2026 DYSLIPIDEMIA GUIDELINE
QUICK REFERENCE

PREVENT Calculator
Select ASCVD (not default)

Use PREVENT-ASCVD for adults ages 30–79 without known ASCVD or subclinical atherosclerosis and with LDL 70–189 mg/dL

PREVENT-ASCVD	LDL + non-HDL goals	Lp(a) once	Selective apoB	Expanded CAC
New risk framework	Numeric and % reduction targets	All adults (19+)	Residual/risk refinement	Reclassify uncertainty

CPR framework: Calculate PREVENT-ASCVD → Personalize with risk enhancers → Reclassify with ApoB/CAC when treatment remains uncertain.

Risk	PREVENT-ASCVD	Initial approach	LDL reduction	Goal if statin used
LOW	<3%	Lifestyle first Moderate-intensity statin reasonable if LDL 160–189 or 30-y risk ≥10%	≥30% if treated	Individualized
BORDERLINE	3% to <5%	Consider risk enhancers If treatment is chosen, start with moderate-intensity statin	≥30–49%	LDL <100 non-HDL <130
INTERMEDIATE	5% to <10%	At least moderate-to-high intensity statin	≥30–49% (or ≥50%)	LDL <100 non-HDL <130
HIGH	≥10%	High-intensity statin Add ezetimibe if goals are not met on maximally tolerated statin	≥50%	LDL <70 non-HDL <100

PERSONALIZE

- Family history/premature ASCVD or suspected inherited dyslipidemia
- CKM risk: diabetes, CKD, metabolic risk, elevated TG
- Elevated Lp(a), selective apoB, and other guideline risk enhancers
- Patient preference, competing risks, life expectancy, medication burden

FOR PRIMARY PREVENTION ONLY

- Known clinical ASCVD → use secondary prevention pathway
- LDL ≥190 mg/dL → use severe hypercholesterolemia pathway
- Known subclinical coronary atherosclerosis → dedicated CAC/subclinical pathway
- Diabetes has its own statin recommendations

Source: Blumenthal RS, et al. 2026 ACC/AHA Multisociety Guideline on the Management of Dyslipidemia. J Am Coll Cardiol. 2026. doi:10.1016/j.jacc.

Educational quick reference; not a substitute for individualized clinical judgment or full guidelines.

SPECIAL PATHWAYS + BIOMARKERS + FOLLOW-UP

LDL ≥190 mg/dL (SEVERE HYPERCHOLESTEROLEMIA)

- **MAXIMALLY TOLERATED STATIN**; treat to targets
- Without additional risk (ASCVD/FH/CAC):
  - ✦ LDL <100 and non-HDL <130
- With additional risk (ASCVD/FH/CAC):
  - ✦ LDL-C <70 and non-HDL-C <100
- With clinical ASCVD:
  - ✦ LDL-C <55 and non-HDL <85

DIABETES *WITHOUT* ASCVD

- Age 40–75: **MODERATE-INTENSITY STATIN** indicated:
  - ✦ ≥30–49% LDL reduction and LDL <100/non-HDL <130
- Age 20-39 with long-duration diabetes or complications:
  MODERATE-INTENSITY STATIN may be reasonable
- Multiple ASCVD risk factors: **HIGH-INTENSITY STATIN** is reasonable
  - ✦ ≥50% reduction and LDL <70/non-HDL <100.

CLINICAL ASCVD

- Not very high risk*: **HIGH-INTENSITY STATIN**
  - ✦ ≥50% LDL reduction and LDL<70/non-HDL <100
- Very high risk*
  - ✦ LDL <55 and non-HDL <85

**Multiple major ASCVD events OR 1 major event + high-risk conditions (FH, LDL≥ 190, T2DM, tobacco use, family history, etc.)*

CAC (WHEN THE DECISION IS UNCERTAIN)

- For intermediate risk & *selected* borderline risk
- CAC = 0: May support *deferring statin* in selected patients
  Exceptions: FH, LDL≥ 190, diabetes, tobacco use, strong family history
- CAC 1–99 and <75th percentile: **MODERATE-INTENSITY STATIN**
  Goal toward LDL <100/non-HDL <130.
- CAC ≥300: intensive therapy toward LDL <55/non-HDL <85.

Lp(a)

Measure at least once in every adult. Value ≥50 mg/dL (≥125 nmol/L) is elevated and should prompt earlier, tighter control of modifiable risk factors. Lp(a) does not respond meaningfully to diet/fasting.

apoB

Useful for residual risk/treatment intensification, especially with ASCVD, CKM syndrome, T2DM, elevated TG, or very low achieved LDL.

Triglycerides/Non-HDL

If TG ≥150 mg/dL, non-HDL or apoB is preferred over LDL alone to guide decisions. If non-fasting TG ≥400 mg/dL, obtain a fasting panel.

MONITOR

- Repeat lipid profile 1–3 months after starting or changing lipid-lowering therapy
- Then every 6–12 months once stable, individualized to risk/adherence/therapy

LIPID PANEL PRACTICALITIES

- Fasting is not required for most routine lipid profiles
- Report non-HDL (Martin/Hopkins or Sampson/NIH calculation method preferred)