Description of Adherence, Switches, and Discontinuations Among Statin Users in a Regional Medicare Health Plan

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Objective

To describe utilization patterns and adherence to statins within a regional Medicare health plan.

Background

• Statin therapy is the current standard of care for patients with hypercholesterolemia or at high risk for cardiovascular disease.
• High-intensity statin therapy, defined as atorvastatin 40 to 80 mg or rosuvastatin 20 to 40 mg, is recommended as first-line treatment for high-risk patient groups.
• Two novel injectable LDL-lowering monoclonal antibodies, PCSK9 inhibitors, alirocumab and evolocumab, have been recently FDA-approved for use in patients with clinical atherosclerotic cardiovascular disease or hereditary hypercholesterolemia who require additional lowering of LDL cholesterol despite maximally tolerated statin therapy.
• Poor adherence or inability to tolerate statins can lead to less than optimal LDL cholesterol control and an increase in overall mortality.
• Furthermore, the Centers for Medicare and Medicaid Services (CMS) have incorporated adherence to cholesterol lowering medications into their Part D Medicare Health and Drug Plan Quality and Performance Ratings (STAR ratings).

Methods

• In this retrospective analysis, pharmacy claims of patients of one regional Medicare plan (approximately 150,000 total covered lives) were reviewed.
• Continuously enrolled patients with at least one claim for a statin between January 1, 2013 and December 31, 2014 were identified.
• Pharmacy claims data were collected for identified patients to determine adherence (using proportion of days covered [PDC] method), number of patients switching statin potencies, statin intolerance, and discontinuations.
• Potency was defined based on the ATP-IV guideline definitions.
• A switch was defined as a change in statin potency.
• Discontinuation was defined as patients who had greater than a 90 day gap in therapy with no statin fills during the remainder of the measurement period.
• New starts were defined as patients who received a first fill of a statin 90 days or later after the first start of the measurement period.
• Potential statin intolerance was defined as patients who tried at least 2 low potency statins with last fill being a low potency statin.
• Results were analyzed using descriptive statistics.

Results

• A high proportion of patients are unable to maintain a PDC of 80% or higher which may potentially increase their risk of not meeting LDL-C treatment goals. Additional LDL-lowering therapy (such as a PCSK9 inhibitor) may be inappropriately prescribed for these patients without first addressing adherence.
• The 17% of patients who discontinued statin therapy may be a part of the patient pool who seek further treatment with PCSK9 inhibitors. However only 0.2% of statin users in this population would meet suggested criteria for statin intolerance based on guideline-recommended diagnostic protocols, which includes requiring patients to try at least 2 low-intensity statins with the last fill being a low potency statin.
• Of the patients who discontinued statin treatment 0.7% had a last fill of a low-intensity statin suggesting that many patients are not following recommended protocols to determine statin intolerance before discontinuing therapy.
• Limitations of this study include:
  • Patient history and progress notes were unavailable to identify reasons for choice of statin therapy, reason for switches, or possible clinical explanations for poor adherence.
  • True reason for discontinuation is unknown. Pharmacy claims alone cannot determine if reason for discontinuation was due to statin intolerance or alternative reason.
  • This study was limited to a Medicare population. Results for adherence and statin intolerance would likely differ for a commercial population.

Disclosures

• This research was conducted by Magellan Rx Management, Newport, RI, without external funding.

References

• Glader RL, Spiller L, Eriksen M, Lundberg M. Persistent use of secondary preventive drugs declines rapidly during the first 2 years after acute stroke. 2010;S2297–S2301.