Reference number(s)
6268-A

Specialty Guideline Management
Ogsiveo

Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated. Over-the-counter (OTC) products are not included unless otherwise stated.

Brand Name	Generic Name
Ogsiveo	nirogacestat

Indications

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indication[1]

Adult patients with progressing desmoid tumors who require systemic treatment

Compendial Uses[2,]

Desmoid tumors without progression – significant symptoms or in location where progression would be morbid

All other indications are considered experimental/investigational and not medically necessary.

Coverage Criteria

Desmoid tumor[1,2]

Authorization of 12 months may be granted for treatment of progressive, morbid, or symptomatic desmoid tumors as a single agent.

Continuation of Therapy

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for an indication listed in the coverage criteria section when there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

References

1. Ogsiveo [package insert]. Stamford, CT: SpringWorks Therapeutics, Inc.; April 2024.
2. The NCCN Drugs & Biologics Compendium® © 2025 National Comprehensive Cancer Network, Inc. https://www.nccn.org. Accessed March 6, 2025.