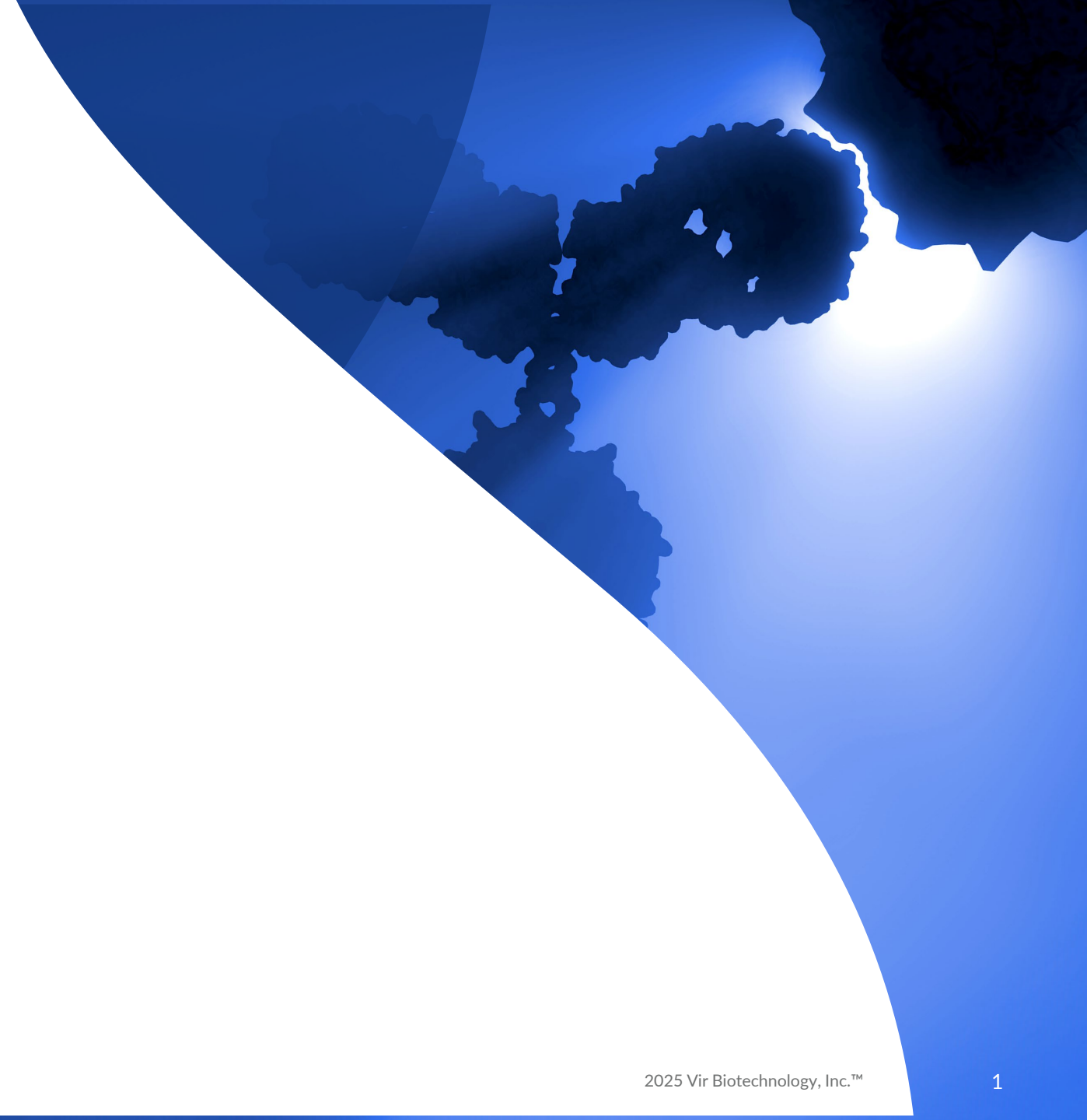


Corporate Overview Presentation

November 2025

Vir Biotechnology™

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 and commercial potential of Vir Biotechnology's CHD program, as well as Vir Biotechnology's strategy, plans and expectations related thereto; the therapeutic and commercial potential of Vir Biotechnology's oncology solid tumor portfolio, preclinical pipeline and the PRO-XTEN® masking technology, 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 anticipated cash runway; Vir Biotechnology's plans and expectations for its clinical development programs, including protocols for and enrollment into ongoing and planned clinical studies, 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; 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 studies or in data readouts, including the occurrence of adverse safety events; risks of unexpected costs, delays or other unexpected hurdles; the timing and amount of Vir Biotechnology's actual operating expenses, as determined in accordance with U.S. Generally Accepted Accounting Principles; difficulties in collaborating with other companies, some of whom may be competitors of Vir Biotechnology or otherwise have divergent interests, and uncertainty as to whether the benefits of Vir Biotechnology's various collaborations can ultimately be achieved; challenges in accessing manufacturing capacity; clinical site activation rates or clinical enrollment rates that are lower than expected; the timing and outcome of Vir Biotechnology's planned interactions with regulatory authorities, as well as general difficulties in obtaining any necessary regulatory approvals; 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 AI and machine learning in its efforts to engineer next-generation proteins and in other research and development efforts; 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 studies may not be indicative of full results or results from later stage or larger scale clinical studies 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 any 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.

This presentation discusses product candidates that are under clinical study, and which have not yet been approved for marketing by the US Food and Drug Administration. 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.

Comparative Data
Certain data in this presentation are based on cross-trial comparisons and are not based on any head-to-head clinical trials. Accordingly, no direct comparisons can be made. Cross-trial data interpretation should be considered with caution as it is inherently limited and may suggest similarities or differences in outcomes that may not be reflected in the actual results of any head-to-head studies, which may differ significantly from these comparisons. Differences exist between study or trial designs, patient populations, subject characteristics, and other factors, and caution should be exercised when comparing data across studies. See individual study publications for complete data and context. We have not independently verified the accuracy or completeness of the data included in publicly available study publications from other companies and make no representations as to the accuracy or completeness of such data.

Our Vision:

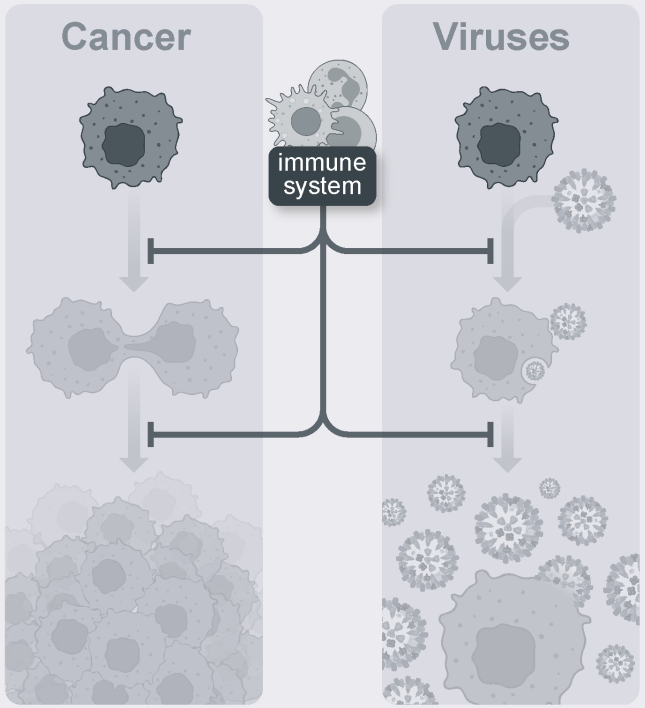
Powering The Immune System To Transform Lives

Vir Biotechnology™

We power the immune system to fight back against two related and formidable threats: cancer and viruses

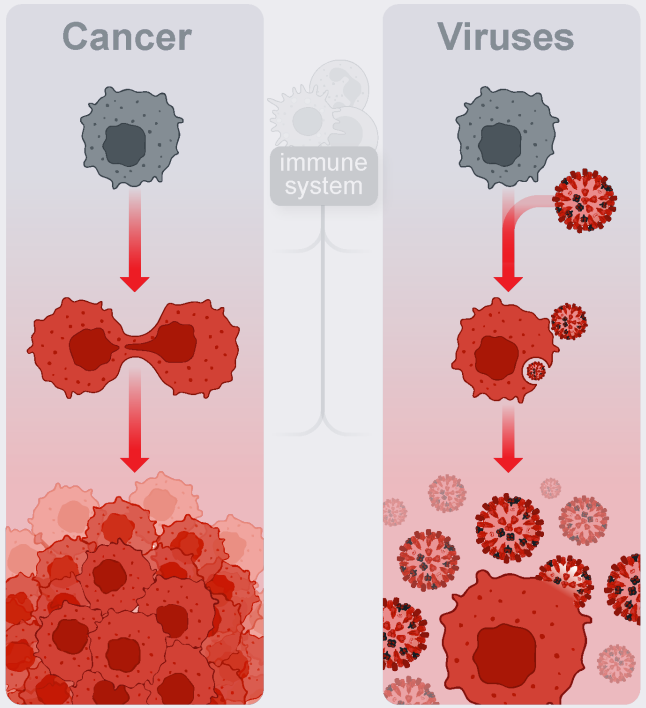
The immune system is powerful…

Protecting us from cancer cells and viruses in normal conditions



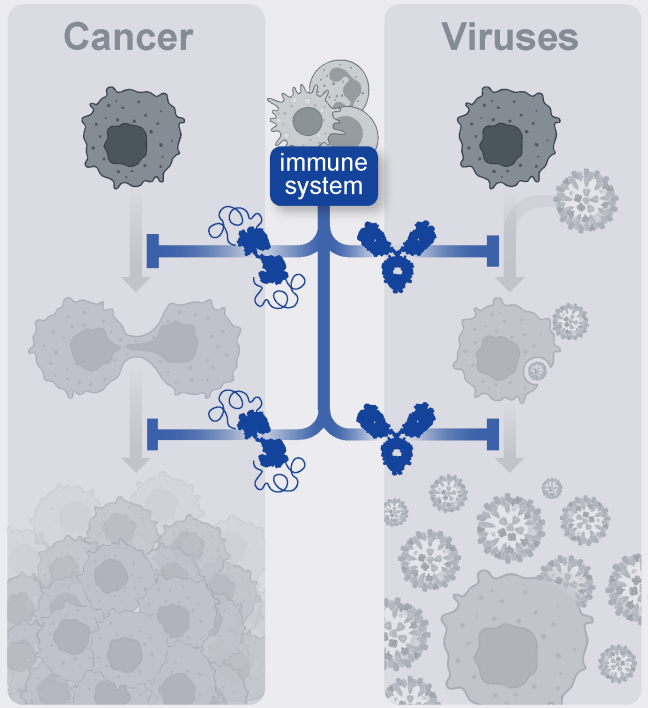
…but sometimes it can be bypassed

Cancer cells and viruses can evade the immune system, causing serious disease



Our approach

We power the immune system to fight back against cancer and infectious disease



Potential best-in-class programs across oncology and infectious disease

Leveraging immune-targeted approaches to transform patient care

Oncology – Solid Tumors

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

Infectious Disease

Hepatitis Delta (Phase 3)
Chronic suppressive treatment Planning direct U.S. launch; partnering for Europe and key international markets[2]

Focused capital deployment: $810.7 million cash and investments[1], cash runway into mid-2027

[1] Represents cash, cash equivalents, and investments as of September 30, 2025
[2] Outside China Territory (People's Republic of China, Hong Kong, Taiwan, and Macau) where Brii Biosciences retains rights

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 prostate cancer; mNSCLC: metastatic non-small cell lung cancer; mHNSCC: metastatic head and neck squamous cell carcinoma

Diversified pipeline in oncology and infectious disease driving near-term and long-term value creation

siRNA Antibody Masked TCE

Disease Area	Product Candidate	Goal	Pre-clinical	Phase 1	Phase 2	Phase 3	Approval
Clinical Programs							
Chronic Hepatitis Delta	tobevibart + elebsiran	Treatment					
Solid Tumors	VIR-5818 (HER2)[1] ± pembrolizumab	Treatment					
Solid Tumors	VIR-5500 (PSMA)[1] ± ARPIs	Treatment					
Solid Tumors	VIR-5525 (EGFR)[1] ± pembrolizumab	Treatment					
Pre-Clinical Programs							
HIV Treatment / Cure[2]	Preclinical antibody candidates	Treatment					
Solid Tumors	Undisclosed PRO-XTEN® TCE targets	Treatment					

1: Masked TCEs licensed from Sanofi
2: In collaboration with the Gates Foundation

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siRNA: small interfering RNA; TCE: T-cell engager; HER2: human epidermal growth factor receptor 2; PSMA: prostate-specific membrane antigen; EGFR: epidermal growth factor receptor; HIV: human immunodeficiency virus; ARPIs: androgen receptor pathway inhibitors.
Tobevibart incorporates Xencor's Xtend™ and other Fc technologies.
PRO-XTEN® is a trademark of Amunix Pharmaceuticals, Inc., a Sanofi company.

Multiple near-term catalysts led by SOLSTICE AASLD presentation and VIR-5500 Q1 2026 data update

Program	Drug Candidates/Regimen	Catalyst	Timing
Hepatitis Delta	tobevibart (mAb) + elebsiran (siRNA)	ECLIPSE 1: enrollment complete	✓ Q4'25
		48-week Phase 2 SOLSTICE data at AASLD	✓ Nov 9th
		ECLIPSE 1: topline data	Q1'27
		ECLIPSE 2: topline data	Q1'27
		ECLIPSE 3: topline data	Q1'27
PSMA-Expressing Prostate Cancer	VIR-5500: dual-masked PSMAxCD3 TCE	Phase 1: initial monotherapy data	✓ Q1'25
		Phase 1: additional late-line data	Q1'26
HER2-Expressing Solid Tumors	VIR-5818: dual-masked HER2xCD3 TCE	Phase 1: initial monotherapy data	✓ Q1'25
		Phase 1: additional clinical data	TBA
EGFR-Expressing Solid Tumors	VIR-5525: dual-masked EGFRxCD3 TCE	Phase 1: study start and first-in-human dose	✓ Q3'25
		Phase 1: initial clinical data	TBA

HER2: human epidermal growth factor receptor 2; CD3: cluster of differentiation 3; TCE: T-cell engager; PSMA: prostate-specific membrane antigen; mAb: monoclonal antibody; siRNA: small interfering RNA; EGFR: epidermal growth factor receptor; TBA: to be announced
Tobevibart incorporates Xencor's Xtend™ and other Fc technologies.

Vir Biotechnology™ | POWERING THE IMMUNE SYSTEM TO TRANSFORM LIVES

Chronic Hepatitis Delta

Potentially Transformative
Chronic Treatment

Hepatitis Delta dramatically increases risk of death, cirrhosis, and cancer

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

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

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

~7M **Worldwide** RNA+ (Active Viremic HDV) Patients[4]

~61K **U.S.** RNA+ (Active Viremic HDV) Patients[5,7]

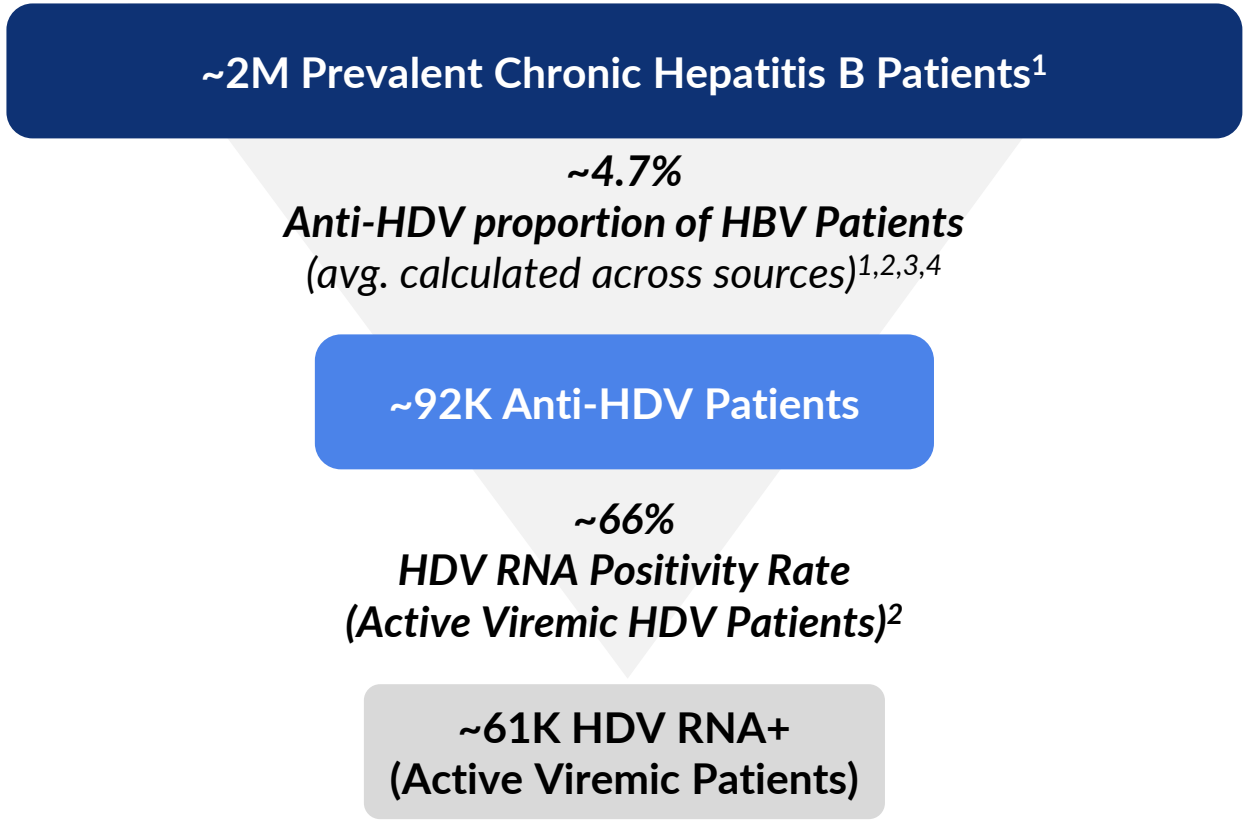
~113K* **Total EU (27 member states)+UK** RNA+ (Active Viremic HDV) Patients[6]

*Estimate ~38k EU4+UK RNA+ (active viremic HDV) patients[6]

HCC: hepatocellular carcinoma; HDV: hepatitis delta virus; RNA+: RNA positive; EU4: France, Germany, Italy, and Spain

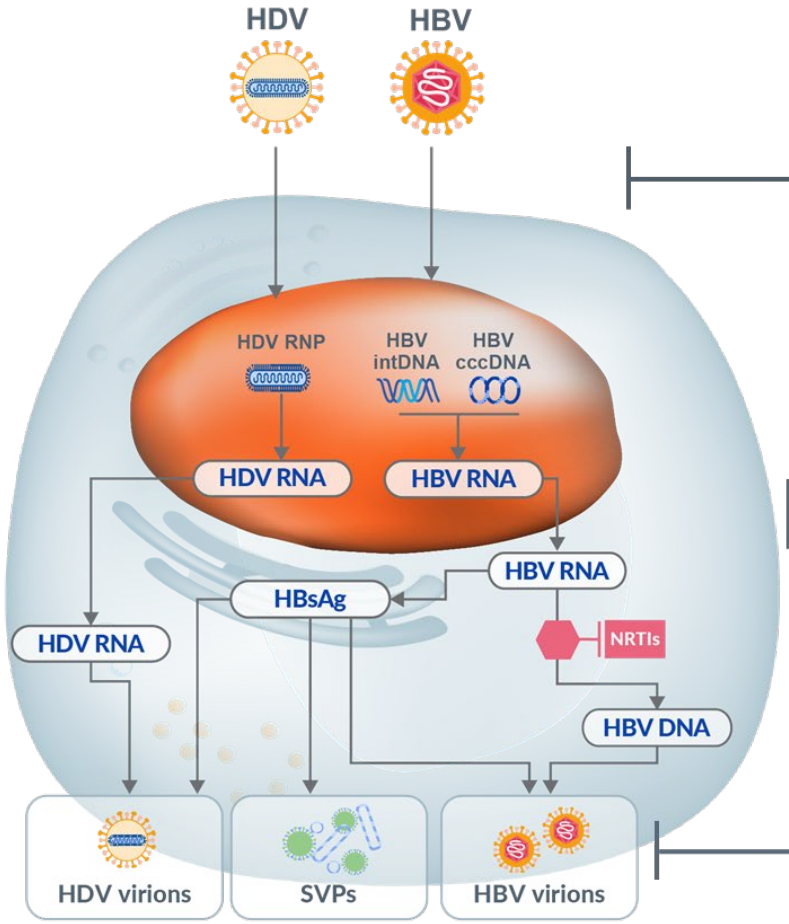
[1] Negro F. (2023). Hepatitis D: A Review. *JAMA*. 330(24):2376–2387; [2] Pan C, (2023). Diagnosis and Management of Hepatitis Delta Virus Infection. Dig Dis Sci. Aug;68(8):3237-3248; [3] Sagnelli C, et al. (2021). HBV/HDV Co-Infection: Epidemiological and Clinical Changes, Recent Knowledge and Future Challenges. Life,11(2):169. https://doi.org/10.3390/life11020169; [4] Stockdale A, et al. (2020). The global prevalence of hepatitis D virus infection: Systematic review and meta-analysis. J Hepatol, 73, 523-32; [5] U.S. sources include Wong 2024, Polaris 2024, Stockdale 2020, Gish 2024; [6] EU sources include Polaris 2024, Delmas 2014, Wong 2024, Heidrich 2009, Reinheimer 2012, Stockdale 2020, Stroffolini 2020, Brancaccio 2019, Annual England Sentinel System 2020, Tseneva-Damyanova 2023, Papatheodoridis 2023, Parames 2016, Genne 2011, Hirzel 2015.

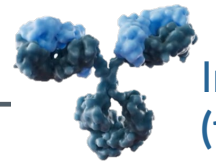
An estimated 61,000 patients in the U.S. have active viremic HDV infection



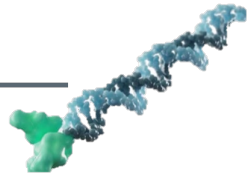
[1] Wong RJ, Brosgart C, Wong SS, Feld J, Glenn J, Hamid S, Cohen C, Zovich B, Ward J, Wedemeyer H, Yurdaydin C, Gish R. Estimating the prevalence of hepatitis delta virus infection among adults in the United States: A meta-analysis. Liver Int. 2024 Jul;44(7):1715-1734. doi: 10.1111/liv.15921. Epub 2024 Apr 2. PMID: 38563728; [2] Polaris Observatory Collaborators. Adjusted estimate of the prevalence of hepatitis delta virus in 25 countries and territories. J Hepatol. 2024 Feb;80(2):232-242. doi: 10.1016/j.jhep.2023.10.043. Epub 2023 Nov 27. PMID: 38030035; [3] Stockdale AJ, Kreuels B, Henrion MYR, Giorgi E, Kyomuhangi I, de Martel C, Hutin Y, Geretti AM. The global prevalence of hepatitis D virus infection: Systematic review and meta-analysis. J Hepatol. 2020 Sep;73(3):523-532. doi: 10.1016/j.jhep.2020.04.008. Epub 2020 Apr 23. PMID: 32335166; PMCID: PMC7438974; [4] Gish RG, Jacobson IM, Lim JK, Waters-Banker C, Kaushik A, Kim C, Cyhaniuk A, Wong R. Prevalence and Characteristics of Hepatitis Delta Virus Infection in Patients with Hepatitis B in the United States: an Analysis of the All-Payer Claims Database. Hepatology. 2024 May 1; 79(5):1117-1128. doi 10. 1097/HEP.0000000000000687. Epub 2023 Nov 16.

Our ambition in HDV: chronic viral suppression to undetectable levels with monthly dosing

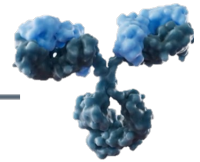




Inhibition of viral entry **(tobevibart)**



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



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

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

Complementary MOAs:

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

HDV: hepatitis D virus
HBV: hepatitis B virus
RNP: ribonucleoprotein
IntDNA: integrated DNA
cccDNA: covalently closed circular DNA
HBsAg: hepatitis B virus surface antigen

NRTI: nucleoside/nucleotide reverse transcriptase inhibitor
SVP: subviral particle
MOA: mechanism of action
mAb: monoclonal antibody
Fc: fragment crystallizable

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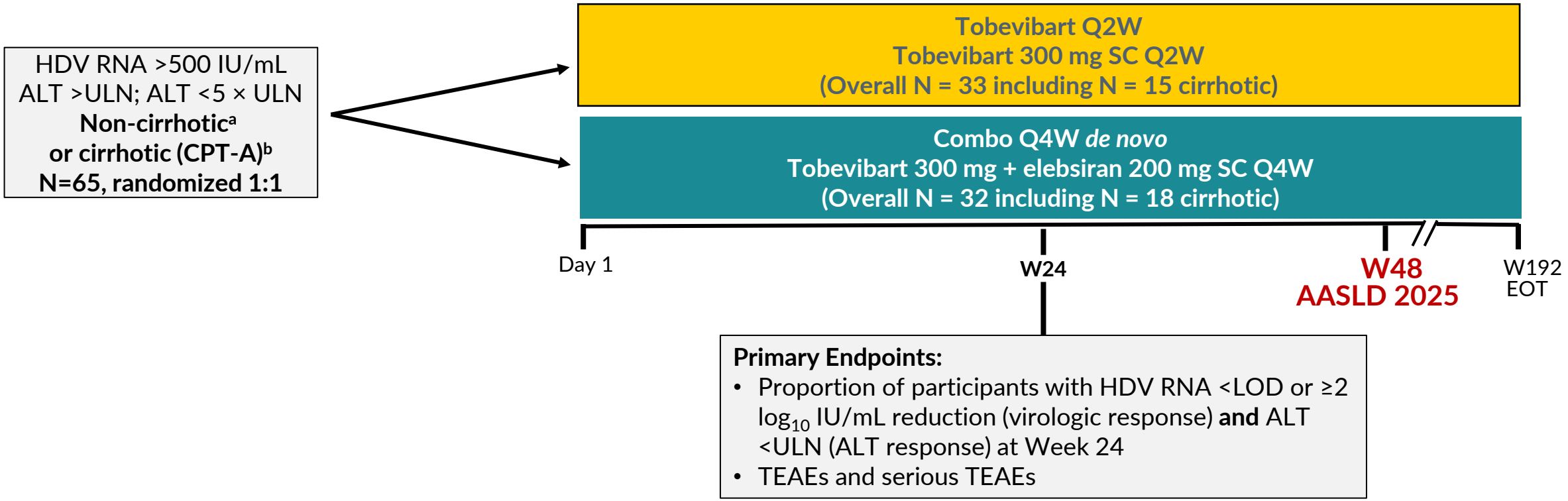
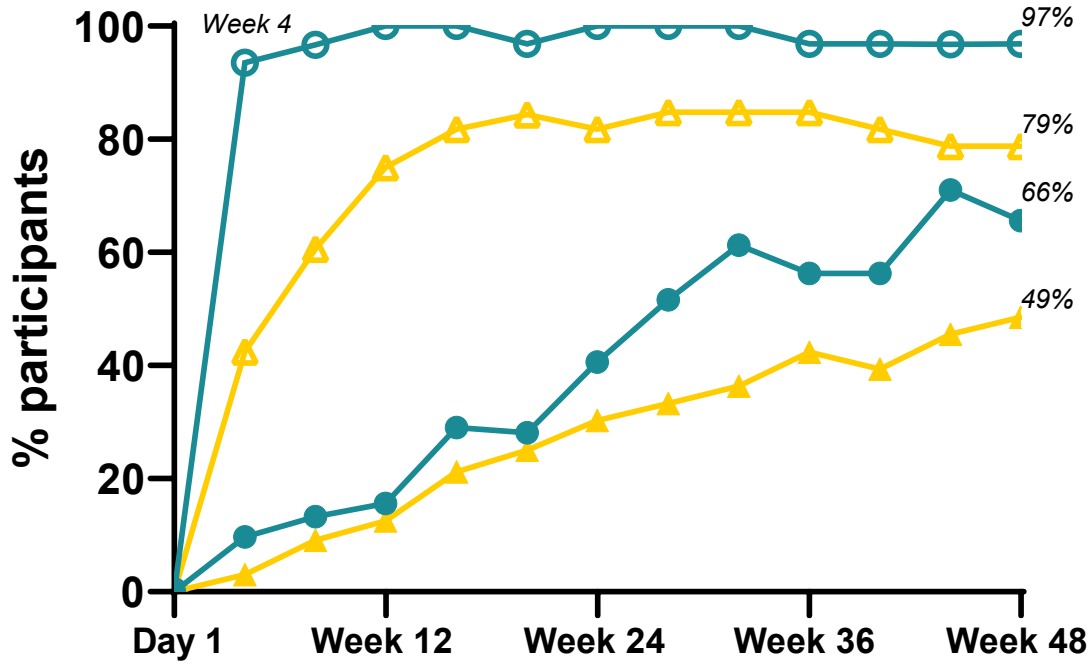
SOLSTICE Study Design: Tobevibart + Elebsiran Q4W and Tobevibart Q2W in participants living with chronic HDV



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.

Higher Antiviral Responses in Participants Receiving Tobevibart + Elebsiran through Week 48



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

- Tobevibart + Elebsiran Q4W (N=32)
- Tobevibart Q2W (N=33)

HDV RNA Target Not Detected (TND)

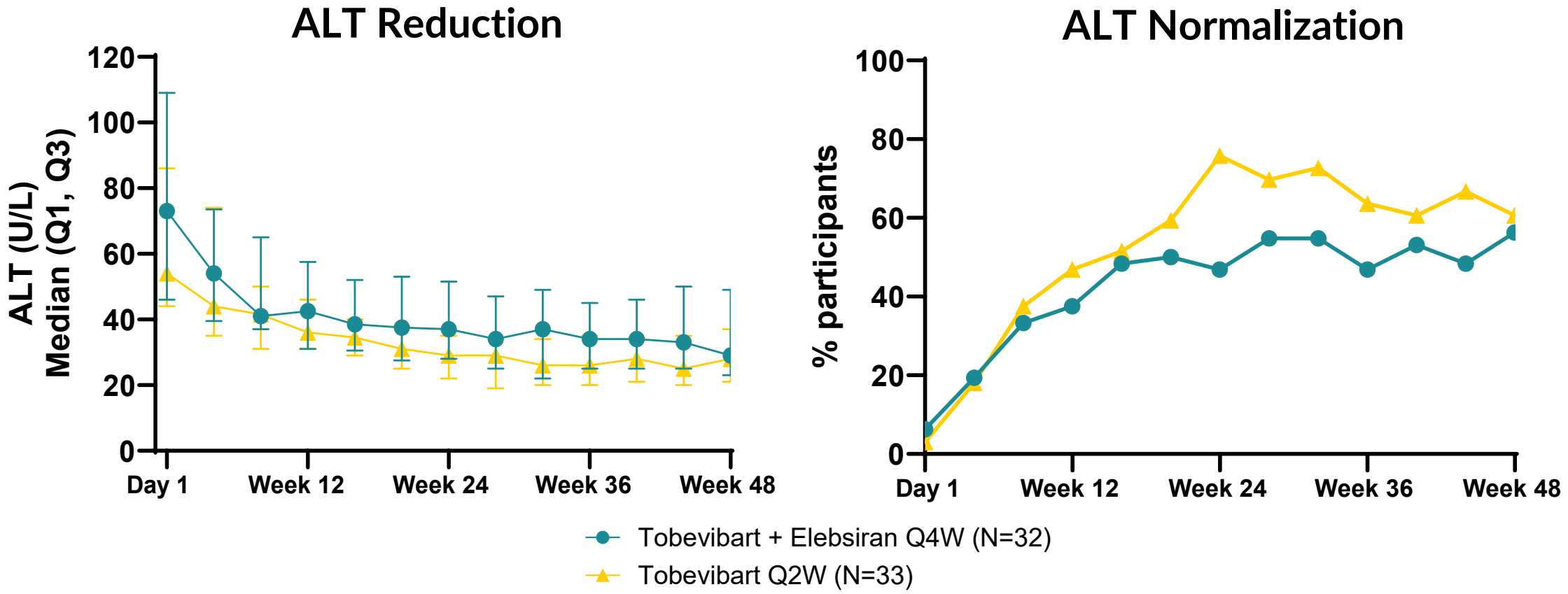
- Tobevibart + Elebsiran Q4W (N=32)
- Tobevibart Q2W (N=33)

Larger proportion of tobevibart + elebsiran cohort achieves HDV RNA TND vs. tobevibart monotherapy

The number of participants reaching HDV RNA TND increased steadily through Week 48

HDV: hepatitis D virus; LOD: limit of detection; 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.

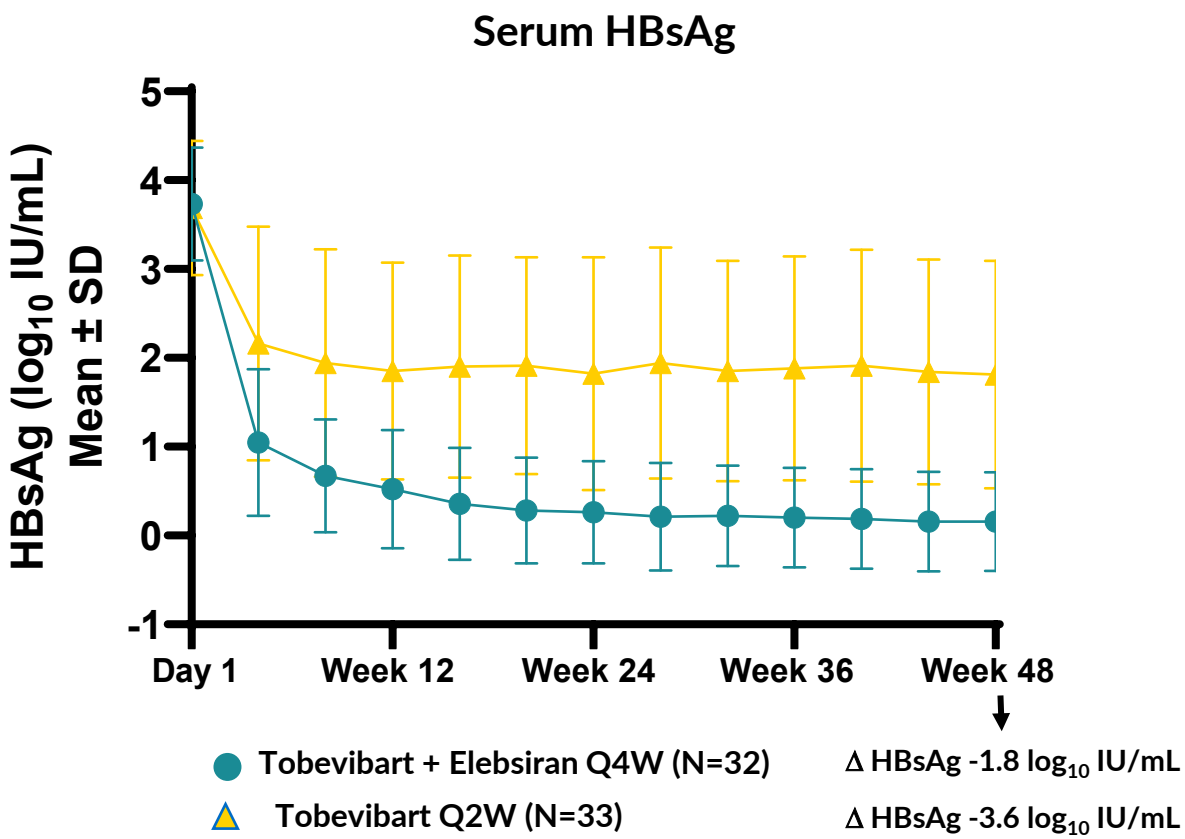
Similar ALT normalization observed in both regimens

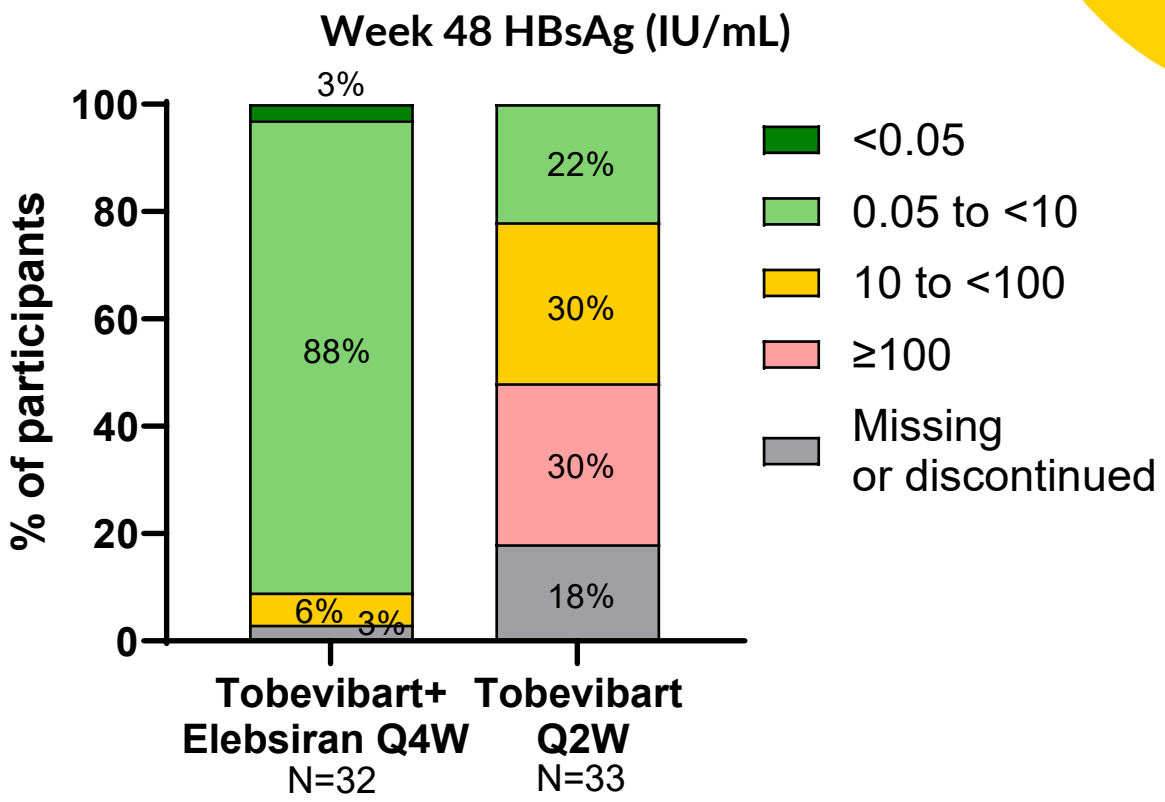


ALT normalization at Week 48 was similar between tobevibart + elebsiran and tobevibart monotherapy

ALT: alanine aminotransferase; 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.

Combination of tobevibart + elebsiran markedly outperforms monoclonal antibody monotherapy in HBsAg reduction





Approximately 90% of participants receiving tobevibart + elebsiran and 22% receiving tobevibart monotherapy achieved HBsAg values <10 IU/mL at Week 48

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.

Majority of Adverse Events were Grade 1-2 and Transient Through Week 48

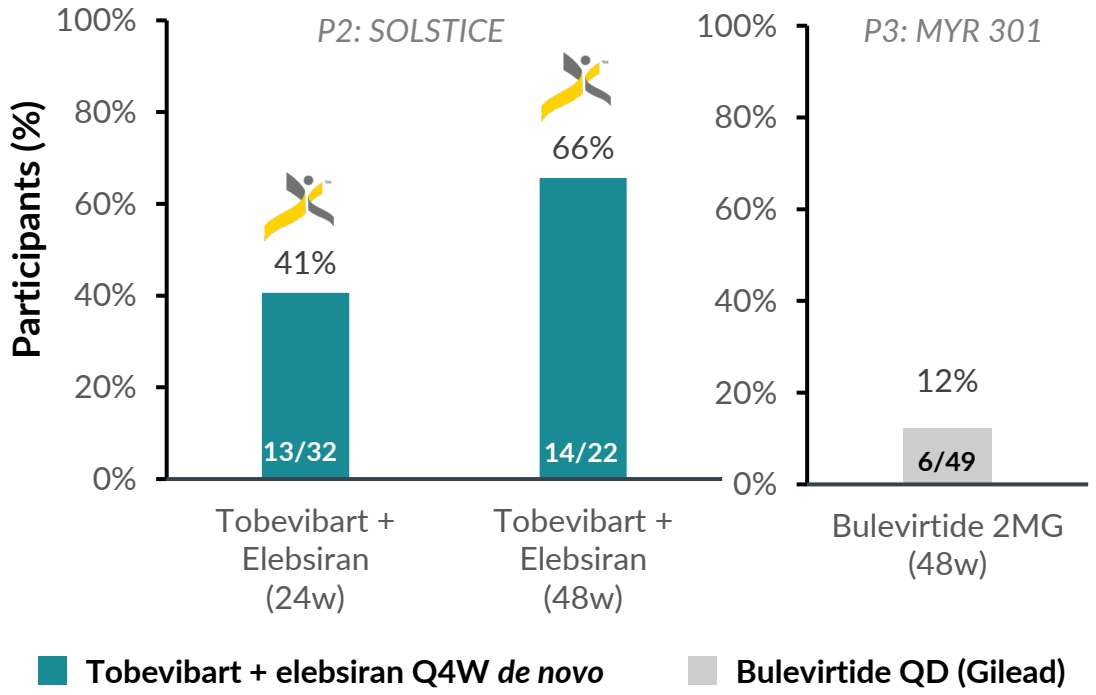
Safety or tolerability measure, n (%)[a]	Tobevibart + elebisran Q4W *de novo* N = 32	Tobevibart Q2W N = 33
Any TEAE	26 (81)	31 (94)
Grade 1-2	26 (81)	29 (88)
Grade 3	0	1 (3)[g]
Grade 4	0	1 (3)[b]
Treatment-related TEAE	23 (72)	26 (79)
Treatment-emergent influenza-like symptoms[c]	22 (69)	25 (76)
Treatment-emergent injection site reactions[d]	4 (13)	4 (12)
TEAE leading to study drug interruption	0	1 (3)[e]
TEAE leading to study drug discontinuation	0	3 (9)[f]
Serious TEAE	0	1 (3)[g]
Treatment-related serious TEAE	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

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: two cases of influenza-like illness (PT term) and one case of hepatocellular carcinoma
[g] Grade 3 hepatocellular carcinoma (SAE) deemed unrelated to study drugs by investigator

Tobevibart + elebsiran combo has shown transformative virological responses in HDV in SOLSTICE P2 trial

Virologic Endpoint:
HDV RNA <Target Not Detected (0 IU/mL)*



Tobevibart (mAb) + elebsiran (siRNA) combination therapy
Key differentiators

1. **Deep HDV antiviral responses**
2. **Convenient monthly dosing**
3. **Lowers HBsAg levels, limiting HDV replication**
4. **Similar efficacy in cirrhotic patients**

mAb: monoclonal antibody; siRNA: silencer select RNA; HDV: hepatitis delta virus; LLOQ: lower limit of quantification; Q4W: once every 4 weeks; QD: once daily; TND: target not detected
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).
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.

Study identifier: NCT05461170
Data cutoff: September 25, 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. See individual study publications for complete data and context.

ECLIPSE registrational clinical trials progressing, with ECLIPSE 1 fully enrolled and topline data for all three studies expected Q1 2027

Supported by:

✓ FDA breakthrough designation ✓ FDA Fast Track ✓ EMA PRIME designation ✓ EMA ODD

ECLIPSE 1 – Phase 3

HDV RNA LLOQ, TND + ALT normalization at week 48

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

ECLIPSE 2 – Phase 3

HDV RNA LLOQ, TND at week 24

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

Pivotal studies supporting marketing application in the U.S. and Europe

ECLIPSE 3 – Phase 2b

HDV RNA LLOQ, TND at week 48

tobevibart + elebsiran vs. bulevirtide naïve (n=100, 2:1) — On track

Study supporting pricing, reimbursement, and label expansion

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

HDV: hepatitis D virus; ODD: orphan drug designation; LLOQ: lower limit of quantification; TND: target not detected; ALT: alanine aminotransferase; HDV RNA TND = no detectable HDV RNA (0 IU/mL)

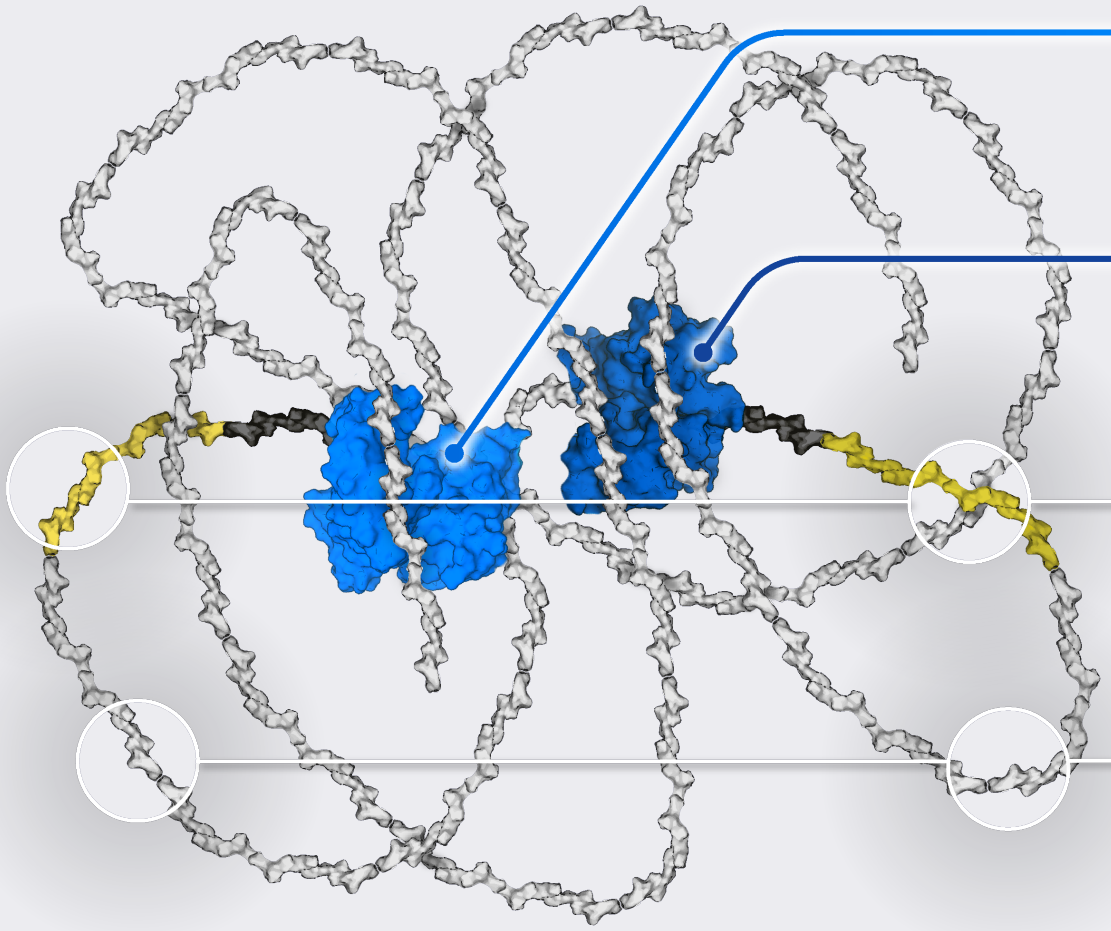
Vir Biotechnology™ | POWERING THE IMMUNE SYSTEM TO TRANSFORM LIVES

PRO-XTEN® Dual-Masked TCE Platform

Potential to Overcome the Challenges of TCEs

PRO-XTEN® masked TCEs have potential best-in-class therapeutic index and long-term durability

PRO-XTEN® dual masking



Tumor binding domain
Variable region binds tumor-associated antigen

T cell binding domain
Variable region designed to bind CD3 to recruit T-cells

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

XTEN mask
XTEN masks prevent off-tumor activity of the TCE and prolong half-life

Expected differentiation

Addressing the challenges of unmasked and single-masked TCEs:

- **Maximize TI**
- **Less toxicity**
- **Longer half-life and Q3W dosing**
- **Clinically validated mask**
- **Universal masking platform**

Vir Biotechnology™

CD3: cluster of differentiation 3; TME: tumor microenvironment; TCE: T-cell engager; TI: therapeutic index; Q3W: once every 3 weeks

PRO-XTEN® masked TCEs can expand the potential of T-cell engagers in cancer treatment

PRO-XTEN® Dual-Masked TCEs

VIR-5500 (PSMAxCD3)[1]: The only dual-masked PSMA-targeted TCE, significant room to dose escalate including Q3W dosing

- Efficacy: 100% PSA decline, 58% PSA_{50} responses at early doses
- Safety: no Gr3 CRS, and very low levels of ≥Gr3 TRAEs

VIR-5818 (HER2xCD3)[2]: The only masked HER2-targeted TCE, significant room to dose escalate including Q3W dosing

- Efficacy: 33% response and 100% biomarker response in mCRC, 50% tumor shrinkage in other HER2 tumors at early doses
- Safety: no Gr3 CRS, and very low levels of ≥Gr3 TRAEs

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

- Phase 1 initiated in Q3 2025
- Target indications: NSCLC, CRC, HNSCC, and cSCC

Masking Technology Platform

Universal PRO-XTEN® masks are designed to be applied to new targets without the need for tailoring

- Potential for rapid dose escalation and expansion to new targets, utilizing learnings from clinical assets

[1]Study identifier: NCT05997615
Data cutoff: November 13, 2024
[2]Study identifier: NCT05356741
Data cutoff: November 11, 2024

Note: detailed clinical data shared during Jan 8th investor event
HER2: human epidermal growth factor receptor 2; CD3: cluster of differentiation 3; TCE: T-cell engager; Q3W: once every 3 weeks; mCRC: metastatic colorectal cancer; CRS: cytokine release syndrome; Gr3: Grade 3; TRAEs: treatment related adverse events; PSMA: prostate-specific membrane antigen; PSA: prostate specific antigen; EGFR: epidermal growth factor receptor; NSCLC, non-small cell lung cancer; CRC, colorectal cancer; HNSCC, head and neck squamous cell carcinoma; cSCC, cutaneous squamous cell carcinoma.
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Phase 1 Clinical Data: VIR-5500 (PSMA)

Potential Best-in-Class Profile in Prostate Cancer

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

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™

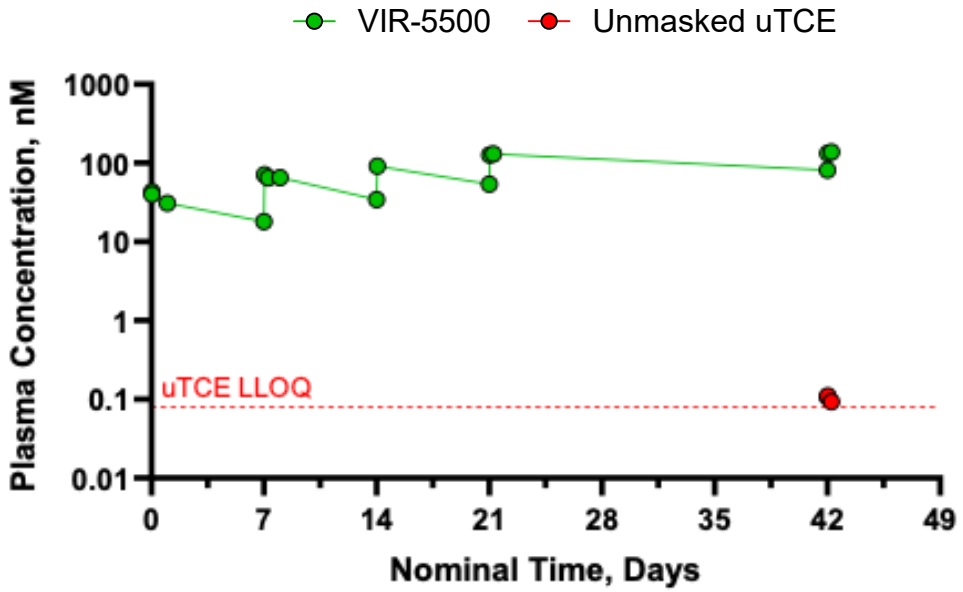
Study identifier: NCT05997615
Data cutoff: November 13th, 2024

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

Minimal systemic unmasking and potential for Q3W dosing

Minimal unmasked TCE outside the tumor

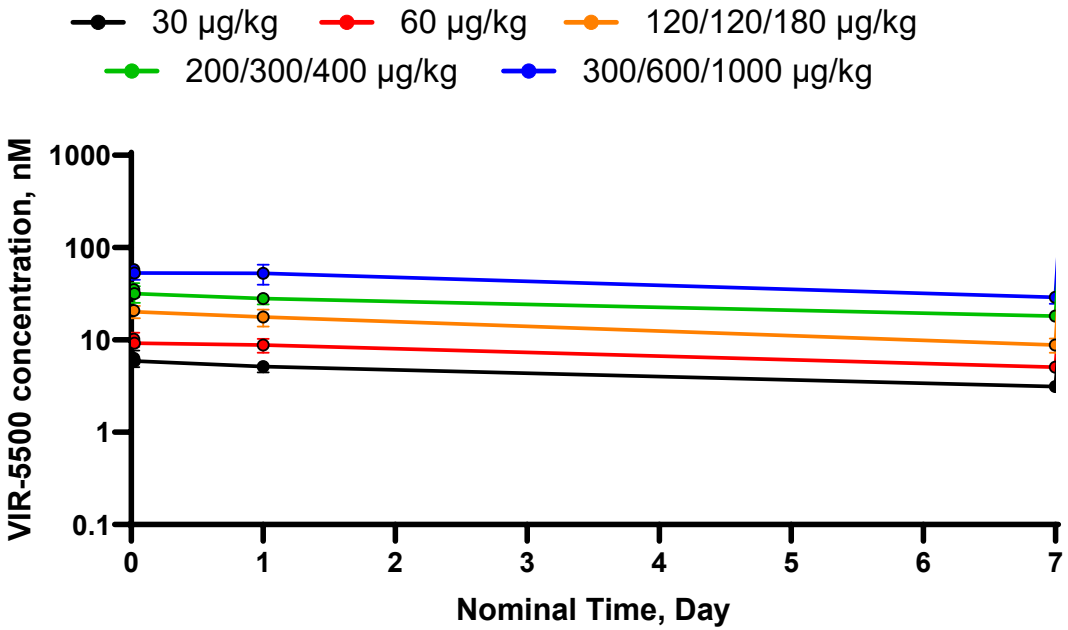
Only one VIR-5500 patient with detectable unmasked TCE (Dose: 200/300/400 µg/kg)



- 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

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

Q3W: once every 3 weeks; TCE: T-cell engager; uTCE: unmasked TCE; PK: pharmacokinetics; LLOQ: lower limit of quantification

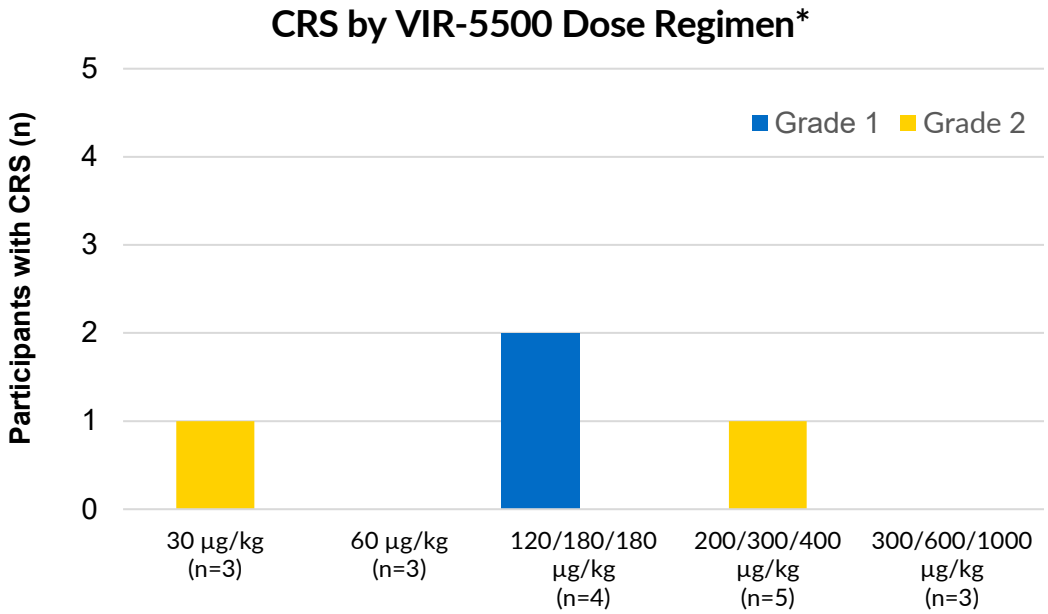
Well-tolerated without prophylactic corticosteroids or anti-IL-6 premedication in early Phase 1 testing

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

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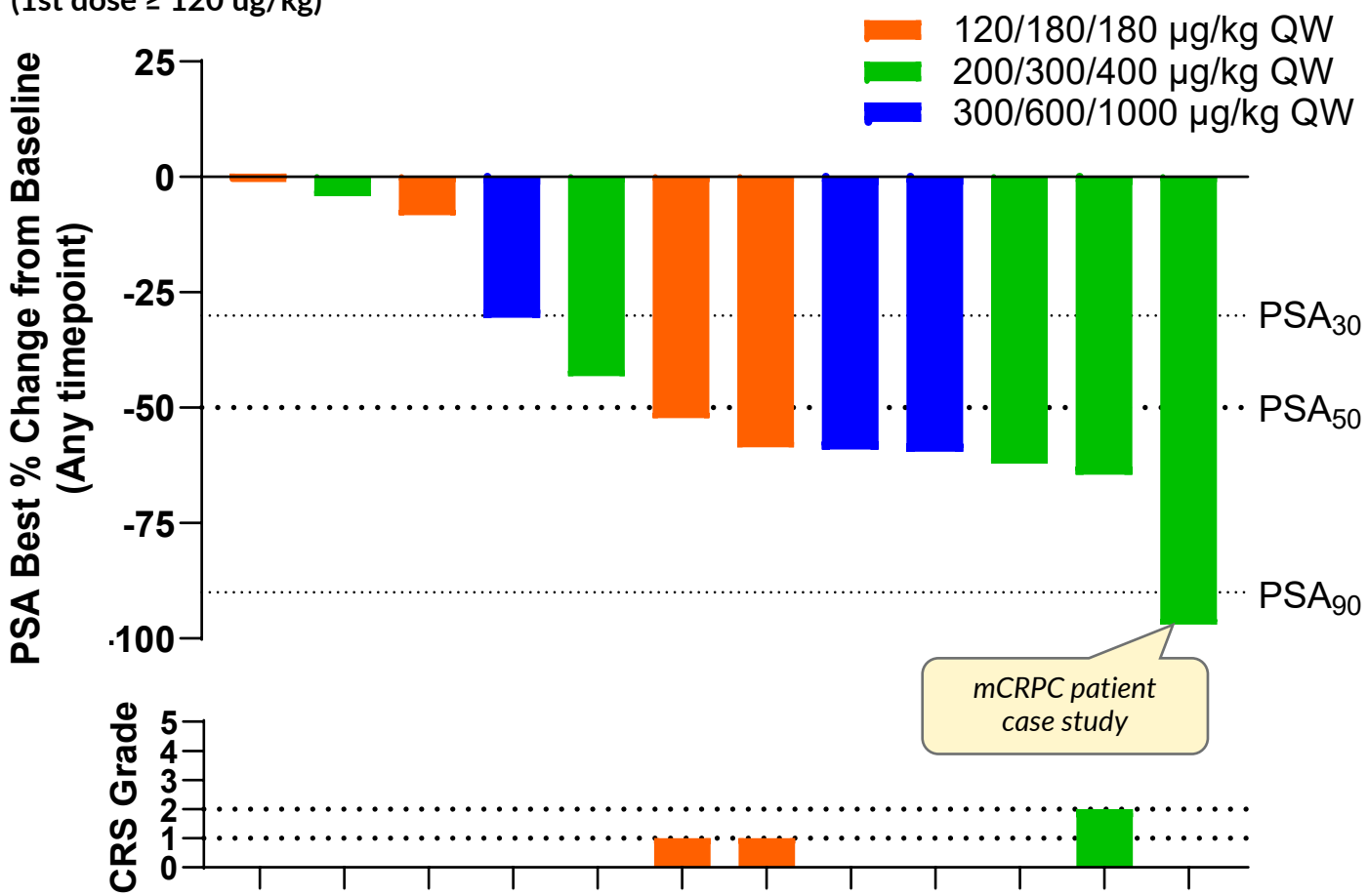
Study identifier: NCT05997615
Data cutoff: November 13th, 2024

*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

Strong PSA_{50} responses and tolerable safety at early doses in Phase 1 testing

PSA Responses

(1st dose ≥ 120 ug/kg)



Early Phase 1 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 across all 12 patients
- No association with CRS, no IL-6 elevations
- Tolerable safety profile
- Significant room to dose escalate; potential for Q3W dosing

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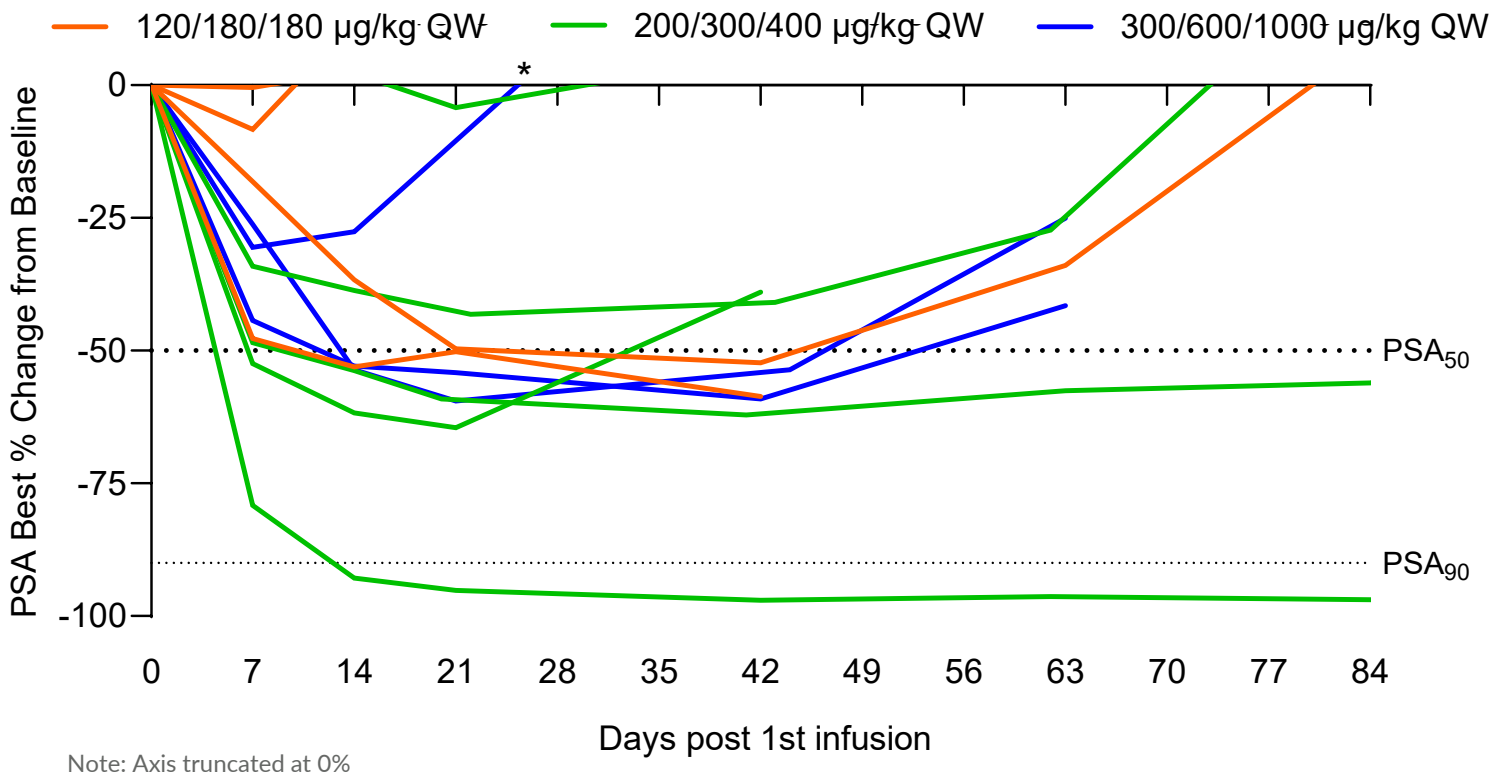
Study identifier: NCT05997615
Data cutoff: November 13th, 2024

PSA: prostate-specific antigen; CRS: cytokine release syndrome; PSMA: prostate-specific membrane antigen; QW: once weekly; mCRPC: metastatic castration resistant prostate cancer

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

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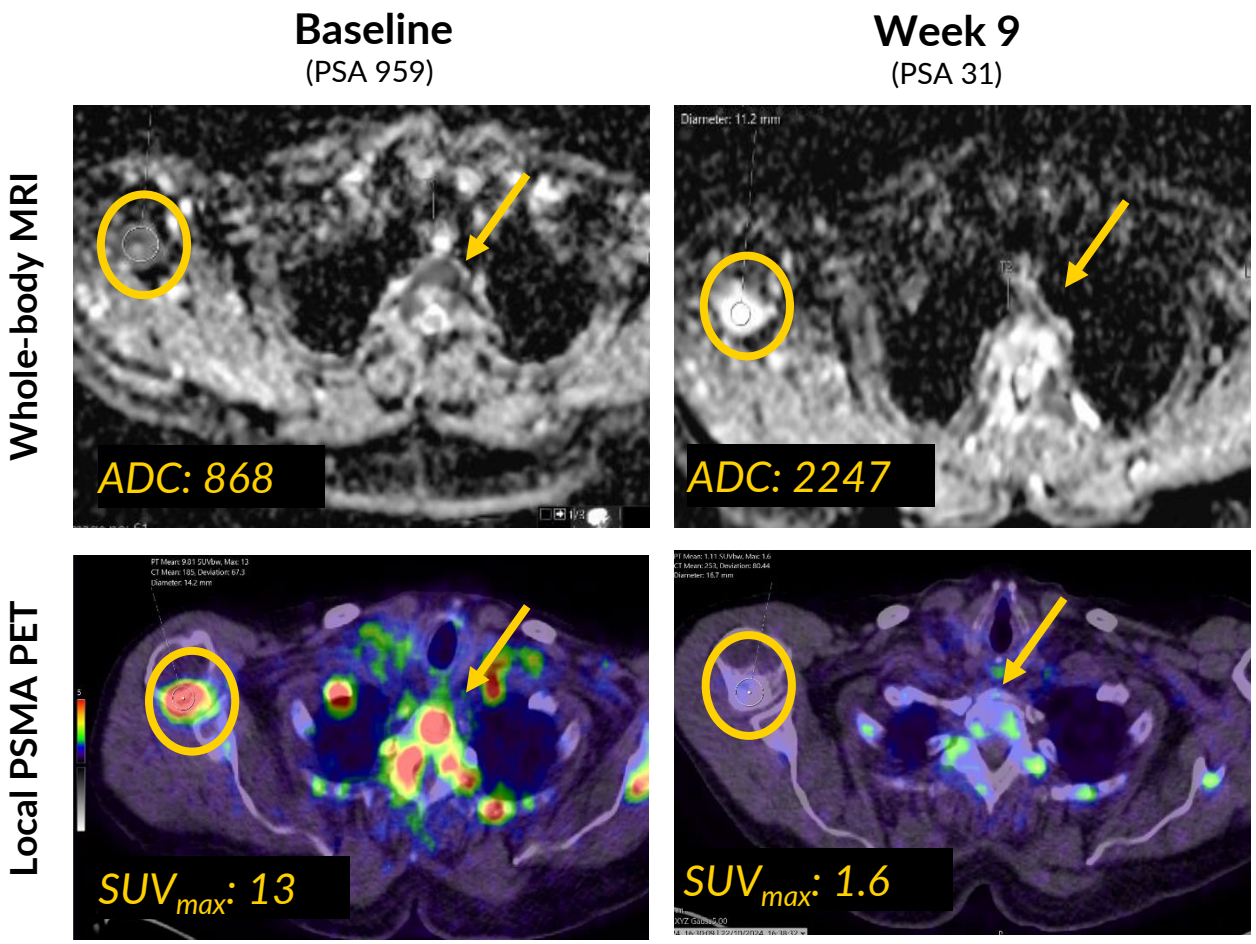
Study identifier: NCT05997615
Data cutoff: December 3, 2024

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

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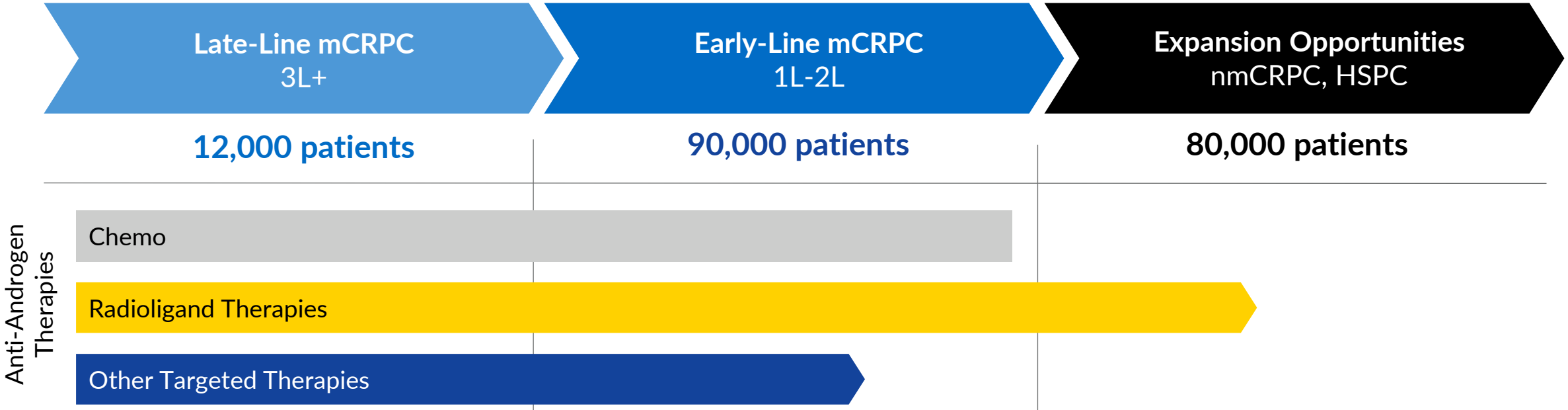
PSA: prostate-specific antigen; AE: adverse event; ADC: apparent diffusion coefficient; PSMA: prostate-specific membrane antigen; SUV: standardized uptake value

Potential for best-in-class therapeutic index 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; TI: therapeutic index

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Phase 1 Clinical Data: VIR-5818 (HER2)

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

The first clinical stage masked HER2 TCE in ongoing Phase 1

Part 1: Monotherapy Dose Escalation - Completed

Recommended expansion dose and schedule

100 → 300 → 1000 µg/kg

100 → 300 → 800 µg/kg[1]

100 → 250 → 600 µg/kg

100 → 200 → 400 µg/kg

200 µg/kg

1 µg/kg

Eligibility:

HER2 IHC2-3+, ISH+, or mutant

Exhausted all SOC

79 patients enrolled

Evaluating QW and Q3W

Demonstrates wide safety margin

Part 2: Pembrolizumab Combination

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

Currently enrolling

Analysis ongoing

Currently Evaluating

Cleared DLT

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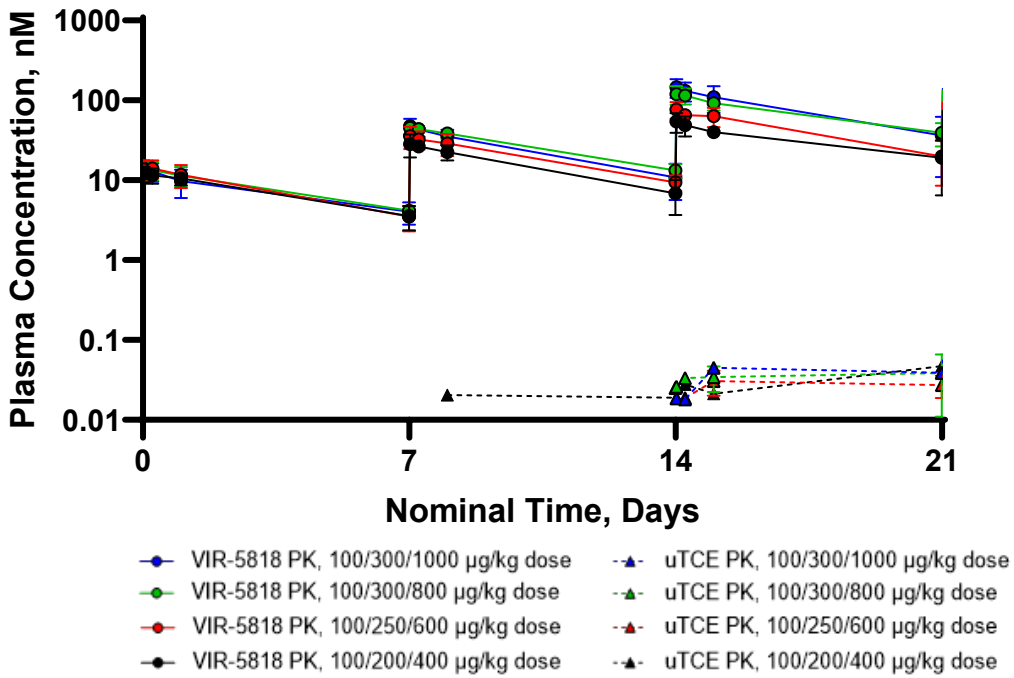
Study identifier: NCT05356741
Data cutoff: November 11, 2024

[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

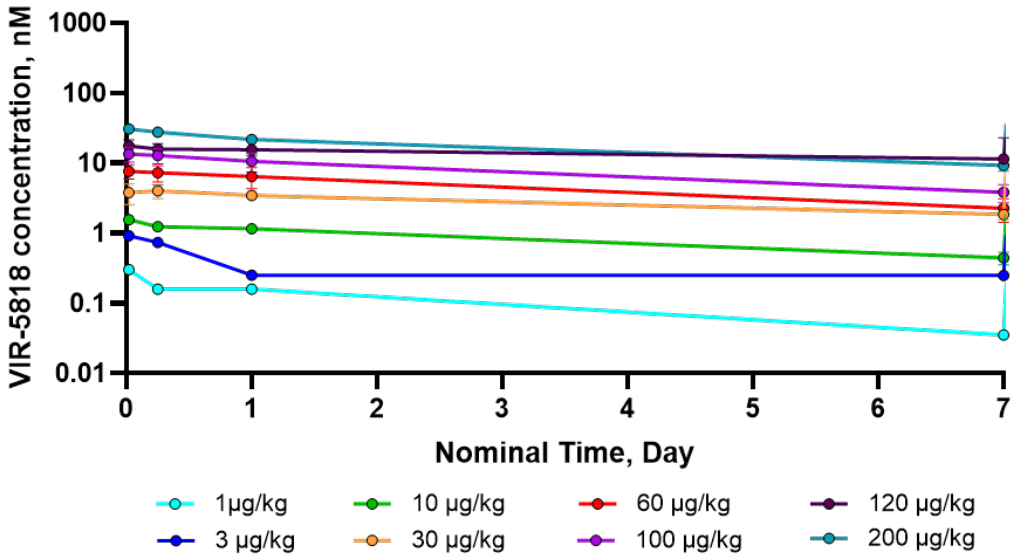
VIR-5818 and uTCE PK, First Cycle*



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

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

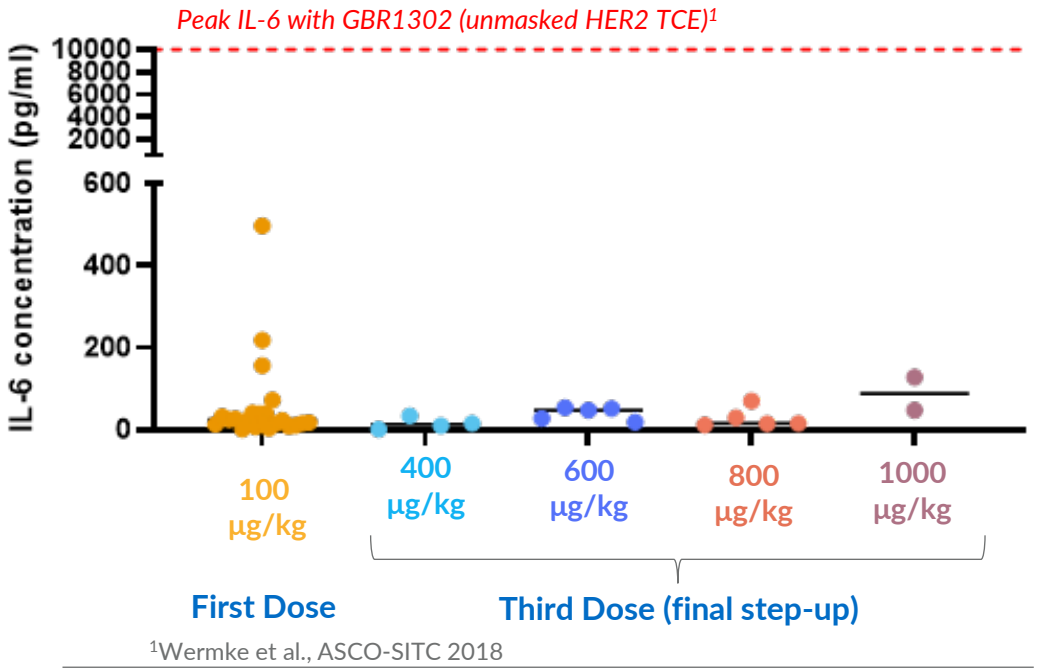
Highly Tolerable Safety

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



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

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

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

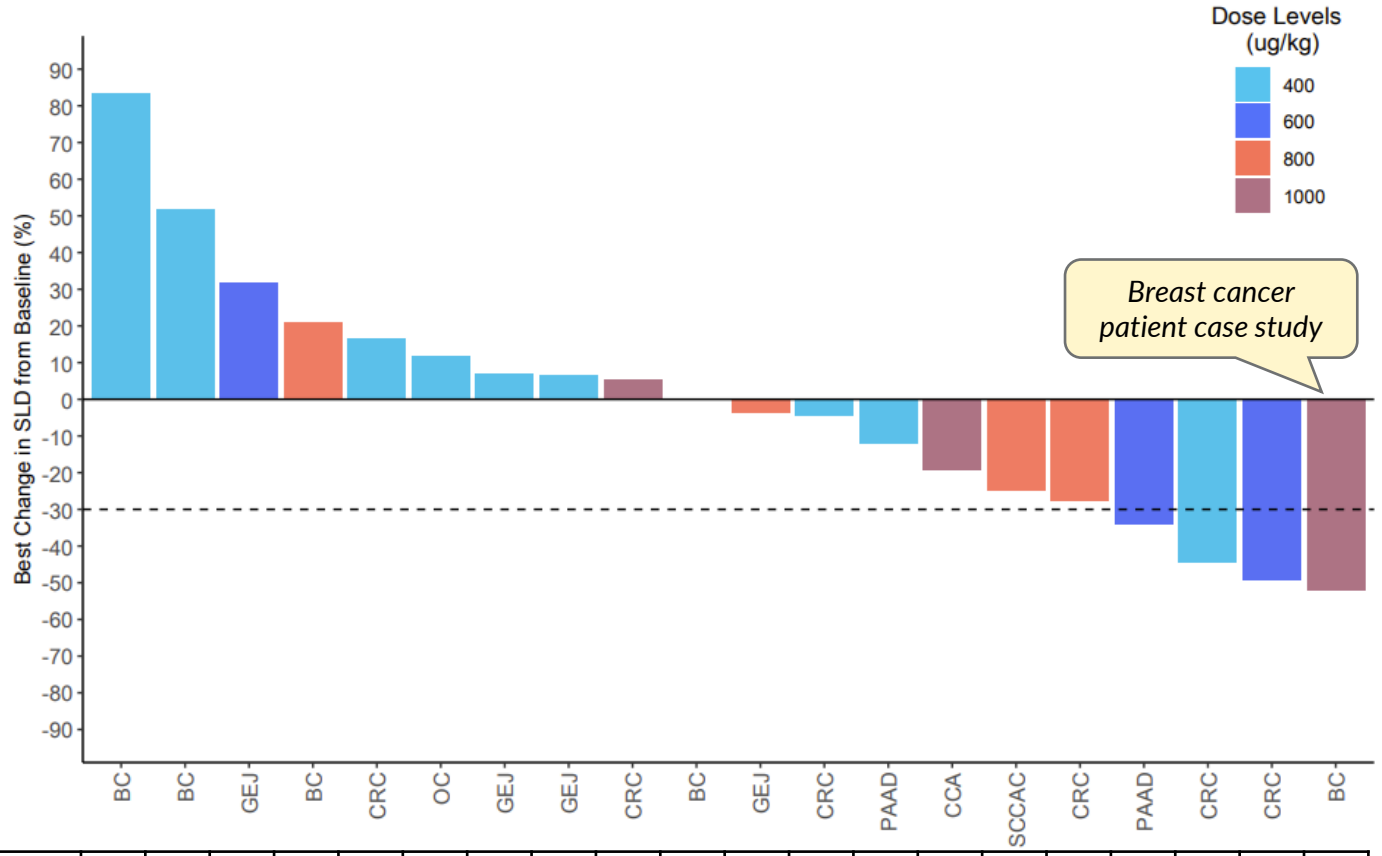
*Two cases of G3 pneumonitis include one event reversible with treatment and one confounded by rapid progression of pulmonary disease

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

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

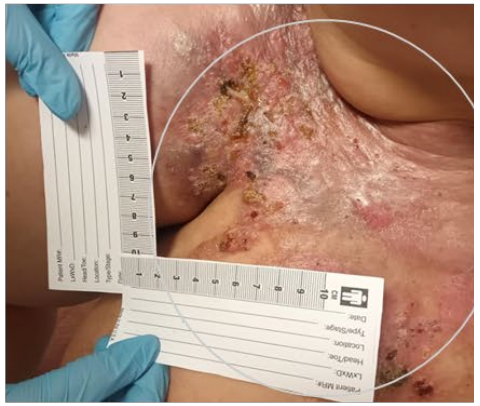
Study identifier: NCT05356741
Data cutoff: November 11, 2024
Note: HER2+ defined as IHC3+ or ISH+

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

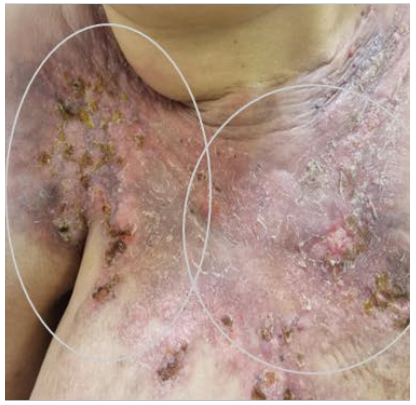
A patient's journey: dramatic response in advanced HER2+ breast cancer

Tumor pain, inflammation

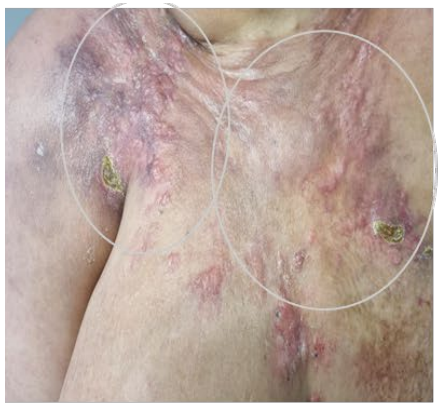
Day 1 Baseline



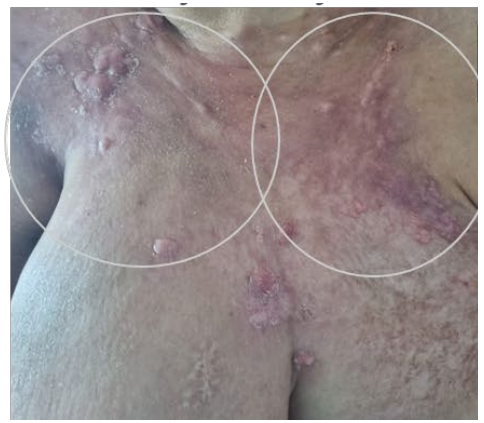
Cycle 1 Day 8



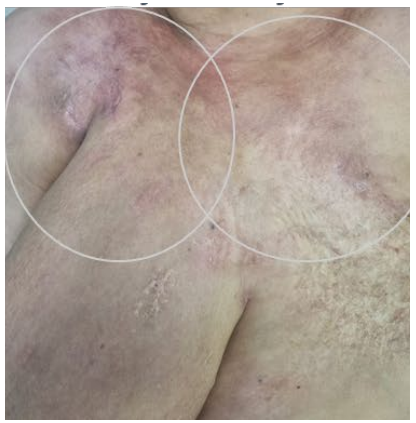
Cycle 2 Day 1



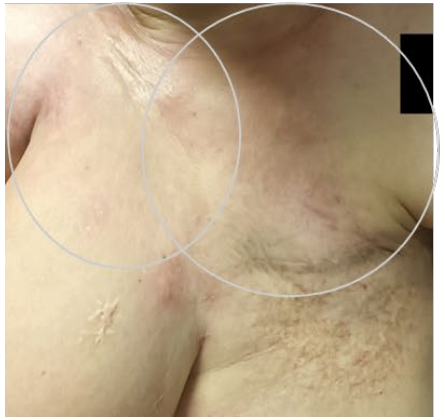
Cycle 2 Day 8



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

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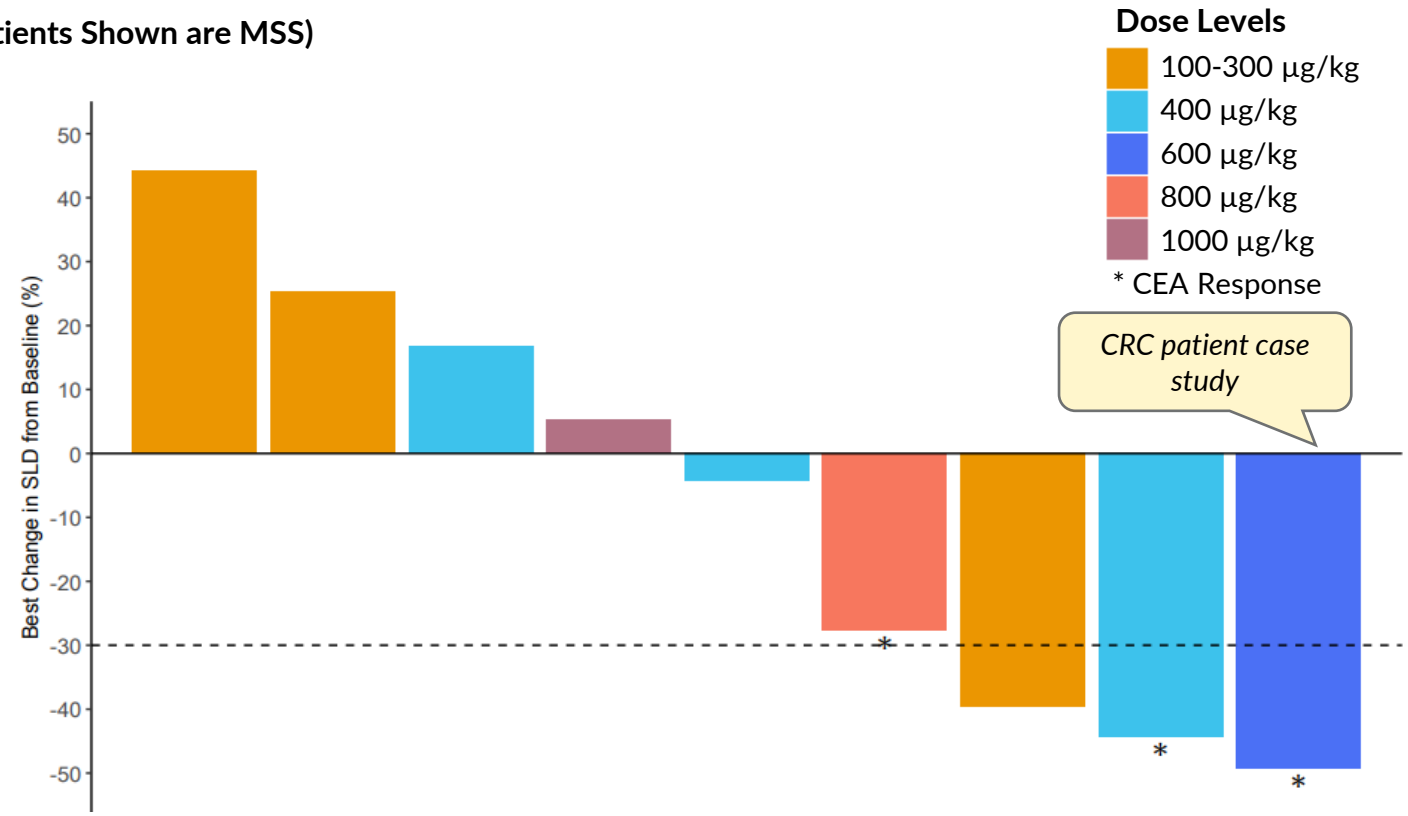
Study identifier: NCT05356741
Data cutoff: November 11, 2024

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

Deep responses at early doses in MSS colorectal cancer, a tumor type traditionally resistant to immunotherapy

HER2+ Colorectal Cancer

(All Patients Shown are MSS)



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

Early Phase 1 efficacy:

Activity	HER2+ CRC ≥400 µg/kg
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 (pt remains on study)
- Significant room to dose escalate; potential for Q3W dosing

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

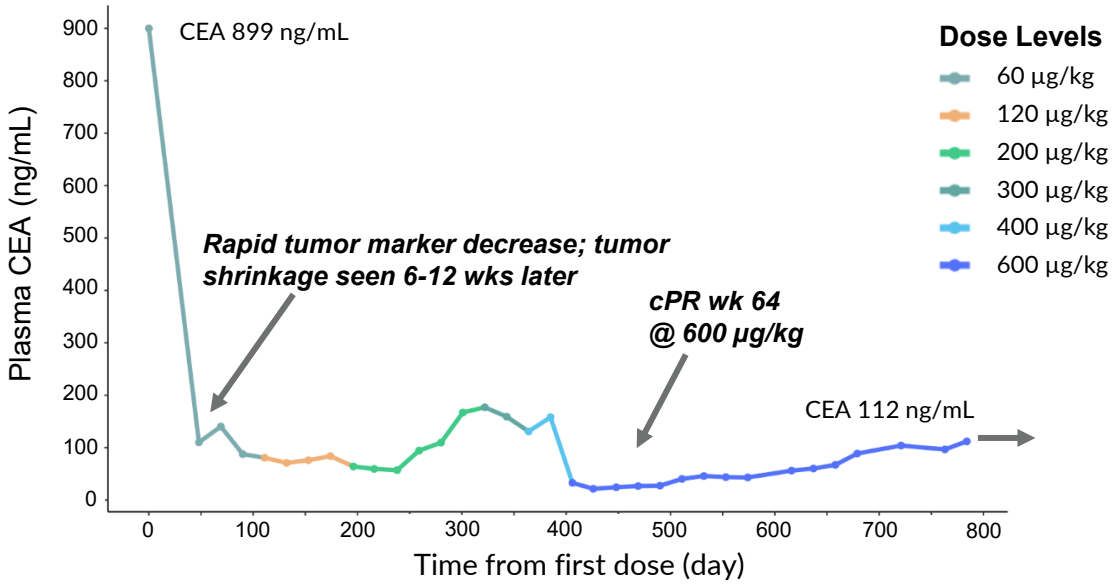
HER2: human epidermal growth factor receptor 2; SLD: sum of longest diameters; cPR: confirmed partial response; CEA: carcinoembryonic antigen; DCR: disease control rate; IHC: immunohistochemistry; ISH: in situ hybridization; MSS: microsatellite stability; CRC: colorectal cancer

* 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

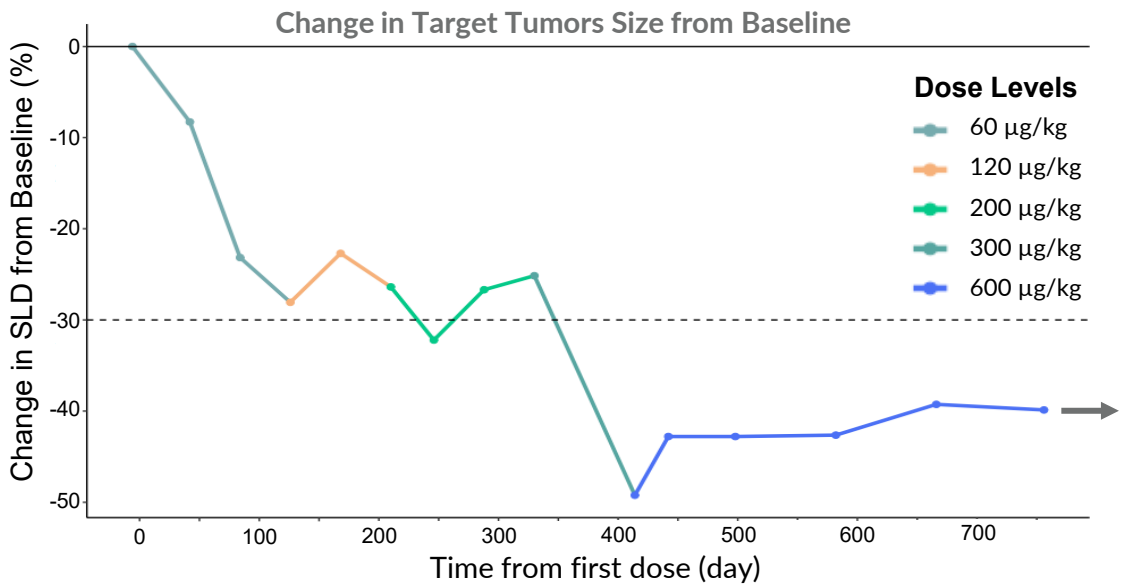
Patient Case Study: 2 years on treatment, exceptional durability

VIR-5818 (HER2)

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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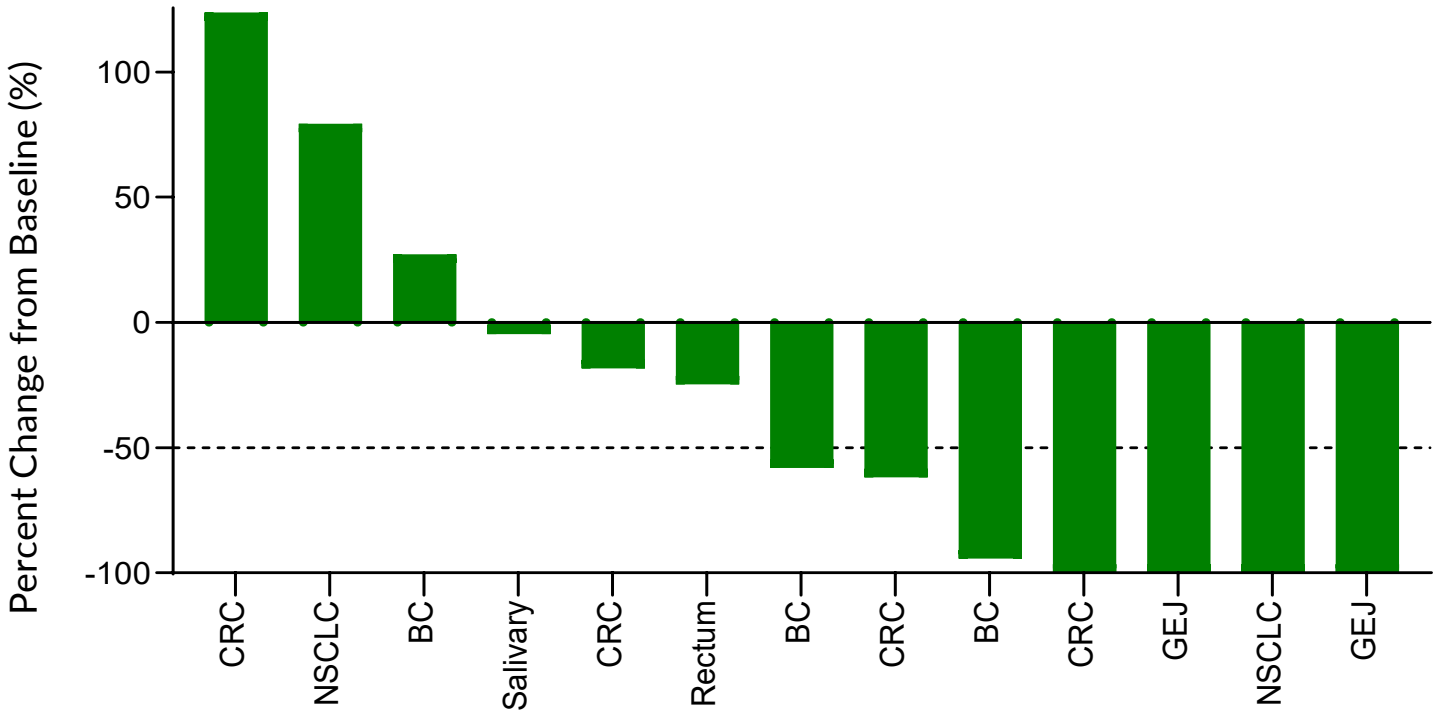
Study identifier: NCT05356741
Data cutoff: November 11, 2024

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

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

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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

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 (≥400 µg/kg)
- 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

Study identifier: NCT05356741
Data cutoff: November 11, 2024

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

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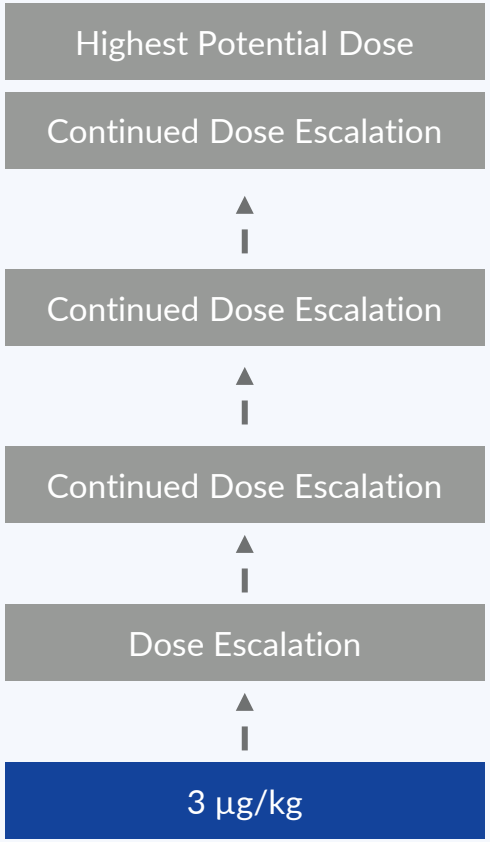
Phase 1 Clinical Program: VIR-5525 (EGFR)

Potential for Effective and Differentiated Targeting of EGFR Expressing Tumors

VIR-5525 Phase 1 study design: dose escalation and expansion

Part 1 & 2: Monotherapy Dose Escalation & Expansion



Indications:
NSCLC (nonsquamous or squamous histology), CRC, HNSCC, cSCC or have a solid tumor with EGFR amplification

Eligibility Criteria:
- ≥18 years old
- Histological, pathological, or cytological confirmation of disease type that is unresectable, locally advanced, or metastatic
- Progressed or was intolerant to all available therapies known to confer clinical benefit appropriate for the tumor type
- At least 1 measurable lesion per RECIST 1.1
- ECOG 0-1

Objectives:
Primary: safety, tolerability, RP2D
Secondary:
- PK, PD, ADA
- Radiographic response

Part 3 & 4: Pembrolizumab Combination Dose Escalation & Expansion

VIR-5525 + Pembrolizumab

Note: Step up dosing and additional schedules may be evaluated based on emerging clinical and PK data

Planned
Currently Evaluating
Cleared DLT

TCE: T-cell engager; NSCLC: non-small cell lung cancer; CRC: colorectal cancer; HNSCC: head and neck squamous cell carcinoma; cSCC: cutaneous squamous cell carcinoma; ECOG: Eastern Cooperative Oncology Group; PK: pharmacokinetics; PD: pharmacodynamics; ADA: anti-drug antibody; Rp2D: recommended phase 2 dose; RECIST: Response Evaluation Criteria In Solid Tumors

Potential to revolutionize treatment in EGFR-expressing cancers

High annual incidence and EGFR expression in key solid tumors

Initial indications

Tumor type	U.S. incidence	E.U. incidence	EGFR expression (%)
NSCLC	199,400	406,900	80–85%
CRC	153,000	521,500	70–82%
HNSCC	71,000	151,700	>90% (HPV-)
Advanced cSCC	10,000 - 15,000	~15,000	70–90%
Pancreatic	66,000	140,000	40–70%
Gastric/GEJ	26,000	69,600	30–60%
ESCC	19,000	53,000	40–70%

Poor survival in advanced EGFR-expressing tumors

No currently approved antibodies directly engage T-cell killing in their mechanism of action

3%-38% 5-year survival rate for metastatic patients with frequently EGFR-expressing tumors

(American Cancer Society. Cancer Facts & Figures 2024.)

	2L–3L NSCLC	2L–3L HNSCC	3L+ CRC
mPFS (months)	2–4	2–3	~2–3
mOS (months)	7–10	6–8	6–7

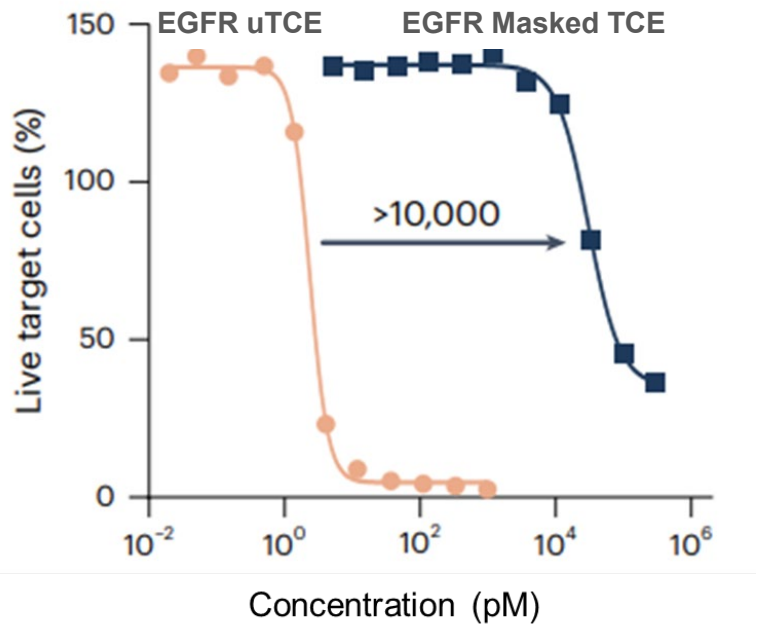
NSCLC, non-small cell lung cancer; CRC, colorectal cancer; HNSCC, head and neck squamous cell carcinoma; cSCC, cutaneous squamous cell carcinoma; Gastric/GEJ, gastric and gastroesophageal junction cancer; Pancreatic, pancreatic cancer; ESCC, esophageal squamous cell carcinoma; mPFS, median progression-free survival; mOS, median overall survival

Incidence: SEER (NCI), GLOBOCAN 2022 (IARC), American Cancer Society, ECIS (European Commission).
EGFR expression: Hirsch FR et al., J Clin Oncol 2003; Spano JP et al., Ann Oncol 2005; Grandis JR et al., Cancer Res 1993; Maubec E et al., J Clin Oncol 2011; Shinozaki E et al., BMC Cancer 2022; Furness AJ et al., Ann Oncol 2008; Stratigos AJ et al., Eur J Cancer 2020
Late-line median PFS and OS:NSCLC: Brahmer J et al., N Engl J Med 2015; Paz-Ares L et al., Lancet 2019. HNSCC: Ferris RL et al., N Engl J Med 2016; Cohen EE et al., Lancet 2015. CRC: Grothey A et al., N Engl J Med 2013; Li J et al., J Clin Oncol 2018

Preclinical data demonstrate potent activity and substantial safety margin with PRO-XTEN® masking

Outside Tumor: masking is maintained, leading to ~10,000-fold shift in cytotoxicity

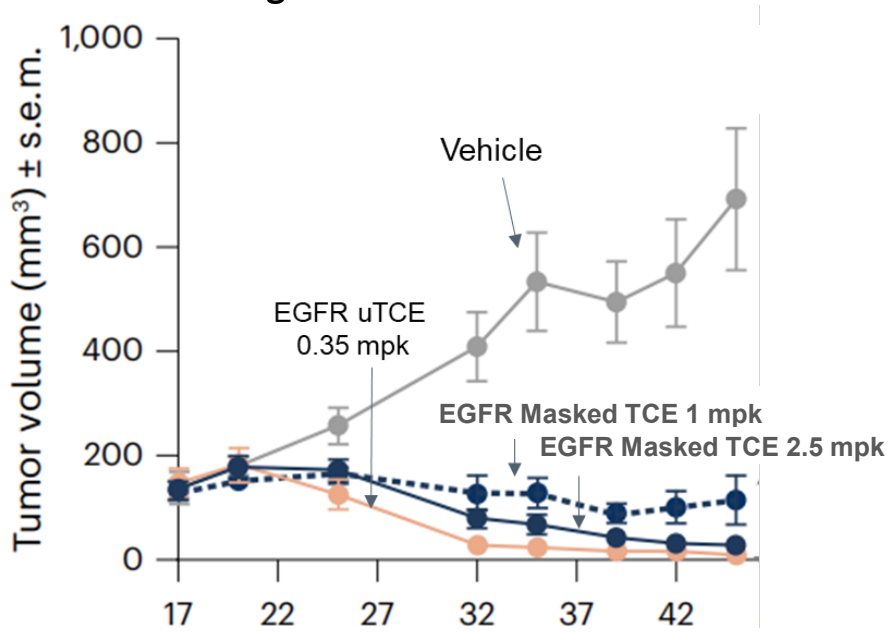
Anti-tumor activity in vitro



EGFR uTCE: EGFR-targeted unmasked T-cell engager

In Tumor: similar anti-tumor activity in PRO-XTEN® masked vs. unmasked EGFR TCE

Tumor growth inhibition in vivo



mpk: milligrams per kilogram

PRO-XTEN® masked EGFR TCE enabled ~250-fold higher tolerated exposure in NHPs vs. unmasked TCE

Source: Adapted from Cattaruzza, F., Nazeer, A., Lange, Z., Hammond, M., Koski, C., Henkensiefken, A., & Schellenberger, V. (2020). HER2-XPAT and EGFR-XPAT: Pro-drug T-cell engagers (TCEs) engineered to address on-target, o ff-tumor toxicity with potent efficacy in vitro and in vivo and large safety margins in NHP. Cancer Research, 80(16_Supplement), 3376-3376.
Cattaruzza, F., Nazeer, A., To, M. et al. Precision-activated T-cell engagers targeting HER2 or EGFR and CD3 mitigate on-target, off-tumor toxicity for immunotherapy in solid tumors. Nat Cancer 4, 485–501 (2023). https://doi.org/10.1038/s43018-023-00536-9. ~250-fold safety margin data from IND filing analysis (>200-fold reported in Nature paper).

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Financials and closing

Q3 2025 Financial Results

$ in millions	Three Months Ended September 30, 2025	2024	Change	%
Total revenues	**$0.2**	**$2.4**	**$(2.2)**	**(92%)**
Operating expenses:				
Cost of revenue	—	0.1	(0.1)	(100%)
Research and development[(1)]	151.5	195.2	(43.7)	(22%)
Selling, general and administrative[(1)]	22.2	25.7	(3.5)	(14%)
Restructuring, long-lived assets Impairment and related charges, net	—	12.7	(12.7)	(100%)
Total operating expenses	**173.7**	**233.7**	**(60.0)**	**(26%)**
Loss from operations	(173.4)	(231.3)	57.9	25%
Total other income	10.5	17.8	(7.3)	(41%)
Provision for income taxes	(0.2)	(0.2)	—	—
Net loss	**$(163.1)**	**$(213.7)**	**$50.6**	**24%**
[(1)] Amount includes stock-based compensation expenses as follows:				
Research and development	$5.5	$8.9	$(3.4)	(38%)
Selling, general and administrative	5.8	7.8	(2.0)	(26%)
Total stock-based compensation expense	**$11.4**	**$16.7**	**$(5.3)**	**(32%)**

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Note: Numbers may not add due to rounding.

Clinical execution underpinned by strict financial discipline, enabling runway into mid-2027 & through multiple catalysts

Financial Highlights

Cash runway into

mid-2027

$810.7 million

cash and investments [1]

Clinical Programs

Hepatitis Delta

- ECLIPSE 1 fully enrolled
- ECLIPSE 2 and 3 enrolling well
- Topline data expected Q1'27

Dual-Masked TCEs

- VIR-5500 (PSMA) data update Q1'26
- VIR-5818 (HER2)
- VIR-5525 (EGFR)

Pre-clinical Programs

- HIV Cure
- Undisclosed PRO-XTEN® TCE targets

[1] Represents cash, cash equivalents and investments as of September 30, 2025

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

PATIENTS ARE WAITING

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