OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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Rezurock™ (Belumosudil) Prior Authorization Form

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Drug Information

Pharmacy billing (NDC: _____***) Start Date (or date of next dose):*** _____

Dose: _____ ***Regimen:*** _____

Billing Provider Information

Pharmacy NPI: _____ ***Pharmacy Name:*** _____

Pharmacy Phone: _____ ***Pharmacy Fax:*** _____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

Criteria

For Initial Authorization

1. **Please indicate the diagnosis and information:**
   - ☐ **Graft-Versus-Host Disease (GVHD)**
     - A. Is diagnosis chronic GVHD? Yes☐ No☐
     - B. Has the member failed at least 2 prior lines of systemic therapy? Yes☐ No☐
   - ☐ **If diagnosis is not listed above, please indicate diagnosis:** _____

Additional Information: _____

_____

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on belumosudil?
   Yes☐ No☐
3. Has the member experienced adverse drug reactions related to belumosudil therapy?
   Yes☐ No☐

If yes, please specify adverse reactions: _____

_____

Prescriber Signature: _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma.**	