Louisiana Medicaid
Belumosudil (Rezurock™)

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for belumosudil (Rezurock™).

Additional Point-of-Sale edits may apply.

*This agent may have a **Black Box Warning** and may be subject to **Risk Evaluation and Mitigation Strategy (REMS)** under FDA safety regulations. Please refer to individual prescribing information for details.*

Approval Criteria

- The recipient is 12 years of age or older on the date of the request; **AND**
- The recipient is post-allogeneic hematopoietic cell transplant (HCT), and this is **stated on the request**; **AND**
- The recipient has a diagnosis of chronic graft-versus-host disease (chronic GVHD); **AND**
- The recipient failed treatment with at least **TWO** prior lines of systemic therapy for the treatment of chronic GVHD (e.g., corticosteroids, calcineurin inhibitors, ibrutinib, MMF, methotrexate, rituximab) (**Medication names and dates must be stated on the request**); **AND**
- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a hematologist or oncologist; **AND**
- By submitting the authorization request, the prescriber attests to the following:
    - The recipient does not have histologic relapse of underlying cancer or post-transplant lymphoproliferative disease; **AND**
    - Belumosudil will not be used in combination with ibrutinib; **AND**
    - The prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements; **AND**
    - All laboratory testing and clinical monitoring recommended in the prescribing information have been completed as of the date of the request and will be repeated as recommended; **AND**
    - The recipient has no concomitant drug therapies or disease states that limit the use of the requested medication and will not be receiving the requested medication in combination with any other medication that is contraindicated or not recommended per FDA labeling.

Reauthorization Criteria

- The recipient continues to meet initial criteria; **AND**
- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy.

Duration of initial and reauthorization approval: 6 months

Reference

Rezurock (belumosudil) [package insert]. Warrendale, PA: Kadmon Pharmaceuticals; July 2021. https://rezurockhcp.com/full-prescribing-information.pdf

Saidu NEB, Bonini C, Dickinson A, Grce M, Inngjerdingen M, Koehl U, Toubert A, Zeiser R and Galimberti S (2020) New Approaches for the Treatment of Chronic Graft-Versus-Host Disease: Current Status and Future Directions. Front. Immunol. 11:578314. doi: 10.3389/fimmu.2020.578314

Revision / Date	**Implementation Date**
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