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RAPIDe-3 Topline Data Disclosure

December 3, 2025

Disclaimer

This Presentation contains certain “forward-looking statements” within the meaning of the federal securities laws that involve substantial risks and uncertainties. All statements contained in this Presentation that do not relate to matters of historical fact should be considered forward-looking statements, including, without limitation, statements relating to our future plans, studies and trials, and any statements containing the words “believe,” “anticipate,” “expect,” “estimate,” “may,” “could,” “should,” “would,” “will,” “intend” and similar expressions. We have based these forward-looking statements largely on our current expectations and projections about future events and trends that we believe may affect our financial condition, results of operations, business strategy and financial needs. Such forward-looking statements are neither promises nor guarantees, and involve known and unknown risks, uncertainties and other important factors which may cause our actual results, financial condition, performance or achievements, or industry results, to be materially different from any future results, performance or achievements expressed or implied by such forward-looking statements. Factors that might cause such a difference include, but are not limited to, uncertainty in the outcome of our interactions with regulatory authorities, including the FDA; the expected timing, progress, or success of our clinical development programs, especially for deucrictibant immediate-release capsules and deucrictibant extended-release tablets, which are in late-stage global clinical trials; our ability to replicate the efficacy and safety demonstrated in the RAPIDe-1, RAPIDe-2, RAPIDe-3, and CHAPTER-1 Phase 2 and Phase 3 studies in ongoing and future nonclinical studies and clinical trials, such as CHAPTER-3 and CREAATE; the timing and outcome of regulatory approvals, including the timing and outcome of our planned submission of an NDA with the FDA in the first half of 2026 for the on-demand treatment of acute attacks of HAE; risks arising from epidemic diseases, which may adversely impact our business, nonclinical studies, and clinical trials; our ability to potentially use deucrictibant for alternative purposes, for example to treat C1-INH deficiency (AAE-C1INH); the value of our ordinary shares; the timing, costs and other limitations involved in obtaining regulatory approval for our product candidates, or any other product candidate that we may develop in the future; our ability to establish commercial capabilities or enter into agreements with third parties to market, sell, and distribute our product candidates; our ability to compete in the pharmaceutical industry, including with respect to existing therapies, emerging potentially competitive therapies and with competitive generic products; our ability to market, commercialize and achieve market acceptance for our product candidates; our ability to produce sufficient amounts of drug product candidates for commercialization; our ability to raise capital when needed and on acceptable terms; regulatory developments in the United States, the European Union and other jurisdictions; our ability to protect our intellectual property and know-how and operate our business without infringing the intellectual property rights or regulatory exclusivity of others; our ability to manage negative consequences from changes in applicable laws and regulations, including tax laws (including the Biosecure Act); our ability to maintain an effective system of internal control over financial reporting; changes and uncertainty in general market conditions; disruptions at the FDA and other agencies; changes and uncertainty in general market, political and economic conditions, including as a result of inflation and geopolitical conflicts; changes in regulations and customs, tariffs and trade barriers; and the other factors described under the headings "Cautionary Statement Regarding Forward-Looking Statements" and "Item 3. Key Information--D. Risk Factors" in our Annual Report on Form 20-F and other periodic filings with the Securities and Exchange Commission. New risks and uncertainties may emerge from time to time, and it is not possible to predict all risks and uncertainties. We undertake no obligation to publicly update any forward-looking statements, whether as a result of new information, future events or otherwise, except as required by law.

This presentation includes data for an investigational product not yet approved by regulatory authorities. Certain information contained in this Presentation relates to or is based on studies, publications, surveys and other data obtained from third-party sources and the Company’s own internal estimates and research. While the Company believes these third-party sources to be reliable as of the date of this presentation, it has not independently verified, and makes no representation as to the adequacy, fairness, accuracy or completeness of, any information obtained from third-party sources. In addition, all of the market data included in this Presentation involves a number of assumptions and limitations, and there can be no guarantee as to the accuracy or reliability of such assumptions. Finally, while we believe our own internal research is reliable, such research has not been verified by any independent source.

RAPIDe-3 topline presenters

Berndt Modig, *CEO Pharvaris*

Marc A. Riedl, M.D., M.S., *Professor of Medicine, Clinical Director of the U.S. Hereditary Angioedema Association (HAEA) Angioedema Center at the University of California San Diego (UCSD); principal investigator in the RAPIDe-3 study*

Peng Lu, M.D. Ph.D., *CMO Pharvaris*

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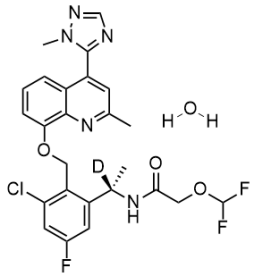
Pharvaris' legacy is rooted in bradykinin B2 receptor antagonism

Leveraging over two decades of scientific expertise

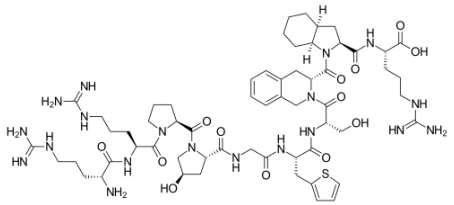
Jochen Knolle



Deucrictibant

Deucrictibant IR capsule

RAPIDe-3



Icatibant

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Deucrictibant XR tablet

CHAPTER-3

Notes: IR: immediate-release capsule formulation of deucrictibant. XR: extended-release tablet formulation of deucrictibant.

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People living with HAE seek unburdened control of their attacks

Simplicity

Oral and convenient

Speed

Rapid onset and complete symptom resolution

Durability

Complete resolution with a single capsule

Notes: HAE: hereditary angioedema.

RAPIDe-3 study design

RAPIDe-3

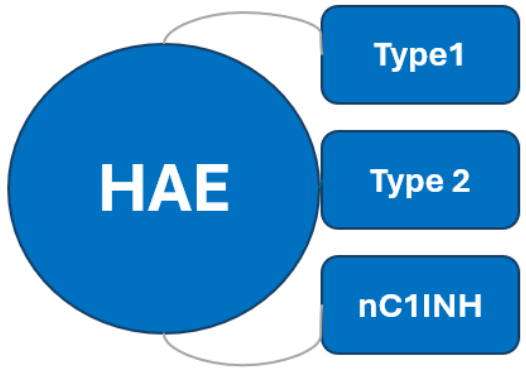
Double-blind crossover treatment with 2 qualifying attack treatment periods

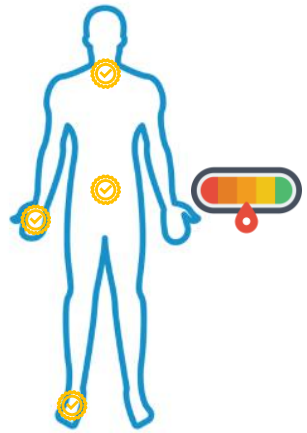
Screening → R → Day 1 Visit*

- **Deucrictibant IR 20 mg** → **Placebo**
- **Placebo** → **Deucrictibant IR 20 mg**

Post-Attack-Visit after first attack treated with study drug

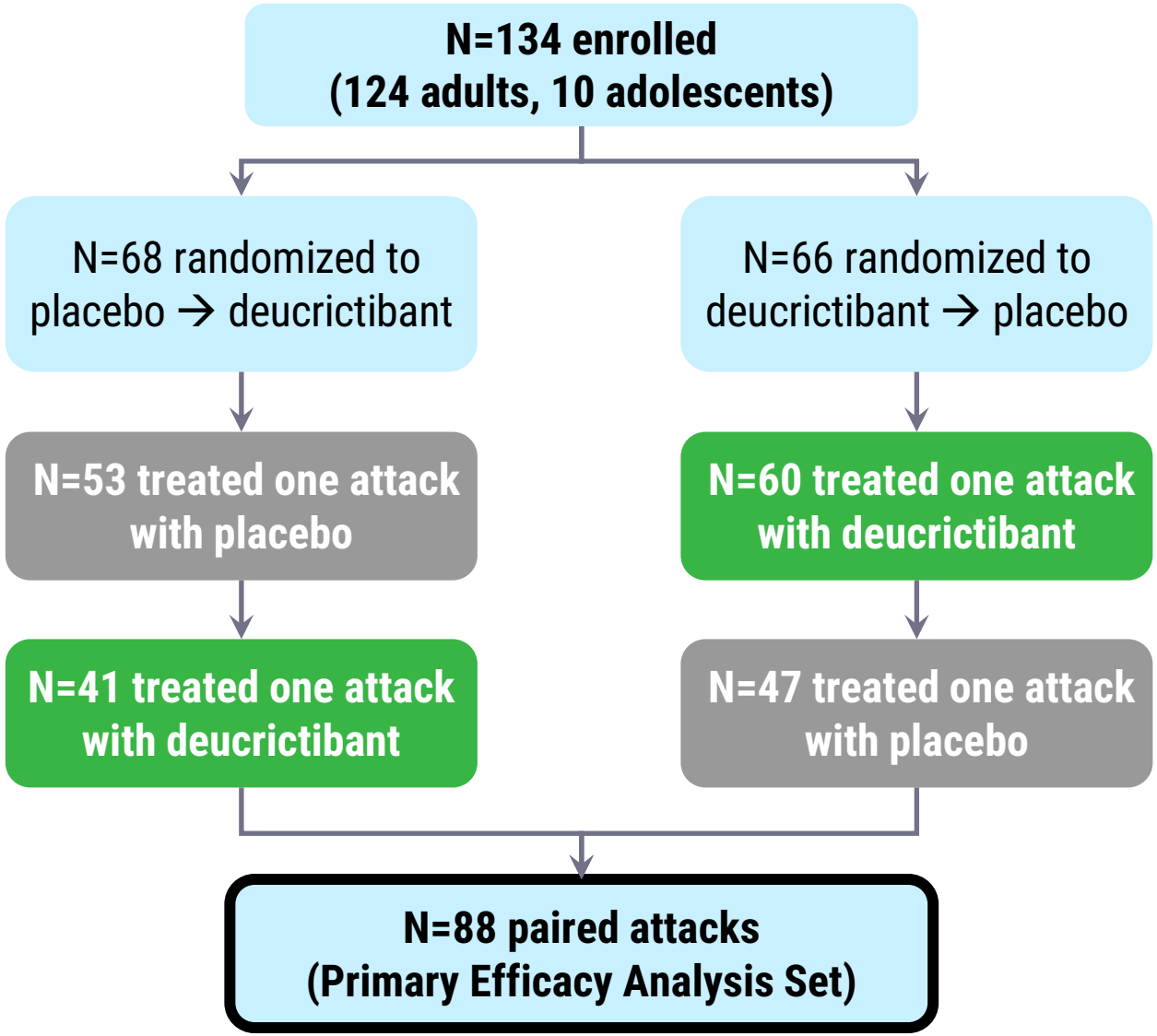
End-of-Study Visit after second HAE attack treated with study drug → **Rollover to open-label extension**





Notes: R: randomization. IR: immediate-release capsule formulation of deucrictibant. HAE: hereditary angioedema. nC1INH: normal C1 inhibitor. LTP: long-term prophylaxis. *Adolescent participants receive a non-attack dose for PK sampling prior to randomization. Source: Maurer M et al. EAACI 2024.

Efficacy analyses based on 88 paired attacks



Notes: N: number of participants.

Participants representative of general HAE population

Baseline Demographics	All Randomized N=134
Age – median (IQR)	38.0 (27.0-50.0)
≥12–<18 years	10 (7.5%)
≥18–<65 years	116 (86.6%)
≥65 years	8 (6.0%)
Sex – n(%): Female	76 (56.7%)
BMI – median (IQR)	25.67 (22.50-29.37)
Race[1] – n(%)	
White	93 (69.4%)
Asian	19 (14.2%)
Black or African American	10 (7.5%)
Region – n(%)	
Europe	56 (41.8%)
North America	38 (28.4%)
Africa, Asia/Pacific, South America	40 (29.9%)

Baseline Disease Characteristics	All Randomized N=134
Time Since Diagnosis (years) – median (IQR)	15.0 (7.0-25.0)
HAE Type – n(%)	
HAE Type 1 or HAE Type 2	130 (97.0%)
HAE nC1INH	4 (3.0%)
Current LTP Use – n(%)	31 (23.1%)
Lanadelumab	13 (41.9%)
Berotralstat	8 (25.8%)
C1INH	6 (19.4%)
Other*	4 (12.9%)
# of attacks within 3 months before screening– median (IQR)	3.0 (2.0-5.0)

Notes: IQR: interquartile range. BMI: body mass index, N, n: number of participants, % = n/N; [1]additional 8.9% include American Indian or Alaska native, other, not reported. HAE: hereditary angioedema. nC1INH: normal C1 inhibitor. LTP: long-term prophylaxis. C1INH: C1 inhibitor. *Other includes danazol and tranexamic acid.

Patient-reported outcome assessments

Patient **G**lobal **I**mpression of **C**hange[1,2]

PGI-C

Much worse | Worse | A little worse | Same | A little better | Better | Much better

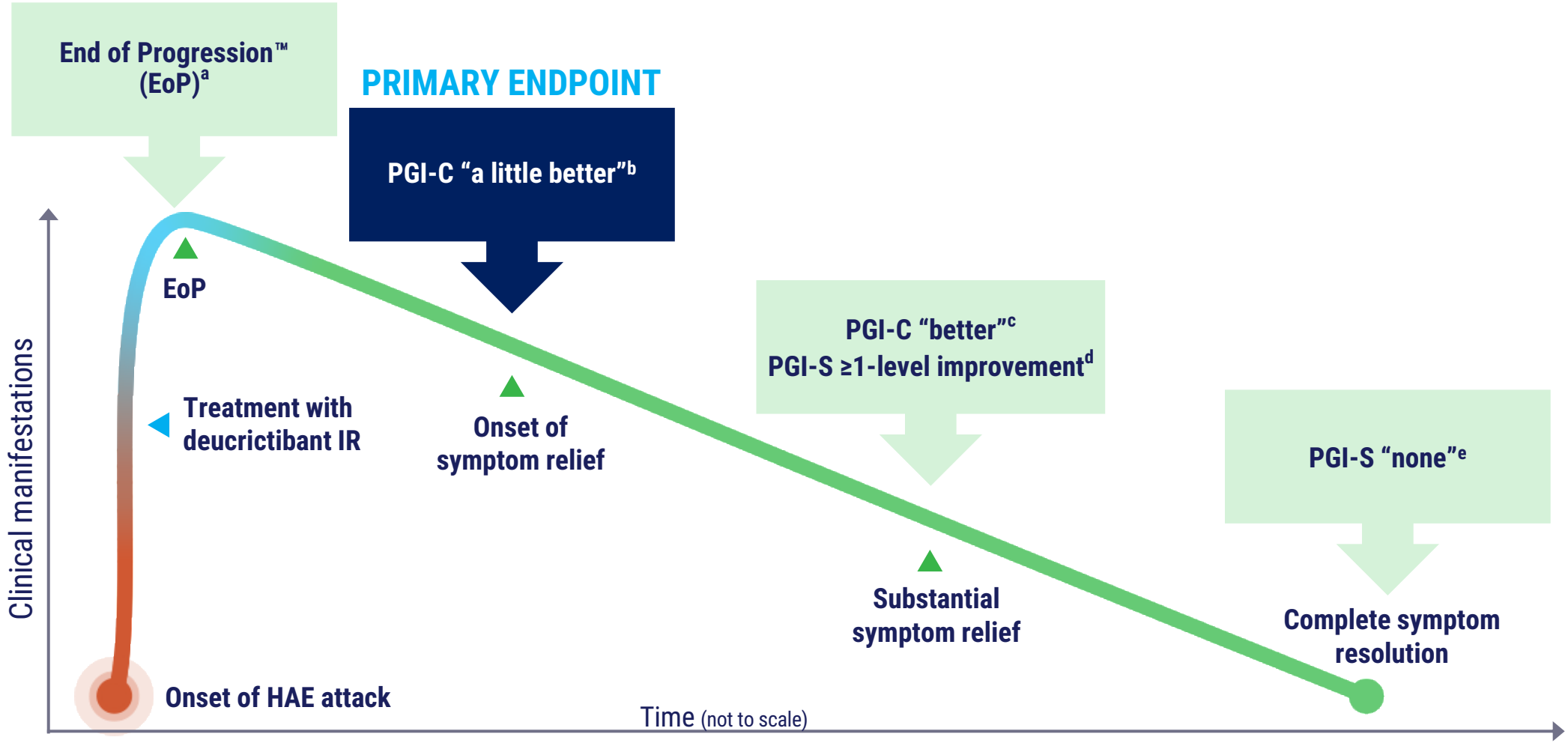
Patient **G**lobal **I**mpression of **S**everity[1,2]

PGI-S

Very severe | Severe | Moderate | Mild | None

Notes: PGI-C, Patient Global Impression of Change; PGI-S, Patient Global Impression of Severity. Source: [1] Cohn DM, et al. Clin Transl Allergy. 2023;13(9):e12288; [2] Mendivil J, et al. Presented at: GA2LEN UCARE Conference 2023; Dec 8, 2023; São Paulo, Brazil

RAPIDe-3 endpoints span the entire HAE attack time course



Source: Maurer M, et al. Presented at: European Academy of Allergy & Clinical Immunology (EAACI) Congress 2024; May 31-June 3, 2024; Valencia, Spain.

a End of Progression (EoP): defined as the earliest post-treatment timepoint after which all subsequent PGI-C ratings are stable or improved b. PGI-C "a little better": Primary endpoint as time to onset of symptom relief, defined as PGI-C rating of at least "a little better" for 2 consecutive timepoints within 12 hours post-treatment. c. PGI-C "better": Time to substantial symptom relief, defined as achieving PGI-C rating of at least "better" for 2 consecutive timepoints within 12 hours post-treatment. d. PGI-S ≥1-level improvement: Time to substantial symptom relief by Patient Global Impression of Severity (PGI-S), defined as achieving ≥1-level improvement in PGI-S from pre-treatment for 2 consecutive timepoints within 12 hours post-treatment. e. PGI-S "none": Time to complete symptom resolution, defined as achieving PGI-S rating of "none" within 48 hours post-treatment. Notes: The term End of Progression is a registered trademark of Pharvaris GmbH.

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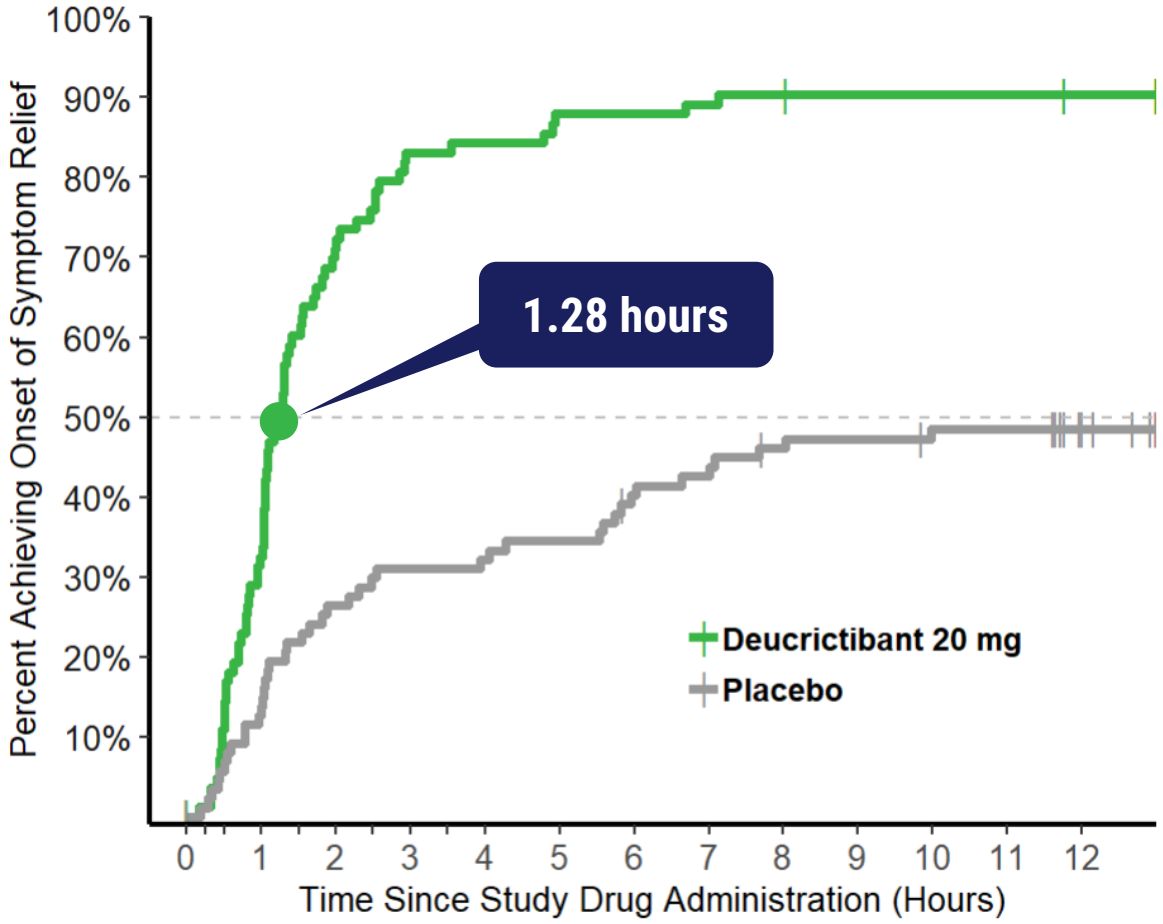
Primary endpoint: significantly faster onset of symptom relief in 1.28 hours

Time to onset of symptom relief by PGI-C vs. placebo within 12 hours
Primary Efficacy Analysis Set



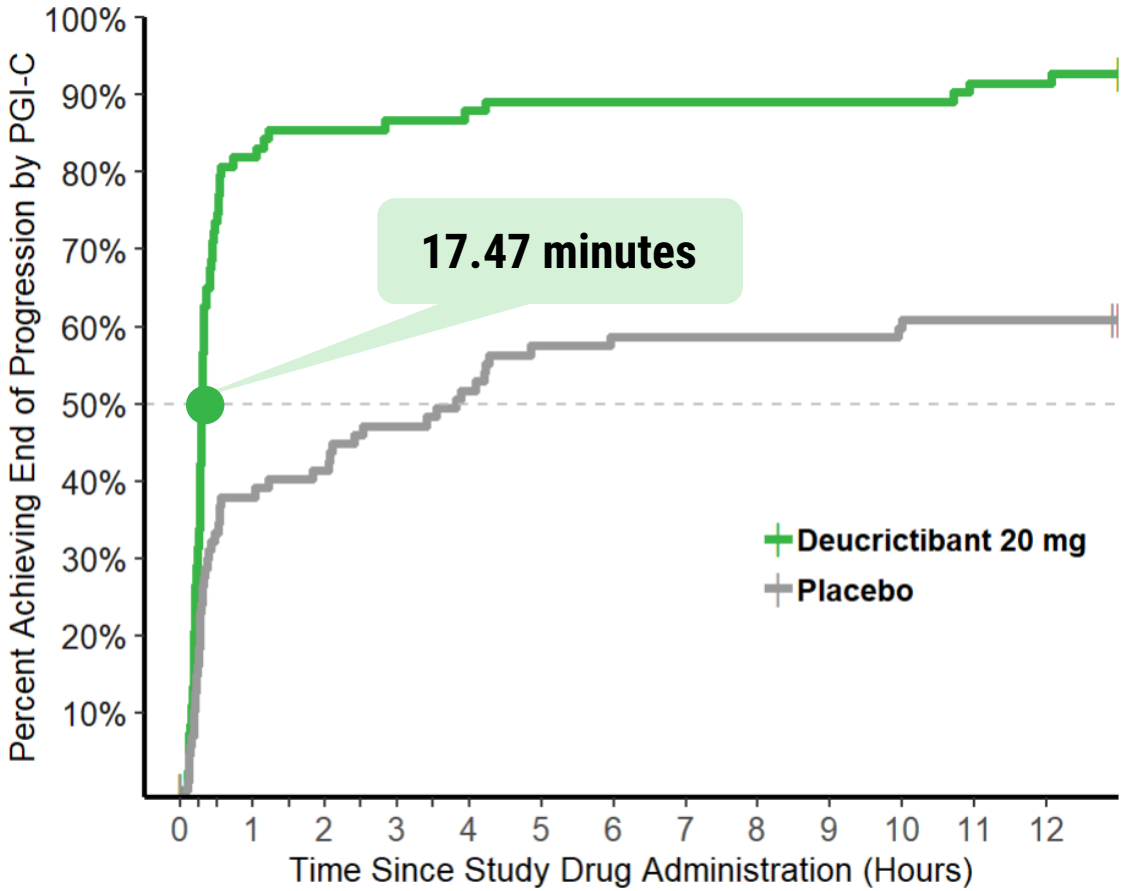
	Placebo N=88	Deucrictibant N=88
Median time (hours)	**NE**	**1.28**
(95% CI)	(5.82, NE)	(1.05, 1.52)
p-value		**<0.0001**

NE: not estimable, median was not reached within the defined 12 hours timeframe

Time to onset of symptom relief is defined as PGI-C rating of at least 'a little better' for 2 consecutive timepoints within 12 hours post-treatment.
Primary Efficacy Analysis Set includes all randomized participants who treated two attacks according to the crossover design and served as the basis for the primary statistical significance test. (N = 88)
Primary statistical test: treatment comparison based on Gehan's generalized Wilcoxon test adapted for 2×2 crossover trials with time-to-outcomes (Feingold & Gillespie, Stat Med 1996). Two-sided p-value evaluated under the prespecified closed-testing procedure with gatekeeping event control of multiplicity.
Median time and 95% CI estimated by Kaplan-Meier method; CI: confidence interval; PGI-C: Patient Global Impression of Change.

Faster *End of Progression*™ (EoP) in 17.47 minutes

Time to EoP in attack symptoms vs. placebo within 12 hours
Primary Efficacy Analysis Set

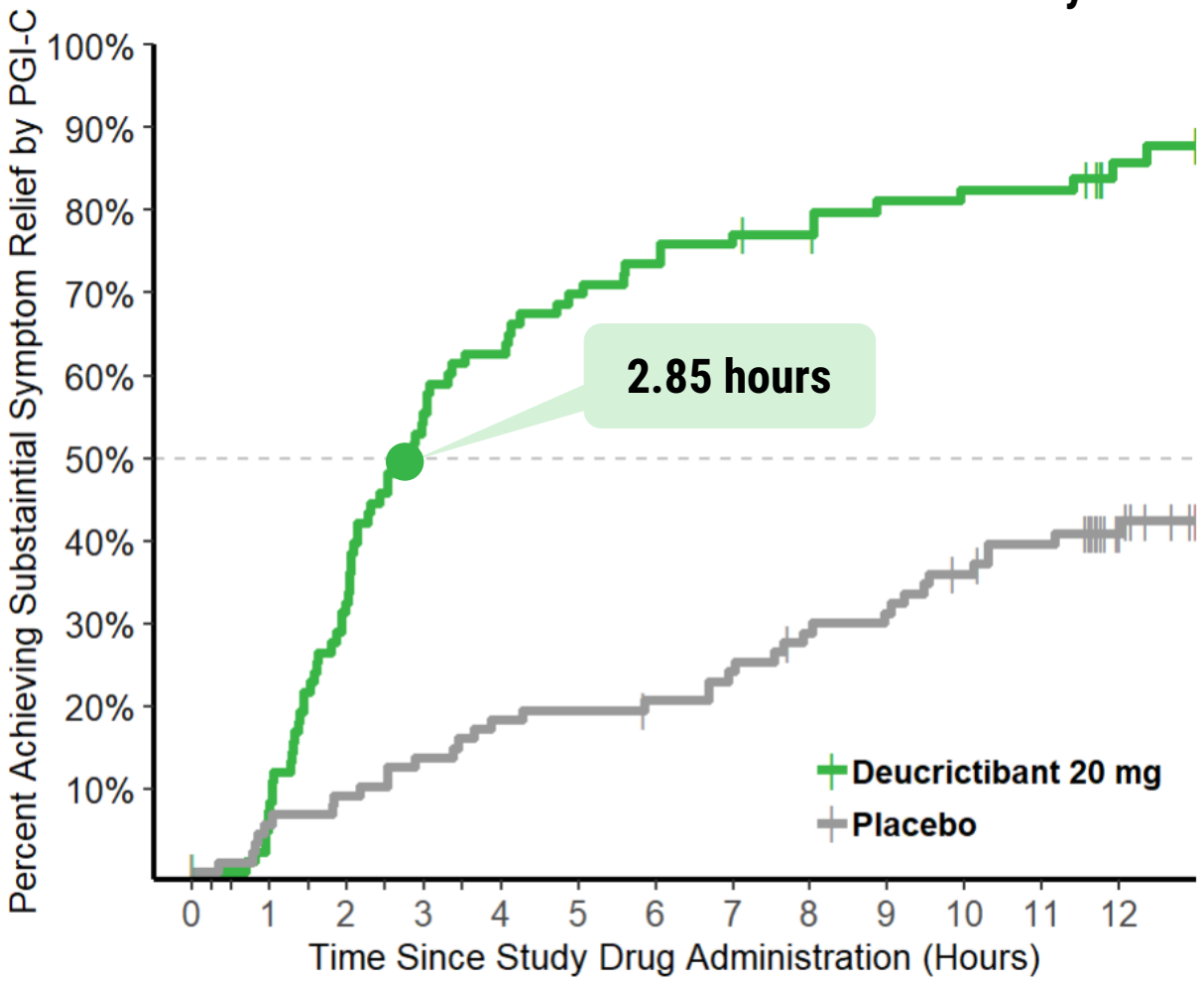


	Placebo N=88	Deucrictibant N=88
Median time (minutes)	**228.67**	**17.47**
(95% CI)	(61.82, 599.60)	(16.27, 19.17)
p-value		**<0.0001**

Time to EoP in attack symptoms within 12 hours, with EoP time defined as the earliest post-treatment timepoint after which all subsequent PGI-C ratings are stable or improved.
Primary Efficacy Analysis Set includes all randomized participants who treated two attacks according to the crossover design and served as the basis for the primary statistical significance test. (N = 88)
Primary statistical test: treatment comparison based on Gehan's generalized Wilcoxon test adapted for 2×2 crossover trials with time-to-event outcomes (Feingold & Gillespie, *Stat Med* 1996). Two-sided p-value evaluated under the prespecified closed-testing procedure with gatekeeping control of multiplicity. Median time and 95% CI estimated by Kaplan-Meier method; CI: confidence interval; PGI-C: Patient Global Impression of Change.
Note: The term End of Progression is a registered trademark of Pharvaris GmbH.

Shorter time to substantial symptom relief by PGI-C in 2.85 hours

Time to substantial symptom relief by PGI-C vs. placebo within 12 hours
Primary Efficacy Analysis Set



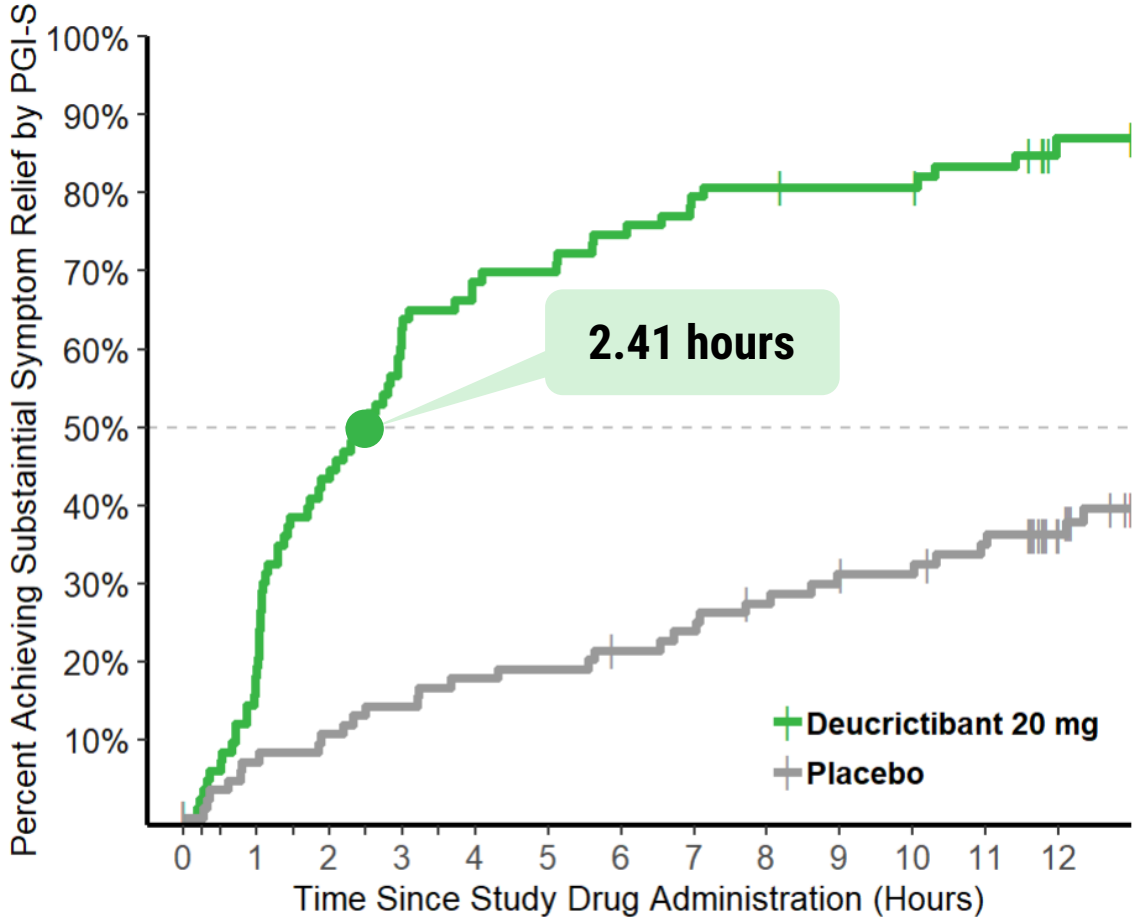
	Placebo N=88	Deucrictibant N=88
Median time (hours)	**NE**	**2.85**
(95% CI)	(10.30, NE)	(2.08, 3.35)
p-value		**<0.0001**

NE: not estimable, median was not reached within the defined 12 hours timeframe

Time to substantial symptom relief, defined as achieving PGI-C rating of at least "better" for 2 consecutive timepoints within 12 hours post-treatment.
Primary Efficacy Analysis Set includes all randomized participants who treated two attacks according to the crossover design and served as the basis for the primary statistical significance test. (N = 88)
Primary statistical test: treatment comparison based on Gehan's generalized Wilcoxon test adapted for 2×2 crossover trials with time-to-event outcomes (Feingold & Gillespie, *Stat Med* 1996). Two-sided p-value evaluated under the prespecified closed-testing procedure with gatekeeping control of multiplicity Median time and 95% CI estimated by Kaplan-Meier method; CI: confidence interval; PGI-C: Patient Global Impression of Change.

Shorter time to substantial symptom relief by PGI-S in 2.41 hours

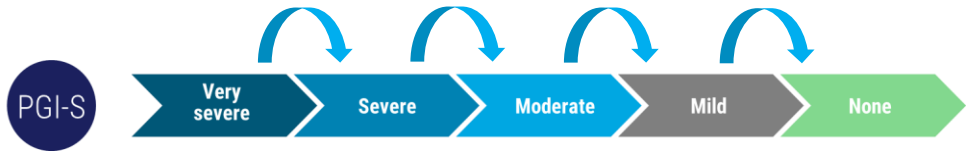
Time to substantial symptom relief by PGI-S vs. placebo within 12 hours
Primary Efficacy Analysis Set



	Placebo N=88	Deucrictibant N=88
Median time (hours)	**NE**	**2.41**
(95% CI)	(12.34, NE)	(1.70, 2.98)
p-value		**<0.0001**

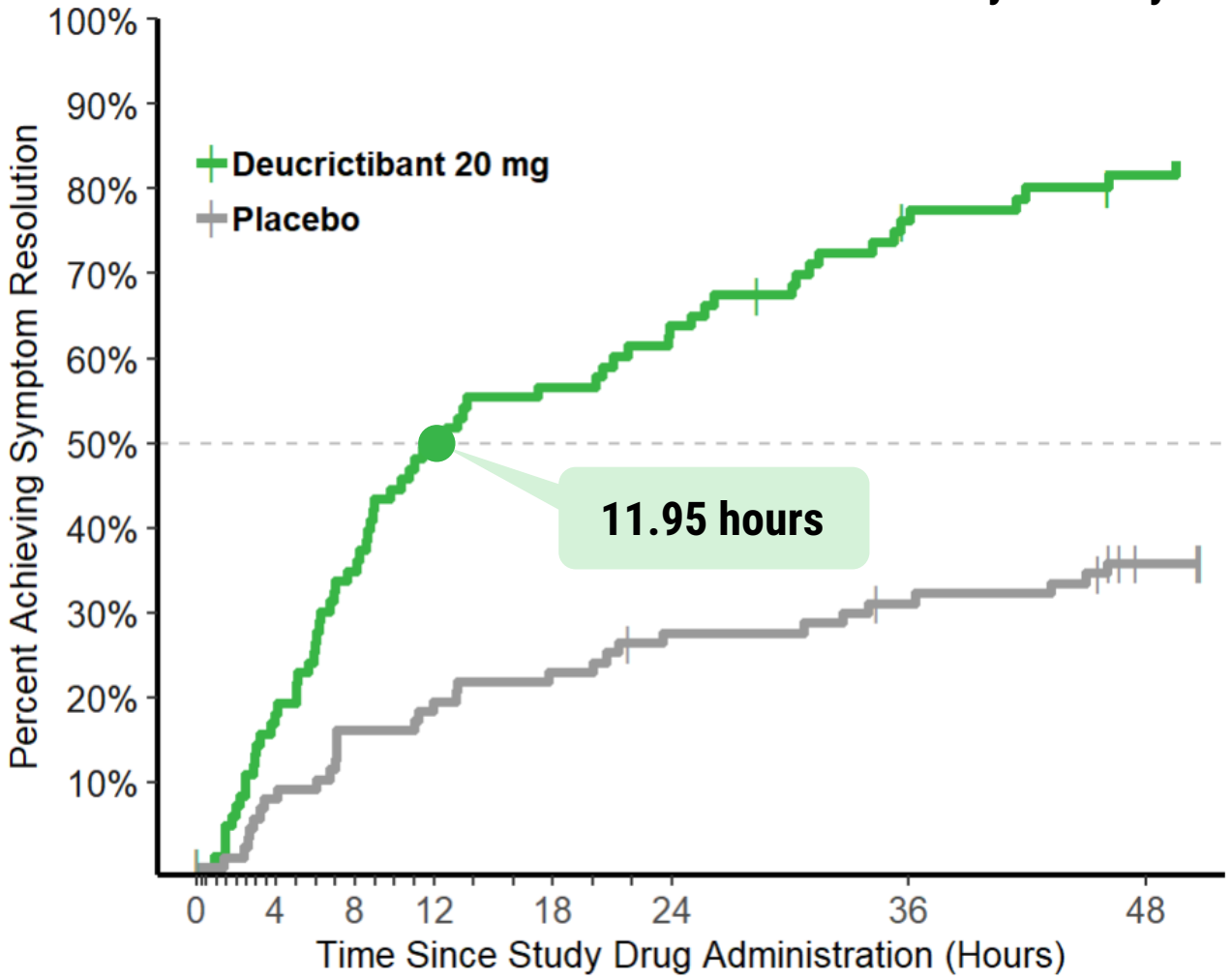
NE = not estimable, median was not reached within the defined 12 hours timeframe

Time to substantial symptom relief, defined as achieving ≥1-level improvement in PGI-S from pre-treatment for 2 consecutive timepoints within 12 hours post-treatment.
Primary Efficacy Analysis Set includes all randomized participants who treated two attacks according to the crossover design and served as the basis for the primary statistical significance test. (N = 88)
Primary statistical test: treatment comparison based on Gehan's generalized Wilcoxon test adapted for 2×2 crossover trials with time-to-event outcomes (Feingold & Gillespie, *Stat Med* 1996). Two-sided p-value evaluated under the prespecified closed-testing procedure with gatekeeping control of multiplicity.
Median time and 95% CI estimated by Kaplan-Meier method; CI: confidence interval; PGI-S: Patient Global Impression of Severity.



Earlier complete symptom resolution in 11.95 hours

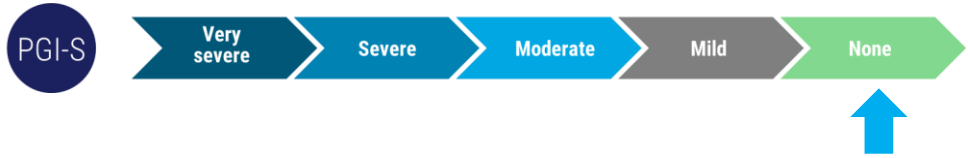
Time to complete symptom resolution vs. placebo within 48 hours
Primary Efficacy Analysis Set



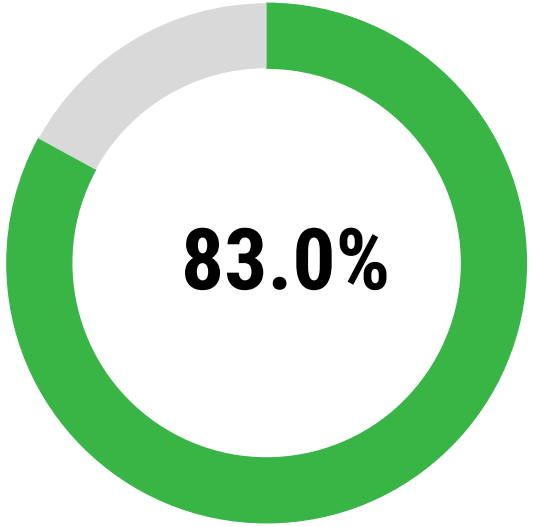
	Placebo N=88	Deucrictibant N=88
Median time (hours)	**NE**	**11.95**
(95% CI)	(NE, NE)	(8.61, 21.79)
p-value		**<0.0001**

NE: not estimable, median was not reached within the defined 48 hours timeframe

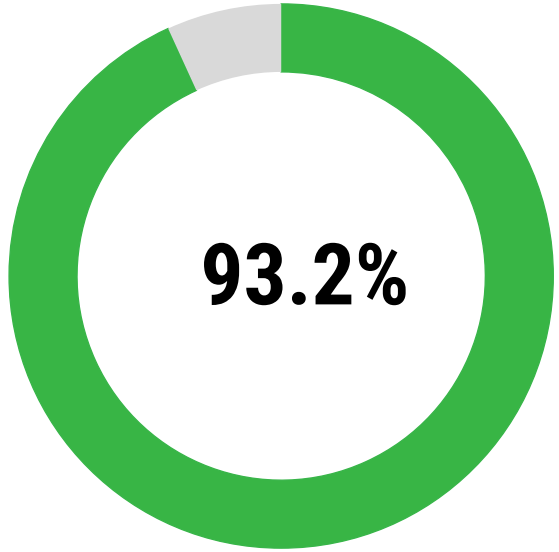
Time to complete symptom resolution, defined as achieving PGI-S rating of 'none' within 48 hours post-treatment.
Primary Efficacy Analysis Set includes all randomized participants who treated two attacks according to the crossover design and served as the basis for the primary statistical significance test. (n = 88)
Primary statistical test: treatment comparison based on Gehan's generalized Wilcoxon test adapted for 2×2 crossover trials with time-to-event outcomes (Feingold & Gillespie, *Stat Med* 1996). Two-sided p-value evaluated under the prespecified closed-testing procedure with gatekeeping control of multiplicity.
Median time and 95% CI estimated by Kaplan-Meier method; CI: confidence interval; PGI-S: Patient Global Impression of Severity.



Most attacks were treated with a single capsule



of attacks were
treated with a single capsule of deucrictibant*
vs. placebo (33.0%)



of attacks were
treated without use of rescue medication*
vs. placebo (63.6%)

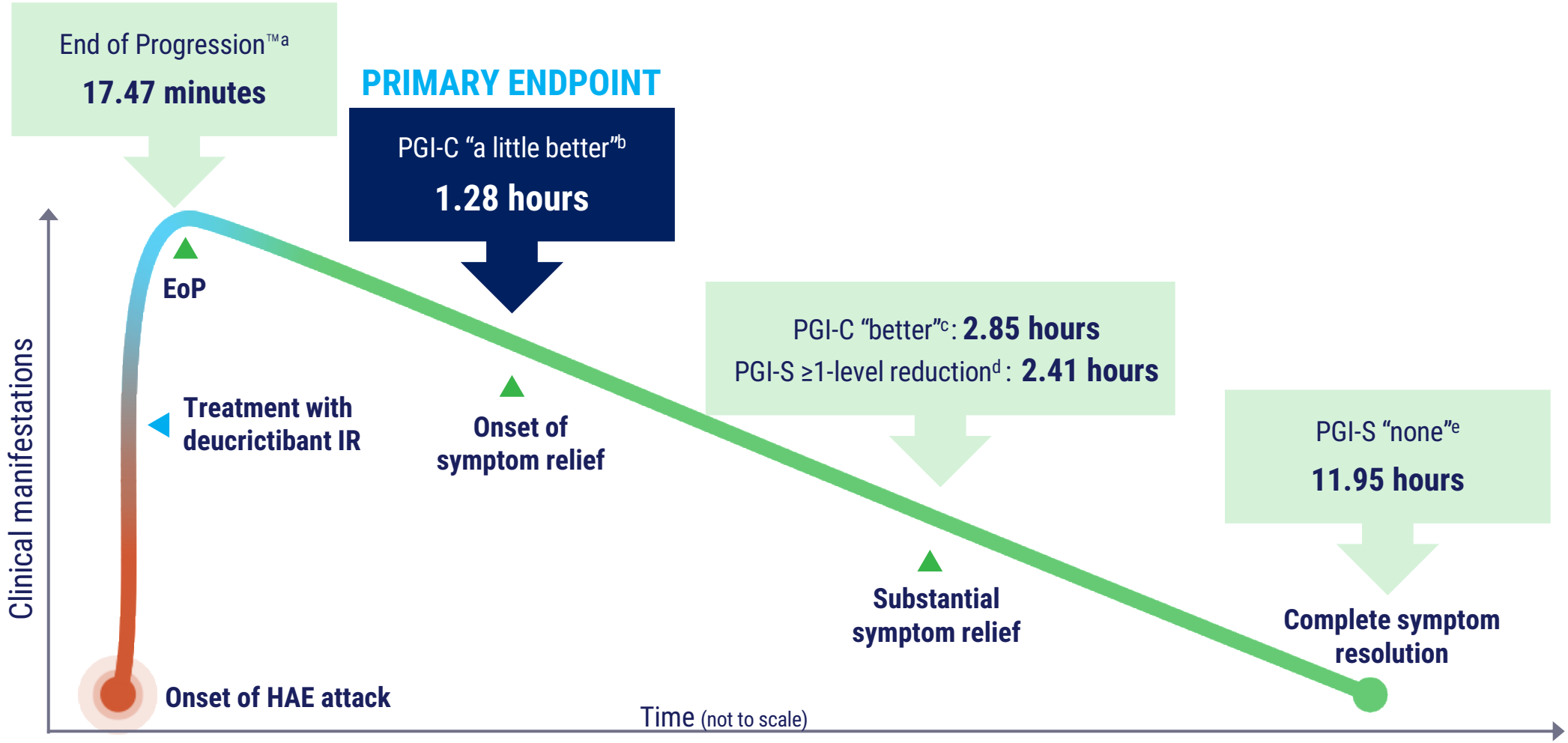
* Within 12 hours timeframe.

Well tolerated and no discontinuation due to TEAE

Participants with ≥1 Treatment-Emergent Adverse Events (TEAEs) – n (%)	Placebo N=101	Deucrictibant N=100
Any TEAEs	17 (16.8)	24 (24.0)
Maximum Grade 1 (Mild)	10 (9.9)	13 (13.0)
Maximum Grade 2 (Moderate)	6 (5.9)	10 (10.0)
Maximum Grade 3 (Severe)	0	1 (1.0)
Maximum Grade 4 (Life-threatening)	1 (1.0)	0
Maximum Grade 5 (Fatal)	0	0
Study drug-related TEAEs	1 (1.0)	5 (5.0)
Treatment-emergent serious adverse events (TESAEs)	1 (1.0)	1 (1.0)
Study drug-related TESAEs	0	0
TEAEs leading to discontinuation	0	0

Data based on Safety Analysis Set, which includes all enrolled participants who received any dose of study drug.
Including all treatment-emergent adverse events. TEAEs are defined as AEs that start from the first study drug administration through the end of study visit.
One participant randomized to the deucrictibant-placebo sequence was incorrectly administered placebo for the first attack; study closure occurred before the participant experienced a second attack.
N: number of participants. n: number of participants with ≥1 event. % = n/N*100%

Earlier symptom relief and complete resolution achieved*

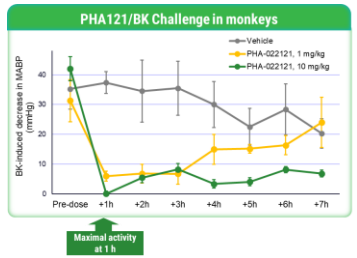


* vs placebo, median time to event; see data on previous slides within this presentation. a. End of Progression (EoP): defined as the earliest post-treatment timepoint after which all subsequent PGI-C ratings are stable or improved within 12 hours post-treatment. The term End of Progression is a registered trademark of Pharvaris GmbH. b. PGI-C "a little better": Primary endpoint as time to onset of symptom relief, defined as PGI-C rating of at least "a little better" for 2 consecutive timepoints within 12 hours post-treatment. c. PGI-C "better": Time to substantial symptom relief, defined as achieving PGI-C rating of at least "better" for 2 consecutive timepoints within 12 hours post-treatment d. PGI-S ≥1-level improvement: Time to substantial symptom relief by Patient Global Impression of Severity (PGI-S), defined as achieving ≥1-level improvement in PGI-S from pre-treatment for 2 consecutive timepoints within 12 hours post-treatment e. PGI-S "none": Time to complete symptom resolution, defined as achieving PGI-S rating of "none" within 48 hours post-treatment.

From scientific concept to future therapies

Nonclinical

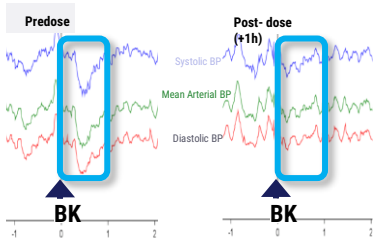
Non-human primate study



Oral deucrictibant suppresses BK effect in NHP faster than SQ icatibant; target exposures for Phase 1[1]

Phase 1

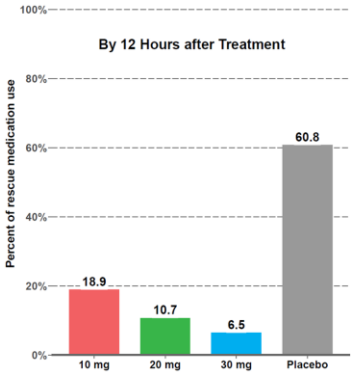
Pharmacodynamic study



EC_{85} assessed in humans at 13.8 ng/mL; target exposure for studies in people living with HAE[2]

Phase 2

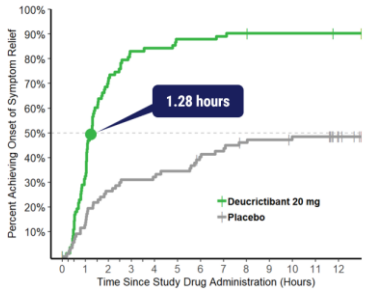
RAPIDe-1



Clinical efficacy correlates with exposure exceeding and remaining above EC_{85}[3]

Phase 3

RAPIDe-3



Clinical efficacy demonstrated based on primary and secondary endpoints met[4]

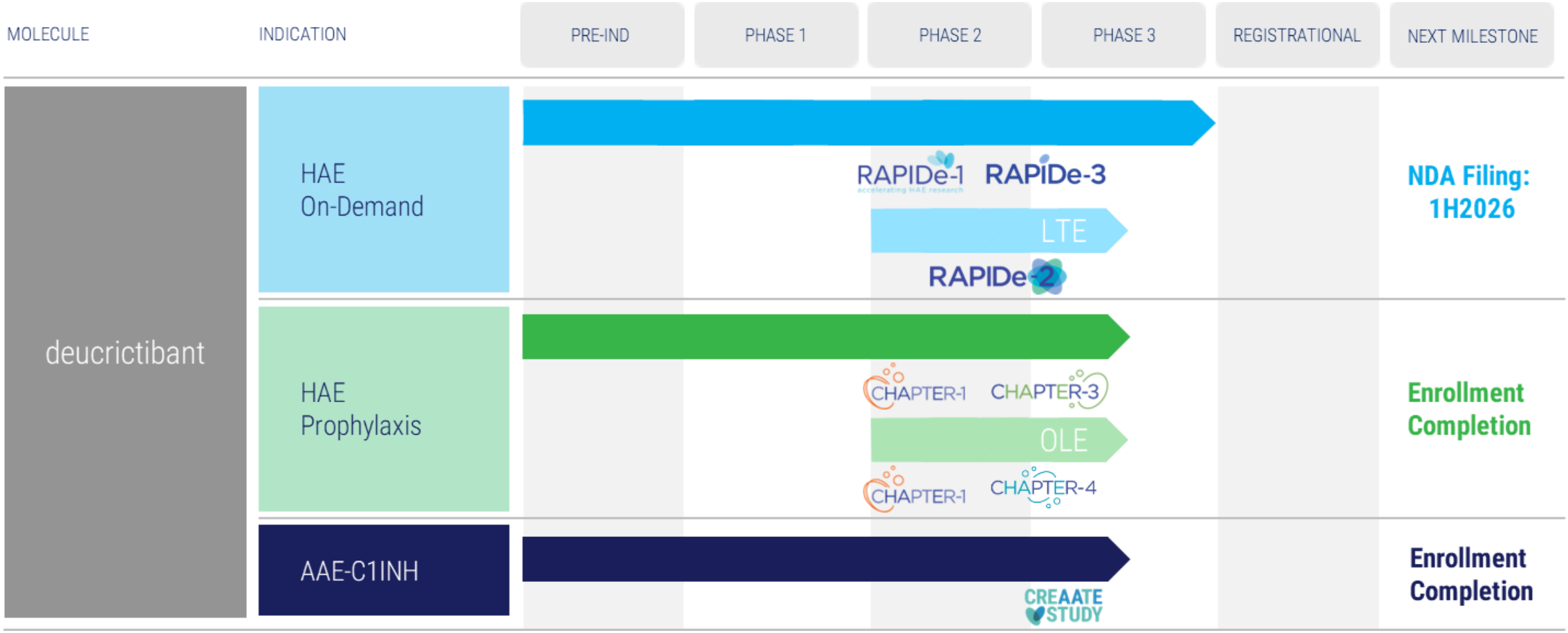
Phase 3

CHAPTER-3

Topline: 2H2026

Notes: BK: bradykinin; NHP: non-human primates; SQ: sub-cutaneous; EC_{85}: effective concentration achieving 85% inhibition of bradykinin effect.
Source:. [1]Lesage et al. *Int. Immunopharmacology*. 2022. [2]Derendorf H et al. ACAAI 2020. [3]Maurer M et al. AAAAI 2023. [4]Data on file.

Pharvaris' next key milestones



Notes: AAE-C1INH: acquired angioedema due to C1 inhibitor deficiency. HAE: hereditary angioedema. LTE: long-term extension. OLE: open-label extension. NDA: New Drug Application.
Source: RAPIDe-1 (NCT04618211). RAPIDe-2 (NCT05396105). RAPIDe-3 (NCT06343779). CHAPTER-1 (NCT05047185). CHAPTER-3 (NCT06669754). CHAPTER-4 (NCT06679881), CREAATE (Cohn DM et al. HAEi-EMEA 2025).

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