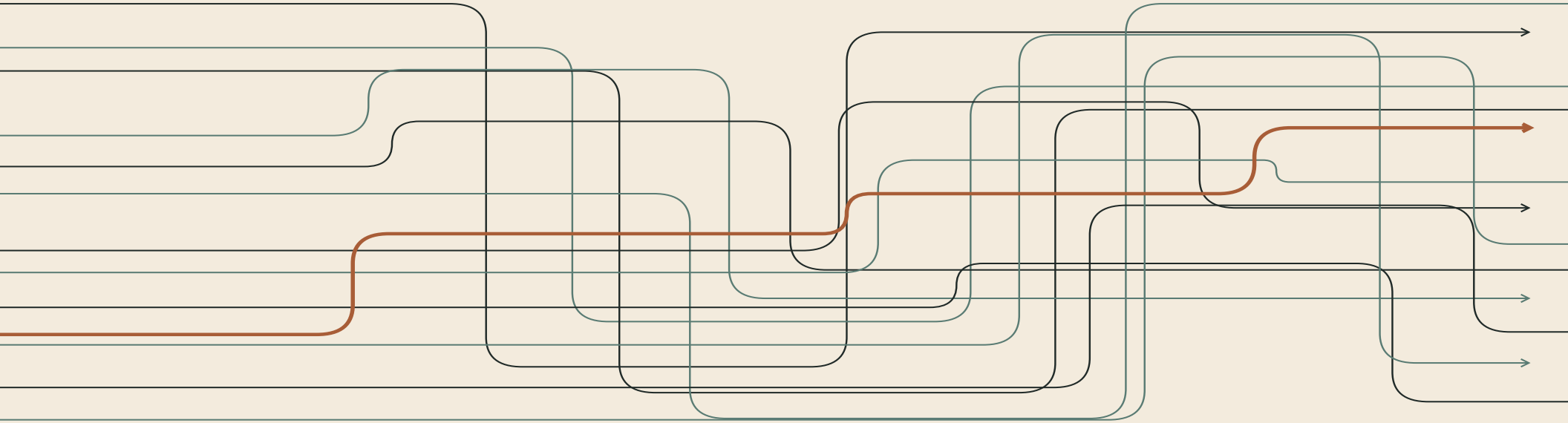
RESEARCH PAPER

Pharma’s Realization Revolution

Realization Management

Pharma’s Essential New Growth Discipline

Realizing the patient and commercial value of prescribed medicines



THE CUSTOMER EXCELLENCE AGENCY

NOVEMBER 2026

EXECUTIVE SUMMARY

Realization is the new brand growth strategy

REALIZE PATIENT AND COMMERCIAL VALUE

The realization lever increases the patient and commercial value achieved from prescribing intent already created. It targets value leakage, the potential left unrealized along that journey, by addressing avoidable barriers to appropriate treatment.

The strategic case for customer experience in pharma is growth and value creation. Leaders should expect a material, measurable contribution to appropriate treatment and commercial performance. Customer consciousness brings patients’ and healthcare professionals’ circumstances into decisions; journey thinking shows how interactions and handoffs shape their progress. Together they inform where and how to apply the realization lever.

In the author’s experience across global pharma, up to 50% of written prescriptions in some therapeutic categories fail to get filled. More prescribing can enlarge that gap when progression remains unchanged. Commercial leaders need to examine how their services work together after the prescription and which barriers they can credibly reduce. Experience belongs inside the growth model.

MAKE REALIZATION A MANAGEMENT DISCIPLINE

Realization Management identifies avoidable barriers to appropriate treatment, assigns a response and assesses its effects. It gives commercial leaders a way to exercise the realization lever responsibly.

The Realization Layer connects journey evidence with accountable teams, decision rights and supporting technology. A completed task has limited meaning if the patient or office still cannot proceed. Shared workflows must carry the response across functional boundaries.

The paper develops the economic and management case. Its one-year illustration follows 9,600 patients with $436.8 million of modeled Earned Value. They realize $241.9 million, leaving $194.9 million unrealized. That gap warrants investigation; recoverability depends on its causes and the effect and cost of intervention. The twelve-week agenda shows how to establish a baseline and begin a test.

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A complete management case

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Companion: the Practice Note develops patient insight and organizational application in greater depth.

EXECUTIVE PERSPECTIVE

What realization means for patients and the business

Value depends on what patients can obtain, use and benefit from after prescribing.

Patient benefit and commercial value meet in the treatment journey, although each requires its own evidence. Progression provides a shared basis for investigating where that journey breaks down.

Dimension	What is being realized or observed	Evidence required
Patient value	Benefits experienced through appropriate treatment: health, function and quality of life, alongside a more manageable treatment journey.	Clinical outcomes and patient-reported outcomes or experience, measured directly.
Commercial value	Net revenue and contribution associated with treatment over a defined period. This paper models net commercial value; delivery costs inform the investment case.	A consistent patient group, time horizon and valuation basis, reconciled with finance.
Patient progression	Observable steps from prescribing through fulfillment, initiation and appropriate continuation. These milestones help explain how value is realized.	Evidence of the specified milestone. Clinical benefit requires a separate assessment.

CUSTOMER CONSCIOUSNESS

Customer consciousness means allowing patients’ and healthcare professionals’ actual circumstances to shape business decisions. Leaders ask whose effort, uncertainty or unmet need a functional result conceals. That perspective directs investigation toward barriers experienced outside the organization’s reporting boundaries.

JOURNEY THINKING

Journey thinking follows progression across functions and organizations. It traces how one interaction affects the next, locating failures in continuity that local measures miss. Experience design then changes the conditions under which patients and professionals proceed.

CEA working definitions. The economic account begins at the written prescription; action can address causes elsewhere in the journey. The companion Practice Note develops patient insight and application. [24]

THE MANAGEMENT PROBLEM

Fragmented accountability allows value leakage to persist

Friction creates commercial drag when no owner can resolve the transition across functions.

The persistent hole in pharma’s commercial model is responsibility for realization. Medical engagement, marketing and field teams support prescribing; access specialists, hubs, pharmacies and support teams help patients obtain and use medicines. Yet these capabilities can perform well individually while the patient’s journey stalls between them. Their presence alone does not give customer experience a central place in commercial management.

Experience includes the effort, uncertainty and confidence involved in proceeding with treatment. Friction increases that effort through information gaps, administrative burden, cost or failed handoffs. Patients may face all four while services meet their targets. Performance must also be examined from their position.

The commercial consequences depend on the mechanism. Delay can defer receipts or shorten treatment within the measurement period; an unresolved barrier can prevent a start or contribute to premature discontinuation. Repeated contacts add cost. Understanding the experience behind these events helps distinguish an addressable failure from other reasons value remains unrealized.

Consider an illustrative rheumatology case. A biologic is prescribed on Tuesday, but the benefits investigation waits for a chart note. Approval eventually reaches the office; the patient receives no clear explanation of affordability support. The pharmacy completes its outreach attempts and the office assumes the case has progressed. Three weeks later, treatment has yet to begin.

Customer consciousness asks whether the patient could proceed. Missing documents need coordination, coverage questions need access expertise, and treatment concerns need qualified clinical support. Leadership connects those responsibilities so patients do not have to reconcile the organization’s separate answers.

Demand creation has long had a visible place in the commercial budget. Schwartz and Woloshin estimated $20.3 billion in pharmaceutical marketing to health professionals and $6.0 billion in prescription-drug consumer advertising in 2016; the professional total included assigned sample value. [13] These historical categories do not measure current support investment. They invite a management question: is responsibility for realizing value as explicit as responsibility for generating prescribing intent?

THE MANAGEMENT PROBLEM

Functional performance can conceal cumulative value leakage

Following the same patients connects local service measures to the decisions that affect progression.

Management dimension	A possible gap to test	Required management connection
Measurement	Each function reports referrals, calls, approvals or cases completed.	Track the same patients after prescribing through defined milestones; retain local activity measures as diagnostic inputs.
Governance	A handoff ends when one party sends the work.	Name who accepts the next responsibility, confirms its completion and escalates an unresolved barrier.
Data	Claims, hub and pharmacy records use different events, clocks and identifiers.	Agree definitions and permitted linkage; disclose coverage, delay and uncertainty.
Investment	Service volume and functional budgets determine what is funded.	Compare incremental progression and contribution with the full cost of the proposed response.
Executive review	Demand, service performance and net sales appear without a reconciliation.	Connect patient progression and value with decisions, owners and a record of prior commitments.

Table 1. CEA management diagnostic. The gaps are hypotheses to assess within a brand or market. [1]

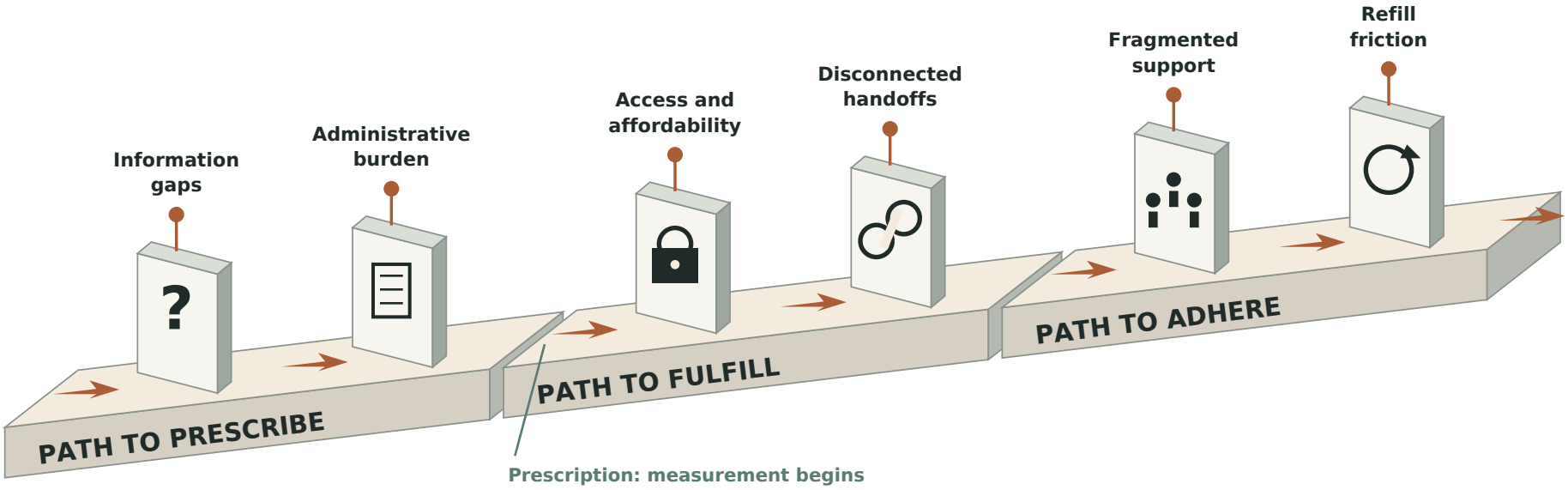
Closing the gap requires shared accountability after prescribing, a mindset that recognizes realization as growth, and an ethos that makes helping patients progress a commercial responsibility. Together, these changes give experience a place in everyday decisions.

The investment discussion can then distinguish a prescribing constraint from a fulfillment or continuity constraint. Local measures help explain the cause; journey evidence directs resources toward the problem patients encounter, across functional boundaries.

THE SOURCES OF LEAKAGE

Journey thinking reveals the connections that functions miss

Follow the experience across prescribing, fulfillment and adherence; begin the economic account at the written script.



A barrier’s origin may precede its visible consequence

An unclear instruction at prescribing may emerge as a missed start. A failed handoff may leave patients repeating information to several teams. Journey thinking traces these connections, directing intervention toward the source of friction rather than its most visible consequence.

Figure A. CEA Path to Prescribe, Path to Fulfill and Path to Adhere framework. Conceptual design by Wayne Simmons / The Customer Excellence Agency. Arrows connect responsibilities; they do not quantify effects or require a linear clinical sequence.

Clinically appropriate stops, informed treatment choices and necessary safeguards are distinct from avoidable friction. Figure 1 measures post-prescription progression; this pathway identifies where to investigate its causes.

EVIDENCE OF INTERRUPTION

A rejected prescription often remains unfilled after follow-up

Access evidence shows why the review must follow the disposition of a prescription.

Levy and colleagues examined approximately 1.17 million people attempting to fill more than two million single-source branded prescriptions from January 2018 through September 2024. Initially, 32.0% of attempts were rejected for formulary exclusion or utilization management. Within 90 days, 38.6% of rejected attempts led to a fill of the original drug and 13.0% to another drug in the class. The remaining 48.4% had no such fill observed. [2]

Substitution closed part of the dispensing gap. For the remainder, the absence of an observed same-class fill raises questions about other care, clinical appropriateness and unresolved barriers. Those questions require follow-up. A rejection count alone cannot tell an access team which patients received an appropriate alternative or which still need help.

Doshi and colleagues studied new specialty oral anticancer prescriptions for blood cancers among 12,134 Medicare and commercially insured patients in 2022. Initial rejection affected 64.9% and 84.0%, respectively. At 90 days, approval reached 85.0% and 62.8%, while approved-and-filled rates were 54.5% and 45.5%. [3] Measuring authorization alone would miss the remaining gap between approval and dispensing.

Affordability can remain a constraint after approval. In a study of 38,111 patients with adjudicated prescriptions for novel oral anticancer medicines, risk-adjusted abandonment was 10.0% at out-of-pocket costs of $10 or less and 49.4% above $2,000. Abandonment meant reversal without a fill of the same agent within 90 days; the analysis also examined alternative anticancer treatment. [19] This association identifies cost as a priority for investigation, without estimating the effect of an affordability intervention.

The issue extends beyond specialty treatment. Fischer and colleagues analyzed 195,930 electronic prescriptions, including 82,245 orders for new medicines. Approximately 28% of the new-medication subset were not filled. [10] This historical result uses new-medication orders as its denominator and should be interpreted in its original setting.

The studies show substantial gaps between prescribing, approval and dispensing, but their populations and definitions prevent a pooled industry loss rate. Their management value lies in directing investigation: where does the brand’s own journey stall, what do patients and offices encounter there, and which constraints could a response change?

THE MEASUREMENT BLIND SPOT

Fill rates reveal only part of the realization story

Managing value realization requires a connected account of the same patients after prescribing.

SELECTED PUBLISHED FILL OBSERVATIONS

Population and source	Filled*
GLP-1 orders, obesity only [5]	37.2%
GLP-1 orders, diabetes only [5]	47.5%
GLP-1 orders, both recorded [5]	64.6%
Oral oncology, Medicare [3]	54.5%
Oral oncology, commercial [3]	45.5%
RA biologics / tofacitinib [6]	59.4%
PCSK9 inhibitors [4]	30.9%
Lipid-lowering therapy [7]	81.8%–90.0%

WHAT LEADERS NEED TO FOLLOW NEXT

Among patients originally prescribed:

Started
Who began treatment, and how long did it take?

Continuing at 90 days
Who continued, and what explains interruption?

Persistent at 12 months
Who remained on treatment at month twelve?

Adapt milestones to the regimen; distinguish appropriate stops and unknown status.

Table 2. Selected published fill observations and the connected account leaders need. Sources retain their own populations, units and windows; these rows are not a pooled benchmark.

Initiation and persistence studies exist. The reviewed sources did not establish a comparable account of these milestones using the same original prescribed population. [1]

* GLP-1: orders filled within 90 days in one Colorado health system, 2018–2022; 9,848 orders for 6,094 patients, including initial and refill orders. The three rows are indication groups from one study. [5] Oral oncology: new prescriptions for blood cancers, 2022; approved and filled within 90 days. [3] RA (rheumatoid arthritis): new electronic prescriptions with a fill or administration within three months; 59.4% is 100% minus 40.6% primary nonadherence. [6] PCSK9: patients prescribed in August 2015–July 2016 who obtained a fill during follow-up. [4] Lipid-lowering therapy: 100% minus 10%–18.2% patient-level initial nonadherence across studies with different windows. [7]

The leadership task is to connect prescribing, initiation and continuity in one patient account, then locate value leakage and act on its causes. The next section explains why separate stage studies cannot supply that account.

EVIDENCE OF INTERRUPTION

Value leakage continues after the first fill

Later-stage studies add evidence, but do not complete the original-prescription account shown in Table 2.

A pharmacy claim confirms dispensing; for a self-administered medicine, it usually cannot confirm the first dose. Patient confirmation, clinical records or validated support signals can help establish initiation. Administration records offer a more direct event for administered therapies. An observed start, a proxy and an unknown status should remain distinguishable.

Early treatment behavior also differs from persistence. Benner and colleagues followed 34,501 older patients who began statin treatment in 1990–1998. At three months, 40% had a proportion of days covered below 80%. [18] This was an adherence threshold among initiators, not a finding that 40% of all prescribed patients had stopped.

In a more recent study of 125,474 adults initiating dual-labeled GLP-1 receptor agonists, estimated one-year discontinuation was 64.8% among people without type 2 diabetes and 46.5% among those with it. Reinitiation also occurred. [8] A discontinuation can be followed by a return, and a study beginning at initiation leaves earlier losses outside its denominator.

The missing account in Table 2 cannot be assembled by joining unrelated studies. [1] Persistence measured among initiators excludes people who never started. Combining that result with a separate fill rate would describe a journey neither study observed. The original prescribed population must remain visible throughout follow-up.

Historical evidence gives context. WHO’s 2003 report described adherence to long-term treatment for chronic illness in developed countries as averaging about 50%. [11] Cutler and colleagues cited a historical US nonadherence cost range of $100 billion to $290 billion. [12] These are different constructs from a contemporary brand’s Realization Rate or recoverable commercial revenue.

Milestones should reflect the treatment’s purpose. Twelve-month persistence may suit ongoing therapy, while course completion may suit a finite regimen. An appropriate stop or informed patient choice remains a legitimate outcome. Investigation should establish what prevented appropriate progression; clinical benefit must be assessed separately.

PATIENT PROGRESSION

Following the same patients makes cumulative loss visible

A consistent starting population addresses the measurement gap in Table 2.

Realization Rate measures the share of originally prescribed patients reaching a specified milestone. Each person enters the account once, and the starting population remains the denominator. Refills and repeat orders therefore cannot inflate the patient count. This gives leaders a consistent view of progression from prescribing onward.

Consider 100 patients prescribed a medicine: 50 fill it and 40 reach day 90. A review of those who filled reports 80% progression. A review of all patients originally prescribed reports 40%. The first describes continuity after dispensing; the second exposes the cumulative gap that leadership must investigate.

The economic illustration applies this approach to 9,600 patients followed for one year. Their progress through treatment and the value they contribute are measured separately. The financial account includes shorter treatment periods before discontinuation, allowing the economic consequences of interruption to be examined.

The Value Leakage Ladder organizes this account as Written → Filled → Started → 90-Day → Persistence. Figure 1 uses explicit assumptions for the illustrative group, preserving a common denominator throughout.

A brand must specify when follow-up starts, how long filling and initiation may take, and what counts as discontinuation. Incomplete follow-up and missing records need visible categories. These rules must also distinguish clinically appropriate stops and informed choices from barriers the organization could address.

Claims, hub and pharmacy records should be reconciled before an apparent gap triggers outreach. The brand’s own consistently measured performance is the first useful benchmark. A change in patient mix, coverage or supply may explain movement that would otherwise be attributed to service quality.

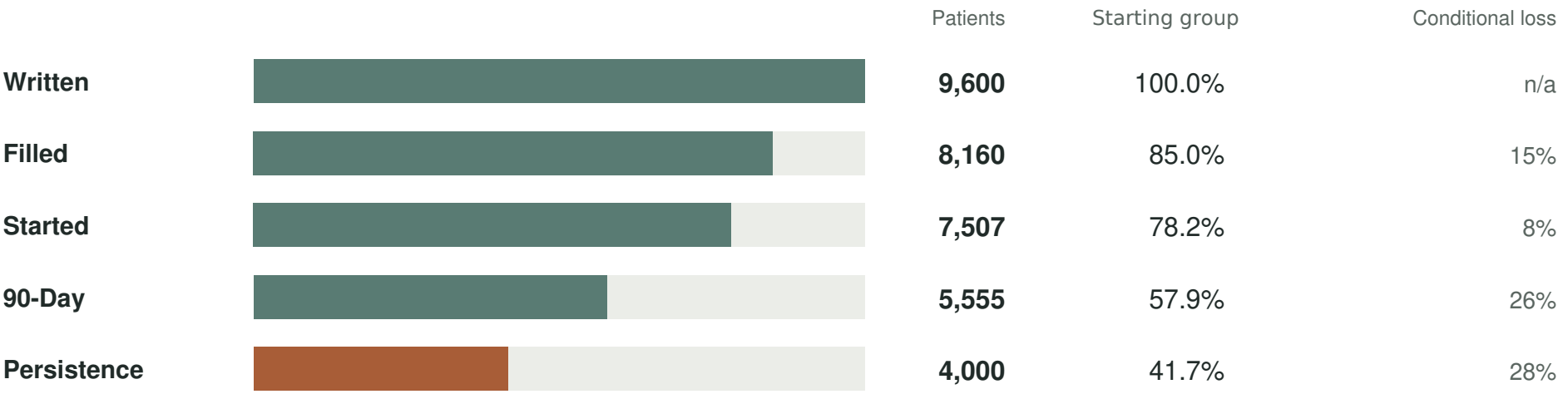
Measurement basis: the economic example uses one year for each patient. Published studies retain their own observation windows. Detailed definitions are on page 34.

PATIENT PROGRESSION

The Value Leakage Ladder follows the same patients for one year

Figure 1. Each milestone is measured against the 9,600 patients originally prescribed the therapy.

ONE-YEAR ILLUSTRATION | 9,600 PATIENTS



Counts rounded; conditional losses apply to patients entering each gate. Twelve-month milestone is illustrative.

The illustration follows 9,600 patients for one full year. Losses of 15% at access, 8% at initiation, 26% at early adherence and 28% at persistence apply to the patients entering each stage. Approximately 4,000 remain at month twelve, a 41.7% Realization Rate.

Figure 2 then counts commercial value from these patients during the year, including treatment before discontinuation. That produces a 55.4% Realization Yield. The distinction matters: the year-end population alone understates the value already realized.

Illustrative model. Counts are rounded expected values. A month-twelve endpoint does not establish uninterrupted therapy or clinical benefit. Later starts and reinitiation are outside this simplified scenario.

PATIENT PROGRESSION

The evidence required changes at each handoff

Data integration begins with event definitions, permissions and visible limits on inference.

Milestone	Candidate evidence	Boundary to disclose
Written	ePrescribing, order and referral records	Incomplete capture; duplicate or amended orders; define a unique patient and index episode.
Filled	Adjudicated pharmacy claims, specialty-pharmacy and hub disposition	Paid or reversed claims must reconcile; dispensing does not confirm self-administration.
Started	Patient confirmation, clinical records, appropriate support or device signals	Coverage can be selective. A proxy needs validation and a confidence label.
90-Day	Claims coverage and permitted follow-up	State the anchor date, allowable gap and whether the outcome is continuation or adherence.
Persistence	Longitudinal claims, administration and follow-up records	Require mature observation; distinguish discontinuation, restart, switch and missingness.

Table 3. Candidate evidence adapted from CEA-RN-2601. Availability and lawful linkage must be established within the actual brand and market. [1]

Useful records may sit with several partners, and access to a complete patient history cannot be assumed. Commercial leaders may need aggregate measures, while authorized support teams require case context. Information access should follow those responsibilities, preserving the separation between patient support and promotional targeting.

The handoff is complete only when its disposition is understood. Resolution, acceptance by another team and a reasoned stop have different implications for progression. An attempted contact records effort; it leaves open whether the patient received what was needed to proceed. Ownership must include responsibility for finding out.

With unchanged progression, additional prescribing increases both realized value and the value left unrealized.

ONE-YEAR ECONOMICS

A one-year value account shows the cost of interrupted progression

Compare full-year potential with the value realized from the same patients during that year.

Earned Value is CEA’s modeled commercial potential at prescription over a defined period. Here, 9,600 patients at $45,500 for a full year represent $436.8 million. This planning baseline is distinct from reported revenue, which follows accounting recognition rules. [1]

Realized Value counts what those patients contribute during the year, including treatment before discontinuation: $241.9 million in this model. For a live brand, finance must establish net price, dose, rebates, returns and timing, then reconcile the account with reported net sales. Contribution also reflects the relevant costs.

The difference is Unrealized Value: $436.8 million less $241.9 million leaves $194.9 million of value leakage. This defines the scale of investigation. Establishing how much could be recovered requires evidence about the causes of interruption.

Realization Yield divides Realized Value by Earned Value for the same patients and period: $241.9 million divided by $436.8 million, or 55.4%. Realization Rate answers a different question: about 4,000 of the original 9,600 patients reach month twelve, or 41.7%. Earlier treatment contributions explain why Yield exceeds the endpoint Rate.

Recoverable value is the expected difference between intervention and no intervention, on a common patient, time and valuation basis. Reach, effectiveness and full delivery cost determine the case. Appropriate stops, constraints beyond the organization’s influence and uneconomic responses limit what can be recovered.

Prospective Customer Value at Risk, or CVaR Exposure, estimates value that may still be lost during the remaining period. [24] A forecast loss can later enter the completed-period gap. The accounts must remain separate, with overlapping risks reconciled so the same value is counted once.

REALIZATION ECONOMICS

Separate patient progression, realized value and future risk

Each measure answers a different management question. Follow the same patients over a defined period.

Measure	Definition	Management use
Earned Value	Modeled commercial potential associated with written prescriptions for a defined patient group and horizon.	Establish a planning baseline. Reported revenue follows accounting recognition rules.
Realization Rate	Patients reaching a specified milestone divided by patients originally prescribed, within a stated observation period.	Locate interruption in the same patient group and investigate its causes.
Realization Yield	Realized Value divided by Earned Value for the same patients and period, including value before discontinuation.	Assess how much commercial potential became realized value.
Unrealized Value (value leakage)	Earned Value less Realized Value over a completed period.	Quantify the gap; establish addressable causes before estimating recovery.
Prospective CVaR Exposure	Expected future value at risk in the remaining period. Simple form: sum of remaining value multiplied by probability of loss.	Assess a possible future loss and the case for a timely response.
Incremental recoverable value	Expected value with an intervention less expected value without it, on the same patient, period and valuation basis.	Compare incremental contribution with the full cost of the response.

Table 4. CEA measurement distinctions. Definitions are conceptual; no risk probabilities are supplied. [1,24]

The simple risk formula treats amounts as fully lost or retained and counts each once. Partial losses and competing risks require fuller estimates, especially when several barriers affect one patient. Several interventions cannot each claim the full benefit.

Clinical need governs care. The economic account informs investment in the system; calls, rework and delivery costs remain separate. Check overlap before combining costs and unrealized value. Progression and revenue measures cannot establish clinical benefit.

REALIZATION ECONOMICS

Equal sustained populations can conceal different value leakage

A milestone-only example separates prescription volume from conversion at month twelve.

Illustrative measure	Brand A	Brand B
Patients with an index prescription	40,000	80,000
Patients at the twelve-month milestone	24,000	24,000
Realization Rate at that milestone	60%	30%
Earned Value at $12,000 per patient	$480M	$960M
Milestone-only value proxy	$288M	$288M
Gap under the milestone-only proxy	$192M	$672M

Table 5. Illustrative CEA comparison. The proxy excludes value from patients who do not reach month twelve; it is not a complete revenue or Realization Yield estimate. [1]

At Brand B, 10% more prescribed patients at unchanged 30% milestone attainment adds 2,400 milestone achievers and $28.8 million under the proxy. Raising attainment from 30% to 40% at the existing 80,000-patient volume adds 8,000 milestone achievers and $96 million. The 3.33 ratio compares different changes; costs and feasibility are not assumed equal.

The proxy gaps differ by a factor of 3.5: $672 million versus $192 million. Including value before month twelve could alter the revenue comparison in either direction. The example exposes an investment choice; achievable contribution after cost must decide it.

ONE-YEAR ECONOMICS

The one-year model reveals $194.9 million of unrealized value

An illustrative immunology scenario connects patient progression with commercial value.

Measure	One-year illustration	Calculation or meaning
Patients originally prescribed	9,600	Each patient is followed for one full year.
Full-year net value per patient	$45,500	$7,000 per fill × 6.5 fills in a full year.
Earned Value	$436.8 million	9,600 patients × $45,500 of full-year potential.
Realized Value	$241.9 million	Total value realized during the year, including shorter periods of use.
Unrealized Value	$194.9 million	Earned Value less Realized Value.
Realization Yield	55.4%	Realized Value ÷ Earned Value.

Illustrative CEA economic model. Amounts are rounded. Loss rates, timing assumptions and unrounded calculations are documented on page 34.

About 4,000 patients reach month twelve, giving a 41.7% Realization Rate. The higher Yield includes value realized before earlier stops. A measure confined to those who persist would leave that contribution out.

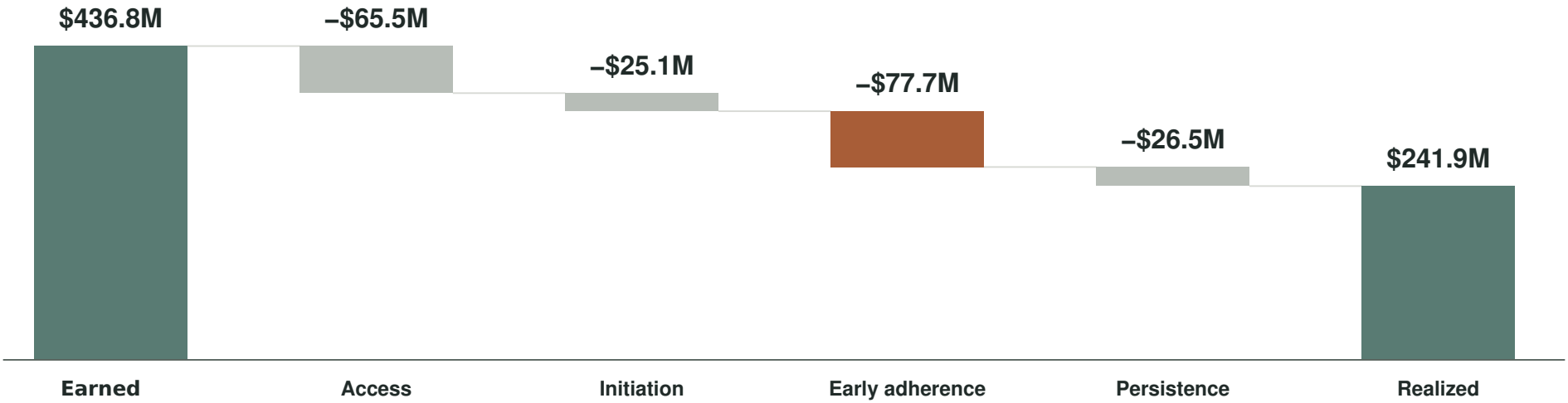
The next question is where the $194.9 million arises. Figure 2 separates the modeled gap by stage, directing attention to the timing and consequences of interruption.

REALIZATION ECONOMICS

Early-adherence leakage carries the largest modeled value gap

Figure 2. One year of commercial value from the same 9,600 patients shown in Figure 1.

SAME PATIENTS AS FIGURE 1 | ONE-YEAR VALUE, $ MILLIONS



Earned $436.8M − unrealized $194.9M = Realized $241.9M | Realization Yield 55.4%

Early-adherence interruption accounts for $77.7 million, about 40% of the $194.9 million gap. Persistence has a higher conditional loss rate, 28% against 26%, yet contributes less leakage because later interruption preserves more treatment value. Timing changes the economic priority.

The largest gap need not offer the strongest investment. A smaller barrier may be more tractable or cheaper to resolve. The journey investigation must establish the cause and plausible response before the financial model can estimate the value of acting.

Illustrative one-year economics. Loss states are mutually exclusive. Value generated before a loss is retained. The calibrated assumptions, including inferred inputs and the paid-fill credit before an unconfirmed start, are documented on page 34.

REALIZATION ECONOMICS

The value of reducing leakage depends on what changes next

Reach, loss timing and downstream progression determine incremental value.

In the illustrative model, lowering early-adherence loss from 26% to 25% retains an additional 75.072 patients at day 90. Applying the unchanged 28% persistence loss to this recovered group gives expected value of 89.5% of a full year: 72% at full value plus 28% at 62.5% value. The comparison patient lost at early adherence already contributed 12.5%. The incremental difference is therefore 77% of $45,500.

Multiplying 75.072 by $45,500 and 77% produces $2.630 million for each percentage-point improvement across the 9,600 patients over one year. A ten-point improvement produces $26.301 million under the same assumptions.

Scale depends on how many patients the response reaches. At twice the starting population, 19,200 patients, the same ten-point improvement produces $52.603 million. A four-point improvement at that larger volume produces approximately $21.0 million. These are one-year modeled values for the stated populations; the effects and full reach remain assumptions to test.

For the larger, 19,200-patient scenario, an assumed delivery cost of $5.2 million against $21.0 million of gross incremental value gives a gross value-to-cost ratio of about 4.0. A net return calculation also requires contribution margin, incremental drug costs, overlap with other programs and uncertainty. A nurse-educator investment case, for example, would need evidence for its expected effect and delivery cost.

Specify the transition an intervention changes and whether its effect applies to reached patients or the full eligible population. Extending a reached-patient effect to everyone overstates value; applying reach again to an already population-wide effect understates it.

A cost-of-delay estimate also needs an arrival rate, start date and effect over time. It must distinguish deferred receipts from permanently forgone value. The overall gap alone cannot supply a monthly cost.

Use a common counterfactual for overlapping interventions. Convert incremental net revenue into contribution, deduct delivery costs and add only separately evidenced operating savings. This establishes an investment case for a specific improvement in experience.

EVIDENCE FOR INTERVENTION

Interventions work through specific barriers and mechanisms

The evidence supports targeted tests of friction reduction; effects depend on setting and design.

Study and design	Finding retained	What management can infer
Adalimumab support program; observational, manufacturer-funded [17]	Abandonment was 5.6% for participants and 20.4% for non-participants in a 17,371-patient study.	An association worth investigating; selection and residual confounding limit causal attribution.
Text-message adherence support; meta-analysis of 16 randomized trials [21]	Pooled odds ratio 2.11; 95% CI 1.52–2.93. Trials were generally short and often used self-report.	Evidence for interventions in studied settings. Odds are not probabilities; the result does not isolate two-way messaging or AI.
REMIND devices; randomized trial, 53,480 patients [22]	No significant adherence improvement from the tested low-cost reminder devices.	A plausible mechanism still needs evaluation; this finding does not establish that every reminder fails.
Full coverage after myocardial infarction; randomized trial [14]	Adherence increased by 4–6 percentage points across the studied drug classes; the primary clinical endpoint was not significantly reduced.	Cost is a modifiable constraint, but removing it does not eliminate other barriers or guarantee clinical benefit.
Patient-support review; 64 studies [15]	41 studies, 64.1%, reported at least one significantly positive clinical outcome.	Heterogeneous evidence; the remainder cannot be described as a known proportion of ineffective programs.
Cochrane adherence review [16]	5 of 17 trials with the lowest risk of bias improved both adherence and clinical outcomes.	Dual improvement is difficult to establish; evaluate progression and clinical outcomes separately.

Table 6. Selected intervention evidence. Findings retain their study designs and outcomes; no pooled effect or ranking is implied.

Reducing value leakage becomes a growth lever when investment changes the sources of friction that patients and teams encounter.

COMMERCIAL INFRASTRUCTURE

Make the treatment journey an operating responsibility

Connect what patients experience with decisions that teams can carry through.

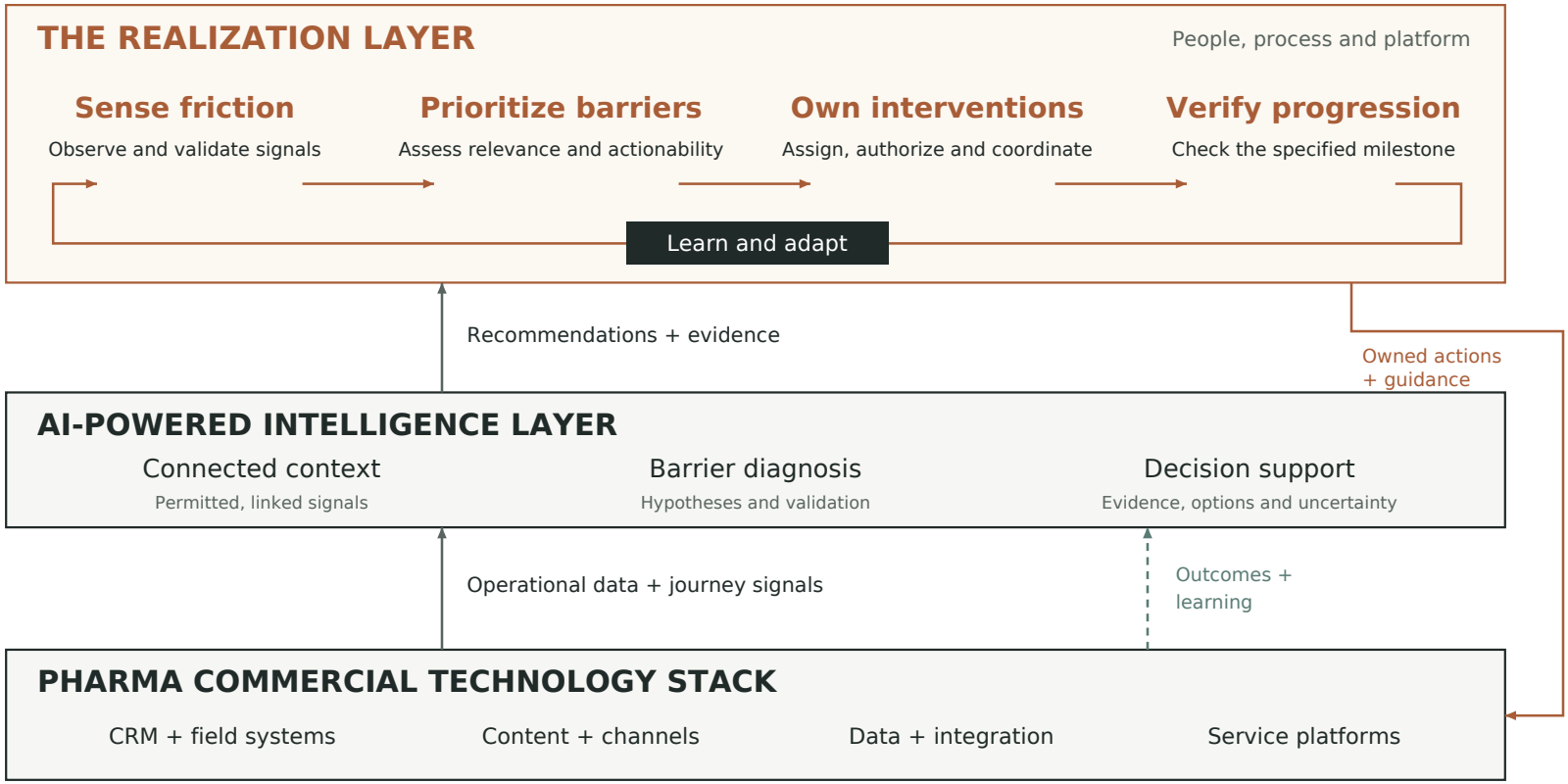


Figure 3. Universal CEA Realization Layer. Arrows indicate intended operating and information flows, not measured causal effects.

Customer consciousness reveals the difficulty; journey thinking traces its connections. The Realization Layer supplies authority and workflows to respond across them. The architecture earns its place when it helps resolve a barrier that would otherwise remain between functions.

OPERATING RESPONSIBILITIES

Give the team responsible for a barrier the authority to act

Each Realization Layer step needs clear responsibility, usable information and a route for resolving delays.

Sense friction begins with evidence of what patients and healthcare professionals encounter. Analysts establish the patient group and observation period, exposing gaps or delays in the records. Their task is to distinguish the event, such as an unfilled prescription, from its still-unproven explanation.

Prioritize barriers asks whether the organization can change the cause and whether the response justifies its cost. Patient consequences inform urgency; commercial consequences inform the investment case. Neither a large value gap nor a compelling anecdote is sufficient on its own.

Own interventions means giving a named person enough authority to coordinate access, support, pharmacy and field responsibilities. A sponsor must resolve resource or decision-rights gaps. The owner also records constraints held elsewhere, including payer requirements, clinical decisions and patient choices.

Verify progression establishes whether the next event occurred. Learn and adapt examines why, linking the action and its cost to the observed result. Keeping this history allows leaders to revise a response on evidence rather than repeat a familiar activity.

Existing teams can undertake this work if responsibilities are explicit. Individual cases need attention while help remains useful. Monthly review can address recurring failures, and quarterly review can reconsider investment. The cadence should follow the time available to resolve the barrier.

Finance reconciles two views of performance: the patient account follows treatment over its observation period; reported net sales follow accounting periods and revenue rules. Differences in timing, net price, patient scope and returns must be explained before leaders interpret either as evidence of improvement.

OPERATING ARCHITECTURE

The Realization Layer connects friction to action and learning

Use one operating loop to find friction, decide what to address, assign the work and check what happened.

Realization Layer step	What the organization does	What to confirm
Sense friction	Bring patient and caregiver accounts together with records the team is permitted to use. Check where progression has stalled and what is known about the cause.	A clear description of the barrier, its source and what remains uncertain.
Prioritize barriers	Assess the patient consequence, value leakage and cost of a response. Establish which part of the barrier the organization can change.	A reason to act, a proposed response and the assumptions that need testing.
Own interventions	Name the responsible person and delivery team. Agree their authority, response timing and route for escalating an unresolved issue.	The team accepts the work, completes the handoff and records what remains open.
Verify progression	Check whether the patient reached the specified next milestone. Measure commercial value over the agreed period.	Evidence of the patient’s next step and a separate account of commercial value.
Learn and adapt	Use the results to improve instructions, handoffs, capacity and investment decisions.	The findings lead to a change in the work or a clear decision to keep, expand or stop it.

Table 7. The universal CEA Realization Layer operating loop. Learn and adapt feeds every step. These are proposed operating responsibilities; roles and permissions must fit the brand, market and clinical context.

Journey thinking changes the meaning of completion. Sending an instruction or transferring a referral leaves open whether the patient could proceed. Teams need to establish whether the receiving party understood the next step and accepted responsibility.

That is where experience becomes operational. A missing document requires coordination; a first-dose concern requires qualified advice. The response should reduce the patient’s or office’s effort and uncertainty, then verify progression. Clinical benefit and commercial value remain separate outcomes to measure.

EQUIPPING THE OPERATING LOOP

Equip teams to carry out the Realization Layer

These capabilities provide the skills, rules and tools needed to perform the operating steps.

Capability	What it enables	Where it supports the operating loop
Experience architecture	Design clear instructions, useful support and handoffs that patients and teams can complete.	Informs Prioritize barriers, the design of interventions and the standards used to Verify progression.
Journey governance	Agree who can decide, who acts and how an unresolved issue moves across teams.	Sets authority for Prioritize barriers and Own interventions, including who checks the result.
Field barrier resolution	Help field colleagues report recurring problems through approved channels and receive feedback.	Connects Sense friction with Own interventions and returns information about the response.
Real-time detection and intervention	Recognize a relevant warning and coordinate help while it can still be useful.	Supports Sense friction and Own interventions; Verify progression checks what followed.
Behavioral and continuity infrastructure	Provide practical support for using treatment and routes to qualified clinical help when concerns arise.	Supplies services and processes used in Own interventions and Verify progression.
Continuous improvement	Test responses and change the work when results reveal a better approach.	Carries Learn and adapt across the operating loop.

Table 8. CEA capability relationships, proposed for implementation. A capability can support several steps. These are not a one-to-one mapping to Customer Excellence Activation’s MOBILIZE domains.

Capability investment should follow the difficulty encountered in delivery. If teams recognize a recurring access problem but cannot coordinate the office and pharmacy, clearer authority may matter more than another detection tool. Experience evidence helps distinguish that need from a shortage of information or clinical support.

Build on the people and services already in place. Strengthen the capability that limits the response, then reassess as evidence reveals the next constraint.

OPERATING ARCHITECTURE

Learning reduces recurring leakage when it changes the work

The intervention register connects evidence to the next operating and investment decision.

Learning starts with the investment decision. Record the barrier, proposed mechanism, eligible population and comparison, together with cost, possible harm and the observation window. Preserving the team’s expectations allows the eventual result to change its judgment.

A disappointing result may reflect the wrong mechanism, poor reach or a receiving team without capacity. Each explanation implies a different correction. Examine delivery alongside outcomes, including uncertainty: a favorable estimate with a wide interval provides little assurance that expansion will succeed.

An ineffective response should release its resources. A promising response delivered badly may warrant another test. Distinguishing an inconclusive result from evidence of little useful effect protects the organization from both premature expansion and premature abandonment.

Owners record progress between meetings. Monthly review can examine recurring barriers; the quarterly forum can compare results with the original investment case. Annual planning then translates supported findings into service standards, partner agreements and budgets. Each review should change a decision appropriate to its horizon.

Patient and caregiver accounts help explain why support was difficult to use or failed to reach people. Customer consciousness becomes organizational learning when this evidence changes instructions, handoffs or capacity. After-action-review literature offers a management precedent for connecting reflection to subsequent action. [23]

Success at one brand creates a proposition to test elsewhere. Transfer depends on comparable barriers, clinical use and delivery conditions. A portfolio register should preserve the assumptions and results of each application, allowing leaders to distinguish a repeatable mechanism from an effect specific to one setting.

OPERATING ARCHITECTURE

Business reviews must carry decisions beyond the meeting

A shared record prevents recurring value leakage from becoming a repeated explanation.

Failure mode to test	Effect on the management account	Required correction
Manual assembly and late extracts	Time is spent reconciling slides while the event data become stale.	Reusable definitions, traceable sources and a stated reporting cut-off.
Changing definitions within a brand	Trend comparisons and prior commitments cannot be interpreted reliably.	Version the patient definitions, windows and measures; explain any restatement.
Inconsistent value logic across brands	Portfolio differences may reflect methods rather than opportunity.	A common economic method with brand-specific clinical horizons and inputs.
Activity without progression	Work completed can obscure an unresolved patient transition.	Review completed tasks alongside whether the barrier was resolved and whether the patient reached the next milestone.
Patient and finance accounts do not reconcile	Leadership cannot tell whether differences arise from timing, scope or error.	A finance-owned reconciliation between the patient-based value account and reported revenue.
Unrecorded decisions and follow-up	The same question returns without evidence of action.	A dated decision record with owner, rationale, next observation and status.

Table 9. CEA diagnostic for business-review design. These are operating hypotheses to assess within the organization.

A useful QBR brings a decision into focus: which source of leakage merits action, why the proposed response should work and what it will cost. The shared workflow carries that decision into daily operations and returns evidence of what happened. This prevents responsibility from ending when the meeting does.

The next review examines delivery against prior commitments. Overdue actions, changed assumptions and observed progression replace another reconstruction of the problem. The QBR becomes a point of judgment within continuous management.

AI IN THE OPERATING LOOP

AI can help teams respond to friction sooner

Connect each proposed AI use to a specific problem, a responsible team and an observable next step.

An authorization waiting for a document creates a response window. A quarterly report may explain the delay after the fact; the patient needs the handoff resolved while treatment can still proceed. Earlier detection matters only if someone has the authority and capacity to respond.

Rules-based automation routes predefined tasks. AI can assist with permitted notes, assemble relevant history and suggest priorities; agentic workflows can coordinate several tasks within agreed permissions. People remain responsible for consequential decisions, and clinical questions remain with qualified professionals.

The question is which part of the journey AI improves. Detection matters when a team can act. Customer consciousness also shapes design: internal efficiency that creates more messages, repeated questions or confusion for patients may leave the underlying barrier intact.

In the illustrative rheumatology case, an authorized record identifies missing documentation. The system assembles the history and drafts a request for access-team review. The team coordinates with the office and confirms acceptance by the receiving organization. Following approval, support colleagues explain the next step and route treatment concerns to clinicians.

Testing should compare this proposed workflow with the current process. Assess accuracy, missed and false alerts, resolution time and the burden imposed on staff and patients. Progression and full cost determine whether faster task handling produces a worthwhile improvement.

“Real time” means early enough to help. Delayed claims or incomplete records may narrow that possibility. Approved sources, human review and safety workflows remain necessary; the promised speed must be judged against the actual response window and the quality of resolution.

AI AND THE RESPONSE WINDOW

Test whether AI-supported work improves patient progression

Evaluate the warning, the team’s response and the patient’s next step together.

Check before expanding	Evidence to examine	Decision it supports
The warning reflects a real problem	Compare alerts with records checked by qualified reviewers. Examine delayed or missing data and cases that the system missed.	Use the warning only for the situations in which it has been validated.
The risk estimate fits these patients	Check whether predicted losses match observed losses in relevant patient groups, and repeat the check as conditions change.	Adjust or stop using the estimate when it becomes unreliable.
A team can act in time	Confirm who accepts the work, what they can do and whether they have enough capacity to complete the handoff.	Fund the response team and workflow alongside the technology.
The response improves progression	Use random assignment or another justified comparison, with sufficient follow-up and checks for unintended harm or burden.	Expand when the evidence supports the claimed improvement.
The additional value justifies the cost	Include staff time, technology, partners and oversight. Check for benefits already credited to another program.	Compare the response with other growth investments using the same economic basis.

Table 10. Proposed evaluation design. Relationships between AI-assisted work, reduced burden and progression remain hypotheses until evaluated.

CMS-0057-F establishes prior-authorization process and interoperability requirements for specified payers, with major process provisions beginning in 2026 and API provisions generally in 2027. Its prior-authorization requirements exclude drugs. [20] Pharmaceutical authorization data availability must therefore be established for the actual workflow.

Evaluate the response through resolution: did the barrier clear, did another team accept responsibility, or was an appropriate stop recorded? Faster closure alone proves little. Compare incremental contribution with the full delivery cost.

LEADERSHIP DECISIONS

Use the realization lever in brand growth decisions

Promotion and realization belong in the same commercial plan.

The realization lever offers growth from prescribing intent already created. A brand may also need more appropriate prescribing. Its next investment should address the constraint with the strongest expected contribution after cost, reflecting brand maturity, access conditions and the experience of treatment.

Launch planning makes this dependency particularly visible. IQVIA’s 2026 analysis reports that an average of 35% of first-year prescriptions were filled across 99 novel medicines launched in the United States from 2020 to 2024. [9] The observation concerns prescriptions in the first year on the market, rather than twelve-month persistence in the same patients. It supports designing access and support before demand scales.

Launch teams should establish pharmacy routing, initiation support and escalation responsibilities alongside the evidence and engagement plan. Early access events can guide correction while the longer follow-up required for adherence and persistence continues. Readiness includes whether patients and offices can navigate the proposed journey.

A common economic method allows comparison across brands while preserving local inputs. Treatment duration, net value, coverage and patient circumstances shape the feasible response. Compare contribution after cost, uncertainty and time to benefit; reconcile shared patients and resources before aggregating the portfolio.

Customer consciousness becomes part of commercial culture when leadership asks how decisions affect patients and healthcare professionals. Reward teams for resolving barriers and accepting handoffs across functions. Field colleagues can report recurring office and process difficulties through permitted channels, while patient-support information retains its distinct purpose and access controls.

Brand plans should therefore connect growth commitments to the experience required to deliver them. The QBR tests whether funded responses are reducing the relevant barriers; incentives sustain the work between reviews. Performance definitions must respect patient choice and clinical exceptions, so commercial ambition supports appropriate treatment.

LEADERSHIP DECISIONS

A first test makes the value-leakage agenda concrete

The twelve-week agenda establishes a baseline and activates the work, with longer follow-up protected.

Timing	Required work product	Decision enabled
Weeks 1–2	Patient and measurement charter: entry criteria, milestones, follow-up period, clinical exceptions, sponsor and decision rights.	Is the intended question clinically and operationally coherent?
Weeks 2–4	Evidence inventory: permissions, coverage, linkage, latency, uncertainty and named operational owners.	Can the selected transition be observed and acted on credibly?
Weeks 4–6	Baseline: progression, reason-coded barriers and a finance-reviewed value bridge.	Where is a material, plausibly addressable constraint?
Weeks 6–8	Intervention design: mechanism, reach, comparison, costs, overlap and expected incremental effect.	Which bounded test deserves funding, and what would change that decision?
Weeks 8–12	Live pilot, intervention register, case escalation and scheduled evidence review.	Is the response reaching the intended population and working as designed?

Table 11. CEA implementation agenda. Timing is indicative and depends on data access, governance and delivery readiness.

Choose one brand and a consequential transition. Patient and HCP accounts should explain the difficulty; operational and financial records should establish its scale. Agree which uncertainty could change the investment decision, then give an accountable team the means to test the response.

Twelve weeks can establish a baseline and begin intervention. Twelve-month persistence requires longer follow-up. Keep retrospective evidence separate from new pilot participants, and fund observation beyond the initial planning cycle.

LEADERSHIP DECISIONS

Make realization a brand growth strategy

Customer consciousness must shape everyday decisions as well as strategic intent.

The next brand review should begin with a patient journey leadership can explain. Where did progression falter, what did patients and offices encounter, and what changed after the organization responded? A credible answer requires coherent evidence and responsibility beyond any one function’s scorecard.

CEA describes operating maturity as Reactive, Responsive, Anticipatory and Learning: from separate case handling to shared routing, validated anticipation and investment informed by results. These are design descriptions, not a validated score or required sequence. Reliable resolution may be more valuable than prediction when teams cannot yet act consistently.

Expansion should preserve what made the first response work. Before transferring it, establish whether the next brand faces a comparable barrier and has the capacity to act. Record local assumptions and outcomes so portfolio growth also improves judgment about where the approach applies.

Service standards and partner agreements can turn that learning into expectations: patients receive usable next-step information, receiving teams accept responsibility, and unresolved barriers reach someone able to act. Review these standards as treatment use and market conditions change. Culture becomes visible in what leadership insists happens after a handoff.

The realization lever gives brand leaders a growth strategy grounded in what happens after prescribing. Its strength depends on understanding experience, managing the journey and learning which barriers can be changed. Customer consciousness makes those choices relevant to the people whose progress gives the strategy its purpose.

Customer experience belongs alongside promotional acumen because both contribute to growth and value creation. The realization lever makes that contribution testable through patient progression, commercial value and the cost of achieving each improvement. The companion Practice Note develops the practical application; Value Unlocked’s executive brief and Masterclass support leadership alignment and activation. [24]

RESEARCH METHOD AND LIMITATIONS

Evidence and assumptions define how to use the analysis

Published findings, illustrative economics and CEA operating propositions have distinct roles.

This practitioner research synthesis combines selected access, adherence and support studies with CEA’s research and operating frameworks. It is not a systematic review. References identify the publications and source records supporting the claims; coverage of the literature is selective.

Published findings retain their original populations, units and observation periods. Cross-study comparisons are descriptive. They cannot establish a pooled industry Realization Rate, an industry-wide recoverable-revenue estimate or a causal effect of the Realization Layer. Leakage and addressability require brand-level evidence.

The rheumatology scenarios are illustrative. CEA’s diagnostic tables, capability relationships and proposed infrastructure require application and evaluation. The companion Practice Note uses patient accounts to inform possible mechanisms and questions, with their descriptive status and limitations stated there. [24]

Wayne Simmons, Founder and Commercial Systems Architect of The Customer Excellence Agency, developed the discipline, architecture and management synthesis. Customer consciousness and journey thinking are proposed operating foundations, not separately validated causal effects. The measures distinguish patient progression from commercial value; neither establishes clinical benefit or makes the entire unrealized gap recoverable.

A cohort is a defined group followed over a stated period. The 9,600 patients enter during a six-month intake, and each has a full twelve-month value horizon. The main text presents this as a one-year patient account. It is not revenue booked during one calendar year. Later starts and reinitiation are outside the simplified scenario.

Losses of 15%, 8%, 26% and 28% apply sequentially to patients entering each stage. They leave 3,999.836 patients at month twelve. The model credits no value before an access loss, one $7,000 fill before an initiation loss, 1.5 months of annual value before an early-adherence loss and 7.5 months before a persistence loss. These calibrated inputs include inferred credits; they are not observed treatment durations.

At $45,500 per full year, the modeled gaps are $65.520 million, $25.133 million, $77.709 million and $26.541 million: $194.902 million in total. Realized Value is $241.898 million and Yield is 55.3795%. The alternative loss assumptions of 17%, 9%, 16% and 27% produce 59.6812% Yield with the same credits. Neither scenario is a commercial benchmark.

Page 20 applies these assumptions to 9,600 and 19,200 patients; volume expansion does not establish calendar-year revenue. The Brand A/B comparison on page 17 excludes value from patients who stop before month twelve. The completed-period value gap is the retrospective cohort value gap; prospective CVaR Exposure remains separate. Missing observations and clinically appropriate stops require explicit treatment in a live account.

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