DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Food and Drug Administration
Rockville, MD 20857

TRANSMITTED VIA FACSIMILE

Rita A. Wittich
Vice President, Worldwide Regulatory Strategy
Regulatory Affairs
Pfizer Inc
235 East 42nd Street
New York, NY 10017

RE: NDA #20-702
Lipitor (atorvastatin calcium) Tablets
MACMIS ID# 9607

Dear Ms. Wittich:

This letter concerns a journal advertisement (BC121A00) for Lipitor (atorvastatin calcium) tablets disseminated by Pfizer Inc. As part of its routine monitoring program, the Division of Drug Marketing, Advertising, and Communications (DDMAC) has reviewed this journal advertisement and concluded it is false or misleading, in violation of the Federal Food, Drug, and Cosmetic Act (Act) and its implementing regulations. Our specific objections follow:

Promotion of Unapproved Use

The first 6 pages of this 8-page journal advertisement (ad) contain pictures of different patients who are apparent "candidates for Lipitor" with the following "name tags" and additional information:

- HELLO I have hyperlipidemia plus...A CHD risk factor
- HELLO I have hyperlipidemia plus...A family history of early CHD
  A family history of hypercholesterolemia can triple the risk of CHD prior to age 60
- HELLO I have hyperlipidemia plus...Hypertension
  Controlled hypertension is still a risk for CHD
- HELLO I have hyperlipidemia plus...I'm over 45
  CHD risk in men aged 45 is about 2 times greater than in men aged 35
- HELLO I have hyperlipidemia plus...Diabetes Mellitus
  Diabetes can increase the risk of CHD by 300%
- HELLO I have hyperlipidemia plus...I smoke
  Smoking can approximately double the risk of developing CHD

In addition, the following claims are presented on page 7:

- Recognize their risk factors and you've just met another candidate for LIPITOR
- Elevated LDL-C combined with even one risk factor increases the threat of CHD (along with the CHD risk factor table)
- Confident LDL-C reduction for patients at risk

As a result of presenting such claims, the journal ad creates an overwhelming impression that Lipitor is indicated to reduce the risk of developing coronary heart disease (CHD). However, the effect of Lipitor on cardiovascular morbidity and mortality has not been established, and Lipitor is not indicated to reduce the risk of developing CHD. As provided in the approved product labeling (PI), Lipitor is indicated "as an adjunct to diet to reduce elevated total-C, LDL-C, apo B, and TG levels and to increase HDL-C in patients with primary hypercholesterolemia and mixed dyslipidemia." Your presentation of the indication on the bottom of page 6 in paragraph format and in small font size, and the disclaimer that "the effect of LIPITOR on cardiovascular morbidity and mortality has not been determined" on page 7, also in small font size, are inadequate to overcome the overall misleading promotional message created by the ad (i.e., that Lipitor is indicated to reduce the risk of developing CHD). Therefore, the journal ad is misleading because it promotes Lipitor for an unapproved use.

Lack of Fair Balance

The journal ad is misleading because it fails to present important information concerning the risks associated with Lipitor with a prominence and readability reasonably comparable to the presentation relating to the effectiveness of the drug. For example, you present efficacy claims such as "Lipitor provides impressive LDL-C reductions," "72% of patients reached their NCEP LDL-C goal at 10 mg," and "Powerful effect on lipid parameters" as large headers that are bolded for further emphasis. You also present specific reductions in LDL-C, TG, and HDL-C very prominently by the use of bolding and large type size. In contrast, important risk information is presented in small type size on the bottom of page 6 and is further de-emphasized by its presentation in paragraph form without any header or signal to alert readers to its importance. Therefore, the journal ad lacks fair balance taking into account implementing factors such as layout, paragraphing, white space, and other techniques apt to achieve emphasis.

Broadening of Indication

The **Indications and Usage** section of the PI states, "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." Your advertisement contains prominent claims about Lipitor's usefulness, such as "Lipitor provides impressive LDL-C reduction." However, you have minimized important information regarding the approved indication for Lipitor. Specifically, the indication statement is presented at the bottom of page 6 in paragraph format and a small font size, making it difficult to read. Moreover, the disclaimer "when diet and exercise fail" is also presented in a much smaller font size than the claims describing Lipitor's use. As a result, the advertisement suggests that all patients, including those with high cholesterol who have not tried to lower cholesterol using diet and exercise, are candidates for Lipitor. Therefore, the ad is misleading because it broadens the approved indication by minimizing information about the correct use of Lipitor.

In order to address these objections, you should immediately cease distribution of this journal ad immediately and all other promotional materials for Lipitor that contain the same or similar claims or presentations. You should respond in writing by July 26, 2001, with your intent and plans to comply with this request. Your response should include a list of materials discontinued, and the date on which these materials were discontinued.

If you have any further questions, please direct them to me by facsimile at 301-594-6771 or at the Food and Drug Administration, Division of Drug Marketing, Advertising, and Communications, HFD-42, Rm 17B-20, 5600 Fishers Lane, Rockville, MD 20857.

We remind you that only written communications are considered official. In all future correspondence regarding this particular matter please refer to MACMIS ID #9607 in addition to the NDA number.

Sincerely,

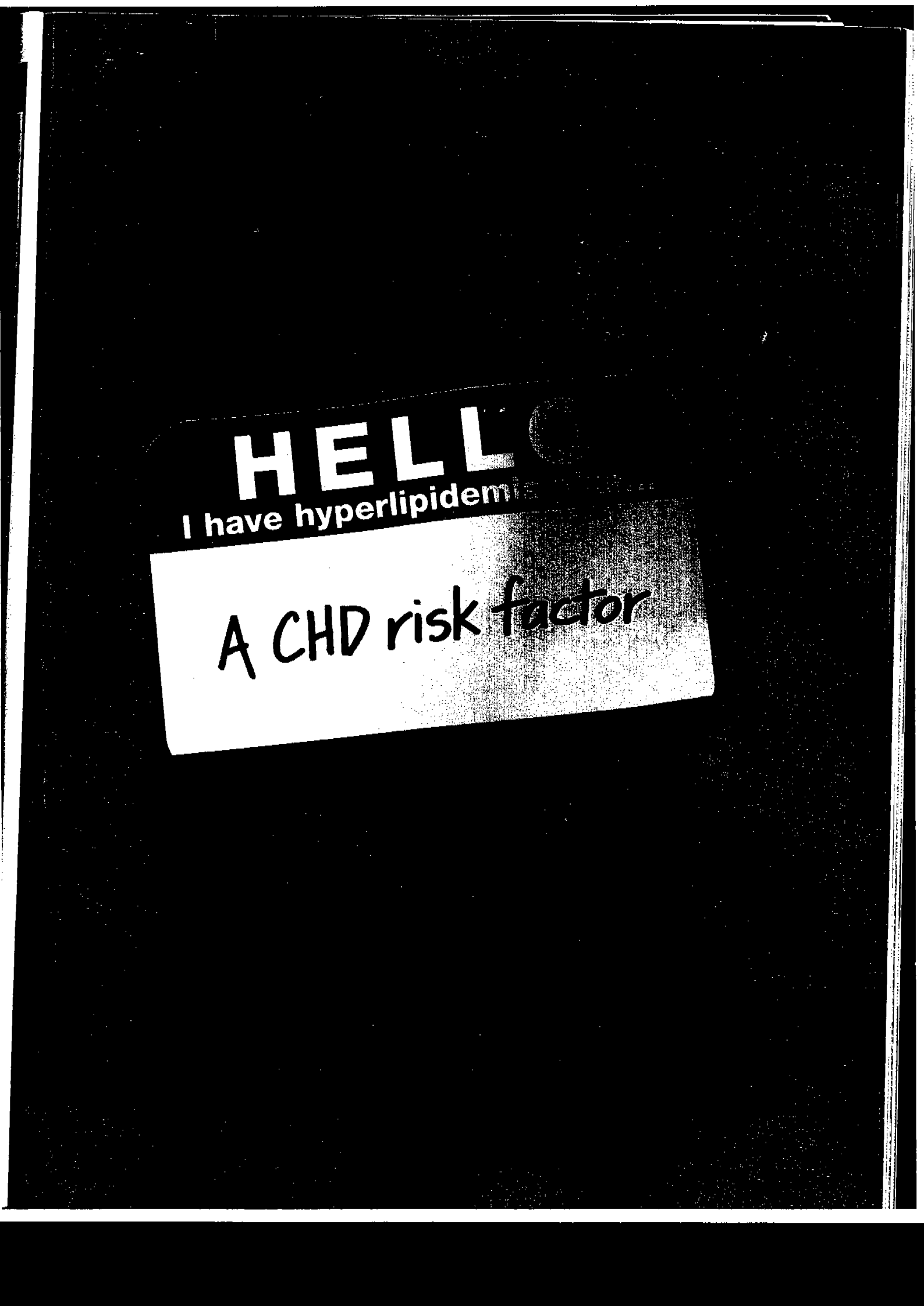
{See appended electronic signature page}

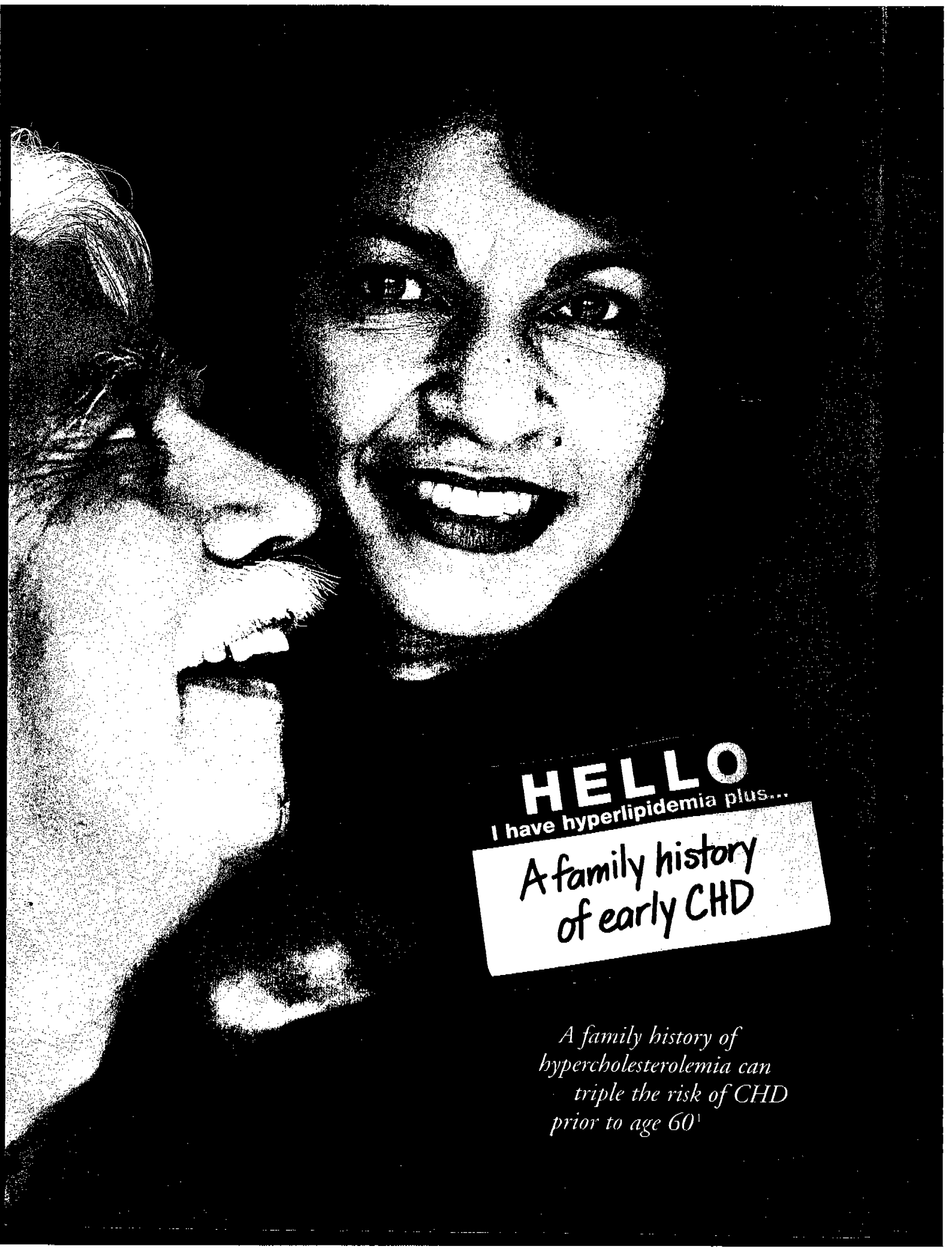
Andrew S.T. Haffer, Pharm.D.
Regulatory Review Officer
Division of Drug Marketing,
Advertising, and Communications

This is a representation of an electronic record that was signed electronically and this page is the manifestation of the electronic signature.

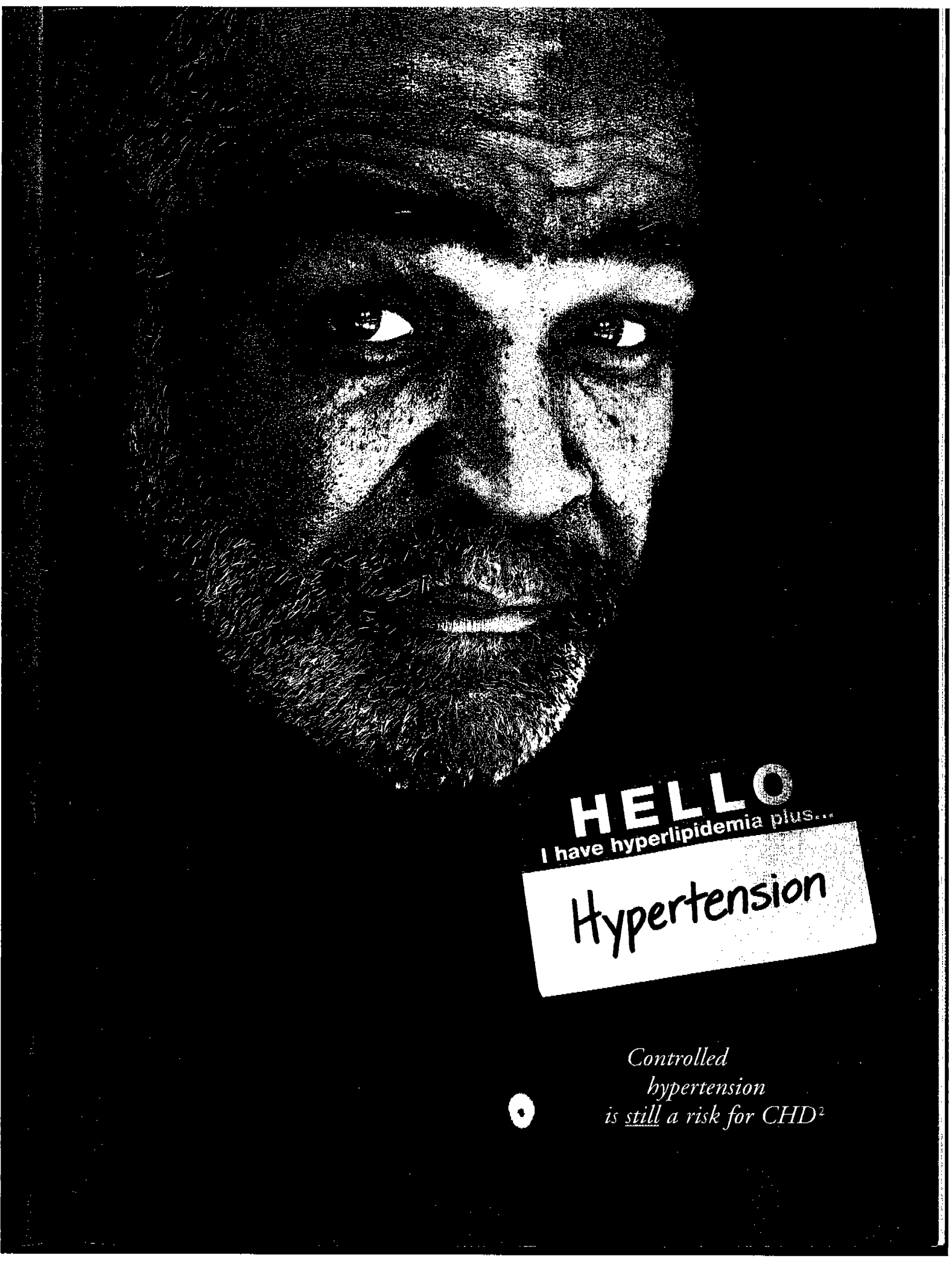
/s/

Andrew Haffer
7/12/01 01:34:15 PM

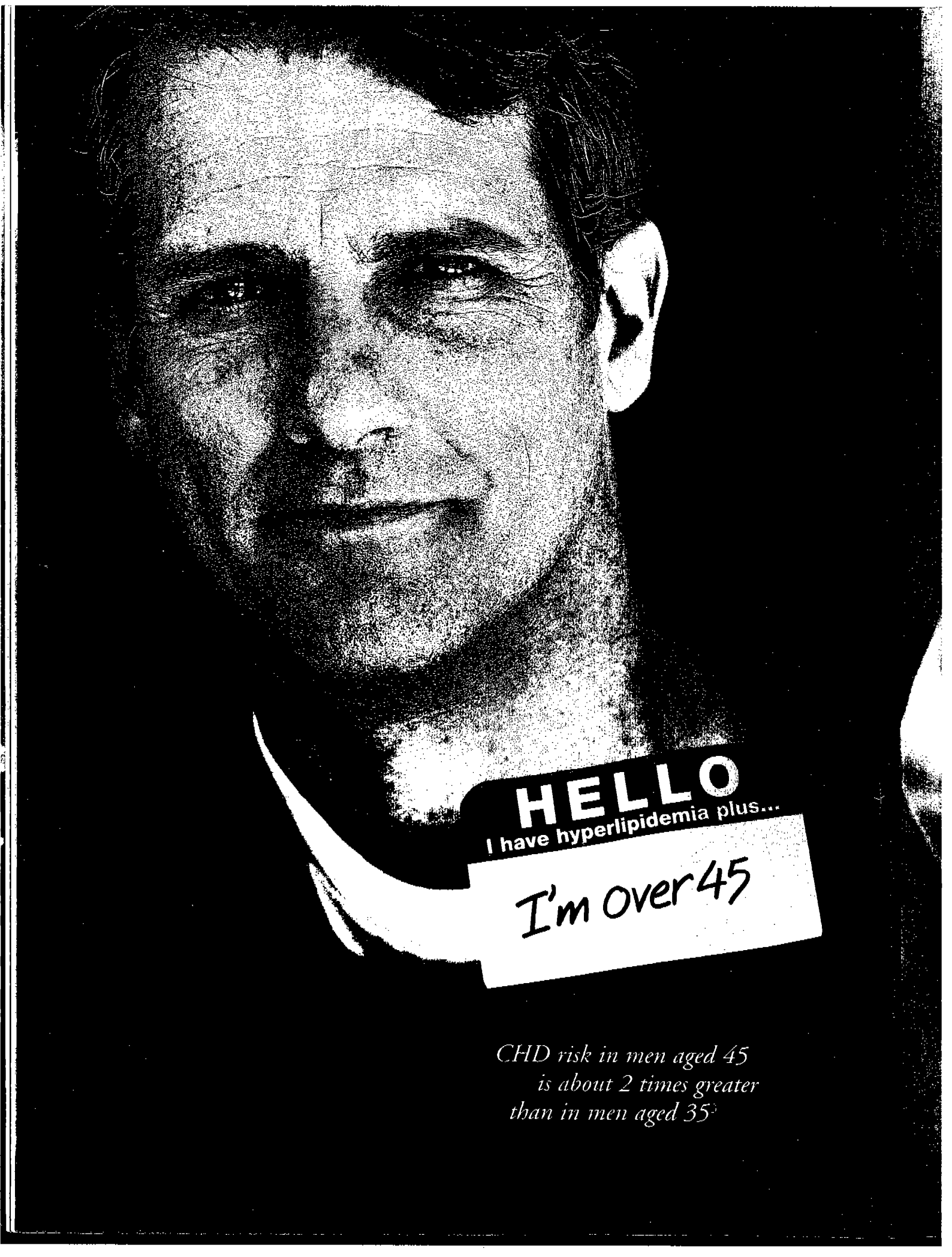

HELL
I have hyperlipidem
A CHD risk factor



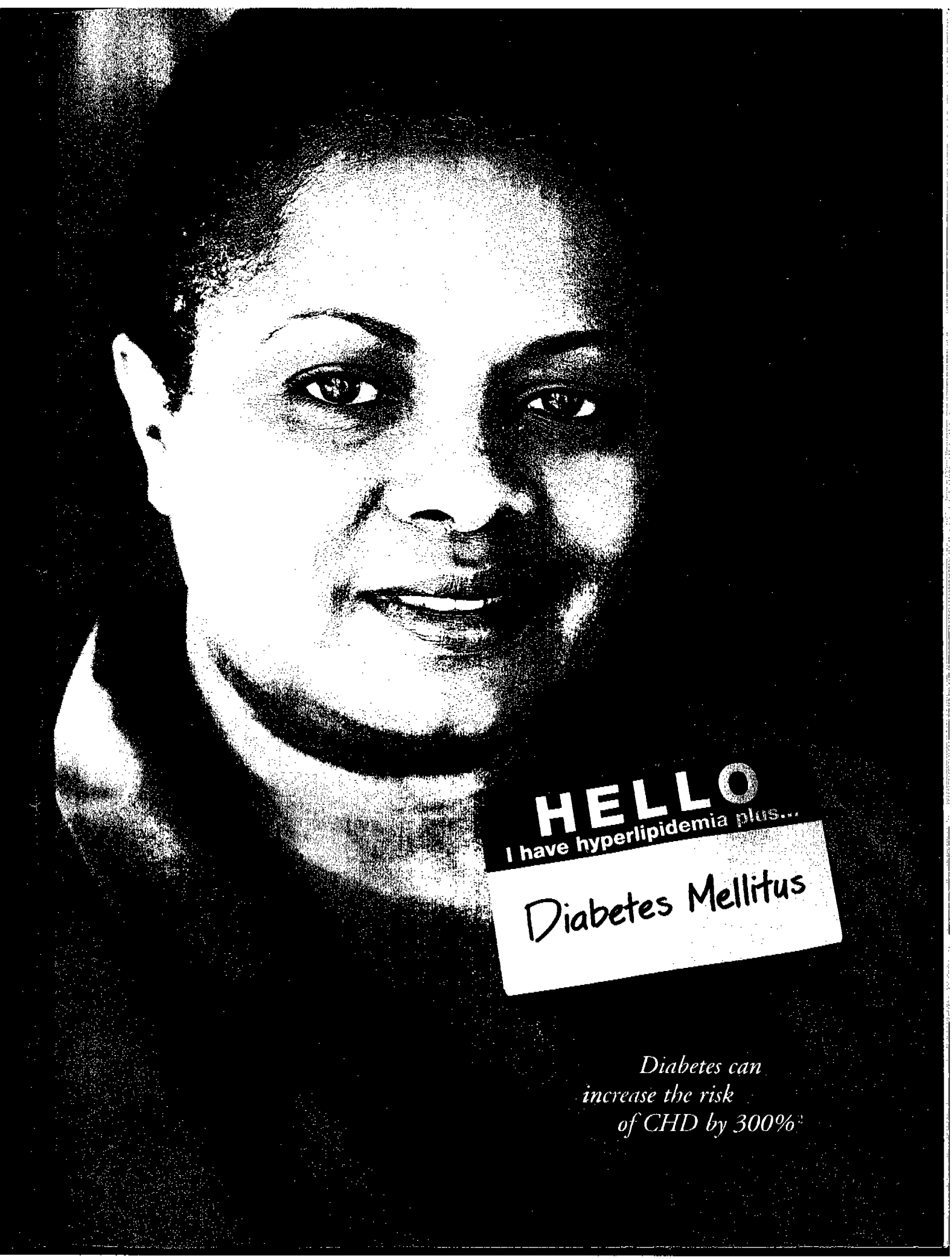
A family history of hypercholesterolemia can triple the risk of CHD prior to age 60[1]



Controlled hypertension is still a risk for CHD[2]



CHD risk in men aged 45 is about 2 times greater than in men aged 35[3]


HELLO
I have hyperlipidemia plus...
Diabetes Mellitus
Diabetes can increase the risk of CHD by 300%[2]

Smoking can approximately double the risk of developing CHD[3]

LIPITOR is indicated as an adjunct to diet to reduce elevated total-C, LDL-C, apoB, and TG levels and to increase HDL-C in patients with primary hypercholesterolemia (heterozygous familial and nonfamilial) and mixed dyslipidemia.

In clinical trials, the most common adverse events were constipation, flatulence, dyspepsia, and abdominal pain.

It is recommended that liver function tests be performed prior to and at 12 weeks following both the initiation of therapy and any elevation of dose, and periodically thereafter.

LIPITOR is contraindicated in patients with hypersensitivity to any component of this medication; in patients with active liver disease or unexplained persistent elevations of serum transaminases; in women during pregnancy and in nursing mothers.

With any statin, tell patients to promptly report muscle pain, tenderness, or weakness. Discontinue drug if myopathy is suspected, if creatine phosphokinase (CPK) levels rise markedly, or if the patient has risk factors for rhabdomyolysis.

Recognize their risk factors and you've just met another candidate for LIPITOR*

*When diet and exercise fail.

Elevated LDL-C combined with even one risk factor increases the threat of CHD[3†]

CHD RISK FACTORS			
Age‡	Diabetes mellitus	Smoking	
Low HDL-C	Family history of early CHD	Hypertension	

‡Male ≥45 years; female ≥55 years or premature menopause without estrogen replacement therapy.

NCEP LDL-C goals are lower for patients with multiple CHD risk factors.[2]

The effect of LIPITOR on cardiovascular morbidity and mortality has not been determined.

LIPITOR provides impressive LDL-C reduction[4§]

More power to reduce LDL-C at the 10-mg starting dose than Zocor® 10 mg, Pravachol® 20 mg, and Mevacor® 20 mg in head-to-head trials[5-7§]

72% of patients reached their NCEP LDL-C goal at 10 mg[3]

In a large clinical trial, the majority of patients reached goal at the 10-mg starting dose‖

Powerful effect on lipid parameters

† Based on information from the Framingham Heart Study.

§ The impact on clinical outcomes of the differences in lipid-altering effects between these treatments is not known. These studies did not compare the effects of LIPITOR 10 mg and higher doses of Zocor®, Pravachol®, and Mevacor®.

‖ A multicenter, double-blind study of all hypercholesterolemic patients taking LIPITOR (10 mg, N=707) for 16 weeks. Baseline lipid level: 192 mg/dL. Target NCEP LDL-C goal based on CHD risk status, percentage of patients reaching goal, and total number of patients: <2 CHD risk factors, <160 mg/dL, 95%, N=329; ≥2 CHD risk factors, <130 mg/dL, 67%, N=268; with CHD, ≤100 mg/dL, 18%, N=110.[3]

Mevacor (lovastatin) and Zocor (simvastatin) are registered trademarks of Merck & Co. Inc; Pravachol (pravastatin sodium) is a registered trademark of Bristol-Myers Squibb Co.

Please see references and brief summary of prescribing information on adjacent page.

LIPITOR®
atorvastatin calcium
tablets

Confident LDL-C reduction for patients at risk.

© 2000 Pfizer Inc. BC121A00

References: 1. Castelli WP Epidemiology of coronary heart disease: The Framingham Study. *Am J Med*.1984;76:4-12. 2. Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults. Summary of the second report of the National Cholesterol Education Program (NCEP) expert panel on detection, evaluation, and treatment of high blood cholesterol in adults (Adult Treatment Panel II). *Circulation*. 1994;89:1329-1445. 3. Data on file. Pfizer Inc., New York, NY. 4. Jones P, Kafonek S, Laurora I, Hunninghake D, for the CURVES Investigators. Comparative dose efficacy study of atorvastatin versus simvastatin, pravastatin, lovastatin, and fluvastatin in patients with hypercholesterolemia (the CURVES Study). *Am J Cardiol*. 1998;81:582-587. 5. Dart A, Jerums G, Nicholson G, et al. A multicenter, double-blind, one-year study comparing safety and efficacy of atorvastatin versus simvastatin in patients with hypercholesterolemia. *Am J Cardiol*. 1997;80:39-44. 6. Bertolini S, Bon GB, Campbell LM, et al Efficacy and safety of atorvastatin compared to pravastatin in patients with hypercholesterolemia. *Atherosclerosis*. 1997;130:191-197. 7. Davidson M, McKenney J, Stein E, et al, for the Atorvastatin Study Group I. Comparison of one-year efficacy and safety of atorvastatin versus lovastatin in primary hypercholesterolemia. *Am J Cardiol*. 1997;79:1475-1481.

LIPITOR® (Atorvastatin Calcium) Tablets

Brief Summary of Prescribing Information

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 CHILDBEARING 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 prior to and at 12 weeks following both the initiation of therapy and any elevation of 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 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 cyclosponne, 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 in full prescribing information). **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. **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 (Wallerian 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. Those 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, spermatid 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/m^2). 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 (rotorod 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 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 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 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 the following table.

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
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	3.2	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, naphritis, 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 therapy reported since market introduction, that are not listed above, regardless of causality assessment, include the following: anaphylaxis, angioneurotic edema, bullous rashes (including erythema multiforme, Stevens-Johnson syndrome, and toxic epidermal necrolysis), and rhabdomyolysis.

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.

Consult package insert before prescribing LIPITOR® (Atorvastatin Calcium) Tablets.

℞ only

Revised March 2000

Manufactured by:
Warner-Lambert Export, Ltd. ©1998-'00
Dublin, Ireland

Distributed by:
PARKE-DAVIS
Div of Warner-Lambert Co
Morris Plains, NJ 07950 USA
MADE IN PUERTO RICO

Marketed by:
PARKE-DAVIS
Div of Warner-Lambert Co and
PFIZER Inc.
New York, NY 10017

0155G247

Pfizer U.S. Pharmaceuticals

BC121A00

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