Pharmacy Pearls

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2026 ACC/AHA/Multisociety Guideline on the Management of Dyslipidemia: Key Updates

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The **2026 guideline** shifts lipid management toward an **earlier, lower, and longer** approach to reducing lifetime ASCVD risk. Use **PREVENT-ASCVD** for contemporary risk estimation, reintroduce **LDL-C/non-HDL-C goals**, and assess **Lp(a)** at least once.

WHAT CHANGED FROM THE 2018 CHOLESTEROL GUIDELINE?

#1: 10-year PREVENT-ASCVD replaces the Pooled Cohort Equations (PCE)

For primary prevention (age 30–79; LDL-C 70-189 mg/dL), 10-year PREVENT-ASCVD risk categories: low, borderline, intermediate, high

#2: Treatment goals are back

LDL-C and non-HDL-C goals guide therapy in addition to achieving the expected percentage LDL-C reduction

#3: Measure Lp(a) at least once in adulthood

Lp(a) measurement is recommended at least once in adulthood for ASCVD risk assessment. Elevated Lp(a) should prompt more intensive management of modifiable ASCVD risk factors.

#4: Refine risk when needed

ApoB and selective CAC scoring can identify residual or subclinical risk when the standard lipid panel or initial risk estimate may not fully capture ASCVD risk

#1: 10-year PREVENT-ASCVD replaces PCE

LOW RISK <3%	BORDERLINE RISK 3% to 5%	INTERMEDIATE RISK 5% to 10%	HIGH RISK ≥10%
Lifestyle modification	Consider moderate intensity statin*	At least moderate intensity statin	High intensity statin

*After clinician-patient discussion; consider risk enhancers/CAC when treatment decision is uncertain

High-intensity Statin	Moderate-intensity Statin
Atorvastatin 40-80 mg	Atorvastatin 10-20 mg
Rosuvastatin 20-40 mg	Rosuvastatin 5-10 mg
	Simvastatin 20-40 mg
	Pravastatin 40-80 mg

#2: Treatment goals are back

Primary-prevention risk group	LDL-C goal	Non-HDL-C goal
Borderline or intermediate (3% to <10%)	<100 mg/dL	<130 mg/dL
High (≥10%)	<70 mg/dL	<100 mg/dL
Clinical ASCVD - very high risk*	<55 mg/dL	<85 mg/dL

*Most adults with clinical ASCVD are expected to meet very-high-risk criteria; those with ASCVD who are not very high risk have an LDL-C goal of at least <70 mg/dL.

#3: Measure Lp(a) at least once	#4: Refine risk when needed	

Lipoprotein(a) (Lp(a))	Apolipoprotein B	Coronary Artery Calcium (CAC)
• Risk-enhancing: ≥125 nmol/L (50 mg/dL) • Higher values confer greater risk (i.e., ≥250 nmol/L (100 mg/dL) is associated with ≥2-fold estimated risk) • Screen first-degree relatives when FH, premature ASCVD, or elevated Lp(a) is present	• Useful after LDL-C/non-HDL-C goals are met when residual lipoprotein risk is suspected • Especially helpful with triglycerides >200 mg/dL, diabetes, or achieving an LDL-C <70 mg/dL • Can uncover risk underestimated by a standard lipid panel	• Use selectively when treatment decisions remain uncertain • Can improve risk assessment in men ≥40 years and women ≥45 years • Can help reclassify ASCVD risk **CAC = 0 → May defer LLT in select patients** **CAC >0 → Initiate LLT** **CAC ≥100 or ≥75%ile → LLT Recommended**

SCREENING

AGE ≥2	AGE 9-11	AGE 19+
Targeted screening if a first- or second-degree relative has premature ASCVD, severe hypercholesterolemia, or FH	Universal pediatric lipid screening if not previously tested	Universal adult screening, at least every 5 years

SECONDARY PREVENTION

VERY HIGH-RISK ASCVD
Treatment goals
≥50% LDL-C reduction
LDL-C <55 mg/dL
Non-HDL-C <85 mg/dL

Very high-risk ASCVD includes:

- Multiple major ASCVD events
  OR
- 1 major ASCVD event plus multiple high-risk conditions (e.g., age >65 years, prior revascularization, current smoking, diabetes, heart failure, hypertension, or LDL-C >100 mg/dL despite maximally tolerated statin + ezetimibe)

Most adults with clinical ASCVD are expected to meet these criteria

CHECK REGULARLY + TREAT LONGER

1 START / ADJUST	2 RECHECK	3 MAINTAIN	4 ADDRESS TG
Begin or intensify lipid-lowering therapy based on risk, goals, tolerance, and shared decision-making.	Repeat lipids 4-12 weeks after therapy initiation or a dose change.	Once stable, monitor approximately every 6-12 months.	Statins remain the foundation for ASCVD risk reduction; pancreatitis prevention may require TG-lowering therapy, especially for TG ≥1000 mg/dL