RxAdvance

0Clinical Policy Title:	belumosudil
Policy Number:	RxA.700
Drug(s) Applied:	Rezurock®
Original Policy Date:	08/19/2021
Last Review Date:	08/28/2024
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. **Initial Approval Criteria**
   A. **Chronic Graft-Versus-Host Disease (cGvHD)** (must meet all):
      1. Diagnosis of cGvHD;
      2. Trial and failure of at least two (2) systemic therapies (e.g. corticosteroids, immunosuppressants) unless contraindicated or clinically significant adverse effects are experienced.

      Approval Duration
      All Lines of Business (except Medicare): 12 months

II. **Continued Therapy Approval**
   A. **Chronic Graft-Versus-Host Disease** (must meet all):
      1. Auto-approval based on lookback functionality within the past 120 days as a proxy for member responding positively to therapy.

      Approval Duration
      All Lines of Business (except Medicare): 12 months

References

1. National Comprehensive Cancer Network. Hematopoietic Cell Transplantation. Version 1.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/hct.pdf. Accessed August 28, 2024.

Review/Revision History	Review/Revision Date	P&T Approval Date
Policy established.	08/19/2021	09/14/2021
Policy was reviewed: 1. Initial Approval Criteria, I.A.5: Updated trial and failure criteria from Trial and failure of at least two (2) systemic therapies (e.g. corticosteroids, immunosuppressants, alemtuzumab, dacluzimab, infliximab, antithymocyte globulin, Mesenchymal stem cells, pentostatin) at up to maximally indicated doses unless contraindicated or clinically significant adverse effects are experienced to Trial and failure of at least two (2) systemic therapies (e.g.	06/27/2022	07/18/2022

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

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corticosteroids, immunosuppressants) at up to maximally indicated doses unless contraindicated or clinically significant adverse effects are experienced. 2. Initial Approval Criteria, I.A.6: Updated to include new combination therapy criteria Rezurock™ is not prescribed concurrently with Imbruvica® or Jakafi®. 3. Continued Therapy Approval Criteria, II.A.3: Updated to include new combination therapy criteria Rezurock™ is not prescribed concurrently with Imbruvica® or Jakafi®. 4. References were reviewed and updated.		
Policy was reviewed: 1. Initial Approval Criteria I.A.2: Updated to add provider criteria as physician experienced in the management of transplant patients. 2. Initial Approval Criteria I.A.4: Updated to remove that member has a history of bone marrow/stem cell transplant. 3. Initial Approval Criteria, Approval Duration for both commercial and Medicaid updated from 6 months to 12 months. 4. Initial Approval Criteria, I.A.6 and II.A.3: Updated to remove that Rezurock™ is not prescribed concurrently with Imbruvica® or Jakafi®. 1. References were reviewed and updated.	05/30/2023	07/13/2023
Policy was reviewed.	10/19/2023	10/19/2023
Policy was reviewed: 1. Removed age restrictions. 2. Removed prescriber restrictions. 3. Removed dose restrictions. 4. Updated Continued therapy approval with auto-approval based on lookback functionality within the past 120 days. 5. Removed other reauthorization requirements including positive response to therapy. 6. Updated approval duration verbiage. 7. References were reviewed and updated.	08/28/2024	09/13/2024

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