

(ON)Path™ Patient Support Enrollment Form

(ON)Path provides comprehensive resources and ongoing, hands-on support to help patients move forward to treatment.



Enroll online at
RevMedOnPath.com

OR



Complete the form on the next page and submit using the provided instructions

STEP 1

Complete

Complete all the information in the form with your patient.

STEP 2

Prescriber Signature & Date

Sign and date the form. Prescriber authorization is required in the form of an original signature following your review of the prescriber authorization.

STEP 3

Obtain Patient Consent

Ensure the patient provides consent on page 2 of the enrollment form. Missing original signatures will delay processing.

STEP 4

Fax Form

Fax the completed form along with a copy of your patient's insurance card and prescription to **1-855-739-2033**.

What to Expect Next

An (ON)Path Patient Access Advocate will call you after the submission to inform you of the next steps, including benefits investigations and patient follow-up.



Questions? Call an (ON)Path Patient Access Advocate at 1-844-ONPATH0 (844-667-2840), Monday-Friday, 8 AM to 8 PM EST or visit RevMedOnPath.com

1 Patient Information

Patient Name (First, Last): _____

Date of Birth: / / Gender: ☐ Male ☐ Female ☐ Other

Address: _____

City/State: _____ ZIP code: _____

Alternate Contact (First, Last): _____

US/US Territory Resident: ☐ Yes ☐ No

Insurance: _____ ☐ Patient has no insurance.

Member ID: _____ Group #: _____

☐ Adult patient with metastatic pancreatic adenocarcinoma (PDAC) who has received at least 1 prior systemic therapy, OR

☐ Adult patient with metastatic PDAC who is not a candidate for multiagent systemic therapy

Primary ICD-10-CM Code: C25. _____

Metastatic Disease: ☐ C77 ☐ C78 ☐ C79

LINE OF THERAPY FOR RASONQUE™ (daraxonrasib):

☐ Second Line ☐ Third Line+ ☐ Other

EAP NUMBER (IF APPLICABLE): _____

Home Phone: _____ Cell Phone: _____

Email: _____

PREFERRED CONTACT: ☐ Home ☐ Cell ☐ Email

BEST TIME TO CONTACT: _____

Alternate Contact Phone: _____

Consent to leave voice messages at the primary or alternative contact number: ☐ Yes ☐ No

Consent to receive text messages: ☐ Yes (cell phone is required) ☐ No

Insurance Phone: _____

BIN #: _____ PCN #: _____

BIOMARKER STATUS/TEST RESULTS: (check all that apply)

☐ RAS Positive ☐ RAS G12 Positive

Most Recent Biomarker Test Date: _____ / _____ / _____

PRIOR SYSTEMIC THERAPY: _____

2 Prescriber Information

Prescriber Name (First, Last): _____

Address: _____

City/State: _____ ZIP code: _____

NPI #: _____

Facility Name: _____

Office Contact Name: _____

Office Contact Email: _____

Office Phone: _____ Fax: _____

3 Prescribing RASONQUE (Restrictions and eligibility criteria apply)

☐ **RASONQUE PRESCRIPTION:**

☐ Two 150-mg tablets daily Alternate Dosing: _____

Quantity: _____

Refill Request: _____

Additional Instructions: _____

Pharmacy: ☐ Biologics by McKesson ☐ Onco360

Other: _____

☐ **OPTIONAL QUICK START IS MEDICALLY NECESSARY FOR PATIENT TO START RASONQUE:**
(for insurance prior authorizations pending at least 3 business days)

☐ RASONQUE 150-mg tablets, take 2 tablets by mouth once daily, 15-day supply, 30 tablets, up to 2 refills

☐ ***Please select only for EAP patients who have been down dosed previously***
RASONQUE 100-mg tablets, take 2 tablets by mouth once daily, 15-day supply, 30 tablets, up to 2 refills

Additional Instructions (ie, last EAP dose): _____

The above therapy is medically necessary for this patient, I understand I am under no obligation to prescribe any Revolution Medicines drug, and I have made the independent decision to prescribe RASONQUE. I understand that any Product provided at no charge to the patient as part of the (ON)Path Patient Support Program is not contingent on any purchase or prescription obligation. I will not submit or cause to be submitted any claims for payment or reimbursement for such Product to any third-party payor, including, without limitation, a federal healthcare program.

PRESCRIBER SIGN HERE

Prescriber Signature (no stamps, please): _____ Date: / /

By signing this form, I attest that the information provided in this enrollment form is complete and accurate to the best of my knowledge.

By submitting this enrollment form, I represent that I have obtained consent to release the patient's protected health information (PHI) included on this form and as may be necessary for Revolution Medicines, the contracted dispensing pharmacy, or other contractors to contact the patient, perform a preliminary verification of the patient's insurance coverage for the Product, and assess the patient's eligibility for participation in a Revolution Medicines patient support or assistance program.

By signing below, I consent to the Program terms and conditions outlined on the next page.

Patient OR Legal Representative* Name (please print): _____

PATIENT SIGN HERE

Patient OR Legal Representative* Signature: _____ Date: / /

(If signed by representative, explain authority to act on behalf of patient and relationship)

*By signing on behalf of the patient, as representative or guardian, I attest that I am legally able to sign such documents on the patient's behalf and am properly acting in my capacity in doing so. Proof of such guardian's or representative's authority to act for the patient may be requested such as power of attorney or legal court order.

4 Patient Consent and Program Terms & Conditions

I authorize my health care provider(s), health insurers, and pharmacies to disclose my personal and health information, which may include my name, demographic information, contact information, insurance information, and information related to my diagnoses, medications, tests, treatments, and health insurance and benefits ("Information"), to Revolution Medicines and its respective partners, affiliates, subcontractors, and agents (collectively, "RevMed"). To the extent that I am eligible, I am enrolling in the (ON)Path PAP program or other RevMed patient support or assistance program (the "Program"). I authorize RevMed to verify my eligibility for the Program, and I understand that such verification may include contacting me or my provider for additional information and/or reviewing additional financial, insurance, and/or medical information. I authorize RevMed under the Fair Credit Reporting Act to use my demographic information to access reports on my individual credit history from consumer reporting agencies, and that such access will not impact my credit score. I further understand and authorize RevMed to use any consumer reports about me and information collected from me, along with other information they obtain from public and other sources, to estimate my income in conjunction with PAP eligibility, if necessary. I further authorize RevMed to use and disclose my Information in connection with the Program to provide me with support, including coverage, financial assistance, and education, verifying my health insurance coverage, facilitating access to RevMed products, and communicating with me by mail, telephone, email, or text, including about products and services that may be of interest to me. I further authorize RevMed to use my Information for research and other purposes described in RevMed's Privacy Policy (<https://www.revmed.com/privacy-policy/>). I understand that once my Information has been disclosed, it may be subject to redisclosure and no longer be protected by federal privacy law. I further understand this authorization is voluntary and, if I do not sign, it will not affect my treatment, payment for treatment, enrollment or eligibility for benefits, but I may not be able to participate in the Program. This authorization expires once I am no longer participating in the Program, unless an earlier time period is required under applicable state law. I have the right to revoke this authorization at any time by submitting a written notice to: (ON)Path. If I revoke this authorization, I will no longer be able to participate in the Program and revocation will not impact any uses and disclosures of my Information made in reliance on this Authorization.