LEVETIRACETAM

THE PRESCRIPTION IS NOT THE MOAT. THE CLINIC WORKFLOW AFTER IT CAN BE.

{MARKET LEADER - CHALLENGER - SELECTIVE-SHARE BRANDS}

COMPETITIVE DISTRIBUTION NOTE

This molecule-level note is being circulated to the leadership teams of major competing levetiracetam brands in India. The opportunity is shared. The first implementation window is not.

CENTRAL PROPOSITION

Own the vulnerable interval between a doctor's levetiracetam prescription and the next safe, informed review - without turning patient support into product promotion or remote medicine.

HOW TO USE THIS DOCUMENT

ONE MOLECULE. THREE COMPETITIVE POSTURES. ONE SERVICE ENGINE.

LEVETIRACETAM
INDIA INTEGRATED MOLECULE PLAYBOOK

This is not a brand plan with the logo removed. It is a molecule-control strategy built around the real failures that occur after levetiracetam has already been selected by the doctor.

PART	WHAT IT ANSWERS	PRIMARY USER
I. Market reality	Why levetiracetam is commercially important, crowded, and difficult to differentiate	Business head, marketing, insights
II. Workflow engine	Which post-prescription failures the clinic can actually prevent or surface	Medical, patient solutions, digital
III. Competitive plays	How leader, challenger, and mid-tier teams should deploy the same engine differently	Brand and sales leadership
IV. Execution	What the field force, clinic, Academy, vendor, privacy, and PV teams do	Sales excellence, operations, compliance
V. Pilot decision	What to approve now, what to measure, and when to stop or scale	Leadership committee

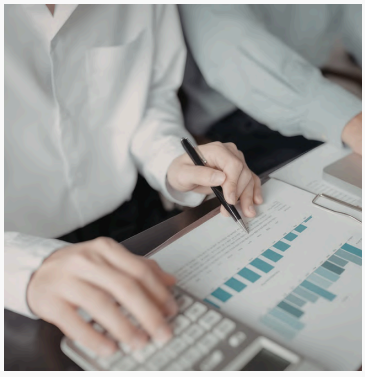
EVIDENCE RULE

Facts are cited. Estimates are labelled. Strategic inferences are explicit. Exact current prescription counts, brand shares, specialty splits, and audited MAT value must be inserted from the recipient's licensed IQVIA, PharmaTrac, AWACS, or C-MARC dataset before external circulation.

The decision this playbook asks for

1. Choose the competitive posture: defend default status, displace the default, or win a narrow share wedge.
2. Authorize a 90-day Academy-certified Seizure Continuity Pathway pilot in a bounded clinic cohort.
3. Nominate medical, pharmacovigilance, privacy, digital, and field owners before patient-facing activation.
4. Measure clinic activation and behaviour proxies first; measure brand outcomes separately and causally where possible.

Language note: 'Academy' refers to the independent education and workflow-certification layer. It does not imply endorsement of any sponsor or brand.



EXECUTIVE SUMMARY

Levetiracetam already has molecule-level clinical legitimacy and market scale. That makes conventional differentiation weaker, not easier.

INR 113 cr **DECEMBER 2025 SALES** IQVIA public market-report mirror; monthly value, not MAT [1]	**+16%** **YEAR-ON-YEAR GROWTH** December 2025 vs same month prior year [1]	**10.1 m** **PEOPLE WITH EPILEPSY** India GBD 2019 estimate; not a current treated-patient count [6]	**111** **LISTED VARIANTS** Across 10 featured brands in one current retail-directory snapshot; not exhaustive [3]

THE MARKET PROBLEM

The molecule is familiar. The patient journey is not controlled. Between visits, patients can misunderstand the prescribed schedule, feel no visible benefit while seizure-free, miss doses, experience sedation or behavioural change, encounter a different pack or formulation, run short before review, or wait until a breakthrough event exposes the gap. The clinic often sees these failures late.

THE STRATEGIC ANSWER

Build an Academy-Certified Seizure Continuity Pathway that starts only after the treating doctor has selected levetiracetam. The pathway keeps the doctor's exact plan visible, surfaces tolerability and mood signals early, protects refill and pack continuity, routes breakthrough events back to the clinic, and prepares scheduled review. Patient content is clinic-branded and brand-neutral. The sponsor appears only in approved HCP and field-force layers.

POSTURE	JOB TO BE DONE	DEPLOYMENT EMPHASIS	WIN CONDITION
Leader	Defend default status	Make continuity a clinic standard across the installed base	Default molecule choice becomes an operating habit, not only recall
Challenger	Displace the default	Target clinics with weak early follow-up and visible leakage	Clinicians associate the challenger with response, review, and execution
Selective share	Win a defined wedge	Own one segment: discharge, paediatrics, behaviour, or Tier 2/3 review continuity	Depth in a chosen micro-market beats thin national imitation

RECOMMENDATION

Do not launch another reminder programme. Fund a clinic-owned continuity system, pilot it in 30 clinics, and reserve the first Academy implementation cohort before a competitor does.

INDIA MARKET REALITY

Levetiracetam is a high-value, high-growth, essential-medicine market with broad formulation coverage and visible brand crowding. Public evidence supports the direction - not an audited brand-share league table.

WHAT IS VERIFIED

EVIDENCE	WHAT IT SAYS	COMMERCIAL MEANING	BOUNDARY
IQVIA Dec 2025 [1]	Levetiracetam was the top-contributing Neuro/CNS subgroup at INR 113 crore for the month, growing 16% year on year.	Large and still expanding; molecule-level relevance is not in question.	Monthly value; do not present as MAT or prescriptions.
IQVIA Jan 2024 [2]	Levetiracetam led Neuro contribution at INR 94 crore for the month, with 8% growth.	The 2025 signal is directionally consistent with an established growth track.	Secondary publication quoting IQVIA.
NLEM 2022 [4]	Listed at secondary/tertiary level in 250, 500, 750 mg tablets; 750 mg modified release; 100 mg/mL oral liquid; and 100 mg/mL injection.	The molecule spans chronic oral, paediatric/liquid, modified-release, and acute hospital use.	NLEM inclusion is not a brand preference statement.
Retail directory Aug 2026 [3]	One current page features 10 major brands and 111 listed variants across them.	High choice density makes pack, strength, formulation, and refill continuity commercially important.	Directory snapshot; not exhaustive and not share data.
Nationwide EMR cohort [22]	In a 6,318-patient Indian EMR cohort published in 2022, levetiracetam was the most commonly prescribed ASM, alone or in combination, at 41.8% (n=2,645).	Supports high prescription prevalence across real-world Indian ambulatory care.	Records span 2001-2019; not a current national prescription audit.
India GBD 2019 [6]	Estimated 10.1 million people with epilepsy in India in 2019.	The underlying care burden is substantial.	Historical burden estimate; not current treated population.

Why price-and-claim competition is structurally weak

- NLEM inclusion and NPPA ceiling-price mechanisms increase the pressure on undifferentiated price premiums [4,5].
- Multiple established companies offer several strengths and dosage forms. Availability is necessary but no longer a complete story [3].
- Guidelines treat levetiracetam as one option among several, selected by seizure type, syndrome, comorbidity, reproductive context, and patient circumstances [7,8].
- No compliant brand can promise superior seizure control merely by wrapping the same molecule in more promotion.

COMMERCIAL DATA REQUIRED BEFORE RECIPIENT CIRCULATION

Insert current audited MAT value; volume and value growth; prescription counts; new-to-brand and repeat prescriptions; brand/pack shares; channel and geography splits; neurologist, physician, paediatric, and hospital contribution; and availability. Keep the public evidence page intact as the external audit trail.

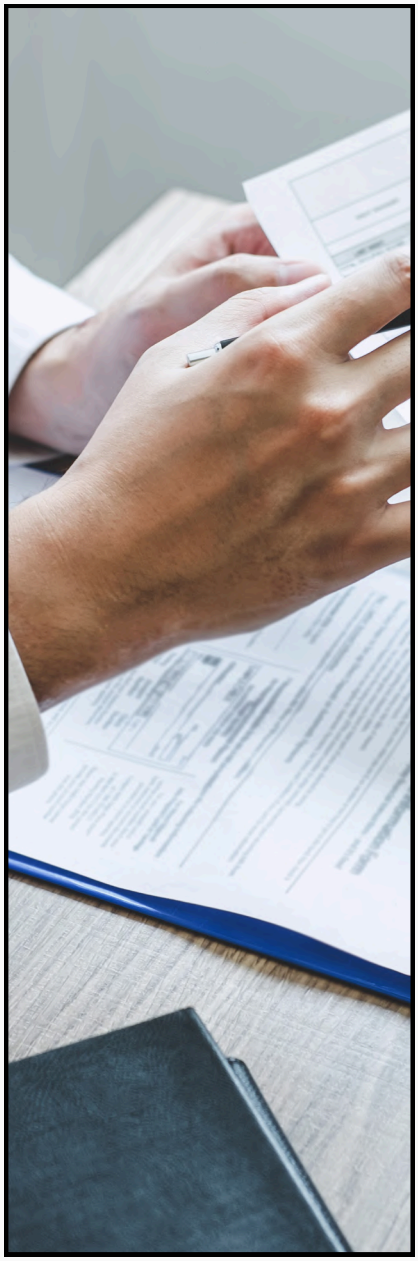
Restricted leadership working document

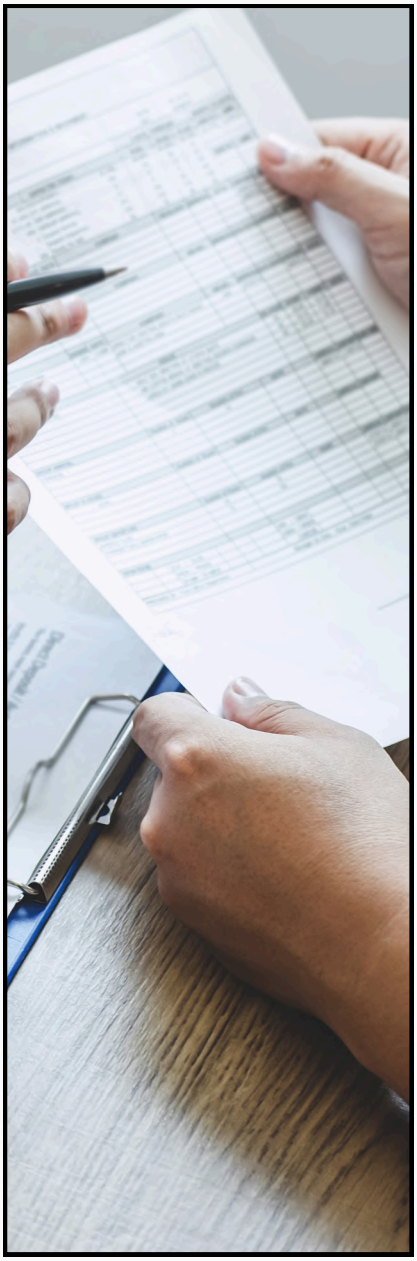
MARKET REALITY - PRESCRIBER MAP

PRESCRIBER SEGMENTS SHOULD NOT RECEIVE THE SAME WORKFLOW

Public sources do not provide a current audited Indian specialty split. The map below is a strategic segmentation hypothesis to be validated against the sponsor's prescription audit.

SEGMENT	ROLE IN THE JOURNEY	HIGH-VALUE FAILURE	WORKFLOW EMPHASIS	VALIDATION NEEDED
Neurologists / neurophysicians	Diagnosis, syndrome classification, long-term regimen, resistant epilepsy	Clinic blind spots between specialist reviews	Early signals, breakthrough brief, planned review, pregnancy	Rx contribution, clinic volumes, revisit intervals
Consulting physicians / internal medicine	Continuing care, first-line management in access-constrained settings, referral	Delayed escalation or weak specialist re-entry	Exact plan, red flags, referral-ready review brief	Appropriate scope by city and institution
Paediatric neurologists / paediatricians	Weight-based prescribing, oral liquid, school and caregiver counselling	Measurement error, caregiver fatigue, behaviour attribution	Caregiver record, formulation check, school safety overlay	Age mix, specialist vs paediatrician share
Emergency / critical care / neurosurgery	Acute seizure management and discharge handoff	Injection-to-home regimen confusion and lost review	Discharge reconciliation and 72-hour clinic handoff	Hospital protocols and formulary access
Obstetric co-management	Pregnancy planning and pregnancy care with epilepsy specialist	Unsupervised stopping or missed monitoring	Specialist routing; no independent medicine advice	Local referral networks and service governance





COMMERCIAL IMPLICATION

A brand should not buy 'neurology reach' in the abstract. It should choose which continuity failure it can operationally own for which prescriber. The same service engine then exposes different modules by segment.

FIRST-PRINCIPLES TEST

If the service would still make sense after removing the sponsor name and the product pack, it is probably a real clinic solution. If it collapses without brand reminders, it is promotion dressed as care.

CENTRAL COMMERCIAL AND BEHAVIOURAL DRIFT

The dangerous period is not only when a seizure occurs. It is the long, quiet interval when the clinic assumes continuity and the patient experiences uncertainty.

DRIFT	PATIENT REALITY	CLINIC BLIND SPOT	BRAND CONSEQUENCE
Benefit invisibility	Seizure-free days can feel like 'nothing is happening.'	Persistence is assumed, not observed.	Refill and continuation become vulnerable to convenience, cost, or substitution.
Early tolerability	Somnolence, dizziness, fatigue, irritability, aggression, low mood, or agitation may emerge [9].	Behaviour may be normalized, hidden, or blamed on personality.	Unstructured discontinuation or negative word of mouth can occur before review.
Regimen ambiguity	Different strengths, immediate vs modified release, liquid vs tablet, and concomitant ASMs can confuse execution.	The prescription may not travel accurately across caregiver, chemist, and discharge settings.	The molecule becomes interchangeable in perception even when the exact plan matters.
Refill friction	Stock, pack, price, travel, and timing create a gap before the next dose is due.	The clinic learns only after missed doses or recurrence.	Availability and pack continuity decide repeat, not promotion.
Breakthrough without context	A seizure returns; details are incomplete and panic is high.	Adherence, pack change, illness, sleep, alcohol, and timing are reconstructed late.	The prescriber may lose confidence in the current regimen or supplier context.
Life-stage change	Pregnancy planning, pregnancy, renal change, ageing, school, work, and driving alter needs.	The patient may not know the change requires review.	A static brand message becomes irrelevant at the moment of highest clinical value.

THE COMMERCIAL TRUTH

In a genericized molecule market, the brand that helps the clinic see and act on drift can become harder to displace. The moat is not a claim. It is a repeated operating behaviour inside the clinic.

What not to build

- A generic pill reminder disconnected from the prescribed plan.
- A patient chatbot that interprets symptoms or advises dose changes.
- A brand-branded epilepsy club that exposes prescription medicine promotion to patients.
- A dashboard that sends patient-level health data to the sponsor.
- A seizure-outcome promise that the workflow cannot causally prove.

MOMENTS THAT MATTER

PRIORITIZE MOMENTS WHERE THE CLINIC CAN PREVENT CONFUSION, DETECT RISK EARLIER, OR IMPROVE THE QUALITY OF THE NEXT CLINICAL DECISION. DO NOT TURN EVERY LIFE ISSUE INTO A MODULE.

MOMENT	VALUE	WHY IT MATTERS	SERVICE ROLE	DECISION
Initiation or discharge: first 72 hours	Very high	Exact strength, formulation, timing, titration, and follow-up are freshest - and easiest to lose.	Capture and replay the doctor's written plan; check access and understanding.	CORE
Days 3-7: tolerability and mood	Very high	Behavioural and CNS effects can damage trust before the first review [9].	Structured check, urgent/self-harm routing, clinic callback.	CORE
Titration checkpoint	High	Patients may confuse the next prescribed step or self-adjust.	Confirm plan visibility; never recommend or alter the step.	CORE
Seven and three days before refill	Very high	Running out, pack mismatch, and pharmacy substitution are preventable continuity failures.	Prompt refill and route mismatch; no brand steering.	CORE
Breakthrough seizure	Very high	It may signal urgent risk or a need for clinical review; context is easily lost.	First-aid instruction, emergency routing, factual event note, expedited clinic review.	CORE
Planned specialist review	High	A better review needs adherence, side effects, mood, events, new medicines, and life changes.	Generate a patient-confirmed review brief for the clinic.	CORE
Pregnancy / reproductive planning	High but conditional	Abrupt stopping and unmonitored concentration change can be harmful [8,10,11].	Immediate specialist review route; no patient-level risk comparison or dosing.	OVERLAY
Paediatric / caregiver / school	High but conditional	Formulation, weight, behaviour, measurement, and school safety need caregiver execution.	Caregiver tools and paediatric review prompts.	OVERLAY
Driving, work, water, heights	Important	Safety advice is individualized and law/context dependent [9,17].	Doctor-led checklist inside plan; not a standalone commercial programme.	EMBED
Concomitant ASMs and new medicines	Important	Regimen reconciliation matters even with levetiracetam's relatively limited metabolic interaction burden.	Record and route changes; no interaction engine for patients.	EMBED

DESIGN CHOICE

The core pathway owns six moments. Everything else appears only when the treating clinic activates the relevant overlay. This keeps the service clinically useful and operationally lean.

INTEGRATED CLINIC-SERVICE CONCEPT

ACADEMY-CERTIFIED SEIZURE CONTINUITY PATHWAY: FROM THE PRESCRIBED PLAN TO THE NEXT SAFE, INFORMED REVIEW.

SERVICE PROMISE

Help the treating clinic keep the exact levetiracetam plan visible, detect important tolerability and behavioural signals, protect refill continuity, route breakthrough events, and prepare review - without diagnosing epilepsy, choosing a medicine, changing a dose, or replacing clinical judgment.

LAYER	PATIENT SEES	CLINIC RECEIVES	SPONSOR ROLE
1. Clinic activation	Clinic-branded plan card and neutral QR	Exact plan record, consent status, follow-up date	Funds approved materials and field activation after medical/legal review
2. Continuity	Short prompts, self-checks, first-aid and contact route	Alerts, incomplete-step list, refill and review cues	No patient contact; no patient-level data
3. Review	Own observation note and appointment reminder	One-page review brief using patient-reported facts	Aggregated process metrics only
4. Academy	Certification mark on clinic service, not product	Monthly case education and workflow quality audit	Supports independent education under written governance
5. HCP execution	Nothing brand-facing	Approved molecule and brand discussion only after doctor has selected levetiracetam	Field force uses compliant story and local activation data

The six non-negotiables

1. Doctor-selected molecule first. The service never recommends levetiracetam.
2. Clinic identity first. Patient-facing content is clinic-branded and molecule/brand-neutral.
3. Exact plan, not generic dosing. Only the clinic's written prescription and instructions are reflected.
4. Alerts go to the treating clinic. Emergency guidance never waits for a callback.
5. Sponsor blindness. No patient identity, prescription, event history, or alert is visible to the brand team.
6. Academy certification covers workflow and education quality. It is not a product endorsement.

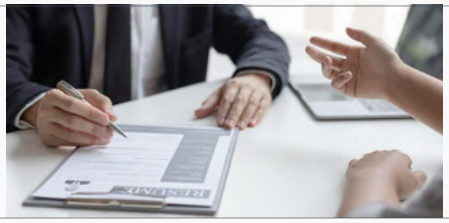
NAMING DISCIPLINE

Use 'Seizure Continuity Pathway' in patient and clinic materials. Use 'Levetiracetam Integrated Molecule Programme' only in internal/HCP execution documents. Never put a sponsor brand beside patient seizure guidance.

DETAILED MODULES AND CADENCE

A small number of timed contacts should change behaviour and surface risk. Frequency is driven by vulnerability, not marketing appetite.

MODULE	TIMING	PATIENT / CAREGIVER ACTION	CLINIC OUTPUT
0. Exact Plan Capture	At prescription or discharge	Receive clinic plan card; confirm preferred language and caregiver role.	Formulation, strength, schedule, titration instructions, concomitant ASMs, missed-dose instruction, action plan, review date.
1. Start Right	Within 24 hours	Confirm medicine obtained and plan understood; raise pack/strength mismatch.	Access problem or mismatch queue; no automatic substitution advice.
2. Early Signal Check	Day 3 and Day 7	Report sleepiness, dizziness, fatigue, unusual irritability/aggression, low mood, agitation, rash, or self-harm thoughts.	Red/amber routing and documented callback; potential ADR enters PV workflow.
3. Titration Visibility	Clinic-set day, commonly week 2 and/or 4	Read back the next written step; contact clinic if unclear.	Confusion flagged before execution; no dose recommendation.
4. Refill Continuity	7 and 3 days before supply ends	Arrange refill; report stock, cost, different pack, strength, or formulation.	Continuity barrier list; clinic/pharmacist resolution.
5. Quiet-Phase Continuity	Monthly until stable review; then clinic-set	Two-question adherence and change check; no 'feel well = stop' inference.	Only exceptions and review due dates surface.
6. Breakthrough Route	Any time	Follow seizure first aid and the individual action plan; submit factual observations after safety is secured.	Immediate emergency instruction where indicated; event summary and expedited review.
7. Review Brief	48 hours before scheduled review	Confirm events, missed doses, side effects, mood, pack changes, new medicines, pregnancy plans, and questions.	One-page clinician brief; no score that recommends treatment.
8. Life-Stage Overlays	Clinic-triggered	Use caregiver, paediatric, pregnancy, renal-change, or safety module only when relevant.	Specialist route and tailored review fields.



CADENCE IS A DEFAULT OPERATING DESIGN, NOT CLINICAL GUIDANCE. THE TREATING CLINIC CONFIGURES TIMING TO THE EXACT REGIMEN, FORMULATION, AGE, DIAGNOSIS, AND FOLLOW-UP PLAN.

MODULE DETAIL

- PATIENT LANGUAGE -

MAKE THE SAFE ACTION OBVIOUS. REMOVE EVERY INVITATION TO SELF-TREAT.

SITUATION	APPROVED PATIENT-FACING DIRECTION	PROHIBITED OUTPUT
Plan is unclear	'Use the dose, timing, and formulation written by your clinic. If your pack or instructions differ, do not guess. Contact the clinic or pharmacist.'	Any dose calculator or titration recommendation
Missed dose	'Use the missed-dose instruction written by your clinic or product leaflet. Do not double a dose. If unsure, call the clinic or pharmacist.'	A generic timing rule presented as universally correct
Feeling well	'Being seizure-free does not mean you should stop or reduce medicine. Only your treating doctor can change the plan.'	Claims that continued therapy guarantees no seizure
Mood / behaviour change	'New irritability, aggression, agitation, low mood, or unusual behaviour deserves attention. Contact your clinic today. If there are thoughts of self-harm, seek urgent emergency help now.'	Reassurance that delays assessment or labels the symptom as definitely drug-related
Different pack / brand / formulation	'Check the medicine name, strength, formulation, and schedule. If anything differs from your plan, confirm with the clinic or pharmacist before taking the changed product.'	Claim that all switching is unsafe or all products are interchangeable
Breakthrough event	'Keep the person safe, time the seizure, follow the clinic's seizure action plan, and seek emergency help when indicated. Do not give food, drink, or medicine by mouth during a convulsive seizure.'	Remote diagnosis, dose change, or unscripted rescue-medication advice

EMERGENCY BOUNDARY

For a convulsive seizure lasting 5 minutes or more, repeated seizures without recovery, serious injury, breathing difficulty, or another action-plan emergency, the patient/caregiver is told to call India's 112 emergency service or seek emergency care immediately [15,16]. The clinic alert is supplementary; the pathway is not an emergency response service.

MODULE DETAIL

OPTIONAL OVERLAYS - ACTIVATE OVERLAYS ONLY WHEN THE CLINIC SELECTS THEM

OVERLAY	TRIGGER	WORKFLOW	CLINICAL BOUNDARY
Pregnancy / reproductive planning	Planning pregnancy, pregnancy, postpartum, or contraception question	Prompt epilepsy-specialist review; record adherence and planned monitoring; coordinate specialist-obstetric care.	No stopping, switching, dose, folate-dose, risk ranking, or breastfeeding advice from the service [8,10,11].
Paediatric / caregiver	Child or dependent adult; oral liquid; school/day-care setting	Caregiver-held exact plan, measurement demonstration by clinic, school first-aid card, behaviour observation, weight/review prompt.	No weight-based dose calculation; no school staff treatment decision beyond the written plan.
Hospital discharge-to-home	IV/oral transition, seizure admission, neurosurgical/critical-care discharge	Reconcile discharge prescription; confirm supply within 24 hours; clinic handoff within 72 hours; review date visible.	No assumption that inpatient and outpatient formulations or schedules are the same.
Renal / ageing	Documented renal impairment, dialysis, acute renal change, frailty, or new comorbidity	Immediate review cue and medication reconciliation.	Levetiracetam dosing is individualized to renal function; the service never calculates or changes it [9].
Safety / driving / occupation	Seizure recurrence, new diagnosis, dose increase, sedation, driving or high-risk work	Doctor-led safety checklist; India licence declaration reminder; written return-to-activity advice.	No legal clearance. Indian Form 1 asks about epilepsy/loss of consciousness, and individual legal/clinical advice is required [17].

PREGNANCY POSITIONING

Levetiracetam has comparatively reassuring pregnancy evidence, but that is not permission for a patient service to promote it. The 2024 AAN/AES/SMFM guideline places selection within syndrome, seizure-control, and comorbidity judgment and calls for monitoring during pregnancy [10].

DOCTOR-FACING DECISION AND SUPPORT LAYER

The tool should improve the quality and timing of clinician judgment. It must never produce a treatment decision. Activation checklist - completed only after levetiracetam is selected

FIELD	WHY IT EXISTS	PATIENT VISIBILITY
Prescribed formulation, strength, schedule	Prevents pack and execution ambiguity	Exact clinic-approved plan only
Titration / next-step instruction	Keeps the written step visible	No independent interpretation
Missed-dose instruction	Avoids unsafe generic advice	Clinic-approved text or approved product leaflet
Concomitant ASMs and key medicines	Supports reconciliation and breakthrough review	Patient can confirm list; no interaction verdict
Renal, pregnancy, paediatric, behaviour flags	Activates only relevant overlays	No diagnosis or risk score
Individual seizure action plan / rescue plan	Separates emergency action from routine support	Exact clinic plan; no new rescue recommendation
Review date and contact route	Creates accountable re-entry	Visible on every touchpoint

ALERT LOGIC

LEVEL	EXAMPLES	PATIENT ACTION	SYSTEM / CLINIC ACTION
RED	Self-harm thoughts; severe allergic/skin symptoms; convulsive seizure >=5 minutes; repeated seizures without recovery; breathing difficulty or major injury	Immediate 112 / emergency instruction; do not wait for clinic response	Send clinic alert immediately; create PV case where applicable; log delivery, not clinical outcome
AMBER	New marked aggression, irritability, agitation, low mood; disabling somnolence/dizziness; breakthrough event not requiring emergency; repeated missed doses; pack/strength/formulation mismatch; pregnancy planning or renal change	Contact clinic today or within clinic-set timeframe; continue only as prescribed unless clinician directs otherwise	Queue callback; review record; capture potential ADR; no automated treatment action
GREEN	Plan understood, medicine available, no new problem, review on track	Continue the clinic's plan and prepare for review	No unnecessary contact; retain only minimal process signal

Alert examples are workflow triggers, not diagnostic criteria. Medical, PV, and legal teams must approve the final wording and service-level response by channel and clinic hours.

DOCTOR SUPPORT - REVIEW BRIEF

ONE PAGE BEFORE THE VISIT. FACTS, NOT RECOMMENDATIONS.

The clinic receives a concise review brief 48 hours before the planned appointment or immediately after a breakthrough route.

BLOCK	CONTENT	WHAT IT MUST NOT DO
Treatment execution	Patient-confirmed formulation, strength, timing, missed-dose days, refill gap, pack change	Score adherence as morality or recommend a dose
Seizure events	Date/time, duration if known, observed features, recovery, injury, sleep/illness/alcohol context, action taken	Label seizure type or establish causality
Tolerability and mood	Somnolence, dizziness, fatigue, irritability, aggression, agitation, depression, self-harm signal, onset relative to plan changes	Decide whether levetiracetam caused the symptom
Regimen context	Other ASMs, new medicines, discharge changes, renal status change reported by patient	Run a patient-facing interaction engine
Life context	Pregnancy planning/pregnancy, school/work/driving safety questions, caregiver concerns	Provide legal clearance or reproductive treatment advice
Questions and decisions	Patient's top three questions; clinician records decisions in EHR/clinic notes	Create a parallel record controlled by the sponsor

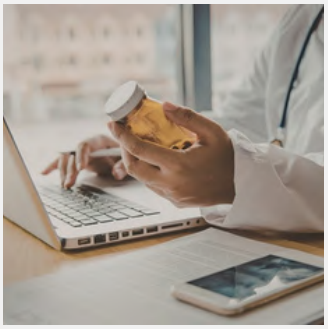
SPECIALTY VARIANTS

- Neurologist: detailed event chronology, polytherapy, pregnancy/renal monitoring cue, drug-resistant epilepsy re-entry.
- Physician: simplified exact-plan and red-flag view, with explicit neurologist referral route.
- Paediatric: caregiver and formulation fields, school plan, behaviour observation, age/weight review cue - no dose calculator.
- Hospital: discharge reconciliation, IV/oral transition record, supply confirmation, and specialist appointment ownership.

WORKFLOW OWNERSHIP

The commercial asset is not the patient list. It is the clinic's repeated use of a safer, faster review routine that the field team can activate and the Academy can certify.

DOCTOR EDUCATION



ACADEMY-BACKED DOCTOR EDUCATION

Education should train the decisions and conversations required by the pathway. It should not become a six-month product-detailing calendar.

MONTH	MINI-CME / CASE	DECISION SKILL	WORKFLOW ASSET
1	After the first or recurrent seizure: classify before you prescribe	Separate a seizure event from epilepsy; align medicine choice to seizure type/syndrome and label/guidance	Exact Plan Capture checklist and referral boundary
2	The difficult first week on levetiracetam	Start/titrate under the documented plan; anticipate CNS and behavioural signals; account for renal function	Day 3/7 Early Signal protocol
3	Irritability, aggression, depression, or the disease itself?	Structured history, urgent self-harm assessment, differential thinking, caregiver input	Mood/Behaviour Review Brief
4	Breakthrough seizure in a previously stable patient	Reconstruct adherence, formulation/pack changes, illness, sleep, alcohol, interacting context, and event features before changing therapy	Breakthrough Event Note and emergency route
5	Polytherapy, substitution, and care transitions	Medication reconciliation; safe clinician-led switching; hospital-to-home continuity	Pack/Formulation Check and Discharge Bridge
6	Women, pregnancy, children, and planned review	Preconception specialist care, pregnancy monitoring, paediatric formulation/caregiver execution, and review frequency	Life-Stage Overlay pack

FACULTY AND CERTIFICATION RULES

1. Independent faculty and Academy-controlled learning objectives, cases, references, and assessment.
2. No sponsor influence on clinical conclusions; any HCP brand session is separate, approved, and consistent with local marketing authorization and UCPMP [18].
3. Workflow certification tests plan capture, alert routing, review preparation, data minimization, and PV escalation - not brand prescribing.
4. Certificate duration: 12 months, contingent on two workflow audits and completion of at least four of six cases.
5. No patient-facing claim that an Academy-certified clinic provides superior medical outcomes.



STRATEGIC VARIANTS BY BRAND POSITION

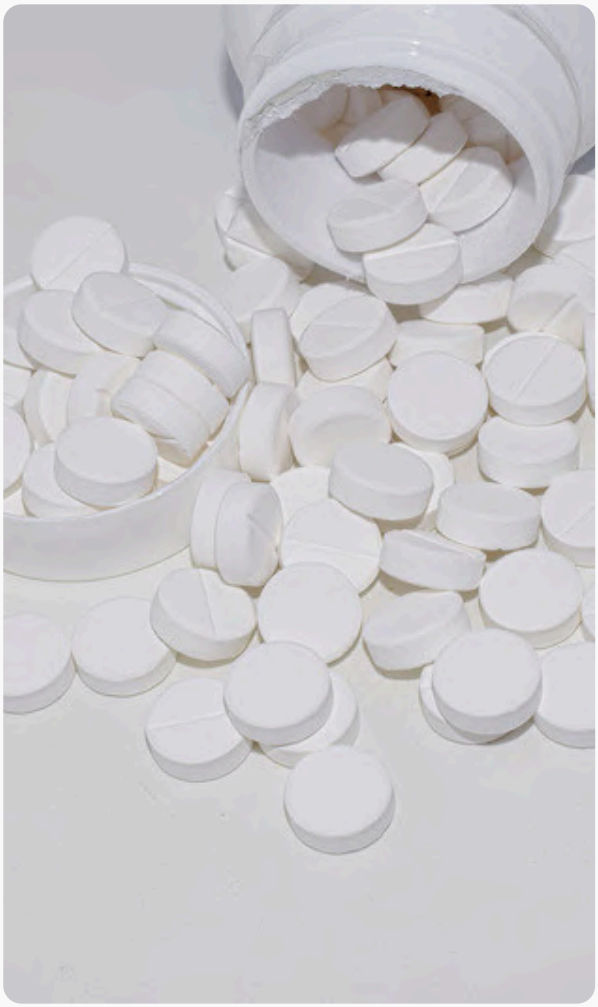
IF YOU ARE THE MARKET LEADER

LEADER STRATEGY

Defend leadership by making continuity the category standard before a challenger defines the standard for you.

MOVE	ACTION	WHY IT DEFENDS	LEADING INDICATOR
Install the standard	Activate the full pathway in highest-value neurologist and physician clinics, then expand by cluster.	Turns installed prescription scale into installed workflow scale.	Live clinics; active coordinators; exact-plan cards
Protect repeat	Make refill and pack-continuity checks operational, especially across multiple strengths/formulations.	Reduces avoidable friction around repeat treatment without asking the service to prefer a brand.	Continuity barriers resolved before run-out
Own safe review	Give clinicians a reliable one-page pre-review brief and rapid breakthrough route.	Makes the leader associated with practice efficiency and continuity, not only familiarity.	Review briefs opened; routed events reviewed
Build Academy density	Certify clusters, not isolated KOLs; include clinic coordinator training.	Creates a local care norm competitors must replicate clinic by clinic.	Certified clinics per micro-market
Prove responsibly	Compare workflow activation and HCP preference against matched territories; use audited brand data.	Defends investment with evidence while avoiding patient-outcome overclaim.	Difference-in-differences signal; no PII

Leader message to the field



TALK TRACK - Doctor, levetiracetam is familiar. The failure now is what happens after the prescription - early mood or tolerability issues, refill gaps, pack confusion, and late breakthrough review. We can help your clinic standardize that interval without branding the patient service or interfering with your plan.'

LEADER RISK - Scale can create complacency. A partial rollout with slow alert handling will expose more failures than it resolves. The leader should launch fewer clinics with strong clinic coordinators, then expand only after service-level performance is stable.

LEADER KPI PRIORITY - Workflow penetration across the installed prescriber base, repeat-prescription proxy, availability continuity, and sustained HCP default preference. Do not use seizure-free rate as a brand KPI.

IF YOU ARE THE CHALLENGER

CHALLENGER STRATEGY

Do not attack molecule efficacy. Attack the leader's unowned post-prescription interval.

MOVE	ACTION	DISPLACEMENT LOGIC	LEADING INDICATOR
Find leakage clinics	Use qualitative research and CRM to identify high-volume clinics with weak early follow-up, refill friction, or poor review preparation.	Targets an operating problem the incumbent may overlook.	Qualified leakage accounts
Lead with the first week	Offer Day 3/7 signal checks and clinic callback protocol as the entry wedge.	Creates immediate, visible service value without comparative efficacy claims.	Check completion and callback closure
Convert proof to consideration	After 30-45 days, show aggregated clinic-process gains and discuss approved brand evidence separately.	Earns the right to a product conversation through execution.	HCP intent and trial, not patient data
Over-resource the pilot	Use fewer clinics, dedicated activation support, and rapid barrier resolution.	A challenger wins through speed and reliability, not breadth.	Time to live; issue closure; active clinic rate
Create a referral network	Link physicians to neurologists for red flags, pregnancy, paediatric complexity, and drug resistance.	Builds local clinical value beyond a detailing call.	Completed referrals / review loops

Challenger message to the field

TALK TRACK - 'Doctor, the molecule may not need another lecture. Your team may need a reliable way to know who is confused, who is struggling with mood or tolerability, who is about to run out, and who needs review after a breakthrough event. We will install that workflow and measure whether it reduces your clinic's blind spots.'

CHALLENGER RISK - Do not convert a neutral service into a hidden switch programme. The patient pathway cannot name the challenger, push a specific pack, or withhold support when a different levetiracetam brand is dispensed. Brand advantage must come from HCP association and field execution after the doctor's molecule choice.

CHALLENGER KPI PRIORITY - New prescriber activation, movement in HCP consideration, trial-to-repeat proxy, clinic response performance, and matched-territory share change from audited data.

IF YOU ARE AN OTHER OR SELECTIVE-SHARE BRAND

SELECTIVE-SHARE / MID-TIER STRATEGY

Do not imitate a national leader with one-tenth of the resources. Own a narrow continuity failure completely.

WEDGE	BEST-FIT ACCOUNTS	OFFER	WHY IT CAN WIN	DO NOT
Paediatric execution	Paediatric neurologists and high-epilepsy paediatricians	Caregiver plan, liquid-measurement confirmation, school first-aid card, behaviour check	Specialist depth and caregiver utility	Turn it into a weight-based dose app
Hospital discharge bridge	Neurosurgery, ICU, emergency, stroke and seizure units	Prescription reconciliation, 24-hour access check, 72-hour clinic handoff	Owns a high-risk transition with institutional visibility	Promote prophylactic/off-label use
Mood / behaviour response	Clinics reporting discontinuation or concern around behavioural symptoms	Day 3/7 check, caregiver observation, urgent route, Academy case series	Addresses a levetiracetam-specific trust failure	Claim the brand prevents behavioural effects
Tier 2/3 review continuity	Physician-led markets with limited specialist access	Exact plan, red flags, tele-referral pathway, pre-neurology brief	Creates access and referral value	Let the service diagnose or replace neurology

Selection rule

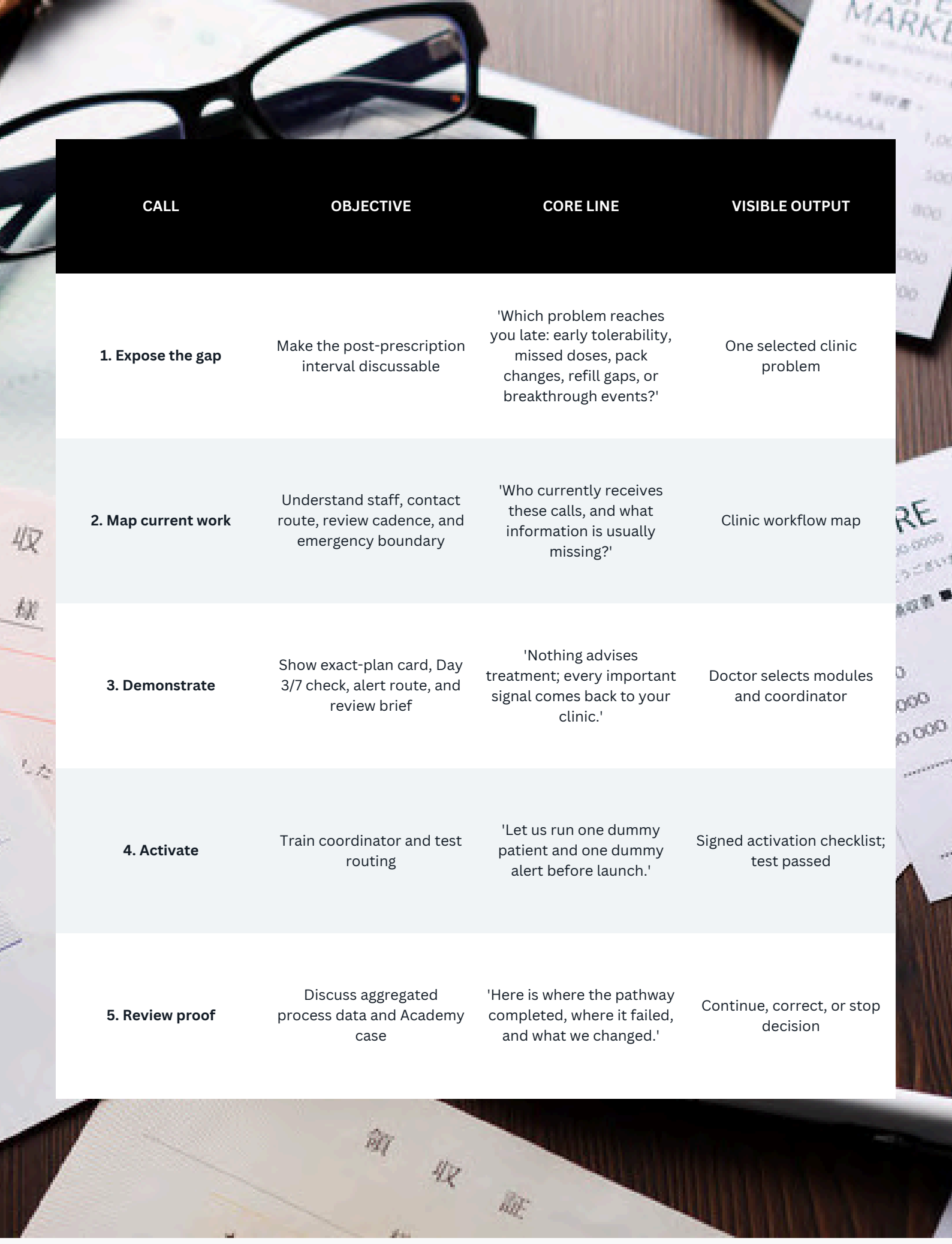
Pick one wedge nationally or two in separate geographies. A mid-tier team that launches all four will build an underpowered programme with no recognizable position.

RECOMMENDED DEFAULT - For most mid-tier brands, start with the hospital discharge bridge in one institutional cluster or the paediatric-caregiver pathway in one specialist cluster. Both create a concrete operating advantage without requiring national media weight.

SELECTIVE-SHARE KPI PRIORITY - Depth: active clinics per chosen cluster, relevant patient starts per clinic, closure of the chosen continuity failure, targeted prescriber gain, and local audited share - not national awareness..

THE FIELD-FORCE STORY

THE REPRESENTATIVE SELLS A CLINIC WORKFLOW AFTER EARNING PERMISSION FOR A MOLECULE CONVERSATION. THE REPRESENTATIVE NEVER OPERATES THE PATIENT WORKFLOW.



CALL	OBJECTIVE	CORE LINE	VISIBLE OUTPUT
1. Expose the gap	Make the post-prescription interval discussable	'Which problem reaches you late: early tolerability, missed doses, pack changes, refill gaps, or breakthrough events?'	One selected clinic problem
2. Map current work	Understand staff, contact route, review cadence, and emergency boundary	'Who currently receives these calls, and what information is usually missing?'	Clinic workflow map
3. Demonstrate	Show exact-plan card, Day 3/7 check, alert route, and review brief	'Nothing advises treatment; every important signal comes back to your clinic.'	Doctor selects modules and coordinator
4. Activate	Train coordinator and test routing	'Let us run one dummy patient and one dummy alert before launch.'	Signed activation checklist; test passed
5. Review proof	Discuss aggregated process data and Academy case	'Here is where the pathway completed, where it failed, and what we changed.'	Continue, correct, or stop decision

APPROVED OBJECTION HANDLING

OBJECTION	RESPONSE
'My patients already get reminders.'	'This is not a reminder layer. It captures the exact clinic plan, checks early mood/tolerability and pack continuity, routes breakthrough events, and prepares review.'
'I do not want more alerts.'	'You choose red/amber thresholds, clinic hours, coordinator, and contact channel. Green patients stay silent.'
'Is this promoting your brand to patients?'	'No. Patient content is clinic-branded and brand-neutral. The sponsor has no patient-level access. Product discussion remains HCP-only and separate.'
'Will it tell me what to change?'	'No. It provides patient-reported facts and workflow triggers. Diagnosis and treatment remain entirely with you.'

FIELD PROHIBITION

Representatives must not enrol patients, view patient dashboards, receive alerts, call patients, collect seizure histories, troubleshoot doses, or ask the clinic which brand a patient received.

IMPLEMENTATION BLUEPRINT

Operating model

The pathway succeeds only if clinic ownership, emergency boundaries, privacy, and pharmacovigilance are designed before the first patient touchpoint.

OWNER	ACCOUNTABILITY	NO-GO BOUNDARY
Treating doctor	Selects treatment; approves plan text, overlays, alert thresholds, and review decisions	Cannot delegate clinical judgment to pathway
Clinic coordinator	Captures consent/local code, issues plan card, monitors clinic inbox, routes callbacks, closes workflow tasks	Does not change treatment
Academy medical governance	Controls clinical content, faculty, certification, audit, and versioning	Does not endorse sponsor/brand
Service vendor	Delivers neutral platform/messages, uptime, security, audit trail, clinic-only alert routing	No secondary use or sponsor patient feed
Sponsor medical / PV	Approves HCP materials; receives and processes reportable safety information under SOP	No promotional ownership of clinical content
Sponsor brand / sales	Funds pilot, selects commercial posture, activates clinics, receives aggregated metrics	No patient identity, event, prescription, or alert access
Privacy / security owner	DPDP notices, contracts, consent, retention, access, breach response, vendor audit	No launch without signed data-flow assessment

Minimum launch kit

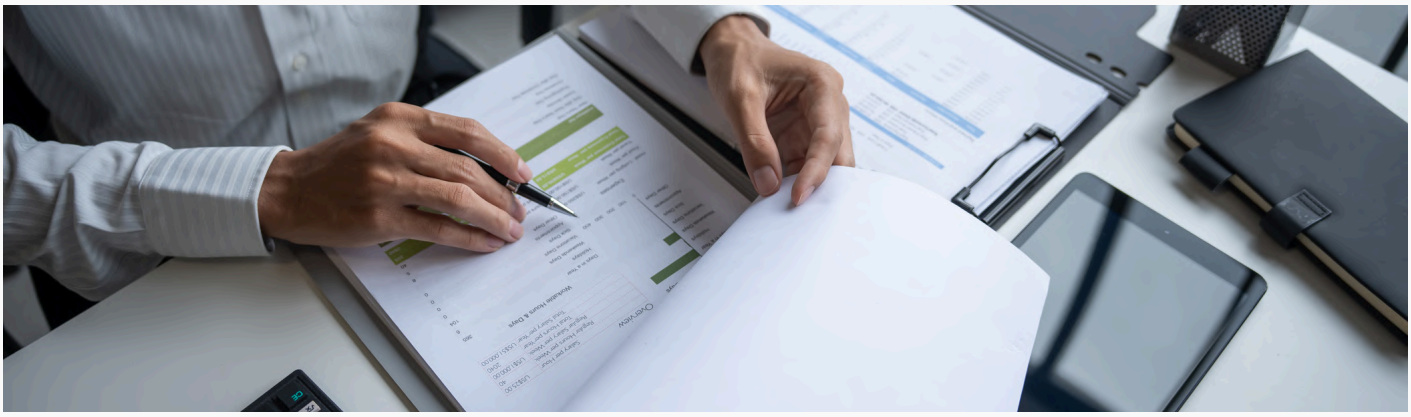
- Clinic activation checklist and signed module selection.
- Exact Plan Capture card, patient/caregiver quick guide, seizure first-aid card, and clinic contact card in approved languages.
- Day 3/7 signal check, refill prompts, breakthrough route, and one-page review brief.
- Clinic dashboard using local patient codes; role-based access; audit logs; no sponsor login.
- PV decision tree, emergency wording, clinic-hours rule, data map, consent/notice, retention schedule, and incident response.
- Field visual aid, objection guide, dummy-patient test, Academy month 1 case, and pilot scorecard.

LAUNCH GATE

No clinic goes live until a dummy patient completes plan capture, a dummy red alert displays immediate emergency instruction and reaches the clinic, an amber alert closes, a potential ADR reaches PV intake, and sponsor access is proven to exclude patient-level data.

IMPLEMENTATION - DATA FLOW

CLINIC-HELD IDENTITY. SPONSOR-BLIND MEASUREMENT.

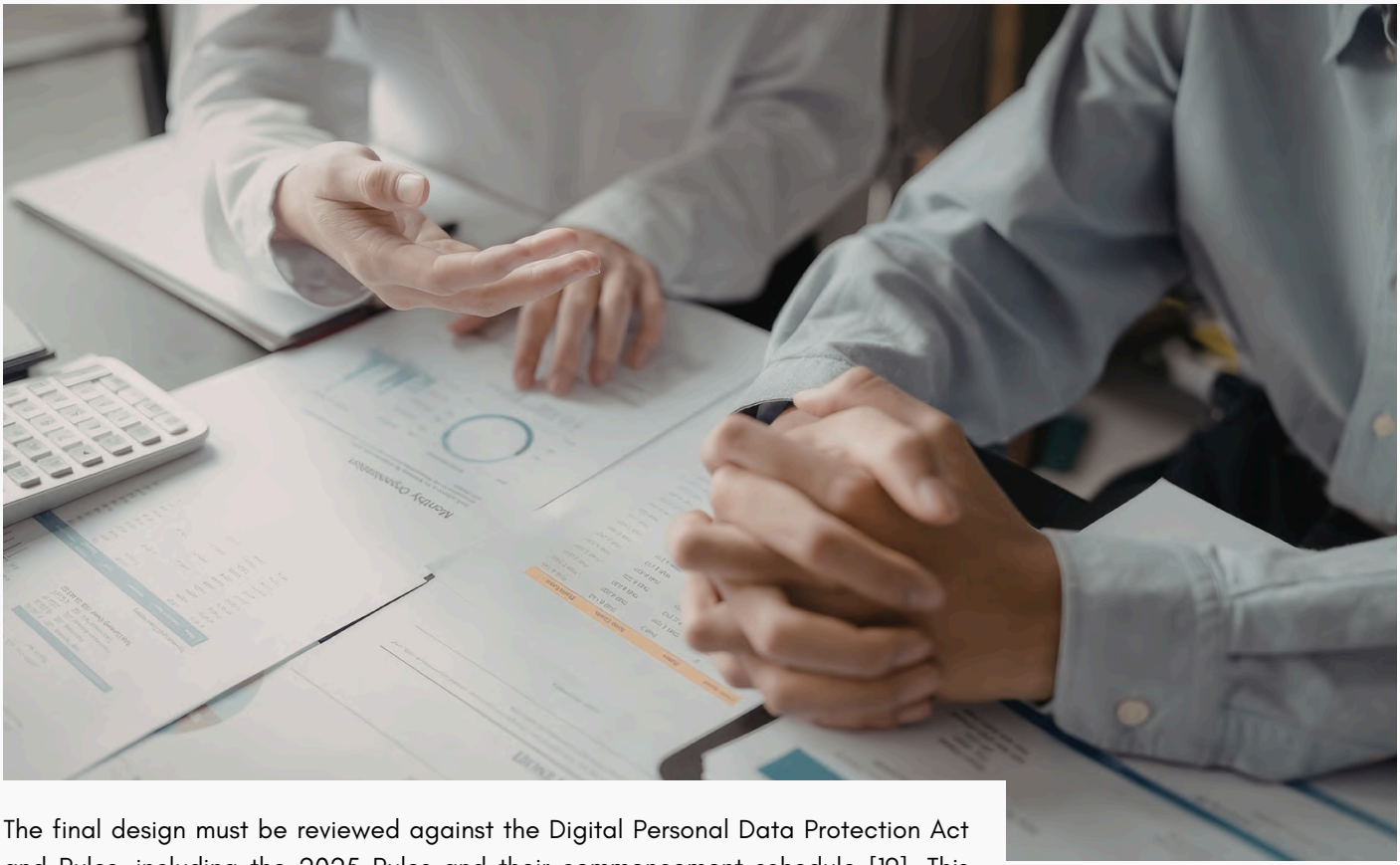


THE SAFEST USEFUL MODEL SEPARATES THE CLINICAL ROUTE FROM THE COMMERCIAL MEASUREMENT ROUTE.

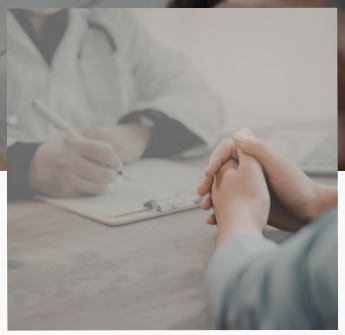
STEP	DATA	WHO CAN SEE IT	RETENTION / OUTPUT
1. Offer	Aggregate count of cards/QRs offered by clinic	Clinic; Academy operations in aggregate	Clinic/day count; no patient identity
2. Activation	Local clinic code, consent, preferred language/contact, exact plan	Clinic and contracted processor under role-based access	Retain only for clinic-set care period; sponsor excluded
3. Check-in	Patient-reported completion, signals, event observations	Clinic; processor only to route	Clinical route and audit; potential AE to PV per SOP
4. Review	One-page patient-confirmed brief and clinician closure	Clinic	Clinic record; aggregate completion status only
5. Sponsor report	Clinic activation, module completion, SLA, aggregate barriers, Academy participation	Sponsor in cells meeting minimum aggregation threshold	No clinic-patient drill-down; suppress cells <10
6. Brand outcome	CRM/HCP research plus licensed market-audit data	Sponsor analytics	Linked only at territory/clinic cohort level, not patient level

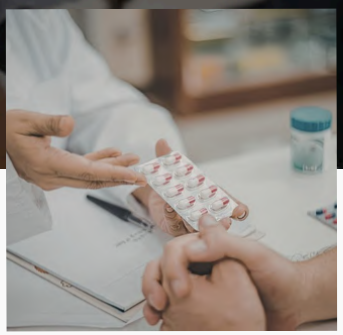
PRIVACY ARCHITECTURE CHOICES

OPTION	USE	TRADE-OFF	PILOT RECOMMENDATION
Clinic-owned roster + neutral QR	Clinic staff hold identity; patient opens generic modules	Lowest data exposure; manual clinic work	Default for first 90 days
Processor-mediated messaging	Vendor sends clinic-authorized messages using minimal contact data	Higher convenience; requires DPDP processor contract and controls	Use only in clinics with coordinator capacity gap
Patient account/app	Persistent history and self-service	Highest consent, security, retention, and adoption burden	Do not use in pilot



The final design must be reviewed against the Digital Personal Data Protection Act and Rules, including the 2025 Rules and their commencement schedule [19]. This playbook is a product and governance design, not legal advice.





MEASUREMENT MODEL

Measure whether the clinic workflow activated and changed observable behaviour before asking whether the brand gained. Keep clinical care metrics and promotional analytics separate.

STAGE	METRIC	SOURCE	INTERPRETATION
Clinic activation	Trained clinics, live clinics, coordinator assigned, dummy test passed, time to live	Academy operations	Can the programme actually install?
Patient workflow	Plan cards issued, Day 3/7 completion, refill checks, review briefs, overlay use	Clinic/processor aggregate	Is the intended pathway being used?
Behaviour proxy	Reported missed-dose gap surfaced, pack mismatch raised before use, refill barrier resolved before run-out, planned review attended	Clinic aggregate; definitions pre-specified	Did the workflow surface or support target behaviours? Not proof of adherence.
Clinic process	Alert delivery, clinic acknowledgement, callback closure, review-brief opening, staff time	Audit log / clinic survey	Does it reduce blind spots without overloading staff?
HCP brand	Awareness of programme sponsor, brand consideration, intended trial/repeat, message association	Blinded/independent HCP research and CRM	Does execution improve HCP preference?
Commercial	New prescribers, repeat proxy, volume/value/share in pilot vs matched control	Licensed IQVIA/PharmaTrac/AWACS and sales data	Association; stronger if difference-in-differences is pre-specified.
Safety / trust	Emergency instruction delivery, PV case completeness, privacy incidents, complaints, opt-outs	Safety/privacy logs	Non-negotiable scale gate.

CAUSAL DISCIPLINE

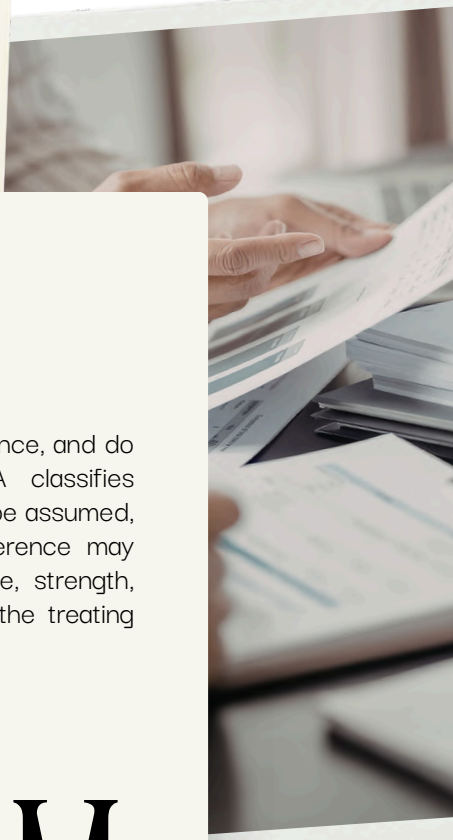
- Freeze baseline and matched-control method before launch; match by specialty, prior brand trend, city tier, and clinic volume.
- Use intention-to-treat clinic cohorts: keep failed/low-activation clinics in the analysis.
- Report workflow outcomes and commercial outcomes separately; do not imply that the service caused seizure control.
- Do not link patient engagement to individual prescribing or sales representative incentives.
- Pre-specify what would falsify the strategy: low clinic use, alert overload, no HCP preference movement, or no incremental commercial signal.

NORTH-STAR METRIC	Percentage of live clinics that complete the full loop – exact plan captured, early signal check completed, exceptions routed, and a review brief used – for at least 10 patients in the pilot. This measures workflow ownership, not medical outcome.

SAFETY, COMPLIANCE, PRIVACY, AND CLINICAL GUARDRAILS

The programme earns commercial value only by respecting the prescription boundary more rigorously than conventional promotion.

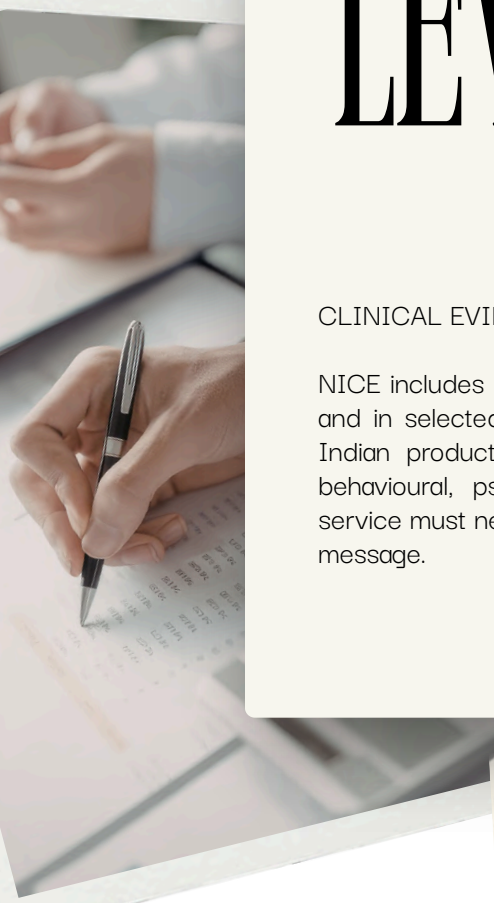
DOMAIN	REQUIRED CONTROL	FAILURE THAT STOPS LAUNCH / SCALE
Clinical scope	Starts only after clinician selects levetiracetam; uses exact plan; no diagnosis, selection, dose, start/stop/switch, rescue, or interaction advice	Any patient-facing treatment recommendation
Emergency	Immediate 112/emergency instruction for configured red events; clinic alert is supplementary; service states it is not monitored emergency care	Patient is told to wait for clinic or sponsor
Behaviour / suicide	Direct wording, urgent route, caregiver inclusion where appropriate, clinic assessment; no causal assumption	Reassurance, delayed response, or promotional minimization
Promotion	HCP claims are on-label, balanced, current, verifiable; patient service is brand-neutral; UCPMP governance [18]	Patient-facing brand promotion or unsupported comparison
Privacy	Clear notice/consent, minimum data, purpose limitation, role access, retention/deletion, processor contract, breach plan [19]	Sponsor patient feed, hidden secondary use, or untested breach response
Pharmacovigilance	Every channel trained to recognize and forward potential AEs, special situations, product complaints, and pregnancy exposures per sponsor SOP; use PvPI routes as appropriate [20]	Lost or late reportable information
Academy independence	Independent content control, faculty disclosures, sponsor separation, no product endorsement	Sponsor edits clinical conclusion to favour brand
Equity and access	Plain language, Indian-language versions, caregiver option, low-data/no-app route, accessibility review	Digital-only service excludes intended clinic population

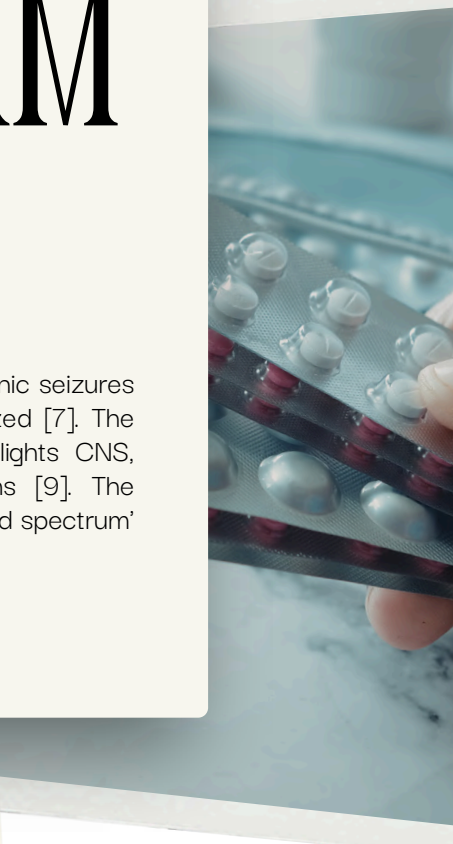


SWITCHING AND SUBSTITUTION GUARDRAIL

Do not claim that generic switching necessarily causes seizure recurrence, and do not claim every product change is clinically irrelevant. MHRA classifies levetiracetam in a group where therapeutic equivalence can generally be assumed, while patient-specific factors such as anxiety, confusion, and adherence may justify continuity [12]. In India, the pathway simply verifies molecule, strength, formulation, schedule, and pack change, then routes uncertainty to the treating clinic or pharmacist.

LEVETIRACETAM





CLINICAL EVIDENCE BOUNDARY

NICE includes levetiracetam as a first-line option for focal and myoclonic seizures and in selected generalized contexts, but choice remains individualized [7]. The Indian product information requires renal individualization and highlights CNS, behavioural, psychiatric, pregnancy, and discontinuation precautions [9]. The service must never flatten this judgment into a universal 'safe and broad spectrum' message.

WHY FIRST MOVER MATTERS

The note is circulating across major competing levetiracetam teams. Urgency is legitimate only if the allocation rule is transparent, finite, and compliant.

WHAT THE FIRST COMMITTED SPONSOR RECEIVES

ASSET	FIRST-MOVER RIGHT	LIMIT
Pilot cohort	First choice of one available 30-clinic cohort or one defined specialist wedge	Subject to Academy capacity, contracting, medical/legal/PV/privacy approval
Implementation sequence	First build sprint and first clinic-coordinator certification calendar	No shortcut around launch gates
Learning advantage	First access to aggregated pilot learning and first option to scale the same design	No access to patient-level data and no ownership of Academy clinical content
Commercial association	Approved HCP/field association with enabling the pathway in the selected cohort	No sponsor branding in patient service; no Academy product endorsement
Category window	A time-limited 90-day non-overlapping pilot in the agreed micro-market where feasible	No permanent exclusivity and no denial of patient support

ALLOCATION GATE

1. Written choice of leader, challenger, or selective-share posture.
2. Named executive sponsor and accountable medical, PV, privacy, digital, sales, and analytics owners.
3. Approved patient-neutral architecture and data-flow assessment.
4. Signed pilot scope, budget, geography/segment, KPIs, stop rules, and source-data plan.
5. Clinic capacity confirmed and Academy clinical governance accepted without sponsor control.

NO RESERVATION BY MEETING

A leadership presentation does not reserve capacity. The first brand to clear the allocation gate secures the first implementation cohort. If it stalls, the cohort is released to the next qualified team.

90-DAY PILOT DESIGN

A bounded pilot should prove that the pathway can install, operate safely, change clinic behaviour, and create a credible HCP/commercial signal.

30 **CLINICS** 10 neurologist, 10 physician, 10 paediatric/hospital mix – adjust after Rx audit	**3** **MICRO-MARKETS** One cluster per city/territory; matched control territories	**360** **PATIENT STARTS** Planning assumption: mean 12 eligible activations per live clinic	**90** **DAYS** Plus two-week approval, training, and baseline runway

PHASE	DAYS	WORK	GATE
0. Build and baseline	-14 to 0	Freeze content, data flow, PV/emergency SOP, matched controls, clinic list, training, and dummy tests	All governance approvals; 100% dummy red/amber routes pass
1. Activate	1-30	Launch first 15 clinics, observe workflow, resolve coordinator and alert issues, start Academy case 1	>=12 clinics live; no unresolved critical safety/privacy issue
2. Stabilize	31-60	Launch remaining clinics, refine non-clinical wording/usability, run cases 2-3, midpoint HCP pulse	>=24 clinics live; acceptable alert load and SLA
3. Prove	61-90	Complete patient loops, review briefs, matched-control analysis, clinic/HCP interviews, scale economics	Pre-specified go/no-go scorecard

CLINIC MIX IS AN ASSUMPTION, NOT A QUOTA

After the recipient inserts audited prescription and account data, rebalance the 30 clinics toward the chosen posture. A leader may favour high-volume neurologists; a challenger may favour leakage clinics; a mid-tier brand may use all 30 in one paediatric or hospital wedge.

ECONOMIC MODEL

Calculate cost per live clinic, cost per completed full loop, incremental HCP trial/repeat proxy, and incremental gross contribution in matched territories. Do not use cost per patient record or reward field teams for patient enrolment.

PILOT - GO / NO-GO

SCALE ONLY IF THE WORKFLOW IS USED, SAFE, AND COMMERCIALLY CREDIBLE

Thresholds below are pilot design assumptions. Freeze the final values before the first clinic launches.

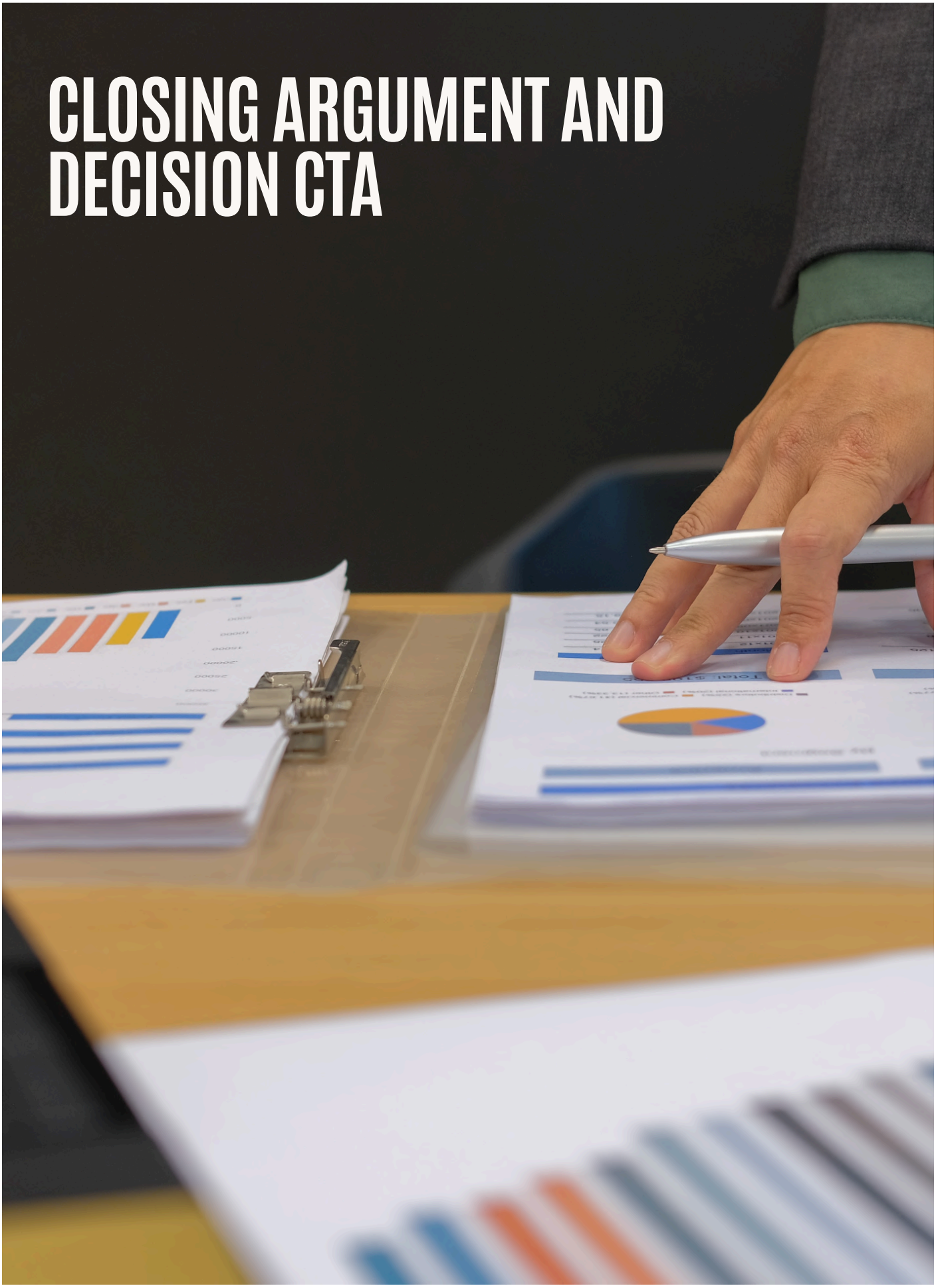
DIMENSION	GO THRESHOLD	NO-GO / CORRECTIVE TRIGGER
Activation	>=24 of 30 clinics live by Day 45; median time-to-live <=14 days after training	<18 live clinics or repeated coordinator failure
Workflow use	>=60% Day 7 completion; >=50% of due review briefs generated; >=70% of live clinics complete 10 full loops	<40% Day 7 completion or pathway used mainly as QR handout
Clinic response	>=90% alert delivery; >=80% amber acknowledgement within one business day; red alert always shows immediate emergency instruction	Any design that asks a patient to wait during emergency; sustained unclosed alert queue
Safety / PV	100% identified potential AEs transferred within sponsor SOP timeline; 100% staff certified	Lost reportable case, untrained channel, or content-induced treatment change
Privacy	Zero sponsor PII access; zero material breach; cell suppression and access audit pass	Any sponsor patient feed, undisclosed use, or material breach
Clinic value	>=70% participating clinicians say the brief/alerts improve visibility without unacceptable burden	<50% value rating or alert burden exceeds agreed limit
HCP / commercial	Positive pre-specified movement in HCP consideration and directional matched-territory brand signal	No preference movement and no credible commercial signal after workflow activation is strong
Economics	Cost per completed loop and projected contribution fit recipient threshold	Scale economics depend on unrealistic patient volume or indefinite subsidy

HARD STOP - Pause immediately for a patient-facing dose/start/stop/switch recommendation, a failed emergency instruction, sponsor access to patient-level data, a material privacy incident, systematic delayed PV reporting, or sponsor interference with Academy clinical conclusions.

GO DECISION

Scale only when all safety/privacy gates pass, workflow activation is strong, clinicians confirm value, and there is at least a directional HCP/commercial signal. A weak commercial signal with strong clinic value warrants one focused iteration - not automatic national rollout.

CLOSING ARGUMENT AND DECISION CTA



CONVENTIONAL PATH	WORKFLOW-OWNERSHIP PATH
Repeat familiar efficacy, safety, and broad-use messages	Help the clinic execute the exact prescribed plan and see drift earlier
Add another undifferentiated adherence reminder	Own initiation, early signals, refill continuity, breakthrough routing, and review preparation
Measure calls, reach, QR scans, and anecdotal feedback	Measure installed clinic loops, behaviour proxies, HCP preference, and matched commercial outcomes
Expose the sponsor in patient content	Keep patients inside a clinic-branded, brand-neutral service; earn advantage in the HCP layer
Wait for audited share loss before changing strategy	Reserve a pilot cohort now and build the first local continuity standard

THE CLOSING CASE	When multiple brands sell the same molecule, the easiest brand to displace is the one that exists only at the moment of prescription. The harder brand to displace is the one associated – in the doctor's mind and clinic routine – with safe initiation, visible tolerability, uninterrupted refill, faster re-entry after breakthrough, and a better next review.

DO NOT FUND ANOTHER REMINDER PROGRAMME. OWN THE CONTINUITY WORKFLOW.

Decision required within 10 business days

1. Select posture: leader, challenger, or one selective-share wedge.
2. Release current licensed market and prescription data for the recipient-specific evidence page.
3. Nominate the six accountable owners: executive, medical, PV, privacy, field, and analytics.
4. Approve the 30-clinic, 90-day design subject to final medical/legal/PV/privacy review.
5. Complete the allocation gate to secure the first available Academy cohort.

EVIDENCE AND MARKET REFERENCES

Sources support the factual and clinical boundaries in this playbook. Commercial figures are not a substitute for the recipient's licensed audit.

SERIAL NO.	SOURCE	USE	BOUNDARY
1	**IQVIA Market Reflection Report, Dec 2025 (public mirror)** Open source	Monthly India molecule value and growth; top Neuro/CNS subgroup	Secondary host; INR 113 crore is one month, not MAT or prescriptions
2	**Medical Dialogues: Indian Pharma Market, Jan 2024, citing IQVIA** Open source	Earlier monthly commercial signal	Secondary publication; INR 94 crore is one month
3	**Tata 1mg levetiracetam generic/brand directory** Open source	Current visible brand and variant crowding snapshot	Retail directory, not exhaustive; no market-share inference
4	**CDSCO National List of Essential Medicines 2022** Open source	Listed levetiracetam formulations and levels of care	Policy/listing source; not a preference or share claim
5	**National Pharmaceutical Pricing Authority: ceiling-price resources** Open source	Indian scheduled-formulation price-control context	Check current notified price for each pack before use

6	**India State-Level Disease Burden Initiative, Lancet Global Health 2021** Open source	2019 India epilepsy burden estimate	Historical modelled estimate; not current treated-patient count
7	**NICE NG217: treating epileptic seizures (updated Jan 2025)** Open source	Guideline placement by seizure type	UK guideline; apply with Indian label and clinical judgment
8	**NICE NG217: treatment principles, safety, monitoring, withdrawal** Open source	Individualized strategy, adherence, review, pregnancy, monitoring	UK guidance; not a patient dosing source
9	**UCB India Keppra prescribing information, May 2022** Open source	India product information: indications, renal dosing, behaviour, pregnancy, driving, AEs	Brand PI used as official molecule safety source; recipient must check own approved label
10	**AAN/AES/SMFM practice guideline on epilepsy and pregnancy, 2024** Open source	ASM selection and pregnancy monitoring evidence	Specialist guidance; does not authorize patient-service recommendations
11	**MHRA safety review: antiepileptic drugs in pregnancy** Open source	Comparative pregnancy evidence and levetiracetam concentration change	UK regulator; use to frame discussion, not a promotional safety claim
12	**MHRA advice on switching manufacturers' antiepileptic products** Open source	Balanced switching/continuity guardrail	UK categorization; not an Indian substitution rule
13	**NICE Quality Standard QS211: epilepsy care plan** Open source	Care-plan content and agreed review date	Quality standard, not a product claim

14	**NICE CG76: medicines adherence** Open source	Non-judgmental adherence assessment and missed-dose information	General medicines guidance
15	**ILAE status epilepticus definition and first-aid resources** Open source	Five-minute emergency threshold for generalized tonic-clonic seizures	Individual seizure action plan remains authoritative
16	**Government of India Emergency Response Support System** Open source	Pan-India emergency number 112	Emergency service availability/response varies by location
17	**MoRTH Central Motor Vehicles Rules, Form 1** Open source	India driving-licence declaration asks about epilepsy/loss of consciousness	Not a complete legal-clearance rule; obtain current individual advice
18	**Department of Pharmaceuticals UCPMP 2024, updated Sep 2025** Open source	On-label, balanced, verifiable, non-disparaging promotional governance	Final materials require company legal/compliance approval
19	**MeitY Digital Personal Data Protection Rules 2025** Open source	Privacy governance and commencement context	Not legal advice; confirm applicable commencement provisions
20	**Indian Pharmacopoeia Commission: PvPI ADR reporting** Open source	India adverse-event reporting routes and helpline	Sponsor SOP and statutory timelines remain controlling
21	**ICMR Standard Treatment Workflow: epilepsy** Open source	India-specific diagnosis, follow-up, specialist and emergency context	2019 workflow; use current specialist judgment and labels
22	**Bansal et al., Cureus 2022: nationwide Indian EMR prescribing cohort** Open source	Prescription-prevalence signal: levetiracetam used in 41.8% of 6,318 patients	Records span 2001-2019; observational EMR cohort, not current audited Rx share

INDITECH HEALTH SOLUTIONS

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