Statin Therapy

Treatment Guidelines 5-Star Best Practices

What Are the Measures?

	Statin Therapy in Patients with Cardiovascular Disease (SPC)	Statin Use in Persons with Diabetes (SUPD)
Definition	The percentage of males 21 to 75 and females 40 to 75 years of age who were identified as having clinical ASCVD and were dispensed at least one **high- or moderate-intensity** statin during the measurement year	The percentage of patients 40 to 75 years of age who were dispensed at least two diabetes medication fills on different dates of service and received one statin of **any intensity** during the measurement year
Exclusions	• Cirrhosis (K74.60) • ESRD • Hospice, palliative care • Myalgia (M79.1), myositis (M60.9), myopathy (G72.9), or rhabdomyolysis (M62.82) • Pregnancy, clomiphene use, or in vitro fertilization • Age 66 and older in I-SNP or has LTI flag • Age 66 and older with frailty and advanced illness	• Cirrhosis (K74.60) • ESRD • Hospice • Myositis (M60.9), myopathy (G72.9), or rhabdomyolysis (M62.82) • Polycystic Ovary Syndrome (E28.2) • Pregnancy, lactation, clomiphene use, or in vitro fertilization • Pre-Diabetes (R73.03, R73.09)
*ICD-10 codes may differ between SUPD and SPC. This is not an all-inclusive list of exclusion criteria.		

How Can the Medical Group Improve Performance?

- Build an electronic medical record alert to notify providers of patients in need of a statin based on their diagnoses.
- Develop a pharmacist protocol to initiate and manage statins in patients who meet the criteria.
- Leverage the SUPD/SPC monitoring report, which SCAN provides on a weekly basis via sFTP, to:
    - Identify patients who meet measure criteria and are not optimized on their statin therapy.
    - Identify which prescribers have the most opportunities for statin initiation.
    - Identify patients who meet measure criteria and met exclusion criteria in the last 1-2 years. Re-apply exclusion codes if still applicable.
- For patients in the SPC denominator, please confirm ASCVD diagnoses and treat accordingly, and apply
- appropriate exclusion codes for statin intolerance (myalgia, myositis etc.).
- Prescribing atorvastatin or rosuvastatin will satisfy both SPC and SUPD measures.
- Consider the following formulary statins for patients who are eligible for these measures:

	High-Intensity	Moderate-Intensity
	LDL-C lowering ≥ 50%	**LDL-C lowering 30% to 50%**
Tier 1 (Preferred Generic)	atorvastatin 40-80mg rosuvastatin 20-40 mg simvastatin 80mg	atorvastatin 10-20mg lovastatin 40mg pravastatin 40-80mg rosuvastatin 5-10 mg simvastatin 20-40mg
Tier 2 (Generic)	amlodipine-atorvastatin 40-80mg	amlodipine-atorvastatin 10-20mg

Note: Ezetimibe-simvastatin is available as a Tier 3

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Medical Group Guidelines 5-Star Best Practices (cont.)

Why Are Statins Important?

According to the 2018 American College of Cardiology/American Heart Association guideline, statins are recommended in the following groups captured by these measures:[1]

- Primary prevention in individuals with diabetes 40 to 75 years of age
- Secondary prevention in individuals with clinical ASCVD

This guideline emphasizes reducing ASCVD risk with the maximum tolerated statin intensity. Statin intensity depends on the percentage change in LDL-C from baseline rather than absolute LDL-C reduction. Recommendations resulted from expert panel reviews of evidence, including:

- In adults with diabetes without established vascular disease, statin therapy reduced the relative risk of cardiovascular and cerebrovascular events by 25 percent, preventing one outcome for every 35 patients treated on average.[2]
- In adults younger than 75 with clinical ASCVD, a high-intensity statin should be initiated or continued with the aim of achieving a 50 percent or greater reduction in LDL-C levels.[1]
- For secondary prevention for patients with clinical ASCVD, there was no evidence in the meta-analysis of trials that indicated a higher-potency statin or more intensive LDL-C reduction increased the risk of statin-related adverse effects.[3]
- In patients experiencing non-severe statin-associated side effects, it is recommended to reassess and to rechallenge to achieve a maximal LDL-C reduction with a lower dose, an alternative dosing regimen or an alternate agent.[1]
    - For example, consider rosuvastatin 5 mg once weekly and up-titrate to as frequently as every other day.[4]

Moderate- or high-intensity statins are recommended for the diabetes group and high-intensity statins are recommended for the clinical ASCVD group. As some patients may experience statin-associated side effects, the SUPD measure permits low-intensity statins and the SPC measure permits moderate-intensity statins

[1] Grundy SM, et al. 2018 Guideline on the Management of Blood Cholesterol: a Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines.

[2] de Vries FM et al. Primary Prevention of Major Cardiovascular and Cerebrovascular Events with Statins in Diabetic Patients, A Meta-Analysis. Drugs 2012; 72 (18): 2365-2373.

[3] Baigent C, Blackwell L. et al. Efficacy and safety of more intensive lowering of LDL cholesterol: a meta-analysis of data from 170,000 participants in 26 randomised trials. Lancet 2010;376:1670–81.

[4] Mampuya WM, Frid D, Rocco M, et al. Treatment strategies in patients with statin intolerance: the Cleveland Clinic experience. Am Heart J. 2013;166(3):597-603.