



Lipid Medication Treatment

Quick Reference Guide

2026

Table of Contents

LANDSCAPE OF LIPID TREATMENT UTILIZATION IN VALUE-BASED CARE	3
Clinical Context in Older Adults	4
Direct Savings and Value Impact Matrix	5
INDICATIONS AND CONTRAINDICATIONS	6
Indications	6
Contraindications and Major Precautions	8
Common Drug and Clinical Interactions	10
RISK ASSESSMENT, TREATMENT SELECTION, AND INTENSIFICATION	11
Calculate, Personalize, Reclassify	11
STATIN-ASSOCIATED SYMPTOMS AND DEINTENSIFICATION	13
TRIGLYCERIDE MANAGEMENT AND PANCREATITIS PREVENTION	14
MONITORING AND CONFIRMING SAFE CONTROL	15
Monitoring Plan	15
MANAGEMENT OF APPARENT TREATMENT FAILURE	16
CLOSED-LOOP PCP-LED CARE PATHWAY	16
PCP and Team Responsibilities	17
COST-SMART PRESCRIBING IN THE UNITED STATES	17
NON-PHARMACOLOGICAL AND PATIENT-CENTERED CARE	19
QUALITY ALIGNMENT	21
Key HEDIS/MIPs Measures	21
TEN KEY TAKEAWAYS FOR LIPID MEDICATION	23
AAVBC SUMMARY AND CONCLUSION	25
REFERENCES	25

LANDSCAPE OF LIPID TREATMENT UTILIZATION IN VALUE-BASED CARE

Dyslipidemia treatment prevents myocardial infarction (MI), ischemic stroke, peripheral artery events, and cardiovascular death by reducing exposure to atherogenic lipoproteins.^{1,2} It also lowers pancreatitis risk when triglycerides are severely elevated.^{3,4} In older adults, value is determined by absolute cardiovascular risk, time to benefit, treatment tolerance, function, medication burden, and whether the regimen can be sustained, not by a laboratory value alone.^{5,6}



AAVBC PERSPECTIVE

The **American Academy of Value-Based Care (AAVBC)** supports primary care ownership of lipid identification, risk estimation, statin initiation, adherence recovery, and stepwise intensification. The **2026 US dyslipidemia guideline** restores low-density lipoprotein cholesterol (LDL-C) and non-high-density lipoprotein cholesterol (non-HDL-C) goals while retaining **percentage reduction** as an important measure of response.^{5,7} **Primary care providers (PCPs) should use the PREVENT-ASCVD equations** for primary-prevention risk assessment in adults aged 30 to 79 years, then **personalize the estimate** with risk-enhancing factors and selectively use **coronary artery calcium (CAC)** to reclassify uncertain decisions.^{5,8}

Generic statins are the high-value foundation because they are inexpensive, effective, and supported by extensive outcomes evidence.^{2,5} When the **LDL-C goal is not reached** on a maximally tolerated statin, **generic ezetimibe** is usually the first add-on because it is oral, well tolerated, and low cost.⁵ Bempedoic acid, proprotein convertase subtilisin/kexin type 9 (**PCSK9**) monoclonal antibodies, inclisiran, and other specialty therapies should follow a **documented assessment of residual risk**, expected absolute benefit, adherence, intolerance, coverage, and patient preference.⁵

Older age alone is not a reason to withhold or discontinue treatment.⁵ For primary prevention after age 75 years, decisions should incorporate frailty, cognition, polypharmacy, life expectancy, function, and goals.^{5,6} Initiating a moderate-intensity statin may be reasonable when estimated life expectancy is at least 2.5 years after shared decision-making.⁵ Deprescribing may be reasonable when life expectancy is less than 1 year or treatment no longer supports the patient's goals.⁵ Secondary prevention generally remains high value unless burden or harm clearly outweighs benefit.⁵

AAVBC Knowledge Hub Premium Content Access

Continue reading your guide
with an AAVBC subscription

Subscribe Now

Already a subscriber? [Sign in](#)

Limited offer

Basic Membership Free

Includes access to downloadable Quick Reference Guides, mailing list for industry updates/medical information, research toolkits, AAVBC events and so much more!

Cancel at any time