Ready Meds Pharmacy

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

If you are interested in Ready Meds Pharmacy administering flu/pneumonia/COVID-19 vaccines at your facility, please return this letter with the attached informed consent completed for each client via fax within 2 weeks. Flu/Pneumonia/COVID-19 shots are available through Original Medicare at no charge. ***Please clearly mark off all vaccinations that are to be administered***. We can bill private insurance or Medicare Advantage Plans. These plans may have applicable co-pays. 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 vaccinations, our prices are as followed:

- Flu vaccine $ 50.00
- High Dose vaccine $100.00
- Prevnar 20 vaccine $300.00
- COVID-19 Vaccine $200.00
- Other vaccinations 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. If you have a hospice patient, the only form of payment we can accept is cash.

This year we are excited to be offering Prevnar 20. The eligibility conditions are below:

- Vaccinated at least one year ago with Pneumovax 23
- Never received a pneumonia vaccination or vaccination history is unknown and:
  - 65+ years of age
  - 19-64yo with conditions or risk factors listed by CDC (See full list on next page)

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 visit. 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/COVID-19 season. ***If all vaccinations are available, they will all be administered at the same visit.*** 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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CDC recommends pneumococcal vaccination for:

Adults 65 years old and older
Adults 19 through 64 years old with certain underlying medical conditions or risk factors listed below:

Alcoholism
Cerebrospinal fluid leak
Chronic heart disease, including congestive heart failure and cardiomyopathies
Chronic liver disease
Chronic lung disease, including chronic obstructive pulmonary disease, emphysema, and asthma
Chronic renal failure
Cigarette smoking
Cochlear implant
Congenital or acquired asplenia
Congenital or acquired immunodeficiency
B- (humoral) or T-lymphocyte deficiency
Complement deficiency, particularly C1, C2, C3, or C4 deficiency
Phagocytic disorder, excluding chronic granulomatous disease
Diabetes mellitus
Generalized malignancy
HIV infection
Hodgkin disease
Iatrogenic immunosuppression, including long-term systemic corticosteroids and radiation therapy
Leukemia
Lymphoma
Multiple myeloma
Nephrotic syndrome
Sickle cell disease or other hemoglobinopathies
Solid organ transplant

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Date:_____

☐ Flu Shot	☐ High Dose Flu	☐ Prevnar 20	☐ COVID-19

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

Name:_____ DOB:_____ Sex: ☐ M ☐ F

Phone #:_____

Allergies:_____ Race _____

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?	☐	☐	☐
10. Have you ever received any pneumonia vaccinations? ☐ Yes? ☐ No?: Date received?_____			
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)

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

Date of Revision: 08/2025