Crysvita

Bahrain · access guide

How to access Crysvita for X-linked hypophosphatemia or tumor-induced osteomalacia from Bahrain: 2026 pathway via Bahrain paediatric endocrinology, adult metabolic bone, and cross-border genetic and oncology coordination

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

Bahrain has a working paediatric endocrinology, adult endocrinology, and nephrology service base across Salmaniya Medical Complex, King Hamad University Hospital (KHUH), Bahrain Defence Force Hospital (BDF), and the private network including American Mission Hospital and Royal Bahrain Hospital. Paediatric endocrinology depth for rare-disease genetic diagnosis is more limited than in the larger Gulf markets, so genetic confirmation of XLH (PHEX sequencing) and complex paediatric workup commonly route cross-border to KFSHRC Riyadh (90-minute drive across King Fahd Causeway) or Sidra Medicine Doha. The National Health Regulatory Authority (NHRA) governs imported-medicine registration. Crysvita (burosumab-twza, Ultragenyx Pharmaceutical with Kyowa Kirin as ex-US partner) is the anti-FGF23 humanized IgG1 monoclonal antibody, dosed subcutaneously every 2 to 4 weeks, that targets X-linked hypophosphatemia (XLH) and tumor-induced osteomalacia (TIO).

For a Bahrain-resident child age 6 months and older with genetic or biochemical XLH, an adult with XLH continuing into adulthood, or an adult with TIO awaiting or following tumor resection, the operational reality is that the diagnostic workup typically anchors at KFSHRC Riyadh for paediatric XLH and at the prescribing-physician's institution (Salmaniya, KHUH, BDF, or KFSHRC) for adult XLH and TIO, with monthly phosphorus monitoring practical at any Bahrain endocrinology clinic with a basic biochemistry laboratory. For paediatric TIO cases, oncology team coordination at KFSHRC Riyadh is the typical route. For adult TIO cases, oncology coordination locally at BDF or KFSHRC Riyadh is available.

This page explains how the pathway works in 2026 for a Bahrain-resident patient: who qualifies, where the prescribing paediatric endocrinologist or adult metabolic bone specialist conversation happens, how Crysvita is dispensed and stored, what the dose-titration rhythm looks like, what the cost band is in BHD, and how the chronic-treatment course fits into a Bahraini family's life.

Why Crysvita, and why now

Crysvita is burosumab-twza, a humanized IgG1 monoclonal antibody that binds and neutralises fibroblast growth factor 23 (FGF23). In XLH, an inactivating mutation in the PHEX gene on the X chromosome causes circulating FGF23 to be inappropriately elevated. Excess FGF23 reduces phosphate reabsorption at the renal proximal tubule and suppresses renal 1-alpha-hydroxylase, leading to chronic phosphate wasting, low serum phosphorus, low active 1,25-dihydroxyvitamin D, defective bone mineralisation, paediatric rickets, short stature, dental abscess vulnerability, and adult osteomalacia with bone pain, fractures, and enthesopathy. In TIO, a mesenchymal phosphaturic tumor secretes FGF23 ectopically.

The historic conventional therapy was lifelong high-dose oral phosphate salts combined with active vitamin D analogs (calcitriol or alfacalcidol). Conventional therapy is partially effective and does not address the underlying FGF23 excess. Crysvita addresses the upstream mechanism: serum phosphorus moves toward the lower-normal range within 4 to 8 weeks; paediatric radiographic rickets scores improve over 1 to 2 years; adult bone pain reduces over months. The FDA approved Crysvita for paediatric XLH age 1 year and older in April 2018, for adult XLH in September 2018, expanded paediatric XLH to age 6 months in March 2020, and added TIO age 2 years and older in June 2020.

Reserve Meds does not advocate Crysvita over conventional therapy in cases where conventional response is adequate. The page describes the Crysvita pathway because Crysvita is the therapy the family has asked about.

What Crysvita is, in plain language

Crysvita is a subcutaneous injection given every 2 to 4 weeks. There is no infusion centre, no inpatient stay. After a supervised first dose, the family may be trained for home self-injection, although many Bahraini families prefer clinic-administered dosing. The vials are 10 mg, 20 mg, and 30 mg single-dose presentations; the dispensed dose is weight-based and titrated by serial phosphorus measurement. Paediatric XLH starting dose is 0.4 to 0.8 mg per kg every 2 weeks. Adult XLH dosing is 1 mg per kg every 4 weeks, capped at 90 mg. TIO dosing is weight-based every 2 weeks.

This is not a short-course therapy. XLH is a lifelong genetic condition; Crysvita is taken for as long as it controls the phosphate-wasting biochemistry. TIO patients may discontinue if and when the underlying tumor is fully localised and resected.

Eligibility at a Bahrain paediatric endocrinology or adult metabolic bone clinic, with cross-border diagnostic depth

For Bahrain-resident patients, the services apply the FDA-label and EMA-label eligibility, with diagnostic confirmation typically anchored at KFSHRC Riyadh for paediatric genetic XLH:

1. Confirmed diagnosis. For XLH: genetic confirmation of a PHEX mutation (typically routed to KFSHRC Riyadh paediatric endocrinology and genetics for paediatric cases; reference-laboratory sequencing for adult cases), OR a clinically compatible picture (low serum phosphorus, normal serum calcium, elevated alkaline phosphatase, elevated FGF23, low or low-normal 1,25-dihydroxyvitamin D) with a positive family history confirmed at Salmaniya, KHUH, or BDF endocrinology. For TIO: an adult with acquired hypophosphatemia, elevated FGF23, oncology team coordination for tumor localisation (typically at KFSHRC or BDF), and a resection plan. 2. Age. Paediatric XLH age 6 months and older. Adult XLH age 18 and older. TIO age 2 and older. 3. Baseline biochemistry. Serum phosphorus, calcium, alkaline phosphatase, 1,25-dihydroxyvitamin D, 25-hydroxyvitamin D, intact PTH, urine phosphate, creatinine and eGFR (all available at Bahrain hospital laboratories). 4. Discontinuation plan for conventional therapy. Oral phosphate supplements and active vitamin D analogs must be discontinued before Crysvita is started. This is essential. 5. Renal imaging baseline. Renal ultrasound. 6. Hypersensitivity history review. 7. Pregnancy planning discussion for women of childbearing potential.

A Bahraini family should arrive at the prescribing conversation with: paediatric endocrinology or adult metabolic bone documentation (from Salmaniya, KHUH, BDF, or KFSHRC), genetic test result if available or family-history pedigree, the most recent biochemistry panel, radiographic rickets score documentation or skeletal survey, the complete conventional therapy history, and NHRA / insurance paperwork.

The Bahrain prescribing and supply picture, plainly

Crysvita NHRA registration status is verified at intake. Ultragenyx commercial supply runs through regional distributors. Where in-country registration is complete, in-country pharmacy dispensing applies. Where registration has not yet caught up, the named-patient European-import pathway covers the case. The pathway is:

1. **Prescribing physician**: a paediatric endocrinologist for paediatric XLH and paediatric TIO, typically anchored at Salmaniya, KHUH, BDF, or with cross-border referral to KFSHRC Riyadh paediatric endocrinology. An adult endocrinologist with metabolic bone expertise for adult XLH and adult TIO, anchored at Salmaniya, KHUH, BDF, or KFSHRC Riyadh. For TIO, oncology team coordination at BDF or KFSHRC Riyadh. 2. **Pharmacy dispensing**: hospital pharmacy with cold-chain refrigeration. Crysvita must be stored at 2 to 8 degrees Celsius; do not freeze; protect from light. Cross-border dispensing from a Riyadh hospital pharmacy is feasible for cases anchored at KFSHRC. 3. **Insurance preauthorisation**: For Bahraini nationals at MOH facilities the institutional rare-disease pathway applies. For BDF-eligible patients, the BDF medical board reviews rare-disease therapy. Commercial insurers handle on a case-by-case basis. 4. **Conventional therapy discontinuation**: the most important operational gate. The prescribing endocrinologist sequences discontinuation of oral phosphate supplements and active vitamin D analogs in the days before the first Crysvita dose. Phosphorus and calcium monitored at baseline, week 2, and serially. 5. **Self-injection or clinic injection training**: typically a supervised first dose, then a training session if the family elects home administration. 6. **Ongoing monitoring**: serum phosphorus, calcium, alkaline phosphatase, 1,25-dihydroxyvitamin D, PTH at week 2, week 4, then monthly during titration, then every 3 months during maintenance. Renal ultrasound annually. Paediatric height and rickets-score reassessment every 6 months. Monthly biochemistry is practical at any Bahrain hospital laboratory.

Cost band

US WAC pricing is weight-dependent. Paediatric XLH annual band approximately USD 165,000 to 250,000. Adult XLH at 1 mg/kg every 4 weeks (typical dose 70 to 90 mg per cycle) approximately USD 240,000 to 340,000. TIO follows adult XLH range. At 2026 indicative cross rates, the BHD-equivalent annual band is approximately BHD 62,000 to 94,000 paediatric XLH and BHD 90,000 to 128,000 adult XLH and TIO. Institutional or insurance coverage reduces out-of-pocket exposure where eligible.

What to expect on Crysvita

Serum phosphorus moves toward the lower end of the age-appropriate normal range within 4 to 8 weeks. In paediatric XLH patients, the radiographic rickets score improves over 1 to 2 years, height velocity improves over the first 12 months, and bowing of the lower extremities slowly remodels. In adult XLH patients, bone pain reduces over months, stiffness improves, and stress-fracture healing accelerates. In TIO patients, biochemical correction precedes definitive surgical tumor resection if resection is delayed.

Most common adverse events: injection-site reactions, headache, restless legs symptoms, dizziness, rarely hypersensitivity. Hyperphosphatemia is possible if conventional therapy is not properly discontinued or if dose titration overshoots; serial phosphorus monitoring is the central operational discipline.

When Crysvita is the wrong drug

Crysvita is the wrong drug for hypophosphatemia that is not FGF23-mediated. It is the wrong drug in severe renal impairment with elevated baseline serum phosphorus, in familial-tumoral-calcinosis-like states, and where the family cannot reliably attend the monthly phosphorus-monitoring visits. For TIO, definitive surgical resection of the localised tumor remains the preferred curative pathway.

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 Bahrain Crysvita case we build the documentation pack with the treating paediatric endocrinologist or adult metabolic bone specialist office, confirm NHRA registration status and the appropriate dispensing pathway (in-country or cross-border to KFSHRC Riyadh), run the institutional or insurance preauthorisation conversation, coordinate the cold-chain supply logistics, organise the conventional-therapy discontinuation sequencing, and stay with the case through the first year of titrated dosing. Clinical decisions remain with your treating endocrinologist or metabolic bone 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.

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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