Additional LDL Lowering Needed (on max tolerated statin)

Statin Intolerance or Contraindication

1st line (as monotherapy or add-on): Ezetimibe (Zetia)

Well-tolerated	↓ LDL ~15-20% monotherapy
Generic available	CV benefits in secondary prevention (in combination with statin)

2nd line (as monotherapy or add-on): Bempedoic Acid (Nexletol)

Minimal muscle side effects	↓ LDL ~20-25% monotherapy
May cause hyperuricemia	CV benefits in very high risk primary and secondary prevention
$$ No generic, covered by Medicaid (PA needed)	

3rd line, or Very High CV Risk (as monotherapy or add-on): PCSK9i

Evolocumab (Repatha) Alirocumab (Praluent)	↓ LDL ~45-60% monotherapy
Every 2-4 weeks subcut injections	CV benefits in secondary prevention
Injection site reactions	Used for familial hypercholesteremia (FH)
$$$ Specialty med, covered by Medicaid (PA needed)	Refer to VMC Cardiology or Lipidologist

Possible Symptoms of Statin Intolerance

- Muscle symptoms are bilateral, symmetrical, usually in proximal large muscle groups, and unrelated to changes in physical activity level
- Onset coincides with new starts or dose adjustments
- Reversible upon stopping statin, and reproducible with re-challenge
- History of intolerance to ≥ 2 statins
- Very rare: CK elevation, rhabdomyolysis (CK>5X ULN)

Symptoms Less Likely Related to Statin

- Tingling, twitching, shooting pain, nocturnal cramps, joint pain
- Muscle symptoms are unilateral, asymmetrical, localized, in more distal muscles
- No temporal relationship to statin initiation or discontinuation

2026 ACC/AHA Lipid Guidelines LDL Goals

	LDL <100	LDL <70	LDL <55
Primary Prevention			
PREVENT Score <10%	✓		
PREVENT Score ≥ 10%		✓	
DM	✓ (No ASCVD risks)	✓ (ASCVD risks)	
LDL ≥ 190	✓ (No ASCVD risks)	✓ (ASCVD risks)	
Secondary Prevention			
Clinical ASCVD		✓	✓ (High risk)
Subclinical ASCVD	CAC 1-99 and <75th percentile	CAC ≥100-299 or ≥ 75th percentile; or CAC ≥300-999	CAC ≥1000