



Drug Coverage Policy

Effective Date3/1/2026

Coverage Policy Number.....IP0728

Policy Title.....Attruby

Amyloidosis – Attruby

- Attruby (acoramidis tablets – Bridgebio)

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer’s particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer’s benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer’s benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

OVERVIEW

Attruby, a transthyretin (TTR) stabilizer, is indicated for the treatment of the **cardiomyopathy of wild-type or variant TRR-mediated amyloidosis (ATTR-CM)** to reduce cardiovascular death and cardiovascular-related hospitalization in adults.¹ Studies excluded patients with New York Heart Association class IV disease.²

Disease Overview

ATTR-CM is a progressive, debilitating, and life-threatening disease that may go unrecognized and result in late-stage diagnosis.^{3,4} ATTR can be caused by an acquired wild-type variant or be an inherited variant that alters the structure and function of TTR. Genetic testing of the TTR gene is done to differentiate patients with the wild type vs. a genetic variant. Although patients with ATTR may present with a variety of symptoms, neuropathy or cardiomyopathy are often the most prominent symptoms. Patients may also present with a mixed phenotype and exhibit signs of both neuropathy and cardiomyopathy. In ATTR-CM, the stability of the TTR tetramer is altered, resulting in misfolding of the TTR protein. This leads to accumulation of amyloid in the body, most commonly the myocardium and peripheral nerves. As a result of amyloid deposits in cardiac tissue and causes the heart muscle to become stiff and rigid. Although the clinical course varies, patients typically exhibit heart failure with preserved ejection fraction. However, some patients may present with right-sided heart failure, atrial fibrillation, aortic stenosis and complete heart block, angina, or cardiogenic shock.

Guidelines

Attruby is currently not addressed in guidelines. The American Heart Association (AHA) scientific statement for the evolving diagnosis and management of cardiac amyloidosis (2020) recognizes tafamidis as a treatment for ATTR-CM.⁵ They note that the benefit of tafamidis has not been observed in patients with NYHA class IV symptoms. Additionally, although combination use of tafamidis with Onpattro® (patisiran lipid complex intravenous infusion) or Tegsedi® (inotersen subcutaneous injection) is appealing to target both TTR silencing and stabilization for the remaining synthesized protein, this approach lacks data and may be cost-prohibitive. Tafamidis should generally be considered the agent of choice in ATTR-CM in patients with reasonable expected survival according to a position statement of the European Society of Cardiology (ESC) working group on myocardial and pericardial disease (2021).⁶ The working group notes that tafamidis is the only drug that has shown efficacy in a randomized trial in patients with ATTR-CM and should be considered in patients with reasonable expected survival. The American College of Cardiology (ACC) expert consensus decision pathway on comprehensive multidisciplinary care for patients with cardiac amyloidosis (2023) make similar comments and recommendations to the AHA and ESC regarding tafamidis.⁷

Coverage Policy

Policy Statement

Prior Authorization is required for prescription benefit coverage of Attruby. All approvals are provided for the duration noted below. Because of the specialized skills required for evaluation and diagnosis of patients treated with Attruby as well as the monitoring required for adverse events and long-term efficacy, initial approval requires the agent to be prescribed by or in consultation with a physician who specializes in the condition being treated.

Documentation: Documentation is required where noted in the criteria. Documentation may include, but not limited to, chart notes, laboratory tests, claims records, and/or other information. All documentation must include patient-specific identifying information.

Attruby is considered medically necessary when the following are met:

FDA-Approved Indication

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, E, and F):

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

- A)** Patient is \geq 18 years of age; AND
- B)** The diagnosis confirmed by ONE of the following (i, ii, or iii):
 - i.** A technetium pyrophosphate scan (i.e., nuclear scintigraphy) [**documentation required**]; OR
 - ii.** A tissue biopsy with confirmatory transthyretin (TTR) amyloid typing by mass spectrometry, immunoelectron microscopy or immunohistochemistry [**documentation required**]; OR
 - iii.** Patient had genetic testing which identified a transthyretin (TTR) pathogenic variant [**documentation required**]; 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.
- F)** Preferred product criteria is met for the product(s) as listed in the below table(s) [Individual and Family Plans]

Individual and Family Plans:

Product	Criteria
Attruby (acoramidis tablets)	The patient has tried, and according to the prescriber, has experienced inadequate efficacy or a significant intolerance with Vyndamax.

Conditions Not Covered

Attruby for any other use is considered not medically necessary, including the following (this list may not be all inclusive; criteria will be updated as new published data are available):

- 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.¹

Note: For patients with hATTR and cardiomyopathy or mixed phenotype (concurrent cardiomyopathy and polyneuropathy), refer to FDA-Approved Indication, above.

References

1. Attruby tablets [prescribing information]. Palo Alto, CA: BridgeBio; November 2024.
2. Gillmore JD, Judge DP, Cappelli F, et al. Efficacy and safety of acoramidis in transthyretin amyloid cardiomyopathy. *NEJM*. 2024;390(2):132-142.
3. National Library of Medicine, StatPearls. Transthyretin Amyloid Cardiomyopathy (ATTR-CM). Available at. <https://www.ncbi.nlm.nih.gov/books/NBK574531/>. Accessed December 1, 2025.
4. Vaishnav J, Brown E, Sharma K. Advances in the diagnosis and treatment of transthyretin amyloid cardiomyopathy. *Prog Cardiovasc Dis*. 2024;82:113-124.
5. Kittleson MM, Maurer MS, Ambardekar AV, et al; on behalf of the American Heart Association Heart Failure and Transplantation Committee of the Council on Clinical Cardiology. AHA scientific statement: cardiac amyloidosis: evolving diagnosis and management. *Circulation*. 2020;142:e7-e22.
6. Garcia-Pavia P, Rapezzi C, Adler Y, et al. Diagnosis and treatment of cardiac amyloidosis: a position statement of the ESC working group on myocardial and pericardial disease. *Eur Heart J*. 2021;42:1554-1568.
7. Kittleson M, Ruberg FL, Ambardekar AV, et al. A report of the American College of Cardiology Solution Set Oversight Committee. 2023 ACC expert consensus decision pathway on comprehensive multidisciplinary care for the patient with cardiac amyloidosis. *JACC*. 2023;81(11):1076-1126.

Revision Details

Type of Revision	Summary of Changes	Date
New	New policy	05/15/2025
Annual Revision	The name of the policy was updated to "Amyloidosis – Attruby PA Policy." Previously, the policy was named "Amyloidosis – Acoramidis PA Policy." There were no other changes to criteria.	3/1/2026

The policy effective date is in force until updated or retired.

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