

Conflict of Interest Disclosure

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- 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 not eligible for serving on the Committee or providing external public comment to the Committee.

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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: Aida E. Amado, ACNP

Signature: 

Date: 10/11/2022

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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: Aimee Schwartz, MD

Signature:  Type text here

Date: 09/27/2022

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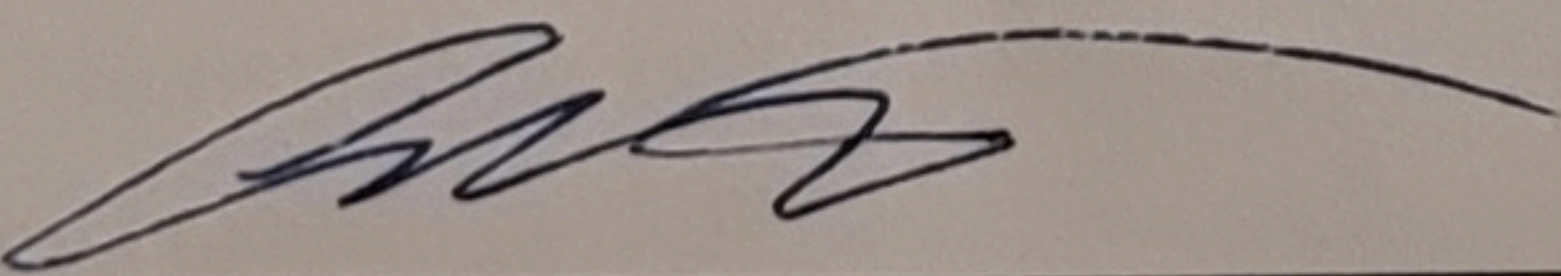
Organization*	Role / Relationship*
Walgreens	Pharmacy manager

**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

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Name: _____

Signature:  _____

Date: _____

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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

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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: Hyun Jung (Evelyn) Kim

Signature: Hyun Jung Kim Digitally signed by Hyun Jung Kim
Date: 2022.10.14 10:33:03 -07'00'

Date: _____

Reset form

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Organization*	Role / Relationship*
UnitedHealthcare	Employee

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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: Kelly Flannigan

Signature: _____ Date: 10/07/2022

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Name: Maria C. Cole

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

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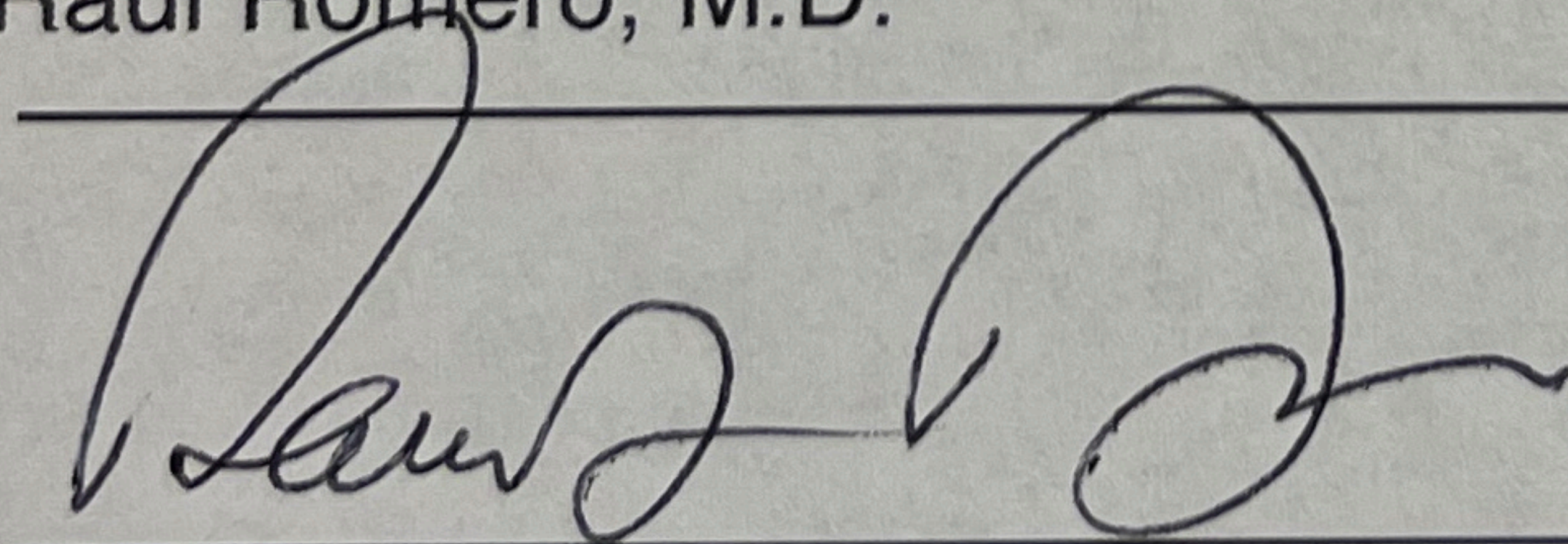
Organization*	Role / Relationship*

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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: Raul Romero, M.D.

Signature: 

Date: 10/17/2022

Reset form

Save form

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Name: Otto Uhrik

Signature: 

Date: 9/27/2022

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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: Sandra Brownstein

Signature: Sandra Brownstein Date: 10/14/22