

Playing to WIN in the *Dynamic Market*

Issues and Considerations for Enhanced Commercial Effectiveness

Change is in the air. As budgets contract and traditional sales models lose steam, pharmaceutical sales and marketing organizations are under increasing pressure to evolve – and often to accomplish more with tighter resources. But practical, productive change doesn't pop out of thin air. It has to be grounded in a new way of understanding the market.

For years, pharmaceutical companies have relied on two metrics, total prescriptions and new prescriptions, to measure their brands' potential and performance. Historically, these were the best available metrics to quantify and model activity at a prescriber level. We have always known but accepted that traditional prescriptions yield a fairly limited, one-dimensional perspective of complex market dynamics – and very few new insights to help the industry cope with current challenges. Fortunately, the availability and robustness of anonymized patient-level data (APLD) have increased in recent years, allowing pharmaceutical companies to isolate the prescriptions that matter most – new-to-brand prescriptions – and gain a multidimensional view of their markets. Now, we can better identify which promotional efforts are successfully growing our brands and which are just depleting our budgets.

New research conducted by IMS reveals that in chronic markets, traditional promotion can influence only about 10% of prescriptions. This dynamic market – composed of new-to-brand prescriptions – is driven by only a third of patients in a given year, and half of these prescriptions may be written by as few as 5% of prescribers. On October 1, 2008, *Pharmaceutical Executive* and IMS conducted a live webcast that outlined the results of this research and its implications for the use of APLD in commercial applications. This summary will describe how professionals in marketing, sales and managed markets can maximize the impact of their efforts and resources by zeroing in on the small proportion of physicians who are actually driving growth.

NOT ALL PRESCRIPTIONS ARE CREATED EQUAL

The dynamic market is composed of new-to-brand prescriptions (including new-to-therapy, switches and add-ons), whereas the static market consists of continuing prescriptions (refills and repeat prescriptions). IMS research indicates that while the static market accounts for the bulk of prescriptions overall, it is extremely resistant to promotional influence. Most efforts targeting the static market aim to improve patient compliance and persistence, but traditional methods of promotion tend to have limited success in influencing these behaviors.

The dynamic market, on the other hand, is where pharmaceutical marketing and sales departments have the best chance to make a significant impact on prescribing. Because the dynamic market is the source of growth in the static market, isolating the new-to-brand performance (NBRx) of a product and its competitors allows companies to see how brands

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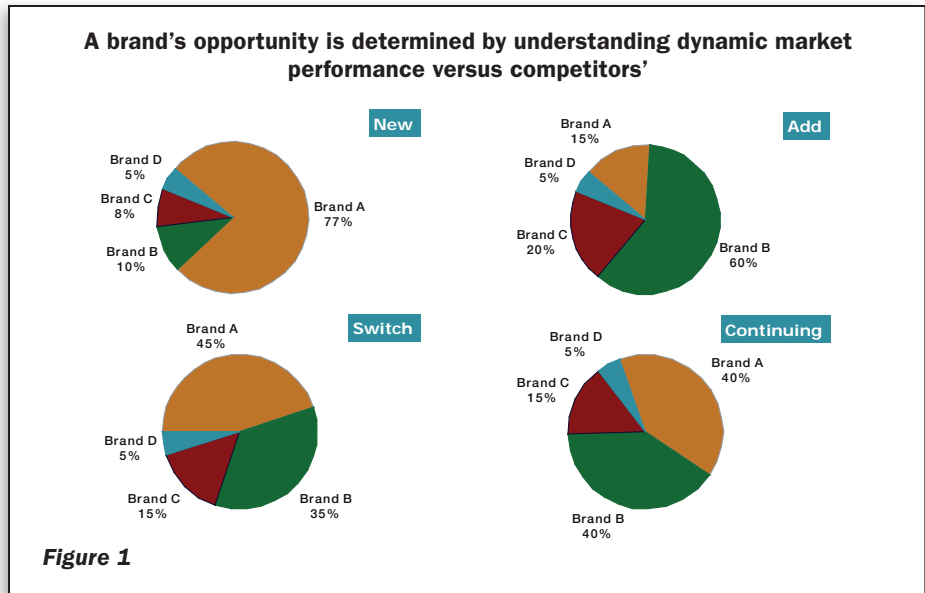
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None of the activities we're suggesting are *new activities*. What we're proposing is that companies do them with a *new lens* focused on the market-driving prescribers and new-to-brand prescriptions – the information that helps you identify and isolate the business that is most important to you.

—Lisa Morris, director of Global Anonymized Patient-Level Data Services for IMS

* While IMS chose to focus the Brand Excellence study on chronic markets, where anonymized patient-level data tend to have the greatest impact, this type of analysis can yield similar insights for the acute care arena as well.



and markets are built over time and identify opportunities for growth. For example, Figure 1 shows the performance of four brands broken out by new-to-therapy, add-on, switch and continuing prescriptions. Brand A appears to be on the right track, with a high percentage of both new therapy starts and switches. But if Brand B has a first-line indication, a change in strategy may be in order, as it seems to be reserved for add-on therapy and a relatively small percentage of switches.

Shifting the focus to the dynamic market can guide companies as they evaluate their approaches to key aspects of commercialization:

Prescriber segmentation: Identify market-driving prescribers (those making active therapy decisions) for more precise segmentation.

Field force allocation: Focus on market-driving prescribers who are more responsive to field force contacts.

Promotion allocation: Improve return on investment by allocating promotional resources to market-driving prescribers.

Market access: Maximize product uptake by capitalizing on pull-through opportunities.

Field force effectiveness: Optimize field force effectiveness by

connecting their activities with the overall brand strategy.

“None of the activities we’re suggesting are *new activities*,” says Lisa Morris, director of Global Anonymized Patient-Level Data Services for IMS. “What we’re proposing is that companies do them with a *new lens* focused on the market-driving prescribers and new-to-brand prescriptions – the information that helps you identify and isolate the business that is most important to you.”

MAPPING THE DYNAMIC MARKET

IMS recently conducted a retrospective analysis of 10 chronic retail markets* that confirms the importance of the dynamic market in refocusing and refining pharmaceutical marketing and sales strategies. The IMS Brand Excellence™ study was based on data from the third quarter of 2007 to the second quarter of 2008 and included more than 50 brands in a diverse group of markets:

- Cholesterol
- Proton pump inhibitors
- Hypertension
- Antipsychotics
- Diabetes
- Antidepressants
- Osteoporosis
- Overactive bladder

- Benign prostatic hypertrophy
- Alzheimer's

The analysis yielded a number of new insights with major implications for pharmaceutical sales and marketing. For example, the study found that across those 10 chronic disease areas, the dynamic market contributes only 10% of total prescription volume – ranging from approximately 5% of diabetes prescriptions to 15% of overactive bladder prescriptions – while the static market accounts for 90%. It is possible for the dynamic portion of the market to increase, but it usually takes a drastic shift in circumstances, such as the entrance of a new drug that alters the treatment paradigm, the release of compelling new clinical research, a major drug withdrawal or a significant change in promotional activity.

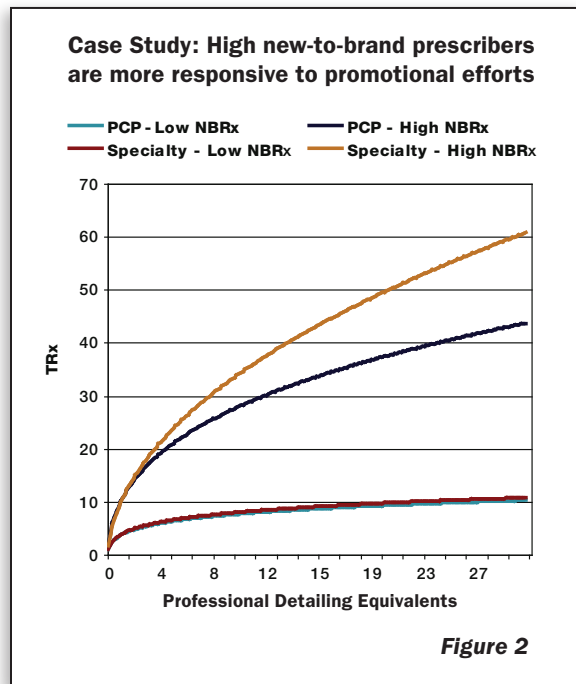
Moreover, IMS found that in a given year, only about a third of patients enter the dynamic market. These patients may be:

- Newly diagnosed and receiving treatment for the first time
- Switching products due to adverse events, a lack of efficacy, a preference for another dosage or delivery system, or managed care issues
- Adding on therapy following disease or symptom progression

On average, 60% of prescriptions in the dynamic market are for patients new to therapy, 30% are switches and 10% are for add-on therapy. “This really underscores the importance of both gaining a first-line indication and executing on that first-line indication, because so much of the business is tied up in new therapy starts,” says Morris.

These facts alone warrant a new look at the way sales and marketing departments evaluate their markets. “How much of the business is really in play?” asks Morris. “It’s easy for us to think about how many total cholesterol patients there might be or how many diagnosed diabetes patients might exist, but really only about a third of them are making any changes in their therapy in a given year.”

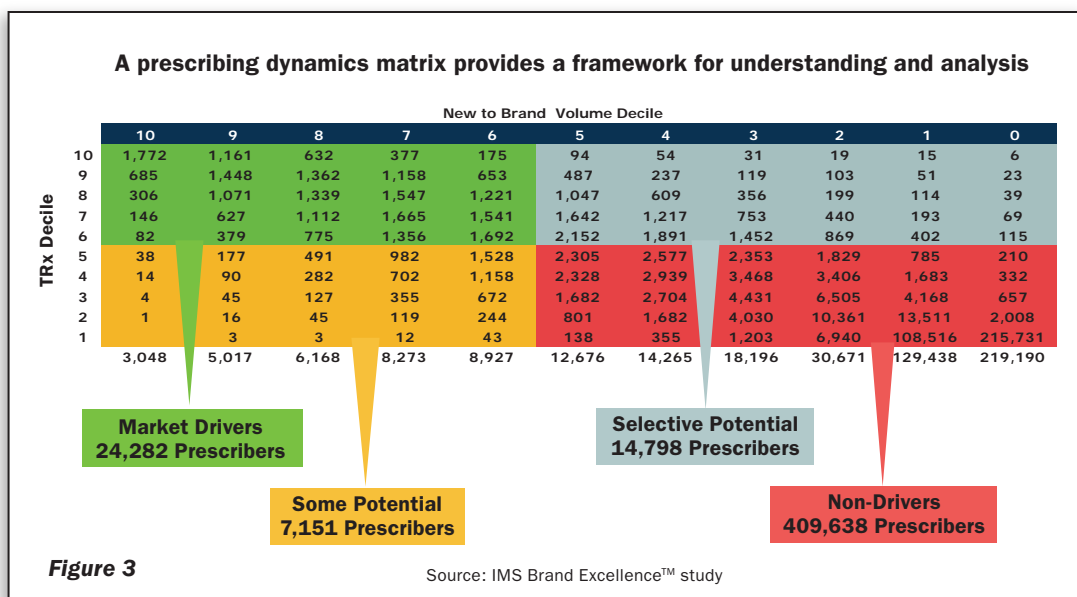
Perhaps the most compelling insight to come out of the IMS Brand Excellence



Physicians' ability to respond to promotional messaging is directly related to their patient flow, as seen in their dynamic prescribing activity.

study is the fact that in some markets, only 5% of physicians are responsible for half of all new-to-brand prescriptions. By looking only at total prescriptions and new prescriptions, pharmaceutical companies may be undervaluing many prescribers and overvaluing others, inadvertently directing valuable field force contacts to prescribers who aren't active in the dynamic market. Figure 2, which shows real-world data from an IMS case study in a chronic market, demonstrates the value of focusing sales efforts on high new-to-brand prescribers. In this case, whether physicians were in primary care or specialty practice, it took only four calls for those active in the dynamic market to reach the 20-prescription threshold. Conversely, physicians with low new-to-brand participation hovered at the 10-prescription mark through 20 calls and beyond. “No matter how many times you call on these physicians, you're not going to influence them,” says Keith Loehlein, a senior principal at IMS. “They simply don't have the opportunity to move the prescriptions. This is eye-opening and supports the premise that you need to look at dynamic prescriptions when you segment your physicians.”

IMS research shows that an overwhelming number of physicians are the focus of unproductive field force and promotional activity.



A FRESH PERSPECTIVE ON PRESCRIBERS

Based on its analysis, IMS recommends a four-step, cyclical approach to optimizing brand performance:

- 1. Understand the brand's dynamic market performance and develop goals based on that knowledge.**
- 2. Optimize and reallocate field force and promotional activities against these goals.**
- 3. Execute the brand strategy and tactics.**
- 4. Track and measure brand performance, beginning the process again.**

The success of this approach depends on the company's ability to get everyone on the same page. "In order to compete effectively, you need a new construct that allows you to align marketing, sales and managed markets," says Morris. "To do that, it's important that you share some common metrics, language and strategies."

A prescribing dynamics matrix provides a framework for developing that shared understanding by determining which physicians can contribute most to a brand's growth. Once these physicians are identified, sales, marketing and managed markets personnel can develop common strategies to reach those doctors.

Figure 3 shows a prescribing dynamics

matrix based on real-world data from a chronic market. This matrix consists of a traditional total-prescription decile ranking overlaid with the corresponding new-to-brand decile ranking. Note the additional "0 decile" – this represents physicians who contribute no volume to the dynamic market because they aren't seeing new patients, starting new patients on therapy, etc.

Dividing the matrix into quadrants reveals four major prescriber groups:

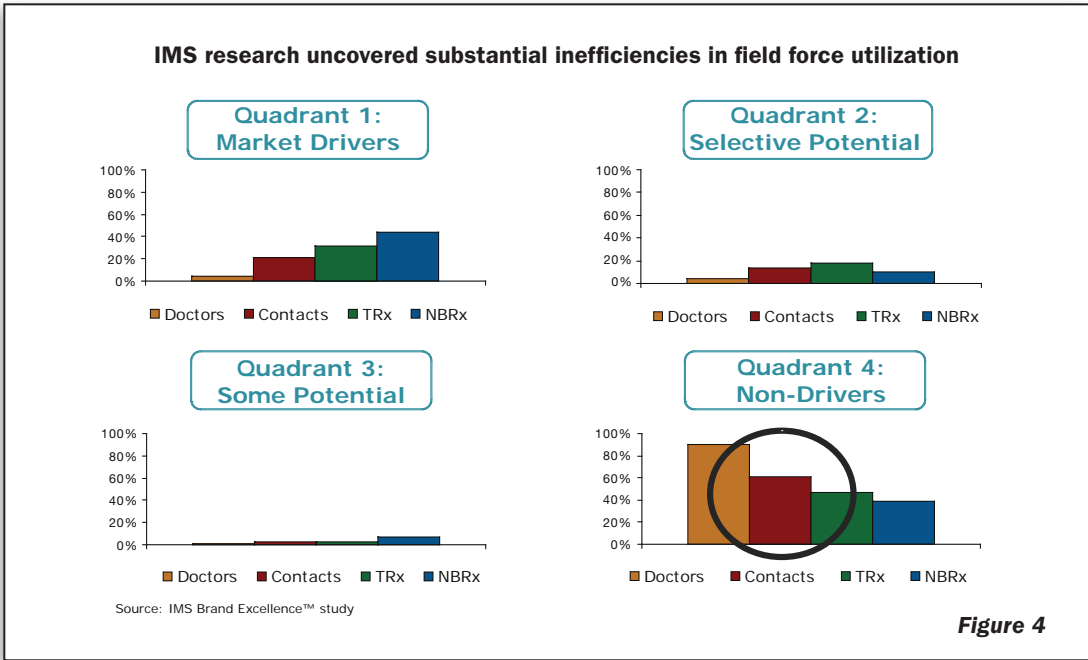
Market drivers: The physicians in the upper left quadrant are driving a large volume of prescriptions overall and in the dynamic market.

Selective potential: The doctors in the upper right quadrant write a high volume of prescriptions overall, but they aren't driving new patient starts, therapy switches or add-ons.

Some potential: The physicians in the lower left quadrant are often ignored due to relatively low total prescription volume, but they are actually involved in a significant number of treatment decisions and changes in therapy.

Non-drivers: The doctors in the lower right quadrant are neither writing a high volume of total prescriptions nor making a significant contribution to the dynamic market.

While the market drivers and selective-



potential physicians write the same volume of total prescriptions, the market drivers' productivity in the dynamic market sets them apart; this quadrant represents only 5% of prescribers, but that small group writes 40% of new-to-brand prescriptions. IMS calculations of new-to-brand productivity per physician show that each market driver contributed more than 60 prescriptions during the period studied, compared with just 17 for each doctor in the selective-potential group. "What we see here is that an overwhelming number of physicians are the focus of unproductive field force and promotional activity," says Morris. "If companies are only focusing on total prescriptions, they are treating the market drivers and the selective-potential physicians exactly the same."

On the other hand, physicians in the some-potential group may deserve more attention than their total prescription rankings suggest. Average new-to-brand productivity per prescriber in this group (38 prescriptions) was significantly higher than that seen among selective-potential physicians with higher total-prescription rankings (17 prescriptions), suggesting that companies would do well to investigate these doctors' ability to drive the business.

When combined with additional

information, the prescribing dynamics matrix can yield even more insights with useful applications in field force deployment, allocation of promotional resources and managed care pull-through:

Contacts. By adding data on physician contacts to the matrix (Figure 4), IMS identified substantial inefficiencies in field force utilization. While market drivers only received 20% of contacts, they wrote 40% of new-to-brand prescriptions – a yield of two prescriptions for each visit. In contrast, selective-potential physicians yielded less than one prescription per visit, and non-drivers received 60% of all contacts but wrote fewer new-to-brand prescriptions than market drivers. "In quadrant four, we're seeing lots of contacts distributed among lots of physicians, but it's very difficult to find the right ones," says Morris.

Samples. IMS found similar opportunities for reallocation of promotional spending by adding samples to the mix. Figure 5 (next page) shows that non-drivers received nearly 60% of samples but yielded only slightly more than 40% of new-to-brand prescriptions, suggesting that some of these samples might be better used elsewhere – most likely among the selective-potential group. "Most companies won't necessarily decide to increase samples

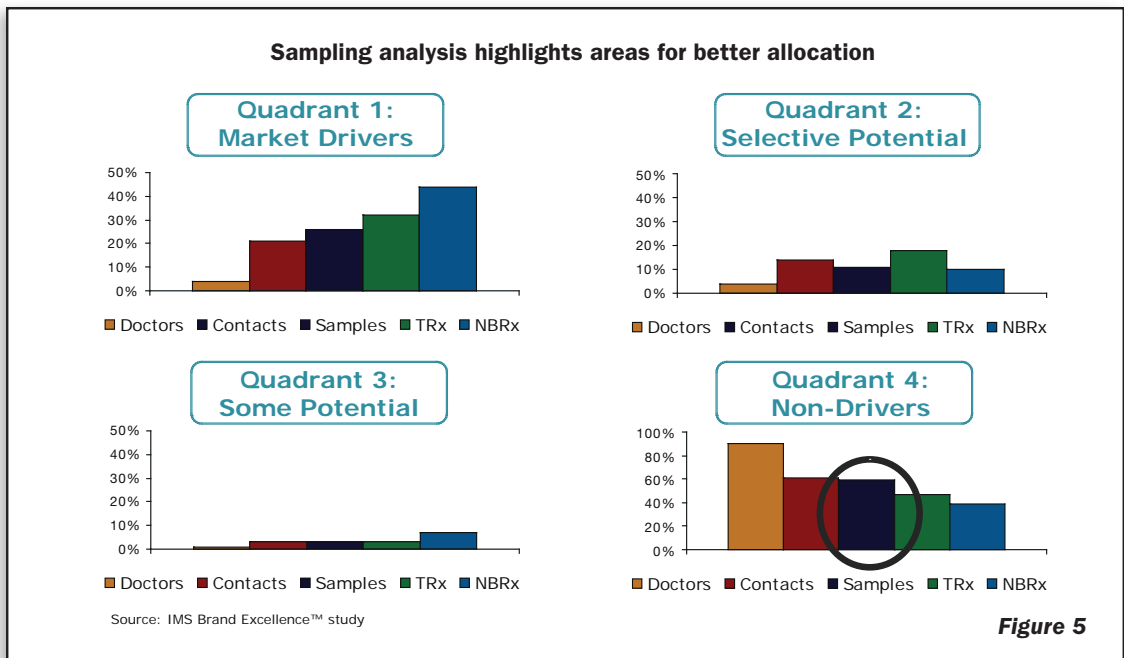


Figure 5

for market drivers because it can slow the growth of new-to-brand prescriptions,” says Morris. “If doctors already see the value of the product for their patients, sampling too much may just drive down volume.”

Managed care. Patient co-pay amounts for branded drugs have skyrocketed in recent years. In fact, IMS data show that the average co-pay for preferred brands jumped from \$13 in 2000 to \$29 in 2007 (compared with a drop from an average of \$7 to \$6 for generics over the same time period). Formulary status and co-pay amounts have a profound influence on therapeutic choices, and this can be seen most clearly through the lens of the dynamic market. From the second quarter of 2007 to the first quarter of 2008, IMS found that new-to-brand activity in seven chronic markets increased by 11% for products with lower co-pays but dropped by more than 4% for those with higher co-pays. By combining the prescribing dynamics matrix with formulary status information, pharmaceutical companies can adjust physician segmentation to account for managed care influence on the dynamic market. “A physician might be in new-to-brand decile eight,” says Loehlein. “But if 50% of their patients come from plans where your product has a negative

formulary position, no matter what you do or how many times you call on that doctor, your chances of influencing their prescribing decisions are probably low.”

The key to this new approach is aligning marketing, sales and managed markets departments so field force tactics can be connected to the overall brand strategy. For example, if the goal is to increase new patient starts, the typical plan might be for representatives to visit physicians with high total-prescription rankings, paint a picture of a new patient and deliver a message about why the product would be the best choice for that patient. But what if those high-decile physicians aren’t seeing new patients? Without the potential for new-to-brand prescriptions, those calls would be wasted. “Let’s change that,” says Loehlein. “Let’s support the doctors differently, whether you’re looking at new patient starts, switching patterns, starting doses, titration patterns, persistence or compliance. These are the types of things that marketing professionals have been talking about for years, but they’ve never had the information at the doctor level that would allow alignment of their strategies with sales targeting.”

Case study: Overlaying dynamic market activity revealed that 16,000 prescribers were undervalued

TRx Decile	New to Brand (NBRx) Decile											Total
	10	9	8	7	6	5	4	3	2	1	0	
10	1,788	869	363	172	100	86	61	75	91	140	147	3,892
9	764	1,857	1,456	850	517	385	221	211	165	208	140	6,774
8	207	1,217	1,931	1,736	1,298	934	549	450	325	289	148	9,084
7	80	572	1,488	2,024	2,064	1,852	1,162	894	604	417	169	11,326
6	37	314	938	1,793	2,273	2,654	2,058	1,770	1,058	627	279	13,801
5	23	163	544	1,176	2,144	2,988	3,020	3,148	2,123	1,183	431	16,943
4	6	82	266	737	1,526	2,825	3,736	5,061	4,283	2,254	721	21,497
3	6	38	149	343	890	2,012	3,461	6,779	8,486	5,807	1,416	29,387
2		18	46	136	333	960	2,190	6,347	15,005	19,265	4,409	48,709
1			1	7	28	121	375	1,904	10,939	114,602	153,527	281,504
Total	2,911	5,130	7,182	8,974	11,173	14,817	16,833	26,639	43,079	144,792	161,387	442,917

SSRI/SNRI Market

Figure 6

THE DYNAMIC MARKET MEETS DAY-TO-DAY BUSINESS

The following case studies illustrate how anonymized patient-level data can fit into everyday business applications, with measurable results.

Case study 1: Physician segmentation.

An IMS client in the SSRI/SNRI market was using traditional total-prescription deciles to value physicians and determine call patterns (from 24 calls a year for each decile 10 physician to six calls a year for each decile four physician).

When IMS overlaid the product's new-to-brand activity deciles onto the total-prescription deciles (Figure 6), the results were surprising. "You would expect to see a lot of doctors fall within the same decile, plus or minus one," says Loehlein. However, only 65% of doctors in deciles three and up fell within that range. "Of course, that leaves the question open: 'What about the other 35%? What am I doing with those doctors?'"

When viewed through this lens, more than 30,000 physicians on the right side of the matrix were not as valuable as they appeared to be from the perspective of total-prescription data alone. "Those physicians may not be seeing a lot of new patients; they may represent more mature offices,"

says Loehlein. "But whatever the reason, we're currently treating them the same as those on the left-hand side. They're simply not bringing the value to warrant that type of activity, resource and spend."

Also, while the client's field force was only visiting doctors in total-prescription deciles four and up, a look at the left side of the matrix showed that some total prescription decile three, two and even one physicians were writing more new-to-brand prescriptions. "These doctors might have been receiving some non-personal promotion, but they weren't being called on," says Loehlein. "Based on this, there were about 6,000 doctors the client now wanted to pull into their call patterns."

The client had previously employed 569 representatives to call on 83,317 physicians (a total of 911,016 calls). After revising its prescriber segmentation models to better quantify physician value, the company found it was able to maintain the same level of impact and revenue with only 465 representatives calling on 67,676 doctors (for a total of 743,652 calls) – a savings of over 18%.

The next step was to segment physicians further by identifying the formulary position of the product versus its competition in relevant managed care plans, along with



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—Keith Loehlein,
senior principal for IMS

physicians' affiliation with those plans. The degree of control a managed care organization exercised over a physician's prescribing choices might increase or decrease that physician's value. By incorporating this information into its field sales targeting, the client was able to achieve an additional 14% savings.

Case study 2: Promotional resource allocation. A client hoped to cut promotional costs in response to increasing competition from both generics and a newer molecule in the marketplace, and thus was reevaluating its previously rep-driven sampling strategy. To do this, the company:

- Divided physicians into six segments, with further sub-segments based on specialty and new-to-brand prescribing
- Developed promotional response curves through regression analysis of historical sampling and detailing levels, as well as prescription results
- Used this information to optimize its sampling levels and allocation for maximum efficiency and profitability

The result was a 20% reduction in samples that saved the company \$3 million. More surprisingly, by reallocating the remaining samples wisely, the client also gained nearly \$2 million in incremental revenue, thus reaping a total of \$5 million in profits.

Both of these examples indicate that by isolating dynamic market prescribing behaviors, pharmaceutical companies can adopt a truly customer-centered approach to sales, marketing and managed markets. “These are real-world examples of bringing these data down to the prescriber level and how it can impact your business today,” says Loehlein. “Allocating your promotion –

both the amount and type of promotion – at the doctor level by looking at the dynamic market segment can really improve the ROI and overall performance of your brand.”

OPPORTUNITY KNOCKS

The industry has been hearing about the potential of anonymized patient-level data for a long time. Now the data have evolved to the point where many pharmaceutical companies are realizing that potential and relying on APLD to support a wide range of commercial functions. But while these metrics have finally become mainstream, the process of incorporating them into everyday business applications still varies by company. “When you look at prescriber segmentation, field force allocation, promotional allocation, market access and field force effectiveness, different companies have different adoption curves in each of those elements,” says Loehlein. “Some may adopt very rapidly. Others may start out with prescriber segmentation and promotional allocation outside of the sales force.”

Wherever they begin, pharmaceutical sales, marketing and managed markets professionals who choose to view their business through the lens of the dynamic market have the opportunity to improve the precision and accuracy of their existing models, to utilize their resources more effectively, and to develop a unified perspective of the patients and prescribers they serve. In challenging times, opportunities like these may make the difference between forging ahead and falling behind.

To replay the free webcast, visit www.PharmExec.com/dynamic

NEW TO APLD?

For an in-depth look at anonymized patient-level data, visit www.PharmExec.com/PatientCentric to view the previous webcast, “Are You Patient Centric? New Essentials That Will Transform Sales & Marketing,” which was recorded in February 2008 and is available for free replay through February 2009.

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