

USFHP Prior Authorization Request Form for  
belumosudil (**Rezurock**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:

**Attn: Pharmacy, 77 Warren St, Brighton, MA 02135**

**QUESTIONS? Call 1-877-880-7007**

<https://www.usfamilyhealth.org/for-providers/pharmacy-information/>

Clinical documentation may be required

**Step 1 Please complete patient and physician information** (please print):

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID #: _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

**Step 2 Please complete the clinical assessment:**

<b>1. Is the patient 12 years of age or older?</b>	<input type="checkbox"/> Yes Proceed to question <b>2</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<b>2. Is the requested medication prescribed by or in consultation with a hematologist or oncologist?</b>	<input type="checkbox"/> Yes Proceed to question <b>3</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<b>3. What is the indication or diagnosis?</b>	<input type="checkbox"/> Chronic graft-versus-host disease (cGVHD) - Proceed to question <b>4</b> <input type="checkbox"/> Other - Proceed to question <b>5</b>	
<b>4. Has the patient failed treatment with steroids alone and at least two prior lines of systemic therapy [for example, abatacept (Orencia), Calcineurin inhibitors (tacrolimus [Prograf], cyclosporine), Etanercept (Enbrel), ECP extracorporeal photopheresis, Hydroxychloroquine, Ibrutinib (Imbruvica), Imatinib (Gleevec), low dose MTX, m-TOR inhibitors (sirolimus [Rapamune]), mycophenolate mofetil (CellCept), pentostatin (Nipent), rituximab (Rituxan), ruxolitinib (Jakafi)]?</b>	<input type="checkbox"/> Yes Proceed to question <b>7</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved

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<p>5. Please provide the indication or diagnosis.</p>	<p align="center">_____ Proceed to question 6</p>	
<p>6. Is the diagnosis cited in a nationally accredited guideline with a moderate strength or higher recommendation?  If so, the guideline society is _____, the strength of recommendation is _____, and the diagnosis is: _____.</p>	<p align="center"><input type="checkbox"/> Yes Proceed to question 7</p>	<p align="center"><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p>7. Is the patient of childbearing potential?</p>	<p align="center"><input type="checkbox"/> Yes Proceed to question 8</p>	<p align="center"><input type="checkbox"/> No <b>Sign and date below</b></p>
<p>8. What is the patient's sex?</p>	<p><input type="checkbox"/> Male – Proceed to question 9 <input type="checkbox"/> Female – Proceed to question 10</p>	
<p>9. Will the patient use effective contraception during treatment and for at least 1 week after the cessation of therapy?</p>	<p align="center"><input type="checkbox"/> Yes <b>Sign and date below</b></p>	<p align="center"><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p>10. Will the patient use effective contraception during treatment and for at least 1 week after the cessation of therapy?</p>	<p align="center"><input type="checkbox"/> Yes Proceed to question 11</p>	<p align="center"><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p>11. Has it been confirmed that the patient is not pregnant by (-) HCG?</p>	<p align="center"><input type="checkbox"/> Yes Proceed to question 12</p>	<p align="center"><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p>12. Will the patient avoid breastfeeding during treatment and for at least 1 week after the cessation of treatment?</p>	<p align="center"><input type="checkbox"/> Yes <b>Sign and date below</b></p>	<p align="center"><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>

**Step 3** I certify the above is true to the best of my knowledge. Please sign and date:

\_\_\_\_\_ Prescriber Signature

\_\_\_\_\_ Date