TAMSULOSIN

THE NEXT SHARE SHIFT WILL BE WON BETWEEN FIRST RELIEF AND THE NEXT INFORMED REVIEW

Competitive Distribution *- Shared with leadership teams of major competing tamsulosin brands in India. The opportunity is molecule-wide. One brand will occupy it first.*

A market-facing playbook for leaders, challengers, and selective-share brands.

One Academy-certified patient pathway. No doctor data entry. Three competitive postures.

Category Proposition *- After the clinician has selected tamsulosin, the winning brand will make an Academy-certified, clinic-branded LUTS Review Companion available without doctor data entry, clinic content approval, or a new monitoring dashboard.*

20 YEARS OF REMINDERS HAVE NOT OWNED WHAT HAPPENS NEXT

THE COMPETITIVE DECISION

THREE POSITIONS. THREE JOBS. ONE UNOWNED INTERVAL.

TAMSULOSIN INDIA INTEGRATED MOLECULE PLAYBOOK

This competitive molecule note is intended for every major tamsulosin team in India. Each reader should recognise its own posture immediately - and see how a direct competitor could move first.

YOUR POSITION	WHAT IS AT RISK	THE COMPETITIVE JOB	DECIDE
MARKET LEADER	Familiarity becomes invisible infrastructure for the category, not a defensible advantage for the brand.	Turn prescription leadership into the clinic's default relief-to-review routine.	DEFEND the default.
CHALLENGER	Another reminder or alpha-blocker claim is neutralised by the leader's habit advantage.	Change the comparison from recall to expectation, early-use support, review, and continuity.	ATTACK the leakage.
SELECTIVE-SHARE / OTHER	Broad imitation spreads resources thin and leaves no owned territory.	Capture one clinically defensible, high-leakage wedge in one dense cluster.	OWN one wedge.

THE PROVOCATION

Tamsulosin is already familiar. The next share shift will come from the brand that makes the interval between first relief and the planned clinical review a ready, patient-operated pathway.

WHAT THIS NOTE IS – AND IS NOT

THIS NOTE IS	THIS NOTE IS NOT
A molecule-wide competitive playbook	A plan for one named brand
A category-control thesis with one executable clinic engine	A product proposal, claim deck, or treatment protocol
A decision memo for leaders, challengers, and selective-share brands	A national share ranking built from unaudited public fragments
A governed post-selection workflow	A diagnostic, prescribing, dose, start/stop/switch, or restart tool

STRATEGIC CHOICE

TAMSULOSIN NEEDS ONE RELIEF-TO-REVIEW WORKFLOW – NOT ANOTHER REMINDER CAMPAIGN

The molecule decision is only the beginning. The opportunity is to give every selected patient a useful, Academy-certified review companion without asking the doctor or clinic team to build or enter an individual plan.

THE OLD COMMERCIAL LOGIC	THE MOLECULE-WIDE OPERATING LOGIC
Repeat alpha-blocker familiarity	Offer a ready-to-use Academy-certified patient service
Treat initiation as the win	Treat the 4-6-week review as the first closed loop
Ask clinics to configure patient plans	Certify the complete clinical pathway once through the Academy; clinics simply adopt it
Add a dashboard or alert queue	Let patients self-activate and use existing clinic contact channels
Count calls, reminders, and QR scans	Measure active clinics, patient journeys, completed reviews, and commercial movement separately

THE FIRST-PRINCIPLES ANSWER

Tamsulosin needs an Academy-Certified LUTS Review Companion: a ready-to-use, clinic-branded and brand-neutral service that the patient operates after prescription. The doctor prescribes normally. Staff hand over a QR card in seconds. The patient receives guideline-aligned support and brings a patient-held summary to review.

STRATEGIC RULE

Certify once through the Academy. Adopt once per clinic. Activate in seconds. No doctor data entry, no clinic content approval, no algorithm configuration, and no new monitoring dashboard.

EXECUTIVE SUMMARY

FAMILIARITY MADE TAMSULOSIN LARGE. FAMILIARITY ALSO MADE IT VULNERABLE.

After more than two decades of brand-reminder marketing, the category still competes heavily at the prescription moment while the commercially decisive patient interval remains fragmented.

THE CATEGORY REPEATS	THE READY-TO-USE SERVICE SHOULD SOLVE
Established alpha-1-blocker familiarity	Give patients a simple, certified explanation of relief, limits, and review
Once-daily brand memory and pack presence	Make refill and substitution questions visible without capturing prescriptions
Symptom-relief language	Help patients prepare a useful symptom record for review
Tolerability reassurance	Prompt clinic re-entry for dizziness, falls, or ejaculation-related concerns
Urology heritage	Provide a standard cataract-surgery disclosure cue and existing clinic contact route

THE CATEGORY-CONTROL THESIS

The next share shift will not be created by explaining alpha-blockade again. It will be created by making one brand synonymous - in the HCP layer - with a useful patient service that reaches review without creating work for the doctor.

THE OPEN COMMERCIAL TERRITORY

A zero-burden, Academy-certified LUTS review service is molecule-wide and still unowned. The first credible operating standard becomes infrastructure; the second becomes imitation.

INDIA MARKET REALITY

MATERIAL DEMAND. VISIBLE COMPETITION. NO PUBLIC NATIONAL LEADERBOARD.

Public evidence proves that male LUTS/BPH matters, tamsulosin is widely preferred, and the category supports large franchises. It does not provide a current auditable national tamsulosin market size, brand count, rank/share table, prescription prevalence, or specialty split.

10.3% **LOCAL LUTS/BPH PROXY** Coimbatore men 50+, n=560 [1]	**65.1%** **FIRST-LINE PREFERENCE** 2018 India clinician survey [2]	**INR 400 cr+** **URIMAX FRANCHISE** all SKUs, MAT Mar 2025 [4]	**7 BIDDERS** **COMPETITION PROXY** one KMSCL 2026 tender [6]

PUBLIC SIGNAL	WHAT IT SUPPORTS	WHAT IT DOES NOT SUPPORT
2026 community study, Coimbatore	Among 560 men aged 50+, 10.32% had LUTS suggestive of BPH; nocturia was common.	Not national prevalence; excluded men already diagnosed or treated; not a prescription audit.
2018 survey of 1,764 Indian clinicians	65.14% preferred tamsulosin first-line among alpha blockers; 58% preferred alpha-blocker monotherapy.	Old, self-reported preference; not current prescriptions, market share, or audited specialty mix.
Cipla FY2024-25 annual report	The Urimax franchise entered the INR 400 crore club; Urimax D was in the IPM Top 100.	Franchise/all-SKU proxy, including combinations; not tamsulosin monotherapy market size or share.
KMSCL 2026-27 procurement notice	Seven suppliers bid for tamsulosin 0.4 mg prolonged-release tablets in one public tender.	Not the active retail brand count and not a national competition ranking.

MANDATORY PRE-CIRCULATION GATE

Insert current licensed IQVIA, PharmaTrac, AWACS, or equivalent MAT value, volume, growth, active brand count, brand ranks/shares, prescription prevalence, urologist-versus-physician/GP split, new/repeat behaviour, price band, channel, and geography. Until then, every posture is strategic - not a public ranking claim.

EMBEDDED CLINICAL ENGINE

ACADEMY CERTIFICATION IS THE OPERATING SYSTEM

The service begins only after a doctor has prescribed tamsulosin. From that point, a pre-certified standard pathway supports the patient without asking the doctor or clinic to build an individual plan.

THE CLINIC DECIDES	THE PATHWAY SUPPORTS	THE PATHWAY NEVER DOES
Academy	Certifies evidence, content, questions, forms, decision rules, outputs, translations, escalation pathways, cadence, versioning, and updates.	Provides the same controlled, brand-neutral standard to every activated patient.
Clinic	Adopts the ready service and supplies its name and normal contact details.	Does nothing beyond usual care and its existing contact process.
Doctor	Retains normal clinical judgement, prescribing, and review.	Prescribes normally; may read the patient-held summary if useful.
Clinic staff	Receives ready QR cards or WhatsApp link and a short orientation.	Hands or shares the access point in under 10 seconds; enters no patient data.
Patient	Needs no app, account, or clinic-created plan.	Self-activates, completes standard checks, contacts the clinic when prompted, and brings the summary.
Brand / sponsor	Funds permitted HCP and field activation under separate MLR, label, legal, privacy, and PV controls.	Receives permitted aggregate service metrics only – never patient identity or clinical details.

The responsible-use spine

- Alpha blockers can improve male LUTS relatively quickly, but full benefit may take weeks.
- They improve symptoms and flow; they do not reduce prostate size or prevent urinary retention or surgery. [8]
- Dizziness, orthostatic symptoms, and falls matter most in susceptible older or polymedicated patients. [8,13]
- Ejaculation-related adverse effects can drive silent discontinuation and require confidential clinic re-entry. [8,11,13]
- Current or prior tamsulosin exposure must be communicated before cataract or glaucoma surgery; the tool never tells the patient to stop. [8,11,13]
- Persistent or complicated symptoms return to clinical reassessment; the pathway does not label every urinary symptom as BPH. [9,12]

NON-NEGOTIABLE OPERATING RULE

No doctor data entry. No clinic content approval. No algorithm configuration. No patient registration by staff. No new inbox or dashboard.

CENTRAL COMMERCIAL DRIFT

THE PRESCRIPTION IS FAMILIAR. THE JOURNEY STILL LEAKS.

Tamsulosin loses value through patient-journey gaps. A service also fails before launch if it asks busy clinics to create, approve, enter, or monitor anything new.

LEAKAGE POINT	WHAT HAPPENS	COMMERCIAL CONSEQUENCE
1. Burden before value	The proposed tool asks the doctor to enter a plan or the clinic to approve content, configure rules, or watch a dashboard.	Adoption stops before the first patient.
2. Expectation mismatch	The patient expects immediate or complete relief, or assumes symptom relief means disease control.	Partial response becomes perceived product failure.
3. Early-use friction	Dizziness, postural symptoms, or fear of falls appears before benefit is clear.	Silent non-use, self-change, or loss of trust.
4. Sexual-friction silence	Ejaculation-related change is not discussed and the patient stops without telling the clinic.	The brand loses continuation without a visible objection.
5. Symptom-noise drift	Nocturia, urgency, frequency, or weak flow is recalled inconsistently.	Poor evidence makes reassessment and switching less disciplined.
6. Medicine uncertainty	Concomitant medicines, missed doses, or an interrupted course create questions.	Informal advice replaces clinician contact.
7. Cataract communication gap	Past or current tamsulosin is not disclosed to ophthalmology.	A preventable cross-specialty safety failure damages molecule trust.
8. Refill, substitution, and review drift	The dispensed pack changes, supply lapses, or the planned review is missed.	Prescription intent and the clinical loop both weaken.

THE CENTRAL COMMERCIAL FACT

The service must remove work before it can own the journey. A clinically elegant pathway that changes clinic behaviour will not scale.

MOMENTS THAT MATTER

NINE MOMENTS DECIDE WHETHER TAMSULOSIN BECOMES A DEFENDED PATHWAY OR AN OPEN PRESCRIPTION

At every moment, the patient-facing service performs a standard Academy-certified task. The clinic intervenes only through normal care when the patient chooses or needs to return.

MOMENT	ACADEMY-CERTIFIED PATIENT SUPPORT	PATIENT ACTION	BRAND OPPORTUNITY
1. Handover	Ready clinic-branded QR card or WhatsApp link after the doctor prescribes.	Scan if tamsulosin was prescribed.	Attach the HCP layer to a useful standard without slowing the consultation.
2. Relief expectations	General education on likely symptom relief, timing uncertainty, and limits.	Follow the prescription; do not self-adjust.	Reduce false failure and false reassurance.
3. Days 3-7	Short self-check for access, dizziness, postural symptoms, falls, and questions.	Use the clinic's existing contact route if concerned.	Surface early friction without a monitoring burden.
4. Symptom tracking	Optional validated score and 3-day bladder diary where relevant.	Keep the result and bring it to review.	Make response reviewable, not anecdotal.
5. Sexual concern	Private cue that ejaculation-related change can be discussed with the doctor.	Choose confidential clinic re-entry.	Protect continuity through respectful discussion.
6. Medicines / interruption	Neutral direction to contact the clinic or pharmacist for medicine questions.	Seek case-specific advice; never infer a restart plan.	Return uncertainty to a responsible professional.
7. Eye-surgery disclosure	Prompt to disclose current or past tamsulosin before cataract or glaucoma surgery.	Tell the ophthalmologist; never stop on the tool's advice.	Create responsible cross-specialty continuity.
8. Refill / substitution	Prompt to compare the dispensed pack with the prescription and question changes.	Ask the clinic or pharmacist about any difference.	Protect prescription intent without disparagement.
9. Planned review	Guideline-aligned reminder and patient-held summary.	Book or attend review and show the summary.	Attach the HCP layer to a completed clinical loop.

INTEGRATED SOLUTION

ACADEMY-CERTIFIED LUTS REVIEW COMPANION

A ready-to-use, clinic-branded and brand-neutral patient service. Clinical content is certified centrally; the clinic simply adopts it.

THE LOOP

1. PRESCRIBE	2. SHARE	3. SELF-ACTIVATE	4. CHECK	5. SUMMARISE	6. REVIEW
Doctor works normally	Staff hands QR in seconds	No app or account	Patient completes prompts	Patient-held output	Doctor reads if useful

BRANDING AND GOVERNANCE ARCHITECTURE

LAYER	VISIBLE TO	ROLE	BRAND PRESENCE
Academy-certified clinical core	Patients, doctors, clinic teams	Entire standard service: evidence, content, forms, questions, rules, outputs, translations, escalation, cadence, and updates	None; Academy certification is not a product endorsement
Clinic identity layer	Patient	Clinic name and normal contact details only	None; adoption is not content or algorithm approval
Tamsulosin HCP execution layer	Doctor, field force, brand team	Permitted activation, orientation, approved product communication, and aggregate measurement	Only after clinician selection and within the approved label

WORKLOAD PROMISE

Doctor: zero data entry. Staff: one share action in under 10 seconds. Patient: operates the service. Clinic: only its existing phone, WhatsApp, emergency, and review processes. Brand: aggregate service metrics only; no patient identity or clinical details.

POSITIONING LINE

A ready-to-use Academy-certified companion can make the selected tamsulosin journey more understandable and reviewable without adding a new clinic workflow.

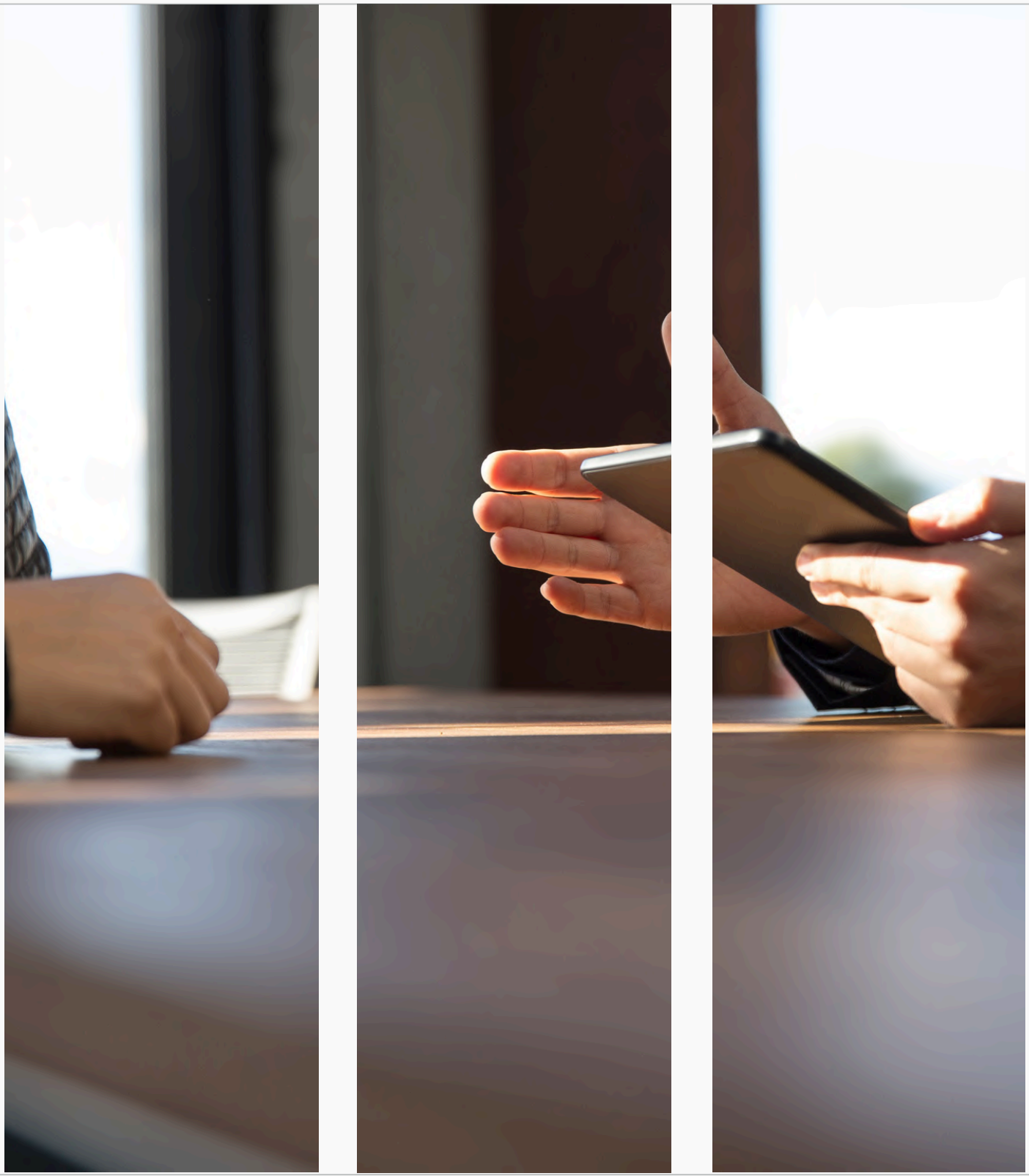
Restricted leadership working document

PLAYBOOK ARCHITECTURE

BUILD THE FIRST CLINICAL LOOP BEFORE ADDING SOPHISTICATION

The patient receives a finished service. Nothing is generated from an individual clinic plan.

MODULE	PATIENT RECEIVES	WHY IT MATTERS	HARD BOUNDARY
1. Relief-and-limits guide	Academy-certified, brand-neutral education on expected symptom relief, timing uncertainty, monitoring, and review.	Reduces early disappointment and false disease-control reassurance.	Follow the doctor's prescription; no drug, dose, start, stop, switch, or restart advice.
2. Early-use self-check	A short day 3–7 prompt covering access, dizziness, postural symptoms, falls, and questions.	Surfaces early friction while the patient can still return to care.	No clinic monitoring queue, reassurance, treatment decision, or automated triage.
3. Symptom-response tracker	Optional validated score and a 3-day bladder diary where storage symptoms or nocturia matter.	Creates a patient-held factual summary for review.	Scores do not diagnose LUTS/BPH or trigger treatment recommendations.
4. Confidential concern cue	Private prompts for dizziness, falls, ejaculation-related change, or another concern.	Makes sensitive discontinuation drivers easier to raise.	Prompts contact through the clinic's existing route; does not interpret causality.



LOW-FRICTION RULE

Access by QR or WhatsApp link. No app, account, name, phone number, diagnosis, prescription, brand, dose, or clinic-entered patient data. Staff only hands or shares the access point.

PLAYBOOK ARCHITECTURE

PROTECT CONTINUITY. SURFACE SENSITIVE FRICTION. RETURN DECISIONS TO THE CLINIC.

The second half of the pathway closes the gaps that conventional reminder marketing leaves open.

MODULE	PATIENT RECEIVES	WHY IT MATTERS	HARD BOUNDARY
5. Medicine-question route	A neutral instruction to use the clinic's or pharmacist's normal contact route for missed-dose, interruption, or concomitant-medicine questions.	Prevents generic instructions from replacing case-specific judgement.	The service never answers dose, start, stop, switch, or restart questions.
6. Eye-surgery disclosure	A portable prompt to disclose current or past tamsulosin before cataract or glaucoma surgery.	Creates a safer cross-specialty handoff.	Never advises stopping or changes surgical planning.
7. Refill and substitution awareness	A prompt to compare the dispensed pack with the prescription and question any change with the clinic or pharmacist.	Protects prescription intent without creating a patient promotion channel.	No competitor disparagement, forced purchase, or brand capture.
8. Review summary and re-entry	A patient-generated summary plus a guideline-aligned 4-6-week review reminder and red-flag return cues.	Makes the next consultation better prepared.	No diagnosis, risk score, or automated treatment decision.

STANDARD ACADEMY-CERTIFIED CADENCE

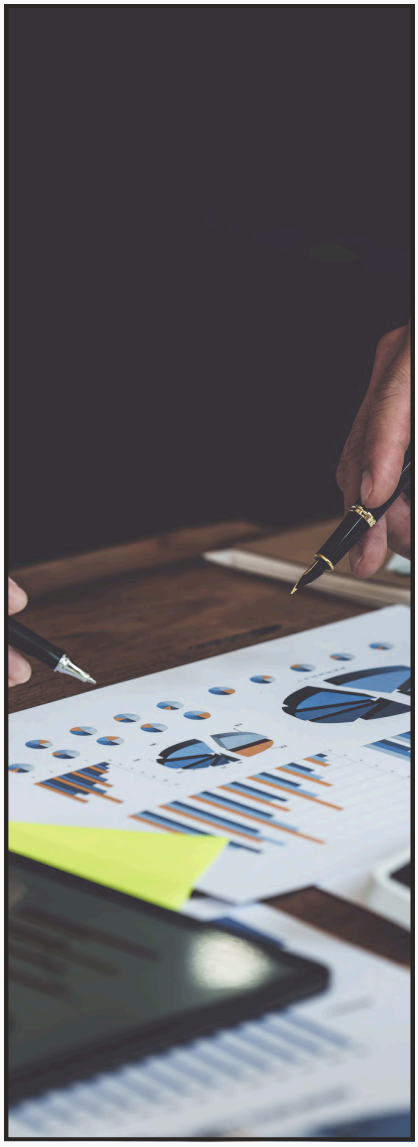
WHEN	STANDARD PATIENT ACTION	ADDITIONAL CLINIC WORK
Handover	Scan the QR card or open the shared link	None beyond normal prescription and a 5-10 second handover
Days 3-7	Complete the private early-use self-check	None unless the patient uses an existing contact route
Before week 4-6	Complete optional diary/score; save the review summary	No preparation, data entry, alert queue, or dashboard
Event-triggered	Use the clinic's existing contact or emergency route when prompted	Respond only as part of normal care
At review	Show the patient-held summary	The doctor reads it if useful and decides as usual

DOCTOR-FACING SUPPORT LAYER

PRESCRIBE NORMALLY. RECEIVE A BETTER-PREPARED PATIENT.

The service is designed around the doctor's existing behaviour. It does not ask for patient entry, plan creation, content approval, alert monitoring, or a new review workflow.

DOCTOR / CLINIC MOMENT	WHAT HAPPENS	ADDITIONAL WORK
Initial consultation	The doctor assesses, selects, prescribes, and counsels as usual.	Zero
Handover	An assistant hands the ready QR card or sends the link.	5–10 seconds of staff time; no patient data entry
Between visits	The patient uses the Academy-certified service privately.	No new inbox, alert queue, monitoring task, or dashboard
Patient concern	The patient uses the clinic's existing phone, WhatsApp, emergency, or appointment route.	Normal care only; no new response obligation
Planned review	The patient shows a concise, patient-held symptom and question summary.	The doctor reads it if useful
Service update	The Academy issues a medically reviewed, version-controlled update.	No clinic content or algorithm review


WHAT STILL REMAINS WITH THE DOCTOR

Diagnosis and differential assessment | selection and dose | medicine review | response to safety concerns | interpretation of symptoms and tests | every continue, change, stop, switch, or restart decision

ADOPTION TEST

If the doctor enters data, the clinic approves content, staff monitors a dashboard, or the service creates a new response obligation, redesign it.

EAU and NICE support symptom scoring, bladder diaries when storage symptoms/nocturia are prominent, and early review of alpha-blocker therapy at approximately 4-6 weeks. [9,10,12]

ACADEMY-BACKED DOCTOR EDUCATION

THE ACADEMY CERTIFIES THE SERVICE – THE CLINIC DOES NOT

Certification covers the complete patient and HCP service. Clinic adoption means accepting a ready, guideline-aligned system - not reviewing its content or algorithms.

ACADEMY CERTIFIES	CLINIC ADOPTS	SPONSOR APPROVES SEPARATELY
Evidence, education, questions, forms, rules, outputs, translations, escalation wording, cadence, versioning, and updates	Clinic name, normal contact details, and distribution by QR card or link	On-label HCP/product communication, field materials, PV, privacy, legal, and permitted aggregate measurement

SIX-MONTH MINI-CME / CASE-SHARE SERIES

MONTH	MINI-CME / CASE-SHARE THEME	WORKFLOW PURPOSE
1	Male LUTS is not a diagnosis: assessment, baseline measures, and red flags	Makes safe selection and review planning the entry standard.
2	Alpha-blocker expectations: speed of relief, what improves, and what does not	Prevents false failure and disease-modification assumptions.
3	Older and polymedicated men: dizziness, orthostasis, falls, and medicine review	Builds a clinically responsible early-use workflow.
4	Ejaculation-related effects and silent discontinuation: respectful counselling cases	Turns a hidden leakage point into confidential clinic re-entry.
5	Nocturia, urgency, frequency, and partial response: IPSS and 3-day diaries	Makes symptoms reviewable before therapy decisions.
6	Cataract/IFIS communication and the first 4-6-week review	Connects urology, physicians, and ophthalmology around a safe handoff.

CERTIFICATION BOUNDARY

Academy certification validates the clinical service. It does not endorse tamsulosin, any brand, any prescription decision, or promotional claim. Company medical, regulatory, legal, privacy, and PV approval remains mandatory for its own layers.



STRATEGIC VARIANTS BY BRAND POSITION

LEADER STRATEGY

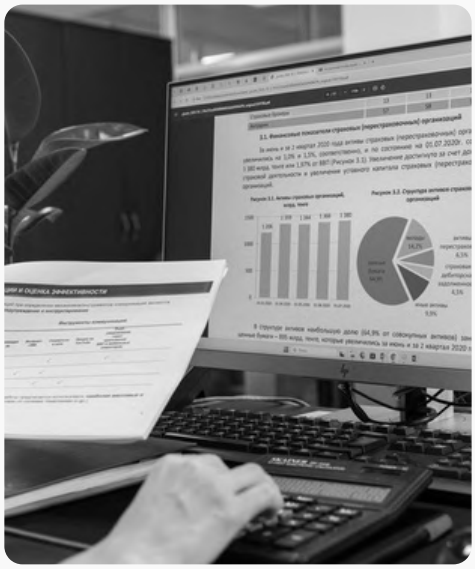
DEFEND THE DEFAULT BY OWNING THE TAMSULOSIN CLINIC PATHWAY

The leader's job is to convert prescription leadership into clinic infrastructure before a challenger makes familiar prescribing look operationally incomplete.

LEADER ADVANTAGE	LEADER RISK	LEADER MOVE
Prescriber habit and broad availability	The brand is written, but the relief-to-review interval is unowned.	Make the ready Academy-certified companion available across representative high-value clinics.
Field reach	Coverage becomes shallow material placement.	Let the field demonstrate one no-burden patient journey and leave ready access cards.
Portfolio and supply scale	Brand/form substitution and stock variance weaken prescription continuity.	Map supply separately; keep the patient service neutral and sponsor-blind.
Data scale	National averages hide early discontinuation, weak review, and cluster leakage.	Use matched clinic measurement and rapid correction.

Leader play

- Make the LUTS Review Companion the easiest post-prescription service for high-volume clinics to adopt.
- Use Academy certification to remove clinic content review and configuration entirely.
- Prove that scale produces more completed planned reviews without additional doctor work.
- Create the operating standard competitors must copy rather than the reminder they can answer.



LEADER FIELD LINE

You already know tamsulosin. This Academy-certified companion is ready to share after you prescribe: no doctor entry, no clinic approval, no dashboard - just a better-prepared patient at review.

LEADER WARNING

If the leader waits, a challenger can turn workflow ownership into the new standard and make default status look passive.

CHALLENGER STRATEGY

DO NOT OUT-REMIND THE LEADER. CHANGE THE BASIS OF COMPETITION.

A challenger wins when doctors stop comparing only familiarity, price, and repeated alpha-blocker claims and start comparing how reliably the prescription reaches an informed review.

DO NOT FIGHT HERE	MOVE THE BATTLE HERE	WHY IT CAN WORK
Generic alpha-blocker familiarity	A ready, Academy-certified relief-to-review companion	The doctor sees an operating difference without an unsupported efficacy claim.
More reminders against greater leader reach	Zero-burden patient self-activation and review preparation	A visible patient-journey difference can displace habit.
National breadth on day one	Dense urology/physician clusters with one measurable leak	Repeated local adoption creates proof and field confidence.
Price-only switching	Refill awareness plus completed review	The HCP layer becomes associated with continuity, while the patient shell remains neutral.

Challenger attack sequence

- Select one visible leak: early tolerability, symptom-response noise, weak 4-6-week review, or substitution.
- Activate a dense cluster where leader habit is strong but post-prescription infrastructure is absent.
- Make the representative demonstrate the patient journey without asking the doctor to change workflow.
- Prove service activation, completed review, and commercial movement through separate licensed data before adding breadth.

CHALLENGER FIELD LINE

The question is not whether your clinic knows tamsulosin. It is which company makes an Academy-certified patient companion available without creating more clinic work.

SELECTIVE-SHARE STRATEGY

OWN ONE HIGH-LEAKAGE WEDGE BEFORE TRYING TO OWN THE MOLECULE

A selective-share brand should choose a wedge with clear clinical value, dense eligible clinics, reliable supply, and a measurable 90-day loop.

RANK	CANDIDATE WEDGE	WHY IT IS DEFENSIBLE	WATCH-OUT
1	Older, multimorbid, high-fall-concern clinics	A standard early-use self-check and easy clinic re-entry address a real risk without clinic monitoring.	Do not imply tamsulosin is unsuitable for all older men; clinician selection controls.
2	High-LUTS-volume urology / physician clusters with weak review	Patient-held tracking and a 4-6-week reminder can improve review readiness quickly.	Do not use symptom scores to diagnose or prescribe.
3	High-substitution geographies	Pack-versus-prescription awareness plus separate supply mapping addresses direct leakage.	The patient service stays brand-neutral; do not disparage competitors.
4	Nocturia / storage-symptom-heavy clinics	A 3-day bladder diary can improve the quality of review where symptoms remain mixed.	Do not promise that tamsulosin will resolve every storage symptom.
5	Cataract-heavy older-male co-management clusters	A neutral disclosure prompt creates a measurable cross-specialty safety routine.	Narrow wedge; never instruct pre-operative stopping.

WEDGE SELECTION TEST

- The problem occurs often enough to measure within 90 days.
- The clinic task is clear and the patient shell can remain neutral.
- The brand has reliable supply and a dense prescriber cluster.
- The workflow improves care without implying product superiority.
- Winning the wedge creates a reusable capability, not a one-off campaign.

SELECTIVE-SHARE RULE

Depth beats breadth. Own one leak end to end, prove it, then decide whether the capability travels.

FIELD FORCE AND ASSET SYSTEM

MOVE THE CALL FROM MOLECULE REPETITION TO WORKFLOW CONTROL

The representative exposes one patient-journey leak, shows a finished Academy-certified service, and asks the clinic to adopt it - not configure it.

OLD CALL	NEW CALL
Repeat alpha-blocker science and brand familiarity	Ask where selected patients are lost before the 4-6-week review
Show another leave-behind	Show the ready Academy-Certified LUTS Review Companion
Ask the doctor to complete a patient plan	Ask staff to hand or share one ready access card after a prescription
Measure reach, calls, and scans	Measure clinic adoption, patient activation, completed checks, and completed planned review

30-SECOND STORYLINE : REP STORY

Doctor, tamsulosin is often lost after you prescribe - when expectations, early dizziness, sensitive concerns, substitution, eye-surgery disclosure, and review become invisible. This Academy-certified companion is ready to share: no data entry, no clinic approval, no dashboard. May your assistant hand the QR card to appropriate patients after you prescribe?

FIVE-MINUTE CALL

MINUTE	REP ACTION	ASSET
0-1	Name the local leakage point	One-page drift map
1-2	Show prescribe-share-self-activate-review	Patient journey card
2-3	Demonstrate the early self-check and patient-held summary	Sample screen / print
3-4	Explain Academy certification, neutrality, safety boundaries, and PV	Governance card
4-5	Ask for clinic adoption and identify where cards will sit	Clinic adoption card

CORE ASSET SET

Drift map | patient-journey card | one-page clinic adoption card | ready clinic-named QR cards | WhatsApp link | relief-and-limits guide | early-use self-check | optional score/diary | medicine and eye-surgery cue | refill check | patient-held review summary | six Academy case-shares | aggregate scorecard | governance/PV card

MEASUREMENT MODEL

MEASURE SERVICE USE AND COMMERCIAL MOVEMENT WITHOUT MIXING THE DATA

The causal hypothesis is explicit: clinic adoption -> patient activation -> useful self-checks -> completed planned review -> commercial movement in separate licensed data.

STAGE	PERMITTED MEASURE	WHAT IT PROVES
1. Clinic adoption	Clinics accepting the service; access cards placed; staff orientation completed	The service is available, not merely presented
2. Patient activation	Anonymous activations per live clinic; completion of the first module	The handover is working without patient registration
3. Useful continuation	Early self-check, optional tracker, review summary, and reminder completion	Patients use the service beyond a scan
4. Planned review	Activated patients self-reporting completion of the planned 4-6-week clinic review	The service closes its intended relief-to-review loop
5. Commercial movement	Licensed Rx/sales movement, new-to-brand/repeat where available, versus matched clinics or baseline	The brand investment may be creating incremental value

OPERATING GATE AND MEASUREMENT DISCIPLINES

- Zero doctor data entry; staff handover under 10 seconds; no clinic dashboard or alert queue.
- Freeze eligibility, denominator, timing, exclusions, control, and data source before activation.
- Separate anonymous service execution, PV/safety reporting, and commercial outcomes.
- The patient service never asks for prescribed brand, prescription image, name, phone, diagnosis, or patient identity.
- Sponsor sees permitted aggregates only; use pre/post and matched-control views where feasible.

PRIMARY DECISION METRIC

Percentage of activated patients completing the planned 4-6-week clinic review. Commercial movement is tested separately through licensed prescription or sales data and matched-clinic analysis.

GOVERNANCE AND GUARDRAILS

COMMERCIAL URGENCY DOES NOT RELAX THE CLINICAL BOUNDARY

The Academy is the clinical authority for the full service. The clinic adopts it; the sponsor cannot convert it or its data into a promotional patient channel.

CONTROL	REQUIRED RULE	FAILURE THAT STOPS ACTIVATION
Academy certification	Evidence, content, questions, forms, rules, outputs, translations, escalation wording, cadence, and updates certified centrally	Clinic asked to approve or configure clinical content or algorithms
Clinic adoption	Clinic name and existing contact routes only; field team may insert them	Doctor data entry, patient registration, new dashboard, or new response obligation
Patient-facing shell	Clinic-branded, brand-neutral, sponsor-blind, plain language, no direct prescription promotion	Sponsor or product persuasion visible to patient
Doctor-facing brand layer	Brand appears only after clinician selects tamsulosin and within approved label	Pre-selection recommendation, comparative superiority, or off-label cue
Approved-label control	Separate company MLR/label approval for HCP/product communication	Patient-facing dose, start/stop/switch/restart, or missed-dose instruction
Orthostatic/fall governance	Standard prompts use existing clinic or emergency routes	Automated reassurance, clinic monitoring queue, or treatment decision
Cataract / IFIS caution	Prompt disclosure of current or past exposure to ophthalmology	Instruction to stop therapy or interference with surgical planning
Red flags and response	Academy-certified wording directs patients to existing clinic or emergency routes	Diagnostic label, delay, or automated treatment decision
Pharmacovigilance	Potential adverse events enter sponsor SOP without commercial filtering and align with Indian reporting routes	Delayed, incomplete, or commercially suppressed report
Data minimisation	Anonymous use where feasible; no name, phone, diagnosis, prescription, brand, or patient-level sponsor access	Sponsor receives identity, symptoms, treatment history, or individual service record

HARD STOP- Pause any doctor data entry requirement,

clinic content or algorithm approval, new monitoring queue, patient-facing diagnosis, tamsulosin recommendation, dose/start/stop/switch/restart advice, failed urgent-care routing, IFIS stop instruction, PV delay, privacy incident, sponsor patient-level data, or unsupported competitor claim.

UCPMP requires promotion to remain on-label, balanced, current, verifiable, and substantiated. India's DPDP Rules 2025 have staged commencement; current legal review is required at launch. [15-18]

WHY FIRST MOVER MATTERS

CERTIFY. ADOPT. PROVE.
The pilot asks one question: can a brand make a useful Academy-certified tamsulosin companion easy enough for clinics to adopt and show credible movement before a competitor does?

PHASE	DAYS	WHAT HAPPENS	GATE
CERTIFY	1-30	Academy locks the standard service; sponsor approves its separate HCP/field, PV, privacy, legal, and measurement layers; test QR access and supply.	No live service until certification and company controls pass. No clinic content review.
ADOPT	31-60	Field team adds clinic name/contact, places ready cards, gives a brief staff orientation, and activates a dense cluster.	Continue only if doctor entry is zero, staff handover is under 10 seconds, and no dashboard is created.
PROVE	61-90	Compare anonymous service use and completed planned review with baseline/control; analyse commercial movement separately in licensed data.	Scale, refine, or stop against pre-agreed service, safety, burden, and commercial gates.

PILOT POSTURE BY MARKET POSITION

LEADER

Make the ready service broadly available in representative high-value urology and physician clinics. Prove adoption without burden.

CHALLENGER

Use a dense attack cluster with strong leader habit and one visible leakage point. Prove a no-burden operating difference.

SELECTIVE SHARE

Own one wedge end to end: older high-fall-concern clinics, weak-review clusters, high-substitution geography, or nocturia-tracking clinics.

GO / NO-GO GATES

GO WHEN	NO-GO WHEN
Clinics adopt; staff shares in under 10 seconds; patients self-activate; planned 4-6-week review completion improves; safety/PV routes work; separate commercial data moves credibly.	Doctor entry or clinic approval is required; staff burden rises; a dashboard appears; the service blurs diagnosis or instructions; safety/PV fails; patient data is exposed; or movement lacks credibility.

FIRST-MOVER RULE

This note can go to every major tamsulosin brand. Finite Academy and activation capacity should go first to the brand that selects a posture, a defensible wedge, and a 90-day proof - not to the brand that asks the clinic to do more work.

CLOSING ARGUMENT AND DECISION CTA

DECIDE WHETHER TO DEFEND, ATTACK, OR SELECTIVELY CAPTURE

The molecule-wide opportunity is now visible. A competitor does not need a new alpha-blocker story. It needs the first credible, Academy-certified, zero-burden relief-to-review service.

IF YOU ARE	DECIDE NOW	DO NOT WAIT FOR
THE LEADER	Will the ready Academy-certified companion become part of the default tamsulosin infrastructure?	A challenger to define no-burden follow-through around the molecule.
THE CHALLENGER	Which leakage point will you attack with a service easier to adopt than the leader's reminders?	More call frequency to overcome an embedded habit.
SELECTIVE SHARE	Which defensible wedge can adopt the finished service in one dense cluster?	National breadth that is unnecessary for the first proof.

THE DECISION

1. Name the posture: defend, attack, or selectively capture.
2. Choose one clinically defensible leakage point and one dense clinic cluster.
3. Confirm the Academy certification boundary, company controls, and current licensed India market baseline.
4. Reserve a 90-day proof before a direct competitor occupies the pathway.

One of you will make the zero-burden standard visible first.

Defend it. Attack it. Or capture one wedge before a competitor does.

FINAL PROVOCATION

Tamsulosin will remain a familiar, crowded molecule. The open question is whether your brand remains another name on the prescription - or becomes the company that made a better patient journey possible without asking the doctor to work differently.

REFERENCES AND SOURCE NOTES

Evidence supports the workflow - not a public market leaderboard : Every clinical statement remains subject to the exact Indian product information and clinician judgement. Every commercial figure carries its period and limitation.

#	SOURCE	USE	BOUNDARY
1	BMJ Open / PubMed - Prevalence and determinants of LUTS suggestive of BPH in Coimbatore, 2026 Open source	Current local Indian community prevalence and symptom-pattern proxy	Single district, men 50+, excludes diagnosed/treated BPH; not national prevalence
2	International Journal of Basic & Clinical Pharmacology - India clinician preference survey, 2019 Open source	Tamsulosin and alpha-blocker preference in 1,764 clinicians surveyed in 2018	Old self-reported preference; not current prescription prevalence or market share
3	Asian Journal of Medical Sciences - Indian urologist BPH survey, 2022 Open source	Small current-practice preference and response-time signal	Only 48 urologists; not a national prescribing audit
4	Cipla Annual Report 2024-25 Open source	Urimax franchise INR 400 crore-plus and Urimax D IPM Top 100 proxy	All-SKU franchise/company disclosure; not total tamsulosin market or brand share
5	IQVIA India - Indian Pharmaceutical Business Quarterly Insights Q2 2025 Open source	Urology therapy growth context in H1 2025	Category-level only; not tamsulosin size, rank, or specialty split
6	Kerala Medical Services Corporation - Special notice for tender 2026-27 Open source	Seven supplier bids for one tamsulosin 0.4 mg prolonged-release tender	Institutional procurement proxy; not active national retail brand count
7	BOBCAPS - Pharmaceuticals sector update, November 2025 Open source	Secondary monthly sales proxy for Urimax and Urimax D in October 2025	Single-month secondary table; not molecule total, rank, or current MAT
8	EAU Guidelines 2026 - Management of non-neurogenic male LUTS: disease management Open source	Alpha-blocker benefit, limits, dizziness/orthostasis, falls, ejaculation effects, and IFIS	International guidance; exact Indian approved PI and clinician judgement remain controlling
9	EAU Guidelines 2026 - Male LUTS diagnostic evaluation Open source	Validated symptom scores, bladder diaries, urinalysis, and clinical assessment	Does not permit a patient tool to diagnose BPH

REFERENCES AND SOURCE NOTES

Governance is part of the competitive strategy : The pathway must be revalidated whenever guidelines, approved product information, law, sponsor procedure, or the India commercial baseline changes.

#	SOURCE	USE	BOUNDARY
10	EAU Guidelines 2026 - Male LUTS follow-up Open source	Review after 4-6 weeks, then periodic follow-up; history, score, flow/PVR and diaries	International guidance; clinic protocol controls
11	American Urological Association - BPH Guideline, 2023 amended 2024 Open source	Alpha-blocker selection, adverse-effect profiles, ejaculation effects, and cataract/IFIS counselling	US guidance; licensing and medical approval required for promotional reuse
12	NICE CG97 - Lower urinary tract symptoms in men: recommendations Open source	Assessment, complicated-LUTS referral, alpha-blocker review, and follow-up	UK guidance; local specialist and Indian PI remain controlling
13	DailyMed - Tamsulosin hydrochloride prescribing information, revised December 2025 Open source	Official label example for orthostasis, ejaculation effects, IFIS, interactions, and interruption caution	US label; do not transfer dose or restart instructions to Indian products
14	Cipla product verification - Urimax 0.4 Open source	Current public India product/form presence proxy	Verification page is not a complete approved PI or comparative claim
15	Department of Pharmaceuticals - UCPMP 2024, updated September 2025 Open source	On-label, balanced, current, verifiable, substantiated, and fair promotion	Company medical/legal approval remains required
16	MeitY - Digital Personal Data Protection Rules, 2025 Open source	Current India data-protection rules and staged commencement	Obtain current legal advice at activation
17	CDSCO - Guidance for industry on pharmacovigilance requirements, version 2.0 Open source	India sponsor pharmacovigilance governance context	Sponsor SOP and applicable regulatory timelines remain controlling
18	Indian Pharmacopoeia Commission - PvPI ADR reporting Open source	India adverse-event reporting routes for HCPs and patients	Does not replace sponsor intake, follow-up, and reporting obligations

DOCUMENT BOUNDARY

This is a strategic competitive molecule playbook, not medical advice, a product label, a diagnostic tool, or a treatment protocol. Activation requires Academy certification of the complete clinical service plus current Indian product information, company medical/regulatory/legal review, privacy and PV controls, and reliable supply. Clinic adoption does not include content or algorithm approval.

INDITECH HEALTH SOLUTIONS

PUBLICATION NO. 2026 08 107