Dayvigo

Saudi Arabia · access guide

How to access Dayvigo for adult insomnia from Saudi Arabia: 2026 pathway via KFSHRC, KAUH Jeddah, KAMC, and the wider Saudi psychiatry and sleep medicine network

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

Saudi Arabia has a mature adult psychiatry and sleep medicine service network anchored on the King Faisal Specialist Hospital and Research Centre (KFSHRC) Riyadh sleep medicine programme, the King Abdulaziz University Hospital (KAUH) Jeddah sleep disorders centre (one of the longest-established sleep laboratories in the region), King Abdulaziz Medical City NGHA sleep medicine, King Fahad Medical City sleep medicine, KFSHRC Jeddah, KAMC NGHA Riyadh, KSMC, PSMMC, and a wider network including King Khalid University Hospital, the Dr Sulaiman Al Habib network sleep medicine and psychiatry, IMC Jeddah, KFSH Dammam, and the Eradah Mental Health Hospital network for the psychiatric-comorbid subset. Dayvigo (lemborexant) is the dual orexin receptor antagonist (DORA) from Eisai, approved by the FDA in December 2019 for insomnia in adults. Dayvigo is registered with the Saudi Food and Drug Authority (SFDA) via Eisai Middle East and is classified as a controlled drug on the SFDA narcotic and psychotropic substances schedule; dispensing requires a controlled-prescription form and the dispensing pharmacy maintains a controlled-drug register entry. For a Saudi-resident adult patient with diagnosed insomnia disorder where cognitive behavioural therapy for insomnia (CBT-I) has been offered or trialled and pharmacotherapy is on the table, the operational question is which prescribing centre fits the case, how the controlled-prescription form runs through the SFDA-governed dispensing pathway, what the insurance pre-authorisation conversation looks like, what the next-morning driving and substance-use screening conversations look like, and how the medication fits into a Saudi family's life.

This page explains how the pathway works in 2026 for a Saudi-resident patient: who qualifies, where the psychiatrist or sleep medicine conversation happens, where the prescription is written and filled, what the realistic out-of-pocket exposure band is in SAR, what to monitor on therapy (depression and suicidality screening, next-day residual sedation, complex sleep behaviours, and substance use being the four primary safety axes), and how the treatment plan fits into a Saudi family's life.

Why Dayvigo, and why now

Dayvigo is lemborexant, a competitive dual antagonist at the orexin-1 and orexin-2 receptors. Orexin signalling from the lateral hypothalamus is the primary wake-promoting drive in the sleep-wake regulatory system. Blocking orexin receptors at bedtime reduces wake-promoting drive and allows sleep to occur and persist. Lemborexant is the second DORA to reach the US market after suvorexant (Belsomra), and was followed by daridorexant (Quviviq) in 2022.

The FDA approved Dayvigo in December 2019 for insomnia characterised by difficulties with sleep onset and/or sleep maintenance in adults. US DEA Schedule IV. SFDA registered via Eisai Middle East with controlled-drug classification. Pivotal Phase 3 programme: SUNRISE-1 (1 month, with zolpidem ER comparator in older adults) and SUNRISE-2 (12 months). Both endpoints (latency to persistent sleep and wake after sleep onset) separated from placebo. Lemborexant separated from zolpidem ER on objective sleep efficiency in older adults.

For a Saudi-resident adult patient with diagnosed insomnia disorder who has either declined CBT-I, has had inadequate response to CBT-I, or needs adjunctive short-term pharmacotherapy alongside CBT-I, Dayvigo is one of several reasonable pharmacological options. The class advantage over benzodiazepines and Z-drugs is the lower amnesia, falls, and abuse-potential signal; the trade-off is the longer half-life (approximately 17 to 19 hours) and next-day residual sedation risk.

What Dayvigo is, in plain language

Oral tablet. 5 mg and 10 mg strengths. Take immediately before bed, with at least 7 hours remaining for sleep. Avoid heavy meals before dosing. Onset approximately 30 minutes. Half-life approximately 17 to 19 hours. Starting dose 5 mg at bedtime. Maximum 10 mg at bedtime. Patients aged 65 and over start and stay at 5 mg. Moderate hepatic impairment caps at 5 mg. Severe hepatic impairment contraindicated.

Dosing nightly continuous, nightly as needed, or intermittently (3 to 5 nights per week). Conventional short-term pharmacotherapy 2 to 4 weeks with reassessment; SUNRISE-2 supports tolerability at 12 months. Reassessment every 3 to 6 months on continued use.

Eligibility at a Saudi psychiatry or sleep medicine clinic

For Saudi-resident adult patients:

1. Confirmed insomnia disorder by DSM-5 or ICSD-3 criteria. 2. Sleep history and OSA screening (STOP-BANG, Epworth Sleepiness Scale, Insomnia Severity Index). Polysomnography referral if STOP-BANG positive. 3. CBT-I conversation documented. Available at KFSHRC behavioural health, KAUH Jeddah sleep clinic, Eradah Mental Health Hospital network, Dr Sulaiman Al Habib psychology, and validated digital CBT-I programmes. 4. Baseline PHQ-9 and C-SSRS. Active untreated severe depression or suicidal ideation requires psychiatric assessment first. 5. Substance use history. Opioid, benzodiazepine, alcohol, or sedative-hypnotic misuse history is a relative contraindication. 6. CYP3A4 interaction screen. Strong inhibitors contraindicated; moderate inhibitors cap dose at 5 mg; strong inducers not recommended. 7. Respiratory function review (COPD, OSA). 8. Hepatic function review. 9. Pregnancy and lactation screen. 10. Age (geriatric 5 mg cap). 11. Concurrent CNS depressant review. 12. Occupational screening for safety-sensitive roles.

A Saudi patient should arrive with a 1 to 2 week sleep diary, complete medication and supplement list, substance use history, prior insomnia treatments, comorbid conditions, and insurance documentation (Tameen, GOSI, MoH for nationals; commercial cover for expatriates).

The Saudi prescribing and dispense picture, plainly

Dayvigo is SFDA-registered via Eisai Middle East and classified as a controlled drug on the SFDA narcotic and psychotropic substances schedule. Dispensing requires the original controlled-prescription form (not a printout or fax). The dispensing pharmacy maintains a controlled-drug register entry for each dispense. The functional supply chain is:

1. **Prescribing physician**: a board-certified Saudi psychiatrist, sleep medicine specialist, neurologist with insomnia experience, or family physician with controlled-prescription authority. Major prescribing centres: - **Sleep medicine reference programmes**: KFSHRC Riyadh sleep medicine, KAUH Jeddah sleep disorders centre, KAMC NGHA Riyadh sleep medicine, KFMC Riyadh sleep medicine, KFSHRC Jeddah, IMC Jeddah sleep clinic, KFSH Dammam. - **Psychiatry**: Eradah Mental Health Hospital network (Riyadh, Jeddah, Dammam, Taif, Madinah, and other regional sites), KSMC psychiatry, PSMMC psychiatry, KKUH psychiatry, the Dr Sulaiman Al Habib network psychiatry. - **Family medicine and primary care**: a wide network of MoH primary health care centres and private clinics with controlled-prescription authority for the lower-complexity cases. 2. **Diagnostic workup**: insomnia disorder diagnosis is clinical. Polysomnography at KFSHRC Riyadh, KAUH Jeddah, KAMC NGHA, KFMC, or partnered sleep laboratories where OSA screening is positive or the complaint is atypical. 3. **Insurance pre-authorisation**: Tameen and commercial insurers cover hypnotic therapy for diagnosed insomnia disorder with controlled-prescription documentation. Controlled-substance scheduling means many insurers cap per-dispense quantity (30 days typical) and require periodic reauthorisation. GOSI and MoH pathways for nationals follow institutional protocols; NUPCO procurement applies for MoH and military hospital supply. 4. **Pharmacy dispense**: 30-day supply at a Saudi community pharmacy with controlled-drug dispensing authority (most of the major chains hold the licence). The patient presents the original controlled-prescription form. The pharmacy maintains the controlled-drug register entry. 5. **Refill cycle**: monthly with a fresh controlled-prescription form. Some plans allow a 3-month controlled prescription with documented stable therapy.

The 2026 pathway, step by step

Week 0 to 1: Reserve Meds builds the documentation pack with the treating psychiatrist or sleep medicine physician's office. Sleep history, sleep diary, STOP-BANG and Epworth and ISI scores, PHQ-9 and C-SSRS baseline, medication and supplement list with CYP3A4 interaction screen, substance use history, prior insomnia treatments, comorbid conditions, insurance documentation.

Week 1 to 2: CBT-I conversation. Trial or referral as appropriate.

Week 2 to 4: Insurance pre-authorisation review (commercial). Tameen and major commercial covers typically turn this around within 1 to 2 weeks.

Week 4: First controlled-prescription written. Starting dose 5 mg at bedtime.

Week 4 to 6: Initial response assessment. Sleep diary review. Tolerability assessment. PHQ-9 and C-SSRS reassessment. Bed-partner check for complex sleep behaviours, sleep paralysis, hypnagogic hallucinations. Dose maintained at 5 mg or escalated to 10 mg.

Month 3 onwards: Maintenance. Monthly controlled-prescription refill. Periodic PHQ-9, C-SSRS, sleep diary, OSA, and substance-use reassessment. Reassessment of ongoing need every 3 to 6 months.

Cost expectation in SAR

US Dayvigo list price (2026) is approximately USD 350 to USD 450 per 30-day supply at 5 mg or 10 mg nightly, annual cost approximately USD 4,000 to USD 5,000 at list price. Eisai Middle East supply through the Saudi channel generally lands in a comparable band.

At indicative 2026 cross rates, a 30-day Dayvigo supply at USD 400 is approximately SAR 1,500, and the annual cost at USD 4,800 is approximately SAR 18,000.

For Saudi nationals on the MoH or GOSI pathways, hypnotic therapy for documented insomnia disorder is typically covered with controlled-prescription documentation. Tameen and commercial covers vary. Out-of-pocket exposure for a covered patient is generally a co-payment band in the SAR 30 to 200 per month range, not the full list price. For cash-pay patients, the absolute cost is meaningfully lower than the specialty-tier biologics in the wider Reserve Meds catalog; the cost conversation is more about controlled-substance access, prescriber availability, and the CBT-I-versus-pharmacotherapy decision than about cost.

Monitoring on therapy

- **Next-day residual sedation and driving**: counsel at first prescription and at dose escalation. Patient must understand individual response before driving. Saudi driving regulations are followed where impairment is documented. - **Complex sleep behaviours**: counsel patient and bed-partner. Immediate discontinuation if any episode of sleep-driving, sleep-eating, or sleep-walking occurs. - **Sleep paralysis and hallucinations**: counsel at first prescription. - **Depression and suicidality**: PHQ-9 and C-SSRS at baseline, 4 to 6 week response visit, every 3 to 6 months on maintenance, and at any clinical change. - **Sleep diary**: continuous. - **OSA reassessment**: any new daytime sleepiness, witnessed apnoeas, or morning headaches. - **Substance use reassessment**: at each follow-up.

Religious, ethical, and family-logistics framing

Dayvigo is an oral small molecule. No animal-source material in standard manufacturing. Halal and kosher acceptability are not in question. The classical Islamic jurisprudential framework for medication in meaningful functional impairment extends to insomnia pharmacotherapy.

The family-logistics dimension sits in the controlled-prescription rhythm (in-person dispense each month with the original prescription form), the next-morning driving counselling (including the bed-partner where present), and the substance-use conversation. Saudi psychiatry and sleep medicine services handle these conversations with discretion as standard practice.

For patients in safety-sensitive occupations (pilots, professional drivers, surgeons, heavy-machinery operators, security personnel, religious officials with early-morning duties), the next-morning impairment is the central operational concern. The conversation needs to happen before the first prescription and is documented in the chart.

For patients with a primary psychiatric diagnosis underlying the insomnia, the insomnia treatment runs alongside the primary psychiatric treatment, not instead of it.

When Dayvigo is not the right call

- Narcolepsy (contraindication). - Severe hepatic impairment (Child-Pugh C; contraindication). - Active opioid, benzodiazepine, alcohol, or sedative-hypnotic use disorder. - Pregnancy and lactation. - Concurrent strong CYP3A4 inhibitor. - Safety-sensitive occupations where next-morning impairment is unacceptable and a shorter-half-life alternative is preferable. - Active untreated severe depression or active suicidal ideation. - Untreated OSA where treating the OSA may resolve the insomnia complaint. - Patients who have not been offered CBT-I.

Alternatives in 2026: CBT-I (first-line), suvorexant (Belsomra), daridorexant (Quviviq, shorter half-life), low-dose doxepin (Silenor, not controlled), melatonin and ramelteon (Rozerem, favourable safety), zolpidem and other Z-drugs, trazodone and mirtazapine off-label, benzodiazepines (short-term or specific scenarios).

Reserve Meds does not push a default. We do not promote one DORA over another. The clinical decision is the prescribing physician's.

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 Dayvigo case we build the documentation pack (sleep history, sleep diary, STOP-BANG and Epworth and ISI scores, PHQ-9 and C-SSRS baseline, medication list with CYP3A4 interaction screen, substance use history, prior insomnia treatments, comorbid conditions, insurance card), submit first-review requests to the chosen prescribing centre, coordinate the CBT-I conversation alongside the pharmacotherapy conversation, coordinate the controlled-prescription pathway with the prescribing office and the dispensing pharmacy, set up the first 30-day dispense, organise the next-morning driving counselling and the bed-partner safety counselling, and stay with the case through the first 3 to 6 months of dosing with handoff to the local psychiatrist or sleep medicine physician for ongoing surveillance. Clinical decisions remain with your treating psychiatrist or sleep medicine physician.

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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