

Lipid Management Service Request & Booking Form

Guidance: All fields require complete population in order for any application to be valid. For queries regarding data processing and storage, please visit the Daiichi Sankyo UK Ltd website. For any difficulties in populating this document, please email grantsanddonations@daiichi-sankyo.co.uk

Please ensure you also submit a fully completed anti-bribery questionnaire (see appendix) with your application, as all donations' applications must be accompanied by this questionnaire.

The objective of the lipid management services is to enhance patient outcomes in areas of highest clinical need. These initiatives aim to assist primary care practices in identifying patients whose lipid management could be optimised.

Only GP practices who meet the eligibility criteria will be approved for the service. The criteria ensures the service is delivered for GP practices with the highest levels of disease burden and therefore the highest need. Eligibility criteria as follows:

- GP practice has a cardiovascular disease prevalence of ≥6.83% based on 2022-23
 Quality and Outcomes Framework (QOF) data and a practice population of over 10,000 patients.
- Only GP practices who can confirm they have the capacity to support the delivery of the service will be considered.

Upon submission of an application, DSUK undertake an assessment of your request and respond to you in a timely manner. If your application is successful, we aim to have these services commenced **within 6 weeks** from submission of application.

During this period DSUK and providers will engage to ensure timely completion of:

- Confirming approval for a lipid management service donation for eligible practices & assigning a provider
- Communication of the service offer & sharing practice level contact details with the provider
- > Supporting practice level data processing assurances and access to onboard the service

If your organisation would like to request a donation from DSUK, please complete the form below.

| Lipid Management Service Request: | | | | |
|-----------------------------------------------|----------|--------------------|---------|--|
| • | ase tick | Pleas | se tick | |
| Lipid Optimisation Programme (Therapy review) | | Lipid QI Dashboard | | |



Section 2: Application details

| Name of Orgaddress | ganisation & | | |
|-----------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|
| Name of leg different fro | | | |
| Name of Pra Lead/Manag | | | |
| Email addre | | | |
| Direct line n | 10. | | |
| PCN Name | | | |
| Practice po | oulation size | | |
| GP IT Syste SystemOne | | | |
| the ICB and h provider: Please tick thi in more detail Practice auth signature rec As authorised communicatin activities will a | ave the authorics sox if you wo corised signatory for any the activities of the acti | cant for this lipid management service has notified ty to subcontract this activity to a third-party service uld like to be contacted to discuss the above services ory for and on behalf of the Primary Care Organisation and on behalf of the practice, I accept full responsibility for contained herein to all members within practice whom to be signatory for and on behalf of the practice I consent to the purpose of research into cardiovascular disease. | or hese |
| | | Practice Authorised Signatory | |
| Name | | | |
| Date | | | |
| Signature | | | |

Lipid Management request form Job Code: UK/DON/06/24/0003



Please return this form to:

For service requests for the Therapy Optimisation Programme (Therapy Review) or the Lipid QI Dashboard, please send this form to Grantsanddonations@daiichi-sankyo.co.uk

Please note: This form is for donation requests only.

For Daiichi Sankyo use only

Service eligibility criteria – Cardiovascular prevalence quartile ranking 1 2 3 4 (circle as appropriate)



Appendix: Anti-bribery questionnaire

'Bribery' is defined as:

'Giving someone a financial or another advantage to encourage that person to perform their functions or activities improperly or to reward that person for having already done so. This could cover seeking to influence a decision-maker by giving some kind of extra benefit to that decision maker rather than by what can legitimately be offered as part of a tender process.'

In order to prevent any unwitting engagement in behaviour which might raise the suspicion of bribery each application for a Grant or Donation must be accompanied by a completed ant-bribery assessment form.

Please read and act in accordance with the Anti-bribery Act.

Please complete the following questions. Dailchi Sankyo will not be able to review your application for a Grant unless these are completed.

| l. | Are you aware of | the Bribery A | Act of 2010? (*Required field) | |
|------|---------------------------------|---------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|--------|
| | ☐ Yes | | No | |
| II. | | en was it red | n previously received a grant or donation from Daiic eceived and what were the nature and purpose of the | |
| | | | | |
| III. | Sankyo, offered | l any payme | Daiichi Sankyo, including third parties retained by D ents or gifts to you or your organisation that were kind being given to Daiichi Sankyo? | aiichi |
| | □ Yes | □ 1 | No | |
| IV. | Have you or yo provide details. | • | ntion ever violated any anti-bribery laws? If so, pleas | e |
| | | | | |



| V. | Does anyone in your Organisation make or influence decisions on any of the following in relation to Daiichi Sankyo products? Please respond with a YES or a NO. | | |
|------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|--|
| | Approval of Product Licenses | | |
| | □ Yes | □ No | |
| | Health Technology App | praisals | |
| | □ Yes | □ No | |
| | Inclusion into Formular | ries, Guidelines or Protocols | |
| | □ Yes | □ No | |
| VI. | • | esponded on behalf of anyone in your organisation with a YES above please complete the following section | |
| | and Name of Person(s) | in the Organisation associated with any of the activities in | |
| | | | |
| Name | of Organisation | | |
| | | | |



| Role within the Organisation |
|---------------------------------------------------------------------------------------------------------------------------------------|
| |
| |
| |
| Name of Daiichi Sankyo Product(s) that the activities in question 5 relate to |
| |
| |
| |
| Nature of Influence |
| |
| |
| |
| $\ \square$ I have to the best of my knowledge answered the questions above accurately and am authorised to do so by my Organisation. |
| Name and Title of Person completing the questionnaire. |
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