Attruby

Saudi Arabia · access guide

How to access Attruby for transthyretin amyloid cardiomyopathy (ATTR-CM) from Saudi Arabia: 2026 pathway via KFSHRC, KAMC, Prince Sultan Cardiac Centre and the wider kingdom cardiology network

By Reserve Meds clinical & regulatory team. Last reviewed 2026-05-20.

Saudi Arabia has built the densest tertiary cardiology and cardiac amyloid infrastructure in the wider region. King Faisal Specialist Hospital and Research Centre in Riyadh runs an amyloid clinic with cardiology and the Centre for Genomic Medicine working alongside on hereditary TTR variant identification, and is the kingdom's reference centre for cardiac amyloidosis management. King Abdulaziz Medical City Riyadh, Prince Sultan Cardiac Centre Riyadh and Prince Sultan Cardiac Centre Khobar, King Fahd Cardiac Centre, and KFSH Jeddah cardiology cover the rest of the country. Several of these centres have been managing transthyretin amyloid cardiomyopathy on tafamidis since the SFDA registration of Vyndamax / Vyndaqel, and the cardiac amyloid community in Saudi Arabia is among the most experienced in MENA. Attruby (acoramidis) is a recent FDA approval, November 2024. For a Saudi patient or family in 2026 with confirmed or suspected ATTR-CM, the operational question is no longer whether a high-potency TTR stabilizer exists; it is how the supply pathway works while SFDA registration progresses, where the diagnostic confirmation is done if it is not already complete, and how the clinical conversation between Attruby, the already-established tafamidis, and the alternative-mechanism amvuttra resolves into a treatment plan.

This page explains how the pathway works in 2026 for a Saudi-resident adult: who qualifies, where the diagnostic workup happens, where the prescription is written and how the supply is procured, what the realistic out-of-pocket exposure band is in SAR, what to monitor on therapy, and how the indefinite oral treatment course settles into the life of an older patient and family. It is concierge documentation written for a family that is already in conversation with a treating cardiologist and wants the operational reality laid out plainly.

Why Attruby, and why now

Attruby is acoramidis, an oral, selective, near-complete transthyretin tetramer stabilizer developed by BridgeBio Pharma. The FDA approved Attruby in November 2024 for adults with transthyretin amyloid cardiomyopathy (both hereditary ATTRv-CM and wild-type ATTRwt-CM) to reduce all-cause mortality and cardiovascular hospitalisation. The pivotal trial is ATTRibute-CM (NEJM 2024), which randomised 632 adults with symptomatic ATTR-CM to acoramidis or placebo for 30 months and showed a significant favourable result on the composite primary endpoint. The all-cause mortality component favoured acoramidis with a hazard ratio of approximately 0.74, with the mortality signal emerging predominantly in the second half of the 30-month follow-up.

For the Saudi patient with confirmed ATTR-CM, the clinical positioning of Attruby is that it achieves near-complete (>90%) TTR tetramer stabilization in pharmacodynamic assessment, which is a more rigorous biochemical profile than tafamidis at standard dose. Whether that biochemistry translates into a clinical edge for a specific patient is the question the treating cardiologist works through alongside the patient's stage, biomarker trajectory, tolerability of any current therapy, and the family framing of treatment burden and cost.

For the Saudi patient already on tafamidis, the conversation often turns on whether to switch. The kingdom has a sizeable cohort of patients on tafamidis since SFDA registration, and the switch decision is rarely automatic. Patients with progressing disease on tafamidis (rising NT-proBNP, worsening NYHA class, recurrent hospitalisations) are the strongest candidates for the switch conversation. Patients well-controlled on tafamidis can reasonably continue. The conversation belongs to the treating cardiologist and ideally to an amyloid MDT.

What Attruby is, in plain language

Attruby is an oral tablet. 712 mg twice daily, with or without food, approximately twelve hours apart. Storage is room temperature; no refrigeration is required. There is no infusion, no inpatient stay, no certified-centre requirement. The prescribing cardiologist writes the first prescription, the dispensing pharmacy (institutional or partnered specialty) fills a 30-day or 60-day supply, and the patient takes Attruby at home.

Treatment is indefinite. ATTR-CM is a progressive disease and the protective effect of TTR stabilization continues for as long as the drug is taken. The patient who tolerates Attruby and continues to benefit clinically remains on it.

The mechanism: TTR normally circulates as a tetramer. In ATTR amyloidosis the tetramer dissociates into monomers, which misfold and aggregate as amyloid fibrils that infiltrate the heart. Acoramidis binds the thyroxine-binding pocket of the TTR tetramer and stabilizes it, preventing the dissociation that initiates amyloidogenesis. The clinical effect emerges as the cumulative protection against further amyloid deposition translates over months and years into stabilisation of cardiac function and reduced cardiovascular events.

The diagnostic gate: confirmed ATTR-CM

Attruby is a TTR-directed therapy. It does not treat AL amyloidosis. It does not treat non-amyloid heart failure. Prescribing it without a confirmed ATTR-CM diagnosis is not appropriate. The eligibility gate is the diagnostic confirmation.

ATTR-CM diagnosis in 2026 rests on:

- **Cardiac biomarkers**: elevated NT-proBNP and troponin in a patient with heart failure or unexplained left ventricular wall thickening. - **Echocardiogram with global longitudinal strain**: characteristic restrictive cardiomyopathy with apical sparing on the strain pattern. - **Cardiac MRI** where available and not contraindicated: tissue characterisation with the late-gadolinium enhancement pattern consistent with infiltrative cardiomyopathy. - **Technetium-pyrophosphate (99mTc-PYP) scintigraphy** with Perugini grade 2 or 3 uptake. This is the non-invasive gold standard for ATTR-CM when AL amyloidosis is excluded. Available at KFSHRC Riyadh nuclear cardiology, KAMC, Prince Sultan Cardiac Centre, and the major tertiary cardiology centres. - **AL exclusion**: serum and urine free light chains plus serum and urine immunofixation electrophoresis. This is a hard exclusion. AL amyloidosis is a haematological disease and requires plasma-cell-directed treatment. - **TTR gene sequencing**: distinguishes hereditary (ATTRv-CM) from wild-type (ATTRwt-CM) disease. For ATTRv, identifies the specific variant. The Saudi cohort includes families with documented hereditary TTR variants where cascade screening of first-degree relatives is part of the standard care plan. KFSHRC Centre for Genomic Medicine is the kingdom's reference service for TTR sequencing and family cascade screening.

If the patient arrives at the conversation without a complete workup, the first step is completion of the diagnostic pathway through the chosen Saudi cardiology service. Reserve Meds does not arrange the diagnosis. We organise the document pack and coordinate the supply once the cardiology service has confirmed ATTR-CM and the cardiologist has decided.

Eligibility at a Saudi cardiology amyloid clinic

For Saudi-resident patients, the major cardiology services apply the FDA label, EMA guidance, and major-guideline criteria:

1. Adult patient (no paediatric indication for Attruby). 2. Heart failure or unexplained left ventricular wall thickening with biomarker, echocardiographic, and imaging features consistent with cardiac amyloidosis. 3. Confirmed ATTR-CM by 99mTc-PYP scintigraphy with Perugini grade 2 or 3 uptake. 4. AL amyloidosis excluded. 5. TTR gene sequencing complete, with hereditary vs wild-type characterisation and variant identification for cascade screening where ATTRv. 6. NYHA functional class I, II, or III. NYHA IV patients have limited data; the treating cardiologist's judgment governs. 7. Baseline cardiac biomarkers (NT-proBNP, troponin) and echocardiogram with strain documented. 8. Renal and hepatic function baseline. 9. Treatment-history review: if already on tafamidis, the switch conversation is documented. If on no TTR-directed therapy, the choice between Attruby, tafamidis, and amvuttra is documented as a clinical-strategy decision.

A Saudi patient should arrive at the cardiology conversation with the most recent diagnostic workup in hand: cardiac MRI or scintigraphy report, echocardiogram with strain, biomarker labs, AL exclusion results, TTR sequencing if completed. Reserve Meds organises this documentation pack so the cardiology team can confirm eligibility on the first review.

The Saudi prescribing and supply picture, plainly

In 2026 the Saudi cardiology centres with active ATTR-CM management experience include:

- **King Faisal Specialist Hospital and Research Centre, Riyadh**: the kingdom's reference centre. Amyloid clinic, nuclear cardiology for 99mTc-PYP scintigraphy, Centre for Genomic Medicine for TTR sequencing, and amyloid MDT. - **KFSHRC Jeddah cardiology**: tertiary cardiology with amyloid workup. - **King Abdulaziz Medical City, Riyadh (KAMC)**: cardiology and cardiomyopathy programme. - **Prince Sultan Cardiac Centre, Riyadh** and **Prince Sultan Cardiac Centre, Khobar**: the kingdom's dedicated cardiac centres with cardiomyopathy and heart-failure subspecialty. - **King Fahd Cardiac Centre, King Saud University Medical City, Riyadh**: cardiology and cardiomyopathy programme. - **Dr Sulaiman Al Habib hospital network**: private-sector tertiary cardiology with cardiomyopathy management. - **King Fahad Medical City (KFMC), Riyadh**: tertiary cardiology service.

The pathway:

1. **Diagnostic confirmation**: at KFSHRC Riyadh, KAMC, or Prince Sultan Cardiac Centre for the full workup. 99mTc-PYP scintigraphy is available at the tertiary nuclear cardiology services. AL exclusion runs through the institutional haematology lab. TTR gene sequencing is best routed to KFSHRC Centre for Genomic Medicine for the Saudi cohort, given the kingdom's documented hereditary TTR variants and the cascade-screening implication. 2. **Amyloid MDT review** where available (KFSHRC Riyadh runs the most established Saudi amyloid MDT). The MDT documents the diagnosis, the staging, the stabilizer-vs-silencer discussion, and the treatment plan. 3. **Regulatory and supply route in 2026**: Attruby is a recent FDA approval (November 2024). SFDA registration status is **[VERIFY: confirm current SFDA dossier progress]**. In the pre-registration window, the supply route is named-patient procurement under the SFDA's personal-import and compassionate-use provisions, coordinated through the prescribing centre's regulatory liaison and Reserve Meds on the US-side supply chain. Where SFDA registration completes, the commercial channel through the local Roche / BridgeBio distributor handles standard pharmacy dispense. 4. **Insurance pre-authorisation**: most Saudi private insurers (Bupa Arabia, Tawuniya, MedGulf, Walaa, AXA Cooperative) handle Attruby on a case-by-case basis given the recent approval and the high price point. Documentation required is the diagnostic confirmation (scintigraphy, AL exclusion, TTR sequencing), cardiology clinical rationale, and NYHA class statement. For Ministry of Health coverage and for institutional patients at KFSHRC, KAMC, and the Prince Sultan centres, the institutional formulary committee handles the high-cost-drug review. Pre-authorisation typically takes 7 to 21 days for a complete file on a recently approved high-cost agent. 5. **Pharmacy dispense**: the prescribing centre's pharmacy or a partnered specialty pharmacy fills a 30-day or 60-day supply. 6. **Refill cycle**: monthly thereafter, with ongoing cardiology follow-up documented.

Cost expectation in SAR

US list price (2026) for Attruby is approximately USD 20,375 per month, USD 244,500 per year. This was set at a modest discount to tafamidis at USD 268,000 per year US WAC. At indicative 2026 cross rates, a single 30-day supply at USD 20,375 is approximately SAR 76,400, and the annual cost at USD 244,500 is approximately SAR 916,800. A 3-year cumulative drug cost (a typical horizon for an ATTR-CM patient who responds to therapy and remains stable) is approximately SAR 2.75 million.

Total cost of care additions include cardiology consultation fees (typically 3 to 4 visits per year), cardiac biomarker laboratory fees (every 3 to 6 months), echocardiogram with strain (every 6 to 12 months), and 99mTc-PYP scintigraphy or cardiac MRI on the standard cardiology follow-up cadence. These add 5 to 10 percent to the drug cost base in Saudi private-sector settings.

For Saudi nationals on Ministry of Health coverage at KFSHRC, KAMC, Prince Sultan Cardiac Centre, KFMC, or KFSH Jeddah, the drug supply is institutional-formulary driven and the patient-side cost is typically minimal or zero once the institutional approval is in place. For expatriate residents and self-pay families, the financial picture is the full private-sector list-price band, and the pre-authorisation pathway with commercial insurers is the gating step before the first dispense.

For families considering Attruby relative to tafamidis at a similar broad cost band, or relative to amvuttra on a quarterly subcutaneous schedule, the financial conversation is part of the clinical-strategy decision. Reserve Meds documents the financial picture honestly so the family can hold the trade-offs alongside the cardiology recommendation.

Monitoring on therapy

The monitoring schedule for Attruby is structured around the principal response and tolerability markers:

- **NT-proBNP and troponin**: every 3 to 6 months on standard cardiology follow-up. Trajectory rather than single value is the meaningful signal. Stabilisation or modest improvement is the expected response on effective TTR-directed therapy. - **Echocardiogram with global longitudinal strain**: every 6 to 12 months or as clinically indicated. Wall thickness and strain pattern change slowly; routine cardiology follow-up cadence is appropriate. - **NYHA functional class and 6-minute walk distance**: documented at each cardiology visit. Functional stabilisation is a meaningful response marker. - **GI tolerability**: transient diarrhoea and abdominal discomfort are the most common adverse events on acoramidis, typically mild and self-limited in the first weeks. Persistent or severe symptoms warrant cardiology and gastroenterology review. - **No specific laboratory monitoring beyond routine cardiology workflow** is required. Acoramidis has a clean drug-interaction profile in published pharmacokinetic studies and is not a CYP3A4 substrate with major clinical interactions. - **Adherence**: the twice-daily oral schedule is the principal adherence task in an older patient already on multiple cardiovascular medications. A simple pillbox, family member co-monitoring, and a written medication chart are the standard adherence support tools.

Religious, ethical, and family-logistics framing

Attruby is an oral small molecule. There is no animal-source material in standard manufacturing, no donor cells, no blood product. Halal and kosher acceptability are not in question. The classical Islamic jurisprudential framework for chronic medication in life-threatening illness already endorses the treatment shape.

The family-logistics burden of Attruby sits in the chronicity and adherence. A 712 mg twice-daily schedule, indefinite, with cardiology follow-up every 3 to 6 months and echocardiograms every 6 to 12 months, fits comfortably into the standard cardiology workflow of a Saudi family. The patient is most often an older adult and the adherence task is shared by family members and the patient.

The hereditary form (ATTRv-CM) carries a cascade-screening implication. First-degree relatives may carry the same pathogenic TTR variant and benefit from early surveillance or early treatment. The Saudi cohort includes families with documented hereditary variants where the cascade conversation has been worked through for siblings, children, and parents. KFSHRC Centre for Genomic Medicine is the reference service for the genetic testing and family-screening conversation in the kingdom.

When Attruby is not the right call

Attruby is the right answer for confirmed ATTR-CM in adults with NYHA I-III disease where the treating cardiologist has decided that high-potency TTR stabilization is the chosen strategy. It is not the right answer for:

- AL amyloidosis (the AL exclusion is non-negotiable; AL routes to haematology and plasma-cell-directed treatment, with KFSHRC haematology and the KAMC haematology services as the Saudi reference points). - Non-amyloid restrictive cardiomyopathy. - Patients well-controlled and stable on tafamidis where the treating cardiologist does not consider the switch warranted. - Combined polyneuropathy plus cardiomyopathy phenotypes where the cardiology and neurology services prefer amvuttra (siRNA silencer) for the mechanism profile. - Patients with very advanced ATTR-CM (NYHA IV with refractory symptoms), where the risk-benefit conversation is more nuanced and limited trial data apply.

For confirmed ATTR-CM where Attruby is not the chosen first-line, the alternatives in 2026 are tafamidis (Vyndamax / Vyndaqel, the established 2019-approved TTR stabilizer, SFDA-registered and widely available) and amvuttra (vutrisiran, the siRNA silencer approved for ATTR-CM on HELIOS-B 2024, subcutaneous every 3 months). The clinical conversation belongs to the treating cardiologist; this page describes Attruby because that is the medication you have asked about.

Reserve Meds does not push a default. The page above describes the Attruby pathway because Attruby is the TTR stabilizer the family has asked about. If the conversation with the treating cardiologist points toward continued tafamidis, or toward amvuttra, the operational pathway shifts accordingly and we coordinate that pathway instead.

What Reserve Meds does on this case

We are a US-based concierge coordinator. We are not the prescriber and not the dispensing pharmacy. On a Saudi Attruby case we build the document pack (cardiac biomarker labs, echocardiogram with strain, scintigraphy report, AL exclusion results, TTR sequencing where completed, cardiology clinical rationale letter, NYHA class statement), submit first-review requests to the chosen Saudi cardiology service, coordinate the insurance pre-authorisation conversation alongside the diagnostic and clinical workup, manage the US-side supply chain for named-patient procurement where the local route requires it, set up the first 30-day or 60-day dispense at the chosen pharmacy, and stay with the case through the refill cycle for as long as the family wants concierge support. Clinical decisions remain with your treating cardiologist and the amyloid multidisciplinary team.

Reserve Meds's role

US-based concierge coordinator for cross-border specialty medicine. We are not the prescriber, not the dispensing pharmacy, and not the manufacturer. All clinical decisions remain with your treating physician.

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reserved for you.

Composite case examples. This document is for general information only and does not constitute medical advice. Please consult your treating physician.
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