Reference number(s)
6897-D

This document applies to the following:

Formulary	Applies
Standard Control (SF)	☑
Standard Control – Choice (SCCF)	☑
Preferred Drug Plan Design (PDPD)	☐
Advanced Control Specialty (ACSF)	☑
Advanced Control Specialty – Choice (ACSCF)	☑
Managed Medicaid Template (MMT)	☐
Marketplace (MF)	☐
Aetna Small Group Affordable Care Act (SG ACA) Aetna Health Exchange (AHE)	☐
Aetna Individual Lives (IVL)	☐
Value (VF)	☑
New to Market (NTM)	☐

Formulary	Applies
Standard Formulary Chart (SFC)	☐
Basic Control Chart Preferred Drug Plan Design (BCC PDPD)	☐
Advanced Control Specialty Formulary Chart (ACSFC)	☐
Value Formulary Chart (VFC)	☐
Medical Benefit	☐
Medical Benefit: Advanced Biosimilars First	☐
Combined Benefit Medical Specialty (CBMS)	☐
Medical Benefit: Managed Medicaid (MMMB)	☐
Medicare Part B	☐
Medicare Part B: Advanced Biosimilars First	☐

Exceptions Criteria Transthyretin Amyloidosis Cardiomyopathy (ATTR-CM)

This document informs prescribers of preferred products and provides an exception process for targeted products through prior authorization.

These criteria were developed to align with the following: Standard Control Formulary (SF), Standard Control Choice Formulary (SCCF), Advanced Control Specialty Formulary (ACSF), Advanced Control Specialty – Choice Formulary (ACSCF), and Value Formulary (VF).

Plan Design Summary

This program applies to the transthyretin stabilizer products specified in this document. Coverage for the targeted products is provided based on clinical circumstances that would exclude the use of the preferred product and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to all members requesting treatment with Vyndaqel. This program also applies to members who are new to treatment with Attruby for the first time.

Each referral is reviewed based on all utilization management (UM) programs implemented for the client.

Table. Transthyretin Stabilizer Products

Medications considered formulary or preferred on your plan may still require a clinical prior authorization review.

	Product(s)
Preferred	• Vyndamax (tafamidis)
Target	• Attruby (acoramidis) • Vyndaqel (tafamidis meglumine)

Exception Criteria

This program applies to members requesting treatment for an indication that is FDA-approved for the preferred product.

Attruby

Coverage for Attruby is provided when either of the following criteria is met:

- Member is currently receiving treatment with Attruby, excluding when the requested product is obtained as samples or via manufacturer's patient assistance programs.
- Member has a documented inadequate response or intolerable adverse event with the preferred product Vyndamax.

Vyndaqel

Coverage for Vyndaqel is provided when the member has had a documented intolerable adverse event to the preferred product Vyndamax, and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information.

References

1. Attruby [package insert]. Palo Alto, CA: BridgeBio Pharma, Inc.; November 2024.
2. Vyndaqel and Vyndamax [package insert]. New York, NY: Pfizer Labs; October 2023.