**Cinryze**

Abu Dhabi · access guide

# Cinryze for hereditary angioedema prophylaxis from Abu Dhabi: 2026 pathway via Abu Dhabi allergy/immunology and home/infusion supply

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

Abu Dhabi's allergy and clinical immunology service network is anchored by Cleveland Clinic Abu Dhabi's allergy and immunology service with complement testing capability, Sheikh Shakhbout Medical City (SSMC) under the Mubadala Health network, Sheikh Khalifa Medical City (SKMC) in the SEHA system, and the Burjeel Medical City and Burjeel Hospital allergy services across the emirate. The Department of Health Abu Dhabi (DoH) governs emirate-level dispensing oversight, and the UAE Emirates Drug Establishment (EDE) governs federal-level product registration for plasma-derived C1 esterase inhibitor.

Cinryze (C1 esterase inhibitor human, nanofiltered, plasma-derived; Takeda) is the intravenous C1-INH replacement biologic indicated for routine prophylaxis against hereditary angioedema attacks in adolescents and adults, with paediatric expansion to ages 6 and above since 2014. For an Abu Dhabi-resident patient or family with confirmed HAE that is attack-rich enough to warrant prophylaxis, the question in 2026 is whether Cinryze is the right fit relative to modern subcutaneous and oral prophylaxis options, how the IV dosing schedule integrates into Abu Dhabi family life, and what the AED-equivalent annual cost band looks like with Thiqa or commercial insurance preauthorisation.

This page explains the 2026 Abu Dhabi pathway: who qualifies, where the allergist-immunologist conversation happens, how Cinryze is dispensed and administered, what insurance preauthorisation typically requires, and how the chronic IV-prophylaxis routine fits into an Abu Dhabi family's life.

## Why Cinryze, and why now

Cinryze is plasma-derived, nanofiltered C1 esterase inhibitor concentrate. Hereditary angioedema is a complement-pathway disorder where deficient or dysfunctional C1-INH protein allows uncontrolled bradykinin generation, producing recurrent attacks of subcutaneous, abdominal, or laryngeal swelling. Replacing the missing protein by intravenous infusion is the most direct mechanistic correction.

The HAE prophylaxis landscape has changed substantially since Cinryze's original 2008 FDA approval. Modern first-line options in most international guidelines are now Takhzyro (lanadelumab; SC anti-kallikrein monoclonal antibody every 2 weeks) and Orladeyo (berotralstat; oral plasma kallikrein inhibitor once daily). Cinryze remains relevant for patients who prefer a plasma-derived replacement biologic, for paediatric patients aged 6 and above where the SC or oral options may not be preferred, and for attack-rich phenotypes where frequent IV C1-INH has demonstrated value. Reserve Meds does not promote one HAE therapy over another.

## What Cinryze is, in plain language

Cinryze is a plasma-derived protein concentrate reconstituted from lyophilised vials and administered intravenously. The adult routine prophylaxis dose is 1000 units IV every 3 to 4 days. The paediatric routine prophylaxis dose is 500 units (ages 6 to 11) or 1000 units (ages 12 and above) IV every 3 to 4 days. Administration is by slow IV push or short infusion, typically over 10 minutes. After supervised training in the clinic or infusion centre, most patients self-administer at home as the steady-state expectation. Alternatively, the dose can be delivered in a clinic infusion suite or via a home-infusion nursing service.

This is a years-long therapy. Patients who achieve adequate attack-rate reduction typically stay on Cinryze indefinitely unless they transition to a different prophylactic class.

## Eligibility at an Abu Dhabi allergy-immunology clinic

For Abu Dhabi-resident patients, the allergy-immunology services apply the standard international diagnostic and prescribing criteria:

1. Confirmed HAE diagnosis. Documented C1-INH functional assay below the reference range plus low or low-normal C4 between attacks, or genetic confirmation in the SERPING1 or F12 lines. Family history is supportive but not required. 2. Attack pattern. Documented recurrent attacks of subcutaneous, abdominal, or laryngeal angioedema; frequency, severity, and quality-of-life impact recorded. 3. Age. 6 years and above per the paediatric label expansion. 4. Suitability for chronic IV access. Most patients use peripheral venous access. Patients with poor peripheral access may require a central venous catheter discussion; the FDA boxed warning for thrombotic events at greater than twice the recommended dose with central venous catheters must be reviewed openly. At standard prophylactic dosing the thrombosis risk profile is reassuring. 5. Viral inactivation reassurance. Nanofiltration, solvent-detergent treatment, and donor screening have produced an excellent modern safety record for plasma-derived C1-INH.

An Abu Dhabi patient or family should arrive at the consultation with C1-INH functional and antigenic levels, C4, family history if known, an attack diary, and any prior on-demand therapy history.

## The Abu Dhabi prescribing and supply picture

Cinryze EDE registration status is verified at intake. Where in-country registration is complete, the prescribing pathway runs through the allergist-immunologist at Cleveland Clinic Abu Dhabi, SSMC, SKMC, or Burjeel, with hospital pharmacy dispensing for the initial supply and arrangement of a home or clinic infusion routine for chronic prophylaxis. Cleveland Clinic Abu Dhabi and SSMC operate home-infusion programmes for haemophilia, immunoglobulin replacement, and chronic IV biologics that extend operationally to C1-INH replacement. Where registration has not caught up with the FDA label, a named-patient pathway under EDE rules covers the import.

Thiqa coverage for Emirati nationals has historically extended to HAE prophylaxis biologics on a case-by-case basis with documented severity and attack-frequency justification. Daman, the major Abu Dhabi commercial insurers, and DoH-administered pathways apply similar criteria. The DoH-coordinated pre-authorisation conversation typically requires documented HAE diagnosis, attack diary, and a confirmed allergist-immunologist prescribing letter.

## Cost band

US wholesale acquisition cost for Cinryze is in the band of approximately USD 480,000 to 590,000 per year for adult routine prophylaxis at 1000 units every 3 to 4 days. The exact annual figure depends on dosing frequency, body weight where dose adjustments apply, and any breakthrough acute-attack dosing. At 2026 indicative cross-rates the AED-equivalent annual band is approximately AED 1.76M to AED 2.17M at list price. Thiqa and commercial insurance preauthorisation reduces out-of-pocket exposure substantially for covered patients.

## What to expect on Cinryze

After the initial consultation, the first 1 to 2 doses are typically administered in the clinic with supervised training in reconstitution and infusion technique. Most adult patients are confident with self-administration after 2 to 4 supervised sessions. For paediatric patients, parents are trained to reconstitute and administer; some families prefer ongoing clinic-administered or home-nursing administration through the early years.

The attack-rate reduction expectation on routine prophylaxis is meaningful but not absolute. Pivotal trial and post-marketing data show approximately 50 percent reduction in attack frequency and reduced attack severity for patients on Cinryze 1000 units every 3 to 4 days versus placebo. Breakthrough attacks can occur; the on-demand therapy plan (Berinert IV, Firazyr SC, or Cinryze at appropriate acute-treatment dose) is set up at the same time as the prophylaxis plan. Follow-up at the prescribing clinic is typically every 3 months in the first year, then every 6 months for stable responders.

## When Cinryze is the wrong drug

For an Abu Dhabi patient with mild HAE and a low attack rate where on-demand acute therapy is sufficient, for a patient unable to manage chronic IV access or where the family cannot integrate twice-weekly IV reconstitution, for a patient who prefers a subcutaneous or oral prophylactic option, or for a severe phenotype where the prescribing physician judges that Takhzyro or Orladeyo is a better operational fit, the pathway shifts. Reserve Meds does not promote one HAE therapy over another. If the conversation with the treating allergist-immunologist points toward Takhzyro, Orladeyo, or Haegarda SC C1-INH, we coordinate that pathway instead.

## 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 an Abu Dhabi Cinryze case we build the documentation pack with the treating allergist-immunologist's office, confirm EDE registration and DoH dispensing details, run the Thiqa or commercial insurance preauthorisation conversation alongside the clinical workup, coordinate the cold-chain supply logistics, organise self-administration training and home or clinic infusion routine, 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 allergist-immunologist and HAE team.

### *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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reservemeds.com · hello@reservemeds.com