AMCP

This activity is supported by an independent medical education grant from BridgeBio Pharma, Inc.

Learning Objectives

1. Recognize the clinical indicators for early screening and diagnosis of Transthyretin Cardiac Amyloidosis (ATTR-CM), particularly among a diverse population.
2. Identify the burden of health disparities in ATTR-CM disease management on health outcomes and access to care in the United States.
3. Distinguish the clinical efficacy, safety, monitoring, and patient selection criteria for new and emerging disease-modifying treatment options for ATTR-CM.
4. Discuss managed care approaches to optimizing diagnosis and the referral process, health outcomes, and equitable access to care for managing ATTR-CM.

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✓ Submit by **October 13, 2025**

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Faculty

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ATTR-CM Overview

Cardiac Amyloidosis

		Transthyretin (TTR)	Light Chain (AL)
Restrictive cardiomyopathy caused by myocardial protein deposition	**Primary location of protein production**	Liver	Bone marrow
Two main types classified based on precursor protein:	**Prognosis without treatment**	Survival < 4 years	Survival < 2 years
	Management	TTR-specific treatments	Chemotherapy

Kittleson MM, et al. *Circulation.* 2020;142(1):e7-e22

Pathophysiology

Kittleson MM, et al. *Circulation.* 2020;142(1):e7-e22

ATTR-CM: A Growing Concern

Type	Estimated Frequency	Estimated Penetrance	Typical Onset Age
Wild-type *(no genetic variants)*	• 12% HFpEF (↑ with age) • 10% HFrEF • 7% carpal tunnel surgery • 7% HCM • >8% severe AS • 21% older patient autopsies	Not genetically inherited	> 60 years
Variant (Hereditary) Val122Ile *(AKA V122I or pV142I)* most common in US	• 3.4% African Americans	• Age > 60 years: ~7-100% • Increases with age • Males > females	> 65 years

Prevalence increasing over time
(improved awareness/diagnostics)
United States 2021: 6.1 per 1,000,000
(54.9 per 1,000,000 age 65+)
2018: 3.9 per 1,000,000
(36.6 per 1,000,000 age 65+)

AS, aortic stenosis, HCM, hypertrophic cardiomyopathy; HFpEF, heart failure with preserved ejection fraction; HFrEF, heart failure with reduced ejection fraction; TTR, transthyretin; US, United States

Ruberg FL, Maurer MS. *JAMA*. 2024 Mar 5;331(9):778-791.
Brown D et al. J Am Coll Cardiol. 2021;77(18 suppl 1).

Clinical Manifestations

Cardiovascular

- GDMT intolerance
- LV hypertrophy
- AV block
- Heart failure
- Arrhythmias

Neuro

- Peripheral neuropathy
- Orthostatic hypotension
- Erectile dysfunction

Gastrointestinal

- Dysmotility (diarrhea, constipation, nausea/vomiting, early satiety)

Musculoskeletal

- Spinal stenosis
- Carpal tunnel syndrome

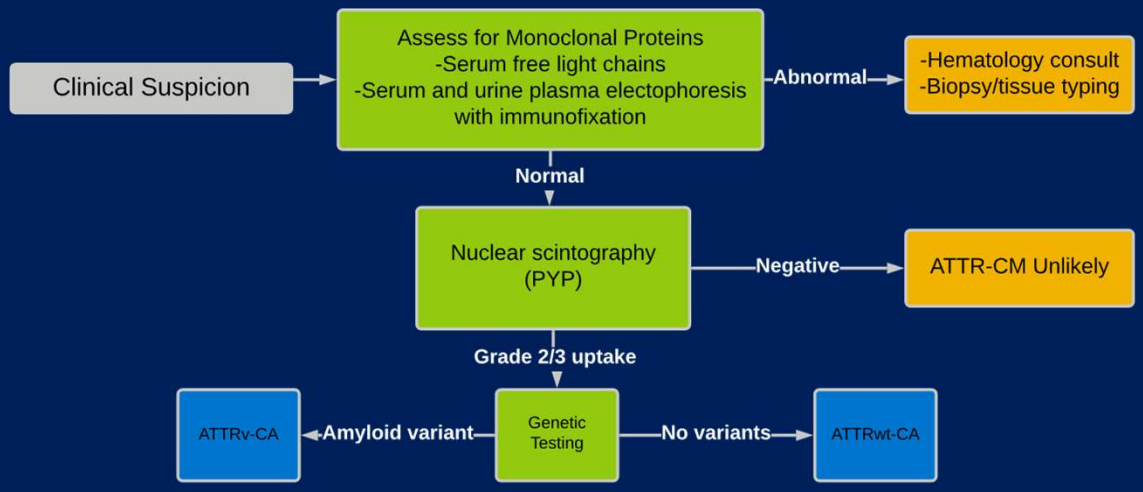
Renal

- Acute and/or chronic kidney disease
- Cardiorenal syndrome

AV, atrioventricular; GDMT, guidelines-directed medical therapy; LV, left ventricular

Ruberg FL, Maurer MS. *JAMA*. 2024 Mar 5;331(9):778-791.

Diagnosis of Suspected ATTR-CM



ATTRv-CA, variant transthyretin cardiac amyloidisis; ATTRwt-CA, wild-type transthyretin cardiac amyloidisis. Ruberg, FL. *JAMA*. 2024 Mar 5;331(9):778-791.

Diagnosis

Clinical suspicion is Key!

Echo
- Helpful for prognosis/therapeutic response
- Not specific from other HF causes

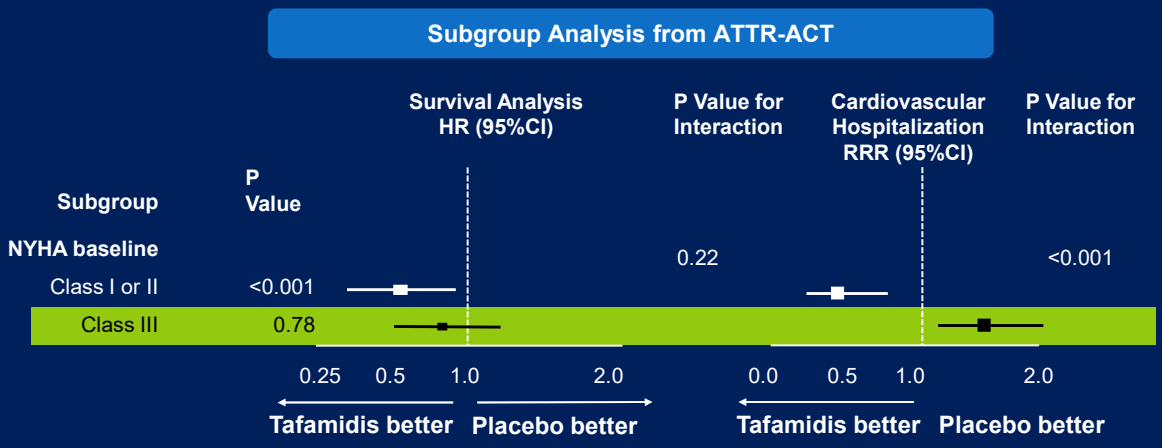
MRI
- Helpful to determine if amyloidosis is present
- Not helpful for distinguishing between amyloid types

PYP
- Sensitivity ~70%
- Not helpful when light chains are positive (~25% false positive in patients with AL)

Biopsy
- Required for AL diagnosis
- Helpful if high clinical suspicion and indeterminate testing
- Distinguishing between types of amyloidosis
- Invasive

Ruberg, FL. *JAMA*. 2024 Mar 5;331(9):778-791.
Kittleson MM, et al. *Circulation*. 2020;142(1):e7-e22

Early Treatment Improves Efficacy



HR, hazard ratio; NYHA, New York Heart Association
Adapted from: Maurer MS, et al. *N Engl J Med*. 2018 Sep 13;379(11):1007-1016.

New and Novel Treatment Advances for ATTR-CM

Disease-Targeted Therapies

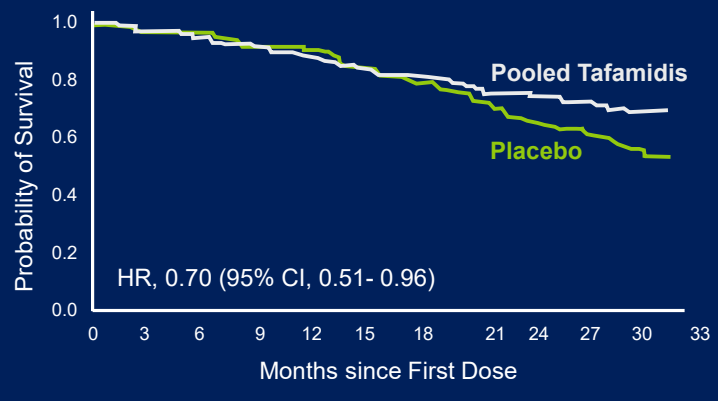
Silencers	Stabilizers	Disrupters
Inhibit hepatic synthesis of TTR	Prevent TTR misfolding	Increases clearance of amyloid fibrils from tissues
Eplontersen, Patisiran, Vutrisiran*	Acoramadis*, Diflunisal, Tafamidis*	Doxycycline, TUDCA

*FDA approved for ATTR-CM

Kittleson MM, et al. *Circulation.* 2020 Jul 7;142(1):e7-e22.
Gillmore JD, et al. *N Engl J Med*. 2024;390(2):132-142.
Fontana M, et al. *N Engl J Med* 2025;392:33-4. Maurer MS, et al. *N Engl J Med*. 2018;379(11):1007-1016;
Maurer MS, et al. *N Engl J Med* 2023;389:1553-1565; Siddiqi OK, et al. *Amyloid*. 2022;29(2):71–78.

ATTRACT-CM (Tafamidis)

441 patients with ATTR-CM randomized to tafamidis or placebo (~76% wild-type, ~61% NYHA II)

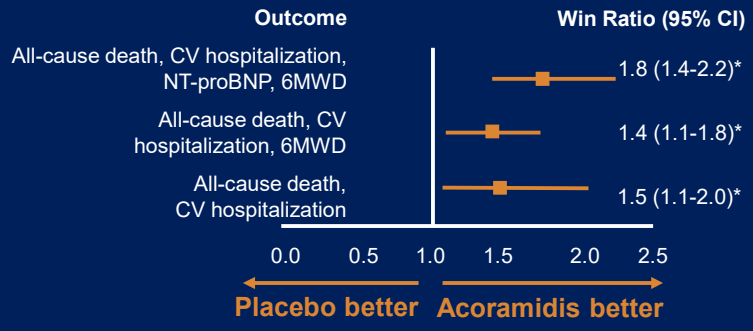


- NNT 8 for death
- Decreased CV hospitalizations RR 0.68 (0.48 vs. 0.70; 95% CI, 0.56 to 0.81; NNT 13)
- Lower rate of decline in 6MWD and KCCQ with tafamidis (p<0.001 for both)
- No difference in adverse events

6MWD, six-minute walk distance; ATTR-CM, transthyretin amyloid cardiomyopathy; CV, cardiovascular; KCCQ, Kansas City Cardiomyopathy Questionnaire; NYHA, New York Heart Association
Adapted from: Maurer MS, et al. *N Engl J Med*. 2018 Sep 13;379(11):1007-1016.

ATTRibute-CM (Acoramidis)

632 patients with ATTR randomized 2:1 to acoramidis or placebo (~90% wild-type, ~72% NYHA II)



No difference in adverse events

NNT 7 for death or CV hospitalization
HR: 0.64; 95% CI 0.50-0.83)
(Curves separated at 3 months)

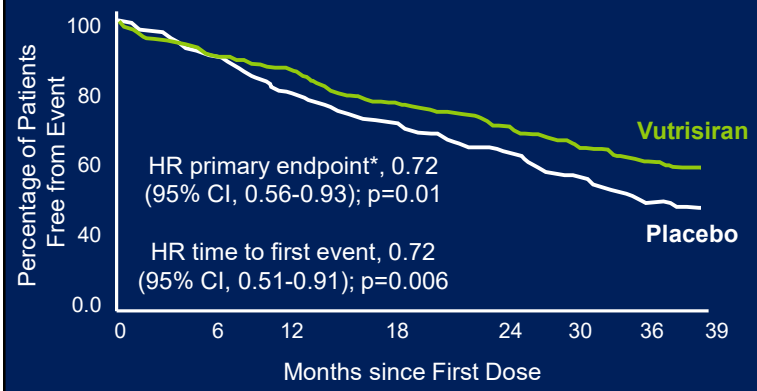
NNT 5 for annual CV hospitalization
RR: 50%; 95% CI: 0.36-0.7

All-cause mortality 19.3% vs. 25.7%
HR 0.77; 95% CI 0.54-1.10

*p<0.001
6MWD, 6 minute walk distance; CV, cardiovascular; CI, confidence interval
Adapted from: Gillmore JD, et al. *N Engl* J Med. 2024 Jan 11;390(2):132-142.
Judge DP, et al. J Am Coll Cardiol. 2025 Mar 18;85(10):1003-1014.

HELIOS-B (Vutrisiran)

655 patients with ATTR-CM randomized 1:1 to vutrisiran or placebo (~88% wild-type, ~78% NYHA II, 40% on tafamidis)



NNT 10 to prevent at least 1 event†

HR 0.67; p = 0.02 for patients not on baseline tafamidis

Lower rate of decline in 6MWD with vutrisiran (p<0.001)

No difference in adverse events

*Composite of all-cause mortality and recurrent CV events
†Based on binary data of at least 1 event (not recurrent event analysis)
6MWD, six-minute walk distance; ATTR-CM, transthyretin amyloid cardiomyopathy; CV, cardiovascular; NYHA, New York Heart Association
Adapted from: Fontana M, et al. *N Engl J Med* 2024;Aug 30:[Epub ahead of print].

Comparing Phase 3 ATTR-CM Trials

ATTR-CM (wild-type or variant)

Trial Criteria	ATTRACT-CM (Tafamidis)	ATTRibute-CM (Acoramidis)	HELIOS-B (Vutrisiran)
Tafamidis use	N/A	Only allowed after 12 months	40% at baseline
NYHA Class	I-III symptoms	I-III symptoms	I-III symptoms Excluded NYHA III at high risk
6MWD	≥100 m	≥150 m	≥150 m
NT-proBNP	≥600 pg/mL	≥300 pg/mL, ≤8500 pg/mL	>300 pg/mL, <8500 pg/mL (>600 pg/mL, <8500 pg/mL in AF)
Primary End Point	Hierarchical composite all-cause death and CV hospitalizations at 30 months	Hierarchical composite all-cause death, CV hospitalizations, ΔNT-proBNP, Δ6MWD at 30 months	Composite all-cause death and recurrent CV events over 36 months

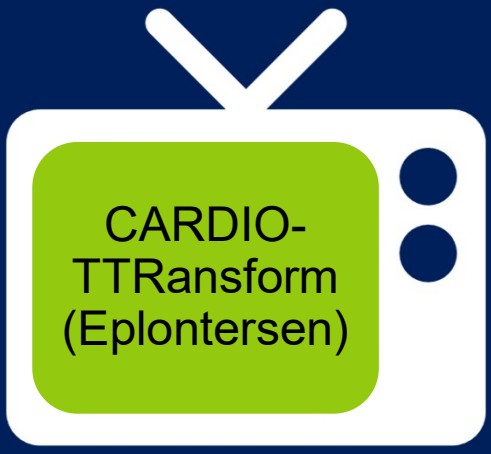
NT-proBNP, N-terminal pro-B-type natriuretic peptide; AF, atrial fibrillation; NYHA, New York Heart Association; 6MWD, 6-minute walk distance.
Hellenbart EL et al. Pharmacotherapy. 2024;45(2):124-144; Maurer MS et al. N Engl J Med. 2018;379(11):1007-1016;
Gillmore JD et al. N Engl J Med. 2024;390(2):132-142; Fontana M et al. N Engl J Med. 2025;392(1):33-44.

Comparing Phase 3 ATTR-CM Trials

Baseline Characteristic	ATTR-ACT (Tafamidis)	ATTRibute-CM (Acoramidis)	HELIOS-B (Vutrisiran)
Age, years (median)	74	77	77
NYHA class, % **I** **II** **III**	 8 60 32	 11 72 17	 13 78 9
6MWD, m (mean)	353	348	375
NT-proBNP, pg/mL (median)	3161	2306	1813
ATTRv (%)	24	10	12

NT-proBNP, N-terminal pro-B-type natriuretic peptide; AF, atrial fibrillation; NYHA, New York Heart Association; 6MWD, 6-minute walk distance.
Hellenbart EL et al. Pharmacotherapy. 2024;45(2):124-144; Maurer MS et al. N Engl J Med. 2018;379(11):1007-1016;
Gillmore JD et al. N Engl J Med. 2024;390(2):132-142; Fontana M et al. N Engl J Med. 2025;392(1):33-44.

Stay Tuned…



- Phase 3 trial in ATTR-CM (hereditary or wild-type)
- Primary outcome: Composite outcome of CV mortality and recurrent CV clinical events
- Data expected to be shared in 2026
- Granted FDA Fast Track designation for patients with ATTR-CM

CARDIO-TTRansform. NCT04136171. Updated December 27, 2024. Accessed April 17, 2025. https://www.clinicaltrials.gov/study/NCT04136171; Ionis. News release. February 8, 2024. Accessed June 3, 2025. https://ir.ionispharma.com/news-releases/news-release-details/eplontersen-granted-us-fda-fast-track-designation-patients

Additional Pipeline Therapies

CRISPR Gene Editing	**Depleters**		
Silencer	Monoclonal antibodies that target and remove amyloid deposits		
MAGNITUDE (Phase 3)	AT-02 (phase 1)	Coramitug (phase 2)	ALXN2220 (phase 3 deplete TTR-CM)

González-López E et al. Eur Heart J. 2025;46(11):999-1013.

Pharmacotherapy for ATTR

Medication	Acoramidis	Diflunisal	Tafamidis	Eplontersan	Patisiran	Vutrisiran
Mechanism	TTR stabilizers			TTR Silencers[+]		
ATTR-CM FDA Approval	2024	Off-Label	2019	Only approved for ATTR polyneuropathy		March 2025
Landmark Trial in ATTR-CM	ATTRibute-CM 2023		ATTR-ACT 2018	Cardio-TTRansform 2026	APOLLO-B 2022	HELIOS-B 2024
Dose	712 mg orally twice daily	250 mg orally twice daily	61 mg orally once daily	45 mg SC once monthly	0.3 mg/kg (max 30 mg) IV every 3 weeks	25 mg SC every 3 months
Adverse Effects	Well tolerated	Renal dysfunction, bleeding	Well tolerated	Infusion-related/site reactions*, vitamin A deficiency		

*Premedication for patisiran
ATTR, Transthyretin amyloidosis; ATTR-CM, Transthyretin amyloidosis cardiomyopathy; FDA, Food and Drug Administration; GI, gastrointestinal; IV, intravenous; PDUFA, Prescription Drug User Fee Act; SC, subcutaneous; TTR, transthyretin

Kittleson MM, et al. *Circulation*. 2020 Jul 7;142(1):e7-e22.
Gillmore JD, et al. *N Engl J Med*. 2024;390(2):132-142.
Fontana M, et al. *N Engl J Med* 2025;392:33-4.
Maurer MS, et al. *N Engl J Med*. 2018;379(11):1007-1016.
Maurer MS, et al. *N Engl J Med*. 2023;389:1553-1565
Siddiqi OK, et al. *Amyloid*. 2022;29(2):71–78.

Monitoring Markers of Disease Progression

BNP NT-proBNP	Troponin	Renal function	VO_2 max
NYHA Class	Blood Pressure	Diuretic dose	?TTR levels

Kittleson MM, et al. *JACC*. 2023 Mar, 81 (11) 1076–1126.
Hood CJ, et al. Curr Heart Fail Rep. 2022 Aug 5;19(5):356–363.

Breaking data from the European Society of Cardiology Annual Congress

Acoramidis

- Acoramidis reduces cardiovascular mortality: results through month 42 from the ATTRibute-CM open-label extension study
- Acoramidis-mediated improvement in NT-proBNP at month 30 compared with placebo in patients with ATTR-CM: results from the ATTRibute-CM study
- Acoramidis has a beneficial effect compared with placebo on change from baseline in NAC ATTR stage at month 30 in patients with ATTR-CM: results from the ATTRibute-CM study

Vutrisiran

- Vutrisiran Reduces Days Lost to Death and/or Hospitalization Versus Placebo in Patients with Transthyretin Amyloidosis with Cardiomyopathy in the HELIOS-B Trial
- HELIOS-B: 12-Month Results from the Open-Label Extension Period of Vutrisiran in Patients with Transthyretin Amyloidosis with Cardiomyopathy

Patient Perspective

Patient Testimonial Video

Health Disparities Impacting ATTR-CM Disease Management

Patient-Level & Social Disparities

Age

- Mean age = 74.5 years (SD 9.7)
- Estimated payer mix ~ 80% Medicare, 15% Commercial, 5% Other

Gender

- Majority of ATTR-CM patients are White (55.4%) males (61%)
- Under recognition in women; different clinical presentation

Regional Disease Burden

- ATTR-CM prevalence highest in Northeast (38.6%) and South (24%)

Race

- Black patients with low socioeconomic status (SES) face greater risk of underdiagnosis and worse outcomes vs. White patients.
- 66% of Black vs. 28% of White patients were in the "most deprived" category, based on national area deprivation index (P = 0.004).
- Higher rates of heart failure hospitalization/death over 5 years vs. White patients (P < 0.001).

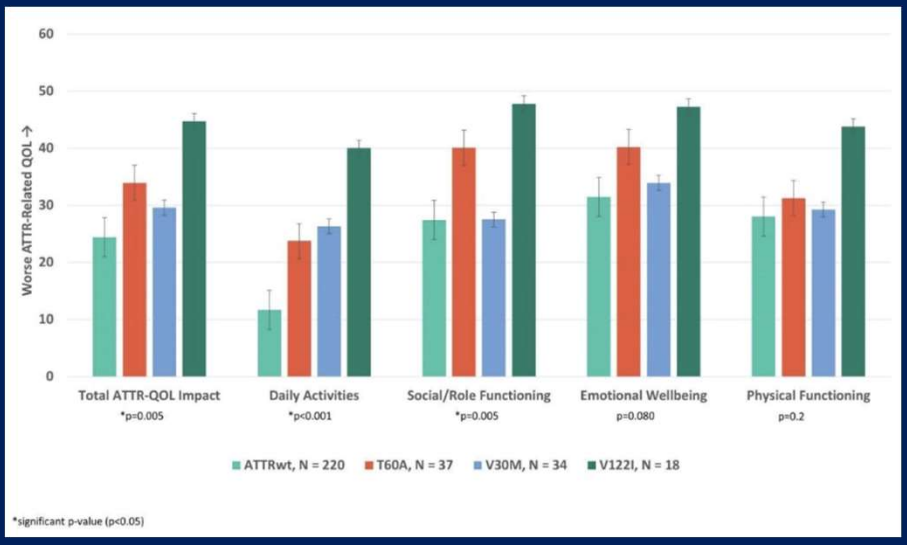
Genetic Disparity: V122I Variant

- Specific mutation in TTR gene
- Predominantly found in individuals of African descent
- Estimated 3.4% of Black individuals in the U.S. carry the mutation (~1.5 million people)
- Predisposes individuals to ATTR-CM
- Associated with more aggressive disease

Geographic and Racial Disparities in ATTR-CM Persist. Rare Disease Advisor. 2025 Mar 28.
Mitchell J et al. Geographic Healthcare Disparities and Diagnostic Trends Among Patients with Transthyretin Amyloid Cardiomyopathy. JACC. Vol. 85, No.12. Suppl A. 2025.
Shankar B et al. Race and Socioeconomic Status Impact Diagnosis and Clinical Outcomes in Transthyretin Cardiac Amyloidosis. JACC: CardioOncology. Vol.6. No.3. 2024.
Madhani A et al. Clinical Penetrance of the Transthyretin V122I Variant in Older Black Patients with Heart Failure: The SCAN-MP Study. J A, Heart Assoc. 2023 Jul 24; 12(15):e028973.

Mean ATTR-QL Scores by Genotype

- According to ARC Burden of Disease Survey data, the V122I variant has the highest reported quality of life impact across multiple domains.
- Findings reinforce genotype-linked disparities, particularly for V122I, which disproportionately affects Black patients and is associated with more severe disease burden.



Rebello S et al. Quality of Life of Patients with Variant and Wild-type Transthyretin Amyloidosis. XIX International Symposium on Amyloidosis Abstracts. Amyloid. 31 (sup 1), S1-S245 (2024). Permission received.

Regional Impact – California Spotlight

Race

- California has the fifth-largest Black population in the U.S. with ~ 2.8 million individuals.
  - The V122I variant may affect an estimated ~100,00 individuals in California alone, based on population prevalence.
- Individuals are at increased risk of disease and disease may be more severe/progressive.

Age

- California has the largest number of Medicare beneficiaries nationally, ~7 million individuals.
- Significant variation in ATTR-CM therapy utilization across Medicare plans.

Plan Size	Utilizers	Utilization Rate per 1,000
45,000 members	30	0.67
14,500 members	4	0.28
7,000 members	16	2.29
4,600 members	3	0.65
3,500 members	6	1.71

Kaiser Family Foundation (KFF). Total Medicare Beneficiaries. KFF State Health Facts. 2024. Available from: https://www.kff.org/medicare/state-indicator/total-medicare-beneficiaries
World Population Review. Black Population by State [Internet]. 2024. Available from: https://worldpopulationreview.com/state-rankings/black-population-by-state

System-Level & Access Disparities

Diagnostic Delays
- Median 2-to-3-year delay from symptom onset to ATTR-CM diagnosis

Genetic Screening
- Underutilized in high-risk populations despite known genetic predisposition

Data Equity
- EHR and claims often lack race/genotype granularity

Specialty Care Accessibility
- Few treatment centers statewide, access limited outside major metro areas

California Amyloidosis Treatment Centers:

California Pacific Medical Center – San Francisco, CA

Cedars-Sinai Hospital

City of Hope

Kaiser Permanente San Francisco Medical Center

Scripps Clinic John R. Anderson V Medical Pavilion

Stanford Health Care – Hematology Program

Stanford Hospital & Clinics – Amyloid Center

UC San Diego Health

UCSF

Spencer-Bonilla G. Curr Cardiovasc Risk Rep. 2021 June; 15(6).
Rozenbaum MH et al. Impact of Delayed Diagnosis and Misdiagnosis for Patients with Transthyretin Amyloid Cardiomyopathy (ATTR-CM): A Targeted Literature Review. Cardiol Ther. 2021 Apr;10(1):141–159. doi: 10.1007/s40119-021-00219-5.
https://amyloidosis.org/resources#treatment-centers

Considerations for Managed Care Management of ATTR-CM in the U.S.

Managed Care Challenges in ATTR-CM

- High-Cost Therapies – lack of head-to-head data comparing the approved therapies makes coverage decisions challenging.
- Growing Patient Population – steady increase in utilization of ATTR-CM therapies since tafamidis approval in 2019.
- Diagnostic Challenges – ensure timely access and coverage of appropriate tests and procedures; genetic sequencing to distinguish hATTR and ATTRwt.
- Specialized Care Coordination – care coordination between multiple discipline including PCP, cardiologist, neurologist, pharmacist, social worker, genetic counselor and/or access to an amyloidosis treatment center to help effectively manage ATTR-CM patients.

ATTR-CM Treatment Landscape

Prescribers are quickly adopting newly approved therapies for ATTR-CM.

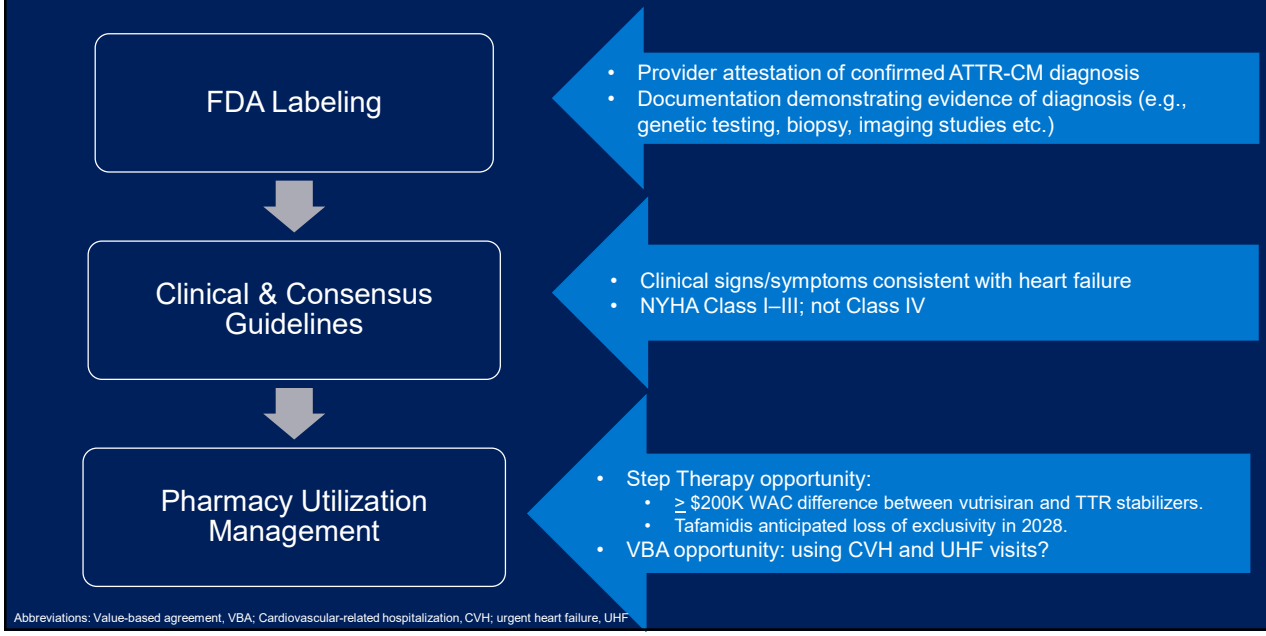
- May 2019 - tafamidis became the first and only FDA-approved therapy for ATTR-CM.
- November 2024 - approval of acoramidis provided another 1st-line option, especially considering its improved TTR stabilization profile and lower WAC.
- March 2025 - availability of vutrisiran since end of March 2025 further expands the patient population being treated; TTR silencer provided differentiated MOA.
- Cardiologists expect the availability of additional therapies will increase treatment uptake, particularly among patients with Stage I HF.

Drug	Vyndaqel/ Vyndamax (tafamidis)	Attruby (acoramidis)	Amvuttra (vutrisiran)
MOA	TTR Stabilizer	TTR Stabilizer	TTR Silencer
ATTR-CM Approval	2019	2024	2025
Dosing	Oral, daily	Oral, twice daily	HCP-administered SC, every 3 months
Annual WAC	$271,710	$244,539	$477,404

Abbreviations: Mechanism of action, MOA; Healthcare professional, HCP; Subcutaneous, SC; Wholesale acquisition cost, WAC.

Source: IPD Analytics, July 2025.

Coverage Criteria Considerations



Abbreviations: Value-based agreement, VBA; Cardiovascular-related hospitalization, CVH; urgent heart failure, UHF

Coverage Criteria Considerations - Combination Therapy?

- ICER research team rated vutrisiran + tafamidis "A" for added benefit over monotherapy, based on HELIOS-B trial results (ICER, 2024).
- HELIOS-B did not show heterogeneity between monotherapy and overall populations, supporting the combination rating.
- **However, ICER's public appraisal panel unanimously disagreed, stating the evidence is not adequate to confirm combination superiority.**
- Cardiologist experts noted the trial was not specifically powered or designed to evaluate combination therapy, and current data suggest but do not prove additional benefit.
- Despite ICER's "A" rating, clinical and payer consensus does not currently support routine coverage of vutrisiran in combination with tafamidis.
- Therefore, payers may reasonably restrict coverage for combination use until more definitive evidence is available.

Combination therapy is a top concern for payers due to the high costs across the category.

With monotherapy alone approaching $3 PMPM for a 1 MM Medicare plan, the potential of combination therapy raises significant budgetary concerns.

Wasfy JH, et al. ICER. 2024, October 21.

Impact of Medicare Part D Redesign Under IRA

2024 change:

1. 5% coinsurance in catastrophic phase eliminated (i.e., $0 patient responsibility in catastrophic phase).
   - Effectively capped patient out-of-pocket (OOP) spend to ~$3,300 per year.

2025 changes:

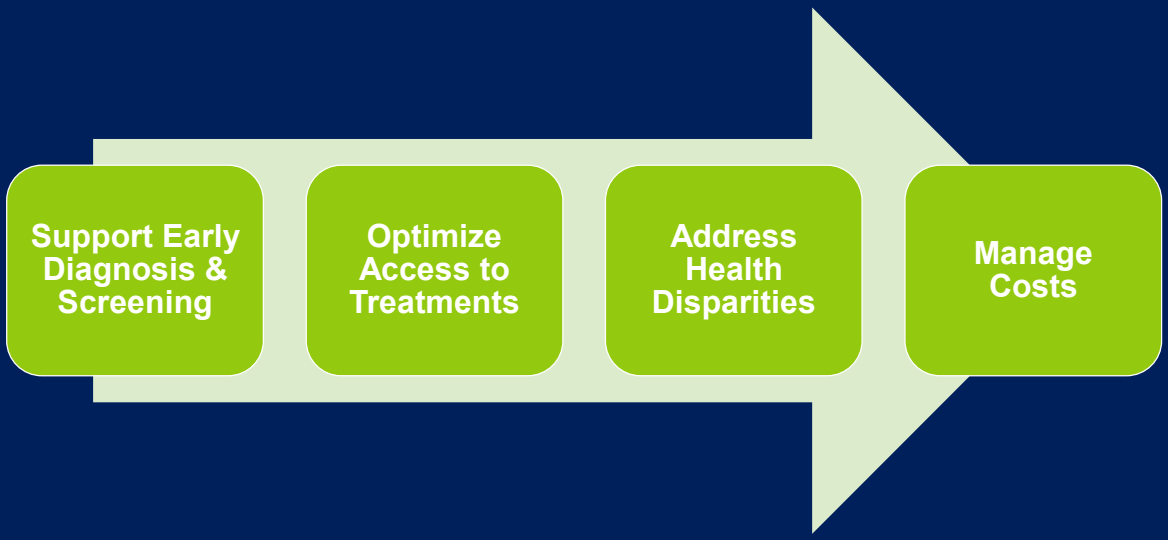
1. "Donut hole" coverage gap eliminated – no separate, higher-cost phase when initial coverage is exhausted. 3 phases only – deductible, initial and catastrophic.
2. $2,000 annual OOP cap on all prescription drug costs for Part D enrollees.
   - Copay smoothing mechanism enables patients to spread OOP costs throughout the year; may improve adherence and reduce cost-related abandonment, especially among fixed-income Medicare patients.
3. Part D plans' share of cost will increase from 15% to 60% above the cap.
   - Higher cost share = Increase access barriers (especially for high-cost specialty drugs).

A 2021 Medicare Part D data analysis found that the mean OOP cost per 30-day fill for tafamidis was $505.59 ($6,067.08 per year). IQVIA stated that in the years before 2024, Standard Medicare patients had OOP cost between $700-$900 per month.

According to an IPD Primary Market Insights survey, the majority of providers report that higher patient OOP costs influence their treatment decisions — reinforcing the access impact of recent Part D changes.

Blatt PJ et al. JAMA Netw Open. 2024;7;(9):e2426086. doi:10.1001/jamanetworkopen.2024.26086

Managed Care Strategies for Optimizing Health Outcomes



Questions

Please go to AMCPLearn.org/code to claim credit.

Scan the QR code for further instructions on how to claim CPE and access the handout.

FACULTY BIOGRAPHY

Stormi Gale, PharmD, BCCP, BCPS, FHFSA Cardiology Pharmacy Specialist Atrium Health Carolinas Medical Center	Dr. Gale is a cardiology clinical pharmacy specialist and cardiology clinical coordinator at Atrium Health Carolinas Medical Center in Charlotte, NC. She earned her Doctor of Pharmacy from Wingate University. She completed her PGY1 at Novant Health Presbyterian Medical Center and her PGY2 cardiology specialty residency at the University of Maryland School of Pharmacy. Dr. Gale is a Fellow of the Heart Failure Society of America and actively involved in the American College of Cardiology and American College of Clinical Pharmacy.

FACULTY BIOGRAPHY

Fiona Tillman, PharmD Director, Market & Financial Insights IPD Analytics	Fiona Tillman is a Director of Market & Financial Insights at IPD Analytics, where she specializes in pharmaceutical financial forecasting and strategic analysis, providing actionable insights that inform key decisions in a complex and rapidly evolving pharmaceutical landscape. One of her key areas of expertise is the rare disease space, with a particular focus on conditions such as spinal muscular atrophy, Friedreich ataxia, Prader-Willi syndrome, and ATTR amyloidosis. Prior to joining IPD Analytics, Fiona served as Pharmacy Manager for Utilization Management (UM) at Health Care Service Corporation (HCSC)—the parent company of five Blue Cross and Blue Shield plans (Illinois, Montana, New Mexico, Oklahoma, and Texas). There, she led pharmacy UM programs across the commercial line of business. Earlier in her career, she was a clinical pharmacist at CVS Caremark, supporting the Pharmacy & Therapeutics (P&T) Committee and contributing formulary recommendations for the National Formulary. Fiona holds a Bachelor of Science in Pharmacology and Toxicology from the University of Toronto and earned her Doctor of Pharmacy (PharmD) from the University of Illinois at Chicago.

FINANCIAL RELATIONSHIP DISCLOSURES

Faculty/Reviewer/Planner	**Reported Relevant Financial Relationships**
Stormi Gale, PharmD, BCCP, BCPS, FHFSA *Faculty*	*Faculty/Speaker*: American Regent
Fiona Tillman, PharmD *Faculty*	Disclosed no relevant financial relationships.
Kristen Tripicchio, PharmD *Peer Reviewer*	Disclosed no relevant financial relationships.
Angela Cassano, PharmD, BCPS, FASHP *Planner*	Disclosed no relevant financial relationships.
Brittany V. Henry, PharmD, MBA *Planner*	Disclosed no relevant financial relationships.