Dayvigo

United Arab Emirates · access guide

How to access Dayvigo for adult insomnia from the UAE: 2026 pathway via UAE psychiatry, sleep medicine, and controlled-prescription pharmacy supply

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

The UAE has one of the deepest adult psychiatry and sleep medicine service networks in the wider region. American Hospital Dubai sleep medicine and psychiatry, Mediclinic City Hospital psychiatry and sleep medicine, Cleveland Clinic Abu Dhabi sleep medicine programme and psychiatry, Sheikh Shakhbout Medical City (SSMC) sleep medicine, NMC Specialty psychiatry, Maudsley Health (NMC) Abu Dhabi, Priory Wellbeing Centre Dubai, the Dr Sulaiman Al Habib network psychiatry and sleep medicine, German Neuroscience Centre Dubai, Burjeel Medical City psychiatry, and family medicine clinics across the seven emirates all manage adult insomnia from the diagnostic conversation through pharmacotherapy where pharmacotherapy is appropriate. 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 Emirates Drug Establishment via Eisai Middle East and is generally treated as a controlled drug for dispensing purposes. For a UAE-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 and pharmacy register entry process runs, 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 UAE family's life.

This page explains how the pathway works in 2026 for a UAE-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 AED, 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 UAE family's life. It is concierge documentation written for a patient who is already in conversation with a treating psychiatrist or sleep medicine physician and wants the operational reality laid out plainly.

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. Loss of orexin signalling causes narcolepsy with cataplexy. 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 the treatment of insomnia characterised by difficulties with sleep onset and/or sleep maintenance in adults. The US DEA placed lemborexant on Schedule IV (controlled substance, same scheduling tier as zolpidem, alprazolam, suvorexant, and daridorexant). The Saudi SFDA, UAE EDE, and most other GCC regulators classify lemborexant as a controlled drug, requiring a controlled-prescription form and a controlled-drug register entry at the dispensing pharmacy.

The pivotal Phase 3 programme (SUNRISE-1 and SUNRISE-2) demonstrated improvement in latency to persistent sleep and wake after sleep onset compared with placebo over 1 and 6 months, with continued tolerability and efficacy through 12 months in SUNRISE-2. Lemborexant separated from placebo on both sleep-onset and sleep-maintenance endpoints. SUNRISE-1 included a zolpidem ER 6.25 mg comparator arm in older adults; lemborexant separated from zolpidem ER on objective sleep efficiency endpoints.

For a UAE-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 (zolpidem, eszopiclone, zaleplon) is the lower amnesia, falls, and abuse-potential signal in head-to-head studies; the trade-off is the longer half-life (approximately 17 to 19 hours) and the next-day residual sedation risk that comes with it.

What Dayvigo is, in plain language

Dayvigo is an oral tablet. Strengths are 5 mg and 10 mg. Take immediately before bed, with at least 7 hours remaining for sleep before the planned time of awakening. Take without a heavy meal (a heavy meal delays onset and reduces peak concentration). Onset of effect is approximately 30 minutes. The half-life of approximately 17 to 19 hours, together with an active metabolite of similar half-life, is the source of the next-day residual sedation risk and is the reason the labelled 7-hours-of-sleep constraint exists.

The starting dose is 5 mg at bedtime. The maximum dose is 10 mg at bedtime, reserved for patients with inadequate response at 5 mg and acceptable tolerability at the lower dose. Patients aged 65 and over should start at 5 mg and not routinely escalate to 10 mg. Patients with moderate hepatic impairment (Child-Pugh B) cap at 5 mg. Severe hepatic impairment (Child-Pugh C) is a contraindication.

Dayvigo can be dosed nightly continuous, nightly as needed, or intermittently (3 to 5 nights per week) depending on the clinical conversation. Insomnia pharmacotherapy is conventionally short-term (2 to 4 weeks) with periodic reassessment, though the SUNRISE-2 trial supports tolerability over 12 months. Reassessment every 3 to 6 months is standard for ongoing prescribing.

Eligibility at a UAE psychiatry or sleep medicine clinic

For UAE-resident adult patients, the psychiatry and sleep medicine services apply the following criteria:

1. Confirmed diagnosis of insomnia disorder by DSM-5 or ICSD-3 criteria: persistent difficulty with sleep initiation, duration, consolidation, or quality, occurring at least 3 nights per week for at least 3 months, despite adequate opportunity for sleep, with clinically significant distress or daytime impairment. 2. Sleep history and screening for secondary causes. Obstructive sleep apnoea (OSA) is the single most important secondary cause to screen for. STOP-BANG, Epworth Sleepiness Scale, and Insomnia Severity Index are the standard screening tools. Referral for polysomnography is standard where the STOP-BANG is positive. Restless legs syndrome, circadian rhythm disorders (shift-work sleep disorder is common in the UAE expatriate workforce), and behavioural causes (poor sleep hygiene, caffeine, alcohol where applicable, irregular sleep schedule) are screened in parallel. 3. CBT-I conversation. Cognitive behavioural therapy for insomnia is the AASM first-line recommendation. The prescribing conversation should document whether CBT-I has been offered, trialled, or declined. CBT-I is available through Maudsley Health Abu Dhabi, Priory Wellbeing Centre Dubai, American Hospital Dubai psychiatry, Cleveland Clinic Abu Dhabi behavioural health, and through validated digital CBT-I programmes accessible from the UAE. 4. Baseline depression and suicidality screening. PHQ-9 and C-SSRS at baseline. Insomnia is itself a risk factor for depression and suicide; baseline screening anchors the ongoing monitoring during therapy. Active untreated severe depression or active suicidal ideation warrants psychiatric assessment before starting any hypnotic. 5. Substance use history. DEA Schedule IV scheduling reflects abuse potential. A history of opioid use disorder, benzodiazepine use disorder, alcohol use disorder, or other sedative-hypnotic misuse is a relative contraindication. The UAE prescribing physician will weigh risk and may prefer a non-controlled alternative (low-dose doxepin, melatonin, ramelteon, or CBT-I only). 6. Drug interaction screen. Lemborexant is a CYP3A4 substrate. Strong CYP3A4 inhibitors (ketoconazole, itraconazole, clarithromycin, ritonavir, cobicistat) are contraindicated for concurrent use. Moderate CYP3A4 inhibitors (fluconazole, diltiazem, verapamil, erythromycin, grapefruit juice) require dose limitation to 5 mg. Strong CYP3A4 inducers (rifampin, phenytoin, carbamazepine, St John's Wort) are not recommended. 7. Respiratory function review. COPD and OSA both raise concerns about respiratory depression and worsening of obstructive events on a CNS-depressant hypnotic. Severe respiratory disease warrants caution. 8. Hepatic function review. Severe impairment is a contraindication; moderate impairment caps the dose at 5 mg. 9. Pregnancy and lactation review. Not recommended in pregnancy; avoid in lactation. 10. Age. Patients aged 65 and over start and stay at 5 mg. 11. Concurrent CNS depressants. Alcohol, opioids, benzodiazepines, gabapentinoids, and sedating antihistamines compound somnolence and respiratory depression risk. 12. Occupational screening. Patients in safety-sensitive occupations (pilots, professional drivers, surgeons, heavy-machinery operators, security personnel) require explicit counselling on next-morning impairment and may require time-restricted prescribing or alternative agents.

A UAE patient should arrive at the psychiatry or sleep medicine conversation with a sleep diary or smartphone sleep-tracker data covering the prior 1 to 2 weeks, a complete medication and supplement list (including CYP3A4 inhibitors and CNS depressants), a substance use history, prior insomnia treatments and response, comorbid conditions (depression, anxiety, OSA, chronic pain, restless legs), and insurance documentation. Reserve Meds organises this documentation pack so the prescribing physician can complete the screening efficiently on the first visit.

The UAE prescribing and dispense picture, plainly

Dayvigo is registered with the Emirates Drug Establishment via Eisai Middle East FZ-LLC. In-country dispensing applies. The drug is generally treated as a controlled substance under UAE MOHAP controlled-drug schedules; the dispensing pharmacy maintains a controlled-drug register entry for each dispense. The functional supply chain is:

1. **Prescribing physician**: a board-certified UAE psychiatrist, sleep medicine specialist, neurologist with insomnia experience, or family physician with controlled-prescription authority and insomnia management experience. Major UAE prescribing centres include American Hospital Dubai psychiatry and sleep medicine, Mediclinic City Hospital psychiatry and sleep medicine, Cleveland Clinic Abu Dhabi sleep medicine programme and behavioural health, Sheikh Shakhbout Medical City sleep medicine and psychiatry, NMC Specialty psychiatry, Maudsley Health (NMC) Abu Dhabi, Priory Wellbeing Centre Dubai, the Dr Sulaiman Al Habib network psychiatry and sleep medicine, German Neuroscience Centre Dubai psychiatry, Burjeel Medical City psychiatry, and a wide network of family medicine and internal medicine clinics across Dubai, Abu Dhabi, Sharjah, and the northern emirates. 2. **Diagnostic workup**: insomnia disorder diagnosis is clinical and based on sleep history. Polysomnography is run at American Hospital Dubai, Cleveland Clinic Abu Dhabi, Mediclinic City sleep lab, Sheikh Shakhbout Medical City sleep lab, or partnered sleep laboratories where OSA screening is positive or the sleep complaint is atypical. STOP-BANG, Epworth Sleepiness Scale, and Insomnia Severity Index are the standard screening tools used at intake. 3. **Insurance pre-authorisation**: most UAE private insurers (Daman, Thiqa for Emirati nationals; Oman Insurance, AXA Gulf, MetLife, Cigna, NEXtCARE, Bupa Global for commercial covers) cover hypnotic therapy with a prescribing psychiatrist or sleep medicine prescription for diagnosed insomnia disorder. Controlled-substance scheduling means many insurers cap the per-dispense quantity (typically 30 days) and require periodic reauthorisation (typically every 3 to 6 months) with documented ongoing need. 4. **Pharmacy dispense**: 30-day supply at a community pharmacy with controlled-drug dispensing authority. The dispensing pharmacy maintains a controlled-drug register entry. The patient presents the original controlled-prescription form (not a printout, not a fax) for each dispense. 5. **Refill cycle**: monthly with a fresh controlled-prescription form for each dispense. Some commercial plans allow a 3-month controlled prescription with documented stable therapy; the prescribing physician determines whether this is appropriate.

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. We collect the sleep history, sleep diary or sleep-tracker data, STOP-BANG and Epworth and Insomnia Severity Index scores, PHQ-9 and C-SSRS baseline, complete medication and supplement list with CYP3A4 interaction screen, substance use history, prior insomnia treatments and response, comorbid conditions, and insurance card details.

Week 1 to 2: CBT-I conversation. If CBT-I has not been offered, the prescribing physician introduces it and documents the response. CBT-I trial can run for 4 to 8 weeks alone, or in parallel with pharmacotherapy.

Week 2 to 4: Insurance pre-authorisation review (where required). Most UAE commercial insurers turn this around within 1 to 2 weeks for hypnotic therapy with diagnosis confirmation.

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 any complex sleep behaviours, sleep paralysis, or hypnagogic hallucinations. Dose maintained at 5 mg if response is adequate; dose escalated to 10 mg if response is inadequate and tolerability is acceptable.

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

Cost expectation in AED

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

At indicative 2026 cross rates, a 30-day Dayvigo supply at USD 400 is approximately AED 1,470, and the annual cost at USD 4,800 is approximately AED 17,650.

For Emirati nationals with Thiqa coverage, hypnotic therapy for documented insomnia disorder is typically covered with controlled-prescription documentation. Daman and other commercial covers vary. Out-of-pocket exposure for a covered patient is generally a co-payment band in the AED 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

The monitoring schedule for Dayvigo is structured around the four primary safety axes:

- **Next-day residual sedation and driving**: counsel at first prescription. Patient must understand individual response before driving the morning after dosing. Document the counselling. Re-counsel at dose escalation to 10 mg. UAE driving regulations are followed where impairment is documented. - **Complex sleep behaviours**: counsel patient and bed-partner at first prescription. Sleep-driving, sleep-eating, sleep-walking, and other complex behaviours are class warnings. Immediate discontinuation if any episode occurs. Re-counsel at each refill. - **Sleep paralysis and hallucinations**: counsel at first prescription. Hypnagogic and hypnopompic hallucinations and sleep paralysis are class warnings; not always indications to stop, but always indications to discuss with the prescribing physician. - **Depression and suicidality**: PHQ-9 and C-SSRS at baseline; reassessment at the 4 to 6 week response visit; reassessment every 3 to 6 months on stable maintenance. Any emergent or worsening depression, suicidal ideation, or behavioural change is a stop-and-reassess signal. Lemborexant is not an antidepressant; insomnia and depression frequently co-occur and the addition of a hypnotic does not treat the depression. - **Sleep diary**: patient-side documentation of sleep onset latency, wake after sleep onset, total sleep time, daytime function, and any adverse events. Drives titration and ongoing-need decisions. - **Respiratory and OSA reassessment**: any new daytime sleepiness, witnessed apnoeas, or worsening morning headaches warrants OSA reassessment. - **Substance use reassessment**: at each follow-up. Any escalation of dose beyond prescribed, early refills, or other misuse signals warrant reassessment and consideration of a non-controlled alternative.

Religious, ethical, and family-logistics framing

Dayvigo is an oral small molecule. There is no animal-source material in standard manufacturing, no donor cells, no biological product. Halal and kosher acceptability are not in question. The classical Islamic jurisprudential framework for medication in functional impairment extends to insomnia pharmacotherapy where the insomnia is causing meaningful functional impairment.

The family-logistics dimension of Dayvigo sits in three places. First, the controlled-prescription form must be presented in person at the dispensing pharmacy each month; this requires a regular pharmacy logistics rhythm. Second, the next-morning driving and complex-sleep-behaviour counselling involves the bed-partner where present; the bed-partner is often the first to observe a complex sleep behaviour or hypnagogic hallucination, and is part of the safety conversation. Third, the substance-use history is a real conversation that the patient and the prescribing physician need to have honestly; the UAE psychiatry services handle these conversations with discretion as standard practice.

For patients in safety-sensitive occupations (pilots, professional drivers, surgeons, heavy-machinery operators, security personnel), the next-morning impairment signal is the central operational concern. The 10 mg dose has documented driving-simulator impairment; the 5 mg dose has less consistent impairment but is not free of risk. The conversation needs to happen before the first prescription, not at the first refill, and the prescribing physician documents the occupational risk assessment in the chart.

For patients with a primary psychiatric diagnosis (depression, anxiety, PTSD) underlying the insomnia, the insomnia treatment runs alongside the primary psychiatric treatment, not instead of it. The PHQ-9 and C-SSRS at baseline and at follow-up anchor this conversation.

When Dayvigo is not the right call

Dayvigo is one of several reasonable pharmacological options for adult insomnia. It is not the right answer for:

- Narcolepsy (contraindication; orexin signalling is already deficient in narcolepsy). - Severe hepatic impairment (Child-Pugh C; contraindication). - Patients with a history of opioid use disorder, benzodiazepine use disorder, alcohol use disorder, or other sedative-hypnotic misuse where a non-controlled alternative is clinically preferable. - Pregnancy and lactation (not recommended; limited human data). - Patients on strong CYP3A4 inhibitors (contraindicated for concurrent use). - Patients in safety-sensitive occupations where next-morning impairment is unacceptable and a shorter-half-life alternative is available. - Patients with active untreated severe depression or active suicidal ideation, where psychiatric stabilisation should precede or run alongside hypnotic therapy. - Patients with untreated OSA, where treating the OSA may resolve the insomnia complaint without any hypnotic. - Patients who have not been offered CBT-I, where CBT-I is the AASM first-line recommendation and should be offered first.

For adult insomnia where Dayvigo is not the chosen agent, the alternatives in 2026 are CBT-I (first-line, evidence-based, no pharmacological exposure), suvorexant (Belsomra, the first DORA), daridorexant (Quviviq, the third DORA, shorter half-life), low-dose doxepin (Silenor, not controlled, good for sleep maintenance in older patients), melatonin and ramelteon (Rozerem, modest efficacy with favourable safety profile, good for circadian-shifted insomnia), zolpidem and the other Z-drugs (effective short-term but with meaningful adverse-event profiles), trazodone and mirtazapine (off-label use, particularly with comorbid depression), and benzodiazepines (reserved for short-term use or specific clinical scenarios).

Reserve Meds does not push a default. The page above describes the Dayvigo pathway because Dayvigo is the hypnotic the patient has asked about. If the conversation with the treating psychiatrist or sleep medicine physician points toward CBT-I, daridorexant, doxepin, ramelteon, or another option, the operational pathway shifts accordingly. Where the patient's class has multiple Reserve Meds catalog entries (suvorexant, lemborexant, and daridorexant all being DORAs), 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 UAE Dayvigo case we build the documentation pack (sleep history, sleep diary, STOP-BANG and Epworth and Insomnia Severity Index scores, PHQ-9 and C-SSRS baseline, complete 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 insurance pre-authorisation conversation, set up the first 30-day controlled-prescription dispense at the chosen pharmacy, 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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