The existence of such financial relationships or affiliation does not necessarily constitute conflict of interest and will not preclude an individual from participating as a Committee member, or, for an individual external to the Committee, from providing verbal or written public comment to the Committee.

Disclosures (select one)

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Organization*	Role / Relationship*

**List additional organizations and role/relationships on additional page(s) if necessary*

Your Attestation

I affirm under penalty of law that the information I have provided on this form is true, accurate, and complete to the best of my knowledge.

Name: Aida E. Amado, ACNP

Signature: A Amado NP Date: 10/11/2022

AHCCCS
Arizona Health Care Cost Containment System

Conflict of Interest Disclosure

As detailed in the Committee Operational Policy ACOM 111, Committee members and public individuals external to the Committee who provide verbal or written public comment to the Committee shall not:

a. Be employed by, subcontract with, or directly or indirectly represent a pharmaceutical manufacturer,

b. Be employed by, subcontract with, or directly or indirectly represent a pharmacy benefits management (PBM) company,

c. Receive payments or compensation from the pharmaceutical industry in excess of the physician mean general payment amount for the most recent year as specified on the CMSO Open Payments website at openpaymentsdata.cms.gov.

Thus, any individual who meets a., b. or c is <u>not</u> eligible for serving on the Committee or providing external public comment to the Committee.

Please initial the following:

[x] I am not employed by, subcontract with, or directly or indirectly represent a pharmaceutical manufacturer;

[x] I am not employed by, subcontract with, or directly or indirectly represent a pharmacy benefits management (PBM) company; and

[x] I do not receive payments or compensation from the pharmaceutical industry in excess of the physician mean general payment amount for the most recent year specified on the CMSO Open Payments website at openpaymentsdata.cms.gov

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Pharmacy and Therapeutics Committee Application

This application is not open to persons representing the pharmaceutical industry, healthcare/pharmaceutical consultants/lobbyists and employees of the pharmaceutical industry - see ACOM 111 AHCCCS Pharmacy and Therapeutics Committee for more information.

Instructions: Please complete this application for consideration for membership on the AHCCCS P&T Committee. If questions are not applicable, enter "NA". *Note: in addition to this application, applicants should include a resume and/or curricula vitae.*

Type of Application (select one):

☐ Initial Appointment ☑ Reappointment

Position applying for (select category then choose from dropdown):

☑ Health care provider Adult psychiatrist

Other:_____

☐ Members of the public Select One

☐ AHCCCS Managed Care Organizations (MCOs) and Regional Behavioral Health Authority (RBHA) representatives: Select One

CONTACT INFORMATION

Schwartz (LAST) | Aimee (FIRST) | (MIDDLE)

ADDRESS | CITY

STATE | ZIP | COUNTY

HOME PHONE | OFFICE PHONE | MOBILE

EMAIL | FAX

CURRENT EMPLOYMENT
(if applicable)

BUSINESS/ORGANIZATION NAME | CURRENT POSITION/TITLE

ADDRESS | CITY

STATE | ZIP | PHONE

Professional Licenses, Registrations, Certifications and/or Experience:

Experience with AHCCCS Programs:

Are you currently an AHCCCS registered provider? ☐ Yes ☐ No

Conflict of Interest Disclosure

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Please initial the following:

AS I am not employed by, subcontract with, or directly or indirectly represent a pharmaceutical manufacturer;

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Disclosures (select one)

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Organization*	Role / Relationship*

**List additional organizations and role/relationships on additional page(s) if necessary*

Your Attestation

I affirm under penalty of law that the information I have provided on this form is true, accurate, and complete to the best of my knowledge.

Name: Aimee Schwartz, MD

Signature:  Type text here

Date: 09/27/2022

AHCCCS
Arizona Health Care Cost Containment System

Conflict of Interest Disclosure

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Organization*	Role / Relationship*
Walgreens	Pharmacy manager

**List additional organizations and role/relationships on additional page(s) if necessary*

Your Attestation

I affirm under penalty of law that the information I have provided on this form is true, accurate, and complete to the best of my knowledge.

Name: Andrew Thatcher

Signature: _____ Date: 10/01/2022

Pharmacy and Therapeutics Committee Application

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Instructions: Please complete this application for consideration for membership on the AHCCCS P&T Committee. If questions are not applicable, enter "NA". *Note: in addition to this application, applicants should include a resume and/or curricula vitae.*

Type of Application (select one):

☐ Initial Appointment ☑ Reappointment

Position applying for (select category then choose from dropdown):

☐ Health care provider Select One

Other:_____

☐ Members of the public Select One

☑ AHCCCS Managed Care Organizations (MCOs) and Regional Behavioral Health Authority (RBHA) representatives: RBHA Medical Director or Pharmacy Director or designee

CONTACT INFORMATION

LAST	FIRST	MIDDLE
Borodkin	Stephen	Lawrence

ADDRESS	CITY
4500 E Cotton Center Blvd	Phoenix

STATE	ZIP	COUNTY
AZ	85040	Maricopa

HOME PHONE	OFFICE PHONE	MOBILE
(480) 306-5373	(602) 263-3000	(602) 955-5553

EMAIL	FAX
BorodkinS@MercyCareAZ.org	

CURRENT EMPLOYMENT
(if applicable)

BUSINESS/ORGANIZATION NAME	CURRENT POSITION/TITLE
Mercy Care	Behavioral Health Medical Director

ADDRESS	CITY
4500 E Cotton Center Blvd	Phoenix

STATE	ZIP	PHONE
AZ	85040	(602) 263-3000

Professional Licenses, Registrations, Certifications and/or Experience:

University of Illinois College of Medicine Doctor of Medicine

University of Michigan Medical Center Psychiatry Residency

Arizona Medical Board Physician License Number 25516

Americal Board of Psychiatry & Neurology certification in General Psychiatry #42297

Experience with AHCCCS Programs:

Supersition Mountain Mental Health (now Horizon Health & Wellness) 10/2005 to 9/2009 Medical Director (direct inpatient & outpatient care)

Choices Network of Arizona (now Terros) 9/2009 to 10/2014 Chief Psychiatrist (direct outpatient care)

Mercy Care 10/2014 to present Behavioral Health Medical Director (utilization & quality management)

Are you currently an AHCCCS registered provider? ☑ Yes ☐ No

I am a registered provider but I do not currently treat members.

Conflict of Interest Disclosure

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Please initial the following:

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Organization*	Role / Relationship*

**List additional organizations and role/relationships on additional page(s) if necessary*

Your Attestation

I affirm under penalty of law that the information I have provided on this form is true, accurate, and complete to the best of my knowledge.

Name: Stephen Borodkin

Signature:  Date: 10/12/2022

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Organization*	Role / Relationship*

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Your Attestation

I affirm under penalty of law that the information I have provided on this form is true, accurate, and complete to the best of my knowledge.

Name: CHARLES GOLDSTEIN

Signature:  Date: 10/12/2022

Conflict of Interest Disclosure

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Organization*	Role / Relationship*
Phoenix Indian Medical Center - Indian Health Service	Current Employer

**List additional organizations and role/relationships on additional page(s) if necessary*

Your Attestation

I affirm under penalty of law that the information I have provided on this form is true, accurate, and complete to the best of my knowledge.

Name: Jonathan Enchinton

Signature: Jonathan Enchinton -S Digitally signed by Jonathan Enchinton -S Date: 2023.10.02 11:46:48 -07'00'

Date: 10/02/2023

Reset form | Save form | Print form | Submit form

Pharmacy and Therapeutics Committee Application

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Type of Application (select one):

☐ Initial Appointment ☑ Reappointment

Position applying for (select category then choose from dropdown):

☐ Health care provider Select One

Other:_____

☐ Members of the public Select One

☐ AHCCCS Managed Care Organizations (MCOs) and Regional Behavioral Health Authority (RBHA) representatives: Select One

CONTACT INFORMATION

Flannigan (LAST) | Kelly (FIRST) | N (MIDDLE)

1 East Washington (ADDRESS) | Phoenix (CITY)

_____ (STATE) | _____ (ZIP) | _____ (COUNTY)

_____ (HOME PHONE) | _____ (OFFICE PHONE) | _____ (MOBILE)

kelly.n.flannigan@uhc.com (EMAIL) | _____ (FAX)

CURRENT EMPLOYMENT
(if applicable)

UnitedHealthcare (BUSINESS/ORGANIZATION NAME) | Regional Pharmacy Director (CURRENT POSITION/TITLE)

1 East Washington (ADDRESS) | Phoenix (CITY)

AZ (STATE) | 85004 (ZIP) | (763) 957-6535 (PHONE)

Professional Licenses, Registrations, Certifications and/or Experience:

Experience with AHCCCS Programs:

Are you currently an AHCCCS registered provider? ☐ Yes ☐ No

Conflict of Interest Disclosure

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Please initial the following:

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Organization*	Role / Relationship*
UnitedHealthcare	Employee

**List additional organizations and role/relationships on additional page(s) if necessary*

Your Attestation

I affirm under penalty of law that the information I have provided on this form is true, accurate, and complete to the best of my knowledge.

Name: Kelly Flannigan

Signature: _____ Date: 10/07/2022

Pharmacy and Therapeutics Committee Application

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Type of Application (select one):

☐ Initial Appointment ☑ Reappointment

Position applying for (select category then choose from dropdown):

☐ Health care provider Select One

Other: _____

☐ Members of the public Select One

☑ AHCCCS Managed Care Organizations (MCOs) and Regional Behavioral Health Authority (RBHA) representatives: MCO Acute Plan Medical Directors or Pharmacy Directors or designees

CONTACT INFORMATION

Cole (LAST) Maria (FIRST) Carolina (MIDDLE)

1850 West Rio Salado Parkway (ADDRESS) Tempe (CITY)

AZ (STATE) 85207 (ZIP) Maricopa (COUNTY)

(HOME PHONE) (OFFICE PHONE) (480) 431-9850 (MOBILE)

mcole@care1staz.com (EMAIL) (FAX)

CURRENT EMPLOYMENT
(if applicable)

Care1st Health Plan Arizona (BUSINESS/ORGANIZATION NAME) Pharmacy Director (CURRENT POSITION/TITLE)

1850 West Rio Salado Parkway (ADDRESS) Tempe (CITY)

AZ (STATE) 85281 (ZIP) (602) 396-8316 (PHONE)

Professional Licenses, Registrations, Certifications and/or Experience:

Experience with AHCCCS Programs:

Are you currently an AHCCCS registered provider? ☐ Yes ☑ No

Conflict of Interest Disclosure

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Organization*	Role / Relationship*

**List additional organizations and role/relationships on additional page(s) if necessary*

Your Attestation

I affirm under penalty of law that the information I have provided on this form is true, accurate, and complete to the best of my knowledge.

Name: Maria C. Cole

Signature: Maria C. Cole Date: 10/04/2022

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Disclosures (select one)

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Organization*	Role / Relationship*

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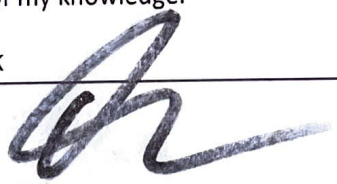
Your Attestation

I affirm under penalty of law that the information I have provided on this form is true, accurate, and complete to the best of my knowledge.

Name: Otto Uhrik

Signature: 

Date: 9/27/2022

Conflict of Interest Disclosure Form

As detailed in the Committee Operational Policy, Committee members and public individuals external to the Committee who provide verbal or written public comment to the Committee shall not:

a. Be employed by, subcontract with, or directly or indirectly represent a pharmaceutical manufacturer,
b. Be employed by, subcontract with, or directly or indirectly represent a pharmacy benefits management (PBM) company,
c. Receive payments or compensation from the pharmaceutical industry in excess of the physician mean general payment amount for the most recent year as specified on openpaymentsdata.cms.gov.

Thus, any individual who meets a., b. or c is not eligible for serving on the Committee or providing external public comment to the Committee.

Please initial the following:
____I am not employed by, subcontract with, or directly or indirectly represent a pharmaceutical manufacturer
____I am not employed by, subcontract with, or directly or indirectly represent a pharmacy benefits management (PBM) company
___I do not receive payments or compensation from the pharmaceutical industry in excess of the physician mean general payment amount of $3,307.06 (2017 openpaymentsdata.cms.gov)

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The existence of such financial relationships or affiliation does not necessarily constitute a

conflict of interest and will not preclude an individual from participating as a Committee member, or, for an individual external to the Committee, from providing verbal or written public comment to the Committee.

Disclosures

X___I do not have a current or recent (within the last 24 months) financial relationship or affiliation with any organization that may have a direct or indirect interest in the business before the Committee.

___I have a financial relationship or affiliation with an organization(s) in the past 24 months that may have a direct or indirect interest in the business before the Committee. ***Please complete table below.***

Organization*	Role / Relationship*

**List additional organizations and role/relationships on additional page(s) if necessary*

I affirm under penalty of law that the information I have provided on this form is true, accurate, and complete to the best of my knowledge.

Name: Raul Romero, M.D.

Signature: _____

Date: 4/29/2019

Submit

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I affirm under penalty of law that the information I have provided on this form is true, accurate, and complete to the best of my knowledge.

Name: Paul Romero MD

Signature: _____

Date: 9/25/19

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Name: Paul Romero MD

Signature: _____

Date: 9/25/19

AHCCCS
Arizona Health Care Cost Containment System

Conflict of Interest Disclosure

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Disclosures (select one)

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Organization*	Role / Relationship*

**List additional organizations and role/relationships on additional page(s) if necessary*

Your Attestation

I affirm under penalty of law that the information I have provided on this form is true, accurate, and complete to the best of my knowledge.

Name: Sandra Brownstein

Signature: Sandra Brownstein Date: 10/14/22

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Name: Raul Romero, M.D.

Signature: _____

Date: 4/29/2019

Submit