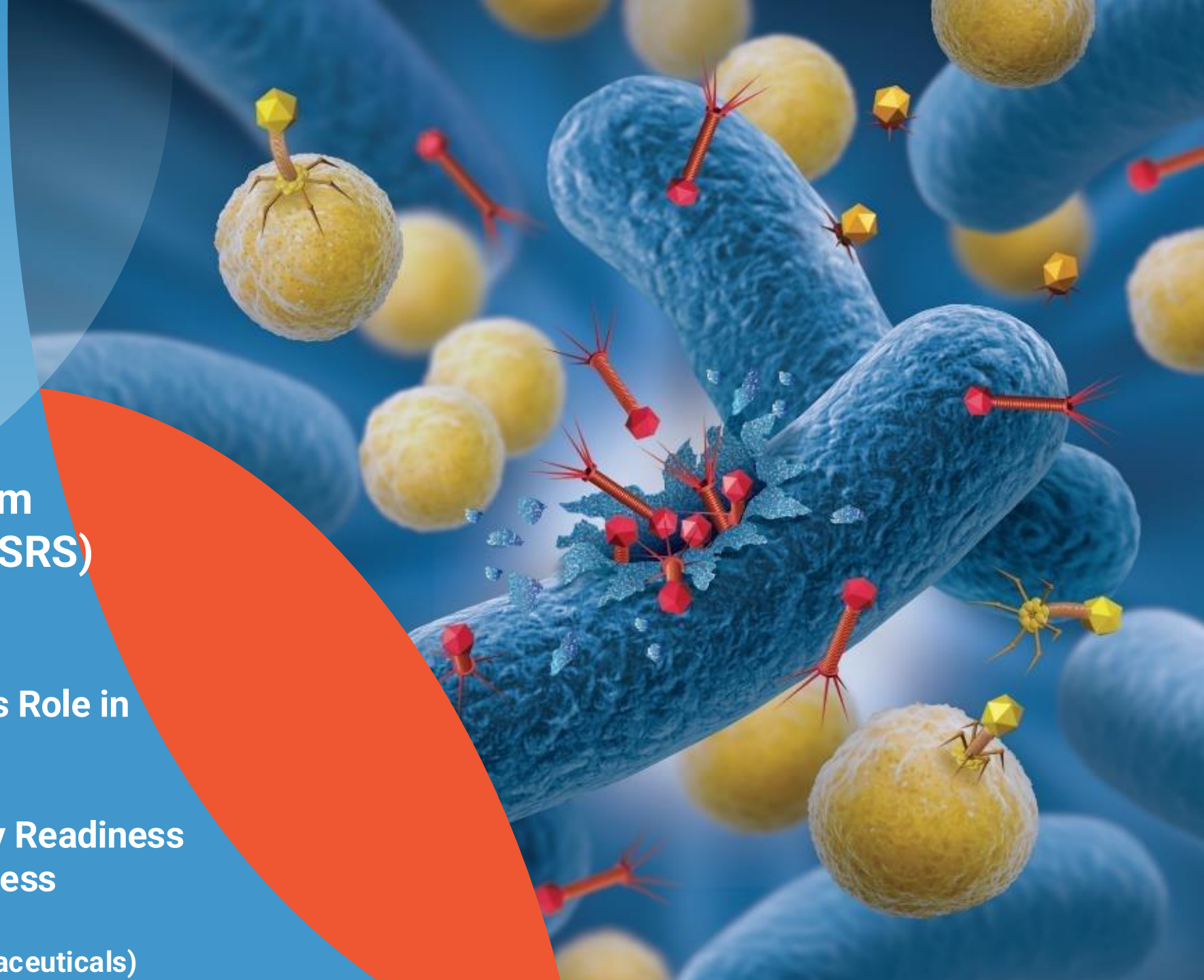
ARMATA PHARMACEUTICALS

PURPOSEFUL • PRECISE • POWERFUL



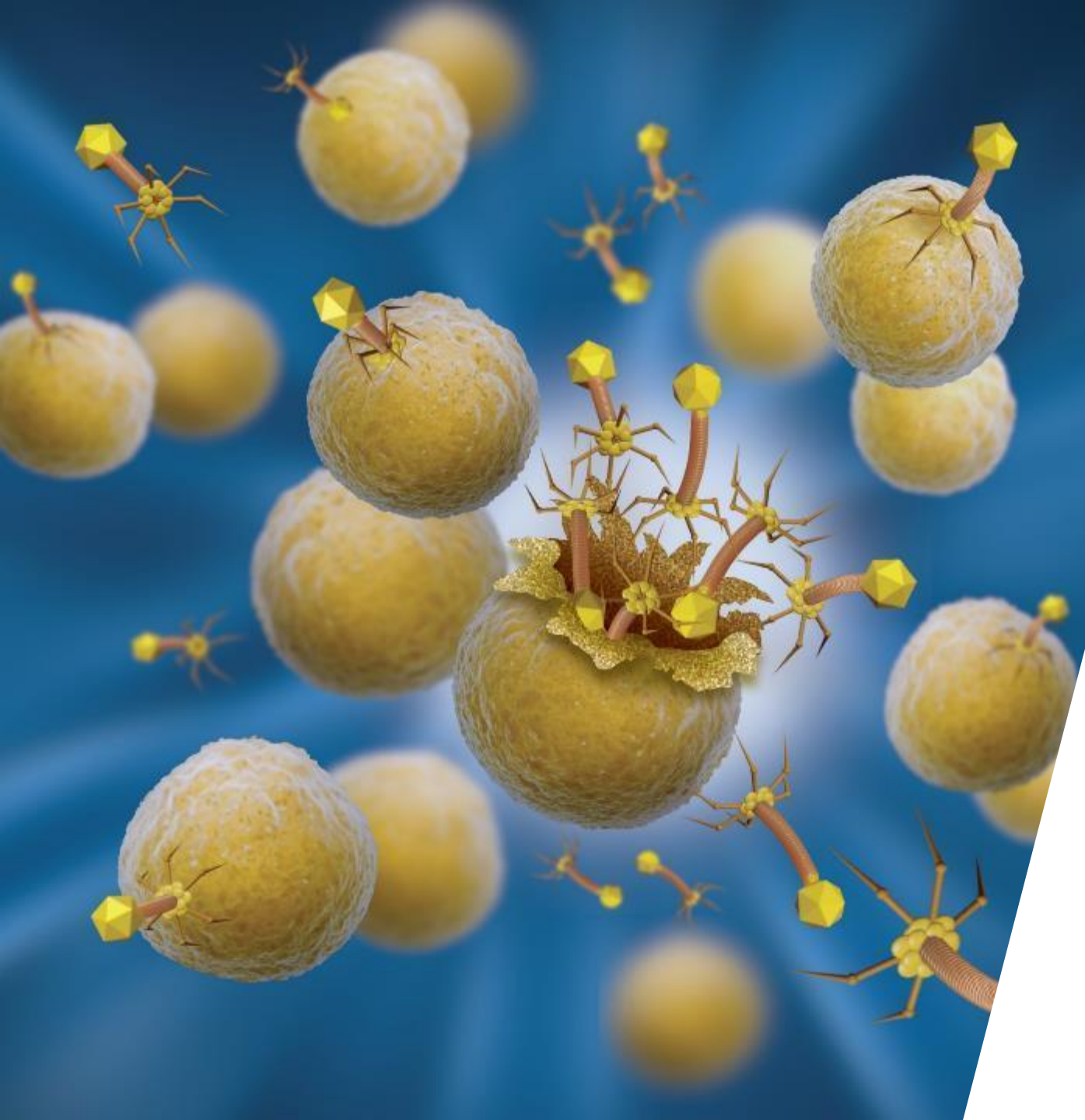
2026 Military Health System Research Symposium (MHSRS)

Kissimmee, FL
August 4, 2026

“From Lab to Line: The Military`s Role in Advancing Infectious Disease Countermeasures.”

Innovation for Enhanced Military Readiness and Frontline Treatment to Address Antimicrobial Resistance

Dr. Deborah Birx (CEO of Armata Pharmaceuticals)



Acknowledgments

Armata's clinical breakthrough has been made possible with the ongoing financial support and partnership from the U.S. Department of War

Armata is the recipient of a $28.7 million DoW award, received through the Medical Technology Enterprise Consortium (MTEC) and managed by the Naval Medical Research Command (NMRC) – Naval Advanced Medical Development (NAMD) with funding from the Defense Health Agency and Joint Warfighter Medical Research Program

Forward Looking Statements

This presentation contains "forward-looking" statements that involve risks, uncertainties and assumptions. If the risks or uncertainties materialize or the assumptions prove incorrect, our results may differ materially from those expressed or implied by such forward-looking statements. All statements other than statements of historical fact could be deemed forward-looking, including, but not limited to: our estimates regarding anticipated operating losses, capital requirements and needs for additional funds; our ability to raise additional capital when needed and to continue as a going concern; our ability to manufacture, or otherwise secure the manufacture of, sufficient amounts of our product candidates for our preclinical studies and clinical trials; our clinical development plans, including planned clinical trials; our research and development plans; our ability to select combinations of phages to formulate our product candidates; our development of bacteriophage-based therapies; the potential use of bacteriophages to treat bacterial infections; the potential future of antibiotic resistance; the ability for bacteriophage therapies to disrupt and destroy biofilms and restore sensitivity to antibiotics; the potential for bacteriophage technology being uniquely positioned to address the global threat of antibiotic resistance; our planned development strategy, presenting data to regulatory agencies and defining planned clinical studies; the expected timing of additional clinical trials, including Phase 1b/Phase 2 or registrational clinical trials; our ability to manufacture and secure sufficient quantities of our product candidates for clinical trials; the drug product candidates to be supplied by us for clinical trials; the safety and efficacy of our product candidates; our anticipated regulatory pathways for our product candidates; the activities to be performed by specific parties in connection with clinical trials; our ability to successfully complete preclinical and clinical development of, and obtain regulatory approval of our product candidates and commercialize any approved products on our expected timeframes or at all; our pursuit of additional indications; the content and timing of submissions to and decisions made by the U.S. Food and Drug Administration (the "FDA") and other regulatory agencies; our ability to leverage the experience of our management team and to attract and retain management and other key personnel; the capacities and performance of our suppliers, manufacturers, contract research organizations ("CROs") and other third parties over whom we have limited control; our ability to staff and maintain our Los Angeles production facility under fully compliant current Good Manufacturing Practices ("cGMP"); the actions of our competitors and success of competing drugs or other therapies that are or may become available; our expectations with respect to future growth and investments in our infrastructure, and our ability to effectively manage any such growth; the size and potential growth of the markets for any of our product candidates, and our ability to capture share in or impact the size of those markets; the benefits of our product candidates; the potential market growth and market and industry trends; maintaining collaborations with third parties including our partnerships with the Cystic Fibrosis Foundation (the "CFF") and the U.S. Department of Defense (the "DoD"); potential future collaborations with third parties and the potential markets and market opportunities for product candidates; our ability to achieve our vision, including improvements through engineering and success of clinical trials; our ability to meet anticipated milestones in the development and testing of the relevant product; our ability to be a leader in the development of phage-based therapeutics; the expected use of proceeds from the $26.2 million DoD award; the effects of government regulation and regulatory developments, and our ability and the ability of the third parties with whom we engage to comply with applicable regulatory requirements; the accuracy of our estimates regarding future expenses, revenues, capital requirements and need for additional financing; our expectations regarding future planned expenditures; our ability to achieve and maintain effective internal control over financial reporting in accordance with Section 404 of the Sarbanes-Oxley Act; our ability to obtain, maintain and successfully enforce adequate patent and other intellectual property protection of any of our products and product candidates; our ability to protect our intellectual property, including pending and issued patents; our ability to operate our business without infringing the intellectual property rights of others; our ability to advance our clinical development programs; the effects of ongoing conflicts between Ukraine and Russia and in the Middle East, the recent and potential future bank failures or other geopolitical events; the potential economic and regulatory impacts on the biotechnology, pharmaceutical and drug manufacturing industries; the effects of artificial intelligence on our business and the industry as a whole; and statements of belief and any statement of assumptions underlying any of the items mentioned. These statements are based on estimates and information available to us at the time of this presentation and are not guarantees of future performance. Actual results could differ materially from our current expectations as a result of these risks and uncertainties, which include, without limitation, risks related to the ability of our lead clinical candidates, AP-PA02 and AP-SA02 (including any modifications thereto) to be more effective than previous candidates; our ability to enhance AP-PA02 to treat both CF and NCFB patients; our ability to develop products as expected; our expected market opportunity for our products; our ability to sufficiently fund our operations as expected, including obtaining additional funding as needed, and to refinance, repay or restructure its debt; and whether Armata will incur unforeseen expenses or liabilities. You should not rely upon forward-looking statements as predictions of future events. Although we believe that the expectations reflected in the forward-looking statements are reasonable, we cannot guarantee that the future results, levels of activity, performance or events and circumstances reflected in the forward-looking statements will be achieved or occur. Moreover, we undertake no obligation to update publicly any forward-looking statements for any reason to conform these statements to actual results or to changes in our expectations except as required by law. We refer you to the documents that we file from time to time with the Securities and Exchange Commission, including our most recently filed Annual Report on Form 10-K, Quarterly Reports on Form 10-Q and Current Reports on Form 8-K. These documents, including the sections therein entitled "Risk Factors," identify important factors that could cause the actual results to differ materially from those contained in forward-looking statements. In addition, this presentation also contains estimates, projections and other information concerning our industry, our business, and the markets for our product candidates, as well as data regarding market research, estimates and forecasts prepared by our management. Information that is based on estimates, forecasts, projections, market research or similar methodologies is inherently subject to uncertainties and actual events or circumstances may differ materially from events and circumstances reflected in this information. These statements are based upon information available to us as of the date of this presentation, and while we believe such information forms a reasonable basis for such statements, such information may be limited or incomplete, and our statements should not be read to indicate that we have conducted an exhaustive inquiry into, or review of, all potentially available relevant information.

Why is this the moment?

Armata is uniquely poised for success: Laser Focused Cost Effective Development of new class of antimicrobial agents

- Armata is on the verge of a scientific breakthrough that could change the future of antimicrobial treatment
  - DoW/MTEC and Innoviva saw this potential 4-5 years ago and embarked on a partnership to move this from concept phase to reality
  - **The Phase 3 superiority trial is the cumulation of that investment**
- Armata is the only company positioned to prove the efficacy of phage in the next decade
  - Focus on high potency high purity phage is the core differentiator of Armata compared to all the other phage companies
- Armata not only progressed rapidly through the Phase 1b/2a stage of development, but in parallel, moved into a 10K S.F. cGMP manufacturing facility to enhance the efficiency of fermentation and purification to dramatically increase production efficiency creating a pathway to full commercialization with low COGs
  - Recently Armata filed the manufacturing changes with the FDA along with full qualified release assays and core validated assays for potency

Phages Are a Novel Biologic Anti-Infectives with Distinct MOA from Antibiotics and Significant Advantages for the Fight Against AMR

Key Advantages of Phage Therapy

Novel therapeutic approach addresses increasing antibiotic-induced microbial resistance

Phage activity independent of antibiotic resistance, including MDR infections
Reduced antibiotic use slows broader resistance development

Agile development approach

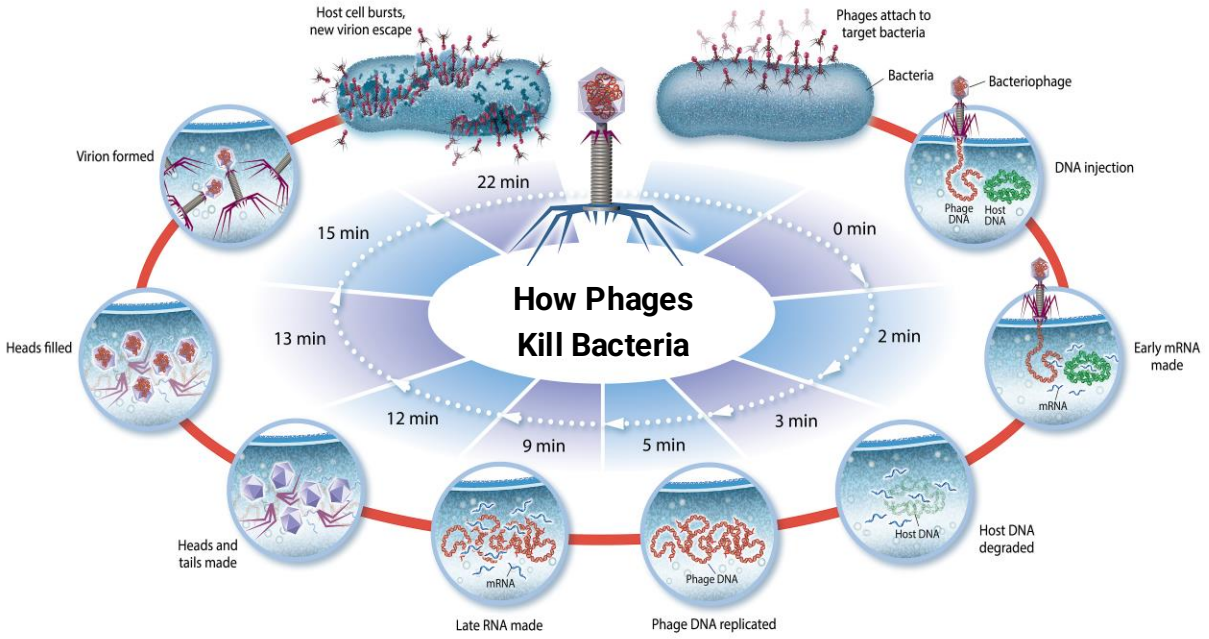
Potential for product modifications as clinical isolate landscape evolves, both during development and after launch

Potential monotherapy or in combination antibiotics

As alternative to, or synergistic to, current SOC

Safety benefits and long-term historical data

Species-specific, front-line therapy eliminates microbiome disruption that occurs with traditional antibiotics
Decades of published data for therapeutic use in Eastern Europe



AMR: Antimicrobial resistance; SOC: Standard of care

Consistent Progress on Clinical Programs for Critical Indications

Phage Evaluation via Randomized-Controlled Clinical Trials

	Product	Indication	Stage	Partner	Latest Clinical Results
Lead clinical program	**AP-SA02**	Complicated *Staphylococcus aureus* bacteremia	**EOP2 Complete: Advancing to Phase 3 Superiority Study**		**Phase 2a (diSArm): 100% clinical response rate** Statistically significant improvement over standard of care No treatment-related SAEs
Additional pipeline programs	**AP-SA02**	*S. aureus* prosthetic joint infections	IND Cleared		
	AP-PA02	Chronic *Pseudomonas aeruginosa* respiratory infections in NCFB	**Phase 2 complete (Tail*wind*)**		Monotherapy correlated with bacterial load reduction No treatment-related SAEs
	AP-PA02	Chronic *P. aeruginosa* respiratory infections in CF	**Phase 2a complete (SWARM-*P.a.*)**	CYSTIC FIBROSIS FOUNDATION	Well tolerated with consistent exposures by dose Bacterial load reduction in highest-dosed subjects
	AP-PA03	Acute *P. aeruginosa* respiratory infections: VAP	IND-Enabling		

ARMATA PHARMACEUTICALS

SWARM-*P.a.* NCT04596319; diSArm NCT05184764; Tail*wind* NCT05616221

Department of Defense (DoD) award received through the Medical Technology Enterprise Consortium (MTEC) and managed by the Naval Medical Research Command (NMRC) – Naval Advanced Medical Development (NAMD) with funding from the Defense Health Agency and Joint Warfighter Medical Research Program

CF: cystic fibrosis; NCFB: non-CF bronchiectasis; PJI: prosthetic joint infection; VAP: ventilator-associated pneumonia

Lead Program: AP-SA02 for Complicated *S. aureus* Bacteremia

Phase 1b/2a "diSArm" Study Design

Study Conduct

Phase 1b (n=8; 3:1): dose escalating

Phase 2a (n=42; 2:1): fully enrolled in <12 months

28 sites

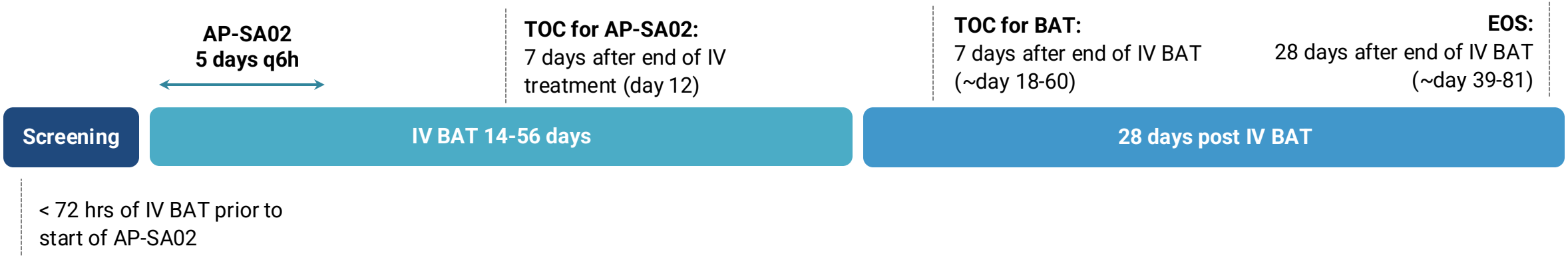
IV dosing every 6 hours for 5 days IV push + Antibiotics

ITT: All subjects that received BAT and >1 dose of AP-SA02 or Placebo (BAT only)

Phase 1b: Safety and tolerability of multiple intravenous (IV) doses of AP-SA02

Phase 2a: Clinical outcome (responder rate[1]) measured at:

- **Test of Cure (TOC) for AP-SA02:** one week following the end of IV treatment with AP-SA02 (day 12)
- **TOC for BAT:** one week following the end of IV BAT
- **End of Study (EOS)**: four weeks following the end of IV BAT



1 – responder defined as all these signs and symptoms resolved from screening: temperature, heart rate, respiratory rate, white blood cell count, systolic blood pressure, pain associated with infection site

Phase 2a Trial Demographics & Infection Site

Demographics	AP-SA02 (n=31)*	Placebo (n=16)*
Age (mean) +/- SD	54.8 +/- 14	52.6 +/-12
Sex Male (%)	22(71)	10(62)
BMI, mean +/- SD	29.8 +/- 7.8	28.5 +/-7.0
White n (%)	21 (67)	12 (75)
Black n (%)	8 (26)	2 (12)
Hispanic n (%)	12 (45)	5 (31)
MRSA n (%)	12 (39)	7 (44)

Site of Infections#, ITT population: All patients that received AP-SA02 or placebo	AP-SA02 (n=29)	Placebo (n=13)
	n (%)	n (%)
Septic Joint	4 (14)	3 (23)
Cellulitis	4 (14)	3 (23)
Osteomyelitis	9 (31)	4 (31)
Pneumonia	3 (10)	0 (0)
Sepsis	6 (21)	3 (23)
L-sided Endocarditis	2 (7)	0 (0)
R-sided Endocarditis	1(3)	1 (8)

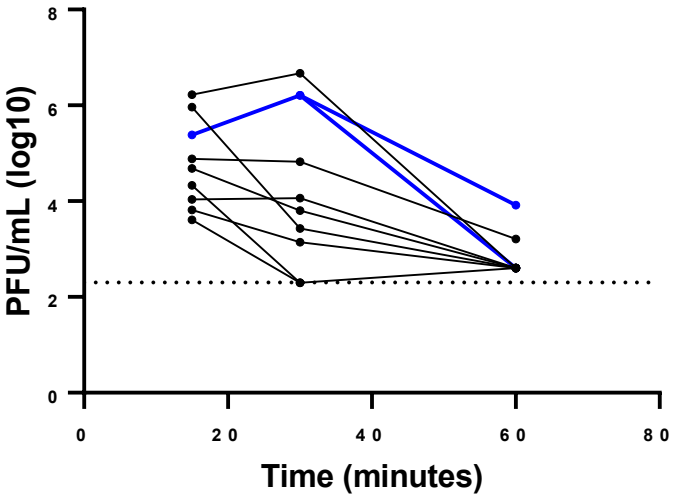
*includes all randomized from phase 2a trial, including not dosed

#phages were injected peripherally or through a central line and traveled through the intravascular space to the site of infections, penetrate the biofilm, infect the Staph bacteria, replicate within the Taph and burst killing the Staph, and self amplified independent of the site of infection

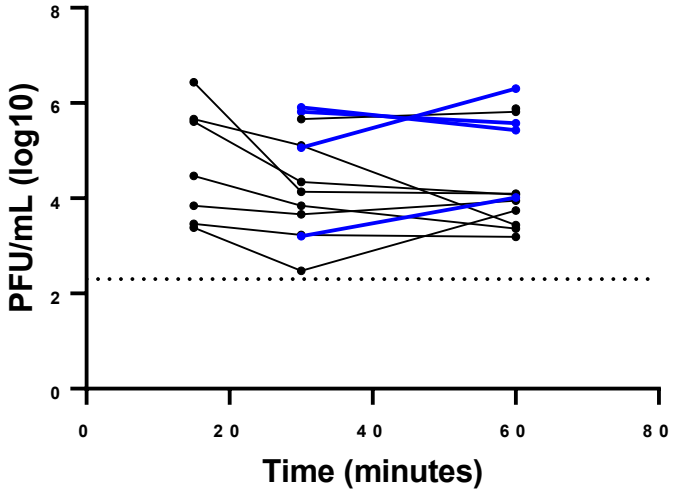
Evidence of AP-SA02 Amplification Observed Upon Dose Escalation to 5E10 PFU

50% of Patients Showed Persistence: Associated with Higher Bacterial Burden

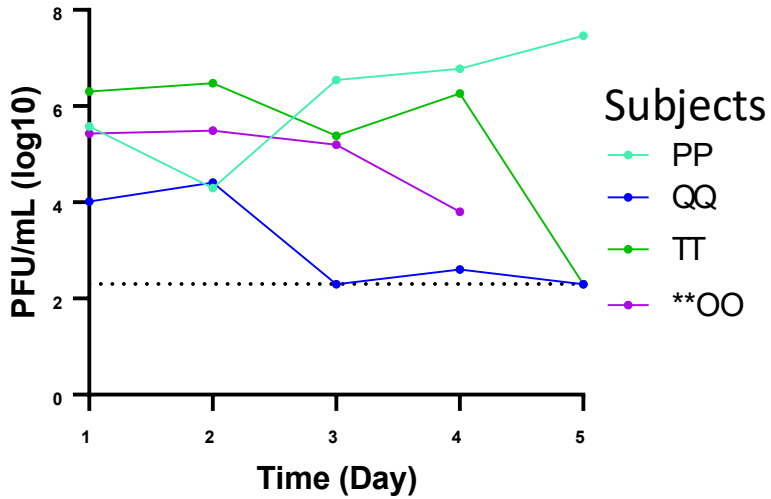
Clearance



Persistence



1 hour post dosing on d1-d5



10 patients were dosed with 5E10 PFU/dose; 6 with active drug (blue lines). 2/6 cleared phage rapidly, while 4/6 showed phage persistence.

4/4 that showed persistence were on the new PK sampling protocol.

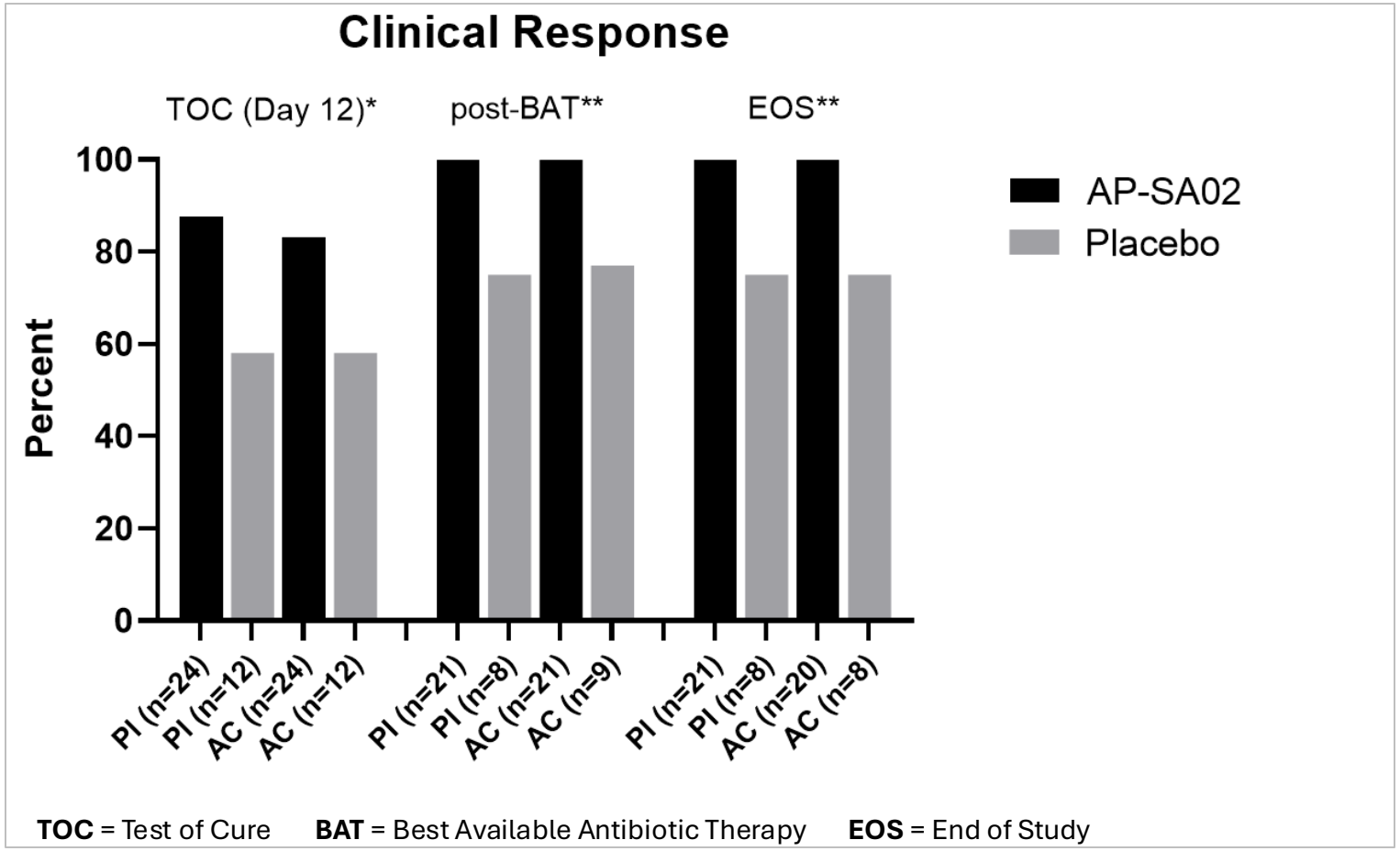
The phages are able to find, penetrate, and replicate, subsequently killing the persistent S. *aureus* despite 48-72 hours of antibiotic use

Phase 2a Trial BAT Antibiotics – phages were effective independent of the class or type of antibiotics

Antibiotics Used*	AP-SA02 (n=29) n (%)	Placebo (n=13) n (%)
Cefazolin	18 (62)	8 (62)
Vancomycin	12 (41)	6 (46)
Oxacillin/nafcillin	9 (31)	2(15)
Daptomycin	5 (17)	5 (38)
Cefepime	2 (7)	1(8)
Ceftriaxone	4 (14)	0 (0)

BAT = Best available therapy
*Some subjects received >1 antibiotic

AP-SA02 Phase 2a Met Endpoints and Showed Statistically Significant Improvement in Clinical Response



TOC = Test of Cure **BAT** = Best Available Antibiotic Therapy **EOS** = End of Study

* Blinded PI, p = 0.047

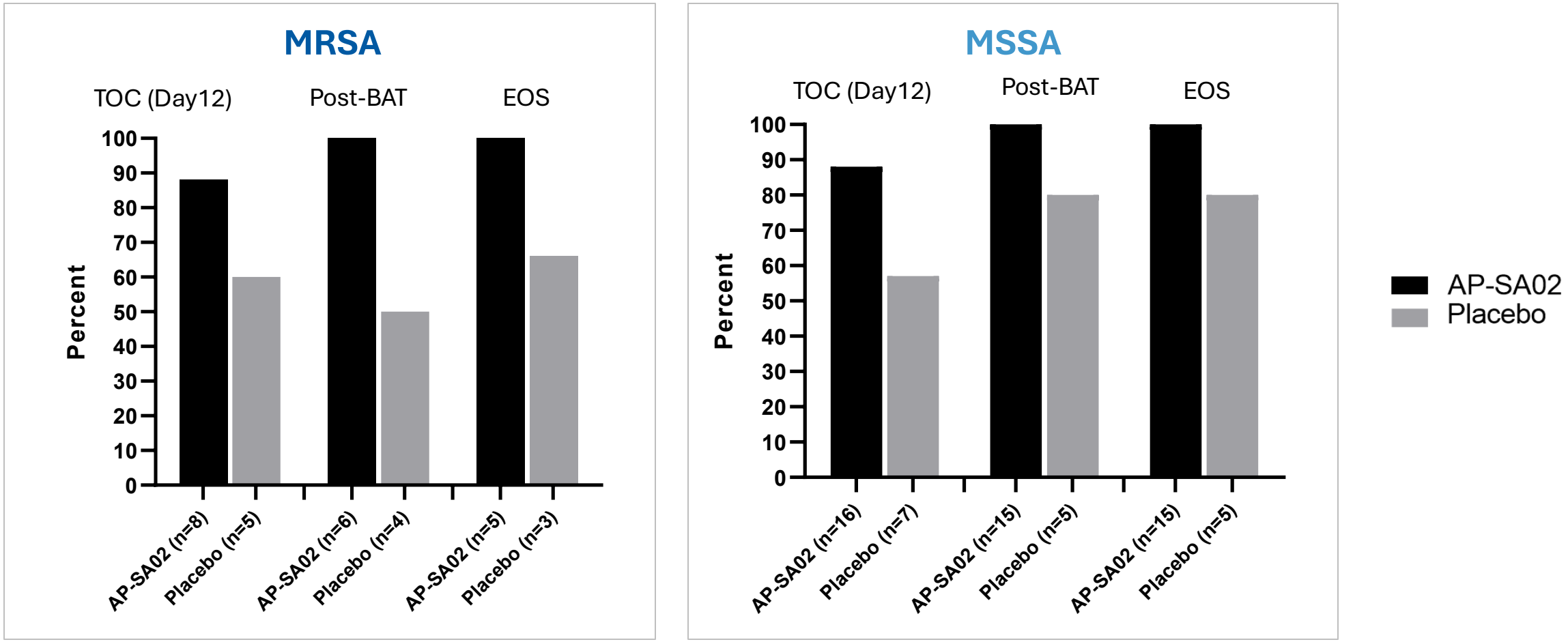
** p = 0.02 for Blinded PI & AC

PI = Principal Investigator

AC = Adjudication Committee

Responder defined as all these signs and symptoms resolved from screening: temperature, heart rate, respiratory rate, white blood cell count, systolic blood pressure, pain associated with infection site

Response in Subjects With MRSA Cleared Infection, No Evidence of Relapse



TOC = Test of Cure **BAT** = Best Available Antibiotic Therapy **EOS** = End of Study

Sensitivity Analysis of Missing Data

Conservative Data Handling Inflates Failure Rates in Both Arms to Greater Than Found in Other Phase 3 Studies but Preserves the Active Arm Advantage

- Missing data (discontinuation, lost to follow up, etc.) counted as non-responder

Missing Data = Non-responder

	Responder	Non-responder	Total	% Responder	% Non-responder
AP-SA02	21	8	29	72%	28%
Placebo	6	7	13	46%	54%

Results are the same at both 7 days post-BAT and at EOS (28 days post-BAT) under this imputation approach.

- 54% placebo non-responder rate exceeds expected range (~25-35%)
- Conservative approach inflates failure rates
  - Treatment effect remains directional consistent
- Sensitivity analysis supports not classifying missing data as non-response

Failure Rates in Previous SAB Trials

SAB Trial	Failure Rates
Phase 2 Exebacase (Placebo)[1]	33%
Phase 2 Exebacase (Active)[1]	35%
Phase 3 Exebacase (Placebo)[2]	27%
Phase 3 Exebacase (Active)[2]	35%
Phase 3 Ceftobiprole[3]	30%
Phase 3 Daptomycin[3]	31%
Armata Phase 2 SAB Trial	
Placebo	33%
AP-SA02	0%

1- J Clin Invest. 2020 Jul 1;130(7):3750-3760
2 - Clin Infect Dis 2024 Jun 14;78(6):1473-1481
3 - N Engl J Med. 2023 Oct 12;389(15):1390-1401

Sensitivity Analysis of Missing Data

Optimistic Data Handling Improves Failure Rates in Both And Preserves the Active Arm Advantage

- Missing data (discontinuation, lost to follow up, etc.) counted as responder

Optimistic Analysis Responder Rates

	Responder	Non-responder	Total	% Responder	% Non-responder
AP-SA02	29	0	29	100%	0%
Placebo	11	2	13	85%	15%

Results are the same at both 7 days post-BAT and at EOS (28 days post-BAT) under this imputation approach.

- 15% placebo non-responder rate lower than expected range (~25-35%)
- Optimistic approach underestimates failure rates
- Treatment effect remains directional consistent
- Optimistic analysis supports the robustness of the observed treatment effect (chi-squared p = 0.03)

AP-SA02 Showed Positive Clinical Trends

Including Reduction of Hospital Stays By 1 Week ($14K-$28K)

Clinical Trends	AP-SA02	Placebo
Time to hospital discharge: Mean Day (n)	11.7 (26)	19.2 (13)
Time to initial SAB resolution: Mean Day (n)	2.7 (25)	9.3 (12)
Mean CRP Day 12 mg/L (n)	50.2 (26)	97.3 (13)

Primary Diagnosis (Infection):

MSSA Sepsis: **A41.01**

MRSA Sepsis: **A41.02**

Secondary Diagnoses (Complications): Document and code any "complicated" manifestations, such as infective endocarditis (e.g., **I33.0**), osteomyelitis (e.g., **M86.-**), or septic arthritis. These often serve as **MCCs** (Major Complications or Comorbidities), which bump the DRG tier and increase reimbursement. *Note:* Uncomplicated bacteremia without systemic signs codes as **R78.81** (as secondary diagnosis), but will not generate a sepsis-level DRG

2. MS-DRG Grouping

MS-DRG 870: Septicemia or Severe Sepsis with **Mechanical Ventilation >96 Hours** (Highest relative weight).

MS-DRG 871: Septicemia or Severe Sepsis **with MCC**.

MS-DRG 872: Septicemia or Severe Sepsis **without MCC**.

3. Payment

Medicare payments are calculated by multiplying the MS-DRG'sRelative Weight (RW) by the hospital's specific base rate.

MS-DRG 871 (with MCC): Typically yields base payments ranging from **$19,000 to $22,000** per case.

MS-DRG 872 (without MCC): Drops significantly, typically yielding **$12,000 to $15,000** per case.

Note: Missing the MSSA/MRSA specification or failing to capture an MCC can lead to "downcoding" to DRG 872, resulting in thousands of dollars in lost revenue.

AP-SA02 Was Well Tolerated

AP-SA02 vs. Placebo: Safety & Tolerability (N=50)

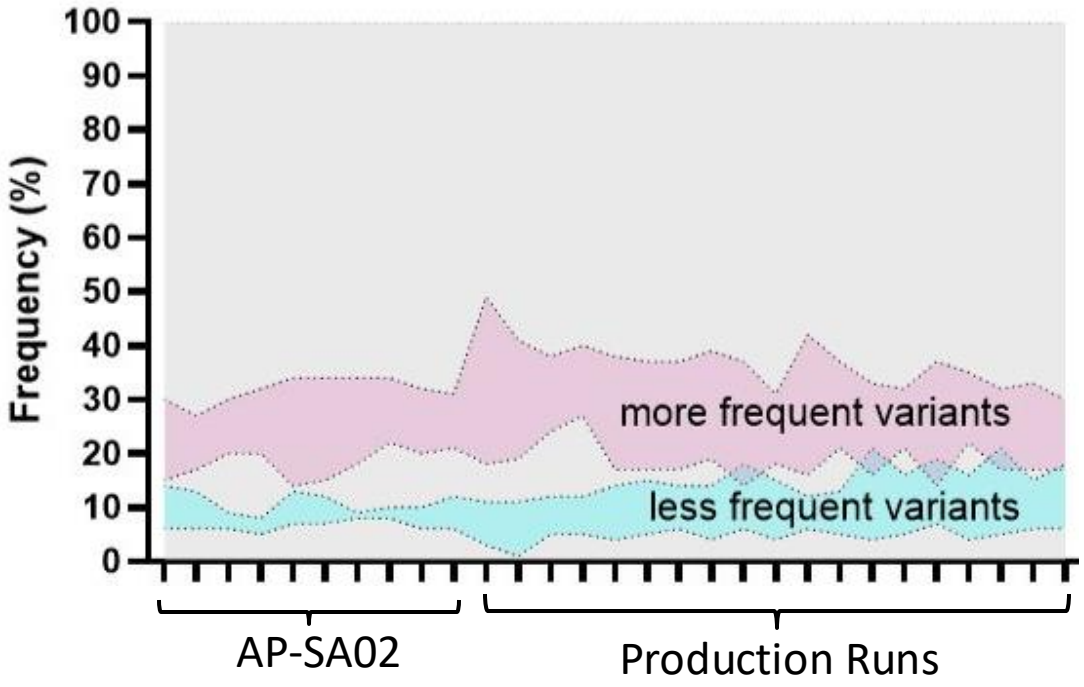
	Phase 1b Uncomplicated SAB		Phase 2a Complicated SAB	
	AP-SA02 (N=6)	Placebo (N=2)	AP-SA02 (N=29)	Placebo (N=13)
	n (%)	n (%)	n (%)	n (%)
Any adverse events (AEs)	6 (100)	2 (100)	19 (66)	12 (92)
Any treatment-emergent AEs (TEAEs)[1]	6 (100)	2 (100)	17 (59)	10 (77)
Any study drug related TEAEs	1 (17)[2]	0	1 (3)[3]	0
Any Best Available Therapy related TEAEs	3 (50)	0 (0)	4 (14)	3 (23)
Any serious AEs (SAEs)	5 (83)	1 (50)	4 (14)	3 (23)
NCI CTCAE Grade 3/4/5 AEs	5 (83)	1 (50)	9 (31)	9 (69)
NCI CTCAE Grade 3/4/5 TEAEs	5 (83)	1 (50)	8 (28)	7 (54)
Any TEAEs leading to interruption of study drug	1 (17)	0	0	0
Any TEAEs leading to withdrawal of study drug	0	0	0	1 (8)
Any TEAEs leading to discontinuation of study	0	0	1 (3)	0
Any AEs leading to death[4]	0	0	1 (3)	0

1. TEAEs are defined as adverse events (AEs) occurring after the first dose of AP-SA02 through TOC (Day 12) or through EOS for SAEs.
2. Concurrent with Vancomycin and resolved with discontinuation of Vancomycin.
3. Transient transaminitis (mean 386 U/L ALT, 316 U/L AST) began on Day 4, persisted through Day 7, and was returned to normal in next blood draw on Day 12.
4. Subject was blood culture negative for *S. aureus* by Day 3/5 of AP-SA02 treatment (8 days before death); fatal (unrelated) event of multiple organ failure determined by study PI to be unrelated to both study drug and vancomycin.

NCI CTCAE = National Cancer Institute Common Terminology Criteria for Adverse Events.

AP-SA02 Binds, Infects, and Lyses Patient Isolates *in vitro*

Genotypic mapping of ARSA0002 Phage

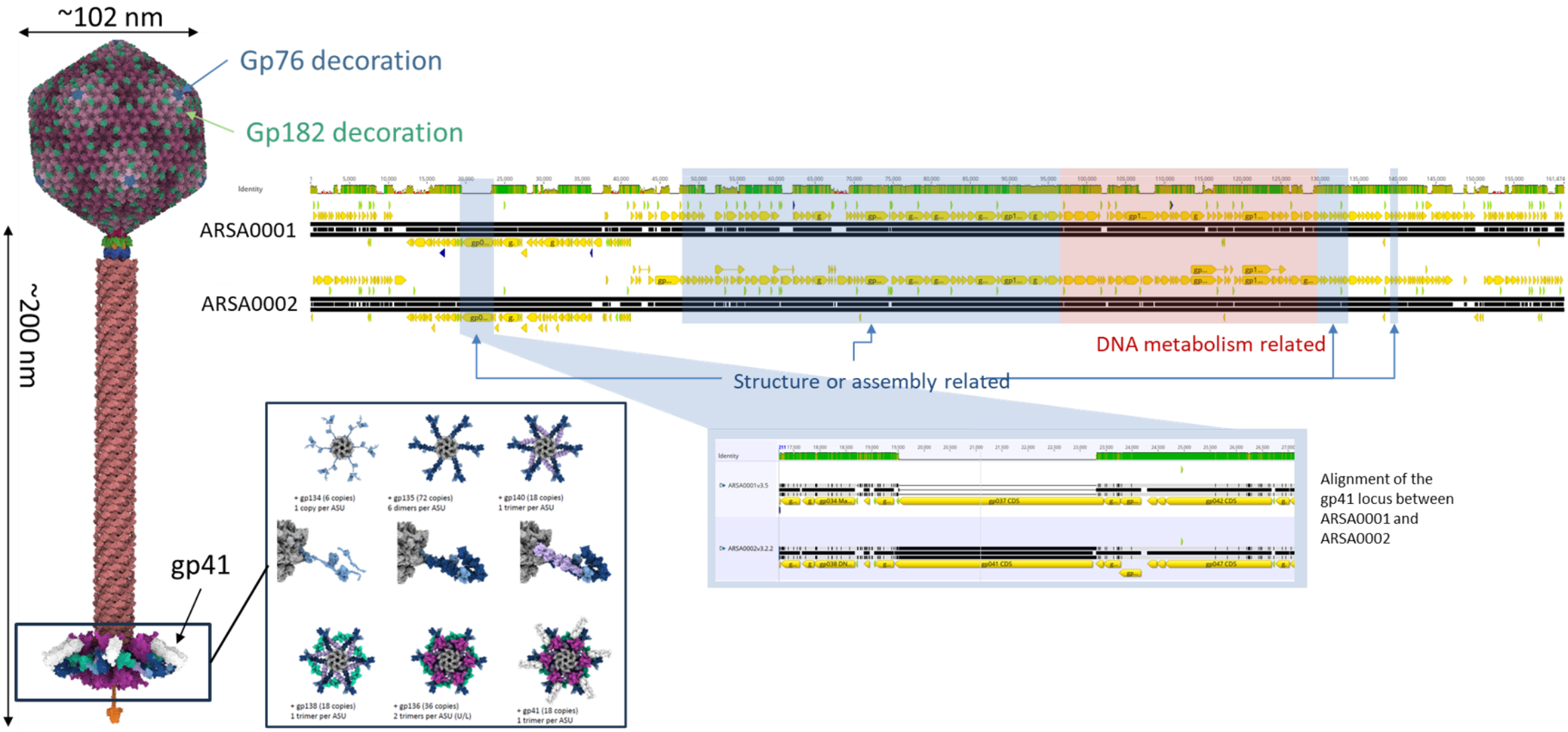


Genetic Variants of ARSA0002 Phage

Patient Isolates	More Frequent Variants			Less Frequent Variants		
	1	2	3	1	2	3
01	21	54	57	3	34	4
02	16	67	65	3	26	4
03	20	58	59	2	29	7
04	17	39	55	3	20	5
05	46		27	23	30	
06	46	20		51	42	
07	3	4	3	1		60
08			100			

Defined phage variants in the AP-SA02 drug product ensure an intrinsic adaptive mechanism — a flexibility that may be key to achieving effective phage therapy from patient to patient

Armata's Staph Phage: A Large and Complex Phage



Alignment of the gp41 locus between ARSA0001 and ARSA0002

Learnings from the Phase 2 Study

Summary

- ✓ Our phages are well-tolerated by repetitive IV push at 5e10 (every 6 hours for 5 days)
- ✓ Demonstrated homing
- ✓ Though injected IV only at one site, the phages homed to the source/site of *S. aureus* infection – independent of the source/site of infection (left- and right-sided endocarditis, septic joint, osteomyelitis)
- ✓ Demonstrated *in vivo* amplification and systemic recirculation (first time this has been demonstrated outside of a test tube or animal)
- ✓ One hour post infusion phages were found in the intravascular space at high levels
- ✓ Achieved microbiologic eradication in difficult-to-treat *S. aureus* infections that often result in amputation

FDA has Agreed that Phase 2 Results Support Advancing to Phase 3

U.S. FOOD & DRUG ADMINISTRATION

NIKUNJ SHARMA -S
Digitally signed by NIKUNJ SHARMA -S
Date: 2025.12.17 19:53:07 -05'00'

Division of Review Management and Regulatory Review (DRMRR)
Office of Vaccines Research and Review (OVRR)
Center for Biologics Evaluation and Research (CBER)

Written Response Only

Our Reference: Type B, End-of-Phase 2 (EOP2) Meeting;
IND 27972.27; Meeting ID: 21947

Clinical

Question 13:
Does the agency agree that the summarized Phase 2 efficacy data are sufficient to start a Phase 3 trial?

FDA Response:
We agree that the summarized Phase 2 efficacy data are sufficient to start a Phase 3 trial.

AP-SA02-301 Objectives N=450 with 300 full 7 days of treatment 95% power to detect a 15% difference at 0-05 alpha

- Primary endpoint
  - Use of Ph2 efficacy endpoint – clinical response[1] is resolution of all signs and symptoms associated with bacteremia and negative blood culture
  - Clinical response composite[2] using 7 and 28 days post BAT
- Secondary endpoints
  - Clinical response at day 14 (TOC)
  - Time to sustained microbiological eradication
- Tertiary objectives
  - Hospital utilization days
  - Staph specific mortality at day 14, 7 days post BAT and/or 28 days post BAT
  - Health resource utilization
  - MRSA specific clinical response
  - Participant self-assessment of improvement
  - Full AP-SA02 exposure on primary and secondary endpoints using the per protocol population

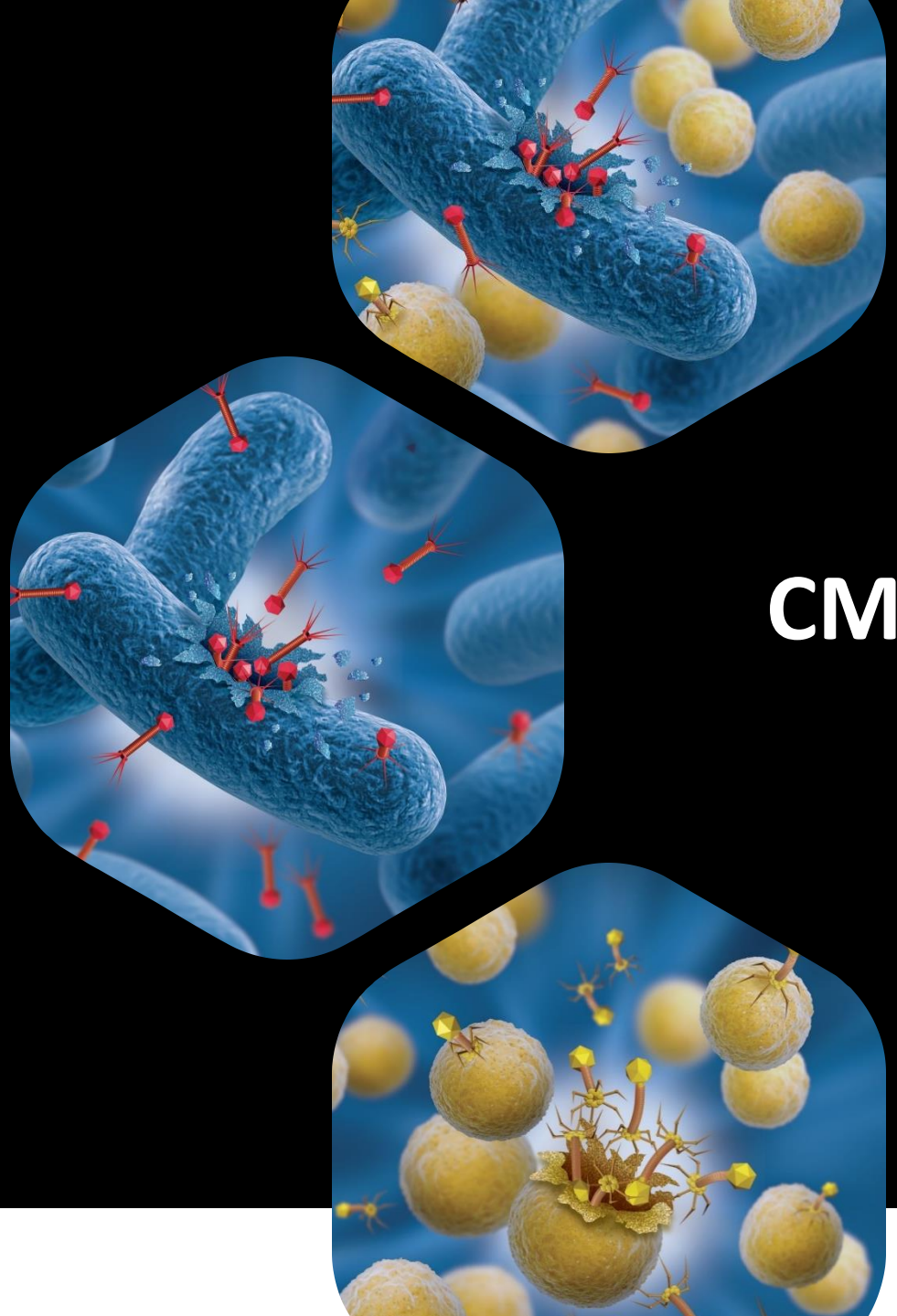
1 – responder defined as all these signs and symptoms resolved from screening: temperature, heart rate, respiratory rate, white blood cell count, systolic blood pressure, pain associated with infection site
2 - clinical response status based on the assessment at 28 days post-BAT takes precedence; if the data at this time point are missing, the assessment at 7 days post-BAT can be used

BAT: Best available therapy; TOC: test of cure (1 week following the end of IV treatment with AP-SA02)

Regulatory Operations for *S. aureus* Bacteremia

Status of Critical Items

CBER Submission	Submission Date	Status
Qualified Infectious Disease Product (QIDP) Designation	Dec 23, 2025	**Granted February 20, 2026**
Fast Track Designation	March 11, 2026	**Granted May 5, 2026**
Initial Pediatric Study Plan (iPSP): Request for Deferral	Feb 17, 2026	**Agreement on Agreed iPSP July 10, 2026**
Phase 3 Protocol	June 29, 2026	Under review by FDA
Responses to EOP2 Meeting WRO	July 7, 2026	Complete Clinical, CMC, Regulatory responses under review by FDA
CMC Amendment	July 7, 2026	Revised Module 3 documents under review by FDA



CMC

- State of the art science translated to high efficiency manufacturing
- Focused on our unique capacity to produce high titer functional phage with high purity at low COGs
- Full in-house capacity ensures product quality while controlling costs
- Current US space supports late-stage clinical development and full commercialization
- Plan to produce commercial lots during the pivotal trial shortening time to BLA

Qualification and Validation Status of QC Release Assays

Test	Method	Status
Potency		Validated
Content Uniformity		Qualified
		Qualified
Identification		Validated
Total Protein		Qualified
Characterization		Qualified
Purity		Validated
		Qualified
		Qualified
		Qualified
		Qualified
		Qualified
		Qualified
		Qualified
pH		Verified*
Osmolality		Verified*
Endotoxin		Verified*
Bioburden		Outsourced
Particulate Matter		Outsourced
Sterility		Outsourced

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*USP methods only need to be verified; equivalent to “validated”

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