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Statin Provider Reference

Separating **Truth** *from* **Myth**

For high risk patients, statin medications are very effective in reducing cardiovascular morbidity and mortality. However, providers report barriers to statin prescribing including patient resistance, effective rechallenge strategies and visibly documenting therapy failures.

Network Health aims to assist you in addressing these barriers through the information and communication strategies outlined in the Statin Provider Reference, such as the following.

1. Responses to commonly encountered statin misconceptions
2. Patient-centered rechallenge strategies
3. Detailed information regarding the Statin Use in Persons with Diabetes (SUPD)
4. Links to Statin Therapy for Patients with Cardiovascular Disease (SPC) and Statin Therapy for Patients with Diabetes (SPD) quality measures
5. Recognized statin exclusions
6. How to visibly document therapy failures

Overcoming Statin Misconceptions

It's estimated that 50% of patients stop taking their statin medication within a year of starting.[1] Overdramatized concerns and myths spread through media, the internet and laypeople are likely to contribute to the issue of statin discontinuation or even hesitancy to start a statin. However, in most situations, the benefits of statin therapy far outweigh the risks and having this discussion with the patient can play an important role in their willingness to start and remain adherent to a statin medication.

Myth #1

Statins are all hype with little benefit

Statins are one of the most valuable medications on the market in terms of the health benefits they provide. In comparison to other cardiovascular health medications such as aspirin, statins provide greater benefits with few side effects. Data show that statins are highly cost effective for patients with risk factors for cardiovascular disease, representing an overwhelming return on investment.[2]

Current statistics suggest that amongst statin users taking this medication for 4-5 years:

For those with existing cardiovascular disease:

One cardiovascular event is prevented for every **20** patients treated[1]

One death is prevented for every **50** patients treated[3]

For those without existing cardiovascular disease:

One cardiovascular event is prevented for every **50** patients treated[1]

One death is prevented for every **200** patients treated[3]

Myth #2

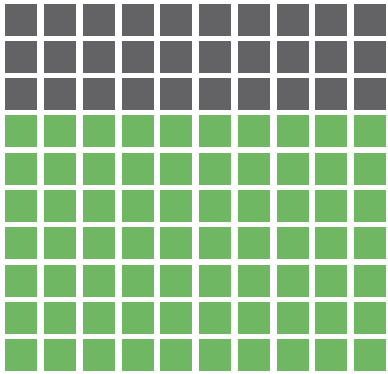
Statins will cause muscle pain

While some statin users experience muscle discomfort, for most there is a statin they can tolerate. Rhabdomyolosis is rare, occurring in only 1 of 23,000 statin users.

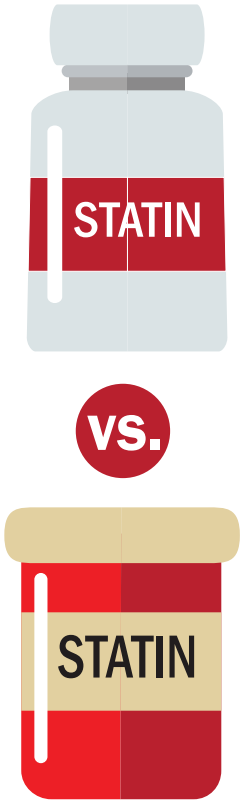
Statins are a heterogenous group of drugs and occurrence of myalgia is influenced by dose, drug interactions and lipophilicity. Higher doses, lipophilic statins and certain drug interactions are associated with higher incidence of muscle pain. Dose reduction, switch to a hydrophilic statin like rosuvastatin or pravastatin, or discontinuation of medications that interact with statins may reduce or eliminate myalgias.[4]

Educating patients about potential muscle pain when starting a statin has been shown to increase the likelihood of experiencing that side effect. Emphasize the important benefits and the options to address muscle pain if it occurs.

Here is a helpful resource to manage mayalgias and find a tolerable statin regimen.



Over 70% of statin users that experience muscle symptoms will ultimately tolerate a statin.[1]

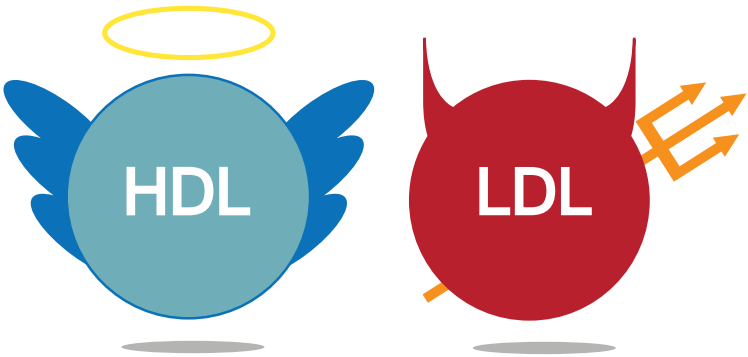


Myth #3

Statins aren't needed if lipid levels are OK

The beneficial effects go beyond lowering lipid levels and they should be prescribed for certain populations even if there is no underlying hyperlipidemia diagnosis.

Current guidelines recommend that patients with diabetes between the age of 40 – 75 years be on statin therapy regardless of pre-treatment lipid levels[2] due to their high risk of cardiovascular disease. For those older than 75 years of age, a decision to continue or initiate a statin should be individually tailored based on their concurrent medical conditions and life expectancy.



Beyond their positive effects on HDL and LDL, the benefits of statins include stabilization of atherosclerotic plaques, reduction of oxidative stress and inhibition of the inflammatory response, among others.[5]

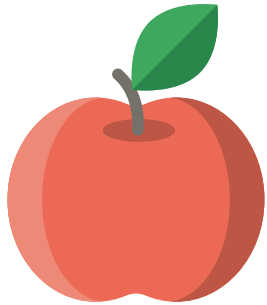
Myth #4

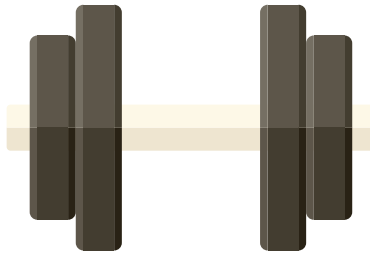
Statins will cause diabetes

In a Lancet review article, it is estimated that there are **50-100 new cases** of diabetes for every **10,000 patients** treated with a statin for **5 years**[6], far fewer compared to the 1/50 deaths prevented by statin use in patients with known cardiovascular disease and the 1/50 cardiovascular events prevented in those without.

The individuals who developed diabetes while on a statin were those with pre-diabetes who were already on the trajectory to develop diabetes with or without statin use.

Diabetes isn't prevented by withholding statin therapy. You can use this opportunity to educate your patient about lifestyle changes that help to prevent diabetes such as proper nutrition, exercise and maintaining a healthy weight.



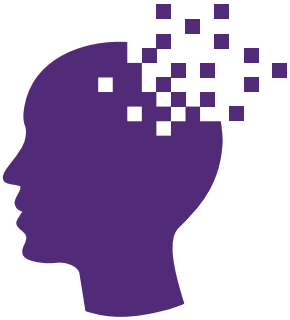


Myth #5

Statins will cause dementia

While anecdotal reports of memory loss may exist, there is no demonstrated link between statin use and the development of dementia.

On the other hand, several studies have suggested an estimated relative risk reduction of dementia in patients taking statins between **15 – 40%**, giving additional credence to the benefits of statins.[7]



The Heart Protection Study showed a **25% reduction in stroke risk** among patients with coronary artery disease, other occlusive arterial disease or diabetes when taking Simvastatin 40mg daily.[8]

Preventing stoke and TIAs can help preserve cognitive function.

If a patient experiences cognitive or memory impairment, it is reasonable to offer a different statin agent, but it is unlikely that the statin was indeed the underlying cause.

Speaking with patients in percentages and statistics may be difficult in getting across the benefit of statins and the limited risk of side effects. Instead, consider focusing on what is important to the patient and developing a strategy with them to help achieve their goals. Emphasizing the importance of a healthy diet, exercise, and appropriately prescribed medications, including statins, can help them maintain and preserve their quality of life.

Truth

Statin Rechallenge Strategies

Joint patient-provider decision making may be helpful when deciding what statin rechallenge strategy to use.

Including patient education emphasizing statin's vital impact on longevity and quality of life by avoiding heart attack and stroke may also be helpful.

Small doses can still provide protective benefits

Decrease daily dose by splitting tablets and/or adjusting frequency, such as 1 – 3 times a week. Several studies showed statins at low doses or reduced frequencies are tolerated in about 70% of all subjects. The studies also demonstrated that these patients can still reap the benefits of statins, with an average **LDL cholesterol reduction of about 34%**.[9]

Start at a low dose and slowly titrate dosage up as tolerated.

Trial of alternative statin

Although all statins function in the same way to lower cholesterol, **there are differences in the way they are distributed throughout the body**. Hydrophilic statins, like pravastatin and rosuvastatin, are less likely to penetrate muscle tissue and cause myalgias. Lipophilic statins are more likely to penetrate muscle tissue and can be associated with a higher incidence of muscle pain.

In the PRIMO study, fluvastatin XL was associated with the lowest rate of muscular symptoms. See the below algorithm published in the PRIMO study to help with alternative statin decision making.[10]

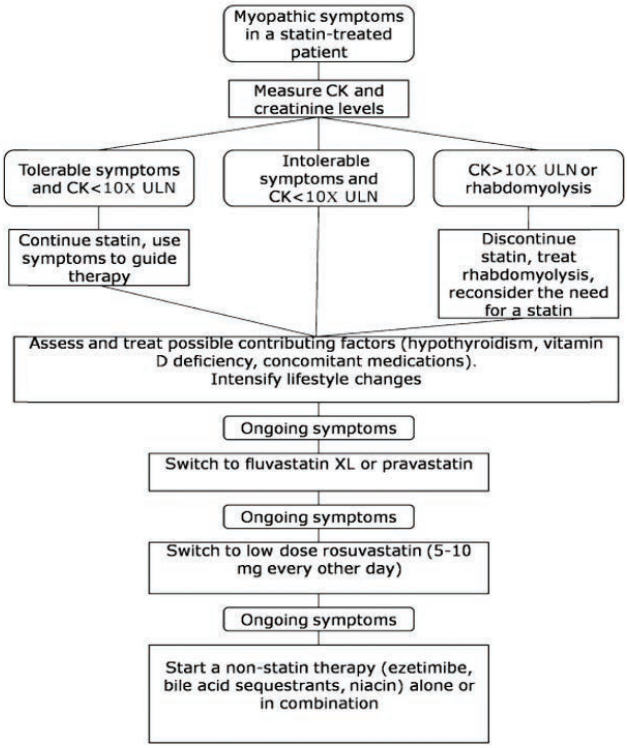


Figure 1—*Proposed algorithm for the management of statin-associated myopathy. ULN, upper limit of normal.*

Coenzyme Q10 supplementation

Some clinical research shows taking Coenzyme Q10 100mg daily reduces pain intensity with statin-induced myalgia. However, not all studies show benefit. **A 30-day trial of Coenzyme** Q10 100 mg daily may be an option to improve statin tolerance.[9]

Documenting Statin Failure, Intolerance or Other Exclusions

The Pharmacy Quality Alliance (PQA) Statin Use in Persons with Diabetes (SUPD) quality measure evaluates the percentage of Medicare members 40-75 years of age with diabetes who take any statin at any dose intensity level. Members are included in this measure when they have been dispensed at least two diabetes medication fills in the measurement year, unless the patient meets exclusion criteria.

If a patient has a qualifying exclusion, this must be documented, coded and billed on an annual basis.

A full list of ICD-10 codes that are considered exclusions for the SUPD measure is located **here**.

For patients with a statin allergy or intolerance documented in their allergy list, be sure to capture the ICD-10 exclusion codes in the problem list as well to facilitate annual re-documentation as a visit code.

2026 CMS Memo SUPD updates: CMS will add a denominator exception for those beneficiaries with diabetes who do not have a prescription claim for a statin but do have one or more prescription claim(s) for either a proprotein convertase subtilisin/Kexin type 9 (PCSK9) inhibitor or bempedoic acid. The SUPD denominator exception was added by the measure steward, PQA, to align with the 2024 American Diabetes Association (ADA) Standards of Care in Diabetes.

Health Effectiveness Data and Information Set (HEDIS®) Statin Therapy for Patients with Diabetes and Cardiovascular Disease (SPD/SPC) and SPC Quality Measure Definitions with Exclusions

To find details of these and other HEDIS quality measure definitions and exclusions visit: **HEDIS 101 Reference Guide (networkhealth.com)**

Notes

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