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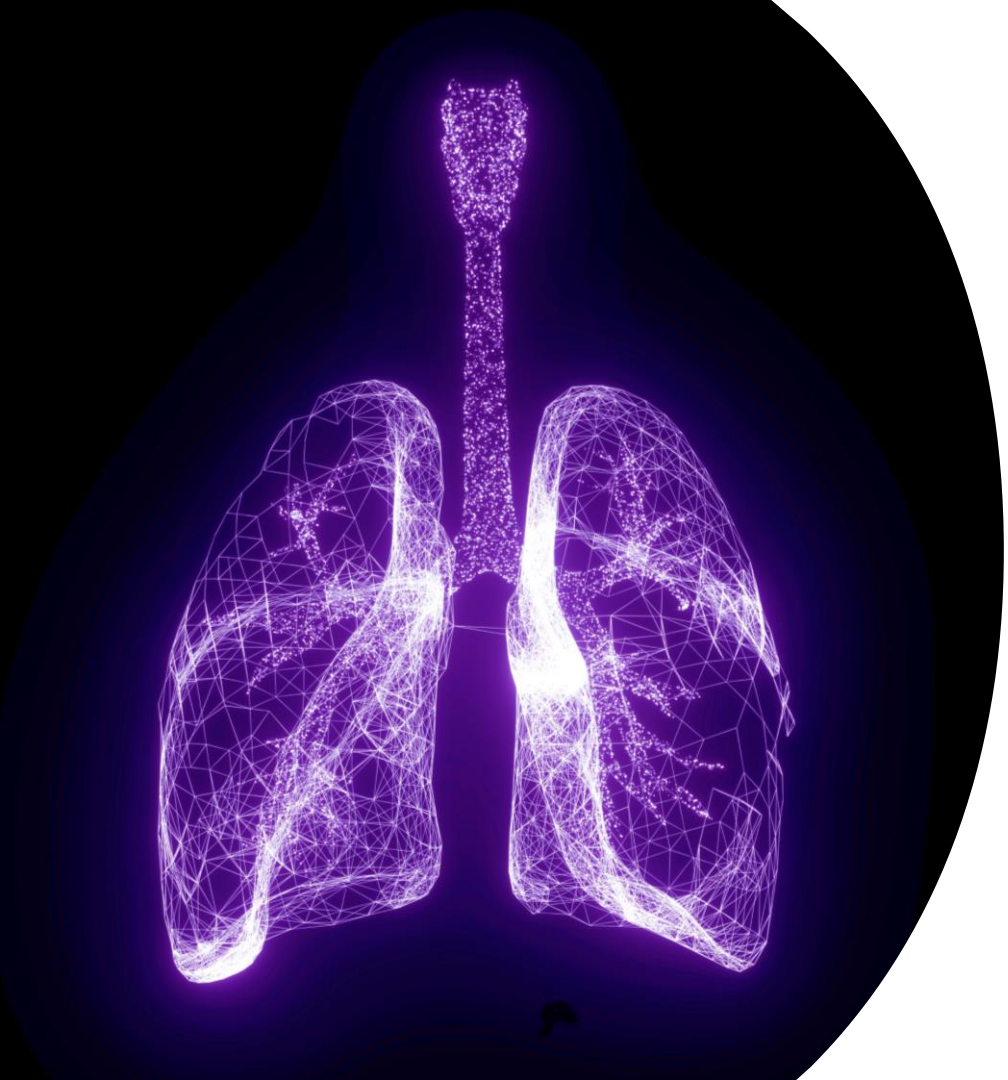

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American Thoracic Society

Sanofi Investor Call

Washington, D.C.

May 22, 2023

Forward-looking statements

This document contains forward-looking statements as defined in the Private Securities Litigation Reform Act of 1995, as amended. Forward-looking statements are statements that are not historical facts. These statements include projections and estimates and their underlying assumptions, statements regarding plans, objectives, intentions and expectations with respect to future financial results, events, operations, services, product development and potential, and statements regarding future performance. Forward-looking statements are generally identified by the words "expects", "anticipates", "believes", "intends", "estimates", "plans" and similar expressions. Although Sanofi's management believes that the expectations reflected in such forward-looking statements are reasonable, investors are cautioned that forward-looking information and statements are subject to various risks and uncertainties, many of which are difficult to predict and generally beyond the control of Sanofi, that could cause actual results and developments to differ materially from those expressed in, or implied or projected by, the forward-looking information and statements. These risks and uncertainties include among other things, the uncertainties inherent in research and development, future clinical data and analysis, including post marketing, decisions by regulatory authorities, such as the FDA or the EMA, regarding whether and when to approve any drug, device or biological application that may be filed for any such product candidates as well as their decisions regarding labelling and other matters that could affect the availability or commercial potential of such product candidates, the fact that product candidates if approved may not be commercially successful, the future approval and commercial success of therapeutic alternatives, Sanofi's ability to benefit from external growth opportunities, to complete related transactions and/or obtain regulatory clearances, risks associated with intellectual property and any related pending or future litigation and the ultimate outcome of such litigation, trends in exchange rates and prevailing interest rates, volatile economic and market conditions, cost containment initiatives and subsequent changes thereto, and the impact that pandemics or other global crises may have on us, our customers, suppliers, vendors, and other business partners, and the financial condition of any one of them, as well as on our employees and on the global economy as a whole. The risks and uncertainties also include the uncertainties discussed or identified in the public filings with the SEC and the AMF made by Sanofi, including those listed under "Risk Factors" and "Cautionary Statement Regarding Forward-Looking Statements" in Sanofi's annual report on Form 20-F for the year ended December 31, 2022. Other than as required by applicable law, Sanofi does not undertake any obligation to update or revise any forward-looking information or statements.

Agenda

American Thoracic Society - Sanofi Investor Call

01 Leadership in immunology

Dietmar Berger, MD, PhD
Global Head of R&D ad interim

02 Lead with Dupixent® in Type 2

Elizabeth Laws, PhD
Global Program Head, Dupixent®

03 Dupixent® BOREAS data in COPD

Surya Bhatt, MD, MSPH
Associate Professor of Medicine, University of Alabama at Birmingham

Klaus F. Rabe, MD, PhD, FERS
Professor of Medicine, LungenClinic Großhansdorf, Germany

04 Q&A (Part 1)

05 Expand and disrupt beyond Type 2

Naimish Patel, MD
Therapeutic Area Head, Immunology & Inflammation

06 Unlock sustainable growth in Immunology

Bill Sibold,
Executive Vice President, Specialty Care

07 Q&A (Part 2)

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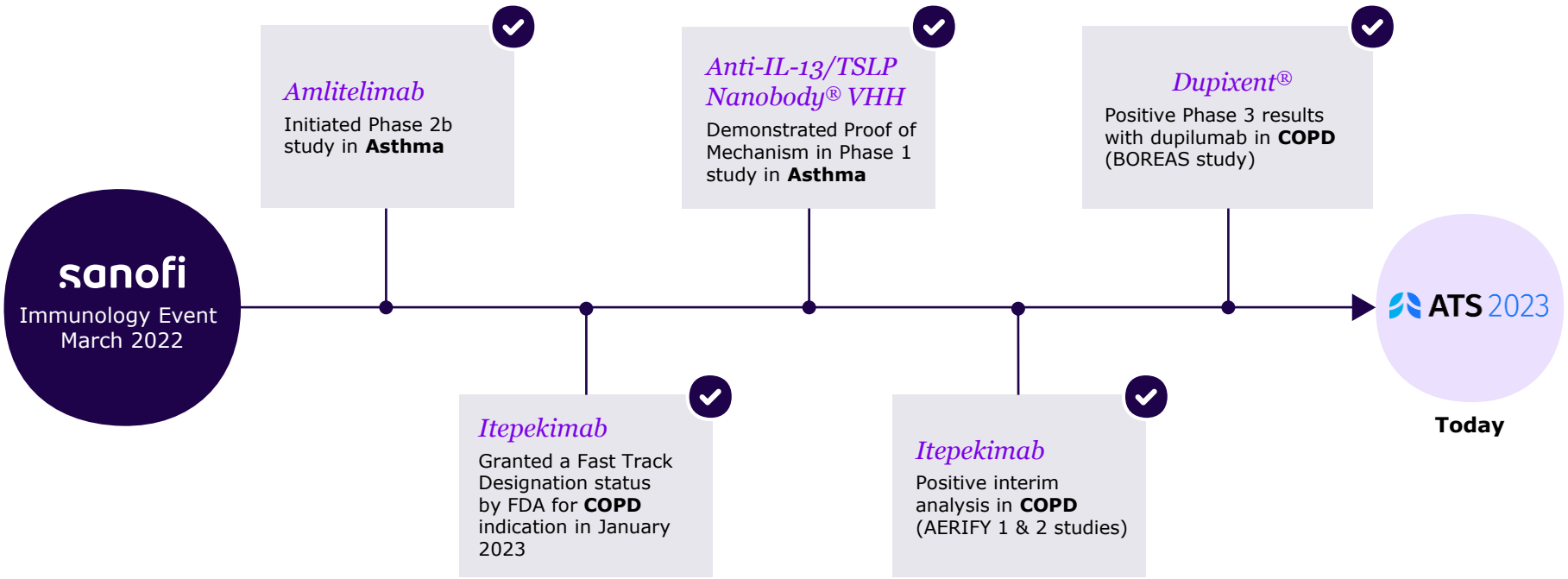
Leadership in immunology

Dietmar Berger MD PhD

Global Head of R&D ad interim

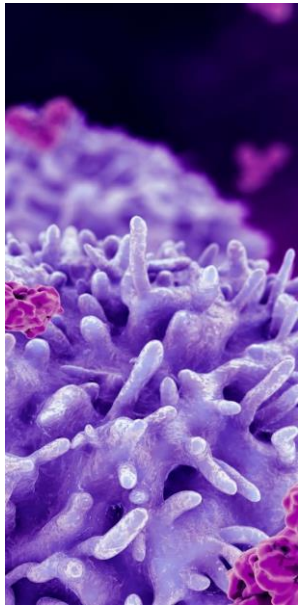
Key *Respiratory development milestones* since March 2022



Dupixent® is jointly developed and co-commercialized with Regeneron. Itepekimab is being developed in collaboration with Regeneron.

Strong *immunology pipeline with 12 novel molecules* to build and expand in leading franchise

		Orals	*Injectables*
Dermatology	AD	rilzabrutinib (BTKi) IRAK4 degrader	Dupixent® amlitelimab (anti-OX40L)
	CSU	rilzabrutinib (BTKi)	Dupixent®
	Psoriasis	Oral TNF inhibitor	
Respiratory	Asthma	rilzabrutinib (BTKi)	Dupixent® amlitelimab (anti-OX40L) Anti-IL-13/TSLP Nanobody® VHH
	COPD		Dupixent® itepekimab (anti-IL-33)
Gastroenterology	EoE		Dupixent®
	EG		Dupixent®
	UC	eclitasertib (RIPK1i)	Dupixent® non-beta IL-2 (Synthorin® compound)
Autoimmune	Lupus	eclitasertib (RIPK1i)	frexalimab (anti-CD40L) Anti-CD38 mAb Next Generation



Dupixent® is jointly developed and co-commercialized with Regeneron. Itepekimab is being developed in collaboration with Regeneron.
Dupixent® is under investigation in CSU, COPD, EG and UC and not yet approved by any regulatory agency to treat these indications. All other agents described above are in clinical development and the safety/efficacy has not been established nor reviewed by any regulatory agency.

Ambition to *transform the practice of medicine* in Respiratory

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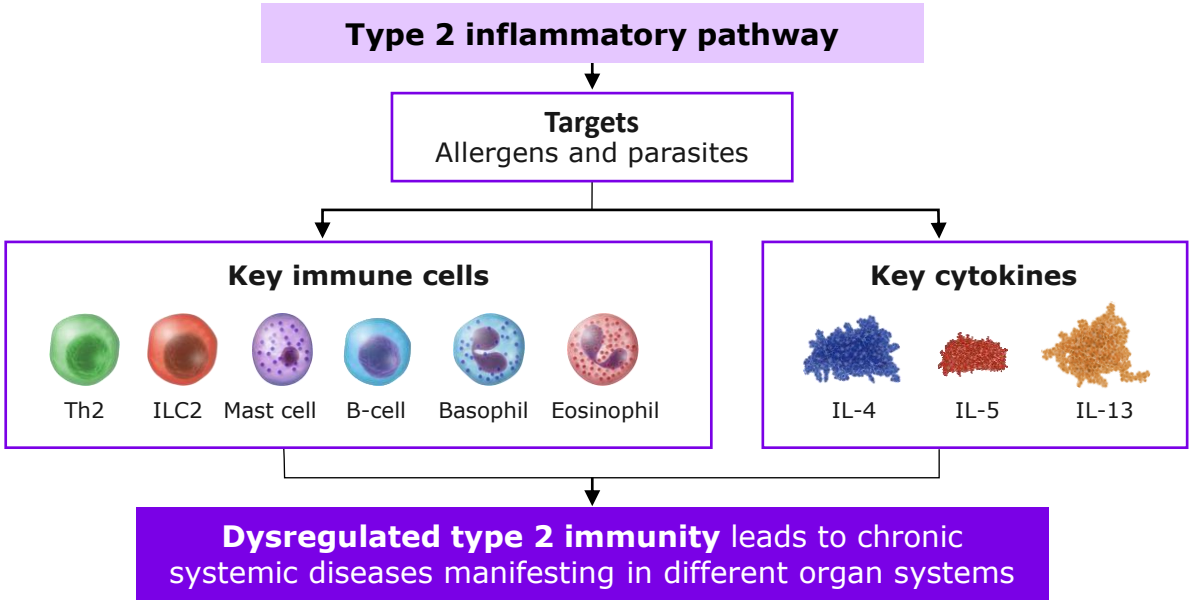
Lead with Dupixent® in Type 2

Elizabeth Laws, PhD

Global Program Head, Dupixent

Tackling *Type 2* inflammatory disease



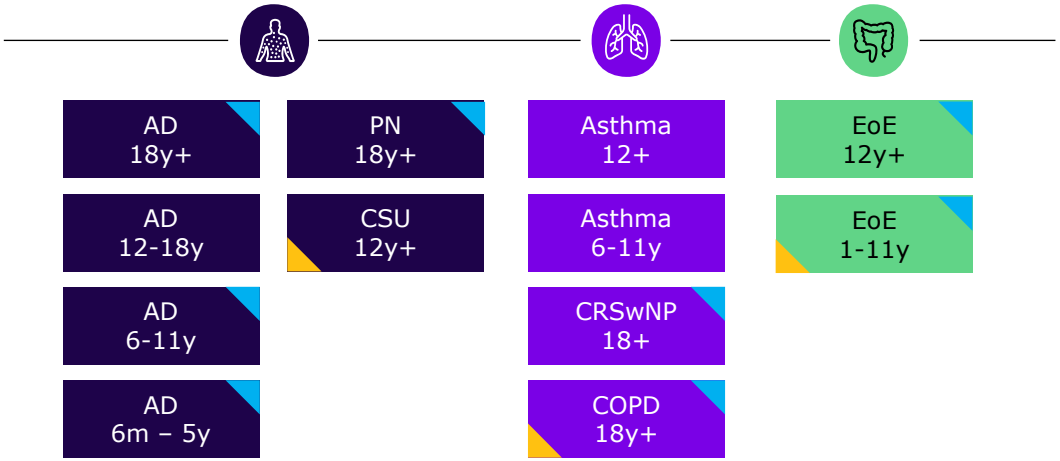
Gandhi NA, et al. Targeting key proximal drivers of type 2 inflammation in disease. Nat Rev Drug Discov. 2016; 15(1): 35–50. McCormick J, et al. Insights into the Implications of Coexisting Type 2 Inflammatory Diseases. J Inflamm Res. 2021; 4: 4259–4266

Leadership strategy

- Lead with science
- Focus on highest unmet need with first-in-class and best-in-class opportunities
- Anchor on strategic pillars
- Be bold and execute with relentless speed

Lead with *Dupixent®* in Type 2

Positive pivotal data across *12 indications* in Dermatology, Respiratory, and Gastroenterology



Studies in 7 additional indications ongoing:

BP, CPUO, UC, EG, Peds (Asthma, PN, CSU)

Dupixent® is under investigation and not yet approved by any regulatory agency to treat these indications

First-in-Class biologics

Efficacy & safety data across multiple Type 2 indications

- 60+ clinical trials with 10,000+ patients
- Safety data up to 5 years
- 1st FDA approval March 2017
- Approved in children as young as 6 months
- More than 600,000 patients on therapy globally

COPD – *Following the science* with decisive actions

Direct-to-Phase 3 program
Investment de-risked with interim analysis

IL4/IL13 plays a mechanistic role in pathologic processes in Type 2 COPD

Prior data support **Type 2 COPD** guided by eosinophils

DUPIXENT® (dupilumab)

Patient population optimized based on IL-5 learnings

Targeting differential efficacy for FiC/BiC

High unmet need with no approved biologics

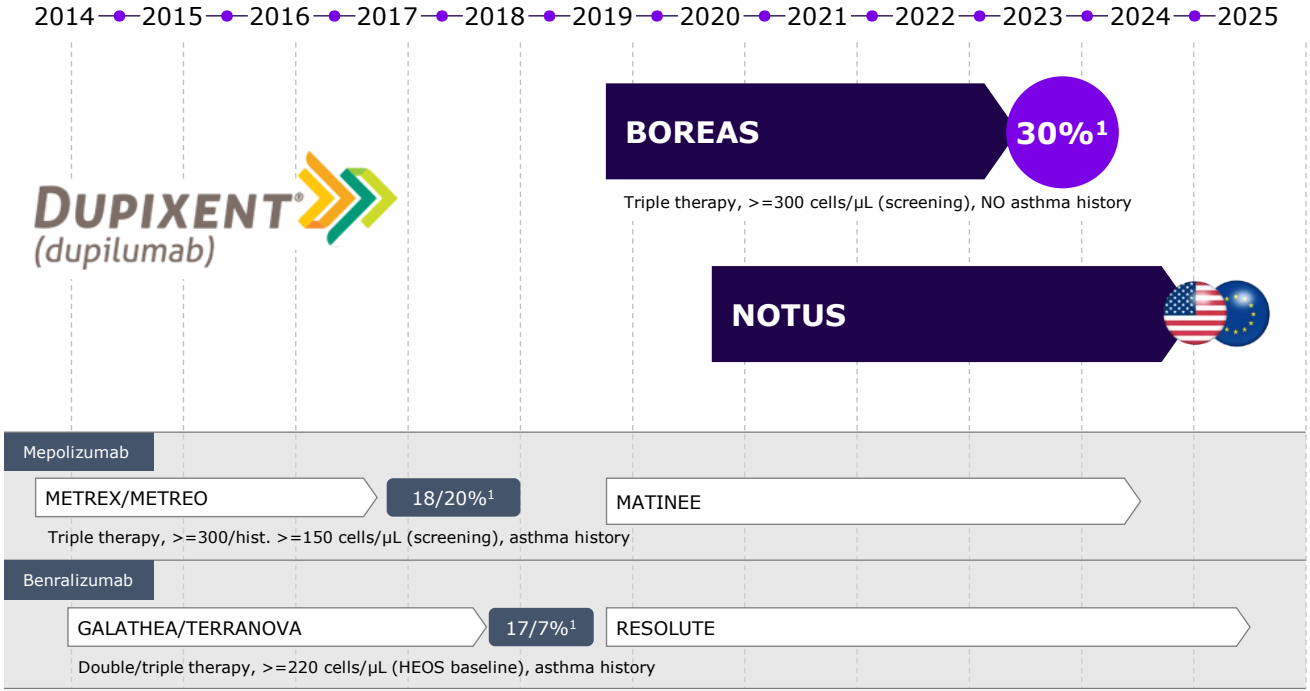
- 3rd leading cause of death WW, COPD carries a severe burden and leads to progressive loss of lung function
- Typically treated with inhaled bronchodilators and steroids -"one size fits all" therapies with small treatment effects

Potential to be first- and best-in-class

Opportunity to reinforce respiratory market leadership

Dupixent® is under investigation in COPD and not yet approved by any regulatory agency to treat this indication.

Dupixent®: *Best-in-class execution* in COPD



1. Reduction in annualized rate in exacerbation vs. placebo
Dupixent® is under investigation in COPD and not yet approved by any regulatory agency to treat this indication. HEOS: High peripheral blood eosinophils (cutoff in cells/µL noted)

Pivotal program resulting in outstanding performance

- BOREAS recruited as many as 500 patients during COVID pandemic
- Highly significant and clinically meaningful improvement in exacerbations, lung function, quality of life, and symptoms
- NOTUS recruitment completed and on track for readout in 2024

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Dupilumab for COPD with Type 2 Inflammation Indicated by Eosinophil Counts

S.P. Bhatt, K.F. Rabe, N.A. Hanania, C.F. Vogelmeier, J. Cole, M. Bafadhel, S.A. Christenson, A. Papi, D. Singh, E. Laws, L.P. Mannent, N. Patel, H.W. Staudinger, G.D. Yancopoulos, E.R. Mortensen, B. Akinlade, J. Maloney, X. Lu, D. Bauer, A. Bansal, L.B. Robinson, and R.M. Abdulai, for the BOREAS Investigators*

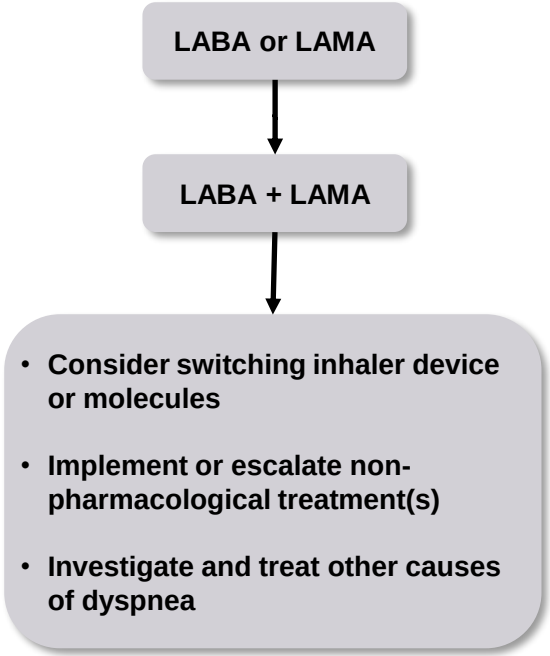
Background

- 50% of patients continue to have persistent symptoms and exacerbations despite optimization of existing therapy
- COPD exacerbations are associated with:
  - Increased risk of subsequent exacerbations
  - Lung function decline
  - High morbidity and increased risk of all-cause mortality

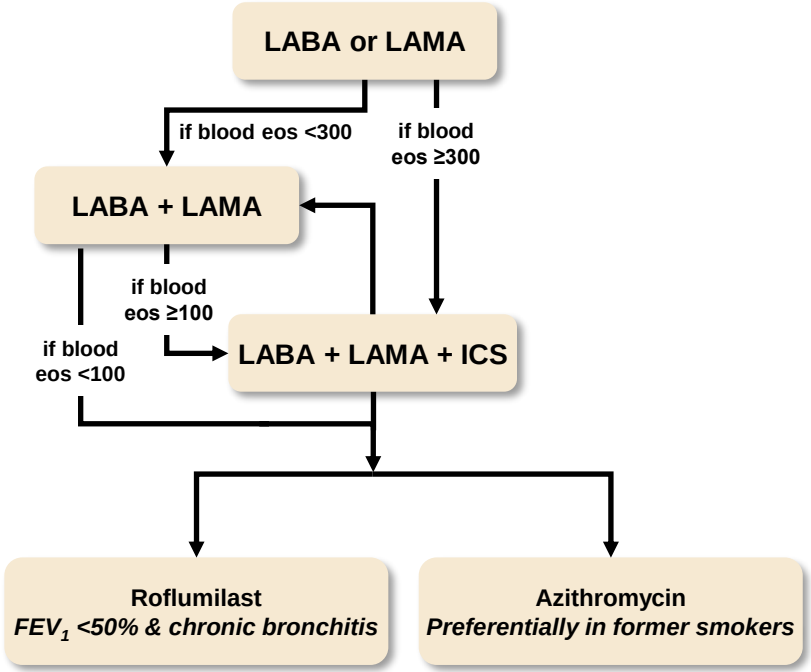
A subgroup of COPD patients have an unmet need for therapies that further reduce exacerbations and improve lung function

Pharmacological Treatment for COPD

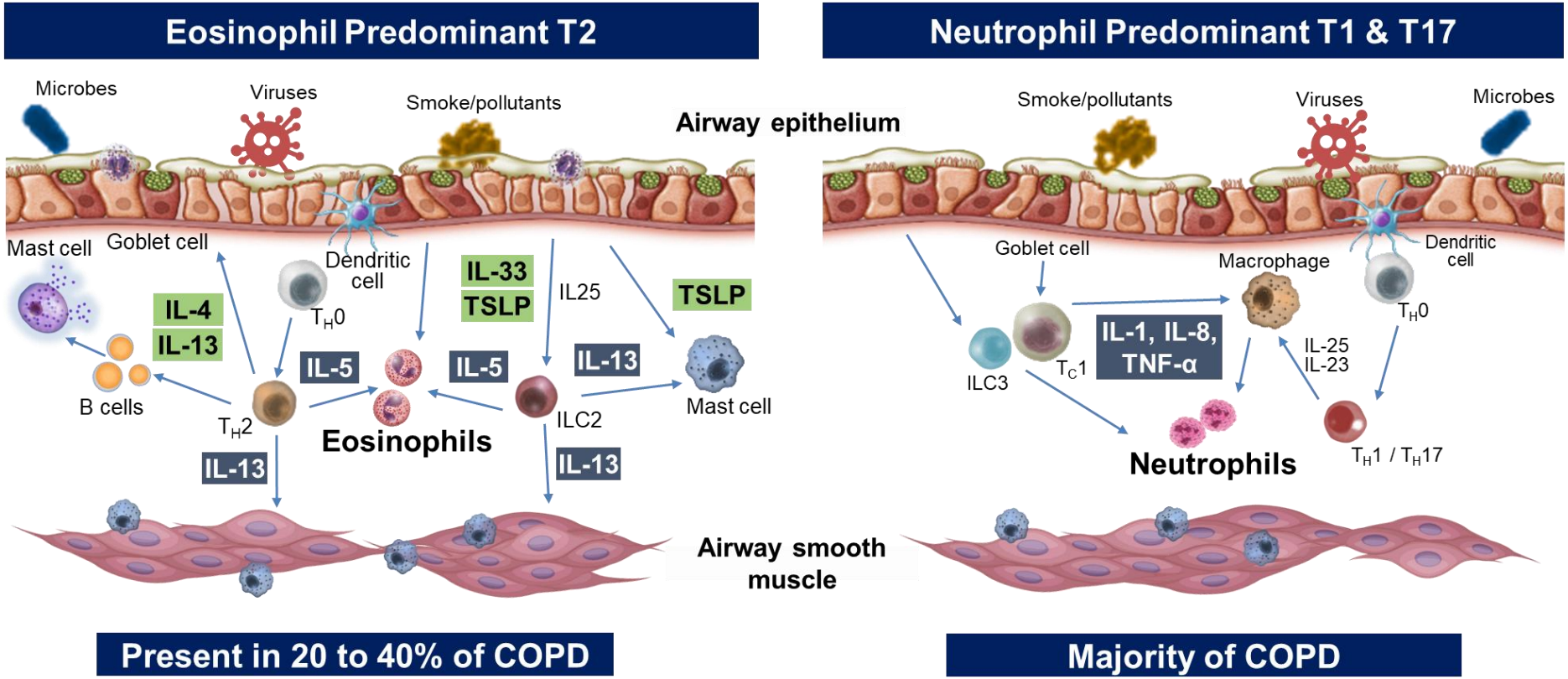
DYSPNEA



EXACERBATIONS



COPD Endotypes: “Type 2 High”



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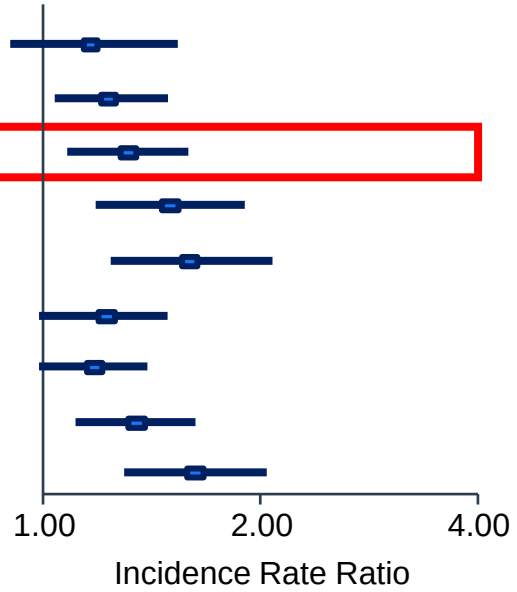
COPD with Type 2 Inflammation is Associated with More Frequent COPD Exacerbations: The COPDGene Study

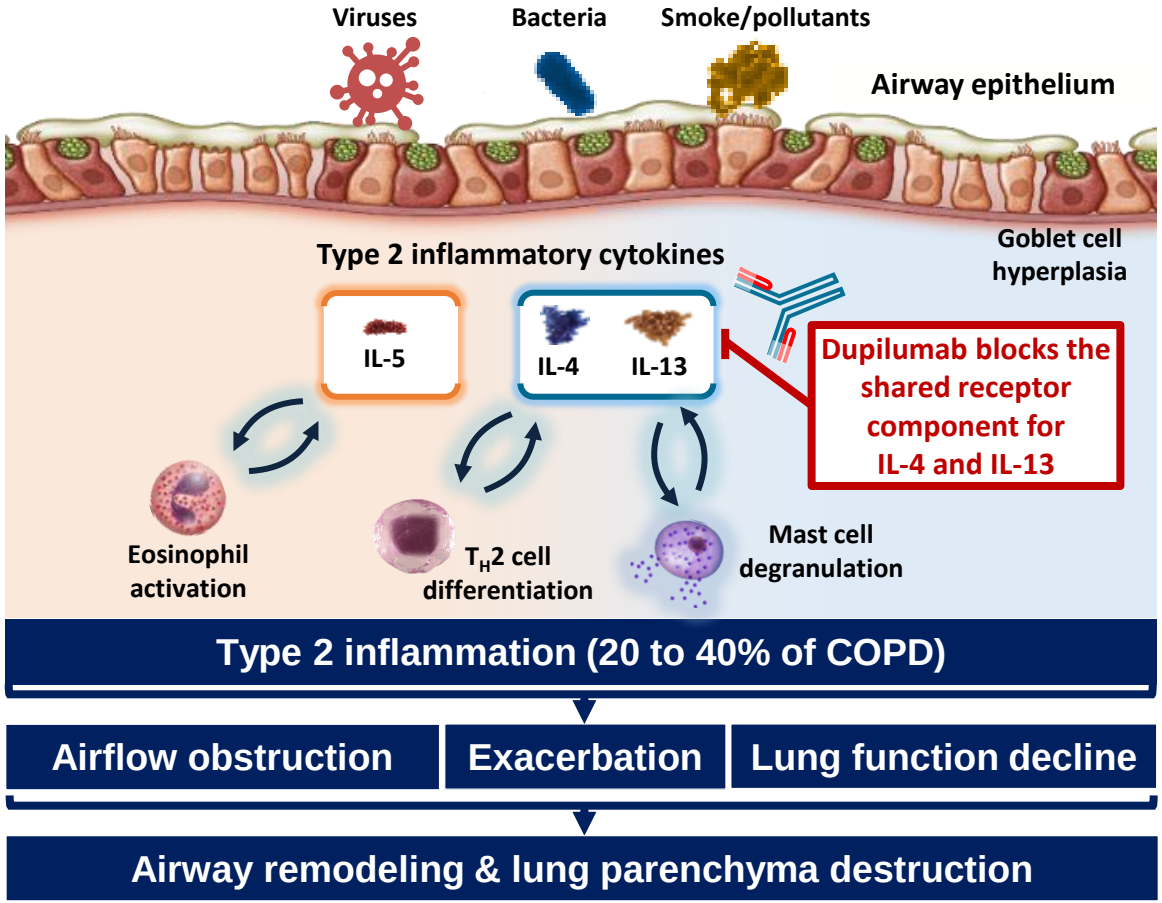
Eosinophil cut-off	<n	≥n	IRR	95% CI
100 cells/μL	223	1330	1.16	0.90–1.52
200 cells/μL	814	739	1.24	1.04–1.48
300 cells/μL	1187	366	1.32	1.08–1.61
340 cells/μL	1350	203	1.50	1.18–1.91
400 cells/μL	1398	155	1.60	1.24–2.08
2%	408	1145	1.22	0.99–1.50
3%	859	694	1.18	0.99–1.40
4%	1166	387	1.35	1.11–1.63
5%	1334	219	1.63	1.30–2.05



A blood eosinophil cut-off of 300 cells/μL identified a subgroup of ~20% of the study population who were at risk of frequent exacerbations

Yun JH, et al. J Allergy Clin Immunol. 2018;141:2037–2047

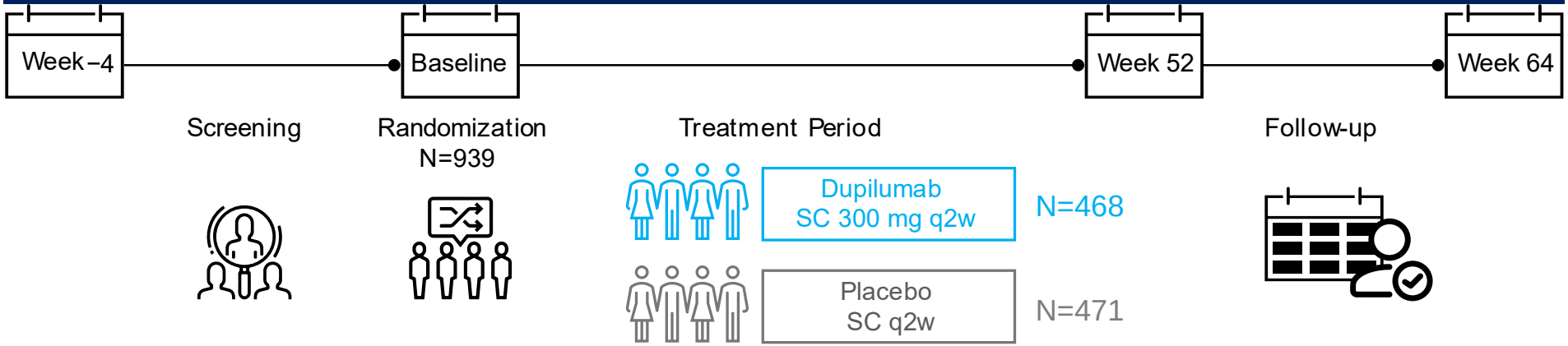
Dupilumab Mechanism of Action



Le Floc'h A, et al. Allergy. 2020

BOREAS Clinical Trial Design (NCT03930732)

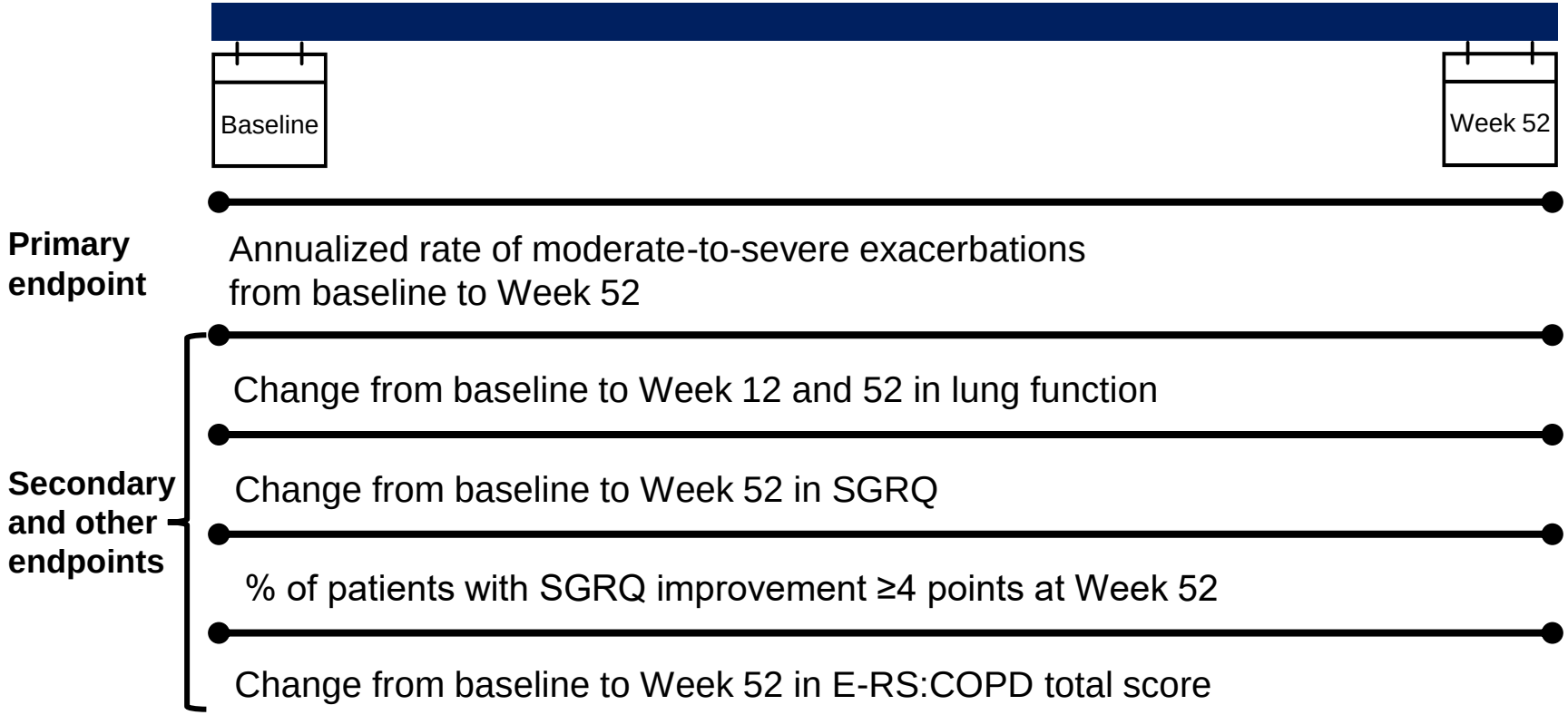
A Randomized, Double-Blind, Placebo-Controlled, Parallel-Group, Multicenter, Phase 3 Study to Evaluate the Efficacy and Safety of Dupilumab Administered Every 2 Weeks in Patients with Moderate or Severe COPD with Type 2 Inflammation



BOREAS Eligibility Criteria

- **Key inclusion criteria**
  - Aged ≥40 to ≤80 years
  - Physician diagnosis of moderate-to-severe COPD
  - History of high exacerbation risk: ≥2 moderate or ≥1 severe exacerbation(s) within the year prior to screening
  - Background triple inhaler therapy (ICS+LAMA+LABA) for at least 3 months prior to randomization with a stable dose for ≥1 month prior to screening; dual therapy (LABA + LAMA) allowed if ICS contraindicated
  - Self-reported signs and/or symptoms of chronic bronchitis for 3 months in the year prior to screening
  - Blood eosinophil count ≥300 cells/μL at the screening visit
  - Current or former smokers with ≥10 pack years smoking history (current smokers capped at 30%)
- **Key exclusion criteria**
  - COPD diagnosis for <12 months
  - Current diagnosis or prior history of asthma
  - Significant pulmonary disease other than COPD

Primary, Secondary, and Other Endpoints



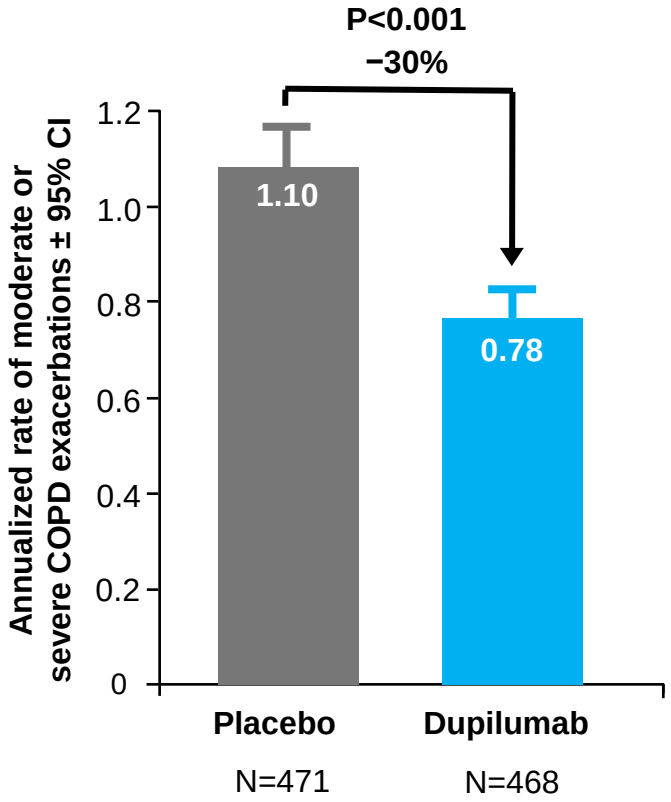
Baseline Demographics and Disease Characteristics

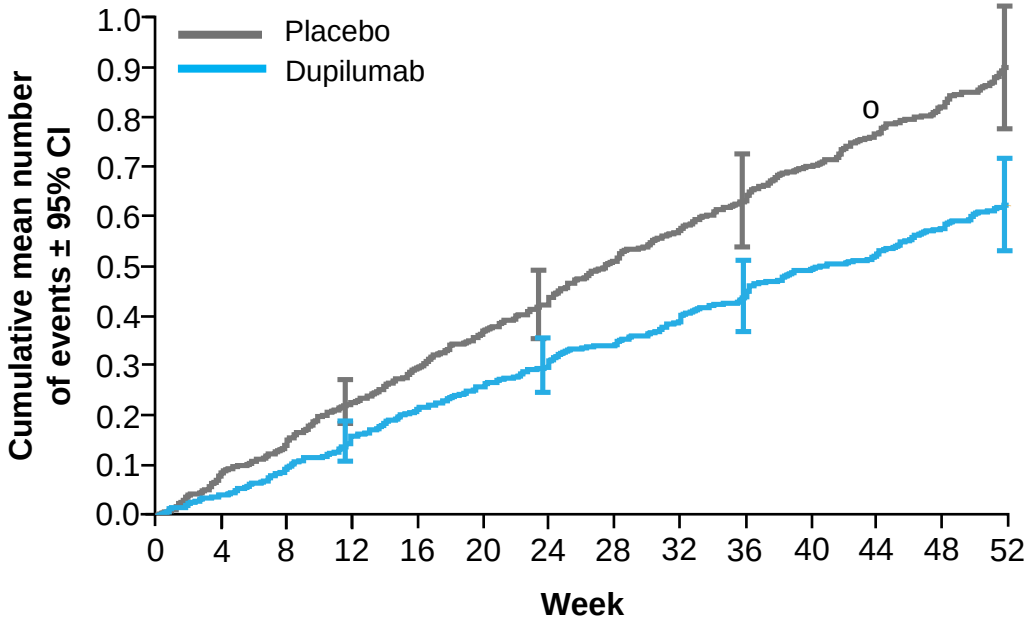
Characteristic	Placebo (N = 471)	Dupilumab (N = 468)	All (N = 939)
Age, mean (SD) — years	65.2 (8.1)	65.0 (8.0)	65.1 (8.1)
Male, no. (%)	322 (68.4)	298 (63.7)	620 (66.0)
Race — White, no. (%)	397 (84.3)	393 (84.0)	790 (84.1)
Ethnicity – Hispanic or Latino, no. (%)	129 (27.4)	132 (28.2)	261 (27.8)
Smoking status			
Former smoker, no. (%)	323 (68.6)	334 (71.4)	657 (70.0)
Current smoker, no. (%)	148 (31.4)	134 (28.6)	282 (30.0)
Pack-years, mean (SD)	41.4 (24.4)	39.6 (22.3)	40.5 (23.4)
BMI, mean (SD) – kg/m^2	27.6 (5.7)	27.5 (5.4)	27.6 (5.6)
Background medication			
Triple therapy (ICS+LAMA+LABA), no. (%)	461 (97.9)	455 (97.2)	916 (97.6)
Inhaled corticosteroid, high dose, no. (%)	126 (26.8)	131 (28.0)	257 (27.4)

Baseline Demographics and Disease Characteristics

Characteristic	Placebo (N = 471)	Dupilumab (N = 468)	All (N = 939)
Type 2 inflammation biomarkers			
Blood eosinophil count at randomization – cells/µL, mean (SD)	408 (331)	394 (261)	401 (298)
Post-BD Fe_{NO} level, ppb, mean (SD)	23.5 (22.0)	25.2 (22.8)	24.3 (22.4)
FE_{NO} level ≥20 ppb, no. (%)	188 (42.5)	195 (45.0)	383 (43.8)
FE_{NO} level <20 ppb, no. (%)	254 (57.5)	238 (55.0)	492 (56.2)
Moderate-severe COPD exacerbations in 1-year prior, mean (SD)	2.3 (1.0)	2.2 (1.1)	2.3 (1.0)
Lung function			
Post-BD FEV_1 (L), mean (SD)	1.41 (0.47)	1.39 (0.47)	1.40 (0.47)
Post-BD FEV_1 % predicted mean (SD)	50.6 (13.0)	50.6 (13.3)	50.6 (13.1)
Post-BD FEV_1/FVC, mean (SD)	0.5 (0.1)	0.5 (0.1)	0.5 (0.1)
SGRQ total score, mean (SD)	48.4 (17.8)	48.4 (17.0)	48.4 (17.4)
E-RS: COPD total score, mean (SD)	13.0 (6.9)	12.9 (7.2)	12.9 (7.1)

Primary Outcome: Annualized Rate of Exacerbations





No. at Risk

Placebo	471	470	466	461	457	457	456	451	451	449	445	442	441	437
Dupilumab	468	467	465	464	462	460	458	457	456	454	451	450	448	437

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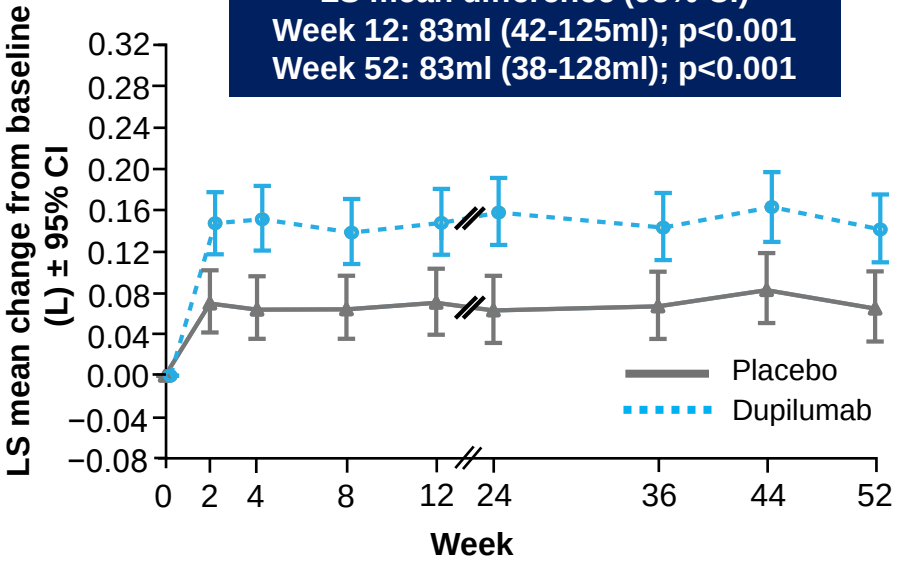
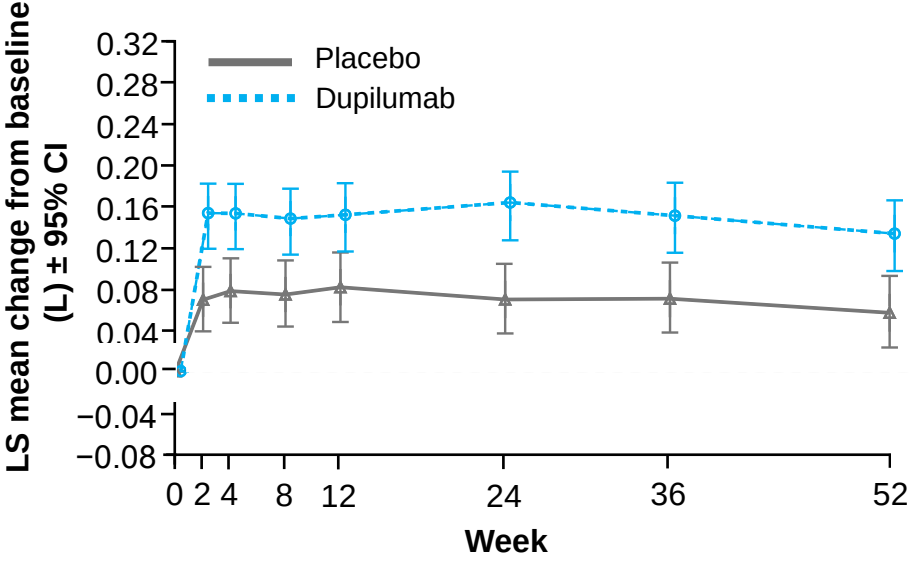
Change in Lung Function Over Time

Pre-BD FEV_1

LS mean difference (95% CI)
Week 12: 83ml (42-125ml); p<0.001
Week 52: 83ml (38-128ml); p<0.001



Post-BD FEV_1



No. of participants with observed change from baseline

Placebo	471	455	459	439	439	435	415	404	420	471	456	458	439	431	410	417	417
Dupilumab	467	457	454	446	449	443	415	410	426	468	457	454	448	436	434	417	423

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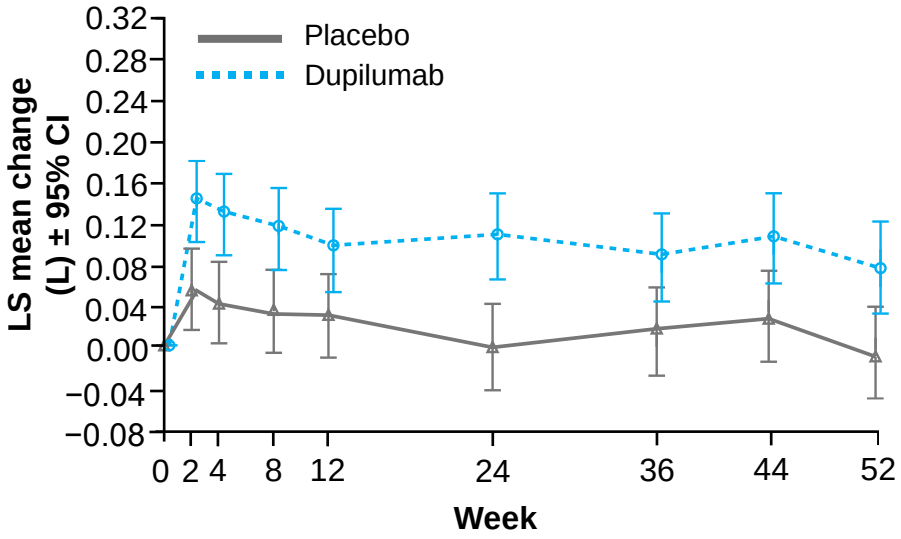
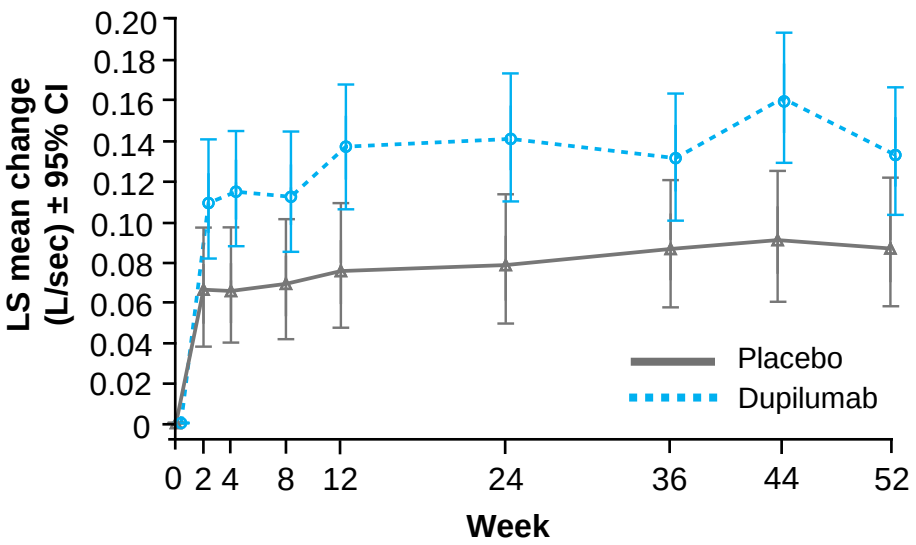
Change in Pre-BD FVC and Pre-BD $FEF_{25–75\%}$ Over Time

Pre-BD FVC



Pre-BD $FEF_{25-75\%}$



No. of participants with observed change from baseline

Placebo	471	455	459	439	439	435	415	404	420
Dupilumab	467	457	454	446	449	443	415	410	426

Placebo	471	455	459	439	439	435	417	404	420
Dupilumab	467	457	454	446	449	443	415	410	426

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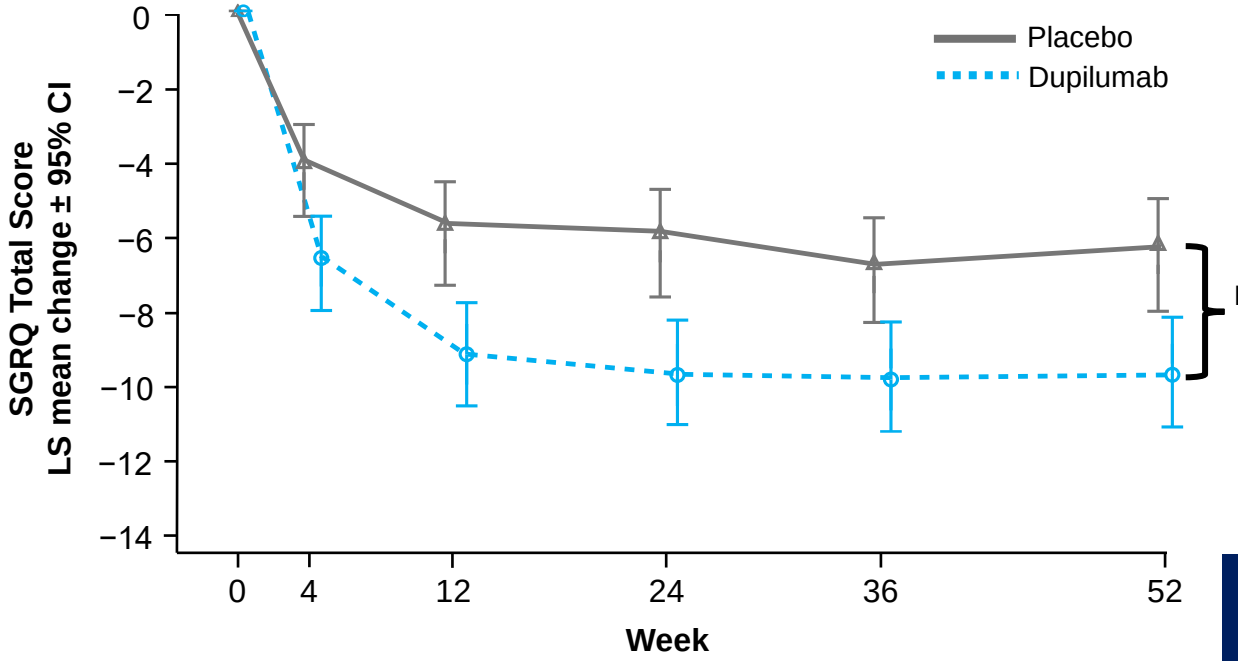
Patient-Reported Outcomes: St. George's Respiratory Questionnaire



Week 52

LS mean difference (95% CI)

−3.4 (−5.5 to −1.3)

P=0.002

Lower score indicates a better quality of life

No. of participants with observed change from baseline

Placebo	461	439	430	407	414	400
Dupilumab	461	444	436	434	407	415

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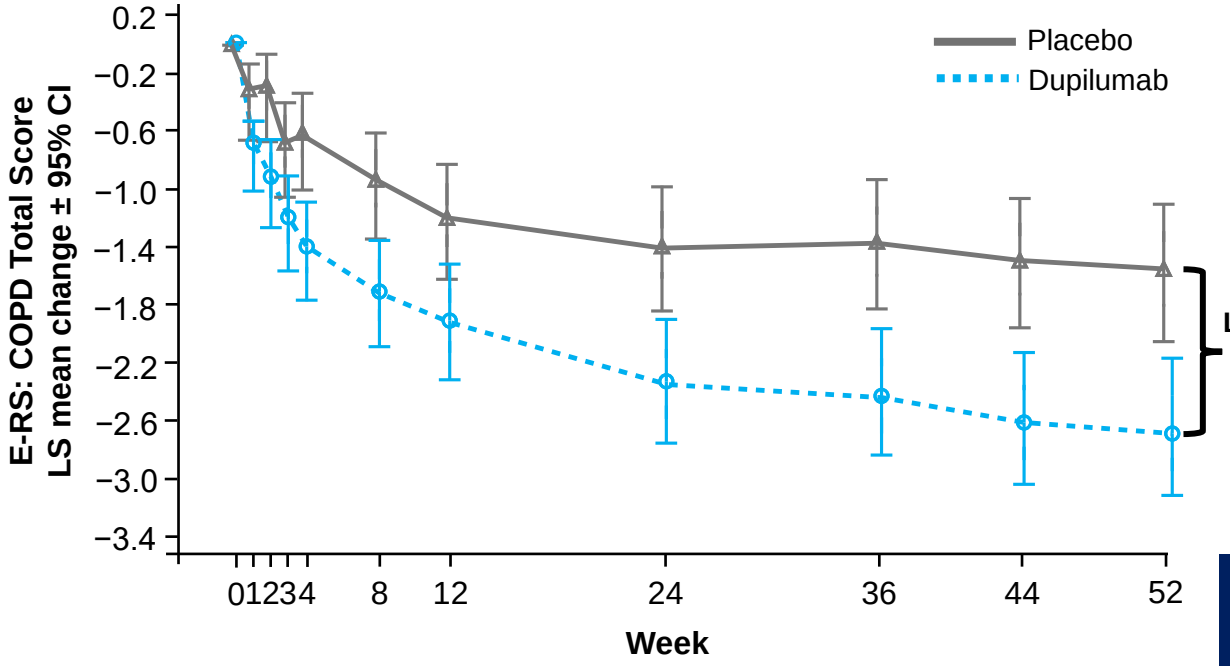
Patient-Reported Outcomes: Symptoms (E-RS:COPD)



Lower score indicates less severe respiratory symptoms

No. of participants with observed change from baseline

Placebo	467	454	448	443	424	414	404	379
Dupilumab	461	446	435	439	428	412	403	380

Treatment-Emergent Adverse Events in the Safety Population*

	Placebo (N = 470)	Dupilumab (N = 469)
Participants with any TEAE, no. (%)	357 (76.0)	363 (77.4)
Participants with any treatment-emergent SAE, no. (%)	73 (15.5)	64 (13.6)
Participants with any TEAE leading to death, no. (%)	8 (1.7)	7 (1.5)
Participants with any TEAE leading to permanent study intervention discontinuation, no. (%)	16 (3.4)	14 (3.0)

* The safety population consisted of all patients who received at least one dose or part of a dose of the investigational medicinal product, analyzed according to the treatment received. One patient assigned to the placebo group inadvertently received dupilumab so was included in the dupilumab safety population.

Treatment-Emergent Adverse Events in the Safety Population*

	Placebo (N = 470)	Dupilumab (N = 469)
Most common TEAEs (≥ 5%), no. (%)		
Nasopharyngitis	45 (9.6)	44 (9.4)
Headache	32 (6.8)	38 (8.1)
Upper respiratory tract infection	46 (9.8)	37 (7.9)
Chronic obstructive pulmonary disease[1]	28 (6.0)	27 (5.8)
Diarrhea	17 (3.6)	25 (5.3)
Back pain	16 (3.4)	24 (5.1)
COVID-19	27 (5.7)	19 (4.1)
Hypertension	28 (6.0)	17 (3.6)

* The safety population consisted of all patients who received at least one dose or part of a dose of the investigational medicinal product, analyzed according to the treatment received. One patient assigned to the placebo group inadvertently received dupilumab so was included in the dupilumab safety population.

1. All COPD-related hospitalizations are initially reported as SAEs (investigator reported)

Conclusions

- Dupilumab reduced the annualized rate of moderate-to-severe exacerbations by 30% compared to placebo
- Dupilumab improved patient reported lung function and patient reported outcomes:
  - 83 mL improvement in FEV_1
  - Significant improvement in quality of life
  - Significant improvement in severity of symptoms
- Safety results were consistent with the known safety profile of dupilumab

Q&A session (Part 1)

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Expand and disrupt beyond Type 2

Naimish Patel MD

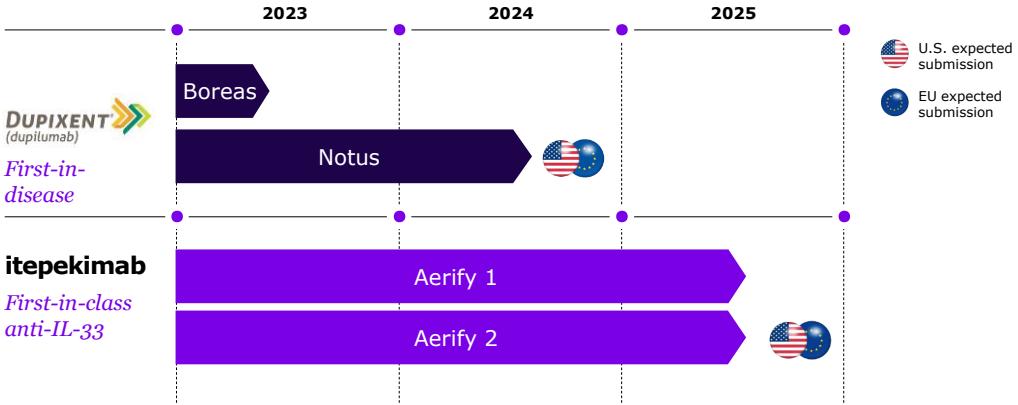
Global Head of Development,
Immunology & Inflammation

Potential to *lead in COPD* with two biologics targeting uncontrolled COPD in patients who failed standard of care

Patient population
G7[1] – 2035e

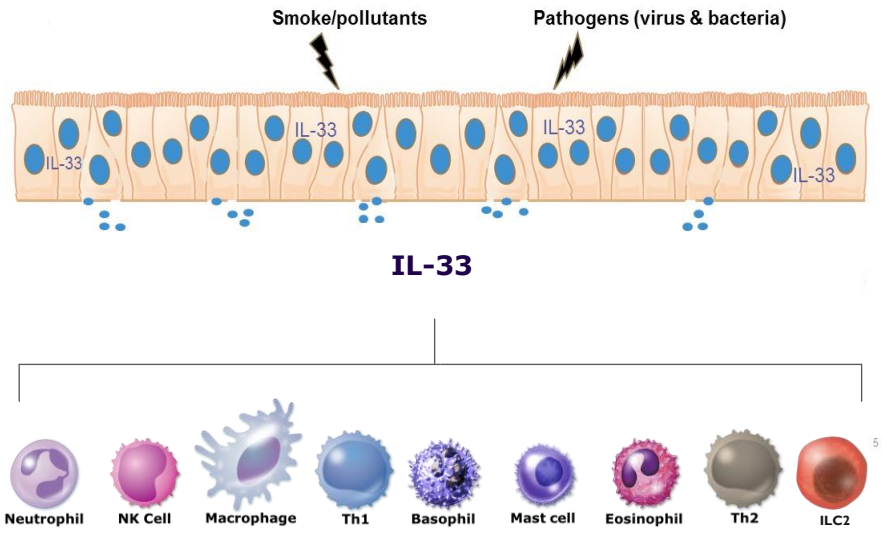
	Non-Type 2	Type 2
Former smokers (70%)	**itepekimab[2]** ~1,139K patients	**Dupixent®[3] and itepekimab[2]** ~640K patients
Current smokers (30%)		**Dupixent®[3] only** ~270K patients

Dupixent® and itepekimab have two distinct mechanisms of action addressing *different COPD populations* with limited overlap



1. G7 countries: U.S., France, Germany, Italy, Japan, UK, Canada. 2. Itepekimab is under investigation and not yet approved by any regulatory agency. Itepekimab is being developed in collaboration with Regeneron. 3. Dupixent® is not yet approved for COPD and is being studied in patients with uncontrolled COPD treated with current SoC triple therapy. Patient populations exclude never smokers.

Itepekimab: *potent* IL-33 blocker with sub-nanomolar affinity



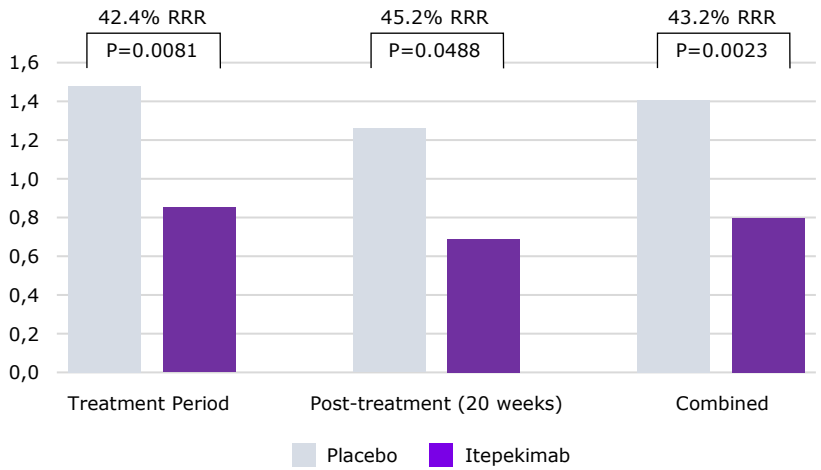
Potential to be *best-in-class and first-in-class* IL-33 biologic

- Binds to human IL-33 with high affinity (K_d=42pM)
- Amongst the longest half-life of anti-IL-33 class
- Amongst the best bioavailability of anti-IL-33 class
- No immunogenicity signals

Itepekimab is under investigation and not yet approved by any regulatory agency. Clinical significance of the mechanism of action has not been established.

Itepekimab: First IL-33 in COPD with *unprecedented exacerbation reduction in former smokers* with and without Type 2 inflammation

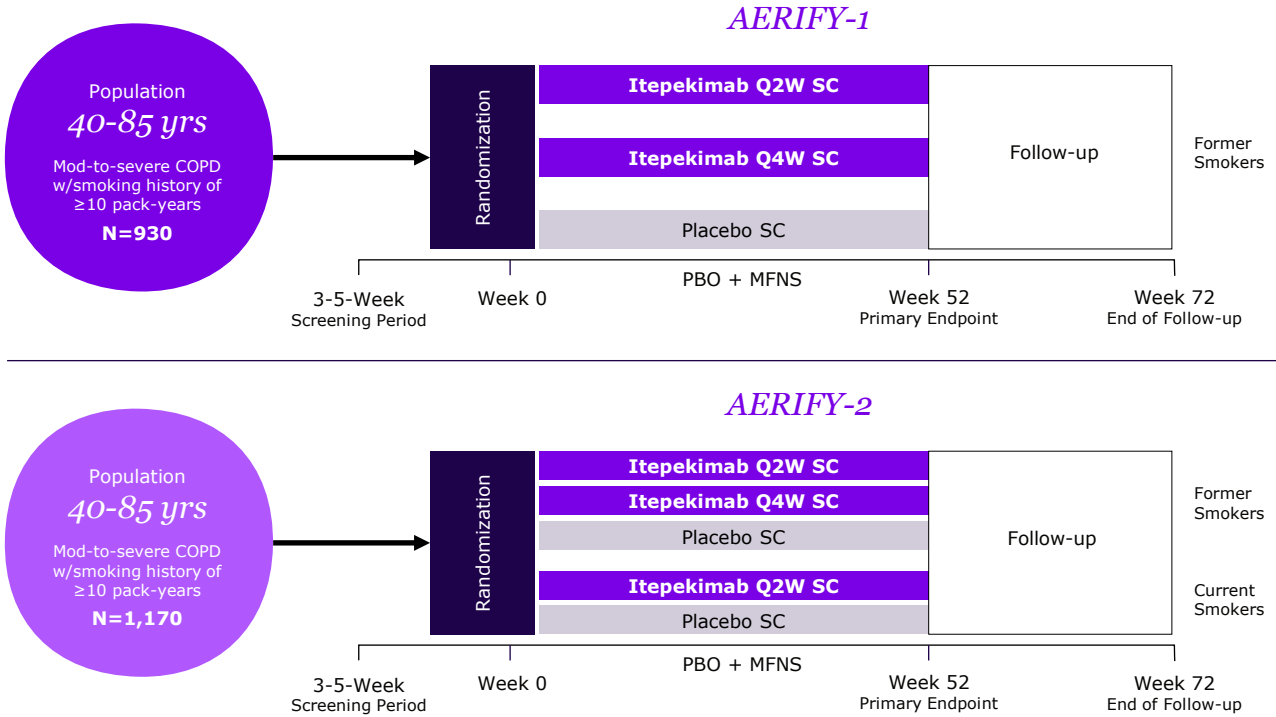
Former smokers into 20 weeks post-treatment period[1]



- >40% reduction in exacerbations in former smokers
- *Effect* present in *both high and low eosinophil* population
- *Sustained efficacy* 20 weeks post treatment
- Only member of IL-33/ST2 class with clinical data in COPD
- Itepekimab was well tolerated in ph2a study

1. Rabe et al. Lancet Respir Med. 2021
Itepekimab is under investigation and not yet approved by any regulatory agency.

Itepekimab: *Positive* Aerify interim analysis



- FDA *Fast Track Designation* for COPD in former smokers in January 2023
- Phase 3 data from AERIFY 1 & AERIFY 2 expected in 2025

Itepekimab is under investigation and not yet approved by any regulatory agency.

Potential to address *remaining unmet need asthma* with disruptive first-in-class assets

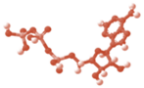
Amlitelimab

OX40L

Antibody

- Non-depleting anti-*OX40L* addresses *both T2 and non-T2 inflammation* to meet patient need for broader high efficacy
- *Long-term disease control* / potential disease modification, infrequent dosing

Rilzabrutinib



BTKi

Small molecule

- *Oral therapy* being targeting type 2 and non-T2 pathways
- Potential to establish *pre-biologic* space and expand treatment of *moderate* asthma patients

Phase 2b asthma readouts **in 2024**

SAR'765

IL13xTSLP

Nanobody® VHH molecule

- Bispecific Nanobody® VHH against both TSLP and IL-13
- Potential for *breakthrough efficacy*
- Long-term disease control/potential *disease modification*

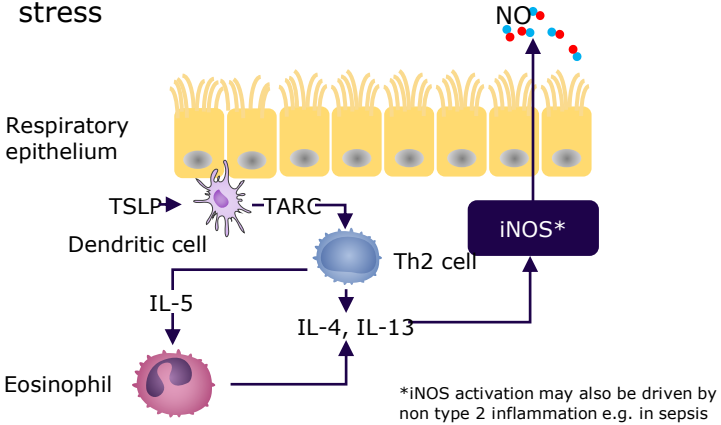
Phase 1b asthma data

Amlitelimab, rilzabrutinib and SAR'765 are under investigation and not yet approved by any regulatory agency.

SAR`765: IL-13/TSLP bispecific shows potential to *break efficacy ceilings in type 2 Inflammation and beyond*

Type 2 inflammation[1–3]

- Mainly driven by IL-4, IL-5 and IL-13
- Drives IgE synthesis, eosinophil recruitment, and FeNO production, indicating nitrosative/oxidative stress



2022 — 2023

SAR`765 *vs.* PLACEBO

Phase 1b

Phase 1b - Proof of mechanism in Asthma

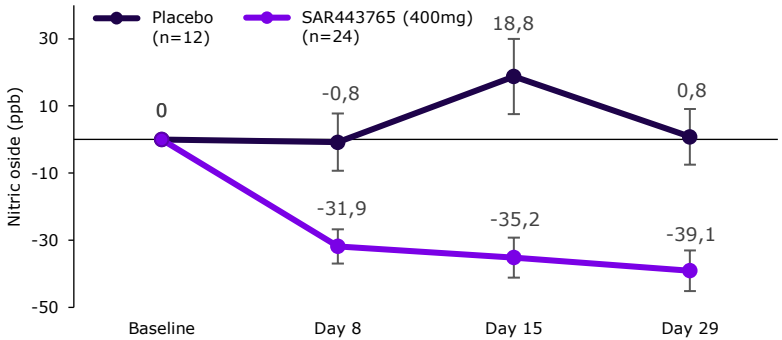
- Mild/moderate asthma with elevated FeNO
- Single dose (400 mg vs placebo) SC
- N=36 (2:1)

- *Bispecific Nanobody® VHH* against both *TSLP and IL-13*
- Potential to benefit from *combined approach*
  - anti-TSLP therapy is effective in reducing exacerbations in asthma with type 2 and non-type 2 inflammation[4–7];
  - anti-IL-13 therapy has mixed effects on exacerbations, but improves lung function and reduces fractional exhaled nitric oxide[8–12]

1. Ziegler, S, et al. Nat Immunol. 2006;7:709-14; 2. Ricciardolo FL, et al. Allergol Immunopathol (Madr). 2015;43:609-16; 3. Munakata M. Allergol Int. 2012;61:365-72, 4. Gavreau GM, et al NEJM. 2014;370:2102-10; 5. Corren JC, et al. NEJM. 2017;377:936; 6. Menzies-Gow A, et al. NEJM. 2021;384:1800-09; 7. Weschler M, et al. Lancet Respir Med. 2022;10:650-60; 8. Corren JC, et al. NEJM. 2011;365:1088-98; 9. Austin CD, et al. Clin Exp Allergy. 2020;50:1342-51; 10. Hanania NA, et al. Thorax. 2015;70:748-56; 11. Panettieri RA, et al. Lancet Respir Med. 2018;6:511-25; 12. Russell RJ, et al. Lancet Respir Med. 2018;6:499-510

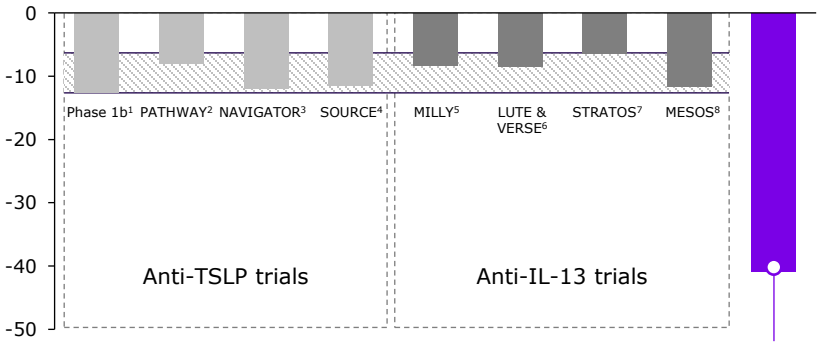
Significant reduction in FeNO observed with SAR'765 suggests the potential for a highly competitive target product profile

Mean (±SEM) change from baseline over time



- Highly elevated FeNO at baseline, consistent with active, Type 2 airway inflammation
- Confirmed pharmacodynamic effect, with FeNO as clinically relevant biomarker for type 2 airway inflammation

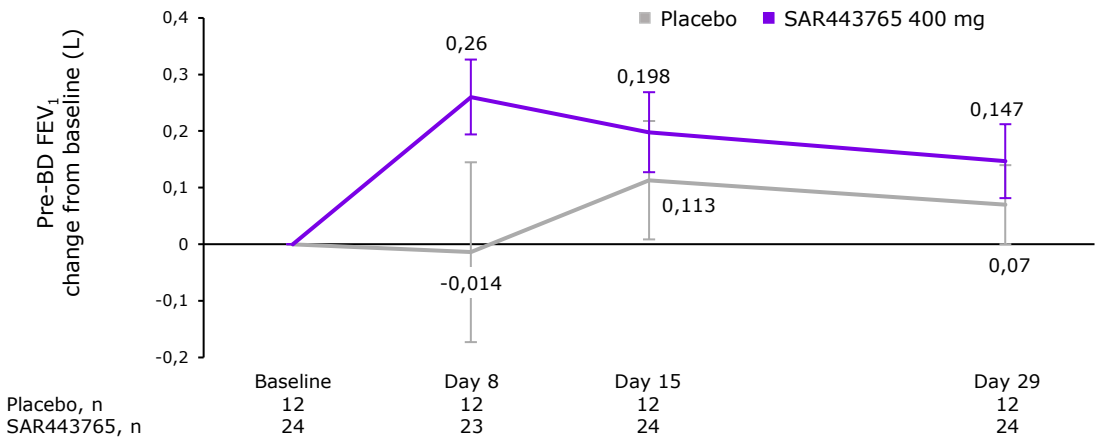
Results of SAR'765 on FeNO suggest a synergistic effect compared to TSLP or IL13 alone[1-8]



SAR443765
–40.9 ppb
(90% CI: –55.4 to –26.4)†

FeNO, fractional exhaled nitric oxide. The clinical significance of FeNO is under investigation *Not head-to-head comparisons; patient populations and baseline characteristics may differ between studies. Estimates of FeNO change from baseline versus placebo derived from published data. †Difference vs placebo estimate from a mixed-effects model over time taking into account baseline FeNO and sex as co-variates. 1. Gavreau GM, et al NEJM. 2014;370:2102-10; 2. Corren JC, et al. NEJM. 2017;377:936; 3. Menzies-Gow A, et al. NEJM. 2021;384:1800-09; 4. Weschler M, et al. Lancet Respir Med. 2022;10:650-60; 5. Corren JC, et al. NEJM. 2011;365:1088-98; 6. Hanania NA, et al. Thorax. 2015;70:748-56; 7. Panettieri RA, et al. Lancet Respir Med. 2018;6:511-25; 8. Russell RJ, et al. Lancet Respir Med. 2018;6:499-510.

Lung function improvement corroborates *SAR'765* mode of action



FEV1 measured in triplicate. If the difference between the 2 largest FEV1 values was ≥0.150 L, the triplicate set was excluded. Maximal FEV1 value from the triplicate used for analysis.

Potential to *suppress airway inflammation* and *preserve airway function* in asthma

- Rapid, numerical improvement in FEV1 after single dose of SAR'765
- Maximal improvement in pre-BD FEV1 at Day 8 largely maintained throughout the 4-week observation period

PD, pharmacodynamic; FEV1, forced expiratory volume in 1 second; BD, bronchodilator SEM, standard error of the mean.

Potential *breakthrough medicines* beyond Type 2

COPD

Itepekimab

- Potent IL-33 blocker with best-in-class and first-in-class potential
- Unprecedented exacerbation reduction in former smokers shown in phase 2, *positive interim analysis* covering AERIFY 1 & 2
- FDA Fast Track Designation status, pivotal data in 2025

Asthma

SAR'765

- Leveraging two proven pathways
- Exciting results of SAR'765 on FeNO suggest a synergistic effect
- Potential to suppress airway inflammation *preserve lung function, and disease modify*
- Phase 2b starting H2 2023

Amlitelimab & rilzabrutinib

- Phase 2 readouts in 2024

Amlitelimab, rilzabrutinib and SAR'765 are under investigation and not yet approved by any regulatory agency.

sanofi

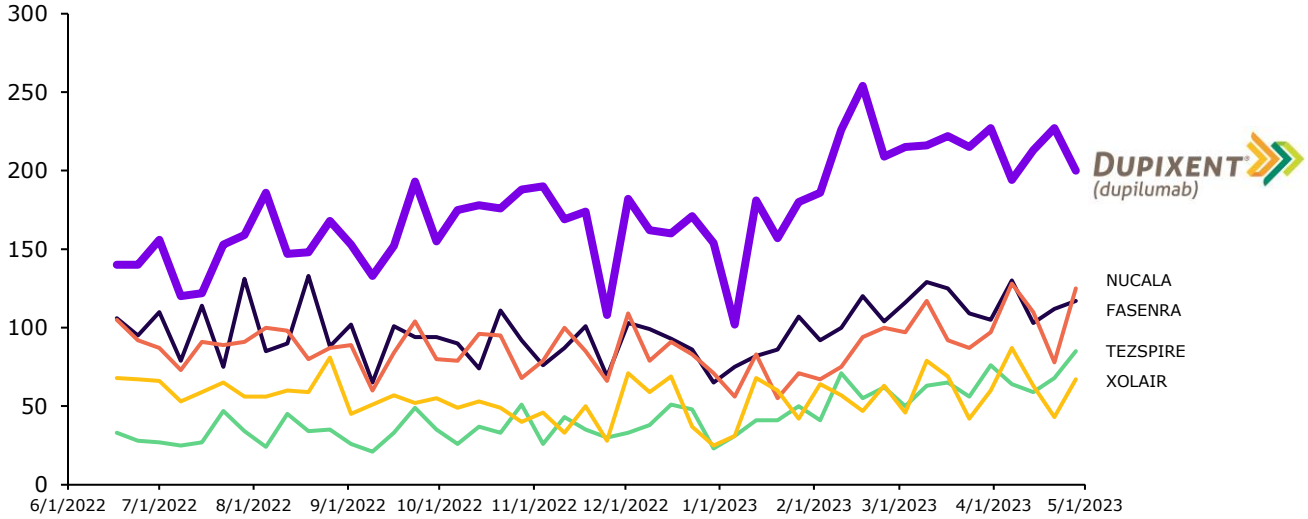
Unlock sustainable growth in Immunology

Bill Sibold

EVP, Global Head of Specialty Care

Dupixent® is the leader in specialty Respiratory

Leading with *Pulmonologist* Weekly NBRx[1]



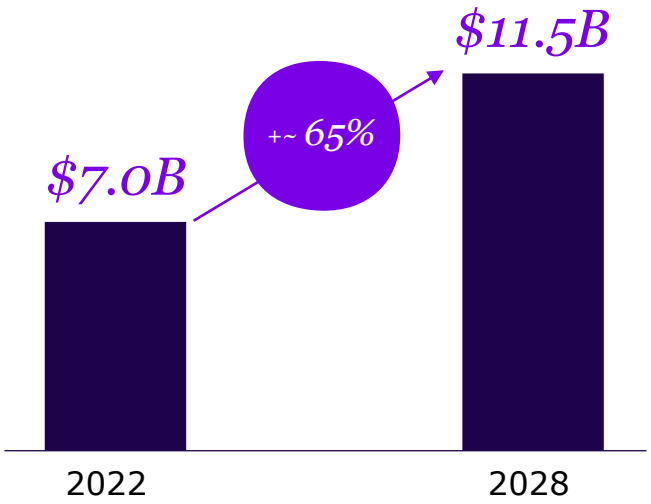
Outstanding performance

- ***#1*** Asthma NBRx share (25%) March 2023[2]
- ***#1*** total Asthma patients share 41% and new patient share 39% in Japan[3]
- Ambition to be *Best-in-disease* Type 2 Asthma profile[4] approved 6Y+ in U.S. & EU and 12Y+ in Japan

1. IQVIA SMART - Patients Insights Edition - weekly NBRx, data through 4/28/2023. 2. IQVIA National Source of Business monthly data with data through 3/31/2023.
3. Japan IQVIA, JMDC Database, Japan local ATU W17 Jan '23. 4. Type 2 phenotype: Eos ≥150 or FeNo ≥ 20 ppb, and/or OCS dependence. Leading Immunology Brand in US NBRx.

Innovative portfolio to address significant remaining need in *fast growing asthma market*

Global asthma advanced therapy market

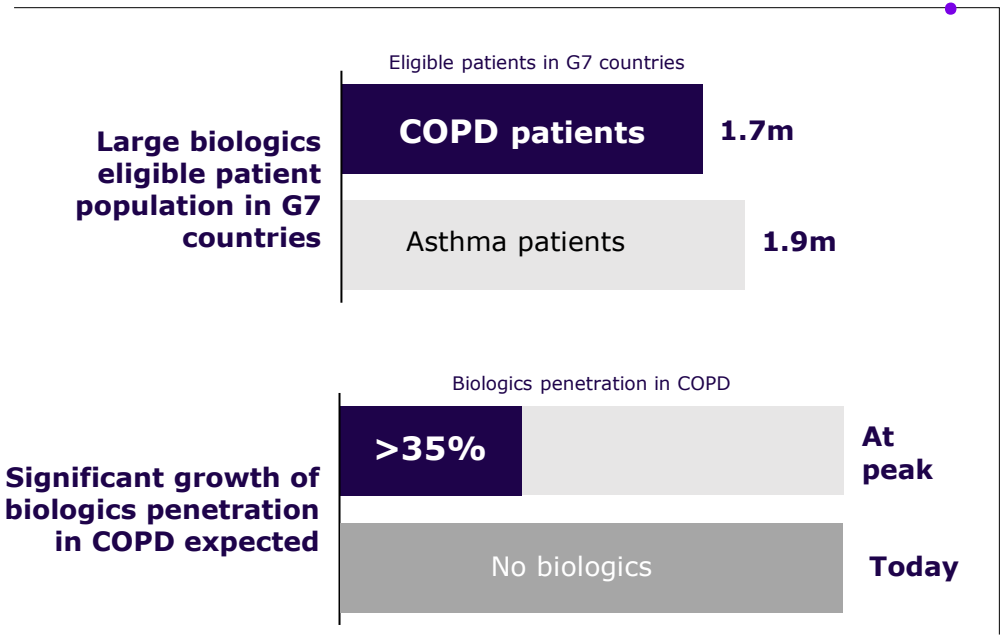


Portfolio with potential to address *remaining unmet needs* in asthma

Efficacy across subtypes	SAR'765	Amlitelimab
Long-term disease control / disease modification	SAR'765	Amlitelimab
Establish new efficacy level	SAR'765	
Safe, effective oral	Rilzabrutinib	

Sales Estimate source: Evaluate Pharma Q2 2023; removed 50% of Xolair sales to account for Chronic Spontaneous Urticaria. Branded advanced therapies only.

Opportunity to bring breakthroughs to large number of *in-need COPD patients*



Potential first-in-market with Dupixent®

- Impressive data in high need, lethal disease
- Addressing ~35% of severe patients at launch

Near-term expansion with itepekimab

- Expanding patient opportunity by >2X

Two complementary, potential best-in-class agents

- Reaching 80+% of the severe population
- Maximized with proven ability to execute

Source: Sanofi Internal Analysis
Dupixent® and itepekimab are under investigation in COPD and not yet approved by any regulatory agency to treat this indication

Multiple blockbuster opportunities to expand Sanofi's leadership in specialty respiratory

Leadership today

DUPIXENT® (dupilumab) Injection 300mg

- #1 in Specialty Respiratory driven by Dupixent leadership across:
- Asthma (launched)
- CRSwNP (launched)
- COPD (positive Ph3 data)

Developing blockbuster opportunities

itepekimab | **amlitelimab** | **rilzabrutinib** | **SAR'765**

- Promising data in hand for itepekimab and SAR'765 poised to deliver towards goal of launching 3-5 new products with €2-5B peak potential in second half of decade
- First asthma readouts in 2024 on amlitelimab, rilzabrutinib to confirm unique profiles and potential to expand beyond lead indications

Dupixent® is under investigation in COPD and not yet approved by any regulatory agency to treat this indication
Itepekimab, amlitelimab, rilzabrutinib and SAR'765 are under investigation and not yet approved by any regulatory agency

Q&A session (Part 2)