

CENTER FOR DRUG EVALUATION AND RESEARCH

Approval Package for:

APPLICATION NUMBER:

20-702/S-008

Trade Name: Lipitor Tablets 10 mg, 20 mg, and 40 mg

Generic Name: atorvastatin calcium

Sponsor: Parke Davis Pharmaceutical Research

Approval Date: November 5, 1997

**CENTER FOR DRUG EVALUATION AND
RESEARCH**

APPLICATION NUMBER:

20-702/S-008

CONTENTS

Reviews / Information Included in this NDA Review.

Approval Letter	X
Approvable Letter	
Labeling	X
Medical Review(s)	
Chemistry Review(s)	
Pharmacology Review(s)	
Statistical Review(s)	
Microbiology Review(s)	
Clinical Pharmacology/ Biopharmaceutics Review(s)	
Administrative/Correspondence Document(s)	X

**CENTER FOR DRUG EVALUATION AND
RESEARCH**

APPLICATION NUMBER:

20-702/S-008

APPROVAL LETTER



NDA 20-702/S-008

Parke-Davis Pharmaceutical Research, Div. of Warner-Lambert Company
Attention: Margaret Uprichard, Pharm.D.
Manager, FDA Liaison, Worldwide Regulatory Affairs
2800 Plymouth Road
P.O. Box 1047
ANN ARBOR, MI 48106-1047

NOV 5 1997

Dear Dr. Uprichard:

Please refer to your supplemental new drug application dated September 5, 1997, received September 8, 1997, submitted under section 505(b) of the Federal Food, Drug, and Cosmetic Act for Lipitor (atorvastatin calcium) Tablets, 10 mg, 20 mg, and 40 mg.

We acknowledge receipt of your submissions dated October 9 and November 5, 1997.

The supplemental application as amended provides for the following additions to the CLINICAL PHARMACOLOGY and the ADVERSE REACTIONS sections of the labeling:

CLINICAL PHARMACOLOGY, "Mechanism of Action," added to the end of the third paragraph--

Although frequently found in association with low HDL-C, elevated plasma TG has not been established as an independent risk factor for coronary heart disease. The independent effect of raising HDL-C or lowering TG on the risk for coronary and cardiovascular morbidity and mortality has not been established.

ADVERSE REACTIONS, the following sentence is added below Table 4--

The events in italics occurred in $\geq 2\%$ of patients and the events in plain type occurred in $\leq 2\%$ of patients.

ADVERSE REACTIONS (The following reactions or their italicization is added):

Chest pain; Nausea; Bronchitis, rhinitis; Insomnia, depression, hypesthesia, hypertonia; *Arthritis; Pruritis; Urinary tract infection*; angina pectoris, hypertension; *Peripheral edema*.

ADVERSE REACTIONS (The following subsection is added.):

Postintroduction Reports

Adverse events associated with Lipitor that have been received since market introduction, that are not listed above, and that may have no causal relationship to drug include the following: angioneurotic edema.

We have completed the review of this supplemental application, including the submitted draft labeling, and have concluded that adequate information has been presented to demonstrate that the drug product is safe and effective for use as recommended in the draft labeling in the submission dated November 5, 1997. Accordingly, the supplemental application is approved effective on the date of this letter.

The final printed labeling (FPL) must be identical to the draft labeling submitted on November 5, 1997.

Please submit 16 copies of the FPL as soon as it is available, in no case more than 30 days after it is printed. Please individually mount ten of the copies on heavy-weight paper or similar material. For administrative purposes, this submission should be designated "FINAL PRINTED LABELING" for approved supplemental NDA 20-702/S-008. Approval of this submission by FDA is not required before the labeling is used.

Should additional information relating to the safety and effectiveness of the drug become available, revision of that labeling may be required.

Should a letter communicating important information about this drug product (i.e., a "Dear Doctor" letter) be issued to physicians and others responsible for patient care, we request that you submit a copy of the letter to this NDA and a copy to the following address:

MEDWATCH, HF-2
FDA
5600 Fishers Lane
Rockville, MD 20852-9787

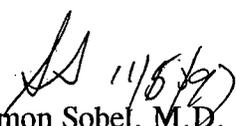
We remind you that you must comply with the requirements for an approved NDA set forth under 21 CFR 314.80 and 314.81.

NDA 20-702/S-008

Page 3

If you have any questions, please contact Margaret Simoneau, R.Ph, Project Manager, at (301) 827-6418.

Sincerely yours,


Solomon Sobel, M.D.

Director

Division of Metabolic and Endocrine Drug
Products

Office of Drug Evaluation II

Center for Drug Evaluation and Research

cc:

Original NDA 20-702

HFD-510/Div. files

HFD-510/CSO/MSimoneau

HFD-510/DOrloff

DISTRICT OFFICE

HF-2/Medwatch (with labeling)

HFD-92/DDM-DIAB (with labeling)

HFD-40/DDMAC (with labeling)

HFD-613/OGD (with labeling)

HFD-735/DPE (with labeling)

HFI-20/Press Office (with labeling)

Drafted by: EMG/November 5, 1997\20702s08.ap

Initialed by: DOrloff *D60 11/5/97*

final: emg/11/5/97

APPROVAL (AP)

**CENTER FOR DRUG EVALUATION AND
RESEARCH**

APPLICATION NUMBER:

20-702/S-008

LABELING

LIPITOR™ (Atorvastatin Calcium) Tablets

1

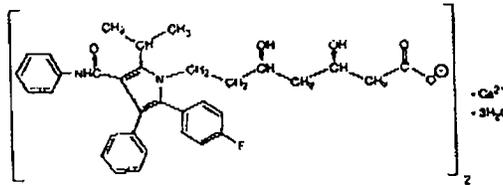
Lipitor®

(Atorvastatin Calcium) Tablets

DESCRIPTION

Lipitor® (atorvastatin calcium) is a synthetic lipid-lowering agent. Atorvastatin is an inhibitor of 3-hydroxy-3-methylglutaryl-coenzyme A (HMG-CoA) reductase. This enzyme catalyzes the conversion of HMG-CoA to mevalonate, an early and rate-limiting step in cholesterol biosynthesis.

Atorvastatin calcium is [R-(R*, R*)]-2-(4-fluorophenyl)-6,8-dihydroxy-5-(1-methylethyl)-3-phenyl-4-[(phenylamino)carbonyl]-1H-pyrrole-1-heptanoic acid, calcium salt (2:1) trihydrate. The empirical formula of atorvastatin calcium is $(C_{27}H_{34}FN_2O_5)_2Ca \cdot 3H_2O$ and its molecular weight is 1209.42. Its structural formula is:



Atorvastatin calcium is a white to off-white crystalline powder that is insoluble in aqueous solutions of pH 4 and below. Atorvastatin calcium is very slightly soluble in distilled water, pH 7.4 phosphate buffer, and acetonitrile, slightly soluble in ethanol, and freely soluble in methanol.

Lipitor tablets for oral administration contain 10, 20, or 40 mg atorvastatin and the following inactive ingredients: calcium carbonate, USP; candelliba wax, FCC; croscarmellose sodium, NF; hydroxypropyl cellulose, NF; lactose monohydrate, NF; magnesium stearate, NF; microcrystalline cellulose, NF; Opadry White YS-1-7040 (hydroxypropylmethylcellulose, polyethylene glycol, talc, titanium dioxide), polysorbate 80, NF; simethicone emulsion.

CLINICAL PHARMACOLOGY**Mechanism of Action**

Atorvastatin is a selective, competitive inhibitor of HMG-CoA reductase, the rate-limiting enzyme that converts 3-hydroxy-3-methylglutaryl-coenzyme A to mevalonate, a precursor of sterols, including cholesterol. Cholesterol and triglycerides circulate in the bloodstream as part of lipoprotein complexes. With ultracentrifugation, these complexes separate into HDL (high-density lipoprotein), IDL (intermediate-density lipoprotein), LDL (low-density lipoprotein), and VLDL (very-low-density lipoprotein) fractions. Triglycerides (TG) and cholesterol in the liver are incorporated into VLDL and released into the plasma for delivery to peripheral tissues. LDL is formed from VLDL and is catabolized primarily through the high-affinity LDL receptor. Clinical and pathologic studies show that elevated plasma levels of total cholesterol (total-C), LDL-cholesterol (LDL-C), and apolipoprotein B (apo B) promote human atherosclerosis and are risk factors for developing cardiovascular disease, while increased levels of HDL-C are associated with a decreased cardiovascular risk.

In animal models, Lipitor lowers plasma cholesterol and lipoprotein levels by inhibiting HMG-CoA reductase and cholesterol synthesis in the liver and by increasing the number of hepatic LDL receptors on the cell-surface to enhance uptake and catabolism of LDL. Lipitor also reduces LDL production and the number of LDL particles. Lipitor reduces LDL-C in some patients with homozygous familial hypercholesterolemia (FH), a population that rarely responds to other lipid-lowering medication(s).

A variety of clinical studies have demonstrated that elevated levels of total-C, LDL-C, and apo B (a membrane complex for LDL-C) promote human atherosclerosis. Similarly, decreased levels of HDL-C (and its transport complex, apo A) are associated with the development of atherosclerosis. Epidemiologic investigations have established that cardiovascular morbidity and mortality vary directly with the level of total-C and LDL-C, and inversely with the level of HDL-C. Although frequently found in association with low HDL-C, elevated plasma TG has not been established as an independent risk factor for coronary heart disease. The independent effect of raising HDL-C or lowering TG on the risk for coronary and cardiovascular morbidity and mortality has not been established.

Lipitor reduces total-C, LDL-C, and apo B in patients with homozygous and heterozygous FH, nonfamilial forms of hypercholesterolemia, and mixed dyslipidemia. Lipitor also reduces VLDL-C and TG and produces variable increases in HDL-C and apolipoprotein A-1. The effect of Lipitor on cardiovascular morbidity and mortality has not been determined.

Pharmacodynamics

Atorvastatin as well as some of its metabolites are pharmacologically active in humans. The liver is the primary site of action and the principal site of cholesterol synthesis and LDL clearance. Drug dosage rather than systemic drug concentration correlates better with LDL-C reduction. Individualization of drug dosage should be based on therapeutic response (see DOSAGE AND ADMINISTRATION).

Pharmacokinetics and Drug Metabolism

Absorption: Atorvastatin is rapidly absorbed after oral administration; maximum plasma concentrations occur within 1 to 2 hours. Extent of absorption increases in proportion to atorvastatin dose. The absolute bioavailability of atorvastatin (parent drug) is approximately 14% and the systemic availability of HMG-CoA reductase inhibitory activity is approximately 30%. The low systemic availability is attributed to presystemic clearance in gastrointestinal mucosa and/or hepatic first-pass metabolism. Although food decreases the rate and extent of drug absorption by approximately 25% and 6%, respectively, as assessed by C_{max} and AUC, LDL-C reduction is similar whether atorvastatin is given with or without food. Plasma atorvastatin concentrations are lower (approximately 30% for C_{max} and AUC) following evening drug administration compared with morning. However, LDL-C reduction is the same regardless of the time of day of drug administration (see DOSAGE AND ADMINISTRATION).

Distribution: Mean volume of distribution of atorvastatin is approximately 381 liters. Atorvastatin is 98% bound to plasma proteins. A blood:plasma ratio of approximately 0.25 indicates poor drug penetration into red blood cells. Based on observations in rats, atorvastatin is likely to be secreted in human milk (see CONTRAINDICATIONS, Pregnancy and Lactation, and PRECAUTIONS, Nursing Mothers).

Not Possible Copy

LIPITOR™ (Atorvastatin Calcium) Tablets

Metabolism: Atorvastatin is extensively metabolized to ortho- and parahydroxylated derivatives and various beta-oxidation products. *In vitro* inhibition of HMG-CoA reductase by ortho- and parahydroxylated metabolites is equivalent to that of atorvastatin. Approximately 70% of circulating inhibitory activity for HMG-CoA reductase is attributed to active metabolites. *In vitro* studies suggest the importance of atorvastatin metabolism by cytochrome P450 3A4, consistent with increased plasma concentrations of atorvastatin in humans following coadministration with erythromycin, a known inhibitor of this isozyme (see PRECAUTIONS, Drug Interactions). In animals, the ortho-hydroxy metabolite undergoes further glucuronidation.

Excretion: Atorvastatin and its metabolites are eliminated primarily in bile following hepatic end/or extra-hepatic metabolism; however, the drug does not appear to undergo enterohepatic recirculation. Mean plasma elimination half-life of atorvastatin in humans is approximately 14 hours, but the half-life of inhibitory activity for HMG-CoA reductase is 20 to 30 hours due to the contribution of active metabolites. Less than 2% of a dose of atorvastatin is recovered in urine following oral administration.

Special Populations

Geriatric: Plasma concentrations of atorvastatin are higher (approximately 40% for C_{max} and 30% for AUC) in healthy elderly subjects (age ≥65 years) than in young adults. LDL-C reduction is comparable to that seen in younger patient populations given equal doses of Lipitor.

Pediatric: Pharmacokinetic data in the pediatric population are not available.

Gender: Plasma concentrations of atorvastatin in women differ from those in men (approximately 20% higher for C_{max} and 10% lower for AUC); however, there is no clinically significant difference in LDL-C reduction with Lipitor between men and women.

Renal Insufficiency: Renal disease has no influence on the plasma concentrations or LDL-C reduction of atorvastatin; thus, dose adjustment in patients with renal dysfunction is not necessary (see DOSAGE AND ADMINISTRATION).

Hemodialysis: While studies have not been conducted in patients with end-stage renal disease, hemodialysis is not expected to significantly enhance clearance of atorvastatin since the drug is extensively bound to plasma proteins.

Hepatic Insufficiency: In patients with chronic alcoholic liver disease, plasma concentrations of atorvastatin are markedly increased. C_{max} and AUC are each 4-fold greater in patients with Childs-Pugh A disease. C_{max} and AUC are approximately 16-fold and 11-fold increased, respectively, in patients with Childs-Pugh B disease (see CONTRAINDICATIONS).

Clinical Studies

Hypercholesterolemia (Heterozygous Familial and Nonfamilial) and Mixed Dyslipidemia (Fredrickson Types IIa and IIb)

Lipitor reduces total-C, LDL-C, VLDL-C, apo B, and TG, and increases HDL-C in patients with hypercholesterolemia and mixed dyslipidemia. Therapeutic response is seen within 2 weeks, and maximum response is usually achieved within 4 weeks and maintained during chronic therapy.

Lipitor is effective in a wide variety of patient populations with hypercholesterolemia, with and without hypertriglyceridemia, in men and women, and in the elderly. Experience in pediatric patients has been limited to patients with homozygous FH.

In two multicenter, placebo-controlled, dose-response studies in patients with hypercholesterolemia, Lipitor given as a single dose over 6 weeks significantly reduced total-C, LDL-C, apo B, and TG (Pooled results are provided in Table 1).

TABLE 1. Dose-Response in Patients With Primary Hypercholesterolemia (Adjusted Mean % Change From Baseline)*

Dose	N	TC	LDL-C	Apo B	TG	HDL-C	Non-HDL-C/ HDL-C
Placebo	21	4	4	3	10	-3	7
10	22	-29	-39	-32	-19	6	-34
20	20	-33	-43	-35	-26	9	-41
40	21	-37	-50	-42	-29	6	-45
80	23	-45	-60	-50	-37	5	-53

*Results are pooled from 2 dose-response studies.

In three multicenter, double-blind studies in patients with hypercholesterolemia, Lipitor was compared to other HMG-CoA reductase inhibitors. After randomization, patients were treated for 10 weeks with either Lipitor 10 mg per day or a fixed dose of the comparative agent (Table 2).

TABLE 2. Mean Percent Change From Baseline at End Point (Double-Blind, Randomized, Active-Controlled Trials)

Treatment (Daily Dose)	N	Total-C	LDL-C	Apo B	TG	HDL-C	Non-HDL-C/ HDL-C
Study 1							
Atorvastatin 10 mg	207	-27 ^a	-36 ^a	-28 ^a	-17 ^a	+7	-37 ^a
Lovastatin 20 mg	191	-19	-27	-20	-6	+7	-26
95% CI for Diff ^b		-9.2, -6.5	-10.7, -7.1	-10.0, -6.5	-15.2, -7.1	-1.7, 2.0	-11.1, -7.1
Study 2							
Atorvastatin 10 mg	272	-25 ^a	-35 ^a	-27 ^a	17 ^a	+6	-36 ^a
Pravastatin 20 mg	77	-17	-23	-17	-9	+8	-28
95% CI for Diff ^c		-10.6, -6.1	-14.5, -8.2	-12.4, -7.4	-14.1, -0.7	-4.9, 1.6	-11.5, -4.1
Study 3							
Atorvastatin 10 mg	132	-29 ^a	-37 ^a	-34 ^a	-23 ^a	+7	-39 ^a
Simvastatin 10 mg	45	-24	-30	-30	-15	+7	-33
95% CI for Diff ^d		-6.7, -2.7	-10.1, -2.6	-8.0, -1.1	-15.1, -0.7	-4.3, 3.9	-9.6, -1.9

^a A negative value for the 95% CI for the difference between treatments favors atorvastatin for all except HDL-C, for which a positive value favors atorvastatin. If the range does not include 0, this indicates a statistically significant difference.

^b Significantly different from lovastatin, ANCOVA, p < 0.05

^c Significantly different from pravastatin, ANCOVA, p < 0.05

^d Significantly different from simvastatin, ANCOVA, p < 0.05

The impact on clinical outcomes of the differences in lipid-altering effects between treatments shown in Table 2 is not known. Table 2 does not contain data comparing the effects of atorvastatin 10 mg and higher doses of lovastatin, pravastatin, and simvastatin. The drugs compared in the studies summarized in the table are not necessarily interchangeable.

In a large clinical study, the number of patients meeting their National Cholesterol Education Program Adult Treatment Panel (NCEP-ATP) II target LDL-C levels on 10 mg of Lipitor daily was assessed. After 10 weeks, 156/167 (93%) of patients with less than 2 risk factors for CHD and baseline LDL-C ≥ 190 mg/dL reached a target of ≤ 160 mg/dL, 141/216 (65%) of patients with 2 or more risk factors for CHD and LDL-C ≥ 160 mg/dL achieved a level of ≤ 130 mg/dL LDL-C, and 27/113 (19%) of patients with CHD and LDL-C ≥ 130 mg/dL reached a target level of ≤ 100 mg/dL LDL-C.

Homozygous Familial Hypercholesterolemia

In a study without a concurrent control group, 29 patients, ages 6 to 37 years with homozygous FH received maximum daily doses of 20 to 80 mg of Lipitor. The mean LDL-C reduction in this study was 18%. Twenty-five patients with a reduction in LDL-C had a mean response of 20% (range of 7% to 53%, median of 24%); the remaining 4 patients had 7% to 24% increases in LDL-C. Five of the 29 patients had absent LDL-receptor function. Of these, 2 patients also had a portacaval shunt and had no significant reduction in LDL-C. The

LIPITOR™ (Atorvastatin Calcium) Tablets

3

INDICATIONS AND USAGE

Lipitor is indicated as an adjunct to diet to reduce elevated total-C, LDL-C, apo B, and TG levels in patients with primary hypercholesterolemia (heterozygous familial and nonfamilial) and mixed dyslipidemia (Fredrickson Types IIa and IIb).

Lipitor is also indicated to reduce total-C and LDL-C in patients with homozygous familial hypercholesterolemia as an adjunct to other lipid-lowering treatments (eg, LDL apheresis) or if such treatments are unavailable.

Therapy with lipid-altering agents should be a component of multiple-risk-factor intervention in individuals at increased risk for atherosclerotic vascular disease due to hypercholesterolemia. Lipid-altering agents should be used in addition to a diet restricted in saturated fat and cholesterol only when the response to diet and other nonpharmacological measures has been inadequate (see *National Cholesterol Education Program (NCEP) Guidelines*, summarized in Table 3).

TABLE 3. NCEP Guidelines for Lipid Management

Definite Atherosclerotic Disease ^a	Two or More Other Risk Factors ^b	LDL-Cholesterol mg/dL (mmol/L)	
		Initiation Level	Minimum Goal
No	No	≥190 (≥4.9)	<160 (<4.1)
No	Yes	≥160 (≥4.1)	<130 (<3.4)
Yes	Yes or No	≥130 ^c (≥3.4)	≤100 (≤2.6)

^a Coronary heart disease or peripheral vascular disease (including symptomatic carotid artery disease).

^b Other risk factors for coronary heart disease (CHD) include: age (males: ≥45 years; females: ≥55 years or premature menopause without estrogen replacement therapy); family history of premature CHD; current cigarette smoking; hypertension; confirmed HDL-C <35 mg/dL (<0.91 mmol/L); and diabetes mellitus. Subtract 1 risk factor if HDL-C is ≥60 mg/dL (≥1.6 mmol/L).

^c In CHD patients with LDL-C levels 100 to 129 mg/dL, the physician should exercise clinical judgment in deciding whether to initiate drug treatment.

At the time of hospitalization for an acute coronary event, consideration can be given to initiating drug therapy at discharge if the LDL-C level is ≥130 mg/dL (NCEP-ATP II).

Prior to initiating therapy with Lipitor, secondary causes for hypercholesterolemia (eg, poorly controlled diabetes mellitus, hypothyroidism, nephrotic syndrome, dysproteinemias, obstructive liver disease, other drug therapy, and alcoholism) should be excluded, and a lipid profile performed to measure total-C, LDL-C, HDL-C, and TG. For patients with TG <400 mg/dL (<4.5 mmol/L), LDL-C can be estimated using the following equation: LDL-C = total-C - (0.20 x TG) + HDL-C. For TG levels >400 mg/dL (>4.5 mmol/L), this equation is less accurate and LDL-C concentrations should be determined by ultracentrifugation.

CONTRAINDICATIONS

Active liver disease or unexplained persistent elevations of serum transaminases.

Hypersensitivity to any component of this medication.

Pregnancy and Lactation

Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. ATORVASTATIN SHOULD BE ADMINISTERED TO WOMEN OF CHILD-BEARING AGE ONLY WHEN SUCH PATIENTS ARE HIGHLY UNLIKELY TO CONCEIVE AND HAVE BEEN INFORMED OF THE POTENTIAL HAZARDS. If the patient becomes pregnant while taking this drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

WARNINGS

Liver Dysfunction

HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Persistent elevations (>3 times the upper limit of normal [ULN]) occurring on 2 or more occasions in serum transaminases occurred in 0.7% of patients who received atorvastatin in clinical trials. The incidence of these abnormalities was 0.2%, 0.2%, 0.6%, and 2.3% for 10, 20, 40, and 80 mg, respectively.

One patient in clinical trials developed jaundice. Increases in liver function tests (LFT) in other patients were not associated with jaundice or other clinical signs or symptoms. Upon dose reduction, drug interruption, or discontinuation, transaminase levels returned to or near pretreatment levels without sequelae. Eighteen of 30 patients with persistent LFT elevations continued treatment with a reduced dose of atorvastatin.

It is recommended that liver function tests be performed before the initiation of treatment, at 6 and 12 weeks after initiation of therapy or elevation in dose, and periodically (eg, semiannually) thereafter. Liver enzyme changes generally occur in the first 3 months of treatment with atorvastatin. Patients who develop increased transaminase levels should be monitored until the abnormalities resolve. Should an increase in ALT or AST of >3 times ULN persist, reduction of dose or withdrawal of atorvastatin is recommended.

Atorvastatin should be used with caution in patients who consume substantial quantities of alcohol and/or have a history of liver disease. Active liver disease or unexplained persistent transaminase elevations are contraindications to the use of atorvastatin (see CONTRAINDICATIONS).

Skeletal Muscle

Rhabdomyolysis with acute renal failure secondary to myoglobinuria has been reported with other drugs in this class.

Uncomplicated myalgia has been reported in atorvastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aches or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values >10 times ULN, should be considered in any patient with diffuse myalgia, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. Atorvastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected.

The risk of myopathy during treatment with other drugs in this class is increased with concurrent administration of cyclosporine, fibric acid derivatives, erythromycin, niacin, or azole antifungals. Physicians considering combined therapy with atorvastatin and fibric acid derivatives, erythromycin, immunosuppressive drugs, azole antifungals, or lipid-lowering doses of niacin should carefully weigh the potential benefits and risks and should carefully monitor patients for any signs or symptoms of muscle pain, tenderness, or weakness, particularly during the initial months of therapy and during any periods of upward dosage titration of either drug. Periodic creatine phosphokinase (CPK) determinations may be considered in such situations, but there is no assurance that such monitoring will prevent the occurrence of severe myopathy.

Atorvastatin therapy should be temporarily withheld or discontinued in any patient with an acute, serious condition suggestive of a myopathy or having a risk factor predisposing to the development of renal failure secondary to rhabdomyolysis (eg, severe acute infection, hypotension, major surgery, trauma, severe metabolic, endocrine and electrolyte disorders, and uncontrolled seizures).

LIPITOR™ (Atorvastatin Calcium) Tablets

4

PRECAUTIONS**General**

Before instituting therapy with atorvastatin, an attempt should be made to control hypercholesterolemia with appropriate diet, exercise, and weight reduction in obese patients, and to treat other underlying medical problems (see INDICATIONS AND USAGE).

Information for Patients

Patients should be advised to report promptly unexplained muscle pain, tenderness, or weakness, particularly if accompanied by malaise or fever.

Drug Interactions

The risk of myopathy during treatment with other drugs of this class is increased with concurrent administration of cyclosporine, fibric acid derivatives, niacin (nicotinic acid), erythromycin,azole antifungals (see WARNINGS, Skeletal Muscles).

Antacid: When atorvastatin and Maalox® TC suspension were coadministered, plasma concentrations of atorvastatin decreased approximately 35%. However, LDL-C reduction was not altered.

Antipyrene: Because atorvastatin does not affect the pharmacokinetics of antipyrene, interactions with other drugs metabolized via the same cytochrome isozymes are not expected.

Colestipol: Plasma concentrations of atorvastatin decreased approximately 25% when colestipol and atorvastatin were coadministered. However, LDL-C reduction was greater when atorvastatin and colestipol were coadministered than when either drug was given alone.

Cimetidine: Atorvastatin plasma concentrations and LDL-C reduction were not altered by coadministration of cimetidine.

Digoxin: When multiple doses of atorvastatin and digoxin were coadministered, steady-state plasma digoxin concentrations increased by approximately 20%. Patients taking digoxin should be monitored appropriately.

Erythromycin: In healthy individuals, plasma concentrations of atorvastatin increased approximately 40% with coadministration of atorvastatin and erythromycin, a known inhibitor of cytochrome P450 3A4 (see WARNINGS, Skeletal Muscles).

Oral Contraceptives: Coadministration of atorvastatin and an oral contraceptive increased AUC values for norethindrone and ethinyl estradiol by approximately 30% and 20%. These increases should be considered when selecting an oral contraceptive for a woman taking atorvastatin.

Warfarin: Atorvastatin had no clinically significant effect on prothrombin time when administered to patients receiving chronic warfarin treatment.

Other Concomitant Therapy: In clinical studies, atorvastatin was used concomitantly with antihypertensive agents and estrogen replacement therapy without evidence of clinically significant adverse interactions. Interaction studies with specific agents have not been conducted.

Endocrine Function

HMG-CoA reductase inhibitors interfere with cholesterol synthesis and theoretically might blunt adrenal and/or gonadal steroid production. Clinical studies have shown that atorvastatin does not reduce basal plasma cortisol concentration or impair adrenal reserve. The effects of HMG-CoA reductase inhibitors on male fertility have not been studied in adequate numbers of patients. The effects, if any, on the pituitary-gonadal axis in premenopausal women are unknown. Caution should be exercised if an HMG-CoA reductase inhibitor is administered concomitantly with drugs that may decrease the levels or activity of endogenous steroid hormones, such as ketoconazole, spironolactone, and cimetidine.

CNS Toxicity

Brain hemorrhage was seen in a female dog treated for 3 months at 120 mg/kg/day. Brain hemorrhage and optic nerve vacuolation were seen in another female dog that was sacrificed in moribund condition after 11 weeks of escalating doses up to 280 mg/kg/day. The 120 mg/kg dose resulted in a systemic exposure approximately 16 times the human plasma area-under-the-curve (AUC, 0-24 hours) based on the maximum human dose of 80 mg/day. A single tonic convulsion was seen in each of 2 male dogs (one treated at 10 mg/kg/day and one at 120 mg/kg/day) in a 2-year study. No CNS lesions have been observed in mice after chronic treatment for up to 2 years at doses up to 400 mg/kg/day or in rats at doses up to 100 mg/kg/day. These doses were 6 to 11 times (mice) and 8 to 16 times (rat) the human AUC (0-24) based on the maximum recommended human dose of 80 mg/day.

CNS vascular lesions, characterized by perivascular hemorrhages, edema, and mononuclear cell infiltration of perivascular spaces, have been observed in dogs treated with other members of this class. A chemically similar drug in this class produced optic nerve degeneration (Wallierian degeneration of retinogenicular fibers) in clinically normal dogs in a dose-dependent fashion at a dose that produced plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility

In a 2-year carcinogenicity study in rats at dose levels of 10, 30, and 100 mg/kg/day, 2 rare tumors were found in muscle in high-dose females: in one, there was a rhabdomyosarcoma and, in another, there was a fibrosarcoma. This dose represents a plasma AUC (0-24) value of approximately 16 times the mean human plasma drug exposure after an 80 mg oral dose.

A 2-year carcinogenicity study in mice given 100, 200, or 400 mg/kg/day resulted in a significant increase in liver adenomas in high-dose males and liver carcinomas in high-dose females. These findings occurred at plasma AUC (0-24) values of approximately 6 times the mean human plasma drug exposure after an 80 mg oral dose.

In vitro, atorvastatin was not mutagenic or clastogenic in the following tests with and without metabolic activation: the Ames test with *Salmonella typhimurium* and *Escherichia coli*, the HGPRT forward mutation assay in Chinese hamster lung cells, and the chromosomal aberration assay in Chinese hamster lung cells. Atorvastatin was negative in the *in vivo* mouse micronucleus test.

Studies in rats performed at doses up to 175 mg/kg (15 times the human exposure) produced no changes in fertility. There was aplasia and aspermia in the epididymus of 2 of 10 rats treated with 100 mg/kg/day of atorvastatin for 3 months (16 times the human AUC at the 80 mg dose); testis weights were significantly lower at 30 and 100 mg/kg and epididymal weight was lower at 100 mg/kg. Male rats given 100 mg/kg/day for 11 weeks prior to mating had decreased sperm motility, sperm head concentration, and increased abnormal sperm. Atorvastatin caused no adverse effects on semen parameters, or reproductive organ histopathology in dogs given doses of 10, 40, or 120 mg/kg for two years.

Pregnancy**Pregnancy Category X****See CONTRAINDICATIONS**

Safety in pregnant women has not been established. Atorvastatin crosses the rat placenta and reaches a level in fetal liver equivalent to that of maternal plasma. Atorvastatin was not teratogenic in rats at doses up to 300 mg/kg/day or in rabbits at doses up to 100 mg/kg/day. These doses resulted in multiples of about 30 times (rat) or 20 times (rabbit) the human exposure based on surface area (mg/m²).

In a study in rats given 20, 100, or 225 mg/kg/day, from gestation day 7 through to lactation day 21 (weaning), there was decreased pup survival at birth, neonate, weaning, and maturity in pups of mothers dosed with 225 mg/kg/day. Body weight was decreased on days 4 and 21 in pups of mothers dosed at 100 mg/kg/day; pup body weight was decreased at birth and at days 4, 21, and 91 at 225 mg/kg/day. Pup development was delayed (rotarod performance at 100 mg/kg/day and acoustic startle at 225 mg/kg/day; pinnae detachment and eye opening at 225 mg/kg/day). These doses correspond to 6 times (100 mg/kg) and 27 times (225 mg/kg) the human AUC at 80 mg/day.

Rare reports of congenital anomalies have been received following intrauterine exposure to HMG-CoA reductase inhibitors. There has been one report of severe congenital bony deformity, tracheo-esophageal fistula, and anal atresia (VATER association) in a baby born to a woman who took lovastatin with dextroamphetamine sulfate during the first trimester of pregnancy. Lipitor should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking Lipitor, it should be dis-

LIPITOR™ (Atorvastatin Calcium) Tablets

5

Nursing Mothers

Nursing rat pups had plasma and liver drug levels of 50% and 40%, respectively, of that in their mother's milk. Because of the potential for adverse reactions in nursing infants, women taking Lipitor should not breast-feed (see CONTRAINDICATIONS).

Pediatric Use

Treatment experience in a pediatric population is limited to doses of Lipitor up to 80 mg/day for 1 year in 8 patients with homozygous FH. No clinical or biochemical abnormalities were reported in these patients. None of these patients was below 9 years of age.

Geriatric Use

Treatment experience in adults age ≥70 years with doses of Lipitor up to 80 mg/day has been evaluated in 221 patients. The safety and efficacy of Lipitor in this population were similar to those of patients <70 years of age.

ADVERSE REACTIONS

Lipitor is generally well-tolerated. Adverse reactions have usually been mild and transient. In controlled clinical studies of 2502 patients, <2% of patients were discontinued due to adverse experiences attributable to atorvastatin. The most frequent adverse events thought to be related to atorvastatin were constipation, flatulence, dyspepsia, and abdominal pain.

Clinical Adverse Experiences

Adverse experiences reported in ≥2% of patients in placebo-controlled clinical studies of atorvastatin, regardless of causality assessment, are shown in Table 4.

**TABLE 4. Adverse Events in Placebo-Controlled Studies
(% of Patients)**

ADVERSE EVENT	Placebo N = 270	Atorvastatin 10 mg N = 882	Atorvastatin 20 mg N = 36	Atorvastatin 40 mg N = 79	Atorvastatin 80 mg N = 94
BODY AS A WHOLE					
Infection	10.0	10.3	2.8	10.1	7.4
Headache	7.0	5.4	16.7	2.5	6.4
Accidental Injury	3.7	4.2	0.0	1.3	3.7
Flu Syndrome	1.9	2.2	0.0	2.5	3.2
Abdominal Pain	0.7	2.8	0.0	3.8	2.1
Back Pain	3.0	2.8	0.0	3.8	1.1
Allergic Reaction	2.6	0.9	2.8	1.3	0.0
Asthenia	1.9	2.2	0.0	3.8	0.0
DIGESTIVE SYSTEM					
Constipation	1.8	2.1	0.0	2.5	1.1
Diarrhea	1.5	2.7	0.0	3.8	5.3
Dyspepsia	4.1	2.3	2.8	1.3	2.1
Flatulence	3.3	2.1	2.8	1.3	1.1
RESPIRATORY SYSTEM					
Sinusitis	2.6	2.8	0.0	2.5	6.4
Pharyngitis	1.5	2.5	0.0	1.3	2.1
SKIN AND APPENDAGES					
Rash	0.7	3.9	2.8	3.8	1.1
MUSCULOSKELETAL SYSTEM					
Arthralgia	1.5	2.0	0.0	5.1	0.0
Myalgia	1.1	3.7	5.6	1.3	0.0

The following adverse events were reported, regardless of causality assessment in patients treated with atorvastatin in clinical trials. The events in italics occurred in ≥2% of patients and the events in plain type occurred in <2% of patients.

Body as a Whole: *Chest pain, facial edema, fever, neck rigidity, malaise, photosensitivity reaction, generalized edema.*

Digestive System: *Nausea, gastroenteritis, liver function tests abnormal, colitis, vomiting, gastritis, dry mouth, rectal hemorrhage, esophagitis, eructation, glossitis, mouth ulceration, anorexia, increased appetite, stomatitis, biliary pain, chills, duodenal ulcer, dysphagia, enteritis, melena, gum hemorrhage, stomach ulcer, tenesmus, ulcerative stomatitis, hepatitis, pancreatitis, cholestatic jaundice.*

Respiratory System: *Tracheitis, rhinitis, pneumonia, dyspnea, asthma, epistaxis.*

Nervous System: *Insomnia, dizziness, paresthesia, somnolence, amnesia, abnormal dreams, libido decreased, emotional lability, incoordination, peripheral neuropathy, torticollis, facial paralysis, hyperkinesia, depression, hyposthesia, hypertonia.*

Musculoskeletal System: *Arthritis, leg cramp, bursitis, tenosynovitis, myasthenia, tendinous contracture, myositis.*

Skin and Appendages: *Pruritus, contact dermatitis, alopecia, dry skin, sweating, acne, urticaria, eczema, scabrothea, skin ulcer.*

Urogenital System: *Urinary tract infection, urinary frequency, cystitis, hematuria, impotence, dysuria, kidney calculus, nocturia, epididymitis, fibrocystic breast, vaginal hemorrhage, albuminuria, breast enlargement, metrorrhagia, nephritis, urinary incontinence, urinary retention, urinary urgency, abnormal ejaculation, uterine hemorrhage.*

Special Senses: *Amblyopia, tinnitus, dry eyes, refraction disorder, eye hemorrhage, deafness, glaucoma, parosmia, taste loss, taste perversion.*

Cardiovascular System: *Palpitation, vasodilatation, syncope, migraines, postural hypotension, phlebitis, arrhythmia, angina pectoris, hypertension.*

Metabolic and Nutritional Disorders: *Peripheral edema, hyperglycemia, creatine phosphokinase increased, gout, weight gain, hypoglycemia.*

Hemic and Lymphatic System: *Echymosis, anemia, lymphadenopathy, thrombocytopenia, ptechia.*

Postmarketing Reports

Adverse events associated with Lipitor that have been received since market introduction, that are not listed above, and that may have no causal relationship to drug include the following: angioneurotic edema

OVERDOSAGE

There is no specific treatment for atorvastatin overdosage. In the event of an overdose, the patient should be treated symptomatically, and supportive measures instituted as required. Due to extensive drug binding to plasma proteins, hemodialysis is not expected to significantly enhance atorvastatin clearance.

LIPITOR™ (Atorvastatin Calcium) Tablets

6

DOSAGE AND ADMINISTRATION

The patient should be placed on a standard cholesterol-lowering diet before receiving Lipitor and should continue on this diet during treatment with Lipitor.

Hypercholesterolemia (Heterozygous Familial and Nonfamilial) and Mixed Dyslipidemia (Fredrickson Types IIa and IIb)

The recommended starting dose of Lipitor is 10 mg once daily. The dosage range is 10 to 80 mg once daily. Lipitor can be administered as a single dose at any time of the day, with or without food. Therapy should be individualized according to goal of therapy and response (see NCEP Guidelines, summarized in Table 3). After initiation and/or upon titration of Lipitor, lipid levels should be analyzed within 2 to 4 weeks and dosage adjusted accordingly.

Since the goal of treatment is to lower LDL-C, the NCEP recommends that LDL-C levels be used to initiate and assess treatment response. Only if LDL-C levels are not available, should total-C be used to monitor therapy.

Homozygous Familial Hypercholesterolemia

The dosage of Lipitor in patients with homozygous FH is 10 to 80 mg daily. Lipitor should be used as an adjunct to other lipid-lowering treatments (eg, LDL apheresis) in these patients or if such treatments are unavailable.

Concomitant Therapy

Atorvastatin may be used in combination with a bile acid binding resin for additive effect. The combination of HMG-CoA reductase inhibitors and fibrates should generally be avoided (see WARNINGS, Skeletal Muscle, and PRECAUTIONS, Drug Interactions for other drug-drug interactions).

Dosage in Patients With Renal Insufficiency

Renal disease does not affect the plasma concentrations nor LDL-C reduction of atorvastatin; thus, dosage adjustment in patients with renal dysfunction is not necessary (see CLINICAL PHARMACOLOGY, Pharmacokinetics).

HOW SUPPLIED

Lipitor is supplied as white, elliptical, film-coated tablets of atorvastatin calcium containing 10, 20, and 40 mg atorvastatin.

10 mg tablets: coded "PD 155" on one side and "10" on the other

N0071-0155-23 bottles of 90

N0071-0155-34 bottles of 5000

N0071-0155-40 10 x 10 unit dose blisters

20 mg tablets: coded "PD 156" on one side and "20" on the other.

N0071-0156-23 bottles of 90

N0071-0156-40 10 x 10 unit dose blisters

40 mg tablets: coded "PD 157" on one side and "40" on the other.

N0071-0157-23 bottles of 90

Storage

Store at controlled room temperature 20 C to 25 C (68 F to 77 F) [see USP].

Caution - Federal law prohibits dispensing without prescription.

© 1997, Warner-Lambert Co.

Revised November 1997

PARKE-DAVIS

Div of Warner-Lambert Co
Morris Plains, NJ 07950 USA
MADE IN GERMANY

Marketed by:

PARKE-DAVIS

Div of Warner-Lambert Co and
PFIZER Inc.
New York, NY 10017

0155G023

**CENTER FOR DRUG EVALUATION AND
RESEARCH**

APPLICATION NUMBER:

20-702/S-008

ADMINISTRATIVE and CORRESPONDENCE
DOCUMENTS



Food and Drug Administration
Rockville MD 20857

NDA 20-702/S-008

SEP 4 1998

Parke-Davis Pharmaceutical Research, agent for
Warner-Lambert Export, Limited
Attention: Byron Scott, R.Ph.
Director Worldwide Regulatory Affairs
2800 Plymouth Road
Ann Arbor, MI 48105

Dear Mr. Scott:

We acknowledge the receipt of your April 18 and December 10, 1997, submissions containing final printed labeling in response to our letters approving your new drug application (NDA) and supplemental application, S-008, respectively, for Lipitor (atorvastatin calcium) Tablets.

We note that your additional supplemental applications S-003 and S-005, approved on July 10, 1998, supersede these applications. Therefore, we will not review these applications but they will be retained in our files.

If you have any questions, contact Margaret Simoneau, R.Ph., Regulatory Management Officer, at (301)827-6418.

Sincerely,

Solomon Sobel, M.D.
Director
Division of Metabolic and Endocrine Drug Products
Office of Drug Evaluation II
Center for Drug Evaluation and Research

cc:

Archival NDA 20-702
HFD-510/Div. Files
HFD-510/M. Simoneau
HF-2/Medwatch
HFD-102/ADRA
HFD-40/DDMAC
HFD-95/DDMS
HFD-613/OGD
HFD-735/OPDRA
DISTRICT OFFICE

Drafted by: Mas/August 28, 1998

Initialed by: E. Galliers 8.31.98

final: Mas 8.31.98

filename: 20702.AR

eng/9.4.98

ACKNOWLEDGE AND RETAIN (AR)

April 18, 1997 (N-doc-FA)

Dec. 10, 1997 (S-008)



December 10, 1997

NDA 20-702

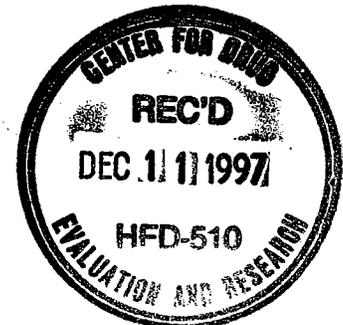
Ref. No. 55

Lipitor® (atorvastatin calcium) Tablets

/ S-008

Re: FINAL PRINTED LABELING
for Approved Supplemental
NDA 20-702/S-008

Solomon Sobel, M.D.
Director
Division of Metabolic and Endocrine
Drug Products (HFD-510)
Document Control Room 14B-19
Center for Drug Evaluation and Research
Food and Drug Administration
5600 Fishers Lane
Rockville, Maryland 20857



Dear Dr. Sobel:

Reference is made to our approved NDA 20-702 for Lipitor® (atorvastatin calcium) Tablets.

Reference is also made to your letter of November 5, 1997, which approved our labeling supplement (S-008) submitted on September 5, 1997. This supplement provided for additions to the CLINICAL PHARMACOLOGY and ADVERSE REACTIONS sections of the labeling. In your approval letter, you requested sixteen copies of final printed labeling as soon as it was available.

Per your request, we are providing you with sixteen copies of the final printed labeling in Attachment 1. The specification number of this package insert is 0155G023 and the revision date is November 1997

If you have any questions or require additional information, please do not hesitate to contact me at 973/540-3113 or FAX 973/540-5972.

REVIEWS COMPLETED	
CSO ACTION:	
<input type="checkbox"/> LETTER	<input type="checkbox"/> N.A.I. <input type="checkbox"/> MEMO
CSO INITIALS	DATE

Sincerely,

James A. Parker, Jr.
Director

Advertising and Labeling
Worldwide Regulatory Affairs

JP\sv\rm t:\nda\20-702\120897-55

Attachment

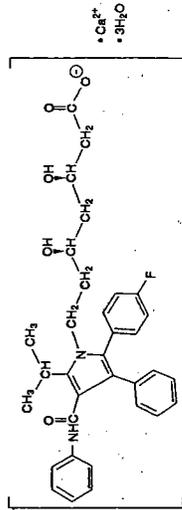


Lipitor® (Atorvastatin Calcium) Tablets

DESCRIPTION

Lipitor® (atorvastatin calcium) is a synthetic lipid-lowering agent. Atorvastatin is an inhibitor of 3-hydroxy-3-methylglutaryl-coenzyme A (HMG-CoA) reductase. This enzyme catalyzes the conversion of HMG-CoA to mevalonate, an early and rate-limiting step in cholesterol biosynthesis.

Atorvastatin calcium is [R-(R*), S-(S*)]-2-(4-fluorophenyl)-5-[2-(4-hydroxy-5-(1-methylethyl)-3-phenyl)-4-(phenylamino)carbonyl]-1H-pyrrole-1-heptanoic acid, calcium salt (2:1) trihydrate. The empirical formula of atorvastatin calcium is $(C_{28}H_{37}FNO_6)_2 \cdot Ca_2 \cdot 3H_2O$ and its molecular weight is 1209.42. Its structural formula is:



Atorvastatin calcium is a white to off-white crystalline powder that is insoluble in aqueous solutions of pH 4 and below. Atorvastatin calcium is very slightly soluble in distilled water, pH 7.4 phosphate buffer, and acetone/triethylamine, slightly soluble in ethanol, and freely soluble in methanol.

Lipitor tablets for oral administration contain 10, 20, or 40 mg atorvastatin and the following inactive ingredients: calcium carbonate, USP; candellilla wax, FCC; croscarmellose sodium, NF; hydroxypropyl cellulose, NF; lactose monohydrate, NF; magnesium stearate, NF; microcrystalline cellulose, NF; Opadry White YS-1-7040 (hydroxypropylmethylcellulose, polyethylene glycol, talc, titanium dioxide); polyorbate 80, NF; simethicone emulsion.

CLINICAL PHARMACOLOGY

Mechanism of Action

Atorvastatin is a selective, competitive inhibitor of HMG-CoA reductase, the rate-limiting enzyme that converts 3-hydroxy-3-methylglutaryl-coenzyme A to mevalonate, a precursor of sterols, including cholesterol. Cholesterol and triglycerides circulate in the bloodstream as part of lipoprotein complexes. With ultracentrifugation, these complexes separate into HDL (high-density lipoprotein), LDL (intermediate-density lipoprotein), LDL (low-density lipoprotein), and VLDL (very-low-density lipoprotein) fractions. Triglycerides (TG) and cholesterol in the liver are incorporated into VLDL and released into the plasma for delivery to peripheral tissues. LDL is formed from VLDL and is catabolized primarily through the high-affinity LDL receptor. Clinical and pathologic studies show that elevated plasma levels of total cholesterol (total-C), LDL-cholesterol (LDL-C), and apolipoprotein B (apo B) promote human atherosclerosis and are risk factors for developing cardiovascular disease, while increased levels of HDL-C are associated with a decreased cardiovascular risk.

In animal models, Lipitor lowers plasma cholesterol and lipoprotein levels by inhibiting HMG-CoA reductase and cholesterol synthesis in the liver and by increasing the number of hepatic LDL receptors on the cell-surface to enhance uptake and catabolism of LDL. Lipitor also reduces LDL production and the number of LDL particles. Lipitor reduces LDL-C in some patients with homozygous familial hypercholesterolemia (FH), a population that rarely responds to other lipid-lowering medication(s).

A variety of clinical studies have demonstrated that elevated levels of total-C, LDL-C, and apo B (a membrane complex for LDL-C) promote human atherosclerosis. Similarly, decreased levels of HDL-C (and its transport complex, apo A) are associated with the development of atherosclerosis. Epidemiologic investigations have established that cardiovascular morbidity and mortality vary directly with the level of total-C

Lipitor® (Atorvastatin Calcium) Tablets

TABLE 1. Dose-Response in Patients With Primary Hypercholesterolemia (Adjusted Mean % Change From Baseline)*

Dose	N	TC	LDL-C	Apo B	TG	HDL-C	Non-HDL-C/HDL-C
Placebo	21	4	4	3	10	-3	7
10	22	-29	-39	-32	-19	6	-34
20	21	-33	-43	-35	-26	9	-41
40	21	-37	-50	-42	-29	6	-45
80	23	-45	-60	-50	-37	5	-53

*Results are pooled from 2 dose-response studies

In three multicenter, double-blind studies in patients with hypercholesterolemia, Lipitor was compared to other HMG-CoA reductase inhibitors. After randomization, patients were treated for 18 weeks with either Lipitor 10 mg per day or a fixed dose of the comparative agent (Table 2).

TABLE 2. Mean Percent Change From Baseline at End Point (Double-Blind, Randomized, Active-Controlled Trials)

Treatment (Daily Dose)	N	Total-C	LDL-C	Apo B	TG	HDL-C	Non-HDL-C/HDL-C
Study 1							
Atorvastatin 10 mg	707	-17*	-36*	-28*	-17*	+7	-37*
Lovastatin 20 mg	181	-20	-27	-20	-6	+7	-28
95% CI for Diff†		-9.2, -6.5	-10.7, -7.1	-10.0, -6.5	-16.2, -7.1	-17.2, 0	-11.1, -7.1
Study 2							
Atorvastatin 10 mg	222	-16*	-36*	-27*	-17*	+6	-36*
Pravastatin 20 mg	77	-17	-23	-17	-9	+8	-28
95% CI for Diff†		-10.8, -6.1	-14.5, -8.2	-13.4, -7.4	-14.1, -0.7	-4.9, 1.6	-11.5, -4.1
Study 3							
Atorvastatin 10 mg	132	-29*	-37*	-34*	-23*	+7	-39*
Simvastatin 10 mg	45	-24	-30	-30	-15	+7	-33
95% CI for Diff†		-8.7, -2.7	-10.1, -2.6	-9.0, -1.1	-15.1, -0.7	-4.3, 3.9	-9.6, -1.9

† A negative value for the 95% CI for the difference between treatments favors atorvastatin for all except HDL-C, for which a positive value favors atorvastatin. If the range does not include 0, this indicates a statistically significant difference.
* Statistically different from pravastatin, ANCOVA, p < 0.05
† Significantly different from simvastatin, ANCOVA, p < 0.05

The impact on clinical outcomes of the differences in lipid-altering effects between treatments shown in Table 2 is not known. Table 2 does not contain data comparing the effects of atorvastatin 10 mg and higher doses of lovastatin, pravastatin, and simvastatin. The drugs compared in the studies summarized in the table are not necessarily interchangeable.

In a large clinical study, the number of patients meeting their National Cholesterol Education Program-Adult Treatment Panel II (NCEP-ATPII) target LDL-C levels on 10 mg of Lipitor daily was assessed. After 16 weeks, 168/167 (95%) of patients with less than 2 risk factors for CHD and baseline LDL-C \geq 190 mg/dL reached a target of \leq 160 mg/dL, 147/128 (95%) of patients with 2 or more risk factors for CHD and LDL-C \geq 160 mg/dL achieved a level of \leq 130 mg/dL LDL-C, and 21/113 (19%) of patients with CHD and LDL-C \geq 130 mg/dL reached a target level of \leq 100 mg/dL LDL-C.

Homozygous Familial Hypercholesterolemia

In a study without a concurrent control group, 29 patients ages 6 to 37 years with homozygous FH received maximum daily doses of 20 to 80 mg of Lipitor. The mean LDL-C reduction in this study was 19%. Twenty-five patients with a reduction in LDL-C had a mean response of 20% (range of 7% to 53%, median of 24%); the remaining 4 patients had 7% to 24% increases in LDL-C. Five of the 29 patients had absent LDL-receptor function. Of these, 2 patients also had a portacaval shunt and had no significant reduction in LDL-C. The remaining 3 receptor-negative patients had a mean LDL-C reduction of 22%.

INDICATIONS AND USAGE

...population that rarely responds to other lipid-lowering medication(s).

A variety of clinical studies have demonstrated that elevated levels of total-C, LDL-C, and apo B (a membrane complex for LDL-C) promote human atherosclerosis. Similarly, decreased levels of HDL-C (and its transport complex, apo A) are associated with the development of atherosclerosis. Epidemiologic investigations have established that cardiovascular morbidity and mortality vary directly with the level of total-C and LDL-C, and inversely with the level of HDL-C. Although frequently found in association with low HDL-C, elevated plasma TG has not been established as an independent risk factor for coronary heart disease. The independent effect of raising HDL-C or lowering TG on the risk for coronary and cardiovascular morbidity and mortality has not been established.

Lipitor reduces total-C, LDL-C, and apo B in patients with homozygous and heterozygous FH, nonfamilial forms of hypercholesterolemia, and mixed dyslipidemia. Lipitor also reduces VLDL-C and TG and produces variable increases in HDL-C and apolipoprotein A-1. The effect of Lipitor on cardiovascular morbidity and mortality has not been determined.

Pharmacodynamics

Atorvastatin as well as some of its metabolites are pharmacologically active in humans. The liver is the primary site of action and the principal site of cholesterol synthesis and LDL clearance. Drug dosage rather than systemic drug concentration correlates better with LDL-C reduction. Individualization of drug dosage should be based on therapeutic response (see DOSAGE AND ADMINISTRATION).

Pharmacokinetics and Drug Metabolism

Absorption: Atorvastatin is rapidly absorbed after oral administration; maximum plasma concentrations occur within 1 to 2 hours. Extent of absorption increases in proportion to atorvastatin dose. The absolute bioavailability of atorvastatin (parent drug) is approximately 14% and the systemic availability of HMG-CoA reductase inhibitory activity is approximately 30%. The low systemic availability is attributed to presystemic clearance in gastrointestinal mucosa and/or hepatic first-pass metabolism. Although food decreases the rate and extent of drug absorption by approximately 25% and 9%, respectively, as assessed by C_{max} and AUC, LDL-C reduction is similar whether atorvastatin is given with or without food. Plasma atorvastatin concentrations are lower (approximately 30% for C_{max} and AUC) following evening drug administration compared with morning. However, LDL-C reduction is the same regardless of the time of day of drug administration (see DOSAGE AND ADMINISTRATION).

Distribution: Mean volume of distribution of atorvastatin is approximately 381 liters. Atorvastatin is ≥98% bound to plasma proteins. A blood/plasma ratio of approximately 0.25 indicates poor drug penetration into red blood cells. Based on observations in rats, atorvastatin is likely to be secreted in human milk (see CONTRAINDICATIONS, Pregnancy and Lactation, and PRECAUTIONS, Nursing Mothers).

Metabolism: Atorvastatin is extensively metabolized to ortho- and parahydroxylated derivatives and various beta-oxidation products. *In vitro* inhibition of HMG-CoA reductase by ortho- and parahydroxylated metabolites is equivalent to that of atorvastatin. Approximately 70% of circulating inhibitory activity for HMG-CoA reductase is attributed to active metabolites. *In vitro* studies suggest the importance of atorvastatin metabolism by cytochrome P450 3A4, consistent with increased plasma concentrations of atorvastatin in humans following coadministration with erythromycin, a known inhibitor of this isozyme (see PRECAUTIONS, Drug Interactions). In animals, the ortho-hydroxy metabolite undergoes further glucuronidation.

Excretion: Atorvastatin and its metabolites are eliminated primarily in bile following hepatic and/or extrahepatic metabolism; however, the drug does not appear to undergo enterohepatic recirculation. Mean plasma elimination half-life of atorvastatin in humans is approximately 14 hours, but the half-life of inhibitory activity for HMG-CoA reductase is 20 to 30 hours due to the contribution of active metabolites. Less than 2% of a dose of atorvastatin is recovered in urine following oral administration.

Special Populations

Geriatric: Plasma concentrations of atorvastatin are higher (approximately 40% for C_{max} and 30% for AUC) in healthy elderly subjects (age ≥65 years) than in young adults. LDL-C reduction is comparable to that seen in younger patient populations given equal doses of Lipitor.

Pediatric: Pharmacokinetic data in the pediatric population are not available.

Gender: Plasma concentrations of atorvastatin in women differ from those in men (approximately 20% higher for C_{max} and 10% lower for AUC); however, there is no clinically significant difference in LDL-C reduction with Lipitor between men and women.

Renal Insufficiency: Renal disease has no influence on the plasma concentrations or LDL-C reduction of atorvastatin; thus, dose adjustment in patients with renal dysfunction is not necessary (see DOSAGE AND ADMINISTRATION).

Hemodialysis: While studies have not been conducted in patients with end-stage renal disease, hemodialysis is not expected to significantly enhance clearance of atorvastatin since the drug is extensively bound to plasma proteins.

Hepatic Insufficiency: In patients with chronic alcoholic liver disease, plasma concentrations of atorvastatin are markedly increased. C_{max} and AUC are each 4-fold greater in patients with Childs-Pugh A disease. C_{max} and AUC are approximately 16-fold and 11-fold increased, respectively, in patients with Childs-Pugh B disease (see CONTRAINDICATIONS).

Clinical Studies

Hypercholesterolemia (Heterozygous Familial and Nonfamilial) and Mixed Dyslipidemia (Fredrickson types IIa and IIb)

Lipitor reduces total-C, LDL-C, VLDL-C, apo B, and TG, and increases HDL-C in patients with hypercholesterolemia and mixed dyslipidemia. Therapeutic response is seen within 2 weeks, and maximum response is usually achieved within 4 weeks and maintained during chronic therapy.

Lipitor is effective in a wide variety of patient populations with hypercholesterolemia, with and without hypertriglyceridemia, in men and women, and in the elderly. Experience in pediatric patients has been limited to patients with homozygous FH.

Two multicenter, placebo-controlled, dose-response studies in patients with hypercholesterolemia, Lipitor given as a single dose over 6 weeks significantly reduced total-C, LDL-C, apo B, and TG (Pooled results are provided in Table 1).

the remaining 4 patients had 7% to 24% increases in LDL-C. Five of the 29 patients had absent LDL-receptor function. Of these, 2 patients also had a portacaval shunt and had no significant reduction in LDL-C. The remaining 3 receptor-negative patients had a mean LDL-C reduction of 22%.

INDICATIONS AND USAGE

Lipitor is indicated as an adjunct to diet to reduce elevated total-C, LDL-C, apo B, and TG levels in patients with primary hypercholesterolemia (heterozygous familial and nonfamilial) and mixed dyslipidemia (Fredrickson Types IIa and IIb).

Lipitor is also indicated to reduce total-C and LDL-C in patients with homozygous familial hypercholesterolemia as an adjunct to other lipid-lowering treatments (eg, LDL apheresis) or if such treatments are unavailable.

Therapy with lipid-altering agents should be a component of multiple-risk-factor intervention in individuals at increased risk for atherosclerotic vascular disease due to hypercholesterolemia. Lipid-altering agents should be used in addition to a diet restricted in saturated fat and cholesterol only when the response to diet and other nonpharmacological measures has been inadequate (see National Cholesterol Education Program (NCEP) Guidelines, summarized in Table 3).

TABLE 3. NCEP Guidelines for Lipid Management

Definite Atherosclerotic Disease ^a	Two or More Other Risk Factors ^b	LDL-Cholesterol mg/dL (mmol/L)	
		Initiation Level	Minimum Goal
No	No	≥190 (≥4.9)	<160 (<4.1)
No	Yes	≥160 (≥4.1)	<130 (<3.4)
Yes	Yes or No	≥130 ^c (≥3.4)	≤100 (≤2.6)

^aCoronary heart disease or peripheral vascular disease (including symptomatic carotid artery disease).

^bOther risk factors for coronary heart disease (CHD) include: age (males: ≥45 years; females: ≥55 years or premature menopause without estrogen replacement therapy); family history of premature CHD; current cigarette smoking; hypertension; confirmed HDL-C <35 mg/dL (<0.91 mmol/L); and diabetes mellitus. Subtract 1 risk factor if HDL-C is ≥60 mg/dL (≥1.6 mmol/L).

^cIn CHD patients with LDL-C levels 100 to 129 mg/dL, the physician should exercise clinical judgment in deciding whether to initiate drug treatment.

At the time of hospitalization for an acute coronary event, consideration can be given to initiating drug therapy at discharge if the LDL-C level is ≥130 mg/dL (NCEP-ATP II).

Prior to initiating therapy with Lipitor, secondary causes for hypercholesterolemia (eg, poorly controlled diabetes mellitus, hypothyroidism, nephrotic syndrome, dysproteinemias, obstructive liver disease, other drug therapy, and alcoholism) should be excluded, and a lipid profile performed to measure total-C, LDL-C, HDL-C, and TG. For patients with TG <400 mg/dL (<4.5 mmol/L), LDL-C can be estimated using the following equation: LDL-C = total-C - (0.20 × [TG] + HDL-C). For TG levels >400 mg/dL (>4.5 mmol/L), this equation is less accurate and LDL-C concentrations should be determined by ultracentrifugation.

CONTRAINDICATIONS

Active liver disease or unexplained persistent elevations of serum transaminases.
Hypersensitivity to any component of this medication.

Pregnancy and Lactation

Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. ATORVASTATIN SHOULD BE ADMINISTERED TO WOMEN OF CHILD-BEARING AGE ONLY WHEN SUCH PATIENTS ARE HIGHLY UNLIKELY TO CONCEIVE AND HAVE BEEN INFORMED OF THE POTENTIAL HAZARDS. If the patient becomes pregnant while taking this drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

WARNINGS

Liver Dysfunction

HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Persistent elevations (>3 times the upper limit of normal [ULN] occurring on 2 or more occasions) in serum transaminases occurred in 0.7% of patients who received atorvastatin in clinical trials. The incidence of these abnormalities was 0.2%, 0.2%, 0.6%, and 2.3% for 10, 20, 40, and 80 mg, respectively.

One patient in clinical trials developed jaundice. Increases in liver function tests (LFT) in other patients were not associated with jaundice or other clinical signs or symptoms. Upon dose reduction, drug interruption, or discontinuation, transaminase levels returned to or near pretreatment levels without sequelae. Eighteen of 30 patients with persistent LFT elevations continued treatment with a reduced dose of atorvastatin.

It is recommended that liver function tests be performed before the initiation of treatment, at 6 and 12 weeks after initiation of therapy or elevation in dose, and periodically (eg, semiannually) thereafter. Liver enzyme changes generally occur in the first 3 months of treatment with atorvastatin. Patients who develop increased transaminase levels should be monitored until the abnormalities resolve. Should an increase in ALT or AST of >3 times ULN persist, reduction of dose or withdrawal of atorvastatin is recommended.

Atorvastatin should be used with caution in patients who consume substantial quantities of alcohol and/or have a history of liver disease. Active liver disease or unexplained persistent transaminase elevations are contraindications to the use of atorvastatin (see CONTRAINDICATIONS).

Skeletal Muscle

Rhabdomyolysis with acute renal failure secondary to myoglobinuria has been reported with other drugs in this class.

Uncomplicated myalgia has been reported in atorvastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aches or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values >10 times ULN, should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly

Lipitor® (Atorvastatin Calcium) Tablets

unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. Atorvastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected.

The risk of myopathy during treatment with other drugs in this class is increased with concurrent administration of cyclosporine, fibric acid derivatives, erythromycin, niacin, or azole antifungals. Physicians considering combined therapy with atorvastatin and fibric acid derivatives, erythromycin, immunosuppressive drugs, azole antifungals, or lipid-lowering doses of niacin should carefully weigh the potential benefits and risks and should carefully monitor patients for any signs or symptoms of muscle pain, tenderness, or weakness, particularly during the initial months of therapy and during any periods of upward dosage titration of either drug. Periodic creatine phosphokinase (CPK) determinations may be considered in such situations, but there is no assurance that such monitoring will prevent the occurrence of severe myopathy.

Atorvastatin therapy should be temporarily withheld or discontinued in any patient with an acute, serious condition suggestive of a myopathy or having a risk factor predisposing to the development of renal failure secondary to rhabdomyolysis (eg, severe acute infection, hypotension, major surgery, trauma, severe metabolic, endocrine and electrolyte disorders, and uncontrolled seizures).

PRECAUTIONS

General

Before instituting therapy with atorvastatin, an attempt should be made to control hypercholesterolemia with appropriate diet, exercise, and weight reduction in obese patients, and to treat other underlying medical problems (see INDICATIONS AND USAGE).

Information for Patients

Patients should be advised to report promptly unexplained muscle pain, tenderness, or weakness, particularly if accompanied by malaise or fever.

Drug Interactions

The risk of myopathy during treatment with other drugs of this class is increased with concurrent administration of cyclosporine, fibric acid derivatives, niacin (nicotinic acid), erythromycin, azole antifungals (see WARNINGS, Skeletal Muscle).

Antacid: When atorvastatin and Maalox® TC suspension were coadministered, plasma concentrations of atorvastatin decreased approximately 35%. However, LDL-C reduction was not altered.

Antipyrine: Because atorvastatin does not affect the pharmacokinetics of antipyrine, interactions with other drugs metabolized via the same cytochrome isozymes are not expected.

Colestipol: Plasma concentrations of atorvastatin decreased approximately 25% when colestipol and atorvastatin were coadministered. However, LDL-C reduction was greater when atorvastatin and colestipol were coadministered than when either drug was given alone.

Cimetidine: Atorvastatin plasma concentrations and LDL-C reduction were not altered by coadministration of cimetidine.

Digoxin: When multiple doses of atorvastatin and digoxin were coadministered, steady-state plasma digoxin concentrations increased by approximately 20%. Patients taking digoxin should be monitored appropriately.

Erythromycin: In healthy individuals, plasma concentrations of atorvastatin increased approximately 40% with coadministration of atorvastatin and erythromycin, a known inhibitor of cytochrome P450 3A4 (see WARNINGS, Skeletal Muscle).

Oral Contraceptives: Coadministration of atorvastatin and an oral contraceptive increased AUC values for norethindrone and ethinyl estradiol by approximately 30% and 20%. These increases should be considered when selecting an oral contraceptive for a woman taking atorvastatin.

Warfarin: Atorvastatin had no clinically significant effect on prothrombin time when administered to patients receiving chronic warfarin treatment.

Other Concomitant Therapy: In clinical studies, atorvastatin was used concomitantly with antihypertensive agents and estrogen replacement therapy without evidence of clinically significant adverse interactions. Interaction studies with specific agents have not been conducted.

Endocrine Function

HMG-CoA reductase inhibitors interfere with cholesterol synthesis and theoretically might blunt adrenal and/or gonadal steroid production. Clinical studies have shown that atorvastatin does not reduce basal plasma cortisol concentration or impair adrenal reserve. The effects of HMG-CoA reductase inhibitors on

Lipitor® (Atorvastatin Calcium) Tablets

Clinical Adverse Experiences

Adverse experiences reported in ≥2% of patients in placebo-controlled clinical studies of atorvastatin, regardless of causality assessment, are shown in Table 4.

TABLE 4. Adverse Events in Placebo-Controlled Studies (% of Patients)

BODY SYSTEM/ Adverse Event	Placebo N = 270	Atorvastatin 10 mg N = 863	Atorvastatin 20 mg N = 36	Atorvastatin 40 mg N = 79	Atorvastatin 80 mg N = 94
BODY AS A WHOLE					
Infection	10.0	10.3	2.8	10.1	7.4
Headache	7.0	5.4	16.7	2.5	6.4
Accidental Injury	3.7	4.2	0.0	1.3	3.2
Flu Syndrome	1.9	2.2	0.0	2.5	3.2
Abdominal Pain	0.7	2.8	0.0	3.8	2.1
Back Pain	3.0	2.8	0.0	3.8	1.1
Allergic Reaction	2.6	0.9	2.8	1.3	0.0
Asthenia	1.9	2.2	0.0	3.8	0.0
DIGESTIVE SYSTEM					
Constipation	1.8	2.1	0.0	2.5	1.1
Diarrhea	1.5	2.7	0.0	3.8	5.3
Dyspepsia	4.1	2.3	2.8	1.3	2.1
Fatulence	3.3	2.1	2.8	1.3	1.1
RESPIRATORY SYSTEM					
Sinusitis	2.6	2.8	0.0	2.5	6.4
Pharyngitis	1.5	2.5	0.0	1.3	2.1
SKIN AND APPENDAGES					
Rash	0.7	3.9	2.8	3.8	1.1
MUSCULOSKELETAL SYSTEM					
Arthralgia	1.5	2.0	0.0	5.1	0.0
Myalgia	1.1	3.2	5.6	1.3	0.0

The following adverse events were reported, regardless of causality assessment in patients treated with atorvastatin in clinical trials. The events in italics occurred in ≥2% of patients and the events in plain type occurred in <2% of patients.

Body as a Whole: *Chest pain, face edema, fever, neck rigidity, malaise, photosensitivity reaction, generalized edema.*

Digestive System: *Nausea, gastroenteritis, liver function tests abnormal, colitis, vomiting, gastritis, dry mouth, rectal hemorrhage, esophagitis, eructation, glossitis, mouth ulceration, anorexia, increased appetite, stomatitis, biliary pain, cheilitis, duodenal ulcer, dysphagia, enteritis, melena, gum hemorrhage, stomach ulcer, tenesmus, ulcerative stomatitis, hepatitis, pancreatitis, cholestatic jaundice.*

Respiratory System: *Bronchitis, rhinitis, pneumonia, dyspnea, asthma, epistaxis.*

Nervous System: *Insomnia, dizziness, paresthesia, somnolence, amnesia, abnormal dreams, libido decreased, emotional lability, incoordination, peripheral neuropathy, torticollis, facial paralysis, hyperkinesia, depression, hypesthesia, hypertonia.*

Musculoskeletal System: *Arthritis, leg cramps, bursitis, tenosynovitis, myasthenia, tendinous contracture, myositis.*

Skin and Appendages: *Pruritus, contact dermatitis, alopecia, dry skin, sweating, acne, urticaria, eczema, seborrhea, skin ulcer.*

Urogenital System: *Urinary tract infection, urinary frequency, cystitis, hematuria, impotence, dysuria, kidney calculus, nocturia, epididymitis, fibrocystic breast, vaginal hemorrhage, albuminuria, breast enlargement, metrorrhagia, nephritis, urinary incontinence, urinary retention, urinary urgency, abnormal ejaculation, uterine hemorrhage.*

Pharmacokinetics and Pharmacodynamics

Other Concomitant Therapy: In clinical studies, atorvastatin was used concomitantly with antihypertensive agents and estrogen replacement therapy without evidence of clinically significant adverse interactions. Interaction studies with specific agents have not been conducted.

Endocrine Function

HMG-CoA reductase inhibitors interfere with cholesterol synthesis and theoretically might blunt adrenal and/or gonadal steroid production. Clinical studies have shown that atorvastatin does not reduce basal plasma cortisol concentration or impair adrenal reserve. The effects of HMG-CoA reductase inhibitors on male fertility have not been studied in adequate numbers of patients. The effects, if any, on the pituitary-gonadal axis in premenopausal women are unknown. Caution should be exercised if an HMG-CoA reductase inhibitor is administered concomitantly with drugs that may decrease the levels or activity of endogenous steroid hormones, such as ketoconazole, spironolactone, and cimetidine.

CNS Toxicity

Brain hemorrhage was seen in a female dog treated for 3 months at 120 mg/kg/day. Brain hemorrhage and optic nerve vacuolation were seen in another female dog that was sacrificed in moribund condition after 11 weeks of escalating doses up to 280 mg/kg/day. The 120 mg/kg dose resulted in a systemic exposure approximately 16 times the human plasma area-under-the-curve (AUC, 0-24 hours) based on the maximum human dose of 80 mg/day. A single tonic convulsion was seen in each of 2 male dogs (one treated at 10 mg/kg/day and one at 120 mg/kg/day) in a 2-year study. No CNS lesions have been observed in mice after chronic treatment for up to 2 years at doses up to 400 mg/kg/day or in rats at doses up to 100 mg/kg/day. These doses were 6 to 11 times (mouse) and 8 to 16 times (rat) the human AUC (0-24) based on the maximum recommended human dose of 80 mg/day.

CNS vascular lesions, characterized by perivascular hemorrhages, edema, and mononuclear cell infiltration of perivascular spaces, have been observed in dogs treated with other members of this class. A chemically similar drug in this class produced optic nerve degeneration (Walleria degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion at a dose that produced plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility

In a 2-year carcinogenicity study in rats at dose levels of 10, 30, and 100 mg/kg/day, 2 rare tumors were found in muscle in high-dose females: in one, there was a rhabdomyosarcoma and, in another, there was a fibrosarcoma. This dose represents a plasma AUC (0-24) value of approximately 16 times the mean human plasma drug exposure after an 80 mg oral dose.

A 2-year carcinogenicity study in mice given 100, 200, or 400 mg/kg/day resulted in a significant increase in liver adenomas in high-dose males and liver carcinomas in high-dose females. These findings occurred at plasma AUC (0-24) values of approximately 6 times the mean human plasma drug exposure after an 80 mg oral dose.

In vitro, atorvastatin was not mutagenic or clastogenic in the following tests with and without metabolic activation: the Ames test with *Salmonella typhimurium* and *Escherichia coli*, the HGPRT forward mutation assay in Chinese hamster lung cells, and the chromosomal aberration assay in Chinese hamster lung cells. Atorvastatin was negative in the *in vivo* mouse micronucleus test.

Studies in rats performed at doses up to 175 mg/kg (15 times the human exposure) produced no changes in fertility. There was aplasia and aspermia in the epididymis of 2 of 10 rats treated with 100 mg/kg/day of atorvastatin for 3 months (16 times the human AUC at the 80 mg dose); testis weights were significantly lower at 30 and 100 mg/kg and epididymal weight was lower at 100 mg/kg. Male rats given 100 mg/kg/day for 11 weeks prior to mating had decreased sperm motility, sperm head concentration, and increased abnormal sperm. Atorvastatin caused no adverse effects on semen parameters, or reproductive organ histopathology in dogs given doses of 10, 40, or 120 mg/kg for two years.

Pregnancy

Pregnancy Category X

See CONTRAINDICATIONS

Safety in pregnant women has not been established. Atorvastatin crosses the rat placenta and reaches a level in fetal liver equivalent to that of maternal plasma. Atorvastatin was not teratogenic in rats at doses up to 300 mg/kg/day or in rabbits at doses up to 100 mg/kg/day. These doses resulted in multiples of about 30 times (rat) or 20 times (rabbit) the human exposure based on surface area (mg/m²).

In a study in rats given 20, 100, or 225 mg/kg/day, from gestation day 7 through to lactation day 21 (weaning), there was decreased pup survival at birth, neonate, weaning, and maturity in pups of mothers dosed with 225 mg/kg/day. Body weight was decreased on days 4 and 21 in pups of mothers dosed at 100 mg/kg/day; pup body weight was decreased at birth and at days 4, 21, and 91 at 225 mg/kg/day. Pup development was delayed (rotarod performance at 100 mg/kg/day and acoustic startle at 225 mg/kg/day; pinnae detachment and eye opening at 225 mg/kg/day). These doses correspond to 6 times (100 mg/kg) and 22 times (225 mg/kg) the human AUC at 80 mg/day.

Rare reports of congenital anomalies have been received following intrauterine exposure to HMG-CoA reductase inhibitors. There has been one report of severe congenital bony deformity, tracheo-esophageal fistula, and anal atresia (VATER association) in a baby born to a woman who took lovastatin with dexamphetamine sulfate during the first trimester of pregnancy. Lipitor should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking Lipitor, it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers

Nursing rat pups had plasma and liver drug levels of 50% and 40%, respectively, of that in their mother's milk. Because of the potential for adverse reactions in nursing infants, women taking Lipitor should not breast-feed (see CONTRAINDICATIONS).

Pediatric Use

Treatment experience in a pediatric population is limited to doses of Lipitor up to 80 mg/day for 1 year in patients with homozygous FH. No clinical or biochemical abnormalities were reported in these patients. None of these patients was below 9 years of age.

Geriatric Use

Treatment experience in adults age ≥70 years with doses of Lipitor up to 80 mg/day has been evaluated in 21 patients. The safety and efficacy of Lipitor in this population were similar to those of patients <70 years of age.

ADVERSE REACTIONS

Lipitor is generally well-tolerated. Adverse reactions have usually been mild and transient. In controlled clinical studies of 2502 patients, <2% of patients were discontinued due to adverse experiences attributable to atorvastatin. The most frequent adverse events thought to be related to atorvastatin were constipation, flatulence, dyspepsia, and abdominal pain.

Musculoskeletal System: *Arthritis*, leg cramps, bursitis, tenosynovitis, myasthenia, tendinous contracture, myositis.

Skin and Appendages: Pruritus, contact dermatitis, alopecia, dry skin, sweating, acne, urticaria, eczema, seborrhea, skin ulcer.

Urogenital System: *Urinary tract infection*, urinary frequency, cystitis, hematuria; impotence, dysuria, kidney calculus, nocturia, epididymitis, fibrocystic breast, vaginal hemorrhage, albuminuria, breast enlargement, metrorrhagia, nephritis, urinary incontinence, urinary retention, urinary urgency, abnormal ejaculation, uterine hemorrhage.

Special Senses: Amblyopia, tinnitus, dry eyes, refraction disorder, eye hemorrhage, deafness, glaucoma, parosmia, taste loss, taste perversion.

Cardiovascular System: Palpitation, vasodilatation, syncope, migraine, postural hypotension, phlebitis, arrhythmia, angina pectoris, hypertension.

Metabolic and Nutritional Disorders: *Peripheral edema*, hyperglycemia, creatine phosphokinase increased, gout, weight gain, hypoglycemia.

Hemic and Lymphatic System: Ecchymosis, anemia, lymphadenopathy, thrombocytopenia, petechia.

Postintroduction Reports

Adverse events associated with Lipitor that have been received since market introduction, that are not listed above, and that may have no causal relationship to drug include the following: angioneurotic edema.

OVERDOSAGE

There is no specific treatment for atorvastatin overdose. In the event of an overdose, the patient should be treated symptomatically, and supportive measures instituted as required. Due to extensive drug binding to plasma proteins, hemodialysis is not expected to significantly enhance atorvastatin clearance.

DOSEAGE AND ADMINISTRATION

The patient should be placed on a standard cholesterol-lowering diet before receiving Lipitor and should continue on this diet during treatment with Lipitor.

Hypercholesterolemia (Heterozygous Familial and Nonfamilial) and Mixed Dyslipidemia (Fredrickson Types IIa and IIb)

The recommended starting dose of Lipitor is 10 mg once daily. The dosage range is 10 to 80 mg once daily. Lipitor can be administered as a single dose at any time of the day, with or without food. Therapy should be individualized according to goal of therapy and response (see *NCEP Guidelines*, summarized in Table 3). After initiation and/or upon titration of Lipitor, lipid levels should be analyzed within 2 to 4 weeks and dosage adjusted accordingly.

Since the goal of treatment is to lower LDL-C, the NCEP recommends that LDL-C levels be used to initiate and assess treatment response. Only if LDL-C levels are not available, should total-C be used to monitor therapy.

Homozygous Familial Hypercholesterolemia

The dosage of Lipitor in patients with homozygous FH is 10 to 80 mg daily. Lipitor should be used as an adjunct to other lipid-lowering treatments (eg, LDL apheresis) in these patients or if such treatments are unavailable.

Concomitant Therapy

Atorvastatin may be used in combination with a bile acid binding resin for additive effect. The combination of HMG-CoA reductase inhibitors and fibrates should generally be avoided (see WARNINGS, Skeletal Muscle, and PRECAUTIONS, Drug Interactions for other drug-drug interactions).

Dosage in Patients With Renal Insufficiency

Renal disease does not affect the plasma concentrations nor LDL-C reduction of atorvastatin; thus, dosage adjustment in patients with renal dysfunction is not necessary (see CLINICAL PHARMACOLOGY, Pharmacokinetics).

HOW SUPPLIED

Lipitor is supplied as white, elliptical, film-coated tablets of atorvastatin calcium containing 10, 20, and 40 mg atorvastatin.

10 mg tablets: coded "PD 155" on one side and "10" on the other.

N0071-0155-23 bottles of 90
N0071-0155-34 bottles of 5000
N0071-0155-40 10 x 10 unit dose blisters

20 mg tablets: coded "PD 156" on one side and "20" on the other:

N0071-0156-23 bottles of 90
N0071-0156-40 10 x 10 unit dose blisters

40 mg tablets: coded "PD 157" on one side and "40" on the other.

N0071-0157-23 bottles of 90

Storage

Store at controlled room temperature 20°C to 25°C (68°F to 77°F) [see USP].

Caution - Federal law prohibits dispensing without prescription.

© 1997, Warner-Lambert Co.

Revised November 1997

PARKE-DAVIS
Div of Warner-Lambert Co
Morris Plains, NJ 07950 USA
MADE IN GERMANY

Marketed by:

PARKE-DAVIS
Div of Warner-Lambert Co and
PFIZER Inc.

New York, NY 10017

0155G023

Pharmaceutical Research 5600 Fishers Lane, Rockville, MD 20857 Phone: (301) 906-7000



November 5, 1997

NDA 20-702
Ref. No. 51
Lipitor® (atorvastatin calcium) Tablets

Re: Amendment to Labeling
Supplement S-008

Solomon Sobel, M.D.
Director
Division of Metabolism and
Endocrine Drug Products (HFD-510)
Document Control Room 14B-19
Center for Drug Evaluation and Research
Food and Drug Administration
Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20857

*Label reviewed
Approved.
D. O'Neil
11-5-97*

*Noted as
acceptable
X-Team*

Dear Dr. Sobel:

Reference is made to approved NDA 20-702 for Lipitor® (atorvastatin calcium) Tablets; to approved labeling supplement S-002 (approved October 28, 1997); to pending supplements

S-007 and S-008 (Ref. Nos. 47 and 50, submitted September 5, 1997, and amended October 9, 1997); and to today's telephone conversation between Ms. Enid Galliers of your Division and Dr. Irwin Martin of Parke-Davis regarding an amendment to labeling supplement S-008.

*Noted
EXP
12/5/97*

comprised two changes to the labeling: the addition of adverse reactions and

both changes were submitted as "Changes Being Effected", and revised labeling was provided with a date of July 1997 (label number 0155G022). On November 4, 1997, I was informed by Ms. Margaret Simoneau of your Division that

Labeling supplement S-008 was thus submitted with draft labeling revising the unapproved July 1997 version of the package insert. Since that time, we have also received approval for S-002 which corrected the volume of distribution and absolute bioavailability in the CLINICAL PHARMACOLOGY section.

Solomon Sobel, M.D.
NDA 20-702
November 5, 1997
Page 2

and made the changes as approved in S-002, and are now submitting the attached revised labeling as an amendment to S-008. This change will be implemented as soon as possible when approved by the Division.

If there are any questions or comments regarding this submission, please contact me at 313/996-4906 or FAX 313/998-3283.

Sincerely,



Margaret J. Uprichard, Pharm.D.
Senior Manager, FDA Liaison
Worldwide Regulatory Affairs

MU\rm

c:\nda\20-702\110597-51

Attachment

Desk Copy: Ms. Enid Galliers (HFD-510)
Ms. Margaret Simoneau (HFD-510)

6 Page(s) Withheld

_____ § 552(b)(4) Trade Secret / Confidential

X _____ § 552(b)(4) Draft Labeling

_____ § 552(b)(5) Deliberative Process

Pharmaceutical
Research

2800 Plymouth Road Phone: (313) 996-7000
Ann Arbor, MI
48105

~~NDA SUPPLEMENT AMENDMENT ORIGINAL~~

SUPPL NEW CORRE

SUC-008

 **PARKE-DAVIS**

November 5, 1997

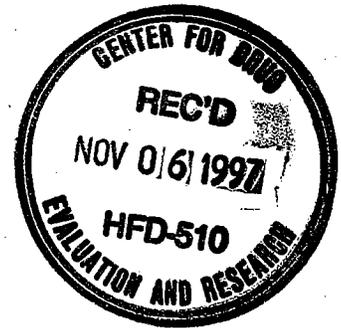
NDA 20-702

Ref. No. 51

Lipitor® (atorvastatin calcium) Tablets

Re: Amendment to Labeling
Supplement S-008

Solomon Sobel, M.D.
Director
Division of Metabolism and
Endocrine Drug Products (HFD-510)
Document Control Room 14B-19
Center for Drug Evaluation and Research
Food and Drug Administration
Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20857



Dear Dr. Sobel:

Reference is made to approved NDA 20-702 for Lipitor® (atorvastatin calcium) Tablets; to approved labeling supplement S-002 (approved October 28, 1997); to pending supplements (and S-008 (Ref. Nos. 47 and 50, submitted September 5, 1997, and amended October 9, 1997); and to today's telephone conversation between Ms. Enid Galliers of your Division and Dr. Irwin Martin of Parke-Davis regarding an amendment to labeling supplement S-008.

(comprised two changes to the labeling: the addition of adverse reactions and (

(Both changes were submitted as "Changes Being Effected", and revised labeling was provided with a date of July 1997 (label number 0155G022). On November 4, 1997, I was informed by Ms. Margaret Simoneau of your Division that (

(Labeling supplement S-008 was thus submitted with draft labeling revising the unapproved July 1997 version of the package insert. Since that time, we have also received approval for S-002 which corrected the volume of distribution and absolute bioavailability in the CLINICAL PHARMACOLOGY section.

Solomon Sobel, M.D.
NDA 20-702
November 5, 1997
Page 2

and made the changes as approved in S-002, and are now submitting the attached revised labeling as an amendment to S-008. This change will be implemented as soon as possible when approved by the Division.

If there are any questions or comments regarding this submission, please contact me at 313/996-4906 or FAX 313/998-3283.

REVIEWS COMPLETED	
CSO ACTION:	
<input checked="" type="checkbox"/> LETTER	<input type="checkbox"/> N.A.I. <input type="checkbox"/> MEMO
<i>Mars</i>	<i>11/5/97</i> <i>1-2-98</i>
CSO INITIALS	DATE

Sincerely,

Margaret J. Uprichard

Margaret J. Uprichard, Pharm.D.
Senior Manager, FDA Liaison
Worldwide Regulatory Affairs

MU\rm
t:\nda\20-702\110597-51

Attachment

Desk Copy: Ms. Enid Galliers (HFD-510)
Ms. Margaret Simoneau (HFD-510)

*Noted
D. O. M. M.
11-28-97*

*noted
exb
12/5/97*

*Noted
K. Y. S. M.
12/4/97*

6 Page(s) Withheld

 § 552(b)(4) Trade Secret / Confidential

X § 552(b)(4) Draft Labeling

 § 552(b)(5) Deliberative Process

Withheld Track Number: Administrative- 20-702

5068

Pharmaceutical
Research

2800 Plymouth Road Phone: 313-996-7000
Ann Arbor, MI
48105

ORIGINAL
NDA SUPPLEMEN



NDA NO. 20702 REF. NO. 008
NDA SUPPL FOR SLR

September 5, 1997

NDA 20-702
Ref. No. 47
Lipitor® (atorvastatin calcium) Tablets

Re: Labeling Supplement

Solomon Sobel, M.D.
Director
Division of Metabolism and Endocrine
Drug Products (HFD-510)
Document Control Room 14B-19
Center for Drug Evaluation and Research
Food and Drug Administration
Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20857



Noted as
acceptable
X. K. Seru
2-007-199-

Noted
EKB
10/2/97

Dear Dr. Sobel:

Reference is made to approved NDA 20-702 for Lipitor® (atorvastatin calcium) Tablets and to my telephone conversations with Dr. David Orloff of your Division on August 26, 28, and September 3, 1997, regarding modifications to the CLINICAL PHARMACOLOGY section of the package insert which would place atorvastatin's effects on plasma triglycerides into perspective. As suggested verbatim by Dr. Orloff, we propose the following modification (in italic type) to the third paragraph of the CLINICAL PHARMACOLOGY, "Mechanism of Action" section:

"A variety of clinical studies have demonstrated that elevated levels of total-C, LDL-C, and apo B (a membrane complex for LDL-C) promote human atherosclerosis. Similarly, decreased levels of HDL-C (and its transport complex, apo A) are associated with the development of atherosclerosis. Epidemiologic investigations have established that cardiovascular morbidity and mortality vary directly with the level of total-C and LDL-C, and inversely with the level of HDL-C. *Although frequently found in association with low HDL-C, elevated plasma TG has not been established as an independent risk factor for coronary heart disease. The independent effect of raising HDL-C or lowering TG on the risk for coronary and cardiovascular morbidity and mortality has not been established.*"

In accordance with 21 CFR 314.70(b)(3), we are submitting for your review and approval the above proposed revision. This change will not be implemented until approved by the Division.

Solomon Sobel, M.D.
NDA 20-702
September 5, 1997
Page 2

If there are any questions or comments regarding this submission, please contact me at 313/996-4906 or FAX 313/998-3283.

Sincerely,



Margaret J. Uprichard, Pharm.D.
Manager, FDA Liaison
Worldwide Regulatory Affairs

MU\rm
t:\nda\20-702\090597-47

Noted.
Change approved
D.22071
9-22-97

noted
apb
9/23/97

REVIEWS COMPLETED	DATE
CSO ACTION: <input checked="" type="checkbox"/> LETTER <input type="checkbox"/> N.A.I. <input type="checkbox"/> MEMO	
CSO INITIALS	
<i>MMB</i>	<i>11-5-97</i>



Food and Drug Administration
Rockville MD 20857

NDA 20-702/S-008

SEP 19 1997

PARKE-DAVIS PHARMACEUTICAL RESEARCH
DIVISION of WARNER-LAMBERT COMPANY
2800 Plymouth Road P. O. BOX 1047
Ann Arbor, MI 48106-1047

Attention: Margaret J. Uprichard, Ph.D., Manager, FDA Liaison Worldwide Regulatory Affairs

Dear Dr. M. J. Uprichard:

We acknowledge receipt of your supplemental application for the following:

Name of Drug: LIPITOR TABLETS

NDA Number: 20-702

Supplement Number: S-008

Date of Supplement: September 5, 1997

Date of Receipt: September 8, 1997

Unless we find the application not acceptable for filing, this application will be filed under Section 505(b)(1) of the Act on November 7, 1997, in accordance with 21 CFR 314.101(a).

All communications concerning this NDA should be addressed as follows:

Center for Drug Evaluation and Research
Division of Metabolic and Endocrine Drug Products, HFD-510
Office of Drug Evaluation II
Attention: Document Control Room 14B-19
5600 Fishers Lane
Rockville, MD 20857

Sincerely,

Enid Galliers

Chief, Project Management Staff
Division of Metabolic and Endocrine
Drug Products, HFD-510
Office of Drug Evaluation II
Center for Drug Evaluation and Research

NDA 20-702/S-008

Page 2

cc:

Original NDA 20-702/S-008

HFD-510/Div. Files

HFD-510/CSO/J. Rhee *M. Simoneau*

filename:

SUPPLEMENT ACKNOWLEDGEMENT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
FOOD AND DRUG ADMINISTRATION

Form Approved: OMB No. 0910-0297
Expiration Date: November 30, 1996

USER FEE COVER SHEET

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any aspect of this collection of information, including suggestions for reducing this burden to:

Reports Clearance Officer, PHS
Hubert Humphrey Building, Room 721-B
200 Independence Avenue, S.W.
Attn: PRA

and to:

Office of Management and Budget
Paperwork Reduction Project (0910-0297)
Washington, DC 20503

Please DO NOT RETURN this form to either of these addresses

See Instructions on Reverse Before Completing This Form

1. APPLICANTS NAME AND ADDRESS

James A. Parker, Jr.
Parke-Davis Regulatory Affairs
201 Tabor Rd.
Morris Plains, NJ 07950

2. USER FEE BILLING NAME, ADDRESS, AND CONTACT

Mary E. Taylor, MPH
Parke-Davis Research and Development
Warner-Lambert Company
2800 Plymouth Road
Ann Arbor, MI 48105

3. TELEPHONE NUMBER (INCLUDE AREA CODE) (313)996-5000

4. PRODUCT NAME

Lipitor® (atorvastatin calcium) Tablets

5. DOES THIS APPLICATION CONTAIN CLINICAL DATA?

YES

NO

IF YOUR RESPONSE IS "NO" AND THIS IS FOR A SUPPLEMENT, STOP HERE AND SIGN THIS FORM

6. USER FEE I.D. NUMBER

7. LICENSE NUMBER

8. IS THIS APPLICATION COVERED BY ANY OF THE FOLLOWING USER FEE EXCLUSIONS? IF SO, CHECK THE APPLICABLE EXCLUSION.

A LARGE VOLUME PARENTERAL DRUG PRODUCT APPROVED BEFORE 9/1/92

THE APPLICATION IS SUBMITTED UNDER 505(b)(2)
(See reverse before checking box.)

AN INSULIN PRODUCT SUBMITTED UNDER 506

FOR BIOLOGICAL PRODUCTS ONLY

WHOLE BLOOD OR BLOOD COMPONENT FOR TRANSFUSION

A CRUDE ALLERGIC EXTRACT PRODUCT

BOVINE BLOOD PRODUCT FOR TOPICAL APPLICATION LICENSED BEFORE 9/1/92

AN "IN VITRO" DIAGNOSTIC BIOLOGIC PRODUCT LICENSED UNDER 351 OF THE PHS ACT

9. a. HAS THIS APPLICATION QUALIFIED FOR A SMALL BUSINESS EXCEPTION?

YES
(See reverse if answered YES) NO

b. HAS A WAIVER OF APPLICATION FEE BEEN GRANTED FOR THIS APPLICATION?

YES
(See reverse if answered YES) NO

This completed form must be signed and accompany each new drug or biologic product, original or supplement.

SIGNATURE OF AUTHORIZED COMPANY REPRESENTATIVE

TITLE

DATE

Director
Advertising and Labeling
Worldwide Regulatory Affairs

December 10, 1997

USER FEE DATA ENTRY/VALIDATION FORM

NDA # 20702 DOCUMENT ID/LETTER DATE SLR-008 9/5/97
APPLICANT NAME PARKE-DAVIS PHARMACEUTICAL RESEARCH
PRODUCT NAME LIPITOR TABLETS

FORM MUST BE COMPLETED ASAP

1. YES User Fee Cover Sheet Validated?

NOTE TO DOCUMENT ROOM:
PLEASE MAKE THE FOLLOWING CHANGES TO THE COMIS DATA ELEMENTS

2. YES NO CLINICAL DATA?
[Check YES if contains study reports or literature reports of what are explicitly or implicitly represented by the applicant to be adequate and well-controlled trials. Clinical data do not include data used to modify the labelling to add a restriction that would improve the safe use of the drug (e.g., to add an adverse reaction, contraindication or warning to the labeling).]

REF IF NO CLINICAL DATA IN SUBMISSION, INDICATE IF CLINICAL DATA ARE CROSS REFERENCED IN ANOTHER SUBMISSION?

3. YES NO NDA BEING SPLIT FOR ADMINISTRATIVE CONVENIENCE (OTHER THAN BUNDLING)? IF YES, list ALL NDA numbers, review divisions & indicate those for which application fees apply.

NDA #	DIVISION	FEE	NO FEE
N _____	_____	FEE	NO FEE

4. YES NO BUNDLING POLICY APPLIED CORRECTLY? NO DATA ENTRY REQUIRED FOR ELEMENT

[Check YES if application is properly designated as one application or is properly submitted as a supplement instead of an original application. Check NO if application should be split into more than one application or submitted as an original instead of a supplement. IF NO, list resulting NDA numbers, and review divisions.]

NDA #	DIVISION	NDA #	DIVISION
N _____	_____	N _____	_____

5. P S PRIORITY OR STANDARD?

Mary Ann Amoreau 9/15/97
6. CSO SIGNATURE/DATE

Ed Walters 9/18/97
SCSO CONCURRENCE SIGNATURE/DATE

COPY DISTRIBUTION: ORIGINAL TO ARCHIVAL AFTER DATA ENTRY, ONE COPY EACH TO DIVISION FILE AND CDER, ASSOCIATE DIRECTOR FOR POLICY HFD-5

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
FOOD AND DRUG ADMINISTRATION

Form Approved: OMB No. 0910-0297
Expiration Date: November 30, 1996

USER FEE COVER SHEET

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any aspect of this collection of information, including suggestions for reducing this burden to:

Reports Clearance Officer, PHS
Hubert Humphrey Building, Room 721-B
200 Independence Avenue, S.W.
Attn: PRA

and to:

Office of Management and Budget
Paperwork Reduction Project (0910-0297)
Washington, DC 20503

Please DO NOT RETURN this form to either of these addresses

See Instructions on Reverse Before Completing This Form

1. APPLICANTS NAME AND ADDRESS

Parke-Davis Research and Development
Division of Warner-Lambert Company
2800 Plymouth Rd.
Ann Arbor, MI 48105

2. USER FEE BILLING NAME, ADDRESS, AND CONTACT

Mary E. Taylor, MPH
Parke-Davis Research and Development
Warner-Lambert Company
2800 Plymouth Road
Ann Arbor, MI 48105

3. TELEPHONE NUMBER (INCLUDE AREA CODE) (313)996-5000

4. PRODUCT NAME

Lipitor® Tablets

5. DOES THIS APPLICATION CONTAIN CLINICAL DATA?

YES

NO

IF YOUR RESPONSE IS "NO" AND THIS IS FOR A SUPPLEMENT, STOP HERE AND SIGN THIS FORM

USER FEE I.D. NUMBER

7. LICENSE NUMBER

20-702

8. IS THIS APPLICATION COVERED BY ANY OF THE FOLLOWING USER FEE EXCLUSIONS? IF SO, CHECK THE APPLICABLE EXCLUSION.

A LARGE VOLUME PARENTERAL DRUG PRODUCT
APPROVED BEFORE 9/1/92

THE APPLICATION IS SUBMITTED UNDER 505(b)(2)
(See reverse before checking box.)

AN INSULIN PRODUCT SUBMITTED UNDER 506

FOR BIOLOGICAL PRODUCTS ONLY

WHOLE BLOOD OR BLOOD COMPONENT FOR
TRANSFUSION

A CRUDE ALLERGIC EXTRACT PRODUCT

BOVINE BLOOD PRODUCT FOR TOPICAL
APPLICATION LICENSED BEFORE 9/1/92

AN "IN VITRO" DIAGNOSTIC BIOLOGIC PRODUCT
LICENSED UNDER 351 OF THE PHS ACT

9. a. HAS THIS APPLICATION QUALIFIED FOR A SMALL BUSINESS EXCEPTION?

YES NO
(See reverse if answered YES)

b. HAS A WAIVER OF APPLICATION FEE BEEN GRANTED FOR THIS APPLICATION?

YES NO
(See reverse if answered YES)

This completed form must be signed and accompany each new drug or biologic product, original or supplement.

SIGNATURE OF AUTHORIZED COMPANY REPRESENTATIVE

TITLE

DATE

Director
Worldwide
Regulatory Affairs

September 5, 1997