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Fixing

THE LAST-LINE ANTIBIOTIC TREATMENT CHOICE DRIFT

A brand-led playbook to make Brand UMI the consciously preferred rescue-therapy choice when MDR Gram-negative treatment escalates

Inditech Health Solutions

Pharma Brands Playbook

Treatment Choice Drift

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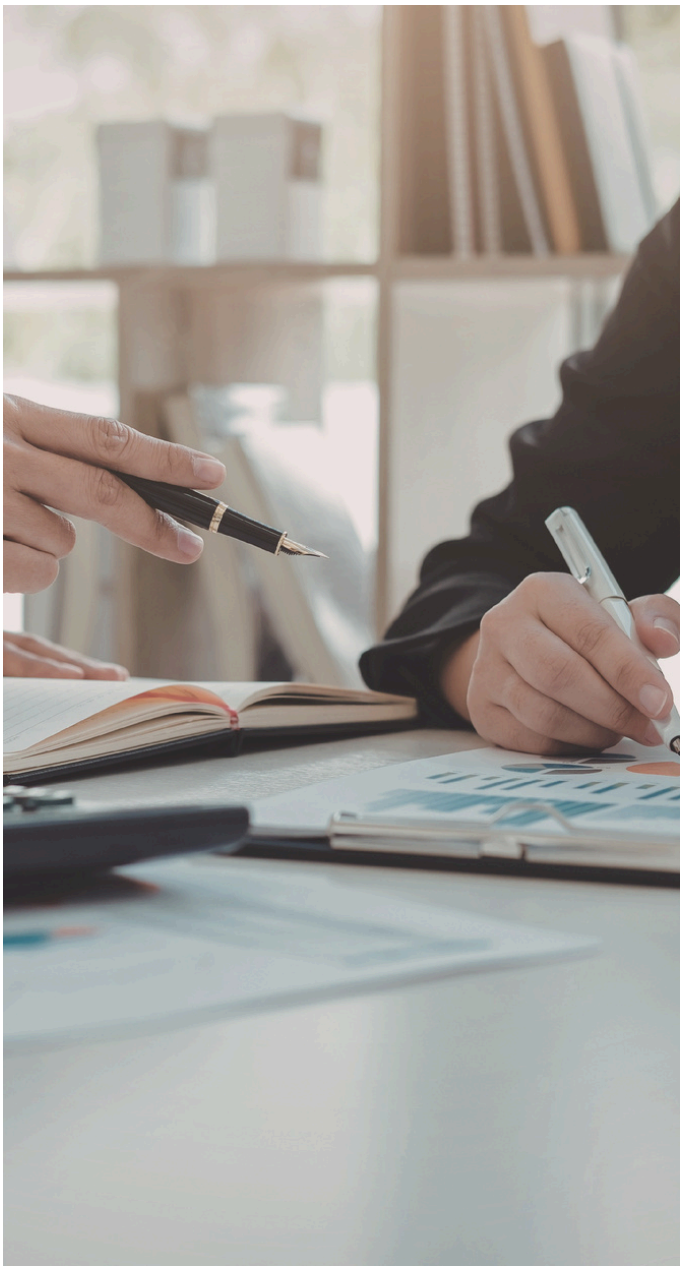


EXECUTIVE SUMMARY

Brand UMI operates within the last-line MDR Gram-negative antibiotic category, where treatment is initiated only after earlier therapies have failed or when culture reports confirm resistant organisms such as Acinetobacter, Pseudomonas, or resistant Enterobacteriaceae.

By design, the brand enters late in the pathway - within high-acuity settings such as severe pneumonia, sepsis, complicated UTI, post-surgical, and hospital-acquired infections across pediatric and adult care. At this stage, the decision to escalate to polymyxin B or colistimethate sodium is rarely in question. The molecule is clinically accepted. Its role is understood.

For Brand UMI, the decision that remains open is the final brand selection under pressure.

Within a category defined by multiple comparable options, differentiation is not inherently visible at the point of care. In moments of urgency, selection is guided by recall, familiarity, and immediate availability.

As a result, Brand UMI operates in a treatment environment where molecule choice is deliberate - but brand choice is instinctive. This is where drift occurs. Not as a rejection of Brand UMI's clinical validity - but as an absence of salient differentiation within the decision moment. Attributes that define reliability in rescue therapy - such as active fraction integrity, impurity control, formulation consistency, freeze-dried stability, reconstitution confidence, and monitoring assurance - remain underrepresented within the physician's rapid evaluation.

The outcome is predictable:

- the molecule is selected with intent
- but the brand defaults to habit

For Brand UMI, the challenge is not to validate the need for last-line therapy. It is to ensure that, at the point of escalation, the brand is mentally available as the most clinically reliable, defensible, and confidence-assured choice under pressure.

MARKET REALITY

Guidelines define when polymyxin B or colistimethate sodium should be used:

- after failure of earlier antibiotics
- when cultures confirm MDR Gram-negative infection
- when susceptibility supports escalation

That clinical framework is well understood. What is not consistently translated into practice is how physicians choose between different brands within the same molecule category.

In real-world practice:

- rescue therapy decisions are often made urgently
- doctors focus on potency and availability
- composition quality, impurity profile, and consistency are rarely considered systematically
- monitoring and follow-up vary widely after initiation

As a result, two brands may appear clinically equivalent at the point of prescription, even when physicians know that differences in active fraction, impurity burden, purification, stability, or reconstitution reliability may matter most in fragile patients.

For Brand UMI, this creates a treatment-choice gap. The physician accepts the need for rescue therapy, but the brand does not yet own the logic that should determine which rescue brand is preferred. The gap is not scientific, but behavioural and operational - emerging from how rescue-antibiotic decisions are compressed and executed under pressure.

PROBLEM FRAMEWORK

THE BRAND PAIN

Brand UMI's ability to become the preferred rescue-antibiotic brand is shaped by three linked constraints within the escalation decision.

Brand UMI enters at a moment where speed overrides evaluation

01

In deteriorating patients, escalation is immediate - priority is placed on initiating active therapy without delay. This compresses the decision window, leaving limited room to assess formulation quality, impurity burden, preparation consistency, or downstream monitoring implications.

As a result, Brand UMI competes in a moment where familiarity outpaces evaluation.

Brand UMI operates within a category perceived as interchangeable

02

Polymyxin B and colistimethate sodium continue to be approached as functional categories rather than differentiated brands.

Even where clinical differences exist, they are not consistently surfaced within the decision process. For Brand UMI, this creates a visibility gap - where scientific distinction does not automatically translate into preference.

Brand UMI is not yet anchored to confidence in post-initiation management

03

Once rescue therapy begins, clinical complexity shifts to renal monitoring, toxicity surveillance, follow-up review, and de-escalation timing. When these are inconsistently managed, the treatment experience is perceived as difficult or high-risk, irrespective of efficacy.

Without a defined role in this phase, Brand UMI remains exposed to being interpreted as another last-line option rather than a controlled, confidence-assured choice.

Strategic Implication

In rescue-antibiotic therapy, Brand UMI's advantage is not built through awareness. It is built by becoming the brand most strongly associated with decisive escalation, visible formulation reliability, and confidence in management after initiation.

The BEHAVIOURAL MOMENT MAP

THREE MOMENTS OF IMPACT

For Brand UMI, rescue-antibiotic choice is shaped across three tightly linked moments.

MOMENT 1: FAILURE RECOGNITION AND ESCALATION READINESS
As the patient fails to respond to earlier antibiotics, clinical suspicion of MDR Gram-negative infection intensifies. This is where Brand UMI enters the physician's consideration set-at the point where escalation becomes imminent.

MOMENT 2: RESCUE-ANTIBIOTIC SELECTION UNDER PRESSURE (DECISIVE)
The physician determines the molecule - polymyxin B or colistimethate sodium - and, within that, selects the brand to initiate. At this point, Brand UMI must compete on trust in formulation, confidence in preparation, and defensibility of choice, all within a compressed decision window.

- *This is the decisive moment where brand preference is formed.*

MOMENT 3: POST-INITIATION MONITORING AND CONFIDENCE FORMATION
Once therapy begins, focus shifts to renal function, toxicity surveillance, response assessment, and de-escalation timing. Brand UMI's long-term credibility is shaped here - through how manageable, predictable, and clinically controllable the treatment experience proves to be.

For Brand UMI, influence must be established at the point of selection and sustained through the monitoring phase. Without presence in Moment 2 and reinforcement in Moment 3, the brand remains clinically valid - but does not become the instinctive choice under pressure.

THE CLINIC-CENTRED SOLUTION FRAMEWORK

For Brand UMI, the objective is not to expand rescue-antibiotic use, but to ensure that, at the point of escalation, the brand is selected as the most reliable, defensible, and confidence-assured pathway.

CLARIFY → DIFFERENTIATE → REASSURE

1. CLARIFY
(Structure the escalation decision)

Brand UMI can bring greater precision to escalation by supporting case-led clinical clarity - helping physicians identify when MDR risk warrants transition, when culture evidence should trigger change, and when delay materially increases patient risk. This shifts escalation from reactive action to structured clinical judgement.

2.DIFFERENTIATE
(Make quality visible at the point of brand choice)

Brand UMI can make otherwise latent attributes clinically visible - active fraction integrity, impurity profile, purification standards, formulation stability, and preparation reliability. In a compressed decision window, the brand becomes easier to justify and more defensible under pressure.

3.REASSURE
(Anchor confidence after initiation)

Brand UMI can extend its role into the post-initiation phase - supporting renal surveillance, toxicity monitoring, defined checkpoints, and de-escalation timing. This positions the brand not only at the point of rescue, but across the management phase that determines clinical confidence.

REPLICATION BLUEPRINT

IMPLEMENTATION MODULES

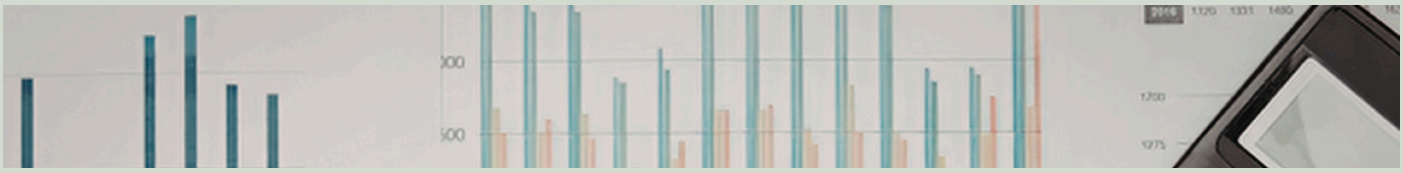
Module	***What the Brand Installs***	***What Problem It Solves***	***What It Delivers for Brand UMI***
Mini-CME Series	Case-led doctor sessions on escalation and rescue use	Doctors escalate inconsistently and often too late	Positions Brand UMI at the point of rescue decision
Quality-Focused Scientific Assets	Simple doctor-facing explainers on formulation quality and impurity profile	Rescue brands are treated as interchangeable	Makes Brand UMI easier to consciously choose
Case Publication Series	Real-world rescue cases in adults and children	Doctors lack practical examples of when and why quality matters	Reinforces brand preference through clinical realism
Monitoring Support Tools	Renal surveillance and toxicity-check guidance	Post-initiation follow-up is often inconsistent	Links Brand UMI to safer rescue therapy
Field-Led Reinforcement	Regular scientific shares through reps	One-time messaging does not change treatment reflex	Sustains brand recall at future escalation moments

TREATMENT CHOICE EXECUTION CHECKLIST

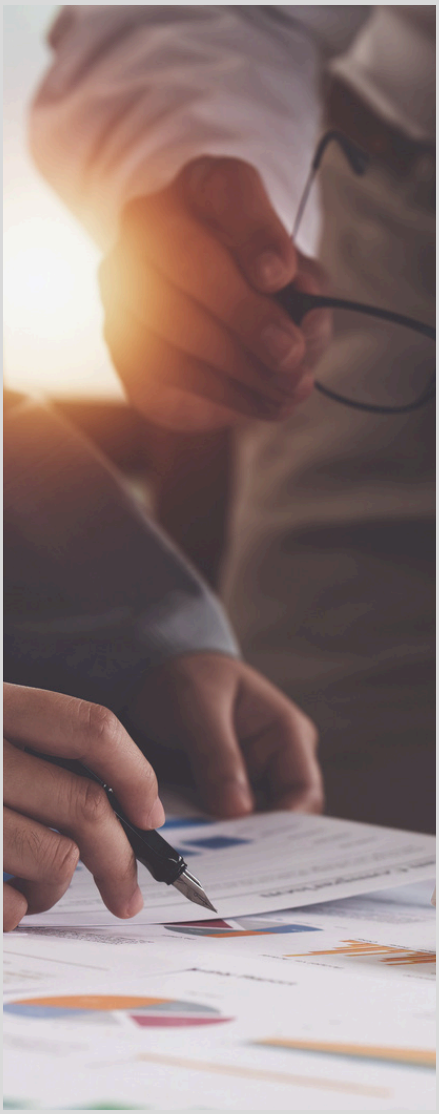
- ☑ Brand UMI is linked to the rescue decision, not just the molecule
- ☑ Physicians can clearly explain why this brand is preferred under pressure
- ☑ Formulation quality becomes part of treatment choice, not an afterthought
- ☑ Monitoring and follow-up strengthen confidence after initiation
- ☑ Brand UMI becomes the instinctive choice when rescue therapy is required

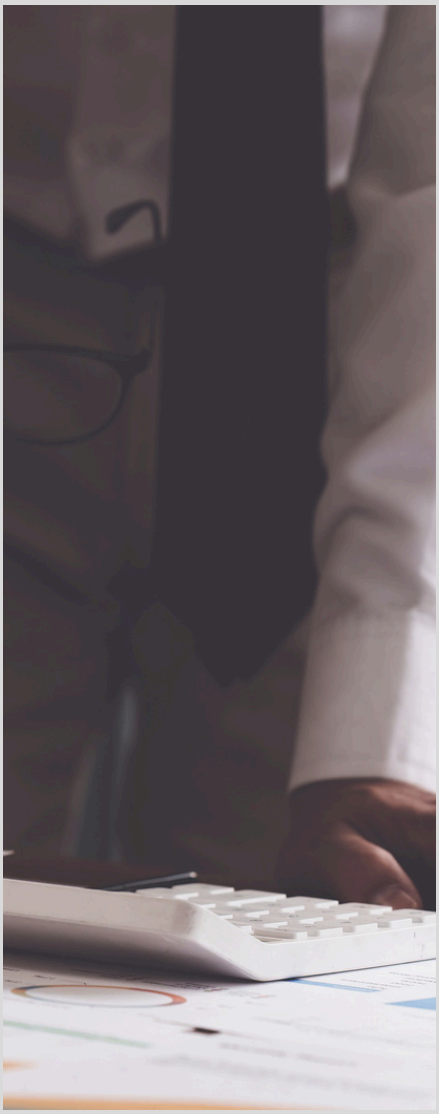
BRAND OUTCOME

MEASUREMENT LOGIC



Measurement Layer	*What Is Tracked*	*Brand Impact*
Doctor Engagement	Participation in mini-CMEs and case discussions	Stronger familiarity with Brand UMI rescue logic
Treatment-Choice Recall	Stated preference in MDR escalation scenarios	Higher mental availability at rescue decision point
Quality Association	Physician agreement that formulation quality matters	Stronger differentiation versus commodity competitors
Monitoring Adoption	Use of renal and toxicity review tools	Greater confidence in Brand UMI after initiation
Brand-of-Use Proxy	Increase in Brand UMI use during rescue escalation	Conversion from category acceptance to brand preference





STRATEGIC OPPORTUNITY & CTA

Brand UMI does not need to convince physicians that polymyxin B or colistimethate sodium matter. That decision has already been made by the clinical situation.

The real opportunity is narrower and more commercially important: to become the brand physicians trust most when they must escalate quickly and cannot afford uncertainty.

By making rescue-antibiotic choice more structured, formulation quality more visible, and post-initiation monitoring more confident, Brand UMI can move from being one more last-line brand to becoming the preferred rescue pathway in MDR Gram-negative care.

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