Understanding the Prior Authorization (PA) Process for RASONQUE™ (daraxonrasib)

This resource is provided to support patient access to RASONQUE. It is for informational purposes only and is not intended to provide recommendations or serve as a comprehensive description of potential payer access and coding requirements for RASONQUE. The prescriber is solely responsible for coding, determining coverage/reimbursement requirements, and submitting the necessary information to payers. Revolution Medicines does not make any representation or guarantee concerning reimbursement, coverage, or coding for any item or service. Nothing within this resource is intended to be a substitute for, or influence on, prescribers' independent medical judgment.

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Understanding Your Patient's Coverage

When you prescribe RASONQUE, write the prescription according to your usual process. Your patient's health plan will confirm if a PA is required. A benefits investigation is key to supporting patients' access to treatment and can be done by calling the patient's plan to learn about their coverage for RASONQUE.

Possible coverage decisions and considerations for next steps

Covered: PA Required The patient's plan requires a PA submission and approval before covering RASONQUE.	**Covered with Restrictions** **Step therapy**: The patient's plan requires trial and failure of a less expensive medication before the plan will cover RASONQUE. **Nonpreferred status**: RASONQUE may not be included on formulary for the patient's plan or list of preferred medications.	**Not Covered: Not on Formulary** The product is not on formulary for the patient's plan.
Next steps: If you and your patient would like to continue the process, submit a PA, as well as required documentation of medical necessity, to their health plan.	**Next steps:** Submit a request for formulary exception, which may include a plan-specific formulary exception letter. A templated letter is available for use as well. A letter of medical necessity (LOMN) may be submitted as part of the exception request.	

Patients with Medicare Part D may access a nonformulary medication through the exception process outlined above. Patients may also opt-in to the Medicare Prescription Payment Plan to manage the out-of-pocket costs for medications covered under Part D. This plan allows for patients' cost shares to be spread over the course of the calendar year with an annual cap of $2100.[1]

Submitting a PA for RASONQUE

The table below includes key information that may be required by your patient's insurance, but it is not an exhaustive list. Always check with your patient's insurance to confirm any plan-specific requirements before submitting a PA. See below for examples of information to include.

Patient Information

- ☐ Name
- ☐ Address
- ☐ Date of birth
- ☐ Insurance member ID, policy number, and group number

HCP Information

- ☐ Name
- ☐ Office address
- ☐ Fax number
- ☐ Phone number
- ☐ NPI number

Patient History

- ☐ Date of diagnosis
- ☐ Previous treatments, procedures, and their dates
- ☐ Contraindications
- ☐ Comorbidities
- ☐ Current symptoms

Clinical Documentation

- ☐ Biomarker test confirmation
- ☐ ECOG status
- ☐ ICD-10-CM codes

CODES	DESCRIPTION[2]
C25.0	Malignant neoplasm of head of pancreas
C25.1	Malignant neoplasm of body of pancreas
C25.2	Malignant neoplasm of tail of pancreas
C25.3	Malignant neoplasm of pancreatic duct
C25.7	Malignant neoplasm of other parts of pancreas
C25.8	Malignant neoplasm of overlapping sites of pancreas
C25.9	Malignant neoplasm of pancreas, unspecified

METASTATIC DISEASE CODES

C78.7	Secondary malignant neoplasm of liver and intrahepatic bile duct
C78.0x	Secondary malignant neoplasm of lung
C79.31	Secondary malignant neoplasm of brain
C79.51	Secondary malignant neoplasm of bone
C77.x	Secondary and unspecified malignant neoplasm of lymph nodes
C79.9	Secondary malignant neoplasm, unspecified site

The information provided above is not intended as a comprehensive list of potentially applicable codes or coding requirements. Coding, coverage, and reimbursement policies may change periodically and without notice. Healthcare providers are solely responsible for determining the appropriate coding for their patients and for verifying applicable coverage, prior authorization, and reimbursement requirements with the relevant payer.

For plans **with restrictions** for RASONQUE, download a sample **Letter of Medical Necessity**.

For plans that **do not include** RASONQUE on formulary, download a sample **Letter of Exception**.

ECOG=Eastern Cooperative Oncology Group; ICD-10-CM=International Classification of Diseases, Tenth Revision, Clinical Modification.

Appealing a Denied PA

Considerations and tips for next steps

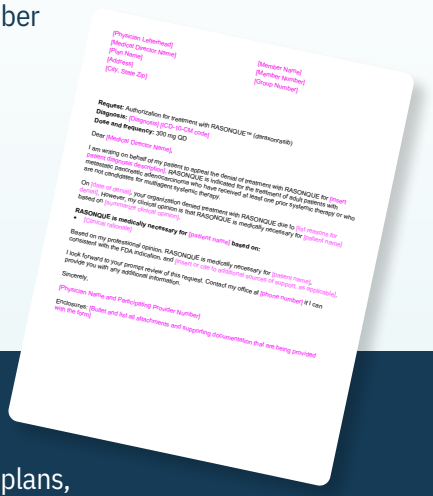
A PA may be denied for several reasons. The most important part of an appeal is identifying the reason for denial, usually included under the Explanation of Benefits, and understanding any insurance-specific guidelines or requirements.

Common reasons for denial

- Missing or inaccurate information
- Step-edit requirement (patient must have tried and failed a different therapy first)
- Incorrect diagnosis code(s) used
- Prescribed treatment is not covered on formulary
- Failure to provide medication justification for nonpreferred formulary products

Necessary information may include but is not limited to:

- Completed appeals form sent by the patient's insurer
- Letter of medical appeal, signed by the treating physician
- Patient's name, date of birth, policy number, ID number, and group number



Download a sample Letter of Appeal

Filing an appeal with traditional Medicare

The appeals process for Medicare Advantage plans, Medicare Prescription Drug plans, and commercial insurance plans are the same. Medicare Part D has a filing limit of 120 days for an appeal after receipt of a notice of claims denial. To file, complete the **CMS-20027 form**. Information that may be required includes, but is not limited to[3]:

- ☐ Beneficiary name
- ☐ Medicare number
- ☐ Specific service(s) and/or item(s) for which a redetermination is being requested
- ☐ Specific date(s) of service
- ☐ Name of the party, or the representative of the party
- ☐ An explanation of why the patient disagrees with the determination

Have questions? We're (ON) it.
Call an (ON)*Path* Patient Access Advocate at 1-844-ONPATH0 (844-667-2840), Monday-Friday, 8 AM to 8 PM EST or visit www.RevMedOnPath.com

References: 1. Centers for Medicare & Medicaid Services. Fact sheet: what's the Medicare Prescription Payment Plan. Medicare.gov. September 2025. Accessed June 26, 2026. https://www.medicare.gov/publications/12211-whats-the-medicare-prescription-payment-plan.pdf **2.** National Center for Health Statistics; Centers for Disease Control and Prevention. ICD-10-CM. 2026. Accessed June 26, 2026. https://icd10cmtool.cdc.gov/ **3.** Centers for Medicare & Medicaid Services. First level of appeal: redetermination by a Medicare contractor. Updated March 10, 2026. Accessed June 26, 2026. https://www.cms.gov/medicare/appeals-grievances/fee-for-service/first-level-appeal-redetermination-medicare-contractor