Clinical Policy: Daraxonrasib (Rasonque)

Reference Number: CP.PHAR.794
Effective Date: 08.26.26
Last Review Date: 08.26
Line of Business: Commercial, HIM/ICHRA, Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Daraxonrasib (Rasonque™) is an inhibitor of the RAS GTPase family.

FDA Approved Indication(s)

Rasonque is indicated for the treatment of adults with metastatic pancreatic adenocarcinoma who have received at least one prior systemic therapy or who are not candidates for multiagent systemic therapy.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Rasonque is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Pancreatic Adenocarcinoma (must meet all)**:**

1. Diagnosis of pancreatic adenocarcinoma;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Disease is metastatic;
5. One of the following (a or b):
   a. Disease progression after receipt of one of the following (i or ii):
      i. One previous line of a fluoropyrimidine or gemcitabine-based therapy for metastatic disease (*see Appendix B*);
      ii. Neoadjuvant or adjuvant therapy if metastatic disease was diagnosed less than 6 months after the last dose of such therapy (*see Appendix B*);
   b. Provider attestation that member is not a candidate for multiagent systemic therapy;
6. If an actionable genetic mutation has been identified other than the RAS mutation, member has received FDA-approved or NCCN guideline-recommended targeted therapy (*see Appendix D*);
7. Member has not previously received RAS-targeted therapy (e.g., Lumakras®, Krazati®);
8. Request meets one of the following (a or b):*
   a. All of the following (i, ii, and iii):
      i. Dose is at least 150 mg per day;

ii. Dose does not exceed 300 mg per day;
iii. Quantity does not exceed 2 tablets per day;

b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Pancreatic Adenocarcinoma (must meet all)**:**

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Rasonque for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets one of the following (a or b):*
   a. All of the following (i, ii, and iii):
      i. New dose is at least 150 mg per day;
      ii. New dose does not exceed 300 mg per day;
      iii. New quantity does not exceed 2 tablets per day;
   b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of

business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or

b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
NCCN: National Comprehensive Cancer Network

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Examples of gemcitabine-based therapy: • Albumin-bound paclitaxel + gemcitabine • Gemcitabine (monotherapy) • Erlotinib + gemcitabine • Albumin-bound paclitaxel + cisplatin + gemcitabine • Cisplatin + gemcitabine (BRCA subgroup) • GTX (gemcitabine fixed-dose-rate + docetaxel + capecitabine)	Varies	Varies
Examples of fluoropyrimidine-based therapy: • FOLFIRINOX (leucovorin + fluorouracil + irinotecan + oxaliplatin) • Modified FOLFIRINOX • NALIRIFOX (liposomal irinotecan + 5-FU/leucovorin backbone) • OFF (oxaliplatin + 5-FU + leucovorin)	Varies	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
• CAPEOX (capecitabine + oxaliplatin) • Capecitabine/gemcitabine		
Examples of neoadjuvant therapy: • Albumin-bound paclitaxel + gemcitabine • Albumin-bound paclitaxel + gemcitabine with consolidative chemoradiation • FOLFIRINOX • Modified FOLFIRINOX	Varies	Varies
Examples of adjuvant therapy: • Capecitabine/gemcitabine • Modified FOLFIRINOX	Varies	Varies

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings
None reported

Appendix D: General Information
- Examples of actionable genetic mutations included in NCCN Pancreatic Adenocarcinoma guidelines:
  - BRAF V600E: dabrafenib, trametinib
  - NTRK gene fusion-positive: entrectinib, larotrectinib, repotrectinib
  - FGFR: erdafitinib
  - HER2 positive: fam-trastuzumab deruxtecan-nxki
  - RET gene fusion-positive: selpercatinib
  - NRG1 gene fusion-positive: zenocutuzumab-zbco

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Pancreatic adenocarcinoma	300 mg PO QD. Permanently discontinue in patients who are unable to tolerate 150 mg PO QD	300 mg/day

VI. Product Availability
Tablets: 100 mg, 150 mg

VII. References
1. Rasonque Prescribing Information. Redwood City, CA: Revolution Medicines, Inc.; August 2026. Available at: https://www.rasonque.com Accessed September 1, 2026.
2. O'Reilly EM, Wainberg ZA, Hendifar AE, et al; RASolute 302 Trial Investigators. Daraxonrasib or chemotherapy in previously treated metastatic pancreatic cancer. N Engl J Med. 2026 May 31. doi: 10.1056/NEJMoa2605555.
3. Wolpin BM, Park W, Garrido-Laguna I, et al; RMC-6236-001 Investigators. Daraxonrasib in previously treated advanced *RAS*-mutated pancreatic cancer. N Engl J Med. 2026 May 7;394(18):1790-1802. doi: 10.1056/NEJMoa2505783.

4. NCT06625320 in ClinicalTrials.gov. Phase 3 study of daraxonrasib (RMC-6236) in patients with previously treated metastatic pancreatic ductal adenocarcinoma (PDAC) (RASolute 302). NIH U.S. National Library of Medicine. Available at: https://clinicaltrials.gov/study/NCT06625320. Accessed September 1, 2026.
5. National Comprehensive Cancer Network. Pancreatic Adenocarcinoma (Version 3.2026). Available at: https://www.nccn.org/professionals/physician_gls/pdf/pancreatic.pdf. Accessed September 1, 2026.

Coding Implications
Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
C9399	Unclassified drugs or biologicals
J8999	Prescription drug, oral, chemotherapeutic, nos

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created pre-emptively	07.14.26	08.26
RT4: Drug is now FDA approved - criteria updated per FDA labeling: revised “pancreatic ductal adenocarcinoma” to “pancreatic adenocarcinoma”; added bypass of required prior therapy if provider attests that member is not a candidate for multiagent systemic therapy; removed requirement that member has an Eastern Cooperative Oncology Group performance status score of 0 or 1; removed requirement that member does not have known central nervous system metastases; updated dosing requirements; references reviewed and updated.	09.01.26	
Added Coding Implications section with HCPCS codes [C9399, J8999].	11.03.26	

Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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