

acoramidis (Attruby™)

Policy # 00929

Original Effective Date: 06/01/2025

Current Effective Date: 06/01/2026

Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the “Company”), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

Investigational or experimental services are not covered. This includes any drug, device, procedure, or service provided under the investigational arm of a clinical trial or clinical study. These services are excluded from coverage under benefits.

Note: Treatment of polyneuropathy of hereditary transthyretin amyloidosis is addressed separately in medical policy 00670. The tafamidis product, Vyndamax™, is addressed separately in medical policy 00694.

When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member’s contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Company may consider acoramidis (Attruby™)† for the treatment of the cardiomyopathy of transthyretin-mediated amyloidosis (ATTR-CM) to be **eligible for coverage**.**

Patient Selection Criteria

Coverage eligibility will be considered for acoramidis (Attruby) when the following criteria are met:

- **Initial**
 - Patient has a diagnosis of cardiomyopathy of wild-type or hereditary transthyretin amyloidosis (ATTR); AND
 - Diagnosis is confirmed by ONE of the following:
 - A technetium pyrophosphate scan (i.e. nuclear scintigraphy); OR
 - Amyloid deposits identified on cardiac biopsy; AND
 - Patient is greater than or equal to 18 years of age; AND
 - Diagnostic cardiac imaging (e.g., echocardiograph, cardiac magnetic resonance imaging) has demonstrated cardiac involvement (e.g., increased thickness of the ventricular wall or interventricular septum); AND
 - Patient has New York Heart Association class I, II, or III heart failure; AND
*(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met.)*
 - Other forms of amyloidosis (e.g., light chain amyloidosis) have been ruled out; AND
*(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met.)*

acoramidis (Attruby™)

Policy # 00929

Original Effective Date: 06/01/2025

Current Effective Date: 06/01/2026

- Patient has NOT received a liver transplant; AND
*(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met.)*
- Requested drug will NOT be used in combination with patisiran (Onpattro™)‡, vutrisiran (Amvuttra™)‡, eplontersen (Wainua™)‡, or a tafamadis product (Vyndamax®, Vyndaqel™)‡.
- **Continuation**
 - Patient has received an initial authorization for the requested drug; AND
 - Patient does NOT have New York Heart Association class IV heart failure; AND
*(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met.)*
 - Patient has NOT received a liver transplant; AND
*(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met.)*
 - Requested drug will NOT be used in combination with patisiran (Onpattro), vutrisiran (Amvuttra), eplontersen (Wainua), or a tafamidis product (Vyndamax, Vyndaqel).

When Services Are Considered Not Medically Necessary

Based on review of available data, the Company considers the use of acoramidis (Attruby) when the patient does not have New York Heart Association class I, II, or III heart failure, other forms of amyloidosis have not been ruled out, or the patient has received a liver transplant to be **not medically necessary.****

Based on review of available data, the Company considers the continued use of acoramidis (Attruby) when the patient has New York Heart Association class IV heart failure or has received a liver transplant to be **not medically necessary.****

When Services Are Considered Investigational

Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

Based on review of available data, the Company considers the use of acoramidis (Attruby) when patient selection criteria are not met (except those noted above as **not medically necessary****) to be **investigational.***

Background/Overview

Attruby is a transthyretin (TTR) stabilizer indicated for the treatment of the cardiomyopathy of wild-type or variant transthyretin-mediated amyloidosis. It is thought to work by binding to TTR and slowing its dissociation into its constituent monomers to slow the formation of amyloid. Attruby is supplied as 356 mg tablets and should be dosed as 712 mg (2 tablets) by mouth twice daily.

Policy # 00929

Original Effective Date: 06/01/2025

Current Effective Date: 06/01/2026

The TTR protein is primarily produced in the liver and circulates as a stable tetramer, transporting vitamin A and thyroxine throughout the body. With aging or in the setting of a mutation of the TTR gene, the stability of the TTR tetramer is altered, resulting in misfolding of the TTR protein. This leads to accumulation of amyloid in organs and tissues, causing symptoms based on the organ(s) involved. The most prominent symptoms are often those of cardiomyopathy or polyneuropathy (ATTR-CM or ATTR-PN). In ATTR-CM, amyloid deposits in cardiac tissue cause a weakening and/or stiffening of the heart. Although the clinical course varies, patients typically exhibit heart failure with preserved ejection fraction, but some patients may present with right-sided heart failure, atrial fibrillation, bundle branch block and complete heart block, angina, or cardiogenic shock. In ATTR-PN, neurologic symptoms include severe sensorimotor disturbances (loss of sensation, pain, muscle weakness, and loss of ambulation) and autonomic dysfunction resulting in orthostatic hypotension, diarrhea, impotence, and bladder disturbances. Patients may also present with a mixed phenotype and exhibit signs of both neuropathy and cardiomyopathy. This condition is progressive, debilitating, and life-threatening and may go unrecognized and result in late-stage diagnosis.

Management of cardiomyopathy associated with ATTR has historically been via standard therapies for heart failure such as diuretics, beta-blockers, mineralocorticoid receptor antagonists, and sodium-glucose cotransporter-2 inhibitors. In 2019, the FDA approved the first disease-modifying therapies for ATTR-CM, the tafamidis products Vyndaqel and Vyndamax. These products contain the same active ingredient and are also selective stabilizers of TTR tetramers. Tafamidis demonstrated efficacy in reducing all-cause mortality in its pivotal trial. More recently, the TTR silencer vutrisiran (Amvuttra) has been FDA approved for ATTR-CM. None of these therapies have been compared head-to-head and differences in clinical trial design make it difficult to compare efficacy and safety among products. The treatment landscape for this disease state will continue to evolve as real-world evidence becomes available.

FDA or Other Governmental Regulatory Approval

U.S. Food and Drug Administration (FDA)

Attruby was approved in November 2024 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.

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to regulations, other plan medical policies, and accredited national guidelines.

The efficacy of Attruby was demonstrated in a multicenter, international, randomized, double-blind, placebo-controlled study in 611 adult patients with wild-type or variant (hereditary or *de novo*) ATTR-CM.

acoramidis (Attruby™)

Policy # 00929

Original Effective Date: 06/01/2025

Current Effective Date: 06/01/2026

Participants were randomized (2:1) to receive Attruby 712 mg (n = 409) or placebo (n = 202) twice daily for 30 months. Treatment assignment was stratified by type of ATTR-CM (variant or wild-type), NT-proBNP level, and estimated glomerular filtration rate (eGFR). Participants were permitted to initiate open-label tafamidis after 12 months in the study. A total of 107 participants received tafamidis: 61 (14.9%) in the Attruby arm and 46 (22.8%) in the placebo arm. The median time to initiation of tafamidis was 17 months.

The primary composite endpoint included all-cause mortality (ACM) and cumulative frequency of cardiovascular-related hospitalizations (CVH) over 30 months, analyzed hierarchically using the stratified Finkelstein-Schoenfeld (F-S) test. The F-S test demonstrated a statistically significant reduction ($p = 0.018$) in ACM and cumulative frequency of CVH in the Attruby arm versus the placebo arm. All-cause mortality was reported in 18% and 26% of participants in the Attruby and placebo groups, respectively. The majority (79%) of deaths were cardiovascular. CVH was reported in 27% and 43% of participants in the Attruby and placebo groups, respectively. The mean number of CVH events was 0.3 vs 0.6 per year. The majority (59%) of VH were heart failure hospitalizations reported in 13% and 26% of participants in the Attruby and placebo groups, respectively. A Cox regression analysis indicated a 35.5% decrease in the risk of the composite of ACM or first CV hospitalization (hazard ratio: 0.645 [95% CI: 0.500, 0.832]).

References

1. Attruby [package insert]. BridgeBio Pharma, Inc. Palo Alto, CA. Updated November 2024.
2. Attruby New Drug Review. IPD Analytics. Updated December 2024.

Policy History

Original Effective Date: 06/01/2025

Current Effective Date: 06/01/2026

05/01/2025 Medical Policy Committee review

05/13/2025 Medical Policy Implementation Committee approval. New policy.

05/07/2026 Medical Policy Committee review

05/13/2026 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.

Next Scheduled Review Date: 05/2027

*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

- A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
- B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or

Policy # 00929

Original Effective Date: 06/01/2025

Current Effective Date: 06/01/2026

diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:

1. Consultation with technology evaluation center(s);
2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
3. Reference to federal regulations.

****Medically Necessary (or “Medical Necessity”)** - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- A. In accordance with nationally accepted standards of medical practice;
- B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
- C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, “nationally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

‡ Indicated trademarks are the registered trademarks of their respective owners.

NOTICE: If the Patient’s health insurance contract contains language that differs from the BCBSLA Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

NOTICE: If an authorization for an ongoing course of treatment has been provided to a member and the member changes from one health plan to another health plan (e.g., a member moves from carrier A to Louisiana Blue), Louisiana Blue may honor the previous health plan’s authorization for the same service under the same type of in-network benefit for a 90-day transition period. Documentation of the authorization for the ongoing course of treatment from the previous health plan must be provided to us by the member or their provider and the services provided for the course of treatment must otherwise be a covered service under the Louisiana Blue health plan. This provision does not apply to medications covered under the plan’s pharmacy benefit.