



# Pharmacy Pearls

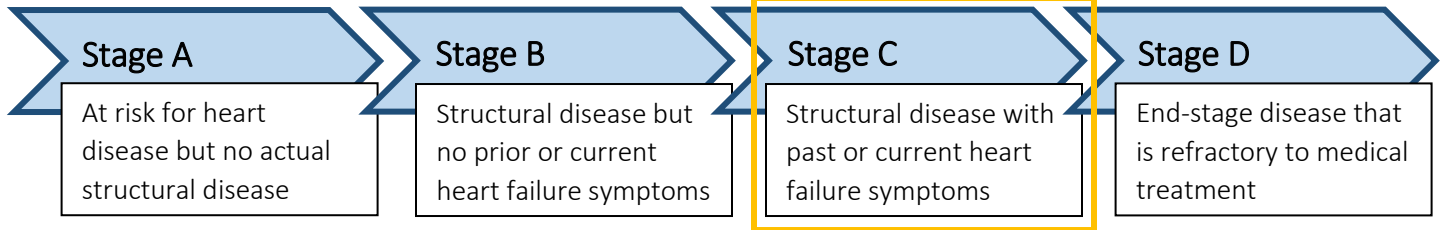
October 2019

## Updates on Medication Management in Patients with Heart Failure with Reduced Ejection Fraction (HFrEF)

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### ACC/AHA Heart Failure (HF) Staging Definitions:

Treatment recommendations in this document apply specifically to HFrEF (LVEF < 40%) – Stage C patients



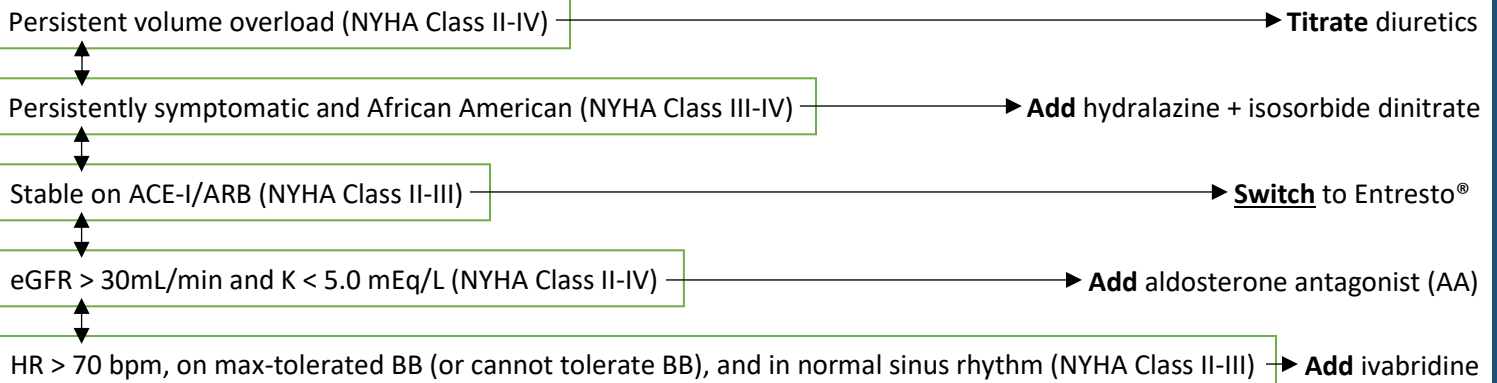
### General Treatment Algorithm (per ACC/AHA updated 2017 recommendations):

**Step 1:** All patients should be initiated on ACE-I/ARB AND guideline-directed Beta Blocker (BB) +/- diuretics as needed

If patient is volume overloaded ("wet") → Initiate ACE-I/ARB first

If patient is not volume overloaded ("dry") and has adequate resting HR ( $\geq 55$  bpm) → Initiate BB first

**Step 2:** Modify therapy as needed based on clinical presentation (choices not mutually exclusive and no preferred order)



### Initial and Target Doses for Common HF Medications:

Class	Medication	Initial Dose	Target Dose	Class	Medication	Initial Dose	Target Dose
ACE-I	Captopril	6.25 mg TID	50 mg TID	BB	Bisoprolol	1.25 mg daily	10 mg daily
	Enalapril	2.5 mg BID	10-20 mg BID		Carvedilol	3.125 mg BID	25-50 mg BID
	Lisinopril	2.5-5 mg daily	20-40 mg daily		Metoprolol XL	12.5-25 mg daily	200 mg daily
	Ramipril	1.25 mg daily	10 mg daily	AA	Eplerenone	25 mg daily	50 mg daily
ARB	Candesartan	4-8 mg daily	32 mg daily		Spirolactone	12.5-25 mg daily	25-50 mg daily
	Losartan	25-50 mg daily	150 mg daily	Vaso-dilators	Hydralazine	25 mg TID	75 mg TID
	Valsartan	40 mg BID	160 mg BID		Isosorbide DN	20 mg TID	40 mg TID
ARNI	Sacubitril/ Valsartan	24/26 mg BID	49/51 mg BID	HCN channel blocker	Ivabridine	2.5-5 mg BID	Titrate to HR of 50-60 bpm (max = 7.5 mg BID)

## Newest HF Medications:

### Angiotensin Receptor-Neprilysin Inhibitor (ARNI)

Sacubitril/Valsartan (Entresto<sup>®</sup>)

**Mechanism of Action:** Sacubitril increases levels of natriuretic peptides that delay the pathogenesis and progression of HF and valsartan inhibits aldosterone release.

**Cost:** \$631 (30-day supply, average cash price)

**Benefits:** Resulted in a 20% reduction in cardiovascular death and HF hospitalizations in clinical trials and is associated with clinical improvement in LVEF. Class 1 (strong) recommendation in ACC/AHA guidelines.

**Limitations:** Risk of angioedema, more symptomatic hypotension than patients on ACE-I, and was not studied in patients with decreased renal function.

**Ideal candidates for therapy:** Patients with NYHA Class II-III symptoms, who can tolerate an ACE-I/ ARB, to further reduce morbidity and mortality. Use of an aldosterone antagonist is also recommended to improve outcomes but is not a mandatory step prior to switching a patient to ARNI.

#### How to Switch Therapy:

**Step 1:** Ensure 36 hours off ACE-I, adequate BP, and eGFR > 30 mL/min

#### Step 2: Select starting dose

Population:	Dose:
<ul style="list-style-type: none"> <li>Low dose ACE-I/ARB</li> <li>ACE-I/ARB naïve</li> <li>Hepatic impairment (Child-Pugh Class B)</li> <li>Elderly age (<math>\geq 75</math> years)</li> </ul>	24/26 mg BID
<ul style="list-style-type: none"> <li>Moderate or high dose of ACE-I/ARB (equivalent of <math>\geq 10</math> mg of enalapril BID or <math>\geq 80</math> mg BID of valsartan)                             <ul style="list-style-type: none"> <li>Full list of equivalent dosages available here: <a href="#">ACE-I / ARB</a></li> </ul> </li> </ul>	49/51 mg BID

**Step 3:** Assess tolerability in 2-4 weeks. If possible, titrate dose to target of 97/103 mg BID. Monitor BP, electrolytes, and renal function during titration and periodically thereafter.

### HCN Channel Blocker

Ivabridine (Corlanor<sup>®</sup>)

**Mechanism of Action:** Reduces heart rate by decreasing spontaneous pacemaker activity at the cardiac sinus node. Does not lower blood pressure.

**Cost:** \$530 (30-day supply, average cash price)

**Benefits:** Resulted in a 5% (statistically significant) reduction of HF hospitalizations in clinical trials.

**Limitations:** Can cause bradycardia, development of atrial fibrillation, and transient blurred vision. Class IIa (moderate) recommendation in ACC/AHA guidelines.

**Ideal candidates for therapy:** Well-compensated patients on optimal/highest-tolerated BB therapy, in sinus rhythm, who have a persistent resting HR > 70 bpm. Highest benefit shown in patients with contraindications to BB therapy, BB doses < 50% of guideline-directed targets, and resting HR > 77 bpm at time of initiation.

#### How to Initiate Therapy:

**Step 1:** Reassess that BB therapy is adjusted to target doses or max-tolerated dose

#### Step 2: Select starting dose

Population:	Dose:
• Age $\geq 75$ years	2.5 mg BID
• Age < 75 years	5 mg BID

**Step 3:** Reassess HR in 2-4 weeks and adjust dose as below. Monitor HR during titration/throughout therapy.

HR < 50 bpm or symptoms of bradycardia

Reduce dose by 2.5 mg BID or discontinue if already at lowest dose.

HR 50-60 bpm

Maintain current dose.

HR > 60 bpm

Increase dose by 2.5 mg BID until at max dose of 7.5 mg BID.