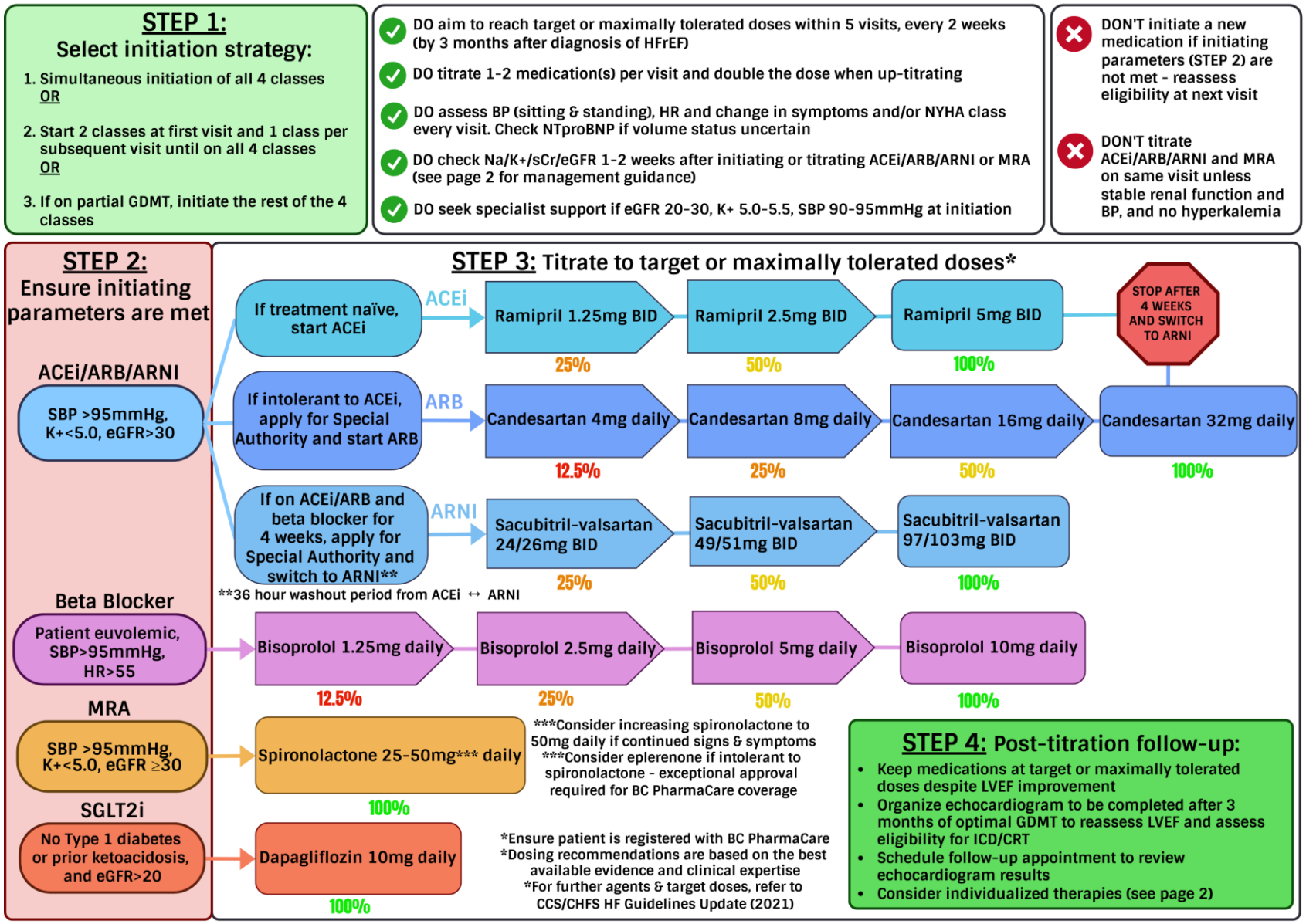
GDMT Initiation and Titration Pathway

For Patients with HFrEF (LVEF ≤ 40%)



Hyperkalemia, Renal Dysfunction & Individualized Therapies

Management of Hyperkalemia

Severity	Initial Management	Reassessing K+	Restarting and/or re-titrating ACEi/ARB/ARNI and/or MRA
Mild **K+ 5.0-5.5 mmol/L**	• Continue ACEi/ARB/ARNI & MRA unless new & major increase in K+ • If so, stop most recently added agent	• Routine measurement unless K+ has been increasing over time • If ACEi/ARB/ARNI and/or MRA has been stopped, recheck within 72 hours	• When K+ decreases to within the patient's usual level, or < 5.0 mmol/L (whichever is higher), ***and*** • Any concomitant condition contributing to recent changes is under control, <u>then</u> • ACEi/ARB/ARNI and MRA should usually be reintroduced 1 at a time with intervening measurement of renal function & electrolytes
Moderate **K+ 5.6-5.9 mmol/L**	• Notify MD/NP (if applicable) • If on MRA, decrease MRA to half current dose* • If not on MRA, decrease ACEi/ARB/ARNI to half current dose* *Unless K+ increasing over time or major increase in K+ • If so, stop most recently added agent	• Within 72 hours • Repeated K+ >5.5: If on MRA, decrease ACEi/ARB/ARNI to half of current dose; If not on MRA, stop ACEi/ARB/ARNI • Repeat measurement in 72 hours • Subsequent repeated K+ >5.5: consider calcium or sodium polystyrene, or sodium zirconium cyclosilicate administration	
Severe **K+ >5.9 mmol/L**	• Notify MD/NP (if applicable) • Contact patient to proceed to ED for clinical assessment & 12-lead ECG • Treatment according to local protocol for serious hyperkalemia • HOLD all ACEi/ARB/ARNI & MRA until reassessment	• Within 4-24 hours, based on local acute hyperkalemia protocol • Repeat approximately 72 hours later	

For ALL hyperkalemic patients:

- Reinforce K+ diet restriction
- Avoid other sources of K+
- Ensure patient is not hypovolemic
- Review all medications & stop K+ supplements

Management of Renal Dysfunction

If increase in sCr > 30% or decrease in eGFR > 30%

Consider:	
• Any new nephrotoxic drugs? • Worsening HF? • Co-morbidities (diabetes, dehydration, CKD)?	Review medications, assess volume status and notify MD/NP (if applicable)

Post-Titration Considerations for Individualized Therapies

Ivabradine → If sinus rhythm, symptoms and HR > 77bpm on 3 consecutive visits by ECG or continuous monitoring despite treatment with GDMT, including target dose or maximally-tolerated dose of beta blocker
Hydralazine/Nitrate → If intolerant to ACEi/ARB/ARNI, or in Black patients on optimal GDMT
Digoxin → If suboptimal rate control for Afib, or persistent symptoms despite optimal GDMT
Vericiguat → If worsening symptoms and HF decompensation in the last 6 months despite optimal GDMT
ICD/CRT → If LVEF ≤ 35% when reassessed 3 months after GDMT titrated to target or maximally tolerated doses, and if patient is ambulatory with NYHA class I-IV - refer for ICD/CRT evaluation
Percutaneous Mitral Valve Repair (PMVR) → If symptomatic despite optimal GDMT and moderate-to-severe functional mitral regurgitation or greater - refer to a MitraClip/TEER Program
Referral for advanced HF therapies and/or referral for supportive/palliative care → If NYHA III/IV, advanced HF or high-risk markers (refer to CCS 2017 HF Guidelines)