



Rezurock Prior Authorization with Quantity Limit Program Summary

POLICY REVIEW CYCLE

Effective Date
03-15-2026

Date of Origin
05-18-2023

POLICY AGENT SUMMARY PRIOR AUTHORIZATION

| Target Brand Agent(s) | Target Generic Agent(s) | Strength | Targeted MSC | Available MSC | Final Age Limit | Preferred Status |
|-----------------------|--------------------------|----------|---------------|---------------|-----------------|------------------|
| Rezurock | belumosudil mesylate tab | 200 MG | M ; N ; O ; Y | N | | |

POLICY AGENT SUMMARY QUANTITY LIMIT

| Target Brand Agent Name(s) | Target Generic Agent Name(s) | Strength | QL Amount | Dose Form | Day Supply | Duration | Addtl QL Info | Allowed Exceptions | Targeted NDCs When Exclusions Exist |
|----------------------------|------------------------------|----------|-----------|-----------|------------|----------|---------------|--------------------|-------------------------------------|
| Rezurock | Belumosudil Mesylate Tab | 200 MG | 60 | Tablets | 30 | DAYS | | | |

CLIENT SUMMARY – PRIOR AUTHORIZATION

| Target Brand Agent Name(s) | Target Generic Agent Name(s) | Strength | Client Formulary |
|----------------------------|------------------------------|----------|---|
| Rezurock | belumosudil mesylate tab | 200 MG | Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL HMO Performance Quarterly ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods |

CLIENT SUMMARY – QUANTITY LIMITS

| Target Brand Agent Name(s) | Target Generic Agent Name(s) | Strength | Client Formulary |
|----------------------------|------------------------------|----------|---|
| Rezurock | Belumosudil Mesylate Tab | 200 MG | Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Quarterly 2025 ; HIM |

| Target Brand Agent Name(s) | Target Generic Agent Name(s) | Strength | Client Formulary |
|----------------------------|------------------------------|----------|---|
| | | | Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL HMO Performance Quarterly ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods |

PRIOR AUTHORIZATION CLINICAL CRITERIA FOR APPROVAL

| Module | Clinical Criteria for Approval | | |
|---|---|---|----------|
| | <p>Initial Evaluation</p> <p>Target Agent(s) will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> 1. ONE of the following: <ol style="list-style-type: none"> A. The requested agent is eligible for continuation of therapy AND the following: <div data-bbox="474 982 1172 1062" data-label="Table"> <table border="1"> <thead> <tr> <th>Agents Eligible for Continuation of Therapy</th> </tr> </thead> <tbody> <tr> <td>Rezurock</td> </tr> </tbody> </table> </div> 1. The prescriber states the patient has been treated with the requested agent (starting on samples is not approvable) within the past 90 days AND is at risk if therapy is changed OR B. BOTH of the following: <ol style="list-style-type: none"> 1. The patient has chronic graft-versus-host disease (chronic GVHD) AND 2. The patient has failed at least two prior lines of systemic therapy AND 2. If the patient has an FDA labeled indication, then ONE of the following: <ol style="list-style-type: none"> A. The patient's age is within FDA labeling for the requested indication for the requested agent OR B. There is support for using the requested agent for the patient's age for the requested indication AND 3. The prescriber is a specialist in the area of the patient's diagnosis (e.g., hematologist, oncologist), or the prescriber has consulted with a specialist in the area of the patient's diagnosis AND 4. The patient does NOT have any FDA labeled contraindications to therapy with the requested agent <p>Length of Approval:</p> <p>BCBSOK: 36 months</p> <p>ALL other plans: 12 months</p> <p>Note: If Quantity Limit applies, please refer to Quantity Limit criteria.</p> <p>The requested agent will also be approved when the following are met:</p> | Agents Eligible for Continuation of Therapy | Rezurock |
| Agents Eligible for Continuation of Therapy | | | |
| Rezurock | | | |

| Module | Clinical Criteria for Approval |
|--------|--|
| | <ol style="list-style-type: none"> 1. The member resides in Ohio AND 2. The plan is Fully Insured or HIM Shop (SG) AND BOTH of the following <ol style="list-style-type: none"> A. The patient does NOT have any FDA labeled contraindications to the requested agent AND B. ONE of the following: <ol style="list-style-type: none"> 1. The patient has another FDA labeled indication for the requested agent and route of administration OR 2. The patient has another indication that is supported in compendia for the requested agent and route of administration OR 3. The prescriber has submitted TWO articles from major peer-reviewed professional medical journals [e.g., Journal of American Medical Association (JAMA), New England Journal of Medicine (NEJM), Lancet] supporting the proposed use(s) as generally safe and effective. Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. NOTE: Case studies are not acceptable [journal articles required] <p>Non-oncology compendia allowed: DrugDex level 1, 2A or 2B, AHFS-DI (narrative text must be supportive)</p> <p>Oncology compendia allowed: NCCN 1 or 2A, AHFS-DI (narrative text must be supportive), DrugDex level 1, 2A, or 2B, or Clinical Pharmacology (narrative text must be supportive), Lexi-Drugs evidence level A, peer-reviewed medical literature</p> <p>Length of Approval:</p> <p>BCBSOK: 36 months</p> <p>ALL other plans: 12 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria</p> <p>Renewal Evaluation</p> <p>Target Agent(s) will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> 1. The patient has been previously approved for the requested agent through the plan's Prior Authorization Review process (Note: patients not previously approved for the requested agent will require initial evaluation review) AND 2. The patient has had clinical benefit with the requested agent AND 3. The prescriber is a specialist in the area of the patient's diagnosis (e.g., hematologist, oncologist), or the prescriber has consulted with a specialist in the area of the patient's diagnosis AND 4. The patient does NOT have any FDA labeled contraindications to the requested agent <p>Length of Approval:</p> <p>BCBSOK: 36 months</p> <p>ALL other plans: 12 months</p> <p>Note: If Quantity Limit applies, please refer to Quantity Limit criteria.</p> |

QUANTITY LIMIT CLINICAL CRITERIA FOR APPROVAL

| Module | Clinical Criteria for Approval |
|--------|--|
| | <p>Quantity Limit for the Target Agent(s) will be approved when ONE of the following is met:</p> <ol style="list-style-type: none"> 1. The requested quantity (dose) does NOT exceed the program quantity limit OR 2. The requested quantity (dose) exceeds the program quantity limit AND ONE of the following: <ol style="list-style-type: none"> A. BOTH of the following: <ol style="list-style-type: none"> 1. The requested agent does NOT have a maximum FDA labeled dose for the requested indication AND 2. There is support for therapy with a higher dose for the requested indication OR B. BOTH of the following: <ol style="list-style-type: none"> 1. The requested quantity (dose) does NOT exceed the maximum FDA labeled dose for the requested indication AND 2. There is support for why the requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does NOT exceed the program quantity limit OR C. BOTH of the following: <ol style="list-style-type: none"> 1. The requested quantity (dose) exceeds the maximum FDA labeled dose of the requested indication AND 2. There is support for therapy with a higher dose for the requested indication <p>Length of Approval: 12 months</p> |