The next share shift in VITAMIN B12

WILL NOT COME FROM ANOTHER 1,500 mcg CLAIM

A COMPETITIVE CATEGORY PLAYBOOK FOR BRAND LEADERS DEFENDING SHARE, CHALLENGERS ATTACKING THE DEFAULT, AND OTHER BRANDS CAPTURING SELECTED PRESCRIBER SEGMENTS.



Competitive Molecule Note



MARKET-FACING PLAYBOOK + EMBEDDED OPERATING ENGINE

IF YOU ARE THE LEADER	Turn brand habit into clinic infrastructure before someone else changes the rules.
IF YOU ARE THE CHALLENGER	Break the default through diagnosis-to-review utility, not louder potency claims.
IF YOU ARE A SELECTIVE-SHARE BRAND	Own one high-leakage pathway or prescriber cluster; scale only after proof.

VITAMIN B12

THIS NOTE IS FOR THE ENTIRE DIRECT COMPETITIVE SET

One market. Three brand positions. Multiple formulation battles. One workflow opportunity.



THE CATEGORY PROVOCATION

THE CATEGORY HAS LEARNED TO SELL B12. IT HAS NOT LEARNED TO OWN B12 CARE.

Most brands sell concentration, combinations, and nerve-health recall. Doctors still manage the uncertainty - and the patient journey - on their own.

B12 is not a weak molecule looking for a new scientific claim. It is a strong category with a weakly owned service layer. In India, B12 appears as standalone oral therapy, injections, and a large universe of B12-led combinations. Yet the commercial conversation often collapses into strength, added ingredients, convenience, and brand memory.

The critical decisions happen elsewhere: who truly needs replacement; whether symptoms are caused by B12 deficiency; which route is appropriate; whether an injection visit or oral routine is completed; when response must be reviewed; and whether continuing treatment is justified.



> “ THE NEW COMPETITIVE QUESTION WHICH B12 BRAND WILL MAKE THE DOCTOR’S CHOSEN TREATMENT PATHWAY ACTUALLY HAPPEN OUTSIDE THE CONSULTATION?

What a molecule-wide note changes

- It makes the market leader realise its default share can be challenged without changing the underlying medicine.
- It gives a challenger a clinically serious way to enter an otherwise habit-led decision.
- It offers smaller brands a narrow, measurable foothold instead of an expensive category-wide reminder war.

The academy-backed clinical content remains independently controlled and patient-facing communication remains clinic-branded. The commercial advantage comes from an enabled clinic service, not from patient-facing product promotion.

This is a strategic model, not evidence of better product efficacy or a promise of additional prescriptions.

MARKET REALITY

INDIA IS LARGE, FRAGMENTED - AND EASY TO MISREAD

Vitamin B12 is a collection of overlapping brand markets, not one audited national league table.

VERIFIED SIGNAL	WHAT IT PROVES	WHAT IT DOES NOT PROVE
184 methylcobalamin brands; 120 marketing companies in a compilation of August 2026 NPPA filings [3].	Visible competition and formulation crowding within recorded methylcobalamin packs.	Not an audited, exhaustive count of every B12-led formulation or active sales.
Mankind: FY2026 Nurokind-Gold ₹188 cr; Nurokind-LC ₹150 cr; Nurokind Plus-RF ₹143 cr [4].	Individual B12-containing formulation families can reach major commercial scale.	These are distinct combinations and represented submarkets, not one pure-B12 market.
Mankind product catalogue includes Nurokind standalone and many B12-containing combinations [5].	A single franchise can compete across standalone therapy and mixtures.	A family's revenue is not a market-size estimate for B12 replacement.
2026 ADA guidance calls for considering B12 assessment with long-term metformin, especially with anaemia or peripheral neuropathy [2].	A recurring legitimate clinic decision point.	It does not mean all metformin users need B12 treatment.

COMMERCIAL CLASSIFICATION FOR PROSPECTING

Segment by product promise and prescribing context - not by every SKU carrying a trace amount of cobalamin. The same prescriber may use more than one category for different purposes.



DO NOT MAKE THE SALES TEAM SAY THIS

> "B12 IS A ₹X-CRORE PURE-MOLECULE MARKET." WE DO NOT HAVE A DEFENSIBLE, CURRENT PUBLIC NUMBER FOR THAT CLAIM.

STRATEGIC CHOICE

ONE NOTE. THREE FORMULATION ARENAS. DIFFERENT WINNING MOVES.



The external note stays unified; the clinic pathways and commercial wedges branch by formulation and use case.

ARENA	WHO COMPETES	WHERE SHARE LEAKS	BEST WORKFLOW WEDGE
A / Standalone oral B12	Methylcobalamin/mecobalamin, cyanocobalamin and other approved oral cobalamin products; route and licensed product vary.	Started without a clear purpose; dose or duration misunderstood; missed doses; no response review.	Correct start, ongoing-cause check, response and continuation review.
B / Injectable B12	Clinician-selected injection products and clinic-based administration schedules.	Injection visits missed; patient assumes one injection fixes everything; long-term maintenance lapses.	Appointment and missed-injection rescue, review and maintenance loop.
C / B12-led combinations	B12 with folate, B6, alpha-lipoic acid, carnitine or other ingredients; only where B12 is central to product positioning.	Every neuropathy treated as deficiency; ingredient claims replace diagnostics; overlapping supplements accumulate.	Evidence-and-indication cue, duplication check, symptom re-evaluation.

What is deliberately outside the core battlefield

- General wellness multivitamins where B12 is incidental, not the reason the brand is chosen.
- Pregabalin or gabapentin combinations presented as if they are simply vitamin B12 replacements.
- Unverified “superior absorption” or “nerve regeneration” claims extrapolated across salts, routes, indications, or populations.

The three commercial positions - leader, challenger and selective-share—apply within each genuine competitive arena. Cross-arena displacement is not assumed.



CENTRAL COMMERCIAL DRIFT

THE B12 BRAND DRIFT: THE PRESCRIPTION IS WRITTEN. THE PATHWAY DISAPPEARS



Four different kinds of drift repeatedly reset the brand decision.

DRIFT	PATIENT / CLINIC REALITY	COMMERCIAL EFFECT
Indication drift	Fatigue, tingling and neuropathy are treated as equivalent to B12 deficiency without adequate review.	The whole category becomes easy to dismiss or substitute.
Route drift	The patient does not understand why an oral product or an injection schedule was chosen.	Formulation choice becomes a price or convenience decision.
Execution drift	Oral doses are missed; injection appointments lapse; other supplements are added without coordination.	Prescription intent does not translate into predictable care.
Review drift	Symptoms persist, improve slowly, or recur; the clinic has no simple return point.	The next visit or refill opens brand choice again.

WHAT BRANDS USUALLY DO

Buy more recall at the first prescription. Leave diagnosis, adherence, response and maintenance to chance.

WHAT THE FIRST MOVER DOES

Give the clinic a trusted B12 pathway that follows the patient through the right review - not just to the pharmacy.

A responsible playbook must never turn unknown neuropathy into automatic vitamin treatment. That would weaken both clinical trust and sustainable brand value. [1, 2]





MOMENTS THAT MATTER

EIGHT MOMENTS DETERMINE WHETHER THE CATEGORY COMPOUNDS – OR RESETS

A clinician-mediated service can make the moments visible without replacing clinical judgment.

MOMENT	PATIENT / CLINIC FRICTION	BRAND-SUPPORTED CLINIC ACTION
1. Suspicion	Symptoms or risk factors have several explanations.	Provide academy-backed recognition and clinical-assessment cue; no self-diagnosis.
2. Confirmation / cause	Borderline results, medication exposure, dietary risk or malabsorption are not automatically resolved.	Doctor-facing reason-for-replacement checklist and clinical documentation prompt.
3. Form / route selection	The patient equates injections with “stronger”, or oral with “weaker”.	Clinic explanation of physician-selected route and what to expect.
4. First week	The patient misses doses, injection visits, or misunderstands administration.	Clinic-branded start confirmation and early barriers check.
5. Response window	Neurologic symptoms can improve more slowly than the patient expects.	Expectation setting and symptom-change check; clinician evaluation of non-response.
6. Refill / appointment	Pharmacy substitution or visit gaps interrupt a planned replacement course.	Prescription integrity reminder; appointment and refill check.
7. Cause-based maintenance	Long-term treatment may be needed for irreversible causes, but not everyone needs life-long use.	Doctor-led continuation, reassessment and recurrence plan.
8. Re-entry	New weakness, worsening balance or persisting symptoms are ignored or self-treated.	Clear clinic/urgent-care triage and next-appointment link.

Timing and treatment decisions are doctor-controlled. NICE NG239 recommends first follow-up at 3 months, earlier based on severity, or 1 month if pregnant or breastfeeding. [1]

RESPONSIBLE-USE SPINE

THE NON-NEGOTIABLE CLINICAL ENGINE

The molecule or product is selected by the doctor before the patient service becomes active.





01 | Recognition is not diagnosis
A risk or symptom screen is a prompt for clinical assessment. Anaemia need not be present in B12 deficiency; neuropathy has multiple possible causes.

02 | Investigate cause where appropriate
Risk context includes diet, autoimmune or gastrointestinal conditions, gastric/ileal surgery, and medicine-associated deficiency. The clinic—not the sponsor - interprets testing.

03 | Select route by clinical need
Dietary, medicine-induced and malabsorption cases can need different treatment strategies. Irreversible causes may require lifelong intramuscular replacement under NICE guidance.

04 | Explain response honestly
Patients may improve in weeks, but some symptoms take months; worsening or new neurological signs require medical reassessment.

05 | Continue or stop only with physician review
No automatic maintenance, switch, escalation, dose adjustment or discontinuation through the digital service.

THE PROMISE IS CLINIC CONTROL, NOT A MEDICAL ALGORITHM
Correct patient → clinician-selected form → correct execution → scheduled review → appropriate continuation.



Clinical sources: NICE NG239 (2024) [1]; ADA Standards of Care 2026 [2].

INTEGRATED SERVICE ARCHITECTURE



THE CLINIC B12 CONTINUITY PATHWAY

A single clinic-branded service with three physician-selected branches.

STAGE	PATIENT-FACING EXPERIENCE	CLINIC / FIELD ROLE
1. Clinic starts the pathway	QR or clinic WhatsApp link; condition-specific plain-language explanation.	Doctor selects pathway; staff share link in seconds.
2. Explain treatment	Purpose, route, schedule and expectation setting based only on clinician-entered orders.	Clinic owns all medical instructions; academy verifies generic education.
3. Early check	“Have you started?” “Any barrier or missed appointment?” “Any new concerns?”	Clinician-approved triage rule delivers meaningful signals to the clinic.
4. Mid-course continuity	Oral adherence, injection attendance, duplicate supplements, reported change in symptoms.	Clinic schedules review; no automatic dose or route changes.
5. Review & re-entry	One-click appointment request and instructions for urgent symptoms.	Doctor documents treatment response, further investigation, or continuation.



Two strict interface rules

- Patient screens are clinic-branded and ingredient-neutral. They never expose sponsor brand or encourage product selection.
- Sponsor receives only contracted, lawful aggregate adoption metrics—no identified diagnoses, clinical histories, contact details or treatment records.

BRAND ADVANTAGE BY DESIGN

The sponsoring brand becomes associated with a service the doctor uses, not a patient-facing promotion the doctor must defend.

FORMULATION PATHWAY A



PATHWAY A: STANDALONE ORAL REPLACEMENT

Own the daily routine without pretending every low-normal laboratory result needs a tablet.

WHO ENTERS

Adults in whom the physician has identified a clinical reason for oral vitamin B12 replacement and selected the product, dose, and review plan. The pathway can support dietary or other clinician-judged cases; it is not a self-screen-to-purchase funnel.

EXECUTION LAYER

1. Clinic explains the indication and why an oral route fits this person.
2. The patient receives a simple clinic plan with the exact doctor-entered regimen and expected review date.
3. Day 7: start confirmation, schedule understanding, missed-dose/barrier check and any new concerns.
4. Day 30: continuing use, tolerability, pharmacy substitution and next-clinic review reminders.
5. At the doctor-set review, the clinician checks response, adherence, underlying cause and whether treatment should continue.



COMMERCIAL EFFECT

The brand stops being just a pack and becomes the clinic's familiar, documented oral-replacement routine. Protection against arbitrary substitution is a by-product of clear prescription communication - not a claim that one generic is superior.

DO NOT CLAIM

"Methylcobalamin is universally more effective than cyanocobalamin." Different approved products and use contexts require evidence - not a blanket sales line.

FORMULATION PATHWAY B

PATHWAY B: INJECTABLE REPLACEMENT

The missed appointment can matter more than the brand reminder.

Who enters : Patients for whom the treating clinician has selected intramuscular replacement, including where malabsorption, neurological/haematological concern, or inability to sustain oral therapy warrants that route under applicable clinical guidance.

CLINIC SERVICE MODULES

MODULE	WHAT THE PATIENT GETS	WHY IT MATTERS
Appointment plan	Clinic-approved dates for injections, with consent-based reminders.	Reduces non-attendance without allowing patients to self-administer or alter schedule.
Missed-visit recovery	A message to contact the clinic to reschedule—not advice to double or change doses.	Protects intended course and clinic oversight.
Response check	Progress questions and concerns prior to doctor's planned review.	Makes treatment experience visible to the treating clinic.
Maintenance review	A doctor-set plan for ongoing therapy in patients with persistent causes.	Prevents silent loss to follow-up or unreviewed continuation.

COMMERCIAL EFFECT

For injection-centred brands, the most valuable asset may be an actual clinic attendance loop. The brand wins a practical place inside clinic operations and may protect treatment continuity where clinically indicated.

NICE NG239 supports lifelong intramuscular replacement in selected irreversible causes. It also advises no repeat of the original diagnostic B12 test solely to monitor someone already on injections. [1]

FORMULATION PATHWAY C

PATHWAY C: B12-LED NEUROTROPIC COMBINATIONS

This is where clinical discipline becomes a differentiator - and where exaggerated claims can destroy it.

THE REAL BATTLEGROUND

The prescriber encounters tingling, burning, numbness, fatigue or diabetic neuropathy and sees a dense field of B12-containing combinations. Some products also contain folate, B6, alpha-lipoic acid, or carnitine. But a neuropathic complaint does not establish B12 deficiency, and a B12 ingredient does not prove efficacy for every neuropathy.

THE SUPERIOR COMMERCIAL ARGUMENT

Be the brand that helps the clinic clarify the purpose of each component, check for overlap with current products, and schedule a meaningful symptom/diagnostic review. The clinic should never rely on a wellness-sounding combination in place of evaluating worsening neurological signs.

OLD COMBINATION CLAIM	NEW CLINIC-FIRST BEHAVIOUR	OLD COMBINATION CLAIM
"More nerve ingredients, therefore more recovery."	Clarify why this product was chosen, what evidence applies, and what remains under diagnostic review.	"More nerve ingredients, therefore more recovery."
"Every diabetic neuropathy case needs B12."	Assess deficiency risk where indicated; diabetes neuropathy also needs its own clinical management.	"Every diabetic neuropathy case needs B12."
"A second B-complex cannot hurt."	Ask about overlapping B6/B12/folate products; excessive supplementary B6 can cause neuropathy [6].	"A second B-complex cannot hurt."
"Repeat until symptoms disappear."	Doctor-defined response and alternative-diagnosis review when symptoms persist or worsen.	"Repeat until symptoms disappear."

THE COMBINATION-BRAND WEDGE : OWN EVIDENCE, CLARITY AND REVIEW—NOT JUST A LONGER INGREDIENT LIST.

DOCTOR EDUCATION

ACADEMY-BACKED EDUCATION: SIX VISITS, SIX CLINICAL DECISIONS

Each topic is a one-page mini-CME plus a short expert video mini-lecture, reviewed independently before use.

VISIT	STRONG OPENING CLINICAL QUESTION	TAKEAWAY FOR THE DOCTOR
1	Does tingling mean B12 deficiency?	Build a clinical differential; use risk factors and appropriate testing.
2	What should a borderline B12 result actually trigger?	Interpret the result in context; review supplements and consider relevant further tests.
3	Oral or intramuscular: what decides the route?	Indication, aetiology, neurological severity, adherence and patient context—not branding.
4	Why did this patient abandon B12 therapy after two weeks?	Set realistic response expectations and remove route-specific execution barriers.
5	When does replacement become maintenance?	Review the underlying cause; distinguish reversible from irreversible deficiency.
6	The diabetic patient with neuropathy: when is B12 the answer—and when not?	Use risk-appropriate testing; avoid conflating diabetic neuropathy with deficiency.

PRESCRIBER AUDIENCES

General physicians, diabetologists/endocrinologists, neurologists, internal medicine physicians, gastroenterologists, selected geriatric/primary-care clinics and hospital follow-up teams. Context-specific mini-cases should be developed for each, without changing the core science.

INDEPENDENT ENDORSEMENT CONDITIONS

Academic reviewers control content, sources and clinical appropriateness; sponsorship is disclosed as required. Academy certification must be obtained, not assumed. Medical content must be separated from commercial execution and comply with applicable UCPMP requirements. [7]



MARKET-LEADER DEFENCE

IF YOU ARE THE LEADER: TURN DEFAULT STATUS INTO INFRASTRUCTURE

The biggest threat is not that doctors forget your brand. It is that another brand becomes more useful.

YOUR RISK : You created familiarity. A challenger can still own the pathway between the prescription and the review.

THE LEADER'S PLAY

1. Install a clinic-branded B12 Continuity Pathway in high-writing clinic clusters before challengers make the service standard.
2. Activate the right branch—oral, injectable, or combination—without implying the same medical criteria apply to all three.
3. Use monthly academy-reviewed micro-education to keep a serious clinical conversation going beyond ingredient recall.
4. Defend exact-brand continuity through prescription clarity, refill availability signals and clinic follow-up—not patient coercion.
5. Prove stable doctor adoption and share retention in activated clinics versus comparable non-activated clinics.

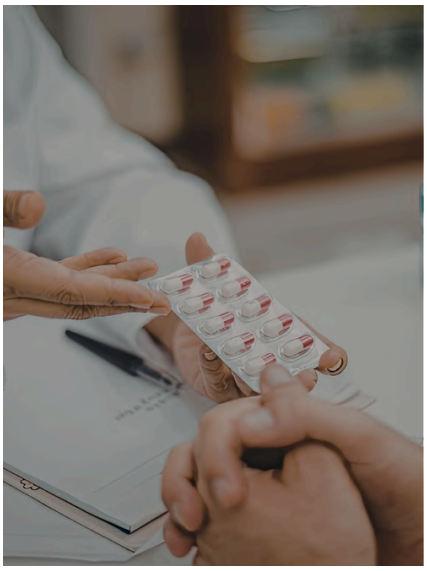
> "THE LEADER'S POSITION SHOULD BE: "WE BUILT THE CLINIC ROUTINE FOR APPROPRIATE B12 CARE BEFORE THE MARKET REALISED IT NEEDED ONE."

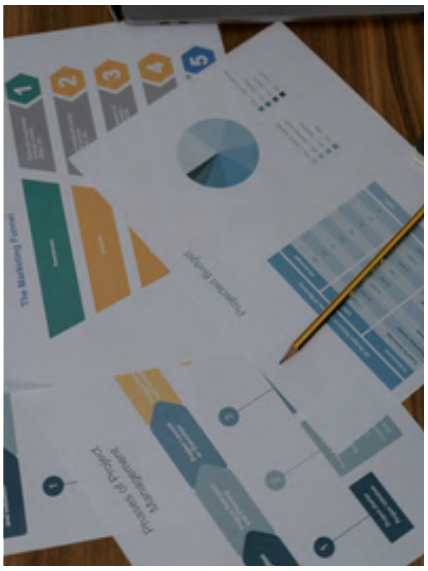
IF YOU ARE THE LEADER: TURN DEFAULT STATUS INTO INFRASTRUCTURE

1. Turning academy-backed material into a disguised detail aid.
2. Using the service to push replacement in patients without a clinical reason.
3. Assuming an existing high-revenue multivitamin brand gives automatic control over deficiency pathways

CHALLENGER ATTACK

IF YOU ARE THE CHALLENGER: BREAK THE LEADER'S HABIT, NOT ITS SCIENCE







Stop asking the doctor to remember a second brand. Give the doctor a better workflow to use.

YOUR OPENING : The market leader owns prescription memory. It may not own cause-based treatment execution or review.

THE CHALLENGER'S PLAY

1. Choose one clinical doorway with genuine execution friction: medicine-associated deficiency, injection adherence, oral start-and-review, or a specific prescriber segment.
2. Build the clinic service around one disciplined medical decision; avoid pretending one salt is superior for all patients.
3. Give doctors an independently certified one-page decision cue and a patient pathway that requires almost no extra clinic labour.
4. Collect adoption and continuation signals without accessing personal medical records as sponsor.
5. Use matched controls to determine whether the service changes doctor preference—after clinical and compliance gates pass.

THE CHALLENGER CONVERSATION

"Doctor, the leading brand is familiar. But what is your clinic using to make sure that a B12 replacement plan is actually started, reviewed and continued appropriately? We can help provide that pathway."

WHAT COUNTS AS DISPLACEMENT?

Not more general awareness. The key signal is measurable movement in the sponsor brand's share of clinically eligible, clinician-chosen B12 use within activated clinics compared with controls, alongside sustained clinic service adoption.

SELECTIVE SHARE CAPTURE

IF YOU ARE A SMALLER BRAND: DO NOT BUY THE WHOLE CATEGORY. OWN A WEDGE.

A focused route or use-context can become a defensible beachhead.

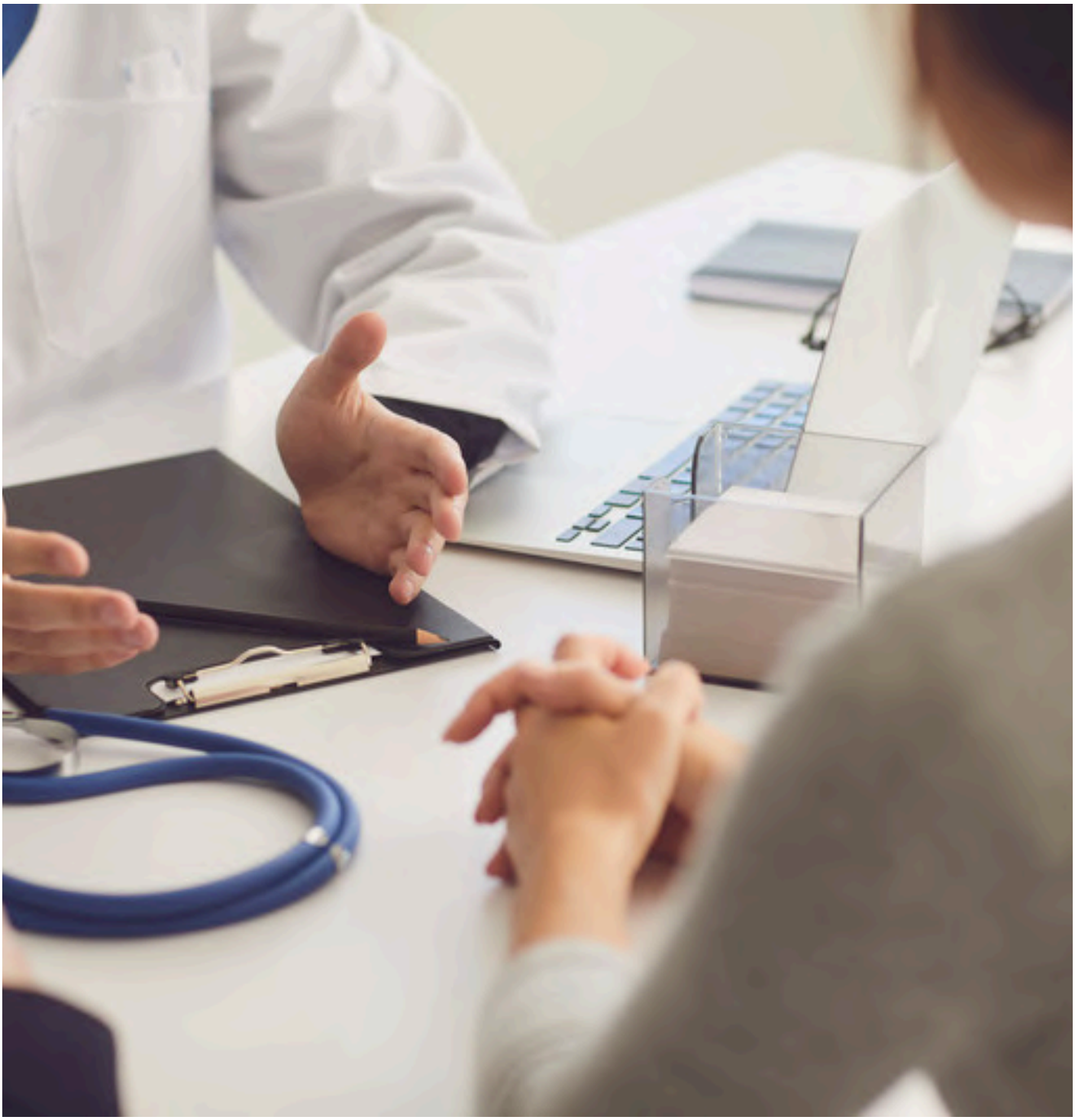
PRACTICAL WEDGE	WHY A DOCTOR MAY CARE	FIRST SERVICE ASSET
Metformin-focused diabetes clinics	Risk assessment can get lost within busy diabetes follow-up; treatment still requires assessment.	Clinic-selected B12 assessment and review prompt; no universal supplement message.
Post-bariatric / GI follow-up	Altered absorption and long-term visit gaps are credible clinical issues.	Replacement-visit and cause-based continuation plan.
Injection-heavy clinics	Missed injections weaken the prescribed plan.	Attendance reminders and missed-visit clinic callback.
Vegetarian / restrictive-diet counselling	The dietary context is common; it is not diagnostic on its own.	Doctor-approved diet/replacement explanation and oral-start check.
Neurology / neuropathy evaluation	Symptoms often have competing explanations.	Symptoms-and-risk cue plus doctor review re-entry; no “all neuropathy is B12” claim.
High-substitution local markets	The molecule is remembered; brand intent can disappear at dispensing.	Prescription clarification and clinic callback for switch confusion.

The expansion rule : Take one wedge through 8–12 weeks of activation, then scale to the next adjacent wedge only after the service is being repeatedly used. A narrow win is more valuable than thousands of passive impressions.

The Small-Brand Strategy : One doctor segment. One behaviour break. One clinic service. One measured share gain.

FIELD FORCE STORYLINE

REPLACE THE OLD REP CALL WITH A CLINIC-UTILITY CALL



The field force installs a service and reinforces academic content. It does not run patient counselling.

THE OLD CALL	THE NEW CALL
"Doctor, our B12 is 1,500 mcg; it contains additional neurotropic nutrients."	"Doctor, after you select B12 replacement, can your clinic see who started, who missed doses or injections, and who needs review?"
Leaves a product reminder.	Leaves a clinic service link, doctor cue and a useful academic case.
Measures samples and recall.	Measures clinic activation, patient execution, review and brand movement.

30-SECOND OPENING

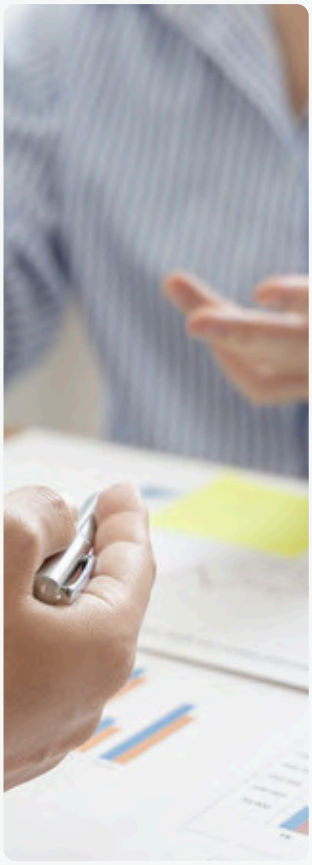
"Doctor, most B12 brands stop at the prescription. We can help your clinic manage the next steps—correct start, oral or injection adherence, symptom review, and safe continuation—through a clinic-branded link and academy-backed education. There is no patient-facing brand promotion and almost no added staff time."

FIVE-MINUTE REP VISIT

1. Name one leakage point observed by this specialty (30 seconds).
2. Show today's one-page academy-backed clinical cue (90 seconds).
3. Demonstrate the clinic-branded QR and workflow branch (90 seconds).
4. Explain the meaningful clinic alerts and what is not automated (60 seconds).
5. Confirm service activation and next-month education topic (30 seconds).

CORE ASSET KIT

Doctor evidence cue | one-page mini-CME PDF | 3–5 minute expert video | clinic-specific QR | patient language library | clinician-approved schedule fields | clinic alert email | aggregate activation dashboard.



MEASUREMENT LOGIC

MEASURE SHARE MOVEMENT. BUT FIRST PROVE A REAL SERVICE EXISTS.

Activity is necessary. Brand impact requires separate, credible measurement.

LAYER	OPERATING METRIC	PROOF STANDARD
Activation	Clinics trained, patient links issued, weekly active clinics.	Independent clinic use persists beyond installation.
Patient execution	Start confirmation, oral missed-dose signal, scheduled injection attendance, follow-up link completion.	Clinic-controlled event counts; not sponsor-visible patient records.
Clinical review	Doctor review due/completed, new/worsening symptom callback, reason-for-maintenance documented.	No automatic diagnosis or treatment decisions.
Commercial continuity	Prescriber-reported exact-brand preference, dispensing retention where consented/legally available, cluster sales.	Report by meaningful formulation submarket.
Incremental effect	Sponsor-brand share delta in activated clinics versus matched controls.	Measure baseline trend, seasonality, channel shifts and competing activity.

Primary commercial decision metric

INCREMENTAL BRAND SHARE

Change in sponsor-brand share among eligible prescriptions in activated clinic clusters, minus matched-control change - subject to validated data access and clinical guardrails.

What not to claim

- Completion signals do not prove biochemical correction or neurological recovery.
- A single clinic's uplift is not automatically causal; brand availability and baseline writing patterns matter.
- A 90-day pilot can test service adoption and early preference movement; long-term clinical outcomes may need a longer window.

FIRST-MOVER PILOT

THE 90-DAY TEST: WHICH BRAND WILL OCCUPY THE CLINIC PATHWAY?



A structured go/no-go—not an indefinite sponsorship proposal

PHASE	WHAT CHANGES	EVIDENCE GENERATED
DAYS 1-15: SELECT	Choose formulation arena, doctor segment, geography and 1-2 clinical leakage points. Obtain independent academic review and regulatory sign-off.	Baseline, clinical rules, brand-position thesis, control-clinic plan.
DAYS 16-35: INSTALL	Activate illustrative 80-120 clinics across two clusters, with a comparable unactivated control set; train existing reps and clinic staff.	Activated clinics, functioning QR/service, staff burden observed.
DAYS 36-70: RUN	Use service for clinician-selected patients; deliver first two academic topics; monitor meaningful alerts and use.	Weekly active use, continuation and review metrics.
DAYS 71-90: DECIDE	Evaluate share trends against matched controls and test repeat clinic use with limited rep input.	Go/no-go, next wedge and commercial feasibility.

DIFFERENT PILOT POSTURE BY COMPETITIVE POSITION

Leader: protect high-share clinic clusters from challenger workflow capture.
Challenger: select a narrowly defined prescriber segment where the leader is least embedded.
Selective-share brand: own an injection attendance, oral adherence, or chronic-risk follow-up wedge before expansion.

GO/NO-GO GATES

- Clinical governance and pharmacy data boundaries pass independent review.
- At least a meaningful fraction of installed clinics remain active without repeated retraining (threshold pre-agreed before launch).
- Patient check completion, useful clinic alerts, and clinician satisfaction reach pre-registered pilot criteria.
- Commercial directional effect is measurable; attribution assumptions are stated openly.

The clinic count and timing here are illustrative design inputs, not promises of client capacity or outcomes.





GOVERNANCE AND ALLOCATION

SPEED MATTERS. BUT TRUST IS THE ASSET THAT CANNOT BE BOUGHT BACK.

The sponsor can fund a clinic utility only within a defensible, transparent governance model.

Non-negotiable controls

- Patient education is clinic-branded and brand-neutral; no direct brand-to-patient call to action or sponsored retargeting.
- Doctors alone choose eligibility, route, dose, tests, treatment duration, monitoring and continuation.
- Clinic owns identified health data and any contact permissions. Sponsor receives only appropriately aggregated, lawfully shared program metrics.
- Academy certification is independently earned and disclosed; sponsoring the programme does not confer a scientific endorsement.
- For B12/B6 combinations, check approved labels, duplication, safety and substantiation; do not assert regeneration or universal efficacy.
- The sponsor must not offer clinic utilities as an inducement conditional on prescribing volume. All support and field interactions require UCPMP/legal review. [7]



> THE URGENCY IS OPERATIONAL, NOT THEATRICAL
>
> THE FIRST BRAND TO INSTALL A USEFUL CLINIC PATHWAY EARNS HABIT. EVERYONE ELSE MUST COMPETE AGAINST A SYSTEM ALREADY IN USE.

FIRST-MOVER ALLOCATION—WHAT CAN LEGITIMATELY BE SAID

This note is designed for circulation across major directly competing B12-centred brand teams. Operational priority may be offered to the first partner that agrees on a defined clinic cluster, compliance-approved support model and field activation commitments. Any exclusive territory or time window must be real, limited and separately agreed. Academic information cannot be selectively distorted for a paying brand.

DECISION CTA

THERE ARE THREE POSSIBLE MOVES. WAITING IS ONE OF THEM.

A decision note—not a brochure and not a bespoke proposal

POSITION	DECISION YOU SHOULD MAKE NOW
MARKET LEADER	Where is our B12 brand still only a remembered product? Which clinic pathway will we defend before a challenger installs it?
CHALLENGER	Which narrow, clinically legitimate workflow can move us from second-choice brand to preferred execution partner?
OTHER BRAND	Which one specialty, route or clinic cluster can we measurably own without fighting the entire category?

> “ THE NEXT WINNING B12 BRAND WILL NOT JUST BE PRESCRIBED. IT WILL BE PART OF A CLINIC ROUTINE THAT ACTUALLY RUNS.

30-MINUTE MOLECULE DECISION REVIEW

Pick your formulation arena. Identify the one highest-value care break. Select a pilot cluster. Decide GO or NO-GO.

No commitment to an open-ended campaign. No speculative clinical claims. No assumption that the field remains unoccupied forever.

EVIDENCE AND SOURCE NOTES

Market signals, clinical guidance and compliance sources used in this playbook.

[1] NICE NG239 (6 March 2024), Vitamin B12 deficiency in over 16s: diagnosis and management. Clinical selection, oral/intramuscular use, follow-up, causes and risk recognition.

[2] American Diabetes Association, Standards of Care in Diabetes 2026, Sections 3 and 4. Periodic B12 assessment with long-term metformin, especially with anemia or neuropathy.

[3] Counterfoil, Methylcobalamin NPPA price-filings compilation, August 2026, retrieved Oct 2026: 184 brands, 120 companies, 245 packs. Listing proxy only; not audited prescription share.

[4] Mankind Pharma management discussion with IQVIA MAT Mar 2026 brand tables, reproduced by India Infoline. FY2026 figures for Nurokind-Gold, Nurokind-LC and Nurokind Plus-RF; each represents a separate category/submarket.

[5] Mankind Pharma product catalogue: Nurokind standalone and Nurokind-family combinations (product compositions vary).

[6] Australian Therapeutic Goods Administration, vitamin B6 supplementary neuropathy safety advisory (updated 25 Feb 2026). Applicable as a safety signal for relevant B6-containing combinations; it is not an India marketing-approval claim.

[7] Department of Pharmaceuticals, India, Uniform Code for Pharmaceutical Marketing Practices (2024; amended September 2025), and July 2026 government clarification.

[8] NICE NG239 rationale and impact: clinical judgment on medicine-induced deficiency, options for oral or intramuscular routes, and review.

[9] Medindia 2024, Mecobalamin brand examples (illustrative, not comprehensive): Nurovita, Macball, Megabol and other Indian listings.

STRATEGIC OPPORTUNITY & CTA

The decision for a vitamin B12 brand team is simple: Will you remain another brand competing on dosage strength, ingredient combinations, and nerve-health claims, or become the brand that helps clinics ensure appropriate replacement is started, executed, and reviewed?

Vitamin B12 doesn't need another potency-led campaign. It needs a brand that owns the diagnosis-to-review pathway - helping clinics connect the reason for replacement with the right clinician-selected route, treatment execution, response assessment, and appropriate continuation.

Old rule: Win the prescription.
New rule: Own the pathway that makes the prescription work in practice.

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The next winning vitamin B12 brand will become the clinic's replacement-continuity partner—helping teams address missed oral doses or injection visits, clarify treatment expectations, identify unresolved symptoms, and bring patients back for clinician-led reassessment.

The opportunity is to turn reliable clinic execution into a competitive advantage - one that goes beyond another strength claim or a longer ingredient list.

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 Vitamin B12 Molecule Diagnostic and identify your brand's competitive position, highest-value treatment gap, priority formulation or prescriber segment, and a focused 90-day pilot.





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