BRINTNALL & NICOLINI, INC.
HEALTHCARE CONSULTING AND RESEARCH

Prozac
Pyramid™ Positioning/
Message Development Research

Prepared for

Eli Lilly

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EXECUTIVE SUMMARY

Eli Lilly and Company (Lilly) contracted with Brintnall and Nicolini, Inc. (B&N) to utilize its Pyramid Positioning/Message Development™ process to reposition Prozac with four physician segments: psychiatrists and primary care physicians (Faders, Undecideds, and Enthusiasts). B&N conducted the work during February/March 2000. The Pyramid process had two work phases. The first phase was developmental and involved marketing management, medical and the advertising agency of record. This expert team sought to develop a more-effective Prozac selling story and positioning as they listened to 20 interviews with a national sample of physicians, including 12 primary care physicians (PCPs) and 8 psychiatrists (PSYCHs) recruited from Lilly's lists. The team debriefed and revised the Prozac selling story between interviews. The second phase of the Pyramid process involved qualitative testing of two developed messages, one for PCPs and the other for PSYCHs. This phase consisted of 25 phone interviews divided among the aforementioned segments. Subsequent to the testing work, B&N conducted another 11 interviews divided about equally between PCPs and PSYCHs, to evaluate refined versions of the same developed messages as well as an alternate PCP message introducing the new idea of Prozac providing "short-term power and long-term protection."

- The developmental process yielded an umbrella Prozac positioning of "power and versatility", which applies across the four segments. The PCP and PSYCH developed messages have similar structures organized around patient types, but the reasons to believe the patient types themselves diverge slightly.
  - For PCPs, power resides in the ability of Prozac to energize depressed, unmotivated patients, and its versatility is in its proven ability to treat specific patient types, including female patients and the elderly. An early version of the PCP message mentions the "dual efficacy of fluoxetine" (due to its potent norfluoxetine metabolite), using this reference as another means of conveying "power." However, this statement was dropped midway through the testing phase.
  - For PSYCHs, the power of Prozac is the ability of Prozac to treat "complex and challenging" patients effectively, including partial and non-responders, and its versatility in its effectiveness and safety in treating female patients and elderly patients with comorbidities. The developed PSYCH message refers to Prozac's effect on other monoamines beyond serotonin.
- Overall, both the PCP and PSYCH developed messages proved effective in stimulating physicians who prescribe less Prozac to consider prescribing Prozac more often, because the messages remind physicians that Prozac is a powerful antidepressant and has long been considered the gold standard for efficacy.

- After reading the message, almost all of the Faders and about half of the Undecideds are inclined to use more Prozac, particularly for women and the elderly. Prozac Faders anticipate the largest increase in usage. This increased usage is predominantly at the expense of Paxil, Zoloft, and Serzone. In general, physicians claim that they already often prefer Prozac in low-energy patients; therefore, they do not anticipate much increase in use for this group.

- Prozac Enthusiasts, in contrast, are less responsive to the message because they feel that it merely confirms their reasons for already preferring Prozac for many patients.

- Similarly, PSYCHs can be divided into two categories: those who are currently prescribing less Prozac and those prescribing more. The lower Prozac prescribers, who are often high users of Zoloft, respond that they will increase Prozac use in elderly patients and women, primarily at the expense of Celexa and Zoloft. In addition, a few say that they would substitute Prozac for Effexor in some instances, because of Prozac's high success rate, 40-mg dosage strength, and better tolerability profile.

♦ The PCP message is compelling because many PCPs find the information new and significant, particularly the fact that Prozac is

  - Safe in renally-insufficient patients, often elderly

  - Safe in pregnancy

  - Effective in relieving even the physical symptoms of PMDD

  - FDA-approved for use in PMDD, bulimia, and the elderly

  - Available in a variety of dosage formulations, including a 40mg dosage-form for patients requiring a higher dose, and a liquid formulation for nursing-home patients

♦ The PSYCH message is also compelling because of new and important information, particularly the facts that

  - Prozac works in Zoloft non-responders

  - Patients stay on Prozac longer than on other SSRIs

  - Prozac is effective even for the physical symptoms of PMDD

  - Prozac does not accumulate

- Importantly, after reading the developed message, PCPs and PSYCHs agree that "powerful and versatile" aptly describes Prozac and supports their clinical experience. Physicians readily accept that Prozac can effectively energize depressed patients, since this confirms their perception of Prozac as an activating antidepressant.
  - Removing the dual-acting metabolite information from the PCP message during the second half of the testing interviews seemingly did not affect PCPs' perception of the power of Prozac but it did address their confusion and disinterest.
  - Replacing power and versatility with "short-term power and long-term protection" in an alternate PCP message tested only with six PCPs, also appears to lead to more questions about Prozac's power. In this alternative message, PCPs expressed confusion about the meaning of "short-term power" and they rejected the claim that Prozac does not require titration.
- The key reasons why physicians do not prescribe even more Prozac in response to the developed messages are:
  - Inappropriateness of Prozac for patients who are anxious-depressed or who require sedation
  - Cost and lack of reimbursement for patients who must pay out of pocket
  - Patient reluctance due to Prozac's perceived side effects, such as loss of libido, violent behavior, and suicidal tendencies
  - Comorbidities such as smoking or ADHD, which may lead physicians to favor the use of other antidepressants
- Importantly, physicians often comment that they expect to use the information in the messages to help overcome the barrier of patient reluctance, but expect that some patients will simply not accept a Prozac prescription.
- Several points in the developed messages generate recurring disinterest, confusion, and skepticism:
  - PSYCHs seem uninterested in the listing of complex and challenging patient types at the beginning of the message. Accordingly, it may be better to start with the idea of "in your hands, Prozac can be a powerful and versatile tool" and then move to the patient types.
  - The Zoloft non-responder claim in the PSYCH message raises questions about doses used in the study and whether Zoloft may also be as effective with Prozac non-responders.

- Similarly, both PCPs and PSYCHs ask for more details about the study, showing that patients stay on Prozac longer than on Zoloft, Paxil, and Celexa.

- Across segments, the idea that Prozac does not accumulate is attractive. Nonetheless, physicians find this claim counterintuitive because of Prozac's long half-life. Prozac sales representatives should be prepared to deal with this potential source of confusion.

- Most PSYCHs comment that it has been their impression that Prozac is metabolized by the cytochrome P450 system in the liver, rendering it potentially problematic in patients on multiple medications, as is typical of the elderly.

- Both PCPs and PSYCHs take away and reject the implication that fatigue and lack of motivation are particularly characteristic of female patients. This suggests a need to fine-tune the connections among patient types in the messages.

Recommendations

Based on the findings from the validation phase of research, Eli Lilly should consider making the following changes to the Prozac messages.

Common to Both Messages

- Consider clarifying the idea that fatigue and lack of motivation are not exclusive to females.

- Consider expanding on the idea that Prozac's long half-life prevents discontinuation syndrome, making direct comparisons to Paxil and Zoloft.

- Explain why Prozac does not accumulate despite its long half-life.

- Possibly combine the sub-bullets under "the most studied in patients with concurrent medical conditions" statement, as physicians ignore the "effective at relieving depression" statement.

- Consider creating a separate headline for the dosage-form information, as may be leveraged more effectively to convey the idea of versatility.

- Consider changing the "10 mg in the elderly statement" to 5 mg, as many physicians state that the 10 mg can be broken in half.

Specific to PCP Message

- Consider rewording the "power and versatility" statement to avoid MDs misconstruing this idea to mean singling females out as having symptoms of fatigue and lack of motivation.
- Consider expressing vague aches and pains by using the words "somatic complaints," as this language seems to mimic physicians' own.
- Consider removing the assertion that Prozac shows efficacy in one week.

Specific to PSYCH Message

- Similar to the PCP message, consider making the opening line more dynamic and attention-grabbing, raising their interest to hear more. Possibly incorporate the fact that new data are available.
- Re-contextualize the phrase "prescription claims studies" so that PSYCHs quickly identify where these data come from, elevating the credibility of this statement.
- If possible, make the Zoloft non-responder data more credible by adding a reference to the study.

OBJECTIVES AND METHODOLOGY

As Prozac (fluoxetine) enters the mature phase of the product lifecycle, it is facing increasing competition as well as the challenges associated with losing patent protection. Hence, Eli Lilly is developing new marketing strategies and tactics intended to protect the brand's share of the antidepressant market during its maturity. To this end, Eli Lilly and Co. contracted with Brintnall & Nicolini, Inc. (B&N) to utilize its proprietary message development process to reposition and develop new selling messages for Prozac. The results from this strategy-development work serve as a communication platform for subsequent tactical campaign elements. Eli Lilly and B&N conducted the work during February/March, 2000.

The specific objectives of the study were to:

- Develop a compelling Prozac positioning designed to be unique, credible, important and behavior-modifying (motivates physician to prescribe)
- Develop a Prozac positioning statement
- Create a product message to communicate the positioning immediately and powerfully
- As appropriate, modify the core communication for different Prozac customer segments
- Uncover how physicians position Prozac vis-a-vis their other therapeutic options
- Provide a qualitative validation of the product messages and some message variations by measuring consistency of response

The Message Development technique is a creative yet rigorous process utilized to develop a powerful selling message and an appropriate positioning statement. The process has three steps: 1) a Strategy Session, 2) Message Transformations, and 3) Message Testing. The next sections describe each of the steps in detail.

Strategy Session. The purpose of the Strategy Session is for B&N to inform the team about the nature of the Message Development process. In addition, the team shares information and insights about the market and reviews motivational goals for the selling messages. Finally, the team reaches agreement on the appropriate starting message to use at the beginning of the transformational process. The Strategy Session for this project was held on the morning of February 14, 2000.

Message Transformations. The transformational work is a creative process in which an expert team develops a compelling message by observing and responding to the reactions of target physicians as seen during in-depth interviews using trial messages. After each transformational interview, there is a thorough debriefing, which identifies barriers and discusses ways to overcome those barriers. The team then agrees on what changes, if any, to make to the selling messages and makes the changes. Following those modifications, the team then introduces the revised message into the next interview. For this research, the team interviewed a sample of eight (8) psychiatrists (PSYCHs) and twelve (12) primary care physicians from three market segments: 6 faders, 3 undecided and 3 enthusiasts, (see the Appendices for the Screening Questionnaire), for a total of 20 interviews. The physicians were about evenly divided across five cities: Philadelphia, Charlotte, Chicago, Denver and Seattle. B&N recruited physicians from lists provided by Eli Lilly. These videoconference and face-to-face interviews took place at the B&N videoconference facility in Philadelphia from February 14 through 18, 2000.

The Message Development interviews are deliberately non-directive and conversational. Physicians initially describe the general nature of their practices. A customized pre-message-exposure exercise follows: physicians estimate the percentage of patients for whom they prescribe various products listed on an allocation grid. After explaining their estimates, physicians review the product message and share their reactions. Then they reallocate their prescriptions and explain any changes. (See Appendices for the Discussion Guide and the Product Allocation Grid.)

Message Testing. The next phase of the Message Development process evaluates the developed messages through a series of in-depth interviews intended to gauge their communicational validity and motivational impact. (See the Appendices for the Developed Messages.) These interviews permit B&N to suggest areas of needed refinement in the developed messages. B&N conducted 25 telephone-depth validation interviews among 8 PSYCHs and 17 PCPs (5 faders, 6 undecided and 6 enthusiasts), for a total of 25 interviews. These interviews were completed on February 24, 2000. During this process, a total of 2 developed messages for PCPs and 1 developed message for PSYCHs were tested. These physicians were also recruited from lists provided by Lilly. All physician participants received appropriate honoraria to encourage participation.

After the initial phase of Testing interviews, B&N conducted an additional 11 interviews with five (5) PSYCHs and six (6) PCPs (both FPs and IMs) to evaluate refined versions of the developed messages as well as an alternative PCP message introducing the new idea of Prozac providing "short-term power and long-term protection." These interviews were completed on March 10, 2000.

Overview of Sample. The full message development process included a total of 56 physician interviews, as summarized in the following table:

Specialty	Development	Testing	Additional Testing	Total
PCPs				
	12			
		17		
			6	
				35
PSYCH				
	8			
		8		

	5
	21
TOTAL	
	20
	25
	11
	56

B&N audio-recorded the interviews for subsequent analysis. Copies of these tapes, if not already provided, accompany this final report.[1]

The next section of this report contains the Detailed Findings, followed by the Appendices. Keep in mind that the transformational work phase of Message Development is not simply market research, but rather is a facilitation process that enables an expert team to respond creatively to insights based on customer listening. The validation phase of Message Development is similar to qualitative market research. Finally, the nature of the entire Message Development research process, as well as this resultant report, are proprietary B&N material subject to a mutual understanding of confidentiality between Lilly and B&N. This understanding prohibits any use or direct/indirect disclosure of B&N's proprietary research techniques or reports to competitors.

[1] According to our covenant with the participants, duplication or distribution of, or quotation from, any interview tapes without the express written permission of B&N is strictly prohibited.

DETAILED FINDINGS

CONTEXT

PCPs report increasing levels of autonomy in the treatment of mild-to-moderate depression.

PCPs consistently report that the treatment of depression is a growing segment of their practices. Since the advent of the SSRIs, PCPs say that they have developed a greater comfort level and are able to treat the vast majority of mild-to-moderate depression successfully without the help of PSYCHs. Almost all PCPs indicate that they refer patients to PSYCHs after the first visit only when patients present with suicidal or homicidal ideations, symptoms of psychosis, or other concomitant psychological disorders that may cloud the diagnosis. PCPs say they also refer patients out to PSYCHs after an inadequate trial of one or two SSRIs.

> *I think with the advent of the newer medications that have fewer adverse effects, we are being more liberal in treatment with medications. I am also thinking more now of the many associated medical or psychological disorders that are associated with depression, such as anxiety and obsessive/compulsive disorders. We are more tuned in to these associated illnesses since these medications have indications for those disorders as well. (PCP-Enthusiast)*

> *I'll use one or perhaps two different types of medications to see if it will help, and if I kind of hit the wall, then I will refer them over to a PSYCH, more for medication management. (PCP-Fader)*

Interestingly, many PCPs also report a reluctance to refer patients into managed care behavioral health systems, due to concern over patients' willingness to navigate through these sometimes complicated systems. Some PCPs even express concern over the quality of care their patients will receive within managed behavioral health systems. This reluctance to refer patients appears to be particularly evident when a trusting relationship between the PCP and patient has already been established. PCPs also report that higher levels of public awareness of depression combined with lower levels of social stigma drive an increasing number of patients into their offices seeking treatment. These are some of the factors that result in PCPs treating depression more often and more aggressively than in the past.

The HMOs' plan is to keep them out of the PSYCHs offices by demanding a psychology referral first, so the patients go into the behavioral health network and get lost in that maze for a while before they get the appropriate referral. So I tell my patients that this is not something I cannot manage for them and often involve them in the decision to see a PSYCH. (PCP-Fader)

Focusing almost exclusively on complex and often difficult-to-treat patients, PSYCHs are employing more sophisticated pharmaceutical regimens than in the past.

PSYCHs report that the use of polypharmacy has become far more prevalent in treating depression, combining agents that address different neurotransmitters. In fact, some PSYCHs say that the majority of their patients are currently taking more than one antidepressant. The reasons behind this new approach stems, in part, from the increased appreciation of the biochemical basis of depression and the recognition that multiple neurotransmitters may play crucial roles. For instance, they may augment SSRI therapy with Wellbutrin because it has an effect on a different neurotransmitter. Polypharmacy also allows them to mitigate side effects by permitting lower doses of each agent.

For me, there is more emphasis on multi-pharmacy where it's appropriate. Mixing various classes of drugs to achieve augmentation strategies or certain goals…more experimentation when I run out of easy solutions and there don't seem to be any other immediate available ones. (PSYCH)

As a third-line option, I may combine an SSRI with Wellbutrin to achieve an enhanced antidepressant effect. (PSYCH)

I think that some patients need a noradrenergic or dopaminergic component to their treatment where the re-uptake is more available. This is when I might choose a drug like Effexor or Wellbutrin. (PSYCH)

While they do not indicate major differences in overall efficacy among SSRIs, both PSYCHs and PCPs consider Prozac to be among the most powerful.

Physicians across specialties acknowledge the fact that Prozac is the oldest SSRI; however, they consistently indicate a high comfort level with the product and a perception that Prozac is still considered to be among the quickest to show efficacy and possibly the most potent overall. In addition, these physicians recognize Prozac as having a wide range of indications. Some physicians even assert that Prozac is the gold standard against which all others are compared. However, physicians across specialties report that efficacy alone does not strongly differentiate the SSRIs. They say that side effects more clearly differentiate these products, and that side-effect profiles more often guide their choice of SSRI. For example, Prozac, with its energizing effect, is often used for patients who need a lift. In contrast, Paxil seems the more popular choice for patients who have an anxiety component to their depression.

> *It's the drug I have most experience with and I have a feeling it is perhaps the most potent, and perhaps … shows effectiveness early on. I think it (Prozac) has the indications for most of the conditions that I've mentioned. And I kind of think of it as restoring more functional patients, back to more normal function more quickly. (PCP – Enthusiast)*

> *Prozac was the first SSRI and actually is one of the best. It went into eclipse a little bit when a lot of competition came out, but it's still…when you look at all the new drugs that came out, have they eclipsed Prozac's efficacy? And the answer is by and large no. As a general picture, Prozac is still one of the most powerful, potent and efficacious SSRIs and it has a long history of being such. (PSYCH)*

> *Paxil ... I have again a perception of it perhaps being a little bit more calming, more sedating for patients with a lot of anxiety, and it has indications for panic disorder. I tend to use it for individuals with depression plus a lot of agitation and anxiety. (PCP – Enthusiast)*

Prozac is primarily prescribed to patients who will benefit from its activating properties without being bothered by untoward effects.

PSYCHs report that most patients who receive Prozac need its activating properties. They often refer to Prozac patients as those with retarded depression. However, a significant number of physicians claim to add trazodone occasionally, when their patients report what they perceive to be Prozac–induced insomnia. Physicians also choose Prozac for patients whom they consider to be non-compliant with medications, due to its long half-life.

> *It tends to energize patients a little bit more than the others do. (PCP – Fader)*

> *Patients that have problems with compliance – the long and lasting effect is good for the non-compliant ones. (PSYCH)*

> *Once-a-day dosing and a lot of experience with it. It doesn't matter much if people miss a dose here or there because of the long half-life. It has brand-name recognition and is neutral on weight. I will use it on any depressed patient, maybe one who is familiar with it, or one who has a lot of trouble taking medications, so the once-a-day dose is important to them. (PSYCH)*

Concern about side effects (especially sexual dysfunction); potential to exacerbate anxiety in more anxious-depressed patients; and drug interactions are the most commonly mentioned reasons for avoiding Prozac. In addition, some physicians claim that some patients refuse Prozac based upon negative perceptions read in the lay press. Among GPs, high cost is also occasionally mentioned as a barrier to use. As a result, a significant number of physicians claim they have been prescribing less Prozac in recent years and more of the newer atypical antidepressants.

> *I try to stay away from Prozac in my younger male patients because of sexual dysfunction. (PSYCH)*

> *I do worry about the P450 interactions in my elderly population. I have started trying some of the other agents in an attempt to avoid that. (PSYCH)*

The negative thing is that some patients are conditioned to not like to use it…they've heard bad press…And they also aren't familiar with it and they feel embarrassed if their friends and relatives were to know that they were on Prozac. They would associate it with perhaps major mental disease. I've had mothers call back and insist that I remove any record from the chart of the patient who they thought was put on Prozac. So some people are fairly emotional about the drug in a negative way. (PCP – Enthusiast)

I use Prozac but I have trouble with patients who say you know…Oh Prozac, I have heard about that. My neighbor had it and died on it. There are still those stories that float around about Prozac. I don't believe them and I take the time to tell patients that they're false. But if a patient comes into my office and says: 'I am not going to take it: that drug killed my uncle', I am just wasting my time trying to convince them. So I don't try to do that anymore. (PCP – Fader)

Most PCPs and PSYCHs are still gaining experience with Celexa, the newest SSRI.

Although Celexa is relatively new to the physicians' armamentarium, common favorable perceptions of Celexa are that it has fewer side effects than the other SSRIs (especially in terms of sexual dysfunction); is less expensive; is included on many formularies; has a favorable drug-drug interaction profile; and comes in scored tablets.

I think of it as perhaps having fewer drug interactions. The pharmaceutical representatives tend to use that sales pitch a lot…so I tend to use that with patients who have multiple medications. (PCP – Enthusiast)

It's pretty new. I'm starting to use it through one plan that has it as the only SSRI, and I've been detailed on it…it looks pretty clean. (PCP – Fader)

One, it's on everybody's formulary right now. Two, it's less expensive if they're not on formulary. Three, it seems to work quite well with fewer side effects. (PCP – Fader)

However, it appears that some physicians are still questioning whether Celexa is truly an improvement over the other SSRIs. For example, a few comment that Celexa may not provide long-term efficacy as well as the other SSRIs, while a few others say that they are witnessing sexual dysfunction with Celexa at rates higher than the company is promoting.

Celexa, I tried when it first came out. It seems to be very well tolerated. Efficacy seems to be the question mark there. I haven't seen overwhelmingly positive results from the feedback I've been getting. (PCP – Undecided)

In the Medical Letter, when they give the introductory piece on Celexa, they mention that out of five double-blind studies, in something like two of them it was no better than placebo. The fact that it has been bounced around in Europe and took so long to come over here makes me wonder why, and then I see about studies: substantial number of the studies showing no better than placebo makes me wonder about the efficacy. (PCP – Fader)

It has a lot of sexual dysfunction. This is false advertising with Celexa, in my opinion, at least false rumors about it. So I've been turned off a bit. Patients have it, and my recollection is I originally got a lot of information saying it wouldn't have any sexual dysfunction. Then I found people had it. So I distanced myself a bit. (PSYCH)

MDs most often use Paxil in depressed patients with symptoms of anxiety; however, its associated fatigue and discontinuation syndrome is sometimes cause for concern.

Because of Paxil's perceived calming side effect, physicians often use it for patients who have significant symptoms of anxiety or insomnia associated with their depression. A significant number of MDs mention the manufacturer's marketing efforts touting its efficacy in social phobia. In addition, the PSYCHs, in particular, generally perceive Paxil as having a wide range of FDA-approved indications. However, few seem to be able to list them. Commonly-perceived drawbacks of Paxil include weight gain, increased fatigue, and withdrawal symptoms upon discontinuation.

I give Paxil to depressed patients, with some mild insomnia, mild agitation. (PSYCH)

If they had insomnia, I wouldn't worry about (Paxil) creating a problem. So I would use it more comfortably in somebody who had insomnia, because I knew I wouldn't be making it any worse. The patient who had some anxiety component along with their depression, I think I'd get a little better result. (PCP – Fader)

Paxil…the positive things about this…I have again the perception of it perhaps being a little bit more calming, more sedating for patients with a lot of anxiety and it has indications for panic disorder. I tend to use it for individuals with depression plus a lot of agitation and anxiety. (PCP – Enthusiast)

PCPs and PSYCHs say they consider Zoloft to be an intermediate product well-suited for the elderly.

Physicians perceive Zoloft to have a slightly milder energizing side-effect profile than Prozac and to be less sedating than Paxil. In fact, these physicians say they often substitute Zoloft for Prozac if patients resist taking Prozac. Some physicians choose Zoloft as their first-line agent for the elderly, because it is not metabolized by the cytochrome P450 system. In addition, many physicians like Zoloft because the 100 mg scored tablet can be broken in two, saving on expense.

> *It's pretty much the same profile as Prozac. Any depressed patient…no particular reason to use it. Maybe if someone has tried Prozac and doesn't like it or they had experience with Zoloft before, doesn't want to be sedated. (PSYCH)*

> *I use that more in elderly patients. I start them out on the low dose. I'm comfortable with the side-effect profile. It seems to work for them. (PCP – Fader)*

> *I'm largely geriatric practice and the short half-life is a little attractive there because of the fact that if you get into trouble, you can get out of trouble faster. Another thing that favors the Zoloft use in our HMO, it is preferred. They tell us to put people on 100 mg and split the pills in two so they can save some money. Virtually all the HMO patients I'll put on, if I put them on an antidepressant, they'll be on Zoloft. Also, it has a little more favorable interaction profile than Prozac. (PCP – Fader)*

MDs across specialties consider Effexor to be more efficacious than the SSRIs, attributing its greater efficacy to its effect on the norepinephrine system.

Currently, Effexor is most often relied upon after one or more SSRIs fail. However, it seems that a growing number of PSYCHs are using it first-line as well. The majority of these physicians attribute Effexor's greater efficacy to its effect on the norepinephrine system. PSYCHs, in particular, report increased use of Effexor since the sustained release formulation was made available. In addition, a significant number of PSYCHs and PCPs cite Effexor's efficacy in treating depression with a prominent anxiety component. Anxiety, they say, is a main theme of the manufacturer's sales pitch. A few PSYCHs report the need to start Effexor at low doses (most often 75mg) and titrate upward to avoid causing nausea.

I use Effexor for depressed patients maybe with some anxiety, as a prominent component of their depression. I tend to think of it more likely for someone who maybe was on other antidepressants or is somewhat treatment-resistant. (PSYCH)

I do use Effexor, but usually after failure with other drugs. (PCP – Enthusiast)

Effexor is used in patients who have anxiety with depression. That seems to help there well. Especially in women, it seems to work quite well. (PCP – Fader)

Effexor makes claims of affecting norepinephrine, and we see higher response rates with that medication. (PSYCH)

PSYCHs, in particular, often use Wellbutrin as second-line to Prozac for its energizing properties and lack of sexual dysfunction and in augmentation strategies with SSRIs.

Besides its use in helping people to quit smoking, Wellbutrin is often used as an "activating" antidepressant, replacing Prozac for tired/fatigued patients who are experiencing sexual dysfunction either as a result of their depression or as a side effect from an SSRI. In addition, PSYCHs say that they are using Wellbutrin for OCD and in combination with an SSRI for patients with refractory depression.

I use Wellbutrin for a depressed patient who is sluggish and sleeping a lot. (PSYCH)

I use that for individuals that may have sexual dysfunction problems to begin with. (PSYCH)

I use Wellbutrin with people who may be smoking and who tend to have a lot of fatigue; younger patients who definitely don't want sexual dysfunction, because they have trouble with that already. (PCP – Fader)

INSIGHTS FROM THE TRANSFORMATIONS

The following section outlines what message transformations were made during the developmental process and provides the supporting rationale for making each change to the messages.

Among primary care physicians, but particularly among psychiatrists, the overwhelming majority perceive themselves as individualizing their choice of antidepressant therapy. Therefore, they rejected the early versions of the messages, which were symptom-oriented, and perceived as promoting Prozac for all depressed patients. The listing of symptoms, such as "tired all the time, unmotivated, having difficulty concentrating, vague aches and pains, overwhelmed by work and family commitments" and even the idea of "re-energizing depressed patients" contributed to this impression of generic depression. Therefore, the developed messages took on a patient-type orientation, reducing the number of symptoms mentioned.

The PCP and PSYCH messages diverged in their patient types. For PCPs the types were 1) the low-energy, 2) the female, and 3) the elderly. For psychiatrists, the low-energy patient type was replaced by the partial or non-responder requiring a more effective treatment. Psychiatrists expressed more interest in the ability of Prozac to handle these more difficult patients and in the concept of other neurotransmitters (norepinephrine) becoming affected at higher doses. In contrast, primary care physicians disliked the idea of needing to titrate an antidepressant, pointing out the cost implications of increasing the dose. Therefore, the PCP message emphasized Prozac's start-with-stay-with efficacy claims.

- In an attempt to maintain PCPs perception of Prozac's power, information was added regarding Prozac's unique dual efficacy stemming from a combination of fluoxetine and its metabolite norfluoxetine. However, PCPs found this information confusing and the team decided to drop it during the refinement phase of research.

The developed Prozac messages are significantly longer than in their initial form: the idea of addressing the needs only of patients requiring more energy or of partial/non-responders tended to confirm current use of Prozac rather than to expand usage. Therefore, both developed messages add two new patient types, the female patient and the elderly patient, in whom physicians anticipate increases in the use of Prozac. These new patient types also allowed the message to elaborate on key Prozac features and benefits as well as to provide context and credibility to the safety record of Prozac (e.g. largest antidepressant safety database in pregnancy).

To further avoid merely confirming physicians' experiences with Prozac, the team bolstered the power story with data from two new comparative trials.

- One study showed that patients on Prozac maintain complete remission for a longer period of time than those on its SSRI competitors.

- Another study showed that Prozac was effective in a majority of patients who did not respond to Zoloft. PSYCHs found the Zoloft data particularly interesting; however, this information did not move the PCPs, who see fewer treatment-resistant patients.

In order to engage primary care physicians and psychiatrists and to meet the objection that the Prozac message does not speak to them, the developed messages added set-up language. For primary care physicians, this language was "today, primary care physicians are being more aggressive in diagnosing and treating depressed patients." In contrast, for psychiatrists, the set-up idea was "your depressed patients are complex and challenging."

In order to broaden the number of depressed patients that PCPs perceive as requiring a boost of energy, the developed message inserted the idea that "fatigue and lack of motivation are two of the most common complaints of depressed patients, affecting two-thirds or more."

Because some physicians doubt that "Prozac is the best choice for re-energizing depressed patients"—in part because of the need to individualize therapy and also because there are atypical antidepressants such as Wellbutrin that are also activating—the developed messages present Prozac as a "tool that can be powerful and versatile" in the hands of the physician. This acknowledges the role of the physician at the outset of the selling story.

Reflecting the reality that many physicians present treatment options to their depressed patients, the developed message closes with a question: "Would you consider discussing Prozac as a treatment option for depressed patients?" The team dropped the sometimes controversial claim of the starting message that "92% of patients taking Prozac report being satisfied."

Reinforcing the importance of the patient who requires a boost of energy, PCPs are intrigued by a statement citing the magnitude of this group: two-thirds or more of all depressed patients. This statement works well in setting PCPs up for the efficacy information that follows.

Reminding physicians of both specialties of the full array of dosage forms for Prozac proves very valuable in conveying the notion that Prozac is versatile and can be used in a variety of situations. This also reminds a significant number of physicians of the 40 mg capsule that was made available last year. The mention of the 10 mg scored tablet enhances the previously-mentioned idea that Prozac is appropriate for use in the elderly.

FLOW OF THE DEVELOPED PCP AND PSYCH MESSAGES

The developed messages position Prozac as a powerful and versatile tool, offering clinical data to prove its superior efficacy and safety, especially in three patients types which differ somewhat between the PCP and PSYCH messages. The PCP message leads the tired and unmotivated patient, while the PSYCH message leads with the complex, partial and non-responder patients. Subsequently, both messages set out to prove Prozac's superiority in female patients with special risks, and elderly patients with co-morbidities and polypharmacy.

The basic flow of the messages is as follows:

Message Section	PCP Message	PSYCH Message
Set-Up	Acknowledgement of PCPs' growing role in the diagnosis and treatment of depression; assertion that Prozac is a powerful and versatile tool	Identifies the complex patient subgroups discussed in the message and asserts that Prozac is a powerful and versatile tool
Efficacy and Safety	Prozac is particularly effective and easy to use in patients requiring a boost of energy	Prozac is able to address the needs of non-responders
	Female patients may have special risks that Prozac can address safely and efficaciously	Same
	Prozac is safe and effective for geriatric patients and others on multiple medications	Same
Ease-of-Use		

Prozac has several dosage forms for your convenience

Same

OVERALL REACTIONS TO THE PCP MESSAGE

Overall, PCPs say that the message clearly reminds them that Prozac is a powerful antidepressant with efficacy in a variety of patient types.

Across the three market segments (Faders, Undecideds and Enthusiasts) physicians appear to read the PCP message similarly. Generally, all three market segments report that the message is valuable because it informs them of new FDA indications and it reminds them that Prozac is the gold standard for antidepressant therapy: tried and true. The message communicates that Prozac is safe in a broad spectrum of patients and that although one dose is effective in many patients, the agent does have dosing flexibility. It also informs PCPs that Prozac is more effective than other SSRIs in some patients, such as those with low energy, and that it is safe in female patients and the elderly.

> *Prozac is the only one with the indications and it is safe across a broad spectrum of patients. One dose works in a lot of people and dosing is flexible. These are all reasons to go back to using it. There are more patients I could be using it in. (PCP – Fader)*

> *It is the gold standard in treating depressed patients. Prozac is more effective in certain groups than other SSRIs. It is also safe to use in pregnant women and geriatric patients, which I had thought the opposite was true. (PCP – Undecided)*

> *This is a powerful case. It shows flexibility with doses and it's tried and true. Prozac probably has the most powerful bang for your buck. (PCP – Enthusiast)*

After reading the message, Faders and Undecideds, in particular, are inclined to use more Prozac, particularly for women and the elderly.

After reviewing the message, PCPs most frequently assert that the information regarding safety in the elderly would make them more inclined to use Prozac rather than Zoloft in this population. They explain that Prozac's energizing effect would often benefit this population; however, concerns about Prozac's safety has made them reluctant to use it in the elderly. In addition, some PCPs say that the message reminds them of Prozac's long half-life, and this information causes them to project use of Prozac over Paxil. The message causes a few PCPs to conclude that when patients fail another SSRI, they would try Prozac before trying Effexor, because Prozac is powerful and easier to use.

> *Zoloft has been my drug of choice in the elderly population. However, according to this, Prozac is just as safe. Patients can miss doses and it is also safer in pregnancy. (PCP-Fader)*

> *If I can go to the 40mg dose of Prozac for improved efficacy, as long as it is not too expensive, I would keep more patients on Prozac longer before going to Effexor. (PCP-Undecided)*

> *Prozac's long half-life is a major advantage over Paxil, and a good reason for choosing Prozac as a first-line agent before Paxil. (PCP-Fader)*

Most PCPs state that low-energy patients comprise the largest group of their depressed patients, but, since they are already using Prozac in these patients, the message does not cause them to project significant additional use for them. In addition, PCPs reject the characterization of female patients as the only ones who present with this symptomatology.

> *Yes, it is true that Prozac is the most alerting of the SSRIs, and where it is an excellent drug is in my patients who are more retarded-lethargic. (PCP-Enthusiast)*

> *Female patients have risks and comorbidities, true, but their presentation is not different from men. (PCP – Enthusiast)*

The following chart summarizes the PCP allocations and reallocations of antidepressant usage before and after reading the developed Prozac message. Reduction in use of Effexor and Paxil seems to reflect the energizing power of Prozac and Zoloft.

Therapy	**Before Prozac Message**	**After Prozac Message**	**% Change**
Prozac	21	25	+4
Celexa	14	14	0
Effexor	13	12	-1
Luvox	1	1	0
Paxil	17	16	-1
Remeron	3	3	0
Serzone	7	7	0
Tricyclics	1	1	0

Trazodone	
	3
	3
	0
Wellbutrin	
	11
	11
	0
Zoloft	
	14
	12
	-2

A few PCPs mention that some of their patients are reluctant to accept Prozac due to Prozac's perceived side effects, such as loss of libido, violent behavior, and suicidal tendencies. In addition, PCPs mention that other medications, such as Effexor and Paxil, have developed strong niches in the market, which favorably influences their use of those medications in certain populations.

> *You have made a strong case here. Prozac probably gives the biggest bang for the buck of all the SSRIs. The reason I don't write it more is that there are good niches for other drugs, for example, Effexor in GAD and Paxil in Anxiety. (PCP-Enthusiast)*

SECTION-BY-SECTION REVIEW OF THE PCP MESSAGE

The opening statement in the PCP message engages physicians because it recognizes their increasing role in the treatment of depression.

- Today, primary care physicians are being more aggressive in diagnosing and treating depressed patients.

PCP's agree with the first statement in the message and feel that it is a fact. They note that because the drugs are now easier to use, the awareness and treatment of the disease is higher. This heightened consciousness of the disease, they indicate, has resulted in more aggressive depression screening in the primary care setting. They are glad to hear that their more aggressive role is accepted.

> *I just feel that that's a statement of fact. That's true. No argument there. That's what I think I mentioned earlier myself. I think that I'm doing that, and I would expect most other doctors are, too. They're more aggressive, because they've got drugs that are relatively easy to use, so consciousness of the diagnosis and treating it is greater. (PCP – Enthusiast)*
>
> *We are looking for it now, as we should. (PCP – Enthusiast)*
>
> *I am glad to hear that our new role is accepted. (PCP – Fader)*

The core positioning idea, "power and versatility," often confirms PCPs' perceptions of Prozac, especially for tired, unmotivated patients.

- In your hands, Prozac can be a powerful and versatile tool, particularly for depressed patients who are tired and unmotivated, female patients, and the elderly.

The typical PCP reaction is to say that Prozac can be powerful for many patients, not just the elderly and women. PCPs often note that many depressed patients present with fatigue and lack of motivation. Therefore, they sometimes wonder why female or elderly patients are being singled out. They commonly mention that male patients can present with these same symptoms.

> *Prozac is powerful for all patients: males, younger ones, even. These are not the only patients that present with these symptoms. (PCP – Undecided)*

> *When I first saw that, why are they talking about female patients? I had never singled female patients out for Prozac and I didn't know what they were talking about. Many patients are tired and apathetic. (PCP – Enthusiast)*

However, the alternative positioning, "short-term power, long-term protection" causes dissonance.

v In your hands Prozac provides short term power, long term protection for three distinct depressed patient types:

PCPs claim that the meaning of the phrase, "short-term power, long-term protection" in the alternative message is confusing and leads to questions about Prozac's power. In particular, others comment that the "short-term power" portion is a "little heavy" or sounds like "sales" language.

> *When we talk about a drug, we usually say that something is more effective or efficacious. When you start talking "short-term power, long-term protection," that sounds more like a catchy sales phrase than it does a description of a medication. (PCP – Undecided)*

PCPs agree with the prevalence of fatigue and lack of motivation in depression, and feel this statement sets the stage for what is coming next.

v Fatigue and lack of motivation are two of the most common complaints of depressed patients, affecting an estimated two-thirds or more. In addition, some have vague aches and pains. These symptoms can impair functioning at work and at home.

Overall, the majority of PCPs simply say that the statement feels like a context setter for what is to come. They overwhelmingly agree that fatigue and lack of motivation are indeed the most common complaints of depressed patients. In fact, some note that it is the somatic symptoms themselves that often lead to a diagnosis of depression. A few also note that irritability and insomnia can also be a symptom of depression. A few would prefer the word apathy to the phrase "lack of motivation".

> *That's basically what happens. It didn't strike me as typically positive or negative, one way or the other. It's just a statement of fact. (PCP – Enthusiast)*

> *I agree. That's true. I think that's my experience. [And about the vague aches and pains]…That's for sure. A lot of patients come to the office not complaining of depression, of course, but complaining about a list that goes on and on of somatic complaints, and pain, discomfort, and all this sort of stuff is a large part of it. Often the diagnosis of depression is arrived at because of the list of complaints rather than the patient coming in and complaining of their mood. (PCP – Enthusiast)*

> *Irritability and insomnia are symptoms of depression as well – important symptoms. (PCP – Fader)*

> *Yes, there is general malaise, but I think apathy is better than lack of motivation. (PCP – Undecided)*

Most PCPs report seeing a clinical impact after two to four weeks of treatment and are sometimes skeptical that improvements can occur in only one week.

> At 20mg QD, Prozac is so effective that patients may start to see improved energy and concentration as early as one to two weeks, as shown in large-scale, placebo controlled studies.

The majority of PCPs agree that Prozac works quickly; however, many of them say that improvement in one week is a bit optimistic. Only a small minority are actually offended at the suggestion of efficacy in just one week.

> *I'd say that's probably true…it takes two weeks, usually, though. Two to four weeks is more realistic. (PCP – Fader)*

> *Two weeks is a bit on the short side…but it's true; I've seen patients at about two weeks…I usually give them samples for two weeks after they come back, and try to encourage them to continue on at that point in time and indeed some patients do notice a significant improvement already in two weeks. (PCP – Enthusiast)*

> *One week? That is different from what the journals say and from my own clinical experience. I disagree with this statement. (PCP-Undecided)*

The "Prozac does not require titration" statement that was in the alternative PCP message is rejected by PCPs, as it is not in concordance with clinical experience.

> Prozac does not require titration, unlike Celexa and Zoloft according to databases reflecting actual clinical practice, making it more convenient for you and your patients to get the short term results

In addition, some PCPs take exception to the claim that "Prozac does not require titration," as used in the alternative version, insisting that in their clinical experience, Prozac does require titration, although perhaps not as much as other products.

> *I don't agree with the fact that Prozac does not need to be titrated at all. I have lots of people that take all different sorts of doses after titration after a while. Maybe titration is not as big a factor as it is with some of the others. I would agree you usually don't have to go to a super-high dose. (PCP – Undecided)*

> *I disagree with that, because I do think it does require titration: many of my patients do require more. For patients that I start with 20 mg for general depression, a fair percentage of them need to go on the higher dosage. And I do see benefits at a higher dose, so I think there is some titration. (PCP – Fader)*

I usually start them on 20 mg and the majority of patients stay on 20 mg. An effective dosage so we don't have to bring patients back more frequently and try to figure out what dosage will work for the patient. (PCP – Fader)

PCPs find the dual metabolite information confusing, so the team removed it from the message during the refinement phase.

> The potency of Prozac is linked to the unique dual efficacy of fluoxetine and its equally potent metabolite, nor-fluoxetine, reducing the likelihood of upward titration.

PCPs are confused when they read the information on Prozac's dual metabolite. Although the majority of them accept the information at face value, they do not know its clinical significance. A few even wonder if the dual metabolite would worsen Prozac's side-effect profile. Therefore, removal of this information from the message has no detrimental impact on Prozac's power and versatility message.

I'll just take it for what it says. It's just a general statement on the active ingredients, and I wouldn't dispute it, but it doesn't necessarily say or mean a whole lot to me. (PCP – Undecided)

Often the breakdown product can be a double-edged sword. On one hand, the point can be made that that makes it more effective. On the other hand, a point can be made that that can potentially double the side effects. (PCP – Enthusiast)

PCPs agree that Prozac needs titrating less often than other SSRIs, so this statement differentiates the product and augments the power story for most.

> Therefore for the majority of your patients, the Prozac 20mg starting dose gets patients well and keeps them well, which is less often true for Celexa and Zoloft according to databases reflecting actual clinical practice.

Overall, PCPs agree that Celexa and Zoloft require titration more often than Prozac. This is an added advantage for a few physicians who comment that needing to titrate the patient's medication can make the patient lose confidence in the treatment and become skeptical of its ability to help.

> *I believe that. I believe that Celexa and Zoloft do need titration more often than Prozac. So I accept that. (PCP – Enthusiast)*

> *I think I mentioned that to you before…when you have to titrate doses, patients tend to lose confidence in the drug and they think it's not working, even if it does ultimately work for them…they are suspicious…the confidence of the drug is diminished. (PCP – Enthusiast)*

However, a few PCPs question how important it is that the starting dose of Prozac is the dose on which most patients stay. They feel that the starting dose is not as important as the head-to-head efficacy of the competing antidepressant therapies.

> *I question whether going head-to-head with Celexa and Zoloft about the starting dose is what we need to be looking at. The real question is whether or not they stayed on Prozac or Celexa or Zoloft for a longer period of time. Not necessarily [the efficacy of] the starting dose. (PCP – Fader)*

In addition, some note that they have not needed to titrate Celexa, either. A few physicians remark that Paxil is missing from this comparison and deduce that the reason for this is that Paxil, similarly to Prozac, does not often need to be titrated.

> *I have not had to go up with Celexa. (PCP – Enthusiast)*

> *That means Paxil probably does the same thing as Prozac or would have titrated too. (PCP – Fader)*

The "stay on Prozac longer" statement enhances PCPs' perception of the Prozac's efficacy and tolerability.

In fact, prescription claims studies have also shown that patients stay on Prozac longer than on Zoloft, Paxil, and Celexa, providing a greater chance of sustaining remission over the long run.

PCPs agree that the full length of therapy is ideal for patients, and ultimately more effective. Hence, the majority of PCPs are very interested in this statement, and many speculate about why this could possibly be so. A significant number of PCPs hypothesize that it could be due to Prozac's tolerability.

> *This is a highlight of the page. I did not know. Of course it is always better if the patients stay on for the full length of therapy. (PCP – Fader)*

> *Why do they stay on the therapy longer? I need to see this data. (PCP – Undecided)*

> *This makes me think that Prozac is a well-tolerated compound. (PCP – Fader)*

Interestingly, physicians who have seen the data before appear to be even more comfortable with this assertion, acknowledging the logic of the supporting story about lack of patient confidence.

> *My reps have shown me those data and that I can accept also. That is sales data that I've seen. They claim that. I think I mentioned that to you before....when you have to titrate doses and whatnot, patients tend to lose the confidence in the drug and they think it's not working, and that kind of destroys the....even if it does ultimately work for them.....they are suspicious.....the confidence in the drug is diminished. (PCP – Enthusiast)*

PCPs view Prozac's long half-life and lack of discontinuation syndrome as a key differentiating attribute from Paxil and Zoloft.

Prozac also protects patients from the re-emergence of depressive symptoms and discontinuation side effects due to missing doses or stopping the medication.

PCPs agree that Prozac, because of its long half-life, does not have the discontinuation effects found with other antidepressants. Some physicians specifically state that the fact that patients can miss a

dose without experiencing discontinuation side effects is a reason to write for Prozac. When reading this statement, they often mention that Paxil does have these side effects.

I know Prozac has capitalized on the long half-life to make that claim, whereas Paxil has been accused of discontinuation syndrome with its short half-life and possibly having significant symptoms if patients miss a day or two of the drug. So, this is accepted generally, too…this is not a problem. (PCP – Enthusiast)

Half-life is one of the biggest benefits. Discontinuation syndrome – missed dose is one of the biggest reasons to write for Prozac. (PCP – Enthusiast)

I think it's one of the big positives of Prozac – the side effect on missing doses, especially. It really makes a big difference. I think that I would be more upfront about the lack of withdrawal, because I think it is a big issue with Paxil, and Zoloft, to a slightly lesser degree. I think it's a big deal and I don't see it mentioned here.. (PCP – Undecided)

PCPs question the exclusivity of females presenting with fatigue and lack of motivation.

- Female depressed patients often present with fatigue and lack of motivation, and some may also have special risks and comorbidities.

PCPs feel that many patients, not just females, present with fatigue and lack of motivation. While they agree that pregnancy is a special risk, they are unsure what comorbidities are being referenced.

Well, I think they're just like everybody else. Females. Male - female, the same symptoms: lack of motivation and fatigue, that's reasonable. Special risks and comorbidities: I presume … pregnancy...that's true. (PCP – Enthusiast)

Well, everybody presents with fatigue and lack of motivation, so I didn't know that 'female' naturally meant that, but they may have some special risks, especially with pregnancy. (PCP – Fader)

The pregnancy database information enhances the perception of Prozac's overall safety.

Prozac has the largest antidepressant safety database in pregnancy, which provides reassurance for those female patients who may have unplanned pregnancies

A significant number of PCPs say that the pregnancy database information might cause them to make Prozac their first choice among women of child-bearing years. Also, some PCPs say that they will use this information to explain to Prozac-resistant patients just how safe the drug is. More than a few PCPs wonder whether or not patients can stay on Prozac throughout the pregnancy. A few question in which category the medication is placed.

I can tell my female patients about the database. I can tell them that many other women have had no problems. (PCP – Enthusiast)

Use in pregnant women is reassuring. It makes me wonder why it can't get an upgraded pregnancy rating. (PCP – Enthusiast)

The general pregnancy database stating that Prozac has the largest antidepressant safety database is more compelling to PCPs than the more clinically-focused version, which includes the size of the database. When the more complex version is used, PCPs begin to lose focus on the overall purpose, shifting their attention to specifics about outcomes.

It doesn't really say that it's safe to use in pregnancy. It just says that there is a lot of information on women using it on pregnancy. Is it safe if I become pregnant? (PCP – Fader)

It's helpful to know. People can potentially become pregnant while they're on any drug, and if they're going to be on it for a long period of time, if that should happen, you'd like to know that the chances of some kind of teratogenic effect is minimal. Of course, it doesn't say if the outcomes are good or bad, it just says it has 2,000 in the database. It could have 1,000 bad outcomes: you don't know. You assume it's good or they wouldn't mention it. (PCP – Undecided)

The weight gain/unwanted sedation statement serves as a positive reminder of Prozac's benefits for female patients.

While individual patients vary, Prozac is generally well tolerated and is usually not associated with unwanted sedation or weight gain.

PCPs state that their female patients are concerned about these side effects, particularly the weight gain, and will sometimes discontinue other medications because they cause weight gain. Overall, PCPs agree that for most patients, Prozac does not cause weight gain or sedation. However, a few note that they occasionally have patients who do suffer these side effects. For a few others, this statement brings to mind the side effects Prozac does have: particularly, overstimulation, increased anxiety and insomnia.

I agree that Prozac does not cause unwanted weight gain. Weight gain is a big deal in females and reason for discontinuation. (PCP – Enthusiast)

The fact that Prozac does not cause unwanted sedation or weight gain is reasonably true. I'd say about 65% of patients on Prozac don't get sedation or weight gain. I think this is a plus on their part. (PCP – Enthusiast)

It is true, generally, of the lack of weight gain and sedation side effects. But, I do worry about overstimulation, increased anxiety, insomnia. (PCP – Fader)

The indications for PMDD and bulimia often sparks PCPs' interest.

Prozac has been shown to treat both the mood (irritability and dysphoria) and physical symptoms (breast tenderness, bloating) of Premenstrual Dysphoric Disorder and is the only drug approved for this indication by the FDA.

Prozac has been proven to reduce both binge eating and vomiting associated with bulimia and is the only agent approved by the FDA for this indication.

PCPs find the information relating to efficacy in PMDD particularly interesting. They are especially curious about how it helps the physical symptoms and how the medication is dosed.

> *I would like to know if they have to stay on a whole month or not. I would assume that they didn't, since it has such a long half-life. Do they have to take it chronically or just 2 weeks out of the month? (PCP – Fader)*

> *The physical symptoms are new to me. Is it a direct effect on physical symptoms or lowering the threshold? (PCP – Fader)*

While PCPs claim to see few bulimic patients, they say that the FDA approval would cause them to make Prozac their drug of choice for this patient population.

> *I am not aware of a specific FDA indication if someone has a solid eating disorder. I do tend to prescribe Prozac. (PCP – Fader)*

> *I can accept that, although I don't see much eating disorders in my practice, and I don't have any personal experience with the drug for that indication…but I believe that's true; it has an indication for that, but it is not an area of great interest for me, because I don't see it too much. (PCP – Enthusiast)*

PCPs report that approval for Prozac in these indications makes it easier for them to justify usage to patients and affords additional medical/legal support for their decision to prescribe it.

> *See, the FDA indications may not change my practice but it is something I can tell my patients that may make Prozac more acceptable. (PCP – Fader)*

> *We've used it, but I did not know it had an official FDA approval. To me it means a lot: you are always nervous if someone has an unfounded effect, and you are giving them an unapproved drug for an indication, then you are pretty much liable for everything that happens. You can still be liable, but if at least it is an approved indication, I think you have a better foot to stand on. (PCP – Undecided)*

The safety-in-the-elderly section generates new interest in Prozac among many PCPs.

Prozac is proven safe and effective in geriatric depression, the only antidepressant with formal FDA approval for these patients

As all patients get older, their renal function declines. Unlike other antidepressants, Prozac does not accumulate and lead to increased side effects in the elderly.

The section on safety in the elderly results in the anticipation of the greatest numbers of prescriptions for Prozac. In general, PCPs seem more willing to accept the safety-in-renally-insufficient information. However, a few PCPs do question how a drug can have a long half-life and not accumulate.

The information about accumulation means it is safe and this makes me think it may work a little bit better in the elderly than the Zoloft I was using. (PCP – Fader)

I knew a patient's renal function declines…I did not realize that Prozac did not accumulate in those patients. Then that may be one reason to use it more in the elderly. (PCP – Fader)

I don't know how that works. I read that – because the page before, you told me it had an active metabolite, you have a steady state. And it would appear to me, if that were the case, then how does it not accumulate in renal failure? …then I figured it had to be cleared by the liver. That's the only way that their statement can be true. So, other antidepressants must be cleared by the kidneys for them to accumulate. So that's what my mind thought as I read that. Gotta be hepatic clearance on that. You don't say that, but that would be the only way that that could be true. (PCP – Fader)

Well, that is also a little bit of a concern since Prozac has such a long half-life. You would think that the drugs with a shorter half-life would be less likely to have the problem than Prozac…so again, that means a little more explanation for me. (PCP – Enthusiast)

PCPs do not question Prozac's safety for elderly patients taking multiple medications or being treated for other concomitant conditions. In fact, most PCPs expect Prozac to be safe and effective in these patients. The fact that Prozac is the most studied is linked back to the fact that Prozac has been on the market the longest.

All I see is diabetes, post-MI and cancer, so that's important for me to know. (PCP – Fader)

I can accept that …it's been around the longest…I would expect it is. Those are a lot of the patients I'm treating. (PCP – Enthusiast)

I like the multiple medication point – that was the one that caught my eye more than the other, because I'm using it for depression, and obviously I expect it to work for depression…but the fact that it's shown to be safe with multiple medications – that was one of the points I brought to you on why I like to use lower doses of the Paxil…because lower dose is less likely to be in medication problems…and you're telling me that you've already done studies which show it is safe on multiple medications. So that's important for me to know. Because that was one of the reasons I was using a competitor. (PCP – Fader)

PCPs acknowledge the difficulty of treating severely ill patients; however, it comes as no surprise that Prozac is effective in these patients.

Prozac is the most studied antidepressant in depressed patients with concurrent medical conditions such as diabetes, post-MI, cancer, and HIV.

- Prozac was effective at relieving depression in these patients
- Prozac was shown to be safe and well tolerated in these often debilitated patients on multiple medications.

PCPs acknowledge that because these patients are suffering from concomitant conditions and on concomitant medications, they are often more difficult to treat. The majority of PCPs expect Prozac to be safe and effective in such patients, mainly because it has been on the market the longest. Therefore, it has had the greatest opportunity to be studied with this population.

Prozac's been around the longest; it has had the greatest chance to be studied. (PCP- Enthusiast)
This seems logical, given how long it's been around. (PCP - Undecided)

I can accept that. It's been around the longest. I would expect it is. (PCP – Enthusiast)

However, a few physicians express some surprise that Prozac is safe in these patients, thinking that other SSRIs would be safer than Prozac for patients on concomitant medications. A few others claim that all of the SSRIs are equally as safe in this group.

The fact that it's shown to be safe with multiple medications – that was one of the points I brought up to you on why I like to use lower doses of Paxil...because lower dose is less likely to be a medication problem. You're telling me that you've already done studies which show it is safe on multiple medications. So that's important for me to know. (PCP -- Fader)

Folks like me tend to avoid Prozac in these patients. (PCP – Fader)

I thought Zoloft would be safer. (PCP -- Enthusiast)

Almost any of the SSRIs are safe. I don't worry about drug interactions. (PCP – Fader)

The multiple dosage form information adds to PCPs' perception that Prozac is easy to use.

Prozac has the flexibility to start at 10 mg in the elderly Prozac is available in several dosage forms, including 10 mg scored tablets, 20mg and 40 mg capsules, and even a liquid formulation

PCPs state that the flexible dosing of Prozac may reduce their likelihood of switching patients to another antidepressant. The ability to start as low as 10 mg makes Prozac an attractive choice for the elderly. A few PCPs say that knowing that a 40 mg dose of Prozac is available may cause them to increase the dose of the drug before switching inadequately-responding patients to Effexor. Some PCPs say that they find the liquid formulation to be especially useful in nursing-home patients.

This is reminding me and making me more willing to try it in the elderly. Prozac gives more dosages, too; I did not know about the 40 mg. (PCP – Fader)

I've got a fairly big nursing-home practice, and that would be a useful thing. Some people that have had bad strokes and they can't speak, and they're on tube-feeding, they still can be depressed, and that can be a useful thing, to be able to give it in liquid form. (PCP – Undecided)

PCPs indicate that the message provides them with some new and valuable information about Prozac.

v Given Prozac's power and versatility, would you consider discussing Prozac as a treatment option for depressed patients who are tired and unmotivated, or female, or the elderly?

The majority of PCPs respond affirmatively to this question. PCPs most often cite the information about Prozac's use in elderly patients as new information. Particularly for some Prozac Faders this information has the potential to motivate them to consider Prozac more often for their elderly patients. For the majority of Prozac Undecideds and Enthusiasts, this message reinforces their current use of Prozac.

> *It has not been my practice to prescribe this for the elderly, but the statement about renal function, I'd think about it. (PCP – Fader)*

OVERALL REACTIONS TO THE PSYCHIATRIST MESSAGE

The majority of PSYCHs say that the message reminds them of why they consider Prozac to be an excellent SSRI, and many are intrigued with new information presented.

After reading the message, most PSYCHs agree that the adjectives "powerful and versatile" are truly characteristic of Prozac. The majority of PSYCHs already consider Prozac to be a "powerful" antidepressant, more powerful than Zoloft and Celexa in particular. They feel that the agent is the

gold standard in antidepressant therapy and this information supports that impression. In addition, PSYCHs say that the word "versatile" refers to the broad range of patients for whom Prozac is appropriate, as well as the range of dosage forms in which Prozac is available. Specifically, they agree that Prozac is a good agent for use in women, elderly with comorbidities, and in some non-responders.

> *Sometimes I forget that it works well. It has been around and it works – especially in certain types of patients like bulimics. Prozac is the gold standard. There is nothing I can argue with here. (PSYCH)*

> *It is effective across a broad spectrum of patients in clinical situations, and it has the significant data to support that. And by situations, I'm including both patient population and diagnosis. (PSYCH)*

> *This reminds me that Prozac is good in a wider range of geriatric and more complicated patients. (PSYCH)*

> *The flexibility of dosing is very, very important, because it allows you to mess around with the dosing. A lot of times it gives the patients a feeling that they have some control over it. I can go down 5 mg or up 5mg or something like that, and the patient feels they have some control over it. And that is good for helping them stay on the medication. (PSYCH)*

The message consistently succeeds in compelling PSYCHs who are low-Prozac prescribers to increase their usage in female and elderly patients, especially at the expense of Zoloft.

Those PSYCHs who project an increase (typically high-users of Zoloft) explain that their usage in elderly patients and women will grow, primarily at the expense of Zoloft and Celexa. In addition, a few say they would substitute Prozac for Effexor in some instances, because of Prozac's high success rate, its possible effect on norepinephrine, its 40-mg dosage strength, and better tolerability profile. A few PSYCHs say their use of Wellbutrin may be slightly reduced, as inclination to utilize expensive combination therapy may diminish based on the power story contained in the message.

Interesting, I always thought of Prozac as an SSRI. I didn't know it could challenge Effexor. (PSYCH)

I was not aware that Prozac had an effect on norepinephrine. It would be interesting if it follows the same response patterns that we get with Effexor. (PSYCH)

This would make me think of Prozac more in my geriatric population. I have been using Zoloft almost exclusively in these patients because it circumvents the CP 450 system. (PSYCH)

I would reduce my Zoloft prescribing because it is closest to Prozac in my mind. The information on side effects in the elderly and the specific indication for this group would give me more confidence. (PSYCH)

The following chart summarizes the mean estimates of the percentages of depressed patients on different types of therapies before exposure to the developed Prozac positioning story and then the changed estimates after exposure to the Prozac information. Physicians assume the Prozac information is accurate and supportable by clinical research and publications. The pre-Prozac PSYCH columns add to more than 100% because some PSYCHs have patients on combination therapies. The after-Prozac columns reflect only the change from the current therapy, and, due to rounding, do not total to 0.[2]

Therapy	**Before Prozac Message**	**After Prozac Message**	**% Change**
Prozac			
	20		
	24		
			+4
Celexa			
	16		
	15		

[2] These mean percentages are merely directional information for qualitative insights and are not projections of the market share.

	-1
Effexor	
	9
	8
	-1
Luvox	
	3
	3
	0
Paxil	
	12
	12
	0
Remeron	
	4
	4
	0
Serzone	
	7
	7
	0
Tricyclics	
	2
	2
	0
trazodone	
	12
	12
	0
Wellbutrin	
	17
	16
	-1
Zoloft	
	15
	13
	-2

However, most of those who do not anticipate a change consider themselves to be high users of Prozac and comment that the message offers little information to expand their usage into new areas. PSYCHs explain that Prozac would be inappropriate for patients who are anxious-depressed or who require sedation. In addition, some PSYCHs say that increasing the dose of Prozac would be prohibitive for some of their patients, due to increased cost. A few PSYCHs mention the presence

of comorbidities such as smoking or ADHD, which may lead them to favor the use of other antidepressants.

SECTION-BY-SECTION REVIEW OF THE PSYCH MESSAGE

The PSYCH message introduction does not effectively engender interest to read on.

- Your depressed patients are often complex and challenging
  - Partial and non-responders
  - Female patients with special risks
  - Elderly with medical comorbidities and polypharmacy

Psychiatrists acknowledge that their partially- and non-responding patients; female patients with special risks; and elderly with medical co-morbidities and polypharmacy are complex and challenging. However, many simply ignore this information, regarding it as an obvious attempt by Lilly to understand and connect them. In addition, they are not sure what "special risks" women may have at this point in the message.

It's true; these are challenging patients, but it seems just a way to try to connect with me. (PSYCH)

What special risks are they talking about? (PSYCH)

This feels like a slippery attempt to show they understand me. (PSYCH)

Psychiatrists agree that Prozac is powerful and versatile but when they read the statement, tend to say that it is just marketing language.

- In your hands, Prozac can be a powerful and versatile tool for such patients.

Psychiatrists appear to agree that this statement is true *prima facie*; however, they resist the point because they often perceive it to be "marketing". To them, versatility refers to the variety of doses and the ease of combining Prozac with other therapies, but this is not new information. They do agree that Prozac is powerful, often referring to it as the gold standard in depression; however, in this context, the assertion of power has not yet been established, and is not distinguishing.

Okay, but what are they getting at? This is marketing. (PSYCH)

Prozac comes in a wide range of doses, can be combined with other medications: this is sort-of true, but so what? That's nothing new. (PSYCH)

Well, that is true. Prozac and other antidepressants on the market are powerful. (PSYCH)

Prozac is the gold standard. (PSYCH)

New information about Prozac's effect on norepinephrine/dopamine is of major interest to PSYCHs and leads them to seek more information about the clinical impact and dosages.

- Patients who are partial or non-responders are particularly challenging to treat
  New scientific data prove that Prozac has added activity on the norepinephrine and dopamine systems at higher doses

The majority of PSYCHs feel that the activity on additional receptors could make Prozac appropriate for more patients and thus allow it to challenge the market share of Effexor, which is viewed by physicians as being more efficacious than the SSRIs. Many indicate that this is new information to them and that they would like to see details about dosing as well as data regarding the clinical impact. When the message was tested without this information, it seemed to lead to more skepticism toward Prozac's power, on the part of PSYCHs.

I think some people need a noradrenergic or dopaminergic component where the reuptake is more available. So it might be good if Prozac had that intrinsic characteristic. (PSYCH)

I did not know this [norepinephrine and dopamine effect]. It means Prozac can challenge Effexor. It is not just an SSRI – you get three bangs for your buck, so to speak. (PSYCH)

I want more information: what are the doses? It would be interesting to see if we see the same response as with Effexor. (PSYCH)

Many PSYCHs believe the statement regarding the increased likelihood of remission with 40 mgs; many also explain that inadequate dosing accounts for many treatment failures.

> Prozac, in recently completed clinical research, significantly increased the likelihood of complete remission (57%, $p<.05$) and also sustained remission over the long term (for at least the 6 month duration of the study) in struggling patients whose dose went from 20mg to 40mg QD

PSYCHs note that increasing the dose of Prozac will generally bring about a greater response. They complain that clinicians should know that some of the patients need more medication than others do. A few note that other antidepressants make similar claims regarding response at higher doses.

I thought that the problem with this is that the clinicians doing this didn't realize the patient needed more medicine. It doesn't surprise me that the patients needed 40, 60, 80 mg of Prozac to achieve remission. (PSYCH)

Sometimes going from 20 to 40 mg of Prozac really makes a difference. (PSYCH)

Paxil and Effexor make the same claims: that you get more response at higher doses. (PSYCH)

Psychiatrists find the lack of discontinuation side effects to be an advantage specific to Prozac.

> Prozac also protects patients from the re-emergence of depressive symptoms and discontinuation side effects due to missing doses or stopping the medication.

The most attractive information in this statement concerns Prozac's lack of discontinuation side effects, which psychiatrists generally find to be an advantage in comparison to agents such as Paxil and Effexor, and perhaps Celexa. For patients who are non-compliant, Prozac's long half-life is a benefit. However, a few indicate that they do not see a problem with discontinuation-side-effects in competing agents.

Yes, that is one of the advantages that Prozac has. (PSYCH)

This is true in the short term, especially versus Paxil and Effexor. (PSYCH)

The long half-life is a major advantage in patients who are non-compliant or who've had withdrawal effects before. (PSYCH)

If they miss a dose or two, it's not a real problem if the patient is generally reliable. If they take a couple of doses here and there, they run into the problems of efficacy, not necessarily discontinuation side effects. It's true of Paxil and Effexor in my experience too. (PSYCH)

Many PSYCHs attribute the "stay on Prozac longer" information to its long half-life.

> In fact, prescription claims studies have also shown that patients stay on Prozac longer than on Zoloft, Paxil, and Celexa, providing a greater chance of sustaining remission over the long run.

The "longer duration" information intrigues physicians and generally generates some positive responses. Some physicians even conclude that Prozac's long half-life will permit patients to miss doses without compromising efficacy or causing withdrawal syndrome. For a few PSYCHs, this information implies that patients stay on Prozac longer, in spite of the side effects, because it is effective in relieving their depression. Only the fact that this information was garnered from a prescription claims study arouses questions.

I think the long half-life really is an advantage. A lot of people get withdrawal if they are on high doses of Zoloft and then stop it suddenly, and they have more side effects from it. Celexa is fairly new; I don't know about that. But I know its half-life is more like Zoloft's: it's shorter. (PSYCH)

I'm fascinated with this idea that patients stay on Prozac longer than those other ones. I can't account for why that is. For example, I think a higher percentage of patients complain of sexual dysfunction with Prozac than any of the others. Yet, even then they tell me "Doc, I feel so much better with this stuff." I don't have that as much with the competition. There really is a certain degree of loyalty. The patients just don't want to go back there. That Prozac may be doing more than treating depression. It may actually be doing more than other SSRIs as far as affecting some underlying alpha male or alpha female sort of issues. (PSYCH)

I think I need more data about what that means. I'm suspect of prescription claim studies. I would just like to see how they did that study. I'm not saying it's not true. It would be interesting if they showed the actual data. But it is a study, which is subject to interpretation: how the study was done, the total number of prescriptions that the pharmacy shows for months and months (PSYCH)

While the Zoloft non-responder information is intriguing, PSYCHs express a high degree of skepticism.

> Prozac, in another recent clinical trial, was effective in reducing the total HAM-D score by at least 50% in a majority (63%) of 106 Zoloft non-responders.

For the majority of PSYCHIs, this statement inspires skepticism. PSYCHIs wonder what doses were used in the comparison and what happens when Prozac non-responders are placed on Zoloft. However, many PSYCHs admit that Zoloft non-responder information could potentially have some of the most powerful impact in the message, and some react as being impressed.

What if it were the other way around? My experience is that sometimes Prozac works, and when it does and it's the right drug, that's great. But sometimes Zoloft works, and in one person Zoloft works and Prozac doesn't. This tries to lead you to think to always use Prozac because it works much better with non-responders, and it's not an accurate representation. (PSYCH)

I'm highly suspicious of that being an objective study. Are they giving comparable doses? This almost reduces the believability about the whole thing, unless they want to give me some specifics about what the doses were in the study. (PSYCH)

Information about Prozac's tolerability and safety in overdose and in combination with other therapies is considered true, although not entirely unique.

Prozac is generally well tolerated at all indicated doses Prozac has been proven safe in overdose Clinical experience has shown that Prozac can be safely augmented

Psychiatrists generally feel that Prozac is well tolerated at the indicated doses for most patients, although some cannot tolerate high doses. PSYCHs agree that Prozac is safe in overdose, but indicate that this is also true of other SSRIs. Similarly, most psychiatrists are aware that Prozac can be safely augmented and that this is true of other SSRIs as well.

Higher doses can cause more side effects. It is not well tolerated in people who can't tolerate a higher dose and get side effects from higher doses. (PSYCH)

It is true that Prozac is safe in overdose; it's true of the others as well. (PSYCH)

I have augmented Prozac with other agents, so this fits with my clinical experience. I am not sure this makes it unique, though. (PSYCH)

Some PSYCHs object to perceived niching of Prozac for women.

v Female depressed patients often present with fatigue and lack of motivation, and some may also have special risks and comorbidities.

Many PSYCHs indicate that they are uncomfortable singling women out as the patients who most often present with fatigue and lack of motivation. They assert that their male patients can also present with these symptoms. However, when this phrase is removed from the message, PSYCHs seem less inclined to question the introduction to the female-patient portion of the message. Most PSYCHs think of pregnancy when they read the line regarding special risks and comorbidities.

I don't know if it's the 'often' part, any more often than men are. Both present…men can present that way, too. Maybe a few more women do, if I think about it, but I don't know about the 'often' part. (PSYCH)

I don't know about that statement. I think male patients also often present fatigue and lack of motivation. I'm not sure that female depressed patients have to show fatigue and lack of motivation more often. (PSYCH)

PSYCHs view the pregnancy database as additional support of Prozac's safety.

Prozac has the largest antidepressant safety database in pregnancy, which provides reassurance for those female patients who may have unplanned pregnancies

PSYCHs find the pregnancy database information to be believable, given its size of more than 2000. However, the majority interpret it more as additional evidence of Prozac's overall safety rather than a reason to prescribe it specifically for pregnant women.

One thing I think that has some validity is its use in pregnancy. It does have an extensive database for pregnant patients, in terms of information regarding the number of women who have taken Prozac during pregnancy. If I need to have a woman on antidepressants, I will, if possible, use Prozac for that reason. It's likely that the other drugs will turn out to be just as safe, but we just don't have the numbers. Yet it's also true that each of the SSRIs are different, so you can't just make an extrapolation that they are the same. By sheer numbers, that's one of the advantages of Prozac, this amount of study and data – it's all clinically relevant. (PSYCH)

It's helpful in reassuring patients, more than anything females that want to get pregnant at some point and worry what will happen if they get pregnant while on Prozac. (PSYCH)

Similarly to PCPs, PSYCHs find the PMDD information compelling; they are less impressed with the bulimia indication.

> Prozac has been shown to treat both the mood (irritability and dysphoria) and physical symptoms (breast tenderness, bloating) of Premenstrual Dysphoric Disorder and is the only drug approved for this indication by the FDA
> Prozac has been proven to reduce both binge eating and vomiting associated with bulimia and is the only agent approved by the FDA for this indication
> Prozac is also indicated for OCD

The information regarding the physical symptoms of PMDD is new to most PSYCHIs and attracts their attention, some even claiming that this would convince them to increase their usage of Prozac in women. However, the point raises questions about dosing and which specific mechanism of action alleviates the physical symptoms.

> *I did not know this. Does this mean women have to take it all the time to see this benefit or can they take it intermittently? (PSYCH)*

> *I don't think I was aware of the fact that it improves the physical symptoms. That's what stands out to me. It's interesting. I'm wondering what the mechanism is for that. Curious as to how it works, why it does that. (PSYCH)*

Most PSYCHs say that they are already using Prozac in bulimia and OCD, so any mention of these conditions as FDA-approved merely supports their own impressions. However, FDA approval does not seem to influence PSYCHs' prescribing behavior, since so much of their prescribing is off-label.

> *An FDA approval alone does not make it the only option for me. (PSYCH)*

> *I know that what drugs get approved by the FDA has a lot to do with the fact that the company decides it wants to put its money into researching. So it may well be true, but other SSRIs could probably get these indications, too, if they wanted to pursue that. (PSYCH)*

The elderly information about formal FDA approval and lack of renal accumulation leads many PSYCHs to consider making Prozac the drug of choice for this population.

- Prozac is proven safe and effective in geriatric depression, the only antidepressant with formal FDA approval for these patients
  - As all patients get older, their renal function declines. Unlike other antidepressants, Prozac does not accumulate and does not lead to increased side effects in the elderly.
  - Prozac improves the quality of life including emotional and physical well being in elderly depressed patients.

Most PSYCHs are surprised that Prozac is formally indicated for geriatric depression. This new information, coupled with the lack of renal accumulation, motivates them to consider using the agent in elderly patients with renal impairment, although they indicate that they would first like to see the data.

> *I didn't realize it's the only antidepressant with formal FDA approval for geriatric depression. (PSYCH)*

> *Geriatric depression is new information to me. That would make me think strongly about using Prozac, if that were true, in patients who had significant renal impairment. I'd like to see that study in more detail. But that might be a benefit that Prozac legitimately has that the others don't have that would influence me to consider using in the elderly. (PSYCH)*

For the majority of physicians, the non-accumulation data enhances the overall perception of Prozac's safety; however, this information is counter-intuitive to many.

Some of their enthusiasm toward the geriatric indication is tempered by concern about Prozac's long half-life and potential interaction with other medications. Therefore, many would like to see information about interactions and the P450 pathway, as well as data about which other drugs the studied patients were taking.

While I'm sure it's true that Prozac was safe and well tolerated, my clinical experience says that would be with careful monitoring. It will take some time before the effects of it are seen, compared to some of the antidepressants with a short half-life; you have to keep an eye out for that over a longer period of time is a little more cautious. (PSYCH)

It's a problem if patients are taking other medications, and that's not included here and that is a big problem. You can get into big trouble if the other medication has P450 enzyme conflicts. (PSYCH)

It's the old problem with multiple medications. I'd like to see the P450 enzyme problem with patients. Which drugs are you talking about and what drugs are interacting? Prozac interacts with several drugs that are problematic: it increases or decreases the efficacy of those other drugs. So it's a more complicated drug to use in elderly patients. (PSYCH)

PSYCHs readily accept the co-morbid condition safety data; however, this information does not directly motivate them to project new prescriptions.

Prozac is the most studied antidepressant in depressed patients with concurrent medical conditions such as diabetes, post-MI, cancer, and HIV.

- Prozac was effective at relieving depression in these patients
- Prozac was shown to be safe and well tolerated in these often-debilitated patients on multiple medications.

PSYCHs also agree that Prozac is the most studied antidepressant because it has been around for the longest time. Therefore, they are generally willing to accept the claim that it can be used safely in patients with diabetes, post-MI, cancer and HIV.

Use in concurrent medical conditions is probably true, probably a function of how long it's been on the market. It's old news. I believe it is effective; it's nothing new. (PSYCH)

I accept that it can be used in concurrent medical conditions. The others could be effective in relieving depression, too. (PSYCH)

PSYCHs appreciate Prozac's multiple dosage strengths and formulations.

> Prozac has the flexibility to start at 10 mg in the elderly
>
> Prozac is available in several dosage forms, including 10 mg scored tablets, 20mg and 40 mg capsules, and even a liquid formulation

PSYCHs appear to appreciate the 10 mg scored tablets, spontaneously mentioning that they have some patients cut the tablet in half. They typically use this low dose in people who may be sensitive to medications or in anyone for whom a lower dose is optimal, such as children or the elderly. It appears that the availability of a 40 mg tablet is not widely known or remembered, but they admit that diversity of dosage-strengths/formulations increases flexibility. The liquid formulation is praised as ideal for the elderly and for people with swallowing difficulties.

I start with the 10 mg in anybody who I think might be sensitive to medications: likely to have side effects or anything. I forgot about the 40 mg capsules. (PSYCH)

I did not know about the 40 mg dose. The tens are scored so they are good for children and adolescents as well as the elderly. (PSYCH)

Many psychiatrists already do discuss Prozac as a treatment option with their patients because it is an efficacious anti-depressant.

> Given Prozac's power and versatility, would you consider discussing Prozac as a treatment option for your complex depressed patients who are partial and non-responders, female with special risks, or elderly?

Psychiatrists report that they have always considered Prozac in the patients discussed and that they find Prozac to be a good antidepressant.

I always consider Prozac in this particular subgroup. And I like Prozac. I like it. It's a great drug. (PSYCH)