Appendix 2:
Medications not recommended for HF and rationale

Medication	Rationale
Statins	For those without a clear indication for statin (such as co-existent ischemic heart disease) there was no benefit solely for the indication of HF in clinical trials. Use statin treatment in accordance to the primary and secondary prevention guidelines for CVD (See CCS 2016 dyslipidemia guidelines).
ASA or other antiplatelets	ASA for the primary prevention in HFrEF is not recommended ASA is only recommended for those patients with clear indications for the secondary prevention of atherosclerotic cardiovascular events.
Anticoagulation	Routine anticoagulation in patients with HFrEF, in sinus rhythm, and no other indications for anticoagulation is not recommended. Do not routinely anticoagulate patients after a large anterior MI and a low EF without the presence of an intracardiac thrombus or another indication for anticoagulation. ***Patients with an LV thrombus should be considered for anticoagulation. If anticoagulation is used, 3 months is a reasonable initial duration prior to reassessing for thrombus.***
Non-steroidal anti- inflammatory drugs (NSAIDs)	Recommend against the use of NSAIDs (including high dose ASA) and COX-2 inhibitors in patients who have HFrEF since it can cause fluid retention, worsen renal function, increase cardiovascular events and worsen HF.
Calcium channel blockers (CCBs)	CCBs including diltiazem, verapamil, nifedipine and felodipine should be avoided in patients with HFrEF due to potential worsening of HF Amlodipine can be used in HFrEF for other indications such as hypertension and angina symptoms. Amlodipine can cause dose-related peripheral edema and should be taken into account when assessing edema potentially related to worsening HF.
Antiarrhythmics	Antiarrhythmics are only recommended if patients have symptomatic arrhythmias despite being on optimal medical therapy. Only amiodarone has been proven to be acceptable in HFrEF patients.

Beique LC, et al. 2017 Guidelines for the management of heart failure by pharmacists. ***Can Pharm J*** (Ott) 2019;152(5).
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