

The Modern Era of Heart Failure Medication Management

A Pharmacist's Guide to Ambulatory HF Care — From Then to Now
Presented to the Montana State Association of Family Physicians

Mason Bowman, PharmD, BCACP

HEART FAILURE BY THE NUMBERS

- ~6.7 million Americans ≥20 years old have HF; Prevalence is rising
- **HFpEF now outweighs HFrEF as the predominant subtype**
- Annual mortality rate ~15% for HFpEF; higher for HFrEF
- HF patients are hospitalized ~1.4 times per year
- **Despite proven therapies, GDMT remains significantly underutilized**
 - Only ~1% of eligible HFrEF patients receive all 4 GDMT classes at target doses

Clinical inertia is the #1 physician-reported reason for not prescribing GDMT
"patient is clinically stable"

Disclosures

No disclosures



JCF Journal of Cardiac Failure



2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure

Heidenreich PA, et al. J Card Fail 2022.

<https://www.ahajournals.org/doi/full/10.1161/JCF.0000000000001063>

Objectives

- Compare ambulatory heart failure management before and after the 2022 AHA/ACC/HFSA HF Guideline
- Describe the "4 Pillars" of guideline-directed medical therapy (GDMT) for HFrEF and the expanded role of SGLT2 inhibitors across the HF spectrum
- Integrate relevant recommendations from the 2025 AHA/ACC Hypertension Guideline and the 2026 ACC/AHA Dyslipidemia Guideline into HF care
- Apply a longitudinal patient case to illustrate pharmacist-driven GDMT optimization
- Identify opportunities for interventions in ambulatory HF management

Classification & Trajectories of HF

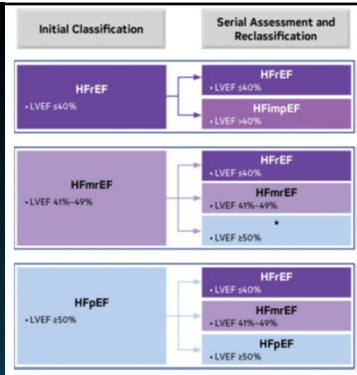
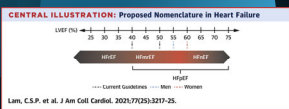
“Frank”

62-year-old rancher from Billings, Montana.

- **PMH:** HTN (20 yrs), T2DM (10 yrs), DLD, former smoker (quit 5 years ago), BMI 32
- **Medications:**
 - Lisinopril 20 mg daily
 - Metoprolol tartrate 50 mg BID
 - Metformin 1000 mg BID
 - Atorvastatin 40 mg daily
 - Hydrochlorothiazide 25 mg daily
 - Aspirin 81 mg daily
- **Presentation:** Progressive exertional dyspnea over 3 months, BLE, 2-pillow orthopnea. BP 148/92 mmHg, HR 88 bpm.
- **Labs:** BNP 680 pg/mL, SCr 1.3 (eGFR 58), K⁺ 4.2, HbA1c 7.8%, LDL-C 98 mg/dL
- **Echo:** LVEF 30%, moderate LV dilation, grade II diastolic dysfunction
- **Diagnosis:** Stage C HFrEF, NYHA Class III

Medication Managem

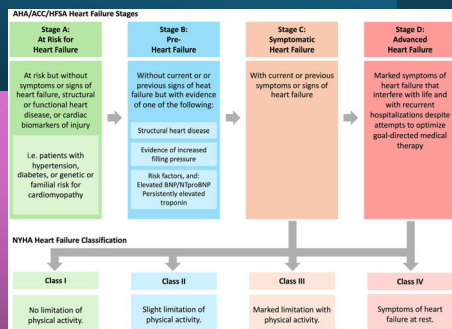
UPDATED HF CLASSIFICATION (2022)



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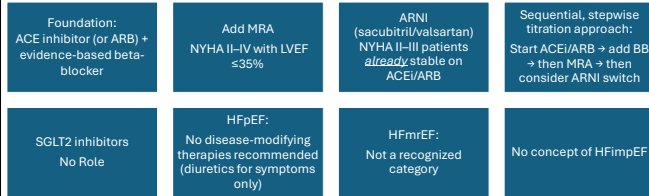
2013/2017 Guidelines

- Continue lisinopril (ACEi — Class I) ✓
- Switch metoprolol tartrate → metoprolol succinate (evidence-based BB — Class I)
- Add spironolactone 25 mg daily (MRA — Class I for NYHA II–IV, LVEF ≤35%)
- Add furosemide for congestion
- Consider ARNI switch later if still symptomatic on ACEi + BB + MRA
- No SGLT2i recommendation for HF
- Titrate sequentially over months

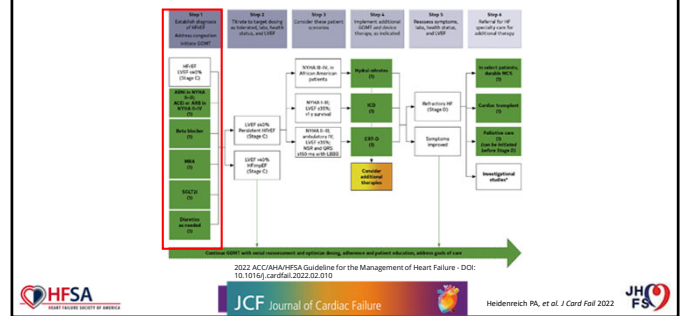
Concerns w/ pre-2022 Approach

- Slow sequential titration delays benefit
- ARNI deferred — requires prior ACEi/ARB stability
- No SGLT2i — missing a pillar that independently reduces mortality
- Metoprolol tartrate is NOT an evidence-based HF beta-blocker
- BP and LDL-C goals may not be addressed aggressively

THE OLD PARADIGM (pre-2022)



GDMT for HFrEF

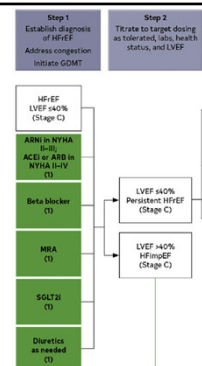


THE NEW PARADIGM

2022 AHA/ACC/HFSA Guideline — Paradigm Shifts

- FOUR Pillars of GDMT for HFrEF (all Class I):
 - RAAS-inhibitor
 - ARNI (preferred) or ACEI/ARB
 - Evidence-based beta-blocker
 - (bisoprolol, carvedilol, metoprolol succinate)
 - MRA
 - (spironolactone or eplerenone)
 - SGLT2 inhibitor
 - (dapagliflozin or empagliflozin)
- ARNI – 1st Line
- Rapid, simultaneous initiation —
 - All 4 drug classes **within 3 months of diagnosis**
- SGLT2i:
 - HFrEF: Class I
 - HFmrEF: Class 2a
 - HFpEF: Class 2a
- HFpEF
 - Disease-modifying options (SGLT2i, MRA, ARNI)

GDMT for HFrEF

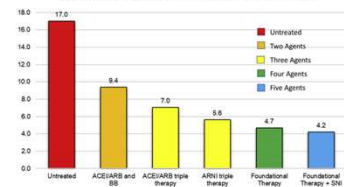


Essential: Inertia

- Rapid, simultaneous initiation —
 - All 4 drug classes **within 3 months of diagnosis**

Miller et al.
Cluster Scheme for HFrEF Drug Therapy

One-year Mortality with Combinations of Medical Therapy



BEFORE vs. AFTER 2022

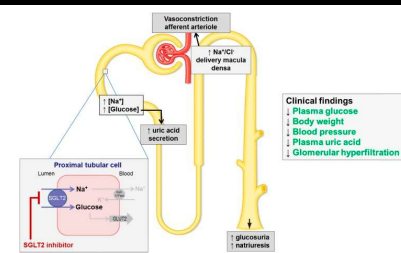
GDMT	RR Reduction in Mortality (%)	NNT for Mortality Reduction (Standardized to 36 mo)	RR Reduction in HF Hospitalizations (%)
ACE inhibitor or ARB	17	26	31
Beta blocker	34	9	41
Aldosterone antagonist	30	6	35
Hydralazine/nitrate	43	7	33

ACE indicates angiotensin-converting enzyme; ARB, angiotensin-receptor blocker; GDMT, guideline-directed medical therapy; HF, heart failure; HFpEF, heart failure with reduced ejection fraction; NNT, number needed to treat; RCTs, randomized controlled trials; and RR, relative risk.

BEFORE vs. AFTER 2022: SIDE-BY-SIDE COMPARISON

Feature	Pre-2022	2022 Beyond
Drug classes for HFrEF	3 Pillars (ACEI/ARB, BB, MRA) ± ARNI switch	4 Pillars (ARNI, BB, MRA, SGLT2)
ARNI initiation	Switch from ACEI/ARB after stabilization	De novo initiation preferred
SGLT2i in HF	Not included	Class I for HFrEF
Titration approach	Sequential, stepwise	Rapid, simultaneous; all 4 within 3 months
HFmrEF (LVEF 41–49%)	Not a category	Recognized; SGLT2i Class 2a
HFpEF treatment	Diuretics only	SGLT2i (2a), MRA (2b), ARNI (2b)
HFimpEF	Not defined	Continue GDMT; do not de-escalate
Biomarkers in staging	Not in Stage B	Elevated BNP/troponin = Stage B
Vericiguat	Not available	Class 2b add-on for high-risk HFpEF

SGLT-2 Inhibitors



LANDMARK TRIALS

Trial	Drug	Population	Key Result
PARADIGM-HF (2014)	Sacubitril/valsartan vs. enalapril	HFpEF, NYHA II–III	20% + CV death or HF hospitalization (HR 0.80); 20% + CV mortality; NNT = 21 over 27 months
DAPA-HF (2019)	Dapagliflozin vs. placebo	HFpEF, NYHA II–IV	26% + CV death or worsening HF (HR 0.74); benefit independent of diabetes status
EMPEROR-Reduced (2020)	Empagliflozin vs. placebo	HFpEF, NYHA II–IV	25% + CV death or HF hospitalization (HR 0.75); slowed eGFR decline
EMPEROR-Preserved (2021)	Empagliflozin vs. placebo	HFpEF, LVEF >40%	21% + CV death or HF hospitalization (HR 0.79); first therapy proven in HFpEF
DELIVER (2022)	Dapagliflozin vs. placebo	HFmrEF/HFpEF, LVEF >40%	18% + CV death or worsening HF (HR 0.82)

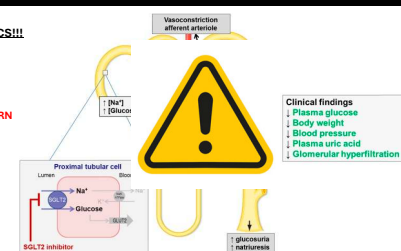
SGLT-2 Inhibitors

LOOP DIURETICS!!!

→ Dose

OR

Discontinue=> PRN



LANDMARK TRIALS

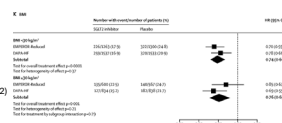
Meta-analysis of DAPA-HF + EMPEROR-Reduced:

- 13% + all-cause death (HR 0.87; 95% CI 0.77–0.98)

- 14% + CV death (HR 0.86; 95% CI 0.76–0.98)

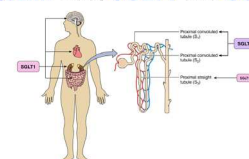
- 26% + CV death or first HF hospitalization (HR 0.74; 95% CI 0.68–0.82)

- Benefits consistent regardless of diabetes status, age, sex, or ARNI use



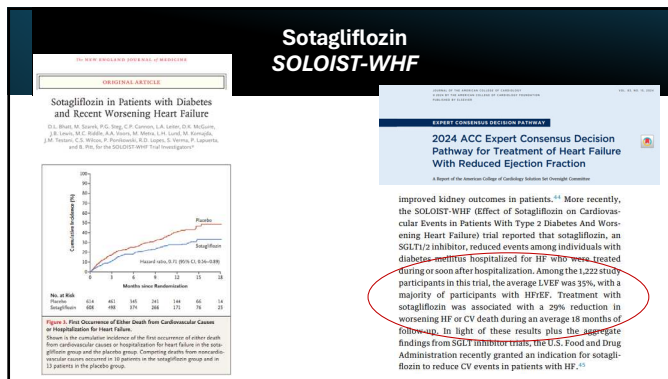
Sotagliflozin

Sotagliflozin: Dual SGLT1 and SGLT2 Inhibitor



- SGLT1 is the primary transporter for absorption of glucose and galactose in the GI tract
- Pharmacologic inhibition by sotagliflozin is independent of insulin and does not depend on kidney function
- Potential effects on atherosclerotic risks
- SGLT2 is expressed in the kidney, where it reabsorbs 90% of filtered glucose
- Pharmacologic inhibition by sotagliflozin is independent of insulin but requires kidney function

SHL 8. Blood 20. Circulation 3024



4) Recommendations for HFimpEF

Improved LVEF is used to refer to those with previous HFrEF who now have an LVEF >40%

COR	LOE	Recommendations
1	B - R	In patients with HFimpEF after treatment, GDMT should be continued to prevent relapse of HF and left ventricular dysfunction, even in patients who may become asymptomatic

2022 ACC/AHA/HFSA Guideline for the Management of Heart Failure - DOI: 10.1177/jccl.2022.02.010

JCF Journal of Cardiac Failure

Heidenreich PA, et al. J Card Fail 2022

JHFS

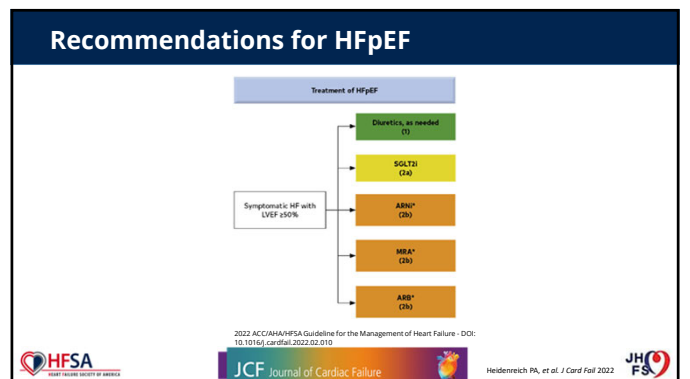
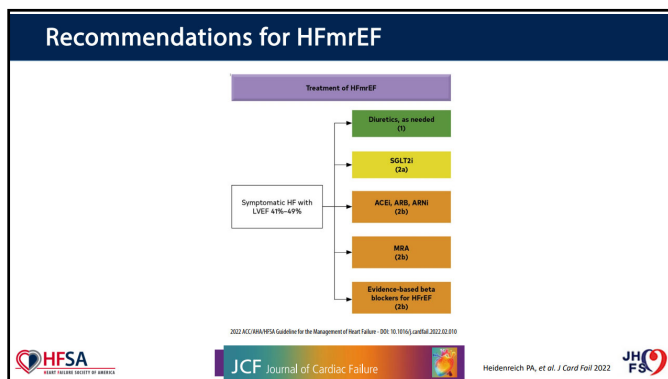
THE 4 PILLARS: DOSING AT A GLANCE

Drug Class	Medication	Starting Dose	Target Dose	Monitoring
ARNI	Sacubitril/Valsartan	24/26 mg-49/51 mg BID	97/103 mg BID	BP, K ⁺ , SCr/eGFR 36-hour washout from ACEi
Beta-blocker	Carvedilol	3.125 mg BID	25-50 mg BID	HR, BP Do not initiate during decompensation
	Metoprolol succinate	12.5-25 mg daily	200 mg daily	
	Bisoprolol	1.25 mg daily	10 mg daily	
MRA	Spirolactone	12.5-25 mg daily	25-50 mg daily	K ⁺ , SCr/eGFR Avoid if eGFR <30 or K ⁺ >5.0 Switch spironolactone to Eplerenone (gynecomastia, ED)
	Eplerenone	25 mg daily	50 mg daily	
SGLT2i	Dapagliflozin	10 mg daily	10 mg daily	Dapagliflozin: eGFR ≥25 Empagliflozin: eGFR ≥25
	Empagliflozin	10 mg daily	10 mg daily	Genital mycotic infect; eDKA

HFpEF: THE EVOLVING LANDSCAPE

2022 Guideline + 2023 ACC Expert Consensus for HFpEF:

- SGLT2i: Class 2a — **First-Line** disease-modifying therapy
- MRA: Class 2b
- ARNI: Class 2b
 - Benefit may be greater in lower EF range and in women
- Diuretics: Class I for congestion/symptom management
- BP control: SBP 130 mmHg
- Exercise training and weight loss:
 - Clinically meaningful improvements in functional capacity
- Comorbidity management: AF, obesity, sleep apnea, CKD, diabetes



HFpEF: THE EVOLVING LANDSCAPE

GLP-1 Receptor Agonists in Obesity-Related HFpEF:

- STEP-HFpEF: Semaglutide 2.4 mg weekly improved KCCQ score by 7.8 points vs. placebo, reduced body weight by 10.7%, improved 6MWD by 20.3 m, and reduced CRP by 43.5%
- STEP-HFpEF DM: Similar benefits in patients with T2DM
- SUMMIT: Tirzepatide reduced worsening HF or CV death by 38% (HR 0.62; 95% CI 0.41–0.95) and improved KCCQ by 6.9 points vs. placebo
- Meta-analysis (3 RCTs, n=1,876): GLP-1 RAs reduced HF events by 60% (RR 0.40), improved KCCQ by 7.2 points, and reduced body weight by 9.8 kg

KEY ADVERSE EFFECTS

Drug Class	Key AEs	Placebo-Adjusted Incremental Risk
ACEi	Cough, hyperkalemia, renal impairment	Cough: ~10–15% incremental; hyperkalemia: modest
ARNI	Hypotension, angioedema (rare)	Symptomatic hypotension: 14% vs. 9.2% (vs. enalapril)
Beta-blocker	Bradycardia, dizziness, fatigue	Bradycardia: variable (1–52%); dizziness: 15–43%
MRA	Hyperkalemia, gynecostasia (spironolactone)	Gynecostasia: ~10% with spironolactone; eplerenone avoids this
SGLT2i	Genital mycotic infections, volume depletion	Genital infections: ~2–5% incremental; UTI: no significant increase

MANAGING COMMON BARRIERS TO GDMT OPTIMIZATION

Barrier 1

Hypotension

- Most common barrier to GDMT titration
- First:
 - Rule out overdiuresis, non-CV drugs with hemodynamic effects, autonomic dysfunction
- Stagger timing of medications
- Tolerate asymptomatic low BP — treat the patient, not the number
- Per 2024 ACC ECDP:
 - ARNI is better tolerated when patient is congested ("wet"); BB is better tolerated when patient is decongested ("dry")

KEY ADVERSE EFFECTS

Drug Class	Key AEs
ACEi	Cough, hyperkalemia, renal impairment
ARNI	Hypotension, angioedema (rare)
Beta-blocker	Bradycardia, dizziness, fatigue
MRA	Hyperkalemia, gynecostasia (spironolactone)
SGLT2i	Genital mycotic infections, volume depletion

Barrier 2

Hyperkalemia

- Low-potassium diet education as first step
- Prioritize SGLT2i — they help mitigate hyperkalemia
- Potassium binders: patiromer (Veltassa) or sodium zirconium cyclosilicate (Lokelma)
 - DIAMOND trial: patiromer allowed 85% of HFrEF patients to be optimized on GDMT
 - REALIZE-K trial: SZC enabled spironolactone optimization in HFrEF patients with hyperkalemia
 - Meta-analysis (6 RCTs, n=1,432): K+ binders increased RAAS inhibitor use (RR 1.14) and reduced hyperkalemia (RR 0.66)
- Reduce/hold MRA first
 - Do NOT reduce ARNI/ACEi/ARB unless K+ ≥6.0

(K+ >5.0 mEq/L)

Barrier 3

Worsening Renal Function

- Modest eGFR decline (30% from baseline) is often acceptable and expected
- Continue GDMT — benefits outweigh CKD risk
- SGLT2i can be initiated at eGFR ≥ 20 –25 mL/min and continued even below this threshold

PRACTICAL UPDATES – Refined Implementation

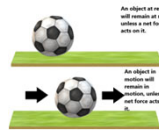
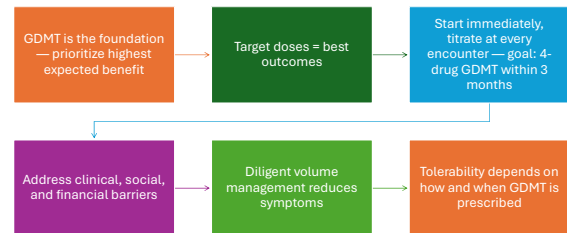
- Simultaneous initiation of all 4 classes at low doses is encouraged
- More than one titration at a time may be done when safely possible
- ARNI is better tolerated when patient is still congested ("wet")
- BB is better tolerated when patient is less congested ("dry")
- Reassess LVEF 3–6 months after achieving target/max tolerated GDMT
- Natriuretic peptide reassessment supports therapeutic decision-making
- Sotagliflozin added as an SGLT2i option (200–400 mg daily)

Barrier 4

Clinical Inertia

The #1 reason for delays in GDMT :

"patient is clinically stable"

**6 Guiding Principles from the 2024 ECDP**

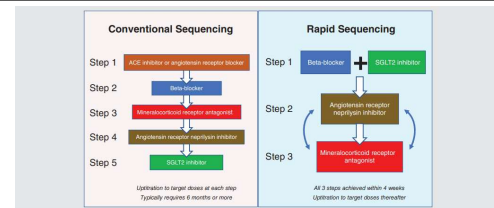
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EXPERT CONSENSUS DECISION PATHWAY

2024 ACC Expert Consensus Decision Pathway for Treatment of Heart Failure With Reduced Ejection Fraction

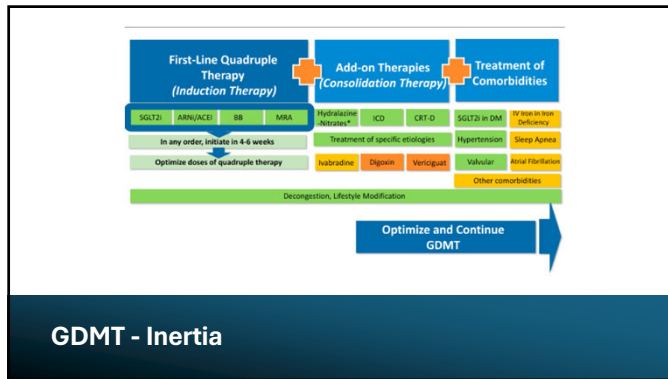
A Report of the American College of Cardiology Solution Set Oversight Committee



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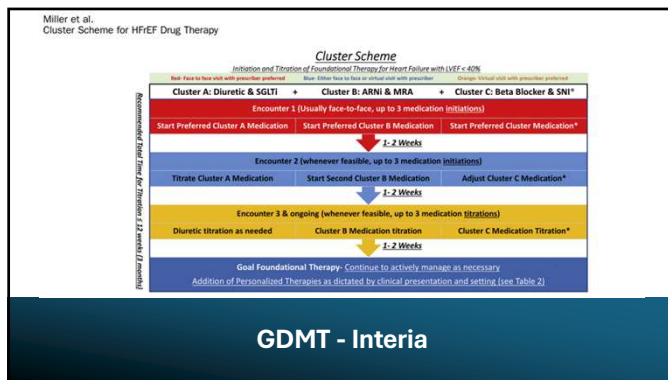
GDMT - Inertia



2025 AHA/ACC HYPERTENSION GUIDELINE

Key Updates Relevant to HF

- Hypertension: $\geq 130/80$ mmHg
- BP goal for ALL adults with HTN: 130/80 mmHg
 - Encouragement to achieve 120 mmHg systolic
- Risk assessment: PREVENT equations 10-year CVD risk $\geq 7.5\%$ = high risk
 - Replaces Pooled Cohort Equations
- HTN is the #1 modifiable risk factor for HF
 - Dose-dependent association
- SPRINT showed intensive BP control reduced incident HF by 38%



2025 AHA/ACC HYPERTENSION GUIDELINE

HFrEF

- Uptitrate HF GDMT to maximally tolerated doses FIRST for BP control
- Goal SBP 130 mmHg should at least be attained
- Diuretics for volume overload
- Dihydropyridine CCBs (e.g., amlodipine) may be added if BP remains elevated despite optimized GDMT
- AVOID nondihydropyridine CCBs (diltiazem, verapamil) — negative inotropic effects may be harmful

Guideline Overlap

2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure

Heidenreich PA, et al. J Card Fail 2022

2025 AHA/ACC Multisociety Hypertension Guidelines

2026 ACC/AHA/AACVPR/ABC/ACPM/ADA/AGS/APhA/ASPC/A/PCNA Guideline on the Management of Dyslipidemia

Logos for American College of Cardiology, American Heart Association, HFSA, JCF, and JACC are displayed.

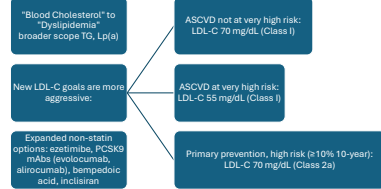
2025 AHA/ACC HYPERTENSION GUIDELINE

HFpEF

- SBP goal 130 mmHg (extrapolated from general HTN trials)
- RAAS agents (ACEi, ARB, MRA, possibly ARNI) are reasonable first-line given HFpEF trial experience
- SPRINT showed intensive BP control reduced incident HF by 38%

2026 AHA/ACC DYSLIPEMIA GUIDELINE

Key Updates Relevant to HF



DRUGS TO AVOID IN HEART FAILURE

2026 AHA/ACC DYSLIPEMIA GUIDELINE

HF-Specific Recommendations:

- HF_rEF due to ischemic heart disease with reasonable life expectancy (3–5 years) and NOT already on a statin: moderate-intensity statin may be reasonable (Class 2b)
- HF_rEF WITHOUT clinical ASCVD or another indication: initiation of LLT is NOT recommended (Class III: No Benefit)
- HF_rEF WITH clinical ASCVD: aggressively treat to LDL-C goal (55 or 70 mg/dL depending on risk)
- Statins appear to reduce incident HF when used for primary or secondary prevention, even without MI

Drugs that may cause/exacerbate HF

Drug/Class	Risk in HF	Recommendation
NSAIDs	Na ⁺ /H ₂ O retention, + BP, + renal function blunt diuretic/ACE effect	AVOID — use acetaminophen instead
Thiazolidinediones	Fluid retention, + HF hospitalization	CONTRAINDICATED in NYHA II–IV
Non-dihydropyridine CCBs (amlodipine, verapamil)	Negative inotropic effects	AVOID in HF _r EF
DPP-4 inhibitors (saxagliptin, linagliptin)	+ HF hospitalization (SAVOR-TIMI 53)	Avoid saxagliptin; use SGLT2i or GLP-1 RA instead
Class I antiarrhythmics (flecainide, propafenone)	Proarrhythmic, negative inotropic	CONTRAINDICATED in HF _r EF
Dronedarone	+ Mortality in severe HF (ANDROMEDA)	CONTRAINDICATED in NYHA II–IV
Alpha-1 blockers (doxazosin, prazosin, tamsulosin)	Neurohormonal activation, fluid retention	Use with caution; avoid if possible
Progabalin/gabapentin	Peripheral edema, fluid retention	Monitor closely

Adults with Heart Failure

Adults with HF _r EF	
COR	RECOMMENDATIONS
3: No Benefit	In adults with heart failure with reduced ejection fraction (HF _r EF) who do not have clinical ASCVD or another indication for LLT, initiation of LLT is not recommended to reduce clinical events or mortality.



Abbreviations: ASCVD indicates atherosclerotic cardiovascular disease; LLT, lipid-lowering therapy; and HF_rEF, heart failure with reduced ejection fraction.

Burnsfield, R.S., Morris, P.B., et al. 2025 ACC/AHA Guideline on the Management of Dyslipidemia. Circulation.

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“Frank”

- 62-year-old rancher from Billings, Montana.
- PMH: Hypertension (20 years), type 2 diabetes (10 years), dyslipidemia, former smoker (quit 5 years ago), BMI 32
- Current Medications (established by PCP):
 - Lisinopril 20 mg daily
 - Metoprolol tartrate 50 mg BID
 - Metformin 1000 mg BID
 - Atorvastatin 40 mg daily
 - Hydrochlorothiazide 25 mg daily
 - Aspirin 81 mg daily
- Presentation: Progressive exertional dyspnea over 3 months, lower extremity edema, 2-pillow orthopnea, BP 148/92 mmHg, HR 88 bpm.
- Labs: BNP 680 pg/mL, SCr 1.3 (eGFR 58), K⁺ 4.2, HbA1c 7.8%, LDL-C 98 mg/dL
- Echo: LVEF 30%, moderate LV dilation, grade II diastolic dysfunction
- Diagnosis: Stage C HF_rEF, NYHA Class III

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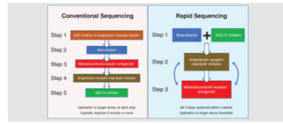
2022+ Guidelines – Modern Era

Visit 1 (Day 0) — Initiate All 4 Pillars:

- STOP lisinopril → START sacubitril/valsartan 24/26 mg BID
 - **after 36-hour washout**
- SWITCH metoprolol tartrate → metoprolol succinate 25 mg daily
- START spironolactone 25 mg daily
- START dapagliflozin 10 mg daily START loop diuretic daily for congestion
 - **CAUTION w/ SGLT2i**
- STOP hydrochlorothiazide
- Continue atorvastatin 40 mg, metformin, aspirin
- Labs in 1 week: BMP (K+, SCr)

Advantages w/ 2022+ Approach

- Rapid Sequencing Improves Outcomes
- ARNI – treatment delay(s) ↓
- SGLT2i — Therapy reducing mortality
- BP and LDL-C goals addressed



Frank at 6 Months

- Symptoms: NYHA Class II
- BP: 116/70 mmHg, HR 60 bpm
- Labs: BNP 180 pg/mL, K+ 4.3, SCr 1.3, eGFR 56, HbA1c 7.2%
- LDL-C: 62 mg/dL (at goal with atorvastatin + ezetimibe) ✓
- Echo: **LVEF 42%** (improved from 30%)
- Reclassification:
 - Frank now has **HFimpEF** (LVEF improved from ≤40% to 42%)
 - **CONTINUE all** GDMT based on lowest previous EF
- **Do NOT** de-escalate therapy

“Frank”

Visit #	# 2 (Week 2)	#3 (Week 4)	#4 (Week 8)
Vitals	BP 132/82, HR 76, K+ 4.5, SCr 1.4 (eGFR 54)	BP 124/78, HR 68, K+ 4.6, SCr 1.4	BP 118/72, HR 62, K+ 4.4, SCr 1.3
RAAS-i	↑ Sacubitril/valsartan → 49/51 mg BID	↑ Sacubitril/valsartan → 97/103 mg BID (TARGET DOSE)	Sacubitril/valsartan 97/103 mg BID
Beta-Blocker	↑ Metoprolol succinate → 50 mg daily	↑ Metoprolol succinate → 100 mg daily	↑ Metoprolol succinate → 200 mg daily (TARGET DOSE)
MRA	Continue spironolactone 25 mg daily	Continue spironolactone 25 mg daily	↑ Spironolactone → 50 mg daily (TARGET DOSE)
SGLT2i	Continue dapagliflozin 10 mg (TARGET DOSE)	Continue dapagliflozin 10 mg	Continue dapagliflozin 10 mg
Other	Furosemide: edema improving → continue 40 mg daily	Furosemide: euvolemic → decrease to 20 mg daily	Furosemide: euvolemic → decrease to 10 mg daily prn

Frank at 2 Years

NYHA Class I-II, active on the ranch

LVEF 48%, BNP 120 pg/mL

All GDMT at target doses, well-tolerated

BP 114/68, LDL-C 58 mg/dL, HbA1c 6.9%, eGFR 55

No HF hospitalizations

Final Medication List:

- Sacubitril/valsartan 97/103 mg BID
- Metoprolol succinate 200 mg daily
- Spironolactone 50 mg daily
- Dapagliflozin 10 mg daily
- Furosemide 20 mg daily (PRN)
- Atorvastatin 40 mg daily + ezetimibe 10 mg daily
- Metformin 1000 mg BID
- Aspirin 81 mg daily

“Frank”

Applying the 2026 ACC/AHA Dyslipidemia Guideline:

- Frank has ischemic risk factors (DM, HTN, former smoker) but no documented ASCVD
- 10-year ASCVD risk: HIGH (diabetes + multiple risk factors)
- Current: atorvastatin 40 mg (high-intensity) → LDL-C 98 mg/dL
- Per 2026 guideline, primary prevention high risk:
 - Goal LDL-C 70 mg/dL
- Action: Add ezetimibe 10 mg daily to achieve LDL-C 70 mg/dL
- If LDL-C remains above goal:
 - Consider PCSK9 mAb or bempedoic acid
- Note: If Frank had HFref without ASCVD or other indication:
 - Statin initiation would NOT be recommended (Class III: No Benefit)

PRACTICE PEARLS

- Always check: Is the patient on ALL 4 pillars? At target doses?
- Metoprolol tartrate ≠ metoprolol succinate — only succinate is evidence-based for HF
- 36-hour washout from ACEi before starting ARNI — counsel patients on the gap
- SGLT2i: fixed dose, no titration, can initiate at eGFR ≥20–25 mL/min
- MRA: check K+ and SCr before and 1 week after initiation/dose change
- Dapagliflozin covers HF + DM + CKD — Maximize this overlap
- HFimpEF: NEVER stop GDMT because EF improved
- Avoid NSAIDs, thiazolidinediones, nondihydropyridine CCBs in HFref
- Educate patients: daily weights, 1500–2000 mg sodium restriction, fluid awareness

Key Lessons

Rapid, simultaneous GDMT initiation is *safe and effective*.

SGLT2i benefit HF, diabetes, AND CKD

ARNI can be started de novo — **No need to wait**

HFimpEF = **Continue** GDMT; **Never stop** based on improved EF

Integrate HTN and lipid management into **every** HF visit

SUMMARY: THE MODERN ERA OF HEART FAILURE

- The 2022 HF guideline established 4-pillar GDMT & expanded treatment across all EF categories
- Rapid, simultaneous initiation replaces slow, sequential titration
- SGLT2 inhibitors are the most impactful addition — Benefit HFcrEF, HFmrEF, HFpEF, DM, and CKD
- The 2025 HTN guideline reinforces:
 - Up-titrate GDMT first for BP control in HF; goal SBP 130 (encourage 120)
- The 2026 Dyslipidemia guideline clarifies:
 - Statins are NOT indicated for HFcrEF alone, but aggressively treat ASCVD/ischemic HF patients to LDL-C 55–70 mg/dL
- **Every** HF visit is an opportunity to optimize, educate, & prevent decompensation
 - Watch, wait, reduce if necessary

QUESTIONS

Thank you!

