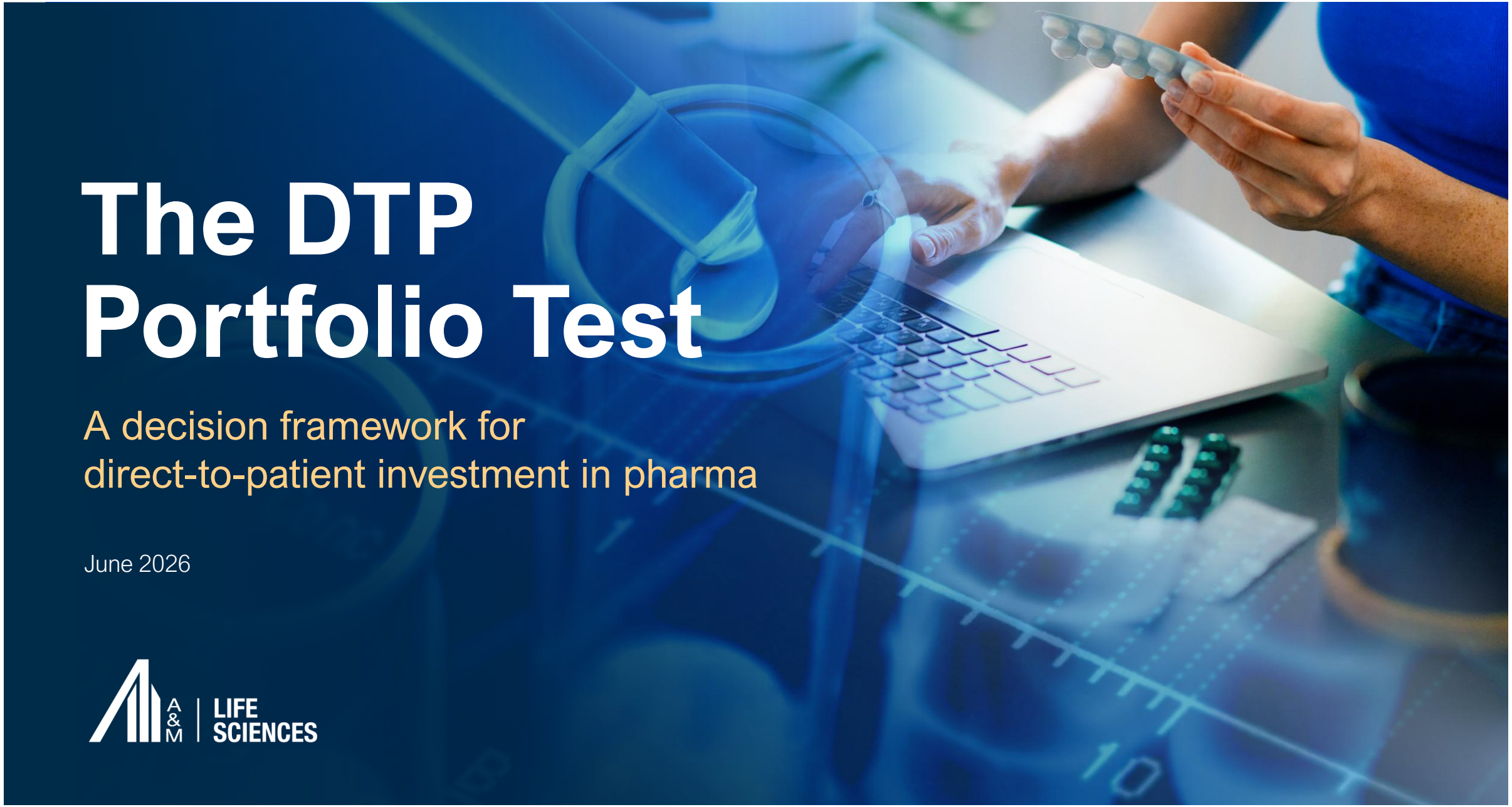


The DTP Portfolio Test

A decision framework for direct-to-patient investment in pharma

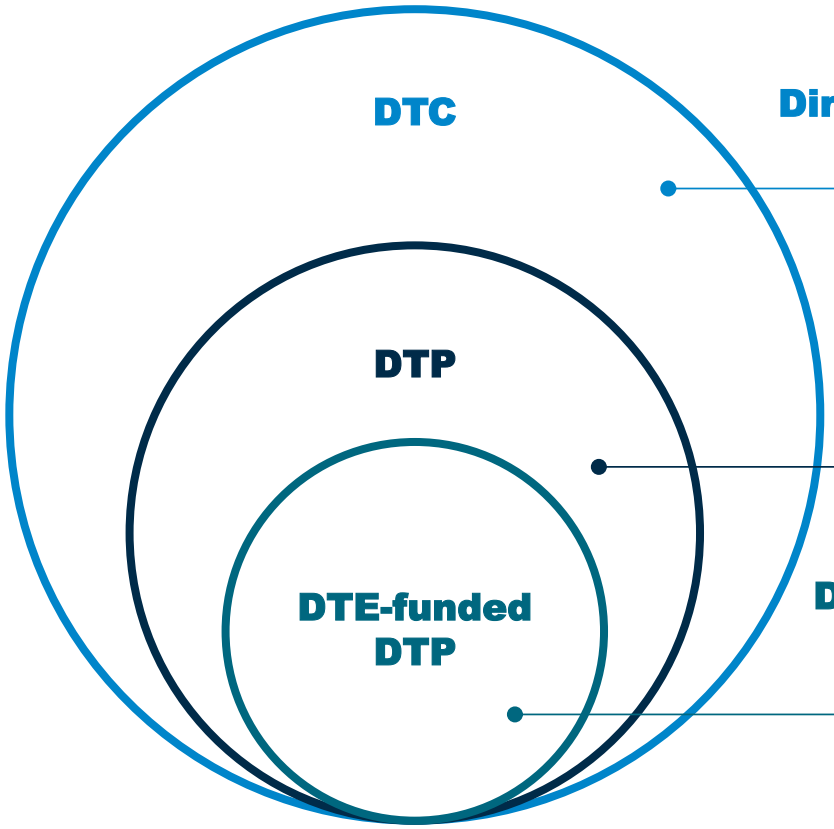
June 2026

A&M | LIFE SCIENCES

The wrong question

Pharma companies are asking whether direct-to-patient (DTP) is real and here to stay. The structural evidence settled that before the first TrumpRx deal was signed. The right question, and the one this paper answers, is whether DTP is real for your portfolio. That depends on what you sell, who buys it, and whether the economics of your specific products favor a direct channel. For some companies, deep platform investment is the smart bet. For others, a compliance portal is the right answer. The most expensive mistake is being in the wrong camp for your portfolio.

Let’s define DTP and distinguish it from DTC and DTE to avoid confusion



Direct-to-Consumer

A consumer is a member of the general public who may not have a diagnosis yet. They are a potential user who might recognize symptoms after seeing an ad. DTC activities are aimed at awareness and creating demand, not creating access.

Direct-to-Patient

A patient is someone actively managing a condition or already using a specific treatment. They have a direct relationship with the drug and often require ongoing support, fulfillment, and monitoring. DTP services are aimed at access and care delivery, and are downstream of conversion. There are many types of DTP, but this paper focuses on manufacturer-led DTP.

Direct-to-Employer

If DTC generates demand and DTP is a channel to meet that demand, DTE-funded DTP is one mechanism to fund DTP services. In addition to self-pay and insured models, employer funding offers financial relief and coordination as an employee benefit, negotiated directly with manufacturers that provide DTP services.

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The central strategic question is whether the DTP trend is structural or political theater

Is the DTP trend structural or political theater?

Structural

Argument: LillyDirect predates the political pressure and patient behavior data reflects durable demand that exists independent of any administration

Signals to watch:
- Rx volume through DTP channels as a % of scripts
- PBM contract restructuring pace
- Deepening of platform capabilities
- Patient retention and refill rates
- Employee/DTE convergence

VS

Political Theater

Argument: The entire acceleration of 2025 is political compliance masquerading as a strategy that could unwind the moment the political pressure shifts

Signals to watch:
- TrumpRx traffic and drug count stagnation
- Pharma price increases despite most-favored-nation (MFN) deals
- Selective participation by market leaders
- Post-tariff-immunity behavior
- Congressional oversight and legal challenges

SOURCE: A&M Analysis

The answer is dependent on the drug, but there is a strong case that for many the change is structural

49% of patients have used an online or home delivery pharmacy[1]

1 in 4 covered US workers are enrolled in high-deductible health plans[2]

LillyDirect launched in January 2024, more than 18 months before TrumpRx was announced. Lilly built it because insurance was suppressing demand for a product patients were willing to pay for. The platform was a solution to a commercial problem.

The demand signal exists far beyond obesity. More than one in four covered US workers are enrolled in high-deductible health plans. This is a structural shift that has held steady for half a decade. This combines with consumer conditioning from Hims & Hers, Ro, and others, which has trained patients to expect a consumer-grade experience.

Another structural demand driver is stigma. Stigma operates as a demand multiplier across nearly every cluster in the DTP landscape. There's stigma from needing help to lose weight (GLP-1), having sexual dysfunction (ED), struggling with gender identity (HRT), being sexually active but not monogamous (HIV PrEP), suffering from chronic pain, and even experiencing menopause.

Stigma doesn't make patients pay any price, but it does increase the perceived value of a channel offering privacy, discretion, and reduced social friction. This, in turn, shifts the willingness-to-pay curve in DTP's favor.

SOURCES: 1. A&M patient survey (N=500); 2. Kaiser Family Foundation, Employee Health Benefits Survey, 2018-2024


Most pharma companies
have launched DTP programs.
They are not all doing the **same thing.**

The split maps to portfolio, not ambition

STRATEGIC PLATFORMS

Companies with these platforms are making genuine strategic bets with real infrastructure investment, clinical pathway integration, and measurable commercial returns.

These share a common portfolio feature in that they were large chronic franchises where patients were demonstrating willingness to pay out of pocket and where insurance friction was suppressing demand.

COMPLIANT PORTALS

Companies with these portals are responding to political pressure. The products they chose, while self-administered and technically DTP-eligible, are priced well above where cash-pay traction has been demonstrated, satisfying the requirement without creating meaningful patient adoption.

These companies will deepen investment only if the economics shift through employer-funded models, payer integration, or pipeline evolution that puts lower-priced products on the platform.

Within the compliant tier, a subset has begun operationalizing distribution capability. They remain compliant in posture today but are building toward strategic. Watch this group as evidence accumulates; they are the most likely to migrate over time.

94% of pharma companies are building or exploring a DTP capability[1]. Participation is universal, but depth is not.

SOURCE: 1. DTP Trends in Pharma, DHCG / ixlayer (September 2025) (link)

NON-EXHAUSTIVE

What is clear is there is a meaningful distinction in platform depth

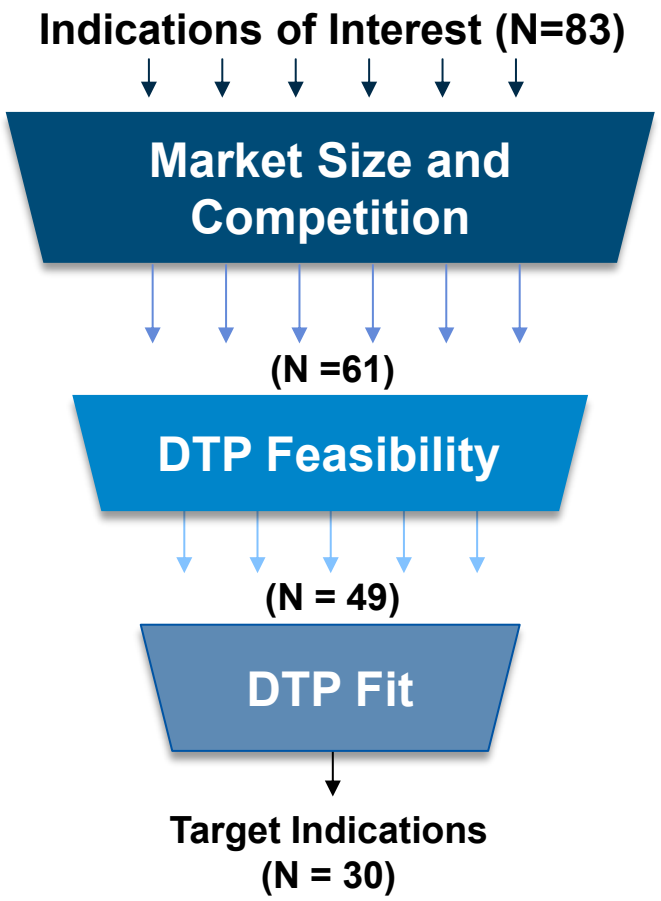
= Operationalized = Partial / partners = Not present

		Launch	Remote Diagnosis	Telehealth	Online Pharmacy & Distribution	Disease Management	Health InsurTech
Strategic	LillyDirect	Jan 2024					
	NovoCare Pharmacy	Aug 2024					
	PfizerForAll	Mar 2025					
Compliant (Capability Building)	Astellas DIGITIVA	Sep 2024					
	AstraZeneca Direct	Oct 2025					
	BMS Patient Connect	Jan 2026					
	Novartis DTP	Sep 2025					
Compliant (MVP)	AbbVie	Jan 2026					
	AmgenNow	Oct 2025					
	Boehringer Ingelheim Access	Sep 2025					
	Gilead Advancing Access	Dec 2025					
	GSK / ViiV	Dec 2025					
	J&J Direct	Mar 2026					
	Merck	Dec 2025					
	Sanofi	Dec 2025					

SOURCES: Galen Growth: Pharma's Direct-to-Patient Pivot (September 2025); Rock Health: Pharma's direct-to-patient era: Building beyond table stakes (November 2025), company announcements, A&M analysis (assessment as of March 2026)

The question isn’t platform or portal.
It’s whether **your portfolio**
justifies the investment.

After screening for indications, 30 demonstrated portfolio-fit for DTP

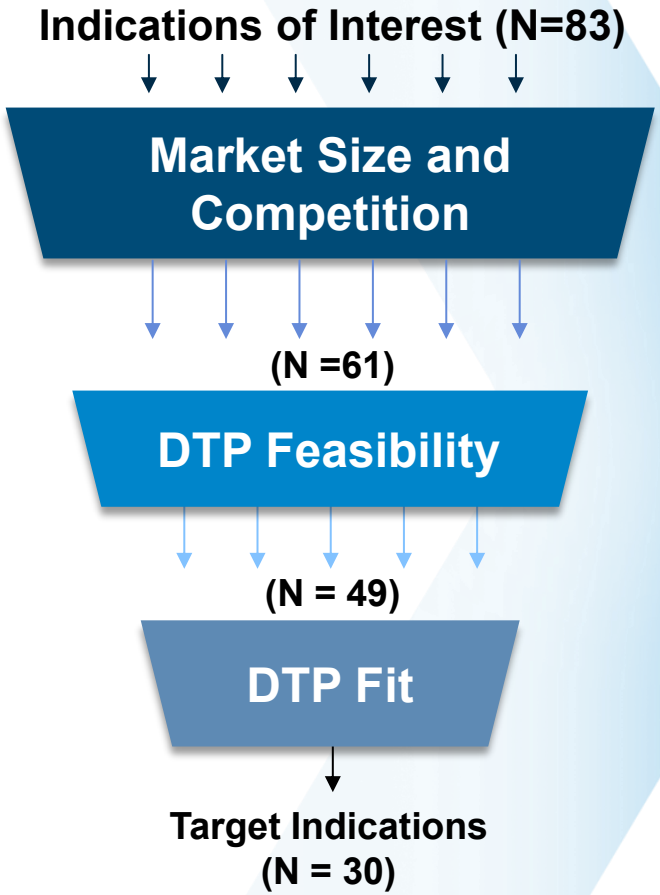


	Screening Criteria
Market Size and Competition	• US Patient Population Size • Chronicity • Market Saturation • Competitive Landscape Intensity (indicating pharma's appetite to differentiate through DTP)
DTP Feasibility	• Self-Administered Route of Administration • Telehealth Suitability • Other Feasibility Considerations (e.g., treatment safety, controlled substances, dosing schedules)
DTP Fit	• Willing-to-Pay Out of Pocket (OOP) • Patient Characteristics Fit for DTP (e.g., awareness of treatment options, need for convenience, speed, or discretion, likelihood to adopt digital solution)

SOURCE: CMS, A&M Analysis

The 30 indications mapped to five therapeutic area clusters

Expand Platform to New Indications



Target Indications / Treatment Categories for DTP

Psych / Neuro

- Alcohol Use Disorder
- Anxiety Disorders
- Depression
- Insomnia
- Migraine
- Post-Traumatic Stress Disorder (PTSD)
- Sleep Apnea
- Substance Use Disorder

Men's / Women's Health

- Benign Prostatic Hyperplasia
- Contraceptives
- Dysmenorrhea
- Endometriosis
- Erectile Dysfunction
- Estrogen or Testosterone Replacement
- Perimenopause Treatments
- Urinary Incontinence

Metabolic / GI

- Diabetes (Type 1 and Type 2)
- Irritable Bowel Syndrome (IBS-C, IBS-D, IBS-M)
- Obesity

Pain

- Chronic Back Pain
- Chronic Pain
- Chronic Pelvic Pain
- Fibromyalgia

Dermatology

- Acne
- Alopecia
- Eczema (Atopic Dermatitis)
- Retinoid Use

SOURCE: A&M Analysis

Screening criteria thresholds were established to eliminate unsuitable options for DTP

		Rationale	Screening Threshold
Market Size and Competition	US Patient Population Size	Larger patient populations create a broader market opportunity for scalability and cost-effectiveness	> 1M
	Chronicity	Chronic diseases require ongoing treatments and ensure need for consistent DTP service	Must be a chronic disease
	Market Saturation	Saturated markets signify a mature segment with high familiarity in the market and are more opportunistic for DTP models	≥ 3 marketed treatments in the US
	Competitive Landscape Intensity	Competitive intensity within a given category indicates pharma's appetite to differentiate its products through convenience of DTP	Medium – High
DTP Feasibility	Self-Administered ROA	Self-administered therapies without provider supervision are necessary for the DTP model	Self-administered treatment options available
	Telehealth Suitability	Ability to treat patients via telehealth is critical; considerations include need for in-person assessment/testing, disease severity, etc.	Medium – High
	Other Feasibility Considerations	Other considerations such as treatment safety, controlled substances, dosing schedules, etc. inform feasibility to implement DTP programs	Screen-out indications with feasibility concerns
DTP Fit	Willingness-to-Pay Out-of-Pocket	DTP adoption is more likely within indications / treatment categories with high consumer demand, urgency, and likelihood to purchase products out-of-pocket based on reimbursement landscape, OOP price, and disease severity	Medium – High
	Patient Characteristics Fit for DTP	High patient awareness of treatment options, extent to which convenience, discretion, and/or speed are valued by patients, and patient demographics (which inform likelihood to adopt a digital solution) inform DTP fit	Medium – High

SOURCE: A&M Analysis

The framework is a diagnostic, not a prediction, as it tells you whether the structural prerequisites exist in your portfolio

The framework is a diagnostic

- The framework does not claim every product in these clusters will succeed through DTP
- It claims that products in these clusters, with monthly OOP in the demonstrated range, meet the structural prerequisites that justify deeper platform investment

Most companies will find products in both camps

- The framework is designed to be applied product by product, not company by company

It's still early days

- Patient adoption data beyond GLP-1 is limited because platforms serving other therapeutic areas are less than a year old
- The next twelve to eighteen months will produce the behavioral evidence that validates or challenges these expectations

DTP economics resolve into three archetypes

Each archetype has its own economic engine, its own PBM role, and a different evidence base

Cash-pay Bypass

What it is

Manufacturer captures the cash transaction directly. Insurance friction was suppressing demand or routing patients to competitor cash channels. DTP unlocks the latent willingness-to-pay at a transparent price.

How the money works

Gross-to-net repurposing. List price minus platform cost beats the insured channel's net realization because the rebate, chargeback, and pharmacy spread that flowed to intermediaries get redirected into the direct channel.

PBM role

Bypassed at the transaction level. The PBM-patient relationship continues for the patient's other prescriptions.

Examples

ED and HRT products, GLP-1 self-pay programs

Friction Reducer

What it is

Manufacturer improves conversion within the existing insured channel. DTP smooths prior authorization, eliminates counter-cost surprises, and improves adherence around the existing payer architecture.

How the money works

List price and rebate structure stay intact. The economic lift comes from better PA approval rates, faster time-to-fill, lower abandonment at the counter, and improved persistence.

PBM role

Partner. PBM adjudicates claims; DTP improves the patient experience around their architecture, not against it.

Examples

PfizerForAll, Boehringer Ingelheim Access, Lilly-Walmart hybrid retail fulfillment.

Direct-to-Employer (DTE)

What it is

Manufacturer contracts with employers, typically through platform orchestrators, for rebate-decoupled pricing administered by the existing PBM at a transparent fee.

How the money works

PBM rebate-spread becomes a transparent admin fee. Employer captures the previously opaque value. Manufacturer gains cleaner economics, direct payer relationship, and PBM contract leverage.

PBM role

Administrator, not profit center. Relationship continues at a transparent fee rather than through opaque rebate flows.

Examples

Lilly DTE, Novo DTE

The archetypes describe distinct economics, not single-product strategies. A sophisticated portfolio plays in multiple archetypes per product to meet the patient where they are.

Manufacturers don’t concede on price with DTP, they just repurpose GTN dollars

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DTP Archetype A Pricing Comparison

Pricing comparison for an illustrative CGRP migraine product with assumptions disclosed

	Traditional Channel	DTP Channel
List price	$900/month	-
GTN erosion (~55%)	~$495	-
Net realized/DTP price	**~$405/month**	**$350/month**
Platform cost	-	~$25/month (est)
Net revenue per patient	**~$405**	**~$325**
Abandonment rate	29%[1]	8%[2]
Revenue per Rx written	**$288**	**$299**

Pharma isn't conceding on price. It's repurposing GTN dollars that were flowing to intermediaries (rebates, chargebacks, wholesaler margins, pharmacy spread) into a direct channel where more of the savings reach the patient. The GTN bubble now exceeds $350 billion annually[3], which is a lot of dry powder to fuel DTP viability.

SOURCES: 1. US Medicine Use Trends 2026, IQVIA (link); 2. Impact of Telehealth on Medication Adherence in Chronic Gastrointestinal Diseases, J. Can Assoc Gastroenterol, 2022 (link); 3. Going Inside the Gross-to-Net Bubble and Its Nuances, Pharmaceutical Commerce, 2024 (link)


The first-generation platforms proved that patients **want this channel.** They did not prove that the model is sustainable.

The early platforms have design flaws that can be improved with each iteration

Flaw	What happened	How to fix
The prescribing relationship	Manufacturers partnered with telehealth providers whose prescribing patterns overwhelmingly favored the drug, creating cursory encounters and aggregate outcomes that raised concerns about the independence of the prescribing decision.	Build a platform where the patient chooses the prescriber using a platform intermediary to create structural financial separation from the prescribing relationship.
Clinical isolation	Prescriptions filled through the platform don't flow back to the patient's PCP or appear in their EHR, creating blind spots for drug-drug interactions, care coordination, and adverse event management. The urgency is already visible with many GLP-1 patients microdosing.	Prompt the patient to share Rx info with their PCP and provide a downloadable summary. Evolve to notify the patient's PCP directly, with patient consent. Ultimately integrate with EHR via FHIR APIs so DTP prescriptions appear in the patient's medical record.
Data governance	First-generation platforms lacked a data governance architecture. Operational data from telehealth, pharmacy, and delivery partners flowed without clear purpose-limitation, access controls, or patient-level consent for its use.	Design a data architecture where data stays at its origin by default, every field maps to a defined function, access is role-based and technically enforced, retention follows deletion schedules, and patient consent is specific.

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PBMs are building competing platforms, so it is important to stress-test your thesis against theirs

The most significant competitive threat to manufacturer-led DTP is not other manufacturers. It is **PBMs building their own digital platforms with a structural advantage no manufacturer can match** (i.e., formulary control).

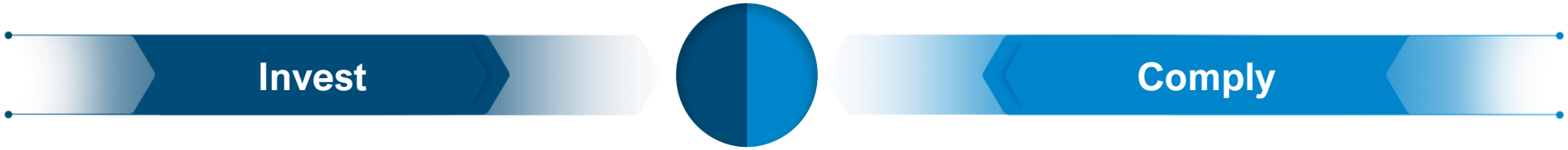
The most probable outcome is **PBM adaptation, not displacement.** DTE creates competitive leverage that gives employers optionality, not a mandate to abandon PBMs. Platform intermediaries like Eversana's Waltz Health are positioning to work with PBMs in a more transparent model, not against them.

As DTE grows and PBMs adapt, the DTP solution must evolve with them.

Stress-test for DTP investment

Model a scenario where your primary PBMs launch competing digital platforms with formulary-integrated telehealth. Does your investment thesis survive if the PBM offers comparable experience with lower patient cost-sharing?

Your portfolio determines whether you invest or comply



Invest		Comply	
Identify which products go first	Start where insurance friction is highest, OOP is in the low hundreds, and branded product is clinically differentiated	Pipeline evolution	Run the screening framework against the pipeline, not just the marketed portfolio. Oral formulations, indication expansions, or acquisitions can shift the calculus
Decide build vs. partner	Telehealth (independent), fulfillment (integrated, including hybrid retail), adherence (core feature), data governance (purpose-limited)	Employer-funded convergence	If employers become a payer channel, products above the individual cash-pay ceiling may become viable in a cost-share model
Unlock multiplier economics	Multiple qualifying products sharing a patient population can justify shared infrastructure. Evaluate employer-funded channels	Payer integration	If insurers accept DTP-fulfilled prescriptions for deductible accumulation, the boundary between direct and insured blurs
Build to the defensibility bar	The model design principles in this paper are structural requirements, not optional additions	Regulatory clarity	Future enforcement defines rules compliant models must respect, reducing risk for companies on the sideline

Staying in the wrong tier costs more than catching up

The most expensive outcome is not being in the wrong tier today. It is staying in the wrong tier for your portfolio as the evidence accumulates.

A company with products in multiple qualifying clusters still running a compliance portal in 2027 will find the cost of catching up exceeds the cost of having invested earlier.

Equally, a company investing heavily in DTP for hospital-infused oncology biologics will find that no platform sophistication creates a cash-pay market for products that cost tens of thousands per month.

The DTP channel is real, it is durable, and for the right portfolio it represents a meaningful commercial advantage.

The discipline is in knowing whether it is right for yours.

Thank you

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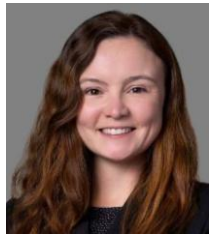

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