



Corporate Presentation

May 2024



Forward Looking Statements

This presentation contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 (“PSLRA”) relating to, among other things, expected commercial and financial results; Rigel’s ability to earn and receive milestone payments; expectations related to the potential and market opportunity of REZLIDHIA® (olutasidenib) as therapeutics for relapsed or refractory acute myeloid leukemia (AML) and other conditions; the potential and market opportunity for TAVALISSE® (fostamatinib) as therapeutics for chronic ITP and other conditions; the regulatory approval and commercialization of fostamatinib or olutasidenib in the U.S. and international markets; and Rigel’s ability to further develop its clinical stage and early-stage product candidates and Rigel’s partnering and collaboration/alliance efforts, including the progress of the Phase 1b clinical trial of R289 for the treatment of lower-risk myeloid dysplastic syndrome (MDS), the advancement of the Phase 2a clinical trial of R552 for the treatment of rheumatoid arthritis, and the development of olutasidenib as a therapy for a broad range of mMDH1+ cancers, including but not limited to AML, MDS, and glioma, and Rigel’s partnering efforts and ability to achieve regulatory and commercial milestones and earn and receive milestone payments; and the potential benefits of Rigel’s acquisition of U.S. rights to GAVRETO (pralsetinib), including opportunities in NSCLC and DTC, Rigel’s ability to leverage its existing commercial infrastructure to market and distribute pralsetinib, Rigel’s ability to transition pralsetinib to its distribution network and provide patients with access to pralsetinib, the payment and timing of milestone and royalty payments and Rigel’s ability to start recognizing product sales in the third quarter of 2024 and the market opportunity for pralsetinib.

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”, “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, 2023 and subsequent filings. Any forward-looking statement made by us in this press release 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.

Growing Our Hematology and Oncology Business

Commercial Execution

Tavalisse[®]
(fostamatinib disodium hexahydrate) tablets



ITP

REZLIDHIA[®]
(olutasidenib) 150 mg capsules



mIDH1 R/R AML

Expansion & Development

In-Licensing and Product Acquisition

- GAVRETO[®] (pralsetinib) added to existing commercial operations
- New late-stage assets which leverage current capabilities and capacity

Development Programs¹

- Evaluate REZLIDHIA in a broad range of IDH1-mutant cancers including AML, MDS and glioma
- R289 IRAK1/4 inhibitor Phase 1b trial in lower-risk MDS



Grow Sales of TAVALISSE in ITP



Tavalisse[®]

(fostamatinib disodium hexahydrate) tablets

Kinase inhibitor indicated for the treatment of thrombocytopenia in adult patients with chronic immune thrombocytopenia (cITP) who have had an insufficient response to a previous treatment.

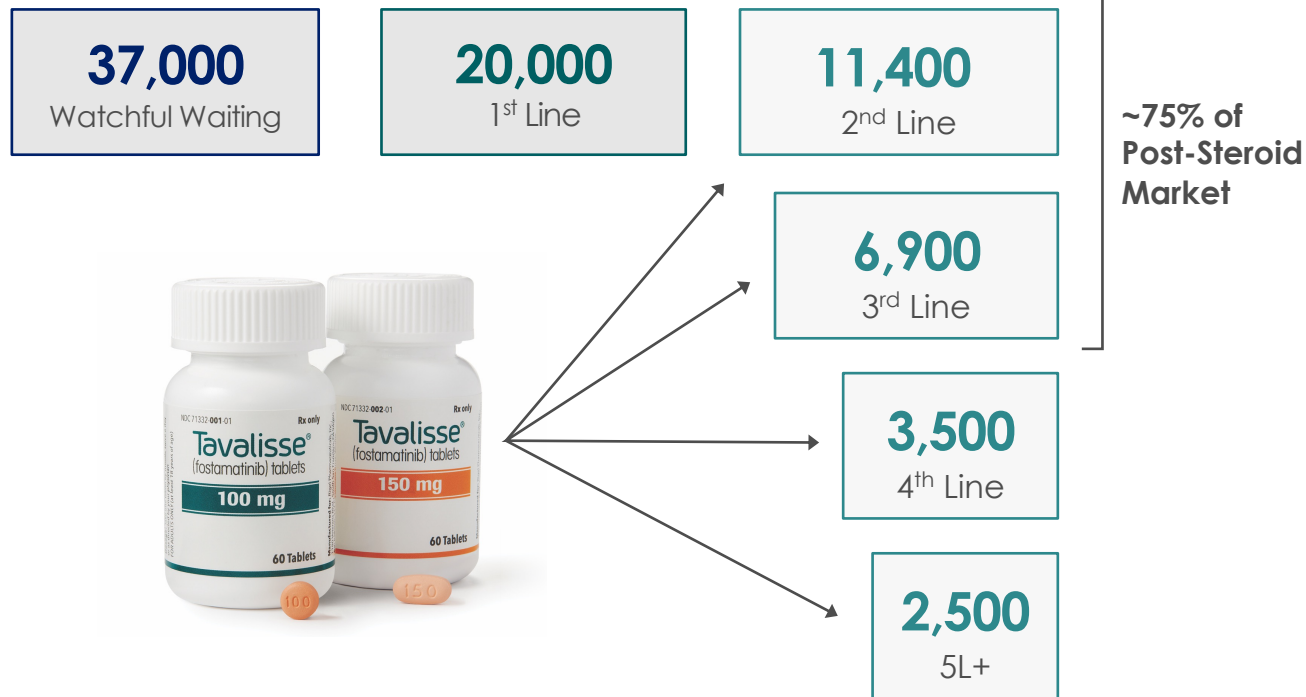
Select Important Safety Information

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.

Creating Opportunities to Gain Market Share

81,300 U.S. Adult cITP Patients¹



44,300 Patients Actively Treated²

- 24,300 patients are 2L or later

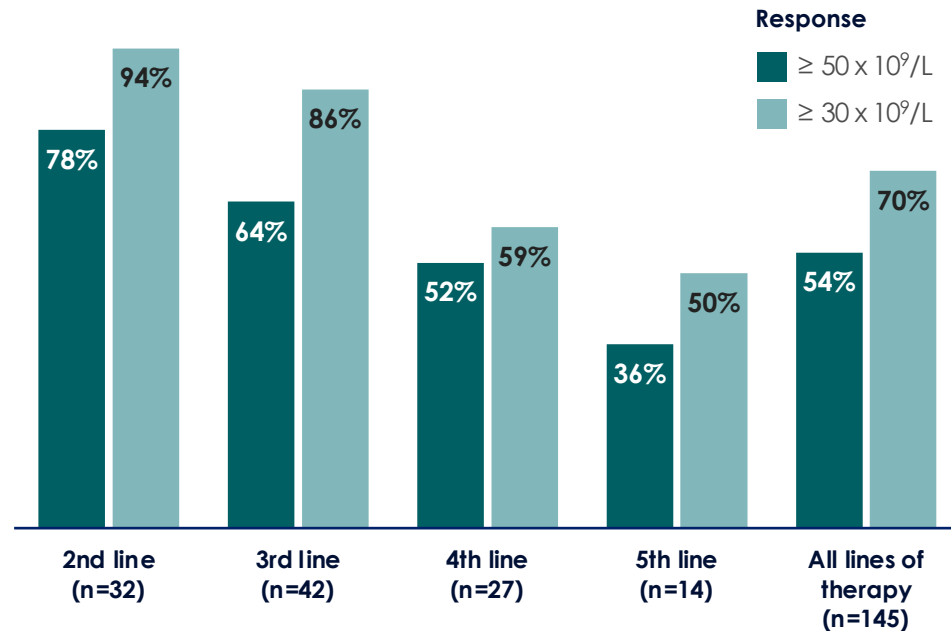
Patient Moving through Therapies Creates New Patient Opportunities

TAVALISSE is Now Preferred on Key Commercial National Formularies

- Significant national commercial coverage
- Reinforces TAVALISSE's proven efficacy and safety
- Strengthens reimbursement confidence
- Spreading awareness among customers through personal and non-personal channels

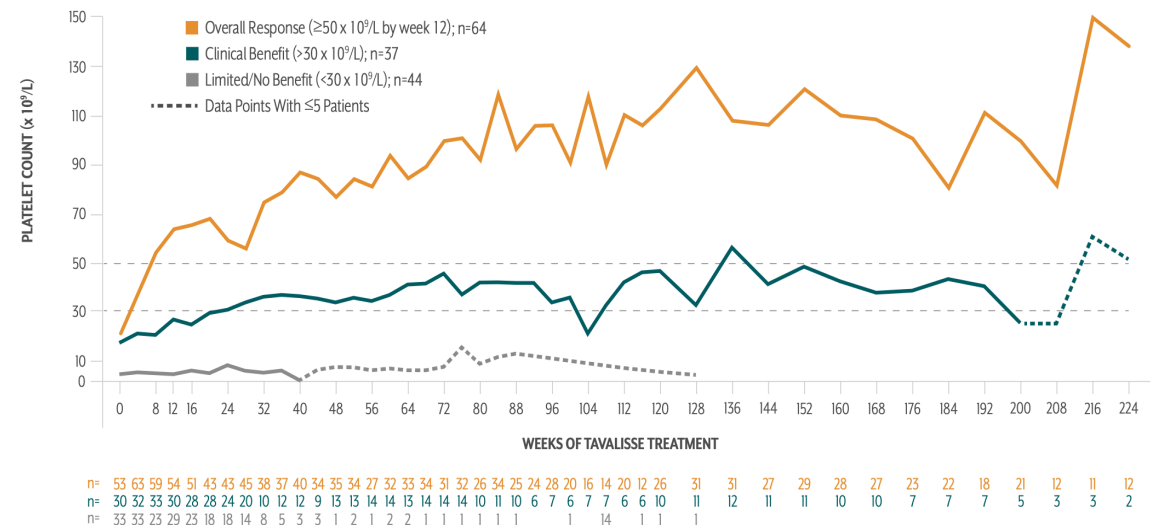
Promotion Efforts Highlight Data Supporting Use in Earlier Lines

Post-hoc Data Analysis Demonstrated Use as 2nd-Line Therapy Resulted in Higher Response Rates^{1,2}



Durable Efficacy was Observed in Responders to TAVALISSE in the FIT Studies
(combined results from FIT-1, FIT-2, and FIT-3)³

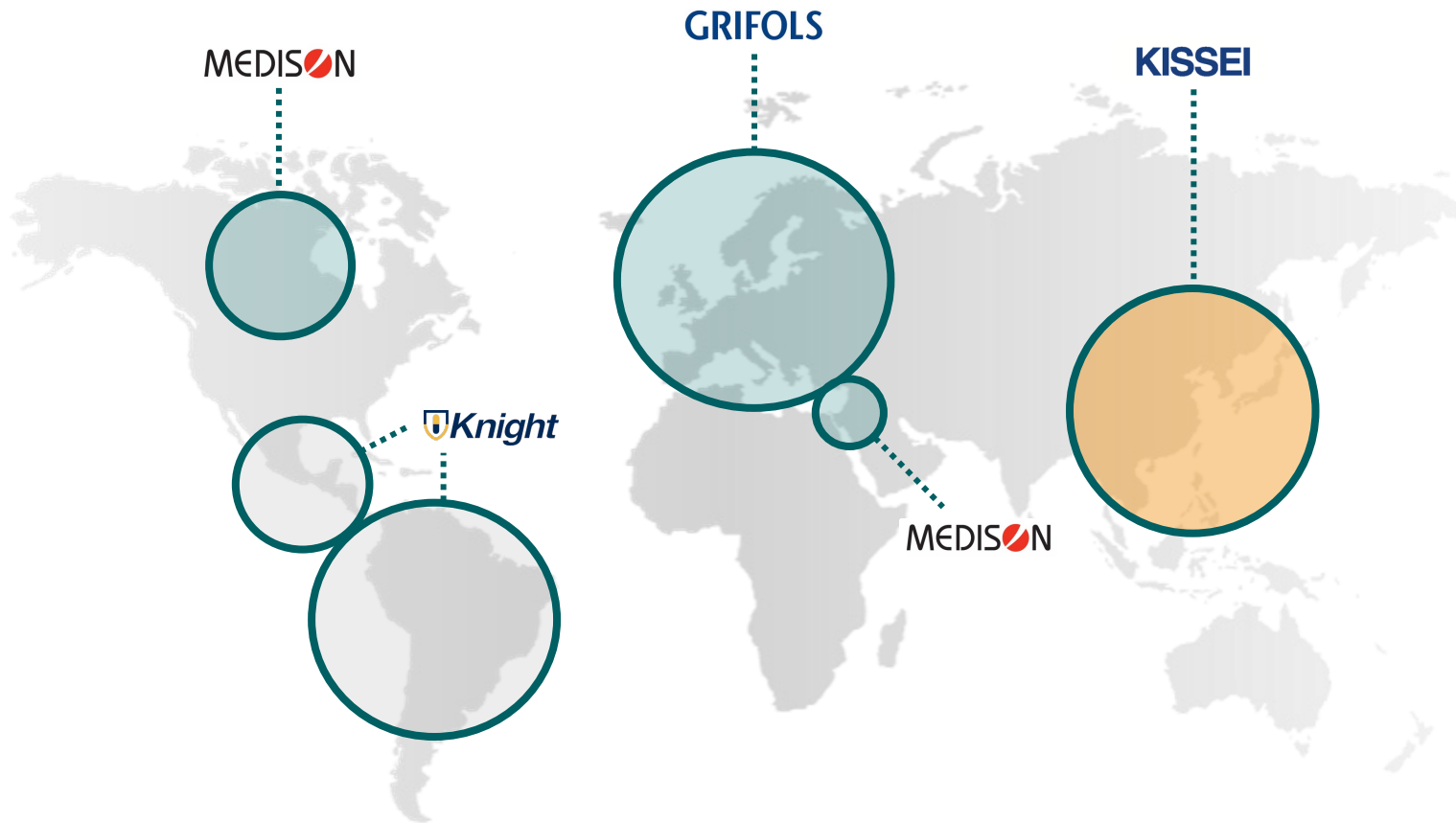
Median Platelet Counts Over Time



FIT, Fostamatinib in ITP

1. Fostamatinib is an effective 2nd-line therapy in patients with immune thrombocytopenia, British Journal of Haematology. 2. Percentage of Patients Achieving Target Platelet Counts at Any Visit. 3. Assessment of thrombotic risk during long-term treatment of immune thrombocytopenia with fostamatinib, Therapeutic Advances in Hematology, 4/30/21. Please see Important Safety Information on slide 51. Please visit www.TAVALISSE.com for Full Prescribing Information.

Expanding Access in Global Markets

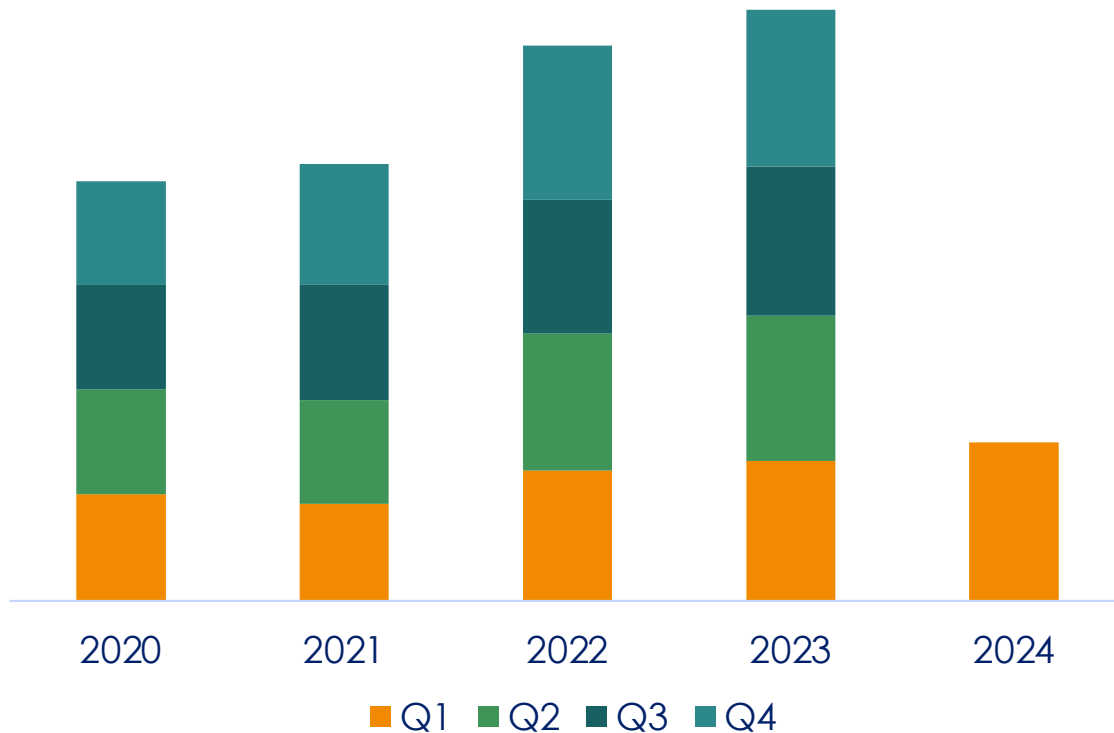


✓ In April 2023, Kissei launched TAVALISSE in Japan for the treatment of chronic ITP

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

TAVALISSE New Patient Starts Continue to Drive Growth

New Patient Starts by Quarter



Drivers of Consistent Quarterly Progress Since 2021

- Continued focus on increasing the breadth and depth of New Patient Starts among prescribers
- Ensuring strong coverage and reimbursement with >95% commercial coverage
- Reinforcing clinical efficacy and safety



Grow Sales of REZLIDHIA in *mIDH1* R/R AML



REZLIDHIA[®]
(olutasidenib) 150 mg capsules

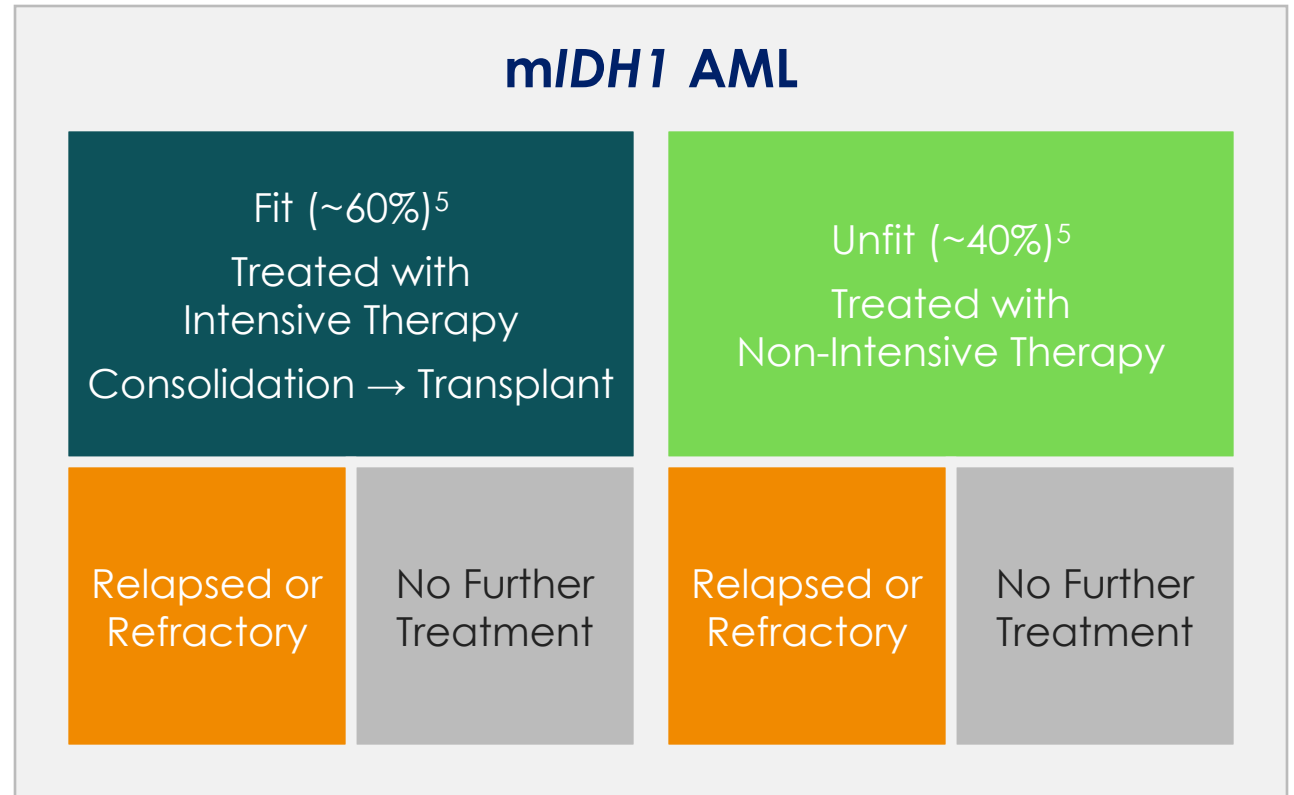
APPROVED AND AVAILABLE IN THE U.S.

REZLIDHIA is 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.

Please see Important Safety Information on slides 43 & 44, including Boxed WARNING regarding differentiation syndrome

mIDH1 Relapsed/Refractory AML Background

- AML is an aggressive, highly complex malignancy typically diagnosed in older adults¹
- AML will be diagnosed in over 20K patients and result in nearly 11.2K deaths in 2024²
- IDH1 mutations are found in 6-9%^{3,4} of AML
- mIDH1 patients are well-identified, and have limited options for treatment, particularly in relapsed/refractory (R/R) disease
- A significant unmet need exists for targeted treatments for mIDH1 R/R AML that are well-tolerated and efficacious



IDH1, isocitrate dehydrogenase-1; mIDH1, mutated IDH1; R/R, relapsed or refractory; AML, acute myeloid leukemia.

1. Leukemia & Lymphoma Society, Facts About Acute Myeloid Leukemia (AML), December 2019. 2. American Cancer Society, Key Statistics for Acute Myeloid Leukemia (AML), 2024. 3. Abbas S et al. Acquired mutations in the genes encoding IDH1 and IDH2 both are recurrent aberrations in acute myeloid leukemia: prevalence and prognostic value. Blood (2010) 116 (12): 2122-2126. 4. Chotirat S et al. Molecular alterations of isocitrate dehydrogenase 1 and 2 (IDH1 and IDH2) metabolic genes and additional genetic mutations in newly diagnosed acute myeloid leukemia patients. J Hematol Oncol 5, 5 (2012). 5. Rigel HCP Quantitative Market Research, 2022 (Data on File).

REZLIDHIA Phase 2 Clinical Trial: Study Design¹

Monotherapy
REZLIDHIA² 150 mg BID

Cohort 1: R/R AML (N=153)

Cohort 2: AML in CR/CRi but MRD positive

Cohort 3: R/R AML/MDS treated previously with IDH1 inhibitor therapy AND standard treatments are contraindicated

Cohort 7: TN AML for whom standard treatments are contraindicated

Combination Therapy
REZLIDHIA² 150 mg BID + AZA³

Cohort 4: R/R AML/MDS naïve to prior HMA and IDH1 inhibitor therapy

Cohort 5: R/R AML/MDS inadequately responded to or progressed on prior HMA

Cohort 6: R/R AML/MDS treated previously with IDH1 inhibitor monotherapy as last prior therapy

Cohort 8: TN AML candidates for AZA as first-line treatment

Primary Endpoint:

- CR+CRh rate

Key Secondary Endpoints:

- ORR, DOR, Transfusion independence, OS
- Safety

Cohort 1: All adults, median age 71 (32-87) years, 73% had intermediate AML cytogenetic risk. Most (75%) had ≥1 co-occurring mutations. Most (97%) had prior induction therapy and a median 2 (1-7) prior treatments (all naïve to mIDH1-inhibitor).

IDH1, isocitrate dehydrogenase-1; *mIDH1*, mutated IDH1; R/R, relapsed or refractory; AML, acute myeloid leukemia; BID, twice daily; CR, complete remission; CRh, CR with partial hematologic recovery; CRi, CR with incomplete count recovery; MRD; minimal residual disease; HMA, hypomethylating agents; ORR, overall response rate; DOR, duration of response, OS, overall survival; AZA, azacitidine.

1. NCT02719574. 2. REZLIDHIA PO given daily over continuous 28-day cycles. 3. AZA IV or SC given daily on Days 1-7 of each 28-day cycle; patients received first dose >6 months prior to data cutoff of June 18, 2021. Source: Journal of Clinical Oncology 39, no. 15_suppl (May 20, 2021) 7006-7006 doi: 10.1200/JCO.2021.39.15_suppl.7006

REZLIDHIA Phase 2 Clinical Trial: Summary

REZLIDHIA[®]
(olutasidenib) 150 mg capsules

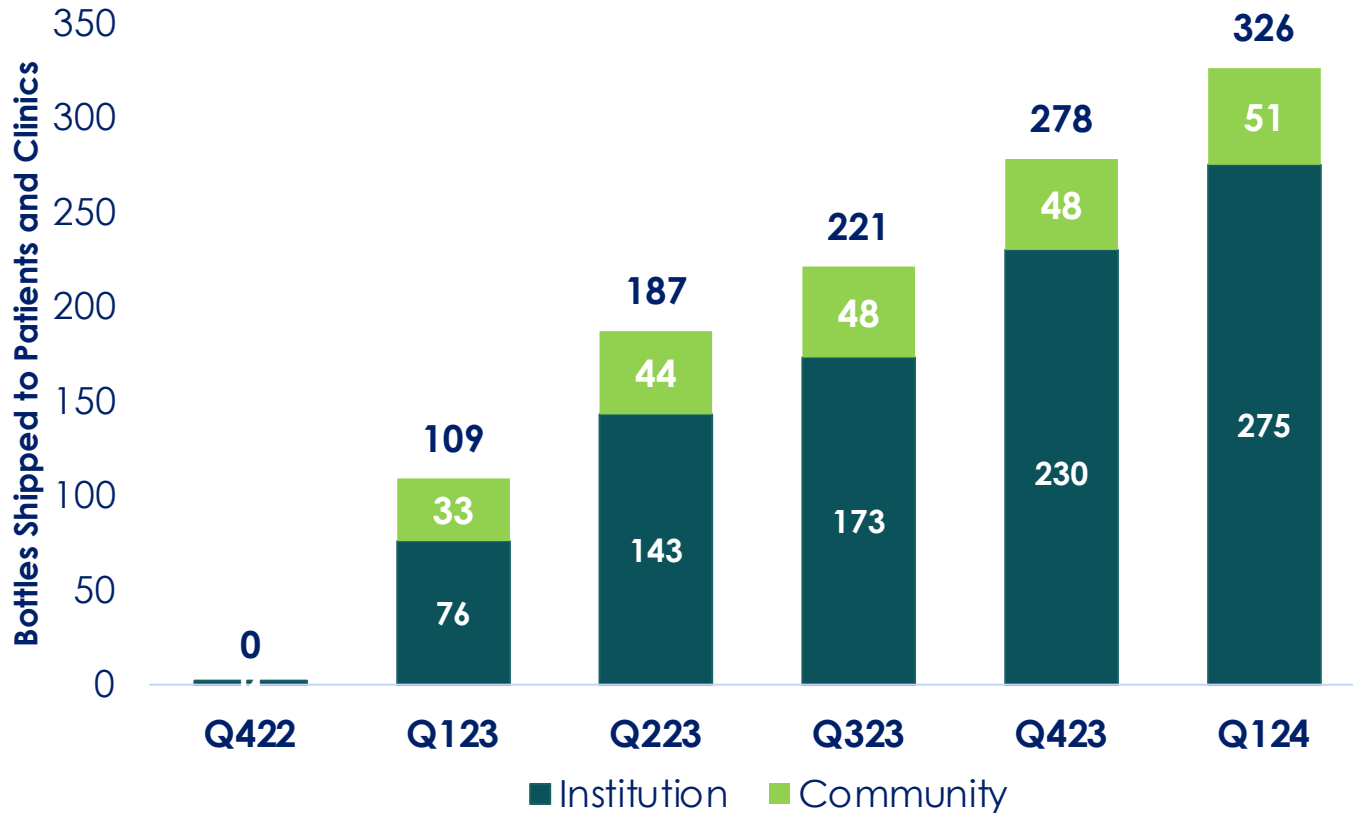


- CR+CRh rate of 35%, with a median duration of response of 25.9 months
- 92% of CR+CRh responders were CR, with a median duration of response of 28.1 months
- Transfusion independence was achieved in all subgroups
- REZLIDHIA has a well characterized safety profile with no cardiac events leading to discontinuation

REZLIDHIA Continued Growth Driven by Institutions



Institutional use accounted for >84% of business in Q1



Q1 2024 REZLIDHIA New Patient Starts

- Institutional new patient starts continued to grow in breadth and depth with academic AML treaters
- Community new patient starts were encouraging, increasing to >25% of Q1 total
- Significant opportunity remains to increase awareness and adoption in community practices, particularly with post-venetoclax data





GAVRETO in RET Fusion-Positive NSCLC or Thyroid Cancer



APPROVED IN THE U.S.

GAVRETO is indicated for the treatment of adult patients with metastatic rearranged during transfection (RET) fusion-positive non-small cell lung cancer as detected by an FDA-approved test, and 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)*

Please see Important Safety Information on slides 45 & 46

* 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).

Acquired U.S. Rights to GAVRETO®



GAVRETO (pralsetinib) is a once daily, small molecule, oral, kinase inhibitor of wild-type RET (rearranged during transfection) and oncogenic RET fusions



Highly synergistic with Rigel's current product portfolio and existing commercial infrastructure and expertise



Generated **~\$28M** in U.S. net product sales in 2023¹



Patents that have issued or are expected to issue covering GAVRETO will have statutory expiration dates between 2036 and 2041

- **Established U.S. marketed product**
- Blueprint will receive a purchase price of **\$15.0M**
 - **\$10.0M** payable upon first commercial sale by Rigel
 - **\$5.0M** payable on the first anniversary of the closing date, subject to certain conditions
- Blueprint is also eligible to receive up to \$97.5M in future commercial milestone payments and up to \$5.0M in future regulatory milestone payments, in addition to tiered royalties ranging from 10% to 30%
- Rigel expects to add GAVRETO to its operations and start recognizing product sales in July 2024

RET, rearranged during transfection.

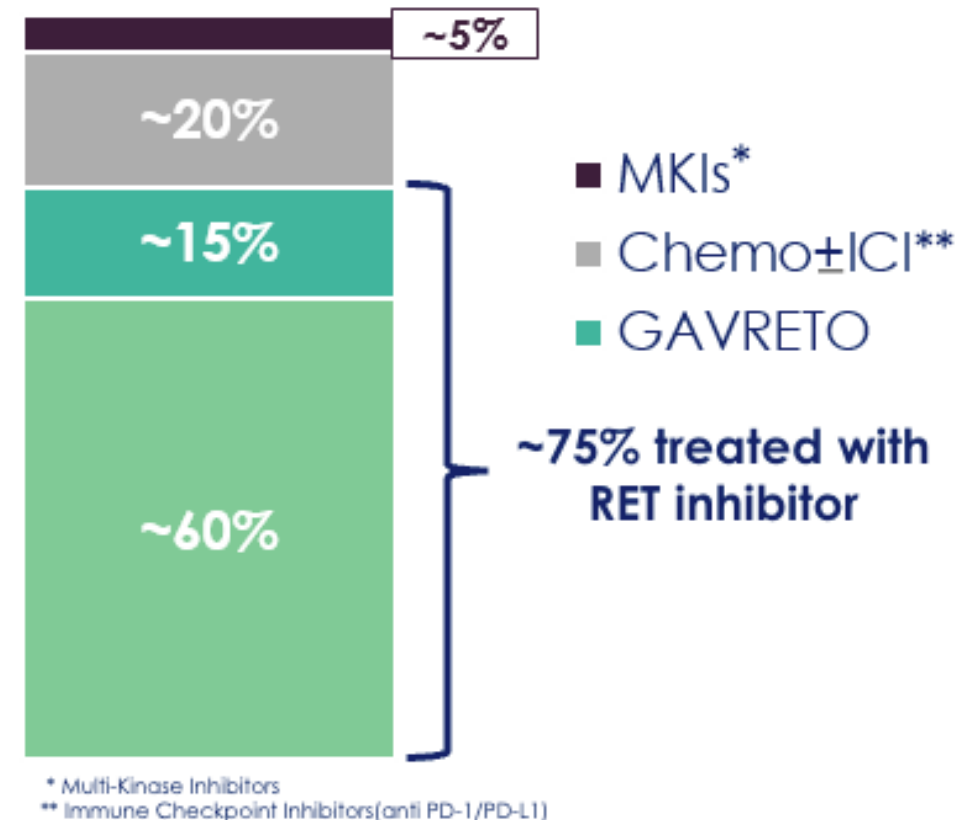
1. U.S. Net sales provided by Blueprint Medicines as reported by Genentech, a member of the Roche group. Please see Important Safety Information on slides 45 & 46. Please visit www.GAVRETO.com for Full Prescribing information.

Growing Our Oncology Targeted Therapy Portfolio

A Compelling and Synergistic Opportunity

- Enables entry into a well-identified subset of large solid tumor market
 - Immediately recognizable population of RET fusion-positive patients
 - Challenging to treat with platinum-based chemotherapy and checkpoint inhibitors
- Leverages patient access
 - Efficient product distribution
 - Responsive Rigel ONECARE patient services
 - Strong coverage and reimbursement
- Complementary to our field capabilities
 - Commercial and Medical Affairs teams in both academic and community settings

1L Treatment of RET fusion-positive NSCLC Patients¹



Biomarker-Based Therapy is Standard of Care for NSCLC

RET-fusion positive cancers

- RET fusions are present in ~2% of NSCLC^{1,2}, the most common type of lung cancer, and ~20% of papillary thyroid cancers³
- Testing for RET is an essential part of the pre-treatment evaluation of NSCLC
- Practice guidelines recommend targeted therapies as first-line treatment for eligible patients with metastatic NSCLC who have actionable genetic variants such as RET fusions

RET-fusion positive NSCLC



Suboptimal responses with platinum-based regimens (ORR ~50%; median PFS: 6-8m)⁴



Inferior outcomes with non-selective multi-kinase inhibitors (ORR <30%)⁵⁻⁹



Low PD-L1 expression so immune checkpoint inhibitors are less effective (ORR <10%)¹⁰

Pralsetinib is an oral highly potent, selective RET inhibitor dosed once daily that is FDA-approved for RET fusion-positive NSCLC or thyroid cancer* (first line or subsequent therapy)

* 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).

NSCLC, non-small cell lung cancer; RET, rearranged during transfection; ORR, overall response rate.

1. Lipson, et al. *Nat Med* 2012 2. Takeuchi, et al. *Nat Med* 2012 3. Santoro, et al. *J Clin Invest* 1992 4. Gautschi O, et al. *J Clin Oncol*. 2017. 5. Drlon A et al. *Nat Rev Clin Oncol* 2018. 6. Lee SH et al. *Annals of Oncology*. 2017. 7. Drlon A et al. *Lancet Oncology*. 2016. 8. Hida T et al. *Lung Cancer*. 2019. 9. Horiike A et al. *Lung Cancer*. 2016. 10. Mazieres J, et al. *J Clin Oncol* 2018;36(15 suppl)

Pralsetinib in RET Fusion + Solid Tumors: Updated Results from the Phase 1/2 “ARROW” Study

Potential for better response rates when used first-line in NSCLC¹

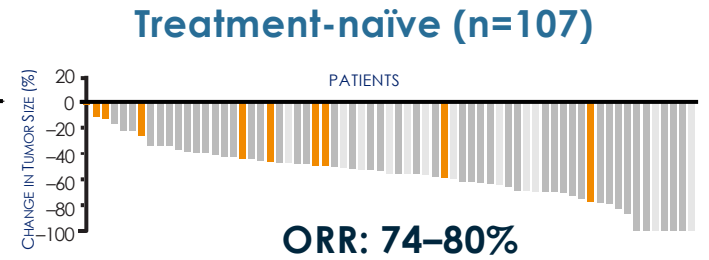
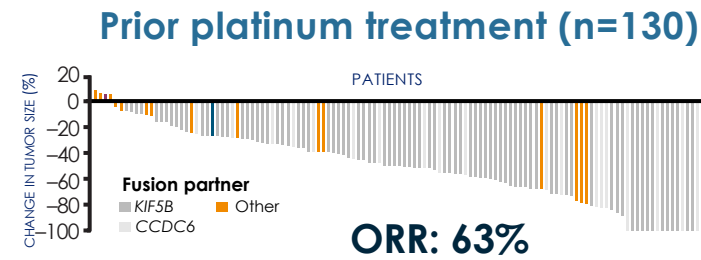
Phase 1:
Dose Escalation
Pralsetinib 30-600 mg
QD or BID

Phase 2
RP2D: 400 mg QD

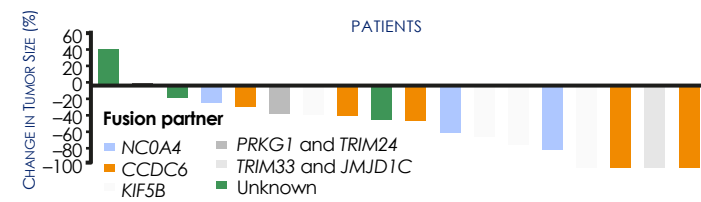
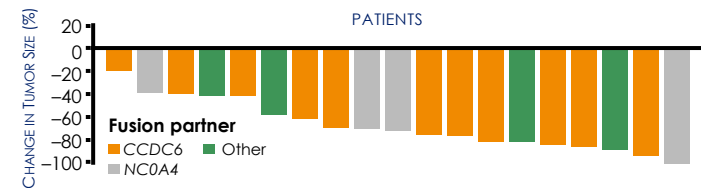
RET fusion+ NSCLC
(n=260)

RET fusion+ TC
(n=22)

Other RET fusion+ solid tumors*
(n=23)
* Investigational use



Median duration of response: 19.1 months (14.5-27.3)¹ (all NSCLC)



Promising Intracranial Efficacy in NSCLC Patients with Brain Metastases – ARROW Study¹

25% of RET fusion-positive NSCLC patients have brain metastases at diagnosis²

Intracranial response in patients with measurable CNS metastases at baseline (n=15)¹

	N=15
CNS ORR, % (95% CI)	53.3 (26.6–78.7)
CR, n (%)	3 (20.0)
PR, n (%)	5 (33.3)
	n=8
Median DOR, months (95% CI)^a	11.5 (9.2–NR)
Median follow-up, months (95% CI)	29.7 (24.1–35.3)

^aPer EMA censoring rule.

CI, confidence interval; CNS, central nervous system; CR, complete response; DOR, duration of response; NSCLC, non-small cell lung cancer; PR, partial response, ORR, overall response rate; RET, rearranged during transfection.

1. Besse B et al. Ann Oncol. 2022; 33(suppl 7) 2. Drilon A., J Thorac Oncol 2018;13

Pralsetinib Has a Differentiated Value Proposition



The **only once daily, oral**, RET inhibitor approved for patients with NSCLC and thyroid cancer with RET gene fusions



High and durable response rates regardless of prior treatment history¹



Promising intracranial efficacy in patients with **brain metastases**¹



Established **safety and tolerability** profile



Practice guidelines **recommended treatment option** for patients with **RET+ mNSCLC and advanced thyroid cancer**

GAVRETO Drivers and Opportunities for Growth

EXPAND Patient Identification



- High awareness of RET
- Testing rate increasing
- Current reasons to not test:
 - Tissue availability
 - Wait for results

Recent data / approvals in early-stage disease will continue to drive the importance of testing

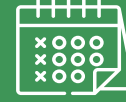
OPTIMIZE Choice of Therapy



- Most oncologists have not tried GAVRETO in 1L RET fusion-positive NSCLC
- Top barrier was comfort and familiarity with other drugs

Clinicians concerned about delaying treatment and those in community practices are more likely to initiate non-targeted treatment

MAXIMIZE Carryover



- High response rates in both treatment naïve and prior platinum treated patients
- Long duration of response

The only once-daily therapy designed to selectively target RET

ENSURE Patient Access



- Access to coverage, reimbursement and patient services
 - Out-of-pocket cost and difficulty obtaining reimbursement are top barriers for RET inhibitor adoption¹



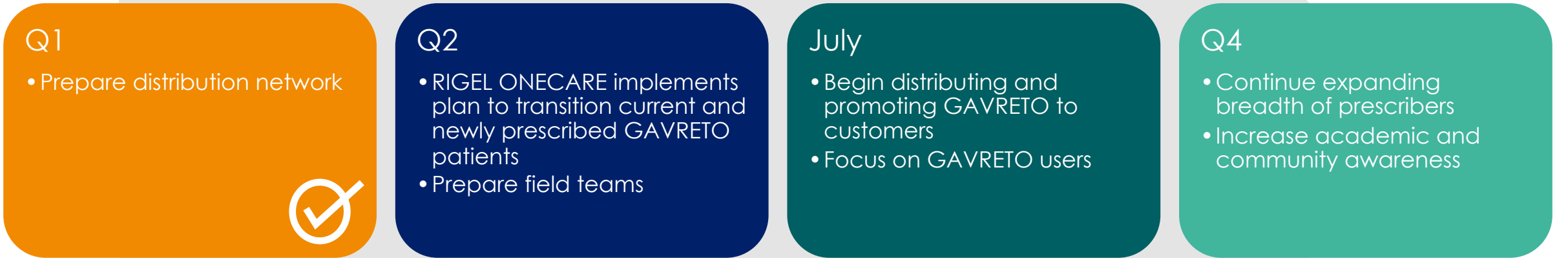
Committed to Access Without Interruption

Ready to serve current and newly prescribed patients



- Rigel's Limited Network will ensure provider and patient choice
- Staff dedicated to GAVRETO at RIGEL ONECARE will ensure high customer service
- New patients enter the network via RIGEL ONECARE or directly to Rigel's established network
- Rigel Network ready to ship GAVRETO in July

2024 Commercialization Timeline



On Track →



Clinical Development Program Update

Hematology and Oncology Pipeline Expansion

Development Opportunities¹

Olutasidenib

- Broad range of *IDH1*-mutant cancers including AML, MDS and glioma

R289 IRAK1/4 Inhibitor

- Lower-risk MDS (LR-MDS)

Fostamatinib

- Investigator sponsored trials

Leverage
Heme/Onc
Capabilities

In-Licensing & Product Acquisition

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

IDH1, isocitrate dehydrogenase-1, mIDH1, mutated IDH1; AML, acute myeloid leukemia; MDS, myelodysplastic syndrome; IRAK1/4, interleukin receptor-associated kinases 1 and 4.

1. Investigational compounds in these indications and not approved by the FDA

Strategic Alliance with MD Anderson to Advance REZLIDHIA (olutasidenib) in AML and Other Cancers¹



- 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 and advanced MPN
- The collaboration will also support the evaluation of olutasidenib as:
 - Monotherapy in *IDH1*-mutated CCUS & lower-risk MDS
 - Post-transplant maintenance therapy for *IDH1*-mutated hematologic malignancies

Rigel will provide \$15 million in time-based milestone payments and study material over the 5-year collaboration

AML, acute myeloid 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 43 & 44. Please visit www.REZLIDHIA.com for Full Prescribing Information, including Boxed WARNING.

Collaboration with CONNECT to Conduct a Phase 2 Trial with Olutasidenib in Glioma¹

- Gliomas account for 29-35% of CNS tumors in children, adolescents and young adults; approximately 1/3 are high grade gliomas (HGG) (800-1000 new cases/year in US)²
- IDH1 mutations are found in up to 36% of HGGs in adolescents and young adults^{3,4,5}
- Safety and preliminary activity of single-agent olutasidenib in adult patients with relapsed/refractory high grade IDH1-mutant gliomas were recently reported⁶
- Olutasidenib will be included in CONNECT's TarGeT-D trial, a molecularly-guided Phase 2 umbrella clinical trial for HGG
- The Rigel-sponsored arm will evaluate olutasidenib¹ in combination with temozolomide and as monotherapy in the maintenance setting for newly-diagnosed adolescent and young adult patients (≤ 39 years) with *IDH1* mutation positive HGG post-radiotherapy

Rigel will provide funding up to \$3 million and study material over the 4-year collaboration

CNS, central nervous system; IDH1, isocitrate dehydrogenase-1

1. Investigational compound in this indication and not approved by the FDA. 2. Tejan P et al, *Adolesc Health Med Ther* 2017; 8. 3. Mackay A et al. *Cancer Cell*. 2017; 32(4) 4. Korshunov A et al. *Acta Neuropathol*. 2015; 129(5) 5. Hartmann C et al. *Acta Neuropathol*. 2009; 118(4) 6. de la Fuente MI et al. *Neuro Oncol* 2023; 25(1)

High grade gliomas: A leading cause of cancer-related death in adolescents and young adults

- Gliomas account for 29-35% of CNS tumors in children, adolescents and young adults; approximately 1/3 are high grade gliomas (HGG) (800-1000 new cases/year in US)¹
- *IDH1* mutations are found in up to 36% of HGGs in adolescents and young adults^{2,3,4}
- Safety and preliminary activity of single-agent olutasidenib in adult patients with relapsed/refractory high grade *IDH1*-mutant gliomas was recently reported⁵

Despite intensive multimodal therapy, prognosis for adolescent, and young adult patients diagnosed each year in the U.S. with HGG remains dismal, with 5-year overall survival (OS) <10%^{6,7}

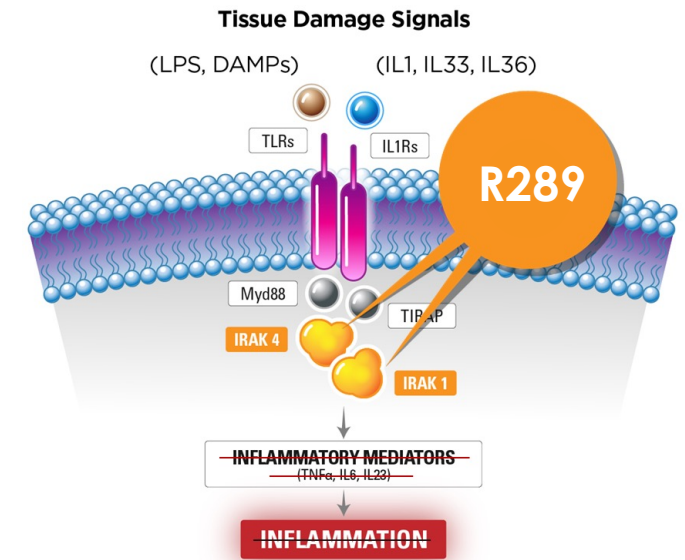
CNS, central nervous system; HGG, high-grade glioma; IDH1, isocitrate dehydrogenase-1; MRI, magnetic resonance imaging; OS, overall survival.

1. Tejan P et al, *Adolesc Health Med Ther* 2017; 8. 2. Mackay A et al. *Cancer Cell*. 2017; 32(4) 3. Korshunov A et al. *Acta Neuropathol*. 2015; 129(5) 4. Hartmann C et al. *Acta Neuropathol*. 2009; 118(4) 5. de la Fuente MI et al. *Neuro Oncol* 2023; 25(1) 6. Fangusaro J. *Front Oncol*. 2012; 2:105. 7. Jones C et al. *Neuro Oncol*. 2017; 19(2)

Dual Targeting of the IRAK1 & IRAK4 Pathways in MDS by R289, an IRAK1 & IRAK4 Inhibitor¹

Dysregulation of immune/inflammatory signaling pathways is associated with MDS

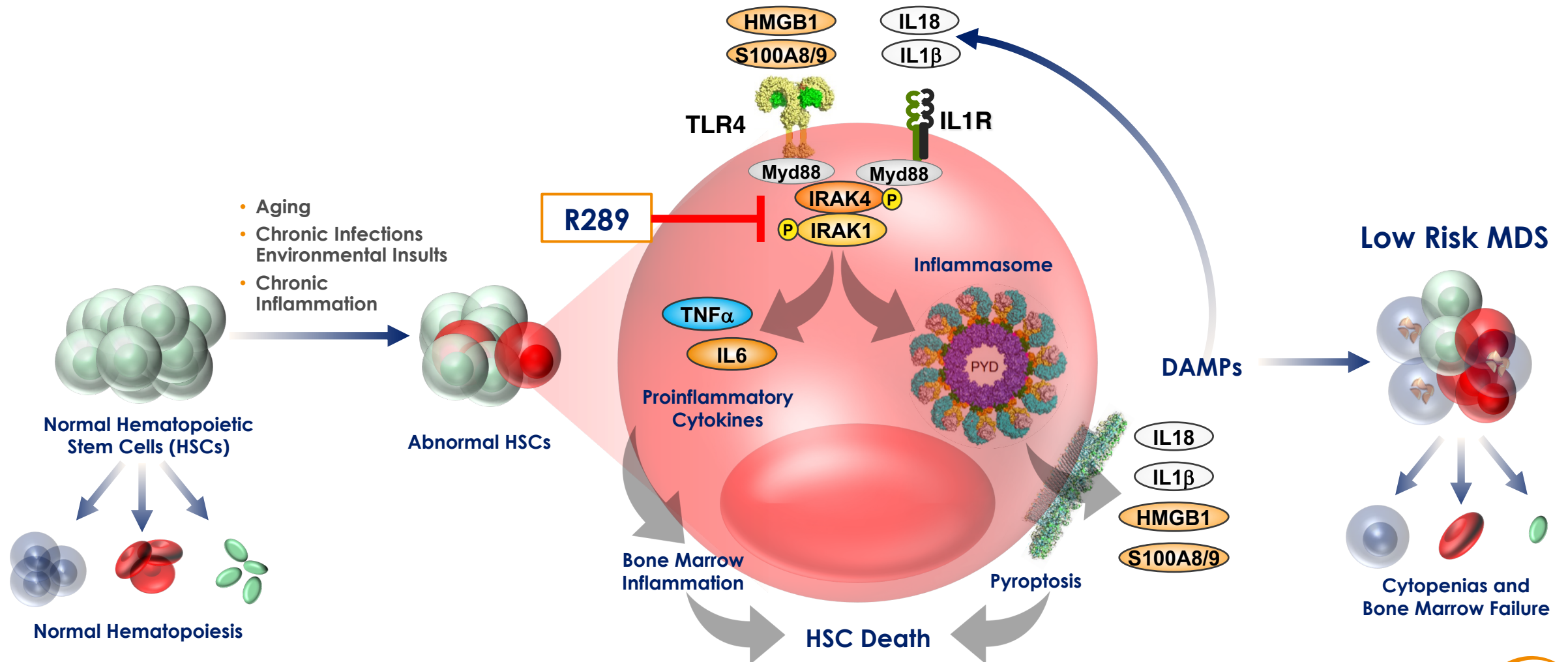
- Chronic stimulation of both the interleukin-1 receptor (IL-1R) and toll-like receptor (TLR) pathways leads to a proinflammatory marrow environment and persistent cytopenias in patients with LR-MDS²
- In addition, IRAK1 and IRAK4 activation were recently reported to occur independently of the TLR/IL-1R signaling pathway³
- Dual inhibition of IRAK1 & IRAK4 showed greater suppression of inflammatory cytokines vs an IRAK4-selective inhibitor *in vitro*⁴
- In healthy volunteer studies, R835 suppressed LPS-induced pro-inflammatory cytokine production vs placebo⁵
- R289 (an oral prodrug that is rapidly converted to R835 in the gut) given once or twice daily was well-tolerated and is now being evaluated in a Phase 1b study in LR-MDS



IRAK1/4, interleukin receptor-associated kinases 1 and 4; MDS, myelodysplastic syndrome

1. R289 is an investigational compound not approved by the FDA. 2. Sallman DA, et al. Front Oncol. 2016;6. 3. Bennett J, et al. Blood. 2023;142. 4. Lamagna C et al. Ann Rheum Dis 2020;79 (suppl 1) 5. Yan L et al. Ann Rheum Dis 2020;79 (suppl 1)

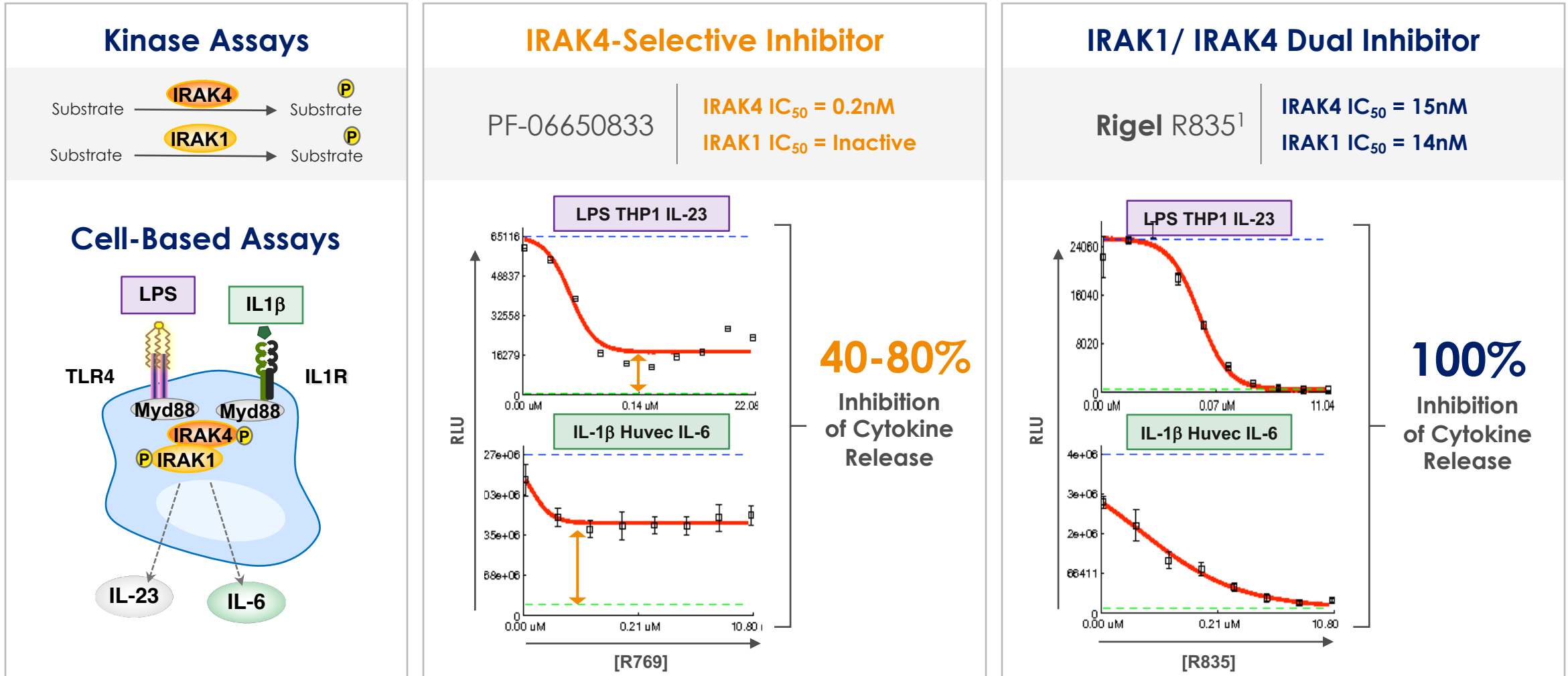
Bone Marrow Failure in Low Risk MDS is Driven by Chronic Inflammation and Pyroptosis of Normal Hematopoietic Stem Cells¹⁻³



MDS, myelodysplastic syndrome; IRAK1/4, interleukin receptor-associated kinases 1 and 4; HSC, hematopoietic stem cell; TLR, toll-like receptor; TNF α , tumor necrosis factor- α ; IL, interleukin; Myd88, myeloid differentiation primary response 88; HMGB1, high mobility group box-1 protein; DAMPs, damage-associated molecular patterns.

Targeting IRAK1 & IRAK4 Pathways in Inflammatory Disease

Dual Inhibition of IRAK1 and IRAK4 Provides Stronger Suppression of Inflammatory Cytokines Compared to IRAK4-selective Inhibitor²

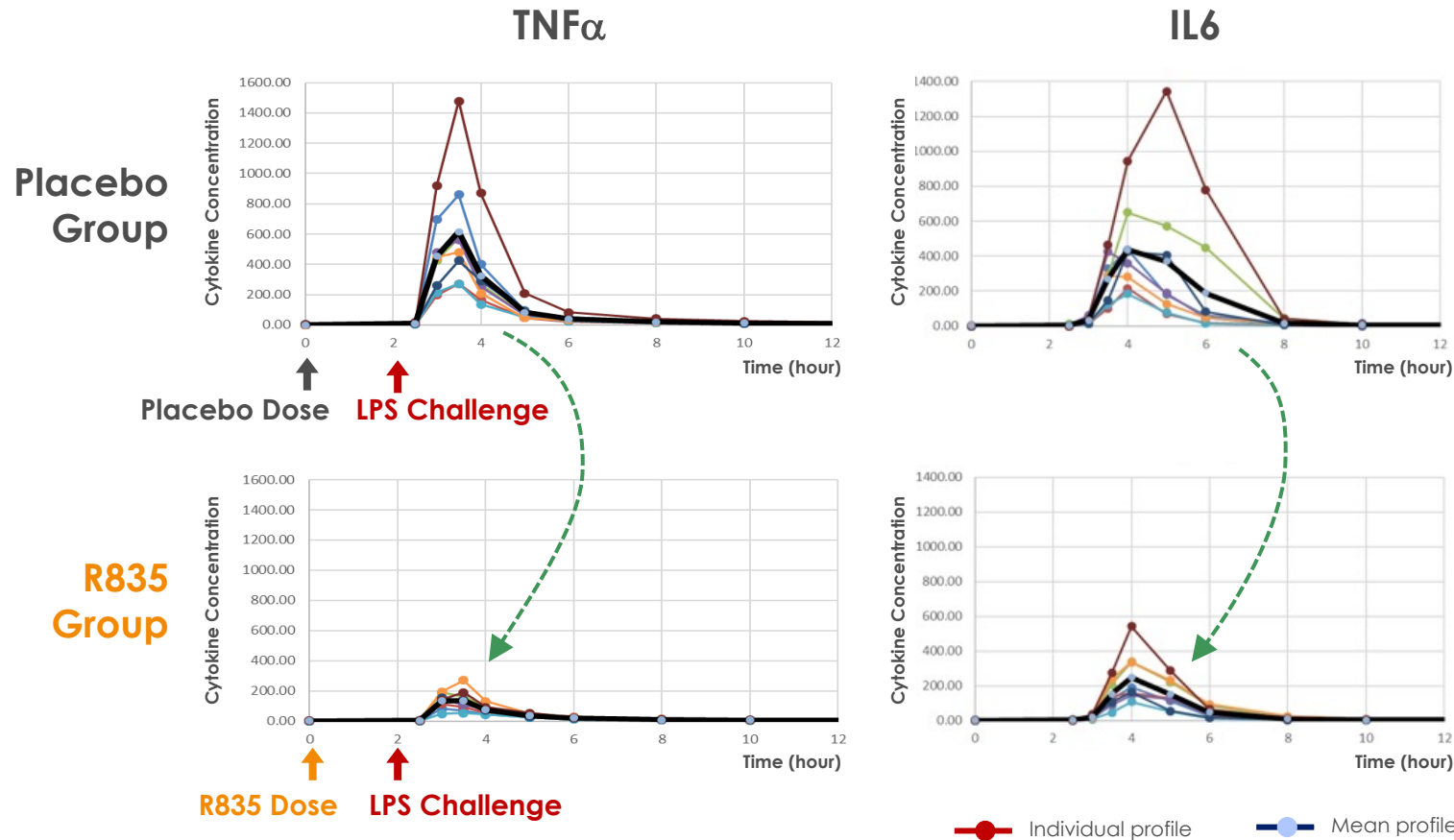


IRAK1/4, interleukin receptor-associated kinases 1 and 4; TLR, toll-like receptor; IL interleukin; LPS, lipopolysaccharide.

1. R835 is an investigational compound not approved by the FDA. 2. Rigel data on file.

R835¹ Proof-of-Mechanism and First-in-Human Studies³

Cytokine Response After LPS Challenge



Proof-of-Mechanism

In LPS² Challenge study in healthy volunteers, R835 profoundly inhibited inflammatory cytokine production²

- Inhibited TNF α , IL-6, and IL-8

First-in-Human

First-In-Human study enrolled 82 adults to characterize the safety, PK, PD of R835

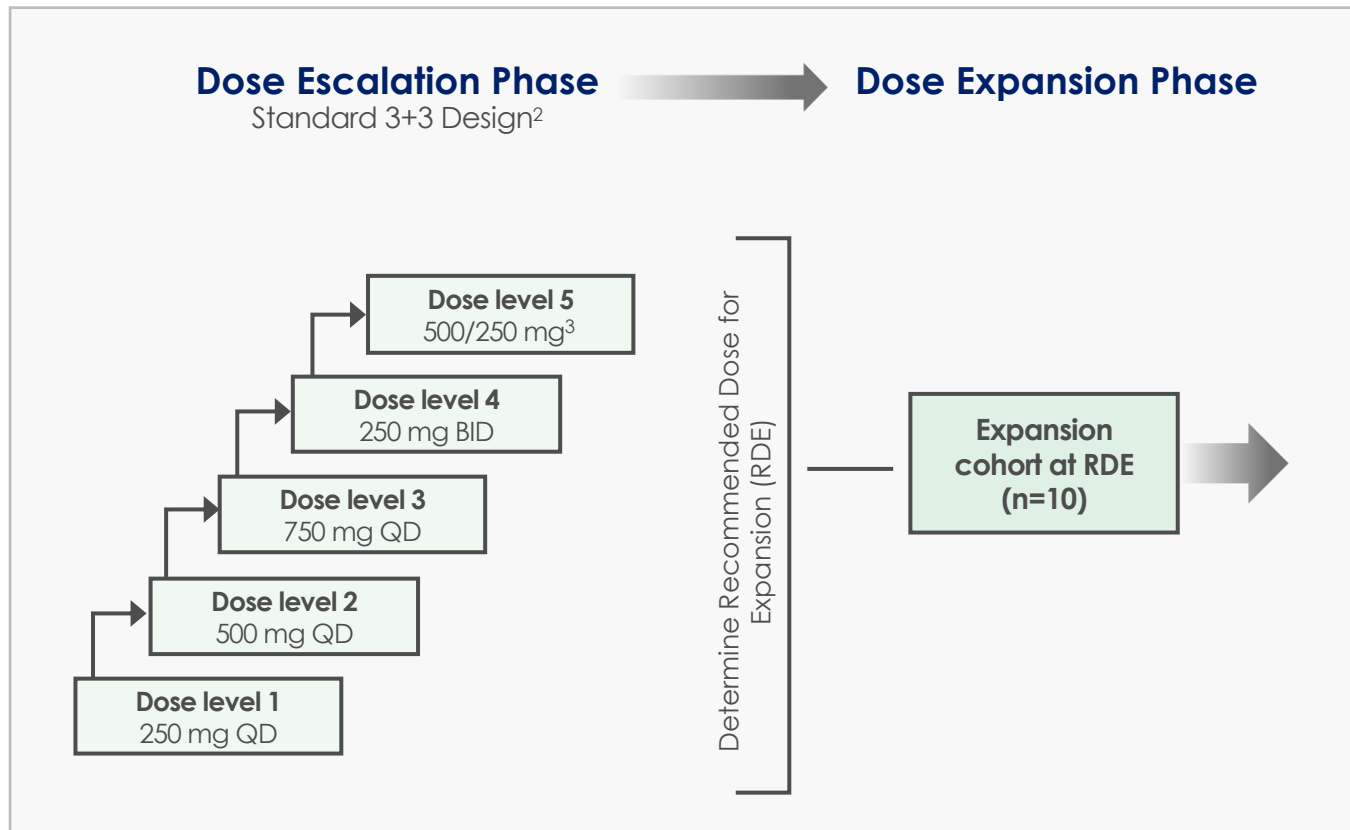
- R835 was well tolerated
- Linear PK profile and dose proportional exposure

LPS, lipopolysaccharides; TNF α , tumor necrosis factor- α ; IL, interleukin; PK, pharmacokinetics; PD, pharmacodynamics; LPS, lipopolysaccharide.

1. R835 is an investigational compound not approved by the FDA. 2. Lipopolysaccharide (LPS, a TLR4 agonist). 3. EULAR 2020 Poster Presentation -Abstract THU0219 - First-in-human Study of Safety, Pharmacokinetics and Pharmacodynamics of IRAK1/4 Inhibitor R835 in Healthy Subjects.

R289¹: Phase 1b Trial in Relapsed/Refractory Lower-Risk MDS

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



Primary Endpoints:

- Incidence of adverse events
- Incidence of dose-limiting toxicities

Secondary Endpoints:

- Transfusion independence
- Response rates
- Hematologic improvement
- PK
- PD

Lower-Risk MDS (LR-MDS) Treatment Landscape

- MDS is a heterogeneous group of diseases primarily of the elderly characterized by cytopenias and increased risk of transformation to AML.
- Therapeutic strategy depends upon MDS risk classification (IPSS scoring system).
- Goal of treatment for LR-MDS: Reduce transfusion needs, improve cytopenias and quality of life

1

**Newly-diagnosed:
RBS transfusions, ESAs,
Luspatercept, lenalidomide**

Erythroid Stimulating Agents (ESAs), luspatercept for anemia; lenalidomide for del5q MDS

2

Relapsed: Luspatercept, Hypomethylating Agents (HMAs), lenalidomide

Luspatercept for ESA failures, oral HMAs for trilineage cytopenias. Durable responses are not common, lack of overall survival gains, potential for toxicity with HMAs.

X

**Recurrent/
refractory**

No drugs approved for HMA failures- high unmet medical need. AlloSCT is only option.

There are currently no approved therapies for lower-risk MDS patients who are refractory/resistant to available second-line therapies

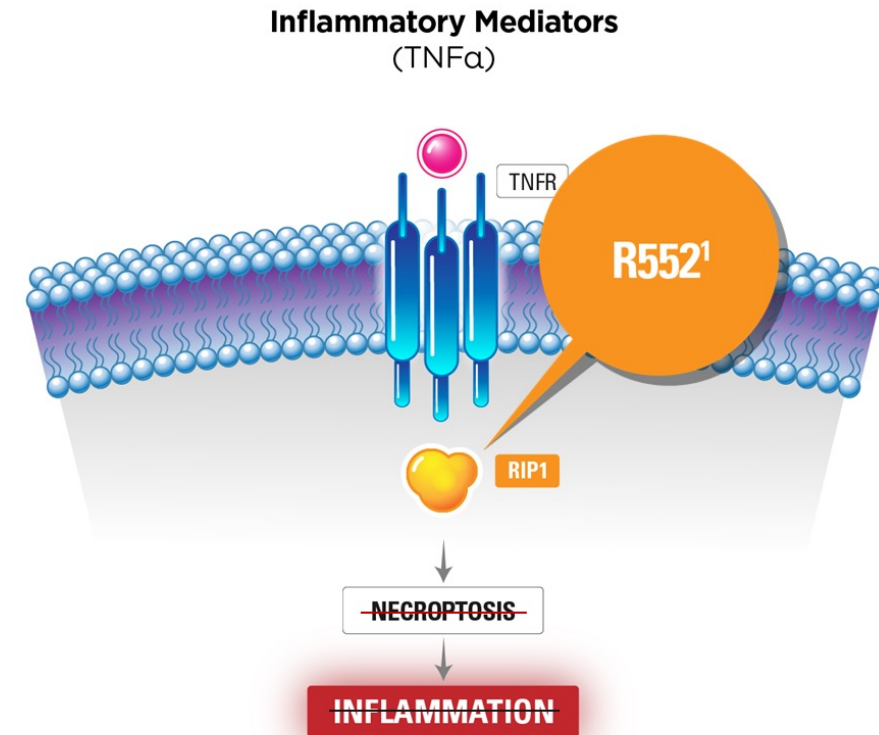
RIPK1 Inhibitor Programs in Immune and CNS Diseases with Partner Lilly

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.



Financials

Q1 2024 Financial Highlights

Total Revenue: \$29.5M

• Net Product Sales: \$26.0M

- TAVALISSE: \$21.1M
- REZLIDHIA: \$4.9M

• Contract revenues from collaborations: \$3.5M

- Kissei \$2.3M
- Grifols \$1.1M
- Medison \$0.1M

Total Bottles Shipped:

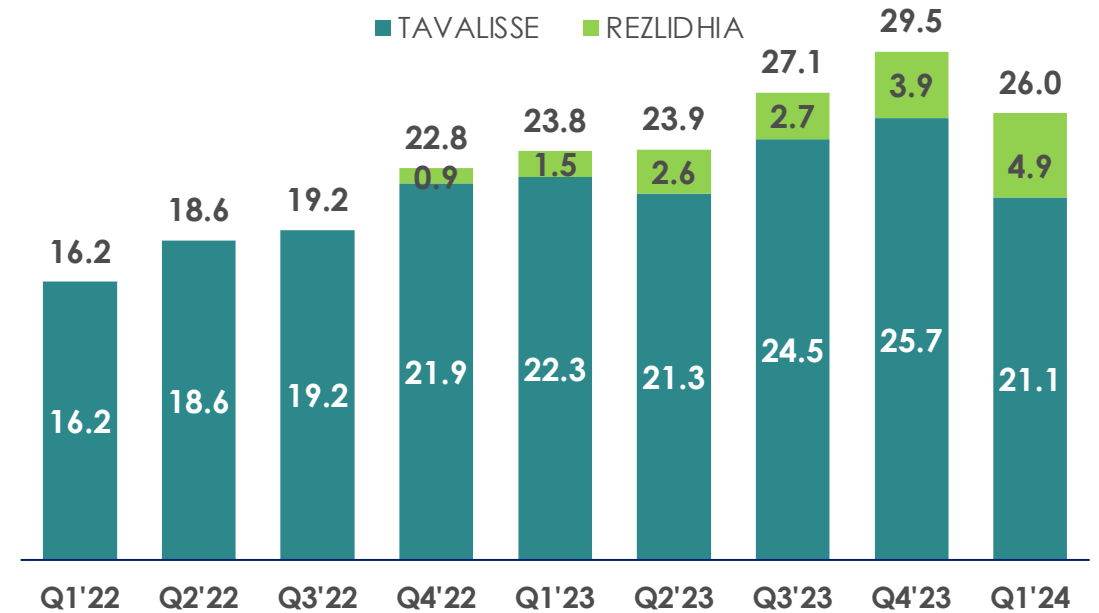
- TAVALISSE: 2,193
- REZLIDHIA: 390

Highest Number of Bottles Shipped to Patients and Clinics Since Launch¹:

- TAVALISSE: 2,483
 - Sequential decline in net revenue resulting from decrease in inventory remaining in distribution channel
- REZLIDHIA: 326

Cash, cash equivalents & short-term investment as of March 31, 2024 was **\$49.6M** compared to \$56.9M as of December 31, 2023

Net Product Sales (\$M)



	Tavalisse	Q1'22	Q2'22	Q3'22	Q4'22	Q1'23	Q2'23	Q3'23	Q4'23	Q1'24
Bottles Shipped to Patients & Clinics ¹	Tavalisse	1836	2054	2026	2196	2256	2265	2412	2463	2483
	Rezlidhia				2	109	187	221	278	326
Change in Bottles in Distribution Channels	Tavalisse	-12	-1	46	221	25	-74	139	208	-290
	Rezlidhia				62	4	13	-11	30	64
Total Bottles Shipped	Tavalisse	1824	2053	2072	2417	2281	2191	2551	2671	2193
	Rezlidhia				64	113	200	210	308	390

2024 Value Drivers

Tavalisse[®]
(fostamatinib disodium
hexahydrate) tablets

REZLIDHIA[®]
(olutasidenib) 150 mg
capsules

GAVRETO[®]
pralsetinib 100mg
capsules

Expanding Product Sales for TAVALISSE and REZLIDHIA

- Continue to broaden TAVALISSE and REZLIDHIA awareness and adoption
- Identify ex-US collaboration(s) for olutasidenib

Commercialize GAVRETO

- Effectively add to Rigel's commercial business

Continued Financial Discipline

Development Programs¹

- Advance olutasidenib in AML, MDS, glioma and other cancers
- Evaluate additional clinical development opportunities and alliances for olutasidenib
- Evaluate heme/onc opportunities for fostamatinib
- Enroll and generate preliminary data for R289 Phase 1b study in lower-risk MDS

In-License and Product Acquisition Opportunities

- Actively pursue new late-stage assets which leverage current capabilities & capacity

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 (\geq 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 ($\geq 5\%$ 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 <http://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 initiate treatment 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 ($\geq 20\%$) 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.

Please see 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. You may also report side effects to Genentech at **1-888-835-2555**.

Please see <https://GAVRETO.com> for Full Prescribing Information and Patient Information



Thank You

www.rigel.com

