Reference number(s)
6268-A

SPECIALTY GUIDELINE MANAGEMENT

OGSIVEO (nirogacestat)

POLICY

I. 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.

A. FDA-Approved Indication
Adult patients with progressing desmoid tumors who require systemic treatment

B. Compendial Use
Desmoid tumors without progression – concerns for morbidity or significant symptoms

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

II. CRITERIA FOR INITIAL APPROVAL

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

III. CONTINUATION OF THERAPY

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

IV. REFERENCES

1. Ogsiveo [package insert]. Stamford, CT: SpringWorks Therapeutics, Inc.; November 2023.
2. The NCCN Drugs & Biologics Compendium® © 2024 National Comprehensive Cancer Network, Inc. https://www.nccn.org. Accessed March 14, 2024.