2026 DYSLIPIDEMIA GUIDELINE – MEDICATION QUICK REFERENCE

1. START WITH STATINS

Medication	Low intensity <30% LDL ↓	Moderate intensity 30–49% LDL ↓	High intensity ≥50% LDL ↓	Administration & dose ceiling
★★ **Atorvastatin** *(Lipitor)*	—	10–20 mg	40–80 mg	Anytime; max 80 mg/day. No renal dose adjustment.
★★ **Rosuvastatin** (*Crestor)*	—	5–10 mg	20–40 mg	Anytime; max 40 mg/day. Renal/ancestry limits below.
Simvastatin (*Zocor)*	10 mg	20–40 mg	—	Evening; max 40 mg/day. Drug interactions below.
Pravastatin (*Pravachol*)	10–20 mg	40–80 mg	—	Anytime; max 80 mg/day. Renal dose limits below.
Pitavastatin (*Livalo)*	—	1–4 mg	—	Anytime; max 4 mg/day. Renal dose limits below

Adult oral daily doses unless specified. Maximum doses assume no renal or interaction-related limit. Intensity doses are not a complete list of strengths.

★★ *Preferred starting statins due to potency/half-life, affordability, convenient dosing, fewer drug interactions, and safety profiles.*

✗ Tricare requires prior authorization or subject to step therapy

BEFORE THE FIRST DOSE [2]

Document baseline lipids and the LDL/non-HDL goal.
Check liver/kidney function, medications, pregnancy plans, & prior symptoms.
Baseline CK only for increased myopathy risk and/or symptoms.

FOLLOW-UP [1,2]

Repeat lipids **1-3 months** after starting/changing therapy, then **every 6-12 months**.
Check adherence, tolerance, & percentage/numeric LDL reduction goals.
CK/liver tests are symptom/risk directed; no routine testing is necessary.

RENAL & OTHER STARTING-DOSE EXCEPTIONS

Rosuvastatin: CrCl <30 mL/min, not on HD: start 5 mg; max 10 mg/day.
Asian patients: start 5 mg/day; individualize titration; carefully assess benefits/risks before exceeding 20 mg/day.
Pravastatin: For severe renal impairment: start 10 mg; max 40 mg/day.
Pitavastatin: eGFR 15–59 mL/min/1.73 m² or on hemodialysis: start 1mg; max 2 mg/day. Requires prior auth with Tricare.

MAJOR DRUG INTERACTIONS

Simvastatin: Max 10 mg/day with verapamil, diltiazem, or dronedarone; max 20 mg/day with amlodipine, amiodarone, or ranolazine. Contraindicated with strong CYP3A4 inhibitors (e.g., clarithromycin, itraconazole, Paxlovid), and separately with gemfibrozil or cyclosporine.
Colchicine: Can increase statin-associated myopathy risk.
Selected interactions only! Always check complete med list, OTC products & supplements.

FOR MYOPATHY SYMPTOMS: ***ASSESS → RECHALLENGE → PRESERVE LDL LOWERING.*** Review timing, exertion, hypothyroidism, & interactions.
For mild-moderate symptoms, consider brief hold, a lower dose, or another statin. Add non-statin therapy as needed to achieve goals.
Severe weakness, marked pain, or dark urine: hold statin; assess CK, creatinine, & urine for rhabdomyolysis.[2]

PREGNANCY & LACTATION: Stop statins in most pregnancies; very-high-risk exceptions need individualized specialist input.
Statins are not recommended during breastfeeding [3]

Sources: [1] Blumenthal et al. 2026 ACC/AHA multisociety dyslipidemia guideline, Tables 5–6; §3.2.3. DOI: 10.1016/j.jacc.2025.11.016. [2] ACC Statin Intolerance Tool. [3] FDA statin pregnancy/lactation communication. Drug-name links open U.S. prescribing information (DailyMed); selected cautions shown.

2. NON-STATINS: WHEN STATIN THERAPY IS INSUFFICIENT OR NOT TOLERATED

Medication	Adult dose & route	LDL reduction*	Key prescribing points
Ezetimibe (*Zetia*) 2-azetidinone, absorption inhibitor	10 mg orally QD	18% alone; ~25% additional reduction w/ statin	No renal dose adjustment Avoid in moderate-severe hepatic impairment Give ≥2 h before or ≥4 h after a bile acid sequestrant
Bempedoic acid (*Nexletol*) ☆ ATP citrate lyase inhibitor	180 mg orally QD	21–24% alone; ~17–18% additional reduction w/ statin	Monitor for hyperuricemia/gout Avoid w/ prior tendon disorder/rupture; d/c for tendon rupture Limit use of simvastatin ≤20 mg/day; pravastatin ≤40 mg/day
Evolocumab (*Repatha*) ☆ PCSK9 monoclonal antibody	140 mg SC every 2 weeks, or 420 mg SC monthly	45–64% (class range)	Injection-site/hypersensitivity reactions No renal dose adjustment
Alirocumab (*Praluent*) ☆ PCSK9 monoclonal antibody	Start 75 mg SC every 2 weeks, or 300 mg SC every 4 weeks If needed: 150 mg every 2 weeks	45–64% (class range)	Injection-site/hypersensitivity reactions With every 4-week dosing, check LDL before next dose Severe renal impairment: limited data
Inclisiran (*Leqvio*) ☆ PCSK9-directed siRNA	284 mg SC initially, at 3 months, then every 6 months	48–52%	Injection-site reactions; administered by HCP No adjustment for renal impairment; ESRD not studied CV outcomes benefit not established
Cholestyramine (*Questran*) Bile Acid Sequestrant	Start 4 g resin QD or BID; usual 8–16 g/day in divided doses; max 24 g/day	10–27% (class range)	Mix powder with liquid; never take dry Other drugs ≥1 h before or 4–6 h after Dose is grams of resin, not total powder weight
Colestipol tablets (*Colestid*) Bile Acid Sequestrant	Start 2 g QD or BID; titrate gradually; max 16 g/day	10–27% (class range)	Swallow tablets whole, one at a time, with plenty of liquid Other drugs ≥1 h before or ≥4 h after

SC = subcutaneous; TG = triglycerides; ESRD = end-stage renal disease; CV = cardiovascular;
☆ Tricare requires prior authorization or subject to step therapy.
* Approximate expected LDL reductions; effects vary with dose, baseline therapy, & adherence. LDL reductions are not additive; each added medication lowers the LDL remaining after other treatment.

OUTCOMES EVIDENCE MATTERS: Ezetimibe & PCSK9 antibodies have event-reduction evidence added to statins; bempedoic acid has outcomes evidence in statin-intolerant high-risk adults. Bile acid sequestrant evidence is principally for cholestyramine. Inclisiran lowers LDL; definitive event-reduction evidence remains pending. [1]

BILE ACID SEQUESTRANTS: Safe for use in pregnancy; may impair absorption of fat-soluble vitamins & folate. Constipation, bloating, pill burden, & reduced absorption also limit use. Avoid if TG ≥300 mg/dL.[1]