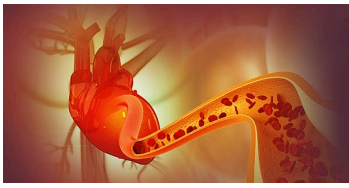

CLINICAL COMPENDIUM

ACHIEVING CLINICAL BENEFIT WITH NONSTATIN THERAPIES AMONG HIGH-RISK PATIENTS — AVOIDING COMMON BARRIERS

Dear Colleague:

Thank you for your recent participation in the CE activity *Achieving Clinical Benefit With Nonstatin Therapies Among High-risk Patients – Avoiding Common Barriers,* with Drs. John Anderson and Seth Martin, developed by the Annenberg Center for Health Sciences. As you continue to advance the care you provide to these patients, we'd like to summarize the key concepts from this activity:

- Traditional atherosclerotic cardiovascular disease (ASCVD) risk factors and the more recently proposed risk-enhancing factors are important to utilize for individual patient risk stratification and overall ASCVD risk assessment.
- ASCVD risk prediction has limitations and challenges. However, incorporating validated risk assessment tools, including the 10-year ASCVD risk calculator and common imaging modalities (eg, coronary artery calcium), into risk stratification, can better inform shared decision-making between patients and clinicians.
- The 2018 ACC/AHA Multisociety Guideline on the Management of Blood Cholesterol has categorized patients with clinical ASCVD as "not at very high-risk" or "very high-risk."
- Elevated lipoprotein a [Lp(a)] is the most common genetic dyslipidemia, affecting approximately 20% of the global population, and is considered an independent, linear, and causal risk factor for ASCVD and calcific aortic stenosis.
- The 2022 ACC Expert Consensus Decision Pathway on the Role of Nonstatin Therapies Guidelines recommended aggressive LDL-C reductions to optimal levels <55 mg/dL, with levels exceeding this considered a threshold to consider additional therapy.
- Risk stratifying patients with clinical ASCVD as "not at very high-risk" or "very high-risk" is essential to determine lipid treatment/targets and improve outcomes.
- If patients with clinical ASCVD receiving maximally tolerated statin therapy and ezetimibe are not at treatment goals, consideration can be given to adding a PCSK9 mAb, bempedoic acid, or inclisiran.
- Clinical inertia and other barriers to initiating and maintaining nonstatins are common. Various clinical strategies can be implemented to navigate the prior authorization process to optimize prescribing.

We hope you will be able to participate in other accredited activities we offer at www.Annenberg.net.

Regards,
The Annenberg Center Team