International AIDS Conference Investor Event

Merck & Co., Inc., Rahway, N.J., USA

August 3, 2026

Forward-looking statement of Merck & Co., Inc., Rahway, N.J., USA

This presentation of Merck & Co., Inc., Rahway, N.J., USA (the “company”) includes “forward-looking statements” within the meaning of the safe harbor provisions of the U.S. Private Securities Litigation Reform Act of 1995. These statements are based upon the current beliefs and expectations of the company’s management and are subject to significant risks and uncertainties. There can be no guarantees with respect to pipeline candidates that the candidates will receive the necessary regulatory approvals or that they will prove to be commercially successful. If underlying assumptions prove inaccurate or risks or uncertainties materialize, actual results may differ materially from those set forth in the forward-looking statements.

Risks and uncertainties include but are not limited to, general industry conditions and competition; general economic factors, including interest rate and currency exchange rate fluctuations; the impact of pharmaceutical industry regulation and health care legislation in the United States and internationally; global trends toward health care cost containment; technological advances, new products and patents attained by competitors; challenges inherent in new product development, including obtaining regulatory approval; the company’s ability to accurately predict future market conditions; manufacturing difficulties or delays; financial instability of international economies and sovereign risk; dependence on the effectiveness of the company’s patents and other protections for innovative products; and the exposure to litigation, including patent litigation, and/or regulatory actions.

The company undertakes no obligation to publicly update any forward-looking statement, whether as a result of new information, future events or otherwise. Additional factors that could cause results to differ materially from those described in the forward-looking statements can be found in the company’s Annual Report on Form 10-K for the year ended December 31, 2025 and the company’s other filings with the Securities and Exchange Commission (SEC) available at the SEC’s Internet site (www.sec.gov).

Agenda

Strategy Overview | Dr. Eliav Barr
SVP, Head of Global Clinical Development & Chief Medical Officer

AIDS 2026 Data Updates | Dr. Liz Rhee
VP, Clinical Research, Infectious Disease

Commercial Opportunity | Brian Foard
EVP & President, Specialty, Pharma & Infectious Diseases

Q&A | All + Gregg Szabo
SVP, Integrated Global HIV Franchise

Strategy Overview

Dr. Eliav Barr
Senior Vice President, Head of Global Clinical Development & Chief Medical Officer

Nearly 40 million people are living with HIV worldwide, more than a million people are diagnosed every year

Current State[1]

40M
People living with HIV

Only 73% of people living with HIV are virally suppressed

1.2M
Annual new HIV infections

~3,300 new HIV infections daily

~66% aged 20-40, requiring decades of treatment to survive

>50%

of those surveyed in 33 countries have discriminatory attitudes towards people living with HIV

UNAIDS 2030 Goals

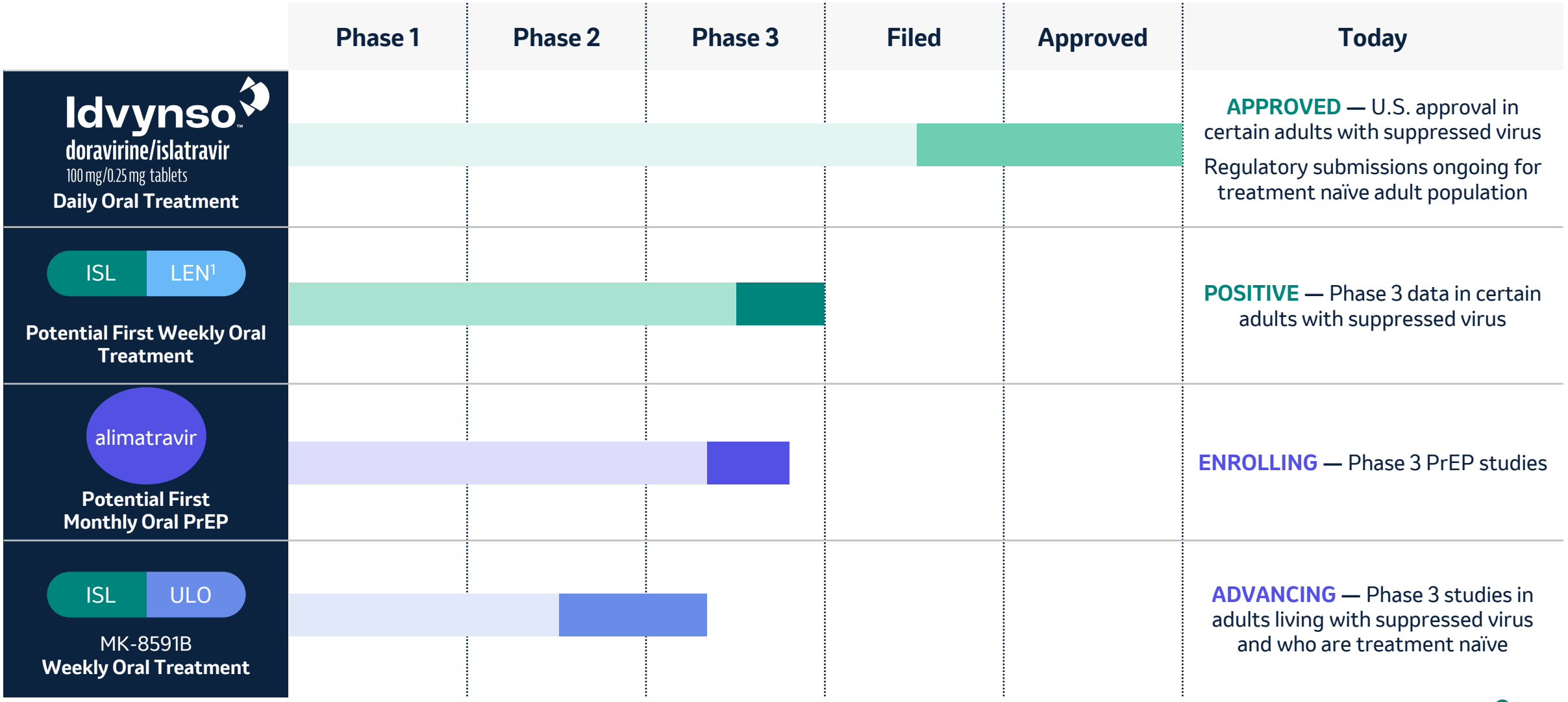
95% **Diagnosed** with HIV • **95%** People living with HIV **treated** • **95%** People living with HIV **suppressed**

200,000
new adult HIV infections per year

ZERO
discrimination

1. 2025 Global AIDS Update

Progressing next wave of HIV innovation to provide new oral options for treatment and PrEP



1. Combination of islatravir and lenacapavir in collaboration with Gilead

Progress since last year

AIDS 2026 Data Updates

Dr. Liz Rhee
Vice President, Clinical Research,
Infectious Disease

Compelling data at AIDS 2026 support potential to bring innovative weekly oral treatment options to people living with HIV

Evolution of oral HIV treatment

1996
16 pills per day
>5,800
pills per year

2006
1 pill per day
365
pills per year

Soon
1 pill per week
52
pills per year

New data presented at AIDS 2026

ISL | LEN[1]

ISLEND-1
Phase 3 study vs B/F/TAF

ISLEND-2
Phase 3 study vs other daily oral antiretroviral regimens

ISL | ULO

Phase 2b study vs B/F/TAF

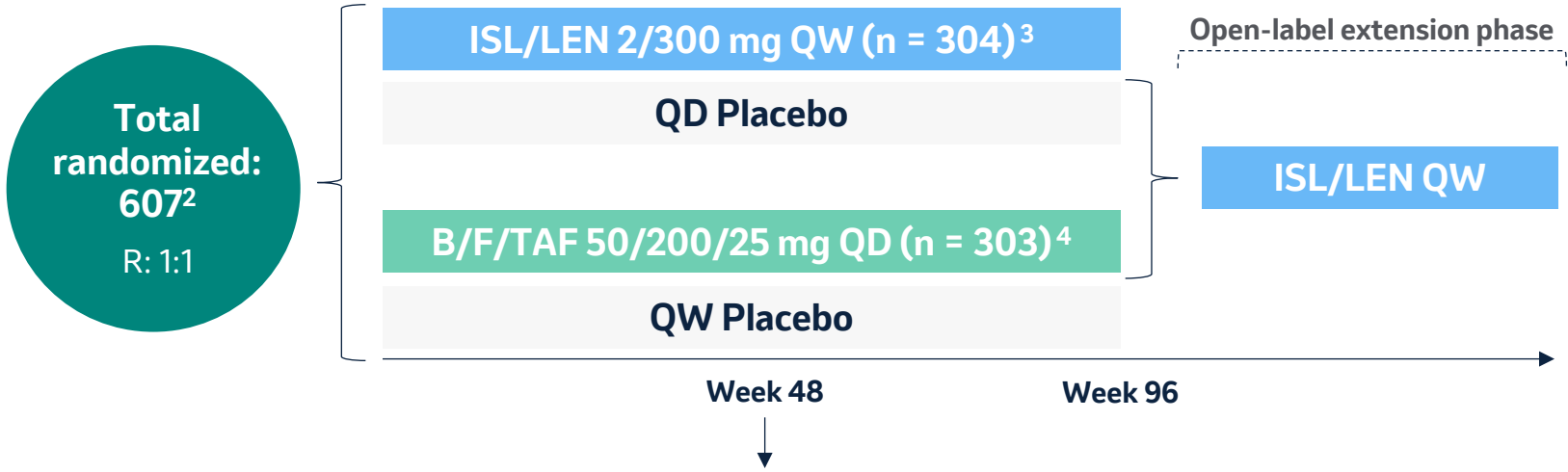
1. Combination of islatravir and lenacapavir in collaboration with Gilead

ISLEND-1 evaluated efficacy and safety of switching to once-weekly islatravir/lenacapavir from B/F/TAF

ISLEND-1 Phase 3 double-blind, active-controlled noninferiority study vs daily oral B/F/TAF

Eligibility Criteria:

- Age ≥ 18 years
- HIV-1 RNA < 50 copies/mL for ≥ 6 months on B/F/TAF
- No prior exposure to ISL or LEN
- No history of virologic failure
- No HBV infection[1]



Primary Endpoint:

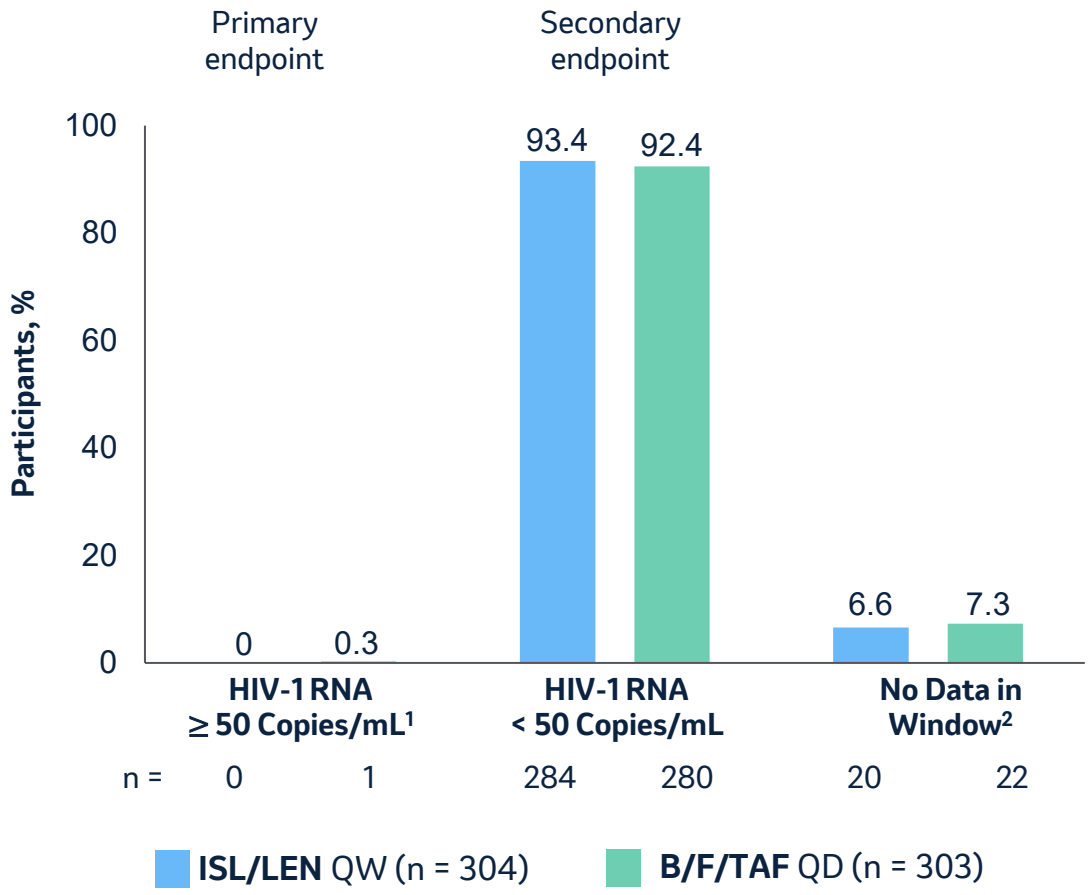
- HIV-1 RNA ≥ 50 copies/mL per US FDA Snapshot

Secondary Endpoints:

- HIV-1 RNA < 50 copies/mL
- Change from baseline in CD4+ T-cell count
- Adverse events leading to treatment discontinuation

1. Positive HBsAg or positive HBcAb and negative HBsAb 2. Randomized: N=609, dosed: N=607 3. Participants received a loading (initiation) dose of ISL/LEN 0.5/300 mg × 2 tablets administered orally on Days 1 and 2, then STR ISL/LEN 2/300 mg tablet administered orally once weekly from Day 8, without regard to food, plus matching B/F/TAF placebo 4. Participants continued B/F/TAF 50/200/25 mg tablet administered orally once daily, without regard to food, and received matching ISL/LEN placebo (loading dose and weekly treatment)

ISLEND-1 provides strong evidence for potential first approval of a once-weekly oral treatment regimen



- ISL/LEN demonstrated **non-inferior efficacy** compared to once-daily B/F/TAF
- **Maintained high rates of virologic suppression** (93%) at Week 48
- **No emergent resistance to ISL or LEN** detected through Week 48

1. Discontinued study drug due to other reasons and last available HIV-1 RNA was ≥50 copies/mL: B/F/TAF, n = 1.
2. Discontinued study drug due to adverse event: ISL/LEN, n = 6; B/F/TAF, n = 4; Discontinued study due to other reasons and last available HIV-1 RNA was <50 copies/mL: ISL/LEN, n = 13; B/F/TAF, n = 15; Missing data during analysis window but still on study drug: ISL/LEN, n = 1; B/F/TAF, n = 3.

ISLEND-1

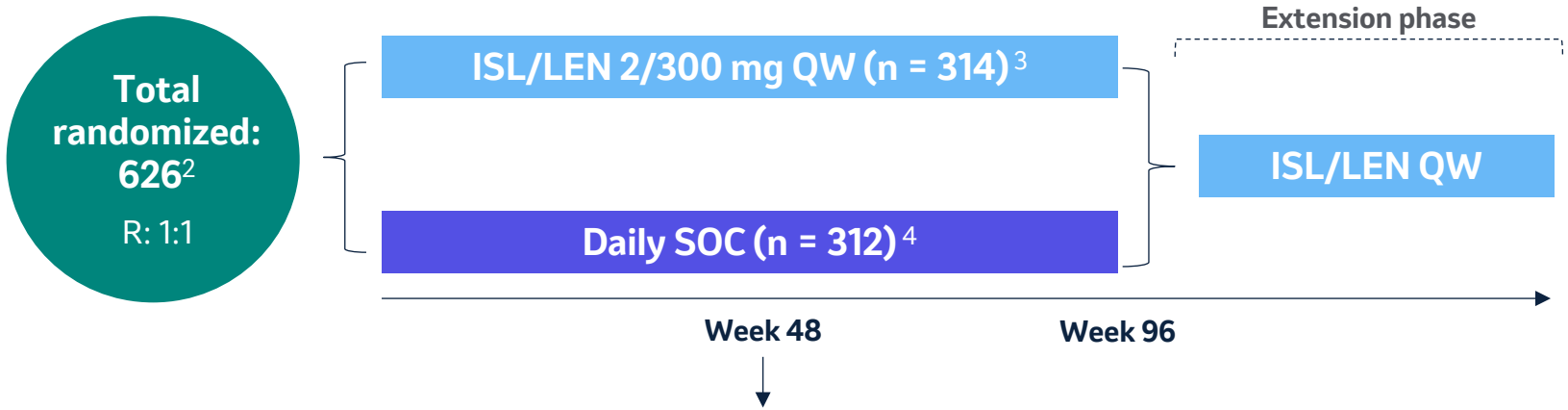
ISLEND-2 evaluated efficacy and safety of switching to once-weekly ISL/LEN from diverse daily oral regimens

ISLEND-2

Phase 3 open-label, active-controlled noninferiority study vs daily oral standard of care[2]

Eligibility Criteria:

- Age ≥ 18 years
- HIV-1 RNA < 50 copies/mL for ≥ 6 months on daily oral SOC
- No prior exposure to ISL or LEN
- No history of virologic failure
- No HBV infection[1]



Primary Endpoint:

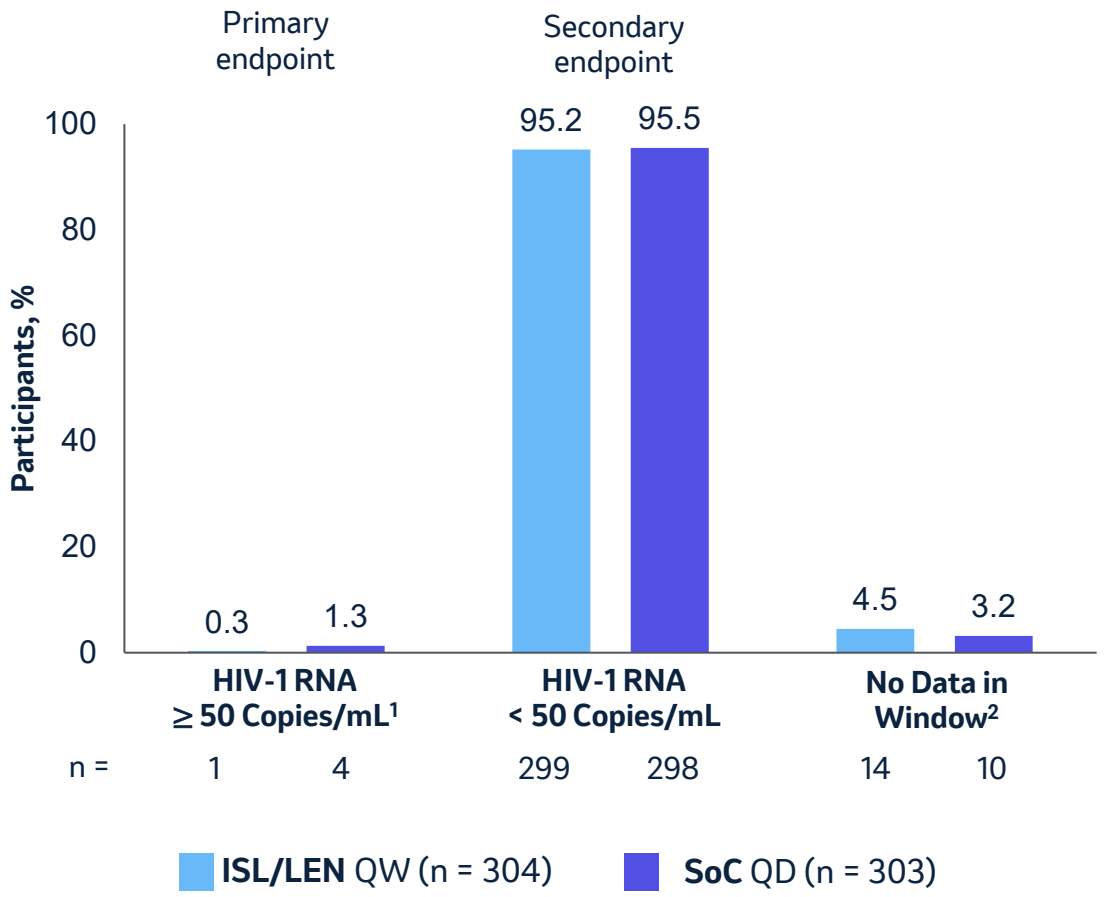
- HIV-1 RNA ≥ 50 copies/mL per US FDA Snapshot

Secondary Endpoints:

- HIV-1 RNA < 50 copies/mL
- Change from baseline in CD4+ T-cell count
- Adverse events leading to treatment discontinuation

1. Positive HBsAg or positive HBcAb and negative HBsAb; SOC includes INSTI + 1 or 2 NRTIs, bPI + 2 NRTIs or NNRTI + 2 NRTIs 2. Randomized: N=634, dosed: N=626. 3. Initiation/loading dose of ISL/LEN 0.5/300 mg × 2 tablets on Days 1 and 2, then an ISL/LEN STR 2/300 mg tablet once weekly from Day 8, without regard to food 4.All SOC treatments were taken once daily, including FDC and STRs, except for raltegravir, which could be taken once or twice daily

High rates of virologic suppression and high barrier to resistance shown in ISLEND-2



- ISL/LEN was **noninferior to daily SOC**
- **Maintained high rates of virologic suppression (95%)** at Week 48
- **No emergent resistance to ISL or LEN** detected through Week 48

1. Combination of islatravir and lenacapavir in collaboration with Gilead; a. HIV-1 RNA ≥ 50 copies/mL in Week 48 window: ISL/LEN, n = 1; SOC, n = 4.; b. Discontinued study drug due to adverse event or death: ISL/LEN, n = 3; SOC, n = 2. Discontinued study drug due to other reasons and last available HIV-1 RNA was< 50 copies/mL: ISL/LEN, n = 9; SOC, n = 4. Missing data during analysis window but still on study drug: ISL/LEN, n = 2; SOC, n = 4.

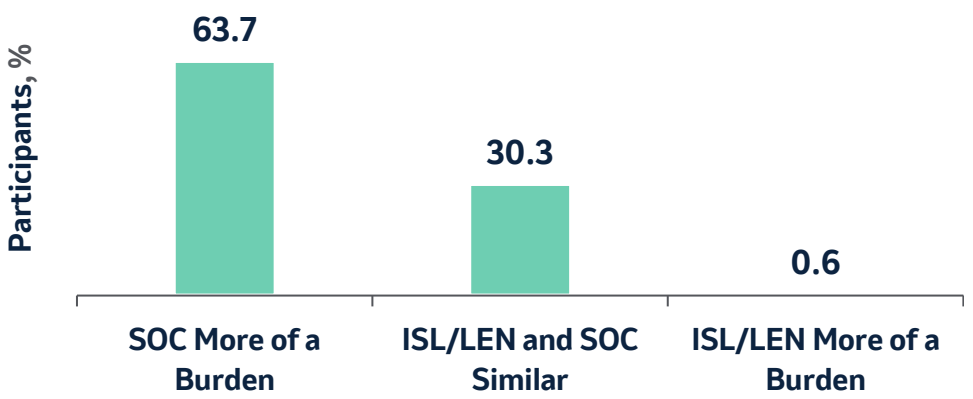
ISLEND-2

Strong participant preference for once-weekly ISL/LEN shown in ISLEND-2 exploratory analysis

More Satisfied With Regimen[1]

Participants were **more satisfied with ISL/LEN (78%)**

Regimen Less of a Burden[1]



Participants found **ISL/LEN** to be **less of a burden compared with daily oral SOC** (64% found SOC more of a burden)

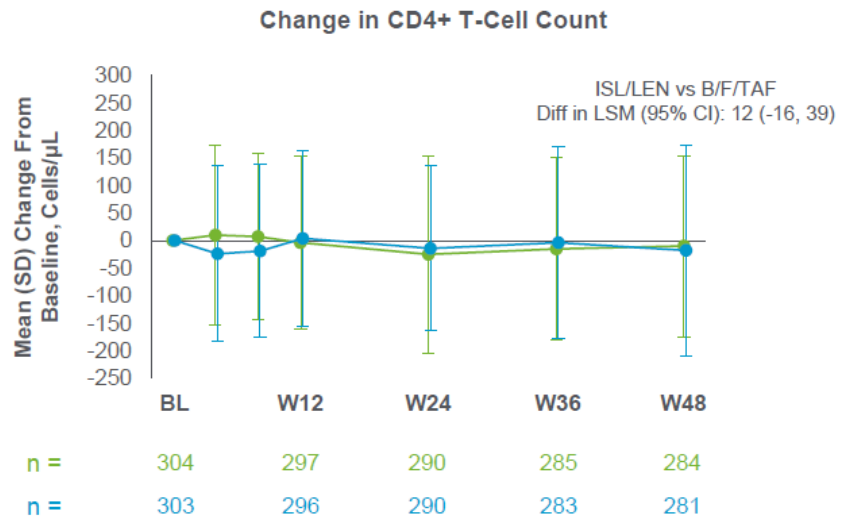
1. N=314. Data missing for 17/314 (5.4%) ISL/LEN participants.

ISLEND-2

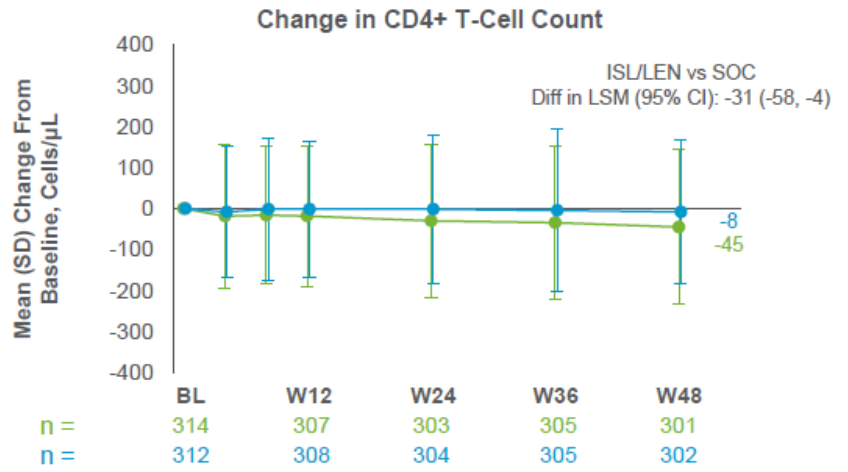
Safety and tolerability profile of once weekly ISL/LEN comparable to once-daily B/F/TAF and standard of care

- **Safety profile** of once-weekly oral **ISL/LEN** was **generally similar to the comparator regimens** studied in the ISLEND trials, and no new safety concerns were identified[1]
- **No clinically meaningful changes** in CD4+ T-cell counts, lymphocytes, or body weight
- **No participants discontinued** due to decreases in CD4+ T-cell or absolute lymphocyte counts

ISLEND-1



ISLEND-2



1. Safety profile overview: Appendix

Results support potential for ISL/LEN to be first once-weekly oral single-tablet regimen for treatment for adults with virologically suppressed HIV

High virologic suppression	No resistance detected	Comparable safety	Satisfaction
≥93.0% with HIV-1 RNA <50 c/mL	**Zero treatment-emergent resistance to ISL or LEN**	**Safety and tolerability comparable with once-daily treatments**	**Favorable participant-reported outcomes**

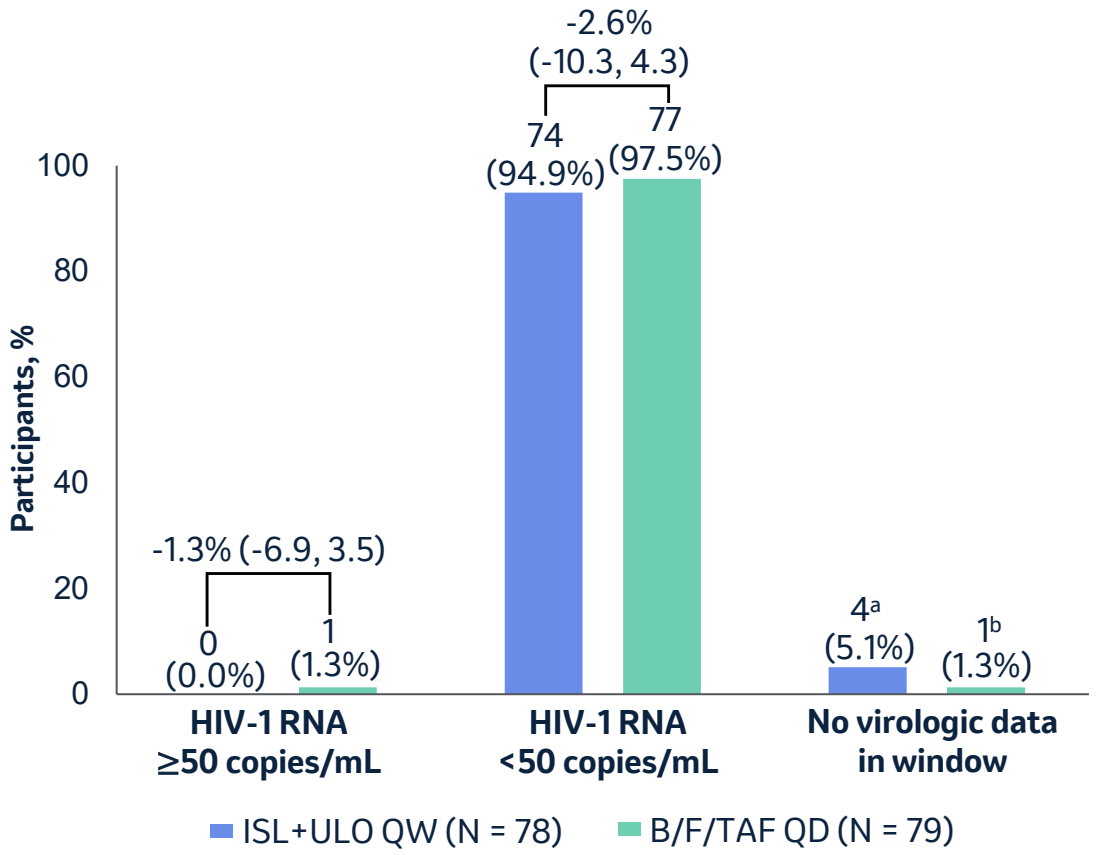
Advancing multiple potential once-weekly treatment options

ISL + LEN[1]	ISL + ULO
Next-generation NRTI / Capsid inhibitor	**Next-generation NRTI / NNRTI**
Positive Phase 3 data in development for adults	Positive Phase 2b data in development for adults
PLWH with suppressed virus	PLWH with suppressed virus and treatment-naïve population
Initiation dose → Single tablet ~1.5 g QW	No loading dose Single tablet ~1 g or less QW Favorable DDI profile[2]
Potential paradigm change with first weekly oral regimen	**Potential to expand weekly dosing option to treatment naïve adults**

1. Combination of islatravir and lenacapavir in collaboration with Gilead 2. Based on preclinical and Phase 1 results

Islatravir + ulonivirine Phase 2b trial showed maintenance of viral suppression compared to B/F/TAF at Week 24

Virologic outcomes (FDA snapshot approach)



- **ISL 2 mg + ULO 200 mg once-weekly maintained viral suppression** through Week 24
- **Efficacy comparable** to continuing B/F/TAF once-daily
  - **No participants on ISL+ULO** with HIV-1 RNA≥50 copies/mL
  - **>94% of participants suppressed** (HIV-1 RNA<50 copies/mL) in both groups
- **No emergent resistance to ISL or ULO** detected through Week 24

[a]Discontinued due to adverse event with HIV-1 RNA <50 copies/mL (n=1), discontinued due to other reason with HIV-1 RNA <50 copies/mL (n=2), missing data in window (n=1; participant subsequently returned, after database lock, with HIV-1 RNA <50 copies/mL within the Week 24 analysis window). [b]Discontinued due to other reason with HIV-1 RNA <50 copies/mL (n=1).

ISL+ULO demonstrated a favorable safety and tolerability profile

Participants with AEs, n (%)	ISL+ULO QW N = 78	B/F/TAF QD N = 79
One or more AEs	**43 (55.1)**	**44 (55.7)**
Drug-related[a] AEs	10 (12.8)[b]	0 (0.0)
Grade 3 or 4 AEs	3 (3.8)	5 (6.3)
Drug-related[a] grade 3 or 4 AEs	0 (0.0)	0 (0.0)
Serious AEs	3 (3.8)[c]	0 (0.0)
Drug-related[a] serious AEs	0 (0.0)	0 (0.0)
Discontinued drug due to an AE	**1 (1.3)**	**0 (0.0)**
Grade 3 or 4 laboratory AEs[d]	9 (11.6)	19 (28.2)

All ISL+ULO QW drug-related AEs were Grade 1 or 2. The only drug-related AE in >1 participant was 'dizziness' (n=2, 2.6%)

- Switching to ISL+ULO was **generally well tolerated**, and **no safety concerns were identified**
- AE profile was **comparable to continuing B/F/TAF**
- **No impacts on total lymphocyte and CD4+ T-cell counts**

[a]Most frequent were nausea (7.7%; n=6), abdominal pain, dizziness, influenza-like illness, nasopharyngitis (all 5.1%; n=4). [b]Most frequent were upper respiratory tract infection (6.3%; n=5), glomerular filtration rate decreased (5.1%; n=4). [c]Determined by the investigator to be related to study treatment. [b]All were Grade 1 or 2. [c]'Psychogenic non-epileptic seizure', 'multiple fractures', and 'myopericarditis' with prior history of myopericarditis (n=1 each). [d]Participants are counted once per laboratory test, according to the highest severity grade reported.

Plan to initiate Phase 3 program to evaluate ISL/ULO in adults who are virologically suppressed and those who are new to treatment

	SYMPHORIA No. 1	SYMPHORIA No. 2	SYMPHORIA No. 3
Phase	Phase 3	Phase 3	Phase 2/3 study
Design	Open-label study	Blinded, active-controlled study	Open-label (Phase 2) Double-blind (Phase 3)
Population	PLWH with suppressed virus switching from daily orals	PLWH with suppressed virus switching from daily orals	Adult treatment-naïve population
Comparator	Baseline ART	B/F/TAF	B/F/TAF
Study	MK-8591B-065	MK-8591B-066	MK-8591B-062
Status	Planned	Planned	Phase 2 Enrolled

Commercial Opportunity

Brian Foard
Executive Vice President & President,
Specialty, Pharma & Infectious Diseases

Large, persistent gaps in HIV treatment and prevention landscape create durable demand

Treatment

Aging population

>70% of people living with HIV in U.S. projected to be age 50+ by 2030, with growing comorbidity and polypharmacy burden

Safety & tolerability

Existing antiretroviral medications generally safe and effective but weight gain, and renal, bone, and CNS effects remain concerns

Treatment fatigue & stigma

For many, daily dosing contributes to stigma and treatment fatigue, driving interest in long-acting oral options

Prevention

Experience

Uptake and persistence hurdles have potential to limit real-world impact

Implementation

Starting and staying on PrEP can be complex

Access

PrEP options could reach far more people who would potentially benefit

IDVYNSO marks beginning of broader portfolio strategy designed to address evolving needs of people living with or at risk of HIV

Establish IDVYNSO in the switch market

First and only non-InSTI 2-drug complete regimen

Potential to address key drivers of switches

Advance novel once-weekly treatment options

Offer less frequent oral long-acting options

Continues evolution towards 2-drug regimens

Innovate in PrEP

Fast onset - predicted within 1 hour for one month of protection

Discreet monthly, oral dosing

Ensure lives are not defined by HIV through transformational inventions, partnerships and access

Weekly oral treatments offer less frequent dosing

Unmet Need

- **Treatment fatigue: 33%** report stress with daily dosing schedule[1]
- **Stigma: 58%** have ever hid or disguised their HIV medications to avoid sharing their HIV status[1]
- **Injection burden:** Long-acting injectable dosing ties people to clinic visits, and risk for injection-site reactions

Oral Weekly Opportunity

- **Less frequent dosing: 86%** reduction in annual pill burden
- **Satisfaction higher with QW oral:** In exploratory analysis, **78%** of participants reported more satisfaction with ISL/LEN than with comparator daily regimens
- **Interest in long-acting: 33%** of people express interest in long-acting oral options

1. de los Rios, et a. *Physical, Emotional, and Psychosocial Challenges Associated with Daily Dosing of HIV Medications and Their Impact on Indicators of Quality of Life: Findings from the Positive Perspectives Study*.

Alimatravir has potential to be first monthly oral PrEP option

Alimatravir has potential to provide:

- **Fast onset of protection** – predicted within 1 hour for a **month of protection** from HIV[1]
- **Discreet monthly oral dosing**
- **Small single tablet** with **no requirement for loading dose**
- **Favorable efficacy, safety** and **DDI profile**
- **Unique molecule** developed only for PrEP
- **Simple oral dosing** and **ease of access**

Commitment to access

- Innovative pre-approval voluntary license agreements to **enable rapid access** in low- and middle-income countries if approved

1. Based on Phase 1 and Phase 2 results

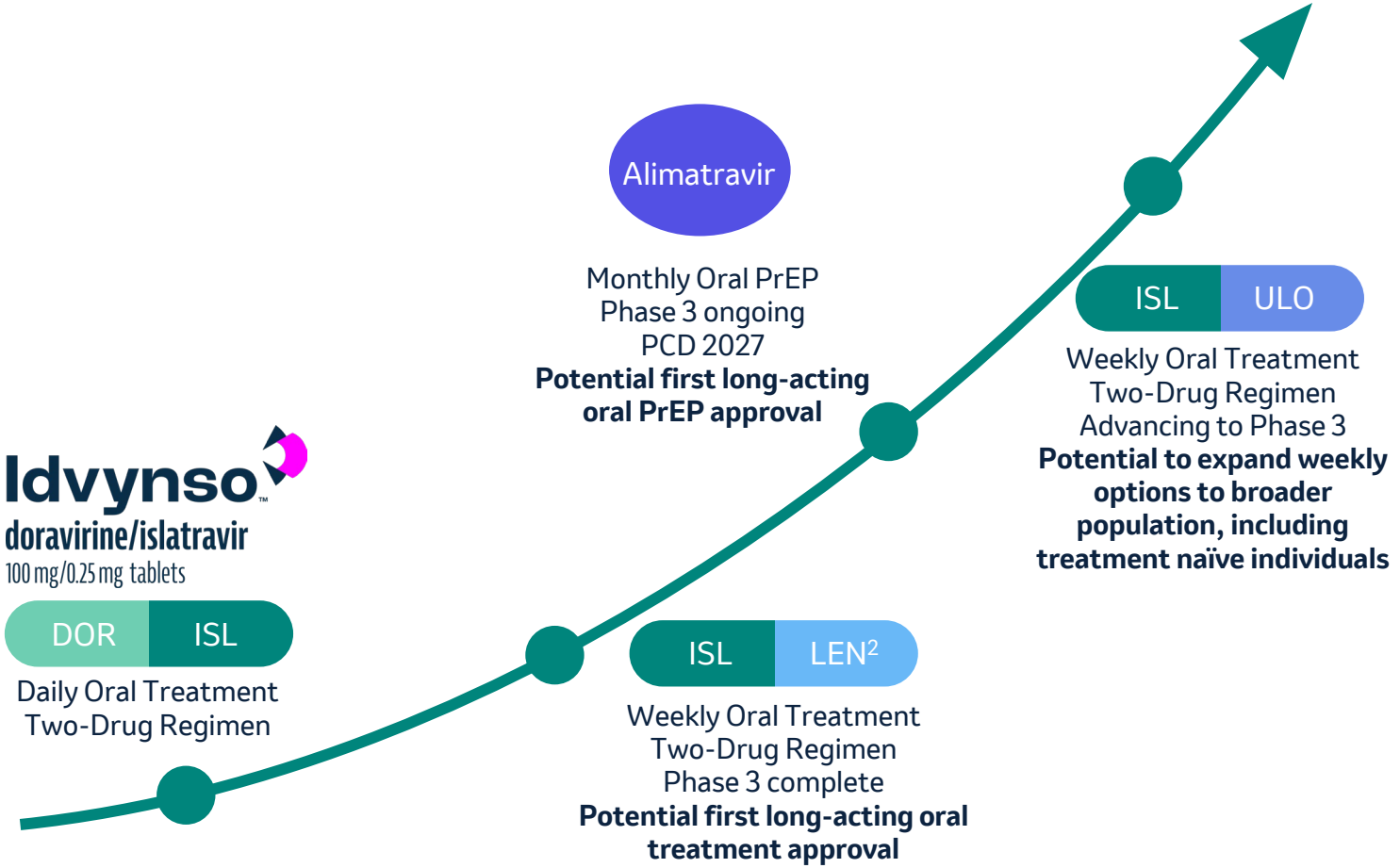
EXPrESSIVE-10 is being conducted with financial support from the Gates Foundation

>$5B opportunity by the mid-2030s from new and potential launches

>$5B

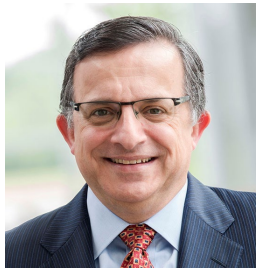
Commercial opportunity by the mid-2030s[1]

Important global opportunities in daily treatment, weekly treatment and monthly PrEP



1. Non-risk adjusted annual sales by the mid-2030s; reflects Merck's share of revenue from collaborations; does not include early-phase pipeline programs 2. Combination of islatravir and lenacapavir in collaboration with Gilead

Q&A



Dr. Eliav Barr
SVP, Head of Global Clinical Development & Chief Medical Officer

Dr. Liz Rhee
VP, Clinical Research, Infectious Disease

Brian Foard
EVP & President, Specialty, Pharma & Infectious Diseases

Gregg Szabo
SVP, Integrated Global HIV Franchise

Peter Dannenbaum
SVP, Investor Relations

Appendix

ISLEND-1: Safety Profile Overview

Participants, n (%)	ISL/LEN QW (n = 304)	B/F/TAF QD (n = 303)
Any AE	241 (79)	238 (79)
Grade ≥ 3	22 (7)	22 (7)
Treatment-related AEs	41 (13)	40 (13)
Most common treatment-related AEs (≥ 2% in the ISL/LEN group)		
Nausea	9 (3)	10 (3)
Headache	9 (3)	8 (3)
Dizziness	6 (2)	0
Serious AEs	16 (5)	14 (5)
AEs leading to study drug discontinuation[1]	6 (2)	5 (2)
Deaths	0	0

Severity grades were defined by the DAIDS Toxicity Grading Scale, version 2.1.
1. Four of these 11 participants had treatment-related AEs leading to treatment discontinuation: myalgia and arthralgia (n = 1), rash maculo-papular (n = 1), arthralgia (n = 1), and brain fog and disturbance in attention (n = 1). Because of the potential for functional unblinding of investigators due to the low frequency of these AEs, they are reported without treatment-group attribution.

ISLEND-2: Safety Profile Overview

Participants, n (%)	ISL/LEN QW (n = 314)	Daily SOC (n = 312)
Any AE	249 (79)	241 (77)
Grade ≥ 3	24 (8)	28 (9)
Treatment-related AEs	58 (18)	1 (< 1)
Grade ≥ 3	0	0
Most common (≥ 2% in the ISL/LEN group)		
Headache	15 (5)	0
Diarrhea	10 (3)	0
Nausea	9 (3)	0
Serious AEs	22 (7)	27 (9)
Treatment related[a]	1 (< 1)	0
AEs leading to study drug discontinuation[b]	2 (1)	1 (< 1)
Deaths[c]	1 (< 1)	2 (1)

Severity grades were defined by the DAIDS Toxicity Grading Scale, version 2.1.
[a]ISL/LEN: seizure (n = 1). [b]ISL/LEN: hyperbilirubinemia in a participant with prior history of hyperbilirubinemia (n = 1, related to treatment) and acute hepatitis B (n = 1, unrelated to treatment); SOC: central nervous system lymphoma (n = 1, unrelated to treatment). [c]ISL/LEN: road traffic accident (n = 1); SOC: pneumonia complicated by cardiogenic shock/cardiac arrest (n = 1), and central nervous system lymphoma (n = 1).

Acronyms & Abbreviations

AEs = Adverse events
ART = Antiretroviral therapy
ARV = Antiretroviral
B/F/TAF = bictegravir/emtricitabine/tenofovir alafenamide
CNS = Central nervous system
DDI = Drug-drug interaction
DOR = doravirine
HBV = Hepatitis B virus
HIV = Human Immunodeficiency Virus
InSTI = Integrase Strand Transfer Inhibitor
ISL = islatravir
LEN = lenacapavir
NNRTI = Non-nucleoside reverse transcriptase inhibitor
PCD = Primary Completion Date
PI = Protease Inhibitor
PLWH = People living with HIV
PrEP = Pre-Exposure Prophylaxis
RNA = Ribonucleic acid
QD = Once a day
QW = Once a week
SOC = Standard of care
STR = Single tablet regimen
ULO = ulonivirine

Eliav Barr, MD

Senior Vice President, Head of Global Clinical Development, Chief Medical Officer

Dr. Eliav Barr is senior vice president and head of Global Clinical Development and Chief Medical Officer at Merck Research Laboratories. He leads all late-stage clinical development for Merck's human health portfolio and pipeline.

Prior to his current role, Eliav led MRL's Global Medical Affairs organization expanding Merck's scientific engagement and implementation efforts in oncology, vaccines and infectious diseases. Since joining Merck in 1995, Eliav has held positions of increasing responsibility including leadership roles in oncology and infectious diseases clinical development. He was also previously Therapeutic Area Head for Infectious Diseases and managed product development teams in Oncology and Infectious Disease.

Eliav is a cardiologist by training. He received his undergraduate degree from Penn State University and his medical degree from Thomas Jefferson University. He completed his Internal Medicine residency and Cardiology Fellowship at Johns Hopkins University, and subsequently pursued post-doctoral training at the University of Michigan. Prior to joining Merck, he held a faculty position at the University of Chicago.

Liz Rhee, MD

Vice President, Clinical Research, Infectious Disease

Dr. Elizabeth (Liz) Rhee is vice president and therapeutic area head of Infectious Disease Clinical Research in Global Clinical Development at Merck Research Laboratories.

She leads the late-stage development of infectious disease pipeline and portfolio products, including medicines for HIV, respiratory viruses, CMV, and bacterial infections. Since joining Merck in 2011, Liz has led and managed development teams across early, late, and post-licensure phases, stepping into her current role in 2022.

Liz is an infectious disease physician and prior to joining Merck had been on faculty at Brigham and Women's Hospital. She received her undergraduate degree from Harvard University and medical degree from SUNY Stony Brook. She completed her internal medicine residency at Brigham and Women's Hospital, infectious disease fellowship at Massachusetts General Hospital and post-doctoral training at Beth Israel Deaconess Medical Center.

Brian Foard

EVP & President, Specialty, Pharma & Infectious Diseases

Brian Foard is executive vice president and president, Specialty, Pharma & Infectious Diseases for Merck. He oversees a portfolio of growth drivers across cardiometabolic and respiratory, infectious diseases, immunology, and ophthalmology.

Prior to joining Merck, he spent nearly a decade at Sanofi consistently taking on broader leadership responsibilities. Most recently he served as executive vice president of Sanofi's specialty care business unit, with global accountability for a diverse portfolio of products spanning immunology, rare diseases, oncology and neurology. Previously, Brian served as head of specialty care North America and U.S. country lead, overseeing one of Sanofi's largest and most strategically important markets.

Earlier in his career, Brian spent almost two decades with Galderma, a Swiss pharmaceutical company that specializes in dermatological treatments. During his tenure at Galderma, he advanced through senior leadership roles across the U.S., France, Australia and Switzerland, playing a pivotal role in positioning the company as a global leader in dermatology.

He is committed to strengthening the life sciences ecosystem and expanding access to careers in biotechnology, serving on the boards of Massachusetts Biotechnology Council and the Biomedical Science Careers Program. Brian received a degree in business from East Carolina University.

Gregg Szabo
SVP, Integrated Global HIV Franchise

Gregg Szabo is currently senior vice president, Integrated Global HIV Franchise, leading global strategy and U.S. execution for Merck's increasingly broad portfolio and pipeline of antiretrovirals for both human immunodeficiency virus (HIV) treatment and prevention.

Previously, he served as senior vice president, Global Vaccines & Infectious Diseases, where he oversaw a broad portfolio of vaccines and treatments for infectious diseases, including more than 30 products spanning human papillomavirus (HPV), pneumococcal disease, pediatric vaccines, antibiotics and other commercialized and pipeline assets. In this role, he also supported collaborations to facilitate broad access to vaccines and medicines around the world, including with longstanding partners Gavi, the Vaccine Alliance and UNICEF.

Prior to these positions, Gregg served in several global and market leadership roles at Merck across marketing, market access and policy and spanning multiple product areas including HPV, HIV, antibiotics/antifungals, molnupiravir for the treatment of SARS-CoV2 and Hepatitis C virus.

Gregg has an MBA from McGill University in Montreal and a degree in chemistry from McMaster University in Hamilton, Canada.