Cinqair

Saudi Arabia · access guide

How to access Cinqair for severe eosinophilic asthma from Saudi Arabia: 2026 pathway via pulmonology/respirology and infusion supply | Reserve Meds

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

Saudi Arabia operates one of the most layered pulmonology service networks in the GCC. King Faisal Specialist Hospital and Research Centre (KFSHRC) Riyadh and KFSHRC Jeddah run the national referral chest medicine and severe asthma programmes. King Abdulaziz Medical City (KAMC) Riyadh under the Ministry of National Guard Health Affairs runs a high-volume chest and allergy service. King Fahad Medical City (KFMC) Riyadh, King Khalid University Hospital (KKUH) Riyadh chest medicine, King Fahd Hospital of the University (KFHU) Khobar, and the Dr Sulaiman Al Habib Medical Group pulmonology service across Riyadh, Jeddah, and Khobar handle adult severe asthma cases through the full ladder: inhaled corticosteroid plus long-acting beta-agonist combinations, leukotriene receptor antagonists, biologic therapy, and the difficult-asthma multi-disciplinary review. Cinqair (reslizumab, Teva Pharmaceuticals) is the anti-IL-5 humanized monoclonal antibody delivered by IV infusion every 4 weeks for adults with severe eosinophilic asthma whose disease is not adequately controlled on inhaled corticosteroid plus add-on therapy. For a Saudi-resident adult who has cycled through the standard severe-asthma ladder and continues to flare with elevated blood eosinophils, the operational question is no longer whether IL-5 blockade is reachable in Riyadh, Jeddah, Dammam, or Khobar: it is which anti-IL-5 agent fits the case best, where the infusion is delivered, what insurance will and will not cover, and how the every-4-week infusion schedule fits into the family's working life.

This page explains how the pathway works in 2026 for a Saudi-resident patient: who qualifies, where the prescribing pulmonologist conversation happens, how Cinqair is procured and infused, what the loading and maintenance schedule looks like, what the realistic out-of-pocket exposure band is in SAR, what to monitor (anaphylaxis being the boxed-warning event), and when Cinqair is the wrong drug. It is concierge documentation written for a Saudi family already in conversation with a treating pulmonologist who wants the operational reality laid out plainly.

Why Cinqair, and why now

Cinqair is reslizumab, a humanized IgG4-kappa monoclonal antibody that binds interleukin-5 (IL-5) and blocks its interaction with the IL-5 receptor on the eosinophil surface. Developed by Teva Pharmaceuticals. The mechanism: IL-5 is the principal cytokine driving eosinophil maturation, recruitment, and survival; blocking IL-5 reduces circulating and airway eosinophil numbers, and in patients whose severe asthma is eosinophil-driven, the reduction in eosinophils translates into fewer exacerbations, lower oral corticosteroid dependence, and improved lung function.

The anti-IL-5 class in 2026 has four agents that a Saudi pulmonologist may choose among: Cinqair (reslizumab, Teva, IV infusion every 4 weeks, weight-based dosing 3 mg/kg), Nucala (mepolizumab, GSK, subcutaneous injection every 4 weeks, fixed 100 mg), Fasenra (benralizumab, AstraZeneca, anti-IL-5 receptor alpha, subcutaneous injection every 8 weeks after loading), and Dupixent (dupilumab, anti-IL-4 receptor alpha, broader Type 2 inflammation pathway, subcutaneous every 2 weeks). Tezspire (tezepelumab, anti-TSLP) sits upstream of the IL-5 pathway and is the alternative when the eosinophil count is borderline.

The FDA approved Cinqair for severe eosinophilic asthma in March 2016 for adults aged 18 and over. The EMA approval is contemporaneous. SFDA registration status in Saudi Arabia is verified at intake; where in-country registration is complete, in-country pharmacy and infusion centre dispensing applies; where registration has lapsed or distribution gaps exist, a named-patient European-import or US-import pathway covers the case.

For a Saudi patient with severe eosinophilic asthma whose blood eosinophil count is 400 cells per microlitre or higher and who continues to exacerbate despite maximum inhaled therapy, Cinqair is the IV-infusion anti-IL-5 option. The conversation about whether to start with Cinqair as first biologic, switch to Cinqair from Nucala or Fasenra for inadequate response, or consider Dupixent or Tezspire instead is the central clinical decision that belongs to the treating pulmonologist. This page is the operational layer underneath that conversation.

Reserve Meds does not promote one anti-IL-5 over another. The page describes the Cinqair pathway because Cinqair is the biologic the patient or the physician has raised.

What Cinqair is, in plain language

Cinqair is an intravenous infusion, not a self-administered injection. There is no home-injection device. The dose is weight-based: 3 mg per kilogram of patient body weight, administered as an IV infusion over approximately 20 to 50 minutes, every 4 weeks. The infusion is given at an infusion centre, a day-care unit, or a hospital outpatient infusion bay; it is not given in a community pharmacy or by the patient at home.

Cinqair carries a boxed warning for anaphylaxis. Anaphylactic reactions have occurred during or within 20 minutes after the infusion in approximately 0.3 percent of patients in the pivotal trials. Cinqair must be administered in a healthcare setting prepared to manage anaphylaxis; the patient must be observed for an appropriate period after infusion. This is the most important operational difference between Cinqair and the subcutaneous anti-IL-5 alternatives, and it is the reason Cinqair is delivered in an infusion centre rather than at home.

This is a long-term therapy. Cinqair is taken for as long as it controls the disease. Patients who achieve a meaningful response, defined as a reduction in exacerbation rate, lower oral corticosteroid need, and improved asthma control, typically stay on Cinqair for years.

Eligibility at a Saudi pulmonologist clinic

For Saudi-resident patients, the pulmonology services apply the FDA and EMA criteria with local SFDA and insurance adaptation:

1. Severe persistent asthma per GINA step 4 or 5 despite high-dose inhaled corticosteroid plus long-acting beta-agonist and an additional controller (long-acting muscarinic antagonist, leukotriene receptor antagonist, or maintenance oral corticosteroid). 2. Blood eosinophil count of 400 cells per microlitre or higher documented within the previous 6 weeks before starting Cinqair. Some institutions accept counts within the prior 3 months, but the FDA-approved population was 400 cells per microlitre or higher with measurement within 6 weeks. 3. Documented exacerbation history. Typically two or more exacerbations requiring systemic corticosteroid in the prior 12 months, or one exacerbation requiring hospitalisation. 4. Adult, 18 years or older. Cinqair is not approved for paediatric use. 5. Anaphylaxis history screen. Prior anaphylactic reaction to reslizumab, to other monoclonal antibodies, or to excipients is a contraindication. History of anaphylaxis from other causes is a relative contraindication that warrants pulmonology and allergy co-management before starting. 6. Pregnancy planning discussion for women of childbearing potential. 7. Confirmation of body weight, since dosing is weight-based; the dose is recalculated for significant weight change. 8. Treatment history documentation, including any prior anti-IL-5 or anti-IL-4Ra trial.

A Saudi patient should arrive at the biologic conversation with the most recent pulmonology documentation: current asthma control test (ACT) score, current FEV1 and lung function trend, recent blood eosinophil count (within 6 weeks ideally), complete exacerbation and hospitalisation history with dates, current inhaler regimen, oral corticosteroid exposure history, prior biologic-trial documentation if applicable, anaphylaxis history if any, and the insurance preauthorisation paperwork that the prescribing office initiates.

The Saudi prescribing and supply picture

Cinqair SFDA registration status is verified at intake. Teva's MENA commercial supply runs through regional distributors. Where SFDA registration and distribution are current, in-country hospital pharmacy and infusion centre dispensing applies. Where registration has lapsed or supply has gapped, a named-patient European-import or US-import pathway covers the case. The pathway is:

1. **Prescribing physician**: a Saudi-licensed pulmonologist (consultant chest physician), commonly co-managed with an allergy and immunology consultant for the severe-asthma diagnostic confirmation and biologic selection. Services that handle this work include KFSHRC Riyadh and KFSHRC Jeddah pulmonology, KAMC Riyadh, KFMC Riyadh, KKUH chest medicine, KFHU Khobar, and the Dr Sulaiman Al Habib network across the Kingdom. 2. **Infusion delivery**: hospital outpatient infusion bay or accredited day-care infusion centre. Cinqair must be infused in a setting prepared to manage anaphylaxis. The infusion takes approximately 20 to 50 minutes, with post-infusion observation per institutional protocol. 3. **Pharmacy supply**: hospital pharmacy holds the cold-chain stock (Cinqair is stored at 2 to 8 degrees Celsius, refrigerated, protected from light, not frozen). The infusion centre draws and administers from the hospital pharmacy supply. 4. **Insurance pre-authorisation**: Bupa Arabia, Tawuniya, MedGulf, and the other major Saudi commercial insurers require biologic pre-authorisation. Documentation typically includes the GINA step 4 or 5 confirmation, the eosinophil count within 6 weeks, the exacerbation and hospitalisation log, and the prior controller trial history. Government coverage for Saudi nationals through MoH, MNGHA, or the military service applies institution-by-institution. 5. **Ongoing monitoring**: pulmonology follow-up at week 4 (after first infusion), week 16, then at minimum quarterly. ACT, FEV1, and eosinophil count tracked. Adverse event review at each visit, with explicit anaphylaxis-history check.

Cost expectation in SAR

US list price for Cinqair runs approximately USD 35,000 to 45,000 per year at maintenance dosing, depending on patient body weight (since the dose is 3 mg/kg every 4 weeks). Heavier patients use more drug; lighter patients use less.

At 2026 indicative cross rates, the SAR-equivalent annual cost band is approximately SAR 131,000 to 169,000 at list price for the typical adult weight range. Insurance preauthorisation reduces out-of-pocket exposure substantially for covered patients; cash-pay exposure depends on the dispensing pharmacy and the import route in effect.

For Saudi nationals with MoH, MNGHA, or military health coverage, the financial conversation goes through the institutional formulary and prior-authorisation committee. For private commercial insurance patients, the pre-authorisation conversation needs to start before the first infusion, not after.

What to expect, week-by-week

Week 0 to 1: Reserve Meds builds the documentation pack with the treating pulmonologist's office. We collect the GINA step 4 or 5 documentation, ACT score, FEV1 and lung function trend, blood eosinophil count within 6 weeks, exacerbation log, current inhaler and controller regimen, oral corticosteroid history, and prior biologic trial history if applicable.

Week 1 to 4: Insurance preauthorisation. Saudi commercial insurers turn this around in 2 to 4 weeks; institutional government formularies vary.

Week 4 to 6: First infusion at the prescribing centre's infusion bay. The dose is calculated from patient weight at 3 mg/kg. The infusion runs over approximately 20 to 50 minutes. Post-infusion observation per institutional protocol, with explicit anaphylaxis monitoring. Patient is discharged the same day.

Week 8: Second infusion. Same dose, same observation protocol. Anaphylaxis risk is highest with the first 2 to 3 infusions; observation discipline does not relax over time, but the patient's familiarity with the routine increases.

Week 12: Third infusion. Initial response assessment at the pulmonology clinic at the same visit or shortly after. ACT score, FEV1, exacerbation history since starting Cinqair.

Week 16 onwards: Continuing every-4-week infusion schedule. Response assessment at minimum at week 16. Patients who do not show meaningful reduction in exacerbation rate or oral corticosteroid need by week 16 to 24 may be candidates for switching anti-IL-5 agent or escalating to alternative biologic pathway.

Ongoing: Every-4-week infusion for as long as Cinqair controls the disease. Quarterly pulmonology follow-up at minimum during the first year; less frequent thereafter for stable responders, though the every-4-week infusion cadence does not change.

When Cinqair is the wrong drug

For a Saudi patient with eosinophil-low asthma (blood eosinophil count below 300 to 400 cells per microlitre), with allergic-pathway-dominant disease where IL-4 and IL-13 blockade (Dupixent) or anti-TSLP (Tezspire) is a better mechanistic fit, with prior anaphylactic reaction to Cinqair or another monoclonal antibody, with active untreated parasitic infection (helminth co-infection is a known precaution with anti-IL-5 therapy), or during pregnancy when the risk-benefit calculus has not been resolved with the treating pulmonologist, the operational pathway shifts:

- **Subcutaneous anti-IL-5 alternatives (Nucala / mepolizumab; Fasenra / benralizumab)**: home or clinic subcutaneous injection, no infusion-centre requirement, no boxed warning for anaphylaxis. Fasenra adds an every-8-week maintenance interval after loading. For Saudi patients where the infusion-centre logistics or the boxed-warning risk profile is the limiting factor, the subcutaneous alternatives are typically the first switch. - **Dupixent (dupilumab)**: broader Type 2 inflammation blockade (IL-4Ra), preferred where allergic disease or atopic dermatitis or chronic rhinosinusitis with nasal polyposis is the dominant phenotype. - **Tezspire (tezepelumab)**: anti-TSLP, useful where the eosinophil count is borderline or where multi-pathway inflammation is suspected. - **Continued maximum inhaler therapy and add-on bronchial thermoplasty referral**: where biologic therapy is contraindicated or where the case has not yet exhausted non-biologic options.

Reserve Meds does not promote one anti-IL-5 over another, and does not push a default biologic class. The page above describes the Cinqair pathway because Cinqair is the biologic raised by the patient or the prescribing physician. If the conversation with the treating pulmonologist points toward a subcutaneous anti-IL-5, toward Dupixent, toward Tezspire, or toward continued maximum non-biologic therapy, 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 Saudi Cinqair case we build the documentation pack with the treating pulmonologist's office, confirm SFDA registration status and the appropriate dispensing pathway, run the insurance pre-authorisation conversation alongside the clinical pre-authorisation conversation, coordinate the supply logistics through the in-country hospital pharmacy or the named-patient import route, organise the infusion-centre scheduling and the anaphylaxis-monitoring protocol confirmation, and stay with the case through the first year of dosing with handoff to the local prescriber for ongoing surveillance. Clinical decisions remain with your treating pulmonologist.

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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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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