# Q1 2026 Financial and Business Update

May 12, 2026

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Market data and industry information used throughout this presentation are based on management's knowledge of the industry and the good faith estimates of management. We also relied, to the extent available, upon management's review of independent industry surveys and publications and other publicly available information prepared by a number of third-party sources. All of the market data and industry information used in this presentation involves a number of assumptions and limitations, and you are cautioned not to give undue weight to such estimates. Although we believe that these sources are reliable, we cannot guarantee the accuracy or completeness of this information, and we have not independently verified this information. While we believe the estimated market position, market opportunity and market size information included in this presentation are generally reliable, such information, which is derived in part from management's estimates and beliefs, is inherently uncertain and imprecise. No representations or warranties are made by the Company or any of its affiliates as to the accuracy of any such statements or projections. Projections, assumptions and estimates of our future performance and the future performance of the industry in which we operate are necessarily subject to a high degree of uncertainty and risk due to a variety of factors, including those described above. These and other factors could cause results to differ materially from those expressed in our estimates and beliefs and in the estimates prepared by independent parties.

# Focused Antiviral Pipeline with De-risked Phase 3 Program

| Program | Therapeutic/ Indication | Preclinical | Phase 1 | Phase 2 | Phase 3 | Milestone |
|---|---|---|---|---|---|---|
| **Flaviviridae** | **Hepatitis C Virus (HCV)**<br>Fixed Dose Combination:<br>**Bemnifosbuvir (BEM)**<br>Nucleotide Prodrug<br>**Ruzasvir (RZR)**<br>NS5A Inhibitor | | | | | Ph 3 **C-BEYOND** trial (US / Canada) enrollment completed (n=> 880); **topline results expected mid-2026** |
| | | | | | | Ph 3 **C-FORWARD** trial (outside North America) patient full enrollment (n=~880) expected mid-2026; **topline results expected year-end 2026** |
| **Hepeviridae** | **Hepatitis E Virus (HEV)**<br>Nucleotide Prodrug<br>AT-587 | | | | | Phase 1 initiation targeted mid-2026 |

Cash and investments: **$256.0 million at 3/31/26**
Cash runway anticipated through 2027

ATEA Pharmaceuticals

# BEM/RZR

# Potential Best-in-Class Regimen for Treatment of HCV

Target Profile

# BEM/RZR: Potential Best-in-Class Treatment for HCV

## First Head-to-Head Phase 3 Program in HCV

### Potential Best-in-Class Treatment for HCV

- HCV product candidate is regimen of **BEM**, the most potent nucleotide inhibitor*, and **RZR**, a highly potent NS5A inhibitor*
- Demonstrated:
  - Efficacy and tolerability
  - Convenient dosing with **short 8-week treatment duration**** and no food effect
  - Low risk of drug-drug interactions, including proton pump inhibitors and statins

### Robust Phase 2 Results Achieved Primary Endpoints

- Phase 2 results (n=275) demonstrated BEM and RZR combination regimen **achieved primary endpoints of sustained virologic response and safety**
- **98% sustained virologic response** at 12 weeks post-treatment (SVR12)
- No drug-related serious adverse events

### Phase 3 BEM / RZR vs. Active Comparator

- Chronic HCV, patients stratified by cirrhosis status and genotype, HIV-co-infected allowed
- Global Clinical Phase 3 program:
  - **First head-to-head** against sofosbuvir (SOF) /velpatasvir (VEL)†
  - 2 trials with ~1,760 total patients; up to 240 sites globally



*BEM *in vitro* studies; RZR preclinical and clinical studies; ** in non-cirrhotic patients; †brand name product marketed as Epclusa®

# BEM/RZR

## Potential Best-in-Class Regimen for Treatment of HCV

Global Phase 3 Program

# Global HCV Phase 3 Program: C-BEYOND (US/Canada) and C-FORWARD (Outside North America)

## Open-label: BEM/RZR Regimen vs Active Comparator in Chronic HCV Patients Randomized (1:1)

Chronic HCV, patients stratified by cirrhosis and genotype, HIV co-infected allowed, prior DAA excluded

Two Phase 3 Trials:

1) N= >880 trial US / Canada (C-BEYOND)

2) N= ~880 trial Outside North America (C-FORWARD)

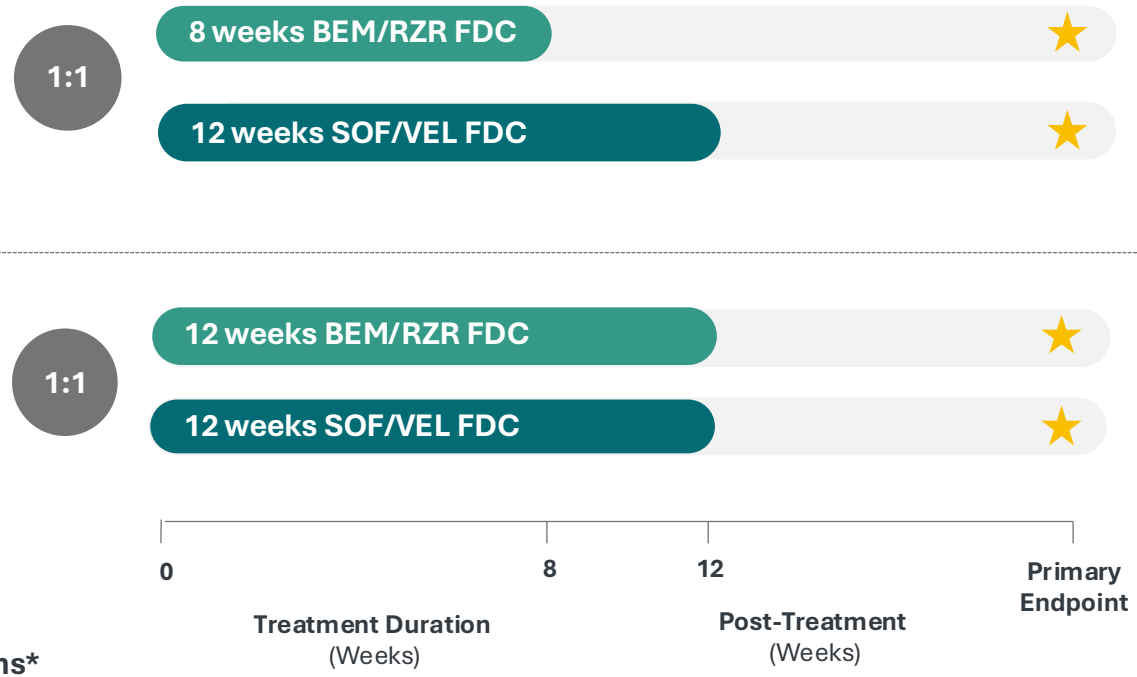
N= ~1,760 total patients

### Non-Cirrhotic

US / Canada Trial
Enrollment Completed
Outside North America
Trial N = ~700

### Cirrhotic

US / Canada Trial
Enrollment Completed
Outside North America
Trial N = ~175




**Primary Endpoint - Encompasses SVR12 in All Arms***

- No cirrhosis: 8 weeks of BEM/RZR vs 12 weeks of active comparator
- Compensated cirrhosis: 12 weeks of BEM/RZR vs active comparator



SVR = Sustained Virologic Response, FDC = Fixed Dose Combination (Dose 2 tb QD BEM/RZR), SOF/VEL = sofosbuvir/velpatasvir
*HCV RNA < lower limit of quantification 24 weeks from start of treatment

# On Track: Global HCV Phase 3 Program

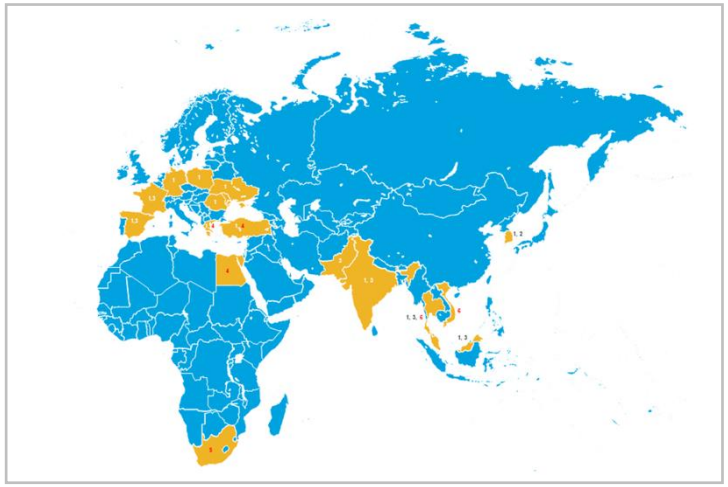
## C-BEYOND

- ~120 sites in US and Canada
- **Enrollment completed n= >880**
- **Cirrhotic population target achieved**
- Topline results expected mid-2026


- Enrolled patient population representative of genotypes and demographics in North America to support a broad label

## C-FORWARD

- ~120 sites in 17 countries outside of North America
- Enrollment completion expected mid-2026
- Topline results expected year-end 2026



- 95% of enrollment completed; continuing to enroll less frequent genotypes such as 4, 5, and 6 to support a broad label

# Phase 3 Endpoints, Patient Populations and Analyses

| | C-BEYOND (US/Canada) | C-FORWARD (Outside North America) |
|---|---|---|
| **Primary Efficacy Endpoint** | SVR at Week 24 **mITT population** | SVR at Week 24 **PP population** |
| **Key Secondary Efficacy Endpoint** | SVR at Week 24 **PP population** | SVR at Week 24 **mITT population** |

| | Modified Intent-To-Treat (mITT) | Per-Protocol (PP) |
|---|---|---|
| **Population:** | All randomized and dosed | All randomized, study drug compliant (≥80% pill count) and SVR assessment at Week 24 (or with SVR12) |
| **Considerations:** | Overall SVR rate will reflect non-drug related discontinuations (as rate **does not** consider compliance or lost to follow-up) | Overall SVR rate will better reflect true efficacy (as rate **does** consider compliance and lost to follow-up) |
| **Ph 2 SVR12 rates w/above handling*** | 95% | 98% |

- Modified intent-to-treat is FDA preferred and per-protocol is EMA preferred
- The same methods for assessing non-inferiority will be conducted in both Phase 3 studies and in both populations
- The reported overall SVR (primary analysis) for each study will differ because of the population used
- Phase 3 studies powered 90% with a 5% non-inferiority margin for expected rate approximating 95% in mITT population



*post-hoc analyses

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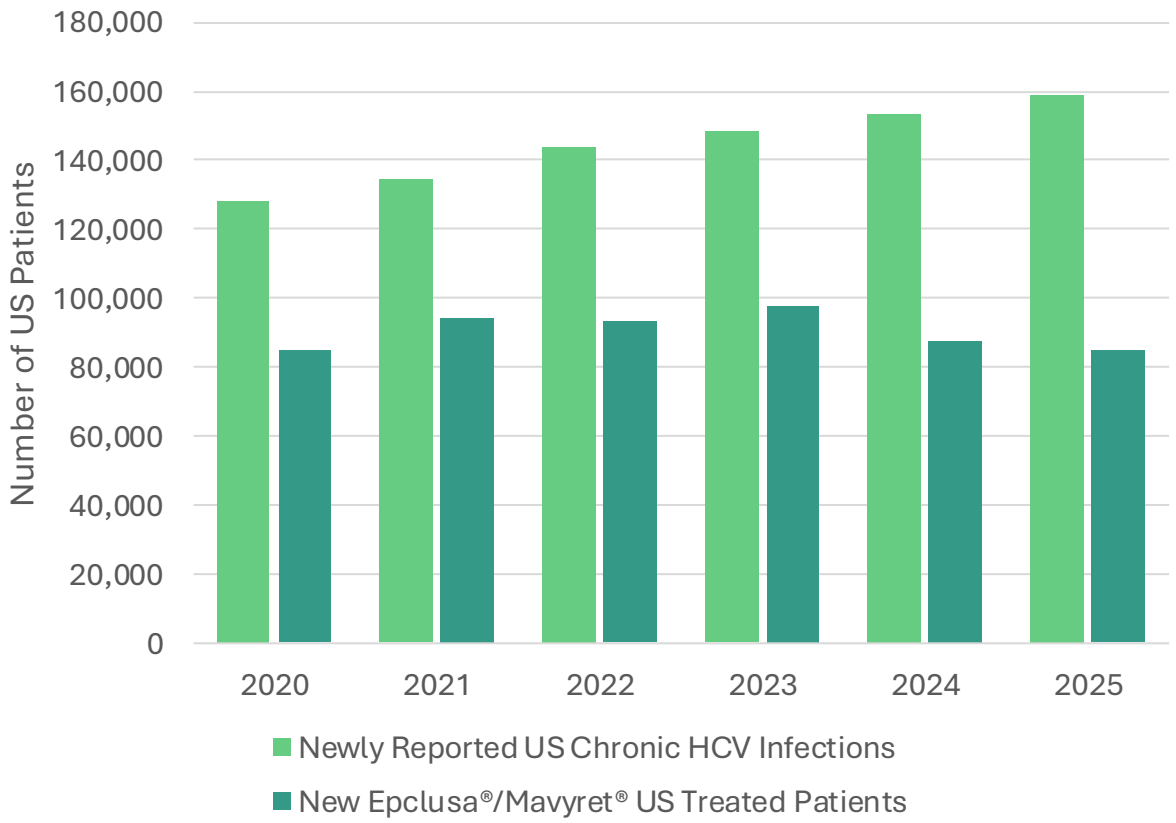
# BEM/RZR

## Test-and-Treat, Market Research and Commercial Readiness

BEM/RZR Market Research

# US New Chronic HCV Infections Continue to Increase Despite Availability of Curative Direct-Acting Antivirals

## Up to 4M People Estimated to be Infected in US[1]




- Out of ~160,000 new chronic infections, ***only*** ~85,000 treated annually[2,3]
- Most countries worldwide, including US, not on track to achieve WHO's goal of HCV elimination by 2030. Current estimates suggest 2050 at earliest[2]
- Chronic HCV is a leading cause of liver cancer in the US[4]

1. CDC: https://www.cdc.gov/hepatitis/hcp/clinical-overview/index.html
2. The CDA Foundation. Hepatitis C – United States. Lafayette, CO: CDA Foundation 2025. Available from https://cdafound.org/Polaris/database-query (accessed 15 Apr 2026)
3. This is based on information licensed from IQVIA: NRx (NPA) Audit for the period Jan 2025 – Dec 2025 reflecting estimates of real-world activity. All rights reserved
4. CDC: https://www.cdc.gov/hepatitis-c/about/index.html (accessed 24 Apr 2026)

# Annual New HCV Infections in US Exceed Treatments

## Test-and-Treat Model of Care Can Expand Diagnosis and Treatment

### HCV Infections Growing Faster Than Treated Patients in US

**~4 M**
Infected Individuals[1]

**~160 K**
Annual New Chronic Infections[2]

**~85 K**
Annual Treatments with Epclusa or Mavyret[3]

**~$1.3 B**
US Net Sales in 2025[4]

### Expansion of Test-and-Treat Model Can Increase Number of Patients Treated and Accelerate HCV Elimination In US

TEST

AND

TREAT


- Rapid diagnosis and treatment at the same time
- Reduces barriers to treatment prescribing / initiation
- Therapy with short treatment duration with low-risk of drug-drug interactions optimal for physicians and patients
- Bipartisan legislative efforts underway with goal to eliminate HCV in US with test-and-treat model of care



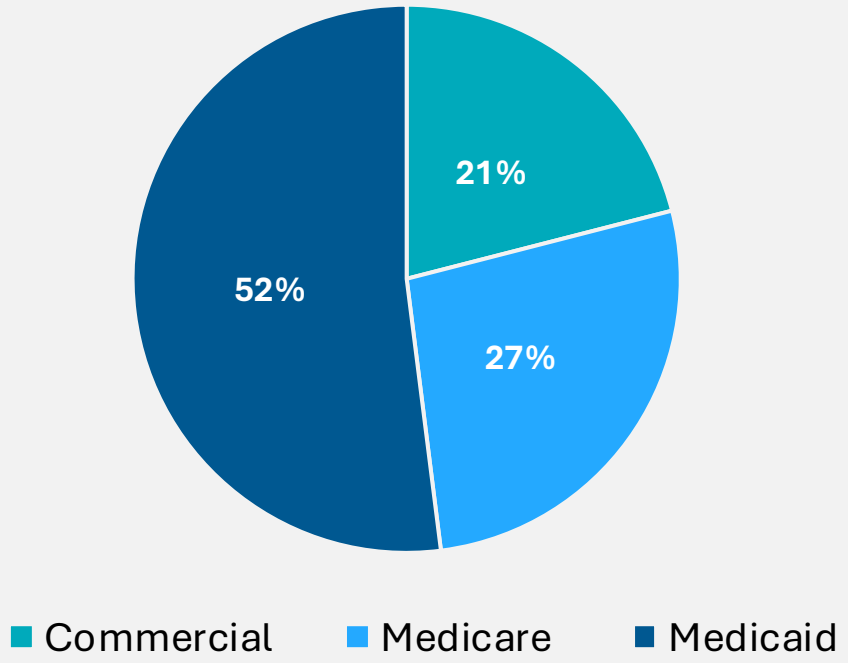
1. CDC: https://www.cdc.gov/hepatitis/hcp/clinical-overview/index.html 2. The CDA Foundation, Lafayette, CO 2025. Hepatitis C – United States. Available from https://cdafound.org/Polaris/database-query/ (Accessed 4/15/2026) 3. IQVIA 2025 4. U.S. Net Sales of Mavyret, Epclusa (and its authorized copy) from AbbVie and Gilead 2025 Annual Reports

# 2025 US HCV DAA Payer Landscape

## BEM/RZR High Likelihood to Be Added to Existing Formularies in All Payer Segments

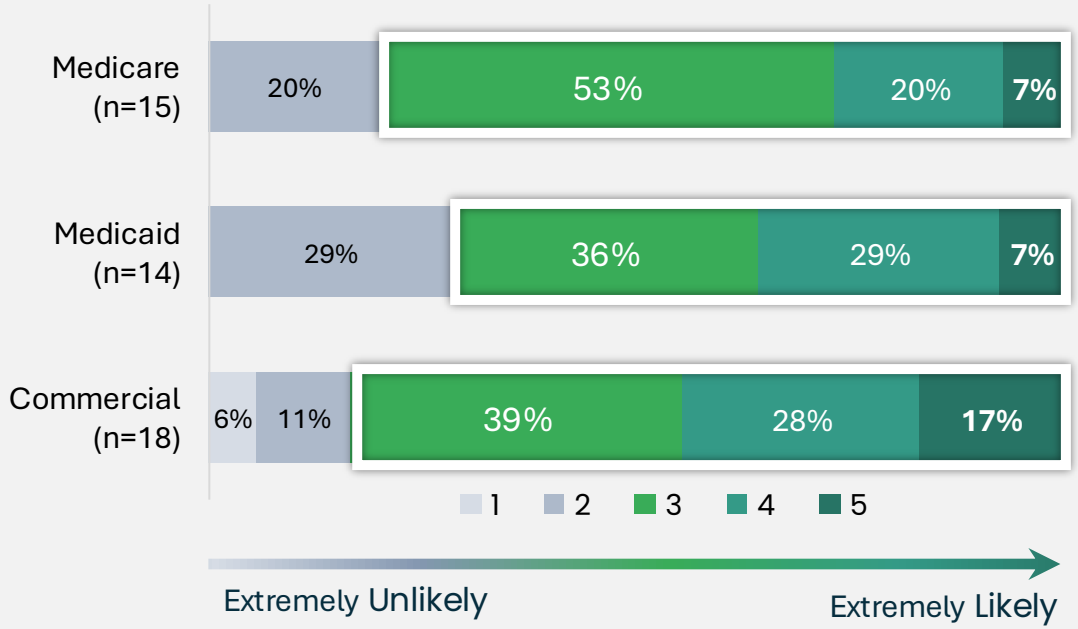
### HCV Patients Getting Access From All Payer Segments

**HCV Prescriptions By Payer[1]**




### High Likelihood of BEM/RZR Being Added to Existing Formularies at Parity Net Pricing Across Payer Segments[2]

**Likelihood of Parity Access at Parity Net Pricing**



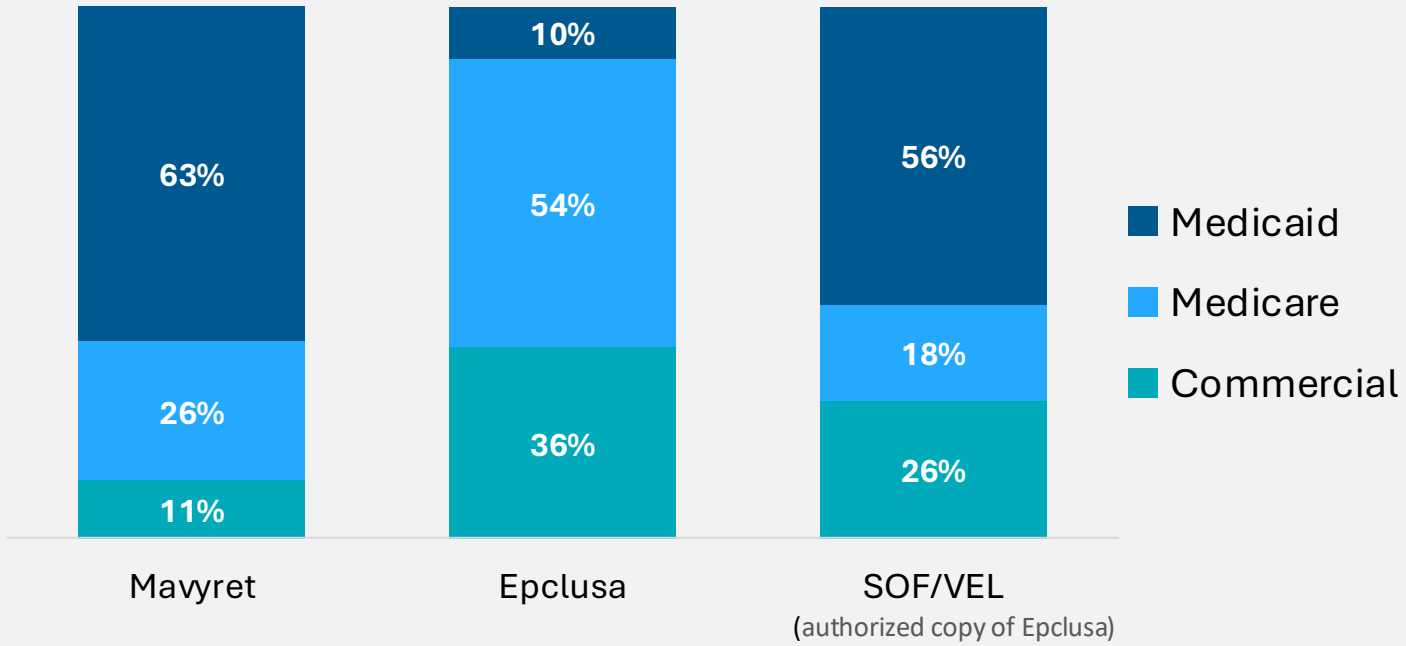



1. Atea custom project using IQVIA LAAD data 2026 2. Atea Custom Market Research, Formulary Insights, June 2024

# Competitive Positions in the US DAA High Value HCV Market

## Different Payer Segments Drive Epclusa and Mavyret Prescriptions

### Payer Distribution by Product[1]



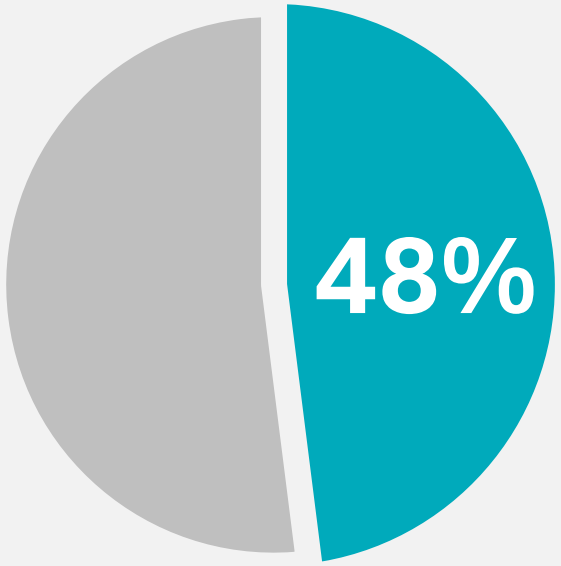

- High Proportion of Mavyret Rxs is from Medicaid
- High Proportion of Epclusa Rxs is from Medicare

1. Atea custom project using IQVIA LAAD NBRx data 2025

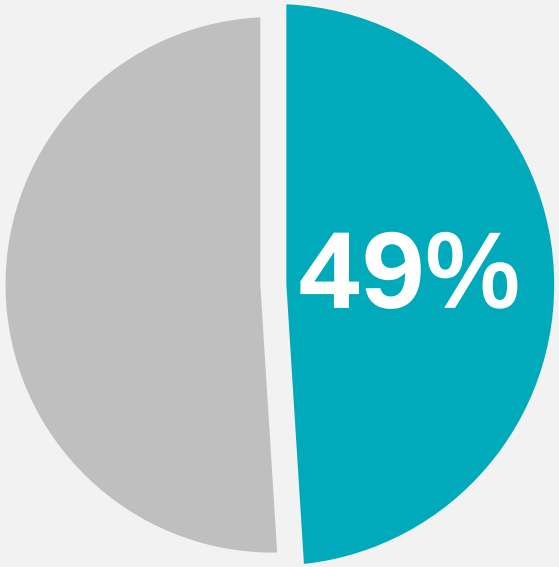
# Highly Attractive BEM/RZR Commercial Profile

## BEM/RZR Has Potential to Gain Significant Market Share

**76% of High DAA Prescribers Extremely Likely to Prescribe BEM/RZR[1]**




**Predicted Share of Non-Cirrhotic Patients[2]**




**Predicted Share of Compensated Cirrhotic Patients[2]**



1. Atea Custom Market Research, IQVIA, June 2025; 2. Predicted share of patients between BEM/RZR, Epclusa, and Mavyret

# BEM/RZR Commercial Readiness

## Commercial Launch Supply Manufacturing in Place & Marketing Planning Underway

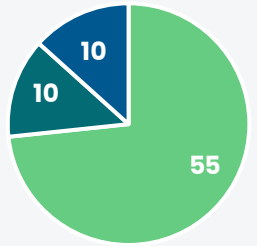

**Launch Supply Following NDA Approval**

- All components and processes for large scale manufacturing in place
- Commercial launch supply underway with low cost of goods relative to net price
- Blister card for convenience and patient adherence


**Concentrated Prescriber Base**

- Specialty care sales force required
  - **~7,800** prescribers write **~80%** of direct acting antiviral prescriptions[1]
- Only 2 competitors with no other product candidates in clinical development

Sales & MSL Headcount ~75




Sales Reps
Sales Management
MSLs

**Expected Short Time to Profitability Post-Launch**



1. IQVIA 2025

ATEA Pharmaceuticals

# New Program

# Hepatitis E Virus

Product Candidate AT-587

# Hepatitis E Virus (HEV) – an Acute and Chronic Liver Disease

## Significant Unmet Need for Patients with Chronic HEV Infection Who are Immunocompromised or at High Risk

HEV **GT 1,2**

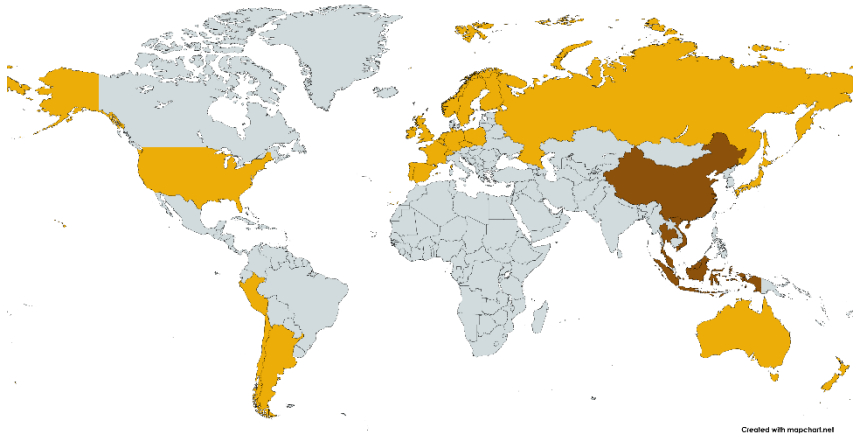
**Waterborne** transmission causes epidemics of acute, mostly self-limiting hepatitis in developing countries



HEV-1 HEV-2

HEV **GT 3,4**

**Foodborne** transmission causes chronic hepatitis in immunocompromised patient populations which can rapidly progress to cirrhosis




HEV-3 HEV-4



Adapted from Khuroo MS, Khuroo MS, Khuroo NS. Hepatitis E: Discovery, global impact, control and cure. World J Gastroenterol 2016; 22(31): 7030-7045

# Chronic HEV Infection Among Immunocompromised Individuals Can Rapidly Progress to Cirrhosis

## At-Risk Populations[1]

- Solid organ transplant recipients
- Hematopoietic stem cell transplant (HSCT) recipients
- Patients with hematologic malignancies
- Patients with pre-existing liver disease

**15%** of infected SOT recipients with chronic HEV rapidly develop cirrhosis in 3-5 years[2]

No approved HEV treatments

| Step | Current Interventions[3] | Rationale | Risks |
|---|---|---|---|
| First Line | Reduce Immunosuppression | Restore Host Immunity | Organ Rejection / Reinfection |
| Second Line | Ribavirin (3 months) | Direct Antiviral Effect | Not Approved / Side Effects / Intolerance |
| Guideline Differences | • WHO: Focus on Acute HEV<br>• EASL: Focus on Chronic HEV | Reflects Distinct Local Epidemiology | |

**March 2026 Roche launched a qualitative *in-vitro* diagnostic for detecting and differentiating HIV, HBV, HCV and HEV**



1. Alexandrova R, et al. HEV Infection Among Immunocompromised Individuals: A Brief Narrative Review. Infection and Drug Resistance. 2014;17 2. Kamar N et al. Factors Associated with Chronic Hepatitis in HEV with SOT. Gastroenter. 2011(140) 3. Dalton H et al. EASL Clinical Practice Guidelines on hepatitis E virus infection. J Hepatology. 2018;16. 1256-1271

# Commercial Opportunity of $750M-$1B* for the Treatment of HEV Infection Among High-Risk Populations in US & EU

## No Approved Treatment

**Annual number of at-risk populations**

- Solid Organ Transplant (SOT)[1] Recipients ~80K
- HSCT Recipients[2] ~37K
- Hematologic Malignancies[3] ~334K

**Chronic HEV**

**~3%****

of at-risk patients develop chronic HEV[4,5]

**Potential Treatment Population of ~13.5K Patients Annually**

Commercial Opportunity **$750M-$1B***

*Assumes pricing estimates of $200K per course of therapy based on similar HDV pricing

***Assumes ~30% treated**

**Assumes similar incidence rates of chronic HEV in HSCT and Hematologic Malignancies as with SOT

1. 2023 SOT patients transplanted in US, EU & UK. Newsletter Transplant: International Figures on Donation and Transplantation 2023. EDQM Vol 29 2024. 2. 2022 HSCT patients transplanted in EU & UK. Passweg, J.R., et al. Utilization of hematopoietic cell transplantation and cellular therapy technology in Europe and associated Countries. Bone Marrow Transplant 60, 227–236 (2025) and 2023 HSCT patients transplanted in US. Health Resources and Service Administration. 3. 2022 Leukemia and non-Hodgkins Lymphoma patients in US, EU & UK. WHO International Agency for Research on Cancer. https://gco.iarc.who.int/today/en Accessed 10/20/25. 4. Hansrivijit P. Et al. HEV in SOT Recipients. World J Gastroenterol. 2021(27). 12. 5. Kamar N et al. Factors Associated with Chronic Hepatitis in HEV with SOT. Gastroenter. 2011(140).

# AT-587: Potent Inhibition of Hepatitis E Virus Replication *In Vitro*

**$EC_{50}$ values in Huh7 HEV-3 Kernow-C1 p6/Gluc replicon cells**

| Compound | Mean ± SD (nM) |
|---|---|
| AT-587 | 79.6 ± 29.2 (n=12) |
| BEM | 458.1 ± 140.7 (n=3) |
| SOF | 5,129 ± 985 (n=3) |
| Ribavirin | 12,551 ± 256 (n=3) |

Note: Antiviral activity of AT-587 confirmed in primary human hepatocytes infected with HEV

- Low protein binding limits the effect of human serum on antiviral activity of AT-587 (2.4-fold shift in $EC_{50}$)
- Plasma metabolites of AT-587 are inactive against HEV-3 ($EC_{50}$ values > 10 uM)
- AT-587: low potential for drug-drug interactions (DDIs) based on *in vitro* data to date

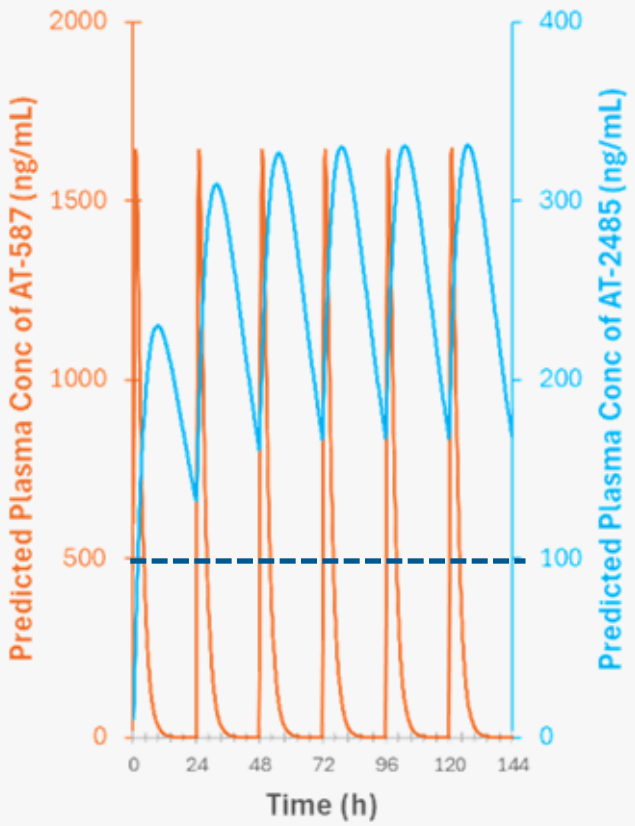
# AT-587 for HEV

## Preclinical Profile Supports Advancement to First-in-Human Study

| Cells | AT-9010 (BEM) | AT-9068 (AT-587) |
|---|---|---|
| Human hepatocytes | 1,360 | 3,920 |

- No inhibition of α, β, γ human DNA polymerases by active triphosphate (AT-9068)
- Negative in GLP *in vitro* genetox assays (Ames, *in vitro* micronucleus)
- No hERG inhibition at clinically meaningful concentrations in *in vitro* GLP assay
- Negative in GLP phototoxicity assay
- No toxicity to human iPS cardiomyocytes and bone marrow $CD34^+$ cells
- **CTA-enabling GLP toxicology and safety pharmacology studies completed**

# AT-587: Human Pharmacokinetics Predicted to Achieve Drug Exposure Above the *In Vitro* Antiviral Activity




Predicted human plasma exposure of AT-587 and AT-2485 (the surrogate of the active intracellular triphosphate metabolite) after oral administration of 600 mg QD

--- $EC_{50}$ of AT-587 (100 ng/ml ~ 300 nM)

— AT-587

— AT-2485

# AT-587 First-in-Human Study

**Population:**
Healthy adult volunteers

**Objectives:**
Safety, tolerability and pharmacokinetics (PK)

**Design:**
Randomized, double-blind, placebo-controlled

**Part A**

**Single Ascending Dose (SAD)**

Up to 4 cohorts, sequentially evaluating increasing single doses of AT-587; embedded food effect

**Part B**

**Multiple Ascending Dose (MAD)**

Up to 3 cohorts, sequentially evaluating increasing multiple doses of AT-587

- Progression based upon review of emerging safety and PK data
- Flexibility to adapt doses based on accumulating data

# Financial Update

First Quarter 2026 Results

# Financial Update

**Condensed Consolidated Statement of Operations and Comprehensive Loss**
(in thousands, except share and per share amounts)
(unaudited)

| | Three Months Ended March 31, | |
|---|---|---|
| | **2026** | **2025** |
| Operating expenses | | |
| Research and development | $ 41,134 | $ 29,584 |
| General and administrative | 6,874 | 9,457 |
| Total operating expenses | 48,008 | 39,041 |
| Loss from operations | (48,008) | (39,041) |
| Interest income and other, net | 2,618 | 4,972 |
| Loss before income taxes | (45,390) | (34,069) |
| Income tax expense | (50) | (203) |
| Net loss | $ (45,440) | $ (34,272) |
| Other comprehensive loss | | |
| Unrealized loss on available-for-sale investments | (271) | (115) |
| Comprehensive loss | $ (45,711) | $ (34,387) |
| Net loss per share - basic and diluted | $ (0.57) | $ (0.40) |
| Weighted-average number of common shares - basic and diluted | 79,198,204 | 85,159,254 |

# Financial Update

**Selected Condensed Consolidated Balance Sheet Data**
(in thousands)
(unaudited)

| | March 31, 2026 | December 31, 2025 |
|---|---|---|
| Cash, cash equivalents and marketable securities | $ 256,006 | $ 301,830 |
| Working capital[1] | 229,830 | 271,207 |
| Total assets | 267,076 | 315,218 |
| Total liabilities | 33,367 | 39,784 |
| Total stockholder's equity | 233,709 | 275,434 |

(1) Atea defines working capital as current assets less current liabilities. See the Company's condensed consolidated financial statements in its Quarterly Report on Form 10-Q for the three months ended March 31, 2026 for further detail regarding its current assets and liabilities.

# Upcoming Key Milestones Across Antiviral Pipeline

## BEM/RZR REGIMEN - PHASE 3 PROGRAM FOR HCV

**Ongoing**
Two Phase 3 Trials (C-BEYOND and C-FORWARD)

**Mid-2026**
Completion of C-FORWARD patient enrollment

Topline Phase 3 results for C-BEYOND

**Year-end 2026**
Topline Phase 3 results for C-FORWARD

**2027**
Anticipated Q1 NDA submission


## AT-587- PROGRAM FOR HEV

**Ongoing**
✓ CTA enabling studies completed; preparing to initiate first-in-human study

**Mid-2026**
Phase 1 clinical study

**2H 2026**
Initiation of POC clinical study

**2H 2027**
Initiation of Phase 2/3 trial

Cash and investments: **$256.0 million at 3/31/26**
Cash runway anticipated through 2027

ATEA Pharmaceuticals

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