Clinical Policy: Aspirin/Dipyridamole (Aggrenox)
Reference Number: CP.PMN.20
Effective Date: 09.01.06
Last Review Date: 02.18
Line of Business: Health Insurance Marketplace, Medicaid

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Aspirin/dipyridamole (Aggrenox®) is a combination antiplatelet agent.

FDA Approved Indication(s)
Aggrenox is indicated to reduce the risk of stroke in patients who have had transient ischemia of the brain or completed ischemic stroke due to thrombosis.

Policy/Criteria
Provider must submit documentation (which may include office chart notes and lab results) supporting that member has met all approval criteria

It is the policy of health plans affiliated with Centene Corporation® that Aggrenox is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Secondary Prevention of Stroke (must meet all):
      1. Age ≥ 18 years;
      2. Medical history includes ischemic stroke or transient ischemic attack (TIA);
      3. Failure of aspirin used as a single agent (e.g., stroke or TIA while on aspirin therapy);
      4. Member is not a candidate for clopidogrel therapy due to contraindications or clinically significant adverse effects/drug interactions;
      5. Dose does not exceed 50 mg aspirin/400 mg extended-release dipyridamole per day (2 capsules per day).
   Approval duration: 12 months

   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): HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid.

II. Continued Therapy
   A. Secondary Prevention of Stroke (must meet all):
      1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
      2. If request is for a dose increase, new dose does not exceed 50 mg aspirin/400 mg extended-release dipyridamole per day (2 capsules per day).
Approval duration: 12 months

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): HIM.PHAR.21 for health insurance marketplace 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 – HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information
Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
TIA: transient ischemic attack

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.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/ Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>aspirin</td>
<td>50-325 mg PO QD</td>
<td>325 mg/day</td>
</tr>
<tr>
<td>clopidogrel (Plavix®)</td>
<td>75 mg PO QD</td>
<td>75 mg/day</td>
</tr>
</tbody>
</table>

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

Appendix C: General Information
Aggrenox is not interchangeable with the individual components of aspirin and dipyridamole tablets.

V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary prevention of stroke</td>
<td>1 capsule PO BID (morning and evening) with or without food</td>
<td>2 capsules/day</td>
</tr>
<tr>
<td></td>
<td>If there are intolerable headaches during initial treatment, switch to 1 capsule at bedtime and low-dose aspirin in the morning; resume twice daily dosing within 1 week</td>
<td></td>
</tr>
</tbody>
</table>
VI. **Product Availability**  
Capsule: 25 mg aspirin/200 mg extended-release dipyridamole

VII. **References**


<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deleted “or intolerance to” under criteria for approval (patients intolerant to aspirin cannot use Aggrenox because it is composed of aspirin) References updated.</td>
<td>02.13</td>
<td>02.13</td>
</tr>
<tr>
<td>Indications updated based on current package insert. Add section for “Unique Population use of Aggrenox”. References updated. Updated References. No other changes.</td>
<td>02.14</td>
<td>02.14</td>
</tr>
<tr>
<td>Updated References. No other changes.</td>
<td>01.15</td>
<td>02.15</td>
</tr>
<tr>
<td>Converted guideline into new policy template; Added age and quantity limit per labeling; Removed criteria for mono-therapy use as this not specific and cannot be truly enforced; Modified background section to include information about mechanism of action and FDA approved use; Updated reference format and added Chest reference.</td>
<td>11.15</td>
<td>02.16</td>
</tr>
<tr>
<td>Converted to new integrated template. Modified stroke diagnosis criteria to exclude the word “recent” as 1) there is no defined time frame for recent and 2) antiplatelet therapy is indicated for secondary prevention in all stroke patients regardless of when the stroke occurred. Removed requirement for diagnosis of stroke to have been made by a neurology specialist or in consult with a neurologist or vascular specialist as other specialties can diagnose stroke (plus, documentation to support diagnosis is now required per new template). Added workflow document. Updated references.</td>
<td>11.16</td>
<td>02.17</td>
</tr>
<tr>
<td>1Q18 annual review:</td>
<td>10.30.17</td>
<td>02.18</td>
</tr>
</tbody>
</table>
Reviews, Revisions, and Approvals

- Policies combined for Centene Medicaid and Marketplace lines of business.
- No significant changes from previous corporate approved policy
- HIM: Removed criterion directing requests for the branded product to the generic product since the branded product is not on formulary.
- References reviewed and updated.

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.
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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.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy.

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