PRESCRIPTION MEDICINE PRICING
OUR PRINCIPLES AND PERSPECTIVES

At Sanofi, we work passionately to prevent, treat and cure illness and disease, understand and solve health care needs of people across the world, and transform the practice of medicine. Our focus spans a number of therapeutic areas in specialty care and general medicines, including immunology, oncology, rare diseases, rare blood disorders, diabetes and cardiovascular diseases, as well as vaccines. Sanofi has a long-standing commitment to promote health care systems that make our treatments accessible and affordable to patients in need.

Countries are increasingly seeking to achieve better value in health care spending. Sanofi understands and shares concerns about the affordability of medicines for patients while also recognizing that we are only one of many stakeholders in the health care system. In the United States, medicines are a small share — about 14%[1] — of total health care spending. In order to maintain an environment that will continue to bring new health care solutions to patients, we must encourage a transition to a value-driven health care system that provides incentives for the highest-quality care. This evolution will enable both affordable access to treatment and continued investment in medical innovation.

Sanofi is committed to helping address this challenge. While many factors, including decisions affecting patient out-of-pocket spending and insurance coverage, are controlled by other stakeholders in the health care system, we believe we have a responsibility to be a leader in solving issues of patient access and system viability. For our part, we price our medicines according to their value, while contributing to broader solutions that improve patient outcomes and support affordability within the U.S. health care system.

OUR PRICING PRINCIPLES: ADVANCING RESPONSIBLE LEADERSHIP

Pharmaceutical innovation brings value to our patients, our society and our health care systems. Given the growing concerns over rising health care costs, our approach to pricing reflects our commitment to patient access while minimizing our contribution to health care inflation. We therefore commit to continued transparency in how we price our prescription medicines and to limit any increase in prices in the United States to no more than the projected National Health Expenditure (NHE) growth rate.

The Pricing Principles we put forth focus on three pillars:

CLEAR RATIONALE FOR PRICING
at the time of launch of a new medicine

LIMITED U.S. PRICE INCREASES
on our medicines over time

CONTINUED TRANSPARENCY IN THE U.S.
around our pricing decisions

[1] The Altarum Institute. Projections of the Prescription Drug Share of National Health Expenditures Including Non-Retail. September 2020.

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CLEAR RATIONALE FOR PRICING

When we set the price of a new medicine, we hold ourselves to a rigorous and structured process that includes consultation with external stakeholders and considers the following factors:

A holistic assessment of value, including 1) clinical value and outcomes, or the benefit the medicine delivers to patients, and how well it works compared to a standard of care; 2) economic value, or how the medicine reduces the need – and therefore costs – of other health care interventions; and 3) social value, or how the medicine contributes to quality of life and productivity. Our assessments rely on a range of internal and external methodologies, including health technology assessment (HTA) and other analyses that help define or quantify value and include patient perspectives and priorities.

Similar treatment options available or anticipated at the time of launch, in order to understand the landscape within the disease areas in which the medicine may be used.

Affordability, including the steps we must take to promote access for patients and contribute to a more sustainable system for payors and health care systems.

Unique factors specific to the medicine at the time of launch. For example, we may need to support ongoing clinical trials to reinforce the value of our medicines (e.g., longer-term outcomes studies), implement important regulatory commitments, or develop sophisticated patient support tools that improve care management and help decrease the total cost of care.

LIMITED U.S. PRICE INCREASES

We acknowledge our role in preserving the sustainability of our health care system and in limiting our contribution to U.S. health care spending growth. Should we take a list price increase on one of our medicines, our guiding principle is to limit the total annual increase during our fiscal year (Jan. 1 to Dec. 31) to a level at or below the projected growth rate for National Health Expenditures for said year.

Our benchmark, the projected U.S. National Health Expenditure (NHE) growth rate, is estimated and published annually by the Centers for Medicare & Medicaid Services (CMS). The NHE projection provides a critical forward-looking view needed for business planning. NHE measures spending across all health care goods and services and reflects payments made by both public and private payors.

Once the NHE projection is updated each year, we will adjust any future planned pricing actions to reflect the projection. Given the need for business planning, we will adopt the updated standard by April 1 each year.[2] More information about the NHE growth rate can be found here.[3]

Should we take a price increase above the NHE growth rate for a given medicine that results in a list price increase greater than $15 for a full course of treatment per year, we will provide our rationale, highlighting clinical value, real-world evidence, regulatory change, new data or other circumstances that support our decision.

[2] As measured by National Health Expenditures, published annually by the Centers for Medicare & Medicaid Services.
[3] To read the full data, please visit https://go.cms.gov/39rnzgf.

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CONTINUED TRANSPARENCY IN THE UNITED STATES

We recognize calls for continued transparency in our pricing practices. Our principles reflect a desire to help our stakeholders better understand our pricing decisions.

Our principles reflect both a desire to help our stakeholders better understand our pricing decisions and to advance a more informed discussion of issues related to the pricing of medicines. To continue this dialogue and provide greater insights about this topic, we will disclose annually our average aggregate U.S. list and net price changes from the prior calendar year. These data may help illustrate how pricing changes accrue to manufacturers versus others in the value chain, highlighting our discrete role in the broader U.S. health care environment and enabling a better-informed discussion on solutions to improve patient access and affordability.

While list prices often receive the most attention, they reflect only the initial prices set for our medicines and are **not** the prices typically paid by the insurers, employers or pharmacy benefit managers who purchase our medicines on behalf of patients in their respective health plans. We negotiate discounts and rebates with these payors, which are designed to offer the health care system lower prices in exchange for greater access and affordability for patients with insurance. List prices also fail to capture the substantial mandated discounts and rebates, sometimes required by law, provided to government programs, including those provided in Medicare Part D, Medicaid and the 340B drug-pricing programs.

The net price is what Sanofi receives after discounts, rebates and fees paid to health plans and other parts of the health care system.

While our efforts focus on securing affordable coverage of our medicines for patients, it is important to note that patient cost-sharing and coverage decisions are ultimately made by payors and employers, not manufacturers of the medicines.

Simply put, patients' out-of-pocket costs depend on how the plan is structured and the extent of the negotiated discounts passed on to patients.

These principles demonstrate Sanofi's commitment to patient access and affordability, a sustainable health care system and greater transparency in our pricing actions. Moreover, our position supports an environment that will enable us to continue to advance scientific knowledge and bring innovative treatments to patients worldwide.

SANOFI 2021 PRICING PRINCIPLES REPORT: ADVANCING RESPONSIBLE LEADERSHIP

In May 2017, Sanofi committed to further addressing concerns over rising health care costs with the introduction of our Pricing Principles, which remain the most comprehensive assessment of corporate pricing decisions in the pharmaceutical industry. Our approach to the pricing of our medicines reflects a continued effort to support patient access while minimizing our contribution to health care spending growth. The following report outlines our 2020 pricing decisions.

CLEAR RATIONALE FOR PRICING

Sarclisa® (isatuximab-irfc): Sarclisa launched in the United States in March 2020 after being approved for use in combination with pomalidomide and dexamethasone for the treatment of adults with relapsed refractory multiple myeloma (RRMM) who have received at least two prior therapies, including lenalidomide and a proteasome inhibitor. For patients with RRMM, their disease has either returned or become resistant to prior treatments, limiting their available treatment options.

Sanofi consulted with patients, physicians and payors before setting the launch price of Sarclisa at $650 per 100 mg vial and $3,250 per 500 mg vial. This meant that, at launch, the cost of the first-full-year-of-therapy in the U.S. for a typical patient weighing between 70-80 kg (154-176 lbs.), including a standard infusion cost, would be lower than the overall cost of the other anti-CD38 treatment on the market at the time for a similar patient. Actual costs to patients for Sarclisa are generally expected to be lower, as the list price does not reflect insurance coverage, copay support or financial assistance from patient support programs.

Because multiple myeloma is a blood cancer that does not yet have a cure, it requires long-term treatment. This imposes a significant burden on patients, who often relapse. A recent study found that the economic burden of the progression of the disease is substantial, no matter what therapies are given. The same study found that treatments that prevent or delay progression are likely to reduce future disease management costs.[4]

Overall, Sanofi has priced Sarclisa, taking into account its efficacy and safety profile, at a point that offers substantial value to the health care system and, most important, patients with difficult-to-treat, relapsed and refractory disease.

Finally, Sanofi is committed to ensuring those who are prescribed Sarclisa have access to the medicine. For patients with RRMM who are prescribed Sarclisa, the CareASSIST Patient Support Program provides reimbursement support and financial assistance to eligible patients who require financial assistance and help in navigating insurance, benefits and reimbursement.

More information about multiple myeloma can be found here.[5]

[4] *Blood*, 2018.
[5] American Cancer Society, 2020.

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LIMITED U.S. PRICE INCREASES

In February 2019, the U.S. National Health Expenditure projected growth rate for 2020 was 5.4%.[6] That figure was updated to 5.2% in March 2020.[7]

In 2020, Sanofi increased the list price of 50 of our 80 prescription medicines. All of these increases were within our Pricing Principles guidelines, the only policy in the industry that limits price increases on all individual medicines to a measure of health spending growth.

Sanofi also took one price decrease, lowering the list price of enoxaparin by 71% in October 2020.

CONTINUED TRANSPARENCY IN THE UNITED STATES

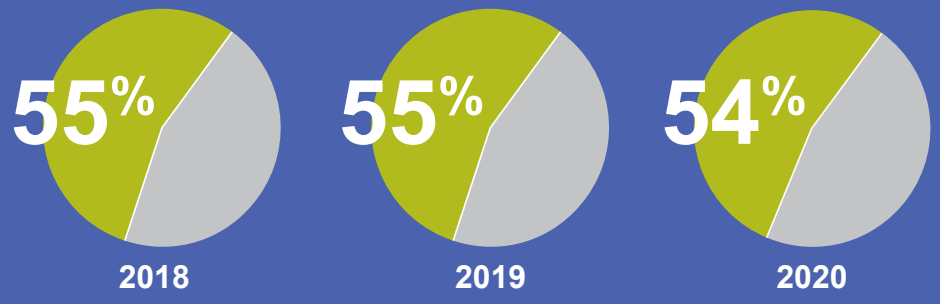
U.S. Portfolio Annual Aggregate Price Change From Prior Year*

Year	Average Aggregate List Price	Average Aggregate Net Price
2016	4.0% INCREASE	2.1% DECREASE
2017	1.6% INCREASE	8.4% DECREASE
2018	4.6% INCREASE	8.0% DECREASE
2019	2.9% INCREASE	11.1% DECREASE
2020**	0.2% INCREASE	7.8% DECREASE

**Aggregated across Sanofi's prescription portfolio.*

***Price increases or reductions that are taken mid-year may have an impact in two calendar years. In our 2019 pricing report, Sanofi announced that it took a price reduction on Admelog® (insulin lispro injection) 100 units/mL in July 2019. The 2020 carryover impact of that change is not included in the 2020 Average Aggregate List Price above. If included, the 2020 Average Aggregate List Price change versus 2019 would have been effectively 0%, and the Average Aggregate Net Price would decrease by 8.0%.*

GROSS SALES GIVEN BACK TO PAYORS AS REBATES



In 2020, 54% of Sanofi's gross sales were given back to payors as rebates, including $5.9 billion in mandatory rebates to government payors and $8.7 billion in discretionary rebates. This marks the third year in a row that Sanofi has paid more than 50% of its revenue in rebates.

[6] Health Affairs, 2019.
[7] Health Affairs, 2020.

UNDERSTANDING REBATES AND NET PRICES

Sanofi recognizes that affordability of medicines is a real challenge for too many Americans. We understand the frustration of patients who cannot afford the medicines they or their loved ones need due to rising out-of-pocket drug costs, and we continue to make access to and affordability of our medicines a priority.

Manufacturers, such as Sanofi, pay significant and increasing discounts, rebates and fees, often as a percentage of the list price, to many entities in the supply chain — including pharmacy benefit managers (PBMs), government and private insurance plans, wholesalers, distributors, 340B-covered entities and group purchasing organizations — in an effort to improve access for patients by ensuring that our medicines are covered by insurance and thus accessible to patients. Many government programs require discounts or rebates that are defined by statute.

Since 2012, for people taking Lantus® (insulin glargine injection) 100 units/mL on commercial and Medicare Part D plans:

▲ **82%** *AVERAGE OOP COSTS*

▼ **44.9%** *LANTUS NET PRICE*

Despite a decline in net insulin prices, patient out-of-pocket costs continue to rise.

While we believe these growing discounts and rebates should result directly in lower out-of-pocket costs for the patients for whom they are intended, we cannot force any of these entities to share the substantial discounts we provide to them with their patients. Insurers and employers determine the benefit design that dictates patient out-of-pocket costs and overall health care coverage, meaning that Sanofi, or any drug manufacturer, alone cannot solve the cost-sharing challenges facing millions of Americans.

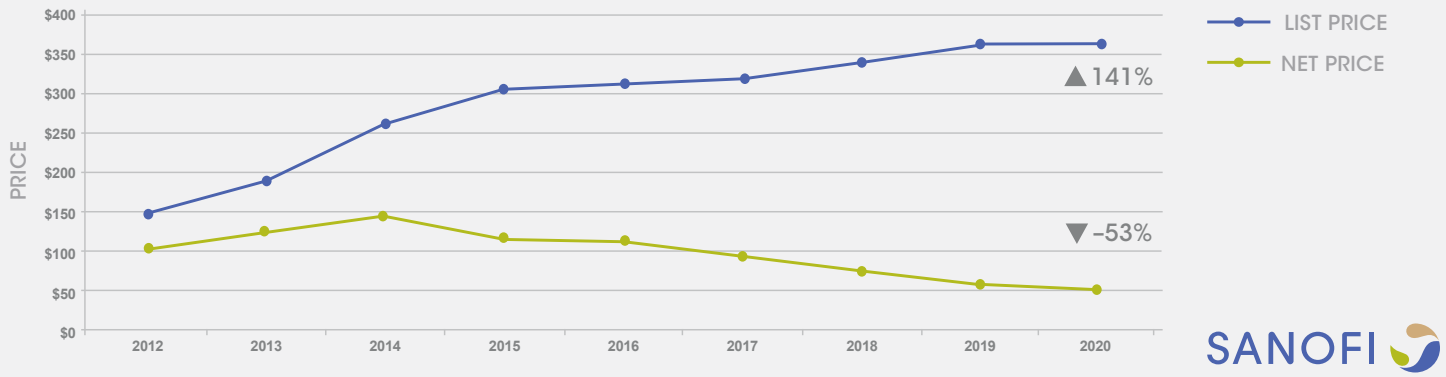
While the list price of a medicine often receives the most attention, it does not reflect the amount Sanofi receives, nor the prices typically paid by the entities above. The price of a medicine after accounting for rebates and discounts is known as the "net price," and it is this price that most accurately reflects what Sanofi receives for its medicines. **In 2020, the average aggregated net price of our medicines declined by 7.8%, the fifth consecutive year our net prices have declined.**

The increasing amount paid in rebates every year and continued declining net prices save the overall health care system money, yet these reductions have not translated into improved access and affordability for patients. Sanofi cannot dictate how those savings are allocated, but we have found that there is little transparency in how those rebates are — or are not — passed on to the patients for whom those discounts are intended.

In insulin, the impact of net prices is even more pronounced. Despite the rhetoric about skyrocketing insulin prices, the net price of insulin has fallen for 6 consecutive years, making our insulins significantly less expensive for insurance plans.

Since 2012, the net price of Sanofi insulins has declined by 53%. Over the same period, the net price in commercial and Medicare Part D plans of our most prescribed insulin, Lantus (insulin glargine injection) 100 units/mL, has fallen 44.9%. Meanwhile, average out-of-pocket costs for Lantus patients with commercial insurance and Medicare have risen approximately 82%. For all the focus from health plans and others on list prices, the average net price of Lantus today is lower than it was in 2006.

INSULIN COST OVER TIME



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A decline in net insulin prices should lead to a corresponding drop in patient out-of-pocket costs, but that does not seem to be the case. While PBMs and health plans are paying less, patients are being asked to pay more. Health plans are placing more of the cost burden onto patients through high deductibles, coinsurance and multiple cost-sharing tiers.

For those in large employer health plans, patient out-of-pocket spending on deductibles increased by 205% from 2007 to 2017.[8] Such high cost-sharing, particularly for high-value and highly rebated therapies such as insulin, creates a financial barrier for patients, limiting access to much-needed treatments and potentially forcing some patients to ration their insulin.

Sanofi's 5 consecutive years of declining aggregate net prices should have improved patient access and affordability to our medicines, but because of the way health benefit plans are often designed, they have not. It is clear that focusing solely on the list price of medicines will not guarantee that patients will be able to get and afford the medicines they need.

In order to solve these access and affordability issues, we must look to tangible policy solutions that directly impact the patient and involve all players across the drug supply chain. If policies are enacted that solely target the list price of medicines without transparency across the drug supply chain and common-sense patient protections, the shared goal of lowering drug costs for patients will not be fully realized.

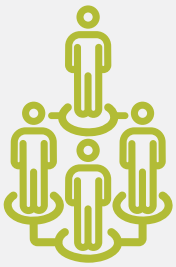
ENCOURAGING PATIENT-FOCUSED POLICY SOLUTIONS

We believe that any policy solution aimed at lowering prescription drug costs should include contributions from across the health care system while ensuring that the patient truly benefits.

Sanofi believes in policies that make reducing patient out-of-pocket costs a top priority...

- Requiring manufacturer rebates and discounts to be passed directly to the patients receiving those medicines
- Delinking supply chain payments from list prices and requiring all health plans to count manufacturer copay coupons towards deductibles and out-of-pocket limits
- Implementing out-of-pocket caps for Medicare Part D beneficiaries
- Requiring CMS, Medicare Part D plans and Marketplace plans to provide information about the availability of patient assistance programs from manufacturers and other sources, such as state pharmaceutical assistance programs (SPAPs) and nonprofit charities

...while continuing to cultivate a competitive, free market system.



To facilitate affordable access to innovative treatments, Congress should enact policies that encourage competition while rewarding the risk-taking necessary to discover and develop life-saving medicines. After a reasonable period of time, generic and biosimilar medicines should be able to quickly enter the market to offer patients long-term access at lower costs. To achieve these goals, Sanofi supports:

- Increasing competition among medicines and limiting manufacturers' ability to unfairly avoid competition
- Increasing system-wide transparency by encouraging relevant information be available to patients and policymakers. Providing greater transparency around what is driving costs in the system, including the role of PBMs and others and why discounts are not reaching patients at the pharmacy counter, will enable increased competition across health care and better-informed decision-making

[8] PhRMA, 2020.

PRIORITIZING PATIENT AFFORDABILITY

Our commitment to transparency extends beyond responsible launch pricing and limited price increases. We recognize that too many patients in the United States are struggling to afford their medications, and that is why we offer a suite of programs to address a range of patient needs.

In 2020, as the world faced the COVID-19 pandemic, Sanofi moved to protect patients and their families and ensure continued access to our existing medicines. The urgency to ensure patient access was clear, and meaningful action was needed to help the millions experiencing unexpected loss of income and health insurance.

To help those who have been impacted as a result of COVID-19, Sanofi introduced temporary changes to the patient assistance component of Sanofi Patient Connection. These changes will remain in place as long as patients continue to remain impacted by the pandemic.

Beyond the ongoing pandemic, Sanofi continues to invest in our innovative and industry-leading savings programs that directly reduce out-of-pocket insulin costs. Sanofi was the first company to introduce a program — our Insulins Val***you*** Savings Program — in which uninsured patients could access one or multiple Sanofi insulins at a fixed price of $99 per month for up to 10 boxes of SoloStar pens and/or 10-mL vials, or 5 boxes of Toujeo® (insulin glargine injection) 300 units/mL Max SoloStar pens. Additionally, the Soliqua® (insulin glargine and lixisenatide injection) 100 units/mL and 33 mcg/mL cash offer allows uninsured people to pay $99 per box of pens, for up to 2 boxes of pens for a 30-day supply.

Our copay assistance programs for commercially insured patients limit out-of-pocket expenses for a majority of participating patients between $0 to $10 per month for their diabetes medicines, regardless of the patient's income level.

In addition, we provide free medications to eligible patients with a demonstrated financial need through Sanofi Patient Connection. Some people facing an unexpected financial hardship may be eligible for a one-time, immediate month's supply of their Sanofi medicine as they wait for their application to process.

Every patient has unique circumstances. Sanofi has live support specialists at **(800) 633-1610** to answer patients' questions and help navigate their individual situations in an effort to find the best resources and programs to help lower their out-of-pocket costs.

2020 PATIENT SUPPORT: BY THE NUMBERS

1.9 million
*# OF TIMES A **SANOFI COPAY ASSISTANCE CARD** WAS USED*

$543 million
*PATIENT SAVINGS FROM USE OF **COPAY ASSISTANCE PROGRAMS***

91,415
*# OF TIMES **INSULINS VALYOU SAVINGS PROGRAM** WAS USED*

$35 million
*PATIENT SAVINGS FROM USE OF **INSULINS VALYOU SAVINGS PROGRAM***

99,693 *# OF PATIENTS WHO RECEIVED FREE MEDICINE THROUGH **PATIENT ASSISTANCE PROGRAMS***

$890 million
*VALUE OF MEDICINE PROVIDED VIA **PATIENT ASSISTANCE PROGRAMS***

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