# DYDROGESTERONE

A COMPETITIVE MOLECULE NOTE FOR : LEADERS | CHALLENGERS | SELECTIVE-SHARE BRANDS

## THE NEXT SHARE

Will not come from another progesterone claim – It will come from the brand that first owns the clinic workflow from appropriate indication to counselling, correct execution, continuation, and review.

## CIRCULATION NOTE

This note is being circulated to the leadership teams of major competing dydrogesterone brands in India. The opportunity is molecule-wide. The advantage will not be.

# THE DECISION IN 90 SECONDS

Dydrogesterone is already large, accepted, crowded, and clinically sensitive. That is precisely why the old playbook is running out of room.

THE MOLECULE IS ACCEPTED. THE BRAND IS STILL LEAKING.

Prescription intent is lost through indication ambiguity, weak handover, pharmacy substitution, missed or mistimed doses, anxiety-driven stopping, and absent review.

THE MARKET REALITY

- A single publicly reported #2 brand generated INR 240 crore in FY2026 and held 17.2% share. That implies a represented dydrogesterone market of about INR 1,395 crore.
- The public table reports 13.1% CAGR for that brand from FY2022 to FY2026. Dydrogesterone is not a niche support product; it is a scaled prescription battlefield.
- Indian use spans emotionally intense and operationally fragile contexts: early-pregnancy bleeding, recurrent-loss histories, infertility, ART luteal support, endometriosis, and menstrual disorders.
- The evidence is context-specific. A brand that overclaims will lose trust. A brand that makes appropriate prescribing executable can own the category's most defensible service layer.

## THE STRATEGIC MOVE

| IF YOU ARE... | YOUR CURRENT RISK | THE MOVE |
|---|---|---|
| **THE LEADER** | Being remembered but no longer being uniquely useful | Use scale to make the clinic pathway the new default before a challenger does |
| **A CHALLENGER** | Competing molecule-to-molecule against an entrenched habit | Force a pause by owning indication precision, execution, and review |
| **A SELECTIVE-SHARE BRAND** | Spreading resources too thinly across a large molecule | Own one high-leakage context, clinic type, or geography and prove repeatability |

## THE CENTRAL PROPOSITION

When a doctor decides dydrogesterone is appropriate, the sponsoring brand helps the clinic convert that prescription into a documented, understood, correctly timed, monitored, and reviewable treatment plan.

*Market-facing strategy note. Clinical use remains doctor-directed and label-governed.*


# INDIA : A MARKET TOO LARGE FOR PASSIVE BRAND MEMORY

The public data is incomplete, but it is strong enough to make inaction hard to defend.

| | | | |
|---|---|---|---|
| **INR 240 Cr**<br>**FY2026 sales**<br>Dydroboon | **17.2%**<br>**FY2026 market share**<br>Rank #2 | **13.1%**<br>**FY2022-26 CAGR**<br>Public company report | **~INR 1,395 Cr**<br>**Implied represented market**<br>240 / 17.2% |

*Source note: Mankind Pharma Annual Report 2025-26; IQVIA MAT Mar 2026 as reproduced by the company. The implied market size is Inditech arithmetic, not a published audit total. [1]*

THE BROADER COMMERCIAL SIGNAL

- Mankind reported a #1 rank in gynaecology with more than 10% share and 23.2% sales growth across FY2021-FY2026. This is a company-level therapy signal, not a dydrogesterone-only growth rate.
- Abbott India publicly lists both 10 mg and 20 mg dydrogesterone products. CDSCO records also show formulation-specific approvals and continuing evidence requirements. The market is evolving at the formulation and execution level, not only the molecule level.
- A complete current brand-share table is not public. Before any recipient-specific version is issued, the sponsoring company should validate rank, price, growth, and represented-market definitions using current IQVIA, PharmaTrac, AWACS, or equivalent audited data.

WHAT INDIAN CLINICAL USE TELLS US

| OBSERVED CONTEXT | SHARE IN SELECTED TREATED COHORT | COMMERCIAL IMPLICATION |
|---|---|---|
| **Threatened miscarriage (study term: threatened abortion)** | 46.90% | High anxiety; assessment, reassurance, red flags, and review cannot be separated |
| **Recurrent pregnancy loss** | 27.30% | Past loss amplifies fear, self-monitoring, and unsupervised continuation risk |
| **Infertility due to luteal insufficiency** | 11.60% | Cycle-day precision and persistence become brand-protection moments |
| **Luteal support in ART** | 10.30% | Dose timing, test dates, and clinic re-entry are operationally measurable |

*Source note: Retrospective descriptive study of 7,287 women already prescribed dydrogesterone across 817 Indian centres. It describes utilization, not disease prevalence, comparative benefit, or market share. [4]*

# WHY THE MOLECULE IS ACCEPTED BUT THE BRAND IS UNPROTECTED

MOST TEAMS ARE STILL FIGHTING FOR PRESCRIPTION CHOICE. THE LARGER LEAK HAPPENS AFTER THE CHOICE.

| OLD BATTLEGROUND | WHY IT IS EXHAUSTED | NEW BATTLEGROUND |
|---|---|---|
| **Oral convenience** | Known across multiple brands | Exact plan capture and timed execution |
| **Progesterone-support story** | Clinically broad and easily copied | Indication-specific counselling with evidence boundaries |
| **Familiarity and recall** | Can survive while brand loyalty erodes | Clinic habit, same-brand continuation, and documented review |
| **More reminders** | Frequency without workflow adds noise | Triggers linked to a doctor-defined decision |
| **Generic reassurance** | Can become false reassurance in a high-risk context | Calm, precise re-entry and red-flag logic |

## THE UNCOMFORTABLE TRUTH

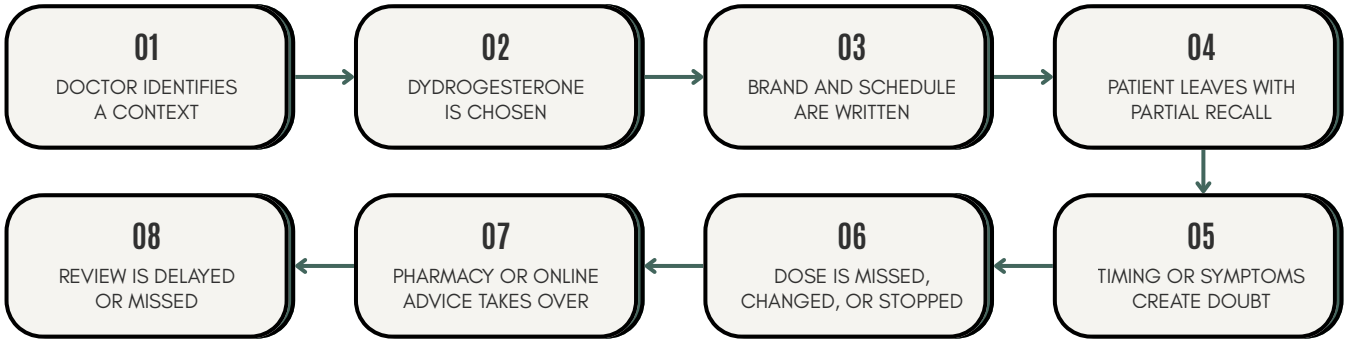
The doctor may intend a specific indication, strength, schedule, duration, and review. The patient often leaves with a much weaker memory: 'a pregnancy-support tablet' or 'a hormone tablet'. That gap creates five losses.

- **Indication loss**: the reason for use becomes vague, so benefit expectations become unrealistic.
- **Execution loss:** cycle-day, transfer-day, dose-time, or stop-date instructions are missed.
- **Confidence loss:** bleeding, pain, a negative home test, or symptom change causes unsupervised stopping or escalation.
- **Brand loss:** the pharmacy substitutes within the molecule because the patient cannot defend the exact prescription.
- **Review loss:** the woman continues, repeats, or stops without the clinic closing the loop.

*In dydrogesterone, the prescription is not the finish line. It is the first handoff in an execution pathway that most brands do not control.*

# THE DYDROGESTERONE DRIFT

WHERE CLINICAL INTENT QUIETLY BECOMES COMMERCIAL LEAKAGE.




THE SIX HIGH-VALUE LEAKS

| LEAK | WHAT HAPPENS | WHAT A CLINIC WORKFLOW CAN OWN |
|---|---|---|
| **Appropriateness** | The indication and evidence boundary are not visible at handoff | Doctor-declared context and locally approved plan |
| **Start** | The first dose, cycle day, or transfer-linked timing is unclear | Exact start instruction and start confirmation |
| **Continuation** | Anxiety, side effects, or symptom change interrupts use | Clinic-approved continuation and contact logic |
| **Substitution** | The molecule is remembered; the brand is not | Brand-of-use confirmation without patient promotion |
| **Review** | There is no planned decision point | Booked review linked to the clinical context |
| **Closure** | Treatment is repeated or stopped without a clear end | Doctor-directed continue, change, or stop decision |

# THE COMMERCIAL REFRAME

Do not compete to be the loudest progesterone brand. Compete to be the brand that makes the doctor's intended course survive contact with the real world.

# THE MOMENTS THAT MATTER

Eight moments determine whether a dydrogesterone prescription becomes a trusted pathway or dissolves into the molecule.

| MOMENT | CLINICAL QUESTION | BRAND RISK IF UNOWNED |
|---|---|---|
| **1. Context** | Why is this patient being considered for treatment? | Indication becomes generic and claims drift |
| **2. Eligibility** | What assessment, scan, cycle information, or history is required? | The service appears to promote self-starting |
| **3. Plan** | What exact strength, schedule, duration, and review did the doctor choose? | Execution varies across brands and formulations |
| **4. Handover** | Can the patient explain the plan back in her own words? | The molecule is remembered; the plan is not |
| **5. First doses** | Did she start at the intended time? | Early failure is invisible |
| **6. Uncertainty** | What should she do after bleeding, pain, a missed dose, or a test result? | Online advice replaces the clinic |
| **7. Review** | When does the clinician reassess? | Continuation and stopping become unmanaged |
| **8. Closure** | Was the course continued, changed, stopped, or replaced by the doctor? | No learning and no brand-of-use signal |

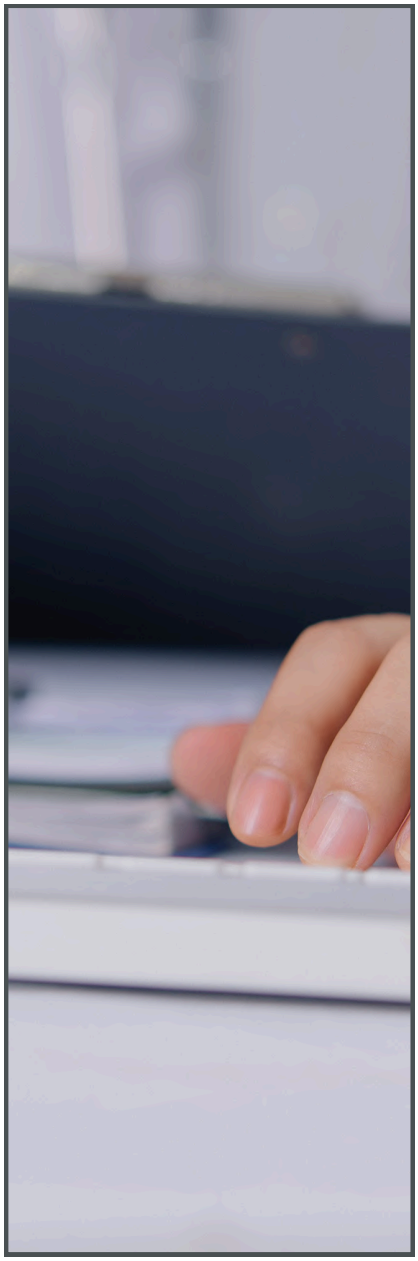
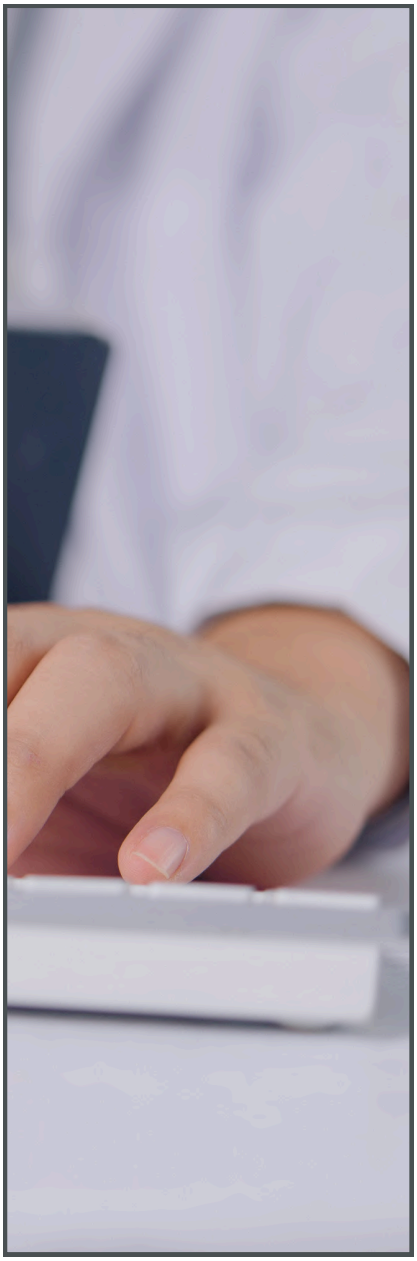
THE WINNING BRAND WILL OWN THE HANDOFFS.

Not the diagnosis. Not the prescription. The handoffs that determine whether the intended plan is understood, executed, and reviewed.

# THE EVIDENCE BOUNDARY IS THE STRATEGY

A clinically credible brand does not turn every pregnancy or every cycle into the same progesterone story.

| CLINICAL CONTEXT | CURRENT EVIDENCE SIGNAL | RULE FOR THE PLAYBOOK |
|---|---|---|
| **Early-pregnancy bleeding** | NICE recommends vaginal micronised progesterone only for scan-confirmed intrauterine pregnancy with bleeding and prior miscarriage. Cochrane found one dydrogesterone trial probably made little or no difference to live birth versus placebo. | No blanket 'pregnancy support' pathway. Clinic assessment, local label, and doctor selection come first. |
| **Recurrent pregnancy loss** | ESHRE and ASRM emphasize evaluation and shared decision-making; routine empiric progesterone benefit remains uncertain outside defined subgroups. | Never imply that the medicine corrects all causes of loss. Build evaluation and reassurance into the journey. |
| **IVF/ICSI luteal support** | ESHRE 2025 conditionally recommends dydrogesterone for luteal support, citing similar pregnancy outcomes to progesterone but also potential safety associations requiring surveillance. | This is the cleanest timing-and-adherence workflow, but it remains protocol-specific and clinic-governed. |
| **Endometriosis and menstrual indications** | Dydrogesterone is approved in various markets for progesterone-insufficiency and cyclic gynaecology contexts; Indian approvals and strengths are formulation-specific. | Configure the workflow to the sponsor's exact Indian PI. Never publish one universal dose card. |

## WHY THIS SHARPENS THE COMMERCIAL IDEA

A weak brand makes a broad claim. A strong brand helps doctors apply a narrow claim correctly, explains uncertainty honestly, and keeps the patient attached to the clinic. That is harder to copy and safer to scale.

*Source note: Evidence synthesis: NICE NG126 (updated June 2026), Cochrane CD013792, ESHRE RPL 2022 update, ASRM 2026 Committee Opinion, and ESHRE Ovarian Stimulation 2025. [5-9]*

# THE SOLUTION: CLINIC DYDROGESTERONE CARE PATHWAY

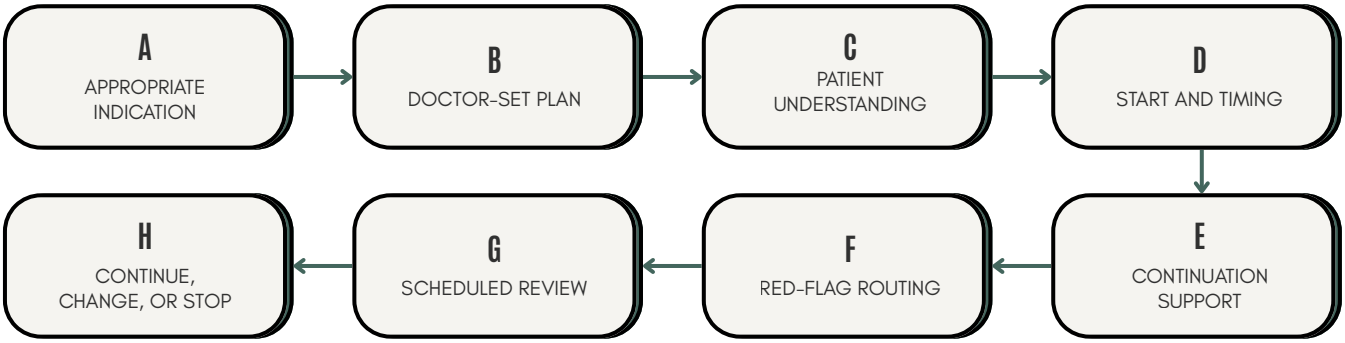
CLINIC OWNED. ACADEMY CERTIFIED. SPONSOR UNDERWRITTEN. SAFETY GOVERNED.

*The pharma brand funds the infrastructure. The clinic owns the patient relationship. The Academy governs the education. Medical Affairs governs the claim boundary.*

Appropriate indication. Exact plan. Calm counselling. Correct execution. Scheduled review.

### THE SERVICE PROMISE

When the clinician has decided that dydrogesterone is appropriate, the pathway converts the prescription into a complete care handoff and keeps every later decision with the clinician.




### THE BRAND ARCHITECTURE

| LAYER | WHAT THE USER SEES | WHAT THE SPONSOR GAINS |
|---|---|---|
| **Patient-facing** | Clinic name, clinic contact, neutral Academy-certified instructions, and doctor-entered plan | Protection of prescription intent without direct-to-patient promotion |
| **Doctor-facing** | Indication cue, evidence card, plan builder, review dashboard, and brand-specific professional information | Useful presence at the point of decision and follow-up |
| **Field-facing** | Clinic activation, education cadence, usage signals, and non-patient-level performance | A more valuable call than another visual aid |
| **Brand-facing** | Aggregated clinic adoption, pathway completion, substitution signals, and matched-control commercial analysis | Measurable evidence that service activity is moving behavior |

# THE INTERNAL SOLUTION ENGINE

NINE MODULES. ONE CONFIGURABLE INFRASTRUCTURE. NO PATIENT-LEVEL DATA TO THE BRAND TEAM.

| MODULE | FUNCTION | NON-NEGOTIABLE CONTROL |
|---|---|---|
| **1. Clinic configuration** | Clinic identity, languages, escalation number, hours, and approved clinical contexts | Medical/legal-approved content pack only |
| **2. Indication declaration** | Clinician selects the care context before any plan is generated | No patient self-selection or self-start |
| **3. Plan capture** | Strength, timing, start, expected duration, and review date | Exact sponsor PI and clinician override |
| **4. Teach-back** | Patient confirms why, when, and how the medicine is being used | No efficacy promise or miscarriage guarantee |
| **5. Timed follow-up** | Clinic-configured checks tied to the selected pathway | No automated dose change |
| **6. Red-flag routing** | Urgent symptom prompts direct the patient to clinic or emergency care | Not a diagnostic tool |
| **7. Review queue** | Staff sees only actionable, role-appropriate flags | Marketing cannot view identifiable data |
| **8. Closure** | Clinician records continue, change, stop, or refer | No indefinite automated renewal |
| **9. Aggregated analytics** | Clinic reuse, completion, substitution, and review signals | Minimum cohort thresholds and privacy-safe reporting |

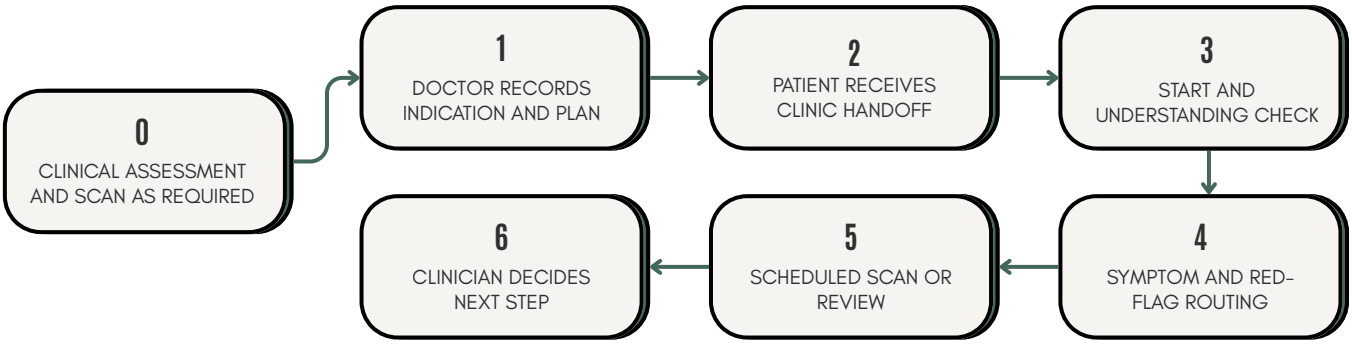
THE PRODUCT IS NOT A REMINDER APP

Its value is the structured decision record: indication, plan, uncertainty, escalation, and review. Reminders are only one small execution component.

# PATHWAY A

## EARLY-PREGNANCY SUPPORT

The workflow must reduce uncertainty without manufacturing false reassurance.




### PATIENT-FACING CONTENT

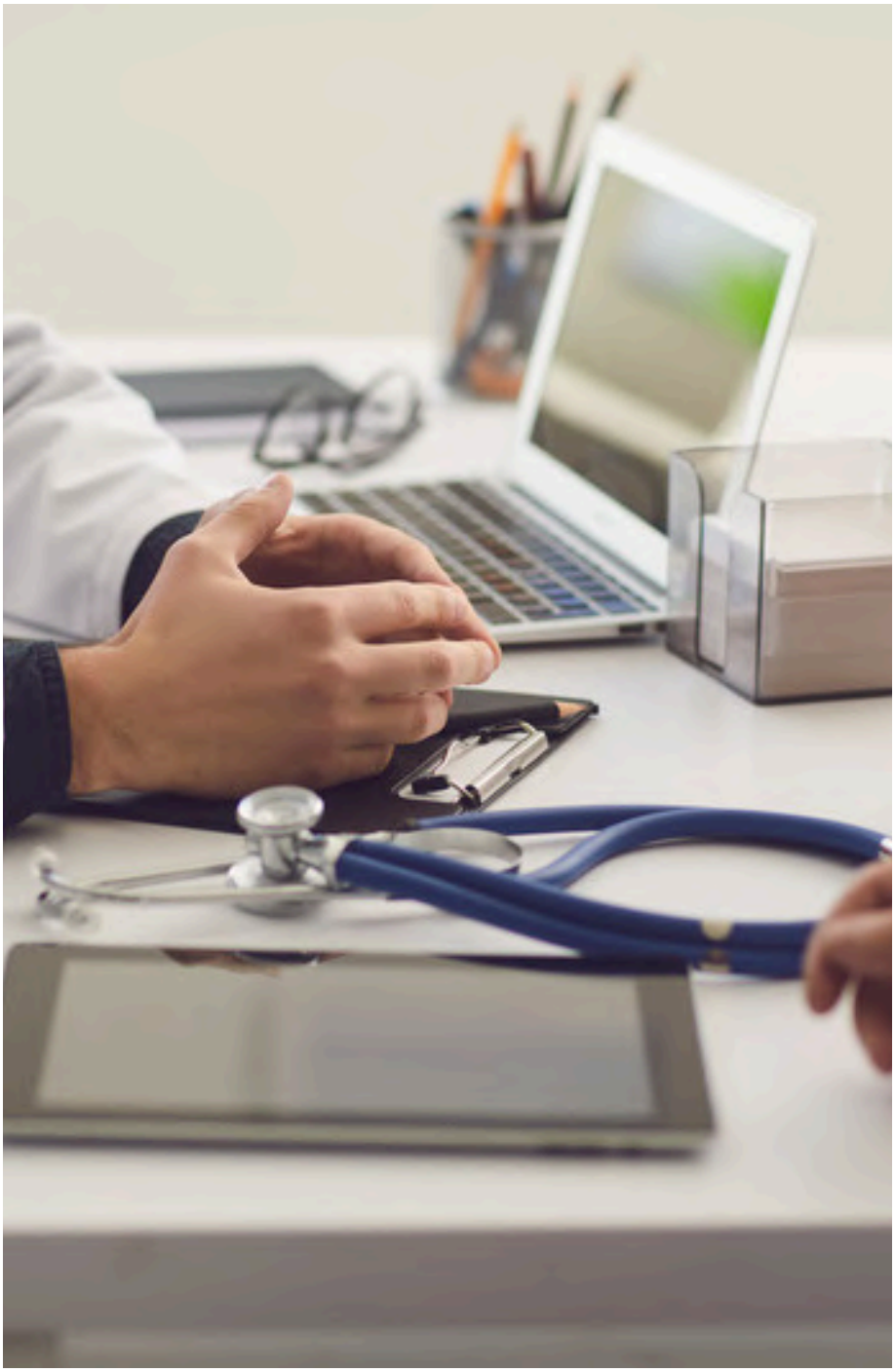
- Why your clinician prescribed this medicine in your specific case - without implying that it can prevent every miscarriage.
- The exact strength and timing entered by the clinic; what to do after a missed dose is the clinic's approved instruction, not a generic double-dose message.
- Bleeding or pain does not automatically mean one outcome. It does require following the clinic's instructions and urgent care when red flags occur.
- Do not stop, restart, extend, or share the medicine because symptoms changed or because online advice differs.
- The next scan or review date is part of the prescription, not an optional add-on.

RED-FLAG ROUTING - FINAL WORDING MUST BE CLINIC APPROVED

Immediate clinical assessment may be required for heavy bleeding, severe or one-sided abdominal pain, shoulder-tip pain, fainting or marked dizziness, fever, breathing difficulty, facial swelling, severe rash, jaundice, or any symptom the clinic has identified as urgent.

COMMERCIAL VALUE

The brand becomes associated with calm, evidence-bound support in the category's most emotionally charged moment - without exploiting the moment or claiming to determine the pregnancy outcome.



# PATHWAY B

## FERTILITY AND IVF LUTEAL SUPPORT

This is the category's cleanest execution pathway because timing, testing, and review are already protocol-driven.

| JOURNEY POINT | PATIENT RISK | CLINIC CONTROL |
|---|---|---|
| **Protocol handoff** | Multiple medicines and routes create confusion | Single clinic schedule with exact names, times, and dates |
| **Start timing** | The first dose is mistimed after retrieval or transfer | Protocol-linked start confirmation |
| **Daily continuation** | Oral convenience is mistaken for low importance | Time-stamped reminder and missed-dose routing |
| **Symptoms or spotting** | The patient stops or adds medication independently | Clinic contact prompt; no automated adjustment |
| **Pregnancy test** | A home test triggers premature stopping or continuation | Clinic-specified test date and interpretation route |
| **Early scan** | Support continues without a planned decision | Review queue and clinician closure |

### THE CHALLENGER OPPORTUNITY IS UNUSUALLY STRONG HERE

The leader may own habit. A challenger can own protocol execution. The commercial claim is not 'our medicine creates more pregnancies.' It is: 'our brand equips the clinic to make its chosen luteal-support plan easier to execute and review.'

- Fertility-centre onboarding with protocol-specific templates.
- Clinic-specific QR or WhatsApp link delivered only by clinic staff.
- Medication schedule that includes all luteal-support products, not only the sponsor's brand.
- Non-adherence, substitution, and missed-review signals aggregated for the clinic.
- Academy module on patient burden, route preference, evidence, and safety surveillance.

*Source note: ESHRE 2025 conditionally recommends dydrogesterone for IVF/ICSI luteal phase support and emphasizes individual clinical judgment and surveillance. [5]*

# PATHWAY C

## CYCLIC GYNAECOLOGY AND ENDOMETRIOSIS

The commercial leak is rarely awareness. It is start-stop accuracy, symptom interpretation, and failure to review after the first cycles.

| CONTEXT | EXECUTION FAILURE | WORKFLOW ASSET |
|---|---|---|
| **Endometriosis** | Long symptom horizon; pain improvement is confused with disease control or stopping permission | Symptom and tolerability tracker plus planned review |
| **Irregular cycles / secondary amenorrhoea** | Cycle-day instructions are forgotten or repeated without assessment | Calendar-based doctor-entered course and closure |
| **Dysfunctional uterine bleeding** | Bleeding response is self-interpreted; recurrence is self-treated | Bleeding tracker, escalation prompts, and clinic re-entry |
| **Dysmenorrhoea / PMS where locally approved** | Treatment becomes another short symptomatic course | Cycle-linked start, adherence, response, and next-cycle plan |
| **HRT adjunct where locally approved** | Sequential regimen and unscheduled bleeding are poorly understood | Regimen calendar and clinician review; HRT risks governed separately |

## WHAT THE SPONSOR MUST NOT DO

- Publish one universal dose or duration across brands, strengths, formulations, and indications.
- Use a symptom tracker to imply diagnosis, cure, or superiority.
- Let a patient-facing path recommend initiation, switching, continuation, or re-treatment.
- Treat missing review as a refill opportunity. It is a clinician decision point.

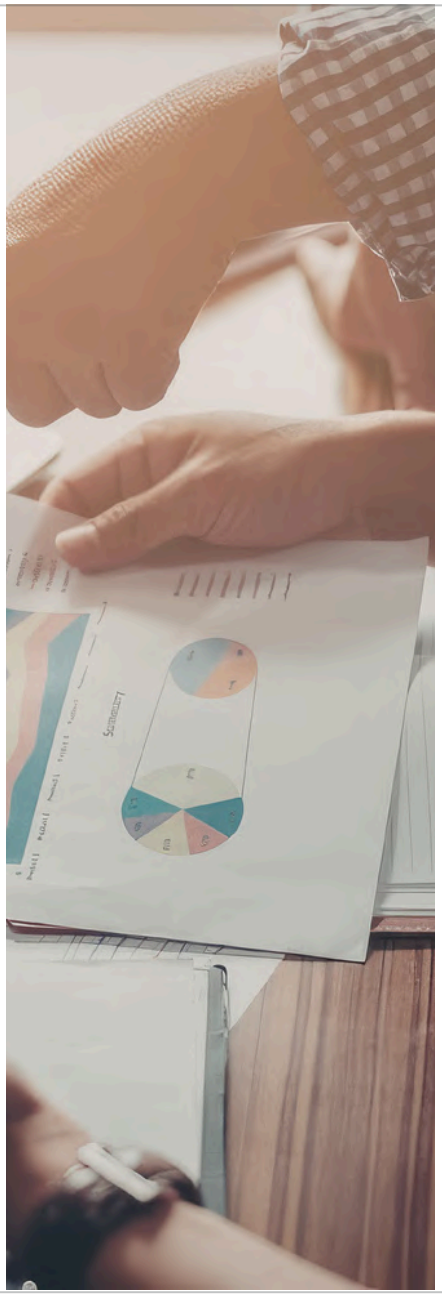
## OWN THE CALENDAR. OWN THE REVIEW. EARN THE REPEAT.

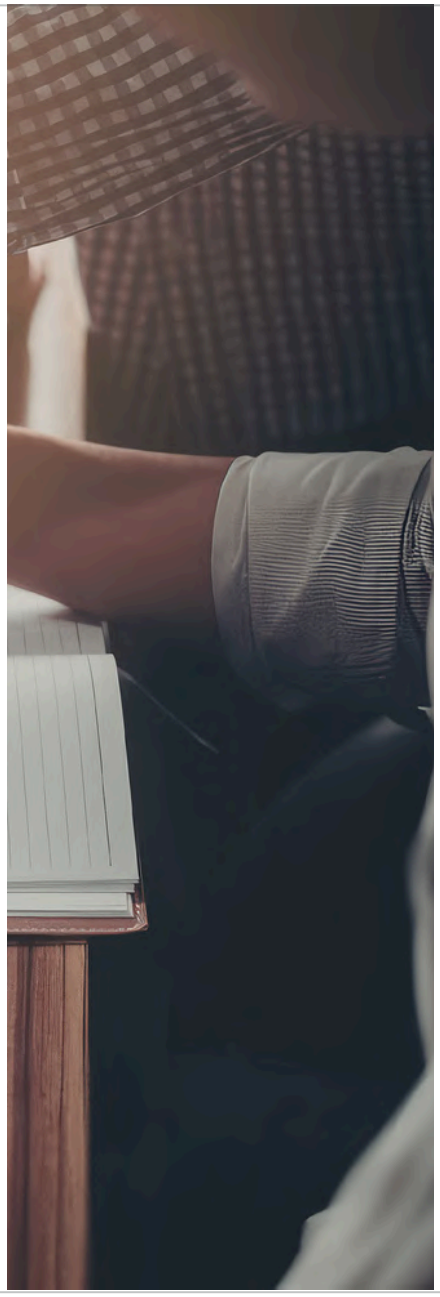
Cyclic therapy is a natural workflow category. The brand that makes the calendar usable can become more defensible than the brand that merely prints it.

# THE ACADEMY LAYER

INDEPENDENT CERTIFICATION TURNS THE SERVICE FROM BRAND CONTENT INTO CLINIC INFRASTRUCTURE – IF GOVERNANCE IS REAL, NOT COSMETIC.

| VISIT | ACADEMY-CERTIFIED MICRO-TOPIC | FIELD USE |
|---|---|---|
| **1** | Dydrogesterone is not one indication: build the context map | Open with clinical precision, not product recall |
| **2** | Early-pregnancy bleeding: assessment, evidence limits, and urgent re-entry | Install the safety and reassurance pathway |
| **3** | Recurrent loss: evaluation before empiricism | Protect trust and avoid broad promises |
| **4** | IVF/ICSI luteal support: timing, route, burden, and adherence | Activate the fertility-centre module |
| **5** | Cyclic therapy: start-stop accuracy and treatment review | Activate the gynaecology calendar |
| **6** | Pharmacovigilance, pregnancy exposure, and communicating uncertainty | Make safety follow-up visible and credible |



CERTIFICATION STANDARD

- Named faculty/editorial board with declared conflicts and term limits.
- Reference date, evidence grade, local-PI cross-check, and version history on every module.
- Sponsor disclosure without sponsor control of clinical conclusions.
- Medical Affairs approval before release; automatic withdrawal when PI or guidance changes.
- Patient material tested for comprehension in the relevant Indian languages and literacy levels.
- No Academy seal on unsupported brand comparison, patient testimonial, or sales claim.

THE FIELD-FORCE ADVANTAGE

Each visit brings one clinic-usable clinical asset, activates one workflow function, and gives the next visit a reason to exist. The rep stops renting attention and starts installing a system.

# STRATEGIC VARIANTS BY BRAND POSITION

# IF YOU ARE THE MARKET LEADER

DEFEND THE DEFAULT BEFORE A CHALLENGER MAKES YOUR SCALE LOOK PASSIVE

## LEADER DEFENCE

Turn molecule leadership into clinic infrastructure

Objective: Make the brand the safest, easiest, and most operationally useful default - without claiming universal superiority.

- Install the pathway broadly across high-volume OBGYN and fertility clinics before any challenger can claim the missing workflow.
- Use the widest permitted indication architecture, but separate every context clinically and operationally.
- Protect same-brand continuation by capturing brand-of-use and pharmacy substitution signals at clinic follow-up.
- Make Academy governance and evidence updating visible; leadership must look responsible, not complacent.
- Use scale to create benchmarks for plan completeness, review completion, and clinic reuse.

### LEADER MESSAGE

The market already knows your brand. Now make the clinic need your system.

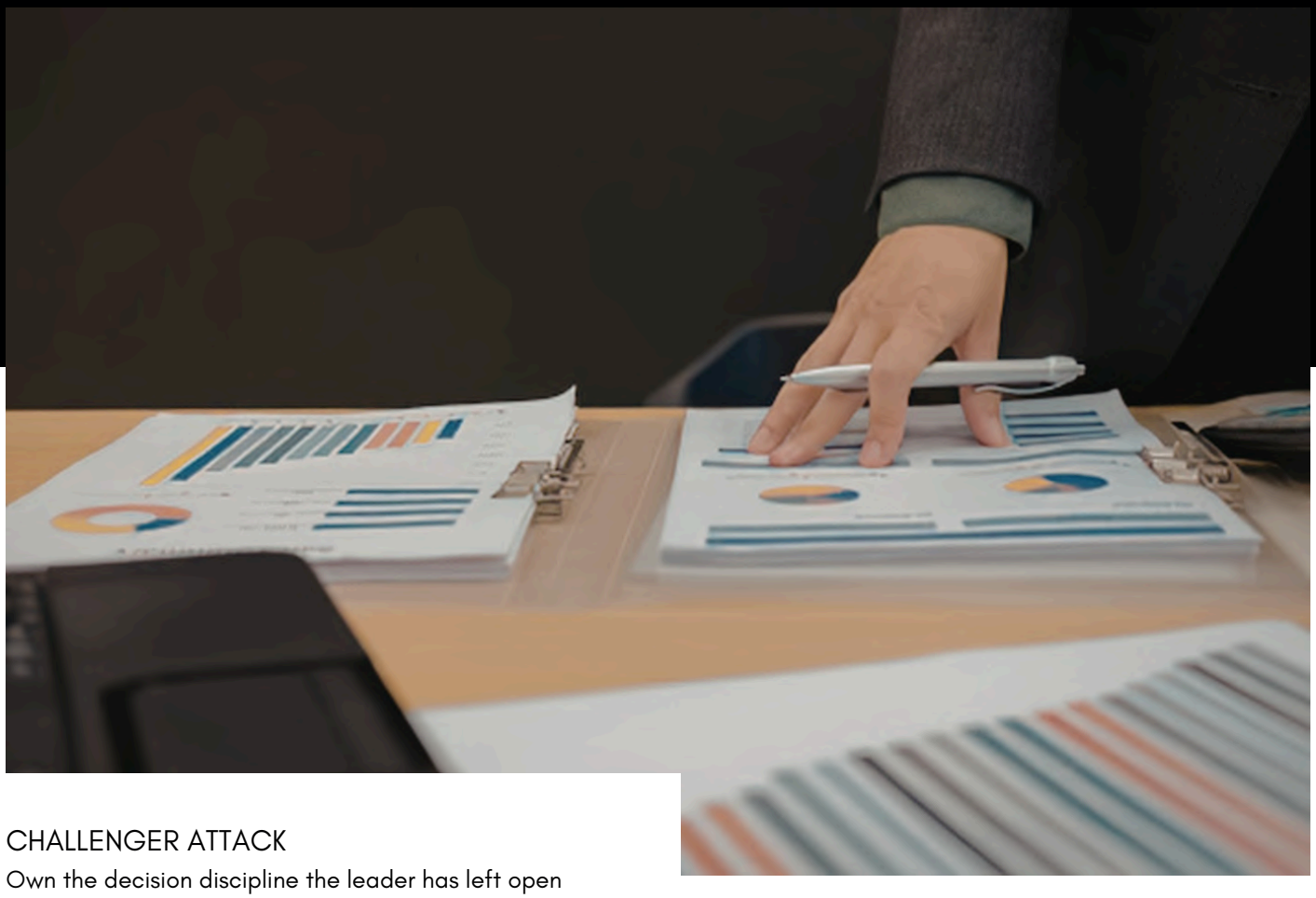
The leader's moat is not another claim. It is the installed workflow, trained clinic staff, trusted education, and accumulated operational benchmark.

## LEADER SCORECARD

| PROTECT | MEASURE | PROOF |
|---|---|---|
| **Default choice** | Share of eligible clinic prescriptions within approved context | Leader remains default where the pathway is active |
| **Brand continuity** | Same-brand use and substitution signals | Prescription intent survives dispensing |
| **Clinic loyalty** | Monthly active clinics and multi-context reuse | Service is embedded, not sampled |
| **Trust** | Academy engagement and safety escalation performance | Leadership is associated with stewardship |

# IF YOU ARE THE CHALLENGER

DO NOT OUT-REMIND THE LEADER. MAKE THE DEFAULT LOOK OPERATIONALLY INCOMPLETE



## CHALLENGER ATTACK

Own the decision discipline the leader has left open

Objective: Create a new reason to prescribe: the brand is attached to a better indication-to-review system.

- Pick one attack wedge first: fertility protocol execution, early-pregnancy review, or cyclic gynaecology precision.
- Use the indication cue to force a pause before habitual brand selection.
- Offer clinic configuration and staff activation the leader has not installed.
- Measure new-to-brand use and retention inside activated clinics, not vanity engagement.
- Expand only when the wedge shows repeat clinic use and a credible commercial signal against matched controls.

## CHALLENGER MESSAGE

The leader owns memory. You can own the moment that makes memory matter.

A challenger should never claim to be better for every patient. It should be demonstrably more useful in a specific, approved, high-leakage clinical workflow.

## THE STRONGEST CHALLENGER WEDGES

| WEDGE | WHY IT CAN MOVE SHARE | EXPANSION TRIGGER |
|---|---|---|
| **IVF protocol execution** | High timing sensitivity and measurable completion | Repeat use across protocols and centres |
| **Early-pregnancy review** | High emotional need and weak existing handover | Safe escalation and review completion |
| **Cycle-calendar precision** | Simple, scalable, language-friendly utility | Repeat use across two or more cycles |

# IF YOU ARE AN OTHER OR SELECTIVE-SHARE BRAND

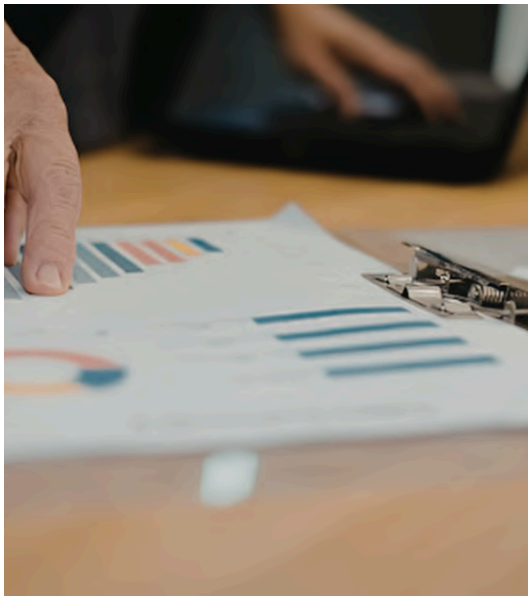
STOP PRETENDING YOU NEED THE WHOLE MOLECULE. YOU NEED A DEFENDABLE BEACHHEAD

## SELECTIVE SHARE GAIN

Own one high-leakage clinic moment completely

Objective: Build a small but repeatable position that can be expanded after commercial proof.

- Choose one clinic universe, one patient context, one language set, and one measurable leak.
- Deploy a lighter pathway with the same medical, privacy, and Academy standards as a national programme.
- Win density in 100-300 clinics rather than visibility across thousands of non-using clinics.
- Use regional availability and pharmacy mapping to make same-brand continuity operationally possible.
- Do not expand until weekly clinic reuse and brand-of-use retention are both visible.



## CREDIBLE WEDGES

| WEDGE | DISTINCTIVE SERVICE | BEST-FIT SPONSOR |
|---|---|---|
| **Tier 2/3 early-pregnancy handover** | Local-language clinic pathway and escalation | Regional brand with strong availability |
| **Fertility-centre luteal support** | Protocol calendar and test-date control | Specialty or premium challenger |
| **Endometriosis follow-up** | Pain/function tracker and planned review | Brand with approved formulation fit |
| **Cycle-day accuracy** | Simple multilingual calendar | High-volume value brand |
| **Pharmacy substitution recovery** | Clinic-led brand-of-use confirmation | Brand with reliable distribution |

SELECTIVE DOES NOT MEAN SMALL

It means choosing a battleground the leader is not defending, proving the workflow, and making expansion a result of evidence rather than ambition.

# THE FIELD-FORCE STORY

A THREE-MINUTE CALL THAT INSTALLS A NEW COMMERCIAL IDEA WITHOUT ASKING THE DOCTOR TO SIT THROUGH ANOTHER BRAND MONOLOGUE.

OPENING

Doctor, dydrogesterone does not leak only at brand choice.

It leaks when the indication is not understood, the schedule is mistimed, a fertility dose is missed, bleeding triggers self-management, the pharmacy substitutes the brand, or the patient never returns for review.

THE OFFER

We have built an Academy-certified, clinic-branded pathway that starts only after you decide treatment is appropriate. It records your exact plan, helps the patient execute it, routes uncertainty back to your clinic, and closes with your review. The patient sees your clinic, not a pharma promotion.

THE ASK

Let us configure one pathway for your clinic, train one staff member, and use it for ten appropriate patients. At the next visit, we will review only four signals: plan completeness, patient follow-up, review completion, and any substitution or safety flags.

REP OPERATING RULES

- The rep activates the clinic; the rep does not enroll patients.
- The rep never sees patient names, phone numbers, pregnancy details, symptoms, or individual outcomes.
- The rep cannot edit Academy or medical content.
- The rep reports suspected adverse events immediately through the approved pharmacovigilance route.
- The rep's next call is triggered by clinic use or an education module - not patient-level activity.

# CLINIC IMPLEMENTATION BLUEPRINT

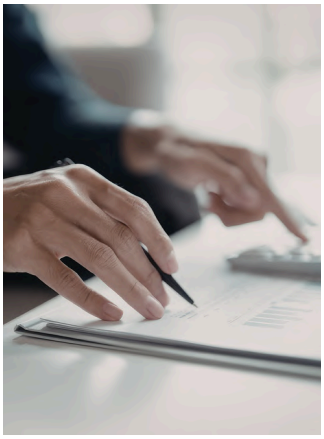
ONE-TIME SETUP. MINIMAL STAFF BURDEN. CLEAR OWNERSHIP AT EVERY HANDOFF

| OWNER | ONE-TIME RESPONSIBILITY | ONGOING RESPONSIBILITY |
|---|---|---|
| **Doctor** | Approve clinical contexts, plan fields, red flags, and review rules | Select indication; approve patient plan; make clinical decisions |
| **Clinic coordinator** | Confirm contact channel, languages, and escalation coverage | Share link; monitor flags; close review queue |
| **Academy** | Certify evidence and patient comprehension | Version and withdraw content as evidence changes |
| **Medical Affairs** | Approve label alignment, safety logic, and product layer | Monitor updates, deviations, and pharmacovigilance |
| **Field team** | Configure clinic and train one staff member | Deliver approved education and adoption support |
| **Technology partner** | Implement access, consent, security, and audit trail | Operate service levels, deletion, and incident response |
| **Brand team** | Define competitive posture and pilot hypothesis | Review aggregated performance only |

## 20-MINUTE CLINIC ACTIVATION

1. 1.Choose one pathway: early pregnancy, fertility/ART, or cyclic gynaecology.
2. 2.Load clinic identity, approved languages, working hours, and escalation number.
3. 3.Select the locally approved product/strength and lock the clinical content version.
4. 4.Train the coordinator on plan capture, patient handoff, red flags, and closure.
5. 5.Run one simulated patient; verify the doctor and coordinator dashboards.
6. 6.Activate only after the clinic signs the data, safety, and content responsibilities.

Design principle : If the clinic cannot use the pathway after one short training, the solution is too complex. Complexity belongs in the rules engine, not at the reception desk.

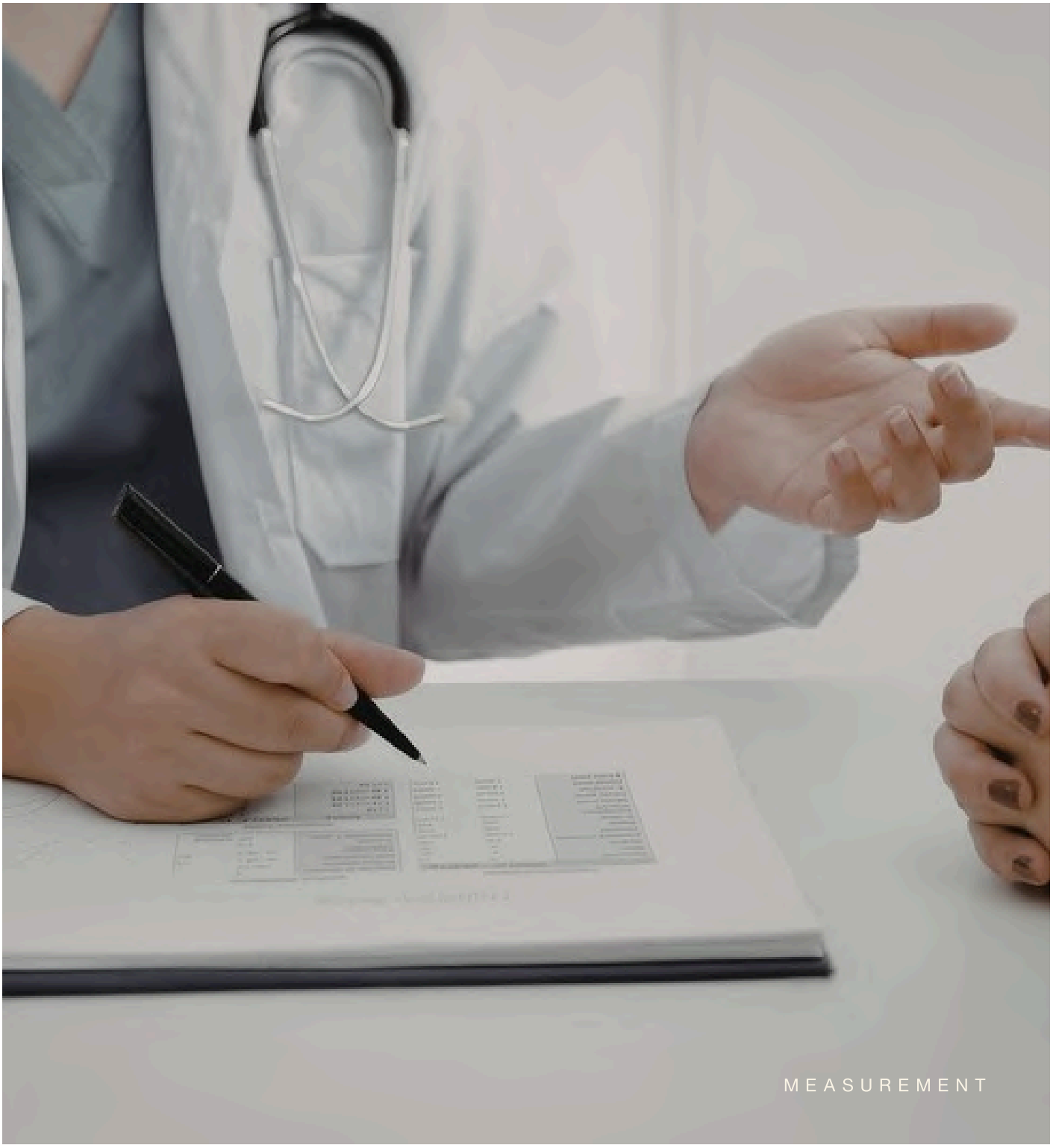


# MEASUREMENT

PROVE WORKFLOW CONTROL, NOT PROMOTIONAL REACH

THE WRONG DASHBOARD WILL TURN A DIFFERENTIATED STRATEGY BACK INTO DIGITAL NOISE.

| LEVEL | PRIMARY MEASURES | WHAT THEY PROVE |
|---|---|---|
| **Activation** | Clinics configured; staff trained; first patient pathway completed | The field can install the service |
| **Clinic habit** | Weekly active clinics; repeat use; multi-context reuse; coordinator closure rate | The service survives after launch |
| **Execution** | Plan completeness; start confirmation; follow-up completion; review completion | The prescription becomes a managed pathway |
| **Commercial** | New-to-brand use; same-brand continuation; substitution signal; sales or Rx movement vs controls | The workflow is associated with brand behavior |
| **Safety** | Red-flag response time; adverse-event routing; content deviations; overdue clinical flags | Scale is not outrunning governance |
| **Privacy** | Consent record; access exceptions; deletion compliance; minimum-cell suppression | No patient surveillance by marketing |

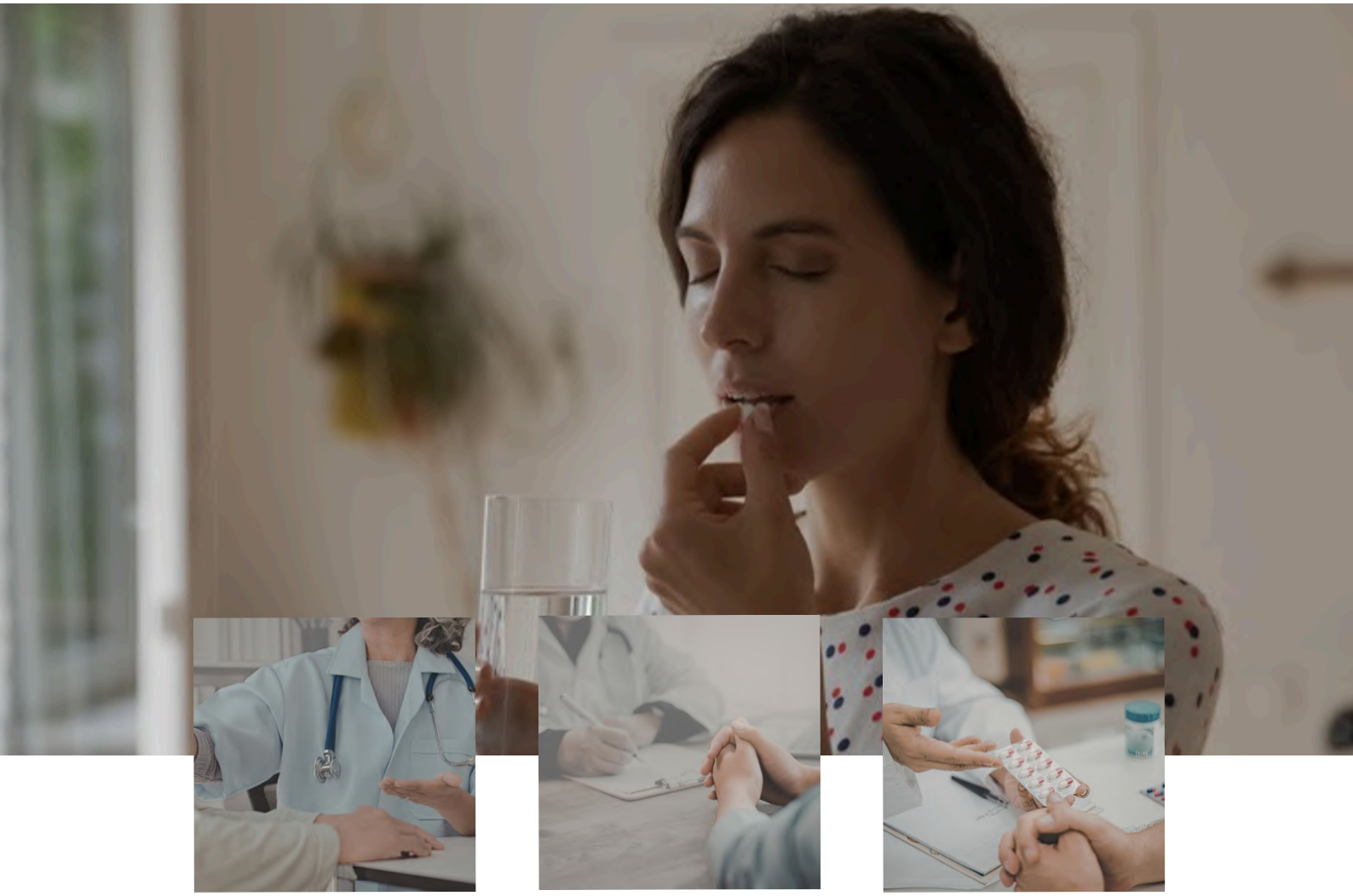



What not to count as success

- Impressions, QR codes printed, or messages sent without clinic reuse.
- Patient enrolment volume without a documented indication and review date.
- Pregnancy outcome, miscarriage reduction, or live birth as a promotional KPI.
- Raw brand sales growth without a baseline, matched controls, and availability checks.
- A high follow-up rate produced by messaging patients more often than the clinic approved.

THE COMMERCIAL TEST IS SIMPLE.

Did activated clinics use the workflow again, did prescription intent survive, and did the sponsoring brand improve against a credible control - without compromising safety or privacy?



# THE 90-DAY PILOT

A DECISION EXPERIMENT, NOT A CEREMONIAL LAUNCH.

| PHASE | DAYS | WORK | EXIT CONDITION |
|---|---|---|---|
| **1. Lock** | 0-15 | Current market audit; sponsor PI; evidence pack; MLR approval; clinic/data contracts; baseline extraction | No unresolved label, privacy, or escalation issue |
| **2. Configure** | 16-30 | Two clusters; clinic segmentation; language assets; staff scripts; dashboard; simulation | All clinics pass dry run |
| **3. Run** | 31-75 | Launch active clinics; deliver two Academy modules; weekly adoption support; safety monitoring | Stable clinic reuse and clean operations |
| **4. Decide** | 76-90 | Matched-control analysis; qualitative interviews; commercial and safety review; scale/no-scale decision | Written decision with evidence |

RECOMMENDED DESIGN

- Two prescribing clusters with 40-60 active clinics and a similar matched-control set. Final sample size should follow baseline variability and the chosen commercial endpoint.
- Stratify clinics by general OBGYN, early-pregnancy focus, and fertility/ART. Do not mix pathways in the analysis.
- Pre-register primary operational measures, the commercial comparison, exclusions, and the minimum cohort size for reporting.
- Use historical baseline plus matched controls. Check stock availability and price changes before attributing movement to the service.

| | | | |
|---|---|---|---|
| **>=80%**<br>**Clinic activation**<br>after training | **>=60%**<br>**Weekly reuse**<br>weeks 9–12 | **>=75%**<br>**Complete plans**<br>context + timing + review | **0**<br>**Material breaches**<br>privacy or compliance |

*Source note: Thresholds are design recommendations, not industry benchmarks. Commercial success criteria should be fixed after the baseline and before outcome review.*

# GOVERNANCE

THE SERVICE ONLY WORKS IF THE BOUNDARIES ARE VISIBLE

Dydrogesterone sits at the intersection of prescription promotion, reproductive health, pregnancy data, and uncertain evidence. Governance is part of the product.

| RISK | FAILURE MODE | REQUIRED CONTROL |
|---|---|---|
| **Off-label promotion** | One molecule-wide workflow implies uses not approved for a sponsor's product | Separate, versioned pathway per Indian PI, strength, and formulation |
| **False reassurance** | Patient believes medicine guarantees pregnancy continuation | Explicit uncertainty language and urgent re-entry cues |
| **Direct-to-patient promotion** | Clinic service becomes branded patient acquisition | Clinic-branded, nonpromotional patient layer; no brand recommendation |
| **Academy capture** | Certification becomes a sponsor seal | Independent editorial control, sponsor disclosure, and conflict policy |
| **Privacy** | Marketing receives reproductive health or pregnancy-level data | Purpose limitation, consent/notice, role-based access, retention/deletion, aggregated reporting |
| **Pharmacovigilance** | Symptoms or pregnancy exposure signals remain in a service queue | Validated AE intake and immediate routing to the MAH safety process |
| **Clinical automation** | Software changes dose, duration, or interpretation | Clinician decision for start, missed dose, continuation, change, stop, and referral |

## NDIA COMPLIANCE BASELINE

- UCPMP 2024, as updated, requires promotion to match marketing approval and claims to be balanced, current, verifiable, and non-misleading.
- The DPDP Act and 2025 Rules require a clear notice, valid consent where relied on, appropriate security, purpose-bound processing, rights handling, and a documented retention/deletion model as provisions come into force.
- The clinic and sponsor must document their roles before launch. No assumption that de-identification alone removes all governance duties.

Source note: Department of Pharmaceuticals UCPMP 2024 updated 1 Sep 2025; MeitY DPDP Rules 2025 and enforcement timeline. [11-12]

# WHY FIRST MOVER MATTERS

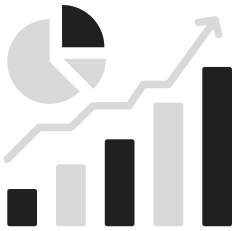
IN A CROWDED MOLECULE, WORKFLOW OCCUPATION COMPOUNDS FASTER THAN ANOTHER CAMPAIGN.

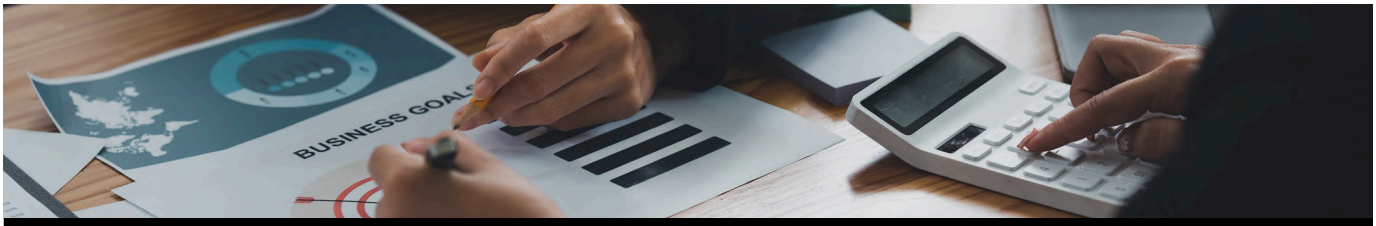
| FIRST MOVER ASSET | WHY IT COMPOUNDS | WHY A LATE ENTRANT LOOKS DERIVATIVE |
|---|---|---|
| **Clinic habit** | Staff learns one path and reuses it | A second workflow adds friction |
| **Academy association** | The sponsor becomes linked to responsible molecule stewardship | Later education feels reactive |
| **Operational benchmark** | The sponsor learns which contexts and clinics convert | Competitors start without the dataset |
| **Field productivity** | Every visit advances adoption or education | Competitors remain in reminder mode |
| **Brand-of-use protection** | Substitution and continuation become visible | Later brands must dislodge an installed routine |

THE DECISION

- Move first and define the indication-to-review workflow.
- Evaluate quickly and choose a leader, challenger, or selective-share posture.
- Wait until another brand has trained the clinics, occupied the Academy territory, and set the benchmark.

Only one of those choices is neutral on a slide. In the market, waiting is a position.






**THIS NOTE HAS GONE TO YOUR COMPETITORS FOR A REASON.**

The structural opportunity belongs to the molecule. The installed advantage will belong to one brand first.

# THE NEXT STEP : A 30-MINUTE MOLECULE DIAGNOSTIC

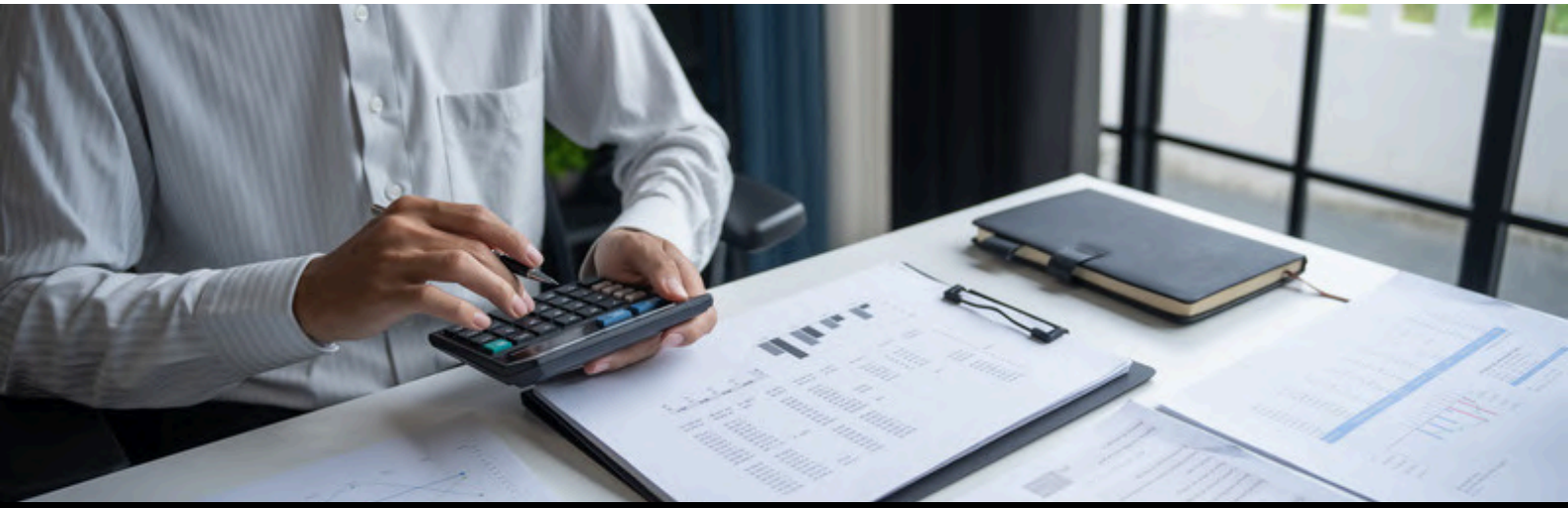
Not a generic capability meeting. A fast go/no-go decision for your exact brand position.

BRING

- Current brand rank, growth, price, stock availability, and prescriber segmentation.
- Indian package insert and any formulation-specific approval conditions.
- The two clinical contexts driving current prescriptions and the one context you want to grow.
- Field-force footprint, clinic universe, and current follow-up assets.
- Medical, legal, privacy, and pharmacovigilance owners.

LEAVE WITH

1. 7.Your posture: leader defence, challenger attack, or selective share capture.
2. 8.The one or two highest-value leaks in your current patient journey.
3. 9.The first clinic pathway and Academy module to build.
4. 10.A 90-day pilot design with controls, metrics, governance, and a go/no-go gate.



DO YOU WANT TO DEFINE THE DYDROGESTERONE WORKFLOW - OR INHERIT ONE BUILT BY A COMPETITOR?

The open decision is not whether patients need more messages. It is whether your brand will become the clinic's operating partner when an appropriate dydrogesterone prescription must be executed and reviewed.

Recommended action: lock one brand posture and one clinic pathway within 10 working days; complete the evidence and governance gate before pilot build.

# EVIDENCE AND MARKET REFERENCES

Current to 7 August 2026. Full URLs are included for audit and refresh.


1. Mankind Pharma Limited. Annual Report 2025-26. Top 20 brand performance; IQVIA MAT Mar 2026 cited by the company. Full source

2. Mankind Pharma Limited. Investor Presentation, Q4 and FY2026. Domestic and gynaecology performance; IQVIA Mar 2026. Full source

3. Abbott India. Women's Health products: Duphaston 10 mg and Duphaston OD 20 mg. Product availability and strength listing. Full source

4. Gupte S, et al. Real-world utilization pattern of dydrogesterone in 7287 Indian women with obstetric and gynecological conditions. Rev Bras Ginecol Obstet. 2024. Descriptive utilization evidence only. Full source

5. ESHRE. Guideline on Ovarian Stimulation for IVF/ICSI. Update 2025. Section 18.2: dydrogesterone for luteal phase support; conditional recommendation and safety discussion. Full source

6. NICE. Ectopic pregnancy and miscarriage: diagnosis and initial management, NG126. Threatened miscarriage recommendations; updated 17 June 2026. Full source

7. Cochrane. Progestogens for preventing miscarriage: a network meta-analysis. CD013792. 2021. Full source

8. ESHRE. Guideline on the management of recurrent pregnancy loss. Update 2022, final version January 2023. Full source

# STRATEGIC OPPORTUNITY & CTA

The decision for a dydrogesterone brand team is simple: Will you continue competing for prescription choice, or become the brand that helps the clinic make the intended prescription survive contact with the real world?

Dydrogesterone does not need another broad progesterone-support claim. The opportunity lies in owning the critical handoffs - from appropriate indication and doctor-set plan to patient understanding, correct timing, continuation, red-flag routing, scheduled review, and clinician-directed closure.

**Old rule:** win the prescription.
**New rule:** make the prescription executable, understood, and reviewable.

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The next winning dydrogesterone brand will not necessarily be the one with the loudest progesterone message.

It will be the brand that becomes the clinic's operating partner when an appropriate dydrogesterone prescription needs to be understood, executed, monitored, and reviewed - while keeping every clinical decision with the doctor.

## Next Steps

If you would like to explore how these ideas can be adapted to your brand strategy, we would be happy to discuss them further.

Get in touch with our team to schedule a 30-minute Dydrogesterone Molecule Diagnostic and identify the highest-value workflow leak, first clinic pathway, and a focused 90-day pilot.

# INDITECH HEALTH SOLUTIONS

PUBLICATION NO. 2026 08 104