Aldurazyme

Oman · access guide

Aldurazyme (laronidase) for a Omani family: what the pathway looks like in 2026

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

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Omani families looking into Aldurazyme for a child with mucopolysaccharidosis type I, MPS I, are in a workable position. The therapy has a long track record in the region. The Oman Directorate General of Pharmaceutical Affairs and Drug Control (DGPADC) operates a mature pharmaceutical regulatory framework. Royal Hospital Muscat and Oman Defence Force Hospital handle the initial workup and the ongoing surveillance. For severe Hurler patients needing HSCT, cross-border BMT-centre referrals to KFSHRC Riyadh, to Saudi German Hospital networks, or to international centres of excellence are operationally familiar to the Omani medical community.

This page is meant to be the first honest read you get on Aldurazyme in Oman, written by the team that would coordinate around your child's case if you decided you wanted operational support on the workup, the MoH treatment-abroad documentation (if applicable), the cross-border logistics, or the long-term cost picture.

We will be specific about MPS I, what the workup decides, the regulatory pathway, the cost in OMR and US dollars, the cross-border infusion patterns, and where Reserve Meds adds value.

What MPS I actually is, in plain terms

MPS I is a lysosomal storage disorder caused by deficiency of the enzyme alpha-L-iduronidase (IDUA). The deficiency leads to progressive accumulation of dermatan sulfate and heparan sulfate in lysosomes across the body. Presentation spans a clinical spectrum: severe Hurler with infant-onset multisystemic disease and progressive cognitive decline, intermediate Hurler-Scheie with somatic features but preserved cognition, and attenuated Scheie often diagnosed in adolescence or adulthood.

Aldurazyme is recombinant alpha-L-iduronidase, administered as a weekly intravenous infusion at 0.58 mg/kg over 3 to 4 hours. The therapy is disease-modifying for non-CNS manifestations. It does not cross the blood-brain barrier and does not address the cognitive decline of severe Hurler.

For severe Hurler infants, the standard of care is hematopoietic stem cell transplantation, HSCT, ideally before age 2 to 2.5. Aldurazyme is used as a bridge to HSCT and often as an adjunct afterwards. For Hurler-Scheie and Scheie patients, ERT alone is typically the long-term answer.

The workup that decides eligibility

The workup has five components: urinary GAG screen, alpha-L-iduronidase enzyme activity assay (the definitive enzymatic confirmation), IDUA gene sequencing for severity classification, baseline organ assessments (echocardiogram, FVC, sleep study, ophthalmology, ENT, hepatomegaly, joint range of motion, 6-minute walk test), and severity classification by the metabolic specialist.

In Oman, the workup typically begins at: - **Royal Hospital Muscat (SMC)**, the public-sector t

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