NCCN Guidelines Panel:

On behalf of Vermillion, Inc., I respectfully request the NCCN Ovarian Cancer Panel members to review the enclosed data for inclusion of OVA1 (Multivariate Index Assay or MIA) in the management and evaluation (workup) of an undiagnosed pelvic mass.

Specific Changes: Recommend the use of OVA1 (MIA) as part of the workup on an undiagnosed (indeterminate) pelvic mass after imaging diagnoses a pelvic mass but it is neither clearly benign nor malignant. Recommend use of OVA1 (MIA) in lieu of CA125 to assess for risk of all histology including less common ovarian histologies (LCOH) in an indeterminate pelvic mass.

FDA Clearance: OVA1® (MIA) is the first protein-based In Vitro Diagnostic Multivariate Index Assay (MIA) cleared by the FDA (510k) in 2009 and utilized in patient care management on over 110,000 patients to date. It was developed to triage women with an adnexal mass to the appropriate care pathway when clinical assessment and ultrasound are inconclusive. OVA1 (AKA Multivariate Index Assay or MIA), a sole-source advanced diagnostic laboratory test (ADLT) is offered exclusively by ASPIRA Labs, since 2015, a wholly owned subsidiary of Vermillion, Inc.

Rationale: In support of the proposed change, numerous peer reviewed published studies clearly show that OVA1 (MIA) has the highest sensitivity and NPV when assessing the risk of ovarian malignancy on an undiagnosed (indeterminate) pelvic mass prior to surgery, and can greatly help in the triage of patients to the appropriate specialist prior to their first surgery. Having a gynecologic oncologist perform the initial ovarian cancer surgery and staging both improves patient survivability, reduces repeat procedures and lowers cost (Eskander, 2016). OVA1 (MIA) superiority is especially true for premenopausal (Ueland, 2011; Ware Miller, 2011; Bristow, 2013a) and non-Caucasian women (Dunton, 2019a, 2019b), as well as sensitivity for early stage ovarian cancer in all patients when patient survivability is highest (Ueland 2011; Bristow 2013a, 2013b; Longoria, 2014). OVA1 (MIA) is now ACOG recommended for, “Consultation with or referral to a gynecologic oncologist is recommended for women with an adnexal mass who meet one or more of the following criteria ... Premenopausal or postmenopausal with an elevated score on a formal risk assessment test such as the multivariate index assay ...” (ACOG Practice Bulletin 174, 2016). ACOG PB 174 also noted that the Goodrich (2014) study which examined OVA1 (MIA) combined with imaging results showed that the NPV is as high as 99% when the OVA1 (MIA) and imaging results are both Low Risk. OVA1 (MIA) sensitivity is also far superior to CA-125 in the detection of LCOH (non-EOC), as the antigen for CA-125 specifically targets epithelial antigens only and LCOH is non-epithelial (Bristow, 2013a). Finally, OVA1 (MIA) includes CA-125 as one of its five markers, and a CA-125 result is also provided to the ordering physician in case a baseline CA-125 is needed for future monitoring to response to therapy if the patient ultimately has ovarian cancer. So any specific CA125 result needed by a provider on an indeterminate pelvic mass can be provided with an OVA1 (MIA) result.
The following articles are submitted in support of this proposed change:

   
   https://doi.org/10.1097/AOG.0000000000001768


   
   doi:10.1016/j.ajog.2013.08.009


   
   doi:10.1177/1179299X19853785

   
   doi:10.1080/03007995.2016.1176014

   
   doi:10.1185/03007995.2015.1123679

   
   doi:10.1016/j.ajog.2014.02.010


   
   https://doi.org/10.1016/j.ygyno.2012.05.02713

   
   doi:10.1016/j.ajog.2013.09.017

   
   doi:10.1097/GRF.0b013e31824970cf


Sincerely,

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