Columvi

Abu Dhabi · access guide

Columvi for relapsed or refractory DLBCL from Abu Dhabi: 2026 emirate pathway via Abu Dhabi haematology and CRS/ICANS-capable infusion centres

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

Abu Dhabi is the UAE emirate with the deepest adult haematology and cellular therapy infrastructure. Cleveland Clinic Abu Dhabi haematology has a maturing cellular therapy programme with CAR-T capacity and the CRS / ICANS monitoring infrastructure that translates directly to CD20 by CD3 bispecific antibody therapy. Sheikh Shakhbout Medical City, Burjeel Medical City, and the Abu Dhabi Stem Cells Centre cover the parallel haematology and cellular therapy roles. For a CD20 by CD3 bispecific case specifically, the Abu Dhabi-resident patient has the rare advantage of in-emirate access to the infusion centre with the right monitoring capacity: no cross-emirate or cross-border referral needed for the step-up dosing week. Columvi (glofitamab-gxbm, Genentech / Roche) is the IV CD20 by CD3 bispecific antibody given as a fixed-duration 12-cycle course with step-up dosing in week 1 to limit cytokine release syndrome.

This page explains the 2026 pathway for an Abu Dhabi-resident patient: DoH coordination, eligibility at the prescribing haematologist clinic, in-emirate infusion centre selection, the obinutuzumab pre-treatment requirement, what CRS and ICANS preparedness means in practical terms at CCAD, SSMC, Burjeel, or ADSCC, the realistic out-of-pocket exposure band in AED, and how the fixed 12-cycle finish-line shapes planning.

Why Columvi, and why now

Columvi is glofitamab-gxbm, a humanized IgG1 bispecific antibody binding CD20 on B-cells and CD3 on T-cells. The FDA approved Columvi in June 2023 under accelerated approval for r/r DLBCL after two or more lines. In July 2025 the FDA converted to full approval and expanded the label to include second-line r/r DLBCL in combination with gemcitabine and oxaliplatin (GemOx) based on the STARGLO trial, which showed an overall survival benefit over the standard second-line GemOx-rituximab regimen.

The fixed-duration 12-cycle design distinguishes Columvi from indefinite therapy. Patients who complete the course are off treatment after roughly 8 to 9 months. For families weighing CAR-T cell therapy (Yescarta, Kymriah, Breyanzi), Columvi is off-the-shelf: no apheresis, no manufacturing wait, no single one-shot infusion. The trade-off is twelve infusions instead of one; the advantage is no apheresis and lower total cost.

Reserve Meds does not promote one CD20 bispecific or one CAR-T over another.

What Columvi is, in plain language

Columvi is an intravenous infusion. The schedule uses step-up dosing across week 1: 2.5 mg on day 1, 10 mg on day 8, 30 mg on day 15. From cycle 2 onwards the dose is 30 mg every 21 days. The total course is 12 cycles. One week before the first Columvi dose, the patient receives a 1000 mg infusion of obinutuzumab to deplete CD20 B-cells and reduce the CRS risk.

The infusion centre requirement is central. The step-up week and cycle 2 require capacity for CRS and ICANS monitoring: trained staff, tocilizumab and corticosteroids immediately available, ICU escalation pathway, and overnight or 24-hour monitoring during early cycles. For an Abu Dhabi-resident patient, CCAD haematology with cellular therapy depth is the primary in-emirate reference; SSMC and Burjeel Medical City offer parallel capacity. By cycle 3 onwards CRS risk drops sharply and outpatient infusion is appropriate.

Eligibility at an Abu Dhabi haematologist clinic

For Abu Dhabi-resident adults the prescribing haematologist applies FDA criteria with local infusion-centre adaptation:

1. Confirmed r/r DLBCL not otherwise specified, or large B-cell lymphoma arising from follicular lymphoma, after two or more lines of therapy. Or candidate for second-line treatment in combination with GemOx under the STARGLO 2025 label. 2. Adult (18+). 3. Performance status compatible with intensive monitoring (ECOG 0 to 2 typically). 4. Adequate organ function. 5. No active CNS lymphoma. 6. HBV and HIV screening. 7. CRS and ICANS preparedness review at the selected infusion centre. 8. Obinutuzumab pre-treatment one week before first Columvi dose. 9. Hospital with intensive monitoring capacity selected before starting (CCAD, SSMC, Burjeel, or ADSCC).

The Abu Dhabi patient should arrive with current oncology documentation: lymph node biopsy with CD20 pathology, prior line of therapy documentation, most recent PET-CT, HBV / HIV serology, and insurance preauthorisation paperwork.

The Abu Dhabi prescribing and supply picture

Columvi DoH coordination, with UAE EDE registration status verified at intake. The pathway is:

1. **Prescribing haematologist**: a board-certified haematologist at Cleveland Clinic Abu Dhabi, Sheikh Shakhbout Medical City, Burjeel Medical City, or Abu Dhabi Stem Cells Centre. 2. **Infusion centre selection**: CCAD haematology with cellular therapy depth is the primary Abu Dhabi reference for Columvi step-up dosing. SSMC, Burjeel Medical City, and ADSCC have parallel capacity for the bispecific monitoring requirement. The Abu Dhabi-resident patient stays in-emirate through the full 12-cycle course; no cross-emirate or cross-border referral needed. 3. **Obinutuzumab pre-treatment supply**: arranged at the same infusion centre one week before the first Columvi dose. 4. **Insurance preauthorisation**: Thiqa for Emirati nationals and Daman, Oman Insurance, AXA Gulf, MetLife, Cigna, and other DoH-network commercial covers handle r/r DLBCL bispecific therapy case-by-case with documented prior lines and pathology confirmation. `[VERIFY: current UAE EDE registration status per indication at intake.]` 5. **Ongoing monitoring**: haematology follow-up at every cycle; PET-CT response assessment at cycle 3 and end of treatment.

Cost band

US list price for Columvi is USD 250,000 to 380,000 across the 12-cycle course. AED-equivalent total-course cost band is approximately AED 920,000 to 1,395,000 at list price. Insurance preauthorisation reduces out-of-pocket exposure substantially for covered patients.

What to expect on Columvi

Week 1 is the step-up dosing phase at CCAD or the equivalent in-emirate infusion centre with intensive CRS and ICANS monitoring. CRS, when it occurs, appears within 6 to 24 hours of day 1 or day 8 dose, presents as fever sometimes with hypotension or hypoxia, and is managed with tocilizumab and corticosteroids. ICANS, when it occurs, appears within the first one to two cycles as confusion or language disturbance and is managed with corticosteroids.

By cycle 3 onwards CRS and ICANS risk drops sharply and outpatient infusion is appropriate at the same Abu Dhabi centre. The patient continues 30 mg every 21 days through cycle 12 and then stops. PET-CT response assessment at cycle 3 and end of treatment.

When Columvi is the wrong drug

For an Abu Dhabi patient with active CNS lymphoma, with a fragile clinical state where the patient cannot tolerate CRS, with very early-line disease where standard chemo-immunotherapy has not yet been tried, or where the prescribing haematologist judges CAR-T cell therapy (Yescarta, Kymriah, Breyanzi) to be a better fit because of curative-intent framing and the patient is fit for apheresis and the manufacturing wait, the pathway shifts. Reserve Meds does not promote one CD20 bispecific or one CAR-T over another.

What Reserve Meds does on this case

We are a US-based concierge coordinator. On an Abu Dhabi Columvi case we build the documentation pack with the treating haematologist office at CCAD, SSMC, Burjeel Medical City, or ADSCC, confirm UAE EDE registration status, run insurance preauthorisation, coordinate the obinutuzumab pre-treatment, confirm CRS and ICANS preparedness at the selected infusion centre, and stay with the case through the 12-cycle course with handoff to the local haematologist for end-of-treatment response assessment. Clinical decisions remain with your treating haematologist and the infusion centre.

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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