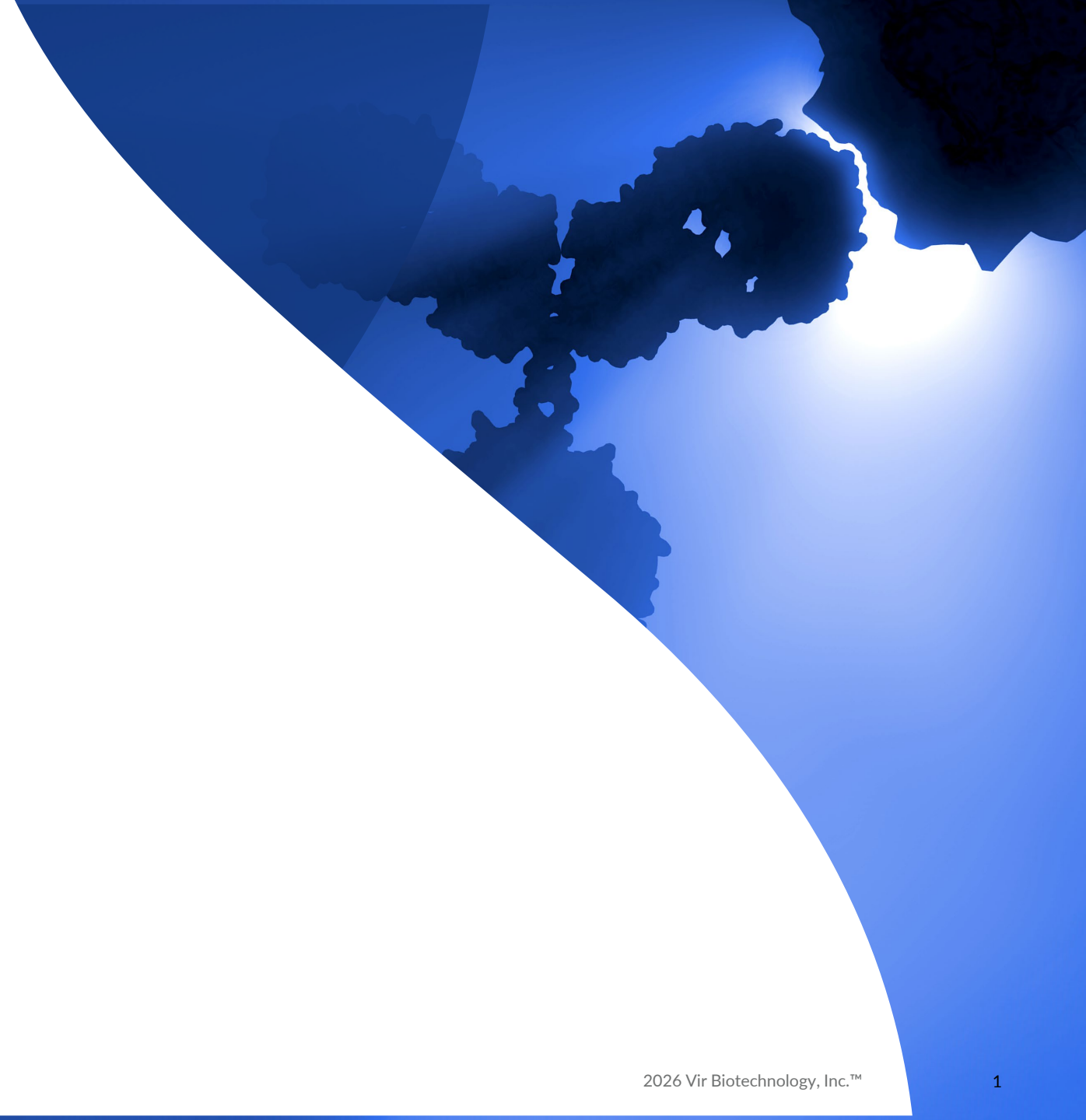


Corporate Overview Presentation

May 2026

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-5500 and the other assets in Vir Biotechnology's oncology solid tumor clinical 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; the potential benefits for Vir Biotechnology as a result of the collaborations with Norgine and Astellas; 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 Vir Biotechnology's actual results to differ from current expectations are discussed in Vir Biotechnology'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.

Product candidates included in this presentation are investigational and have not been approved by the US Food and Drug Administration or other regulatory authorities. No representation is made or intended regarding their safety or efficacy or that of other investigational agents mentioned herein. Any comparative data presented are based on cross-trial comparisons and not head-to-head clinical studies; therefore, caution should be exercised in interpreting these data.

PRO-XTEN® is a trademark of Amunix Pharmaceuticals, Inc., a Sanofi company

Our path to delivering transformational therapies to people living with devastating diseases

Commercializing our chronic hepatitis delta (CHD) combination therapy will drive near-term revenue sustainability

Accelerating our masked T-cell engager (TCE) immunotherapy portfolio offers key value inflection points

Aiming Vir Bio's discovery engine at developing a robust pipeline of cancer immunotherapies creates sustainable long-term growth

Strategic Collaborations

Selectively partner drug candidates to focus internal resources, unlock the value of our pipeline and maximize benefit to patients

We've developed a powerful Vir Bio discovery engine to fuel the next generation of therapeutics

Our distinctive capabilities

World class protein engineering, antibody / TCE discovery

dAIsY™ AI/ML for antibody / TCE optimization

Exclusive PRO-XTEN® universal masking technology

Building on legacy of infectious disease innovation

Ebanga™
(ansuvimab-zykl)
for the treatment of ebola virus

Xevudy®
(sotrovimab)
for the treatment of SARS-COVID 19

to deliver next generation of powerful medicines, including cancer immunotherapies with better therapeutic index

dAIsY™: (dataAI structure and antibodY) AI engine; TCE: T-cell engager
Ebanga is a trademark of Ridgeback Bio. Xevudy is a registered trademark of GSK

Delivering a differentiated 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-5500 (PSMA)[1] ± ARPIs	Treatment					
Solid Tumors	VIR-5818 (HER2)[1] ± pembrolizumab	Treatment					
Solid Tumors	VIR-5525 (EGFR)[1] ± pembrolizumab	Treatment					
PRE-CLINICAL PROGRAMS							
HIV Treatment / Cure[2]	Preclinical antibody candidates	Treatment					
Solid Tumors	7 PRO-XTEN® TCE programs including lung, colorectal and bladder cancers	Treatment					

[1] Masked TCEs licensed from Sanofi
[2] In collaboration with the Gates Foundation
ARPIs: androgen receptor pathway inhibitors; EGFR: epidermal growth factor receptor; HER2: human epidermal growth factor receptor 2; HIV: human immunodeficiency virus; PSMA: prostate-specific membrane antigen; siRNA: small interfering RNA; TCE: T-cell engager
Tobevibart incorporates Xencor's Xtend™ and other Fc technologies
Norgine holds exclusive license for the commercial rights to the combination of tobevibart and elebsiran in Europe, Australia and New Zealand
Brii Biosciences retains rights to the combination of tobevibart and elebsiran in the Greater China Territory (People's Republic of China, Hong Kong, Taiwan and Macau)
Astellas holds co-development and co-commercialization rights for VIR-5500 for the treatment of prostate cancer

Upcoming clinical milestones

PROGRAM	DRUG CANDIDATES REGIMEN	CATALYST	TIMING
Hepatitis Delta	tobevibart (mAb) + elebsiran (siRNA)	SOLSTICE: 72 & (partial) 96-week data	✓ Jan'26
		ECLIPSE 1: topline data	4Q'26
		ECLIPSE 2: topline data	1Q'27
		ECLIPSE 3: topline data	1Q'27
PSMA-Expressing Prostate Cancer	VIR-5500 dual-masked PSMAxCD3 TCE	**Phase 1** dose escalation response data	✓ Feb'26
HER2-Expressing Solid Tumors	VIR-5818 dual-masked HER2xCD3 TCE	**Phase 1** dose escalation response data	2H'26
EGFR-Expressing Solid Tumors	VIR-5525 dual-masked EGFRxCD3 TCE	**Phase 1** initial dose escalation clinical data	TBA

CD3: cluster of differentiation 3; EGFR, epidermal growth factor receptor; HER2: human epidermal growth factor receptor 2; mAb: monoclonal antibody; PSMA: prostate-specific membrane antigen; siRNA: small interfering RNA; TBA, to be announced; TCE: T-cell engager

Our clinical programs address large and growing unmet needs

Infectious Disease

CHD

Tobevibart + elebsiran
Phase 3
Active Viremic Patients

174K
U.S.[1] + UK + EU[2] (all 27 member states)

Oncology – Solid Tumors
2032 prevalence estimate for U.S., EU4 and UK

PSMA

VIR-5500
Phase 1
Drug-treated Patients[3]

100K
mCRPC

60K
mHSPC

HER2

VIR-5818
Phase 1
Drug-treated Patients[3]

27K
HER2+ mUC

11K
HER2+ mCRC

EGFR

VIR-5525
Phase 1
Drug-treated Patients[3]

431K
mNSCLC

69K
mHNSCC

271K
mCRC

[1] U.S. sources include Wong 2024, Polaris 2024, Stockdale 2020, Gish 2024
[2] 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
[3] Clarivate DRG, projected drug treated patients, 2032
CHD: chronic hepatitis delta; EGFR: epidermal growth factor receptor; EU4: France, Germany, Italy and Spain; HER2: human epidermal growth factor receptor 2; mCRC: metastatic colorectal cancer; mCRPC: metastatic castrate-resistant prostate cancer; mHNSCC: metastatic head and neck squamous cell carcinoma; mHSPC: metastatic hormone-sensitive prostate cancer; mNSCLC: metastatic non-small cell lung cancer; mUC: metastatic urothelial carcinoma; PSMA: prostate-specific membrane antigen

Our path to delivering transformational therapies to people living with devastating diseases: chronic hepatitis delta

Commercializing our chronic hepatitis delta (CHD) combination therapy will drive near-term revenue sustainability

Accelerating our masked T-cell engager (TCE) immunotherapy portfolio offers key value inflection points

Aiming Vir Bio's discovery engine at developing a robust pipeline of cancer immunotherapies creates sustainable long-term growth

Strategic Collaborations

Selectively partner drug candidates to focus internal resources, unlock the value of our pipeline and maximize benefit to patients

CHD: devastating liver disease, significantly underserved with high mortality

>50%

Liver-related **death in 10 years**[1]

5 years

Average progression to **cirrhosis** and **liver failure**[2]

3X

Risk of liver cancer (HCC) vs. HBV[3]

~61K

Active viremic patients[4] in **U.S.**

~113K

Active viremic patients[5] in total **EU** (27 member states) and **UK**

~7M

Active viremic patients[6] **worldwide**

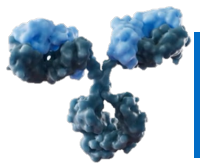
[1] Negro F. (2023). Hepatitis D: A Review. *JAMA*. 330(24):2376–2387; [2] Pan C, (2023). Diagnosis and Management of Hepatitis Delta Virus Infection. Dig Dis Sci. Aug;68(8):3237-3248; [3] Sagnelli C, et al. (2021) HBV/HDV Co-Infection: Epidemiological and Clinical Changes, Recent Knowledge and Future Challenges. Life,11(2):169. https://doi.org/10.3390/life11020169; [4] U.S. sources include Wong 2024, Polaris 2024, Stockdale 2020, Gish 2024; [5] 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; [6] Stockdale A, et al. (2020). The global prevalence of hepatitis D virus infection: Systematic review and meta-analysis. J Hepatol, 73, 523-32
CHD: chronic hepatitis delta; HBV: hepatitis B virus; HCC: hepatocellular carcinoma

Accelerating access to our CHD regimen to patients in Europe and ANZ through collaboration with Norgine

- Norgine is a leading European-focused specialty pharma with market-leading products in hepatology/GI, rare disease and pediatric oncology
- Exclusive commercial license in Europe, Australia, New Zealand
  - €55M initial reimbursement paid at closing
  - Up to €495M in clinical, regulatory and sales milestones
  - Tiered mid-teen to high-twenties percent royalties on net sales
  - ~25% sharing of future ECLIPSE external clinical costs
- Vir Biotechnology retains all commercialization rights in the U.S. and all other markets outside of the Greater China Territory[1]

[1] Brii Biosciences retains rights to the combination of tobevibart and elebsiran in the Greater China Territory (People's Republic of China, Hong Kong, Taiwan and Macau)
Norgine holds exclusive license for the commercial rights to the combination of tobevibart and elebsiran in Europe, Australia and New Zealand
AZN: Australia and New Zealand; CHD: chronic hepatitis delta; GI: gastroenterology

Complementary mechanisms give tobevibart + elebsiran best-in-class potential



Tobevibart
(mAb)

Inhibition of viral entry

Elebsiran
(siRNA)

Degradation of HBV RNA & reduction of HBsAg production

Neutralization of HDV & HBV virions

Characteristics of a best-in-class CHD therapy

1. **Eliminating the virus:** Undetectable HDV RNA
2. **Patient convenience:** Monthly dosing (SC injections)
3. **Flexible delivery:** Physician or patient administration
4. **Well-tolerated:** Favorable safety profile
5. **Broad activity:** In cirrhotic and non-cirrhotic pts

Vir Biotechnology™

cccDNA: covalently closed circular DNA; CHD: chronic hepatitis delta; HBsAg: hepatitis B virus surface antigen; HBV: hepatitis B virus; HDV: hepatitis D virus; Int: integrated; mAb: monoclonal antibody; MOA: mechanism of action; NRTI: nucleoside/nucleotide reverse transcriptase inhibitor; Pts: patients; RNP: ribonucleoprotein; SC: subcutaneous; siRNA: small interfering RNA; SVP: subviral particle

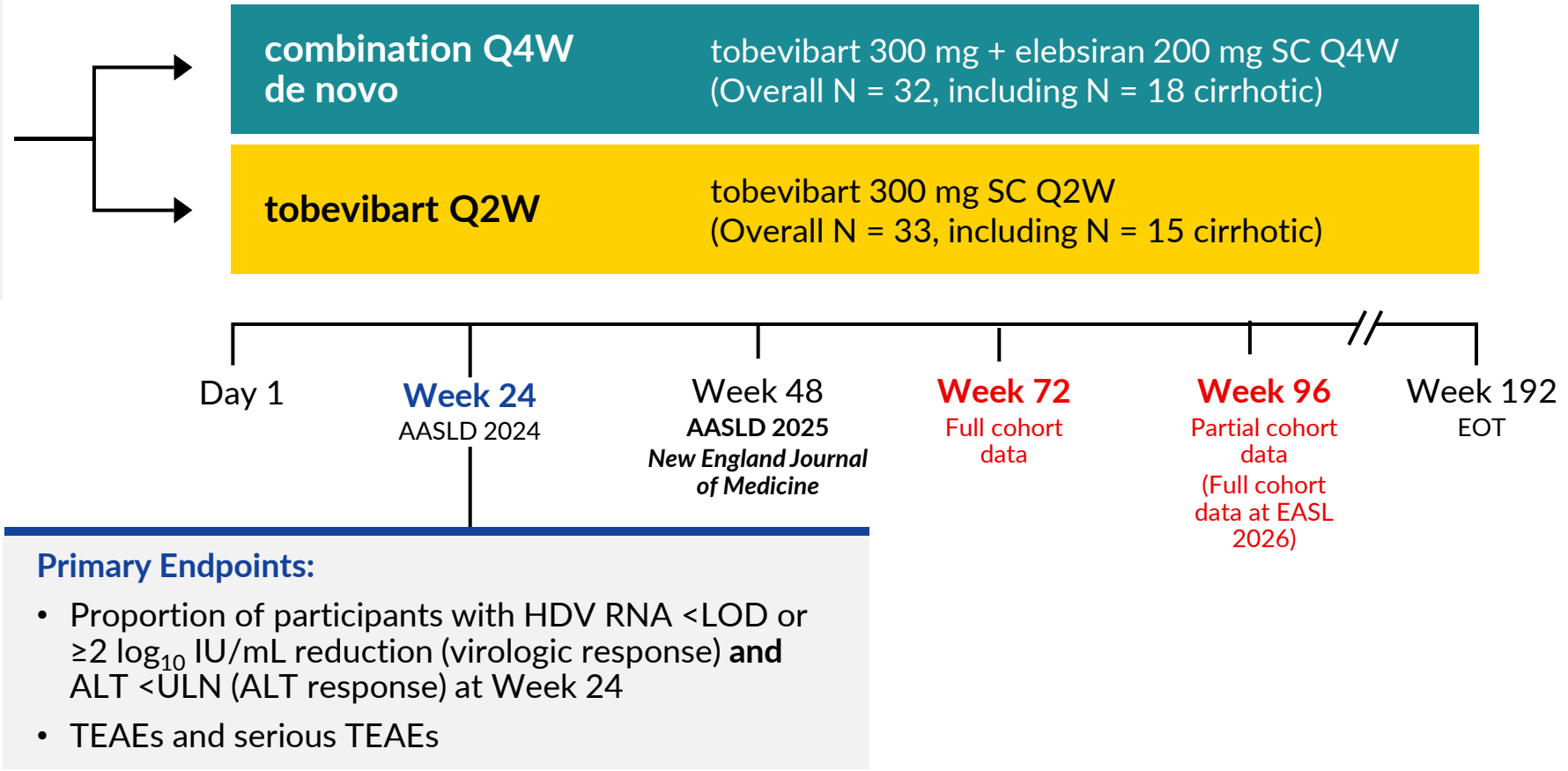
Ph2 SOLSTICE trial evaluating potential best-in-class therapy for CHD

Study design: tobevibart + elebsiran combination therapy Q4W and tobevibart monotherapy Q2W

CHD

Inclusion criteria:

- HDV RNA ≥500 IU/mL
- ALT >ULN; ALT <5 × ULN
- **Non-cirrhotic[a] or cirrhotic (CTP-A)[b]**
- **N = 65, randomized 1:1**



Primary Endpoints:

- Proportion of participants with HDV RNA <LOD or ≥2 $\log_{10}$ IU/mL reduction (virologic response) **and** ALT <ULN (ALT response) at Week 24
- TEAEs and serious TEAEs

[a] Non-cirrhotic: liver biopsy with METAVIR F0 to F3 or liver stiffness <12 kPa within 12 months of screening and platelet count >150 × 103/µL

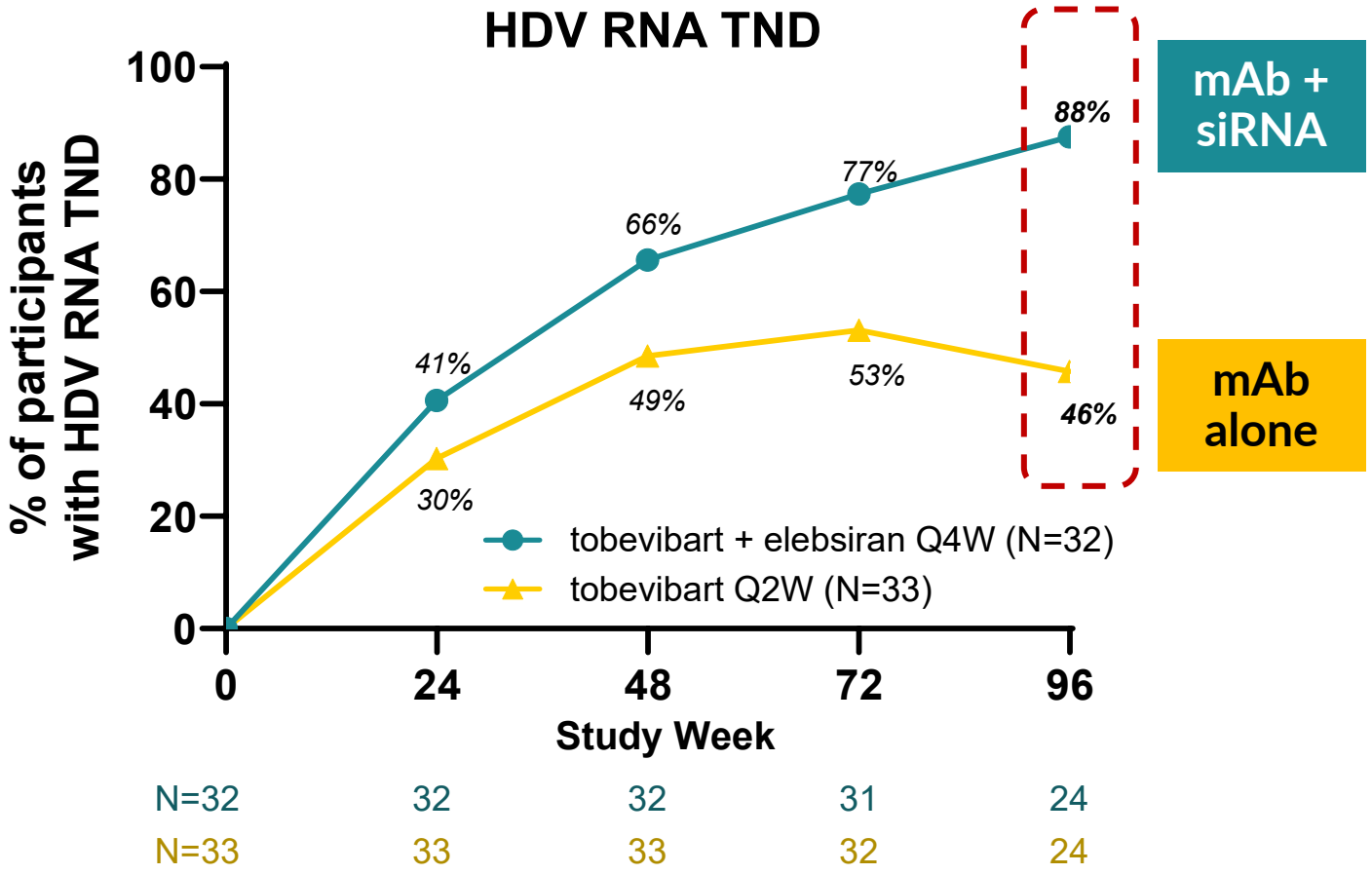
[b] Compensated cirrhotic participants: liver biopsy with METAVIR F4 or liver stiffness ≥12 kPa within 12 months of screening, a platelet count >90 × 103/µL, and a CTP score of 5 or 6, inclusive at screening and at the start of the study

ALT: alanine aminotransferase; CHD: chronic hepatitis delta; CTP: Child-Turcotte-Pugh; EOT: end of treatment; HDV: hepatitis D virus; LOD: limit of detection; Q2W: once every 2 weeks; Q4W: once every 4 weeks; SC: subcutaneous; TEAE: treatment-emergent adverse event; ULN: upper limit of normal

SOLSTICE ClinicalTrials.gov Identifier: NCT05461170

Ph2 SOLSTICE trial evaluating potential best-in-class therapy for CHD

Monthly combo therapy achieved undetectable HDV RNA in 88% of patients that reached Week 96 vs. 46% with monotherapy

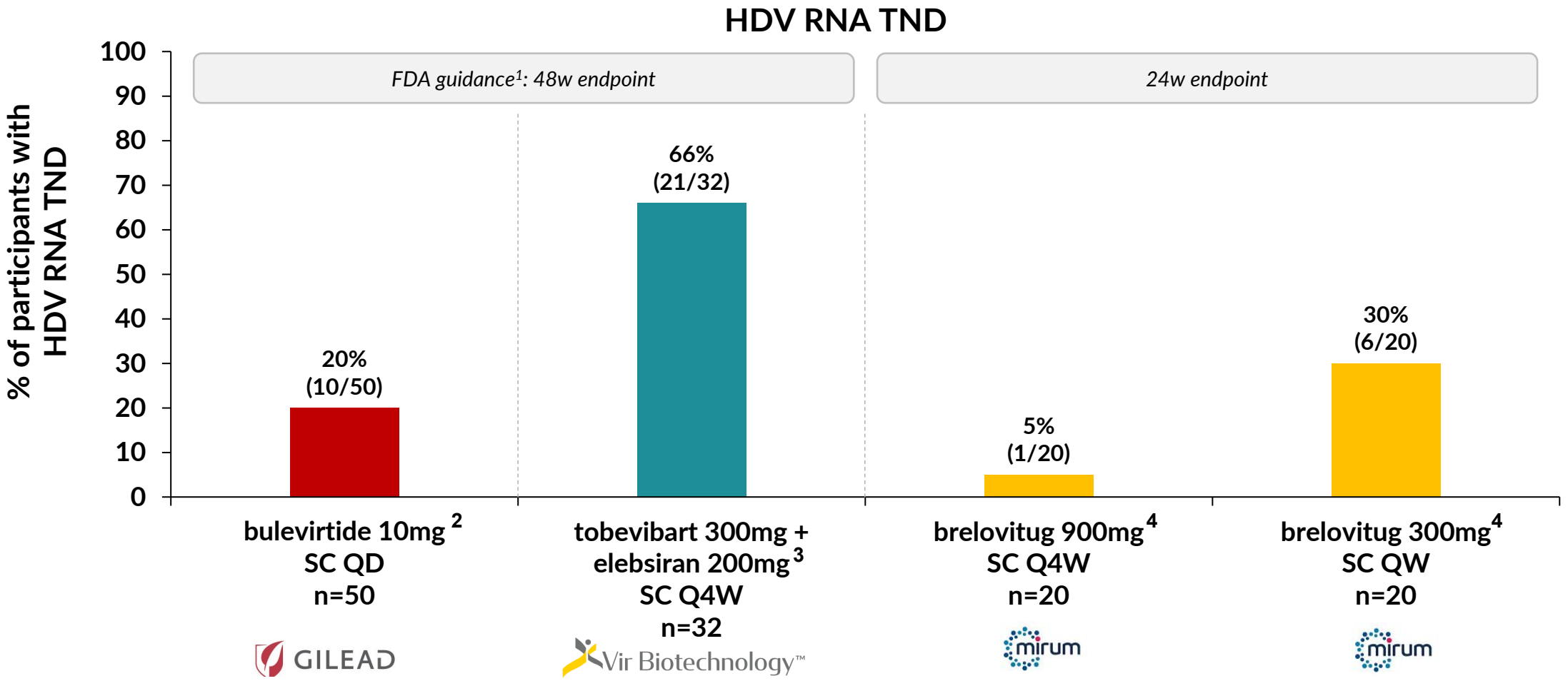


> *"Undetectable HDV RNA is a known driver of improved CHD patient outcomes. Data from the ongoing SOLSTICE Phase 2 trial are encouraging, as they continue to show* ***the potential of the tobevibart and elebsiran combination to achieve robust HDV suppression*** *by tackling the viral cycle through multiple mechanisms."*

Tarik Asselah, M.D., Ph.D.
Professor of Hepatology at the Hôpital Beaujon, APHP

CHD: chronic hepatitis delta; HDV, hepatitis D virus; mAb: monoclonal antibodies; Q2W: once every 2 weeks; Q4W: once every 4 weeks; siRNA: small interfering RNA; TND: target not detected
HDV RNA TND = undetectable HDV RNA
Data are reported for participants who completed the visit with non-missing HDV RNA and ALT or discontinued treatment before the visit
By week 96, N=3 participants discontinued tobevibart+elebsiran Q4W and N=7 participants discontinued in tobevibart Q2W and are counted as failures in analysis; n=7 and n=8 Respectively have not yet reached the week 96 visits but remain on treatment; 1 participant receiving tobevibart Q2W is censored after week 52 due to a site protocol deviation
Data as of 11/19/25

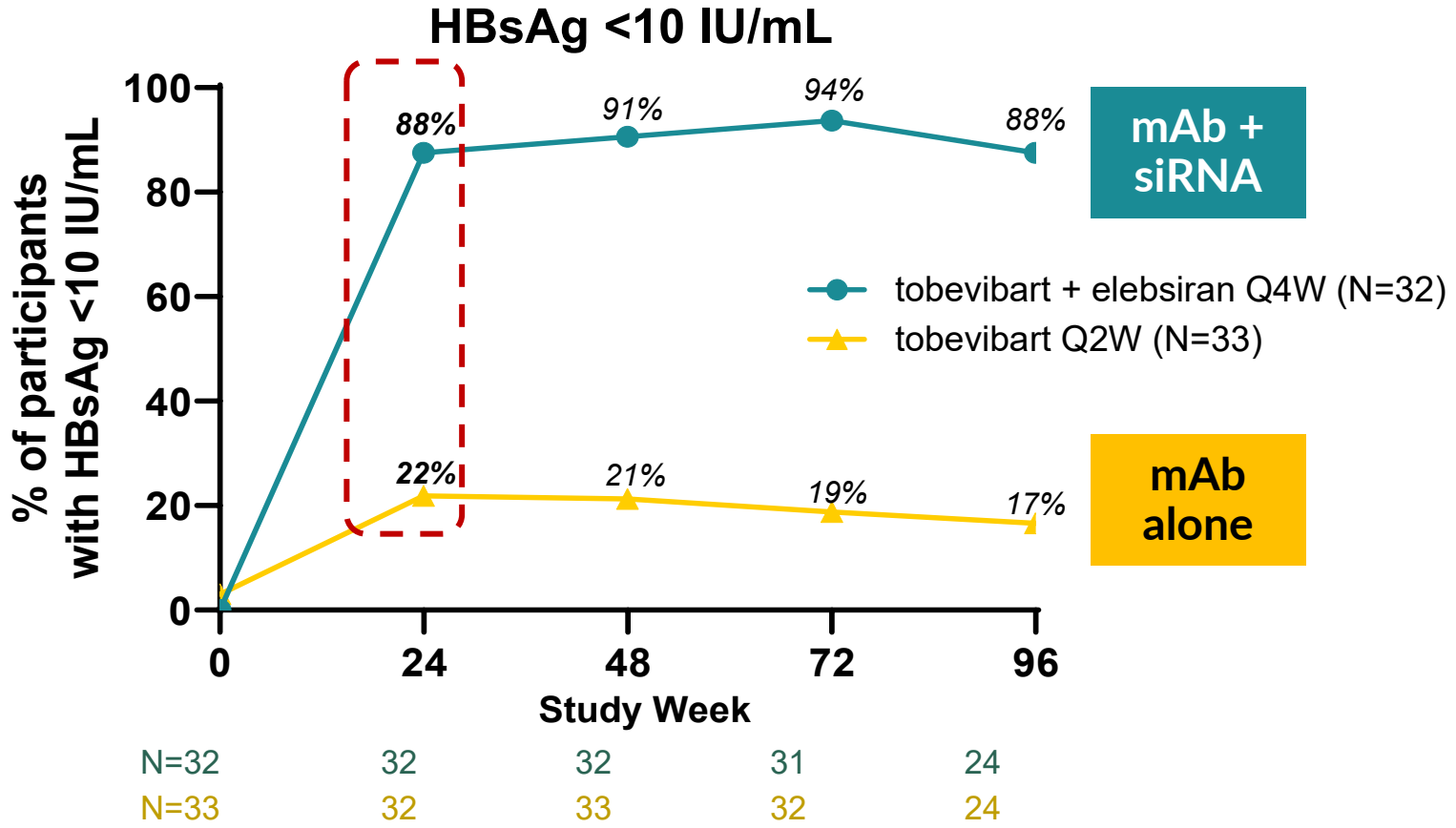
Tobevibart + elebsiran shows higher rates of viral elimination



[1] Based on FDA feedback in FDA meetings; [2] Gilead ClinicalTrials.gov Identifier NCT03852719; [3] Vir Bio ClinicalTrials.gov Identifier: NCT05461170;
[4] Mirum ClinicalTrials.gov Identifier: NCT06907290, Mirum corporate presentation dated April 27, 2026
CHD: chronic hepatitis delta; HDV: hepatitis delta virus; HDV RNA TND = undetectable HDV RNA; mAb: monoclonal antibody; QD: once daily; QW: once weekly; Q4W: once every 4 weeks; siRNA: small interfering RNA; SC: subcutaneous; TND: target not detected
FOR ILLUSTRATIVE PURPOSES ONLY: No head-to-head trials have been conducted. Cross-trial comparisons may not be reliable due to differences in study design, patient populations, and other factors. Data from public sources have not been independently verified. See individual study publications for complete data and context.

Ph2 SOLSTICE trial evaluating potential best-in-class therapy for CHD

~90% of participants receiving tobevibart + elebsiran achieved very low HBsAg values by Week 24 and maintain suppression

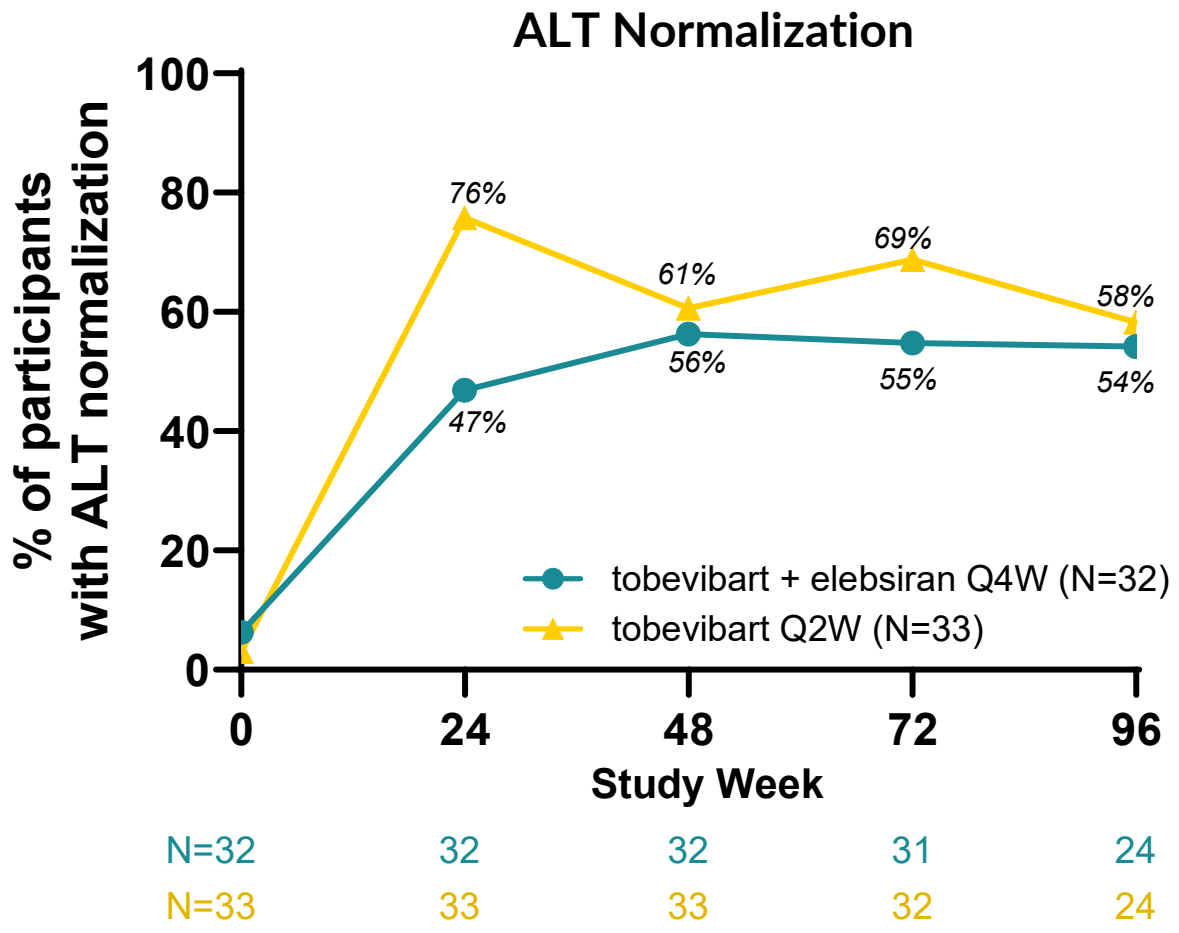


Hepatitis delta virus (HDV) requires serum HBV surface antigen (HBsAg) to replicate and complete its lifecycle; clearing HBsAg limits HDV replication

CHD: chronic hepatitis delta; HDV: hepatitis D virus; mAb: monoclonal antibodies; Q2W: once every 2 weeks; Q4W: once every 4 weeks; siRNA: small interfering RNA
Data are reported for participants who completed the visit with non-missing HBsAg measurement or discontinued treatment before the visit
By week 96, N=3 participants discontinued tobevibart+elebsiran Q4W and N=7 participants discontinued in tobevibart Q2W and are counted as failures in analysis; n=7 and n=8 respectively have not yet reached the week 96 visits but remain on treatment; 1 participant receiving tobevibart Q2W is censored after week 52 due to a site protocol deviation
Data as of 11/19/25

Ph2 SOLSTICE trial evaluating potential best-in-class therapy for CHD

ALT normalization was similar between tobevibart + elebsiran and tobevibart monotherapy



ALT: alanine aminotransferase; Q2W: once every 2 weeks; Q4W: once every 4 weeks; ULN: upper limit of normal
ALT ULN (male) = 40 IU/mL; ALT ULN (female) = 33 IU/mL.
Data are reported for participants who completed the visit with non-missing HDV RNA and ALT or discontinued treatment before the visit.
By week 96, N=3 participants discontinued tobevibart+elebsiran Q4W and N=7 participants discontinued in tobevibart Q2W and are counted as failures in analysis; n=7 and n=8 respectively have not yet reached the week 96 visits but remain on treatment; 1 participant receiving tobevibart Q2W is censored after week 52 due to a site protocol deviation
Data as of 11/19/25

Combination therapy generally well-tolerated

Majority of adverse events were grade 1 or 2 and transient through Week 72 with no drug-related SAEs[1]

Safety or tolerability measure, n (%)[a]	Tobevibart + elebisran Q4W *de novo* N = 32	Tobevibart Q2W N = 33
Any TEAE	28 (88)	32 (97)
Grade 1-2	27 (84)	30 (91)
Grade 3	1 (3)[b]	1 (3)[c]
Grade 4	0	1 (3)[d]
Treatment-related TEAE	23 (72)	26 (79)
TEAE leading to study drug interruption	0	1 (3)[e]
TEAE leading to study drug discontinuation	0	3 (9)[f]
Serious TEAE	1 (3)[g]	1 (3)[c]
Treatment-related serious TEAE	0	0

[1] The most common TEAE was flu-like symptoms which were mild to moderate, transient and only occurred beyond the first dose in 3% (1/32) of patients.
Q2W: once every 2 weeks; Q4W: once every 4 weeks; SAE: serious adverse event; TEAE: treatment-emergent adverse event.
[a]A participant with multiple events within a category is counted only once in that category.
[b]Grade 3 worsening of diabetes mellitus type 2 deemed unrelated to study drugs by investigator.
[c]Grade 3 hepatocellular carcinoma (SAE) deemed unrelated to study drugs by investigator.
[d]Grade 4 neutropenia on Week 12 and Week 16; recovered to grade 2 or 3 after Week 16 without treatment.
[e]Reason for study drug interruption: neutropenia (Preferred term).
[f]Reason for discontinuation: 2 cases of influenza-like illness (Preferred term) and 1 case of hepatocellular carcinoma.
[g]One participants with 2 concurrent SAEs of worsening nasal septum deviation and worsening nasal concha hyperplasia (both Grade 2) who underwent planned admission to the hospital for surgery; both SAEs were deemed unrelated to study drugs by investigator.

Ph2 SOLSTICE results to-date show monthly tobevibart + elebsiran combo is well tolerated with robust and durable efficacy

Summary of available data through Week 96

CHD

- Monthly combination therapy achieves and maintains HDV RNA TND in 88% of participants who reached Week 96
- High reductions in serum HBsAg; ~90% of participants on combination therapy achieved HBsAg reductions to <10 IU/mL by Week 24 and maintained suppression
- ALT normalization at Week 48 was similar between combination and monotherapy cohorts and remained stable
- No grade 3 or higher treatment-related adverse events (TRAEs) with the combination therapy, and TRAEs were generally mild to moderate and transient

ALT: alanine aminotransferase; CHD: chronic hepatitis delta; HBsAg: hepatitis B surface antigen; HDV: hepatitis D virus; TND: target not detected
HDV RNA TND = undetectable HDV RNA

Clear dosing advantage: monthly administration of tobevibart + elebsiran

Monthly dosing offers greater flexibility and may lead to higher adoption

Subcutaneous dosing enables patient **at-home administration**

Physician administration option for up to 20% of CHD patients who are not capable of self-administering at home[1]

Streamlined co-packaged format designed for **ease of use**

Dosing frequency and method of administration optimize patient convenience

[1] Trinity commercial and access market research, July 2024, n=18 U.S. HCPs
CHD: chronic hepatitis delta

Registrational ECLIPSE program progressing ahead of schedule

Initial topline data anticipated in Q4 2026

CHD

- FDA breakthrough designation
- FDA Fast Track
- EMA PRIME designation
- EMA Orphan Drug designation

ECLIPSE 1

Phase 3

- HDV RNA TND + ALT normalization at **Week 48**
- Tobevibart + elebsiran vs. deferred treatment (n=120, 2:1)

★

Fully enrolled

ECLIPSE 2

Phase 3

- HDV RNA TND at **Week 24**
- Tobevibart + elebsiran vs. bulevirtide switch* (n=150, 2:1)

Enrollment On Track

ECLIPSE 3

Phase 2b

- HDV RNA TND at **Week 48**
- Tobevibart + elebsiran vs. bulevirtide naïve (n=100, 2:1)

★

Fully enrolled

*Defined as failure to achieve HDV RNA < 500 IU/mL with bulevirtide
ALT: alanine aminotransferase; HDV: hepatitis D virus; TND: target not detected
HDV RNA TND = undetectable HDV RNA
ECLIPSE ClinicalTrials.gov Identifiers: ECLIPSE 1 NCT06903338, ECLIPSE 2 NCT07128550, ECLIPSE 3 NCT07142811

Our path to delivering transformational therapies to people living with devastating diseases: cancer immunotherapy

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Accelerating our masked T-cell engager (TCE) immunotherapy portfolio offers key value inflection points

Aiming Vir Bio's discovery engine at developing a robust pipeline of cancer immunotherapies creates sustainable long-term growth

Strategic Collaborations

Selectively partner drug candidates to focus internal resources, unlock the value of our pipeline and maximize benefit to patients

T-cell engagers (TCEs) are a powerful modality in cancer therapy

Our masked TCEs act like Trojan Horses, powered by the PRO-XTEN® platform

TCEs hold tremendous potential, limited by toxicity

- 10 TCE breakthrough immunotherapies already on the market[1]
- Application in solid tumors limited due to toxicity and off-tumor activation
- Masking ensures TCEs are **only activated in the tumor microenvironment**

The PRO-XTEN® masking platform

- Clinically validated, used on a blockbuster drug for hemophilia A[2]
- Universal, plug-and-play platform enables acceleration of next generation of drug candidates

Our masked TCEs act like Trojan Horses, designed to maximize therapeutic index

- **Masks cleaved off** by the proteases in the tumor microenvironment
- Designed to reduce toxicity, enabling higher dosing and **wider therapeutic window**
- Longer drug half-life supports **optimization of dosing schedules**

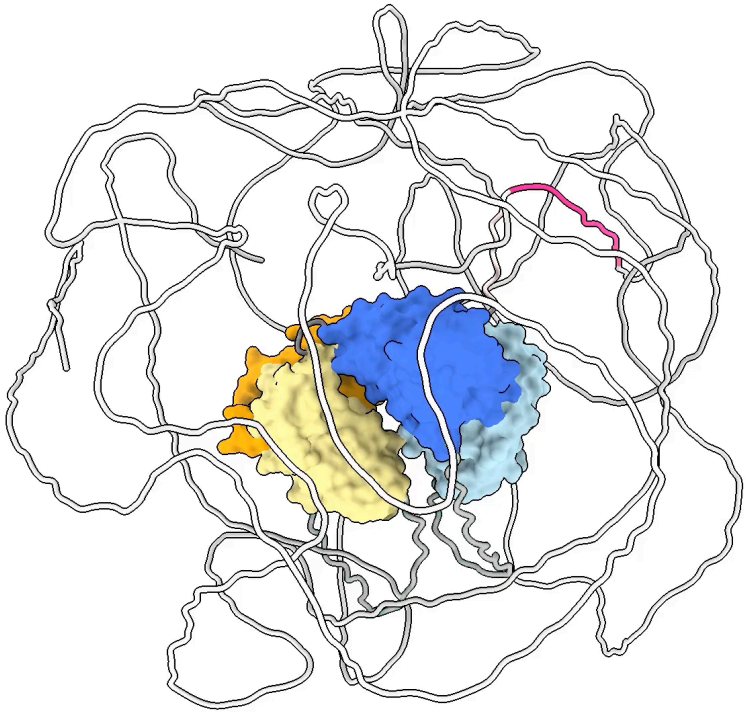
[1] Glaser, A., Kochanowski, K., Oh, D., Porritt, R. A., & Kim, H. (2024). T cell engagers emerge as a compelling therapeutic strategy for solid tumors. Journal of Experimental Medicine
[2] ALTUVIIIO® [Antihemophilic Factor (Recombinant), Fc-VWF-XTEN Fusion Protein-ehtl] is marketed for hemophilia A and is a registered trademark of Sanofi
Q3W: once every three weeks

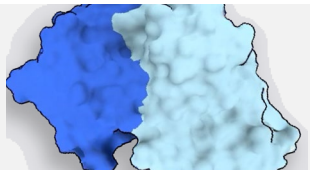
Our unique pipeline of TCEs is enabled by the PRO-XTEN® masking platform

Allows our TCEs to overcome challenges of unmasked and single-masked TCEs

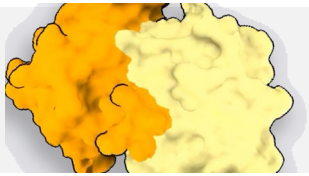
TCE

Shields the TCE, expanding potential in cancer therapy



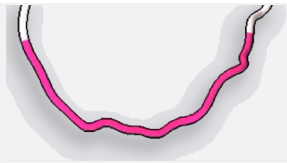


Tumor-binding domain
Variable region binds tumor-associated antigen



T-cell-binding domain
Variable region binds CD3 to recruit T-cells

PRO-XTEN® mask
XTEN masks off-tumor activity of the TCE and prolongs half-life



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

CD3: cluster of differentiation; TCE: T-cell engager; TME: tumor microenvironment

Phase 1 Clinical Data:
VIR-5500 (PSMA)

Presented February 2026

Landmark strategic collaboration with Astellas maximizes potential of VIR-5500 in prostate cancer

Vir Biotechnology™ astellas

Collaboration pairs Astellas' world class capabilities in prostate cancer with Vir Bio's potential best-in-class T-cell engager VIR-5500, powered by PRO-XTEN® masking technology

$1.7B
in upfront payments and milestones[1]

50/50
profit/loss share in the U.S.
Co-promote option for Vir Bio

40/60 Vir Bio / Astellas global development cost share[2]
Tiered, **double-digit royalties** on ex-U.S. net sales

Positions Vir Bio to accelerate clinical development of VIR-5500 into pivotal trials in 2027

[1] Amounts shown exclude payments to third parties. Sanofi is entitled to 20% of certain collaboration proceeds, including: upfront and the portion of milestones, profit share & royalties that exceed the amounts already owed to Sanofi under the terms of the existing Sanofi agreement, effective September 9, 2024.
[2] R&D cost share: Global studies Vir Bio 40% & Astellas 60%; U.S.-specific studies Vir Bio 50% & Astellas 50%; ex-U.S.-specific studies Astellas 100%

Collaboration summary: accelerates development, access to expertise, and delivers attractive economics[1]

Scope

Global development and commercialization collaboration for VIR-5500 in prostate cancer

Commercial rights

U.S. commercialization based on **50/50 profit share**
Vir Bio option to U.S. co-promote

Ex-U.S. Astellas has exclusive rights to commercialize

Royalties

Tiered double-digit royalties on ex-U.S. net sales

Global development cost share

40 / 60 global development cost share (Vir Bio / Astellas)[2]

Upfront and near-term payments[4]

$240M in upfront cash and **$75M** from equity[3]

$20M near-term milestone payment[4]

$335M combined upfront and near-term payments

Additional milestones

Up to **$1.37B** in additional development, regulatory and ex-U.S. sales milestones

[1] Amounts shown exclude payments to third parties. Sanofi is entitled to 20% of certain collaboration proceeds, including: upfront cash payment and the portion of milestones, profit share & royalties that exceed the amounts already owed to Sanofi under the terms of the existing Sanofi agreement, effective September 9, 2024.
[2] R&D cost share: Global studies Vir Bio 40% & Astellas 60%; U.S.-specific studies Vir Bio 50% & Astellas 50%; ex-U.S.-specific studies Astellas 100%
[3] Equity investment at $10.36 per share.
[4] Near-term milestone represents a $20M manufacturing technology transfer payment, anticipated in the second quarter or third quarter of 2027.

VIR-5500 monotherapy study of PSMA-targeted dual-masked TCE in prostate cancer

All dose escalation cohorts have cleared DLT (N=58)

QW dose escalation (N=26)

- 1000 → 2000 → 3000 µg/kg (N=4)
- 500 → 1000 → 2000 µg/kg (N=3)
- 300 → 600 → 1000 µg/kg (N=4)
- 200 → 300 → 400 µg/kg (N=5)
- 120 → 180 → 180 µg/kg (N=4)
- ↑
- 60 µg/kg (N=3)
- ↑
- 30 µg/kg (N=3)

Q3W dose escalation (N=32)

- 1000 → 2000 → 4000 µg/kg w/ Prophylactic Steroids (N=3)
- 800 → 2000 → 3500 µg/kg (n=9)
- 800 → 1500 → 3000 µg/kg (N=5)
- 1000 → 2000 → 3000 µg/kg (N=5)
- ↑
- 500 → 1000 → 2000 µg/kg (N=4)
- 300 → 600 → 1000 µg/kg (N=6)

Eligibility criteria:

- Documented progressive metastatic CRPC
- ≥ 1 prior taxane regimen
- ≥ 1 prior ARPI
- 0 to 1 ECOG status
- Life expectancy >6 months

No requirement of prophylactic steroids or IL-6 therapy except for exploratory analysis in high dose cohort (n=3)

ARPI: androgen receptor pathway inhibitor; CRPC: castration-resistant prostate cancer; DLT; dose limiting toxicities; ECOG; Eastern Cooperative Oncology Group; PSMA: prostate-specific membrane antigen; QW: once weekly; Q3W: once every 3 weeks; TCE: T-Cell Engager
VIR-5500-V101 ClinicalTrials.gov Identifier: NCT05356741 Data as of: January 9, 2026

Late-line mCRPC population including patients with liver metastases

VIR-5500 baseline characteristics NCT05997615	VIR-5500 N=58
Median age, years (range)	68 (49-81)
Prior lines of therapy (Any Setting)	
Number, Median (Min, Max)	4 (2, 7)
Prior Taxane, n (%)	55 (94.8)
Prior ARPI, n (%)	58 (100)
Prior PSMA-radioligand therapy [a], n (%)	7 (12.1)
Baseline Central PSA, ng/mL	79
Median (min, max)	(4, 3708)
Disease Characteristics	
RECIST-evaluable [b], n (%)	30 (51.7)
Bone metastases, n (%)	52 (92.9)
Lymph node metastases, n (%)	18 (32.1)
Visceral metastases [c], n (%)	25 (44.6)
Liver metastases, n (%)	10 (17.9)

Study & enrollment details:

Heavily pre-treated participants:

- Median 4 prior lines of therapy
- 95% prior taxanes in any setting*
- 12% prior PSMA-radioligand therapy (mostly in low dose cohorts)
- 2 with prior STEAP1 TCE

Significant disease burden in all cohorts:

- 93% of subjects with bone metastases
- 45% visceral metastases
  - 18% liver metastases (poor prognosis)

*Participants who were deemed clinically unsuitable to be treated with a taxane regimen or have refused treatment with a taxane regimen are considered eligible.

[a] 4 of 7 Prior PSMA-radioligand therapy treated patients received VIR-5500 doses ≤ 120 µg/kg.
[b] RECIST-evaluable population is defined as having measurable disease documented at baseline according to RECIST v1.1 criteria and at least one follow-up tumor assessment after a full cycle of treatment
[c] Visceral metastases include site of lesions in lung, adrenal and liver.
Max: maximum; mCRPC; metastatic castration-resistant prostate cancer; Min: minimum; N: number of participants; PSA: prostate-specific antigen; PSMA: prostate-specific membrane antigen; RECIST: Response Evaluation Criteria in Solid Tumors; STEAP1: Six-transmembrane epithelial antigen of the prostate 1; TCE: T Cell Engager
VIR-5500-V101 ClinicalTrials.gov Identifier: NCT05997615. Data as of: January 9, 2026

VIR-5500 Phase 1 study shows favorable safety profile with meaningful anti-tumor activity

Well tolerated with no dose limiting toxicities

- 12% Grade ≥ 3 TRAEs
- Limited CRS 50% (29/58) primarily seen in first cycle and mostly Grade 1 (Fever Only)
- No DLTs

Dose-dependent and meaningful anti-tumor activity

- Clear dose-response relationship with deeper PSA declines observed with higher doses
- 45% (5/11) ORR of RECIST-evaluable* patients (Q3W ≥3,000 µg/kg)
  - 4 patients confirmed up to Week 27
  - 1 patient pending confirmation

Early signs of PSA and radiographic durability

- Emerging evidence of durable PSA_{50}, PSA_{90} and RECIST responses

≥3,000 µg/kg Q3W	
CRS	
All Grades	59% (13/22)
Grade 1	50% (11/22)
Grade 2	9% (2/22)
Grade 3	0
PSA Response	
PSA_{50}	82% (14/17)
PSA_{90}	53% (9/17)
PSA_{99}	29% (5/17)

Safety evaluable population is defined as all enrolled participants who have received at least one dose of VIR-5500.

PSA evaluable population is defined as participants who received ≥1 cycle of VIR-5500 and must have at least one pre-treatment and at least one post-treatment PSA measurement.

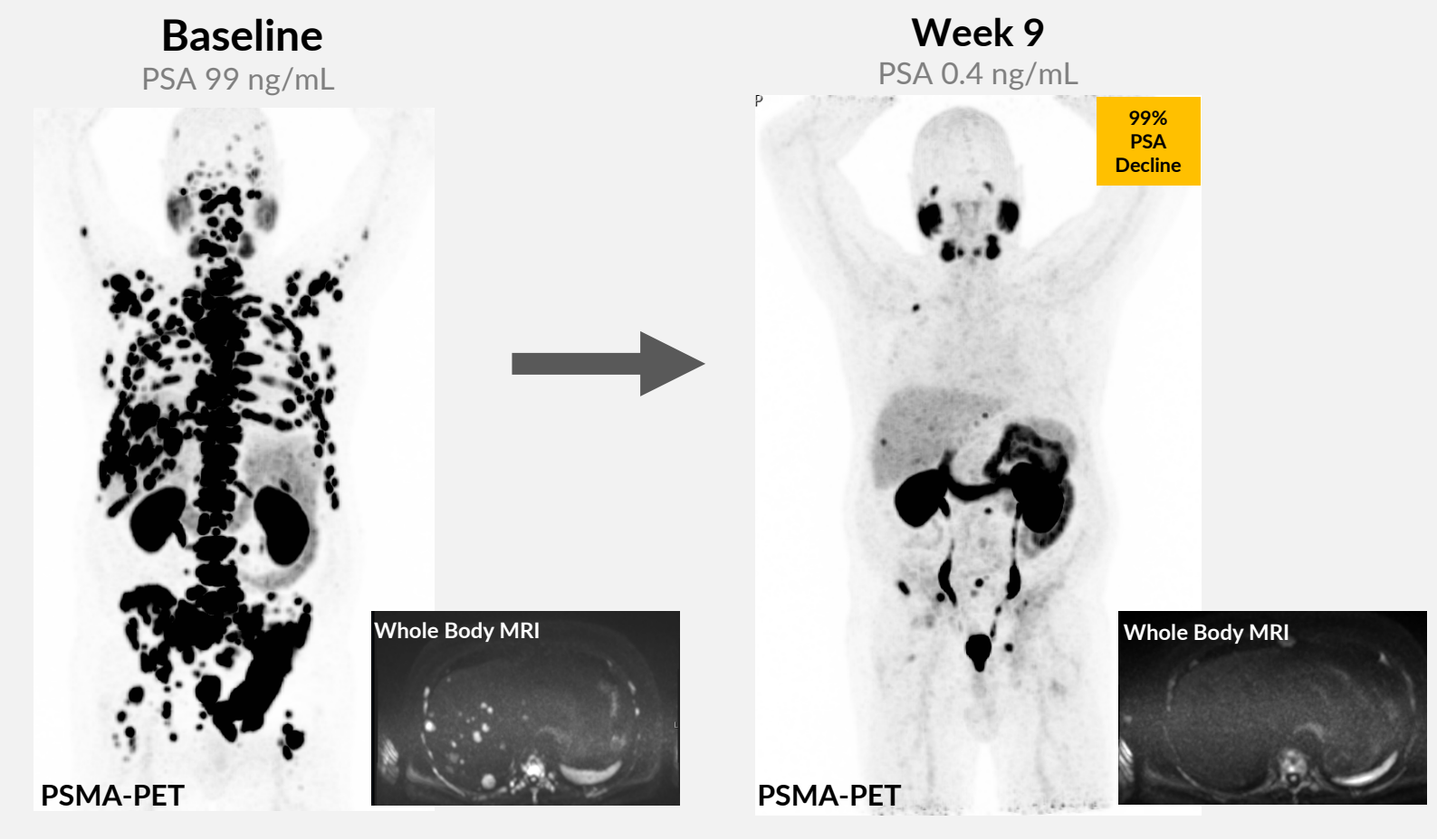
PSA_{50}, PSA decline of 50%-100% from baseline;
PSA_{90}, PSA decline of 90%-100% from baseline;
PSA_{99}, PSA decline of 99%-100% from baseline

*RECIST-evaluable population is defined as having measurable disease documented at baseline according to RECIST v1.1 criteria and at least one follow-up tumor assessment after a full cycle of treatment
CRS: cytokine release syndrome; DLT: dose limiting toxicities;G3+: Grade ≥ 3; ORR; objective response rate; PSA: prostate-specific antigen;Q3W; once every 3 weeks; RECIST: Response Evaluation Criteria in Solid Tumors; TRAE: treatment related adverse event
VIR-5500-V101 ClinicalTrials.gov Identifier: NCT05997615. Data as of: January 9, 2026

Vir Biotechnology™

Case Study 1: complete resolution of multiple (>14) liver lesions at Week 9; PSA_{99}

Q3W Cohort 800/1500/3000 µg/kg



Case study detail

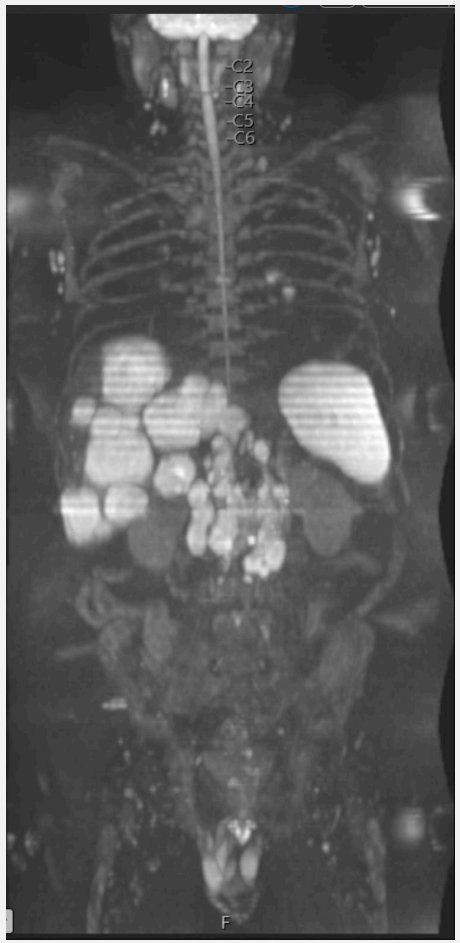
- 63-year-old male
- High-disease burden: liver and bone lesions
- 5 Prior Lines of Treatment: Docetaxel, Olaparib, Cabazitaxel, Abiaterone, MOMA-313-001
- **uPR, 63% decrease in tumor diameter**
- Metabolic response of PSMA-avid bone and hepatic lesions
- Patient bone pain resolved
- Continues on treatment (Cycle 6)

PSA: prostate-specific antigen; PSMA: prostate-specific membrane antigen; Q3W: once every 3 weeks; uPR; unconfirmed partial response
VIR-5500-V101 ClinicalTrials.gov Identifier: NCT05997615. Data as of: January 9, 2026

Case Study 2: significant RECIST response in large liver lesions

Q3W cohort 800/2000/3500 µg/kg

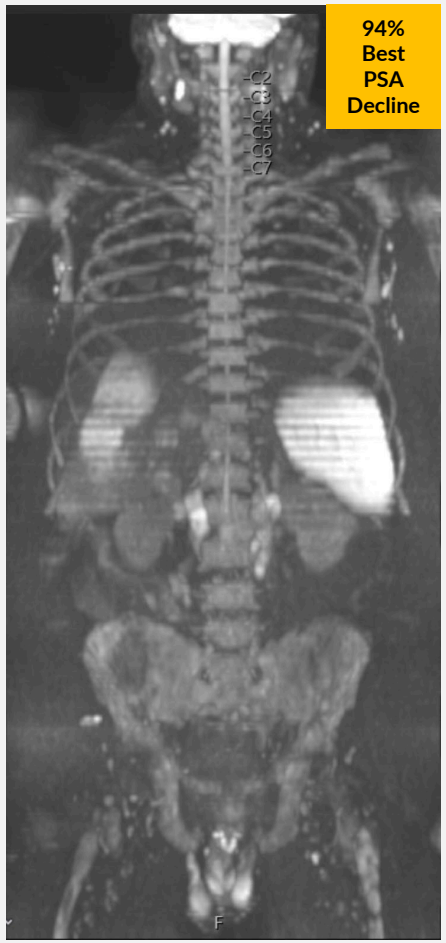
Baseline
PSA 403 ng/mL



2 Liver Lesions SLD Changes:
- **6.3 to 3.1 cm**
- **3.2 to 1.2 cm**

2 lymph-node lesions, SLD changes: A) 2.1 to 2.0 cm; B) 2.7 to 1.7 cm

Week 9
PSA 44 ng/mL



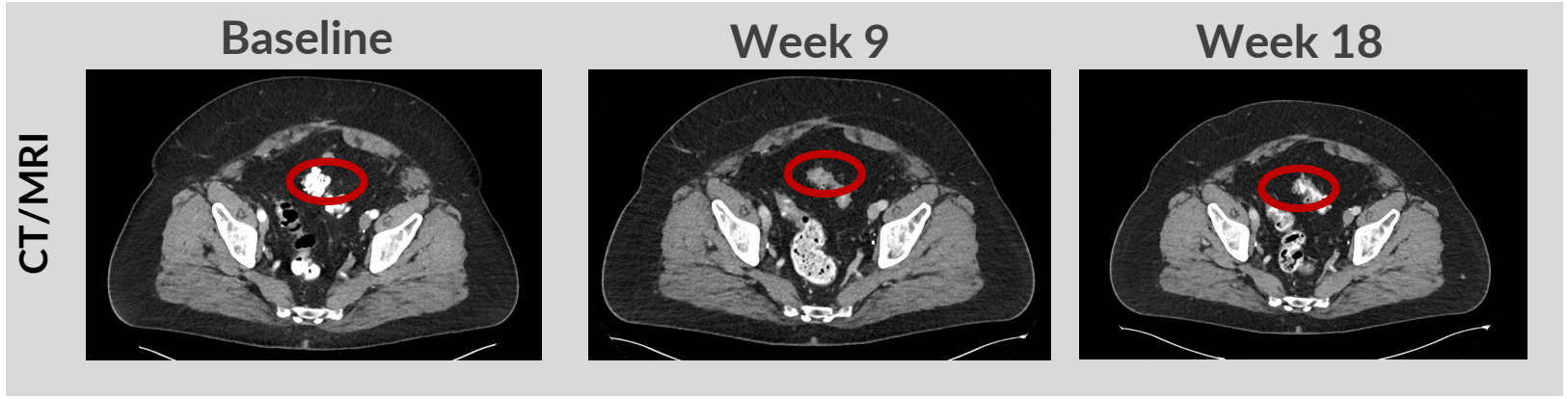
Case study detail

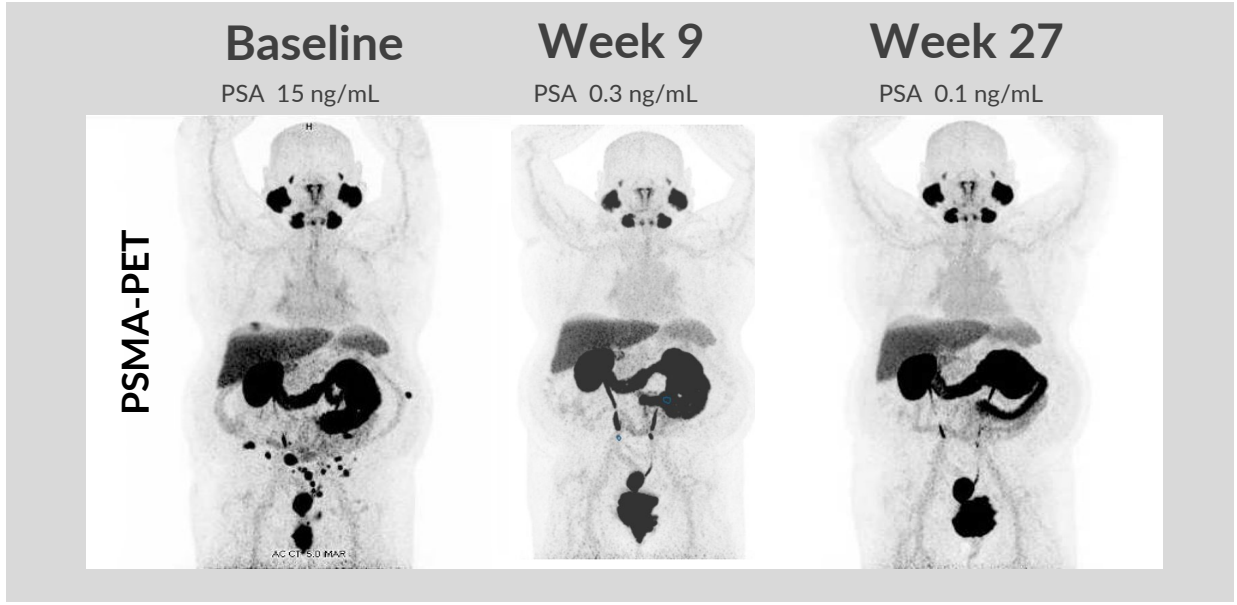
- 75-year-old male
- High-disease burden; liver and lymph-nodes (no bone lesions)
- 6 Prior Lines of Treatment: Enzalutamide, Docetaxel, Cabazitaxel, and NX-1607
- **Confirmed PR, 46% decrease in tumor diameter**
- Disappearance of majority of PSMA-avid hepatic lesions
- Continues on study (Cycle 10)

PR: partial response; PSA: prostate-specific antigen; PSMA: prostate-specific membrane antigen; Q3W: once every 3 weeks; RECIST: Response Evaluation Criteria in Solid Tumors; VIR-5500-V101 ClinicalTrials.gov Identifier: NCT05997615. Data as of: January 9, 2026

Case Study 3: durable RECIST, PSMA-PET and deep PSA response up to 8 months

Q3W cohort 800/2000/3500 µg/kg





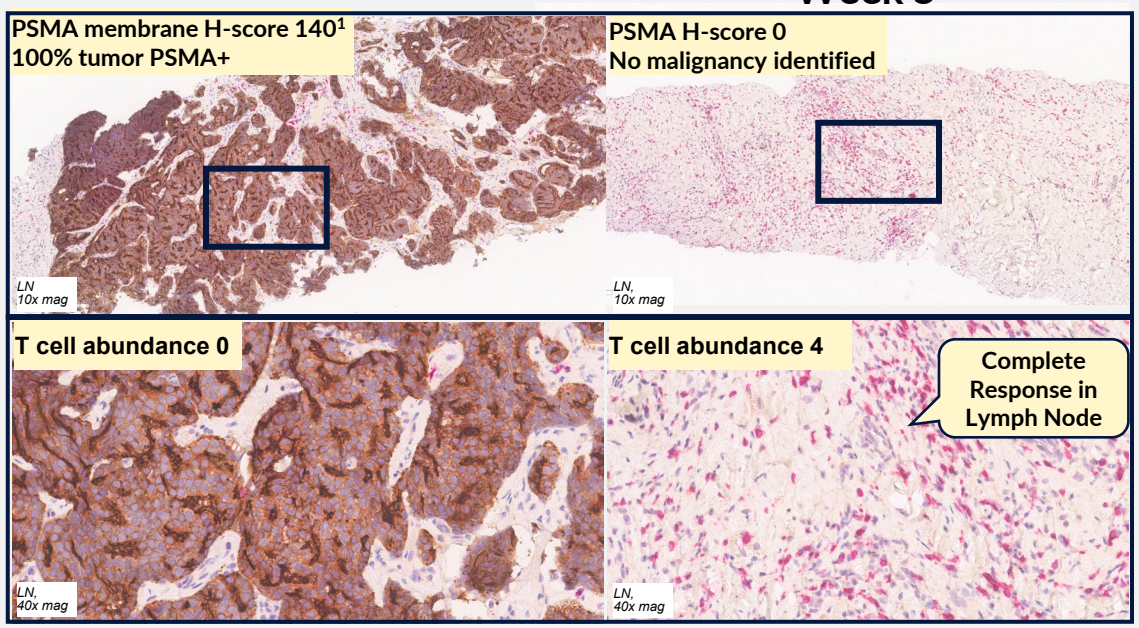
Case study detail

- 70-year-old male with peritoneal and abdominal wall lesions
- 3 Prior lines of Treatment: Enzalutamide, Docetaxel, Cabazitaxel
- **Confirmed PR,** complete resolution of small lesions
- Ongoing sustained PSA_{90} response at 8 months
- Complete PSMA-PET response
- Excellent Quality of life
- Continues on study (Cycle 10)

PET: positron emission tomography; PR: partial response; uPR: unconfirmed partial response; PSA: prostate-specific antigen; PSMA: prostate-specific membrane antigen; Q3W: once every 3 weeks; RECIST: Response Evaluation Criteria in Solid Tumors
VIR-5500-V101 ClinicalTrials.gov Identifier: NCT05997615. Data as of: January 9, 2026

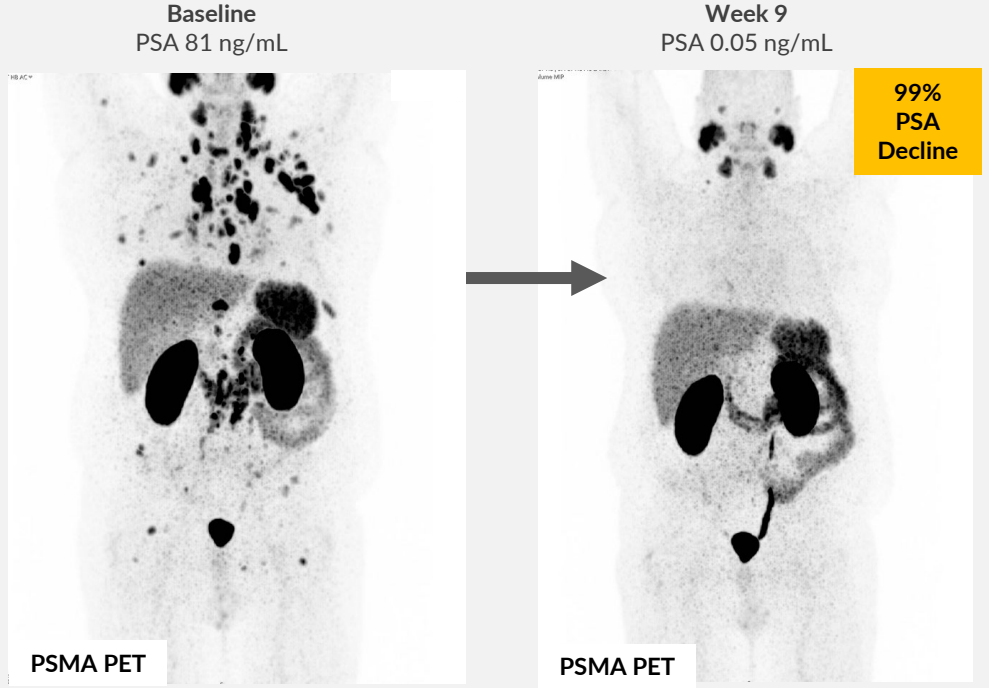
Case Study 4: complete response in diffuse lesions with prior radioligand therapy

Lymph Node Biopsy
PSMA/CD3 Duplex IHC



Brown = PSMA+ tumor cells Pink = CD3 T cells

Q3W Cohort 1000/2000/4000 µg/kg with Prophylactic Steroids

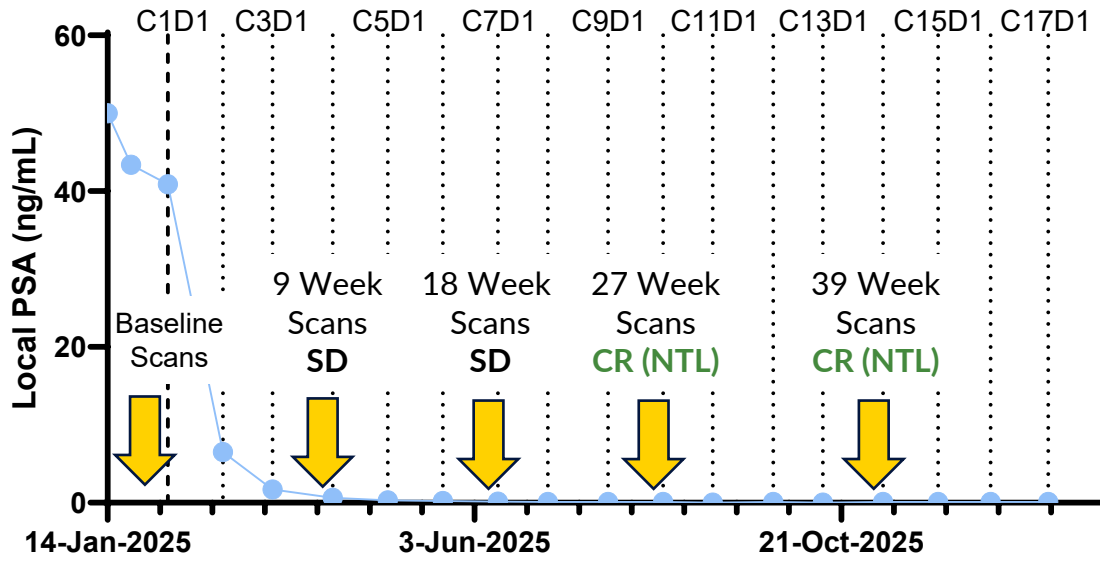


Case Study Detail

- 63-year-old male with lymph-node and bone lesions
- 5 prior lines of Treatment including Enzalutamide, Docetaxel, TAS3681 AR antagonist, and RLT (^{225}Ac-pelgifatama)
- **CR for target lesions** and non-CR/non-PD for non-target bone lesions; PSA_{99} at Cycle 2 Day 1 (Week 4)
- Excellent quality of life, with significant reduction in pain
- Patient withdrew from the study on Cycle 5, while in remission since deriving significant benefit

AR: androgen receptor; CD3: cluster of differentiation 3; CR: complete response H-score: histo-score; IHC: immunohistochemistry; PD: progressive disease; PSA: prostate-specific antigen; PSMA: prostate-specific membrane antigen; Q3W: once every 3 weeks; RLT: radioligand therapy
VIR-5500-V101 ClinicalTrials.gov Identifier: NCT05997615. Data as of: January 9, 2026

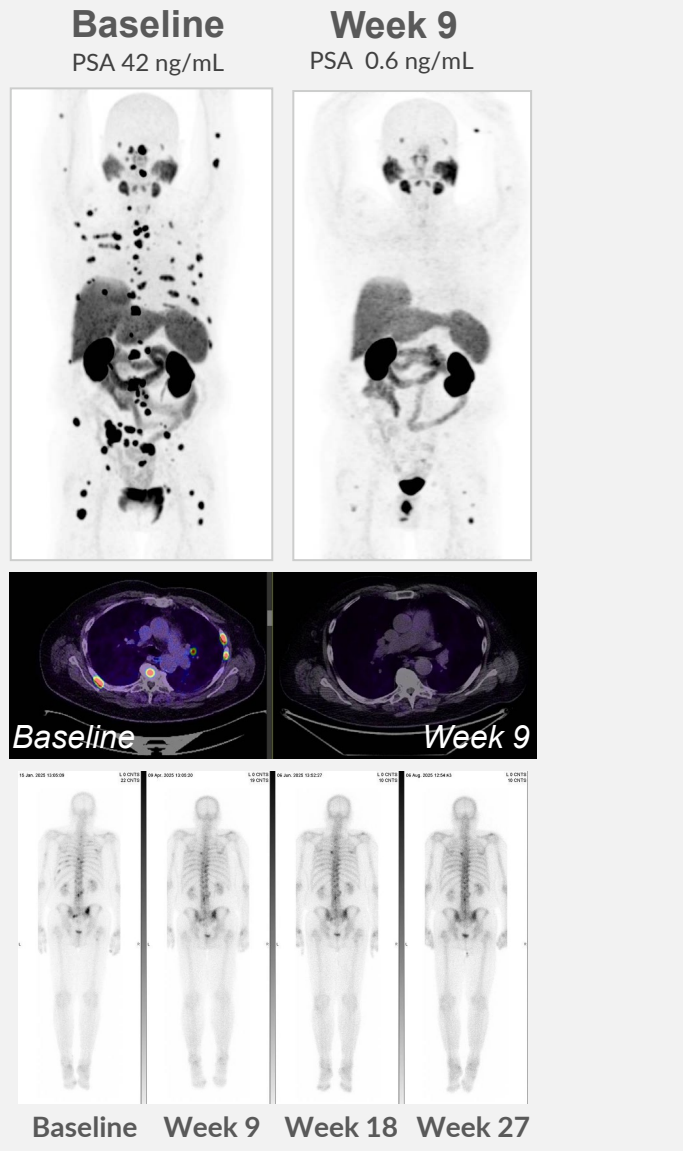
Case Study 5: complete response with ~12 months of durability



Case study detail

- 77-year-old male
- Significant disease burden including >20 bone lesions and positive lymph nodes
- 4 prior lines of Treatment:
- Darolutamide, Abiraterone, Olaparib, and Docetaxel
- **Complete Response** per PCWG3 at Cycle 9/Week 27
- Significant PSA responder with PSA_{90} response starting at Cycle 3 Day 1 and PSA currently undetectable
- Continues on treatment (Cycle 17)

Q3W cohort 300/600/1000 µg/kg



CR: complete response; NTL: non-target lesion; PCWG3: prostate cancer working group 3; PSA: prostate-specific antigen; Q3W: once every 3 weeks; SD: stable disease

VIR-5500-V101 ClinicalTrials.gov Identifier: NCT05997615. Data as of: January 9, 2026

Well-tolerated with favorable safety profile

12% grade ≥ 3 TRAEs, limited CRS, mostly grade 1 (Fever Only), and no DLTs

Limited High-Grade Events and Tx Discontinuations

TEAEs in any Participant n (%) (N=58)	
Any TEAE	58 (100)
Related TEAE	50 (86.2)
Serious Related TEAE	17 (29.3)
Related Grade ≥ 3 TEAE#	7 (12.1)
TEAE Leading to Treatment Discontinuation^	2 (3.4)

Related Grade ≥ 3 TEAE: AST increased, neutrophil count decreased, WBC count decreased, cytokine release syndrome (in participant at 200-300-400 ug/kg undergoing intraparticipant dose escalation), tumor flare/arthralgia, neutropenia, blurred vision, lymphocyte count decreased, bone pain

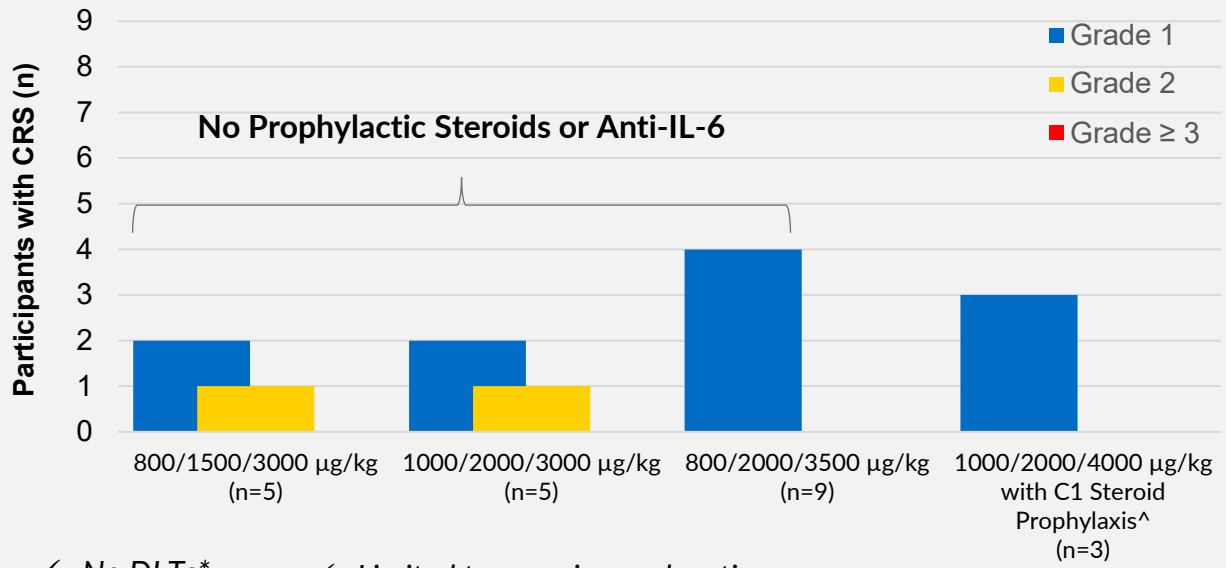
^ One unrelated spinal cord compression requiring radiation therapy and one Grade 4 treatment-related blurred vision event that improved, with unclear pathophysiology & non-specific MRI findings.

Treatment Related AEs (Most Frequent) in Doses ≥3,000 µg/kg Q3W (N=22)

Preferred Term	Grade 1	Grade 2	Grade ≥ 3
Participant with at least 1 TRAE	9 (41)	9 (41)	3(14)[1]
Cytokine Release Syndrome	11 (50)	2 (9)	0
Back Pain	3 (14)	2 (9)	0
Fatigue	3 (14)	2 (9)	0
Infusion Related Reaction	4 (18)	1 (5)	0
Anemia	1 (5)	3 (14)	0
Asthenia	4 (18)	0	0
Nausea	4 (18)	0	0
Blurred Vision	1 (5)	0	2 (9)

[1] G3 Neutropenia (2), G3 Tumor Flare, G3 Bone Pain (2), G3 Lymphocyte Decrease; G3 Vision Blurred, G4 Vision Blurred

Low Grade CRS in Doses ≥3,000 µg/kg Q3W (N=22)



- ✓ *No DLTs**
- ✓ *No ICANS*
- ✓ *Limited transaminase elevation*
- ✓ *Very Low incidence of hypoacusis, xerostomia, dry eye, stomatitis or dysgeusia; Grade 1 only*[1]

No requirement of prophylactic steroids or IL-6 therapy except for exploratory analysis in high dose cohort (n=3)

* Two blurred vision events at the 4,000 ug/kg dose were reviewed and incorporated into dose-escalation considerations and ongoing study conduct

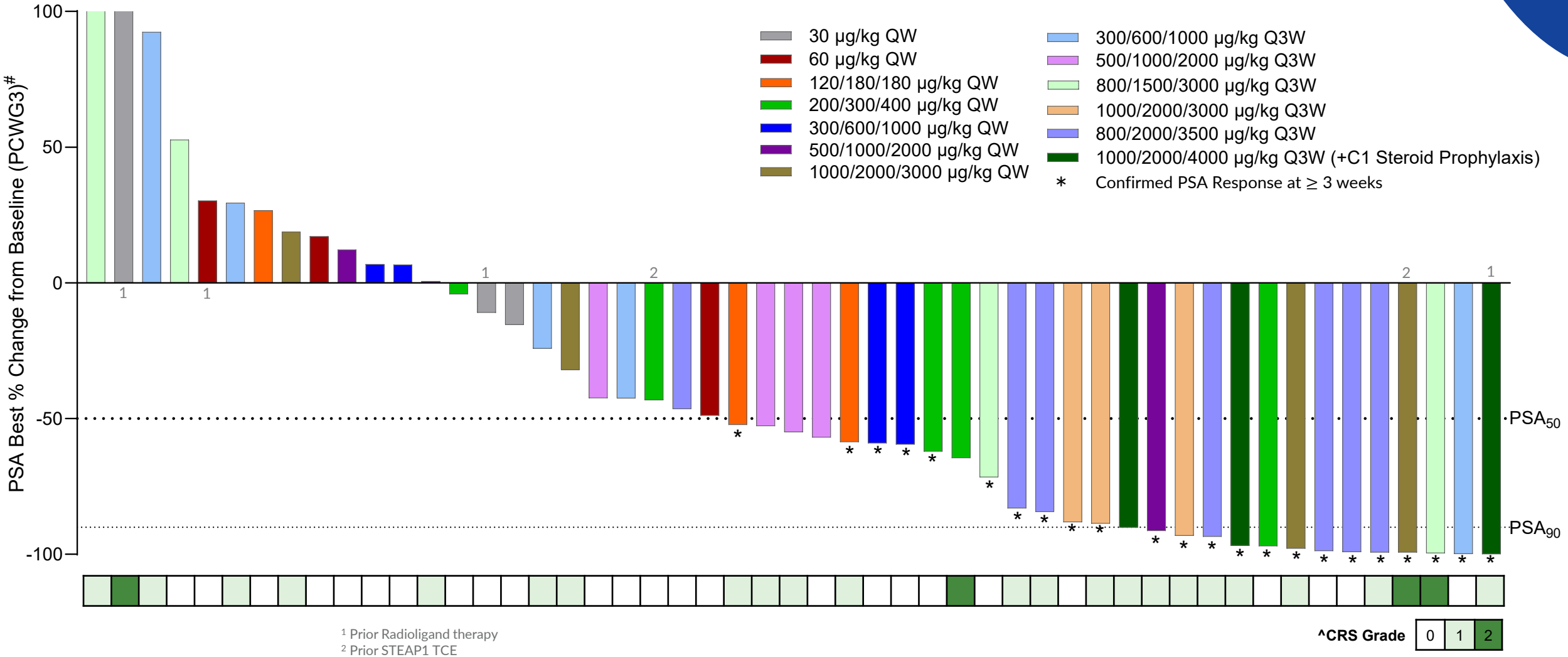
^ 4-8 mg of Dexamethasone premedication in cycle 1 evaluated in 1000-2000-4000 ug/kg Q3W cohort.

[1] Grade 1 events: Dry Mouth/Xerostomia (4), Dry Eye (2), Hypoacusis (5), Stomatitis (1), Dysgeusia (1), Renal toxicities (2); as well as 3 unrelated SAEs of Acute Kidney Injury and Hematuria

AE: adverse event; C1: cycle one; CRS: cytokine release syndrome; DLT: dose limiting toxicities; ICANS: immune effector cell-associated neurotoxicity syndrome; Q3W: once every 3 weeks; TEAE: treatment emergent adverse event

VIR-5500-V101 ClinicalTrials.gov Identifier: NCT05997615. Data as of: January 9, 2026

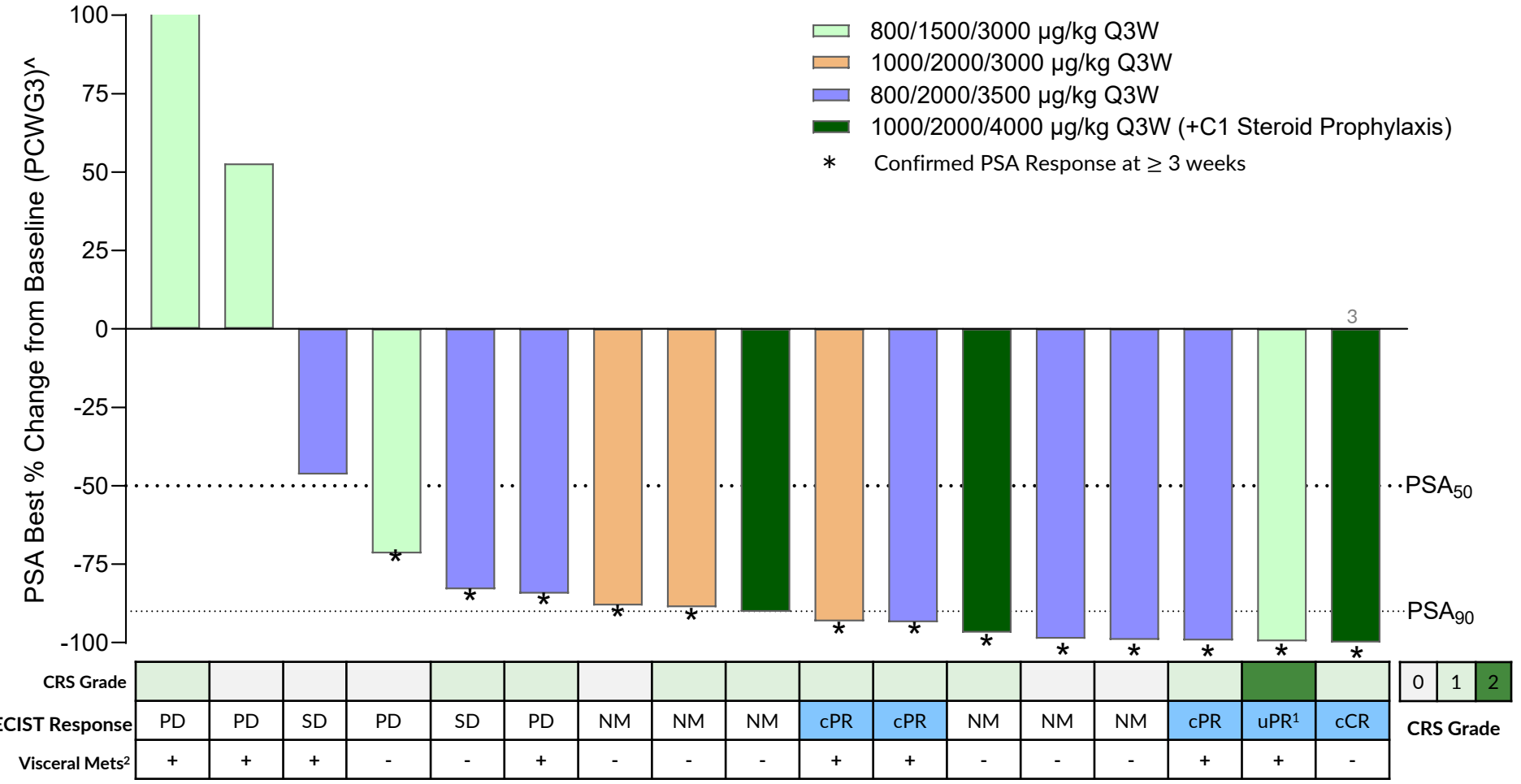
Dose response relationship: deeper PSA declines and confirmed PSA responses at higher doses



[1] Prior Radioligand therapy
[2] Prior STEAP1 TCE
PCWG3 (Prostate Cancer Working Group 3) measured PSA rise or fall at ≥C2D1. Y-axis truncated at 100. All Best PSA %Changes occurred prior to intra-patient dose escalation
^ CRS event grade at dose indicated, prior to any intra-patient dose escalation
C1: cycle one; PSA: prostate-specific antigen
VIR-5500-V101 ClinicalTrials.gov Identifier: NCT05997615. Data as of: January 9, 2026

Deep PSA declines observed as early as Cycle 1 Day 8, evidence of concordant RECIST responses in evaluable patients

Doses ≥ 3000 ug/kg Q3W



[1] Week 18 visit pending for RECIST confirmation
[2] Visceral metastases include site of lesions in lung, adrenal and liver
[3] Prior Radioligand therapy
C1: cycle one; cCR: confirmed complete response; cPR: confirmed partial response; CRS: cytokine release syndrome; NM: non-measurable disease; PD: progressive disease; PR: partial response; PSA: prostate-specific antigen; Q3W: once every 3 weeks; RECIST: Response Evaluation Criteria in Solid Tumors; SD: stable disease; uPR: unconfirmed partial response

≥ 3000 µg/kg Q3W

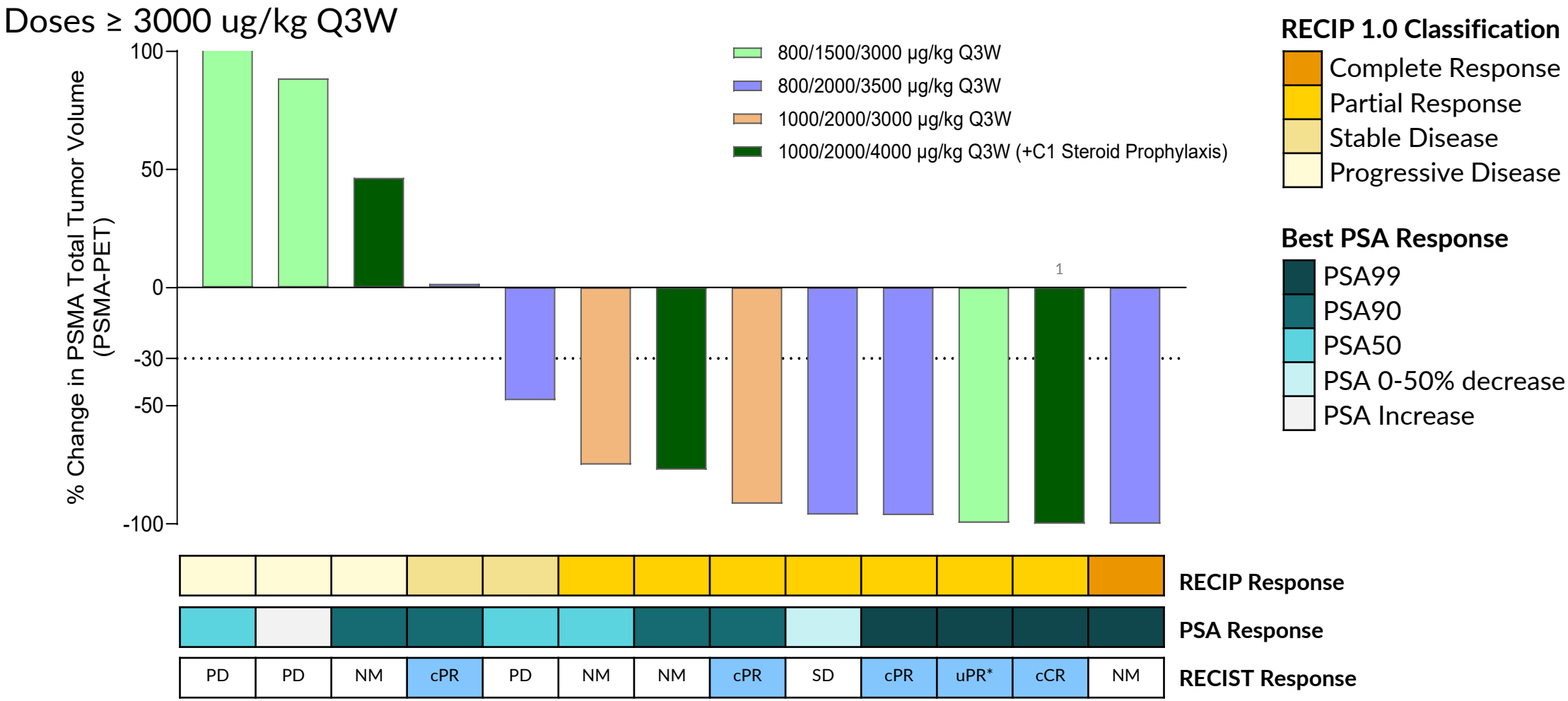
Any PSA Decline	15/17 (88%)
PSA_{50}	14/17 (82%)
PSA_{90}	9/17 (53%)
PSA_{99}	5/17 (29%)

Significant Anti-tumor Responses:

- Rapid and deep responses as soon as Cycle 1 Day 8
- Participants with the deepest PSA responses (PSA_{90} & PSA_{99}) often had confirmed RECIST responses

PSA_{50}, PSA decline of 50%-100% from baseline;
PSA_{90}, PSA decline of 90%-100% from baseline;
PSA_{99}, PSA decline of 99%-100% from baseline
Evaluable participants who received ≥1 cycle of VIR-5500
PCWG3 measured PSA at ≥C2D1. Y-axis truncated at 100
VIR-5500-V101 ClinicalTrials.gov Identifier: NCT05997615. Data as of: January 9, 2026

Reduction in PSMA total tumor volume by central PSMA PET analysis, RECIP responses associated with deep PSA declines and RECIST responses



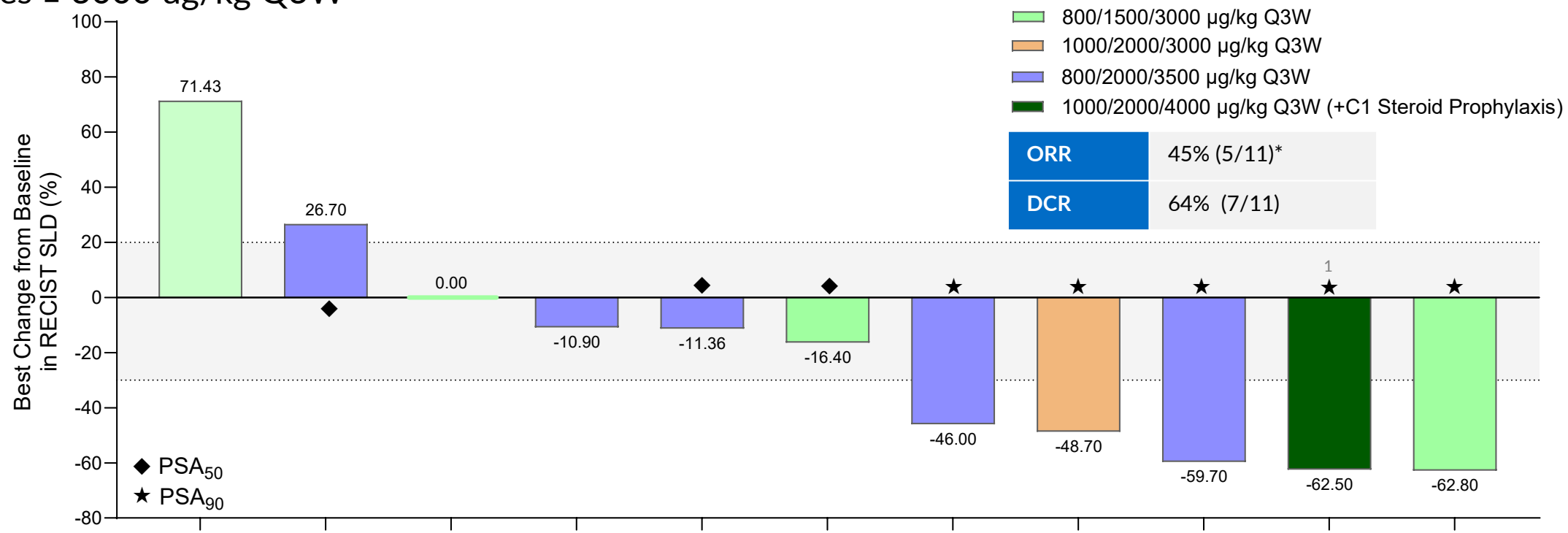
Imaging performed at baseline and at 9 weeks, or EOT, whichever comes first.
PSMA-Total Tumor Volume is the sum of all PSMA-avid lesions (bone and soft tissue) in cubic centimeters.
https://pubmed.ncbi.nlm.nih.gov/40473460/
Y-axis truncated at 100%

C1: cycle one; cCR: confirmed complete response; cPR: confirmed partial response; EOT: end of treatment; NM: non-measurable disease; PD: progressive disease; PET: positron emission tomography; PSA: prostate-specific antigen; PSMA; prostate-specific membrane antigen; Q3W: once every 3 weeks; RECIP: Response Evaluation Criteria in PSMA; RECIST: Response Evaluation Criteria in Solid Tumors; SD: stable disease; uPR: unconfirmed partial response

[1] Prior Radioligand therapy

Robust RECIST responses with VIR-5500 monotherapy in RECIST-evaluable participants

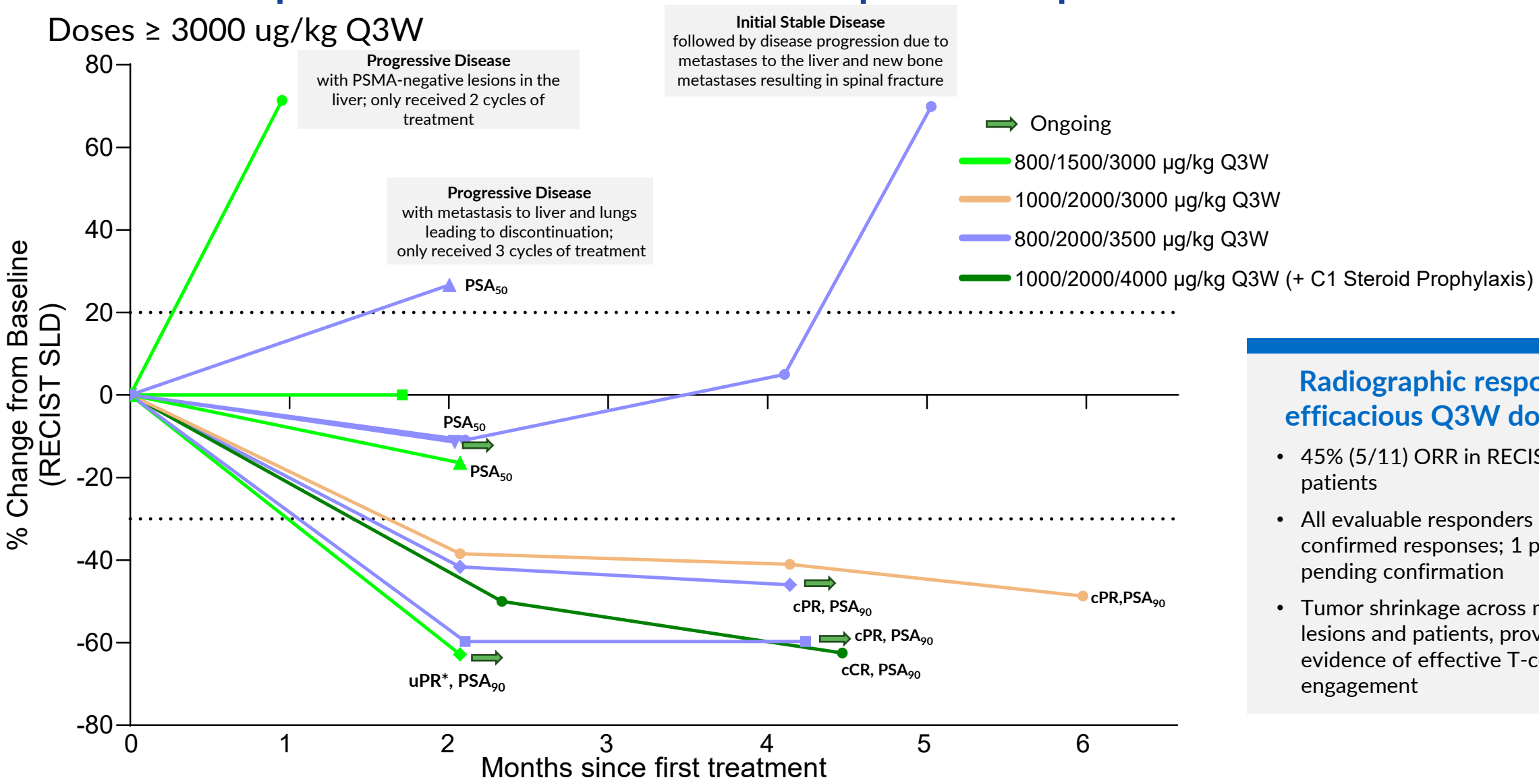
Doses ≥ 3000 ug/kg Q3W



Measurable Lesion Site	Liver	Liver, Adrenal	Adrenal gland	Liver, Abdom wall	Lymph nodes	Lymph node	Liver, LN	Lymph Nodes	Peritoneal implants	Lymph node	Liver
Best Overall Response	PD	PD	PD (new lesions)	SD	SD	PD (new lesions)	**cPR**	**cPR**	**cPR**	**cCR**	**uPR** (Wk 18 pending)
PSMA PET Response (SUVmax)	Not available	-79.6%	8.3	-78%	-64.1%	-22.6%	-89.7%	-95%	-81%	-88.2%	-97.3%

[1] Prior Radioligand therapy
* 4 patients with confirmed responses and 1 patient pending confirmation
Imaging performed every 9 weeks
Baseline Assessment: patient must have measurable disease per RECIST criteria at baseline
Post-Baseline Assessment: at least one follow-up tumor assessment after starting treatment is required to determine response (CR, PR, SD, PD)
C1: cycle one; cCR: confirmed complete response; cPR: confirmed partial response; DCR: Disease Control Rate (includes SD+PR+CR); NM: non-measurable disease; ORR: objective response rate; PD: progressive disease; PET: positron emission tomography; PR: partial response; PSA: prostate-specific antigen; PSMA: prostate-specific membrane antigen; Q3W: once every 3 weeks; RECIST: Response Evaluation Criteria in Solid Tumors; SD: stable disease; SLD: sum of longest diameters; QW: once weekly; PD: progressive disease; uPR: unconfirmed partial response

RECIST responses concordant with deep PSA responses



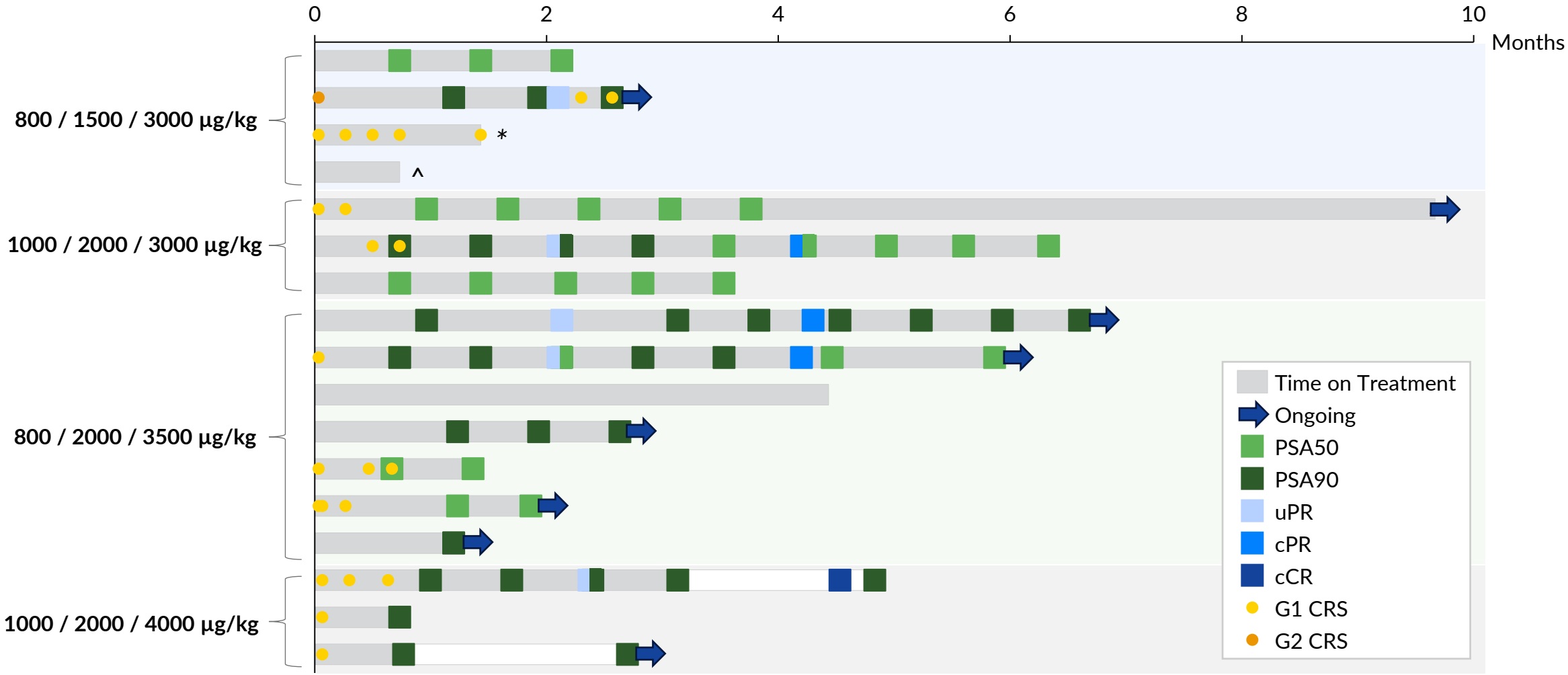
Radiographic responses at efficacious Q3W dose levels

- 45% (5/11) ORR in RECIST-evaluable patients
- All evaluable responders achieved confirmed responses; 1 patient pending confirmation
- Tumor shrinkage across multiple lesions and patients, providing evidence of effective T-cell engagement

Imaging performed every 9 weeks
* Week18 visit pending
C1: cycle one; cCR: confirmed complete response; cPR: confirmed partial response; ORR: objective response rate; PSA: prostate-specific antigen; PSMA: prostate-specific membrane antigen; Q3W: once every 3 weeks; RECIST: Response Evaluation Criteria in Solid Tumors; SLD: sum of longest diameters; uPR: unconfirmed partial response
VIR-5500-V101 ClinicalTrials.gov Identifier: NCT05997615. Data as of: January 9, 2026

Emerging evidence of PSA and radiographic durability

Doses ≥ 3000 ug/kg Q3W, CRS Restricted to Early Cycles



*101-1007: PSMA-positive brain lesions, early progressor, received 3 cycles of VIR-5500
^101-1006: PSMA-negative liver lesions, early progressor, received 2 cycles of VIR-5500
cCR: confirmed complete response; cPR: confirmed partial response; CRS: cytokine release syndrome; G1: Grade 1; G2: Grade 2; PSA: prostate-specific antigen; Q3W: once every 3 weeks; uPR: unconfirmed partial response
VIR-5500-V101 ClinicalTrials.gov Identifier: NCT05997615. Data as of: January 9, 2026

Next steps for VIR-5500: rapid advancement into earlier treatment setting in prostate cancer

Conclusion of monotherapy QW and Q3W dose escalation in late-line mCRPC

Initial monotherapy recommended expansion dose

- Q3W 800/2000/3500 µg/kg (Late-line) ✓

Progressing toward initiating expansion dose cohorts in 2Q'26

- Late-line mCRPC (Monotherapy) ✓
- Early-line mCRPC (Combination)
- mHSPC (Combination)

Plans to initiate Phase 3 program in 2027

QW: once weekly; Q3W: once every 3 weeks; mCRPC: metastatic castration-resistant prostate cancer; mHSPC: metastatic hormone-sensitive prostate cancer

Our clinical pipeline of masked TCEs demonstrates promise of the PRO-XTEN® platform

TCE

VIR-5500 (PSMA)

The **most advanced dual-masked TCE** in clinical development for prostate cancer

Well-tolerated with favorable safety profile

Potent anti-tumor activity

Potential to move into earlier treatment settings and initiate pivotal trials in 2027

VIR-5818 (HER2)

The **only dual-masked TCE** in clinical development for HER2 tumors

PD-1 combination dose escalation **ongoing**

Phase 1 dose escalation data in 2H'26

VIR-5525 (EGFR)

Dual-masked TCE in clinical development for EGFR tumors (NSCLC, CRC, HNSCC and cSCC)

Phase 1 evaluating monotherapy and in combination with pembrolizumab **ongoing**

Phase 1 initial dose escalation data TBD

7 Preclinical Programs

Universal masking platform allows us to rapidly expand into other solid tumors with high unmet need

7 preclinical programs across solid tumors, including lung, colorectal and bladder cancers

Progressing to development candidate selection by early 2027

CRC: colorectal cancer; cSCC: cutaneous squamous cell carcinoma; EGFR: epidermal growth factor receptor; HER2: human epidermal growth factor receptor 2; HNSCC: head and neck squamous cell carcinoma; NSCLC: non-small cell lung cancer; PSMA: prostate-specific membrane antigen; TCE: T-cell engager

Financials and Closing

Q1 2026 Financial Results

$ in millions	Three Months Ended March 31, 2026	2025	Change	%
Total revenues	$—	$3.0	$(3.0)	(100%)
Operating expenses:				
Research and development [1]	108.9	118.6	(9.7)	(8%)
Selling, general and administrative [1]	23.3	23.9	(0.6)	(3%)
Total operating expenses	132.3	142.6	(10.3)	(7%)
Loss from operations	(132.3)	(139.5)	7.2	(5%)
Total other income	6.8	18.6	(11.8)	(63%)
Provision for income taxes	(0.2)	—	(0.2)	(100%)
Net loss	$(125.7)	$(121.0)	$(4.7)	4%

[1] Amount includes stock-based compensation expenses as follows:

Research and development	$6.0	$7.0	$(1.0)	(14%)
Selling, general and administrative	6.1	7.1	(1.0)	(14%)
Total stock-based compensation expense	$12.1	$14.1	$(2.0)	(14%)
Ending headcount (full-time & part-time)	365	406	(41)	(10%)

Note: Numbers may not add due to rounding.

Our strategic approach creates short and long-term value drivers

chronic hepatitis delta

ECLIPSE 1 **topline data in 4Q'26**

ECLIPSE 2 & 3 **topline data in 1Q'27**

universal masked TCEs

VIR-5500 **PSMA pivotal trials** to initiate in **2027**

VIR-5818 **HER2 data update in 2H'26**

discovery engine

7 preclinical PRO-XTEN® TCE targets identified

Progressing to **development candidate selection** by early **2027**

Strategic Collaborations

Selectively partner drug candidates to focus internal resources, unlock the value of our pipeline and maximize benefit to patients

Financial Highlights

$809.3M cash and investments[1] with **cash runway into 2H 2028**[2]

[1] Vir Bio reported cash, cash equivalents and investments of $809.3 million as of March 31, 2026. Amount excludes $315 million combined upfront and equity investment from Astellas collaboration to be received in the second quarter of 2026.

[2] Cash runway projection based on the current operating plan and incorporating the effects of the Astellas collaboration agreement.

PATIENTS ARE WAITING

Vir Biotechnology

Phase 1 Clinical Data:
VIR-5818 (HER2)

Presented January 2025

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

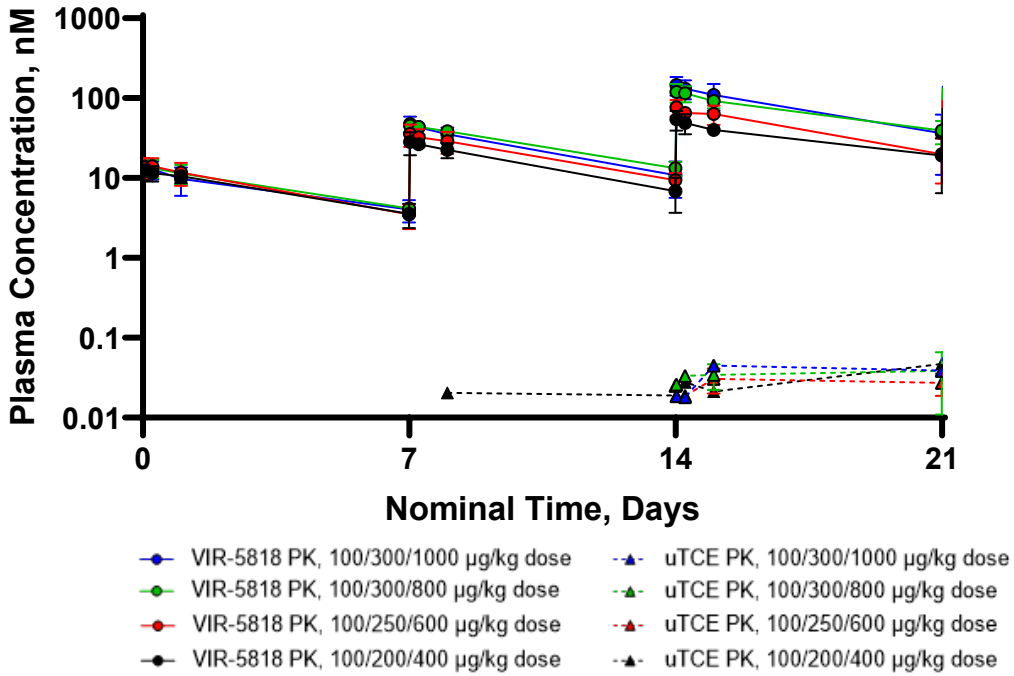
Cleared DLT

[1] Evaluating 800 µg/kg Q3W maintenance dose (cycle ≥ 2) in parallel
HER2: human epidermal growth factor receptor 2; IHC: immunohistochemistry; ISH: in situ hybridization; QW: once weekly; Q3W: once every 3 weeks; SOC: standard of care; TCE: T-cell engager
VIR-5818 ClinicalTrials.gov Identifier: NCT05356741; Data cutoff: November 11, 2024

Minimal unmasked TCE in circulation and potential for Q3W dosing

Minimal unmasked TCE outside the tumor

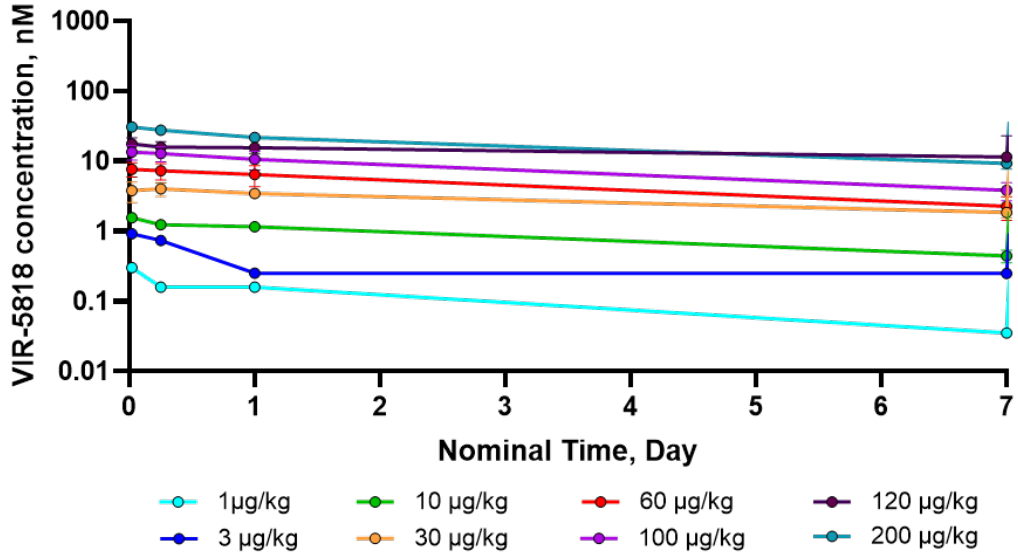
VIR-5818 and uTCE PK, First Cycle*



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
CRS: cytokine release syndrome; PK: pharmacokinetic; Q3W: once every 3 weeks; QW: once weekly; TCE: T-cell engager; uTCE: unmasked T cell engager

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

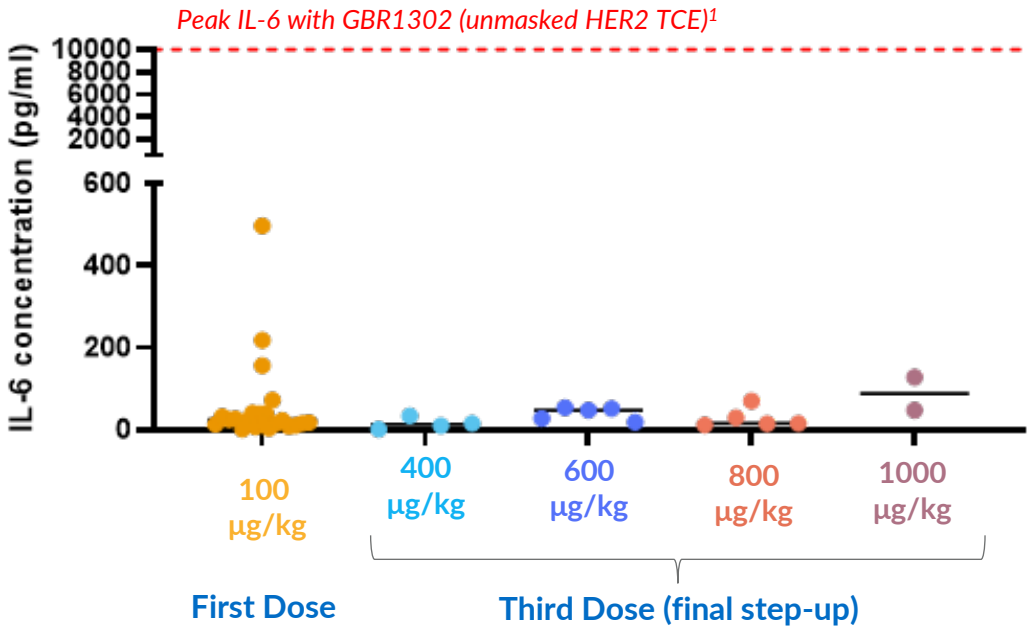
Highly Tolerable Safety

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

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

Low Cytokine Levels, Even at Higher Doses

Peaks of IL-6 Secretion Post VIR-5818 Dosing



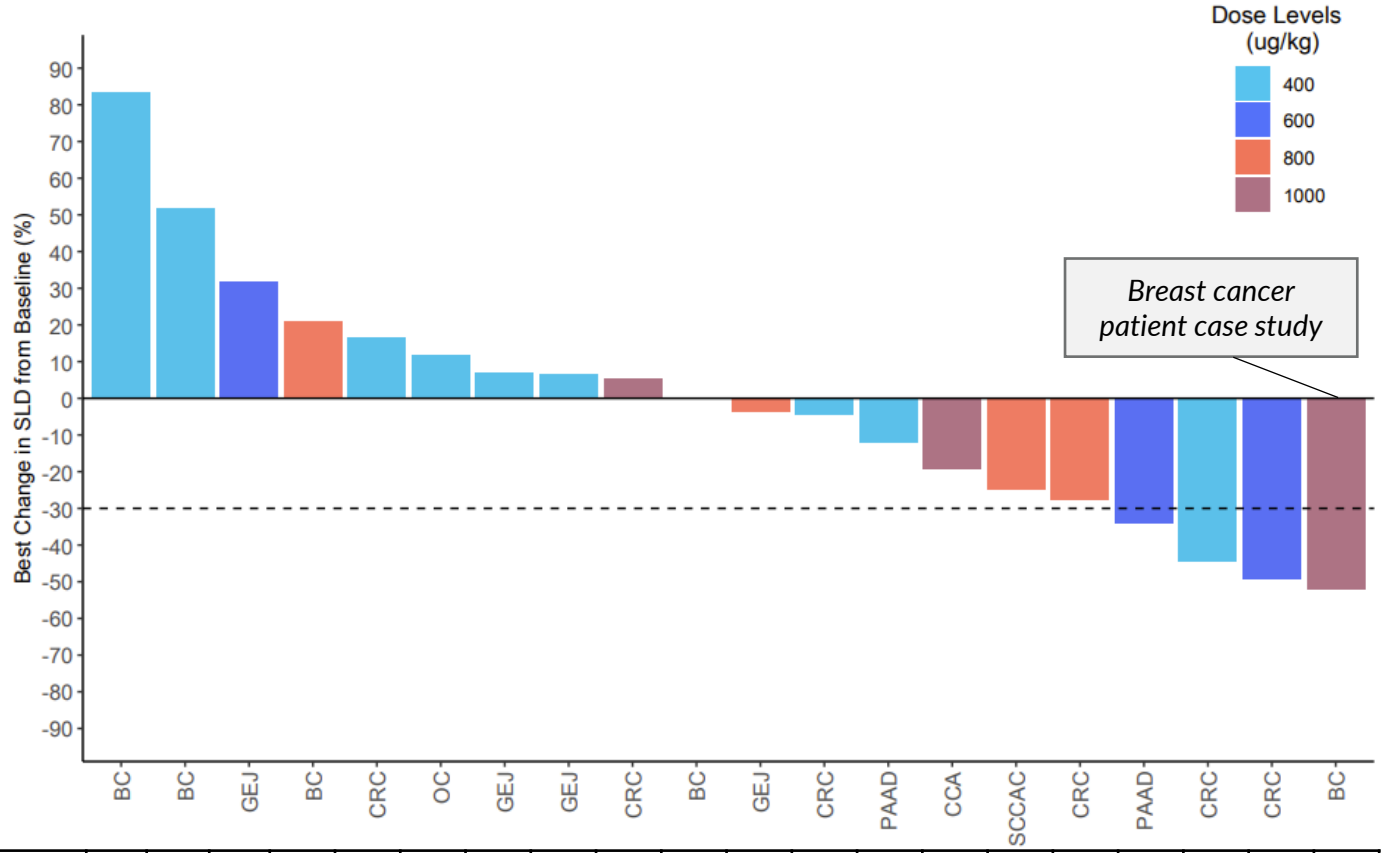
IL-6 release significantly lower than for unmasked TCEs, despite higher VIR-5818 dose

[1] Wermke et al., ASCO-SITC 2018
*Two cases of G3 pneumonitis include one event reversible with treatment and one confounded by rapid progression of pulmonary disease
CRS: cytokine release syndrome; IL-6: interleukin-6; TCE: T-cell engager; TRAE, treatment-related adverse event
VIR-5818 ClinicalTrials.gov Identifier: NCT05356741; Data cutoff: November 11, 2024

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 metastases	■	■	■	■	■		■	■	■		■		■	■	■	■	■			

Efficacy detail:

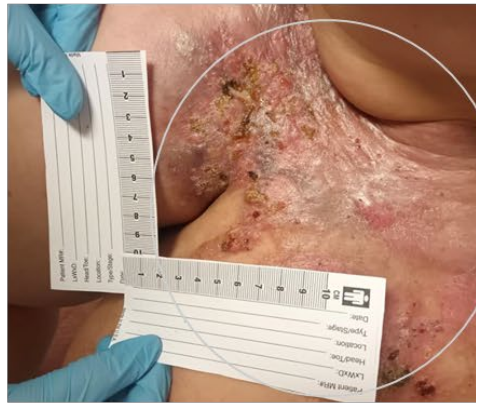
- ≥ 400 µg/kg drive significant RECIST responses
  - Dose escalation continues in QW and Q3W regimens
- 50% observed tumor shrinkage (10/20 patients), with a DCR of 65%
  - 4/20 responses to date*
  - Responses in patients with up to 9 prior lines
  - 14/20 with prior HER2 treatment

*Includes cPR, uPR, and mixed responses
Note: HER2+ defined as IHC3+ or ISH+
BC: breast cancer; CCA: cholangiocarcinoma; cPR: confirmed partial response; CRC: colorectal cancer; DCR: disease control rate; GEJ: gastroesophageal junction; HER2: human epidermal growth factor receptor 2; IHC: immunohistochemistry; ISH: in situ hybridization; OC: ovarian cancer; PAAD: pancreatic adenocarcinoma; QW: once weekly; Q3W: once every 3 weeks; RECIST: Response evaluation criteria in solid tumors; SCCAC: squamous cell carcinoma of the anal canal; SLD: sum of longest diameters; uPR: unconfirmed partial response
VIR-5818 ClinicalTrials.gov Identifier: NCT05356741; Data cutoff: November 11, 2024

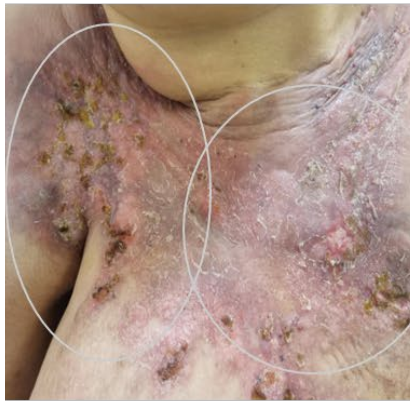
A patient's journey: dramatic response in advanced HER2+ breast cancer

Tumor pain, inflammation

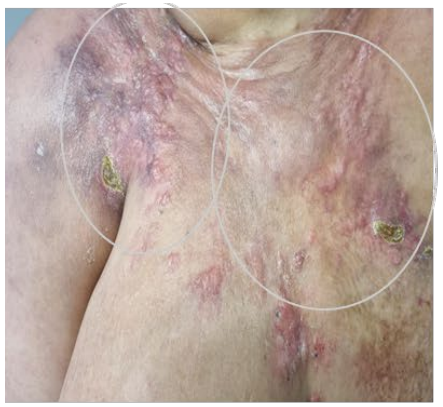
Day 1 Baseline



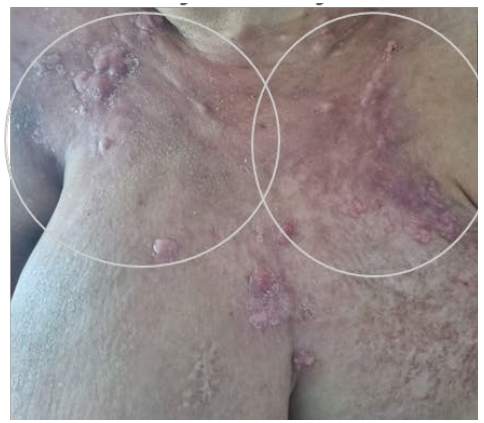
Cycle 1 Day 8



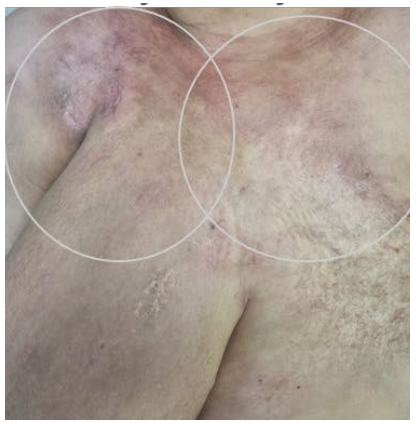
Cycle 2 Day 1



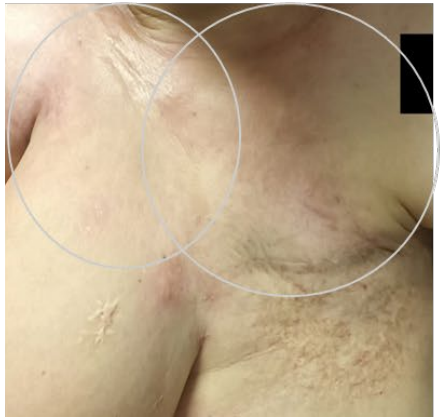
Cycle 2 Day 8



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

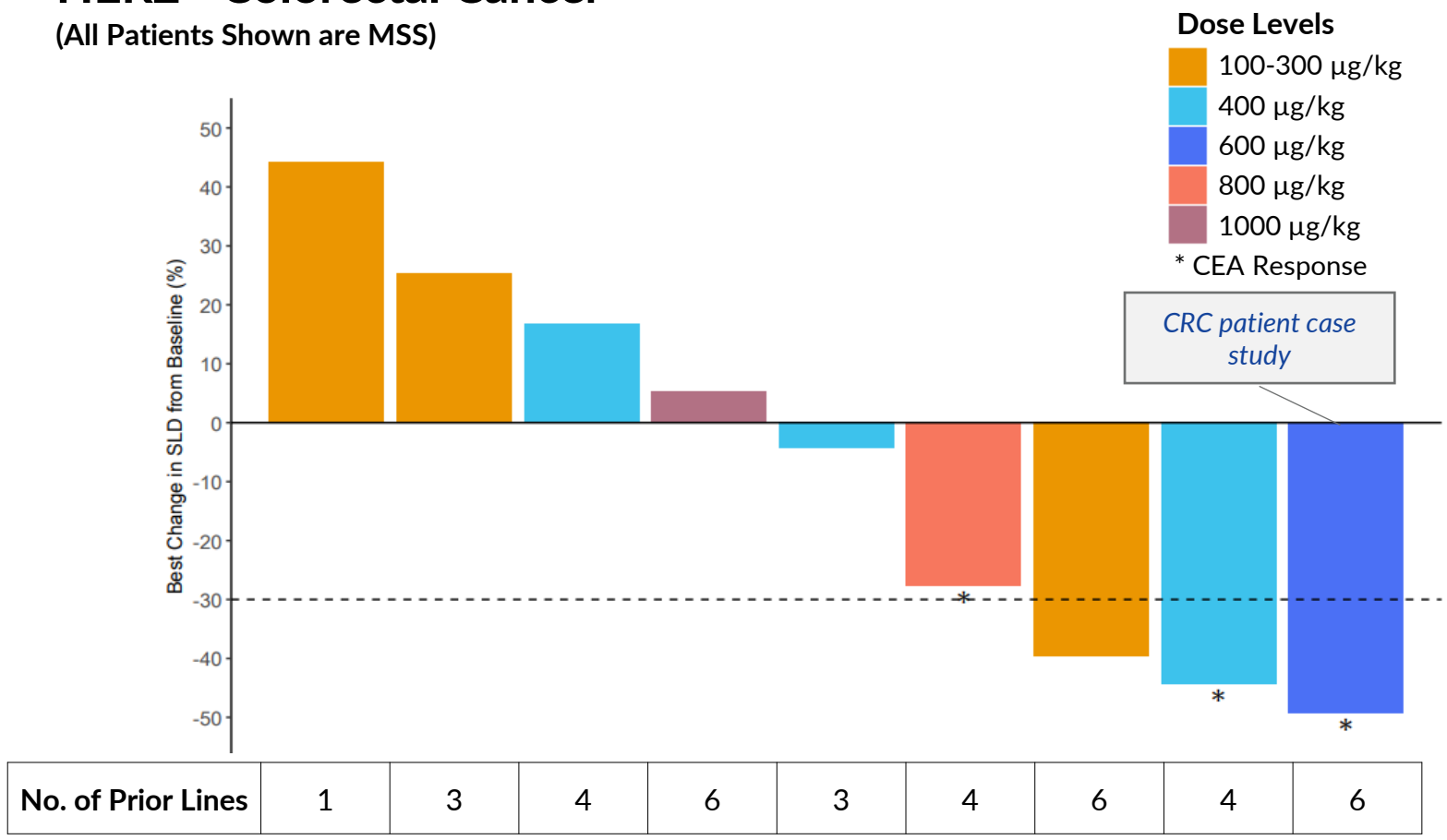
52% tumor shrinkage from baseline

HER2: human epidermal growth factor receptor 2
VIR-5818 ClinicalTrials.gov Identifier: NCT05356741; Data cutoff: November 11, 2024

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%)

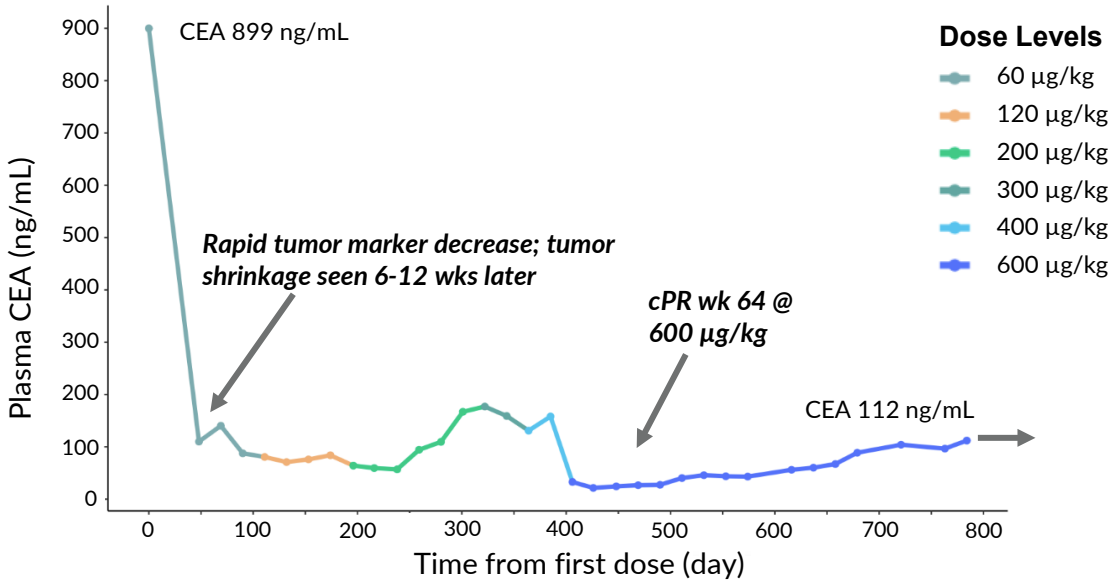
- 33% response and 100% biomarker response in mCRC
- Up to 18.1 months duration of response (pt remains on study)
- Significant room to dose escalate; potential for Q3W dosing

Note: HER2+ defined as IHC3+ or ISH+
* CEA response defined as >50% decrease in CEA post-treatment. Denominator includes all pts with longitudinal data
[1] DCR defined as stable disease or better
CEA: carcinoembryonic antigen; cPR: confirmed partial response; CRC: colorectal cancer; DCR: disease control rate; HER2: human epidermal growth factor receptor 2; IHC: immunohistochemistry; ISH: in situ hybridization; MSS: microsatellite stability; SLD: sum of longest diameters
VIR-5818 ClinicalTrials.gov Identifier: NCT05356741; Data cutoff: November 11, 2024

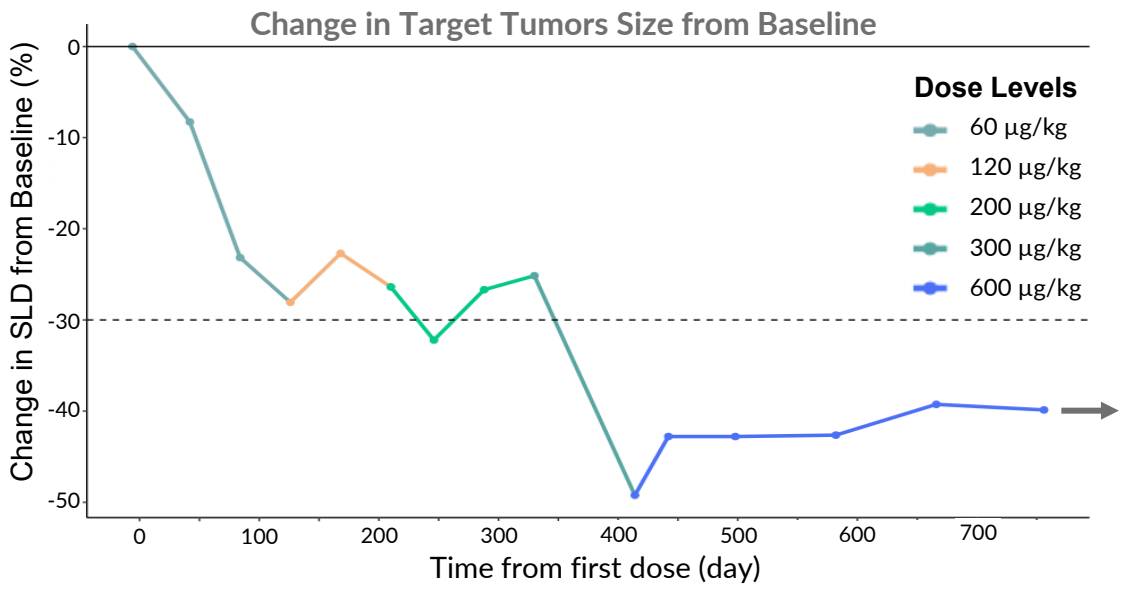
Vir Biotechnology™

Patient Case Study: 2 years on treatment, exceptional durability

Rapid and Sustained Decrease Over Time



Dose-Dependent Tumor Shrinkage



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

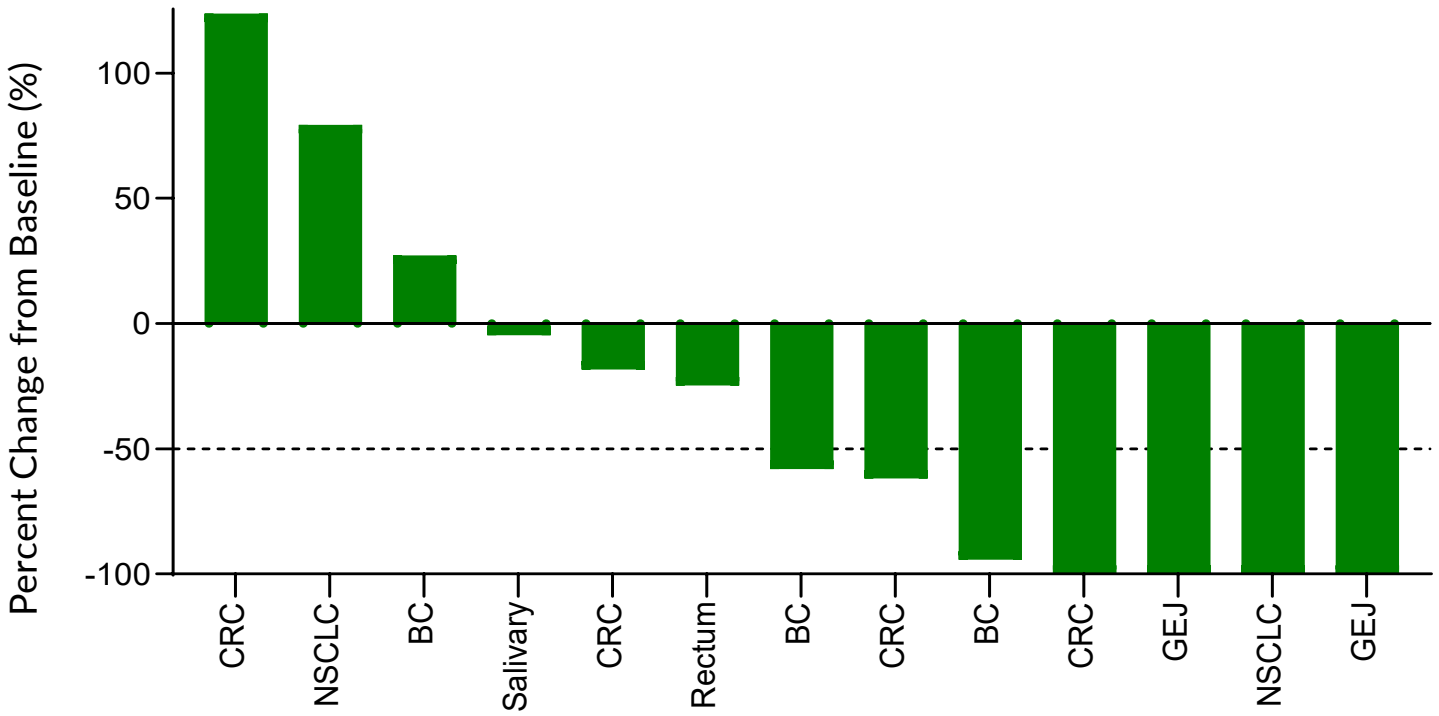
- 57-Year-old male w/ colorectal cancer (MSS/TMB Low)
- Status: remains on study (current dose: 600 µg/kg QW)
- HER2 status: IHC 3+
- 6 prior lines including trastuzumab / tucatinib
- Significant improvement on quality of life
- 114 doses as of data cutoff, patient remains on study

CEA: carcinoembryonic antigen; cPR: confirmed partial response; IHC: immunohistochemistry; MSS: microsatellite stability; QW: weekly; SLD: sum of longest diameters; TMB: tumor mutational burden
VIR-5818 ClinicalTrials.gov Identifier: NCT05356741; Data cutoff: November 11, 2024

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

BC: breast cancer; CRC: colorectal cancer; ctDNA: circulating tumor DNA; GEJ: gastroesophageal junction; NSCLC: non-small-cell lung cancer; RECIST: Response evaluation criteria in solid tumors

VIR-5818 ClinicalTrials.gov Identifier: NCT05356741; ctDNA data cutoff: November 19th, 2024; EDC data cutoff: November 11, 2024

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

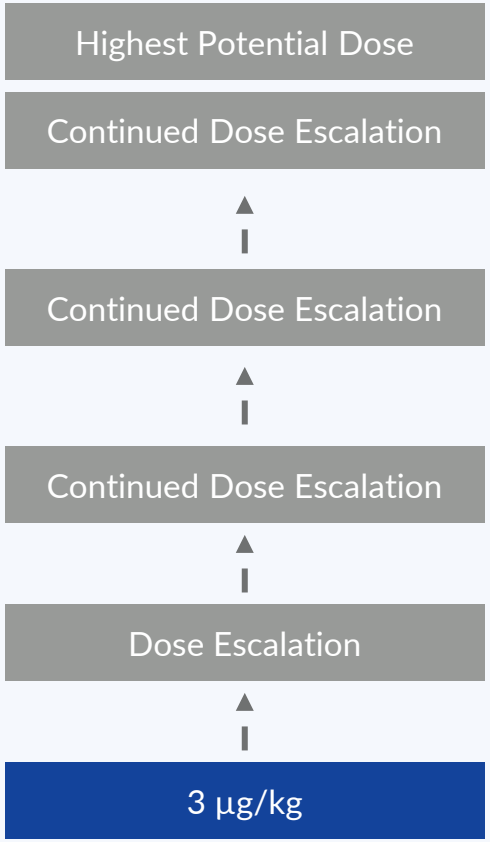
- Potential rapid dose escalation for VIR-5500 (PSMA) and other targets

CRC: colorectal cancer; CRS: cytokine release syndrome; ctDNA: circulating tumor DNA; Gr3: Grade 3; HER2: human epidermal growth factor receptor 2; PSMA: prostate-specific membrane antigen; TCE: T-cell engager; TI: therapeutic index; TRAE: treatment-related adverse event
VIR-5818 ClinicalTrials.gov Identifier: NCT05356741; Data cutoff: November 11, 2024

Phase 1 Clinical Program:
VIR-5525 (EGFR)

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

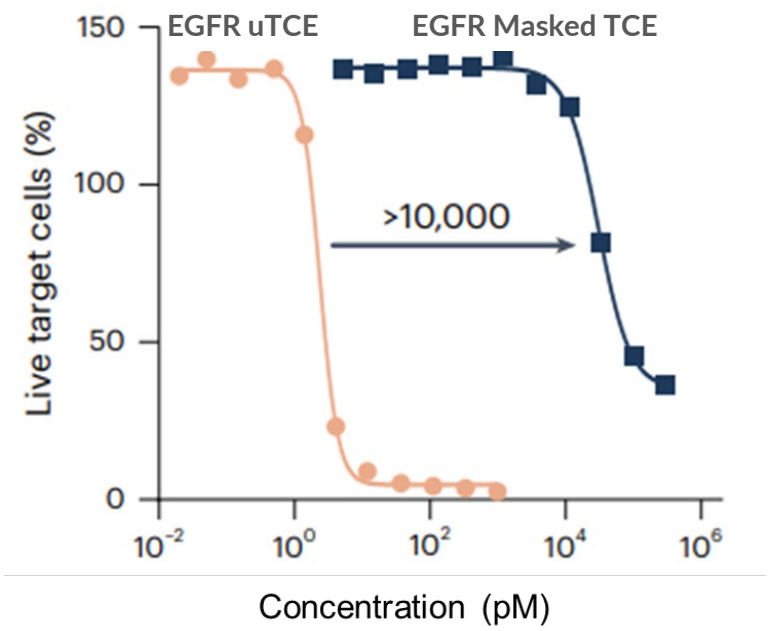
Planned
Currently Evaluating
Cleared DLT

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

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

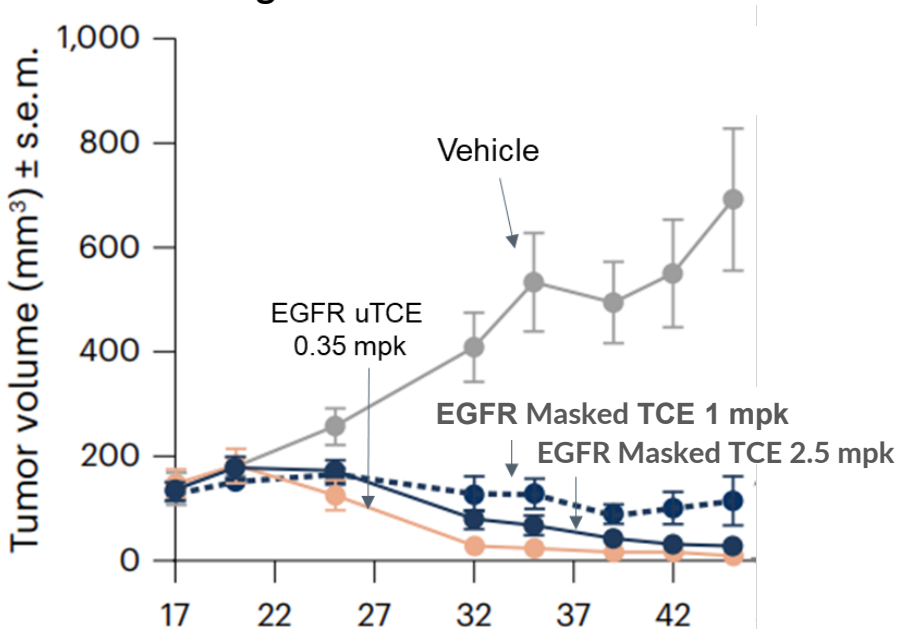
Outside Tumor: masking is maintained, leading to ~10,000-fold shift in cytotoxicity

Anti-tumor activity in vitro[1]



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

Tumor growth inhibition in vivo[1]



PRO-XTEN® masked EGFR TCE enabled ~250-fold higher tolerated exposure in NHPs vs. unmasked TCE[2]

[1] 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).
[2] 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, off-tumor toxicity with potent efficacy in vitro and in vivo and large safety margins in NHP. Cancer Research, 80(16_Supplement), 3376-3376.
EGFR: epidermal growth factor receptor; EGFR uTCE: EGFR-targeted unmasked T-cell engager; mpk: milligrams per kilogram; NHP: non-human primate; TCE: T-cell engager

Vir Biotechnology™