Vir Biotechnology™

POWERING THE IMMUNE SYSTEM
TO TRANSFORM LIVES

PRO-XTEN™ Masked T Cell Engagers: Investor Call

January 8, 2025

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 therapeutic potential of Vir Biotechnology's oncology solid tumor portfolio, preclinical pipeline and PRO-XTEN™ masked TCE platform, as well as Vir Biotechnology's strategy, plans and expectations related thereto; the therapeutic potential of Vir Biotechnology's CHD and CHB programs, as well as Vir Biotechnology's strategy, plans and expectations related thereto; the potential of and Vir Biotechnology's expectations for its other pipeline programs; Vir Biotechnology's cash balance and anticipated cash runway; Vir Biotechnology's clinical development plans and expectations for its oncology and hepatitis programs, including protocols for and enrollment into ongoing and planned clinical trials, potential partnering opportunities, and data readouts and presentations, as well as anticipated timelines; the potential benefits, safety and efficacy of Vir Biotechnology's investigational therapies; the potential impacts of artificial intelligence and machine learning on Vir Biotechnology's research and development efforts; and any assumptions underlying any of the foregoing. 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 Vir Biotechnology, as well as assumptions made by and information currently available to management. Such statements reflect the current views of Vir Biotechnology with respect to future events and are subject to known and unknown risks, including, without limitation: unexpected safety or efficacy data or results observed during clinical trials or in data readouts; the timing and outcome of Vir Biotechnology’s planned interactions with regulatory authorities; difficulties in obtaining regulatory approval; uncertainty as to whether the anticipated benefits of Vir Biotechnology's various collaborations can be achieved, including potential difficulties in collaborating with other companies that might be competitors of Vir Biotechnology or otherwise have divergent interests; 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 Vir Biotechnology's competitors, as well as changes in expected or existing competition; Vir Biotechnology'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, Vir Biotechnology'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, Vir Biotechnology undertakes no obligation to publicly update any forward-looking statements, whether as a result of new information, future events or otherwise. Vir Biotechnology 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.

Legal disclaimer (continued)

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This presentation includes certain preliminary, estimated, and unaudited financial results as of January 1, 2025. Such preliminary estimated data constitute forward-looking statements based solely on information available to us as of the date of this presentation and may differ materially from actual results. This data should not be considered a substitute for the financial information to be filed with the SEC in our Annual Report on Form 10-K for the fiscal year ended December 31, 2024, once it becomes available.

Today's agenda

Speaker	Topic
Marianne De Backer, M.Sc., Ph.D., MBA **Chief Executive Officer and Director**	**Opening Remarks** *Differentiated Cancer Modalities Through the PRO-XTEN™ Platform*
Mika Derynck, M.D. EVP, Therapeutic Area Head Oncology	**Phase 1 Clinical Data: VIR-5818 (HER2 expressing tumors)[1]** *PRO-XTEN™ Proof of Concept and Potential First-in-Class HER2 Immunotherapy*
Josep Tabernero, M.D., Ph.D. Vall d'Hebron Institute of Oncology (VHIO)	**KOL Perspective** *On VIR-5818 Data and Masked TCEs in HER2*
Mika Derynck, M.D. EVP, Therapeutic Area Head Oncology	**Phase 1 Clinical Data: VIR-5500 (PSMA expressing tumors)[2]** *Potential Best-in-Class Profile in Prostate Cancer*
Johann de Bono MD, MSc, PhD, FRCP, FMedSci The Institute of Cancer Research and the Royal Marsden NHS Foundation Trust	**KOL Perspective** *On VIR-5500 Data and Activity in mCRPC patients*
Marianne De Backer, M.Sc., Ph.D., MBA	**Closing Remarks**
All	**Q&A Session**

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[1,2] Interim Phase 1 data

Opening Remarks

Marianne De Backer, M.Sc., Ph.D., MBA

Vir Biotechnology™

POWERING THE IMMUNE SYSTEM
TO TRANSFORM LIVES

Expanding the potential of T-cell engagers in cancer treatment

PRO-XTEN™ Masked TCEs

VIR-5818 (HER2xCD3): The only masked HER2-targeted TCE, early Phase 1 data show broad activity and a compelling safety profile

- 50% tumor shrinkage at efficacious doses, deepening as dose increases
- No Gr3 CRS, and very low levels of ≥Gr3 TRAEs (some patients on treatment for >2 years)

VIR-5500 (PSMAxCD3): The only dual-masked PSMA-targeted TCE, potential best-in-class therapeutic index (TI) based on early Phase 1 data

- 100% PSA decline, 58% PSA50 response, potential for Q3W dosing enabled by long half-life
- No Gr3 CRS, and very low levels of ≥Gr3 TRAEs

Pipeline and Platform

VIR-5525 (EGFRxCD3): Potential to unlock multiple high-value indications

- Planned Phase 1 start in H1 2025

Universal masks designed to be applied to new targets without the need for tailoring

- Potential for rapid dose escalation, utilizing learnings from clinical assets

Focused Capital Allocation

Robust cash position of ~$1.1B*

*We estimate our cash, cash equivalents, and investments to be approximately $1.1 billion as of January 1, 2025. This is a preliminary, estimated, and unaudited financial result. Actual results may differ from this estimate

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HER2: human epidermal growth factor receptor 2; PSMA: prostate-specific membrane antigen; EGFR: epidermal growth factor receptor; CRS: cytokine release syndrome; Gr3: Grade 3; TRAEs: treatment related adverse events; Q3W: once every 3 weeks; TCE: T Cell Engager; PSA: prostrate specific antigen; CD3: cluster of differentiation 3

Advancing clinical programs in oncology and infectious disease

Leveraging Immune-Targeted Approaches to Transform Patient Care

Oncology – Solid Tumors

HER2 (Phase 1)	PSMA (Phase 1)	EGFR (Initiating Phase 1)
Potential HER2 tumors: mBC mCRC Others	mCRPC	mNSCLC mCRC mHNSCC Others

Focus of today's call

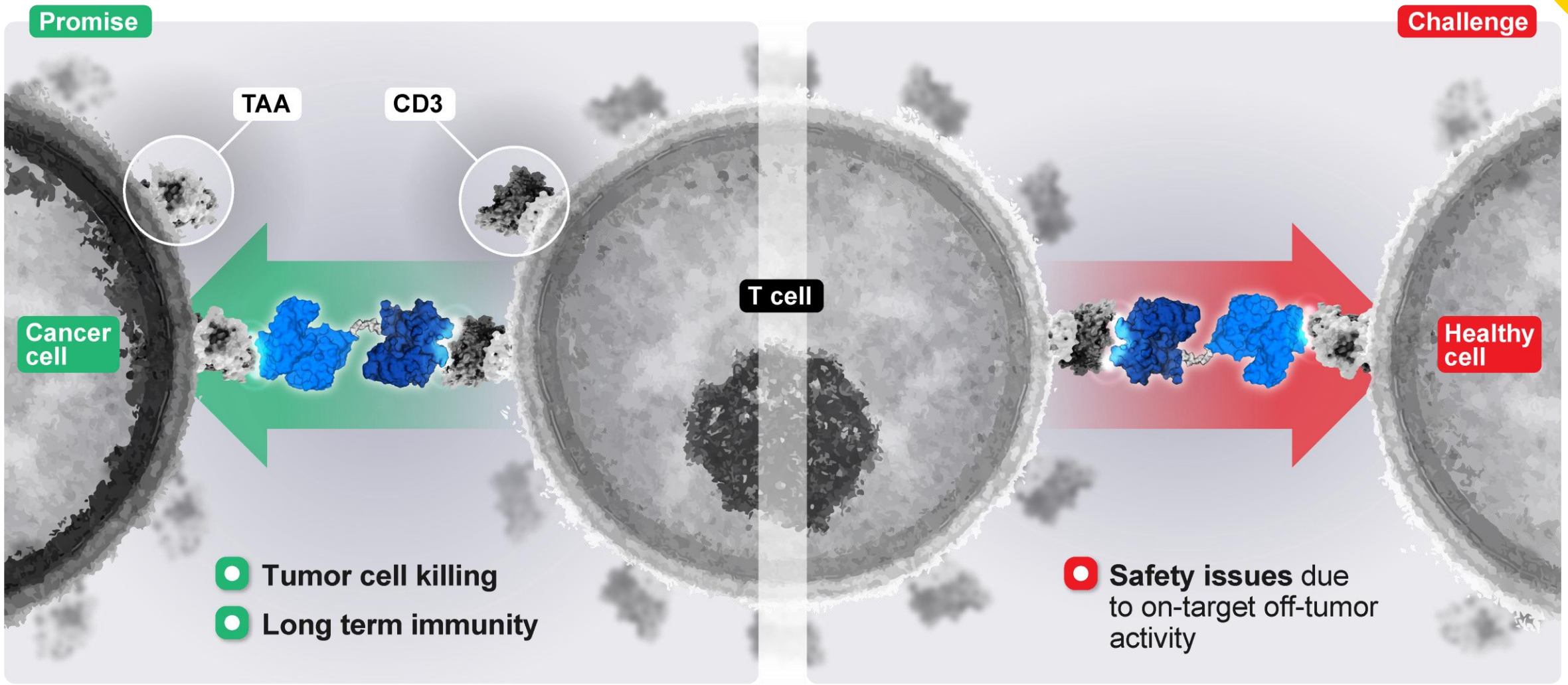
Infectious Disease

Hepatitis Delta (Initiating Phase 3)	Chronic Hepatitis B (Phase 2)
Chronic suppressive treatment	Pursuing functional cure Further development contingent on partner support

AI-driven antibody discovery, protein engineering and masking technology

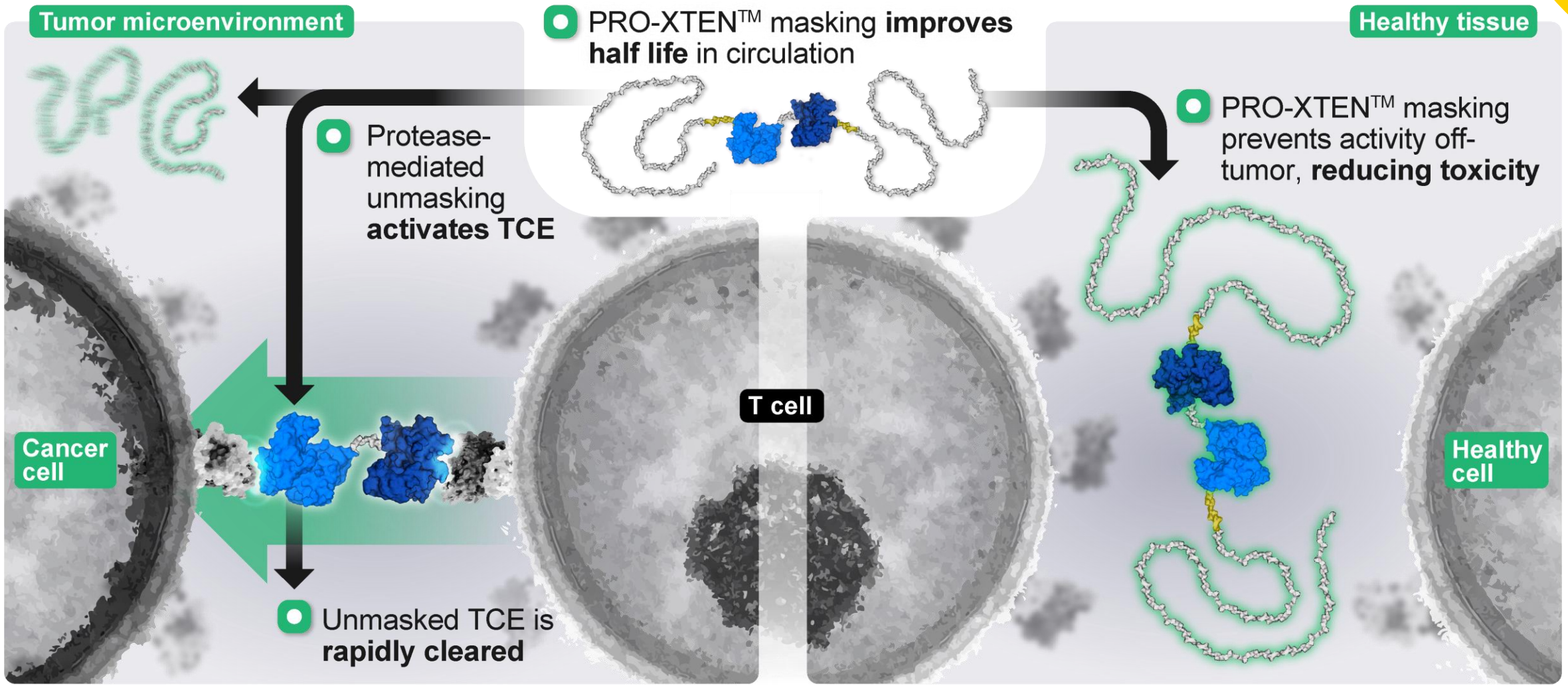
HER2: human epidermal growth factor receptor 2; PSMA: prostate-specific membrane antigen; EGFR: epidermal growth factor receptor; mBC: metastatic breast cancer; mCRC: metastatic colorectal cancer; mCRPC: metastatic castration resistant prostrate cancer; mNSCLC: metastatic non-small cell lung cancer; mHNSCC: metastatic head and neck squamous cell carcinoma

The Promise and the Challenge of T-Cell Engagers



TCE: T Cell Engager; CD3: cluster of differentiation 3; TAA: tumor associated antigen

PRO-XTEN™ masks could overcome the challenges of unmasked TCEs



TCE: T Cell Engager

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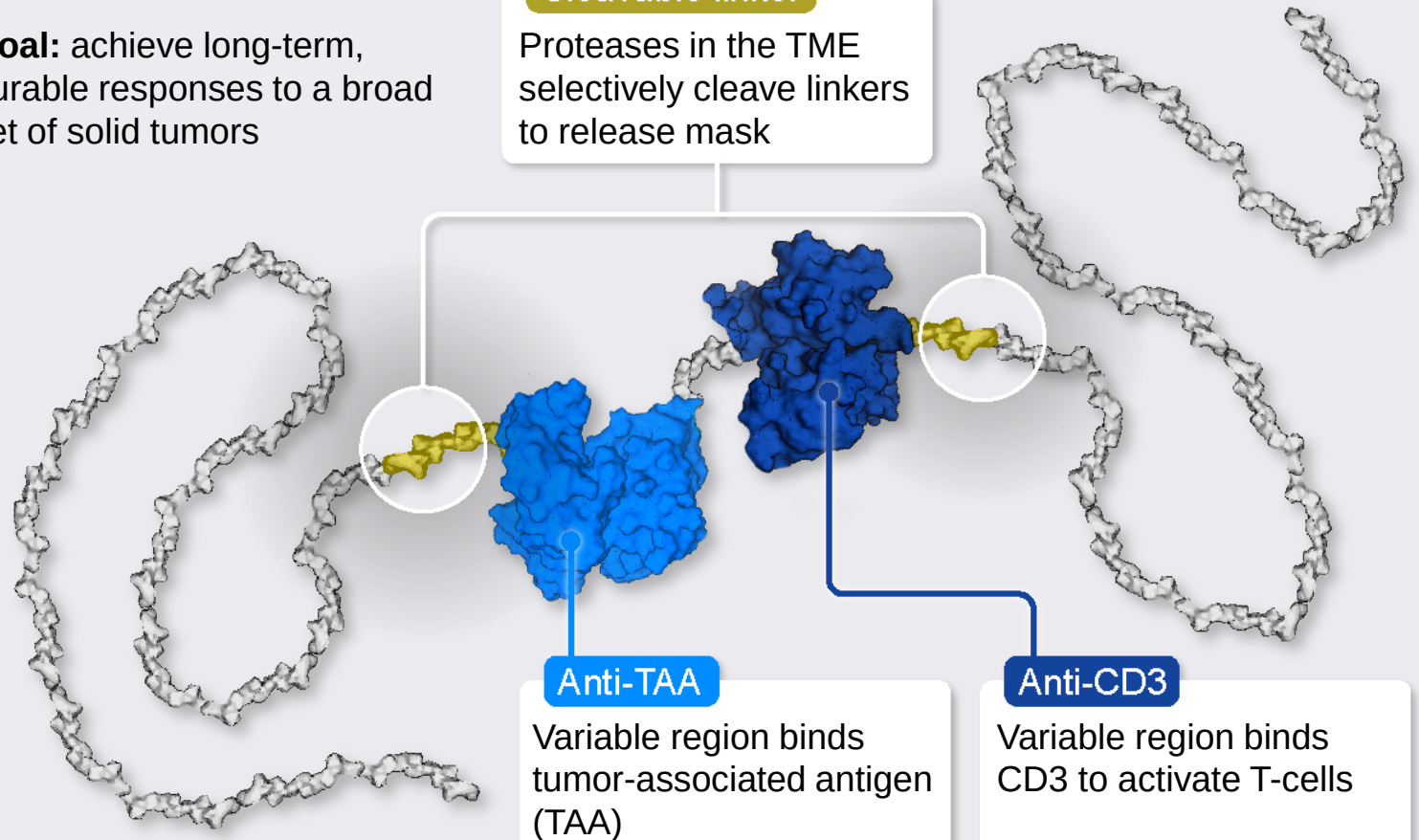
PRO-XTEN™: potential for best-in-class therapeutic index and long-term durability

PRO-XTEN™ dual masking

Goal: achieve long-term, durable responses to a broad set of solid tumors

Cleavable linker
Proteases in the TME selectively cleave linkers to release mask



Anti-TAA
Variable region binds tumor-associated antigen (TAA)

Anti-CD3
Variable region binds CD3 to activate T-cells

Expected differentiation

- Masking both TAA and CD3 binding domains to **maximize TI**
- **Lower toxicity** vs. unmasked or single-masked TCEs (e.g., minimal CRS without prophy. corticosteroids)
- **Longer half-life**, supporting potential for Q3W dosing
- **Clinically validated mask**
- **Universal masking platform** designed to accelerate clinical development into new targets

TME: tumor microenvironment; TCE: T Cell Engager; CD3: cluster of differentiation 3; TAA: tumor associated antigen; CRS: cytokine release syndrome; Q3W: once every 3 weeks

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Phase 1 Clinical Data: VIR-5818 (HER2)

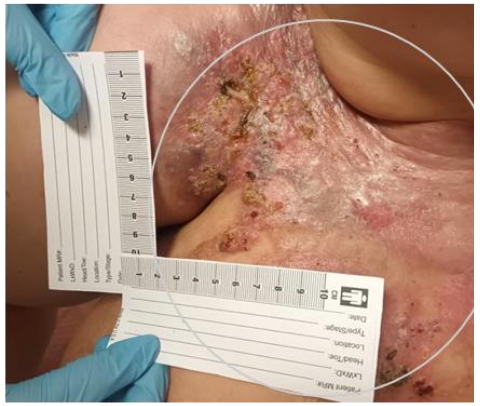
PRO-XTEN™ Platform Proof of Concept in HER2 Expressing Tumors

Mika Derynck, M.D.

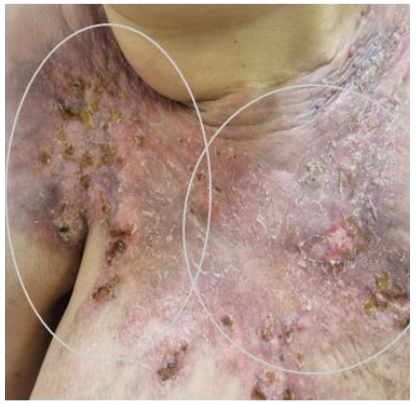
A patient's journey: dramatic response in advanced HER2+ breast cancer

Tumor pain, inflammation

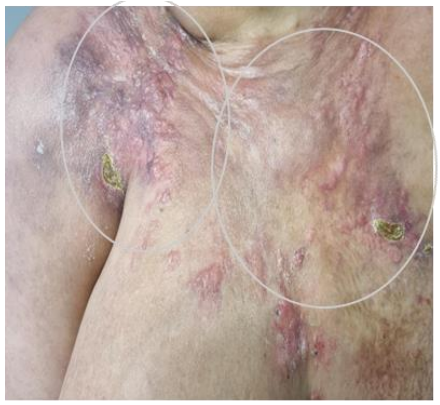
Day 1 Baseline



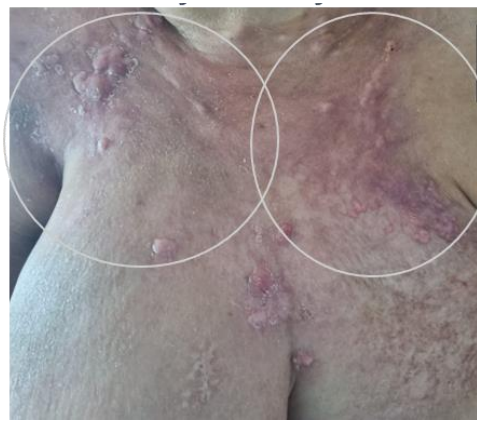
Cycle 1 Day 8



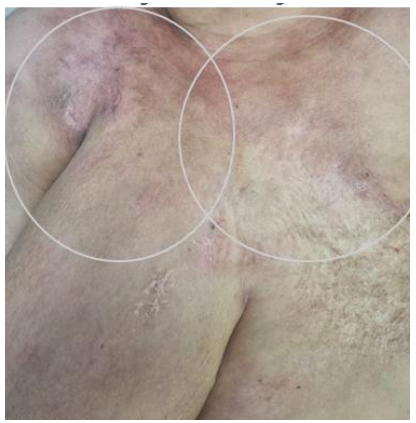
Cycle 2 Day 1



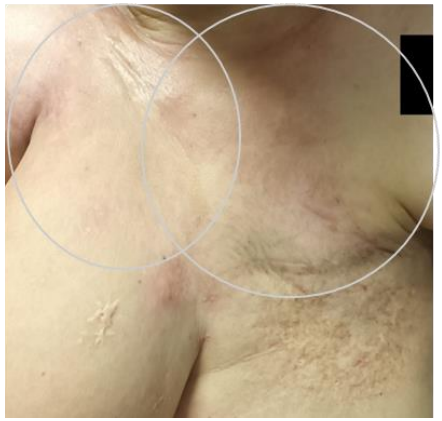
Cycle 2 Day 8



Cycle 3 Day 8



Cycle 4 Day 1



VIR-5818 Case Study

Compelling activity in breast cancer patient by Cycle 1 with transformative clearance of tumor

9 prior lines of therapy, including Enhertu

Dose: 100/300/1000 µg/kg

Well-tolerated

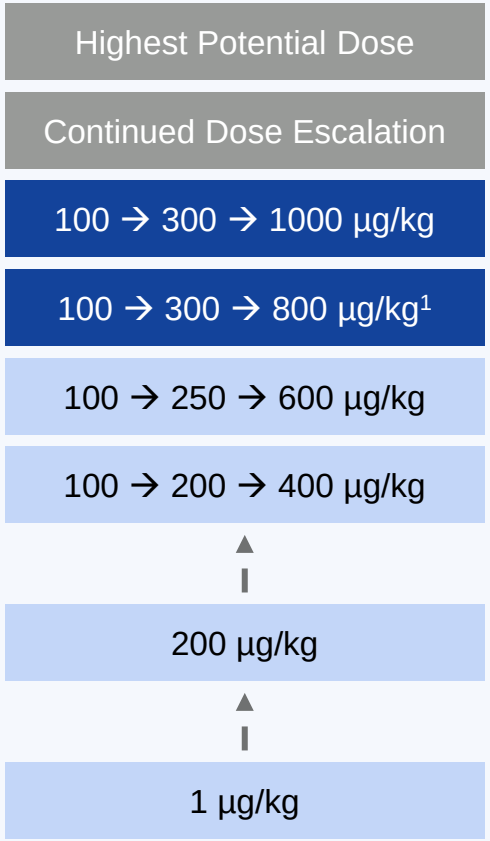
52% tumor shrinkage from baseline

Vir Biotechnology™ Study identifier: NCT05356741 data cutoff: November 11, 2024

HER2: human epidermal growth factor receptor 2; mBC: metastatic breast cancer; SLD: sum of longest diameters

The first clinical stage masked HER2 TCE in ongoing Phase 1 dose escalation

Part 1: Monotherapy Dose Escalation



Eligibility:

HER2 IHC2-3+, ISH+, or mutant

Exhausted all SOC

79 patients enrolled

Evaluating QW and Q3W

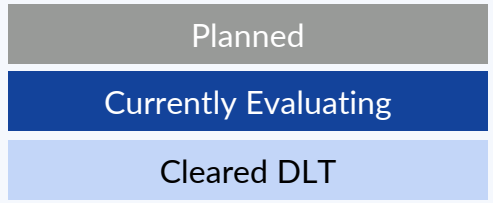
1 µg/kg start, now dosing up to 1000 µg/kg

Demonstrates wide safety margin

Part 2: Pembrolizumab Combination

VIR-5818 QW and Q3W + **Pembrolizumab Q3W** 200 mg

Currently enrolling



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Study identifier: NCT05356741
Data cutoff: November 11, 2024

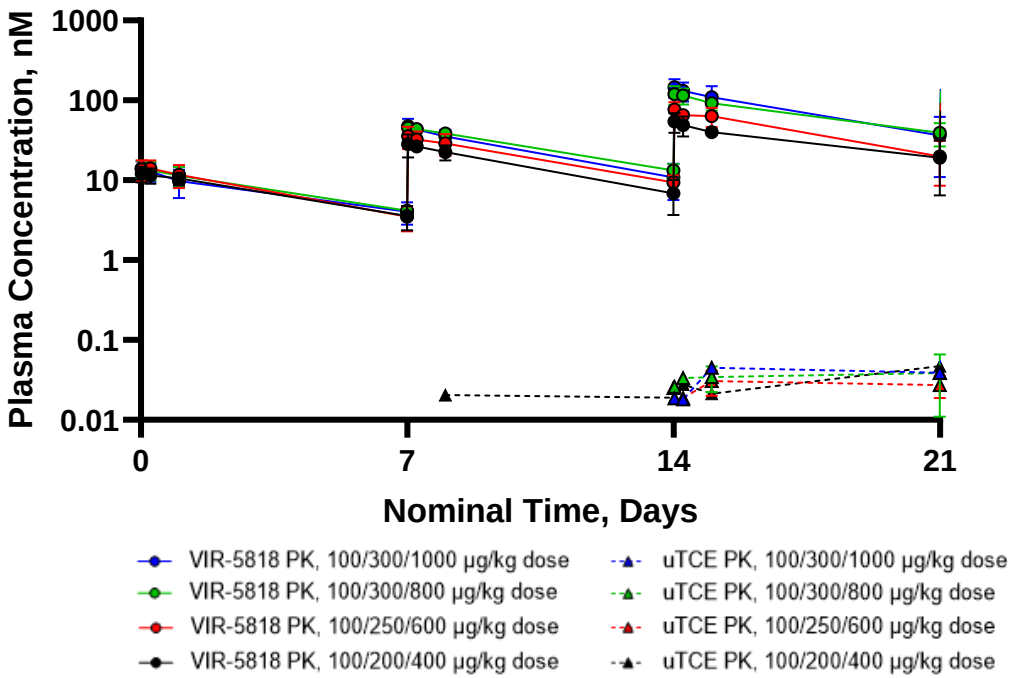
[1]Evaluating 800 µg/kg Q3W maintenance dose (cycle ≥ 2) in parallel

HER2: human epidermal growth factor receptor 2; QW: once weekly; Q3W: once every 3 weeks; TCE: T Cell Engager

Minimal unmasked TCE in circulation and potential for Q3W Dosing

Minimal unmasked TCE outside the tumor

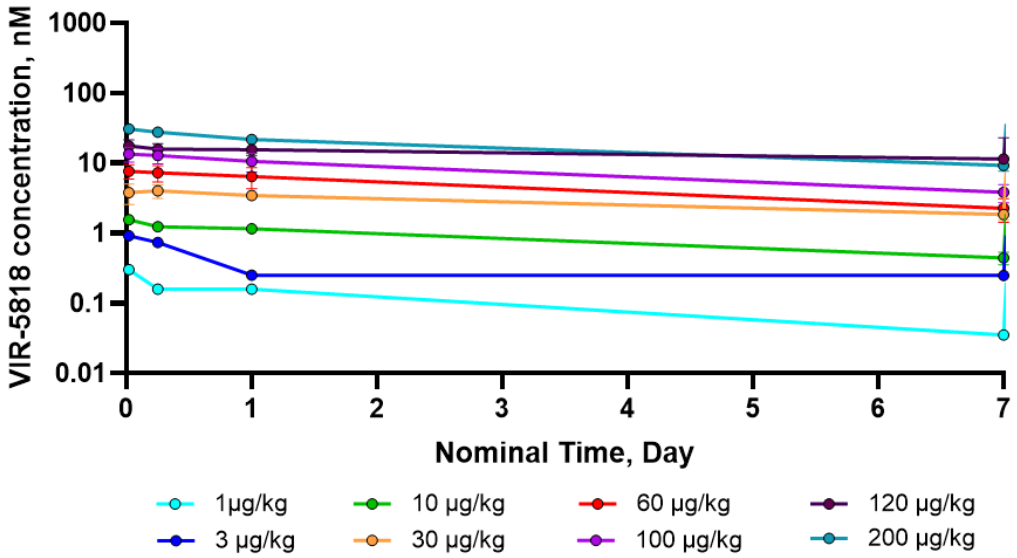
VIR-5818 and uTCE PK, First Cycle*



Low levels of uTCE in circulation, consistent with minimal CRS

half-life of ~ 6 days unlocks potential Q3W dosing

VIR-5818 PK, First Dose



Linear and dose proportional PK

*All patients with PK data in step-up cohorts with 100 µg/kg starting dose
QW: once weekly; Q3W: once every 3 weeks; TCE: T Cell Engager; uTCE: unmasked T cell engager; PK: pharmacokinetic

Enrolling a heterogeneous and heavily pretreated HER2 population

VIR-5818 Study Disposition NCT05356741	VIR-5818 (N = 79)
Male, n (%)	40 (50.6)
Median age, years (range)	60 (35-78)
Prior lines of therapy, n (%)	
1-2	29 (36.7)
3-4	29 (36.7)
5+	20 (25.3)
HER2 Status, n (%)	
IHC3+	33 (41.8)
IHC2+	21 (26.6)
ISH+	22 (27.8)
Mutant	14 (17.7)
Tumor Type, n (%)	
Breast	13 (16.5)
Colorectal	19 (24.1)
Gastric/GEJ	13 (16.5)
Other	34 (43.0)

Study & Enrollment detail:

- Heavily pre-treated patients:
  - ~62% with over 3 lines of therapy
  - ~25% with over 5 lines of therapy
- Heterogeneous population, including:
  - Breast cancer
  - Colorectal cancer
  - Gastric/GEJ cancer
- Includes patients with liver metastases

Study identifier: NCT05356741
Data cutoff: November 11, 2024

HER2: human epidermal growth factor receptor 2; IHC: Immunohistochemistry; ISH: In situ hybridization; GEJ: gastroesophageal junction

Preliminary safety data indicates VIR-5818 is not dose-limited by CRS

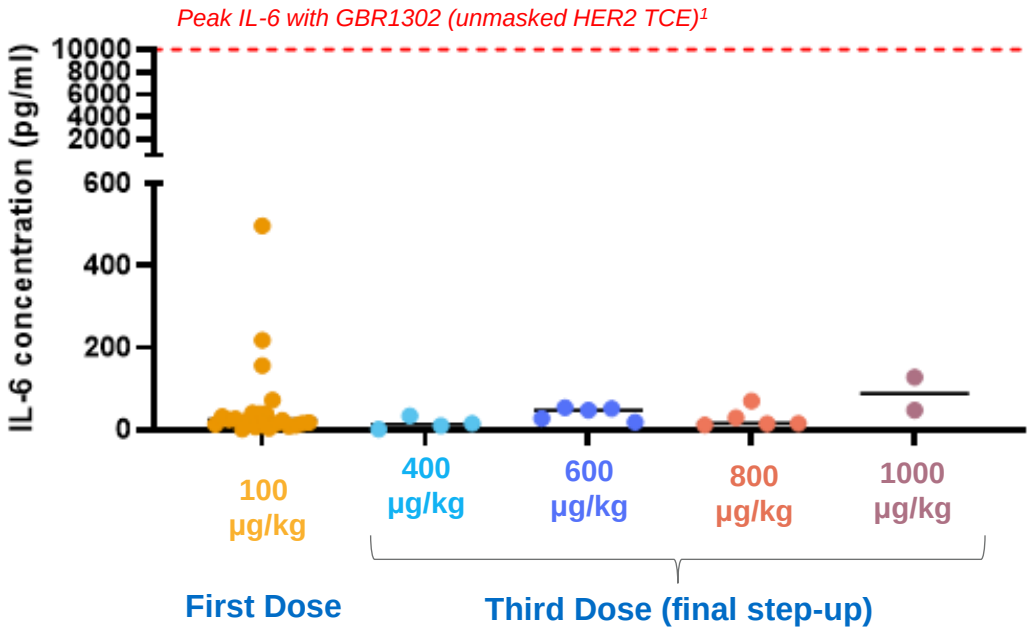
Highly Tolerable Safety

TRAE *(max grade) in >15% of pts*

VIR-5818 N = 79	Grade 1 N (%)	Grade 2 N (%)	Grade ≥ 3 N (%)
Any TRAE	15 (19.0)	35 (44.3)	13 (16.5)
Pneumonitis*	16 (20.3)	9 (11.4)	2 (2.5)*
CRS	16 (20.3)	8 (10.1)	0
Nausea	12 (15.2)	8 (10.1)	0
Asthenia	12 (15.2)	6 (7.6)	1 (1.3)
Diarrhoea	14 (17.7)	5 (6.3)	0
Pruritus	13 (16.5)	1 (1.3)	0
Vomiting	8 (10.1)	6 (7.6)	0

Low Cytokine Levels, Even at Higher Doses

Peaks of IL-6 Secretion Post VIR-5818 Dosing



IL-6 release significantly lower than for unmasked TCEs, despite higher VIR-5818 dose

Vir Biotechnology™ Study identifier: NCT05356741
Data cutoff: November 11, 2024

*Two cases of G3 pneumonitis include one event reversible with treatment and one confounded by rapid progression of pulmonary disease

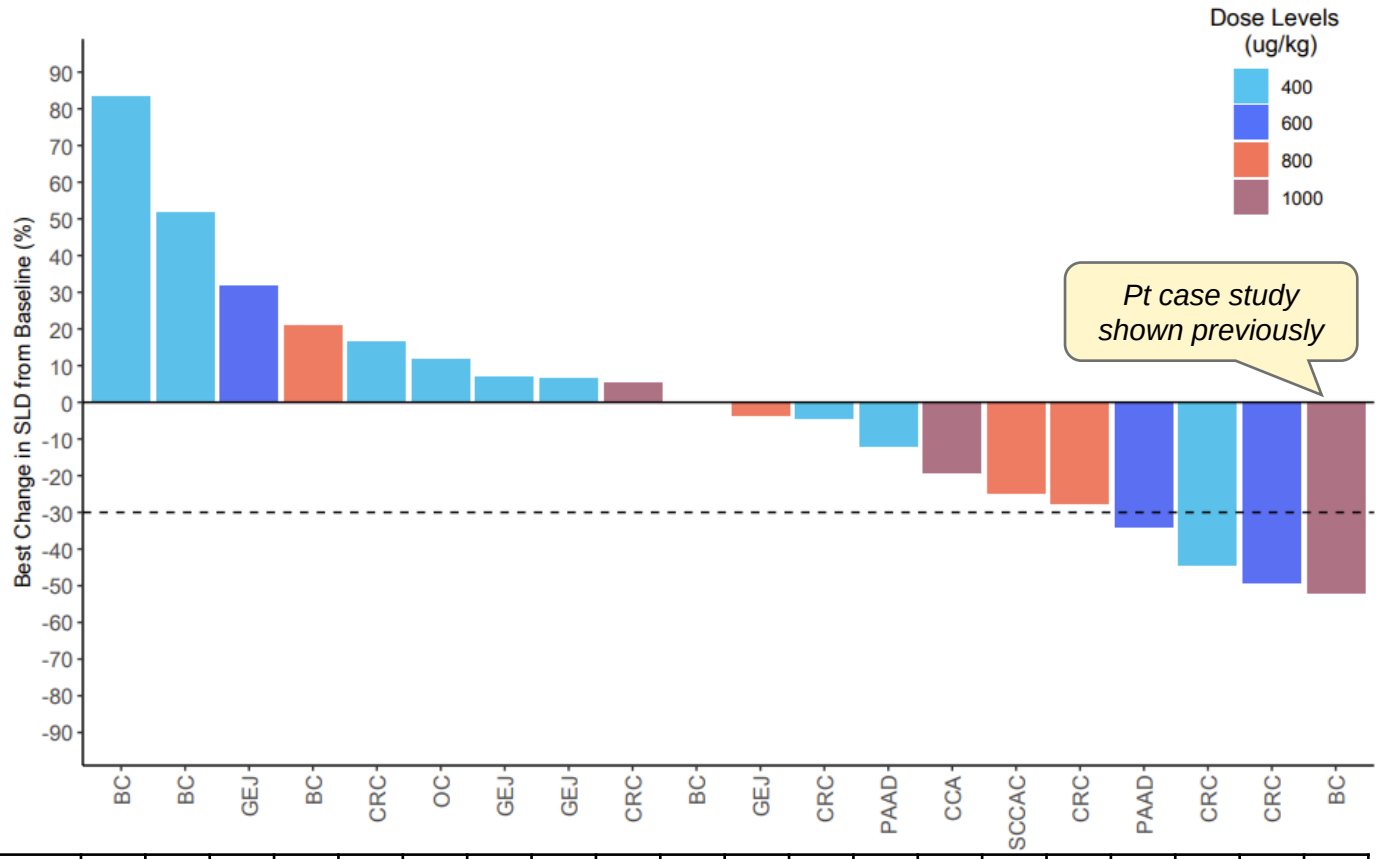
TRAE, treatment-related adverse event; CRS: cytokine release syndrome; TCE: T Cell Engager; IL-6: interleukin-6

[1]Wermke et al., ASCO-SITC 2018

Notable tumor shrinkage observed during dose escalation

HER2+ Solid Tumors

(Doses ≥ 400 µg/kg)



No of prior lines	3	7	3	4	4	4	2	3	6	5	1	3	3	1	1	4	1	4	6	9
Liver mets	■	■	■	■	■		■	■	■		■		■	■	■	■	■			

Efficacy detail:

- ≥ 400 µg/kg drive significant RECIST responses
  - Dose escalation continues in QW and Q3W regimens
- 50% observed tumor shrinkage (10/20 patients), with a DCR of 65%
  - 4/20 responses to date*
  - Responses in patients with up to 9 prior lines
  - 14/20 with prior HER2 treatment

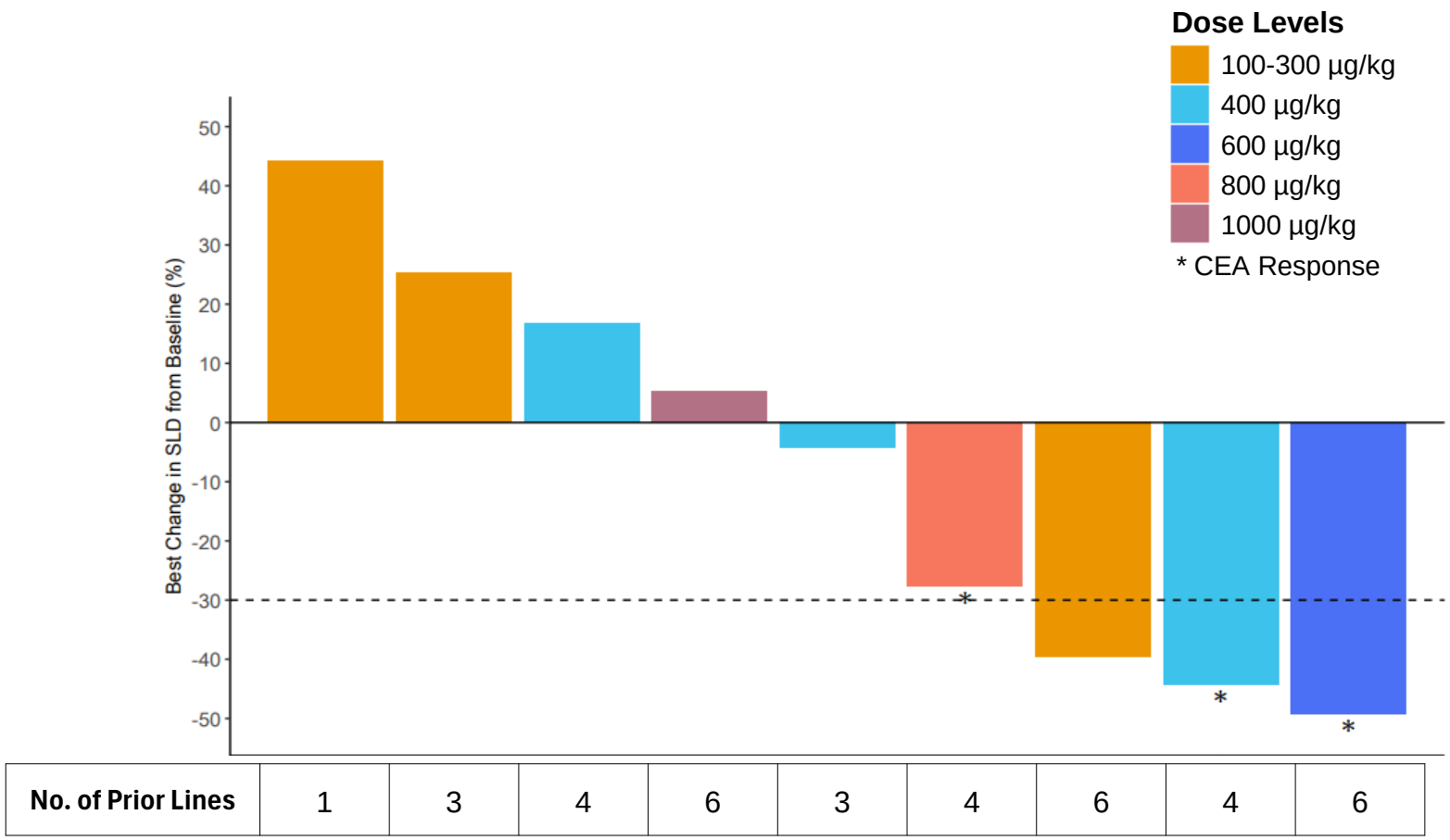
*Includes cPR, uPR, and mixed responses

Study identifier: NCT05356741
Data cutoff: November 11, 2024
Note: HER2+ defined as IHC3+ or ISH+

HER2: human epidermal growth factor receptor 2; BC: Breast Cancer; GEJ: Gastroesophageal Junction; CRC: Colorectal Cancer; OC: Ovarian Cancer; PAAD: Pancreatic Adenocarcinoma; CCA: Cholangiocarcinoma; SCCAC: Squamous Cell Carcinoma of the Anal Canal; RECIST: Response evaluation criteria in solid tumors; SLD: sum of longest diameters; IHC: immunohistochemistry; ISH: in situ hybridization

Deep responses observed in HER2+ mCRC at early doses

HER2+ Colorectal Cancer
(All Patients Shown are MSS)



No. of Prior Lines	1	3	4	6	3	4	6	4	6

Efficacy detail:

Activity	HER2+ CRC ≥400 µg/kg[1]
cPR	2/6 (33%)
CEA Response*	3/3 (100%)
DCR[1]	5/6 (83%)

33% response and 100% biomarker response in mCRC

- Up to 18.1 months duration of response (patient remains on study)
- All anti-tumor activity in MSS patients; historically resistant to immunotherapy

~6% mCRC patients are HER2+

Study identifier: NCT05356741
Data cutoff: November 11, 2024
Note: HER2+ defined as IHC3+ or ISH+

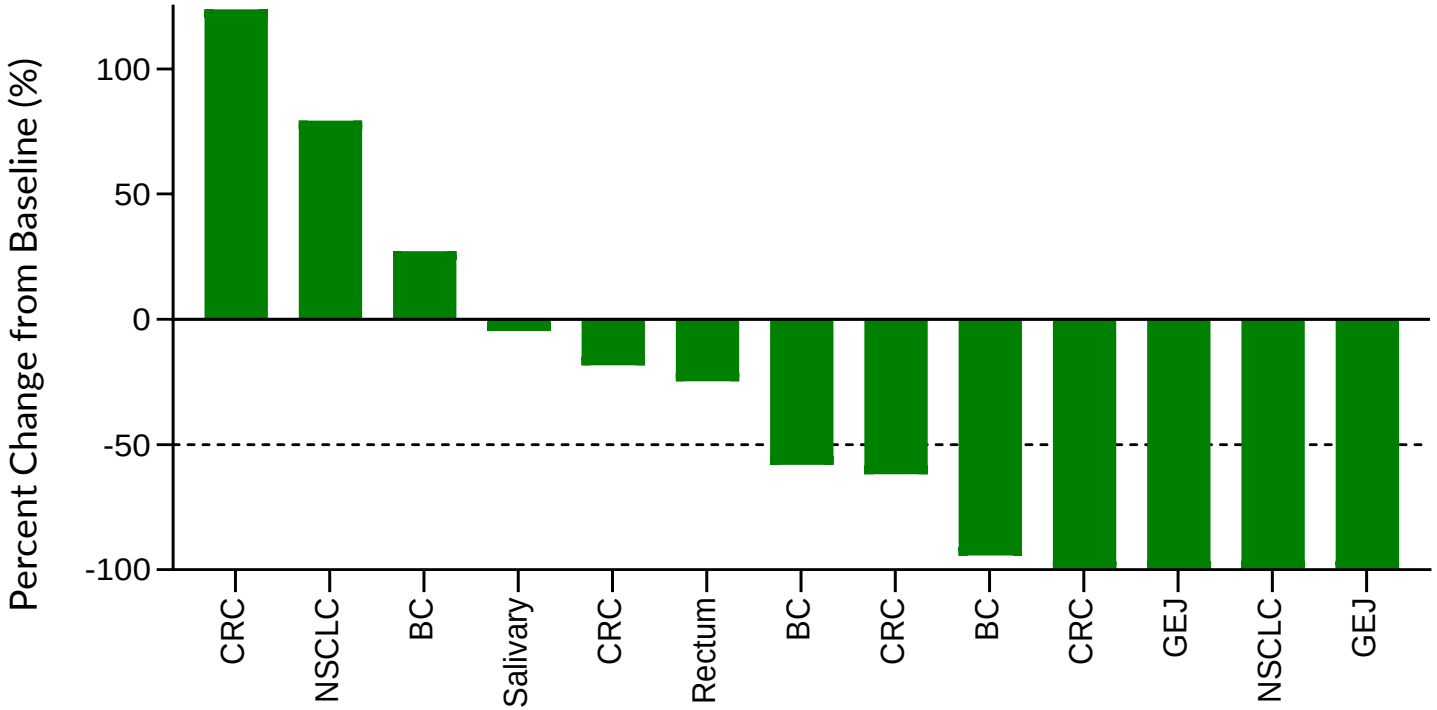
HER2: human epidermal growth factor receptor 2; SLD: sum of longest diameters; cPR: confirmed partial response; CEA: carcinoembryonic antigen; DCR: disease control rate; IHC: Immunohistochemistry; ISH: In situ hybridization; MSS: microsatellite stability; CRC: colorectal cancer

* -- CEA response defined as >50% decrease in CEA post-treatment. Denominator includes all pts with longitudinal data
1 – Disease control rate (DCR) defined as stable disease or better

Molecular evidence of anti-tumor activity across multiple cancer types

Molecular Responses: ctDNA

(Step-up doses only)



Dose (µg/kg)	100	60	100	100	60	60	100	100	100	100	60	60	100
	200	120	250	300	120	120	300	300	250	200	120	120	300
	400	120	600	1000	300	200	800	1000	600	400	200	200	800

Detail:

- High value of biomarkers for immunologics
- RECIST responses may be confounded by tumor inflammation
- With on-treatment ctDNA collection, VIR-5818 has **molecular response for 54% subjects**[1]
- Now universally collecting ctDNA

1 - molecular response defined as >50% decline in overall ctDNA

Study identifier: NCT05356741
ctDNA data cutoff: November 19th, 2024;
EDC data cutoff: November 11, 2024

ctDNA: circulating tumor DNA; CRC: colorectal cancer; GEJ: Gastroesophageal Junction; NSCLC: Non-Small-Cell Lung Cancer; RECIST: Response evaluation criteria in solid tumors; BC: breast cancer

A potential first-in-class HER2 TCE designed to clinically validate the PRO-XTEN™ platform

Dose escalation continuing

Part 1 Single Agent

VIR-5818 QW

Current dose:
100/300/1000 µg/kg QW

VIR-5818 Q3W

Current dose:
100/300/800 µg/kg Q3W

Part 2 PD-1 Combo

VIR-5818 + anti-PD-1

Enrollment ongoing

Clear activity based on early Phase 1 data with potential for long-term durable responses

Emerging activity: wide TI in heavily pretreated population

- Unprecedented tolerability: no Gr3+ CRS, 16% all GR3+ TRAEs
- 33% response in heavily pre-treated CRC patients
- ctDNA Molecular response in 54% of subjects

Proof of concept for PRO-XTEN™ platform

- Clear evidence of unmasking with antitumor activity

Universal masks: mechanism designed to apply across platform

- Potential rapid dose escalation for VIR-5500 (PSMA) and other targets

Further VIR-5818 advancement will be guided by a measured, data-driven approach

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HER2: human epidermal growth factor receptor 2; QW: once weekly; Q3W: once every 3 weeks; TI: therapeutic index; CRC: colorectal cancer; CRS: cytokine release syndrome; TRAE: treatment-related adverse event; ctDNA: circulating tumor DNA; TCE: T Cell Engager; PSMA: prostate-specific membrane antigen; PD-1: programmed death-1

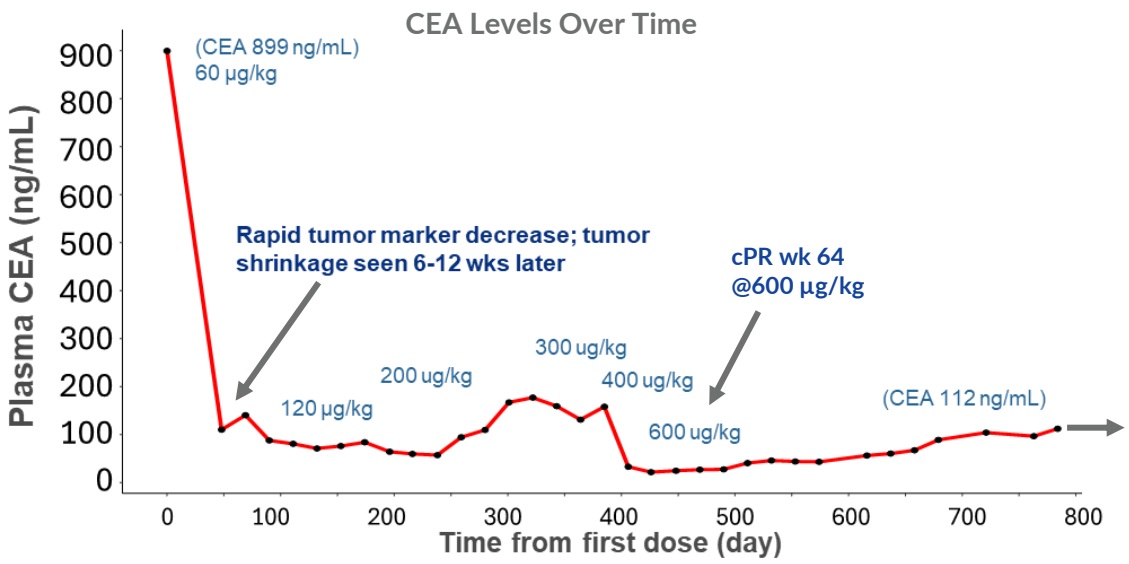
KOL Perspectives

On VIR-5818 Data and Masked TCEs in HER2

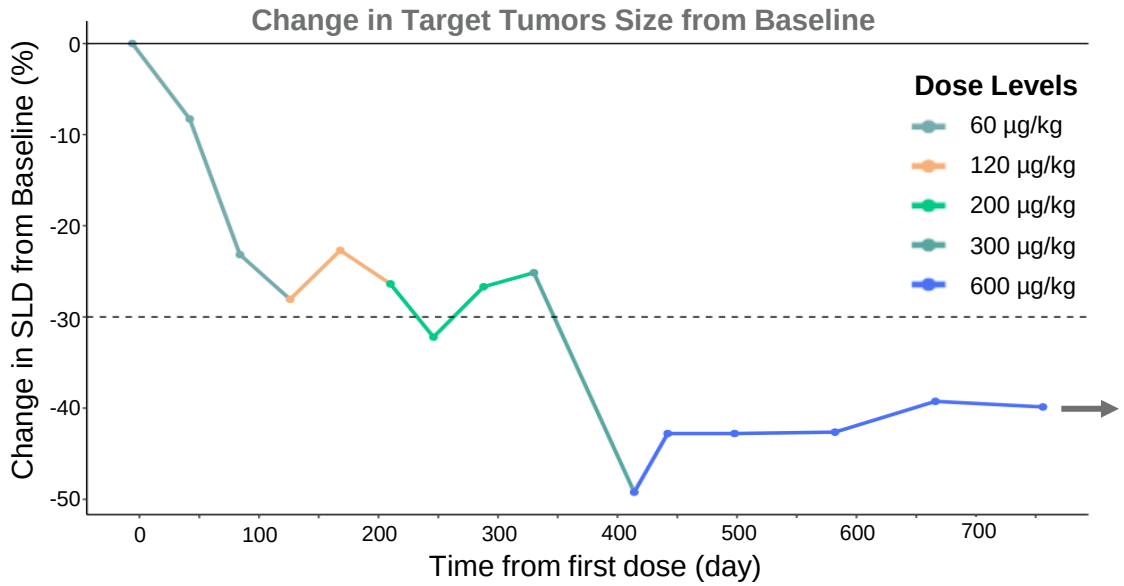
Josep Tabernero, M.D., Ph.D.

Patient Case Study: 2 years on treatment, exceptional durability

Rapid and Sustained Decrease Over time



Dose-Dependent Tumor Shrinkage



Rapid and sustained CEA decrease with deeper tumor shrinkage when dose escalates

- 57-Year-old male w/ colorectal cancer (MSS/TMB Low)
- Status: remains on study (current dose: 600 µg/kg QW)
- HER2 status: IHC 3+
- 6 prior lines including trastuzumab / tucatinib
- Significant improvement on quality of life
- 114 doses as of data cutoff, patient remains on study

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Study identifier: NCT05356741
Data cutoff: November 11, 2024

SLD: sum of longest diameters; cPR: confirmed partial response; CEA: carcinoembryonic antigen; IHC: Immunohistochemistry; ISH: In situ hybridization; MSS: microsatellite stability; CRC: colorectal cancer; QW: weekly; TMB: tumor mutational burden

Phase 1 Clinical Data: VIR-5500 (PSMA)

Potential Best-in-Class Profile in Prostate Cancer

Mika Derynck, M.D.

Ongoing dose escalation of first dual-masked TCE in prostate cancer

VIR-5500 (PSMA)

QW Dose Escalation

QW Highest Potential Dose

Continued Dose Escalation

500 → 1000 → 2000 µg/kg

300 → 600 → 1000 µg/kg

200 → 300 → 400 µg/kg

120 → 180 → 180 µg/kg

60 µg/kg

30 µg/kg

Eligibility:

Documented progressive metastatic CRPC

≥ 1 prior taxane regimen

Participants unsuitable for standard of care

0 to 2 ECOG status

Life expectancy >6 months

18 patients enrolled up to 1000 µg/kg

Q3W Dose Escalation

Q3W Highest Potential Dose

Continued Dose Escalation

500 → 1000 → 2000 µg/kg

Q3W enrollment ongoing

- Starting at 500 → 1000 → 2000 µg/kg dose level

Planned

Currently Evaluating

Cleared DLT

Vir Biotechnology™

Study identifier: NCT05356741
Data cutoff: November 11, 2024

QW: once weekly; Q3W: once every 3 weeks; TCE: T Cell Engager; CRPC: castration resistant prostate cancer; ECOG; Eastern Cooperative Oncology Group

Enrolling a heavily pretreated mCRPC population

VIR-5500 Study Disposition

NCT05997615

	VIR-5500 N = 18
Median age, years (range)	69 (57-79)
Prior lines of therapy	
Number, Median (Min, Max)	4 (3, 6)
Prior Taxane, n (%)	17 (94.4)
Prior PSMA-radioligand therapy [a], n (%)	4 (22.2)
Baseline Central PSA, ng/mL	
Median (min, max)*	77.1 (4.4-3,708)*
Disease Characteristics	
RECIST-evaluable [b], n (%)	8 (44.4)
Bone metastases, n (%)	18 (100)
Lymph node metastases, n (%)	10 (55.6)
Visceral metastases [c], n (%)	0 (0)

Study & Enrollment detail:

Heavily pre-treated patients:

- 4 median prior lines of therapy
- 94% having prior chemotherapy
- 22% with prior PSMA-radioligand therapy
- 1 patient with prior STEAP1 TCE

Significant disease burden in all cohorts:

- 100% of subjects with bone metastases
- >50% lymph node metastases

Study identifier: NCT05997615. Data cutoff: November 13th, 2024.

Notes: N = number of participants. * PSA-evaluable patients n=17

[a] note that all Prior PSMA-radioligand therapy treated patients received doses under 120 µg/kg.

[b] RECIST-evaluable population is defined as subjects with non-missing target lesion dimensions at baseline.

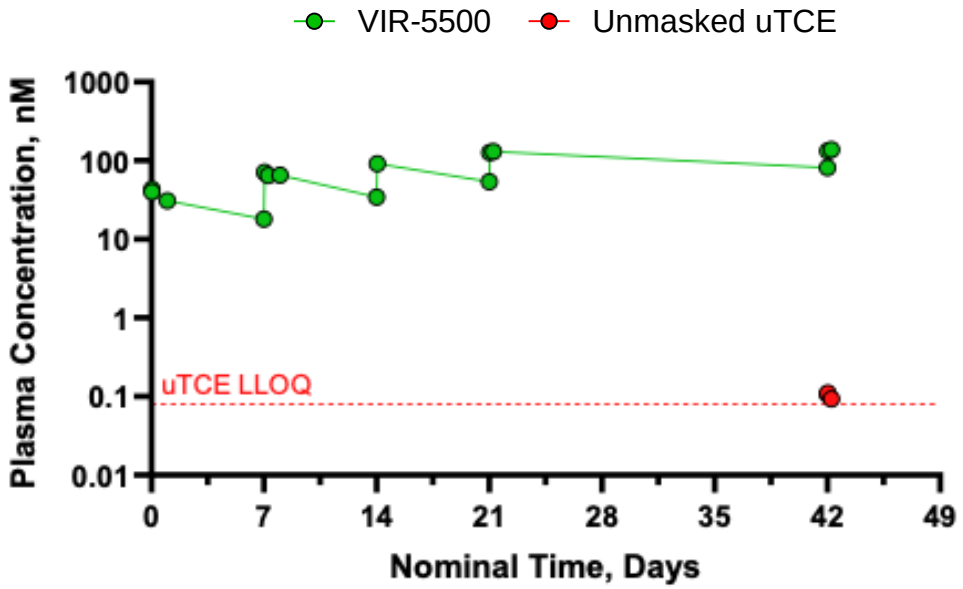
[c] Visceral metastases include recurrent site for lungs, liver, and brain.

Max: maximum; Min: minimum; PSMA: prostate-specific membrane antigen; PSA: prostate-specific antigen; TCE: T Cell Engager; RECIST:, Response Evaluation Criteria in Solid Tumors.

Minimal systemic unmasking and potential for Q3W dosing

Minimal unmasked TCE outside the tumor

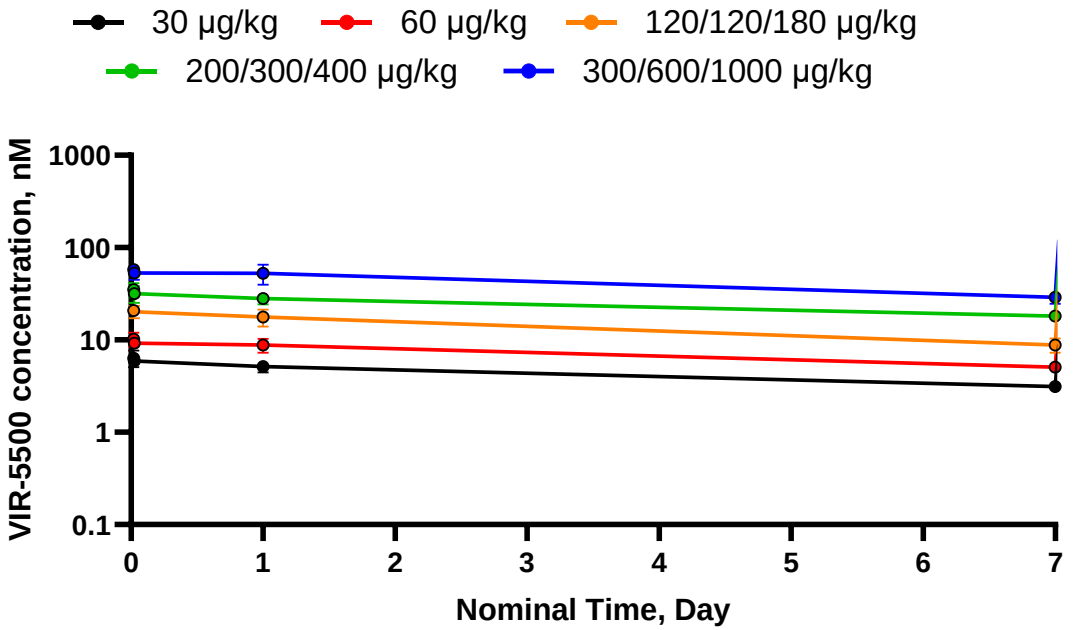
Only one VIR-5500 patient with detectable unmasked TCE (Dose: 200/300/400 µg/kg)



- For 13 out of 14 evaluable patients, unmasked TCE concentrations were below LLOQ
- *Single patient with detectable uTCE shown above*

8-10 Day Half-Life: Supportive of Q3W Dosing

VIR-5500 Dose 1 (All Patients, n=18)



- Linear, dose proportional PK observed with potential for Q3W dosing

Study identifier: NCT05356741
Data cutoff: November 11, 2024

Q3W: once every 3 weeks; TCE: T Cell Engager; uTCE: unmasked TCE; PK: pharmacokinetics; LLOQ: lower limit of quantification

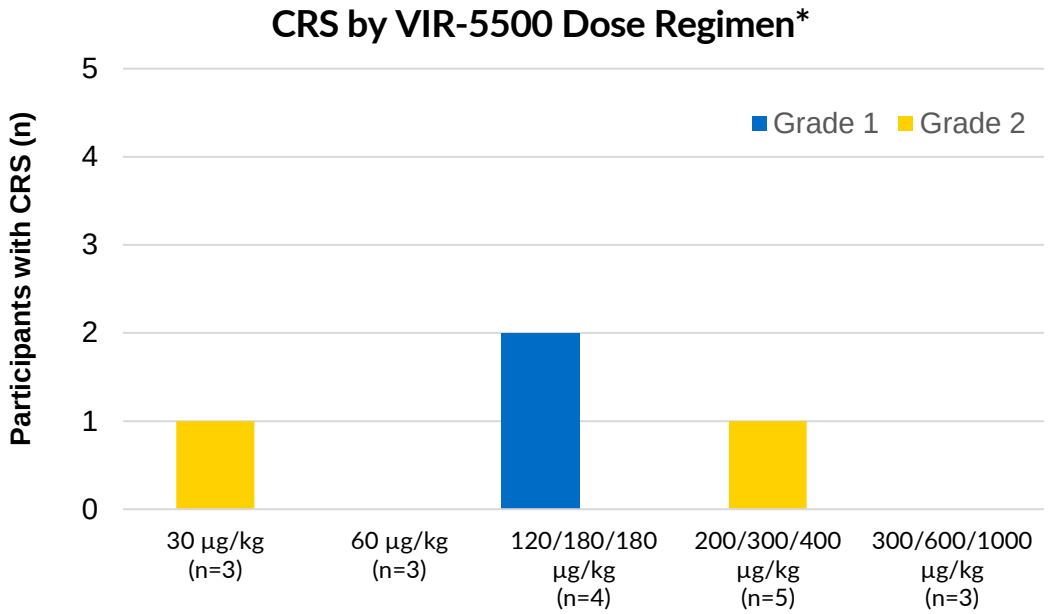
Well tolerated without prophylactic corticosteroids or anti-IL-6 premedication in early Phase 1 testing

Potential Best-in-Class Safety

Vir-5500 (n=18)	Grade 1 N (%)	Grade 2 N (%)	Grade ≥ 3 N (%)
TEAEs (max grade) in any patients n (%)			
Any TEAE	18 (100)	17 (94.4)	2 (11.1)
Related TEAE	6 (33.3)	4 (22.2)	2 (11.1)
***TRAEs** (max grade) in >10% of pts (n=18)*			
CRS	3 (16.7)	2 (11.1)	0 (0)
Fatigue	3 (16.7)	2 (11.1)	0 (0)
Decreased appetite	2 (11.1)	0 (0)	0 (0)
Anaemia	1 (5.6)	1 (5.6)	0 (0)
AST increase	1 (5.6)	0 (0)	1 (5.6)

- ✓ No DLTs reported
- ✓ No ICANS or hearing loss observed

No Anti-IL-6, No Corticosteroids, No Gr ≥3 CRS



No corticosteroid or anti-IL-6 premedication requirement

- No grade ≥3 CRS events at any dose
- No CRS events at highest dose

*Note: highest CRS grade per participant shown
TEAE: treatment emergent adverse event; CRS: cytokine release syndrome; AST: aspartate aminotransferase; AE: adverse event; DLT: dose limiting toxicities; ICANS: immune effector cell-associated neurotoxicity syndrome; IL6: interleukin-6

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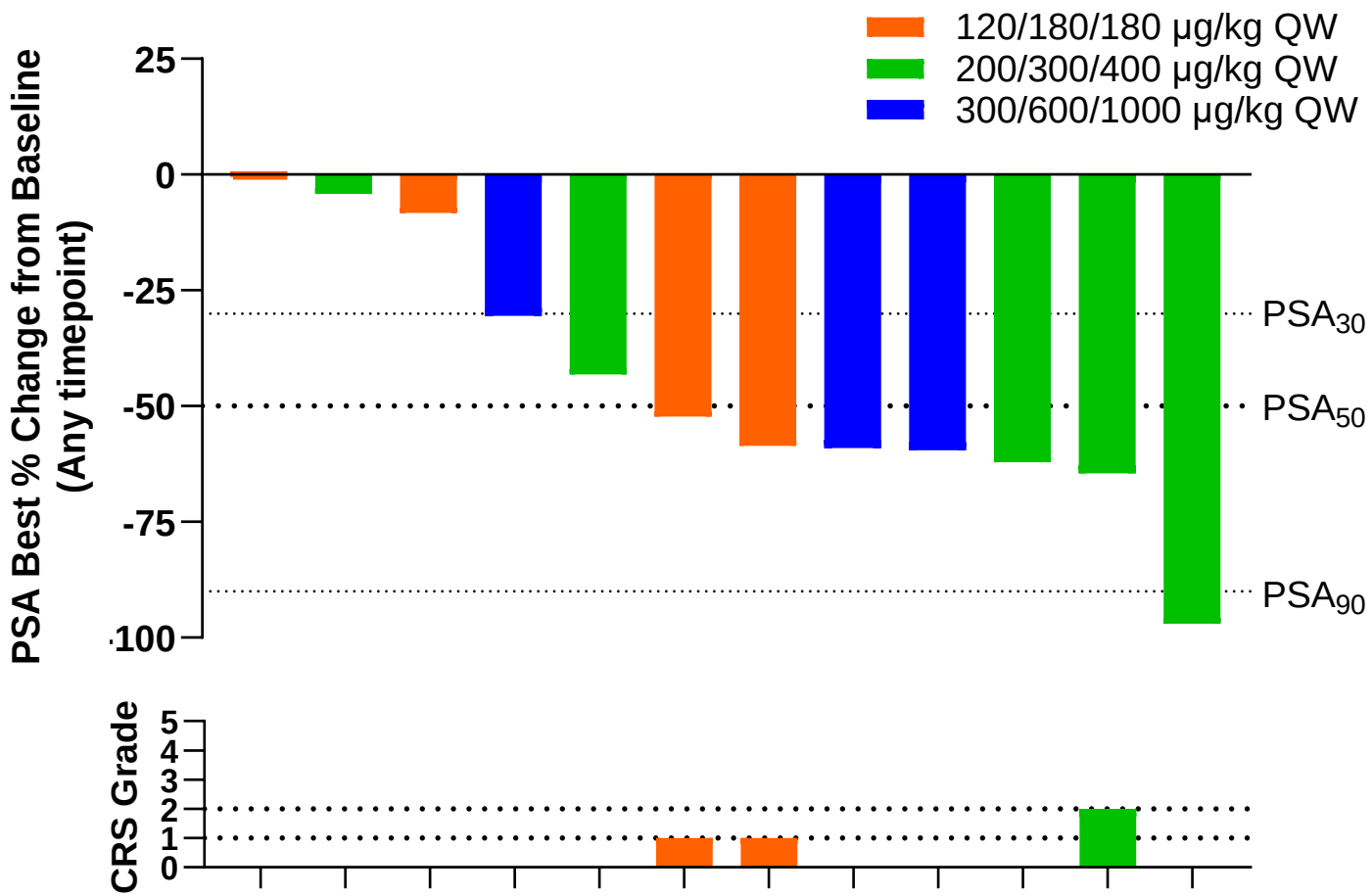
Study identifier: NCT05997615
Data cutoff: November 13th, 2024

Strong PSA_{50} response with limited and low-grade CRS at early doses in Phase 1 testing

PSA Responses (1st dose ≥ 120 µg/kg)



Early Responses:

PSA Responses (1st dose ≥ 120 µg/kg)	
Any decline	12/12 (100%)
PSA_{50}	7/12 (58%)
PSA_{90}	1/12 (8%)

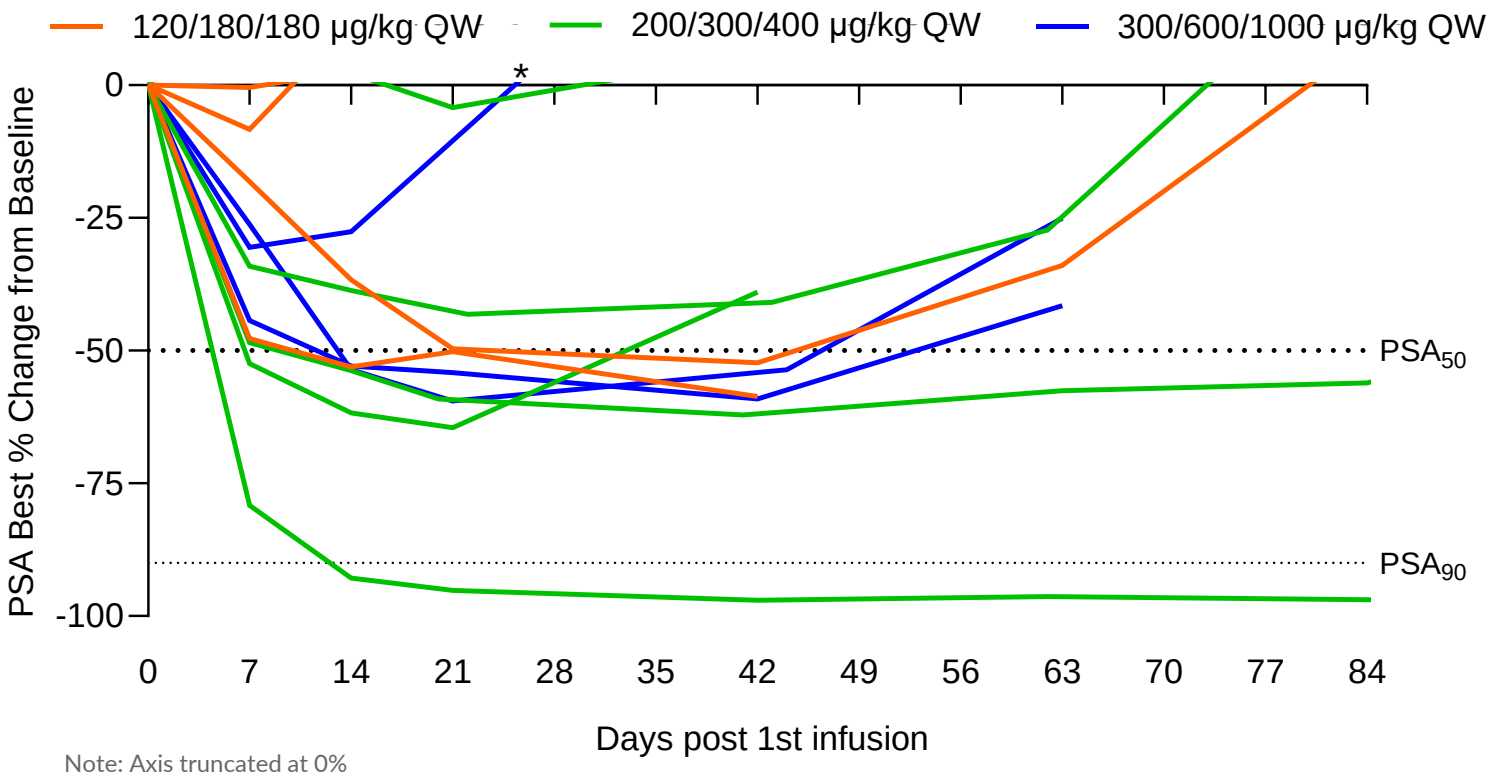
- Early response signals across all 12 patients on step-dosing schedules
- No apparent association of anti-tumor activity with CRS
- No IL-6 elevations observed
- Tolerable safety profile, significant headroom to dose escalate

Study identifier: NCT05997615
Data cutoff: November 13th, 2024

PSA: prostate-specific antigen; CRS: cytokine release syndrome; PSMA: prostate-specific membrane antigen; QW: once weekly

Meaningful responses and evidence of durability at early dose cohorts

Longitudinal Responses



Note: Axis truncated at 0%

*__Note__: Participant had **dose interruption at Day 20** due to unrelated case of bronchial infection

Detail

- 7/12 (58%) subjects demonstrate confirmed PSA_{50} response^
- Trend towards increased durability with dose escalation
- Anticipate deeper and more durable responses as dose escalates

Study identifier: NCT05997615
Data cutoff: December 3, 2024

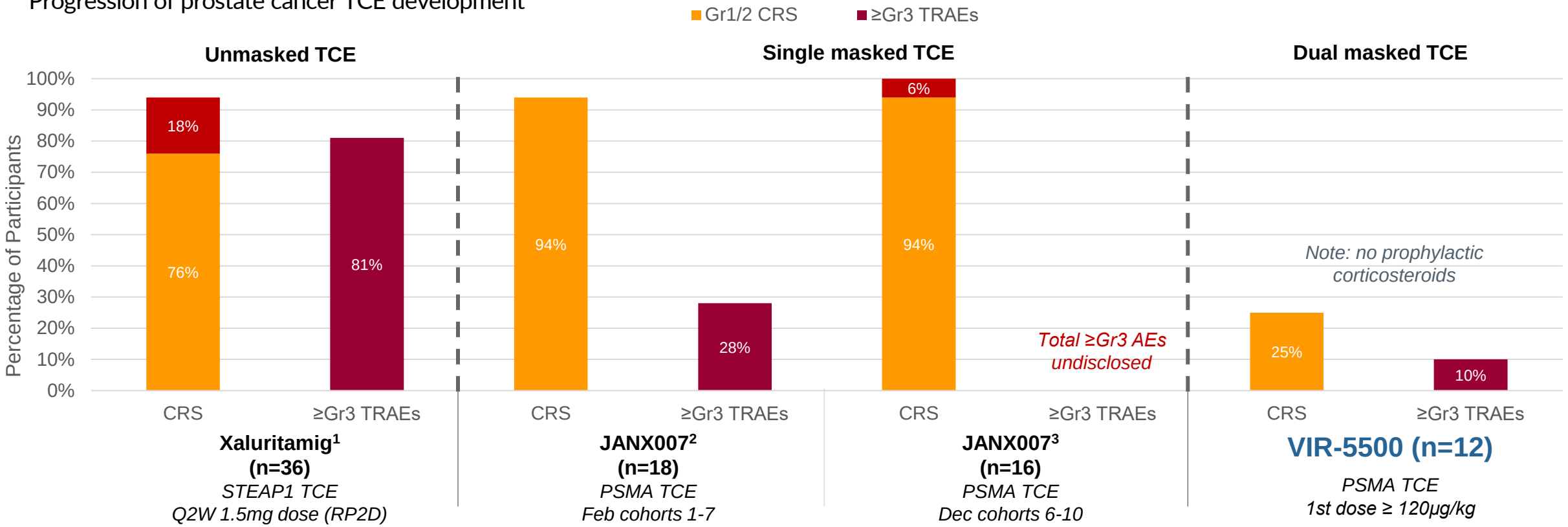
PSA: prostate-specific antigen; CRS: cytokine release syndrome; QW: once weekly
^Confirmed by a second evaluation at least three weeks later

VIR-5500 TI provides significant room for dose escalation based on early Phase 1 data

VIR-5500 (PSMA)

CRS Incidence and ≥Gr3 TRAEs

Progression of prostate cancer TCE development



[1]Source: Kelly, W. K., et al. ESMO 2024, Poster #1598P.
[2]Source: Janux Therapeutics. Investor Event. February 26, 2024.
[3]Source: Janux Therapeutics. Investor Event. December 2, 2024

CRS: cytokine release syndrome; Gr3: Grade 3; PSMA: prostate-specific membrane antigen; TCE: T Cell Engager; STEAP1: six-transmembrane epithelial antigen of the prostate 1

Vir study identifier: NCT05997615
Data cutoff: November 13th, 2024

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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. Data from public sources have not been independently verified. See individual study publications for complete data and context.

Potential for deeper PSA responses at higher doses

Initial Dose Cohorts

Janux Feb'24[1] (≥0.1mg n=18)	PSA_{50}	56%
	PSA_{90}	6%
	CRS	94%

Higher Dose Cohorts

Janux Feb'24[1] (≥0.2mg n=6)	PSA_{50}	83%
	PSA_{90}	17%
	CRS	100%

Janux Dec'24[2] (≥0.2mg n=16)	PSA_{50}	100%
	PSA_{90}	63%
	CRS	100% *(6% Gr3)*

Vir Jan'25 (1st dose >120 µg/kg n=12)	PSA_{50}	**58%**
	PSA_{90}	**8%**
	CRS	**25%** (No corticosteroids)

Significant room for VIR-5500 QW and Q3W dose escalation

[1]Source: Janux Therapeutics. Investor Event. February 26, 2024.
[2]Source: Janux Therapeutics. Investor Event. December 2, 2024

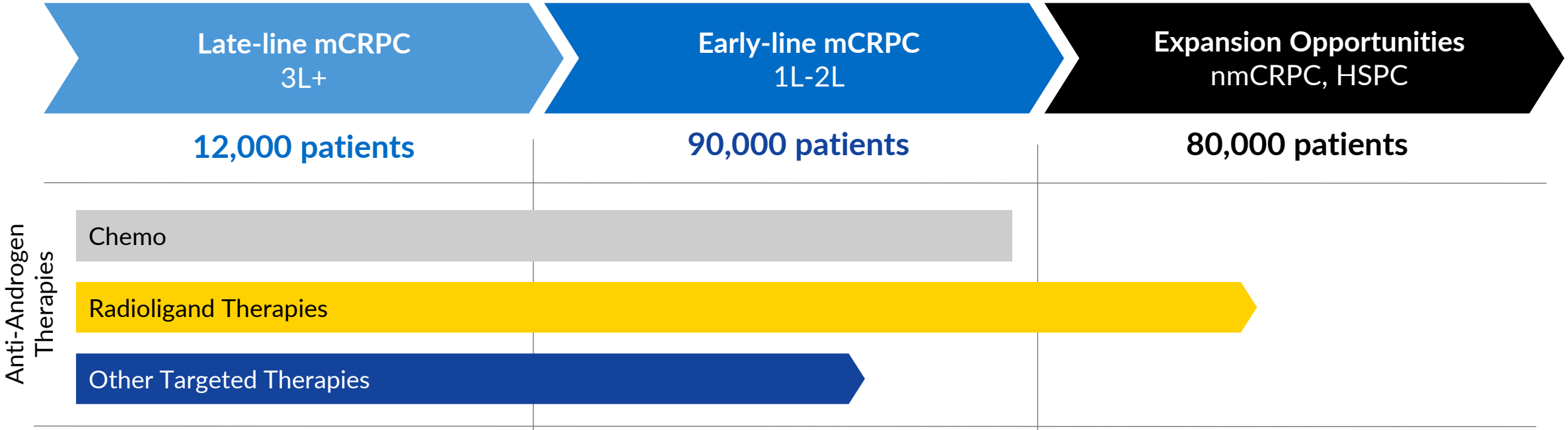
PSA: prostate-specific antigen;
CRS: cytokine release syndrome

Vir study identifier: NCT05997615
Data cutoff: November 13th, 2024

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. Data from public sources have not been independently verified. See individual study publications for complete data and context.

Potential for best-in-class TI and positioning in both early and late lines

VIR-5500 (PSMA)



- Clear initial activity in heavily pre-treated patients
- Anticipate deeper and more durable responses as dose escalates

- Long half-life supports potential Q3W dosing
- Favorable safety profile is critical for early line success

- Dual-masking may give competitive advantage in nmCRPC or HSPC
- Mono and combination development is viable

HSPC: hormone sensitive prostate cancer; nmCRPC: non-metastatic castration resistant prostate cancer; mCRPC: metastatic castration resistant prostate cancer; TCE: T Cell Engager; CRS: cytokine release syndrome; AE: adverse event; Q3W: once every 3 weeks

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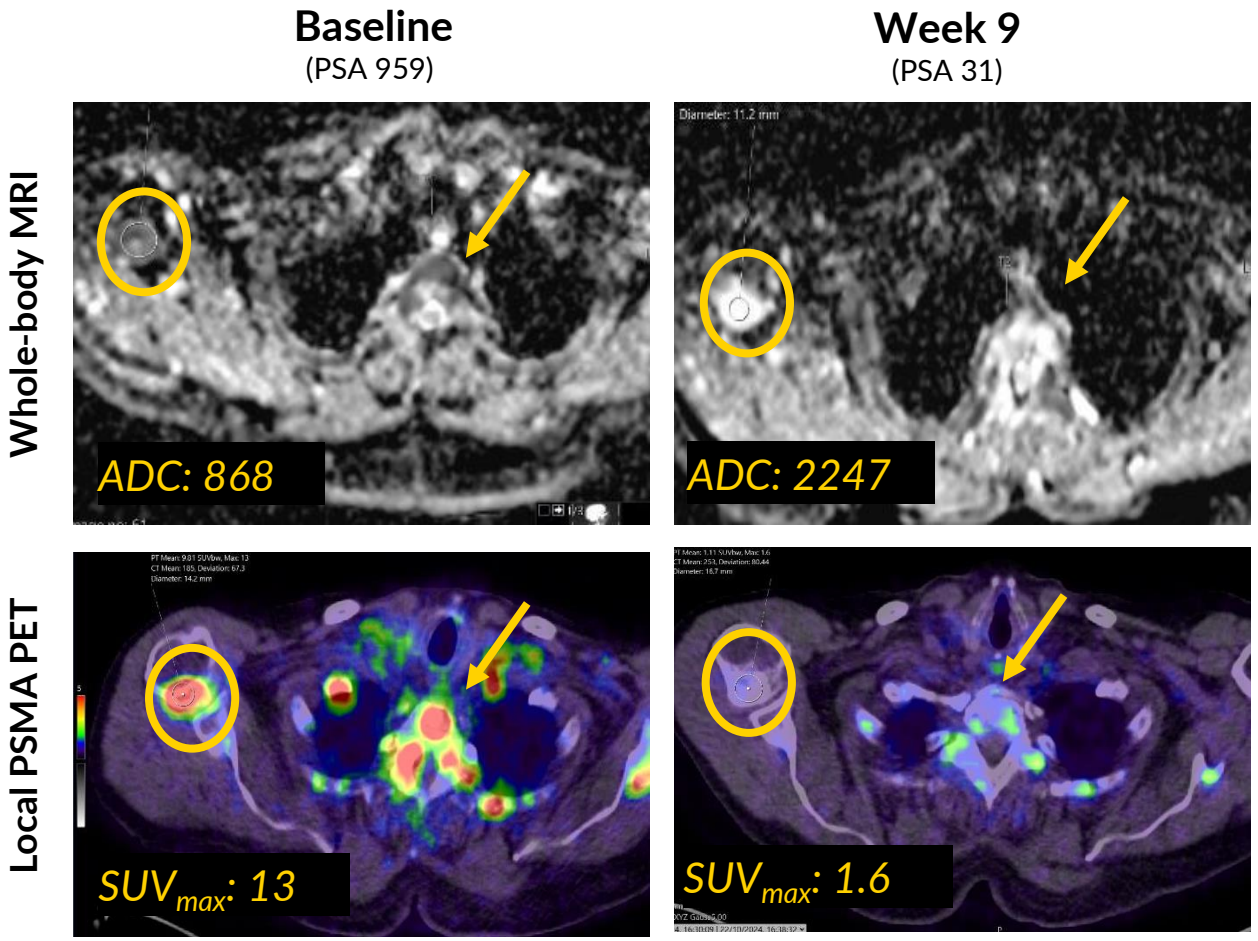
KOL Perspectives

On VIR-5500 and Masked TCEs in mCRPC

Johann de Bono, MD, MSc, PhD, FRCP, FMedSci

Patient case study: whole-body MRI and PSMA-PET show widespread and homogeneous changes indicative of tumor cell death

Individual case subject 200/300/400 µg/kg



Case Study Detail:

- Prior treatment: Cabazitaxel, Docetaxel and Darolutamide
- Related AEs: G1 Hypotension, G1 flare up of lower back pain
- Patient reports significant improvement of pain symptoms
- Significant >90% PSA decline
- Continues to be on treatment (Cycle 4)

Local PSMA PET and whole-body MRI Assessment:

- The right humerus shows significant increase in ADC (apparent diffusion coefficient, 868 to 2247), indicative of tumor cell necrosis/lysis, and correlated drop in PSMA (SUV mean 13 to 1.6), indicative of decrease in PSMA-positive tumor cells
- Similar changes observed in the indicated thoracic vertebra and across most skeletal lesions (investigator communication)

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PSA: prostate-specific antigen; AE: adverse event; ADC: apparent diffusion coefficient; PSMA: prostate-specific membrane antigen; SUV: standardized uptake value

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Closing Remarks:

Advancing Immune-Powered Therapies to Transform Patient Care

Marianne De Backer, M.Sc., Ph.D., MBA

PRO-XTEN™ masked TCEs: expanding the potential for T-cell engagers in cancer treatment

Universal dual-masking designed to apply across platform

Potential **best-in-class therapeutic index** tied to MOA

Early Phase 1 data show **clear efficacy signals** in HER2 and PSMA with room for **further dose escalation**

Differentiated **PK profile** with potential for **Q3W dosing**

Rapid development for **future PRO-XTEN™ targets**

MOA: mechanism of action; HER2: human epidermal growth factor receptor 2; PSMA: prostate-specific membrane antigen; Q3W: once every 3 weeks; TCE: T Cell Engager

Executing toward multiple important near-term catalysts

Program	Drug Candidates/Regimen	Catalyst	Timing
HER2 solid tumors	VIR-5818: Dual-masked HER2xCD3 TCE	Phase 1: initial monotherapy data	✓ Jan. 8th
PSMA solid tumors	VIR-5500: Dual-masked PSMAxCD3 TCE	Phase 1: initial monotherapy data	✓ Jan. 8th
Hepatitis Delta	tobevibart (mAb) + elebsiran (siRNA)	ECLIPSE: registrational study start	H1'25
EGFR solid tumors	VIR-5525: Dual-masked EGFRxCD3 TCE	Phase 1: study start and first-in-human dose	H1'25
Chronic Hepatitis B	tobevibart (mAb) + elebsiran (siRNA) +/- PEG-IFN-α	MARCH-B Phase 2: 24-week post-treatment (functional cure) clinical data	Q2'25

PEG-IFN-α: peg-interferon alfa-2a; mAb: monoclonal antibody; siRNA: small interfering RNA; HER2: human epidermal growth factor receptor 2; PSMA: prostate-specific membrane antigen; EGFR: epidermal growth factor receptor; TCE: T Cell Engager; CD3: cluster of differentiation 3; H1: First half. Tobevibart incorporates Xencor's Xtend™ and other Fc technologies.

Financial discipline and portfolio prioritization enable runway into mid-2027

Financial Highlights

Cash runway into

mid-2027

~$1.1 billion

cash and investments*

Accelerate and Invest

Hepatitis Delta

Phase 3 starts H1’25

Masked TCEs

VIR-5818 (HER2)

VIR-5500 (PSMA)

VIR-5525 (EGFR)

Partnership Program

Hepatitis B

Functional cure data Q2’25

Further advancement is contingent upon securing a worldwide development and commercialization partner

*We estimate our cash, cash equivalents, and investments to be approximately $1.1 billion as of January 1, 2025. This is a preliminary, estimated, and unaudited financial result. Actual results may differ from this estimate.

HER2: human epidermal growth factor receptor 2; PSMA: prostate-specific membrane antigen; EGFR: epidermal growth factor receptor

Vir Biotechnology: poised to deliver in ’25 and beyond

Our Mission

Powering the immune system to transform lives

Core Capabilities

AI-driven antibody discovery, protein engineering and PRO-XTEN™ masking

Strategic Pillars

- Advancing **HDV registrational program** for potential new SOC
- Delivering on promise of **dual-masked TCEs** in cancer treatment
- Focused capital deployment, cost discipline and **strategic partnerships**

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TCE: T Cell Engager; HDV: hepatitis delta; SOC: standard of care
PRO-XTEN™ is a trademark of Amunix Pharmaceuticals, Inc., a Sanofi company

PATIENTS ARE WAITING

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