Abecma

United Arab Emirates · access guide

How to access Abecma for relapsed or refractory multiple myeloma from the UAE: 2026 pathway via UAE certified cell therapy centres

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

The UAE has built one of the deepest adult cell therapy and bone marrow transplant infrastructures in the wider region. Cleveland Clinic Abu Dhabi, Sheikh Shakhbout Medical City, and Burjeel Medical City all run adult haematology programmes that handle multiple myeloma from diagnosis through fourth-line salvage. Abecma is registered with the Emirates Drug Establishment, and authorised cell therapy administration capability is evolving across this network in coordination with Bristol Myers Squibb's global Cell Therapy 360 programme. For a UAE patient with triple-class-exposed relapsed or refractory multiple myeloma, the operational question is no longer whether BCMA-directed CAR-T is reachable: it is which certified centre fits the case, which cross-border path is the backstop, and what the total cost of care looks like once apheresis, manufacturing wait, bridging therapy, inpatient infusion and the post-infusion REMS-restricted month are added together.

This page explains how the pathway works in 2026 for a UAE-resident adult: who qualifies, where the workup happens, where the cells are collected and infused, what the timeline looks like, what the realistic cost band is, and what to expect from the four-week REMS-restricted period after infusion. It is concierge documentation written for a family that is already in conversation with a treating haematologist and wants the operational reality laid out plainly.

Why Abecma, and why now

Abecma is idecabtagene vicleucel, a one-time autologous BCMA-directed CAR T-cell therapy developed by Bristol Myers Squibb in partnership with 2seventy bio. It was the first cell therapy approved anywhere for multiple myeloma, reaching the US market in March 2021. The original FDA label required four or more prior lines of therapy. In 2024 the label expanded to adults with two or more prior lines of therapy including an immunomodulatory agent, a proteasome inhibitor, and an anti-CD38 monoclonal antibody. That expansion was based on the KarMMa-3 randomised Phase 3 trial, which compared a single Abecma infusion against investigator's choice of five standard regimens in 386 triple-class-exposed patients. Median progression-free survival on Abecma was 13.3 months versus 4.4 months for standard of care, with overall response rate 71 percent versus 42 percent.

For a UAE patient who has cycled through bortezomib-anchored induction, daratumumab-pomalidomide-dexamethasone, possibly autologous stem-cell transplant, and a carfilzomib-based salvage, the question of whether to move to BCMA CAR-T versus a bispecific T-cell engager such as Tecvayli or Talvey is a real clinical decision. Cell therapy offers a one-time treatment with durable remissions in a meaningful fraction of patients but requires apheresis, a four to five week manufacturing wait, lymphodepletion, inpatient infusion, and the REMS-mandated four-week post-infusion proximity period. Bispecifics are off the shelf with no manufacturing wait but require ongoing dosing. The clinical team weighs disease tempo, performance status, and family logistics. This page is the operational layer underneath that conversation.

What Abecma is, in plain language

A small volume of the patient's own blood is collected by apheresis. The T cells from that collection are sent to BMS's manufacturing facility, where they are transduced with a lentiviral vector that teaches them to recognise BCMA, a protein expressed almost exclusively on plasma cells and myeloma cells. The engineered T cells expand to therapeutic dose over four to five weeks. While manufacturing happens, the patient continues bridging therapy to control disease burden. When the product is ready, the patient receives three days of fludarabine plus cyclophosphamide lymphodepletion to make room for the CAR-T cells to expand in vivo, then a single intravenous infusion of the manufactured Abecma. Inpatient monitoring for cytokine release syndrome and immune effector cell-associated neurotoxicity syndrome typically runs seven to fourteen days. The patient and a caregiver then stay within two hours of the treating centre for four weeks for REMS-mandated monitoring.

This is not a chronic medication. It is a one-time cell therapy, and the operational complexity sits in the apheresis, the manufacturing wait, the lymphodepletion, and the post-infusion month. Most of the chronic-care infrastructure that a multiple myeloma patient is already familiar with (monthly clinic visits, infusion days, laboratory monitoring) collapses into a concentrated three-month operational window built around the infusion.

Eligibility at a UAE haematologist's clinic

For UAE-resident patients, the certified haematology programmes apply the FDA and EMA criteria with local adaptation:

1. Confirmed relapsed or refractory multiple myeloma after two or more prior lines including an IMiD, a PI, and an anti-CD38 monoclonal antibody. 2. ECOG performance status 0 to 1; ECOG 2 reviewed case by case. 3. Adequate left ventricular ejection fraction, typically 45 percent or greater. 4. Adequate pulmonary function consistent with tolerating fludarabine-cyclophosphamide and a potential CRS event. 5. Adequate hepatic, renal, and bone marrow reserve. 6. No active central nervous system involvement of myeloma. 7. No active infection requiring systemic therapy. 8. A bridging therapy plan agreed with the treating haematologist for the manufacturing window. 9. A caregiver commitment for the four-week REMS-restricted period after infusion.

A UAE patient should arrive at the cell therapy referral conversation with the most recent diagnostic workup in hand: serum and urine protein electrophoresis with immunofixation, serum free light chain assay, bone marrow biopsy and aspirate with cytogenetics including FISH for high-risk markers (del17p, t(4;14), t(14;16), gain 1q), skeletal survey or whole-body MRI, PET-CT, beta-2-microglobulin, albumin, and a current treatment history with response durations. Reserve Meds organises this documentation pack so the certified centre can give a yes or no eligibility opinion on the first review, not the fifth.

The UAE administration picture, plainly

In 2026 the UAE network of cell therapy centres relevant to commercial Abecma includes:

- Cleveland Clinic Abu Dhabi, with an established adult haematology and BMT programme and an active interest in expanding adult cell therapy services. CAR-T programme alignment for commercial BCMA products is evolving; confirm current authorisation status at intake. - Sheikh Shakhbout Medical City, with an MD Anderson affiliation and an adult haematology service that takes cell therapy referrals. - Burjeel Medical City, with an oncology and BMT programme. - Sheikh Khalifa Medical City, which performed the UAE's first paediatric DMD gene therapy in 2024 and operates as a national reference for advanced therapies generally. - Yas Clinic Hospital Abu Dhabi, which administered the UAE's first Casgevy gene therapy in April 2026 and runs an expanding cell therapy programme that may extend to BCMA CAR-T as authorisation progresses.

For UAE-resident adults where the in-country authorisation timing is incompatible with the disease tempo, the cross-border alternatives include King Faisal Specialist Hospital and Research Centre in Riyadh (long-established BMT and cellular therapy programme with deep CAR-T experience), King Hussein Cancer Center in Amman (the largest dedicated cancer centre in MENA with adult cell therapy accreditation), and select European or US centres for patients with international medical coverage.

The 2026 pathway, step by step

Week 0 to 2: Reserve Meds builds the document pack with the treating haematologist's office. We collect the most recent imaging, marrow biopsy, cytogenetics, treatment history, and laboratory panels. We submit a first-review request to one or two certified cell therapy centres in parallel so a single slow response does not stall the process.

Week 2 to 4: The certified centre's cell therapy committee reviews the case. If accepted, the centre opens a manufacturing slot with BMS and schedules apheresis. The financial pre-authorisation conversation starts in parallel; Thiqa coverage for Emirati nationals and Daman or other commercial cover for residents are confirmed at this stage. Out-of-pocket exposure ranges are clarified before commitment.

Week 4 to 5: Apheresis at the certified centre. One to two sessions, outpatient, typically a single half-day. The collected T cells are shipped to BMS for manufacturing.

Week 5 to 9: Manufacturing wait. During this window the patient continues bridging therapy under the treating haematologist's direction. Bridging regimens are physician-choice and depend on prior exposures and refractoriness profile. Reserve Meds coordinates the bridging-therapy logistics where the bridging happens at a centre different from the treating haematologist.

Week 9: Lymphodepletion. Three days of fludarabine plus cyclophosphamide as outpatient or short-stay inpatient.

Week 9 to 10: Single inpatient Abecma infusion. Day 0 of the cell therapy clock.

Week 10 to 11: Inpatient monitoring for CRS and ICANS. Tocilizumab and corticosteroids per protocol. Median CRS onset is days one to two; ICANS, when it occurs, typically follows CRS.

Week 11 to 14: REMS-restricted four-week post-infusion period. Patient and caregiver stay within two hours of the treating centre. No driving. Infection precautions. Twice-weekly clinic visits typically.

Month 4 onwards: Outpatient follow-up. Monthly disease assessment for the first year; then quarterly. Long-term haematology surveillance for cytopenias, infections, hypogammaglobulinaemia, and second-primary malignancies.

Cost expectation in AED

US list price for the Abecma product itself is USD 419,500 (some 2024 wholesale acquisition cost references quote USD 498,410; confirm at intake for any commercial contract). Real-world total cost of care including apheresis, bridging therapy, lymphodepletion, inpatient infusion and monitoring, CRS or ICANS management, and one-year follow-up commonly runs USD 700,000 to USD 1.0 million in US data. At 2026 indicative cross rates the AED-equivalent product price is approximately AED 1.54 million and the total cost of care band is approximately AED 2.6 to 3.7 million. Outliers run higher when prolonged ICU support or sustained cytopenias drive admission length.

Thiqa coverage for Emirati nationals has historically extended to authorised advanced therapies on a case-by-case basis; the pre-authorisation conversation needs to start before apheresis, not after infusion. Daman and other commercial covers vary in cell therapy coverage; the financial pre-authorisation review at the certified centre is the gating step.

Religious, ethical, and family-logistics framing

Cell-based therapy sits within the Islamic jurisprudential framework that already permits blood transfusion, organ transplantation, and assisted reproduction with appropriate safeguards. Abecma is the patient's own T cells engineered ex vivo and re-infused; there is no donor element, no foreign genetic material in the broad sense (the lentiviral vector is a research tool used during manufacturing, not a permanent transgenic modification of germline tissue), and the cells return to a patient whose marrow and immune system remain their own. The dominant ethical frame in MENA Islamic medical ethics for this kind of therapy has been permissive, with the standard expectation that the family makes the treatment decision in consultation with the treating physician and according to the patient's own informed wish.

The family-logistics burden of the four-week REMS-restricted post-infusion period is the practical pressure point. For UAE-resident patients treated locally the logistics are simpler; for patients travelling cross-border to KSA or Jordan, the four-week stay in proximity to the treating centre requires deliberate planning. A caregiver must be present continuously; many UAE families build a rotating caregiver schedule across two or three relatives. Reserve Meds documents the proximity-accommodation, transport, and pharmacy logistics in advance so the family arrives prepared rather than improvising.

When Abecma is not the right call

For a UAE patient where disease tempo is too rapid to accommodate the four to five week manufacturing wait, where performance status has degraded below ECOG 2, where active CNS involvement has emerged, or where caregiver availability for the post-infusion month cannot be arranged, the operational alternative is a BCMA-directed bispecific T-cell engager such as Tecvayli (teclistamab) or Elrexfio (elranatamab), which are off-the-shelf, require step-up admission rather than apheresis, and have no manufacturing wait. Talvey (talquetamab) targets GPRC5D rather than BCMA and is the alternative bispecific when BCMA exposure has already happened. The other commercial BCMA CAR-T product, Carvykti (ciltacabtagene autoleucel), is also accessible in select certified centres internationally; comparative eligibility is a clinical conversation rather than a one-size-fits-all default.

Reserve Meds does not push a default. The page above describes the Abecma pathway because Abecma is the BCMA CAR-T the patient has asked about. If the conversation with the treating haematologist points toward a bispecific or a different cell therapy, 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 Abecma case we build the document pack, submit first-review requests to one or two certified centres in parallel, run the financial pre-authorisation conversation alongside the clinical pre-authorisation conversation, coordinate the bridging-therapy logistics during the manufacturing window, organise the proximity accommodation and caregiver logistics for the four-week REMS-restricted period, and stay with the case through one-year follow-up. Clinical decisions remain with your treating haematologist and the certified cell therapy programme.

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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