MARKET

INTELLIGENCE

AND COMPETITIVE

EXECUTION

Standalone esomeprazole and esomeprazole plus domperidone

The next PPI share shift will happen after the prescription

YOUR NEXT COMPETITOR MAY BECOME MORE USEFUL BETWEEN VISITS THAN YOUR BRAND IS DURING THE SALES CALL

ESOMEPRAZOLE INTEGRATED COMPETITIVE FORMULATION PLAYBOOK

INDITECH X INDIA X GASTROENTEROLOGY



PPI marketing has spent years competing on potency, speed, familiarity and combination breadth. Yet a prescription can still end in incorrect use, silent substitution, unresolved symptoms or an unreviewed repeat. The commercially valuable interval begins where the conventional brand call ends.

The opportunity is a clinic-branded Acid-Control & Review Pathway extending from prescription to home use, planned review and clinically appropriate re-entry. Targeted patient education and selected episodic check-ins support that journey where useful. Monthly academy education equips doctors to act on what the pathway reveals.

For standalone esomeprazole, the contest is correct use and appropriate continuity. For esomeprazole plus domperidone, it is appropriate selection, safety and timely reassessment. These pathways share a service architecture, but they must never share an automatic prescribing rule.

Your competitive position	Your strategic move
Market leader	Make a useful patient journey the default across the existing prescriber base.
Challenger	Give clinics a useful reason to reconsider the incumbent.
Selective-share brand	Win one defined gap in understanding, execution, review or recurrence.

A category-wide opportunity. This playbook is offered to major competing esomeprazole brand teams. The first team to establish a trusted clinic routine can gain a practical lead in operating experience and repeated use. Evaluate the opportunity while that routine is still open to competition.

THE DECISION IN ONE PAGE

COMPETE FOR A BETTER MANAGED TREATMENT EPISODE, NOT FOR A LONGER PRESCRIPTION

Evidence anchor	What it establishes
₹643.80 crore	Historical MAT sales base in an NPPA 40 mg esomeprazole plus 30 mg domperidone worksheet using March 2024 data. Not the whole esomeprazole market or a 2026 forecast. [1]
62.03%	Combined Sompraz D and Nexpro RD share within that worksheet's segment, calculated as 33.41% + 28.62%. Concentration makes both defence and targeted displacement relevant. [1]
20.20%	Esomeprazole share among 687 APD patients with comorbidities in a four-clinic EMR study published in 2026, using 2017–2020 records. Not national prescription share. [2]
481 of 8,839	Outpatient prescriptions containing a domperidone–PPI FDC in a 13-centre study published in 2025; 8.11% of those FDC prescriptions contained esomeprazole. [3]

THE COMMERCIAL THESIS

Brand recall does not ensure that the patient receives the intended product, understands the instructions or returns for a treatment decision. A clinic workflow can make those failures visible. Whether that translates into incremental brand share is a testable commercial hypothesis, not an established outcome.

THE OPERATING PROPOSITION

One clinic identity connects a product-specific patient plan, targeted education, selected digital checks, a clinical review and a route back when needed. The clinic enables only the components that solve a defined problem. Standalone and combination pathways have separate rules. Monthly academy education supports both; it is one component of the service.

THE FIRST 90 DAYS

Test 60 activated clinics against 60 matched controls, or a smaller feasibility cohort if scale is limited. Establish a baseline before launch. Measure patient understanding, useful follow-up, timely review and incremental brand performance separately for standalone and combination prescriptions. Treat unsafe combination activation as a stop signal, regardless of sales.

Decision required : Choose the pathway, competitive posture and clinic problem you intend to win. Then test whether clinics use the service and whether appropriate brand share improves. A video library or QR count cannot answer that question.

THE INDIAN REVENUE BENCHMARK

A large, concentrated combination segment is visible in public evidence. Current market totals require current licensed data.

NPPA file 19(4278)/2024/DP/NPPA/DIV.II reports the following March 2024 MAT values for esomeprazole 40 mg plus domperidone 30 mg presentations. Values below are rupees converted to crore; the underlying worksheet is a pricing dataset, not audited company revenue. [1]

Brand	Company in worksheet	MAT ₹ crore	Share
Sompraz D	Sun Pharma Laboratories	215.08	33.41%
Nexpro RD	Torrent Pharmaceuticals	184.25	28.62%
Raciper D	Ranbaxy Laboratories*	38.2	5.93%
Esofag D	Micro Labs	26.54	4.12%
Esoz D	Integrace Health	26.35	4.09%
Esomac D	Cipla	21.61	3.36%
Zosa DSR	Zuventus Healthcare	14.61	2.27%
Espra DSR	Zydus Cadila ZHL	13.06	2.03%
Esolembic D	Alembic	12.57	1.95%
Whole worksheet segment	All included presentations	643.8	100%

**Historical company naming retained for traceability; Sun's current catalogue lists Raciper and Raciper D. [4] Totals for a brand with several packs must be aggregated across those packs. Selected rows above are not a full market ranking. [1]*

READ THE BOUNDARY BEFORE READING THE OPPORTUNITY

This is a single strength combination benchmark. It does not include all standalone esomeprazole, all strengths, injections, eradication kits or other prokinetic combinations. It cannot be relabelled "India esomeprazole market 2026". Historical concentration is a reason to investigate current leadership, not permission to assert it.

WHAT THE NEXT DATASET MUST RESOLVE

Obtain the latest licensed IQVIA or Pharmarack extract with the period, channel coverage and value basis stated. Separate standalone oral products from domperidone FDCs, split strengths and packs, and reconcile brand-family and company ownership. Add regional and specialty prescribing data from a licensed prescription audit where available.

Commercial implication : The combined pathway can defend an existing franchise or open a focused challenger route. Neither argument needs an invented market CAGR or a fabricated national prescription count.



THE CURRENT COMPETITIVE FIELD

Use the product and company map to define the battle. Do not infer market rank from a retail listing.

Brand family	Company or commercial relationship	Pathways evidenced
Sompraz	Sun Pharmaceutical Industries	Standalone 20/40 mg; Sompraz D 20/30 and 40/30 mg. [4]
Nexpro	Torrent Pharmaceuticals	Standalone 20/40 mg; Nexpro RD 20/30 and 40/30 mg. Other standalone presentations also listed. [5,6]
Raciper	Sun Pharmaceutical Industries	Standalone 20/40 mg; Raciper D 40/30 mg. [4]
Esomac	Cipla	Standalone 40 mg; Esomac D 40/30 mg current listings. [7,8]
Neksium	Pfizer brand; Cipla marketing and distribution partnership	Standalone and Neksium D listed. Confirm SKU scope and operational responsibility under the agreement. [9,10]
Esoz	Integrace	Standalone 20/40 mg on company site; Esoz D appears in historical NPPA data. [1,11]
Zosa	Zuventus Healthcare	Standalone tablet in official price list; Zosa DSR 40/30 mg in company prescribing information. [12,13]

Composition order in this playbook is esomeprazole/domperidone. Catalogue presence establishes a marketed presentation; it does not prove stock in every location. Retail sources are used for product identity only, not clinical recommendations.

THE LONG TAIL MATTERS LOCALLY

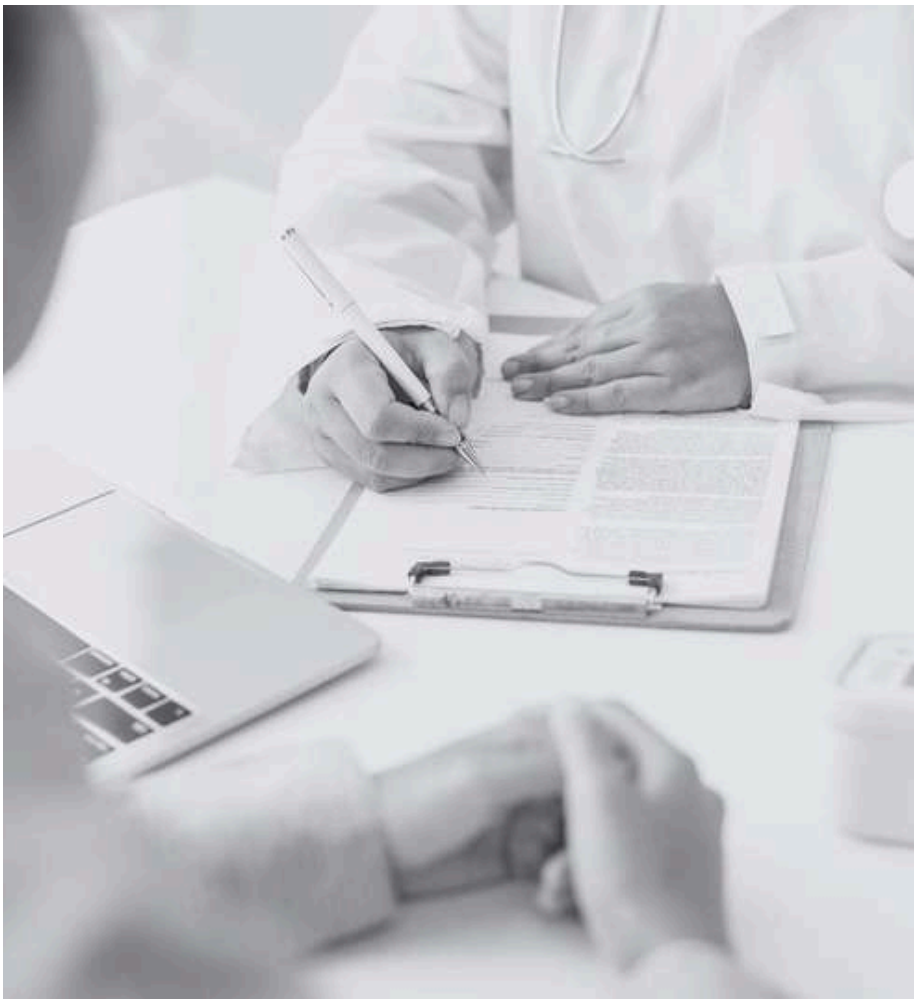
The historical worksheet also identifies Micro Labs' Esofag D, Zydus' Espra DSR, Alkem's Yees D, Macleods' Esofine DSR, Abbott Healthcare's Esokem D and Lupin's Lupisoz-D. Validate their current SKU, marketer and local supply before including them in a territory battlecard. [1]

TWO COMPETITIVE RINGS

Within esomeprazole : same-molecule substitutes, company portfolios and local pharmacy supply can change brand-of-use. Across acid suppression: pantoprazole, rabeprazole and other PPIs compete for the clinical decision; newer potassium-competitive acid blockers add a different class of competition. Torrent's FY2024–25 report describes Nexpro as the second-largest esomeprazole brand in the IPM and reports a vonoprazan launch. This is a dated company-reported signal, not a fresh independent ranking. [14]

Portfolio strategy must prevent two teams from giving the same clinic contradictory treatment messages. A clinic's regimen change should remain clinically led even when it moves revenue outside the sponsor's portfolio.





WHAT PRESCRIPTION RESEARCH CAN ESTABLISH



Published use is evidence of practice. It is not evidence that every prescription was necessary.

THE MOLECULE-USE SIGNAL

The 2026 four-clinic retrospective study included 687 adults with acid peptic disease and comorbidities. Esomeprazole accounted for 20.2% of PPI use, behind pantoprazole at 51.7%; rabeprazole accounted for 13.0%. Records covered January 2017 to December 2020 and required at least two follow-ups. Sun Pharma funded the study. Selection, setting, age of records and sponsorship limit generalisation; the results cannot establish today's national share or brand superiority. [2]

THE COMBINATION SIGNAL

The 2025 multicentre outpatient prescription audit found domperidone–PPI FDCs in 5.44% of 8,839 prescriptions across 13 tertiary centres. Within 481 FDC prescriptions, esomeprazole combinations represented 8.11%, versus pantoprazole 64.86% and rabeprazole 23.49%. The authors identified deficiencies in indication, dose and other prescribing details. These denominators describe that sample, not all Indian PPI prescriptions. [3]

THE STRATEGIC INTERPRETATION

Esomeprazole is established enough to support competing brand franchises. The use of domperidone combinations is also established, but observed volume does not validate routine combination treatment. A responsible challenger can compete on review quality; a leader can protect trust by improving the discipline surrounding its installed base.

Question a brand team should ask	Evidence needed before claiming an answer
Do we lead nationally in either pathway?	Current formulation-specific value and unit share; do not use mother-brand or all-PPI rank as a substitute.
Where does prescribing become dispensing loss?	Consented clinic plan versus patient-reported product received, with missing responses reported.
Is poor response a brand problem?	Clinician review of use, diagnosis, symptoms and treatment; service data alone cannot prove comparative efficacy.
Will the service change share?	Prospective comparison with matched clinics, baseline adjustment and appropriate-use safeguards.

Evidence discipline : Market figures, clinical research, product listings and pilot assumptions answer different questions. Keep their labels visible in every business review and every field briefing.







TWO PATHWAYS AND SIX COMPETITIVE PLAYS



One patient service can support six strategies. Clinical rules do not change with market position.

Pathway	Leader defence	Challenger attack	Selective share
Standalone esomeprazole	Make patient understanding and episode review routine across existing prescribers.	Win clinics with unresolved home-use errors or missed reviews through a targeted episode service.	Own one local gap in instructions, review or recurrence re-entry.
Esomeprazole plus domperidone	Defend trust through documented selection and a separate domperidone review.	Challenge unreviewed combination habit with a clinically controlled alternative workflow.	Serve a narrow set of appropriate adult cases in clinics able to perform safety screening.



STANDALONE IS NOT A WAITING ROOM FOR COMBINATION TREATMENT

Persistent symptoms should trigger verification and clinical reassessment. The service must not automatically recommend adding domperidone, increasing esomeprazole or moving to another brand. Likewise, a patient who no longer needs the combination must be able to leave it without losing access to clinic follow-up.

THE INTEGRATED ADVANTAGE IS CONTINUITY ACROSS A CLINICAL DECISION

A clinician may continue standalone therapy, stop unnecessary treatment, investigate another cause, or prescribe a label-appropriate alternative. A patient receiving the combination may later need acid suppression without domperidone. Keep the same clinic record and review history through those decisions; change the medicine instructions only after a new clinical authorisation.

SCOPE

The core service covers adult outpatient oral esomeprazole and adult esomeprazole–domperidone use selected by a doctor. Standard 20/40 mg standalone products and the common 20/30 or 40/30 mg combinations provide the initial operating scope. Exact approved product information governs each presentation.

Paediatric treatment, hospital IV use, Helicobacter pylori eradication regimens, high-dose or specialised release regimens, and combinations with itopride or levosulpiride require separate approved modules. Their existence does not justify importing their instructions into these two pathways. [4,5]

Positioning: Help the clinic make the right treatment decision executable. Earn brand preference through that usefulness; do not make continued drug exposure the definition of success.

WHERE COMMERCIAL VALUE AND PATIENT CARE DIVERGE

A BRAND CAN WIN THE PRESCRIPTION AND LOSE THE EPISODE

Moment that matters	Standalone problem	Additional combination problem
Assessment	“Acidity” may conceal another diagnosis or an alarm symptom.	A combination can be selected before the reason for adding domperidone is established.
Treatment selection	A familiar PPI is prescribed without an explicit purpose or review date.	Two medicines are treated as a single routine acid-control choice.
Dispensing	Different strength, product or availability changes what the patient receives.	The patient may not realise the capsule also contains domperidone.
Early use	Timing, missed doses and premature expectations can produce apparent failure.	Other antiemetics or interacting medicines may be added without review.
Symptom review	Partial response becomes an informal switch or repeat prescription.	Persisting reflux can be mistaken for a reason to continue both ingredients.
Continuation	Relief leads either to early abandonment or indefinite self-repeat.	The need for domperidone is not reassessed separately from acid suppression.
Recurrence	The patient restarts an old prescription or returns to a different provider.	An old combination is reused despite new medicines or changed cardiac risk.

THE PATIENT PROBLEM

Patients need a clear answer to four practical questions: what am I taking, how should I use it, what should make me seek help, and when will the doctor decide what comes next? A general acidity leaflet does not close those gaps.

THE CLINIC PROBLEM

A busy clinic cannot manually chase every patient. It needs short, structured checks, a manageable exception queue and a recorded decision. A tool that creates unowned alerts simply moves the workload.

THE COMMERCIAL PROBLEM

Conventional reporting rarely separates intended brand, product actually received, correct execution and clinically justified continuation. Without those distinctions, a sales increase may reflect channel inventory, longer exposure or genuine competitive gain. The playbook measures them separately.



THE INTEGRATED ACID CONTROL AND REVIEW PATHWAY

The clinic owns the journey. The service continues wherever the patient needs to act. The Acid-Control & Review Pathway connects a doctor-selected treatment plan with what happens at the pharmacy, at home and at the next decision. Clinic-based explanation is the entry point. The competitive opportunity lies in helping patients execute the plan and helping the clinic recognise when it needs to intervene.

Component	Specific job	When it earns its place
Patient education	Explain the prescribed plan, correct use, expectations and when to seek help through a clinic-branded sheet, short video or audio.	A patient needs to understand or carry out a concrete action.
Episodic digital check-in	Ask a few questions at a useful treatment or review point; route meaningful answers to the clinic.	An answer can uncover an execution problem or inform a scheduled decision.
Review and re-entry	Prepare a short review summary; record the doctor's decision; offer a route back if symptoms recur.	A course ends, symptoms persist, treatment changes or the patient seeks help again.
Doctor education	Monthly academy-certified short PDFs and expert videos reinforce decisions and interpretation.	The clinic needs a better clinical or operational response to the issues surfaced.

The patient experience : After consultation, the patient receives a clinic QR or consented WhatsApp/SMS link. The landing page shows My plan, How to use it, My review date and Get help. It works without an app download. Paper, staff-assisted and consented caregiver routes remain available. The same link can provide education alone or an agreed sequence of checks; enrolment does not automatically activate every module.

The clinic experience : The clinic sets the indication, exact product instructions, review date and follow-up mode. Staff see an exception queue and a concise review summary, rather than every routine answer. The doctor decides whether to continue, change, investigate or stop. A factual record of the prescribed brand supports prescription continuity; the patient service remains clinic-branded and non-promotional.

The competitive mechanism : Useful education can reduce avoidable confusion; a well-timed check can expose a problem before it becomes silent abandonment; review and recurrence re-entry can preserve the clinic relationship. Those mechanisms create a reason for professional brand preference. Their effect on brand share must be demonstrated in the pilot, not assumed from engagement counts.

One service, variable intensity: select the smallest set of modules that solves the identified problem. Access remains available if the doctor changes the medicine or brand.

CHOOSE SUPPORT ACCORDING TO THE EPISODE

A check-in is justified by the decision it supports, not by the availability of a messaging platform.

Patient situation	Useful support	Boundary
New standalone course with unclear use or a likely follow-up gap	Targeted start education; optional early execution check; reminder and summary for the planned review.	No daily symptom diary unless the doctor identifies a reason.
Straightforward episode with clear instructions and dependable follow-up	Brief education and the agreed review information may be sufficient.	Do not add a digital sequence merely to increase enrolments.
Selected esomeprazole plus domperidone use	Two-ingredient education, an early safety/use check where feasible and a separately recorded domperidone review.	Digital answers do not replace initial clinical screening or authorise renewal.
Persistent or recurring symptoms	Patient-initiated contact and structured review preparation: symptoms, use and new medicines.	No automatic diagnosis, escalation or repeat of the old prescription.
Clinician-confirmed ongoing standalone treatment	A reminder aligned to the actual review plan; selected periodic checks if they can inform care.	No default monthly surveillance or indefinite adherence campaign.
Closed episode with no further clinical follow-up need	Clear closure message and instructions for returning if needed.	Stop scheduled prompts; retain only data justified by the approved policy.



Three tests before enabling a module

- Name the problem: for example, uncertainty about administration, missed review or recurrence managed through an old prescription.
- Name the next action: a corrected instruction, staff contact, earlier assessment or a doctor's continuation decision.
- Name the owner: someone in the clinic must receive and act on relevant responses within its stated service hours.

If a module fails these tests, leave it out. If the clinic already has an effective follow-up channel, integrate with that process rather than creating duplicate messages. Where a patient cannot use the digital channel, preserve the same review purpose through the clinic's existing route.

Recommended starting point : a short episode-based pathway for selected new courses and combination reviews. Add maintenance follow-up only for a documented continuing indication and a clinician-defined review plan. This is a proposed service design, not a universal treatment schedule.

PATIENT EDUCATION TIED TO THE NEXT ACTION

Education should resolve a practical uncertainty at the moment the patient needs to act.

Moment and uncertainty	Education asset	Action to reinforce
Starting: "What am I taking and how?"	One-page clinic plan plus an optional 60-90 second video or audio explanation in the preferred language.	Follow the exact prescribed directions and identify the review date.
Using: "It has not worked yet"	Short explanation of the doctor's expected response and how to raise a concern.	Check use and contact the clinic rather than self-escalating or casually switching.
Daily habits: "What should I change?"	A small, personalised set of clinician-approved habits such as meal timing or relevant triggers.	Choose feasible actions; avoid sweeping food bans. [15]
Combination: "Is this just an acidity capsule?"	Clear two-ingredient explanation, duplicate-domperidone warning and safety contact instructions.	Report new medicines and keep the early review. [6,12]
Review: "I feel better, so why return?"	Brief explanation of the next treatment decision and what information to bring.	Attend or complete the agreed review even if improved.
After a doctor-led stop: "Symptoms have returned"	Clinician-approved recurrence and rebound explanation, where relevant.	Use the return-to-clinic route rather than restarting an old combination. [17]

Delivery that follows the patient home : The clinic link keeps the plan and selected education available after the visit. Send only the relevant asset at the agreed moment. Use medically reviewed English, Hindi, Marathi, Tamil, Telugu, Kannada, Malayalam or Bengali versions according to need; offer audio or a consented caregiver route when useful. The patient does not have to watch a video to access care or report a problem.

CHECK UNDERSTANDING ONCE AND USE THE ANSWER

Ask: “When did your doctor ask you to take this medicine?” and “When is your next review?” A wrong or uncertain answer triggers the approved instruction or clinic clarification. Repeat the relevant explanation, not the whole content library. Use the exact local product label; different release presentations may need different instructions. [16]

MAKE URGENT ADVICE EASY TO FIND

Severe chest pain, fainting, vomiting blood or black stools require urgent medical assessment. Swallowing difficulty, unexplained weight loss or persistent vomiting require prompt clinical review. Put the help route before the questionnaire, with clinic hours and out-of-hours instructions. Education must never encourage someone to wait for a digital reply. [6,15,20]

Proof of usefulness: understanding of the prescribed plan and fewer unresolved use problems. Opens and video views measure reach; they do not establish understanding, adherence or improved clinical outcomes.







STANDALONE SUPPORT THROUGH A DEFINED EPISODE

Use a small number of purposeful contacts between the prescription and the next treatment decision. At initiation, the doctor records the indication, exact regimen and review date. For conventional GERD treatment, guidelines support PPI administration before a meal; the medical team reconciles the exact product directions. Gastric protection, erosive disease and other indications need their own review logic. [15,16]

Point in the episode	What the patient is asked or given	What happens next
Start at the consultation	Clinic plan; relevant education; baseline symptom pattern; agreed contact preferences.	Doctor selects education alone or a defined follow-up sequence.
Optional early check around day 3–7	Obtained and started? Timing clear? Any missed doses, different product, new medicine or concerning symptom?	Clarify instructions or route an exception. Skip if another clinic contact already covers it.
Optional response check at 10 to 14 days	Better, unchanged or worse? Days with heartburn, nights disturbed, regurgitation and interference with normal activity; execution difficulties.	Send a brief summary to the clinic when the answer may change review timing or preparation.
The prescribed review date	Reminder and a short summary of use, symptom change and unresolved concerns.	Doctor records continuation, change, investigation or stop.
After the decision	Updated plan or episode-closure instructions; route back if symptoms recur.	Cancel obsolete prompts. Further follow-up needs a new defined purpose.

Illustrative check-in text : “This is your clinic checking how the prescribed plan is going. Have you started it, are the instructions clear, and is anything making it difficult to follow? Tell us if you received a different product or started another medicine. For urgent symptoms, use the emergency advice on this page.”

The review remains clinical : An uncomplicated empirical GERD course may use a clinician-set review within a 4–8 week window; that is not a rule for every indication. Earlier review depends on symptoms and risk. The service records patient reports without producing a diagnostic score or declaring treatment failure. [15,17]

Standalone safeguards : check interacting medicines, including contraindicated nelfinavir; flag clopidogrel without advising the patient to stop it. High-dose methotrexate, warfarin, digoxin and tacrolimus may need specific management. Pregnancy and significant liver disease require clinical assessment. [16]

All digital intervals above are configurable service examples. The objective is a completed, appropriate treatment decision - not more contacts or longer exposure.

COMBINATION SELECTION BEFORE ACTIVATION

ESOMEPRAZOLE PLUS DOMPERIDONE NEEDS A REASON FOR BOTH INGREDIENTS

The Indian indication and the evidence tension : CDSCO's approval list records the 20/30 mg and 40/30 mg sustained-release combinations for adult GERD not responding to esomeprazole alone. Current publicly available Indian product information also describes that indication. This is not a licence to add domperidone for every complaint of acidity, fullness or belching. [6,12,18]

ACG guidance recommends against routine prokinetic treatment of GERD unless gastroparesis is objectively demonstrated. The playbook therefore acknowledges a difference between the Indian labelled indication and international guideline recommendations. A qualified doctor must assess the individual case; the programme must not represent the FDC as universally guideline-preferred. [15]

THE ACTIVATION RECORD

Gate	What must be documented
Adult and indication	Adult patient; relevant GERD diagnosis and reason for choosing this combination under the exact Indian label.
Prior treatment review	What esomeprazole regimen was tried, whether administration and adherence were checked, and why the response is inadequate. No algorithm-defined "failure".
Benefit sought	The symptom or clinical problem the doctor expects the added ingredient to address.
Safety review	Complete medicine reconciliation and contraindication review, with further tests when clinically indicated.
Time boundary	Prescription end or reassessment date and a separately visible domperidone decision.
Patient understanding	The patient knows this is a two-ingredient medicine and should not add another domperidone-containing product.

When to leave the enrolment screen : Alarm symptoms, uncertain diagnosis, an unresolved interaction or a contraindication require clinical resolution. They cannot be cleared by a sales representative, a patient checkbox or a workflow disclaimer. Persistent symptoms despite correct treatment may need investigation rather than another combination.

Commercial boundary : Combination strategy competes for the appropriate subset of patients. Expanding that subset by weakening selection would undermine both medical credibility and the claimed workflow advantage.

DOMPERIDONE SAFEGUARDS

A NORMAL SALES RESULT CANNOT COMPENSATE FOR AN UNSAFE ACTIVATION.

Safety domain	Clinic rule before and during treatment
Cardiac and electrolyte risk	Review known QT prolongation, bradycardia, heart failure or other relevant cardiac disease, unexplained syncope and significant electrolyte disturbance. Contraindications must block activation. [6,12]
Interactions	Check all prescribed, OTC and recently started medicines for QT effects and CYP3A4 inhibition. Examples needing specific review include clarithromycin, erythromycin, systemic azoles and selected antiarrhythmics, antidepressants and antipsychotics. [6,19]
Dose accumulation	Reconcile total domperidone from every product. A common 30 mg SR capsule already provides 30 mg; twice-daily use would provide 60 mg. The service must not suggest this escalation. [6,19]
Other contraindications	Check moderate/severe hepatic impairment, prolactinoma and situations in which stimulating gut motility is harmful, including obstruction, perforation or GI bleeding. [12]
Higher-risk situations	Age over 60 increases concern; severe renal impairment can require special dosing review. Pregnancy and breastfeeding need individual clinical assessment. A fixed combination may not allow the required adjustment. [12,19]
Monitoring and escalation	Doctor decides on ECG and potassium/magnesium assessment where indicated. A normal ECG does not cancel a contraindicated interaction. New medicines require a fresh check.

Do not confuse international restrictions with Indian law : European and UK regulators restrict oral domperidone to nausea/vomiting, generally no more than 30 mg daily and usually no longer than one week, using the lowest effective dose for the shortest time. These are international safety benchmarks, not a statement that the Indian FDC indication has been withdrawn. [19,20]

Immediate symptoms need immediate action : New fainting, a rapid or irregular heartbeat, or concerning chest symptoms require urgent medical assessment. Patient material must direct the person to emergency care when appropriate, rather than asking them to wait for an app response. Suspected arrhythmia requires urgent clinician review of domperidone, including stopping it where indicated. [20]

Protocol control: Default to an early clinician review no later than day 7 for combination enrolments, or sooner if the prescription ends earlier. This is a proposed conservative service rule; continuation requires a documented doctor decision and an approved local protocol. It is not an automated seven-day prescription.

THE REVIEW MUST CHANGE WHAT HAPPENS NEXT

THE PROGRAMME IS INCOMPLETE UNTIL THE CLINIC RECORDS A DECISION.

Review finding	Required clinical decision route
Symptoms improved	Confirm indication and tolerability. Doctor chooses continuation, reduction, on-demand use or withdrawal where appropriate. Improvement alone does not authorise a repeat.
Symptoms persist	Check what was taken, timing, adherence and new medicines; assess diagnosis and need for investigation. Do not auto-add a prokinetic or infer brand failure.
Combination benefit no longer justified	Doctor reviews stopping domperidone. If acid suppression remains appropriate, issue a separate authorised standalone plan; do not simply renew the FDC.
Ongoing combination selected	Document reason, reassessed risks and next review. Keep this visible as a medical exception requiring review, not a commercial retention win.
Alarm or adverse symptoms	Use urgent or routine pathways according to clinical severity; complete adverse-event reporting through the approved process.
Patient does not respond	Attempt the consented reminder and staff follow-up; mark outcome unknown. Never code a non-response as symptom resolution or adherence.

Protect necessary long-term treatment : AGA advice supports regular indication review and consideration of deprescribing when there is no continuing indication. Severe erosive disease, peptic stricture, Barrett's oesophagus and high upper-GI bleeding risk are examples requiring caution against routine withdrawal. The decision should be based on clinical need, not fear generated by observational associations. [17]

Prepare patients for an authorised step down : Explain that temporary rebound symptoms can occur after stopping long-term acid suppression. The doctor supplies a plan for managing recurrence and when to return. The platform must not automatically restart a PPI, restore the combination or send a refill promotion. [17]

Keep both decisions visible : For a combination patient, record "Does acid suppression remain indicated?" and "Does domperidone remain indicated?" as separate clinician decisions. This is the defining feature of the integrated pathway. A shared patient journey should make separation easier, not hide it.

RECURRENCE AND MAINTENANCE NEED DIFFERENT FOLLOW UP

A return of symptoms is a new clinical question. Continued treatment is a separate documented decision.

Recurrence after an episode has closed : Leave the patient with a clear clinic contact route and instructions about when to use it. A patient-initiated “Symptoms have returned” check can capture when symptoms returned, their pattern, medicines currently used and whether the old prescription was restarted. This prepares the consultation; it does not diagnose recurrent GERD or recommend esomeprazole.

If the doctor expects a particular follow-up need after stopping or changing therapy, schedule one defined check at that time. Otherwise, keep the return route available and stop routine prompts. Temporary rebound symptoms can follow withdrawal of long-term PPI treatment; the clinic must distinguish that possibility from persistent disease or another diagnosis. [17]

Ongoing standalone treatment : For a documented continuing indication, align follow-up to the doctor’s review plan. A pre-review check can ask about current use, symptom control, new medicines and outstanding clinician-ordered investigations. Stable patients may need only the review reminder. Routine monthly questionnaires are not the default.

Situation	Useful contact	Required endpoint
Patient reports recurrence	Short patient-initiated history and clinic contact option.	Clinical reassessment or appointment advice.
Doctor has planned a post-change check	One check at the specified point; capture the agreed concerns.	Record the review and close or revise the plan.
Continuing standalone indication	Review-linked reminder; optional brief check where clinically useful.	Confirm indication and next review date.
Combination is stopped but acid suppression continues	Explain the new authorised plan and update the patient link.	Remove obsolete combination instructions and reminders.
Patient has completed the episode	Closure message, help instructions and communication preferences.	No automatic refill, restart or recurring survey.

A USEFUL RECURRENCE MESSAGE

“If symptoms return, contact your clinic using this link and tell us when they returned and what medicines you are now taking. Do not restart an old combination prescription without checking. Seek urgent care for the warning symptoms shown here.”

Competitive role : retain a useful relationship with the clinic across treatment decisions. The commercial opportunity is appropriate future preference and clinic re-entry, not keeping every patient continuously on treatment.

MAKE DIGITAL ANSWERS LEAD TO ACTION

A CHECK-IN HAS VALUE ONLY WHEN THE PATIENT AND CLINIC KNOW WHAT HAPPENS NEXT.

Response or event	Patient-facing action	Clinic action
Instructions unclear or product differs	Show the recorded plan and a contact route; avoid declaring a supplied brand inferior.	Staff reconcile with the prescription and pharmacist; doctor resolves treatment changes.
Persistent or worsening symptoms without an immediate alarm	Acknowledge and explain how the clinic will respond.	Review symptom trajectory, actual use and need for earlier assessment.
New medicine during combination use	Prompt contact and collect the medicine name where possible.	Clinician or pharmacist checks interaction risk; the software does not clear the combination.
Serious warning symptom	Immediate advice to seek urgent care; no need to finish the survey.	Urgent escalation and safety reporting through the approved route.
Review is due	One agreed reminder and the relevant preparation questions.	Record the doctor's decision, not merely a message-delivered status.
No response or opt-out	For non-response, one agreed reminder. Stop routine messages on opt-out.	Record outcome unknown. Any further contact follows the clinic's risk-based protocol.

The combination has a shorter decision loop : Where a digital route is useful, an early contact can ask about duplicate domperidone, new medicines and concerning symptoms. It supports the separate clinician review described in the safety section. If the patient cannot respond digitally, arrange that review through another clinic channel. A completed questionnaire is never clearance to continue the combination.

The minimum review summary : Show the recorded indication and regimen; symptom baseline and latest report; understanding or execution gaps; product mismatch; new medicines; flags; and review due date. The doctor selects the next action and records a revised plan. Staff see only the information needed for their role; the field force does not see patient-level responses.

Make the process reliable before scaling it : Configure clinic name, languages, hours, alert owner and deputy, consent, product instructions and escalation rules. Use a secure link and a neutral notification on shared phones. Show an immediate acknowledgement without implying that a clinician has reviewed the answer. Display realistic response hours and a telephone fallback.

Minimum standard: no unattended alert queue, duplicate reminder stream or silent auto-renewal. Test the whole sequence - from the patient's answer to a recorded clinic action - before enrolling patients.

LEADER STRATEGIES FOR BOTH PATHWAYS

DEFEND LEADERSHIP BY MAKING THE CLINIC'S WORK EASIER BEFORE ANOTHER BRAND DOES.



STANDALONE LEADER DEFENCE

Attack surface : A large prescriber base can conceal weak dispensing continuity and poor review completion. Familiarity makes the brand easy to remember, but does not make it operationally useful.

Prioritise existing prescribers where patients misunderstand the plan or miss review. Establish the clinic's take-home education and review route first; enable episodic digital checks where they can expose those gaps. For appropriate maintenance patients, link contact to the doctor's review plan. Maintain availability so the intended prescription can be supplied.

Protect clinically appropriate maintenance relationships through recorded review dates and clear plans. Where the doctor chooses to stop, close the episode. The defence is the clinic's confidence in the process, not a mechanism that makes patients stay on the molecule.

Proof : Less avoidable dispensing mismatch; more completed reviews; sustained clinic reuse; and better standalone share versus matched clinics. Separate these effects from trade stocking and increased call intensity.



COMBINATION LEADER DEFENCE

Attack surface : Historical scale is vulnerable if a challenger makes selection and safety review the standard expected by doctors. An incumbent cannot credibly defend leadership by normalising unreviewed combination repeats.

Make two-ingredient patient understanding, documented screening and an early domperidone decision standard across priority clinics. Use a short digital check when it adds timely information, with a non-digital review route when needed. Preserve the patient's clinic link when the doctor changes to standalone therapy or stops treatment. Leadership should retain trust across that decision.

Proof : High completion of the selection gate and early review; no increase in contraindicated or unsupported starts; sustained clinic reuse; and competitive gains within appropriate combination use. Track the standalone destination separately when the doctor changes therapy.

What the leader must refuse : Do not reward field teams for combination duration, repeat packs without review, or the percentage of reflux patients placed on the FDC. Do not use national share to bypass a matched pilot. Existing scale makes mistakes larger as well as making adoption faster.

Leadership test : If a challenger installed this workflow in your highest-value clinics, would your next molecule presentation be enough to displace it?

CHALLENGER STRATEGIES FOR BOTH PATHWAYS

ATTACK THE INCUMBENT'S SERVICE GAP, THEN PROVE THAT THE CLINIC CHANGES BEHAVIOUR

STANDALONE CHALLENGER ATTACK

Entry point : Clinics where patients return with "the medicine did not work" but the team lacks a reliable record of timing, product received or follow-up. Offer a short clinic workflow demonstration before asking for broad prescribing preference.

Select a manageable cluster with adequate supply and a credible medical team. Demonstrate a patient receiving instructions at home, reporting a use problem and reaching a prepared clinical review. Let the clinic test whether that sequence adds value. Academy education reinforces the interpretation of non-response. Brand selection remains independent, and the service works with another product.

Competitive claim : "We help your clinic see whether the selected plan was followed and whether a review is needed." Do not replace one unsupported superiority claim with another about the service.

Proof : New prescriber adoption and standalone brand share movement versus comparable clinics, supported by documented clinic reuse and dispensing availability. A rising enrolment count with flat share is a useful service result, not yet a competitive win.

COMBINATION CHALLENGER ATTACK

Entry point : Clinics that want to review existing FDC use and manage selected non-responding adults more carefully. Lead with appropriate selection and the separate domperidone decision, not "two actions are better than one".

Demonstrate a realistic sequence: an appropriately selected patient receives the two-ingredient explanation, reports a newly started medicine through the clinic link, and reaches clinical reassessment before continuation. Pair this with the initial safety gate. The service differentiates review quality without portraying another approved brand as intrinsically unsafe.

Offer a time-bounded, medically supervised pilot. Never manufacture a combination indication to generate trial. If most screened patients need standalone therapy or investigation, that is evidence about the clinic segment and should change the commercial plan.

Proof : Appropriate new combination prescribing attributable to independent doctor choice, timely reassessment and a measurable gain against the relevant baseline. Count safe non-activation and clinically appropriate exit in the safety dashboard.



THE CHALLENGER DISCIPLINE

A challenger needs a narrower initial footprint than a leader, a faster feedback cycle and a clear reason for the next doctor visit. Concentrate where use-and-review failures are visible and staff can act. Expand only when the clinic uses the pathway without persistent rep prompting. Attack the missing workflow. Do not attack sound clinical judgement.

SELECTIVE SHARE STRATEGIES FOR BOTH PATHWAYS

A FOCUSED BRAND CAN WIN A CLINIC PROBLEM WITHOUT ATTEMPTING NATIONAL CATEGORY LEADERSHIP

Pathway and wedge	Why it can work	What must be proven
Standalone in one regional physician cluster	Local supply, language and relationships make a simple review workflow easier to embed.	Repeat clinic use and local share gain after adjusting for distribution changes.
Standalone where access or instructions fail	Affordable prescribed options, clear administration and a paper fallback address a visible barrier.	Fewer access failures and reviewed episodes, without claiming one brand is clinically superior.
Standalone continuity after doctor-led FDC exit	A documented standalone plan can preserve the clinic relationship when domperidone is no longer needed.	Clinical justification for the transition; no algorithmic portfolio switching.
Combination in specialist-linked clinics	A narrow group of appropriate adult cases can be served by teams able to assess risks and review early.	Selection quality, complete medicine reconciliation and reliable review ownership.
Combination review in an existing prescriber pocket	A focused brand can improve an existing practice process without building a national sales machine.	Incremental appropriate share and reliable review, with no increase in unreviewed exposure.

Start with one named problem : Choose a geography, prescriber type and service failure that the team can actually address. For example: “adult reflux patients in 30 consultant-physician clinics who frequently miss their planned review.” A segment defined only as “all acid-peptic disease” is too broad for a selective-share strategy.

Match the pathway to delivery capacity : Combination screening and early review need dependable medical and clinic capacity. Begin with the patient problem the team can support completely. A regional-language education module and a single planned review may be sufficient for one standalone segment; a combination segment also needs the separate safety and continuation process.

EXPANSION RULE

Win sustained use in the initial cluster, verify the source of appropriate share movement, and then replicate the same operating method in a neighbouring cluster. Avoid a scattered list of inactive clinics that looks impressive in a launch presentation and produces no useful learning.

Selective-share test: Can the team name the clinic problem, the patient group, the accountable operator and the measurement denominator in one sentence?

MONTHLY ACADEMY CERTIFIED DOCTOR EDUCATION



ONE SHORT PDF AND ONE EXPERT LECTURE EACH MONTH, LINKED TO A CHANGE IN CLINIC PRACTICE

Use an independent, appropriately qualified academy to certify the educational content and completion process. Certification is a launch requirement; no academy affiliation, endorsement or accredited CME credit is claimed until formally agreed. A completion certificate must not be presented as statutory CME credit without the relevant approval.

Month	PDF and expert video topic	Clinic behaviour to reinforce
1	Before calling a PPI ineffective	Verify indication, actual product, timing and adherence; identify alarm symptoms.
2	Who should receive the domperidone combination	Distinguish labelled use from routine add-on prescribing; complete safety review.
3	The review that separates the two ingredients	Record the ongoing need for acid suppression and domperidone separately.
4	Persistent symptoms and diagnostic reassessment	Recognise when further evaluation is needed instead of automatic escalation.
5	Appropriate long-term PPI use and deprescribing	Protect valid maintenance indications; explain clinician-led withdrawal and rebound.
6	Making review work in a busy clinic	Use exception queues, patient language and audit feedback to close episodes.

A REPEATABLE MONTHLY PACKAGE

Each month: a two-page, referenced PDF; an 8–12 minute expert video; one case; five knowledge-check questions; and one clinic action card. Month 2 should include a clinical pharmacologist contribution on interactions. Months 1 and 4 should include gastroenterology expertise. Practical primary-care commentary keeps the service relevant beyond specialists.

EDITORIAL INDEPENDENCE AND CERTIFICATION

The academy owns learning objectives, faculty selection, evidence balance and assessment. Faculty disclose conflicts. The sponsor's medical review verifies accuracy and local-label compliance without turning the module into a disguised brand advertisement. Use a documented pass standard, for example 80%, and permit a repeat attempt.

WHAT THE FIELD FORCE DOES WITH IT

The representative shares the approved doctor module and links it to a patient-journey issue, such as unclear timing, a new medicine or an overdue review. Each month should improve the service as well as inform the doctor. The rep does not interpret an ECG, judge eligibility or answer patient-specific treatment questions. Medical questions go to the medical team.

Measure completed learning and the associated workflow change. Video views alone do not establish learning, clinical quality or prescribing impact.

FIELD FORCE EXECUTION

INSTALL A USEFUL CLINIC ROUTINE AND RETURN WITH A REASON TO IMPROVE IT

Contact	Field action	Proof of completion
First discussion	Identify one patient-journey gap. Demonstrate only the education, check-in and review modules relevant to that gap.	Named clinic problem and an interested clinical owner.
Configuration visit	Set clinic identity, patient assets, selected check-ins, review dates, staff roles and response rules.	Doctor approval, staff training and test alert completed.
First week	Test the patient journey outside the clinic: link delivery, understanding, replies, routed issues and review preparation.	Real use observed with consent; operational faults corrected.
Monthly review	Bring one academy module, one aggregate finding and one agreed workflow improvement.	Action assigned and checked at the next visit.
Day 90 decision	Review patient usefulness, clinic adoption, clinical safeguards and brand movement with medical and business owners.	Scale, modify or stop decision recorded.

The opening conversation : “After you prescribe acid-control treatment, how do you know whether the patient took it correctly and whether it should continue? We can help your clinic make that review easier. For combination patients, the added medicine receives its own safety and continuation check.”

DEFINE THE ROLES BEFORE THE FIRST PATIENT

Doctor : diagnosis, selection, prescription and review decisions. Clinic coordinator: consented enrolment, reminders and routing. Medical team: protocols, training, complex queries and audit. Service operator: reliability, security and queue delivery. Representative: approved education and operational adoption. Brand team: strategy, resources and aggregate performance.

A realistic workload test : Design for a short staff-assisted enrolment and a one-minute patient check, then measure actual time in the pilot. Do not advertise these as proven timings. Limit routine notifications and display only actionable exceptions. Keep a paper option for patients unable or unwilling to use a smartphone.

SUPPLY IS PART OF EXECUTION

Assess ordinary stock availability and affordability in the target locality before launch. Fix legitimate supply failures through normal distribution operations. Do not create pharmacy incentives, exclusive dispensing requirements or clinical pressure to favour the sponsor.

Rep scorecard : Active clinic reuse, trained staff, education completion and resolved operational issues. No score for longer treatment, combination escalation or patient-identifiable prescription capture.

MEASUREMENT THAT SEPARATES CARE FROM SALES

USE EXPLICIT DENOMINATORS AND KEEP THE TWO FORMULATION PATHWAYS SEPARATE

Metric	Operational definition	Interpretation
Active clinic reuse	Clinics with ⩾5 eligible enrolled episodes in each of two consecutive 30-day periods ÷ configured clinics.	Pilot definition; adjust to clinic volume before launch.
Correct use understanding	Respondents able to state the prescribed timing ÷ respondents assessed; also report response coverage.	Understanding proxy, not observed adherence.
Dispensing match	Episodes with confirmed intended product received ÷ episodes with a dispensing response.	Report unknowns and strength/composition mismatches separately.
Review completion	Clinician decisions recorded by the due date plus agreed grace period ÷ episodes due for review.	A reminder click is not a completed review.
Combination safety gate	Combination starts with all required selection and risk fields signed ÷ combination starts.	Documentation measure; audit a sample for clinical quality.
Appropriate episode closure	Due episodes with a recorded decision and next plan ÷ due episodes.	Includes clinically appropriate stop or switch.
Brand share	Index brand units or audited prescriptions ÷ all units or prescriptions in the same defined formulation segment.	Use a consistent source; report standalone and FDC separately.
Safety and privacy	Missed contraindications, overdue serious alerts, suspected events and data incidents.	Review each event; absence of reports does not prove safety.

MEASURE THE VALUE OF THE ADDED CONTACTS

Check-in response rate = valid responses divided by delivered checks. Action yield = reviewed responses leading to a relevant clinic action divided by reviewed responses. Report non-response, opt-outs and action turnaround separately; more alerts are not automatically better care.

THE MAIN COMMERCIAL QUESTION

Does activation improve the brand's performance relative to comparable clinics or territories, while maintaining appropriate selection and review? Prescription share and sales share are different measures. Patient-reported dispensing is a third, incomplete measure. Triangulate them without calling any one a complete market audit.

Measure same-brand continuity only during authorised treatment. Report appropriate stops, switches and transitions separately, with all enrolled episodes in the denominator.

Reporting design: Clinic receives patient-level operational information. Sponsor receives lawful, aggregated analytics with small-cell suppression and no patient re-identification. Commercial audit data should be obtained independently of the care record wherever possible.



PROVE WHICH PART OF THE SERVICE EARNS ITS PLACE

SEPARATE PATIENT USEFULNESS, CLINIC ADOPTION AND COMPETITIVE MOVEMENT

A comparison that tests the added follow up : here feasible, compare matched clinics using the same patient education and doctor education with clinics that also use the selected episodic digital checks. This helps establish whether the extra follow-up adds useful review information or simply generates more messages. If there are too few clinics for that comparison, run a smaller feasibility test and avoid causal claims.

Question	Evidence to examine	Decision
Does patient education resolve a problem?	Understanding of directions and review date; unresolved questions; need for repeat explanation.	Retain, simplify or replace the specific asset.
Does a digital check reveal useful information?	Valid responses, issues found and proportion with a documented relevant clinic action.	Keep checks that change execution or review; remove repetitive low-value contacts.
Does the clinic sustain use?	Repeated use, staff workload, alert completion and reliance on rep prompting.	Adapt the process before widening deployment.
Does recurrence support bring patients back appropriately?	Contact requests followed by an appropriate clinic review; no unauthorised self-restart encouraged.	Preserve the return route without promoting unnecessary medication.
Does brand performance improve?	Formulation-specific share or new prescriber adoption versus the agreed baseline and matched controls.	Scale a competitive strategy only with evidence of appropriate movement.

MEASURE BRAND MOVEMENT SEPARATELY

Use a four-week pre-launch baseline. Match on specialty, geography, baseline volume and share, supply and field activity; randomise by clinic cluster when feasible. Compare the change in activated-clinic share with the change in control-clinic share. Report uncertainty, missing data and external influences such as distribution or promotional changes.

A 90-day operational pilot can establish feasibility and early signals; it may be too small to demonstrate a reliable sales effect. Service data cannot establish comparative drug efficacy. Report standalone and combination results separately, including appropriate movement out of the combination.

Remove what does not help : a check with low response, no actionable findings or excessive follow-up burden should be simplified or retired. Engagement volume alone is not a reason to retain it.

COMPLIANCE AND OPERATING SAFEGUARDS

THE PROGRAMME MUST REMAIN USEFUL WHEN THE DOCTOR CHOOSES A DIFFERENT MEDICINE



CLINICAL AND PROMOTIONAL SEPARATION

Keep clinic education and care messages separate from approved HCP promotion. No public prescription-drug advertising, unsupported superiority claims, inducements tied to prescribing, or conditions that restrict patient choice. Review the programme under UCPMP 2024 as amended and the applicable professional, drug and advertising rules. Sponsoring education does not create an exemption from those requirements. [21]

PRIVACY BY DESIGN

Provide clear consent and purpose notices, communication preferences and an easy withdrawal route. Define fiduciary and processor responsibilities contractually. Apply access controls, encryption, logs, retention limits and incident handling. DPDP Rules 2025 have a phased implementation timetable; legal review must map the obligations in force at actual launch. The design should meet the intended protection standard now. [22]

The sponsor must not acquire a promotional patient list through the service. Identify patients only where needed for clinic care or required safety reporting. Keep identifiers until follow-up is completed under the approved retention policy, then delete or irreversibly de-identify them unless a legitimate clinical or legal retention duty applies. Do not promise a universal deletion period that conflicts with those duties.

ADVERSE EVENTS AND SERVICE RELIABILITY

Define the pharmacovigilance intake route, trained recipient, reconciliation process and applicable reporting timelines. An adverse-event report is not handled solely as a customer-support ticket. Transfer the minimum required information securely to the authorised safety team under the relevant notice and lawful basis.

Use immediate on-screen emergency advice for urgent symptoms, staffed escalation procedures and explicit operating hours. Pilot operational targets should include same-working-day triage of non-emergency safety flags and escalation of unacknowledged flags to a named deputy. These are service targets, not substitutes for emergency care or statutory reporting deadlines.

CONTROL CHANGES AND CONFLICTS

Version every clinical rule, translation and product instruction. Medical, regulatory, legal, privacy and safety owners approve release. Retire obsolete content promptly. Maintain sponsor data separation and disclosure of competing programmes. No rep can override a contraindication or alter a clinical algorithm to improve a sales metric.

Certification boundary : Academy approval concerns education. It does not endorse a brand, establish product superiority or validate the software as a medical device. Assess the software's actual functions and applicable regulatory requirements before deployment.

THE 90 DAY PILOT

MAKE THE DECISION TO SCALE DIFFICULT TO FAKE

Period	Work	Decision output
Days 1-15	Select posture and pathway; identify 60 activation and 60 control clinics; obtain baseline data; agree the selected modules, analysis and measures.	Named owner, bounded cohort and pre-specified measures.
Days 16-30	Approve patient assets and selected check-ins; train staff; test complete response-to-review routing and consent; deliver academy month 1.	Launch gate signed by accountable functions.
Days 31-60	Enrol selected adults; deliver academy month 2; test understanding and useful digital responses; review safety weekly.	Fix workflow failures; pause unsafe sites or modules.
Days 61-90	Deliver academy month 3; assess useful contacts, decisions due, repeated clinic use and controlled brand movement.	Scale, modify or stop with evidence and an operating owner.

CHOOSE A PILOT SIZE THAT CAN ANSWER THE QUESTION

The 60-plus-60 design is an illustrative operational starting point. Obtain statistical input on expected effect, baseline variability and clustering before claiming the sample can prove commercial impact. A 20–30 clinic feasibility test is appropriate for workflow learning but should not be presented as national market validation.

Suggested go or no go thresholds

- At least 70% of configured clinics meet the predefined active-reuse standard during the final assessment period, with declining reliance on rep prompting.
- At least 80% of due episodes have a documented clinical decision; separately report early combination reviews, withdrawals and unknown outcomes.
- Every combination start has completed required safety and selection documentation. Any missed contraindication or serious routing failure triggers immediate review and a pause where needed.
- Commercial movement exceeds the predefined minimum effect versus controls, or the pilot yields a justified extension with a clear unanswered question. A positive point estimate alone is insufficient.
- Each retained patient module solves its named problem. Review unanswered contacts, alert burden and patient opt-outs; simplify or remove checks that add no useful action.

These are proposed pilot targets, not clinical standards or promised results. Lock them before launch and use pathway-specific denominators. Follow every enrolled episode through its due review, even when that falls after day 90; the decision date does not terminate the clinic's responsibility.

EVALUATE BEFORE THE CLINIC HABIT IS ESTABLISHED

THE SAME OPPORTUNITY IS AVAILABLE TO YOUR COMPETITORS. USEFUL EXECUTION IS THE ADVANTAGE TO WIN FIRST.

PPI brands do not lack messages. Clinics lack a consistent way to see whether a selected treatment was used correctly, whether symptoms require reassessment and whether the prescription should continue. That is a practical problem a competitor can solve while another team is still debating its next campaign theme.

FOR A LEADER

Use your existing reach to establish the review routine. If you leave the workflow open, a challenger can become useful inside clinics where your brand is already familiar.

FOR A CHALLENGER

Give the clinic a reason to test a different relationship. Prove that the service improves execution and that brand performance moves with it. A sharper claim without a changed workflow is still the old contest.

FOR A SELECTIVE-SHARE BRAND

Pick the problem you can serve completely. A small cluster that repeatedly uses a dependable pathway is more defensible than a national launch with no follow-through.

The decision for the next brand review : Within the next 30 days, convene brand, medical and sales leadership for a focused Acid-Control & Review Diagnostic. Bring the latest pathway-specific market data and a shortlist of clinics. Leave with five decisions: the competitive posture, the clinic problem, the formulation scope, the accountable medical owner and the 90-day proof standard.

Decide whether to defend, attack or focus before another team establishes the routine your clinics choose to use. Delaying that evaluation is itself a competitive choice.

FIRST MOVER URGENCY WITHOUT INVENTED SCARCITY

Inditech is presenting this integrated opportunity across major competing brand teams. Early execution can generate clinic learning and operating experience. It does not create guaranteed exclusivity, prevent doctors from joining another programme or justify withholding neutral clinical education. Any real capacity limits or non-overlapping pilot arrangements must be disclosed and agreed explicitly. The durable advantage is a patient journey that remains useful after the visit and brings the right questions back to the doctor. Evaluate it before a competing brand team establishes that relationship in your priority clinics.



Market-facing strategic playbook. Clinical content and deployment assets require formal review before field use. No individual company proposal or product endorsement is implied.

SOURCES AND EVIDENCE NOTES

[1] NPPA price computation worksheet 19(4278)/2024/DP/NPPA/DIV.II
March 2024 MAT dataset; esomeprazole 40 mg plus domperidone 30 mg. Publicly indexed copy of the regulator's worksheet. Pages 1–2 contain the table used; calculations are rounded to two decimal crore. Historical sales benchmark, not current audited revenue.

[2] Garje and colleagues 2026 Indian PPI utilisation study
Drugs Real World Outcomes 13:513–524. Four-clinic retrospective EMR analysis; 687 adults; 2017–2020 data. Sun Pharma funded; publication date does not make the underlying prescribing observations current.

[3] Shukla and colleagues 2025 domperidone PPI prescribing audit
Indian Journal of Pharmacology. DOI 10.4103/ijp.ijp_744_23. Thirteen tertiary centres and 8,839 outpatient prescriptions. Sample percentages are not national prescription or revenue shares.

[4] Sun Pharmaceutical Industries India product catalogue
Primary product identity source for Sompraz, Sompraz D, Raciper and Raciper D; catalogue also distinguishes other combinations and IV presentations. No efficacy inference is drawn from the listing.

[5] Torrent Pharmaceuticals India product information catalogue
Primary catalogue for Nexpro standalone, release variants, RD, IV and other combinations. Product-specific instructions require the approved version applicable at launch.

[6] Torrent Nexpro RD full prescribing information
Public full PI, revision February 2022, reviewed for composition, adult indication and safety sections. The public abbreviated PI contains inconsistencies; it must not be used to populate dosing rules. Obtain the current reconciled approved PI from the sponsor before deployment.

[7] Tata 1mg Esomac 40 product listing
Current retail identity and composition check only. Page updated September 2026. Not a source for treatment recommendations or nationwide availability.

[8] Tata 1mg Esomac D 40 product listing
Current retail identity check for Cipla and the 40 mg esomeprazole / 30 mg domperidone presentation; clinical retail claims are not adopted.

SOURCES FOR MARKET AND CLINICAL BOUNDARIES

[9] Pfizer and Cipla stock exchange disclosure 19 December 2025
Primary company announcement of exclusive marketing and distribution arrangements including Neksium; Pfizer continues manufacture, sourcing and supply. Confirm specific SKU responsibilities before outreach or programme deployment.

[10] Neksium current product listings
Neksium D 40/30 mg listing. Standalone Neksium also listed at https://www.1mg.com/drugs/Neksium-Tablet-793879. Catalogue company fields can lag commercial agreements; source 9 governs the partnership description.

[11] Integrace Health Esoz product page
Primary source for current company/product identity and oral strengths. Promotional superiority language on the page is not adopted.

[12] Zuventus Zosa DSR product information
Indian 40/30 mg product information; leaflet revision September 2024. Used for indication, contraindications and special population considerations; not to generalise every brand's approved directions.

[13] Zuventus revised product price list September 2025
Used only to confirm standalone Zosa tablet listing. No claim that the listed historical price is the current MRP.

[14] Torrent Pharmaceuticals annual reports
FY2024–25 gastrointestinal portfolio discussion provides the dated Nexpro rank and PCAB launch signal. FY2025–26 report at https://www.torrentpharma.com/pdf/investors/AR-2025-26.pdf continues to identify Nexpro among key GI brands but does not supply a clean current formulation-specific market total used here.

[15] ACG Clinical Guideline for GERD 2022
Katz and colleagues, American Journal of Gastroenterology 117:27–56. Supports administration optimisation, appropriate evaluation and the restriction against routine prokinetics absent objective gastroparesis. International guidance; not an Indian marketing authorisation.

[16] Torrent Nexpro 20 and 40 full prescribing information
Indian product-specific reference for standalone administration and interaction review. Clinician instructions and product labelling must be reconciled rather than replacing the label with a universal software rule.

SOURCES FOR REVIEW SAFETY AND GOVERNANCE

[17] AGA Clinical Practice Update on PPI deprescribing 2022
Primary society summary of Targownik, Fisher and Saini; DOI 10.1053/j.gastro.2021.12.247. Supports indication review, protecting necessary treatment and explaining rebound symptoms.

[18] CDSCO historical fixed dose combination approvals
Entry 418 records esomeprazole 20/40 mg plus domperidone 30 mg SR, approved 1 June 2004, for adult GERD not responding to esomeprazole alone. A historical approval list does not replace the current brand-specific licence and PI.

[19] European Medicines Agency domperidone restrictions
Primary regulator review of cardiac risk, higher-risk groups, interactions and EU dose/duration restrictions. International safety benchmark, not an assertion of Indian withdrawal or identical national labelling.

[20] MHRA domperidone cardiac safety update
UK Drug Safety Update; includes December 2019 paediatric update. Used for urgent heart-symptom advice and reassessment principles; the playbook's core combination pathway is adult-only.

[21] Department of Pharmaceuticals UCPMP and amendments
Official code and September 2025 amendment index. July 2026 government confirmation: https://www.pib.gov.in/PressReleasePage.aspx?PRID=2288768&lang=1&reg=3. Apply the current provisions to the final programme and educational arrangements.

[22] Government notification summary for DPDP Rules 2025
MeitY release dated 14 November 2025 describes notification and an 18-month phased compliance period. Confirm the relevant commencement dates and actual obligations against the Act, Rules and notifications at launch.

How to read this playbook : Historical market data, current product evidence, clinical guidance and proposed operating choices are labelled separately. Workflow timing, targets, sample sizes and the competitive effect of the service are design assumptions to test. They are not established treatment standards, accredited education claims or forecasts.

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STRATEGIC OPPORTUNITY & CTA

The decision for an esomeprazole brand team is simple: Will you remain another brand competing on potency, speed and formulation breadth, or become the brand that helps clinics turn every appropriate prescription into a clearly understood, properly executed and clinically reviewed treatment episode?

Esomeprazole doesn't need another acidity or acid-control campaign. It needs a brand that owns the prescription-to-review pathway - helping clinics support correct use, identify dispensing and execution gaps, address unresolved symptoms, and bring patients back for the right clinical decision. For standalone esomeprazole, the focus is appropriate use and continuity; for esomeprazole plus domperidone, it is appropriate selection, safety and timely reassessment.

Old rule: Win the prescription.
New rule: Own the treatment episode that follows it.

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The next winning esomeprazole brand will become the clinic's Acid-Control & Review partner—connecting patient education, selected follow-up, doctor-led review and appropriate re-entry, while keeping standalone and combination treatment decisions clinically distinct.

The opportunity is to make a useful clinic routine - not another molecule claim or repeat-prescription campaign - he reason doctors choose to work with your brand.

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 Esomeprazole Acid-Control & Review Diagnostic and identify your brand's competitive posture, priority formulation pathway, highest-value clinic workflow gap, accountable medical owner, and a focused 90-day pilot.





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