# ****Astellas policy AND Application criteriA****

## Application request will only be considered if it meets the following criteria:

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| 1. Potential to increase HCP’s medical/clinical knowledge, and to have a positive impact on the quality of care for patients. 2. Provides an opportunity for medical education that might not otherwise be available to the HCP due to cost, travel, or other financial constraints. |
| 1. The reputation and standing of the HCP in his/her scientific or medical community are reasonably related to the level of meeting for which support is sought. |
| 1. The HCP’s specialty, expertise, knowledge, experience, and areas of scientific or medical interest are directly related to the purpose, topics and agenda of the meeting. |
| 1. The travel distance for an HCP to the geographical location of the specific meeting for which provision of costs to support individual HCPs is sought is reasonable in light of the topic and agenda of the meeting and other available meeting locations given the HCP’s qualifications, training, and interests. 2. HCP must be able to understand the language used etc. (e.g., English or local language) 3. The HCP has not received frequent and/or repeated support from the local Astellas affiliate, in accordance with the local process. *This is a maximum of three unique events per year, of which a maximum of two may be inter-continental.* 4. Any support must not be used as an incentive or reward for prescribing, administering, recommending, purchasing, paying for, reimbursing, authorising, approving or supplying any product or service sold or provided by Astellas, or to obtain any other improper advantage for Astellas. |

**PRIOR TO SUBMITTING AN APPLICATION PLEASE NOTE THE FOLLOWING:**

**If the request does not meet all of the above criteria it will not be considered and will be immediately declined. Please do not submit any requests that do not meet the above criteria.**

# out of scope

Requests relating to:

* Corporate Sponsorship of a meeting/event/congress, and not an individual HCP.
* Medical/Educational Grants or Donations.
* Charitable Donations to bona fide and not for profit charitable organisations that are not either a Healthcare Organisation or Patient Organisation.

# Application process

Once you have read the above, if you wish to submit an application please do the following steps:

1. Complete Section IV and V below.
2. Send to Astellas, to the following email address: [gr.hcp@astellas.com](mailto:gr.hcp@astellas.com).

**PRIOR TO SUBMITTING AN APPLICATION PLEASE NOTE THE FOLLOWING:**

* Any provision of support will be subject to follow-up communications where evidence of support utilisation according to the applicable signed agreement/contract will be requested by Astellas. Any support not utilised according to the signed agreement will be immediately withdrawn by Astellas.
* Any approved support will be publically disclosed according to local and international transfer of value disclosure requirements.
* <<Insert Astellas Entity Name & Address>> (hereinafter “the Company”) shall comply with all data protection and privacy laws and regulations, including without limitation, all applicable legislation, regulations and guidance implemented pursuant to EC Directives 95/46/EC and 2002/58/EC, as amended. In the course of this support application, you may provide the Company with your personal data (as requested below) and such personal data relating to this activity may be shared with and processed by: (i) the Company and its affiliated companies; (ii) third parties the Company engages as service providers who may be located outside of the European Union/European Economic Area; and (iii) any relevant regulatory authority and/or enforcement body.
* Once a request has been declined by Astellas, the decision is final, and the request will not be reconsidered under any circumstances.

# contact details

|  |  |  |
| --- | --- | --- |
| Requestor details | | |
| Title: | Forename: | Surname: |
| Medical/Scientific Professional Qualification(s): | | |
| Area(s) of Specialty: | | |
| Current Employer: | | |
| Job title: | | |
| Professional address: | | |
| Professional email address: | | |

# Details of request

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Funding amount requested (if applicable): | | Date of educational meeting/congress: | | |
| Title and description of educational meeting/ congress: |  | | | |
| Objective of educational meeting/congress: |  | | | |
| Draft agenda of educational meeting/congress: |  | | | |
| Support requested & Estimated cost: (If known, please tick/enter, as applicable) | Registration Fee:  Est. cost: 0.00 | | Travel:  Est. cost: 0.00 | Accommodation:  Est. cost: 0.00 |
| If any additional support is being requested please provide details, and a cost breakdown here: |  | | | |
| Any additional information relating to the request including details of potential to increase HCP’s medical/ clinical knowledge and potential positive impact on the quality of care for patients: |  | | | |
| Please provide details of any other confirmed or potential partners / supporters in relation to this request: |  | | | |

# review and approval (to be completed by Astellas INTERACTION OWNER)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Request number:** | | | **Does the request meet criteria 1-6 in section 1 above?** | | | |
| Yes: | | No : | |
| **Date reviewed:** | **Outcome of review:** | | | | | |
| **Approved:** | **Approved subject to amends (specify below):** | | **Further Info required (specify below):** | | **Declined (specify below):** |
| **Comments:** | | | | | | |