Alzheimer Europe

Changing perceptions, policy and practice to improve the lives of people affected by dementia

AE position on access to anti-amyloid treatments in Europe

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Background

Dementia currently affects over 12 million people in Europe, with numbers projected to reach 20 million by 2050. Alzheimer's disease is the leading cause of dementia, accounting for 60-80% of cases.

Prior to 2025, only a small number of symptomatic therapies were authorised for Alzheimer's disease in Europe: the acetylcholinesterase inhibitors donepezil, rivastigmine and galantamine, and the NMDA receptor antagonist memantine, the last of which was authorised by the European Medicines Agency (EMA) in 2002. None of these medicines modify the underlying, biological causes of Alzheimer's disease.

The European marketing authorisations for lecanemab in April 2025, and donanemab in September 2025, therefore marked a turning point for the Alzheimer's disease community in Europe, ending a gap of over two decades without a new approved treatment. Alzheimer Europe welcomed the authorisation of lecanemab and donanemab, as the first disease-modifying therapies for Alzheimer's disease. We acknowledged that these treatments carry very real safety risks, that their benefits are modest and confined to the earliest stages of the disease, and that healthcare systems must be well-resourced to deliver them safely. However, the organisation also stated that people living with early Alzheimer's disease deserve the opportunity to discuss these treatments with their doctor and to make an informed choice with their families, based on their individual circumstances and preferences.

Alzheimer Europe therefore notes with growing concern the lack of coverage by national health services and insurers in Europe, which is restricting access to those who can afford to pay privately or travel abroad for treatment. At the time of writing, Health Technology Assessment (HTA) agencies in Denmark, Finland, France, Germany, the Netherlands, Sweden and the United Kingdom have concluded their initial assessments, issuing negative coverage recommendations on lecanemab. In Luxembourg, a controlled access programme was established in January 2026, with costs covered via hospital budgets pending a formal pricing and reimbursement application. Assessments are ongoing elsewhere, but the vast majority of patients in Europe are not currently able to access these authorised therapies through publicly funded mechanisms.

Experience from the United States and Japan, where lecanemab and donanemab have been available and reimbursed since 2023 and 2024, offers a useful counterpoint to some of the concerns that may have influenced European HTA deliberations. Side effects, including amyloid-related imaging abnormalities (ARIA), have occurred at rates consistent with clinical trial data, underscoring the importance of careful patient selection, shared decision-making, and robust safety monitoring. Real-world uptake has also been more modest than early projections suggested. To date, health systems in the US and Japan have not been overwhelmed with demand for treatment. Rather, treatment has been confined to a small, well-defined group of patients who are likely to benefit from anti-amyloid therapies. Treated patients, with biomarker-confirmed early Alzheimer's disease and without contraindications, represent a small fraction of the broader dementia population.

Alzheimer Europe values and respects the rigorous health economic assessments that national HTA bodies conduct and recognises the difficult judgements they are asked to make in the interests of patients and health systems alike. However, the organisation is concerned that the current situation raises fundamental questions of equity, with access determined by financial means, geography and socioeconomic status. Alzheimer Europe also notes that without reimbursed access within national health systems, it will be hard to generate the real-world evidence on long term outcomes, patient selection and treatment delivery that is needed to refine clinical practice and prepare for future therapies. In addition, the organisation is concerned that HTA frameworks may not fully reflect the value these medicines may hold for patients, caregivers,

clinicians and health systems, with insufficient consideration, involvement and weighting being given to the perspectives of people living with Alzheimer's disease and their carers.

Alzheimer Europe recognises that anti-amyloid therapies, while a significant step forward, represent only one dimension of the unmet need faced by people with dementia and their carers. Across Europe, people living with dementia continue to experience difficulties in accessing the support, guidance, interventions, treatments and care they need. Investment in new treatments must not be at the expense of funding for these services, and for the health and social care workforce that delivers them. As the number of people living with dementia in Europe continues to grow, additional, protected and cross-sectoral investment is urgently needed.

The following statement sets out five areas of concern for Alzheimer Europe and the wider dementia community.

1. The importance of lived experience in assessing the value of new treatments

HTA bodies use health economic modelling to weigh the clinical benefits of treatments against their costs, to determine whether they provide value for the healthcare system. HTA bodies in many European countries have applied standard frameworks to assess anti-amyloid therapies and, in most cases, have concluded that the benefits of treatment do not justify the cost. Alzheimer Europe understands and respects this process, and acknowledges the elevated cost of treatment and safety monitoring. However, the organisation is concerned that the frameworks currently being applied do not fully capture the benefits these treatments may hold for people living with Alzheimer's disease and their carers.

Until very recently, no disease-modifying treatments existed for the millions of people living with Alzheimer's disease in Europe. Following rigorous scientific evaluation and re-examination, the EMA concluded that the benefits of lecanemab and donanemab, for the indicated population, outweigh the risks. Alzheimer Europe recognises that the EMA and national HTA bodies operate under different mandates. Nevertheless, the organisation believes that the EMA's benefit-risk evaluation for the indicated population should be taken as a starting point for national assessments, which can then focus on questions of value, access, and affordability.

For people living with Alzheimer's disease and their carers, extra months in a less severe disease stage can represent a meaningful gain at the personal level, even where the effect size measured by clinical rating scales appears modest. Meaningful benefit is shaped by individual circumstances and lived experience, dimensions that are hard to capture using clinical scales of cognition and function. Cost-effectiveness models built around short-term trial data and single patient health outcomes may also not fully reflect the societal dimensions of treatment. Across Europe, the majority of care for people with Alzheimer's disease is provided by family members and informal carers, often at significant personal cost to their health, employment and wellbeing, with a total economic value estimated at over EUR 170 billion annually across the EU. Assessments that do not adequately account for these costs may therefore underestimate the full impact of slowing disease progression for family members and informal carers.

Central to any meaningful assessment of value is the genuine and substantive involvement of people with lived experience of Alzheimer's disease and their carers, as well as the organisations that represent them. Alzheimer Europe is concerned that their perspectives have been insufficiently considered and weighted in national assessments of anti-amyloid therapies. The organisation is firmly committed to the principle that the people most affected by a treatment decision – patients and their families – must have a meaningful role in shaping how value is defined and measured from the outset of any assessment, with their contribution clearly documented in the outcome.

Standard health economic frameworks may not fully capture the value of disease-modifying treatments for people affected by Alzheimer's disease. What constitutes a meaningful benefit is shaped by individual circumstances and lived experience, dimensions that are difficult to quantify using clinical rating scales alone. Understanding these dimensions requires the direct involvement of people affected by Alzheimer's disease.

The societal cost of the disease, including the significant and often invisible impact on informal carers, should also be fully reflected in assessments of treatments for Alzheimer's disease. The EMA has already determined that the benefits of lecanemab and donanemab outweigh the risks for the indicated population, which should serve as the starting point for national assessments that focus on questions of value, access and affordability.

Alzheimer Europe calls on HTA bodies to ensure their methodologies reflect the full value of these treatments, giving genuine and documented weight to the perspectives of people with lived experience of Alzheimer's disease and their carers. People with lived experience, and the patient organisations that represent them, should be involved in all assessments from the outset, with their contribution clearly documented in the outcome.

2. Every person should have the right to a timely and accurate diagnosis

Several national assessments have cited the inadequacy of existing diagnostic infrastructure as part of their reasoning for recommending against coverage. In France, the Haute Autorité de Santé (HAS) highlighted operational constraints around the processes required to ascertain eligibility, including genetic testing and biomarker-based diagnosis, as part of its reasoning for refusing early access.

Alzheimer Europe shares the concern that systems must be ready to deliver these treatments safely, a point that was a key focus of our 2024 Position Paper on anti-amyloid therapies. However, the use of infrastructure gaps as a justification for denying access is of concern, because the provision of a timely, accurate diagnosis of Alzheimer's disease should be a human right, irrespective of treatment.

A timely and accurate diagnosis is valuable in its own right, independent of whether any treatment is available or reimbursed. Alzheimer Europe's longstanding position is that every person with dementia has a right to know their diagnosis, and to be informed of their state of health. A timely and accurate diagnosis allows people to plan for the future, to make informed decisions while they retain capacity to do so, to access care and support, and to participate in research. For families and carers, diagnosis can provide clarity and the opportunity to prepare for the future. In short, having a timely and accurate diagnosis is a starting point for living as well as possible with Alzheimer's disease. The cost of diagnosis should not be treated as part of the cost of therapy, and the adequacy of diagnostic services should not be used as a reason to withhold access to treatment.

A timely and accurate diagnosis is valuable in its own right, enabling people to plan for the future, make informed decisions while they retain capacity, access care and support, and participate in research. The right to diagnosis exists independently of whether any treatment is available or reimbursed, and diagnostic infrastructure gaps should not be used as a justification for withholding access to authorised therapies. Investment in diagnostic capacity also underpins Europe's readiness for the next generation of treatments.

Alzheimer Europe calls on healthcare systems across Europe to develop and invest in pathways for timely, accurate diagnosis of Alzheimer's disease and other dementias. The cost of diagnosis should not be treated as a component of the cost of treatment in HTA assessments.

3. Patients and their families deserve the opportunity to make informed, supported choices about treatment

Alzheimer Europe endorses the model of shared, supported decision-making, in which the individual is at the centre of decisions about their own care, supported by their doctor(s), family and carers. This is especially relevant for lecanemab and donanemab, as decision-making capacity is typically preserved in the mild cognitive impairment and mild dementia stages of Alzheimer's disease, the stages at which anti-amyloid therapies are indicated.

Genuinely informed decision-making depends not only on the capacity to decide, but also on the quality and accessibility of information on which the decision is based. People living with Alzheimer's disease and their families deserve clear, accurate and accessible information about the expected benefits of treatment, the potential risks involved, the burden of treatment and the uncertainties that remain. This also applies to the wider, public conversation about anti-amyloid therapies, which should be clear and balanced, avoiding language that reinforces prevailing stigma which too often results in the needs of people with dementia being overlooked. Alzheimer Europe notes that what constitutes a meaningful benefit is not determined by clinical measures alone, but is also shaped by the individual circumstances and lived experience of the person affected, underlining the importance of shared, supported decision-making for patient-centred care.

In practice, however, the opportunity to make this informed, supported decision depends on whether treatment is accessible. Where treatments are not reimbursed by public healthcare systems, people with the same diagnosis and clinical eligibility may have very different experiences depending on where they live and what they can afford. In several European countries, anti-amyloid therapies are only available to those who can pay for it privately, or who are able to travel to access it. Alzheimer Europe is concerned that national decisions not to reimburse anti-amyloid therapies mean that many patients will not have the opportunity to decide, together with their doctors and families, whether the benefits of treatment justify the risks involved.

> People living with Alzheimer's disease at the mild cognitive impairment and mild dementia stages typically retain full decision-making capacity. Shared, supported decision-making, in which the individual, together with their doctor and family, weighs the benefits, risks and uncertainties of treatment in the context of their own circumstances, must be at the heart of any treatment pathway. In practice, however, this opportunity can only be exercised where treatment is accessible.
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> *Alzheimer Europe calls on national HTA bodies and governments to ensure that, where a treatment has been authorised as safe and effective, people with Alzheimer's disease have the opportunity to discuss it with their doctor and to consider whether treatment is right for them, taking account of their own circumstances, values and preferences. Pathways to access, including compassionate use frameworks, pilot programmes and small-scale real-world studies, could be established to enable this, while wider reimbursement decisions continue.*

4. Lack of coverage by national health systems risks worsening inequity

A marketing authorisation by the European Commission grants the right to market a medicine across all EU Member States. It is, however, only the first step in the pathway to patient access. An important determinant of access is reimbursement, which is decided at national level by individual health systems. Where reimbursement is not granted, a medicine that has been authorised as safe and effective remains available in principle, but access becomes contingent on the ability to pay privately, and/or to travel to a location where the treatment is available.

This is a reality for many eligible patients in Europe, where access through public health systems remains the exception rather than the rule. In Germany, patients have been able to access lecanemab through the statutory health insurance system during the period following EU authorisation, but the recent negative benefit assessment by the Gemeinsamer Bundesausschuss is expected to result in restrictions to reimbursed access in the near future. In France and Sweden, HTA assessments have concluded negatively, limiting access to those who can pay privately. In Finland, the first patient treated with lecanemab in the Nordic countries was treated at a private clinic in Helsinki. In the United Kingdom, both lecanemab and donanemab have been licensed by the MHRA but are not currently reimbursed through the National Health Service. According to Alzheimer's Research UK, private treatment with lecanemab has been advertised at between GBP 60,000 and GBP 80,000 per year.

Where public reimbursement is unavailable and private access is the only option, the consequences for equity are significant, as private provision favours individuals with higher incomes, those who live near major specialist centres, and those with higher health literacy. This situation disproportionately affects people from minority ethnic groups, those in rural areas, and individuals who are socioeconomically disadvantaged.

Pricing has been a contributing factor to certain negative reimbursement recommendations, with HTA bodies concluding that lecanemab and donanemab are not cost-effective at their submitted list prices. Alzheimer Europe therefore encourages manufacturers to engage constructively with European health systems on pricing, taking into account the health economic realities of publicly funded healthcare. The organisation hopes that the development of subcutaneous formulations and new imaging technologies will be more convenient and accessible for patients, whilst also reducing cost for national health systems. Until pricing and reimbursement issues are resolved, however, the consequences for equity described above will persist.

The equity implications of negative reimbursement recommendations are compounded by the nature of the treatments themselves. Lecanemab and donanemab are indicated for people in the early symptomatic stages of Alzheimer's disease, specifically those with mild cognitive impairment (MCI) due to Alzheimer's disease or mild Alzheimer's dementia. Clinical trials indicate that people with MCI due to Alzheimer's disease may derive greater benefit from treatment with anti-amyloid therapies than those with mild Alzheimer's disease dementia. Moreover, people who progress beyond the mild dementia stage are no longer eligible for treatment. This means that a person who meets the clinical criteria today but cannot access treatment due to the absence of reimbursement, lack of diagnostic infrastructure, or inability to pay privately, may no longer be eligible by the time a reimbursement decision is revisited.

More broadly, however, Alzheimer Europe recognises that inequity in dementia extends well beyond access to new treatments. Across Europe, significant disparities already exist in access to a timely diagnosis, psychosocial support, medical specialists, and social care services. These disparities vary between and within European countries, and between socioeconomic and ethnic groups. Introducing new treatments without addressing underlying, structural inequalities in health and social care risks worsening, rather than reducing, those disparities. Governments and health systems must take a holistic view, ensuring that investment in new treatments does not compromise or replace investment in the services and support that people with dementia and their carers rely on.

In many European countries, lecanemab and donanemab are currently accessible only to those who can afford to pay privately or travel to access treatment. This situation raises serious concerns for equity, disproportionately affecting people from lower socioeconomic backgrounds, those in rural areas, and those from minority ethnic groups. Negative reimbursement decisions are particularly consequential for Alzheimer's disease given the narrow and time-limited treatment window. Access to new treatments is, however, only one dimension of the inequity that people living with dementia face across Europe.

Alzheimer Europe calls on national governments, health systems and manufacturers to work together to ensure that access to authorised treatments is not determined by wealth, location or socioeconomic circumstance. Manufacturers are encouraged to engage constructively with European health systems on pricing, and governments are asked to explore compassionate use and early access mechanisms to ensure that eligible patients do not lose their treatment window while reimbursement decisions are concluded. Governments must address inequities in dementia that affect access to diagnosis, support and care, and investment in new treatments must be additional to, and not at the expense of, investment across the full spectrum of dementia care, which is urgently needed.

5. Managed access frameworks and pilot programmes could provide pathways for treatment whilst generating real-world evidence for the future

Under many European frameworks for health technology assessment, a treatment either meets the threshold for full reimbursement, or it does not. For novel treatments, conditions with high unmet need, uncertain long-term evidence, and a small eligible patient population, this binary approach can cause issues, as lack of coverage means that clinicians may have little opportunity to develop practical experience, guidance and data from treating patients in the real-world setting.

Several European countries have developed pathways to address this situation. In oncology, managed access frameworks, cancer drugs funds, and coverage-with-evidence-development schemes have allowed conditional reimbursement under defined clinical criteria, with mandatory evidence collection and scheduled reassessment. These managed access pathways (sometimes termed controlled access pathways) allow for the provisional reimbursement and use of high-cost or novel treatments before comprehensive, long-term evidence of cost-effectiveness is fully established. For example, in England, the new Cancer Drugs Fund was established in 2016, with an annual budget of GBP 340 million. To date, over 60 managed access agreements have been reached between NHS England and pharmaceutical companies, providing patients with access to promising cancer treatments while real-world evidence is gathered to inform a full reimbursement decision. A related and complementary approach is the use of small-scale pilot programmes, in which a carefully defined group of eligible patients receives treatment within a monitored clinical setting.

Importantly, published data suggest that the population eligible for and actively seeking anti-amyloid therapies is considerably smaller than early projections assumed. A study of a tertiary memory clinic population in the Netherlands found that just 8% were initially eligible for lecanemab, with the eligible group narrowing to 6% after strict clinical exclusions were applied. Real-world experience in countries where these treatments are reimbursed is broadly consistent. In Japan, for example, approximately 6,000 patients were treated with lecanemab in the first year after approval by the national regulator, representing a small fraction of the estimated five million people aged 65 and over living with dementia in that country. Taken together, these figures suggest that actual demand for anti-amyloid therapies may be considerably lower than projected. A number of our member organisations have called for dementia drugs funds that could act as a middle ground, moving current and future treatments from clinical trial into small-scale clinical practice pilots, generating real-world evidence while giving patients access.

A related point is that anti-amyloid therapies are a “first step”, comparable to early treatments for conditions such as cancer and multiple sclerosis where initial benefits of treatment were limited but improved substantially as research progressed and clinical experience accumulated. Investments in access to treatments, while the evidence base was still developing, helped build the clinical infrastructure and expertise that led to better treatments for cancer and multiple sclerosis over time.

People with Alzheimer’s disease deserve the same considered response that has been extended to people living with other serious conditions. They should not be overlooked or placed at the back of the queue for new medicines, and they deserve the opportunity to decide for themselves, together with their families and doctors, whether treatment is right for them.

People living with Alzheimer's disease deserve the same serious consideration as patients with other life-changing conditions, including a genuine opportunity to weigh authorised treatment options with their doctors and families. However, the binary nature of many HTA frameworks presents difficulties for novel treatments in conditions with high unmet need, few existing medical treatments, and an evolving evidence base. In the absense of full reimbursement, managed access frameworks and small-scale pilot programmes, already established for conditions such as cancer, offer a middle ground, helping eligible patients to access treatment, while generating the real-world evidence and clinical pathways that health systems will need for future disease-modifying therapies.

Alzheimer Europe calls on national governments and HTA bodies to establish pathways for managed access, including dementia drugs funds, compassionate use schemes and pilot programmes, with appropriate safeguards including narrow eligibility criteria, robust informed consent, independent monitoring and periodic reassessment. A pan-European approach to piloting access, enabling the sharing of costs, learning and evidence across health systems, should also be explored.

The way forward

The European Commission's authorisation of lecanemab and donanemab marks the beginning of a new era in the treatment of Alzheimer's disease, as the first disease-modifying therapies for a condition that affects millions of people across Europe. Alzheimer Europe recognises that these are modest first steps, that the benefits are limited to a defined group of eligible patients, and that the infrastructure required to deliver these treatments safely does not yet exist at scale across Europe. Nevertheless, the organisation is deeply concerned that the vast majority of eligible patients across Europe cannot access these new treatments, due to negative appraisals by national HTA bodies.

Alzheimer Europe notes that the current lack of reimbursement may have consequences beyond the immediate impact on patients. Clinical infrastructure, diagnostic pathways and experienced research networks are built and sustained through real-world treatment experience, and Europe will need this foundation to be ready for future advances, including combination approaches targeting multiple disease pathways and interventions integrating disease-modifying therapies with lifestyle and psychosocial support. Without it, Europe risks becoming a less attractive environment for clinical research and therapeutic innovation that could benefit future patients.

Alzheimer Europe also recognises that countries in Europe differ widely with respect to diagnostic architecture, specialist capacity and health system approaches. A pan-European approach to piloting access to anti-amyloid therapies may help countries pool resources, share real-world evidence and learn collectively, also reinforcing Europe’s position as a leading environment for dementia research. At the national level, small-scale pilot schemes may represent a practical first step towards equitable access, generating clinical experience and real-world evidence before health systems commit to full-scale rollout.

Alzheimer Europe hopes that the concerns and recommendations set out in this paper will help inform discussions on anti-amyloid therapies, including current and future reviews. Alzheimer Europe remains committed to supporting the European dementia movement in its work on access to treatments, including anti-amyloid therapies, and to raising awareness of the wider concerns set out in this paper at the EU level.

Alzheimer Europe therefore calls on European and national policymakers, HTA bodies, health systems, manufacturers and the research community to work together to address the five areas of concern set out in this statement. Specifically, the organisation calls for:

- *HTA bodies to establish requirements for meaningful Public Involvement in all assessments of Alzheimer's disease treatments, ensuring that the perspectives of people with lived experience, and the associations that represent them, are embedded from the outset;*
- *HTA bodies to use assessment methodologies for these novel treatments that take as their starting point the EMA's benefit-risk determination, and give full and meaningful weight to the perspectives of people with lived experience of Alzheimer's disease;*
- *HTA bodies and national governments to establish pathways for managed access, such as dementia drug funds, compassionate use schemes and similar mechanisms that enable eligible patients to make an informed treatment decision with their physician, whilst building clinical experience and generating real-world evidence;*
- *European institutions, national governments and manufacturers to explore pan-European collaboration on pilot access schemes for anti-amyloid therapies, enabling the sharing of costs, learning and evidence across health systems and reinforcing Europe's position as a leader in dementia research;*
- *Manufacturers to engage constructively with European health systems on pricing, and to consider pricing at a rate that reflect the health economic realities of publicly funded healthcare;*
- *National governments to invest now in the diagnostic infrastructure and specialist capacity needed to identify eligible patients and deliver these and other treatments safely now, and in the future, recognising that the right to a timely and accurate diagnosis is universal, independent of whether a treatment is available or reimbursed;*
- *Health authorities, clinicians, researchers and media to adopt clear and responsible communications when reporting on new treatments, ensuring people with dementia and their families are well informed and that dementia is not further stigmatised in public discourse.*

The organisation notes that anti-amyloid therapies are indicated only for a small group of patients in the earliest stages of the disease, and that the majority of people living with Alzheimer's disease in Europe will not be eligible for these treatments. Clinical studies show that disease progression is modestly slowed (by approximately 30% over an 18-month period) but not halted by treatment with the current generation of anti-amyloid therapies, which carry a significant risk of amyloid-related imaging abnormalities (ARIA) and other adverse events requiring careful monitoring. Moreover, Europe has an aging population, with more than 20% of adults aged 65 or above in 2020, with dementia prevalence estimated to reach over 14 million by 2050 in the European Union alone. This means that even if all currently authorised therapies were fully accessible, significant unmet medical need would still remain.

Alzheimer Europe therefore reiterates its call for sustained investment in research, including into symptomatic therapies and treatments for people with different types of dementia and at more advanced stages of disease. Looking ahead, the organisation is hopeful that continued progress will deliver more effective, accessible and affordable treatments across a broader range of disease stages and dementia types.

As therapies improve, and as disease-modifying treatments for non-Alzheimer's dementias are developed, a greater share of the cost of dementia that is currently borne by patients and informal carers may

progressively shift to the healthcare system. In the future, Alzheimer Europe hopes that new treatments, as well as benefiting patients, will reduce the impact of dementia on the health, employment and wellbeing of family members and informal carers. Alzheimer Europe remains committed to a holistic approach to Alzheimer's disease and dementia, where innovative new treatments are included alongside counselling, support and adequate care of people with dementia and their carers throughout the disease process.

While this position is focused on medical treatments, we must not forget that informal care costs for dementia are estimated at nearly EUR 170 billion across the EU annually, and that the social care workforce is already under significant strain. The need for sustained investment across sectors is urgent: both to support those affected today, and to build the capacity that a growing and ageing population will require in the years ahead. The organisation therefore urges governments across Europe to invest additional funds in research, health and social care systems, to meet the scale of this challenge.

This position was adopted by the AE Board on 4 May, 2026.

Declaration of interests: *Alzheimer Europe had an audited income of EUR 3,142,316 in 2025. Sponsorship by the developing companies of lecanemab and donanemab in 2025 amounted to EUR 90,000 (Lilly), EUR 37,500 (Biogen) and EUR 35,000 (Lilly) or 5.17% of the organisation's income in 2025. Sponsorship by pharmaceutical companies is only accepted in accordance with the organisation's Sponsorship guidelines and, in line with the European Medicines Agency criteria for patient organisations, declared in full transparency on the Alzheimer Europe website: https://www.alzheimer-europe.org/about-us/governance/finances/alzheimer-europe-sponsors*