

# Pharmacy & Therapeutics Committee and Drug Utilization Review Board

## Conflict of Interest Disclosure

As stewards of public funds, the practicing clinicians who serve (or apply to serve) on the Committee strive to uphold the highest standards of transparency and impartiality. Identifying financial, professional, and other interests contribute to the effective management of perceived, potential, and/or real conflicts of interest/bias that could affect Committee determinations. (WAC 182-50)

This Conflict of Interest form must be completed by an applicant for appointment to the State of Washington Pharmacy and Therapeutics Committee (“P&T Committee”) or appointment to any of its subcommittees or work groups.

A member of the P&T Committee or any of its subcommittees or work groups may not participate in discussions or deliberations of any class of drugs or any agenda item for which a conflict of interest is identified and may not vote on any such matter.

If a conflict of interest is so great as to make it difficult for any member to participate meaningfully in the work of the P&T Committee, that member may be asked to resign.

### 1

## Applicant information

First name:

Middle initial:

Last name:

Phone number:

Email:

### 2

## Financial interests

Disclose your financial interests and relationships occurring over the last twenty-four months.

**List amounts totaling \$1,000 or more from a single source.**

**Indicate the category** of financial interest/relationship by referring to the disclosure categories below. Select the letter corresponding to your financial interest(s). You may indicate multiple categories.

**Indicate the source and date** of the financial interest. For each chosen category, include date and if your activities are ongoing.

**Indicate the recipient.** Family: spouse, domestic partner, child, stepchild, parent, sibling (his/her spouse or domestic partner) currently living in your home.

### Financial interest categories

Use these categories to indicate the nature of the financial interest:

- |  |  |   |
|--|--|---|
| A. Payment from parties with a financial or political interest in the outcome of work as part of your appointment or activity. | C. Ownership or owning stock (stock, options, warrants) or holding debt or other significant proprietary interests or investments in any third party that could be affected. | D. Receiving a proprietary research grant or receiving patents, royalties, or licensing fees. |
| B. Employment including work as an independent contractor, consultant, whether written or unwritten.                           |  | E. Participating on a company's proprietary governing boards.                                 |
|  |  | F. Participating in a speakers bureaus.   |
|  |  | G. Receiving honoraria.   |

Please list your financial interests on the next page. Attach additional sheets if necessary.

## Financial interest disclosures

Category (A-G)	Source of income and date	Amount	Recipient
			Self      Family
			Self      Family
			Self      Family
			Self      Family
			Self      Family
			Self      Family

## 3 Other interests

Please respond to the following questions. Disclose all interests that may apply to topics covered in upcoming meetings.

**Have you authored, coauthored, or publicly provided an opinion, editorial, or publication related to any meeting topic? Topics(s):**

**Are you involved in formulating policy positions or clinical guidelines related to any meeting topic? Topics(s):**

**Could a coverage determination based on a Committee decision conflict with policies you have promoted or are obliged to follow? Topic(s):**

## 4 Signature

I have read the Conflict of Interest Disclosure form. I understand the purpose of the form and agree to the application of the information to determine conflicts of interest. The information provided is true and complete as of the date the form was signed. If circumstances change, I am responsible for notifying committee staff in order to amend this disclosure. I will complete this form annually by July 1st of each year of committee membership.

To sign this request, do **not** use the “Fill & Sign” function; instead, simply click in the signature field to add your signature.

Signature

Date

If for any reason you feel you cannot sign this statement as worded, or if you have further questions, please contact Donna Sullivan, Chief Pharmacy Officer, at [donna.sullivan@hca.wa.gov](mailto:donna.sullivan@hca.wa.gov).

or email form to Leta Evaskus at [leta.evaskus@hca.wa.gov](mailto:leta.evaskus@hca.wa.gov)