Besremi

United Arab Emirates · access guide

How to access Besremi for polycythemia vera from the UAE: 2026 pathway via UAE haematology and pharmacy supply

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

The UAE has one of the deepest adult haematology service networks in the wider region. Cleveland Clinic Abu Dhabi haematology, Sheikh Shakhbout Medical City (SSMC) haematology, Mediclinic City Hospital, American Hospital Dubai haematology, Burjeel Medical City, Tawam adult haematology in Al Ain, and the major private tertiaries in Dubai and Sharjah all run adult haematology services that treat myeloproliferative neoplasms (MPN) including polycythemia vera (PV). Besremi (ropeginterferon alfa-2b-njft) was approved by the FDA in November 2021 as the first interferon explicitly approved for PV, regardless of treatment history, and the first novel PV therapy in over fourteen years. The EMA approved Besremi in February 2019 under a slightly older label. For a UAE-resident adult with confirmed JAK2 V617F-positive polycythemia vera, the operational question is no longer whether long-acting interferon therapy is reachable: it is whether Besremi is the right cytoreductive choice over hydroxyurea or ruxolitinib, whether the patient is 1L or switching, how the prescription is dispensed under cold chain, what insurance will and will not underwrite, and how the patient handles the every-2-week self-injection routine that later spaces to every 4 weeks.

This page explains how the pathway works in 2026 for a UAE-resident patient: who qualifies, where the prescribing haematologist conversation happens, how Besremi is dispensed and stored, what the dosing and titration schedule looks like, what the realistic out-of-pocket exposure band is in AED, what to monitor (depression and suicidality, liver function, and thyroid function being the headline signals), and how the long-term multi-year treatment course fits into a UAE patient's life. It is concierge documentation written for a patient who is already in conversation with a treating haematologist and wants the operational reality laid out plainly.

Why Besremi, and why now

Besremi is ropeginterferon alfa-2b-njft, a monopegylated proline-substituted recombinant interferon alfa-2b conjugated to a single 40 kDa methoxy-polyethylene glycol moiety. It binds to type I interferon receptors on haematopoietic cells, triggering JAK/STAT-coupled intracellular signalling. The clinical effect in polycythemia vera is to suppress the abnormal JAK2 V617F-mutated clone (the dominant driver clone in over 95% of PV cases), reduce erythrocyte and platelet production, and bring blood counts to target ranges. With sustained therapy, Besremi can drive measurable reduction in JAK2 V617F allele burden, which is the molecular signature of disease. Hydroxyurea (the conventional cytoreductive choice in PV) and ruxolitinib (a JAK1/2 inhibitor approved as a second-line therapy after hydroxyurea failure) control blood counts but do not produce molecular response. The molecular-response question is the differentiating clinical claim for Besremi.

The FDA approved Besremi in November 2021. The EMA approved it in February 2019 under a slightly narrower label (without symptomatic splenomegaly). The pivotal evidence comes from PROUD-PV and its long-term extension CONTINUATION-PV: at 36 months, Besremi was superior to hydroxyurea for complete haematologic response with normal spleen size (53% versus 38%), and the molecular response advantage continues to deepen at 5-plus years of follow-up.

For a UAE patient newly diagnosed with PV, or one who has been on hydroxyurea for years with adequate haematologic control but is now asking about the molecular-response question, or one who has had inadequate haematologic control or intolerance on hydroxyurea, Besremi is the operational pathway to a long-acting interferon with a clean MPN-specific indication and a real molecular-response track record. The conversation about whether to choose Besremi over continued hydroxyurea or a switch to ruxolitinib is the central clinical decision. This page is the operational layer underneath that conversation.

Reserve Meds does not promote one PV cytoreductive over another. Where a UAE haematologist concludes that hydroxyurea or ruxolitinib is the right answer for this patient, the operational pathway shifts accordingly.

What Besremi is, in plain language

Besremi is a subcutaneous injection. There is no infusion centre, no inpatient stay, no specialty-centre referral required. After an initial training session with the prescribing haematologist or a clinical nurse educator, the patient self-injects at home using a prefilled syringe.

The starting dose is 100 mcg subcutaneous every 2 weeks. The treating haematologist titrates the dose upward by 50 mcg every 2 weeks based on the CBC trend: target haematocrit below 45%, platelet count below 400,000/microL, white cell count below 10,000/microL, and resolution of microvascular symptoms. The maximum dose is 500 mcg every 2 weeks. Most patients reach their effective dose within 3 to 6 months.

After sustained haematologic response, which is typically achieved by 6 to 12 months, the haematologist transitions the patient to maintenance dosing at the same dose, every 4 weeks instead of every 2 weeks. Maintenance dosing continues indefinitely so long as the patient tolerates therapy and haematologic control persists.

Injection sites are the thigh, the abdomen, or the outer upper arm. Sites are rotated between doses to reduce injection-site reactions. Acetaminophen pre-medication 30 to 60 minutes before injection plus bedtime dosing reduces the flu-like symptoms typical of interferon therapy in the early weeks.

This is not a short course. Besremi is taken for as long as it controls the disease and the patient tolerates therapy. The treatment course is measured in years, often a decade or more.

Eligibility at a UAE haematologist's clinic

For UAE-resident patients, adult haematology services apply the WHO 2016 or 2022 PV diagnostic criteria with local insurance adaptation:

1. Confirmed diagnosis of polycythemia vera by a haematologist applying WHO 2016 or 2022 criteria: persistent erythrocytosis (haemoglobin or haematocrit elevated for sex), JAK2 V617F mutation (or rarely JAK2 exon 12 mutation), suppressed serum erythropoietin level, and characteristic bone marrow morphology where biopsy is obtained. 2. Treatment-history documentation. Is this 1L therapy for newly diagnosed PV, or is the patient switching from hydroxyurea, anagrelide, ruxolitinib, or peginterferon alfa-2a? The reason for the switch (intolerance, inadequate haematologic control, desire for molecular response, family planning considerations) shapes the conversation. 3. Baseline CBC with differential and reticulocyte count, plus serum ferritin to anchor the haematocrit target conversation. 4. Baseline comprehensive metabolic panel including liver function tests (ALT, AST, bilirubin, alkaline phosphatase). Severe hepatic impairment is a contraindication. Mild-moderate hepatic impairment requires careful baseline workup and may require dose adjustment. 5. Baseline thyroid function (TSH, free T4) and thyroid antibody screen where indicated. Interferon-class therapy can trigger or unmask autoimmune thyroid disease. 6. Baseline depression and suicidality screen using PHQ-9 or equivalent. Interferon-class therapy carries a class-wide warning for depression and suicidality. Patients with active untreated major depression, recent suicide attempt, or severe unstable psychiatric history are not appropriate candidates for Besremi. 7. Pregnancy testing for women of childbearing potential. Besremi is contraindicated in pregnancy. Effective contraception for both partners is required during therapy and for a defined washout period after discontinuation. 8. Autoimmune disease review. Pre-existing autoimmune conditions (rheumatoid arthritis, lupus, psoriasis, inflammatory bowel disease, autoimmune hepatitis) can flare on interferon therapy. The decision to treat depends on disease severity and stability. 9. Cardiovascular risk assessment. PV itself elevates thrombosis risk; standard PV workup documents age, prior thrombosis history, and cardiovascular risk factors. Besremi is the cytoreductive choice in high-risk PV (age over 60 or prior thrombosis); low-risk PV is sometimes managed with phlebotomy and low-dose aspirin alone, with Besremi added if haematocrit control becomes difficult or symptoms emerge.

A UAE patient should arrive at the Besremi conversation with the most recent haematology documentation: full diagnostic workup confirming PV, the JAK2 V617F result with allele burden if available, the bone marrow biopsy report if obtained, recent CBC and LFT and TSH results, any prior cytoreductive therapy history with reasons for switch, baseline PHQ-9 result, and the insurance pre-authorisation paperwork that the haematologist's office typically initiates.

The UAE prescribing and supply picture, plainly

Besremi's MENA registration status is younger than the established interferon products and varies by market. [VERIFY: Besremi UAE EDE registration and current dispensing pathway at intake.] Where Besremi is registered and commercially supplied, in-country dispensing applies. Where it is not yet locally registered, a named-patient pathway can apply for documented physician-initiated prescriptions referencing the FDA, EMA, or MHRA approved indications. The pathway is:

1. **Prescribing haematologist with myeloproliferative neoplasm expertise**: any board-certified UAE adult haematologist treating PV. MPN expertise concentrates at the major UAE tertiary centres: Cleveland Clinic Abu Dhabi haematology, SSMC haematology, Mediclinic City Hospital, American Hospital Dubai haematology, Burjeel Medical City, and Tawam adult haematology in Al Ain. Public sector haematology at SKMC and the Dubai Health Authority hospitals handles the same role for Emirati nationals. Sidra Medicine is paediatric-only and is not the venue for Besremi. 2. **Pharmacy dispensing**: hospital pharmacy for inpatient or specialty outpatient prescriptions; community or specialty pharmacy with cold-chain refrigeration capability for ongoing every-2-week or every-4-week dispensing. Besremi is stored at 2 to 8 degrees Celsius. Do not freeze. The product can be at room temperature briefly before injection. 3. **Insurance pre-authorisation**: Thiqa coverage for Emirati nationals has extended to long-acting interferon therapy in PV on a case-by-case basis with appropriate haematologist justification. Daman and the major commercial insurers (Oman Insurance, AXA Gulf, MetLife, Cigna, others) require similar documentation. The most common pre-authorisation conversation is the rationale for Besremi versus hydroxyurea, particularly for 1L use; documented intolerance or inadequate control on hydroxyurea typically simplifies approval. 4. **Self-injection training**: a single supervised session at the prescribing haematologist's clinic or a clinical nurse educator visit is typical. The prefilled syringe is designed for straightforward patient use; most patients self-inject after 1 to 2 supervised sessions. 5. **Ongoing monitoring**: monthly CBC and LFT during titration (typically the first 3 to 6 months); TSH every 3 months; PHQ-9 depression screen at each clinic visit. After haematologic response and transition to maintenance every 4 weeks, CBC and LFT space to every 3 months; TSH to every 3 to 6 months; PHQ-9 continues at each visit. JAK2 V617F allele burden is measured annually where the assay is available.

The 2026 pathway, step by step

Week 0 to 1: Reserve Meds builds the documentation pack with the treating haematologist's office. We collect the full PV diagnostic workup, the JAK2 result, the bone marrow biopsy report if obtained, recent CBC and LFT and TSH results, any prior cytoreductive therapy history, baseline PHQ-9 result, and insurance card details. The haematologist's office submits insurance pre-authorisation.

Week 1 to 4: Insurance pre-authorisation review. Most UAE commercial insurers turn this around within 2 to 4 weeks. The conversation is usually about the Besremi-versus-hydroxyurea rationale and the patient's treatment history.

Week 4 to 6: First dispensing at the haematologist's clinic or partner pharmacy. First dose of 100 mcg administered (or self-administered under supervision) with self-injection training on the prefilled syringe. Acetaminophen pre-medication and bedtime injection timing are coached at this visit.

Month 1 to 6: Titration phase. Patient self-injects every 2 weeks at home. Reserve Meds coordinates the cold-chain delivery for each scheduled dose. Monthly CBC and LFT, TSH every 3 months, PHQ-9 at each haematology visit. Dose increases by 50 mcg every 2 weeks based on the CBC trend until target haematocrit, platelet, and white cell counts are achieved.

Month 6 to 12: Stabilisation phase. Patient continues every-2-week dosing at the effective dose. Monitoring continues at the same cadence. Haematologic response is formally assessed at 12 months (complete haematologic response definition: haematocrit below 45% without phlebotomy, platelet below 400K, white cell below 10K, no progressive disease, no thrombotic event).

Month 12 onwards: Maintenance phase. Patients with sustained haematologic response transition to every-4-week dosing at the same dose. CBC and LFT every 3 months; TSH every 3 to 6 months; PHQ-9 at each visit. JAK2 V617F allele burden measured annually where available. Maintenance continues indefinitely so long as the patient tolerates therapy and haematologic control persists.

Cost expectation in AED

US list price (WAC) for Besremi is approximately USD 12,000 to 14,000 per month at typical maintenance dosing, which translates to roughly USD 140,000 to 170,000 per year. MENA pharmacy pricing typically lands below US WAC at the wholesale level but Besremi remains firmly in the specialty-drug tier. Cash-pay retail in regional specialty pharmacies could realistically sit in the USD 8,000 to 12,000 per month range, giving an annual cash-pay band of roughly USD 96,000 to 144,000.

At 2026 indicative cross rates, the AED-equivalent annual cost band is approximately AED 350,000 to 530,000 at cash-pay retail. Insurance pre-authorisation reduces out-of-pocket exposure substantially for covered patients; cash-pay exposure depends on the dispensing pharmacy's regional pricing.

For Emirati nationals with Thiqa coverage, the financial pre-authorisation conversation needs to start before the first dispensing, not after. Daman and other commercial covers vary; the prescribing haematologist's office is the gating step. PharmaEssentia and AOP Health patient-support programmes may apply to specific cohorts. [VERIFY: PharmaEssentia/AOP MENA patient-support programme reach at intake.]

What to monitor

The headline adverse-event signals for Besremi are depression and suicidality, liver function abnormality, thyroid dysfunction, and autoimmune flare. The interferon class warning is real and shapes the monitoring schedule.

Depression and suicidality. Interferon-class therapy carries a class-wide warning. Baseline PHQ-9 plus ongoing PHQ-9 at each clinic visit is the standard. Patients and families should be coached to report mood changes, sleep changes, withdrawal, irritability, hopelessness, or thoughts of self-harm immediately rather than minimise them. New depression on therapy is managed by dose reduction, dose interruption, or discontinuation depending on severity, sometimes alongside psychiatric referral and antidepressant therapy.

Liver function abnormality. Monthly LFTs during titration catch most cases of transaminase elevation. Mild elevations are managed by continued monitoring; significant elevations trigger dose reduction or interruption.

Thyroid dysfunction. TSH every 3 months catches new-onset hypothyroidism (the most common pattern) or, less often, hyperthyroidism. New-onset hypothyroidism is usually managed with levothyroxine while continuing Besremi.

Autoimmune flare. Patients with pre-existing autoimmune disease can flare on interferon. Patients without pre-existing autoimmune disease can rarely develop new autoimmune phenomena (autoimmune hepatitis, lupus-like syndromes, rheumatoid arthritis). Clinical vigilance through the symptom history at each visit is the standard.

Flu-like symptoms (fever, chills, myalgia, fatigue, headache) are common in the first several weeks and typically improve over the first 2 to 3 months. Acetaminophen pre-medication and bedtime dosing mitigate.

Injection-site reactions (redness, swelling, mild pain) are common and typically resolve as the patient learns the injection technique and rotates sites.

Mild reversible alopecia and skin changes can affect adherence in some patients; frank conversation at initiation reduces surprise.

Pregnancy is contraindicated.

Religious, ethical, and family-logistics framing

Besremi is a recombinant interferon produced in E. coli expression system, then chemically conjugated to a synthetic mPEG polymer. There is no animal-source material, no human or animal donor element, no foreign genetic content in the patient. The classical analogy to vaccines and other recombinant injectable biologics holds in MENA Islamic medical ethics, where recombinant biologics are generally treated as permissive with the standard expectation that the patient and family decide in consultation with the treating physician.

The self-injection element is the practical pressure point for some UAE patients, particularly those who have been on oral hydroxyurea for years and are considering the switch. Patients uncomfortable with home injection can request clinic-administered dispensing, though this adds friction and is rarely necessary given the prefilled-syringe design. Most UAE patients are comfortable with self-injection after the initial training; the volume is small, the every-2-week cadence is forgiving compared with weekly biologics, and the eventual every-4-week maintenance is easy to integrate into life.

The chronic-treatment nature of Besremi means a years-long, often decade-plus routine. UAE patient logistics should plan for cold-chain pharmacy access (most UAE community pharmacies handle this), travel-friendly storage planning for trips, and haematology follow-up cadence.

The depression and suicidality signal deserves a separate cultural note. In some MENA family contexts mental-health symptoms are under-reported. The interferon-class warning is real and the PHQ-9 monitoring is non-negotiable. Families should treat mood changes, withdrawal, sleep changes, or any thought of self-harm as urgent medical signals and report them to the haematologist immediately rather than tolerate silently.

When Besremi is not the right call

For a UAE patient where the diagnosis is not clearly polycythemia vera, where well-controlled blood counts have been achieved on hydroxyurea over years and no molecular-response question is being raised, where untreated severe depression or recent suicide attempt makes interferon-class therapy unsafe, where the patient is pregnant or planning pregnancy in the near term, where severe hepatic impairment exists, or where unstable autoimmune disease exists, the operational pathway shifts:

- **Hydroxyurea (Hydrea)**: oral cytoreductive, decades of use, low cost, well-tolerated for most patients. The conventional first-line in high-risk PV. Does not produce molecular response. - **Ruxolitinib (Jakafi)**: oral JAK1/2 inhibitor approved for PV after hydroxyurea failure or intolerance. Effective for symptom control and splenomegaly. Does not produce molecular response. - **Peginterferon alfa-2a (Pegasys)**: the older long-acting interferon, used off-label in PV for many years before Besremi. Weekly subcutaneous dosing. Some MPN programmes still use it where Besremi is unavailable. - **Anagrelide**: oral platelet-lowering agent, used primarily for essential thrombocythemia; occasional use in PV with isolated thrombocytosis. - **Phlebotomy and low-dose aspirin alone**: the foundational therapy for low-risk PV. - **Allogeneic stem cell transplantation**: reserved for transformation to myelofibrosis or acute myeloid leukaemia.

Reserve Meds does not push a default. The page above describes the Besremi pathway because Besremi is the therapy the patient has asked about. We do not promote one PV cytoreductive over another. If the conversation with the treating haematologist points toward continued hydroxyurea, a switch to ruxolitinib, or continued phlebotomy alone, 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 Besremi case we build the documentation pack with the treating haematologist's office, confirm the UAE EDE registration status and the appropriate dispensing pathway, run the insurance pre-authorisation conversation alongside the clinical pre-authorisation conversation, coordinate the cold-chain supply logistics for ongoing every-2-week or every-4-week dispensing, organise self-injection training, and stay with the case through the first year of dosing with handoff to the local haematologist for ongoing surveillance. Clinical decisions remain with your treating haematologist.

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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