Copiktra

Qatar · access guide

How to access Copiktra for r/r CLL/SLL from Qatar: 2026 pathway via Qatar haematology and pharmacy supply | Reserve Meds

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

Qatar's adult haematology and oncology reference centre is the National Center for Cancer Care and Research (NCCCR) at Hamad Medical Corporation (HMC) in Doha. NCCCR runs the adult haematology service that treats chronic lymphocytic leukemia (CLL) and small lymphocytic lymphoma (SLL) through the full therapeutic ladder: BTK inhibitors (Brukinsa, Calquence, Imbruvica), BCL2 inhibitors (Venclexta with obinutuzumab), and into the PI3K class for patients whose disease has progressed beyond the first two lines. Sidra Medicine is the paediatric reference centre and is not the relevant centre for adult Copiktra; Copiktra is an adult-only oncology drug. Where complexity or third-line targeted-therapy access friction exceeds the in-country capacity, the established cross-border haematology referral path is to KFSHRC Riyadh, Cleveland Clinic Abu Dhabi, or KHCC Amman. Copiktra (duvelisib, Verastem Oncology) is the oral dual PI3K-delta and PI3K-gamma inhibitor, approved by the FDA in September 2018 for adult patients with relapsed or refractory CLL/SLL after at least two prior therapies, and is the operational option for a Qatar-resident adult whose CLL has progressed after a BTK inhibitor and a BCL2 inhibitor.

This page explains how the pathway works in 2026 for a Qatar-resident patient: who qualifies, where the prescribing haematologist conversation happens, how Copiktra is dispensed under MOPH coordination, what insurance will and will not cover, what the four boxed warnings mean operationally, and how the family handles the daily oral routine. It is concierge documentation written for a family already in conversation with a treating haematologist who wants the operational reality laid out plainly.

Why Copiktra, and why now

Copiktra is duvelisib, a small-molecule oral dual inhibitor of phosphoinositide 3-kinase delta (PI3K-delta) and PI3K-gamma. Developed by Verastem Oncology. The mechanism is what distinguishes Copiktra from the rest of the BCR-pathway class: BTK inhibitors (Brukinsa / zanubrutinib, Calquence / acalabrutinib, Imbruvica / ibrutinib) block Bruton tyrosine kinase upstream; BCL2 inhibitors (Venclexta / venetoclax) act on apoptosis; Copiktra blocks the PI3K-delta and PI3K-gamma isoforms, suppressing B-cell receptor signalling and disrupting the tumour microenvironment by acting on regulatory T cells and tumour-associated macrophages. PI3K-delta-only competitors idelalisib (Zydelig, Gilead) and umbralisib (Ukoniq, withdrawn from the US market in 2022) sit in the same class; the class as a whole is challenged on safety, and Copiktra positioning is third-or-later-line CLL after BTK inhibitor failure and BCL2 inhibitor failure.

The FDA approval history matters for context. Copiktra received FDA approval in September 2018 for r/r CLL/SLL after at least two prior therapies, and on the same date received accelerated approval for r/r follicular lymphoma after at least two prior systemic therapies. The follicular lymphoma accelerated approval was voluntarily withdrawn in December 2021 by Verastem following discussions with the FDA about the safety profile and the limited patient population. The CLL/SLL approval remains in force. This page is the operational layer for the CLL/SLL indication.

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

What Copiktra is, in plain language

Copiktra is an oral capsule taken twice daily, continuously. The dose is 25 mg by mouth twice daily (BID). There is no infusion centre, no cold chain, no injection. The capsule is taken with or without food. Patients on a strong CYP3A inhibitor require dose reduction to 15 mg BID; strong CYP3A inducers are avoided.

Pre-treatment is the operational gate. Before the first capsule is dispensed: hepatitis B and hepatitis C serology, HIV testing, cytomegalovirus (CMV) screening, baseline liver function tests, baseline lipid panel, and baseline fasting glucose. Pneumocystis jirovecii pneumonia (PCP) prophylaxis with trimethoprim-sulfamethoxazole (or alternative for sulfa-allergic patients) is initiated before or at start of Copiktra and continued throughout treatment.

This is not a fixed-duration therapy. Copiktra is continued until disease progression or unacceptable toxicity. Median duration of treatment in the pivotal trial was approximately 9 months.

Eligibility at a Qatar haematologist clinic

For Qatar-resident patients, the NCCCR haematology service applies the FDA criteria with local adaptation:

1. Confirmed diagnosis of relapsed or refractory CLL or SLL with at least two prior therapies, one of which must include a BTK inhibitor and a BCL2 inhibitor in the appropriate sequence. 2. Adult (18+). No paediatric label for Copiktra. Paediatric haematology cases are not the Copiktra population; Sidra Medicine handles paediatric haematology and is not the referral centre for adult Copiktra. 3. Hepatitis B surface antigen, hepatitis B core antibody, hepatitis C antibody, HIV serology, and CMV serology all reviewed at intake. Active HBV or HIV requires infectious disease co-management before Copiktra. 4. PCP prophylaxis initiated. TMP-SMX is the default; alternatives for sulfa-allergic patients arranged at intake. 5. Baseline liver function tests within normal range or stable. Active or chronic hepatic dysfunction is a relative contraindication. 6. Baseline fasting glucose and lipid panel. Hyperglycemia is a known Copiktra adverse event; pre-existing diabetes requires endocrinology co-management. 7. No active serious infection. Active untreated infection is a hard contraindication. 8. No severe pre-existing colitis or inflammatory bowel disease. Severe diarrhoea or colitis is one of the four boxed warnings. 9. No severe pre-existing pneumonitis or interstitial lung disease. Pneumonitis is one of the four boxed warnings. 10. No history of severe cutaneous adverse reaction (TEN, SJS, DRESS) to any prior therapy. Severe cutaneous reactions are one of the four boxed warnings. 11. Drug interaction review. Strong CYP3A inhibitors require dose reduction to 15 mg BID; strong CYP3A inducers should be avoided.

A Qatar patient should arrive at the Copiktra conversation with the most recent haematology documentation: current CBC with differential, peripheral smear, flow cytometry, FISH and karyotype if available, complete treatment history including BTK inhibitor and BCL2 inhibitor exposure with response durations and reasons for failure, recent imaging, hepatitis and HIV serology, baseline LFTs and lipid panel and fasting glucose, and the HMC pharmacy or commercial-insurance preauthorisation paperwork.

The Qatar prescribing and supply picture, plainly

Copiktra MOPH registration status is verified at intake. Where in-country registration is complete, NCCCR pharmacy dispensing applies. Where registration has not yet caught up, the named-patient US-import pathway covers the case. The pathway is:

1. Prescribing physician: a board-certified adult haematologist at NCCCR Hamad Medical Corporation in Doha; or a cross-border board-certified haematologist at KFSHRC Riyadh, Cleveland Clinic Abu Dhabi, or KHCC Amman where in-country third-line targeted-therapy experience is the constraint. The boxed-warning awareness and the prior-line documentation are what gate the dispensing decision. 2. Pharmacy dispensing: NCCCR pharmacy under haematology supervision is the default for the first cycle. Continued dispensing at NCCCR or via the HMC outpatient pharmacy network for stable patients. 3. Insurance pre-authorisation: HMC public-sector coverage for Qatari nationals; commercial insurers (Daman International, Allianz Care, Cigna, others) for expatriate residents. Documented BTK inhibitor and BCL2 inhibitor prior trial-and-failure plus prior-line documentation is the gating evidence. 4. PCP prophylaxis dispensing: TMP-SMX or alternative dispensed alongside Copiktra; the prescribing office initiates this before the first Copiktra capsule. 5. Ongoing monitoring: weekly LFTs for the first three months, then every two weeks for the next three months, then monthly. CBC monthly. Fasting glucose monthly. Lipid panel quarterly. Diarrhoea grading at every visit; grade 3 or greater diarrhoea prompts immediate discontinuation. Pulmonary symptom check at every visit; new cough, dyspnoea, or hypoxia prompts immediate chest imaging and pulmonology review.

Cost band

US list price for Copiktra is approximately USD 16,000 to 23,000 per month at WAC, depending on prescription. Annual cost at list price is approximately USD 200,000 to 280,000. At 2026 indicative cross rates, the QAR-equivalent annual cost band is approximately QAR 728,000 to 1,020,000 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.

What to expect on Copiktra, week-by-week

Week 0 to 2: First capsule taken at home after the prescribing haematologist office confirms PCP prophylaxis is in place and baseline labs are clean. Patient takes 25 mg BID with or without food. Diarrhoea, when it occurs, typically begins in the first 2 to 6 weeks.

Week 2 to 12: Weekly LFTs. Transaminase elevation is common; grade 1 to 2 elevation is managed with continued treatment plus monitoring; grade 3 or higher prompts dose hold and haematology review. Diarrhoea is graded at every contact; grade 1 to 2 is managed with loperamide and hydration plus dose hold consideration; grade 3 or higher prompts immediate Copiktra discontinuation and infectious workup (rule out CMV colitis, C. difficile, immune-mediated colitis). CBC monthly to monitor for neutropenia and lymphopenia.

Week 12 to 24: LFTs every two weeks, then monthly if stable. Diarrhoea vigilance continues. Pulmonary symptom check at every contact. Fasting glucose monthly. Lipid panel at week 12 and quarterly thereafter.

Week 24 onwards: Disease assessment. Patients with response continue on Copiktra until progression or unacceptable toxicity. Patients without response transition to next line of therapy.

Ongoing: Boxed-warning vigilance does not relax. Infection vigilance (fever, cough, dyspnoea), diarrhoea/colitis vigilance, pneumonitis vigilance, and cutaneous reaction vigilance (any new rash) continue throughout treatment. PCP prophylaxis continues for the duration of Copiktra and for the post-treatment period per haematologist guidance.

When Copiktra is the wrong drug

For a Qatar patient where BTK inhibitor (Brukinsa, Calquence, Imbruvica) and BCL2 inhibitor (Venclexta) are still viable options that have not been fully trialled, where the patient has a severe pre-existing infection risk (uncontrolled HBV, active HIV, recent serious opportunistic infection), where there is a severe pre-existing colitis or inflammatory bowel disease history, where there is a severe pre-existing pneumonitis or interstitial lung disease history, where there is a history of severe cutaneous adverse reaction (TEN, SJS, DRESS) to any prior therapy, or where there is significant hepatic dysfunction, the operational pathway shifts away from Copiktra:

- BTK inhibitors (Brukinsa, Calquence, Imbruvica) as the first-line and second-line oral targeted option. - BCL2 inhibitor (Venclexta) with obinutuzumab or rituximab as the alternative second-line or third-line option. - Allogeneic stem cell transplant assessment at NCCCR HMC for selected fit patients, or cross-border to KFSHRC Riyadh or Cleveland Clinic Abu Dhabi. - Clinical trial enrolment at NCCCR or a regional reference centre.

Reserve Meds does not promote one targeted therapy over another. The page above describes the Copiktra pathway because Copiktra is the drug the patient has asked about. If the conversation with the treating haematologist points toward a BTK inhibitor, a BCL2 inhibitor, allogeneic transplant, or clinical trial enrolment, 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 Qatar Copiktra case we build the documentation pack with the treating haematologist office at NCCCR, confirm MOPH registration status and the appropriate dispensing pathway, run the insurance pre-authorisation conversation alongside the clinical pre-authorisation conversation, coordinate the supply logistics for ongoing dispensing, organise PCP prophylaxis and baseline screening that the prescribing office requires, and stay with the case through the first six months of dosing with handoff to the local prescriber for ongoing surveillance. Clinical decisions remain with your treating haematologist.

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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