Elahere

Qatar · access guide

How to access Elahere for FRα-positive platinum-resistant ovarian cancer from Qatar: 2026 pathway via NCCCR Hamad Medical Corporation or cross-border named-patient supply

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

Elahere (mirvetuximab soravtansine-gynx) is the first antibody-drug conjugate approved for platinum-resistant ovarian cancer and the first folate receptor alpha (FRα)-directed therapy approved for any indication. AbbVie acquired ImmunoGen for USD 10.1 billion in February 2024 primarily to bring this drug into its oncology portfolio. The FDA converted the November 2022 accelerated approval to full traditional approval in March 2024 based on the MIRASOL Phase 3 randomised trial, which demonstrated a statistically significant overall survival benefit (median 16.46 months vs 12.75 months on investigator-choice chemotherapy). For a Qatar-resident adult woman with platinum-resistant epithelial ovarian, fallopian tube, or primary peritoneal cancer whose tumor pathology shows FRα-positive expression at the labelled threshold, Elahere is the first targeted therapy with overall survival benefit in a setting historically defined by 12 to 14 month median survival.

This page explains how the pathway works in 2026 for a Qatar-resident adult: the FRα biomarker gate, eligibility, the operational fact that the in-country adult oncology reference is NCCCR (National Center for Cancer Care and Research) at Hamad Medical Corporation in Doha, the every-3-week IV schedule with boxed-warning ocular toxicity protocol, the named-patient supply pathway where SFDA-equivalent MOPH registration is still in progress, cost expectation in QAR, and the psychosocial dimensions.

Sidra Medicine Doha is the paediatric reference centre for Qatar; ovarian cancer is an adult disease and Sidra is NOT a relevant centre for Elahere.

Why Elahere, and why the FRα biomarker comes first

Elahere is a humanised IgG1 kappa monoclonal antibody (mirvetuximab) targeting folate receptor alpha, conjugated via a cleavable disulfide linker to the maytansinoid microtubule inhibitor payload DM4, with a drug-antibody ratio of approximately 3.4. The mechanism is FRα-mediated tumor cell internalisation, intracellular DM4 release, microtubule disruption, mitotic arrest, and apoptosis.

Folate receptor alpha is highly expressed on approximately 35 to 40 percent of epithelial ovarian cancers at the high-expression threshold (PS2+ staining in at least 75 percent of viable tumor cells by FDA-approved companion diagnostic) that defines Elahere eligibility. The biomarker is the gate. Without a confirmed FRα-positive tumor by the Roche VENTANA FOLR1 (FOLR1-2.1) RxDx Assay or an equivalent validated IHC method, Elahere is not indicated.

For a Qatar patient the operational order is: (1) the treating gynae-oncologist or medical oncologist at NCCCR confirms platinum-resistant disease and 1 to 3 prior systemic lines; (2) pathology runs FOLR1 IHC on the most recent representative tumor block (NCCCR/Hamad pathology FOLR1 capability VERIFY at intake; cross-border to KFSHRC Riyadh, KAMC, or Cleveland Clinic Abu Dhabi where in-country capability is not yet established); (3) ONLY IF FRα-positive at the threshold does eligibility proceed; (4) if FRα-negative or FRα-low, pivot to standard platinum-resistant chemotherapy, bevacizumab combinations, PARP inhibitor maintenance, or clinical trial enrolment.

What Elahere is, in plain language

Elahere is an intravenous infusion every 3 weeks at 6 mg/kg adjusted ideal body weight. First infusion runs over 1 hour; subsequent infusions over 30 minutes if tolerated. Premedications before each infusion: corticosteroid (dexamethasone 10 mg IV), antihistamine (diphenhydramine 25 to 50 mg IV), antipyretic (paracetamol 650 to 1000 mg orally), anti-emetic per protocol. Ophthalmic supportive regimen around every infusion: prednisolone acetate 1 percent drops 6 times daily for the day before, day of, and 4 days after infusion; lubricating preservative-free artificial tears at least 4 times daily continuously through the course; cycloplegic drops if pre-existing dry eye. Treatment continues until disease progression or unacceptable toxicity.

Eligibility at an NCCCR or private-network gynae-oncologist clinic in Qatar

1. Confirmed platinum-resistant epithelial ovarian, fallopian tube, or primary peritoneal cancer (progression within 6 months of last platinum, per GCIG). 2. One to three prior systemic regimens. 3. FRα-positive tumor: at least 75 percent PS2+ on FOLR1 IHC. Load-bearing gate. 4. ECOG 0 or 1 (ECOG 2 case by case). 5. Adequate marrow, liver, renal function per labelled cutoffs. 6. No active ocular disease; pre-existing dry eye or mild prior keratopathy requires baseline ophthalmology and tailored supportive regimen. 7. No grade 3 or higher peripheral neuropathy at baseline. 8. Pregnancy excluded; effective contraception during treatment and for 7 months after last dose.

A Qatar patient should arrive with original pathology report, current imaging, CA-125 trend, complete prior treatment history with response durations, current labs, baseline ophthalmology examination, and a representative tumor block released for FOLR1 IHC.

The Qatar administration picture, plainly

The Qatar adult gynae-oncology and medical oncology reference centre is the National Center for Cancer Care and Research (NCCCR) at Hamad Medical Corporation in Doha. NCCCR has the gynae-oncology, medical oncology, and pathology infrastructure to run Elahere with the standard ADC supportive footprint. Pathology FOLR1 IHC capability development VERIFY at intake; cross-border specimen referral to KFSHRC Riyadh or Cleveland Clinic Abu Dhabi is the operational fallback if in-country capability is not yet established.

Private-network adult oncology services in Doha (Al Ahli Hospital, Doha Clinic Hospital) provide ambulatory medical oncology and can coordinate referrals into NCCCR for the more complex ADC-administration workflow.

Sidra Medicine Doha is paediatric-only and EXCLUDED from Elahere consideration; ovarian cancer is an adult disease and Sidra does not run adult oncology services.

Qatar MOPH is the regulator. AbbVie regional commercial coordination via the Middle East office. Elahere is within the 24-month post-FDA-full-approval window; Qatar MOPH registration status VERIFY at intake. Where domestic registration is in progress, the named-patient programme via NCCCR's pharmacy and the MOPH single-patient import authorisation is the operational supply pathway.

For ophthalmology partnership on the every-2-cycle monitoring rhythm, NCCCR works with Hamad Eye Hospital and the wider Hamad ophthalmology service.

The 2026 pathway, step by step

Week 0 to 2: Reserve Meds assembles the document pack with the treating oncologist at NCCCR or with a private-network gynae-oncologist coordinating into NCCCR.

Week 2 to 4: FOLR1 IHC on the tumor block (in-house at NCCCR/Hamad pathology if available; cross-border to KFSHRC Riyadh or Cleveland Clinic Abu Dhabi with 10 to 14 day turnaround if not). THIS IS THE GATE.

Week 4: Baseline ophthalmology examination. Financial pre-authorisation conversation in parallel. Qatari nationals: MoH funding for high-cost oncology is the standard path; pre-authorisation against the FDA labelled indication and FRα-positive pathology is the gating step. Qatar-resident expatriates: employer-sponsored cover or self-pay; pre-authorisation against the labelled indication with oncology benefit ceilings reviewed. AbbVie patient-access programmes explored where coverage is partial.

Week 5: First infusion at NCCCR. Day 0 of the Elahere clock. Premedications, 1-hour first infusion, observation. Ophthalmic drop protocol begins.

Cycles 2 onwards: every-3-week infusion (30 minutes from cycle 2 if first dose tolerated). Ophthalmology every 2 cycles for the first 8 cycles. CA-125 every cycle. Imaging response assessment every 6 to 9 weeks. Treatment continues until progression, intolerable toxicity, or patient decision.

Boxed warning ocular toxicity protocol

Elahere carries an FDA boxed warning for ocular toxicity. Approximately 50 percent of patients develop some grade of visual symptom (blurred vision, dry eye, photophobia, keratopathy, cataract, keratitis); approximately 9 percent develop grade 3 to 4 ocular AEs. Onset typically within the first 2 to 4 cycles. The operational discipline is non-negotiable: baseline ophthalmology before first dose; ophthalmology every 2 cycles for the first 8 cycles, then per protocol; any patient-reported visual change triggers urgent ophthalmology review; ophthalmic drop schedule is part of treatment; dose modification per CTCAE grade. NCCCR works with the Hamad ophthalmology service to integrate ADC-class ocular monitoring into the treatment rhythm.

Cost expectation in QAR

US wholesale acquisition cost approximately USD 28,000 per 100 mg vial. A 70 kg patient at 6 mg/kg AIBW uses approximately 4 vials per cycle, approximately USD 112,000 per cycle. With median 8 to 10 cycles in MIRASOL, treatment course cost is approximately USD 950,000 to USD 1.2 million. QAR-equivalent at 2026 indicative cross rates is approximately QAR 3.5 to 4.4 million per treatment course.

For Qatari nationals: MoH high-cost oncology funding is the standard pathway through NCCCR; pre-authorisation against the FDA labelled indication and FRα-positive pathology is the gating step. For Qatar-resident expatriates: employer-sponsored commercial cover or self-pay; pre-authorisation against the labelled indication, with oncology annual benefit ceilings reviewed case by case. AbbVie patient-access programmes for the GCC are an active operational pathway where coverage is partial.

Monitoring and mental-health screening

Per-cycle laboratory monitoring: CBC with differential, comprehensive metabolic panel including AST, ALT, total bilirubin, creatinine, CA-125. Per-cycle symptom monitoring: vision, peripheral neuropathy, fatigue, nausea, diarrhea, abdominal pain. Pneumonitis risk low but present.

Platinum-resistant ovarian cancer carries a median overall survival under 18 months on standard chemotherapy. Elahere extends survival to a median 16.5 months in MIRASOL but is not curative. The MDT integrates baseline and periodic mental-health screening from day one: PHQ-9 depression screen at baseline and every 2 to 3 cycles; caregiver-burden screening at baseline and 3-month intervals; routine social work involvement; low threshold for psychiatric referral. Hamad psychiatry and Hamad social work are the in-system partners at NCCCR.

Religious, ethical, and family-logistics framing

Elahere is a recombinant monoclonal antibody manufactured in mammalian cell culture (CHO cells) conjugated to a small-molecule cytotoxic payload. No porcine, bovine, or human-derived component is used in the final product. The infusion is permissible across MENA Islamic jurisprudence on the same footing as other recombinant biologic and ADC therapies.

The decision to proceed with treatment, to limit treatment scope, or to transition to comfort care when response is lost is a family decision in consultation with the treating gynae-oncologist. The every-3-week infusion schedule, the every-2-cycle ophthalmology rhythm, and the daily ophthalmic drop regimen create a sustained operational load on the patient and the primary caregiver; family involvement in the ophthalmic drop schedule is part of the protocol for many patients.

When Elahere is NOT the right option

- FRα-negative or FRα-low tumor: Elahere not indicated; pathway pivots to standard platinum-resistant chemotherapy, bevacizumab combinations, PARP inhibitor maintenance for eligible patients, or clinical trial enrolment. - More than 3 prior lines: outside the labelled indication. - Active grade 3 or higher peripheral neuropathy: defer. - Active corneal disease or recent ocular surgery: defer. - Pregnancy or refusal of effective contraception: contraindicated. - ECOG 3 or 4: not labelled. - Platinum-sensitive disease: not yet the labelled indication; clinician-discretion named-patient use only.

Reserve Meds does not push a default. If FOLR1 IHC returns FRα-negative or FRα-low, or if the conversation with the treating physician points elsewhere, the operational pathway shifts accordingly and we coordinate that pathway instead.

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 Qatar Elahere case we build the document pack, arrange the FOLR1 IHC pathology referral (in-country at NCCCR/Hamad where capability exists, or cross-border to KFSHRC Riyadh or Cleveland Clinic Abu Dhabi where it does not), coordinate baseline ophthalmology and the every-2-cycle monitoring rhythm, run the MoH funding or commercial pre-authorisation conversation, engage AbbVie patient-access programmes, support the MOPH named-patient supply application where domestic registration is still in progress, and stay with the case through response assessment and progression. Clinical decisions remain with your treating gynae-oncologist and the NCCCR multidisciplinary tumour board.

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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