Briumvi

United Arab Emirates · access guide

How to access Briumvi for relapsing multiple sclerosis from the UAE: 2026 pathway via UAE neurology and infusion supply

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

The UAE has one of the deepest neurology service networks in the wider region. Cleveland Clinic Abu Dhabi's neurology institute, American Hospital Dubai, Mediclinic City and Mediclinic Parkview, NMC Specialty and Aster Hospitals across Dubai and Sharjah, Burjeel Medical City, Saudi German Hospital Dubai, and the Dr Sulaiman Al Habib network in Dubai all run multiple sclerosis (MS) services that treat MS patients from first attack through the modern disease-modifying therapy era. Briumvi (ublituximab-xiiy) is TG Therapeutics' anti-CD20 monoclonal antibody, approved by the FDA in December 2022 and by the EMA in May 2023 as the third anti-CD20 biologic for relapsing MS (joining Ocrevus and Kesimpta). For a UAE-resident adult with confirmed relapsing-remitting MS, active secondary-progressive MS, or clinically isolated syndrome on MRI evidence, who has either failed prior disease-modifying therapy or wants a high-efficacy first-line option, the operational question is no longer whether anti-CD20 therapy is reachable: it is whether Briumvi, Ocrevus, or Kesimpta is the right fit, where the infusion is run, what insurance will cover, and how the twice-yearly dosing schedule fits into the patient's working and family life over many years.

This page explains how the pathway works in 2026 for a UAE-resident adult patient: who qualifies, where the prescribing neurologist conversation happens, how the loading regimen and maintenance infusions are delivered, what the realistic out-of-pocket exposure band is in AED for the annual cost of therapy, what to monitor (infusion reactions, infection risk, immunoglobulin levels, hepatitis B reactivation, JC virus), and how the multi-year treatment plan fits into a UAE patient's life. It is concierge documentation written for an adult who is already in conversation with a treating neurologist and wants the operational reality laid out plainly.

Why Briumvi, and why now

Briumvi is ublituximab-xiiy, a glycoengineered humanised anti-CD20 monoclonal antibody. CD20 is a surface antigen on B-lymphocytes. By binding CD20 and triggering antibody-dependent cellular cytotoxicity (ADCC), complement-dependent cytotoxicity, and direct B-cell apoptosis, Briumvi depletes the B-cell pool that drives MS relapse activity and new MRI lesion formation. The glycoengineering (low-fucose Fc) makes Briumvi a more potent ADCC trigger than the prior generation of anti-CD20 antibodies, which is the basis for its lower per-dose milligram amount and substantially shorter infusion time.

The FDA approved Briumvi in December 2022 for relapsing forms of MS, including relapsing-remitting MS (RRMS), active secondary-progressive MS (SPMS), and clinically isolated syndrome (CIS). The EMA approved Briumvi in May 2023. The pivotal trials, ULTIMATE I and ULTIMATE II, were randomised, double-blind, active-controlled studies against teriflunomide 14 mg oral daily, and showed a 49 to 59 percent reduction in annualised relapse rate plus significant reduction in MRI new and enhancing lesion burden across roughly 1,100 patients (Steinman L et al., New England Journal of Medicine 2022).

For a UAE patient who has either tried one or more disease-modifying therapies without adequate disease control (continued relapses, MRI lesion accumulation, disability progression) or who wants to start with a high-efficacy option from the outset, Briumvi is the operational pathway to a twice-yearly infusion that targets the B-cell component of MS biology directly. The conversation about whether to start with Briumvi versus Ocrevus versus Kesimpta versus continuing on a moderate-efficacy oral agent (teriflunomide, dimethyl fumarate, fingolimod) is the central clinical decision. This page is the operational layer underneath that conversation.

What Briumvi is, in plain language

Briumvi is delivered as an intravenous infusion at a hospital or clinic infusion suite. It is not a self-administered injection. There is no home-dosing option.

The loading regimen is the first two doses:

- **Day 1**: 150 mg IV infusion over approximately 4 hours including premedication and observation. - **Day 15**: 450 mg IV infusion over approximately 1 hour (plus premedication and post-infusion observation, total visit ~3 hours).

The maintenance regimen begins at Week 24 and continues every 24 weeks (twice yearly):

- **Week 24, Week 48, Week 72, and so on indefinitely**: 450 mg IV infusion over approximately 1 hour (plus premedication and observation, total visit ~2 to 3 hours).

The one-hour maintenance infusion time is the operational differentiator versus Ocrevus, which has a 3 to 4 hour maintenance infusion. For an adult patient with work, family, and travel logistics, the difference between a 6-hour infusion day (Ocrevus) and a 3-hour infusion day (Briumvi) twice per year is real.

Premedication before each infusion typically includes a corticosteroid (methylprednisolone 100 mg IV or equivalent), an antihistamine (diphenhydramine 25-50 mg IV or oral), and an antipyretic (acetaminophen / paracetamol 650 mg oral). The premedication reduces infusion-reaction incidence and severity.

This is not a short course. Briumvi is taken for as long as it controls the relapse burden and disability accumulation. There is no fixed stop point in the FDA label. Some patients continue indefinitely; some discontinue after disability stabilises and the neurologist documents prolonged absence of disease activity. The stopping conversation is a neurology decision informed by serum immunoglobulin levels, infection history, and individual disease trajectory.

Eligibility at a UAE neurologist's clinic

For UAE-resident patients, neurology services apply the FDA and EMA criteria with local insurance adaptation:

1. Confirmed diagnosis of relapsing MS by a neurologist applying the 2017 McDonald criteria. Relapsing-remitting MS, active secondary-progressive MS, or clinically isolated syndrome with MRI evidence of dissemination. 2. Recent MRI brain and cervical/thoracic spine within 3 months of initiation, documenting baseline lesion burden. 3. Active disease evidence: clinical relapse within the past 12 to 24 months, or new or enhancing MRI lesions, or continued disability accumulation on prior therapy. 4. Trial and inadequate response or intolerance of prior disease-modifying therapy is the most common UAE insurance threshold for the first anti-CD20 agent. Some commercial insurers approve anti-CD20 as first-line for highly active disease at diagnosis (multiple lesions, brainstem or spinal-cord involvement, early disability). 5. Pre-treatment infectious disease screening completed: hepatitis B surface antigen and anti-HBcore antibody (HBV screening for reactivation risk), JC virus serology (PML risk monitoring), HIV serology, tuberculosis screening per regional norms. 6. Serum quantitative immunoglobulins (baseline IgG, IgM, IgA) documented. 7. Vaccination status reviewed: inactivated vaccines (influenza, COVID-19, pneumococcal) administered at least 2 weeks before first infusion where possible. Live vaccines contraindicated during treatment. 8. Pregnancy planning discussion for women of childbearing potential. Contraception during treatment and for 6 months after last infusion. Family planning is part of the initiation conversation. 9. Cardiac assessment if history of cardiac disease (rare infusion-related arrhythmia).

A UAE patient should arrive at the Briumvi conversation with the most recent MRI report, a written MS disease history from the treating neurologist, prior disease-modifying therapy history with response durations and reasons for switch, baseline lab work, and the insurance pre-authorisation paperwork that the neurologist's office typically initiates.

The UAE prescribing and supply picture, plainly

Briumvi UAE Emirates Drug Establishment (EDE) registration status is verified at intake. As of mid-2026 Briumvi is either registered or in late-cycle review with the EDE; named-patient supply via the regulatory affairs office of the prescribing centre remains a parallel pathway during any registration transition window. The dual NPP/domestic framing applies here: for a registered indication and stocked product, supply runs through the standard Novartis distribution lane (TG Therapeutics MENA partner); for an unstocked or registration-pending scenario, named-patient compassionate-use supply runs through the prescribing centre's regulatory office under EDE authorisation.

The pathway is:

1. **Prescribing neurologist with MS expertise**: any board-certified UAE neurologist treating MS, ideally with multiple sclerosis as a primary clinical focus. MS-specialised neurology services are concentrated at the major UAE tertiary centres: Cleveland Clinic Abu Dhabi (neurology institute), American Hospital Dubai, Mediclinic City Hospital Dubai, Mediclinic Parkview, NMC Specialty and Aster Hospitals, Burjeel Medical City, Saudi German Hospital Dubai, and the Dr Sulaiman Al Habib network. Public sector neurology at SKMC, Tawam, and Dubai Health Authority hospitals handles the same role for Emirati nationals. 2. **Infusion centre logistics**: Briumvi is administered in a neurology day-infusion suite. Most UAE tertiary centres run neurology infusion programmes that also handle Ocrevus, natalizumab (Tysabri), and IVIG. The patient typically infuses at the same centre that handles their neurology follow-up. 3. **Pharmacy dispensing**: hospital pharmacy supplies the vials to the infusion centre. There is no community-pharmacy retail dispensing pathway for Briumvi; the drug ships from sponsor to centre. 4. **Insurance pre-authorisation**: Thiqa coverage for Emirati nationals has extended to anti-CD20 MS therapies on documentation of disease activity and prior DMT failure. Daman, Oman Insurance, AXA Gulf, MetLife, Cigna, and the other major UAE commercial insurers handle Briumvi on a case-by-case basis with similar documentation requirements. The most common pre-authorisation friction is documentation of prior DMT failure; insurers sometimes specify which classes count as adequate prior trials. 5. **Pre-treatment workup completion**: HBV screening, JC virus serology, serum immunoglobulins, HIV, TB screening, and vaccination update completed before first infusion. Reserve Meds coordinates the workup checklist with the prescribing centre. 6. **Ongoing monitoring**: neurology follow-up every 3 to 6 months for disease assessment. MRI annually or per neurologist judgement. Serum IgG monitoring quarterly during treatment. Symptom-based monitoring for infection at each follow-up.

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 MS disease history, prior DMT history, current MRI, baseline labs, vaccination history, and insurance card details. The neurologist's office initiates insurance pre-authorisation and orders pre-treatment infectious disease screening if not already complete.

Week 2 to 6: Insurance pre-authorisation review. Most UAE commercial insurers turn this around within 2 to 4 weeks. Some require additional documentation of which DMTs have been trialled and at what dose. We surface these requirements early. In parallel, pre-treatment screening (HBV, JC virus, serum immunoglobulins, HIV, TB) results return.

Week 6 to 8: First infusion (Day 1, 150 mg) at the prescribing centre's infusion suite. Full-day appointment, approximately 4 to 6 hours including premedication, infusion, and post-infusion observation.

Week 8 to 10: Second infusion (Day 15, 450 mg). Approximately 3 hours total visit.

Week 8 to 32: Patient returns to baseline neurology follow-up cadence. No infusion visits in this window.

Week 32 (originally Week 24 of the FDA schedule, adjusted for the calendar starting from first infusion): First maintenance infusion at 450 mg. Approximately 2 to 3 hours total visit.

Week 56, 80, 104, and onward: Maintenance infusions every 24 weeks (twice yearly). Approximately 2 to 3 hours per visit.

Annual MRI brain and spine. Quarterly serum IgG monitoring (or per neurologist judgement). Neurology clinical follow-up every 3 to 6 months.

Cost expectation in AED

US list price (WAC) for Briumvi is approximately USD 59,000 per 450 mg infusion. MENA pharmacy pricing for biologics typically lands lower at the wholesale level; the cash-pay band in regional specialty pharmacies and tertiary centres sits in the USD 45,000 to 55,000 per 450 mg vial range. The Day 1 loading dose (150 mg) is a partial vial at proportional cost.

Year 1 total cost of therapy (loading regimen + first maintenance infusion): - US list price equivalent: approximately USD 137,000 to 140,000. - MENA cash-pay band: approximately USD 105,000 to 130,000. - At 2026 indicative cross rates: AED 385,000 to 477,000 cash-pay for Year 1.

Year 2 and beyond steady state (two maintenance infusions per year): - US list price equivalent: approximately USD 117,000 to 120,000. - MENA cash-pay band: approximately USD 90,000 to 110,000. - AED equivalent: AED 330,000 to 404,000 per year cash-pay.

Insurance pre-authorisation reduces out-of-pocket exposure substantially for covered patients. Thiqa coverage for Emirati nationals covers anti-CD20 MS therapy on documented eligibility. Cash-pay exposure depends on the dispensing pharmacy and the centre's biologics pricing.

The conversation about long-term cost matters because Briumvi is a years-long commitment. A 10-year treatment course is not unusual for a patient who maintains response. The cost arithmetic deserves to be on the table at initiation.

What to monitor

The notable adverse-event signals for Briumvi are infusion reactions, infections, hepatitis B reactivation, JC virus reactivation, and hypogammaglobulinaemia.

Infusion reactions are common (~48 percent in ULTIMATE trials), occur predominantly with the Day 1 first infusion, and are mostly mild to moderate (chills, headache, fever, throat irritation, fatigue, nausea). Premedication with corticosteroid plus antihistamine plus acetaminophen reduces incidence and severity. Severe reactions (anaphylaxis, hypotension, bronchospasm, angioedema) are rare but possible. Infusion centre staff are trained to slow or stop the infusion and manage reactions; this is standard infusion-suite practice.

Infection risk. Upper respiratory tract infections, urinary tract infections, herpes infections (zoster, simplex), and respiratory infections are reported at increased frequency. Bacterial, viral, and fungal opportunistic infections are reported less commonly. Patients are counselled to report fever, persistent cough, urinary symptoms, or unusual skin lesions promptly to the neurology team.

Hepatitis B virus (HBV) reactivation. Pre-treatment screening for HBsAg and anti-HBcore antibody is mandatory. Patients with chronic HBV (HBsAg positive) need hepatology coordination and antiviral prophylaxis (entecavir or tenofovir) before and during Briumvi treatment. Patients with resolved HBV (HBsAg negative but anti-HBcore positive) need a frank discussion of reactivation risk and may also warrant antiviral prophylaxis. This is a hepatology coordination point that Reserve Meds flags early.

Progressive multifocal leukoencephalopathy (PML) is a rare brain infection caused by JC virus reactivation. PML has been reported with other anti-CD20 agents (rituximab, ocrelizumab) and is theoretically possible with Briumvi. JC virus antibody serology at baseline establishes risk stratification; positive serology is not a contraindication but informs surveillance. Any new neurological symptom (cognitive change, motor deficit, behavioural change) during Briumvi treatment warrants prompt neurology re-evaluation with MRI.

Hypogammaglobulinaemia. Chronic B-cell depletion reduces serum immunoglobulin levels over time. Quarterly IgG monitoring is the standard. Serum IgG dropping below 4 g/L warrants a re-assessment of infection risk and possibly IVIG supplementation. This is a several-year-into-treatment consideration, not an early signal.

Vaccinations require planning. Inactivated vaccines (annual influenza, COVID-19, pneumococcal) should be administered at least 2 weeks before first infusion when possible. Live vaccines (yellow fever, MMR, varicella, BCG) are contraindicated during Briumvi treatment and for 6 months after the last infusion. Patients planning Hajj or travel to areas requiring yellow fever vaccination need to plan accordingly.

Religious, ethical, and family-logistics framing

Briumvi is a recombinant humanised IgG1 monoclonal antibody produced in mammalian cell culture. There is no donor element, no human tissue source, no foreign genetic content in the patient. The classical analogy to vaccines and other injectable biologics holds in MENA Islamic medical ethics, where biologics are generally treated as permissive with the standard expectation that the patient and family decide in consultation with the treating physician.

The twice-yearly infusion cadence is the practical advantage for many UAE patients. A working adult plans two half-day or full-day clinic visits per year. Family caregivers plan ride-and-return logistics for two days per year. There is no daily pill, no weekly self-injection, no monthly clinic visit beyond the standard neurology follow-up. For a multi-year treatment course this matters.

The pre-treatment workup deserves cultural attention. HBV screening, JC virus serology, immunoglobulin testing, and vaccine update are not always familiar to patients moving from a moderate-efficacy oral DMT. The reasoning is straightforward: the immune system is being modulated long-term, and the safety case rests on knowing the baseline status of the relevant infectious-disease and immunoglobulin parameters. Reserve Meds explains the workup at intake; the laboratory burden is one-off at initiation plus the ongoing quarterly IgG check.

Pregnancy planning is the conversation that lands hardest for younger UAE patients. Briumvi requires contraception during treatment and for 6 months after the last infusion. For a patient or couple actively planning family, the conversation centres on whether to defer pregnancy, time conception in the 6-month window between maintenance doses (after careful neurology discussion of relapse risk during pregnancy off-DMT), or use an alternative DMT during the family-building years. This is a conversation that belongs at initiation, not after the first infusion.

When Briumvi is not the right call

For a UAE patient whose MS disease activity is well controlled on a moderate-efficacy oral agent (teriflunomide, dimethyl fumarate, fingolimod), whose disease is primary-progressive (Briumvi is not indicated; ocrelizumab is the anti-CD20 agent with PPMS approval), where serum immunoglobulin levels are already low at baseline (hypogammaglobulinaemia is a relative contraindication), where active or chronic untreated hepatitis B precludes immunosuppression without hepatology co-management, or where pregnancy is imminent and DMT washout is not an option, the operational pathway shifts:

- **Ocrevus (ocrelizumab)**: the other major IV anti-CD20 agent for MS. Same class, very similar efficacy, longer infusion time (3 to 4 hours maintenance). Approved for RRMS, SPMS, and PPMS (the latter is unique to ocrelizumab among anti-CD20 agents). Often interchangeable with Briumvi in the conversation about which IV anti-CD20 to start. - **Kesimpta (ofatumumab)**: the subcutaneous anti-CD20 agent. Self-administered monthly at home, no infusion centre visit required. Different operational profile (monthly home injection vs twice-yearly infusion) suits different patient preferences. Same efficacy class. - **Off-label rituximab**: used in some MENA centres for MS where cost and supply favour it. Off-label in MS (not FDA-approved for MS). Some neurology services use 1000 mg IV every 6 months. Reserve Meds notes this as an option that exists in clinical practice; the on-label anti-CD20 agents (Briumvi, Ocrevus) are the regulatory primary path. - **Natalizumab (Tysabri)**: high-efficacy non-anti-CD20 option. JC virus serology determines suitability; PML risk in JCV-positive patients limits long-term use. - **High-efficacy oral agents**: cladribine (Mavenclad), siponimod (Mayzent for SPMS), ozanimod (Zeposia for RRMS). Alternative high-efficacy lanes that some patients prefer for the oral route. - **Moderate-efficacy oral agents**: teriflunomide, dimethyl fumarate, fingolimod. For patients with low disease activity and good tolerance, these remain reasonable options.

Reserve Meds does not promote one anti-CD20 MS therapy over another. The choice between Briumvi, Ocrevus, Kesimpta, or off-label rituximab is made with your treating neurologist based on infusion logistics, prior exposure, immunoglobulin levels, infection history, and patient preference. The page above describes the Briumvi pathway because Briumvi is the agent the patient has asked about. If the conversation with the treating neurologist points toward Ocrevus, Kesimpta, or another option, 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 Briumvi case we build the documentation pack with the treating neurologist's office, run the insurance pre-authorisation conversation alongside the clinical pre-authorisation conversation, coordinate the pre-treatment workup (HBV, JC virus, immunoglobulins, vaccinations) with the prescribing centre's laboratory, organise the infusion-suite scheduling for the loading regimen and the first maintenance infusion, and stay with the case through the first 18 months of dosing with handoff to the local neurologist for ongoing surveillance. Clinical decisions remain with your treating neurologist.

Frequently asked patient questions

How is Briumvi different from Ocrevus? Briumvi is glycoengineered for stronger immune-cell recruitment per dose, which is why the maintenance dose is 450 mg (vs Ocrevus 600 mg) and the maintenance infusion runs about 1 hour (vs Ocrevus 3 to 4 hours). Efficacy is very similar in the comparable trials. Patient preference and infusion logistics drive most choices between the two.

Will I need to stop my current MS medication before starting Briumvi? Most prior DMTs require washout. The neurologist plans the timing. Anti-CD20 agents in particular need careful washout coordination.

How long do I take Briumvi for? For as long as it controls your MS. There is no fixed stop point. Stopping decisions are made with your neurologist if disability stabilises over years, if infections recur, or if immunoglobulin levels drop persistently.

Can I get pregnant on Briumvi? Contraception during treatment and for 6 months after the last infusion. Family planning conversation happens at initiation. Some patients time conception in the 6-month window between maintenance doses with neurology coordination; others defer pregnancy plans.

What about vaccines? Get inactivated vaccines (annual flu, COVID-19, pneumococcal) at least 2 weeks before first infusion. Live vaccines are off-limits during treatment and for 6 months after.

What does the infusion day look like? Day 1 (150 mg loading): about 4 hours total including premedication, infusion, and observation. Day 15 (450 mg loading): about 3 hours. Maintenance (q24 weeks, 450 mg): about 2 to 3 hours. Day-procedure, no overnight stay.

Can my employer absences accommodate Briumvi? Most UAE employers accommodate the twice-yearly infusion days as medical leave. The advantage over weekly or monthly DMTs is the predictable, low-frequency cadence.

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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