

Dalvance

Saudi Arabia · access guide

How to access Dalvance for acute bacterial skin and skin-structure infection (ABSSSI) from Saudi Arabia: 2026 pathway via Saudi infectious diseases services and KFSHRC

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

Saudi Arabia has the deepest adult infectious diseases bench in the wider region. King Faisal Specialist Hospital and Research Centre (KFSHRC) Riyadh and Jeddah, King Abdulaziz Medical City (KAMC) Riyadh, King Fahd Medical City (KFMC) Riyadh, Prince Sultan Military Medical City Riyadh, King Khaled University Hospital, Dr Sulaiman Al Habib network, Saudi German Hospital, Mouwasat, and the Aramco medical services in the Eastern Province all run ID consultation services and outpatient parenteral antimicrobial therapy (OPAT) pathways that handle the full spectrum of skin and soft-tissue infection management: cellulitis, wound infection, post-surgical and post-trauma infection, recurrent presentations, and the cases that arrive after a course of oral or short IV antibiotics has not delivered. Dalvance (dalbavancin, AbbVie; Xydalba in EU and UK markets) is the second-generation lipoglycopeptide IV antibiotic with a 14-day half-life that lets a single 30-minute infusion cover the full 2-week therapeutic window for an adult ABSSSI. For a KSA-resident adult with cellulitis, a wound infection, or a drainable abscess where the prescribing ID specialist has decided the operational priority is to compress IV antibiotic delivery to a single infusion rather than a multi-day inpatient course of vancomycin, the question is no longer whether long-acting IV lipoglycopeptide therapy is reachable: it is how the single dose is sourced and dispensed, which infusion-capable site delivers it, what payer coverage looks like, and how the post-infusion follow-up fits into the family's routine.

This page explains how the pathway works in 2026 for a Saudi-resident adult: who qualifies, where the prescribing ID conversation happens, how Dalvance is sourced and dispensed (most often via the named-patient European-import route given limited GCC commercial registration), how the single 30-minute IV infusion is delivered, what the cost band looks like in SAR, what to monitor (clinical response at 48 to 72 hours and at day 14, infusion-related reactions, hepatic enzymes), and how the follow-up assessments fit into a KSA family's life. It is concierge documentation written for a family already in conversation with a treating infectious disease specialist who wants the operational reality laid out plainly.

Why Dalvance, and why now

Dalvance is dalbavancin, a second-generation semi-synthetic lipoglycopeptide. It is structurally related to teicoplanin and vancomycin but carries a long lipophilic side chain that anchors the molecule to bacterial cell membranes and sustains its serum and tissue concentrations for approximately 14 days after a single intravenous dose. The mechanism is the classical glycopeptide pathway: inhibition of bacterial cell wall biosynthesis by binding the D-alanyl-D-alanine terminus of the peptidoglycan precursor, blocking the cross-linking that the bacterium uses to build its wall. What distinguishes dalbavancin from vancomycin or daptomycin operationally is the half-life. Vancomycin needs twice-daily IV dosing for the course; daptomycin needs once-daily IV dosing for 5 to 14 days. Dalbavancin needs one IV infusion, 30 minutes, and the course is done.

The FDA approved Dalvance for ABSSSI in adults in May 2014, then expanded the label to the single-dose 1500 mg IV regimen in January 2018, then added a paediatric indication in July 2021 (this page is adult-focused). The EMA approved Xydalba in February 2015. Saudi SFDA registration status is verified at intake; dalbavancin has limited commercial registration in the GCC as of 2026, and the named-patient European-import pathway (Xydalba ex-EU) is the operational supply route for most KSA cases.

For a KSA adult with an ABSSSI episode where the prescribing ID specialist has decided that a single-dose IV regimen is the right pathway, Dalvance is the lipoglycopeptide that the conversation centres on. The clinical decision about Dalvance versus inpatient IV vancomycin admission versus oral antibiotics is the ID specialist's. This page is the operational layer underneath that decision.

Reserve Meds does not promote one antibiotic over another. The page describes the Dalvance pathway because Dalvance is the drug the patient has been prescribed or has asked about.

What Dalvance is, in plain language

Dalvance is an intravenous drug. There is no tablet or capsule form. The patient receives the dose at an infusion-capable outpatient or short-stay facility. The single-dose regimen is 1500 mg given as a 30-minute IV infusion. The alternative two-dose regimen is 1000 mg IV over 30 minutes, then 500 mg IV over 30 minutes one week later. The single-dose option is the operationally dominant choice since 2018.

There is no daily medication, no home injection, no infusion-pump portable device. The patient walks in, receives the 30-minute infusion, is observed on-site for at least 30 minutes afterwards, and goes home. Standard wound care (drainage if there is an abscess, dressing changes, elevation, pain control) continues independently of the infusion.

Dalvance is not interchangeable with oritavancin (Orbactiv), which is a different long-acting lipoglycopeptide with a different dosing regimen.

Eligibility at a Saudi infectious diseases clinic

For KSA-resident patients, the ID services apply the FDA and EMA criteria with local operational adaptation:

1. Confirmed clinical diagnosis of ABSSSI: cellulitis or erysipelas with a defined area of inflammation, wound infection (post-surgical, post-trauma, or chronic), or drainable cutaneous abscess. 2. Adult (18 or older). Paediatric ABSSSI cases route to a paediatric infectious disease specialist. 3. Causative pathogen review. Gram stain and wound culture where possible before the first dose; empiric coverage is appropriate when culture has not yet resulted. Dalvance is suitable for empiric Gram-positive cover where MRSA is plausible. 4. Renal function check. Serum creatinine and estimated CrCl. No dose adjustment for CrCl 30 mL/min or greater. For CrCl below 30 mL/min in patients not on regular haemodialysis, dose reduction applies. Patients on regular haemodialysis do not require adjustment. 5. Hepatic function check. Standard liver panel. Use with caution in moderate or severe hepatic impairment. 6. Pregnancy and breastfeeding review. Limited human data. Use only if benefit clearly outweighs risk. 7. Allergy review. Prior hypersensitivity to glycopeptide antibiotics (vancomycin, teicoplanin, telavancin, oritavancin) is a relative or absolute contraindication depending on severity. 8. Infusion-reaction precaution. Infusion over 30 minutes minimises the risk of red-man-syndrome-like reactions. 9. Hospital admission triage. Patients with sepsis, severe systemic toxicity, immune compromise, suspected necrotising fasciitis, or suspected bone or joint involvement need hospital-level care; single-dose dalbavancin is not the right tool for those scenarios. 10. Outpatient logistics. Infusion-capable outpatient site (KFSHRC infusion services, KAMC OPAT, KFMC infusion suite, Prince Sultan Military Medical City infusion services, Dr Sulaiman Al Habib infusion centre, Saudi German Hospital infusion suite, or hospital outpatient pharmacy), post-infusion observation, and documented follow-up wound assessment at 48 to 72 hours and at day 14.

A KSA patient should arrive at the Dalvance conversation with the most recent clinical documentation: photograph or measurement of the affected area, culture result if available, current medication list, allergy history, renal and hepatic baseline labs, and the insurance preauthorisation paperwork that the prescribing office initiates.

The Saudi prescribing and supply picture, plainly

Dalvance Saudi SFDA registration status is verified at intake. Commercial registration of dalbavancin in the GCC is limited as of 2026; the operational supply route for most KSA cases is the named-patient European-import pathway, with Xydalba ex-EU coordinated through licensed regional specialty distributors and the prescribing centre's hospital pharmacy. The pathway is:

1. Prescribing physician: a board-certified KSA infectious diseases specialist. KFSHRC Riyadh runs the deepest ID programme in the country and the most developed OPAT pathway. KFSHRC Jeddah, KAMC Riyadh, KFMC Riyadh, Prince Sultan Military Medical City, King Khaled University Hospital, and the Aramco medical service in the Eastern Province are the principal alternatives. The private sector ID services at Dr Sulaiman Al Habib, Saudi German Hospital, and Mouwasat handle ID consultation for the commercially insured population. 2. Pharmacy dispensing and supply: hospital pharmacy at the prescribing centre. Where in-country registration is in place, in-country dispensing applies. Where registration is not in place, named-patient European import via licensed regional distributors covers the case. Lead time from order to infusion is typically 5 to 10 business days. For an acute ABSSEI that cannot wait, the patient is started on standard empiric IV antibiotics during the lead time and switched to single-dose dalbavancin once the supply arrives, or in some cases is treated entirely on vancomycin. 3. Insurance pre-authorisation: for Saudi nationals, MoH and state-funded hospital coverage extends to ID-prescribed antimicrobial therapy at KFSHRC, KAMC, KFMC, and military medical centres. For expat residents, commercial insurance pre-authorisation is the path; the framing that lands best with payers is the total-cost-of-care comparison: single-dose dalbavancin plus 30-minute infusion plus 14-day follow-up versus 5 to 7 day inpatient admission for IV vancomycin with bed days, daily IV, monitoring, and ID consultation. The cost case typically favours single-dose dalbavancin on a total basis. [VERIFY: current Saudi SFDA registration status at intake.] 4. Ongoing monitoring: clinical wound assessment at 48 to 72 hours after the infusion (erythema reduction, pain reduction, defervescence), and at day 14 for clinical success. Liver enzymes at day 14 if there was hepatic baseline concern. Standard wound care continues independently.

Cost band and insurance positioning

US list price for a single 1500 mg dose of Dalvance (three 500 mg vials) sits at approximately USD 4,200 to 5,800 at WAC depending on package and contract. The two-dose regimen lands in a similar range.

At 2026 indicative cross rates, the SAR-equivalent course cost band for cash-pay is approximately SAR 18,700 to 31,900 per complete single-dose course inclusive of the named-patient supply and infusion centre fees. The cost case versus a 4 to 7 day inpatient admission for IV vancomycin in a KSA private tertiary hospital (which can run SAR 25,000 to 60,000 for the bed days plus daily IV, monitoring, and ID consultation) often favours single-dose Dalvance on a total-cost-of-care basis.

For Saudi nationals at KFSHRC, KAMC, KFMC, or military medical centres, the state-funded pathway is the dominant pre-authorisation route. For expat residents, the commercial insurance pre-authorisation conversation needs to start before the named-patient order is placed.

What to expect on Dalvance, from infusion day forward

Infusion day: arrival at the infusion-capable outpatient site, IV access established, 30-minute IV infusion of 1500 mg dalbavancin, 30 minutes of on-site observation, then discharge home. Standard wound care continues. Most patients tolerate the infusion without symptoms; the most common infusion-related symptoms are mild flushing or itching, which resolve when the infusion rate is slowed.

48 to 72 hours after infusion: clinical assessment by the prescribing ID office or by the family physician with ID guidance. The expected finding is a reduction in erythema spread, a reduction in pain, and resolution of fever if it was present. If clinical response is inadequate at this point, the ID specialist reassesses.

Day 14: final clinical assessment. Expected finding is clinical success. The ID specialist documents clinical success and the course is complete.

When Dalvance is the wrong drug

For a KSA patient with sepsis or severe systemic toxicity, with suspected necrotising fasciitis, with suspected osteomyelitis or septic arthritis, with neutropenic infection requiring broader empiric coverage, with a confirmed or suspected Gram-negative pathogen, with vancomycin-resistant *Enterococcus faecium*, with prior severe hypersensitivity to glycopeptide antibiotics, or in pregnancy where benefit does not clearly outweigh risk, the operational pathway shifts:

- Inpatient IV vancomycin with therapeutic drug monitoring for severe ABSSSI or deeper-tissue infection.
- Daptomycin IV daily for ABSSSI or bacteraemia.
- Linezolid PO or IV where oral switch is operationally needed.
- Ceftaroline IV for MRSA where the prescribing ID prefers a beta-lactam mechanism.
- Combination empiric therapy where Gram-negative or anaerobe coverage is needed.
- Surgical drainage as the primary intervention where an abscess is the dominant feature.
- Hospital admission for source control where the case profile requires it.

Reserve Meds does not promote one antibiotic over another. If the conversation with the treating ID specialist points toward inpatient vancomycin, oral stepdown, surgical drainage as the primary intervention, or broader empiric coverage, the operational pathway shifts accordingly.

What Reserve Meds does on this case

We are a US-based concierge coordinator. On a KSA Dalvance case we build the documentation pack with the treating infectious diseases office, confirm Saudi SFDA registration status and the appropriate supply pathway, coordinate the named-patient supply order through licensed regional specialty distributors where in-country registration is not in place, run the insurance or state-funded pre-authorisation conversation with the total-cost-of-care framing, organise baseline screening, coordinate the infusion-capable outpatient site booking, and stay with the case through the 48-to-72-hour and day-14 follow-up assessments with handoff to the local prescriber for ongoing surveillance. Clinical decisions remain with your treating infectious diseases specialist.

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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reserved for you.

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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