

MOLINA HEALTHCARE OF WASHINGTON

HYPERLIPIDEMIA CLINICAL PRACTICE GUIDELINE

Molina Healthcare of Washington has reviewed its screening and treatment for Hyperlipidemia. The current guideline is based on the American College of Cardiology/American Heart Association (ACC/AHA) in collaboration with the National Heart, Lung, and Blood Institute (NHLBI). The ACC/AHA recommendations were adopted by the Molina Healthcare of Washington Clinical Quality Improvement Committee on October 25, 2006, September 25, 2008, September 2, 2010, September 6, 2012, September 4, 2014 and January 22, 2016, February 15, 2017, March 9, 2018.

The Clinical Practice Guideline may be accessed from: [2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults](#)

Important Points Hyperlipidemia Practice Guideline

ATP IV guideline published in November, 2013 and is not on the NHLBI website. No new information has been published since 2014 CPG update as previously noted.

1. New ACC/AHA guidelines quite different than ATP III.
2. Lifestyle changes still emphasized.
3. Drug recommendations now apply only to statins, at “moderate” or “high” intensity depending on circumstance.
4. No longer specific LDL targets for treatment (for either primary or secondary prevention), rather relative reductions.
5. Patients eligible to receive statins can be identified by 4 questions:
 - a. Does the patient have clinical ASCVD (CAD, Stroke, TIA, PAD)?
 - b. Does the patient have an LDL-C ≥ 190 mg/dL without treatment?
 - c. Is the patient 40-75 years of age and have diabetes with LDL-C 70-189 mg/dL?
 - d. Is the patient 40-75 years of age with LDL-C 70-189 and a 10-year risk of cardiovascular events $\geq 7.5\%$?
6. There is insufficient evidence to support routine use of non-statin drugs for reducing ACSVD events, either in addition to statin therapy or monotherapy in statin-tolerant patients.
7. Statin therapy is safe when used in properly selected individuals who are appropriately monitored.
 - a. Routine monitoring of creatine kinase and transaminase levels is not necessary (unless the patients symptoms indicate a possibility of myopathy or hepatotoxicity).
8. Please see the table below which identifies high and moderate treatment intensity based on patient group.

Patient Group		Recommended Statin Intensity
Clinical ASCVD	Age ≤ 75 years (no statin safety concerns)	High-intensity
	Age > 75 years OR with statin safety concerns	Moderate-intensity
LDL ≥ 190 mg/dL without clinical ASCVD	Age > 21 years	High-intensity
Diabetic patients Type 1 or 2, Age 40-75 years	10-year ASCVD risk < 7.5%	Moderate-intensity
	10-year ASCVD risk ≥ 7.5%	High-intensity
Non-diabetic patients without clinical ASCVD, age 40-75 years, with LDL 70-189 mg/dL	10-year ASCVD risk ≥ 7.5%	Moderate to high intensity

Statin safety concerns: impaired renal or hepatic function; history of statin intolerance or muscle disorders; unexplained ALT elevations ≥ 3 times upper limit of normal; age > 75 years.

10-year ASCVD risk calculated using Pooled Cohort Equations – available at: <http://my.americanheart.org/cvriskscalculator>.

Patient Subgroups for Which the Benefits of Statins Outweigh the Risks		
Patient Group		Recommended Intensity of Statin Treatment
Clinical ASCVD* (secondary prevention)	Age ≤ 75 years with no statin-related safety concerns †	High
	Age > 75 years or with statin-related safety concerns	Moderate
LDL ≥ 190 mg/dL without clinical ASCVD	Ages ≥ 21 years	High
Diabetic patients without clinical ASCVD, ages 40-75 years, with LDL 70-189 mg/dL	10-year ASCVD risk < 7.5% ‡	Moderate
	10-year ASCVD risk ≥ 7.5%	High
Non-diabetic patients without clinical ASCVD, ages 40-75 years, with LDL 70-189 mg/dL	10-year ASCVD risk ≥ 7.5%	Moderate-to-high