Competitive Formulation Playbooks

MAGNESIUM

INTEGRATED COMPETITIVE FORMULATION PLAYBOOK

The next magnesium share shift will be won by the brand that earns the next clinical decision

FOR MARKET LEADERS, CHALLENGERS AND BRANDS SEEKING SELECTIVE MARKET-SHARE GAINS



INDITECH



MAGNESIUM

YOUR POSITION	THE DECISION
Market leader	Make dependable clinic follow-up part of the established franchise.
Challenger	Make clinics compare the work completed after selection.
Selective-share brand	Win one clinical task in a dense, serviceable cluster.

Magnesium has a bigger opportunity than another salt story. Help the clinic decide who needs supplementation, make the elemental dose clear, resolve early friction and complete a useful review. That is a service a doctor can judge and a competitor must answer.

The strategic territory: a clinic-branded, Academy-certified Magnesium Fit, Replacement & Review Pathway.

ONE OPPORTUNITY OFFERED ACROSS THE CATEGORY

Inditech is offering this same category-wide opportunity to major competing magnesium brand teams in India. Each team can defend its position, challenge an incumbent or concentrate on one valuable local segment. This is a common competitive playbook, not a proposal reserved for one company.

The first-mover advantage comes from installing a useful clinic routine, building operational evidence and learning faster. No competitor commitment, existing allocation or exclusive Academy endorsement is implied.

THE COMPETITIVE CHOICE

BUILD THE CATEGORY AROUND FIT AND REVIEW

The commercial unit should be a clinically appropriate, completed supplementation episode. A bottle sold without a clear reason, a usable plan or a review can create revenue once and uncertainty afterwards.

THE PROPOSITION TO EVERY BRAND TEAM

Support a neutral service that the doctor shares from the clinic. The service helps the patient understand the clinic's plan, records what was actually obtained, captures tolerability and medicine questions, and brings a factual summary back for review. The brand earns recognition in the professional engagement around that service.

This is a testable commercial thesis: useful clinic execution may strengthen consideration, appropriate initiation and continued use when needed. It does not establish superiority or guarantee share. Competitors may benefit from the same neutral patient service; commercial value must be earned through execution, availability, affordability and credible HCP engagement.

POSTURE	WHERE TO COMPETE	WHAT SUCCESS MEANS
Defend leadership	Existing priority clinics with repeat demand and incomplete review routines.	Protect appropriate consideration and resolve avoidable access or follow-up gaps.
Displace the default	Clinics dissatisfied with unclear doses, weak handover or unresolved tolerability questions.	Earn a fair place in future clinician choices; measure matched-clinic movement.
Capture selectively	One clinic segment, one problem and one geography.	Produce a repeatable result within affordable service capacity.

HOW TO USE THE PLAYBOOK

Read the market and formulation sections to define the competitive universe. Use the pathway and Academy sections to define the service. Choose one of the three postures, then commit to the 90-day pilot, its measurement rules and the first-mover allocation process.

Recommended starting point: selected adult physician clinics managing assessed magnesium need, with one named person responsible for closing reviews.

INDIA MARKET EVIDENCE

THERE IS GROWTH EVIDENCE WITHOUT A RELIABLE CURRENT LEADERBOARD

The category crosses prescription-influenced retail, nutraceuticals and direct consumer channels. Their coverage differs. A national market number is useful only when its ingredients, routes, combinations and channels are defined.

PUBLIC SIGNAL	WHAT IS VERIFIED	HOW TO USE IT
Historical category value [1]	Mint reported Pharmarack magnesium-supplement MAT value of INR 8 crore in December 2020 and INR 42 crore in December 2024.	Dated reported retail-category signal. It is not audited company revenue or the total October 2026 oral market.
Mineral-category context [1]	The same report cited INR 305 crore for the mineral-supplement market at December 2024.	Do not add calcium, antacids, injectable magnesium or all multivitamins to this denominator.
Online demand [1]	Tata 1mg described roughly twofold growth in magnesium demand on its platform in the preceding year.	Company-reported channel signal. It does not establish national prescriptions or growth.
Prescription prevalence [2]	An ICMR network analysis included 4,838 prescriptions; its magnesium-containing antacid FDCs belong to a different clinical market.	Do not present antacid use, or all vitamin/mineral prescribing, as oral magnesium-supplement prevalence.

The responsible market conclusion : Public evidence supports a developing category with visible competition. No current, nationally representative oral-magnesium prescription rate, complete brand rank table or comparable magnesium-only company revenues were verified for this playbook. Online listings establish presence, not leadership. Historic sales must not be projected into 2026 without new data.

The data cut that makes a ranking usable : Commission a current licensed MAT and latest-quarter cut: exact SKU, salt, elemental content, standalone versus magnesium-led combination, marketer, channel, value, units, geography and prescriber specialty. Request the audit's coverage and exclusions. Separate prescription-linked demand from self-purchase; deduplicate overlapping online and retail datasets.

MAT means sales over the preceding 12 months. The commercial hypotheses and pilot do not depend on an invented national market size. Add named leadership claims only after validating the relevant dataset.

NAMED COMPETITIVE LANDSCAPE

START WITH THE EXACT FORMULATION IN THE CLINIC CHANNEL

Selected Indian products below establish competitive presence. They are not a ranking, an endorsement or a list of products approved for treating hypomagnesaemia. A company selling pharmaceuticals can also market a food supplement.

BRAND AND COMPANY	PUBLIC FORMULATION SIGNAL	STRATEGIC IMPLICATION
MGD3 Pharmed [3,4]	Company brochure: magnesium glycine complex providing 250 mg elemental magnesium plus vitamin D3 1,000 IU per tablet.	A magnesium and D3 proposition needs a reason for both ingredients; avoid automatic addition to every D3 prescription.
MGD3 60K Pharmed [3,5]	Company brochure: a combi kit with one D3 60,000 IU tablet and 14 magnesium tablets, each with 250 mg elemental magnesium.	A kit is not a single daily fixed-dose combination. Record two separate schedules.
Ultra Magnesium Meyer Organics / Vitabiotics India [6]	Official Indian product page lists Ultra Magnesium 200 mg and identifies Meyer Organics. Retail ingredient panel lists magnesium oxide [7].	Compete on dose transparency and clinic execution. Confirm the current pack panel and licensed category before claims.
Vitanova D3 MG Zuventus [8,9]	Company advertisement: magnesium bisglycinate equivalent to 250 mg magnesium plus D3 600 IU. Retail panel supports the quantities.	Verify current pack: some retail listings confuse salt, elemental quantity or D3 strength.
Magvion Healers Nutraceuticals [10]	Retail listing: magnesium oxide 400 mg. It does not establish 400 mg elemental magnesium.	Presence verified at retail level only. Require manufacturer label and regulatory status before pathway mapping.

WHAT THE ROSTER CHANGES

A magnesium-focused team competes against a standalone option, a combination convenience story and a consumer brand that the patient already knows. The useful response is a clear product record and a dependable review process. Broad corporate size does not establish magnesium leadership.



CONSUMER AND HYBRID COMPETITION

THE PATIENT CAN CHANGE THE COMPETITIVE SET AFTER LEAVING THE CLINIC

Consumer-facing magnesium brands are relevant even when the programme is doctor-mediated. Patients may bring an online product, a different serving size or a mixed supplement into the same clinical episode.

BRAND AND COMPANY	OBSERVED PUBLIC PRODUCT	WHAT THE CLINIC MUST RECONCILE
Revital Magnesium Sun Pharma [11]	Official site describes magnesium bisglycinate and states 440 mg elemental magnesium.	Serving size and complete ingredient panel; do not treat the headline as the amount in one tablet.
HK Vitals HealthKart [12]	Official page: glycinate; 220 mg magnesium per two-tablet serving; 120-tablet pack.	Per tablet versus per serving. Product pages and older packs can differ.
Tata 1mg Tata 1mg Healthcare Solutions [13]	Own-brand listing: bisglycinate buffered with hydroxide; 440 mg elemental magnesium per two tablets.	Read the full blend. A glycinate front label does not imply a single unbuffered source.
Triple Magnesium Complex Wellbeing Nutrition [14]	Official page lists bisglycinate, threonate and citrate; 60-capsule pack.	Verify elemental amount on the current panel. Multiple forms do not prove a better clinical result.
A to Z Expert Magnesium Alkem [15]	Retail listing identifies Alkem as marketer and a triple-magnesium health supplement with added nutrients.	Confirm exact sources, serving quantities and co-ingredients from the manufacturer before clinical use.

THE COMPETITIVE IMPLICATION

The brand team has to win a professional decision and help the clinic handle an open retail market. The service should record what the patient actually uses, including competitor products, without becoming a shopping recommender or a brand-switch engine.

Consumer pages contain claims about sleep, relaxation, recovery and absorption. These pages are used here only to document product presence and declared composition. Their promotional claims are not adopted as clinical evidence.

Make the label understandable. Make the next review happen. Do not compete by making the largest number on the bottle larger.





DEFINE THE FORMULATION CATEGORY



ONE MAGNESIUM HEADING CONTAINS SEVERAL DIFFERENT MARKETS

Use a narrow core market and separately labelled adjacencies. Otherwise both the business case and the clinical programme become misleading.

ARENA	SCOPE RULE	PATHWAY POSITION
Oral standalone magnesium	Magnesium is the principal nutrient or therapeutic ingredient. Include only intended human oral products.	Core arena after clinician assessment and exact product verification.
Magnesium-led combinations	Magnesium is a stated primary reason for use; additional D3, zinc, B vitamins or other actives require their own rationale.	Core subsegment, analysed separately from standalone products.
Calcium-led and multivitamin products	Magnesium is one of many supporting ingredients.	Adjacent competition and a source of duplicate intake; exclude from core sales unless the universe explicitly includes them.
Hospital magnesium sulfate	Parenteral use for acute correction and specific obstetric or other hospital indications. [16,24]	Separate setting, evidence and market. No outpatient supplement conversion.
Antacids and laxatives	Hydroxide, oxide or other magnesium-containing products used primarily for GI effects.	Separate therapeutic market; record as co-use because exposure and interactions still matter.
Urinary alkalinisers and stone products	Potassium/magnesium citrate combinations used for a distinct urinary indication.	Separate clinical pathway; not interchangeable with nutritional replacement.
Other magnesium names	Esomeprazole magnesium and magnesium stearate as an excipient are not magnesium supplementation.	Exclude from the core inventory.

A CLASSIFICATION DECISION BEFORE ANY SALES TOTAL

Classify each SKU by intended use, ingredient role, route, regulatory category and declared elemental magnesium. Count each SKU once. A combination may be relevant to two brand teams but its sales cannot be counted twice in a category total.

Clinical evidence for one route, indication or finished formulation cannot automatically support another. The hospital pathway remains outside this programme.

SALT CHOICE AND LABEL CLARITY

COMPARE THE ELEMENTAL AMOUNT AND THE WHOLE PRODUCT

The salt is one part of the choice. Clinical purpose, approved use, elemental content, practical dosing, tolerability, co-ingredients, quality, access and cost all matter. A universal ranking of salts is not justified.

FORM OR PRODUCT TYPE	USEFUL DISTINCTION	DECISION RULE
Oxide	Indian standalone listings exist. Salt mass and elemental mass are different.	Read the declared elemental dose and assess the actual patient response and tolerability.
Glycinate or bisglycinate	Standalone and D3 combinations are visible in India. Some products are buffered blends.	Read the full panel; do not infer purity, absorption or outcome from the front label.
Citrate	Appears in supplements and separately in urinary or bowel products.	Check the intended use and co-ingredients; the salt name alone does not define the clinical job.
Threonate and multi-salt blends	Visible in premium consumer formulations.	No automatic cognitive, sleep or neurological advantage; require indication-specific product evidence.
Chloride, lactate, aspartate, glycerophosphate	Relevant oral magnesium salts in clinical literature and international formularies. [16,17]	Do not assume Indian availability, licensing or equivalence. Verify each actual product.
Orotate and other specialist claims	May appear in niche retail ranges.	Exclude superiority or organ-protection claims without adequate product-specific clinical evidence.

HANDLE ABSORPTION EVIDENCE HONESTLY

NIH describes absorption differences between forms in small studies; NHS SPS does not identify significant bioavailability differences among oral salts in its practical replacement guidance. These are not grounds for a universal winner. Absorption findings alone do not establish better patient outcomes or superiority of an Indian finished product. [16,17]

No automatic salt conversion. The doctor chooses the product and regimen; the service reconciles that decision with the pack the patient has.

THE DOSE AND VALUE COMPARISON

A LARGE SALT NUMBER CAN HIDE A SMALL USABLE DOSE

Elemental magnesium is the comparable quantity. Show the amount per unit and per serving, then record the doctor's intended daily regimen. Never infer a patient dose from a front-of-pack number.

LABEL QUESTION	WHAT MUST BE RECORDED
What is the magnesium source?	Exact salt or blend, including any declared buffering ingredient.
How much is elemental?	Declared elemental magnesium per tablet, capsule, sachet or measured liquid volume.
What is one serving?	Number of units in the nutrition panel. Two tablets are not one tablet.
What else is present?	D3, calcium, zinc, B6, B12, potassium, botanicals and other relevant ingredients.
What is the actual plan?	Clinician-entered units, frequency, duration, review date and any medicine-spacing instructions.
What does the patient pay?	Pack price, pack units, daily cost under the actual plan, and availability.

Two simple examples : If the panel says 220 mg elemental magnesium per two tablets, each tablet provides 110 mg. If another pack says 400 mg magnesium oxide, that does not mean 400 mg elemental magnesium. Use the manufacturer's elemental declaration; do not guess from the brand name or a retail search result.

Illustrative price arithmetic only: a 30-tablet pack at INR 300, with 100 mg elemental magnesium per tablet, costs INR 10 per 100 mg. A 60-tablet pack at INR 480 with the same elemental content costs INR 8 per 100 mg. At a hypothetical clinician-selected two units daily, the costs are INR 20 and INR 16 a day. This is not a dosing recommendation or evidence of clinical equivalence.

Do not confuse three different numbers : Dietary requirement is total intake from food and other sources. A supplement safety limit is a separate concept. A therapeutic replacement regimen is a clinical decision. The US adult supplemental upper limit of 350 mg/day is not an Indian licensing limit or a universal ceiling on supervised treatment. [17]

A percentage of RDA is not an indication to prescribe. A lower cost per elemental milligram does not establish overall value, tolerability or product quality.

PATIENT SELECTION

THE FIRST CLINICAL WIN MAY BE DECIDING NOT TO SUPPLEMENT

The pathway has two distinct tracks. The clinic selects the track before the patient enters a product-support episode. A symptom questionnaire never diagnoses magnesium deficiency.

TRACK	CLINICAL PURPOSE	ENTRY AND EXIT
A Replacement and review	A clinician has assessed documented deficiency or a specific medically established replacement need.	Clinician confirms outpatient suitability, renal and medicine assessment, exact product/regimen and review plan. Exit includes correction, referral or revised diagnosis.
B Dietary fit and review	A clinician identifies inadequate intake or another justified nutritional need, without labelling the person deficient solely from symptoms.	Food assessment and advice come first. Supplement only if selected within the product's permitted use. Review need and duplication; testing is not automatic.
Separate specialist route	Complex renal disease, unstable illness, severe deficiency, pregnancy, children or a distinct indication such as migraine prevention.	Not a routine pilot enrolment. Use specialist-owned protocols and appropriate product evidence.

WHERE ASSESSMENT IS ESPECIALLY RELEVANT

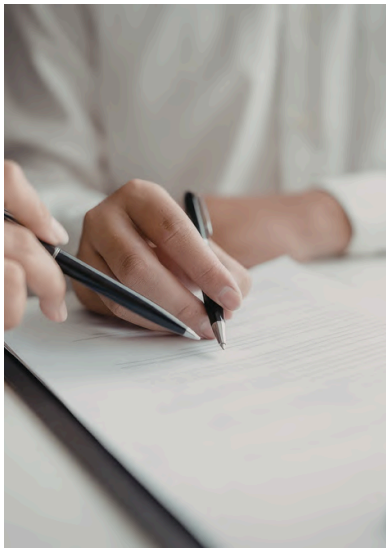
Persistent GI losses, malabsorption, certain medicines and other clinical contexts can justify evaluation. Long-term PPI use deserves medicine review where relevant; it does not justify automatic magnesium for every PPI user. The doctor must address the cause as well as any replacement need. [16,18]

THE PRODUCT BOUNDARY MATTERS

Many named products in this market are supplements. Their presence in a clinic or a prescription does not convert them into drugs licensed to treat hypomagnesaemia. Medical and regulatory review must map each product to the permitted communication. The pathway can teach deficiency management neutrally without claiming that a sponsor's nutraceutical treats disease. [25]

No mass "Are you magnesium deficient?" funnel. No routine magnesium add-on for everyone with fatigue, diabetes, cramps, poor sleep or a vitamin D prescription.

EVALUATION AND CLINICAL REVIEW



ESTABLISH THE REASON AND THE REVIEW PLAN BEFORE THE FIRST PACK

The clinical record needs a question to answer: what is being corrected or supported, what might explain it, and what evidence will guide the next decision?

Evaluation belongs to the clinician : Serum magnesium is useful but does not perfectly reflect total-body stores. A normal result does not settle every clinical question, and a vague symptom list is not an alternative diagnostic test. The clinician interprets the result, units, laboratory range, medicines and clinical context. [17]

For assessed deficiency, the doctor considers cause, renal function and associated potassium or calcium disturbances. Severe or symptomatic cases may require hospital care rather than an oral supplement pathway. NHS SPS uses less than 0.5 mmol/L as severe; local protocols, symptoms and clinical judgement control. [16]

REVIEW QUESTION	RECORD OR ACTION
Was the original indication valid?	Confirm the working reason and whether another cause requires assessment.
What was actually taken?	Reconcile pack, elemental content, units, dates, missed doses and co-used products.
Was treatment tolerated?	Record symptoms and timing without assigning causality; the clinician decides changes.
Were ordered tests completed?	Carry original results, units and dates into the review; do not auto-grade them.
What happens next?	Clinician documents continue, adjust, change product, stop, investigate, refer or close.

Timing follows the clinical track : For oral replacement of hypomagnesaemia, NHS SPS advises checking serum magnesium around seven days after initiation and again after one to three months depending on cause. This is a reference for clinician configuration, not an automatic schedule for all Indian supplements. Nutritional support without diagnosed deficiency needs a proportionate review, not reflex serial testing. [16]

The service schedules only the clinic-approved actions. It does not prescribe replacement doses, interpret laboratory results or authorise treatment extensions.

EVIDENCE AND CLAIM DISCIPLINE



EARN CREDIBILITY BY REFUSING WEAK INDICATIONS

The programme should teach clinicians to distinguish a plausible mechanism, a small study, an established indication and a claim permitted for the exact product. They are different standards.

CLAIM OR USE	EVIDENCE POSITION	PROGRAMME RULE
Assessed magnesium deficiency	Replacement is a clinical task; severity, cause, route and renal function matter. [16]	Core clinical teaching. No assumption that every marketed supplement is an approved therapeutic product.
Dietary inadequacy	Nutritional support can be appropriate after assessment.	Food-first explanation; no prevalence claim that most Indians are deficient.
Sleep or anxiety	NCCIH describes limited and conflicting sleep evidence. [19] Anxiety is not a default indication here.	No sleep score or anxiety score that triggers magnesium; no promised calm or better sleep.
Muscle cramps	Cochrane found clinically meaningful prophylaxis unlikely in older adults; pregnancy evidence was uncertain. [20]	Cramps may prompt clinical assessment. They do not establish deficiency or a general treatment claim.
Neuropathy	Magnesium is not positioned here as a general treatment for neuropathic pain or nerve repair.	Investigate the complaint. Do not borrow claims from B vitamins or other combination ingredients.
Migraine prevention	Some evidence exists, with limited certainty and clinician supervision needed. [21]	Optional separate specialist module; exclude from the initial core pilot and generic consumer promises.
Salt or combination superiority	Mechanistic or absorption differences do not prove a superior finished-product clinical outcome.	No “best salt”, universal “gentle”, or class-wide efficacy hierarchy.

Claims about normal physiological function must still be accurate, substantiated and permitted for the product. “Natural”, “chelated”, “liposomal”, “triple” and “100% RDA” are not substitutes for clinical justification.

Hospital magnesium sulfate evidence, including eclampsia prevention and treatment, must never be transferred to oral nutritional products. [24]



Competitive Molecule Notes

MOMENTS THAT MATTER

FIND THE POINT WHERE THE CLINICAL PLAN STARTS TO DRIFT

Each moment creates a practical clinic task. The competitive opportunity is to make that task easier and more reliable, without using patient support to pressure a product choice.

MOMENT	WHAT CAN GO WRONG	WHAT THE PATHWAY DOES
1 Patient selection	A common symptom becomes a supplement sale without assessment.	Doctor records a clinical or nutritional reason, or chooses no supplement.
2 Deficiency evaluation	A number is read without units, context or a cause assessment.	Carry the original report and the clinician's investigation plan.
3 Formulation choice	Salt name, product status or a combination ingredient is misunderstood.	Use a medically approved product record with full composition.
4 Elemental dose	Per serving is mistaken for per tablet; two products overlap.	Record elemental amount per unit and the actual regimen.
5 Initiation	The patient buys a different pack or never starts.	Ask what was obtained and whether the instructions are understood.
6 Tolerability	Diarrhoea, discomfort or worry leads to silent self-change.	Capture facts and connect the patient to the clinic.
7 Medicine interactions	New antibiotics, thyroid treatment or other products complicate timing.	Request an updated medicine list; clinic or pharmacist verifies the schedule.
8 Adherence and access	Cost, swallowing burden, confusing schedules or stock gaps interrupt the plan.	Surface the specific barrier; avoid guilt-based reminders.
9 Monitoring	An ordered test is missed or the result never reaches the clinician.	Remind, record completion and prepare a review brief.
10 Clinical review	A refill substitutes for reassessing need.	Record a clinician decision and close or renew the episode explicitly.

A completed review can appropriately end supplementation. (That is successful care, not a failed retention target. The frequency and commercial impact of each gap are pilot questions. No national leakage rate is assumed.)

THE INTEGRATED PATHWAY

MAGNESIUM FIT REPLACEMENT AND REVIEW CONNECTS THE WHOLE EPISODE

The patient sees the clinic's name and approved education. The doctor sees a short worklist and a factual review brief. The Academy governs the educational standard. The sponsor sees permitted aggregate programme performance.

LAYER	WHAT IT CONTAINS	WHO CONTROLS IT
Clinic-branded patient link	Reason for support; current clinician-entered plan; short videos; check-ins; next review; clinic contact and urgent-care instructions.	Clinic authorises enrolment, patient content and clinical contact routes.
Clinic workspace	Consent record, track, product reconciliation, due tasks, reported concerns, original test reports and review outcomes.	Treating team. Medical decisions remain in its clinical record.
Academy programme	Evidence-reviewed PDF mini-CMEs, expert video lectures, cases, assessments, translations and version history.	Independent clinical faculty and Academy governance.
Field and brand layer	Approved HCP introduction, clinic onboarding aids, deployment status and relevant approved product information.	Brand team and field management within medical and compliance approval.
Measurement layer	Adoption, review completion, workload, safety response, patient burden and separately analysed commercial signals.	Programme evaluator with role-based access and defined data rules.

ONE SIMPLE OPERATING SEQUENCE

The doctor assesses fit and selects the track. Clinic staff record the plan and obtain consent. The patient receives the clinic link. Check-ins surface practical questions. The clinic handles concerns and reviews ordered evidence. The doctor records the next decision. The episode closes or receives a new, explicit review date.

WHAT MAKES IT USABLE

No patient app installation. A short mobile page works from a clinic-shared link or QR. Start with English, Hindi and the selected cluster's main language. Offer a paper plan and telephone route. A clinic should not need a full EMR integration to participate.

Academy-certified describes the intended released programme after documented approval. It is not an existing accreditation claim. Sponsorship does not determine treatment eligibility or patient access.

ENROLMENT AND FOLLOW-UP

SHARE THE LINK AT A CLINICAL TRIGGER WITH A CLEAR NEXT STEP

The doctor or authorised clinic staff shares the link. Representatives do not collect patient numbers, recruit patients into a product funnel or manage clinical messages.

TRIGGER OR TIME	CLINIC ACTION	PATIENT EXPERIENCE
Assessment ends with no supplement	Offer a separate clinic education link only if useful.	Food and assessment information without a product recommendation or refill journey.
Replacement or support is selected	Record track, plan, contact route, review date and consent.	A plain-language explanation of why the clinic has shared the pathway.
First pack obtained	Reconcile actual pack and directions, ideally within 2–3 days.	Confirm receipt, understanding and any access difficulty.
Early check-in	Use one short check-in around day 3–7, adjusted by the clinic.	Report use, stomach effects, new medicines and questions.
Clinic-ordered test is due	Send a reminder only for an existing order.	Bring or upload the original report using an authorised route.
Review is due	Remind shortly before the clinic-selected date and prepare the brief.	Attend or contact the clinic; symptoms alone do not determine success.
Visit missed or plan changes	Make a limited re-entry attempt; update the current plan after clinical review.	No automatic restart, extension or duplicate reminder sequence.

CADENCE AND WORKLOAD

These are proposed service timings, not medical instructions. Replacement follow-up may need to happen earlier than a standard nutritional-support review. The doctor's schedule overrides the default. Limit non-response chasing to two routine attempts over seven days unless a clinician identifies a safety reason for further action.

Record declined support, unreachable contact and completed clinical closure separately. The system must never treat absence of a response as proof that treatment was taken or that a patient is well.

Every invitation must tell the patient what to do next and who can answer a clinical question.

CLINIC TOOLS

GIVE THE CLINIC FOUR SMALL RECORDS THAT CLOSE THE LOOP

Use structured fields for facts and free text for the clinician's reasoning. The minimum record should be short enough to complete during normal clinic work.

RECORD	MINIMUM FIELDS	GUARDRAIL
1 Fit and consent	Clinic and episode ID; adult status; track; clinician reason; renal or specialist review flag; consent version; communication preference.	Staff record the clinician's decision. There is no patient-facing deficiency score.
2 Product and plan	Exact product, route, salt/blend, elemental amount per unit, units and frequency, co-ingredients, start/review dates and medicine-spacing instructions.	The clinician or authorised pharmacist verifies the plan against current product information.
3 Check-in	Actual use; pack change; missed-use reason; GI symptoms or other concern; new medicine/supplement; access issue; contact request.	No auto-diagnosis, causality judgement or treatment recommendation.
4 Review and closure	Ordered tests with original units/dates; patient-reported use; unresolved concerns; clinician decision; next date or closure reason.	Only an authorised clinical review counts as completed.

The factual review brief : Example: "Track A; review due today. Patient reports taking the planned product on five of the past seven days. Two missed days were attributed to loose stools. A new antibiotic was started elsewhere; timing has not been checked. Ordered report attached. Patient asks whether the plan should change."

The brief does not say "magnesium intolerance", "treatment failure" or "switch to glycinate". It gives the clinician the facts needed to assess those questions. Staff should be able to prepare it in about three minutes; the pilot tests that workload assumption.

Keep instructions current : A changed regimen creates a dated replacement of the active plan. Archive the old instructions, cancel obsolete reminders and retain an audit trail. A new pack requires reconciliation, not an automatic equivalence calculation.

PATIENT EDUCATION

EXPLAIN THE PLAN IN LANGUAGE THE PATIENT CAN ACT ON

Patient education is clinic-branded and neutral. It carries the treating clinic's contact details and approved content; it does not promote a sponsor's formulation or promise a symptom outcome.

SHORT VIDEO	THE PATIENT TAKEAWAY
Why your clinic is reviewing magnesium	A supplement is useful only for an appropriate reason. Feeling tired or sleeping poorly does not prove deficiency.
What the number on the pack means	The elemental amount, serving size and complete ingredient list matter. Bring the pack if uncertain.
Your medicines and supplements together	Tell the clinic about every medicine, antacid, laxative, vitamin and supplement you use.
When taking it becomes difficult	Report loose stools, discomfort, cost, swallowing difficulty or confusion early.
Why the review matters	The doctor checks whether the plan remains appropriate, whether tests are needed and what happens next.
Food and the longer-term plan	Beans, nuts, seeds, whole grains and green leafy vegetables contribute magnesium. Supplements do not replace a varied diet. [23]

EXAMPLE CLINIC MESSAGES

At enrolment: "Your clinic has shared this link to help you follow the plan discussed today. Read the plan and tell us if the product or instructions are unclear. This link does not diagnose a condition or change your treatment."

Early check-in: "Have you obtained the planned product? Have you had difficulty taking it, stomach symptoms, a change in medicines or a question for the clinic? Please report what happened. Your clinical team will decide if the plan needs to change."

Before review: "Your clinic review is due. Bring the product pack, your medicine list and any reports the clinic requested. Do not assume that a new pack is needed until the planned review has clarified what comes next."

Proposed scripts for Academy and clinic approval. Use short audio, large text and patient teach-back. Messages must not include diagnoses or sensitive details in lock-screen notifications.

TOLERABILITY INTERACTIONS AND SAFETY

THE CONTACT ROUTE MUST WORK BEFORE THE FIRST ENROLMENT

The programme must surface safety information without pretending that a check-in is continuous medical monitoring. Show operating hours, a reachable clinic number, a backup and emergency instructions on every relevant screen.

SITUATION	REQUIRED RESPONSE
Seizure, collapse, severe breathlessness, chest pain or severe acute weakness	Direct the patient to immediate emergency care. Do not ask them to wait for the routine service. Notify the clinic according to its emergency process.
Possible adverse reaction or persistent GI symptoms	Capture the patient's words and timing. Route to the clinical team; do not attribute causality or independently change treatment.
Kidney disease, acute kidney injury, dialysis or transplant context	Require clinician/specialist review before routine participation. Reduced clearance can make unsupervised supplementation hazardous. [16,17]
Tetracycline or quinolone antibiotic, bisphosphonate or thyroid medicine	Clinic or pharmacist checks the exact interacting medicine and label, then enters a schedule. There is no one spacing rule for every medicine. [17,22]
Another supplement, antacid or laxative is added	Reconcile total exposure and other active ingredients. A different clinical use does not remove the need to count co-use.
D3 60,000 IU kit or multiple D3 products	Show the clinician-entered D3 schedule separately from magnesium. Never copy a daily magnesium schedule onto a high-dose D3 component.



PROPOSED RESPONSE STANDARD

Urgent clinical messages are immediately signposted to direct care. During staffed hours, the designated clinic owner checks high-priority reports within one working hour; other clinical questions are reviewed by the next working day. These are proposed operating targets, subject to clinic capability, not a promise of 24-hour monitoring.

Record receipt, acknowledgement, handover and closure. If the owner is unavailable, use the named backup. An unhandled urgent report pauses new enrolment until the failure is investigated and corrected.

Staff forward suspected adverse events and product complaints to the designated safety function under an approved process. Reporting is separate from clinical care and does not wait for causality confirmation.

ACADEMY GOVERNANCE

CERTIFY A USEFUL CLINICAL SERVICE WITH AN INDEPENDENT STANDARD

The Academy is the clinical education and review partner to be appointed for the programme. Its role is to examine evidence, approve content and assessment, and maintain the standard across languages and channels.

CERTIFICATION OBJECT	WHAT IS REVIEWED	EVIDENCE RETAINED
Pathway	Selection boundaries, referral rules, tools, patient scripts, interactions, escalation and review closure.	Named reviewers; signed version; scope and expiry/review date.
Mini-CME module	Learning objectives, evidence, clinical cases, PDF and expert video consistency.	Faculty disclosures; references; approved master and assessment.
Translations	Clinical meaning, readable language, dose/unit integrity and emergency wording.	Clinician language review and patient comprehension checks.
Learner completion	Module completion and demonstrated application to a case.	Assessment result and verifiable certificate record.
Continuing quality	Complaints, content corrections, new evidence and implementation incidents.	Version history, corrective actions and periodic faculty review.

Three approvals must stay separate : Academy certification means the Academy has reviewed the defined programme or learner achievement. It does not mean a magnesium product is endorsed. It is not formal CME credit unless the competent accrediting body separately grants that credit. Product promotion requires its own medical, regulatory and compliance approval.

The completion standard : Proposed standard: each monthly module pair includes short pre- and post-assessment questions, one clinic case and a practical task. Award completion after the learner meets an agreed pass mark, proposed at 80%, and correctly handles all critical safety items after remediation. Never tie certification to prescriptions or brand preference.

The Academy retains the right to reject a claim and revise or suspend content. Sponsor support is disclosed. Faculty selection and payment reflect genuine educational work and documented fair value, not expected prescribing. [26]

SIX MONTH ACADEMY PROGRAMME

MONTHS ONE TO THREE ESTABLISH FIT DOSE CLARITY AND SAFE INITIATION

Two focused mini-CMEs each month. Every mini-CME is delivered as both an Academy-certified PDF and a short video mini-lecture by a leading doctor or expert, after content approval. Each must work as a standalone learning unit.

MONTH AND TITLE	OPENING CLINICAL QUESTION	TAKEAWAY AND CLINIC TASK
1A Who actually needs magnesium	A patient reports fatigue and poor sleep. What justifies evaluation or supplementation?	Distinguish deficiency, nutritional need and alternative explanations. Record one appropriate no-supplement decision.
1B Read a magnesium result in context	Does a normal serum result settle the question, and does a low result explain the cause?	Interpret results clinically; identify relevant further assessment. Audit five records for a documented reason.
2A Decode the elemental dose	Does a 2,000 mg headline mean 2,000 mg magnesium?	Separate salt, elemental quantity, unit and serving. Reconcile three current packs.
2B Choose a product without a salt myth	What evidence would justify changing an oxide product to a chelate or blend?	Compare patient fit and whole-product evidence. Build a neutral product-check record.
3A Start with a usable medicine schedule	How should magnesium fit around a new antibiotic or thyroid medicine?	Use exact medicine-specific checks. Complete one pharmacist-reviewed schedule.
3B Handle early difficulty safely	The patient develops loose stools and misses doses. What needs review?	Separate symptom reporting from causality and treatment decisions. Practise a clinic handover.



FACULTY AND FORMAT

Use an internist or clinical nutrition expert for selection; a laboratory-aware physician or nephrologist for interpretation; and a clinical pharmacologist or pharmacist with a physician for formulation and interactions. Faculty disclose relevant interests.

Each unit: proposed 4–6-page PDF, 12–15-minute expert video, opening case, three decision points, one-page clinic aid and five assessment questions. Modules 1A–3B form the pilot curriculum. Clinical anchors: [16–22,25,26].

SIX MONTH ACADEMY PROGRAMME

MONTHS FOUR TO SIX MAKE REVIEW AND CLOSURE ROUTINE

The second half strengthens monitoring, combination discipline and decisions about continuing or ending supplementation. Continuing education should improve judgement, not merely repeat the product story.

MONTH AND TITLE	OPENING CLINICAL QUESTION	TAKEAWAY AND CLINIC TASK
4A Protect the patient with kidney risk	When does a seemingly simple supplement need specialist oversight?	Recognise limits of the routine pathway. Test the renal and acute-illness exclusion process.
4B Turn an ordered test into a review	The report is available but nobody has acted on it. Is the episode complete?	Connect test completion to clinician interpretation and a plan. Close five overdue review tasks.
5A Give every combination ingredient a reason	Does a D3, calcium, B-vitamin or zinc component improve fit for this patient?	Check necessity, duplication and schedule. Audit one high-dose D3 kit handover.
5B Respond to sleep cramp and nerve claims	What should the doctor say when the patient brings a persuasive online claim?	Explain uncertainty without dismissing symptoms. Practise a balanced patient conversation.
6A Decide when supplementation should end	The bottle is empty. Is a refill the right next action?	Review cause, need, response and burden. Record stop, continue or referral with rationale.
6B Improve the clinic pathway using evidence	Did the programme improve care execution, or just create more activity?	Interpret denominators and missing data. Review a clinic scorecard and one process change.



A MONTHLY LEARNING RHYTHM

Week 1 releases the first PDF and expert lecture. Week 2 applies the clinic task. Week 3 releases the second PDF and lecture. Week 4 closes the case assessment and a short faculty discussion. Clinics can use asynchronous materials when live attendance is impractical.

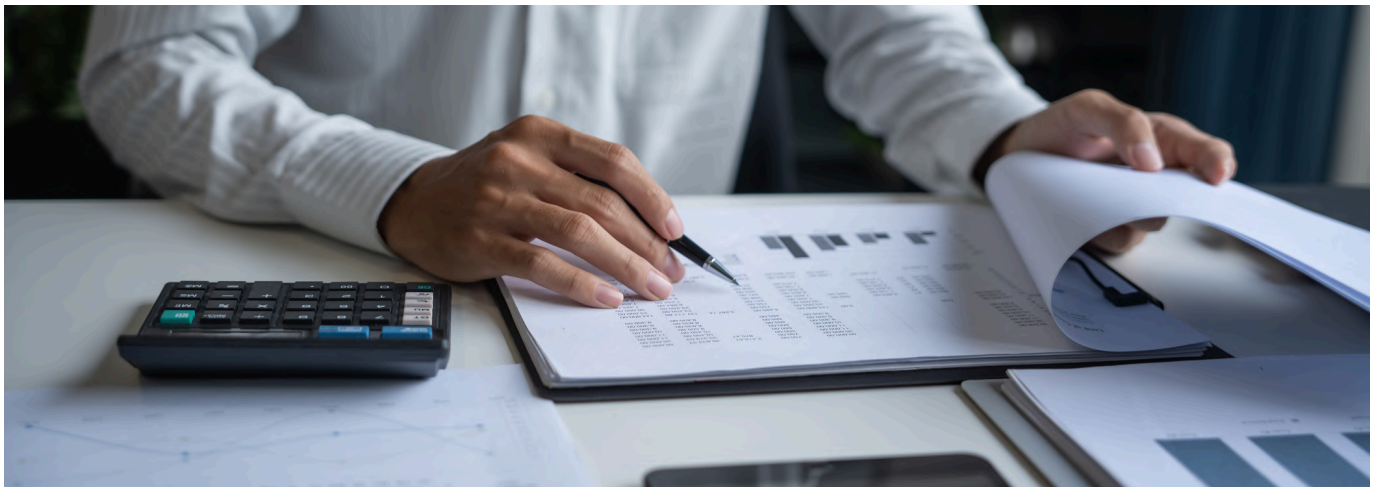
EVALUATE APPLICATION RATHER THAN ATTENDANCE ALONE

Measure knowledge change, completion of the practical task and sampled record quality. Report these separately from prescribing. Do not use positive learner feedback as evidence of better patient outcomes or brand sales.

The six-month programme comprises 12 PDFs and 12 expert mini-lectures. A shorter clinic-staff training covers consent, factual recording, escalation and the review worklist. It does not authorise staff to prescribe.

LEADERSHIP DEFENCE

MAKE THE ESTABLISHED BRAND USEFUL AFTER SELECTION



A leader should protect the clinical relationship that made it large. That means dependable operations across its priority clinics, not an expensive nationwide launch before the pathway works.

The strategic job : Turn reach, supply and professional familiarity into a routine that clinics use without repeated representative prompting. Start with high-value existing clinics where assessed need is present and one specific task, such as product reconciliation or review completion, is failing.

PRIORITY	EXECUTION	EVIDENCE TO SEEK
Protect appropriate consideration	Offer the full pathway through established HCP relationships, with neutral patient access.	Clinic adoption and continued use; independently measured consideration where appropriate.
Resolve avoidable friction	Use field insights to improve supply, pack clarity and affordability. Keep clinical issues with the clinic.	Access gaps resolved and fewer unreconciled product changes.
Strengthen combination discipline	Give each portfolio SKU a distinct role and label-aware instructions.	Fewer duplicate or obsolete plans; correct high-dose D3 scheduling.
Make quality repeatable	Train managers to audit service adoption and response quality.	Review completion, safe handovers and acceptable clinic workload across clusters.

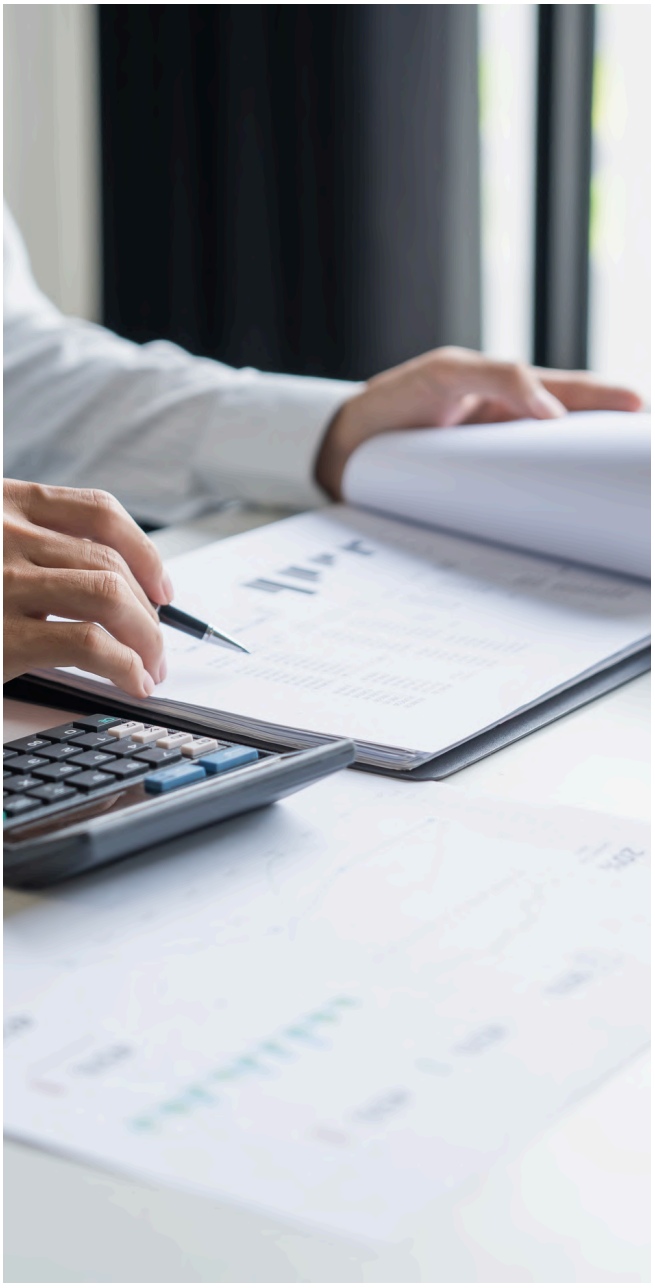
The competitor response to anticipate : A challenger can copy the terminology and offer a similar QR link. The defence is verified operational reliability: a clinic owner, accurate records, available supply, completed reviews and quick correction of failures. More branding on patient pages weakens that defence.

The leader's economic discipline : Concentrate investment where existing reach reduces onboarding cost. Treat expansion into every wellness complaint as a separate, unproven growth thesis. Do not protect a repeat-purchase target by discouraging clinically appropriate stopping or switching.



Leadership decision:

put the first budget behind reliable execution in existing priority clinics, then expand only where the evidence supports it.





CHALLENGER DISPLACEMENT

CHANGE THE COMPARISON FROM BRAND HABIT TO WORK COMPLETED



A challenger needs a reason for a doctor to reconsider a future appropriate choice. Better follow-up execution can create that reason; an unsupported claim against the incumbent cannot.

Choose a gap the clinic recognises : Enter clinics with an observed problem: unclear elemental content, confusion between supplement and treatment, a D3 kit used incorrectly, unresolved tolerability questions or reviews that do not happen. Use a baseline audit to establish the gap rather than asserting that the incumbent caused it.

CHALLENGER MOVE	HOW TO EXECUTE	BOUNDARY
Win a fair comparison	Demonstrate a complete mock patient journey with the clinic's workflow.	Do not show invented outcome gains or unsupported salt superiority.
Make the product legible	Provide verified elemental amount, serving size, ingredients, status, pack price and availability.	Compare exact products only with approved substantiation and compliant materials.
Earn a small trial of the service	Activate a manageable group of clinics with a named owner and three modules.	No commitment to prescribe and no patient benefit conditional on sponsor use.
Prove local reliability	Show aggregate closed reviews and resolved practical barriers.	Operational performance is not proof of product efficacy.
Measure future consideration	Use permitted independent HCP research and matched market data.	Do not use individual patient records for sales targeting.



Challenger decision: *choose one visible clinic problem and prove it can be solved consistently before buying broader reach.*

What displacement should mean : The doctor may choose a different product for a future appropriate patient because its evidence, access, cost and service support fit the task. The patient service itself does not advise a brand switch. An individual patient already doing well should not be moved merely to create a conversion metric.

Expect the incumbent to match the offer. The challenger's advantage must come from speed of learning, staff support and a tightly chosen cluster, with a clinical standard that remains independent of sales.





SELECTIVE MARKET-SHARE CAPTURE



OWN ONE USEFUL TASK IN ONE REACHABLE SEGMENT

A smaller brand does not need to imitate a leader's footprint. It needs a narrow opportunity where its product fits, stock is dependable and the service can be delivered economically.

NO.	FOCUSED OPPORTUNITY	WHY IT MAY WORK	LIMIT
1	Physician clinics with assessed deficiency and weak follow-up	Clear clinical purpose and a review that can be observed.	Enough eligible episodes and an appropriate product are essential.
2	Clinics facing pack and combination confusion	Elemental-dose reconciliation and separate schedules solve a concrete task.	Do not create a reason to add unnecessary ingredients.
3	A regional cluster with access and language barriers	Local-language support and reliable availability can improve execution.	Geography alone is not differentiation; demonstrate a real service gap.
4	Specialist-selected migraine or other adjacent use	A separate clinical owner may support a narrowly governed extension.	Later option only; distinct evidence, indication and measurement needed.

Select the cluster with five tests : Confirm an appropriate clinical population, a product that fits its permitted use, a recurring task worth solving, a clinic owner who can respond and a distribution radius the team can serve. Reject the cluster if any one of these is absent.

Use a lighter operating model : Start with the clinic link, six short patient videos, a simple worklist and a review brief. Use the common Academy materials. Avoid bespoke integrations and continuous outbound calling until the pilot shows they add value. Concentrate manager attention on a few clinics rather than spreading it across a nominally large panel.

Protect the ability to say no : Do not enter a sleep or neuropathy niche because demand looks large if clinical fit and permitted claims are weak. A segment that can only be won through exaggeration is not a defensible segment.

Selective-share decision: *prefer a small, clinically clear and serviceable cluster over broad awareness with no review capacity.*



FIELD-FORCE EXECUTION

MAKE EVERY FIELD CALL END IN A CLINIC ACTION

The representative's job is to introduce, demonstrate and help activate the service. The clinic's job is to select patients and manage care. Field success is reliable adoption, not possession of patient data.

CALL STAGE	REPRESENTATIVE ACTION	RECORD IN FIELD CRM
Prepare	Confirm relevant clinic mix, product availability, approved material and manager support.	Clinic eligibility and known service gap; no patient details.
Open	Discuss one recognisable problem in assessed magnesium use.	The task the doctor wants to improve.
Demonstrate	Show the clinic-branded patient page, one check-in and the factual review brief using dummy data.	Whether the workflow fits and what needs configuring.
Activate	Identify the clinic owner, backup, preferred language and training slot.	Owner role, launch date and readiness status.
Return	Ask whether the clinic used the service and whether staff can close reviews.	Aggregate adoption and operational barriers.
Escalate	Send product questions to medical, supply issues to distribution and service defects to operations.	Issue owner, due date and resolution status.

A 30-second opening : "Doctor, magnesium is easy to recommend and easy to misunderstand. We support an Academy-reviewed, clinic-branded pathway that makes the reason, elemental dose and next review clear. Your team keeps clinical control. Can I show you the one-page review brief and the staff task it replaces?"

Three objections to handle directly : "I already prescribe magnesium." The value is the work between selection and review. "My staff have no time." Start only if the workflow replaces effort and the clinic has response capacity. "Will this prove my brand is better?" No. It can test service performance; product claims need their own evidence.

Manager discipline : Use a weekly adoption review and a fortnightly joint field demonstration. Score the quality of the activation and resolved barriers. Do not reward patient recruitment, quantities of test orders, prescriptions, prolonged use or suppression of adverse-event reports.

DELIVERY AND ACCOUNTABILITY



ONE NAMED OWNER FOR EVERY TASK

The commercial team may fund the programme. It cannot become the clinical decision maker. A small, explicit responsibility map prevents a useful concept from becoming an unowned messaging service.

OWNER	ACCOUNTABILITY	RELEASE EVIDENCE
Clinic medical lead	Entry criteria, clinical plan, test orders, treatment decisions and escalation rules.	Approved clinic protocol and reachable backup.
Clinic coordinator	Consent, factual check-ins, worklist, reports and review preparation.	Training completion and a successful simulated episode.
Academy and faculty	Evidence standard, all 12 modules, assessments and translations.	Versioned approvals, disclosures and certification rules.
Inditech operations	Programme configuration, onboarding, support, content distribution and service quality.	Tested workflow, incident log and operational handover.
Sponsor medical and regulatory	Exact product status, label mapping, claim permissions and promotional approval.	Current label/PI dossier and separately approved HCP material.
Safety function	Suspected adverse events, complaints and required reporting.	Approved handoff process with reconciled case logs.
Independent evaluator	Definitions, data quality, workload, economics and commercial analysis.	Frozen analysis plan and documented data permissions.

The minimum launch assets : Clinic protocol; consent and notice; four small clinical records; patient page and six video explainers; multilingual messages; six pilot mini-CME PDFs and six expert lectures; field demonstration; product evidence library; escalation and safety process; metrics dictionary; and a named support route. Months four to six add the remaining six PDFs and six lectures.

Version control : Every clinical asset has an owner, version, approval date and review date. A change in product, claim, safety wording or language triggers the relevant review. Withdraw superseded content and preserve records of what each clinic and patient received.

These are operating standards for the common category programme, not a sponsor-specific statement of work or a quoted commercial package.





MEASUREMENT

SEPARATE CARE EXECUTION FROM BRAND PERFORMANCE

One dashboard cannot legitimately turn every click into a prescription or every completed review into incremental revenue. Track the clinical, operational and commercial questions separately.

MEASURE	DEFINITION	INTERPRETATION
Primary review completion	Episodes reviewed by an authorised clinician within 14 days of the original due date / enrolled episodes with a review due in the analysis window.	Count documented continue, change, stop, refer or close decisions. Keep the original due date fixed for analysis.
Plan completeness	Episodes with reason, track, verified elemental dose, regimen, contact route and review date / enrolled treatment-support episodes.	A data-quality and safe-handover measure.
Indicated test completion	Episodes with an ordered test completed before review / episodes with that test ordered and due.	Not a target to order more tests. Report missing results separately.
Tolerability and safety handling	Reports acknowledged and clinically handed over within the approved time / reports requiring that response.	Show severity and overdue counts; a small numerator is not proof of safety.
Clinic adoption	Clinics using the worklist and recording reviews without repeated rep prompting / activated clinics.	Measure active behaviour, not registration.
Workload and patient burden	Staff minutes per episode, brief-preparation time, contact attempts, patient travel/test costs and opt-outs.	Commercial scale depends on manageable effort and access.
Commercial movement	Change in sponsor share or units in the predefined core SKU universe versus matched comparison and baseline.	A separate observational estimate. Report coverage, uncertainty and confounders.

Report replacement and dietary-support tracks separately. Report planned treatment completion, clinically directed stopping, switching and referral as distinct outcomes. Do not score them as non-adherence. A patient who declines the service remains eligible for normal clinical care.

Primary analysis includes eligible enrolled episodes even if unreachable or withdrawn from communication, subject to permitted data use. Do not erase failures; show missingness and withdrawal categories explicitly.

ATTRIBUTION AND DATA INTEGRITY

TEST A COMMERCIAL EFFECT WITHOUT FORCING THE ANSWER

The service can help a clinic and still fail to pay for itself. It can also raise measured activity without changing clinical decisions. Design the pilot to distinguish those outcomes.

Use a defined comparison : Select comparison clinics or territories before launch, matching on specialty, estimated eligible volume, baseline brand share, distribution, price band and service access. Observe both groups over the same period. Where feasible, randomise activation order within matched pairs. Otherwise describe the design as observational.

Estimate change as: intervention post-period share minus its baseline share, less the same change in the comparison group. Report percentage-point changes and sample sizes. Account for major stock-outs, discounts, new launches, doctor turnover and other campaigns. A difference does not by itself prove causation.

Define the commercial denominator : Use only the agreed oral standalone and magnesium-led SKUs. Keep other supplements and unrelated magnesium therapies separate. Use value and units because price changes can imitate growth. Record authorised brand-selection data independently from the care database; patient-level sales attribution is not required for this pilot.

VALID SIGNAL	INVALID SHORTCUT
A prespecified, matched change with a stated coverage limit	Treating all sponsor sales growth as programme impact.
Actual dispensed-product information volunteered to the clinic for reconciliation	Requiring a purchase receipt or sponsor pack to access care support.
Independent, consented HCP consideration research	Using a certificate, honorarium or benefit to secure prescribing.
Appropriate course continuation with documented ongoing need	Counting more days of supplementation as inherently better.

MISSING DATA MUST STAY VISIBLE

Deduplicate patients within the clinic's permitted record system and define an episode consistently. Report eligible, invited, consented, enrolled, due, reviewed and closed counts. Show the reason for missing review evidence. Do not move the due date retrospectively to make performance look better.

This is a feasibility and learning pilot. It is not sized to prove clinical efficacy or a statistically secure change in national market share.





PILOT AND SCALE ECONOMICS

DO NOT CONFUSE A WORTHWHILE PILOT WITH A PROFITABLE NATIONAL PROGRAMME



The business case needs two budgets: one-time learning and set-up, then recurring delivery at realistic throughput. No sales forecast should be built by multiplying every enrolled patient by a lifetime refill value.

ILLUSTRATIVE 90-DAY COST	INR
Clinical design, Academy review and six pilot PDF/video mini-CMEs	160,000
Configuration, patient assets and selected language adaptation	120,000
Clinic onboarding and field training	80,000
Coordination and operational supervision	120,000
Data quality, evaluation and reporting	60,000
Contingency	60,000
TOTAL PLANNING ENVELOPE	600,000

These figures are management assumptions, not an Inditech quotation or market rates. Replace them with actual costs, taxes and agreed responsibilities. Patient consultations and clinically indicated tests are excluded; their cost and funding still need explicit planning. Faculty payments are for genuine educational work.

WHAT THE PILOT COST MEANS

At 240 enrolled episodes, INR 600,000 equals INR 2,500 per episode. At 70% completed reviews, 168 reviews cost about INR 3,571 each. These are feasibility costs and should not be presented as sustainable unit economics.

THE BREAK-EVEN TEST AT SCALE

Illustration: recurring monthly programme cost of INR 60,000 and verified net contribution of INR 150 per incremental appropriate completed course require 400 incremental courses a month to break even. With 1,000 eligible episodes, that is a demanding 40% incremental conversion assumption. At only 100 incremental courses, contribution is INR 15,000.

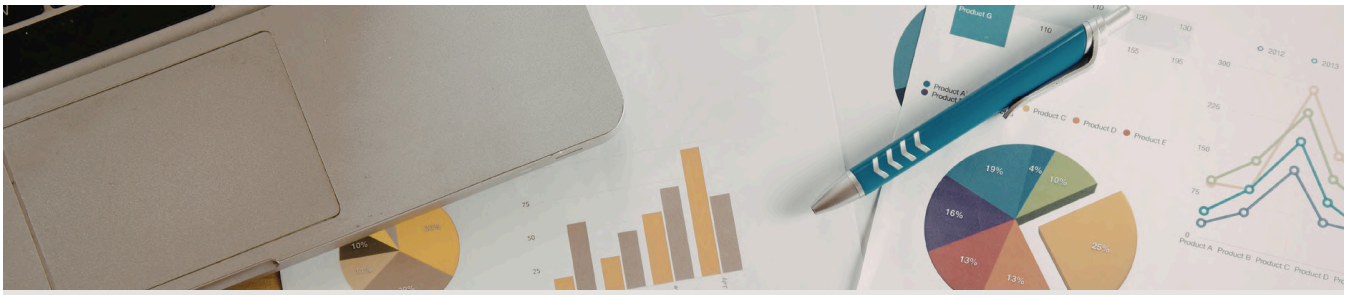
Use contribution after product costs, trade terms, discounts and relevant fulfilment costs. Exclude sales that would have happened anyway. Allocate programme costs transparently if a portfolio shares the infrastructure. Do not count the same benefit twice.

If credible incremental contribution cannot cover recurring cost, simplify delivery, narrow the segment or stop. Clinical usefulness does not make every commercial model viable



GOVERNANCE AND INDEPENDENCE

MAKE THE SERVICE SAFE TO USE WITH ANY APPROPRIATE CLINICAL DECISION



Before launch, local legal and privacy review confirms applicable Indian requirements, responsibilities and notices. The controls above are programme design requirements, not a claim that a particular technical setup automatically satisfies law.

The governance model is part of the competitive product. Clinics should trust that the service will still support a patient if the doctor selects another brand, ends supplementation or makes a referral.

Clinical and promotional separation : The clinic controls care. The Academy controls its educational standard. Sponsor branding and approved product promotion remain in the HCP layer, with funding disclosed appropriately. Patient pages carry no promotional comparisons, purchase targets or sponsor-only access conditions. UCPMP requires balanced, substantiated promotion and fair comparisons; competitor-name comparisons need particular compliance review. [26]

Product classification before claims : Maintain each SKU's current Indian label, licensed category, ingredients, limits, warnings and permitted claims. Do not infer a drug approval from a retail "Rx" icon. FSSAI's health-supplement framework and medicinal product rules serve different purposes. A nutraceutical cannot acquire disease-treatment claims by being placed beside a clinical education module. [25]

Privacy by design : Collect only what the clinic needs. Use clinic episode identifiers, role-based access, encryption, access logs, a defined retention period and a breach response. Keep clinical records separate from sales CRM. Consent for messages is specific and withdrawable; it is not consent for advertising or cross-selling. Use secure links rather than sensitive clinical detail in message previews.

Sponsors receive aggregated reporting with small-cell suppression and no patient identity, contact list, laboratory report or symptom narrative. Proposed rule: suppress cells below ten episodes and combinations that could identify a person. Essential safety reporting follows its own lawful, approved process.

Safety and continuity : Maintain suspected adverse-event and product-complaint handoffs, audit unresolved cases and reconcile with the safety owner. A programme shutdown must transfer open tasks to the clinic, stop unnecessary messaging and apply agreed retention/deletion rules. Clinical support cannot depend on a continuing sponsorship relationship.

THE 90-DAY PILOT

ACTIVATE A SMALL COHORT AND EARN THE RIGHT TO EXPAND

Proposed design: 12 intervention physician clinics in two serviceable clusters and six matched comparison clinics or equivalent authorised territory comparators. Plan capacity for about 240 adult episodes, without enrolment quotas or pressure to create magnesium need.

PERIOD	WORK	EVIDENCE AT THE GATE
Days 1–15 Define and approve	Choose tracks and exact product universe; collect a four-week retrospective baseline; appoint Academy and clinic owners; approve content, consent and safety process.	Signed operating protocol, analysis plan, comparator list and product dossier. No patient launch before approval.
Days 16–30 Activate carefully	Train clinics; run simulations; begin with two clinics before completing the cohort; release month-one modules.	Successful end-to-end episode, reliable urgent handoff and usable review brief.
Days 31–60 Operate and correct	Expand only within response capacity; release month-two modules; review defects weekly.	Real enrolment, record quality, workload, barriers and completed reviews.
Days 61–75 Consolidate	Begin month-three modules; close due tasks; freeze analysis definitions and clean duplicates; keep ordinary clinical support running.	Locked primary cohort and explained missing data.
Days 76–90 Evaluate	Complete observation windows, compare with baseline/comparators and review economics with clinic and faculty leads.	A documented expand, redesign, extend observation or stop decision.

KEEP THE PRIMARY COHORT OBSERVABLE

Enrolment for the planned pilot cohort ends by day 60. The primary endpoint includes episodes whose original review date falls on or before day 75, allowing the full 14-day window by day 89. Episodes due later remain under normal clinic care and are reported separately, with follow-up resourced beyond day 90.

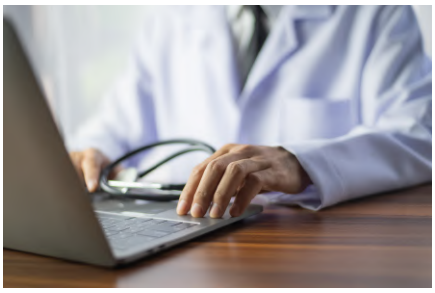
Track A and Track B are analysed separately. Use specialist and urgent referral routes outside the routine cohort. If eligible volume is lower than planned, report it and assess feasibility; do not broaden the indication to hit a target.

The comparison group receives usual care. Do not withhold necessary information, treatment or safety action for the evaluation. Obtain appropriate review and permissions if the design constitutes research.

DECISION GATES AND FIRST-MOVER ALLOCATION

RESERVE REAL DELIVERY CAPACITY AND MAKE THE TERMS VISIBLE





The same opportunity is offered to competing category teams. Scarcity must come from actual faculty, language and implementation capacity, not an invented claim that a competitor has already signed.

PILOT GATE	PROPOSED THRESHOLD	IF MISSED
Safety and independence	Every urgent report has a documented clinical handoff; no uncorrected critical safety, privacy or promotional failure.	Pause affected enrolment, investigate and correct before expansion.
Record quality	At least 95% of sampled episodes have a documented reason, track, verified plan, contact route and review date.	Repair training and forms; audit again.
Primary review completion	At least 70% of eligible due episodes close within the window; seek at least a 15-point gain over baseline.	Examine causes and comparator change; redesign rather than declare success from activity.
Independent adoption	At least eight of 12 clinics use the worklist without repeated rep prompting by day 75.	Narrow the segment or simplify the staff task.
Workload and economics	Median coordinator effort at or below 15 minutes per episode; credible recurring-cost coverage at realistic throughput.	Reduce support intensity or stop the uneconomic model.



Allocate the first cohort on readiness

Publish the number of launch cohorts that the delivery team can actually support. A team secures a place only after confirming its clinical scope, budget owner, cluster, product dossier, data permissions and implementation sponsor. Use a dated readiness register; incomplete reservations lapse after a stated, reasonable readiness period.

Any limited commercial exclusivity must be written: named territory or clinic cohort, scope, duration, performance milestones and expiry. Do not promise national category exclusivity unless it is actually agreed and deliverable. Clinics, patients, clinical knowledge and independent Academy decisions remain outside exclusivity.

First-mover value is earlier learning, trained clinics and operating evidence. It is not ownership of patients or a right to influence prescribing.

Market evidence and clinic-channel products

[1] Jani J. Mint. Magnesium mania. 22 January 2025.
Secondary reporting of Pharmarack MAT values and company channel comments. Historic category signal, not current brand revenue or prescription share.

[2] ICMR Rational Use of Medicines Centres Network. Prescription analysis in Indian tertiary care hospitals. 2023.
Original prescription research. Its magnesium-containing antacid combinations cannot be used as prevalence of oral supplementation.

[3] Pharmed Limited. Corporate Brochure 2025.
Company-published composition for MGD3 and MGD3 60K; the latter is a combi kit with separately scheduled components.

[4] Pharmed Limited. MGD3 Tablets product page.
Primary product presence and combination description. Manufacturer promotional efficacy language is not adopted as independent evidence.

[5] Pharmed Limited. MGD3 60K Tablets product page.
Primary confirmation of the magnesium and D3 combi-kit format; read alongside the corporate brochure.

[6] Vitabiotics India. Ultra Magnesium 200 mg 15-tablet product page.
Official India product page identifying Meyer Organics, pack strength and FSSAI licence information.

[7] SastaSundar. Ultra Magnesium 200 mg product listing.
Secondary retail ingredient panel: magnesium oxide and 200 mg elemental magnesium. Current manufacturer pack remains the deployment authority.

Product presence and formulation evidence

[8] NARCHI Delhi. Souvenir 2025, company advertisements.
Published company advertisement for Vitanova D3 MG composition. Advertising is used only as product evidence, not proof of clinical benefit.

[9] RetailerShakti. Vitanova D3 MG 10 Tablets.
Secondary panel transcription: magnesium bisglycinate source, 250 mg magnesium and D3 600 IU per tablet. Confirm current pack.

[10] Apollo Pharmacy. Magvion Tablet.
Secondary listing identifies Healers Nutraceuticals and magnesium oxide 400 mg. Salt mass is not established elemental content.

[11] Sun Pharma consumer brand site. Revital Magnesium Bisglycinate.
Primary product presence and declared elemental quantity. Complete pack panel and serving size still require verification; consumer claims are not endorsed.

[12] HK Vitals. Magnesium Glycinate product page.
Primary listing with 220 mg per two-tablet serving in the observed product. Formulas and older packs can differ.

[13] Tata 1mg. Magnesium Glycinate own-brand tablets, 60-tablet listing.
Own-brand listing declares 440 mg elemental magnesium per two tablets and hydroxide buffering. Used for composition and presence only.

[14] Wellbeing Nutrition. Triple Magnesium Complex.
Primary product page identifies multiple magnesium forms. No claim of superiority or specific symptom efficacy is inferred.

Clinical selection and evidence limits

[15] Tata 1mg. A to Z Expert Magnesium Triple Complex for Adults.
Secondary listing identifies Alkem as marketer and health-supplement status. Exact current formulation requires manufacturer confirmation.

[16] NHS Specialist Pharmacy Service. Treating acute hypomagnesaemia in adults. 19 December 2024.
UK clinical practice guidance for replacement, severity, renal considerations and monitoring. It is not an Indian product approval or universal supplement protocol.

[17] US NIH Office of Dietary Supplements. Magnesium Health Professional Fact Sheet.
Assessment limitations, elemental magnesium, forms, interactions and US dietary reference concepts. US upper limits are not Indian licensing rules.

[18] UK MHRA. Proton pump inhibitors in long-term use and hypomagnesaemia.
Regulator safety advice on clinically considered magnesium testing during prolonged PPI use, especially with relevant co-medication.

[19] US NCCIH. Sleep Disorders and Complementary Health Approaches.
Evidence limitations for magnesium and insomnia; not a basis for a broad sleep claim.

[20] Garrison SR et al. Magnesium for skeletal muscle cramps. Cochrane Review. 2020. CD009402.
Systematic review: limited support for routine cramp prophylaxis; population-specific findings and uncertainty matter.

[21] US NCCIH. Headaches What You Need To Know.
Limited evidence for selected migraine prevention and need for clinician supervision. Kept outside the initial core pilot.

Patient information and programme governance

[22] DailyMed. Levothyroxine Sodium Tablets, prescribing information.
Official US label hosted by NLM. Illustrates absorption interactions and label-specific spacing; exact Indian medicine information governs a patient schedule.

[23] US NIH Office of Dietary Supplements. Magnesium Consumer Fact Sheet.
Plain-language dietary sources and patient information. Adapt education to Indian foods, language and clinic context.

[24] WHO. Recommendations for Prevention and Treatment of Pre-Eclampsia and Eclampsia.
WHO recommendations hosted by NCBI. Magnesium sulfate evidence concerns a distinct obstetric hospital pathway, not oral supplements.

[25] Food Safety and Standards Authority of India. Health Supplements standards and regulatory resources.
Official regulatory entry point. Confirm the current applicable regulations, directions and exact product category before releasing claims.

[26] Department of Pharmaceuticals. Uniform Code for Pharmaceutical Marketing Practices 2024, updated 1 September 2025.
Official marketing code covering substantiation, comparisons, educational activity and related governance. Check subsequent applicable updates at release.

STRATEGIC OPPORTUNITY & CTA

CHOOSE THE CLINIC TASK BEFORE A COMPETITOR MAKES IT ROUTINE

The category does not need another reason to prescribe magnesium to everyone. It needs a better way to handle appropriate use from the first decision to the next review.

IF YOU ARE	MAKE THIS CHOICE NOW
The leader	Use established reach to make reliable clinic execution part of your franchise.
The challenger	Give selected clinics a concrete reason to reconsider future appropriate product choices.
Seeking selective share	Choose one segment where clinical fit, a useful task and service economics align.

BRING FIVE DECISIONS TO THE FIRST WORKING SESSION

Name the competitive posture. Define the oral formulation universe. Choose one clinical task and two pilot clusters. Appoint the clinical, commercial and operating owners. Commit a learning budget and agree the evidence that will justify expansion or stopping.

ASK INDITECH TO MAP THE FIRST COHORT

Use this playbook to open a category-fit and pilot-design session. Bring the current product dossier, licensed market cut if available, cluster list and access assumptions. The output should be a concrete 90-day decision: where to operate, what clinics will do, who will respond, what will be measured and when the investment will be judged.

The same opportunity is available to major competing magnesium teams. A team earns first-mover value by becoming ready and executing well. Delay leaves the clinic routine open for another team to establish.

Defend the default. Challenge the habit. Or win one focused segment. Choose your position and put the first clinic cohort into motion.

EMAIL:
Amit@inditech.co.in

WEBSITE:
Www.inditech.co.in





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