Commercial PA Criteria

Effective: January 30, 2025

Prior Authorization: Attruby

Products Affected: Attruby (acoramidis) oral tablets

Medication Description: Attruby, a transthyretin (TTR) stabilizer, is indicated for the treatment of the cardiomyopathy of wild-type or variant transthyretin-mediated amyloidosis (ATTR-CM) in adults to reduce cardiovascular (CV) death and CV-related hospitalization.

Covered Uses: cardiomyopathy of wild-type or variant transthyretin-mediated amyloidosis (ATTR-CM) in adults to reduce cardiovascular (CV) death and CV-related hospitalization.

Exclusion Criteria:

1. Concurrent use with other medications indicated for the treatment of polyneuropathy of hereditary transthyretin-mediated amyloidosis or transthyretin-mediated amyloidosis-cardiomyopathy (e.g., Amvuttra [vutrisiran subcutaneous injection], Onpattro [patisiran intravenous infusion], Tegsedi [inotersen subcutaneous injection], Wainua [eplontersen subcutaneous injection], or a tafamidis product).
   The requested medication should not be administered in combination with other medications indicated for polyneuropathy of hereditary transthyretin-mediated amyloidosis or transthyretin-mediated amyloidosis-cardiomyopathy. Combination therapy is generally not recommended due to a lack of controlled clinical trial data supporting additive efficacy.
2. Polyneuropathy of Hereditary Transthyretin–Mediated Amyloidosis (hATTR). Attruby is not indicated for treatment of symptoms of polyneuropathy associated with hATTR.
   Note: For patients with hATTR and cardiomyopathy or mixed phenotype (concurrent cardiomyopathy and polyneuropathy), refer to FDA-Approved Indication, above.

Required Medical Information:

1. Diagnosis
2. Medical History
3. Medication History

Prescriber Restriction: The medication is prescribed by or in consultation with a cardiologist or a physician who specializes in the treatment of amyloidosis.

Age Restriction: Patient must be 18 years of age or greater.

Coverage Duration: 12 months

Other Criteria:

Initial Approval Criteria

1. **Cardiomyopathy of Wild-Type or Hereditary Transthyretin-Mediated Amyloidosis (ATTR-CM).**

Approve for 1 year if the patient meets ALL of the following (A, B, C, D, **AND** E):

Note: Variant Transthyretin Amyloidosis is also known as Hereditary Transthyretin Amyloidosis.

A. Patient is ≥ 18 years of age; **AND**
B. The diagnosis was confirmed by ONE of the following (i, ii, **OR** iii):
    i. A technetium pyrophosphate scan (i.e., nuclear scintigraphy); **OR**
    ii. A tissue biopsy with confirmatory transthyretin (TTR) amyloid typing by mass spectrometry, immunoelectron microscopy or immunohistochemistry; **OR**
    iii. Patient had genetic testing which, according to the prescriber, identified a transthyretin (TTR) pathogenic variant; **AND**
    Note: Examples of TTR variants include Val122Ile variant and Thr60Ala variant. If the patient has wild-type amyloidosis, this is **not** a TTR pathogenic variant.
C. Diagnostic cardiac imaging has demonstrated cardiac involvement; **AND**
    Note: Examples of cardiac imaging include echocardiogram and cardiac magnetic imaging. Examples of cardiac involvement on imaging include increased thickness of the ventricular wall or interventricular septum.
D. Patient has heart failure, but does **not** have New York Heart Association class IV disease; **AND**
E. The medication is prescribed by or in consultation with a cardiologist or a physician who specializes in the treatment of amyloidosis.

References:

1. Attruby tablets [prescribing information]. Palo Alto, CA: BridgeBio; November 2024.

Policy Revision history

Rev #	Type of Change	Summary of Change	Sections Affected	Date
1	New Policy	New Policy	All	01/30/2025