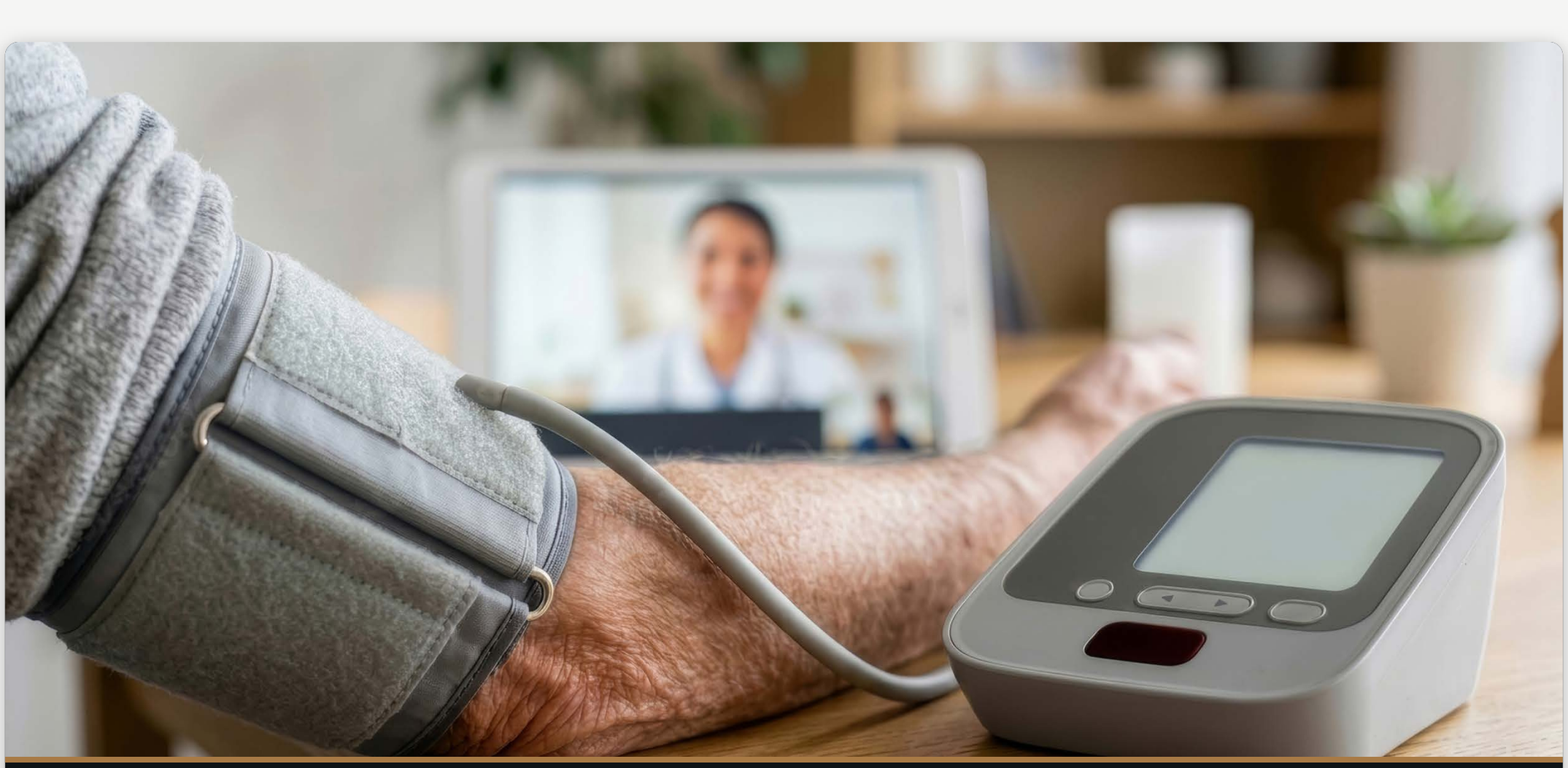

WHITE PAPER / DIRECT TO PATIENT

The DTP program launched. The channel didn't.

Why some direct-to-patient programs plateau after go-live — and the four numbers that tell you what it is costing your brand.

Kairos Meridian
WHERE STRATEGY MEETS THE MOMENT

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EXECUTIVE SUMMARY

98M	44M	$80M
new therapy prescriptions abandoned at U.S. pharmacies in 2023	of those abandoned when the patient cost was under $10	annual pool on a brand writing 50,000 new scripts (page 6)

A live program is not a channel. The gap is measurable, and it repeats every quarter.

Standing up a direct-to-patient program is one of the hardest things a commercial organization can do. It asks marketing, market access, patient services, data, analytics, IT, legal and regulatory to operate as one system — in step with an agency of record, a media partner, a co-pay vendor, a telehealth provider and a pharmacy. Most of those groups had never done it before. The companies that got a program live earned it.

Then, for a lot of programs, the work stopped. Launching the program *was* the success. The listing went up, the price was published, the compliance sign-off was filed — and the program has not changed since.

That is the pattern worth naming. Not a failure of execution. A definition of success that ended at go-live.

Read it as an opportunity, not a warning. Direct to patient is the rare channel where the brand's interest and the patient's are the same thing — fewer days to therapy, more patients started — and it can be stood up, promoted and measured in weeks.

This paper does two things. It names the two failure modes we have seen across five DTP programs, and it gives you the arithmetic — four numbers you already have — to size what the plateau is costing your brand.

WHAT THIS PAPER ARGUES

01 **Launch is the floor, not the ceiling.** A published cash price satisfies a compliance clock. It does not build a channel.

02 **The problem is promotion, not demand.** 72% of adults would buy direct. 22% ever have.

03 **Cash pay is a feature.** The job is removing friction between recognizing a problem and starting therapy.

04 **The measurement gap is the fixable one.** Put a number on the pool and the funding argument writes itself.

SECTION ONE

When the DTP launch became the finish line

Timing shaped a lot of this. The Executive Order signed in May 2025 and the February 2026 launch of TrumpRx.gov put an entire industry on a compliance clock at once. When you build under that kind of deadline, the work goes to the people who manage pricing and compliance. The finish line becomes the launch itself: a program exists, a cash price is published, the listing is live.

That was a real accomplishment. It was also a narrow definition of success. TrumpRx.gov launched with 43 drugs from five manufacturers. A House Energy and Commerce Democratic staff report released in February 2026 — titled "TrumpRx: Big Talk, Little Savings" — found a cheaper generic available but undisclosed for 15 of them, and pre-existing GoodRx coupons at the same or similar price for at least seven more. Publishing a cash price is not the same as making a medicine affordable. It is nowhere near the same as building a channel that drives revenue.

HALF THE MARKET WOULD BUY DIRECT. IT NEVER HAS.

U.S. adults on buying prescriptions directly from a manufacturer. Each dot is one percent.

22% HAVE USED
Bought direct at least once.

50% THE GAP
Would use it. Never have.

28% WOULD NOT
Not the market.

Model N / Dynata survey of 1,000 U.S. adults aged 25+, fielded June 2025. Interest held steady across every income bracket.

That is a fifty-point gap between the people who would use these programs and the people who have. It is not a demand problem. It is a promotion problem.

> A program nobody knows about is not a channel. It is a landing page with a compliance sign-off.

SECTION TWO

Cash pay is a feature. It is not the DTP program.

Start with what a cash price cannot do. It is built for the patient who has no coverage — and most of your prescriptions belong to patients who do.

The cash lane itself was a rational response. Large numbers of commercially insured Americans had no coverage at all in the categories that built these platforms, and manufacturers built a way to reach them. That was the right call.

What followed is the problem. On the leading self-pay pharmacy option, insurance is not required or accepted. Self-pay purchases do not count toward a patient's deductible or out-of-pocket maximum, so nothing the patient spends accumulates toward their plan limits. For a patient with good pharmacy coverage, the cash lane can be the most expensive way to fill.

ONE GLP-1, ONE MONTH, 2026 — INSURED COPAY VERSUS SELF-PAY CASH

$0–$50	$499	$0
monthly cost for an insured patient using savings-card coverage	the self-pay cash price for the same medicine, same month	of that self-pay spend counts toward the patient's deductible

> A program that only knows how to take cash has locked out its own best-covered patients — and it cannot tell you which is which.

That is the real job of DTP: reducing the friction between a patient recognizing a problem and starting the therapy that helps. Benefits verification and prior-authorization support for the insured patient. A cash lane for the one without coverage. Faster access to a prescriber, delivery, and one form instead of three for both.

WHAT HAPPENS TO 100 NEW PRESCRIPTIONS — ILLUSTRATIVE, AT A 25% PRIMARY ABANDONMENT RATE

100 written
75 filled — −25 never filled
23 still on therapy at 12 months — 31% of those who started (IQVIA)

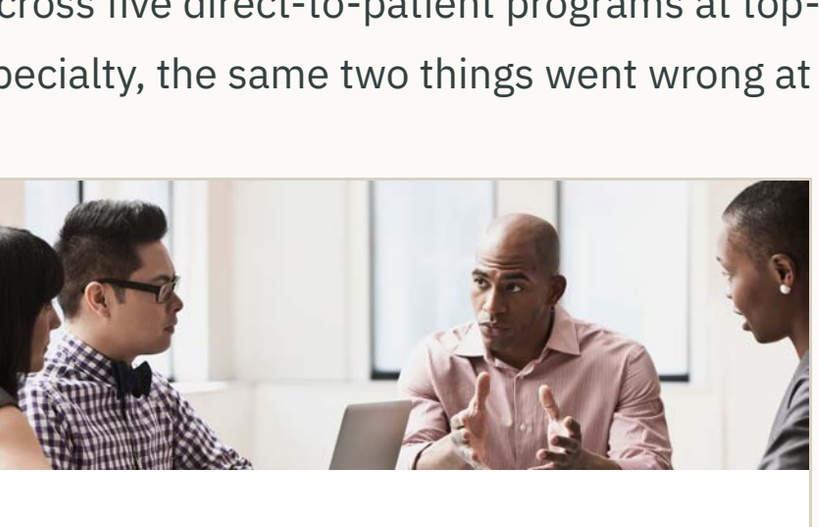
98M	44M	60%
new therapy prescriptions abandoned in 2023	of them at a patient cost under $10, some at no cost to the patient at all	of specialty patients struggled to get a first dose

Close to half of abandonment happens on prescriptions that cost the patient under $10. Price is the problem we fund. Friction is the problem we ignore.

SECTION THREE

What goes wrong after go-live

Across five direct-to-patient programs at top-20 pharma and emerging specialty, the same two things went wrong at almost every one.

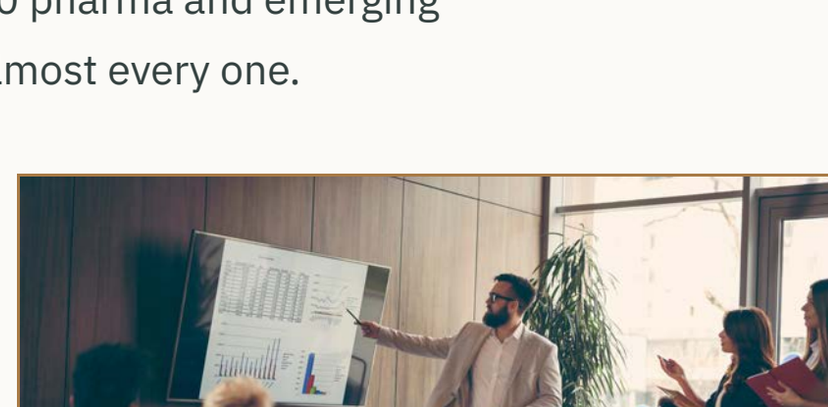


FAILURE MODE ONE

The promotional wall

The program was sound. The strategy was right. Volume stayed flat because the budget and the promotional expertise sat in a function that was not in the room.

STRUCTURAL — NEEDS A MANDATE



FAILURE MODE TWO

The measurement gap

Nobody could say what the program was worth. So nobody could argue for more of it. So it stayed exactly the size it was on launch day.

FIXABLE THIS QUARTER

The second one is addressable now. When you can put a number on what the program is leaving on the table, the funding argument writes itself. That is why the arithmetic on the next page exists. It is the argument that should have been on the table.

WHERE PROGRAMS STALL

01 Idea	02 Live	03 Plateaued	04 Scaled
Business case, no build	Listing up, price published	Unpromoted, unmeasured	Promoted, measured, accountable

SECTION FOUR

Do the DTP arithmetic on your own brand

Every brand team should be able to answer this in an afternoon. It does not require a benchmark, a vendor study or an industry average. It requires four numbers you already have.

A	B	C	D
Annual new-to-brand prescriptions	Primary abandonment rate, the share never filled	Discontinuation rate in the first six months	Net revenue per patient per year

WORKED EXAMPLE — 50,000 NEW SCRIPTS, 25% ABANDONMENT, 40% DISCONTINUATION, $4,000 NET PER PATIENT / YEAR

NEVER STARTED
$50M
50,000 × 25% = 12,500 patients
Prescribed your medicine and never took it. At $4,000 each: prescribed and never realized.

STARTED AND STOPPED
$30M
37,500 started → 15,000 stop by month 6
Capturing roughly $2,000 instead of $4,000 each.

THE POOL
Run your own four numbers and the arithmetic will be different. The order of magnitude will not.
$80M per year, repeating

DTP captures a slice of that pool. That slice is worth more than several channels you are already funding — and it does something no other channel does: it puts the brand directly next to the patient, and it tells you within days whether it worked.

WORKSHEET

Your four numbers

Brand ______________
Date ______________

Fill this in on screen or by hand. Everything below comes from data you already own — no benchmark required.

A	Annual new-to-brand prescriptions	50,000
B	Primary abandonment rate (%)	25%
C	Six-month discontinuation rate (%)	40%
D	Net revenue per patient per year ($)	$4,000

NEVER STARTED
A × B × D

STARTED AND STOPPED
A × (1−B) × C × (D ÷ 2)

YOUR ANNUAL POOL
The two lines above, added together. This is the figure that repeats every year the program sits unpromoted.
$

> If the pool is small, DTP is not your fight this year. If it is large, that is a conversation worth having.

SECTION FIVE

What the number is telling you

None of this is theoretical. In the second quarter of 2025, roughly 35% of new Zepbound prescriptions were being fulfilled through LillyDirect self-pay. GLP-1s are their own category, and no other brand should expect that share. The point is narrower: a direct channel can carry a meaningful slice of new starts, and it reports what it did in days rather than quarters.

THE LOSS IS NOT A ONE-TIME EVENT — IT BOOKS EVERY QUARTER

Q1	Q2	Q3	Q4	=	YEAR ONE, TOTAL
$20M	$20M	$20M	$20M	=	$80M

Every quarter the program sits unpromoted, another cohort is prescribed your medicine and never starts it. Nothing about next year resets the meter.

Year two: $80M again

Launch is the floor of a DTP program, not the ceiling.

Whatever your number came to, it has been sitting there since launch, uncounted, because the program was declared finished on the day it went live. The compliance clock is satisfied and the price is published; what nobody has been asked to do is promote the program weekly and hold it accountable for new patient starts the way every other line of promotional spend already is.

Here is the part that should bother you. Your number is not a one-time loss. It recurs. Every year you defer the work, the same pool books again.

Meanwhile almost every component you need already exists inside the organization. Co-pay. Patient services. Data. Analytics. Pharmacy relationships. Funded and staffed. What is missing is not a capability. It is a spine — one strategy, one metric set, and one leader connecting marketing, market access, patient services, the data layer and the vendor bench so they optimize the same thing instead of five different things.

That spine is buildable, and ambition is the only scarce part. Done well, the same channel that adds starts for the brand is the one that gets a patient on therapy in days instead of months — impact at scale, on both sides of the prescription.

NEXT STEP

Run the DTP numbers. Then talk to Kairos Meridian.

Pull your four numbers before your next planning cycle — then send them over. If the pool is small, DTP is not your fight this year. If it is large, that is a conversation worth having, and it starts with the problem keeping you up at night.

WHAT THE WORK LOOKS LIKE

01 **Create the strategy**
One strategy, one metric set, one owner across marketing, access, patient services and the data layer.

02 **Map & measure the experience**
End to end, from first symptom search to refill, with every point of friction quantified.

03 **Design & evolve the ecosystem**
Access, patient services, data and the vendor bench built to work as one system, then kept current.

04 **Optimize performance**
Weekly, against one number, with someone accountable for new patient starts.

Four moves, one outcome: a program that reaches impact at scale for the brand precisely because it takes the friction out of the patient's way.

Whether your program is an idea, live, or plateaued — and whether you want a second opinion, a standing voice, or a partner inside the work.

BOOK A CONVERSATION TODAY

The first conversation is short, and it is not a pitch.

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ABOUT

Kairos Meridian

Where strategy meets the moment. Big agency thinking at boutique speed.

Pharma marketing, analytics and innovation in service of impact.

We do this work because direct to patient is the rare channel where the brand's upside and the patient's are the same thing: fewer days to therapy, fewer forms, fewer reasons to walk away — and more patients started, counted every week. We set the strategy, help build the program, scale it, and stand up a measurement discipline that holds it accountable for new patient starts and improved lifetime value — run with an e-commerce mentality, not the traditional pharma program one.

Whether you have yet to launch a program, one live and unpromoted, or one ready for its next level, the work starts with a conversation — not a pitch — about your DTP opportunity and what is standing between your patients and the therapy you have already earned for them.

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SOURCES

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