ZOOMRX

INTEGRATED ATU AND PCA PULSE CASE STUDY

Hyperlipidemia treatment decisions in 2026

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2026 has reset the hyperlipidemia conversation. A new ACC/AHA guideline brought back LDL-C goals and widened who qualifies for treatment. The first oral PCSK9 inhibitor reached the US market. A late-stage Lp(a) outcomes trial missed its primary endpoint, and Europe approved its first oral CETP inhibitor. For anyone following cardiovascular care, the practical question is whether these changes have reached the exam room yet. ZoomRx brand tracking, which pairs an awareness, trial and usage (ATU) survey with patient chart analysis (PCA), gives an early answer from the physicians making the decisions.

A practice-changing year

Four developments since March shape how physicians weigh advanced lipid-lowering options, and each one bears on a finding from the pulse.

DATE	WHAT HAPPENED	WHY IT MATTERS FOR TREATMENT DECISIONS
13 Mar 2026	2026 ACC/AHA dyslipidemia guideline. Brings back LDL-C goals (<100, <70 and <55 mg/dL by risk), replaces the Pooled Cohort Equations with PREVENT, and recommends measuring Lp(a) at least once. [2–5]	Sets explicit targets for escalation. Epic Research estimates that the share of adults without ASCVD eligible for lipid-lowering therapy rises from 41% to 55%. [3]
16 Jul 2026	FDA approves Merck's LIPFENDRA® (enlicitide), the first once-daily oral PCSK9 inhibitor. LDL-C fell 56% vs. placebo at week 24. The CORALreef Outcomes trial (>14,500 patients) is ongoing. [6] Reviewed in about 1 to 2 months under the FDA's new Commissioner's National Priority Voucher program, it launched at a list price of $315 a month before discounts, and Merck plans to sell it through the direct-to-patient TrumpRx program. [11]	Offers PCSK9 lowering without an injection, at roughly half the list price of other PCSK9 products. [11] Merck states that it is not yet known whether LIPFENDRA reduces cardiovascular events.
4 Sept 2026	Novartis reports that Lp(a)HORIZON missed its primary endpoint. Pelacarsen lowered Lp(a) in 8,323 patients with established CVD but did not reduce major adverse cardiovascular events. [7]	Lowering a biomarker did not translate into fewer events. That raises the evidence bar for every new agent, and it leaves LDL-C lowering as the main lever for patients with high Lp(a).
26 Sept 2026	EC approves obicetrapib (Ubeslo) and obicetrapib + ezetimibe (Evlarco) from NewAmsterdam and Menarini, oral CETP inhibitors that lowered LDL-C by up to ~40% and ~50% vs. placebo. The PREVAIL outcomes trial is ongoing. [8]	A second oral, non-statin class is now approved outside the US, a sign that the move toward pills extends beyond one brand.

The incumbents' evidence has moved too.



In VESALIUS-CV, evolocumab (Repatha) reduced major cardiovascular events in more than 12,000 high-risk patients with no prior heart attack or stroke, which extends its outcomes advantage into primary prevention. [9]



Amgen has also competed on price: since October 2025 it has offered Repatha directly to patients at about 60% below list price. [12] LIPFENDRA's lower list price and TrumpRx plan therefore enter a market where the leading injectable already has a discounted cash route.



AstraZeneca is also running a Phase III outcomes trial of its oral PCSK9 candidate, AZD0780. [10]

How ZoomRx measured it

The pulse ran from August 31 to September 9, 2026, about seven weeks after LIPFENDRA's approval. 46 US HCPs answered the awareness questions and 34 qualified for the main survey. Most were endocrinologists, cardiologists and family physicians in community practice. The ATU covered awareness, prescribing, stated priorities and expected switching. The PCA added 85 recent patient charts (25 LIPFENDRA®, 50 Repatha® and 10 Leqvio®) with each patient's lipid and risk picture, insurance, the alternatives considered and any patient request. HCPs also told each patient's story in their own words, and AI-moderated interviews probed trade-offs, access and switching. [1]

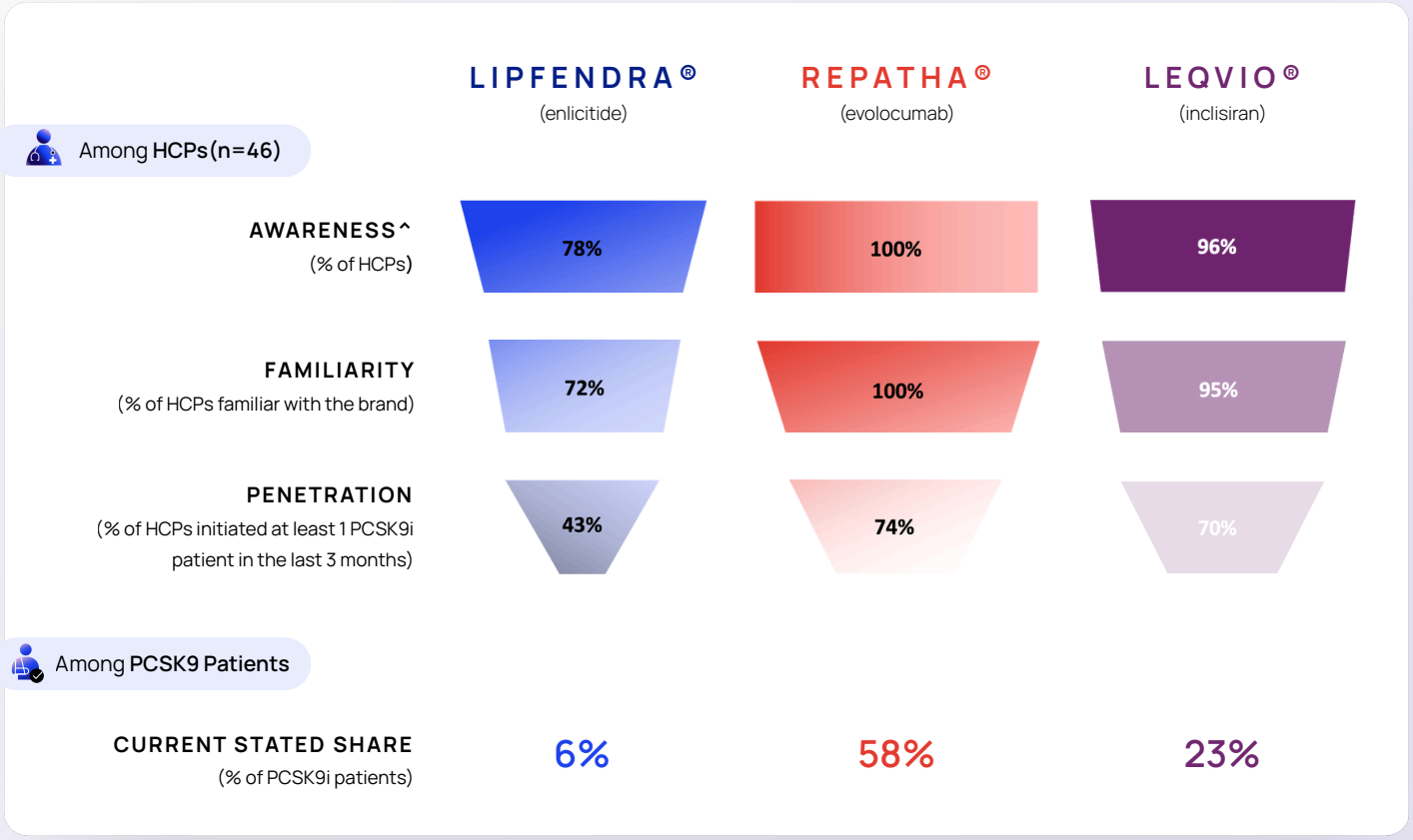
LIPFENDRA is a registered trademark of Merck Sharp & Dohme LLC. Repatha is a registered trademark of Amgen Inc. LEQVIO is a registered trademark of Novartis AG. ZoomRx is not affiliated with, and this paper is not sponsored or endorsed by, these companies.

What physicians are doing today

1. Clinical need opens the door, and the gap is wide by then

Escalation still starts with an LDL-C number. Mean LDL-C at the advanced therapy decision was 113 to 126 mg/dL across the three brands, against mean goals of 62 to 68 mg/dL. HCPs described goals of <55 to 70 mg/dL, in line with the guideline's thresholds for high-risk and very-high-risk patients. A cardiologist put it simply: the key need is "efficacy in lowering LDL." Patient preference or access settles which drug a patient gets, but only after the LDL-C gap has made the case for escalation. [1]

How to read: For **LIPFENDRA**, **78% are aware, 72% familiar and 43% have recently initiated a patient** - all based on the **same HCP base, not a successive funnel.** The **6% stated share** separately reflects recent PCSK9i-pathway patient starts.



- Beyond awareness, **Repatha** remains the **most confidently named treatment anchor**
- **LIPFENDRA** is increasingly **entering HCPs' escalation narrative**, but largely as **a conditional oral option for injection averse patients** or selected **primary-prevention patients**
- **Leqvio** remains a more **situational choice tied to adherence and access.**

Figure 1. (above) Awareness, familiarity and penetration share the same base of 46 HCPs and are not a successive funnel. The stated share separately reflects recent PCSK9i-pathway starts (n = 34). Source: ZoomRx pulse

2. Awareness arrived quickly; use is still selective

78% of HCPs were aware of LIPFENDRA, higher compared to ZoomRx's 67% benchmark for a top 10 manufacturer's launch at three months, and it got there in about seven weeks. 43% had started at least one patient. Even so, LIPFENDRA accounted for 6% of recent PCSK9i-pathway starts, against 58% for Repatha and 23% for Leqvio. Familiarity is also shallower: 67% of aware HCPs were extremely or very familiar with LIPFENDRA, compared with 97% for Repatha. An endocrinologist explained the hesitation: "I just need more familiarity with the drug and more experience with how patients respond." [1]

3. Patients are asking for a pill, not a brand

The charts show where demand for LIPFENDRA comes from. Of 25 LIPFENDRA patients, 18 (72%) had asked for an oral option or for the brand by name. Requests for "a pill" far outnumbered requests for LIPFENDRA itself (60% vs. 12%). Across all 85 charts, 39% of patients voiced a preference, and HCPs honored 28 of 33 of those requests (85%). One cardiologist recalled, "The patient had a preference for being on oral therapy. I had originally prescribed an injectable. The patient had no interest in it." [1]

ONE PATIENT'S PATH TO LIPFENDRA

WHO

A 61-year-old woman in high-risk primary prevention, with type 2 diabetes, hypertension and obesity.

WHERE SHE STOOD

LDL-C of 112 mg/dL against a goal of <70, despite a high-intensity statin plus ezetimibe.

WHY LIPFENDRA

She needed substantial additional lowering but strongly preferred not to inject herself.

THE PLAN

Keep her background therapy, add LIPFENDRA and recheck in about three months. An injectable PCSK9 inhibitor remains the fallback if she does not reach goal.

This is the widest gap between what HCPs say and what they do. In the ATU, HCPs gave patient preference about 1 of 100 importance points and route of administration about 7, against 25 for LDL-C lowering and 23 for outcomes evidence. In the charts, oral route was among the top reasons for 44% of LIPFENDRA choices. [1]



Figure 2. Stated priorities from 34 HCPs; brand-choice reasons from 25 LIPFENDRA, 50 Repatha and 10 Leqvio charts.
Source: ZoomRx pulse

4. The oral option is widening the pool

Most LIPFENDRA patients did not come off an injectable. HCPs said 77% of their LIPFENDRA starts had no prior PCSK9i-pathway therapy. Switches from PCSK9i-pathway therapy made up 23%, and in the charts, route or patient preference drove 5 of 6 switches from an injectable. Asked what each LIPFENDRA patient would otherwise have received, HCPs named Repatha for 17 of 25 and Leqvio for 4. LIPFENDRA patients were also younger than Repatha patients (mean age 53 vs. 60), more often in primary prevention (60%) and more often commercially insured (88%). [1]

5. Evidence and coverage set the ceiling

LIPFENDRA was considered but not chosen for 29 patients, and 20 of them went to Repatha. For 11 of those 20, the plan favored Repatha and LIPFENDRA would have cost the patient more; 8 of the 11 were on Medicare or Medicaid. 63% of HCPs (n = 27) said they want LIPFENDRA outcomes data to build confidence, especially in secondary prevention. As one put it, "If they have the cardiovascular trials, that's really where it will… become a huge hit." [1]

6. Stable injectable patients are staying put

Across 60 patients currently stable on Repatha or Leqvio, only 7% were rated very or extremely likely to be switched to LIPFENDRA within six months, and 43% were not at all likely. HCPs see no reason to disrupt a regimen that is working: LDL-C is at goal, the patient tolerates the injection, and the HCP knows the drug and its outcomes data. A switch usually needs a trigger, such as a patient asking for a pill, injection fatigue, a coverage change or LDL-C that stays above goal. These figures are expectations, not observed switches. [1]

Where practice and the 2026 guideline agree, and where they don't

The guideline was published four months before LIPFENDRA's approval, so it does not position an oral PCSK9 inhibitor. HCPs are fitting the new option into the guideline's framework on their own. Comparing the two shows five points worth watching.

WHAT THE 2026 GUIDELINE SAYS	WHAT THE PULSE SHOWS	WHAT IT MEANS
LDL-C goals return: <70 mg/dL for high-risk primary prevention and <55 mg/dL for very-high-risk ASCVD. [2,4]	HCPs set goals of <55 to 70 mg/dL; mean chart goals were 62 to 68 mg/dL.	Aligned. The targets are in use. The open question is how quickly patients are escalated to reach them.
Escalate faster and combine therapies. Ezetimibe is the first add-on, followed by a PCSK9 antibody, bempedoic acid or inclisiran. [5]	Patients arrived ~50 to 60 mg/dL above goal. 56% of LIPFENDRA patients were already on ezetimibe, and 52% of starts came straight from a statin with or without ezetimibe.	Partly aligned. LIPFENDRA enters at the same step as injectable PCSK9 therapy but has no named place in the sequence yet.
Favor therapies with outcomes evidence. The committee noted that inclisiran's outcomes trials are still ongoing. [4,5]	63% of HCPs want LIPFENDRA outcomes data; 5 of 20 losses to Repatha cited outcomes or more established data.	Aligned. HCPs apply the guideline's evidence bar, most strictly in secondary prevention.
Patient preference informs the add-on choice, e.g. inclisiran for patients who prefer infrequent dosing. [5]	Patient preference gets about 1 of 100 stated importance points, yet 72% of LIPFENDRA starts followed a request.	Gap. Preference shapes far more decisions than HCPs report, and the shift to oral is coming from patients.
Wider eligibility via PREVENT and a 3% risk threshold: 41% to 55% of adults without ASCVD, with gains concentrated among women and adults aged 70 to 79. [3]	LIPFENDRA is strongest in high-risk primary prevention (32% first choice for Type 2 vs. 18 to 21% in other types; 9% share) and among commercially insured patients.	Opportunity, with a catch. Growth is upstream, in primary prevention, where LIPFENDRA does best. But more of that pool will be Medicare patients, where LIPFENDRA most often lost on coverage, and Repatha now has primary-prevention outcomes data. [9]

The oral shift is real, but it is not yet brand loyalty

The pulse supports the industry view that patients would rather take a pill than inject, with one qualification: the pull is "I want a pill," not "I want LIPFENDRA." That distinction matters because the oral field is filling. Obicetrapib is now approved in Europe, alone and with ezetimibe, and AstraZeneca has an oral PCSK9 candidate in Phase III. [8,10] Today LIPFENDRA is the only oral PCSK9 inhibitor US physicians can prescribe, so it collects most of that demand. As other oral agents arrive, demand tied to the route rather than the brand will be open to competition.

What to watch next



Outcomes readouts.
CORALreef Outcomes for LIPFENDRA and PREVAIL for obicetrapib. HCPs named outcomes data as the trigger for broader use in secondary prevention.



Formulary coverage and direct-to-patient pricing.
Most of LIPFENDRA's access driven losses occurred in Medicare and Medicaid plans, and guideline driven eligibility is growing among older adults. Watch whether its lower list price wins formulary position, and how TrumpRx and Amgen's discounted direct Repatha offer change what patients pay.



Switching beyond patient requests.
Today a switch needs an active trigger. Watch whether HCPs start offering the pill to stable injectable patients unprompted.



Lp(a) testing and the next trials.
Whether universal testing changes escalation, and whether the remaining Lp(a) outcomes trials (lepodisiran, olpasiran, muvalaplin) succeed where pelacarsen did not. [7]



Obicetrapib in the US.
Whether the EU approval is followed by a US filing, which would give US patients a second oral option.

Why the ATU and PCA integrated approach matters

Neither method alone would have found these patterns. The ATU showed the market pattern and what HCPs say they value: broad awareness, low share and clinical priorities. The PCA showed what happened patient by patient, including the alternatives that lost and why. Together they separate three different reasons a therapy wins or loses (oral preference, affordability and confidence in the evidence) and show which patients each one applies to. For brand, market access and medical teams, that is the difference between knowing the share and knowing what would move it.

Talk to ZoomRx about a tailored ATU and PCA pilot wave.

Connect what physicians say about your brand with the patient decisions behind its use.

TAILOR AN ATU PILOT →

TAILOR A PCA PILOT →

Sources:

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ZoomRx is a life sciences consultancy combining primary pharmaceutical research, proprietary data infrastructure, and AI-enhanced analytics to help biopharma make commercial decisions faster. Trusted by 100+ leading biopharma companies across the world.

ZoomRx ATU tracks how HCP awareness, trial, and usage of a brand change over time. ZoomRx Patient Chart Audits show how HCPs treat their patients, based on real patient charts. Together, they connect what HCPs say with what they do in practice.

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