



PRIOR AUTHORIZATION POLICY

POLICY: Oncology (Oral – RAS Inhibitor) – Rasonque Prior Authorization Policy

- Rasonque™ (daraxonrasib tablets – Revolution Medicines)

REVIEW DATE: 08/27/2026

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT WHERE APPROPRIATE AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. WHERE COVERAGE FOR CARE OR SERVICES DOES NOT DEPEND ON SPECIFIC CIRCUMSTANCES, REIMBURSEMENT WILL ONLY BE PROVIDED IF A REQUESTED SERVICE(S) IS SUBMITTED IN ACCORDANCE WITH THE RELEVANT CRITERIA OUTLINED IN THE APPLICABLE COVERAGE POLICY, INCLUDING COVERED DIAGNOSIS AND/OR PROCEDURE CODE(S). REIMBURSEMENT IS NOT ALLOWED FOR SERVICES WHEN BILLED FOR CONDITIONS OR DIAGNOSES THAT ARE NOT COVERED UNDER THIS COVERAGE POLICY (SEE "CODING INFORMATION" BELOW). WHEN BILLING, PROVIDERS MUST USE THE MOST APPROPRIATE CODES AS OF THE EFFECTIVE DATE OF THE SUBMISSION. CLAIMS SUBMITTED FOR SERVICES THAT ARE NOT ACCOMPANIED BY COVERED CODE(S) UNDER THE APPLICABLE COVERAGE POLICY WILL BE DENIED AS NOT COVERED. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Rasonque, an inhibitor of the RAS GTPase family, is indicated for the treatment of **metastatic pancreatic adenocarcinoma** in adult patients who have received at least one prior systemic therapy or who are not candidates for multiagent systemic therapy.¹

Guidelines

Rasonque is not addressed in the treatment algorithm of the National Comprehensive Cancer Network (NCCN) pancreatic adenocarcinoma guidelines (version 3.2026 – August 6, 2026).² However, Rasonque is addressed in the discussion section noting that it is available through an expanded access program for eligible patients with previously treated pancreatic cancer.

Regimens for first-line therapy for metastatic disease is categorized based on performance status.² Options for good performance status (0 or 1) are provided

below. Refer to the NCCN guidelines for intermediate and poor performance status options, category 2B recommendations, and for biomarker-directed therapies.

- **First-line therapy:** The “Preferred” options are albumin-bound paclitaxel with gemcitabine (category 1), FOLFIRINOX (5-fluorouracil, leucovorin, irinotecan, oxaliplatin) [category 1], NALIRIFOX (category 1), and modified FOLFIRINOX. Under “Other Recommended” therapies, erlotinib + gemcitabine and gemcitabine monotherapy are category 1 recommended options. Albumin-bound paclitaxel + cisplatin + gemcitabine and capecitabine + gemcitabine combinations are both category 2A recommended therapies.
- **Subsequent therapy:** The “Preferred” options are categorized based on if the patient had received prior gemcitabine-based therapy or prior fluoropyrimidine-based therapy.
 - If prior gemcitabine-based therapy, the options are fluorouracil/leucovorin/liposomal irinotecan (category 1 for metastatic disease), capecitabine, CAPEOX, continuous infusion fluorouracil, bolus fluorouracil/leucovorin, FOLFIRI, FOLFIRINOX or modified FOLFIRINOX, FOLFOX (5-fluorouracil, leucovorin, and oxaliplatin), and OFF (all others category 2A).
 - If prior fluoropyrimidine-based therapy, the options are albumin-bound paclitaxel + gemcitabine, erlotinib + gemcitabine, and fluorouracil + leucovorin + liposomal irinotecan (if no prior irinotecan), gemcitabine (all category 2A).
 - Under “Useful in Certain Circumstances”, Krazati (adagrasib tablets) or Lumakras (sotorasib tablets) are recommended if *KRAS* G12C mutation-positive (category 2A for both). Other biomarker-targeted therapies are also recommended.

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Rasonque. All approvals are provided for the duration noted below.

Rasonque™ (daraxonrasib tablets - Revolution Medicines) is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):

FDA-Approved Indication

- 1. Pancreatic Adenocarcinoma.** Approve for 1 year if the patient meets ALL of the following (A, B, and C):
 - A)** Patient is ≥ 18 years of age; AND
 - B)** Patient has metastatic disease; AND
 - C)** Patient meets ONE of the following (i or ii):
 - i.** Patient has tried at least one prior systemic therapy; OR

- Note: Examples include regimens with one or more of the following: albumin-bound paclitaxel, gemcitabine, fluorouracil, leucovorin, oxaliplatin, irinotecan, cisplatin, capecitabine, erlotinib.
- ii. Patient is not a candidate for multiagent systemic therapy.

CONDITIONS NOT COVERED

Rasonque™ (daraxonrasib tablets - Revolution Medicines) is(are) considered not medically necessary for ANY other use(s) including the following. Criteria will be updated as new published data are available.

REFERENCES

1. Rasonque™ tablets [prescribing information]. Redwood City, CA: Revolution Medicines; August 2026.
2. The NCCN Pancreatic Adenocarcinoma Clinical Practice Guidelines in Oncology (version 3.2026 – August 6, 2026). © 2026 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed August 27, 2026.

HISTORY

Type of Revision	Summary of Changes	Review Date
New Policy	--	08/27/2026

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