Dojolvi

Qatar · access guide

How to access Dojolvi for long-chain fatty acid oxidation disorders from Qatar: 2026 pathway via Sidra Medicine Doha (paediatric) and Hamad Adult Metabolic Clinic, with KFSHRC Riyadh as the regional reference

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

Qatar has stood up paediatric and adult metabolic-genetics services across the Hamad Medical Corporation (HMC) and Sidra Medicine networks over the last decade. Sidra Medicine in Doha is the paediatric-only tertiary centre and runs paediatric metabolic and clinical-genetics services for Qatari children, including diagnostic workup and ongoing management for long-chain fatty acid oxidation disorders (LC-FAOD). Hamad Medical Corporation runs the Adult Metabolic Clinic that picks up Qatari adults with inborn errors of metabolism, including adult-onset LC-FAOD and the transition of Sidra paediatric patients into adult care. Dojolvi (triheptanoin) is the only FDA-approved adjunctive therapy for 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 Qatar MOPH formulary as of 2026; access at Sidra and at Hamad is via hospital-mediated named-patient import coordinated with Ultragenyx International. For a Qatari family with a child detected on the Hamad national newborn screening programme with abnormal long-chain acylcarnitines, or for an adult presenting with cardiomyopathy, rhabdomyolysis, or hypoketotic hypoglycaemia attributable to LC-FAOD, the operational question is which Qatar centre runs the diagnostic confirmation, how the named-patient import is coordinated, what the lifelong dosing schedule looks like, and how HMC funding interacts with the supply pathway for a high-cost lifelong therapy.

This page explains how the pathway works in 2026 for a Qatar-resident paediatric or adult patient with confirmed LC-FAOD: when Dojolvi is indicated, who confirms the diagnosis, how the named-patient import 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 absorbed and 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 tricarboxylic acid (TCA) cycle intermediate. This anaplerotic effect, replenishment of TCA cycle intermediates, distinguishes triheptanoin from the conventional even-chain medium-chain triglyceride (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 Qatari family with a child detected on the HMC national newborn screening (NBS) programme with abnormal long-chain acylcarnitine markers (elevated C14, C16, C18, C18:1; reduced C2 acetylcarnitine), the Dojolvi conversation begins at 6 months of age after confirmatory acylcarnitine profile and molecular testing have established the LC-FAOD diagnosis. For an older paediatric or adult 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 clinic with a metabolic specialist and a metabolic dietitian, not through a general paediatrician or general internist clinic.

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 (sometimes longer) 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 for intercurrent illness. 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 regardless.

This is also a diet-first medicine. Dojolvi is the adjunct, not the substitute. The metabolic dietitian is a central member of the care team. The metabolic specialist coordinates overall clinical management. Cardiology consultation is integrated for VLCAD and LCHAD subtypes for cardiomyopathy surveillance; hepatology consultation is integrated for the hepatic-presentation subtypes.

Eligibility for Dojolvi at a Qatar metabolic centre

The Sidra and Hamad metabolic teams apply the FDA-aligned eligibility criteria:

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 (dicarboxylic aciduria), and molecular sequencing is the standard pathway for NBS-detected cases. The HMC NBS programme covers acylcarnitine profile nationally. 2. Age 6 months or older. Younger infants are managed with conservative dietary management plus conventional even-chain MCT first; Dojolvi is added at 6 months when a longer feeding schedule is in place. 3. Established or escalating clinical disease (cardiomyopathy, hepatic dysfunction, rhabdomyolysis, hypoglycaemic events, progressive myopathy), 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.

The diagnostic workup that confirms eligibility runs through the Qatar paediatric or adult metabolic centre depending on the patient's age:

- **Sidra Medicine, Doha**: paediatric metabolic and clinical-genetics service. Sidra is the paediatric-only tertiary centre in Qatar and is the relevant Qatar centre for paediatric LC-FAOD. Acylcarnitine profile, plasma and urine biochemistry, and molecular sequencing are run on-campus or through Sidra's reference laboratory network. Sidra dispenses Dojolvi via hospital-mediated named-patient import for confirmed paediatric LC-FAOD cases. - **Hamad Adult Metabolic Clinic, Doha**: adult metabolic-genetics service within Hamad Medical Corporation. The Adult Metabolic Clinic manages adult-onset LC-FAOD and transitions Sidra paediatric patients into adult care. The diagnostic workup for adult-presenting patients is run through Hamad with reference-laboratory support; Dojolvi access is via hospital-mediated named-patient import.

The metabolic specialist drives diagnosis. The metabolic dietitian leads the dietary intervention plan. The cardiologist (for VLCAD and LCHAD subtypes) leads cardiomyopathy surveillance with annual echocardiograms. A Qatari family or patient is not making the eligibility determination; the conversation runs through Sidra (paediatric) or Hamad (adult).

The Reserve Meds concierge role on this pathway is to coordinate the named-patient import logistics with Ultragenyx International in parallel with the metabolic-clinic conversation, to support family logistics including financial pre-authorisation, and to coordinate cross-border referral to KFSHRC Riyadh when warranted (KFSHRC Riyadh is the regional reference centre for MENA LC-FAOD diagnosis and management for the rare-subtype or complex-case subset).

The Qatar prescribing and supply picture, plainly

The Qatar Ministry of Public Health (MOPH) is the national regulator. Dojolvi does not have in-country commercial registration on the standard MOPH formulary as of 2026. Sidra and Hamad access Dojolvi via hospital-mediated named-patient import filed through their pharmacy departments and coordinated with Ultragenyx International. The named-patient import process typically takes 4 to 10 weeks from prescription to first delivery; monthly resupply runs through the same channel with shorter lead times once the patient is established. [VERIFY: current MOPH registration status and named-patient lead time at Sidra and at Hamad at intake.]

For Qatari nationals, HMC funding for rare-disease therapies is the primary mechanism. The rare-disease pathway through Hamad covers the drug-acquisition cost for documented paediatric LC-FAOD cases at Sidra and for documented adult LC-FAOD cases at Hamad Adult Metabolic Clinic, subject to pre-authorisation through the HMC pharmacy and therapeutics committee. Out-of-pocket exposure for Qatari nationals is typically modest. 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. A paediatric patient at 60 mL/day target is in the lower portion of the range; an adult at 100 mL/day target is in the upper portion. At indicative 2026 cross rates the annual drug-only band is approximately QAR 218,000 to QAR 364,000. Full cost of care including metabolic clinic visits, metabolic dietitian time, cardiac and hepatic surveillance, and intercurrent emergency care runs approximately 20 to 40 percent above drug-only cost.

This is a lifelong cost. Qatari nationals at Sidra (paediatric) and Hamad Adult Metabolic Clinic who qualify for HMC rare-disease funding have substantially reduced out-of-pocket exposure; expatriate residents have variable cover through private insurance. Financial pre-authorisation runs in parallel with the clinical pathway and is initiated at the time of metabolic-clinic diagnosis, not retrospectively.

What to expect on the Dojolvi pathway

Week 0 (diagnostic confirmation): metabolic specialist at Sidra (paediatric) or Hamad (adult) confirms LC-FAOD diagnosis through plasma acylcarnitine profile, molecular testing, and clinical correlation. Metabolic dietitian initiates dietary planning and family education. Cardiology consultation engaged for VLCAD and LCHAD subtypes. Hospital-mediated named-patient import process initiated with Ultragenyx International. Financial pre-authorisation initiated with HMC or with the private insurance carrier.

Weeks 1 to 10 (drug procurement and titration): named-patient import paperwork complete, drug arrives in 4 to 10 weeks. Once drug arrives, 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. Gastrointestinal tolerance assessed at each metabolic-clinic visit; titration rate adjusted as needed.

Weeks 10 to 24 (early maintenance): target dose maintained; metabolic-clinic visits every 4 to 8 weeks initially, transitioning to every 12 weeks once stable. Cardiac surveillance baseline established (echocardiogram and ECG) and repeated annually or more frequently per clinical indication. Liver function tests and creatine kinase monitored. Sick-day plan written, family trained, emergency-letter documentation issued.

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; HMC or insurance pre-authorisation renewal as required (typically annually).

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

For a Qatari 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 via acetyl-CoA but does not provide TCA cycle anaplerosis through propionyl-CoA. The clinical conversation about this trade-off happens at the metabolic clinic. For a patient with suspected LC-FAOD on NBS or clinical grounds but without molecular confirmation, the diagnostic workup is completed first; Dojolvi initiation waits for molecular confirmation.

Carnitine supplementation (L-carnitine) is commonly used adjunctively in LC-FAOD with documented total or free carnitine deficiency; clinical practice on routine carnitine supplementation varies by subtype and clinician and is independent of the Dojolvi decision.

Family screening, consanguinity, and pregnancy planning

LC-FAOD is autosomal recessive. Consanguinity is common in Qatar and in the wider Gulf, and autosomal recessive disorders including the LC-FAOD subtypes have higher carrier and affected prevalence in consanguineous extended-family pedigrees. Carrier testing for siblings and at-risk extended-family members is a routine part of the metabolic-genetics conversation in any newly diagnosed Qatari LC-FAOD family. Sidra and Hamad run the clinical-genetics service for carrier testing and for pregnancy-planning conversations.

Pregnancy planning for women of childbearing age with LC-FAOD or with carrier status for LCHAD or TFP requires coordination across the metabolic clinic, the maternal-fetal medicine service, and the obstetric team at Hamad. 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. Continuation of Dojolvi during pregnancy is generally favoured to maintain maternal metabolic stability; pregnancy-specific data are limited and the conversation is individualised.

Religious-ethical considerations

Triheptanoin is a synthetic triglyceride manufactured from heptanoic acid of vegetable or fermentation origin, esterified to glycerol. 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; the conversation is brief and well-supported by established jurisprudence in the metabolic-disease setting.

What Reserve Meds does on this case

We are a US-based concierge coordinator. We are not the prescriber and not the dispensing pharmacy, and on a Dojolvi case we are not driving the clinical decision-making at Sidra or at Hamad. On a Qatar Dojolvi case we coordinate named-patient import logistics with Ultragenyx International in parallel with the metabolic-clinic conversation, run financial pre-authorisation alongside clinical pre-authorisation (HMC pathway for Qatari nationals; private insurance pathway for expatriates), support the family through the titration period and ongoing maintenance, coordinate cross-border referral to KFSHRC Riyadh when warranted, and stay with the family for the long arc of lifelong therapy management. Clinical decisions remain with your treating metabolic specialist and the metabolic clinic care team at Sidra or Hamad.

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