Transitions in Heart Failure Therapy Prior to Acoramidis Use in Transthyretin Cardiomyopathy: Real World Insights From the German StarTTR Cohort

Caroline Morbach[1], Christoph Ohlmeier[2], Teresa Trenkwalder[3], Fabian aus dem Siepen[4], Silvia Kruppert[5], Gereon Keuken[5], Thomas Evers[6], Roman Pfister[7], Stefan Herrmann[8], Stefan Störk[1]

[1]Department of Clinical Research & Epidemiology, Comprehensive Heart Failure Center and Department of Medicine I, University Hospital Würzburg, Würzburg, Germany; [2]Bayer AG, Berlin, Germany; [3]Department of Cardiology, TUM University Hospital, German Heart Center, Munich, Germany; [4]University Hospital Heidelberg, Heidelberg, Germany; [5]IQVIA, Frankfurt, Germany; [6]Bayer AG, Wuppertal, Germany; [7]Department of Cardiology, Heart Center, Faculty of Medicine, University of Cologne, Cologne, Germany; [8]Bayer Vital GmbH, Leverkusen, Germany

INTRODUCTION

- Transthyretin amyloid cardiomyopathy (ATTR-CM) is a progressive disease that is increasingly recognised as a cause of heart failure.[1–3]
- Therapeutic advances have raised awareness of ATTR-CM and emphasise the importance of early diagnosis and treatment, which is associated with improved outcomes.[4]
- Acoramidis, a highly selective transthyretin (TTR) stabiliser that achieves near-complete TTR stabilisation, is approved for the treatment of wild-type and variant ATTR-CM in the United States, European Union, Japan, United Kingdom, and Switzerland.[5–10]
- Beyond clinical trials, little is known about who receives acoramidis and how their heart failure medications evolve in the lead-up to treatment.
- We sought to map the changing pattern of heart failure medications in patients in Germany with ATTR-CM who were initiated on acoramidis to better understand how real-world practice adapts around this therapy.

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METHODS

Study design

- We performed a retrospective, non-interventional, observational cohort analysis using anonymised prescription claims from the IQVIA™ Longitudinal Prescription (LRx) database, which covers approximately 82% of prescriptions reimbursed by Germany's statutory health insurance.

Study participants

- Adults (≥18 years of age) with first acoramidis dispensation between 1 April and 30 September 2025 (index date) were included; no exclusion criteria were applied.
- Patients with ≥12 months of observable data before acoramidis initiation and ≥3 months of follow-up were selected.

Concomitant medication

- Assuming the first prescription signalled a new ATTR-CM diagnosis, dispensations were analysed in predefined 3-month intervals across five periods: 12–10, 9–7, 6–4, and 3–1 months before acoramidis initiation, and 1–3 months afterwards.

Analysis

- Analyses were exploratory and descriptive, and were conducted using SAS Enterprise Guide Version 8.2 (SAS Institute, Cary, NC, USA).

RESULTS

Patient demographics and characteristics

- Between April and September 2025, 128 patients who initiated first-line acoramidis and were observable for 12 months pre-initiation and 3 months post-initiation were identified; the median age was 82 years (quartile [Q] 1 to Q3: 78–85); 14% were female.
- Most prescriptions originated from hospital outpatient departments (91%).

Use of comedications before and after acoramidis initiation

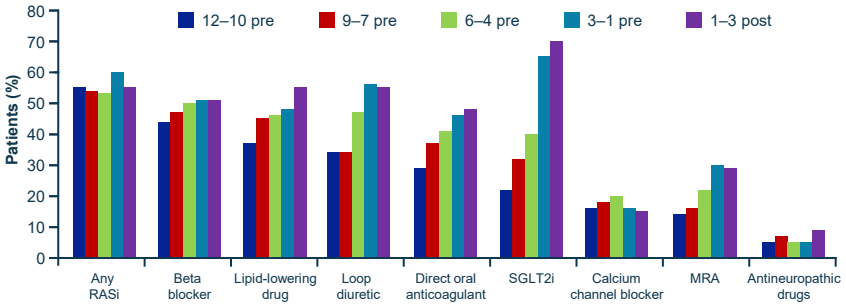
- Comedication use was relatively stable between the 12–10-month and 3–1-month pre-initiation intervals for (**Table 1**; **Figure 1**):
  - Renin-angiotensin system inhibitors (56% vs 60% of patients, respectively), beta blockers (44% vs 52% of patients), and calcium channel blockers (16% in both periods).
- Substantial increases between the 12–10-month and 3–1-month pre-initiation intervals were observed for:
  - Mineralocorticoid receptor antagonists (14–31%, respectively), loop diuretics (34–56%), direct oral anticoagulants (29–46%), and sodium-glucose co-transporter 2 inhibitors (22–65%).
- These trends persisted in the first 3 months after acoramidis initiation.

Table 1. Use of comedication in the 12 months before and the 3 months after initiating acoramidis as first-line therapy in patients with ATTR-CM (N=128)

Comedication	Months relative to acoramidis initiation				
	12–10 pre (n=108)	9–7 pre (n=111)	6–4 pre (n=112)	3–1 pre (n=121)	1–3 post (n=125)
Any RASi	56	54	53	60	55
ACEi	25	26	23	27	26
ARB	27	22	22	24	22
ARNi	5	7	11	14	9
Beta blocker	44	48	50	52	52
Lipid-lowering therapy	38	45	46	48	55
Loop diuretic	34	34	47	56	55
Thiazide diuretic	2	2	2	6	8
Direct oral anticoagulant	29	37	41	46	48
SGLT2i	22	32	41	65	70
Analgesic drug	21	21	20	23	24
Calcium channel blocker	16	18	20	16	15
MRA	14	16	23	31	30
Antineuropathic therapy	6	7	6	6	9
Antiarrhythmic drug	3	4	2	3	4
Vitamin K antagonist	2	2	1	2	1
Glycoside	2	2	2	1	1

Data are presented as percentage of patients (%).
ACEi, angiotensin converting enzyme inhibitor; ARB, angiotensin receptor blocker; ARNi, angiotensin receptor neprilysin inhibitor; ATTR-CM, transthyretin amyloid cardiomyopathy; MRA, mineralocorticoid receptor antagonist; RASi, renin-angiotensin system inhibitor; SGLT2i, sodium-glucose co-transporter 2 inhibitor.

Figure 1. Pharmacotherapy in the 12 months before and the 3 months after initiation of acoramidis as first-line therapy in patients with ATTR-CM (N=128)



ATTR-CM, transthyretin amyloid cardiomyopathy; MRA, mineralocorticoid receptor antagonist; RASi, renin-angiotensin system inhibitor; SGLT2i, sodium-glucose co-transporter 2 inhibitor.

CONCLUSIONS

- These real-world data reveal that patients who initiated acoramidis therapy as a first-line treatment often had complex medication regimens and exhibited intensification of several cardiovascular drug classes in the year beforehand.
- The findings highlight two key points:
  - Heart failure therapy is actively intensified at specialised centres where diagnoses are made.
  - Large-scale prescription databases (like LRx) offer a valuable lens through which to monitor the adoption and impact of new treatments.