UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 8-K

CURRENT REPORT
Pursuant to Section 13 or 15(d)
of the Securities Exchange Act of 1934

Date of Report (Date of earliest event reported): October 22, 2023

REVOLUTION MEDICINES, INC.
(Exact name of registrant as specified in its charter)

Delaware	**001-39219**	**47-2029180**
(State or other jurisdiction of incorporation)	**(Commission File Number)**	**(IRS Employer Identification Number)**

700 Saginaw Drive
Redwood City, California 94063
(Address of principal executive offices, including Zip Code)

Registrant's telephone number, including area code: (650) 481-6801

Check the appropriate box below if the Form 8-K filing is intended to simultaneously satisfy the filing obligation of the registrant under any of the following provisions:

☐ Written communications pursuant to Rule 425 under the Securities Act (17 CFR 230.425)

☐ Soliciting material pursuant to Rule 14a-12 under the Exchange Act (17 CFR 240.14a-12)

☐ Pre-commencement communications pursuant to Rule 14d-2(b) under the Exchange Act (17 CFR 240.14d-2(b))

☐ Pre-commencement communications pursuant to Rule 13e-4(c) under the Exchange Act (17 CFR 240.13e-4(c))

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	**Trading Symbol**	**Name of each exchange on which registered**
Common Stock, $0.0001 par value per share	RVMD	The Nasdaq Stock Market LLC (Nasdaq Global Select Market)

Indicate by check mark whether the registrant is an emerging growth company as defined in Rule 405 of the Securities Act of 1933 (§230.405 of this chapter) or Rule 12b-2 of the Securities Exchange Act of 1934 (§240.12b-2 of this chapter).

Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Item 7.01 Regulation FD Disclosure.

On October 22, 2023, Revolution Medicines, Inc. (the "Company") posted an updated corporate presentation to the investor section of the Company's website at: ir.revmed.com/events-and-presentations. The Company's updated corporate presentation is attached hereto as Exhibit 99.1.

The furnishing of the attached presentation is not an admission as to the materiality of any information therein. The information contained in the slides is summary information that is intended to be considered in the context of more complete information included in the Company's filings with the U.S. Securities and Exchange Commission (the "SEC") and other public announcements that the Company has made and may make from time to time by press release or otherwise. The Company undertakes no duty or obligation to update or revise the information contained in this Current Report on Form 8-K, although it may do so from time to time as its management believes is appropriate. Any such updating may be made through the filing of other reports or documents with the SEC, through press releases or through other public disclosures. For important information about forward looking statements, see the slide titled "Legal Disclaimer" in Exhibit 99.1 attached hereto.

The information furnished under this Item 7.01 and in the presentation attached as Exhibit 99.1 to this Current Report on Form 8-K shall not be deemed "filed" for purposes of Section 18 of the Exchange Act or otherwise subject to the liabilities of that section or Sections 11 or 12(a)(2) of the Securities Act. The information contained in this Item 7.01 and in the presentation attached as Exhibit 99.1 to this Current Report on Form 8-K shall not be incorporated by reference into any filing with the SEC made by the Company, whether made before or after the date hereof, regardless of any general incorporation language in such filing.

Item 8.01 Other Events.

On October 22, 2023, the Company provided the following pipeline updates.

RMC-6236

The Company reported updated preliminary safety and anti-tumor data for RMC-6236, its RAS^{MULTI}(ON) Inhibitor.

In the Company's ongoing RMC-6236-001 Phase 1/1b trial, a total of 111 patients with either non-small cell lung cancer ("NSCLC") (n=46) or pancreatic ductal adenocarcinoma ("PDAC") (n=65) treated across six dose cohorts ranging from 80 mg daily to 400 mg daily were evaluated for safety and tolerability as of a data cut-off date of October 12, 2023 (the "Data Cut-off Date"). Patients at dose levels below 80 mg daily were not included in this analysis based on the Company's preclinical and pharmacokinetics predictions that these dose levels would not be associated with tumor regressions in patients and its clinical observations of these doses. Common RAS mutations in patients evaluated included G12D, G12V, G12R, G12A and G12S. Patients with $KRAS^{G12C}$ mutations were excluded from the study due to the availability of currently approved $KRAS^{G12C}$(OFF) inhibitors. All of these patients had previously been treated with standard of care appropriate for tumor type and stage. Patients with NSCLC had received a median of two prior lines of therapy (range: 1–6) and patients with PDAC had received a median of three prior lines of therapy (range: 1–7).

As of the Data Cut-off Date, the Company observed that RMC-6236 demonstrated an acceptable safety profile that was generally well tolerated across the dose levels analyzed (Table 1). Median duration of treatment as of the Data Cut-off Date was 2.1 months (range: 0.2–10.9). The most common treatment-related adverse events ("TRAEs") were rash and gastrointestinal ("GI")-related toxicities that were primarily Grade 1 or 2 in severity. One previously reported Grade 4 TRAE occurred in a patient with PDAC at the 80 mg dose level who had a large intestine perforation at the site of an invasive tumor that reduced in size while on treatment, which resulted in treatment discontinuation. No fatal TRAEs were observed. No safety signals were observed that indicated an elevated risk of hepatotoxicity, which has been reported for some $KRAS^{G12C}$(OFF) inhibitors.

Table 1. RMC-6236-001: Select treatment-related adverse events for patients with NSCLC and PDAC Treated at ≥80 mg daily

Total (N=111)					
Maximum Severity of Treatment-Related AEs (TRAEs)	**Grade 1**	**Grade 2**	**Grade 3**	**Grade 4**	**Any Grade**
TRAEs occurring in ≥10% of patients, n (%)					
Rash‡	58(52)	25(23)	7(6)	—	90(81)
Nausea	40(36)	11(10)	—	—	51(46)
Diarrhea	28(25)	14(13)	1(1)	—	43(39)
Vomiting	30(27)	7(6)	—	—	37(33)
Stomatitis	13(12)	9(8)	2(2)	—	24(22)
Fatigue	11(10)	6(5)	—	—	17(15)
Other select TRAEs, n (%)					
ALT elevation	8(7)	1(1)	—	—	9(8)

Maximum Severity of Treatment-Related AEs (TRAEs)	Grade 1	Grade 2	Grade 3	Grade 4	Any Grade
AST elevation	8(7)	—	—	—	8(7)
Electrocardiogram QT prolonged	1(1)	—	—	—	1(1)
TRAEs leading to dose reduction*, n (%)	—	10(9)	5(5)†	—	15(14)
TRAEs leading to treatment discontinuation, n (%)	—	—	—	1(1)^	1(1)

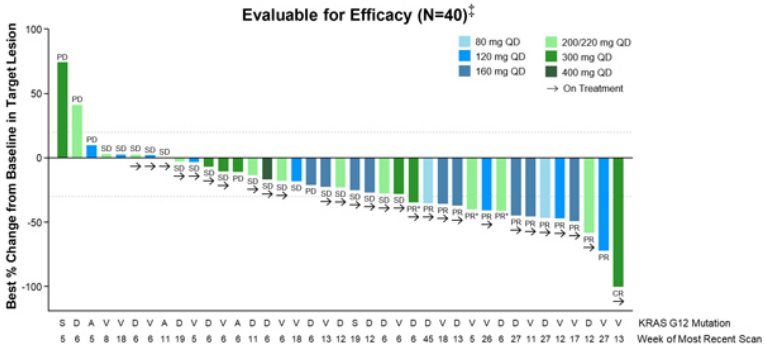
AE, adverse event; ALT, alanine transaminase; AST, aspartate transferase; TRAEs, treatment-related adverse events.

‡ Includes preferred terms of dermatitis acneiform, rash maculopapular, rash, rash pustular, erythema, rash erythematous; multiple types of rash may have occurred in the same patient.
* The most common reason for dose reduction was rash.
† Grade 3 TRAEs leading to reduction were rash (n=4), including one patient with a dose reduction due to rash and decreased appetite, and stomatitis (n=1).
^ One Grade 4 TRAE occurred in a patient with PDAC at the 80 mg dose level who had a large intestine perforation at the site of an invasive tumor that reduced in size while on treatment.

Clinical activity was evaluated as of the Data Cut-off Date in patients with NSCLC (n=40) and PDAC (n=46) who had received the first dose of RMC-6236 at least eight weeks prior to the Data Cut-off Date (n=86). Confirmed objective responses included tumors harboring KRAS mutations G12D, G12V or G12R, and disease control was observed across all KRAS mutations, including G12A and G12S.

As of the Data Cut-off Date, RMC-6236 demonstrated preliminary evidence of clinical activity in efficacy-evaluable NSCLC patients (Figure 1).

Figure 1. RMC-6236-001: Change in tumor burden from efficacy-evaluable KRAS^{G12X} NSCLC patients



Data extracted October 12, 2023.

QD, daily dosing; PD, progressive disease; SD, stable disease; PR, partial response; PR*, unconfirmed PR per Response Evaluation Criteria in Solid Tumors ("RECIST") 1.1; CR, complete response.

‡ Patients who received first dose of RMC-6236 at least eight weeks prior to data extract date.

Among the efficacy evaluable NSCLC patients, the objective response rate was 38 percent, with one patient achieving a complete response ("CR") as a best response and 14 patients achieving a partial response ("PR") (including three unconfirmed PRs) (Table 2). The disease control rate ("DCR") in this NSCLC population was 85 percent.

Table 2. RMC-6236-001: Tumor Response per RECIST for efficacy-evaluable KRAS^{G12X} NSCLC patients

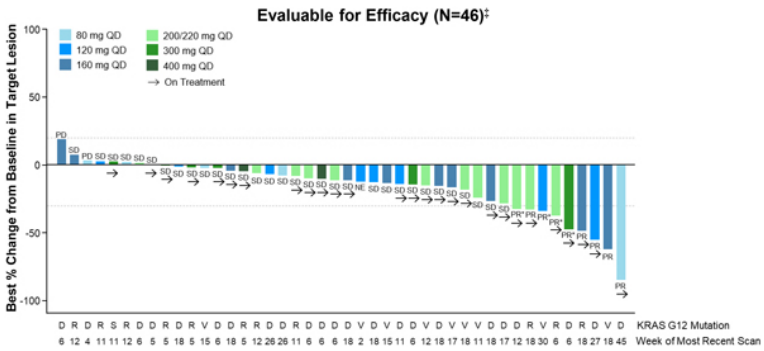
Tumor Response (per RECIST 1.1)	
Best Overall Response, n (%)	
CR	1(3)
PR	14(35)
SD	19(48)
PD	5(13)
NE†	1(3)
ORR, n (%)	15(38)
Confirmed, n	12
DCR (CR+PR+SD), n (%)	34(85)

CR, complete response; PR, partial response; SD, stable disease; PD, progressive disease; NE, not evaluable; ORR, objective response rate; DCR, disease control rate.

† One subject withdrew from study without post-baseline scans.

As of the Data Cut-off Date, RMC-6236 demonstrated preliminary evidence of clinical activity in efficacy-evaluable PDAC patients (Figure 2).

Figure 2. RMC-6236-001: Change in tumor burden from efficacy-evaluable KRAS^{G12X} PDAC patients



Data extracted October 12, 2023.

QD, daily dosing; PD, progressive disease; SD, stable disease; PR, partial response; PR*, unconfirmed PR per RECIST 1.1.

‡ Patients who received first dose of RMC-6236 at least eight weeks prior to data extract date.

Among the efficacy-evaluable PDAC patients, the objective response rate was 20 percent, with nine patients achieving a PR (including four unconfirmed PRs) as a best response (Table 3). The DCR in this PDAC population was 87 percent.

Table 3. RMC-6236-001: Tumor Response per RECIST for efficacy-evaluable KRAS^{G12X} PDAC patients

Tumor Response (per RECIST 1.1)	
Best Overall Response, n (%)	
PR	9(20)
SD	31(67)
PD	3(7)
NE†	3(7)
ORR, n (%)	9(20)
Confirmed, n	5
DCR (CR+PR+SD), n (%)	40(87)

PR, partial response; SD, stable disease; PD, progressive disease; NE, not evaluable; ORR, objective response rate; DCR, disease control rate.

† Two patients died prior to first post-baseline scan; one patient had scan after 11 days of treatment and subsequently died due to PD.

The Company is planning a global randomized phase 3 trial comparing RMC-6236 against docetaxel in patients with previously treated RAS-mutated NSCLC who have been treated with immunotherapy and platinum-containing chemotherapy. The study design for this planned trial is subject to change based on regulatory authority feedback. The Company is aiming to initiate this study in 2024.

The Company may potentially plan a global randomized phase 3 trial comparing RMC-6236 against a physician's choice of chemotherapy regimens in patients with previously treated RAS-mutated PDAC. The study design for this potential trial is subject to change based on regulatory authority feedback. The Company expects to make a decision regarding plans for this study after additional patient follow-up regarding durability of response and dose optimization, but the Company believes the study could potentially be initiated in 2024.

Planning is underway for one or more combination pivotal clinical trials for RMC-6236 with standard of care therapies.

RMC-6291

Active recruitment of patients is underway for the Phase 1/1b clinical trial to evaluate the combination of RMC-6236 and RMC-6291.

RMC-4630

Based on the Company's review of the complete data set from the RMC-4630-03 study, the Company concluded that the combination of RMC-4630 (200 mg intermittent dosing D1D2) with sotorasib (960 mg daily dosing) showed additive side effects compared to either agent alone and that tolerability was insufficient to confer a clinical benefit (objective response rate or durability) due to dose interruptions and discontinuations. The Company has no immediate plans for further development of RMC-4630, but believes this compound remains an option for potential evaluation in other combinations.

Forward-Looking Statements

This Current Report on Form 8-K contains forward-looking statements within the meaning of the U.S. Private Securities Litigation Reform Act of 1995. Any statements in this report that are not historical facts may be considered "forward-looking statements," including, without limitation, statements regarding the scope, progress and results of developing the Company's product candidates, and conducting clinical trials. Forward-looking statements are typically, but not always, identified by the use of words such as "may," "will," "would," "believe," "intend," "plan," "anticipate," "estimate," "expect" and other similar terminology indicating future results. Such forward-looking statements are subject to substantial risks and uncertainties that could cause the Company's development programs, future results, performance or achievements to differ materially from those anticipated in the forward-looking statements. Such risks and uncertainties include, without limitation, risks and uncertainties inherent in the drug development process, including the Company's programs' early stage of development, the process of designing and conducting preclinical and clinical trials, the

regulatory approval processes, the timing of regulatory filings, the challenges associated with manufacturing drug products, the Company's ability to successfully establish, protect and defend its intellectual property, other matters that could affect the sufficiency of the Company's capital resources to fund operations, reliance on third parties for manufacturing and development efforts, changes in the competitive landscape and the effects on the Company's business of global events and other macroeconomic conditions. For a further description of the risks and uncertainties that could cause actual results to differ from those anticipated in these forward-looking statements, as well as risks relating to the business of the Company in general, see the Company's Quarterly Report on Form 10-Q filed with the SEC on August 8, 2023, and its future periodic reports to be filed with the SEC. Except as required by law, the Company undertakes no obligation to update any forward-looking statements to reflect new information, events or circumstances, or to reflect the occurrence of unanticipated events.

Item 9.01 Financial Statements and Exhibits.

(d) Exhibits.

Exhibit No.	Description
99.1	Company presentation dated October 22, 2023.
104	Cover Page Interactive Data File (embedded within the Inline XBRL document).

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, as amended, the registrant has duly caused this report to be signed on its behalf by the undersigned hereunto duly authorized.

REVOLUTION MEDICINES, INC.

Date: October 23, 2023

By: /s/ Mark A. Goldsmith
Mark A. Goldsmith, M.D., Ph.D.
President and Chief Executive Officer

Exhibit 99.1

Revolution Medicines

On Target to Outsmart Cancer

October 22, 2023

Legal Disclaimer

This presentation contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act. All statements other than statements of historical facts contained in this presentation, including statements regarding our future results of operations and financial position, business strategy, prospective products, availability of funding, ability to manage existing collaborations and establish new strategic collaborations, licensing or other arrangements, the scope, progress, results and costs of developing our product candidates or any other future product candidates, conducting clinical trials, the potential market size and size of the potential patient populations for our product candidates, the timing and likelihood of success of obtaining product approvals, plans and objectives of management for future operations, the scope of protection we are able to establish and maintain for intellectual property rights covering our product candidates, future results of anticipated products the impact of global events and other macroeconomic conditions on our business, the expected timing of closing of the proposed transaction with EQRx, Inc. (EQRx) and the expected benefits of the proposed transaction are forward-looking statements. These statements involve known and unknown risks, uncertainties and other important factors that may cause our actual results, performance or achievements to be materially different from any future results, performance or achievements expressed or implied by the forward-looking statements. Because forward-looking statements are inherently subject to risks and uncertainties, some of which cannot be predicted or quantified and some of which are beyond our control, you should not rely on these forward-looking statements as predictions of future events. The events and circumstances reflected in our forward-looking statements may not be achieved or occur and actual results could differ materially from those projected in the forward-looking statements. The information included in these materials is provided as of October 22, 2023 unless specified elsewhere herein, and is qualified as such. Except as required by applicable law, we undertake no obligation to update any forward-looking statements or other information contained herein, whether as a result of any new information, future events, changed circumstances or otherwise.

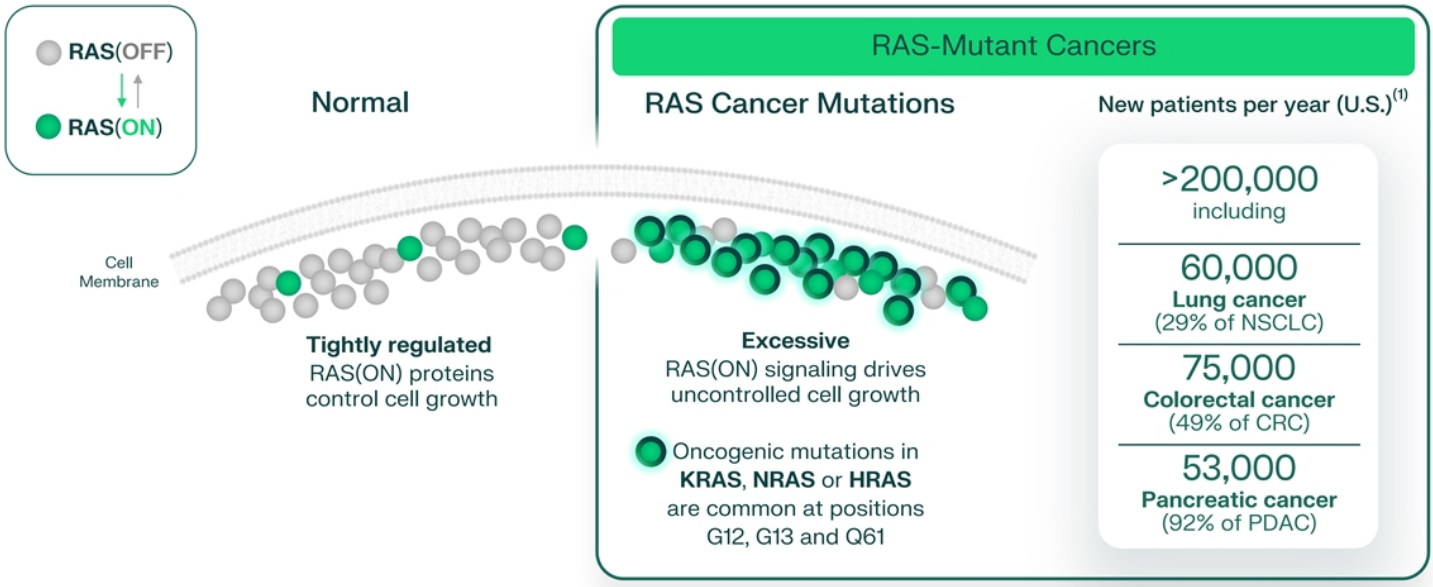
For a further description of the risks and uncertainties that could cause actual results to differ from those anticipated in these forward-looking statements, as well as risks relating to the business of Revolution Medicines in general, see Revolution Medicines' Quarterly Report on Form 10-Q filed with the Securities and Exchange Commission on August 8, 2023, and its future periodic reports to be filed with the Securities and Exchange Commission.

This presentation concerns product candidates that are under clinical investigation and which have not yet been approved for marketing by the U.S. Food and Drug Administration (FDA). These product candidates are currently limited by Federal law to investigational use, and no representation is made as to their safety or effectiveness for the purposes for which they are is being investigated.

Mission: to revolutionize treatment for patients with RAS-addicted cancers through the discovery, development and delivery of innovative, targeted medicines.

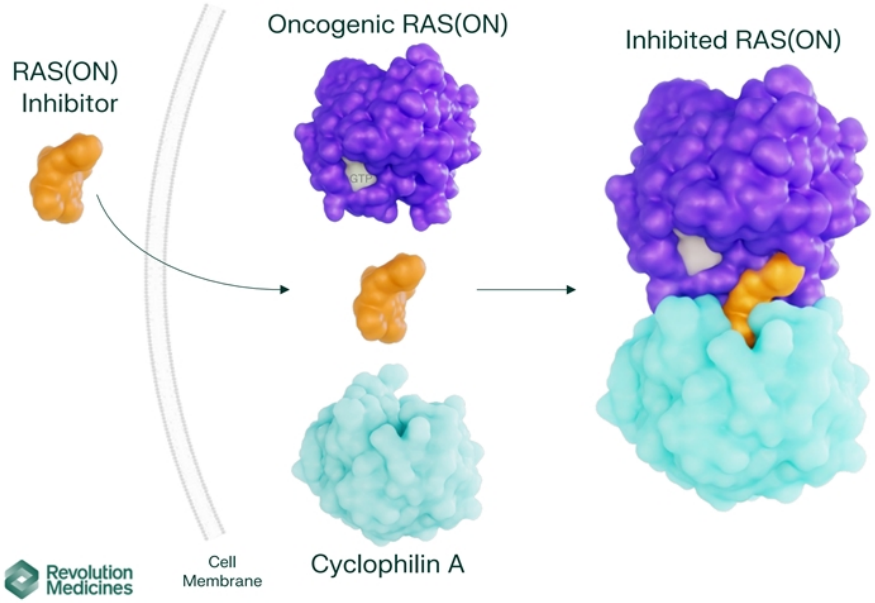
- **Pioneering class of drug candidates** designed to serve RAS-addicted cancer patients by targeting oncogenic RAS(ON) drivers of common, life-threatening cancers
- **Unprecedented RAS^{MULTI} inhibitor (RMC-6236) and RAS^{G12C}-selective inhibitor (RMC-6291)** show highly differentiated and promising initial clinical profiles
- **Innovative single agent and combination development strategies** aim to deliver durable clinical benefit broadly to patients with RAS-addicted cancers

Excessive RAS(ON) Signaling Drives 30% of Human Cancers, Targeted by Our RAS(ON) Inhibitors



(1) Estimated using tumor mutation frequencies from Foundation Medicine Insights March 2022 and scaled to estimated patient numbers using cancer incidence from ACS Cancer Facts and Figures 2023 (see appendix for additional detail); NSCLC = non-small cell lung cancer; CRC = colorectal cancer; PDAC = pancreatic ductal adenocarcinoma

Pioneering Tri-complex RAS(ON) Inhibitors Designed to Deliver Robust and Durable Anti-Tumor Activity

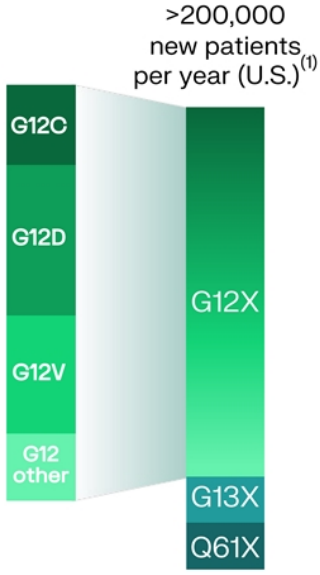


- **Direct inhibition of RAS(ON) cancer drivers**
- **Deep and durable suppression of RAS cancer signaling designed to defy common drug resistance mechanisms**
- **Clinical validation of first two RAS(ON) Inhibitors studied as single agents**

Development-Stage RAS(ON) Inhibitor Portfolio Designed to Treat Nearly All Patients with RAS-Addicted Cancers

MULTI		RAS Selectivity
RMC-6236	clinical	multiple mutations (initial focus on G12X) and WT

Mutant-Selective		
RMC-6291	clinical	G12C
RMC-9805	clinical	G12D
RMC-5127	IND-enabling	G12V
RMC-0708	IND-enabling	Q61H
RMC-8839	IND-enabling	G13C



(1) Estimated using tumor mutation frequencies from Foundation Medicine Insights March 2022 and scaled to estimated patient numbers using cancer incidence from ACS Cancer Facts and Figures 2023 (see appendix for additional detail).

Complementary RAS(ON) Inhibitors Designed for Monotherapy and Combination Strategies Against RAS-Addicted Cancers

RAS^{MULTI}

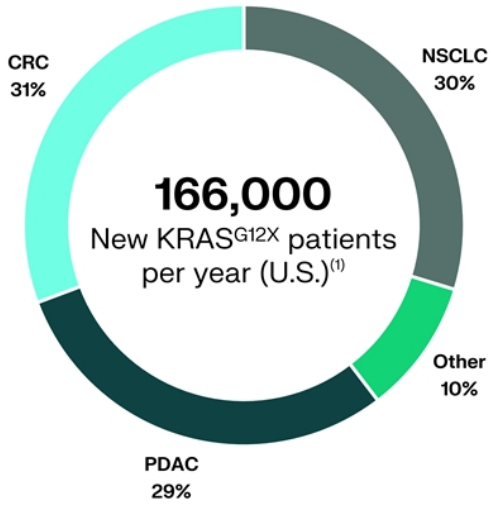
- Monotherapy with broad potential for RAS-addicted cancers
- Backbone of RAS(ON) Inhibitor doublets with mutant-selective RAS(ON) Inhibitors
- Targeted agent for SOC combinations, including immunotherapies

RAS Mutant-Selective

- Alternative monotherapy approaches
- Complementary to RAS^{MULTI} Inhibitor in RAS(ON) Inhibitor doublets
- Differentiated targeted agent profiles for SOC combinations, including immunotherapies

SOC = standard of care

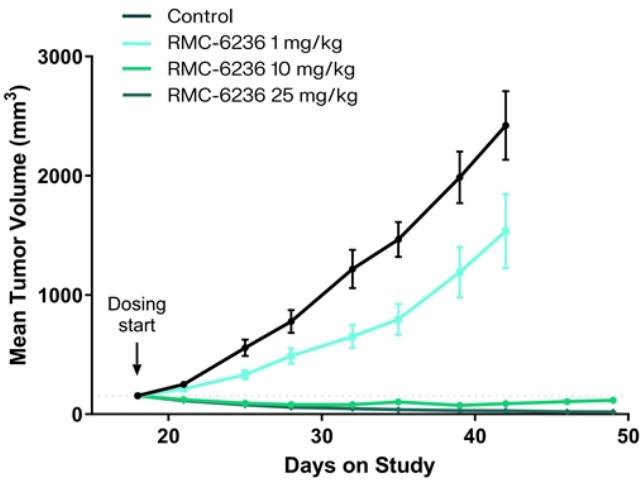
RMC-6236: First-in-Class, RAS^{MULTI}(ON) Inhibitor with Broad Potential Against RAS-Addicted Cancers

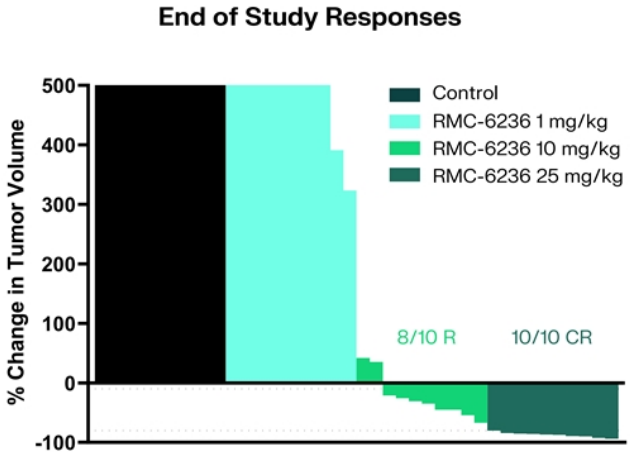


- Highly selective for RAS(ON) proteins with broad and deep anti-tumor activity in preclinical models
- Orally bioavailable and generally well-tolerated in patients at active doses
- Unprecedented clinical profile with anti-tumor activity observed across diverse RAS cancer mutations; multiple potential monotherapy registrational paths
- Profound combinatorial activity with mutant-selective RAS(ON) Inhibitors in preclinical models; potential for targeted RAS(ON) Inhibitor doublets in patients

(1) Estimated using tumor mutation frequencies from Foundation Medicine Insights March 2022 and scaled to estimated patient numbers using cancer incidence from ACS Cancer Facts and Figures 2023 (see appendix for additional detail); NSCLC = non-small cell lung cancer; CRC = colorectal cancer; PDAC = pancreatic ductal adenocarcinoma

RMC-6236: Dose-Dependent Anti-Tumor Activity at Low Doses in RAS-Addicted NSCLC Model





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RVMD preclinical research
NSCLC = non-small cell lung cancer
NCI-H441 CDX (NSCLC, $KRAS^{G12V/WT}$); All doses given orally, once daily
R = number of regressions >10% from initial; CR = number of regressions ≥80% from initial
Each animal represented as a separate bar in waterfall plot

RMC-6236: Highly Active with Durable Responses Across Models of Major Human Cancers with RAS^{G12X} Drivers

NSCLC

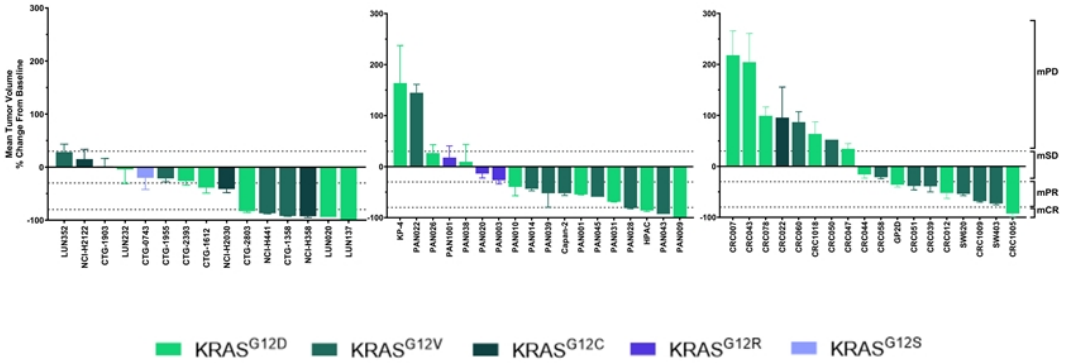
53% ORR (8/15)
100% DCR (15/15)

PDAC

61% ORR (11/18)
89% DCR (16/18)

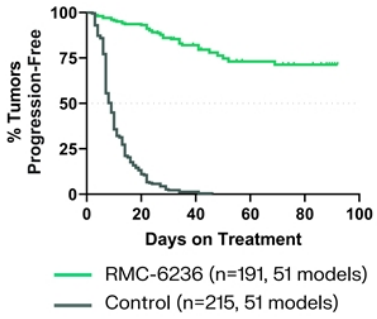
CRC

44% ORR (8/18)
56% DCR (10/18)



PFS

RMC-6236 – Median not reached
Control – Median 9 days



RVMD preclinical research as of 06/01/22
NSCLC = non-small cell lung cancer; PDAC = pancreatic ductal adenocarcinoma; CRC = colorectal cancer
RMC-6236 dosed at 25 mg/kg po qd; n=1-10/group
Progression defined as tumor doubling from baseline; Responses assigned according to mRECIST:
mPD = progressive disease; mSD = stable disease; mPR = partial response; mCR = complete response; ORR = objective response rate; DCR = disease control rate; PFS = progression-free survival

RMC-6236-001 Phase 1 Study Design

Key Eligibility Criteria

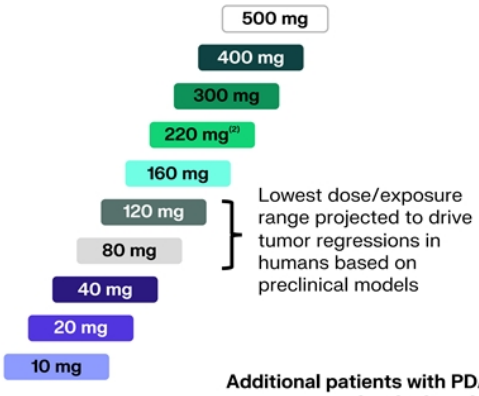
- Advanced solid tumors with $KRAS^{G12X}$ mutations[1] (currently excluding $KRAS^{G12C}$)
- Received prior standard therapy appropriate for tumor type and stage
- ECOG PS 0–1
- No active brain metastases

Key Endpoints

- Safety and tolerability
- Pharmacokinetics
- Anti-tumor activity

Dose Escalation

RMC-6236 administered orally QD



Dose Expansion / Optimization

Additional patients with PDAC or NSCLC were enrolled at dose levels that cleared DLT evaluation

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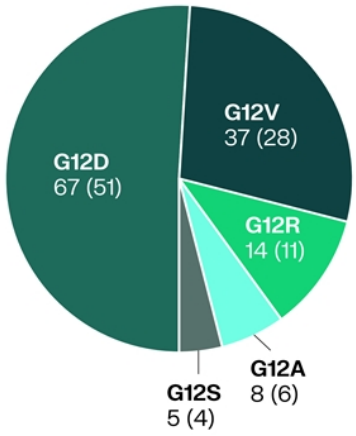
(1) $KRAS^{G12X}$ defined as mutation at codon 12 which encodes glycine (G) to X where X = A, D, R, S, or V.
(2) 220 mg cleared DLT evaluation and a dose of 200 mg was selected for further expansion/optimization.
DLT, dose-limiting toxicity; ECOG PS, Eastern Cooperative Oncology Group Performance Status; QD, once daily.

RMC-6236: Patient Demographics and Baseline Characteristics

	Total n=131
Age, median (range), years	64 (30–86)
Male, n (%)	69 (53)
Tumor type, n (%)	
PDAC	69 (53)
NSCLC	47 (36)
CRC	10 (7)
Other*	5 (4)
ECOG PS, n (%)	
0	40 (31)
1	91 (69)
Number of prior anti-cancer therapies, median (range)	2 (1–7)

Tumor KRAS Genotypes, n (%)



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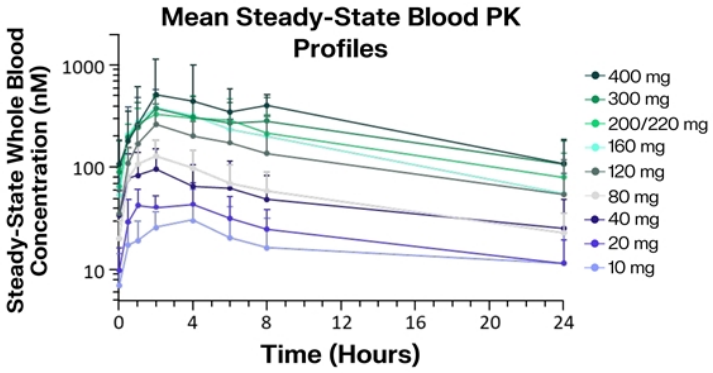
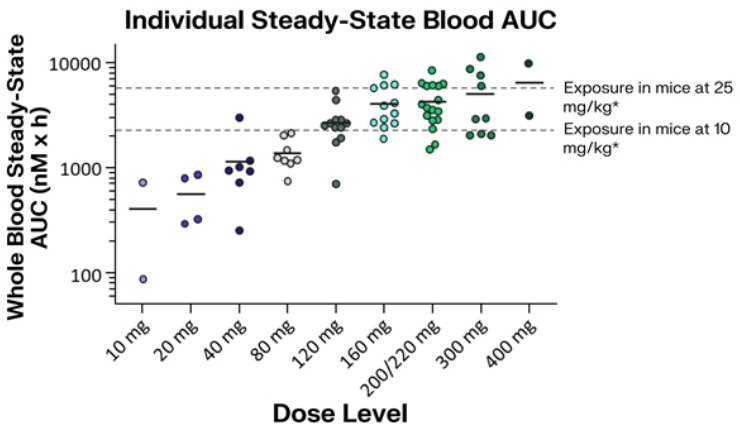
PDAC = pancreatic ductal adenocarcinoma; NSCLC = non-small cell lung cancer; CRC = colorectal cancer
ECOG PS, Eastern Cooperative Oncology Group Performance Status

Data Extracted 11 Sep 2023.

RMC-6236: Dose-Dependent Increases in Exposure





- Dose-dependent increases in exposure with minimal accumulation were observed after repeat daily dosing
- Dose levels ≥80 mg achieved exposures that induced tumor regressions in human xenograft models with $KRAS^{G12X}$ mutations in mice[1]
  - 10 mg/kg QD induces tumor regressions in sensitive models
  - 25 mg/kg QD induces tumor regressions in the majority of models

*Exposure corrected with cross-species protein binding and blood/plasma partitioning. Left: steady-state concentrations from Cycle 1 Day 15. Error bars represent standard deviation; right: steady-state AUC is Cycle 1 Day 15 AUC_{last}. Each circle represents an individual patient AUC. Horizontal bars represent mean AUC for each dose level (10 mg: n=2; 20 mg: n=4; 40 mg: n=7; 80 mg: n=8; 120 mg: n=12; 160 mg: n=12, 200 mg: n=13; 220 mg: n=4; 300 mg: n=9; 400 mg: n=2); AUC, area under the curve; PK, pharmacokinetics.

(1) Singh M, et al. Presentation at American Association for Cancer Research Annual Meeting, 8–13 April 2022, New Orleans, USA; abstract #3597.

Data Extracted 22 Sep 2023.

RMC-6236: Summary of Treatment-Related Adverse Events

	Total (n=131)				
Maximum severity of TRAEs	**Grade 1**	**Grade 2**	**Grade 3**	**Grade 4**	**Any Grade**
TRAEs occurring in ≥10% of patients, n (%)					
Rash*	57 (44)	29 (22)	6 (5)	0	92 (70)
Nausea	41 (31)	14 (11)	0	0	55 (42)
Diarrhea	32 (24)	9 (7)	1 (1)	0	42 (32)
Vomiting	27 (21)	9 (7)	0	0	36 (28)
Stomatitis	10 (8)	9 (7)	2 (2)	0	21 (16)
Fatigue	12 (9)	4 (3)	0	0	16 (12)
Other select TRAEs, n (%)					
ALT elevation	6 (5)	1 (1)	1 (1)‡	0	8 (6)
AST elevation	6 (5)	0	1 (1)‡	0	7 (5)
Electrocardiogram QT prolonged	1 (1)	0	0	0	1 (1)
TRAEs leading to dose reduction†, n (%)	0	9 (7)	2 (2)	0	11 (8)
TRAEs leading to treatment discontinuation, n (%)	0	0	0	1 (1)	1 (1)

- Median duration of treatment at the time of data extraction was 2.27 months (range: 0.2–14)
- One Grade 4 TRAE occurred in a patient with PDAC treated at 80 mg who had a large intestine perforation at the site of an invasive tumor that reduced in size while on treatment (TRAE leading to treatment discontinuation)
- No fatal TRAEs were observed. Two patients discontinued study treatment due to death: one patient with PDAC (120 mg) died due to PD; one patient with NSCLC (200 mg) died due to unknown cause reported as unrelated to RMC-6236

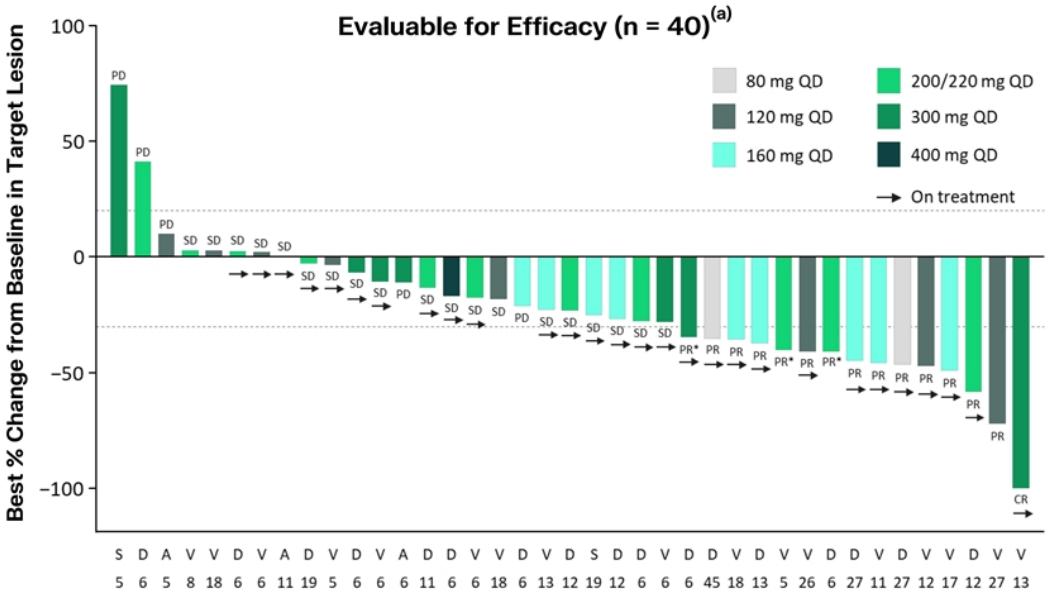
‡ Post-data extraction, the Grade 3 ALT and AST elevations were associated with biliary obstruction and reported as unrelated to RMC-6236

Revolution Medicines

*Includes preferred terms of dermatitis acneiform, rash maculopapular, rash, rash pustular, dermatitis psoriasiform, erythema, rash erythematous; multiple types of rash may have occurred in the same patient; †The most common TRAE leading to dose reduction was rash (acneiform or maculopapular); there were no reductions at doses ≤80 mg. AE, adverse event; ALT, alanine transaminase; AST, aspartate transferase; PD, progressive disease; TRAEs, treatment-related adverse events.

Data Extracted 11 Sep 2023.

KRAS^{G12X} NSCLC: Best Overall Response to RMC-6236

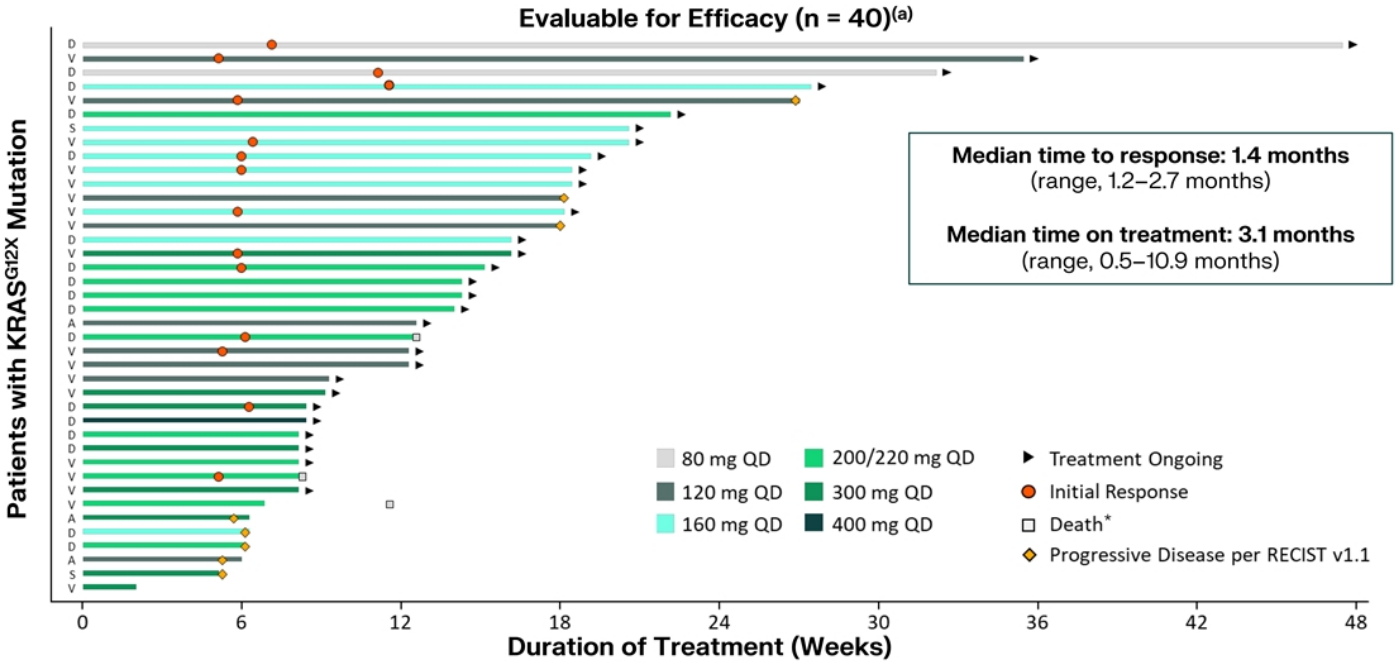


Tumor Response (per RECIST 1.1)	
Best overall response, n (%)	
Complete response	1 (3)
Partial response	14 (35)
Stable disease	19 (48)
Progressive disease	5 (13)
Not evaluable[b]	1 (3)
ORR, n (%)	15 (38)
Confirmed, n	12
DCR (CR+PR+SD), n (%)	34 (85)

*Unconfirmed PR per RECIST 1.1.
(a) Patients who received first dose of RMC-6236 at least 8 weeks prior to data extract date.
(b) One subject withdrew from study without post-baseline scans.

Data Extracted 12 Oct 2023.

KRAS^{G12X} NSCLC: Duration of Treatment and Responses to RMC-6236



Revolution Medicines

(a) Patients who received first dose of RMC-6236 at least 8 weeks prior to data extract date.
*Death due to PD (n=1), Death due to unrelated AE (n=1), Death due to unknown cause reported as unrelated to RMC-6236 (n=1).

Data Extracted 12 Oct 2023.

Case Report: Patient with KRAS^{G12V} NSCLC on RMC-6236

Demographics and Baseline Characteristics

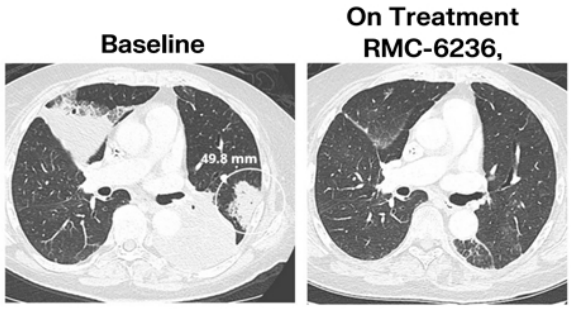
- 83-year-old woman
- Former smoker (~60 pack years)
- Diagnosed with NSCLC in 2021

Treatment History

- Prior therapies:
  - Ipilimumab/nivolumab
  - Paclitaxel
  - Carboplatin/pemetrexed

RMC-6236 Treatment Course

- Started at 300 mg QD
- Clinical improvement in cough and dyspnea within one week of start of treatment
- Dose reduced to 200 mg due to Grade 2 fatigue
- Complete response achieved at Week 6 (confirmed); ongoing

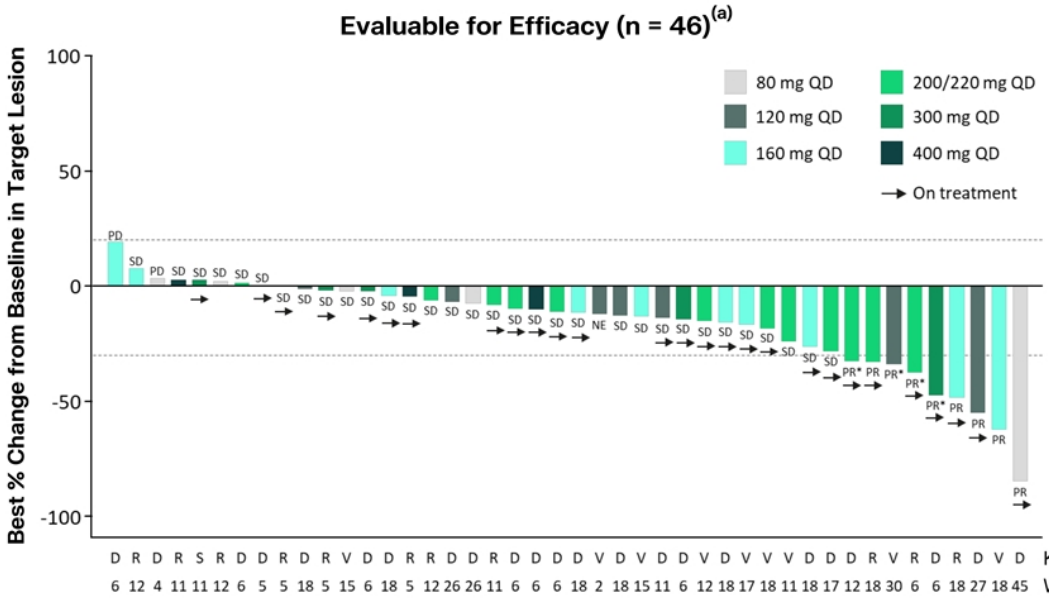


Target Lesion: Lung, Left Lower Lobe

Target Lesion	Baseline	On Treatment
1. Lung (left upper lobe)	11.6 mm	0 mm
2. Lung (left lower lobe)	49.8 mm	0 mm
Sum of Diameters	61.4 mm	0 mm (−100% ↓)
Overall Response (RECIST 1.1)	--	CR

Revolution Medicines

KRAS^{G12X} PDAC: Best Overall Response to RMC-6236

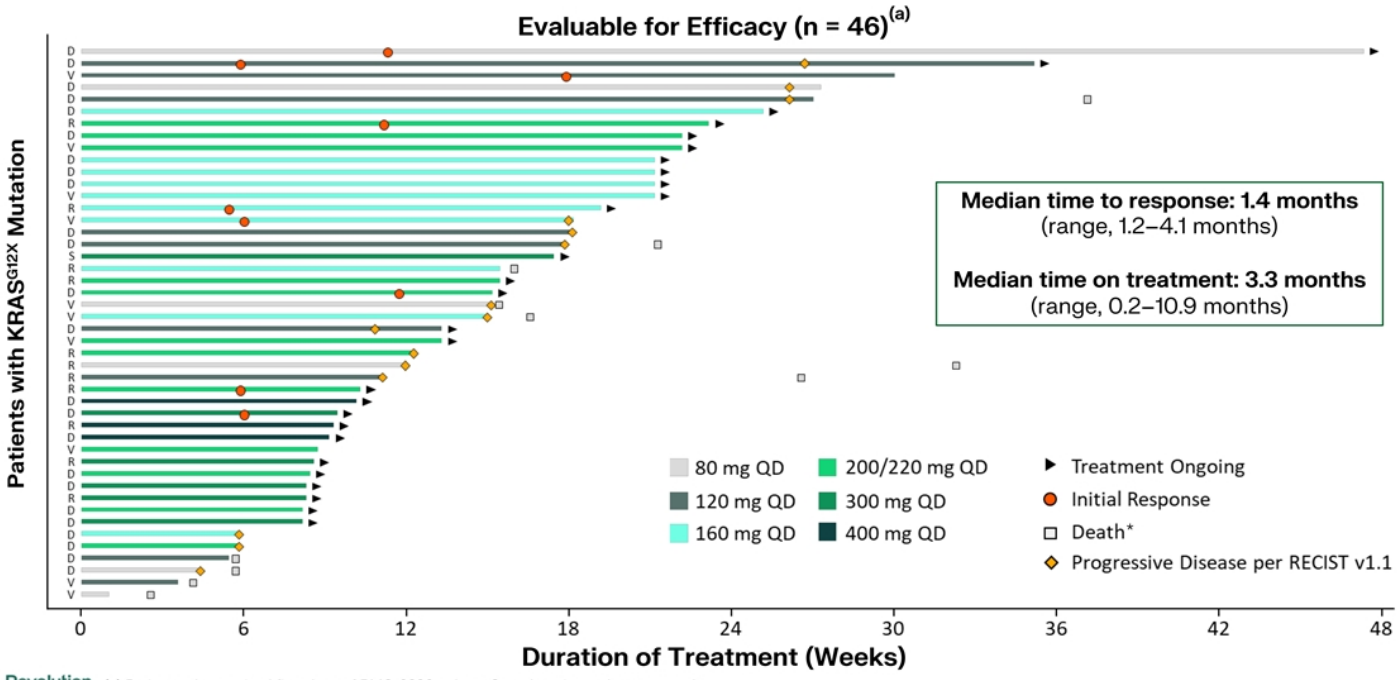


Tumor Response (per RECIST 1.1)	
Best overall response, n (%)	
Partial response	9 (20)
Stable disease	31 (67)
Progressive disease	3 (7)
Not evaluable[b]	3 (7)
ORR, n (%)	9 (20)
Confirmed, n	5
DCR (CR+PR+SD), n (%)	40 (87)

*Unconfirmed PR per RECIST 1.1.
(a) Patients who received first dose of RMC-6236 at least 8 weeks prior to data extract date.
(b) Two patients died prior to first post-baseline scan; 1 patient had scan after 11 days of treatment and subsequently died due to PD.

Data Extracted 12 Oct 2023.

KRAS^{G12X} PDAC: Duration of Treatment and Responses to RMC-6236



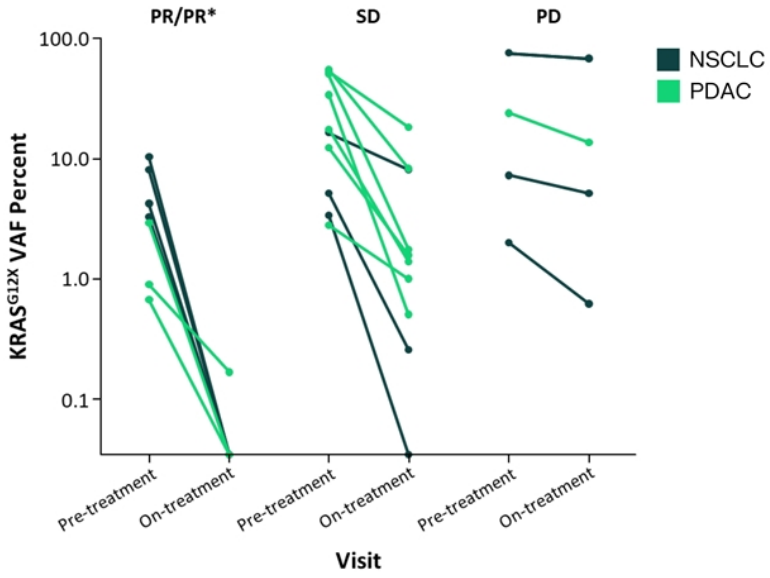
Revolution Medicines

(a) Patients who received first dose of RMC-6236 at least 8 weeks prior to data extract date.
*Death due to PD (n = 9), Death due to unrelated AE (n = 2).

Data Extracted 12 Oct 2023.

KRAS Variant Allele Frequency in ctDNA Across Tumor Types and Correlation with Clinical Response

- Patients with NSCLC or PDAC were dosed at 80–300 mg
- Overall, 23/50 patients (46%) were evaluable for change in mutant KRAS VAF while on-treatment[(a)]
- In total, 8/10 (80%) patients with NSCLC and 12/13 (92%) patients with PDAC showed >50% reduction of the mutated KRAS allele

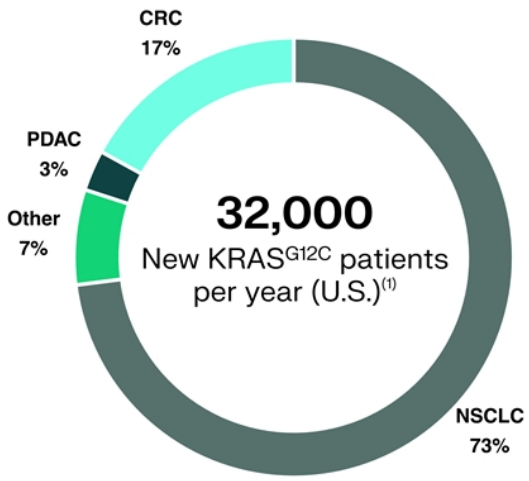


Revolution Medicines

(a) $KRAS^{G12X}$ VAF at Cycle 1 Day 1 (pre-treatment) to Cycle 2 Day 1 or Cycle 3 Day 1 (on-treatment) determined by Guardant Health ctDNA test; $KRAS^{G12X}$ defined as mutation at codon 12 which encodes glycine (G) to X where X= A, D, R, or V;
Two patients were non-evaluable for best overall response; *Unconfirmed partial response per RECIST 1.1.

Data Extracted 12 Oct 2023.

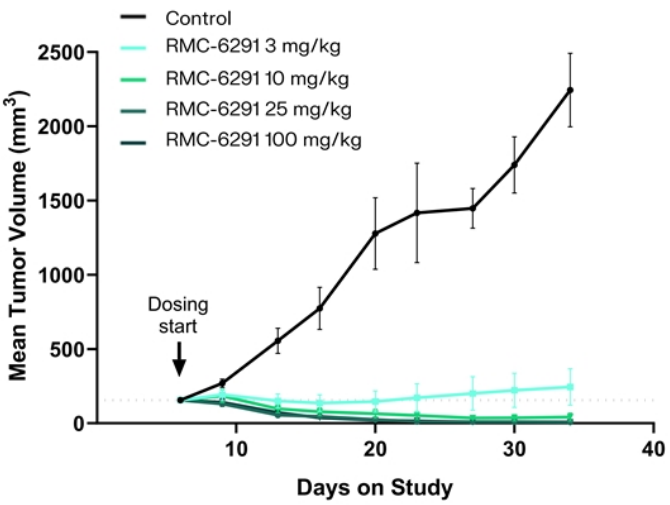
RMC-6291: Mutant-Selective, Covalent RAS(ON) Inhibitor with Differentiated Clinical Profile for KRAS^{G12C} Cancers

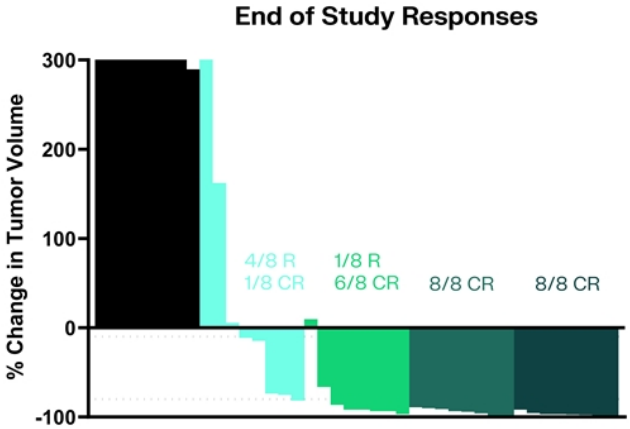


- Highly selective for KRAS^{G12C}(ON) with potent activity across a range of preclinical models
- Orally bioavailable and generally well-tolerated in patients at active doses
- Promising and differentiated initial clinical profile in previously-treated NSCLC and treatment-naïve CRC
- Profound combinatorial activity with RMC-6236 in preclinical models, potential for targeted RAS(ON) doublets
- High potential for checkpoint inhibitor combination given low evidence of hepatotoxicity

(1) Estimated using tumor mutation frequencies from Foundation Medicine Insights March 2022 and scaled to estimated patient numbers using cancer incidence from ACS Cancer Facts and Figures 2023 (see appendix for additional detail); NSCLC = non-small cell lung cancer; CRC = colorectal cancer; PDAC = pancreatic ductal adenocarcinoma

RMC-6291 Drives Tumor Regressions at Low Doses in Preclinical Models of KRAS^{G12C} NSCLC

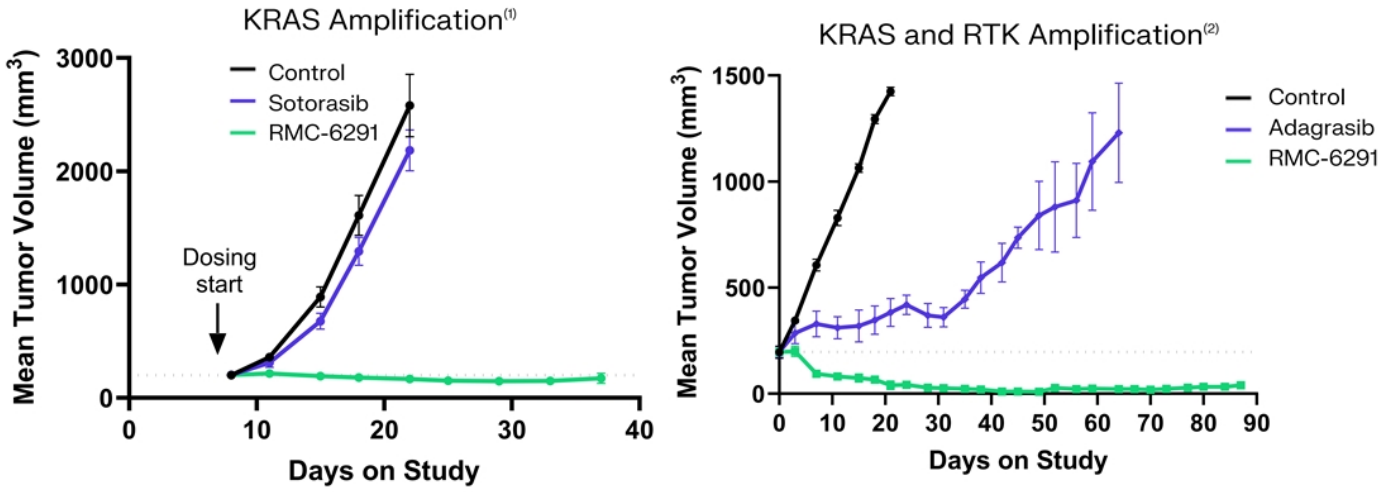




RVMD preclinical research
NSCLC = non-small cell lung cancer
NCI-H358 CDX (NSCLC, KRAS$^{G12C/WT}$); all doses given orally, once daily
R = number of regressions >10% from initial; CR = number of regressions ≥80% from initial
Each animal represented as a separate bar in waterfall plot

Revolution Medicines

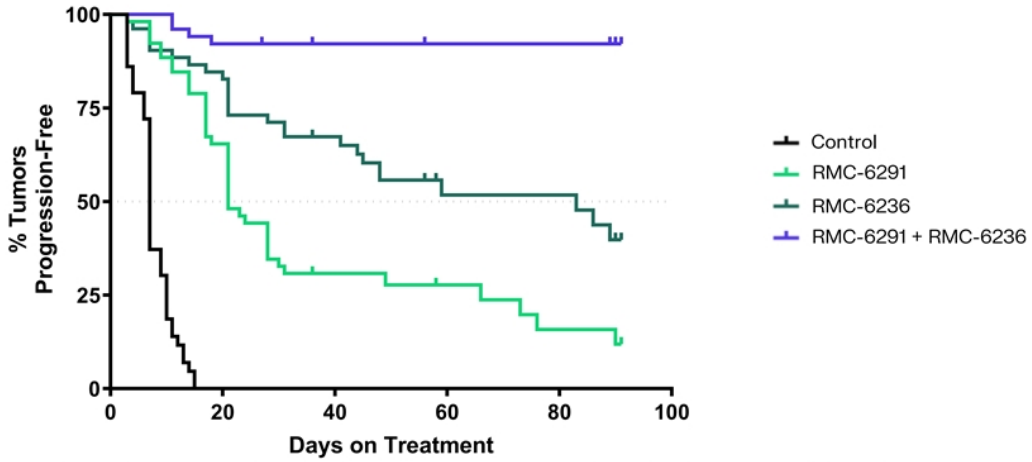
RMC-6291 Drives Tumor Regressions in Preclinical Models of KRAS^{G12C}(OFF) Inhibitor Clinical Resistance Mechanisms



Revolution Medicines

RVMD preclinical research
NSCLC = non-small cell lung cancer; PDAC = pancreatic ductal adenocarcinoma
(1) Sotorasib-Resistant MIA PaCa-2 CDX (PDAC, KRAS$^{G12C/G12C}$, KRAS^{amp}). RMC-6291 dosed at 100 mg/kg po qd; Sotorasib dosed at 100 mg/kg po qd
(2) LUN055 PDX (NSCLC, KRAS$^{G12C/WT}$, ERBB3^{amp}, KRAS^{amp}). RMC-6291 dosed at 200 mg/kg po qd; Adagrasib dosed at 100 mg/kg po qd

RMC-6236 + RMC-6291 Doublet Overcomes Resistance and Prolongs Durability in KRAS^{G12C} NSCLC Models



- RAS(ON) Inhibitor doublet evaluated across seven models, including five identified as resistant to RMC-6291 monotherapy

Revolution Medicines

RVMD preclinical research
NSCLC = non-small cell lung cancer
RMC-6236 dosed at 25 mg/kg po qd (n=52); RMC-6291 dosed at 100 or 200 mg/kg po qd (n=52); Combination (n=51).
For each group, n = total number of animals from the seven models that comprise the dataset.
Progression defined as tumor doubling from baseline.

RMC-6291-001 Phase 1 Study Design

Key Eligibility Criteria

- Advanced solid tumors with $KRAS^{G12C}$ mutations
- Received prior standard therapy including treatment with $KRAS^{G12C}$(OFF) inhibitors
- ECOG PS 0–1
- No active brain metastases

Key Endpoints

- Safety and tolerability
- Pharmacokinetics
- Anti-tumor activity

Dose Escalation

RMC-6291 administered orally QD or BID

400 mg BID
300 mg BID
200 mg BID
100 mg BID
200 mg QD
100 mg QD
50 mg QD ← Lowest dose projected to drive tumor regressions in humans based on preclinical models

→ **Dose Expansion / Optimization**

Additional patients with NSCLC or CRC were enrolled at dose levels that cleared DLT evaluation (backfill enrollment and dose optimization)

DLT=dose-limiting toxicity; ECOG PS=Eastern Cooperative Oncology Group Performance Status; QD=once daily; BID=twice daily

RMC-6291: Patient Demographics and Baseline Characteristics

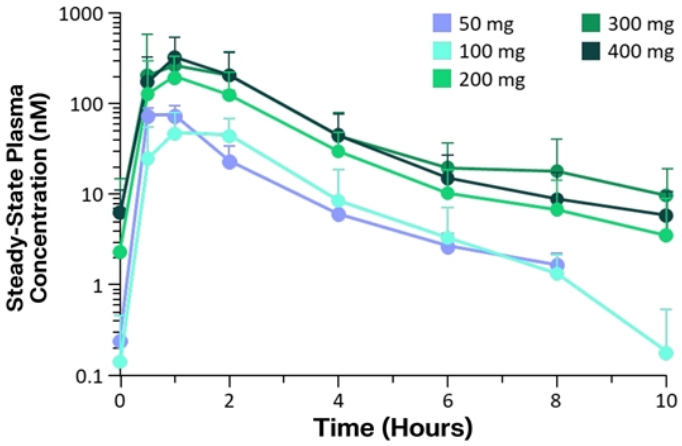
	NSCLC n=23	CRC n=33	Other n=7	All Histologies n=63
Age, median (range), years	65 (45–85)	54 (26–84)	66 (52–78)	64 (26–85)
Male, n (%)	13 (57)	21 (64)	2 (29)	36 (57)
ECOG PS, n (%)				
0	8 (35)	13 (39)	3 (43)	24 (38)
1	15 (65)	20 (61)	4 (57)	39 (62)
Smoking status, n (%)				
Current	5 (22)	2 (6)	0	7 (11)
Past	18 (78)	12 (36)	1 (14)	31 (49)
Never	0	19 (58)	6 (86)	25 (40)
Number of prior therapies, median (range)	3 (1–7)	3 (1–7)	4 (2–6)	3 (1–7)
Prior KRAS^{G12C} inhibitor, n (%)				
Yes	13 (57)	8 (24)	4 (57)	25 (40)
No	10 (44)	25 (76)	3 (43)	38 (60)
Time between prior KRAS^{G12C} inhibitor and RMC-6291 first dose, median (range), weeks	6 (2–86)	10 (3–31)	9 (8–128)	9 (2–128)
Prior checkpoint inhibitor within 12 weeks of RMC-6291 first dose				
Yes	9 (39)	0	1 (14)	10 (16)
No	14 (61)	32 (97)	6 (86)	52 (83)

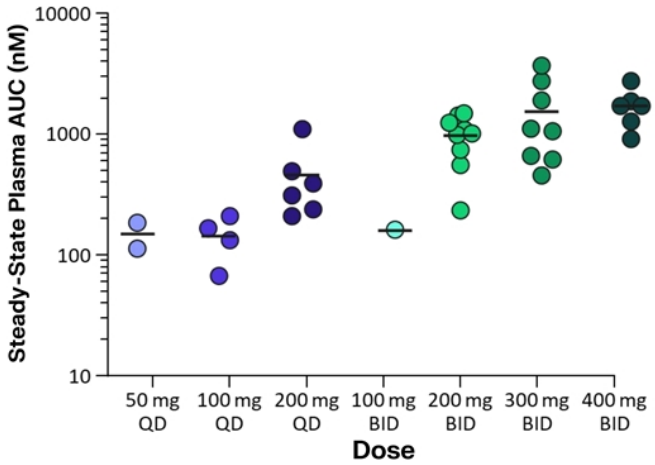
Revolution Medicines

NSCLC = non-small cell lung cancer; CRC = colorectal cancer

Data Extracted 05 October 2023.

RMC-6291: Dose-Dependent Increases in Exposure





- Exposure/target engagement relationship in preclinical studies predicts ≥ ~90% cross-linking of $KRAS^{G12C}$ in patients receiving 100 mg BID or higher

Revolution Medicines

*PK curves for 100 and 200 mg up to 10 hours post-dose represent combined QD and BID cohorts following the first dose on Cycle 1 Day 15; no accumulation observed following repeat dose of RMC-6291.
AUC=area under the curve; PK=pharmacokinetics.

Data Extracted 06 September 2023.

RMC-6291: Summary of Treatment-Related Adverse Events

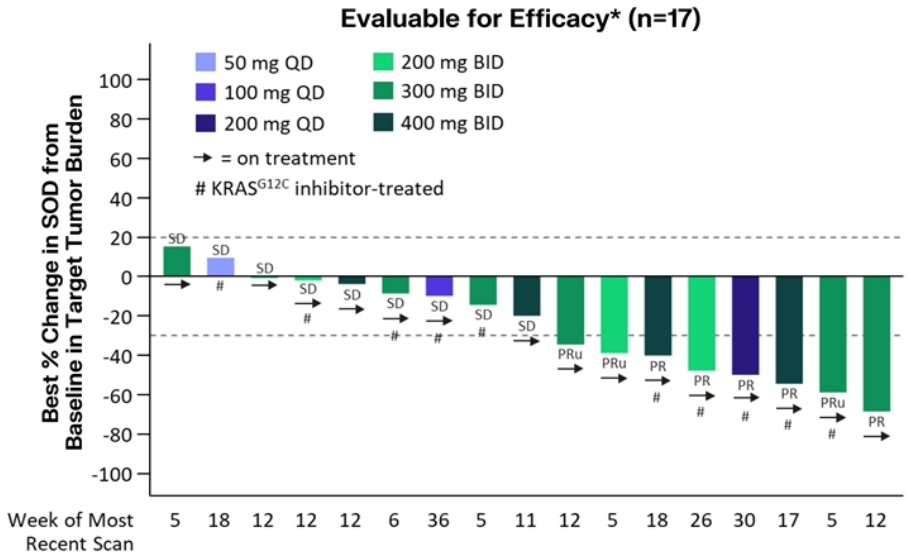
Total (n=63)				
Maximum Severity of TRAEs	**Grade 1**	**Grade 2**	**Grade 3**	**Any Grade**
TRAEs occurring in ≥10% of patients, n (%)				
Diarrhea	10 (16)	7 (11)	1 (2)	18 (29)
Nausea	14 (22)	3 (5)	0	17 (27)
ECG QT prolonged	8 (13)	1 (2)	7 (11)	16 (25)
QTcF* ≥ 501 ms	–	–	1 (2)	–
Fatigue	4 (6)	4 (6)	0	8 (13)
Vomiting	6 (10)	2 (3)	0	8 (13)
AST increased	7 (11)	0	0	7 (11)
TRAEs leading to dose reduction, n (%)	0	1 (2)	8 (13)	9 (14)
TRAEs leading to treatment discontinuation, n (%)	0	0	1 (2)	1 (2)

- No treatment-related Grade 4 or 5 AEs or SAEs have been reported.
- No patients had cardiac sequelae (e.g., torsade de pointes) associated with an ECG QT prolonged event

*QTcF refers to QT interval corrected for heart rate by Fridericia's formula.
AE, adverse event; AST, aspartate transferase; ECG, electrocardiogram; SAE, serious adverse event, TRAE, treatment-related adverse event.

Data Extracted 05 October 2023.

KRAS^{G12C} NSCLC Previously Treated with or Naïve to a KRAS^{G12C}(OFF) Inhibitor: Best Overall Response to RMC-6291



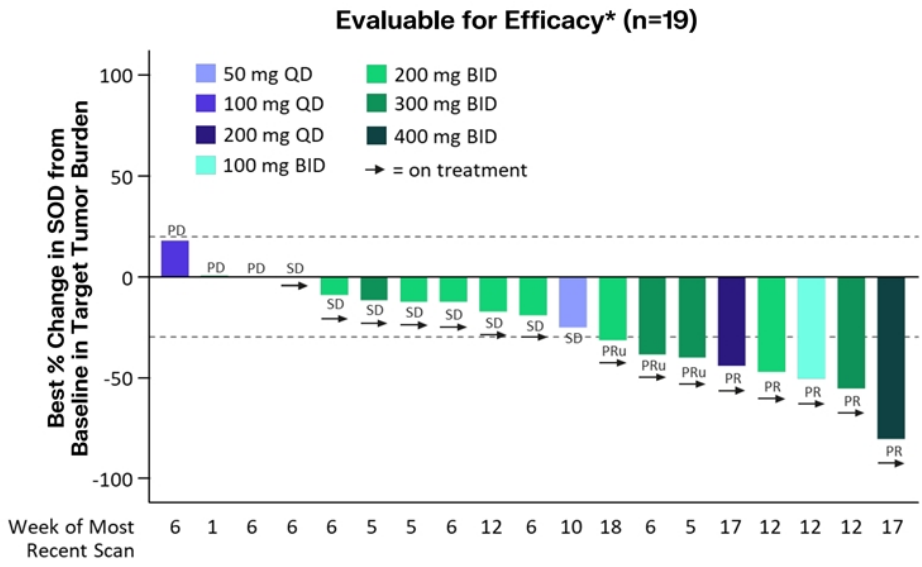
Tumor Response (per RECIST 1.1)		
Best overall response, n (%)	**Prior G12Ci (n=10)**	**Naïve to G12Ci (n=7)**
Partial response†	5 (50)	3 (43)
Stable disease	5 (50)	4 (57)
Progressive disease	0	0
ORR, n (%)	5 (50)	3 (43)
DCR (CR+PR+SD), n (%)	10 (100)	7 (100)

Revolution Medicines

*All treated patients who received a first dose of RMC-6291 at least 8 weeks prior to data extract date; †PR includes 5 confirmed and 3 unconfirmed.
CR, complete response; DCR, disease control rate; G12Ci, G12C inhibitor; PD, progressive disease; PR, partial response; PRu, unconfirmed partial response; SD, stable disease; SOD, sum of diameters; ORR objective response rate; DCR, disease control rate; RECIST, response evaluation criteria in solid tumors.

Data Extracted 05 October 2023.

KRAS^{G12C} CRC Naïve to KRAS^{G12C}(OFF) Inhibitor: Best Overall Response to RMC-6291



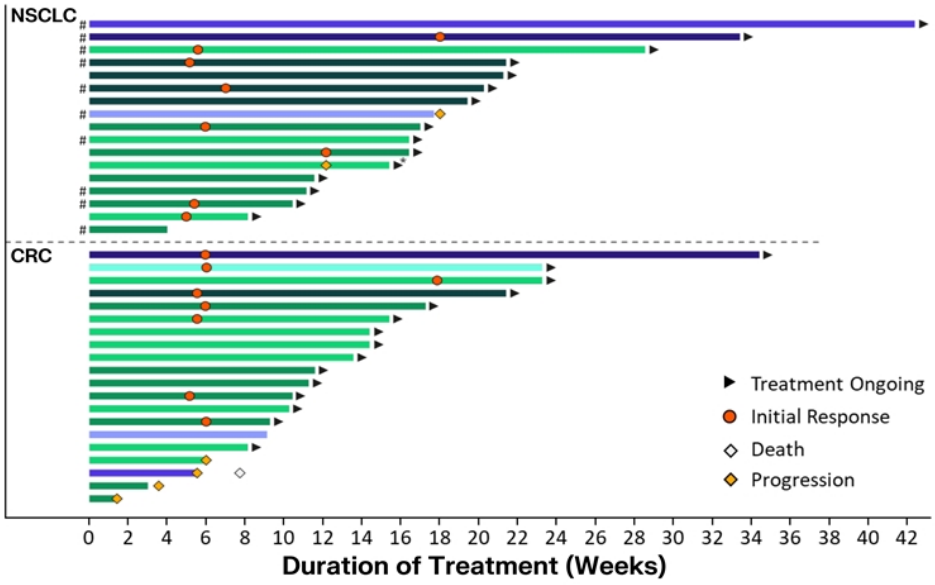
Tumor Response (per RECIST 1.1)	
Best overall response, n (%)	**n=20†**
Partial response‡	8 (40)
Stable disease	8 (40)
Progressive disease†	4 (20)
ORR, n (%)	8 (40)
DCR (CR+PR+SD), n (%)	16 (80)

Revolution Medicines

*All treated patients who received first dose of RMC-6291 at least 8 weeks prior to data extract date
†One patient had PD due to a new lesion and target lesion measurements were not available; ‡PR includes 5 confirmed and 3 unconfirmed.

Data Extracted 05 October 2023.

Duration of Treatment and Responses to RMC-6291 for KRAS^{G12C} Inhibitor-Treated or Naïve NSCLC and Naïve CRC



Median time to response: 1.3 months
(range: 1.1–4.1 months)

Median time on treatment: 3.5 months
(range: 0.3–9.8 months)

Median time to response: 1.4 months
(range: 1.2–4.1 months)

Median time on treatment: 2.4 months
(range: 0.3–7.9 months)

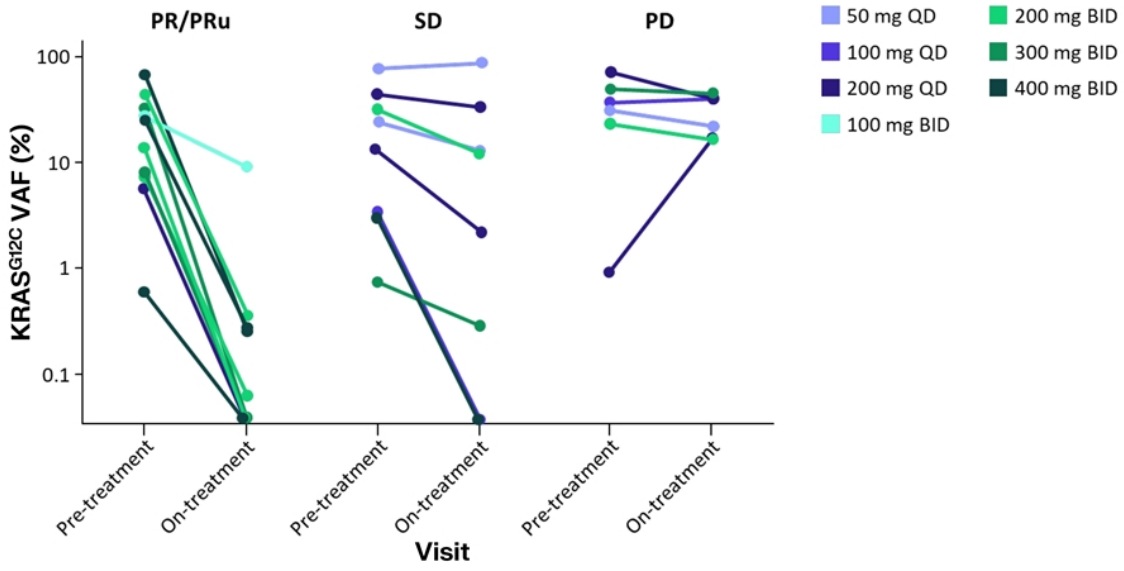
50 mg QD | 100 mg QD | 200 mg QD | 100 mg BID | 200 mg BID | 300 mg BID | 400 mg BID

Revolution Medicines

= KRAS^{G12C} inhibitor-treated; *The date of treatment discontinuation due to PD was missing as of data extract date.

Data Extracted 05 October 2023.

Reduction in ctDNA of the KRAS^{G12C} Allele Across Doses Correlates with Clinical Response

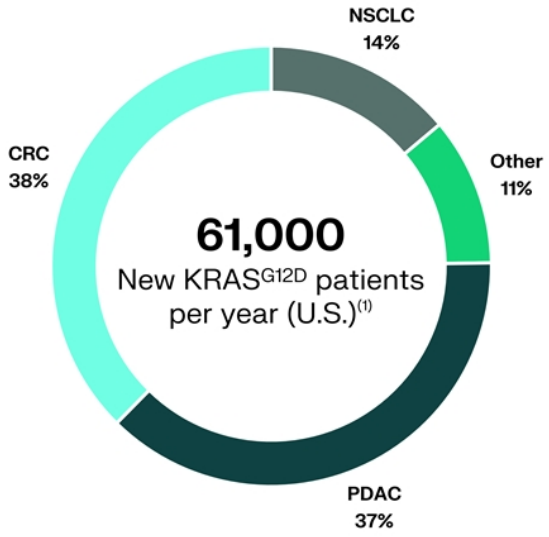


Revolution Medicines

KRAS^{G12C} VAF at Cycle 1 Day 1 (pre-treatment) to Cycle 2 Day 1 or Cycle 3 Day 1 (on-treatment) determined by Guardant Health ctDNA (circulating tumor DNA) test.
ctDNA, circulating tumor DNA; VAF, variant allele frequency.

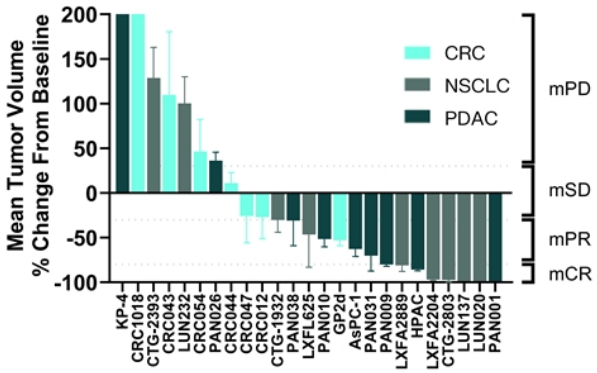
Data Extracted 05 October 2023.

RMC-9805: Clinical Stage, Mutant-Selective, Covalent RAS(ON) Inhibitor for KRAS^{G12D} Cancers



Selective Covalent Binding to KRAS^{G12D}(ON)

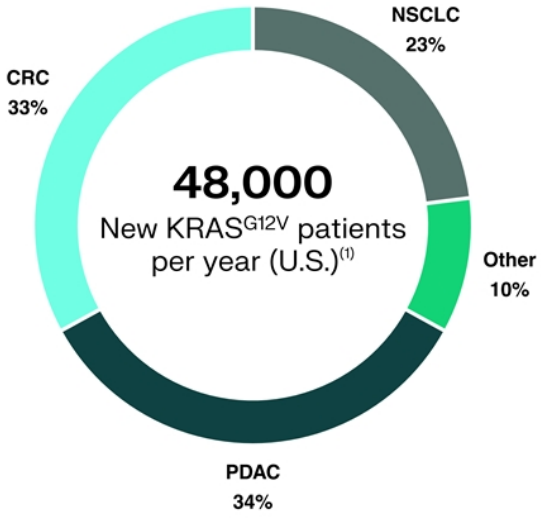
***In Vivo* Anti-Tumor Activity across KRAS^{G12D} Cancer Models**



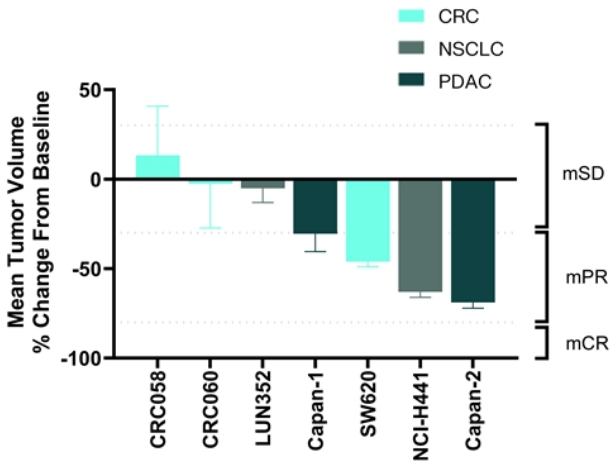
Revolution Medicines

(1) Estimated using tumor mutation frequencies from Foundation Medicine Insights March 2022 and scaled to estimated patient numbers using cancer incidence from ACS Cancer Facts and Figures 2023 (see appendix for additional detail); RVMD preclinical research as of 11/02/22; NSCLC = non-small cell lung cancer; PDAC = pancreatic ductal adenocarcinoma; CRC = colorectal cancer
RMC-9805 dosed at 100 mg/kg po qd; n=3-8/group; Responses assigned according to mRECIST: mPD = progressive disease; mSD = stable disease; mPR = partial response; mCR = complete response

RMC-5127: First-in-Class Mutant-Selective RAS(ON) Inhibitor for KRAS^{G12V} Cancers



***In Vivo* Anti-Tumor Activity across KRAS^{G12V} Cancer Models**



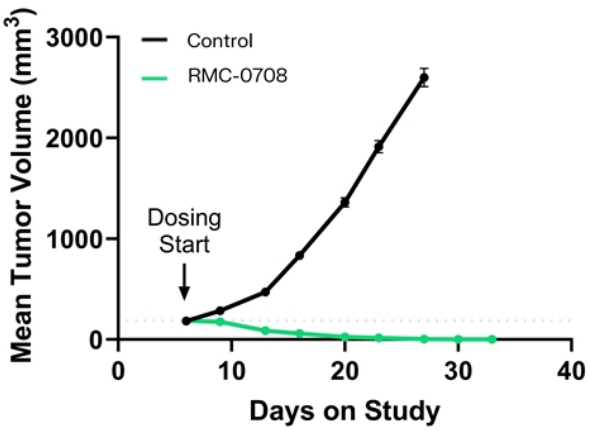
Revolution Medicines

(1) Estimated using tumor mutation frequencies from Foundation Medicine Insights March 2022 and scaled to estimated patient numbers using cancer incidence from ACS Cancer Facts and Figures 2023 (see appendix for additional detail); RVMD preclinical research as of 09/27/23; NSCLC = non-small cell lung cancer; PDAC = pancreatic ductal adenocarcinoma; CRC = colorectal cancer
RMC-5127 dosed at 100 mg/kg po qd; n=3-8/group; Responses assigned according to mRECIST: mPD = progressive disease; mSD = stable disease; mPR = partial response; mCR = complete response

First-in-Class Mutant-Selective RAS(ON) Inhibitors Targeting KRAS^{Q61H} and KRAS^{G13C} Cancers

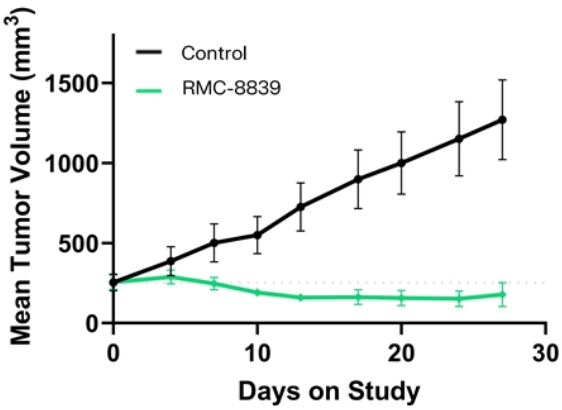
RMC-0708

KRAS^{Q61H} NSCLC(1)



RMC-8839

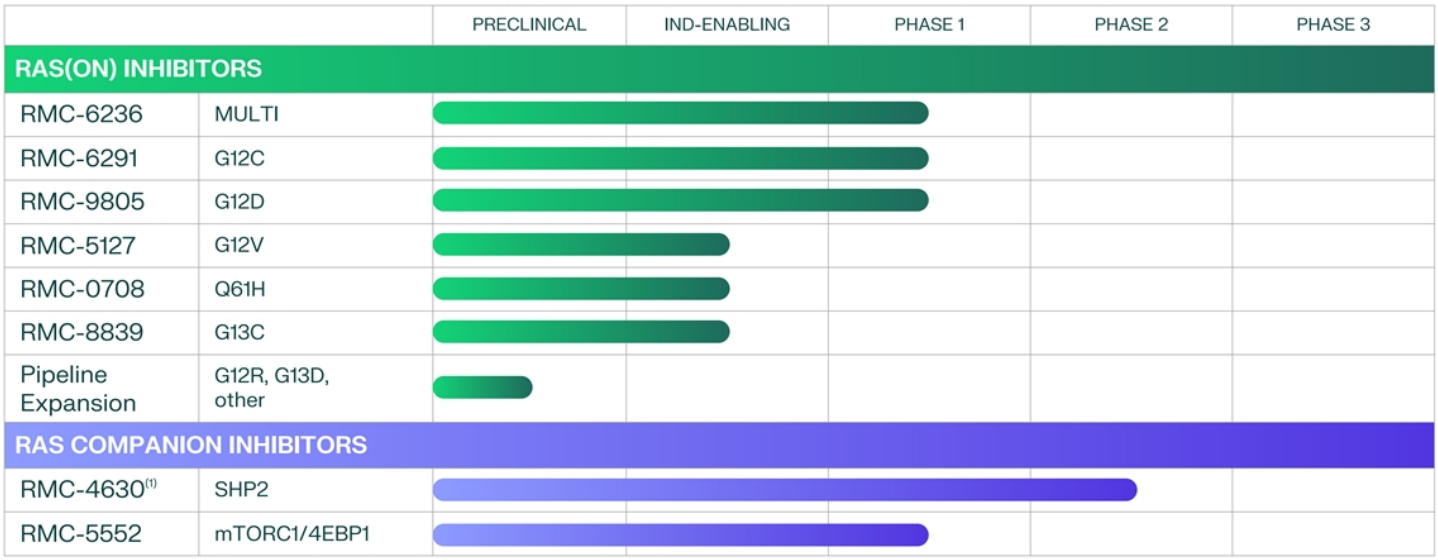
KRAS^{G13C} NSCLC(2)



Revolution Medicines

RVMD preclinical research
NSCLC = non-small cell lung cancer
(1) HCC2108 CDX (NSCLC, KRAS$^{Q61H/Q61H}$) RMC-0708 dosed at 30 mg/kg po qd
(2) ST2822B CDX (NSCLC, KRAS$^{G13C/WT}$) RMC-8839 dosed at 100 mg/kg po qd

Deep Pipeline of Targeted Therapies for Majority of RAS-Addicted Cancers



(1) Development paused subject to potential future evaluation in combination with RAS(ON) Inhibitors

Revolution Medicines

Clinical Development Vision for RMC-6236

Proven to be broadly active in patients
in multiple common tumor types and RAS genotypes

Parallel strategies to prioritize speed + breadth
including both late-stage monotherapy trial(s) and combinations

Pursuing multiple dimensions
for efficient expansion: RAS genotypes, lines of therapy, tumor types

RMC-6236 Clinical Development Plan Designed to Benefit the Greatest Number of Patients

Expand in three dimensions:

RAS Mutations	KRAS G12-mutant (G12)	→	(K/N/H) RAS-mutant (G12, G13, Q61)
Lines of Therapy	2L+ Patients with Monotherapy	→	1L / Adjuvant Patients with Monotherapy or Combinations
Tumor Types	Tumor specific ***NSCLC*** ***PDAC*** ***CRC***	→	Tissue Agnostic ***NSCLC, PDAC, CRC*** ***Other Solid Tumors***

Randomized trials with nested design and hierarchical testing

Focused exploration of RAS(ON) Inhibitor doublets, combinations with SOC, including checkpoint inhibitors and other agents

Potential conversion of RMC-6236-001 study to single-arm Phase 2 Tissue Agnostic Registration Trial

Efficacy Benchmarks from Standard of Care for Patients with Previously-Treated RAS^{MUT} NSCLC

2L+ Therapy[1]

All patients
Docetaxel
Docetaxel + ramucirumab

$KRAS^{G12C}$ only
Sotorasib (accelerated approval)
Adagrasib (accelerated approval)

Efficacy Benchmarks[2]	Docetaxel	Sotorasib
N	174	171
ORR (%)	13.2	28.1
mDOR (m)	6.8	8.6
mPFS (m)	4.5	5.6
mOS (m)	11.3	10.6

Revolution Medicines

(1) Sotorasib PDUFA date: 24 December 2023. Target assumptions to be discussed with regulatory authorities.
(2) Efficacy benchmarks for docetaxel and sotorasib taken from CodeBreaK 200, Lancet (2023) 401: 733-746.

Proposed Global Randomized Phase 3 Trial in Patients with Previously-Treated RAS^{MUT} NSCLC

Trial Design[1]

R

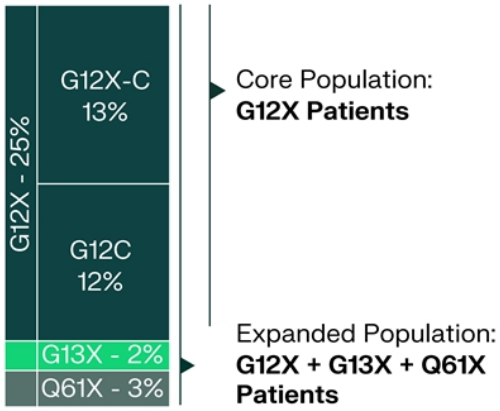
- RMC-6236
- Docetaxel

Endpoints

PFS
OS
Patient Reported Outcomes

- **N** > 400 patients
- **Prior therapies**: Anti-PD-(L)1 and platinum-containing regimen in metastatic setting; RAS inhibitor naïve (including G12C inhibitor)
- **Biomarker**: RAS G12X, G13X, or Q61X mutation
- **Study Initiation**: Aiming for 2024

Potential Patient Populations[1,2]



- Potential for nested trial design to enable evaluation of core and expanded patient populations[1]

Revolution Medicines

R = Randomized
(1) Study design subject to change based on regulatory authority feedback
(2) Percentages of all NSCLC patients with tumors bearing RAS G12X, G13X, or Q61X genotypes; estimated using tumor mutation frequencies from Foundation Medicine Insights March 2022 and scaled to estimated patient numbers using cancer incidence from ACS Cancer Facts and Figures 2023 (see appendix for additional detail);

Efficacy Benchmarks from Standard of Care in Patients with Previously-Treated PDAC

2L+ Therapy[1]

FOLFIRINOX
mFOLFIRINOX
Gemcitabine+nab-Paclitaxel (GnP)
FOLFOX
FOLFIRI

post-GnP only
liposomal irinotecan + 5-FU

Efficacy Benchmarks[2]	lipo-irino + 5-FU	GnP
ORR (%)	7.7	11
mPFS (m)	3.1	3.5
mOS (m)	6.1	7.1

Revolution Medicines

(1) No clearly established standard of care.
(2) Efficacy benchmarks for lipo-irino+5-FU taken from Lancet (2016) 387: 545-557; GnP taken from Br J Cancer (2022) 126:1394-1400.

Potential Global Randomized Phase 3 Trial of RMC-6236 in Patients with Previously-Treated PDAC

Trial Design[1]

R

RMC-6236

Physician's choice: e.g., GnP or mFOLFIRINOX

Endpoints

PFS
OS
Patient Reported Outcomes

- **N** > 500 patients
- **Prior therapies**: fluoropyrimidine or gemcitabine-based regimen; RAS inhibitor naïve (including G12C inhibitor)
- **Biomarker**: All comers, RAS mutation testing (G12X, G13X, or Q61X) to allow stratification
- **Study Initiation**: Potentially in 2024

Potential Patient Populations[1,2]

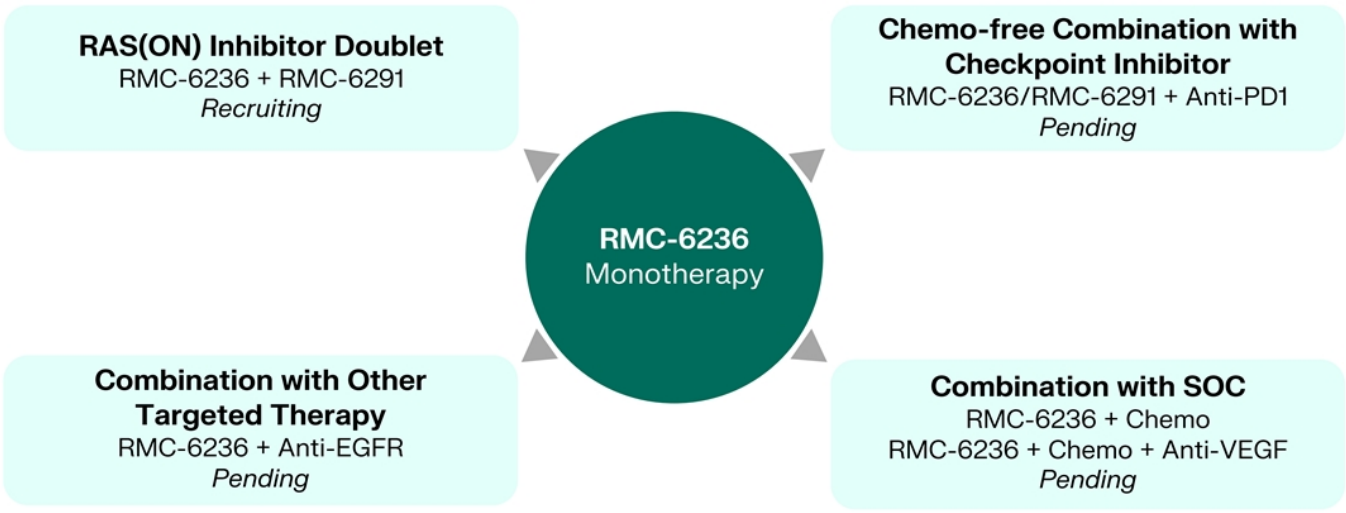
Core Population:
G12X Patients

Expanded Populations:
- **G12X + G13X + Q61X patients**
- **All PDAC patients**

- Potential for nested trial design to enable evaluation of core and expanded patient populations[1]

R = Randomized; WT=wild-type
(1) Study design subject to change based on regulatory authority feedback
(2) Percentages of all PDAC patients with tumors bearing RAS G12X, G13X, Q61X or WT genotypes; estimated using tumor mutation frequencies from Foundation Medicine Insights March 2022 and scaled to estimated patient numbers using cancer incidence from ACS Cancer Facts and Figures 2023 (see appendix for additional detail);

Parallel Execution of Multiple Approaches to Expand from Monotherapy to Combinations



First Two RAS(ON) Inhibitors Clinically Validated Against RAS^{G12X} Cancer Drivers and Major Tumor Types

Validated - RAS^{G12X}

- 150,000 new patients per year among PDAC, NSCLC and CRC[1,2]

Expansion – additional tumor types and RAS^{G13X} + RAS^{Q61X}

- > 200,000 new patients combined across RAS genotypes and tumor types broadly[1]

Revolution Medicines

(1) New RAS^{MUT} patients per year (U.S.) estimated using tumor mutation frequencies from Foundation Medicine Insights March 2022 and scaled to estimated patient numbers using cancer incidence from ACS Cancer Facts and Figures 2023 (see appendix for additional detail); *G13X < 1000 new PDAC patients per year (U.S.)
(2) G12X genotypes validated based on clinical data from RMC-6236-001 (data extracted 12 Oct 2023) and RMC-6291-001 (data extracted 05 October 2023)

Financial Information

Financial Position	
Cash, cash equivalents and marketable securities as of June 30, 2023	$909.5 million[1]

2023 Financial Guidance
2023 GAAP net loss of $360 million to $400 million[2]

(1) With current cash, cash equivalents and marketable securities, the company projects it can fund planned operations into 2025
(2) Includes non-cash stock-based compensation expense of approximately $40 million to $50 million
Financial guidance does not include impact of proposed EQRx acquisition

Summary of Pending EQRx Transaction

- RVMD to acquire EQRx in an all-stock transaction to gain more than $1B in additional capital
- Strengthened balance sheet intended to support RVMD's parallel, late-stage development for RAS(ON) Inhibitor pipeline
- Shareholder meeting to vote on the transaction scheduled for November 8, 2023 at 11:00am Eastern time
- Deal expected to close shortly following shareholder vote, subject to satisfaction of customary closing conditions
- Stock exchange ratio to be determined using a blended average share price to account for developments in our business and potential movement in RVMD share price
  - ~20% based on a determined RVMD share price at signing
  - ~80% based on RVMD share price as determined in close proximity to shareholder vote (subject to 6% discount)
- RVMD to continue focus on mission to revolutionize treatment for patients with RAS-addicted cancers through the discovery, development and delivery of innovative, targeted medicines

On Target to Outsmart Cancer™

Appendix

- All RAS cancer epidemiology statistics are estimated using tumor mutation frequencies from Foundation Medicine Insights March 2022 and scaled to estimated patient numbers using cancer incidence from ACS Cancer Facts and Figures 2023:
  - RAS mutations include: KRAS G12(A,C,D,F,L,R,S,V), KRAS G13(C,D,R,V), KRAS Q61(E,H,K,L,P,R) NRAS G12(A,C,D,R,S,V), NRAS G13(C,D,R,V), NRAS Q61(H,K,L,R), HRASG12(C,D,S,V), HRASG13(C,D,N,R,S,V), HRASQ61(K,L,R).
  - Includes 13 major solid cancer types: non-small cell lung cancer, colorectal, pancreatic ductal adenocarcinoma, renal, esophageal, head and neck squamous cell, ovarian, stomach, biliary, and carcinomas of unknown primary (CUP), and advanced melanoma, bladder and endometrial cancers causing mortality.
    - KRASQ61H epidemiology statistics include multiple myeloma in addition to 13 major solid cancer types named above

- RAS mutations drive 30% of human cancers per Prior et al., *Cancer Research* 2020

- Mouse tumor responses assigned according to mRECIST (modified from Gao et al. Nat Med. 2015):
  - mPD = progressive disease; mSD = stable disease; mPR = partial response; mCR = complete response