



Blind Spots in Launch Tracking

Why Standard Research Isn't Enough

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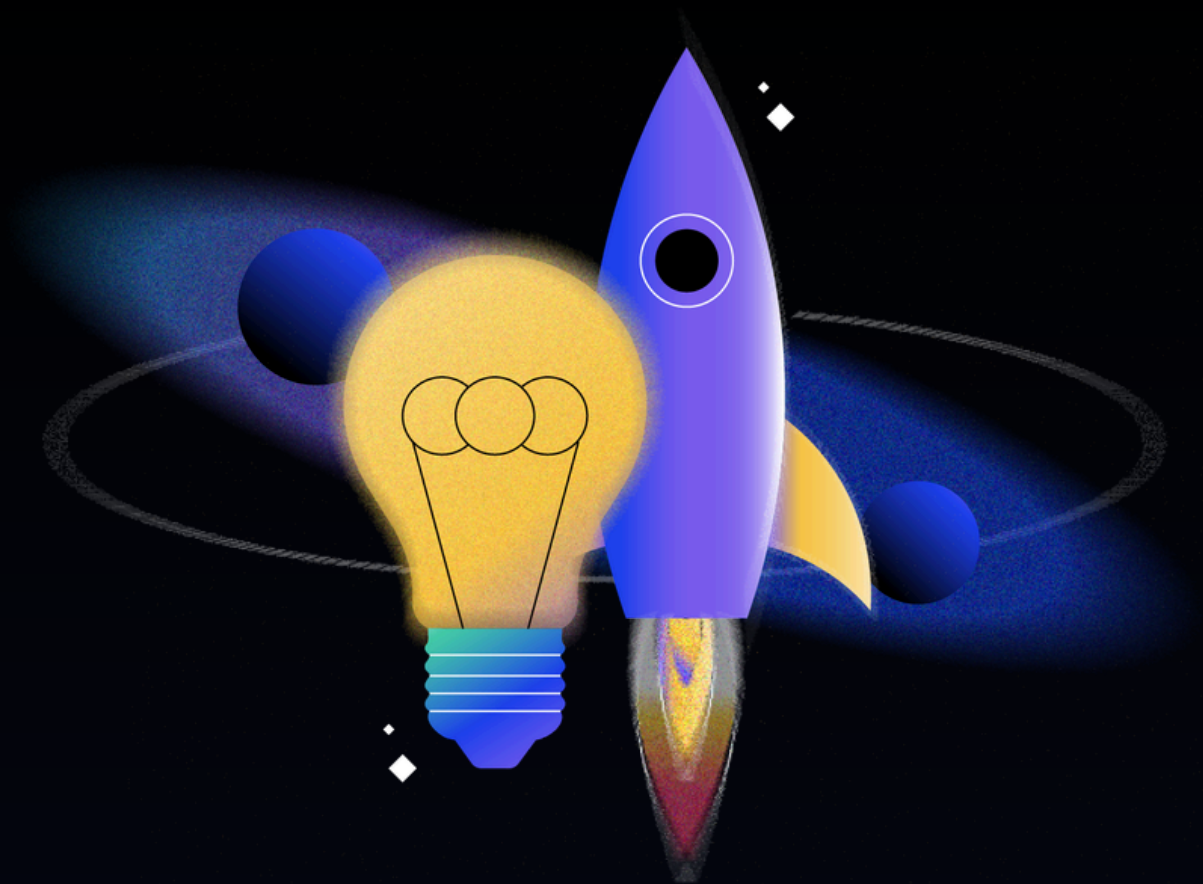
READING TIME

20-30 minutes

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Varsha Sundaram is a Product Owner and Lead for Brand Performance Tracking at ZoomRx, bringing nearly a decade of experience in pharmaceutical and healthcare market research. She specializes in brand tracking, and launch strategy development, with a focus on translating complex market dynamics into actionable insights for life sciences clients.

Varsha is a key architect of ZoomRx's Integrated Launch Tracking offering, which challenges the conventional approach of siloed research in favor of a more connected, comprehensive view of launch performance. Her work is grounded in the belief that fragmented insights lead to fragmented decisions – and that an integrated approach is essential for launch success in today's competitive landscape.

90+

Launch Studies Conducted
in the last 2 years

130+

Launch Brands tracked
in the last 5 years

1.2 M+

Launch Benchmark
datapoints in the last 5 years

Introduction

In the excitement of preparing for launch, the signals can look encouraging. Awareness is building, forecasts are holding, and early feedback suggests the market is moving in the right direction. But a positive topline read can also make a launch feel more certain than it really is. It can show that the market is moving, without always showing what is driving that movement, where resistance is being built, or what decision needs attention next.

That is how blind spots usually form. Sometimes the team can sense that something is off, but the existing read is not specific enough to explain it. Other times, the data points broadly in the right direction, making the unresolved issue harder to see until plans, spend, or field activity have already started to move. The challenge is rarely a lack of data. It is that the available data may not match the level of detail, timing, or decision the launch now requires.

This white paper looks at five real, blinded ZoomRx client partnerships where that moment came into focus. Each team was at a different point in the launch arc, with a different brand situation and a different blind spot to resolve.

FIVE CASE STUDIES

The Launch Question, The Answer Mechanism, and The Outcome

A small specialty biotech launching behind a same-mechanism competitor.

Are we assuming the competitor owns the market, or do we know which patients they are actually winning?

A top ten pharma entering a market anchored by an entrenched standard-of-care.

Are we trying to compete everywhere, or is there a specific place where the standard of care is weaker?

A mid-size biotech hearing that patients were being scared off online.

Are patients really afraid of the brand, or are we just repeating the loudest story we have heard?

A top twenty pharma with four strong messages but softening prescribing intent.

If all four messages tested well, why are they not moving prescribing?

A top five pharma expanding into a much larger PCP-led patient population.

Are we assuming PCPs will respond like specialists, or do they need a different playbook?



Across these five cases, the teams were not operating without data. In many cases, they had strong trackers, secondary data, message testing, advisory board feedback, or early field signals. But the question that mattered most sat just outside the read they already had. ZoomRx Launch Tracking helped bring that question into focus early enough for the team to act.

The impact was not simply better measurement. It was better timing, sharper diagnosis, and more confident decision-making while the launch window was still open. In each case, the team moved from a broad signal to a more actionable read, and from a general sense of performance to a clearer understanding of where to focus next.

SCENARIO 1

A same-mechanism competitor launched six months ahead. Is there still room?

LAUNCH QUESTION

The dashboard said the market was forming. The unanswered question was which patient archetypes had already hardened.

If the competitor takes the early-progressor segment,
what happens to our peak share?



VISIBLE SIGNAL

Awareness was growing quickly, but the market still looked broadly addressable.



BLIND SPOT

Aggregate data could not show which archetypes the competitor was capturing.



LAUNCH RISK

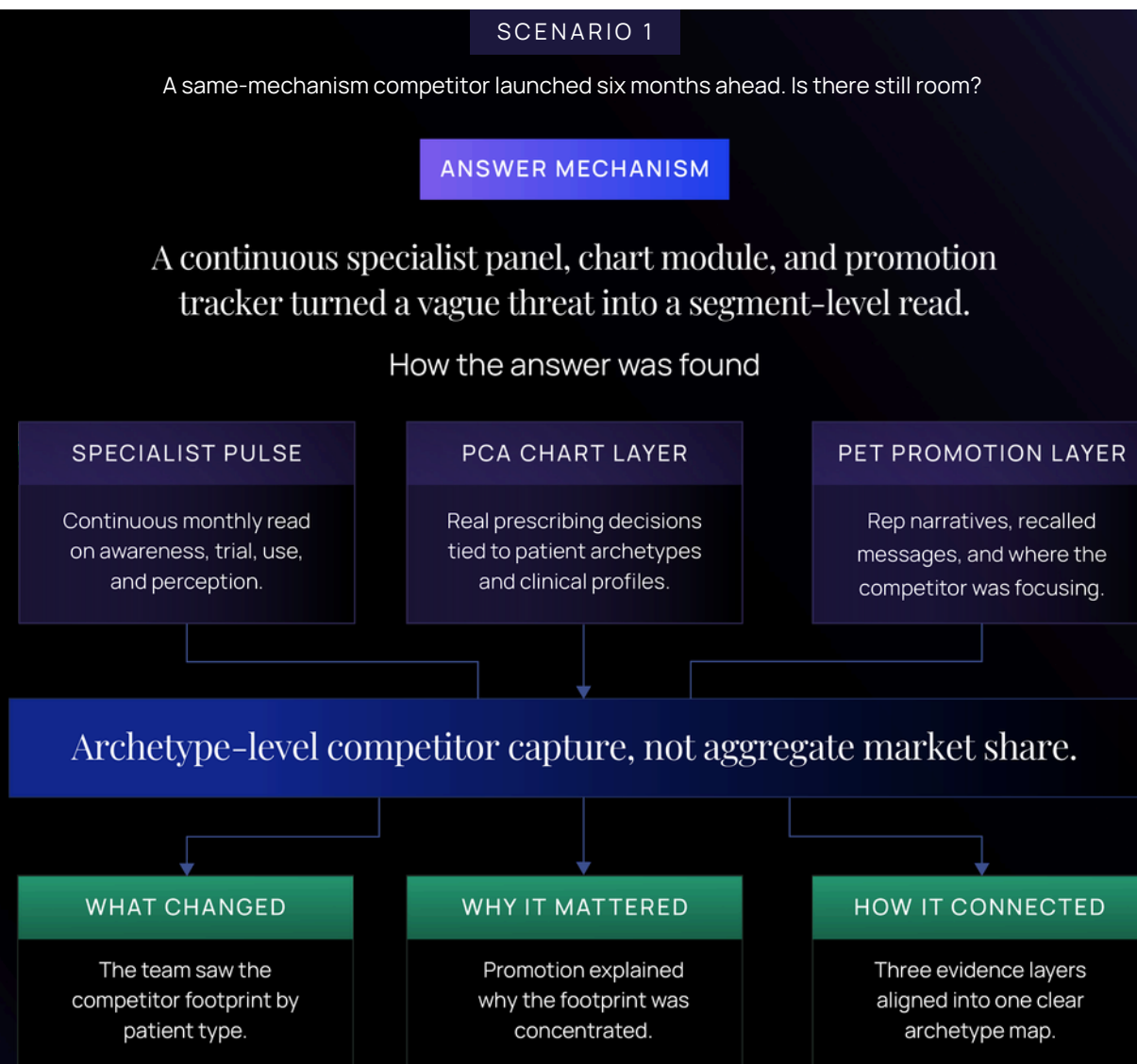
The field force could fight for patients that were already gone.

Situation

A small specialty biotech was preparing to launch its first-ever brand as a second-in-class entrant, with a same-mechanism competitor already six months into the market. Early signals were encouraging with the syndicated data and advisory board feedback suggested the market was still forming, and the competitor had not yet fully defined the category. But the aggregate read left an important question unresolved. Was the competitor gaining broadly, or was its early traction concentrated in one patient archetype that could materially affect the new brand's peak-share assumptions? The team needed to understand where the competitor was actually winning before field strategy and launch messaging were locked in.

ZoomRx's approach

ZoomRx used a continuous Launch Tracking Pulse with treating specialists, combining ATU, patient chart data, and competitive promotion tracking to see where the competitor was gaining traction by patient archetype, not just in aggregate.



Impact

By the second wave, the team had a clearer view of the competitor's early footprint. The chart data showed that the competitor's traction was concentrated in one specific patient archetype, with limited uptake across the segments where the new asset was more differentiated. The promotion read helped explain the pattern: the competitor's rep narrative was closely aligned to that archetype's clinical profile and was not strongly contesting the broader market.

This changed how the team thought about launch execution. Rather than treating the market as broadly closed, the team focused on the segments that remained open. Field-force training was re-cut around those patient archetypes, and launch messaging was adjusted six weeks before launch, while there was still time to influence the plan.

SCENARIO 1

A same-mechanism competitor launched six months ahead. Is there still room?

OUTCOME AND LESSON

The competitor owned one post-failure archetype.
Adjacent segments were genuinely open.

Usage patterns were broadly similar across segments, with Patient Subgroup 4 showing relatively higher competitive consideration despite lower rep reach.

At a glance, usage remained relatively consistent across segments

SEGMENT	OVERALL USAGE	PRESCRIBING AND CONSIDERATION
Patient subgroup 1	33%	45% — 56%
Patient subgroup 2	41%	40% — 48%
Patient subgroup 3	43%	36% — 44%
Patient subgroup 4	32%	35% — 70%
Patient subgroup 5	39%	50% — 56%

% HCPs

Patient subgroup where the competitor is actively competing for mindshare versus legacy therapies

SEGMENT	REP REACH
Patient subgroup 1 treaters	93%
Patient subgroup 2 treaters	51%
Patient subgroup 3 treaters	37%
Patient subgroup 4 treaters	20%
Patient subgroup 5 treaters	45%

% HCPs

Competitor rep reach was minimal among treaters in this subgroup

● Competitor product is the only therapy considered ● Competitor product prescribed

SCENARIO 2

Entering a market with titans. Where do we fit?

LAUNCH QUESTION

A decade of durability narrative made road first-line competition unrealistic, but dominance is not vulnerability.

Where is the standard of care actually vulnerable, and for which patients?



VISIBLE SIGNAL

The entrenched therapy owned first-line physician preference.



BLIND SPOT

Secondary data showed where prescribing happened, but not where switching was plausible.



LAUNCH RISK

A broad challenge would burn field attention in unwinnable territory.

Situation

A top-ten pharma was preparing to launch a new combination regimen into a major solid-tumor indication where a single first-line therapy had defined the standard of care for nearly a decade. A direct head-to-head challenge was unlikely to be the right path. The team's secondary data showed where prescribing was happening, but not where the standard of care was most vulnerable or where a new entrant could credibly compete.

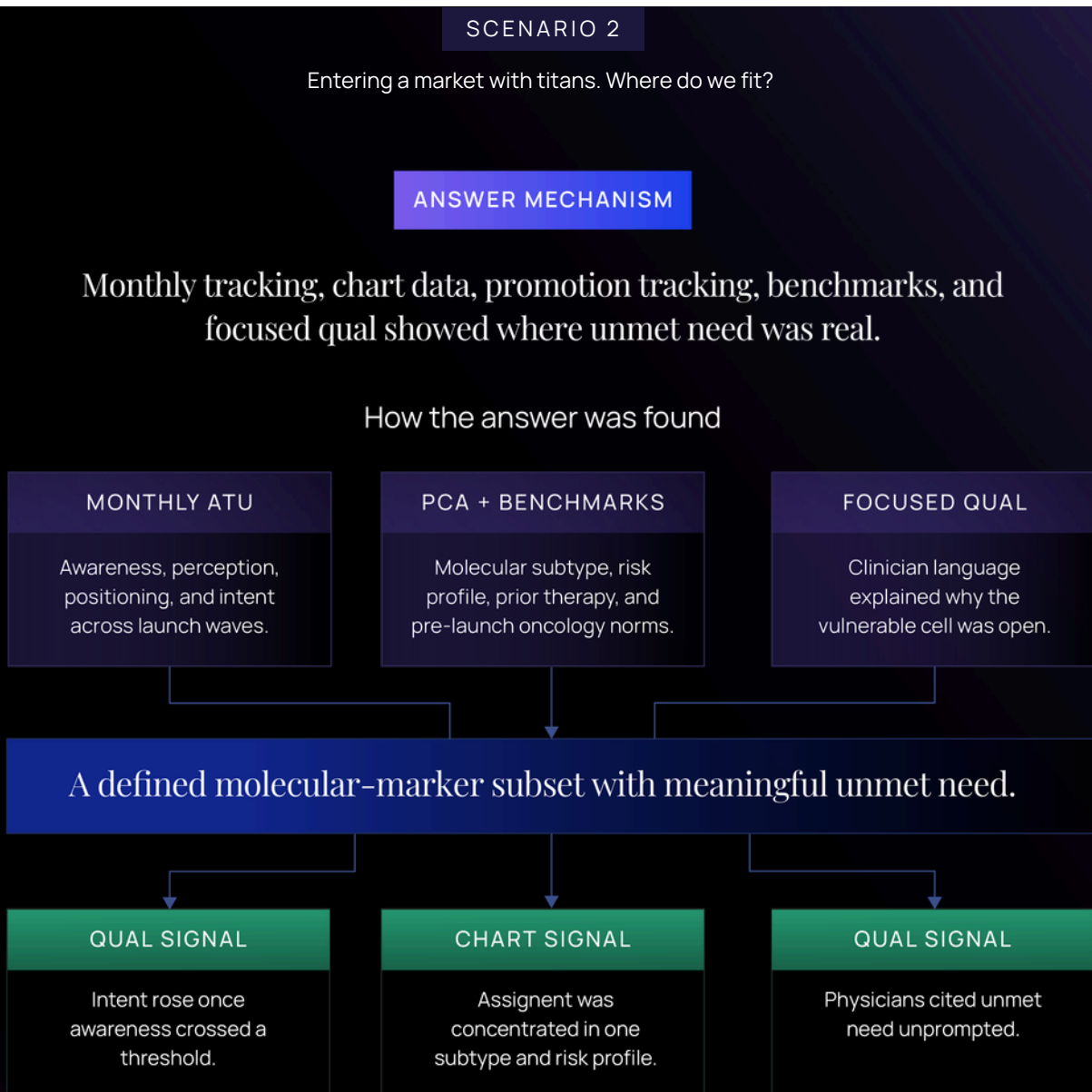
That question was becoming more urgent. Over the next six months, three competitive readouts were expected, each with the potential to shift physician perception and reshape the team's positioning choices. The team needed a clearer read on where the market was truly open before those decisions became harder to change.

ZoomRx's approach

ZoomRx built a monthly integrated tracker combining ATU, patient chart data, competitive promotion tracking, oncology benchmarks, and focused qualitative interviews, giving the team a clearer read on where the standard-of-care was truly vulnerable.

Impact

ZoomRx identified that post-progression positioning was already crowded, with physicians largely continuing to favor the standard-of-care's durability narrative in that setting. The stronger opportunity sat elsewhere: a specific molecular-marker subset with a defined risk profile, where physicians were already citing unmet need unprompted.



Once awareness crossed a critical threshold, physicians in this subset began assigning the new regimen at meaningful rates. This gave the team a clearer launch wedge. Instead of positioning broadly across the full first-line indication, the team focused on the subset where the standard-of-care was most vulnerable, retrained the field force around that opportunity, and shifted lead messaging toward the durability gap that mattered most in that patient group.

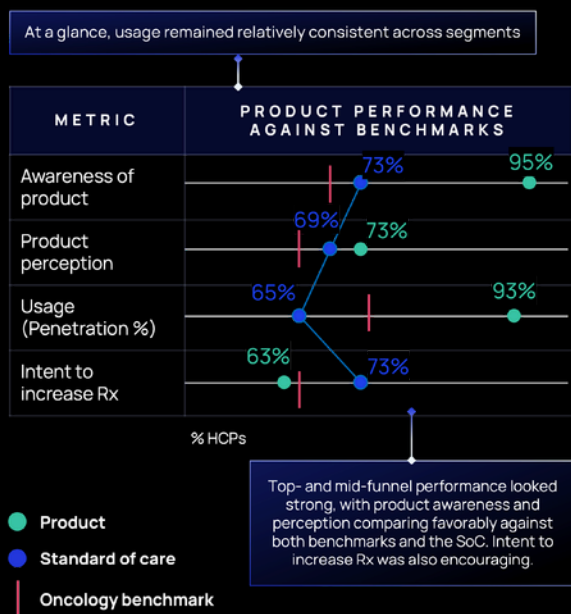
SCENARIO 2

Entering a market with titans. Where do we fit?

OUTCOME AND LESSON

The opportunity sat in a defined molecular-marker subset physicians already saw as underserved.

Benchmarked tracking showed the launch was progressing well overall, while patient-level and qualitative analysis pointed to Biomarker B high-risk patients as the strongest opportunity for focused adoption.



NEW REGIMEN CONSIDERATION		
	Low-risk profile	Defined risk profile
Biomarker A	Low	Moderate
Biomarker B	Moderate	High
Biomarker C	Low	Low

Patient-level analysis revealed one segment with higher openness to switching

Qualitative interviews showed that physicians were not ready to broadly displace the SoC but were more open to the new regimen in a high-risk biomarker subgroup where durability concerns were greater.

BIOMARKER SEGMENT	PHYSICIAN QUOTE	WHAT IT INDICATED
Biomarker A	"I'm still comfortable with the established regimen here. It has durability that is hard to move away from."	SoC remained difficult to displace
Biomarker B	"Biomarker B patients with higher-risk features are where I would look harder at a new option."	Strongest openness to the new regimen
Biomarker C	"A broad first-line message would not be enough for me to switch in this group."	Limited near-term openness

SCENARIO 3

Headline clinical data, but patients are reportedly being scared off online.

LAUNCH QUESTION

The market narrative blamed safety fear, while the funnel leak appeared after awareness and discussion were healthy.

Are patients actually scared, or are we projecting the loudest story onto the funnel?



VISIBLE SIGNAL

Provider adoption was tracking and patient awareness was high.



BLIND SPOT

Patients dropped between discussion and offer, not where safety fear predicted.



LAUNCH RISK

A reassurance campaign could amplify a fear patients were not expressing.

Situation

A mid-size biotech was in the first year of launch for its second product in a rare specialty disease. Provider adoption was tracking in line with expectations, but a concerning narrative had started to form around the brand. Advocacy groups, reps, and forum discussions were all pointing to the same explanation: patients were being held back by safety concerns circulating in patient communities. Based on that signal, the team was preparing to commit the next quarter's budget to a patient reassurance campaign. Before doing so, they needed to know whether safety fear was truly driving the hesitation, or whether the market was reacting to a story that had not yet been tested.



ZoomRx's approach

ZoomRx re-cut the patient ATU to examine the funnel in more detail, then layered in social listening and HCP-patient conversations to test whether the leak was driven by patients, online narratives, or clinic dynamics.

SCENARIO 3

Headline clinical data, but patients are reportedly being scared off online.

ANSWER MECHANISM

A re-cut Patient ATU, social listening read, and HCP-patient conversation tracker pressure-tested the fear hypothesis.

How the answer was found



Impact

ZoomRx helped the team test whether the safety concern was real, and the answer was clearer than expected. Patient communities were not showing a widespread safety narrative, and specialists were continuing to discuss the brand in clinic. The leak was not being driven by fear, but by confidence.

Less-engaged patients knew of the brand, but did not feel familiar enough with it to raise the topic themselves. Many were waiting to hear from peers before starting the conversation, which meant a reassurance campaign would have answered the wrong problem. The team shifted instead to peer-experience content and conversation starters, helping narrow the funnel leak within two waves.

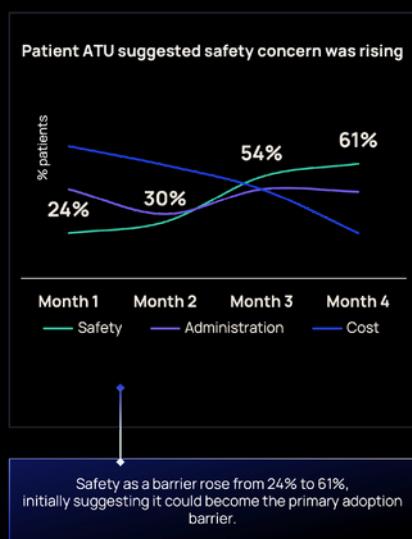
SCENARIO 3

Headline clinical data, but patients are reportedly being scared off online.

OUTCOME AND LESSON

Patients were waiting for familiarity, peer experience, and permission to start the conversation.

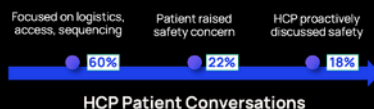
Although patient ATU initially suggested safety concerns were becoming a barrier, social listening and HCP-patient conversations showed the deeper issue was limited confidence, familiarity, and peer validation.



But social listening did not show an organic safety narrative

PATIENT COMMUNITY SIGNAL	READ
Safety concerns	Low volume
Practical questions	Higher volume
Peer experience sharing	Higher volume
Organized safety narrative	Not observed

Limited safety discussion may have left patients with lower awareness and familiarity, even though specialists were not avoiding the brand and conversations were largely practical.



SCENARIO 4

The same four messages. The wrong order.

LAUNCH QUESTION

MOA scored highest in standalone testing, but prescribing intent kept weakening among message-recalling specialists.

Are the messages weak, or are we delivering them in the wrong order?



VISIBLE SIGNAL

All four priority messages tested as effective in isolation.



CONTRADICTION

Intent softened even among specialists recalling the messages.



LAUNCH RISK

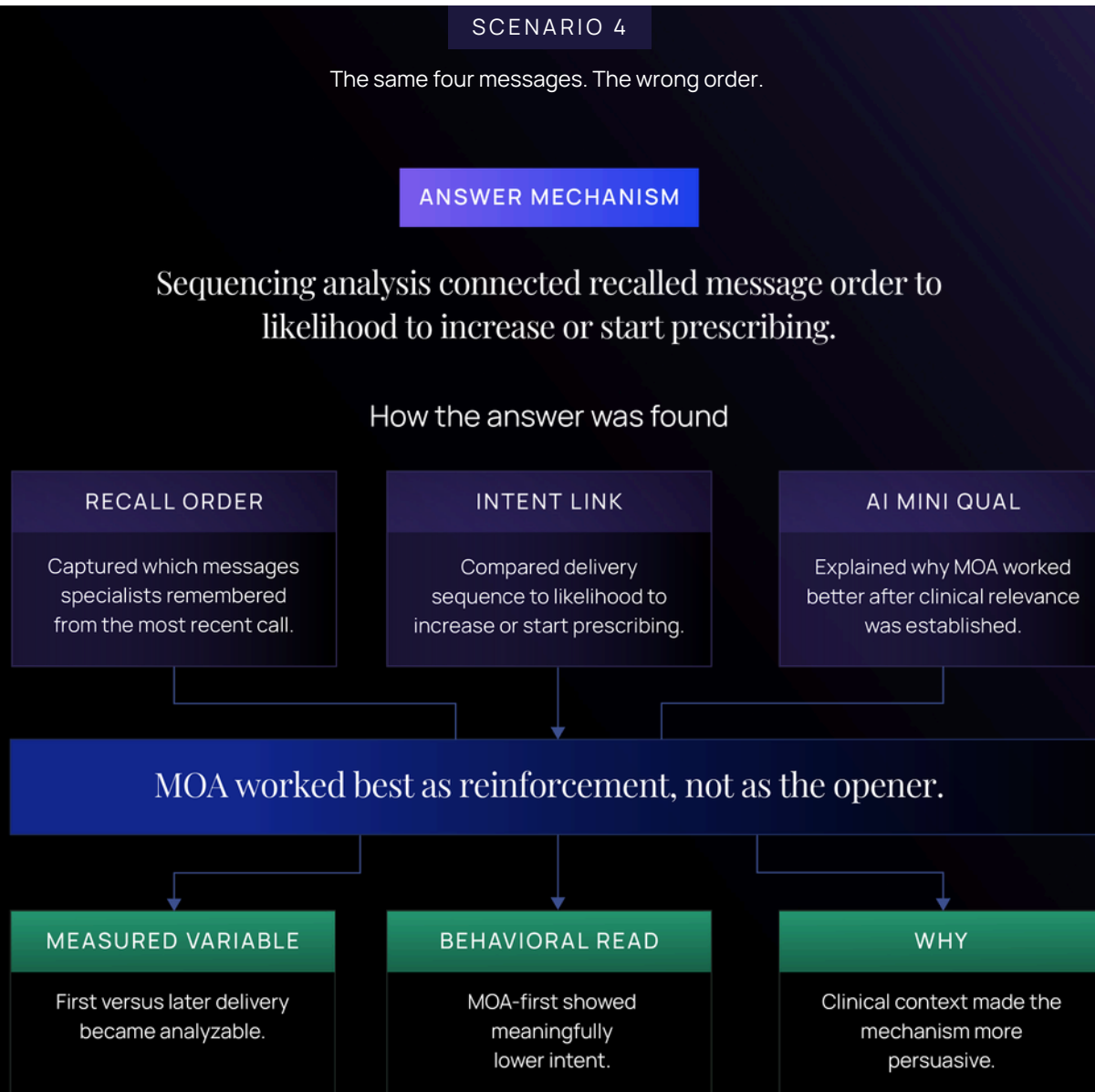
The team could spend behind the wrong message lever.

Situation

A specialty oncology brand at a top-twenty pharma had launched with four message claims, all of which had tested well in standalone research. The mechanism of action message was rated highest, but prescribing intent among specialists who recalled the messages was softening across waves, and scripts were falling short of forecast. The team was divided on how to respond. Some believed the field force should continue leading with mechanism, while others argued for opening with clinical data. What they lacked was a clear read on whether the issue was the message content itself, or how the messages were being delivered in the call.

ZoomRx's approach

ZoomRx added sequencing analysis to PET, linking the order of messages recalled from the most recent rep interaction to specialists' likelihood to prescribe, turning a long-running field debate into a measurable variable.



Impact

ZoomRx found that prescribing intent was tied not just to message recall, but to message order. Specialists showed lower intent when MOA was the first message they recalled, while intent was stronger when MOA appeared later in the call, after clinical relevance had already been established. The same pattern appeared across the other messages, but the effect was sharpest for MOA. AI-moderated exploratory interviews helped explain the pattern. Specialists saw MOA as important, but not as the best opener. Once the clinical rationale was clear, MOA made the story more credible. Based on this read, the field force was retrained to open with clinical relevance and use MOA as reinforcement. Prescribing intent recovered within one cycle.

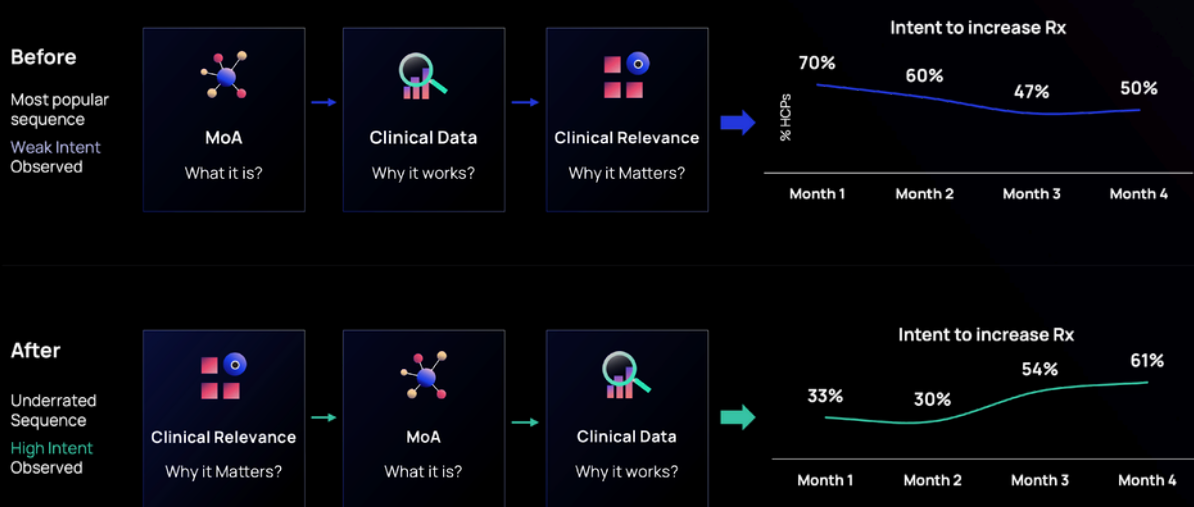
SCENARIO 4

The same four messages. The wrong order.

OUTCOME AND LESSON

When MOA came later, after clinical context, intent was meaningfully stronger.

When clinical relevance frames the conversation first, mechanism and data become more persuasive because physicians understand why the message matters.



SCENARIO 5

A new patient population, and the prescribers we need have never written our drug.

LAUNCH QUESTION

The readout expanded the patient pool 10x, but the new audience lived with PCPs who had never prescribed the brand.

Will the specialist playbook move PCPs before four months of spend are locked in?



VISIBLE SIGNAL

The expanded indication multiplied the addressable patient pool.



BLIND SPOT

Aggregate HCP reporting hid PCP and specialist differences.



LAUNCH RISK

Quarterly tracking would diagnose the mismatch after spend was committed.

Situation

A top five pharma chronic-disease brand had a positive readout in an expanded indication, opening up a much larger addressable patient population. The opportunity was significant, but it also shifted the center of gravity for the brand. The newly eligible patients were managed primarily by PCPs, most of whom had little to no experience prescribing the drug. Six weeks after the readout, the field force began seeing softer PCP receptivity than the team's model had anticipated. Standard quarterly tracking would eventually show whether that signal was real, but not before several months of PCP-targeted spend had already been committed.



The team needed a faster read on whether the issue was awareness, message relevance, or a deeper mismatch in how PCPs were responding to the brand.

ZoomRx's approach

ZoomRx launched a weekly post-readout pulse across PCPs and specialists, tracking awareness, message recall, effectiveness, prescribing likelihood, and motivation scores to see which claims were actually moving behavior before spend was locked in.

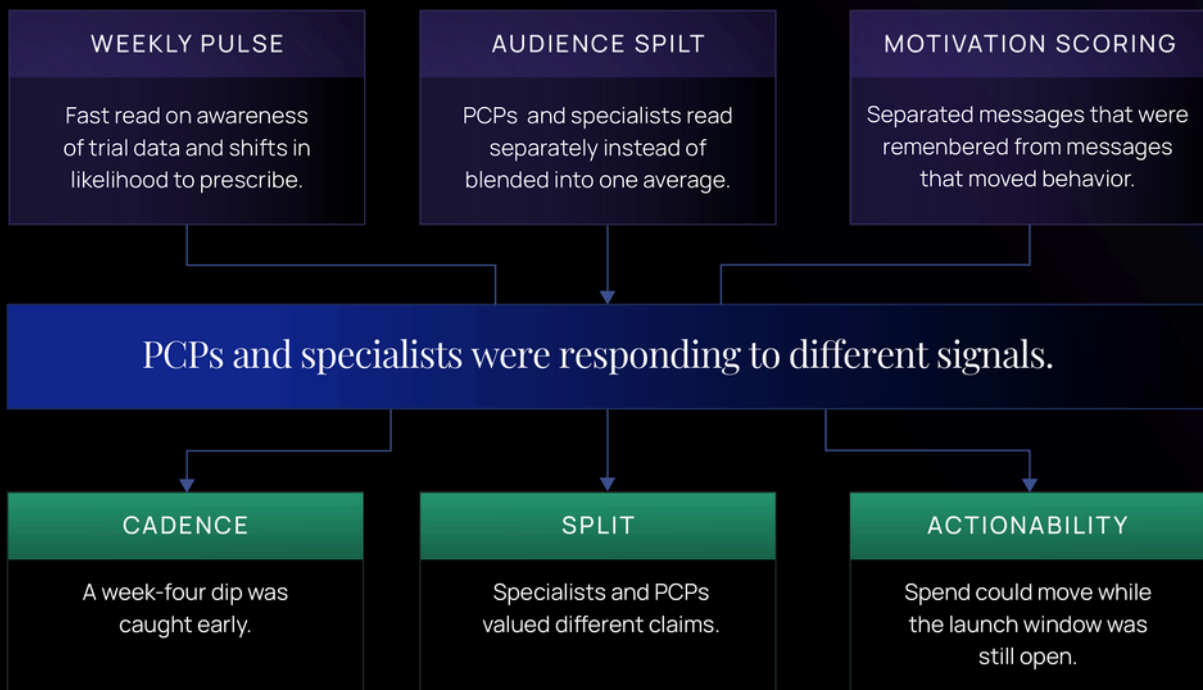
SCENARIO 5

A new patient population, and the prescribers we need have never written our drug.

ANSWER MECHANISM

Audience-split pulse waves tracked awareness, recall, prescribing likelihood, and derived motivation before spend locked in.

How the answer was found



Impact

ZoomRx found that PCPs and specialists were responding to different drivers. The aggregate HCP view had been masking that split, while the audience-level read made it clear where the mismatch was coming from. The weekly cadence also captured a sharp shift in message effectiveness that monthly tracking would likely have missed. With that read, the team rebalanced PCP-targeted spend, rotated out weaker messages, and adjusted the plan before the mismatch compounded. Instead of discovering the issue months later, the team was able to protect launch momentum through Month 5.

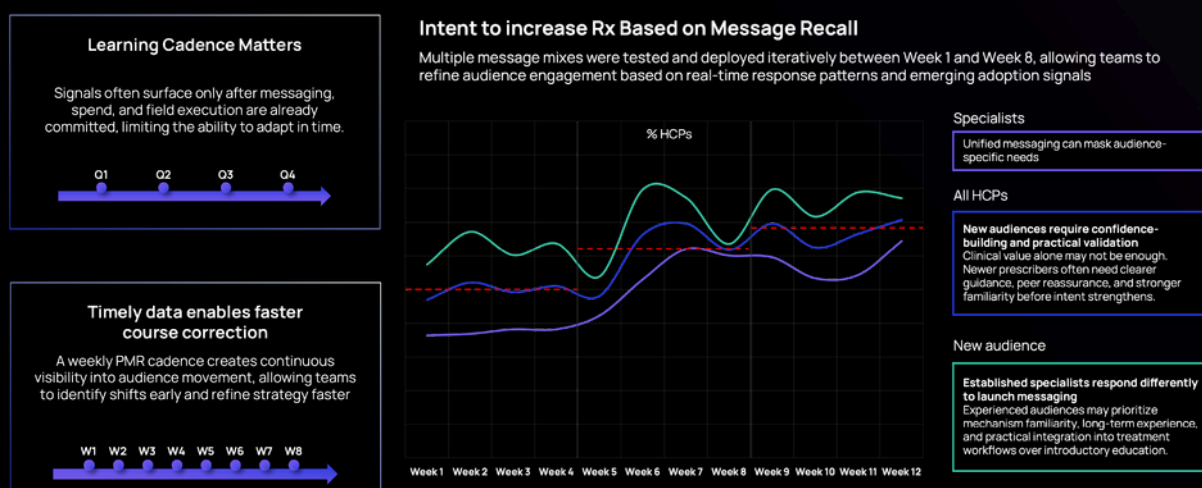
SCENARIO 5

A new patient population, and the prescribers we need have never written our drug.

OUTCOME AND LESSON

PCPs and specialists responded to different claims. the aggregate average described neither.

Weekly learning loops help launch teams detect audience-specific barriers early, enabling faster message refinement, channel optimization, and course correction before momentum is lost.



The pattern across the five

Five teams. Five therapy areas. Five different points in the launch arc. The specific failure modes were different: segment misallocation, head-to-head positioning against an entrenched titan, projecting a fear narrative onto a confidence problem, treating an effectiveness problem as a content problem, and treating two distinct audiences as one. The structural failure underneath was the same.

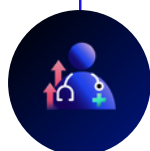
Across the five cases, the teams were not short on data. They had syndicated scripts, claims dashboards, advisory board readouts, conference share-of-voice, patient ATU data, and message-effectiveness scores. These inputs were useful, but they were not enough to answer the more specific question shaping each launch decision.

What mattered most sat just outside the existing read: which patient archetype the competitor was winning, where the standard-of-care was most vulnerable, what was driving the patient funnel leak, how message order was affecting intent, and why PCPs and specialists were responding differently to the same claim. These are not unusual questions. They are the kinds of questions launch teams eventually face, and the value lies in answering them early enough to change the plan.

SCENARIO	THE BLIND SPOT	ZOOMRX LAUNCH TRACKING INSTRUMENT	IMPACT
1	Competitor's segment-level footprint, invisible in aggregate data	Continuous specialist panel + patient chart module + competitive promotion module	Re-cut field-force training and messaging to the open archetypes six weeks before launch
2	Where the entrenched standard-of-care was actually vulnerable	Integrated tracker + patient chart module + qualitative pressure-test, scored against ZoomRx oncology benchmarks	Narrowed launch wedge to a defined molecular-marker subset; retrained field force around it
3	Whether the safety-fear narrative was real or projected	Patient ATU re-cut at higher funnel resolution, corroborated by social listening and an HCP-P read	Pivoted from a counterproductive reassurance campaign to a peer-experience program; funnel leak closed in two waves
4	Whether the messaging problem was content or sequence	Promotional Effectiveness Tracker (PET) with structured sequencing analysis	Field force retrained on sequenced delivery; prescribing intent recovered within one cycle
5	Whether PCPs and specialists were responding to the same messages	Weekly post-readout Pulse Study with stated and derived motivation scoring	Rebalanced PCP-targeted spend; held launch trajectory through Month 5 instead of discovering misalignment at Month 9

ZoomRx Launch Tracking, in one place

The instrument that ran underneath all five of these stories is ZoomRx's Launch Tracking solution. It is a single integrated capability with a few core pieces, configurable to the question the brand actually needs answered.



CONTINUOUS HCP PANELS

Specialist or PCP, fielded at the cadence the launch is moving at: monthly, biweekly, weekly, or in the case of post-congress moments, even tighter. Tracks awareness, perception, message recall, message effectiveness, intent, and behavior change over time.



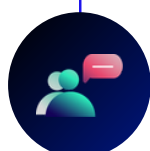
PATIENT CHART MODULES

Real prescribing decisions on real patients, captured from the same HCPs in the same waves. This is what surfaces archetype-level competitor footprints, molecular-marker subsets, and treatment-sequence dynamics that aggregate share data cannot.



COMPETITIVE PROMOTION MODULES

What the competitor's rep is saying in the room, what physicians are recalling, and how those messages are landing on prescribing intent. Closes the gap between conference share-of-voice and what is actually moving in field.



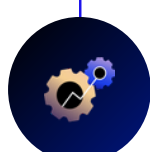
PATIENT ATU AND HCP PATIENT CONVERSATIONS (HCP-P)

Patient ATU models the demand-side funnel; HCP-P captures what HCPs are telling patients in clinic. Together they triangulate where in the room a leak is actually sitting.



PROMOTIONAL EFFECTIVENESS TRACKER (PET)

Message recall, perceived effectiveness, derived motivation scoring, and sequencing analysis: not just what messages are landing, but in what order, against which audience, and with what behavioral lift.



PRE-LAUNCH BENCHMARKS

Every metric scored against where comparable launches in the same therapy area actually sat at the same point in their arc. Numbers in isolation can flatter or alarm; numbers against benchmark tell you whether you are on track.



SOCIAL LISTENING AND QUALITATIVE READS

Layered onto the quantitative tracker as corroboration or pressure-test instruments: useful when the quant signal is ambiguous, when patient narrative is doing real work, or when the question requires the why in respondents' own words.



These instruments are not separate products. They are configurable layers on the same continuous Launch Tracking platform, fielded against the same panels in the same waves, designed to be triangulated against each other when a single read is not enough.

This is the work that closes the gap between the dashboards and the questions that actually decide a launch. It is what each of these five teams had access to that comparable teams in similar positions did not.

Conclusion

Every launch eventually reaches the question that defines it. The teams that succeed are the ones that hear the answer early enough to act on it.

If any of these five scenarios feels familiar, whether it is the conversation happening in the room today or the one you know is coming next, there is a clear next step. Reach out, and we can walk through how Launch Tracking can be tailored to the specific question your launch needs to answer. If you would prefer to see it applied to a live challenge first, we can run a focused pulse study and show you exactly what the instrument uncovers before any broader commitment.

Because ultimately, these stories are about the cost of finding out too late. The cost of finding out in time is simply a conversation.

SCHEDULE A CONSULTATION WITH ZOOMRX

Want to see how our launch tracking approach can help your brand?

Schedule a 15-minute benchmark conversation with our launch research experts.

GET IN TOUCH



ABOUT ZOOMRX

ZoomRx is a life sciences consultancy trusted by 19 of the top 20 global biopharma firms to deliver AI-powered market research that turns complex data into launch-ready decisions. Our ZoomRx Integrated Launch Tracking unifies ATU, PET, PCA, and HCP-patient dialogue into a single, continuous research program spanning pre-launch through post-launch.

To learn more about ZoomRx Integrated Launch Tracking and how it can work for your team, visit zoomrx.com or reach out to your ZoomRx account representative.

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