QIBR

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Better Pharma QBRs. Better Outcomes.

The QBR no one has to endure

How the High-Impact Pharma QBR turns the most dreaded meeting of the quarter into the core of a Realization Management system.

EXECUTIVE SUMMARY

The QBR is the one event that gets everyone's attention. Four times a year it focuses a brand's leadership and its functions on the same picture, and connects the evidence, the money and the authority to act. Yet most brand teams spend weeks preparing a story built to get through the meeting, about a quarter that has already happened. This paper sets out how the High-Impact Pharma QBR turns that meeting into the core of a Realization Management system, built to maximize both patient and commercial impact, and how AI makes that practical. At the heart of QIBR's proposition is a better experience of the QBR for executives, commercial leaders and brand teams.

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01 Nothing else in the quarter gets everyone's attention

Four times a year, a pharma brand gets something no dashboard or steering committee can command: everyone's attention at the same time.

Leadership clears the hour. Finance, market access, patient services, analytics and medical, functions that otherwise meet in pairs and manage their own numbers, all look at the same brand on the same day. For weeks beforehand the date pulls work toward it. Data that would have waited gets pulled. Questions that would have drifted get answered, because the QBR is coming and nobody wants to arrive without an answer.

The QBR focuses. For one hour, the whole of a brand's performance is narrowed to a few questions: how is it doing, what is in the way, and what will we do about it.

And the QBR connects. It is the only point in the quarter where each function's separate view is brought into a single picture. It is where the path from a prescription to a patient on treatment, which no one function owns, can be seen from end to end. And it is where the evidence, the money and the authority to commit it sit in the same place.

> *No other event in commercial pharma focuses this much talent, attention and authority on one brand at one time. The QBR does it four times a year, on schedule.*

That is an extraordinary asset. Every company already has it and already pays for it. This paper is about what that hour is usually spent on, and what it could be doing instead.

02 The weeks nobody sees

Getting ready for that hour takes weeks, and most of the work falls on the brand team, who become the human integration layer. It starts three weeks before the meeting.

It begins with the data requests, sent to five functions that each close their books on a different day. It continues with the first draft of the story, written before half the numbers exist, and the second draft, written after the numbers arrive and contradict the first. Finance sends a forecast through September. The dispensing report stops in August. Market access delivers its figure on the Thursday before, and it moves the story enough that two slides have to be rebuilt.

By Sunday evening the deck is on version eleven. Patient services has still not sent theirs. One chart is being rehearsed more than the others, because its weakest point is obvious and the challenge always comes.

Underneath the work runs something nobody puts on a slide. Leadership gives this brand one hour a quarter. Careers are shaped in that hour. Budgets are released or withheld in it. It cannot be skipped, delegated or replaced with a document, and everyone preparing for it knows which of their numbers will not hold if somebody presses.

> *People dread the QBR because it matters. No other meeting carries this much weight for the brand, or for the people presenting it.*

03 A story built to survive the meeting

Somewhere in those three weeks the objective changes. Nobody announces it. The work stops being about what the brand should do next and becomes about getting through the hour.

A story built to survive a meeting has a recognizable shape. It looks backward, because the past is the only territory where every question has an answer. It explains variance thoroughly and commits to little, because commitments are what get tested. Its recommendations arrive late and stay soft. The team's best analytical minds spend the most important two weeks of the quarter reconstructing what already happened, in order to defend it, in front of the only audience with the power to change what happens next.

Then it resets. The deck is archived. Next quarter the team opens a blank template and builds the story again from nothing, with new numbers and no thread back to what was promised, what was funded or what it delivered. Each QBR stands alone.

That reset is the deepest cost, and the least noticed. Confidence in a business comes from continuity: a commitment made in March, an expectation written down, a result in September that holds or does not. A QBR that starts over every quarter cannot produce it. Leadership never watches a decision play out, so it never learns which of the brand's judgments to trust. The brand lead never accumulates the one asset that makes the next request easy, which is a record.

> *The team spends the quarter's most important hour explaining the past, when it should be shaping the brand's future.*

04 "Adherence remains a challenge" is the most expensive slide in pharma

Here is what the hour itself produces.

The slide is titled *Adherence remains a challenge*. It has appeared in this brand's QBR four times in two years, with a different chart each time and the same three bullets underneath. Nobody disputes it. Nobody can say what it cost.

The first forty minutes of the meeting go on establishing whose figures are right. By the time the brand lead reaches the actual request, three hundred thousand dollars for a program against a defined access barrier, the attention that decision needed has been spent on arithmetic. The request is deferred. Not rejected: deferred, because the assumptions behind it were never tested in advance and there is no time left to test them now. Somebody suggests bringing it back next quarter with more detail.

Weeks of preparation across five functions, the most consequential hour the brand gets, and the output is a delay.

> *Multiply that by every brand and every quarter. It is the most expensive recurring hour in commercial pharma, and most of it is spent agreeing what already happened.*

What makes the pattern durable is that none of it looks like failure. The analysis was thorough. The deck was well made. Everyone behaved reasonably. The QBR simply had no mechanism for converting evidence into a commitment that could be judged later, so it produced the only output it was built to produce: an account of a quarter nobody can now change.

05 The question that ends the QBR's credibility

Late in that same meeting, a commercial VP asks something reasonable.

What follows is familiar. The program launched on time, which somebody confirms. Enrollment is up, though whether it is up more than it would have been is not established. The figure offered compares a month of this quarter with a quarter of last year. A second person observes that a payer changed its policy in the same window. The conversation moves on, because nothing in the meeting is capable of settling it.

The program was approved on an expectation. Nobody wrote that expectation down in a form that could be tested, named who would bring the evidence back, or set a date when the answer would be fair to ask for. After eight months of spending, nobody can say whether it worked.

For the brand lead this is the worst moment of the hour. A refusal would at least be clear. Here, nobody can say whether the last investment worked, and that doubt carries straight over to the request on the table today.

> *If a brand cannot show whether its past decisions worked, every new request is a matter of opinion, and leadership treats it that way.*

06 The most dreaded and mundane ritual in the calendar is one of the most untapped opportunities in the pharma commercial system

The instinct after a QBR like that is to fix the deck. Better charts, a tighter agenda, a pre-read circulated earlier. It never works, because the deck is not the problem.

Go back to where this paper began. The QBR gets everyone's attention, focuses it on one brand, and connects functions that otherwise never look at the same picture. Those are exactly the properties a management system needs at its core, and almost nothing else in the business has them. Every company already holds this hour and already pays for it, in the time of its most senior people. Nearly every company spends it looking backward.

Every other part of the business that matters is run as a system. Supply has forecasting, signals and exception handling. Finance has a close calendar, approvals and audit. Clinical development has protocols, endpoints and pre-specified analysis. Each decides in advance what it will measure, who approves it and what will count as the answer. The space between a prescription and sustained treatment has none of that. It is the one part of the commercial model where a brand spends real money against an expectation nobody wrote down, on programs nobody evaluates, reported in a meeting that cannot reach a verdict.

Realization Management is the discipline that closes that space: managing what happens between prescribing and sustained treatment, with accountable decisions and evidence of what they delivered, to maximize both patient and commercial impact. [4] Any management system needs a core, a recurring point where evidence becomes commitment and commitment is judged. The QBR is that core. It is already on the calendar. A QBR run this way is what this paper calls a High-Impact Pharma QBR.

Patients and HCPs do not exist neatly in quarters. They live in a dynamic, real-time world and a complex healthcare ecosystem, where a payer changes a policy one month and a patient abandons a prescription the next. A brand has to stay vigilant to the friction points and barriers they run into, and take decisive action on them, because those barriers hold back both goals at once: the patient's treatment and the brand's performance.

That takes a management system that runs all year, built to maximize both patient and commercial impact, with the QBRs as its anchors. The system does two things. It detects signals: the first signs that patients or HCPs are running into friction. And it executes interventions to remove that friction. Between QBRs, the signals keep coming in and the interventions keep running. At each QBR, leadership takes stock of what the signals show, decides which interventions to start, change or stop, and commits the resources.

> *A Realization Management system detects signals and executes interventions to remove friction. That turns the QBR from a relatively passive event into a dynamic system.*

In a passive QBR, a team reports what happened. In a dynamic system, the business acts on what is happening. Until recently this would have needed more analyst time than any brand could spare. AI has changed that, as a later section explains.

> *Every competitor works hard at creating demand. Almost nobody manages what happens after the prescription as a system. That is where the unclaimed advantage is.*

Run this way, the same hour changes character. It stops reporting a quarter and does the four things a management system requires: establishing what the evidence shows, locating where value is lost, quantifying a commitment, and judging the last one. The story no longer has to be rebuilt from nothing, because each QBR picks up where the last one ended. Preparation becomes less stressful too. A brand lead who can show what past decisions delivered has far less to defend.

07 Five attributes define the High-Impact Pharma QBR, and their benefits go beyond the decision

DEFINITION

A High-Impact Pharma QBR is a quarterly business review run as the anchor of a Realization Management system, which detects signals and executes interventions to remove friction for patients and HCPs. It is connected, continuous, vigilant and accountable, and AI makes it practical. Its purpose is to maximize both patient and commercial impact.

A better decision in the meeting is only part of what this gives a business. Each attribute also changes something outside the meeting: how the weeks before it are spent, what leadership can trust, and how quickly a brand sees a problem.

ATTRIBUTE	WHAT IT MEANS	WHAT IT GIVES THE BUSINESS
Connected	Every function brings its evidence into one picture, with each figure tied to its source and period	The meeting is spent on the decision, and nobody argues about whose numbers are right
Continuous	Each QBR opens with what the last one's decisions delivered	Confidence through continuity, and a growing record of what works for this brand
Vigilant	Signals of friction for patients and HCPs are detected between QBRs, as they develop	Problems are seen in weeks, while there is still time to act
Accountable	Every decision and intervention carries its value, its cost, an accountable owner and a date to judge it	Budget goes to what delivers value, and stops going to what does not
AI-enabled	AI does the integration, and people keep the judgment	Weeks of preparation go back to the brand team

Running one takes three things. **An intervention mindset:** the QBR stops being a report on the quarter, and each signal of friction is answered with an intervention that carries its value, its cost, an accountable owner and a date to judge it. **Tailored workflows:** no two companies run the QBR the same way, so the frameworks, workflows, business rules and blueprints are fitted to how the company prepares, decides and follows through. **A platform for continuity:** decisions, owners and results carry from one QBR to the next, so nothing is rebuilt from a blank template.

Figure 1 shows how these fit together, with one QBR at the center.

08 The value is already earned, and so is the patient's treatment

By the time a prescription is written, the brand has spent almost everything it will spend on that patient. The science, the trial, the approval, the launch, the access negotiation and the field effort are all behind it. The prescription is the point at which that investment converts into an earned claim on revenue. What happens next determines how much of the claim arrives, and almost none of it is managed.

The prescription is also the point at which a physician has decided what a patient should receive. Every unrealized prescription is therefore two losses counted once: revenue the brand earned and did not collect, and a treatment a patient was meant to have and did not get, or did not stay on. The commercial gap and the patient gap are the same gap. A system that closes one closes the other.

The published evidence on that stretch is blunt. A 2026 JAMA study of IQVIA claims covering 1.17 million individuals found that formulary-related rejections of initial fill attempts for single-source branded drugs rose from 24.3% in 2018 to 40.7% in 2024. Of the attempts initially rejected, 48.4% had no recorded fill of any drug in the same therapeutic class within 90 days. [2]

Those figures describe a market, not a brand. They do not establish your rate, and they do not show that every unfilled prescription left a patient untreated. What they establish is the size of the territory a QBR is not looking at.

Four measures make that territory countable. They describe prescribing potential and what became of it, they reconcile to the financial account, and they stay distinct from recognized revenue.

MEASURE	WHAT IT MEANS IN THE QBR
Earned Value	Modeled net revenue associated with the cohort's prescriptions over the agreed treatment horizon. Prescription potential, not revenue booked
Realized Value	Net revenue associated with observed paid treatment for that cohort over the same horizon, on Finance's approved method
Value at Risk	The difference between the two. An unrealized gap to investigate, of which only part is addressable
Realization Yield	Realized divided by Earned. Comparisons require consistent populations, horizons and valuation assumptions

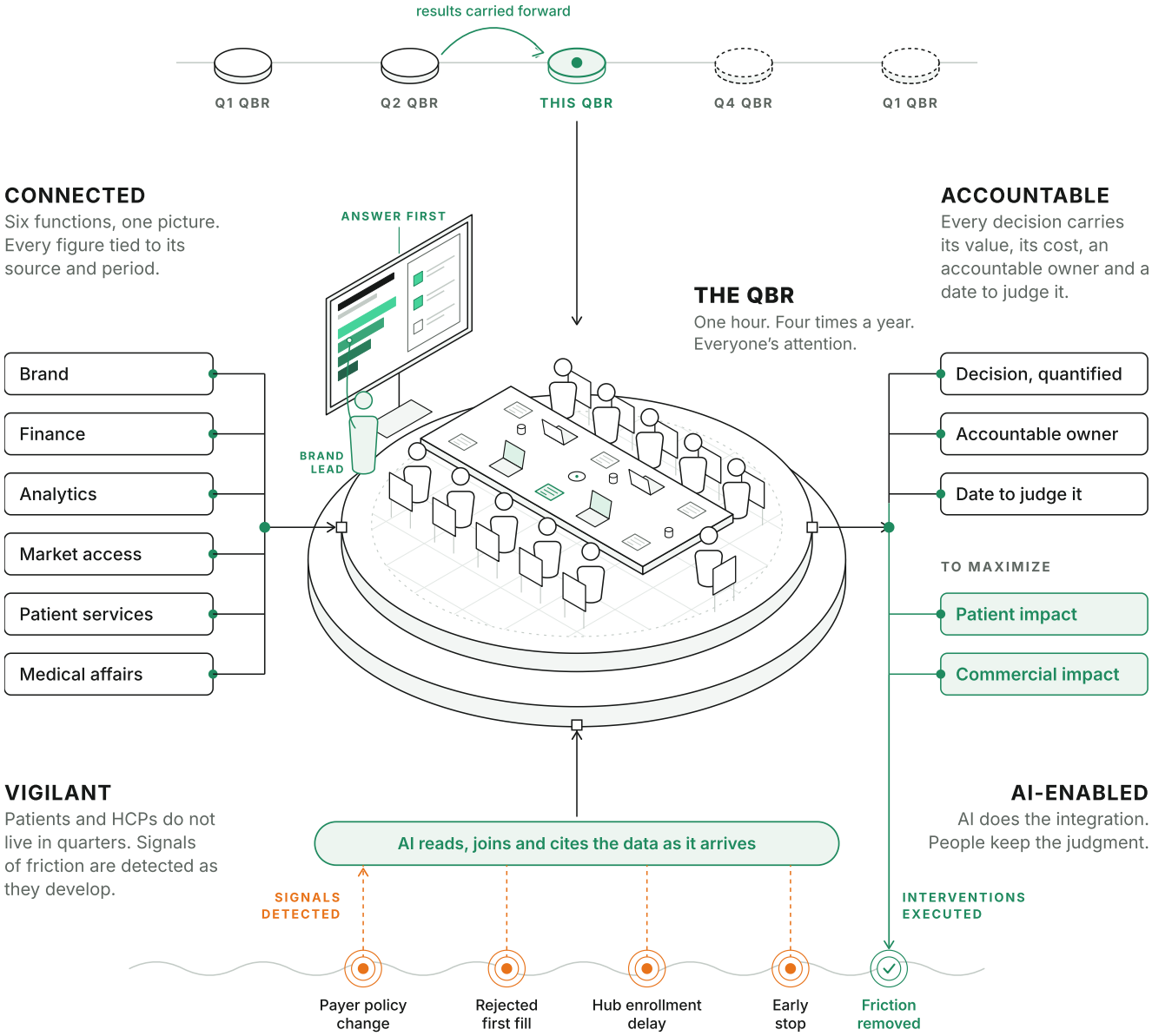
FIGURE 1 · THE HIGH-IMPACT PHARMA QBR

THE QBR AS THE ANCHOR OF A MANAGEMENT SYSTEM

A dynamic system that detects signals and executes interventions to remove friction.

CONTINUOUS

Each QBR opens with what the last one's decisions delivered. Confidence builds through continuity.



BEYOND THE DECISION · WHAT IT GIVES EACH GROUP

Executives

A QBR they can decide from, with the evidence settled.

Commercial leaders

A view of what past decisions delivered, and where to commit next.

Brand teams

Weeks of preparation back, and a record instead of a story to defend.

Patients

Barriers seen and removed sooner, so more start and stay on treatment.

Two cautions keep this honest, and both matter more than the headline figure. Observed revenue and projected revenue always appear separately: a patient prescribed in the last month of the quarter has not had twelve months in which to continue treatment, and a QBR that reads that absence of follow-up as a shortfall is reporting a loss that has not happened. And not all of the gap is recoverable. Patients complete treatment, switch therapy and stop for sound clinical reasons. Medical affairs identifies that share, and it never belongs in a figure described as addressable.

> *The addressable part of the gap is routinely larger than every program decision on the agenda combined. It goes unclaimed mainly because nobody has quantified it.*

The weeks of preparation are the problem people feel. The value already earned, and the patients behind it, are the larger opportunity. A QBR run as the core of a Realization Management system addresses both.

09 Four obligations put the High-Impact Pharma QBR into practice

A High-Impact Pharma QBR meets four obligations. Each one changes what happens before the meeting rather than during it.

One: settle the evidence before anyone presents. A finance forecast running through September and a dispensing report closing in August are both correct. They cannot support a comparison that treats them as the same period, and discovering that in the meeting costs the meeting. Citing a figure is not the same as settling it.

RECORD	WHAT THE QBR MAKES CLEAR
Source	The file, system or analysis the figure came from, with its version or extraction date
Period	The period represented, and the date through which the source is complete
Population	The patients, prescriptions, accounts or transactions included, with exclusions stated
Definition	The counting rule, unit and denominator, including how reversals and duplicates are treated
Approval	The function accountable for the figure, and any qualification that limits its use

One obligation inside this is easy to skip and fatal to skip. Counts drawn from unrelated populations cannot describe where the same patients progressed or stopped. A count of prescriptions, a count of patients and a count of fills describe three different things, and a funnel assembled from all three describes none of them. FDA guidance on real-world data sets out why source coverage and follow-up determine what these records can support. [1]

Two: follow the patient past the prescription. Revenue against plan establishes the result. The explanation sits downstream of it.

POINT OF OBSERVATION	WHAT THE QBR ESTABLISHES
Written	The defined group of new treatment prescriptions available in the source. The prescribing plan is reviewed separately
Filled	A first dispensing event under agreed counting rules, with rejected and reversed claims treated consistently
Started	An observed first dose or administration. Any proxy used when initiation cannot be observed is named
Continued at day 90	Continued treatment among patients with sufficient follow-up, under a treatment-specific rule for permitted gaps
Persistent at month 12	Continued treatment over the longer window, among patients eligible for that assessment

A dispensing record establishes that a prescription was filled, not that a patient took a first dose. Day-90 continuation measures persistence, which is whether treatment continued; adherence is a separate question about how a regimen was followed. Ninety days and twelve months suit continuing therapies and are not clinical standards. [1, 3]

Three: quantify every decision so Finance can rebuild it. Leadership will not stand behind an estimate it cannot check. Before approval, Finance signs off the net revenue assumptions, the expected treatment duration and the deductions, and the estimate follows a defined cohort over a stated period. It credits the revenue a patient delivered before discontinuing, because a patient who stopped at month six counts for six months, not nothing.

Four: open the next QBR by judging the last one. A decision stays open until it has a measured result, not until the intervention launches. This is the obligation almost nobody meets, and it is the one that compounds. A brand that reopens its decisions accumulates evidence about what works on its own patients. A brand that does not starts every quarter from opinion.

10 What a decision looks like when it is quantified

Return to the three hundred thousand dollars.

The team can reach 200 eligible patients and expects the program to improve first-fill probability by 10 to 20 percentage points against the current approach. Each additional first fill carries an average of six incremental paid treatment months inside a twelve-month horizon, an assumption that already allows for later discontinuation. Finance puts net revenue at $3,000 per paid month and incremental contribution margin at 80% before program cost.

ASSUMPTION OR RESULT	LOWER	CENTRAL	UPPER
Improvement in first-fill probability	10 points	15 points	20 points
Additional first fills	20	30	40

ASSUMPTION OR RESULT	LOWER	CENTRAL	UPPER
Additional paid treatment months	120	180	240
Incremental net revenue	$360,000	$540,000	$720,000
Contribution before program cost	$288,000	$432,000	$576,000
Program cost	$300,000	$300,000	$300,000
Expected incremental contribution	−$12,000	$132,000	$276,000

Every figure here is an illustrative assumption, not an industry benchmark or a QIBR customer result.

The program needs about 21 additional first fills to cover its cost, an improvement of roughly 10.4 percentage points across the 200 patients it can reach. The lower case loses money.

> *When a business case shows only upside, nobody tests it. Showing the downside invites the questions that make the decision sound.*

Leadership can now examine three things that matter: whether the evidence supports an improvement above breakeven, whether the reach estimate holds, and whether three hundred thousand dollars is the right price for that exposure. That is a different meeting from the one where the request was deferred.

Note the scale. This decision is deliberately modest, and the arithmetic is the point rather than the sum. The same method applied across the brand's annual cohort is where the latent value sits, and that figure is almost never on a QBR agenda.

What makes the decision assessable is the record taken at approval.

THE DECISION RECORD	THIS EXAMPLE
Decision requested	Fund one quarter of access support for 200 eligible patients
Approved cost	$300,000 incremental
Central assumption	15 point improvement in first-fill probability, 30 additional first fills
Expected result	$540,000 incremental net revenue, $132,000 contribution after program cost
Breakeven	21 additional first fills, about 10.4 points
Accountable owner	Patient services lead, with market access
Evidence for the next QBR	First-fill results for the agreed population and period, actual cost, access changes

THE DECISION RECORD	THIS EXAMPLE
Financial assessment due	When twelve-month cohort results mature
Status today	Proposed. No observed result

Where delay carries a cost, estimate it over a defined period on the same assumptions. Presenting the entire opportunity as the automatic cost of waiting is not an argument, and an experienced leadership team will treat it as one.

11 Judging what was delivered, without flattering it

A program can launch on schedule and change nothing. The next QBR has to separate two questions that are routinely merged: was the action delivered, and did it deliver value.

The record above supplies the comparison. An accountable owner asked only whether the program launched has no reason to prepare the evidence that would judge the investment, and will not.

Keep the original expectation visible. Open with what was implemented, what it cost, and how the observed result compares with what was recorded at approval. Where reach fell short of plan, that sits beside the outcome rather than replacing it.

Give the evidence its own clock. An operational measure may be readable at the next QBR while the financial result is immature. A fall in unresolved access cases is an early signal. It does not establish the twelve-month contribution.

Separate the intervention from everything else that moved. Payer policy, patient mix and a second initiative can all shift the same measure. Agree the comparison before launch where the data allow a comparison group. State what the evidence supports and where attribution stays open.

Leadership then continues, amends or stops the activity, and records why. Over several quarters the brand builds an account of which commitments delivered value and which assumptions have to change. That record is the most valuable thing the QBR produces. It gives leadership confidence through continuity: they have seen this brand's judgments play out and know which to trust.

12 Who is accountable for what

Ownership fails in the seams between functions. It holds when the team agrees who approves each input and who is accountable for the action that follows.

CONTRIBUTOR	WHAT THEY OWN IN THE QBR
Brand lead	The recommendation and the approval it seeks; earlier decisions brought back for assessment

CONTRIBUTOR	WHAT THEY OWN IN THE QBR
Finance	The financial account and the economics of proposed actions, including net revenue, costs and assumptions
Analytics and insights	Definitions, reporting periods and cohort comparability; the line between observed results and estimates
Market access	Payer changes and access barriers, with the evidence behind a proposed response
Patient services	Service delivery and reach, and the measured results of support activity
Medical affairs	Clinically appropriate treatment patterns and the interpretation of discontinuation

Agree the leadership brief before commissioning a deck. The brief names the decisions needing attention and the evidence required to take them, so the analysis is prepared against an explicit question and differences are resolved before anyone presents.

Then run the meeting in that order. Earlier decisions and what they delivered. The proposed commitment, with its economics and its uncertainty. Detailed evidence only where it bears on the choice. Close by recording the decision, the accountable owner, the measure and the date the result can fairly be assessed.

> *If time runs short, cut the detailed evidence, not the decision.*

13 AI is what makes this practical now

Everything in this paper could, in principle, have been done ten years ago. It was not, for a simple reason: the work was too heavy. Joining five functions' data, tying every figure to its source, quantifying every decision and keeping track of every commitment, quarter after quarter, would have taken more analyst time than any brand could spare. So the brand team did the integration by hand, as well as it could, and the QBR stayed a backward-looking report.

AI changes what is practical. It can read the source material as it arrives, including finance packs, payer updates and patient services reports, and bring it together into one picture of the brand. It can assemble the QBR from that picture, with each figure tied to its source and period. It can draft the story from the cited figures, flag where two sources disagree, and help keep the record of decisions and results up to date between QBRs. Work that took weeks of manual effort can be ready in minutes, and redone whenever a number changes.

That also changes the rhythm. Because the picture can be refreshed as new data arrives, the brand can see friction points and barriers as they develop, in something close to real time, instead of finding out at the end of a quarter. By the time of the QBR, the team already knows what happened. The meeting can be spent deciding what to do about it.

AI does not replace judgment, and it should not be trusted blindly. Every figure it reports has to trace back to a source a person can check. It should work on aggregate data, with no individual patient or prescriber records. And the people accountable for the brand still approve the inputs,

interpret the results and own the recommendation.

> *AI takes the weeks of assembly out of the QBR. The judgment and the accountability stay with people.*

14 Start with one brand and a decision somebody already regrets

Take the most recent QBR for a single brand, alongside a commitment leadership will ask about again. Establish whether the record holds enough to judge what was approved. The gaps are the specification for the next one.

Agree the available data and who approves each input. Settle the populations and the reporting periods. Where a measure is unavailable, decide how the limitation appears and whether it changes the recommendation. Then run one QBR in the new order, and reopen it the quarter after. Most teams reach a defensible first figure inside two weeks. Most are surprised by it.

QIBR is pharma QBR software that puts AI to work in this way. It builds the QBR in one click from the brand's supplied data, with every figure cited to its source and its period, every proposed decision carrying its value and cost, and each quarter opening with an account of what the last set of decisions delivered. QIBR takes over the integration, so the brand team can go back to judgment. The team remains accountable for the inputs, the interpretation and the recommendation.

At the heart of QIBR's proposition is a better experience of the QBR for the people who live it. Executives get a QBR they can decide from, with the evidence settled and each decision quantified. Commercial leaders can see what past decisions delivered and where to commit next. Brand teams get their weeks back, and arrive with a record instead of a story to defend. When the experience improves for all three, the QBR gets better, and so do the outcomes for patients and for the brand.

Four services exist because software produces the QBR and people still have to change how they use the hour. **The QBR Value Diagnostic** examines one brand's gaps and quantifies them commercially, which produces the brand's own figure rather than an industry one. **Platform Configuration** goes beyond QIBR as it stands: it tailors the pre-defined frameworks, workflows, business rules and blueprints to the company's own QBR process, and prepares approved sources for QIBR or the company's approved AI environment, with source traceability built in. **Facilitated QBRs** support the discussion while the team adopts the new order, because the first two quarters are where the habit is set or lost. **Realization Coaching** continues between meetings, holding progress against commitments while there is still time to adjust.

Realization Management is the discipline. The QBR is its core. QIBR is the platform that runs it. The advantage goes to the brands that stop surviving the quarter's most important hour and start using it.

Arrange a walkthrough around one brand's QBR.

See it on your own brand qibr.ai

SOURCES AND MEASUREMENT NOTES

[1] US Food and Drug Administration. *Real-World Data: Assessing Electronic Health Records and Medical Claims Data to Support Regulatory Decision-Making for Drug and Biological Products.* July 2024. The guidance informs the measurement cautions in this paper. It does not prescribe a commercial QBR process. https://www.fda.gov/media/152503/download

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QIBR

WHAT TO DO NEXT

Quantify the gap on one brand.

The first step takes two weeks and no new technology. One brand, one period, and the three figures that follow: earned, realized, and the gap between them.

Most teams are surprised by the answer. That answer is what a High-Impact Pharma QBR is built on.

If you want that figure checked against your own data, that is the conversation to have.

See it on your own brand qibr.ai

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