American Heart Association.

TRANSCRIPT

Episode 4 – Pharmacologic Management of ASCVD

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Narrator: Cholesterol is one of the primary causal risk factors for the development of atherosclerosis. As we know, managing atherosclerotic cardiovascular disease or ASCVD, requires a holistic approach across multiple disciplines working together to achieve guideline-directed lipid management. Through the support of Novartis Pharmaceuticals Corporation, the American Heart Association has created a podcast series that explores multiple perspectives of ASCVD care with clinical subject matter experts from across the country.

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Narrator: Let us take you on a journey through the patient care pathway to understanding ASCVD.

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Liz Olson: A healthy lifestyle, including the management of lipids is a key component to reducing ASCVD risk. For those with ASCVD, medication is an important part of managing the disease. On today's podcast, we'll look more closely at the role medication plays in managing ASCVD. I'm Liz Olson with the American Heart Association, and today I'm here to speak with Dr. Megan Supple to discuss the pharmacological management of ASCVD. Dr. Supple, how are you today?

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Dr. Supple: Doing well, thanks for having me on your podcast today.

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Liz Olson: Great, thanks. Can you tell us a little bit about yourself.

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Dr. Supple: Sure. I'm a native from Rochester, New York, and I received my Doctor of Pharmacy degree from Northeastern University up in Boston. And from there I moved to Greensboro, North Carolina, to pursue residency at Moses Cone Hospital. And since then, for the past five years, I've been working at Cone Health medical group Heart Care, our large outpatient cardiology clinic. And our pharmacy team here specializes in cardiovascular risk reduction, where we manage disease states from hyperlipidemia and hypertension to heart failure and anticoagulation.

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Liz Olson: Great. It's wonderful to have you here with us. Let's just dive right in. What would you say are the most common medications used when treating hyperlipidemia related to ASCVD?

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Dr. Supple: A really exciting part of lipid management is that the landscape of treatment options has really expanded even over the last five years or so. When we usually think of lipid management, we think of statin therapy like Rosuvastatin and Atorvastatin, and statins do remain the cornerstone of lipid management. They're the most widely prescribed medication class for lowering cholesterol and have excellent data and cardiovascular risk reduction for both primary and secondary prevention. In my clinic, in particular, we treat a lot of statin-intolerant patients. So, we tend to move beyond our traditional first-line statin therapies and other medications that can be used to treat hyperlipidemia-related ASCVD include other pills like as Ezetimibe and more recent additions to the market, both Nexletol and Nexlizet. These newer medications work to inhibit ATP citrate lyase, which is a few steps upstream of statins in the hepatic cholesterol synthesis pathway. We also have subcutaneous injections available like our PCSK9 inhibitors, Repatha and Praluent, that are given either every two weeks or once monthly. And with so many options to choose from, tailoring medication regimens to target individual needs has become a really creative and exciting process.

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Liz Olson: That's very interesting. So, what would you say then are the most important considerations when placing a patient on a medication regimen for their ASCVD risk?

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Dr. Supple: Yeah, determining an individual patient's treatment goals based off of their risk factors is the most important place to start when we're determining which lipid lowering therapy may be most appropriate. If our patient does not have a history of ASCVD, we may be more lenient and choose an LDL goal of less than 100 mg/dL or less than 130 mg/dL. Looking at any family history of coronary artery disease, calculating their ten-year ASCVD risk and checking on coronary calcium score are all valuable tools too, to help us determine how aggressively we should be treating one of our primary patient's cholesterol. For our secondary prevention patients who already have a history of ASCVD, more aggressive treatment is definitely warranted. Typically, an LDL goal of less than 70 mg/dL for these patients is appropriate and national guidelines have become a lot more aggressive targeting lower goals, as more primary literature has shown better cardiovascular outcomes. With our PCSK9 inhibitor cardiovascular outcomes trials in particular, we now have data to support that an LDL of 30 mg/dL reduces the risk of an MI or stroke more than an LDL of 90 mg/dL, and really without too much worry of dropping LDL cholesterol too low. In 2020 the AACE and ACE guidelines actually issued an update that targeting an LDL goal of less than 55 mg/dL is warranted in patients with progressive or recurrent ASCVD. And this more stringent goal of less than 55 mg/dL comes after a similar update to look at guidelines that were put out by the European Society of Cardiology Guidelines in 2019. And they actually have an LDL goal of less than 40 mg/dL for their highest risk patients with recurrent disease. So, we're really seeing this trend towards more aggressive cholesterol management, especially for these higher risk secondary prevention patients.

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Dr. Supple: Once we assess our patients' risk factors and we can determine that LDL goal, from there we can look at their baseline cholesterol and determine what percentage LDL lowering that patient requires to achieve their goal. If they need about a 20% LDL lowering, then a lower intensity statin, or Ezetimibe or Nexletol if your patient is statin-intolerant, are appropriate options. If a 50 or 60% LDL lowering is required, using a high intensity statin or a PCSK9 inhibitor would definitely be warranted based on their higher efficacy rates. Cost and prior medication intolerances are two other important considerations to keep in mind before selecting a particular medication.

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Dr. Supple: So, having multiple options is really great because it allows us to tailor medications to an individual patient's needs.

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Liz Olson: Cost brings up a very important question. Can you talk a bit about how patient access impacts successful pharmacological intervention of hyperlipidemia?

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Dr. Supple: Sure. Patient access to their medications can definitely impact our treatment of hyperlipidemia. Luckily, almost all statins are available as generics. So, patients who do have insurance typically don't pay much, if anything, for these medications. For patients without medication insurance, a lot of pharmacies have discounted drug pricing for generic medications available, including statins. Cost can be a bit tougher to navigate for newer drugs that are only available as branded medications. Depending on a patient's insurance, there can be co-pay cards available or a manufacturer or patient assistance programs,

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Dr. Supple: if the co-pays too high. It's not uncommon for branded medications to cost somewhere between $35 and $100 per month, depending on the formulary tier, particularly for our patients who have a Medicare Part D plan. So that cost in and of itself can be a huge barrier to medication therapy. These branded medications also typically need prior authorizations that have to be submitted by the doctor's office to the insurance company, which can be a bit time consuming. So, navigating the cost of branded medications can be frustrating for the patient who may go to the pharmacy, see a medication co-pay that's too high, and just never pick up their prescription.

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Dr. Supple: And if they don't let their doctor know, that patient may go untreated until they see their provider potentially up to a year later. So patient access and affordability definitely play huge roles when it comes to implementing successful medication regimens.

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Liz Olson: What resources are out there for patients to ensure they have access to their lipid-lowering medication?

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Dr. Supple: That's a great question. There are a few different resources that can be helpful to increase access to these medications. For patients without medication insurance who are paying cash, GoodRx is a website that provides medication coupons and can be helpful for certain medications. Many pharmacies have that discounted drug list for many generic medications that are listed on their websites, and for branded medications, pharmaceutical companies may have patient assistance programs that are available to help with medication costs for uninsured patients.

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Dr. Supple: For patients who have commercial insurance plans, copay cards can help to reduce the price of branded medications quite a bit. And for patients with Medicare insurance, there may be patient assistance grants available to help with some higher branded co-pays, but it's definitely best for patients to ask their providers about these since they can change depending on the medication. Pharmacists are also a really great resource when it comes to patient access. We're in a unique position where we understand the pharmacology of medications and the guideline recommendations for treatment, as well as the access piece as it relates to co-pays, deductibles and various patient assistance options.

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Liz Olson: I'd love it if you could describe for us the typical barriers that you see to pharmacological intervention of hyperlipidemia.

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Dr. Supple: Sure. There can be a lot of different barriers to treatment for cholesterol, and a big one is time. Many patients see their physician once a year for 15 minutes or so, and when there are more urgent matters to discuss, cholesterol management can easily be overlooked and not even mentioned at all. Concern over side effects is also a pretty big barrier. Statins tend to have a bad reputation from a side effect standpoint, even though they're very effective medications in preventing cardiovascular disease. So, we do run into patients who can be pretty resistant to starting therapy.

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Dr. Supple: Maybe they've experienced muscle aches on a statin before. Maybe a relative had an issue with cognition or an increase in their blood sugar. And there can also be a perceived lack of benefit of lipid lowering therapy. Maybe no one has ever explained the full benefits of these medications. You know, patients don't feel better when they take a statin. It's not like an antibiotic or a pain reliever where they really feel better and notice a difference when they take the medication. Ideally, our patients really shouldn't feel any different when they take a statin, but if they're not feeling better, they may not fully understand the benefit of that medication.

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Dr. Supple: Patients are usually told that they also need to remain on their cholesterol medication indefinitely. So over time they may become nonadherent and stop taking their medication and still feel fine and maybe not fully understand that risk of cardiovascular disease or a recurrent MI that comes with that untreated, elevated cholesterol.

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Liz Olson: What solutions do you feel would remedy these identified barriers?

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Dr. Supple: Utilizing mid-level practitioners is a great way to increase patient access to their health care team, especially if physicians' schedules are overbooked. This can allow patients to be seen more quickly or more frequently if needed. Clinic nurse practitioners, physician assistants and pharmacists are all great resources to help discuss lipid-lowering medications with patients. From the side effect concern, many times this can be overcome with a thorough discussion and close follow up. Statin intolerance in particular can look different for everybody.

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Dr. Supple: This is really a conversation to have between patient and provider. One patient may be willing to try their fourth or fifth statin, whereas another patient may have had a large CK or LFT elevation on their first statin therapy. For many patients discussing that not all statins are created equally, that hydrophilic statins tend to be

tolerated better than lipophilic statins, and that starting with a lower dose or extending the timing in between doses can improve tolerability are all really helpful tools for opening the door to successful medication therapy.

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Dr. Supple: Following up closely with patients who have had prior side effects on lipid-lowering therapy can help to ensure that there are no gaps in care, and that alternative options can be tried in an appropriate timeframe. Since I tend to treat patients with multiple medication intolerances, I usually like to provide them with my direct number in the office so that they can call me with any issues tolerating their medications. Then we can strategize and come up with a new medication plan, oftentimes much sooner than if they had waited until their next appointment to mention those medication side effects. With regards to medication noncompliance, checking annual lipid panels is a great way to catch potential medication noncompliance. For those patients who don't fully understand why they need to take medication for their cholesterol, take the time to have a comprehensive discussion with patients about why lowering their cholesterol through medications is so beneficial. Explaining that cholesterol medications can help to reduce the risk of stroke, MI and death is a powerful conversation starter that can help to improve long term medication adherence.

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Liz Olson: In your experience, how do you navigate those tough conversations about medications, education and medication adherence?

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Dr. Supple: I'm definitely fortunate that I can spend 30 or more minutes with patients to really delve more deeply into anything that might be contributing towards nonadherence. Patients may come to clinic with concerns over side effects or wonder why they even need to take cholesterol medication in the first place. And really taking the time to listen to patients' concerns and spending the time to address their questions is really the best strategy that I found. Oftentimes, I'll discuss why lowering cholesterol is important and tie that back into my patients' long-term goals that living a longer, healthier life and discussing that lowering cholesterol medications can help them achieve those goals.

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Dr. Supple: I also like to present them with multiple medication options and describe the benefits of each. I obviously can't be there every day to make sure that a patient's actually taking their medication. So, I do want to be able to address any concerns that a patient has before they leave our office, so that I'm confident that they believe in the medication that they're taking. Then following up closely with your phone calls and lab work is a great way to make sure that patients are tolerating their medications and taking them as directed.

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Liz Olson: Dr. Supple, it's been great to talk with you today on this very important topic. I appreciate your time.

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Dr. Supple: Yeah, thank you so much for having me here today.

14:03-14:20

Liz Olson: This has been ASCVD perspectives. To learn more about managing ASCVD for yourself, a loved one or your patients, you can visit the American Heart Association's website, heart.org/quality for tools, resources and more. I'm Liz Olson with the American Heart Association. Thank you for listening.

14:21-15:00

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