Cabometyx

United Arab Emirates · access guide

How to access Cabometyx for advanced RCC, HCC, DTC, or NET from the UAE: 2026 pathway via UAE medical oncology and pharmacy supply

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

The UAE has the deepest adult medical oncology bench in the wider region. Cleveland Clinic Abu Dhabi medical oncology (the MD Anderson affiliation runs the multidisciplinary tumour boards), Sheikh Shakhbout Medical City, Tawam Hospital (the long-established Abu Dhabi oncology centre of excellence), Burjeel Medical City medical oncology, Mediclinic City Hospital, American Hospital Dubai medical oncology, and the wider Dubai private hospital network all run programmes that treat advanced renal cell carcinoma, hepatocellular carcinoma, differentiated thyroid cancer, and the newer neuroendocrine tumour indication through the full sequence of systemic therapy: cytotoxic chemotherapy where applicable, immune checkpoint inhibitors, multi-kinase tyrosine kinase inhibitors, and combination therapy. Cabometyx (cabozantinib, Exelixis Inc; Ipsen partners ex-US) is the oral multi-kinase TKI that hits VEGFR, MET, AXL, RET, and ROS1 alongside other targets, and is the backbone TKI choice for several of the toughest advanced solid tumours where the prescribing physician has run out of cleaner options. For a UAE-resident adult with advanced RCC (first-line or after prior systemic therapy), HCC after sorafenib, RAI-refractory DTC, or the newer March 2025 NET indication, the operational question is no longer whether oral multi-kinase TKI therapy is reachable: it is whether Cabometyx is the right fit, how the prescription is dispensed, what insurance will and will not cover, and how the family handles the months-long oral-tablet routine with its distinctive adverse-event burden.

This page explains how the pathway works in 2026 for a UAE-resident patient: who qualifies, where the prescribing medical oncologist conversation happens, how Cabometyx is dispensed and stored, what the daily empty-stomach tablet routine looks like, what the realistic out-of-pocket exposure band is in AED, what to monitor (blood pressure, thyroid function, urine protein, hand-foot syndrome, GI tolerance), and how the long-term treatment course fits into a UAE family's life. It is concierge documentation written for a family already in conversation with a treating medical oncologist who wants the operational reality laid out plainly.

Why Cabometyx, and why now

Cabometyx is cabozantinib (S-malate), an oral small-molecule inhibitor of multiple receptor tyrosine kinases including VEGFR1, VEGFR2, VEGFR3, MET, AXL, RET, ROS1, TIE2, KIT, FLT3, and TRKB. Developed by Exelixis Inc, with Ipsen as the ex-US commercial partner. The mechanism is what distinguishes Cabometyx from the rest of the oral TKI class: pure VEGFR-focused TKIs (axitinib, pazopanib) block angiogenesis cleanly but do not hit MET or AXL, which are the resistance-driver kinases that come up after first-line VEGFR blockade in renal cell carcinoma; lenvatinib hits VEGFR and FGFR but not MET or AXL with the same potency. Cabometyx's broader kinase footprint translates into activity in tumours that have progressed on prior anti-VEGF therapy and into the differentiated thyroid cancer setting where RET fusions and MET amplification matter.

The FDA approved Cabometyx for advanced renal cell carcinoma in April 2016 (after VEGFR-targeted therapy), expanded the label to first-line RCC in December 2017, added hepatocellular carcinoma after sorafenib in January 2019, added the nivolumab combination first-line RCC indication in January 2021, added RAI-refractory differentiated thyroid cancer in September 2021, and most recently added pancreatic and extra-pancreatic neuroendocrine tumours in March 2025. The EMA approvals are broadly aligned. UAE EDE registration status is verified at intake; the European-import named-patient supply route covers UAE dispensing where in-country registration has not yet caught up with the EMA label for a specific indication.

For a UAE patient with advanced RCC who has had prior anti-VEGF therapy, with HCC that has progressed on sorafenib, with RAI-refractory DTC where lenvatinib or sorafenib have failed or were not tolerated, or with NET that fits the March 2025 expansion, Cabometyx is the multi-kinase TKI that the prescribing physician has put on the shortlist. The conversation about Cabometyx monotherapy versus the Cabometyx + nivolumab combination first-line RCC arm, or about Cabometyx versus other TKIs in the class, is the central clinical decision. This page is the operational layer underneath that conversation.

Reserve Meds does not promote one TKI over another. The page describes the Cabometyx pathway because Cabometyx is the drug the patient has asked about.

What Cabometyx is, in plain language

Cabometyx is an oral tablet. There is no infusion, no injection, no specialty-centre administration. The patient takes the tablet at home, on an empty stomach, once daily. Empty stomach means no food in the 2 hours before or 1 hour after the dose. For most patients this means dosing first thing in the morning with water, then breakfast at least an hour later.

Tablet strengths are 20 mg, 40 mg, and 60 mg. The standard starting dose for renal cell carcinoma monotherapy and for hepatocellular carcinoma is 60 mg once daily. The starting dose for RCC in combination with nivolumab is 40 mg once daily. The starting dose for differentiated thyroid cancer is 60 mg once daily. Dose reductions to 40 mg and 20 mg are common during the first few months as the prescribing physician titrates against tolerability.

Cabometyx is taken for as long as the disease responds and the adverse-event burden is tolerable. Some patients stay on Cabometyx for many months, others for years. There is no fixed treatment duration.

Note: Cabometyx tablets are not interchangeable with Cometriq capsules. Cometriq is the older capsule formulation approved only for medullary thyroid cancer; Cabometyx is the tablet formulation used for the indications above.

Eligibility at a UAE medical oncologist clinic

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

1. Confirmed indication. Histologically confirmed advanced RCC (clear cell or non-clear cell per the recent expansions), HCC (Child-Pugh A preferred), RAI-refractory DTC documented through structural progression and prior RAI exposure, or pancreatic or extra-pancreatic NET per the March 2025 label. 2. Treatment history. First-line in RCC if pursuing the nivolumab combination; after prior systemic therapy for monotherapy RCC, post-sorafenib HCC, post-RAI DTC, or appropriately staged NET. 3. Adult (18+). No paediatric label. 4. Blood pressure controlled to under 140/90 mmHg before initiation. Hypertension is one of the most common Cabometyx adverse events; uncontrolled baseline hypertension must be managed first. 5. Thyroid function tested at baseline. Cabometyx induces hypothyroidism; baseline TSH and free T4 documented. 6. Urinalysis for proteinuria. Baseline urine protein-to-creatinine ratio documented. 7. No major surgery within 28 days before starting. Cabometyx impairs wound healing. 8. No active GI perforation, fistula, or recent severe haemorrhage history. Class-wide VEGF-pathway risks. 9. Dental review before starting. Osteonecrosis of the jaw is a class precaution; pre-treatment dental clearance reduces risk. 10. Drug-interaction review. Strong CYP3A4 inhibitors (ketoconazole, itraconazole, clarithromycin, ritonavir) and inducers (rifampin, phenytoin, carbamazepine, St John's wort) require dose modification or avoidance. Proton pump inhibitors and H2 blockers should be avoided or spaced where possible because of pH-dependent absorption. 11. Pregnancy planning discussion for women of childbearing potential; effective contraception during treatment is required.

A UAE patient should arrive at the Cabometyx conversation with the most recent oncology documentation: imaging confirming advanced or metastatic disease, prior systemic therapy history with response durations and reasons for change, recent blood pressure log, thyroid panel, urinalysis, dental clearance note, current medication list for DDI review, and the insurance preauthorisation paperwork that the prescribing office typically initiates.

The UAE prescribing and supply picture, plainly

Cabometyx UAE EDE registration status is verified at intake. Exelixis and Ipsen 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 EMA label, a named-patient European-import pathway covers the case. The pathway is:

1. Prescribing physician: a board-certified UAE medical oncologist. The major UAE oncology services include Cleveland Clinic Abu Dhabi medical oncology (MD Anderson affiliation, multidisciplinary tumour boards), Sheikh Shakhbout Medical City medical oncology, Tawam Hospital oncology centre of excellence in Al Ain, Burjeel Medical City medical oncology, Mediclinic City Hospital, and American Hospital Dubai medical oncology. Specialty referral to an endocrine oncologist or hepatobiliary oncologist applies for DTC and HCC respectively. 2. Pharmacy dispensing: hospital pharmacy attached to the prescribing oncology service for the initial fill and dose-titration months; community pharmacy with oncology dispensing capability for ongoing maintenance. Cabometyx is stored at room temperature, no cold chain needed. 3. Insurance pre-authorisation: Thiqa coverage for Emirati nationals has historically extended to oral TKI therapy for these indications on a case-by-case basis with documented histology and prior-therapy lines. Daman and the major commercial insurers (Oman Insurance, AXA Gulf, MetLife, Cigna, others) require similar documentation. Multidisciplinary tumour board note is the highest-yield document. Some insurers require prior TKI trial-and-failure documentation before approving Cabometyx in RCC where pazopanib, sunitinib, or axitinib could be considered first; this is the most common pre-authorisation friction point. [VERIFY: current UAE EDE registration status per indication at intake.] 4. Ongoing monitoring: blood pressure log (home and clinic), thyroid panel every 4 to 6 weeks for the first 6 months then quarterly, urinalysis for proteinuria at every visit, complete blood count and liver function tests every 2 to 4 weeks early then monthly, hand-foot syndrome inspection at every visit, dental review at any new oral symptom.

Cost band and insurance positioning

US list price for Cabometyx 60 mg once daily is approximately USD 15,000 to 18,000 per month at WAC; annual cost at list price is approximately USD 180,000 to 220,000. The 40 mg once daily dose (RCC + nivolumab combination, or DTC) sits at the lower end of that band.

At 2026 indicative cross rates, the AED-equivalent annual cost band is approximately AED 660,000 to 810,000 at list price for monotherapy. The nivolumab combination first-line RCC arm adds the immune-checkpoint inhibitor cost on top. Insurance preauthorisation reduces out-of-pocket exposure substantially for covered patients; cash-pay exposure depends on the dispensing pharmacy and named-patient supplier.

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 Cabometyx, week-by-week

Week 0 to 2: First fill at the dose the prescribing physician has chosen (60 mg for monotherapy RCC or HCC, 40 mg for combination RCC or for DTC). Establish the empty-stomach dosing rhythm. Daily home BP log. Watch for diarrhoea, fatigue, hand-foot syndrome onset (typically week 2 to 4), oral mucositis, dysphonia.

Week 2 to 6: First major dose-titration window. Most patients require at least one dose reduction during this period for diarrhoea, hand-foot syndrome, or hypertension. The prescribing oncology service is in close contact during this period; weekly to fortnightly visits or calls are typical.

Week 6 to 12: Tolerability settles for most patients at the patient-specific dose (often 40 mg, sometimes 20 mg, occasionally maintained at the starting dose). Thyroid function check and proteinuria check at week 8 and week 12. First imaging assessment of disease response at week 8 to 12 per the prescribing physician's protocol.

Week 12 onwards: Maintenance dosing at the patient-specific tolerated dose. Monthly clinic visits for the first 6 months, then every 6 to 8 weeks if stable. Imaging every 8 to 12 weeks. Thyroid panel quarterly. Urinalysis at every visit. BP log reviewed at every visit.

The medication is continued for as long as the disease responds and the adverse-event burden is tolerable.

When Cabometyx is the wrong drug

For a UAE patient with uncontrolled hypertension that cannot be managed, with active GI perforation or fistula history, with severe wound-healing impairment or recent major surgery within 28 days, with active untreated osteonecrosis of the jaw, with severe hepatic impairment (Child-Pugh C HCC), with recurrent serious haemorrhage, during pregnancy when effective contraception cannot be ensured, or where strong CYP3A4 inducers cannot be discontinued, the operational pathway shifts:

- Other VEGFR-pathway TKIs in RCC: sunitinib (Sutent), pazopanib (Votrient), axitinib (Inlyta), lenvatinib (Lenvima, often in combination with everolimus or pembrolizumab). All have different adverse-event profiles; cleaner-VEGFR-only TKIs may be better tolerated by patients who cannot manage the broader cabozantinib toxicity. - Other TKIs and biologics in HCC: lenvatinib first-line, regorafenib (Stivarga) post-sorafenib, ramucirumab (Cyramza) for AFP-high HCC, atezolizumab + bevacizumab as the immune-combination first-line standard. - Other TKIs in DTC: lenvatinib is the alternative VEGFR TKI; sorafenib is the older option. - Selpercatinib (Retevmo) or pralsetinib (Gavreto) where RET fusions or mutations make selective RET inhibition a cleaner choice than broad multi-kinase blockade. - Continued immune checkpoint inhibitor monotherapy or combination, where the histology and prior-line history make immunotherapy the better next step. - Best supportive care, where the disease burden and patient performance status make further systemic therapy unlikely to add quality time.

Reserve Meds does not promote one TKI over another, and does not push a default class. The page above describes the Cabometyx pathway because Cabometyx is the drug the patient has asked about. If the conversation with the treating medical oncologist points toward another TKI, a RET-selective inhibitor, an immune-checkpoint combination, or best supportive care, 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 Cabometyx case we build the documentation pack with the treating medical oncologist's office, confirm UAE EDE registration status per indication and the appropriate dispensing pathway, run the insurance pre-authorisation conversation alongside the clinical pre-authorisation conversation, coordinate the named-patient supply where in-country registration is incomplete, organise the baseline screening (BP, thyroid, proteinuria, dental, DDI review) that the prescribing office requires, and stay with the case through the first 6 months of dosing with handoff to the local prescriber for ongoing surveillance. Clinical decisions remain with your treating medical oncologist.

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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reserved for you.

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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