# Cholesterol medication list

Lipid-lowering drug classes, statin intensity and safety, and a patient therapy record

Page 1 is the class reference. Page 2 sets statin intensity by dose and the interactions and monitoring that go with it. Page 3 is the patient record, including the trial history payers ask for at prior authorization.

## 1. LIPID-LOWERING DRUG CLASSES

| CLASS AND MECHANISM | GENERIC (BRAND) | DOSE RANGE | LDL-C REDUCTION | INDICATION |
|---|---|---|---|---|
| **Statins** Block HMG-CoA reductase, so the liver makes less cholesterol and pulls more LDL from the blood | **Atorvastatin (Lipitor), rosuvastatin (Crestor), simvastatin (Zocor), pravastatin (Pravachol), lovastatin (Altoprev), fluvastatin (Lescol XL), pitavastatin (Livalo)** | See page 2. Doses run from simvastatin 10 mg to atorvastatin 80 mg and rosuvastatin 40 mg | 18–63% by drug and dose | First line. Clinical ASCVD, LDL-C 190 mg/dL or above, diabetes at ages 40–75, and primary prevention by calculated risk |
| **Cholesterol absorption inhibitor** Blocks NPC1L1 uptake in the small intestine | **Ezetimibe (Zetia)** | 10 mg once daily | 13–20% alone; about 20–25% added to a statin | The usual first add-on when a statin alone misses the LDL-C target, and an option in statin intolerance |
| **PCSK9 monoclonal antibodies** Bind PCSK9 so LDL receptors are recycled rather than degraded | **Alirocumab (Praluent), evolocumab (Repatha)** | Alirocumab 75–150 mg SC every 2 weeks, or 300 mg every 4 weeks. Evolocumab 140 mg SC every 2 weeks, or 420 mg monthly | 50–60% | Clinical ASCVD or familial hypercholesterolemia when maximally tolerated statin and ezetimibe fall short |
| **siRNA against PCSK9** Silences hepatic PCSK9 mRNA before the protein is made | **Inclisiran (Leqvio)** | 284 mg SC at baseline, again at 3 months, then every 6 months | About 50% | Adjunct in ASCVD or familial hypercholesterolemia. Twice-yearly dosing suits a patient who will not self-inject |
| **ATP citrate lyase inhibitor** Blocks cholesterol synthesis upstream of HMG-CoA reductase; activated only in the liver, not muscle | **Bempedoic acid (Nexletol); with ezetimibe (Nexlizet)** | 180 mg once daily; 180/10 mg as the combination | 17–18% alone; about 38% with ezetimibe | Statin intolerance, and as an adjunct. Carries a cardiovascular risk-reduction indication. Lowers uric acid in some patients but raises it in others |
| **Bile acid sequestrants** Bind bile acids in the gut, forcing the liver to use cholesterol to replace them | **Cholestyramine (Prevalite), colesevelam (Welchol), colestipol (Colestid)** | Cholestyramine 4–16 g/day; colesevelam 3.75 g/day; colestipol 2–16 g/day | 15–30% | Adjunct where a statin is not tolerated. Raises triglycerides, so avoid when they are already high |
| **Fibrates** PPAR-alpha agonists that clear triglyceride-rich particles | **Fenofibrate (Tricor, Trilipix), gemfibrozil (Lopid)** | Fenofibrate 48–145 mg daily; gemfibrozil 600 mg twice daily | Variable, and LDL-C can rise | Severe hypertriglyceridemia, mainly to prevent pancreatitis. Lowers triglycerides 30–50% |
| **Omega-3 fatty acids** Reduce hepatic VLDL assembly and secretion | **Icosapent ethyl (Vascepa), omega-3-acid ethyl esters (Lovaza)** | Icosapent ethyl 2 g twice daily; omega-3-acid ethyl esters 4 g daily | Minimal | Triglycerides of 500 mg/dL or above. Icosapent ethyl also reduces cardiovascular events on top of a statin |
| **Niacin** Reduces hepatic triglyceride synthesis and VLDL release | **Extended-release niacin (Niaspan), immediate-release (Niacor)** | 500–2,000 mg at bedtime, titrated slowly | 5–20% | Not recommended for routine cardiovascular risk reduction. Two large trials found no added benefit on top of a statin, with more harm |
| **Combination products** Two mechanisms in one tablet | **Ezetimibe / simvastatin (Vytorin), bempedoic acid / ezetimibe (Nexlizet), amlodipine / atorvastatin (Caduet)** | Vytorin 10/10 to 10/40 mg; Nexlizet 180/10 mg | As for the components combined | Fewer tablets where a patient already needs both agents. Check the statin component against the interactions on page 2 |

Homozygous familial hypercholesterolemia has its own agents, which sit outside the ten classes above: lomitapide (Juxtapid), an MTP inhibitor, and evinacumab (Evkeeza), an ANGPTL3 antibody given by infusion. Both are restricted to that diagnosis.

## 2. STATIN INTENSITY BY DOSE

| INTENSITY | DRUG AND DAILY DOSE |
|---|---|
| **High**<br>LDL-C down 50% or more | Atorvastatin 40–80 mg • Rosuvastatin 20–40 mg |
| **Moderate**<br>LDL-C down 30–49% | Atorvastatin 10–20 mg • Rosuvastatin 5–10 mg • Simvastatin 20–40 mg • Pravastatin 40–80 mg • Lovastatin 40–80 mg • Fluvastatin XL 80 mg • Fluvastatin 40 mg twice daily • Pitavastatin 1–4 mg |
| **Low**<br>LDL-C down less than 30% | Simvastatin 10 mg • Pravastatin 10–20 mg • Lovastatin 20 mg • Fluvastatin 20–40 mg |

Three traps worth checking before you write the dose. **Rosuvastatin 5 mg and atorvastatin 10 mg are moderate intensity, not high** — the drug name does not set the band, the dose does. **Pitavastatin never reaches high intensity** at any approved dose. And **simvastatin 80 mg** is restricted to patients who have already taken it for 12 months without muscle injury. Bands as defined by the ACC/AHA dyslipidemia guideline; the 2026 revision keeps the 2018 thresholds.

## KEY INTERACTIONS TO SCREEN BEFORE PRESCRIBING

| COMBINATION | WHAT HAPPENS | WHAT TO DO |
|---|---|---|
| **Simvastatin or lovastatin + strong CYP3A4 inhibitors** (clarithromycin, erythromycin, itraconazole, ketoconazole, posaconazole, voriconazole, HIV protease inhibitors, cobicistat, nefazodone) | Statin levels rise sharply, and with them the risk of rhabdomyolysis | Contraindicated. Switch the antibiotic, or hold the statin for the course |
| **Simvastatin + verapamil, diltiazem or dronedarone** | Moderate rise in simvastatin exposure | Cap simvastatin at 10 mg daily. With amiodarone, amlodipine or ranolazine, cap it at 20 mg |
| **Any statin + gemfibrozil** | Myopathy risk rises well above that of either drug alone | Avoid the pairing. Use fenofibrate when a fibrate is needed alongside a statin |
| **Rosuvastatin + cyclosporine or gemfibrozil** | Transporter inhibition raises rosuvastatin levels | Cap rosuvastatin at 5 mg with cyclosporine, and at 10 mg with gemfibrozil |
| **Bempedoic acid + simvastatin or pravastatin** | Simvastatin exposure roughly doubles; pravastatin rises about 1.5-fold | Avoid simvastatin above 20 mg and pravastatin above 40 mg |
| **Bile acid sequestrants + levothyroxine, digoxin, warfarin, fat-soluble vitamins** | The resin binds the other drug in the gut and absorption drops | Separate doses by at least 4 hours. Colesevelam interacts least |
| **Fibrates + warfarin** | INR rises | Check INR within a week of starting or stopping, and adjust the warfarin dose |
| **Ezetimibe + cyclosporine** | Both drug levels rise | Monitor cyclosporine levels and liver function |
| **Statins + azithromycin** | Negligible CYP3A4 inhibition | No change needed. This is the macrolide to reach for when a statin must continue |

## MONITORING

**Lipid panel — 4 to 12 weeks.** Repeat 4 to 12 weeks after starting therapy or changing a dose, to confirm both the response and that the patient is taking it. Then every 3 to 12 months once stable.

**ALT — at baseline only.** Measure hepatic transaminases before the first statin dose. Routine periodic liver testing is no longer recommended, so repeat only if the patient develops symptoms such as unusual fatigue, abdominal pain, jaundice or dark urine.

**Creatine kinase — only if symptoms appear.** Do not order it routinely. Measure CK when a patient reports muscle pain, tenderness, weakness or cramping, and take a baseline only in patients already at raised risk of muscle events.

**Worth adding by agent.** Uric acid on bempedoic acid, which also carries a tendon rupture warning. Triglycerides on a bile acid sequestrant, which pushes them up. HbA1c or fasting glucose on a statin, which modestly raises the chance of new-onset diabetes without outweighing the cardiovascular benefit.

## 3. PATIENT LIPID THERAPY RECORD

Patient name: _____ Date of birth: _____ mm / dd / yyyy

MRN: _____ Date of review: _____ mm / dd / yyyy

Risk category: _____ LDL-C goal (mg/dL): _____

### Lipid results

| DATE | TOTAL CHOLESTEROL | LDL-C | HDL-C | TRIGLYCERIDES | NON-HDL-C |
|---|---|---|---|---|---|
| | | | | | |
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All values in mg/dL. Non-HDL-C is total cholesterol minus HDL-C, and needs no fasting sample.

### Current agents

| DRUG (GENERIC / BRAND) | DOSE AND FREQUENCY | START DATE | INDICATION OR TARGET |
|---|---|---|---|
| | | | |
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| | | | |
| | | | |

### Agents tried and stopped

Record every agent the patient has come off, and why. Payers ask for this at prior authorization: approval for a PCSK9 inhibitor or inclisiran usually turns on documented trials of statins at an adequate dose, with the dates and the reason each one ended.

| AGENT | DOSE REACHED | DATES (FROM – TO) | REASON STOPPED | DOCUMENTED BY |
|---|---|---|---|---|
| | | | | |
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Reasons to choose from: muscle symptoms with or without raised CK, raised transaminases, inadequate LDL-C response at the maximum tolerated dose, drug interaction, patient preference, cost or coverage.

### Next review

Next lab due: _____ mm / dd / yyyy Tests requested: _____

Clinician signature | Printed name and role | Date

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