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Section:	Prescription Drugs	**Effective Date:**	April 1, 2026
Subsection:	Neuromuscular Drugs	**Original Policy Date:**	December 27, 2024
Subject:	Attruby	**Page:**	1 of 4

Last Review Date: March 6, 2026

Attruby

Description

Attruby (acoramidis)

Background
Attruby (acoramidis) is a selective stabilizer of transthyretin (TTR). Attruby binds TTR at thyroxine binding sites and slows dissociation of the TTR tetramer into its constituent monomers, the rate-limiting step in amyloidogenesis (1).

Regulatory Status
FDA-approved indication: Attruby is a transthyretin stabilizer indicated for the treatment of the cardiomyopathy of wild-type or variant transthyretin-mediated amyloidosis (ATTR-CM) in adults to reduce cardiovascular death and cardiovascular-related hospitalization (1).

The recommended dosage of Attruby is 712 mg orally twice daily (1).

Initiation of Attruby causes an increase in serum creatinine and decrease in eGFR which generally occurs within 4 weeks of starting therapy and stabilizes. The changes in serum creatinine and eGFR were reversible after treatment discontinuation (1).

In clinical studies, subjects were primarily (87.9%) white and so Attruby's safety and efficacy in other races may be limited (1).

The safety and effectiveness of Attruby in pediatric patients less than 18 years of age have not been established (1).

Related policies
Vyndaqel Vyndamax

Policy

This policy statement applies to clinical review performed for pre-service (Prior Approval, Precertification, Advanced Benefit Determination, etc.) and/or post-service claims.

Attruby may be considered **medically necessary** if the conditions indicated below are met.

Attruby may be considered **investigational** for all other indications.

Prior-Approval Requirements

Age 18 years of age or older

Diagnosis

Patient must have the following:

Cardiomyopathy of wild-type or variant transthyretin-mediated amyloidosis (ATTR-CM)

AND ALL of the following:

1. Diagnosis has been confirmed by a genetic test **OR** tissue biopsy showing amyloid deposition
2. Clinical signs and symptoms of cardiac involvement by **ALL** of the following:
   a. End-diastolic interventricular septal wall thickness ≥ 12 mm by echocardiography
   b. History of heart failure with at least one hospitalization for heart failure **OR** clinical evidence of heart failure with signs and symptoms of volume overload or elevated intracardiac pressures requiring treatment with a diuretic for improvement
   c. Baseline NT-proBNP ≥ 300 pg/mL
3. NYHA class I – III symptoms due to ATTR cardiomyopathy
4. **NO** light-chain amyloidosis

Prior – Approval *Renewal* Requirements

Age 18 years of age or older

Diagnosis

Patient must have the following:

Cardiomyopathy of wild-type or variant transthyretin-mediated amyloidosis (ATTR-CM)

AND the following:

a. Patient's condition has improved or stabilized [e.g., reduced number of hospitalizations, improved 6-minute walk test (6-MWT), or improved Kansas City Cardiomyopathy Questionnaire Overall Summary Score (KCCQ-OS)]

Policy Guidelines

Pre - PA Allowance

None

Prior - Approval Limits

Quantity 336 tablets per 84 days

Duration 12 months

Prior – Approval *Renewal* Limits

Same as above

Rationale

Summary

Attruby is a transthyretin stabilizer indicated for the treatment of the cardiomyopathy of wild-type or variant transthyretin-mediated amyloidosis (ATTR-CM) in adults to reduce cardiovascular death and cardiovascular-related hospitalization. The safety and effectiveness of Attruby in pediatric patients less than 18 years of age have not been established (1).

Prior authorization is required to ensure the safe, clinically appropriate, and cost-effective use of Attruby while maintaining optimal therapeutic outcomes.

References

1. Attruby [package insert]. Palo Alto, CA: BridgeBio Pharma, Inc.; November 2024.
2. Eidos Therapeutics Inc. Treatment of Symptomatic ATTR Cardiomyopathy Protocol Amendment. June 16, 2022. Accessed January 10, 2025. https://cdn.clinicaltrials.gov/large-docs/35/NCT03860935/Prot_000.pdf

Policy History

Date	Action
December 2024	Addition to PA
March 2025	Annual review. Per SME, added statement in regulatory section regarding the primarily white composition of the trial population
March 2026	Annual review

Keywords

This policy was approved by the FEP® Pharmacy and Medical Policy Committee on March 6, 2026 and is effective on April 1, 2026.