WHITE PAPER

Moving beyond first in class, best in class

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Getting a launch right or wrong can mean the difference of billions of dollars over an asset's lifetime. Arguably, everyone in biopharmaceuticals understands the stakes. Consequently, it's common for planning cycles to last well over a year and to require tens of thousands of hours of work across the organization. In the lead up to a first indication launch, companies can spend more than $100M to prepare the market and organization. This cost often excludes investment in direct-to-consumer advertising in the U.S. (commonly used for high prevalence, chronic conditions such as diabetes, asthma, insomnia, etc.) where TV advertisements alone can easily cost several hundred millions of dollars.[1]

Yet despite the significant investment of time and resources, ZS research found that around 40% of global launches between 2015-2020 failed to meet analyst consensus expectations.[2] The COVID-19 pandemic has further exacerbated this trend. In the 2019-2021 timeframe, ZS analysis shows that 53% of U.S. launches underperformed compared to analyst expectations across organizations, therapeutic categories and asset types.[3] This is particularly concerning as launch performance in markets outside the U.S. tends to mirror U.S. performance. As the U.S. tends to be the first launch country in the majority of launches and represents more than 50% of global product revenue,[4] the trajectory set in this country significantly shapes overall global performance.

Why pharma launches fail

The reasons are multifaceted but usually relate to a mismatch in strategy, execution and resourcing against the realistic opportunity—often driven by the first-in-class/best-in-class mindset.

While the first-in-class/best-in-class strategy has driven success for many products, it also created challenges for others. Overconfidence led many companies to believe that if their products are not first in class, their products can be best in class. This mindset caused them to make strategic and investment decisions that resulted in suboptimal performance.

The fact is that we now live in a world where developing products that truly meet either of those criteria is becoming incredibly challenging. And while first in class does still provide

[1] Beth Snyder Bulik, "The top 10 ad spenders in Big Pharma for 2020," Fiercepharma.com.

[2] ZS Ex-U.S. launch performance in first 18-24 months for 2015-2020. Includes first 18-24 months of launch for new molecular entities (NMEs) only. Focus is on specialty pharma products launched between 2015-2020 in the U.S. and ex-U.S. Limited to EvaluatePharma data availability for 90 products. Performance classification: Underperform: < 80% of sales; Met expectation: 80% to 120% of sales; Overperform: >120% of sales.

[3] ZS analysis for blockbuster products for last 10 years (2022).

[4] ZS analysis on the Value of Focus (2021).

an advantage, it is fleeting and rarely lasts longer than a year,[5] especially in dynamic therapy areas like oncology. On the other hand, there is also a limit to what best in class will provide. The biggest fallacy of the best in class strategy is that the best product will always win. The argument is flawed for two reasons: One, there is no objective, universal agreement on the definition of "best" in class and two, short of a "cure," there is a limit to meaningful incremental innovation.

Identifying opportunity drivers of launch success

ZS research into commercial drivers of performance[6] highlighted the importance of aligning commercial strategy and execution to what drives success. To quantify the factors that drive commercial performance against established standards of care (SOC), the analysis looked at performance drivers of 96 drug launches spanning across 10 indications in oncology,

[5] ZS research on oncology competitive differentiation (2021).

[6] Sean Walter, Komal Gurnani and Saumya Mukhopadhyay, "What actually drives drug launch success?" ZS.com.

immunology and primary care. The eight launch performance drivers included level of unmet need in the disease; order of entry; efficacy; safety; convenience; product novelty, defined as mechanism of action (MOA); marketing spend across channels and payer influence.

This analysis demonstrated that, for products addressing high unmet need indications and offering high efficacy, performance isn't as much driven by promotional spend. This indicates that there are probably opportunities to go leaner on launch investment without compromising the opportunity.

However, if launching into a highly competitive space where the need is largely met, high investment to achieve share of voice is essential. Failing to provide significant investment into customer-facing teams and promotion almost certainly means planning to underperform.

It seems intuitive, yet launch planning and investment is rarely done in alignment with strategic priorities. The interest in a "lean launch" usually is about finding ways to reduce investment in headcount—in customer-facing teams specifically. The desire to reduce this investment is what is driving a large portion of the interest in the digital-first launch. Yet taking a lean approach to a launch is not always appropriate, particularly those launches highly sensitive to promotional effort.

This is where diagnosing the launch archetype can highlight the realistic opportunity and how and where to make strategic investments.

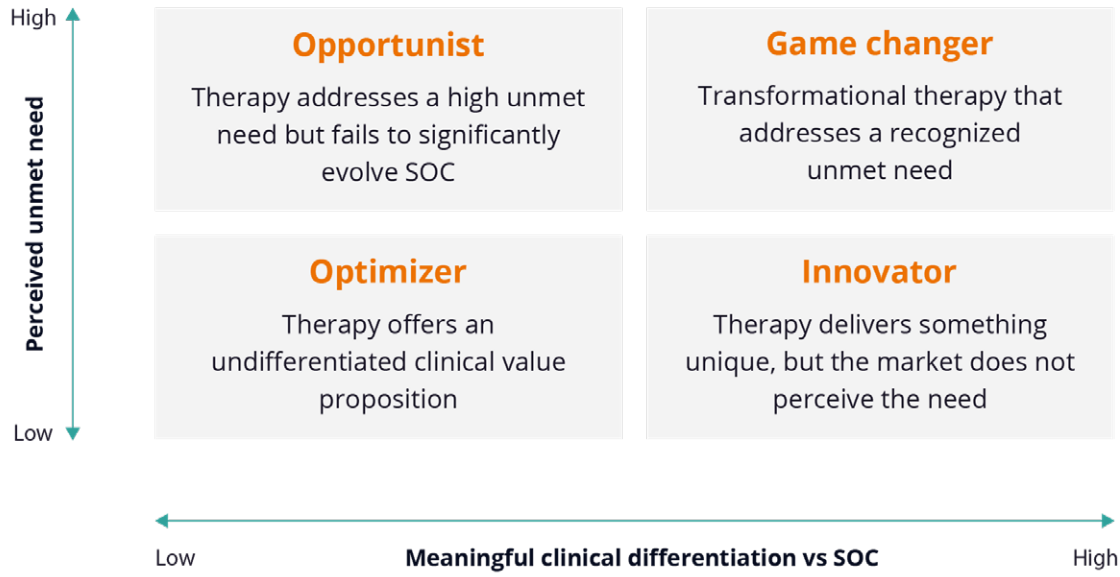
Pharma launch archetypes

Assessing the launch archetype starts with understanding the perceived unmet need as it relates to meaningful differentiation. The perceived unmet need is the existing disease burden as recognized or acknowledged by the market by customers (i.e., healthcare providers and payers) and the possibility to manage the disease by other treatment options. Meaningful differentiation is the extent the product provides a relevant clinical improvement. This improvement could be in terms of efficacy, safety, route of administration (ROA) or MOA versus existing SOC.

Based on these dimensions, the below framework in Figure 1 can diagnose the launch archetype.

FIGURE 1:

Launch archetype diagnostic



The Y-axis represents the overall perception of unmet need in any given disease area or indication. An example of a high unmet need disease area is metastatic pancreatic cancer, with its five-year mortality of about 90%-95%. Conversely, we see low perceived unmet need in diseases such as TRK-fused tumors and early-stage breast cancer. (Note: This should reflect the general perception of unmet need in the disease, not the nuanced perception that arises from key-opinion-leader-heavy advisory boards.)

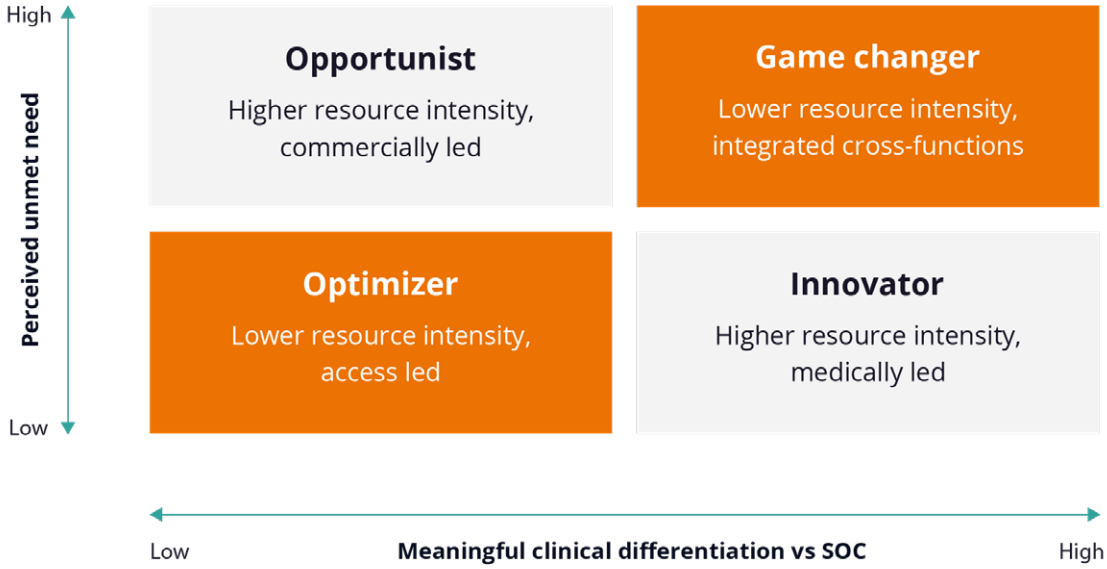
The X-axis reflects the perceived level of meaningful clinical differentiation the therapy delivers. Sticking with oncology, therapies that offer around a three-to-six month progression-free survival (PFS) improvement over SOC or that provide only response rate data would fall in the lower half of the framework (i.e., optimizers or innovators). Therapies that deliver a greater than 18-month PFS improvement (and preferably overall survival) over SOC would fall in the top half (i.e., opportunists or game changers).

Based on these definitions, some clear differentiation strategies[7] and resourcing paradigms emerge.

[7] Emily Mandell and Joshua Hattem, "The growing challenge of product differentiation," ZS.com.

FIGURE 2:

Lower resource intensity archetypes



Upper right: The game changers. These molecules essentially sell themselves, which is why the first-in-class/best-in-class concept is so powerful. They tend to employ a strong clinical differentiation strategy that raises the bar in the SOC. As our commercial driver analysis showed, these launches are not particularly sensitive to promotional effort. Provided the manufacturer does an adequate job of getting the data published in the appropriate scientific journals and conferences, these molecules tend to have strong launches. The challenge is that many teams misdiagnose themselves as being in this bucket when they are not.

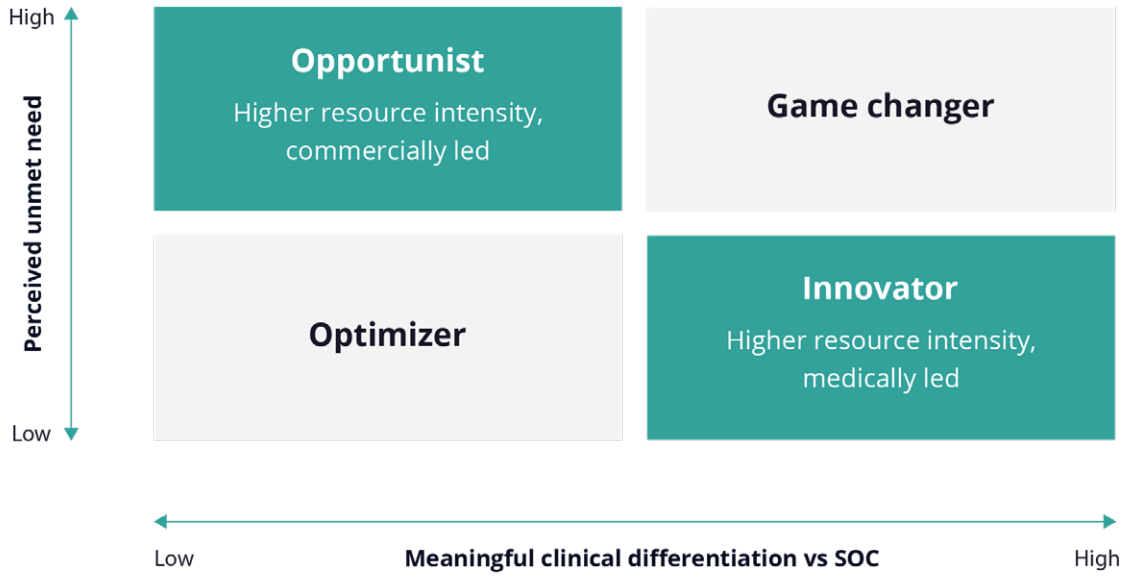
Lower left: The optimizers. Most companies do not want to admit that their asset falls into this category unless they are a generic or biosimilar manufacturer or a company like EQRx. Product differentiation strategies are limited to nonclinical aspects and solving a different problem, such as reducing cost of care or simplifying care delivery. Promotional effort is one of the main levers to affect launch; however, the returns in this category don't often justify the costs of heavy promotion. For these therapies, the key is to focus on payers as the primary customer rather than the healthcare professional (HCP). Launch teams who diagnose themselves here correctly can leverage their position and deploy innovative and disruptive business models.[8]

Both squares on this diagonal represent opportunities for much leaner launch models and offer opportunities to disrupt the status quo.

[8] EQRx is a good example, as documented in: Joshua Cohen, "EQRx seeks to establish a more competitive market for oncology drugs in the U.S." Forbes.com.

FIGURE 3:

Higher resource intensity archetypes



The archetypes on the downward diagonal are high resourcing, with the upper left being led by commercial and the lower right being led by medical. Getting the resourcing right, both in terms of size and functional focus, is critical to delivering the full promise of the brand's launch.

Upper left: The opportunists. These molecules target high unmet need diseases but fail to make a meaningful impact on the SOC. Examples here include the novel chemotherapies (e.g., albumin) or liposomal encapsulation of a traditional small molecule. Many novel MOAs also fall into this bucket despite their noble ambitions. These launches need heavy commercial support to survive, typically from field-facing teams where reach and frequency matters.

Lower right: The innovators. These therapies deliver something truly unique but in an area of lower perceived need. Some examples that fit this archetype are gene therapies in areas like hemophilia and sickle cell disease. Here companies can employ a precision play

differentiation strategy by being the most effective for a clearly defined patient group (e.g., biomarkers, treatment history and patient characteristics). Successfully landing this strategy requires high investment in shaping the market of the treatment flow and disease ecosystem (HCPs, payers, diagnostic partners, etc.) to demonstrate value. Successful companies might graduate into the game changers archetype, but only if they manage their launch right. These molecules require strong support from medical affairs to build and deliver a strong integrated evidence strategy.

FIGURE 4:

Lean resourcing potential across archetypes

Archetype	Strategic lever	Potential for lean resourcing
Opportunist	**Commercial** Drive high SOV with significant promotional effort and focus on nonclinical differentiation strategy	**Lower** Requires dedicated customer-facing teams; limited potential to replace with digital engagement
Innovator	**Medical** Significant market shaping to recognize unmet need or novelty	**Lower** Requires high medical-driven engagement; limited potential to replace with digital engagement
Game changer	**Medical or Commercial** Maximize strong value proposition with integrated strategy and execution	**Higher** Integrated, adaptive engagement model with higher potential for digitally driven engagement
Optimizer	**Access** Ensure favorable access via nonclinical differentiation strategy (e.g., cost)	**Higher** Payer- and access-focused engagement model; higher potential for digitally driven engagement

How company context matters in optimizing launch strategy

While archetypes identify strategic levers and priorities, company context informs how to optimize them. Assessing molecules in a vacuum misses a critical piece of the puzzle—the company context. Not all companies enter disease spaces on equal footing.
Some have long-standing relationships and presence in the disease space. Others might lack presence today but have a willingness to invest and a legacy of successfully capturing

markets. Still, others might have neither of these. But they have decided the disease is a critical strategic lever for their future success. Each of these companies may consider different commercialization strategies based on the therapy.

As a result, there are three company context elements that matter most in determining if or how to deploy resources to meet the opportunity:

1. Existing therapeutic area (TA) presence
2. Strategic intent
3. Company size and resources

Of these, existing TA presence, and more specifically leadership, is the most correlated with future launch success.

1. Existing therapeutic area presence

This reflects the company's ability to leverage existing commercialization infrastructure, established customer relationships, and depth of market and customer understanding to support a launch.

In a 2021 ZS analysis on the value of focus,[9] companies with average or better TA focus—meaning more than 66% of their revenues were in three therapeutic categories—saw a significant payoff relative to peers. They were also more than two times as likely to launch a future blockbuster when more than 30% of their revenues came from that TA at launch.

Companies with an established presence have more opportunities available to innovate with leaner, disruptive commercial models while balancing the risk across a portfolio of launches. Those considering a digital-first launch will need an existing TA presence, customer data and customer relationships.

2. Strategic intent

This captures the short- versus longer-term vision and ambition in a TA (maximizing the value of a single asset versus building a portfolio) and implications for the required investment to commercialize. Companies that are new to a TA, geography or commercializing an asset (e.g., an emerging pharma company) will likely need to increase investment compared to

[9] Joshua Hattem, "The value and challenge of focus in pharma," ZS.com.

those companies already established. Whether this is the right decision depends on the longer-term vision and ambition of the company in that TA.

3. Company size and resources

This reflects the company's ability to invest in a launch. Companies with a global footprint and existing portfolios in the launch TA will have significantly more resources to dedicate to launch, including the ability to scale, adjust and deliver globally. In comparison, emerging pharma companies will be significantly more resource constrained.

If none of the three company context elements are present, partnering is likely the most effective commercialization approach. While the decision to partner or go it alone is mainly relevant for small and emerging pharma companies, the wider concept of how company context influences the ability to go lean and how to build strategic launch excellence capabilities.

The implications of using a custom archetype plan strategy

Bringing together the archetypes and company context highlights the opportunities for different resourcing models and prerequisites for success.

Taking this view also highlights how to tailor the launch strategy and plan for one launch based upon the opportunity, strategic lever and required resourcing. Organizations looking to optimize launches will need to focus on two main areas: How to get better at diagnosing the realistic opportunity and how to build strategic launch excellence capabilities.

Diagnosing the realistic opportunity

The main challenge to overcome is ensuring the internal organization is realistic both about the opportunity of the next launch and their overall pipeline. The pressure to hit milestones creates a powerful bias when organizations try to make realistic molecule assessments, especially when specific revenue expectations exist. This bias is especially strong during the phase 3 and launch milestones when a global team wants to build excitement about the portfolio and win buy-in.

Sequestering a small core team able to make recommendations independent of undue influences and a portfolio management team empowered to make decisions will help combat this bias and allow the organization to maintain a realistic outlook on the situation.

These teams should exist at these two levels:

Brand and asset. For these launch teams, the goal is to optimize against the realistic opportunity. The product is already shaped, and the launch teams need to do the best they can with the asset they have. They need to keep focused on diagnosing the launch archetype and identifying the priority strategic levers. Then, taking into account the company context, they can customize the launch plan and resource investment.

Companies launching without prior TA experience will need to resist the temptation to underinvest or overrely on digital. In the short- to near-term, building customer relationships is very important and a digital-first engagement strategy has yet to meet customer needs.

Franchise and portfolio. For annual franchise and TA reviews, the goal is to ensure a high-quality pipeline of assets that better serve customers, differentiate themselves against the competition and maximize commercial synergies across a portfolio. The focus here is on assets phase 1 to phase 3 and to inform strategic reviews. If early assessments place assets in a challenging launch archetype, there is an opportunity to adjust clinical development decisions and, if successful, evolve these assets into another archetype.

Building strategic launch excellence capabilities

Organizations need to invest in evolving from just launching drugs in their pipeline to being data-driven launch strategists and advisors that can succeed at execution. Achieving this requires redefining launch excellence, moving this concept away from a project management function to a data-driven strategic advisory function that focuses on commercialization across a portfolio of launches. This change means being able to advise pre-launch decisions, such as diagnosing the launch archetype, investing in the correct strategic levers and knowing how to operationalize a broader range of commercialization and go-to-market strategies across geographies. This approach will allow for a post-launch, real-time diagnostic of leading indicators of launch performance with local feedback mechanisms that will result in campaigns that can adapt alongside wider regional and global strategies for subsequent launches.

Being able to deliver this value to the organization requires evolving the capabilities

(people, processes, tools and data and information) to support better decision-making and execution across launch strategy, launch management and long-term performance tracking and feedback loops.

A future-forward strategy for launch

To ensure launch success, pharma companies need to do better at assessing the realistic opportunity and aligning strategic and investment decisions accordingly.

Assessing the opportunity accurately requires understanding the product, market and company context at launch and identifying what is critical to get right from a market access, medical and commercial perspective to capture that opportunity.

Once companies understand where they are playing and what strategic levers to dial up, they can define how best to allocate resources.

Best in class/first in class will continue to lose steam as resource allocation will continue to get more sophisticated and, presumably, this shift in mindset will become the new standard way of thinking about launches into the future. Companies would be wise to adopt these archetypes and solutions early. Otherwise, they risk falling behind their peers.

About the authors

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