(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

Fax the completed form to **1-855-739-2033** or complete online at **RevMedOnPath.com**.

(ON) Path™

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 #:

Primary ICD-10-CM Code: C25.___

Metastatic Disease: ☐ C77 ☐ C78 ☐ C79

LINE OF THERAPY FOR RASONQUE™ (daraxonrasib):

Second Line Third Line+

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
(15-day supply, 30 tablets, up to 2 refills)

Additional Instructions:

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 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.