2. METHODS

2.1. Background

In 2013, the ACC launched "LDL: Address the Risk" as a multistakeholder quality initiative designed to improve patient outcomes by driving awareness of gaps in lipid management and the importance of managing LDL-related risk. On September 16, 2015, the second LDL: Address the Risk Think Tank was convened to bring together expert clinicians along with a broad set of stakeholders from patient advocacy groups, health plans, pharmacy benefit managers, drug manufacturers, electronic health record vendors, and health systems to discuss the newest developments in management of dyslipidemia and to consider implications for the care of high-risk patients with dyslipidemia. Participants in this LDL: Address the Risk Think Tank identified the need for expert consensus guidance regarding the incorporation of nonstatin therapies (ezetimibe and PCSK9 mAbs) into treatment strategies for higher-risk patients as a critical gap in clinical care. The 2017 ACC nonstatin ECDP was subsequently published and helped to inform the 2018 AHA/ACC/multisociety cholesterol guideline.[6,7] With the rapid development and commercial availability and changes in pricing and access to newer nonstatin agents (bempedoic acid, evinacumab, and inclisiran), the ACC convened this writing committee for the 2022 ACC Expert Consensus Decision Pathway on the Role of Nonstatin Therapies for LDL-Cholesterol Lowering in the Management of Atherosclerotic Cardiovascular Disease Risk to provide guidance for implementation of these newer nonstatin therapies.

2.2. Process

The ACC and the Solution Set Oversight Committee recognize the importance of avoiding real or perceived relationships with industry (RWI) or other entities that may affect clinical policy. The ACC maintains a database that tracks all relevant relationships for ACC members and persons who participate in ACC activities, including those involved in the development of ECDPs. ECDPs follow ACC RWI policy in determining what constitutes a relevant relationship, with additional vetting by the Solution Set Oversight Committee.

ECDP writing groups must be chaired or cochaired by an individual with no relevant RWI. Although vice chairs and writing group members may have relevant RWI, they must constitute less than 50% of the writing group. Relevant disclosures for the writing group and comprehensive disclosures for external peer reviewers can be found in Appendixes 1 and 2. To ensure complete transparency, a comprehensive list of disclosure information for the writing group, including relationships not pertinent to this document, is available in a Supplemental Appendix. Writing committee members are discouraged from acquiring relevant RWI throughout the writing process.

The writing committee began its deliberations by endorsing the construct of the 4 patient management groups identified by the 2018 AHA/ACC/multisociety cholesterol guideline (see **Figure 1**).[2] The writing committee then considered the potential for net ASCVD risk-reduction benefit of the use or addition of nonstatin therapies in each of the 4 groups. Within each of these groups, higher-risk subgroups were considered separately, given the potential for differences in the approach to combination therapy in each of these unique groups.

Lifestyle intervention: In agreement with the 2013 ACC/AHA and 2018 AHA/ACC/multisociety cholesterol guidelines, for all patient groups, the current consensus emphasizes that lifestyle modifications (ie, adherence to a heart-healthy diet, regular exercise habits, avoidance of tobacco products, and maintenance of a healthy weight) remain critical components of ASCVD risk reduction, both before and in concert with the use of cholesterol-lowering drug therapies. Dietary adjuncts for lowering atherogenic cholesterol may also be considered for patients with dyslipidemia, including phytosterols and viscous soluble dietary fibers.[28] In addition, referral to a registered dietitian (RD)/registered dietitian nutritionist (RDN) may be considered to improve understanding of heart-healthy dietary principles and individualize nutrition recommendations. Adherence to lifestyle modifications should be regularly assessed at the time of initiation or modification of statin therapy and during monitoring of ongoing therapy. As this ECDP specifically addresses considerations for the incorporation of nonstatin therapies in selected high-risk patient populations, it is critical that the clinician assess and reinforce adherence to intensive lifestyle changes before the initiation of these additional agents. The reader is referred to the 2021 Dietary Guidance to Improve Cardiovascular Health: A Scientific Statement from the American Heart Association and the 2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease: Executive Summary: A Report of the ACC/AHA Task Force on Clinical Practice Guidelines for comprehensive recommendations.[29,30]

Monitoring of response to LDL-C–lowering therapies: In agreement with the 2013 ACC/AHA and 2018 AHA/ACC/multisociety guidelines, the writing committee recommends the use of an initial fasting lipid panel (total cholesterol, triglycerides, HDL-C, and LDL-C), followed by