

Dupixent

Bahrain · access guide

How to access Dupixent for atopic dermatitis, asthma, CRSwNP, EoE, prurigo nodularis, or COPD with eosinophilic phenotype from Bahrain: 2026 pathway via Salmaniya Medical Complex, BDF Hospital, King Hamad University Hospital, and Bahrain NHRA coordination | Reserve Meds

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

Bahrain operates a compact specialty network for the type 2 inflammation conditions where Dupixent is the prescriber's first-line biologic. Salmaniya Medical Complex (the national MOH referral hospital), Bahrain Defence Force Hospital, King Hamad University Hospital, Royal Bahrain Hospital, American Mission Hospital, and Bahrain Specialist Hospital all run dermatology, pulmonology, allergy, ENT, and gastroenterology services covering moderate-to-severe atopic dermatitis in adults and children, severe eosinophilic and oral-corticosteroid-dependent asthma in adults and children, chronic rhinosinusitis with nasal polyposis, eosinophilic esophagitis, prurigo nodularis, and chronic obstructive pulmonary disease with an eosinophilic phenotype. Complex paediatric subspecialty cases cross-border to KFSHRC Riyadh or HMC Doha when warranted. Dupixent (dupilumab, Regeneron and Sanofi) is the fully human IgG4 monoclonal antibody that blocks IL-4Ra and thereby suppresses both IL-4 and IL-13 type 2 cytokine signalling. Bahrain NHRA registration status is verified at intake; the European-import named-patient pathway covers Bahrain dispensing where local registration has not yet caught up with the latest FDA or EMA label.

This page leads with the atopic dermatitis pathway (the most common GCC entry point) and covers the other five approved indications with eligibility per indication. It is concierge documentation written for a family already in conversation with a treating specialist who wants the operational reality laid out plainly.

Why Dupixent, and why now

Dupixent is dupilumab, a fully human IgG4 monoclonal antibody developed jointly by Regeneron and Sanofi. The molecule binds IL-4Ra and blocks the downstream signalling of both IL-4 and IL-13, the two central cytokines of type 2 inflammation. Type 2 inflammation is the unifying mechanism across atopic dermatitis, eosinophilic asthma, CRSwNP, EoE, prurigo nodularis, and the eosinophilic phenotype of COPD.

FDA approval timeline: adult atopic dermatitis March 2017; adult and adolescent asthma October 2018; adolescent AD March 2019; CRSwNP June 2019; paediatric AD 6 to 11 years May 2020; paediatric asthma 6 to 11 years October 2021; AD 6 months to 5 years June 2022; EoE adult and adolescent May 2022; prurigo nodularis September 2022; EoE paediatric 1 to 11 years January 2024; COPD with eosinophilic phenotype September 2024; paediatric asthma 6 months to 5 years April 2025.

Reserve Meds does not promote one biologic over another. The competing type 2 inflammation biologic landscape in 2026 includes omalizumab (Xolair), mepolizumab (Nucala), reslizumab (Cinqair), benralizumab (Fasenra), tezepelumab (Tezspire), tralokinumab (Adbry), lebrikizumab (Ebglyss), and nemolizumab (Nemluvio). JAK inhibitor alternatives for adult AD: abrocitinib (Cibinqo), upadacitinib (Rinvoq).

What Dupixent is, in plain language

Dupixent is a subcutaneous injection given every 2 weeks for most adult indications, every 4 weeks for the lighter paediatric AD subsets, and weekly for EoE. After an initial training session at the prescribing physician's clinic or with a Sanofi nurse educator, most adult patients self-administer at home using the pre-filled pen or syringe. Caregivers administer for paediatric patients. Cold-chain storage at 2 to 8 degrees Celsius.

Adult atopic dermatitis dose: 600 mg load then 300 mg every 2 weeks. Adult asthma dose: 400 mg load then 200 mg every 2 weeks, or 600 mg load and 300 mg q2w for OCS-dependent or comorbid AD asthma. CRSwNP: 300 mg every 2 weeks. EoE: 300 mg once weekly (distinct cadence). Prurigo: 600 mg load then 300 mg every 2 weeks. COPD with eosinophilic phenotype: 300 mg every 2 weeks. Paediatric AD: weight-tiered (200 mg q4w for 5 to less than 15 kg; 300 mg q4w for 15 to less than 30 kg; 400 mg load then 200 mg q2w for 30 to less than 60 kg; adult regimen for 60 kg and above).

This is a chronic therapy taken for as long as it controls the disease.

Eligibility at a Bahrain specialist clinic

For Bahrain-resident patients, the prescribing specialties apply FDA and EMA criteria with local insurance and NHRA adaptation. Eligibility is indication-specific:

- 1. Atopic dermatitis (adult and paediatric 6 months and older):** dermatologist or paediatric dermatologist confirms moderate-to-severe disease by IGA, EASI, BSA, DLQI. Documented inadequate response to topical therapies.
- 2. Asthma (adult and paediatric 6 months and older):** pulmonologist or allergist (paediatric pulmonologist for younger patients) confirms moderate-to-severe asthma by GINA Step 4 or 5 with eosinophilic phenotype or OCS dependence.
- 3. CRSwNP (adult):** ENT confirms bilateral nasal polyposis with inadequate response to INCS plus systemic corticosteroid courses or sino-nasal surgery.
- 4. EoE (adult and paediatric 1 year and older, at least 15 kg):** gastroenterologist confirms by endoscopy with biopsy at least 15 eos per HPF after PPI trial.
- 5. Prurigo nodularis (adult):** dermatologist confirms multiple intensely pruritic nodules, chronic course at least 6 weeks.
- 6. COPD with eosinophilic phenotype (adult):** pulmonologist confirms COPD by post-bronchodilator spirometry, blood eosinophils at least 300, inadequate control on optimised triple inhaled therapy.

Shared baseline elements: treatment history with documented failure of (or contraindication to) appropriate prior therapy; CBC with eosinophil count, comprehensive metabolic panel, total IgE (informative); helminth screen for patients with epidemiologic risk; live vaccines not recommended during therapy; conjunctivitis history review for AD patients; pregnancy and lactation discussion.

A Bahrain patient should arrive at the biologic conversation with the most recent specialist documentation, complete treatment history, prior biologic trial documentation if any, baseline screening labs, vaccination record, and the insurance pre-authorisation paperwork.

The Bahrain prescribing and supply picture, plainly

Bahrain NHRA (National Health Regulatory Authority) governs the regulatory pathway. Dupixent registration status for adult AD and adult asthma is in place; newer indications and age subsets are at various registration stages. Where registration is complete, in-country pharmacy dispensing applies; where it has not caught up with the FDA or EMA label, named-patient European import covers the case. The pathway:

1. **Prescribing physician:** Salmaniya Medical Complex (MOH national referral, dermatology, pulmonology, allergy, ENT, gastroenterology, paediatrics), BDF Hospital (military and civilian), King Hamad University Hospital (university), Royal Bahrain Hospital, American Mission Hospital, Bahrain Specialist Hospital. Complex paediatric subspecialty cases cross-border to KFSHRC Riyadh or HMC Doha when warranted. 2. **Pharmacy dispensing:** hospital pharmacy or licensed community pharmacy with cold-chain handling. Dupixent requires 2 to 8 degree Celsius transport and storage. 3. **Insurance pre-authorisation:** MOH coverage at Salmaniya for nationals; commercial covers (BUPA Arabia, AXA, Cigna Bahrain, GIG, others) for residents. Dupixent pre-authorisation for adult AD and adult asthma is routine; newer indications and age subsets vary. 4. **Self-injection training:** at the prescribing physician's clinic or via Sanofi nurse educator visit. 5. **Ongoing monitoring:** specialty-specific follow-up at week 4, 12, and 16, then quarterly through year one. Conjunctivitis surveillance at every visit for AD patients. Eosinophil count at baseline and periodically.

The 2026 pathway, step by step

Week 0 to 1: documentation pack assembled with the treating specialist's office.

Week 1 to 4: insurance pre-authorisation review.

Week 4 to 6: first dispensing. Indication-specific loading dose and self-injection training.

Week 4 onwards: patient (or caregiver) self-injects at home per the indication-specific schedule.

Week 4 to 16: loading-phase completion and early-response assessment.

Week 16 onwards: response assessment. Maintenance dosing for responders.

Cost band and insurance positioning

US WAC list price for Dupixent 300 mg is approximately USD 3,800 to 4,300 per device. The every-2-week adult regimen at list is approximately USD 91,000 to 103,000 per year. The weekly EoE regimen lands materially higher; paediatric q4w regimens land lower.

At 2026 indicative cross rates, the BHD-equivalent annual cost band for the every-2-week adult 300 mg regimen is approximately BHD 34,200 to 39,400 at list price. Paediatric q4w regimens land lower. The weekly EoE regimen lands materially higher. Pre-authorisation reduces out-of-pocket exposure substantially.

What to expect on Dupixent, by indication

Atopic dermatitis: EASI-75 in approximately 50 percent and IGA 0 or 1 in approximately 38 percent at week 16 in adult monotherapy trials; higher with TCS. Itch reduction often within 2 to 4 weeks.

Asthma: approximately 46 to 47 percent reduction in annualised severe exacerbation rate in QUEST. OCS-dependent patients: median 70 percent OCS dose reduction; 48 percent achieve complete OCS discontinuation in VENTURE.

CRSwNP: nasal polyp score reduction by approximately 2 points at week 24. Time to first sino-nasal surgery extended.

EoE: histologic remission at week 24 in approximately 60 percent on weekly dupilumab.

Prurigo nodularis: at least 4-point Worst Itch NRS reduction at week 24 in approximately 60 percent.

COPD with eosinophilic phenotype: approximately 30 to 34 percent annualised reduction in moderate or severe exacerbations.

Other approved indications, eligibility summary

- **Asthma (adult and paediatric 6 months and older)**: moderate-to-severe with eosinophilic phenotype or OCS dependence. Pulmonology or allergy. - **CRSwNP (adult)**: bilateral polyposis, inadequate response to INCS and OCS courses or surgery. ENT. - **EoE (1 year and older, at least 15 kg)**: endoscopy and biopsy at least 15 eos per HPF after PPI trial. Weekly dosing. Gastroenterology. - **Prurigo nodularis (adult)**: chronic intensely pruritic nodules. Dermatology. - **COPD with eosinophilic phenotype (adult)**: COPD plus blood eosinophils at least 300 plus inadequate control on optimised triple inhaled therapy. Pulmonology.

What to monitor

Conjunctivitis is the most distinctive Dupixent monitoring item, especially for AD patients (approximately 10 to 20 percent incidence). Ophthalmology referral at first sign that does not resolve in 48 hours.

Eosinophil count at baseline and periodically. Transient eosinophilia common and usually benign.

Injection-site reactions, oral herpes (HSV reactivation), and other common AEs usually managed without therapy interruption.

Helminth surveillance for patients with epidemiologic exposure.

Hypersensitivity including rare anaphylaxis: stop therapy if it occurs.

Live vaccines avoided during therapy.

Long-term safety: 7-plus years post-marketing, reassuring profile.

Religious, ethical, and family-logistics framing

Dupixent is a fully human IgG4 monoclonal antibody produced in CHO cell culture. No donor element, no human or animal source material in the active ingredient. The classical analogy to vaccines and other recombinant biologics holds in Bahrain Islamic medical ethics.

Self-injection at home is the standard; clinic-administered dispensing is available for families who prefer it.

Cold-chain storage in the Bahrain summer climate: home refrigerator placement, insulated cold-chain bag for travel, 14-day room-temperature allowance in the original unopened carton.

Severe AD in a child, severe asthma in a child, EoE in a child, and CRSwNP in an adult carry meaningful family-burden and quality-of-life dimensions. The clinical conversation addresses these dimensions.

Dupilumab itself has no CNS or mood signal.

Ramadan considerations: q2w and q4w regimens unaffected by fasting. EoE weekly patients plan injection timing around meal schedule.

Hajj and Umrah travel: meningococcal conjugate (inactivated) permitted and recommended.

When Dupixent is the wrong drug

- Acute asthma exacerbation: standard rescue therapy. - Asthma without eosinophilic phenotype and without OCS dependence: tezepelumab covers patients across asthma phenotypes who do not fit the eosinophilic profile. - CRSwNP responding adequately to INCS alone: Dupixent is for inadequate response. - EoE responding adequately to PPI or dietary elimination: Dupixent is for inadequate response. - COPD without eosinophilic phenotype: does not benefit. - Active helminth infection: treat before initiation. - Hypersensitivity to dupilumab or excipients: contraindicated. - Active serious infection: defer. - Need for live vaccination in the near term: complete the vaccination then initiate. - Severe conjunctivitis history with poor ophthalmology support: ophthalmology co-management plan first. - Pregnancy: limited data; individualised decision.

Alternatives: omalizumab, mepolizumab, reslizumab, benralizumab, tezepelumab, tralokinumab, lebrikizumab, nemolizumab; JAK inhibitor alternatives for adult AD: abrocitinib, upadacitinib.

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 Dupixent case we build the documentation pack with the treating specialist office, confirm Bahrain NHRA registration status per indication and per age subset, run the insurance pre-authorisation conversation alongside the clinical conversation, coordinate the cold-chain supply logistics for ongoing maintenance dispensing, organise self-injection training and the baseline screening, set up the ophthalmology co-management plan for AD patients where indicated, and stay with the case through the first year of dosing with handoff to the local prescriber for ongoing surveillance. Clinical decisions remain with your treating specialist.

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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reserved for you.

Composite case examples. This document is for general information only and does not constitute medical advice. Please consult your treating physician.

Reserve Meds is in pre-launch. Published timelines and cost ranges are indicative, not guarantees.

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