Ready Meds Pharmacy
Renton • Spokane • Lacey • Everett

1412 SW 43RD STREET · Suite 120 · Renton, WA 98057
·Phone (877) 425-MEDS (6337) www.readymedspharmacy.com
·Fax (877) 509-MEDS (6337) newadmit@readymedspharmacy.com

If you are interested in Ready Meds Pharmacy administering flu/pneumonia vaccines at your facility, please return this letter with the attached informed consent forms completed for each client via fax within 2 weeks. Flu/Pneumonia shots are available through Medicare Part B at no charge. We can bill private insurance or Medicare Advantage Plans but there may be an applicable co-pay. Please check with your client's pharmacy insurance carrier if you have any questions on his or her copay.

If your client does not have insurance or his/her insurance does not cover the flu vaccine, our prices are as followed:

- Flu shots are $45.00
- High Dose flu shots are $75.00
- Pneumonia shots are $135.00
- Prevnar shots are $230.00

We have a limited amount of high dose flu shots (Fluzone High-Dose) for patients 65+ available this year. Please inquire about availability. High dose flu shots are first come, first serve.

We cannot bill Medicare Part B, or Medicare Advantage plans for Hospice patients. Claims for hospice patients in previous years were all denied. If you have a hospice patient, the only form of payment we can accept is cash.

CDC currently recommends people 65 and older receive both Pneumovax-23 and Prevnar-13 vaccines. Some patients under 65 with certain medical conditions may qualify. Please inquire with the pharmacy regarding patient specific needs. Please only check one pneumonia box as both vaccines cannot be given at the same time. If your clients are 65 and over and have previously received both of these pneumonia vaccines, they may still require revaccination with Pneumovax-23. Inquire with the pharmacy regarding patient specific needs.

Please have all payments ready on the day of your vaccination visitation. You may also prepay by calling our pharmacy up to 1 day prior to your appointment. We are not able to include the cost of vaccination on your client's AR account with the pharmacy.

Because of the high volume of requests we get from our facilities, we will only be able to visit each home once this flu season. We will try our best to schedule your visitation on a day where all your clients are present. If for any reason one or more of your clients are not available on your visitation date, they will need to find another way to get their vaccine. We are sorry for any inconvenience this may cause you.

(See additional COVID-19 pandemic information on the back of this sheet)

Name of Facility

Address

Phone Number (Contact Name)

Total number of clients receiving vaccination

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Flu/Pneumonia Vaccine COVID-19 Addendum

Due to the ongoing COVID-19 pandemic in Washington State, additional steps and safe guards are being put in place to protect our patients, caregivers, and pharmacy staff. We appreciate your understanding during this difficult time as we work together to continue to provide uninterrupted immunization services in a safe manner.

Face masks/coverings will be required for all staff, patients, and pharmacy staff during vaccine administration. Our pharmacists will also wear face shields, gloves, and gowns as part of enhanced infection control measures this season. Unless actively providing immunization, social distancing of at least 6 feet apart will be maintained.

Our flu shot coordinators will work with your team in advance to prepare for a successful visit with a goal of completing visits in as little as 15 minutes to minimize exposure to all parties. In addition to vaccination screening questions included in previous years, each patient will also be asked the following COVID-19 specific questions:

1. Do you currently or have you in the past 14 days, experienced the new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea?

2. In the past two weeks, have you had contact with someone who tested positive for COVID-19?

One day prior to your scheduled vaccination visit, our flu shot coordinators will reach out via phone to complete screening questions, and review the enhanced infection control measures outlined above. Coordinators will verify an answer of "No" to both COVID-19 specific screening questions as it pertains to all members of the home. **A flu shot coordinator will gladly reschedule a visit at a later date if any of the screening questions are answered with "Yes".** On the day of the visit, the pharmacist providing vaccination will contact the home on the way to the location to remind them of their appointment, review infection control measures, and complete screening questions. In an effort to promote contactless completion of screening questions on the day of the visit, caregivers will be asked to digitally complete a copy of the screening questions on site. **Access to the questions listed above will be provided through a scannable *QR Code* shown below or via a link sharable through email/phone.**

Thank you for partnering with our pharmacy team in providing annual immunizations to include these additional safety measures. We do so in the interest of the health and well-being of all of our clients, caregivers, and staff.

SCAN THE QR CODE ON YOUR PHONE OR TABLET TO GAIN ACCESS TO THE FORM

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Date:_______________

☐ Flu Shot ☐ High Dose Flu ☐ Prevnar 13 ☐ Pneumovax 23

☐ Medicare # ☐ Other Insurance (provide copy of card) ☐ Private Pay (have cash/check ready)

Name:____________________________ DOB:________________________ Sex: ☐ M ☐ F
Phone #:_____________

Allergies:____

The following questions will help us determine which vaccines you may be given today. If you answer "YES" to any questions, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

		YES	NO	DON'T KNOW
1.	Do you have allergies to medications, food or any vaccine?	☐	☐	☐
2.	Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
3.	Do you have a long-term health problem with heart disease, lung disease, asthma kidney disease, metabolic disease (i.e. diabetes), anemia, or other blood disorder?	☐	☐	☐
4.	Do you have cancer, leukemia, AIDS, or any other immune system problem?	☐	☐	☐
5.	Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	☐	☐	☐
6.	Have you had a seizure, brain, or other nervous system problem?	☐	☐	☐
7.	During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
8.	For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
9.	Have you received any vaccinations in the past 4 weeks?	☐	☐	☐
	COVID-19 Screening questionnaire for immunization			
1.	Do you currently or have you in the past 14 days, experienced the new onset of a fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea?	☐	☐	☐
2.	In the past two weeks, have you had contact with someone who tested positive for COVID-19?	☐	☐	☐

Please read the following statements and sign below on the signature line.

I have read or have had explained the information provided about the vaccine I am about to receive. I have received and read a vaccine information statement. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of vaccination and ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request. Medicare, I do hereby authorize Ready Meds Pharmacy to release information and request payment. I certify that the information given by me in applying for payment under Medicare is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

X____ Date: __________________
Signature of person to receive vaccine or person authorized to make request (parent or guardian)

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For office use only

Vaccine	Vaccine	Vaccine
Lot: #	Lot: #	Lot: #
Mfr.	Mfr.	Mfr.
Date on VIS	Date on VIS	Date on VIS
Site	Site	Site
Date given	Date given	Date given

X____ Date: __________________
Signature of Administrator