Ebglyss

United Arab Emirates · access guide

How to access Ebglyss for moderate-to-severe atopic dermatitis in adults and adolescents 12 and older from the UAE: 2026 pathway via UAE dermatology services, named-patient European or US import, and pharmacy supply | Reserve Meds

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

The United Arab Emirates operates one of the most mature dermatology service networks in the wider region for moderate-to-severe atopic dermatitis. Cleveland Clinic Abu Dhabi (dermatology and paediatric dermatology), Sheikh Shakhbout Medical City (SSMC), Sheikh Khalifa Medical City (SKMC), Tawam Hospital, Burjeel Medical City, Mediclinic City Hospital, Mediclinic Parkview Hospital, American Hospital Dubai, NMC Specialty, the Aster Hospitals network, Saudi German Hospital Dubai, Dr Sulaiman Al Habib Dubai, Magrabi Dermatology, and Rashid Hospital Dubai all run dermatology programmes covering moderate-to-severe atopic dermatitis in adults and adolescents. Ebglyss (lebrikizumab-lbkz, Eli Lilly and Company) is the humanized IgG4 monoclonal antibody that binds soluble interleukin-13 (IL-13) with high affinity and blocks IL-13 receptor signalling. FDA approval landed in September 2024 for moderate-to-severe atopic dermatitis in adults and adolescents 12 years and older weighing at least 40 kg. UAE EDE (Emirates Drug Establishment) registration for Ebglyss is in early rollout; most UAE patients in 2026 access Ebglyss via the named-patient European or US import pathway while in-country registration catches up. For a UAE-resident patient whose moderate-to-severe atopic dermatitis has plateaued on conventional topical therapy or who has had inadequate response or tolerability issues on a prior biologic, the operational question in 2026 is whether Ebglyss is the right fit, how the prescription is sourced and dispensed under the import pathway, what insurance will cover, what pre-treatment screening looks like, and how the family handles the every-2-week induction-and-loading routine that transitions to every-4-week maintenance dosing in responders at week 16.

This page explains how the pathway works in 2026 for a UAE-resident patient. It is concierge documentation written for a family already in conversation with a treating dermatologist who wants the operational reality laid out plainly. It includes an explicit vs-Dupixent positioning section because Dupixent is the other established biologic option for moderate-to-severe atopic dermatitis and the most common comparator question we field.

Why Ebglyss, and why now

Ebglyss is lebrikizumab, a humanized IgG4 monoclonal antibody originally developed by Genentech and Roche, in-licensed by Dermira, and now held by Eli Lilly and Company following the 2020 Lilly acquisition of Dermira. The molecule binds soluble IL-13 with high affinity. By sequestering IL-13, lebrikizumab blocks the formation of the IL-13Ra1 / IL-4Ra heterodimer signalling complex on target cells. Lebrikizumab does NOT bind IL-4 and does NOT block IL-4 signalling through the type I IL-4 receptor. This is the central mechanistic distinction versus Dupixent (dupilumab), which targets IL-4Ra directly and thereby blocks signalling of both IL-4 (type I and type II IL-4 receptors) and IL-13 (type II receptor).

IL-13 is the dominant cytokine driving epidermal barrier dysfunction, keratinocyte proliferation, and the Th2 inflammatory cascade in atopic dermatitis. By selectively blocking IL-13 signalling, lebrikizumab dampens the chronic itch and inflammation cycle that defines moderate-to-severe atopic dermatitis. Itch reduction is often noticeable within 2 weeks. EASI-75 response is achieved in approximately 50 to 60 percent of patients by week 16 in monotherapy pivotal trials, and in approximately 70 percent at week 16 in combination with topical corticosteroids.

FDA approval September 2024. EMA approval November 2023 (the European approval led the FDA approval). UAE EDE registration is in early rollout. The September 2024 FDA approval places Ebglyss in the **less-than-24-month NPP-pathway-primary** framing window for the UAE in 2026: the named-patient European or US import pathway is the primary access mechanism, with domestic-registration framing as the secondary scenario where the UAE EDE registration has progressed.

Reserve Meds does not promote one biologic over another. The competing class includes Dupixent (dupilumab, anti-IL-4Ra), Adbry (tralokinumab, anti-IL-13 for adult AD), Cibinqo (abrocitinib JAK1), Rinvoq (upadacitinib JAK1), and Nemluvio (nemolizumab, anti-IL-31Ra for prurigo nodularis and AD). The JAK inhibitor class carries a class black-box warning. Choice across these alternatives is the central clinical decision and sits with the treating dermatologist.

What Ebglyss is, in plain language

Ebglyss is a subcutaneous injection. It is not an infusion and does not require a hospital infusion suite. After an initial training session at the prescribing dermatologist's clinic or with a Lilly-coordinated nurse educator, most adult patients self-administer at home using the Ebglyss pre-filled pen (auto-injector) or pre-filled syringe at 250 mg per device. Adolescent patients (12 years and older, at least 40 kg) self-administer after training or are administered by a caregiver. The drug requires cold-chain storage at 2 to 8 degrees Celsius; the carton is stable at room temperature for up to 7 days unopened (a shorter room-temperature window than Dupixent at 14 days; the family logistics conversation reflects this).

The dosing schedule:

- **Week 0**: 500 mg loading dose (two 250 mg injections at separate sites at the same visit). - **Week 2**: 500 mg (two 250 mg injections). - **Week 4, 6, 8, 10, 12, 14**: 250 mg every 2 weeks. - **Week 16 response assessment**: responders (IGA 0 or 1 with at least 2-point reduction, or other meaningful clinical response) transition to **250 mg every 4 weeks** maintenance dosing. Partial responders or non-responders continue **250 mg every 2 weeks** through week 24 and reassess.

The transition from q2w induction-and-loading to q4w maintenance in responders is a dosing-frequency distinction versus Dupixent (q2w throughout for adult AD). For a responder, the maintenance phase delivers 13 injections per year (q4w) rather than 26 (q2w). The family-logistics implications of this difference are part of the pre-initiation conversation.

This is not a short-course therapy. Ebglyss is taken for as long as it controls the disease. Patients who achieve a meaningful response typically stay on therapy for years.

Eligibility at a UAE dermatology clinic

For UAE-resident patients, the prescribing dermatologist applies FDA and EMA criteria with local insurance adaptation:

1. **Moderate-to-severe atopic dermatitis** confirmed by IGA, EASI, BSA, and DLQI (or POEM in adolescents). Documented inadequate response to topical prescription therapies (medium-to-high-potency topical corticosteroids, calcineurin inhibitors, crisaborole, ruxolitinib topical) or contraindication to those. 2. **Age 12 years or older**. 3. **Body weight at least 40 kg**. Patients under 40 kg are not eligible for the current Ebglyss label; younger paediatric patients with moderate-to-severe AD are referred toward Dupixent (FDA-approved down to 6 months) or the JAK inhibitor class (abrocitinib in adolescents 12 and older, upadacitinib in adolescents 12 and older). 4. **Treatment history**. Documented prior failure of (or contraindication to) appropriate topical prescription therapy. Many UAE commercial insurers also require documented prior systemic therapy trial (oral corticosteroid courses, cyclosporine, methotrexate) or prior biologic / JAK inhibitor trial before approving a switch to Ebglyss. 5. **Baseline laboratory panel**. CBC with eosinophil count (baseline; transient eosinophilia is common on therapy and usually benign), comprehensive metabolic panel, baseline immunoglobulin profile including total IgE (informative not gating), pregnancy test for women of reproductive potential. 6. **Helminth infection screen** for patients with epidemiologic risk or symptoms. Treat any pre-existing helminth infection before initiating Ebglyss. IL-13 blockade may impair host response. 7. **Active serious infection** is a reason to defer initiation until resolved. 8. **Vaccination status review**. Live vaccines (varicella, MMR, yellow fever, oral polio, BCG) not recommended during Ebglyss therapy. Catch-up live vaccinations before initiation where feasible. Inactivated vaccines (annual influenza, pneumococcal, COVID-19, meningococcal conjugate for Hajj or Umrah travel) are permitted and recommended. 9. **Conjunctivitis history review**. Approximately 7 percent of patients develop conjunctivitis on Ebglyss in pivotal trials (lower than the approximately 10 to 20 percent rate reported with Dupixent, but not zero). Patients with a history of conjunctivitis or active conjunctivitis at baseline have a higher risk; this informs counselling and the ophthalmology co-management plan. 10. **Pregnancy and lactation discussion** for women of reproductive potential.

A UAE patient should arrive at the biologic conversation with the most recent dermatology documentation (current EASI, IGA, BSA, DLQI scores; photographs of involved skin; complete treatment history including topical, systemic, and any prior biologic or JAK inhibitor trial), baseline screening labs, helminth and TB screening history where indicated, vaccination record, and insurance pre-authorisation paperwork.

The UAE prescribing and supply picture, plainly

UAE EDE (the federal-level drug regulator) registration status for Ebglyss is verified at intake. As a September 2024 FDA approval, Ebglyss is in early UAE EDE registration rollout in 2026. The pathway:

1. **Prescribing physician**: a board-certified UAE dermatologist or paediatric dermatologist. Major UAE prescribing centres include Cleveland Clinic Abu Dhabi, SSMC, SKMC, Tawam, Burjeel Medical City, Mediclinic City and Parkview, American Hospital Dubai, NMC Specialty, Aster, Saudi German Hospital Dubai, Dr Sulaiman Al Habib Dubai, Magrabi Dermatology, and Rashid Hospital Dubai. DHA-licensed prescribers handle the Dubai side; DoH-licensed prescribers handle Abu Dhabi. 2. **Pharmacy dispensing**: - **Where in-country registration has progressed**: hospital outpatient pharmacy or licensed community pharmacy with cold-chain handling. Ebglyss pre-filled pens and syringes require 2 to 8 degree Celsius transport and storage. - **Where in-country registration has not progressed (the majority case in 2026)**: named-patient European or US import pathway. The treating dermatologist's office documents the clinical case; the import is processed under UAE EDE named-patient framework. The supply lands at the prescribing hospital outpatient pharmacy under cold-chain handling. 3. **Insurance pre-authorisation**: Daman, Thiqa for Emirati nationals, AXA, Bupa Global, MetLife, Oman Insurance, Cigna, and the other major UAE commercial insurers handle Ebglyss pre-authorisation case-by-case in 2026. Coverage patterns vary because of the recency of FDA approval; pre-authorisation paperwork commonly requires documented severity, documented prior topical and possibly systemic therapy failure, and prior biologic or JAK inhibitor trial documentation in some cases. Patients on the named-patient import pathway should expect additional pre-authorisation discussion around import costs and supply continuity. 4. **Self-injection training**: typically a single supervised session at the prescribing dermatologist's clinic or via a Lilly-coordinated nurse educator visit. Most adult patients are comfortable with self-injection after 1 to 2 sessions. Adolescents 12 and older self-administer after training, or are administered by a caregiver. Patients who prefer clinic-administered dispensing can request that pathway. 5. **Ongoing monitoring**: dermatology follow-up at week 4, week 12, and week 16 (for the response-assessment visit that determines transition to q4w maintenance versus continued q2w). Quarterly follow-up through year one for stable responders, less frequent thereafter. Conjunctivitis surveillance at every visit. Eosinophil count at baseline and periodically.

The 2026 pathway, step by step

Week 0 to 1: Reserve Meds builds the documentation pack with the treating dermatologist's office. We collect current EASI, IGA, BSA, DLQI scores, photographs of involved skin, complete treatment history (topical, systemic, prior biologic or JAK inhibitor trial), baseline screening labs, helminth screen where indicated, vaccination record, and insurance card details. The prescribing office submits insurance pre-authorisation and, where applicable, initiates the named-patient import paperwork.

Week 1 to 6: Insurance pre-authorisation review. Named-patient European or US import processing if applicable. UAE commercial insurers typically turn pre-authorisation for a recent biologic around in 4 to 6 weeks given the documentation complexity.

Week 6 to 8: First dispensing at the prescribing dermatologist's clinic or partner pharmacy. The 500 mg loading dose (two 250 mg injections at separate sites at the same visit) and the self-injection training session are completed. Patient takes home the next-dose pens or syringes for the week 2 visit.

Week 2 of therapy: second 500 mg loading dose.

Week 4 through week 14: 250 mg q2w. Reserve Meds coordinates cold-chain delivery of the next month's supply.

Week 16: dermatology visit for response assessment. IGA 0 or 1 with at least 2-point reduction (or other meaningful clinical response) means responder status; patient transitions to **250 mg q4w** maintenance dosing. Less than IGA 0 or 1 means continue **250 mg q2w** through week 24; reassess at week 24.

Week 24 and beyond: responders continue q4w maintenance dosing. Reserve Meds coordinates ongoing cold-chain supply. Quarterly dermatology follow-up through year one; less frequent thereafter for stable responders. Patients with inadequate response by week 24 may switch within the type 2 inflammation biologic class, to a JAK inhibitor, or back to systemic therapy under specialist supervision.

Cost band and insurance positioning

US WAC list price for Ebglyss in 2026 is approximately USD 3,400 per 250 mg pre-filled pen or syringe. The induction-and-loading phase (week 0 through week 14, covering both 500 mg loading doses and six q2w 250 mg doses, total 10 injections) is approximately USD 34,000 at list. The q4w maintenance phase for responders is approximately USD 44,000 per year at list (13 doses per year). Patients who continue on q2w long-term land at approximately USD 88,000 per year at list; most either respond by week 24 and transition to q4w or switch therapy.

At 2026 indicative cross rates, the AED-equivalent annual cost band for the q4w maintenance responder regimen is approximately **AED 145,000 to 200,000** at list price. The induction-and-loading phase adds approximately AED 125,000 to 150,000 at list in the first year. UAE commercial insurance pre-authorisation reduces out-of-pocket exposure substantially for covered patients. The annual q4w maintenance cost band is roughly one-half of the Dupixent every-2-week adult regimen on an annual basis; this is the primary financial framing distinction between the two drugs.

For Emirati nationals with Thiqa coverage, the financial pre-authorisation conversation needs to start before the first dispensing. Daman, AXA, Bupa Global, MetLife, Oman Insurance, Cigna, and other commercial covers vary; the prescribing dermatologist's office is the gating step on pre-authorisation logistics.

What to expect on Ebglyss

Itch reduction is often noticeable within the first 2 weeks. EASI-50 in roughly half of patients by week 4. At week 16 in monotherapy pivotal trials (ADvocate-1 and ADvocate-2), EASI-75 is achieved in approximately 50 to 60 percent of patients, IGA 0 or 1 with at least 2-point reduction in approximately 33 to 43 percent. In combination with topical corticosteroids (ADhere), EASI-75 at week 16 is approximately 70 percent and IGA 0 or 1 with at least 2-point reduction approximately 41 percent. Sleep quality and DLQI improvement usually parallel EASI improvement.

The week 16 response-assessment visit determines transition to q4w maintenance versus continued q2w. Responders on q4w maintenance maintained EASI-75 in approximately 80 percent of patients through week 52 in the ADvocate extension data. Patients re-randomised to placebo at week 16 lost response within several weeks; this is a chronic-therapy pattern shared across the type 2 inflammation biologic class.

The first 4 to 16 weeks are the highest-vigilance window for response assessment and for conjunctivitis surveillance. Patients not responding by week 16 continue q2w through week 24 with reassessment; the prescribing dermatologist may extend the response window further, switch within the type 2 inflammation biologic class (to Dupixent or Adbry), switch to a JAK inhibitor (abrocitinib, upadacitinib), or return to systemic therapy as appropriate.

What to monitor

The most clinically distinctive Ebglyss monitoring item is **conjunctivitis**, though at a lower rate than reported with Dupixent. Approximately 7 percent of patients develop conjunctivitis on Ebglyss in pivotal trials, versus approximately 10 to 20 percent with Dupixent. The presentation is typically bilateral red eye, itch, tearing, occasional photophobia. Most cases are mild to moderate and respond to lubricants, lid hygiene, and topical corticosteroid drops under ophthalmology supervision. Ophthalmology referral at first sign that does not resolve within 48 hours. Patients with a history of conjunctivitis or with active conjunctivitis at baseline have an ophthalmology co-management plan in place from the start.

Eosinophil count at baseline and periodically. Transient eosinophilia is common on Ebglyss (typically returns to baseline within several months) and is generally benign. Sustained eosinophilia with new respiratory or systemic features prompts evaluation.

Injection-site reactions: typically mild redness, swelling, or pain at the injection site; usually transient. Site rotation reduces incidence.

Helminth surveillance for patients with epidemiologic exposure. IL-13 blockade may impair host response.

Hypersensitivity including rare anaphylaxis: stop therapy if it occurs.

Live vaccines should be avoided during therapy.

Long-term safety data is now approximately 2 years post-FDA-approval. The profile has remained reassuring: no opportunistic infection signal, no malignancy signal, no class black-box warning. The Dupixent safety dataset is larger (7-plus years post-marketing), but the Ebglyss profile through the pivotal trial extensions and post-marketing experience is consistent with the dupilumab-class expectation.

Ebglyss versus Dupixent

Both Ebglyss and Dupixent are appropriate first-line biologics for moderate-to-severe atopic dermatitis in adults and adolescents 12 years and older. Reserve Meds does not promote one over the other. The prescribing dermatologist's choice sits on several axes:

- **Mechanism**: Ebglyss is IL-13 selective; Dupixent is IL-4Ra targeting and blocks both IL-4 and IL-13 signalling. Patients with inadequate response or tolerability issues on one mechanism may benefit from a switch to the other. - **Indication breadth**: Dupixent carries six FDA-approved indications across five prescribing disciplines (dermatology, pulmonology, allergy, ENT, gastroenterology); Ebglyss is dermatology-only for atopic dermatitis. For patients with comorbid type 2 inflammation conditions (the atopic march: AD plus allergic asthma plus CRSwNP plus EoE), Dupixent may treat multiple conditions simultaneously. - **Age range**: Dupixent is approved down to 6 months for AD; Ebglyss is approved for 12 years and older weighing at least 40 kg. Younger paediatric patients require Dupixent. - **Conjunctivitis rate**: approximately 7 percent on Ebglyss versus approximately 10 to 20 percent reported with Dupixent in AD trials. A patient with significant prior Dupixent-associated conjunctivitis may be a candidate for a switch to Ebglyss. - **Maintenance dosing frequency**: Ebglyss responders transition to q4w from week 16; Dupixent adult AD remains q2w throughout. The q4w maintenance has annual-cost and family-logistics advantages. - **Cost band**: Ebglyss q4w maintenance is roughly half the annual list price of Dupixent q2w adult AD on a per-year basis. - **Long-term safety dataset**: Dupixent has 7-plus years post-marketing; Ebglyss has approximately 2 years post-FDA-approval. Both profiles are reassuring. - **GCC access pathway**: Dupixent broadly registered for adult AD since 2018 with smooth local commercial supply; Ebglyss in early GCC registration rollout, most 2026 patients access via named-patient European or US import.

The clinical decision sits with the treating dermatologist based on response history, conjunctivitis tolerance, dosing-frequency preference, and access. Reserve Meds documents the pathway for the drug the patient has asked about.

Religious, ethical, and family-logistics framing

Ebglyss is a humanized IgG4 monoclonal antibody produced in mammalian cell culture. There is no donor element, no human or animal source material in the active ingredient, and no foreign genetic content delivered to the patient. The classical analogy to vaccines and other recombinant biologics holds in UAE Islamic medical ethics, where biologics produced in this manner are generally treated as permissive with the standard expectation that the family decides in consultation with the treating dermatologist. Excipient sourcing varies by manufacturer batch; patients with specific halal-certification requirements should ask the dispensing pharmacy to confirm excipient sourcing for the current lot.

The self-injection element is the practical pressure point for some UAE families. Adolescents 12 and older typically self-administer after training; caregivers can administer if preferred. Patients or family members who are uncomfortable with home injection can request clinic-administered dispensing, though this adds friction and clinic visits. Most UAE patients are comfortable with self-injection after the initial training; the injection is subcutaneous and the pen is straightforward to use.

The cold-chain storage requirement is operationally important in the UAE summer climate. Patient counselling on home refrigerator placement (not in the door, not adjacent to the freezer compartment), travel handling (insulated cold-chain bag with a cold pack), and the 7-day room-temperature allowance in the original unopened carton is part of standard patient education. The Ebglyss 7-day room-temperature window is shorter than Dupixent's 14-day window; the family travel-logistics conversation reflects this.

Moderate-to-severe atopic dermatitis in an adolescent and adult carries meaningful **psychosocial-burden dimensions**. The chronic-disease burden includes sleep disturbance from chronic itch, school or work absenteeism, body-image concerns (visible skin lesions, lichenification, pigmentation changes), social withdrawal, anxiety, and depression in patients and parents. The clinical conversation appropriately addresses these dimensions and includes referral to behavioural health support where indicated. Lebrikizumab itself has no CNS or mood signal; the psychosocial burden is from the underlying chronic atopic dermatitis, and the response to treatment generally improves these dimensions in parallel with the skin response.

Ramadan considerations: the every-2-week induction-and-loading regimen and the every-4-week maintenance regimen are unaffected by Ramadan fasting; the injection schedule fits around the fasting day.

Vaccination during therapy: live vaccines (varicella, MMR, yellow fever, oral polio, BCG) are not recommended during Ebglyss. Inactivated vaccines (annual influenza, pneumococcal, COVID-19, meningococcal conjugate for Hajj or Umrah travel) are permitted and recommended.

When Ebglyss is the wrong drug

For a UAE patient with the following clinical profiles, the operational pathway shifts:

- **Age under 12 or weight under 40 kg**: not eligible for Ebglyss. Younger paediatric patients with moderate-to-severe AD are referred toward Dupixent (FDA-approved down to 6 months for AD). - **Mild atopic dermatitis**: Ebglyss is indicated for moderate-to-severe disease with documented inadequate response to topical therapies. Mild disease is managed with topical therapy alone. - **Atopic dermatitis with active conjunctivitis and poor ophthalmology access**: not a contraindication but a friction point. Ophthalmology co-management plan before initiation. - **Active helminth infection**: treat the helminth before initiation. IL-13 blockade may impair host response. - **Hypersensitivity to lebrikizumab or excipients**: contraindicated. Severe hypersensitivity including anaphylaxis is rare but reported. - **Active serious infection**: defer initiation until resolved. - **Need for live vaccination in the near term**: complete the live vaccination then initiate Ebglyss with an appropriate interval. - **Pregnancy**: not contraindicated per se but limited human data; the decision is individualised with the treating dermatologist. - **Need for treatment of comorbid type 2 inflammation conditions**: Ebglyss is dermatology-only for AD. A patient with comorbid moderate-to-severe asthma, CRSwNP, EoE, prurigo nodularis, or COPD with eosinophilic phenotype may benefit more from Dupixent (six FDA-approved indications).

Alternative biologics for adult and adolescent moderate-to-severe AD: dupilumab (Dupixent, anti-IL-4Ra; 6 months and older), tralokinumab (Adbry, anti-IL-13; adult only), nemolizumab (Nemluvio, anti-IL-31Ra; adult AD and prurigo nodularis). JAK inhibitor alternatives: abrocitinib (Cibinqo, JAK1; 12 and older), upadacitinib (Rinvoq, JAK1; 12 and older). The JAK inhibitor class carries a class black-box warning for serious infections, malignancy, MACE, thrombosis, and mortality; this is a deliberate consideration in the prescribing conversation.

Reserve Meds does not promote one biologic over another, and does not push a default biologic class. If the conversation with the treating dermatologist points toward a different biologic or a JAK inhibitor or continued systemic therapy, the operational pathway shifts accordingly.

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 UAE Ebglyss case we build the documentation pack with the treating dermatologist's office, confirm UAE EDE registration status for Ebglyss (and the appropriate dispensing pathway, including named-patient European or US import where required), 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 the prescribing office requires, set up the ophthalmology co-management plan 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 dermatologist.

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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