Harvard Pilgrim Health Care | TUFTS Health Plan

Pharmacy Medical Necessity Guidelines: Rezurock™ (belumosudil)

Effective: March 1, 2026

Guideline Type	☒ Prior Authorization ☐ Non-Formulary ☐ Step-Therapy ☐ Administrative

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; Fax: 617-673-0988

☒ Tufts Health Plan Commercial products; Fax: 617-673-0988

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 617-673-0988

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Overview

Food and Drug Administration – Approved Indications

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 after failure of at least two prior lines of systemic therapy.

Clinical Guideline Coverage Criteria

The plan may authorize coverage of Rezurock for Members when **ALL** of the following criteria are met:

1. Documented diagnosis of chronic graft versus host disease

AND

2. The patient is at least 12 years of age or older

AND

3. Documentation of failure with at least two prior lines of systemic therapies (e.g., corticosteroids).

Limitations

1. For a non-formulary medication request, please refer to the Pharmacy Medical Necessity Guidelines for Formulary Exceptions and submit a formulary exception request to the plan as indicated.

Codes

None

References

1. Clinicaltrials.gov. Efficacy and safety of KD025 in subjects with cGVHD after at least 2 prior lines of systemic therapy. Updated August 16, 2021. Accessed August 18, 2021.
2. Cutler CS, Lee SJ, Arai S, et al. Belumosudil for chronic graft-versus-host disease (cGVHD) after 2 or more prior lines of therapy: the ROCKstar study. Blood. Published online July 15, 2021. Jul 15; doi: 10.1182/blood.2021012021.
3. Ramachandran V, Kolli S, Strowd L. Review of graft-versus-host disease. Dermatol Clin. 2019;37(4):569-582. doi: 10.1016/j.det.2019.05.014.
4. Hamilton BK. Updates in chronic graft-versus-host disease. Hematology Am Soc Hematol Educ Program. 2021;2021(1):648–654.
5. Herzog S, et al. Chronic GVHD after steroid-sensitive, -dependent, and -refractory acute GVHD: incidence and clinical outcomes. Blood Adv. 2023;7(14):3644–3650
6. Rezurock (belumosudil) [package insrt]. Warrendale, PA: Kadmon Pharmaceuticals, LLC; January 2026.

Approval And Revision History

September 13, 2022: Reviewed by the Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

- July 11, 2023: No changes
- June 11, 2024: No changes
- February 11, 2025: No changes
- February 10, 2026: No changes
- February 2026: Administrative update to remove CareLink from Medical Necessity Guideline template.

Background, Product and Disclaimer Information

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.