Medi-Cal Rx

Updated Guidance for the Treatment of Dyslipidemia

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Learning Objectives

- Review the 2026 ACC/AHA/AACVPR/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Dyslipidemia (American College of Cardiology/American Heart Association [ACC/AHA]/Multisociety Dyslipidemia Guideline).
- Describe the role of the Predicting Risk of Cardiovascular Disease Events (PREVENT) equations in the evaluation and management of dyslipidemia and atherosclerotic cardiovascular disease (ASCVD).
- Discuss strategies to improve lipid management through evidence-based statin and nonstatin use, optimization of therapy intensity, and medication adherence.

Key Points

- Lifestyle modifications are an essential component of lipid management.
- The PREVENT-ASCVD equation should be used instead of the Pooled Cohort Equations (PCE) to estimate 10- and 30-year ASCVD risk for primary prevention.
- For primary prevention, the low-density lipoprotein-cholesterol (LDL-C) goal should be <100 mg/dL for those at borderline or intermediate risk and <70 mg/dL for those at high risk. LDL-C levels should be reduced by ≥30%, optimally by ≥50%, in individuals at higher risk.
- LDL-lowering therapy is recommended for primary prevention in certain patient populations regardless of LDL-C level, including adults aged 40 to 75 years with diabetes, chronic kidney disease (CKD) stage 3 or 4, or HIV.
- For secondary prevention in those at very high risk of ASCVD events, LDL-C should be reduced by ≥50% with a goal of LDL-C <55 mg/dL. For those at lower risk, the LDL-C goal is <70 mg/dL.
- Statins remain the cornerstone of primary and secondary prevention of ASCVD and are considered first-line pharmacotherapy for reducing LDL-C.
- If LDL-C levels are not adequately lowered by healthy lifestyle habits and statin therapy, adding a nonstatin therapy is recommended. Evidence-based options include ezetimibe, bempedoic acid, and PCSK9 inhibitors.
- Several first-line therapies for dyslipidemia are on the *Medi-Cal Rx Contract Drugs List* (CDL) and are available to Medi-Cal members with a prescription.

Background

ASCVD, including myocardial infarction and stroke, is the leading cause of death in the U.S.[1] Elevated LDL-C is a strong predictor of future ASCVD events but can be effectively treated with appropriate pharmacotherapy and lifestyle interventions.[1] Despite the availability of highly effective agents to reduce LDL-C, the majority of individuals who are indicated for pharmacotherapy remain un- or undertreated.[1,2] In the U.S., it is estimated that 25% of adults have an elevated LDL-C, and among those, only 25% to 50% receive guideline-recommended lipid-lowering therapy.[2] Even among those who are prescribed an HMG-CoA reductase inhibitor (statin), many are not on the appropriate statin intensity.[2,3] A recent national simulation study estimates that 39,196 fewer coronary deaths, 96,330 fewer non-fatal myocardial infarctions, 87,559 fewer coronary revascularizations, and 65,063 fewer strokes would occur annually if eligible individuals were treated according to the ACC/AHA lipid treatment guidelines.[4] Improving adherence to guideline-directed treatment recommendations represents a key opportunity to reduce cardiovascular risk at the population level.

The ACC/AHA publishes guidance on the management of elevated blood cholesterol. Most recently, the ACC/AHA published the 2026 ACC/AHA/Multisociety Dyslipidemia Guideline, which provides recommendations on the evaluation and management of patients with high blood cholesterol, hypertriglyceridemia, and elevated lipoprotein (a) [Lp(a)].[5] Although the 2026 ACC/AHA/Multisociety Dyslipidemia Guideline reviews recommendations for several major patient management groups, this article will focus on significant updates to screening and management of LDL-C in adults, including guidance for estimating ASCVD risk, first-line pharmacotherapy to lower LDL-C, treatment goals, and side effect monitoring. Clinicians are encouraged to review the complete guideline for comprehensive recommendations on the management of dyslipidemias, including guidance on lipid-lowering therapy for patients with severe hypercholesterolemia, hypertriglyceridemia, diabetes, and subclinical atherosclerosis. Special considerations are also reviewed for pediatric patients, pregnant individuals, and those with certain conditions such as heart failure, chronic inflammatory diseases, CKD, and HIV.[5]

Screening for Dyslipidemias

Abnormal lipid levels can occur before adulthood, with approximately 20% to 25% of children and adolescents in the U.S. reported to have an elevated LDL-C.[6] As the impact of LDL-C on ASCVD risk is further magnified by cumulative exposure across the lifespan, the ACC/AHA recommends lipid screening at least once in adolescents aged 9 to 11 years to identify individuals with inherited lipid disorders who would benefit from earlier intervention. Among adults, ACC/AHA recommends routine lipid screening starting at age 19, with repeat testing every 5 years or sooner if additional ASCVD risk factors are present.[5]

Use of Cardiovascular Risk to Guide Treatment Decisions

When evaluating if an individual is indicated for lipid-lowering therapy, the first step is to determine whether the patient is considered primary or secondary prevention. Primary prevention refers to individuals without a history of ASCVD. Secondary prevention includes strategies to reduce the risk of a second ASCVD event in individuals with existing ASCVD.

The ACC/AHA recommends clinicians use the CPR Model when making treatment decisions for lipid management in primary prevention. The CPR Model includes the following:

1. **C**alculate 10-year ASCVD risk.
2. **P**ersonalize the estimated risk to the specific patient by considering factors not included in the PREVENT equations.
3. **R**eclassify through the selective use of coronary artery calcium (CAC) scans, and reassess treatment recommendations.

Recent evidence suggests that newer cardiovascular risk prediction models, including the PREVENT-ASCVD equation, can more precisely estimate cardiovascular risk and improve decision-making for lipid-lowering therapy compared with prior risk tools, such as the PCE. Instead of the previously recommended PCE, the 2026 ACC/AHA/Multisociety Dyslipidemia Guideline recommends using the PREVENT-ASCVD equation to estimate 10-year (and 30-year) ASCVD risk for adults aged 30 to 79 years with LDL-C 70-189 md/dL who do not have known cardiovascular disease (CVD). The PREVENT-ASCVD equation incorporates cardiovascular, kidney, and metabolic health measures to guide primary prevention treatment decisions, including factors such as blood pressure and glucose control, total cholesterol and high-density lipoprotein (HDL), renal function, body mass index (BMI), current statin and antihypertensive therapies, cigarette use in the prior 30 days, and social deprivation index.

For primary prevention in adults aged 30 to 79 years with LDL-C levels 70 to 189 mg/dL, clinicians should calculate the 10-year ASCVD risk with the PREVENT-ASCVD equation. An individual's risk can then be categorized as low (<3%), borderline (3% to <5%), intermediate (5% to <10%), or high (≥10%).

In addition to 10-year ASCVD risk estimation, other risk-enhancing factors should be considered when evaluating an individual's overall ASCVD risk, such as family history of premature ASCVD, chronic inflammatory conditions, metabolic disorders, Lp(a), apolipoprotein B, and high-risk ancestry.

LDL-C remains the primary target for ASCVD risk assessment and treatment. Still, additional lipid biomarkers, such as Lp(a) and apolipoprotein B (apoB), are now recommended to enhance ASCVD risk assessment. Atherogenic lipoproteins, such as LDL, very-low-density lipoprotein (VLDL), and Lp(a), are the primary drivers of plaque formation and atherosclerosis, ultimately leading to ASCVD.[5]

Unlike LDL-C, which reflects the cholesterol mass within LDL particles, apoB quantifies the total number of atherogenic lipoproteins. In those with certain medical conditions, such as elevated triglycerides, diabetes, ASCVD, and cardiovascular-kidney-metabolic (CKM) syndrome, an

individual's LDL-C can appear to be at the goal level. At the same time, the total number of atherogenic lipoproteins remains high. Testing apoB in these populations can identify those with residual risk despite achieving the LDL-C target and better inform decisions on treatment intensity.[5]

Up to 20% of the United States population has elevated Lp(a), defined as ≥125 nmol/L or ≥50 mg/dL.[2] Elevated Lp(a) is associated with an approximate 40% increase in relative risk of ASCVD and is considered to be a risk-enhancing factor.[5] The ACC/AHA recommends that all individuals are screened at least once for Lp(a). If Lp(a) is elevated, more intensive management of risk factors, including further LDL-lowering with nonstatin agents, should be considered.[5]

For individuals without known ASCVD, assessment of subclinical coronary atherosclerosis with a special CT-scan generating a CAC score further improves risk assessment by quantifying the overall amount of calcified coronary plaque. The CAC score can reclassify a large proportion of statin-eligible adults, particularly those at intermediate risk, into higher- or lower-risk categories. The ACC/AHA recommends CAC scoring in men aged 40 or older and women aged 45 or older to improve risk assessment and guide LDL-C and non–HDL-C goals.[5]

Lifestyle Modifications

The 2026 ACC/AHA/Multisociety Dyslipidemia Guideline emphasizes the importance of lifestyle modification approaches for lipid management and ASCVD prevention. Healthy behaviors, such as those described in the AHA's Life's Essential 8, remain the first line of care for all adults to improve cardiovascular health. Recommended strategies include following a heart-healthy diet, reducing intake of saturated and trans fats, increasing physical activity, managing weight, and avoiding tobacco products. Lifestyle changes can reduce LDL-C and enhance the effectiveness of pharmacotherapy.[5,7]

Pharmacotherapy Options for Lowering LDL-C

Statins are the cornerstone of pharmacotherapy for lowering both LDL-C and the risk of ASCVD events, with numerous clinical trials supporting their safety, tolerability, and efficacy. Nonstatin medications may be needed in addition to statin therapy to lower LDL-C further or as an alternative treatment for patients with statin intolerance. Nonstatins remain underutilized due to clinical inertia, misconceptions that only statin therapy reduces ASCVD risk, medication access barriers, concerns about potential side effects, and perceived lack of need by clinicians and patients. Several oral and subcutaneous nonstatin medications are available, including ezetimibe, proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitors, bempedoic acid, and bile acid sequestrants.[5]

For most patients who require a nonstatin, prescribing ezetimibe, bempedoic acid, or a PCSK9 inhibitor is preferred due to their favorable tolerability profile and ASCVD risk reduction compared to bile acid sequestrants. Ezetimibe lowers LDL-C levels by a mean of 18%, with an additional 25% reduction when used with statin therapy. PCSK9 inhibitors can lower LDL-C by 45% to 64% and reduce ASCVD events in patients at very high risk when added to statin therapy.[5]

Several LDL-C-lowering therapies are available on the CDL. Selected products are listed in **Table 1**.

Table 1. Selected LDL-C Lowering Agents on the CDL*

Drug Class	Drug Names
HMG-CoA reductase inhibitors (statins)	• atorvastatin • lovastatin • pravastatin • rosuvastatin • simvastatin
PCSK9 inhibitors	• evolocumab
Cholesterol absorption inhibitors	• ezetimibe • ezetimibe/simvastatin
Bile acid sequestrants	• cholestyramine/aspartame (light) • cholestyramine with sugar (regular) • colesevelam • colestipol

* For current information on covered products, refer to the Contract Drugs & Covered Products Lists page on the Medi-Cal Rx Web Portal.

Statin therapy intensity is categorized by the expected percent reduction in LDL-C, as observed in clinical trials. High-intensity statin therapy is expected to lower LDL-C levels by ≥50%, moderate-intensity statin therapy by ≥30% to 49%, and low-intensity statin therapy by <30%. Intensity categories for statins available on the CDL are listed in **Table 2**.

Table 2. Statins on the CDL Categorized by Intensity

	High Intensity	Moderate Intensity	Low Intensity
Expected % LDL-C Reduction	≥50%	30%–49%	<30%
Preferred Statins	• atorvastatin 40 mg • atorvastatin 80 mg • rosuvastatin 20 mg • rosuvastatin 40 mg	• atorvastatin 10 mg • atorvastatin 20 mg • rosuvastatin 5 mg • rosuvastatin 10 mg	----
Other Statins	----	• lovastatin 40 mg • pravastatin 40 mg • pravastatin 80 mg • simvastatin 20 mg • simvastatin 40 mg	• lovastatin 10 mg • lovastatin 20 mg • pravastatin 10 mg • pravastatin 20 mg • simvastatin 5 mg • simvastatin 10 mg

* For current information on covered products, refer to the Contract Drugs & Covered Products Lists page on the Medi-Cal Rx Web Portal.

General Approach for Treatment Initiation and Selection

In addition to lifestyle management, initiation of lipid-lowering medication is an important step in reducing ASCVD risk. The decision to initiate LDL-C-lowering therapy and the need for treatment intensification depend on whether the patient is considered primary or secondary prevention, comorbidities, LDL-C goals, tolerability, and patient preferences.[5]

For primary prevention, decisions to start pharmacotherapy additionally depend on risk category and baseline LDL-C. When the decision to initiate lipid-lowering pharmacotherapy for the primary prevention of ASCVD has been made, the first-line therapy for primary prevention of ASCVD is statin therapy. If a decision is made to initiate statin therapy, LDL-C levels should be reduced by ≥30% in most patients and optimally by ≥50% in individuals at higher risk. If LDL-C reduction is inadequate, patient adherence should be assessed, and treatment intensification should be considered. In many cases, the first nonstatin treatment should be ezetimibe, based on data showing additional benefit in certain primary prevention populations, as well as safety and tolerability.[5] **Table 3** summarizes the 2026 ACC/AHA/Multisociety Dyslipidemia Guideline recommendations for initiating pharmacotherapy in primary prevention patients by risk category.

Table 3. Selected Recommendations for Treatment Initiation in Primary Prevention

Population	Risk Category	Recommendations
Adults aged 30-59 with 10-year ASCVD risk <3% who also have: • LDL-C <160 mg/dL and • 30-year ASCVD risk <10%	Low Risk	• Counseling on health behaviors, including dietary patterns and physical activity • Maintenance of a healthy weight, obtaining adequate amounts of sleep, management of stress, and avoidance of tobacco products
Adults aged 30-59 with 10-year ASCVD risk <3% who have either: • LDL-C 160-189 mg/dL or • 30-year ASCVD risk ≥10%	Low Risk	• Moderate-intensity statin can be considered to reduce cumulative exposure to atherogenic lipoproteins
Adults with 10-year ASCVD risk 3% to <5%	Borderline Risk	• Moderate-intensity statin can be considered to achieve ≥30% to 49% LDL-C reduction • If there is clinical uncertainty or patient indecision after risk assessment, CAC measurement can be useful for refining predicted risk

Population	Risk Category	Recommendations
Adults with 10-year ASCVD risk 5% to <10%	Intermediate Risk	• At least a moderate-intensity statin is recommended to achieve ≥30% to 49% LDL-C reduction • For those in the higher end of this risk range, a high-intensity statin is recommended to further reduce LDL-C by ≥50% • If there is clinical uncertainty or patient indecision after risk assessment, CAC measurement can be useful for refining predicted risk
Adults with 10-year ASCVD risk >10%	High Risk	• Start a high intensity statin to achieve >50% LDL-C reduction

*10-year and 30-year ASCVD risk estimates calculated by the PREVENT-ASCVD equation.

Clinicians should note that therapy to lower LDL-C is recommended for primary prevention in certain patient populations regardless of LDL-C level, including adults aged 40 to 75 years with diabetes, CKD stage 3 or 4, or HIV. Individuals with severe hypercholesterolemia (LDL ≥ 190) are typically indicated for a high-intensity statin and have additional considerations discussed in the guideline.[5] For more information about the management of LDL-C in these populations, clinicians can refer to the full 2026 ACC/AHA/Multisociety Dyslipidemia Guideline. Of note, the American Diabetes Association (ADA) "Standards of Care in Diabetes – 2026" (Standards of Care) concurs with the recommendation of a statin for the primary prevention of ASCVD in adults aged 40 to 75 years with diabetes.[8] The 2026 ACC/AHA/Multisociety Dyslipidemia Guideline provides a helpful algorithm for recommended pharmacological therapy for primary prevention in adults aged 30 – 79 years without ASCVD in Figure 6.

For secondary prevention, a high-intensity statin should be initiated in all patients. If high-intensity statin therapy is not tolerated or insufficient to achieve LDL goals, ezetimibe and/or a PCSK9 inhibitor should be added based on the degree of LDL lowering required and patient preferences. The 2026 ACC/AHA/Multisociety Dyslipidemia Guideline provides algorithms for secondary ASCVD prevention in adults at very high risk (Figure 11) and in those not at very high risk (Figure 12).

Safety Considerations for LDL-C Lowering Agents

Statin safety has been extensively evaluated. In individuals for whom statin treatment is recommended, the benefits of reducing ASCVD events greatly outweigh the risks. Although statins are generally well tolerated, approximately 10% of patients do not tolerate maximum statin doses, most often due to complaints of muscle-related symptoms such as myalgia or muscle weakness. These symptoms may be due to the prescribed statin alone, altered statin

metabolism due to a drug-drug interaction (DDI), excessive muscular activity, primary muscle or metabolic disorders, or patient expectations that statin therapy causes muscle side effects.[5]

Factors that support a statin etiology for muscle symptoms include new-onset bilateral, symmetrical, proximal muscle pain or weakness that occurs within weeks after statin initiation or a dose increase. Symptoms caused by a statin typically resolve within a similar period after statin discontinuation and may recur upon reinitiation of statin therapy. Before concluding that such symptoms are due to statin therapy, the clinician should exclude excessive muscular activity, consider disease states associated with muscle pain or weakness, and DDIs that raise statin blood levels. For those with muscle weakness, a physical examination should be performed, and when muscle symptoms are severe, a creatine kinase (CK) level should be measured. Adults with severe myalgia or muscle weakness and CK levels ≥10 times the upper limit of normal should withhold statin therapy.[5]

Before initiating statin therapy, clinicians should assess for DDIs to minimize the risk of statin-associated adverse events. Common medications that have DDIs with statins are listed in Table 8 of the 2026 ACC/AHA/Multisociety Dyslipidemia Guideline. When a DDI exists, risk mitigation strategies include avoiding use of the co-administered interacting medication, using an alternative statin that does not have the drug interaction, and limiting the statin dose when appropriate. Clinicians can refer to the 2016 AHA Scientific Statement for recommendations on managing clinically significant DDIs with statins.[9] In addition, a clinician tool was created to assist with managing statin DDIs and is available in the ACC Statin Intolerance Tool (Lipid Manager App).

In the case of statin-attributed muscle symptoms (SAMS), a systematic approach to LDL-C lowering therapy should be used. The 2026 ACC/AHA/Multisociety Dyslipidemia Guideline provides an algorithm for clinical management of patients with SAMS, stratified by cardiovascular risk level for patients with and without established CVD (Figure 18). The general recommendations for the management of patients with SAMS include lifestyle modifications to lower LDL-C, prescribing the maximally tolerated statin dose, considering less-than-daily statin frequency when needed, and adding evidence-based nonstatins.[5]

Non-statin LDL-C–lowering therapies are generally well tolerated but also require safety monitoring. Ezetimibe is not recommended for patients with moderate or severe hepatic impairment. When added to a statin, hepatic transaminase levels should be monitored due to an increased risk of elevation during combination therapy. PCSK9 inhibitors can cause injection site reactions and rarely hypersensitivity reactions, including angioedema. Bile acid sequestrants are less often used due to poor tolerability with common side effects including abdominal pain, bloating, dyspepsia, nausea, and constipation.[5] However, these medications are often used in pregnancy.

Dyslipidemia Treatment Goals & Monitoring Efficacy

Assessment of treatment response and adherence to therapy should be performed routinely to guide clinical decisions regarding lipid-lowering medications. In individuals on lipid-lowering medications, clinicians should obtain a lipid profile 4 to 12 weeks after initiation of therapy or a dose adjustment, and again 6 to 12 months thereafter to reassess treatment efficacy.[5]

Treatment intensification should be based on LDL-C goals discussed in the 2026 ACC/AHA/Multisociety Dyslipidemia Guideline. For primary prevention, most patients at borderline or intermediate 10-year ASCVD risk who are started on LDL-C-lowering therapy will have an LDL-C target of <100 mg/dL and a non-HDL-C target of <130 mg/dL. For those at high 10-year ASCVD risk, an LDL-C goal of <70 mg/dL and a non-HDL-C goal of <100 mg/dL is recommended.[5] Additional considerations for treatment goals in patients with diabetes, severe hypercholesterolemia (LDL ≥190), and familial hypercholesterolemia are reviewed in the 2026 ACC/AHA/Multisociety Dyslipidemia Guideline.

For secondary prevention, most individuals will have a recommended LDL-C goal of <55 mg/dL, including those considered at very high risk. Individuals at very high risk include those with a history of multiple major ASCVD events or one major ASCVD event and multiple high-risk conditions. The detailed criteria for determining whether an individual is at very high risk for ASCVD, including definitions of ASCVD events and other high-risk conditions, are provided in the 2026 ACC/AHA/Multisociety Dyslipidemia Guideline (Figure 10). In adults with clinical ASCVD who are not at very high risk, high-intensity statin therapy should be initiated to achieve a ≥50% reduction in LDL-C, LDL-C <70 mg/dL, and non–HDL-C <100 mg/dL to reduce the risk of recurrent ASCVD events.[5]

Dyslipidemia in the Medi-Cal Population

A retrospective administrative claims analysis was conducted to evaluate the recent use of recommended first-line dyslipidemia therapies among Medi-Cal members, including statins, ezetimibe, PCSK9 inhibitors, bempedoic acid, and bile acid sequestrants. All paid medical and pharmacy claims were reviewed for eligible Medi-Cal members with a date of service (DOS) between June 1, 2025, and May 31, 2026. A 90-day lookback period was included to account for any days' supply that overlapped with the measurement year, covering pharmacy claims paid before June 1, 2025. Eligible members included both Medi-Cal fee-for-service (FFS) and managed care plan (MCP) members, who were also not dually eligible for Medicare.

The monthly rate of statin adherence over time was also calculated for eligible Medi-Cal members during the measurement year. Non-adherence was defined as a gap of 10 or more days during the previous 90 days.

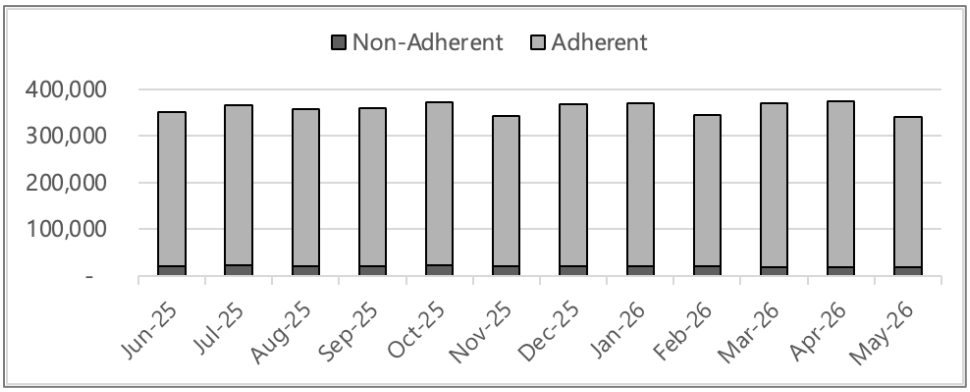
Finally, as LDL-lowering therapy is recommended for primary prevention in adults aged 40 to 75 years with diabetes, regardless of LDL-C level, medical and pharmacy claims data were reviewed to determine how many Medi-Cal members in this population could benefit from initiating statin therapy.

Results

During the measurement year, a total of 1,245,163 Medi-Cal members had at least one paid claim for a first-line dyslipidemia medication, with the majority (93.4%; n = 1,162,365) of members having at least one paid claim for a statin, and (4.6%; n = 56,900) having at least one paid claim for both a statin and a recommended nonstatin therapy.

As shown in **Figure 1**, the use of recommended first-line medications for treating dyslipidemia was consistent throughout the measurement year, with adherence during the previous 90 days fluctuating between 93.8% and 94.8%. Adherence to statins during this same period ranged from 94.3% to 95.1%.

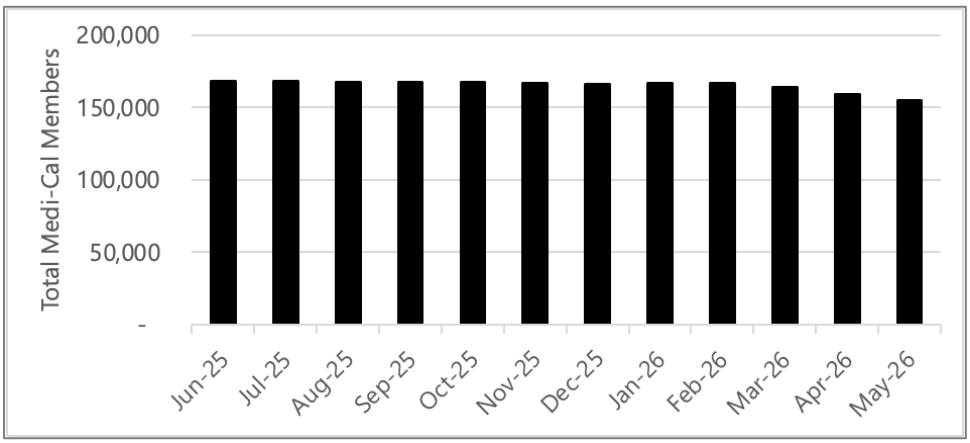
Figure 1. Total Medi-Cal Members with ≥ 1 Paid Claim for First-Line Dyslipidemia Medications, Stratified by Adherent or Non-Adherent



Among members on statin therapy during the measurement year, 40.8% (n = 474,522) had a paid claim for a high-intensity statin, 55.5% (n = 645,116) had a paid claim for a moderate-intensity statin, and 3.7% (n = 42,727) had a paid claim for a low-intensity statin.

A review of adult Medi-Cal members aged 40 to 75 years with diabetes found that each month during the measurement year, over 150,000 Medi-Cal members had no paid claims for any statin medication in the prior 90 days (**Figure 2**), despite recommendations for statin therapy from both the 2026 AHA/ACC guideline and the ADA's Standards of Care.

Figure 2. Total Medi-Cal Members Aged 40 to 75 Years with Diabetes and No Paid Claims for any Statin Therapy in the Prior 90 Days



Conclusion/Discussion

The 2026 ACC/AHA guideline emphasizes earlier and more precise intervention to reduce cumulative exposure to atherogenic lipoproteins and prevent ASCVD. The incorporation of updated risk prediction tools, LDL-C treatment goals, and expanded use of biomarkers enables more individualized care.[5] However, real-world evidence continues to demonstrate gaps in treatment initiation, intensity, and adherence. Drug utilization review programs are uniquely positioned to identify these gaps and implement targeted interventions to improve lipid management and reduce cardiovascular risk at the population level.

Clinical Recommendations

Prevention, Screening, and Risk Assessment for Dyslipidemia

- Lifestyle modifications are recommended for all adults as an important component of dyslipidemia prevention and treatment, including but not limited to following a heart-healthy eating pattern (such as the Dietary Approaches to Stop Hypertension [DASH] diet), reducing intake of saturated and trans fats, adopting a moderate physical activity program, maintaining or achieving a healthy weight, smoking cessation, and reducing or eliminating alcohol intake.
- The PREVENT-ASCVD equation should be used to estimate 10- and 30-year cardiovascular risk and guide lipid-lowering therapy decisions. Risk categories include low (<3%), borderline (3% to <5%), intermediate (5% to <10%), and high (≥10%).
- In all adults, Lp(a) should be measured at least once for ASCVD risk assessment.
- In adults on lipid-lowering therapy who have achieved the LDL-C goal, particularly those with ASCVD, CKM syndrome, type 2 diabetes, or elevated triglycerides, measurement of apoB should be considered to guide therapeutic intensification.
- In individuals without known ASCVD, CAC scoring is recommended in men at least 40 years of age and women at least 45 years of age to improve risk assessment and guide LDL-C and non–HDL-C goals.

Initiation of Dyslipidemia Treatment

- Risk-enhancing factors should be considered when determining treatment intensity, including family history of premature ASCVD, chronic inflammatory conditions, metabolic disorders, and high-risk ancestry.
- In adults aged 30 to 59 years with a low (<3%) 10-year estimated risk for ASCVD who have an LDL-C <160 mg/dL and a 30-year risk estimate of <10%, counseling on health behaviors is recommended to reduce LDL-C and ASCVD risk.
- LDL-lowering therapy can be considered for individuals aged 30-59 years with low (<3%) 10-year ASCVD risk who have an LDL-C 160 to 189 mg/dL or a 30-year ASCVD risk ≥10%.
- LDL-lowering therapy with a moderate-intensity statin can be considered in adults for primary prevention of ASCVD with a 10-year ASCVD risk of 3% to < 5% (borderline risk) and should be considered for those at 5% to <10% risk (intermediate risk).

- LDL-lowering therapy with a high-intensity statin should be initiated for primary prevention in individuals with a high (>10%) 10-year ASCVD risk.
- LDL-lowering therapy is recommended for primary prevention in certain patient populations regardless of LDL-C level, including adults aged 40 to 75 years with diabetes, CKD stage 3 or 4, or HIV.
- If statin therapy is not tolerated or is insufficient to reach LDL goals, ezetimibe and/or a PCSK9 inhibitor should be added based on the degree of LDL lowering needed, tolerability, and patient preferences.
- For secondary prevention, a high-intensity statin should be initiated in all patients. If high-intensity statin therapy is not tolerated or insufficient to achieve LDL goals, ezetimibe and/or a PCSK9 inhibitor should be added based on the degree of LDL lowering required.
- In adults with dyslipidemia, an individualized clinician-patient discussion before initiating lipid-lowering medication is recommended to review the benefits and risks of pharmacotherapy, thereby promoting patient engagement and medication adherence.

Treatment Goals

- For many primary prevention patients, LDL-C should be reduced by ≥30%, with LDL-C <100 mg/dL and non-HDL-C <130 mg/dL. For patients at higher risk, LDL-C should be reduced by ≥50% with an LDL-C goal <70 mg/dL and a non-HDL-C goal <100 mg/dL.
- If a decision is made to initiate lipid-lowering therapy in primary prevention patients, LDL-C levels should be reduced by ≥30% and optimally by ≥50% in individuals at higher risk.
- For secondary prevention in patients at very high risk for ASCVD events, it is recommended to achieve ≥50% reduction in LDL-C and to reduce LDL-C to <55 mg/dL and non-HDL-C to <85 mg/dL.
- For secondary prevention in patients who are not at very high risk, it is recommended to achieve ≥50% reduction in LDL-C and a goal of LDL-C <70 mg/dL and non–HDL-C <100 mg/dL.

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