SPEAKER: I agree. It's a new world for PCSK9 inhibitors. And I think we've been waiting to get to this point. We're getting to the point where the drug was really, essentially, for people familial hypercholesterolemia, and now we have access to the wide swath of our patients who need aggressive LDL lowering. Because we've seen the tolerability of the drug. We've seen the safety of low LDLs.

And importantly, now we've seen cost reductions down to reasonable costs that are starting to match the cost effectiveness ratios that we see from multiple analyses, from ICER, from independent research groups. And we've seen at the AHA, Dr. [INAUDIBLE] presented from ODYSSEY OUTCOMES the cost effectiveness analysis based on the mortality results, coming to a cost that's right about what we're seeing in clinical-- where we can get our patients on in clinical practice right now. So finally, the cost is getting to a point where we can use this in a wide swath of patients.

Going for a drug, I guess, that perhaps we thought of as a niche drug that we'd only use in select patients who just really didn't have many other options, to now just a routine drug within our armamentarium, particularly for patients who can't get below their threshold, I would say, on statins and ezetimibe. Which is a number of patients-- something like 15% of patients at least in secondary prevention in our practices who, for reasons of statin intolerance, or just high LDL, or can't take another drug just can't get to where we need them to be. And PCSK9 is accessible, I think, in those patients now.

And I think we're going to see barriers fall in terms of preauths and things because of the cost reduction to a reasonable price. I said reasonable in the sense that I think a lot of us have been pushing for the prices that are now present in the marketplace, in the range of a lot of other drugs we use, frankly, in secondary prevention.

So in those patients, you find that the residual risk is from lipids. For example, the LDL is above 70 and maybe they're on a statin or ezetimibe or they can't take one of those two drugs. I think we don't need to twice about getting them on a PCSK9 inhibitor now, where we might have in the past.

So I think in 2018, 2019, it's just a different world for PCSK9 inhibitors just starting to enter, I guess, into our thinking for the average patient-- average secondary prevention patient. That's the way I approach the patients. Sometimes my patients need additional glucose lowering-- they're diabetic. Sometimes they need additional blood pressure lowering. But those patients that need additional lipid lowering, I think of PCSK9 inhibitors as one of our best options to get their LDL down very low.