Delstrigo

Saudi Arabia · access guide

How to access Delstrigo for HIV-1 from Saudi Arabia: 2026 pathway via the MOH HIV programme and the Saudi infectious-disease network

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

Saudi Arabia delivers HIV care through the Ministry of Health (MOH) HIV programme combined with infectious-disease services at the major tertiary centres. King Faisal Specialist Hospital and Research Centre (KFSHRC) Riyadh and Jeddah, King Saud Medical City Riyadh, King Abdulaziz Medical City (NGHA), Prince Sultan Military Medical City, King Khalid University Hospital, King Fahad Specialist Hospital Dammam, and the major Dr Sulaiman Al Habib network sites run infectious-disease services with HIV-treatment capacity. NUPCO handles institutional pharmaceutical supply for MOH and military facilities; the SFDA (Saudi Food and Drug Authority) governs regulatory status and registration. Delstrigo (doravirine / lamivudine / tenofovir disoproxil fumarate) is Merck's once-daily fixed-dose single-tablet regimen for adult HIV-1 treatment, approved by FDA in August 2018 and by EMA in November 2018. For a Saudi-resident adult with confirmed HIV-1 infection who is starting antiretroviral therapy or who is virologically suppressed on a current regimen and considering a switch, the operational question is which infectious-disease specialist, which procurement channel for Delstrigo in 2026, what the eligibility and resistance-testing workup looks like, and how the monitoring schedule and refill cycle fit into a Saudi patient's life.

This page explains how the pathway works in 2026 for a Saudi-resident patient: who qualifies, where the infectious-disease conversation happens, where the prescription is written and filled, what the realistic cost picture looks like, what to monitor on therapy, and how the lifelong-therapy framing fits into the patient's life. It is concierge documentation written for a patient (or a patient and partner, or a patient and family member) already in conversation with an infectious-disease physician who wants the operational reality laid out plainly. Reserve Meds is not the prescriber. We coordinate the documentation pack and the logistical pathway around the clinical decision your treating infectious-disease physician makes with you.

Why Delstrigo, and why now

Delstrigo is a fixed-dose combination single tablet of doravirine 100 mg (a second-generation non-nucleoside reverse transcriptase inhibitor, the new molecule in the combination), lamivudine 300 mg (a long-established nucleoside reverse transcriptase inhibitor), and tenofovir disoproxil fumarate 300 mg (an established nucleotide reverse transcriptase inhibitor). One tablet, once daily, taken with or without food.

The clinical positioning of Delstrigo sits on four points:

1. **Once-daily single-tablet regimen** (STR). One pill a day for life. Adherence drives outcomes in HIV treatment, and a one-pill regimen is the simplest possible adherence shape. 2. **Doravirine resistance profile**. Doravirine retains in-vitro activity against several common NNRTI resistance mutations including K103N, Y181C, G190A, and K101E. This is the principal differentiator from first-generation NNRTIs such as efavirenz and nevirapine. 3. **Favourable lipid profile**. In the DRIVE-AHEAD and DRIVE-FORWARD pivotal trials, doravirine showed a more favourable fasting lipid endpoint profile than the efavirenz-based and darunavir-boosted comparator regimens. This matters for long-term cardiovascular risk management on lifelong therapy. 4. **No neuropsychiatric black-box warning**. Doravirine is not efavirenz. The historical efavirenz CNS side-effect profile (vivid dreams, depression, suicidality) is materially reduced with doravirine. Abnormal dreams, dizziness, and headache are listed as common adverse events in the Delstrigo label, but at lower frequency than efavirenz historical comparators.

Delstrigo is one of several modern single-tablet HIV-1 treatment regimens. The other widely used STRs in 2026 are Biktarvy (bictegravir / emtricitabine / tenofovir alafenamide, an INSTI-based regimen widely preferred as first-line in major international guidelines), Symtuza (darunavir / cobicistat / emtricitabine / tenofovir alafenamide, a boosted-PI-based regimen), Dovato (dolutegravir / lamivudine, a two-drug regimen for selected patients), Triumeq (dolutegravir / abacavir / lamivudine, for HLA-B*5701-negative patients), and Juluca (dolutegravir / rilpivirine, two-drug switch regimen). The choice among STRs belongs to the treating infectious-disease physician.

Delstrigo is NOT a pre-exposure prophylaxis (PrEP) regimen. The PrEP regimens approved by FDA are Truvada (emtricitabine / tenofovir disoproxil fumarate) and Descovy (emtricitabine / tenofovir alafenamide). Delstrigo is NOT a post-exposure prophylaxis (PEP) regimen. Delstrigo is exclusively for the treatment of established HIV-1 infection in adults.

What Delstrigo is, in plain language

One tablet a day. Take it at approximately the same time every day. With food or without. Tablet swallowed whole. Storage at room temperature; no refrigeration. No injection, no infusion, no certified-centre requirement for ongoing therapy after the prescribing infectious-disease physician completes the initial workup. The infectious-disease specialist writes the prescription, the hospital pharmacy fills it, the patient takes Delstrigo at home, returns for periodic lab monitoring and infectious-disease follow-up, and continues on Delstrigo indefinitely as long as virologic suppression is sustained and tolerability is acceptable.

Treatment duration is lifelong. Delstrigo is not a cure for HIV. The clinical goal is sustained virologic suppression (HIV-1 RNA below the limit of detection on the standard assay, generally less than 50 copies per millilitre), which preserves immune function, prevents disease progression, and is the foundation of treatment-as-prevention (U=U, undetectable equals untransmittable, meaning a person with sustained virologic suppression does not transmit HIV sexually to partners). Discontinuing or interrupting therapy risks viral rebound, resistance development, and (for patients co-infected with hepatitis B virus) severe HBV reactivation flare. The lifelong-therapy commitment is part of the prescribing conversation.

Eligibility at a Saudi infectious-disease clinic

For Saudi-resident patients, the infectious-disease services apply the FDA, EMA, WHO, and IAS-USA criteria:

1. Confirmed HIV-1 infection documented by a standard HIV-1 diagnostic algorithm (4th-generation antigen / antibody combination assay confirmed by HIV-1 / HIV-2 differentiation assay or HIV-1 RNA quantification). 2. For the initial-therapy indication, no prior antiretroviral treatment history. For the regimen-switch indication, virologic suppression (HIV-1 RNA less than 50 copies per millilitre) on a stable antiretroviral regimen for at least six months, no history of treatment failure, and no known substitutions associated with resistance to doravirine, lamivudine, or tenofovir. 3. Baseline genotypic resistance testing confirming susceptibility to all three Delstrigo components. 4. Baseline HIV-1 RNA viral load and CD4 count. 5. Renal function: estimated creatinine clearance of 50 millilitres per minute or above. Delstrigo is NOT recommended for patients with CrCl below 50; the TDF component cannot be dose-adjusted within the fixed-dose combination. Alternative regimens (tenofovir-alafenamide-based combinations or non-tenofovir backbones) are appropriate for those patients. 6. Hepatitis B virus co-infection screen (HBsAg, anti-HBs, anti-HBc). HBV co-infection is operationally important because TDF and lamivudine both have anti-HBV activity, and stopping a TDF-containing regimen in a co-infected patient can cause severe HBV reactivation flare (a black-box warning on the Delstrigo label). Hepatitis C virus screen at the same visit. 7. Drug interaction screen for current medications. Strong CYP3A4 inducers are CONTRAINDICATED with Delstrigo and need to be stopped or substituted before initiation, or an alternative ART regimen needs to be selected. The list includes rifampin and rifapentine (anti-tuberculosis drugs of particular relevance in the Saudi epidemiological context where tuberculosis exposure or co-infection occurs), carbamazepine, phenytoin, phenobarbital (antiepileptics), enzalutamide, mitotane, and St John's wort. 8. Mental-health screening: PHQ-9 and C-SSRS at baseline and at periodic follow-up. The mental-health burden associated with an HIV diagnosis is meaningful and is independent of drug-specific neuropsychiatric pharmacology. 9. Pregnancy and lactation review for women of reproductive potential. TDF has the largest pregnancy safety database among NRTIs and is considered safe in pregnancy. Lamivudine is considered safe in pregnancy. Doravirine has limited human pregnancy data; current guidelines recommend caution and shared decision-making for women planning pregnancy. 10. Baseline metabolic and organ-function workup: complete blood count, comprehensive metabolic panel, fasting lipid panel, urinalysis with urine protein-to-creatinine ratio and urine glucose (the TDF proximal-tubule monitoring baseline). Bone mineral density assessment for patients with traditional osteoporosis risk factors or anticipated long treatment duration. 11. U=U education conversation: documentation that the patient understands sustained virologic suppression eliminates sexual transmission to partners.

A Saudi patient should arrive at the infectious-disease conversation with prior HIV testing results (where available), the most recent CD4 and viral load (where available), the complete antiretroviral-treatment history with response and tolerability data (for switch patients), the prior genotype report (where available), current medications, and identification. Reserve Meds organises this documentation pack so the infectious-disease team can confirm eligibility on the first review.

The Saudi prescribing and dispense picture, plainly

HIV care in Saudi Arabia routes through the MOH HIV programme and infectious-disease services at the major tertiary centres, not through community general-practice clinics or community pharmacies. The functional supply chain is:

1. **Prescribing infectious-disease physician**: a board-certified infectious-disease specialist at a Saudi tertiary centre or major private hospital with HIV-treatment capacity. Major Saudi prescribing centres include King Faisal Specialist Hospital and Research Centre (KFSHRC) Riyadh and Jeddah, King Saud Medical City Riyadh, King Abdulaziz Medical City NGHA Riyadh and Jeddah, Prince Sultan Military Medical City, King Khalid University Hospital, King Fahad Specialist Hospital Dammam, and the major Dr Sulaiman Al Habib infectious-disease services. The MOH HIV programme coordinates national procurement and patient management for Saudi nationals. 2. **Diagnostic and resistance-testing workup**: HIV-1 RNA quantification, CD4 count, and genotypic resistance testing run at the diagnosing centre's reference laboratory. KFSHRC operates the deepest molecular virology and immunology infrastructure in the region. 3. **Procurement pathway**: Delstrigo procurement in Saudi Arabia depends on SFDA registration status and on the MOH HIV programme formulary. For patients managed through the MOH HIV programme, the procurement channel is institutional via NUPCO and the patient-facing cost is typically zero or nominal for nationals. For patients managed through private infectious-disease services, the operational reality depends on whether Delstrigo is commercially available locally or whether named-patient European-import supply applies. Reserve Meds confirms current procurement status at intake. 4. **Insurance pre-authorisation**: CCHI-governed commercial plans cover antiretroviral therapy in the standard pharmacy benefit in most cases, but some employer-sponsored plans exclude HIV-related care; the patient's specific plan needs to be checked. Where named-patient import applies and where insurance coverage is partial or absent, cash-pay supply is the operational pathway. 5. **Refill cycle**: monthly or quarterly thereafter, tied to infectious-disease follow-up visits. Continued dispensing requires documentation of virologic suppression, lab monitoring compliance, and visit attendance.

The 2026 pathway, step by step

Week 0 to 2: Reserve Meds builds the documentation pack with the patient. We collect prior HIV testing results, prior CD4 and viral load reports, the complete antiretroviral-treatment history (for switch patients), the prior genotype report, current medications list, and identification. We coordinate first-visit booking with the chosen Saudi infectious-disease service.

Week 2 to 4: Infectious-disease first visit. Confirmation of HIV-1 diagnosis (or review of prior diagnostic data), CD4 and viral load, baseline genotypic resistance testing (or review of prior genotype), renal function, HBV and HCV screening, lipid panel, urinalysis, mental-health screen (PHQ-9 / C-SSRS), pregnancy review where relevant, drug-interaction screen.

Week 4 to 6: Regimen-selection conversation. The infectious-disease physician reviews resistance profile, renal function, HBV status, drug interactions, and patient preference, and (where Delstrigo is the appropriate choice) writes the prescription. Insurance pre-authorisation submitted where required; MOH HIV programme channel activated for nationals.

Week 6 to 8: First dispense. Delstrigo started at one tablet once daily. Mental-health screening repeated at 2 to 4 weeks for any early-onset symptoms.

Week 12: First on-treatment viral load. The target is at least a 1 log10 reduction from baseline by week 4 to 8, with full suppression by week 24.

Week 24: Confirmation of virologic suppression (target less than 50 copies per millilitre). CD4 count, renal function, lipid panel, urinalysis.

Ongoing: Maintenance dosing one tablet once daily. Monthly or quarterly pharmacy refill. Periodic infectious-disease follow-up (every 3 to 6 months in stable virologically suppressed patients). Quarterly viral load in the first year, then every 6 months in stable suppression. Annual fasting lipid panel, annual renal function and urinalysis, periodic CD4 (less frequent once sustained suppression is established). Annual mental-health re-screen at minimum.

Cost expectation in SAR

US WAC list price for Delstrigo in 2026 is approximately USD 1,950 to USD 2,150 per 30-day supply, with annual list-price cost approximately USD 24,000 to USD 26,000 per patient.

For Saudi patients managed through the MOH HIV programme, end-user cost to nationals is typically zero or nominal under the national infectious-disease procurement channel.

For patients on the named-patient European-import pathway (where local supply is not available or not preferred), the indicative cash-pay band is USD 22,000 to USD 30,000 per year inclusive of named-patient supply, courier, and patient services. At indicative 2026 cross rates, the annual cost at USD 26,000 is approximately SAR 97,500.

For Saudi nationals with MOH HIV-programme coverage, HIV antiretroviral therapy is covered. For CCHI commercial covers, ART coverage is the norm in most plans but the specific Delstrigo coverage band varies by plan; the prescribing infectious-disease team's insurance liaison runs the pre-authorisation conversation where required. Out-of-pocket exposure for a covered patient is generally a co-payment band in the SAR 200 to 1,800 per month range, not the full list price.

Monitoring on therapy

The monitoring schedule for Delstrigo is structured around HIV virologic control, the renal and bone signals associated with TDF, the metabolic profile, the HBV co-infection signal, and the mental-health burden of an HIV diagnosis:

- **HIV-1 RNA viral load**: at baseline, at 2 to 4 weeks after starting, at 12 weeks, at 24 weeks, then every 3 to 6 months in stable virologically suppressed patients. A confirmed viral load above 200 copies per millilitre after established suppression triggers an adherence assessment and a regimen-revisit conversation. - **CD4 count**: at baseline and at 3 to 6 month intervals during the first one to two years. Less frequently in patients with sustained suppression and CD4 above 350 cells per microlitre. - **Renal function**: serum creatinine, calculated creatinine clearance, urinalysis with urine protein-to-creatinine ratio and urine glucose at baseline, at 3 to 6 months in the first year, then annually. More frequent monitoring for patients with diabetes, hypertension, age above 50, low body weight, or concurrent NSAID use. - **Bone health**: baseline bone mineral density assessment for patients with traditional osteoporosis risk factors or anticipated long treatment duration. Calcium and vitamin D supplementation in patients with documented deficiency. - **Liver function tests**: AST, ALT, bilirubin at baseline and periodically; more frequent in HBV or HCV co-infected patients and during the first three months of therapy. HBV DNA quantification in HBV co-infected patients at baseline and periodically. Counselling on the discontinuation flare risk: do not stop Delstrigo abruptly without alternative anti-HBV cover in place. - **Fasting lipid panel**: at baseline and at 3 to 6 month intervals in the first year, then annually if stable. - **Mental health**: PHQ-9 and C-SSRS at baseline, at 3 months, at least annually thereafter. More frequent in patients with prior history of depression, anxiety, or suicidality, or in patients reporting new mental-health symptoms during the regimen-initiation window. The infectious-disease team coordinates referral to a psychiatrist or mental-health counsellor where clinically indicated. - **Adherence assessment**: self-reported adherence, pharmacy refill history, and viral load suppression are the three operational adherence anchors. - **Drug-interaction re-screen**: at each follow-up visit and any time a new medication is added.

Religious, ethical, and family-logistics framing

Delstrigo is a small-molecule oral tablet. The Merck Delstrigo formulation does not list animal-derived gelatin in the tablet coating; patients with specific halal-certification requirements may ask the dispensing pharmacy to confirm excipient sourcing for the current lot. There is no biological, donor-derived, or animal-cell-derived component in the active ingredients.

The lifelong-therapy framing for HIV treatment is compatible with the classical Islamic jurisprudential framework that supports the use of medicine to preserve life and health. Ramadan dosing is straightforward: the treating infectious-disease physician can advise on whether to take the once-daily dose at suhoor (pre-dawn) or at iftar (sunset). Both are acceptable provided the consistent-time-of-day discipline is maintained.

For pregnancy planning, the TDF and lamivudine backbones are well established in pregnancy. Doravirine has limited human pregnancy data; the standard recommendation is shared decision-making with the treating infectious-disease physician for women planning pregnancy. Vertical-transmission prevention with maternal ART and infant prophylaxis is the standard-of-care framework.

The family-logistics burden of Delstrigo sits primarily in the chronicity, the adherence discipline, and the social and disclosure dimensions of an HIV diagnosis. The pill itself is straightforward: one tablet, once a day, with or without food, room-temperature storage, travel-friendly.

Stigma, dignity, disclosure, and the residency conversation

HIV is a chronic, manageable, transmissible viral infection. People living with HIV on effective antiretroviral therapy have life expectancy approaching the general population. Treatment is personal health, public health, and partner protection.

The U=U principle (undetectable equals untransmittable) is one of the most important clinical and human messages in modern HIV care. A person with sustained virologic suppression does not transmit HIV sexually to partners. U=U is endorsed by the WHO HIV treatment guidelines, the IAS-USA recommendations, the British HIV Association guidelines, and the US Department of Health and Human Services adult and adolescent HIV treatment guidelines. Sustained virologic suppression is the operational endpoint of Delstrigo therapy.

Disclosure to partners, family, or employers is a personal decision with medical, social, and legal dimensions. Reserve Meds does not give disclosure advice. The recommended pathway is the conversation with the treating infectious-disease physician and, where indicated, with a social worker, counsellor, or local lawyer. The medical record is confidential within the treating institution.

Residency and employment considerations are real and vary by patient circumstance. Saudi Arabia operates visa medical-screening protocols at visa issuance and renewal that have historically included HIV testing in most cases, with implications that vary over time and depend on local policy. Reserve Meds does not provide legal advice. The recommended language for the patient conversation is: consult your treating infectious-disease physician about the social, employment, and residency considerations specific to your situation.

The clinical relevance of HIV is the same regardless of how the patient was infected. The Reserve Meds page set does not assume any particular sexual orientation, transmission route, or behavioural context for any patient.

When Delstrigo is not the right call

Delstrigo is the right answer for confirmed HIV-1 infection in adults meeting the eligibility criteria above. It is not the right answer for:

- Pre-exposure prophylaxis (PrEP). Use Truvada or Descovy in a PrEP-specific pathway. - Post-exposure prophylaxis (PEP) after potential HIV exposure within the last 72 hours. Use a PEP-specific triple-drug regimen. - Patients with estimated creatinine clearance below 50 millilitres per minute. Alternative regimens (Biktarvy, Symtuza, Dovato, Genvoya) are appropriate. - Patients with documented baseline resistance to doravirine, lamivudine, or tenofovir. - Patients requiring strong CYP3A4 inducers that cannot be stopped or substituted. - Patients with significant hepatic impairment (Child-Pugh C); data are limited. - Patients with HIV-2 infection or dual HIV-1 / HIV-2 infection. Doravirine has activity against HIV-1 only. - Paediatric patients. Delstrigo is not FDA-approved for paediatric use.

For HIV-1 in adults where Delstrigo is not the chosen regimen, the alternatives in 2026 include Biktarvy, Symtuza, Dovato, Triumeq, Juluca, Genvoya, and the long-acting injectable Cabenuva. The choice belongs to the treating infectious-disease physician.

Reserve Meds does not push a default. The page above describes the Delstrigo pathway because Delstrigo is the regimen the patient has asked about. If the conversation with the treating infectious-disease physician points toward Biktarvy, Symtuza, Dovato, or another regimen, the operational pathway shifts accordingly.

What Reserve Meds does on this case

We are a US-based concierge coordinator. We are not the prescriber, not the dispensing pharmacy, and not a legal or immigration adviser. On a Saudi Delstrigo case we build the documentation pack (prior HIV testing results where available, prior CD4 and viral load, prior antiretroviral-treatment history, prior genotype, current medications, identification), submit first-visit booking requests to the chosen Saudi infectious-disease service, coordinate the insurance pre-authorisation conversation or MOH HIV-programme channel activation as applicable, set up the first 30-day dispense through the appropriate procurement channel, organise the baseline-plus-week-12-plus-week-24 monitoring schedule, and stay with the case through the first year of dosing with handoff to the local infectious-disease specialist for ongoing surveillance. Clinical decisions remain with your treating infectious-disease physician. Disclosure, residency, and employment considerations are conversations with your treating physician and, where indicated, with a local lawyer.

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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