Corporate Overview Presentation

February 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 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 Principales; 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 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 artificial intelligence 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 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.

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:

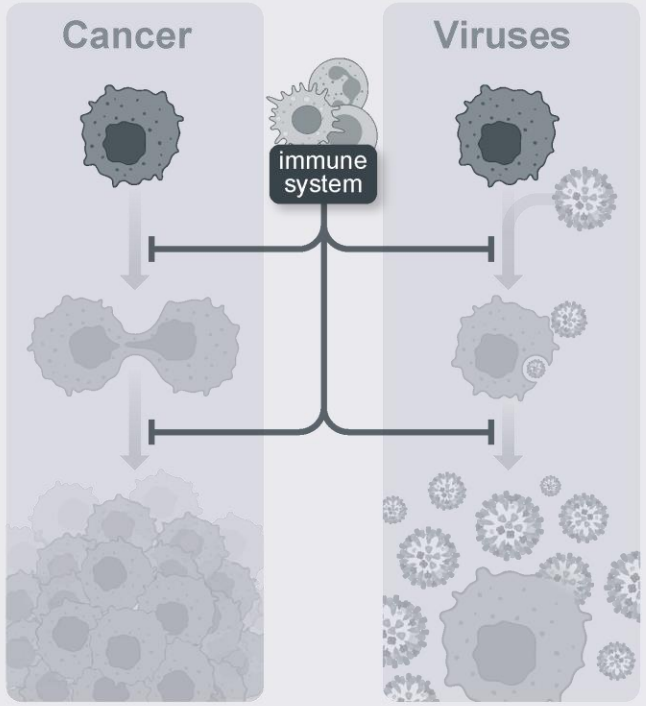
Powering The Immune System To Transform Lives

Vir Biotechnology™

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

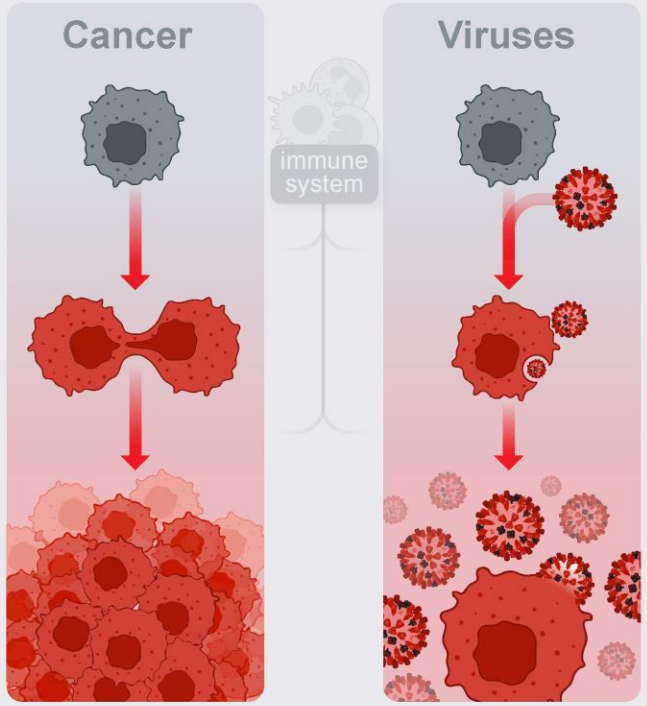
The immune system is powerful…

Protecting us from cancer cells and viruses in normal conditions



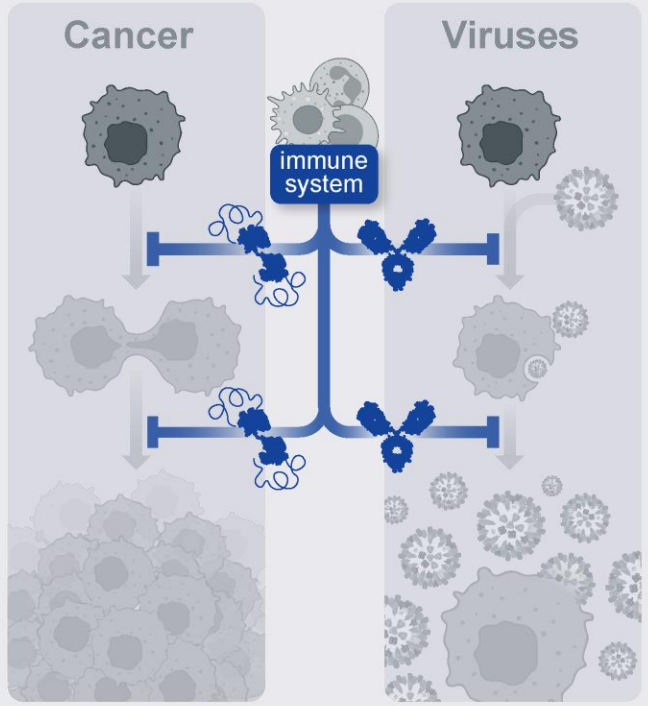
…but sometimes it can be bypassed

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



5 clinical programs across 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

Infectious Disease

Hepatitis Delta (Initiating Phase 3)	Chronic Hepatitis B (Phase 2)
Chronic suppressive treatment	Pursuing functional cure Further HBV advancement contingent on securing a worldwide development and commercialization partner[1]

Focused capital deployment: $1.1 billion cash and investments[2], cash runway into mid-2027

[1]Outside of Greater China (China, Hong Kong, Taiwan, Macau) where Brii Biosciences retains rights [2] Represents cash, cash equivalents, and investments as of December 31, 2024

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

We are well positioned for near-term value creation in oncology and infectious disease

siRNA Antibody Masked TCE

Disease Area	Product Candidate	Goal	Pre-clinical	Phase 1	Phase 2	Phase 3	Approval
Accelerate and Invest							
Chronic Hepatitis Delta	tobevibart ± elebsiran	Treatment					
Solid Tumors	VIR-5818 (HER2)[1] ± pembrolizumab	Treatment					
Solid Tumors	VIR-5500 (PSMA)[1]	Treatment					
Solid Tumors	VIR-5525 (EGFR)[1]	Treatment					
Partnership Programs							
Chronic Hepatitis B	tobevibart + elebsiran ± PEG-IFN-α[2]	Functional Cure					
HIV Cure[3]	Preclinical antibody candidates	Treatment					
Solid Tumors	Undisclosed PRO-XTEN™ TCE targets	Treatment					

1: Masked TCEs licensed from Sanofi
2: MARCH study (Part B)
3: In collaboration with the Bill & Melinda Gates Foundation

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HIV: Human Immunodeficiency Virus; 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. Tobevibart incorporates Xencor's Xtend™ and other Fc technologies.
PRO-XTEN™ is a trademark of Amunix Pharmaceuticals, Inc., a Sanofi company

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Chronic Hepatitis Delta

Potentially Transformative Chronic Treatment

In infectious disease, we target Hepatitis Delta, which 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]

~100,000

US Patients[4]

~200,000

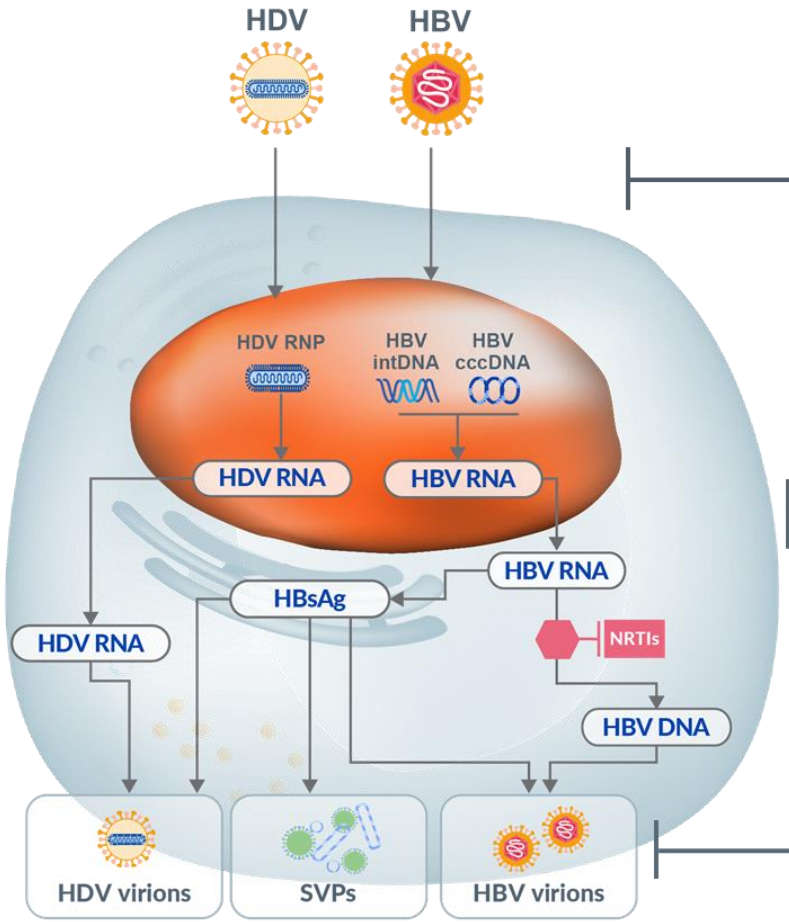
EU Patients[4]

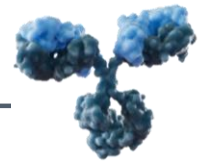
~12M

Patients WW[4]

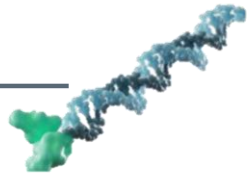
1.Negro F. (2023). Hepatitis D: A Review. *JAMA*. 330(24):2376–2387; 2. Pan C, (2023) . Diagnosis and Management of Hepatitis Delta Virus Infection. Dig Dis Sci. Aug;68(8):3237-3248; 3. Sagnelli C, et al. (2021) HBV/HDV Co-Infection: Epidemiological and Clinical Changes, Recent Knowledge and Future Challenges. 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.

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

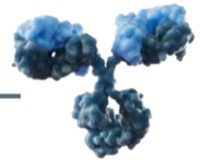




Inhibition of viral entry **(tobevibart)**



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

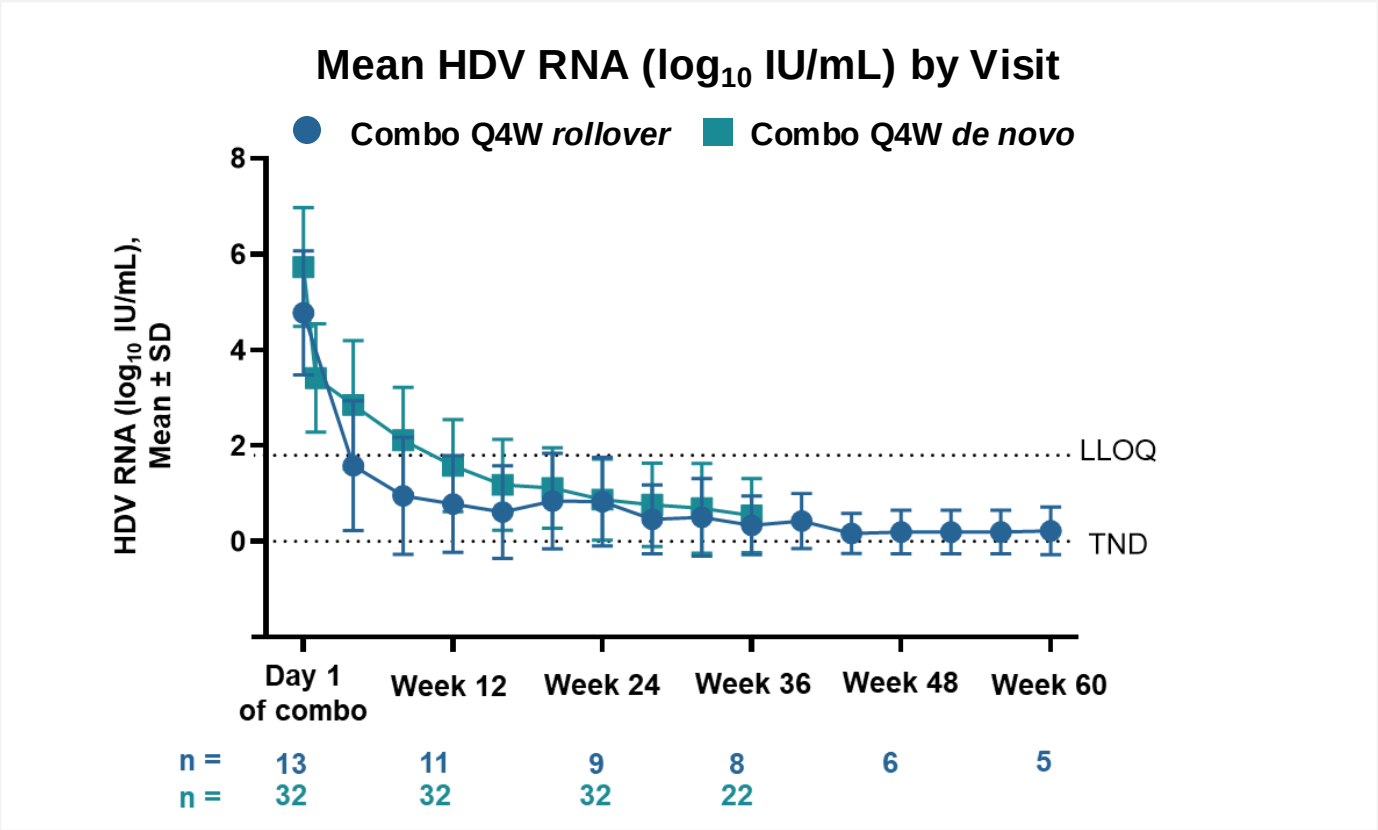
Elebsiran

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

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

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

Rapid and sustained HDV RNA suppression with tobevibart + elebsiran combination



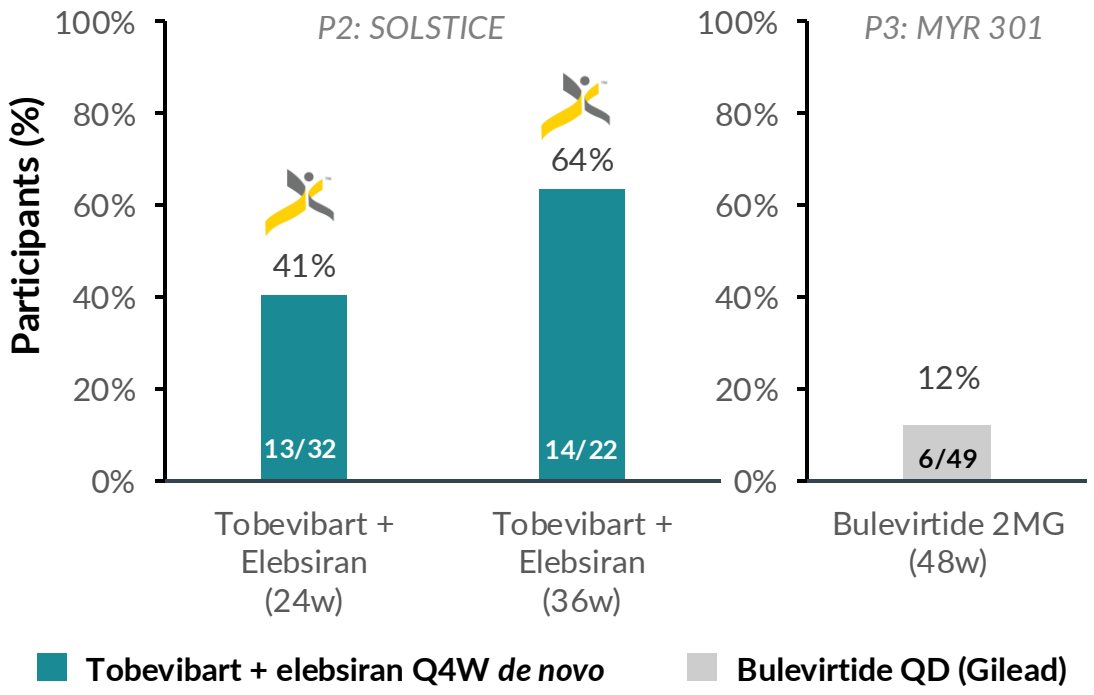
HDV RNA levels decreased rapidly in the tobevibart + elebsiran combination Q4W cohorts and these decreases were maintained over time

Study identifier: NCT05461170

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

Tobevibart + elebsiran combo has shown transformative virological responses in HDV in our ongoing 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. **Continued deepening of response over time**
3. **Lowers HBsAg levels, limiting HDV replication**
4. **Similar efficacy in cirrhotic patients**

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.

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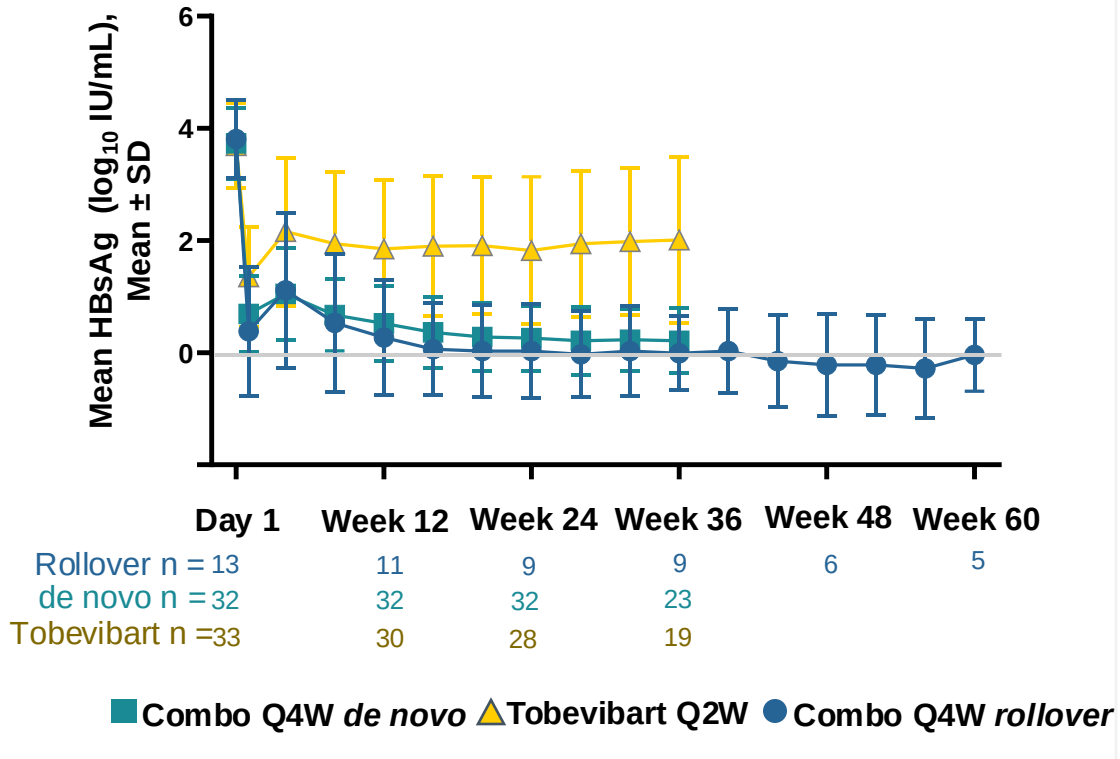
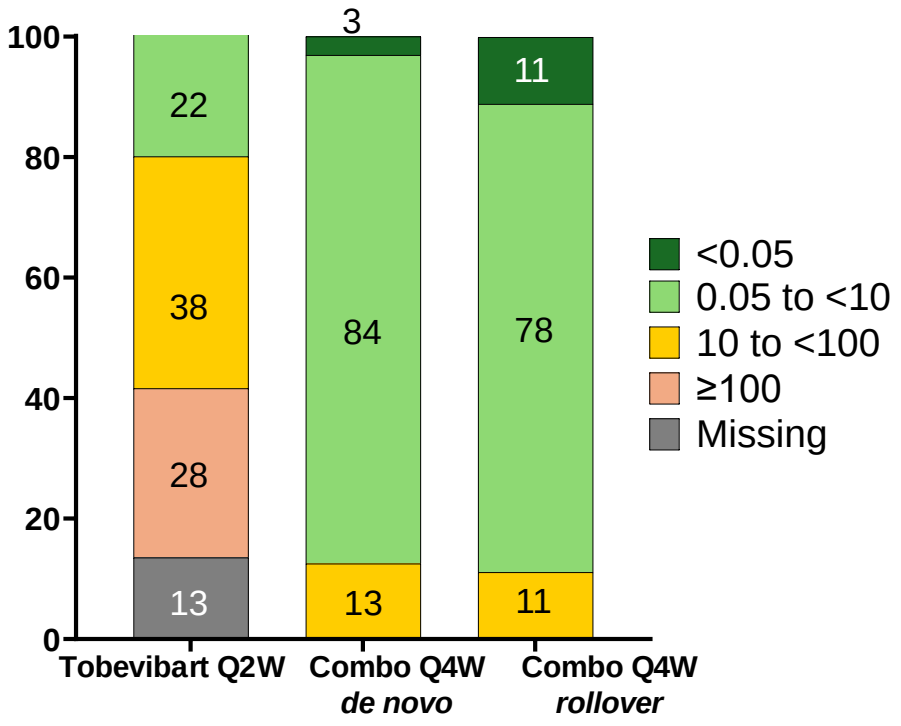
*FOR ILLUSTRATIVE PURPOSES ONLY: No head-to-head trials have been conducted. Cross-trial comparisons may not be reliable due to differences in study design, patient populations, and other factors. See individual study publications for complete data and context.

Study identifier: NCT05461170

Combination of tobevibart + elebsiran markedly outperforms monoclonal antibody monotherapy in HBsAg reduction at Week 24





90% of participants receiving tobevibart + elebsiran achieved HBsAg <10 IU/mL, compared to only 22% with tobevibart monotherapy Q2W at Week 24

Study identifier: NCT05461170

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

Majority of adverse events were Grade 1-2 & transient, no Grade 2 or higher ALT elevations have occurred to date

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

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

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

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Study identifier: NCT05461170

We aim to establish a new standard of care in HDV, and ECLIPSE registrational clinical trials begin in H1 2025

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)

ECLIPSE 2 – Phase 3

HDV RNA LLOQ, TND at week 24

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

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

ECLIPSE 3 – Phase 2b

HDV RNA LLOQ, TND at week 48

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

Study supporting ex-U.S. 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)

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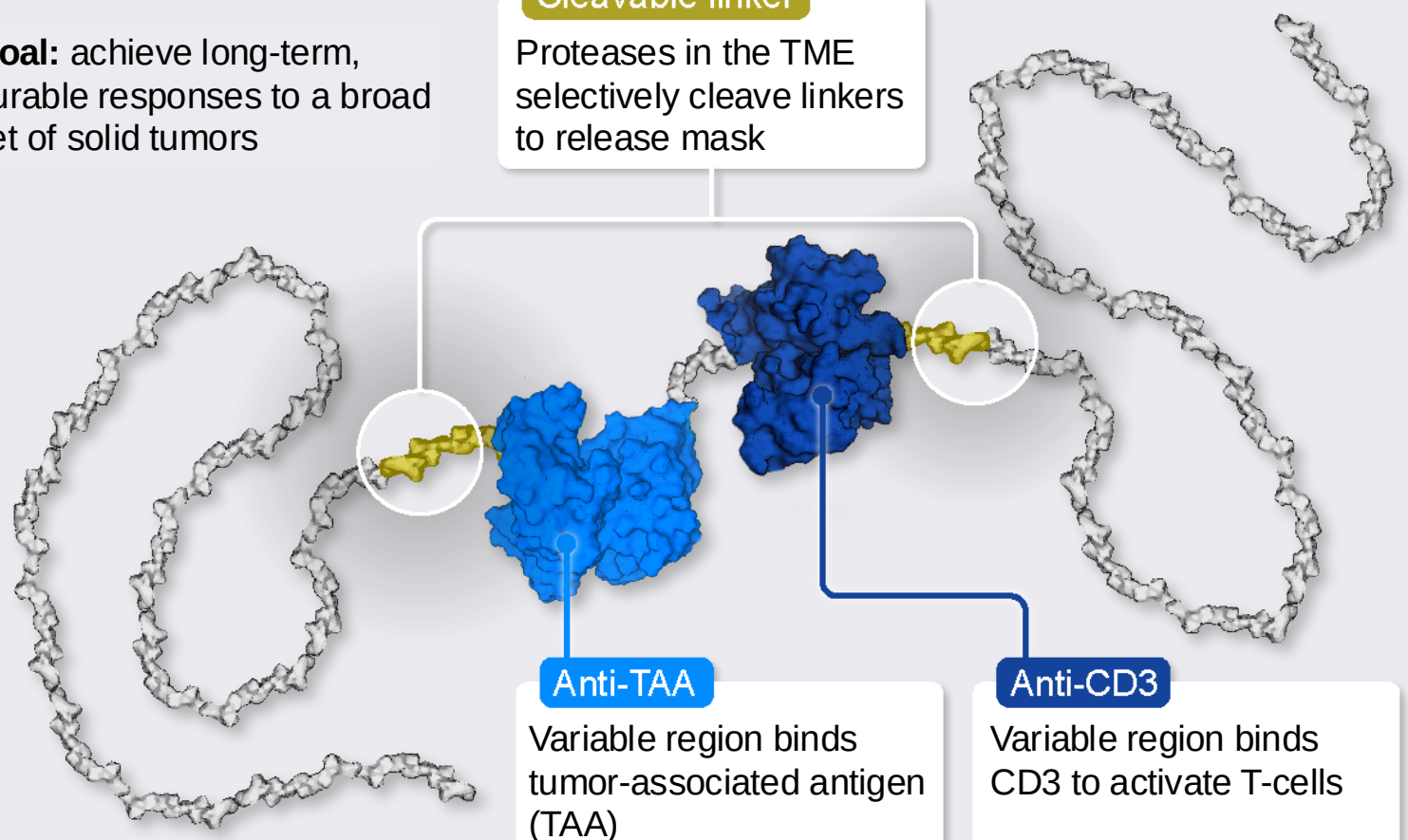
PRO-XTEN™ Dual-Masked TCE Platform

Potential to Overcome the Challenges of Unmasked TCEs

In oncology, PRO-XTEN™ masked TCEs have potential 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



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**

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

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

PRO-XTEN™ Masked TCEs

VIR-5818 (HER2xCD3): 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-5500 (PSMAxCD3): 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

Pipeline and Platform

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

- Planned Phase 1 start in H1 2025

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

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

Note: detailed clinical data shared during Jan 8th investor event
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
PRO-XTEN™ is a trademark of Amunix Pharmaceuticals, Inc., a Sanofi company

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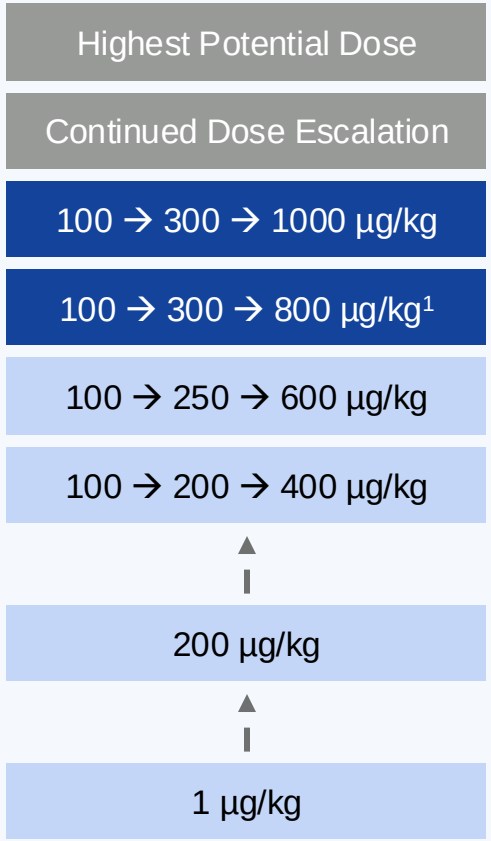
Phase 1 Clinical Data: VIR-5818 (HER2)

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

The first clinical stage masked HER2 TCE in ongoing Phase 1 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

Planned

Currently Evaluating

Cleared DLT

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Study identifier: NCT05356741
Data cutoff: November 11, 2024

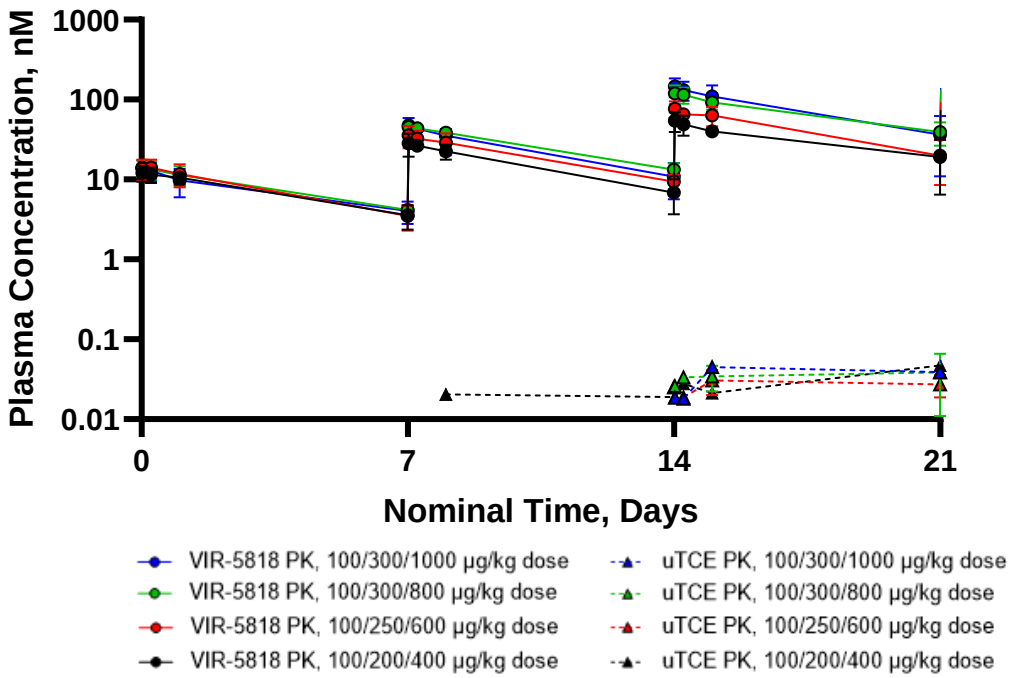
[1]Evaluating 800 µg/kg Q3W maintenance dose (cycle ≥ 2) in parallel

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

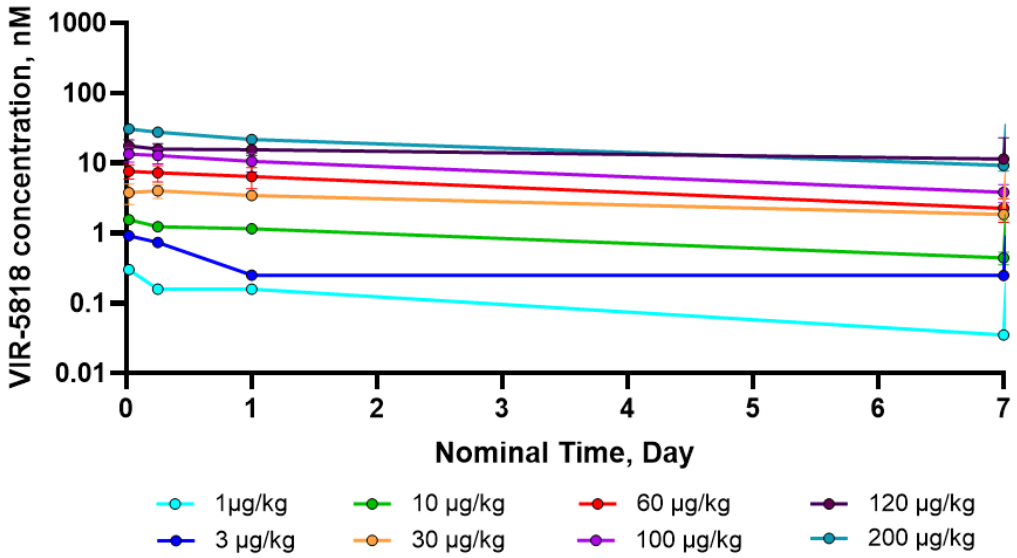
VIR-5818 and uTCE PK, First Cycle*



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

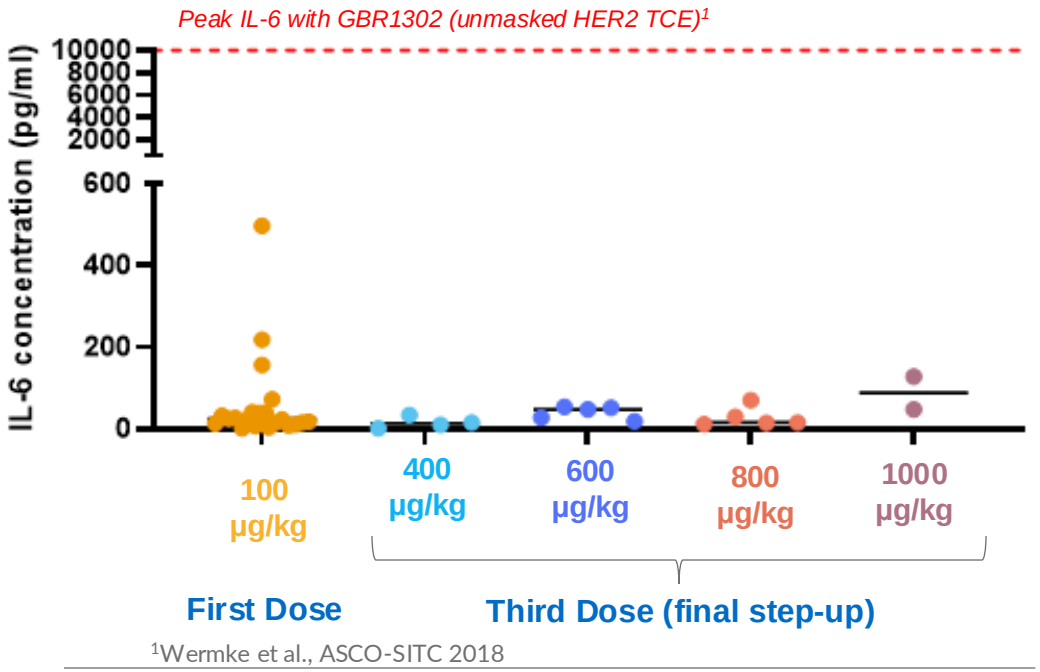
Highly Tolerable Safety

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

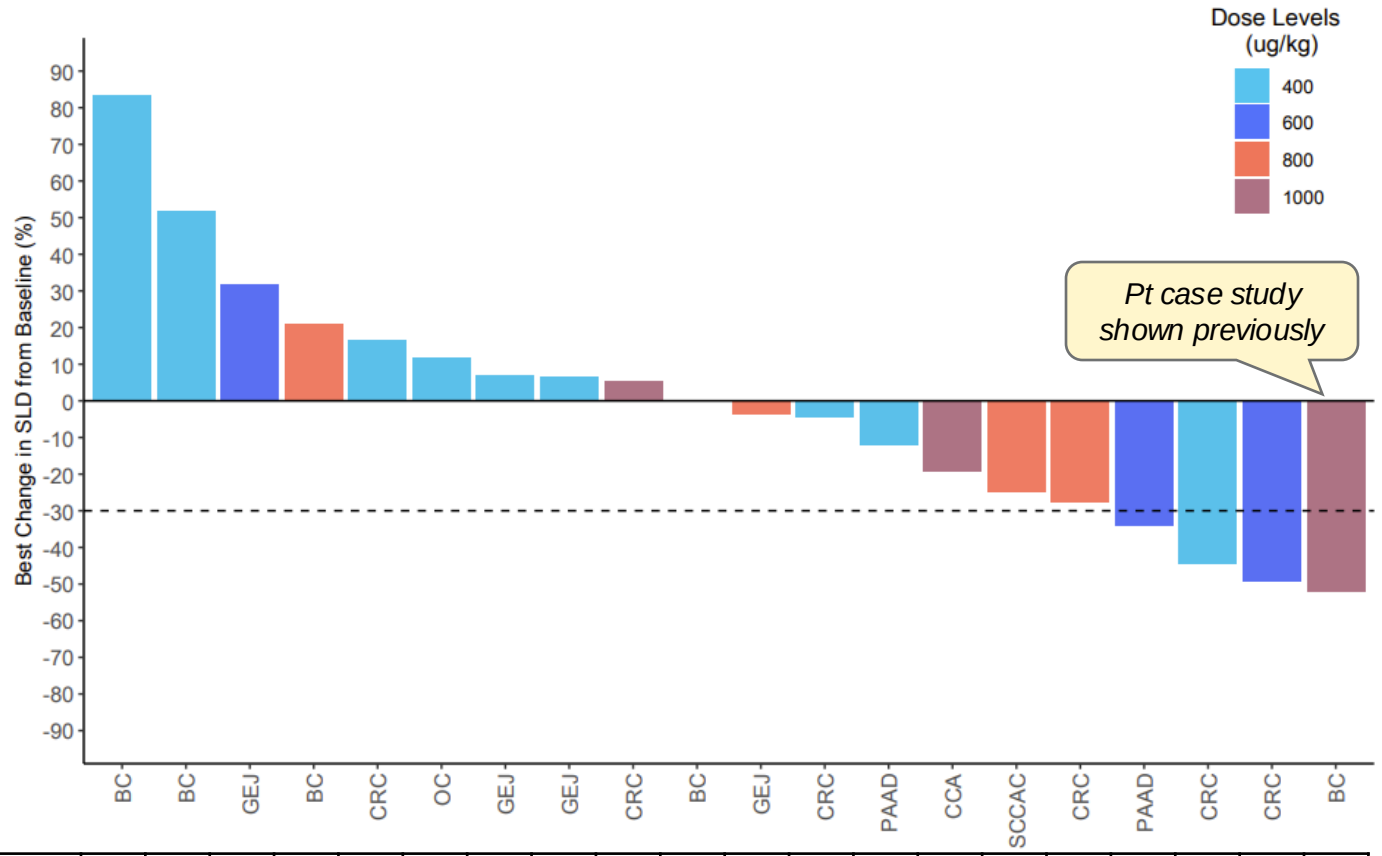
*Two cases of G3 pneumonitis include one event reversible with treatment and one confounded by rapid progression of pulmonary disease

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

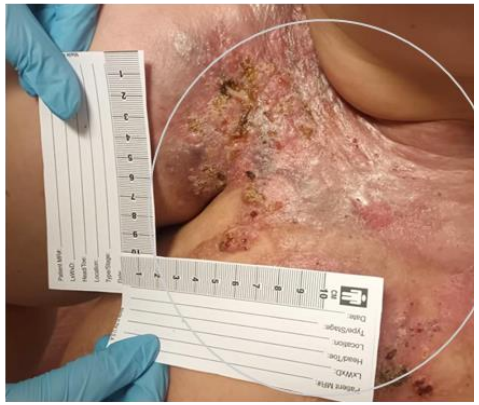
Study identifier: NCT05356741
Data cutoff: November 11, 2024
Note: HER2+ defined as IHC3+ or ISH+

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

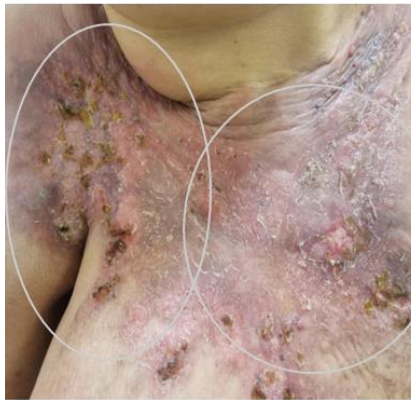
A patient's journey: dramatic response in advanced HER2+ breast cancer

Tumor pain, inflammation

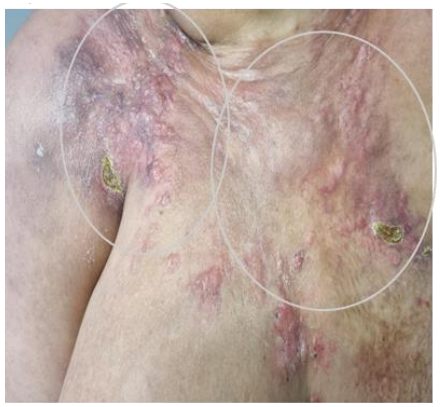
Day 1 Baseline



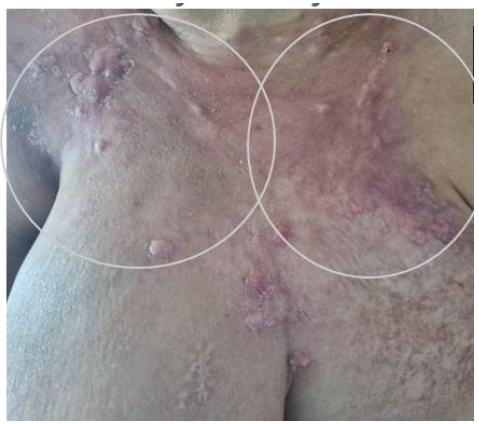
Cycle 1 Day 8



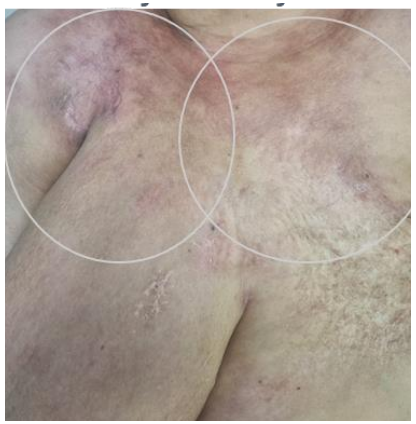
Cycle 2 Day 1



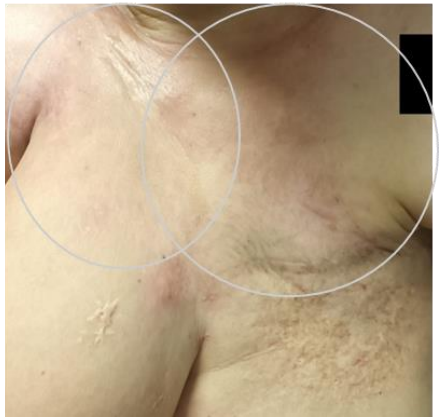
Cycle 2 Day 8



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

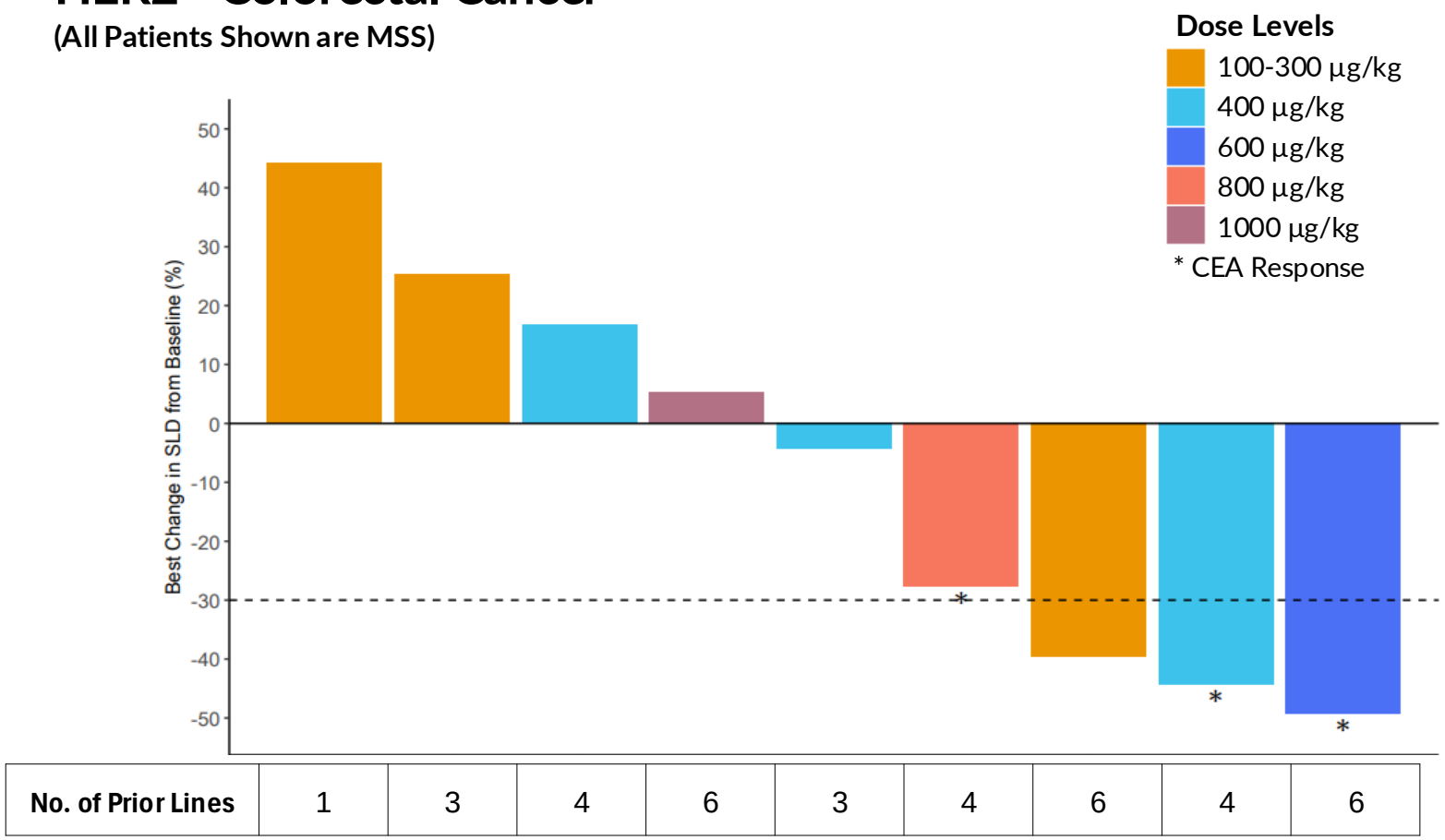
Study identifier: NCT05356741 data cutoff: November 11, 2024

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

Deep responses at early doses in mCRC and other HER2 tumors

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+

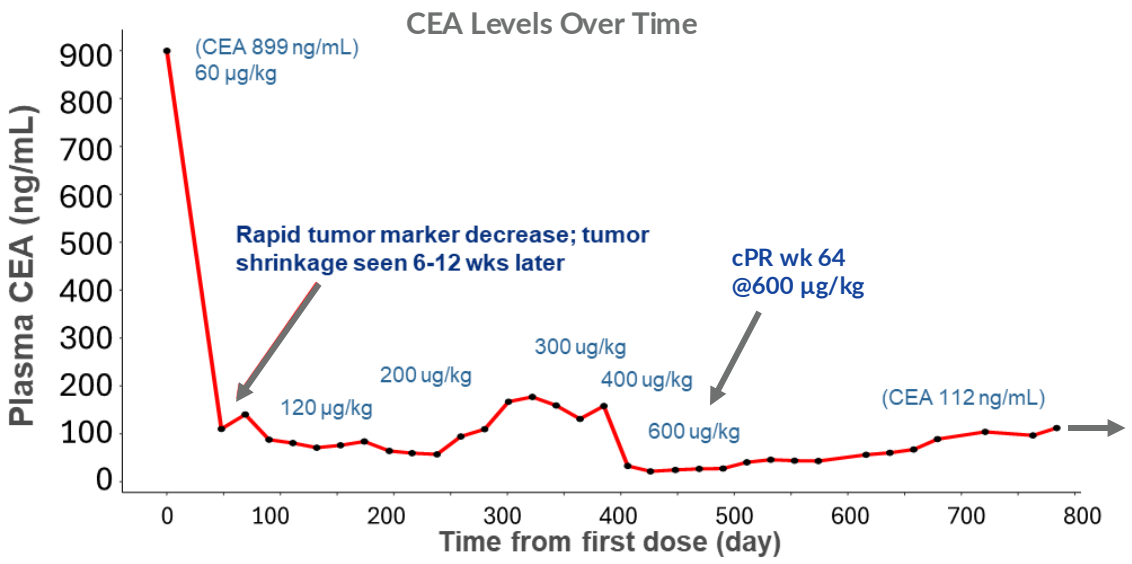
HER2: human epidermal growth factor receptor 2; SLD: sum of longest diameters; cPR: confirmed partial response; CEA: carcinoembryonic antigen; DCR: disease control rate; IHC: Immunohistochemistry; ISH: In situ hybridization; MSS: microsatellite stability; CRC: colorectal cancer

* 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

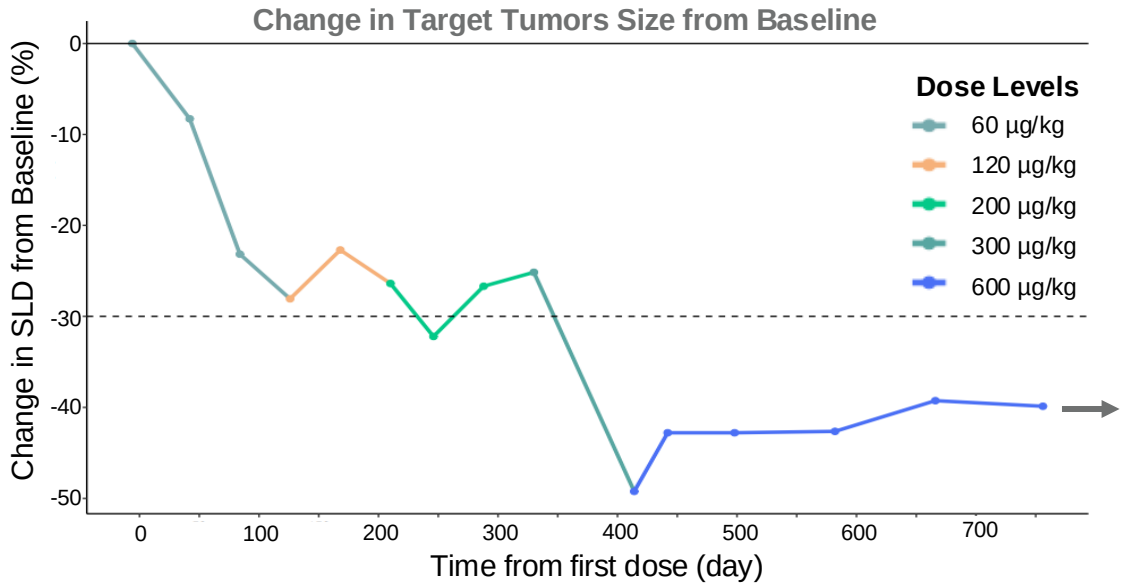
Patient Case Study: 2 years on treatment, exceptional durability

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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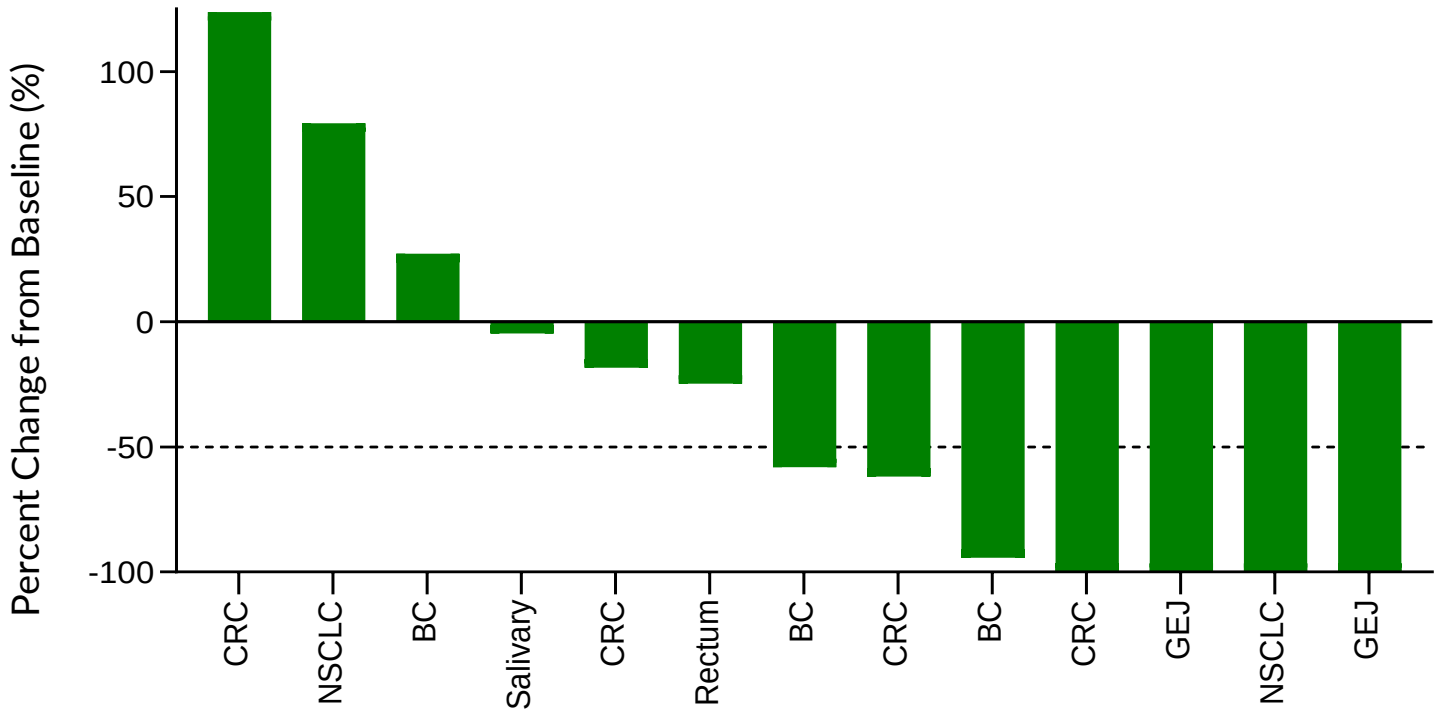
Study identifier: NCT05356741
Data cutoff: November 11, 2024

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

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 (≥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

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

Vir Biotechnology™

PRO-XTEN™ is a trademark of Amunix Pharmaceuticals, Inc., a Sanofi company.
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 Data: VIR-5500 (PSMA)

Potential Best-in-Class Profile in Prostate Cancer

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™

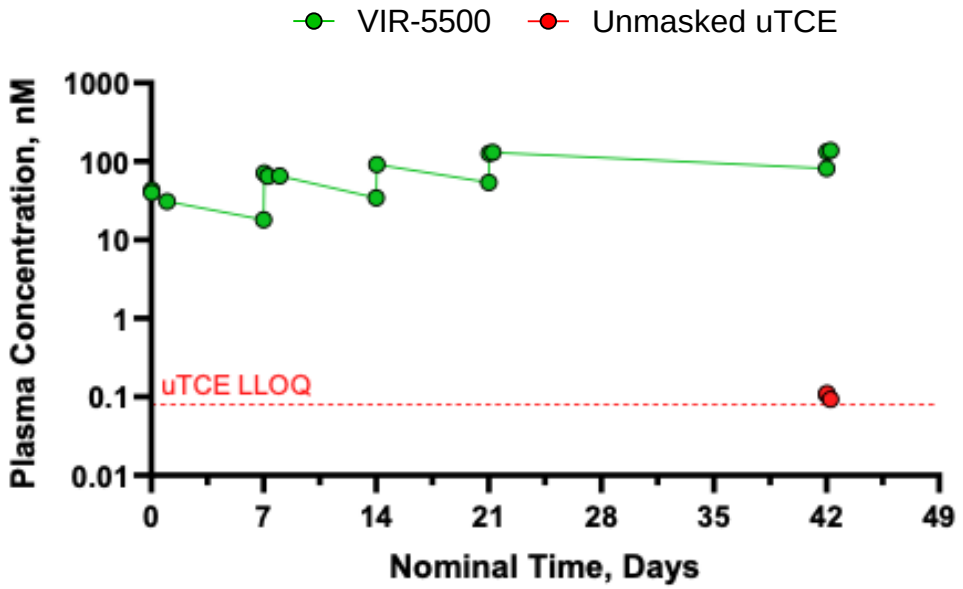
Study identifier: NCT05356741
Data cutoff: November 11, 2024

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

Minimal systemic unmasking and potential for Q3W dosing

Minimal unmasked TCE outside the tumor

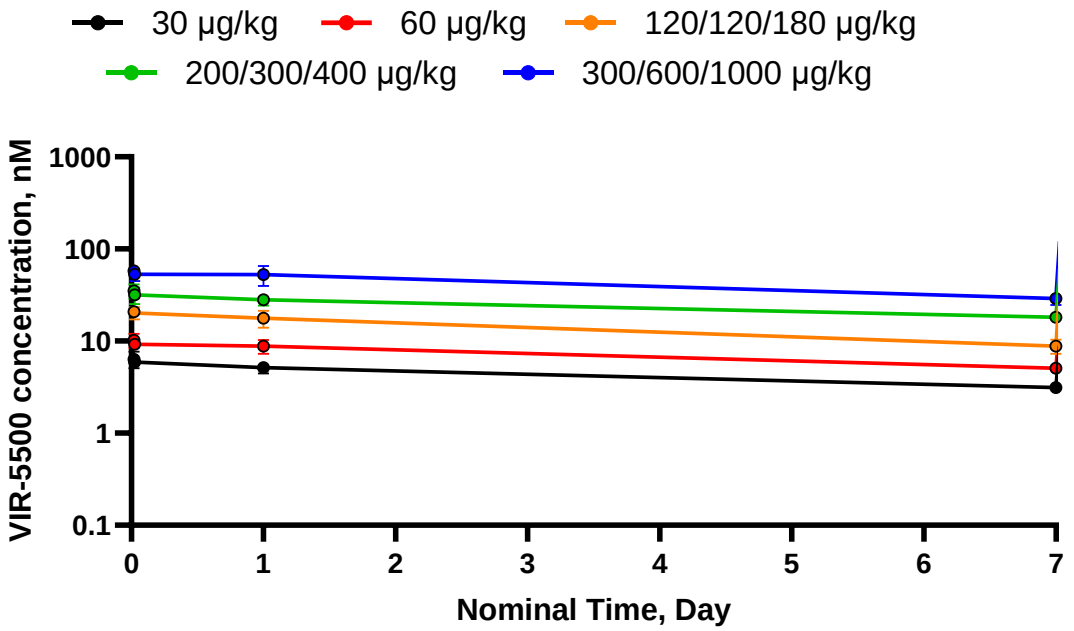
Only one VIR-5500 patient with detectable unmasked TCE (Dose: 200/300/400 µg/kg)



- 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: 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

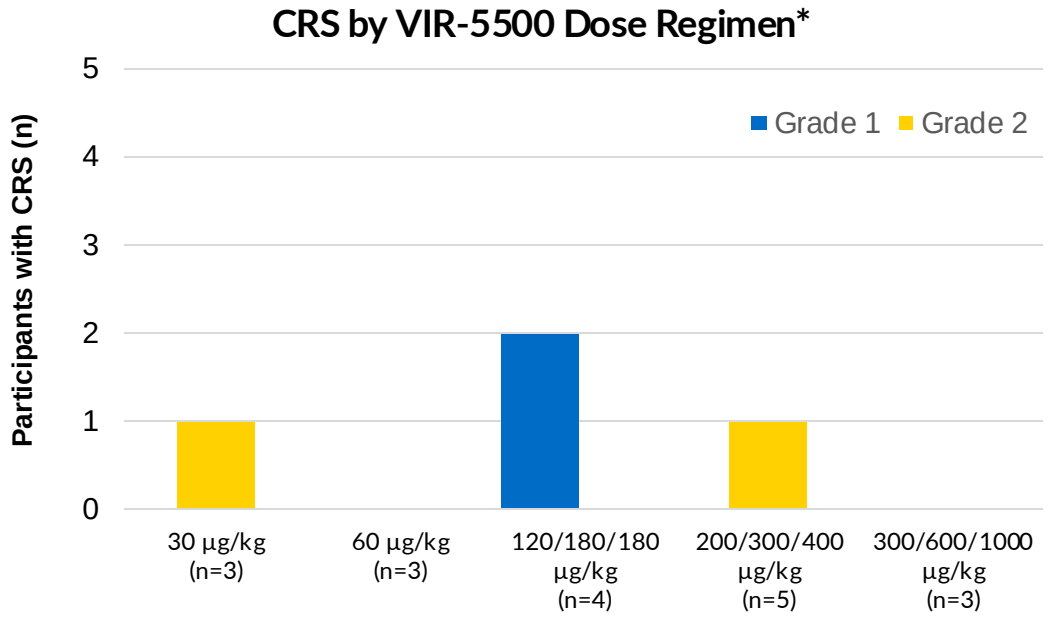
Well tolerated without prophylactic corticosteroids or anti-IL-6 premedication in early Phase 1 testing

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

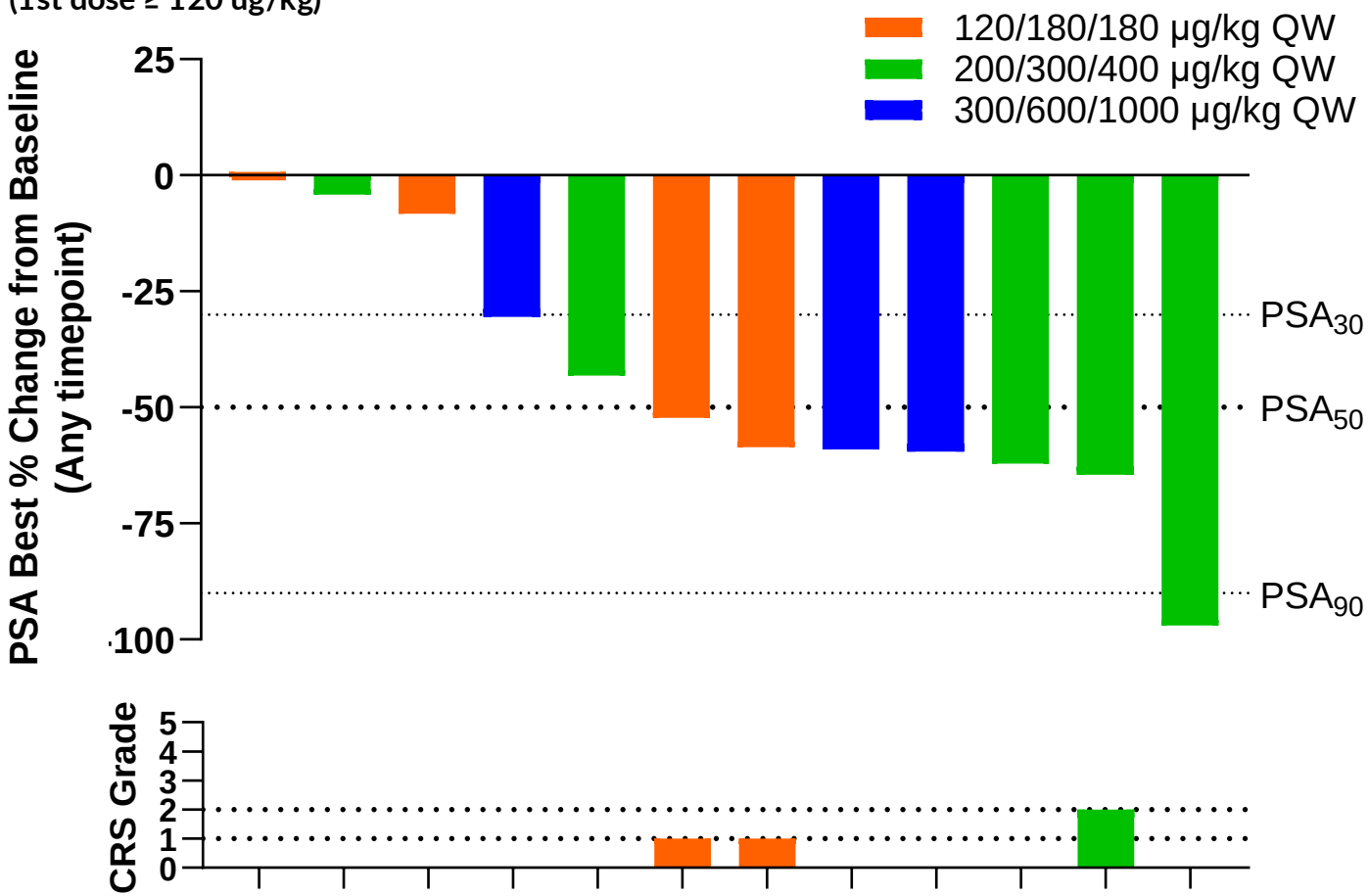
Vir Biotechnology™

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

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

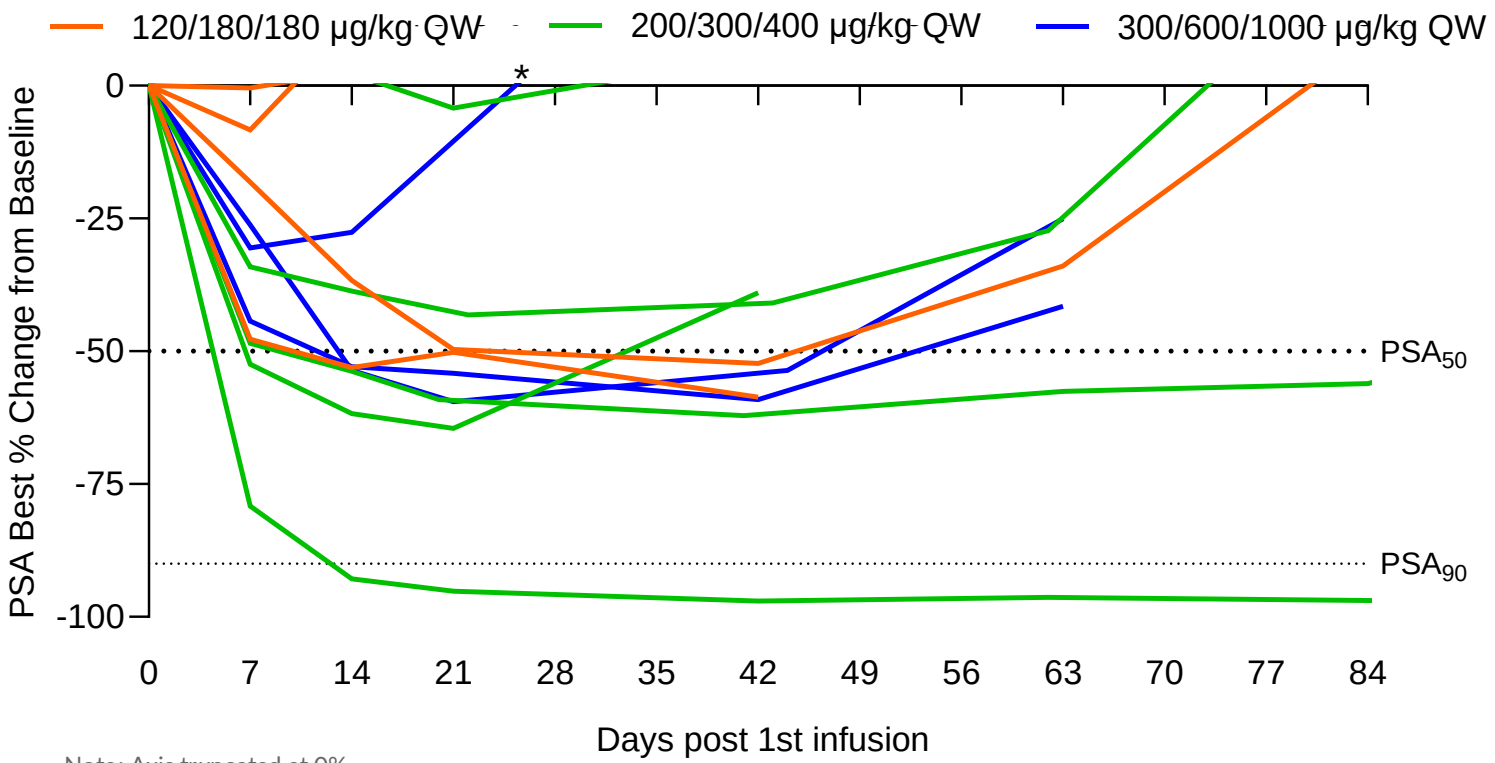
Vir Biotechnology™

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

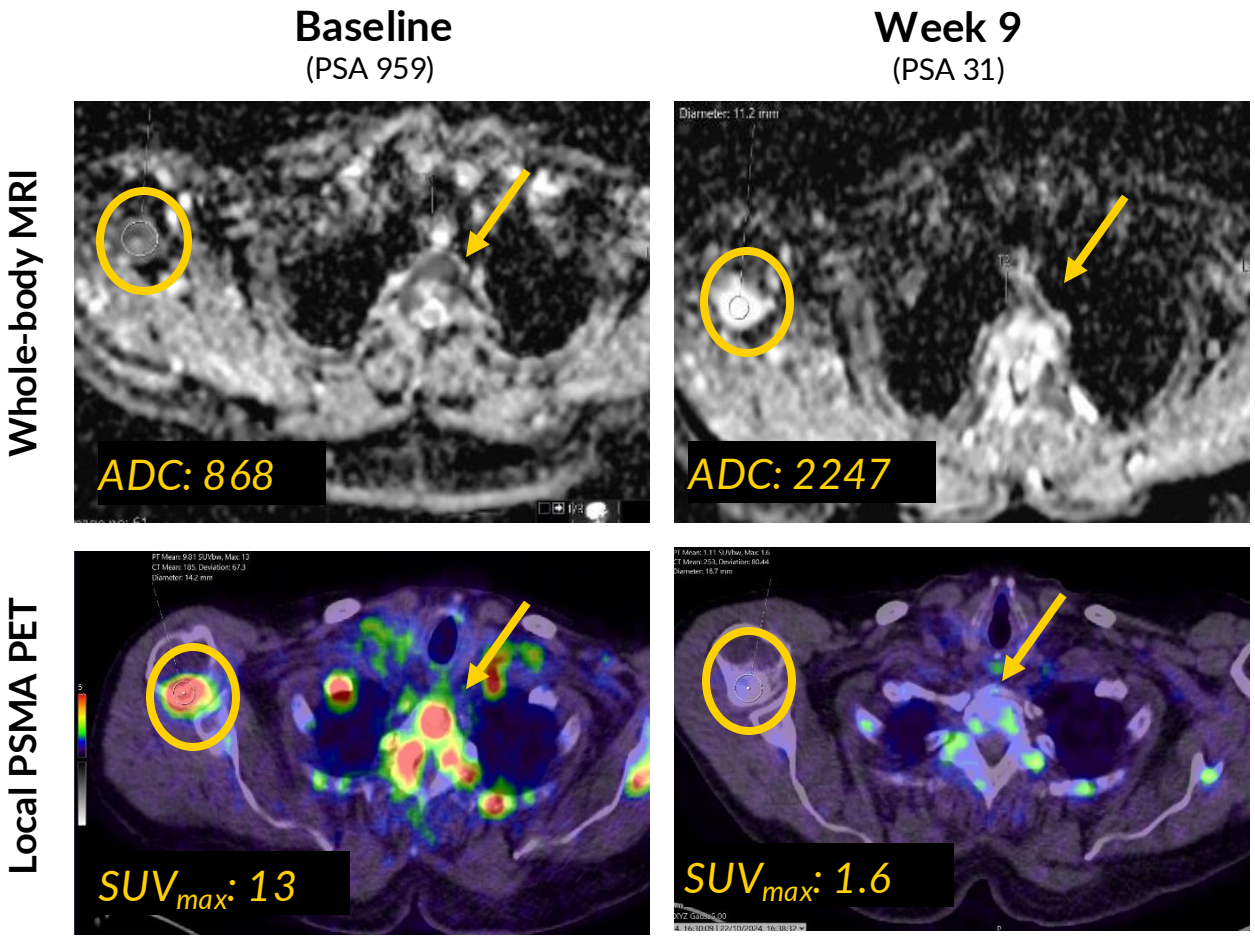
- 7/12 (58%) subjects demonstrate confirmed PSA_{50} response^
- Trend towards increased durability with dose escalation
- Anticipate deeper and more durable responses as dose escalates

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

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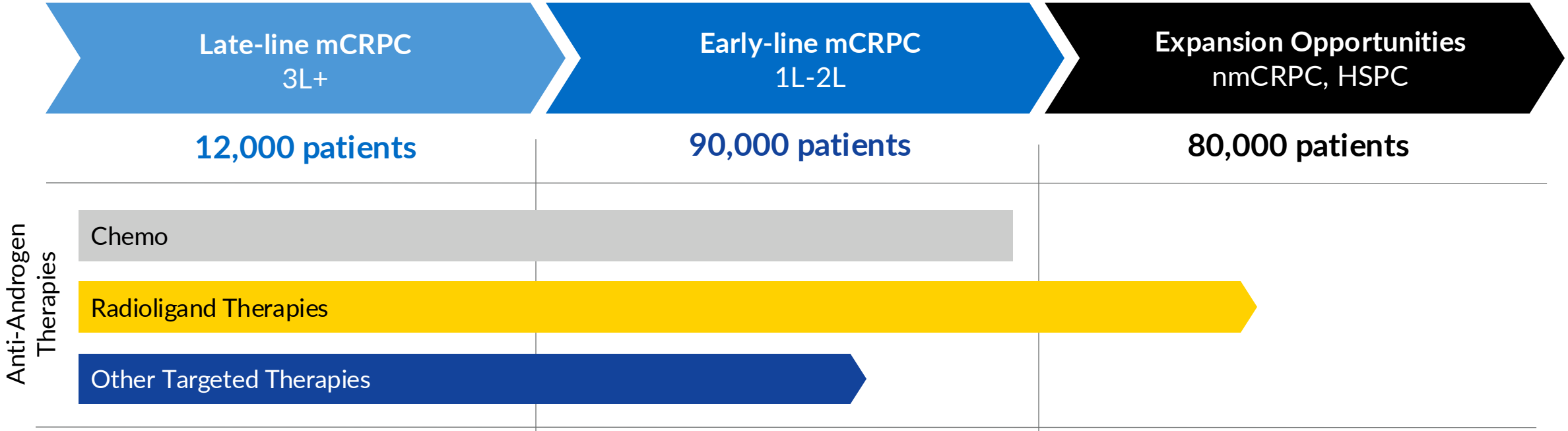
PSA: prostate-specific antigen; AE: adverse event; ADC: apparent diffusion coefficient; PSMA: prostate-specific membrane antigen; SUV: standardized uptake value

Potential for best-in-class 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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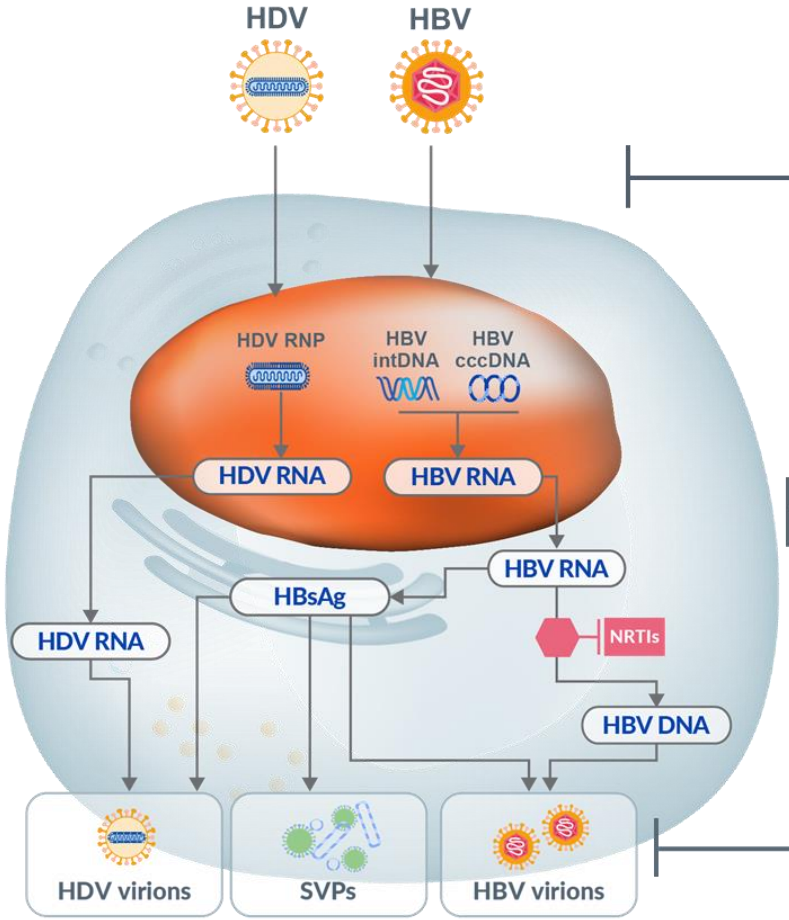
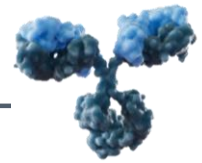
Chronic Hepatitis B (CHB)

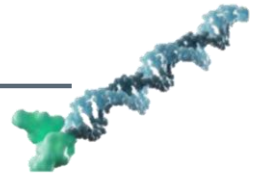
Pursuit of a Functional Cure

Our ambition in HBV: functional cure following finite treatment regimen

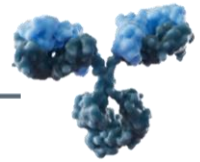




Inhibition of viral entry **(tobevibart)**



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



Neutralization of HBV virions **(tobevibart)**

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

Complementary mechanisms of action:

Tobevibart

mAb: Fc-engineered monoclonal antibody

- Designed to bind to HBsAg on virions

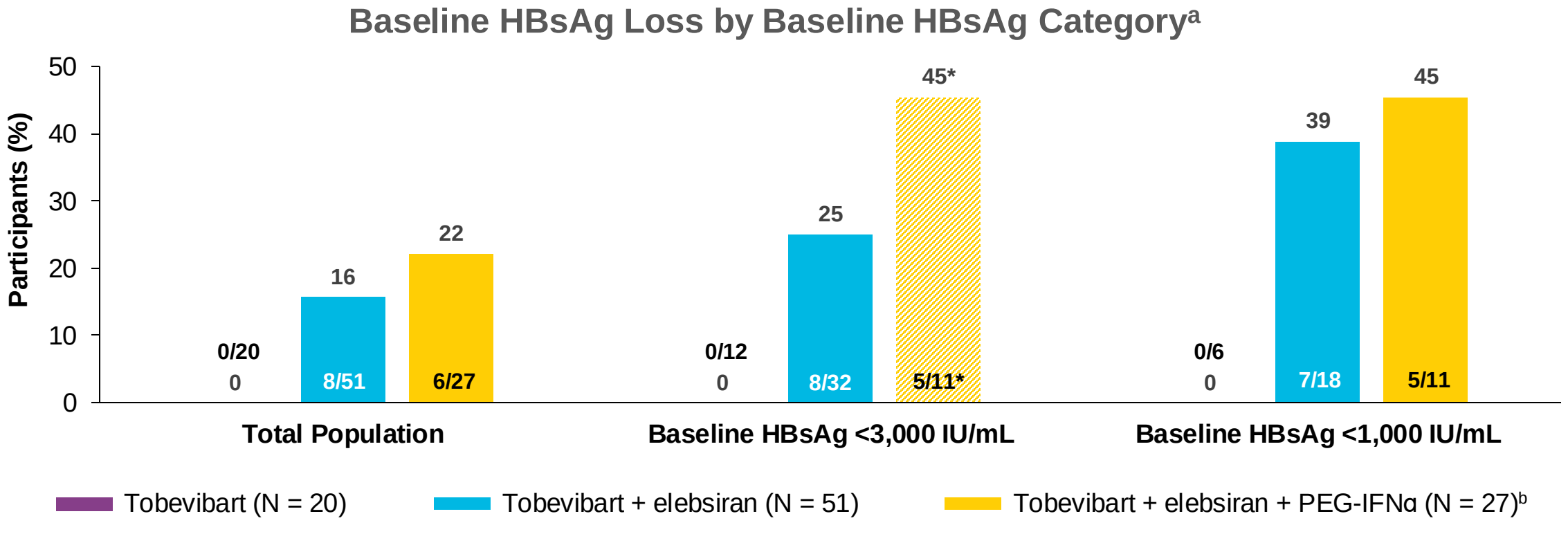
Elebsiran

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

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

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

CHB: HBsAg loss of up to 45% at EOT with Vir regimens



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

Study identifier: NCT04856085

- EOT, end of treatment; HBsAg, hepatitis B surface antigen; PEG-IFNα, pegylated interferon alfa-2a.
- *Note: all 11 Tobevibart + elebsiran + PEG-IFNα participants enrolled with with baseline HBsAg <3,000 IU/mL also had baseline HBsAg <1,000 IU/mL

[a]HBsAg loss was defined as HBsAg <0.05 IU/mL (lower of limit of quantification).
[b]EOT data available for N = 27/50 participants enrolled.

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CHB: MARCH phase 2 functional cure data in Q2 2025

Completion of Enrollment

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

‘25

24w Off Treatment Data

(48w Post-Treatment)

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

Q3 2023 | Q4 2024 | Q2 2025

48w End of Treatment Data

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

Further advancement contingent on securing a WW development and commercialization partner[1]

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

[1]Outside of Greater China (China, Hong Kong, Taiwan, Macau) where Brii Biosciences retains rights.

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Financials and closing

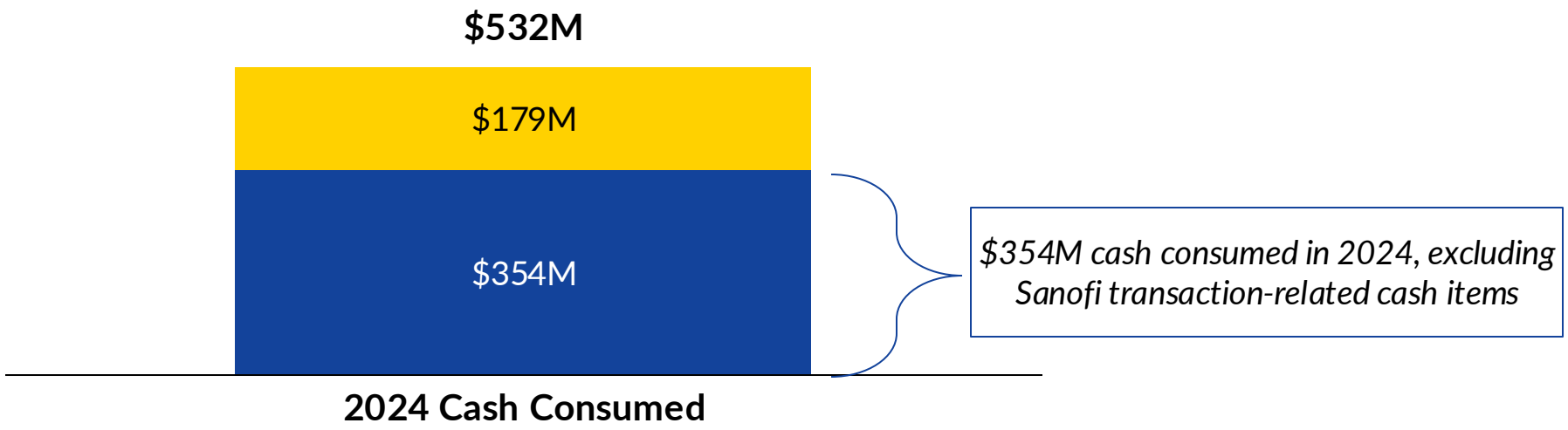
2024 Financial Results

$ in millions	Years Ended December 31, 2024	2023	Change	%
Total revenues	$74.2	$86.2	$(12.0)	(14%)
Operating expenses:				
Cost of revenue	0.8	2.8	(1.9)	(68%)
Research and development	506.5 [A]	579.7	(73.2)	(13%)
Selling, general and administrative	119.0	174.4	(55.4)	(32%)
Restructuring, long-lived assets Impairment and related charges	35.0	13.6	21.4	157%
Total operating expenses	661.4	770.5	(109.1)	(14%)
Loss from operations	(587.2)	(684.3)	97.1	(14%)
Total other income	64.1	56.1	7.9	(14%)
Benefit from income taxes	1.1	13.1	(11.9)	(91%)
Net loss	$(522.0)	$(615.1)	$93.1	(15%)
Ending headcount (full-time & part-time)	408 [B]	587	(179)	(31%)

Note: Numbers may not add due to rounding.

[A] 2024 R&D Operating Expense includes $102.8 million of the Sanofi in-licensed upfront payment that was recognized as in-process research and development expense.
[B] 2024 year-end headcount includes approximately 50 former Sanofi employees with T-cell engager expertise.

2024 cash consumption of $354M, *excluding Sanofi transaction cash items;* runway into mid-2027



Note: Numbers may not add due to rounding.

2025 Financial Guidance:
Based on current operating plans, the Company expects its $1.1 billion in cash, cash equivalents and investments to fund its operations into mid-2027

[1] In 2024, $179 million in Sanofi transaction-related cash consumption occurred, including the $75.0 million pending payment held in escrow, that was classified as restricted cash in 2024, and is subject to VIR-5525 achieving "first in human dosing" by 2026.

Clinical development is underpinned by strict financial discipline, enabling runway into mid-2027

Financial Highlights

Cash runway into

mid-2027

~$1.1 billion

cash and investments [1]

Accelerate and Invest

Hepatitis Delta

Phase 3 ECLIPSE starts H1'25

Masked TCEs

VIR-5818 (HER2)
VIR-5500 (PSMA)
VIR-5525 (EGFR)

Partnership Programs

Hepatitis B

Functional cure data Q2'25

Further advancement is contingent on securing a worldwide development and commercialization partner[2]

[1] In addition to the $1.1 billion in cash, cash equivalents and investments as of December 31, 2024, Vir Biotechnology had $95.7 million in restricted cash and cash equivalents, which includes the $75.0 million pending payment held in escrow, and subject to VIR-5525 achieving "first in human dosing" by 2026

[2] Outside of Greater China (China, Hong Kong, Taiwan, Macau) where Brii Biosciences retains rights.

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

We anticipate multiple important near-term program catalysts

Program	Drug Candidates/Regimen	Catalyst	Timing
Solid Tumors	VIR-5818: dual-masked HER2xCD3 TCE 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
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
Solid Tumors	VIR-5818: dual-masked HER2xCD3 TCE VIR-5500: dual-masked PSMAxCD3 TCE	Phase 1: additional clinical data	TBA

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; TBC: to be confirmed; Tobevibart incorporates Xencor's Xtend™ and other Fc technologies.

PATIENTS ARE WAITING

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