



1412 SW 43RD STREET · Suite 120 · Renton, WA 98057

· (877) 425-6337 Phone

· (877) 509-6337 Fax

www.readymedspharmacy.com

readymedspharmacy@gmail.com

www.facebook.com/readymedspharmacy

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 \$80.00
- Prevnar 20 shots are \$270.00
- 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. 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 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



1412 SW 43RD STREET · Suite 120 · Renton, WA 98057

· (877) 425-6337 Phone

· (877) 509-6337 Fax

www.readymedspharmacy.com

readymedspharmacy@gmail.com

www.facebook.com/readymedspharmacy

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



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

Date: _____

<input type="checkbox"/> Flu Shot	<input type="checkbox"/> High Dose Flu	<input type="checkbox"/> Prevnar 20
<input type="checkbox"/> Medicare #	<input type="checkbox"/> Other Insurance (Provide copy of card)	<input type="checkbox"/> 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever had a serious reaction after receiving a vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have cancer, leukemia, AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had a seizure, brain, or other nervous system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you received any vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever received the immunization below: <input type="checkbox"/> Pneumovax 23? Date _____? <input type="checkbox"/> Prevnar 13? Date _____?			
COVID-19 Screening questionnaire for immunization			
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?			
1. In the past two weeks, have you had contact with someone who tested positive for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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