

PHARMACY COVERAGE GUIDELINE

REZUROCK™ (belumosudil) oral Generic Equivalent (if available)

This Pharmacy Coverage Guideline (PCG):

- Provides information about the reasons, basis, and information sources we use for coverage decisions
- Is not an opinion that a drug (collectively “Service”) is clinically appropriate or inappropriate for a patient
- Is not a substitute for a provider’s judgment (Provider and patient are responsible for all decisions about appropriateness of care)
- Is subject to all provisions e.g. (benefit coverage, limits, and exclusions) in the member’s benefit plan; and
- Is subject to change as new information becomes available.

Scope

- This PCG applies to Commercial and Marketplace plans
- This PCG does not apply to the Federal Employee Program, Medicare Advantage, Medicaid or members of out-of-state Blue Cross and/or Blue Shield Plans

Instructions & Guidance

- To determine whether a member is eligible for the Service, read the entire PCG.
 - This PCG is used for FDA approved indications including, but not limited to, a diagnosis and/or treatment with dosing, frequency, and duration.
 - Use of a drug outside the FDA approved guidelines, refer to the appropriate Off-Label Use policy.
 - The “Criteria” section outlines the factors and information we use to decide if the Service is medically necessary as defined in the Member’s benefit plan.
 - The “Description” section describes the Service.
 - The “Definition” section defines certain words, terms or items within the policy and may include tables and charts.
 - The “Resources” section lists the information and materials we considered in developing this PCG
 - **We do not accept patient use of samples as evidence of an initial course of treatment, justification for continuation of therapy, or evidence of adequate trial and failure.**
 - Information about medications that require prior authorization is available at www.azblue.com/pharmacy. You must fully complete the [request form](#) and provide chart notes, lab workup and any other supporting documentation. The prescribing provider must sign the form. Fax the form to BCBSAZ Pharmacy Management at (602) 864-3126 or email it to Pharmacyprecert@azblue.com.
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- **Criteria for initial therapy:** Rezerock (belumosudil) and/or generic equivalent (if available) is considered **medically necessary** and will be approved when **ALL** the following criteria are met:

1. Prescriber is a physician specializing in the patient’s diagnosis or is in consultation with a Transplant Specialist
2. Individual is 12 years of age (who weigh at least 40 kg) or older
3. Individual has a confirmed diagnosis of **ONE** of the following:
 - a. Chronic graft-versus-host disease (chronic GVHD) after failure of at least 2 prior lines of systemic therapy (e.g., mycophenolate, tacrolimus, cyclosporine, sirolimus, ruxolitinib, ibrutinib, imatinib, methylprednisolone, etc.)

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- b. Other request for a specific oncologic direct treatment use that is found and listed in the National Comprehensive Cancer Network (NCCN) Guidelines with Categories of Evidence and Consensus of 1 and 2A
4. There is evidence of persistent chronic GVHD manifestations
5. Individual received an allogeneic hematopoietic cell transplant
6. Individual is receiving stable dose of glucocorticoid therapy
7. **If available:** Individual has failure after adequate trial, contraindication per FDA label, intolerance, or is not a candidate for a **generic equivalent** [Note: Failure, contraindication or intolerance to the generic should be reported to the FDA] ([see Definitions section](#))
8. Individual has received and completed **ALL** the following **baseline tests** before initiation of treatment and with continued monitoring of the individual as clinically appropriate:
 - a. Negative pregnancy test in a woman of childbearing potential
 - b. **ONE** of the following:
 - i. **For individual 16 years of age or older:** Karnofsky Performance Score of greater than or equal to 60
 - ii. **For individual between 12 years of age and less than 16 years of age:** Lansky Performance Score of greater than or equal to 60
9. Individual does not have moderate to severe hepatic impairment (Child-Pugh Class B or C) without liver GVHD

Initial approval duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Rezurock (belumosudil) and/or generic equivalent (if available) is considered **medically necessary** and will be approved when **ALL** the following criteria are met (**samples are not considered for continuation of therapy**):
1. Individual continues to be seen by a physician specializing in the patient's diagnosis or is in consultation with a Transplant Specialist
 2. Individual's condition has responded while on therapy with response defined as **TWO** of the following:
 - a. No evidence of disease progression
 - b. No evidence individual has developed any significant unacceptable adverse drug reactions that may exclude continued use
 - c. Achieved and maintains at least a 7-point reduction in Lee Chronic Graft-versus-Host Symptom Scale Score over baseline
 3. Individual has been adherent with the medication
 4. **If available:** Individual has failure after adequate trial, contraindication per FDA label, intolerance, or is not a candidate for a **generic equivalent** [Note: Failure, contraindication or intolerance to the generic should be reported to the FDA] ([see Definitions section](#))

ORIGINAL EFFECTIVE DATE: 08/19/1921 | ARCHIVE DATE: | LAST REVIEW DATE: 08/15/2024 | LAST CRITERIA REVISION DATE: 08/15/2024

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- 5. Individual has not developed any significant adverse drug effects that may exclude continued use such as:
 - a. Hepatotoxicity
 - b. Other life-threatening adverse effects
- 6. Individual does not have moderate to severe hepatic impairment (Child-Pugh Class B or C) without liver GVHD

Renewal duration: 12 months

➤ Criteria for a request for non-FDA use or indication, treatment with dosing, frequency, or duration outside the FDA-approved dosing, frequency, and duration, refer to one of the following Pharmacy Coverage Guideline:

- 1. **Off-Label Use of Non-Cancer Medications**
- 2. **Off-Label Use of Cancer Medications**

Description:

Rezurock (belumosudil) is a kinase inhibitor indicated for the treatment of adult and pediatric patients 12 years and older with chronic graft-versus-host disease (chronic GVHD) after failure of at least two prior lines of systemic therapy.

Belumosudil is an inhibitor of rho-associated, coiled-coil containing protein kinase (ROCK) which inhibits ROCK1 and ROCK2. Belumosudil down-regulates proinflammatory responses via regulation of signal transducer and activator transcription (STAT) 3 and STAT 5 phosphorylation and shifting Th17/Treg balance in *ex-vivo* or *in vitro* human T cell assays. Belumosudil also inhibited aberrant pro-fibrotic signaling, *in vitro*. *In vivo*, belumosudil demonstrated activity in animal models of chronic GVHD.

Definitions:

U.S. Food and Drug Administration (FDA) MedWatch Forms for FDA Safety Reporting
[MedWatch Forms for FDA Safety Reporting | FDA](#)

Clinical manifestations of chronic GVHD include:

- Skin involvement (e.g., resembling lichen planus or cutaneous manifestations of scleroderma)
- Dry oral mucosa with ulcerations and sclerosis
- Gastrointestinal tract effects (e.g., exudates, erosions, ulceration)
- Lungs (e.g., bronchiolitis obliterans diagnosed by biopsy)

Acute GVHD commonly includes presence of a classic maculopapular rash; abdominal cramps with diarrhea; and arising serum bilirubin concentration

Karnofsky Performance Scale:

| Score | Description |
|-------|-------------|
| | |

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| 100 | Normal, no complaints, no evidence of disease | Able to carry on normal activity and to work |
| 90 | Able to carry on normal activity, only minor signs or symptoms of disease present | |
| 80 | Normal activity with effort, some signs or symptoms of disease present | No special care needed |
| 70 | Cares for self, but unable to carry on normal activity or do active work | Unable to work but able to live at home and care for most personal needs |
| 60 | Requires occasional assistance from others, but is able to care for most of his/her needs | |
| 50 | Requires considerable assistance from others and needs frequent medical care | Various degrees of assistance may be needed |
| 40 | Disabled, requires special care and assistance | Unable to care for self |
| 30 | Severely disabled, hospitalization indicated, but death not imminent | |
| 20 | Very sick, hospitalization indicated, active support treatment is necessary but death not imminent | Requires equivalent of institutional or hospital care |
| 10 | Moribund, fatal process progressing rapidly | |
| 0 | Dead | |

Lansky Performance Scale:

| Score | Description |
|-------|---|
| 100 | Fully active, normal |
| 90 | Minor restrictions in physical strenuous activity |
| 80 | Active, but tires more quickly |
| 70 | Both greater restriction of, and less time spent in, play activity |
| 60 | Up and around, but minimal active play; keeps busy with quieter activities |
| 50 | Gets dressed, but lies around much of the day; no active play; able to participate in all quiet play and activities |
| 40 | Mostly in bed, participates in quiet activities |
| 30 | In bed, needs assistance even for quiet play |
| 20 | Often sleeping, play entirely limited to very passive activities |
| 10 | No play, does not get out of bed |
| 0 | Dead |

Lee Chronic Graft-versus-Host Symptom Scale:

| Lee chronic graft versus host symptom scale | |
|---|--|
| Have you been bothered by any of the following problems in the last month | 0 = not at all 1 = slightly 2 = moderately 3 = quite a bit 4 = extremely |
| Skin: | |
| a. Abnormal skin color | 0 1 2 3 4 |
| b. Rashes | 0 1 2 3 4 |
| c. Thickened skin | 0 1 2 3 4 |
| d. Sores on skin | 0 1 2 3 4 |
| e. Itchy skin | 0 1 2 3 4 |

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|---|-----------|
| Eyes and mouth: | |
| f. Dry eyes | 0 1 2 3 4 |
| g. Need to use eyedrops frequently | 0 1 2 3 4 |
| h. Difficulty seeing clearly | 0 1 2 3 4 |
| i. Need to avoid certain foods due to mouth pain | 0 1 2 3 4 |
| j. Ulcers in mouth | 0 1 2 3 4 |
| k. Receiving nutrition from an intravenous line or feeding tube | 0 1 2 3 4 |
| Breathing: | |
| l. Frequent cough | 0 1 2 3 4 |
| m. Colored sputum | 0 1 2 3 4 |
| n. Shortness of breath with exercise | 0 1 2 3 4 |
| o. Shortness of breath at rest | 0 1 2 3 4 |
| p. Need to use oxygen | 0 1 2 3 4 |
| Eating and digestion: | |
| q. Difficulty swallowing solid foods | 0 1 2 3 4 |
| r. Difficulty swallowing liquids | 0 1 2 3 4 |
| s. Vomiting | 0 1 2 3 4 |
| t. Weight loss | 0 1 2 3 4 |
| Muscles and joints: | |
| u. Joint and muscle aches | 0 1 2 3 4 |
| v. Limited joint movement | 0 1 2 3 4 |
| w. Muscle cramps | 0 1 2 3 4 |
| x. Weak muscles | 0 1 2 3 4 |
| Energy: | |
| y. Loss of energy | 0 1 2 3 4 |
| z. Need to sleep more/take naps | 0 1 2 3 4 |
| aa. Fevers | 0 1 2 3 4 |
| Mental health and emotional: | |
| bb. Depression | 0 1 2 3 4 |
| cc. Anxiety | 0 1 2 3 4 |
| dd. Difficulty sleeping | 0 1 2 3 4 |

Resources:

Rezurock (belumosudil) product information, revised by Kadmon Pharmaceuticals, LLC. 04-2024. Available at DailyMed <http://dailymed.nlm.nih.gov>. Accessed June 07, 2024.

Zeiser R. Clinical manifestations and diagnosis chronic graft-versus-host disease. In: UpToDate, Negrin RS, Chao NJ, Rosmarin AG (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at <http://uptodate.com>. Literature current through June 2024. Topic last updated February 27, 2024. Accessed July 16, 2024.

Zeiser R. Treatment of chronic graft-versus-host disease. In: UpToDate, Negrin RS, Chao NJ, Rosmarin AG (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at <http://uptodate.com>. Literature current through June 2024. Topic last updated January 17, 2023. Accessed July 16, 2024.

National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Hematopoietic Cell Transplantation (HCT) Version 1.2024 – Updated April 26, 2024. Available at <https://www.nccn.org>. Accessed July 16, 2024.

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Cutler C, Lee SJ, Arai S, et al.: Belumosudil for chronic graft-versus-host disease after 2 or more prior lines of therapy: the ROCKstar Study. *Blood* 2021 Dec 2; 138(22): 2278–2289. Accessed July 16, 2024.

[ClinicalTrials.gov](https://clinicaltrials.gov) [Internet]. Bethesda (MD): National Library of Medicine (US). Identifier NCT03640481. A Phase 2, Randomized Multicenter Study to Evaluate the Efficacy and Safety of KD025 in Subjects with Chronic Graft Versus Host Disease (cGVHD) After At Least 2 Prior Lines of Therapy (The ROCKstar Study). Last Update Posted Aug 03, 2021. Available from: <http://clinicaltrials.gov>. Accessed August 08, 2021. Re-reviewed on July 16, 2024.

Lee SJ, Cook EF, Soiffer R, Antin JH.: Development and validation of a scale to measure symptoms of chronic graft-versus-host disease. *Biology of Blood and Marrow Transplantation* 2002; 8:444-452. Accessed August 09, 2021. Re-reviewed on July 16, 2024.

Off Label Use of Cancer Medications: A.R.S. §§ 20-826(R) & (S). Subscription contracts; definitions.

Off Label Use of Cancer Medications: A.R.S. §§ 20-1057(V) & (W). Evidence of coverage by health care service organizations; renewability; definitions.

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