

Generic Name: Belumosudil

Preferred: N/A

Therapeutic Class or Brand Name: Rezurock®

Non-preferred: N/A

Applicable Drugs (if Therapeutic Class): N/A

Date of Origin: 9/8/2025

Date Last Reviewed / Revised: 9/8/2025

PRIOR AUTHORIZATION CRITERIA

(May be considered medically necessary when criteria I through IV are met)

- I. Documented diagnosis of chronic graft-versus-host disease (cGVHD) and all the following criteria are met:
 - A. Documented treatment failure of at least two lines of systemic therapy (eg, corticosteroids, tacrolimus, mycophenolate mofetil, etc.).
 - B. Minimum age requirement: 12 years old.
- II. Treatment must be prescribed by or in consultation with an oncologist or a hematologist.
- III. Request is for a medication with the appropriate FDA labeling and dosage, or its use is supported by current clinical practice guidelines.
- IV. Refer to the plan document for the list of preferred products. If the requested agent is not listed as a preferred product, must have a documented failure, intolerance, or contraindication to a preferred product(s).

EXCLUSION CRITERIA

- Moderate (Child-Pugh B) or severe (Child-Pugh C) hepatic impairment.
- Concurrent use of Jakafi, Imbruvica, or Niktimvo.

OTHER CRITERIA

- N/A

QUANTITY / DAYS SUPPLY RESTRICTIONS

- 30 tablets per 30 days.

APPROVAL LENGTH

- **Authorization:** 12 months.
- **Re-Authorization Length and Renewal Criteria:** 12 months. An updated letter of medical necessity or progress notes showing current medical necessity criteria are met and that the medication is effective.

APPENDIX

N/A

REFERENCES

1. Rezurock. Prescribing information. Kadmon Pharmaceuticals; 2025. Accessed August 17, 2025. <https://products.sanofi.us/rezurock/rezurock.pdf>
2. Cutler C, Lee SJ, Arai S, et al. Belumosudil for Chronic Graft-Versus-Host Disease after 2 or More Prior Lines of Therapy: The ROCKstar Study. *Blood*. 2021;138(22):2278-2289. doi:10.1182/blood.2021012021
3. NCCN Clinical Practice Guidelines in Oncology. Hematopoietic Cell Transplantation. Version 2.2025. Updated June 3, 2025. Accessed August 17, 2025. https://www.nccn.org/professionals/physician_gls/pdf/hct.pdf

DISCLAIMER: Medication Policies are developed to help ensure safe, effective and appropriate use of selected medications. They offer a guide to coverage and are not intended to dictate to providers how to practice medicine. Refer to Plan for individual adoption of specific Medication Policies. Providers are expected to exercise their medical judgement in providing the most appropriate care for their patients.