Competitive Molecule Notes

EMPAGLIFLOZIN

The next empagliflozin share shift will be won between the prescription and the next clinical decision

FOR LEADERS DEFENDING DEFAULT STATUS, CHALLENGERS DISPLACING HABIT, AND SELECTIVE-SHARE BRANDS CAPTURING ONE NEGLECTED CLINIC WORKFLOW



Integrated molecule playbook



MOLECULE-WIDE CIRCULATION

YOUR POSITION	THE COMPETITIVE JOB
LEADER Defend default	Turn prescription leadership into the clinic's routine for safe initiation, cardiorenal follow-up and continuity.
CHALLENGER Displace habit	Make the doctor compare completed care tasks, early safety confidence and reliable review support.
SELECTIVE SHARE Capture one wedge	Own one dense clinic segment where follow-up, tolerability review or prescription fulfilment repeatedly breaks down.

EMPAGLIFLOZIN

This note is shared with leadership teams of major competing empagliflozin brands in India. Direct competitors are being shown the same opportunity.

The category has moved beyond sugar. Has the brand strategy moved beyond reminders?

The territory is prescription-to-reviewed-plan continuity across the clinician-selected diabetes, heart-failure and kidney-care pathways. The clinic owns care. A brand earns preference by helping that care happen.



STRATEGIC CHOICE

MAKE THE COMPLETED REVIEW THE COMPETITIVE UNIT

Empagliflozin can enter through different specialists for different reasons. A patient may hear “diabetes tablet” when the clinician’s purpose also involves heart or kidney outcomes. The same patient may receive conflicting fluid advice, miss a safety review or disappear after a treatment interruption. Another reminder cannot reconcile that care.

REMINDER CAMPAIGN	MOLECULE-WIDE CLINIC WORKFLOW
Repeat glucose and organ-protection claims	Record the clinician’s indication, exact prescription, follow-up owner and next decision.
Count tablets taken	Establish whether the current plan remains appropriate and understood. A prescribed interruption is not non-adherence.
Send the same advice to every patient	Use one common continuity spine with clinician-selected T2D, HF and CKD modules.
Reassure away early symptoms	Provide a private route to assessment and record whether the concern was acted on.
Promote the next combination	Give the clinician a reconciled medicine list and a factual account of response, access and tolerability.
Count scans and reminder opens	Count due reviews completed with a documented clinical plan.

THE FIRST-PRINCIPLES ANSWER

Own the clinic routine that connects the reason for treatment, early safety, condition-specific follow-up and the next authorised plan. The organising event is a reviewed plan; adherence, tests and refills are inputs to that decision. “Workflow ownership” means dependable service adoption, never control over prescribing, patients or clinic data.

One molecule-wide operating system. Different clinical modules. Every treatment decision stays with the treating clinician.

CATEGORY PROVOCATION

THE SCIENCE CROSSED SPECIALTIES BEFORE THE MARKETING DID

SGLT2 therapy has expanded the clinical conversation beyond HbA1c. Empagliflozin has evidence and labelled uses in selected cardiovascular, HF and CKD settings. That broadens the commercial battleground to the work required to sustain the clinician's intended care. It does not make every person with diabetes eligible for every cardiorenal claim.

CLINICAL CONTEXT	WHAT THE EVIDENCE SUPPORTS	THE UNFINISHED CLINIC TASK
Type 2 diabetes	Individualised glucose management; outcome-directed therapy in appropriate comorbidity settings, sometimes irrespective of HbA1c. [9,13]	Explain the selected purpose and arrange glucose review where relevant; avoid "normal sugar means treatment is over."
Heart failure	Empagliflozin evidence spans reduced and preserved EF; guideline use includes people without diabetes. [15,23]	Connect the HF team's symptom, volume and medicine plan to a named follow-up owner.
Chronic kidney disease	Kidney-outcome evidence extends beyond diabetes in selected CKD populations. Eligibility remains evidence- and label-specific. [10,14]	Make ordered renal/albuminuria follow-up and the clinician's interpretation visible.
Overlap between conditions	The 2026 CKM guideline addresses coordinated care across cardiology, endocrinology, nephrology and primary care. [16]	Resolve who reviews what, and who communicates the final plan to the patient.

THE COMMERCIAL CONSEQUENCE

The brand reminder ends at recall. The prescribing relationship continues through a first pack, an uncomfortable symptom, a renal report, another specialist's prescription and a refill. Those handovers create repeated opportunities to earn trust or lose relevance. A clinic service can make them visible; its effect on brand preference must still be demonstrated.

If the prescription has three possible clinical purposes, a one-purpose reminder strategy leaves value unclaimed.

INDIA MARKET EVIDENCE

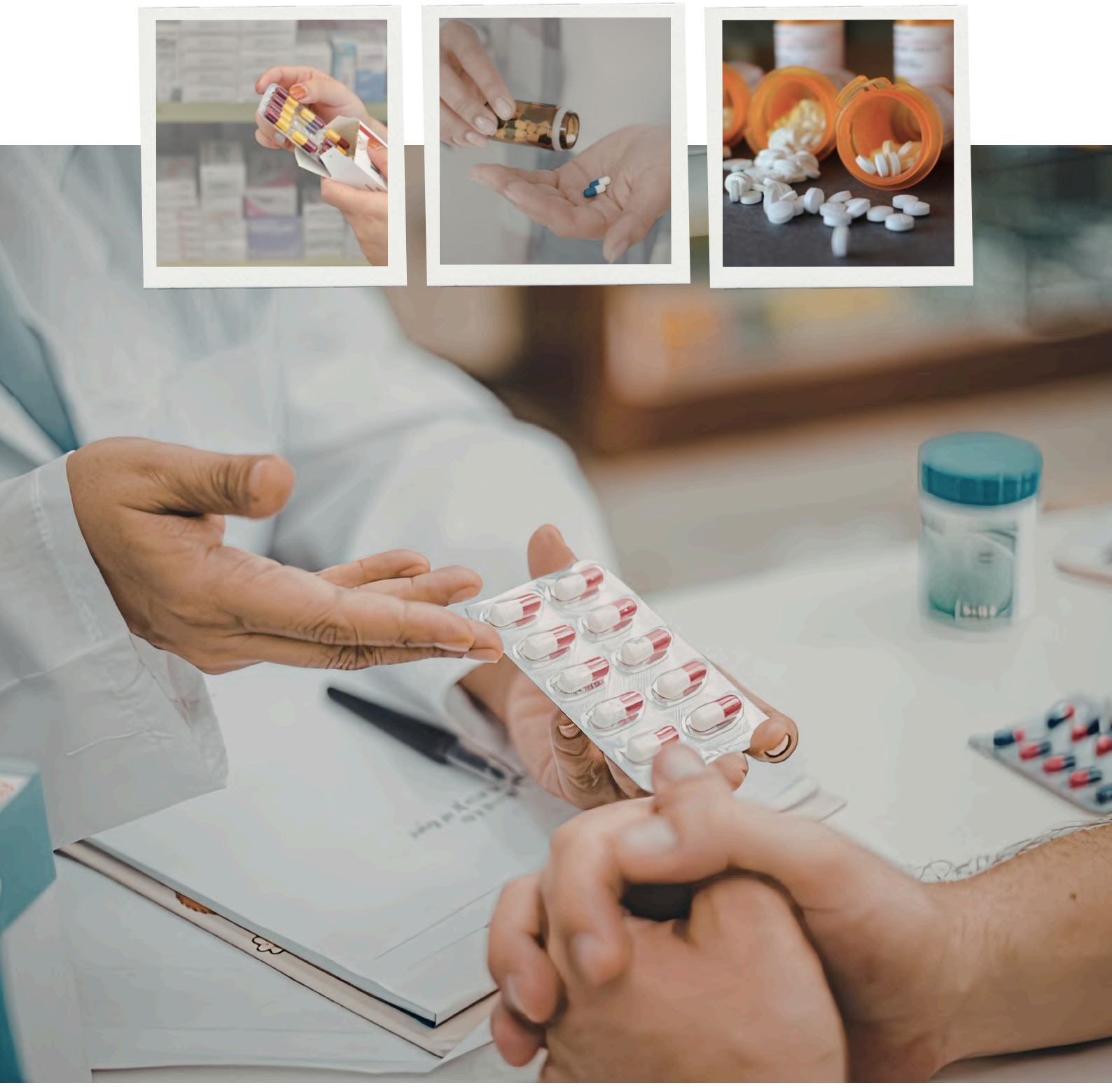
CROWDED COMPETITION IS VISIBLE BUT TODAY'S LEADERBOARD IS NOT

Public evidence verifies the post-patent expansion and provides dated market and prescribing proxies. It does not establish an auditable October 2026 national empagliflozin value, prescription prevalence, specialty split or brand ranking.

PUBLIC SIGNAL	VERIFIED FIGURE AND PERIOD	WHAT IT DOES NOT ESTABLISH
Market value [1]	ETPharma, citing Pharmarack, reported approximately INR745 crore for empagliflozin and related combinations as of April 2025.	A current monotherapy market value, current revenue forecast or independently inspected licensed dataset.
Competitive entry [1]	The same report counted 147 brands from 37 companies in plain empagliflozin and combinations in April 2025, versus 86 brands and 19 companies in March.	147 distinct monotherapy franchises or 147 brands still active in October 2026; the underlying counting rules are not fully exposed.
India prescribing proxy [2]	A 2026 Kochi nephrology study reports SGLT2 prescriptions in 81/399 eligible patients (20.3%) in its 2024 cohort; only 2 patients received empagliflozin.	National empagliflozin prevalence or post-patent uptake. This is one tertiary centre and largely dapagliflozin use.
Current strategic presence [6]	Mankind's May 2026 investor presentation names empagliflozin within its chronic-therapy expansion.	Molecule sales, a brand rank or prescription share.
Price and support pressure [3]	Alkem's March 2025 launch stated prices about 80% below innovator products and multilingual education linked from packs.	A current price comparison or proof that education closes a clinical review.

More brands make recall harder to defend. They do not prove equal shares, equal labels or equal execution.

Figures retain their source dates and denominators. Do not add unlike market definitions or extrapolate growth from these snapshots. Current rank/share claims require a licensed IQVIA, PharmaTrac, AWACS or equivalent audit.



COMPETITIVE MAP AND PRESCRIBERS

DEFINE THE MARKET BEFORE CALLING ANYONE THE LEADER

A team can lead one formulation or geography and challenge in another. Separate plain empagliflozin from metformin, DPP-4 and triple combinations. Separate brand families, strengths, packs and independent marketers before comparing shares.

ILLUSTRATIVE PRESENCE	PUBLIC BASIS	USE IN THIS NOTE
Jardiance; Empanorm; Glempa	Innovator named in the market report; Alkem and Glenmark official launch disclosures. [1,3,4]	Examples of competing franchises, without assigning a current national rank.
Empazio; Cospiaq; related FDCs	Torrent's Indian portfolio and Cospiaq prescribing information. [5,8]	Product presence and label examples; no assumption that all FDCs inherit plain-tablet indications.
Other major and regional entrants	The dated 37-company market report and Mankind's FY26 strategy. [1,6]	An open competitive universe; this list is illustrative, not exhaustive.

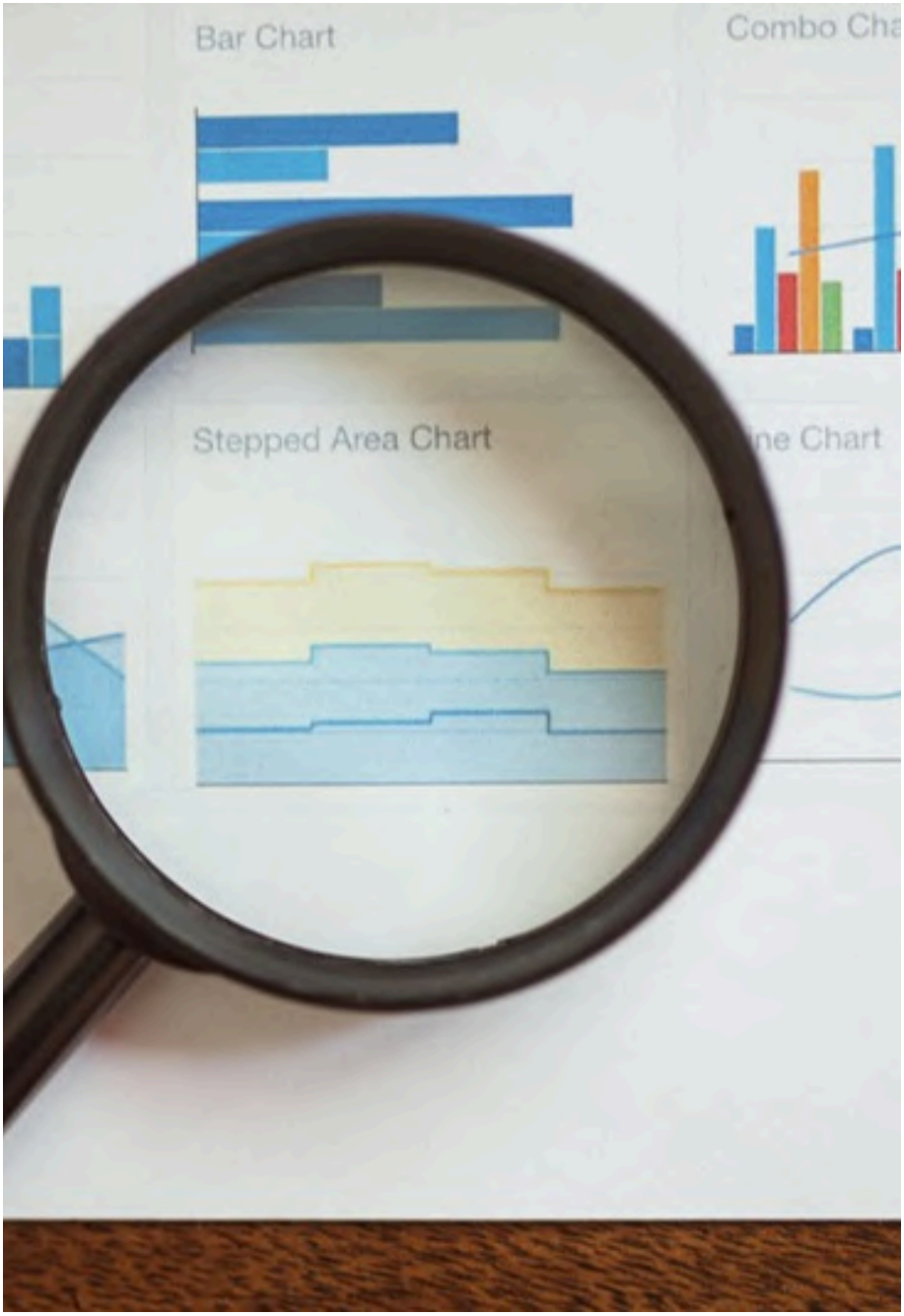
PRESCRIBER SEGMENT	WORKFLOW PRIORITY
Diabetologists and endocrinologists	Treatment purpose, glucose review, combination reconciliation, hypoglycaemia-risk and sick-day counselling.
Physicians and family/general practitioners	Longitudinal use, access, refill and specialist handover; identify one clinician responsible for closure.
Cardiologists and HF teams	HF indication, discharge handover, volume/diuretic context and timely symptom review.
Nephrologists	CKD indication, Indian-label eligibility, eGFR/UACR interpretation and shared-care follow-up.

These are clinical deployment priorities, not a verified ranking of national prescription volumes. Obtain specialty-level new/repeat prescriptions before allocating field resources. The audit should include MAT plus recent quarters, value/units, exact formulation, marketer ownership, geography, prices and channel coverage.

Alkem's FY25 report describes leadership across key SKUs but also reports formulation-specific ranks [7]. A company claim or SKU position cannot establish current leadership of the entire molecule.

Key terms: T2D = type 2 diabetes; HF = heart failure; CKD = chronic kidney disease; FDC = fixed-dose combination; eGFR = estimated glomerular filtration rate; UACR = urine albumin-to-creatinine ratio; PI = prescribing information; HCP = healthcare professional.





EMBEDDED CLINICAL ENGINE

RESPONSIBLE USE IS THE OPERATING SPINE

Entry begins only after the treating clinician has diagnosed the condition, assessed suitability and selected empagliflozin. This is a continuity service for consenting adults under an identified clinic, with a reachable clinical contact and an emergency-care alternative.

NON-NEGOTIABLE	WHAT MUST EXIST BEFORE OR DURING SUPPORT
Indication and label fit	Clinician-confirmed purpose and product-specific Indian PI check; exact formulation and current prescription reconciled. [8]
Renal and volume context	Clinician assessment of renal function and volume status; relevant diuretics, low intake and vulnerability reviewed. [8,14,17]
Purpose understood	The clinic explains the patient's selected glucose, heart or kidney goal without implying that every benefit applies to everyone. [9,13]
Safety education delivered	Private symptom contact route, urgent warning signs and direct clinician-issued illness/procedure instructions. Staff confirm understanding, not treatment eligibility. [12,17,18]
A booked next review	Date, accountable clinician, ordered tests and conditional module recorded. Test completion alone is not review completion.
A documented disposition	Continuation, further assessment, interruption, switch, referral or re-entry is a clinician decision. The service records the authorised next step.

The patient service never diagnoses T2D, HF or CKD; recommends empagliflozin; chooses a dose; or tells a patient to start, stop, switch or restart therapy.

Pregnancy or breastfeeding, suspected type 1 diabetes/insulin deficiency, acute unstable illness, dialysis, transplantation and other complex exceptions need individual clinician assessment and the applicable label. They are outside the routine pilot. No automatic enrolment from a glucose reading, eGFR value or pharmacy purchase.

A safety concern can justify moving away from the original treatment. Such a decision is successful clinical closure, never a failure to retain the brand.

INDIAN LABEL AND EVIDENCE BOUNDARIES



ONE MOLECULE DOES NOT MEAN ONE UNIVERSAL ELIGIBILITY RULE

The HCP layer must distinguish guideline evidence from the approved Indian information for the exact product. Public Cospiaq PI provides a concrete warning against copying international renal thresholds into every Indian brand asset. [8]

ISSUE	SOURCE DISTINCTION	OPERATING RULE
Kidney threshold	KDIGO recommends SGLT2 therapy for T2D with CKD at eGFR ⩾20; other CKD recommendations depend on albuminuria/HF. Cospiaq's public CKD indication specifies eGFR 30-90. [8,14]	Do not use ⩾20 as a universal Indian brand eligibility rule. Verify the currently approved product/indication.
Heart failure	International HF evidence is broader than a glucose-lowering indication. Cospiaq's public PI limits HF prescribing to eGFR >30. [8,15,23]	Record the selected HF indication and label requirements. Do not infer eligibility from diabetes status or EF alone.
Glycaemic use	Public Cospiaq PI does not recommend glycaemic use below eGFR 30. Glucose-lowering response and cardiorenal goals are distinct. [8,9]	A modest HbA1c response is not an automatic conclusion that cardiorenal therapy failed.
Strength and combinations	The public PI uses 10 mg for HF/CKD; its 25 mg escalation relates to additional glycaemic control. FDC ingredients bring separate restrictions. [8,17]	No "stronger cardiorenal dose" storyline; no transfer of monotherapy outcomes to every FDC.
Regulatory evidence	CDSCO's September 2025 SEC minutes refer to the January 2024 CKD permission and postmarketing conditions. [22]	Committee minutes support context; they do not replace the current product approval and full PI.



The lowest eGFR in a trial is not automatically the lowest eGFR in the selected Indian brand's label.

eGFR units throughout: mL/min/1.73 m^2. Public PI is an observed example, not assurance of every brand's current authorisation. Medical review must obtain the latest approved Indian PI and reconcile any update before deployment.

CENTRAL COMMERCIAL AND BEHAVIOURAL DRIFT

VALUE LEAKS WHEN NOBODY CLOSES THE NEXT DECISION

The central drift is an unreviewed plan: the clinical purpose becomes unclear, a symptom or test creates uncertainty, and the patient changes behaviour without returning to the clinic. Refill loss and brand substitution are visible downstream effects; the earlier reasons often remain hidden.

LEAKAGE POINT	WHAT THE CLINIC MAY MISS	COMPETITIVE CONSEQUENCE
Purpose collapses to sugar	A patient with HF or CKD questions treatment when glucose is normal.	The clinical rationale is lost before the refill.
First-week uncertainty	Urinary frequency, dizziness, genital symptoms, cost or conflicting advice go unreported.	Concern becomes silent non-use.
One fluid message for all	Generic “drink more” advice conflicts with an HF/CKD fluid plan.	Poor service undermines trust in the enabling brand.
Renal report without review	A change in eGFR is interpreted informally or ignored.	The medicine is blamed or continued without assessment.
Interruption without re-entry	Illness or surgery produces an unresolved treatment status.	A temporary clinical decision becomes an indefinite lapse.
Specialty handover fails	Each clinician assumes another owns the next test or review.	A broad clinical franchise becomes a fragmented experience.
Combination and supply drift	The dispensed pack, old tablets and new prescription are not reconciled.	Prescription intent and actual use diverge.
Refill without reassessment	Supply continues while an important concern or due review remains open.	Pack movement disguises an unfinished care task.

These are testable leakage mechanisms, not measured national rates. Audit a clinic’s actual gaps before sizing the commercial opportunity. Affordability, patient choice, a clinically appropriate switch and a prescribed pause are not avoidable leakage by definition.

The useful competitive asset is a clinic routine that resolves uncertainty before it becomes unobserved dropout.

Competitive Molecule Notes

MOMENTS THAT MATTER

NINE MOMENTS MAKE THE MOLECULE STRATEGY TANGIBLE



Each moment produces a usable clinic action after molecule selection. The commercial opportunity stays in the HCP relationship; the patient receives neutral care support.

MOMENT	CLINIC TASK	PATIENT RISK OR FRICTION	BRAND OPPORTUNITY
1 Handover	Record purpose, label fit and next review.	“Why this medicine?”; several specialists.	Make the chosen plan executable.
2 First pack	Confirm access and understanding.	Cost, stock, changed pack, unclear use.	Support prescription fulfilment.
3 Early check	Receive tolerability, intake and volume concerns.	Dizziness or genital symptoms stay private.	Earn safety confidence through reachable care.
4 Illness or procedure	Provide an individual clinician plan.	Fasting, infection, vomiting or surgery.	Make safe handover and re-entry reliable.
5 Weeks 2–4	Review use, symptoms and ordered tests.	A check-in happens without a decision.	Compete on completed early reviews.
6 Condition follow-up	Review HbA1c, renal or HF information as selected.	The wrong test or no named reviewer.	Connect the relevant specialty pathway.
7 Refill	Reconcile current prescription and supply.	Substitution, money, stock or missed doses.	Reduce avoidable continuity loss.
8 Partial response	Assess goal, actual use and whole regimen.	“It did not work”; duplicate therapy.	Support disciplined clinician reassessment.
9 Return or transition	Close lapse, admission or specialist handover.	Old instructions remain active.	Keep the clinic relationship useful over time.

Timing is an operating design, adjusted by the clinic. Urgent symptoms bypass routine cadence. A 2–4 week check is not a universal guideline-mandated renal test or an adequate substitute for earlier HF follow-up. [8–18]

INTEGRATED CLINIC SERVICE

CARDIO RENAL METABOLIC CONTINUITY

Cardio-Renal-Metabolic Continuity is the generic clinic service architecture. The patient-facing identity is “[Clinic name] Care Continuity”. One plan, one accountable clinic contact and one due-review list connect the selected modules.

LAYER	VISIBLE EXPERIENCE	ACCOUNTABILITY
Neutral patient shell	Plain-language purpose recorded by the clinic; appointments, ordered tests, private concerns and contact options.	Clinic identity; no brand promotion or treatment recommendation.
Clinic worklist	Due reviews, unacknowledged concerns, unresolved access barriers and clinician dispositions.	Named coordinator and covering clinician.
Conditional modules	T2D, HF and/or CKD fields activated by the clinician; one reconciled medicine record across modules.	Treating clinician selects the relevant content and cadence.
Academy clinical engine	Reviewed education, forms, response rules, translations, training cases and version control.	Independent Academy panel certifies the full service before use.
HCP brand layer	Approved product information and transparent service-support attribution after empagliflozin selection.	Medical and field teams; distinct from patient content.
Evaluation layer	Aggregate workflow measures plus separately sourced brand/sales audit data.	Authorised analytics team; no patient-level sales targeting.

LOW FRICTION IS PART OF THE STRATEGY

Use a short clinic-approved mobile page or message route and a paper/telephone alternative. Avoid mandatory app downloads, repeated questionnaires and duplicate entry. Start with the next review and one contact route. Add data only when someone is responsible for using it.

A neutral service can support a competitor’s patient. The enabling brand must earn preference through execution, evidence, availability and price.

Working architecture name only. No trademark ownership, Academy approval already obtained, exclusive clinic access or clinical outcome is implied.

MODULES AND CADENCE

START WITH AN UNDERSTOOD PLAN AND AN ACCESSIBLE CLINIC

The proposed contact cadence is deliberately light. It supports the clinician's plan and can be shortened, brought forward or omitted when clinically appropriate. Each contact must create a record someone will review.

WHEN	MODULE AND CLINIC TASK	COMPLETION RECORD
Day 0 **After selection**	Record purpose, exact medicine/formulation, relevant baseline renal assessment, volume context, other medicines, next review and named clinician. The clinician gives individual illness/procedure and missed-dose instructions.	Plan acknowledged; clinic contact saved; selected module and due date recorded.
Days 3–7 **Optional early contact**	Confirm access and understanding. Offer a private route for genital/urinary symptoms, dizziness, poor intake and other concerns. Use the clinic's fluid advice; avoid a universal litre target.	Barrier or concern documented and routed; no symptom interpretation by non-clinical staff.
Any time **Safety or illness**	Urgent symptoms go to urgent/emergency care. New illness, reduced intake, fasting or a planned procedure triggers direct clinical contact and an individual plan.	Time of report, handoff and acknowledgement; emergency routing does not wait for a form.
Weeks 2–4 **Early review**	Review tolerability, actual use, access, relevant volume status and any tests the clinician ordered. Confirm treatment purpose and next review.	Clinician disposition and date; unresolved actions retain an owner.
Before supply ends **Refill coordination**	Ask about stock, affordability or a changed pack using the current prescription. Reconcile any clinical change before pursuing continuity.	Supply status or documented barrier; exact-brand measure remains separate from patient messaging.

A completed contact is not a completed review. Closure requires an authorised clinical plan or a documented decision that assessment is still needed.

Telephone and paper routes carry the same core record. A patient can decline digital support without losing usual care. Messages must disclose staffed hours and the urgent-care alternative; the service must not imply continuous monitoring.

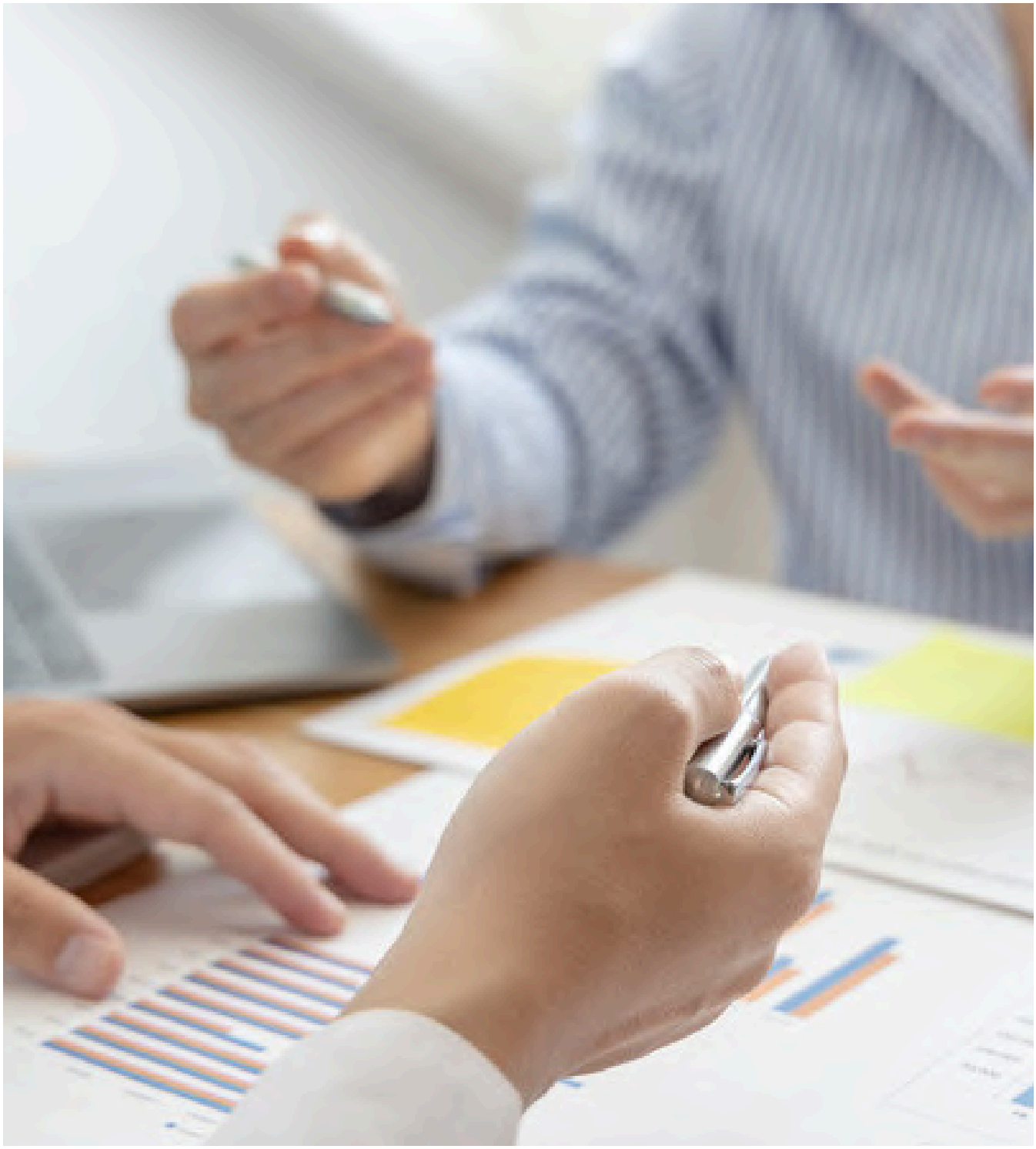
Clinical content is grounded in the selected Indian PI and safety guidance [8,12,17,18,24]. Days 3–7 and weeks 2–4 are pilot settings, not universal prescribing requirements.

CONDITION SPECIFIC FOLLOW-UP

ACTIVATE ONLY THE MODULE THE CLINICIAN NEEDS

The core loop is shared. The clinical information is conditional. A person receiving empagliflozin for HF without diabetes should not be pushed through a compulsory glucose-monitoring programme.

MODULE	INFORMATION FOR THE CLINIC	CADENCE AND BOUNDARY
T2D review	Clinician's glycaemic goal; actual use; hypoglycaemia history; home glucose record only if requested; HbA1c and other ordered tests.	ADA commonly supports HbA1c about every 3 months after change/not at goal and twice yearly when stable. No default daily testing for everyone. [11]
HF review	Named HF clinician; discharge/visit plan; symptoms; weight/BP/volume observations only as requested; relevant diuretic and other medicine changes.	HF team sets follow-up and alert thresholds. Recent discharge may need earlier review than 2–4 weeks. No automated diagnosis or diuretic adjustment. [15,23]
CKD review	Date and original report for eGFR and UACR where ordered; illness/volume context; other kidney-related medicines; clinician interpretation.	Monitoring follows CKD risk, clinical change and the clinic's plan. An extra early renal test is not mandatory for every SGLT2 start. [10,14]
Overlap or handover	One current medicine list; which clinician owns renal, glucose and HF review; next appointment and unresolved actions.	One accountable lead prevents duplicate requests or conflicting instructions. Information sharing requires the patient's permission and secure routes.
Re-entry	Reason for lapse/interruption; current medicines; intervening illness/admission; clinician review and updated plan.	Restart is never triggered by a refill, elapsed days or a "feeling better" response. [12,17,18]



ONE FACTUAL REVIEW BRIEF

Patient identifier in the clinic record; selected purpose; current prescription; what was actually taken; questions and symptoms in the patient's words; ordered reports with units/dates; access barriers; clinician assessment; disposition; next owner and date. Unknown information stays marked unknown.

HbA1c, eGFR and weight are not interchangeable success scores. The clinician decides what each means for this patient.

SAFETY AND ESCALATION



A SYMPTOM ROUTE MUST WORK BEFORE THE FIRST ENROLMENT

The following is a service-routing design for medical approval. It is not a diagnostic algorithm. Patient-facing wording requests care, never labels the condition or generates a treatment change. [8,17,18,24]

SIGNAL OR SITUATION	SERVICE RESPONSE	CLINICAL RESPONSIBILITY
Severe breathlessness, collapse, confusion, severe allergic symptoms or severe hypoglycaemia	Seek emergency care immediately through local emergency services/nearest emergency department; do not wait for a message reply.	Emergency assessment; the clinic is informed without delaying care.
Possible ketoacidosis symptoms: vomiting, abdominal pain, unusual severe weakness or breathing difficulty	Urgent medical assessment now, even if a glucose reading is not high. Severe symptoms use the emergency route.	Clinician assesses ketones/acidosis and takes urgent treatment decisions under the PI. No “normal glucose means safe” reassurance.
Genital/perineal pain or swelling with fever or feeling very unwell	Immediate urgent/emergency assessment. Do not place in a routine infection queue.	Assess serious infection including Fournier’s gangrene; urgent management where indicated.
Genital itching, discharge or soreness; burning urination	Private prompt clinic contact; fever, flank pain or systemic illness warrants urgent assessment.	Distinguish genital mycosis, urinary infection and other causes; treatment and medicine decisions remain clinical.
Dizziness, faintness, low intake, vomiting/diarrhoea or fluid concerns	Prompt same-day clinical contact; severe illness, collapse or inability to keep fluids down needs urgent care.	Assess volume status and medicines; reconcile HF/CKD fluid restrictions.
New foot wound, ulcer or infection; pregnancy/breastfeeding concern; other adverse effect	Route promptly to the clinic, with urgent care if severe/systemically unwell.	Individual assessment and appropriate medicine review; capture suspected adverse events.

Urgency examples are not exhaustive. Patients may use urgent care directly without completing questions or waiting for a clinic callback. The clinic approves local language, staffed hours, escalation coverage and tested fallback routes before activation.

RENAL REVIEW AND TREATMENT INTERRUPTIONS

PREVENT UNCERTAINTY WITHOUT AUTOMATING A MEDICINE DECISION

Two predictable sources of confusion deserve explicit design: a renal result after initiation, and a temporary interruption for illness or a procedure. Both require a named clinician and a closed follow-up plan.

HCP ISSUE	CLINIC ACTION	PATIENT SERVICE BOUNDARY
Initial eGFR change	KDIGO notes that the early reversible eGFR decrease is generally not itself a reason to discontinue. Assess the patient, volume context and clinically significant change. [14]	Carry the original dated report to the clinician. Do not reassure that every fall is harmless or calculate a continue/stop instruction.
Monitoring frequency	Assess renal function before treatment and as clinically indicated under the PI; use risk-based CKD monitoring. [8,10]	Remind only for ordered tests. No standing 2-week renal panel imposed on every participant.
Planned surgery or prolonged fasting	FDA labelling specifies withholding empagliflozin at least 3 days beforehand if possible; ADA gives a 3–4 day SGLT2 class interval. The responsible clinician reconciles the Indian PI and procedure. [8,12,17]	Ask the patient to contact the treating/procedure team early. The service never generates the interruption date or medicine instruction.
Acute illness or suspected ketoacidosis	Clinician provides direct sick-day and emergency instructions. Suspected ketoacidosis requires urgent evaluation and clinician-led discontinuation under the PI. [17,18]	Confirm that direct clinical counselling occurred. Route symptoms urgently; do not wait for a routine review or use normal glucose to dismiss risk.
Restart and handover	Clinician checks recovery, intake and resolution of relevant risks, then authorises the next plan. [12,17,18]	Record the authorised plan and next appointment. No automatic restart after a fixed number of days.

A safety pause without a named reviewer is an unfinished plan. A refill reminder cannot finish it.

The neutral service must never weaken the approved safety instructions. The prescriber delivers patient-specific medication instructions directly as part of care; the service records their receipt and supports contact, documentation and review. Medical teams must validate that separation before launch.





DOCTOR-FACING SUPPORT





GIVE THE DOCTOR A BETTER REVIEW RATHER THAN ANOTHER CLAIM SHEET

The doctor-facing layer begins after independent molecule selection. It helps execute and reassess the chosen treatment. It must also make it easy for the clinician to conclude that the current regimen should change.

REVIEW TOPIC	HCP SUPPORT ASSET	CLINICAL CHECK
Patient fit and purpose	One-page indication/Indian-label checklist	Confirm selected indication, renal context and exclusions; no automated eligibility recommendation. [8,9,14]
Counselling and safety	Teach-back card and symptom-routing map	Purpose, private infection concerns, individual fluid plan, illness/procedure route and missed-dose clarification. [17,18,24]
Metformin or metformin FDC	Full ingredient/strength reconciliation	Check separate renal, illness and procedure restrictions; preserve formulation and dosing instructions. [9,10]
DPP-4 or GLP-1 therapy	Combination review prompt	Review the entire regimen. ADA does not recommend concurrent DPP-4 inhibitor plus GLP-1-based therapy for added glucose lowering. [9]
Insulin or secretagogue	Hypoglycaemia-risk review prompt	Clinician assesses any dose changes; the service never reduces insulin or encourages omission. Insulin reduction/deficiency can contribute to ketoacidosis risk. [9,17]
HF and kidney medicines	Shared-care medicine list	Review diuretics, volume status and renal context; other disease-modifying therapies remain part of the full care plan. [14,15,23]
Partial response or concern	Factual brief with patient use, access and reports	Assess goals and actual use before clinician-led intensification, add-on, switch or referral. No automatic dose ladder. [9,13]

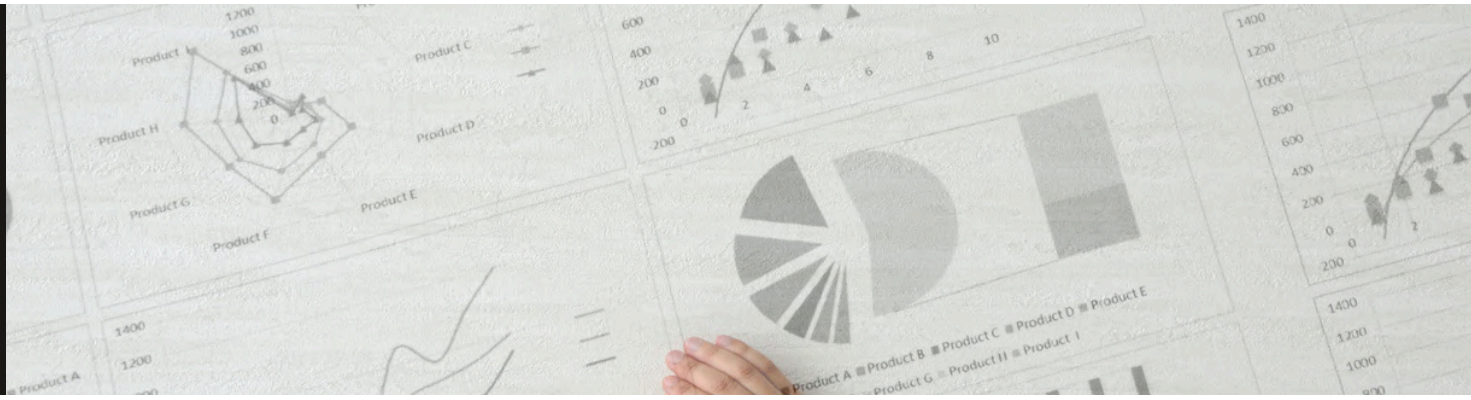


Better patient fit and safety confidence are earned through appropriate clinical review, never through a sales-led selection tool.

Molecule evidence does not establish superiority of any Indian brand. Comparative or formulation claims require their own substantiation and company medical-legal-regulatory approval.

ACADEMY-BACKED EDUCATION

SIX MONTHS TO MAKE THE WORKFLOW ROUTINE



The Academy governs the full clinical service: education, forms, questions, response rules, outputs, translations, escalation routes and updates. The series below trains clinicians to use that service. Academy certification is separate from sponsor endorsement and is required before operational release; it is not claimed as already obtained.

MONTH	MINI CME AND CASE SHARE	PRIMARY AUDIENCE AND PRACTICE TASK
1	The treatment purpose beyond HbA1c	Diabetologists, endocrinologists and physicians: a T2D patient with near-goal HbA1c and comorbidity; document the clinician's purpose and Indian-label fit. [9,13]
2	The first weeks without unsafe reassurance	Physicians, family practitioners and diabetes teams: an older patient on diuretics reports dizziness; practise volume-context review and safe routing. [17,18]
3	Private symptoms and illness plans	All prescriber segments: genital symptoms versus systemic illness; possible euglycaemic ketoacidosis; fasting or surgery and direct clinician instructions. [12,17,24]
4	Renal reports that lead to decisions	Nephrologists, diabetologists and physicians: interpret eGFR in context, plan UACR/renal follow-up and reconcile FDC restrictions. [10,14]
5	HF continuity across discharge and outpatient care	Cardiologists, HF teams and shared-care physicians: named follow-up owner, individual fluid/weight plan and medicine reconciliation. [15,16,23]
6	Combination review and clinician-led re-entry	Endocrinologists and all shared-care specialties: partial response, insulin/DPP-4/GLP-1 context, affordability and return after interruption. [9,13]

A USABLE LEARNING RHYTHM

Each month: a concise case-based session, a one-page clinic tool and an anonymised case discussion at the next meeting. Assess case decisions and whether the workflow is used, not prescriptions generated. Nurses and coordinators receive a separate role-specific briefing on consent, routing and documentation.

Certification covers the clinical service. Sponsorship does not buy a scientific conclusion, a prescription commitment or access to patient records.

The Academy's identity, independent review panel, certification wording and any CME accreditation must be documented. No CME credit claim until formally granted. Sponsorship, speaker arrangements and funding disclosures follow applicable UCPMP requirements. [19]



LEADER STRATEGY

TURN DEFAULT PRESCRIBING INTO CLINIC INFRASTRUCTURE



The leader's exposure is complacency. Familiarity can win the first prescription while a competitor builds the routine that resolves the patient's next problem. Defend default status by making dependable continuity part of the clinic's normal operation.

LEADER MOVE	EXECUTION CHOICE	PROOF TO DEMAND
Cover the whole continuity loop	Activate the shared spine across diabetes-led clinics, then add HF/CKD modules where teams have capacity and label fit.	High clinic adoption with no module activated merely to widen promotion.
Prioritise valuable existing relationships	Select clinics with meaningful empagliflozin use and visible review or access gaps; use an audited baseline.	More due reviews closed without unsafe retention or increased clinic burden.
Make the service reliable	Provide an accountable service team, regular worklist review and escalation coverage.	Staff keep using it when the representative is absent.
Connect the franchise carefully	Maintain one current prescription record through clinically appropriate mono/FDC transitions.	Fewer unresolved medicine mismatches; no inferred cardiorenal claim for an FDC.
Defend availability and affordability	Track aggregate stock and access barriers alongside the clinical service.	Resolved supply friction and sustainable margin; no patient pressure to remain with an unaffordable pack.
Publish an operating standard	Use Academy-governed tools, a clinic adoption guide and a measured review routine.	Clinical and operational performance that is reproducible across clinics.

WHAT THE LEADER SHOULD REFUSE

A nationwide QR campaign with no clinic owner; retention targets that penalise appropriate discontinuation; brand-name reminders in the patient shell; and a large activation number without evidence that clinicians close reviews. Scale amplifies these defects.

> The leader's advantage is reach. Convert that reach into a routine competitors must work to displace.

Defence thesis: useful service adoption may reinforce HCP preference. It is a hypothesis to validate alongside price, supply and existing prescription habit, not a guaranteed moat or claim to exclusive clinic access.





CHALLENGER STRATEGY

CHANGE WHAT THE DOCTOR COMPARES



The challenger should not out-remind the leader. It should make one important care gap visible, solve it reliably and let the doctor compare the operating experience. A useful service creates a fresh reason to consider the challenger after the clinician has independently selected empagliflozin.

CHALLENGER MOVE	EXECUTION CHOICE	EVIDENCE OF TRACTION
Enter through an unfinished task	Start with newly initiated patients whose early review is often missed, or one shared-care handover gap.	Documented baseline gap and a named clinic owner.
Demonstrate early safety confidence	Show how private symptom reporting reaches a clinician and how urgent routes bypass the routine queue.	Acknowledged concerns and appropriate dispositions; no promise of fewer adverse events.
Make patient fit an HCP discipline	Provide an approved indication/renal/volume checklist after selection, without turning representatives into prescribers.	Clinicians use the checklist and can reject unsuitable use without commercial friction.
Make cardiorenal follow-up concrete	Connect ordered information to a booked review and written next step.	More reviewed plans in the chosen cohort than under the pre-specified comparison.
Earn a reason to revisit the brand	Use an aggregate clinic workflow review and approved HCP product information as the next call.	Independent brand consideration or market movement, measured separately from care records.
Keep support neutral	Continue service access when the clinic prescribes a competitor or chooses a different treatment.	Trust survives the prescribing decision; commercial value comes from quality of execution.



The strongest challenger call is a completed clinic task the incumbent has left unfinished.

THE CHALLENGER'S TRADE-OFF

A narrower pilot gives a clearer demonstration but less immediate reach. A broad launch may generate many introductions and little proof. Begin where the team can close the clinical loop, establish incremental workflow value, then test whether HCP preference and commercial movement follow.

No competitor disparagement, unsupported safety comparison or claim that the service makes one empagliflozin brand clinically superior to another.





SELECTIVE SHARE AND MID TIER STRATEGY



CHOOSE ONE WEDGE AND FINISH THE WORK

For a mid-tier or other brand, a broad replica of the leader's programme spreads service capacity thin. The default starting wedge is newly initiated T2D patients in clinics with a documented early-review gap and reliable clinical coverage. More complex wedges require the corresponding specialty capacity.

RANKED WEDGE	WHY IT CAN WORK	ENTRY CONDITION AND TRADE-OFF
1 New T2D starts	Clear entry date and observable 2-4 week review loop.	Documented molecule selection and review capacity; simpler pilot, but no assumed large leakage rate.
2 Diabetes plus CKD shared care	Renal reports and specialty handovers create concrete coordination tasks.	Product-specific label fit and named renal-review owner; higher clinical complexity.
3 Diabetes plus HF clinics	Discharge/OPD handover, volume context and prescription reconciliation matter.	HF team owns follow-up and urgent escalation; a generic call centre is insufficient.
4 Refill or substitution cluster	Stock, price and changed packs create a measurable fulfilment problem.	Local evidence of avoidable mismatch; solve affordability and supply rather than pressuring brand retention.
5 Unresolved genital-symptom concerns	Privacy and access to prompt review can reduce silent disengagement.	Select clinics with an observed reporting gap. Recurrent infection is a clinical risk, not a growth audience.

THE SELECTION RULE

Rank candidate clinics on documented gap size, ability to respond, patient access, label fit and service cost. Choose one wedge before adding another. A brand with strong nephrology relationships may reasonably start at rank 2; the ordering is an execution judgement, not a prescription-volume estimate.

> Own one high-leakage task completely before paying for molecule-wide visibility.

Reject wedges built around unsafe persistence, unreviewed low eGFR, off-label use, people with suspected type 1 diabetes or repeated infection despite the clinician's concerns. A selective-share strategy must be selective about what it will not try to retain.

"High-leakage" must be established from local baseline evidence. No national infection-dropout or substitution rate is assumed.



FIELD FORCE STORYLINE

MOVE THE CALL FROM PRODUCT RECALL TO CLINIC ADOPTION



The representative introduces the operating routine and follows up on aggregate adoption. Clinical concerns go to clinicians; suspected adverse events go through the approved pharmacovigilance route. Patient details never enter sales notes.

OLD CALL	NEW CALL
Repeat the molecule's benefit claims	Identify one gap between prescription and the next reviewed plan.
Leave a generic diabetes leaflet	Show a neutral clinic plan and a factual review brief using synthetic data.
Ask for more prescriptions	Ask for a named clinic owner, a cohort and a review of operating results.
Treat symptoms as sales objections	Use the clinical/PV handoff; never reassure, diagnose or advise treatment.
Count QR scans as conversion	Review active clinics, completed reviews and unresolved operational barriers.

THIRTY-SECOND STORYLINE

"Doctor, after you select empagliflozin, the next challenge is keeping its purpose, safety questions and follow-up connected. Care Continuity gives your clinic a neutral patient plan, a due-review list and a brief for your next decision. You choose the diabetes, heart or kidney module and all treatment decisions. The first test is whether more due reviews are completed."

THE FIVE-MINUTE STORYLINE

TIME	CONVERSATION
Minute 1	Identify the largest local gap: early review, private symptoms, renal report, HF handover or access.
Minute 2	Demonstrate the clinic-branded plan and direct contact route with synthetic data.
Minute 3	Show how the coordinator brings information to the clinician and records the disposition.
Minute 4	Explain Academy governance, role boundaries, privacy and pharmacovigilance.
Minute 5	Agree the clinic owner, first cohort, operating cadence and date to inspect results.

Any product claim remains approved-label, substantiated HCP communication after molecule selection. The service invitation cannot be tied to prescription commitments. [19]

ASSET SYSTEM

EVERY ASSET MUST CLOSE A SPECIFIC CLINIC TASK

The asset system should be small enough to use between consultations. Each item has one owner, one purpose and a version date. Avoid turning the service into a content library that nobody operates.

CORE ASSET	USER AND TASK	RELEASE CHECK
Clinic plan card	Patient: retain purpose, next appointment, ordered tests and direct clinic contact.	Clinic identity; no sponsor promotion; understandable local language and paper alternative.
Initiation and review checklist	Clinician: confirm label fit, relevant renal/volume context and follow-up ownership.	Medical/Academy review; no automated medicine recommendation.
Private symptom contact form	Patient/coordinator: report concerns in the patient's words.	Minimum necessary fields; emergency message before data entry; no intimate images requested.
Safety and illness discussion card	Clinician: give individual counselling, including genital hygiene and symptom reporting, fluid plan and procedure/illness instructions.	Accurate urgency; no universal fluid volume or automated start/stop instruction. [17,18,24]
Due-review list and brief	Coordinator/doctor: gather ordered information and close the next plan.	Named owner, dates, original reports and auditable disposition.
Prescription and supply record	Clinic: reconcile mono/FDC changes and access barriers.	Exact brand stays in the clinic-only record; the patient shell uses neutral wording and no brand prompts.
Six case tools and faculty guide	HCPs: practise the monthly workflow tasks.	Independent Academy certification and separate MLR review where product content is present.
Field demonstration and scorecard	Representatives: show the service and review aggregate adoption.	Synthetic demonstration; no clinical records, patient names or symptom details.

No mandatory app. No duplicated case history. No data field without an operational use and accountable owner.

The clinic reconciles exact-brand fulfilment against its prescription record. Patient messages ask about access or changed packs in neutral terms and refer questions back to the clinic; brand names and promotion remain in the HCP/field-force layers.

MEASUREMENT MODEL

MEASURE A REVIEWED PLAN BEFORE MEASURING SHARE

The evaluation chain is clinic activation → appropriate-use support and reported adherence → safety/review capture → prescription and exact-brand continuity → commercial movement. Each step needs its own denominator; success at one step does not prove the next.

Primary decision metric: on-time reviewed-plan completion rate among enrolled patients whose first clinic-set review has become due.

Numerator: patients whose due review is completed by the responsible clinician within the pre-specified window, with a documented disposition and next date or care transition. Denominator: all enrolled patients whose first review window has elapsed. Set the date/window at enrolment; do not move it retrospectively to improve the score. Unknown, unreachable and incomplete reviews are not successes. Report withdrawal and loss-to-follow-up explicitly.

STEP	SUPPORTING MEASURE	INTERPRETATION
Clinic activation	Clinics with a trained owner, tested escalation route and at least one enrolled patient; weekly active clinics.	A signed interest form or QR display is not activation.
Appropriate-use support	Completeness of indication/PI check and counselling documentation; patient-reported barriers and use.	Check documentation against sampled clinical records. Self-report does not prove ingestion or appropriateness.
Safety and review	Primary completion rate; time to acknowledgement and clinician disposition; overdue urgent signals.	An appropriate stop, switch or referral counts as clinical closure. Safety failures override commercial success.
Continuity	Refill gaps and reasons; current prescription reconciled; exact-brand fulfilment where the clinician retains that prescription.	Separate clinical change, patient preference, affordability, stock substitution and unknown status.
Commercial movement	Audited value/unit/Rx share in the defined market plus HCP adoption/preference research.	Use independent aggregate data; do not link identifiable care records to sales targeting.

For a stable new-start pilot, a first review in weeks 2–4 may be the clinic-selected window. HF discharge or clinical concerns can require earlier review. Compare like cohorts and retain the original due date. Consent withdrawal/data deletion must follow the approved retention policy.

COMMERCIAL PROOF AND ECONOMICS

A USEFUL CATEGORY SERVICE MUST STILL EARN ITS ECONOMICS



Brand-neutral support can benefit competitors. That is an operating fact to price into the model, not a reason to restrict care. A commercial advantage must come from HCP trust, better execution and reliable supply, and survive comparison with what would have happened anyway.

QUESTION	EVALUATION DESIGN	LIMIT
Did the workflow improve?	Compare the primary metric with a pre-specified baseline and matched clinics, or a phased rollout when feasible. Adjust for specialty, indication and starting performance.	A before/after rise alone is weak causal evidence. Report clinic-level variation and missing data.
Was the care routine safe?	Review all urgent-route failures and a sample of completed and unresolved cases. Track reported AE capture and disposition.	More reported events may mean better capture; a lower count is not proof of safer treatment.
Did exact-brand continuity change?	Verified same-brand fulfilments divided by all refill opportunities where the clinician kept that exact prescription; unknowns remain unverified.	Report clinical switches and patient choice separately. No claim that a brand switch is inherently clinically harmful.
Did market performance move?	Compare aggregate share/units in the same formulation, channel and geography against suitable controls and prior trends.	Price cuts, availability, launch effects, competitor activity and field effort can explain movement.
Can the service scale?	Track total cost, active-clinic cost, staff minutes per patient and cost per additional on-time reviewed plan.	Only compute incremental cost per completion if a defensible positive increment is established.



THE ECONOMIC RULE

Estimate incremental gross contribution from independently audited incremental sales, using realised net contribution per unit, then subtract the full service and field-support cost. Show conservative, base and upside assumptions; do not multiply all enrolled patients by an assumed brand lifetime value. The 90-day pilot tests adoption and operating economics, not long-term cardiorenal outcomes.

If clinics value the workflow but brand movement is absent, revise the commercial model. Do not contaminate the patient service to manufacture conversion.

No numerical ROI, market-share gain or clinical benefit is forecast in this note. Pilot metrics and thresholds are proposed decision rules, not published standards.

GOVERNANCE AND GUARDRAILS

PROTECT THE CLINICAL SERVICE FROM THE SALES OBJECTIVE

The operating model requires separate clinical, Academy, product-promotion, privacy and pharmacovigilance responsibilities. They must be assigned before enrolment, with a versioned protocol and a tested fallback when digital contact fails.

CONTROL	REQUIRED OPERATING RULE
Clinical authority and identity	Clinic-branded neutral patient shell; an identified treating clinician owns assessment, tests, diagnosis and every treatment decision. Product claims appear only in approved HCP/field layers after molecule selection.
Medical and Academy release	Map each indication/strength/FDC to its current Indian PI. Academy certification covers the full clinical service and translations; company MLR approves promotional claims separately. Neither approval is claimed as complete here.
Safety operations	Define emergency bypass, staffed hours, clinical acknowledgement, overdue escalation and backup coverage. Direct clinician counselling covers infection, volume, ketoacidosis, renal and interruption/restart risks.
Pharmacovigilance [21]	Capture suspected AEs without waiting for causality confirmation or excluding competitor products. Route promptly to the designated PV process; reconcile duplicates and follow-up. PV staff classify organised-program reports and apply applicable timelines.
Consent and data [20]	Explain purpose, clinic/controller roles, processors, data sharing, contact preferences and withdrawal. Minimise collection; use role-based access, secure storage, audit logs and defined retention/deletion. No advertising trackers or sales access to patient records.
Commercial and education conduct [19]	No prescription-linked rewards, gifts, enrolment quotas tied to prescribing, brand-conditioned care, competitor disparagement or hidden sponsorship. Apply current UCPMP and applicable professional requirements.
Automation and quality	No automated diagnosis, risk score, dose, hold, restart, switch or result interpretation. Automation may schedule and route under approved rules. Human clinical review owns closure; incidents can pause enrolment.

DPDP Rules 2025 have phased commencement; verify the provisions applicable on the actual launch date and other applicable privacy obligations. Build the stated protections now. Aggregate sponsor reporting must suppress small cells and prevent re-identification; PV reporting follows its separate lawful safety process. [20,21]

FIRST-MOVER PILOT



NINETY DAYS TO CONFIGURE ACTIVATE AND PROVE

The pilot should reveal whether clinics adopt the routine and whether more due reviews close. It should also expose the staffing and supply problems that would make expansion fail. Illustrative clinic counts below are planning choices, not a power calculation or a statement of available capacity.

PHASE	OPERATING WORK	EXIT EVIDENCE
Days 1-15 Configure	Choose one formulation universe and initial cohort; baseline the gap; approve clinical content, Indian PI mapping, data/PV arrangements, Academy process and evaluation plan; train and test clinic staff.	Named owners; label and content release; successful urgent-route simulation; comparison design and frozen metric definitions.
Days 16–45 Activate	Enrol in manageable waves; confirm patient understanding and access; operate early checks and due reviews; inspect exceptions weekly.	A mature first cohort with observable due dates; worklists used by clinic staff without rep dependence.
Days 46–75 Prove	Complete review windows; assess unresolved concerns, refill barriers and staff time; compare workflow results and separately audit commercial signals.	Auditable numerator/denominator, safety review, clinic-level performance and economic evidence.
Days 76–90 Decide	Use mature cohorts only for completion analysis; stress-test capacity; decide expand, refine or stop. Maintain care handover for enrolled patients.	Written decision against pre-set gates; no abandoned patient worklist if the pilot ends.

POSTURE	ILLUSTRATIVE PILOT SHAPE
Leader	20–30 existing high-value clinics across two clusters; core spine first, conditional specialty modules only where staffed. Test breadth and sustained adoption.
Challenger	12–18 matched or phased-rollout clinics in one accessible specialty corridor. Test incremental closure of one neglected task and independent HCP consideration.
Selective share	6–10 clinics in one wedge and geography. Test repeatable execution, density and cost before widening the footprint.

An effectiveness study or research publication may require ethics and other approvals beyond routine service evaluation. Decide that status before recruiting; do not retrofit a research claim to a commercial pilot.





DECISION GATES AND CAPACITY

EXPAND ONLY WHEN THE CLINIC CAN CARRY THE PROMISE



Freeze the gates before the first enrolment. The following numerical settings are illustrative management thresholds and must be adjusted to baseline, sample size and staffing before launch. Safety and label requirements are non-negotiable.

GATE	ILLUSTRATIVE DECISION RULE	IF IT FAILS
Readiness	Every active clinic has approved content/PI mapping, trained owners, consent/PV process and a passed urgent-route test.	Do not enrol until the missing requirement is resolved.
Primary workflow result	Target ⩾80% on-time reviewed-plan completion and ⩾15 percentage-point improvement versus the pre-specified comparison, using mature cohorts.	Investigate baseline imbalance, missingness and clinic variation; refine or extend the test rather than claim success.
Safety	No unresolved critical failure of the service's urgent routing; every reported urgent signal has a documented handoff audit.	Pause affected enrolment, investigate and correct. This is a service-safety gate, not a zero-AE target.
Adoption and burden	Target ⩾70% of activated clinics using the workflow weekly in the final month; measure coordinator time against a staffed budget.	Simplify the process or reduce enrolment. Representative-led data entry is not sustained clinic adoption.
Commercial and cost	At least a credible directional commercial signal in the defined audit universe, with acceptable unit economics under conservative assumptions.	Continue clinical support as appropriate, but withhold commercial scale claims; revise the enabling model.
Expansion capacity	Medical oversight, coordinators, training, response coverage and supply support can accommodate the next wave.	Hold the next wave; preserve care for existing participants.

LEGITIMATE FIRST-MOVER URGENCY

The same architecture is being circulated across the molecule. Advantage comes from earlier clinic adoption, learning and dependable service, not an artificial deadline. Allocate funded implementation capacity to clinically ready cohorts with accountable owners. Specify actual staffing and dates before committing to a wave; no finite slot count or territorial exclusivity is claimed here.

Being first matters only if the clinic keeps the routine. A premature launch hands the competitor the lesson for free.

LEADERSHIP DECISION



DEFEND ATTACK OR CAPTURE BEFORE A COMPETITOR MAKES THIS ROUTINE

Empagliflozin's competitive field now includes more formulations, more price points and more clinical entry routes. Another molecule reminder leaves the same care tasks unfinished. The decision is which task the brand will make dependable, and where it can prove the difference.

CHOOSE THE POSTURE	MAKE THE COMMITMENT	DEMAND THE PROOF
DEFEND **Market leader**	Make the complete cardio-renal-metabolic continuity spine part of the existing clinic relationship.	The service survives at scale, clinicians keep using it and prescription leadership becomes harder to displace.
ATTACK **Challenger**	Change the comparison through a measurable improvement in early review, safety confidence and cardiorenal follow-up.	Clinics close more due reviews, HCP consideration changes and independent commercial signals follow.
CAPTURE **Selective-share brand**	Choose one documented high-leakage wedge and resource it deeply enough to finish the work.	A repeatable clinic routine and viable economics before a broader rollout.

THE DECISION TO TAKE NOW

Name the posture, the first clinic cohort, the clinical owner and the review-completion metric. Fund a 90-day test with the safety gates intact. Require auditable evidence before claiming national leadership, workflow superiority or commercial return.

The first-mover advantage is practical: clinics learn a routine, teams learn how to operate it and competitors must then displace an experience rather than a slogan. That advantage remains contestable. It has to be renewed through performance.

This opportunity is being shown to direct competitors. Decide which clinic workflow to occupy before another empagliflozin team makes it the expected standard.

Inditech competitive thesis: clinically useful service → better clinic continuity → HCP trust in the enabling team → an opportunity to earn brand preference. Every arrow requires evidence. The patient service remains clinic-branded, neutral and subordinate to clinical judgement.







India market evidence and source boundaries

[1] ETPharma. NPPA sets empagliflozin combos retail prices as domestic brands initiate generic contest. 9 May 2025.
Secondary commercial report attributing market figures to Pharmarack/PharmaTrac. April 2025 plain-plus-combination proxy, not October 2026 market data or an independently inspected licensed audit.

[2] Gopal A et al. Prescription Patterns of Sodium-Glucose Co-Transporter 2 Inhibitors among Nephrologists. Indian Journal of Nephrology. 2026;36(5):596–600.
Published 28 August 2026; one Kochi tertiary-centre cohort reported for 2024. Abstract and Table 1: 399 eligible; 81 SGLT2 users, including only two empagliflozin users. Not national prevalence.

[3] Alkem Laboratories. Launch of generic empagliflozin and combinations under Empanorm. 12 March 2025.
Primary company disclosure of entry, price positioning and pack-linked education. Price comparison is the company's dated launch claim, not a current independent comparison.

[4] Glenmark Pharmaceuticals. Launch of empagliflozin and fixed-dose combinations in India. 12 March 2025.
Primary portfolio-presence source for Glempa, Glempa-L and Glempa-M. Promotional efficacy language in this release is not adopted as a blanket claim.

[5] Torrent Pharmaceuticals. Indian product information directory.
Public listing of empagliflozin and combination products. Establishes presence, not market share or identical indications across products.

[6] Mankind Pharma. Investor presentation.
FY26 strategic context: empagliflozin named within chronic-therapy expansion. No molecule-specific current market size or rank inferred.

Indian label and diabetes guidance

[7] Alkem Laboratories. Annual Report 2024–25. Chronic-therapy discussion and new product performance.
Company-reported selected-SKU leadership and formulation-specific positions. These statements are not treated as a current complete molecule leaderboard.

[8] Torrent Pharmaceuticals. Cospiaq empagliflozin 10 mg and 25 mg prescribing information. Public Indian PI.
Sections 1, 2 and 5: indication-specific renal limits, assessment, dosing context and safety. Observed public version; obtain the latest approved Indian PI for the actual product before use.

[9] American Diabetes Association. Pharmacologic Approaches to Glycemic Treatment. Standards of Care in Diabetes 2026, section 9.
Treatment selection, comorbidity goals, combination review and recommendation 9.18 on DPP-4 plus GLP-1–based therapy. HCP guidance, not an Indian product approval.

[10] American Diabetes Association. Chronic Kidney Disease and Risk Management. Standards of Care in Diabetes 2026, section 11.
Kidney-risk assessment and monitoring; SGLT2 and broader treatment context. Individual monitoring and Indian-label constraints remain clinician-led.

[11] American Diabetes Association. Glycemic Goals Hypoglycemia and Hyperglycemic Crises. Standards of Care in Diabetes 2026, section 6.
HbA1c follow-up, individualised glucose-monitoring needs and hypoglycaemia assessment. Source supports differentiated follow-up rather than compulsory glucose testing for every HF/CKD user.

[12] American Diabetes Association. Diabetes Care in the Hospital. Standards of Care in Diabetes 2026, section 16.
Perioperative SGLT2 interruption, acute illness and resumption context. This note does not generate patient-specific medication instructions.

Cardiorenal guidance and safety sources

[13] Davies MJ et al. Management of type 2 diabetes 2026. ADA and EASD consensus report. Published 2 October 2026.
Current consensus expands attention to whole-person care and organ outcomes. Country-specific indications and evidence remain essential; no blanket recommendation for all patients.

[14] KDIGO. Clinical Practice Guideline for the Evaluation and Management of Chronic Kidney Disease. 2024.
Recommendations 3.7.1–3.7.3 and associated practice points: eligibility context, temporary withholding situations, monitoring and early eGFR change. The 2024 guideline remains the published standard while a focused update is in development.

[15] McDonagh TA et al. 2023 Focused Update of the 2021 ESC Guidelines for acute and chronic heart failure. European Heart Journal. 2023;44:3627–3639.
HF recommendations across EF categories and early follow-up after acute HF. Use with the full HF care plan and the applicable Indian label.

[16] AHA ACC ADA and ASN. Guideline for Prevention Detection Evaluation and Management of Cardiovascular-Kidney-Metabolic Syndrome. 9 June 2026.
Official guideline hub and summary support coordination across specialties. This service does not perform CKM staging or apply a risk calculator.

[17] US Food and Drug Administration. Jardiance prescribing information. Revised October 2025.
Sections 2 and 5: assessment, perioperative interruption, ketoacidosis, volume depletion, genitourinary infection and other safety. US information is used as a safety reference, not Indian marketing authorisation.

[18] Boehringer Ingelheim. Empagliflozin 10 mg and 25 mg film-coated tablets. UK Summary of Product Characteristics.
Current public SmPC reviewed for renal, volume, infection and interruption/restart precautions. UK authorisation does not override the selected Indian PI.

Governance implementation and source notes

[19] Department of Pharmaceuticals. Uniform Code for Pharmaceutical Marketing Practices 2024 and official guidelines portal.
Official entry point for applicable code and guidance. Medical/legal teams must use the current text and amendments for promotional claims, education, sponsorship and professional interactions.

[20] Ministry of Electronics and Information Technology. Digital Personal Data Protection Rules 2025 and enforcement timeline.
Official Rules, corrigendum and phased enforcement materials. Launch-date legal applicability must be checked; the privacy design in this note is an operating requirement, not a legal compliance certification.

[21] Indian Pharmacopoeia Commission. Pharmacovigilance Programme of India adverse reaction reporting resources.
Official HCP and patient reporting resources. Organised-program capture, company obligations, timelines and safety-data sharing require an approved PV procedure.

[22] CDSCO. Recommendations of the SEC Renal meeting held on 18 September 2025.
Empagliflozin entry refers to CKD permission dated 18 January 2024 and postmarketing conditions. A committee recommendation is not a substitute for a current product permission or full PI.

[23] Metra M et al. SGLT2 Inhibitors for the Prevention and Treatment of Heart Failure. Scientific statement of the HFA and HFAI. ESC Heart Failure. 2025;12(6).
Primary society statement on HF evidence and implementation, including selected early post-hospital care. It does not validate this service or a specific Indian brand.

[24] UK Kidney Association. Clinical Practice Guideline on SGLT2 Inhibition in Adults with Kidney Disease. 2023 update.
Final published guideline; implementation recommendations include genital hygiene, private symptom counselling, illness precautions and appropriate clinical review. Distinct from the earlier consultation draft.

STRATEGIC OPPORTUNITY & CTA

The decision for an empagliflozin brand team is simple: Will you remain another brand competing on molecule recall and cardiorenal benefit claims, or become the brand that helps clinics turn every appropriate prescription into a completed, reviewed, and clinically managed care plan?

Empagliflozin doesn't need another reminder campaign. It needs a brand that owns the prescription-to-reviewed-plan connection - helping clinics preserve treatment purpose, address early concerns, coordinate diabetes, heart failure and kidney-care follow-up, and ensure every next step has a clear clinical owner.

Old rule: Win the prescription.
New rule: Own the clinic routine that completes the next clinical decision.

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The next winning brand will become the clinic's cardio-renal-metabolic continuity partner - connecting the first pack, safety concerns, condition-specific reviews, prescription fulfilment, and clinician-authorised re-entry after an interruption.

The opportunity is to turn reliable execution across specialties into a distinctive reason for HCP preference - not just another reason to remember the molecule.

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 Empagliflozin Molecule Diagnostic and identify your brand's competitive position, highest-value clinic workflow gap, priority prescriber segment, and a focused 90-day pilot.





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