

WHITEPAPER

Beyond the Portal.

Rethinking patient-facing digital portals for a patient-led, AI-mediated healthcare journey.

AUTHORED BY

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Inside this paper

— The Case in Brief

The whole argument in one page — what changed, what is still open, and what to do about it.

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Why distance from the patient was rational design — and how all three reasons for it eroded.

02 Then Everyone Else Started Moving Closer

Eight D2C platforms in twenty-six months — and the players who reached the patient first.

03 The Market Has Moved. The Patient Journey Has Not.

Five gaps still open, and the line between what BioPharma cannot own and what it has not claimed.

04 Two Starting Lines, One Narrowing Window

Two starting postures — establish or consolidate — both converging on a decision that grows more urgent by the month.

05 A Discipline for Deciding Where the Entry Point Belongs

A five-decision method, scored on five value pillars, elaborated into a directional playbook — run per archetype, drawn from work alongside a BioPharma and built to travel across the industry.

06 Conclusion

Ties the five sections into one decision — and the discipline for making it, archetype by archetype.

THE CASE IN BRIEF

The patient moved first. Meeting them again takes one method, run per archetype — not per brand.

BioPharma engineered distance from the patient into its commercial model — a defensible posture that regulation and prescriber gatekeeping once required, until both gave way. AI adoption has moved the patient's first step from the clinic to the search bar and the AI Overview. Small biotechs are testing single-brand microsites, mid-size BioPharmas are bundling adherence tools around flagship therapies, and large BioPharma is building full-scale patient platforms. What follows sets out the method for closing that ground: scoring each patient archetype against five value pillars to shape an entry-point strategy fitted to the portfolio. Fragmentation is gap one for a reason — it cannot be resolved brand by brand, only by clustering the portfolio the way patients actually experience care.



BioPharma Was Built Around the Prescriber, Not the Patient

Traces why keeping distance from the patient was rational design, not neglect, and how the regulatory and commercial logic behind it quietly stopped applying.



Then Everyone Else Started Moving Closer

Charts the scale of the response — eight BioPharma platforms launched in twenty-six months — against the AI search, telehealth and consumer-health players that reached patients first.



The Market Has Moved. The Patient Journey Has Not.

Maps the five gaps still open across the journey, and draws the line between what BioPharma is legally barred from owning and what it has simply left uncontested.



Two Starting Lines, One Narrowing Window

Sets out why the task differs by posture — establishing a first position versus consolidating scattered investments — and why three forces make the decision time-bound for both.



A Discipline for Deciding Where the Entry Point Belongs

Lays out the five-decision method itself — scoring a patient archetype against five value pillars and resolving it into one call: build, partner, or fund.

\$114.1B

revenue at risk over the next decade, third-party-only
Deloitte, 2025

~30%

of U.S. obesity/diabetes drug market is D2C
Pfizer CEO, 2026

~75%

of BioPharma searches now return an AI Overview
EVERSANA, 2026

17% / 22%

used a platform / very aware one exists
EMARKETER, 2025

Read what follows as a decision brief: what changed, what is still unclaimed, and how to choose where to stand.

Distance was not a failing. It was the rational design.

That arrangement was not improvised. BioPharma built a commercial system in which the people who took its medicines were reached through someone else at every step, because at the time no alternative existed. The posture held for decades because nothing pressed against it.

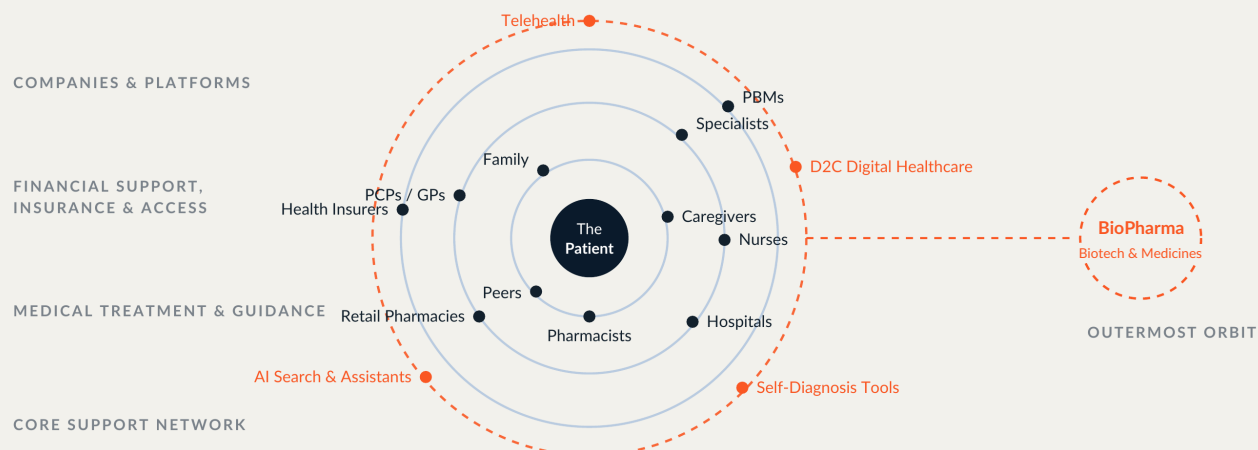
The field force, the data and the spend were organised around the prescriber. The relationships that mattered were with physicians; the data that mattered was prescribing data; the customer, in every practical sense, was the doctor. A regulatory perimeter limiting direct patient promotion — and no channel of scale to reach patients directly — completed the picture.

Every part of that design made sense on its own terms. Regulation drew a firm line; the field force served the prescriber, not the household; and no digital channel existed even if the other constraints had not applied. What changed is not any of the three constraints being lifted — it is that the patient built an alternative around them.

EXHIBIT 1

The Patient Care Experience Ecosystem

Concentric rings of relationship, radiating out from the patient



Distance was not a failing. It was the rational design. Nothing had yet tested it.

THE TAKEAWAY

Three separate, sound reasons kept BioPharma at a distance — none of them required BioPharma's permission to erode.

Eight platforms, twenty-six months — and BioPharma is not moving fastest.

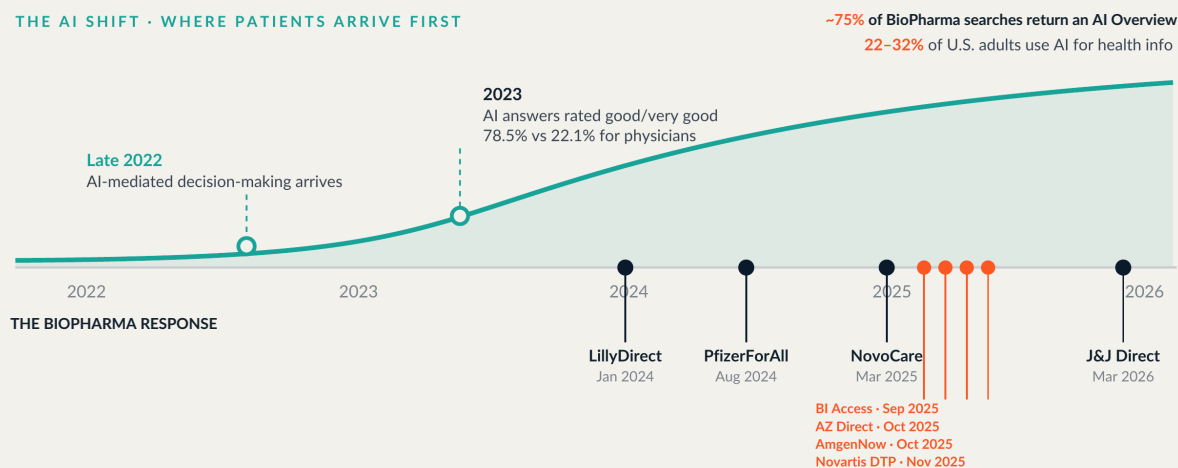
Two waves changed what patients expect: ordinary digitisation made seamless self-service a baseline, and AI-mediated decision-making — arriving in late 2022 — now shapes where people go next. What started with LillyDirect in January 2024 became the near-universal large-BioPharma answer within twenty-six months — the same forty months in which patients made AI their first stop for health information.

EXHIBIT 2

Two Curves, One Window

Patient adoption of AI for health information and BioPharma direct-to-patient launches, on one clock
GSK committed to a direct-purchase respiratory platform in December 2025.

THE AI SHIFT • WHERE PATIENTS ARRIVE FIRST



SEP-NOV 2025 • 4 LAUNCHES IN 9 WEEKS

Forty months: patients moved to AI; BioPharmas built the entry point.

Direct-to-consumer channels now account for roughly 30% of the U.S. obesity and diabetes drug market (Pfizer CEO estimate). But BioPharma is not moving alone or fastest — AI search, telehealth and consumer-health platforms meet patients first.

\$14.2B

digital health funding 2025,
+35% YoY
Rock Health, 2026

22-32%

of U.S. adults use AI for
health info
KFF / Pew, 2026

74%

of physicians offer
telehealth, from 14% in
2018
AMA, 2022

57%

own a connected health
device
Rock Health, 2026

THE TAKEAWAY

Direct-to-patient engagement proved itself in twenty-six months — but adjacent players got there first. The distance is now closing from both sides at once: the question is no longer whether BioPharma engages directly, but where, for whom, and in which moments.

More portals have not produced a better path.

For a BioPharma that has not yet moved, this can look like a race already lost. It is not — nobody has solved the patient journey end to end. More portals have not produced a better path. They have produced more portals.

EXHIBIT 3

What Moved — and What Didn't

WHAT MOVED

Eight D2C platforms

live by March 2026, standing start Jan 2024

\$14.2B funding

+35% YoY — 54% to AI-enabled companies

~75% of searches

now return an AI Overview

74% of physicians

offer telehealth (2022), from 14% in 2018

WHAT DIDN'T

Fragmentation

No one orchestrates the journey end to end

Discoverability

22% very aware · 17% have used one

Pre-diagnosis blind spot

First contact happens where BioPharma is least visible

Friction & perishable relationship

~13 hrs/week lost to PA; ownership contested

Five gaps remain open, and each is unclaimed by any single player — five different problems, not degrees of one, sitting in different places on the journey. That is exactly why a single, brand-by-brand fix keeps failing to close any of them.

EXHIBIT 4

Where the BioPharma Engages Today — and What to Do About It

WELLNESS	SYMPTOM	DIAGNOSIS	INITIATION	MANAGEMENT	ADHERENCE
BioPharma absent	AI search owns this	Regulatory constrained	Prior auth · friction	Contested — still open	Support programmes

① Fragmentation — spans the entire journey; no single orchestrator

② Discoverability — fewer than one in five patients know these portals exist

③ Pre-diagnosis blind spot — first contact happens where BioPharma is least visible

④ Friction core — ~13 physician-hours a week lost to prior authorisation

⑤ Perishable, unowned relationship — contested, not settled

Enable

Enable

Partner

Build

Build

Build

The friction core sits exactly where BioPharmas have spent the most and patients have felt the least improvement. Prior authorisation consumes around 13 hours of physician and staff time each week; 95% of physicians say it delays necessary care and 79% report patients abandoning treatment outright.

But the White Space Is Not All BioPharma's to Own

The gaps fall into two categories that look similar from the patient's side and demand opposite responses. Confusing them is how digital budgets get spent in places they can never win.

CONSTRAINED — A LEGAL OR STRUCTURAL CANNOT

BioPharma sees the gap and cannot own it outright. FDA has peer-reviewed evidence that unbranded disease-awareness content leads consumers to conflate it with a specific drug's benefits; its 2004 draft guidance on help-seeking communications was withdrawn in 2015 and never replaced. CMS routes navigation reimbursement to physician-supervised health systems, not BioPharma programmes. The play: fund, enable, shape — not own.

CONTESTED — A STRATEGIC WILL NOT

No legal barrier; a third party moved first. Ada Health reports 40M+ assessments; Buoy Health holds preferred-partner status across a 25M-member consortium. But this ground isn't settled either — Babylon Health filed Chapter 7 in 2023, K Health shut its consumer app in 2025. The play: partner or acquire, knowing a partner today can be gone tomorrow.

Telling these apart is the first discipline a BioPharma needs, before reaching for a value framework — treating a contested gap as constrained under-invests where it could win; treating a constrained gap as contested wastes years and legal exposure on something it was never going to own outright.

EXHIBIT 5

The White Space Scales With the Condition, Not the Brand

Where friction concentrates, and how large the unclaimed space is, by care-experience archetype

ARCHETYPE	WHERE FRICTION CONCENTRATES	SPACE	TIME TO DIAGNOSIS
Acute / one-time	Symptom recognition, then triage		Days to a week
Chronic / lifelong	Initiation and ongoing management		Median 2 months
Rare disease	The diagnostic odyssey		4.7 years
Oncology	Bimodal — delay, then financial shock		1 in 4 via the ED

Five gaps remain unclaimed — shared by every BioPharma, from different starting lines.

Every BioPharma is heading to the same place, from a different starting line.

The opportunity is common; the starting point is not. The digitally forward BioPharma's problem is no longer presence but coherence — years of investment produced multiple entry points without one connected journey, and its task is to consolidate. The more traditionally postured BioPharma's task is to establish a first position while meaningful white space remains. More than 80% of BioPharma executives report satisfaction with their engagement strategy, while only about a third of HCPs say those resources meet their needs.

EXHIBIT 6

Two Starting Points, One Consolidated Patient Relationship

One consolidated patient relationship

TRADITIONALLY POSTURED

Establish

a first position, before the opening narrows

The risk is not absence. It is unawareness of the absence.

DIGITALLY FORWARD

Consolidate

the scattered bets already made

The risk is not that it hasn't built. It is that what it built doesn't add up.

Neither posture is a reason to wait — and neither buys time. The same three forces narrow the window regardless of where a BioPharma starts.

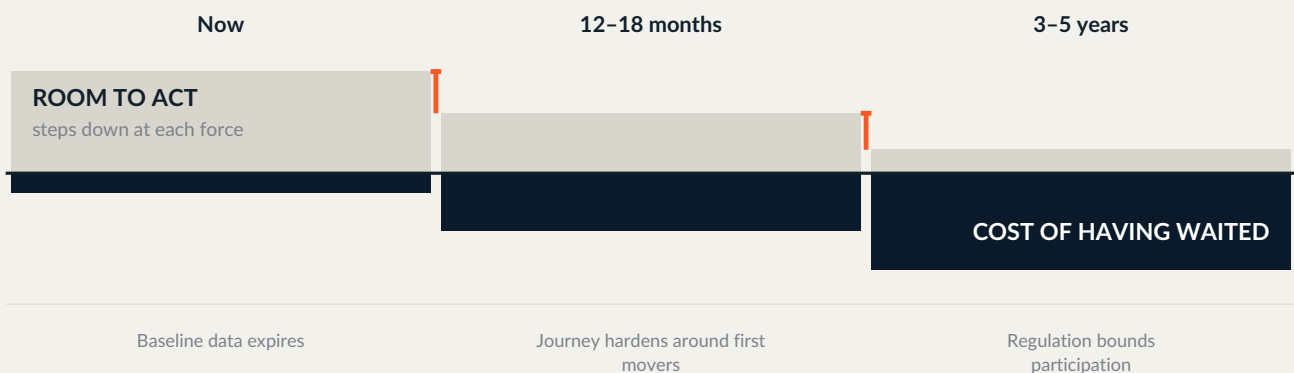
The Room to Act Steps Down. The Cost of Waiting Steps Up.

Three forces make the decision time-bound, not merely important.

EXHIBIT 7

The Room to Act Steps Down. The Cost of Waiting Steps Up.

Each of the three forces takes a step out of the window — and adds to the bill for having waited



1 Data perishability

The earliest signals — symptoms, questions, decision context before treatment — can only be captured once. Miss the moment and the baseline is gone, not delayed.

2 First-mover hardening

Journeys form around whoever earns the first credible interaction; AI-mediation sharpens the effect. Blinded evaluators rated AI answers good/very good 78.5% of the time vs. 22.1% for physicians. BioPharma's AI-answer visibility trails patient-advocacy orgs.

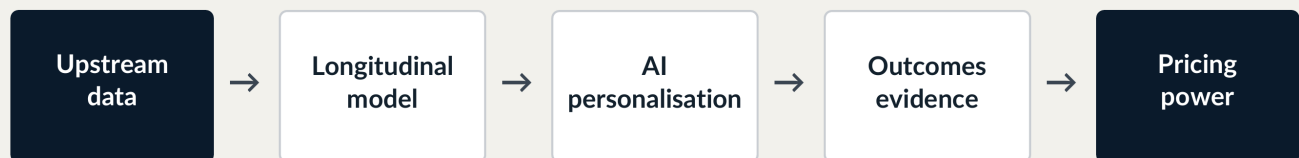
3 Regulation bounds — it does not close

FDA oversight intensified from September 2025, emphasizing net impression — relevant to AI-generated content. Privacy law now reaches well beyond HIPAA. These shape how a BioPharma participates, not whether it can.

EXHIBIT 8

The Engagement Chain — an Appreciating Asset, Not a Marketing Cost

captured only before the first prescription ↓



reinvested — each cycle compounds the asset

Acting now preserves upstream data, builds an AI-ready foundation and strengthens the BioPharma's negotiating position over time. Waiting lowers near-term spend and lets patient relationships, data assets and market positions form somewhere else — permanently. The cost and risk are real — proprietary infrastructure, a tightening regulatory perimeter, organizational silos — but the companies that move first are already compounding an advantage that gets harder to close every quarter.

THE TAKEAWAY

Every BioPharma is heading to the same place from a different starting line — but the window narrows at the same rate for both. Waiting doesn't just delay the decision; it compounds the cost of having made it late.

Run it once per archetype — not once per brand.

The challenge is no longer whether to build a direct patient channel. It is deciding where the entry point belongs, for which patients, and what role the BioPharma should play there. That decision cannot be made brand by brand — patient needs diverge structurally by the condition a person lives with. The right unit of decision is the patient archetype, not the drug.

EXHIBIT 9

Five Decisions, Five Gaps

How each decision in the methodology closes one of the gaps mapped in Exhibit 4

THE DECISION	THE GAP IT CLOSES
01 Archetypes Cluster by patient experience	→ ③ Pre-diagnosis blind spot Clustering by lived condition exposes the pre-diagnosis moments a brand-by-brand view never sees.
02 Journey map Phases × engagement themes	→ ① Fragmentation Mapping phases end to end names the orchestrator role — and every hand-off in between.
03 Value assessment Score the five pillars	→ ④ Friction core Scoring the pillars prices where friction actually concentrates, not where spend already sits.
04 Prioritisation Rank by significance and fit	→ ⑤ Perishable, unowned relationship Ranking by urgency moves the pre-Rx baseline to the front of the queue, before it expires.
05 Action Build · partner · fund	→ ② Discoverability Build, partner or fund puts the entry point where patients already arrive — not another portal to find.

THE FIVE VALUE PILLARS

Reach · Share · Duration · Position · Assets

The five decisions above are not abstract theory. Each has a distinct, repeatable method behind it — developed and pressure-tested working alongside a BioPharma, and directional enough to travel to any portfolio, in any therapeutic area. The pages that follow walk through each decision in turn.

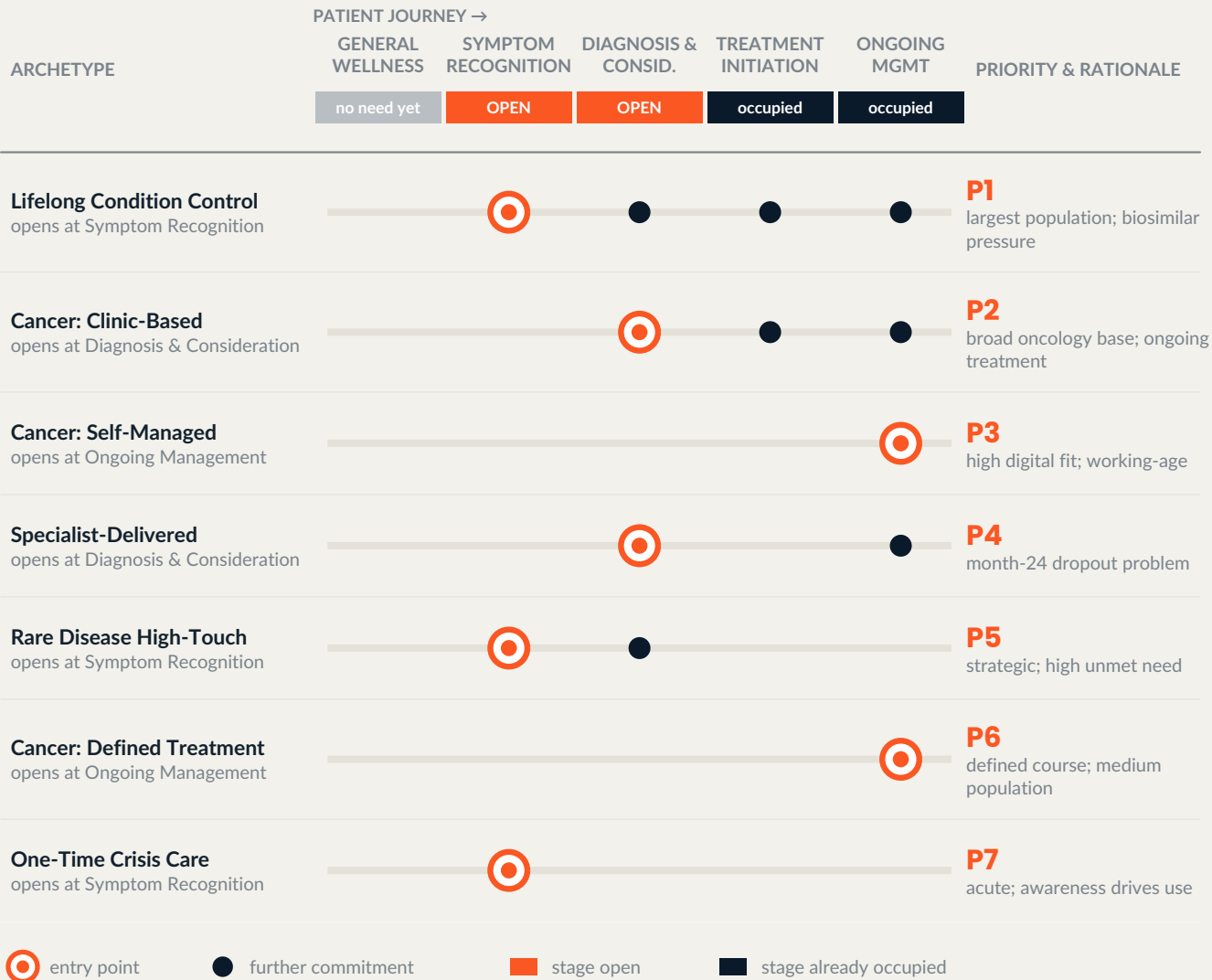
01 · 02 Archetypes & Journey Map — Where the Journey Splits Into Different Entry Points

Start with the journey, not the brand. Run all five stages past three lenses: where the need is real, where the BioPharma already stands, and where somebody else got there first. Where all three break the same way, that is the entry point. Cluster the conditions that break the same way and the archetypes fall out of the journey — same five stages, a different entry point for each.

EXHIBIT 10

From Journey Stages to Ranked Archetypes

Illustrative Example — three lenses across five stages; the archetypes and their priority fall out of the read



You now know which archetypes matter and where each one's entry point sits. Next: what that entry point is worth, and what to build first.

03 · 04 Value Assessment & Prioritization — Score the Five Pillars, Then Sequence the Moves

Price the entry point before building it. Every lever on the journey is scored against the same five value pillars — reach, share, duration, position, assets. The scores say where the value sits; urgency and feasibility say when to go. Read together, they turn a list of good ideas into a sequence with a first move.

EXHIBIT 11

Five Pillars Scored, Then Sequenced

Illustrative Example — where value concentrates, and the order the levers should be funded in

EXPERIENCE LEVER — BY JOURNEY STAGE	REACH surface underserved	SHARE win the decision	DURATION reduce dropout	POSITION hard to replicate	ASSETS RWD for pipeline	PRIORITY CALL
General wellness No lever — need has not formed	—	—	—	—	—	Not now
Symptom recognition Condition-aware education & symptom orientation	STRONG	—	n/a	MODERATE	STRONG	NOW
Diagnosis & consideration Pathway navigation & decision support	MODERATE	STRONG	—	—	STRONG	NEXT
Treatment initiation Self-service access & benefits navigation	—	STRONG	MODERATE	—	MODERATE	NOW
Ongoing management Adherence & persistence support	—	—	STRONG	MODERATE	MODERATE	LATER
NOW • 0–12 MONTHS Symptom-recognition education + self-service access Highest upstream value and the deepest friction. Both show a measurable result inside a year. NEXT • 12–24 MONTHS Pathway navigation & decision support Needs partners and clinical governance. Start once the entry point exists to hang it on. LATER • 2–5 YEARS Adherence & persistence at scale Compounds only after an identity layer carries the patient across every handoff.						

Value concentrates upstream, where the business does not yet stand; friction concentrates at initiation, where it already does. Fund both now — then act.

05 Action — Five Moves That Put the Entry Point Where Patients Already Arrive

Five moves turn the sequence into work. One builds the entry point across the whole journey; four keep patients arriving at it and finishing what they came to do. Run them in this order — visibility first, because it decides whether anyone finds the entry point; friction next, because it decides whether they get through it; then the data layer, because it is what makes everything after the first visit worth more than the first visit.

EXHIBIT 12

The Five Moves, Mapped to the Journey

Illustrative Example — one move builds the entry point; four decide whether patients arrive and finish

A One entry point, end to end

A single entry point from wellness through medication delivery captures the relationship at every stage — and stops it leaking to fragmented adjacent-sector players.

GENERAL WELLNESS	SYMPTOM RECOGNITION	DIAGNOSIS & CONSIDERATION	TREATMENT INITIATION	ONGOING MANAGEMENT
Health & lifestyle habit tracking	AI-oriented symptom triage & education	HCP finders, appointments, lab tests, prescription management	Benefits indication, electronic prior-auth tracking, pharmacy support	Support communities, outcome & symptom tracking

B Answer-engine optimisation

ACTS AT · SYMPTOM RECOGNITION

- Audit AI-answer visibility against competitors and advocacy organisations.
- Restructure content for citation, not ranking.

AI VISIBILITY SCORE (OUT OF 100)

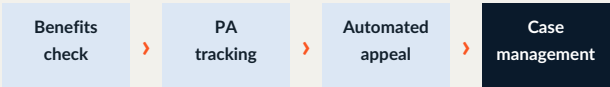
BioPharma		37
Close competitor		45
Advocacy organisation		76

C Remove the access friction

ACTS AT · TREATMENT INITIATION

- Proactive prior-authorisation navigator plus a self-service benefits portal.
- Cuts the delay, dropout and call volume phone-only access creates.

ONE TRACKED ACCESS PATH, NOT FOUR PHONE CALLS



D Shift the channel mix

ACTS AT · INITIATION → ONGOING

- Audit task parity: what can be done on the phone but not digitally?
- Anything short of full task completion reads as a second-class channel.

CHANNEL MIX FOR CORE PATIENT TASKS

Today	phone digital
Target	phone digital

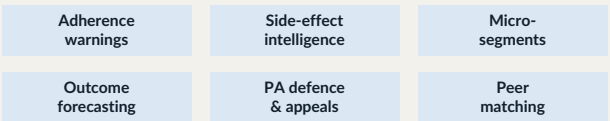
keep a human path open at every step

E Personalise from the data you now hold

ACTS AT · ONGOING MANAGEMENT

- Only possible once moves A–D feed one identified patient record.

ONE IDENTIFIED PATIENT RECORD



Strategic outcome: an end-to-end method of gathering data on patients in order to serve them better — the asset every later move compounds.

What each move takes

None of these moves is a platform decision. Each is a specific, auditable first action with evidence already forcing it. Start with the audit in each row — it is the cheapest way to find out how far the gap actually runs.

EXHIBIT 13

What Each Move Takes — First Action and the Evidence Behind It

Illustrative Example — audit first; the audit is what sizes the gap

THE MOVE	THE FIRST ACTION	THE EVIDENCE FORCING IT
A • One entry point	Map every patient and caregiver task to a journey stage, then give each one an owner and a surface. Close the gaps before adding features.	Fragmented touchpoints leak the relationship — and the data behind it — to adjacent-sector players.
B • Answer-engine optimisation	Run an AI-visibility audit against close competitors and advocacy organisations. Restructure content for citation, not ranking.	About a third of adults now use AI for health information; blinded evaluators rated AI answers good or very good 78.5% of the time versus 22.1% for physicians.
C • Access friction	Stand up a proactive PA navigator and self-service benefits portal: benefits indication, PA tracking, automated appeal creation, case management.	94% of physicians say prior authorisation delays care and 78% report patients abandoning treatment; a single authorisation can take 15 minutes to two hours by phone.
D • Channel mix	Audit self-service against call-centre task parity, then move the core tasks digital and keep a human path open.	61% prefer self-service for simple issues and 74% expect phone-equivalent digital completion — but 89% still want the option of a person.
E • Hyper-personalisation	Use the identified patient record to run adherence warnings, side-effect intelligence, micro-segments, outcome forecasting and peer matching.	Without journey-wide tracking, personalisation defaults to generic — and returns little against core KPIs.

EXHIBIT 14

Where Move B Starts — the Visibility Gap

Illustrative benchmark: the answer engine is citing somebody else

AI VISIBILITY, ILLUSTRATIVE OUTSIDE-IN READ	BIOPHARMA BRAND	CLOSE COMPETITOR	PATIENT-ADVOCACY ORGANISATION
Visibility score (out of 100)	37	45	76
Mentions • cited pages	1.1K • 81	1.6K • 225	6K • 2.4K
AI-cited pages as % of referring domains	6.2%	12.5%	7.7%

THE TAKEAWAY

The entry point is not a portal. It is the mechanism that holds the relationship at every stage — and the data asset that makes every move after the first one worth more.

Not a Technology Gap. It's a Decision Gap.

A portal was always a proxy for something harder to build: a relationship with the patient that survives every handoff. BioPharma's distance was never neglect — it was rational design for a world that has since rearranged itself around search bars and AI overviews faster than the three reasons for that distance ever eroded on their own. The market's response so far has produced fragments, not a journey — eight platforms launched, none of them an orchestrator. What's left is not a technology gap. It's a decision gap: which archetype to meet first, and what role to play once there.

That decision doesn't get easier by waiting. Every quarter of hesitation lets a baseline expire, a first-mover advantage harden, or a regulatory line settle before a company has chosen which side of it to stand on. The five-decision method in this paper prices that trade-off, archetype by archetype — a starting discipline, not a finished map. What it leaves deliberately open is the question only a portfolio can answer for itself: which entry point belongs to it — and every quarter spent undecided is a quarter spent letting someone else answer it instead.

What This Means for You

- 01 Distance from the patient was a defensible design choice once — but treating it as permanent now costs more with every quarter that passes.
- 02 There is no safer moment left to wait for. The market already moved without asking anyone's permission.
- 03 Not every open gap is yours to take. Know which ones are legally constrained and which are simply undefended before committing budget to either.
- 04 Every quarter spent undecided lets someone else's baseline, first-mover position, or regulatory footing harden into fact.
- 05 Strategy should follow how a condition is lived, not which brand treats it — score entry points by patient archetype, not by drug.
- 06 This is a discipline to repeat, not a project to close out — run it once per archetype, and revisit it as the market moves again.

Sources and Method Note

Method note. Every figure in this paper was independently re-verified against a primary source in August 2026. Figures that could not be traced to a primary source, or that proved to be misstated in circulation, were removed rather than softened; where a source is a projection, an executive estimate or a vendor analysis, it is labelled as such at the point of use.

AHIP (2026). Health Plans Take Action to Simplify Prior Authorization.

American Medical Association (2026). 2025 Prior Authorization Physician Survey, released 13 May 2026.

Ayers, J.W. et al. (2023). Comparing Physician and AI Chatbot Responses to Patient Questions. JAMA Internal Medicine.

Betts, K.R., Aikin, K.J., Miles, S. & Eisenberg Colman, M.H. (2024). Disease Awareness and Prescription Drug Communications on Television. Health Communication 39(13):3405–3415.

Bloomberg Law. State Privacy Legislation Tracker (accessed Aug 2026).

Brixner, D. et al. (2019). Patient support program outcomes. Journal of Managed Care & Specialty Pharmacy 25(7):770–779.

CMS (2024). CY2024 Medicare Physician Fee Schedule Final Rule — Principal Illness Navigation codes G0023/G0024.

CNBC (23 Jan 2026). Weight-loss GLP-1 drugs: next steps for Eli Lilly, Novo Nordisk, Pfizer.

Company press releases: Eli Lilly (Jan 2024), Pfizer (Aug 2024), Novo Nordisk (Mar 2025), Boehringer Ingelheim (Sep 2025), AstraZeneca (Oct 2025), Amgen (Oct 2025), Novartis (Nov 2025), Johnson & Johnson (Mar 2026), GSK (Dec 2025).

Covington & Burling (2025). FDA Advertising and Promotion Enforcement Activities Update.

Deloitte (18 Nov 2025). 2026 Life Sciences and Health Care Industry Outlook.

Deloitte (2025). Life Sciences Executive Outlook; and (Sept 2024) CRM in life sciences.

Dubief, C. & Faye, F. (2024). The diagnostic odyssey of people living with a rare disease. EURORDIS Rare Barometer; European Journal of Human Genetics.

Edward, J. et al. (2023). Financial navigation in haematologic cancer. JCO Oncology Practice 19(5):e696–e705.

EMARKETER (2025). Consumer awareness of pharma D2C platforms; Model N (2025). D2C medication services survey.

EVERSANA INTOUCH (2026). Pharma AI Overviews Report, via pharmaphorum.

Federal Register (6 May 2015). Withdrawal of Draft Guidance Documents Published Before 31 December 2013.

KFF (2026). Tracking Poll on Health Information and Trust; Pew Research Center (7 Apr 2026); West Health–Gallup (14 Apr 2026).

McKinsey & Company (15 Aug 2018). From product to customer experience: the new way to launch in pharma.

Oncology Nursing Society (2024). Patient preferences for early financial conversations in breast cancer.

Rock Health (Jan 2026). 2025 Year-End Digital Health Funding Overview; and 2025 Consumer Adoption of Digital Health Survey.

Solomon, A.J. et al. (2025). Diagnostic delay in multiple sclerosis. Multiple Sclerosis Journal — Experimental, Translational and Clinical.

Trilliant Health (2025). Cancer patients, ED visits and diagnostic delay, 2018–2024.

Wang, S. et al. (2024). Financial toxicity prevalence meta-analysis. European Journal of Oncology Nursing 68:102489.

ZS Associates (Mar 2026). Analysis of 340 pharmaceutical launches, 2008–2025.

Let's talk about your archetype.

Talk to Incedo's Life Sciences practice about running your portfolio through this framework — five pillars, a ranked priority list, and a path to your first move.

[Book a Conversation](#)

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