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 completed for each client via fax within 2 weeks. Flu/Pneumonia shots are available through Original Medicare at no charge. We can bill private insurances 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 flu vaccination, 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
- Other shots Please inquire

We have a limited amount of High Dose flu shots available this year, please inquire about availability. High Dose flu shots are first come, first serve.

Our Suppliers do not carry "Preservative Free" shots.

We cannot bill Original Medicare or Medicare Advantages plans for Hospice patients. Claims for hospice patients 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 over get both Pneumovax 23 and Prevnar 13 vaccines. Some patients under 65 with certain medical conditions may qualify. Please inquire with the pharmacy. 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 ever received either of these pneumonia vaccines, they no longer need the pneumonia shots per CDC recommendations.

Please have payment ready on the day of your flu shot visitation. You may also prepay by calling our pharmacy up to 1 day prior to your visitation. 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.

Name of Facility

Address

Phone Number (Contact Name)

Total number of clients receiving vaccination

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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:____ ___Ethnicity ____________________

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

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Risk Group	Underlying Medical Condition	PCV13	PPSV23	
		Recommended	Recommended	Revaccination at 5 years after first dose
Immunocompetent persons	Chronic Heart disease		✓	
	Chronic Lung disease		✓	
	Diabetes mellitus		✓	
	CSF leaks	✓	✓	
	Cochlear implants	✓	✓	
	Alcoholism		✓	
	Chronic liver disease		✓	
	Cigarette smoking		✓	
Persons with functional or anatomic asplenia	Sickle cell disease/other hemoglobinopathies	✓	✓	✓
	Congenital or acquired asplenia	✓	✓	✓
Immunocompromised Persons	Congenital or acquired immunodeficiencies	✓	✓	✓
	HIV infection	✓	✓	✓
	Chronic renal failure	✓	✓	✓
	Nephrotic syndrome	✓	✓	✓
	Leukemia	✓	✓	✓
	Lymphoma	✓	✓	✓
	Hodgkin disease	✓	✓	✓
	Generalized malignancy	✓	✓	✓
	Solid organ transplant	✓	✓	✓
	Multiple myeloma	✓	✓	✓