

UnitedHealthcare Pharmacy  
Clinical Pharmacy Programs

Program Number	2026 P 1466-2
Program	Prior Authorization/Notification
Medication	Attruby™ (acoramidis)
P&T Approval Date	1/2025, 1/2026
Effective Date	4/1/2026

**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<sup>a</sup>:**

**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.**

<sup>a</sup> 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; August 2025.

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<b>Change Control</b>	
1/2025	New program.
1/2026	Annual review. No changes to coverage criteria.