POWERING THE IMMUNE SYSTEM
TO TRANSFORM LIVES

Corporate Overview

June 8, 2024



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Legal Disclaimer

Forward-Looking Statements

Statements in this presentation that are not statements of historical fact are forward-looking statements. Such forward-looking statements include, without limitation, statements regarding the near-term financial performance of Vir Biotechnology, Inc. (the "Company" or "Vir"); the Company's strategy and plans; capital allocation; financial and operating results and its expectations related thereto; potential of, and expectations for, the Company's pipeline; the Company's clinical development programs, clinical trials, including the enrollment of clinical trials, and data readouts and presentations; clinical data from the Company's ongoing trials of tobevibart and elebsiran; the ability of tobevibart and elebsiran (as monotherapies or combination therapies) to treat and/or prevent chronic hepatitis Delta (CHD) or chronic hepatitis B virus (CHB); timing and outcome of the Company's planned interactions with the U.S. Food and Drug Administration (FDA); whether the Company receives any accelerated development paths from the FDA for tobevibart and elebsiran (as monotherapies or combination therapies) to treat and/or prevent CHD or CHB; the Company's preclinical pipeline;the Company's preclinical pipeline; the Company's collaboration with the Biomedical Advanced Research and Development Authority (BARDA); the Company's use of artificial intelligence and machine learning in its efforts to engineer next-generation proteins and in other research and development efforts; the timing and amount of actual expenses, including, without limitation, the Company's anticipated combined GAAP R&D and SG&A expenses; and the Company's plans for its CHD, CHB, human immunodeficiency virus (HIV), RSV/MPV, Influenza, pre-cancerous HPV lesions, and COVID-19 portfolios.

Words such as "aim," "anticipate," "believe," "could," "expect," "goal," "intend," "may," "plan," "potential," "promising," "will," and similar expressions are intended to identify forward-looking statements, though not all forward-looking statements necessarily contain these identifying words. These forward-looking statements are based on the beliefs of the management of the Company as well as assumptions made by and information currently available to the Company. Such statements reflect the current views of the Company with respect to future events and are subject to known and unknown risks, including unexpected safety or efficacy data or results observed during clinical trials or in data readouts; the timing and outcome of the Company's planned interactions with regulatory authorities; difficulties in obtaining regulatory approval; uncertainty as to whether the anticipated benefits of the Company's collaborations with BARDA and other companies can be achieved; difficulties in collaborating with other companies; challenges in accessing manufacturing capacity; clinical site activation rates or clinical trial enrollment rates that are lower than expected; successful development and/or commercialization of alternative product candidates by the Company's competitors; changes in expected or existing competition; the Company's use of artificial intelligence and machine learning in its efforts to engineer next-generation proteins and in other research and development efforts; the timing and amount of actual expenses, including, without limitation, the Company's anticipated combined GAAP R&D and SG&A expenses; geopolitical changes or other external factors; and unexpected litigation or other disputes. In light of these risks and uncertainties, the events or circumstances referred to in the forward-looking statements may not occur. Drug development and commercialization involve a high degree of risk, and only a small number of research and development programs result in commercialization of a product. Results in early-stage clinical trials may not be indicative of full results or results from later stage or larger scale clinical trials and do not ensure regulatory approval. The actual results may vary from the anticipated results and the variations may be material. Other factors that may cause the Company's actual results to differ from current expectations are discussed in the Company's filings with the U.S. Securities and Exchange Commission, including the section titled "Risk Factors" contained therein. These forward-looking statements should not be taken as forecasts or promises nor should they be taken as implying any indication, assurance or guarantee that the assumptions on which such forward-looking statements have been made are correct or exhaustive or, in the case of the assumptions, fully stated in this presentation. You are cautioned not to place undue reliance on the scientific data presented or these forward-looking statements, which speak only as of the date of this presentation. Except as required by law, the Company undertakes no obligation to publicly update any forward-looking statements, whether as a result of new information, future events or otherwise. The Company claims the protection of the safe harbor for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995 for all forward-looking statements.

This presentation discusses product candidates that are under clinical study, and which have not yet been approved for marketing by the FDA. No representation is made as to the safety or effectiveness of these product candidates for the use for which such product candidates are being studied. The trademarks included herein are the property of the owners thereof and are used for reference purposes only. Such use should not be construed as an endorsement of such products.

Marketing Authorization/Emergency Use of Sotrovimab

Sotrovimab has been granted a marketing authorization in the EU (inclusive of 27 member states), Norway, Iceland, Great Britain (conditional), Switzerland (conditional), Australia (provisional) and Bahrain. In Japan, a Special Approval in Emergency has been granted and temporary/emergency authorization in Oman and the UAE. In the United States, sotrovimab has not been approved, but has been authorized for emergency use by the FDA under an Emergency Use Authorization (EUA), to treat mild-to-moderate COVID-19 in adults and pediatric patients (12 years of age and older weighing at least 40 kg) with positive results of direct SARS-CoV-2 viral testing, and who are at high risk for progression to severe COVID-19, including hospitalization or death. In March and April 2022, the FDA amended the EUA fact sheet to exclude sotrovimab use in geographic regions where infection is likely to have been caused by a non-susceptible SARS-CoV-2 variant based on available information, including variant susceptibility to these drugs and regional variant frequency. With this EUA revision, sotrovimab is not currently authorized for use in any U.S. region, and we cannot predict whether (if at all) or to what extent sotrovimab may be reauthorized for use by the FDA in any U.S. region in the future. In addition, there can be no assurance with respect to how long the EUA will remain in effect or whether the EUA will be further revised or revoked by the FDA following the termination of the underlying public health emergency declaration on May 11, 2023, or for other reasons.

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Vir Biotechnology: Powering the Immune System to Transform Lives

Our Scientific Capabilities

- **Uniquely discovered and engineered human & mouse mAbs**
- **World-class immunology & virology expertise**
- **Leading machine learning & AI capabilities**
- **Ability to rapidly advance pipeline candidates**

Strategy

Infectious Disease

- **Hepatitis Delta**
- **Hepatitis B**
- COVID
- Influenza
- RSV +/- MPV
- HIV

Beyond Infectious Disease

- Viral-associated disease
  including HPV-associated cancers and pre-cancerous lesions
- Immune targeting
  for infectious disease and oncology

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Vir in 2024: Anticipated Value-Driving Catalysts

Program	Drug Candidates/Regimen	Catalyst	Timing
HIV	VIR-1388 (T cell vaccine)	Phase 1: Initial immunogenicity data	H2
Chronic Hepatitis Delta	tobevibart (mAb) monotherapy tobevibart (mAb) + elebsiran (siRNA) combo	Phase 2: Additional SOLSTICE clinical data 30 participants per regimen at 24w	Q4
Chronic Hepatitis B	tobevibart (mAb) + elebsiran (siRNA) +/- PEG-IFN-α for 48 weeks	Phase 2: MARCH-B clinical data at 48w EOT ~50 tobevibart + elebsiran participants ~30 tobevibart + elebsiran + PEG-IFN-α participants	Q4
COVID-19	VIR-7229 (prophylactic mAb)	IND filing	Q4

HIV: Human Immunodeficiency Virus;
IND: Investigational New Drug

mAb: monoclonal antibody;
siRNA: small interfering RNA;
PEG-IFN-α: peginterferon alfa-2a
EOT: End of treatment

MARCH: NCT04856085
SOLSTICE: NCT05461170
PREVAIL: NCT05612581
VIR-1388: NCT05854381

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Broad Pipeline to Deliver Near-Term Growth

siRNA Antibody T-cell

Disease Area	Product Candidate	Treatment / Prevention	Preclinical	Phase 1	Phase 2	Phase 3	Authorized	Collaborator
Chronic Hepatitis Delta	tobevibart +/- elebsiran	Treatment						Alnylam
Chronic Hepatitis B	elebsiran + PEG-IFN-α	Treatment						Alnylam
	tobevibart + elebsiran ± PEG-IFN-α[1]	Treatment						Alnylam
	elebsiran + TLR8[2] + PD-1[3]	Treatment						Alnylam/ Gilead Sciences
HIV	VIR-1388	Prevention						Bill & Melinda Gates Foundation/HVTN/NIAID
	Cure: mAb combination	Treatment						Bill & Melinda Gates Foundation
RSV +/- MPV	VIR-8190* Preclinical antibody candidates	Prevention						
Influenza	VIR-2981 (Influenza A+B) ADCs	Prevention						
Pre-cancerous HPV lesions	VIR-1949	Treatment						
COVID-19	VIR-7229	Prevention						
	Sotrovimab	Treatment (Early)						GSK

Sotrovimab incorporates Xencor's Xtend™ technology. Tobevibart incorporates Xencor's XtendTM and other Fc technologies.
HIV: Human Immunodeficiency Virus; RSV: Respiratory Syncytial Virus; hMPV: human Metapneumovirus; HPV: Human Papilloma Virus; PEG-IFN-α: peg-interferon alfa-2a; mAb: monoclonal antibody
*Per the collaboration agreement announced in February 2021, Vir and GSK are continuing to advance new monoclonal antibody therapeutics for RSV.
ADCs = Antibody-drug conjugates

HVTN: HIV Vaccine Trials Network; NIAID: National Institute of Allergy and Infectious Diseases
1: MARCH trial (Part B); 2: GS-9688; 3: nivolumab
†sotrovimab for early treatment by IV currently has marketing approval, temporary authorization or emergency use authorization in >40 countries.
In April 2022, the FDA deauthorized sotrovimab's use in all US regions.

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POWERING THE IMMUNE SYSTEM
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PHASE 2 CATALYST:

Potentially Transformative Treatment for Chronic Hepatitis Delta (Delta)

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Hepatitis Delta: The Most Severe Form of Viral Hepatitis

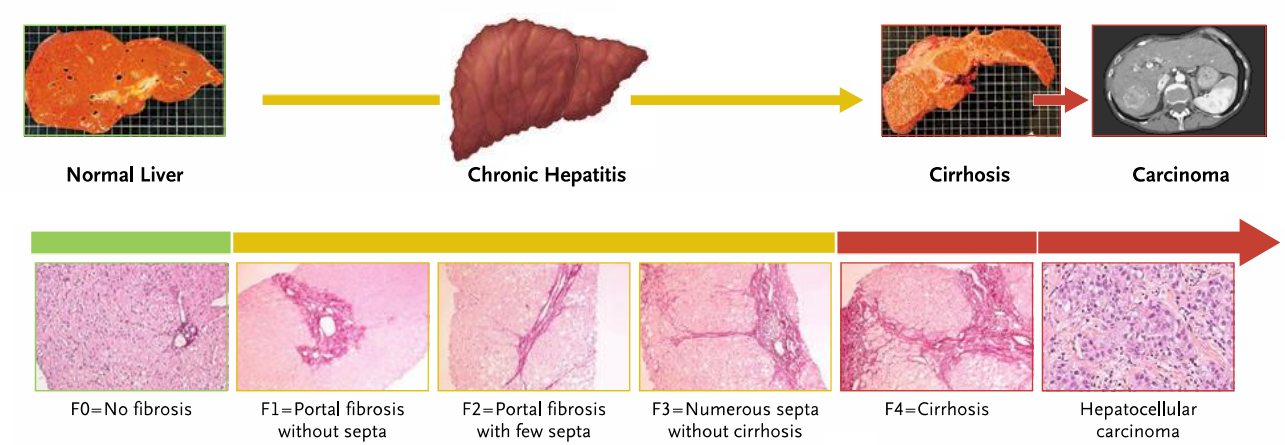
Severe unmet need

At least
12M living with hepatitis delta globally[1-5]

300K patients across U.S. (~100k) and Europe (~200k)[6]
- No approved therapy in U.S.

+29% Higher annual healthcare costs per person, than CHB alone[8]

Irreversible progression to cirrhosis[1]



~41% develop cirrhosis[2]

Avg. ~5 years to cirrhosis progression[3]

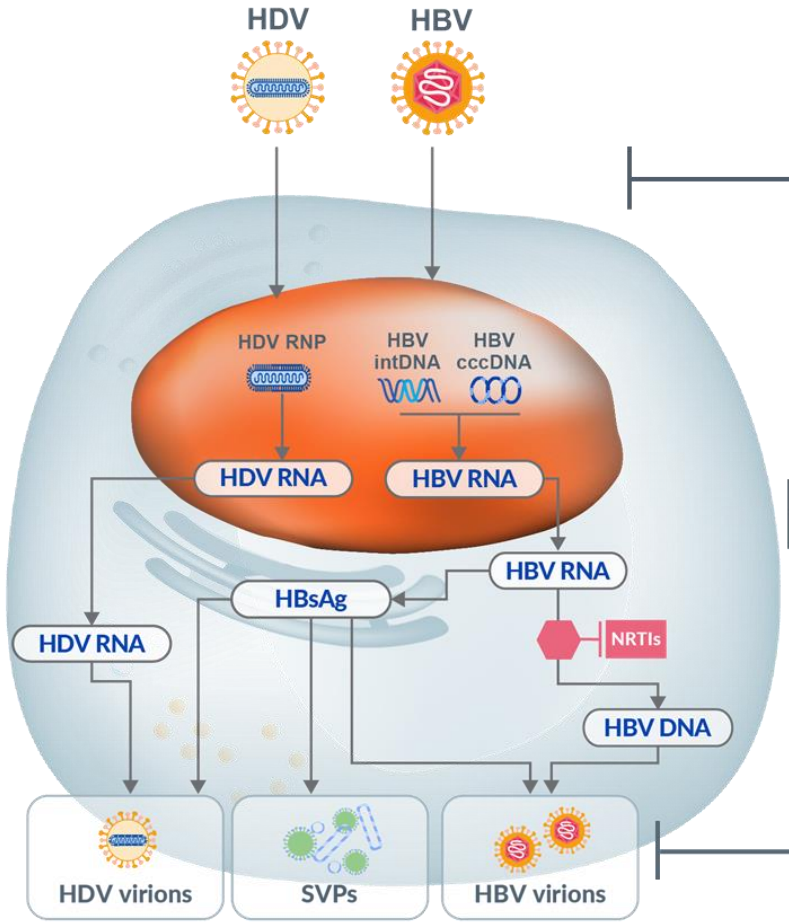
>50% mortality from liver disease within 10 years[7]

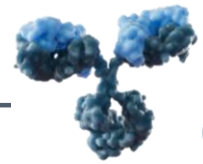
Avg. ~10 years to HCC progression[3]

Source:
1 - Asselah, Tarik, and Mario Rizzetto. "Hepatitis D virus infection." New England Journal of Medicine 389.1 (2023): 58-70, Figure 5.
2 - Chen, Hai-Yan, et al. "Prevalence and burden of hepatitis D virus infection in the global population: a systematic review and meta-analysis." Gut 68.3 (2019): 512-521.
3 - Miao, Zhijiang, et al. "Estimating the global prevalence, disease progression, and clinical outcome of hepatitis delta virus infection." The Journal of infectious diseases 221.10 (2020): 1677-1687.
4 - Wedemeyer H, Manns MP. Epidemiology, pathogenesis and management of hepatitis D: update and challenges ahead. Nat Rev Gastroenterol Hepatol. 2010;7: 31–40. doi:
5 - Stockdale AJ, Kreuels B, Henrion MYR, Giorgi E, Kyomuhangi I, de Martel C, et al. The global prevalence of hepatitis D virus infection: Systematic review and meta-analysis. J Hepatol. 2020;73: 523–532. doi: 10.1016/j.jhep.2020.04.008
6 - NHANES (2019), Stockdale (2020), Rizzetto 2012; Ho 2013; Krastev 2013; Manesis 2013; Gheorghe 2015; Jelen 2016; Ordieres 2017; Vlachogiannakos 2020; Sperle 2020; Beudeker 2021, European Centre for Disease Prevention and Control. Systematic review on hepatitis B and C prevalence in the EU/EEA. Stockholm: ECDC; 2016.
7 - Negro F, Lok AS. Hepatitis D: A Review. JAMA. 2023 Dec 26;330(24):2376-2387. doi: 10.1001/jama.2023.23242. PMID: 37943548.
8 - Elsaid, Mohamed I., et al. "Economic and health care burdens of hepatitis delta: a study of commercially insured adults in the United States." Hepatology 72.2 (2020): 399-411.

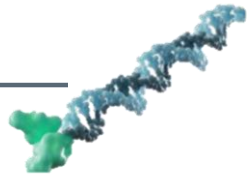
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Our Ambition: Transformative Viral Suppression with 1-2X/Month Dosing

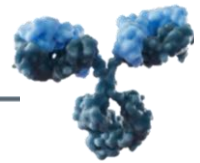




Inhibition of viral entry **(tobevibart)**



Degradation of HBV RNA & reduction of HBsAg production **(elebsiran)**



Neutralization of HDV & HBV virions **(tobevibart)**

MOA: mechanism of action
cccDNA: covalently closed circular DNA
HBsAg: hepatitis B virus surface antigen
HBV: hepatitis B virus
HDV: hepatitis D virus

Int: integrated
NRTI: nucleoside/nucleotide reverse transcriptase inhibitor
RNP: ribonucleoprotein
SVP: subviral particle

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HBsAg is the key viral protein responsible for recognition, binding, and entry of HBV and HDV virions to hepatocytes

Complementary mechanisms of action in combination:

Tobevibart

mAb: Fc-engineered monoclonal antibody

- Designed to bind to HBsAg on HDV virions

Elebsiran

- **siRNA:** small interfering ribonucleic acid
- Designed to degrade HBV RNA transcripts & limit the production of HBsAg

Preliminary Data From the Ongoing Phase 2 SOLSTICE Trial

Based on preliminary data presented at the European Association for the Study of the Liver, EASL™ Congress 2024

- **Sustained HDV RNA virologic suppression** for tobevibart + elebsiran combination rollover
- **High rates of virologic suppression** achieved in participants receiving tobevibart alone, or in combination with elebsiran, **with >50% achieving HDV RNA TND** in the de novo combination cohort
- **Rates of ALT normalization increased** from week 12 to 24 with **>50% normalization at week 24** in both tobevibart monotherapy and de novo combination cohorts
- **No treatment related SAEs or ALT flares** have occurred to date; majority of AEs were transient and Grade 1 or 2
- **Similar rates of virologic suppression and ALT normalization** at week 24 observed in participants **without cirrhosis (n=6) and compensated cirrhosis (CPT-A, n=5),** in de novo tobevibart + elebsiran combination therapy[1,2]

[1]Insufficient data to assesses preliminary differences participants with non-cirrhosis compared to participants with cirrhosis in the monotherapy treatment regimen.
[2]Number of participants with cirrhosis: week 12 = 13, week 24 = 5

Preliminary data, ITT analysis

ALT: alanine aminotransferase,
SAE: serious adverse event
TND: target not detected
ITT: Intent to treat

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Key Data Summary

Preliminary data from SOLSTICE Trial Suggest the Potential for a Transformative Treatment Option

Combination Cohort: De Novo

Tobevibart 300mg + Elebsiran 200mg, Q4W to 96 weeks
(Non-Cirrhotic or CPT-A)

Week 24: N=11

- HDV RNA < LLOQ: **11/11 (100%)**
- HDV RNA < LOD: **10/11 (91%)**
- TND: **6/11 (55%)**
- ALT normalization: **7/11 (64%)**

Week 24: N=32

Q4 2024

Monotherapy Cohort

Tobevibart 300 mg, Q2W, to 96 weeks
(Non-Cirrhotic or CPT-A)

Week 24: N=11

- HDV RNA < LLOQ: **6/11 (55%)[1]**
- HDV RNA < LOD: **5/11(46%)[1]**
- TND: **2/11 (18%)[1]**
- ALT normalization: **7/11 (64%)[1]**

Week 24: N=33

Q4 2024

No treatment related serious adverse events reported to date

ALT: alanine transaminase
LLOQ (lower limit of quantification) = 63 IU/mL
LOD (limit of detection) = 14 IU/mL
TND: target not detected
ITT: Intent to treat

CPT, Child Pugh Turcotte
NCT05461170

[1]Responses on ITT basis, and include 4 participants who discontinued treatment

Preliminary data, ITT analysis

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Next Steps for Clinical Development in Hepatitis Delta

Q2

EASL Presentation

- Oral presentation on Saturday 8th June
- Latest SOLSTICE data

Q3

Regulatory Engagement

- Next steps on development
- Explore appropriate accelerated development paths

Q4

Additional Data

- ~30 participants per regimen at 24 weeks will be reported in Q4

Q2 2024 → Q3 2024 → Q4 2024

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Preliminary Data from Three Cohorts in the Phase 2 SOLSTICE Trial

Combination and Monotherapy for the Chronic Treatment of Hepatitis Delta Infection

Combination Cohort: Rollover

Tobevibart lead-in
Once every 4 weeks
12 weeks (N=4)

Elebsiran lead-in
Once every 4 weeks
12 weeks (N=2)

Tobevibart 300mg
+ Elebsiran 200mg SC

Once every 4 weeks *rollover*,
up to 96 weeks

N = 6 (Non-Cirrhotic)

Combination Cohort: De Novo

Tobevibart 300mg
+ Elebsiran 200mg SC

Once every 4 weeks,
up to 96 weeks

N = 32 (Non-Cirrhotic or CPT-A)

Monotherapy Cohort

Tobevibart 300mg SC

Once every 2 weeks,
up to 96 weeks

N = 33 (Non-Cirrhotic or CPT-A)

SC: Subcutaneous
CPT, Child Pugh Turcotte
NCT05461170
ITT: Intent to treat

Preliminary data, ITT analysis

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SOLSTICE Trial Endpoints Include Virologic Response and ALT Normalization at Week 24

Participant Criteria:

- Male or female ages 18-70 y/o
- HDV RNA > 500 IU/Ml
- ULN < ALT < 5x ULN
- On NRTI

Primary Endpoints

- **Combined Endpoint (CE) = virologic response and ALT normalization at Week 24**
  - Virologic response = Undetectable HDV RNA (< limit of detection, 14 IU/mL) or ≥ 2 log_{10} IU/mL decrease
  - ALT Normalization = ALT ≤ upper limit of normal (F = 33 U/L M = 40 U/L)
- **Proportion with treatment-emergent adverse events (TEAEs) and serious adverse events (SAEs)**

Key Secondary Endpoints

Proportion of participants with undetectable HDV RNA:

- Less than lower limit of quantitation (LLOQ)
- Less than limit of detection (LOD)

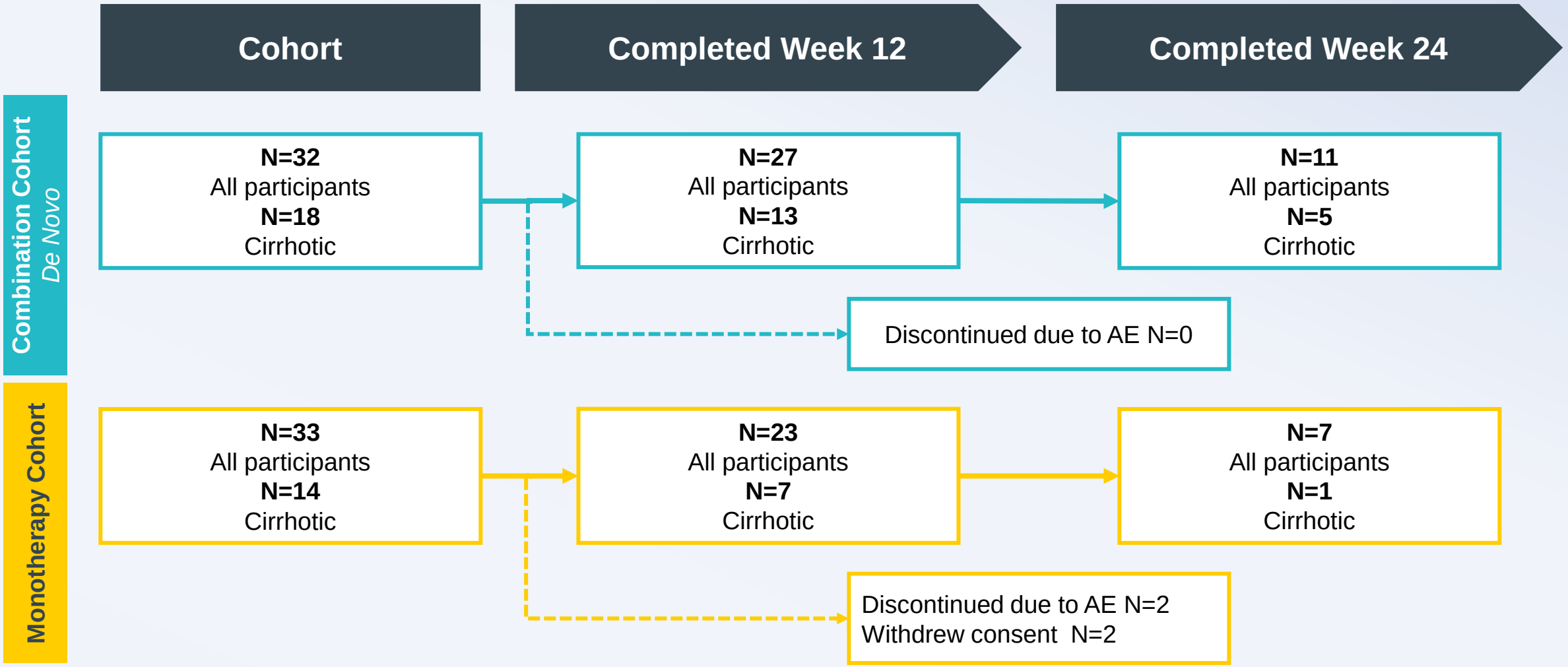
IU/mL: International units per milliliter
NRTI: Nucleotide Reverse Transcriptase Inhibitor
ULN: Upper Limit Normal
ALT: alanine transaminase
ITT: Intent to treat

SC: Subcutaneous
HBsAg, hepatitis B surface antigen
CPT, Child Pugh Turcotte
NCT05461170

Preliminary data, ITT analysis

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Dispositions for De Novo Combination and Monotherapy Cohorts as of May 2024



AE: adverse event
ITT: intent to treat
NCT05461170
ITT: Intent to treat

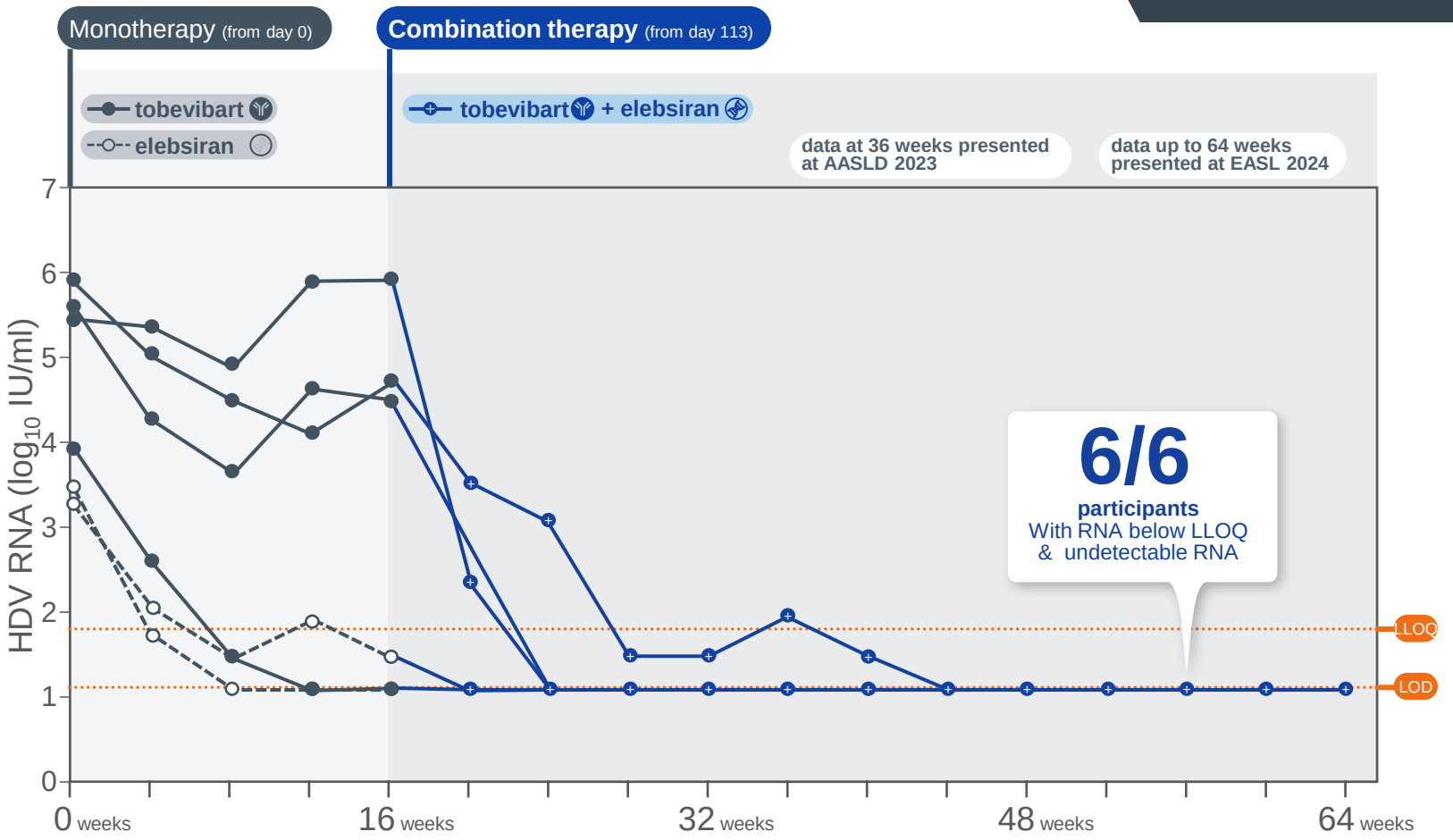
Preliminary data, ITT analysis

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Sustained HDV RNA Virologic Suppression Observed for Tobevibart + Elebsiran Combination Rollover Following Monotherapy Lead-in

Durable Anti-HDV Activity

SOLSTICE TRIAL: rollover tobevibart + elebsiran combination therapy [1]



Rollover cohort: All 6 participants remained on therapy

- 5 participants at week 64, 1 at week 56 (48 weeks and 40 weeks of combination therapy respectively)

Virologic Suppression:

- 6/6 below LLOQ
- 5/6 below LOD
- 5/6 achieved TND

ALT Normalization:

- Observed in 3 out of 6 trial participants

1: Cohort 2C has 6 total participants enrolled with 5 participants reaching at least 40 weeks. From the 6 participants who have reached at least 40 weeks, 5 participants achieved HDV RNA < LLOQ at 40 weeks. Participants achieving primary endpoint at Week 12 transitioned to extended dosing (Q8W) monotherapy. Participants not achieving ALT normalization and virologic response at Week 12 transitioned to combination therapy.

HDV: Hepatitis Delta Virus; RNA: RiboNucleic Acid ; LLOQ (lower limit of quantification) = 63 IU/mL; LOD (limit of detection) = 14 IU/mL; AEs: Adverse Events, ITT: Intent to treat

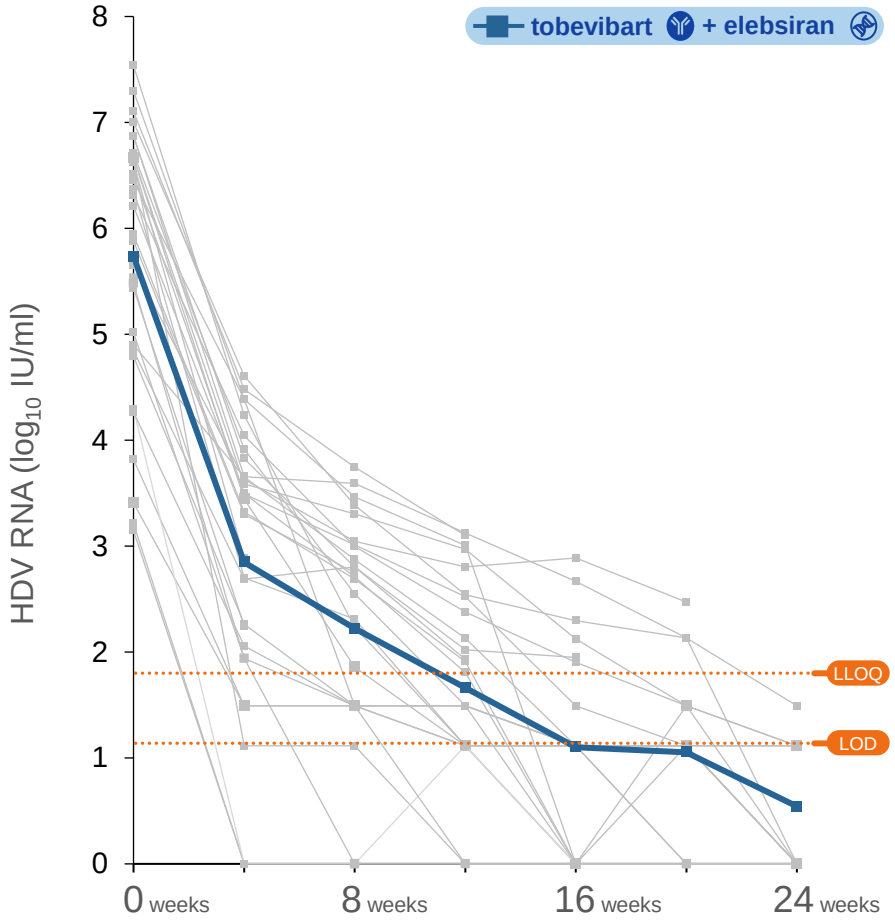
Preliminary data, ITT analysis

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De Novo Tobevibart + Elebsiran: Rapid Virologic Response and High Rates of HDV RNA Virologic Suppression and ALT Normalization

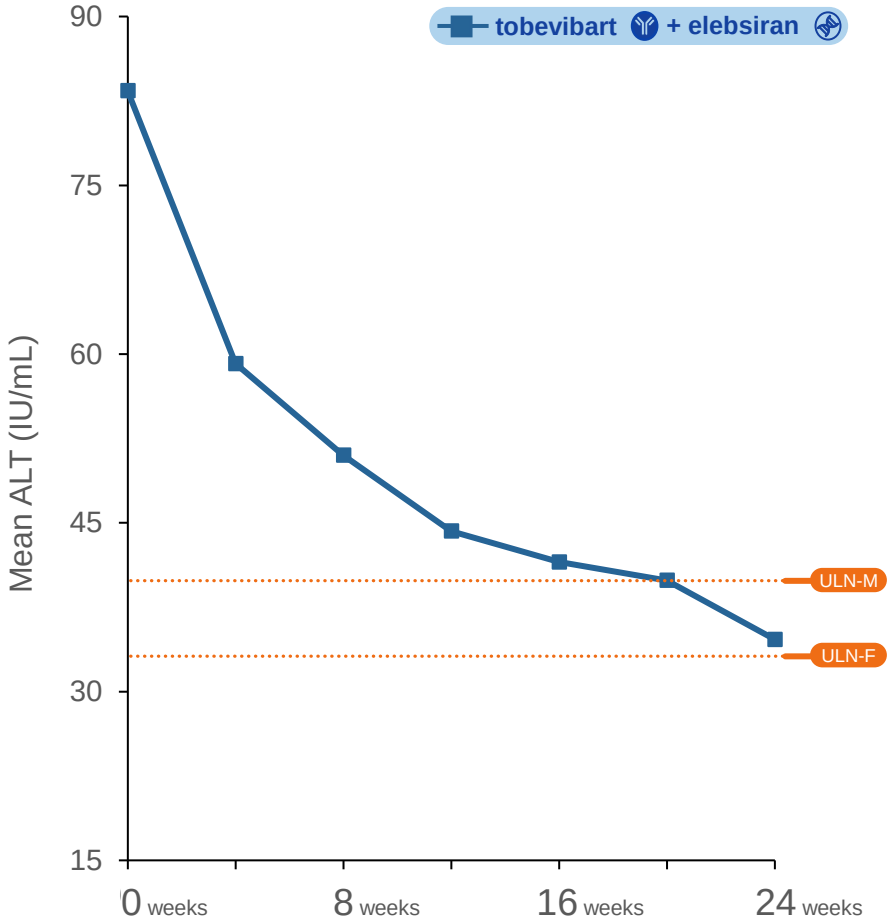
Rapid Virologic Response

De novo tobevibart + elebsiran combination therapy



Demonstrated ALT normalization

De novo tobevibart + elebsiran combination therapy



	Week 12 n=27	Week 24 n=11
Virologic Response[2]	27/27 (100%)	11/11 (100%)
HDV RNA < LLOQ	14/27 (52%)	11/11 (100%)
HDV RNA < LOD	10/27 (37%)	10/11 (91%)
HDV RNA TND	4/27 (15%)	6/11 (55%)
ALT normalization	12/27 (44%)	7/11 (64%)
Combined Endpoint[3]	12/27 (44%)	7/11 (64%)

- High rates of virologic suppression observed, with >50% achieving TND HDV RNA at week 24
- Virological suppression was similar in participants with and without cirrhosis[1]
- The proportion of participants with ALT normalization increased over time

[1]Number of participants with cirrhosis: week 12 = 13, week 24 = 5
[2]HDV RNA < LOD or ≥ 2 $\log_{10}$ IU/mL decrease from baseline
[3]Virologic Response and ALT normalization

HDV: Hepatitis Delta Virus RNA: RiboNucleic Acid, TND: target not detected, ULN: Upper Limit Normal; ALT: alanine transaminase, LLOQ (lower limit of quantification) = 63 IU/mL; LOD (limit of detection) = 14 IU/mL, ITT: Intent to treat

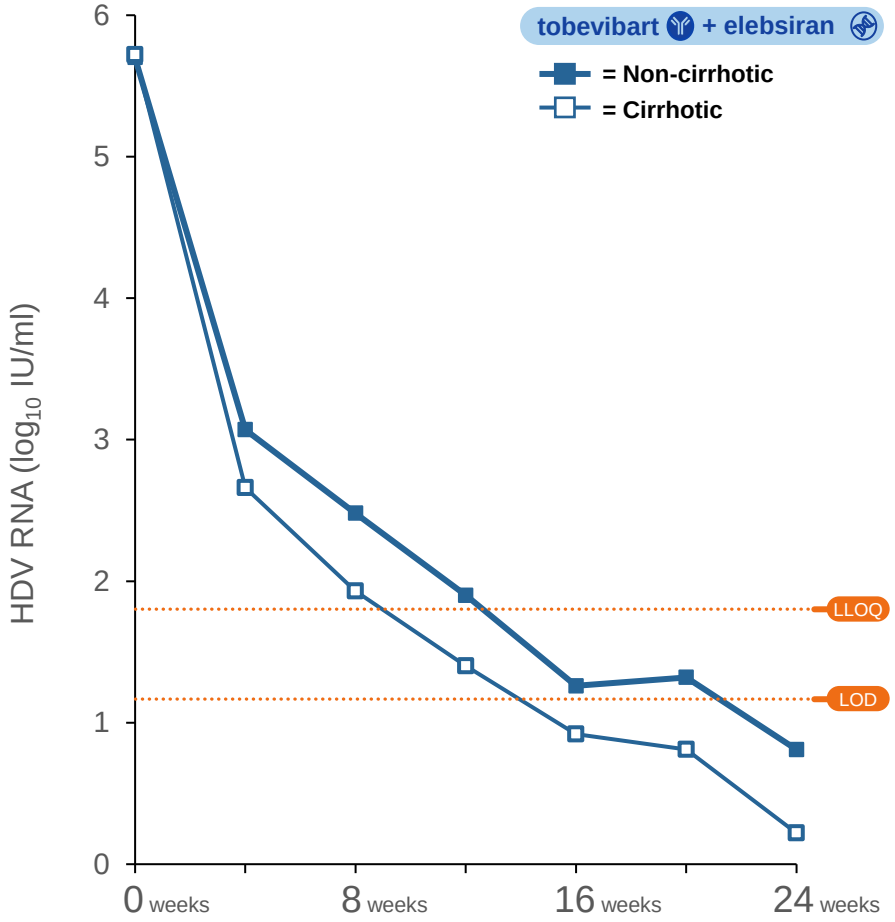
Preliminary data, ITT analysis

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De Novo Tobevibart + Elebsiran: virologic and ALT response across both cirrhotic and non-cirrhotic participants

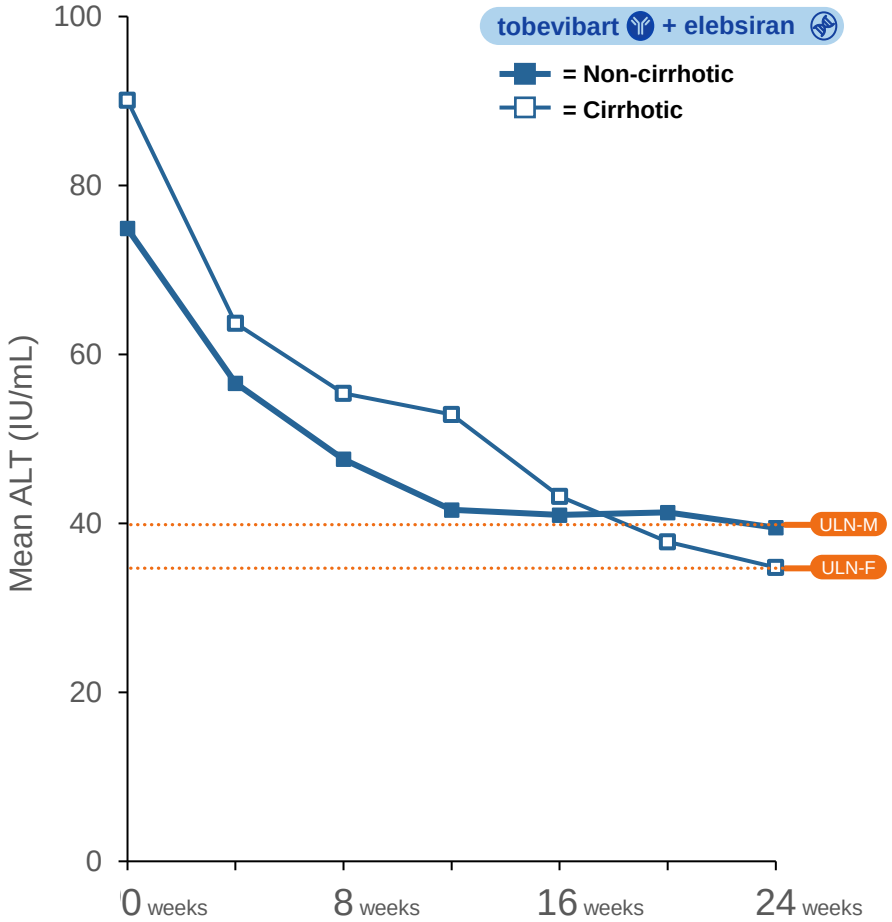
Virologic Response

De novo tobevibart + elebsiran combination therapy



ALT Response

De novo tobevibart + elebsiran combination therapy



	Non-cirrhotic		Cirrhotic	
	Week 12 n=14	Week 24 n=6	Week 12 n=13	Week 24 n=5
HDV RNA < LLOQ	6/14 (43%)	6/6 (100%)	8/13 (62%)	5/5 (100%)
HDV RNA < LOD	4/14 (29%)	5/6 (83%)	6/13 (46%)	5/5 (100%)
HDV RNA TND	2/14 (14%)	2/6 (33%)	2/13 (15%)	4/5 (80%)
ALT normal-ization	7/14 (50%)	3/6 (50%)	5/13 (39%)	4/5 (80%)

- No ALT flares were observed among cirrhotic participants
- Analysis for compensated cirrhotic participants receiving Tobevibart once every two weeks (Q2W) has not yet been conducted due to limited number of participants at week 24

HDV: Hepatitis Delta Virus RNA: RiboNucleic Acid, TND: target not detected, ULN: Upper Limit Normal; ALT: alanine transaminase, LLOQ (lower limit of quantification) = 63 IU/mL; LOD (limit of detection) = 14 IU/mL, ITT: Intent to treat

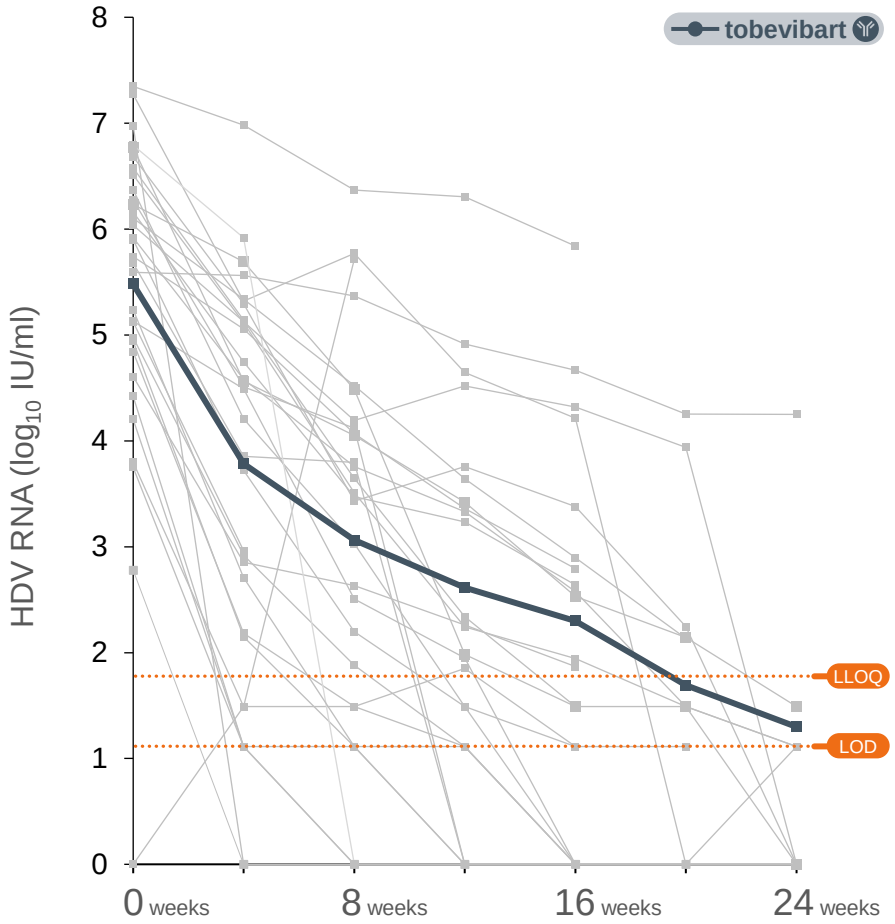
Preliminary data, ITT analysis

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Tobevibart Monotherapy: High Rates of HDV RNA Virologic Suppression and ALT Normalization

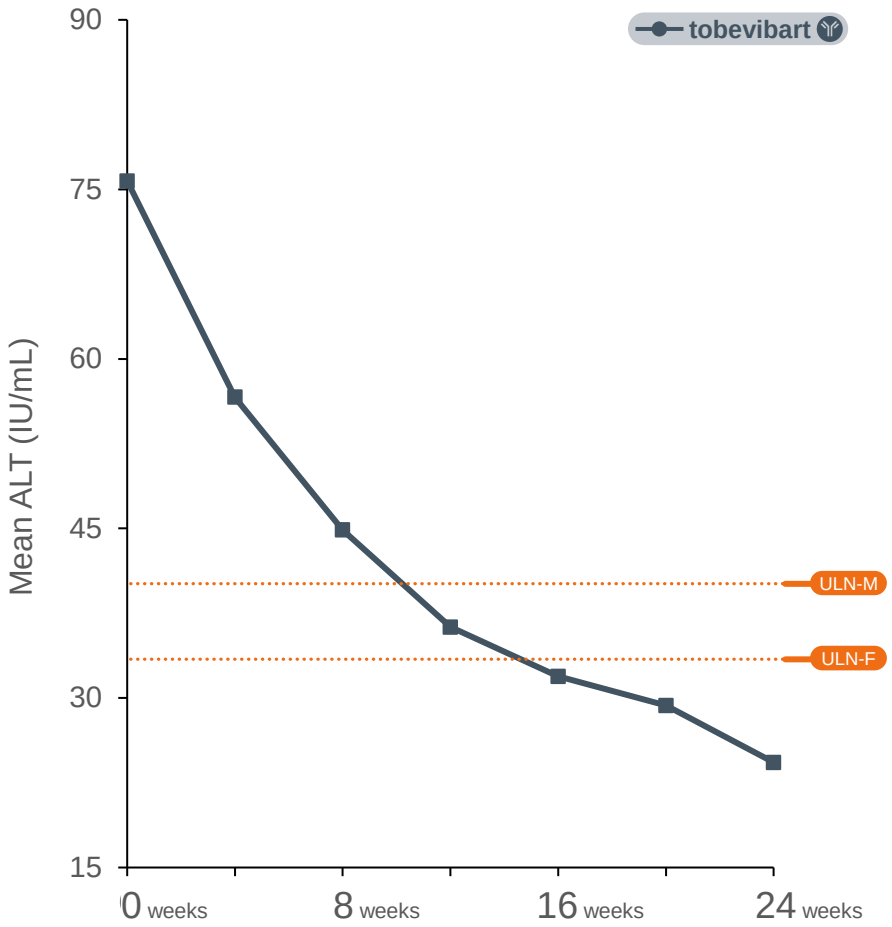
High Rate of Virologic Response[1]

tobevibart monotherapy



Demonstrated ALT normalization

tobevibart monotherapy



	Week 12 n=26[4]	Week 24 n=11[4]
Virologic Response[2]	19/26 (73%)	6/11 (55%)
HDV RNA < LLOQ	7/26 (27%)	6/11 (55%)
HDV RNA < LOD	5/26 (19%)	5/11 (46%)
HDV RNA TND	2/26 (8%)	2/11 (18%)
ALT normalization	14/26 (54%)	7/11 (64%)
Combined Endpoint[3]	10/26 (38%)	6/11 (55%)

- High rates of virologic suppression observed[4]
- The proportion of participants with ALT normalization increased over time

[1]Due to limited number compensated cirrhotic participants receiving tobevibart monotherapy at week 24, analysis not performed
[2]HDV RNA < LOD or ≥ 2 log_{10} IU/mL decrease from baseline
[3]Virologic Response and ALT normalization
[4]Responses on ITT basis, and include 4 participants who discontinued treatment

HDV: Hepatitis Delta Virus RNA: RiboNucleic Acid, TND: target not detected, ULN: Upper Limit Normal; ALT: alanine transaminase, LLOQ (lower limit of quantification) = 63 IU/mL; LOD (limit of detection) = 14 IU/mL, ITT: Intent to treat

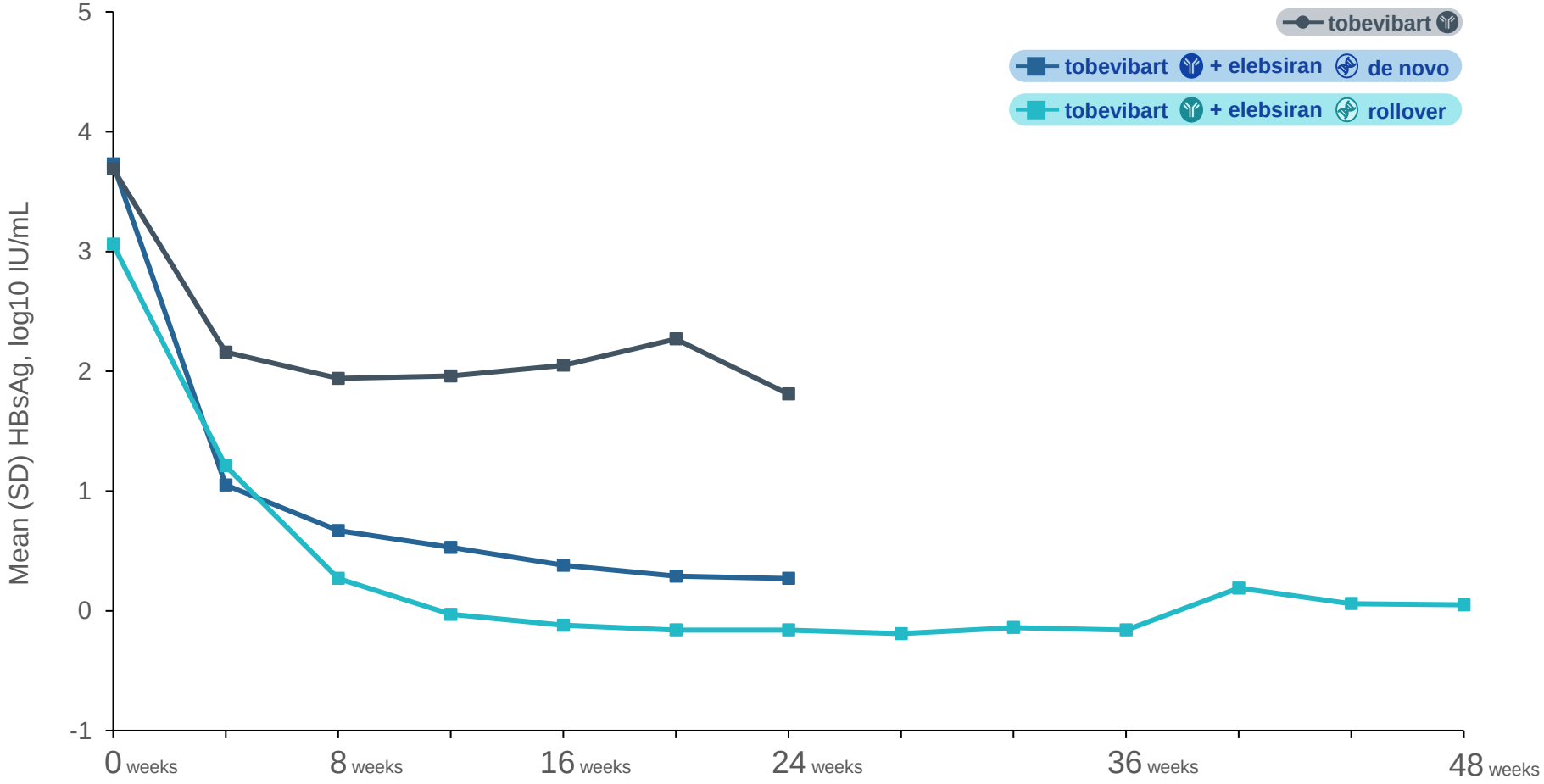
Preliminary data, ITT analysis

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HBsAg Response Responses: All Three Cohorts Show Rapid Response and Suppression of HBsAg

Sustained HBsAg Suppression

SOLSTICE TRIAL: Tobevibart monotherapy, de novo tobevibart + elebsiran combination therapy, and rollover tobevibart + elebsiran combination therapy[1]



Change in HBsAg relative to Day 1 (Mean ± SD)[2], log_{10} IU/mL

	Wk 12 N=25[3]	Wk 24 N=9[3]
tobevibart monotherapy	-1.7 ± 0.8	-1.8 ± 0.9

	Wk 12 N=29[3]	Wk 24 N=14[3]
de novo Combo Q4W	-3.2 ± 0.5	-3.3 ± 0.5

	Wk 12 N=6[3]	Wk 24 N=6[3]	Wk 48 N=5[3]
Rollover Combo Q4W	-3.1 ± 1.0	-3.2 ± 0.9	-3.5 ± 0.8

- Rapid and potent suppression of HBsAg was observed:
  - HBsAg suppression was sustained through 48 weeks of treatment

1: Cohort 2C has 6 total participants enrolled with 5 participants reaching at least 40 weeks. From the 6 participants who have reached at least 40 weeks, 5 participants achieved HDV RNA < LLOQ at 40 weeks. Participants achieving primary endpoint at Week 12 transitioned to extended dosing (Q8W) monotherapy. Participants not achieving ALT normalization and virologic response at Week 12 transitioned to combination therapy.
2: For Combo Q4W rollover Day 1 = Day 1 of Combination therapy
3: N is the number of participants who have completed the study visit or discontinued before the study visit

HBsAg, hepatitis B virus surface antigen; SD, Standard Deviation; Q4W, every 4 weeks; Q2W, every 2 weeks.

Preliminary data, ITT analysis

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Summary of Preliminary Safety and Tolerability

No ALT flares observed in participants receiving tobevibart alone, or in combination with elebsiran

No treatment related serious adverse events to tobevibart alone, or in combination with elebsiran, were observed

The majority of AEs were Grade 1-2 and transient, with low incidence of injection site reactions

- Most common were influenza-like illness, chills, arthralgias, myalgias and pyrexia

High treatment continuation rates: 2 participants receiving tobevibart monotherapy discontinued treatment due to an adverse event

AEs: Adverse Events, ALT: alanine transaminase, ITT: Intent to treat

Preliminary data, ITT analysis

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TO TRANSFORM LIVES

PHASE 2 CATALYST:

Pursuit of a Functional Cure in Chronic Hepatitis B (CHB)

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CHB: Two Approaches with Potential for Achieving a Functional Cure

Unmet Need

NEED FOR FUNCTIONAL CURE

~254M
people live with CHB globally [1]

Up to 40%
of patients experience significant clinical consequences [2]

Vir's Approach

tobevibart + **elebsiran** ± **PEG-IFN-α**

Investigational neutralizing mAb engineered for immune engagement

Investigational HBV-targeted siRNA

Immunomodulator to augment immune response

Market Leadership Goal:

SUSTAINED FUNCTIONAL CURE*

1: WHO Global Hepatitis Report 2024
2: Lok, AS, and McMahon, BJ. Chronic hepatitis B. N Engl J Med 346.22 (2002): 1682-1683.

CHB: Chronic Hepatitis B; mAb: monoclonal antibody; HBV: Hepatitis B Virus; siRNA: small interfering RNA

PEG-IFN-α: peginterferon alfa-2a

*Functional cure: undetectable hepatitis B virus surface antigen (HBsAg), defined as less than 0.05 international units per milliliter, as well as HBV DNA less than the lower limit of quantification in the blood six months after the end of therapy

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CHB: Two Approaches with Potential for Achieving a Functional Cure

	VIR-2218-1001 TRIAL	MARCH TRIAL	
	elebsiran + PEG-IFN-α	tobevibart + elebsiran	tobevibart + elebsiran + PEG-IFN-α
EOT after 24w Tx	5.6% (N=1 of 18) HBsAg seroclearance	15.0% (N=3 of 20) HBsAg seroclearance	14.3% (N=3 of 21) HBsAg seroclearance
EOT after 48w Tx	25.8% (N=8 of 31) HBsAg seroclearance	Data Expected in Q4 2024	
24w Off Tx (Post-48w Tx)	16.1% (N=5 of 31) Sustained HBsAg loss	Data Expected in Q2 2025	

* Based on preliminary data
CHB: Chronic Hepatitis B;
HBsAg: hepatitis B virus surface antigen, 2 HBsAg > 10 mIU/mL
PEG-IFN-α: peginterferon alfa-2a

Tx: Treatment
EOT: End of treatment

2218-1001: NCT03672188
MARCH: NCT04856085

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Chronic Hepatitis B: MARCH Part B Trial Design

A Phase 2 Study to Evaluate the Safety, Tolerability, and Efficacy of Regimens Containing tobevibart (VIR-3434), elebsiran (VIR-2218) and/or PEG-IFN-α in Participants With Chronic Hepatitis B Virus Infection

Dual Combination Regimen Cohort

Tobevibart 300 mg + Elebsiran 200 mg SC every 4 weeks up to 48 weeks (N = ~ 50)

Triple Combination Regimen Cohort

Tobevibart 300 mg + Elebsiran 200 mg + PEG-IFN-α every 4 weeks up to 48 weeks (N = ~30)

Primary Endpoints:

- Proportion of participants with hepatitis B surface antigen (HBsAg) loss (defined as undetectable HBsAg) at end of treatment
- Proportion of participants with HBsAg loss (defined as undetectable HBsAg) at 24 weeks post-end of treatment

Participant Criteria:

- Male or female ages 18-<66 y/o
- Chronic HBV infection for ≥ 6 months
- On NRTI therapy for ≥ 2 months at the time of screening

IU/mL: International units per milliliter
NRTI: Nucleotide Reverse Transcriptase Inhibitor

NCT04856085

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CHB: MARCH Phase 2 Data Readouts Expected in 2024/5



‘24

48w End of Treatment Data

- ~50 tobevibart + elebsiran participants
- ~30 tobevibart + elebsiran + PEG-IFN-α participants

‘25

24w Off Treatment Data

(Post-48w Tx)

- ~50 tobevibart + elebsiran participants
- ~30 tobevibart + elebsiran + PEG-IFN-α participants

CHB: Chronic Hepatitis B;
EOT: End of treatment
PEG-IFN-α: peginterferon alfa-2a

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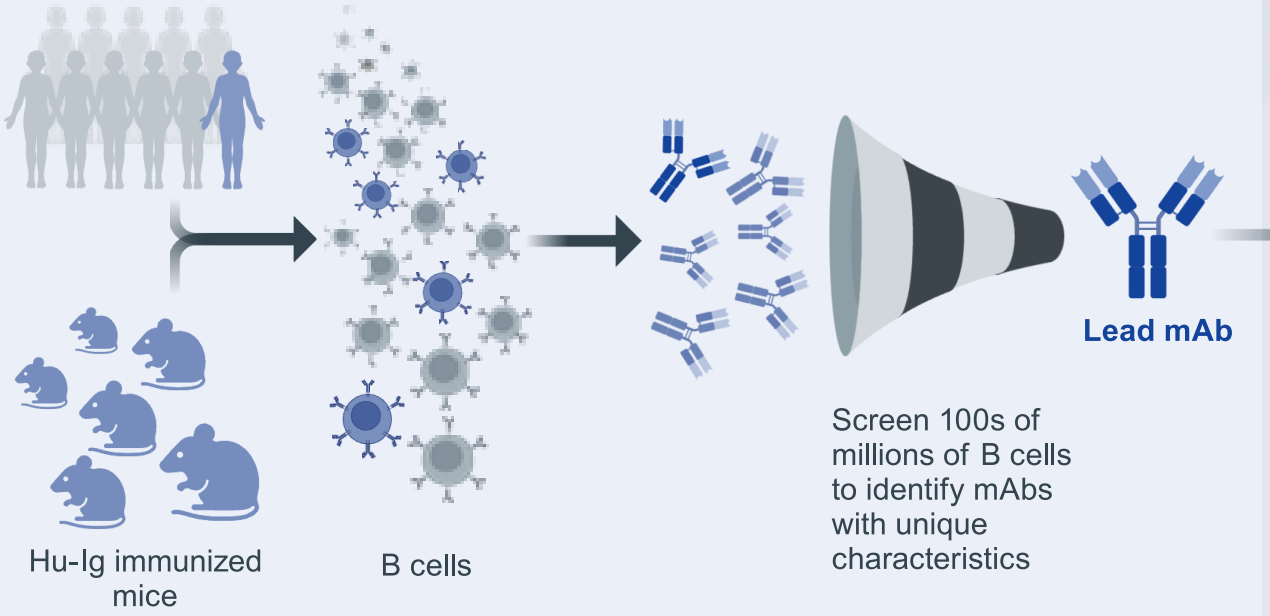
GROWTH BEYOND HEPATITIS:

Next-Generation Research & Development

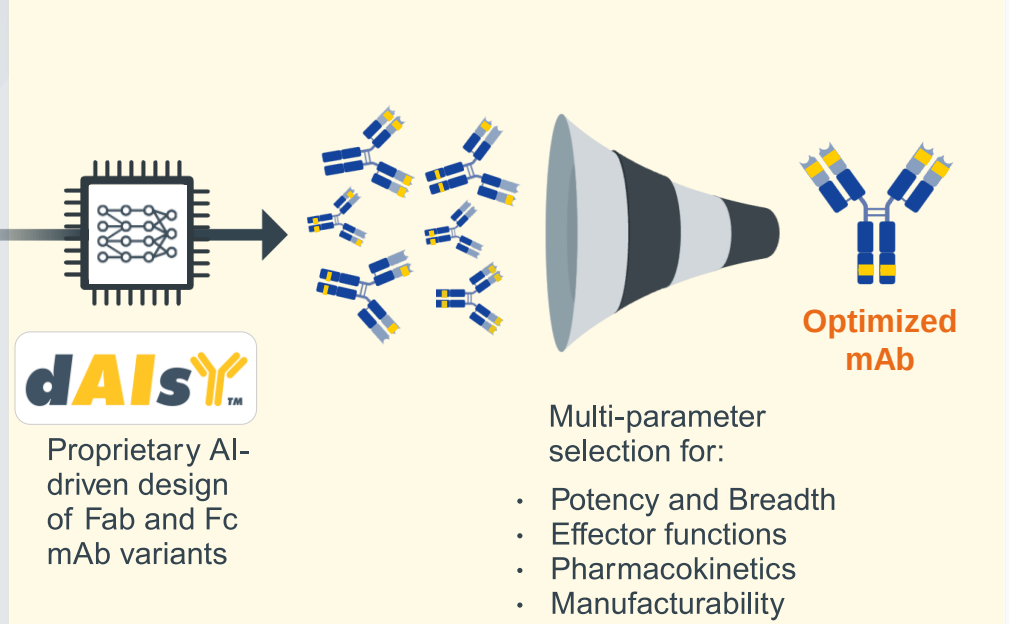
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Vir's Proprietary mAb Platform:
Our Goal: Best-in-Class mAbs via Discovery and Protein Engineering

Discovery



Protein Engineering

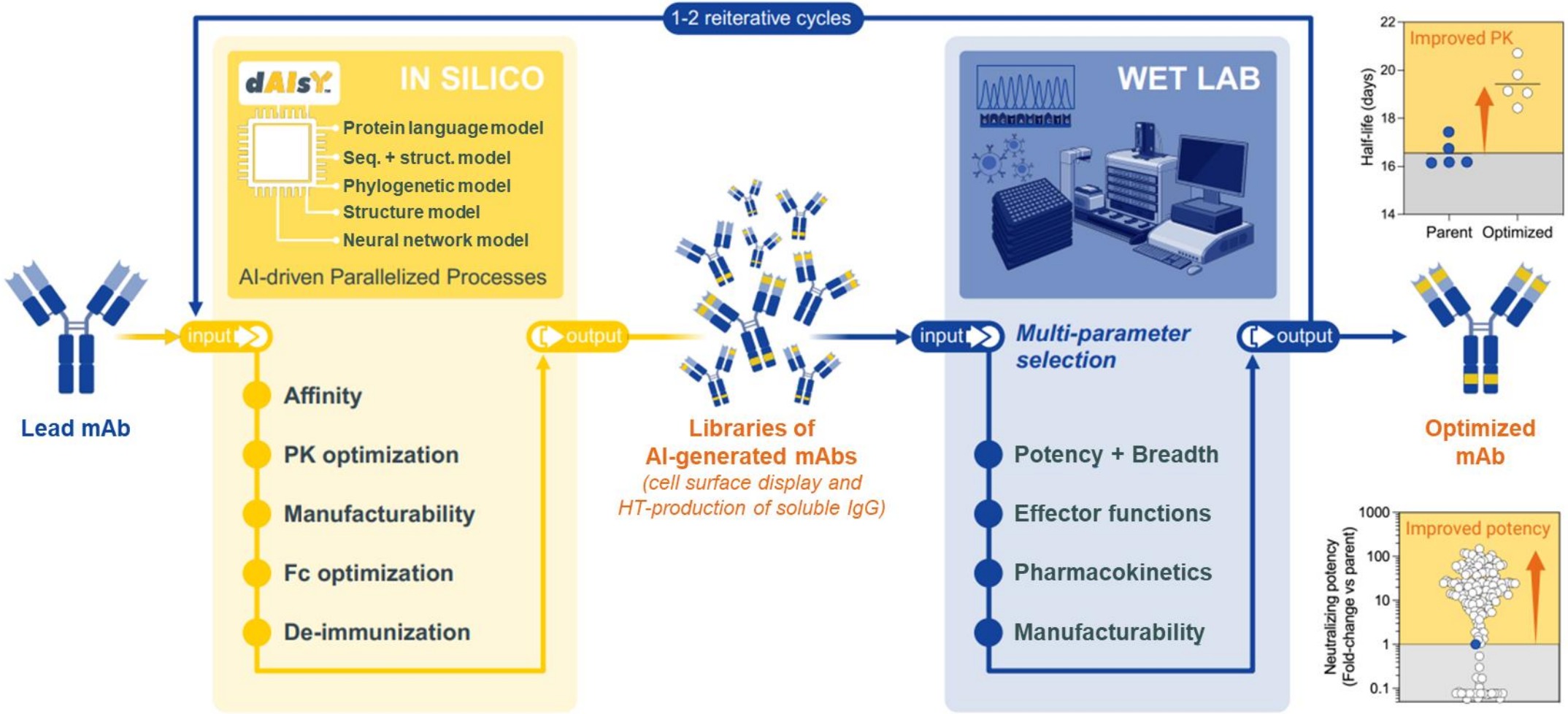


Platform enables mAb identification with unique features, combined with multi-parameter optimization

mAb: monoclonal antibody;
AI: artificial intelligence;
Hu-Ig: humanized immunoglobin

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Next-Gen Protein Engineering:
Leveraging Proprietary AI/ML Tools and High Throughput Wet Lab Selection



Proprietary process for holistic optimization of mAb properties that reduces time to clinic

AI: artificial intelligence;
ML: machine learning;
mAb: monoclonal antibody;
PK: pharmacokinetics
HT: high throughput;
IgG: immunoglobulin G

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Example: Using an AI-Powered Approach to Develop a Next-Gen COVID mAb

Sotrovimab

>2M doses delivered since 2020, authorized in multiple markets ex-US

- Tolerates diversity in the target epitope
- Cross-reactivity to SARS-CoV-1
- Intravenous administration

OUR GOAL

A "variant-proof" next-gen CoV mAb

VIR-7229

Broad, potent, and more resistant to viral evolution in preclinical testing

- Tolerates high diversity in the target epitope
- Potential for intramuscular administration

Supported by ~$50M in BARDA funding*

mAb: monoclonal antibody;
AI: artificial intelligence;

BARDA: Biomedical Advanced Research and Development Authority

*The development of VIR-7229 has been supported in whole or in part with federal funds from the Department of Health and Human Services (HHS); Administration for Strategic Preparedness and Response (ASPR); Biomedical Advanced Research and Development Authority (BARDA), under Other Transaction Number: 75A50122C00081.

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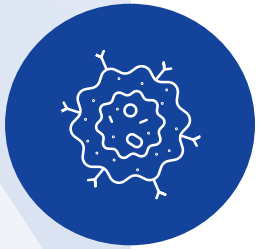
Antibody Candidates: Expected to Enter the Clinic in the Next 12-24 Months



Influenza A and B: Prevention

VIR-2981 (neuraminidase-targeting mAb)

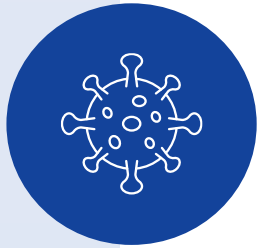
- Potent preclinical activity against major strains of influenza A and B viruses



RSV +/- MPV: Prevention

VIR-8190 (& other investigational AI-engineered mAbs)

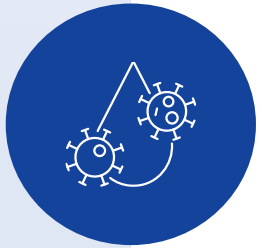
- Ability to potently neutralize both RSV and hMPV strains



COVID-19: Prevention

VIR-7229 (pan-sarbecovirus AI engineered mAb)

- Broadly neutralizing vs. COVID-19 variants demonstrated in vitro



HIV Cure: Treatment

Potential AI engineered broadly neutralizing antibodies

- Vir Fc modifications to control viral load and achieve functional cure of HIV

AI: artificial intelligence
mAb: monoclonal antibody;
RSV: respiratory syncytial virus;
hMPV: human metapneumovirus;
HIV: Human Immunodeficiency Virus

The development of VIR-7229 has been supported in whole or in part with federal funds from the Department of Health and Human Services (HHS); Administration for Strategic Preparedness and Response (ASPR); Biomedical Advanced Research and Development Authority (BARDA), under Other Transaction Number: 75A50122C00081.

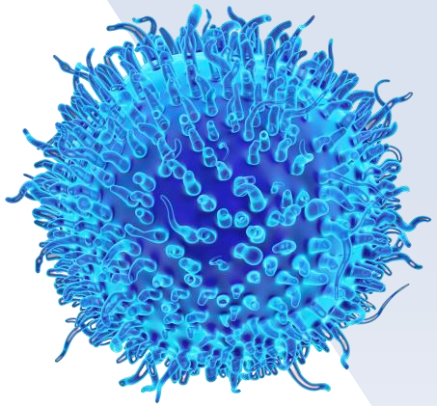
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T Cell-Based Viral Vector Platform: Clinical Proof-of-Concept in 2024

T Cell-Based Viral Vector

DIFFERENTIATORS

- ✓ Generates unique, potent and long-lasting T cell responses using CMV viral vector
- ✓ Applicability in oncology and beyond



Platform supported by over $80M in Bill & Melinda Gates Foundation funding to date

Featured in Nature's "11 clinical trials that will shape medicine in 2024"[1]

HIV: Prevention

VIR-1388 HIV T cell vaccine candidate

- Designed to elicit abundant T cells that recognize viral proteins to abort primary infection

Anal/Cervical HPV: Treatment

VIR-1949 therapeutic vaccine candidate

- Designed to induce high frequencies of antigen-specific, tissue-localizing effector memory T cells to reverse dysplasia

CMV: Cytomegalovirus;
HIV: Human Immunodeficiency Virus

HPV: human papillomavirus

1: Arnold, C., Webster, P. 11 clinical trials that will shape medicine in 2024. Nat Med 29, 2964–2968 (2023). https://doi.org/10.1038/s41591-023-02699-5

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FINANCIAL STRENGTH:

Poised to Achieve Our Near- and Long-term Goals

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Strong Balance Sheet Enables Execution of Strategic Priorities

Financial Highlights



$1.51 billion

cash and investments*

- Well capitalized

2024 Capital Allocation Priorities

Phase 2 pipeline advancement

- Chronic Hepatitis Delta
- Chronic Hepatitis B

Antibody platform

generating multiple potential near-term INDs

Flexibility to invest in innovation

*Represents cash, cash equivalents, and investments as of March 31, 2024

IND: Investigational New Drug

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GAAP 2024 Financial Guidance

Vir reiterates its full year 2024 guidance, originally provided in February 2024 (in millions)

	2024 guidance (Provided on May 2, 2024)**			2023 actual
GAAP combined R&D and SG&A expense range:	**$650**	to	**$680**	**$768**
The following expenses are included in the GAAP combined R&D & SG&A expense range:				
Non-cash stock-based compensation	$115	to	$105	$111
Restructuring charges	$35*	to	$25*	$14

- Approximately 3-4 percent of the GAAP combined R&D and SG&A expense will be funded by grants. These grants are recognized as revenue.
- The GAAP combined R&D and SG&A expense guidance does not include the effect of GAAP adjustments caused by events that may occur subsequent to the publication of this guidance, including, but not limited to, business development activities, litigation, in-process R&D impairments, and changes in the fair value of contingent considerations.

* Restructuring charges are primarily non-cash expenditures, related to the closing of two R&D sites previously announced on December 13, 2023.

** Provided on May 2, 2024, as part of an oral presentation and is qualified by such, contains forward-looking statements, actual results may vary materially; Vir disclaims any duty to update.

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Q1 2024: Financial Results

$ in millions	Three Months Ended March 31, 2024	2023	Change
Total revenues	$56.4	$63.0	$(6.6)
Operating expenses:			
Cost of revenue	0.1	1.9	(1.8)
Research and development	100.1	157.6	(57.5)
Selling, general and administrative	36.3	46.8	(10.5)
Total operating expenses	136.5	206.3	(69.8)
Loss from operations	(80.1)	(143.4)	63.3
Total other income	15.1	0.2	14.9
Benefit from income taxes	(0.3)	2.2	(2.5)
Net loss	$(65.3)	$(141.0)	$75.7

Note: Numbers may not add due to rounding.

Investor Relations – NASDAQ GS : VIR

Analyst Coverage:

- Bank of America: Geoff Meacham, Ph.D
- Barclays: Gena Wang, Ph.D., CFA
- Cowen: Phil Nadeau, Ph.D.
- Goldman Sachs: Paul Choi
- H.C. Wainwright: Patrick Trucchio, MBA
- J.P. Morgan: Eric Joseph, Ph.D.
- Morgan Stanley: Mike Ulz
- Needham: Joseph Stringer, Ph.D.
- Leerink: Roanna Ruiz Ph.D.

$1.51 billion cash, cash equivalents and investments as of March 31, 2024

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Thank You

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