Crenessity

Saudi Arabia · access guide

How to access Crenessity for classic congenital adrenal hyperplasia from Saudi Arabia: 2026 pathway via Saudi endocrinology and named-patient pathway

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

Saudi Arabia runs one of the deepest paediatric and adult endocrinology service networks in the wider region. King Faisal Specialist Hospital and Research Centre (KFSHRC) Riyadh and Jeddah adult and paediatric endocrinology, King Abdulaziz Medical City (KAMC) Riyadh and Jeddah, King Fahad Medical City (KFMC) Riyadh, King Abdulaziz University Hospital (KAUH) Jeddah, King Fahad Hospital Dammam, KFSHRC Jeddah paediatric endocrinology, the Dr Sulaiman Al Habib network adult and paediatric endocrinology, and the Saudi German Hospital endocrinology network all run programmes that diagnose and manage classic congenital adrenal hyperplasia (CAH, 21-hydroxylase deficiency) through the full operational arc: newborn screening, lifelong glucocorticoid replacement, mineralocorticoid dosing for salt-wasting subtypes, monitoring of growth and androgen suppression, fertility planning, and adult transition. Crenessity (crinecerfont, Neurocrine Biosciences) is the first-in-class oral corticotropin-releasing factor type 1 (CRF1) receptor antagonist, FDA-approved in December 2024 for classic CAH in adults and paediatric patients aged 4 years and older, and reframes the chronic-treatment proposition: it is a glucocorticoid-sparing adjunct that allows the treating endocrinologist to reduce the background hydrocortisone or prednisone dose while improving androgen control. For a Saudi-resident patient or family with confirmed classic CAH already on stable glucocorticoid replacement, the operational question in 2026 is whether Crenessity is the right fit, how the named-patient supply pathway works while in-country SFDA registration catches up with the December 2024 FDA approval, what the cash-pay cost exposure looks like, and how the family handles the careful glucocorticoid dose titration that the drug requires.

This page explains how the pathway works in 2026 for a Saudi-resident patient: who qualifies, where the prescribing endocrinologist conversation happens, how Crenessity is supplied via named-patient pathway, what the realistic out-of-pocket exposure band is, what to monitor during the first weeks of glucocorticoid down-titration, and how the long-term routine fits into a Saudi family's life. It is concierge documentation written for a family already in conversation with a treating endocrinologist who wants the operational reality laid out plainly.

Why Crenessity, and why now

Crenessity is crinecerfont, a first-in-class oral selective antagonist of the corticotropin-releasing factor type 1 (CRF1) receptor in the hypothalamic-pituitary-adrenal (HPA) axis. The mechanism is the central innovation: by blocking CRF1 signalling, Crenessity reduces ACTH drive on the adrenal cortex, which in classic CAH reduces the substrate flux that gets shunted into androgen overproduction when 21-hydroxylase is deficient. The clinical translation is that the treating endocrinologist can reduce the supra-physiologic glucocorticoid doses historically required to suppress androgens, while still achieving androgen control. The pivotal CAHtalyst trials in adults and in paediatric patients aged 4 years and older both demonstrated meaningful reductions in daily hydrocortisone-equivalent dosing alongside reductions in androstenedione and 17-hydroxyprogesterone.

The FDA approved Crenessity in December 2024 for classic CAH in adults and paediatric patients aged 4 years and older. This is a brand-new drug, on-market for under 18 months at the time of this page. SFDA registration timeline is verified at intake; the named-patient European-import or US-direct supply pathway covers Saudi dispensing where in-country registration has not yet caught up. The EMA review is in progress.

For a Saudi patient with classic CAH already on lifelong hydrocortisone (paediatric) or prednisone (adult) replacement, who has been carrying the chronic side-effect burden of glucocorticoid therapy (weight gain, growth attenuation in children, Cushingoid features, metabolic effects, bone density concerns), Crenessity is the first agent that offers a structural alternative: a glucocorticoid-sparing adjunct that reduces the daily steroid dose required for androgen control. The conversation about whether to start Crenessity, when to time the addition during the calendar year, and how aggressively to titrate down the background glucocorticoid is the central clinical decision. This page is the operational layer underneath that conversation.

Reserve Meds does not advocate Crenessity over a stable glucocorticoid-only regimen. The page describes the Crenessity pathway because Crenessity is the drug the family has asked about.

What Crenessity is, in plain language

Crenessity is an oral capsule (adults: 100 mg twice daily) or an oral solution (paediatric: weight-based twice daily dosing). It is not an injection, not an infusion, and not given in a clinic. The patient or family administers Crenessity at home, twice daily, with food. It is taken alongside the patient's existing glucocorticoid replacement (hydrocortisone for children, prednisone or hydrocortisone for adults) and any mineralocorticoid (fludrocortisone) the patient is on for salt-wasting CAH.

Crenessity is not a replacement for hydrocortisone or prednisone. The patient does not stop the steroid. What changes is the steroid dose: under endocrinology supervision, the daily glucocorticoid dose is reduced from the historically supra-physiologic level toward the physiologic-replacement range, with Crenessity providing the upstream androgen control that the higher steroid dose had been carrying.

This is a chronic, lifelong adjunct. Crenessity is taken for as long as the endocrinologist judges it is contributing to androgen control and steroid-sparing.

Eligibility at a Saudi endocrinologist clinic

For Saudi-resident patients, the endocrinology services apply the FDA criteria with local supply adaptation:

1. Confirmed classic congenital adrenal hyperplasia, 21-hydroxylase deficiency confirmed by elevated 17-hydroxyprogesterone, elevated ACTH, elevated androgens (androstenedione, testosterone), and confirmatory CYP21A2 genetics where available. 2. Age 4 years and older for paediatric patients; age 18 and older for adult patients. 3. Current stable glucocorticoid replacement regimen (hydrocortisone in children, prednisone or hydrocortisone in adults), with the patient having been on a consistent dose for at least several months and considered medically stable. 4. Baseline labs documented: 17-hydroxyprogesterone, androstenedione, ACTH, cortisol axis function, electrolytes, renal and hepatic function. 5. Endocrinology team in place for ongoing follow-up. This is not a drug that can be started and run by primary care; the entire mechanism requires careful glucocorticoid titration that only the treating endocrinologist can direct. 6. Family or patient willingness to commit to the careful glucocorticoid dose titration that Crenessity introduces. Steroid reduction must be gradual, supervised, and reversible if the patient develops symptoms of adrenal insufficiency. 7. Pregnancy planning conversation for women of childbearing potential. Crenessity is not studied in pregnancy and the implications of HPA modulation during pregnancy are unaddressed. 8. CYP3A modifier review: strong CYP3A inhibitors and inducers affect crinecerfont exposure and require dose adjustment or avoidance. 9. Live vaccine review for any patient who may need adjustment on chronic glucocorticoid replacement.

A Saudi family should arrive at the Crenessity conversation with the most recent endocrinology documentation: current 17-hydroxyprogesterone, androstenedione, and ACTH values, the current glucocorticoid dose with the historical record of how it was titrated, growth records for paediatric patients, bone density assessment if available in adults, and the family's documentation of fatigue, mood, or steroid-related side effects that motivated the Crenessity conversation.

The Saudi prescribing and supply picture, plainly

Crenessity SFDA registration status is verified at intake. Neurocrine Biosciences' MENA commercial pathway is in early stages given the December 2024 FDA approval recency. The supply pathway is named-patient European-import or US-direct sourcing until in-country registration is in place. The operational pathway is:

1. **Prescribing physician**: a board-certified Saudi endocrinologist (adult or paediatric depending on patient age). The major services include KFSHRC Riyadh and Jeddah adult and paediatric endocrinology, KAMC Riyadh and Jeddah, KFMC Riyadh paediatric endocrinology, KAUH Jeddah, King Fahad Hospital Dammam, the Sulaiman Al Habib network adult and paediatric endocrinology, and the Saudi German Hospital endocrinology network. 2. **Pharmacy dispensing**: named-patient import via the prescribing hospital pharmacy, with ongoing maintenance dispensing typically every 1 to 3 months once the supply chain is stable. 3. **Insurance pre-authorisation**: with a December 2024 FDA approval, Saudi commercial insurance coverage is not yet routine. Initial-year exposure is typically cash-pay; the prescribing endocrinologist's office initiates any case-by-case insurance preauthorisation that may be available. CCHI-regulated insurers and the major commercial covers (Bupa Arabia, Tawuniya, MedGulf, AXA Cooperative, Allianz Saudi Fransi) handle Crenessity on a case-by-case basis. `[VERIFY: current SFDA registration status at intake.]` 4. **Glucocorticoid titration support**: the endocrinology office directs the steroid down-titration. This is not optional. The family should have a clear written taper plan, the patient should have a hydrocortisone stress-dose plan for illness or surgery, and contact arrangements for endocrinology should be in place for the first several months. 5. **Ongoing monitoring**: endocrinology follow-up at weeks 2, 4, 8, 12, then quarterly during the first year. Labs at each visit (17-hydroxyprogesterone, androstenedione, ACTH, electrolytes, cortisol axis where indicated).

Cost expectation in SAR

US list price for Crenessity is approximately USD 110,000 to 145,000 annual at WAC, depending on adult versus paediatric dosing and the weight-based paediatric dose. At 2026 indicative cross rates, the SAR-equivalent annual cost band is approximately SAR 412,000 to 543,000 at list price for named-patient supply during the registration-catch-up period. Insurance preauthorisation reduces out-of-pocket exposure for covered patients; cash-pay exposure depends on the named-patient import quotation.

For Saudi nationals with public coverage, the financial preauthorisation conversation needs to start before the first dispensing, not after. Commercial insurance varies; the prescribing endocrinologist's office is the gating step.

What to expect on Crenessity

The first 4 to 8 weeks are the steroid down-titration phase. The endocrinology office directs a gradual reduction in the daily glucocorticoid dose, typically by 10 to 20 percent every 2 to 4 weeks, with lab and clinical monitoring at each step. The patient may experience fatigue, headache, or mild dizziness during this phase, partly from Crenessity itself and partly from the steroid taper. These are typically manageable and resolve over weeks.

Over months, the androstenedione and 17-hydroxyprogesterone values trend downward, indicating that Crenessity is doing the upstream work that the higher steroid dose had been carrying. The endocrinologist continues to titrate, with the goal of reaching a physiologic-replacement glucocorticoid dose (roughly 10 to 15 mg/m2/day hydrocortisone equivalent in children, similar physiologic equivalents in adults) while maintaining androgen control.

Live-vaccine considerations remain on the chronic glucocorticoid replacement (now at lower dose). Stress-dose hydrocortisone for illness, surgery, or significant injury remains essential and is unchanged by Crenessity.

When Crenessity is the wrong drug

For a Saudi patient with non-classic CAH (Crenessity is approved only for classic CAH, not for the non-classic 21-hydroxylase deficient variant), with unstable adrenal function, with inability or unwillingness to commit to endocrinology follow-up during the titration phase, with a paediatric patient under 4 years of age, or with a pregnancy plan that has not been addressed with the treating endocrinologist, the operational pathway shifts:

- **Continued glucocorticoid-only regimen**: the historical standard. For families who are clinically stable on hydrocortisone or prednisone and not carrying meaningful steroid side-effect burden, the steroid-only regimen remains a legitimate choice. - **Alternative dosing or formulation of the existing steroid**: modified-release hydrocortisone, dose-splitting, or chronotherapy approaches that some endocrinology services use. - **Watchful waiting on Crenessity**: with a December 2024 FDA approval, some families and endocrinologists may prefer to wait for additional post-marketing data and for in-country SFDA registration before starting.

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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 Crenessity case we build the documentation pack with the treating endocrinologist office, confirm SFDA registration status and the appropriate named-patient supply pathway, run the insurance preauthorisation conversation where applicable, coordinate the named-patient import logistics, and stay with the case through the first year of dosing with handoff to the local endocrinologist for ongoing surveillance. Clinical decisions remain with your treating endocrinologist.

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.

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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