AmeriHealth Caritas
District of Columbia

To: **AmeriHealth Caritas DC Adult Primary Care and Behavioral Health Providers**

Date: **November 13, 2020**

Subject: **Clinical Practice Guidelines Update—Human Immunodeficiency Virus (HIV) and Hyperlipidemia**

As a part of AmeriHealth Caritas District of Columbia's commitment to providing quality care to our enrollees, we are updating some of our Clinical Practice Guidelines (CPG) so that they are current with industry best practices. Please review the summaries of the updated guidelines.

Human Immunodeficiency Virus (HIV) (*DC Department of Health*, updated July 2019)

Clinical trials have shown that using effective antiretroviral therapy (ART) to consistently suppress plasma HIV RNA levels to <200 copies/mL prevents transmission of HIV to sexual partners. When ART is used to prevent HIV transmission, this strategy is called treatment as prevention (TasP), commonly known as Undetectable = Untransmittable or U=U.

The Panel on Antiretroviral Guidelines for Adults and Adolescents (the Panel) has added a new section to help providers integrate TasP into their clinical practice. The key recommendations include:

- Providers should inform persons with HIV that maintaining HIV RNA levels <200 copies/mL with ART prevents HIV transmission to sexual partners.
- Persons starting ART should use another form of prevention with sexual partners for at least the first 6 months of treatment and until an HIV RNA level of <200 copies/mL has been documented. Many experts recommend confirming sustained suppression before assuming that there is no risk of sexual HIV transmission.
- Persons with HIV who rely on ART for prevention need to maintain high levels of ART adherence. They should be informed that transmission is possible during periods of poor adherence or treatment interruption.
- Providers should inform patients that maintaining an HIV RNA level of <200 copies/mL does not prevent acquisition or transmission of other sexually transmitted infections.

For full guideline: https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/whats-new-guidelines

Hyperlipidemia Clinical Practice Guideline *(American College of Cardiology/ American Heart Association Taskforce on Clinical Practice Guidelines*, updated 2018)
Update Recommendations:

- In all patients, emphasize a heart-healthy lifestyle across the life course. A heart healthy lifestyle reduces atherosclerotic cardiovascular disease (ASCVD) risk at all ages.

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- In patients with clinical ASCVD, reduce low-density lipoprotein cholesterol (LDL-C) with high density statin therapy or maximally tolerated statin therapy. The more LDL-C is reduced on statin therapy, the greater will be subsequent risk reduction.
- In very high risk ASCVD, use a LDL-C threshold of 70 mg/dL (1.8 mmol/L) to consider addition of non-statins to statin therapy. Very high risk includes history of multiple major ASCVD events or one major ASCVD event and multiple high-risk conditions.
- In patients with severe primary hypercholesterolemia (LDL-C level ≥ 190 mg/dL), without calculating 10-year ASCVD risk, begin high-intensity statin therapy.
- In patients age 40-75 with diabetes mellitus and LDL-C ≥ 70 mg/dL, start moderate intensity statin therapy without calculating 10-year ASCVD risk.
- In adults age 40-75 without diabetes mellitus and LDL-C ≥ 70 mg/dL, at a 10-year ASCVD risk of ≥ 7.5%, start a moderate intensity statin if a discussion of treatment options favors statin therapy.
- In adults age 40-75 without diabetes mellitus and LDL-C ≥ 70 mg/dL to 189 mg/dL, at a 10 year ASCVD risk level of ≥ 7.5% to 19.9%, if a decision about statin therapy is uncertain, consider measuring Coronary Artery Calcium (CAC).
- Assess adherence and percentage response to LDL-C-lowering medications and lifestyle changes with repeat lipid measurements 4 to 12 weeks after statin initiation or dose adjustment, repeated every 3 to 12 months as needed.

For full guideline, visit: https://www.ahajournals.org/doi/10.1161/CIR.0000000000000624.