POWERING THE IMMUNE SYSTEM
TO TRANSFORM LIVES

Hepatitis Investor Event at AASLD

November 19, 2024

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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 chronic hepatitis Delta (CHD) or chronic hepatitis B virus (CHB) programs of Vir Biotechnology, Inc. (the "Company" or "Vir"); the Company's strategy and plans 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 CHD or CHB; the Company's oncology solid tumor portfolio and preclinical pipeline and 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.

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.

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Agenda

Speaker	Topic
Marianne De Backer, M.Sc., Ph.D., MBA Chief Executive Officer and Director	**Opening Remarks, Addressing Significant Unmet Medical Need in Hepatitis Delta (HDV) & Chronic Hepatitis B (CHB)**
Mark Eisner, M.D., M.P.H. Chief Medical Officer	**Phase 2 SOLSTICE Data update at AASLD & Next Steps for Clinical Development**
Nancy Reau, M.D. Richard B. Capps Chair of Hepatology, Associate Director of Solid Organ Transplantation and Section Chief of Hepatology at Rush University Medical Center	**KOL Perspective on Hepatitis Delta Data & the Unmet Medical Need**
Mark Eisner, M.D., M.P.H.	**Phase 2 MARCH Part B Data Update at AASLD**
Nancy Reau, M.D.	**KOL Perspective on MARCH Part B Data & Chronic Hepatitis B**
Marianne De Backer, M.Sc., Ph.D., MBA	**Closing Remarks**
All	**Q&A Session**

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Opening Remarks

Marianne De Backer

VIR'S MISSION:

POWERING THE IMMUNE SYSTEM **TO TRANSFORM LIVES**

Strategic Pillars Driving Our Mission Forward

5 clinical-stage assets in infectious disease and oncology with near term catalysts

Focused investments in areas of high unmet need

Industry-leading and AI-driven antibody discovery, protein engineering and masking technology

Vir Today: Advancing Infectious Disease and Oncology Programs to Drive Growth

Leveraging Immune-Targeted Approaches to Transform Patient Care

Infectious Disease

- **Hepatitis Delta (Phase 2)**
  - Goal: Chronic suppressive treatment
- **Chronic Hepatitis B (Phase 2)**
  - Goal: Functional cure

Focus of today's call

- **Preclinical:** HIV Cure
- **Preclinical:** RSV

Oncology – Solid Tumors

- **HER2 (Phase 1)**
  - mBC
  - mCRC
- **PSMA (Phase 1)**
  - mCRPC
- **EGFR (Initiating Phase 1)**
  - NSCLC
  - CRC
  - mHNSCC
  - Others

Uniquely positioned: Industry-leading and AI-driven antibody discovery, protein engineering and masking technology

Transformational Data in Hepatitis Delta (HDV)

Hepatitis Delta (HDV)

Transformative Data

(combo Q4W de novo)

- Large proportion of patients achieving undetectable HDV RNA <LLOQ, TND
- Decreasing ALT for the majority of patients
- Responses maintained to week 60 in rollover combination cohort
- No grade 3 or higher TEAEs

Next Steps

HDV Registrational Study

- FDA Type C Meeting Held
- ECLIPSE will be a Ph 3 registrational program
- Starting in 1H 2025

Promising End of Treatment Seroclearance in Chronic Hepatitis B (CHB)

Chronic Hepatitis B (CHB)

Promising EOT Seroclearance

(HBsAg <1,000 IU/mL)

- ~39% for tobevibart + elebsiran
- ~46% for tobevibart + elebsiran + PEG-IFNα
- HBsAg Loss at EOT is Associated With Development of Anti-HBs Antibodies, particularly in triplet regimen

Next Steps

CHB Functional Cure Data

- 24w-off treatment, functional cure data in Q2 2025

Hepatitis Delta: Occurs Exclusively in Patients with HBV Infection and Dramatically Increases Risk of Death, Cancer and Cirrhosis

>50% Liver-Related **Death in 10 Years**[1]

5 year Average Progression to **Cirrhosis** and **Liver Failure**[2]

~12M **Worldwide Prevalence** Up to 300,000 in the US and EU[3]

3x Risk of **Liver-Related Death vs. HBV**[4]

3x Risk of **Liver Cancer (HCC) vs. HBV**[5]

2x Higher Annual **Healthcare Costs vs. HBV**[6]

1.Negro F. (2023). Hepatitis D: A Review. *JAMA.* 330(24):2376–2387. 2. Pan C,, (2023) . Diagnosis and Management of Hepatitis Delta Virus Infection. Dig Dis Sci. Aug;68(8):3237-3248. 3: Stockdale A, et al. (2020). The global prevalence of hepatitis D virus infection: Systematic review and meta-analysis. J Hepatol, 73, 523-32. 4: John, B, et al. (2024). Association of hepatitis delta virus infection and hepatocellular carcinoma, hepatic decompensation, all-cause and liver-related death in a national cohort. Hepatology. DOI: 10.1097/HEP.0000000000001092 5. Sagnelli C, et al. (2021) HBV/HDV Co-Infection: Epidemiological and Clinical Changes, Recent Knowledge and Future Challenges. Life,11(2):169. https://doi.org/10.3390/life11020169 6.. Maughn K, et al. (2022) Hepatitis Delta Virus Patient Characteristics, Health Care Resource Utilization, and Costs Among Medicaid-Insured Adults in the United States: An Analysis of All-Payer Claims Database. Poster presented at the Academy of Managed Care Pharmacy (AMCP) Nexus 2022; October 11-14, 2022; National Harbor, MD

Hepatitis Delta:

A Threat to Adults in Their Prime Years across all ethnicities

Hepatitis Delta:

The most severe form of viral hepatitis

Current Patient Challenges

1. No approved treatments in the US, limited options outside of the US
2. Underdiagnosis and no reflex testing[1] in AASLD guidelines
3. Severe clinical outcomes drive significant financial burden
4. Limited physician and public awareness

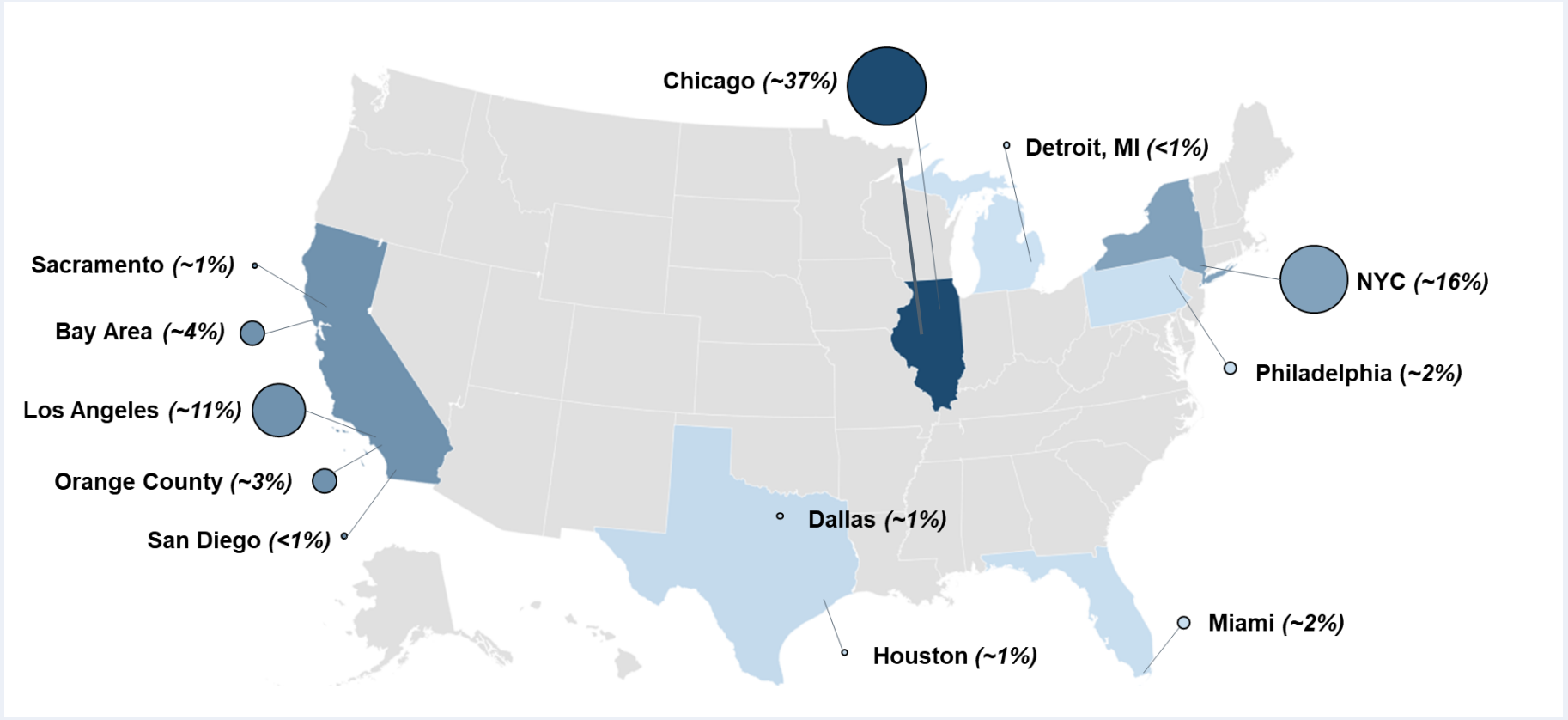
1. Reflex testing: An automatic secondary test performed when initial test results meet pre-defined criteria. In this context, it refers to automatically testing for hepatitis delta virus when a patient tests positive for hepatitis B virus.

Hepatitis Delta: Geographic Concentration of US Patients will allow for Lean, Targeted Vir Commercialization Effort

Implications:

- ✓ Concentrated in urban centers
- ✓ Relatively few HDV specialists
- ✓ Activation through targeted awareness / testing drives resource efficient launch

% of total diagnosed US population[1]



1.Percent of total diagnosed US population 2014-2023 adapted from: Terrault N, et al. (November 2023). Prevalence of Hepatitis B and D Virus Among a Nationally Representative Insured Population in the United States. AASLD, Boston, MA.

Key Patient Challenges

1. No US approved treatments, limited options outside of the US
2. Underdiagnosis and no reflex testing[1] in AASLD guidelines
3. Severe clinical outcomes drive significant financial burden
4. Limited physician and public awareness

Vir Priorities

- Advancing a transformative efficacious treatment
- Understanding who Delta patients are, to bridge testing to treatment
- Ensuring the earliest possible access through payor engagement
- Accelerating treatment rates through patient and provider education

1. Reflex testing: An automatic secondary test performed when initial test results meet pre-defined criteria. In this context, it refers to automatically testing for hepatitis delta virus when a patient tests positive for hepatitis B virus.

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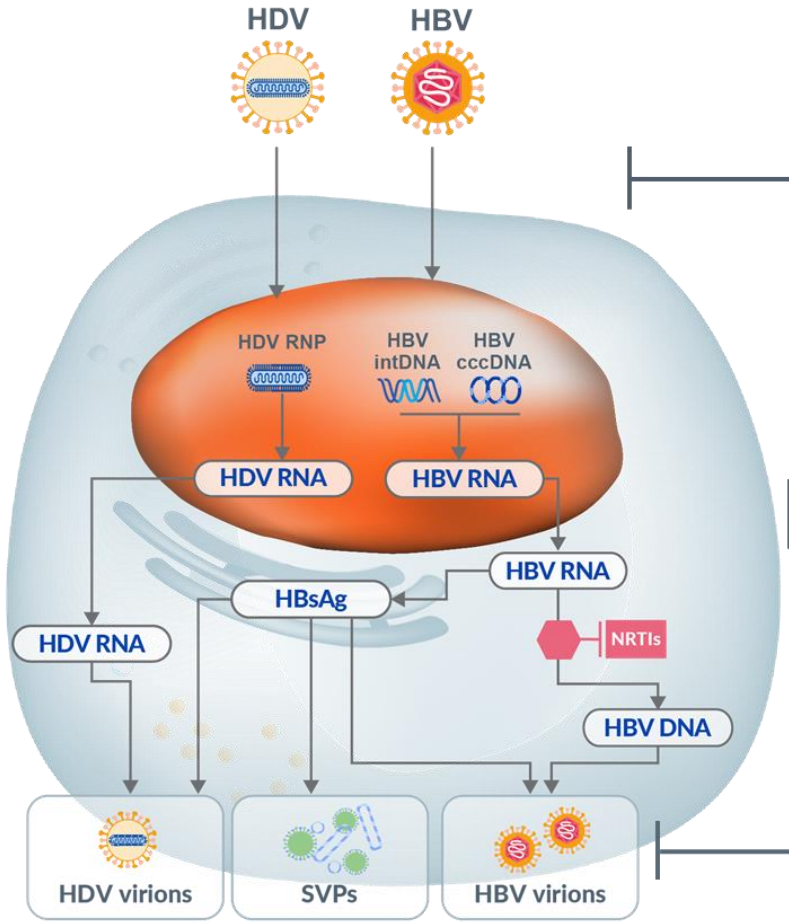
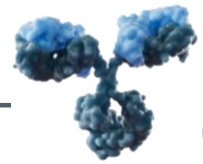
PHASE 2 SOLSTICE Data Update at AASLD:

Potentially Transformative Treatment for Chronic Hepatitis Delta

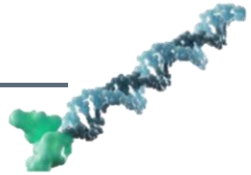
Mark Eisner

Our Ambition in HDV: Chronic Viral Suppression to undetectable levels with Monthly Dosing

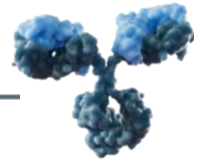




Inhibition of viral entry **(tobevibart)**



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

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

Complementary mechanisms of action:

Tobevibart

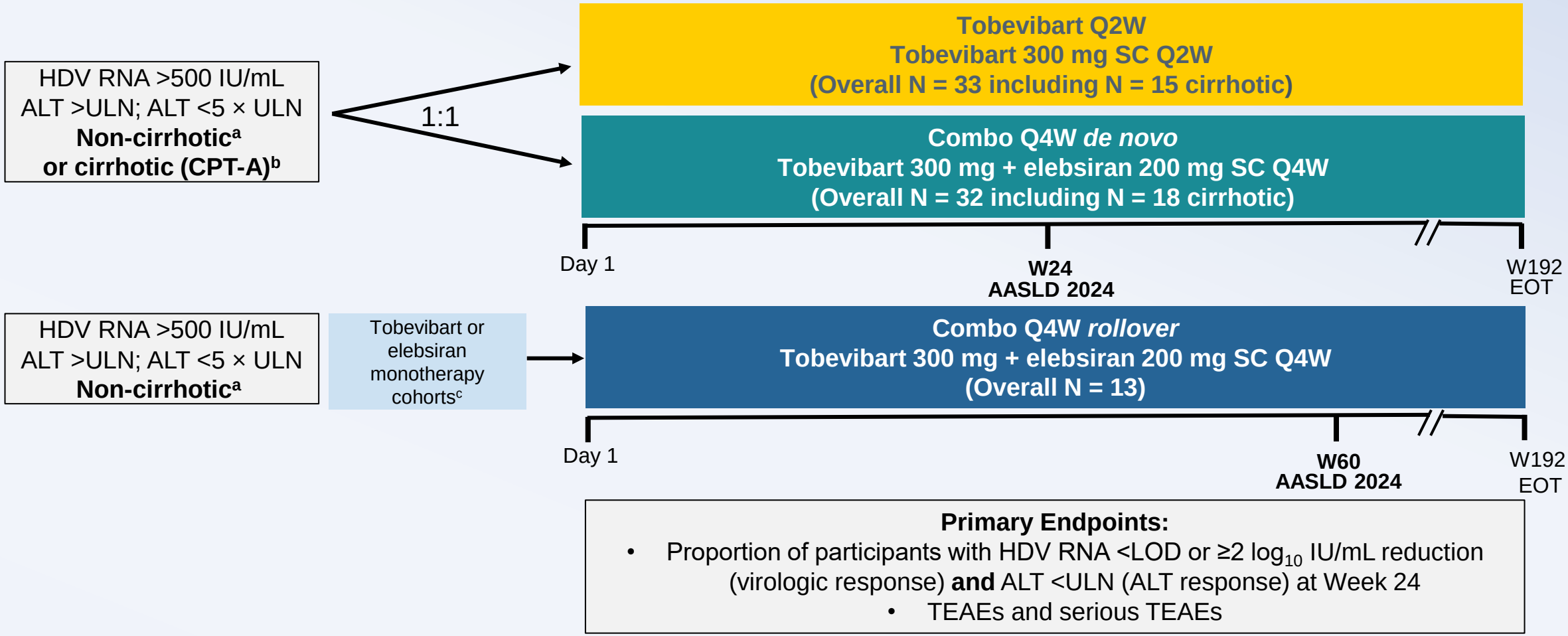
mAb: Fc-engineered monoclonal antibody

- 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

In the SOLSTICE Phase 2 trial, Vir is Evaluating Tobevibart and Elebsiran with the Goal of Achieving Transformational HDV Virologic Suppression



SOLSTICE ClinicalTrials.gov Identifier: NCT05461170. ALT, alanine aminotransferase; CHD, chronic hepatitis delta; CPT, Child Pugh Turcotte; EOT, end of treatment; HDV, hepatitis D virus; NRTI, nucleos(t)ide reverse transcriptase inhibitor; Q2W, once every 2 weeks; Q4W, once every 4 weeks; SC, subcutaneous; R, randomized; TEAE, treatment-emergent adverse event; ULN, upper limit of normal.

[a]Non-cirrhotic: liver biopsy with METAVIR F0 to F3 or liver stiffness <12 kPa within 12 months of screening and platelet count >150 × 10^3/µL.

[b]Compensated cirrhotic participants: liver biopsy with METAVIR F4 or liver stiffness ≥12 kPa within 12 months of screening, a platelet count >90 × 10^3/µL, and a CPT score of 5 or 6, inclusive at screening and at the start of the study.

[c]The rollover cohort included participants who transitioned after elebsiran Q4W [3 doses], N = 2; tobevibart Q4W [3 doses], N = 4; tobevibart Q4W [7 doses], N = 3; tobevibart Q4W [13 doses], N = 3; tobevibart Q2W [25 doses], N = 1.

Demographic and Baseline Characteristics were Generally Balanced Across the Treatment Groups

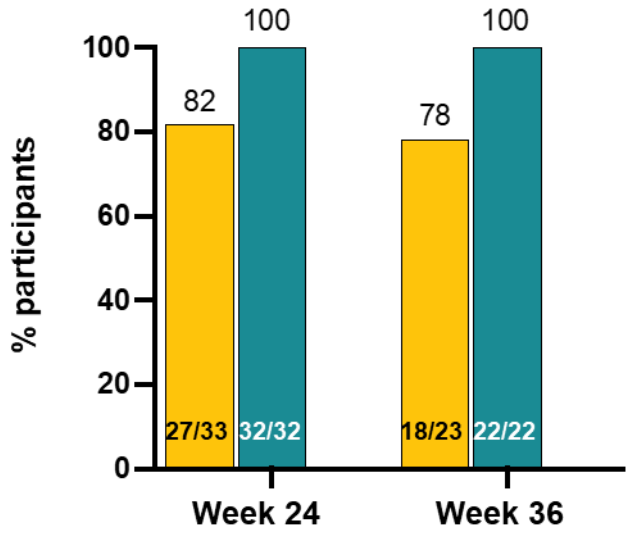
	Tobevibart Q2W N = 33	Combo Q4W *de novo* N = 32	Combo Q4W *rollover*[a] N = 13
Age, y, mean ± SD	44.8 ± 9.2	41.5 ± 8.0	42.5 ± 8.8
Male, n (%)	16 (48.5)	18 (56.3)	9 (69.2)
Race, n (%)			
White	28 (84.8)	25 (78.1)	12 (92.3)
Black or African American	2 (6.1)	4 (12.5)	1 (7.7)
Asian	1 (3.0)	2 (6.3)	0
Other	2 (6.1)	1 (3.1)	0
ALT, U/L, mean ± SD	75.7 ± 58.8	83.4 ± 47.1	68.4 ± 26.4
HDV RNA, log_{10} IU/mL, mean ± SD	5.6 ± 1.1	5.7 ± 1.2	4.8 ± 1.3
HDV genotype, gt (%)	gt1 (97%); gt5 (3%)	gt1 (97%); gt5 (3%)	gt1 (100%)
HBsAg, log_{10} IU/mL, mean ± SD	3.7 ± 0.8	3.7 ± 0.6	3.8 ± 0.7
HBeAg positive, n (%)	8 (24.2)	3 (9.4)	3 (23.1)
HBV DNA, log_{10} IU/mL, mean ± SD	0.7 ± 0.8	0.7 ± 0.7	0.9 ± 0.6
Cirrhotic participants, n (%)	15 (45.5)	18 (56.3)	0
Platelets, 10^9/L, mean ± SD	200.2 ± 74.5	189.4 ± 58.0	255.0 ± 135.9
Liver stiffness, kPa, mean ± SD	13.5 ± 8.7	13.5 ± 7.3	7.9 ± 2.4
FibroTest score, mean ± SD	0.5 ± 0.2	0.5 ± 0.3	0.4 ± 0.2

Demographic and baseline characteristics were generally balanced across the treatment groups

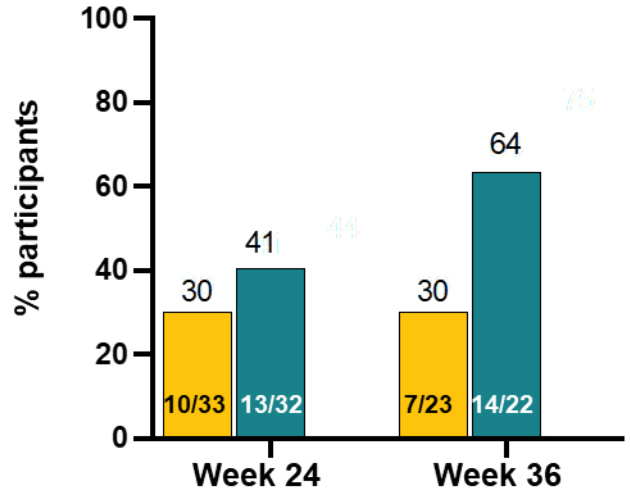
ALT, alanine aminotransferase; gt, genotype; HBeAg, hepatitis e antigen; HBsAg, hepatitis B surface antigen; HBV, hepatitis B virus; HDV, hepatitis D virus; Q2W, once every 2 weeks; Q4W, once every 4 weeks; SD, standard deviation.
[a]Baseline is Day 1 of combination therapy in the combo Q4W *rollover* cohort.

High Rates of Undetectable HDV Viremia were Achieved and Maintained in Participants Receiving the Tobevibart + Elebsiran Combination

HDV RNA ≥2 log_{10} decrease or HDV RNA <LOD
Protocol defined endpoint



HDV RNA <LLOQ, TND

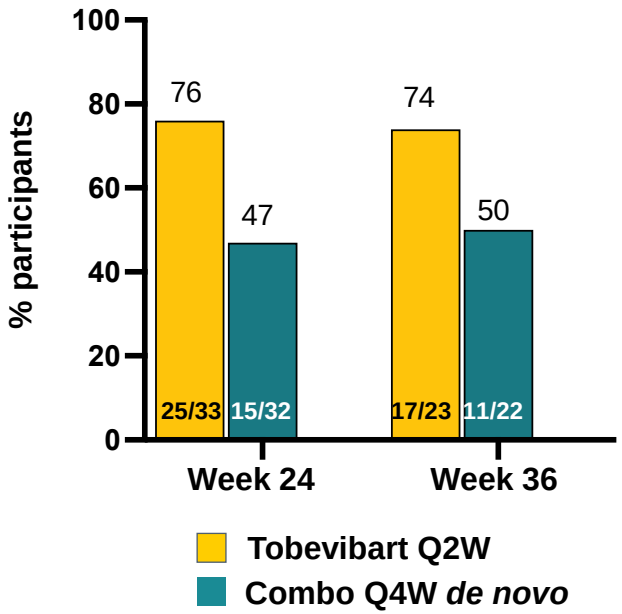


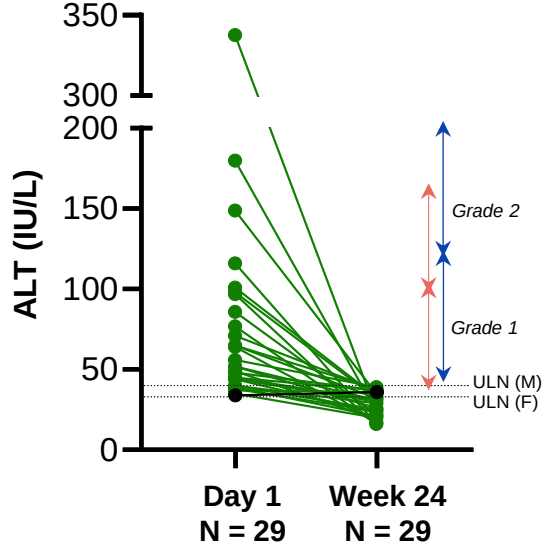
Tobevibart Q2W **Combo Q4W *de novo***

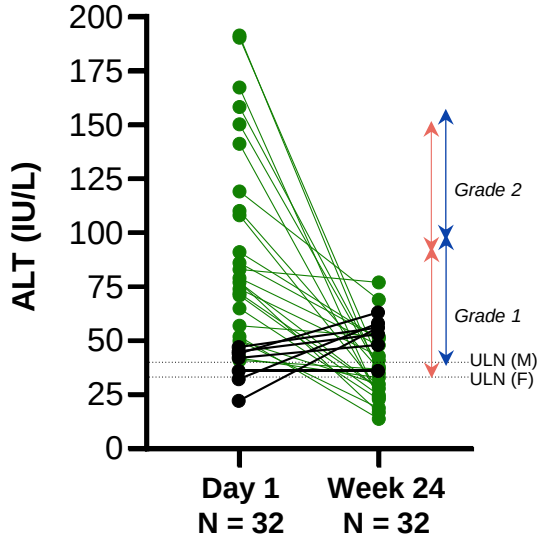
High proportions of virologic suppression as measured by HDV RNA target not detected were achieved and maintained in participants receiving tobevibart + elebsiran combination

Combo, Tobevibart + Elebsiran; HDV, hepatitis D virus; LOD, limit of detection; LLOQ, lower limit of quantification; Q2W, once every 2 weeks; Q4W, once every 4 weeks; TND, target not detected
Data are reported for participants who completed the visit and had an HDV RNA measurement or who discontinued treatment before the visit.
HDV RNA LOD = 14 IU/mL; HDV RNA TND = no detectable HDV RNA (0 IU/mL).

ALT Decreased in the Majority of Participants Between Day 1 and Week 24







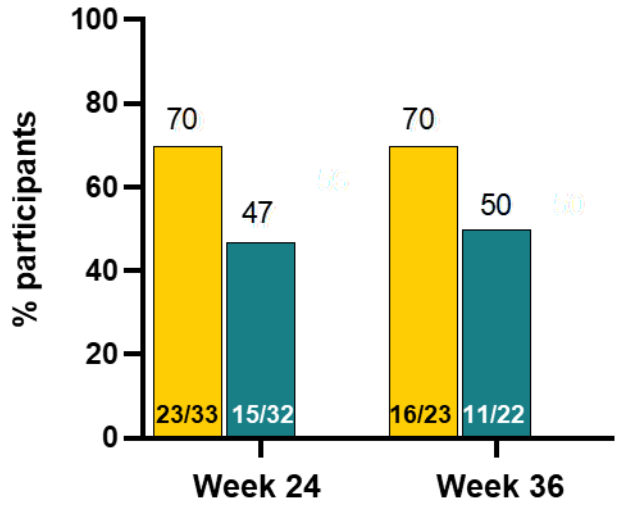
ALT decreased in most participants between Day 1 and Week 24
Approximately 50% of participants in the Combo cohort normalized ALT by Week 24

ALT, alanine aminotransferase; Combo, Tobevibart + Elebsiran; ULN, upper limit of normal; Q2W, once every 2 weeks; Q4W, once every 4 weeks.
Data are reported for participants who completed the visit and had an ALT measurement or who discontinued treatment before the visit.
ALT ULN (male) = 40 IU/mL; ALT ULN (female) = 33 IU/mL.

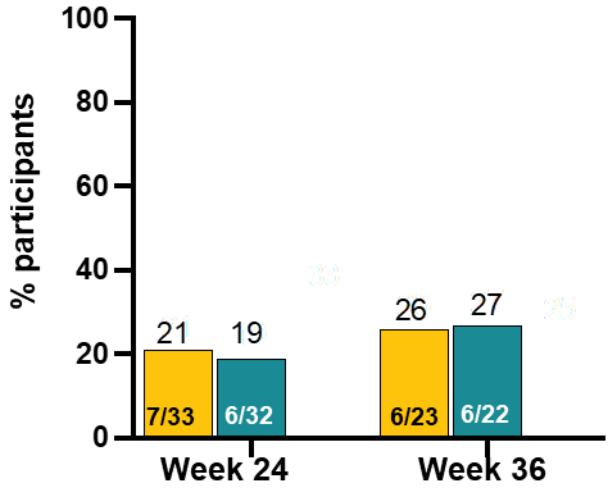
Majority of Patients Achieved the Protocol Defined Endpoint, Over Half had Undetectable HDV Viremia in the Combination Cohort

HDV RNA ≥2 log_{10} decrease or HDV RNA <LOD + ALT Normalization

Protocol defined endpoint



HDV RNA <LLOQ, TND + ALT Normalization

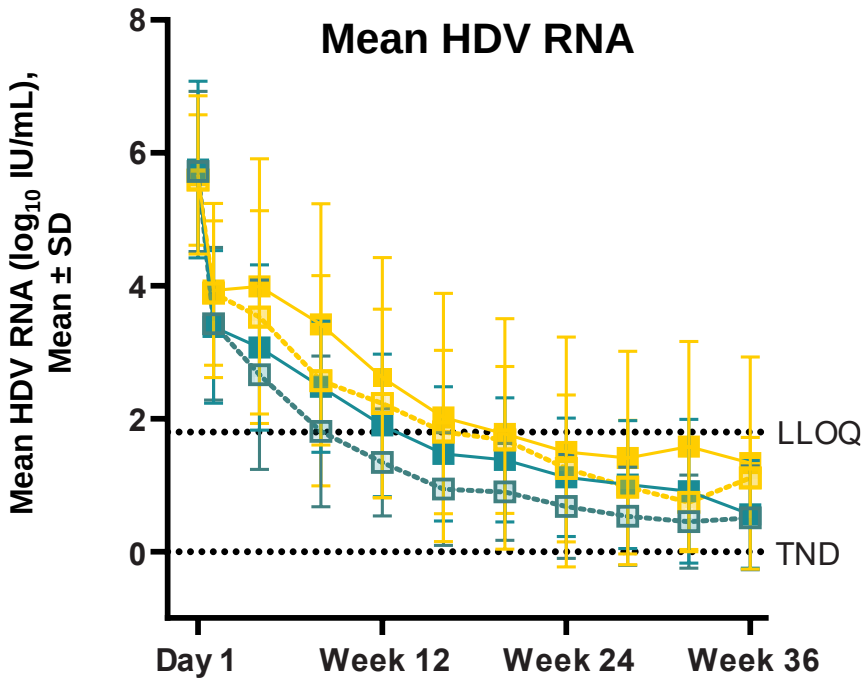


Tobevibart Q2W Combo Q4W *de novo*

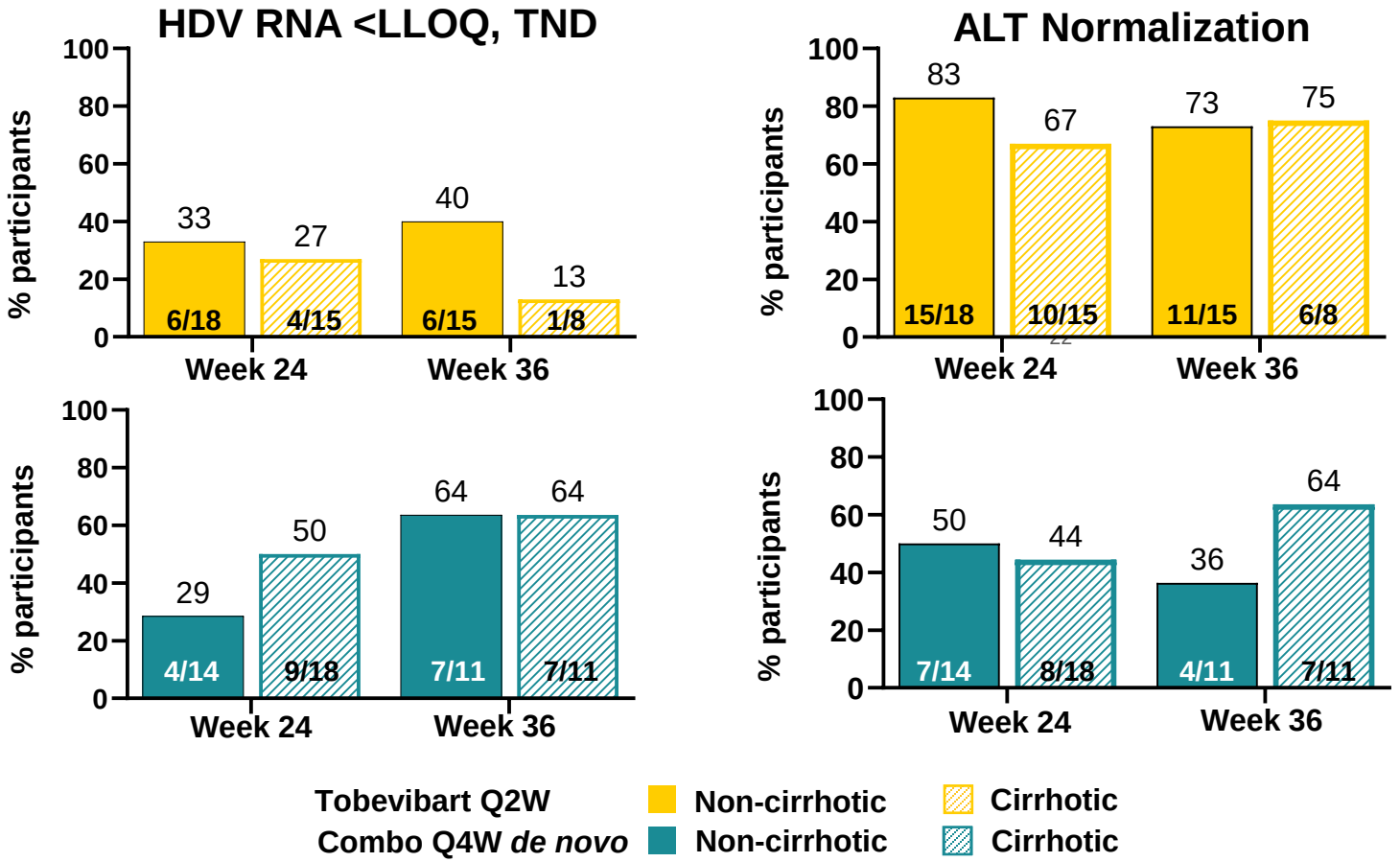
HDV RNA <LLOQ, TND + ALT normalization rates increased over time

ALT, alanine aminotransferase; Combo, Tobevibart + Elebsiran; LOD, limit of detection; LLOQ, lower limit of quantification; Q2W, once every 2 weeks; Q4W, once every 4 weeks; TND, target not detected.
Data are reported for participants who completed the visit and had an HDV RNA and ALT measurement or who discontinued treatment before the visit.
HDV RNA LOD = 14 IU/mL; HDV RNA TND = no detectable HDV RNA (0 IU/mL); ALT ULN (male) = 40 IU/mL; ALT (female) = 33 IU/mL.

Virologic Efficacy & ALT Normalization were Similar Between Non-Cirrhotic and Cirrhotic Participants Receiving Tobevibart + Elebsiran



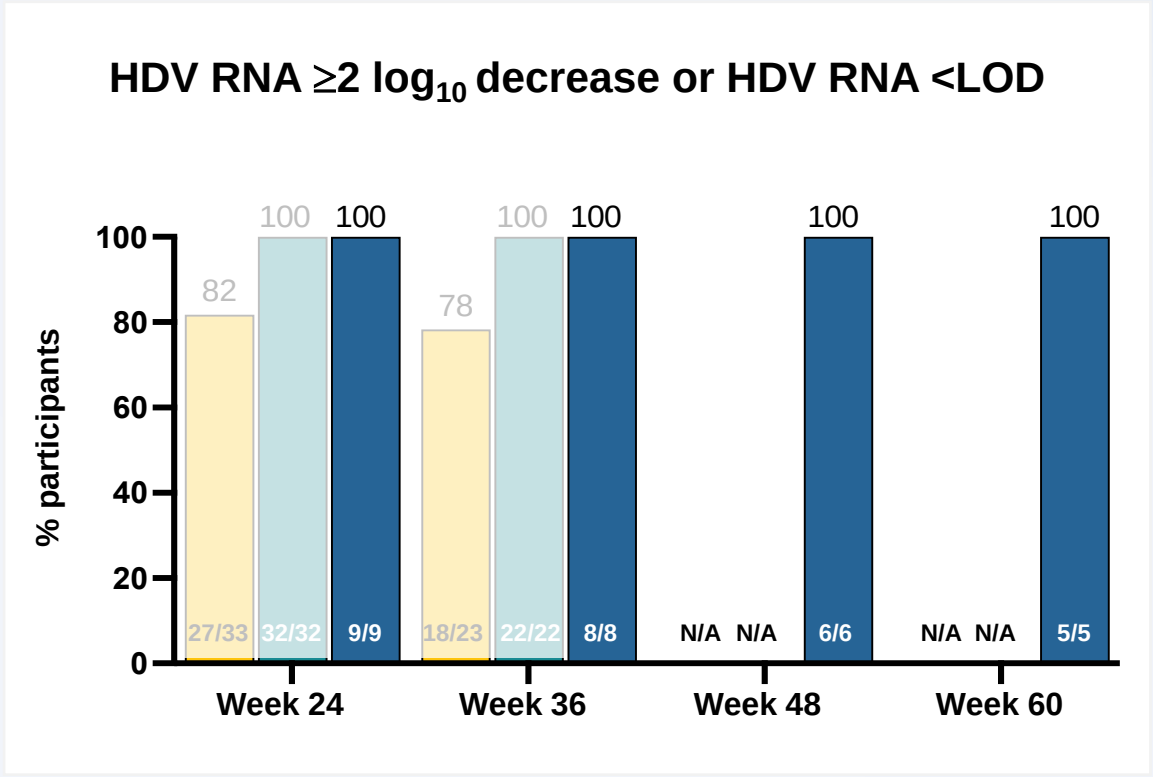
Non-cirrhotic n =14	14	14	11
Cirrhotic n = 18	18	18	11
Non-cirrhotic n =18	16	16	13
Cirrhotic n =15	13	13	6

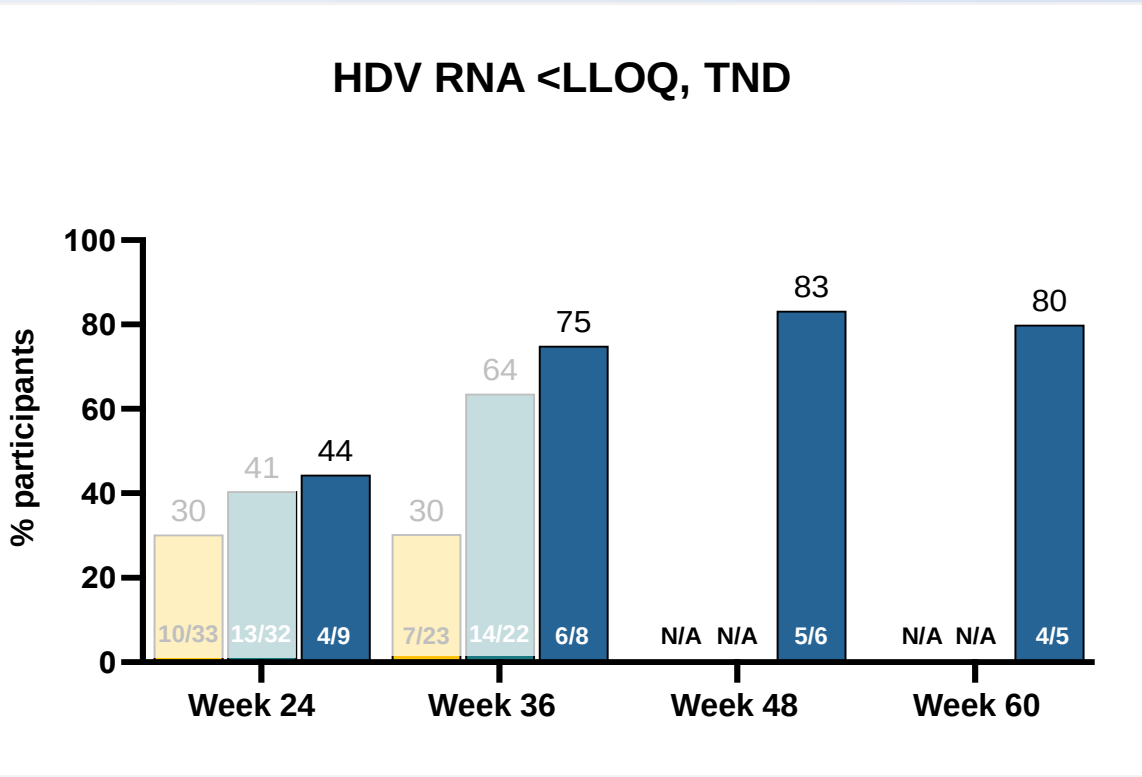


Virologic efficacy and ALT normalization were similar between non-cirrhotic and cirrhotic participants receiving tobevibart + elebsiran

ALT, alanine aminotransferase; Combo, Tobevibart + Elebsiran; LLOQ, lower limit of quantification; Q2W, once every 2 weeks; Q4W, once every 4 weeks; SD, Standard Deviation; TND, target not detected.
Data are reported for participants who completed the visit and had an HDV RNA and ALT measurement or who discontinued treatment before the visit.
HDV RNA LLOQ = 63 IU/mL; HDV RNA TND = no detectable HDV RNA (0 IU/mL); ALT ULN (male) = 40 IU/mL; ALT ULN (female) = 33 IU/mL.

High Rates of Virologic Suppression were Achieved and Maintained in Participants in Combination Rollover Cohort



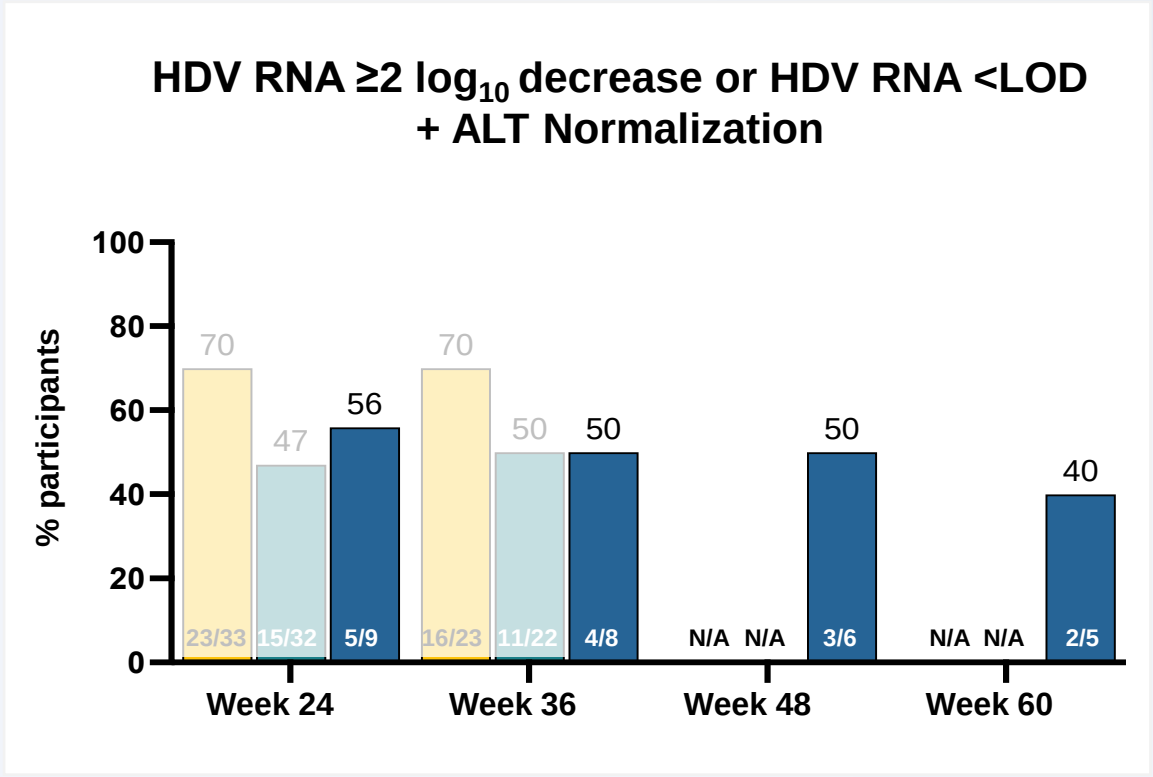


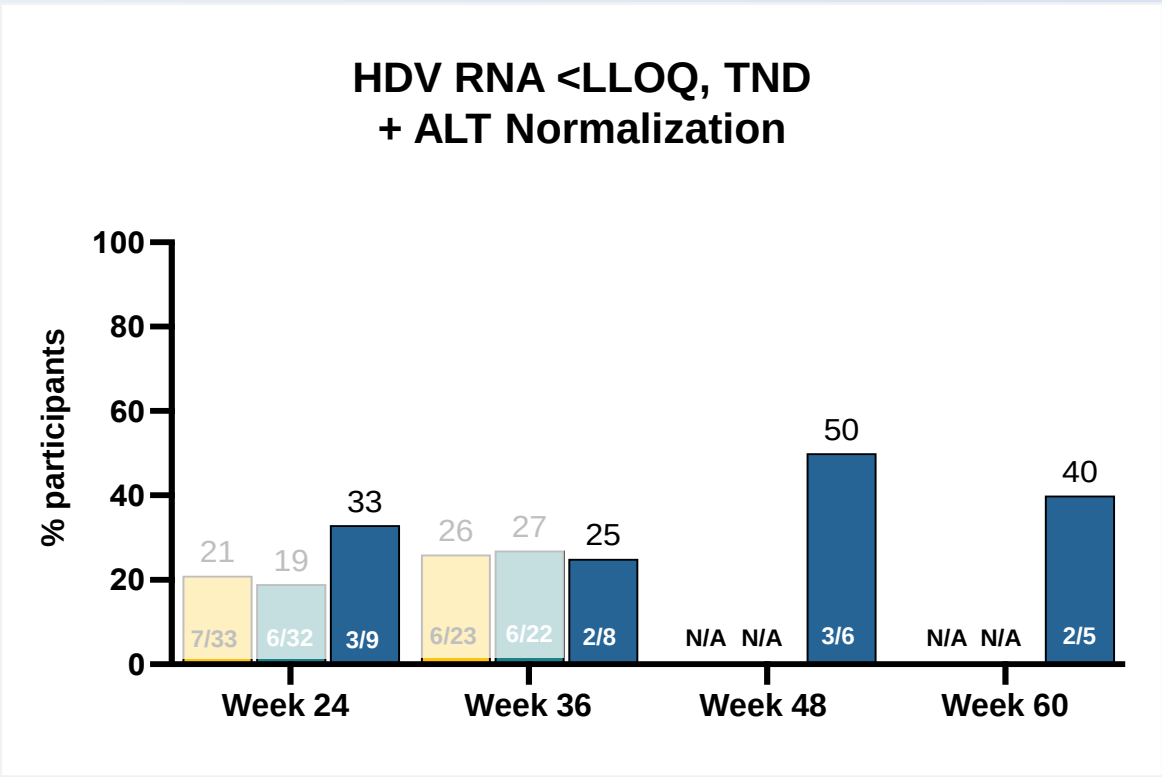
Tobevibart Q2W Combo Q4W *de novo* **Combo Q4W *rollover***

High rates of virologic suppression as measured by HDV RNA target not detected were achieved and maintained in participants receiving tobevibart + elebsiran combination

HDV, hepatitis D virus; Combo, Tobevibart + Elebsiran; LOD, limit of detection; LLOQ, lower limit of quantification; N/A, not available; TND, target not detected; Q2W, once every 2 weeks; Q4W, once every 4 weeks.
Data are reported for participants who completed the visit and had an HDV RNA measurement or who discontinued treatment before the visit. Where indicated, data are N/A as participants have not yet completed this visit.
HDV RNA LOD = 14 IU/mL; HDV RNA TND = no detectable HDV RNA (0 IU/mL).

HDV RNA <LLOQ, TND + ALT Normalization Rates Increased Over Time for the Combination Rollover Cohort



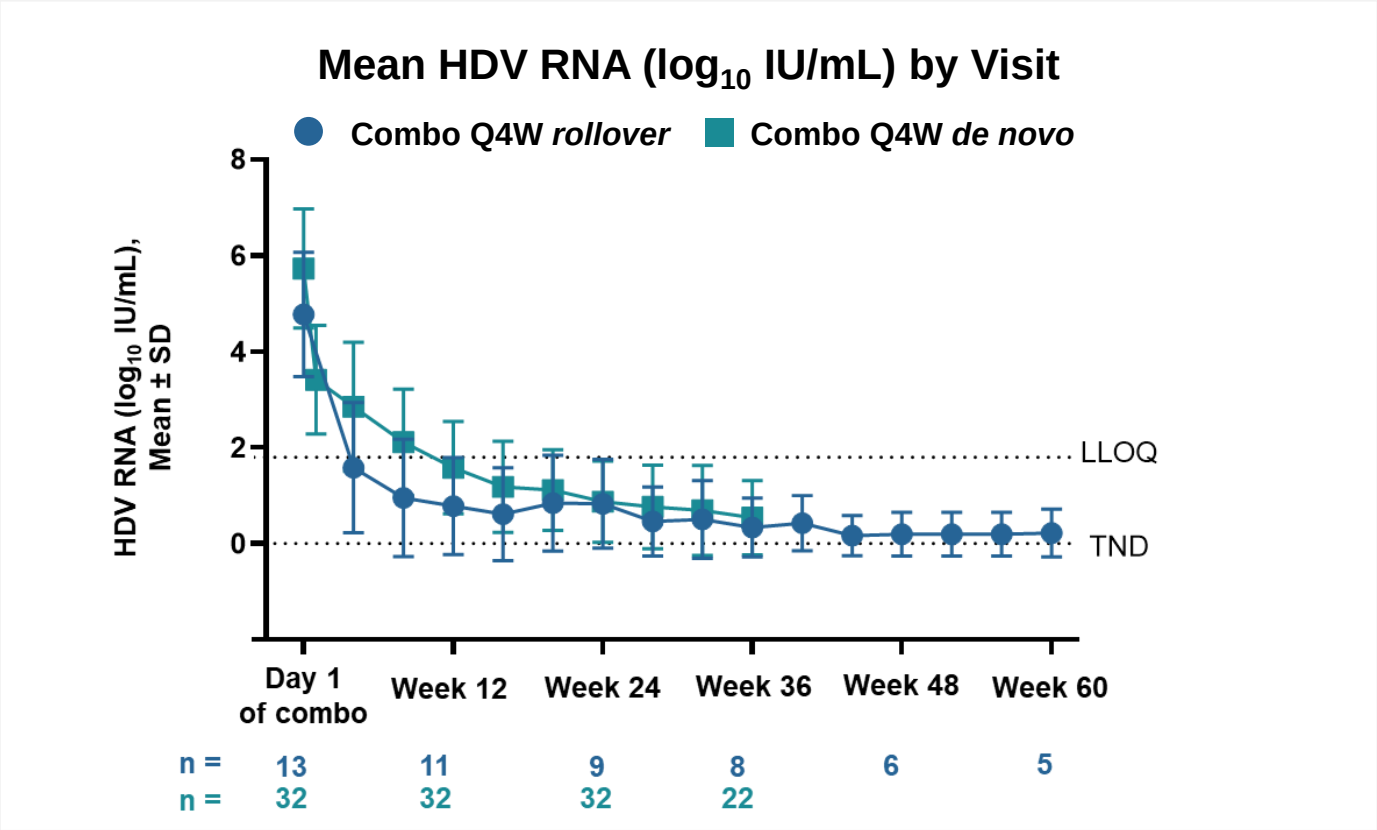


Tobevibart Q2W Combo Q4W *de novo* **Combo Q4W *rollover***

HDV RNA <LLOQ, TND + ALT normalization rates increased over time

ALT, alanine aminotransferase; Combo, Tobevibart + Elebsiran; LOD, limit of detection; LLOQ, lower limit of quantification; N/A, not available; Q2W, once every 2 weeks; Q4W, once every 4 weeks; TND, target not detected.
Data are reported for participants who completed the visit and had an HDV RNA and ALT measurement or who discontinued treatment before the visit. Where indicated, data are N/A as participants have not yet completed this visit.
HDV RNA LOD = 14 IU/mL; HDV RNA TND = no detectable HDV RNA (0 IU/mL); ALT ULN (male) = 40 IU/mL; ALT (female) = 33 IU/mL.

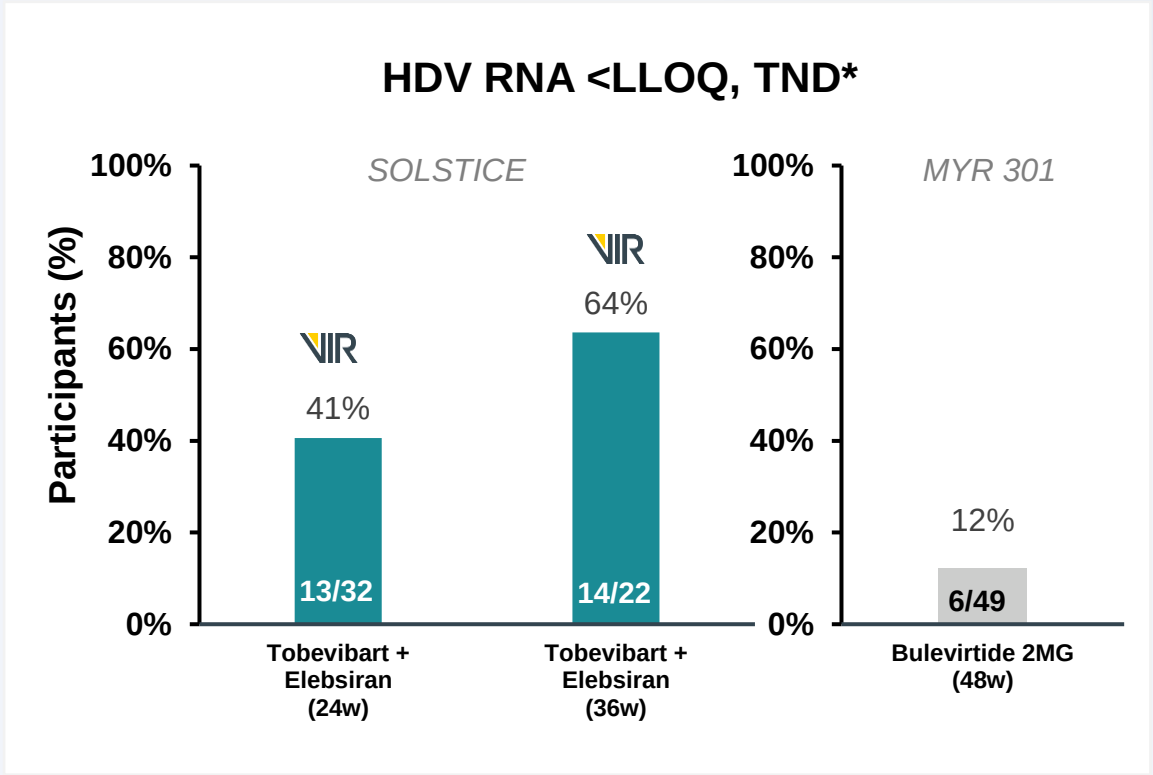
Rapid and Sustained HDV RNA Suppression with Tobevibart + Elebsiran Combination

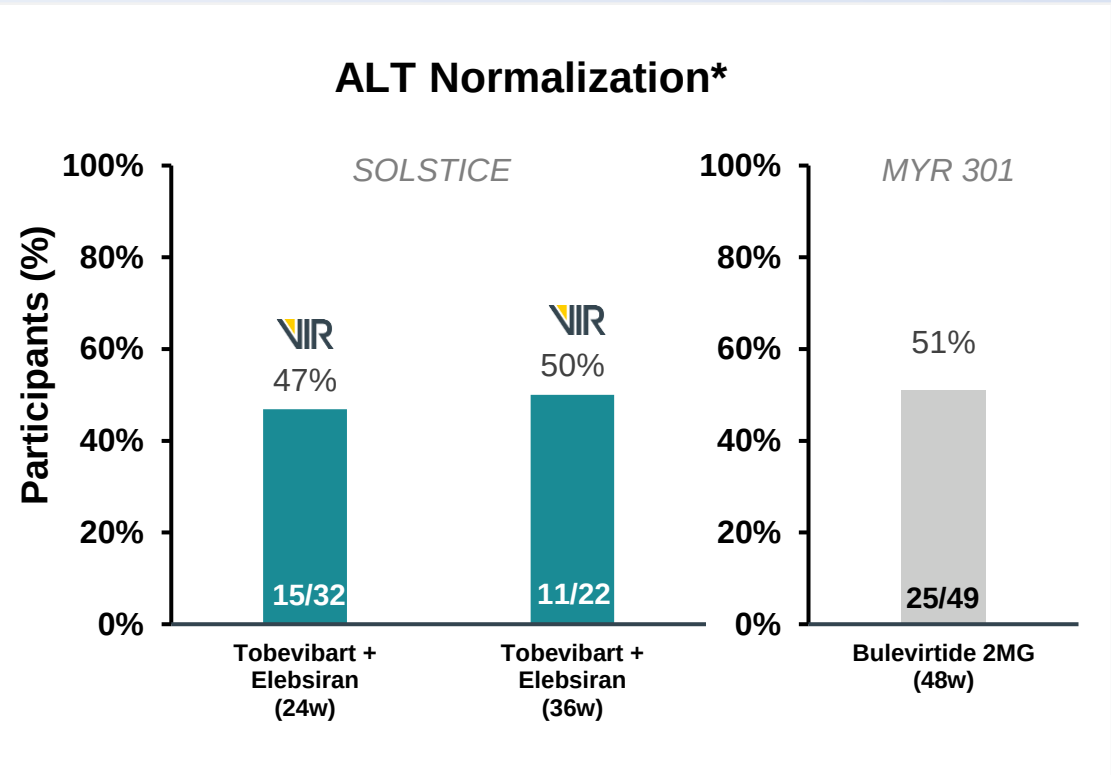


HDV RNA levels decreased rapidly in the tobevibart + elebsiran combination Q4W cohorts and these decreases were maintained over time

HDV, hepatitis D virus; LLOQ, lower limit of quantification; TND, target not detected; Q4W, once every 4 weeks.
Data are reported for participants who completed the visit and had an HDV RNA measurement or who discontinued treatment before the visit.
Combo Q4W rollover data are displayed from Day 1 after transition from monotherapy.
HDV RNA LLOQ = 63 IU/mL; HDV RNA TND = no detectable HDV RNA (0 IU/mL).

Our SOLSTICE phase 2 Results Show Substantial Virologic and Biochemical Response in Hepatitis Delta (Cross Trial Comparison)





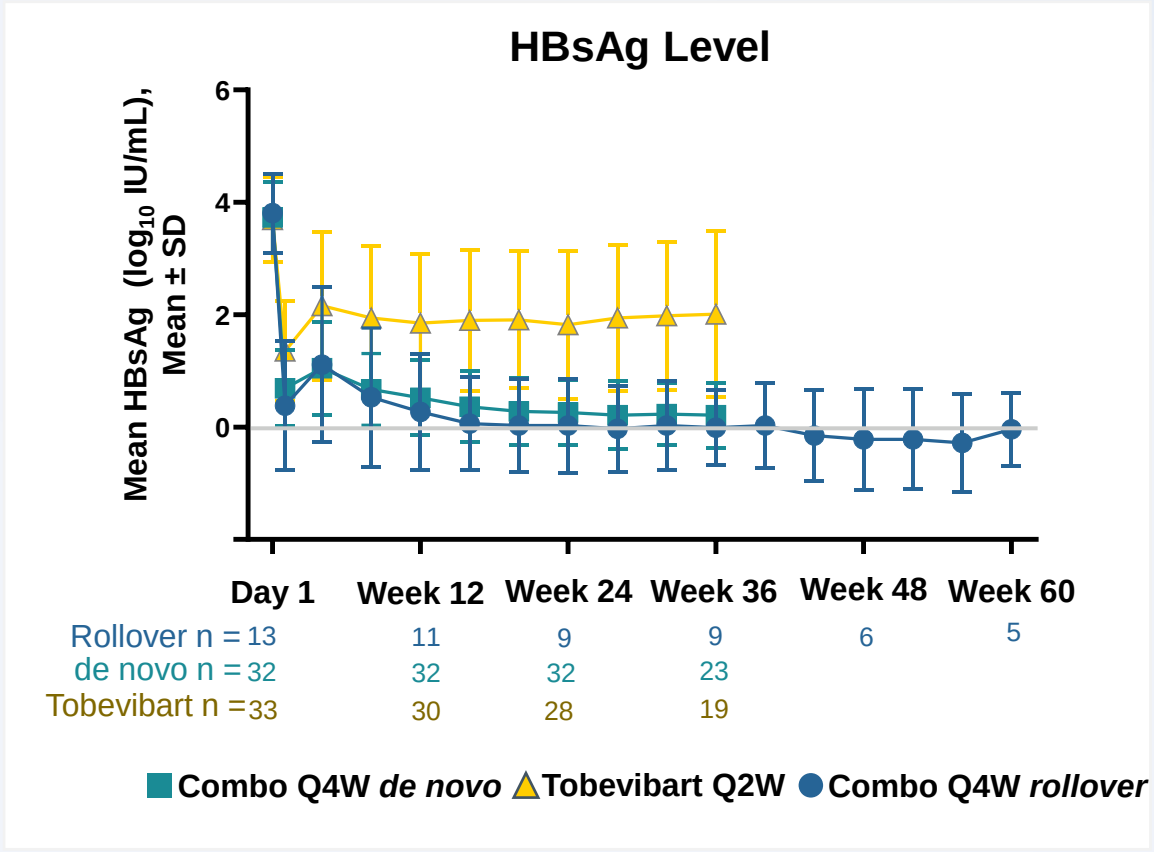
Tobevibart + elebsiran Q4W *de novo* **Bulevirtide QD (Gilead)**

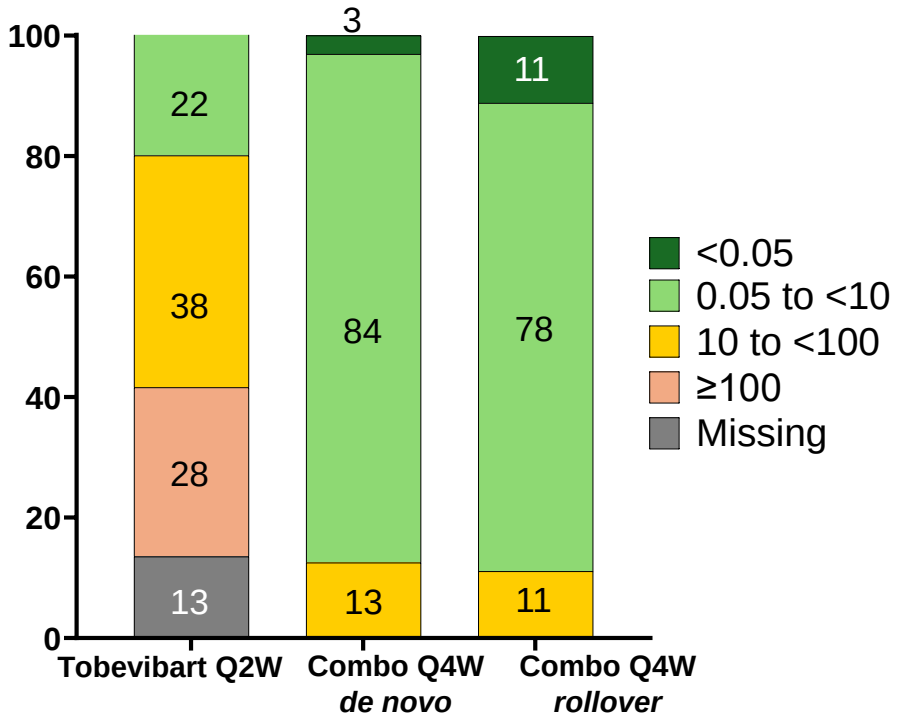
High levels of virologic response suggest a potentially transformative treatment for HDV patients

HDV, hepatitis D virus; LLOQ, lower limit of quantification; Q4W, once every 4 weeks; QD, once daily; TND, target not detected; ALT, alanine aminotransferase
Data are reported for participants who completed the visit and had an HDV RNA measurement / ALT measurement or who discontinued treatment before the visit.
HDV RNA TND = no detectable HDV RNA (0 IU/mL); ALT ULN (male) = 40 IU/mL; ALT ULN (female) = 33 IU/mL.
Source: Wedemeyer, Heiner, et al. "A phase 3, randomized trial of bulevirtide in chronic hepatitis D." New England Journal of Medicine 389.1 (2023): 22-32.

*FOR ILLUSTRATIVE PURPOSES ONLY: No head-to-head trials have been conducted. Cross-trial comparisons may not be reliable due to differences in study design, patient populations, and other factors. See individual study publications for complete data and context.

~90% of Participants Achieved HBsAg <10 IU/mL with Tobevibart + Elebsiran at Week 24: A Potential Key Milestone Controlling both Viruses





Approximately 90% of participants receiving tobevibart + elebsiran achieved HBsAg values <10 IU/mL and approximately 22% receiving tobevibart Q2W at Week 24

HBsAG, hepatitis B surface antigen; Q2W, every 2 weeks; Q4W; every 4 weeks.
Data are reported for participants who completed the visit and had an HBsAg measurement or who discontinued treatment before the visit.
Combo Q4W rollover subjects are displayed from Day 1 after transition from monotherapy.

Majority of Adverse Events were Grade 1-2 & Transient, no Grade 2 or Higher ALT Elevations Have Occurred to Date

Safety or tolerability measure, n (%)[a]	Tobevibart Q2W N = 33	Combo Q4W *de novo* N = 32	Combo Q4W *rollover* N = 13
Any TEAE	29 (87.9)	25 (78.1)	5 (38.5)
Grade 1-2	28 (84.9)	25 (78.1)	5 (38.5)
Grade 3	0	0	0
Grade 4	1 (3.0)[b]	0	0
Treatment-related TEAE	25 (75.8)	22 (68.8)	2 (15.4)
Treatment-emergent influenza-like symptoms[c]	25 (75.8)	21 (65.6)	3 (23.1)
Treatment-emergent injection site reactions[d]	2 (6.1)	4 (12.5)	0
TEAE leading to study drug interruption[e]	1 (3.0)	0	0
TEAE leading to study drug discontinuation[f]	2 (6.1)	0	0

Most TEAEs were Grade 1 or 2 across treatment groups and the most common TEAE (influenza-like illness) was generally mild to moderate and transient
No ALT flares were observed

TEAE, treatment-emergent adverse event.
[a]A participant with multiple events within a category is counted only once in that category.
[b]Grade 4 neutropenia on wk 12 and wk 16, recovered to grade 2-3 after week 16 without treatment
[c]Influenza-like symptoms include arthralgia, chills, fatigue, fever, headache, influenza like illness, myalgia, and pyrexia.
[d]Injection site reactions include pain, pruritus, erythema, swelling
[e]Reason for study drug interruption: neutropenia (PT term)
[f]Reason for discontinuation: influenza-like illness (PT term)

Conclusions: Preliminary Results from the Phase 2 SOLSTICE Trial

The combination **rapidly reduces HDV RNA** leading to high rates of undetectable HDV RNA

Among patients with data through 36 weeks in the de novo combination cohort, **64% achieved HDV <LLOQ, TND**

Decreasing ALT for the majority of patients in the de novo combination cohort

Similar HDV response and ALT normalization in **cirrhotic and non-cirrhotic participants**

No grade 2 or higher ALT elevations have occurred to date

ALT: alanine aminotransferase,
TND: target not detected

Development Plan: Registrational Clinical Trials Starting in 1H'25

Phase 2 Supportive Trial in HDV*

Q4 2024

SOLSTICE

- 24w complete data + 36w preliminary data

Registrational Clinical Program

ECLIPSE 1 – Phase 3
HDV RNA LLOQ, TND + ALT normalization at week 48

- tobevibart + elebsiran vs. deferred treatment (n=120, 2:1)

ECLIPSE 2 – Phase 3
HDV RNA LLOQ, TND at week 24

- tobevibart + elebsiran vs. bulevirtide switch* (n=150, 2:1)

Pivotal Studies Supporting marketing application in the U.S. & Europe

ECLIPSE 3 – Phase 2b
HDV RNA LLOQ, TND at week 48

- tobevibart + elebsiran vs. bulevirtide naïve (n=120, 2:1)

Supporting ex-U.S. pricing, reimbursement, & label expansion

*all patients with hepatitis delta are also co-infected with HBV

*Defined as failure to achieve HDV RNA < 500 IU/mL

POWERING THE IMMUNE SYSTEM
TO TRANSFORM LIVES

KOL Perspective

Perspective on Hepatitis Delta Data and Unmet Medical Need in HDV

Nancy Reau. M.D.

Richard B. Capps Chair of Hepatology,
Associate Director of Solid Organ Transplantation and Section Chief of Hepatology at Rush University Medical Center

POWERING THE IMMUNE SYSTEM
TO TRANSFORM LIVES

PHASE 2 MARCH Part B Data Update at AASLD

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

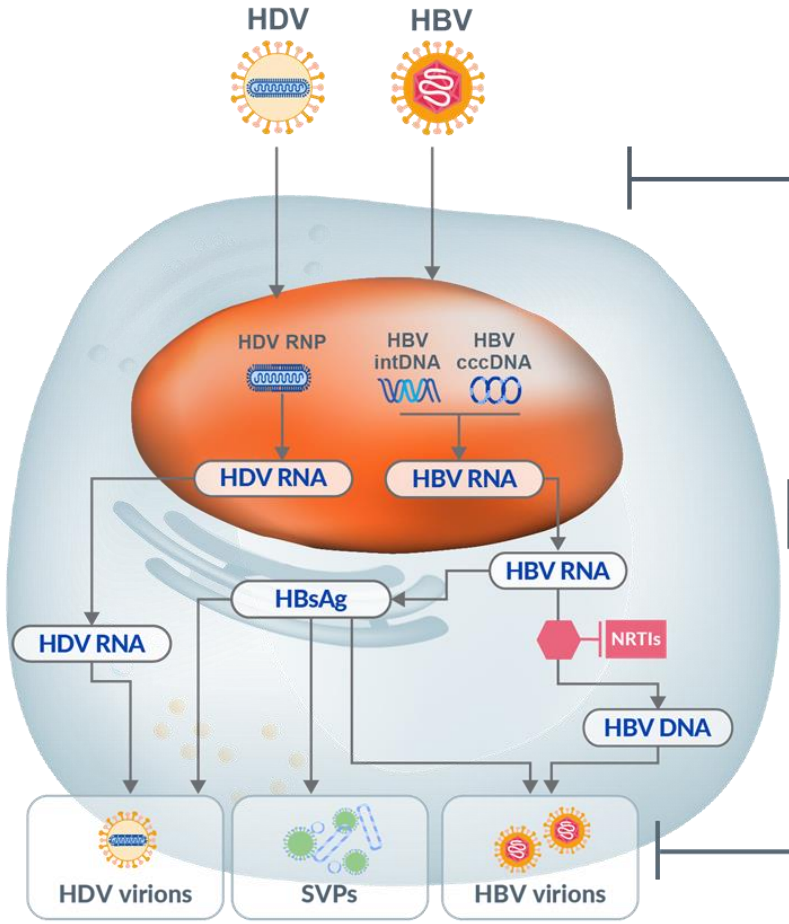
Chronic Hepatitis B: A Global Challenge with Unmet Needs

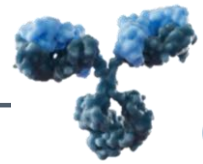
- Chronic HBV infection is estimated to affect approximately 254 million people globally[1]
  - ~1.6 million in the United States and ~2.8 million in Europe[6]
- Chronic HBV infection has been associated with long-term liver outcomes and complications, including[2,3]:
  - Cirrhosis, liver cancer, liver failure, liver transplantation, and liver-related death
  - Stigma, discrimination, and reduced quality of life
- There continues to be an unmet medical need for further improvement of long-term liver outcomes via sustained off-treatment HBsAg loss (functional cure)[4,5]
- Antiviral and immunomodulatory combination therapies may achieve functional cure of chronic HBV infection[4,5]

HBsAg, hepatitis B surface antigen; HBV, hepatitis B virus.

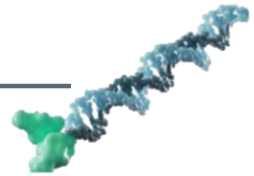
1. World Health Organization. *Global Hepatitis Report 2024: Action for Access in Low- and Middle-income Countries*. World Health Organization; 2024. 2. Younossi ZM, et al. *Clin Gastroenterol Hepatol.* 2023;21(8):1978-1991. 3. Varbobitis I, Papatheodoridis GV. *Clin Mol Hepatol.* 2016;22(3):319-326. 4. Terrault NA, et al. *Hepatology.* 2018;67(4):1560-1599. 5. European Association for the Study of the Liver. *J Hepatol.* 2017;67(2):370-398. 6. Razavi-Shearer, Devin et al. (2023) Global prevalence, cascade of care, and prophylaxis coverage of hepatitis B in 2022: a modelling study. The Lancet Gastroenterology & Hepatology, Volume 8, Issue 10, 879 - 907

Our Ambition in HBV: Functional Cure Following Finite Treatment Regimen

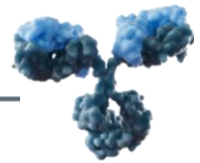




Inhibition of viral entry **(tobevibart)**



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



Neutralization of 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

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

Complementary mechanisms of action:

Tobevibart

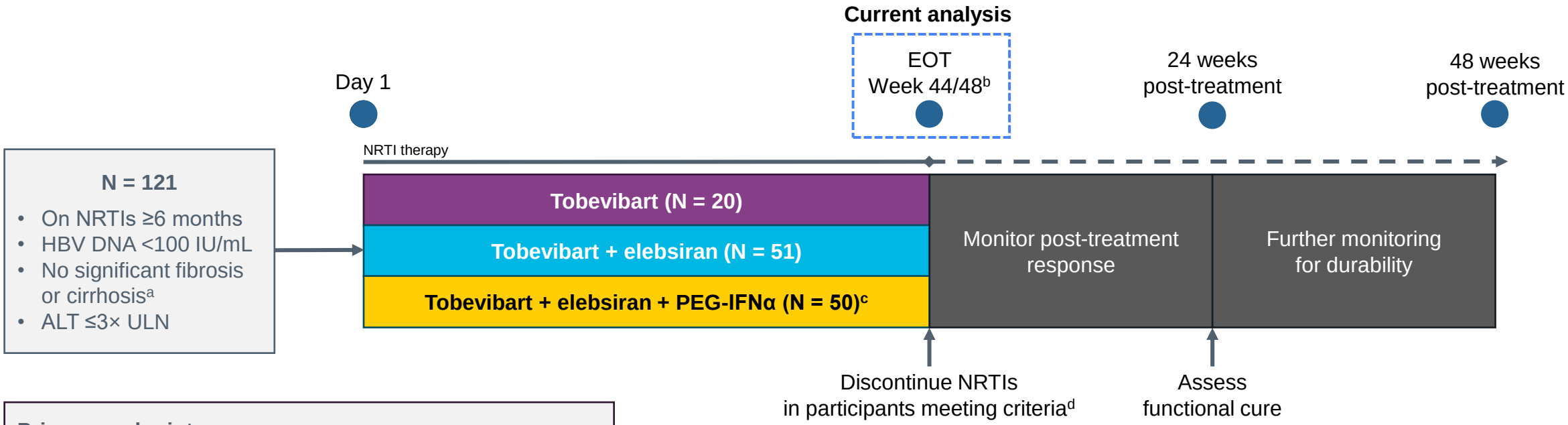
mAb: Fc-engineered monoclonal antibody

- Designed to bind to HBsAg on virions

Elebsiran

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

MARCH Part B Evaluates 3 Regimens with the Goal of Achieving and Maintaining High Rates of HBsAg Loss, Today we are at End of Treatment



Primary endpoints

Proportion of participants with:

- Treatment-related AEs
- Serious treatment-related AEs
- HBsAg loss at EOT
- HBsAg loss at 24 weeks post-EOT (data not yet available)

Current analysis includes the following EOT data:

- All participants treated with tobevibart and tobevibart + elebsiran
- 27/50 participants treated with tobevibart + elebsiran + PEG-IFNα

AE, adverse event; ALT, alanine aminotransferase; EOT, end of treatment; HBeAg, hepatitis B e antigen; HBsAg, hepatitis B surface antigen; HBV, hepatitis B virus; NRTI, nucleos(t)ide reverse transcriptase inhibitor; PEG-IFNα, pegylated interferon alfa-2a; Q4W, every 4 weeks; QW, every week; SC, subcutaneous; ULN, upper limit of normal.
MARCH ClinicalTrials.gov Identifier: NCT04856085.
Study drugs were administered as follows: tobevibart 300 mg SC Q4W, elebsiran 200 mg SC Q4W, PEG-IFNα 180 µg SC QW.

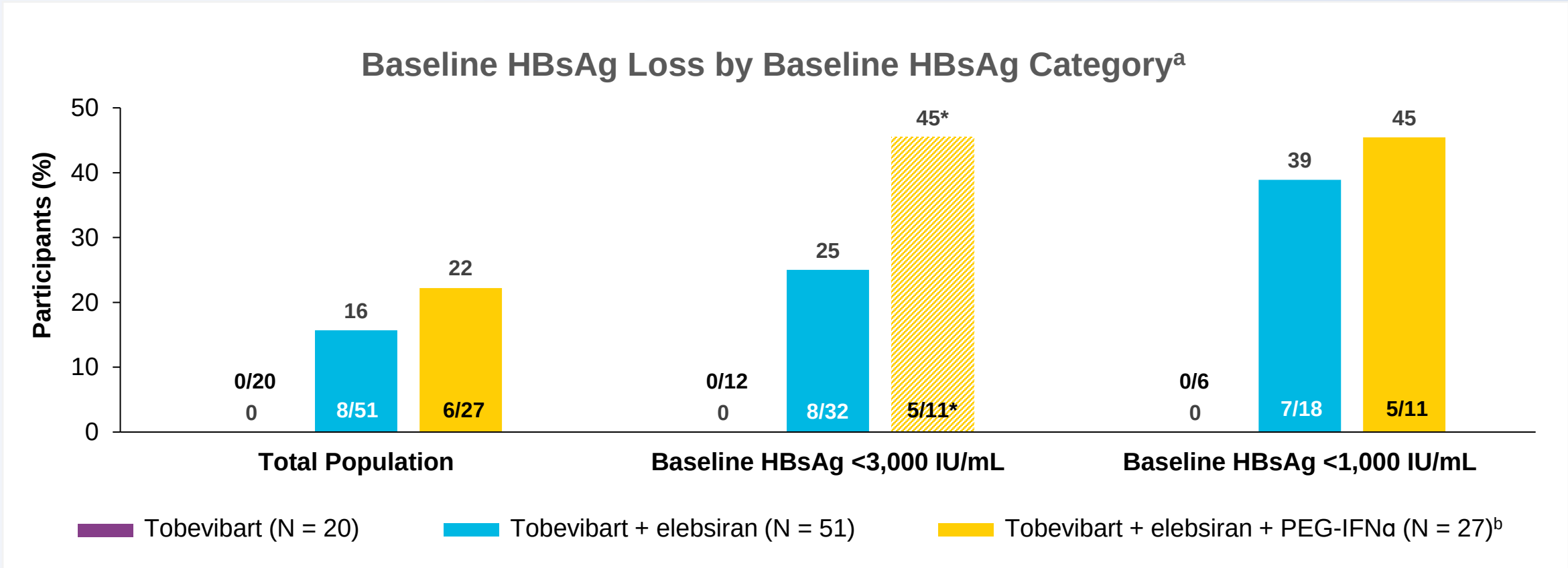
[a]Fibrosis and cirrhosis were defined as FibroScan >8.5 kPa at screening or METAVIR F3/F4 liver biopsy <1 year.
[b]Tobevibart and tobevibart + elebsiran regimens were 44 weeks; tobevibart + elebsiran + PEG-IFNα regimen was 48 weeks.
[c]EOT data available for N = 27/50 participants enrolled.
[d]NRTI discontinuation criteria: HBsAg loss, suppressed HBV DNA, HBeAg-negativity, and ALT ≤2× ULN.

Baseline Characteristics were Generally Balanced Across Treatment Groups

	Tobevibart (44 weeks) N = 20	Tobevibart + elebsiran (44 weeks) N = 51	Tobevibart + elebsiran + PEG-IFNα (48 weeks) N = 27[a]
Age, y, mean ± SD	45.6 ± 10.8	47.3 ± 8.3	47.6 ± 9.5
Male, n (%)	12 (60.0)	39 (76.5)	14 (51.9)
Race, n (%) **Asian** **Black or African American** **White** **Other**	 13 (65.0) 1 (5.0) 5 (25.0) 1 (5.0)	 33 (64.7) 4 (7.8) 13 (25.5) 1 (2.0)	 20 (74.1) 1 (3.7) 6 (22.2) 0
HBsAg, log_{10} IU/mL, median (range)	3.32 (1.9 to 4.2)	3.15 (−0.4 to 4.2)	3.55 (1.5 to 4.7)
Baseline HBsAg, n (%) **<100 IU/mL** **100 to <1,000 IU/mL** **1,000 to <3,000 IU/mL** **3,000 to <10,000 IU/mL** **≥10,000 IU/mL**	 1 (5.0) 5 (25.0) 6 (30.0) 6 (30.0) 2 (10.0)	 5 (9.8) 13 (25.5) 14 (27.5) 15 (29.4) 4 (7.8)	 2 (7.4) 9 (33.3) 0 13 (48.1) 3 (11.1)
HBeAg negative, n (%)	14 (70.0)	39 (76.5)	19 (70.4)

EOT, end of treatment; HBeAg, hepatitis B e antigen; HBsAg, hepatitis B surface antigen; PEG-IFNα, pegylated interferon alfa-2a; SD, standard deviation.
[a]EOT data available for N = 27/50 participants enrolled.

Combination of Tobevibart + Elebsiran Results in High Levels of HBsAg Loss at EOT Without or With PEG-IFNα in Lower HbsAg Participants

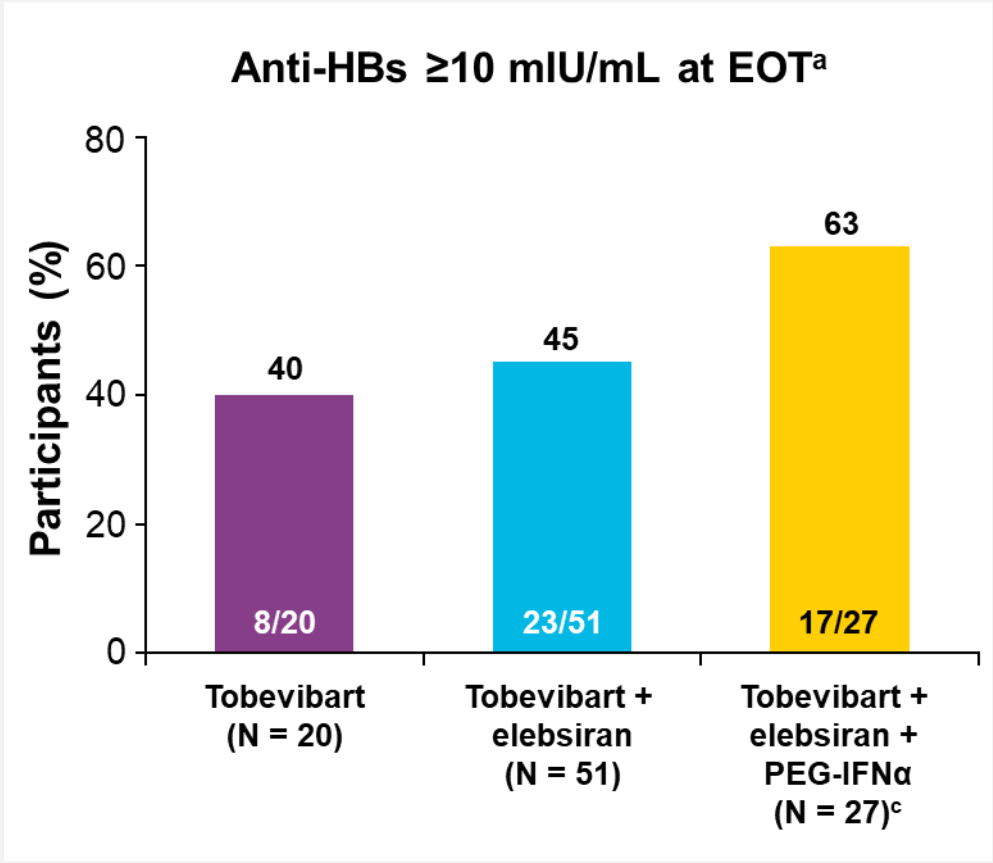


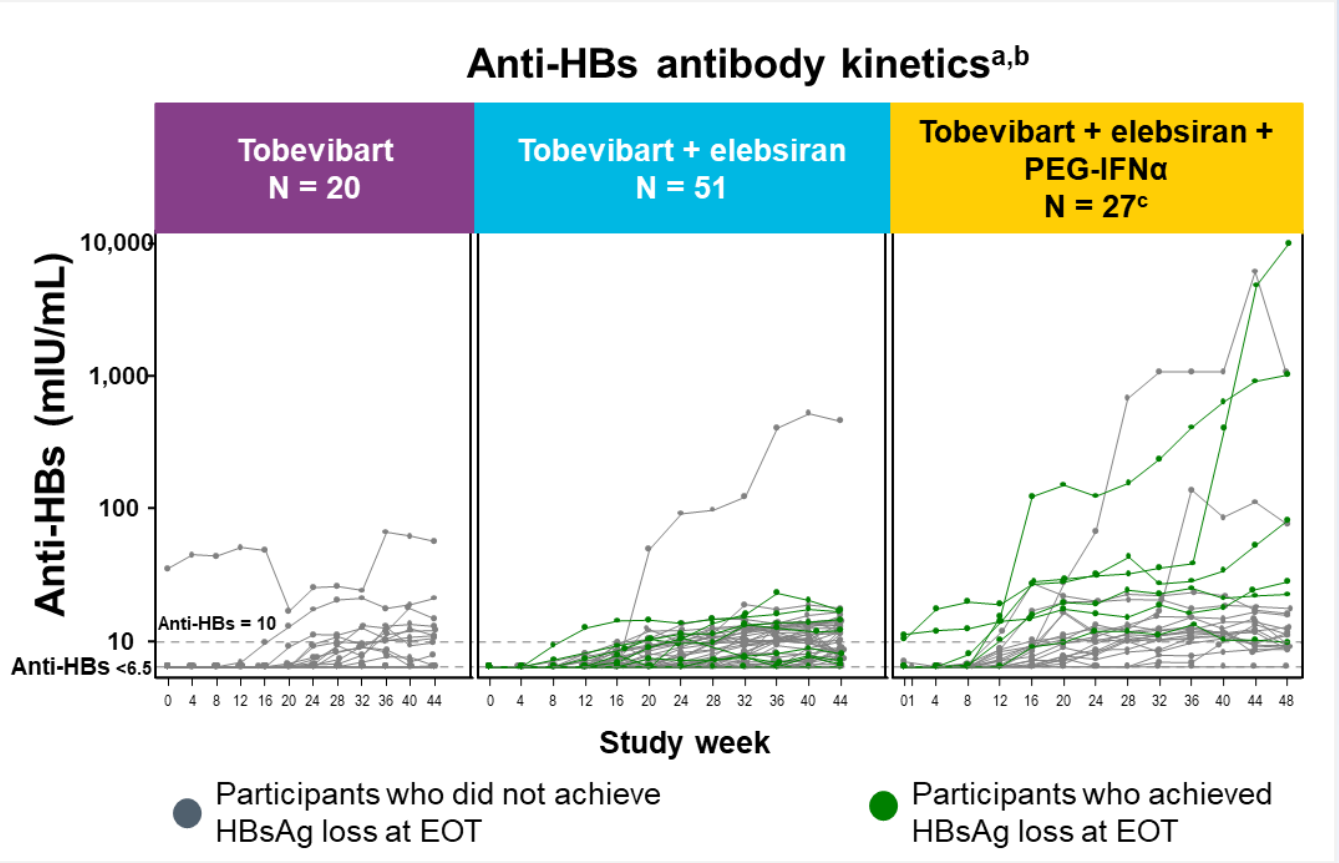
HBsAg loss at EOT was similar for tobevibart + elebsiran without or with PEG-IFNα

HBsAg loss at EOT was highest among participants with lower baseline HBsAg

EOT, end of treatment; HBsAg, hepatitis B surface antigen; PEG-IFNα, pegylated interferon alfa-2a.
*Note: all 11 Tobevibart + elebsiran + PEG-IFNα participants enrolled with with baseline HBsAg <3,000 IU/mL also had baseline HBsAg <1,000 IU/mL
[a]HBsAg loss was defined as HBsAg <0.05 IU/mL (lower of limit of quantification).
[b]EOT data available for N = 27/50 participants enrolled.

A Large Number of Patients Developed Protective Levels of Anti-HBs Antibodies (≥10 mIU/mL) at End of Treatment, and Indicator of Immune Response



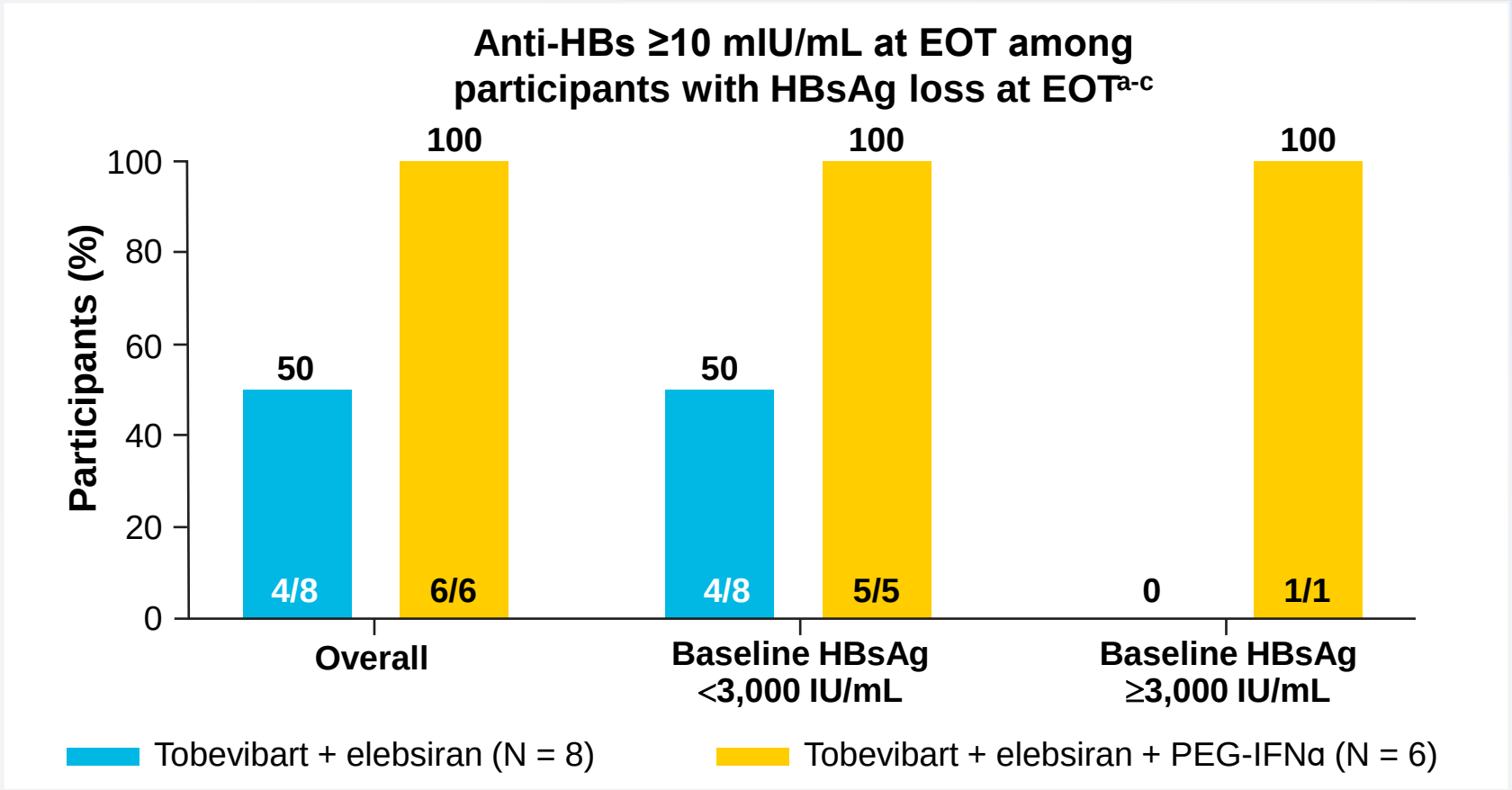


Strong anti-HBs development across all regimens studied

Tobevibart + elebsiran + PEG-IFNα is associated with the highest antibody levels

EOT, end of treatment; HBsAg, hepatitis B surface antigen; anti-HBs, anti–hepatitis B surface antibody; PEG-IFNα, pegylated interferon alfa-2a.
[a]Anti-HBs levels were determined via Roche Elecsys Anti-HBs kit on the cobas8000 e801 module; a tobevibart-binding blocker was added to samples prior to analysis, preventing assay interference by tobevibart.
[b]HBsAg loss was defined as HBsAg <0.05 IU/mL (lower limit of quantification).
[c]EOT data available for N = 27/50 participants enrolled.

HBsAg loss at EOT is Strongly Associated with Development of Anti-HBs Antibody



All participants with HBsAg loss in the tobevibart + elebsiran + PEG-IFNα group achieved anti-HBs positivity

EOT, end of treatment; HBsAg, hepatitis B surface antigen; anti-HBs, anti–hepatitis B surface antibody; PEG-IFNα, pegylated interferon alfa-2a.
[a]HBsAg loss was defined as HBsAg <0.05 IU/mL (lower limit of quantification).
[b]HBsAg loss was not achieved in the tobevibart monotherapy cohort.
[c]Anti-HBs levels were determined via Roche Elecsys Anti-HBs kit on the cobas8000 e801 module; a tobevibart-binding blocker was added to samples prior to analysis, preventing assay interference by tobevibart.

Adverse Events were Generally Mild to Moderate and Transient

Safety or tolerability measure, n (%)[a]	Tobevibart (44 weeks) N = 20	Tobevibart + elebsiran (44 weeks) N = 51	Tobevibart + elebsiran + PEG-IFNα (48 weeks) N = 27[b]
Any AE	14 (70.0)	43 (84.3)	25 (92.6)
Grades 1-2	14 (70.0)	41 (80.4)	16 (59.3)
Grade 3	0	1 (2.0)	8 (29.6)
Grade 4	0	1 (2.0)[c]	1 (3.7)[d]
Treatment-related AE	9 (45.0)	29 (56.9)	23 (85.2)
Tobevibart-related AE **Grades 3-4**	9 (45.0) 0	28 (54.9) 0	13 (48.1) 1 (3.7)
Elebsiran-related AE **Grades 3-4**	–	28 (54.9) 0	13 (48.1) 1 (3.7)
PEG-IFNα–related AE **Grades 3-4**	– –	– –	23 (85.2) 7 (25.9)
SAE **Treatment-related SAE**	0 0	2 (3.9) 0	5 (18.5) 2 (7.4)
AE leading to study drug interruption	0	2 (3.9)	2 (7.4)
AE leading to study drug discontinuation	0	0	3 (11.1)[e]

- The most common tobevibart- or elebsiran-related AEs (headache and influenza-like illness) were generally mild to moderate and transient
- PEG-IFNα–related AEs were consistent with the established safety and tolerability profile of PEG-IFNα monotherapy
- Treatment-related SAEs were reported in 2 participants in the tobevibart + elebsiran + PEG-IFNα cohort
  - Leukopenia related to PEG-IFNα
  - Hepatitis[f] related to tobevibart, elebsiran, and PEG-IFNα
  - Both events improved without sequelae
- No AEs leading to death were observed

AE, adverse event; EOT, end of treatment; PEG-IFNα, pegylated interferon alfa-2a; SAE, serious AE.
[a]A participant with multiple events within a category is counted only once in that category. [b]EOT data available for N = 27/50 participants enrolled. [c]Multivessel coronary artery disease (not related to tobevibart or elebsiran). [d]Neutrophil count decrease (related to PEG-IFNα). [e]Hepatitis (related to tobevibart, elebsiran, and PEG-IFNα) in 1 participant; body aches/pain (related to tobevibart, elebsiran, and PEG-IFNα) in 1 participant; and pruritus, diarrhea, photophobia, and alopecia (related to PEG-IFNα) in 1 participant. [f]SAE of hepatitis consisted of elevated alanine aminotransferase and aspartate aminotransferase (both grade 1), increased FibroScan from baseline, and elevated alpha fetoprotein (peak 129.3 ng/mL) and resolved without sequelae upon study drug discontinuation.

Preliminary Conclusions from the Phase 2 MARCH Part B Trial

Compelling HBsAg loss and anti-HBs development at end of treatment with 48 weeks of tobevibart + elebsiran, without or with PEG-IFN

~39% HBsAg loss for the tobevibart + elebsiran regimen, in participants with baseline HBsAg<1,000 IU/mL

~46% HBsAg loss for the tobevibart + elebsiran + PEG-IFNα regimen, in participants with baseline HBsAg<1,000 IU/mL

Encouraging anti-HBs development across both regimens, particularly in the tobevibart + elebsiran + PEG-IFNα regimen

This data is **promising for Hepatitis B patients**, and we expect **functional cure data in Q2 2025** for both regimens

EOT, end of treatment; HBsAg, hepatitis B surface antigen; anti-HBs, anti–hepatitis B surface antibody; HBV, hepatitis B virus;; PEG-IFNα, pegylated interferon alfa-2a.

CHB: MARCH Phase 2 Functional Cure Data in Q2 2025

Q3 2023

Completion of Enrollment

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

Q4 2024

48w End of Treatment Data

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

Q2 2025 (‘25)

24w Off Treatment Data

(48w Post-Treatment)

- ~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

POWERING THE IMMUNE SYSTEM
TO TRANSFORM LIVES

KOL Perspective

KOL Perspective on MARCH Part B Data & Chronic Hepatitis B

Nancy Reau. M.D.

Richard B. Capps Chair of Hepatology,
Associate Director of Solid Organ Transplantation and Section Chief of Hepatology at Rush University Medical Center

POWERING THE IMMUNE SYSTEM
TO TRANSFORM LIVES

Closing Remarks:

Poised to Achieve Our Near- and Long-term Goals

Breakthrough Results: Transformational HDV Data and Promising CHB Seroclearance

Hepatitis Delta (HDV)

Transformative Data
(combo Q4W de novo)

- Large proportion of patients achieving undetectable HDV RNA <LLOQ, TND
- Decreasing ALT for the majority of patients
- Responses maintained to week 60 in rollover combination cohort
- No grade 3 or higher TEAEs

Chronic Hepatitis B (CHB)

Promising EOT Seroclearance
(HBsAg <1,000 IU/mL)

- ~39% for tobevibart + elebsiran
- ~46% for tobevibart + elebsiran + PEG-IFNα
- HBsAg Loss at EOT is Associated With Development of Anti-HBs Antibodies, particularly in triplet regimen

Next Steps

HDV Registrational Study Starting 1H 2025

- FDA Type C Meeting Held
- ECLIPSE will be a Ph 3 registrational program

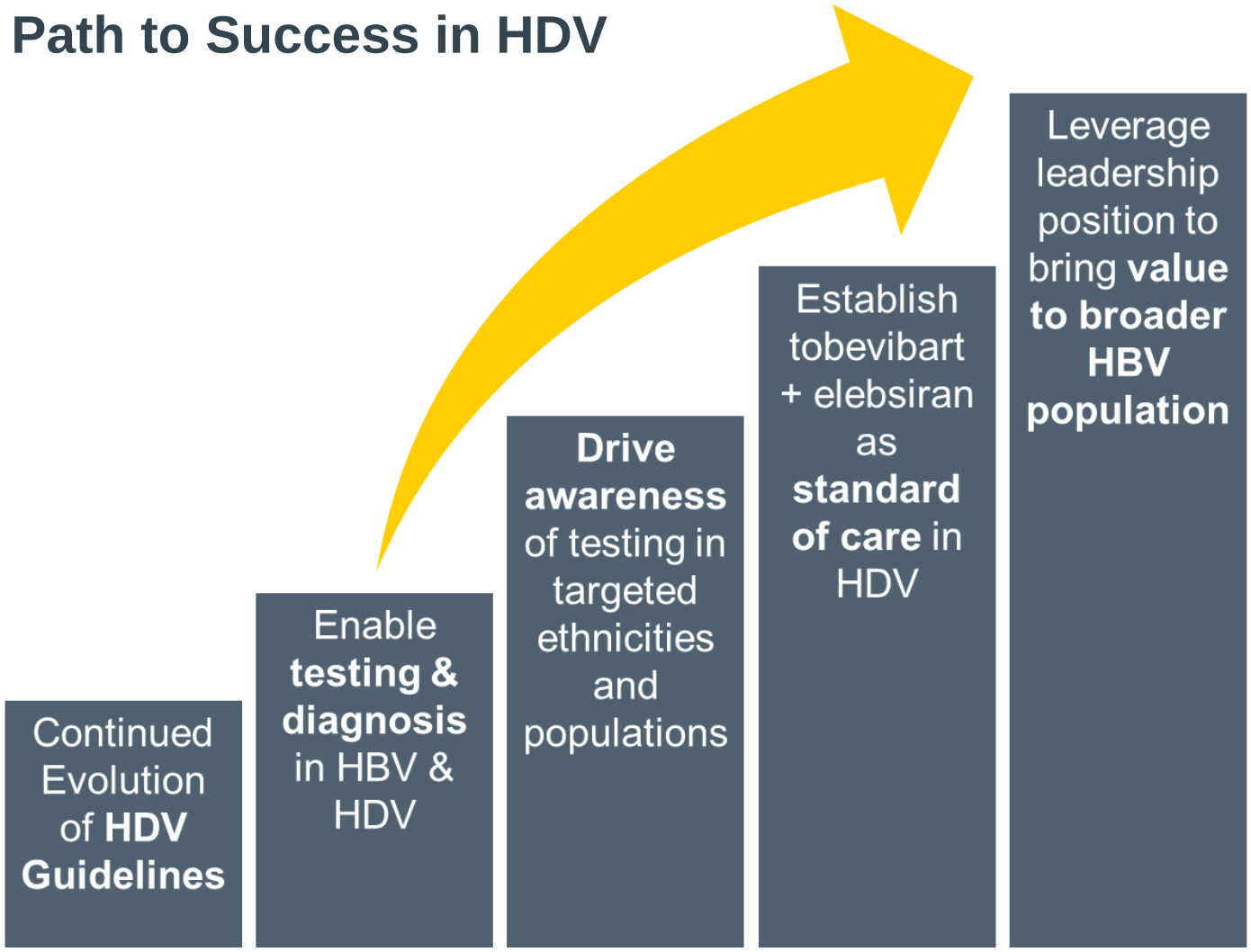
CHB Functional Cure Data

- Expect 24w-off treatment functional cure data in Q2 2025

Vir HDV Priorities

- Bring forward a transformative efficacious treatment
- Understanding who Delta patients are, to bridge testing to treatment
- Ensuring the earliest possible access through payor engagement
- Accelerating treatment rates through patient and provider education

Path to Success in HDV



Our Development Priorities are Poised to Accelerate Near-Term Value

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	tobevibart + elebsiran ± PEG-IFN-α[1]	Treatment						Alnylam
Solid Tumors	SAR446309 (HER2)[2] ± pembrolizumab AMX-818	Treatment						
	SAR446329 (PSMA)[2] AMX-500	Treatment						
	SAR446368 (EGFR)[2] AMX-525	Treatment						
RSV	Preclinical antibody candidates*	Prevention						GSK
HIV Cure	Preclinical antibody candidates	Treatment						Bill & Melinda Gates Foundation

Note: HDV registrational program expected to start 1H'25

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

1: MARCH study (Part B);
2: masked TCEs licensed from Sanofi, pending HSR review and clearance and closing of the transaction

We Anticipate Important Near-Term Catalysts

Program	Drug Candidates/Regimen	Catalyst	Timing
Hepatitis Delta	tobevibart (mAb) +/- elebsiran (siRNA)	SOLSTICE Phase 2: additional clinical data	✓ Q4’24
Chronic Hepatitis B	tobevibart (mAb) + elebsiran (siRNA) +/- PEG-IFN-α	MARCH-B Phase 2: 48-week end of treatment clinical data	✓ Q4’24
Hepatitis Delta	tobevibart (mAb) + elebsiran (siRNA)	ECLIPSE: registrational study start	1H’25
HER2 solid tumors	SAR446309 (AMX-818) Dual-masked HER2xCD3 TCE +/- pembrolizumab	Phase 1: initial monotherapy data	Q1’25
PSMA solid tumors	SAR446329 (AMX-500) Dual-masked PSMAxCD3 TCE	Phase 1: initial monotherapy data	Q1’25
EGFR solid tumors	SAR446368 (AMX-525) Dual-masked EGFRxCD3 TCE	Phase 1: study start and first-in-human dose	Q1’25
Chronic Hepatitis B	tobevibart (mAb) + elebsiran (siRNA) +/- PEG-IFN-α	MARCH-B Phase 2: 24-week post-treatment (functional cure) clinical data	Q2’25

Updated and accelerated data catalysts

mAb: monoclonal antibody; siRNA: small interfering RNA; PEG-IFN-α: peginterferon alfa-2a; EOT: End of treatment; TCE: T-cell engager; EGFR: epidermal growth factor receptor; HER2: human epidermal growth factor receptor 2; PSMA: prostate-specific membrane antigen

MARCH: NCT04856085
SOLSTICE: NCT05461170

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