Second Quarter Financial and Business Update

August 7, 2024

NASDAQ: AVIR

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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.

Achieved and Upcoming Significant Clinical Milestones in 2024

Fully Funded Through Key Inflection Points

COVID-19 – Global Phase 3 SUNRISE-3 Trial

Sunrise-3

- ✓ Full enrollment achieved with 2,221 patients in monotherapy cohort, 74 in combination cohort Mar'24
- Topline results ***2H'24***
- NDA submission target ***~YE'24***

2024 → **2025**

HCV

- ✓ Reported SVR4 rate for lead-in cohort of 60 patients & resumed enrollment Jan'24
- ✓ Preclinical and Ph 2 SVR12 97% rate at EASL Jun'24
- ✓ Selected fixed dose tablet Mid'24
- Ph 2 complete SVR12 results ***4Q'24***
- Ph 3 Initiation target ***YE'24***

HCV – Global Phase 2 Study

$502.2 M

Cash, cash equivalents & marketable securities at 6/30/24

Cash runway anticipated into 2027

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HEPATITIS C

Program Update: Potential Best-in-Class Pan-Genotypic Regimen

- Phase 2 Open Label Study of Bemnifosbuvir + Ruzasvir

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HCV

Continues to be a healthcare crisis in US

Recognized ongoing unmet needs by US healthcare providers

UNMET MEDICAL NEED in US:

~2-4M estimated to have HCV[1]

New chronic HCV cases (~100,000) reported each year *exceed* annual cures with direct-acting antivirals

Best-in-Class Target Profile - Bemnifosbuvir + Ruzasvir

Bemnifosbuvir is the most potent nucleotide inhibitor for HCV[2] and ruzasvir is a highly potent NS5A inhibitor[3]

- Potential for fewer side effects, low risk for drug-drug interactions and no food effect
- Short 8-week treatment with low daily pill burden
- Protease inhibitor-free treatment

Global Market Opportunity:

>$3B net sales in 2023	Primarily **2** product market	**No** competitors in clinical development

1. CDC 2022 estimates; HHS https://www.hhs.gov/hepatitis/learn-about-viral-hepatitis/data-and-trends/index.html#:~:text=2.4%20million%20people%20are%20estimated,as%20low%20as%202.5%20million.
2. PLoS ONE 15(1):e0227104 https://doi.org/10.1371/journal.pone.0227104
3. Journal of Viral Hepatitis, 2019, September:26 (9); 1127-1138.

US HCV Market: Epclusa® & Mavyret®

	2022	2023
# of Patients (NRxs) Treated[1]	93,452	98,412
Total US HCV Market Net Revenues[2]	$1,599M	$1,518M
Net Revenues Per Patient Treated	$17,110	$15,425
Epclusa®* NRx Market Share[1]	53%	54%
Mavyret® NRx Market Share[1]	43%	42%

Market demand grew ~5% 2023

Stable market share

2023

$1.5B
US Net Revenues for DAAs

98,412
# of US Patients Treated (NRxs)

Potential US HCV Market Value

Treatment of all current chronic HCV patients

>$20B+
Potential Market Value[3]

~2-4M[4]
Chronic US HCV Prevalence

FUTURE DRIVERS

- US government initiatives
- Optimal product profile
- Removal of HCV prescribing barriers by payors

**Epclusa includes both brand and authorized generics 1. IQVIA NPA Data 2. Net Revenues from Gilead and Abbvie's full-year 2023 earnings press release 3. Assumes treatment of all currently chronically infected HCV patients of 2.2M at $10,000 Net Revenue/Patient. 4.* CDC 2022 estimates; HHS https://www.hhs.gov/hepatitis/learn-about-viral-hepatitis/data-and-trends/index.html#:~:text=2.4%20million%20people%20are%20estimated,as%20low%20as%202.5%20million.

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Profile of Today's HCV-Infected Patient

Predominately Younger Patient Population (30-39 yrs old)[1], Newly Infected[1] Therefore <10% Cirrhotic[2]

Unmet Need Due to DDIs

High proportion of current HCV-infected patients **take concomitant medications**

i.e., HIV medications, antipsychotics, statins, protein pump inhibitors, other

Unmet Need for Convenient Therapy

Populations at highest risk for HCV infection are frequently **poorly adherent to medication**

Substance abuse disorders (opioid, methadone, people who inject drugs, other)

Mental health disorders

BEM + RZR addresses current unmet needs of **low risk of drug-drug interactions** combined with **convenient short treatment duration** and **no food effect**

1. CDC: https://www.cdc.gov/hepatitis/statistics/2020surveillance/hepatitis-c/table-3.6.htm. 2. Gastroenterol Hepatol (N Y). 2019 Nov; 15(11): 616–618.

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Bemnifosbuvir (BEM) + Ruzasvir (RZR) Target Product Profile

BEM + RZR Profile Addresses Unmet Needs of Today's HCV-Infected Patients

Profile		BEM+RZR	MAVYRET®	EPCLUSA®
Treatment Duration	Non-Cirrhotic	8 Weeks	8 Weeks	12 Weeks
	Compensated Cirrhosis	8 Weeks	8 Weeks	12 Weeks
	Decompensated Cirrhosis	12 Weeks (No RBV)	✗	12 Weeks + RBV
Short Duration		✓	✓	✗
Protease-Inhibitor Free		✓	✗	✓
Low Potential for Drug-Drug Interactions		✓	✗	✓
No Food Effect		✓	✗	✓

RBV= Ribavirin

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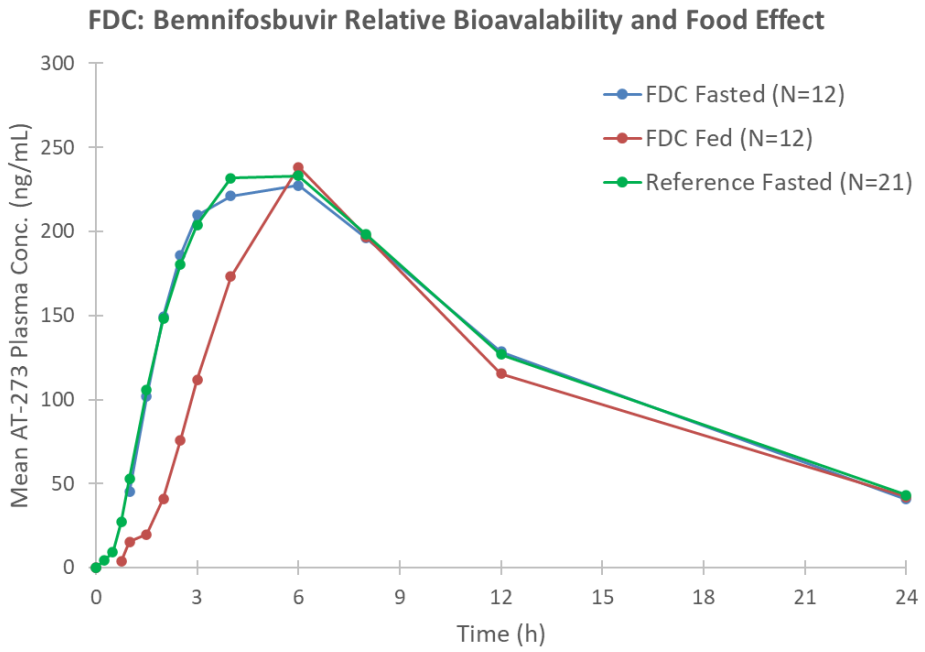
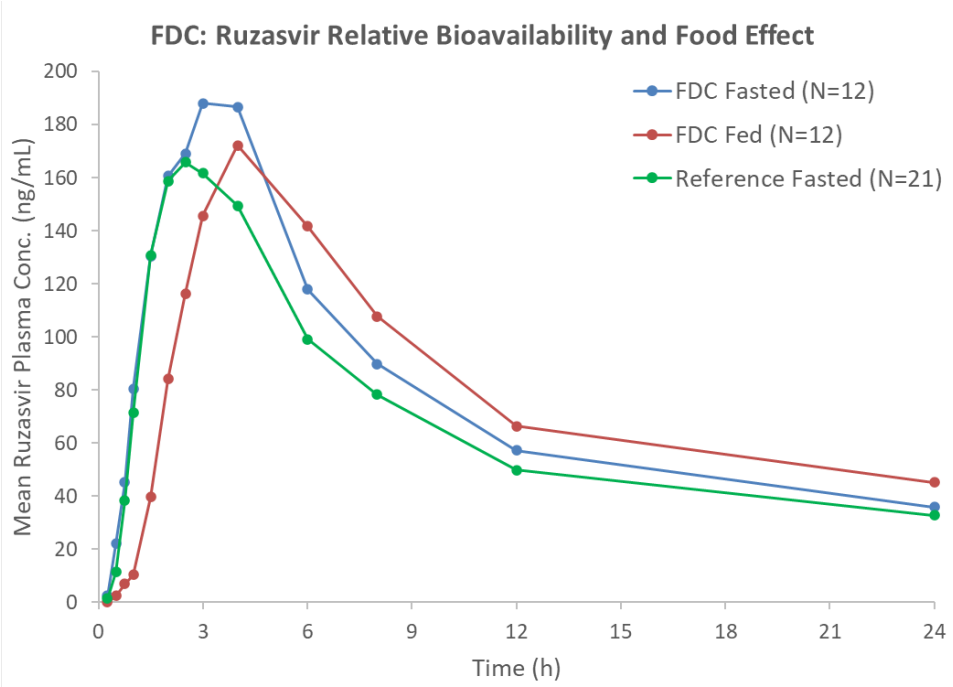
New Fixed Dose Combination (FDC) Tablet Achieved Drug Exposure Comparable to Individually Administered BEM + RZR Used in Phase 2 & Other Studies

FDC Tablet for Phase 3 Program and Subsequent Commercialization



AT-273 is the plasma surrogate marker for active intracellular triphosphate metabolite of BEM



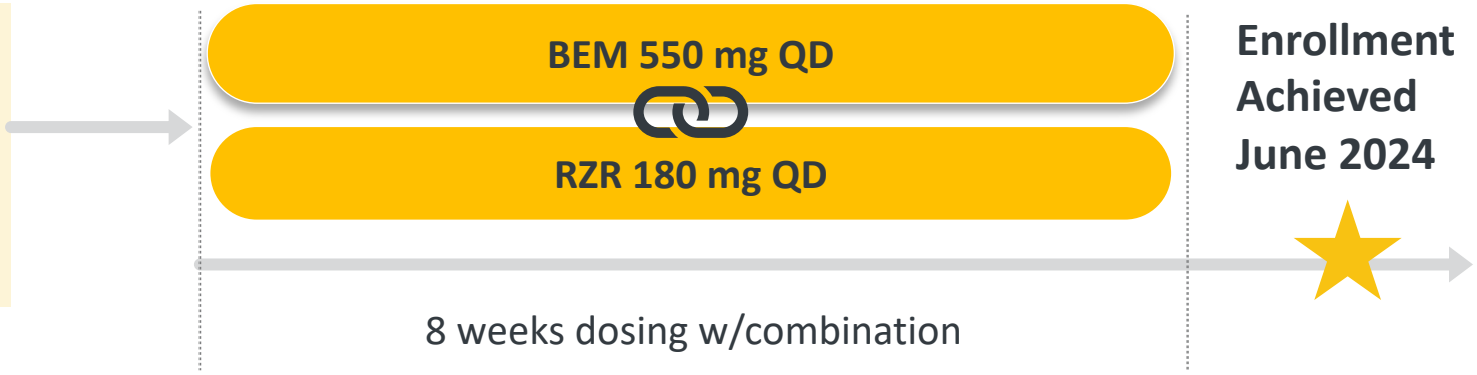
Healthy participants received single dose of BEM 550 mg and RZR 180 mg under fasting conditions as 2x275 mg BEM tablets/2x90 mg RZR capsules (reference), and 2x FDC tablets (275 mg BEM/90 mg RZR) under fasting and fed (high-fat/high-calorie test meal) conditions

- ✓ FDC tablet reduces daily pill count from 4 pills (Ph 2 study) to 2 pills (Ph 3 & commercialization)
- ✓ No FDC food effect: high-fat/high-calorie meal did not affect exposure of BEM or RZR

Phase 2 Open Label Study of BEM + RZR in HCV Patients

Study Design: Open label combination

N= 275 patients: including lead-in cohort



Patient Population:

- HCV-infected patients, including compensated cirrhosis
- Direct-acting antiviral naïve
- All genotypes

60 Patient Lead-in Cohort:

- Safety and tolerability
- Sustained virologic response (SVR) at Week 4 post-treatment (SVR4)

Primary Endpoints:

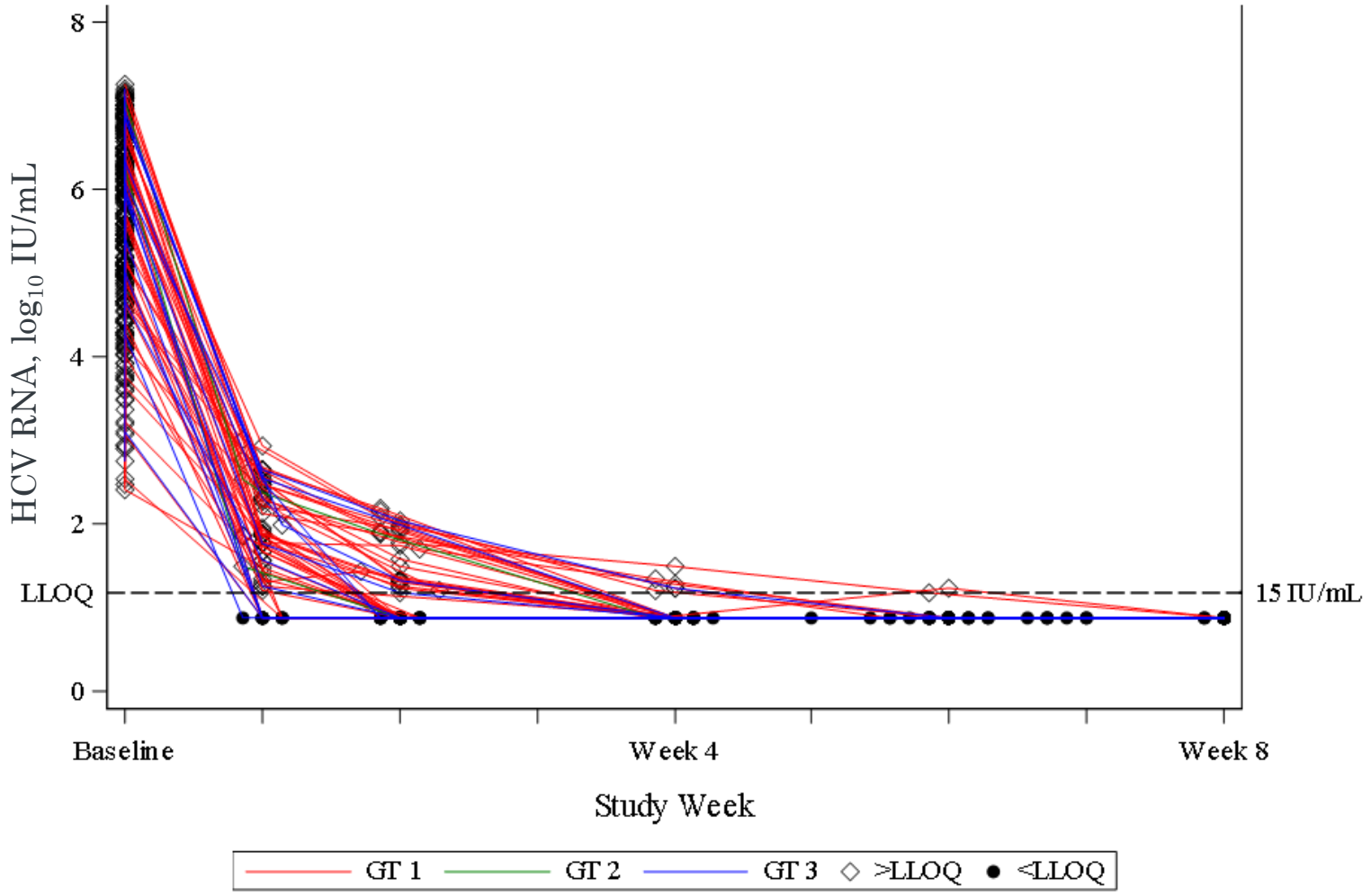
- SVR at Week 12 post-treatment (SVR12)
- Safety

Other Endpoints:

- Virologic failure
- SVR at Week 24 post-treatment (SVR24)
- Resistance

On-treatment Viral Kinetics – Individual Patient Data (n=60)

Phase 2 Open Label Study of BEM + RZR Lead-in Cohort

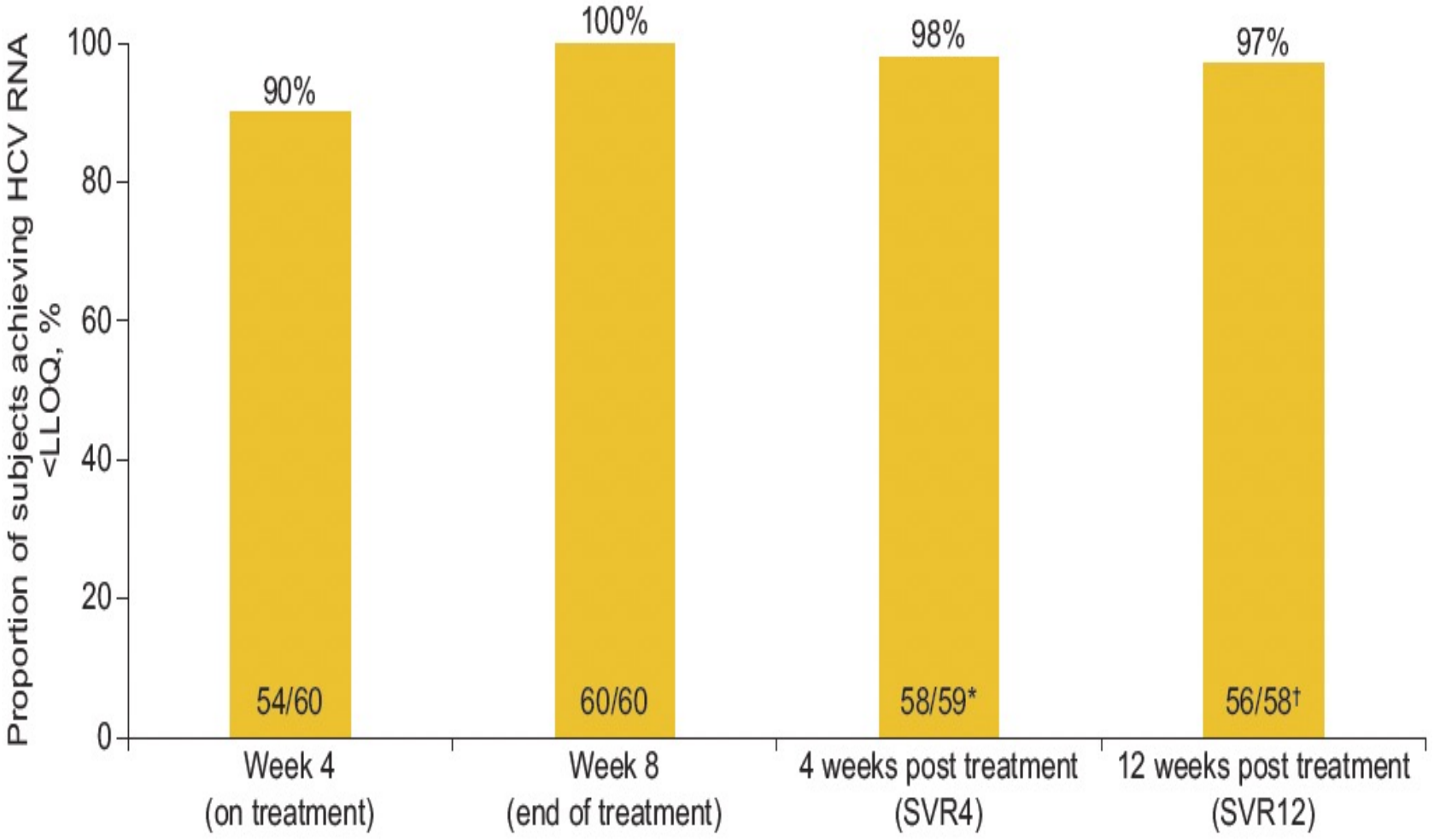


- Rapid viral reduction in all patients within the first week regardless of baseline viremia and genotype
- Viral load in all patients near or below LLOQ by Week 4 supports an 8-week regimen

LLOQ=Lower limit of quantification

HCV RNA Qualitative Results – All Genotypes (N=60)

Phase 2 Open Label Study of BEM + RZR Lead-in Cohort



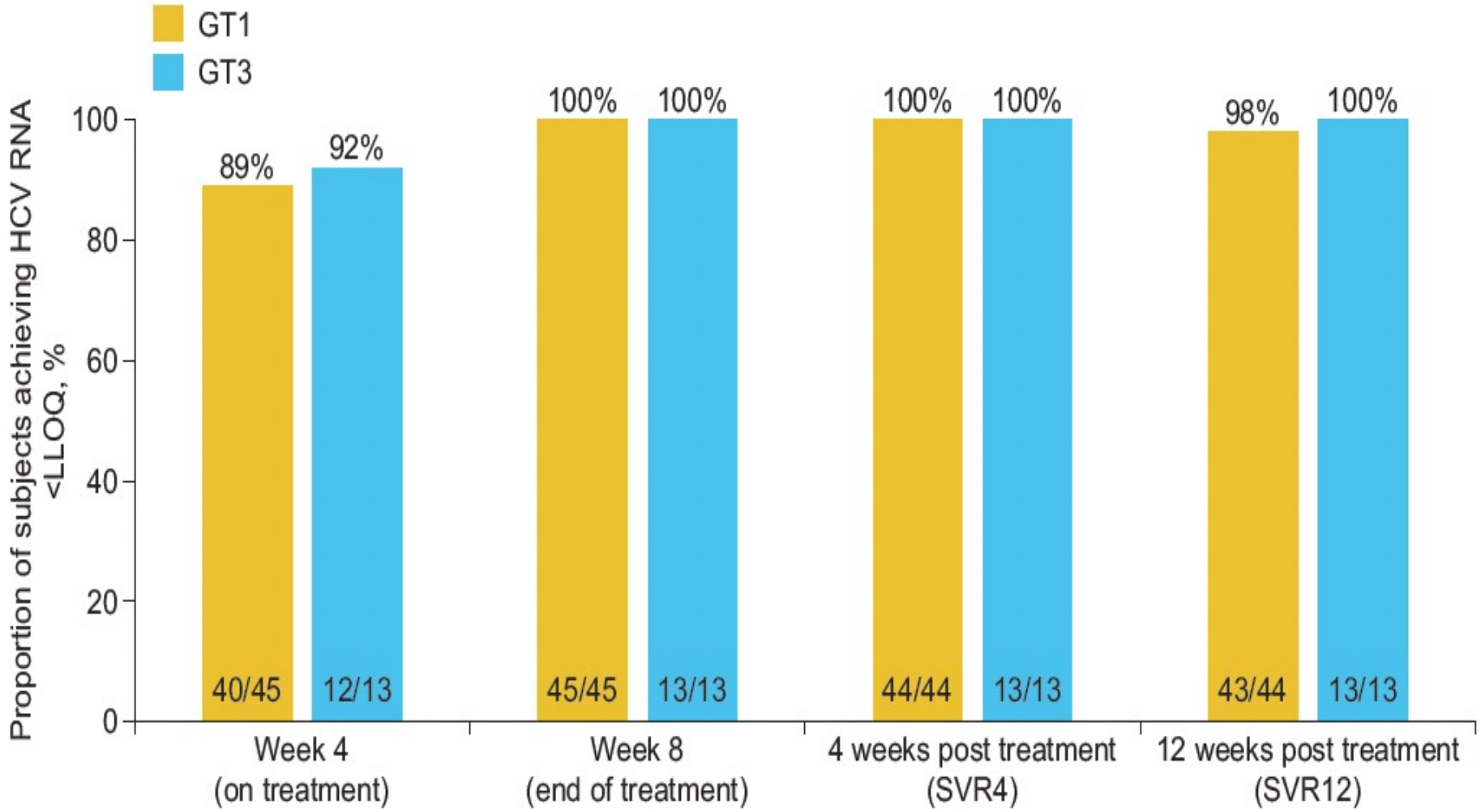
- 97% SVR12 rate in lead-in cohort
- 2 subjects (GT1b and GT2b) with post-treatment relapse
  - Low plasma drug levels and similar viral mutations at baseline and 12-weeks post-treatment timepoints ***indicate relapse was due to treatment non-adherence vs viral resistance***

LLOQ=Lower limit of quantification

Two subjects with missing post-treatment data (1 withdrew consent after Week 8*, and 1 non-drug-related death after SVR4†)

HCV RNA Qualitative Results – Genotypes 1 and 3

Phase 2 Open Label Study of BEM + RZR Lead-in Cohort

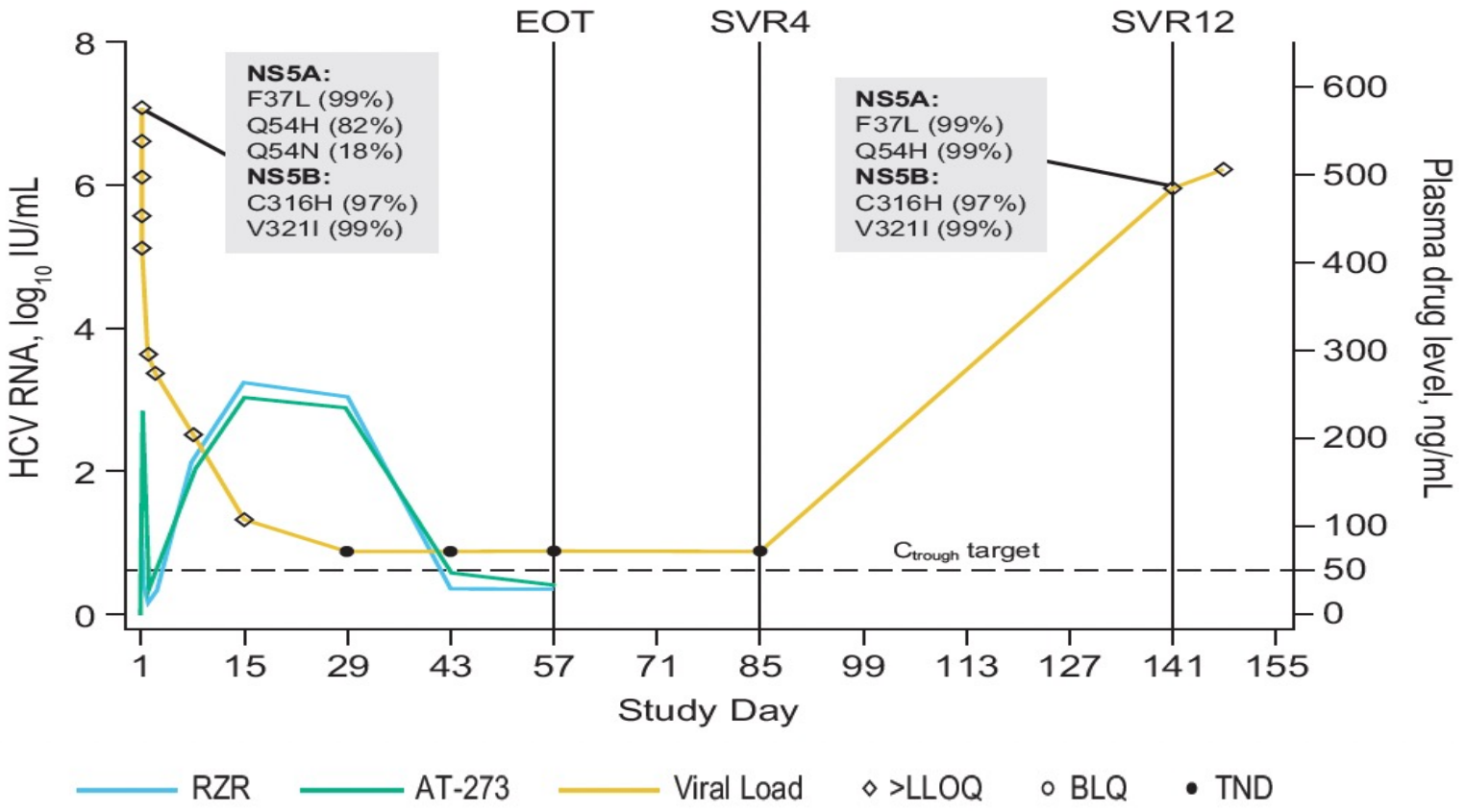


- High SVR12 rates in historically difficult to treat HCV patients
- Similar viral kinetics in GT1 and GT3

LLOQ=Lower limit of quantification

Post-Treatment Relapse – GT1b-infected Patient

Phase 2 Open Label Study of BEM + RZR Lead-in Cohort



Kinetics of viral load, drug exposure and presence of NS5A/NS5B RASs are presented (left), alongside plasma drug levels at each timepoint (right). The horizontal dashed line represents the expected trough concentrations (C_{trough}) of BEM and RZR. LLOQ, lower limit of quantitation; BLQ, below limit of quantitation; EOT, end of treatment; TND, target not detected.

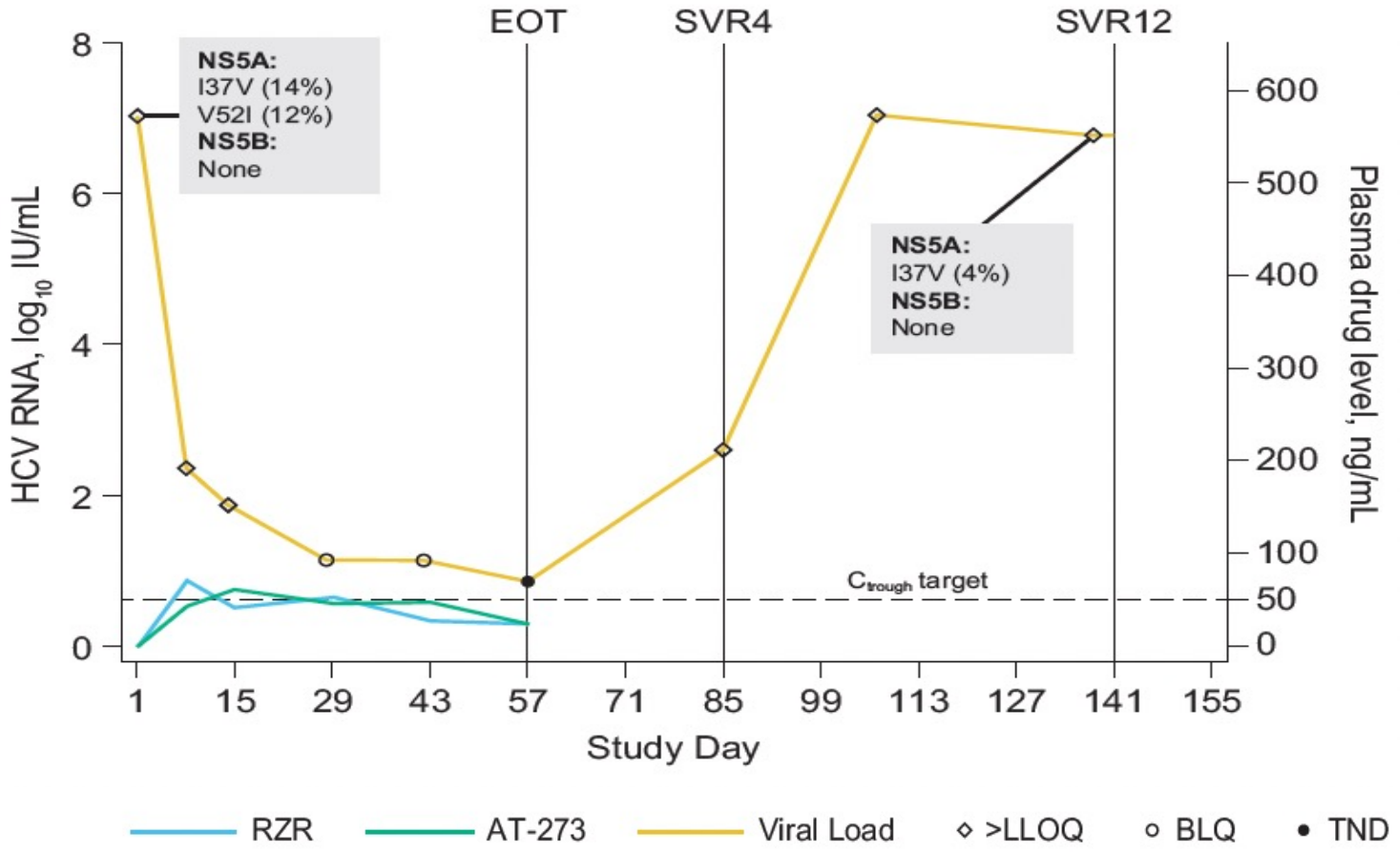
DAY	Plasma drug level, ng/mL	
	AT-273	RZR
1	BLQ	BLQ
8	161	173
15	246	263
29	235	248
43	45.7	28.1
57	33.2	28.3

AT-273 is the surrogate for the BEM active triphosphate

- Low plasma drug levels and similar viral mutations at baseline and 12-weeks post-treatment timepoints ***indicate relapse was due to treatment non-adherence vs viral resistance***

Post-Treatment Relapse – GT2b-infected Patient

Phase 2 Open Label Study of BEM + RZR Lead-in Cohort



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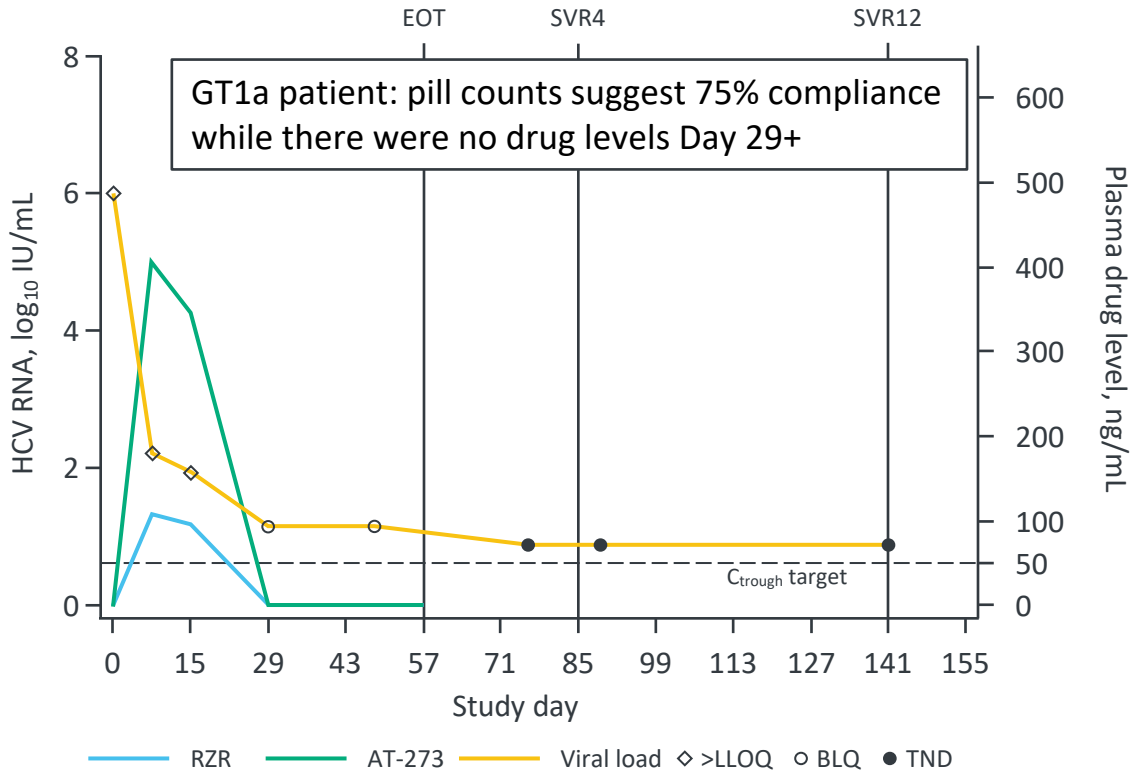
DAY	Plasma drug level, ng/mL	
	AT-273	RZR
1	BLQ	BLQ
8	42.6	70.9
15	61.36	42.2
29	46.6	53.3
43	47.4	27.6
57	24.4	24.4

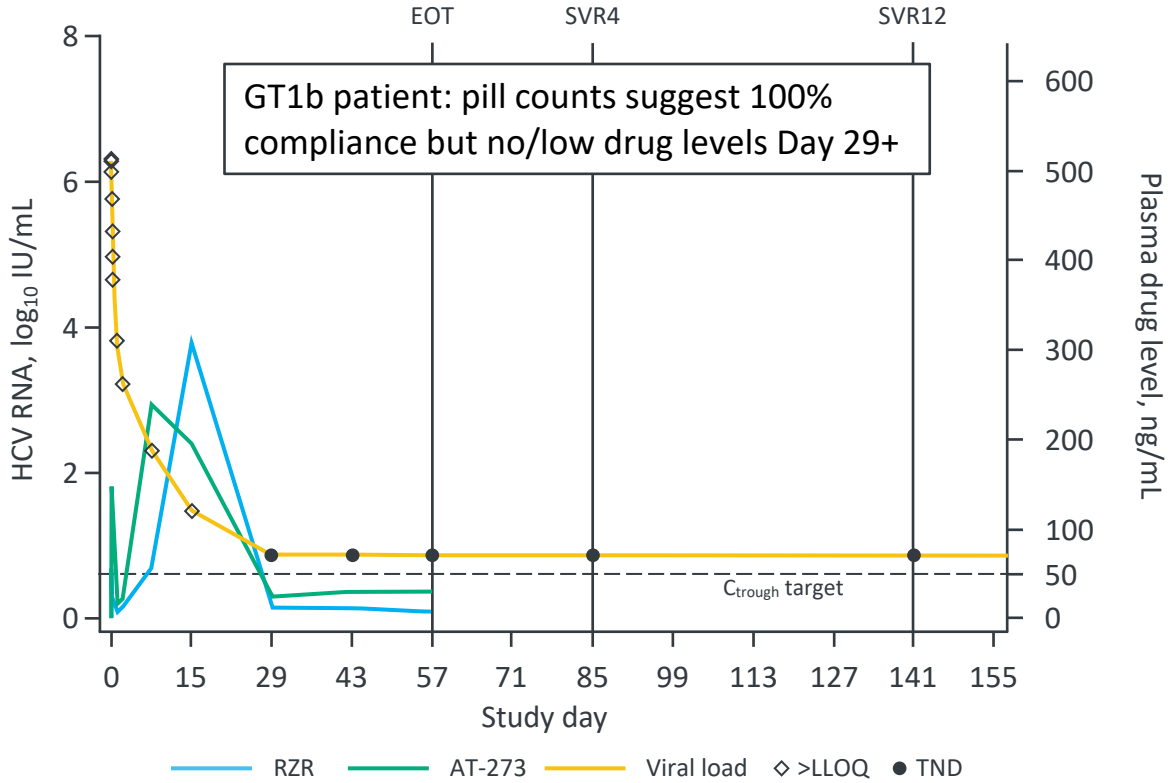
AT-273 is the surrogate for the BEM active triphosphate

- Low plasma drug levels and similar viral mutations at baseline and 12-weeks post-treatment timepoints ***indicate relapse was due to treatment non-adherence vs viral resistance***

Individual Profiles – Lower Exposures Achieving SVR12

Phase 2 Open Label Study of BEM + RZR Lead-in Cohort





AT-273 is the surrogate for the BEM active triphosphate Compliance based on pill count

- Despite poor medication adherence, patients with low drug exposures at Day 29+ ***still achieved SVR12***
- Pill count alone does not inform study drug compliance; needs to be corroborated with drug exposures

Open Label Phase 2 Lead-in Cohort Results (n=60)

Phase 2 Open Label Study of BEM + RZR Lead-in Cohort

Safety Summary

- All patients (n=60) completed the 8-week treatment period
- Bemnifosbuvir + ruzasvir was generally safe and well tolerated
- No drug-related SAEs or premature treatment discontinuations
- No trends observed in adverse events (mostly mild) or safety laboratory parameters

Strong Operational Execution, Preparing for Global Phase 3 Program

BEM + RZR: Potential Best-in-Class Pan-genotypic Regimen

- **Achieved** patient enrollment **June 2024 (n=275)**
- **Selected** fixed dose combination tablet

- Phase 2 complete SVR12 results **expected Q4'24**

- **Preparing for global Phase 3 program**
  - Pending discussion with regulatory agencies, Phase 3 program to include DAA-naïve patients with chronic HCV infection across all genotypes
    - Study with active comparator (N=~1000 patients)
    - Additional study (N=~250 patients)

- Full program to include >1000 HCV-infected patients receiving combination of BEM + RZR across all genotypes

HCV **unmet medical needs** include **fewer contraindications**, particularly due to drug-drug interactions with **shorter treatment duration**

COVID-19

Bemnifosbuvir Phase 3 Program

- COVID-19 Unmet Medical Need
- Global Phase 3 SUNRISE-3 Trial

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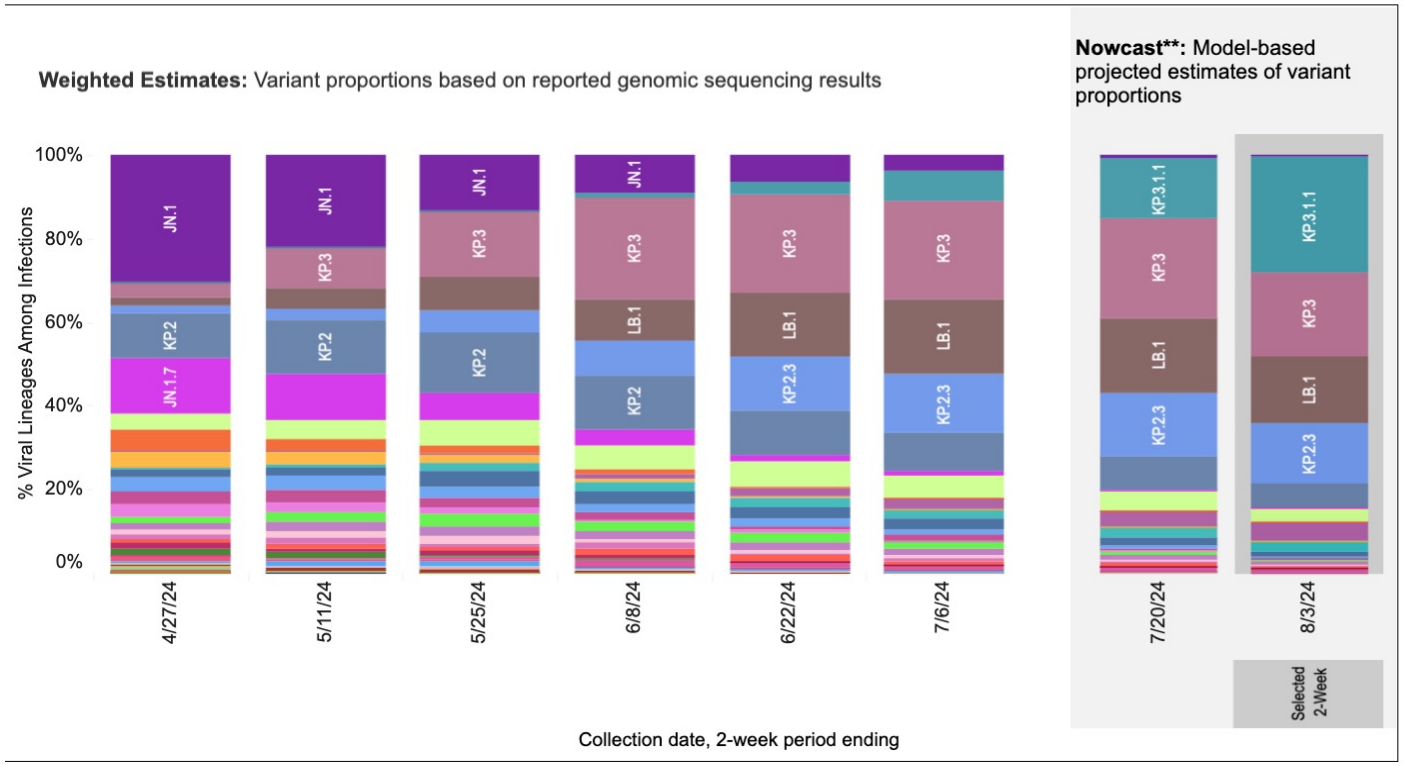
COVID-19 Variants Continue to Rapidly Emerge Creating Waves of Infection

Early Summer Wave Driven by KP Variants and Closely Related LB.1

Weighted and Nowcast Estimates in United States for 2-Week Periods in 4/14/2024 – 8/3/2024



Nowcast Estimates in United States for 7/21/2024 – 8/3/2024

USA

WHO label	Lineage #	US Class	%Total	95%PI
Omicron	KP.3.1.1	27.8%	23.0-33.2%	
	KP.3	20.1%	17.2-23.4%	
	LB.1	16.0%	13.5-18.7%	
	KP.2.3	14.2%	11.2-17.8%	
	KP.2	5.7%	4.2-7.6%	
	LP.1	4.5%	3.1-6.4%	
	KP.1.1	3.2%	2.4-4.4%	
	KP.1.1.3	2.6%	1.7-3.8%	
	JN.1.16.1	1.2%	0.8-1.8%	
	LF.3.1	1.1%	0.7-1.7%	
	KS.1	0.9%	0.6-1.4%	
	KP.4.1	0.4%	0.2-0.9%	
	JN.1.18	0.4%	0.2-0.6%	
	JN.1.11.1	0.3%	0.2-0.5%	
	JN.1	0.3%	0.2-0.5%	
	XDV.1	0.3%	0.2-0.5%	
	KW.1.1	0.2%	0.1-0.4%	
	JN.1.16	0.2%	0.2-0.3%	
	JN.1.7	0.2%	0.1-0.3%	
	KP.1.2	0.1%	0.1-0.2%	
	JN.1.13.1	0.0%	0.0-0.1%	
	KQ.1	0.0%	0.0-0.1%	
	JN.1.8.1	0.0%	0.0-0.0%	
	XDP	0.0%	0.0-0.0%	
	JN.1.4.3	0.0%	0.0-0.0%	
	JN.1.32	0.0%	0.0-0.0%	
	KV.2	0.0%	0.0-0.0%	
	BA.2	0.0%	0.0-0.0%	

** These data include Nowcast estimates, which are modeled projections that may differ from weighted estimates generated at later dates

Enumerated lineages are US VOC and lineages circulating above 1% nationally in at least one 2-week period. "Other" represents the aggregation of lineages which are circulating <1% nationally during all 2-week periods displayed. While all lineages are tracked by CDC, those named lineages not enumerated in this graphic aggregated with their parent lineages, based on Pango lineage definitions, described in more detail here: https://web.archive.org/web/20240116214031/https://www.pango.network/the-pango-nomenclature-system/statement-of-nomenclature-rules.

CDC: https://covid.cdc.gov/covid-data-tracker/#variant-summary

COVID-19

Continuing Threat, Particularly for Those Vulnerable to Severe Disease

New, Safe and Well-Tolerated Oral Therapies Needed

UNMET MEDICAL NEED:

- Drug-drug interactions
- Safety concerns
- Tolerability issues

Bemnifosbuvir Target Profile:

- Low risk of drug-drug interactions
- Generally safe and well-tolerated
- Distinct MOA with high barrier to resistance

In the MORNINGSKY trial, risk of hospitalization was 71% lower for bemnifosbuvir vs. placebo; 82% in patients >40 years old***

Oral Antiviral Global Market Opportunity:

~$4-5B+	2	Opportunity to expand market with improved product profile
annual sales	product market	

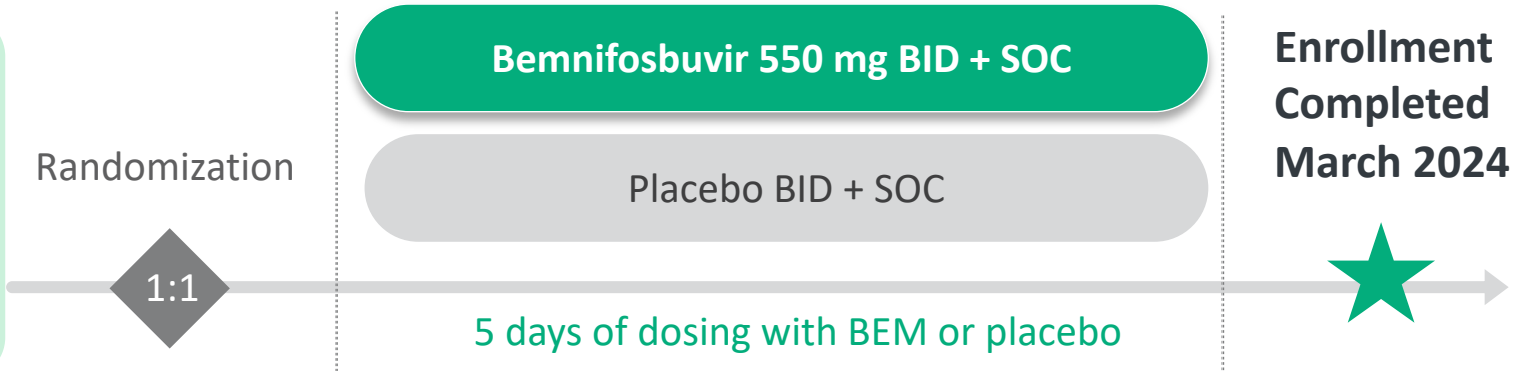
*https://www.futuremedicine.com/doi/full/10.2217/fvl-2023-0115 **Secondary endpoint

SUNRISE-3: Global Phase 3 Trial in High-Risk COVID-19 Outpatients

Bemnifosbuvir – U.S. Fast Track Designation for COVID-19

Inclusion Criteria: High-risk outpatients with mild or moderate COVID-19, regardless of vaccination status; symptom onset ≤5 days before randomization

Geography: US, Europe, Japan and ROW



Phase 3 Study Design:

- Randomized, double-blind, placebo-controlled
- Bemnifosbuvir or placebo initiated same time as locally available standard of care (SOC)
- Two study populations:
  - *supportive care monotherapy* **(primary analysis, n=2221)**
  - *combination therapy* **(secondary analysis**, local SOC includes treatment with other antiviral drugs against COVID-19) **(n=74)**

High-risk outpatients: ≥70, ≥55 w/ one+ risk factors, ≥50 with two+ risk factors, ≥18 immunocompromised conditions

Primary Endpoint

All-cause hospitalization or death through Day 29 in monotherapy population

Secondary Endpoints Through Day 60 (last patient visit was May 2024):

- COVID-19 related hospitalizations and deaths
- Medically attended visits
- Symptom rebound / relapse
- Viral load rebound

Strong Operational Execution of Global Phase 3 SUNRISE-3 Trial

*Only Current Phase 3 Program in **High-Risk Patients** with Hospitalization as Primary Endpoint*

- SUNRISE-3 enrolled **ahead of guidance**
- Enrolled **2,221 patients in monotherapy cohort** and 74 patients on combination cohort

- Primary endpoint is **through Day 29 post-treatment**
- Secondary endpoints measure patient outcomes **through Day 60 post-treatment**

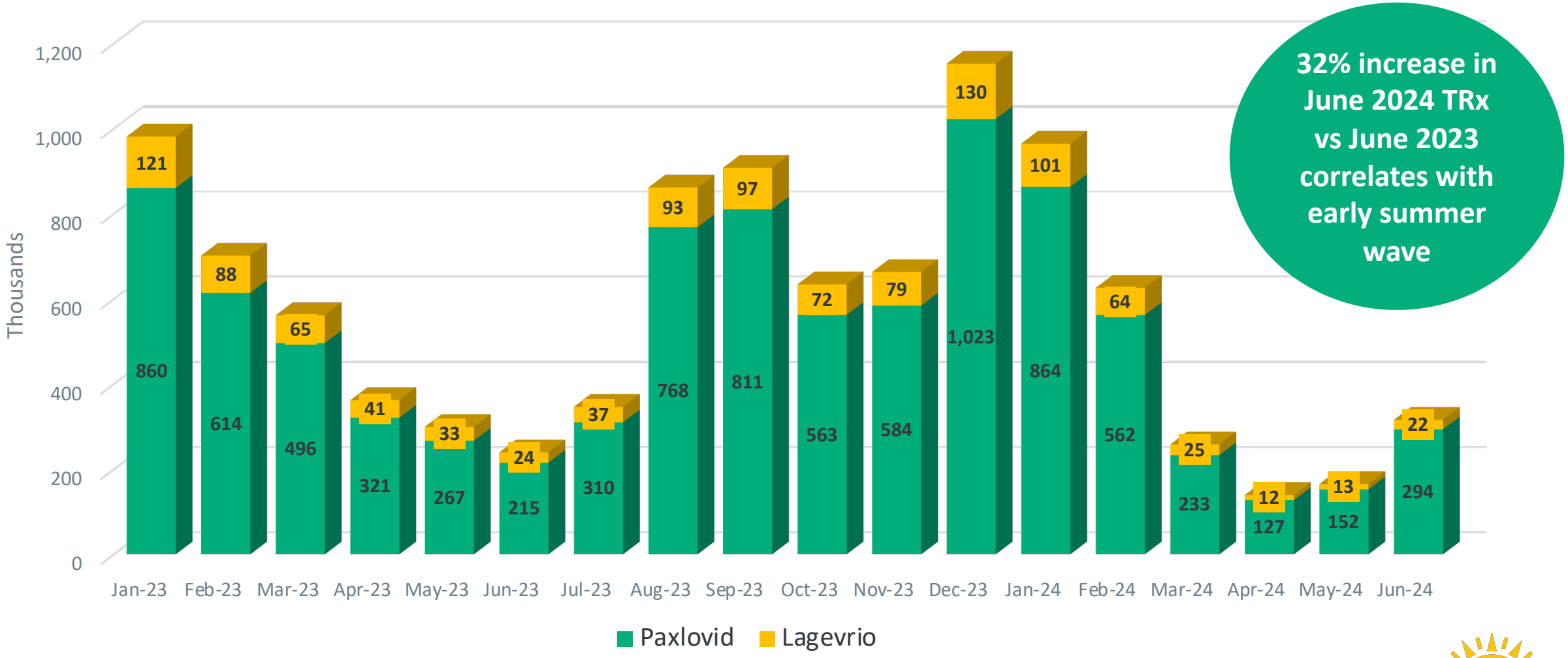
- Results expected **2H'24**
- NDA submission **targeted ~YE'24**

Unmet Medical Need Remains in High-Risk Population

Most vulnerable: elderly, immunocompromised, undervaccinated, and those with underlying risk factors

US TRx Demand for COVID-19 Oral Antivirals Correlates with Infections

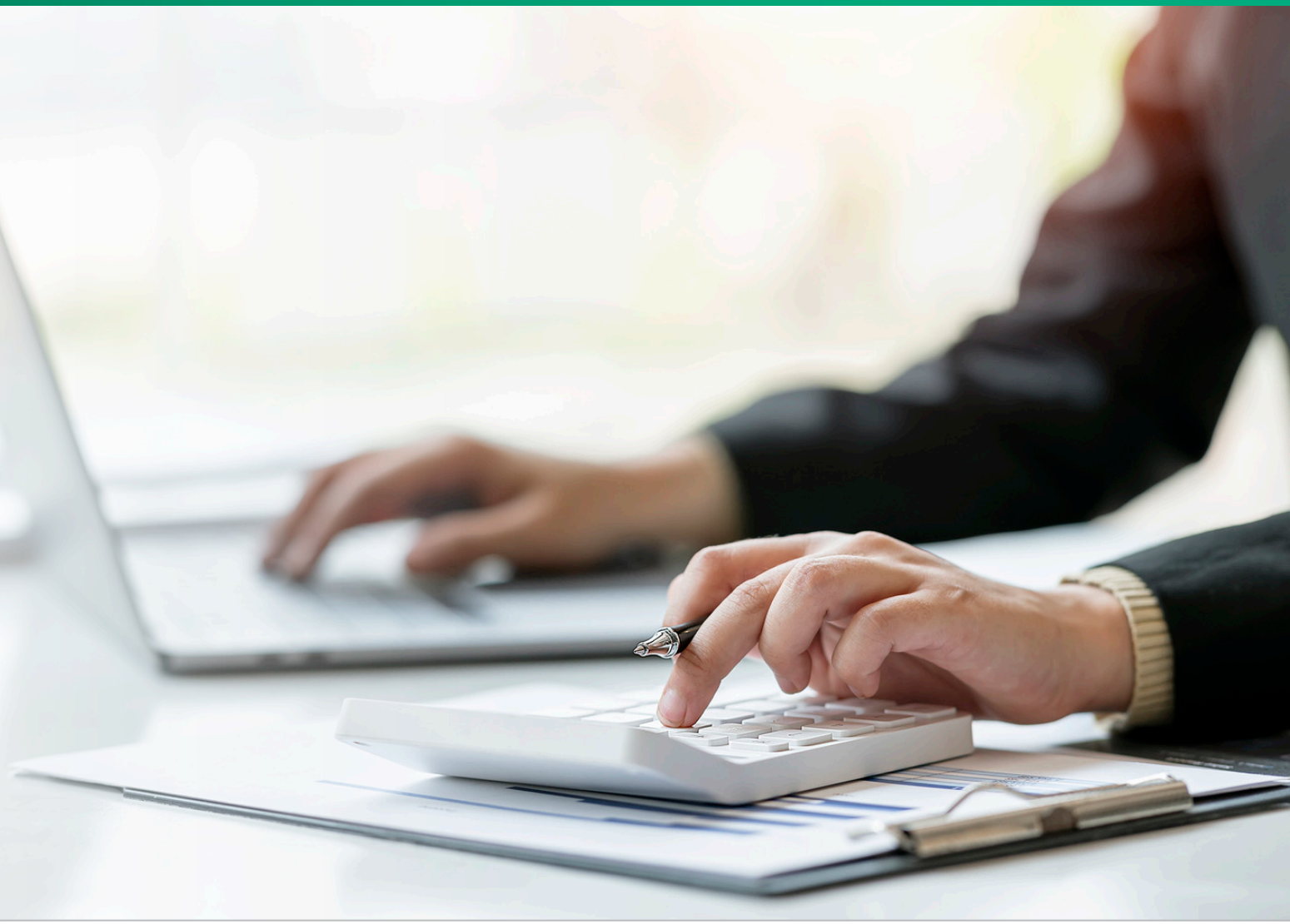
US Demand: Monthly COVID-19 Oral Antiviral Prescriptions Dispensed *(thousands)*



32% increase in June 2024 TRx vs June 2023 correlates with early summer wave

Source: IQVIA NPA June 2024

Financial Summary



Financial Update Second Quarter 2024

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2024	**2023**	**2024**	**2023**
Operating expenses				
Research and development	$ 34,696	$ 22,063	$ 92,271	$ 51,017
General and administrative	12,220	13,172	24,451	25,787
Total operating expenses	46,916	35,235	116,722	76,804
Loss from operations	(46,916)	(35,235)	(116,722)	(76,804)
Interest income and other, net	6,637	7,303	13,505	13,602
Loss before income taxes	(40,279)	(27,932)	(103,217)	(63,202)
Income tax expense	(243)	(251)	(474)	(448)
Net loss	$ (40,522)	$ (28,183)	$ (103,691)	$ (63,650)
Other comprehensive loss				
Unrealized gain (loss) on available-for-sale investments	(99)	(3)	(487)	374
Comprehensive loss	$ (40,621)	$ (28,186)	$ (104,178)	$ (63,276)
Net loss per share - basic and diluted	$ (0.48)	$ (0.34)	$ (1.23)	$ (0.76)
Weighted-average number of common shares - basic and diluted	84,253,700	83,399,377	84,069,646	83,361,398

Financial Update Second Quarter 2024

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

	June 30, 2024	December 31, 2023
Cash, cash equivalents and marketable securities	$ 502,214	$ 578,106
Working capital[(1)]	479,750	558,079
Total assets	510,384	594,968
Total liabilities	33,914	39,776
Total stockholder's equity	476,470	555,192

(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 June 30, 2024 for further detail regarding its current assets and liabilities.

Closing Remarks

NASDAQ: AVIR

Focused Antiviral Pipeline, Strong Operational Execution Across Programs

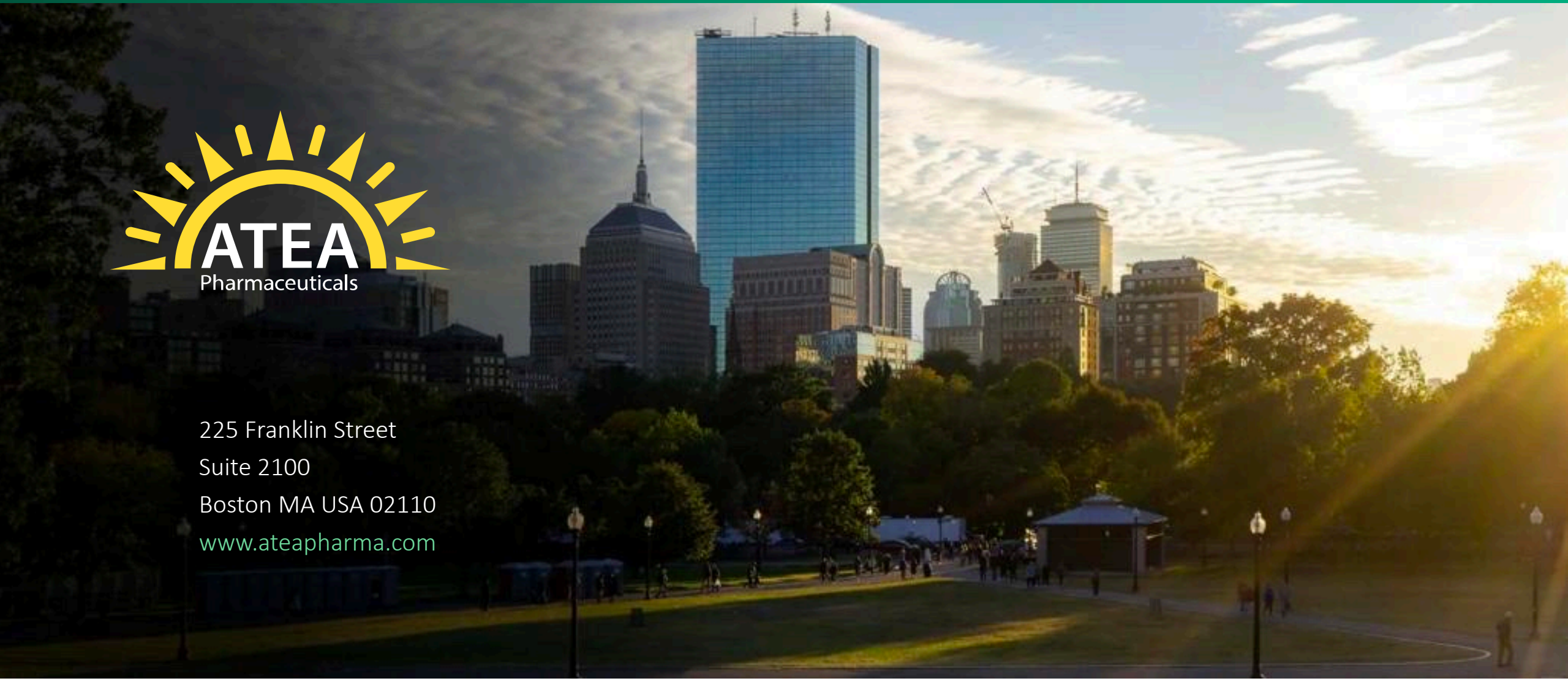
Key Clinical Data Expected in 2024: Phase 3 SUNRISE-3 Results and Complete Phase 2 HCV Results

PROGRAM	THERAPEUTIC INDICATION		PRECLINICAL	PHASE 1	PHASE 2	PHASE 3	MAJOR MILESTONES 2024
Coronaviridae Sunrise-3	**COVID-19**	**Bemnifosbuvir (AT-527) Nucleotide***					**Full enrollment achieved March 2024 with 2,221 patients in monotherapy cohort** • Topline results 2H'24 • NDA submission target ~YE'24
		Protease Inhibitor					**Protease inhibitor** • Program update 2H'2024
Bemnifosbuvir + Ruzasvir Combination Program	**Hepatitis C**	**Bemnifosbuvir Nucleotide[1]**					**Multiple preclinical and Phase 2 SVR12 data presented at EASL June 5-8, 2024** • Phase 2 complete SVR12 4Q'24 • Phase 3 initiation target YE'24
		Ruzasvir NS5A Inhibitor[1]**					

Cash, cash equivalents & marketable securities: **$502.2 M at 6/30/24** -- Cash runway anticipated into 2027

*Bemnifosbuvir (generic name for AT-527) is a double prodrug nucleotide analog. ** Worldwide exclusive license for all uses from Merck.

1. Bemnifosbuvir and ruzasvir have each separately generated clinical results and are being developed as a combination for HCV.



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