Aptiom

United Arab Emirates · access guide

How to access Aptiom for partial-onset (focal) epilepsy from the UAE: 2026 pathway via UAE neurology and community pharmacy supply

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

The UAE has one of the deepest adult and paediatric neurology service networks in the wider region. Cleveland Clinic Abu Dhabi runs a comprehensive epilepsy programme with video-EEG monitoring, neurosurgical evaluation, and the full antiepileptic-drug formulary. American Hospital Dubai neurology, Mediclinic City Hospital neurology, Sheikh Shakhbout Medical City (SSMC) neurology, NMC and Aster neurology services, and Tawam paediatric neurology in Al Ain all treat partial-onset (focal) epilepsy from the initial diagnostic workup through long-term medication management and, where indicated, surgical evaluation. Aptiom (eslicarbazepine acetate; the international Zebinix brand is the same molecule from Bial) is the third-generation sodium-channel inhibitor in the dibenzazepine family, once-daily, with a cleaner enzyme-induction and hyponatraemia profile than carbamazepine or oxcarbazepine. For a UAE-resident adult or paediatric patient aged 4 or over with confirmed partial-onset seizures who has either failed an initial first-line antiepileptic or is moving off carbamazepine or oxcarbazepine for tolerability reasons, the operational question is no longer whether a third-generation sodium-channel agent is reachable: it is which prescribing centre fits the case, whether the local supply runs as Aptiom or as Zebinix, what the insurance pre-authorisation conversation looks like, and how the monthly refill cycle and serum sodium monitoring schedule settle into a UAE family's life.

This page explains how the pathway works in 2026 for a UAE-resident patient: who qualifies, where the neurologist or epileptologist conversation happens, where the prescription is written and filled, what the realistic out-of-pocket exposure band is in AED, what to monitor on therapy (serum sodium being the distinctive Aptiom concern), and how the longer-term treatment course fits into a UAE family's life. It is concierge documentation written for a family that is already in conversation with a treating neurologist and wants the operational reality laid out plainly.

Why Aptiom, and why now

Aptiom is eslicarbazepine acetate, a once-daily oral voltage-gated sodium channel blocker. The molecule is a prodrug that is rapidly hydrolysed after absorption to eslicarbazepine, the active S-enantiomer of the carbamazepine 10-monohydroxy metabolite. Developed by Bial (Portugal), commercialised internationally as Zebinix, and licensed to Sunovion as Aptiom for the US market. The molecule sits in the third generation of the dibenzazepine antiepileptic family alongside carbamazepine and oxcarbazepine.

The FDA approved Aptiom in November 2013 as adjunctive therapy for partial-onset seizures in adults, expanded to monotherapy in September 2015, and expanded to paediatric patients aged 4 and over in September 2017. The EMA approved Zebinix in April 2009 with a parallel paediatric label expansion. The pivotal Phase 3 programme (BIA-2093-301, -302, -303 in adults; BIA-2093-208 and -305 in paediatric cohorts) demonstrated median seizure reduction of approximately 35 to 45 percent at the 1,200 mg/day adjunctive dose, with responder rates (50 percent or greater seizure reduction) of 35 to 45 percent versus 14 to 22 percent for placebo.

For a UAE patient who has trialled an initial first-line antiepileptic such as levetiracetam or lamotrigine without adequate seizure control, or who is moving off carbamazepine because of hyponatraemia or off oxcarbazepine for the same reason, Aptiom is the operational answer that combines once-daily dosing, a cleaner enzyme-induction profile than carbamazepine, and lower hyponatraemia incidence than oxcarbazepine in head-to-head comparisons. The conversation about whether to start with Aptiom, switch to Aptiom from another sodium-channel agent, or add Aptiom as adjunctive therapy on top of an existing regimen is the central clinical decision. This page is the operational layer underneath that conversation.

What Aptiom is, in plain language

Aptiom is an oral tablet, taken once daily, with or without food, at approximately the same time each day. The tablets are available in 200 mg, 400 mg, 600 mg, and 800 mg strengths. Tablets may be crushed if swallowing is difficult. Storage is room temperature; no refrigeration is required. There is no infusion, no inpatient stay, no certified-centre requirement. After the prescribing neurologist writes the first prescription and the dispensing pharmacy fills it, the patient takes Aptiom at home, returns for serum sodium and liver function monitoring on the defined schedule, and returns for neurology review at the cadence the treating physician sets.

The adult titration schedule starts at 400 mg once daily for one week, then increases to 800 mg once daily for the second week, with most patients maintained at 800 mg or 1,200 mg daily and some up-titrated to 1,600 mg/day for adequate control. The paediatric titration (ages 4 to 17) is weight-based with weekly titration, generally to a maintenance dose of 20 to 30 mg/kg/day capped at the adult range.

For epilepsy that responds, treatment is indefinite. The standard expectation is years of continuous use with periodic neurology review, sodium and LFT monitoring, and seizure-diary documentation. The chronic-treatment shape is comparable to other long-term antiepileptic regimens.

Eligibility at a UAE neurologist's clinic

For UAE-resident patients, the neurology and epileptology services apply the FDA, EMA, and major-guideline criteria:

1. Confirmed diagnosis of partial-onset (focal) epilepsy by a neurologist or epileptologist, with EEG documentation of focal interictal or ictal discharges, MRI brain imaging to characterise structural substrate (mesial temporal sclerosis, cortical dysplasia, post-stroke gliosis, tumour, vascular malformation, or no structural lesion identifiable), and a seizure history compatible with focal onset. 2. Age 4 or older for paediatric prescribing; adult prescribing has no upper-age limit but renal function adjustment applies at any age. 3. Treatment history demonstrating either failure of an initial first-line antiepileptic for seizure control, or a tolerability-driven need to move off carbamazepine or oxcarbazepine. 4. Baseline serum sodium and liver function tests. Sodium documentation is the operational anchor for the periodic monitoring schedule that follows. 5. Hormonal contraceptive review for women of reproductive potential. Aptiom induces CYP3A4 and reduces combined oral contraceptive efficacy; barrier or non-hormonal contraception is the standard recommendation during treatment. 6. Pregnancy and lactation screen. Human data are limited; effective contraception is required during treatment. Folate supplementation if pregnancy is planned. 7. Drug interaction screen for current medications, including any statins, warfarin, ciclosporin, tacrolimus, voriconazole, phenytoin, omeprazole, and herbal products. 8. Hepatic and renal function review. Severe hepatic impairment is a contraindication; renal dose adjustment applies for creatinine clearance below 50 mL/min. 9. HLA screening is considered in specific high-risk groups. HLA-B*1502 is associated with carbamazepine-class severe cutaneous adverse reactions primarily in East Asian populations and is less directly relevant for most MENA patients; HLA-A*3101 confers risk across broader ancestries and may be screened where clinically indicated.

A UAE patient should arrive at the neurology conversation with the most recent diagnostic workup: EEG report, MRI brain report and images, complete seizure history with frequency and triggers, the complete antiepileptic-drug history with response and tolerability data, and the insurance pre-authorisation paperwork that the prescribing office typically initiates. Reserve Meds organises this documentation pack so the neurology team can confirm eligibility on the first review.

The UAE prescribing and dispense picture, plainly

Zebinix (the international brand for eslicarbazepine acetate) is registered with the Emirates Drug Establishment; US Aptiom-branded supply is rare in the UAE and generally only relevant for a US-resident patient on a named-patient import pathway. The functional supply chain is:

1. **Prescribing neurologist or epileptologist**: a board-certified UAE neurologist, ideally with epilepsy clinical experience, or a fellowship-trained epileptologist at a comprehensive epilepsy programme. Major UAE prescribing centres include Cleveland Clinic Abu Dhabi (with the comprehensive epilepsy programme), American Hospital Dubai neurology, Mediclinic City Hospital neurology, Sheikh Shakhbout Medical City neurology, Burjeel Medical City neurology, NMC and Aster neurology services across Dubai and Sharjah, Saudi German Hospital Dubai neurology, and Dr Sulaiman Al Habib network neurology. For paediatric cases (ages 4 to 17), Tawam paediatric neurology in Al Ain and the paediatric neurology services at Cleveland Clinic Abu Dhabi, SSMC, and Mediclinic City handle the conversation. Public sector neurology at Mafraq, Rashid, and Latifa hospitals handles the same role for Emirati nationals. 2. **Diagnostic workup**: EEG is run at the diagnosing centre's neurophysiology lab; standard 30-minute EEG, prolonged ambulatory EEG, or in-patient video-EEG monitoring depending on case complexity. MRI brain (typically a 3 Tesla epilepsy protocol with thin-cut coronal T2 and FLAIR through the temporal lobes) is run at the diagnosing centre or a partnered neuroimaging service. 3. **Insurance pre-authorisation**: most UAE private insurers (Daman, Thiqa for Emirati nationals; Oman Insurance, AXA Gulf, MetLife, Cigna, NEXtCARE, Bupa Global for commercial covers) include antiepileptic drugs in the standard pharmacy benefit. The specialty-tier price band for Aptiom or Zebinix means some commercial insurers require a clinical rationale letter documenting prior antiepileptic-drug failure or intolerance before approving coverage at the maintenance dose tier. Pre-authorisation typically takes 5 to 14 days for a complete file. 4. **Pharmacy dispense**: 30-day supply at the prescribing centre's outpatient pharmacy or a community pharmacy with the antiepileptic-drug inventory line. Bial's MENA commercial distributor network handles the supply chain for Zebinix-branded supply. Where Aptiom-branded supply is requested (typically only relevant for a US-resident patient), named-patient import through Cigalah, Bin Sina, or Gulf Pharmaceutical Industries applies. 5. **Refill cycle**: monthly thereafter. Continued dispensing typically requires documentation of ongoing seizure-diary review at neurology follow-up and the periodic serum sodium monitoring described below.

The 2026 pathway, step by step

Week 0 to 2: Reserve Meds builds the documentation pack with the treating neurologist's office. We collect the EEG report, MRI brain report, complete seizure history, complete antiepileptic-drug history with response and tolerability data, baseline labs (sodium, LFTs, renal function), and insurance card details. The neurologist's office submits insurance pre-authorisation if applicable.

Week 2 to 4: Insurance pre-authorisation review (where required). Most UAE commercial insurers turn this around within 1 to 3 weeks for antiepileptic drug coverage.

Week 4 to 5: First dispense. Starting dose 400 mg once daily for the first week.

Week 5 to 6: Up-titration to 800 mg once daily. Most patients maintained at this dose; some up-titrated to 1,200 mg or 1,600 mg/day at the neurologist's discretion based on seizure control.

Week 4: Serum sodium check at one month after starting Aptiom. Documented in the chart and reviewed by the prescribing neurologist.

Month 3: Serum sodium check at three months. Documented and reviewed.

Month 3 to 6: Neurology follow-up to assess seizure-diary response, tolerability, and adherence. Dose adjustment if seizures continue or if hyponatraemia is documented.

Ongoing: Maintenance dosing once daily, monthly pharmacy refill, annual serum sodium check if stable (more frequent if on diuretics, on other hyponatraemia-associated medications, or with prior hyponatraemia history), periodic LFT monitoring, continuous seizure diary review at each neurology visit.

Cost expectation in AED

US Aptiom list price (2026) is approximately USD 1,200 to USD 2,000 per 30-day supply at the maintenance dose tier, with annual cost approximately USD 14,000 to USD 24,000 per patient at list price. International Zebinix supply through Bial's distributor network in the UAE generally lands at a somewhat lower price point than US WAC; confirm current local pricing at point of dispense.

At indicative 2026 cross rates, a 30-day Aptiom supply at USD 1,500 is approximately AED 5,500, and the annual cost at USD 18,000 is approximately AED 66,000. Zebinix supply through the UAE channel typically lands in the AED 3,500 to 5,500 monthly band at the maintenance dose tier, with annual cost in the AED 40,000 to 65,000 band.

For Emirati nationals with Thiqa coverage, antiepileptic drugs at the maintenance dose tier are typically covered with documented neurology prescription. Daman and other commercial covers vary; the prescribing neurologist's insurance liaison runs the pre-authorisation conversation where required. Out-of-pocket exposure for a covered patient is generally a co-payment band in the AED 50 to 500 per month range, not the full list price.

Monitoring on therapy

The monitoring schedule for Aptiom is structured around the distinctive class toxicities:

- **Serum sodium**: at baseline, at one month after starting Aptiom, at three months, then annually if stable. More frequent monitoring (every 3 to 6 months) for patients on diuretics, on other hyponatraemia-associated medications (SSRIs, desmopressin, chlorpropamide, carbamazepine or oxcarbazepine co-prescription), with prior hyponatraemia history, or with new symptoms suggestive of hyponatraemia (nausea, headache, confusion, lethargy, gait unsteadiness, new or worsening seizures). - **Liver function tests**: at baseline and periodically; more frequent if clinically indicated or if other hepatotoxic agents are co-prescribed. - **Seizure diary**: continuous patient-side documentation of seizure frequency, duration, and identifiable triggers. The diary drives titration and maintenance decisions and is the single most important data input at every neurology follow-up visit. - **Skin review**: patient counselled to report any new rash promptly. Stevens-Johnson syndrome and toxic epidermal necrolysis are rare but reported with the dibenzazepine class; immediate discontinuation and medical review if a rash develops. - **Alcohol caution**: alcohol can worsen sedation and lower the seizure threshold; counselling at first prescription. - **Driving caution**: UAE driving regulations for patients with active epilepsy follow international standard. A seizure-free interval (typically 6 to 12 months depending on jurisdiction) is required before driving privileges are reinstated. The prescribing neurologist documents the driving-status conversation. - **Bone health**: long-term enzyme-inducing antiepileptic drug therapy is associated with reduced bone mineral density. Vitamin D supplementation and bone health monitoring are appropriate for patients on long-term therapy.

Religious, ethical, and family-logistics framing

Aptiom is an oral small molecule. There is no animal-source material in standard manufacturing, no donor cells, no biological product. Halal and kosher acceptability are not in question. The classical Islamic jurisprudential framework for chronic medication in serious illness already endorses antiepileptic therapy.

The family-logistics burden of Aptiom sits in the chronicity, the adherence discipline, and the social context of an epilepsy diagnosis. Once-daily dosing is the operational advantage; one tablet at approximately the same time each day for years. Many UAE families find the once-daily schedule a meaningful improvement over the twice-daily or thrice-daily schedules of carbamazepine and oxcarbazepine.

Epilepsy carries a heavier social stigma in some MENA settings than in many Western contexts, particularly for unmarried adolescent and young adult patients where the diagnosis can affect marriage prospects. The clinical conversation often includes a family-confidentiality dimension. UAE neurology services handle this with discretion as standard practice; the medical record is confidential and the diagnosis is shared only with the patient (and parents, for paediatric patients) at the patient's direction.

For paediatric patients (ages 4 to 17), parental involvement in the medication-administration routine is standard. The once-daily schedule simplifies the school-day logistics: the dose can be given at breakfast or at bedtime depending on family preference, and there is no mid-day dose to coordinate with school staff.

For women of reproductive potential, the hormonal contraceptive interaction is a real conversation. The CYP3A4 induction reduces combined oral contraceptive efficacy. Barrier contraception or a non-hormonal intrauterine device is the standard recommendation during treatment. This conversation needs to happen before prescribing, not at the first refill, and the prescribing neurologist documents it.

When Aptiom is not the right call

Aptiom is the right answer for confirmed partial-onset (focal) epilepsy in the indications above. It is not the right answer for:

- Primary generalised epilepsies (absence seizures, juvenile myoclonic epilepsy, generalised tonic-clonic seizures without focal onset). Aptiom is not indicated for these seizure types and may worsen them in some patients. - Severe hyponatraemia history (the class hyponatraemia risk makes Aptiom an unfavourable choice for patients with a documented history of significant hyponatraemia on carbamazepine, oxcarbazepine, or another precipitant). - Stevens-Johnson syndrome or toxic epidermal necrolysis history on a dibenzazepine antiepileptic (carbamazepine or oxcarbazepine). Cross-reactivity within the class is well documented. - Severe hepatic impairment (Child-Pugh C); dose-adjustment data is limited and the agent is contraindicated. - Pregnant women without specialist counsel. Human pregnancy data is limited; an epilepsy-and-pregnancy specialist consultation is the appropriate first step. - Patients with HLA-A*3101 positivity where clinically indicated. Cross-reactivity with the dibenzazepine class is documented and an alternative antiepileptic may be more appropriate.

For partial-onset epilepsy where Aptiom is not the chosen agent, the alternatives in 2026 are levetiracetam (broad-spectrum, minimal interactions, first-line in most MENA centres), lamotrigine (broad-spectrum, slower titration, well tolerated long term), carbamazepine (classical sodium-channel agent, broader CYP3A4 induction, twice-daily dosing), oxcarbazepine (similar to Aptiom mechanistically but with a higher hyponatraemia incidence), lacosamide (slow-inactivation sodium-channel, twice-daily, well tolerated), brivaracetam (cleaner psychiatric tolerability than levetiracetam), perampanel (AMPA receptor antagonist for refractory cases), and surgical evaluation at a comprehensive epilepsy centre for medication-refractory cases with localisable onset.

Reserve Meds does not push a default. The page above describes the Aptiom pathway because Aptiom is the antiepileptic the patient has asked about. If the conversation with the treating neurologist points toward levetiracetam, lamotrigine, lacosamide, or another agent, the operational pathway shifts accordingly.

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 Aptiom case we build the documentation pack (EEG report, MRI brain report, complete seizure history, prior antiepileptic-drug history, baseline labs), submit first-review requests to the chosen prescribing centre, coordinate the insurance pre-authorisation conversation alongside the clinical workup, set up the first 30-day dispense at the chosen pharmacy, organise the baseline-plus-one-month-plus-three-month serum sodium monitoring schedule, and stay with the case through the first year of dosing with handoff to the local neurologist for ongoing surveillance. Clinical decisions remain with your treating neurologist or epileptologist.

> ***Reserve Meds's role***
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> 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.

Composite case examples. This document is for general information only and does not constitute medical advice. Please consult your treating physician.
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