Treat patients with a statin if one or more of the following is present:

- History of clinical atherosclerotic cardiovascular disease (ASCVD)
- LDL 190 mg/dL or ↑
- Aged 40-75 yrs of age with diabetes (but w/o clinical ASCVD) and LDL 70-189 mg/dL
- No ASCVD or diabetes, with LDL 70-189 mg/dL and 10-year risk score* of 7.5% or ↑

Additional considerations for Statin Treatment

If patient does not fit into one of the previously identified 4 groups, but there is clinical suspicion statin therapy would be beneficial, consider treatment if:

- LDL 160 mg/dL or ↑ or hx of genetic hyperlipidemia
- CVD onset in 1° male relative before age 55 or a 1° female relative before age 65
- High-sensitivity C-reactive protein 2 mg/dL or ↑
- Elevated lifetime risk of ASCVD
- Ankle-Brachial index <0.9
- Statin Adverse Reactions
- Coronary artery calcium (CAC) score 300 Agatston units or ↑, or 75th percentile or ↑ for age, gender, ethnicity
- Statin Drug interactions
- Patient Preferences

Pharmacology Treatment Options

Use high dose Statins to achieve an average LDL reduction about 50% or higher

- Atorvastatin 80 mg QD (use 40 mg if 80 mg not tolerated)
- Rosuvastatin 20 mg to 40 mg QD

*Pooled Cohort Equations Cardiovascular Risk Calculator: http://myamericanheart.org/cvriskcalculator

Source: Adapted from Therapeutic Research Center, January 2014
Pharmacology Treatment Options

Use Moderate dose Statins to achieve an average LDL reduction about 30 - <50
- Atorvastatin 10-20 mg QD
- Fluvastatin 40 mg BID or 80 mg (XL) QD
- Lovastatin 40 mg QD
- Pitavastatin 2-4 mg QD
- Pravastatin 40-80 mg QD
- Rosuvastatin 5-10 mg QD
- Simvastatin 20-40 mg QD

Patients that cannot tolerate a high dose statin
- Pitavastatin 1 mg QD
- Pravastatin 10-20 mg QD
- Lovastatin 20 mg QD
- Simvastatin 10 mg QD
- Fluvastatin 20-40 mg QD

Primary prevention in adults 40-75 yrs with LDL 70-189 mg/dL and an estimated 10-yr risk of ASCVD of 7.5% or ↑*

For patients that cannot tolerate a high or moderate dose statin, use Low dose Statins to achieve an average LDL reduction about <30%:
- Pitavastatin 1 mg QD
- Pravastatin 10-20 mg QD
- Lovastatin 20 mg QD
- Simvastatin 10 mg QD
- Fluvastatin 20-40 mg QD

Monitoring Statin Therapy

- ALT (alanine aminotransferase ) should be checked at baseline.
- Assess prior to starting therapy for any muscle-related symptoms and document.
- If a patient is at increased risk for myopathy, consider checking a CK (creatine kinase) prior to starting therapy. Repeat if patient develops symptoms.
- If the patient develops severe muscle symptoms or fatigue that is unable to be attributed to other causes, hold the statin and check a creatinine and U/A to rule out the presence of rhabdomyolysis.

Non-statin Therapy:
- Reinforce statin adherence and lifestyle changes, and check for secondary causes before adding a non-statin
- Do not add gemfibrozil to statin therapy
- Adding a non-statin to a statin has not been shown to further decreases CV risk

Triglycerides 500 mg/dL or ↑: use fatty acid

Patients intolerate to recommended statin dose, do not achieve expected response or are at high risk

Check fasting lipid panel 4-12 weeks after statin initiation, then Q 3-12 months
Check adherence to statin & lifestyle interventions if LDL drop is less than expected
Consider statin dose reduction if two consecutive LDL measurements are less than 40 mg/dL
Monitor for new-onset diabetes per diabetes screening guidelines

*Pooled Cohort Equations Cardiovascular Risk Calculator http://myamericanheart.org/cvriskcalculator

Source: Adapted from Therapeutic Research Center, January 2014