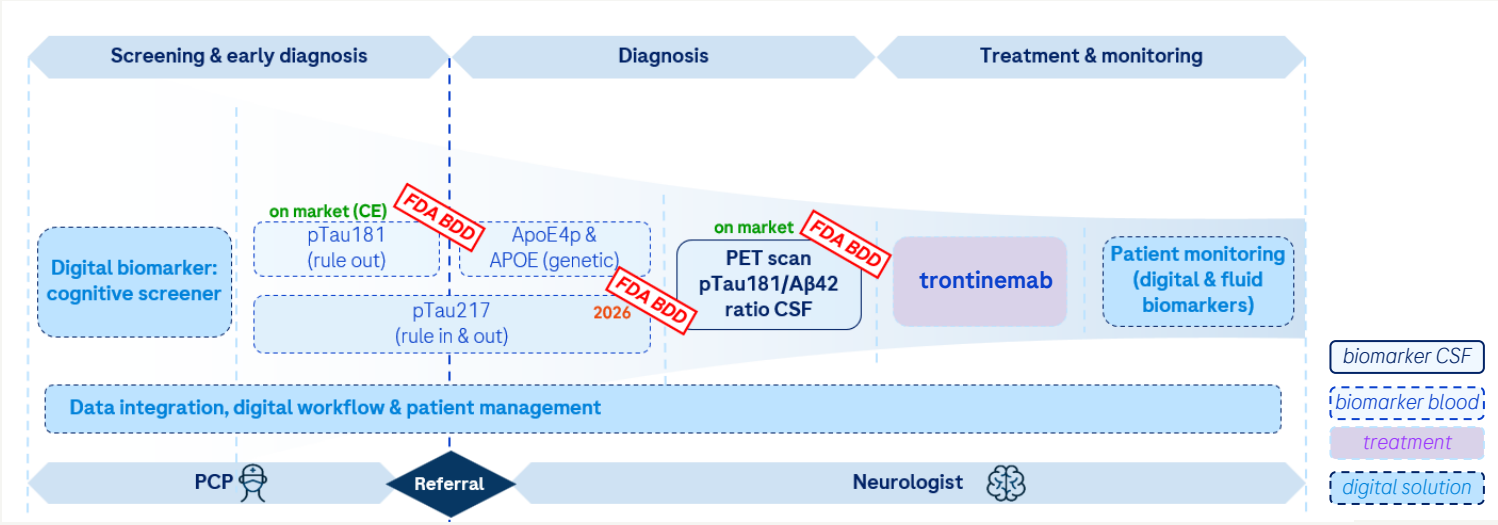
>55m people
with dementia, with AD being the most common cause

75% of pts undiagnosed
Despite showing symptoms[2]

2.8 years to diagnosis
On average post symptom onset[3]

- 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



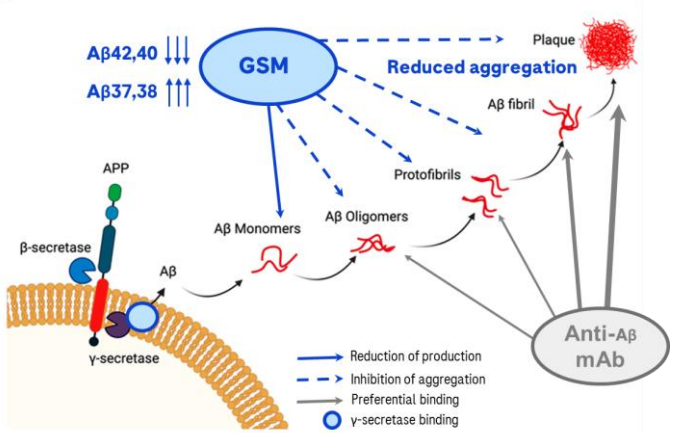
- Elecsys® pTau217 blood-based biomarker test provides comparable results to PET scan and CSF diagnostics for rule-in and rule-out diagnosis of amyloid pathology (launch in 2026)
- Development of blood-based biomarkers enables early screening, including of preclinical population
- Elecsys® pTau217 test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

Aβ42: Amyloid-beta 42; AD: Alzheimer's disease; APOE: Apolipoprotein E; BDD: Breakthrough device designation; CSF: Cerebrospinal-fluid; DMT: Disease modifying therapy; PCP: Primary care providers; PET: Positron emission tomography; pTau: Phosphorylated tau

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

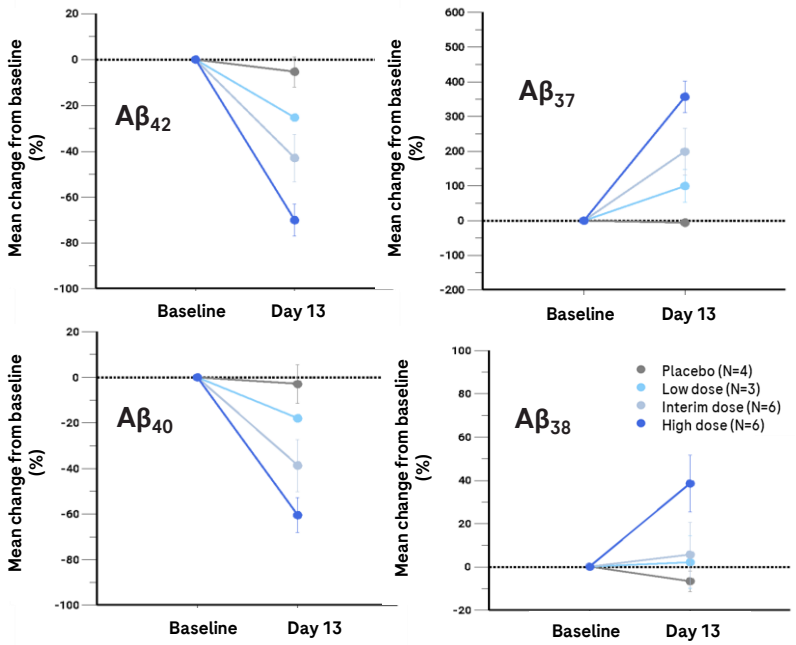
Targeting amyloid precursor protein processing to prevent Aβ-aggregation

GSM to reduce Aβ aggregation[1]



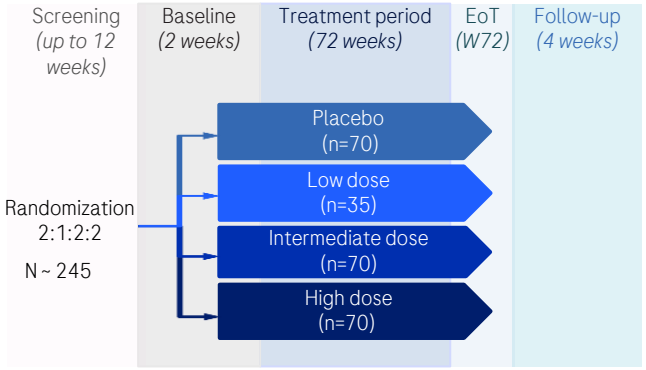
- Nivegacetor is a highly potent and selective oral GSM
- GSMs alter APP processing: less Aβ42/40 and increase of Aβ38/37
- GSMs prevent amyloid accumulation and halt plaque formation in animal models of AD

Ph I dose escalation results[2]



- Once daily intake of nivegacetor decreased Aβ42/40 and increased Aβ37/38 in CSF dose-dependently (HV)

Ph IIa (GABriella) study design[3]



- 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; Aβ: 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		Examples
Optimize pathways	*Improve known pathways/targets for transformational benefit*	Multiple approaches for enhanced B-cell depletion, targeting multiple disease areas (i.e. Gazyva, Lunsumio, CD19xCD3, and CAR-T)
Combinations	*Target multiple pathways to achieve improved efficacy and deeper remission*	p40xTL1A combines orthogonal, validated targets to raise efficacy
Endotypes	*Identify patients' subsets to improve efficacy and guide therapy*	Afimkibart IBD trials explore biomarkers to predict better response to treatment
Cure	*Aim for curative treatment to achieve long-term remission*	P-CD19CD20-ALLO1 CAR-T has potential to achieve durable B-cell depletion and immune reset
E2E investment	*Invest end-to-end in select disease areas from discovery, R&D, to commercialization*	Inflammatory bowel disease (IBD) and chronic obstructive pulmonary disease (COPD)

IBD: Inflammatory bowel disease; CAR-T: Chimeric antigen receptor T cell

Immunology pipeline

Broad development portfolio across several disease areas

Phase I

RG6382	**CD19 x CD3** SLE
RG6418	**selnoflast** Asthma
RG6421	**TMEM16A potentiator** COPD
RG6631	**afimkibart** MASH
RG6377	**undisclosed** IBD
RG6540	**P-CD19CD20-ALLO1*** SLE
CHU	**anti-HLA-DQ2.5 x gluten peptides** Celiac disease
CHU	**RAY121 (anti-C1s recycling Ab)** Immunology

Phase II

RG6536	**vixarelimab** IPF/SSc-ILD
RG7828	**Lunsumio** SLE
RG6631	**afimkibart** Atopic dermatitis
RG6631	**afimkibart** Rheumatoid arthritis
RG6730	**p40 x TL1A** Ulcerative colitis
RG6287	**flizasertib** CS-AKI

Phase III

RG7159	**Gazyva** Membranous nephropathy
RG7159	**Gazyva** SLE
RG7159	**Gazyva** Childhood onset INS
RG6149	**astegolimab** COPD
RG6299	**sefaxersen** IgAN
RG6631	**afimkibart** Ulcerative colitis
RG6631	**afimkibart** Crohn's disease

Registration

RG7159	**Gazyva** Lupus nephritis ✓

Data in-house and to be discussed with regulators and shared at an upcoming medical meeting

- Immune-mediated kidney diseases
- Respiratory & allergy
- Gastroenterology
- Others/undisclosed

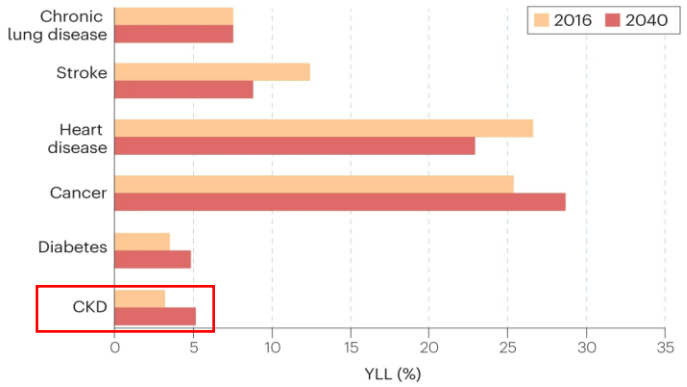
- Small molecule
- Antibody
- Locked nucleic acid / antisense
- Bispecifics
- Allogeneic CAR-T
- ✓ Primary endpoint met

*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 2040[1]

Years of life loss due to CKD predicted to continue to increase[5]



- Chronic kidney disease (CKD) is a common and debilitating condition that affects around 1 in 10 people worldwide[1]
- CKD is among the most expensive diseases for health systems, with a cost estimated at 24% of annual US Medicare budget[2] and EUR 140bn annually in Europe[3]
- Up to 25% of lupus and IgAN patients develop ESKD despite treatment with current available therapies[4]

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

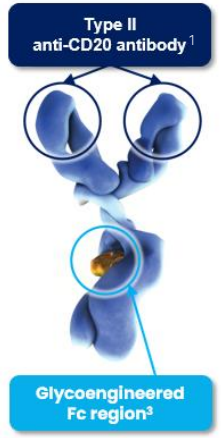
✓ Primary endpoint met

1. K.J. Jager, C. Kovesdy, R. Langham, et al. Kidney Int, 96 (2019), pp. 1048-1050; 2. US Dept of Health 2020; 3. A systematic EU approach to chronic kidney disease - European Parliament Question Feb 2022; 4. Arthritis Rheumatol. 2023 April ; 75(4): 567–573. doi:10.1002/art.42375; 5. Francis A et al, Nature Reviews Nephrology 20 473-485 (2024); aHUS: Atypical hemolytic uremic syndrome; ESKD: End stage kidney disease; IgAN: IgA nephropathy; INS: Idiopathic nephrotic syndrome (Childhood onset INS also known as PNS: Pediatric nephrotic syndrome); LN: Lupus nephritis; MOA: Mechanism of action; MN: Membranous nephropathy; SLE: Systemic lupus erythematosus; *Includes COMMUTE-a and COMMUTE-p

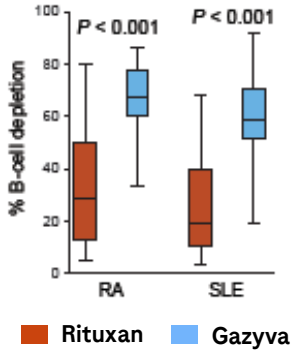
Gazyva: Deeper B-cell depletion key to improved clinical response

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

Gazyva (anti-CD20 mAb)



B cell depletion vs Rituxan[4]



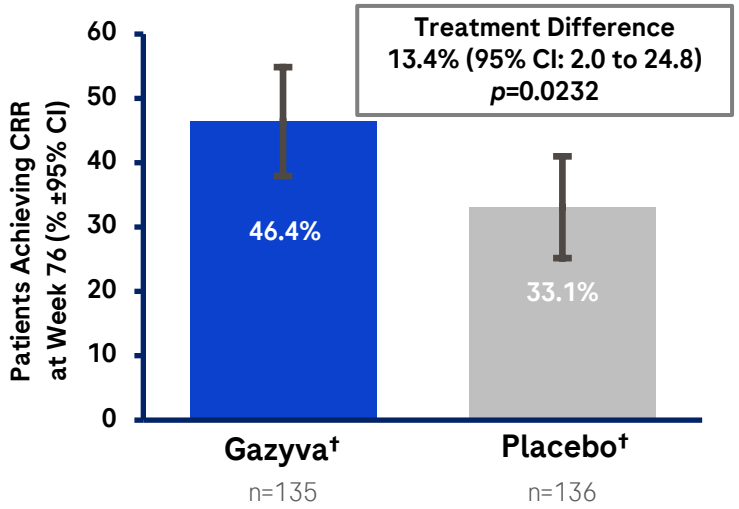
- Type II anti-CD20 region with increased direct cell death, decreased CDC and reduced internalization
- Glycoengineered Fc region with higher FcγR affinity and increased ADCC/ADCP[2,3]
- Greater potency than Rituxan in depleting peripheral and tissue B-cells

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



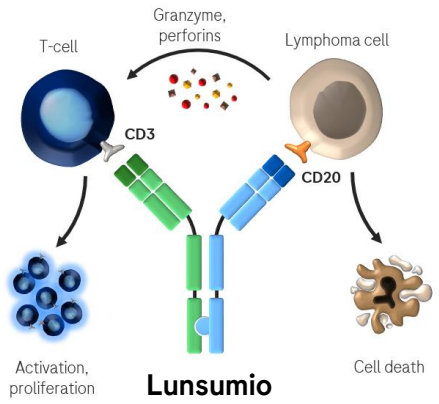
- Primary endpoint of CRR at week 76 achieved with statistically significant and clinically meaningful treatment difference of 13% (95% CI: 2.0 to 24.8)
- International and national Lupus Nephritis Guidelines have already been updated with 1L positioning of Gazyva, including Gazyva as a combination therapy (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

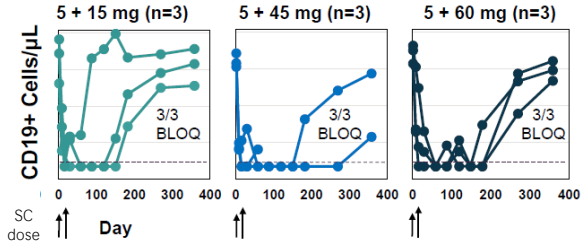
Multiple B cell depletion approaches for SLE/LN in development

Initiated Ph II study for Lunsumio and Ph I study for P-CD19CD20-ALLO1

Bispecifics: Lunsumio (CD20xCD3) & CD19xCD3

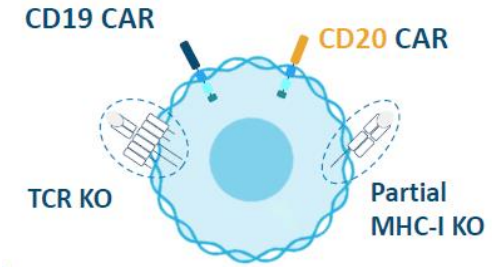


B-Cell Depletion in pts with SLE treated with Lunsumio[1]



- 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 MS[2]
- FDA IND filed for P-CD19CD20-ALLO1 CAR-T in SLE/LN; Ph I to start in 2025

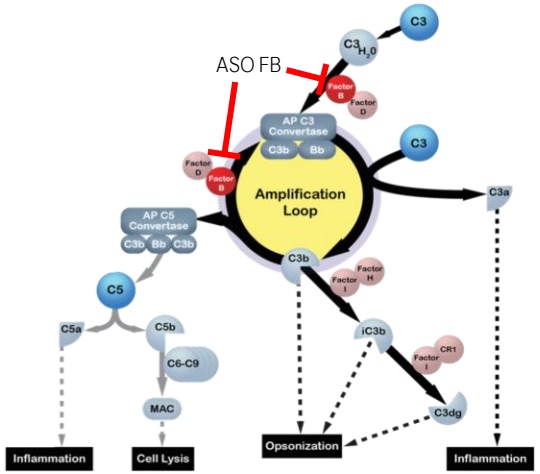
1. Chindalore V, et al. EULAR 2025; 2. Poseida Cell Therapy R&D Day, Nov 2024; IND: Investigational new drug; SC: Subcutaneous; R/R: Release refractory; NHL: Non-Hodgkins lymphoma; PK: Pharmacokinetics; CAR-T: Chimeric antigen receptor T cells; KO: Knock out; LN: Lupus nephritis; MHC: Major histocompatibility 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)

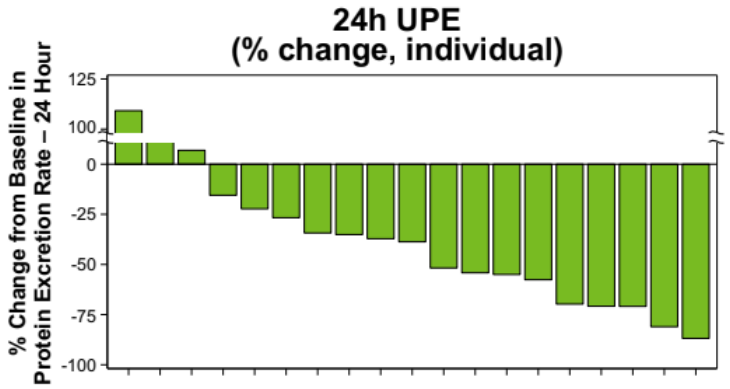
Alternative complement pathway



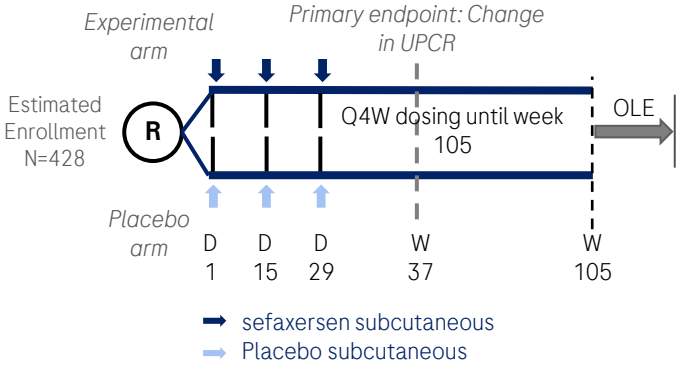
- Globally, IgAN is the most common primary GN that can progress to renal failure
- High levels of CFB are associated with IgAN[1,2]
- Sefaxersen downregulates CFB production by inhibiting mRNA translation

Clinical development program in IgAN

Early Ph II results[3]



Ph III (IMAGINATION) trial design



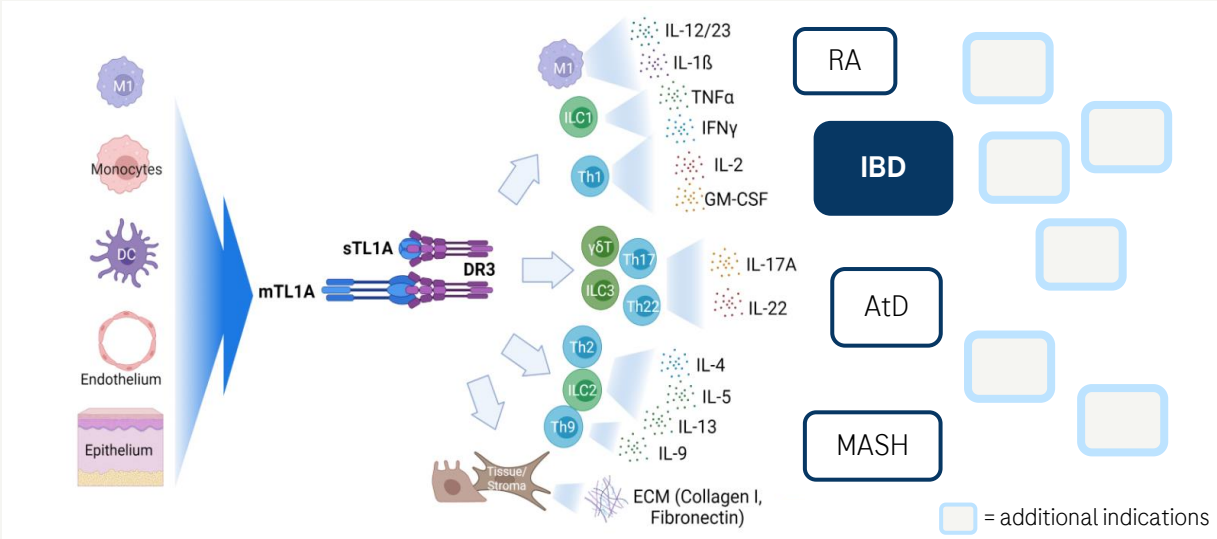
- Ph II study met its primary endpoint of change in 24-hour urinary protein, with 43% mean reduction in proteinuria at week 29[3,4]
- Improvement also seen in secondary outcomes of change in UPCR from baseline to week 29; kidney function stable during the study[3]
- Ph III (IMAGINATION) results expected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

Sefaxersen in partnership with IONIS Pharmaceuticals; Figure adapted from: Barbour et al. ASN Annual Meeting 2024; 1. Chiu et al. Front Immunol. 2021; 12: 638309; 2. Yeo et al. Pediatr Nephrol 2018: 33:763-777; 3. Hladunewich et al. ERA 2024; 4. IONIS press release 2022; ASO: Antisense oligonucleotide; GN: Glomerulonephritis; CFB: Complement factor B; IgAN: IgA nephropathy; MoA: Mechanism of action; mRNA: Messenger RNA; Q4W: Every 4 weeks; SC: Subcutaneous; UPCR: Urine protein/creatinine ratio; UPE: Urinary protein excretion; D: Day; W: Week; OLE: Open label extension

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 potential



- TL1A/DR3 binding acts as a key amplifier of inflammatory pathways and tissue remodeling in immune-mediated diseases[1]
- 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

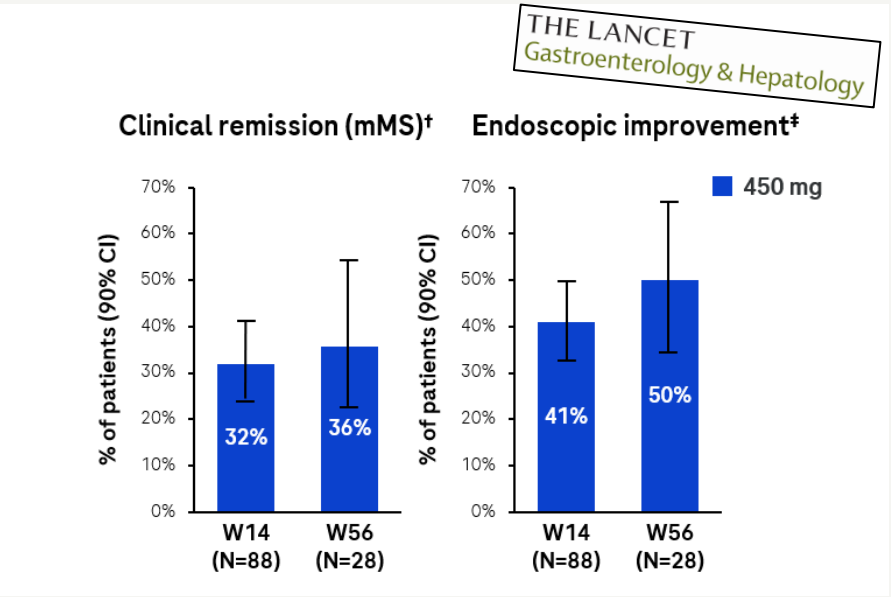
- Initiated Ph II in rheumatoid arthritis
- Initiated pediatric UC and CD registrational studies
- CD, AtD, and MASH recruitment on track
- Continuing to explore additional indications

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: Atomic dermatitis; TL1A: Tumor necrosis factor-like cytokine 1A; UC: Ulcerative colitis; ECM: Extracellular matrix; FPI: First patient in

Afimkibart in UC: Significant recruitment acceleration

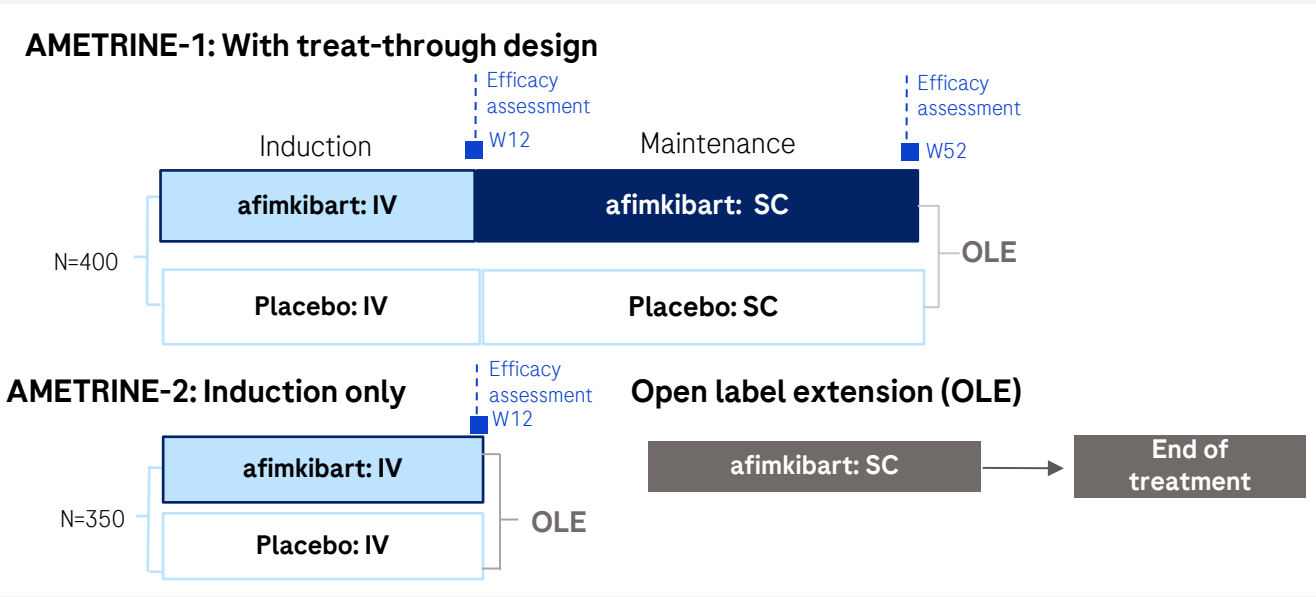
Fast-Track designation enabled expedited trial enrollment and execution

Ph IIb (TUSCANY-2) in UC[1]



- 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



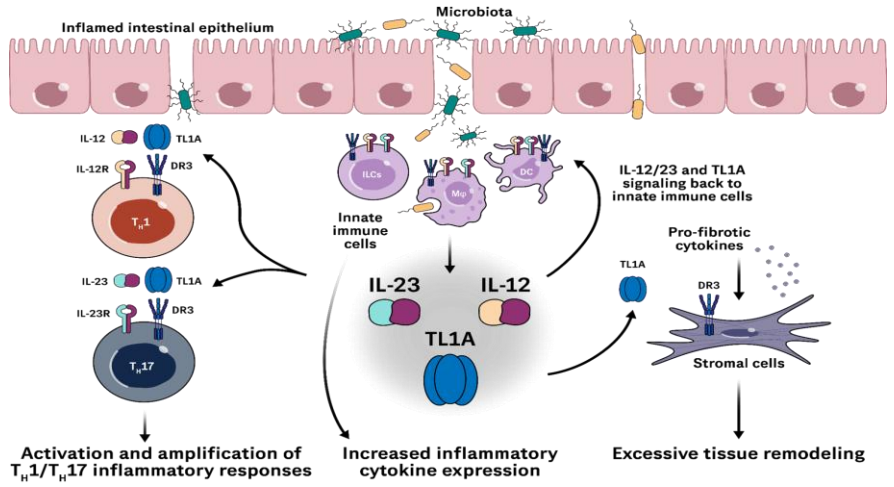
- Ph III (AMETRINE-1&2) accelerated recruitment by up to 6 months; Ph III results expected 2027
- Ph III (SIBERITE 1&2) in CD, Ph II in AtD, and Ph I in MASH recruitment on track
- Exploring biomarker test which may predict better response to treatment

1. Danese S. et al. The Lancet Gastroenterology & Hepatology 2025, ISSN 2468-1253, https://doi.org/10.1016/S2468-1253(25)00129-3; †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; CI: 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

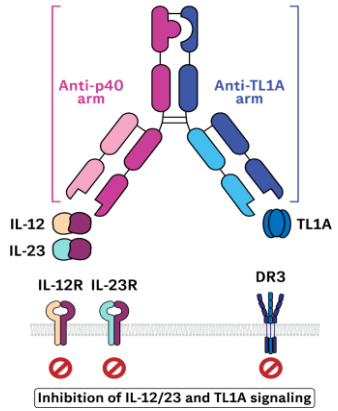
p40xTL1A bispecific: Simultaneously targeting two pathways in IBD

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]



- IL-12 and IL-23 are proinflammatory cytokines that both contain the p40 subunit, promote intestinal inflammation, and are strongly associated with IBD pathology[6-8]
- 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 ceiling[1-5]

Development program

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

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

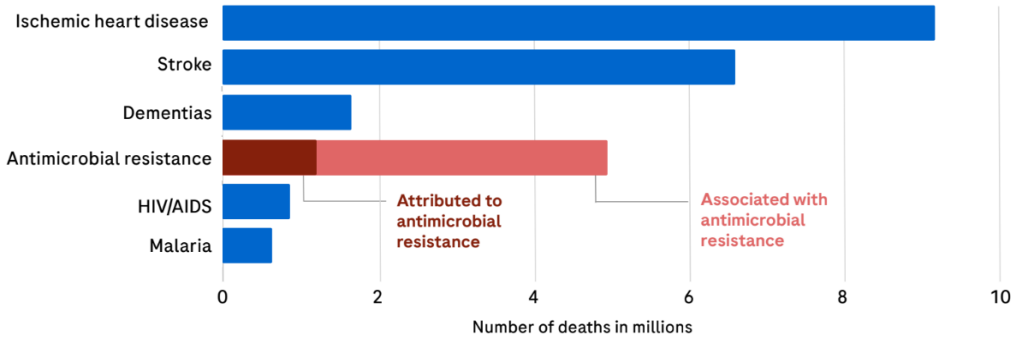
*Global collaboration with Pfizer; 1. Selin KA, et al. J Crohns Colitis. 2021;15(11):1959-1973.; 2. Schmitt H, et al. Gut. 2019;68(5):814-828.; 3. Valatas V, et al. Front Immunol. 2019;10:583. 4. Strober W, Fuss IJ. Gastroenterology. 2011;140(6):1756-1767.; 5. Li L, et al. Arch Dermatol Res. 2014;306(10):927-932.; 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

Zosurabalpin in antimicrobial resistance

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

Antimicrobial resistance (AMR)

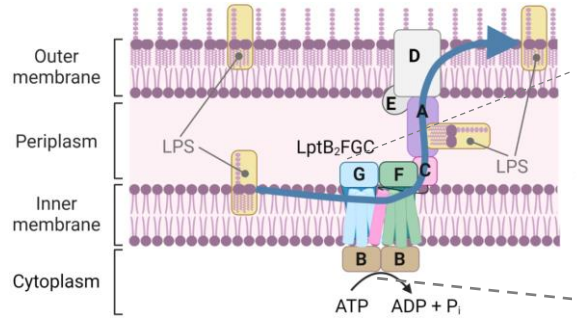
The global burden of AMR is a present and growing danger[3]



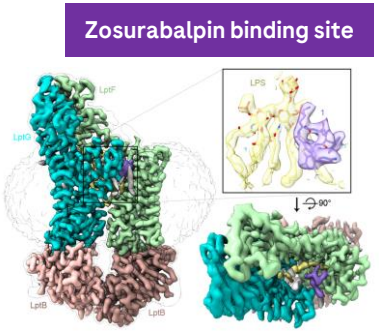
- AMR is a 'silent pandemic' expected to claim more lives over the next 30 years than cancer today
- Despite the need for antibiotics and the rise of antibiotic resistance, no novel class of antibiotics effective against gram-negative bacteria has been discovered since 1968

Zosurabalpin (Abx macrocyclic peptide)

Localization of the LPS transport system in gram-negative cell envelope[1]



Cryo-EM structure of zosurabalpin bound to the $LptB_2FBG$ transporter and LPS[2]



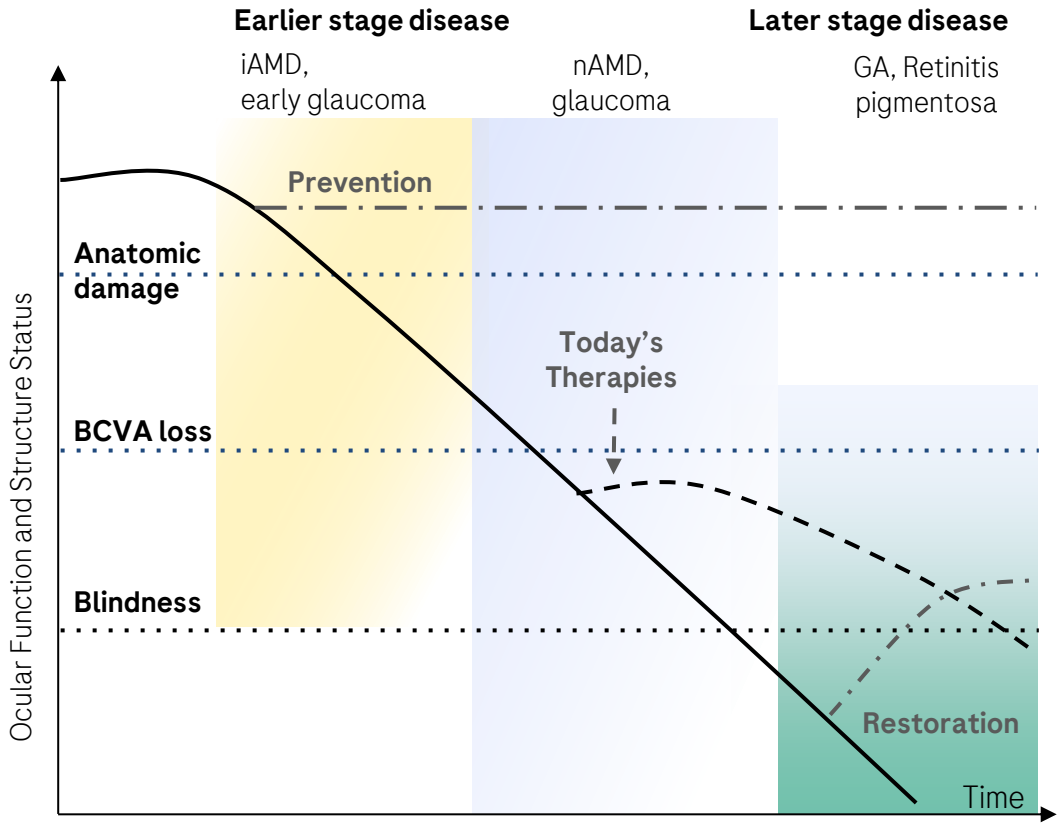
- Zosurabalpin blocks transport of lipopolysaccharide (LPS) by inhibition of LptB2FG complex
- This novel MoA prevents *carbapenem-resistant A. baumannii* (the highest threat pathogen according to WHO and CDC) from properly constructing its protective membrane
- Ph III to initiate in 2026

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

BCVA: Best-corrected visual acuity; GA: Geographic atrophy; iAMD: Intermediate age-related macular degeneration; nAMD: Neovascular age-related macular degeneration

Ophthalmology R&D focus areas

Improving patient outcomes and reducing treatment burden

Critical Capabilities	Examples
Novel MoAs & new indications, addressing multiple disease pathways	New MoAs to target a broader range of disease pathways and address additional indications
Extended durability & future technologies	Multiple approaches for long-acting delivery, intravitreal targets, and potential for vision restoration
Digital capabilities	Expanded capabilities that apply biomarkers and data analytics, remote vision monitoring, and AI-supported clinical decision-making
E2E investment	Invest end-to-end in retinal vascular disease (RVD), geographic atrophy (GA) and iAMD from discovery, R&D, to commercialization

MoA: Mechanism of action; iAMD: intermediate age-related macular degeneration

Ophthalmology pipeline

Further improving the standard of care and expanding in new indications

Phase I

- RG6209 — **VEGF x IL6 DutaFab** DME
- RG6120 — **zifibancimig** nAMD
- RG6327 — **Undisclosed** GA

Phase II

- RG6179 — **vamikibart** DME
- RG6501 — **OpRegen® cell theraphy**[1] GA
- RG6351 — **Tie-2 agonist** DME

Data to be presented at future medical congress; Pivotal development to focus on VEGFxIL6 DutaFab

Phase III

- RG6179 — **vamikibart** UME
- RG6168 — **satralizumab** TED
- RG7716 — **Vabysmo** CNV
- RG6321 — **Susvimo** nAMD (36-week)

Data to be presented at AAO and to be shared with regulators

Data to be presented at ASOPRS

Antibody
DutaFab
Port Delivery Platform
Stem cell therapy

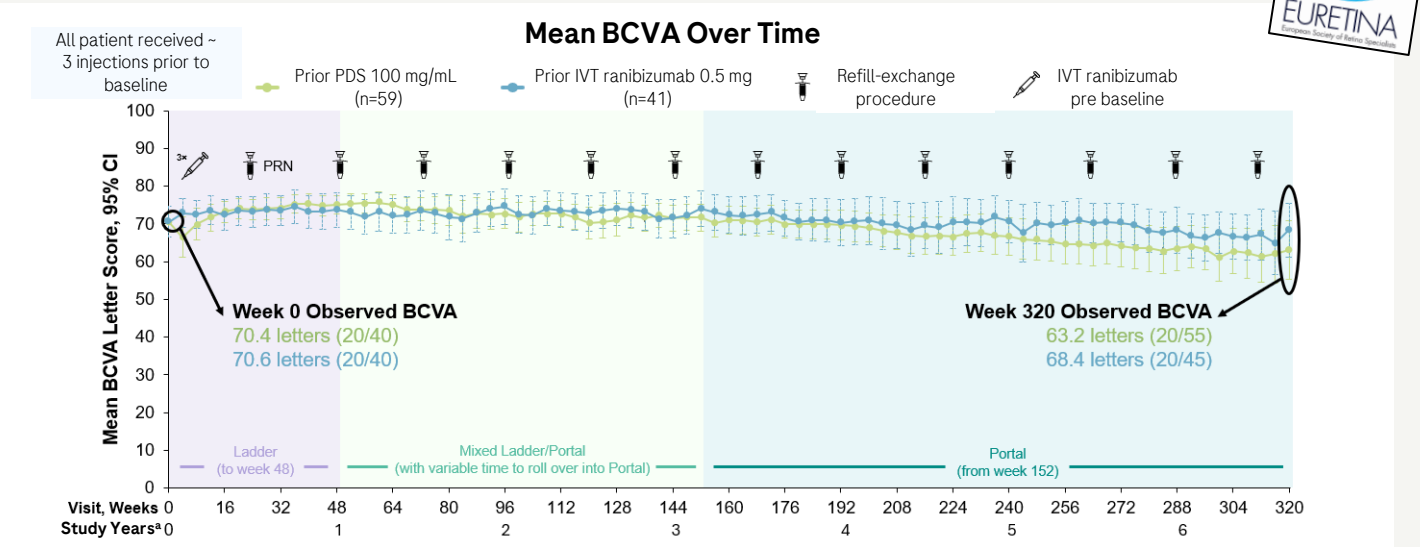
nAMD
DME/UME
GA
TED
CNV

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/yrs

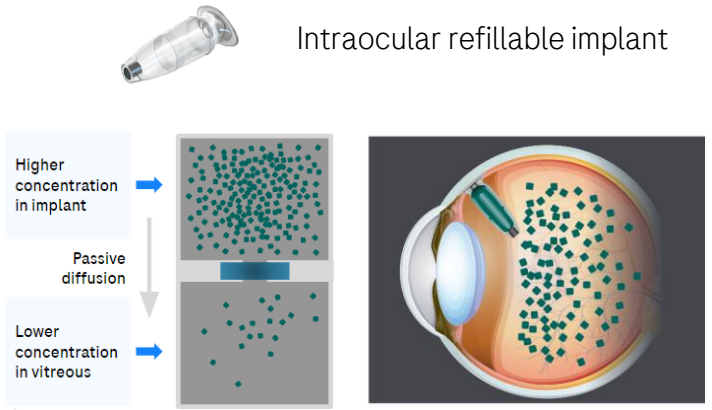
Continuing to innovate on Port Delivery Platform with multiple assets in development

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



- 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

Port Delivery Platform (PDP)



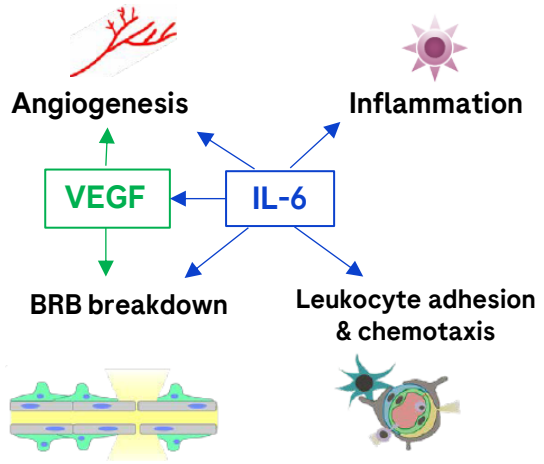
- PDP is designed for continuous delivery of customized molecules through passive diffusion and addresses the key challenge of frequent IVT injections
- Two DutaFabs and multiple preclinical molecules in development with PDP

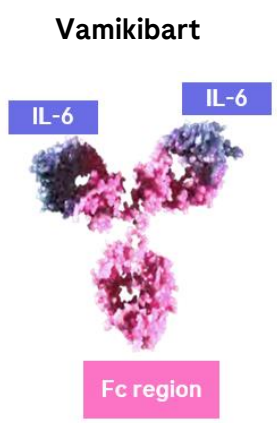
1. Khanani A et al, EURETINA 2025; a. Study year = 48 weeks, based on 12 months comprising 4 weeks; DutaFab: Dual targeting fragment antigen-binding; BCVA: Best corrected-visual acuity; CI: Confidence interval; IVT: Intravitreal; nAMD: Neovascular age-related macular degeneration; OLE: Open label extension;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





- 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

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

- 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

IL-6: Interleukin-6; VEGF: Vascular endothelial growth factor; UME: Uveitic macular edema; DME: Diabetic macular edema; DutaFab: Dual targeting fragment antigen-binding; BRB: Blood-retinal barrier; IVT: Intravitreal

Roche

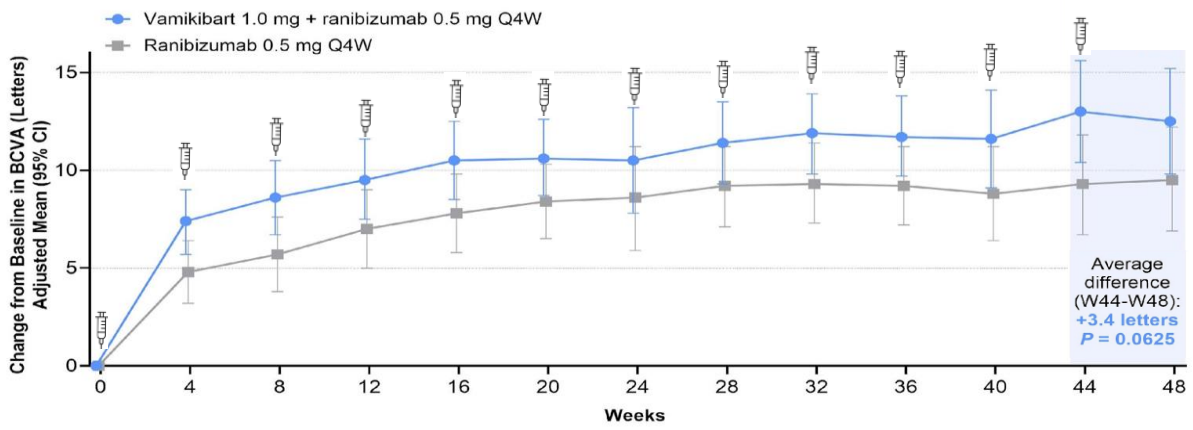
IR Ophtha Update @ ASOPRS/AAO Oct 21st

VEGFxIL6 DutaFab: A next generation bispecific for DME

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

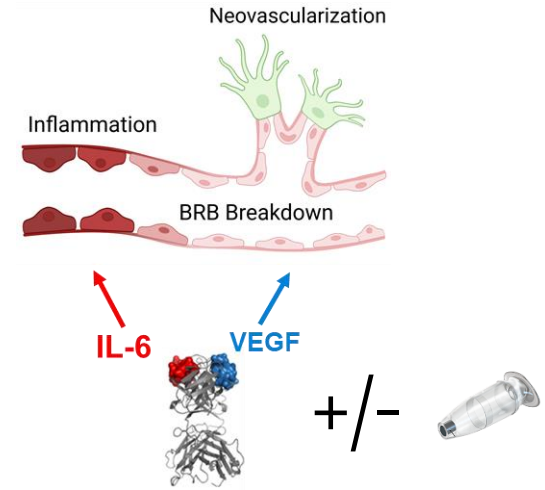
Ph II (BARDENAS): Anti-IL-6 (vamikibart) + anti-VEGF (ranibizumab) showed superior efficacy in DME[a]

Primary endpoint: Change from baseline in BCVA for treatment-naïve patients



- 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

Roche

IR Ophtha Update @ ASOPRS/AAO Oct 21st

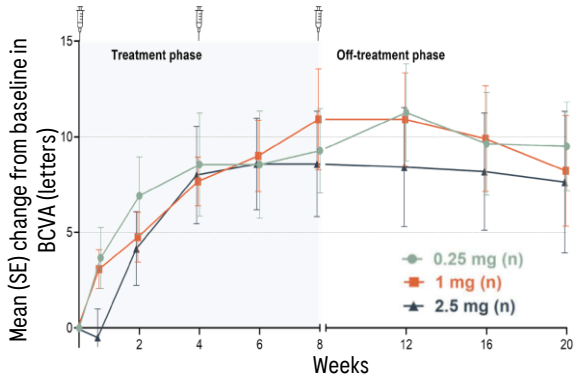
Vamikibart in UME: Potential FIC non-steroid IVT treatment

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

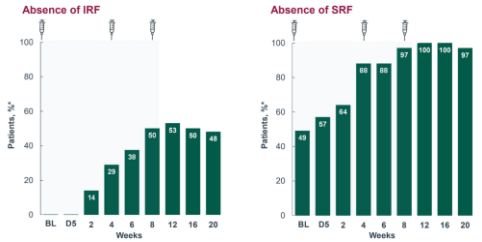
Ph I (DOVETAIL) results for vamikibart in UME[1]

ARVO 2023

Change from baseline in BCVA

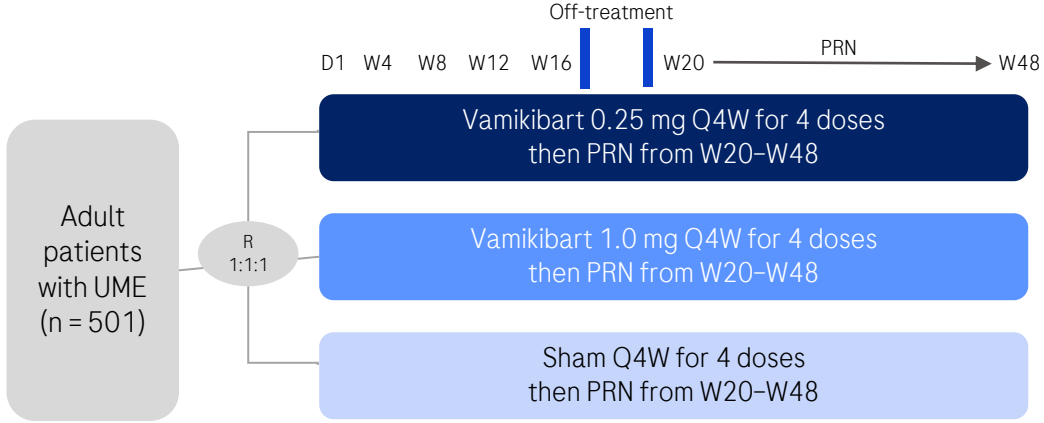


Patients with absence of retinal fluid



- UME is the leading cause of vision loss[2], affecting around one-third of patients with NIU[3]
- 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



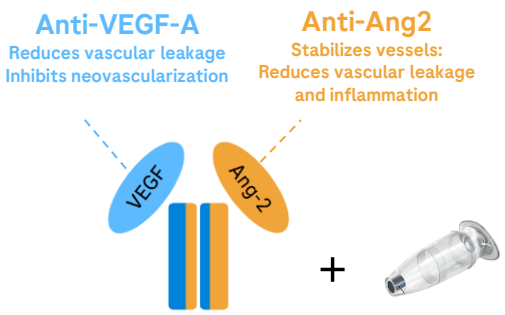
- Ph III (SANDCAT/MEERKAT) in UME completed; data in-house and to be presented at AAO 2025
- Data demonstrate improvements in vision and anatomy with no serious safety concerns identified
- Data support a favorable benefit-risk profile and will be shared with regulators

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

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

Zifibancimig (VEGFxAng-2 DutaFab)

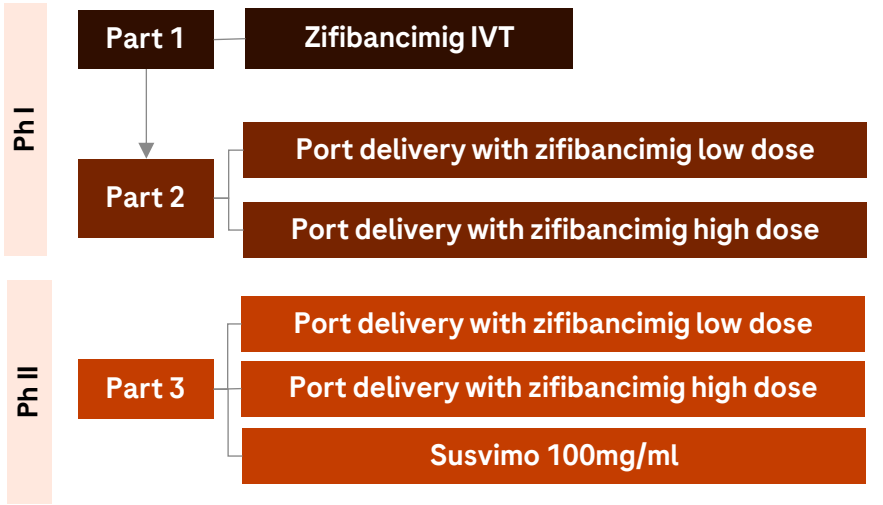


Single antigen-binding fragment binding two targets independently with high potency and selectivity

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 (~40× weaker)	229 pM (~60× weaker)
VEGF-A165	~2 pM (ref)	224 pM (~100× weaker)	160 pM (~80× weaker)
Ang-2–RBD	~2 pM (ref)	7000 pM (~3500× 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 molecules[1]
- Potential to offer optimized disease control and outcome certainty with the potential for extended dosing intervals

PhI/II (BURGUNDY) trial design



- 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

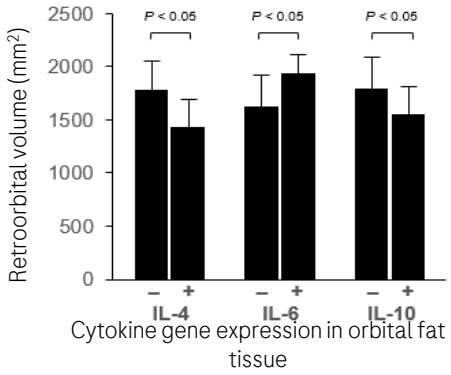
Satralizumab: Potential to be the first SC therapy in TED

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

IR Ophtha Update @ ASOPRS/AAO Oct 21st

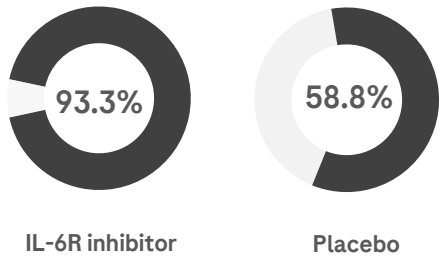
IL-6 pathway plays a key role in TED[1] and clinical evidence supports IL-6R inhibition

IL-6 expression correlates with orbital tissue expansion[2]



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

Proportion of patients with ≥ 2-point CAS reduction from baseline, week 16

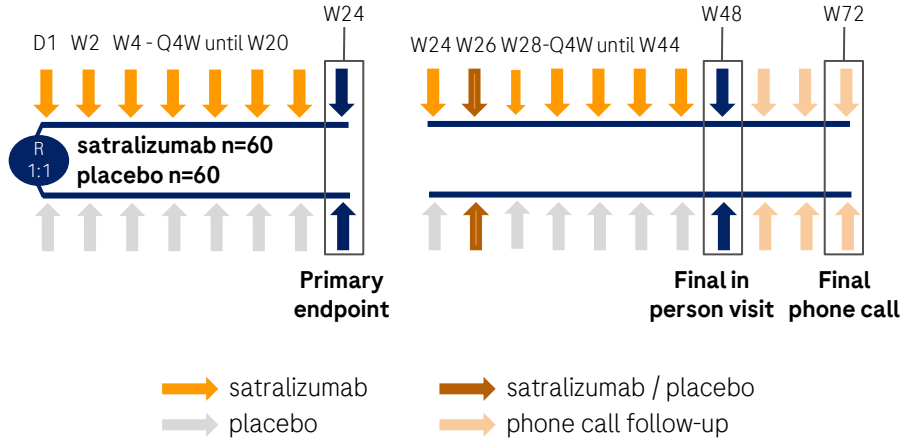


- IL-6 is a key mediator of inflammation and drives fibrosis in TED; blocking IL-6R signaling has the potential to reverse the manifestation of the disease
- In a placebo-controlled randomized trial, CAS reduction of ≥2 point and proptosis reduction were achieved
- Satralizumab is designed to enable 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**



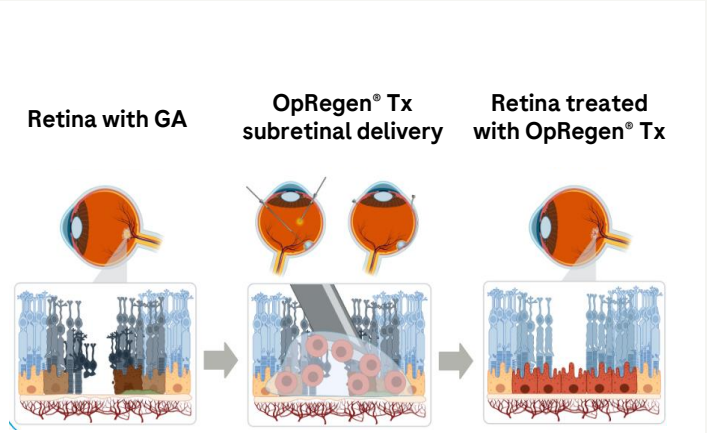
- Ph III (SatraGO-1/SatraGO-2) trials in TED data in-house and to be presented at ASOPRS

1. Ezra D et al, ASOPRS 2023;2. Slowik M et al. Endocr Res. 2012;37(2):89–95; 2. Hiromatsu Y et al. J Clin Endocrinol Metab. 2000;85(3): 1194–99; 3. Perez-Moreiras JV et al. AJO. 2018;195:181–90;
CAS: Clinical activity score; IL-6: Interleukin-6; IL-6R: Interlukin-6 receptor; Q4W: Every four weeks;TED: Thyroid eye disease; SC: Subcutaneous

OpRegen® Tx in GA: Replenishing the retinal pigment epithelium

Ph IIa GAlette surgical development study ongoing

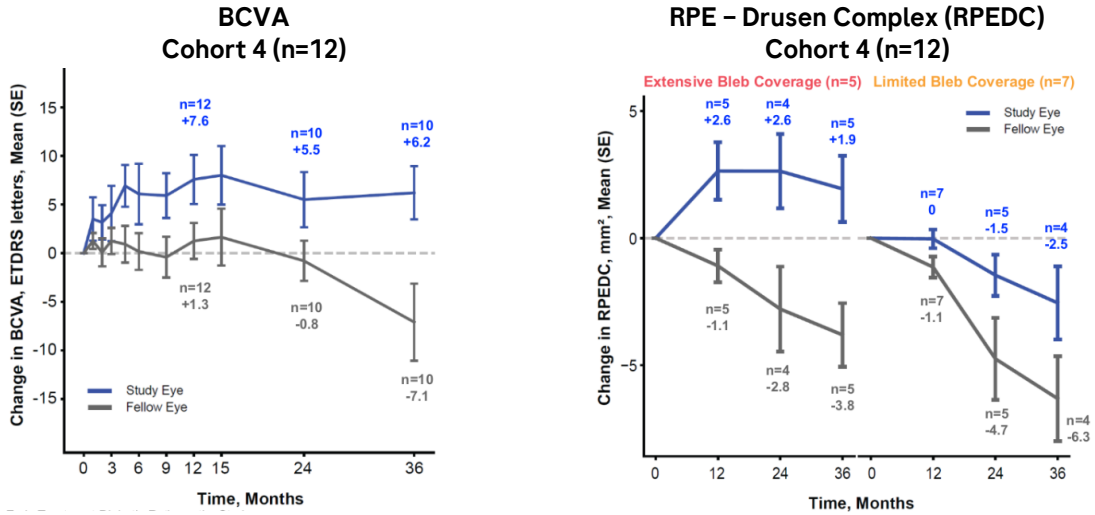
Potential to treat RPE loss in GA



- 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 36[1]

FDA RMAT



- 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

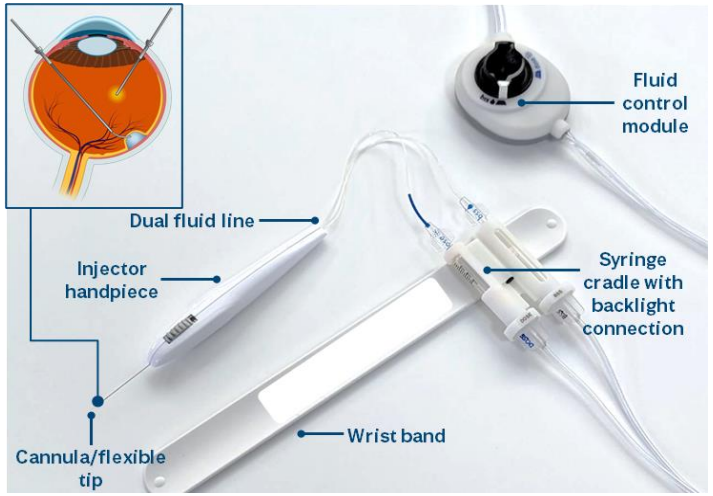
In collaboration with Lineage Cell Therapeutics, Inc. (LCTX); 1. Riemann, C., et al. Clinical Trials Summit 2025 ; BCVA: Best-corrected visual acuity; GA: Geographic atrophy; RMAT: Regenerative medicine advanced therapy; RPE: Retinal pigment epithelium; Tx: Treatment; ETDRS: Early treatment diabetic retinopathy study; RPEDC: Retinal pigment epithelium-drusen complex; SE: Standard error

Acquired proprietary surgical devices for OpRegen® Tx development

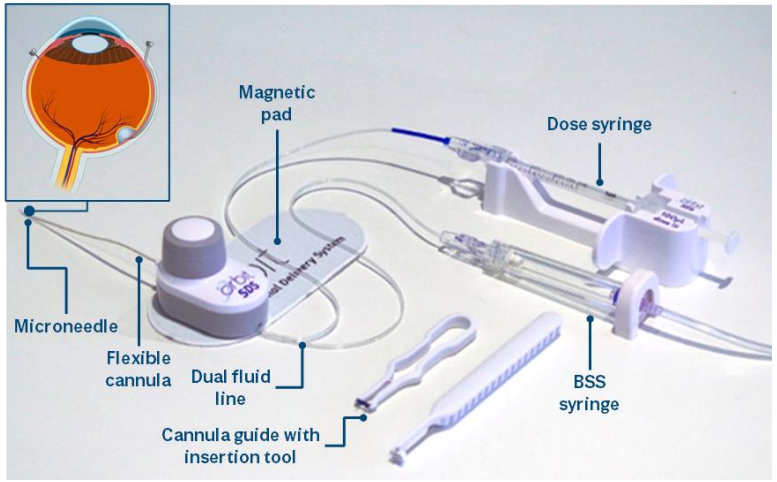
Potential for broader application in the delivery of other pipeline assets across different modalities

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

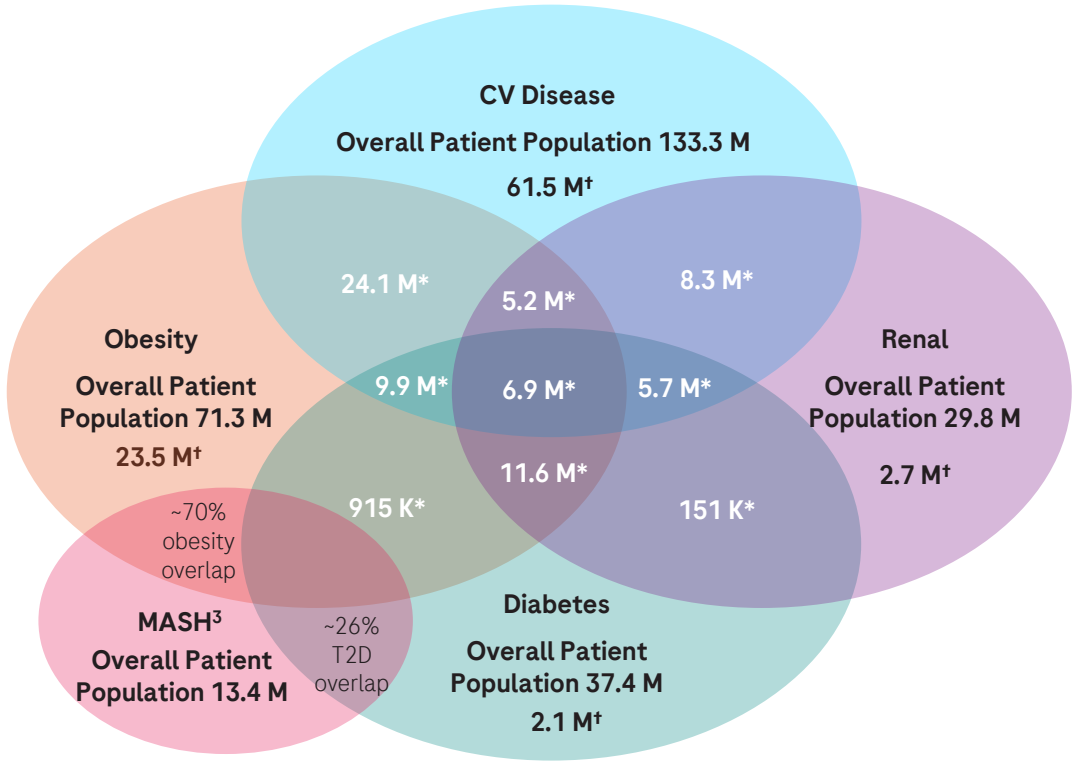
GA: Geographic atrophy; Tx: Treatment

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 spectrum[1]

1 in 4 US adults have a CVRM condition and 1 in 10 have more than one[2]



- 85% of people with **T2D** are also living with **overweight or obesity**[4]
- 75% of people with **MASH** are living with either **overweight or obesity** and/or **T2D**[13]
- >60% of patients with **CKD** also have **CVD**[10]
- 37% of adults with diabetes have been diagnosed with **CKD**[11]
- 22% of patients with **diabetes** will develop **heart failure**[12]
- Nearly 2-fold increased risk for multiple chronic conditions in those with **HTN** [7]

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, Chibuike 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		Examples
Incretins and beyond	*Combat obesity as a driver for metabolic diseases*	**CT-388:** Obesity ± T2D **CT-996:** Obesity ± T2D **Petrelintide:** Obesity ± T2D
Combinations	*Establish a portfolio of combination therapies*	**Add-on and/or Fixed-dose combination:** e.g., CT-388 + petrelintide, incretin + emugrobart
Comorbidities	*Address additional causal factors of metabolic disease*	**HTN:** Zilebesiran + SoC in people with established/high risk of CVD **MASH:** Pegozafermin* and afimkibart **CKD, HF, AD:** Combinations within portfolio
Holistic patient solutions	*Synergies with Roche Diagnostics and Digital Health solutions*	**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

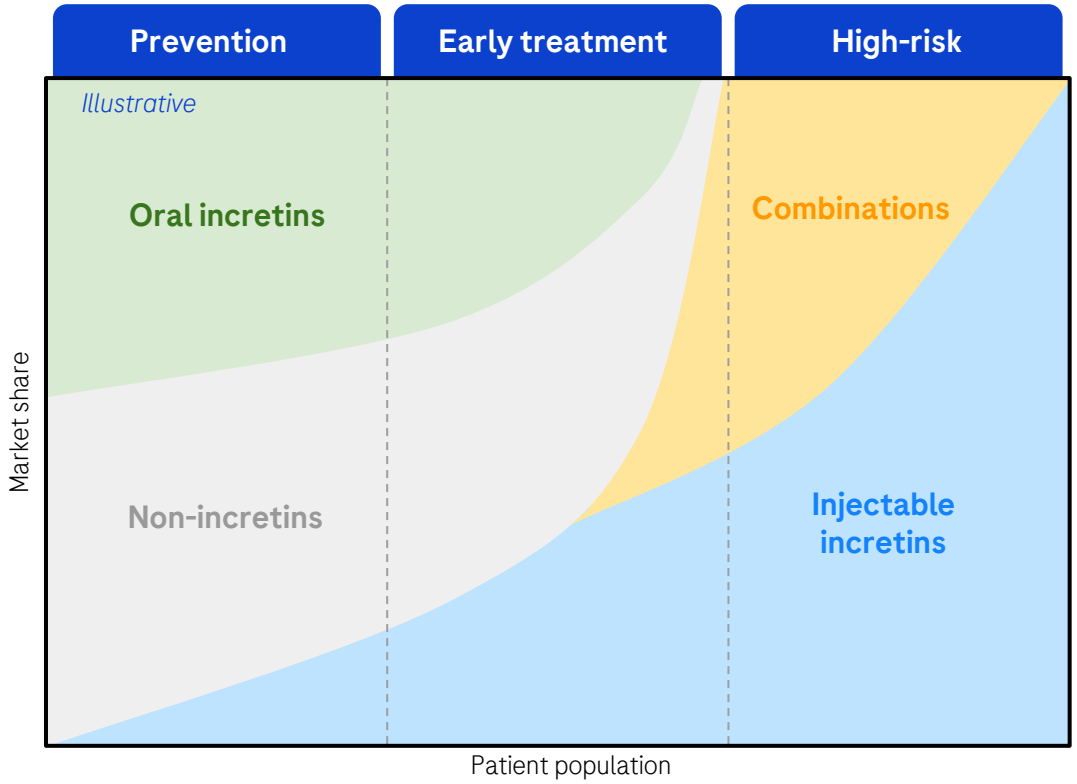
Diverse patient needs will lead to increased market segmentation

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	

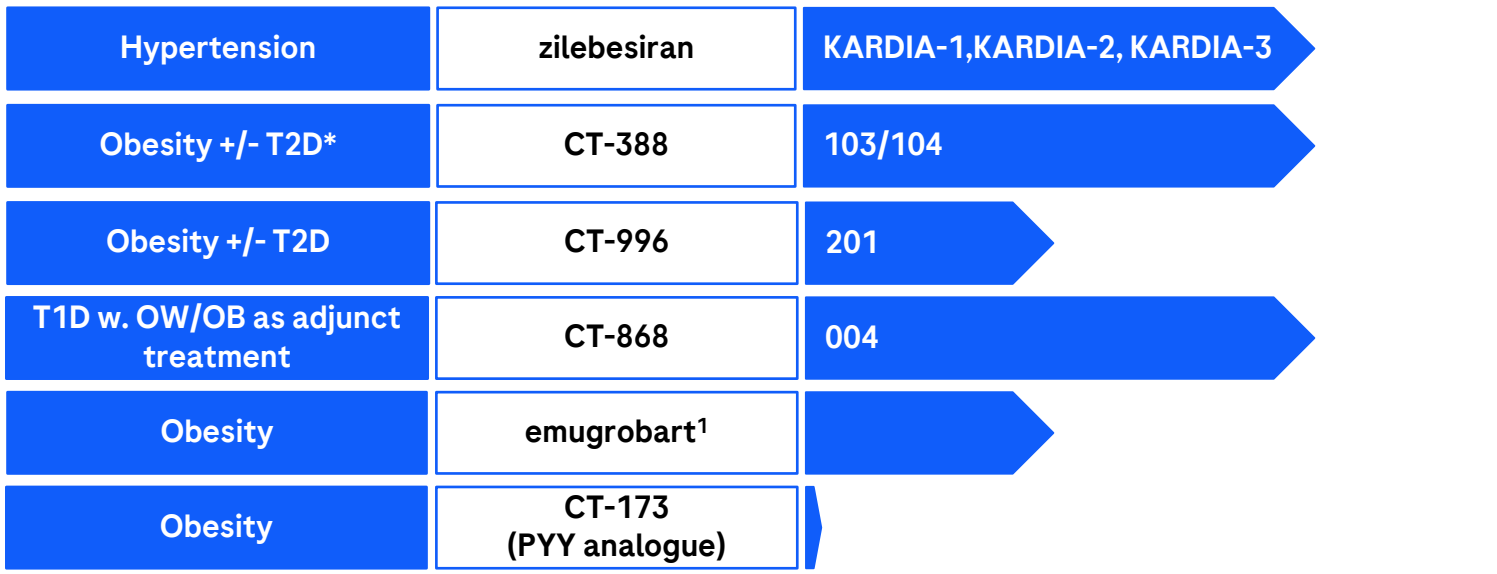
Obesity market outlook by segment and drug class



Simon Kucher Roche TPP Testing in Obesity (Sep 2024) - 30+ Experts interviewed (US, DE, FR); KOL: Key opinion leader

2024: Starting to build an innovative CVRM portfolio

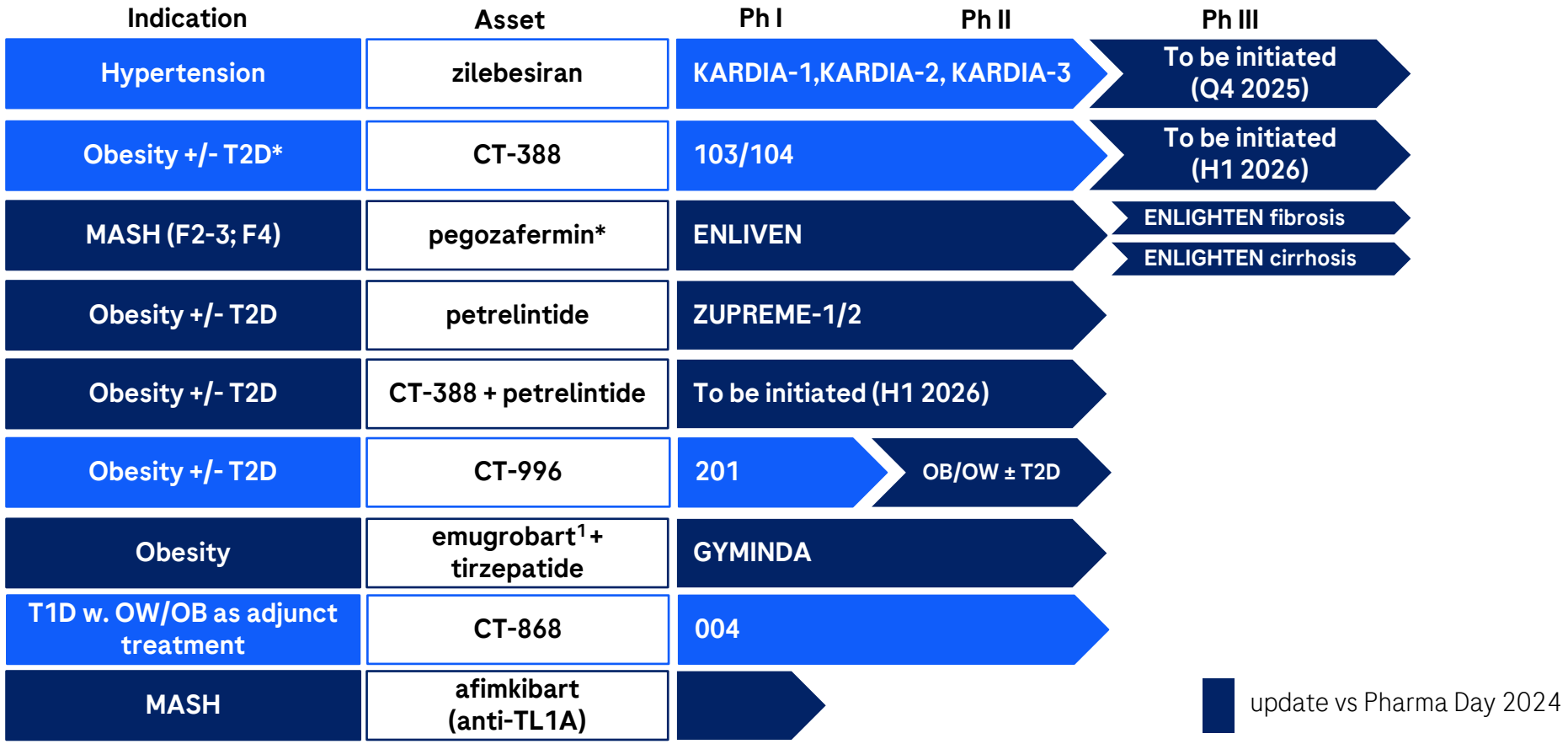
Clinical development



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

Clinical development

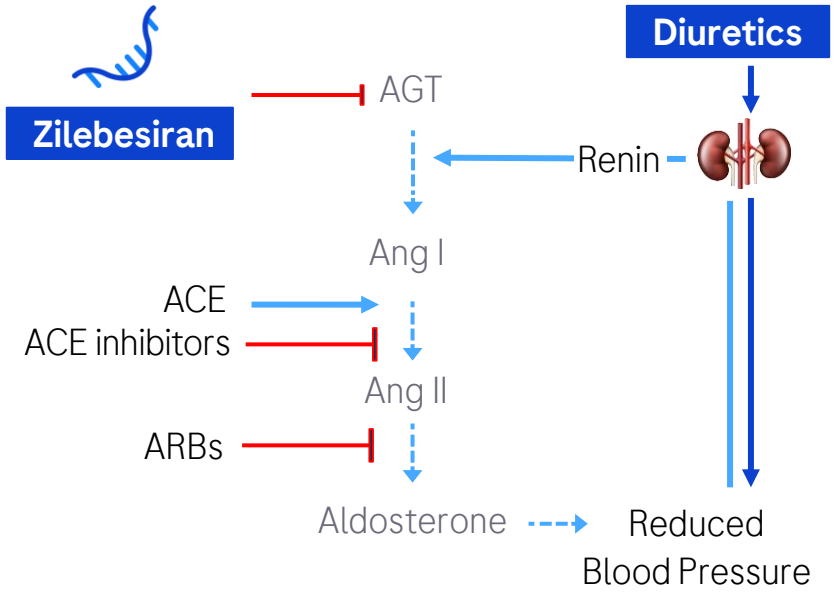


*Pending deal closure; 1. GYM 329; OB: Obesity; OW: Overweight; T1D/T2D: Type-1/2 diabetes; MASH: metabolic dysfunction-associated steatohepatitis; *Patients with obesity or overweight with at least one weight-related comorbidity including type 2 diabetes; petrelintide in partnership with Zealand Pharma,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

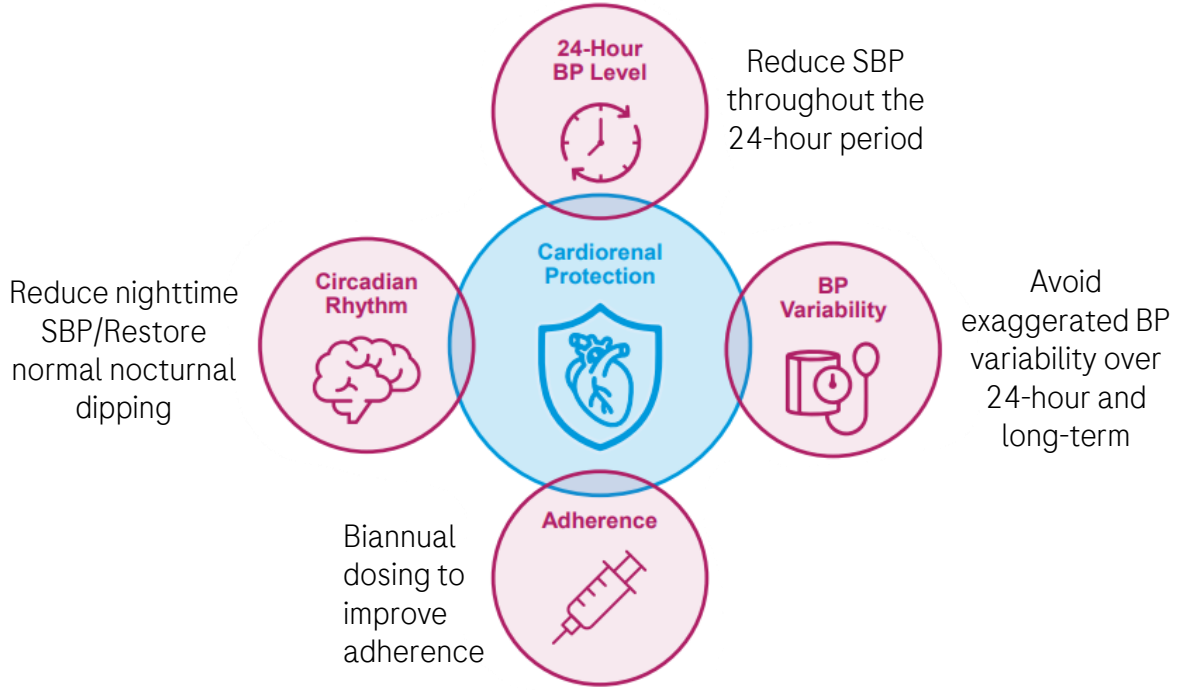
Zilebesiran, a novel therapy targeting AGT for uncontrolled HTN

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

Potential for tightest control of BP by blocking upstream of the RAAS pathway[1]



Biannual dosing offers a unique value proposition in uHTN leading to continuous control of BP up to 6 months[2]



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

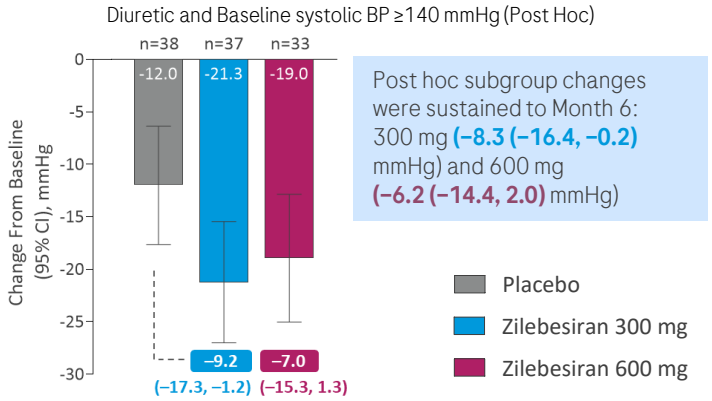
KARDIA-1

Zilebesiran monotherapy in pts with mild-to-mod HTN[1] ✔

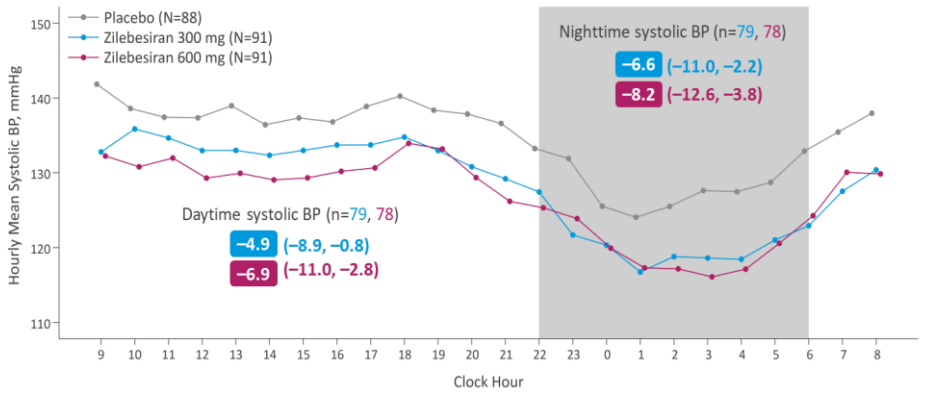
KARDIA-2

Zilebesiran add on to 1 SoC in pts with mild-to-mod HTN[2] ✔

KARDIA-3 Post Hoc Subgroup Analysis: Placebo-Adjusted Change from Baseline to Month 3 in Office SBP[3]



Hourly Mean (Exploratory) and Placebo-Adjusted Change From Baseline (Secondary) in Mean Daytime/Nighttime Ambulatory SBP at Month 6[3]



- 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)

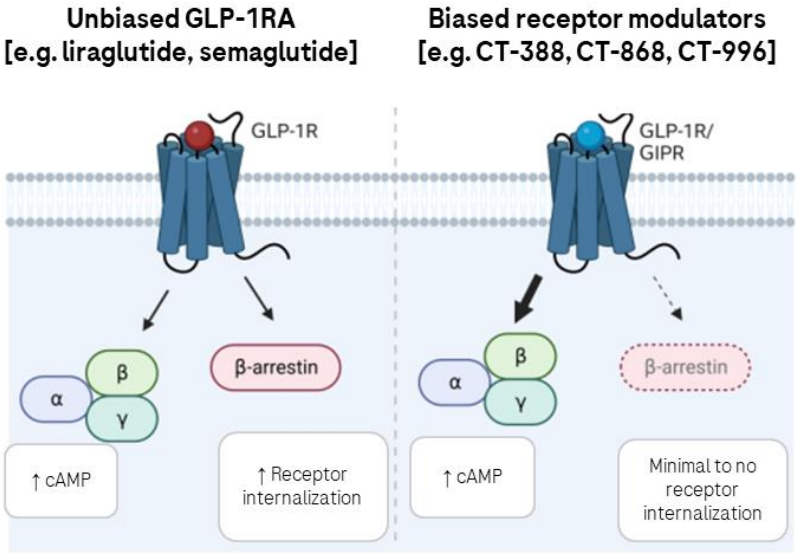
- Ph III (ZENITH) will be a 11,000-patient CVOT study evaluating zilebesiran (300 mg) every six months compared to placebo in patients with uncontrolled hypertension at high CV risk on two or more antihypertensives, one being a diuretic
- Data expected to enable a launch around 2030

CV: Cardiovascular; HTN: Hypertension; Q6M: Every 6 months; SoC: Standard of care; SBP: Systolic blood pressure; Tx: Treatment; zilebesiran in partnership with Alnylam Pharmaceuticals

Expanding CVRM portfolio, creating optionality with differentiated MoAs

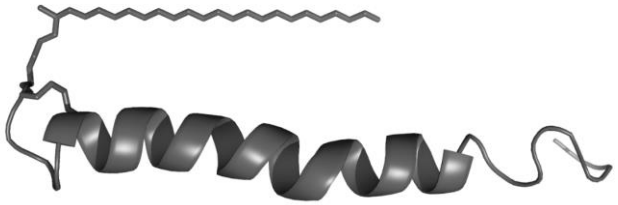
Leveraging biased GLP-1/GIP and amylin agonism for potentially greater efficacy and tolerability

CT-388, CT-868 and CT-996 are biased agonists[1]



- 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 efficacy[1]

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

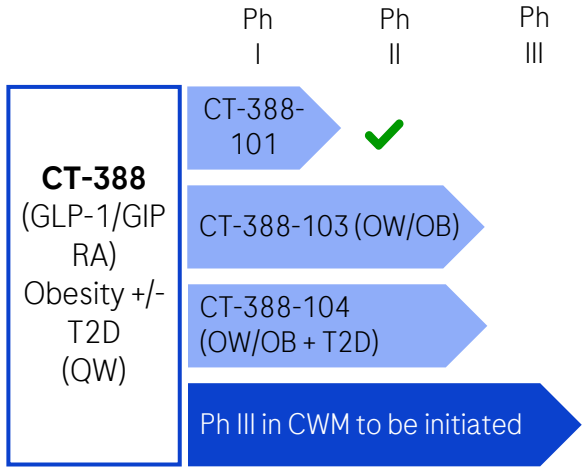
- Long-acting amylin analog, suitable for Q1W dosing[2,3]
- Potent balanced agonist effect on amylin and calcitonin receptors[2,4]
- Favorable physicochemical properties, allow for co-formulation and co-administration with other peptides[5,6]

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. Skarbaliene 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

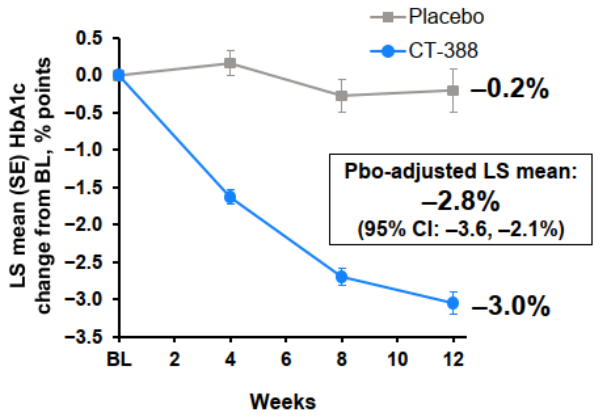
Development program



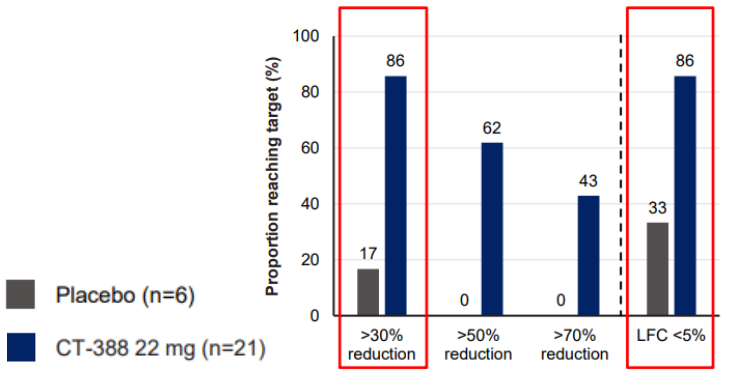
- Ph II trials in OW/OB ± T2D ongoing
- Ph III trial in chronic weight management to be initiated (H1 2026)

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

PhI CT-388-101 (cohort 13)[2] Glycemic control



PhI CT-388-101 (cohort 12)[1]: LFC target achievement at w24[1]



LFC ≥5% indicates MASLD

- CT-388 treatment in people living with obesity and T2D over12 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

Phase 1

CT-388-101 (cohorts 11, 12, and 13) - weight loss at week 12/24

Without T2D[1]			With T2D[2]
Placebo 0.9% (w12)/ 0.1% (w24) (n=10)	**CT-388 8 mg 10.2% (w12)** (n=12)	**CT-388 22 mg 12.4% (w12)/ 18.9% (w24)** (n=24)	**CT-388 22 mg 8.6% (w12)** (n=14)

- Well tolerated with a safety profile consistent with other incretin-based therapeutics, despite brisk up-titration
- Once-weekly subcutaneous dosing is supported by pharmacokinetic data
- Dose-dependent weight loss was observed after the first dose and improved with repeated dosing, with no plateau observed
- Clinically meaningful improvement in markers of glucose metabolism

Phase 2

Two Ph II dose-finding trials are ongoing, aiming to evaluate the efficacy and safety of CT-388 at low, middle, and high doses

CT-388-103, n=~450 with obesity[3]

CT-388-104, n=~360 with obesity/overweight and T2D[4]

Phase 3

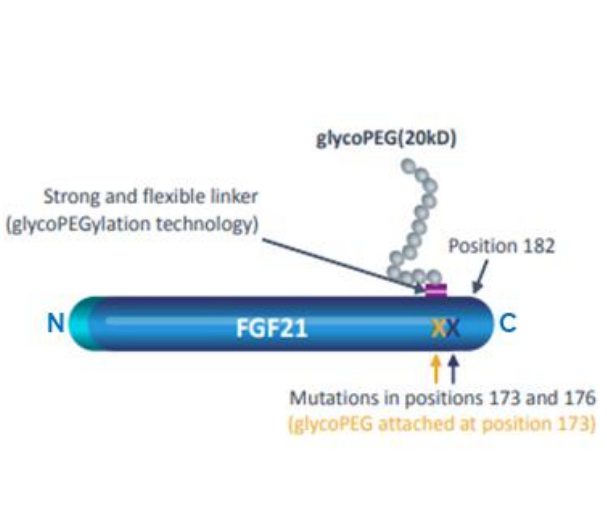
Chronic weight management
to be initiated H1 2026

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

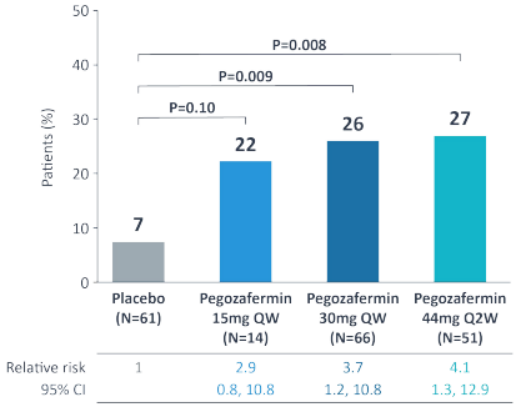
Pegozafermin[1]



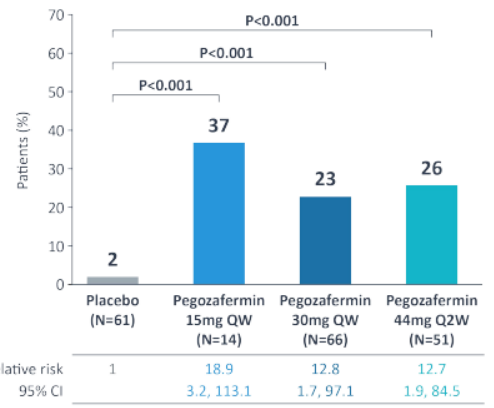
- Pegozafermin is an FGF21 analog engineered to balance efficacy and extended dosing
- Anti-fibrotic and anti-inflammatory downstream effects improve insulin resistance and reduce oxidative stress

Ph II (ENLIVEN) week 24 results in pts with MASH and fibrosis (F2-F4)[2*]

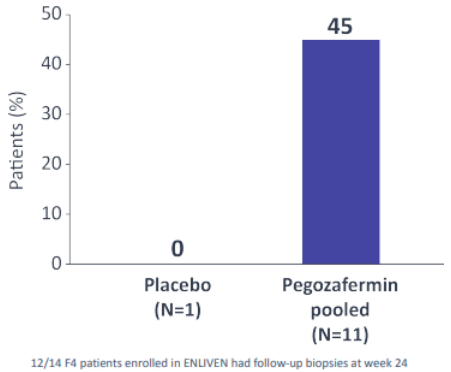
Fibrosis improvement ≥ 1stage without worsening of MASH



MASH resolution without worsening of fibrosis



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



12/14 F4 patients enrolled in ENLIVEN had follow-up biopsies at week 24

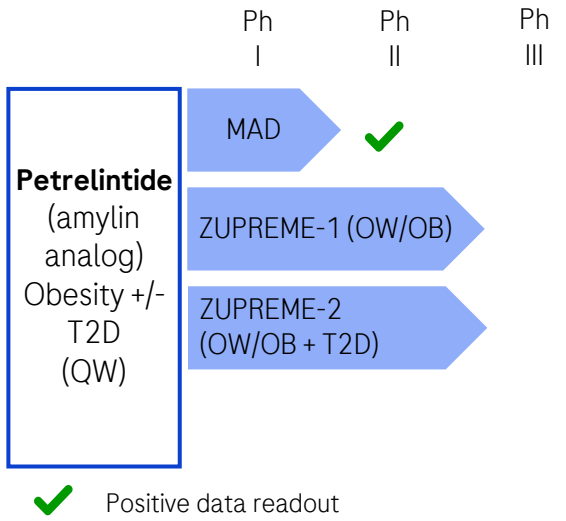
- Ph II study of pegozafermin showed fibrosis improvement and MASH at week 24
- Ph II showed fibrosis improvement at w24 in pts with well-compensated cirrhosis (F4) at baseline*
- Sustained benefits on fibrosis markers were observed vs. placebo in patients on background GLP-1 therapy at week 48 (ENLIVEN 48-week extension data[1])
- 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

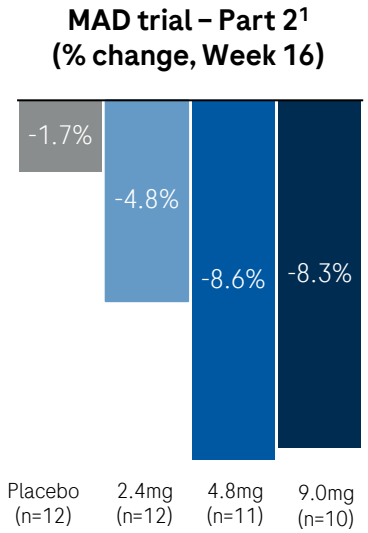
Strengthening our growing CVRM portfolio with a long-acting amylin analog

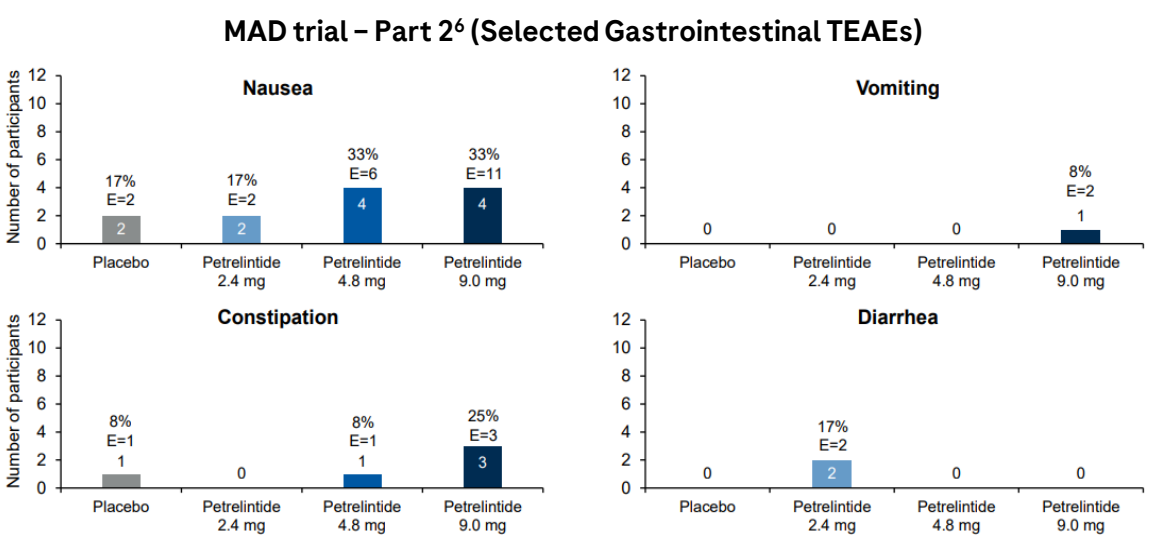
Development program



- 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





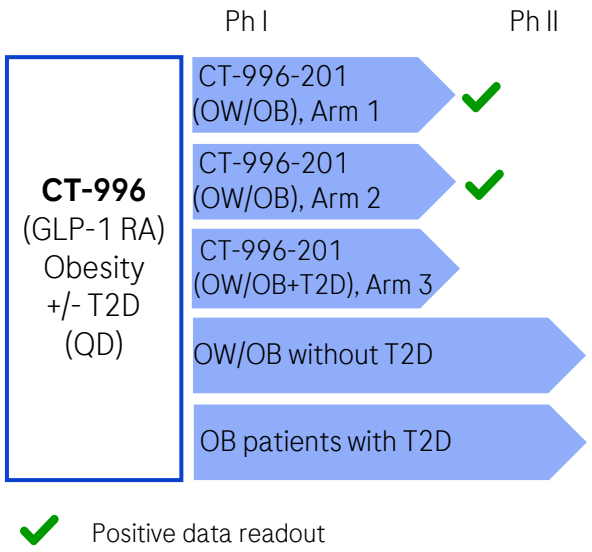
- After 16 weeks of treatment, mean weight loss was up to 8.6% with petrelintide vs 1.7% with placebo
- Petrelintide was well tolerated: All GI AEs mild, except two moderate events in one patient who discontinued
- Combined Ph I data suggest a potential for weight loss comparable to mono GLP-1, but with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

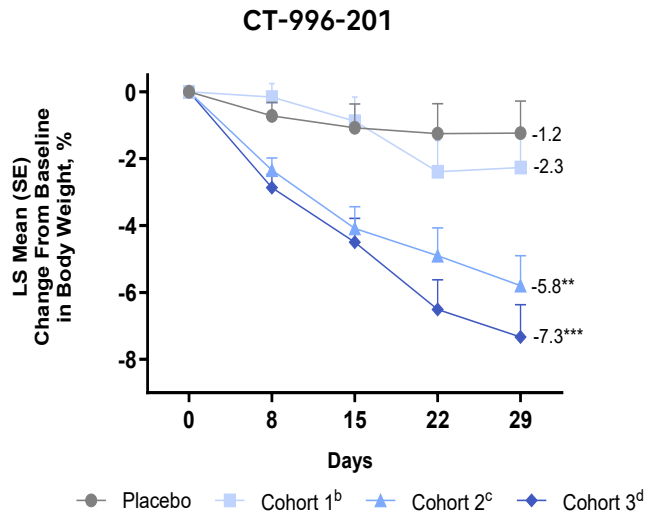
Oral small molecule with high bioavailability and no food restrictions

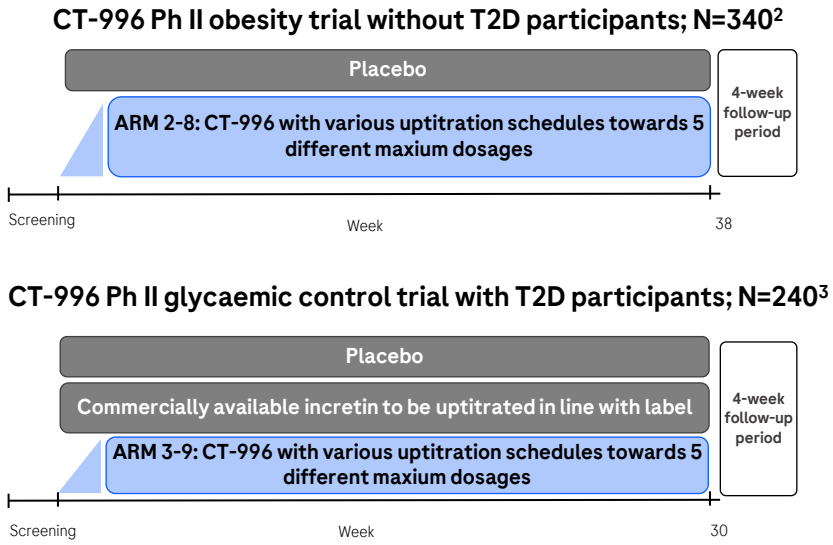
Development program



- 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





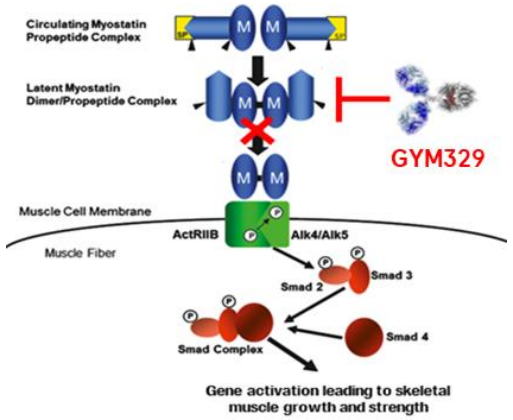
- Once daily oral dosing of CT-996 showed clinically meaningful placebo-adjusted weight loss up to 7.3% within 4 weeks in Ph I trial; GI-Related TEAEs were mostly mild and none were severe[1]
- Plasma half-life (17-22 hrs) supports once-daily dosing

*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).

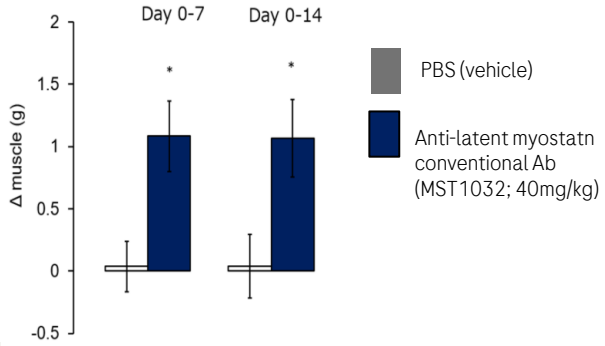
Emugrobart + tirzepatide Ph II (GYMINDA) results expected in 2026

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

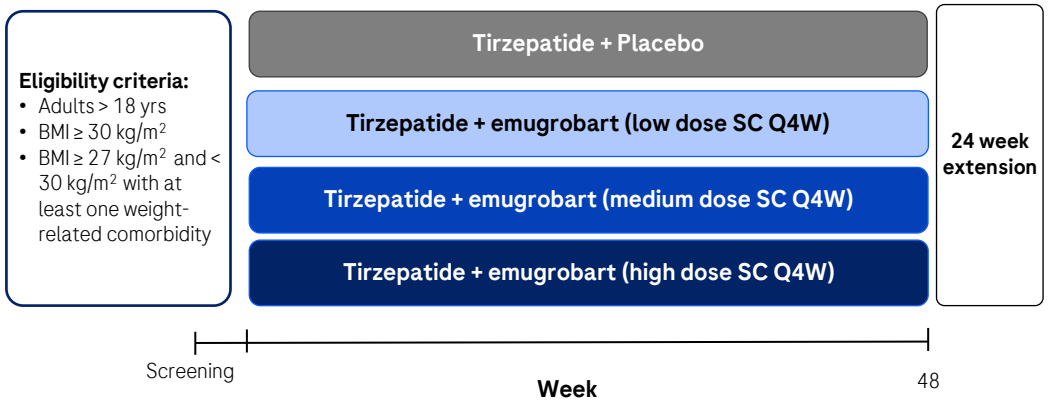


N=8, mean±SE *p<0.05; **p<0.01; ***p<0.001 Dunnett's test

- 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 GDF11[2], 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

Ph II GYMINDA, n=234[5]



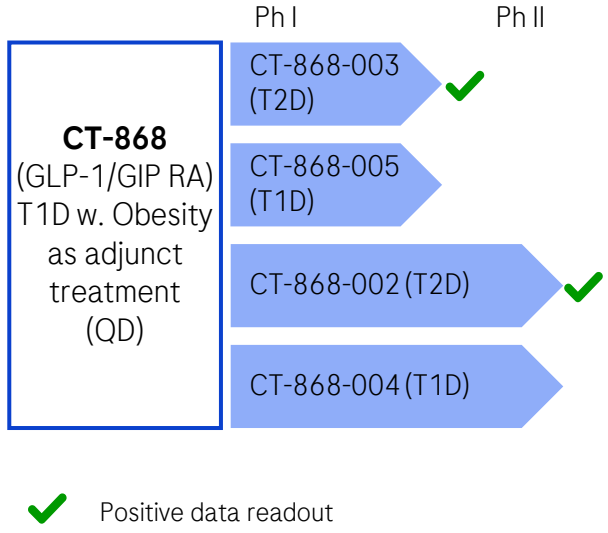
- Current anti-obesity therapies cause loss of lean mass; preservation of lean muscle mass during WL is a therapeutic goal[3,4]
- Emugrobart in combination with incretin-based therapies has the potential to improve weight loss, preserve muscle mass, and improve weight maintenance via increased metabolic 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 Rc 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

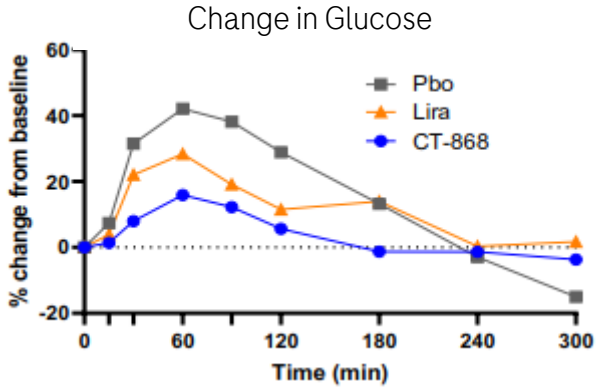
Development program

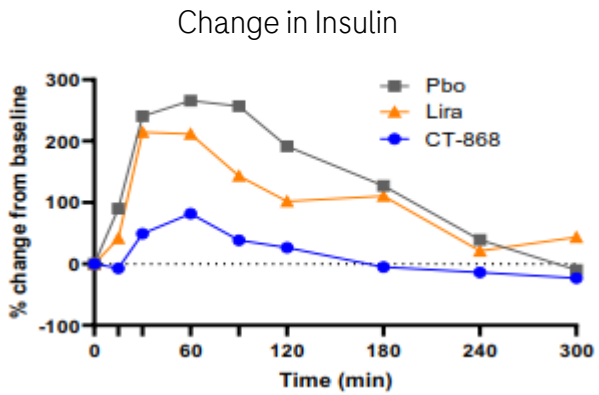


- Ph II PoC trial in T2D completed
- Ph I study in T1D ongoing
- Ph II PoC trial in T1D ongoing, results Q4 2025

CT-868 concomitantly reduces plasma glucose and insulin excursion[1]

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





- 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

1. Chakravarthy MV, et al. EASD 2023; GLP-1: glucagon-like peptide 1; GIPR: glucose-dependent insulinotropic polypeptide receptor; T1D: type-1 diabetes; T2D: type-2 diabetes; OW: overweight; OB: obesity

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

Ceiling effect on weight loss

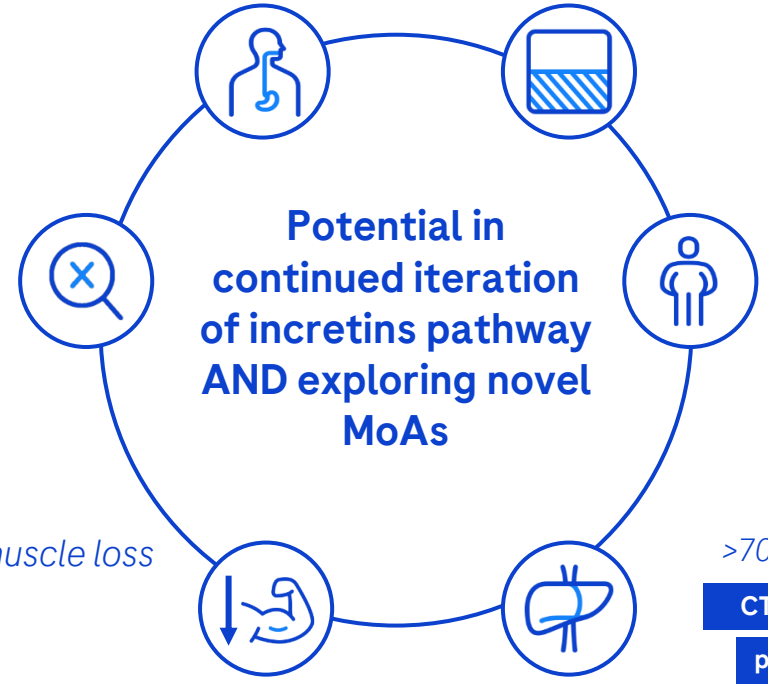
e.g., weight loss plateaus after 12–18 months

petrelintide | CT-388 | CT-388 + petrelintide

No or suboptimal response

to incretins in up to 20%[1] of patients

petrelintide | CT-388 + petrelintide



Weight maintenance

Majority of patients regain weight after stopping treatment

petrelintide | CT-388 | CT-996

Lean muscle loss

Up to 40% of weight loss comes from muscle loss

incretin + emugrobart

Comorbidities

>70% of PwO have at least one comorbidity

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

Cardiovascular and renal (CVR)

Improvement in cardiometabolic outcomes

zilebesiran | CT-868

* 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

Preparing for future growth

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

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
- ✓ **Zosurabalpin** 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

○ *Data in-house*

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
	Itovebi + fulvestrant	post CDKi HR+ mBC	Ph III INAVO121
	Itovebi + 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

*Preliminary, to be updated at FY 2025 -outcome studies are event-driven: timelines may change

Changes to the development pipeline

Pharma Day update

New to phase I

1 NME:
CHU pan-KRAS inhibitor (AUBE00) – solid tumors

New to phase II

1 NME:
RG6652 GLP-1 RA (CT-996) - obesity +/- T2D

1 AI:
RG6114 Itovebi - early-stage, PIK3CA-mut. BC

New to phase III

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 zosurabalpin - 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

New to registration

Removed from phase I

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

Removed from phase II

1 NME:
CHU anti-IL-8 – endometriosis

1 AI:
RG6107 PiaSky - sickle cell disease

Removed from phase III

1 AI:
RG1594 Ocrevus higher dose - PPMS

Approvals

* Pending deal closure; Status as of September 22, 2025

Roche Group development pipeline

Phase I (38 NMEs + 7 AIs)

RG6026	Columvi monotherapy + combos	heme tumors
RG6076	englumafusp alfa combos	heme tumors
RG6114	Itovebi	solid tumors
RG6160	cevostamab	r/r multiple myeloma
RG6171	giredestrant monotherapy + combos	solid tumors
RG6221	LTBR agonist	solid tumors
RG6330	divarasib monotherapy + combos	solid tumors
RG6344	mosperafenib (BRAF inhibitor (3))	solid tumors
RG6411	-	solid tumors
RG6468	-	solid tumors
RG6505	PanRAS inhibitor	solid tumors
RG6537	AR degrader	mCRPC
RG6538[1]	P-BCMA-ALLO1	r/r multiple myeloma
RG6540[1]	P-CD19 x CD20 - ALLO1	heme tumors
RG6561	-	solid tumors
RG6596[2]	HER2 TKI	HER2+ BC
RG6620	KRAS G12D inhibitor	solid tumors
RG6648[3]	cMET ADC	solid tumors
RG7828	Lunsumio monotherapy + combos	heme tumors
RG6794	CDK4/2i	HR+ HER2- BC
RG6810[4]	DLL3 ADC	SCLC
CHU	DLL3 trispecific	solid tumors
CHU	codrituzumab	HCC
CHU	MINT91	solid tumors
CHU	anti-CTLA-4 switch antibody	solid tumors
CHU	pan-KRAS inhibitor (AUBE00)	solid tumors
RG6382	CD19 x CD3	SLE
RG6377	-	IBD
RG6418*	selnoflast	inflammation
RG6421	TMEM16A potentiator	Muco-obstructive respiratory disease
RG6631	afimkibart (anti-TL1A)	MASH
RG7828	Lunsumio	SLE
CHU	anti-HLA-DQ2.5 x gluten peptides	celiac disease
CHU	anti-C1s recycling antibody	immunology
RG6035	Brainshuttle™ CD20	multiple sclerosis
RG6182	MAGL inhibitor	multiple sclerosis
RG6434	-	neurodegenerative disorders
RG6662	HTT miRNA GT (SPK-10001)	Huntington's disease
RG6120	zifibancimig	nAMD
RG6209	VEGF-IL-6 DutaFab	DME
RG6327	-	geographic atrophy
RG6006	zosurabalpin	bacterial infections
RG6436	LepB inhibitor	complicated urinary tract infection
CHU	REVN24	acute diseases
CHU	BRY10	chronic diseases

Phase II (17 NMEs + 8 AIs)

RG6114	Itovebi	early-stage, PIK3CA-mut. BC
RG6171	giredestrant	endometrial cancer
RG6180	autogene cevumeran	solid tumors
RG6797	SPK-8011QQ	hemophilia A
RG6512	FIXa x FX (NXT007)	hemophilia
RG6287	flizasertib	CS-AKI
RG6536	vixarelimab	IPF/SSc-ILD
RG6631	afimkibart (anti-TL1A)	atopic dermatitis
RG6237	emugrobart (GYM 329)	obesity
RG6615[5]	zilebesiran	hypertension
RG6641	GLP-1/GIP RA (CT-868)	T1D with BMI ≥ 25
RG6640	GLP-1/GIP RA (CT-388)	obesity +/- T2D
RG6849[6]	petrelintide	obesity +/-T2D
RG6652	GLP-1 RA (CT-996)	obesity +/- T2D
RG6042	tominersen	Huntington's
RG6168	Enspryng	DMD
RG6237	emugrobart (GYM 329) + Evrysdi	SMA
	emugrobart (GYM 329)	FSHD
RG6289	nivegacetor (gamma-secretase modulator)	Alzheimer's
RG6356	Elevidys	0 to <4 year old DMD
RG7816	alogabat	Angelman syndrome
RG7935	prasinezumab	Parkinson's
RG6179	vamikibart	DME
RG6351	Tie2 agonist	DME
RG6501	OpRegen	geographic atrophy

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

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

Post Bar projects
Pre Bar projects
Oncology / Hematology
Immunology
Cardiovascular, Renal & Metabolism
Neurology
Ophthalmology
Other

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, zosurabalpin

Roche Group development pipeline

Phase III (9 NMEs + 28 AIs)

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

Registration US & EU (1 NME + 4 AIs)

RG7446	Tecentriq + lurbinectedin[1]	1L maintenance SCLC
RG7828	Lunsumio SC	3L+ FL
RG7159	Gazyva	lupus nephritis
RG6152	Xofluza[1]	influenza direct transmission
RG6356	Elevidys[2;3]	DMD

T:Tecentriq
*also known as pediatric nephrotic syndrome (PNS)
[1]Filed in US
[2]Approved in US, negative CHMP opinion July 2025
[3]US rights with Sarepta

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, zosurabalpin

Doing now what patients need next