

**Clinical Policy: Amlodipine/Atorvastatin (Caduet)**

Reference Number: CP.PMN.176

Effective Date: 12.01.18

Last Review Date: 11.20

Line of Business: Commercial, Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

**Description**

Amlodipine/atorvastatin (Caduet<sup>®</sup>) is a combination of amlodipine, a calcium channel blocker, and atorvastatin, an HMG CoA-reductase inhibitor.

**FDA Approved Indication(s)**

Caduet is indicated in patients for whom treatment with both amlodipine and atorvastatin is appropriate.

Amlodipine is indicated for the treatment of:

- Hypertension, to lower blood pressure
- Coronary artery disease (CAD)
  - Symptomatic treatment of chronic stable angina
  - Treatment of confirmed or suspected vasospastic angina (Prinzmetal's or Variant Angina)
  - Angiographically documented CAD
    - To reduce the risk for hospitalization for angina and coronary revascularization procedure in patients with recently documented CAD by angiography and without heart failure or an ejection fraction < 40%

Atorvastatin is indicated as an adjunct therapy to diet for:

- Prevention of Cardiovascular Disease:
  - Reduce the risk of myocardial infarction (MI), stroke, and revascularization procedures and angina in adult patients without clinically evident coronary heart disease (CHD), but with multiple risk factors for coronary heart disease (such as age, smoking, hypertension, low high-density lipoprotein cholesterol (HDL-C), or a family history of early coronary heart disease)
  - Reduce the risk of MI and stroke in patients with type 2 diabetes, and without clinically evident CHD, but with multiple risk factors (such as retinopathy, albuminuria, smoking, or hypertension)
  - Reduce the risk of non-fatal MI, fatal and non-fatal stroke, revascularization procedures, hospitalization for congestive heart failure (CHF), and reduce the risk of angina in patients with clinically evident CHD
- Hyperlipidemia
  - Heterozygous Familial and Nonfamilial Hypercholesterolemia:
    - As an adjunct to diet to reduce elevated total-cholesterol (C), low-density lipoprotein cholesterol (LDL-C), apolipoprotein B (apo B), and triglyceride (TG) levels and to increase HDL-C in patients with primary hypercholesterolemia (heterozygous familial and nonfamilial) and mixed dyslipidemia (Fredrickson types IIa and IIb)

- Elevated Serum TG Levels:
  - As an adjunct to diet for the treatment of patients with elevated serum TG levels (Fredrickson type IV)
- Primary Dysbetalipoproteinemia:
  - Treatment of patients with primary dysbetalipoproteinemia (Fredrickson type III) who do not respond adequately to diet
- Homozygous Familial Hypercholesterolemia:
  - Reduce total-C and LDL-C in patients with homozygous familial hypercholesterolemia as an adjunct to other lipid-lowering treatments (e.g., LDL apheresis) or if such treatments are unavailable
- Pediatric Patients:
  - As an adjunct to diet to reduce total-C, LDL-C, and apo B levels in pediatric patients, 10 to 17 years of age, with heterozygous familial hypercholesterolemia if after an adequate trial of diet therapy the following findings are present:
    - LDL-C remains  $\geq 190$  mg/dL or
    - LDL-C remains  $\geq 160$  mg/dL and:
      - There is a positive family history of premature cardiovascular disease or
      - Two or more other cardiovascular disease (CVD) risk factors are present in the pediatric patients

Limitation(s) of use: Atorvastatin has not been studied in conditions where the major lipoprotein abnormality is elevation of chylomicrons (Fredrickson types I and V dyslipidemias).

### Policy/Criteria

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that Caduet is **medically necessary** when the following criteria are met:

### I. Initial Approval Criteria

#### A. All FDA-Approved Indications (must meet all):

1. Diagnosis of one of the following (a, b, c, or d):
  - a. Hypertension;
  - b. Chronic stable angina;
  - c. Confirmed or suspected vasospastic angina (Prinzmetal's or Variant Angina);
  - d. Coronary artery disease documented by angiography and without heart failure or an ejection fraction  $< 40\%$ ;
2. Diagnosis of hyperlipidemia or one of the diagnoses for which atorvastatin is FDA-approved;
3. Medical justification supporting inability to use the individual components concurrently: atorvastatin and amlodipine;
4. Failure to achieve National Cholesterol Education Program (NCEP) goals (*see Appendix D*) to at least one generic formulary statin (e.g., lovastatin, pravastatin, simvastatin, atorvastatin), followed by ezetimibe/simvastatin (Vytorin<sup>®</sup>) or

- rosuvastatin (Crestor<sup>®</sup>), unless all are contraindicated or clinically significant adverse effects are experienced;
5. Dose does not exceed 80 mg (1 tablet) per day of atorvastatin.

**Approval duration: Length of Benefit**

**B. Other diagnoses/indications**

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial and CP.PMN.53 for Medicaid.

**II. Continued Therapy**

**A. All FDA-Approved Indications (must meet all):**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed 80 mg (1 tablet) per day of atorvastatin.

**Approval duration: Length of Benefit**

**B. Other diagnoses/indications (must meet 1 or 2):**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.  
**Approval duration: Duration of request or 12 months (whichever is less);** or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial and CP.PMN.53 for Medicaid.

**III. Diagnoses/Indications for which coverage is NOT authorized:**

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial and CP.PMN.53 for Medicaid or evidence of coverage documents.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

|                                   |  |
|-----------------------------------|--|
| apo B: apolipoprotein B           | HDL-C: high-density lipoprotein cholesterol  |
| CAD: coronary artery disease      | LDL: low-density lipoprotein cholesterol     |
| CHD: coronary heart disease       | MI: myocardial infarction                    |
| CHF: congestive heart failure     | NCEP: National Cholesterol Education Program |
| CVD: cardiovascular disease       | TG: triglyceride                             |
| FDA: Food and Drug Administration |  |

*Appendix B: Therapeutic Alternatives*

*This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.*

| Drug  | Dosing Regimen   | Dose Limit/<br>Maximum Dose |
|---|--|-----------------------------|
| atorvastatin (Lipitor <sup>®</sup> )          | 10 to 80 mg PO QD  | 80 mg/day                   |
| amlodipine (Norvasc <sup>®</sup> )            | 2.5 to 10 mg PO QD   | 10 mg/day                   |
| lovastatin (Mevacor <sup>®</sup> )            | 10 to 80 mg PO QD or BID   | 80 mg/day                   |
| pravastatin (Pravachol <sup>®</sup> )         | 10 to 80 mg PO QD  | 80 mg/day                   |
| simvastatin (Zocor <sup>®</sup> )             | 5 to 40 mg PO QD (Note: coverage of the 80 mg strength requires PA)              | 80 mg/day                   |
| ezetimibe/simvastatin (Vytorin <sup>®</sup> ) | 10/10 mg to 10/80 mg PO QD (Note: coverage of the 10/80 mg strength requires PA) | 10/80 mg/day                |
| rosuvastatin (Crestor <sup>®</sup> )          | 5 to 40 mg/day PO QD   | 40 mg/day                   |

Therapeutic alternatives are listed as Brand name<sup>®</sup> (generic) when the drug is available by brand name only and generic (Brand name<sup>®</sup>) when the drug is available by both brand and generic.

*Appendix C: Contraindications/Boxed Warnings*

- Contraindication(s):
  - Active liver disease, which may include unexplained persistent elevations in hepatic transaminase levels
  - Pregnancy
  - Lactation
- Boxed warning(s): none reported

*Appendix D: NCEP Goals*

| Risk Category                                      | LDL Goal    |
|--|-------------|
| CHD or CHD Risk Equivalents (10-year risk* >20%)   | < 100 mg/dL |
| Multiple (2+) Risk Factors and 10-year risk* ≤ 20% | < 130 mg/dL |
| 0 to 1 risk factor                                 | < 160 mg/dL |

\*Refer to Framingham point scores for 10-year risk %  
(<https://www.nhlbi.nih.gov/files/docs/guidelines/atglance.pdf>)

**V. Dosage and Administration**

| Indication   | Dosing Regimen   | Maximum Dose  |
|--|--|---|
| For patients whom treatment with both amlodipine and atorvastatin is appropriate | <u>Initial</u><br>Adults: 2.5/10 mg PO QD<br><br>Pediatrics (age 10 to 17 years):<br>2.5/10 mg PO QD | Adult: 10/80 mg per day<br><br>Pediatric: 5/20 mg per day |

**VI. Product Availability**

Tablets: 2.5/10 mg, 2.5/20 mg, 2.5/40 mg, 5/10 mg, 5/20 mg, 5/40mg, 5/80 mg, 10/10 mg, 10/20 mg, 10/40 mg, 10/80 mg

**VII. References**

1. Caduet Prescribing Information. New York, NY: Pfizer, Inc.; May 2019. Available at: <http://labeling.pfizer.com/ShowLabeling.aspx?id=531>. Accessed August 21, 2020.

2. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2020. Available at: <http://clinicalpharmacology-ip.com/>.

| Reviews, Revisions, and Approvals   | Date     | P&T Approval Date |
|---|----------|-------------------|
| Policy created: adapted from CP.CPA.237 (to be retired); no significant changes; references reviewed and updated.                                   | 07.31.18 | 11.18             |
| 4Q 2019 annual review: clarified that CI/ADR applies to all preferred step-through agents; no significant changes; references reviewed and updated. | 08.13.19 | 11.19             |
| 4Q 2020 annual review: no significant changes; references reviewed and updated.   | 08.21.20 | 11.20             |

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible

for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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**Note:**

**For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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