JP Morgan Healthcare Conference

January 15, 2026

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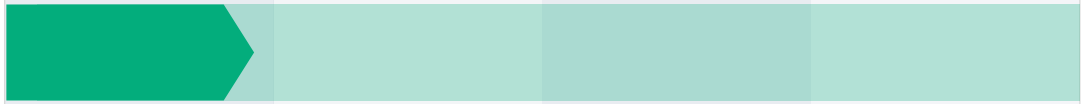
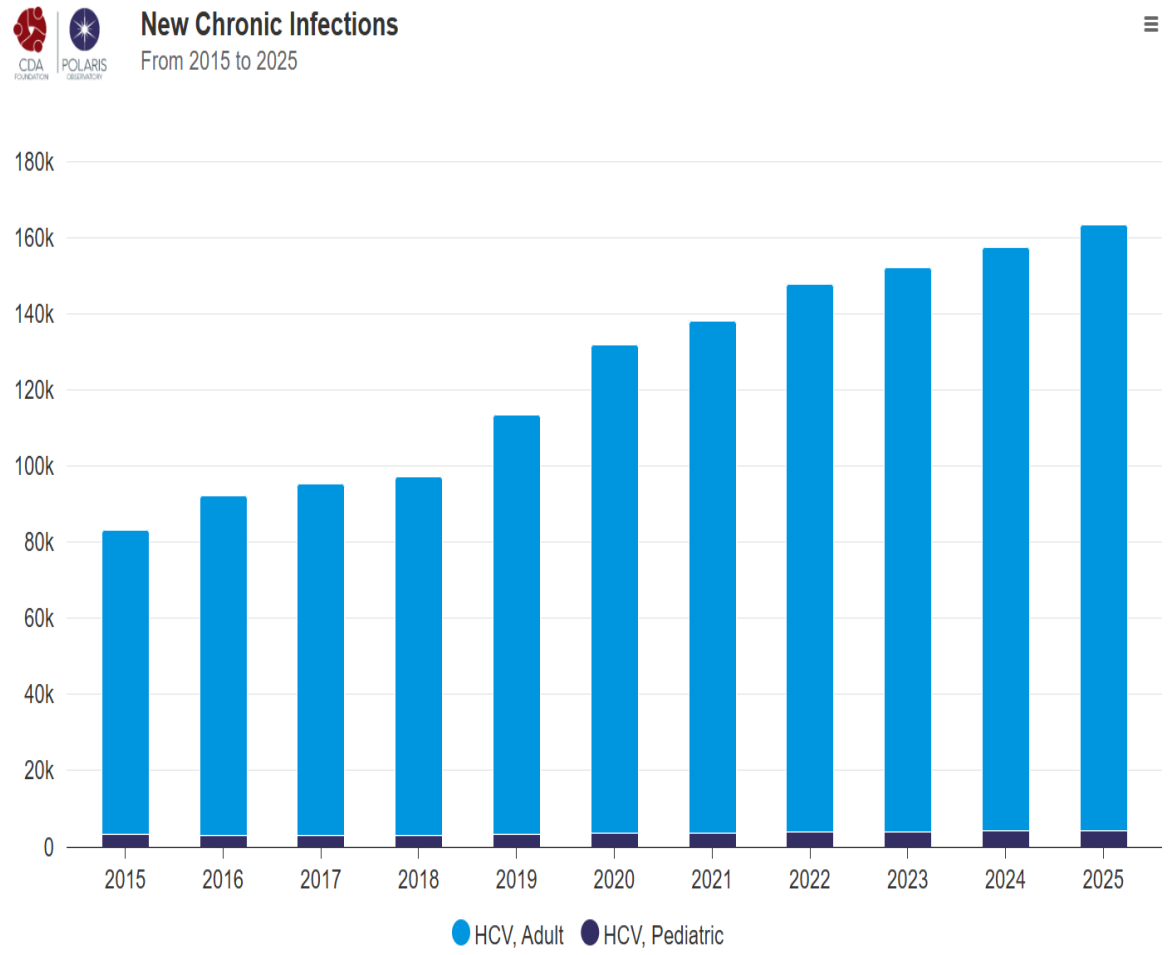
Market data and industry information used throughout this presentation are based on management's knowledge of the industry and the good faith estimates of management. We also relied, to the extent available, upon management's review of independent industry surveys and publications and other publicly 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.

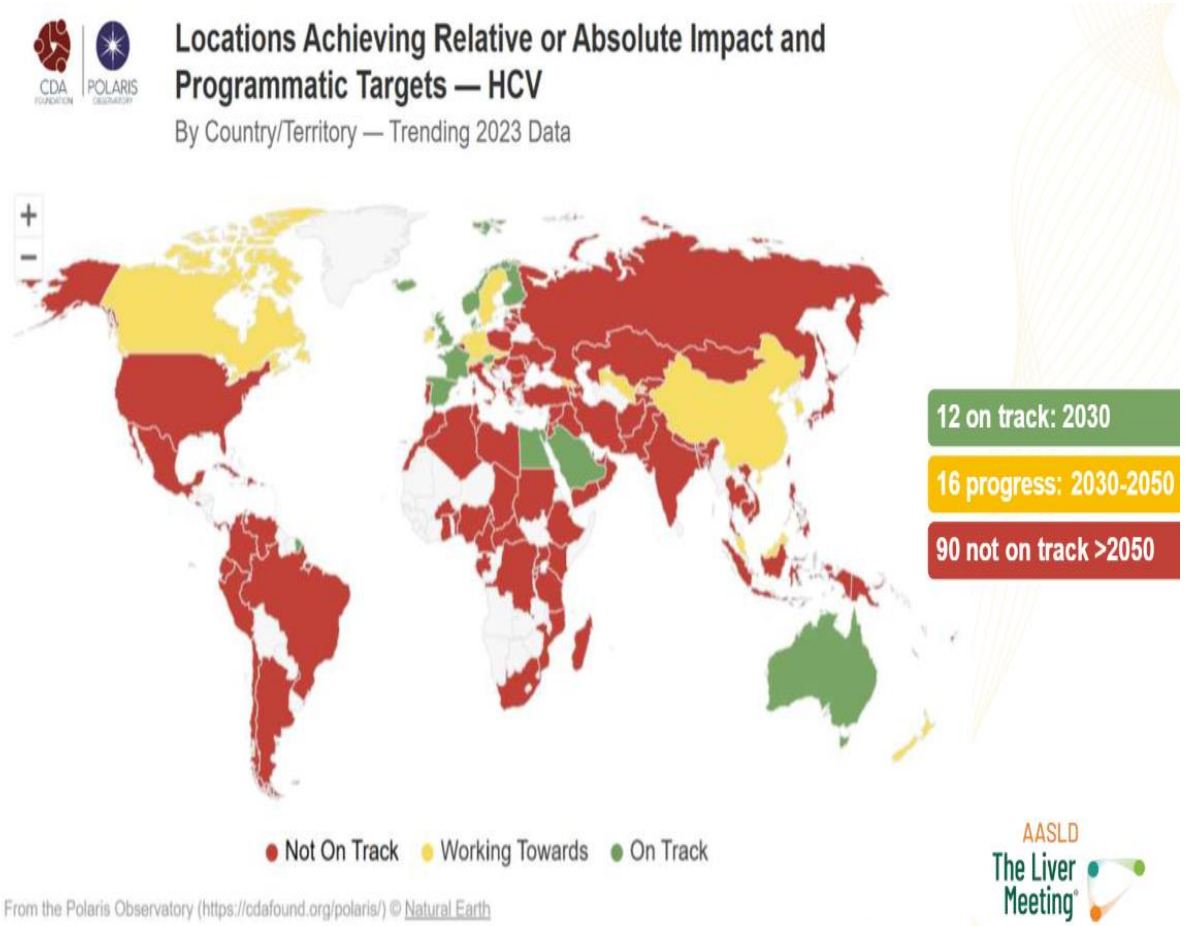
Focused Antiviral Pipeline with De-risked Phase 3 Program

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

Cash and investments: **$301.8 million at 12/31/25**
Cash runway anticipated through 2027

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





AASLD The Liver Meeting

ATEA Pharmaceuticals

BEM/RZR

Potential Best-in-Class Regimen for Treatment of HCV

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
  - **Low risk of drug-drug interactions, including proton pump inhibitors**
  - Convenient dosing with **short 8-week treatment duration**** and **no food effect**

Robust Phase 2 Results Achieved Primary Endpoints

- Phase 2 results (n=275) -- 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 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

KOL Feedback
Test-and-Treat & Market Research

BEM/RZR Market Research

KOLS: BEM/RZR Profile Well Suited for Rapid Test-and-Treat Care

While you're waiting, they're spreading HCV. You want to to poke a patient's finger, get a result and give the course of medication... **If you have short duration, less pill burden, no food effect, minimal DDIs, you're perfectly aligned with a test-and-treat model.** *Anthony Martinez, MD, University of Buffalo, Erie County Medical Center* **...Shorter is better. It's just a simple fact**.

If we're able to enlarge number of healthcare providers that treat HCV, the multiplier effect on getting treatment across the US is exponential... **A regimen is needed that is uncomplicated and easy to use and providers aren't afraid of or worried about.** *Eric Lawitz, MD, Texas Liver Institute, UT Health San Antonio* **...**People say 8 versus 12 weeks, maybe not that big a deal, but actually**, the focus on a shorter duration is very, very important.**

What we found is that **if we can get them on to their first dose of medication, our success rate of getting people to complete treatment is incredibly high**... *Jordan Feld, MD, MPH, University of Toronto, Toronto General Hospital, Canada*

Delay in treatment increases the risk of transmission. You now have to treat a lot more individuals than you would have if you treated someone earlier in their infection. *Nancy Reau, MD, Rush University Medical Center, Chicago*

Annual New HCV Infections in US Exceed Annual Treatments

Test-and-Treat Can Expand Diagnosis and Treatment of HCV Infections

US HCV INFECTIONS GROWING FASTER THAN TREATED PATIENTS

~4 Million
Infected Individuals[1]

>160 Thousand
New Chronic Annual Infections[2]

~90 Thousand
Treated Annually with Epclusa or Mavyret[3]

~$1.5B
US net sales in 2024[4]

EXPANSION OF TEST-AND-TREAT MODEL OF CARE CRITICAL TO ACCELERATE HCV ELIMINATION IN US

- Rapid diagnosis and treatment at the same time
- Reduces barriers to treatment prescribing / initiation
- 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

1. CDC; 2. The CDA Foundation, Lafayette, CO 2025. Hepatitis C – United States. Available from https://cdafound.org/Polaris/database-query/ (Accessed 1/8/2026);
3. IQVIA 2024; 4. U.S. Net Sales of Mavyret, Epclusa (and its authorized copy) from AbbVie and Gilead 2024 Annual Reports

Highly Attractive BEM/RZR Commercial Profile

BEM/RZR Has Potential to Become Most Prescribed Treatment in HCV Market

PRESCRIBERS

Quantitative Market Research of High DAA Prescribers

% of patients likely to be prescribed BEM/RZR[1]

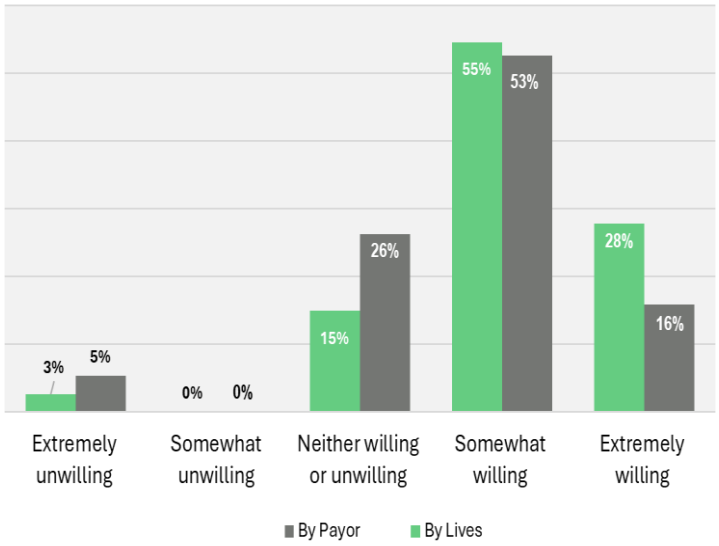
48%
Non-Cirrhotic Patients

49%
Compensated Cirrhotic Patients

PAYORS

Research of Payors Covering >130M Lives

High willingness to add BEM/RZR regimen onto formulary[2]



MARKET

Concentrated Prescriber Base

- Distribution of HCV prescribers by IQVIA[3]
- Specialty Care Sales Force Required
  - ~6,000 Prescribers write
  - ~80% Direct Acting Antiviral Prescriptions
- Limited competition with no competitors in clinical development

1. Predicted share of patients between BEM/RZR, Epclusa, and Mavyret. Atea Custom Market Research, IQVIA, June 2025; 2. Atea Custom Market Research, Formulary Insights, June 2024; 3. IQVIA 2022

BEM/RZR

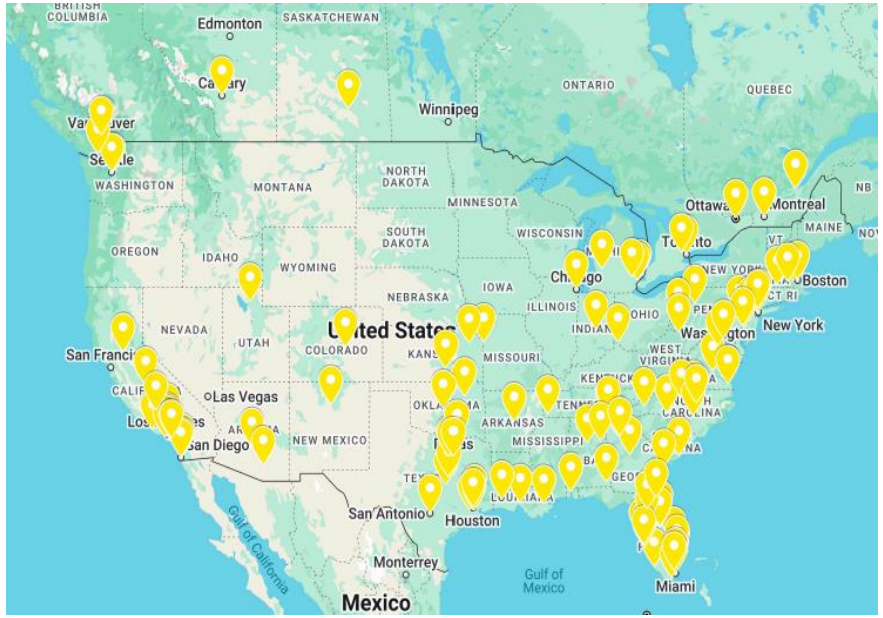
Potential Best-in-Class Regimen for Treatment of HCV

Global Phase 3 Program Update

On Track: Global HCV Phase 3 Program

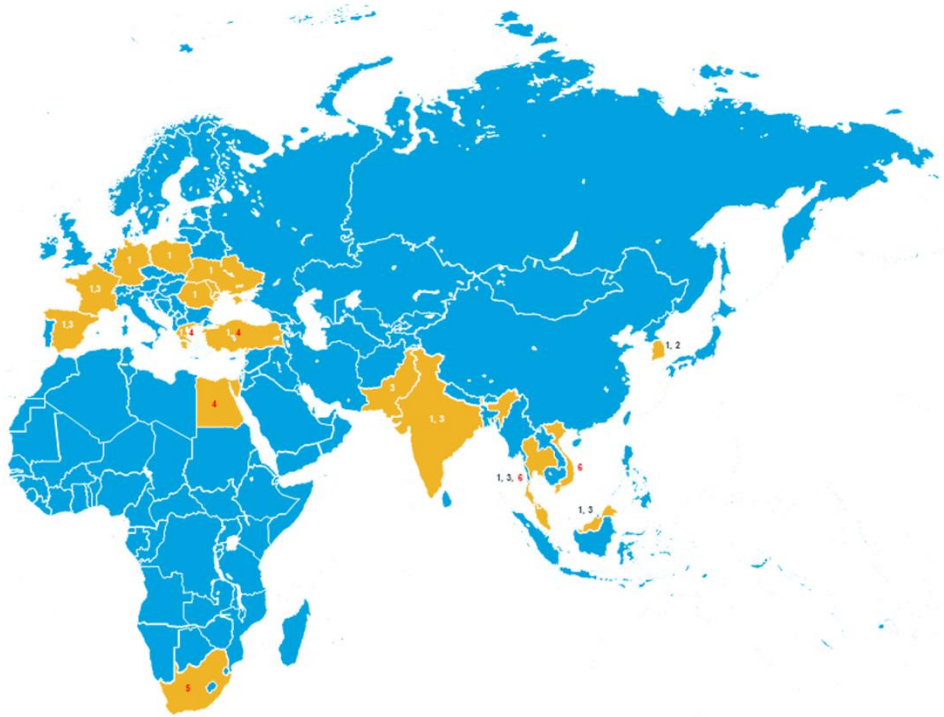
C-BEYOND

- ~120 sites in US and Canada
- **Enrollment completed**
- **Cirrhotic population target achieved**
- Results expected mid-2026



C-FORWARD

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



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

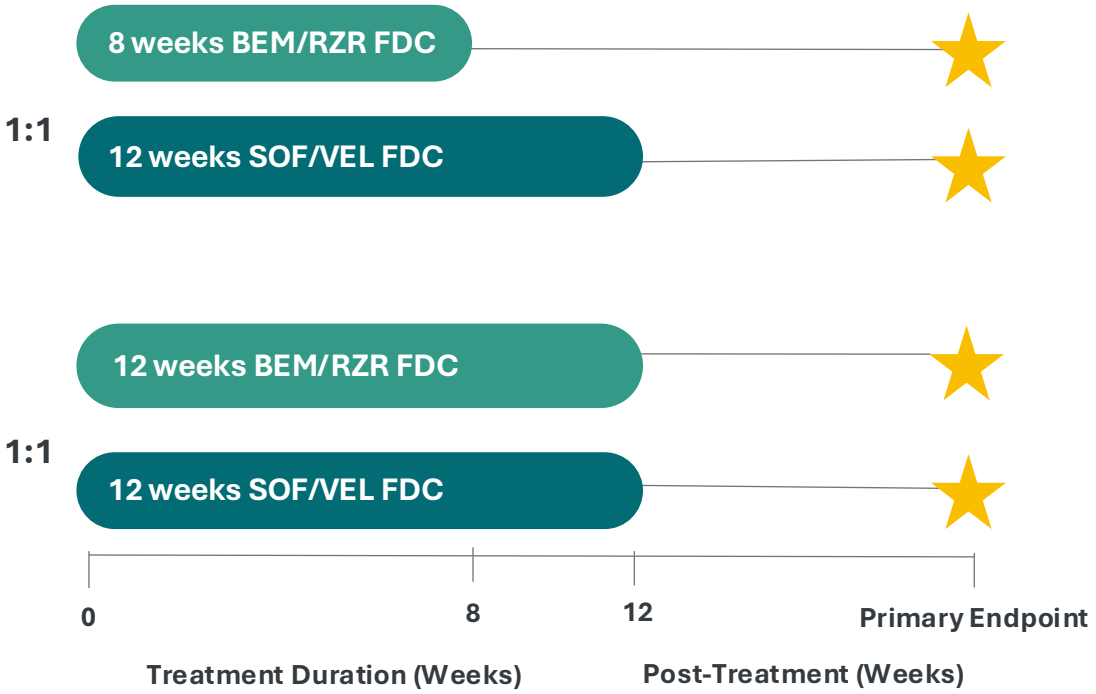
US / Canada Trial Enrollment Completed

Outside North America Trial N= ~704

Cirrhotic

US / Canada Trial Enrollment Completed

Outside North America Trial N= ~176



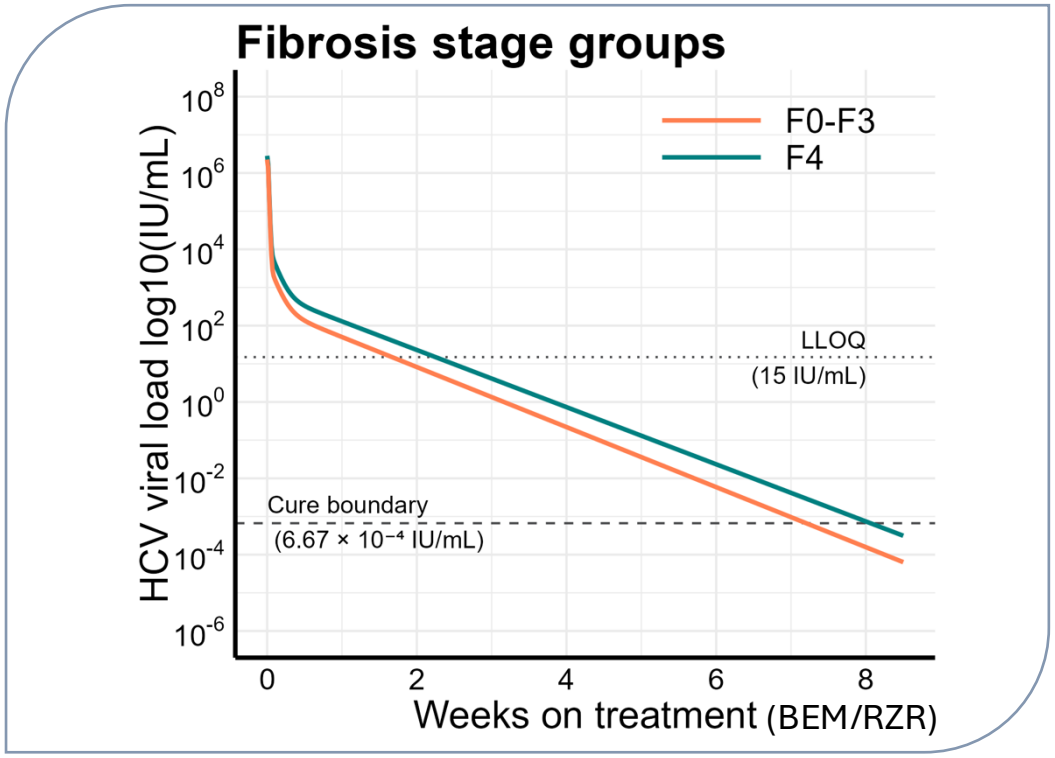
Primary Endpoint - Encompasses SVR12 in All Arms*

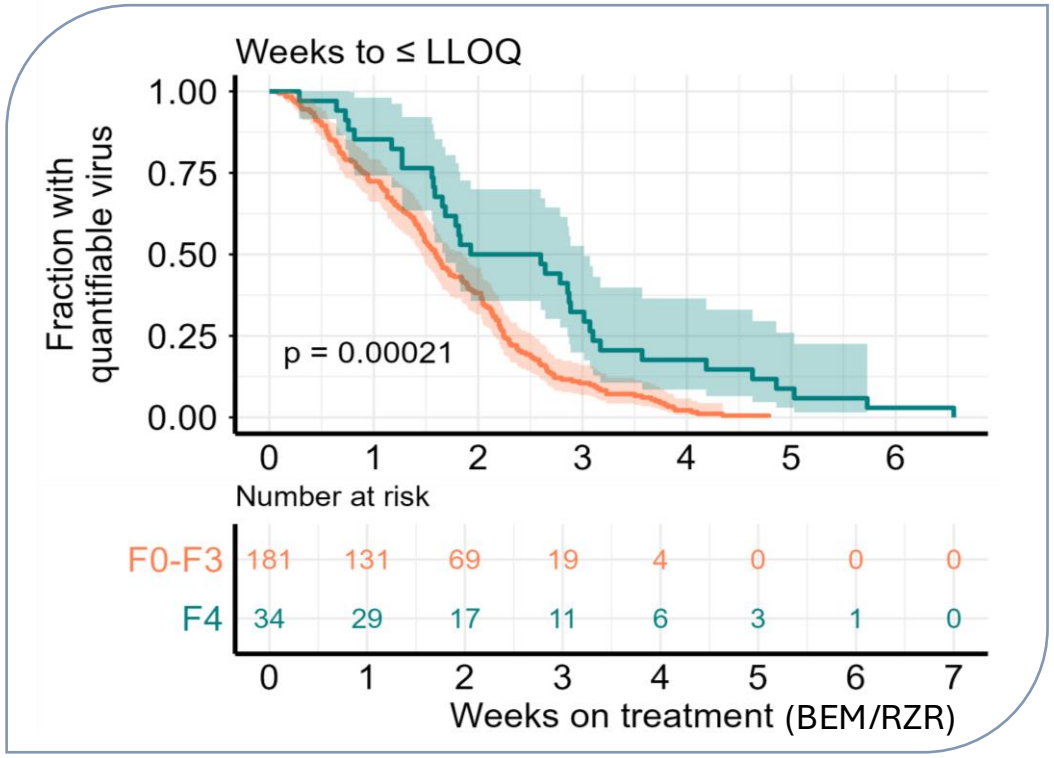
- No Cirrhosis: 8 weeks of BEM/RZR vs 12 weeks of active comparator
- Compensated Cirrhosis: 12 weeks of BEM/RZR vs active comparator

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

Predicted Median Time to Viral Clearance by Fibrosis Stage Based on Ph 2 Results

Time to Cure Estimates Support 8-Week Treatment for Non-cirrhotic and 12-Week Treatment for Compensated Cirrhosis





MEDIAN TIME TO LLOQ BASED ON MODEL PREDICTION:

- F0–F3: 12 days [CI_{95}:2—27]
- F4: 16 days [CI_{95}:4—41]

MEDIAN TIME TO CURE BASED ON MODEL PREDICTION:

- F0–F3: 7.3 weeks [CI_{95}:5—14]
- F4: 8.2 weeks [CI_{95}:5—16]

VIROLOGIC RESPONSE (VR) BASED ON MODEL PREDICTION:

RAPID VR: 95.4% OVERALL

- 97.8% in F0–F3 [CI_{95}:94.5—99.1]
- 82.4% in F4 [CI_{95}:66.5—91.7]

Zitzmann C et al. Presented at The Liver Meeting® 2025, American Association for the Study of Liver Diseases (AASLD), November 7–11, 2025, Washington, D.C., USA

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**
Major 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 5% non-inferiority for expected rate approximating 95% in mITT population

*post-hoc analyses

BEM/RZR Commercial Readiness

Commercial Supply Available for Launch at NDA Approval

All components and processes for large scale manufacturing are in place

Manufacture of commercial launch supply underway

Blister card for convenience and patient adherence

Low cost of goods relative to net price *(*low single digit percent)

Simple weekly dosing package
4 weekly blister cards packaged into a carton for 1-month supply

Expected Short Time to Profitability Post Launch

New Program

Hepatitis E Virus

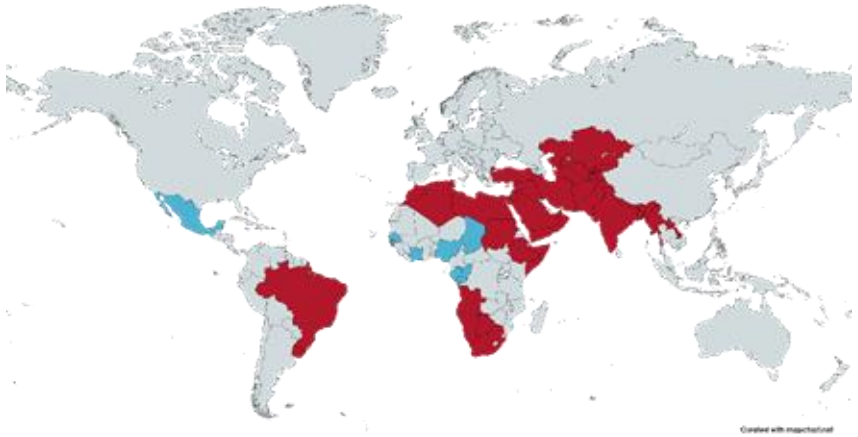
Product Candidate AT-587

Hepatitis E Virus (HEV) Overview

WHO estimates up to 20 million global HEV infections annually[1]

HEV[2] **GT 1,2**

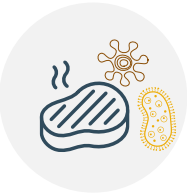
Waterborne transmission causes acute epidemics in developing countries

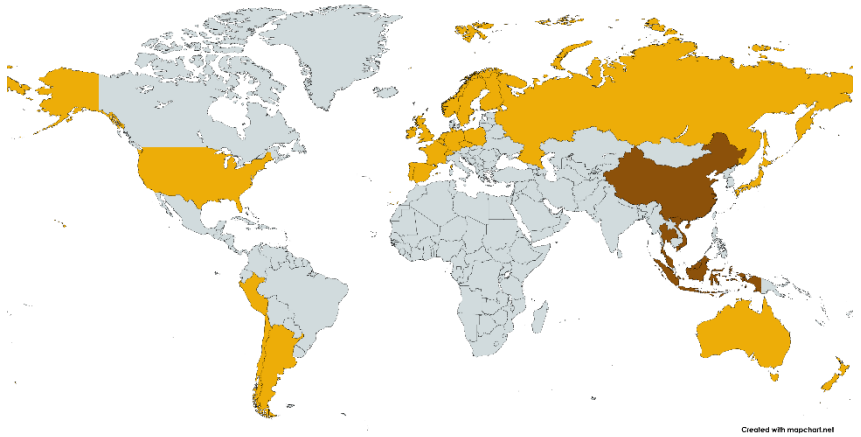


HEV-1 **HEV-2**

HEV[2] **GT 3,4**

Foodborne transmission causes chronic infection in the immunocompromised in developed countries





HEV-3 **HEV-4**

1. WHO most recent estimate. http://www.who.int/mediacentre/factsheets/fs280/en/ Accessed 1/8/2026.
2. 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 with GT-3 and GT-4 Can Lead to Rapid Progression 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 Epidemic HEV (GT1, GT2) • EASL: Focus on Chronic HEV (GT3)	Reflects Distinct Local Epidemiology	

1. Alexandrova R, et al. HV 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

Estimated HEV Infection Among High-Risk Populations in US & EU Leads to Commercial Opportunity of $750M-$1B*

A growing number of patients in high-risk populations in US & EU with no approved treatment

Incidence among at-risk populations

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

Incidence rate of 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 Antiviral Activity Against Multiple HEV-3 Strains and Ribavirin Resistant Virus in Replicons

EC_{50} VALUES (NM) AGAINST HEV STRAINS IN HUH7 CELLS

Compound	HEV-3 p6 WT	HEV-3 p6 G1634R (RBV RAS)*	HEV-3 83.2.27
Bemnifosbuvir	477 ± 121 (n=4)	---	---
AT-587	86.1 ± 20.1 (n=5)	83.9 ± 1.6	142.2 ± 1.6
Ribavirin	> 10,000 (n=5)	12,793 ± 945	19,111 ± 335
Fitness (%)	100.0	144.2*	115.0

n = minimum of 2 except where indicated

* The G1634R mutation confers an advantage for viral replication *in vitro*, which contributes to treatment failure, yet does not appear to alter its sensitivity to ribavirin

- AT-587 is potent against various HEV GT-3 strains and remains active against clinical ribavirin RAS
- Antiviral activity of AT-587 confirmed in primary human hepatocytes infected with HEV
- An animal model confirmed *in vivo* potency of BEM at 250 mg/kg/day (unpublished data)

Comparable Exposure of Active Triphosphate Metabolite Surrogate Achieved with AT-587 and Bemnifosbuvir Following a Single Oral Dose to Rats and Monkeys

Bemnifosbuvir				AT-587			
Species	PK Parameter	Parent Drug	Surrogate Metabolite	Species	PK Parameter	Parent Drug	Surrogate Metabolite
Monkey[1]	Dose (mg/kg)	100		Monkey	Dose (mg/kg)	100	
	AUC_{last} (ng·h/mL)	1,100	**3,032**		AUC_{last} (ng·h/mL)	3,321	**3,723**
	C_{max} (ng/mL)	783	**131**		C_{max} (ng/mL)	1,819	**331**
	T_{max} (h)	1-2	4		T_{max} (h)	1	4
Rat[2]	Dose (mg/kg)	500; adjusted to 100		Rat	Dose (mg/kg)	100	
	AUC_{last} (ng·h/mL)	16	**1,928**		AUC_{last} (ng·h/mL)	ND	**1,913**
	C_{max} (ng/mL)	12	**108**		C_{max} (ng/mL)	< 1.0	**176**
	T_{max} (h)	0.25	6-8		T_{max} (h)	ND	4

[1] Doses administered as powder in capsules
[2] Doses administered in suspension in aqueous 0.5% CMC/0.5% Tween 80

Doses administered as homogeneous suspension (0.5% CMC + 1% Tween 80)

AT-587 Forms High Levels of Active Triphosphate Metabolite (AT-9068) in Human Hepatocytes (Site of Viral Replication)

Triphosphate $AUC_{0\text{-}24h}$ (h*pmol /10^6 cells)

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 screening *in vitro* genetox assays (2-strain AMES, chromosomal aberration)
- Clean in screening hERG assay
- No toxicity to human iPS cardiomyocytes
- Minor effect on bone marrow $CD34^+$ cells, with mean IC_{50} > 30 uM
- IND/CTA enabling studies ongoing with GLP toxicology studies

Upcoming Key Milestones Across Antiviral Pipeline

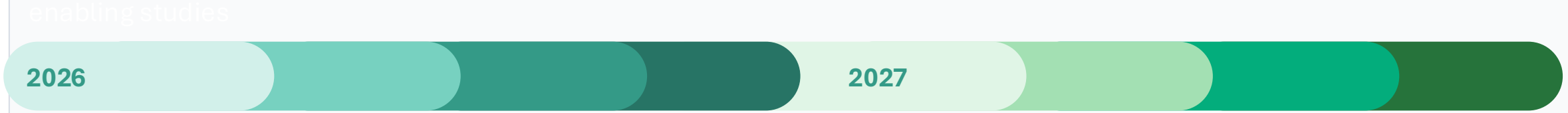
BEM/RZR REGIMEN - PHASE 3 PROGRAM FOR HCV

Ongoing
- Two Phase 3 Trials

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
- IND/CTA enabling studies

Mid-2026
- Phase 1 clinical study

2H 2026
- Initiation POC clinical study

2H 2027
- Initiation Phase 2/3 trial

Cash and investments: **$301.8 million at 12/31/25**
Cash runway anticipated through 2027

ATEA Pharmaceuticals

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