Bristol Myers Squibb & Johnson & Johnson Alliance

Independent Medical Education

Request for Educational Support (RFE)

Date	May 6, 2026
RFE Requestor Information	Name: Briana Botros, PharmD, RPh, BCPS Title: Associate Director, Medical Education E-mail: Briana.Botros@bms.com Name: Kenneth Todd Moore, DBE, MS, FAHA, FCP Title: Scientific Director, Cardiovascular Disease E-mail: Tmoore17@its.jnj.com
RFE Code	RFE-26-THR-102
Therapeutic Area	Cardiovascular
Area of Interest	**Stroke prevention in atrial fibrillation (AF) and secondary stroke prevention (SSP)**
Educational Design	Bristol Myers Squibb and Johnson & Johnson alliance is interested in supporting a comprehensive, innovative, and interactive initiative: **An interactive live satellite symposium at the following congresses:** • **American Society of Health-System Pharmacists (ASHP) Midyear Clinical Meeting in Orlando, FL (December 6-9th, 2026)** Program design includes: • Live – Interactive in-person and virtual satellite symposium • On-demand - Web-based enduring activity leveraging the medical content from the live meeting • Online resource tools (encouraged, but not required) • Health Equity component acknowledging the differences in disease burden across diverse racial/ethnic/sex populations (encouraged, but not required) • The activity(ies) should measure improvement of learners' knowledge, confidence, competence, and performance and should achieve at least a Moore's Level 4 impact. Activities that achieve Moore's Levels 5 and 6 outcomes are highly favored and recommended when possible. • Leverage evidence-based content
Intended Audience (may include, but not limited to)	Pharmacists and other healthcare practitioners (HCP) who are involved in the care of AF and SSP

Budget/Budget Range	The maximum amount of funding available for this RFE is $350,000 for each individual grant submission
Accreditation	ACPE
Geographic Coverage	United States
Deadline for Submission	June 10, 2026 by 5 PM EST via the BMS portal

Background:

Thrombosis is a significant global health concern, contributing to 1 in 4 deaths worldwide. It serves as the common underlying mechanism for the majority of myocardial infarctions, strokes, and venous thromboembolism, making it a leading cause of both morbidity and mortality.[1]

Between 2010 and 2019, the global prevalence of atrial fibrillation (AF) has increased from 33.5 million to 59 million individuals.[2] In the US alone, it is estimated that at least 6 to 16 million people will have AF by 2050,[3] and 10% (672,000) of the total AF prevalence is comprised of undiagnosed AF.[4] AF patients have an average 4 to 6 times increased risk of stroke. In those over 80 years of age, 25% of all strokes are directly caused by AF.[5] Not all patients with AF present with symptoms; approximately 20% of stroke patients discover they have AF at the time of the stroke.[6] Bleeding and fear of bleeding remain a major challenge for AF patients treated with DOACs, as approximately 40% of patients diagnosed with AF are untreated or undertreated due to fear of bleeding.[7,8] Likewise, about 50% of AF patients receiving a low-dose DOAC do not meet label criteria and experience similar bleeding rates to those on a standard dose while carrying a higher risk of thromboembolic events.[9,10] Unfortunately, about 25% of AF patients discontinue anticoagulation within the 1st year.[8,12] Subtherapeutic dosing of oral anticoagulants (OAC) or withholding treatment leads to negative consequences for patients.[10,11] Therefore, suboptimal AF detection and inadequate treatment remain barriers in the setting of primary prevention of stroke in AF.

According to the Global Burden of Disease (GBD) estimates, there were around 12.2 million incident cases of stroke, 143 million disability-adjusted life-years (DALYs) lost, and 6.6 million deaths globally, making stroke the second leading cause of death and third leading cause of disability worldwide.[13] In the United States, 1 in 6 deaths (17.5%) from cardiovascular disease was due to stroke.[14] About 87% of all strokes are ischemic strokes, leading to long-term disability.[15] In addition, the risk of having a first stroke is nearly twice as high for non-Hispanic Black adults as for White adults, with the highest stroke mortality residing in the Non-Hispanic Black and Pacific Islander adult patient populations.[14,15] Lifestyle modifications and risk reduction have remained a mainstay of therapy, including management of blood pressure and cholesterol, healthy diet, physical activity, and smoking cessation. Pharmacologic therapy plays a crucial role in the treatment of noncardioembolic ischemic stroke, including initiation of dual antiplatelet therapy (DAPT).[16] However, despite adhering to guideline-recommended therapy, 1 in 4 patients experiences a secondary stroke within 5 years of the initial stroke, many of which are preventable, and recurrent strokes are associated with worse disability and mortality than primary strokes.[16,17] Therefore, low adherence to DAPT and underuse of anticoagulants due to increased risk of bleeding represent ongoing challenges in the management of secondary stroke prevention.[18,19]

Investigational new approaches targeting anticoagulation are promising and differentiate their mechanisms by attenuating thrombosis without significantly increasing bleeding, as opposed to the

current standard of care anticoagulation which acts on the common pathway and does not distinguish between normal clotting and pathologic thrombosis. These strategies for targeting FXI/FXIa across all thrombotic indications include antisense oligonucleotides, monoclonal antibodies, and small molecules. Small molecules and monoclonal antibodies (MABs) are currently under investigation in phase 2 and phase 3 trials for AF, SSP, PAD, and CAT. Small molecules are synthetic compounds that are designed to block the active site of FXIa with oral administration, a rapid onset of action, a shorter half-life, and limited renal elimination.[20,21] MABs act by inactivating FXIa or blocking activation and/or activity of FXI with parental administration, a rapid onset and long duration of action, and are metabolized via proteolysis by the reticuloendothelial system.[21,22] In conclusion, educating healthcare providers about investigational anticoagulation is critical in the future management of thrombosis.

Education Needs and Professional Practice Gaps:

The BMS & J&J Alliance has identified, through insights from educational needs assessments, literature search, learning outcomes, and other methods, the need to address the following:

- Review the prevalence and unmet needs of thrombosis management, focusing on AF and SSP
- Evaluate the pros and cons of current US guideline recommended standards of care for the treatment of AF and SSP and implications of inadequate treatment
- Identify emerging anticoagulant strategies, including data from investigational clinical trials and their potential place in the management of AF and SSP, including patient populations who may benefit

The educational program should ensure timely and effective communication of the latest science, clinical trial data, evidence-based guidelines, barriers to care, and practice gaps related to stroke prevention.

Specific Area of Interest

BMS & J&J Alliance is seeking grant applications for the development and implementation of a well-designed, innovative, interactive, and educational program that addresses the above educational needs and professional practice gaps. Based on a series of systematic reviews conducted by Dr. Cervero to assess the impact of CME, activities that are more interactive, apply multiple methods and multiple exposures, and are focused on outcomes that are considered important by physicians, lead to more positive outcomes.[23] Proposals that incorporate such findings into the design and development of the educational activity will be given higher priority.

The content and/or the format of the CME/CE activity and its related materials must be current and designed in such a way that it addresses the educational needs of the intended audience as described in this RFE.

Grant Proposals should include, but not be limited to, the following information:

- **Executive Summary: The Executive Summary should consist of 1-2 pages and highlight the key areas as described below.**

- **Needs Assessment/Gaps/Barriers:** Needs assessment should be referenced and demonstrate an understanding of the specific gaps and barriers of the target audiences. The needs

assessment must be independently developed and validated by the educational provider through triangulation.

- **Target Audience and Audience Generation:** Target audience for educational program must be identified within the proposal. In addition, please describe methods for reaching target audience(s) and any unique recruitment methods that will be utilized. The anticipated or estimated participant reach should also be included, with a breakdown for each modality included in the proposal, as applicable (e.g., number of participants for the live activity, the live webcast, and enduring activity).

- **Learning Objectives:** The learning objectives must be written in terms of what the learner will achieve as a result of attending. The objectives must be clearly defined, measurable, attainable, and address the identified gaps and barriers.

- **Program Evaluation and Outcomes Reporting:** Description of the approach to evaluate the quality of the educational program. Describe methods used for determining the impact of the educational program on closing identified healthcare gaps.
    - Please refer to "Guidance for Outcomes Report" (on the BMS grants website) for a detailed explanation of preferred outcomes reporting methods and timelines.
    - Remember that knowledge, performance and competency based outcome measures according to Moore's Levels 4 & 5 are required. Level 6 outcomes are highly favored and recommended when possible.

- **Educational Design and Methods:** Describe the approach used to address knowledge, competence, and performance gaps that underlie identified healthcare gaps. The proposal should include strategies that ensure reinforcement of learning through use of multiple educational interventions and include practice resources and tools, as applicable.

- **Communication and Publication Plan:** Provide a description of how the provider will communicate the progress and outcomes of the educational program to the supporter. It is highly recommended to describe how the results of the activity will be presented, published, or disseminated.

- **Innovation:** Describe how this project is innovative and engages the learners to improve knowledge, competence and/or performance. Further describe how this project might build on existing work, pilot projects or ongoing projects developed either by your institution or other institutions related to this topic.

- **Budget:** Detailed budget with rationale of expenses, including breakdown of costs, content cost per activity, out-of-pocket cost per activity, and management cost per activity.

Note: The accredited provider and, if applicable, the medical education partner (MEP) or other third party executing the activities, are expected to comply with current ethical codes and regulations. They must have a conflict-of-interest policy in place to identify and resolve all conflicts of interest from all contributors and staff involved in developing the content of the activity prior to delivery of the

program, and must have a separate company providing/accrediting independent medical education if they are also performing promotional activities.

If your organization wishes to submit an educational grant request, please use the online application available on the Bristol Myers Squibb Independent Medical Education website.
http://www.bms.com/responsibility/grantsandgiving

References:

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