Q4 and Full Year 2025 Financial and Business Update

March 5, 2026

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Industry Information

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.

Strong Execution Sets Stage for Pivotal Catalysts in 2026

Global HCV Program

Advanced Global Phase 3 Program

- Topline results from C-BEYOND (North America) trial expected mid-2026
- Topline results from C-FORWARD (outside North America) trial anticipated year-end 2026

Presented results reinforcing BEM/RZR as potential best-in-class regimen at 2025 EASL Congress and The Liver Meeting® 2025, the Annual Meeting of AASLD, and other forums

Hosted 2 KOL Events: physician KOLs underscored need for new optimized HCV regimen to address treatment paradigm shifts, including test-and-treat care model

Pipeline Expansion with HEV Program

Presented *in vitro* data at CROI 2026 demonstrating AT-587 to be highly potent against HEV

In vitro and in vivo data support AT-587 as potential first-in-class inhibitor against HEV

IND/CTA enabling studies ongoing for AT-587 with initiation of first-in-human program expected mid-2026

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	**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

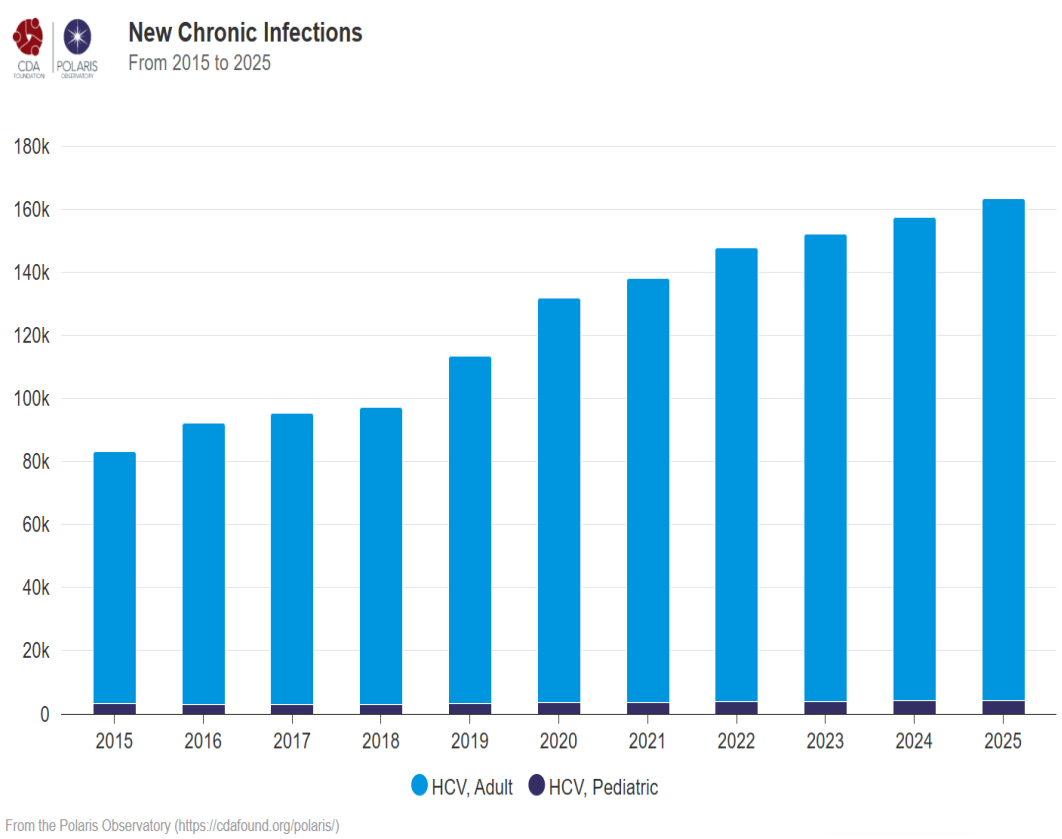
ATEA Pharmaceuticals

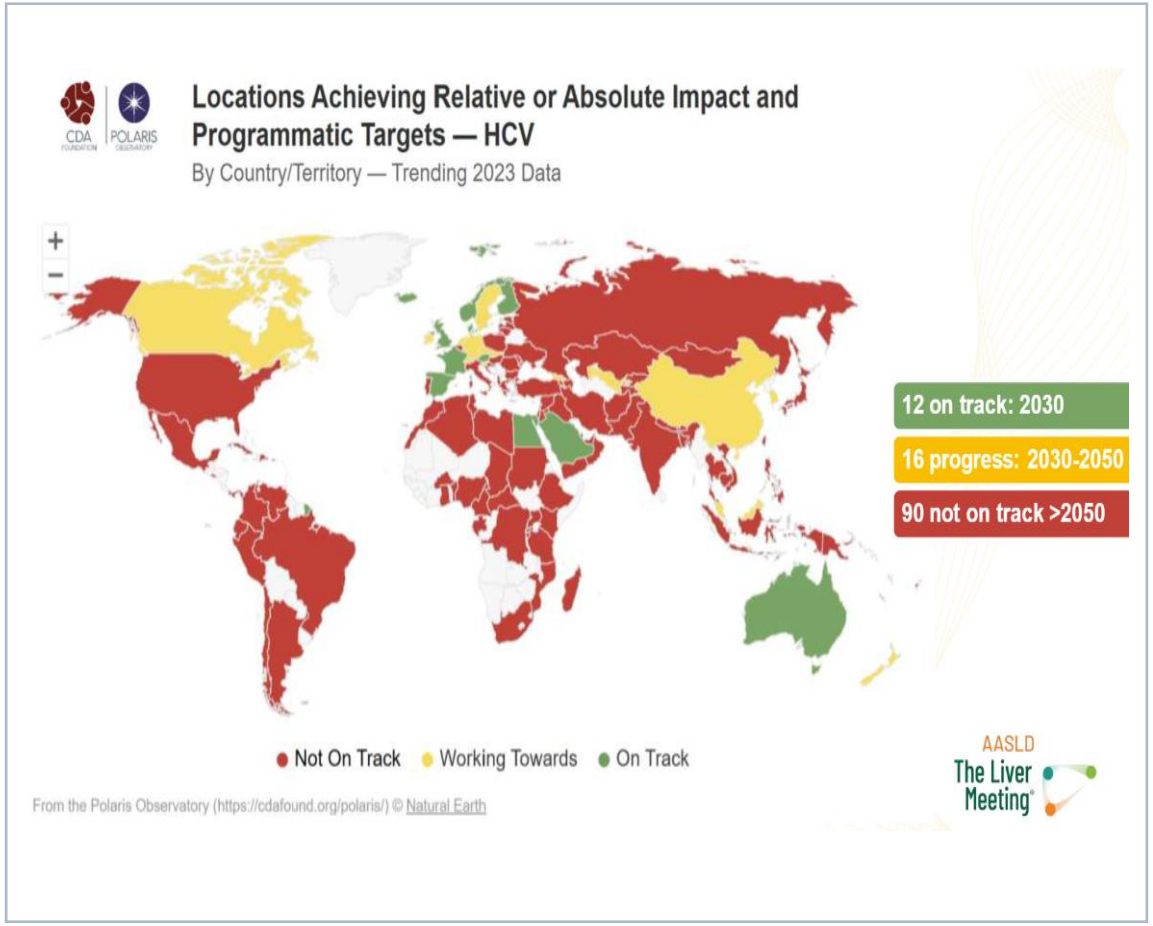
BEM/RZR

Potential Best-in-Class Regimen for Treatment of HCV

Target Profile

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





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

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®

Results Reinforce BEM/RZR as Potential Best-in-Class Regimen

Results presented at 2025 EASL Congress, The Liver Meeting® 2025, the Annual Meeting of AASLD, and other forums

- ✓ Achieved 98% SVR12 in treatment-adherent population, 95% SVR12 in efficacy-evaluable population in Phase 2 study[1]
- ✓ High barrier to resistance in resistance analyses[2]
- ✓ Low risk of DDIs, including with proton pump inhibitors[3], H2 blockers (famotidine)[2] and standard HIV treatment[1]
- ✓ No need for dose adjustment of BEM in patients with hepatic or renal impairment[1]
- ✓ Can be administered with or without food[2]
- ✓ In addition to inhibiting HCV RNA replication through chain termination, recent data demonstrate that BEM also inhibits assembly / secretion of new HCV virions, further explaining the high antiviral potency of BEM/RZR regimen[3]

1. EASL Congress 2025 2. AASLD The Liver Meeting 2025 3. Atea earnings call November 12, 2025

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)

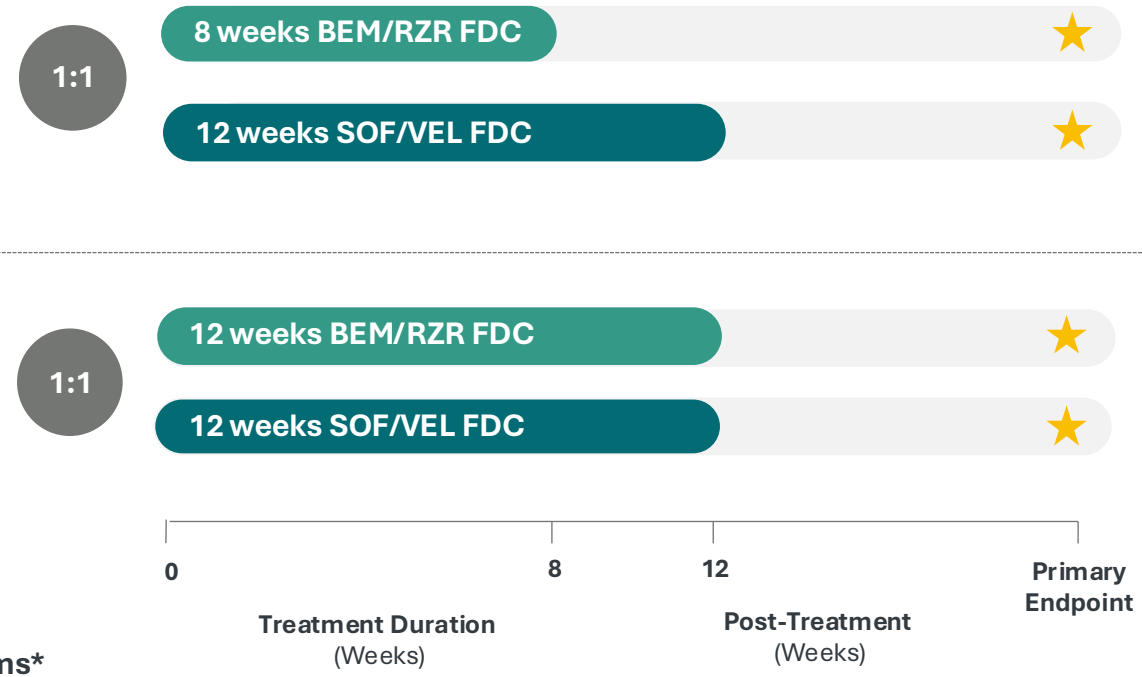
N= ~1,760 total patients

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

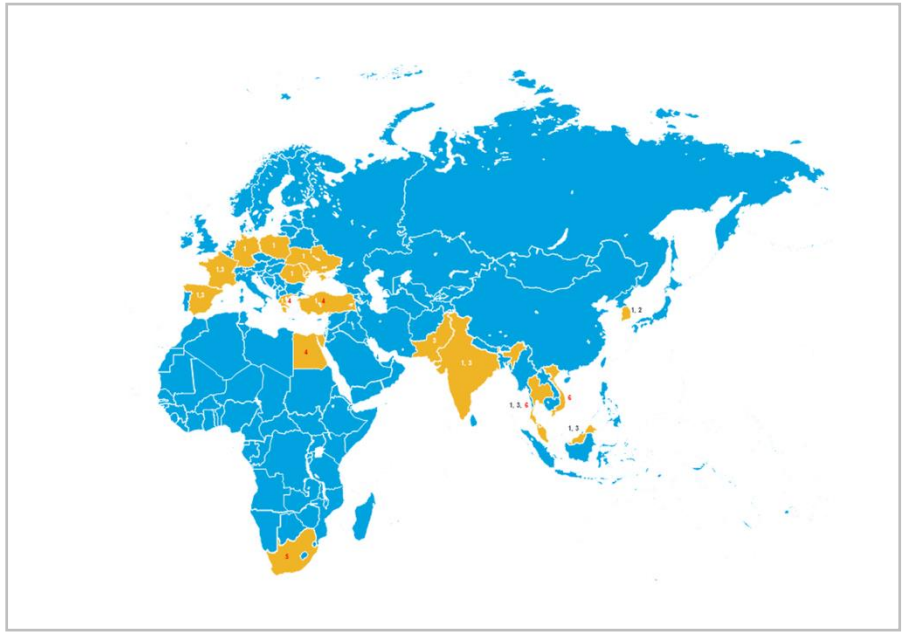
On Track: Global HCV Phase 3 Program

C-BEYOND

- ~120 sites in US and Canada
- **Enrollment completed n= >880**
- **Cirrhotic population target achieved**
- 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



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

ATEA Pharmaceuticals

BEM/RZR

Test-and-Treat, Commercial Readiness and Market Research

BEM/RZR Market Research

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 Of Care Critical To Accelerate HCV Elimination In US

TEST

AND

TREAT

- 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 of care

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 2025 4. U.S. Net Sales of Mavyret, Epclusa (and its authorized copy) from AbbVie and Gilead 2025 Annual Reports

BEM/RZR Commercial Readiness

Commercial Launch Supply Manufacturing in Place & Marketing Planning Underway

Commercial Supply

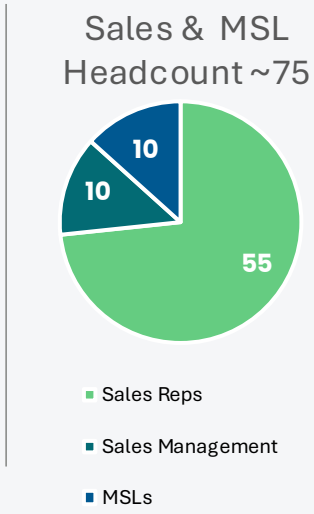
Launch Supply at NDA Approval

- 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

Specialty Commercial Planning

Concentrated Prescriber Base

- Specialty care sales force required
  - **~6,000** prescribers write **~80%** of direct acting antiviral prescriptions[1]
- 2 competitors with no other product candidates in clinical development



Expected Short Time to Profitability Post-Launch

1. IQVIA 2022

Highly Attractive BEM/RZR Commercial Profile

BEM/RZR Has Potential to Gain Significant Market Share

PRESCRIBERS

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

48%

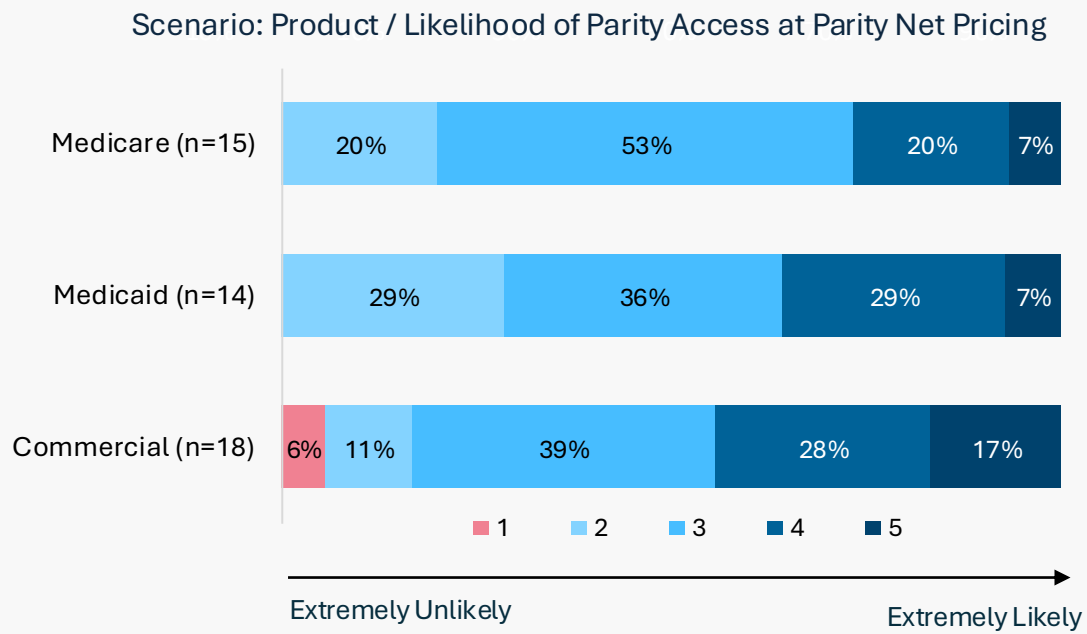
Predicted Share of Non-Cirrhotic Patients[2]

49%

Predicted Share of Compensated Cirrhotic Patients[2]

PAYORS

High Likelihood of Being Added to Existing Formularies at Parity Pricing Across Payor Segments[3]



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

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

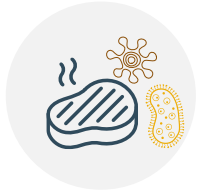
HEV **GT 1,2**

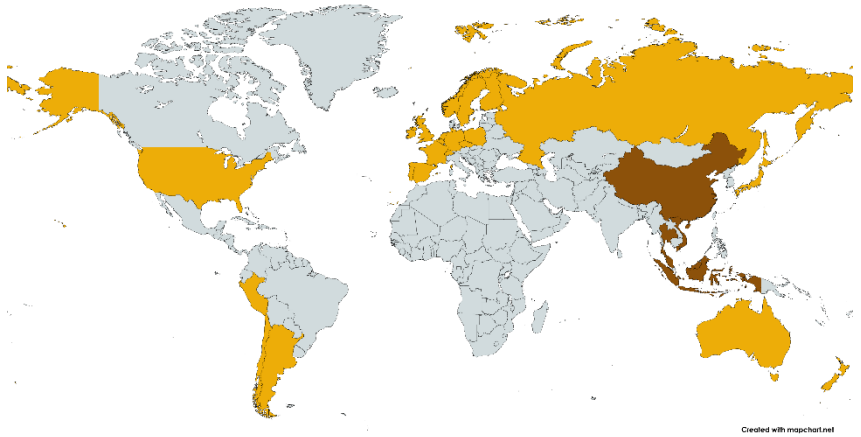
Waterborne transmission causes epidemics of acute, mostly self-limiting hepatitis in developing countries

HEV-1 HEV-2

HEV **GT 3,4**

Foodborne transmission causes chronic hepatitis in the immunocompromised 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 • EASL: Focus on Chronic HEV	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

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

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

AT-587			
Species	PK Parameter	Parent Drug	Surrogate Metabolite
Monkey	Dose (mg/kg)	100	
	AUC_{last} (ng·h/mL)	3,321	**3,723**
	C_{max} (ng/mL)	1,819	**331**
	T_{max} (h)	1	4
Rat	Dose (mg/kg)	100	
	AUC_{last} (ng·h/mL)	ND	**1,913**
	C_{max} (ng/mL)	< 1.0	**176**
	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 GLP *in vitro* genetox assays (Ames, *in vitro* micronucleus)
- Negative in photoxicity assay
- Clean in screening hERG assay
- No toxicity to human iPS cardiomyocytes and bone marrow $CD34^+$ cells
- IND/CTA enabling studies ongoing with GLP toxicology studies

Financial Update

4th Quarter and Full Year 2025 Results

Financial Update

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

	Three Months Ended December 31,		Year Ended December 31,	
	2025	**2024**	**2025**	**2024**
Operating expenses				
Research and development	$ 47,818	$ 25,671	$ 148,024	$ 144,101
General and administrative	7,116	13,355	32,863	48,849
Total operating expenses	54,934	39,026	180,887	192,950
Loss from operations	(54,934)	(39,026)	(180,887)	(192,950)
Interest income and other, net	3,299	5,708	16,376	25,490
Loss before income taxes	(51,635)	(33,318)	(164,511)	(167,460)
Income tax benefit (expense)	6,768	(225)	6,162	(925)
Net loss	$ (44,867)	$ (33,543)	$ (158,349)	$ (168,385)
Other comprehensive loss				
Unrealized (loss) gain on available-for-sale investments	(64)	(408)	(59)	26
Comprehensive loss	$ (44,931)	$ (33,951)	$ (158,408)	$ (168,359)
Net loss per share - basic and diluted	$ (0.57)	$ (0.40)	$ (1.94)	$ (2.00)
Weighted-average number of common shares - basic and diluted	78,126,796	84,463,059	81,495,352	84,264,715

Financial Update

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

	December 31, 2025	December 31, 2024
Cash, cash equivalents and marketable securities	$ 301,830	$ 454,721
Working capital[(1)]	271,207	443,752
Total assets	315,218	464,668
Total liabilities	39,784	25,801
Total stockholder's equity	275,434	438,867

(1) Atea defines working capital as current assets less current liabilities. See the Company's consolidated financial statements in its Annual Report on Form 10-K for the year ended December 31, 2025 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
IND/CTA enabling studies

Mid-2026
Phase 1 clinical study

2H 2026
Initiation of POC clinical study

2H 2027
Initiation of Phase 2/3 trial

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

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