Belumosudil

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Related Coverage Resources

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.

Overview

This policy supports medical necessity review for Rezurock™ (belumosudil).

Medical Necessity Criteria

Belumosudil (Rezurock) is considered medically necessary when the following are met:

1. **Graft-Versus-Host Disease.** Individual meets ALL of the following criteria (A, B and C):
   A. Individual is 12 years of age or older
   B. Documented diagnosis of chronic graft-versus-host disease
   C. Documentation of ONE of the following (i or ii):
      i. Individual has had an inadequate response to at least TWO conventional systemic treatments for chronic graft-versus-host disease (for example, methylprednisolone, Imbruvica® [ibrutinib], cyclosporine, tacrolimus, sirolimus, mycophenolate mofetil, imatinib)
ii. Individual has a contraindication per FDA label, significant intolerance, or is not a candidate* for ALL conventional systemic treatments for chronic graft-versus-host disease (for example, methylprednisolone, Imbruvica® [ibrutinib], cyclosporine, tacrolimus, sirolimus, mycophenolate mofetil and imatinib)

*Note: Not a candidate due to being subject to a warning per the prescribing information (labeling), having a disease characteristic, individual clinical factor[s], or other attributes/conditions or is unable to administer and requires this dosage formulation

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Note: Receipt of sample product does not satisfy any criteria requirements for coverage.

**Reauthorization Criteria**

Belumosudil (Rezurock) is considered medically necessary for continued use when initial criteria are met AND there is documentation of beneficial response.

**Authorization Duration**

Initial and reauthorization approval duration is up to 12 months.

**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**