Dovato

United Arab Emirates · access guide

How to access Dovato for HIV-1 from the UAE: 2026 pathway via UAE infectious-disease services and MOHAP-coordinated antiretroviral supply

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

The UAE delivers HIV care through a dedicated Ministry of Health and Prevention (MOHAP) national HIV programme combined with infectious-disease services at the major public and private hospitals. Sheikh Khalifa Medical City Abu Dhabi, Cleveland Clinic Abu Dhabi, Rashid Hospital Dubai, Mediclinic City Hospital Dubai, American Hospital Dubai, and Sheikh Shakhbout Medical City all run infectious-disease services with HIV-treatment capacity. Dovato (dolutegravir / lamivudine) is ViiV Healthcare's once-daily fixed-dose 2-drug single-tablet regimen for adult HIV-1 treatment, approved by FDA in April 2019 and by EMA in July 2019. For a UAE-resident adult with confirmed HIV-1 infection who is starting antiretroviral therapy for the first time and meets the 2-drug-regimen eligibility criteria, or who is virologically suppressed on a current 3-drug regimen and considering a switch to a simplified 2-drug regimen, the operational question is which infectious-disease specialist, which procurement channel for Dovato in 2026, what the eligibility and resistance-testing workup looks like (including the load-bearing HBV-negative confirmation), and how the monitoring schedule and refill cycle fit into a UAE family's life.

This page explains how the pathway works in 2026 for a UAE-resident patient: who qualifies, where the infectious-disease conversation happens, where the prescription is written and filled, what the realistic out-of-pocket exposure band is, 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 Dovato, and why now

Dovato is a fixed-dose combination single tablet of dolutegravir 50 mg (a second-generation integrase strand transfer inhibitor, INSTI, the new molecule in the combination as a 2-drug complete regimen) and lamivudine 300 mg (a long-established nucleoside reverse transcriptase inhibitor, NRTI). One tablet, once daily, with or without food. No second NRTI. No tenofovir component, no abacavir component.

The clinical positioning of Dovato sits on four points relevant to a UAE patient choosing among modern antiretroviral regimens:

1. **2-drug complete regimen**. Dovato is one of the first complete-regimen single-tablet 2-drug regimens (2DR-STR) for HIV-1, with a broad initial-therapy indication for treatment-naive adults meeting eligibility criteria. Traditional standard-of-care HIV regimens use 3 drugs (typically two NRTIs plus a third agent). Dovato removes the second NRTI, which simplifies the long-term toxicity surface and the drug-interaction surface. The price of the simplification is the eligibility gates that distinguish a 2-drug-eligible patient from a 3-drug-required patient. For a UAE patient whose viral load, resistance profile, and HBV status all fall within the eligibility window, the 2-drug approach is an option; outside that window, a 3-drug regimen is the appropriate choice. 2. **No tenofovir, no abacavir**. The absence of tenofovir means no TDF-associated renal proximal-tubule dysfunction or bone mineral density loss signal, and no TAF-associated weight-gain or lipid signal characteristic of TAF combinations. The absence of abacavir means no HLA-B*5701 hypersensitivity screen requirement and no abacavir-cardiovascular debate. For patients with long-anticipated treatment duration and concern about cumulative tenofovir-related renal or bone effects, the 2-drug regimen profile is clinically attractive. 3. **Dolutegravir resistance barrier**. Dolutegravir has the highest in-vitro barrier to resistance of any INSTI to date. In the GEMINI 1 and GEMINI 2 pivotal initial-therapy trials, no patient in either arm developed treatment-emergent INSTI or NRTI resistance through 144 weeks. The high barrier is the clinical foundation for the 2-drug-regimen approach: a dual regimen would not be a viable initial-therapy option without the resistance protection that dolutegravir provides. 4. **Eligibility-gated, not universal**. Dovato is NOT a universal first-line regimen. The eligibility gates are clinically important and load-bearing: HIV-1 RNA at or below 500,000 copies per millilitre, no INSTI or lamivudine resistance, no HBV co-infection, no concurrent rifampin or rifabutin or strong CYP inducer. For patients outside any of these gates, a 3-drug regimen such as Biktarvy, Symtuza, Delstrigo, or Triumeq is appropriate. The eligibility conversation with the treating infectious-disease physician is what determines whether Dovato is the right regimen for a given UAE patient.

Dovato is one of several modern single-tablet HIV-1 treatment regimens. Other widely used STRs in 2026 are Biktarvy (bictegravir / emtricitabine / tenofovir alafenamide, a 3-drug INSTI-based regimen widely preferred as first-line in major international guidelines), Symtuza (darunavir / cobicistat / emtricitabine / tenofovir alafenamide, a 3-drug boosted-PI-based regimen), Delstrigo (doravirine / lamivudine / tenofovir disoproxil fumarate, a 3-drug NNRTI-based regimen), Triumeq (dolutegravir / abacavir / lamivudine, a 3-drug regimen for HLA-B*5701-negative patients), and Juluca (dolutegravir / rilpivirine, the OTHER ViiV 2-drug regimen restricted to switch only after stable suppression). The choice among STRs is made by the treating infectious-disease physician based on the patient's resistance profile, renal function, HBV co-infection status, drug interactions, lipid and weight trajectory, bone health, and patient preference.

Dovato 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). Dovato is NOT a post-exposure prophylaxis (PEP) regimen after potential HIV exposure within the last 72 hours; PEP uses a different triple-drug regimen initiated through emergency-department or infectious-disease services. Dovato is exclusively for the treatment of established HIV-1 infection in adults.

What Dovato 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 Dovato at home, returns for periodic lab monitoring and infectious-disease follow-up, and continues on Dovato indefinitely as long as virologic suppression is sustained and tolerability is acceptable.

Polyvalent cation timing is part of routine patient counselling: take Dovato either 2 hours BEFORE or 6 hours AFTER antacids, calcium supplements (apart from calcium taken with a meal alongside Dovato), iron supplements, or sucralfate. Multivitamin discipline is part of the conversation. During Ramadan, the meal-window compression makes the polyvalent-cation timing rule explicit conversation territory with the treating physician.

Treatment duration is lifelong. Dovato 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 and resistance development. The lifelong-therapy commitment is part of the prescribing conversation.

Eligibility at a UAE infectious-disease clinic

For UAE-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 AND baseline HIV-1 RNA at or below 500,000 copies per millilitre. 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 dolutegravir or lamivudine. 3. Baseline genotypic resistance testing confirming susceptibility to both Dovato components. Patients with documented INSTI resistance or 3TC resistance (M184V/I) are NOT eligible. 4. **Hepatitis B virus (HBV) co-infection screen confirmed negative** (HBsAg negative, anti-HBc reviewed): this is the LOAD-BEARING pre-initiation gate. Dovato is INADEQUATE for HBV co-treatment because lamivudine monotherapy rapidly selects HBV-resistant variants. Any HBV-positive patient needs a tenofovir-containing regimen (Biktarvy, Symtuza, Delstrigo, Genvoya, or other TDF / TAF-containing combination), NOT Dovato. HCV screen at the same visit. 5. Renal function: estimated creatinine clearance of 50 millilitres per minute or above. Dovato is NOT recommended for patients with CrCl below 50; lamivudine dose adjustment cannot be achieved within the fixed-dose combination. Alternative regimens with adjustable backbones are appropriate for those patients. Note: dolutegravir causes a small predictable rise in serum creatinine (typically 10 to 15 percent) without a true glomerular filtration rate change; this is expected and benign. 6. Drug interaction screen for current medications. Rifampin is contraindicated; oxcarbazepine, phenytoin, phenobarbital, carbamazepine, and St John's wort are to be avoided. Dofetilide is contraindicated. Metformin requires dose monitoring with close glucose checks when starting or stopping Dovato. 7. Polyvalent cation counselling: antacid, calcium supplement, iron supplement, and sucralfate timing rule (2 hours before OR 6 hours after Dovato; or with a meal alongside Dovato for calcium and iron specifically). 8. Mental-health screening: PHQ-9 (Patient Health Questionnaire 9-item) and C-SSRS (Columbia Suicide Severity Rating Scale) 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. Dolutegravir-specific neuropsychiatric adverse events (insomnia, anxiety, depression) are reported at approximately 5 to 10 percent and are more pronounced than with bictegravir or raltegravir; most cases are mild and may resolve with continued therapy, some patients require regimen switch. The screening conversation also addresses disclosure stress, partner-notification anxiety, and adherence support needs. 9. Pregnancy and lactation review for women of reproductive potential. The 2018 Tsepamo neural-tube-defect signal with periconception dolutegravir exposure was attenuated by subsequent cohort data through 2020; current WHO and US DHHS guidelines consider dolutegravir-based regimens safe in pregnancy with appropriate counselling. Lamivudine is well established in pregnancy. 10. Baseline metabolic and organ-function workup: complete blood count, comprehensive metabolic panel, fasting lipid panel, weight, body mass index, blood pressure, fasting glucose. The dolutegravir weight-gain signal makes baseline metabolic profiling part of standard care. 11. U=U education conversation: documentation that the patient understands sustained virologic suppression eliminates sexual transmission to partners (treatment-as-prevention). This conversation is part of the prescribing visit, not optional.

A UAE 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), HBV serology (where available), current medications including over-the-counter supplements (calcium, iron, multivitamin, antacid use particularly), and identification. Reserve Meds organises this documentation pack so the infectious-disease team can confirm eligibility on the first review.

The UAE prescribing and dispense picture, plainly

HIV care in the UAE routes through Ministry of Health and Prevention infectious-disease departments and the infectious-disease services at the major hospitals, 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 or HIV-trained internist at a UAE hospital with established HIV-treatment capacity. Major UAE prescribing centres include Sheikh Khalifa Medical City (SKMC) Abu Dhabi infectious disease, Cleveland Clinic Abu Dhabi infectious disease, Sheikh Shakhbout Medical City Abu Dhabi infectious disease, Rashid Hospital Dubai infectious-disease unit, Mediclinic City Hospital Dubai infectious disease, and American Hospital Dubai infectious disease. MOHAP coordinates the national HIV programme. 2. **Diagnostic and resistance-testing workup**: HIV-1 RNA quantification, CD4 count, and genotypic resistance testing run at the diagnosing centre's reference laboratory or sent to a partnered reference laboratory. HBV serology is part of the same lab panel. 3. **Procurement pathway**: Dovato procurement in the UAE depends on registration status with the Emirates Drug Establishment and on the national HIV programme formulary. For patients managed through the MOHAP national HIV programme, the procurement channel is institutional 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 Dovato is commercially available through local pharmacies or whether named-patient European-import supply applies. Reserve Meds confirms current procurement status at intake. 4. **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 antiretroviral therapy for HIV under the standard pharmacy benefit in most plans. 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, HBV serology where available, current medications list including over-the-counter and herbal products and supplements, and identification. We coordinate first-visit booking with the chosen UAE 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 (creatinine and calculated CrCl), HBV and HCV screening, lipid panel, fasting glucose, weight and BMI and blood pressure, mental-health screen (PHQ-9 / C-SSRS), pregnancy review where relevant, drug-interaction screen, polyvalent cation counselling.

Week 4 to 6: Regimen-selection conversation. The infectious-disease physician reviews resistance profile, renal function, HBV status (Dovato requires HBV negative confirmation), baseline viral load (Dovato eligibility caps at 500,000 copies per millilitre for initial therapy), drug interactions, weight and metabolic baseline, and patient preference, and (where Dovato is the appropriate choice) writes the prescription. Insurance pre-authorisation submitted where required.

Week 6 to 8: First dispense. Dovato started at one tablet once daily. Mental-health screening repeated at 2 to 4 weeks for any early-onset neuropsychiatric 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, weight, blood pressure, fasting glucose.

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, weight and BP and glucose, annual renal function, periodic CD4 (less frequent once sustained suppression is established and CD4 is above 350 cells per microlitre). Annual mental-health re-screen at minimum, more frequent in patients with prior history or new symptoms.

Cost expectation in AED

US WAC list price for Dovato in 2026 is approximately USD 2,950 to USD 3,250 per 30-day supply, with annual list-price cost approximately USD 36,000 to USD 40,000 per patient. US payer coverage (Medicaid, Medicare Part D, ADAP, commercial) typically reduces patient out-of-pocket exposure to a low monthly co-payment.

For UAE patients managed through the MOHAP national HIV programme, end-user cost to nationals is typically zero or nominal under the national infectious-disease procurement channel. For private-sector dispensing where commercial registration applies, the GCC list-price band is approximately AED 1,800 to 2,400 per month, comparable to Biktarvy and Symtuza.

For patients on the named-patient European-import pathway (where commercial UAE supply is not available or not preferred), the indicative cash-pay band is USD 24,000 to USD 32,000 per year inclusive of named-patient supply, courier, and patient services. At indicative 2026 cross rates, the annual cost at USD 28,000 is approximately AED 102,800.

For Emirati nationals with Thiqa coverage, HIV antiretroviral therapy is covered through the national infectious-disease pathway. For Daman commercial and other UAE commercial covers, ART coverage is the norm in most plans but the specific Dovato 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 AED 50 to 500 per month range, not the full list price.

Monitoring on therapy

The monitoring schedule for Dovato is structured around HIV virologic control, the dolutegravir-specific neuropsychiatric and weight-gain signals, the renal serum-creatinine pattern, hepatic function, 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, a polyvalent-cation timing review, a resistance-testing review, and a regimen-revisit conversation with the infectious-disease physician. - **CD4 count**: at baseline and at 3 to 6 month intervals during the first one to two years. Less frequently in patients with sustained virologic suppression and CD4 above 350 cells per microlitre. - **Renal function**: serum creatinine and calculated creatinine clearance at baseline, at 3 to 6 months in the first year, then annually. Expected small rise in serum creatinine in the first weeks of therapy due to dolutegravir OCT2 inhibition (typically 10 to 15 percent) is benign and does not signal renal toxicity. A sustained decline beyond this expected pattern requires evaluation. - **Liver function tests**: AST, ALT, bilirubin at baseline and periodically; more frequent during the first three months of therapy. - **Fasting lipid panel**: at baseline and at 3 to 6 month intervals in the first year, then annually if stable. - **Weight, blood pressure, fasting glucose**: at baseline and at 3 to 6 month intervals in the first year, then annually. The dolutegravir weight-gain signal (typically 3 to 5 kg in the first year for INSTI regimens, with magnitude attributable to dolutegravir alone in a 2-drug regimen less well characterised but clinically meaningful) makes structured metabolic surveillance part of standard care. Dietary and physical-activity counselling at baseline. - **Mental health**: PHQ-9 and C-SSRS at baseline, at 4 to 6 weeks (mid-window check for dolutegravir-specific neuropsychiatric signal), 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. The screening conversation also addresses disclosure stress and adherence support needs. - **Adherence assessment**: self-reported adherence, pharmacy refill history, and viral load suppression are the three operational adherence anchors. Sustained suppression is the most reliable adherence indicator. The treating physician's clinical assessment at each visit is the operational discipline. - **Drug-interaction re-screen**: at each follow-up visit and any time a new medication or supplement is added. Polyvalent cation timing rules apply continuously. New rifamycin, anticonvulsant, or dofetilide prescription requires regimen review.

Religious, ethical, and family-logistics framing

Dovato is a small-molecule oral tablet. The ViiV Dovato 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, including lifelong chronic treatment for serious illness. Ramadan dosing is straightforward in principle: 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 across the day. The polyvalent-cation timing rule needs explicit conversation during Ramadan because meal-window compression makes antacid, calcium, and iron supplement timing relative to the Dovato dose narrower than during non-fasting months.

For pregnancy planning, dolutegravir-based regimens are now considered safe in pregnancy by WHO and US DHHS guidelines, with the 2018 Tsepamo neural-tube-defect signal attenuated by subsequent cohort data through 2020 and beyond. The treating physician will address pregnancy planning in the same shared-decision-making framework. Vertical-transmission prevention with maternal ART and infant prophylaxis is the standard-of-care framework.

The family-logistics burden of Dovato sits primarily in the chronicity, the adherence discipline, the polyvalent-cation timing rule, 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. Carrying a 30 to 90 day supply across international travel in original labelled packaging with a copy of the prescription is the recommended practice; for patients travelling for work or to visit family abroad, a referral letter from the prescribing infectious-disease physician can support continuity of care.

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 (HIV-1 RNA below the limit of detection on the standard quantitative assay for at least six months on stable ART) 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 Dovato therapy and is the foundation of treatment-as-prevention.

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. The UAE 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. Where indicated, the treating institution can refer to local legal counsel.

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. Clinical, factual, dignified.

When Dovato is not the right call

Dovato 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 (emtricitabine / tenofovir disoproxil fumarate) or Descovy (emtricitabine / tenofovir alafenamide) in a PrEP-specific pathway. Dovato is NOT a PrEP regimen. - Post-exposure prophylaxis (PEP) after potential HIV exposure within the last 72 hours. Use a PEP-specific triple-drug regimen initiated through an emergency-department or infectious-disease service. Dovato is NOT a PEP regimen. - Treatment-naive patients with HIV-1 RNA above 500,000 copies per millilitre. A 3-drug regimen (Biktarvy, Symtuza, Delstrigo, Triumeq) is appropriate for initial therapy at higher baseline viral load. - Patients with HBV co-infection. Dovato is INADEQUATE for HBV co-treatment because lamivudine monotherapy rapidly selects HBV-resistant variants. Use a tenofovir-containing regimen (Biktarvy, Symtuza, Delstrigo, Genvoya) so HBV is concurrently treated. - Patients with documented INSTI resistance or 3TC resistance (M184V/I). - Patients with estimated creatinine clearance below 50 millilitres per minute. Lamivudine dose adjustment cannot be achieved within the fixed-dose combination. - Patients requiring rifampin (contraindicated) or rifabutin without regimen adjustment, or strong anticonvulsants (oxcarbazepine, phenytoin, phenobarbital, carbamazepine), or St John's wort. - Patients requiring dofetilide. - Patients with significant hepatic impairment (Child-Pugh C); data are limited. - Patients with HIV-2 infection or dual HIV-1 / HIV-2 infection. HIV-2 typically managed with a 3-drug regimen and HIV-2-experienced infectious-disease specialist. - Paediatric patients. Dovato is not FDA-approved for paediatric use.

For HIV-1 in adults where Dovato is not the chosen regimen, the alternatives in 2026 include Biktarvy (3-drug INSTI-based STR widely preferred as first-line in major international guidelines), Symtuza (3-drug boosted-PI-based STR), Delstrigo (3-drug NNRTI-based STR), Triumeq (3-drug for HLA-B*5701-negative patients), Juluca (the other ViiV 2-drug regimen for switch only after stable suppression), Genvoya (elvitegravir-based 3-drug STR), and the long-acting injectable Cabenuva (cabotegravir + rilpivirine) for selected patients who prefer injection over oral therapy. The choice among regimens belongs to the treating infectious-disease physician and the patient.

Reserve Meds does not push a default. The page above describes the Dovato pathway because Dovato is the regimen the patient has asked about. If the conversation with the treating infectious-disease physician points toward Biktarvy, Symtuza, Delstrigo, 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 UAE Dovato case we build the documentation pack (prior HIV testing results where available, prior CD4 and viral load, prior antiretroviral-treatment history for switch patients, prior genotype, HBV serology, current medications including over-the-counter products and supplements, identification), submit first-visit booking requests to the chosen UAE infectious-disease service, coordinate the insurance pre-authorisation conversation where required, set up the first 30-day dispense at the chosen pharmacy 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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