Cinryze

United Arab Emirates · access guide

Cinryze for hereditary angioedema prophylaxis from the UAE: 2026 pathway via UAE allergy/immunology and home/infusion supply

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

The UAE has one of the deepest allergy and clinical immunology service networks in the Gulf. Cleveland Clinic Abu Dhabi runs adult allergy and immunology with complement testing capability and chronic IV biologic infrastructure. Sheikh Shakhbout Medical City (SSMC) and Sheikh Khalifa Medical City (SKMC) handle adult immunology in the Abu Dhabi public-and-academic sector. American Hospital Dubai's allergy clinic and Mediclinic City Hospital in Dubai run allergy-immunology services with home-infusion partner arrangements. NMC Specialty and Aster Hospitals across Dubai and the northern emirates handle allergy referrals into these tertiary services. The UAE Emirates Drug Establishment (EDE) governs registration of plasma-derived C1 esterase inhibitor products.

Cinryze (C1 esterase inhibitor human, nanofiltered, plasma-derived; Takeda, originally ViroPharma and Shire) 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 a UAE-resident patient or family with confirmed HAE that is attack-rich enough to warrant prophylaxis, the operational question in 2026 is no longer whether C1-INH replacement is reachable: it is whether Cinryze is the right fit relative to modern subcutaneous and oral prophylaxis options, how the IV dosing schedule integrates into the family's life, where the home or clinic infusion programme runs, and what the AED-equivalent annual cost band looks like.

This page explains the 2026 UAE 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 a UAE 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. Cinryze restores functional C1-INH activity, suppresses kallikrein-bradykinin pathway activation, and reduces attack frequency and severity in patients on routine prophylaxis.

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, Takeda; SC anti-kallikrein monoclonal antibody every 2 weeks) and Orladeyo (berotralstat, BioCryst; 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 delivery has demonstrated value. Reserve Meds does not promote one HAE therapy over another. The page describes the Cinryze pathway because Cinryze is the therapy the patient or family has asked about.

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, many adult patients and the families of paediatric patients are taught to reconstitute and self-administer at home, which is the steady-state expectation for chronic prophylaxis. Alternatively, the dose can be delivered in a clinic infusion suite or via a home-infusion nursing service where available.

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 a UAE allergy-immunology clinic

For UAE-resident patients, the major 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, but the clinical conversation about catheter selection, anticoagulation considerations, and risk-factor stratification belongs at the start of treatment. 5. Viral inactivation reassurance. Plasma-derived products carry a theoretical residual transmission risk; nanofiltration, solvent-detergent treatment, and donor screening have produced an excellent modern safety record.

A UAE patient or family should arrive at the allergy-immunology conversation with C1-INH functional and antigenic levels, C4, family history if known, attack diary documenting frequency severity and triggers, and any prior on-demand therapy history.

The UAE 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, American Hospital Dubai, or Mediclinic City; hospital pharmacy dispensing for the initial supply; and arrangement of a home or clinic infusion routine for chronic prophylaxis. Cleveland Clinic Abu Dhabi and Mediclinic operate home-infusion programmes for haemophilia, immunoglobulin replacement, and chronic IV biologics that extend operationally to Cinryze. Where registration has not caught up with the FDA label, a named-patient pathway under EDE rules covers the import. Insurance preauthorisation across Thiqa for Emirati nationals, Daman, Oman Insurance, AXA Gulf, MetLife, and Cigna typically requires documented HAE diagnosis, attack-frequency justification for prophylaxis, 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 on top of the prophylactic schedule. At 2026 indicative cross-rates the AED-equivalent annual band is approximately AED 1.76M to AED 2.17M at list price. Insurance preauthorisation reduces out-of-pocket exposure substantially for covered patients; cash-pay exposure depends on the dispensing pharmacy's regional pricing and named-patient supply margin.

What to expect on Cinryze

After the initial allergy-immunology consultation, the first 1 to 2 doses are typically administered in the clinic with the patient or family observing the reconstitution and infusion technique. A supervised training session covers vial reconstitution with sterile water, swirling rather than shaking to avoid foaming, slow IV push or short infusion, and disposal of supplies. 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 itself for acute treatment at appropriate 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 a UAE 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 subcutaneous 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 a UAE Cinryze case we build the documentation pack with the treating allergist-immunologist's office, confirm EDE registration and the appropriate dispensing pathway, run the 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.

reservemeds.com · hello@reservemeds.com