ROSUVASTATIN

THE NEXT SHARE SHIFT WILL BE WON AT THE LDL REVIEW YOUR BRAND MAKES HAPPEN

For leaders defending default status, challengers displacing habit, and selective-share brands capturing one unfinished clinic task.



ROSUVASTATIN

MOLECULE-WIDE CIRCULATION

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

Another statin reminder leaves the most valuable question unanswered: did the prescription become a reviewed lipid result and a clear next clinical decision?

YOUR POSITION	THE COMPETITIVE JOB
LEADER Defend default	Turn prescription leadership into the clinic's routine for lipid testing, response review and long-term continuity.
CHALLENGER Displace habit	Make completed LDL reviews and resolved patient friction part of the doctor's comparison.
SELECTIVE SHARE Capture one wedge	Own one dense clinic segment where testing, tolerability review or refills repeatedly break down.

The strategic territory is prescription-to-LDL-review continuity after the clinician has selected rosuvastatin. The clinic owns care. The competing brand earns relevance in the doctor-facing layer by helping that care happen.

STRATEGIC CHOICE

MAKE THE LDL REVIEW THE COMPETITIVE UNIT

Rosuvastatin is prescribed for a risk the patient usually cannot feel. Its effect is assessed through a laboratory result, interpreted against the clinician's goal and the treatment actually taken. The valuable workflow therefore ends with a clinical decision, not with a reminder delivered.

ANOTHER REMINDER CAMPAIGN	ONE MOLECULE-WIDE CLINIC WORKFLOW
Repeat statin potency and brand recall	Record the clinician's goal, baseline, test date and review appointment.
Ask whether the patient took the tablet	Establish what was taken, what interfered, and what the clinician needs to assess.
Send a laboratory reminder	Close the sequence from ordered test to available result to clinician-reviewed action.
Treat muscle concerns as objections	Create a neutral route for disclosure and clinical assessment.
Treat every switch as commercial loss	Separate avoidable supply substitution from an appropriate clinical change.
Count scans, clicks and contacts	Count completed reviews, documented plans and sustainable clinic adoption.

ONE ARCHITECTURE ACROSS THE MOLECULE

The common engine combines a patient-held plan, a clinic worklist, a factual review brief, Academy-governed education and a separate HCP brand layer. Individual clinics choose their clinical protocol and contact routes. Each competing brand chooses where and how well to execute the architecture.

The defendable asset is the clinic's adopted routine for completing the next decision. A logo on a generic reminder does not create that routine.

Clinical foundation: Indian lipid guidance, ACC/AHA 2026 and ESC/EAS 2025 [6–10,21]. Workflow ownership means service adoption, never ownership of patients, clinical decisions or clinic data.

CATEGORY PROVOCATION

FAMILIARITY PROTECTS THE INCUMBENT AND EXPOSES THE CATEGORY

A familiar molecule makes a first prescription easier to win. It also makes competing brands easier to treat as interchangeable when the patient leaves the clinic. The next contest is over who helps the clinic complete the work that familiar prescribing leaves unfinished.

FAMILIAR CATEGORY LANGUAGE	THE UNFINISHED TASK	COMMERCIAL EXPOSURE
LDL lowering	Was the intended reduction checked and interpreted?	Potency claims do not establish response in this patient.
Cardiovascular protection	Does an asymptomatic patient understand the reason for review?	The absence of symptoms can weaken persistence.
High-intensity treatment	Does the prescribed regimen fit this patient and the applicable label?	A dose ladder alone is an incomplete growth strategy.
Tolerability reassurance	Did the patient disclose pain, weakness or fear before disappearing?	Unresolved concern can become silent discontinuation.
A wide franchise	Was the new prescription reconciled after an add-on or formulation change?	Portfolio breadth can leave duplicate or outdated instructions.

THE REAL COMPETITIVE TEST

A clinic may appreciate the service while continuing to prescribe a competitor. That is a foreseeable category benefit. A commercial advantage must be earned through reliable execution, useful HCP engagement and available, affordable supply; it cannot be manufactured by restricting patient support to a sponsor's pack.

If every brand can tell the same molecule story, make the doctor judge the work completed after the story ends.

Leakage mechanisms are hypotheses to measure locally. The playbook assumes no national rate of non-adherence, substitution or missed reviews, and no guaranteed share gain.

INDIA MARKET EVIDENCE

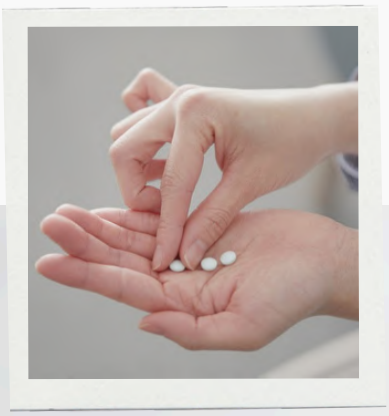
LARGE PUBLIC SIGNALS WITHOUT A COMPLETE NATIONAL LEADERBOARD

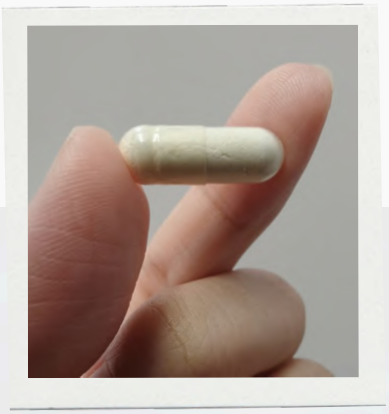
Current public sources support a commercially meaningful, crowded category. Their dates and denominators differ. They do not establish an October 2026 all-India rosuvastatin market size, prescription share or rank table.

EVIDENCE	AUDITABLE PUBLIC SIGNAL	BOUNDARY
Prescribing proxy [1]	OLS enrolled 1,860 stable CAD patients in 10 interventional cardiology centres, August–November 2023. Rosuvastatin was prescribed in 59.4%.	Selected specialist cohort, presented in 2024; not current national Rx prevalence.
Execution gap [1]	In the same cohort, 25.9% achieved LDL-C <50 mg/dL and 46.4% achieved <70 mg/dL.	All-cohort attainment; not rosuvastatin-specific failure, causality or today's universal target.
Brand scale [2]	ICICI Direct's 1 February 2026 report lists Rosuvas at approximately INR569 crore for MAT December 2025.	Broker-reported brand sales proxy. Its rank 1 is within the displayed Sun top-brand table, not a molecule rank.
Defined FDC market [3]	NPPA's 2026 worksheet, based on June 2025 data, reports INR94.99 crore total MAT for rosuvastatin 10 mg + clopidogrel 75 mg tablets.	One formulation and strength. It is neither monotherapy value nor the total rosuvastatin-containing market.
Competition count [3]	The same worksheet lists 36 pack rows with 36 distinct brand labels; 8 companies meet its ⩾1% threshold.	Own count from a dated pricing worksheet, not all active rosuvastatin brands in India.

The evidence establishes scale and competition. It does not license an invented national leaderboard.

MAT = moving annual total. Do not add brand, franchise and FDC values from different periods. Public company and product listings [4,5,22] establish presence; listings alone do not prove market share.







COMPETITION AND PRESCRIBERS



CHOOSE THE BATTLEFIELD BEFORE ASSIGNING THE POSTURE

Separate rosuvastatin monotherapy, each lipid-lowering FDC and antiplatelet-containing combinations. Their clinical jobs, labels, price bands and competitive sets differ. A brand can lead one universe and challenge in another.

MARKET QUESTION	WORKING ANSWER	DECISION IMPLICATION
Who is present?	Sun's public list includes Rosuvas and Rozavel; Torrent publishes Rozucor information. Dated NPPA combinations include Rosulip, Roseday, Rosumac and other families. [3-5,22]	Illustrative competitive presence, not a ranked or exhaustive roster. Reconcile current marketer and parent ownership.
Is the market fragmented?	Many labels coexist with concentration: in the June 2025 10/75 mg tablet worksheet, the top two labels together hold 69.37% of value. [3]	A long tail does not imply equal shares. Do not extrapolate this FDC structure to monotherapy.
Which specialties matter?	Cardiology and internal/general medicine are the first workflow priorities; diabetology/endocrinology adds high-risk continuity, nephrology adds selected CKD complexity. [1,6,7,17]	Deployment inference from clinical use, not a verified national specialty-volume ranking.
Who else can activate?	Family physicians and general practitioners managing long-term lipid care can use the core loop. Discharge teams and nurses can support handover.	Select by follow-up capacity and patient access, not professional title alone.

THE DATASET REQUIRED FOR A NAMED COMPETITIVE CLAIM

Obtain a licensed IQVIA, PharmaTrac or equivalent cut before stating current national rank, share, total value, active-brand count or specialty split: MAT plus recent quarters; value and units; mono versus exact FDC; new/repeat Rx; geography; price band; parent ownership; and coverage rules. Count brands separately from strengths, packs and independent companies.





EMBEDDED CLINICAL ENGINE

RESPONSIBLE USE IS THE OPERATING SPINE

Entry begins after a treating clinician has assessed the patient and chosen rosuvastatin. Risk identification, diagnosis and treatment selection remain upstream clinical work. No public screening funnel should recommend the molecule.

NON-NEGOTIABLE	WHAT THE PATHWAY RECORDS OR SUPPORTS
A documented clinical plan	Exact current medicine and formulation in the clinic record, prescribed use, baseline lipid date, individual goal, ordered tests and next review.
An interpretable response [8,11]	A clinic-set lipid reassessment after initiation or treatment change, commonly within 4–12 weeks. NICE specifies 2–3 months. Timing belongs to the clinician.
Persistence with an explicit purpose	Plain-language explanation of the clinic's prevention goal, lifestyle plan and why feeling well does not replace follow-up.
A route for symptoms [5,12,14]	Unexplained muscle symptoms and other concerns reach the clinic; staff record facts without assigning causality or diagnosing intolerance.
Clinical action after the result	Clinician assessment of response, use, access and tolerability; any intensification, add-on, interruption or switch is a recorded clinical decision.
The selected Indian label	Medical approval maps each brand, strength and FDC to its current Indian prescribing information. International guidance does not override it.

The service never diagnoses, recommends rosuvastatin, chooses a dose or tells a patient to start, stop, switch or restart treatment.

Routine population: consenting adults under an identified clinic. Pregnancy, paediatric lipid disorders, acute unstable illness and complex specialist exceptions require their own clinician-managed route. The clinic must retain a reachable alternative when the digital service is unavailable.

LDL GOALS AND CLAIM DISCIPLINE



RECORD THE CLINICIAN'S GOAL RATHER THAN INVENTING ONE

Risk systems and target definitions differ. The doctor-facing layer should make those differences visible. The patient-facing layer records the clinician's agreed goal and next action without assigning risk or grading the result.

SOURCE OR ISSUE	CLINICAL CONTEXT	OPERATING RULE
Indian guidance [6,7]	CSI provides an Indian clinical framework. LAI consensus uses an LDL-C goal <50 mg/dL for very-high-risk patients, with separate extreme-risk categories.	The clinic selects its framework and documents the patient-specific goal. Do not merge risk categories from different guidelines.
ACC/AHA 2026 [8,9]	Restores LDL-C goals: <100 mg/dL for borderline/intermediate primary-prevention risk; <70 for high risk; <55 for very-high-risk ASCVD.	These are HCP examples, not automatic rules for Indian patients. No patient-facing US risk calculator or universal <55 target.
ESC/EAS 2025 [10]	Adds current evidence to the 2019 framework, including earlier intensive LDL lowering after ACS and combination approaches when appropriate.	Do not force a routine waiting period when the cardiologist needs earlier action or combination treatment.
Surrogate and service outcomes	A lower LDL result and a completed review are different measures. Neither proves that this service prevents infarction or improves brand preference.	Keep clinical evidence, operational performance and commercial inference separate.
Rosuvastatin versus a brand	Molecule evidence does not establish superiority of one Indian brand, universal safety or interchangeability of all formulations.	Every HCP claim needs its own substantiation and approved-label check.



A laboratory reference range is not the patient's treatment goal. A result marked "normal" still needs the treating clinician's interpretation.

The pathway carries the original report and units. It does not issue automated LDL alerts, calculate treatment changes or convert a risk category into a prescription.

CENTRAL COMMERCIAL AND BEHAVIOURAL DRIFT

THE LOST VALUE SITS BETWEEN RESULT AND ACTION

The central leakage is an incomplete decision loop: an agreed prevention plan becomes uncertain use, a missed or uninterpreted test, and no documented next step. Refills and brand switching matter because they can interrupt that loop.

LEAKAGE POINT	WHAT THE CLINIC CANNOT SEE	COMMERCIAL CONSEQUENCE
No recorded goal	The patient hears “cholesterol tablet” without an agreed review purpose.	The prescription becomes a generic purchase.
Silent non-use	Feeling well, cost or forgetfulness displaces the agreed routine.	Repeat demand weakens before the next call.
Missing test	The order exists but the result never arrives.	Response remains unassessed; perceived failure is hard to investigate.
Result without review	The patient treats a report as a decision or postpones the visit.	The brand has no useful place in the next clinical conversation.
Unresolved muscle concern	Symptoms, worry or informal advice lead to unreported changes.	The patient leaves the pathway without a review.
Unclosed treatment change	An add-on or new regimen leaves old instructions active.	The franchise journey fragments at intensification.
Supply or affordability drift	A refill gap or pack change is never reconciled.	Prescription intent and dispensed product diverge.
No re-entry route	A missed visit becomes months without an updated plan.	Every future prescription reopens the contest.

The commercial opportunity is to make clinical uncertainty visible soon enough for the clinic to act.

Measure the frequency and causes of these gaps before sizing the opportunity. Do not label clinically appropriate switches, patient choice or prescribed interruptions as avoidable leakage.



Leadership Edition

MOMENTS THAT MATTER

NINE MOMENTS CONNECT THE PRESCRIPTION TO THE NEXT DECISION

Each moment earns a place because it produces something the clinic can use. The brand opportunity is an HCP relationship benefit; it is never a patient-facing product recommendation.

MOMENT	CLINIC TASK	PATIENT FRICTION	BRAND OPPORTUNITY
1 Selection	Record goal, plan, baseline and review.	No symptoms; unclear purpose.	Make the prescribed plan executable.
2 First week	Check understanding and access.	Cost, conflicting advice, first pack.	Support a credible start.
3 Missed use	Review the barrier and clarify the prescribed instruction.	Forgotten doses or self-devised catch-up.	Prevent uncertainty from becoming dropout.
4 Symptoms	Assess reported pain, weakness or other concerns.	Fear of harm or reluctance to report.	Make review easier to reach.
5 Refill	Reconcile current prescription and supply.	Stock, price, changed pack or strength.	Reduce avoidable prescription mismatch.
6 Lipid test	Arrange the clinician-ordered reassessment.	Expense, travel, no appointment.	Close an observable execution gap.
7 LDL review	Interpret response against the recorded goal.	“Normal” report mistaken for completion.	Become associated with completed reviews.
8 Next action	Document continuation or clinical change.	Duplicate packs and unclear revised use.	Support the next phase of care.
9 Long-term return	Set the next review and safe re-entry route.	Improvement, lapse or disengagement.	Sustain useful clinic relevance.

Timing is clinic-set. Routine lipid reassessment is commonly 4–12 weeks after initiation/change; symptoms and high-risk follow-up may require earlier action. [8,10,11]

INTEGRATED CLINIC SERVICE

LIPID CONTROL AND CONTINUITY

A generic clinic service architecture for completing the lipid review and the next care decision. The patient sees the clinic's identity and contact details. Competing brand teams see a common operating opportunity with different ways to win.

LAYER	VISIBLE EXPERIENCE	OWNER
Clinic-branded patient shell	My clinic plan, test and visit dates, practical questions, refill friction and a contact route. No sponsor product logos, brand prompts or comparative claims.	Treating clinic
Clinic worklist	Patients due, results awaiting review, reported concerns, unresolved contacts and revised plans.	Named coordinator with clinician backup
Review brief	Baseline/report dates, current use, access barriers, symptoms and questions. The clinician records the decision.	Clinic clinical team
Academy clinical engine	Reviewed education, case discussions, staff training, translated content and governance of every clinical service component.	Independent clinical faculty and programme governance
Doctor-facing brand layer	Approved scientific material and evidence of service execution, presented after independent molecule selection.	Medical and field teams
Commercial evaluation	Aggregate activation and completion measures plus separately sourced market movement. No patient-level targeting.	Authorised analytics team

A LOW-FRICTION SERVICE BY DESIGN

Use a short mobile page or clinic-approved messaging route with a paper alternative; no mandatory app download. Allow the patient to keep the plan without creating an account. Where the clinic needs contact details, explain the purpose and collect only those needed for follow-up.

One useful record, one booked review, one accountable clinic contact. Add a module only when it closes a measured gap.

Lipid Control and Continuity is the working architecture name, not a claim of registered ownership, clinical certification already obtained or guaranteed target achievement.

MODULES AND CADENCE

START CLEARLY AND KEEP PRACTICAL FRICTION VISIBLE

The first phase turns a prescription into a plan the patient understands. Contacts should be brief, optional where appropriate, and linked to an action the clinic can complete.

MODULE AND TIMING	CONTENT AND CLINIC ACTION	COMPLETION EVIDENCE
Plan capture **At enrolment**	Clinic records baseline report/date, individual goal, medicine plan, ordered tests, review date and contact route. Verify the patient can explain the next step.	Clinician-approved plan and dates recorded.
Treatment-start support **Days 3–7 as configured**	Ask whether the plan is understood and medicine is available. Offer general diet/activity support approved by the clinic. Route questions on use or missed doses to its approved instruction or callback.	Question resolved, or an accountable clinic task opened.
Use and access check **At the first agreed contact**	Ask neutrally about missed use, cost, travel and competing advice. Record what the patient says without scoring them as compliant/non-compliant.	Barrier type and clinic response recorded.
Refill loop **Before expected supply ends**	Use patient/clinic-confirmed supply dates; ask about availability and affordability. A changed pack triggers clinic/pharmacist reconciliation.	Supply confirmed or access problem referred.
Long-term continuity **After the clinical review**	Record the next clinic-set review. ACC/AHA suggests lipid monitoring every 6–12 months after the initial reassessment. Offer re-entry after a missed visit. [8]	Current plan replaces outdated tasks.

KEEP MESSAGES PROPORTIONATE

A start contact, a refill contact and a test/review contact may be sufficient for the routine pilot. Combine contacts when dates overlap. Stop unnecessary reminders after a reply and let patients change channel or opt out without affecting care.

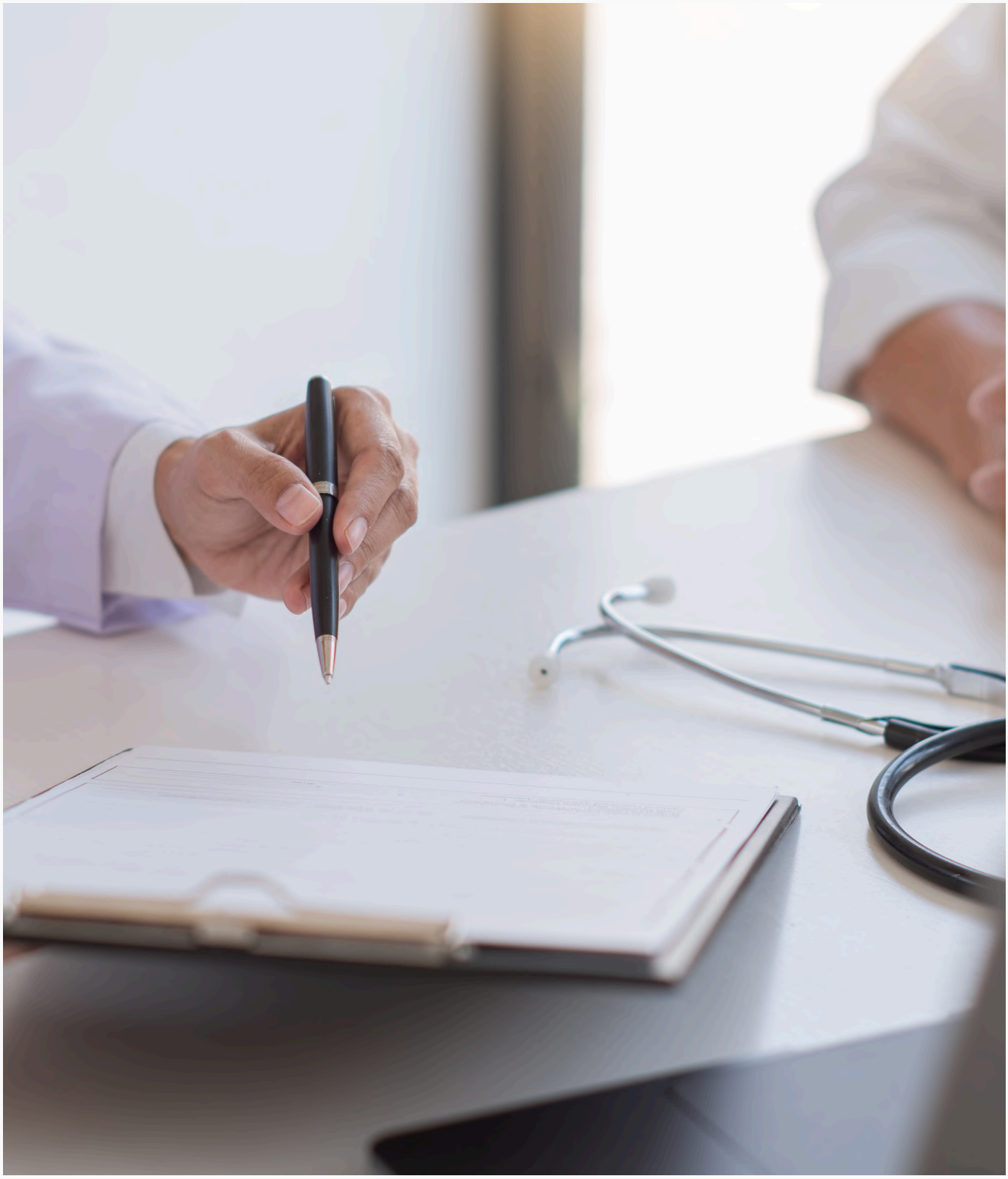
Days 3–7 and reminder frequency are proposed service settings, not guideline-mandated rosuvastatin monitoring intervals. Exact administration and missed-dose wording must follow the selected Indian label and clinic approval.

THE LIPID REVIEW LOOP

CLOSE THE RESULT WITH A DOCUMENTED CLINICAL ACTION

A test reminder is an intermediate event. The loop is complete only when the treating clinician has reviewed the result, addressed relevant barriers and recorded what happens next.

STEP	OPERATING DETAIL	FAILURE TO PREVENT
Book	At entry, record the clinician's test and review dates. Common routine reassessment is 4–12 weeks after initiation or change; use an earlier schedule when clinically needed. [8,10]	A generic day-90 reminder that delays a required review.
Prepare	Before the appointment, collect the original lab report, actual use, current medicine list, access issues, symptoms and questions.	A number without units, date or treatment context.
Review	Clinician interprets absolute LDL-C, change from a valid baseline where useful, risk context, adherence, tolerability and secondary causes. [6,8]	Automatic advice based on a single LDL value.
Act	Clinician records continuation, further assessment, intensification, add-on or change as appropriate, with reasons and follow-up.	Retaining the original regimen merely to protect brand metrics.
Reconcile	Update the plan and retire superseded instructions. Confirm understanding of any new regimen and monitoring.	Duplicate statins, old doses or omitted components after an FDC change.
Re-enter	If the result or visit is missed, make a clinic task. If a patient has already stopped, seek clinical review without instructing a restart.	Silence counted as successful continuation.



Above-goal LDL-C is a prompt for clinician review. It is not an automated rosuvastatin dose-escalation trigger.

The service does not promise lipid control, interpret reports or choose add-on therapy. Laboratory costs and access barriers must be explicit; no diagnostic purchase is required for commercial participation.

SYMPTOM CAPTURE AND SAFE RE-ENTRY

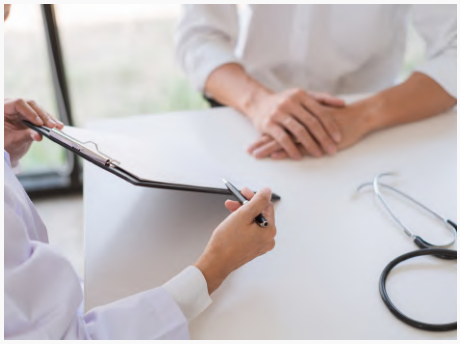
TREAT THE CONCERN AS REAL AND LEAVE CAUSALITY TO THE CLINICIAN

Capture what changed, when it started, severity, effect on daily activity, recent exertion, other medicines and what the patient has already done. Acknowledgement of symptoms is essential even when their cause is uncertain.

SITUATION	PATIENT-SERVICE RESPONSE	CLINICAL BOUNDARY
Unexplained muscle pain, tenderness or weakness	Offer prompt contact with the clinic and record the concern in the patient's words.	No diagnosis of myopathy or reassurance that symptoms are harmless. [5,14]
Severe weakness or muscle pain with dark urine, reduced urine or systemic illness	Display clinic-approved urgent-assessment instructions immediately; do not wait for a routine digital reply.	Urgent routing is not a diagnosis or a medicine instruction. [14]
Jaundice or other serious new concern	Route for prompt medical assessment using the clinic's severity protocol.	The patient service does not interpret liver tests. [14]
Fear of statins or a prior "intolerance" label	Invite a clinician discussion and record prior experiences.	NLA defines partial/complete intolerance after at least two statin trials, including one at the lowest approved daily dose. Clinician
Pregnancy, pregnancy plans or breastfeeding	Provide a prominent prompt to contact the prescriber promptly, and suspend routine engagement pending clinician review.	Apply the selected Indian contraindications and counselling. Do not send independent stop/continue/restart advice. [5,15,16]
A lapse or self-directed change	Arrange clinic re-entry and medication reconciliation.	Never generate a rechallenge, intermittent-dose or alternative-statin schedule.

SAMSON supports a role for expectation-related symptoms in selected patients previously reporting statin side effects; it used atorvastatin and does not prove that an individual's rosuvastatin symptoms are a nocebo effect. [13]

DOCTOR-FACING SUPPORT







A CONCISE AID FOR THE DECISION ALREADY OWNED BY THE DOCTOR

After rosuvastatin selection, the HCP layer should reduce the effort of counselling and follow-up. It should contain enough clinical context to prevent an oversimplified “increase the dose” sales story.

HCP SUPPORT CARD	WHAT IT HELPS THE CLINIC CHECK
Patient fit and risk	Indication, ASCVD/diabetes/CKD context, secondary causes, frailty, preferences, individual LDL goal and the source framework. [6,7,17]
Baseline and test plan	Baseline lipid context, renal function, transaminases and other tests as clinically indicated; book reassessment. CK is not a routine test for asymptomatic statin users. [11]
Rosuvastatin safety cue	Asian ancestry, renal impairment, liver disease and interacting medicines can affect suitability or dose limits. Check the current Indian PI rather than importing a foreign dosing schedule. [5,14,16]
Counselling	Purpose despite no symptoms; lifestyle; disclosure of problems; cost and access; clinic-approved use and missed-dose instructions; reproductive counselling.
Response and intolerance review	Consider actual use, time on current regimen, muscle symptoms, alternative causes and medication interactions before labelling failure or intolerance. [8,12]
Intensification or add-on review	Assess risk, achieved LDL, maximum tolerated therapy, preferences and access. Consider guideline-supported non-statin options when indicated, with product-specific label checks. [8,10]
Long-term continuation	Record the decision, next testing/review interval and reconciliation after a change. A patient who feels better or reaches goal still needs the clinician’s continuing plan.



Example of why label mapping matters: the cited Indian Rozucor EZ 20/40 information says it is unsuitable for initial therapy and restricts 40/10 mg in Asian patients. An FDC is not a generic step on a statin ladder. [16]

Doctor material may identify the sponsor's selected rosuvastatin brand after molecule choice. Patient material remains clinic-branded and brand-neutral. No comparative brand-quality claims are implied.

ACADEMY-BACKED EDUCATION

SIX MONTHS OF EDUCATION BUILT AROUND UNFINISHED CLINIC DECISIONS



Use a monthly mini-CME and a short moderated case-share to improve the workflow. Cardiologists, physicians and diabetologists share the core series; nephrologists and family physicians receive cases that fit their practice.

MONTH AND THEME	CASE AND PRACTICE QUESTION	WORKFLOW OUTPUT
1 Risk and goal clarity	Asymptomatic patient with cardiometabolic risk: how does the clinician explain the agreed LDL goal and test plan?	Clinic goal-and-review card.
2 The first response review	A lipid result returns without a visit: what makes response assessable after initiation/change?	One-page review brief and results worklist.
3 Muscle symptoms	Patient has stopped after pain: what history, clinical assessment and investigations are appropriate?	Neutral symptom history and clinician re-entry route.
4 Above-goal LDL	Patient reports regular use but remains above goal: what must be checked before intensification or add-on?	Documented decision and plan reconciliation.
5 High-risk transitions	Post-ACS handover or diabetes/CKD case: who owns the next lipid review, interactions and monitoring?	Named clinician handover and due-date record.
6 Sustained care	Improved report, refill gap or a missed visit: how does the clinic maintain appropriate long-term follow-up?	Audit of closed reviews and safe re-entry.

GOVERN THE FULL CLINICAL SERVICE

Academy approval should cover the entire clinical service: patient and HCP content, questions, forms, translations, routing rules, outputs, training and version updates. Certification is a launch gate, not a status already achieved. It is distinct from sponsor endorsement, product approval or accredited CME credit.

Use independent faculty, declared support, de-identified cases and an editorial firewall. Offer a 15–20 minute learning unit plus a 20-minute case discussion; measure case decisions and clinic adoption rather than prescribing. No product pitch, patient acquisition list or reward tied to Rx. [18]

Educational basis: [6–17]. Specialist tracks must retain their own clinical judgement; CKD, dialysis, transplantation and post-ACS care are not interchangeable cohorts.



LEADER STRATEGY

TURN DEFAULT PRESCRIBING INTO DEFAULT CLINIC INFRASTRUCTURE



The leader's vulnerability is an established prescription habit with a weak follow-up routine. A challenger does not need to rewrite lipid science if it becomes more useful at the next LDL decision.

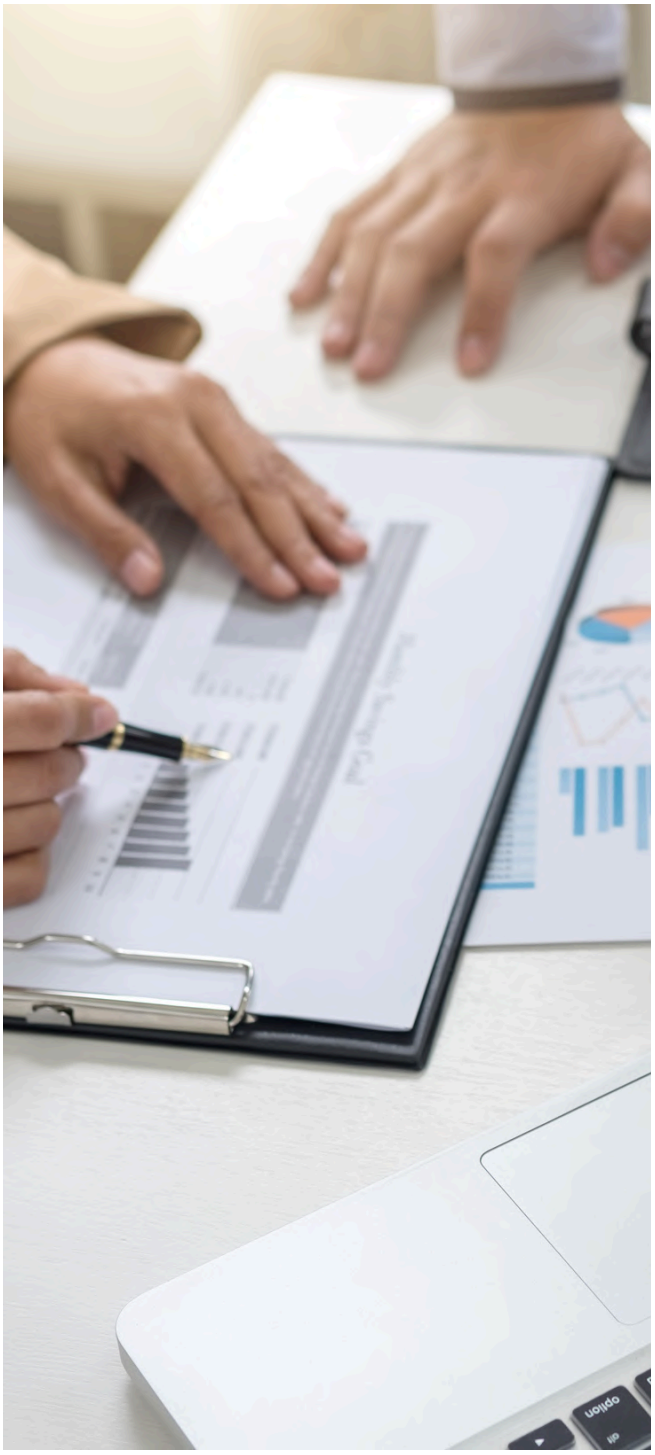
LEADER MOVE	EXECUTION	PROOF TO DEMAND
Defend the core	Activate the highest-value existing clinics where prescription reach is strong but result review is weak.	Adoption across routine visits, not one enthusiastic doctor.
Standardise the useful task	Make the clinic's chosen LDL review brief and coordinator worklist habitual.	Completed result-to-action loops and manageable staff effort.
Protect continuity ethically	Fix supply visibility, affordability questions and prescription reconciliation after changes.	Fewer avoidable gaps; appropriate switches remain unrestricted.
Make the franchise coherent	Carry the updated plan across clinician-selected mono, add-on and FDC stages.	Retired old instructions; no duplicate treatment prompted by the service.
Build evidence the challenger lacks	Audit repeat clinic use and completion against baseline/comparison clinics.	Demonstrated operating value plus independent commercial movement.

THE LEADER'S FIRST 90 DAYS

Use breadth within a tightly managed region rather than a national launch. Recruit a mix of strong prescribers and clinically capable but under-served clinics. Make regional medical and operations teams accountable for adoption, then test whether service use strengthens preference without greater inducement or promotional pressure.

DEFAULT STATUS IS DEFENDED WHEN THE CLINIC WOULD MISS THE ROUTINE IF IT DISAPPEARED.

Leadership must be established from the recipient's current market data. This note assigns no named company a current national rank and promises no clinic exclusivity.





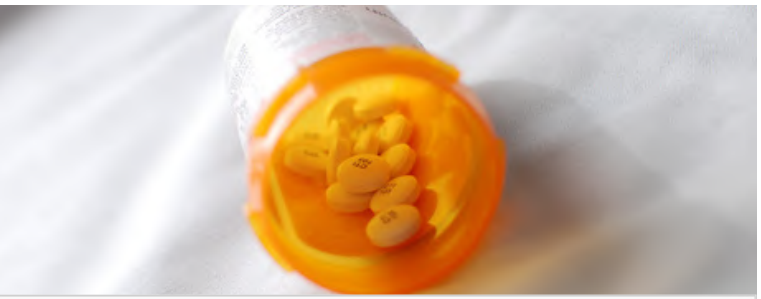
CHALLENGER STRATEGY

CHANGE WHAT THE DOCTOR COMPARES



Do not out-remind the leader. Demonstrate that the clinic can complete more LDL reviews, resolve concerns sooner and leave fewer patients without a next plan. The challenger wins only if that execution is useful enough to influence future HCP preference.

CHALLENGER MOVE	EXECUTION	DISCIPLINE
Find exposed clinics	Select clinics with sufficient rosuvastatin use and a documented testing/review gap.	Avoid targeting individual competitor patients or importing their records.
Show a working routine	Demonstrate a synthetic patient journey from plan to result to clinician action.	Use synthetic data; no branded patient recommendation.
Make progress visible	Return a compact aggregate clinic scorecard and discuss unresolved workflow barriers.	Clinical data stays in the clinic; the rep does not manage alerts.
Earn the next conversation	Pair approved molecule science with evidence that the pathway reduces unfinished work.	No unsupported superiority, disparagement or guaranteed target claims.
Verify commercial relevance	Compare territory share and units with matched areas and baseline trends.	Do not confuse patient enrolment, stock loading or service appreciation with prescription conversion.



A USEFUL CHALLENGE TO THE INCUMBENT IS "LOOK AT THE COMPLETED REVIEWS", BACKED BY EVIDENCE FROM ORDINARY CLINIC WORK.

THE CHALLENGER'S FIRST 90 DAYS

Concentrate on a small number of clinic clusters with reliable laboratory access, a named coordinator and a clear comparison group. Make LDL-review completion the common clinical proof. Keep a separate commercial test: do brand units or audited prescriptions improve relative to comparable areas without changing access to the neutral service?

A clinic's decision to use the service is not a commitment to prescribe a sponsor's brand. Category spillover is an accepted cost of a credible patient-neutral model.





SELECTIVE SHARE AND MID TIER STRATEGY



OWN ONE DEFENSIBLE GAP BEFORE BROADENING

The strongest first wedge is a missed lipid-review loop in clinics already using rosuvastatin. It is observable, common to the molecule and close enough to routine operations to test within 90 days. Additional wedges need stronger specialist capacity.

PICK	WEDGE	WHY IT CAN WORK	CONDITION
1	Diabetes or physician clinics with documented missed lipid reviews	Recurring visits create an existing route to close the test-to-decision gap.	Clinician-selected patients; recorded targets and baseline gap.
2	Stable post-ACS follow-up after discharge	A named handover can prevent the next lipid assessment becoming nobody's task.	Cardiology-led plan; no delay of early intensive treatment or acute care.
3	High refill-gap or substitution clusters	Supply and prescription reconciliation create a narrow operational job.	Demonstrate the gap first; preserve affordability and patient choice.
4	Selected non-dialysis CKD clinics	Complex medicine lists and monitoring make coordinated review useful.	Nephrologist oversight, exact label checks and no universal renal-protection claim.
Later	Clinician-led intolerance/rechallenge service	Structured review can help patients who have left treatment without resolution.	Specialist capacity and safety governance; no automatic rechallenge or promise to retain rosuvastatin.

WHAT DOES NOT QUALIFY AS A WEDGE

Mass screening that steers patients to rosuvastatin; a “kidney-safe statin” campaign; universal high-dose escalation; a nocebo chatbot; or a refill programme that discourages a clinically appropriate change. Newly diagnosed patients can enter after clinician selection, but diagnosis alone is a weaker differentiator than a measured review gap.

> CHOOSE ONE SPECIALTY CLUSTER, ONE LEAKAGE POINT AND ONE ACCOUNTABLE ROUTINE. EXPANSION FOLLOWS REPEATABLE PROOF.

Priority is a strategic judgement, not an audited specialty ranking. Clinical boundaries draw on Indian lipid guidance, ESC/EAS, NLA and KDIGO. [6,7,10,12,17]



FIELD FORCE STORYLINE

MOVE THE CALL FROM REPETITION TO A CLINIC DECISION



The representative introduces and supports adoption of the service. A clinician handles treatment, symptoms and results. Field teams must never become the clinical contact route.

OLD CALL	NEW CALL
Repeat familiar statin features	Identify one unfinished lipid-review task in the clinic.
Leave another generic patient leaflet	Show the clinic-branded plan and a completed synthetic review brief.
Ask for more prescriptions	Ask whether the clinic will appoint an owner and test the routine.
Count QR scans as conversion	Review adoption, due-review completion and unresolved operational friction.
Respond to a symptom as a sales objection	Use the approved clinical/PV handoff and record no patient details in sales notes.

THIRTY-SECOND STORYLINE

“Doctor, after you choose rosuvastatin, the next useful event is a lipid result you can review with the patient’s actual use and concerns. Lipid Control and Continuity gives your clinic a simple plan, a due list and a review brief under your name. The clinical decisions remain yours. The first test is whether more due reviews are actually completed.”

THE FIVE-MINUTE STORYLINE

TIME	JOB
Minute 1	Identify the clinic’s main gap: test completion, result review, symptoms or refill access.
Minute 2	Show the patient plan and neutral contact route with synthetic data.
Minute 3	Show how the coordinator closes a result with a recorded clinician action.
Minute 4	Explain the Academy series, role boundaries, privacy and PV handoff.
Minute 5	Agree one clinic owner, the first cohort, its due dates and a review of operating results.

ASSET SYSTEM

EVERY ASSET MUST FINISH A REAL TASK

Build a small reusable system, then translate and adapt it to local clinic practice. The asset set should reduce staff effort and leave the patient with a clear next step.

CORE ASSET	PURPOSE	CONTROL
Clinic plan card	Goal recorded by clinician; tests, visit and contact dates; plain-language purpose.	Clinic identity only; no sponsor product branding.
Short patient learning units	Asymptomatic prevention, test preparation per clinic/lab, reporting concerns and refill planning.	Academy-reviewed; language and comprehension checks.
Neutral concern form	Patient wording, onset, impact, new medicines and contact preference.	No diagnosis, causal score or automated treatment advice.
Coordinator worklist	Due dates, pending results, review completion and unanswered contacts.	Role-limited clinic access with a named backup.
Lipid review brief	Original report, use and access history, symptoms and clinician action.	Clinical record; no raw upload to the sponsor.
HCP decision support	Risk/goal context, safety cues, monitoring and intensification review prompts.	Scientific approval and selected Indian label mapping.
Academy case-share kit	Six monthly cases, facilitator notes and a practical clinic audit.	Independent faculty; no product promotion.
Rep demonstration and scorecard	Synthetic journey and aggregate operating measures.	No patient dashboard; no promotional claims inferred from service data.

Low friction means no mandatory download, no repeated data entry and no contact without a clear job.

Channel options include paper, a secure short web page or the clinic's approved messaging process. Do not place health details in notification previews or open messaging groups. Digital participation is optional.

MEASUREMENT MODEL

MEASURE THE WHOLE CHAIN WITHOUT CONFUSING ITS LINKS

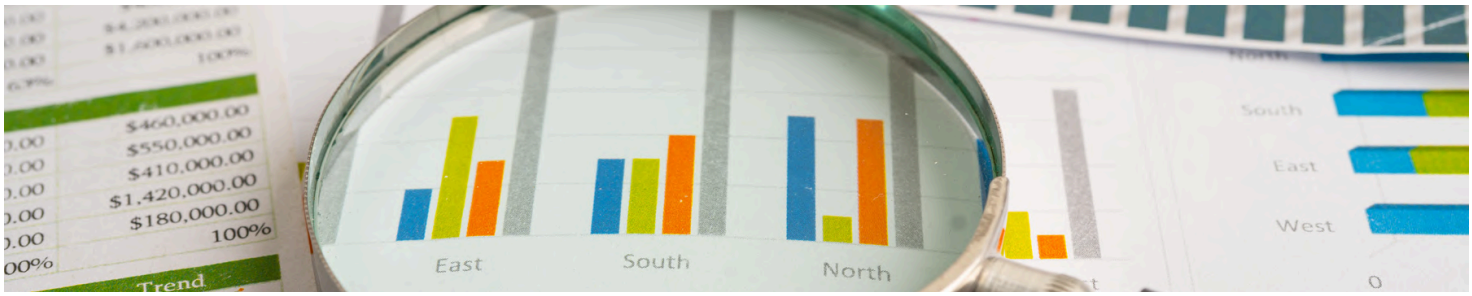
Clinic activation → use and persistence → lipid follow-up and target review → prescription and brand continuity → commercial movement. Each link needs its own denominator and evidence; none proves the next by itself.

LINK	MEASURE	WHAT IT MEANS
Clinic activation	Active clinics / trained clinics; an active clinic has enrolled eligible patients and used the review worklist.	Measures actual adoption, not training attendance.
Use and persistence	Reported use, refill coverage where documented, gaps and re-entry; keep self-report separate from dispensing evidence.	Neither a reminder response nor a refill proves ingestion.
Lipid follow-up	Completed ordered tests / patients whose tests were due; report outstanding results separately.	Testing is necessary evidence for review, not an outcome by itself.
Target review	Primary metric: completed lipid review rate in a predefined cohort due for review.	Requires result plus clinician assessment and a next plan.
Clinical response	Clinician-recorded target attainment and LDL change in a paired-result cohort, with coverage and missingness.	Exploratory clinical signal; case mix and treatment changes matter.
Exact-brand continuity	Same prescribed brand/form/strength among evaluable refills where that prescription remained current.	A secondary commercial measure; excludes approved changes from the unchanged-plan denominator.
Commercial movement	Audited brand units/value or Rx share versus baseline and comparison territory.	Commercial effect remains a separate hypothesis.

Report the number and reasons for all excluded or unevaluable refills separately, including affordability, approved substitution, clinical change and missing information. Do not conceal them to inflate continuity.

PRIMARY DECISION METRIC

USE COMPLETED LIPID REVIEW RATE TO DECIDE WHETHER THE ENGINE WORKS



The primary decision metric is the proportion of the prespecified due cohort that completes the lipid review. It tests the core workflow directly and remains valid when appropriate care changes the medicine or brand.

DEFINITION	SECONDARY MEASURE
Numerator	A lipid result is available; the treating clinician has documented response/goal review and addressed recorded use or symptom concerns; a next plan/date is recorded by the review deadline.
Denominator	All eligible, consented adults in the locked cohort whose clinician-set lipid review was due within the evaluation window, regardless of later brand or regimen change.
Missing or changed plans	Missing results or undocumented review are incomplete. Clinically cancelled/deferred tests are reported separately and remain in the original main cohort; show a justified sensitivity analysis.
Timing	The clinic selects the medically appropriate due date at entry. Freeze the measurement grace period before launch; never reschedule for a better score.
Comparison	Use matched clinics with the same eligibility, due windows and ascertainment. Report baseline-adjusted difference in completion, denominators and uncertainty, allowing for clinic clustering.
Illustrative decision threshold	At least 70% completion and a ⩾15 percentage-point baseline-adjusted advantage over comparison clinics, subject to all safety and feasibility gates. These are proposed targets.



COMMERCIAL AND ECONOMIC CHECKS

Cost per additional completed review = incremental programme cost divided by estimated additional reviews versus the comparison. Count staff time, training, platform, medical governance and any test subsidy. Set the acceptable ceiling before launch using real costs; do not invent a return on investment.

Assess brand movement separately using independent aggregate data. Adjust for price changes, distribution, stock loading, rep coverage and concurrent campaigns. A 90-day signal cannot establish lasting share gain or fewer cardiovascular events.

A clinician-approved switch can still satisfy the primary metric. Safety outcomes and patient choice must never be traded for a higher continuity score.

GOVERNANCE AND GUARDRAILS

CLINICAL INTEGRITY IS WHAT MAKES THE SERVICE CREDIBLE

The operating rules must be visible in training, patient messages and review records. Medical, legal and regulatory approval applies to the actual service configuration and each product-specific HCP layer.

CONTROL	REQUIRED IMPLEMENTATION
Patient neutrality	Clinic identity and ordinary care language. No sponsor brand recommendation, discount funnel, comparative claims or requirement to buy a particular pack.
HCP brand boundary	Brand content appears only in approved HCP/field materials after rosuvastatin selection. Do not turn a support enrolment into a prescribing commitment.
Label and guideline hierarchy	Map the current Indian PI for each selected formulation. Retain local contraindications, dose restrictions and interactions; international documents are context. [5,14,16]
Liver and CK governance	The clinician orders and interprets tests. NICE includes transaminases at 2–3 months and 12 months, then when indicated; it advises against routine CK in asymptomatic users. [11]
Pregnancy and reproduction	Apply the Indian product's pregnancy/lactation contraindications and contraception counselling where relevant. The FDA's 2021 class change is not permission to override Indian labelling. [15,16]
No automated clinical decisions	No diagnostic labels, dose ladder, stop/continue/restart instruction, intolerance classification or automated clearance of abnormal results.
Promotional ethics	Substantiated balanced HCP information, transparent support and compliant education. No incentives tied to enrolment, targets or prescriptions. Review under UCPMP and applicable rules. [18]

Exact-brand continuity is subordinate to clinical appropriateness, lawful dispensing, affordability and patient choice.

The publicly hosted Rozucor monotherapy abbreviated PI carries an October 2015 code. It is a source example, not proof of the latest label. Activation requires the current complete approved Indian PI for every participating product.

DATA AND SAFETY OPERATIONS

THE CLINIC NEEDS CLINICAL DETAIL AND THE SPONSOR DOES NOT

Keep clinical care, pharmacovigilance and commercial evaluation in separate access-controlled processes. Separation must survive daily use, staff turnover and urgent cases.

PROCESS	ACCOUNTABILITY AND DATA RULE
Care record	Clinic retains identities, contact details, prescriptions, reports, symptoms and clinician responses. A contracted processor may handle only authorised functions under defined access and retention rules.
Sponsor analytics	Provide aggregate counts with small-cell suppression and no direct identifiers, raw reports, prescriptions, free text or patient-level linkage. Sales staff see no clinical worklist.
Pharmacovigilance	Capture suspected events without waiting for proof of causality; route through the agreed PV process and applicable timelines. Share minimum necessary case data only with authorised PV personnel, separately from commercial teams. [20]
Consent and privacy	Explain purpose, channels, recipients, retention and withdrawal in the patient's language. No promotional reuse or sales profiling. Map obligations to the DPDP commencement schedule and other applicable law at launch. [19]
Escalation ownership	Name the treating clinician, coordinator and backup. Proposed service level: same-working-day human review of non-emergency concerns, with explicit operating hours and escalation if unanswered.
Urgent care	Severe or rapidly worsening symptoms, chest pain, breathlessness, fainting or stroke-like symptoms require immediate medical help through locally approved emergency instructions. Do not queue for a digital reply.
Service interruption	Keep the clinic's ordinary contact route visible. On a service outage or withdrawal, hand over open clinical tasks and retain required safety records under policy.

The proposed response time is an operating standard, not a medical promise or statutory PV deadline. It must be staffed before activation. PV obligations are not erased by a patient withdrawing from routine reminders.

FIRST-MOVER PILOT

CONFIGURE ACTIVATE AND PROVE IN 90 DAYS

Use the first pilot to show that ordinary clinics can complete more due lipid reviews without excess workload or unsafe brand pressure. Day 90 is a decision point for the operating model, not proof of long-term clinical benefit.

PHASE	ACTION	EVIDENCE REQUIRED
CONFIGURE Days 1-14	Choose one geography and wedge. Establish baseline and comparison clinics; lock definitions. Approve labels, Academy content, data roles, consent, PV and escalation. Train staff using synthetic cases.	Signed readiness checklist, capacity-tested clinical routing and a locked evaluation plan.
ACTIVATE Days 15-28	Enrol the prespecified first cohort. Record clinician-set due dates and supply context. Run the plan, contact and review worklist in live clinic operations.	Consecutive eligible-patient log, consent, plan completeness and early issue resolution.
PROVE Days 29-90	Close due tests and reviews; audit a sample of records; review workload, cost, safety and commercial signals. Keep later cohorts separate.	Primary metric plus comparison, missingness, safety cases, costs and continuation decision.

DIFFERENT POSTURES NEED DIFFERENT PILOT FOOTPRINTS

POSITION	FIRST PILOT EMPHASIS
Leader	Illustrative 20-30 active clinics across existing strongholds; test repeatable adoption and defence of routine preference.
Challenger	Illustrative 12-20 clinics in a few contestable clusters; demand proof of execution plus independently measured commercial direction.
Selective share	Illustrative 8-12 clinics around one wedge; prove the same routine can work repeatedly before adding segments.

Clinic counts are capacity-planning examples, not powered sample sizes. Add a comparable control group and size the cohort from baseline completion and clustering. A 12-week review due after day 90 stays immature; follow it later rather than shorten clinical timing.





DECISION GATES AND CAPACITY

SCALE ONLY WHAT IS SAFE USEFUL AND MEASURABLE



Agree gates before enrolment. A strong sales signal cannot rescue a failed clinical process, and a good service signal does not by itself justify national commercial expansion.

GATE	GO	HOLD OR NO GO
Readiness	All clinical materials, current labels, Academy approval, staffing, consent and PV routes are signed off.	Any missing owner, untested escalation or unapproved instruction.
Safety and integrity	Urgent routes work; relevant cases are handled within the agreed protocol; no unauthorised treatment advice or serious unresolved privacy issue.	A missed urgent handoff or data exposure requires immediate review and correction; a system failure blocks expansion.
Primary metric	Illustrative: ⩾70% completed lipid reviews and ⩾15-point baseline-adjusted advantage over comparison clinics.	No improvement, severe missingness, changing denominators or too few mature cases. Extend observation where necessary.
Feasibility	Illustrative: ⩾75% of activated clinics still use the routine in the final month; median coordinator work ⩽10 minutes per patient per month outside clinical consultation.	Workload exceeds local capacity, alerts accumulate or routine care is displaced.
Economics	Cost per additional completed review stays within the prespecified ceiling.	Unknown staff cost, hidden subsidies or no credible incremental review gain.
Commercial relevance	Independent data show favourable direction consistent with the chosen posture and an acceptable business case.	Service improves but no commercial signal: retain the learning, redesign the commercial layer or extend measurement before scaling.

Allocate pilot capacity by readiness and the ability to prove a useful clinic routine. Do not manufacture scarcity or promise exclusivity that has not been agreed.

The same opportunity is being shown to direct competitors. Early advantage can come from staff training, adopted workflows and accumulated operating evidence. It is contestable and depends on continued usefulness.

LEADERSHIP DECISION



CHOOSE THE WORKFLOW BEFORE A COMPETITOR BECOMES THE USEFUL DEFAULT

Rosuvastatin does not need another explanation of why LDL-C matters. The competitive opening is to help clinics finish the result, review and next-action sequence after they have chosen the molecule.

CHOOSE THE POSTURE	MAKE THE COMMITMENT	DEMAND THE PROOF
DEFEND	Make the LDL-review routine dependable across the leader's important clinics.	Repeat adoption, completed reviews and independently measured defence of position.
ATTACK	Show that a challenger can close more unfinished clinic work.	A better review process and evidence of commercial movement beyond extra promotional activity.
CAPTURE SELECTIVELY	Concentrate on one specialty/geographic cluster with one measured gap.	A reproducible operating result and viable economics before expansion.

THE NEXT LEADERSHIP MEETING SHOULD SETTLE FIVE DECISIONS

Choose the posture from current market data. Select the first clinic wedge. Name the accountable medical and operations owners. Reserve real capacity for a neutral service. Lock the primary metric, comparison and day-90 decision gates.

The first team does not win by announcing a programme. It earns a harder-to-displace position when clinics repeatedly use its support and patients reach the next clinical decision with fewer unresolved barriers.

Defend the default. Displace it. Or capture the gap it ignores. The same molecule-wide opportunity is already in front of the competition.

This is a generic competitive molecule note for leadership discussion. It is not a claim of current market rank, a clinical protocol ready for patient deployment or a promise of share gain. Patient activation follows the approvals and readiness gates in this playbook.







INDIA EVIDENCE AND MARKET SOURCE NOTES

[1] OLS registry investigators. Attainment of LDL cholesterol goals in Indian patients with coronary artery disease. Conference poster, 2024; cohort August–November 2023.
Primary observational poster; n=1,860. Selected CAD cohort, not a national prescription audit.

[2] ICICI Direct Research. Sun Pharmaceutical Industries result update. 1 February 2026, Exhibit 3, page 3.
Dated public broker source; MAT December 2025 brand-value proxy, not a complete molecule leaderboard.

[3] NPPA. Retail-price worksheet 19(4990)/2026/DP/NPPA/Div.II, I/12967/2026. Rosuvastatin 10 mg plus clopidogrel 75 mg tablets.
June 2025 dataset; 36 distinct listed labels; INR949,896,494 total MAT. Top two listed label shares sum to 69.37%. Own counts and arithmetic.

[4] Sun Pharmaceutical Industries. Product price list; published GST revision effective 22 September 2025.
Portfolio-presence source, including Rosuvas and Rozavel. Not a current ranking or an affordability comparison.

[5] Torrent Pharmaceuticals. Rozucor 5/10/20/40 abbreviated prescribing information.
Public Indian monotherapy label example; internal code October 2015. Obtain the current complete approved PI before deployment.

[6] Cardiological Society of India. Clinical practice guidelines for dyslipidemia management executive summary. Indian Heart Journal. 2024;76(Suppl 1):S6–S19.
Indian clinical framework; DOI 10.1016/j.ihj.2023.11.271. Clinical guidance is distinct from brand promotion.

[7] Puri R et al. Navigating cardiovascular risk and lipid management in Indian patients: key messages from LAI 2024 Consensus Statement IV.
Indian risk and goal context. Source supports the <50 mg/dL very-high-risk goal; categories must retain their source definitions.

LIPID MANAGEMENT AND SAFETY SOURCES

[8] ACC/AHA and partner societies. 2026 guideline on the management of dyslipidemia. Circulation.
Current multisociety guidance; monitoring, clinical response and treatment review. Replaces the 2018 cholesterol guideline.

[9] American College of Cardiology. ACC/AHA issue updated guideline for managing lipids and cholesterol. 13 March 2026.
Official summary of the 2026 goals and risk framework. US risk estimates must not be treated as an automatic Indian patient rule.

[10] Mach F et al. 2025 focused update of the 2019 ESC/EAS guidelines for the management of dyslipidaemias. European Heart Journal. 46:4359–4378.
DOI 10.1093/eurheartj/ehaf190. Adds or changes recommendations within the 2019 framework, including intensive care after ACS.

[11] NICE. NG238 cardiovascular disease risk assessment and reduction including lipid modification. Recommendations.
Baseline assessment; 2–3 month lipid/transaminase reassessment; symptom-led CK and subsequent review. Not a rosuvastatin-first recommendation.

[12] National Lipid Association. Scientific statement on statin intolerance. 2022.
Clinical definition and assessment; distinguishes partial and complete intolerance. It is not a patient-service diagnostic rule.

[13] Howard JP et al. Side effect patterns in a crossover trial of statin placebo and no treatment. Journal of the American College of Cardiology. 2021.
SAMSON: selected prior statin side-effect population; atorvastatin study. Supports careful discussion of expectations without dismissing symptoms.

[14] DailyMed. CRESTOR rosuvastatin prescribing information. Current public label retrieved 4 October 2026.
US reference for muscle, hepatic, renal, interaction and Asian-exposure cautions; not an Indian dosing authority.

PRODUCT GOVERNANCE AND IMPLEMENTATION SOURCES

[15] US FDA. Removal of the strongest pregnancy warning for statins while advising discontinuation in most pregnant patients. 20 July 2021.
Explains the US regulatory distinction. Does not supersede Indian pregnancy/lactation contraindications or authorise automated treatment advice.

[16] Torrent Pharmaceuticals. Rozucor EZ 20 and 40 prescribing information.
Indian FDC example: initial-therapy, ancestry, renal and reproductive restrictions. Do not generalise this label to every rosuvastatin product.

[17] KDIGO. 2024 clinical practice guideline for the evaluation and management of chronic kidney disease. Section 3.15.
CKD risk and lipid-management context. Dialysis and transplant populations need distinct specialist judgement.

[18] Department of Pharmaceuticals. Uniform Code for Pharmaceuticals Marketing Practices 2024. Consolidated text updated 1 September 2025.
Promotional claims, comparisons, representative conduct and educational governance. Check for further changes at activation.

[19] Ministry of Electronics and Information Technology. Digital Personal Data Protection Rules 2025 and enforcement timeline.
Official rules and commencement materials. Apply the provisions in force and plan for later commencement; do not presume all provisions began together.

[20] Indian Pharmacopoeia Commission. Pharmacovigilance Programme of India adverse drug reaction reporting.
HCP and consumer reporting routes. Programme PV governance must also meet applicable sponsor and regulatory obligations.

[21] American College of Cardiology. Getting to goals: applying the 2026 dyslipidemia guideline in high-risk patients. September 2026.
Recent official implementation discussion linking lipid testing and follow-up to goal assessment; not evidence that this proposed service improves outcomes.

[22] NPPA. Worksheet 19(4786)/2025/DP/NPPA/Div.II, I/11412/2025. Rosuvastatin 10 mg, aspirin 75 mg and clopidogrel 75 mg capsules.
December 2024 data; dated evidence of multiple competing brand families. Do not use old company labels as current ownership records.

STRATEGIC OPPORTUNITY & CTA

The decision for a rosuvastatin brand team is simple: Will you remain another brand competing on potency, LDL lowering and statin recall, or become the brand that helps clinics turn every prescription into a completed lipid review and a clear next clinical decision?

Rosuvastatin doesn't need another statin reminder campaign. It needs a brand that owns the prescription-to-LDL-review connection—helping clinics make the treatment goal clear, close the testing gap, resolve concerns, and document what happens next.

Old rule: Win the prescription.
New rule: Own the review that makes the prescription assessable.

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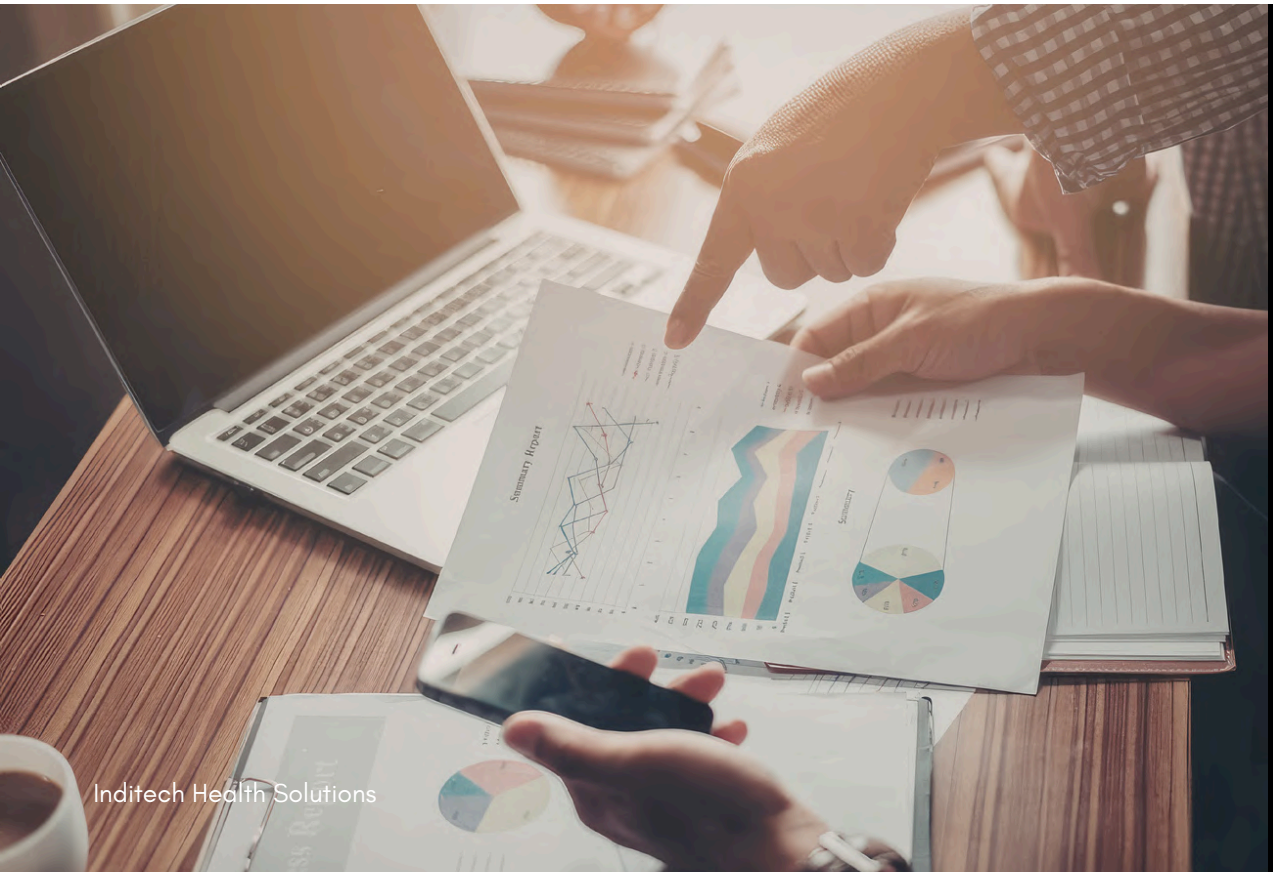
The next winning brand will become the clinic's LDL-review partner - connecting the prescribed plan to testing, interpretation, clinical action, and long-term continuity.

The opportunity is to make the completed clinical decision - not the prescription itself - the new basis of HCP preference.

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 Rosuvastatin LDL-Control Diagnostic and identify your brand's market posture, highest-value review gap, priority clinic cluster, and a focused 90-day pilot.





INDITECH HEALTH SOLUTIONS

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