

Prescriber Criteria Form

Rezurock 2024 PA Fax 4854-A v1 010124.docx  
Rezurock (belumosudil)  
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.  
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**.  
Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process.  
When conditions are met, we will authorize the coverage of Rezurock (belumosudil).

Drug Name:  
Rezurock (belumosudil)

**Patient Name:**

**Patient ID:**

**Patient DOB:**

**Patient Phone:**

**Prescriber Name:**

**Prescriber Address:**

**City:**

**State:**

**Zip:**

**Prescriber Phone:**

**Prescriber Fax:**

**Diagnosis:**

**ICD Code(s):**

**Please circle the appropriate answer for each question.**

1	Is the requested drug being prescribed for the treatment of chronic graft-versus-host disease (chronic GVHD)? [If no, then no further questions.]	Yes	No
2	Is the patient 12 years of age or older? [If no, then no further questions.]	Yes	No
3	Has the patient failed at least two prior lines of systemic therapy?	Yes	No

Comments:

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

**Prescriber (or Authorized) Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_