Brukinsa

United Arab Emirates · access guide

How to access Brukinsa for chronic lymphocytic leukaemia, mantle cell lymphoma, Waldenstrom macroglobulinaemia, marginal zone lymphoma, and follicular lymphoma from the UAE: 2026 pathway via UAE haematology and pharmacy supply

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

The UAE operates one of the deepest adult haematology and lymphoma service networks in the wider region. Cleveland Clinic Abu Dhabi haematology and medical oncology, Sheikh Shakhbout Medical City (MD Anderson affiliation), Tawam Hospital Al Ain (oncology centre of excellence), Burjeel Medical City, American Hospital Dubai haematology, Mediclinic City Hospital, King's College Hospital London Dubai, NMC Specialty, and the Saudi German Hospital network all run adult haematology services that diagnose and treat B-cell malignancies across the full therapeutic ladder: observation for indolent disease, chemoimmunotherapy regimens, Bruton tyrosine kinase (BTK) inhibitors, BCL-2 inhibitors, anti-CD20 monoclonal antibodies, and, where indicated, autologous stem cell transplantation or CD19 CAR-T cell therapy. Brukinsa (zanubrutinib, BeiGene) is the second-generation, more selective BTK inhibitor on the prescribing physician's shortlist for patients with chronic lymphocytic leukaemia (CLL), small lymphocytic lymphoma (SLL), mantle cell lymphoma (MCL), Waldenstrom macroglobulinaemia (WM), marginal zone lymphoma (MZL), or follicular lymphoma (FL, in combination with obinutuzumab) where chronic BTK inhibition is the preferred long-term strategy.

This page explains how the pathway works in 2026 for a UAE-resident adult: who qualifies, where the prescribing haematologist conversation happens, how Brukinsa is dispensed, what insurance pre-authorisation looks like in the UAE, what the realistic annual cost band is in AED, what to monitor across the first 6 months, and how the years-long treatment course fits into family life. It is concierge documentation written for a family already in conversation with the treating haematologist who wants the operational reality laid out plainly.

Why Brukinsa, and why now

Brukinsa is zanubrutinib, an oral, selective, second-generation Bruton tyrosine kinase inhibitor developed by BeiGene Ltd. The mechanism is covalent inhibition of BTK, the kinase that sits downstream of the B-cell receptor and that is essential to the survival of malignant B-cells in CLL, MCL, WM, MZL, and FL. What separates Brukinsa from the first-generation BTK inhibitor ibrutinib (Imbruvica) is selectivity: ibrutinib hits a wider range of off-target kinases, which translates into a higher rate of atrial fibrillation, bleeding, hypertension, and infection over the years of chronic therapy. Brukinsa's narrower kinase footprint translated into the ALPINE head-to-head trial in relapsed or refractory CLL: lower rate of atrial fibrillation, lower bleeding signal, and superior progression-free survival versus ibrutinib at 30 months.

The FDA approved Brukinsa for mantle cell lymphoma in November 2019 (accelerated), Waldenstrom macroglobulinaemia in August 2021, marginal zone lymphoma in September 2021, chronic lymphocytic leukaemia and small lymphocytic lymphoma in January 2023, and follicular lymphoma in combination with obinutuzumab in March 2024. UAE EDE registration status is verified at intake; named-patient European-import supply covers any indication where in-country registration has not yet caught up with the FDA label.

For a UAE patient with CLL who needs treatment, or with relapsed or refractory MCL after one prior line, or with newly diagnosed or relapsed WM, or with relapsed or refractory MZL after a prior anti-CD20 regimen, or with relapsed or refractory FL after two prior lines (in combination with obinutuzumab), Brukinsa is the second-generation BTK inhibitor with a cleaner cardiovascular and bleeding profile than ibrutinib. The conversation about whether to start with Brukinsa, switch from ibrutinib for tolerability, or consider acalabrutinib (Calquence) or pirtobrutinib (Jaypirca) as alternative selective BTK inhibitors is the central clinical decision. This page is the operational layer underneath that conversation.

Reserve Meds does not promote one BTK inhibitor over another.

What Brukinsa is, in plain language

Brukinsa is an oral capsule. There is no infusion centre, no inpatient stay, no specialty-centre administration required. The patient takes the capsules at home. The standard dose is 160 mg twice daily (BID), or 320 mg once daily (QD); both schedules are FDA-approved and produce equivalent steady-state exposure. The capsules can be taken with or without food.

This is not a short course. Brukinsa is taken continuously for as long as it controls the disease. Patients with CLL or WM typically stay on Brukinsa for years; patients with MCL or MZL stay on it until progression or intolerable toxicity.

Eligibility at a UAE haematologist clinic

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

1. Confirmed indication. CLL/SLL, MCL (typically after at least one prior line for the FDA-accelerated label), WM, MZL after anti-CD20 therapy, or FL after two prior lines (in combination with obinutuzumab). Diagnosis confirmed by flow cytometry, immunohistochemistry, and where indicated FISH, IGHV mutation status, TP53 status, and bone marrow biopsy. 2. Treatment history. First-line eligible in CLL and WM; later-line eligible in MCL, MZL, FL. 3. Adult (18 years or older). No paediatric label for Brukinsa. 4. Hepatitis B screen. HBsAg and anti-HBc both checked. BTK inhibition has caused HBV reactivation in chronic-carrier patients; HBV-positive patients need hepatology co-management and antiviral prophylaxis before starting. 5. HIV screen. 6. Pregnancy planning for women of childbearing potential; effective contraception required during treatment and for at least 1 week after the last dose. 7. Drug-interaction review. Strong CYP3A inhibitors (clarithromycin, itraconazole, ritonavir-boosted regimens) require dose reduction; strong CYP3A inducers (rifampin, phenytoin, carbamazepine, St John's wort) should be avoided. Concomitant antiplatelet or anticoagulant therapy should be minimised where the underlying indication allows. 8. Second primary malignancy counselling. BTK inhibitors as a class are associated with a small excess risk of non-melanoma skin cancer and other second primaries; annual dermatology surveillance is recommended.

A UAE patient should arrive at the haematology conversation with the most recent diagnostic workup: complete blood count, flow cytometry, immunoglobulin levels (for WM), bone marrow biopsy report where applicable, FISH and TP53 results for CLL, hepatitis serology, and the prescribing office's preauthorisation paperwork.

The UAE prescribing and supply picture, plainly

Brukinsa UAE EDE registration status is verified at intake. BeiGene's MENA commercial supply runs through regional distributors. Where in-country registration is complete, in-country pharmacy dispensing applies. Where registration for a specific indication has not yet caught up with the FDA label, a named-patient European-import pathway covers the case. The pathway is:

1. **Prescribing haematologist**: a board-certified haematology or haematology-oncology specialist at Cleveland Clinic Abu Dhabi, SSMC, Tawam, Burjeel Medical City, American Hospital Dubai, Mediclinic City, King's College Hospital London Dubai, or the NMC Specialty network. Multidisciplinary tumour board discussion is standard for first-line and later-line decisions. 2. **Pharmacy dispensing**: hospital pharmacy at the prescribing centre for the first 1 to 3 months of supply; community pharmacy thereafter (Brukinsa is shelf-stable at room temperature). Monthly or 3-monthly dispensing rhythm is typical. 3. **Insurance pre-authorisation**: Thiqa coverage for Emirati nationals has historically extended to BTK inhibitors for documented haematological malignancy with appropriate diagnosis. Daman and the major commercial insurers (Oman Insurance, AXA Gulf, MetLife, Cigna, others) require similar documentation. Prior-line documentation is required for MCL, MZL, and FL indications. 4. **Baseline labs**: complete blood count, comprehensive metabolic panel, hepatitis B serology, HIV, ECG (atrial fibrillation baseline), blood pressure measurement. 5. **Ongoing monitoring**: haematology follow-up monthly for the first 3 months, then quarterly. CBC at each visit. Blood pressure check at every visit. Annual dermatology surveillance for second primary malignancy.

Cost band and insurance positioning

US list price for Brukinsa is approximately USD 14,000 to 16,500 per month at WAC. Annual cash list price is approximately USD 165,000 to 200,000.

At 2026 indicative cross rates, the AED-equivalent annual cost band is approximately AED 605,000 to 735,000 at list price. Insurance preauthorisation substantially reduces out-of-pocket exposure 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 physician's office is the gating step.

What to expect on Brukinsa, week-by-week

Week 1 to 4: First weeks on Brukinsa. CBC, blood pressure, and side-effect check at the first follow-up. Most patients tolerate the start well. Common early side effects: fatigue, bruising, mild infection (upper respiratory or urinary).

Week 4 to 12: Response assessment begins. For CLL and WM, lymphocyte counts may rise transiently in the first 4 to 8 weeks (lymphocytosis is a known on-target effect, not progression). For MCL, MZL, FL: response assessment by imaging at week 12.

Month 3 to 6: Continued tolerability check. Watch for atrial fibrillation (new palpitations or shortness of breath), new-onset hypertension, infections, easy bruising or bleeding.

Month 6 and beyond: Quarterly haematology follow-up. Annual dermatology surveillance. Continuous BTK inhibition for as long as the drug controls the disease.

When Brukinsa is the wrong drug

For a UAE patient with active hepatitis B not yet under hepatology management, with severe hepatic impairment, with active serious bleeding, requiring chronic strong CYP3A inhibitor therapy that cannot be substituted, during pregnancy, or with a strong personal preference for a fixed-duration treatment course rather than a continuous-therapy strategy, the operational pathway shifts:

- **Venetoclax-based regimens (Venclexta with obinutuzumab or rituximab)**: BCL-2 inhibition with a fixed 12-month or 24-month treatment course in CLL. - **Acalabrutinib (Calquence) or pirtobrutinib (Jaypirca)**: alternative selective or non-covalent BTK inhibitors with different tolerability profiles. - **Chemoimmunotherapy (FCR, BR)**: still appropriate for selected fit younger patients with mutated IGHV CLL. - **CD19 CAR-T cell therapy or bispecific antibodies**: for relapsed or refractory disease after multiple lines.

Reserve Meds does not promote one BTK inhibitor over another. The page above describes the Brukinsa pathway because Brukinsa is the BTK inhibitor the patient has asked about. If the conversation with the treating haematologist points toward a different BTK inhibitor or a non-BTK strategy, 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 Brukinsa case we build the documentation pack with the treating haematologist's office, confirm EDE registration status and the appropriate dispensing pathway, run the insurance pre-authorisation conversation alongside the clinical pre-authorisation conversation, coordinate the monthly or quarterly supply logistics, organise baseline screening, 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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