AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Rezurock™ (belumosudil)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

Recommended Dose: 200 mg given orally once daily until progression of Chronic Graft vs. Host Disease (cGVHD) that requires new systemic therapy

Quantity Limits: 30 tablets per 30 days

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 6 months

- ❑ Member is at least 12 years of age or older
- ❑ Provider is an oncologist/hematologist
- ❑ The requested medication is being used for disease related to allogeneic hematopoietic stem cell transplantation
- ❑ Member does **NOT** have histologic relapse of underlying cancer or post-transplant lymphoproliferative disease

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- ❑ Member has failed two or more previous lines of systemic therapy for the treatment of cGVHD (e.g., corticosteroids, immunosuppressants) **(verified by pharmacy paid claims)**
- ❑ Therapy will be used in combination with stable doses of systemic therapies for cGVHD which must include, but are not limited to, corticosteroids, calcineurin inhibitors [cyclosporine; tacrolimus], sirolimus, mycophenolate mofetil, methotrexate, rituximab **(verified by pharmacy paid claims)**
- ❑ Provider has submitted progress notes and/or clinical assessment documenting the symptomology and staging/severity of cGVHD (i.e. NIH Global Severity Score, NIH Organ-specific Score)

Reauthorization Approval: 6 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member has experienced a positive treatment response as evidenced by stabilization or improvement in disease
- ❑ Provider has submitted recent progress notes and/or clinical assessment recording the response in symptomology and staging/severity of cGVHD (i.e. NIH Global Severity Score, or NIH Organ-specific Score)
- ❑ Member is **NOT** experiencing any unacceptable toxicity from Rezurock™ therapy (e.g., grade 4 hepatotoxicity, elevated blood pressure or pneumonia requiring discontinuation)

Medication being provided by Specialty Pharmacy - PropriumRx

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

*****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee**: 11/12/2021
REVISED/REFORMATTED/UPDATED: ~~12/13/2021; 12/23/2021;~~ **10/30/2023**