JOHNS HOPKINS MEDICINE JOHNS HOPKINS HEALTHCARE	Johns Hopkins HealthCare LLC **Pharmacy Public** **Pharmacy Management Drug Policies**	*Policy Number*	MEDS136
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	Subject **Rezurock**	*Revision Date*	10/20/2021
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This document applies to the following Participating Organizations:

Priority Partners

Keywords: Rezurock

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I. POLICY

Rezurock (belumosudil) will require prior authorization to ensure appropriate use. The process for initiating a prior authorization request can be found in policy PHARM 20.

1. PPMCO members are subject to the Priority Partners formulary, available at www.ppmco.org.
2. USFHP members are subject to prior authorization criteria, step-edits and days-supply limits outlined in the Tricare Policy Manual. Tricare Policy supersedes JHHC Medical/Pharmacy Policies. Tricare limits may be accessed at: http://pec.ha.osd.mil/formulary_search.php?submenuheader=1

II. POLICY CRITERIA

A. **Rezurock** may be approved for patients meeting all the following:
   1. Patient is 12 years of age or older
   2. Documented diagnosis of chronic graft-versus-host disease (cGVHD)
   3. Documentation of the following:
      a. Patient has had allogenic hematopoietic cell transplant (HCT)
      b. There is evidence of persistent cGVHD manifestations (skin changes, gastrointestinal effects, lung involvement. etc.)
      c. Patient is on a stable dose of glucocorticoid therapy
      d. Patient has had trial and inadequate response with at least two prior lines of systemic therapy
      e. Patient has had trial and failure with Imbruvica, or has a medical reason why Imbruvica cannot be tried
      f. Additional caveat requirement:
         1. Evidence of a negative pregnancy test in female patients of child bearing potential
   4. Prescriber is, or has consulted with, a transplant specialist, oncologist, or hematologist

III. AUTHORIZATION PERIOD/LIMITATIONS

A. Initial therapy may be approved for 6 months
B. Continuation of therapy may be approved in 12-month intervals with documentation showing all of the following:
   1. No evidence of disease progression

2. Patient has achieved or maintained at least a 7-point reduction in Lee Chronic Graft-versus-Host Symptom Scale Score

IV. EXCLUSIONS

A. Rezurock will not be approved for the following:
   1. Patients that are less than 12 years of age
   2. Any indications or uses that are not FDA-approved, or guideline-supported

B. The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.

V. REFERENCES

1. Rezurock [prescribing information]. Warrendale, PA: Kadmon Pharmaceuticals LLC; July 2021.
2. Cutler CS, Lee SJ, Arai S, et al. Belumosudil for chronic graft-versus-host disease (cGVHD) after 2 or more prior lines of therapy: the ROCKstar study. Blood. Published online July 15, 2021. doi:10.1182/blood.2021012021.
3. Chao NJ. Clinical manifestations, diagnosis, and grading of chronic graft-versus-host disease. In: UpToDate, Negrin RS, Rosmarin AG (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Accessed on September 17, 2021.
4. Chao NJ, Zeiser R. Treatment of chronic graft-versus-host disease. In: UpToDate, Negrin RS, Rosmarin AG (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Accessed on September 17, 2021.

VI. APPROVALS

Signature on file at JHHC

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