UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 8-K

CURRENT REPORT
Pursuant to Section 13 or 15(d)
of The Securities Exchange Act of 1934

Date of Report (Date of earliest event reported)
March 31, 2026

ORIC Pharmaceuticals, Inc.
(Exact name of registrant as specified in its charter)

Delaware	001-39269	47-1787157
(State or other jurisdiction of incorporation)	(Commission File Number)	(IRS Employer Identification No.)

240 E. Grand Ave, 2nd Floor
South San Francisco, CA 94080
(Address of principal executive offices, including zip code)

(650) 388-5600
(Registrant's telephone number, including area code)

Not Applicable
(Former name or former address, if changed since last report)

Check the appropriate box below if the Form 8-K filing is intended to simultaneously satisfy the filing obligation of the registrant under any of the following provisions:

☐ Written communications pursuant to Rule 425 under the Securities Act (17 CFR 230.425)

☐ Soliciting material pursuant to Rule 14a-12 under the Exchange Act (17 CFR 240.14a-12)

☐ Pre-commencement communications pursuant to Rule 14d-2(b) under the Exchange Act (17 CFR 240.14d-2(b))

☐ Pre-commencement communications pursuant to Rule 13e-4(c) under the Exchange Act (17 CFR 240.13e-4(c))

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common stock, par value $0.0001 per share	ORIC	The Nasdaq Global Select Market

Indicate by check mark whether the registrant is an emerging growth company as defined in Rule 405 of the Securities Act of 1933 (§230.405 of this chapter) or Rule 12b-2 of the Securities Exchange Act of 1934 (§240.12b-2 of this chapter).

Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Item 8.01 Other Events.

ORIC Pharmaceuticals, Inc. (the "Company") presented a rinzimetostat (ORIC-944) program update (the "Program Update") on March 31, 2026. The Program Update covered recently announced dose optimization data from the Company's Phase 1b trial of rinzimetostat. A presentation containing the data presented in the Program Update is attached as Exhibit 99.1 hereto and is incorporated herein by reference.

Item 9.01 Financial Statements and Exhibits.

(d) Exhibits.

Exhibit Number	Description
99.1	Presentation
104	Cover Page Interactive Data File (embedded within the Inline XBRL document)

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned hereunto duly authorized.

ORIC PHARMACEUTICALS, INC.

Date: March 31, 2026

By: /s/ Christian V. Kuhlen
Christian V. Kuhlen, M.D., J.D.
General Counsel

Exhibit 99.1

ORIC

OVERCOMING RESISTANCE IN CANCER

Rinzimetostat
Dose Optimization Data Update
March 31, 2026

Forward-Looking Statements

This presentation contains forward-looking statements that involve substantial risks and uncertainties. All statements other than statements of historical facts contained in this presentation, including statements regarding ORIC Pharmaceuticals, Inc.'s ("ORIC", "we", "us" or "our") future financial condition, results of operations, business strategy and plans, and objectives of management for future operations, as well as statements regarding industry trends, are forward-looking statements. In some cases, you can identify forward-looking statements by terminology such as "anticipate," "believe," "continue," "could," "estimate," "expect," "intend," "may," "plan," "potentially," "predict," "should," "will" or the negative of these terms or other similar expressions. Forward-looking statements contained in this presentation also include, but are not limited to, statements regarding: the potential best-in-class profile of our product candidates; our development plans and timelines; the potential advantages of, and commercial opportunities for, our product candidates and programs; plans for the clinical trials and development of enozertinib (ORIC-114) and rinzimetostat (ORIC-944); enozertinib and rinzimetostat clinical outcomes, which may materially change as patient enrollment continues or more patient data becomes available; the expected timing of reporting data from our clinical trials; our anticipated milestones and clinical updates; and the period over which we estimate our existing cash and investments will be sufficient to fund our current operating plan.

We have based these forward-looking statements largely on our current expectations and projections about future events and trends that we believe may affect our financial condition, results of operations, business strategy and financial needs. These forward-looking statements are subject to a number of risks, uncertainties and assumptions, including, among other things: the timing of the initiation, progress and results of our preclinical studies and clinical trials; risks associated with the process of developing and commercializing drugs that are safe and effective for use in humans and operating as an early clinical stage company; negative impacts of health emergencies, economic instability or international conflicts on our operations, including clinical trials; the potential for current or future clinical trials of product candidates to differ from preclinical, initial, interim, preliminary or expected results; our ability to advance product candidates into, and successfully complete, clinical trials; the timing or likelihood of regulatory filings and approvals; changes in our plans to develop and commercialize our product candidates; our estimates of the number of patients who suffer from the diseases we are targeting and the number of patients that may enroll in our clinical trials; the commercializing of our product candidates, if approved; our ability to successfully manufacture and supply our product candidates for clinical trials and for commercial use, if approved; potential benefits and costs of strategic arrangements, licensing and/or collaborations; the risk of the occurrence of any event, change or other circumstance that could give rise to the termination of our license or collaboration agreements; our estimates regarding expenses, future revenue, capital requirements and needs for financing and our ability to obtain capital; the sufficiency of our existing cash and investments to fund our future operating expenses and capital expenditure requirements; our ability to retain the continued service of our key personnel and to identify, hire and retain additional qualified professionals; the implementation of our business model and strategic plans for our business and product candidates; the scope of protection we are able to establish and maintain for intellectual property rights, product candidates and our pipeline; our ability to contract with third-party contract research organizations, suppliers and manufacturers and their ability to perform adequately; the pricing, coverage and reimbursement of our product candidates, if approved; developments relating to our competitors and our industry, including competing product candidates and therapies; regulatory developments in the United States and foreign countries; general economic and market conditions; and the other risks, uncertainties and assumptions discussed in the public filings we have made and will make with the Securities and Exchange Commission ("SEC"). These risks are not exhaustive. New risk factors emerge from time to time and it is not possible for our management to predict all risk factors, nor can we assess the impact of all factors on our business or the extent to which any factor, or combination of factors, may cause actual results to differ materially from those contained in, or implied by, any forward-looking statements. You should not rely upon forward-looking statements as predictions of future events. Although we believe that the expectations reflected in the forward-looking statements are reasonable, we cannot guarantee future results, levels of activity, performance or achievements.

This presentation also contains estimates and other statistical data made by independent parties and by us relating to market size and other data about our industry. This data involves a number of assumptions and limitations, and you are cautioned not to give undue weight to such data and estimates. In addition, projections, assumptions and estimates of our future performance and the future performance of the markets in which we operate are necessarily subject to a high degree of uncertainty and risk.

Except as required by law, we undertake no obligation to update any statements in this presentation for any reason after the date of this presentation.

We have filed Current Reports on Form 8-K, Quarterly Reports on Form 10-Q, Annual Reports on Form 10-K, and other documents with the SEC. You should read these documents for more complete information about us. You may obtain these documents for free by visiting EDGAR on the SEC website at www.sec.gov.

This presentation discusses our product candidates that are under preclinical or clinical study, and which have not yet been approved for marketing by the U.S. Food and Drug Administration. No representation is made as to the safety or effectiveness of our product candidates for the therapeutic use for which they are being studied.

Rinzimetostat Dose Optimization Data Update

Agenda

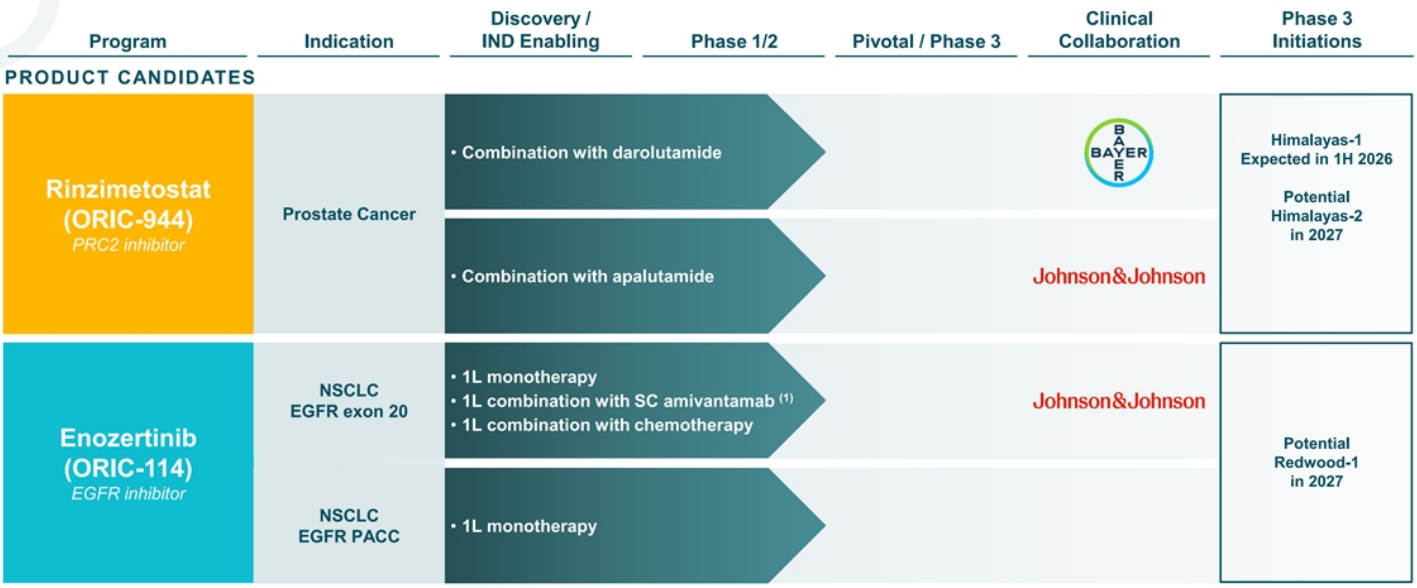
- Executive Summary
- Preclinical Differentiation
- Clinical Program Update and Next Steps
  - Selection of Phase 3 Dose
  - Preliminary Profile of Phase 3 Dose
  - Next Steps and Registrational Strategy
- Commercial Potential for Himalayas-1 and Beyond
- Q&A

ORIC Participants

- Jacob Chacko, Chief Executive Officer
- Lori Friedman, Chief Scientific Officer
- Pratik Multani, Chief Medical Officer
- Matt Panuwat, Chief Business Officer
- Dominic Piscitelli, Chief Financial Officer
- Keith Lui, SVP Commercial and Medical Affairs


ORIC
Executive Summary

Clinical Pipeline Focused on Advancement of Rinzimetostat and Enozertinib



Clinical-stage pipeline includes two potential best-in-class programs addressing large solid tumor market opportunities; Both programs approaching initiation of registrational trials

Note: PACC – P-loop and alpha C-helix compressing. Abiraterone refers to abiraterone acetate.
(1) Clinical collaboration with Johnson & Johnson to evaluate enozertinib in combination with amivantamab and hyaluronidase-lpuj subcutaneous injection (SC amivantamab) in patients with first-line NSCLC with EGFR exon 20 mutations.

Rinzimetostat Continues to Demonstrate Its Potential as a Best-In-Disease New Therapeutic Option for Prostate Cancer

- **PRC2 inhibitors have shown significant rPFS in mCRPC, comparing favorably to approved & emerging therapies**
- **Rinzimetostat is a next-generation PRC2 inhibitor designed to have best-in-class drug properties**
- **Rinzimetostat 400 mg QD with darolutamide selected as provisional RP3D for first Phase 3**
  - **Highly competitive emerging efficacy profile (rPFS, PSA, ctDNA) supportive of durable clinical benefit**
  - **Highly differentiated, potential best-in-disease safety profile, with significantly lower frequency and severity of adverse events than competitor regimens, and conducive to long term dosing**
- **First Phase 3 trial in post-abiraterone mCRPC expected to initiate in 1H26; additional trials under consideration**
- **Post-abiraterone mCRPC is a significant unmet need and commercial opportunity, representing a $3.5bn total addressable market annually in the US with lack of oral and well-tolerated therapies**

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Source: ORIC data on file. ©DRG 2025, Raval et al. J Clin Oncol (2025), Gebrael et al. J Clin Oncol (2025) and Schweizer et al. ASCO GU (2025).

PRC2 Inhibitors Are Associated with Significant Radiographic Progression-Free Survival in Post-ARPI mCRPC, Comparing Favorably to Available Therapies

Therapies for 1L+ mCRPC (Post-ARPI)

Treatment	Status	5-Month rPFS	Median rPFS (months)
Enzalutamide (Xtandi®)	Approved	60%	6.2
Cabazitaxel (Jevtana®)	Approved	65%	8.0
Docetaxel (Taxotere®)	Approved	75%	8.3
Lutetium Lu 177 vipivotide tetraxetan (Pluvicto®)	Approved	75%	9.3
Mevrometostat + Enzalutamide	Phase 3	80% to 84%	~12 to 14
Rinzimetostat + Darolutamide	**Starting Phase 3**	**84% to 85%**	**Not mature**

PRC2 inhibitors in combination with an AR inhibitor have demonstrated much longer rPFS (key regulatory primary endpoint) than what has been reported with other approved and emerging therapies

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Source: Morris et al. Lancet (2024), Petrylak et al. J Clin Oncol (2025), de Wit et al. N Engl J Med (2019), Schweizer et al. ASCO GU (2025), Schweizer et al. ASCO (2024), and Matsubara et al. ASCO GU (2026).
Note: Androgen receptor pathway inhibitor (ARPI) represents abiraterone, enzalutamide, apalutamide and darolutamide. Competitor rPFS percentages estimated from published data.

Combination of Rinzimetostat + Darolutamide Compares Favorably to Competitor PRC2 Combination and to AR Inhibitor Monotherapy In Post-Abiraterone mCRPC

Rinzimetostat Dose Optimization Update (March 2026)

	Enzalutamide	Mevrometostat 1250 mg BID Fasted + Enzalutamide	**Rinzimetostat 400 mg QD + Darolutamide**
3-Month rPFS	78%	92%	**93%**
4-Month rPFS	70%	86%	**84%**
5-Month rPFS	60%	80%	**84%**
PSA50	15%	34%	**33%**
SAFETY (All Grade / Grade ≥3)	• Fatigue (43% / 3%) • Nausea (25% / 0%) • Anemia (23% / 3%) • Diarrhea (18% / 0%) • Decreased appetite (18% / 0%) • Dysgeusia (8% / 0%)	• Diarrhea (78% / 17%) • Dysgeusia (59% / 0%) • Decreased appetite (59% / 0%) • Fatigue (56% / 5%) • Anemia (49% / 5%) • Nausea (42% / 0%) • Alopecia (39% / 0%) • Thrombocytopenia (29% / 2%); 2% Gr 4 • Neutropenia (22% / 7%); 2% Gr 4 • Vomiting (22% / 0%) • Arthralgia (22% / 0%) • Rash (20% / 2%) • *AE cutoff of ≥20%*	• Fatigue (39% / 0%) • Diarrhea (22% / 0%) • Nausea (22% / 0%) • Blood creatinine increased (17% / 0%) • Decreased appetite (11% / 0%) • Anemia (11% / 0%) • *AE cutoff of ≥10%*

Rinzimetostat + ARi safety profile compatible with long-term dosing, with the majority of AEs Grade 1, and no Grade 4/5 events

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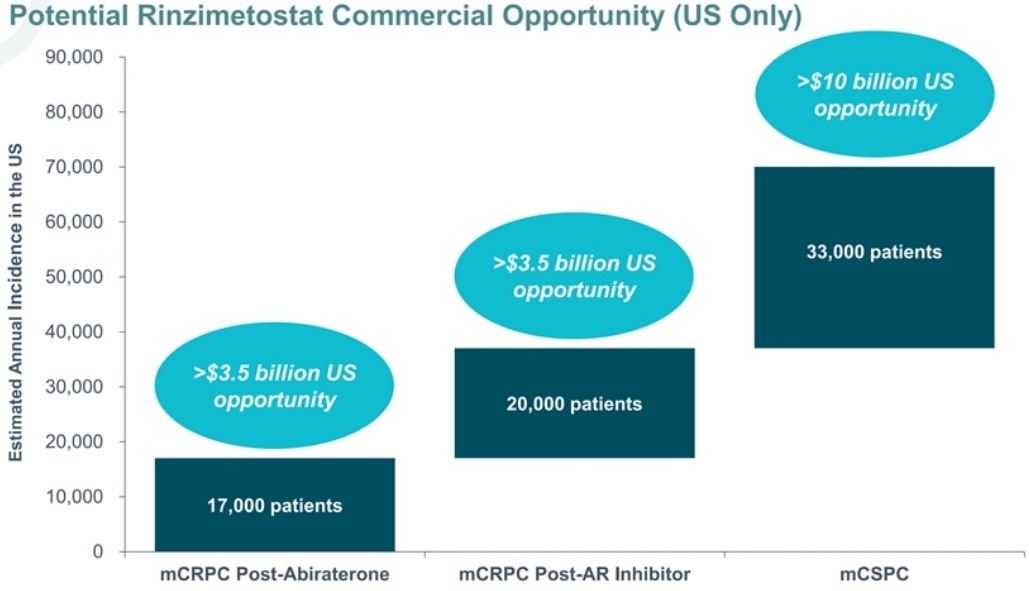
Source: ORIC data on file. Enzalutamide and mevrometostat + enzalutamide data from Schweizer et al. ASCO GU (2025) and Matsubara et al. ASCO (2025). AEs <30% estimated from Matsubara et al. ASCO (2025).
Note: Competitor rPFS percentages estimated from published data. PSA50 represents confirmed responses. Cross-trial comparison in previously treated mCRPC patients shown. Rinzimetostat + darolutamide efficacy data as of March 6, 2026, and TRAE data as of January 16, 2026. Enzalutamide AEs represent TEAE cutoff >30% across both mevrometostat 1250 mg BID + enzalutamide and enzalutamide monotherapy.

Rinzimetostat Has the Potential to Address Multiple Large Market Opportunities in Prostate Cancer, with Several Development Opportunities in Other Solid Tumors

Potential Rinzimetostat Commercial Opportunity (US Only)



Future Development Opportunities

	Est. Annual US Incidence
mCRPC (RLT, TCE, ADC Combo)	37,000
NSCLC (KRASi Combo)	45,000
CRC (KRASi Combo)	65,000
Breast Cancer (ERi Combo)	220,000

Rinzimetostat has the potential to address ~70,000 patients in the US with prostate cancer annually

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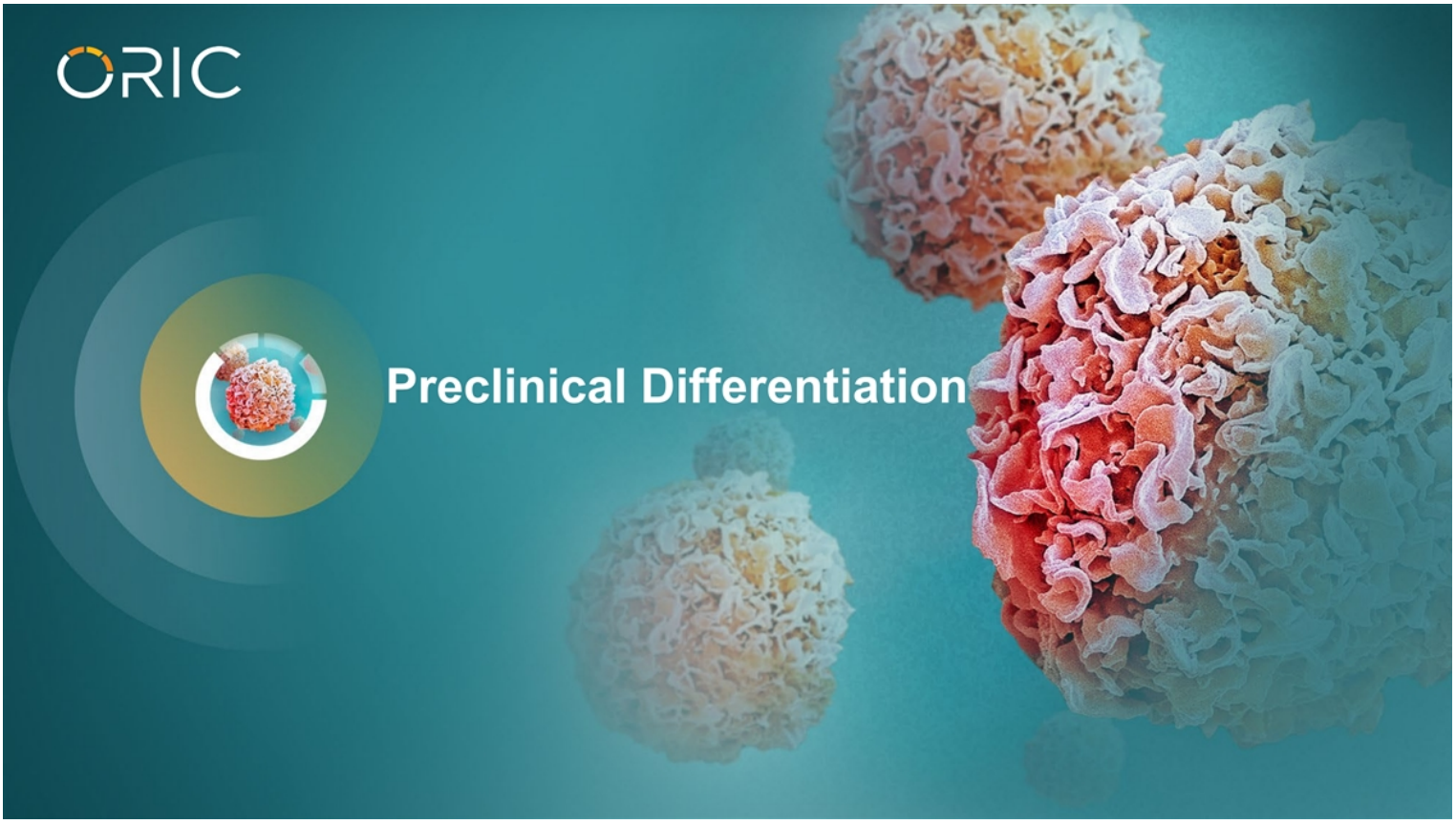
Source: ©DRG 2025, Swami et al. J Clin Oncol (2025), Raval et al. J Clin Oncol (2025), Gebrael et al. J Clin Oncol (2025), SEER Cancer Stat Facts: Female Breast Cancer Subtypes, and ORIC data on file.
Note: Addressable market assumes current price of ARPIs for illustrative purposes. RLT – radioligand therapy; TCE – T-cell engager; ADC – antibody-drug conjugate.


ORIC
Preclinical Differentiation

Rinzimetostat: Next-Generation PRC2 Inhibitor Designed for Best-in-Class Drug Properties

PRC2 Inhibitor Landscape in Prostate Cancer

Potential Best-in-Class

Key Features	CPI-1205 (1st gen)	Tazemetostat (1st gen)	Mevrometostat (2nd gen)	Rinzimetostat (3rd gen)	
Cellular Potency				✓ Cellular Potency	Superior potency vs. 1st gen programs across prostate cancer models
In Vivo Activity				✓ In Vivo Activity	Improved single agent and combination activity across prostate cancer models
Strong Drug Properties (PK, solubility, no CYP autoinduction)				✓ Strong Drug Properties	Higher and more consistent clinical exposures
Long Clinical Half-Life				✓ Long Clinical Half-Life	Sustained target coverage and QD dosing (~20-hour half-life)
Development Status	Discontinued	Discontinued	Phase 3 trials ongoing	**First Phase 3 initiation expected 1H 2026**	

Rinzimetostat is a potential best-in-class PRC2 inhibitor that addresses the limitations of earlier generation PRC2 inhibitors

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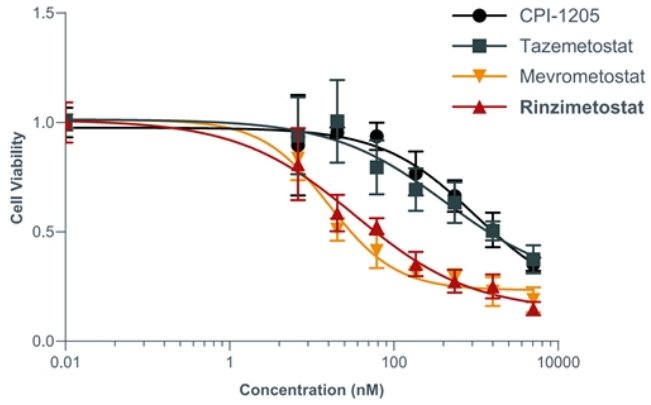
Source: Friedman et al. AACR (2024), Vaswani et al. J Med Chem (2016), Motwani et al. and Bradley et al. AACR-EORTC-NCI (2019), Schweizer et al. ESMO (2022), Italiano et al. Lancet (2018), and Harb et al. TAT (2018).
Note: Drug properties include absorption, CYP profile and metabolism, pharmacokinetic (PK) and solubility profile.

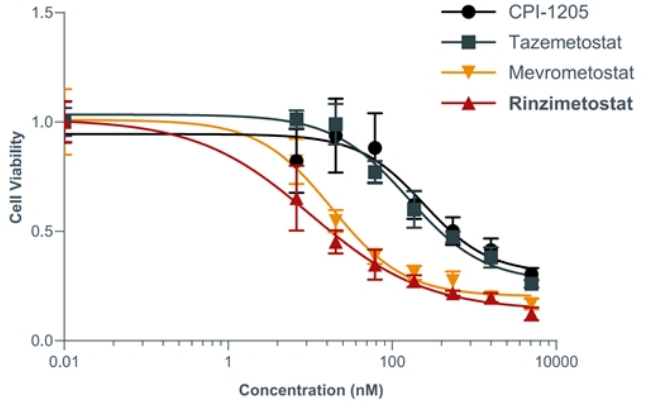
Rinzimetostat Demonstrates Superior In Vitro Potency vs. First-Gen PRC2 Inhibitors

In Vitro Potency in Prostate Cancer Cells

LNCaP
(AR-Positive Prostate Cancer Cells)



CWR22PC
(AR-Positive Prostate Cancer Cells)



Rinzimetostat demonstrates potency in AR+ prostate cancer cell lines comparable to mevrometostat and superior to tazemetostat and CPI-1205

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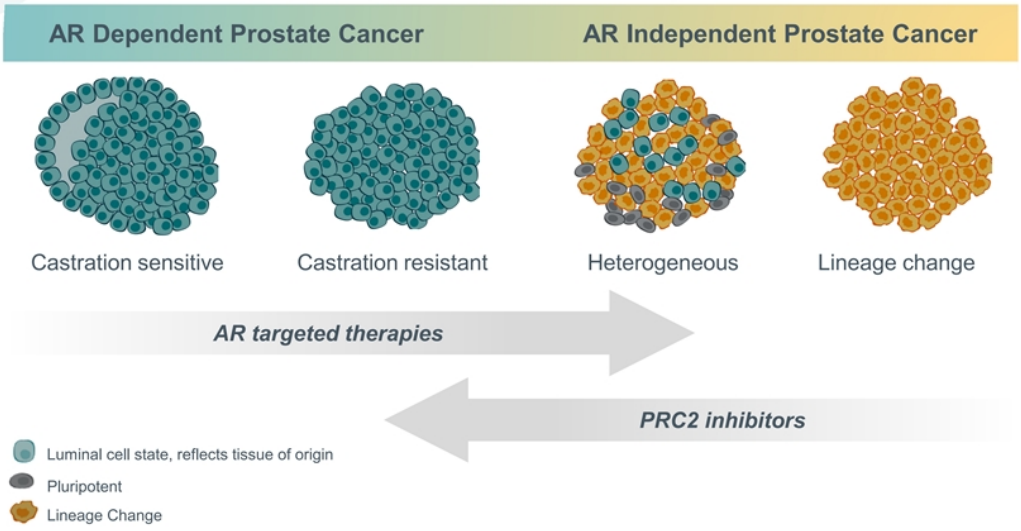
Note: Head-to-head in vitro cell viability analysis with CellTiterGlo assay.

PRC2 Epigenetic Dysregulation Plays a Key Mechanistic Role During the Progressive Reprogramming of Prostate Cancers Treated with AR Inhibitors

PRC2 Role in Prostate Cancer



- Prostate cancer cells evade therapies by cellular reprogramming to an AR independent state
- PRC2 inhibition can reverse or prevent this process, such that prostate cancer cells regain or maintain AR dependency
- Randomized data with PRC2 inhibitor + AR inhibitor demonstrated significant PFS improvement

Therapeutic potential of PRC2 inhibitors in prostate cancer is maximized in combination with AR inhibitors

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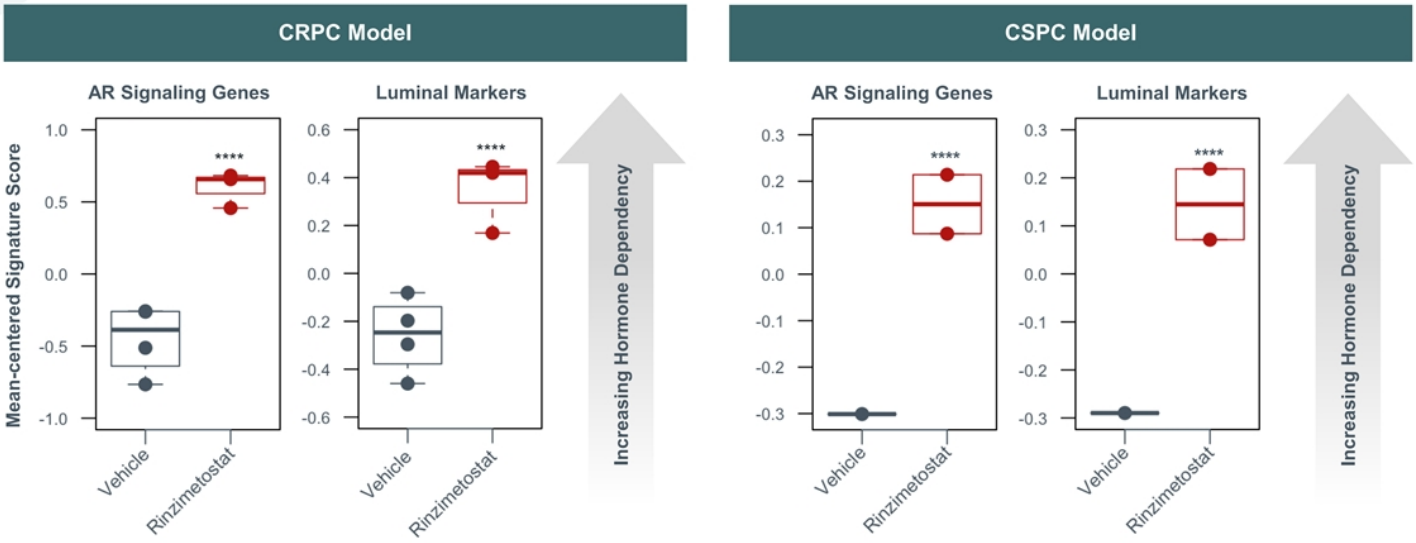
Source: Mu et al. Science (2017), Dardenne et al. Cancer Cell (2016), Davies et al. Nat Cell Biol (2021), Nouruzi et al. Nat Commun (2022), Goel et al. Semin Cancer Bio (2022), and Schweizer et al. ASCO GU (2025).

Rinzimetostat Increases AR Signaling and Induces Luminal State to Drive Synergy in Prostate Cancer Models

Rinzimetostat Impact on AR Signaling Genes and Luminal Markers



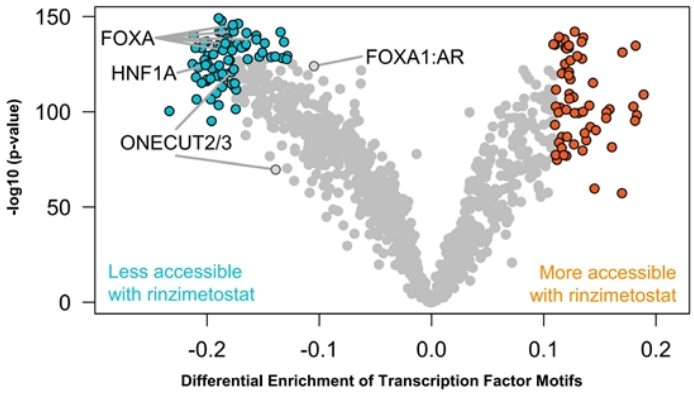
Rinzimetostat enhances AR signaling and luminal markers to restore a cell state which has enhanced sensitivity to AR inhibition, providing strong mechanistic rationale for clinical combination

Note: C4-2 CRPC xenograft tumors grown in intact mice (left), and LNCaP CSPC in vitro cells treated for 14 days (right), were assessed by RNA-seq. Boxplots show average mean-centered expression of luminal markers (Daemen et al. AACR 2025) and AR signaling genes (Daemen et al. AACR 2024). Rinzimetostat vs. vehicle, weighted Stouffer test on DESeq2 results using inversed log2 fold change standard errors as weights: ****, p<0.0001.

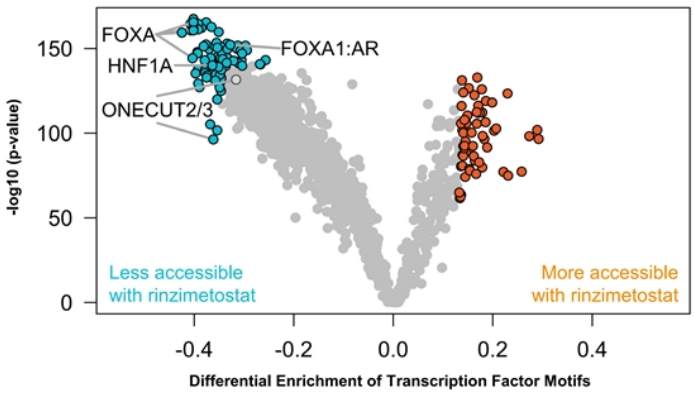
Rinzimetostat Remodels Chromatin to Block Transcription Factor Sites that Drive Lineage Escape

Rinzimetostat Impact on Accessibility to Lineage Escape Factors

CRPC Model



CSPC Model



Rinzimetostat reduces accessibility to lineage escape factors in both CRPC and CSPC

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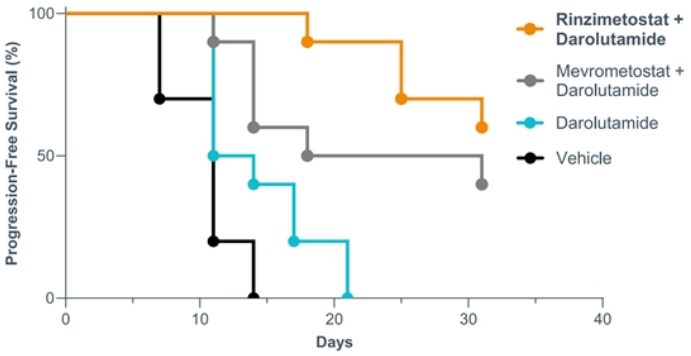
Note: Comparison of transcription factor motif accessibility based on ATAC-sequencing data in CRPC C4-2 intact xenografts (left) and CSPC LNCaP intact xenografts (right) treated with rinzimetostat + darolutamide vs. darolutamide. The accessibility change for every transcription factor motif and its associated p-value are calculated using TOBIAS [Bentsen et al., Nat Comm (2020)]. Motifs that are significantly more accessible following combination treatment are shown in dark orange; more accessible motifs with darolutamide treatment are shown in blue. FOXA1:AR represents the FOXA1 motif juxtaposed to the AR half motif.

Rinzimetostat Increases Progression-Free Survival in Combination with Darolutamide in Prostate Cancer Xenograft Tumors

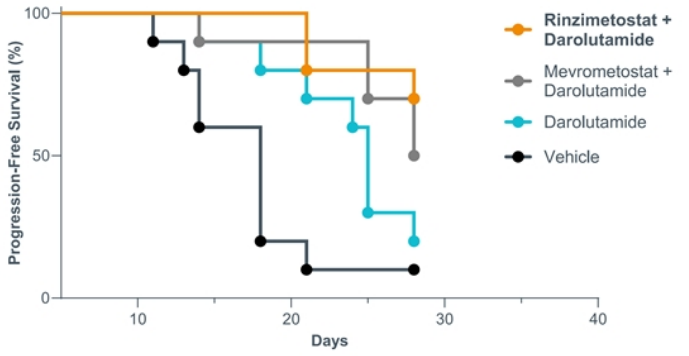
Progression-Free Survival in Prostate Cancer Xenografts

CRPC Model



	Vehicle	Daro	Mevro	Rinzi	Mevro + Daro	**Rinzi + Daro**
Median PFS (days)	11	12.5	15.5	27	24.5	**Not Reached**

CSPC Model



	Vehicle	Daro	Mevro	Rinzi	Mevro + Daro	**Rinzi + Daro**
Median PFS (days)	18	25	21	19.5	28	**Not Reached**

Rinzimetostat combination with darolutamide improves progression-free survival in CRPC and CSPC settings in vivo

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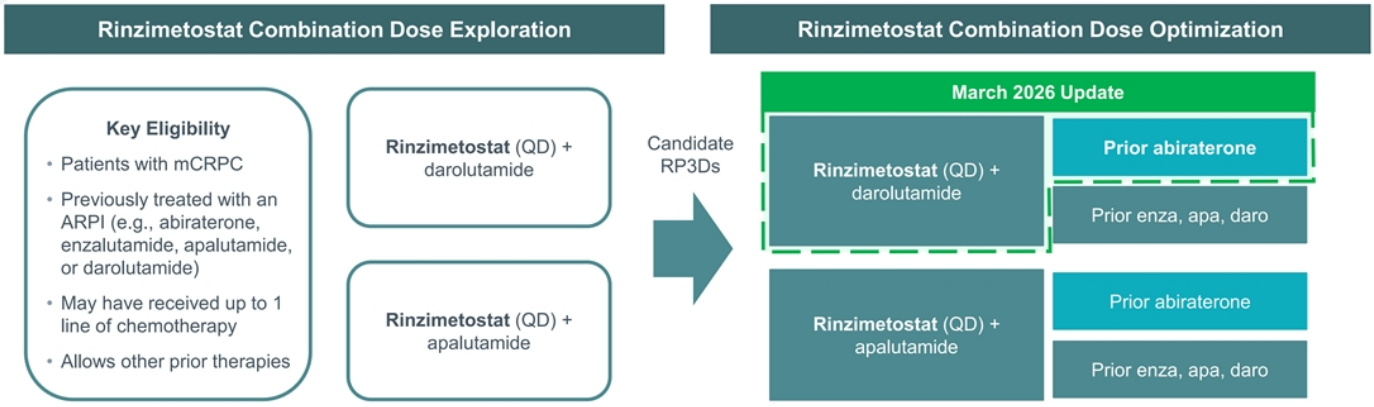
Note: C4-2 CRPC model (left) grown in castrated mice and LNCaP CSPC (fast-growing clone) model (right) grown in intact mice. Darolutamide 50 mg/kg BID, mevrometostat 100 mg/kg BID, and rinzimetostat 100 mg/kg QD. No drug-related tolerability issues. Progression event for either tumor volume >800 mm3 or morbidity.


ORIC
Clinical Program Update
and Next Steps
Selection of Phase 3 Dose

Rinzimetostat Is Being Explored in Combination with Darolutamide and Apalutamide in Metastatic CRPC

Phase 1b, Multicenter, Open-Label Trial (in Collaboration with Bayer and Johnson & Johnson)



Primary endpoints: Safety and Recommended Phase 3 Dose
Key secondary endpoints: rPFS, ORR, and DOR
Exploratory endpoints: PSA, ctDNA, H3K27 trimethylation, PRC2 target gene expression, and genomics

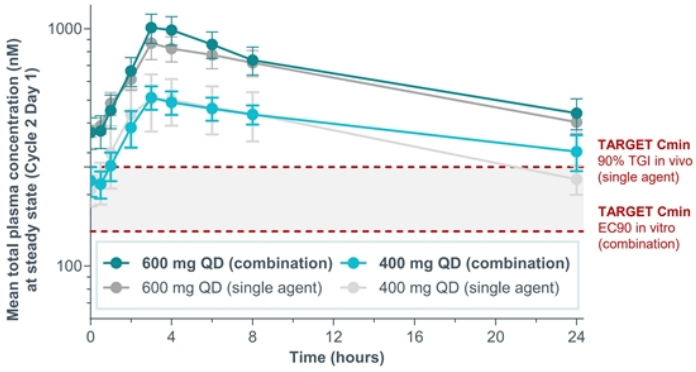
Dose optimization data reported in post-abiraterone mCRPC, with Phase 3 trial initiation expected in 1H 2026; ORIC continuing to evaluate rinzimetostat in combination with darolutamide and apalutamide in mCRPC patients

Note: ClinicalTrials.gov identifier: NCT05413421. Rinzimetostat dosed in combination with approved doses of darolutamide (600 mg BID) and apalutamide (240 mg QD). RP3D – recommended Phase 3 dose; rPFS – radiographic progression free survival; ORR – objective response rate; DOR – duration of response: PSA – prostate-specific antigen; ctDNA – circulating tumor DNA.

Rinzimetostat Demonstrates a Favorable Pharmacokinetic and Pharmacodynamic Profile as a Single Agent and in Combination with Darolutamide

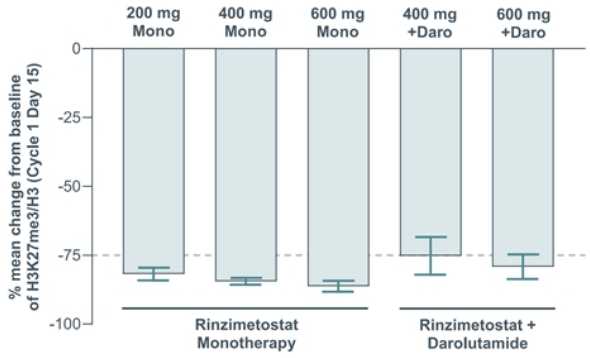
Pharmacokinetic and Pharmacodynamic Profile Summary

Rinzimetostat Pharmacokinetic Profile
(Total Plasma Concentration)



- Increased exposure with dose, exceeding target Cmin for ~24h; no drug-drug interaction; half-life of ~20h supports QD dosing

Rinzimetostat Pharmacodynamic Profile
(H3K27me3 Inhibition in PBMCs)



- Maximal decrease (≥75%) in H3K27me3 achieved as monotherapy and in combination with darolutamide

Rinzimetostat pharmacokinetic and pharmacodynamic data were highly consistent as a single agent and in combination with darolutamide, and supportive of dose optimization of 400 mg and 600 mg QD

ORIC

Note: Left graph: Dashed lines represent the range of Cmin of the predicted human PK based on achieving 90% tumor growth inhibition in CDX in vivo prostate cancer models of rinzimetostat as a single agent and EC90 in CDX in vitro prostate cancer models of rinzimetostat in combination with an AR inhibitor, accounting for human and mouse species difference observed for plasma protein binding. Right graph: n=3 or 4 patients per group; monotherapy activity measured in monocytes derived from PBMCs and combination activity measured in granulocytes derived from PBMCs. Error bars shown as SEM. PBMCs – peripheral blood mononuclear cells.

Phase 1b Dose Optimization Trial Enrolled Heavily Pretreated Post-Abiraterone mCRPC Patients

Demographics and Baseline Characteristics

Characteristic	Rinzimetostat 400 mg QD + Darolutamide (n=18)	Rinzimetostat 600 mg QD + Darolutamide (n=15)
Age, median (range), years	67 (51, 85)	77 (58, 91)
Race, White / Black / Asian, %	56 / 33 / 6	67 / 27 / 0
ECOG Performance Status, 0 / 1, %	56 / 44	53 / 47
Gleason Score, <8 / ≥8 / unknown, %	6 / 67 / 28	33 / 40 / 27
Baseline PSA, median, ng/mL	26	12
Prior lines of therapy, median (range)	2 (1-4)	2 (1-4)
Prior systemic therapy, n (%)		
Abiraterone	18 (100)	15 (100)
Docetaxel	7 (39)	2 (13)
Immune therapy	3 (17)	2 (13)
PARP inhibitor	1 (6)	3 (20)
Ra 223	3 (17)	0
Other	1 (6)	0
Metastases at baseline, n (%)		
Bone	15 (83)	12 (80)
Lymph nodes	9 (50)	4 (27)
Lung	1 (6)	3 (20)

Patients previously treated with a median of two prior therapies, including abiraterone, docetaxel, and a variety of other approved and investigational treatment regimens

Source: ORIC data on file as of January 16, 2026.
Note: Immune therapy includes nivolumab, pembrolizumab, atezolizumab, and sipuleucel-T. Other therapies includes cabozantinib. Number of prior lines of therapy excludes background androgen deprivation therapy or first-generation AR inhibitors.

Rinzimetostat in Combination with Darolutamide Has been Generally Well Tolerated in Post-Abiraterone mCRPC Patients

TEAEs Attributed to Rinzimetostat Plus Darolutamide (≥10% Total Incidence)

Rinzimetostat 400 mg QD + Darolutamide (n=18)

Preferred Term, n (%)	Grade 1	Grade 2	Grade 3	All Grade
Fatigue	3 (17)	4 (22)	–	**7 (39)**
Diarrhea	3 (17)	1 (6)	–	**4 (22)**
Nausea	4 (22)	–	–	**4 (22)**
Blood creatinine increased	2 (11)	1 (6)	–	**3 (17)**
Decreased appetite	1 (6)	1 (6)	–	**2 (11)**
Anemia	1 (6)	1 (6)	–	**2 (11)**

- 6% Grade 3
- No Grade 4 or 5

Rinzimetostat 600 mg QD + Darolutamide (n=15)

Preferred Term, n (%)	Grade 1	Grade 2	Grade 3	All Grade
Fatigue	4 (27)	2 (13)	–	**6 (40)**
Diarrhea	3 (20)	2 (13)	–	**5 (33)**
Nausea	2 (13)	2 (13)	–	**4 (27)**
Blood creatinine increased	2 (13)	–	–	**2 (13)**
Decreased appetite	–	1 (7)	–	**1 (7)**
Anemia	2 (13)	–	–	**2 (13)**

- No Grade 3
- No Grade 4 or 5

In post-abiraterone patients, rinzimetostat in combination with darolutamide is generally well-tolerated, with almost all TRAEs Grade 1 or 2 in severity; 400 mg dose minimizes AEs that most impact patient quality of life

ORIC

Source: ORIC data on file as of January 16, 2026.
Note: Severity grade according to NCI CTCAE v5.0.

Rinzimetostat in Combination with Darolutamide Has been Generally Well Tolerated in Post-ARPI mCRPC Patients

TEAEs Attributed to Rinzimetostat Plus Darolutamide (≥10% Total Incidence)

Rinzimetostat 400 mg QD + Darolutamide (n=37)

Preferred Term, n (%)	Grade 1	Grade 2	Grade 3	All Grade
Fatigue	4 (11)	6 (16)	–	**10 (27)**
Diarrhea	6 (16)	1 (3)	–	**7 (19)**
Nausea	7 (19)	–	–	**7 (19)**
Blood creatinine increased	3 (8)	2 (5)	1 (3)	**6 (16)**
Decreased appetite	4 (11)	1 (3)	–	**5 (14)**
Anemia	3 (8)	1 (3)	–	**4 (11)**

- 8% Grade 3
- No Grade 4
- No Grade 5

Rinzimetostat 600 mg QD + Darolutamide (n=35)

Preferred Term, n (%)	Grade 1	Grade 2	Grade 3	All Grade
Fatigue	5 (14)	3 (9)	–	**8 (23)**
Diarrhea	8 (23)	5 (14)	–	**13 (37)**
Nausea	5 (14)	3 (9)	–	**8 (23)**
Blood creatinine increased	5 (14)	3 (9)	–	**8 (23)**
Decreased appetite	1 (3)	4 (11)	–	**5 (14)**
Anemia	2 (6)	3 (9)	1 (3)	**6 (17)**

- 11% Grade 3
- One Grade 4 of acute kidney injury
- No Grade 5

In a broader post-ARPI safety dataset, rinzimetostat in combination with darolutamide is generally well-tolerated, with almost all TRAEs Grade 1 or 2 in severity; 400 mg dose minimizes AEs that most impact patient quality of life

ORIC

Source: ORIC data on file as of January 16, 2026. Includes post-abiraterone patients.
Note: Severity grade according to NCI CTCAE v5.0.

Rinzimetostat 400 mg QD in Combination with Darolutamide Is More Tolerable than 600 mg QD in mCRPC Patients

Rinzimetostat Plus Darolutamide Tolerability Summary

	Rinzimetostat 400 mg QD + Darolutamide		Rinzimetostat 600 mg QD + Darolutamide	
	Post-Abiraterone (n=18)	**Post-ARPI** (n=37)	**Post-Abiraterone** (n=15)	**Post-ARPI** (n=35)
Dose interruptions (%)	**6%**	**11%**	13%	17%
Dose reductions (%)	**None**	**3%**	7%	9%
Treatment discontinuations (%)	**6%**	**3%**	13%	11%

Rinzimetostat 400 mg QD in combination with darolutamide demonstrated an excellent tolerability profile, supportive of long-term dosing and sustained patient adherence

ORIC

Source: ORIC data on file as of January 16, 2026. Post-ARPI includes post-abiraterone patients.

Rinzimetostat Exposure-Response Analyses Supports 400 mg QD as RP3D Based on Lower Toxicity, Fewer Dose Modifications, and Comparable Efficacy

Rinzimetostat Exposure-Response Analyses

- **Objective:** Select the RP3D between 400 mg QD vs 600 mg QD by evaluating relationships between exposure of rinzimetostat to various safety / tolerability and efficacy measures
- **Methods:** Exposure-response analyses were conducted using data across the entire rinzimetostat clinical dataset (single-agent and combination, n=113 patients)

Measures			Statistically Significant Correlation to Exposure	Key Takeaways
Exposure Parameters (Cmax, Cmin, AUC)	**Safety / Tolerability**	Adverse Events (G2+, G3+, SAEs)	Significant correlation	**Favors 400 mg QD**
		Specific AEs (e.g., GI, heme)	Significant correlation	
		Treatment modifications	Significant correlation	
	Efficacy	Radiographic PFS	No correlation	**600 mg QD dose not superior to 400 mg QD dose**
		PSA reduction	No correlation	
		ctDNA reduction	No correlation	
		Changes in H3K27me3 trimethylation	No correlation	

Analyses demonstrated no exposure-efficacy correlation; however, 400 mg QD was associated with lower toxicity and fewer dose modifications, supporting its selection as the RP3D in combination with darolutamide

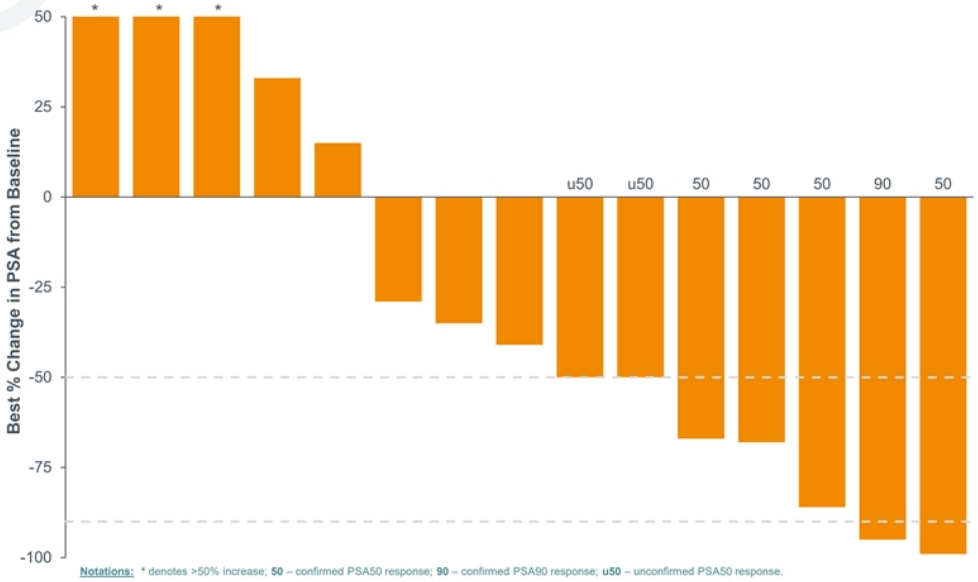
ORIC

Source: ORIC data on file as of January 16, 2026. Cmax – maximum observed plasma concentration; Cmin – minimum observed plasma concentration; AUC – area under the observed plasma concentration versus time curve.


ORIC
Clinical Program Update
and Next Steps
Preliminary Profile of Phase 3 Dose

Rinzimetostat in Combination with Darolutamide Continues to Demonstrate Strong Clinical Activity in Post-Abiraterone mCRPC Patients

PSA Response Data of Rinzimetostat 400 mg QD Plus Darolutamide



Notations: * denotes >50% increase; **50** – confirmed PSA50 response; **90** – confirmed PSA90 response; **u50** – unconfirmed PSA50 response.

Response	Unconfirmed	Confirmed
PSA50	7/15 (47%)	5/15 (33%)
PSA90	2/15 (13%)	1/15 (7%)

- Rinzimetostat at 400 mg QD plus darolutamide demonstrated strong clinical activity
  - Multiple patients remain on treatment with potential for deepening of responses

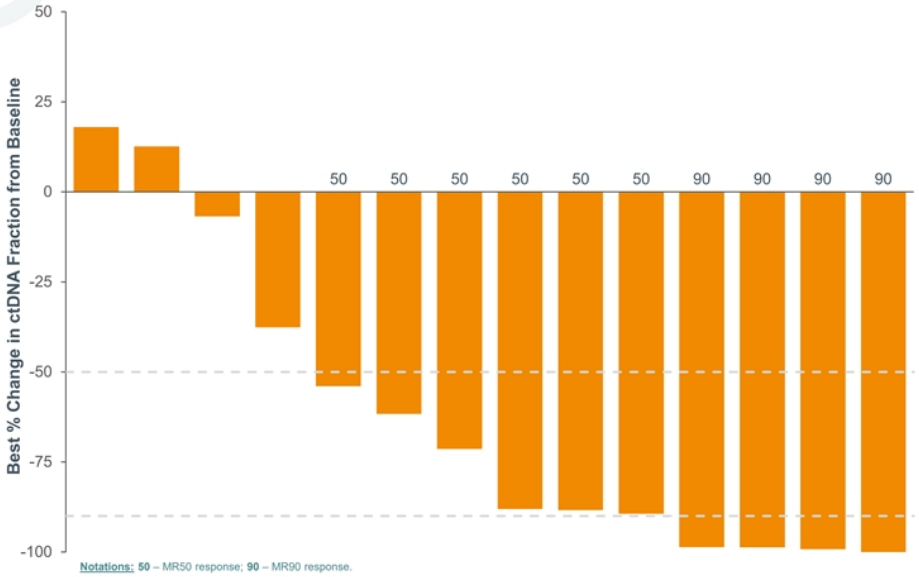
Broad and deep PSA responses observed for 400 mg QD rinzimetostat in combination with darolutamide

ORIC

Source: ORIC data on file as of March 6, 2026.
Note: All patients treated with 600 mg BID of darolutamide. Excludes three patients without post-baseline PSA assessments. Patients were previously treated with a median of two prior therapies, including abiraterone, up to one prior chemotherapy, and a variety of other approved or investigational agents. This median does not include background androgen deprivation therapy or first-generation AR inhibitors that the patients may have received.

Rinzimetostat in Combination with Darolutamide Demonstrates Impressive ctDNA Molecular Response in Post-Abiraterone mCRPC Patients

ctDNA Molecular Response Data of Rinzimetostat 400 mg QD Plus Darolutamide



MR50	10/14 (71%)
MR90	4/14 (29%)

- ctDNA molecular responses across a breadth of genotypes including AR mutations, AR amplified, AR wildtype
- Deep ctDNA reductions for the vast majority of patients treated with 400 mg QD rinzimetostat, with 71% of patients demonstrating >50% ctDNA reduction

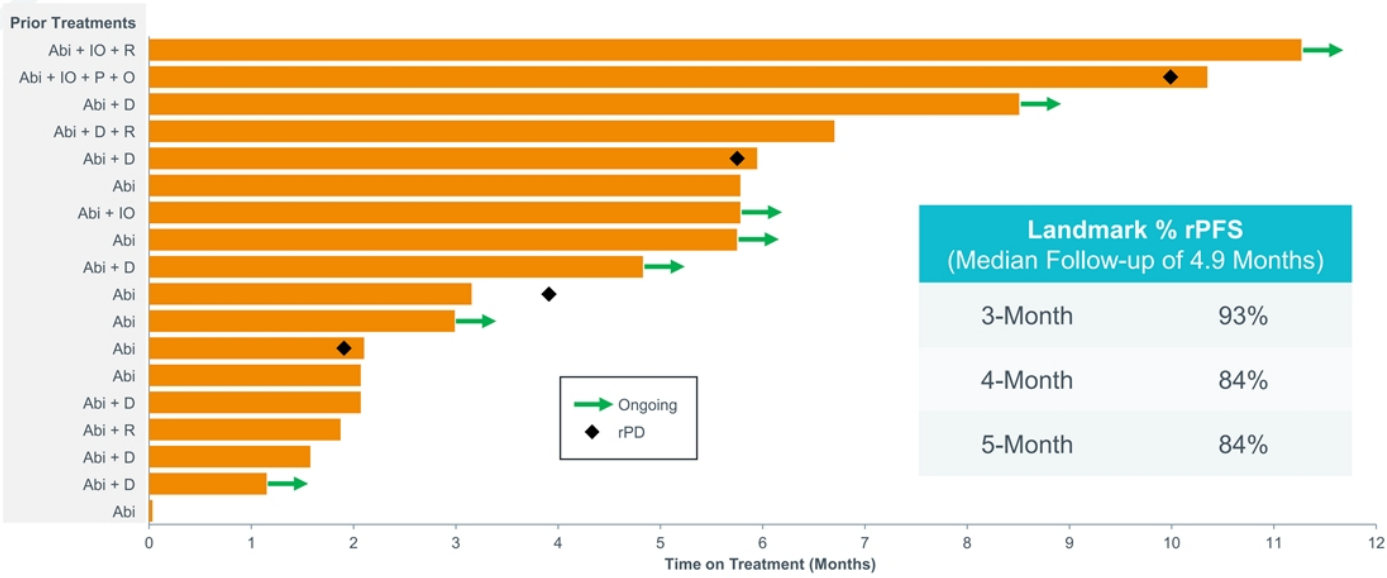
High molecular response rate observed in post-abiraterone patients treated with 400 mg QD rinzimetostat

ORIC

Source: ORIC data on file as of March 11, 2026.
Note: All patients treated with 600 mg BID of darolutamide. Excludes one patient without evidence of ctDNA at baseline, and three patients without ctDNA data available. Likely germline variants and clonal hematopoiesis variants were excluded from ctDNA analysis. Molecular response (MR) defined as decrease in ctDNA fraction relative to baseline. Best percent change in ctDNA fraction from baseline assessed at the start of cycle 2, cycle 7, or end of treatment.

Radiographic Progression-Free Survival Data Are Immature, but Early Landmark Analyses Are Promising

Rinzimetostat 400 mg QD Plus Darolutamide Dose Optimization: Time on Treatment



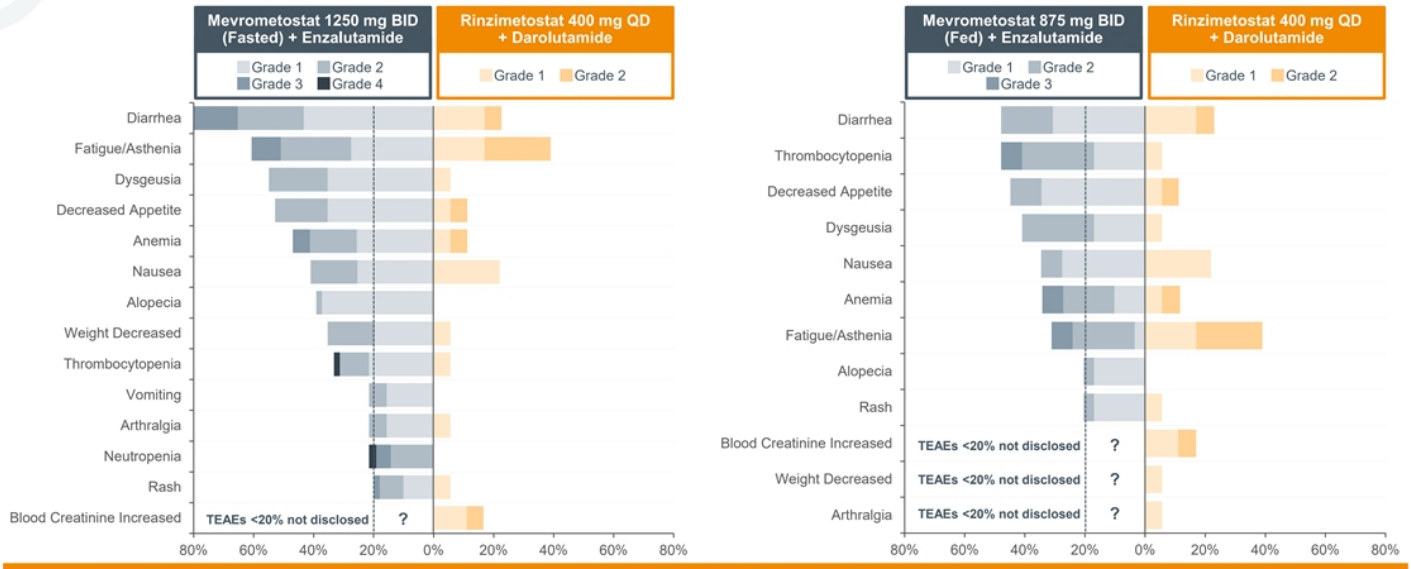
Landmark % rPFS (Median Follow-up of 4.9 Months)	
3-Month	93%
4-Month	84%
5-Month	84%

Many patients remain on treatment with few reports of radiographic progression

Source: ORIC data on file as of March 6, 2026.
Note: Abi – abiraterone; D – docetaxel; IO – immune therapy; P – PARP inhibitor; R — radium 223; O – other; rPD – radiographic progressive disease.

Rinzimetostat 400 mg QD in Combination with Darolutamide in Post-Abiraterone mCRPC Demonstrate a Clearly Differentiated Safety Profile

Rinzimetostat Adverse Event Comparison to Mevrometostat



400 mg QD rinzimetostat in combination with darolutamide demonstrates a clearly differentiated safety profile, with the majority of adverse events Grade 1, enabling long-term dosing and sustained patient adherence

ORIC

Source: ORIC data on file as of January 16, 2026. Mevrometostat 1250 mg BID data represents 41 post-abiraterone mCRPC patients from Matsubara et al. ASCO (2025) and mevrometostat 875 mg BID data represents 29 post-ARPI mCRPC patients from Matsubara et al. ASCO GU (2026).
Note: Severity grade according to NCI CTCAE v5.0.

Tolerability of Rinzimetostat 400 mg QD Plus Darolutamide Compares Favorably to Competitor Regimens

Rinzimetostat Dose Modifications Comparison to Mevrometostat

	Mevrometostat 875 mg BID Fed + Enzalutamide (n=14)	Mevrometostat 1250 mg BID Fasted + Enzalutamide (n=41)	Rinzimetostat 400 mg QD + Darolutamide (n=18)
Grade ≥3 TRAEs	36%	49%	**6%**
Serious TRAEs	21%	24%	**None**
Dose reductions (%)	7%	37%	**None**
Treatment discontinuations (%)	7%	2%	**6%**

Rinzimetostat at 400 mg QD with darolutamide demonstrated an excellent tolerability profile, supportive of long-term dosing and sustained treatment exposure and comparing favorably to competitor regimens

ORIC

Source: ORIC data on file as of January 16, 2026, Matsubara et al. ASCO (2025), and Matsubara et al. ASCO GU (2026).

Rinzimetostat Demonstrates Competitive Early Landmark rPFS in Post-Abiraterone mCRPC and Does So with a Highly Differentiated Safety Profile

Landmark rPFS and Safety Benchmark Comparisons

	Median Follow-up	3-Month rPFS	4-Month rPFS	5-Month rPFS	Grade ≥3 TRAEs	Dose Reductions / Discontinuations
Mevrometostat 875 mg BID Fed + Enzalutamide (n=14)	9.2 Months	92%	92%	84%	36%	7% / 7%
Mevrometostat 1250 mg BID Fasted + Enzalutamide (n=41)	11.7 Months	92%	86%	80%	49%	37% / 2%
Enzalutamide Monotherapy (n=40)	9.0 Months	78%	70%	60%	23%	8% / 5%
Rinzimetostat 400 mg QD + Darolutamide (n=18)	**4.9 Months**	**93%**	**84%**	**84%**	**6%**	**None / 6%**

Preliminary rinzimetostat rPFS landmark analysis, albeit early, compares favorably to competitor benchmarks with a far cleaner safety profile, despite more heavily pretreated patients

ORIC

Source: ORIC data on file, Schweizer et al. ASCO GU (2025), and Matsubara et al. ASCO GU (2026).
Note: Competitor rPFS percentages estimated from published data.


ORIC
Clinical Program Update
and Next Steps
Next Steps and Registrational Strategy

Himalayas-1: Global Phase 3 Study of Rinzimetostat in Combination with Darolutamide in Patients with mCRPC Previously Treated with Abiraterone

Rinzimetostat Global Phase 3 mCRPC Trial

Himalayas-1

- **Patients with mCRPC**
- **Prior abiraterone** in mCSPC or mCRPC setting
- Up to 1 prior chemotherapy in mCSPC setting

R

1:1

Rinzimetostat + Darolutamide (n=300)

Physician's Choice (AR inhibitor or chemotherapy) (n=300)

- **Primary Endpoint:**
  - Radiographic progression-free survival (rPFS)
- **Key Secondary Endpoint:**
  - Overall survival (OS)
- **Other Secondary Endpoints:**
  - PSA response rate
  - ORR (RECIST 1.1 and PCWG3)
  - Patient reported outcomes

Rinzimetostat's first global registrational Phase 3 trial is designed to evaluate combination with darolutamide compared to AR inhibitor and chemotherapy

Himalayas-1 Steering Committee Comprised of Global Leaders in Prostate Cancer

Chair – Matthew Smith, MD PhD
Mass General Hospital Cancer Center - Boston

Co-Chair – Karim Fizazi, MD PhD
Institut Gustave Roussy - Paris

Johann de Bono, MD PhD
The Institute of Cancer Research & Royal Marsden - London

Arun Azad, MD PhD
Peter MacCallam Cancer Centre - Melbourne

Elizabeth Heath, MD
Mayo Clinic - Rochester

Joaquin Mateo, MD PhD
Vall d'Hebron University Hospital - Barcelona

Rahul Aggarwal, MD
University of California San Francisco

Wassim Abida, MD PhD
Memorial Sloan Kettering Cancer Center – New York

Rinzimetostat Plus Darolutamide Is Being Evaluated in a Food Effect Cohort Prior to Initiation of Himalayas-1 Phase 3 Trial

Food Effect Cohort: Design and Preliminary Data

Food Effect Cohort

- Rinzimetostat is being studied in a food effect cohort to potentially enable dosing under fed conditions, consistent with darolutamide dosing

- **Patients with mCRPC**
- Prior abiraterone or AR inhibitor
- Up to 1 prior chemotherapy

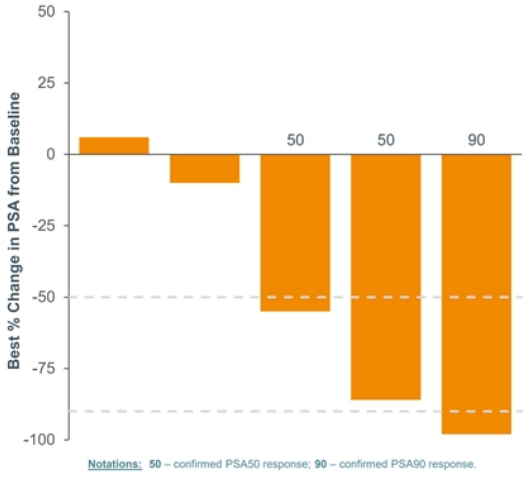
Rinzimetostat
400 mg QD (Fed) **+**

Darolutamide
600 mg BID (Fed)

(n=12)

- **Primary Endpoint:**
  — Pharmacokinetics
- **Key Secondary Endpoint:**
  — Safety and tolerability
- **Other Secondary Endpoints:**
  — PSA response rate
  — rPFS

Preliminary PSA Response



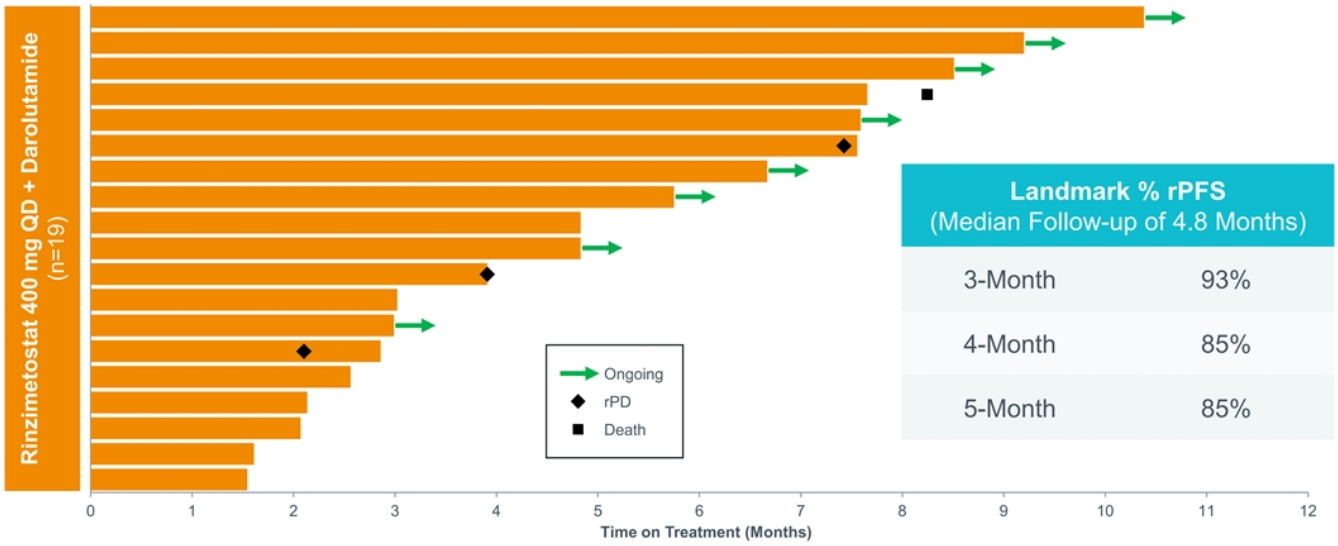
Notations: **50** – confirmed PSA50 response; **90** – confirmed PSA90 response.

ORIC is currently evaluating the impact of food for rinzimetostat plus darolutamide on PK, PD, safety and efficacy

ORIC Note: ORIC data on file as of March 6, 2026.

Rinzimetostat Is Being Explored in Other Patient Populations that Could Form the Basis of Future Phase 3 Trials, Including Post-AR Inhibitor mCRPC

Rinzimetostat 400 mg QD Plus Darolutamide in Post-ARi mCRPC: Time on Treatment



Landmark % rPFS (Median Follow-up of 4.8 Months)	
3-Month	93%
4-Month	85%
5-Month	85%

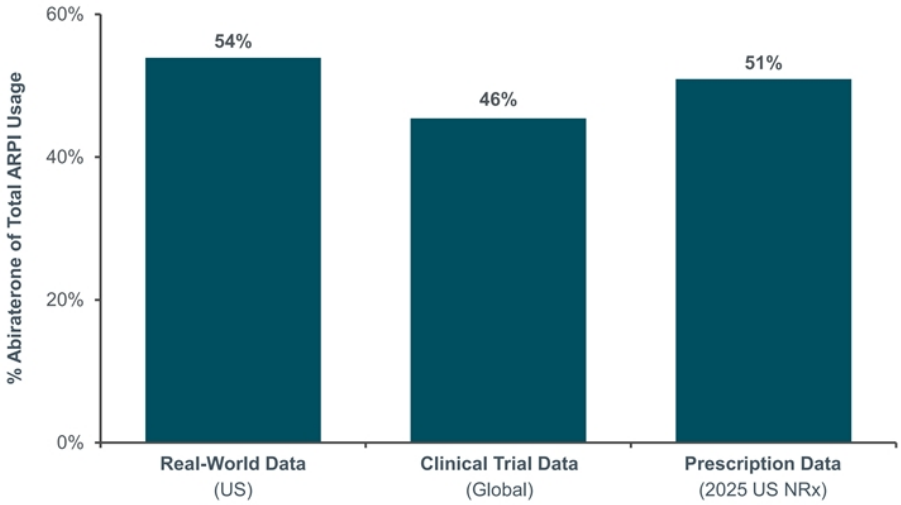
Preliminary data in second mCRPC population, albeit early, are promising

Source: ORIC data on file as of March 6, 2026 from dose optimization trial.
Note: rPD – radiographic progressive disease.


ORIC
Commercial Potential
for Himalayas-1 and
Beyond

Abiraterone Remains the Leading ARPI Prescribed in the US, Accounting for Approximately Half of New ARPI Prescriptions

Overview of Abiraterone Market Share Among ARPIs



Abiraterone remains the leading ARPI, maintaining >50% market share of new prescriptions over the last five years

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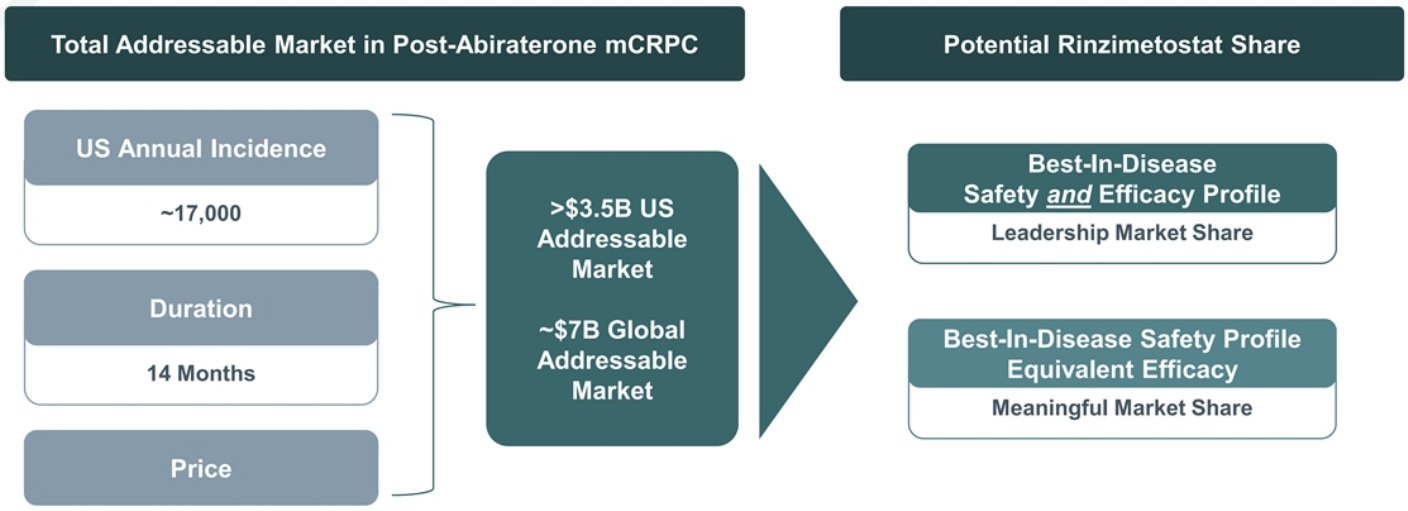
Source: Narayan et al. Clin Genitourin Cancer (2024), Tagawa et al. ESMO (2025), Morris et al. Lancet (2023) and IQVIA.
Note: Clinical trial data represents average of PSMAddition and PSMAfore. NRx – new prescriptions.

Rinzimetostat Is Initially Pursuing a Significant Addressable Market in Post-Abiraterone mCRPC

Rinzimetostat Total Addressable Market in Post-Abiraterone mCRPC



Post-abiraterone mCRPC is a large addressable market with limited effective therapeutic options that are oral and well-tolerated; Rinzimetostat is positioned to capture substantial share with its potential best-in-disease profile

ORIC

Source: ©DRG 2025, Swami et al. J Clin Oncol (2025), Raval et al. J Clin Oncol (2025), Gebrael et al. J Clin Oncol (2025), Schweizer et al. ASCO GU (2025), and ORIC data on file.
Note: Addressable market assumes current price of ARPIs for illustrative purposes.

Independent Physician Market Research Demonstrates Rinzimetostat Has Best-In-Class Potential in Prostate Cancer

Key Insights from Independent Market Research Testing Blinded Target Product Profiles (TPPs)

Overview of US Prescriber Survey

Urologists and oncologists (n=18) surveyed across academic and community settings were shown two blinded TPPs:

	Product Z + enzalutamide	Product Y + darolutamide
Efficacy	*Similar*	
Safety	Competitor PRC2 inhibitor data	~400 mg QD

Key Takeaways

Surveyed physicians estimated that Product Y would capture

80% share of PRC2 class

*"I would **automatically go with Product Y** … simply because it's much better tolerated"*

*" … They look similar in terms of efficacy, but **Product Y seems more tolerable, particularly with the hematologic toxicities** … "*

*"I would **prefer daro [over enzalutamide] since it is a little bit more tolerable** ..."*

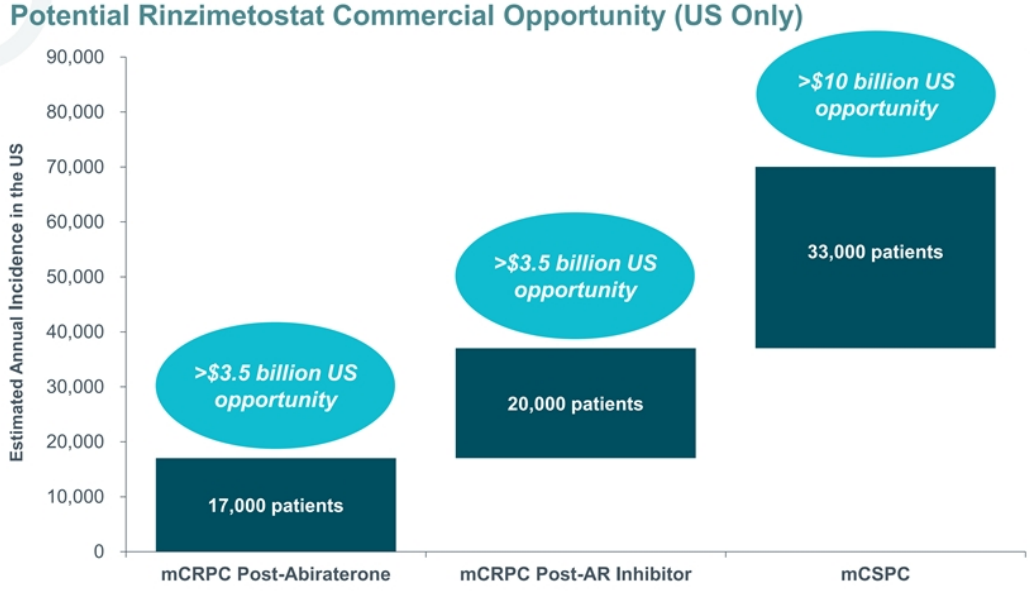
Market research demonstrates that a safety benefit alone is sufficient for rinzimetostat to achieve substantial share; A differentiated efficacy profile offers even more upside

ORIC

Source: ORIC market research 2025.
Note: Product Y reflects the tested target product profile for rinzimetostat.

Rinzimetostat Has the Potential to Address Multiple Large Market Opportunities in Prostate Cancer, with Several Development Opportunities in Other Solid Tumors

Potential Rinzimetostat Commercial Opportunity (US Only)



Future Development Opportunities

	Est. Annual US Incidence
mCRPC (RLT, TCE, ADC Combo)	37,000
NSCLC (KRASi Combo)	45,000
CRC (KRASi Combo)	65,000
Breast Cancer (ERi Combo)	220,000

Rinzimetostat has the potential to address ~70,000 patients in the US with prostate cancer annually

ORIC

Source: ©DRG 2025, Swami et al. J Clin Oncol (2025), Raval et al. J Clin Oncol (2025), Gebrael et al. J Clin Oncol (2025), SEER Cancer Stat Facts: Female Breast Cancer Subtypes, and ORIC data on file.
Note: Addressable market assumes current price of ARPIs for illustrative purposes. RLT – radioligand therapy; TCE – T-cell engager; ADC – antibody-drug conjugate.


ORIC
Q&A

ORIC Pharmaceuticals: Dedicated to **O**vercoming **R**esistance **I**n **C**ancer

Validated Targets in High Unmet Need Populations
- Potential best-in-class PRC2 inhibitor for prostate cancer
- Potential best-in-class TKI for NSCLC with EGFR exon 20 and EGFR PACC mutations

Late-Stage Clinical Pipeline
- Rinzimetostat (ORIC-944) and enozertinib (ORIC-114) rapidly advancing towards potential Phase 3 initiations

Experienced Management Team
- Heritage of discovering, developing, and commercializing oncology therapies at Ignyta, Medivation, Aragon, Pharmacyclics, Deciphera, and Genentech

Strong Financial Position
- Cash and investments of $412 million expected to fund company into 2H 2028 (1)
- Funding through primary endpoint readout from first Phase 3 trial of rinzimetostat

Anticipated Milestones
- Rinzimetostat for mCRPC:
  - ✓ 1Q26: Combination dose optimization data with AR inhibitor
  - – 1H26: Initiate first global Phase 3 registrational trial in post-abiraterone mCRPC
  - – 2H26: Program update
- Enozertinib for NSCLC:
  - – 2H26: 1L EGFR exon 20 monotherapy data and combination data with SC amivantamab (2)
  - – 2H26: 1L EGFR PACC monotherapy data

Two potential best-in-class programs approaching Phase 3 initiation; Cash runway into 2H28, beyond rinzimetostat Phase 3 data

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Note: PACC – P-loop and alpha C-helix compressing. Abiraterone refers to abiraterone acetate.
(1) Represents cash and investments of approximately $392 million as of December 31, 2025, plus approximately $20 million in net proceeds raised post quarter-end via ATM facility.
(2) Clinical collaboration with Johnson & Johnson to evaluate enozertinib in combination with amivantamab and hyaluronidase-lpuj subcutaneous injection (SC amivantamab) in patients with first-line NSCLC with EGFR exon 20 mutations.


ORIC
Thank You