Q1 2025 Financial Results Presentation

May 6, 2025

Forward Looking Statements

This presentation contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1955 ("PSLRA") relating to, among other things, continued development and expansion of our business, projected financial performance including sales and revenue growth, potential results of our Phase 1b study of R289 in R/R lower-risk MDS, future Phase 2 studies of olutasidenib in recurrent glioma, potential identification of opportunities and completion of acquisition or in-license of new accretive late-stage assets, efficacy of products in clinical trials and related future performance, potential clinical benefit and market opportunity for our commercial portfolio, regulatory agency approval in other markets or indications for fostamatinib or olutasidenib or pralsetinib, success of our partnering efforts including business growth and financial and commercial milestone achievements, and Rigel's ability to achieve the projected 2025 financial outlook.

Any statements contained in this presentation that are not statements of historical fact may be deemed to be forward-looking statements and as such are intended to be covered by the safe harbor for "forward-looking statements" provided by the PSLRA. Forward-looking statements can be identified by words such as "plan", "potential", "may", "outlook", "anticipates", "expects", "will" and similar expressions in reference to future periods. Forward-looking statements are neither historical facts nor assurances of future performance. Instead, they are based on Rigel's current beliefs, expectations, and assumptions and hence they inherently involve significant risks, uncertainties and changes in circumstances that are difficult to predict and many of which are outside of Rigel's control. Therefore, you should not rely on any of these forward-looking statements. Actual results and the timing of events could differ materially from those anticipated in such forward looking statements as a result of these risks and uncertainties, which include, without limitation, risks and uncertainties associated with the commercialization and marketing of fostamatinib, olutasidenib or pralsetinib; risks that the FDA, European Medicines Agency, PMDA or other regulatory authorities may make adverse decisions regarding fostamatinib, olutasidenib or pralsetinib; risks that clinical trials may not be predictive of real-world results or of results in subsequent clinical trials; risks that fostamatinib, olutasidenib or pralsetinib may have unintended side effects, adverse reactions or incidents of misuses; the availability of resources to develop, manufacture and commercialize Rigel's product candidates; market competition; and those other risks detailed from time to time in Rigel's reports filed with the Securities and Exchange Commission, including its Annual Report on Form 10-K for the year ended December 31, 2024 and subsequent filings. Any forward-looking statement made by us in this presentation is based only on information currently available to us and speaks only as of the date on which it is made. Rigel does not undertake any obligation to update forward-looking statements, whether written or oral, that may be made from time to time, whether as a result of new information, future developments or otherwise, and expressly disclaims any obligation or undertaking to release publicly any updates or revisions to any forward-looking statements contained herein, except as required by law.

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Growing Our Hematology and Oncology Business

Commercial Execution

Tavalisse® (fostamatinib disodium hexahydrate) tablets

ITP

REZLIDHIA® (olutasidenib) 150 mg capsules

m*IDH1* R/R AML

GAVRETO® pralsetinib 100 mg capsules

RET Fusion-Positive NSCLC and TC

Development & Expansion

Development Programs[1]

- Continue evaluation of R289, a dual IRAK1/4 inhibitor, in Phase 1b study in R/R lower-risk MDS
- Expand olutasidenib beyond m*IDH1* R/R AML, with plans to initiate a Phase 2 study in recurrent glioma

In-Licensing and Product Acquisition

- Identify new late-stage assets which leverage current capabilities and capacity

Financial Discipline

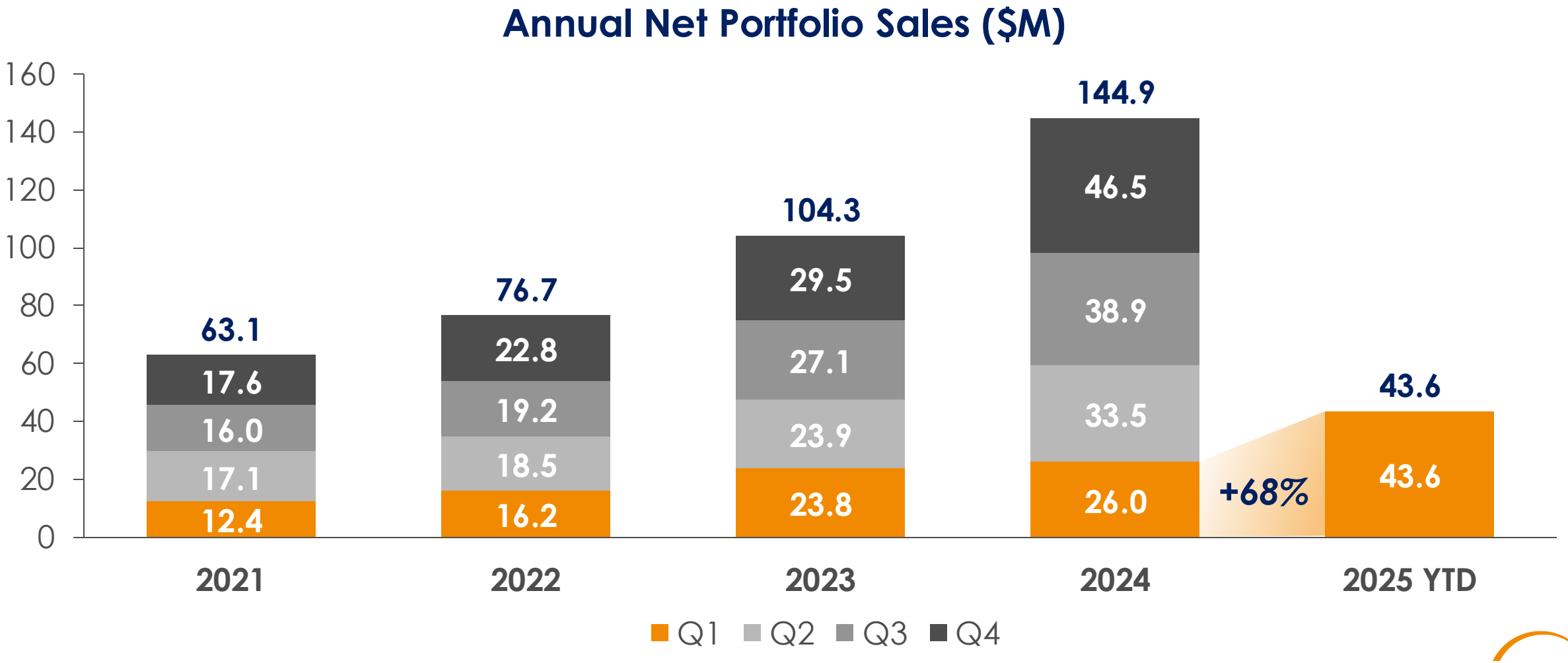
ITP, immune thrombocytopenia; IDH1, isocitrate dehydrogenase-1; m*IDH1*, mutated IDH1; R/R, relapsed or refractory; AML, acute myeloid leukemia; RET, rearranged during transfection; NSCLC, non-small cell lung cancer; TC, thyroid cancer; MDS, myelodysplastic syndrome; IRAK1/4, interleukin receptor-associated kinases 1 and 4. **1.** Investigational compounds in these indications and not approved by the FDA. Please see Important Safety Information on slides 33-37. Please visit www.TAVALISSE.com for Full Prescribing Information. Please visit www.REZLIDHIA.com for Full Prescribing Information, including Boxed WARNING. Please visit www.GAVRETO.com for Full Prescribing Information.

Commercial Portfolio

Please see Indications and Important Safety Information on slides 33-37. Please visit www.TAVALISSE.com for Full Prescribing Information. Please visit www.REZLIDHIA.com for Full Prescribing Information, including Boxed WARNING. Please visit www.GAVRETO.com for Full Prescribing Information.

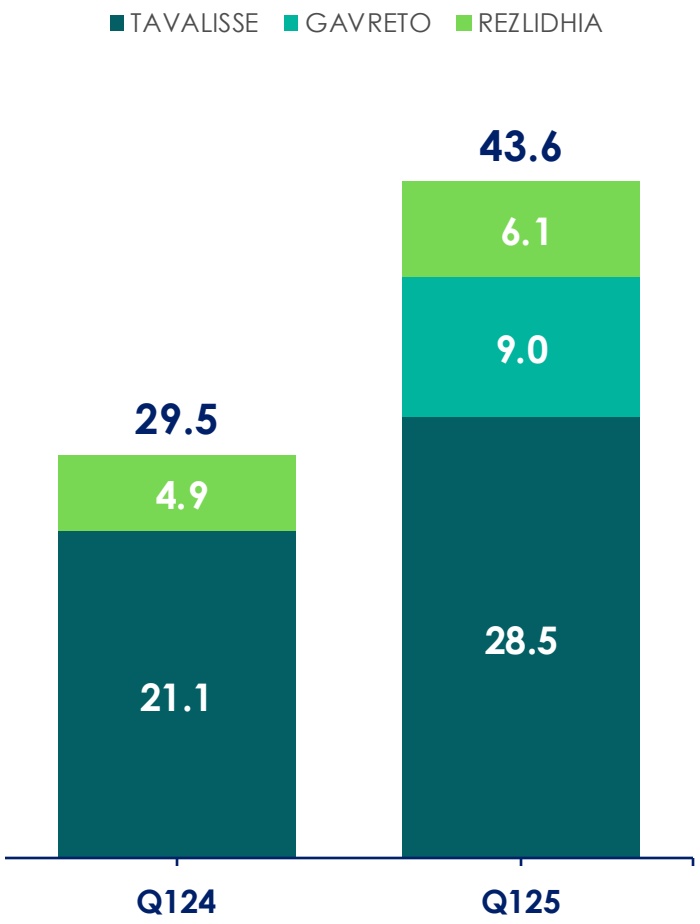
US Net Product Sales Growth

Q1 2025 Net Portfolio Sales grew $17.6M (68%) vs. Q1 2024



Q1 2025 Commercial Performance

Net Product Sales ($M)



Tavalisse® (fostamatinib disodium hexahydrate) tablets

$28.5M
Q1 2025 Net Product Sales

35%
Growth vs. Q1 2024

GAVRETO® pralsetinib 100mg capsules

$9.0M
Q1 2025 Net Product Sales

Available June 2024

REZLIDHIA® (olutasidenib) 150 mg capsules

$6.1M
Q1 2025 Net Product Sales

25%
Growth vs. Q1 2024

Q1 2025 Commercial Performance

Tavalisse® (fostamatinib disodium hexahydrate) tablets

- Quarterly demand continued to grow through new patient starts and carryover
- Successfully streamlined distribution network to improve efficiency

GAVRETO® pralsetinib 100mg capsules

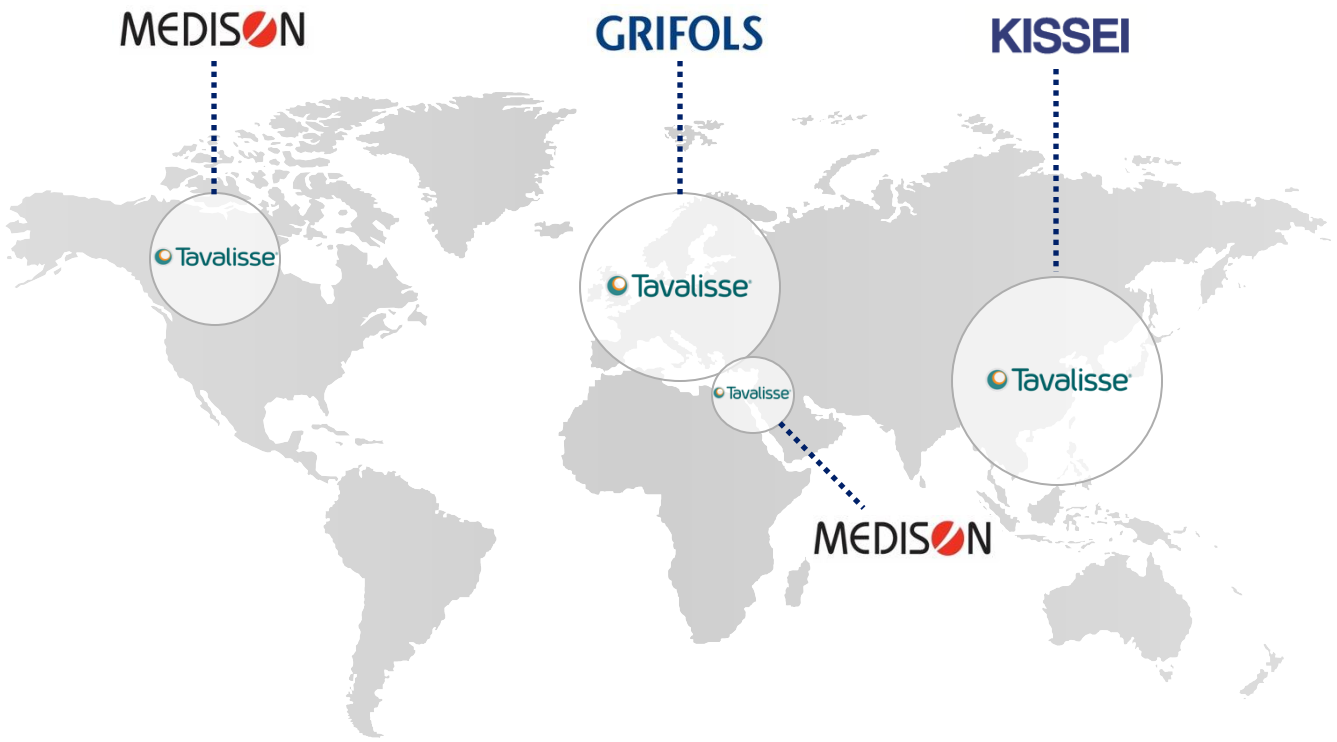
- Seamless transition of existing patients provided platform for growth
- Continued demand drove 18% net sales growth vs. Q4 2024

REZLIDHIA® (olutasidenib) 150 mg capsules

- Continued to generate new patients as awareness grows
- Additional focus on educating clinicians on the importance of keeping patients on therapy

Expanding Commercial Availability in Global Markets

TAVALISSE is commercially available in Japan, key European countries (TAVLESSE), Canada and Israel



Q1 2025 Collaboration Revenues

- Grifols $4.7M
- Kissei $4.6M[1]
- Medison $0.4M

TAVALISSE Regulatory Approvals

- Knight announced regulatory approval in Mexico (Dec 2024)
- Kissei announced regulatory approval in Republic of Korea (Jan 2025)

REZLIDHIA Opportunity[2]

- Executing on ex-U.S. opportunities for development and commercialization
  - Expanded relationship with Kissei to include REZLIDHIA in Japan, the Republic of Korea, and Taiwan
  - Entered relationship with Dr. Reddy's in Latin America and other territories[2]

1. Kissei revenue includes $3.0 million related to a milestone payment from sublicensing fostamatinib. **2.** Forma, now Novo Nordisk, is entitled to a certain portion of Rigel's sublicensing revenue from olutasidenib. 2. Dr. Reddy's territory includes Latin America, South Africa, certain countries in the Commonwealth of Independent States (CIS), India, certain countries in Southeast Asia and North Africa, Australia and New Zealand.

Clinical Development Program Update

Hematology and Oncology Portfolio Expansion

Leverage Hematology/Oncology Capabilities

Development Pipeline[1]

R289 IRAK1/4 Inhibitor

- Evaluating in lower-risk MDS
- Granted Fast Track and Orphan Drug designations by the FDA[2]

Olutasidenib

- Expand beyond m*IDH1* R/R AML
- Plan to initiate a Phase 2 clinical study in recurrent glioma

Fostamatinib

- Investigator sponsored trials

In-Licensing & Product Acquisition

- Differentiated asset(s) in hematology, oncology or related areas
- Late-stage programs
- Synergistic to current in-house capabilities and capacity

IRAK1/4, interleukin receptor-associated kinases 1 and 4; FDA, U.S. Food & Drug Administration; MDS, myelodysplastic syndrome; IDH1, isocitrate dehydrogenase-1, *m*IDH1, mutated IDH1; R/R, relapsed or refractory; AML, acute myeloid leukemia. **1**. Investigational compounds in these indications and not approved by the FDA. **2**. R289 granted Fast Track designation for previously-treated transfusion dependent lower-risk MDS and Orphan Drug designation for MDS by the U.S. FDA.

R289
IRAK1/4 Inhibitor

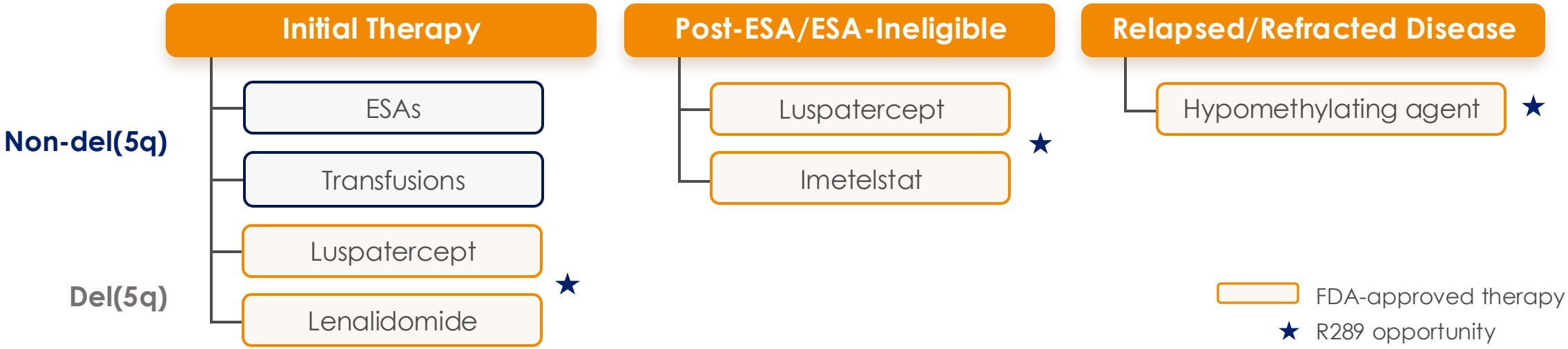
R289[1] Program Value Proposition for Lower-Risk MDS

Unmet Medical Need	• **~12,200 lower-risk MDS patients that have been previously treated[2]** • **Therapies for previously-treated[3] transfusion dependent lower-risk MDS patients are lacking** (HMAs approved >20 years ago)
Novel Mechanism of Action	• **Dysregulated inflammatory signaling** is associated with MDS • **Co-targeting IRAK 1/4 may** suppress inflammation and LSPC function and **restore hematopoiesis** • **Blocks TLR and IL-1R signaling** *in vitro*; **active in preclinical models of inflammation[4]**
Clinical Proof of Concept	• **Markedly suppressed LPS-induced cytokine release** was observed in a randomized controlled trial in healthy volunteers[5]
Regulatory Designations	• **Fast Track designation** for previously-treated transfusion dependent LR-MDS (Nov 2024) • **Orphan Drug designation** for treatment of myelodysplastic syndromes (Jan 2025)
Encouraging Clinical Profile	• **Promising preliminary safety and efficacy in a Phase 1b study** in elderly, heavily pre-treated patients with R/R LR-MDS (n=22) (presented at ASH 2024)[6]

MDS, myelodysplastic syndrome; LR-MDS, lower-risk myelodysplastic syndrome; ESAs, erythropoiesis-stimulating agents; LSPC, liver stem/progenitor cells; TLR, toll-like receptor; IL-1R, interleukin 1 receptor; LPS, lipopolysaccharide; R/R, relapsed or refractory. **1.** Investigational compound not approved by the FDA. **2.** Rigel data analysis on file. Patient population represents previously-treated patients. **3.** Previously-treated by FDA-approved therapy. **4.** Sallman DA, et al. Front Oncol. 2016;6. **5.** Yan L et al. Ann Rheum Dis 2020;79 (suppl 1). **6.** ASH Poster #4595: R289, a Dual IRAK 1/4 Inhibitor, in Patients with Relapsed/Refractory (R/R) Lower-Risk Myelodysplastic Syndrome (LR-MDS): Initial Results from a Phase 1b Study.

Lower-Risk MDS Treatment Landscape

- MDS is a clonal disorder of hematopoietic stem cells (HSCs) leading to dysplasia and ineffective hematopoiesis
  - Consequences: Cytopenias (anemia), infections, iron overload and organ dysfunction, progression to AML
- Primary goal of therapy: Reduce/limit transfusion-dependency
- Recent approvals (luspatercept, imetelstat) have been for first-line therapy



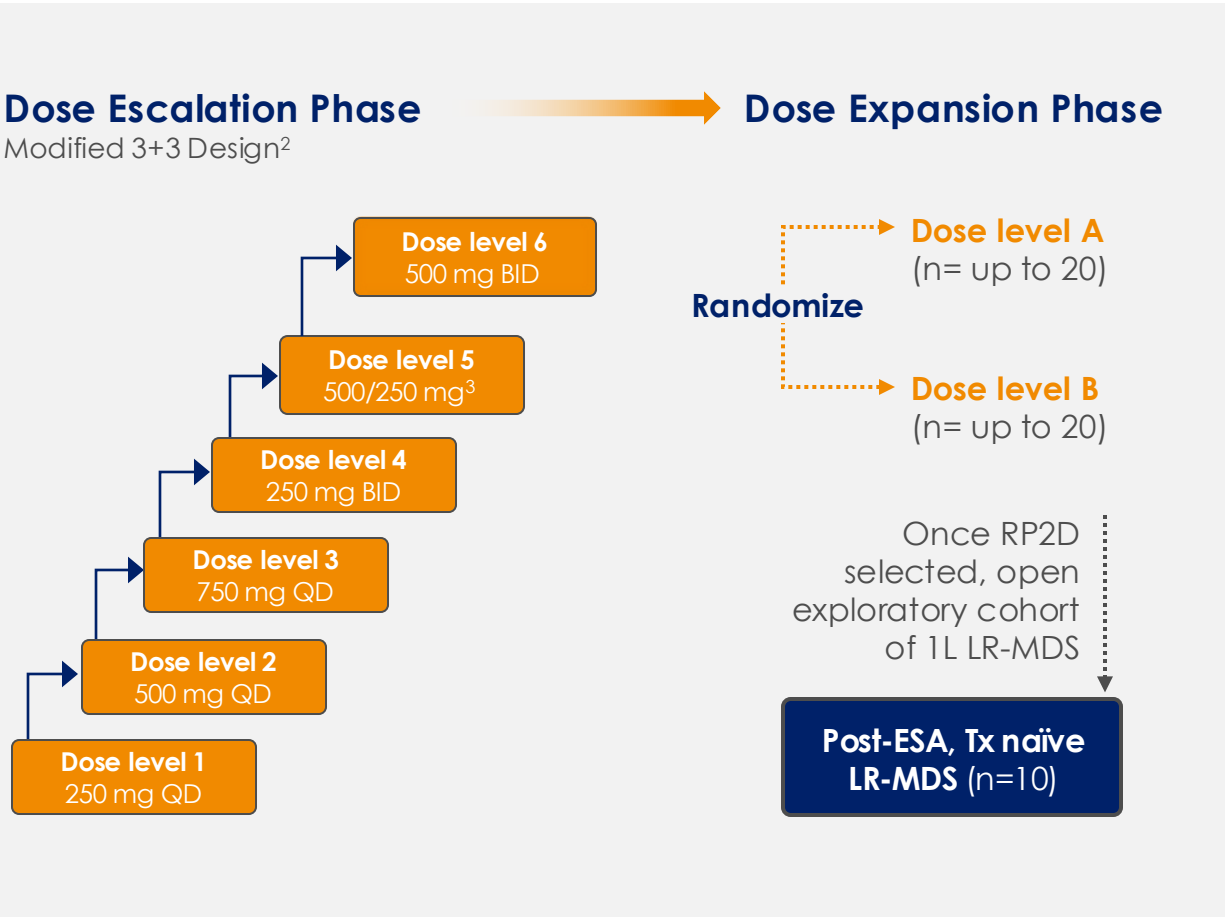
Therapies for previously-treated[1] transfusion dependent lower-risk MDS patients are lacking

MDS, myelodysplastic syndrome; LR-MDS, lower-risk myelodysplastic syndrome; AML, acute myeloid leukemia; ESAs, erythropoiesis-stimulating agents; HMA, hypomethylating agent.

1. Previously treated by FDA-approved therapy.

R289[1]: Phase 1b Study in Relapsed/Refractory Lower-Risk MDS

Open-label, multicenter study to evaluate the safety, tolerability, PK and preliminary activity of R289 in patients with LR-MDS (NCT05308264)



Key Eligibility Criteria

- R/R LR-MDS or inadequate response to prior therapies. Del(5q): R/R to lenalidomide
- Symptomatic anemia (Hb ≤9.0 g/dL) or TD (≥2u RBCs/16wks)

Assessments

- Hematologic responses [TI and HI-E] per IWG 2018 criteria[4] and other responses per IWG 2006 criteria[5], from 8 weeks

Primary Endpoints

- Incidence of adverse events and dose-limiting toxicities

Secondary Endpoints

- Transfusion independence, hematologic improvement, response rates
- PK / PD
- Patient-reported outcomes (FACIT-Fatigue scale)

Initial data presented at ASH 2024

MDS, myelodysplastic syndrome; LR-MDS, lower-risk MDS; PK, pharmacokinetics; QD, daily; BID, twice daily; RP2D, recommended Phase 2 dose; Tx, treatment; Hb, hemoglobin; TD, transfusion dependent; TI, transfusion independence; HI-E, hematologic improvement - erythroid; PD, pharmacodynamics; FACIT-Fatigue scale, The Functional Assessment of Chronic Illness Therapy – Fatigue Scale. **1.** Investigational compound not approved by the FDA. **2.** Jaki T et al. *Cancer Chemother Pharmacol.* 2013; 71. **3.** Split dose: 500 mg q AM, 250 mg q PM. **4.** Platzbecker U et al. Blood 2019;133(10). **5.** Cheson BD et al. Blood 2006;108.

Safety

- The most common AEs (≥20%) were diarrhea and fatigue (each 6,27%), chills, nausea and pruritus (all 5,23%); all G1/2
- The most frequent G3/4 AEs were anemia, platelet count decreased, pneumonia and ALT increased (all n=2,9%)
- Serious AEs (SAEs) occurred in 8 patients (36%); SAEs in ≥2 patients were pneumonia and upper GI bleed (n=2 each; all unrelated)

Treatment-related AEs Occurring in ≥2 Patients by Dose Level

	250 mg QD (n=3)		500 mg QD (n=6)		750 mg QD (n=6)		250 mg BID (n=6)		500/250 mg QD (n=1)		Total (n=22)	
Preferred Term	**All**	**G3/4**	**All**	**G3/4**	**All**	**G3/4**	**All**	**G3/4**	**All**	**G3/4**	**All**	**G3/4**
Diarrhea	0	0	1 (17%)	0	2 (33%)	0	0	0	0	0	3 (14%)	0
Dyspnoea	0	0	1 (17%)	0	2 (33%)	0	0	0	0	0	3 (14%)	0
Nausea	0	0	0	0	3 (50%)	0	0	0	0	0	3 (14%)	0
Neut. Count Decreased	0	0	0	0	2 (33%)	1 (17%)	0	0	1	0	3 (14%)	1 (4%)
ALT Incr.*	0	0	0	0	2 (33%)	2 (33%)	0	0	0	0	2 (9%)	2 (9%)
AST Incr.*	0	0	0	0	2 (33%)	1 (17%)	0	0	0	0	2 (9%)	1 (4%)
Constipation	0	0	0	0	2 (33%)	0	0	0	0	0	2 (9%)	0

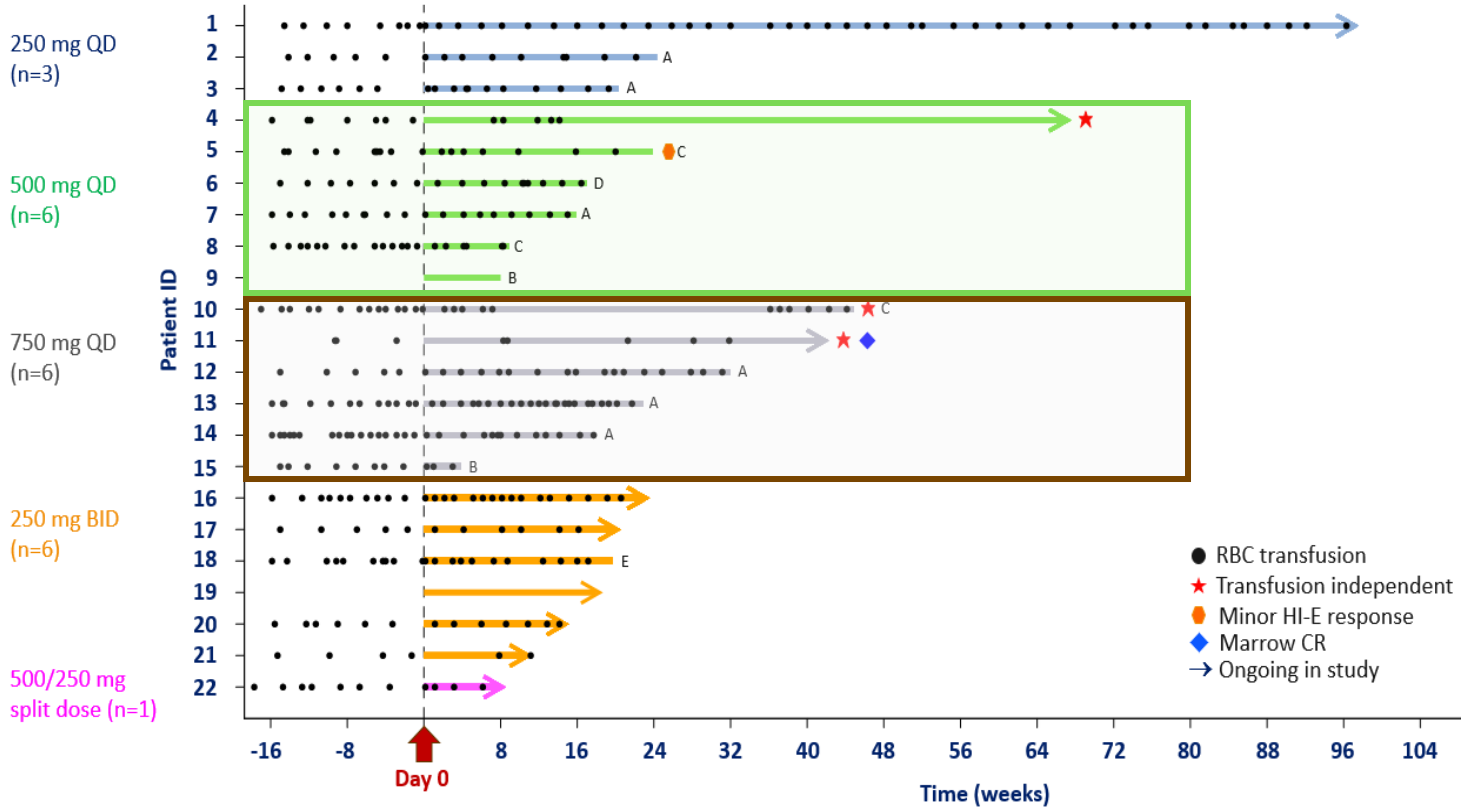
R289 was generally well tolerated with a low incidence of grade 3/4 cytopenias and infections

*Dose limiting toxicity: G3 ALT/G4 AST ↑ in 1 pt at 750 mg QD.

AE, adverse event; ALT, alanine aminotransferase; AST, aspartate aminotransferase; BID, twice daily; G, grade; incr, increased; neut, neutrophil; QD, once daily.

Efficacy: Hematologic Responses

RBC Transfusion Frequency by Dose Level



- 18 patients were evaluable for efficacy
- 3 patients achieved RBC-TI ≥8 wks: 1 at 500 mg QD and 2 at 750 mg QD
- 2 patients achieved RBC-TI ≥ 24 wks
- Median duration of RBC-TI: 29 wks (range 12.7-51.9 wks)
- 1 HTB patient at 500 mg QD had a minor HI-E response (64% reduction in RBCs compared to BL)
- At doses ≥500 mg QD, R835 plasma concentrations reached or exceeded those correlating with 50% or 90% LPS-induced cytokine inhibition previously observed in HVs

At 500 & 750 mg QD doses, RBC-TI/HI-E responses occurred in 4/10 (40%) of evaluable TD patients

Reasons for discontinuation - A: no clinical benefit (6); B: adverse event [2 - Pt 9: hyperuricemia (not related); Pt 15: G3 AST/G4 ALT increase (related)]; C: Investigator decision (3); D: progressive disease (1); E: patient withdrew consent (1)

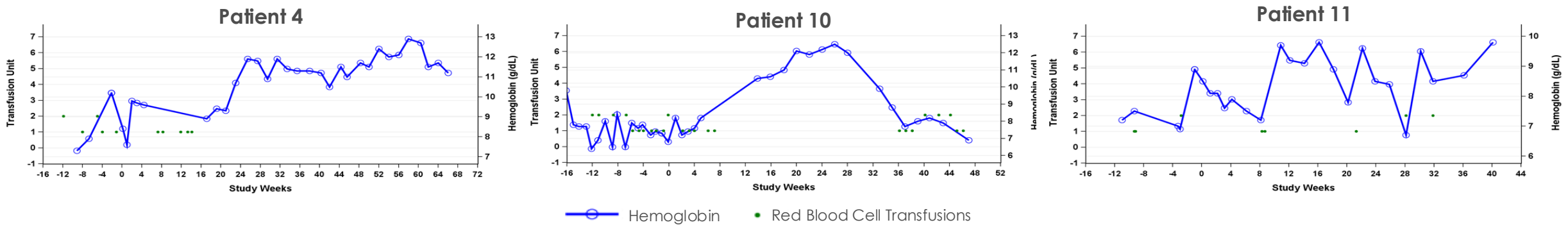
RBC, red blood cell; TI, transfusion independence; wks, weeks; QD, once daily; HI-E, hematologic improvement - erythroid; BL, baseline; LPS, lipopolysaccharide; HV, healthy volunteer; BID, twice daily; CR, complete response; G, grade; ALT, alanine aminotransferase; AST, aspartate aminotransferase.

Efficacy: Summary of Responders

Patient Profiles

Pt ID	Sex, Age	Dose Level	BL RBCs	Prior Therapies	HI-E Response	Response Duration
4	76, M	500 mg QD	HTB	ESA, canakinumab, ALK2 inhibitor, decitabine	TI	51.9 w
5	75, M	500 mg QD	HTB	ESA, azacitidine, luspatercept, fostamatinib, anti-TIM 3-ab	Minor (64% RBC ↓)	16.9 w
10	59, M	750 mg QD	HTB	Azacitidine, lenalidomide, luspatercept	TI	28.9 w
11	50, F	750 mg QD	LTB	Darbopoetin, luspatercept	TI (+ marrow CR)	12.7 w

Hemoglobin Levels



Patients achieving TI had peak hemoglobin increases ranging from 2.3 – 5.6 g/dL vs baseline

ID, identification; QD, once daily; HTB, high transfusion burden; LTB, low transfusion burden; ESA, erythropoiesis-stimulating agent; ALK, anaplastic lymphoma kinase; TIM-3, T-cell immunoglobulin and mucin domain-containing protein 3; Ab, antibody; RBC, red blood cell; TI, transfusion independence; CR, complete response; w, weeks.

Olutasidenib
mIDH1 Inhibitor

rigel

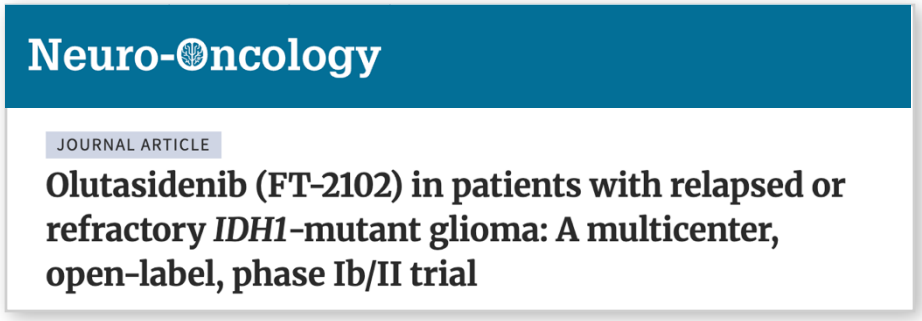
m*IDH1* Glioma Has a Clear Unmet Need

High unmet need remains in glioma

- Diffuse gliomas are the most common primary brain tumor in adults, affecting ~20K people in the US each year[1]
- *IDH1* mutations are common in Grade 2/3 glioma (in 70%)[2], and are found in up to 35% of HGGs in adolescents and young adults[3]
- Most disease recurs, with no standard of care therapy for relapsed disease[4]

Recent approval of vorasidenib in Grade 2 low-grade glioma underscores the potential for IDH1 inhibitors

Clinical proof of concept for olutasidenib in R/R m*IDH1* glioma was established in a Phase 1b/2 trial[5]



- **R/R m*IDH1* glioma (n=26; 85% G3/4)**
- **Preliminary evidence of clinical activity:**
  - 2 PR (G3 and G4; both with enhancing tumors)
  - 10 (40%) with SD; in 8, SD for ≥ 4 months
  - Disease control rate (OR + SD) = 48%

IDH1, isocitrate dehydrogenase-1; m*IDH1*, mutated IDH1; CNS, central nervous system; HGG, high-grade glioma; R/R; relapsed or refractory; G, Grade; PR, partial response; SD, stable disease; OR, objective response. **1.** American Cancer Society reports. **2.** Yan et al. N Engl J Med. 2009. **3.** Pollack et al. Childs Nervous Syst. 2011 Jan;27(1):87-94. **4.** Wen et al. NeuroOncology 2020. **5.** de la Fuente et al. Neuro Oncol. 2023 Jan 5;25(1):146-156. doi: 10.1093/neuonc/noac139.

Advancing Olutasidenib into m*IDH1* Glioma[1]

CONNECT's TarGeT Phase 2 Clinical Study

- Gliomas account for 29-35% of CNS tumors in children, adolescents & young adults[2]
- As part of CONNECT's "TarGeT" study in HGG, olutasidenib is being evaluated in combination with temozolomide as a maintenance regimen in newly-diagnosed adolescent and young adult patients with *IDH1* mutation positive HGG in the Rigel-sponsored "TarGeT-D" Phase 2 study arm
  - Study is open for enrollment

Rigel's Phase 2 Clinical Study

- Rigel is planning to initiate a Phase 2 clinical study in recurrent glioma in 2025
- More details to be provided later in the year

IDH1, isocitrate dehydrogenase-1; m*IDH1*, mutated IDH1; HGG, high-grade glioma.

1. Investigational compound in this indication and not approved by the FDA. **2.** Diwanji TP, et al. Adolesc Health Med Ther. 2017 Sep 22;8:99-113.

Strategic Alliance with MD Anderson Cancer Center to Advance Olutasidenib in AML and Other Cancers[1]

All four studies are now open for enrollment

Rigel and The University of Texas MD Anderson Cancer Center will evaluate olutasidenib in combination with other agents to treat newly-diagnosed and relapsed/refractory patients with *IDH1*-mutated:

- AML
- Higher-risk MDS, CMML and advanced MPN

The collaboration will also support the evaluation of olutasidenib as:

- Monotherapy in *IDH1*-mutated CCUS & lower-risk MDS/CMML
- Post-transplant maintenance therapy for *IDH1*-mutated hematologic malignancies

AML, acute myeloid leukemia; CMML, chronic myelomonocytic leukemia; CCUS, clonal cytopenia of undetermined significance; MDS, myelodysplastic syndrome; MPN, myeloproliferative neoplasms

1. Investigational compound in these indications and not approved by the FDA. Please see Important Safety Information on slides 34 & 35. Please visit www.REZLIDHIA.com for Full Prescribing Information, including Boxed WARNING.

RIPK1 Inhibitor Partner Program

rigel

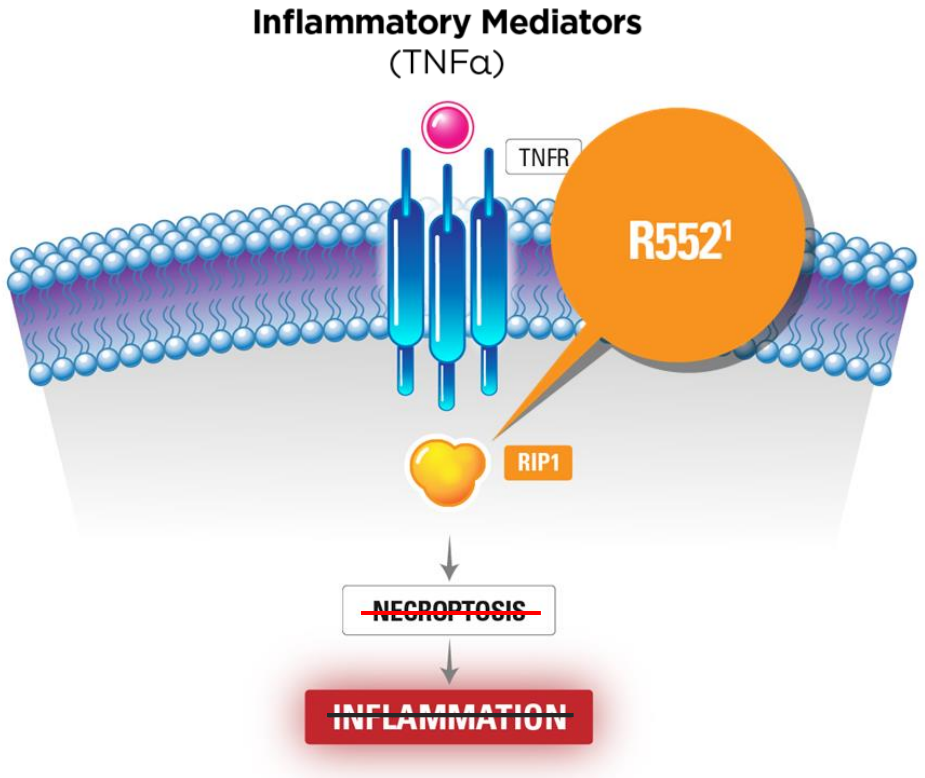
RIPK1 Inhibitor Programs in Immune and CNS Diseases with Partner Lilly

Immune Diseases

- R552, a potent and selective RIPK1 inhibitor, completed a Phase 1 study which demonstrated potential best-in-class status compared to competition
- Lilly initiated a Phase 2a clinical trial studying ocadusertib (previously R552 or LY3871801) in adult patients with moderately to severely active rheumatoid arthritis (RA)

CNS Diseases

- Selection of RIPK1 inhibitor candidates that cross the blood-brain barrier for CNS diseases is underway
- Lilly would lead clinical development of brain-penetrating RIPK1 inhibitors in CNS diseases



RIPK1 inhibitors play key role in TNF signaling and induction of pro-inflammatory necroptosis, which could support broad potential in RA, psoriasis and IBD, and with their experience, Lilly is the ideal partner.

RIPK1, receptor-interacting protein kinase 1; CNS, central nervous system; TNF, tumor necrosis factor; RA rheumatoid arthritis; IBD, inflammatory bowel disease.

1. Investigational compound not approved by the FDA. https://www.clinicaltrials.gov/study/NCT05848258

Expected Development Key Milestones in 2025

R289

- Completion of dose escalation part of Phase 1b study
- Initiate dosing in expansion phase
- Interactions with the FDA regarding potential registrational path
- Present dose escalation data from Phase 1b study at a medical meeting in the second half of the year

Olutasidenib

- Initiate a Phase 2 clinical study in recurrent glioma in 2025
- Continue support of four MD Anderson studies and CONNECT study

Financials

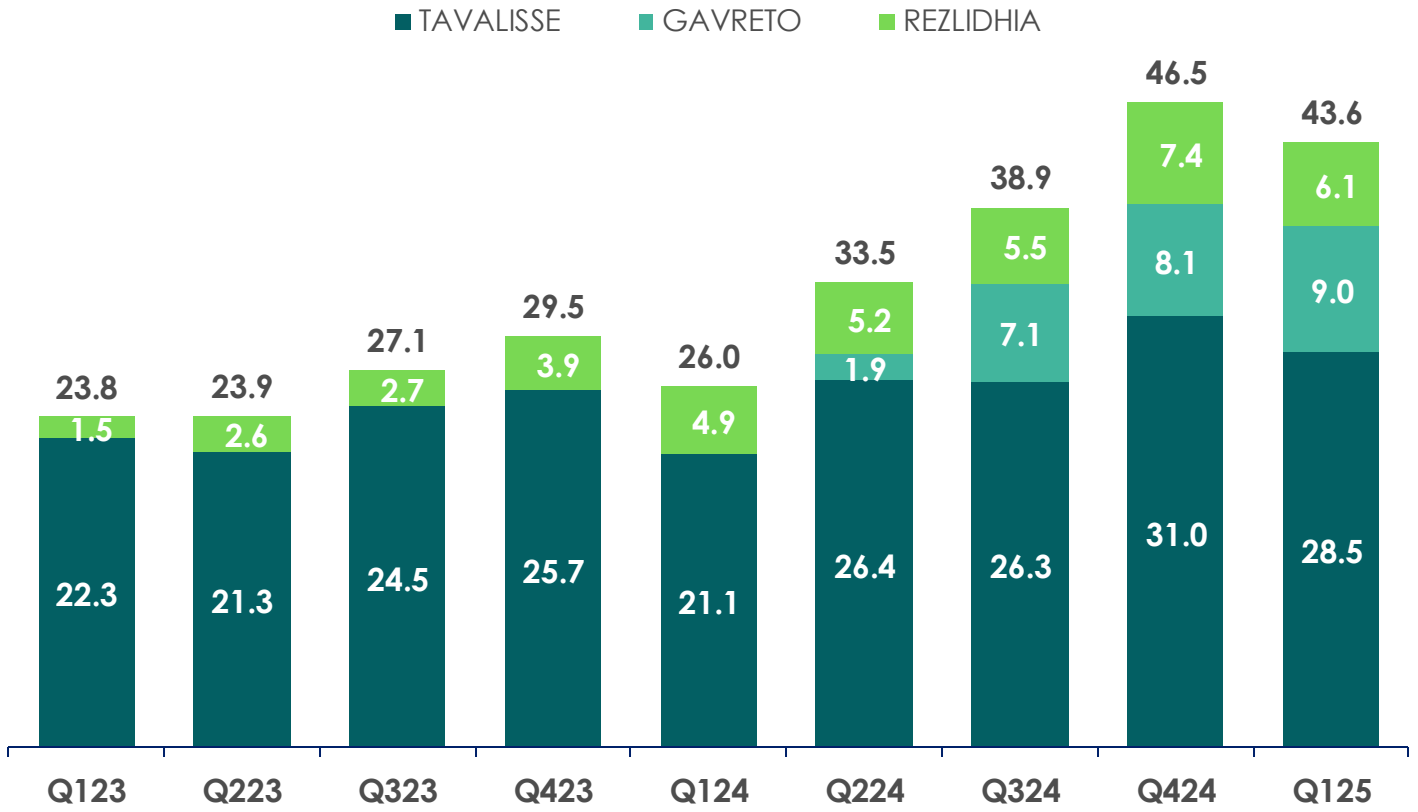
Q1 2025 Financial Highlights

Q1 2025 Net Product Sales: $43.6M

- TAVALISSE $28.5M
- GAVRETO $9.0M
- REZLIDHIA $6.1M

Q1 2025 Contract Revenues from Collaborations: $9.8M

- Grifols $4.7M
- Kissei $4.6M[1]
- Medison $0.4M
- Other $0.1M



1. Kissei revenue includes $3.0 million related to a milestone payment from sublicensing fostamatinib.

Q1 2025 Financial Results and 2025 Financial Outlook

(In thousands, except for per share amounts)

	Three Months Ended March 31,	
	2025	2024
Revenues		
Net Product Sales	$ 43,550	$ 26,003
Contract revenues from collaborations	9,783	3,531
Total revenues	53,333	29,534
Costs and expenses:		
Cost of product sales	4,409	2,025
Research and development	8,436	6,026
Selling, general and administrative	27,715	28,449
Total costs and expenses	40,560	36,500
Income (loss) from operations	12,773	(6,966)
Interest income	591	593
Interest expense	(1,853)	(1,874)
Income (loss) before income taxes	11,511	(8,247)
Provision for income taxes	(65)	-
Net income (loss)	$ 11,446	$ (8,247)
Net income (loss) per share, basic[1]	$ 0.64	$ (0.47)
Net income (loss) per share, diluted[1]	$ 0.63	$ (0.47)
Weighted average shares used in computing net income (loss) per share, basic[1]	17,808	17,520
Weighted average shares used in computing net income (loss) per share, diluted[1]	18,169	17,520

Cash, cash equivalents & short-term investments as of March 31, 2025 was **$77.1M** compared to $77.3M as of December 31, 2024

2025 Financial Outlook

Rigel anticipates 2025 total revenue of ~$200M to $210M[2]

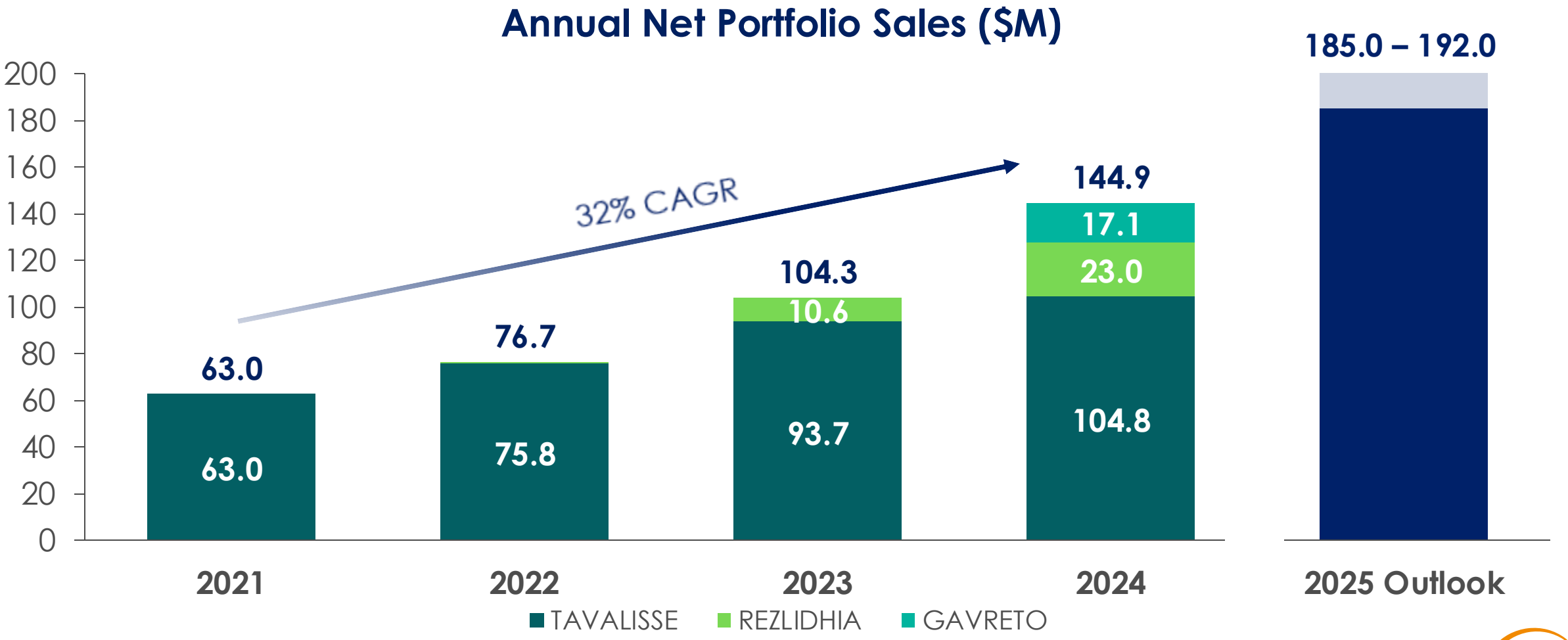
- Net product sales of ~$185M to $192M
- Contract revenues from collaborations of ~$15M to $18M

Rigel continues to anticipates it will report positive net income for the full year 2025, while funding existing and new clinical development programs

1. Share and per share amounts have been restated to reflect the 1-for-10 reverse stock split effected on June 27, 2024 on a retroactive basis for prior period presented. **2.** Rigel's 2025 revenue guidance ranges exclude approximately $40.0 million in non-cash revenue that Rigel expects to recognize in the second quarter of 2025 resulting from the release of the remaining cost share liability currently on the balance sheet related to the collaboration with Eli Lilly for the development and commercialization of ocadusertib.

Continued Net Product Sales Growth

Anticipate approximately 28% to 32% year-over-year growth in 2025 at the midpoint of guidance



CAGR, compound annual growth rate.

2025 Value Drivers

Grow Product Sales for TAVALISSE, GAVRETO and REZLIDHIA

- Expand adoption of commercial portfolio
- Expect strong year-over-year growth in net product sales

Advance Development Programs[1]

- Complete dose escalation part of R289 Phase 1b clinical study in lower-risk MDS and initiate dosing in expansion phase
- Present updated data from R289 Phase 1b clinical study in lower-risk MDS
- Initiate Phase 2 clinical study for olutasidenib in recurrent glioma

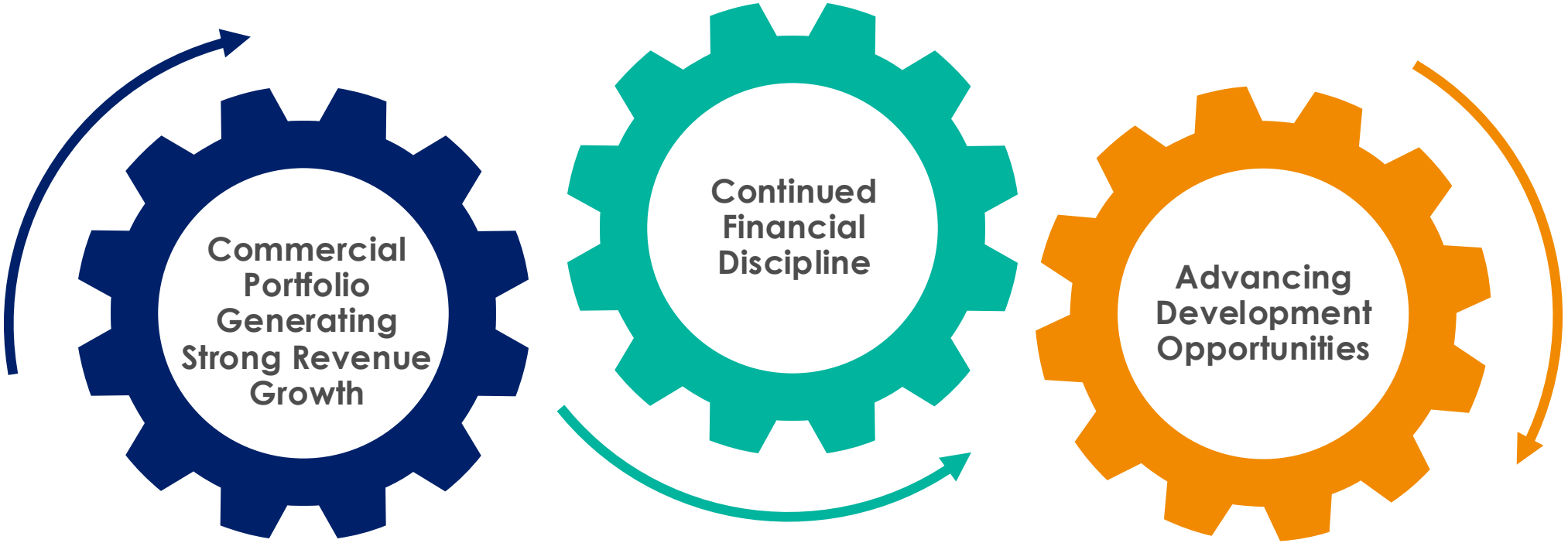
Identify In-License and Product Acquisition Opportunities

- Pursue late-stage assets which leverage current capabilities & capacity

Continue Financial Discipline

AML, acute myeloid leukemia; MDS, myelodysplastic syndrome. **1.** Investigational compounds in these indications and not approved by the FDA. Please see Important Safety Information on slides 33-37. Please visit www.TAVALISSE.com for Full Prescribing Information. Please visit www.REZLIDHIA.com for Full Prescribing Information, including Boxed WARNING. Please visit www.GAVRETO.com for Full Prescribing Information.

Well Positioned to Drive Future Growth



Tavalisse® (fostamatinib disodium hexahydrate) tablets

REZLIDHIA® (olutasidenib) 150 mg capsules

GAVRETO® pralsetinib | 100 mg capsules

rigel®

TAVALISSE® (fostamatinib disodium hexahydrate) Tablets

INDICATION

- TAVALISSE® (fostamatinib disodium hexahydrate) tablets is indicated for the treatment of thrombocytopenia in adult patients with chronic immune thrombocytopenia (ITP) who have had an insufficient response to a previous treatment.

IMPORTANT SAFETY INFORMATION | WARNINGS AND PRECAUTIONS

- Hypertension can occur with TAVALISSE treatment. Patients with pre-existing hypertension may be more susceptible to the hypertensive effects. Monitor blood pressure every 2 weeks until stable, then monthly, and adjust or initiate antihypertensive therapy for blood pressure control maintenance during therapy. If increased blood pressure persists, TAVALISSE interruption, reduction, or discontinuation may be required.
- Elevated liver function tests (LFTs), mainly ALT and AST, can occur with TAVALISSE. Monitor LFTs monthly during treatment. If ALT or AST increase to ≥3 x upper limit of normal, manage hepatotoxicity using TAVALISSE interruption, reduction, or discontinuation.
- Diarrhea occurred in 31% of patients and severe diarrhea occurred in 1% of patients treated with TAVALISSE. Monitor patients for the development of diarrhea and manage using supportive care measures early after the onset of symptoms. If diarrhea becomes severe (≥Grade 3), interrupt, reduce dose or discontinue TAVALISSE.
- Neutropenia occurred in 6% of patients treated with TAVALISSE; febrile neutropenia occurred in 1% of patients. Monitor the ANC monthly and for infection during treatment. Manage toxicity with TAVALISSE interruption, reduction, or discontinuation.
- TAVALISSE can cause fetal harm when administered to pregnant women. Advise pregnant women the potential risk to a fetus. Advise females of reproductive potential to use effective contraception during treatment and for at least 1 month after the last dose. Verify pregnancy status prior to initiating TAVALISSE. It is unknown if TAVALISSE or its metabolite is present in human milk. Because of the potential for serious adverse reactions in a breastfed child, advise a lactating woman not to breastfeed during TAVALISSE treatment and for at least 1 month after the last dose.

DRUG INTERACTIONS

- Concomitant use of TAVALISSE with strong CYP3A4 inhibitors increases exposure to the major active metabolite of TAVALISSE (R406), which may increase the risk of adverse reactions. Monitor for toxicities that may require a reduction in TAVALISSE dose.
- It is not recommended to use TAVALISSE with strong CYP3A4 inducers, as concomitant use reduces exposure to R406.
- Concomitant use of TAVALISSE may increase concentrations of some CYP3A4 substrate drugs and may require a dose reduction of the CYP3A4 substrate drug.
- Concomitant use of TAVALISSE may increase concentrations of BCRP substrate drugs (eg, rosuvastatin) and P-Glycoprotein (P-gp) substrate drugs (eg, digoxin), which may require a dose reduction of the BCRP and P-gp substrate drug.

ADVERSE REACTIONS

- Serious adverse drug reactions in the ITP double-blind studies were febrile neutropenia, diarrhea, pneumonia, and hypertensive crisis, which occurred in 1% of TAVALISSE patients. In addition, severe adverse reactions occurred including dyspnea and hypertension (both 2%), neutropenia, arthralgia, chest pain, diarrhea, dizziness, nephrolithiasis, pain in extremity, toothache, syncope, and hypoxia (all 1%).
- Common adverse reactions (≥5% and more common than placebo) from FIT-1 and FIT-2 included: diarrhea, hypertension, nausea, dizziness, ALT and AST increased, respiratory infection, rash, abdominal pain, fatigue, chest pain, and neutropenia.

Please see https://www.tavalisse.com/ for full Prescribing Information

To report side effects of prescription drugs to the FDA, visit http://www.fda.gov/medwatch or call 1-800-FDA-1088 (1-800-332-1088)

About REZLIDHIA® (olutasidenib)

INDICATION

REZLIDHIA is an isocitrate dehydrogenase-1 (IDH1) inhibitor indicated for the treatment of adult patients with relapsed or refractory acute myeloid leukemia (AML) with a susceptible IDH1 mutation as detected by an FDA-approved test.

IMPORTANT SAFETY INFORMATION

WARNING: DIFFERENTIATION SYNDROME

Differentiation syndrome, which can be fatal, can occur with REZLIDHIA treatment. Symptoms may include dyspnea, pulmonary infiltrates/pleuropericardial effusion, kidney injury, hypotension, fever, and weight gain. If differentiation syndrome is suspected, withhold REZLIDHIA and initiatetreatment with corticosteroids and hemodynamic monitoring until symptom resolution.

WARNINGS AND PRECAUTIONS

Differentiation Syndrome

REZLIDHIA can cause differentiation syndrome. In the clinical trial of REZLIDHIA in patients with relapsed or refractory AML, differentiation syndrome occurred in 16% of patients, with grade 3 or 4 differentiation syndrome occurring in 8% of patients treated, and fatalities in 1% of patients. Differentiation syndrome is associated with rapid proliferation and differentiation of myeloid cells and may be life-threatening or fatal. Symptoms of differentiation syndrome in patients treated with REZLIDHIA included leukocytosis, dyspnea, pulmonary infiltrates/pleuropericardial effusion, kidney injury, fever, edema, pyrexia, and weight gain. Of the 25 patients who experienced differentiation syndrome, 19 (76%) recovered after treatment or after dose interruption of REZLIDHIA. Differentiation syndrome occurred as early as 1 day and up to 18 months after REZLIDHIA initiation and has been observed with or without concomitant leukocytosis.

If differentiation syndrome is suspected, temporarily withhold REZLIDHIA and initiate systemic corticosteroids (e.g., dexamethasone 10 mg IV every 12 hours) for a minimum of 3 days and until resolution of signs and symptoms. If concomitant leukocytosis is observed, initiate treatment with hydroxyurea, as clinically indicated. Taper corticosteroids and hydroxyurea after resolution of symptoms. Differentiation syndrome may recur with premature discontinuation of corticosteroids and/or hydroxyurea treatment. Institute supportive measures and hemodynamic monitoring until improvement; withhold dose of REZLIDHIA and consider dose reduction based on recurrence.

Hepatotoxicity

REZLIDHIA can cause hepatotoxicity, presenting as increased alanine aminotransferase (ALT), increased aspartate aminotransferase (AST), increased blood alkaline phosphatase, and/or elevated bilirubin. Of 153 patients with relapsed or refractory AML who received REZLIDHIA, hepatotoxicity occurred in 23% of patients; 13% experienced grade 3 or 4 hepatotoxicity. One patient treated with REZLIDHIA in combination with azacitidine in the clinical trial, a combination for which REZLIDHIA is not indicated, died from complications of drug-induced liver injury. The median time to onset of hepatotoxicity in patients with relapsed or refractory AML treated with REZLIDHIA was 1.2 months (range: 1 day to 17.5 months) after REZLIDHIA initiation, and the median time to resolution was 12 days (range: 1 day to 17 months). The most common hepatotoxicities were elevations of ALT, AST, blood alkaline phosphatase, and blood bilirubin

IMPORTANT SAFETY INFORMATION (Cont.)

WARNINGS AND PRECAUTIONS

Hepatotoxicity

Monitor patients frequently for clinical symptoms of hepatic dysfunction such as fatigue, anorexia, right upper abdominal discomfort, dark urine, or jaundice. Obtain baseline liver function tests prior to initiation of REZLIDHIA, at least once weekly for the first two months, once every other week for the third month, once in the fourth month, and once every other month for the duration of therapy. If hepatic dysfunction occurs, withhold, reduce, or permanently discontinue REZLIDHIA based on recurrence/severity.

ADVERSE REACTIONS

The most common (≥20%) adverse reactions, including laboratory abnormalities, were aspartate aminotransferase increased, alanine aminotransferase increased, potassium decreased, sodium decreased, alkaline phosphatase increased, nausea, creatinine increased, fatigue/malaise, arthralgia, constipation, lymphocytes increased, bilirubin increased, leukocytosis, uric acid increased, dyspnea, pyrexia, rash, lipase increased, mucositis, diarrhea and transaminitis.

DRUG INTERACTIONS

- Avoid concomitant use of REZLIDHIA with strong or moderate CYP3A inducers.
- Avoid concomitant use of REZLIDHIA with sensitive CYP3A substrates unless otherwise instructed in the substrates prescribing information. If concomitant use is unavoidable, monitor patients for loss of therapeutic effect of these drugs.

LACTATION

Advise women not to breastfeed during treatment with REZLIDHIA and for 2 weeks after the last dose.

GERIATRIC USE

No overall differences in effectiveness were observed between patients 65 years and older and younger patients. Compared to patients younger than 65 years of age, an increase in incidence of hepatotoxicity and hypertension was observed in patients ≥65 years of age.

HEPATIC IMPAIRMENT

In patients with mild or moderate hepatic impairment, closely monitor for increased probability of differentiation syndrome.

You may report side effects to the FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

Please see https://www.REZLIDHIA.com/ for full Prescribing Information, including Boxed WARNING.

About GAVRETO® (pralsetinib)

INDICATIONS

GAVRETO (pralsetinib) is indicated for the treatment of:

- Adult patients with metastatic rearranged during transfection (RET) fusion-positive non-small cell lung cancer (NSCLC) as detected by an FDA-approved test
- Adult and pediatric patients 12 years of age and older with advanced or metastatic RET fusion-positive thyroid cancer who require systemic therapy and who are radioactive iodine-refractory (if radioactive iodine is appropriate)*

*This indication is approved under accelerated approval based on overall response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trial(s).

IMPORTANT SAFETY INFORMATION

- **Interstitial Lung Disease (ILD)/Pneumonitis:** Severe, life-threatening, and fatal ILD/pneumonitis can occur in patients treated with GAVRETO. Pneumonitis occurred in 12% of patients who received GAVRETO, including 3.3% with Grade 3-4, and 0.2% with fatal reactions. Monitor for pulmonary symptoms indicative of ILD/pneumonitis. Withhold GAVRETO and promptly investigate for ILD in any patient who presents with acute or worsening of respiratory symptoms (e.g., dyspnea, cough, and fever). Withhold, reduce dose or permanently discontinue GAVRETO based on severity of confirmed ILD.

- **Hypertension:** Occurred in 35% of patients, including Grade 3 hypertension in 18% of patients. Overall, 8% had their dose interrupted and 4.8% had their dose reduced for hypertension. Treatment-emergent hypertension was most commonly managed with anti-hypertension medications. Do not initiate GAVRETO in patients with uncontrolled hypertension. Optimize blood pressure prior to initiating GAVRETO. Monitor blood pressure after 1 week, at least monthly thereafter and as clinically indicated. Initiate or adjust anti-hypertensive therapy as appropriate. Withhold, reduce dose, or permanently discontinue GAVRETO based on the severity.

- **Hepatotoxicity:** Serious hepatic adverse reactions occurred in 1.5% of patients treated with GAVRETO. Increased aspartate aminotransferase (AST) occurred in 49% of patients, including Grade 3 or 4 in 7% and increased alanine aminotransferase (ALT) occurred in 37% of patients, including Grade 3 or 4 in 4.8%. The median time to first onset for increased AST was 15 days (range: 5 days to 2.5 years) and increased ALT was 24 days (range: 7 days to 3.7 years). Monitor AST and ALT prior to initiating GAVRETO, every 2 weeks during the first 3 months, then monthly thereafter and as clinically indicated. Withhold, reduce dose or permanently discontinue GAVRETO based on severity.

- **Hemorrhagic Events:** Serious, including fatal, hemorrhagic events can occur with GAVRETO. Grade ≥3 events occurred in 4.1% of patients treated with GAVRETO including one patient with a fatal hemorrhagic event. Permanently discontinue GAVRETO in patients with severe or life-threatening hemorrhage.

- **Tumor Lysis Syndrome (TLS):** Cases of TLS have been reported in patients with medullary thyroid carcinoma receiving GAVRETO. Patients may be at risk of TLS if they have rapidly growing tumors, a high tumor burden, renal dysfunction, or dehydration. Closely monitor patients at risk, consider appropriate prophylaxis including hydration, and treat as clinically indicated.

IMPORTANT SAFETY INFORMATION (Cont.)

- **Risk of Impaired Wound Healing:** Impaired wound healing can occur in patients who receive drugs that inhibit the vascular endothelial growth factor (VEGF) signaling pathway. Therefore, GAVRETO has the potential to adversely affect wound healing. Withhold GAVRETO for at least 5 days prior to elective surgery. Do not administer for at least 2 weeks following major surgery and until adequate wound healing. The safety of resumption of GAVRETO after resolution of wound healing complications has not been established.
- **Embryo-Fetal Toxicity:** Based on findings from animal studies and its mechanism of action, GAVRETO can cause fetal harm when administered to a pregnant woman. Advise pregnant women of the potential risk to a fetus. Advise females of reproductive potential to use effective non-hormonal contraception during treatment with GAVRETO and for 2 weeks after the last dose. Advise males with female partners of reproductive potential to use effective contraception during treatment with GAVRETO and for 1 week after the last dose.
- **Common adverse reactions (≥25%)** were musculoskeletal pain, constipation, hypertension, diarrhea, fatigue, edema, pyrexia, and cough. **Common Grade 3/4 laboratory abnormalities (≥2%)** were decreased lymphocytes, decreased neutrophils, decreased hemoglobin, decreased phosphate, decreased leukocytes, decreased sodium, increased aspartate aminotransferase (AST), increased alanine aminotransferase (ALT), decreased calcium (corrected), decreased platelets, increased alkaline phosphatase, increased potassium, decreased potassium, and increased bilirubin.
- Avoid coadministration of GAVRETO with **strong or moderate CYP3A inhibitors, P-gp inhibitors, or combined P-gp and strong or moderate CYP3A inhibitors.** If coadministration cannot be avoided, reduce the GAVRETO dose. Avoid coadministration of GAVRETO with **strong or moderate CYP3A inducers**. If coadministration cannot be avoided, increase the GAVRETO dose.
- **Lactation:** Advise women not to breastfeed during treatment with GAVRETO and for 1 week after the last dose.
- **Pediatric Use:** Monitor open growth plates in adolescent patients. Consider interrupting or discontinuing GAVRETO if abnormalities occur.

You may report side effects to the FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

Please see https://www.GAVRETO.com/ for full Prescribing Information.

Thank You

www.rigel.com