Cigna National Formulary Coverage Policy

Prior Authorization
Immunosuppressive Agents – Rezurock™ (belumosudil tablets)

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Product Identifier(s) 79778

INSTRUCTIONS FOR USE
The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer’s particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer’s benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer’s benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

National Formulary Medical Necessity

Cigna covers belumosudil tablets (Rezurock™) as medically necessary when the following criteria are met for FDA Indications or Other Uses with Supportive Evidence:

Prior Authorization is recommended for prescription benefit coverage of Rezurock. All approvals are provided for the duration noted below.

FDA Indication(s)

1. Graft-Versus-Host Disease. Approve for 1 year if the individual meets the following criteria (A, B, and C):
   A) Individual is ≥ 12 years of age; AND
   B) Individual has chronic graft-versus-host disease; AND
   C) Individual has tried at least two conventional systemic treatments for chronic graft-versus-host disease.
   Note: Examples of systemic therapy may include methylprednisolone, Imbruvica® (ibrutinib capsules and tablets), cyclosporine, tacrolimus, sirolimus, mycophenolate mofetil, imatinib.

Conditions Not Covered
Belumosudil (Rezurock) is considered experimental, investigational or unproven for ANY other use.

**Background**

**Overview**
Rezurock, a kinase inhibitor, is indicated for the treatment of patients ≥ 12 years of age with chronic graft-versus-host disease (GVHD) after failure of at least two prior lines of systemic therapy.1

**Guidelines**
The National Comprehensive Cancer Network (NCCN) Hematopoietic Cell Transplantation (version 3.2021 – July 26, 2021) guidelines recommend Rezurock for chronic GVHD as additional therapy in conjunction with systemic corticosteroids following failure (steroid-refractory disease) to ≥ two prior lines of systemic therapy.2,3

**References**

**Revision History**

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<th>Type of Revision</th>
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<tbody>
<tr>
<td>New Policy</td>
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