

Clinical Policy: Aspirin/Dipyridamole (Aggrenox)

Reference Number: CP.PMN.20

Effective Date: 09.01.06

Last Review Date: 02.20

Line of Business: HIM*, Medicaid

[Revision Log](#)

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

Description

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

**For Health Insurance Marketplace (HIM), if request is through the pharmacy benefit, Brand Aggrenox is non-formulary and should not be approved using these criteria; refer to the formulary exception policy, HIM.PA.103.*

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 (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[®] 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 \geq 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 (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. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed 50 mg aspirin/400 mg extended-release dipyridamole (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.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
aspirin	50-325 mg PO QD	325 mg/day
clopidogrel (Plavix [®])	75 mg PO QD	75 mg/day

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: Contraindications/Boxed Warnings

- Contraindication(s):
 - Hypersensitivity to any product ingredients
 - Patients with known allergy to NSAIDs
 - Patients with the syndrome of asthma, rhinitis, and nasal polyps
- Boxed warning(s): none reported

Appendix D: General Information

- Aggrenox is not interchangeable with the individual components of aspirin and dipyridamole tablets.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Secondary prevention of stroke	1 capsule PO BID (morning and evening) 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	2 capsules/day

VI. Product Availability

Capsules: 25 mg aspirin/200 mg extended-release dipyridamole

VII. References

1. Aggrenox Prescribing Information. Ridgefield, CT: Boehringer Ingelheim Pharmaceuticals Inc.; November 2018. Available at: <https://www.aggrenox.com>. Accessed October 30, 2019.
2. Kernan WN, Ovbiagele B, Black HR, et al. Guidelines for prevention of stroke in patients with stroke and transient ischemic attack: a guideline for healthcare professionals from the American Heart Association/American Stroke Association. *Stroke*. 2014; 45(7): 2160-2236.
3. Lansberg MG, O'Donnell MJ, Khatri P et al. Antithrombotic and thrombolytic therapy for ischemic stroke: antithrombotic therapy and prevention of thrombosis, 9th ed.: American College of Chest Physicians evidence-based clinical practice guidelines. *Chest*. 2012; 141(2 Suppl): e601S-636S.
4. Powers WJ, Rabinstein AA, Ackerson T, et al. 2018 guidelines for the early management of patients with acute ischemic stroke: a guideline for healthcare professionals from the American Heart Association/American Stroke Association. *Stroke*. 2018;49:e46-e99.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Updated References. No other changes.	01.15	02.15
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.	11.15	02.16
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.	11.16	02.17

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q18 annual review: 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.	10.30.17	02.18
1Q 2019 annual review: no significant changes; references reviewed and updated.	10.30.18	02.19
1Q 2020 annual review: no significant changes; references reviewed and updated.	11.09.19	02.20

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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