Dojolvi

Bahrain · access guide

How to access Dojolvi for long-chain fatty acid oxidation disorders from Bahrain: 2026 pathway via Salmaniya Medical Complex and cross-border referral to KFSHRC Riyadh or Sidra Doha

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

Bahrain has limited dedicated paediatric and adult metabolic-genetics infrastructure in-country. Salmaniya Medical Complex (SMC) in Manama runs the principal in-country paediatric and adult metabolic referral service; complex paediatric and adult LC-FAOD cases are routinely referred to KFSHRC Riyadh (the MENA regional reference centre for paediatric and adult metabolic genetics) or to Sidra Medicine Doha (the regional paediatric metabolic centre) for diagnostic confirmation and ongoing management. Dojolvi (triheptanoin) is the only FDA-approved adjunctive therapy for long-chain fatty acid oxidation disorders (LC-FAOD), a group of rare autosomal-recessive metabolic disorders that includes CPT-II deficiency, CACT deficiency, VLCAD deficiency, LCHAD deficiency, and TFP deficiency. Dojolvi is not on the standard Bahrain NHRA registered formulary as of 2026. Access for a Bahraini patient typically follows the cross-border referral pathway, with the drug procured by the treating centre in KSA or Qatar; alternatively, hospital-mediated named-patient import into Bahrain via SMC is possible. For a Bahraini family with a child detected on the national newborn screening extended panel with abnormal long-chain acylcarnitines, or for an older paediatric or adult patient presenting with cardiomyopathy, rhabdomyolysis, or hypoketotic hypoglycaemia attributable to LC-FAOD, the operational question is which cross-border centre runs the workup, how the import is coordinated, and how the MoH funding pathway for cross-border care interacts with the lifelong supply.

This page explains how the pathway works in 2026 for a Bahrain-resident paediatric or adult patient with confirmed LC-FAOD: when Dojolvi is indicated, who confirms the diagnosis, how the cross-border or in-country named-patient pathway works, what the day-to-day dosing and dietary structure looks like, and what the realistic cost band is.

Why Dojolvi, and when

Dojolvi is triheptanoin, a synthetic medium-odd-chain triglyceride composed of three molecules of heptanoic acid (the seven-carbon fatty acid, C7) esterified to glycerol. The FDA approved it in June 2020 as a source of calories and fatty acids in paediatric and adult patients aged 6 months and older with molecularly confirmed LC-FAOD. The clinical rationale is anaplerotic: triheptanoin is hydrolysed to heptanoic acid, which is metabolised through medium-chain beta-oxidation. The odd-chain length means the final cycle of beta-oxidation produces propionyl-CoA in addition to acetyl-CoA. Propionyl-CoA is metabolised to succinyl-CoA, a TCA cycle intermediate. This anaplerotic effect distinguishes triheptanoin from conventional even-chain MCT preparations (C8 and C10) that have been the dietary mainstay of LC-FAOD management for decades. Standard MCT provides acetyl-CoA only; triheptanoin provides acetyl-CoA plus succinyl-CoA precursors.

For a Bahraini family with a child detected on the NBS extended panel with abnormal long-chain acylcarnitine markers, the Dojolvi conversation begins at 6 months of age after confirmatory acylcarnitine profile and molecular testing have established the LC-FAOD diagnosis, typically via cross-border referral to KFSHRC Riyadh or Sidra Doha for the confirmatory workup. For an older patient presenting with cardiomyopathy, rhabdomyolysis, or hypoketotic hypoglycaemia, the conversation begins at the time of molecular confirmation. In both cases, the conversation runs through a metabolic-genetics service with a metabolic specialist and a metabolic dietitian.

What Dojolvi is, in plain language

Triheptanoin is a clear yellow oil taken orally, mixed into food or beverages at room temperature. The target dose is approximately 25 to 35 percent of total daily caloric intake from triheptanoin, divided across 4 or more daily doses taken with meals and snacks. Typical paediatric dosing is 1 to 3 mL/kg/day; typical adult dosing is determined by total daily caloric target and body weight, with most adults at 80 to 100 mL/day in divided doses. Titration starts at approximately 0.5 to 1 mL/kg/day and increases over 1 to 2 weeks to target, primarily to manage gastrointestinal tolerance.

This is a lifelong therapy. Once started, Dojolvi is continued indefinitely. Dojolvi is an adjunct to dietary management (long-chain fat restriction, structured carbohydrate intake, frequent feeding, fasting avoidance), accompanied by a written sick-day plan. The drug reduces but does not eliminate the risk of acute metabolic decompensation during illness, fasting, or surgery. Dietary discipline and sick-day planning remain non-negotiable.

Eligibility and the Bahrain cross-border pathway

The eligibility criteria are FDA-aligned:

1. Molecular confirmation of LC-FAOD: pathogenic or likely-pathogenic variants in CPT2, CPT1A, SLC25A20, ACADVL, HADHA, or HADHB. NBS-detected abnormal long-chain acylcarnitine profile followed by confirmatory plasma acylcarnitine profile, urine organic acids, and molecular sequencing is the standard pathway for NBS-detected cases. The Bahrain NBS extended panel covers LC-FAOD acylcarnitine markers. 2. Age 6 months or older. 3. Established or escalating clinical disease, or NBS-detected asymptomatic infant initiated at 6 months to pre-empt clinical events. 4. Capacity for adherence to the structured 4-or-more daily dosing schedule and for the gastrointestinal titration period. 5. Access to a metabolic dietitian for diet planning, dose calculation, sick-day management training, and family education.

For a Bahraini patient, the diagnostic workup and ongoing management most commonly run through cross-border referral:

- **King Faisal Specialist Hospital and Research Centre (KFSHRC), Riyadh**: regional reference centre for MENA paediatric and adult metabolic genetics. Genetic disorders centre runs molecular and biochemical diagnostic workup for LC-FAOD; metabolic clinic dispenses Dojolvi via named-patient import; cardiology and hepatology consult integration for VLCAD and LCHAD subtypes. KFSHRC is the standard cross-border destination for Bahraini complex paediatric and adult metabolic-genetics cases. - **Sidra Medicine, Doha**: paediatric metabolic and clinical-genetics service. Paediatric-only mandate. The relevant Qatar centre for paediatric LC-FAOD diagnostic confirmation and ongoing management. Sidra is the standard cross-border destination for paediatric Bahraini cases where Doha is operationally closer or where the family has existing care relationships in Qatar. - **Salmaniya Medical Complex (SMC), Manama**: paediatric and adult medical service; runs the in-country referral pathway and coordinates the cross-border logistics. SMC also coordinates in-country named-patient import via its hospital pharmacy where the family chooses to maintain primary care in Bahrain.

The metabolic specialist at the cross-border centre drives diagnosis. The metabolic dietitian leads the dietary intervention plan. The cardiologist (for VLCAD and LCHAD subtypes) leads cardiomyopathy surveillance with annual echocardiograms.

The Bahrain prescribing and supply picture, plainly

The Bahrain National Health Regulatory Authority (NHRA) is the national regulator. Dojolvi is not on the standard NHRA registered formulary as of 2026. Two operational pathways apply for a Bahraini patient confirmed to have LC-FAOD:

1. **Cross-border centre supply**: the drug is procured by the treating centre at KFSHRC Riyadh or at Sidra Doha through that centre's named-patient pathway; the patient travels to the centre for initial titration and for periodic surveillance visits, and the drug supply may be carried by the patient back to Bahrain for daily use or shipped as part of the cross-border care arrangement. The MoH cross-border care pathway in Bahrain (for Bahraini nationals referred abroad through the MoH-approved channel) covers the relevant cross-border care components. 2. **In-country named-patient import via SMC**: SMC's hospital pharmacy files a named-patient import authorisation with NHRA and coordinates with Ultragenyx International for direct supply into Bahrain. Lead time is typically 6 to 12 weeks for the first dispense, longer than the KSA or UAE pathways given the smaller-volume Ultragenyx distribution into Bahrain. Monthly resupply runs through the same channel.

[VERIFY: current NHRA registration status and named-patient import lead times at SMC at intake.]

For Bahraini nationals using the MoH cross-border pathway to KFSHRC or to Sidra, MoH funding typically covers the drug-acquisition cost as part of the cross-border care episode, subject to pre-authorisation. For Bahraini nationals using the in-country named-patient import via SMC, MoH funding through the rare-disease pathway is the typical mechanism, subject to case-by-case pre-authorisation. For expatriate residents, private insurance pre-authorisation runs in parallel; carrier and plan tier matter substantially for a high-annual-cost lifelong therapy.

Cost band and insurance positioning

US list price for Dojolvi is approximately USD 60,000 to USD 100,000 per year, varying by patient weight and target dose. At indicative 2026 cross rates the annual drug-only band is approximately BHD 22,600 to BHD 37,700. Full cost of care including the cross-border centre visits or in-country metabolic care, metabolic dietitian time, cardiac and hepatic surveillance, and intercurrent emergency care runs approximately 20 to 40 percent above drug-only cost. The cross-border pathway adds travel and accommodation costs that the MoH pathway may or may not cover depending on the case.

This is a lifelong cost. Bahraini nationals using the MoH cross-border or in-country rare-disease pathway have substantially reduced out-of-pocket exposure; expatriate residents have variable cover through private insurance.

What to expect on the Dojolvi pathway

Week 0 (cross-border referral and diagnostic confirmation): SMC coordinates the cross-border referral to KFSHRC Riyadh or to Sidra Doha for diagnostic confirmation. The cross-border metabolic specialist confirms LC-FAOD diagnosis through plasma acylcarnitine profile, molecular testing, and clinical correlation. Metabolic dietitian initiates dietary planning. Cardiology consultation engaged for VLCAD and LCHAD subtypes. Named-patient import process initiated at the cross-border centre or in parallel at SMC.

Weeks 1 to 12 (drug procurement and titration): named-patient import paperwork complete; drug arrives at the cross-border centre or at SMC in 4 to 12 weeks depending on pathway. Once drug is available, titration begins at approximately 0.5 to 1 mL/kg/day and increases over 1 to 2 weeks to target 1 to 3 mL/kg/day in paediatric patients, with proportional adult dosing. Daily 4-or-more divided doses with meals and snacks.

Weeks 12 to 24 (early maintenance): target dose maintained; metabolic-clinic visits at the cross-border centre or at SMC every 4 to 8 weeks initially, transitioning to every 12 weeks once stable. Cardiac surveillance baseline established and repeated annually. Sick-day plan written, family trained.

Ongoing (lifelong): metabolic-clinic visit every 12 weeks in stable patients; metabolic dietitian review at each visit; annual cardiac surveillance for VLCAD and LCHAD subtypes; intercurrent illness management per the sick-day plan; named-patient resupply monthly; insurance or MoH pre-authorisation renewal as required.

When Dojolvi is the wrong drug or not yet the right drug

For a Bahraini patient under 6 months of age, conservative paediatric metabolic management with conventional even-chain MCT, structured carbohydrate intake, and frequent feeding is the operational pathway; Dojolvi is added at 6 months. For a patient with confirmed LC-FAOD who cannot tolerate the gastrointestinal titration of Dojolvi despite slower titration and adjusted dose-distribution, the operational alternative is to remain on conventional even-chain MCT plus dietary management; conventional MCT provides energy substrate but does not provide TCA cycle anaplerosis. For a patient with suspected LC-FAOD on NBS or clinical grounds but without molecular confirmation, the diagnostic workup is completed first.

Family screening, consanguinity, and pregnancy planning

LC-FAOD is autosomal recessive. Consanguinity is common in Bahrain and the wider Gulf. Carrier testing for siblings and at-risk extended-family members is a routine part of the metabolic-genetics conversation. The cross-border centre at KFSHRC Riyadh or Sidra Doha typically coordinates the carrier-testing pathway alongside the index-case workup. Pregnancy planning for women of childbearing age with LC-FAOD or with carrier status for LCHAD or TFP requires multidisciplinary coordination across the metabolic clinic, maternal-fetal medicine, and obstetrics. HELLP syndrome and acute fatty liver of pregnancy (AFLP) are documented elevated-risk conditions in pregnancies where the fetus is LCHAD-affected or where the mother is heterozygous for LCHAD or TFP variants.

Religious-ethical considerations

Triheptanoin is a synthetic triglyceride manufactured from heptanoic acid of vegetable or fermentation origin. The product is not derived from animal tissue or human plasma. There is no porcine, bovine, or other religiously-significant animal component. The Islamic bioethics consensus on prescribed therapies for lifelong metabolic disorders is broadly permissive, and the synthetic vegetable-origin sourcing removes the dietary-law concerns that arise with some animal-derived products. Families typically consult with their religious advisors before committing.

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 Dojolvi case we coordinate the cross-border referral logistics with SMC and the cross-border centre (KFSHRC Riyadh or Sidra Doha), coordinate named-patient import logistics with Ultragenyx International, run financial pre-authorisation alongside clinical pre-authorisation (MoH cross-border or in-country rare-disease pathway; private insurance for expatriates), support the family through the titration period and ongoing maintenance, and stay with the family for the long arc of lifelong therapy management. Clinical decisions remain with your treating metabolic specialist at the cross-border centre or at SMC.

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.

reservemeds.com · hello@reservemeds.com