May 21, 2026

Rigel Announces Oral and Poster Presentations at the 2026 ASCO Annual Meeting and EHA2026 Congress

- *Oral presentation at ASCO Annual Meeting to feature final data from the Phase 3 AcceleRET-Lung clinical trial of GAVRETO® (pralsetinib) as first-line treatment in patients with RET fusion-positive NSCLC*
- *Final analysis from the Phase 1/2 ARROW clinical trial of pralsetinib in patients with advanced or metastatic RET-altered thyroid cancer to be presented in a poster session*
- *Real-world data further supports the useof REZLIDHIA® (olutasidenib) in patients with R/R mIDH1 AML that have received prior venetoclax*

SOUTH SAN FRANCISCO, Calif., May 21, 2026 /PRNewswire/ -- Rigel Pharmaceuticals, Inc. (Nasdaq: RIGL), a commercial stage biotechnology company focused on hematologic disorders and cancer, today announced the final data from the Phase 3 AcceleRET-Lung clinical trial of GAVRETO® (pralsetinib) as first-line treatment of rearranged during transfection (*RET*) fusion-positive non-small cell lung cancer (NSCLC) will be presented in an oral session at the 2026 American Society of Clinical Oncology (ASCO) Annual Meeting on Friday, May 29, 2026.

In addition, the ASCO Annual Meeting and European Hematology Association (EHA) 2026 Congress will feature poster presentations that include additional data for pralsetinib and data for REZLIDHIA® (olutasidenib) for the treatment of relapsed or refractory (R/R) isocitrate dehydrogenase-1 (m*IDH1*)-mutated acute myeloid leukemia (AML). The ASCO Annual Meeting is being held in Chicago, Illinois and virtually from May 29 to June 2, 2026 and the EHA2026 Congress is being held in Stockholm, Sweden and virtually from June 11 to June 14, 2026.

"Having an oral presentation at ASCO as well as multiple additional data presentations at both upcoming medical conferences underscores the continued clinical relevance of our oncology portfolio. We're pleased that data from the AcceleRET-Lung clinical study will be presented for the first time and the real-world outcome data for olutasidenib will be presented for patients with relapsed/refractory m*IDH1* AML previously treated with venetoclax, further validating its role as a treatment option for these patients," said Raul Rodriguez, Rigel's president and CEO. "Together, these data reinforce our ability to deliver targeted therapies that significantly improve the lives of patients with difficult-to-treat

cancers. We look forward to sharing these data with the medical community."

Key highlights from the presentations at ASCO and EHA include:

- In the Phase 3 AcceleRET clinical trial, pralsetinib met the primary progression-free survival (PFS) endpoint and had a significantly greater overall response rate and more durable response vs. standard of care, demonstrating the clinical utility of pralsetinib in *RET* fusion-positive NSCLC. In terms of safety, there were 32 (30.0%) and 26 (25.0%) deaths in the pralsetinib and standard of care groups, respectively, with 8 (7.4%) and 0 due to infection. Increased monitoring suggests severe infection risk can be effectively managed.
- In the Phase 1/2 ARROW clinical study of pralsetinib in patients with *RET* altered thyroid cancer and medullary thyroid cancer, pralsetinib yielded clinically meaningful and durable responses with a manageable safety profile, consistent with prior reports.
- In an analysis of the patient, disease and molecular characteristics of long-term (LT) complete remission (CR)/CR with partial hematologic recovery (CRh) (>12 months duration of response) in the registrational Phase 2 clinical trial evaluating olutasidenib in patients with R/R m*IDH1* AML, olutasidenib enabled LT CR/CRh in half of patients with CR/CRh without transplant (longest response >54 months). Estimated 48-month overall survival was 74% (95% CI: 51%, 88%).
- In a separate real-world assessment evaluating treatment patterns, safety and effectiveness of adults with R/R m*IDH1* AML receiving olutasidenib following a venetoclax-based therapy in routine practice (73% of patients received olutasidenib as second-line therapy), a subgroup of patients that historically has very poor outcomes, 51 charts were collected from 18 physicians. Olutasidenib demonstrated robust real-world effectiveness with a CR/CRh rate of 60.8% and CR rate of 57% and a median response duration of 30.3 months. Substantial reductions in transfusion dependence further support olutasidenib as a viable post-venetoclax therapeutic option. These findings suggest that earlier sequencing of olutasidenib in the treatment paradigm may optimize patient outcomes.

ASCO Annual Meeting abstracts may be accessed online via https://www.asco.org/abstracts. EHA2026 Congress abstracts may be accessed online via the EHA Library.

ASCO Presentations

Abstract Title	Lead Author / Presenter	Presentation Type / Abstract #	Session Title	Session Date / Time (CT)
GAVRETO (pralsetinib)				
Efficacy and safety of pralsetinib as first-line treatment of RET fusion-positive advanced or metastatic non-small cell lung cancer (NSCLC): The phase 3 AcceleRET-Lung study	Sanjay Popat, MBBS, FRCP, PhD	Oral presentation #8504	Lung Cancer—Non-Small Cell Metastatic	Friday, May 29, 2026 1:00pm – 4:00pm
Efficacy and safety of pralsetinib in advanced or metastatic RET-altered thyroid cancer (TC): Final analysis of the phase 1/2 ARROW study	Vivek Subbiah, MD	Poster presentation #6028	Head and Neck Cancer	Saturday, May 30, 2026 1:30pm – 4:30pm
Efficacy and Safety of Pralsetinib in RET Fusion-Positive Solid Tumors: Data From the TAPISTRY Trial	Chia-Chi Lin, MD, PhD	Poster presentation #3144	Developmental Therapeutics—Molecularly Targeted Agents and Tumor Biology	Saturday, May 30, 2026 1:30pm – 4:30pm
Clinical factors driving use of RET inhibitor pralsetinib and associated real-world outcomes in RET fusion–positive NSCLC: A retrospective chart review	Makenzi Evangelist, MD	Publication #e20731	Lung Cancer—Non-Small Cell Metastatic	
REZLIDHIA (olutasidenib)				
Acute myeloid leukemia (AML) patient, disease, and molecular characteristics associated with a long-term (LT) response to olutasidenib	Justin M. Watts, MD	Poster presentation #6523	Hematologic Malignancies—Leukemia, Myelodysplastic Syndromes, and Allotransplant	Monday, June 1, 2026 9:00am – 12:00pm
Real-World Treatment Patterns and Outcomes with Olutasidenib After Venetoclax in IDH1-Mutated AML Using EHR Data	Yasmin Abaza, MD	Publication #e18514	Hematologic Malignancies—Leukemia, Myelodysplastic Syndromes, and Allotransplant	
Treatment Patterns and Outcomes with Olutasidenib After Venetoclax in IDH1-Mutated AML Using Real-World Data from Chart Review	Pinkal Desai, MD, MPH	Publication #e18527	Hematologic Malignancies—Leukemia, Myelodysplastic Syndromes, and Allotransplant	
Evaluating the cost per month of response for olutasidenib (OLU) versus ivosidenib (IVO) for patients with relapsed/refractory (R/R) mutant IDH1 (mIDH1) acute myeloid leukaemia (AML)	Yasmin Abaza, MD	Publication #e18504	Hematologic Malignancies—Leukemia, Myelodysplastic Syndromes, and Allotransplant	

EHA Presentations

Abstract Title	Lead Author / Presenter	Presentation Type / Abstract #	Session Date / Time (CEST)
REZLIDHIA (olutasidenib)			
Treatment Patterns and Outcomes with Olutasidenib After Venetoclax in IDH1-Mutated AML Using Real-World Data from Chart Review	Pinkal Desai, MD, MPH	Poster presentation #PS1502	Saturday, June 13, 2026 (18:45 - 19:45 CEST)
Acute myeloid leukemia (AML) patient, disease, and molecular characteristics associated with a long-term (LT) response to olutasidenib	Stéphane de Botton, MD, PhD	Poster presentation #PS1625	Saturday, June 13, 2026 (18:45 - 19:45 CEST)
Delphi Consensus on Optimal Treatment Strategies Using IDH1 Inhibitors in Patients with R/R mIDH1 AML	Justin M. Watts, MD	Publication #PB2795	
Real-World Treatment Patterns and Outcomes with Olutasidenib After Venetoclax in IDH1-Mutated AML Using EHR Data	Yasmin Abaza, MD	Publication #PB2610	
TAVALISSE (fostamatinib disodium hexahydrate)			
Health-Related Quality of Life (HRQoL) Among Patients With Immune Thrombocytopenia (ITP) Treated With Fostamatinib in the FORTE Study	Amber Afzal, MD, MSCI	Publication #PB4295	

About NSCLC

It is estimated that over 229,000 adults in the U.S. will be diagnosed with lung cancer in

2026. Lung cancer is the leading cause of cancer death in the U.S., with non-small cell lung cancer (NSCLC) being the most common type accounting for 77% of all lung cancer diagnoses.[1] RET fusions are implicated in approximately 1-2% of patients with NSCLC.[2]

About AML

Acute myeloid leukemia (AML) is a rapidly progressing cancer of the blood and bone marrow that affects myeloid cells, which normally develop into various types of mature blood cells. AML occurs primarily in adults and accounts for about 1 percent of all adult cancers. The American Cancer Society estimates that there will be about 22,720 new cases in the United States, most in adults, in 2026.[3]

Relapsed AML affects about half of all patients who, following treatment and remission, experience a return of leukemia cells in the bone marrow.[4,5] Refractory AML, which affects between 10 and 40 percent of newly diagnosed patients, occurs when a patient fails to achieve remission even after intensive treatment.[6] Quality of life declines for patients with each successive line of treatment for AML, and well-tolerated treatments in relapsed or refractory disease remain an unmet need.

About ITP

In patients with immune thrombocytopenia (ITP), the immune system attacks and destroys the body's own blood platelets, which play an active role in blood clotting and healing. Common symptoms of ITP are excessive bruising and bleeding. Patients suffering with chronic ITP may live with an increased risk of severe bleeding events that can result in serious medical complications or even death. Current therapies for ITP include steroids, blood platelet production boosters (TPO-RAs), and splenectomy. However, not all patients respond to existing therapies. As a result, there remains a significant medical need for additional treatment options for patients with ITP.

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

WARNING: SERIOUS INFECTIONS, INCLUDING OPPPORTUNISTIC INFECTIONS
GAVRETO may increase the risk for serious infections, including bacterial, fungal, viral and opportunistic infections, which can lead to hospitalization or death. Withhold, reduce the dose or permanently discontinue GAVRETO based on severity.

WARNINGS AND PRECAUTIONS

- **Serious Infections, Including Opportunistic Infections:** GAVRETO may increase the risk for serious infections, including fatal and opportunistic infections. In the AcceleRET-Lung trial, infections occurred in 72% of patients who received GAVRETO, including 18% with Grade 3 and 3.7% with Grade 4 and 7% with fatal outcomes. Among the patients who received chemotherapy/immunotherapy, infections occurred in 52%, including 10% with Grade 3. Infections in the GAVRETO arm included pneumonia, urinary tract infection, opportunistic infections (such as pneumocystis jirovecii pneumonia and fungal infections) and others. Monitor patients for signs and symptoms of infection and treat appropriately. Withhold, reduce the dose, or permanently discontinue GAVRETO based on severity.
- **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.
- **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.

ADVERSE REACTIONS

- 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.

DRUG INTERACTIONS

- **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.

Click here **for Important Safety Information and Full Prescribing Information, including Boxed WARNING.**

About REZLIDHIA®

INDICATION
REZLIDHIA is indicated for the treatment of adult patients with relapsed or refractory acute myeloid leukemia (AML) with a susceptible isocitrate dehydrogenase-1 (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.

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.

Click here **for Important Safety Information and Full Prescribing Information, including Boxed WARNING.**

About TAVALISSE®
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.

Click here **for Important Safety Information and Full Prescribing Information.**

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

About Rigel

Rigel Pharmaceuticals, Inc. (Nasdaq: RIGL) is a biotechnology company dedicated to discovering, developing and providing novel therapies that significantly improve the lives of patients with hematologic disorders and cancer. Founded in 1996, Rigel is based in South San Francisco, California. For more information on Rigel, the Company's marketed products and pipeline of potential products, visit www.rigel.com.

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Forward Looking Statements

This press release contains forward-looking statements relating to, among other things, the presentation of data at the 2026 ASCO Annual Meeting and EHA2026 Congress, the potential therapeutic benefit and clinical utility of pralsetinib and olutasidenib, including the potential impact of treatment sequencing, and Rigel's expectations regarding the development and commercialization of its products and product candidates. Any statements contained in this press release that are not statements of historical fact may be deemed to be forward-looking statements. Words such as "look forward," "suggest," "may," "potential," "expect," and similar expressions are intended to identify such forward-looking statements. Forward-looking statements are based on Rigel's current expectations and assumptions and are subject to risks and uncertainties that could cause actual results to differ materially from those expressed or implied by such statements. These risks and uncertainties include, without limitation, risks that clinical trial or real-world data may not be predictive of future clinical outcomes or results in broader patient populations; risks that further data, analyses or experience may alter current understanding of the safety, efficacy or therapeutic utility of pralsetinib or olutasidenib; risks associated with the timing, conduct and availability of data analyses and scientific presentations; risks associated with the commercialization and market acceptance of Rigel's products; and other risks described from time to time in Rigel's filings with the Securities and Exchange Commission, including its Quarterly Report on Form 10-Q for the quarter ended March 31, 2026 and subsequent filings. Any forward-looking statement contained in this press release speaks only as of the date on which it was made. Rigel undertakes no obligation to update any forward-looking statements contained herein, except as required by law.

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