Second Quarter Financial and Business Update

August 7, 2025

DISCLAIMERS

Forward-Looking Statements

This presentation contains "forward-looking statements" within the meaning of the Private Securities Litigation Reform Act of 1995. Forward-looking statements are neither historical facts nor assurances of future performance. Instead, they are based on our current beliefs, expectations and assumptions regarding the future of our business, future plans and strategies, our clinical results and other future conditions including without limitation the future of the HCV landscape and related commercial market opportunities. All statements other than statements of historical facts contained in this presentation are forward-looking statements, including statements by Atea Pharmaceuticals, Inc. (the "Company") regarding future results of operations and financial position, including our anticipated cash runway; business strategy; current and prospective product candidates; anticipated milestone events; potential benefits of our product candidates and market opportunity; clinical trials, including, without limitation, anticipated initiation, enrollment, regulatory submission and data readout timelines; preclinical activities; product approvals; manufacturing availability; degree of market acceptance of any products that may be approved; estimated total addressable market; research and development costs; prospective collaborations and strategic partnerships; and prospects and opportunities for investors. In some cases, you can identify forward-looking statements by terms such as "may," "will," "should," "expects," "plans," "anticipates," "could," "intends," "targets," "projects," "contemplates," "believes," "estimates," "predicts," "potential" or "continue" or the negative of these terms or other similar expressions.

The information in this presentation, including without limitation the forward-looking statements contained herein, represent our views as of the date of this presentation. These statements are neither promises nor guarantees, but involve known and unknown risks, uncertainties and other important factors that may cause our actual results, performance or achievements to be materially different from any anticipated results, performance or achievements expressed or implied by the forward-looking statements. Risks and uncertainties that may cause actual results to differ materially include uncertainties inherent in the drug discovery and development process and the regulatory submission or approval process, unexpected or unfavorable safety or efficacy data or results observed during clinical trials or in data readouts; delays in or disruptions to clinical trials or our business; our reliance on third parties over which we may not always have full control, our ability to manufacture sufficient commercial product, competition from approved treatments for HCV, and other important risks and uncertainties that are described in our Annual Report on Form 10-K filed for the year ended December 31, 2024 and our most recent quarterly report on Form 10-Q filed with the Securities and Exchange Commission ("SEC") and our other filings with the SEC. New risk factors and uncertainties may emerge from time to time, and it is not possible to predict all risk factors and uncertainties. Accordingly, you are cautioned not to place undue reliance on these forward-looking statements.

Except as required by applicable law, we do not plan to publicly update or revise any forward-looking statements contained herein, whether as a result of any new information, future events, changed circumstances or otherwise. No representations or warranties (expressed or implied) are made about the accuracy of any such forward-looking statements.

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.

Q2 2025 HCV Program and Business Highlights

HCV Program Update

- First patient dosed in Phase 3 trial C-BEYOND in US and Canada (April)
- Four scientific posters presented at EASL 2025 Congress, including final results from global Phase 2 study (May)
- Hosted KOL event with panel of six HCV experts and prescribers who are leaders in hepatology, gastroenterology, infectious diseases, and HCV research in the US, Canada and Europe (May)
- First patient dosed in Phase 3 trial C-FORWARD outside North America (June)

Business Update

- Repurchase of up to $25 million of Company's common stock authorized and initiated (April)
- Refreshed Board of Directors with addition of Howard H. Berman, PhD (April)
- Identification of opportunities to enhance shareholder value (ongoing)

Broad Antiviral Pipeline with De-risked Phase 3 Program

Program	Therapeutic/ Indication	Preclinical	Phase 1	Phase 2	Phase 3	Milestone
Flaviviridae	**Hepatitis C** Fixed Dose Combination: **Bemnifosbuvir (BEM)** Nucleotide **+Ruzasvir (RZR)** NS5A Inhibitor					Ph 3 C-BEYOND trial (US / Canada) first patient dosed April 2025 Ph 3 C-FORWARD (outside North America) first patient dosed June 2025
RNA Viruses	**Respiratory** Protease Inhibitor					
RNA Viruses	**Other RNA viruses** Nucleotide AT587, AT2490					

Cash, cash equivalents & marketable securities: **$379.7M at 6/30/25**
Cash runway anticipated through 2027

Global HCV: Large Market with Undertreatment of Infections

WHO Worldwide Numbers

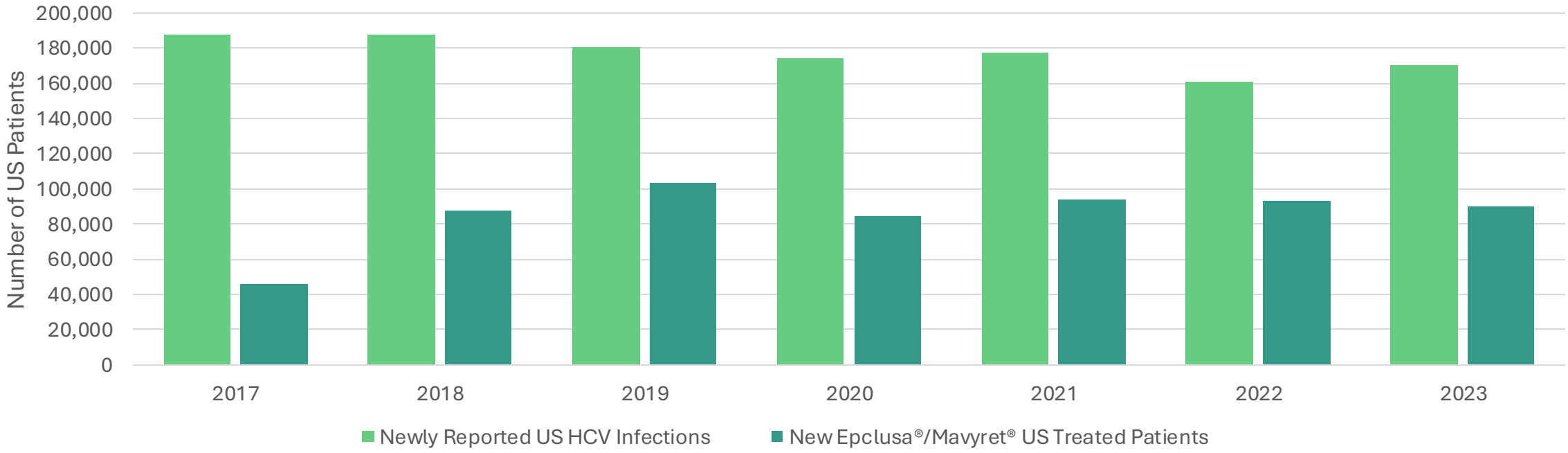
50 Million
People Infected[1]

1 Million
New Infections Annually[1]

Chronic HCV is **Leading Cause of Liver Cancer** in North America, Europe & Japan[2]

242,000
Annual Deaths[1]

CDC US: 2.4 – 4 Million Untreated[3], >170K Newly Reported Annual Infections[4]* Exceed Annual Cures[5]



1. WHO April 2024 2. www.cancer.gov/types/liver 3. https://www.cdc.gov/hepatitis-c/about/index.html *Newly reported chronic and acute HCV infections in US 4. CDC 2023 Viral Hepatitis Surveillance Report 5. IQVIA National Prescription Audit December 2024

US HCV: Major Commercial Opportunity Poised for Growth

Attractive Near-Term Opportunity

Primarily **2** product market

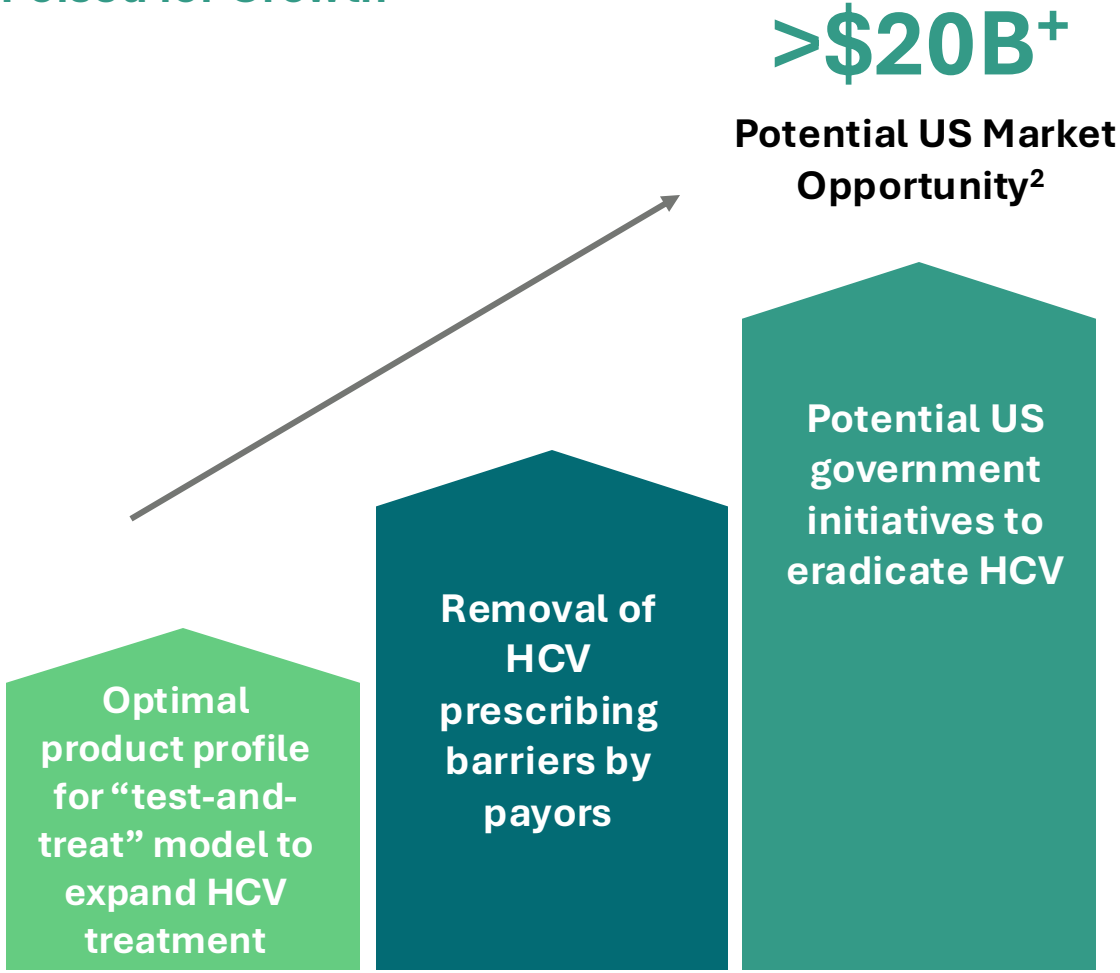
No competitors in clinical development

~$3B global net sales in 2024[1]

~$1.5B US net sales in 2024[1]

US Treatment	2022	2023	2024
Total US HCV Market Net Revenues[1]	~$1.6B	~$1.5B	~$1.5B
Net revenue per patient treated	~$17K	~$15K	~$17K

Poised for Growth



[1] Based on Global Net Revenues from Gilead and AbbVie's year end 2022, 2023 and 2024 financial reports [2] Assumes treatment of 2.2 million chronically infected HCV patients at $10,000 net revenue per patient.

BEM/RZR

Second Quarter Highlights

Multiple Presentations at EASL 2025

Q2 Highlights: Multiple Presentations at EASL Congress May 7-10, 2025

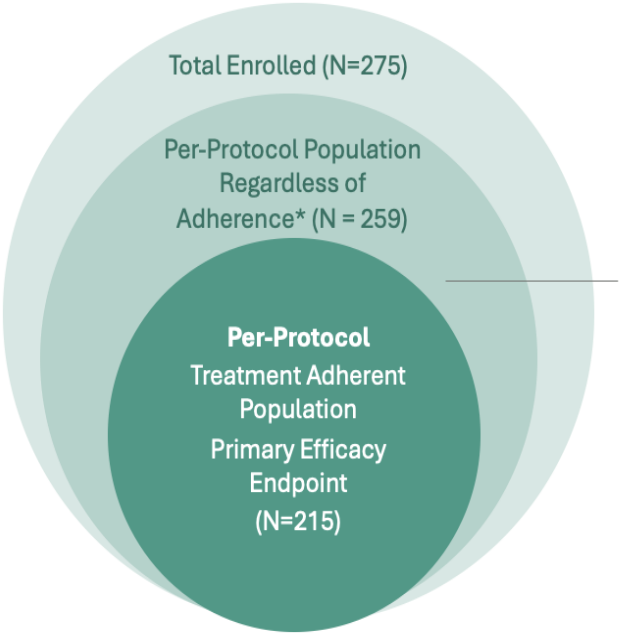
Four Poster Presentations at the European Association for the Study of the Liver (EASL)
Efficacy and Safety of Bemnifosbuvir and Ruzasvir after 8 Weeks of Treatment in Patients with Chronic Hepatitis C Virus (HCV) Infection (TOP-251) *These results reinforce the potential of the combination regimen of bemnifosbuvir and ruzasvir as a best-in-class treatment for HCV.*
Pharmacokinetics of Bemnifosbuvir in Participants with Hepatic Impairment (WED-278) *These results support the use of BEM without dose adjustment in patients with hepatic impairment.*
No DDI Between Bemnifosbuvir/Ruzasvir and Bictegravir/Emtricitabine/Tenofovir Alafenamide (WED-279) *These results support the inclusion of HCV/HIV co-infected patients receiving these HIV therapies in the Phase 3 clinical development program for BEM/RZR.*
Pharmacokinetics of Bemnifosbuvir in Participants with Renal Impairment (WED-280) *These findings suggest that BEM may be used without dose adjustment in patients with renal dysfunction, including those undergoing dialysis.*

EASL posters are available on Atea's website https://ir.ateapharma.com/news-and-events/publications

Efficacy Primary Endpoint: Robust SVR12 Rates with 98% SVR12

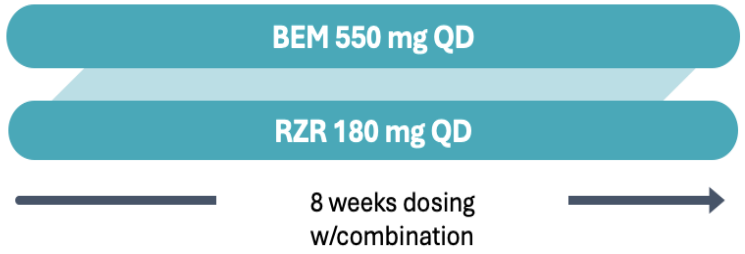
95% SVR12 Regardless of Adherence

Patient Population: HCV-infected patients including compensated cirrhosis, direct-acting antiviral naïve, all genotypes



~17% of Patients Non-Adherent as Measured by Pill Count & Pharmacokinetics

*Also called "efficacy evaluable" population – those who met eligibility criteria with a viral load assessment at week 12 post-treatment

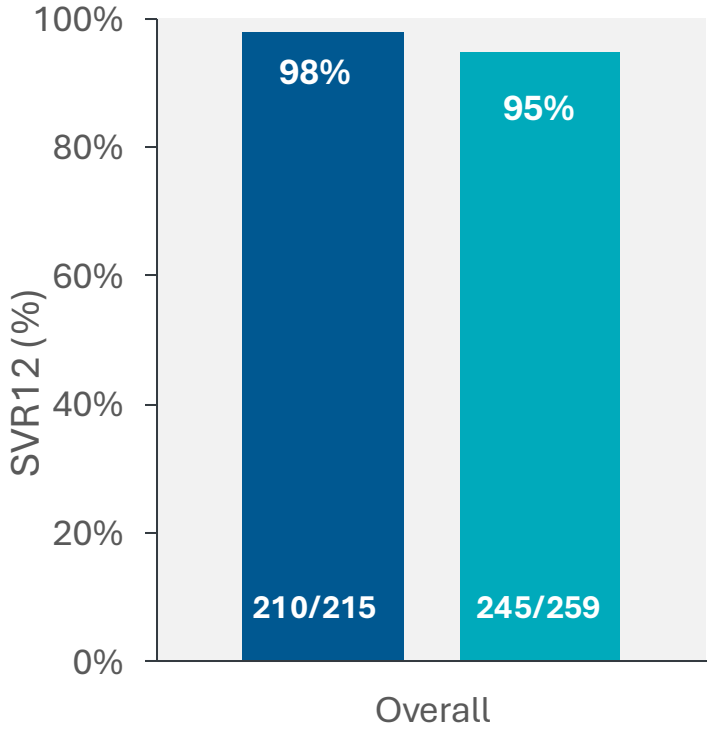


Primary Endpoints:

- *SVR at Week 12 post-treatment (SVR12) in per-protocol treatment adherent population*
- *Safety*

Secondary & Other Endpoints:

- SVR12 in per-protocol population regardless of treatment adherence (efficacy evaluable population)
- SVR at Week 24 post-treatment (SVR24)
- Virologic failure
- Resistance



Robust potency with drug forgiveness

Treatment adherent patients: **98% SVR12** (primary endpoint analysis)

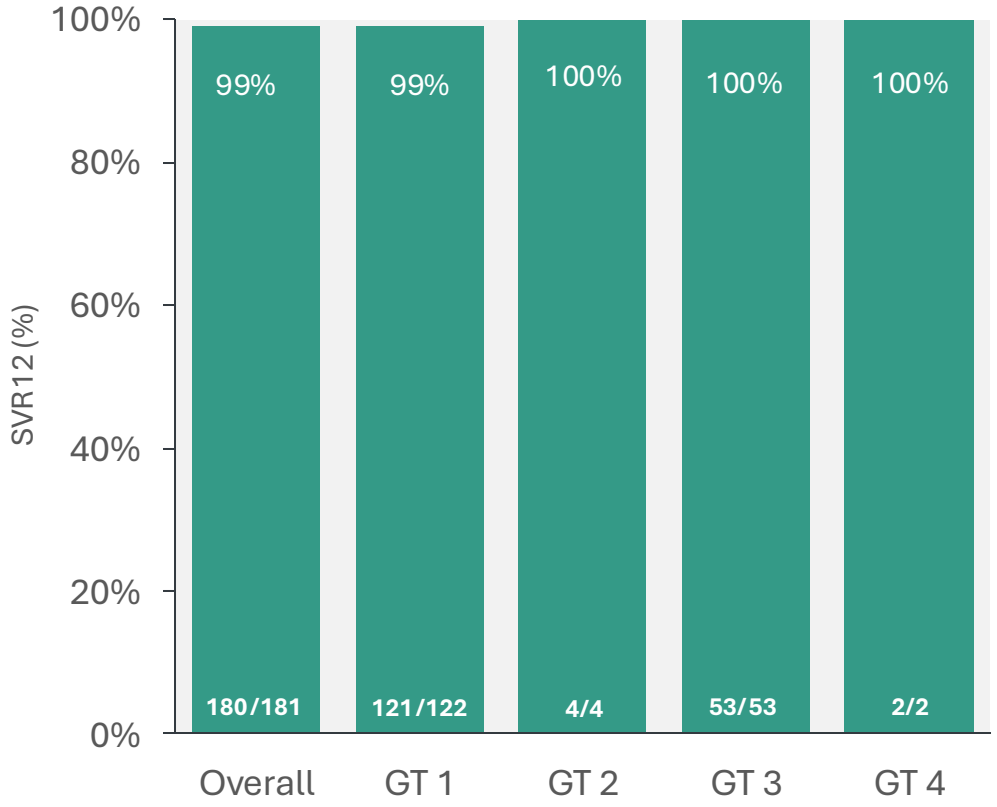
Patients regardless of treatment adherence: **95% SVR12**

EASL™ Poster presentation, EASL Congress May 7-10, 2025

Phase 2 Results: 99% SVR12 in Non-Cirrhotic Treatment Adherent Patients Across Genotypes

97% SVR12 Regardless of Adherence

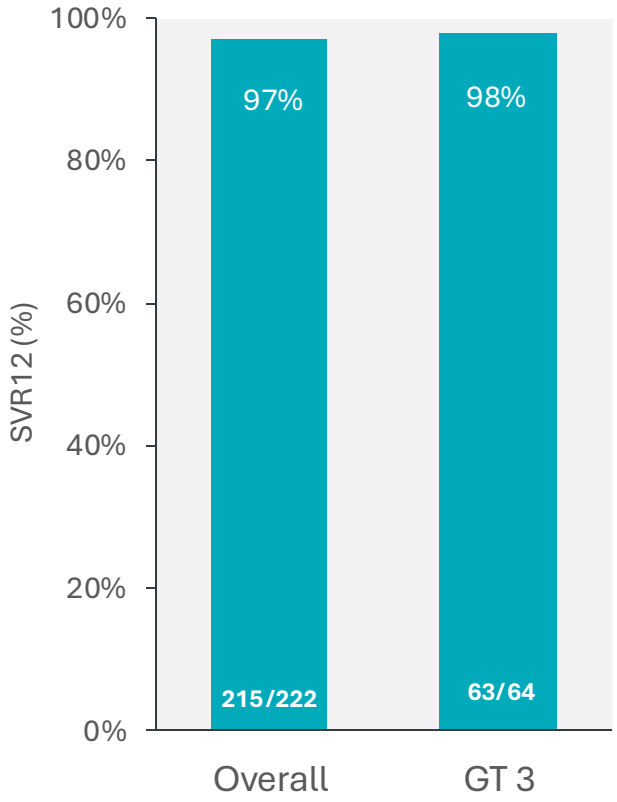
Robust SVR12 cure rates in non-cirrhotic patients across genotypes



Overall:
99% SVR12
Non-cirrhotic treatment adherent patients ***with a short 8-week treatment***

100% Efficacy
Non-cirrhotic treatment adherent genotype 3

Robust potency and drug forgiveness



97% SVR12
Non-cirrhotic patients regardless of treatment adherence

98% SVR12
Non-cirrhotic genotype 3 patients regardless of adherence

EASL™ Poster presentation, EASL Congress May 7-10, 2025

BEM/RZR

Potential Best-in-Class Pan-Genotypic Regimen

Global Phase 3 Program Update

Global HCV Phase 3 Program
C-BEYOND in US / Canada & 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)

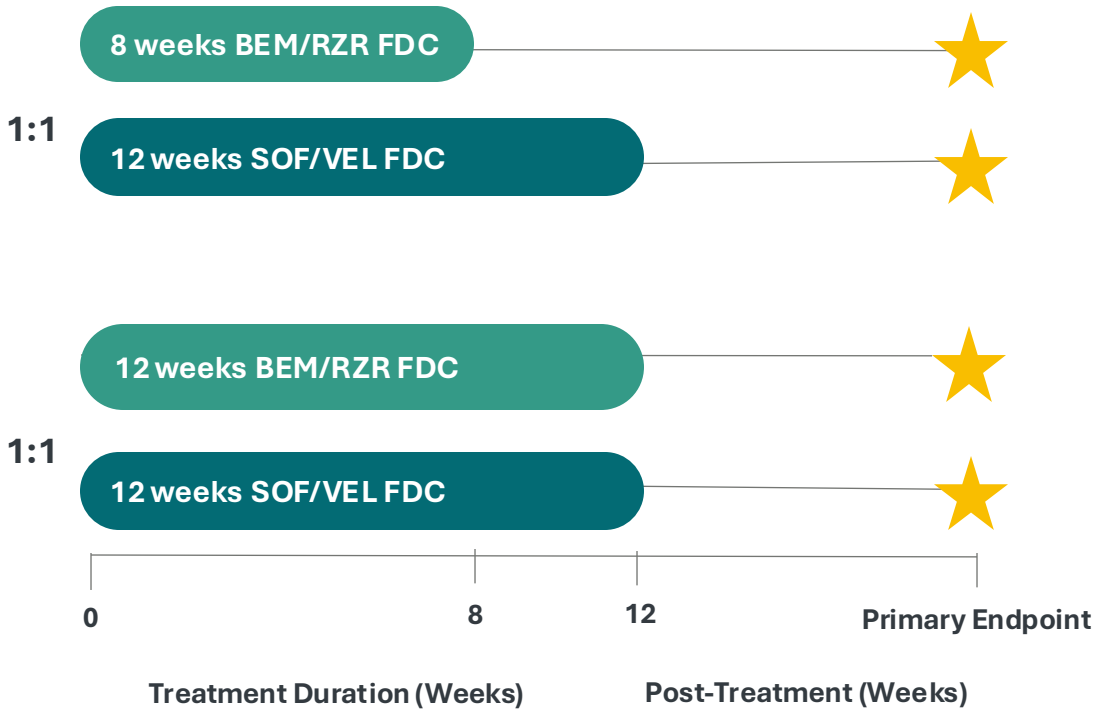
N=1,760 total patients

Non-Cirrhotic

US / Canada Trial ~N=~748
Outside North America Trial N= ~704

Cirrhotic

US / Canada ~N=132
Outside North America N=~176



Primary Endpoint = Encompasses SVR12 (Cure) 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
- Regulatory authorities require SVR measurement at the same time

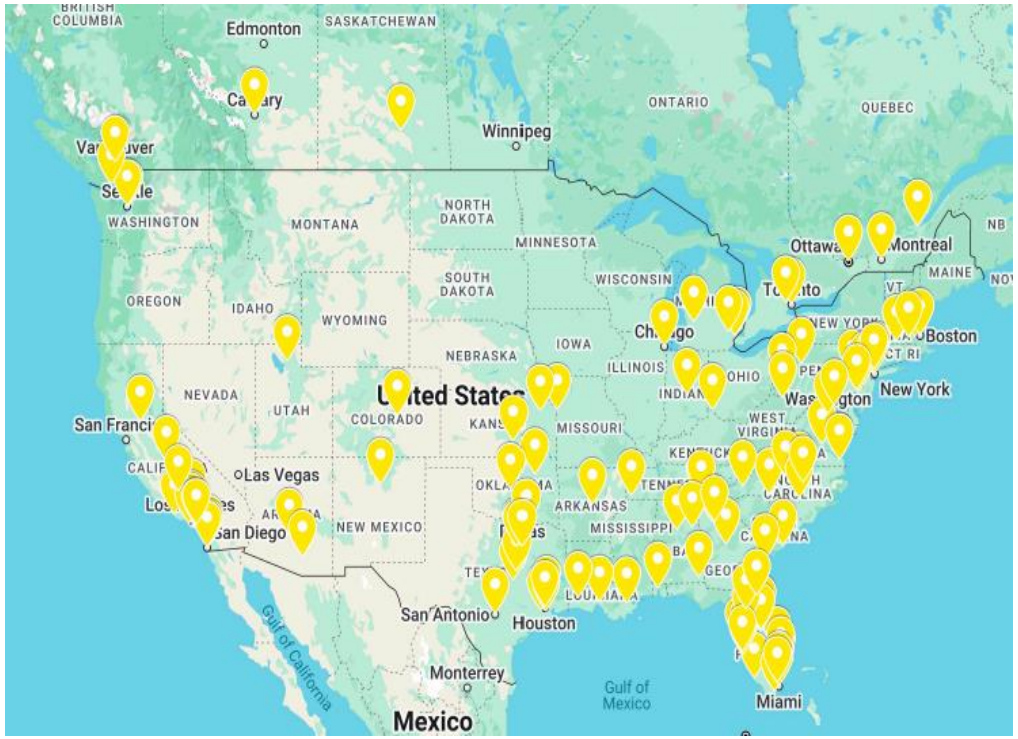
SVR = Sustained Virologic Response
FDC = Fixed Dose Combination (Dose 2 tb QD BEM/RZR)
SOF/VEL = sofosbuvir/velpatasvir

*HCV RNA < LLOQ 24 weeks from start of treatment

Global HCV Phase 3 Program

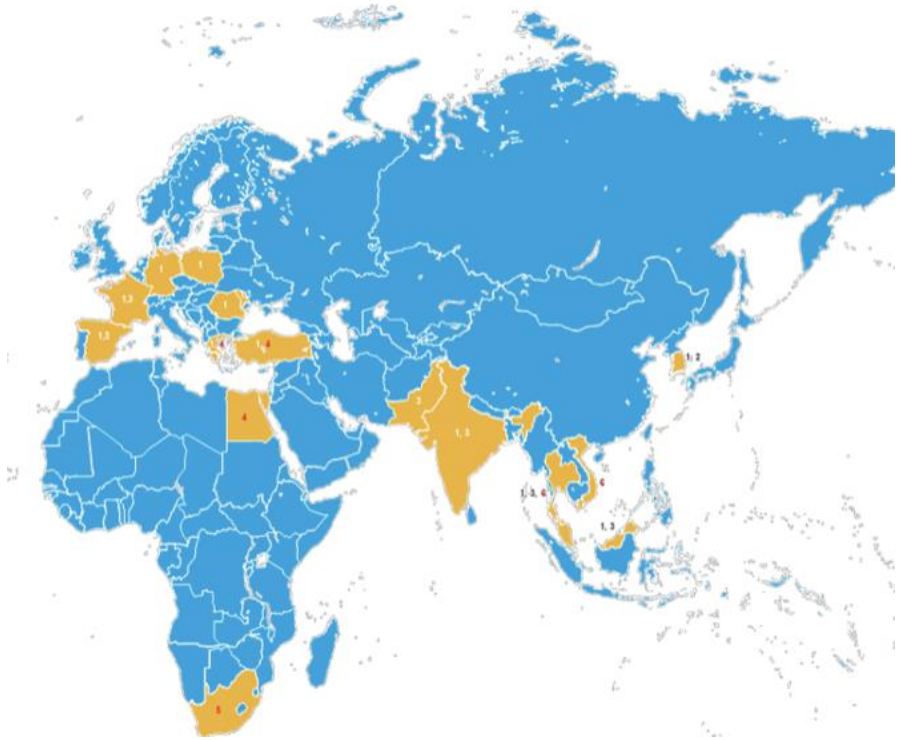
C-BEYOND

- Targeting ~120 sites in US and Canada



C-FORWARD

- Targeting ~120 sites in 16 countries outside of North America



Potential Best-in-Class Pan-Genotypic Regimen

HCV KOL Panel Event

Target Best-in-Class Profile

Q2 Highlights: HCV KOL Panel Event Held on May 14, 2025

Leaders in Hepatology, Gastroenterology, Infectious Diseases and HCV Research

Eric Lawitz, MD	Texas Liver Institute, University of Texas Health San Antonio, US
Anthony Martinez, MD	University of Buffalo, Erie County Medical Center, US
David Wyles, MD, FIDSA	University of Colorado, Denver Health Medical Center, US
Tarik Asselah, MD, PhD	Hôpital Beaujon, University of Paris-Cité, France
Joaquin Cabezas, MD	Marques de Valdecilla University Hospital, Santander, Spain
Jordan Feld, MD, MPH	University of Toronto, Toronto General Hospital, Canada

Replay of the KOL panel event is available https://lifescievents.com/event/atea/

Q2 Highlights: HCV KOL Panel Event Held on May 14, 2025

Key Takeaways from KOL Panel Discussion

- HCV prevalence has not slowed despite existing available DAA treatments. In 2015, there was ~2.5 million people infected in the US, now ≥4 million.
- HCV patients have evolved to a younger and more complicated population, and more treatments are needed.
- Baby boomers did not perpetuate the spread of HCV. Today, there is a huge shift to younger patients who inject drugs, which is a problem that is only getting worse.
- For patients and healthcare providers simplicity is very important for HCV treatment -- short duration with a simplified risk.
- An individualized treatment approach is needed, specifically, a third treatment optimized for the patient with concurrent medications.
- The profile doctors are looking for is a short treatment duration to encourage adherence with limited drug-drug interactions, no food effect and small pill burden.
- The HCV patient today needs a provider readiness model and neither approved regimen is perfect. A new treatment option with the profile of bemnifosbuvir and ruzasvir for the test-and-treat model of care to eradicate HCV is needed.

Replay of the KOL panel event is available https://lifescievents.com/event/atea/

BEM/RZR: Target Best-in-Class Profile for HCV

BEM/RZR: Next generation, pan-genotypic, fixed dose regimen

- **BEM:** most potent HCV nucleotide has been shown to be approximately 10-fold more active than sofosbuvir in *in vitro* studies; ~2,000 individuals exposed to date
- **RZR:** highly potent HCV NS5A inhibitor with pan-genotypic antiviral activity (picomolar range); ~2,000 individuals exposed to date
- **Target Indications:** Treatment of adult patients 18 years+ with chronic HCV infection, with and without compensated cirrhosis

Profile	Patient Population	BEM/RZR	MAVYRET®	EPCLUSA®
Treatment Duration	Non-Cirrhotic	8 Weeks	8 Weeks	12 Weeks
Treatment Duration	Compensated Cirrhosis (<10% of US cases)	12 Weeks	8 Weeks	12 Weeks
Short Duration		✓	✓	✗
Protease-Inhibitor Free		✓	✗	✓
Low Potential for Drug-Drug Interactions		✓	✗	✓
No Food Effect		✓	✗	✓

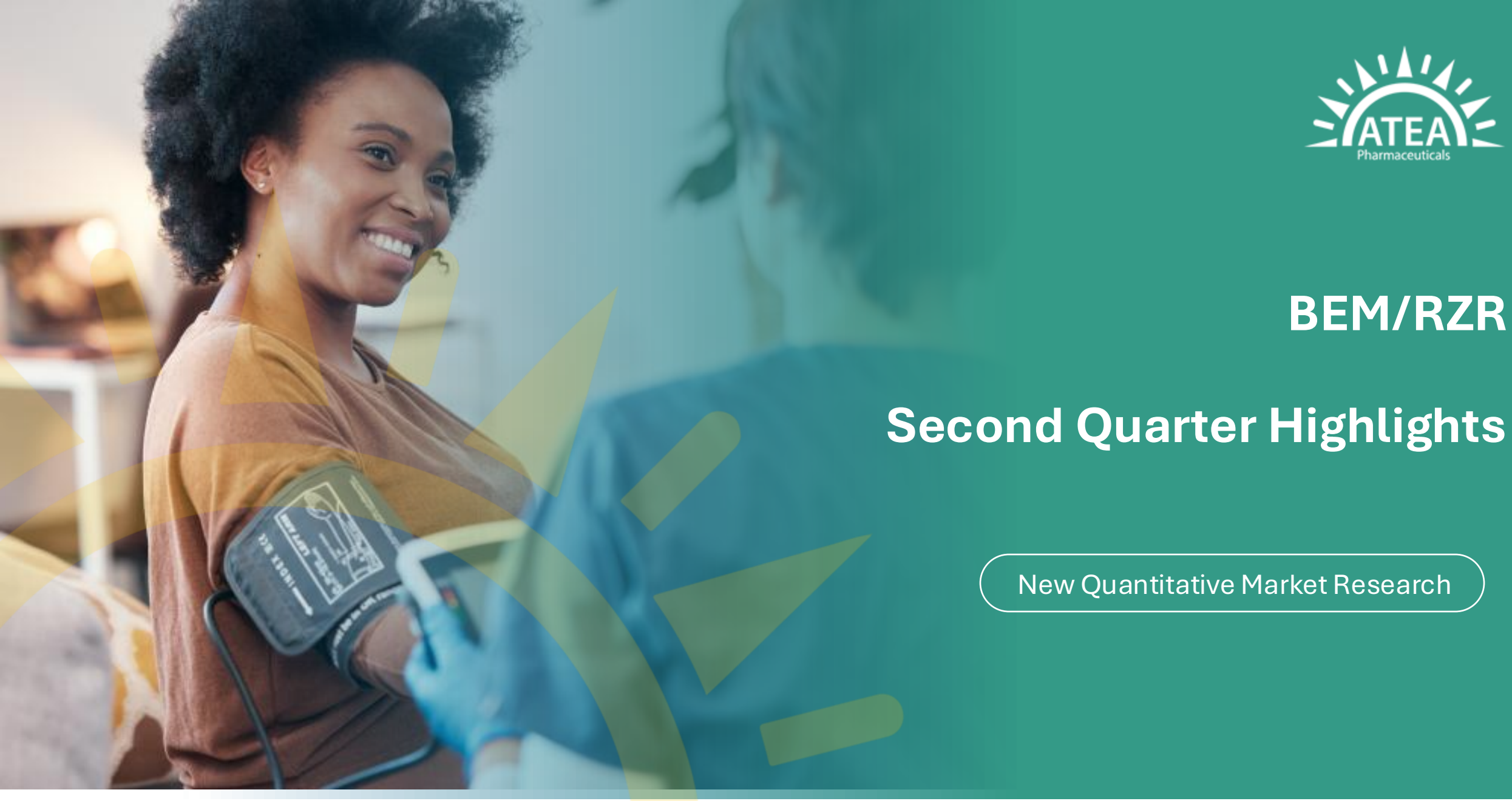
Drug-Drug Interaction Profile of BEM/RZR Regimen is a Key Differentiator -- ~80% of HCV Patients Take Concomitant Medications[1]

Healthcare Providers Prefer Therapies Convenient to Prescribe

Drug	BEM/RZR	MAVYRET®	EPCLUSA®
Oral Contraceptives[2]	✓	✗	✓
Protease Inhibitor-Containing HIV Drugs	✓	✗	✗ ✓
Statins	✓	✗ ✓	✓
Immunosuppressants[3]	✓	✗	✓
Antiarrhythmics[4]	✓	✓	✓
Proton Pump Inhibitors[5]	✓	✓	✓

- ✓ Confirmed in phase 1 trials
- ✓ No clinically meaningful DDI expected; clinical data pending
- ✗ Contraindicated
- ✓ Permitted but require dose modification/TDM
- ✗ ✓ Certain drugs (doses) in the class are contraindicated while others are permitted
- ✗ ✓ Certain drugs (doses) in the class are contraindicated while others are permitted but require dose modification/TDM

[1]Atea Custom Market Research, IQVIA 2024, Atea clinical/in vitro DDI data [2] Ethinyl estradiol > 20 µg - containing product [3] Cyclosporin > 100 mg/d[4] Digoxin [5] Omeprazole



BEM/RZR

Second Quarter Highlights

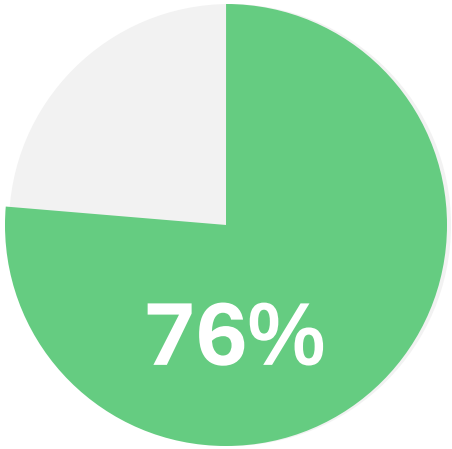
New Quantitative Market Research

Recent US Quantitative Market Research

DAA Prescribers Reveal High Preference for BEM/RZR

IQVIA independent quantitative market research, with 153 top US DAA prescribers (86 GI/Hepatologists, 34 IDs and 33 IMs).

The prescribers reviewed on their own BEM/RZR profile including the Phase 2 results and expressed their preferences to prescribe BEM/RZR on 7-point scale (1=unlikely to prescribe, 7=extremely likely to prescribe).



Of High DAA Prescribers*

EXTREMELY LIKELY TO PRESCRIBE BEM/RZR
(6/7 ON PREFERENCE SCALE)

% OF PATIENTS LIKELY TO BE PRESCRIBED BEM/RZR

48%
Non-Cirrhotic Patients

49%
Compensated Cirrhotic Patients

*Treated at least 15 adult HCV patients with DAAs in the past year

Strong Preference for BEM/RZR Consistent Across Studies

US Prescriber Market Research Studies Over Time Consistently Predict Significant BEM/RZR Product Market Share

Despite high satisfaction with current therapies, multiple independent quantitative market research studies with high DAA prescribers* indicate a high likelihood to prescribe BEM/RZR

	December 2023 N = 157	November 2024 N = 77	June 2025 N = 153
Predicted share** of patients for BEM/RZR	39%	34%	48%
Share based on	Prior to Phase 2 Results		Post Phase 2 Results

*Treated at least 15 adult HCV patients with DAAs in the past year
**BEM/RZR share compared with Epclusa and Mavyret

Financial and Business Update

2nd Quarter 2025 Results

Financial Update

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,	
	2025	2024	2025	2024
Operating expenses				
Research and development	$ 32,275	$ 34,696	$ 61,859	$ 92,271
General and administrative	9,070	12,220	18,527	24,451
Total operating expenses	41,345	46,916	80,386	116,722
Loss from operations	(41,345)	(46,916)	(80,386)	(116,722)
Interest income and other, net	4,391	6,637	9,363	13,505
Loss before income taxes	(36,954)	(40,279)	(71,023)	(103,217)
Income tax expense	(207)	(243)	(410)	(474)
Net loss	$ (37,161)	$ (40,522)	$ (71,433)	$ (103,691)
Other comprehensive loss				
Unrealized gain (loss) on available-for-sale investments	(81)	(99)	(196)	(487)
Comprehensive loss	$ (37,242)	$ (40,621)	$ (71,629)	$ (104,178)
Net loss per share - basic and diluted	$ (0.44)	$ (0.48)	$ (0.85)	$ (1.23)
Weighted-average number of common shares - basic and diluted	83,747,335	84,253,700	84,449,318	84,069,646

Financial Update

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

	June 30, 2025	December 31, 2024
Cash, cash equivalents and marketable securities	$ 379,713	$ 454,721
Working capital[(1)]	365,485	443,752
Total assets	391,605	464,668
Total liabilities	27,189	25,801
Total stockholder's equity	364,416	438,867

(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, 2025 for further detail regarding its current assets and liabilities.

Business Update Q2 2025

Financial

- Repurchase of up to $25 million of the Company's common stock was authorized and initiated in April 2025. Initiative reflects Company's commitment to return capital to shareholders, while maintaining capacity to complete global Phase 3 HCV program. As of June 30, 2025, 4.6 million shares had been repurchased.

Refreshment of Board of Directors

- Refreshed Board of Directors with the addition of Howard H. Berman, PhD
- Dr. Berman has over 20 years of entrepreneurial and life science industry experience working at the interplay of science and business

ATEA Pharmaceuticals

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