Division: Pharmacy Policy	Subject: Prior Authorization Criteria
Original Development Date: Original Effective Date: Revision Date:	February 13, 2020 June 16, 2022, February 20, 2023

Amlodipine (NORLIQVA® and KATERZIA®) oral solution/suspension

LENGTH OF AUTHORIZATION: 6 months

REVIEW CRITERIA:

- Patient must be ≥ 6 years of age.
- Trial and failure of preferred calcium channel blockers or rationale why preferred agents cannot be tried.
- Patient has hypertension **OR**
- Patient has coronary artery disease
    - Chronic stable angina,
    - Vasospastic angina (Prinzmetal's or Variant Angina)
    - Angiographically documented coronary artery disease (documented by angiography without heart failure or an ejection fraction <40%).

CONTINUATION OF THERAPY

- Patient met initial review criteria; **AND**
- Documentation of improved clinical response; **AND**
- Patient has not experienced any treatment-restricting adverse effects; **AND**
- Dosing is appropriate as per labeling or is supported by compendia.

DOSING AND ADMINISTRATION:

- Refer to product labeling at https://www.accessdata.fda.gov/scripts/cder/daf/
- Available as 1 mg/mL oral suspension (Katerzia®) and 1mg/mL oral solution (Norliqva®).