AAVBC

AMERICAN ACADEMY OF VALUE BASED CARE

Lipid Medication Treatment Quick Reference Guide

2026

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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]*

Clinical Context in Older Adults

CLINICAL SCENARIO	CLINICAL SIGNIFICANCE[5,9,10]	KEY PCP CONSIDERATIONS*[5,6,10]
Established atherosclerotic cardiovascular disease (ASCVD)	**Recurrent-event risk is high**	Use **high-intensity** or **maximally tolerated statin** and add nonstatin therapy to the risk-based goal
LDL-C at least 190 mg/dL	Suggests **severe primary hypercholesterolemia** or **familial hypercholesterolemia** (**FH**)	**Treat without relying on a short-term risk calculator**; assess family history and cascade screening
Diabetes, stage 3 or 4 chronic kidney disease (CKD), or human immunodeficiency virus (HIV), age 40 to 75 years	Confers **elevated ASCVD risk**	**LDL-lowering therapy** is recommended regardless of calculated risk or baseline LDL-C
Age 65 to 79 years without ASCVD	**PREVENT-ASCVD** remains applicable	Discuss therapy at **intermediate** or **high 10-year risk** and individualize at borderline risk
Age 75 years or older	Trial evidence is **less complete** and competing risks increase	**Consider**: life expectancy, frailty, function, polypharmacy, CAC when uncertain, and patient priorities
Frailty or life-limiting illness	Treatment burden may **exceed delayed preventive benefit**	**Simplify or deprescribe** when goal-concordant; do not use age alone
Persistent muscle symptoms	**Common cause of abandonment** and inaccurate allergy labeling	**Evaluate**: timing, interactions, thyroid disease, and rechallenge **before declaring complete intolerance**
Triglycerides at least 1000 mg/dL	**Pancreatitis risk** becomes a dominant concern	**Address secondary causes urgently** and institute a very-low-fat diet plus indicated triglyceride-lowering therapy

ABBREVIATIONS: ASCVD = atherosclerotic cardiovascular disease; PCP = primary care provider; LDL-C = low-density lipoprotein cholesterol; FH = familial hypercholesterolemia; CKD = chronic kidney disease; HIV = human immunodeficiency virus; PREVENT = Predicting Risk of cardiovascular disease EVENTs; CAC = coronary artery calcium
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

Direct Savings and Value Impact Matrix

VALUE LEVER	CLINICAL STRATEGY[5,11,12]	FINANCIAL MECHANISM AND IMPACT[5,13,14]
Acquisition-cost efficiency — generic statin first	Use **generic atorvastatin** or **rosuvastatin** at the intensity required, or another low-cost statin when tolerability or interactions dictate	Produces **large LDL-C reductions** at **minimal pharmacy cost**
Enhanced efficacy — goal-based combination therapy	**Add generic ezetimibe before a specialty agent** when clinically appropriate	Delivers **incremental LDL-C lowering** and may delay high-cost injectable therapy
Adherence recovery — persistence optimization	Use refill review, 90-day supplies, synchronization, and shared decisions about adverse effects	Prevents events caused by **silent discontinuation** and **avoids unnecessary escalation**
Waste avoidance — statin-intolerance pathway	Dechallenge, **address reversible causes**, and rechallenge with a different dose or statin	**Prevents low-value permanent statin abandonment** and inappropriate specialty spending
Targeted high-cost therapy — risk-based specialty treatment	Reserve PCSK9-directed therapy and inclisiran for patients with **sufficient residual risk and documented need**	**Concentrates high-cost therapy** where absolute event reduction is greatest
Diagnostic precision — Lp(a) and selective ApoB testing	Measure **lipoprotein(a)** once and use **apolipoprotein B** when standard lipids may underestimate risk	**Improves targeting** without converting biomarkers into indiscriminate repeated testing
Decision resolution — CAC for uncertainty	**Use CAC selectively**, not as routine screening or serial treatment monitoring	Resolves borderline decisions and **reduces** both **undertreatment** and **low-benefit prescribing**
Care-transition closure — post-event reconciliation	**Reconcile lipid therapy after**: MI, stroke, revascularization, or hospitalization	**Prevents**: failure to initiate, unintended discontinuation, and avoidable recurrent events

ABBREVIATIONS: LDL-C = low-density lipoprotein cholesterol; PCSK9 = proprotein convertase subtilisin/kexin type 9; Lp(a) = lipoprotein(a); ApoB = apolipoprotein B; CAC = coronary artery calcium; MI = myocardial infarction
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

INDICATIONS AND CONTRAINDICATIONS

Indications

Secondary Prevention

Clinical ASCVD includes prior acute coronary syndrome or MI, stable coronary disease, coronary or other arterial revascularization, ischemic stroke or transient ischemic attack attributable to atherosclerosis, and peripheral artery disease.[5,7] **Most patients should receive a high-intensity or maximally tolerated statin**.[5] For those at very high risk, the 2026 guideline recommends **LDL-C below 55 mg/dL** and **non-HDL-C below 85 mg/dL**.[5] Patients with ASCVD who are **not at very high risk** generally have an **LDL-C goal below 70 mg/dL**.[5] Risk status, achieved percentage reduction, tolerance, and patient preference **determine add-on therapy**.[5]

Primary Prevention

- **Severe hypercholesterolemia**: **LDL-C at least 190 mg/dL** generally warrants statin therapy **without PREVENT-ASCVD calculation**. Exclude secondary causes and **evaluate for FH**[5]
- **Diabetes, CKD, or HIV**: Adults aged 40 to 75 years with diabetes, stage 3 or 4 CKD, or HIV should receive LDL-lowering therapy **regardless of calculated risk or LDL-C level**. Intensity should reflect **risk enhancers** and **treatment goals**[5,8]
- **Risk-based treatment**: For adults without ASCVD or subclinical atherosclerosis and LDL-C 70 to 189 mg/dL, use **PREVENT-ASCVD**. Therapy can be considered at **3%** to **less than 5% 10-year risk** and should be considered at **5%** to **less than 10%** after clinician-patient discussion. High-risk adults should generally receive therapy capable of **at least a 50% LDL-C reduction** and achievement of **LDL-C below 70 mg/dL**[5,9]
- **Borderline or intermediate risk**: An LDL-C goal **below 100 mg/dL** and a **30%** to **49%** reduction are generally appropriate when medication is selected, with greater lowering as risk increases[5,7]
- **Older adults**: For adults aged **75 years or older** with life expectancy of **at least 2.5 years**, initiating **moderate-intensity statin therapy** may be reasonable after shared decision-making. Continue effective therapy when benefit remains aligned with goals[5,6]

Hypertriglyceridemia

Statins remain the foundation for ASCVD risk reduction **when triglycerides are persistently elevated**.[5] **Triglycerides from 150 to 499 mg/dL should prompt** correction of diet, alcohol exposure, diabetes, obesity, hypothyroidism, kidney or liver disease, and contributing medications.[5] **Icosapent ethyl** may reduce residual cardiovascular risk in **selected statin-treated patients** with established ASCVD or diabetes plus additional risk features and **persistent triglyceride elevation**.[5]

At triglycerides at least **500 mg/dL**, and especially at least **1000 mg/dL**, **pancreatitis prevention** becomes increasingly important.[5] Use a **very-low-fat diet** at the highest levels, **eliminate alcohol**, treat **hyperglycemia** and **secondary causes**, and consider **prescription omega-3 fatty acid** or fenofibrate therapy.[5] Acute abdominal pain, vomiting, or systemic illness **requires urgent evaluation**.[5]

Special Considerations in Older Adults

CONSIDERATION	KEY POINTS*[5,15–19]
Secondary prevention	Evidence supports **maximally tolerated statin** (± ezetimibe/PCSK9i) **regardless of chronological age**; ASCVD benefit is robust at any age, so **do not withhold on age alone**
Primary prevention ≥75	**RCT data are limited**; moderate-intensity statin may be reasonable if **life expectancy ≥2.5 years** after shared decision-making; relative benefit is smaller and no clear all-cause mortality benefit
Individualize, not by age alone	Base initiation/continuation on multimorbidity, frailty, polypharmacy, function, and patient priorities; **never on chronological age or life expectancy alone**
Time-to-benefit	**Primary-prevention benefit takes ~2.5 years to accrue**; weigh against life expectancy before starting
Selective CAC use	When the decision is uncertain in adults >75 with life expectancy ≥2.5 years, **CAC of 0** (or 1–10) can **reclassify downward** and **support avoiding LLT**
Deprescribing	Reasonable when **risks outweigh benefits or priorities shift**; in life expectancy <1 year, **stopping LLT is safe and may improve quality of life**
Muscle symptoms	**SAMS are the most common complaint**; true **myopathy/rhabdomyolysis is rare** but higher with high-dose statins in older/CKD patients; much reported intolerance is nocebo; manage rather than reflexively stop
New-onset diabetes	Small dose-related risk in those with **prediabetes risk factors**; ASCVD benefit outweighs it = **not a reason to avoid or stop statins**
Cognition	Evidence **does not support** statin-induced cognitive impairment; effects are neutral or possibly protective = **not a reason to withhold**
CKD and dosing	**CKD favors LLT**; prefer lower-renal-clearance statins (atorvastatin), cap rosuvastatin (≤10 mg if eGFR <30); **statin initiation is not beneficial on dialysis** but may be continued
Polypharmacy/ interactions	Reconcile **CYP3A4** and **other interacting drugs**; **avoid gemfibrozil** with statins; simplify regimens to reduce burden and adverse events
Hypertriglyceridemia	Statin remains foundational; treat secondary causes; **icosapent ethyl** may lower residual risk in **selected ASCVD/diabetes patients**; at **TG ≥500 mg/dL** use **fibrate** or **prescription omega-3** to prevent pancreatitis

CONSIDERATION	KEY POINTS*[5,15–19]

ABBREVIATIONS: PCSK9i = proprotein convertase subtilisin/kexin type 9 inhibitor; ASCVD = atherosclerotic cardiovascular disease; RCT = randomized controlled trial; CAC = coronary artery calcium; LLT = lipid-lowering therapy; SAMS = statin-associated muscle symptoms; CKD = chronic kidney disease; eGFR = estimated glomerular filtration rate; CYP3A4 = cytochrome P450 3A4; TG = triglycerides
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

CLINICAL PEARL: CHANGES TO STATIN THERAPY RECOMMENDATIONS IN UPDATED 2026 AHA/ACC DYSLIPIDEMIA GUIDELINES

The 2026 guideline expands primary prevention assessment from ages **40–75 to 30–79** and replaces the pooled cohort equations with **PREVENT-ASCVD**.[5] Statins remain recommended **regardless of calculated risk for LDL-C ≥190 mg/dL and adults ages 40–75 with diabetes**; stage ≥3 CKD and HIV are now added to this group.[5] Statin therapy is also more strongly supported for **borderline 10-year risk** (3% to <5%) and may be reasonable **even at low risk** when **LDL-C is 160–189 mg/dL** or **30-year risk is ≥10%**.[5] For older adults, **use PREVENT through age 79** and consider **coronary artery calcium scoring** when treatment remains uncertain.[5] **Beyond age 79**, **individualize decisions** around ASCVD burden, frailty, polypharmacy, life expectancy, and patient goals.[5]

Contraindications and Major Precautions

CATEGORY	CONTRAINDICATION/ PRECAUTION*[5,17,17,20]	APPLIES TO*	PCP RESPONSE*[5,17,20]
Active serious liver injury	Unexplained **acute hepatitis** or **decompensated hepatic disease**	Statins and selected non-statins	**Defer initiation during acute injury**, evaluate cause, and use product labeling and specialty input
Pregnancy	FDA removed the class-wide absolute contraindication, but **most pregnant patients should stop statins**	Statins	**Stop in most pregnancies**; consider continuation only in **rare very-high-risk patients** with specialist and obstetric input
Lactation	**Statin exposure** may occur in breast milk	Statins	**Avoid breastfeeding if statin therapy must continue**; discuss alternatives
Severe hypersensitivity	Prior serious reaction to the drug or excipient	All classes	**Avoid the implicated product** and select an alternative

CATEGORY	CONTRAINDICATION/ PRECAUTION*[5,17,17,20]	APPLIES TO*	PCP RESPONSE*[5,17,20]
Gallbladder disease	May increase **gallstone risk**	Fibrates	**Avoid or use with caution** according to product labeling
Severe renal impairment	**Raises fibrate exposure** and **myopathy risk**	Fenofibrate and gemfibrozil	Apply **renal restrictions** and **dose adjustments**; monitor kidney function
Hypertriglyceridemia	Bile acid sequestrants can **raise triglycerides**	Bile acid sequestrants	Avoid with **severe hypertriglyceridemia** or **prior hypertriglyceridemic pancreatitis**
Gout or hyperuricemia	Bempedoic acid can **increase uric acid**	Bempedoic acid	Review history and monitor clinically; counsel about **tendon symptoms**
Older age, frailty, polypharmacy, CKD, or hypothyroidism	Increases susceptibility to **muscle symptoms** and **interactions**	Statins, especially higher exposures	Select dose and product carefully; **correct reversible risks** and monitor symptoms

ABBREVIATIONS: PCP = primary care provider; FDA = Food and Drug Administration; CKD = chronic kidney disease
***Consult current FDA labeling for agent-specific dosing, renal thresholds, contraindications, reversal, and peri-procedural interruption**

CLINICAL PEARL: ESSENTIAL PCP PRE-TREATMENT CHECKS

Before initiating or materially changing therapy:

- **Define the indication**: document primary or secondary prevention, ASCVD events and dates, FH suspicion, diabetes, CKD, HIV, triglyceride severity, and the **intended LDL-C and non-HDL-C goals**[5]
- **Establish baseline lipids**: obtain total cholesterol, LDL-C, high-density lipoprotein cholesterol (HDL-C), triglycerides, and non-HDL-C. **Repeat a surprising result** and obtain a fasting sample when triglycerides are high or a calculation is unreliable[5,21]
- **Assess risk and enhancers**: use **PREVENT-ASCVD** when applicable; **measure Lp(a) at least once**; consider ApoB when triglycerides exceed 200 mg/dL, diabetes is present, or achieved LDL-C is below 70 mg/dL but residual risk is uncertain[5]
- **Check safety and secondary causes**: obtain alanine aminotransferase (ALT), review kidney function, diabetes status, thyroid disease, alcohol, medications, and baseline muscle symptoms. **Creatine kinase** (**CK**) is selective, **not routine**[5,21]
- **Measure feasibility**: review swallowing, cognition, injection capacity, cost, pharmacy access, adherence history, and patient priorities **using teach-back**[5]

Common Drug and Clinical Interactions

COMBINATION	MAIN RISK*[7,17,22]	PCP STRATEGY*[5,7,17]
Simvastatin or lovastatin plus strong CYP3A4 inhibitor	Markedly **increased statin exposure and myopathy**	Hold or select a **non-CYP3A4 statin**; follow agent-specific restrictions
Atorvastatin plus strong CYP3A4 inhibitor	**Increased statin plasma concentration** (systemic drug exposure)	Temporarily **hold**, **reduce**, or **substitute** according to interaction guidance
Ritonavir-boosted antiviral, including nirmatrelvir/ritonavir	Severe statin interaction for selected agents	Check the current interaction resource **before prescribing**; hold contraindicated statins for the specified interval
Statin plus gemfibrozil	Increased **myopathy** and **rhabdomyolysis risk**	**Avoid when possible**; fenofibrate is generally preferred if a fibrate is necessary
Statin plus cyclosporine or selected transplant drugs	**Large increase in statin plasma drug levels** (systemic exposure)	Use **specialist-guided statin selection** and dose limits
Bile acid sequestrant plus another oral medication	**Reduced absorption**	**Separate administration** according to the interacting product, commonly at least **1 hour before** or **4 to 6 hours after**
Icosapent ethyl plus antithrombotic therapy	**Increased bleeding risk**; atrial fibrillation signal	**Review bleeding and rhythm history** and monitor clinically
Grapefruit with simvastatin, lovastatin, or atorvastatin	**Increased exposure** depending on quantity and product	Counsel using **product-specific limits** or choose an alternative statin

ABBREVIATIONS: CYP3A4 = cytochrome P450 3A4; PCP = primary care provider
***Consult current FDA labeling for agent-specific dosing, renal thresholds, contraindications, reversal, and peri-procedural interruption**

RISK ASSESSMENT, TREATMENT SELECTION, AND INTENSIFICATION

Calculate, Personalize, Reclassify

Use the 2026 guideline's CPR model:

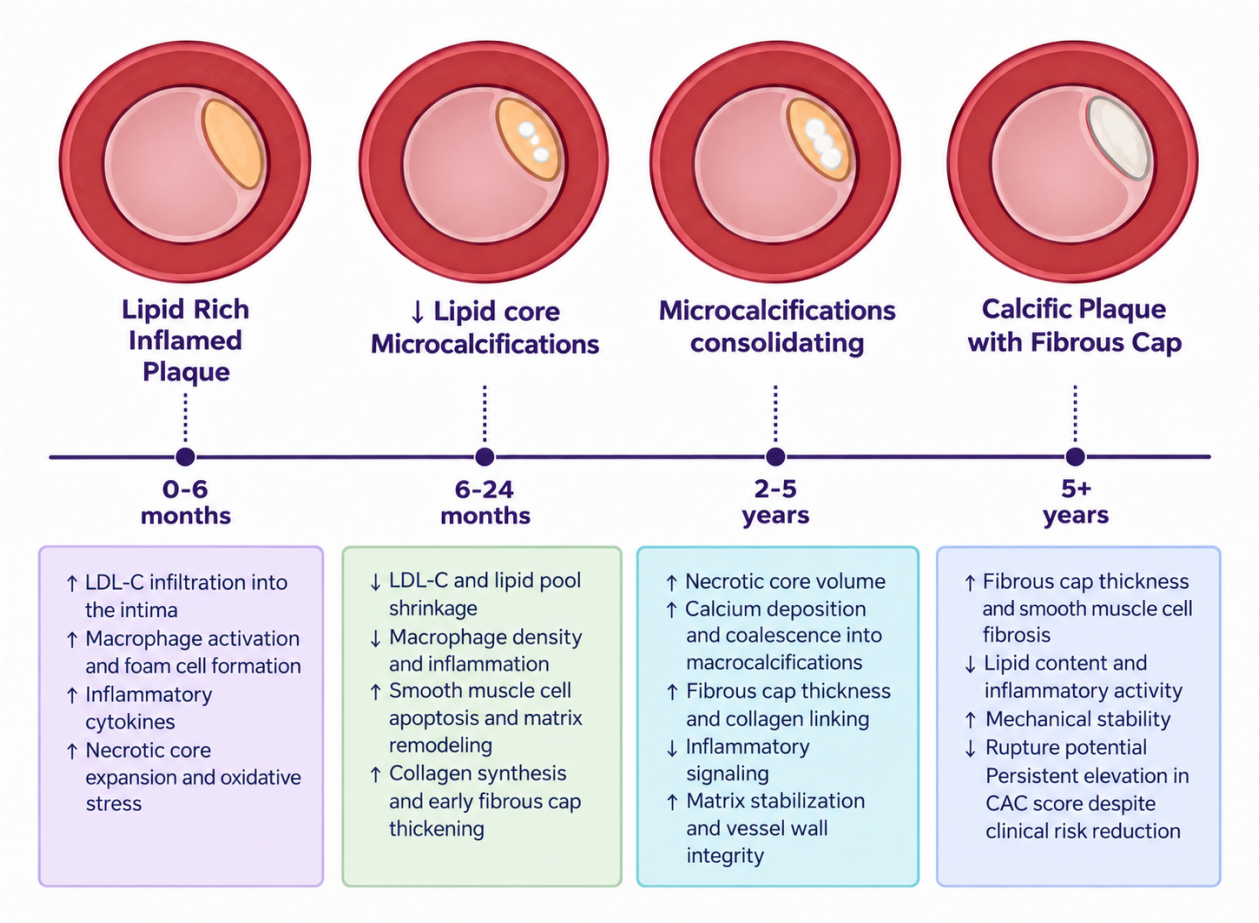
- **Calculate**: estimate **10-year PREVENT-ASCVD risk** in eligible adults aged **30 to 79 years**[5,23]
- **Personalize**: consider **family history** of premature ASCVD, LDL-C 160 to 189 mg/dL, metabolic syndrome, inflammatory disease, elevated triglycerides, CKD, HIV, **premature menopause** or **adverse pregnancy outcomes** when relevant, and elevated Lp(a), ApoB, high-sensitivity C-reactive protein, or low ankle-brachial index[5,24]
- **Reclassify**: use **CAC selectively** when a borderline or intermediate decision remains uncertain, then reassess the treatment recommendation with the patient[5,25]

PREVENT-ASCVD is **not used to decide whether to treat a patient with established ASCVD**, LDL-C at least **190 mg/dL**, or **established subclinical atherosclerosis**. It should support, not replace, clinical judgment.[5]

Coronary Artery Calcium

CAC is most useful when the **decision is genuinely uncertain**.[5,25] Any CAC supports **active LDL lowering**, with lower goals as calcium burden rises.[5,24] A **CAC score of 0** can support **deferring medication** in selected primary-prevention adults, but it **does not create a guarantee of safety** and should not overrule diabetes, LDL-C at least 190 mg/dL, cigarette smoking, or strong premature family history.[5,25] **In adults older than 75 years**, CAC of 0 to 10 may help **reclassify risk downward** when life expectancy is at least 2.5 years and the treatment decision remains uncertain.[5,26]

Do not use serial CAC scanning to judge statin effectiveness. Statins may **increase plaque calcification density** while stabilizing plaque, so **a rising Agatston score does not necessarily indicate treatment failure**.[27,28]



Practical Medication Categories

CATEGORY	TYPICAL LDL-C EFFECT*[5,29]	MAIN ROLE[5,24]	VALUE AND SAFETY CONSIDERATIONS[5,17,30,31]
High-intensity statin	**At least 50%** reduction	**ASCVD**, **LDL-C at least 190 mg/dL**, and high-risk **primary prevention**	**Generic atorvastatin 40 to 80 mg** or **rosuvastatin 20 to 40 mg** is usually highest value
Moderate-intensity statin	**30% to 49%** reduction	Borderline or intermediate primary prevention and many **adults aged 75 years or older**	**Select by**: interactions, kidney function, tolerance, and formulary
Ezetimibe	About **15% to 25%** additional reduction	**First oral add-on** or monotherapy when statin use is limited	**Generic**, once daily, and **generally well tolerated**
Bempedoic acid	About **15% to 25%** reduction	**Statin intolerance** or **additional oral LDL lowering**	Outcomes benefit demonstrated in **statin-intolerant populations**; review gout and tendon risk

CATEGORY	TYPICAL LDL-C EFFECT*[5,29]	MAIN ROLE[5,24]	VALUE AND SAFETY CONSIDERATIONS[5,17,30,31]
PCSK9 monoclonal antibody	About **50% to 60%** additional reduction	**Very-high-risk ASCVD**, FH, or severe residual LDL elevation	**Strong LDL lowering** and outcomes evidence, but **specialty cost and self-injection burden**
Inclisiran	About **50%** reduction	Selected patients needing durable, **clinician-administered LDL lowering**	**Twice-yearly maintenance dosing** may improve implementation; cardiovascular outcomes evidence and coverage **differ from PCSK9 antibodies**
Bile acid sequestrant	About **15% to 25%** reduction	Selected patients **when triglycerides are controlled**	Constipation, pill or powder burden, and binding interactions **limit use in older adults**

ABBREVIATIONS: LDL-C = low-density lipoprotein cholesterol; ASCVD = atherosclerotic cardiovascular disease; PCSK9 = proprotein convertase subtilisin/kexin type 9; FH = familial hypercholesterolemia
***Consult FDA labels for the most up-to-date dosage and duration information, contraindications, and drug-drug interactions**

Stepwise LDL-Lowering Pathway

This pathway applies to both **primary** and **secondary ASCVD prevention**, providing a sequential escalation strategy to reach the patient's **risk-stratified LDL-C goal** while balancing efficacy, tolerability, and treatment burden:

- Start an **evidence-based statin intensity** and document the **expected percentage reduction and goal**[5,29]
- Repeat lipids in **4 to 12 weeks** and **assess**: actual use, tolerance, diet, secondary causes, and interactions[29]
- Titrate to a **high-intensity** or **maximally tolerated statin when indicated**[5]
- **Add ezetimibe** when the goal remains unmet and the **expected benefit justifies treatment**[5,24]
- For persistent high risk, select **bempedoic acid**, a **PCSK9 monoclonal antibody**, **inclisiran**, or another indicated therapy **based on**: required LDL lowering, outcomes evidence, route, adherence, contraindications, access, and patient preference[5,24]
- **Reassess after every transition and simplify** when treatment burden exceeds likely benefit[5]

STATIN-ASSOCIATED SYMPTOMS AND DEINTENSIFICATION

Statin-associated muscle symptoms require evaluation, not automatic permanent discontinuation.[5] **Document**: symptom location, symmetry, timing, severity, weakness, urine color, exercise change, acute illness, and relation to starting, stopping, or rechallenging therapy.[5] Review hypothyroidism, vitamin D deficiency when clinically suspected, kidney or liver dysfunction, alcohol, interacting medications, and strenuous activity.[5,17] **Measure CK** for severe symptoms, objective weakness, or concern for myopathy or rhabdomyolysis, not routinely for mild aches.[5]

If symptoms are clinically significant, **hold the statin until they improve**, **address reversible causes**, and **rechallenge** with a lower dose, a different statin, or less frequent dosing.[5] Many patients can tolerate some statin exposure.[5] **Combine** the maximally tolerated dose **with ezetimibe** or **another evidence-based nonstatin** rather than accepting uncontrolled risk.[5] Persistent weakness or CK elevation after statin withdrawal warrants **urgent specialty evaluation** for rare immune-mediated necrotizing myopathy.[5]

Deintensification is appropriate when serious adverse effects recur, the medication no longer matches goals, frailty or pill burden substantially changes, or **life expectancy is too short for meaningful preventive benefit**.[5] For patients with life expectancy less than 1 year, **discontinuation** may be reasonable **after shared decision-making**. Avoid deprescribing solely because a patient crossed an age threshold.[32]

CLINICAL PEARL: COQ10 FOR STATIN-ASSOCIATED MUSCLE SYMPTOMS

The rationale is mechanistic: statins inhibit the **mevalonate pathway**, lowering endogenous ubiquinone (CoQ10) and potentially impairing mitochondrial energy production in myocytes—the leading hypothesis for **statin-associated muscle symptoms** (**SAMS**).[33–35] However, because CoQ10 is generally **well tolerated** and **inexpensive**, a time-limited trial of **200–400 mg daily** may be considered for select patients with **confirmed SAMS** who remain symptomatic and **may otherwise discontinue statin therapy**. Continue only if **symptoms clearly improve**.[35]

TRIGLYCERIDE MANAGEMENT AND PANCREATITIS PREVENTION

Persistent triglyceride elevation should trigger **confirmation and evaluation** for uncontrolled diabetes, alcohol, high refined-carbohydrate intake, obesity, hypothyroidism, pregnancy, CKD, liver disease, nephrotic syndrome, and medications such as glucocorticoids, estrogen, retinoids, atypical antipsychotics, selected HIV therapies, or immunosuppressants.[5,36]

For **triglycerides 150 to 499 mg/dL**, prioritize lifestyle, weight and glycemic management, and statin-based ASCVD prevention.[5] **Do not substitute** a fibrate or nonprescription fish oil **for indicated LDL-lowering therapy**.[5] Icosapent ethyl is not interchangeable with mixed eicosapentaenoic acid/docosahexaenoic acid supplements and should be **reserved for the evidence-based population**.[5,37]

For **triglycerides at least 1000 mg/dL**, institute a very-low-fat eating plan, stop alcohol, treat hyperglycemia, and add indicated prescription triglyceride-lowering therapy.[5] **Fenofibrate is generally preferred over gemfibrozil** if combination with a statin is needed.[5] **Once pancreatitis risk is controlled**, **return attention to** LDL-C, non-HDL-C, and global ASCVD risk.[5,36]

MONITORING AND CONFIRMING SAFE CONTROL

Monitoring Plan

- **Lipid panel**: **repeat 4 to 12 weeks after initiation**, dose change, or adherence intervention, then **every 3 to 12 months** according to stability and risk[5,36]
- **Percentage reduction and goals**: compare with the **untreated baseline when available** and **document LDL-C and non-HDL-C goal attainment**[5]
- **ALT**: repeat for symptoms of hepatotoxicity or a relevant clinical change, **not automatically at every lipid check**[5]
- **CK**: obtain for severe muscle symptoms, weakness, or high-risk presentations, **not routine surveillance**[5]
- **ApoB**: use selectively when triglycerides, diabetes, or very low achieved LDL-C may **leave discordant residual atherogenic particle risk**[5,38]
- **Lp(a)**: measure **at least once**; routine serial measurement is **usually unnecessary** because levels are **largely genetically determined** and no approved therapy is currently used solely to normalize Lp(a)[39]
- **Therapy-specific monitoring**: review uric acid or gout with **bempedoic acid**, renal function with **fibrates**, injection technique and reactions with **PCSK9-directed therapy**, and atrial fibrillation or bleeding concerns with **icosapent ethyl**[5,40]

Criteria for Safe Maintenance

Control is adequate when the patient has achieved the **risk-based LDL-C and non-HDL-C goals** or an agreed **maximally achievable reduction**, is taking the regimen consistently, has **no unacceptable toxicity**, and can **sustain the cost** and **administration plan**.[5] A low LDL-C on paper does not establish value if the patient has stopped therapy, is using samples with no continuation plan, or cannot manage the injection schedule.[5]

MANAGEMENT OF APPARENT TREATMENT FAILURE

Before escalating therapy,**perform a structured review**:

- **Measurement**: confirm fasting status when relevant, calculation method, baseline value, laboratory variation, and whether triglycerides make LDL-C estimation unreliable[5]
- **Medication**: confirm the exact drug, dose, frequency, refill access, missed doses, intolerance, drug interactions, and unintentional discontinuation after hospitalization[5]
- **Metabolic causes**: assess hypothyroidism, nephrotic syndrome, cholestatic liver disease, uncontrolled diabetes, weight change, alcohol, and causative medications[5]
- **Lifestyle**: reassess saturated fat, ultraprocessed food, refined carbohydrate, alcohol, activity, sleep, and tobacco **without implying that lifestyle failure explains all genetic risk**[5]
- **Required magnitude**: calculate how much **additional LDL-C lowering is needed**, then select the **least burdensome therapy** capable of achieving it[41]

Refer to a lipid specialist or cardiology for suspected homozygous or severe heterozygous FH, LDL-C remaining markedly elevated despite verified combination therapy, recurrent ASCVD events despite goal-directed treatment, true complete statin intolerance, severe hypertriglyceridemia that persists after secondary causes are treated, pregnancy with extreme ASCVD risk, or **need for advanced agents beyond local experience**.[5]

CLOSED-LOOP PCP-LED CARE PATHWAY

- **Identify the indication**: primary prevention, secondary prevention, severe LDL elevation, FH, or pancreatitis prevention[5]
- **Calculate and personalize risk**: use **PREVENT-ASCVD** when applicable, risk enhancers, Lp(a), and selective ApoB[5]
- **Set the treatment goal**: document LDL-C, non-HDL-C, and expected percentage reduction[5]
- **Choose the highest-value feasible regimen**: **generic statin first**, then generic ezetimibe when appropriate[13]
- **Close access**: confirm formulary coverage, pharmacy pickup, 90-day supply when appropriate, and a **sustainable plan** after samples or prior authorization[42]
- **Reassess in 4 to 12 weeks**: evaluate response, adherence, adverse effects, and secondary causes[5]

- **Intensify or simplify**: add therapy according to residual risk and required reduction, or deprescribe when burden exceeds benefit[5,41]
- **Close transitions**: reconcile lipid therapy after every cardiovascular hospitalization, specialist visit, and formulary switch[5]

PCP and Team Responsibilities

- **PCP**: identify risk, order baseline and follow-up testing, initiate statins, manage common intolerance, add ezetimibe, address lifestyle and tobacco, and document goals[42,43]
- **Clinical pharmacist**: complete interaction review, formulary comparison, adherence outreach, prior authorization support, and injection education[42,43]
- **Dietitian**: provide a culturally and financially realistic **cardioprotective eating plan** and a **very-low-fat plan** when severe hypertriglyceridemia requires it[42]
- **Cardiologist**: optimize very-high-risk secondary prevention and coordinate therapy after acute coronary, cerebrovascular, or revascularization events[13]
- **Lipid specialist**: manage FH, complex intolerance, refractory triglycerides, advanced therapies, and cascade screening[5,42]
- **Patient and caregiver**: use teach-back to confirm medication identity, schedule, adverse-effect plan, and refill strategy[43]

COST-SMART PRESCRIBING IN THE UNITED STATES

Start with the generic therapy that can meet the clinical goal. **Atorvastatin** and **rosuvastatin** provide high-intensity options; **pravastatin**, lower-dose **rosuvastatin**, and other statins may solve interaction or tolerability problems.[5] **Generic ezetimibe** usually provides the **lowest-cost incremental LDL reduction**.[5,41] Avoid expensive fixed-dose combinations when **separate generics provide the same clinically appropriate components at lower net cost** and acceptable pill burden.[5]

Do not assume a discount-card price is always better. For Medicare beneficiaries, prescriptions purchased outside Part D generally do not count toward plan spending or the 2026 annual Part D **out-of-pocket threshold of $2,100**.[44,45] Compare the plan copay, preferred pharmacy, mail order, cash price, and impact on **total annual spending**.[46] Commercial manufacturer copay cards generally cannot be used by Medicare beneficiaries, but Extra Help, charitable assistance, and plan-specific programs may apply.[46]

For PCSK9 monoclonal antibodies, **inclisiran**, and other specialty therapies, document the indication, baseline and treated LDL-C, prior statin doses and dates, adverse effects and rechallenges, ezetimibe use, FH criteria, and ASCVD history **before submission**.[5,41] Confirm whether coverage is under the pharmacy or medical benefit and who owns renewal. **Avoid nonmedical gaps** during prior authorization by **maintaining the best tolerated oral regimen**.[5,41]

The lowest acquisition price is not automatically the lowest total cost. A specialty agent can be **high value** in a patient with **very-high-risk ASCVD** and major **residual LDL elevation**, while it can be **low value** in a **low-risk patient** who has not tried a statin or ezetimibe.[41,47] Judge value by absolute event reduction, safety, persistence, and total cost of care.[48]

BRAND OR HIGHER-COST OPTION[37,41,49,50]	GENERIC/ ALTERNATIVE (EST. COST)*[49,51–53]	EST. SAVINGS + COST-SMART TIP*[41,54,55]
Brand atorvastatin (Lipitor ~$30/mo cash for 20 mg; historically up to 10× generic)	**Generic** atorvastatin 10–80 mg (**~$4–$15/mo**; median OOP **~$5/mo**)	**~$25/mo cash** **High-intensity generic** (40–80 mg) is the **highest-value foundation**; no evidence brand is clinically superior = **prescribe generic to protect adherence**
Brand rosuvastatin (Crestor ~$260–$310/mo cash)	**Generic** rosuvastatin 5–40 mg (~$8–$30/mo)	**~$230–$300/mo** High-intensity option (20–40 mg); full **generic competition made rosuvastatin high-value** → no advantage remains for the brand
Brand ezetimibe (Zetia ~$400–$500/mo cash)	**Generic** ezetimibe 10 mg (**~$8–$30/mo**; net **<$10/mo**)	**~$370–$490/mo** **First-line oral add-on before any injectable**; high value (**<$50,000/QALY**) added to maximally tolerated statin
Brand ezetimibe/statin fixed-dose combo	Separate **generic** statin + **generic** ezetimibe (**~$12–$45/mo** combined)	**Variable; usually lower with generics** **Two low-cost generics achieve ≥50% LDL-C reduction**; avoid brand fixed-dose combos when separate generics give the same components
Bempedoic acid (Nexletol) or bempedoic acid/ezetimibe (Nexlizet), no generic (~$400–$500/mo)	**Generic** ezetimibe ± maximally tolerated/alternative statin first (**~$8–$30/mo**)	**~$370–$490/mo** **Reserve for statin intolerance** or residual LDL after statin + ezetimibe; intermediate value (**$50,000–$150,000/QALY**); review gout/tendon risk
PCSK9 mAb — evolocumab (Repatha) or alirocumab (Praluent) (~$500–$600/mo; self-injected)	Maximally tolerated statin + **generic** ezetimibe first (**~$12–$45/mo**)	**Reserve; adds cost** **Highest value in very-high-risk ASCVD/FH** with major residual LDL after statin + ezetimibe; proven MACE benefit but 61% payer rejection/15% abandonment when access not secured
Inclisiran (Leqvio), no generic (~$3,250/dose, twice yearly; clinician-administered)	PCSK9 mAb or statin + ezetimibe per residual risk	**Reserve; adds cost** **Second-line pending CVOTs** (ORION-4/VICTORION-2P); consider for documented poor adherence to PCSK9 mAb; **confirm medical- vs pharmacy-benefit** billing and buy-and-bill site

BRAND OR HIGHER-COST OPTION[37,41,49,50]	GENERIC/ ALTERNATIVE (EST. COST)*[49,51–53]	EST. SAVINGS + COST-SMART TIP*[41,54,55]
Brand icosapent ethyl (Vascepa ~$300–$360/mo)	**Generic** icosapent ethyl (**~$70–$150/mo**); **do NOT substitute OTC fish oil**	**~$180–$290/mo** **Reserve for evidence-based REDUCE-IT population** (statin-treated ASCVD/diabetes, TG 150–499); OTC mixed EPA/DHA supplements are not equivalent
Brand fenofibrate/ fenofibric acid (branded formulations ~$150–$300/mo)	**Generic** fenofibrate 40–200 mg or gemfibrozil 600 mg BID (**~$10–$40/mo**)	**~$120–$280/mo** **For TG ≥500 mg/dL to prevent pancreatitis**; fenofibrate preferred over gemfibrozil with a statin; reduce dose in CKD
Preventable PCSK9/statin nonadherence, unfilled specialty scripts, or cost-related discontinuation	**Out-of-pocket cost review** + mail-order/ 90-day fills + Extra Help/patient assistance; confirm Part D vs cash	**Avoids event-driven spending** **1 in 8 CVD patients report cost-related nonadherence**; review OOP at initiation, use assistance programs; IRA $2,000 (2025)/ $2,100 (2026) cap **lowers specialty burden**

ABBREVIATIONS: OOP = out-of-pocket; QALY = quality-adjusted life-year; LDL-C = low-density lipoprotein cholesterol; PCSK9 = proprotein convertase subtilisin/kexin type 9; mAb = monoclonal antibody; ASCVD = atherosclerotic cardiovascular disease; FH = familial hypercholesterolemia; MACE = major adverse cardiovascular events; CVOT = cardiovascular outcomes trial; OTC = over-the-counter; TG = triglycerides; EPA = eicosapentaenoic acid; DHA = docosahexaenoic acid; BID = twice daily; CKD = chronic kidney disease; CVD = cardiovascular disease; IRA = Inflation Reduction Act

***Consult FDA labels for the most up-to-date dosage and duration information, contraindications, and drug-drug interactions**

NON-PHARMACOLOGICAL AND PATIENT-CENTERED CARE

- **Emphasize**: vegetables, fruits, whole grains, beans, nuts, seeds, unsaturated fats, and lean proteins while **limiting ultraprocessed food**, **trans fat**, and **excess saturated fat**[5,56]
- **Replace saturated fats with unsaturated fats** rather than simply lowering total fat[5,56]
- Use **soluble fiber** and **plant sterol-containing foods** as adjuncts, not replacements for indicated medication[57,58]
- Support physical activity, smoking cessation, healthy sleep, blood-pressure control, diabetes care, and weight management **according to ability and goals**[5,13]
- **Screen for**: food insecurity, swallowing problems, cognitive impairment, depression, medication beliefs, and financial toxicity[56]
- Preserve protein intake, muscle, and function in frail older adults; **avoid restrictive diets that worsen malnutrition**

- Consider a **time-limited CoQ**[10] trial for select patients with **confirmed statin-associated muscle symptoms**, and **vitamin K-2** in those with **vascular calcification concerns**, while counseling that outcomes evidence for both remains limited[33]
- Explain that plaque stabilization may increase calcification density and that **repeat CAC is not a medication-response test**[28,59]
- Ask about **red yeast rice** and other supplements because potency, contamination, hepatotoxicity, myopathy, and interactions **may be clinically important**[60,61]

Patient-Centered Conversation Framework

- **Explain the target**: "The goal is to **lower cholesterol enough to reduce heart attack and stroke risk** and reach your risk-based LDL-C and non-HDL-C goal—**not to chase a single 'normal' number**." Frame the discussion around **estimated ASCVD risk** and **anticipated benefit**[5]
- **Use teach-back**: Ask the patient to restate the drug and dose, timing (including bile acid sequestrant separation and PCSK9 dosing intervals), lab schedule, supplements/OTC products to avoid, warning symptoms, and who to call[5,41]
- **Separate lifestyle foundation from pharmacotherapy**: Explain that diet, weight loss, and activity are **foundational but usually do not replace an indicated statin**, which provides the outcome-proven LDL-C reduction[5,17]
- **Discuss treatment burden**: Compare oral daily agents (statins, ezetimibe, bempedoic acid), self-injected PCSK9 antibodies, twice-yearly inclisiran, and prescription omega-3/fibrates by route, cost, prior authorization, and monitoring—not percentage LDL-C reduction alone[41]
- **Make the intolerance record durable**: Document **confirmed statin-associated muscle symptoms**, hypersensitivity, or true intolerance in the adverse-reaction field and discharge materials; **avoid labeling a nocebo or reversible reaction as permanent**, since most patients tolerate some exposure after rechallenge[5,17]
- **Define emergencies and drug-specific warning signs**: Urgent evaluation for **severe muscle pain/weakness with dark urine** (rhabdomyolysis), **jaundice or RUQ pain** (hepatotoxicity), **angioedema** with injectables, **acute tendon pain** (bempedoic acid), new palpitations or bleeding (icosapent ethyl), and **severe abdominal pain with vomiting** (pancreatitis)[5,17]

QUALITY ALIGNMENT

Key HEDIS/MIPs Measures

Several lipid medication and cardiovascular disease–specific MIPS and HEDIS measures are active in MY2026:

- **MIPS #441**: Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control)
- **MIPS #438**: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
- **HEDIS SPC-E**: Statin Therapy For Patients With Cardiovascular Disease
- **HEDIS SMC**: Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia
- **HEDIS MAC**: Medication Adherence For Cholesterol (Statins)
- **HEDIS SPD-E**: Statin Therapy For Patients With Diabetes
- **HEDIS SUPD**: Statin Use in Persons With Diabetes

2026 MEASURE	STANDARD	LIPID MEDICATION APPLICABILITY*[1,7,57–59]
MIPS #441: Ischemic Vascular Disease (IVD) All-or-None Outcome Measure (Optimal Control)	**Denominator**: patients ≥18 with IVD (prior ASCVD event or procedure, or active CAD/ischemic diagnoses); **Numerator**: patients meeting ALL control targets—most recent BP <140/90 mmHg **AND** on a statin (or documented statin use) **AND** on daily aspirin/antiplatelet unless contraindicated (higher rate is better); **Exclusions**: documented contraindications/intolerance, patient factors	This is a secondary-prevention population where **statin benefit is robust regardless of age**; in older adults, avoid failing the statin/antiplatelet component reflexively → document true intolerance or bleeding contraindication **rather than omitting therapy**, and individualize the BP component to avoid orthostasis and falls

2026 MEASURE	STANDARD	LIPID MEDICATION APPLICABILITY*[1,7,57–59]
MIPS #438: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	**Denominator**: three groups (**1**) ≥21 with clinical ASCVD; (**2**) ≥21 with LDL-C ≥190 mg/dL; (**3**) 40–75 with diabetes; **Numerator**: prescribed/on a statin of appropriate intensity during the year (higher rate is better); **Exclusions**: pregnancy/lactation, ESRD, cirrhosis, rhabdomyolysis/ myopathy, hospice, active-liver-disease/statin-intolerance documentation	**Most older adults with**: ASCVD, severe hypercholesterolemia, or diabetes **fall in the denominator**; age alone is not a reason to withhold; in secondary prevention continue maximally tolerated statin, and **clearly record intolerance or a valid exclusion** rather than leaving a numerator gap
HEDIS SPC-E: Statin Therapy for Patients With Cardiovascular Disease	**Denominator**: males 21–75 and females 40–75 with clinical ASCVD (event or diagnosis); **Numerator**: **two rates** (**1**) dispensed a moderate/high-intensity statin during the year; (**2**) statin adherence with PDC ≥80% (higher rate is better); **Exclusions**: pregnancy/lactation, IVF, ESRD, cirrhosis, myopathy/ rhabdomyolysis, hospice/palliative, frailty+advanced illness (age criteria)	Secondary-prevention statin benefit persists in older adults, so **treat and support adherence**; the "-E" version allows exclusion for members ≥66 with frailty plus advanced illness or long-term institutional residence → use it when time-to-benefit is exceeded **rather than deprescribing without documentation**
HEDIS SMC: Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	**Denominator**: patients 18–64 with schizophrenia/schizoaffective disorder AND cardiovascular disease; **Numerator**: an LDL-C test during the measurement year (higher rate is better); **Exclusions**: hospice, palliative care	Although the base denominator caps at 64, the **principle extends to older adults** with serious mental illness who often have monitoring gaps; pair routine lipid testing with **caregiver-supported adherence review**, as cognitive/psychiatric barriers raise nonadherence and dosing-error risk
HEDIS MAC: Medication Adherence for Cholesterol (Statins)	**Denominator**: patients ≥18 with ≥2 fills of a statin on different dates; **Numerator**: proportion of days covered (PDC) ≥80% during the measurement period (higher rate is better); **Exclusions**: ESRD, hospice, and (per Part D/Star specifications) certain end-of-life and institutional statuses	**Adherence**, not just prescribing, drives **event prevention**; in older adults, use 90-day fills, refill synchronization, and cost/OOP review; simplify polypharmacy and manage (rather than reflexively stop) muscle symptoms to **protect the PDC and prevent silent discontinuation**

2026 MEASURE	STANDARD	LIPID MEDICATION APPLICABILITY*[1,7,57–59]
HEDIS SPD-E: Statin Therapy for Patients With Diabetes	**Denominator**: patients 40–75 with diabetes and **NO** clinical ASCVD; **Numerator**: two rates (**1**) dispensed a moderate/high-intensity statin; (**2**) statin adherence PDC ≥80% (higher rate is better); **Exclusions**: pregnancy/lactation, ESRD, cirrhosis, myopathy/rhabdomyolysis, hospice/palliative, and frailty+advanced illness for the "-E" set	**Nearly all diabetic patients 40–75 qualify**; those >75 with diabetes remain high-risk and typically benefit from moderate-intensity therapy weighed against life expectancy; **document statin prescription and adherence** while accounting for polypharmacy and drug-interaction burden common in this group
HEDIS SUPD: Statin Use in Persons With Diabetes	**Denominator**: patients 40–75 with diabetes dispensed a diabetes medication (including insulin); **Numerator**: dispensed at least one statin of ANY intensity during the year (higher rate is better); **Exclusions**: pregnancy/lactation, ESRD, cirrhosis, myalgia/myopathy/rhabdomyolysis, hospice/palliative care	**Any diabetes-medication dispensing places older adults in this denominator**; ensure a statin is prescribed unless a documented exclusion exists; the small statin-associated diabetes risk is **outweighed by ASCVD benefit** and is not a reason to withhold or stop therapy

ABBREVIATIONS: MIPS = Merit-based Incentive Payment System; IVD = ischemic vascular disease; ASCVD = atherosclerotic cardiovascular disease; CAD = coronary artery disease; BP = blood pressure; LDL-C = low-density lipoprotein cholesterol; ESRD = end-stage renal disease; HEDIS = Healthcare Effectiveness Data and Information Set; SPC-E = Statin Therapy for Patients With Cardiovascular Disease (Electronic); PDC = proportion of days covered; IVF = in vitro fertilization; SMC = Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia; MAC = Medication Adherence for Cholesterol; OOP = out-of-pocket; SPD-E = Statin Therapy for Patients With Diabetes (Electronic); SUPD = Statin Use in Persons With Diabetes
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

TEN KEY TAKEAWAYS FOR LIPID MEDICATION

1 The 2026 guideline reshapes primary prevention eligibility

The central change is a broader, earlier, and more granular risk framework: primary-prevention assessment now spans ages 30–79 (previously 40–75), PREVENT-ASCVD replaces the Pooled Cohort Equations, and stage ≥3 CKD and HIV join diabetes, LDL-C ≥190 mg/dL, and established ASCVD as conditions warranting statins independent of calculated risk.

2 Use PREVENT-ASCVD, not the retired Pooled Cohort Equations

Apply PREVENT for eligible primary-prevention adults aged 30 to 79 years, recognizing it generally yields lower estimated risk than the prior equations.

3 Treat statin-indicated conditions without waiting for a calculator

Established ASCVD, LDL-C at least 190 mg/dL, diabetes (ages 40–75), and now stage ≥3 CKD and HIV justify statins independent of a computed score.

4 Set both a percentage-reduction expectation and a risk-based goal

Document an anticipated LDL-C lowering and a risk-stratified LDL-C and non-HDL-C target at initiation.

5 Generic high-intensity statins plus generic ezetimibe are the core cost-smart sequence

Escalate along this backbone before advancing to higher-cost agents.

6 Measure Lp(a) at least once and use ApoB selectively

Apply ApoB when standard lipids may underestimate residual risk, particularly in hypertriglyceridemia or metabolic syndrome

7 Use CAC only to resolve genuinely uncertain decisions

CAC can refine borderline/intermediate risk, but CAC 0 does not override major high-risk conditions such as diabetes, LDL-C ≥190 mg/dL, or established ASCVD.

8 Evaluate and rechallenge statin-associated symptoms before labeling intolerance

Assess timing, secondary causes, and interactions, and attempt rechallenge or an alternative statin before declaring complete intolerance.

9 Treat severe hypertriglyceridemia and pancreatitis risk urgently

Address secondary causes and initiate triglyceride-lowering therapy promptly, especially at triglycerides at least 1000 mg/dL.

10 **Individualize therapy in adults older than 75 and close the loop after transitions**

Weigh life expectancy, frailty, function, polypharmacy, and goals rather than chronological age, and reassess after every initiation, cardiovascular hospitalization, prior authorization, and formulary change.

AAVBC SUMMARY AND CONCLUSION

High-value lipid treatment pairs accurate risk assessment with reliable long-term implementation.[5] **PCPs should calculate PREVENT-ASCVD risk when appropriate**, personalize the result with clinical and biomarker risk enhancers, use CAC selectively, and establish explicit LDL-C and non-HDL-C goals.[5,8] **Generic statins remain the first-line clinical and financial anchor**, with generic ezetimibe as the usual first add-on.[5,13] Advanced therapy is appropriate when residual risk and required LDL lowering justify its cost and burden.[5,41] **In older adults**, treatment should be continued, intensified, simplified, or deprescribed **according to expected benefit**, **frailty**, **function**, **life expectancy**, and **patient priorities**.[5] The value endpoint is fewer cardiovascular and pancreatitis events **with sustainable treatment**, not prescription volume or an isolated lipid result.[5]

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