LULICONAZOLE

COMPETITIVE MOLECULE NOTE

INDIA

THE NEXT SHARE SHIFT

IN LULICONAZOLE WILL NOT COME FROM ANOTHER ONCE-DAILY CLAIM

A clinic-centred tinea-completion and recurrence-control workflow for brands defending leadership, attacking leadership, or taking selective share

Shared with the leadership teams of major competing luliconazole brands in India

The molecule is familiar. The application pathway and recurrence cycle are not owned.

Luliconazole brands compete in a market where patients may self-label every itchy patch as fungal, arrive after steroid-containing combination use, accept a pharmacy substitute, apply cream only to the visible centre or only until itching improves, and treat recurrence as a reason to buy another tube. In that environment, once-daily convenience is category property. It is not a durable brand advantage.

"In luliconazole, the first brand to own application precision and recurrence review will make every other brand look as if it only sells a tube."

Inditech | Competitive Molecule Note | Luliconazole

If you are...	This playbook is the route to...
Market leader	Defending the default by owning application discipline, course completion, and recurrence review.
Challenger brand	Breaking the leader's habit by becoming the useful brand behind the clinic's tinea-control workflow.
Selective share brand	Capturing high-recurrence, high-substitution, or steroid-misuse clusters with a measurable service wedge.

STRATEGIC CHOICE

DECISION

ONE MOLECULE PLAYBOOK, WITH A BROADER TINEA-CONTROL SPINE EMBEDDED INSIDE IT.

Luliconazole should be sent to its direct brand competitors as a stand-alone molecule note. A broad “topical antifungal” document would weaken the competitive trigger. The operating engine, however, must address the full clinic-controlled pathway around localized dermatophytosis: diagnosis, topical-fit decision, exact application, completion, recurrence, and re-entry.

Strategic question	Luliconazole decision
Commercial battlefield	A molecule-specific branded-generic market where most brands share the same basic clinical role and compete through recall, availability, claims, and habit.
Primary drift	Self-diagnosis, prior steroid-combination use, substitution, incomplete or imprecise application, early stopping, and unreviewed recurrence.
Winning workflow	Clinician decision -> exact brand handoff -> exact application -> prescribed-course completion -> response / recurrence review.
Trust boundary	The service activates only after clinical assessment. It does not diagnose a rash, recommend luliconazole, or encourage topical-only treatment in extensive, atypical, recurrent, or otherwise unsuitable cases.

The outward-facing story stays molecule-specific so every luliconazole brand manager feels the direct competitive threat. The clinical spine stays broader so the service solves the real dermatophytosis workflow.

EXECUTIVE SUMMARY

CATEGORY PROVOCATION

Luliconazole is clinically familiar. That familiarity has made the market commercially lazy. Many brands still compete as if the battle ends when the doctor remembers the molecule: emphasize once-daily use, repeat antifungal language, secure a prescription, and leave the rest to the patient and pharmacy.

The Indian dermatophytosis context makes that model exposed. ECTODERM India described widespread, chronic, recurrent, multisite, and corticosteroid-modified presentations, recommended point-of-care KOH where appropriate, reserved topical monotherapy for localized naïve tinea corporis or cruris, and strongly discouraged topical corticosteroid use in tinea. A 2024 expert review also highlighted treatment-resistant dermatophytoses, particularly in the Indian subcontinent, and the need for diagnostic discipline and antifungal stewardship.

- The patient may arrive after self-treatment or an irrational steroid-containing combination has altered the presentation.
- The doctor may choose topical luliconazole appropriately, but the patient may receive another product at the pharmacy.
- The patient may apply too little, treat only the visible or itchy spot, miss surrounding skin instructed by the clinic, or stop as soon as itching settles.
- The patient may not understand whether a new lesion is persistence, recurrence, reinfection, or a different dermatosis.
- The clinic rarely sees the application error or early stop that later gets interpreted as product failure.

The next winning luliconazole brand will not say "once daily" louder. It will help clinics convert an appropriate topical prescription into exact, completed, reviewable use.

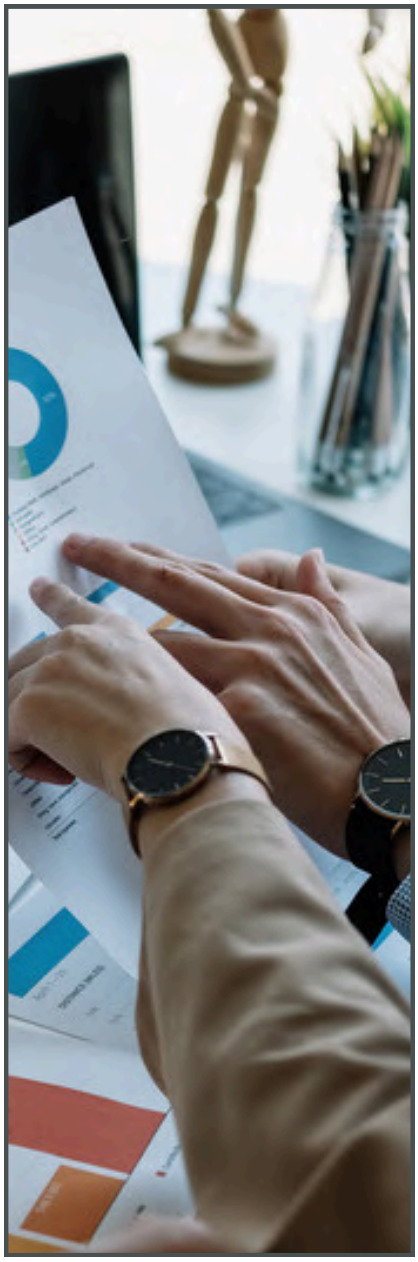
THE EMBEDDED TOPICAL-ANTIFUNGAL ENGINE

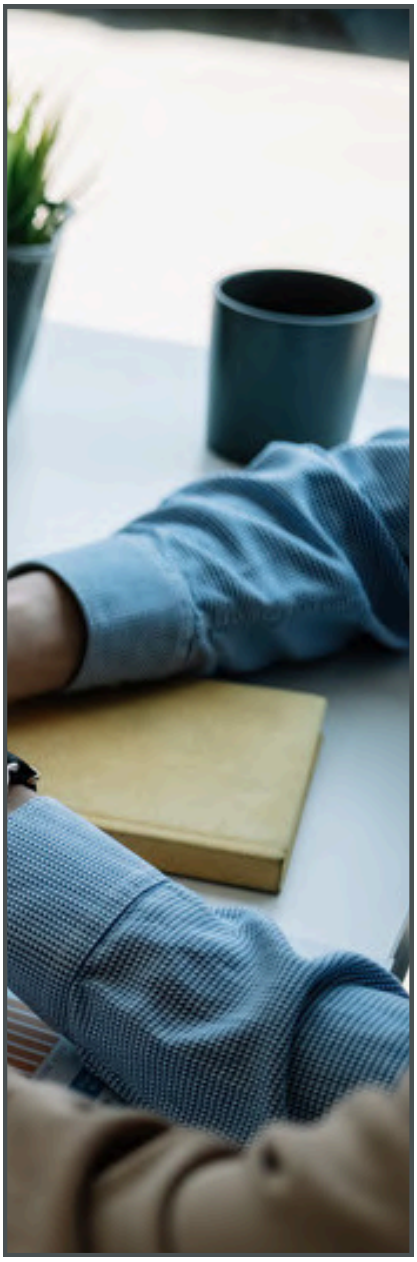
THE COMMON SPINE INSIDE THIS PLAYBOOK

The common engine is: *Assess right. Choose topical therapy right. Dispense right. Apply exactly. Complete as directed. Review recurrence.*

The commercial agenda must be protected by a stricter clinical agenda. The sponsoring brand appears only after the clinician has assessed the rash and independently chosen luliconazole. The patient-facing service is clinic-branded, non-promotional, and designed to prevent casual self-treatment.

Journey moment	Clinic problem	Brand opportunity
Rash start	The patient self-diagnoses “fungal”, reuses an old tube, or buys a steroid-containing combination.	Bring the patient back under clinic authority before any brand activation.
Clinical sort	Tinea can be confused with eczema, psoriasis, candidiasis, contact dermatitis, or steroid-modified disease.	Support diagnostic discipline and escalation rather than indiscriminate topical use.
Topical-fit decision	Localized, treatment-naïve disease differs from extensive, recurrent, hair-bearing, nail, scalp, or complicated disease.	Make the sponsor visible only after the doctor selects topical luliconazole.
Dispensing	Availability, price, or pharmacy habit can replace the prescribed brand.	Use clinic authority to protect the exact prescription without patient promotion.
Application	Site, area, quantity, frequency, hygiene, and duration may be misunderstood.	Install an exact clinic-entered application map.
Completion / review	Itch improvement triggers early stop; non-response and recurrence are managed outside the clinic.	Create completion and recurrence decision points that return signals to the clinic.





THE SERVICE ARCHITECTURE HAS SIX NON-NEGOTIABLE FUNCTIONS

- Clinic-branded tinea-care link, activated only after consultation.
- Doctor-facing luliconazole fit and recurrence cue, academy-backed and brand-visible only in the clinician layer.
- Prescription and application map with exact product, site, frequency, duration, and clinic instructions.
- Early start / substitution check and end-of-prescribed-course completion check.
- Recurrence and no-self-reuse loop that routes the patient back to the clinic.
- Dashboard plus monthly academy education for the doctor and field representative.

THE DRIFT DEFINITION

LULICONAZOLE-SPECIFIC DRIFT

The drift in luliconazole is not a lack-of-awareness problem. It is a prescribed-tube-to-uncontrolled-use problem.Pattern: itchy patch -> self-treatment / steroid mix -> clinical assessment -> luliconazole selected -> brand written -> pharmacy substitution or casual application -> itch improves -> early stop -> recurrence -> fresh tube or fresh brand decision.

Leak	What happens	Why it matters to the brand
Diagnosis leak	The patient or non-specialist assumes every itchy, scaly, or groin rash is fungal.	The molecule becomes associated with casual self-treatment and inappropriate use.
Steroid-mix leak	Prior use of steroid-containing combinations suppresses inflammation, alters morphology, and delays correct review.	A simple “antifungal cream” message loses credibility with careful doctors.
Dispensing leak	The clinic writes one luliconazole brand; the patient receives another product or a combination.	Prescription intent does not reliably become brand use.
Application leak	The cream is applied only to the centre, only where it itches, too inconsistently, or without following the clinic-entered area and duration.	Execution failure is blamed on the product or triggers switching.
Completion leak	The patient stops when itching or redness improves rather than completing the clinician-directed course.	The brand does not build continuity, and recurrence resets choice.
Recurrence leak	A new or persistent lesion leads to self-reuse, household cycling, or pharmacy advice instead of clinical reassessment.	The market reopens while the clinic and original brand lose control.

The commercial task is to move luliconazole from “another antifungal tube” to a clinic-owned tinea completion and recurrence system.

PATIENT JOURNEY

THE MOMENTS THAT MATTER

1. Rash onset: itching, scaling, redness, annular lesions, groin discomfort, or foot symptoms trigger self-interpretation before the clinic speaks.
2. Prior-treatment disclosure: the clinic identifies old antifungals, steroid-containing combinations, mixed creams, or repeated self-treatment that may have altered the presentation.
3. Clinical confirmation and sort: the doctor decides whether this is likely localized dermatophytosis, another dermatosis, steroid-modified disease, extensive / recurrent disease, or a case requiring testing or escalation.
4. Topical-fit decision: only after clinical assessment does the doctor decide whether topical luliconazole fits the patient, site, extent, and approved label.
5. Brand choice and dispensing: the hand moves quickly, and the pharmacy can still substitute unless the clinic creates a protected handoff.
6. First application: the patient must understand exactly where, how often, how long, and how much to apply according to the clinic's instructions.
7. Symptom-improvement moment: reduced itch or redness can be misread as permission to stop before the prescribed course is complete.
8. End-of-course and recurrence moment: persistent, recurrent, spreading, or atypical disease must return to the clinic instead of triggering repeat self-treatment.

The decisive commercial moments are the topical-fit decision, the application handoff, and the end-of-course / recurrence review. Own those three moments and luliconazole becomes a clinic system, not a commodity cream.

SERVICE DESIGN

SOLUTION CONCEPT: LULICONAZOLE TINEA COMPLETION & RECURRENCE REVIEW PROGRAM

The objective is not to increase indiscriminate topical antifungal use. The objective is to make the sponsoring brand the preferred luliconazole brand when the clinician has independently decided that topical luliconazole is appropriate, by helping the clinic protect the prescription, teach exact application, complete the prescribed course, and review recurrence.

PROGRAM PROPOSITION:

ASSESS RIGHT. APPLY EXACTLY. COMPLETE AS DIRECTED. REVIEW RECURRENCE.

Module	What it does	Brand role
Clinic Tinea Care Link	Clinic-branded, multilingual, non-promotional link shared after consultation; reinforces clinic instructions and review triggers.	No patient-facing brand. Sponsor underwrites a useful clinic service.
Luliconazole Fit & Recurrence Cue	Doctor-facing aid on localized topical-fit, prior steroid use, diagnosis / testing logic, and when topical-only treatment is insufficient.	Brand visible only after the clinician has chosen luliconazole.
Prescription & Application Map	Clinic enters exact product, site, application area, frequency, duration, hygiene cues, and next review point.	Protects prescription intent and reduces execution ambiguity.
Day-3 Start & Dispensing Check	Confirms the prescribed product was obtained, application started, instructions understood, and no unapproved substitution occurred.	Creates early visibility into leakage.
End-of-Course Completion Check	Captures completion, missed applications, local irritation, improvement, persistence, spread, or clinic-defined concerns.	Turns completion into a brand-supported decision point.
Recurrence / No-Reuse Loop	A later lesion or recurrence triggers clinic review, not automatic reuse of an old tube or steroid combination.	Builds clinic re-entry and repeat same-brand preference when clinically appropriate.
Household & Environment Cue	Clinic-approved guidance on not sharing towels / clothing, keeping affected areas dry, and asking contacts with symptoms to seek assessment.	Reduces avoidable cycling without diagnosing or treating contacts.
Dashboard & Academy Reinforcement	Tracks activation, substitution, application, completion, recurrence, and review signals with monthly doctor education.	Creates measurable clinic utility and a reason for the field force to return.

DOCTOR EDUCATION INFRASTRUCTURE

ACADEMY LAYER

The education layer must make luliconazole clinically practical. It should not look like another antifungal efficacy presentation. Each module should be one page, academy-certified, doctor-facing, English-language, and deliverable by a field representative in under five minutes.

Month	Micro-education topic	Commercial purpose
1	Not every itchy patch is tinea: clinical sorting, KOH logic, and the cost of casual diagnosis.	Build trust by putting diagnosis before product.
2	Steroid-modified tinea and irrational combination use: what changes after the rash has been suppressed.	Make responsible use a reason to prefer the sponsor.
3	Application precision: site, surrounding area, frequency, duration, and quantity as prescribed and locally approved.	Protect execution and reduce product-blame switching.
4	Itch relief is not the same as treatment completion.	Create the rationale for the completion check.
5	Persistence, recurrence, relapse, reinfection, or a different diagnosis: what question should the clinic ask next?	Own the recurrence-review conversation.
6	Localized topical-fit versus extensive, recurrent, hair-bearing, nail, scalp, or complicated disease.	Show that the brand knows where topical luliconazole belongs and where it does not.

THE ACADEMY LAYER SHOULD MAKE THE BRAND MORE CREDIBLE PRECISELY BECAUSE IT DOES NOT TRY TO MAKE LULICONAZOLE THE ANSWER TO EVERY RASH.

STRATEGIC VARIANTS BY BRAND POSITION

MARKET-LEADER STRATEGY

Defend the default before recurrence control becomes the challenger's weapon.

A DEFAULT BRAND THAT DOES NOT OWN THE TINEA WORKFLOW IS ONLY ONE CHALLENGER INSTALLATION AWAY FROM LOOKING ORDINARY.

IF YOU ARE THE LEADER

A luliconazole leader is unlikely to lose because doctors suddenly forget the brand. It is more likely to lose when a challenger changes what leadership means. If the challenger becomes the first brand to own application discipline, anti-steroid-misuse education, course completion, and recurrence review, the leader can start to look like legacy recall attached to a tube.

LEADER OBJECTIVE

- Turn prescription scale into clinic tinea-control infrastructure.
- Own responsible topical use before a challenger defines it as a reason to switch.
- Protect the prescription from pharmacy substitution and irrational combination replacement.
- Standardize application and completion across the leader's high-value clinics.
- Use recurrence and re-entry data to deepen clinic dependence and field productivity.
- Make later entrants look like claim-led brands without an operating system.

LEADER ACTIVATION

Deploy the full program across high-value existing prescribers first. Segment clinics by leakage pattern: high substitution, high prior steroid-combination exposure, high recurrent tinea load, weak application counselling, or weak follow-up. The leader should position itself as the brand that does not disappear when the tube leaves the clinic.

CHALLENGER STRATEGY

Do not outshout the leader. Make the leader look like a tube-only brand.

IF YOU ARE THE CHALLENGER

The leader owns recall. The challenger can own the new standard. The attack is not “our luliconazole is also once daily.” The attack is: “topical treatment fails when diagnosis, application, completion, and recurrence are not controlled - and we have built the clinic system that controls them.”

CHALLENGER OBJECTIVE

- Interrupt habit after the clinician has selected luliconazole, without widening inappropriate molecule use.
- Give doctors a concrete reason to trial the challenger in already-appropriate topical cases.
- Use anti-steroid-misuse and application education to make the incumbent’s reminder model look incomplete.
- Show meaningful clinic signals: substitution, missed application, early stop, persistence, and recurrence.
- Convert service usefulness into repeat preference rather than depending on a national recall war.

CHALLENGER ACTIVATION

Start in 100–300 clinics where the leader is strong but the workflow is weak. Choose one or two high-leakage clusters, install the full service, compare against matched controls, and scale only after the challenger proves that clinic utility can break default writing.

THE CHALLENGER’S SHARPEST LINE: “DOCTOR, WHEN YOU CHOOSE TOPICAL LULICONAZOLE, OUR BRAND HELPS YOUR CLINIC MAKE SURE THE PATIENT APPLIES IT CORRECTLY, COMPLETES IT, AND RETURNS BEFORE RECURRENCE BECOMES ANOTHER SELF-TREATED EPISODE.”

SELECTIVE SHARE-GAIN STRATEGY

Do not try to own all dermatophytosis. Own one high-leakage wedge.

IF YOU ARE A SHARE-GAIN BRAND

A mid-tier, regional, or portfolio-support brand should not imitate the market leader across every dermatology and GP clinic. It should choose a narrow universe where topical luliconazole is already used appropriately and where a specific behavioural leak can be measured and corrected.

POSSIBLE WEDGES

- Dermatology and GP clusters with high recurrent localized tinea and weak post-prescription follow-up.
- Semi-urban markets where pharmacy substitution or steroid-containing combination use is common.
- High-volume primary-care clinics that need a simple diagnosis-to-review pathway for localized tinea.
- Clinics where patients repeatedly stop after itch relief or return with incomplete-course recurrence.
- Tinea pedis–heavy clinics where foot hygiene, application area, and reservoir / recurrence counselling are weak, within the local approved label.
- Defined occupational or climate-heavy clusters where sweating, occlusion, shared facilities, or repeat exposure drive clinic volume.

SELECTIVE-SHARE PROMISE

“We are not asking to own every fungal prescription. We are helping your clinic solve one high-leakage topical-treatment problem that competitors have left unowned.”

SELECTIVE OWNERSHIP BEATS GENERIC VISIBILITY: ONE CLINIC SEGMENT, ONE LEAKAGE PROBLEM, ONE MEASURABLE WORKFLOW, THEN EXPANSION.

FIELD FORCE STORYLINE

THE SALES CALL CHANGES FROM PRODUCT REMINDER TO CLINIC INSTALLATION.

Old call	New call
Doctor, please remember our luliconazole brand. It is a convenient once-daily topical antifungal.	Doctor, topical tinea prescriptions often fail after the patient leaves the clinic. Patients accept substitutes, use steroid combinations, apply the cream incompletely, stop when itching settles, and self-treat recurrence. We have built a clinic-branded completion and recurrence-review system that activates only after you choose topical luliconazole.

30-SECOND OPENING

“Doctor, the molecule is familiar. The uncontrolled part is what happens after the prescription. This program protects your diagnosis, your exact prescription, your application instructions, and your recurrence review - without showing the brand to patients.”

WHAT THE REPRESENTATIVE INSTALLS

- Clinic name, logo, language choices, and approved clinic communication channel.
- Clinic-specific Tinea Care Link and QR / WhatsApp sharing process.
- Doctor-facing Luliconazole Fit & Recurrence Cue.
- Prescription & Application Map with clinic-entered instructions.
- Day-3, end-of-course, and recurrence review timing.
- Staff escalation rules and academy-backed monthly micro-topic.

WHY THE REPRESENTATIVE CAN RETURN EVERY MONTH

The rep is no longer repeating one visual. The rep returns with a new clinical micro-topic, clinic usage data, a leakage insight, and a practical improvement to the workflow. That makes the relationship harder for a competitor to neutralize with another reminder.

IMPLEMENTATION MODULES

A 90-DAY PILOT THAT PROVES CLINIC DEPENDENCE BEFORE SCALE-UP.

PHASE 1 –
CLUSTER SELECTION

Choose cities, specialties, clinic types, and leakage pattern: substitution, steroid-mix exposure, incomplete application, early stopping, recurrence, or poor review.

PHASE 2 –
CLINIC ONBOARDING

Configure clinic branding, language options, QR / WhatsApp link, doctor-facing cue, approved local-label boundary, and review timing.

PHASE 3 –
STAFF ACTIVATION

Train staff to share the link only after consultation and to route persistence, spread, recurrence, adverse reactions, or diagnostic uncertainty to the doctor.

PHASE 4 –
PRESCRIPTION HANDOFF

Clinic enters the exact product and application instructions; patient is told not to substitute, extend, repeat, or add a steroid-containing product without clinic advice.

PHASE 5 –
REVIEW CHECKS

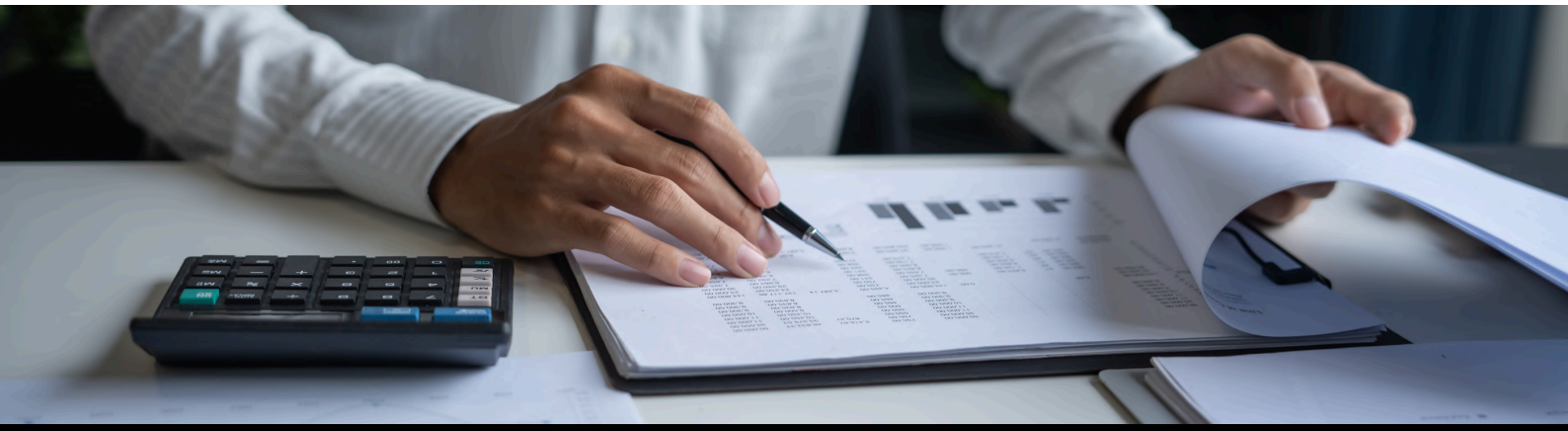
Run Day-3 start / substitution check, end-of-prescribed-course completion check, and a clinician-defined recurrence / re-entry check.

PHASE 6–
ACADEMY REINFORCEMENT

Representative returns monthly with one evidence-aligned, academy-backed topic and a clinic-usage insight.

PHASE 7 –
GO / NO-GO REVIEW

Compare activated clinics with matched controls for workflow use, prescription retention, completion, recurrence re-entry, brand-of-use, and sales movement.



RECOMMENDED CLINIC UNIVERSE

Dermatologists, high-volume general physicians, family physicians, and selected primary-care clinics managing localized tinea within the product's approved label. The pilot should exclude any attempt to standardize treatment of extensive, recurrent, atypical, scalp, nail, hair-bearing, immunocompromised, or other clinically unsuitable presentations through a patient-facing algorithm.

MEASUREMENT MODEL

MEASURE WORKFLOW CONTROL, NOT JUST VISIBILITY.

Metric block	What to track
Clinic activation	Clinics onboarded; active clinics per week; links shared; repeat usage; staff adoption; doctor continuation after Month 1.
Prescription handoff	Exact-brand confirmation; pharmacy substitution signals; combination-product substitution signals; application-map completion.
Patient workflow	Start confirmation; missed-application signals; application-module completion; early-stop signals; local irritation / concern flags; end-of-course completion.
Recurrence and review	Persistence, spread, recurrence, self-reuse, prior steroid-mix signals, and clinic re-entry triggered by the service.
Doctor engagement	Monthly education completion; cue usage; discussion rate; willingness to continue and expand the system.
Brand outcome proxies	Brand-of-use in activated clinics; prescription-to-dispensing retention; repeat same-brand use when clinically appropriate; sales lift versus matched controls.
Trust and discipline	Share of patient journeys activated only after consultation; reduction in unreviewed repeat-use signals; doctor perception of the brand as a responsible topical-antifungal partner.

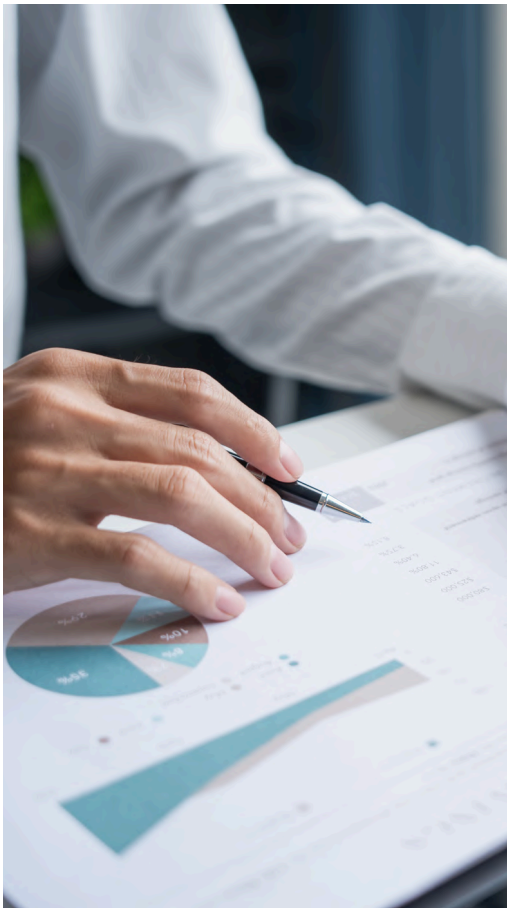
The strongest dashboard is not “more luliconazole reminders.” It is more clinician-selected luliconazole prescriptions converted into exact, completed, reviewable, same-brand use.

COMPLIANCE AND TRUST GUARDRAILS

The patient-facing layer must never look like direct-to-patient antifungal promotion or automated rash diagnosis.

FOR LULICONAZOLE, THE RESPONSIBLE CLAIM IS NOT "USE MORE CREAM." IT IS "USE ONLY AFTER CLINICAL ASSESSMENT, APPLY EXACTLY AS PRESCRIBED, COMPLETE THE CLINICIAN-DIRECTED COURSE, AND RETURN WHEN THE RASH DOES NOT BEHAVE AS EXPECTED."

- No brand name, molecule recommendation, superiority claim, or promotional retargeting in patient-facing screens.
- No automated diagnosis from symptoms or photographs, and no claim that every itchy, red, scaly, annular, groin, or foot rash is fungal.
- No instruction to start, stop, extend, repeat, share, or switch luliconazole; frequency, duration, site, and application area must come from the doctor / clinic and approved local label.
- No patient-facing instruction to use a steroid-containing combination, oral antifungal, or any add-on therapy.
- No attempt to manage extensive, recurrent, rapidly spreading, steroid-modified, scalp, nail, hair-bearing, pregnancy, paediatric, immunocompromised, diabetic-foot, or otherwise complicated cases outside clinician review.
- Clear clinic-contact prompts for worsening, spreading, pain, pus, fever, severe irritation, facial / genital / mucosal involvement, repeated recurrence, or other clinic-defined concerns.
- No treatment of household contacts through the service; symptomatic contacts are prompted to seek clinical assessment.
- No unnecessary patient-identifiable data. Clinical images, if ever used, require explicit consent, secure clinic governance, and a separately approved workflow.
- The India-approved label, company medical / legal review, and physician judgement override all generic program content.



FIRST-MOVER ADVANTAGE

The first brand to install the tinea-control workflow changes the basis of competition.

- First claim on clinic-owned topical-treatment completion and recurrence-review infrastructure.
- First association with diagnostic discipline and anti-steroid-misuse education.
- First habit loop with doctors and clinic staff at the application handoff.
- First behavioural data on substitution, application, early stop, persistence, and recurrence.
- First chance to make competitors look as if they only sell antifungal tubes.
- First ability to reserve high-value clinic clusters before another brand installs a competing workflow.

RECOMMENDED ALLOCATION RULE

The note can be circulated market-wide, but the operating offer should not be identical and simultaneous for direct competitors in the same defined clinic cluster. Inditech should reserve one sponsoring luliconazole brand per agreed pilot cluster and pathway during the pilot term, subject to medical, legal, commercial, and contracting approval.

WHY THE URGENCY IS REAL

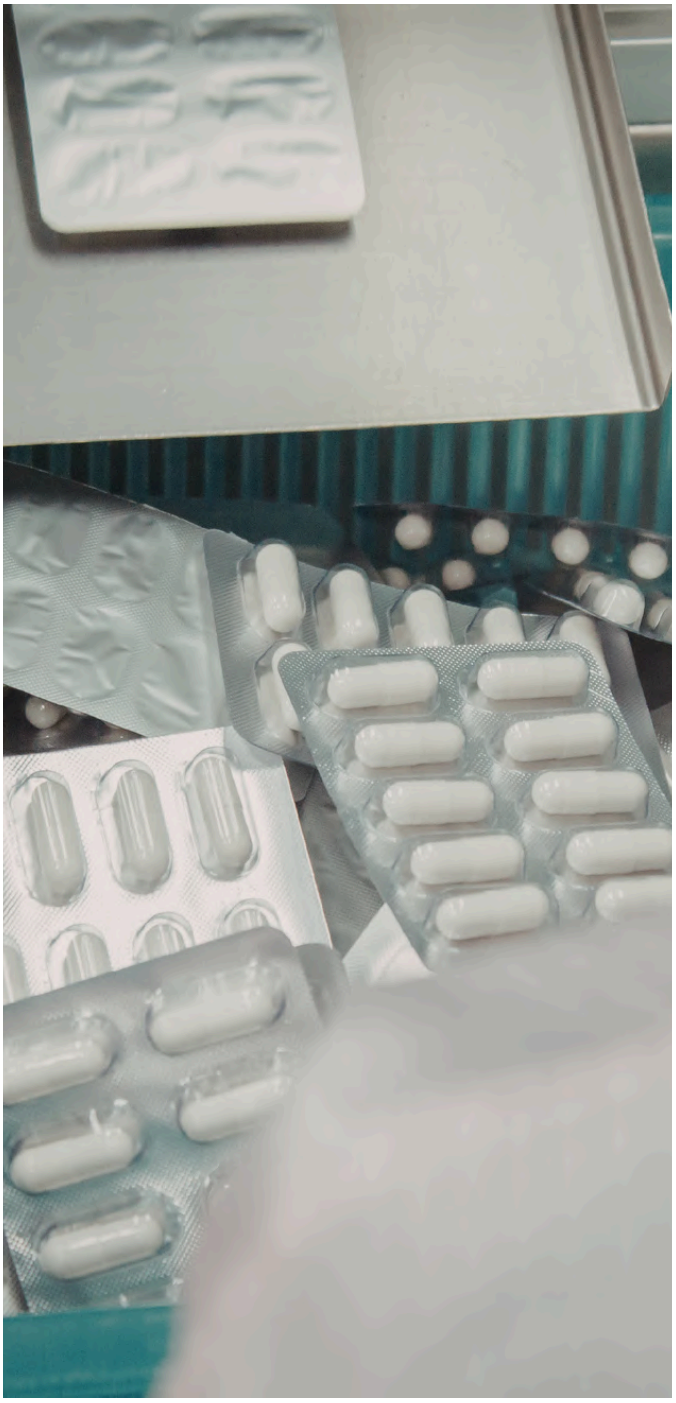
Later entrants can copy a headline, a patient leaflet, or a steroid-misuse visual. They cannot easily displace a clinic-branded workflow that staff already use, doctors already trust, and the sponsoring brand already measures.

THE MARKET-WIDE NOTE CREATES AWARENESS. THE FIRST-QUALIFIED CLUSTER ALLOCATION CREATES THE REASON TO DECIDE.

PILOT DESIGN AND COMMERCIAL CTA

THE FIRST COMMERCIAL STEP IS A 90-DAY CLINIC-CONTROL PILOT.

Pilot element	Recommendation
Pilot name	Luliconazole Tinea Completion & Recurrence Review Program
Duration	90 days
Clinic base	100–300 dermatology, GP, family-medicine, or selected high-volume primary-care clinics in defined clusters.
Primary leakage test	Substitution, prior steroid-combination use, incomplete application, early stop, poor course completion, or unreviewed recurrence.
Primary commercial test	Does the workflow create enough clinic usage, prescription protection, completion, recurrence re-entry, and brand-of-use lift to justify scale-up?
Control design	Matched non-activated clinics in the same geography and specialty mix, with pre-defined measurement windows.
Commercial CTA	Run a 30-minute Luliconazole Tinea-Control Diagnostic to define leader defence, challenger attack, or selective share-gain deployment.



THE 30-MINUTE DIAGNOSTIC ANSWERS FIVE QUESTIONS

1. Where is the brand losing value: diagnosis, substitution, application, completion, or recurrence?
2. Which clinic cluster is commercially attractive and clinically appropriate?
3. Which strategic posture applies: defend leadership, attack the default, or own a selective wedge?
4. What should the 90-day workflow and matched-control design look like?
5. Can the brand reserve a pilot cluster before a direct competitor does?

The decision for any luliconazole brand team is direct: remain one more brand fighting for tube recall, or become the brand clinics use to make topical tinea care exact, completed, and reviewable.

SOURCE NOTES AND EVIDENCE BOUNDARIES

These notes support the market framing, service boundary, and safety guardrails. They do not replace the India-approved product label, local medical guidance, company medical / legal review, diagnostic testing, or physician judgement.

1. Rajagopalan et al. - Expert Consensus on The Management of Dermatophytosis in India (ECTODERM India)
BMC Dermatology. 2018;18:6. The consensus recommends KOH microscopy as a point-of-care test, culture in chronic / recurrent / recalcitrant / multisite cases, topical monotherapy for localized naïve tinea corporis / cruris, and strongly discourages topical corticosteroid use in Indian tinea management.

2. Hill et al. - Expert Panel Review of Skin and Hair Dermatophytoses in an Era of Antifungal Resistance
American Journal of Clinical Dermatology. 2024;25:359–389. The review notes increasing reports of dermatophytoses not responding to standard care, highlights the Indian subcontinent and Trichophyton indotineae, recommends diagnostic suspicion and antifungal stewardship, and considers mycological confirmation best practice when feasible.

3. U.S. FDA - LUZU (luliconazole) Cream, 1% prescribing information
The U.S. label identifies luliconazole as a topical azole for specified tinea pedis, cruris, and corporis indications, directs application to affected and surrounding skin for label-defined durations, states topical-only use, and lists application-site reactions among observed adverse events. It is used here only to establish general product boundaries; India-approved labeling governs the program.

4. Evidence boundary for commercial claims
This playbook does not claim superiority over other topical antifungals, guaranteed cure, reduced resistance, or universal suitability. Any brand-specific efficacy, safety, duration, age, site, formulation, or comparative statement must be derived from the sponsor's approved Indian label and cleared through its medical, regulatory, and legal processes.

STRATEGIC OPPORTUNITY & CTA

The decision for a luliconazole brand team is simple: Will you remain another brand competing on once-daily convenience, or become the brand that helps clinics ensure every topical treatment is applied correctly, completed as prescribed, and reviewed before recurrence?

Luliconazole doesn't need another "once-daily" campaign. It needs a brand that transforms every prescription into a structured, clinic-controlled treatment pathway.

Old rule: win the prescription.
New rule: own the treatment journey after it.

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The next winning luliconazole brand won't compete on another convenience claim.

It will own the exact-use pathway - from prescription protection and precise application to course completion, recurrence review, and prevention of casual self-treatment.

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 Luliconazole Tinea-Control Diagnostic and discover how your brand can defend leadership, challenge established competitors, or build selective market share through a clinic-centred treatment completion and recurrence-control system.

INDITECH HEALTH SOLUTIONS

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