Rezurock (belumosudil)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

Continued on next page.

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ graft-versus-host disease (chronic GVHD) ☐ Other diagnosis: _____ICD-10_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

- ☐ Does the patient have a diagnosis of Chronic Graft versus Host Disease (cGVHD)? ☐ **Yes** ☐ **No**
- ☐ Will the patient avoid concomitant therapy with all of the following?
  - Coadministration with proton-pump inhibitors (PPIs), or if therapy is unavoidable, the patient will be monitored closely for adverse reaction and dose modifications will be implemented; ☐ **Yes** ☐ **No**
  - Coadministration with strong CYP3A inducers (e.g., rifampin, carbamazepine, St. John's Wort, etc.) or if therapy is unavoidable, the patient will be monitored closely for adverse reaction and/or dose modifications will be implemented ☐ **Yes** ☐ **No**
- ☐ Will the medication be used in combination with ibrutinib (subsequent therapy is allowed)? ☐ **Yes** ☐ **No**
- ☐ Is the patient post-allogeneic stem cell transplant (generally 3 or more months)? ☐ **Yes** ☐ **No**
- ☐ Does the patient have histologic relapse of underlying cancer or post-transplant lymphoproliferative disease? ☐ **Yes** ☐ **No**
- ☐ Has the patient failed two or more previous lines of systemic therapy for the treatment of cGVHD (e.g., corticosteroids, immunosuppressants, etc.)? ☐ **Yes** ☐ **No**
- ☐ Is the medication being used in combination with stable doses of systemic therapies for GVHD, which can include corticosteroids (e.g., calcineurin inhibitors [cyclosporine; tacrolimus], sirolimus, mycophenolate mofetil, methotrexate, rituximab, etc.)? ☐ **Yes** ☐ **No**

If renewal:

- ☐ Does the patient have absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include grade 4 hepatotoxicity, etc. ☐ **Yes** ☐ **No**
- ☐ Does the patient have response to therapy with an improvement in one or more of the following?
  - Clinician assessments (e.g., NIH Skin Score, Upper GI Response Score, NIH Lung Symptom Score, etc.) ☐ **Yes** ☐ **No**
  - Patient-reported symptoms (e.g., Lee Symptom Scale, etc.) ☐ **Yes** ☐ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ Date: _____

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811