Ogsiveo™ (nirogacestat) Prior Authorization Form

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

Drug Information

*Pharmacy Billing (NDC:*_____) *Start Date (or date of next dose):*_____
*Dose:*_____ *Regimen:*_____

Pharmacy 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:

    ☐ **Desmoid Tumor**

    A. Is tumor progressing, requiring systemic treatment? Yes☐ No☐

    B. Will nirogacestat be used as a single agent? Yes☐ No☐

    ☐ **Other** _____

Additional Information: _____
_____

For Continued Authorization:

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

Additional Information:_____

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.**