Statin Therapy Management

Document Title: Statin Therapy Management: Recommendations for the Treatment of Blood Cholesterol to Reduce ASCVD Risk		
Index #: HLN.P.015	Created by: Cardiology CPC, Adult CPC	Approved by: Cardiology CPC, Adult CPC, QCCC, and HLN BOD
Effective Date: 3/1/2018	Last Revision date: 4/19/2022	Last Review Date: 4/19/2022
Supporting Documents: HLN Pediatric Leader CPC (Screening in children)		Next Review Date: Q4 2023

Purpose:

The HLN Statin Therapy Management clinical standard has been developed to promote evidence-based medical management and quality of life for patients diagnosed with hyperlipidemia. In conjunction with the clinical standard and current HEDIS measures, our population health focus remains on ensuring individual treatment decisions for managing LDL-Cholesterol and non-HDL Cholesterol to reduce the ASCVD risk in adults.

Four Statin Benefit Groups:

Primary Prevention:			Secondary Prevention:
≥ 20 yrs with baseline LDL-C ≥ 190 mg/dL	40-75 yrs without clinical ASCVD but with diabetes & baseline LDL-C ≥70 mg/dL	40-75 yrs without clinical ASCVD or diabetes, with baseline LDL-C 70-189 mg/dL & an estimated 10-yr risk for ASCVD of ≥ 7.5%	≥ 20 yrs with clinical ASCVD or equivalent (ie. PVD)

Special populations that are **not** included in 1 of the 4 statin benefit groups:

- patients with heart failure,
- patients on maintenance hemodialysis,
- and women considering pregnancy or already pregnant

Pediatrics:

A universal baseline lipid screening is recommended by age 12, in accordance with American Academy of Pediatrics and HLN Pediatric Leader Committee.

ASCVD Risk Enhancers:

Family history of premature ASCVD
Persistently elevated LDL-C ≥160 mg/dL
Chronic Kidney Disease (eGFR less than 60)
Metabolic Syndrome
Conditions specific to women: Preeclampsia; Premature Menopause
Inflammatory Diseases (especially Rheumatoid Arthritis, Psoriasis, HIV)
Ethnicity (e.g., South Asian ancestry)
CAC score above 300
Lipid/Biomarkers • Persistently elevated triglycerides ≥175 mg/dL
In selected individuals if measured: • hs-CRP ≥2.0 mg/L • Lp(a) levels >50mg/dL or >125 nmol/L • apoB (Apolipoprotein B Test) • Ankle-brachial index (ABI) <0.9

Primary Prevention & Lifestyle Modifications:

Primary ASCVD prevention requires attention to ASCVD risk factors early in life. ASCVD Risk Enhancers address major issues related to managing cholesterol. In reference to the American College of Cardiology's 2018 Cholesterol Clinical Practice Guidelines, risk factors indicate priority should be given to estimating lifetime risk and promoting healthy lifestyles through diet, exercise, smoking cessation, alcohol consumption, etc. Clinicians are also encouraged to monitor patients' response to lifestyle changes and medication adherence to statin or LDL lowering medications.

2019 ACC_AHA Guideline on the Primary Prevention of Cardiovascular Disease

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STATIN THERAPY INITIATED:

- Assess adherence and response to statin therapy at 4-12 weeks based on lifestyle changes and statin therapy

LDL reduction achieved →

LDL reduction not achieved ↓

- **Maximize Statin** to tolerated intensity
- **Change statin** based on patient tolerance or adverse effects
- Assess adherence and response to statin therapy at 4-12 weeks based on lifestyle changes and statin therapy

LDL reduction achieved →

LDL reduction not achieved ↓

- **Add Ezetimibe 10mg daily** (additional 20% LDL reduction)
- Assess adherence and response to statin therapy at 4-12 weeks based on lifestyle changes and statin therapy

LDL reduction achieved →

LDL reduction not achieved ↓

- **Consider referral** (cardiology, endocrinology)
- Consider the following options:

- Repatha 140mg sq every two weeks or 420mg monthly
- Praluent 75mg sq every two weeks, or 300mg every 4 weeks
- Nexletol 180mg daily
- Leqvio 284mg sq initial, 3 months, then every 6 months

*[*Note Evolocumab (Repatha) FOURIER study showed CV mortality reduction]*

*NOTE: When assessing Triglyceride lowering needs (TG ≥150 mg/dL + ASCVD or DM w/ ≥2 risk factors), may add Icosapent Ethyl 2gm BID [*Note: Reduce-IT study demonstrated CV mortality reduction]*

✓ Recheck in 3-12 months, monitor statin adherence and lifestyle changes

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Intensity	Medication	Dose
High ≥50% LDL lowering	* +Atorvastatin	40-80mg
	Amlodipine-atorvastatin	40-80 mg
	*Rosuvastatin	20-40mg
Moderate 30-49% LDL lowering	* +Atorvastatin	10-20 mg
	Amlodipine-atorvastatin	10-20 mg
	*Rosuvastatin	5-10 mg
	+Simvastatin	20-40 mg
	+Ezetimibe-simvastatin	20-40 mg
	* +Pravastatin	40-80 mg
	Lovastatin	40 mg
	Fluvastatin	40-80 mg
	Pitavastatin	1-4 mg

1.) Statin Therapy for Patients with Cardiovascular Disease, HEDIS 2022
2.) AACE 2017 Guidelines for the Management of Dyslipidemia and Prevention of Cardiovascular Disease, Endocr Pract.2017;23 (Suppl 2)
** - Primary Prevention & CV mortality data (pg 56)*
+ - Secondary Prevention & CV mortality data (pg 57)
Link: American Association of Clinical Endocrinologists and American College of Endocrinology Guidelines for Management of Dyslipidemia and Prevention of Cardiovascular Disease - Endocrine Practice

Quality Measures Management:

Statin Therapy for Patients with Cardiovascular Disease (SPC)

Population Measure: % of males 21-75 years of age or % of females 40-75 years of age
Patients who were identified as having ASCVD and received statin therapy for at least one **high or moderate intensity** statin medication during the measurement year
ASCVD Event/Diagnosis Criteria: MI (acute/non acute IP stay); CABG; PCI; IVD diagnosis
Exclusions for Statin Treatment: Pregnancy; IVF treatment; At least one Rx of clomiphene; ESRD or Dialysis; Cirrhosis; Myalgia, myositis, myopathy, or rhabdomyolysis; receiving hospice or palliative care services anytime during the measurement year

Statin Use in Persons with Diabetes (SUPD)

Population Measure: % of patients between ages 40-75 years with diabetes
who have had at least 2 diabetes medication fills and who also received at least one statin medication fill within the measurement year
Exclusions: Hospice, ESRD diagnosis or dialysis

Statin Medication Adherence

Population: Patients 18 years and older with at least two statin cholesterol medication fills during the measurement period
Adherence Measure: % of patients with a statin who fill their prescription to cover 80% or more of the time during the measurement period (PDC = Proportion of Days Covered)
Key to Success: Educate patients on importance of taking statin medication as prescribed, explore barriers, side effects, and cost options to assist with compliance

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Documenting Statin Therapy Exclusions

Statin myopathy G72.0	Statin-induced rhabdomyolysis M62.82	Myalgia due to statin M79.10
Statin-induced myositis M60.9	Rhabdomyolysis due to statin therapy M62.82	Statins contraindicated Z53.09
Surgical contraindication to statin therapy Z53.09	Hepatotoxicity due to statin drug K71.9	Medical contraindication to statin therapy Z53.09

**Document statin intolerance within the Visit Diagnosis or Problem List*

References

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National Lipid Association. (2017). 2017 Focused Update of the 2016 ACC Expert Consensus Decision Pathway on the Role of Non-Statin Therapies for LDL-Cholesterol Lowering in the Management of Atherosclerotic Cardiovascular Disease Risk. *A Report of the American College of Cardiology Task Force on Expert Consensus Decision Pathways*.

This document has been developed with input from clinicians within the HLN. It is intended to provide recommendations and guidance for Population Health programs. Clinical care decisions related to the care of individual patients is determined by the patient's provider.

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MODIFICATION HISTORY

Type	Revised By	Revised Date	Approval Date *(If Applicable)*	Notes
Creation		3/1/2018	3/1/2018	
Revision	Megan Rainey	4/19/2022	4/19/2022	Renamed and added new guidelines, note that statin Intolerance or allergies does not exclude them from the measure; must list one of the diagnosis; 2nd page – Algorithm on treatment; 3rd page – 3 quality population measures. Revision approved by QCCC on 4/19/2022.
Approval			5/25/2022	Approval by the HLN Board of Directors

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