The presentations for Eli Lilly’s investment community meeting contain forward-looking statements that are based on management’s current expectations, but actual results may differ materially due to various factors. The company’s results may be affected by factors including, but not limited to, the risks and uncertainties in pharmaceutical research and development; competitive developments; regulatory actions; the extent and duration of the effects of the COVID-19 pandemic; litigation and investigations; business development transactions; economic conditions; and changes in laws and regulations, including health care reform.

For additional information about the factors that affect the company’s business, please see the company’s latest Forms 10-K, 10-Q, and any 8-Ks filed with the Securities and Exchange Commission. In addition, certain financial information in this presentation is presented on a non-GAAP basis. Investors should refer to the reconciliations included in these presentations and should consider the company’s non-GAAP measures in addition to, not as a substitute for or superior to, measures prepared in accordance with GAAP.

The company undertakes no duty to update forward-looking statements except as required by applicable law.
DAN SKOVRONSKY, M.D., PH.D.
Chief Scientific and Medical Officer, and President of Lilly Research Laboratories

ANDREW ADAMS, PH.D.
Vice President, Lilly Genetic Medicine

2021 INVESTMENT COMMUNITY MEETING
AFTER 145 YEARS, OUR PURPOSE REMAINS AS CRITICAL AS EVER

We unite caring with discovery to create medicines that make life better for people around the world.
1. Obesity is a treatable disease; and by reversing it we can dramatically improve population health outcomes

2. Age-related neurodegeneration will become preventable

3. Medicines comprised of nucleic acids will become a major component of disease treatments

Lilly is investing heavily behind each of these three trends, while also growing a diversified portfolio that expands our leadership in targeted oncology and novel immunology opportunities
### OUR TRANSFORMATION JOURNEY

#### Dec 2018 R&D update focus:

- Transforming our drug discovery engine
- Improving our development speed and success rates
- Improving productivity (20 medicines in 10 years)

#### What we’ve accomplished:

- Created a genetic medicine platform anchored in siRNA and gene therapy
- Refocused molecule making technologies to address hard-to-drug targets with potentially best-in-class therapeutics
- Identified novel targets across therapeutic areas
- Achieved industry-leading speeds across preclinical and clinical development
- Significantly increased clinical success rates while still working in high-risk / high-reward areas
- 16 new medicines delivered in 8 years, with good visibility to 5 more potential launches
- Many have outsized potential to help patients, for example 7 of these molecules have ~$3B or more in peak sales potential*

#### What’s next:

- Lilly has created an industry-leading discovery and development engine that has yielded a number of high-value medicines
- Now we take on the dual challenge of maximizing our existing game-changing molecules while also creating new ones
- Reaching more patients through significant NILEX investment in priority medicines
- Sustaining and enhancing R&D productivity, with improvements in speed, success rates, and value creation
- Enriching the next generation of innovation through platform investments

---

*Based on Wall Street peak sales consensus
<table>
<thead>
<tr>
<th>THERAPEUTIC AREA</th>
<th>2018: Where We Were</th>
<th>2021: What We’ve Done Since</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oncology</td>
<td>Actively seeking the next wave of IO, including a bet on IL10; believed Verzenio would be differentiated but limited clinical evidence at the time; no small molecule pipeline</td>
<td>✓ Acquired Loxo Oncology and delivered Retevmo ✓ Built out a small molecule portfolio focused on high conviction assets ✓ Maximized Verzenio reach</td>
</tr>
<tr>
<td>Immuno</td>
<td>Recent launches of Taltz and Olumiant; seeking to translate discovery/pre-clinical work into clinical portfolio</td>
<td>✓ Expanded indications for Taltz and Olumiant ✓ Acquired lebrikizumab, mirikizumab positive Phase 3 data ✓ Built an early-stage clinical pipeline with promising proof of concept read-outs</td>
</tr>
<tr>
<td>Neuro/Pain</td>
<td>Despite setbacks in Alzheimer’s disease, we saw donanemab as a differentiated molecule and designed a thoughtful Phase 2 study heavily leveraging diagnostics with the goal of changing the trajectory of AD</td>
<td>✓ Generated positive registration data for donanemab ✓ Pursued next-gen Alzheimer’s medicines ✓ Created an early-phase pain pipeline</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Aspirations to deliver innovation in incretins and insulins; strong early efficacy data on tirzepatide motivated us to take big bets; competitiveness of Trulicity was questioned</td>
<td>✓ Reinforced Trulicity with strong efficacy data ✓ Progressed innovation across insulins &amp; incretins ✓ Generated positive Phase 3 data for tirzepatide ✓ Created focus around obesity and potential in CV disease</td>
</tr>
</tbody>
</table>
ON TRACK TO DELIVER 20 NEW MEDICINES IN 10 YEARS

16 New Medicines Delivered in 8 Years

2014: trulicity, Jardiance, CYRAMZA
2015: basaglar, Portrazza
2016: taltz, Lartruvo
2017: Verzenio, olumiant
2018: Emgality, Tyvyt
2019: baqsimi, LYUMJEV
2020: REYVOW, Retevmo
2021: bamlanivimab, etesevimab

Potential Launches

2022 - 2023

- Tirzepatide
- Donanemab
- Pirtobrutinib
- Lebrikizumab
- Mirikizumab

-3B+ wall street consensus peak sales

* Sales from EUAs

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2021 INVESTMENT COMMUNITY MEETING
INVESTED TO MAXIMIZE TRULICITY

PROGRESS SINCE 2018

- CVOT: Novel REWIND design demonstrated CVOT benefit in broadest patient population in GLP-1 class
- ADA and EASD guidelines updated to include:
  - GLP-1s recommended as 1st injectable medication
  - GLP-1 or SGLT2 with proven CV benefit recommended for patients with CVD
- Higher doses of Trulicity were submitted in <2 years from FRD and now represent over 20% of weekly prescriptions
- Continued market leadership with ~48% TRx SOM of fast-growing injectable GLP-1 class (>25%)

INCREASED GROWTH

Trulicity U.S. TRx have more than doubled since December 2018

CVOT = cardiovascular outcomes trial; ADA = American Diabetes Association; EASD = European Association for the Study of Diabetes; FRD = first registration dose; TRx = total prescriptions; SOM = share of market
Data source: U.S. IQVIA NPA as of week ending 11.19.2021
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INVESTED TO MAXIMIZE JARDIANCE

PROGRESS SINCE 2018

Following EMPA-REG Outcome, the first positive CVOT trial in diabetes, we invested heavily to maximize reach of Jardiance with the intent to fundamentally change how customers think about and treat CV risk in diabetes

HFrEF: Approved in U.S., Europe, and Japan in 2021

HFpEF: Jardiance first therapy to show statistically significant improvement in adults with HFpEF, submitted in U.S., Europe and Japan in 2021

Since Dec. 2018, Jardiance has driven class expansion from ~10% to ~25% in annual TRx growth and Jardiance TRx SOM has increased from ~40% to ~60%

INCREASED GROWTH

Jardiance U.S. TRx have more than doubled since December 2018

CVOT = cardiovascular outcomes trial; CV = cardiovascular; HFrEF = heart failure with reduced ejection fraction; HFpEF, heart failure with preserved ejection fraction; TRx = total prescriptions; SOM = share of market

Data source: U.S. IQVIA NPA as of week ending 11.19.2021

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INVESTED TO MAXIMIZE TALTZ

PROGRESS SINCE 2018

- Superiority vs. competitors established in multiple head-to-head studies
- Approvals in radiographic-axSpA and non-radiographic axSpA to expand reach in rheumatology
- With strong efficacy data, we have improved access for patients with TRx more than doubling since Dec 2018
- Continued opportunity for growth, as anti-TNF share remains at ~40% of dermatology and ~70% of rheumatology total prescriptions

INCREASED GROWTH

Taltz U.S. TRx have more than doubled since December 2018

AxSpA = axial spondyloarthritis; TRx = total prescriptions; TNF = tumor necrosis factor
Data source: U.S. IQVIA NPA as of week ending 11.19.2021
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PROGRESS SINCE 2018

Believed Verzenio was a differentiated CDK 4/6 and we invested in collecting data to prove it

Monarch2: positive, significant OS data and label update in metastatic breast cancer

High-risk early breast cancer:
- Only CDK 4/6 with positive Phase 3 data in early breast cancer to date (monarchE)
- Approval in the U.S. in high Ki-67 subpopulation
- Expected approval in Japan before the end of 2021 and in Europe in the first half of 2022
- Approved label increases U.S. addressable market by 8-10k patients

Prostate: CYCLONE-2 moved to Phase 3 portion of trial based on Phase 2 interim analysis; CYCLONE-2 U.S. addressable market ~7-14k patients

INCREASED GROWTH

Verzenio U.S. TRx have more than tripled since December 2018

OS = overall survival; TRx = total prescriptions; NBRx = new to brand prescriptions; SOM = share of market
Data source: IQVIA NPA 13-week average SOM data as of week ending 11.19.21 Note: Q2 2020 IQVIA data was impacted by an addition of data for Verzenio

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Most cases of nausea, vomiting and diarrhea were mild-to-moderate and most frequently occurred during the dose-escalation period across all doses of tirzepatide.
TIRZEPATIDE T2D SURPASSED EXPECTATIONS
HELPED UP TO 97% AND 62% OF PATIENTS REACH HBA1C BELOW 7.0% AND 5.7%, RESPECTIVELY

**Patients achieving HbA1c target <7.0%**

SURPASS-1 vs. placebo (40 weeks)
- Placebo: 20%
- Active Comparator: 87%
- T2P 5 mg: 92%
- T2P 10 mg: 88%
- T2P 15 mg: 92%

SURPASS-2 vs. semaglutide 1mg (40 weeks)
- Placebo: 81%
- Active Comparator: 85%
- T2P 5 mg: 89%
- T2P 10 mg: 92%

SURPASS-3 vs. insulin degludec (52 weeks)
- Placebo: 61%
- Active Comparator: 90%
- T2P 5 mg: 93%

SURPASS-4 vs. insulin glargine (52 weeks)
- Placebo: 51%
- Active Comparator: 81%
- T2P 5 mg: 88%
- T2P 10 mg: 91%

SURPASS-5 add on to insulin glargine (40 weeks)
- Placebo: 34%
- Active Comparator: 93%
- T2P 5 mg: 97%
- T2P 10 mg: 94%

**Patients achieving HbA1c target <5.7%**

Placebo: 1%
- Active Comparator: 31%
- T2P 5 mg: 52%
- T2P 10 mg: 51%
- T2P 15 mg: 45%

SURPASS-1 vs. placebo (40 weeks)
- Placebo: 20%
- Active Comparator: 34%
- T2P 5 mg: 31%

SURPASS-2 vs. semaglutide 1mg (40 weeks)
- Placebo: 20%
- Active Comparator: 29%
- T2P 5 mg: 45%
- T2P 10 mg: 51%

SURPASS-3 vs. insulin degludec (52 weeks)
- Placebo: 5%
- Active Comparator: 29%
- T2P 5 mg: 39%

SURPASS-4 vs. insulin glargine (52 weeks)
- Placebo: 3%
- Active Comparator: 23%
- T2P 5 mg: 33%

SURPASS-5 add on to insulin glargine (40 weeks)
- Placebo: 3%
- Active Comparator: 26%
- T2P 5 mg: 43%

*denotes statistical significance to comparator; + denotes not controlled for type I error
T2P = tirzepatide; Results presented using the efficacy estimand, which represents efficacy prior to discontinuation of study drug or initiating rescue therapy for persistent severe hyperglycaemia

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TIRZEPATIDE DURABILITY
SURPASS-4 CHANGE FROM BASELINE IN HBA1C TO END OF STUDY

Overall mean baseline HbA1c = 8.54%

HbA1c reduction plateaued by ~24 weeks and was maintained up to 104 weeks for all three tirzepatide doses

MMRM analysis; Modified intent-to-treat population (efficacy analysis set); Data presented are LS means ± standard errors; tirzepatide vs. insulin glargine at 104 weeks: *p<0.001.

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2021 INVESTMENT COMMUNITY MEETING
TIRZEPATIDE WEIGHT LOSS
PROVIDED STATISTICALLY SIGNIFICANT WEIGHT REDUCTION VERSUS ALL COMPARATORS STUDIED

Baseline Weight [kg]
- SURPASS-1 vs. placebo (40 weeks)
  - 85.9 kg
- SURPASS-2 vs. semaglutide 1mg (40 weeks)
  - 93.7 kg
- SURPASS-3 vs. insulin degludec (52 weeks)
  - 94.3 kg
- SURPASS-4 vs. insulin glargine (52 weeks)
  - 90.3 kg
- SURPASS-5 add on to insulin glargine (40 weeks)
  - 95.2 kg

Patients achieving ≥5% weight loss
- SURPASS-1
  - Placebo: 67% (78%*77%*)
  - 5 mg: 67%
  - 10 mg: 58%
  - 15 mg: 14%
- SURPASS-2
  - Placebo: 58% (69%*82%*86%*)
  - 5 mg: 58%
  - 10 mg: 53%
  - 15 mg: 15%
- SURPASS-3
  - Placebo: 66% (84%*88%*)
  - 5 mg: 66%
  - 10 mg: 66%
  - 15 mg: 53%
- SURPASS-4
  - Placebo: 8% (78%*85%*)
  - 5 mg: 8%
  - 10 mg: 36%
  - 15 mg: 2%
- SURPASS-5
  - Placebo: 6% (54%*65%*)
  - 5 mg: 6%
  - 10 mg: 36%
  - 15 mg: 23%

Patients achieving ≥10% weight loss
- SURPASS-1
  - Placebo: 31% (40%*47%*)
  - 5 mg: 25%
  - 10 mg: 38%
  - 15 mg: 1%
- SURPASS-2
  - Placebo: 25% (38%*53%*65%*)
  - 5 mg: 25%
  - 10 mg: 36%
  - 15 mg: 9%
- SURPASS-3
  - Placebo: 36% (56%*69%*)
  - 5 mg: 36%
  - 10 mg: 56%
  - 15 mg: 37%
- SURPASS-4
  - Placebo: 2% (53%*66%*)
  - 5 mg: 2%
  - 10 mg: 53%
  - 15 mg: 2%
- SURPASS-5
  - Placebo: 1% (23%*47%*51%*)
  - 5 mg: 1%
  - 10 mg: 23%
  - 15 mg: 1%

Patients achieving ≥15% weight loss
- SURPASS-1
  - Placebo: 13% (17%*27%*)
  - 5 mg: 0%
  - 10 mg: 15%
  - 15 mg: 13%
- SURPASS-2
  - Placebo: 9% (15%*28%*40%*)
  - 5 mg: 9%
  - 10 mg: 15%
  - 15 mg: 1%
- SURPASS-3
  - Placebo: 13% (28%*43%*)
  - 5 mg: 0%
  - 10 mg: 28%
  - 15 mg: 1%
- SURPASS-4
  - Placebo: 1% (14%*24%*37%*)
  - 5 mg: 1%
  - 10 mg: 24%
  - 15 mg: 0%
- SURPASS-5
  - Placebo: 0% (7%*27%*32%*)
  - 5 mg: 0%
  - 10 mg: 7%
  - 15 mg: 7%

*denotes statistical significance to comparator; All TZP arms were not controlled for type 1 error
TZP = tirzepatide; Results presented using the efficacy estimate, which represents efficacy prior to discontinuation of study drug or initiating rescue therapy for persistent severe hyperglycaemia

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Weight loss plateaued at ~52 weeks and was maintained up to 104 weeks; ~15% weight difference at 104 weeks between tirzepatide 15mg and insulin glargine

MMRM analysis; Modified intent-to-treat population (efficacy analysis set); Data presented are LS means ± standard errors; tirzepatide vs. insulin glargine at 104 weeks: *p<0.001. BMI = body mass index

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Continued Investment to Maximize Tirzepatide
Significant Investment Beyond T2D to Expand Reach

Investigating the potential for earlier and sustained glycemic control and weight reduction in T2D and clinically relevant weight loss.

Generating data in the SURMOUNT program with the goal of making tirzepatide the standard of care for obesity and providing evidence that lower body weight improves outcomes.

Conducting clinical trials in NASH, HFP EF, obstructive sleep apnea, and renal impairment.

T2D = Type 2 Diabetes; NASH = Nonalcoholic Steatohepatitis; HFP EF = Heart failure with preserved ejection fraction.
Consistency of TRAILBLAZER-ALZ Results Across Statistical Methods

DPM = Disease Progression Model; MMRM = Mixed Model for Repeated Measure; NCS2 = Natural Cubic Spline with 2 degrees of freedom; NCS3 = Natural Cubic Spline with 3 degrees of freedom; QMM = Quadratic Mixed Model; For frequentist analyses *p<0.05; **p<0.01 vs. placebo; for DPM ** indicates posterior probability of at least 0% slowing >99%; iADRS = Integrated Alzheimer’s Disease Rating Scale; CDR-SB = Clinical Dementia Rating-Sum of Boxes

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DONANEMAB BIOMARKER DATA
IMPACT ON BOTH AMYLOID AND TAU PATHOLOGY IN TRAILBLAZER-ALZ

DONANEMAB LOWERED AMYLOID PLAQUE

Amyloid plaque significantly lowered with donanemab treatment (MMRM)

Donanemab slowed regional tau growth on flortaucipir PET

Data points show mean +/- standard error
LS = Least Square; MMRM = Mixed Model Repeated Measures; PET = Positron Emission Tomography; p = p-value

** p<0.01; *** p<0.001; **** p<0.0001 vs placebo
All p-values are nominal

Adapted from Palmqvist et al. 2020, JAMA Neurology

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CONTINUOUS INVESTMENT TO MAXIMIZE DONANEMAB
SIGNIFICANT INVESTMENT IN GENERATING ADDITIONAL DATA FOR THE FIELD

Expanding globally from 500 to over 1,500 patients for potentially confirmatory study of donanemab in patients with early Alzheimer’s disease

Testing donanemab for prevention of Alzheimer’s disease in pre-symptomatic population using novel decentralized trial design and p-Tau 217 diagnostic for inclusion

Initiating head-to-head study vs aducanumab to assess superiority on the level of brain amyloid plaque clearance in early symptomatic Alzheimer’s disease at specific timepoints

Investing in next-generation N3pG antibody amyloid-lowering agent with potential for subcutaneous dosing
PIRTOBRUTINIB
PRECLINICAL DATA PROMPTED INITIAL THESIS IN C481-MUTANT POPULATION

KINOME SELECTIVITY

Highly selective for BTK\(^1\)

XENOGRAGFT MODELS

*In vivo* activity similarly effective as ibrutinib in WT; superior in C481S

**TMD8 BTK-WT**

**TMD8 BTK-C481S**

- Nanomolar potency against WT & C481-mutant BTK in cell and enzyme assays\(^2\)
- >300-fold selectivity for BTK vs 370 other kinases\(^2\)
- Due to reversible binding mode, BTK inhibition not impacted by intrinsic rate of BTK turnover\(^2\)
- Favorable pharmacologic properties allow sustained BTK inhibition throughout dosing interval\(^2\)

BID, twice-daily; BTK, Bruton tyrosine kinase. \(^1\)Mato et al, Lancet. 2021;397:892-901.

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2021 INVESTMENT COMMUNITY MEETING
PIRTOBRUTINIB DATA IN CLL/SLL

Data cutoff date of 16 July 2021. *Patients with >100% increase in SPD. Data for 30 patients are not shown in the waterfall plot due to no measurable target lesions identified by CT at baseline, discontinuation prior to first response assessment, or lack of adequate imaging in follow-up. **Efficacy evaluable patients are those who had at least one post-baseline response assessment or had discontinued treatment prior to first post-baseline response assessment. iORR includes patients with a best response of CR, PR, and PR-L. Response status per iwCLL 2018 according to investigator assessment. Total % may be different than the sum of the individual components due to rounding. CLL = Chronic lymphocytic leukemia; SLL = small lymphocytic lymphoma; CR = complete response; PR = partial response; SD = stable disease

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PIRTOBRTUNIB DATA IN MCL

BTK Pre-Treated MCL Patients
n=100
Overall Response Rate (ORR)\textsuperscript{2}, % (95% CI) 51% (41-61)
Best Response
CR, n (%) 25 (25)
PR, n (%) 26 (26)
SD, n (%) 16 (16)

BTK Naive MCL Patients
n=11
Overall Response Rate\textsuperscript{2}, % (95% CI) 82% (48-98)
Best Response
CR, n (%) 2 (18)
PR, n (%) 7 (64)
SD, n (%) 1 (9)

Data cutoff date of 16 July 2021. Data for 20 MCL patients are not shown in the waterfall plot due to no measurable target lesions identified by CT at baseline, discontinuation prior to first response assessment, or lack of adequate imaging in follow-up. *Indicates patients with >100% increase in SPD. 1Efficacy evaluable patients are those who had at least one post-baseline response assessment or had discontinued treatment prior to first post-baseline response assessment.
2ORR includes patients with a best response of CR and PR. Response status per Lugano 2014 criteria based on investigator assessment. Total % may be different than the sum of the individual components due to rounding; CR = complete response; PR = partial response; SD = stable disease
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CONTINUED INVESTMENT TO MAXIMIZE PIRTOBRUTINIB
SIGNIFICANT INVESTMENT TO MAXIMIZE REACH

Initiating a significant Phase 3 program, with five trials in more than 2,000 patients studying pirtobrutinib alone and in combination in first-line and refractory patients in CLL, SLL, and MCL

Program focused on establishing pirtobrutinib as the potential preferred agent for people with relapsed disease following a covalent BTK inhibitor, as well as exploring potential to move to earlier lines of treatment, including a head-to-head superiority trial compared to ibrutinib

In-licensed a preclinical BCL-2 inhibitor now in Phase 1 with the potential for combination with pirtobrutinib in hematological malignancies

CLL = chronic lymphocytic leukemia; SLL = small lymphocytic lymphoma; MCL = mantle cell lymphoma
MIRIKIZUMAB & LEBRIKIZUMAB
POSITIVE PHASE 3 RESULTS FOR TWO NEW MOLECULES IN IBD AND DERM

MIRIKIZUMAB

Positive Phase 3 induction and maintenance results for ulcerative colitis
Global submission in H1 2022 could lead to first-in-class anti-IL-23p19 monoclonal antibody treatment for ulcerative colitis
Crohn’s disease Phase 3 readout in early 2024
Addressable markets with unmet need:
- Ulcerative colitis ~1.1M patients in U.S. and ~1.2M patients in Europe
- Crohn’s disease ~900K patients in U.S. and ~1M patients in Europe

LEBRIKIZUMAB

Positive Phase 3 monotherapy induction results in 2021 for atopic dermatitis establishes competitive profile vs. Dupixent
Phase 3 results expected in late 2021/early 2022 for atopic dermatitis in combination with topical corticosteroids
Monotherapy maintenance data expected in H1 2022, with global submissions expected by year-end 2022
Addressable market with unmet need:
- ~18M patients in U.S. and ~2.5M receive diagnosis
- ~400K patients diagnosed as moderate-to-severe

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2021 INVESTMENT COMMUNITY MEETING

26
COVID-19 THERAPEUTICS

DISCOVERY and DEVELOPMENT

In partnership with AbCellera, went from discovery to EUA for bamlanivimab in only eight months

EUA for bamlanivimab + etesevimab granted in Q1 2021

Authorized for both ambulatory and post-exposure prophylaxis use in U.S.

Baricitinib evaluated to treat critically ill COVID-19 patients

SUPPLY

Supplied U.S. and international markets beginning in November 2020

BARDA estimates that bamlanivimab alone and bamlanivimab + etesevimab saved over 10,000 lives in the U.S. alone

~2 million doses of COVID-19 neutralizing antibodies supplied globally in past 13 months

PATIENT ACCESS and EASE OF USE

Worked with governments to ensure neutralizing antibodies at no cost to patients wherever possible

Donated 400k baricitinib tablets to India and royalty-free licensing to combat COVID-19 pandemic

Developed partnerships to provide access to COVID-19 neutralizing antibodies for patients in low-income countries
RESULTS FROM OUR TRANSFORMATION JOURNEY

- Improved development speed
- Target identification to clinical testing in < 3 years
- Industry leading speed
- Improved clinical success rates
- Improved Phase 3 success rates
- Novel target identification
- Significant value creation
- Record productivity: On track for 20 launches in 10 years
- Access to novel modalities
Target Identification to Clinic Entry (Years)

- **2014-2016**: 4.7 years
- **2015-2017**: 4.7 years
- **2016-2018**: 4.2 years
- **2017-2019**: 3.5 years
- **2018-2020**: 3.0 years
- **2019-2021**: 2.9 years

**GGG Tri-agonist**: Target to clinic in ~2.5 years

**ANGPTL3 siRNA & Lp(a) siRNA**: Target to clinic in ~2 years

**Imlunestrant**: Target to clinic in ~3.4 years
### Faster Clinical Development Timelines

#### First Human Dose to Launch (Years)

<table>
<thead>
<tr>
<th>Period</th>
<th>Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010 - 2014</td>
<td>11.5</td>
</tr>
<tr>
<td>2011 - 2015</td>
<td>9.9</td>
</tr>
<tr>
<td>2012 - 2016</td>
<td>8.9</td>
</tr>
<tr>
<td>2013 - 2017</td>
<td>7.7</td>
</tr>
<tr>
<td>2014 - 2018</td>
<td>7.6</td>
</tr>
<tr>
<td>2015 - 2019</td>
<td>7.2</td>
</tr>
<tr>
<td>2016 - 2020</td>
<td>6.2</td>
</tr>
<tr>
<td>2017 - 2021</td>
<td>5.9</td>
</tr>
</tbody>
</table>

- **Tirzepatide**: First human dose to submission in 5.3 years
- **Pirtobrutinib**: First human dose in March 2019
- **Bamlanivimab & Etesevimab**: First human dose to EUA in <8 months
WE CONTINUE TO GROW OUR PORTFOLIO

PHASE 1 ENTRIES

- Avg. 2016-2018: 10
- Avg. 2019-2021: 14

36%

PHASE 2 ENTRIES

- Avg. 2016-2018: 5
- Avg. 2019-2021: 9

60%

PHASE 3 ENTRIES

- Avg. 2016-2018: 2
- Avg. 2019-2021: 3

80%

NILEX
NME
### INCREASED CLINICAL SUCCESS RATES

<table>
<thead>
<tr>
<th>Industry Average</th>
<th>Lilly Overall Clinical Success Rate 5-year moving average</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2016-2020</strong></td>
<td></td>
</tr>
<tr>
<td>Phase 1</td>
<td>42%</td>
</tr>
<tr>
<td></td>
<td>45%</td>
</tr>
<tr>
<td>Phase 2</td>
<td>34%</td>
</tr>
<tr>
<td></td>
<td>31%</td>
</tr>
<tr>
<td>Phase 3</td>
<td>73%</td>
</tr>
<tr>
<td></td>
<td>81%</td>
</tr>
<tr>
<td>Registration</td>
<td>99%</td>
</tr>
<tr>
<td></td>
<td>91%</td>
</tr>
<tr>
<td>Clinical Overall</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>10%</td>
</tr>
</tbody>
</table>

* Industry peers are based on the Pharmaceutical Benchmarking Forum’s participant companies: AbbVie, Inc.; Allergan PLC (which was acquired by AbbVie, Inc. in May 2020); Bayer AG; Bristol-Myers Squibb Company; Eli Lilly and Company; Gilead Sciences, Inc.; Johnson & Johnson Corporation; Merck & Co, Inc.; Novartis AG; Pfizer; Roche, Inc. and Sanofi S.A.

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LILLY R&D PRODUCTIVITY VS. PEERS

Data sources:
- y-axis: EvaluatePharma consensus estimates for current NME pipelines and NME launches since 2014, as of August 20, 2021
- x-axis: Company reported R&D OPEX FY2020 + estimate of one-time M&A expenditures for pipeline assets through 1H 2021

- Donanemab $35.3B
- Tirzepatide $28.6B
- Trulicity $19.6B
- Verzenio $17.2B
- Taltz $9.8B
- Cyramza $6.8B
- Jardiance $5.1B
- Tyyt $5.0B
- Rtevmo $4.4B
- Emsgalit $3.9B

2021 INVESTMENT COMMUNITY MEETING
WE ARE WELL POSITIONED TO DELIVER

STRONG SCIENTIFIC FOUNDATION

Deep Expertise in neurodegenerative pathology, insulins and incretins, targeted small molecules for oncology, and immunology check points

Best-in-class Molecule Making against difficult targets

Building a portfolio of Novel Modality Platforms with siRNAs and gene therapies that access the CNS + strategic focus on additional tissues & enabling technologies

DIFFERENTIATED CLINICAL EXECUTION

Translating our Operational Excellence to new ways of working; became the first company to obtain EUA for COVID-19 therapies

Making research more diverse and accessible for every patient using Decentralized Capabilities to run the first-ever decentralized Alzheimer’s trial

External Innovation that expands our capabilities with free-standing units like Loxo Oncology, and access to novel targets and platforms
EXTERIAL INNOVATION THAT EXPANDS OUR CAPABILITIES

Free Standing Units
- Avid Radiopharmaceuticals
- LOXO Oncology
- Prevail Therapeutics
- Protomer Technologies

Molecules
- Retevmo Pirtobrutinib
- Lebrikizumab
- SSTR4 Agonist
- RIPK1 Inhibitor
- P2X7 Receptor Antagonist
- GLP-1 Non-Peptide Agonist
- PI3Kα inhibitor
- Barlanivimab Etesivimab

Novel Targets
- disArm Therapeutics
- sitryX
- KQ
- ImmuNext

Modality Platforms
- Dicerna
- Precision Biosciences
- Merus
- Avidity Biosciences
- ProQR
- VERGE Genomics
- FOGHorn Therapeutics

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2021 INVESTMENT COMMUNITY MEETING
NOVEL MODALITIES WILL DRIVE THE NEXT WAVE OF INNOVATION

~20,000 human proteins

In 2017, approved drugs only targeted 667 human proteins

Significant opportunity to reach historically undruggable targets with novel therapeutics

NOVEL MODALITIES AT LILLY

Develop expertise in novel modalities & genetic medicine

Access novel chemistry platforms via external innovation

Pursue delivery approaches to unlock new tissues & targets
EMBRACING THE POWER OF PLATFORMS

Building capabilities internally

- Established a team of dedicated subject matter experts in Indianapolis & Cambridge
- Quickly integrated personnel and technologies
- Intensively built development capabilities to support clinical study of oligonucleotides
- Progressed initial candidates into clinical testing with accelerated timelines

External innovation has allowed us to access foundational science

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Genetic medicines now represent >20% of Lilly’s diabetes, immunology, and neuroscience research portfolio
Circulating Apo(a) is reduced >99% by LP[a] siRNA in cynomolgus monkey between weeks 3-7 following a single dose

- Sustained suppression of Apo(a) protein in monkeys
- Potential for best-in-class Lp(a) efficacy and durability – targeting 3-6 month dosing

Key goals

- Meaningful outcomes
  Genetic evidence is promising
- Compelling preclinical data
  >99% sustained LP[a] reduction in NHP
- Infrequent dosing
  Targeting Q3 to Q6 monthly dosing
- Competitive cost to manufacture
  On track
INTERNAL PROGRESS IN DELIVERY OF RNA THERAPEUTICS TO THE CNS

Proprietary Lilly siRNA Design
Novel delivery moiety with favorable biodistribution, including to disease-relevant deep brain structures (e.g., Cortex)

Compelling preclinical data
>90% sustained reduction in target RNA in gold standard NHP model

Early durability is encouraging
Sustained reduction in mRNA out to 28 days following a single dose

CNS = central nervous system; GAPDH = glyceraldehyde-3-phosphate dehydrogenase; PBS = phosphate buffered saline; NHP = nonhuman primate; IT = intrathecal; KD = equilibrium dissociation constant
WHAT’S NEXT

Strong scientific foundation

Differentiated clinical execution

GGG Tri-Agonist
Weekly Basal Insulin Fc
CD200R Agonist Ab
Imlunestrant
IDH1/2 Inhibitor
Tau siRNA

GLP-1 Receptor NPA
ANGPTL3 siRNA
CXCR1/2L
KRAS G12C
PI3Ka mutant selective
N3pG IV

Oxymontodulin
IL-2 Conjugate
RIPK1 Inhibitor
PD-1 Agonist Ab
BTLA Agonist Ab
FGFR3 Inhibitor

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