



**Washington State Health Care Authority**  
**Prescription Drug Program**

626 8<sup>th</sup> Ave SE, Olympia, WA 98501 • 206-521-2029

<https://www.hca.wa.gov/about-hca/prescription-drug-program>

February 22, 2021

Re: Solicitation for one Physician and one Physician Assistant to serve on the Washington State Pharmacy and Therapeutics Committee. Applications are due COB March 23, 2021.

Dear Interested Parties:

The Washington State Health Care Authority is seeking applications from interested physicians and physician assistants to fill two openings on the Washington State Pharmacy & Therapeutics (P&T) Committee beginning on April 21, 2021.

The purpose of the committee is to evaluate the available evidence of the relative safety, efficacy, and effectiveness of prescription drugs within a class of prescription drugs and make recommendations to the appointing authority for its deliberation in the development of the preferred drug list established in RCW 70.14.050. The P&T Committee also serves as the Apple Health (Medicaid) Drug Utilization Review (DUR) Board.

The initial term of appointment is 3 years. Members of the committee are expected to attend six full day meetings a year, with a few hours of reading to prepare for the meeting. Members of the committee will be compensated for attendance at meetings in accordance with a personal services contract executed after appointment to the committee.

Applicants should submit a current CV or resume, and fill out the attached form demonstrating that they meet the following criteria set forth in WAC 182-50-025:

- Members must be actively practicing in their clinical area of expertise throughout the entire term of their appointments.
- Members must have knowledge and expertise in one or more of the following:
  - Clinically appropriate prescribing of covered outpatient drugs;
  - Clinically appropriate dispensing and monitoring of covered outpatient drugs;
  - Drug use review;
  - Medical quality assurance;
  - Disease state management; or
  - Evidence-based medicine.
- Members of the committee shall not be employed by a pharmaceutical manufacturer, a pharmacy benefits management company, or by any state agency administering state purchased health care programs during their term and shall not have been so employed for eighteen months prior to their appointment.

- A member shall not have a substantial financial conflict of interest including any interest in any pharmaceutical company, including the holding of stock options or the receipt of honoraria or consultant moneys. The appointing authority in its sole discretion may disqualify any potential member if it determines that a substantial conflict of interest exists.
- As part of the application process, prospective committee members shall complete a conflict of interest disclosure form, provided by the appointing authority, and after appointment, annually by July 1st of each year. Members must keep their disclosure statements current and provide updated information whenever circumstances change.
- Applicants with state licensure actions or Medicaid/Medicare sanctions will be considered case-by-case.
- Committee members must agree to keep all proprietary information confidential.

Applications must be received no later than close of business March 23, 2021.

Please submit applications to Leta Evaskus, [leta.evaskus@hca.wa.gov](mailto:leta.evaskus@hca.wa.gov). For more information, please contact Donna Sullivan, PharmD at (360) 725-1564, or [donna.sullivan@hca.wa.gov](mailto:donna.sullivan@hca.wa.gov).

Sincerely,

A handwritten signature in black ink that reads "Donna Sullivan". The signature is written in a cursive, flowing style.

Donna Sullivan, Chief Pharmacy Officer  
Clinical Quality and Care Transformation  
Washington State Health Care Authority  
[PDP website](#)

## Washington State Pharmacy and Therapeutics (P&T) Committee Application for Membership

1

### Contact information

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First name:

Middle initial:

Last name:

Address:

Phone number:

Best method, time to reach you:

Email:

Are you:

Applying for membership

Nominating another person for membership?

Name of nominee:

2

### Training and experience

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Education (list degrees):

Health care practitioner licenses:

Professional affiliations:

Board certifications, formal training, or other designations:

Current position (title and employer):

Current practice type and years in practice:

Total years as an active practitioner:

Location of practice (city):

Describe your experience treating women, children, elderly persons, or people with diverse ethnic and racial backgrounds.

### 3

## Ability to serve

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Are you able to participate in all-day meetings, an estimated six times per year? Yes No

Are you willing to commit to the responsibilities of a committee member, including:

- Attending meetings prepared for the topics of the day;
- Actively participating in discussions;
- Evaluate the presented evidence on prescription drugs for safety and efficacy? Yes No

Could you, or any relative, benefit financially from the decisions made by the P&T Committee? Yes No

Provide a brief explanation (up to 500 words) why you would like to serve on the clinical committee and the contributions you would like to make.

### 4

## References

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**Provide three professional references including: name, title, relationship, contact email and phone number.**

**1.**Name: Title:

Relationship:

Contact email:

Phone number:

**2.**Name: Title:

Relationship:

Contact email:

Phone number:

**3.**Name: Title:

Relationship:

Contact email:

Phone number:

**Gender:**

Male      Female      X/non-binary<sup>1</sup>

**Pronouns (select all that apply)**

She/her      He/him      They/them      Other (subj./obj.):

**Race or Ethnicity**

American Indian or Alaska Native

Asian or Pacific Islander American

Black/ African American

Latino, Hispanic, Spanish

White/ Caucasian

Other:

**Military Service**

If you have served in active duty in the U.S. Armed Forces, list branch and dates:

Branch \_\_\_\_\_ Date \_\_\_\_\_

Branch \_\_\_\_\_ Date \_\_\_\_\_

Branch \_\_\_\_\_ Date \_\_\_\_\_

Branch \_\_\_\_\_ Date \_\_\_\_\_

**Disability**

Do you have a permanent physical, sensory, or mental condition that limits your major life functions?

*(Examples include working, caring for yourself, walking, doing things with your hands, seeing, hearing, speaking or learning):*

Yes      No

If “yes,” please explain:

Today’s date \_\_\_\_\_

Return completed application, curriculum vitae and **conflict of interest disclosure** to: [leta.evaskus@hca.wa.gov](mailto:leta.evaskus@hca.wa.gov).

<sup>1</sup> Non-binary (X) is an umbrella term used to describe those who do not identify as exclusively male or female. This includes but is not limited to people who identify as genderqueer, gender fluid, agender, or bigender.