UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 1466-1
Program	Prior Authorization/Notification
Medication	Attruby™ (acoramidis)
P&T Approval Date	1/2025
Effective Date	4/1/2025

1. Background:

Attruby (acoramidis) 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.

2. Coverage Criteria[a]:

A. Transthyretin (ATTR)-mediated amyloidosis with cardiomyopathy (ATTR-CM)

1. **Initial Authorization**

a. **Attruby** will be approved based on **all** of the following criteria:

(1) Diagnosis of transthyretin (ATTR)-mediated amyloidosis with cardiomyopathy (ATTR-CM)

-AND-

(2) Patient is not receiving Attruby in combination with an RNA-targeted therapy for ATTR amyloidosis [i.e., Amvuttra (vutrisiran), Onpattro (patisiran), Tegsedi (inotersen), Vyndaqel/Vyndamax (tafamadis), or Wainua (eplontersen)]

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Attruby** will be approved based on **both** of the following criteria:

(1) Documentation that the patient has experienced a positive clinical response to Attruby (e.g., improved symptoms, quality of life, slowing of disease progression, decreased hospitalizations, etc.)

-AND-

(2) Patient is not receiving Attruby in combination with an RNA-targeted therapy for ATTR amyloidosis [i.e., Amvuttra (vutrisiran), Onpattro (patisiran), Tegsedi (inotersen), Vyndaqel/Vyndamax (tafamadis), or Wainua (eplontersen)]

Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Programs:

- Medical Necessity may be in place
- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. Attruby [package insert]. BridgeBio Pharma, Inc: Palo Alto, CA; November 2024.

Program	Prior Authorization/Notification - Attruby™ (acoramidis)
Change Control	
1/2025	New program.