

Supplementary, e-method 1. Clarification of the survey set-up.

The idea of the survey was issued from the discussion between heart failure specialists within a European group of alumniees from the Post-Graduate Course of Heart Failure (PCHF) in Zurich (2018-2020), following the presentation of the 2021 European Society of Cardiology Heart Failure guidelines. The last author of the manuscript drafted a first version of the survey and then shared it via mail, for revision and approval within the PCHF group. The PCHF group included senior authors from the PCHF teaching staff and persons with significant involvement in the Heart Failure Association (HFA - W. Mullens, F. Ruschitzka, A. Flammers, M. Tokmakova). Then the second version of the survey was submitted to the board of ESC Academy Alumni Task Force, including cardiologists from different horizons than heart failure, from Europe. The draft was revised and approved subsequently. Finally, the 3rd version of the survey was submitted to the whole board of the French Heart Failure Group and the board of Young Cardiologists in Training from the French society of Cardiology. The 4th version of the survey was issued from this last round.

1 **Supplementary table, 1. Survey questionnaire.**

QUESTION NUMBER	QUESTION STATEMENT	PROPOSITIONS
1	How old are you ?	Free text
2	Gender	Female / Male
3	In what country do you practice?	List of the countries
4	Where do you practice?	University Hospital General Hospital Private Hospital Private practice
5	What is your primary subspecialty in cardiology?	General cardiology Heart failure Intensive care Interventional Imaging Medical student or resident Other
6	Have you attended one of the European Society of Cardiology Academy Course (Post graduate course in heart failure, advanced studies in cardiac arrhythmia, etc...)?	Yes / No
7	What is for you the accurate LVEF limit to define heart failure with reduced ejection fraction (HFrEF) in your clinical routine? < xx %	Free text
8	Classify the following list of first line guidelines directed medical therapies, from the most efficient (1) to the least efficient (5)?	ACEi ARNi Bblockers MRAs SGLT2i I don't know
9	Do you think a low dose of each one of the four heart failure drug classes to start is better than three at the maximal tolerated dose?	Yes / No
10	What would be your standard best heart failure drug sequencing among the following drugs in a patient with a first episode of HFrEF (classify by order of introduction: 1 the first to 4 the last)	ACEi or ARNi Bblockers MRAs SGLT2i
11	In a primary HFrEF patient without prior HF drug treatment, do you start with ARNi instead of ACEi or ARBs?	Yes / No
12	Do you think it is possible to introduce all four drugs classes within the initial hospitalization and have	Yes / No

	them on the discharge prescription?	
13	In your clinical experience, what is the most realistic and safe timing to reach titration of all heart failure drug classes?	One week 15 days One month Six months 12 months
14	In your experience, is titrating more important than adding another heart failure drug class?	Yes / No
15	Do you introduce MRA in heart failure patients with GFR < 30 mL/min, with careful kaliemia monitoring?	Yes / No
16	When do you monitor iron status in your heart failure patients (ferritin and transferrin saturation coefficient)? (Multiple answer allowed)	At each hospitalization At each outpatient Every 6 months Once a year Randomly
17	How often do you modify/optimize your heart failure drug prescription during an outpatient visit for patients with HFrEF?	< 25% 26-50% 51-75% > 75% I don't know
18	What is the major side effect you expect with ACEi?	Symptomatic hypotension Worsening of kidney function Hyperkalemia Cough Angioedema
19	What is the major side effect you expect with ARNi?	Symptomatic hypotension Worsening of kidney function Hyperkalemia Cough Angioedema
20	What is the major side effect you expect with MRA?	Symptomatic hypotension Worsening of kidney function Hyperkalemia Cough Angioedema
21	What is the major side effect you expect with betablockers?	Symptomatic hypotension Bradycardia Worsening of heart failure Bronchitis exacerbation None
22	What is the major side effect you expect with SGLT2i?	Symptomatic hypotension Worsening kidney function

		Urinary tract infection Acido-cetosis None
23	According to your rule of thumb, in how many patients do you achieve titration to full doses in clinical routine?	< 25% 26-50% 51-75% > 75%
24	If you had to choose one drug class only for a heart failure patient, which one would you choose?	ACEi or ARNi Bblockers MRA SGLT2i

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2 Abbreviations: LVEF: left ventricular ejection fraction, GFR: glomerular filtration rate,

3 HFrEF: Heart Failure with reduced Ejection Fraction, SGLT2i: sodium-glucose

4 cotransporter 2 inhibitors, MRA: mineralocorticoid receptor antagonism, BB: beta-blockers,

5 ACEi: angiotensin-converting enzyme inhibitor, ARNi: angiotensin-receptor neprilysin-

6 inhibitor.

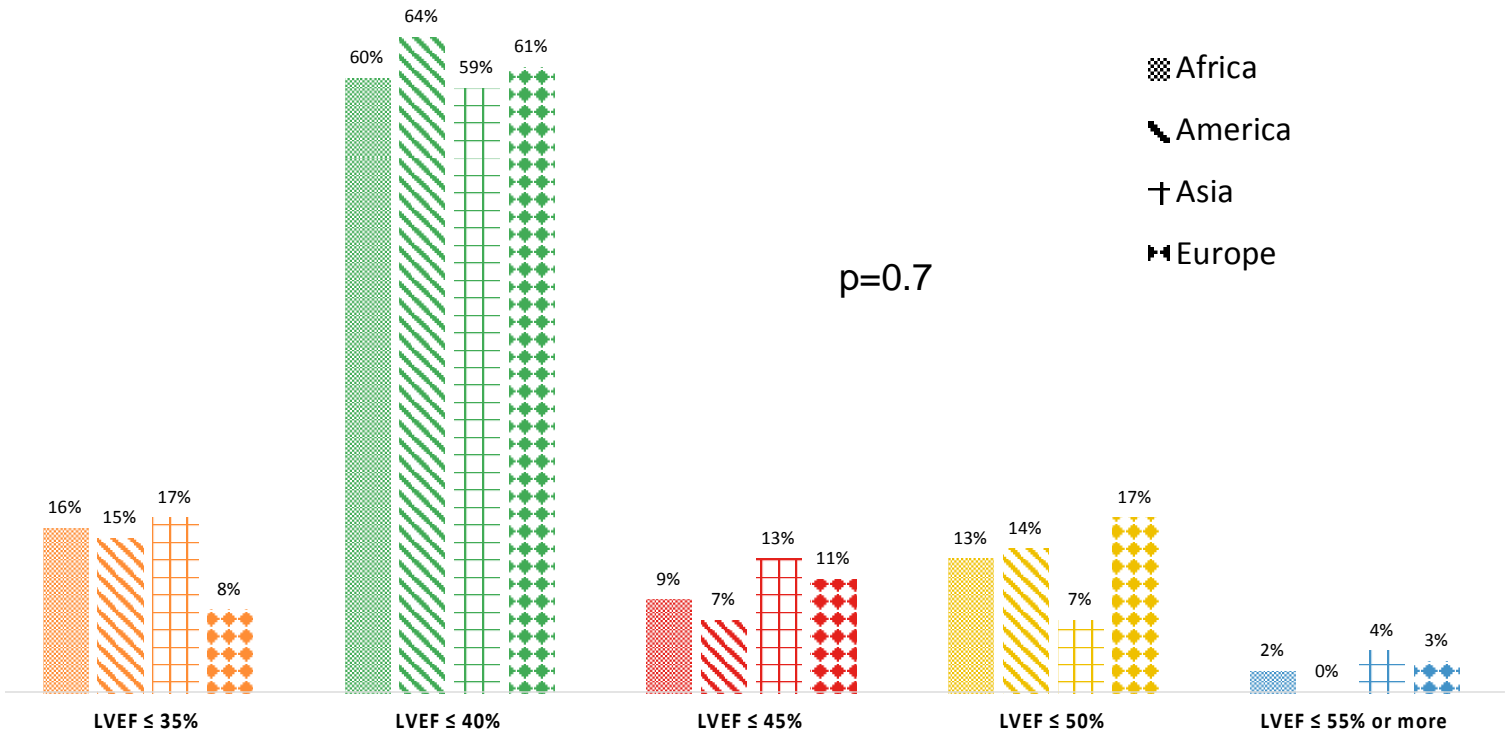
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Supplementary material, e-method 2. Clarification on the survey distribution.

The survey was published on the SurveyMonkey platform and shared via mail to the mailing list of the French Heart Failure and Cardiomyopathy group of the French Society of Cardiology and the French Young Cardiologist in Training group of the French Society of Cardiology on the 15th of March. The survey was also sent to the mailing lists of the ESC Academy and the Zurich Postgraduate Course in Heart Failure (PCHF) network and several members of the Heart Failure Association (AHF) board on the same day. The link for the survey was posted on several social networks (LinkedIn, Facebook, Twitter). All recipients of this invitation were invited to send the link of this survey to their respective local and national networks.

The survey was available for one month (from the 15th of March to the 16th of April 2022) on the web platform. Three successive invitations were sent to all networks within this time frame. The first one was sent on the 15th of march, the second one was sent on the 30th of March, and the third and final one was sent, as a final reminder, on the 8th of April.

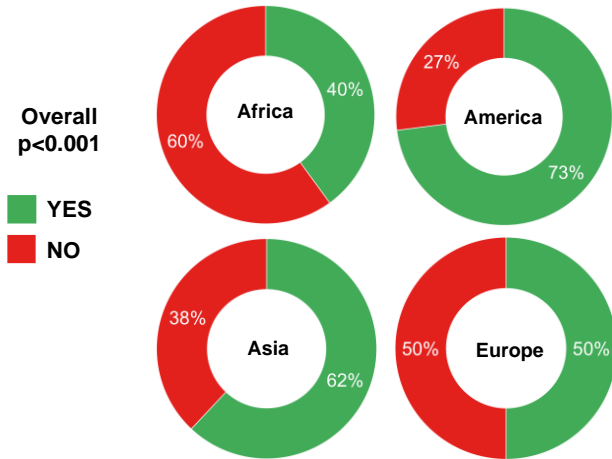
1 **Supplementary, figure 1. What is the accurate LVEF threshold to define HF_rEF?**
2 **subgroup analysis according to the continent of origin of the participants.**



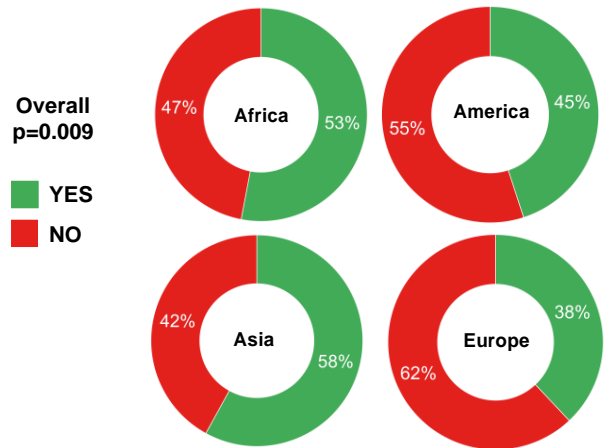
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4 *Abbreviations: LVEF: left ventricular ejection fraction, HF: heart failure, MD: medical*
5 *doctor.*

1 **Supplementary, figure 2. Subgroup analysis according to the continent of origin of the**

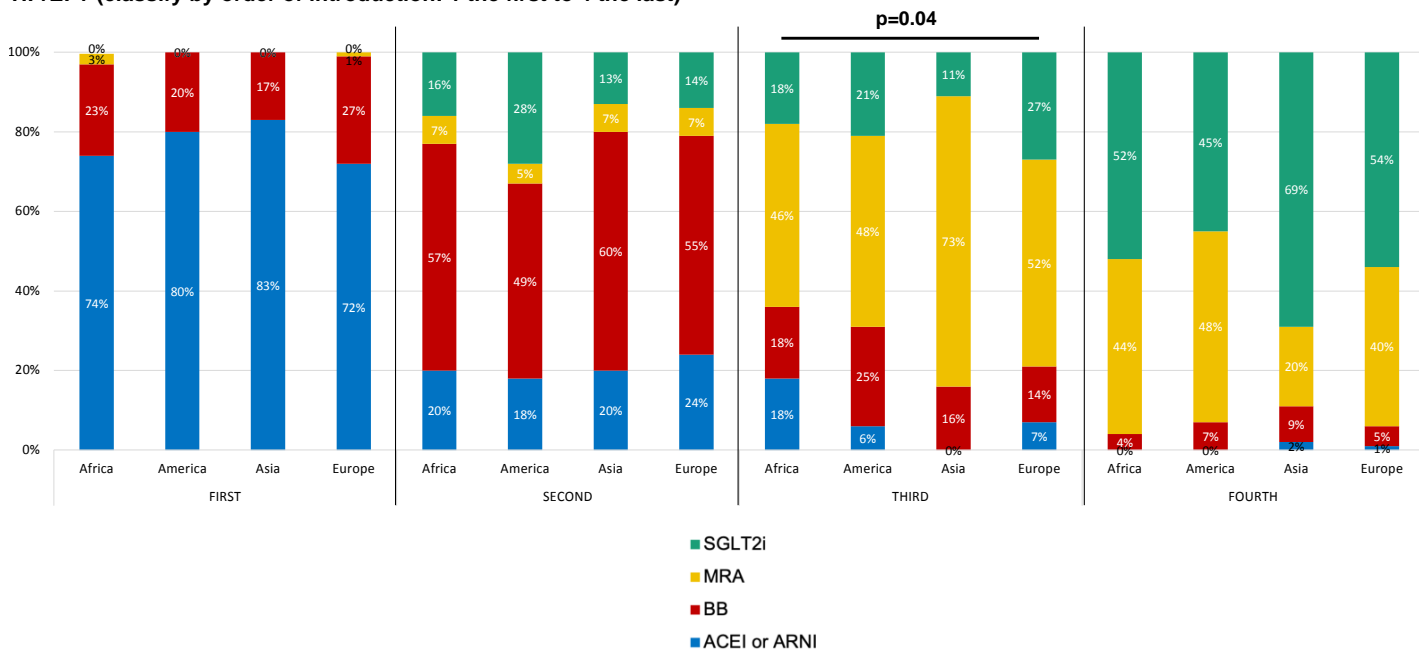
A. In a primary HFrEF patient without prior HF drug treatment, do you start with ARNi instead of ACEi or ARBs?



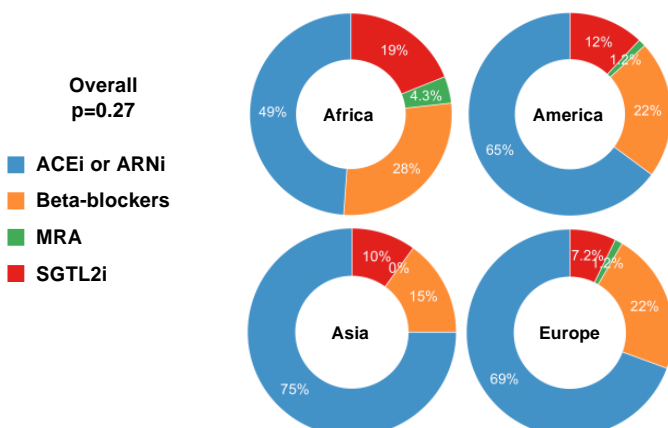
B. In your experience, is titrating more important than adding another heart failure drug class?



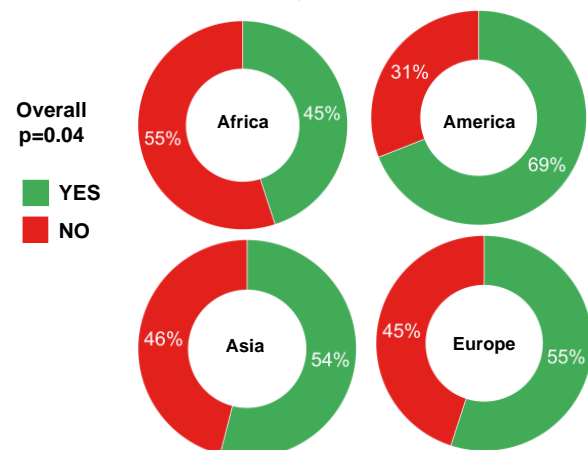
C. What would be your standard best heart failure drug sequencing among the following drugs in a patient with a first episode of HFrEF? (classify by order of introduction: 1 the first to 4 the last)



D. If you had to choose one drug class only for a heart failure patient, which one would you choose?



E. Do you introduce MRA in heart failure patients with GFR < 30 mL/min, with careful kaliemia monitoring?



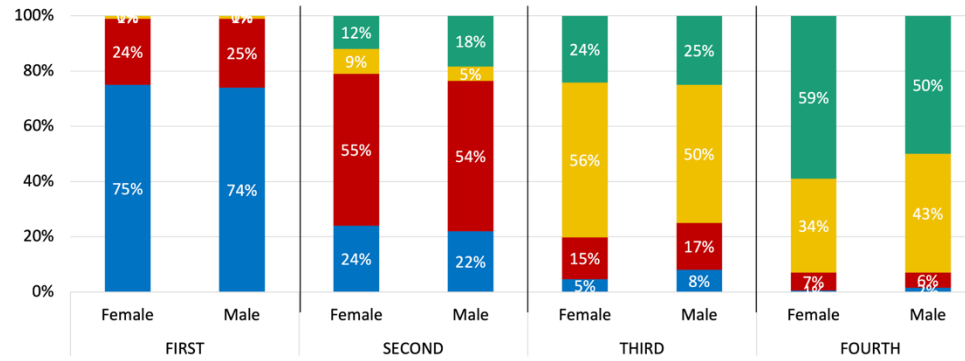
1 **participants.**

2 Abbreviations: SGLT2i: sodium-glucose cotransporter 2 inhibitors, MRA: mineralocorticoid

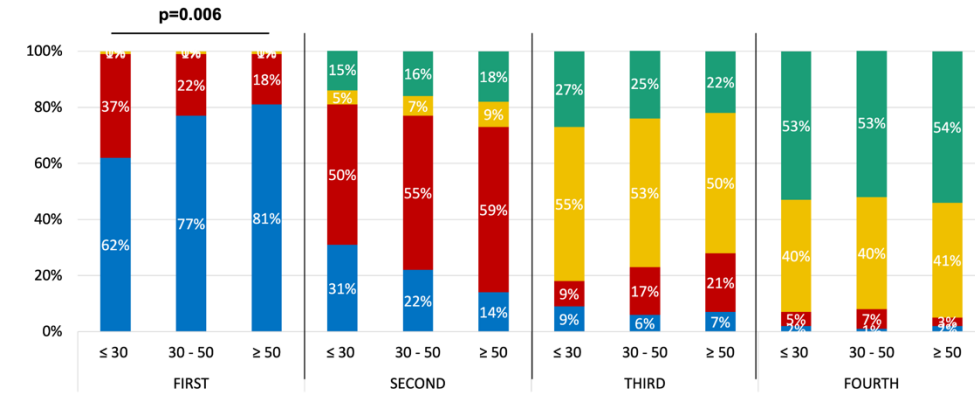
3 receptor antagonism, BB: beta-blockers, ACEi: angiotensin-converting enzyme inhibitor,

4 ARNi: angiotensin-receptor neprilysin-inhibitor.

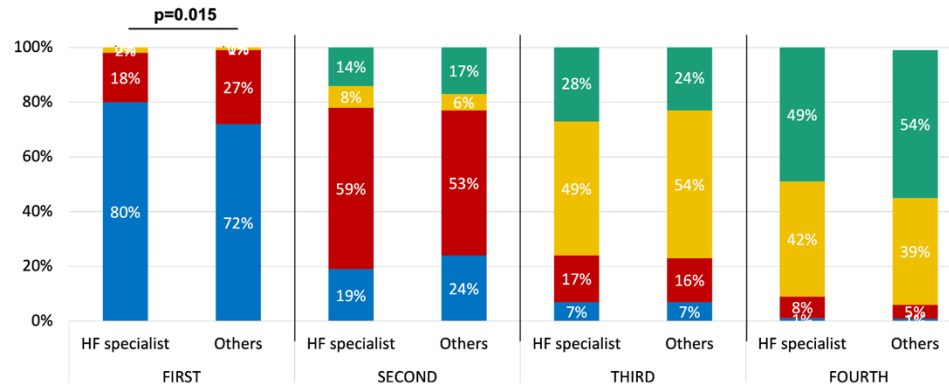
A. Gender comparison



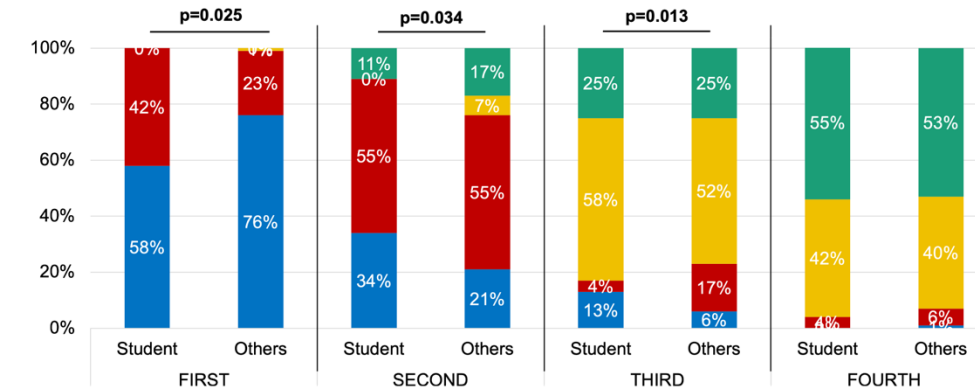
B. Age comparison



C. HF specialists versus non specialists



D. Student/resident versus MD



1 **Supplementary, figure 3. Subgroup analysis: what would be your standard best HF drug sequencing (classify by order of introduction)?**

2

- 1 Abbreviations: *SGLT2i: sodium-glucose cotransporter 2 inhibitors, MRA: mineralocorticoid receptor antagonism, BB: beta-blockers, ACEi:*
- 2 *angiotensin-converting enzyme inhibitor, ARNi: angiotensin-receptor neprilysin-inhibitor.*