



Beyond What Was Prescribed

The Case for Capturing Clinical Reasoning in Patient Chart Audits

What AI-powered conversational chart audits reveal across Ulcerative Colitis, Hidradenitis Suppurativa, and Multiple Myeloma — and what that intelligence is worth to brand teams making commercial decisions.

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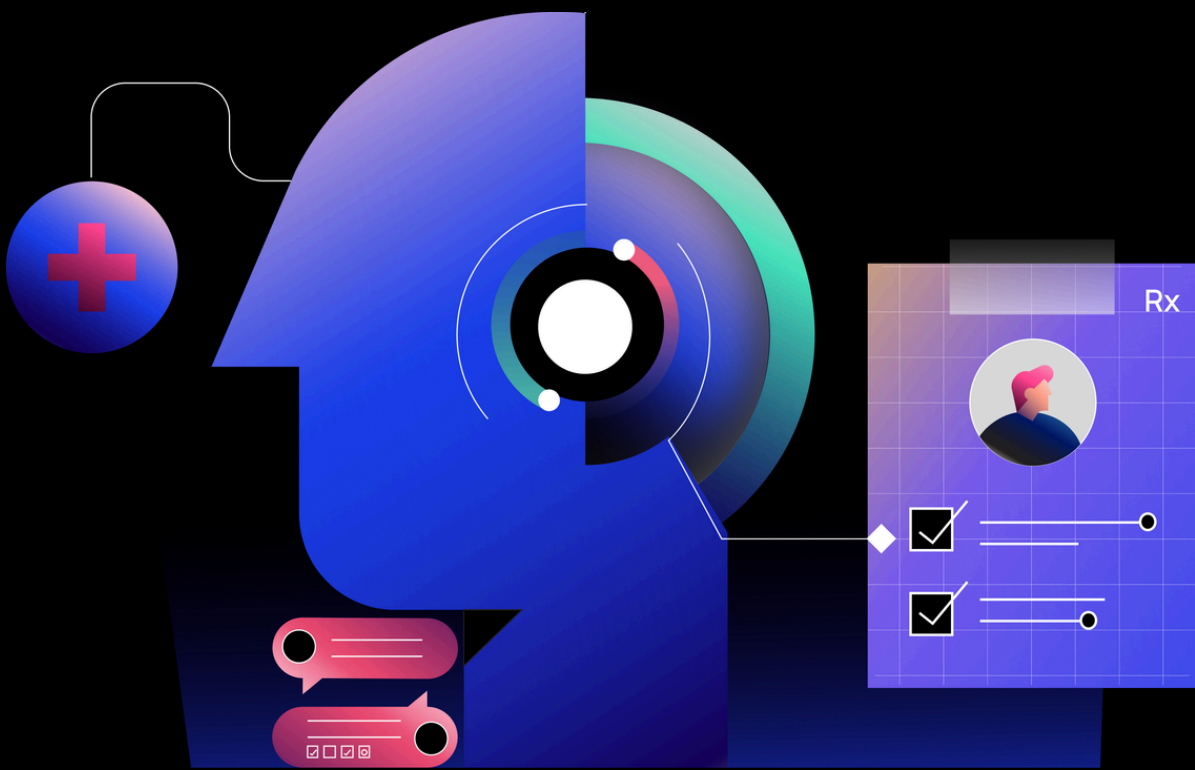
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Madhumitha is a Product Manager for Patient Chart Audits (PCA) at ZoomRx, bringing over 10 years of analytics and consulting experience with 7+ years specializing in life sciences and primary market research.

She leads the strategic development and evolution of the PCA research, transforming traditional chart audit methodologies with AI-powered conversational interfaces that deliver deeper, more actionable insights for pharmaceutical clients.

Executive Summary

Most pharma insight teams believe their patient chart audits are working. The data comes in, the dashboard updates, and decisions get made. The problem is rarely the data itself – **it is what the data was never designed to capture.**

Traditional patient chart audits (PCAs) record what physicians prescribed. They rarely capture why. The clinical reasoning, the patient-driven preferences, the access barriers, the real-world experience that overrides published trial data – these are the insights that determine commercial strategy. And the checkbox format that most chart audits use is structurally incapable of surfacing them.

This whitepaper presents findings from ZoomRx's Patient Scribe, an AI-powered conversational chart audit platform, deployed across three indications: Ulcerative Colitis, Hidradenitis Suppurativa, and Multiple Myeloma. For each, we show what the conversational charts captured that a traditional survey would have missed and what that insight is worth to brand teams trying to act on it.

SECTION 1

An Honest Assessment of AI in Market Research

The conversation around AI in market research tends to swing between hype and skepticism. The reality, however, is more nuanced. Below, we outline how conversational AI navigates this middle ground to drive results for insights leaders.

What conversational AI gets right

1. CAPTURES REASONING, NOT JUST ACTIONS

When a physician speaks about a patient case in their own words, the clinical logic becomes audible. When a physician selects “disease progression” as the reason for a treatment switch, that answer is technically correct but it conceals the actual story: the hesitation, the workaround, or the patient preference that overrode the clinical instinct. None of this survives translation into a checkbox.

2. FOLLOWS THE THREAD

Conversational AI doesn't advance to the next predetermined question when an answer reveals something unexpected. It probes. A passing mention of a comorbidity becomes a line of inquiry. A hint of access friction gets explored. This is how qualitative research works when it is done well — now available at chart audit scale.

“The questions that matter most are often the ones no one thought to include in the instrument. Conversational AI follows the thread — and what it finds changes the strategy.”

ZOOMRX RESEARCH TEAM

3. REDUCES THE BURDEN THAT CORRUPTS DATA QUALITY

A physician navigating a 40-question survey at the end of a clinical session is not producing their best thinking. Conversation is cognitively lighter — speaking about a patient case in your own words is fundamentally less demanding than filling out a form and the data reflects it.

What it doesn't replace

Conversational AI does not design the study or build the strategic narrative that turns data into commercial decisions. It gives researchers better raw material. The researcher's job doesn't disappear. It improves.

SECTION 2

Conversational Charts: Unlocking the “Why” behind Rx

The findings below come from conversational AI-powered chart audits conducted via ZoomRx's Patient Scribe platform across gastroenterology, dermatology, and hematology/oncology. Each illustrates a category of insight that traditional PCAs systematically miss.

Ulcerative Colitis — Gastroenterology

Drugs in consideration: Tremfya · Skyrizi · Rinvoq · Humira/biosimilar · Entyvio

Intra-class selection in UC is driven by formulation, lifestyle, and payer dynamics — not comparative efficacy. But the same dataset shows a second clinical logic running in the opposite direction: when patient safety profile demands it, class selection overrides everything else.

WHEN SKYRIZI WAS PASSED OVER

- A 21-year-old biologic-naïve patient wanted **at-home induction**. Skyrizi ruled out because it does not offer subcutaneous (SC) induction. Physician on trial data: “I’m more interested in real-world experience. The trial data is all pretty similar regardless of the drug.”
- Another physician chose Tremfya over Skyrizi purely **on payer grounds**. Subcutaneous induction clears insurance approval easily than IV — that friction, not clinical preference, was the deciding factor.

“Subcutaneous induction is easier to get approved whereas intravenous infusion is more difficult to approve with insurances. The insurance is the big factor.”

GASTROENTEROLOGIST, TREMFYA PRESCRIBED OVER SKYRIZI

WHEN SKYRIZI WAS THE ONLY RIGHT ANSWER

- A 42-year-old with pancolitis and a history of recurrent Basal Cell Carcinoma. JAK inhibitors and anti-TNFs explicitly ruled out on malignancy risk. Skyrizi was the physician’s first clinical choice — not a payer step edit — anchored on three-year durability data and a safety profile no other class could match for this specific patient.

“Safety was the most important consideration because of her history of recurrent Basal Cell Carcinoma. The data for Skyrizi has shown durable remission in Ulcerative Colitis upto three years, and I really wanted to start this patient on a therapy she could stay on long term.”

GASTROENTEROLOGIST, TREMFYA PRESCRIBED OVER SKYRIZI

COMMERCIAL IMPLICATION

UC tells two distinct Skyrizi stories — both invisible to a traditional PCA. When Skyrizi loses, the reason is payer friction and home induction architecture. When Skyrizi wins, it is the only defensible class for a patient where JAK inhibitors and anti-TNFs carry documented malignancy risk. Both stories require different commercial responses — and neither surfaces in checkbox output.

Hidradenitis Suppurativa — Dermatology

Drugs in consideration: Bimzelx · Humira · Cosentyx

In HS, what drives a physician to Bimzelx is often a sequence of partial failures, escalating disease burden, and clinical experience that builds confidence faster than trial data alone. The switch story is the commercial story.

THE SWITCH NARRATIVE

- A 34-year-old on Humira for two years had “some control” — but was still getting active painful lesions in the inguinal folds at follow-up visits. The inadequacy was anatomically specific and tracked over multiple visits. A checkbox records only “inadequate efficacy.”
- A second patient had cycled through antibiotics, Kenalog injections, deroofing procedures, Humira (six months), and Cosentyx (three months) — all inadequate.

“This was the next logical step after all the failures patient already had.” The clinical inevitability in that sentence does not surface in structured data.

“They were on Humira and while they had some control, they were still getting some active painful lesions in their inguinal folds. So I switched them to Bimzelx in order to get better efficacy.”

DERMATOLOGIST, HUMIRA TO BIMZELX SWITCH

“I have used Bimzelx on quite a few other HS patients. I find that it works pretty fast. Some patients feel a difference within as soon as two weeks — improved pain, decreased inflammation, decreased number of draining sinuses and nodules.”

DERMATOLOGIST, REAL-WORLD SPEED OF RESPONSE OF BIMZELX

COMMERCIAL IMPLICATION

In a traditional PCA, the Humira-to-Bimzelx switch is “inadequate efficacy.” Patient Scribe reveals the texture underneath: which body locations were still active, how long partial control was tolerated before switching, and the fear of irreversible structural damage that drove urgency. The commercial lever for Bimzelx is peer case sharing, not additional efficacy data. Physicians who have used it are already convinced. The barrier is exposure, not evidence.

Relapsed/Refractory Multiple Myeloma — Hematology

Drugs in consideration: Daratumumab + Teclistamab · CAR-T (Carvykti / Abecma) · Standard triplets

Pre-launch intelligence: physicians are already forming clear positioning opinions about Daratumumab+Teclistamab (Darzalex+Tecvayli) before approval. Conversational AI captures the commercial reality before it hardens — and before it shows up in any prescribing data.

THE 1L DATA GARING PROBLEM

- “A lot of your patients are already getting Dara in the first line, so I think they’re already going to be refractory by 2L. The patients that would get Darzalex+Tecvayli are those that are CAR-T ineligible for whatever reason, or they’ve got aggressive disease and can’t wait for CAR-T manufacturing.”
- “Most of those patients [in the trial] didn’t have prior DARA in first line — only 5% of patients were actually DARA-exposed. The insurances would need to pay for it. We don’t know what the additional benefit is.” Physician naming the real-world evidence gap between trial population and current standard of care.

CAR VS. DARZALEX-TECVAYLI - SEQUENCING TENSIONS

- Sequencing concern: “I would caution giving Daratumumab+Teclistamab prior to BCMA CAR-T.” Physicians are pre-emptively managing sequencing risk before the drug is even on formulary.
- Access reality: Community vs. academic split: “I would still expect many standard triplets to remain preferred for broader community use, with combination use more selectively at experienced centers.” Adoption will concentrate where CRS management infrastructure exists.

“It would be a good option in 2L but I think you need to consider whether insurances will pay for this, given most patients in my practice already got Darzalex in first line. CAR-T is still the one and done. Get on with your life. That aligns with this patient’s goals the most.”

HEMATOLOGIST, DARZALEX+TECVAYLI PRE-LAUNCH POSITIONING

COMMERCIAL IMPLICATION

No traditional PCA would capture this – the regimen isn't approved yet. But across five hematologist conversations, a consistent commercial reality is already forming: Darzalex+Tecvayli will occupy a niche, not a broad 2L standard. The addressable pool in heavily DARA-exposed practices is smaller than the label implies. CAR-T sequencing is the key objection. “Off the shelf for patients who cannot wait” is the positioning that resonates. This is intelligence a launch team needs 12 months before approval.

SECTION 3

The Patient Scribe Solution

Patient Scribe replaces the structured questionnaire with a voice-first conversational interface moderated by AI. Physicians describe patient cases the way they actually think – in clinical narrative, not checkbox categories. The system listens, probes when it detects nuance, and structures the output. The result is richer data, produced faster, with significantly less burden on participating physicians.

“Chart audits are burdensome and they need not be. This is a feasible and practical AI application”

DIRECTOR, ANALYTICS & INSIGHTS, TOP 5 PHARMA

Three things Patient Scribe does differently:

- It captures the clinical reasoning behind a prescription, not just the prescription itself
- It follows the thread when something unexpected surfaces
- It reduces the cognitive burden that causes physicians to rush through structured surveys and produce data that requires remediation.

~75%

of HCPs highly enjoyed the conversational audit experience vs. traditional surveys

~60%

of HCPs stated they shared MORE clinical detail when reporting patient charts through Scribe v. Traditional

What Patient Scribe doesn't replace: researcher judgment, study design, or the strategic thinking that turns data into commercial decisions.

SECTION 4

What Traditional PCAs are Costing Your Brand

The business case for higher-quality PCA data is straightforward, even if it's rarely calculated explicitly. There are three distinct costs that accumulate every time a research cycle runs on a checkbox format.*

30–40%

of PCA project time spent on data remediation, not strategic analysis

3–6 mo

insight lag with fixed collection cycles — after markets have already moved

1 in 3

commercial decisions based on PCAs is solving the wrong problem

*based on ongoing interviews and conversations with Pharma Insight Leaders

Cost 1 — The Remediation Tax

Insight teams spend 30–40% of project time clarifying ambiguous entries, resolving inconsistencies, and rebuilding clinical logic that the survey format destroyed at the point of entry. Conversational AI captures the observation in its natural form. There is no remediation because there was no compression.

Cost 2 — The Timing Penalty

Quarterly or annual cycles mean insights arrive 3–6 months after the markets they were designed to describe. When data quality is high from the point of collection, the cycle from fieldwork to strategic insight compresses significantly.

Cost 3 — The Decision Quality Gap

The UC data illustrates this precisely. A traditional PCA shows Skyrizi being passed over — the natural commercial conclusion is a messaging or awareness problem. The actual driver is IV induction architecture and payer friction. Deploying awareness spend anyway only crowds out the patient services investment that would actually move the metric.

In MM, the 1L Darzalex exposure dynamic is shaping the commercial ceiling for Daratumumab+Teclistamab - before any prescribing data exists. The brand team that knows this today can invest in 1L access strategies that preserve the 2L market. The team that learns it from a traditional PCA six months from now is solving a problem that has already hardened.

ACROSS THREE INDICATIONS, THE SAME PATTERN

INDICATION	WHAT THE PCA SHOWS	WHAT THE CONVERSATION REVEALS	COMMERCIAL DECISION CHANGED
Ulcerative Colitis	Tremfya preferred; Skyrizi passed over. Switch reason: efficacy / disease control.	Skyrizi lost on home induction architecture and payer friction. When it won, it was the only defensible class for a patient with BCC history where JAK inhibitors and anti-TNFs carry documented malignancy risk.	Payer support and patient services for the access battle. Targeted safety messaging for the malignancy-history patient profile where Skyrizi has a clinical argument no competitor can easily match.
Hidradenitis Suppurativa	Humira → Bimzelx; inadequate response. Prior failures: topical, antibiotic, TNF inhibitor.	Personal clinical experience, not trial data drove the decision. Urgency tied to irreversible scarring risk. "Starting a biologic was urgent due to the scarring nature, and overall severity of the patient."	Peer-to-peer case sharing has more commercial impact than HCP promotion. The barrier is exposure, not evidence.
Multiple Myeloma	2L therapy: CAR-T or triplet regimen. Darazalex+Tecvayli awaiting approval	Physicians pre-sorting Darazalex+Tecvayli as niche before approval. Broad 1L DARA exposure already constraining the 2L addressable pool.	Position around CAR-T-ineligible patients and aggressive disease. The commercial window is closing before the prescribing data confirms it.

This is the business case for conversational AI in chart audits. Not only richer research outputs but also the commercial decisions that get made based on research, and the cost of making those decisions on structurally incomplete information.

Conclusion

The Gap Between What You Know and What is Actually Driving Prescribing

The prescribing decisions that determine market share are made in clinical reasoning, patient conversations, and access negotiations that traditional PCAs were never designed to capture. That gap is not a flaw in your research vendor. It is a structural limitation of the checkbox format itself.

Conversational AI doesn't solve every research problem. It doesn't replace the judgment of experienced insight leaders or the strategic thinking that turns data into commercial action. What it does is close the gap between what physicians actually said and what our research recorded.

Across Ulcerative Colitis, Hidradenitis Suppurativa, and Multiple Myeloma, that gap contained the most commercially consequential insights in the dataset – the Skyrizi insurance dynamic, the Bimzelx experience gap, and the 1L Darzalex ceiling forming before a single Darzalex+Tecvayli prescription was written.

“Voice-powered Patient Scribe works much faster and more efficiently than traditional surveys. I’m able to give a much more detailed and complete response in a much shorter period of time.”

PHYSICIAN

SEE WHAT PATIENT SCRIBE WOULD UNCOVER FOR YOUR BRAND

ZoomRx is offering a zero-cost pilot wave — same rigor as a full PCA study, no commitment required. 100+ brands have already made the switch to ZoomRx trackers. We make the transition seamless.

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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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