Attruby

United Arab Emirates · access guide

How to access Attruby for transthyretin amyloid cardiomyopathy (ATTR-CM) from the UAE: 2026 pathway via UAE cardiology amyloid clinics and named-patient supply

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

The UAE has built one of the deepest adult cardiology infrastructures in the wider region, and within that infrastructure a small number of centres now run dedicated cardiac amyloid programmes. Cleveland Clinic Abu Dhabi has the most established amyloid clinic, with technetium-pyrophosphate scintigraphy on site, cardiac MRI capability, and an amyloid multidisciplinary team that has been managing transthyretin amyloid cardiomyopathy cases on tafamidis since the late 2010s. Sheikh Shakhbout Medical City, Mediclinic City Hospital's Heart and Vascular Institute, American Hospital Dubai cardiology, Burjeel Medical City cardiology, and King's College Hospital London Dubai cardiology all manage ATTR-CM in the standard tertiary-cardiology pathway. Attruby (acoramidis) is a recent FDA approval, November 2024, and the question for a UAE patient or family with confirmed or suspected ATTR-CM in 2026 is no longer whether a high-potency TTR stabilizer exists, but how the regulatory and supply pathway works while EDE registration progresses, how the diagnosis is confirmed where it has not yet been, and how the choice between Attruby and the already-established tafamidis (or the alternative-mechanism amvuttra) is made.

This page explains how the pathway works in 2026 for a UAE-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 AED, 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, with the mortality component emerging predominantly in months 18 to 30.

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

For the UAE patient already on tafamidis and stable, the question is whether to switch. The answer is rarely automatic. Patients with progressing disease on tafamidis (rising NT-proBNP, worsening NYHA class, recurrent decompensations) are the strongest candidates for the switch conversation. Patients well-controlled on tafamidis can reasonably continue. The conversation happens with the treating cardiologist; this page describes the Attruby pathway because that is the medication you have asked about.

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. There is no fixed stop date. The patient who tolerates Attruby and continues to benefit clinically remains on it.

The mechanism, in clinical shorthand: 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. Slowing further amyloid deposition gives the heart time, and over 18 to 30 months of treatment a survival signal emerges in the trial data.

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 on site at Cleveland Clinic Abu Dhabi, SSMC, and the major Dubai tertiary cardiology services. - **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, not TTR-targeted therapy. - **TTR gene sequencing**: distinguishes hereditary (ATTRv-CM) from wild-type (ATTRwt-CM) disease. For ATTRv, identifies the specific variant and opens the cascade-screening conversation with first-degree relatives.

If the patient arrives at the conversation without a complete workup, the first step is completion of the diagnostic pathway through the chosen 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 that Attruby is the right treatment.

Eligibility at a UAE cardiology amyloid clinic

For UAE-resident patients, the cardiology services with cardiac amyloid experience 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 (distinguishes hereditary from wild-type and identifies variant for cascade screening). 6. NYHA functional class I, II, or III. NYHA IV patients have limited data and the treating cardiologist's judgment governs the risk-benefit conversation. 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 UAE 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 UAE prescribing and supply picture, plainly

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

- **Cleveland Clinic Abu Dhabi**, with the deepest adult cardiology amyloid programme in the UAE. Amyloid clinic, 99mTc-PYP scintigraphy on site, cardiac MRI capability, amyloid MDT. - **Sheikh Shakhbout Medical City (SSMC)**, with cardiology service and MD Anderson Cancer Center affiliation; AL exclusion workup runs through SSMC haematology. - **Mediclinic City Hospital Heart and Vascular Institute**, with comprehensive cardiology service and tertiary referral pattern. - **American Hospital Dubai cardiology**, with established heart-failure and cardiomyopathy programme. - **Burjeel Medical City cardiology**, with a tertiary cardiology programme that handles cardiomyopathy referrals. - **King's College Hospital London Dubai cardiology**, with international consultant coverage and referral relationships back to UK cardiology amyloid centres.

The pathway:

1. **Diagnostic confirmation**: typically at the diagnosing centre, with 99mTc-PYP scintigraphy and AL exclusion in-house at the major UAE tertiary centres. TTR gene sequencing routed to the centre's molecular pathology or to KFSHRC Centre for Genomic Medicine, Caris Life Sciences, or another reference lab. 2. **Amyloid MDT review** where available (Cleveland Clinic Abu Dhabi runs the most established UAE 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). UAE EDE registration status is **[VERIFY: confirm current EDE registration status]**. In jurisdictions where formal EDE registration is not yet complete, the supply route is named-patient procurement through the EDE's compassionate-use and personal-import provisions, coordinated through the prescribing centre's regulatory liaison and Reserve Meds on the US-side supply chain. Where EDE registration is complete, the commercial supply through Roche / BridgeBio's regional distributor handles standard pharmacy dispense. 4. **Insurance pre-authorisation**: most UAE private insurers (AXA Gulf, NEXtCARE, MSH, Bupa Global, Allianz Care) 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. Daman and Thiqa for Emirati nationals follow institutional pathways. 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 AED

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 AED 74,800, and the annual cost at USD 244,500 is approximately AED 897,000. A 3-year cumulative drug cost (a typical horizon for an ATTR-CM patient who responds to therapy and remains stable) is approximately AED 2.69 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 UAE private-sector settings.

Thiqa coverage for Emirati nationals has historically extended to cardiology medications on the EDE-approved formulary; the pre-authorisation conversation runs through the prescribing centre's insurance liaison. Daman and other commercial covers vary; the financial pre-authorisation review at the prescribing centre is the gating step before the first dispense.

For families considering Attruby relative to tafamidis at the same broad cost band, or relative to amvuttra on a quarterly subcutaneous schedule, the financial conversation is part of the clinical-strategy decision. Reserve Meds does not push one option over another; we document 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 GI symptoms warrant cardiology and gastroenterology review and a discussion of whether the patient is the right fit for continued therapy. - **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, is an operational commitment that fits comfortably into a UAE family's standard cardiology workflow. 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 family conversation around genetic testing for siblings, children, and parents is a real part of the ATTRv pathway and is handled through the prescribing centre's clinical genetics service or through KFSHRC Centre for Genomic Medicine on referral.

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). - 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, widely available across MENA) and amvuttra (vutrisiran, the siRNA silencer approved for ATTR-CM on HELIOS-B 2024, subcutaneous every 3 months). The clinical conversation with the treating cardiologist about which agent to start, or whether to switch from a current regimen, is real and worth having. 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 UAE 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 UAE 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.

Reserve Meds is in pre-launch. Published timelines and cost ranges are indicative, not guarantees.
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