Vaccine Administration Record (VAR)

Informed Consent for Vaccination in Long Term Care Facility (LTCF)

☐ **Resident** ☐ **Staff** ☐ **Other**

SECTION A-1 Please print clearly.

First name:____________________ **Last name:**____________________

Date of birth:__________ **Age:**______ **Gender:** ☐ Female ☐ Male ☐ Unk/Undftd **Phone:**________________

Race: ________________ ☐ Unknown **Ethnicity:** ________________ ☐ Unknown

LTCF Name:____________________ **Address:**____________________

City:________ **State:**______ **ZIP code:**________ **Patient Email address:**________________

I want to receive the following vaccination(s): ☐ **COVID-19 Vaccination** ☐ **Influenza Vaccination** ☐ **Other Vaccination:** ____________

SECTION A-2 I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient; or (c) a person authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves. Further, I hereby give my consent to PharMerica Corporation and the licensed healthcare professional administering the vaccine, as applicable (each an “applicable Provider”), to administer the vaccine(s)) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the Vaccine Information Sheet (VIS) or EUA Fact Sheet on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised that the patient should remain near the vaccination location for observation for approximately 15 minutes after administration. On behalf of the patient, the patient’s heirs and personal representatives, I hereby release and hold harmless each applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above.

I acknowledge that: (a) I understand the purposes/benefits of my state’s vaccination registry (“State Registry”) and my state’s health information exchange (“State HIE”); and (b) the applicable Provider may disclose my vaccination information to the State Registry, to the State HIE, or through the State HIE to the State Registry, or to any state or federal governmental agencies or authorities (“Government Agencies”), such as state, county, or local Departments of Health or the federal Department of Health and Human Services, the Center for Disease Control and Prevention, or their respective designees as may be required by law, for purposes of public health reporting, or to my healthcare providers enrolled in the State Registry and/or State HIE for purposes of care coordination. I acknowledge that, depending upon my state’s law, I may prevent, by using a state-approved opt-out form or, as permitted by my state law, an opt-out form (“Opt-Out Form”) furnished by the applicable Provider: (a) the disclosure of my vaccination information by the applicable Provider to the State HIE and/or State Registry; or (b) the State HIE and/or State Registry from sharing my vaccination information with any of my other healthcare providers enrolled in the State Registry and/or State HIE. The applicable Provider will, if my state permits, provide me with an Opt-Out Form. I understand that, depending on my state’s law, I may need to specifically consent, and, to the extent required by my state’s law, by signing below, I hereby do consent to the applicable Provider reporting my vaccination information to the Government Agencies, State HIE, or through the State HIE and/or State Registry to the entities and for the purposes described in this Informed Consent form. Unless I provide the applicable Provider with a signed Opt-Out Form, I understand that my consent will remain in effect until I withdraw my permission and that I may withdraw my consent by providing a completed Opt-Out Form to the applicable Provider and/or my State HIE, as applicable.

I understand that even if I do not consent or if I withdraw my consent, my state’s laws or federal law may permit certain disclosures of my vaccination information to or through the State HIE or to Government Agencies as required or permitted by law. I further authorize the applicable Provider to: (a) release my medical or other information, including any communicable disease (including HIV), and mental health information, to, or through, the State HIE or Government Agencies to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment; (b) submit a claim to my insurer for the above requested items and services; and (c) request payment of authorized benefits be made on my behalf to the applicable Provider with respect to the above requested items and services. I further agree to be fully financially responsible for any cost-sharing amounts, including copays, coinsurance and deductibles, for the requested items and services, as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service or, if the applicable Provider invoices me after the time of service, upon receipt of such invoice. PharMerica Corporation may disclose your vaccination information from this visit for public health purposes and will send this information to the Medical Director or Administrator of the LTCF identified above. If you are an employee of the LTCF, PharMerica Corporation will send your vaccination information to your employer as required. I hereby acknowledge that I have received PharMerica's Notice of Privacy Practices.

Print Name: ________________ **Patient/Authorized Person signature:**________________ **Date:**________

SECTION B-1 **SCREENING QUESTIONS**. The following questions will help us determine your eligibility to be vaccinated today.

1. Have you received a previous dose of COVID-19 vaccine? ☐ Yes ☐ No ☐ Don’t know
2. Do you feel sick today? ☐ Yes ☐ No ☐ Don’t know
3. In the last 10 days, have you had a COVID-19 test, been exposed to an individual with COVID-19, or traveled? ☐ Yes ☐ No ☐ Don’t know
4. Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days? ☐ Yes ☐ No ☐ Don’t know
5. Do you have allergies to latex, medications, food, vaccines or any component of vaccines (examples: Polyethylene glycol (PEG) or polysorbate). If yes, please list: ________________ ☐ Yes ☐ No ☐ Don’t know
6. Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy? ☐ Yes ☐ No ☐ Don’t know
7. Do you have a bleeding disorder or are you on a blood thinner? ☐ Yes ☐ No ☐ Don’t know
8. **For women of childbearing age**: Are you pregnant or considering becoming pregnant in the next month? ☐ Yes ☐ No ☐ Don’t know

Recipient Name: ______________________________

SECTION B-2 I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient or representative of; or (c) a representative of the LTCF and, based upon clinical observation, have sufficient knowledge of the patient's condition to answer the Screening Questions. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.

Patient/LTCF Representative: ______________________________ **Date:** ______________

Responsible Party: ______________________________ **Date:** ______________

SECTION B-3 **Check any known conditions the patient has:**

☐ **Blood Disorder** ☐ **Cancer** ☐ **Chronic Lung Disease (e.g. COPD, asthma, etc)** ☐ **Diabetes** ☐ **Heart Disease** ☐ **High Blood Pressure**

☐ **Immunocompromised** ☐ **Kidney Disease** ☐ **Liver Disease** ☐ **Overweight (BMI ≥25 kg/m²)/Obesity (BMI ≥30 kg/m²)** ☐ **Pregnancy** ☐ **Other***

***I attest that I am at high risk of severe COVID-19 disease as defined by the CDC and am eligible for an additional COVID dose** ______________________
Signature

SECTION B-4 **COVID-19 Vaccine Tracking History (*Pfizer booster dose only authorized if patient received 2 doses of Pfizer as initial vaccine series*)**

Dose 1 ____________/____________ **Dose 2** ____________/____________
Date/Manufacturer Date/Manufacturer

SECTION C INSURANCE – PATIENT TO COMPLETE IF APPLICABLE

Please ensure to record BOTH pharmacy AND medical insurance information since there are multiple ways immunizations can be billed.

Non-Medicare:	Pharmacy Card	Medical Card
Plan Name:		
Insurance Plan/Plan ID:		
Member/Recipient ID #:		
RX BIN:		
RX PCN:		
Group Number:		
Plan Phone Number:		

Medicare:	Medicare Part B
Medicare Number*:	

*Medicare Claim Number for cards distributed earlier than 2018.

Please provide a photocopy of both sides of your insurance cards and identification.

For residents - Please provide a Face Sheet with relevant demographics and insurance information.

☐ **Uninsured**

Is the patient the cardholder? ☐ Yes ☐ No
If no, please provide cardholders name, date of birth (MM/DD/YYY) and relationship: ______________________

SECTION D

Complete AFTER vaccine administration

COVID-19 Vaccine Manufacturer	Expiration	Lot Number	Dosage	Site of administration	EUA Fact Sheet/VIS date
				☐ **L** Deltoid ☐ **R** Deltoid ☐ Other:	

☐ Dose 1 ☐ Dose 2 ☐ Dose 3 - Immunocompromised ☐ Dose 3 - Booster

Clinician's name (print): ______________ **Clinician's signature:** ______________ **Title:** ______________

If applicable, intern/tech name (print): ______________ **Administration date:** ______________ **Date EUA Fact Sheet/VIS given to patient:** ______

Influenza Vaccine Manufacturer	Expiration	Lot Number	Dosage	Site of administration	VIS published date
				☐ **L** Deltoid ☐ **R** Deltoid ☐ Other:	

Clinician's name (print): ______________ **Clinician's signature:** ______________ **Title:** ______________

If applicable, intern/tech name (print): ______________ **Administration date:** ______________ **Date VIS given to patient:** ______________

Other Vaccine:	Expiration	Lot Number	Dosage	Site of administration	VIS published date
Manufacturer:				☐ **L** Deltoid ☐ **R** Deltoid ☐ Other:	

Clinician's name (print): ______________ **Clinician's signature:** ______________ **Title:** ______________

If applicable, intern/tech name (print): ______________ **Administration date:** ______________ **Date VIS given to patient:** ______________

1. Update the patient's record with any new allergy, health condition or primary care provider information.
2. Enter vaccine lot #, expiration date and site of administration, then scan the VAR form into the patient's record.

St. Teresa Rehabilitation and Nursing Center
Bishop Primeau Senior Living Community
519 Bridge Street
Manchester, NH 03104
T: 603-668-2373
F: 603-668-0059
stteresarehabcenter.org

September 29, 2021

Hello Residents, staff and families!

Happy fall, the weather is changing and we are decorating…. The loft has transformed to our fall festival, leaves are chasing on our windows and hallways and doors are festive. Our sun worshippers still get out in the sun when they can.

We will be reaching out to get consents for both vaccines. I am attaching a presentation from our pharmacy about the **Pfizer** Booster for those who have had the **Pfizer** doses more than 6 months ago. Most of our residents and tenants of BPA receive their Pfizer 2nd dose either 1/18 or 2/8. They are all eligible to receive a booster at this time. We are making this available to our staff as well. The booster is only applicable to those who received the **Pfizer** vaccination.

The other document I have attached is the VAR or vaccination administration record that needs to be signed for or by those receiving the booster. Please call if you have any questions about the flu or Pfizer booster.

Time to pull out the jackets. Stay safe. NH and Hillsborough County remain in HIGH transmission. We are testing the few remaining staff who have only had one dose twice a week, Mondays and Thursdays. By the end of October, I will only have one staff member, who had a month extension granted, who will need to be tested. We are requiring all new hires to have had at least one dose before they start. We are well on our way to be fully vaccinated.

If you know of anyone who would like to join our Culinary team, or housekeeping, please send our way! Also, looking for a hairdresser! I have one that will help us out in October, but send interested parties my way.

Kindly,

Luanne Rogers, LNHA
Administrator
St. Teresa Rehabilitation and Nursing Center
519 Bridge Street
Manchester, NH 03104
(603)668-2373 x 4680
(603)668-0059 FAX

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COVID-19 Booster Vaccine – Pfizer-BioNTech

Timeline

- On 9/17/2021 – FDA's advisory committee, VRBPAC, unanimously *recommends* a booster (3rd dose) of Pfizer's mRNA vaccine at least 6 months after the second dose for
  - Individuals aged 65 years or older
  - Individuals at high risk of severe COVID-19
- On 9/22/2021 – FDA authorizes a single booster dose at least 6 months after the second dose for
  - Individuals aged 65 years or older
  - Individuals aged 18-64 at high risk of severe COVID-19
  - Individuals aged 18-64 whose frequent institutional or occupational exposure to SARS-CoV-2 puts them at high risk of serious complications of COVID-19 including severe COVID-19
- On 9/23/2021 – CDC's advisory committee, ACIP, meets and…

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COVID-19 Booster Vaccine – Pfizer-BioNTech

Timeline

- On 9/23/2021 – ACIP meets and ***recommends*** a single booster (3rd dose) of Pfizer's mRNA vaccine at least 6 months after the second dose of a ***Pfizer 2 dose series*** for
  - Individuals ≥ 65 years old and those residing in LTCFs
  - Individuals aged 50-64 years old with underlying medical conditions
  - Individuals aged 18-49 years old with underlying medical conditions may receive a booster based on their individual benefits and risks
- On 9/24/2021 – CDC approves a single booster (3rd dose) of Pfizer's mRNA vaccine at least 6 months after the second dose of a ***Pfizer 2 dose series*** for
  - ***Should*** receive:
    - Individuals ≥ 65 years old and those residing in LTCFs
    - Individuals aged 50-64 years old with underlying medical conditions
  - ***May*** receive:
    - Individuals aged 18-49 years old with underlying medical conditions based on their individual benefits and risks
    - Healthcare and frontline workers ≥ 18 years whose frequent institutional or occupational exposure to SARS-CoV-2 puts them at high risk of serious complications of COVID-19 including severe COVID-19
      - Added by CDC Director to align with FDA's Emergency Use Authorization

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COVID-19 Vaccines – EUAs as of 9/23/21

- Pfizer-BioNTech
  - 2-dose series for primary vaccination to prevent COVID-19 in individuals ≥ 12 years old administered 21 days apart
  - Third dose to individuals ≥ 12 years old who have been determined to have certain kinds of immunocompromise at least 28 days after second dose
  - A single booster dose at least 6 months after second dose in
    - Individuals aged 65 years or older
    - Individuals aged 18-64 at high risk of severe COVID-19
    - Individuals aged 18-64 whose frequent institutional or occupational exposure to SARS-CoV-2 puts them at high risk of serious complications of COVID-19 including severe COVID-19
- Moderna
  - 2-dose series for primary vaccination to prevent COVID-19 in individuals ≥ 18 years old administered 28 days apart
  - Third dose to individuals ≥ 18 years old who have been determined to have certain kinds of immunocompromise at least 28 days after second dose
- J&J
  - Single dose for primary vaccination to prevent COVID-19 in individuals ≥ 18 years old

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Frequently Asked Questions

Q: If we need a booster shot, does that mean that the vaccines aren't working?

A: No. COVID-19 vaccines are working well to prevent severe illness, hospitalization, and death, even against the widely circulating Delta variant. However, public health experts are starting to see reduced protection, especially among certain populations, against mild and moderate disease.

Q: What should people who received Moderna or Johnson & Johnson's Janssen vaccine do?

A: The Advisory Committee on Immunization Practices (ACIP) and CDC's recommendations are bound by what the U.S. Food and Drug Administration's (FDA) authorization allows. **At this time, the Pfizer-BioNTech booster authorization only applies to people whose primary series was Pfizer-BioNTech vaccine.**

People in the recommended groups who got the Moderna or J&J/Janssen vaccine will likely need a booster shot. More data on the effectiveness and safety of Moderna and J&J/Janssen booster shots are expected in the coming weeks.

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Frequently Asked Questions

Q: What are the risks to getting a booster?

A: For many who have completed their primary series with Pfizer-BioNTech vaccine, the benefits of getting a booster shot outweigh the known and potential risks. So far, reactions reported after the third Pfizer-BioNTech shot were similar to that of the 2-shot primary series.

Fatigue and pain at the injection site were the most commonly reported side effects, and overall, most side effects were mild to moderate. However, as with the 2-shot primary series, serious side effects are rare, but may occur.

Q: Does this change the definition of "fully vaccinated" for those eligible for booster shots?

A: People are still considered fully vaccinated two weeks after their second dose in a 2-shot series, such as the Pfizer-BioNTech or Moderna vaccines, or two weeks after a single-dose vaccine, such as the J&J/Janssen vaccine. This definition applies to all people, including those who receive an additional dose as recommended for moderate to severely immunocompromised people and those who receive a booster shot.

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Frequently Asked Questions

Q: Can you explain these "permissive" recommendations related to people 18 to 49 with underlying medical conditions, and people 18 to 64 who may be exposed due to occupational/institutional setting? How are these different from the other two recommendations?

A: Adults 18–49 who have underlying medical conditions are at increased risk for severe illness from COVID-19, as are people 18-64 are in an occupational or institutional setting where the burden of COVID-19 infection and risk of transmission are high. However, that risk is likely not as high as it would be for adults 50 years and older who have underlying medical conditions, or people who live in long-term care settings. With the lower risk, the data do not support that everyone who falls into this group should get a booster shot.

Therefore, CDC's recommendation is not as strong for these populations, but still allows a booster shot to be available for those who would like to get one. People 18 and older who are at high risk for severe COVID-19 due to underlying medical conditions or their occupation should consider their individual risks and benefits when making the decision of whether to get a booster shot. This recommendation may change in the future as more data become available.

Link to CDC's list of underlying medical conditions:

https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html

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Frequently Asked Questions

Q: Will providers accept anyone who says they're eligible to receive a booster shot? Will people need to show a doctor's note/prescription or other documentation?

A: It's important to note that individuals can self-attest (i.e. self-report that they are eligible) and receive a booster shot wherever vaccines are offered. This will help ensure there are not additional barriers to access for these select populations receiving their booster shot.

Our updated VAR has a self-attestation in **Section B-3**

SECTION B-3 Check any known conditions the patient has:

☐ **Blood Disorder** ☐ **Cancer** ☐ **Chronic Lung Disease (e.g. COPD, asthma, etc)** ☐ **Diabetes** ☐ **Heart Disease** ☐ **High Blood Pressure**

☐ **Immunocompromised** ☐ **Kidney Disease** ☐ **Liver Disease** ☐ **Overweight (BMI ≥25 kg/m²)/Obesity (BMI ≥30 kg/m²)** ☐ **Pregnancy** ☐ **Other***

*I attest that I am at high risk of severe COVID-19 disease as defined by the CDC and am eligible for an additional COVID dose ____________________
Signature

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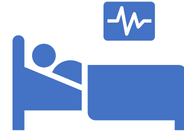
Vaccine Program Strategy…

Skilled Nursing Facilities

PMC Maintenance Program

Facilities are strongly encouraged to have a subcontractor agreement in place for easy vaccine delivery



Assisted Living Facilities

Walgreens Led Clinics

Facilities are strongly encouraged to use the Walgreens Led Clinics to assist with timely vaccine administration

IDD Facilities

Walgreens Led Clinics / Health Departments

Due to the low volume structure, IDD Facilities are strongly encouraged to use the Walgreens Led Clinics or a local Health Department to assist with vaccine administration

PMC Immunization

PMC Led Clinics*

PMC Led Clinics should only be used on an exception basis, as vaccine administration will be dependent on PMC resource availability

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Vaccine Program Order Form

The COVID-19 Weekly Vaccine Order form has been updated to help guide facilities as to which vaccines are authorized for which use.

- Primary Series
- 3rd Dose for Immunocompromised
  - 28 days after second dose of primary series
- Booster Dose
  - 6 months after second dose of primary series
  - For those individuals who received primary series of Pfizer ONLY

PharMerica

COVID-19 WEEKLY VACCINE ORDER

PLEASE CONTACT PHARMACY WEEKLY FOR AVAILABILITY

Orders must be returned by **Monday at 6pm EST** for **Thursday** Delivery.
(Recognized Monday holidays will push order submission deadline to Tuesday at 9am EST).

Any orders after cut off will be fulfilled with following week's order.

Primary Series

☐ PFIZER DOSES NEEDED: ____________
☐ MODERNA DOSES NEEDED: ____________
☐ JANSSEN DOSES NEEDED: ____________

3rd Dose for Immunocompromised Individuals (28 days after second dose)

☐ PFIZER DOSES NEEDED: ____________
☐ MODERNA DOSES NEEDED: ____________

Booster Dose (6 months after second dose)

☐ PFIZER DOSES NEEDED: ____________

Date: ____________

Facility Name (acct # opt): ____________

Servicing Pharmacy/State: ____________

Sender's Name: ____________

Sender's Phone: ____________

Total # Pages (including cover page): ____________

THIS DOCUMENT MAY CONTAIN CONFIDENTIAL OR PROPRIETARY INFORMATION, INCLUDING PATIENT HEALTH INFORMATION THAT IS PROTECTED UNDER HIPAA AND OTHER STATE AND FEDERAL CONFIDENTIALITY LAWS. PLEASE DELIVER IMMEDIATELY ONLY TO THE INTENDED RECIPIENT. IF THIS TRANSMISSION WAS RECEIVED IN ERROR, PLEASE CONTACT THE SENDER IMMEDIATELY AND DO NOT DISTRIBUTE THE INFORMATION TO ANY OTHER PERSON.

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Vaccine Administration Record (VAR) Updates

Vaccine Administration Record (VAR)
Informed Consent for Vaccination in Long Term Care Facility (LTCF)

PharMerica

☐Resident ☐ Staff ☐ Other

SECTION A-1 Please print clearly.

First name: ______ **Last name:** ______

Date of birth: ______ **Age:** ______ **Gender:** ☐Female ☐ Male ☐ Unk/Undfd **Phone:** ______

Race: ______ ☐ Unknown **Ethnicity:** ______ ☐ Unknown

LTCF Name: ______ **Address:** ______

City: ______ **State:** ______ **ZIP code:** ______ **Patient Email address:** ______

I want to receive the following vaccination(s): ☐**COVID-19 Vaccination** ☐**Influenza Vaccination** ☐**Other Vaccination:** ______

SECTION A-2 I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient; or (c) a person authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves. Further, I hereby give my consent to PharMerica Corporation and the licensed healthcare professional administering the vaccine, as applicable (each an "applicable Provider"), to administer the vaccine(s)) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the Vaccine Information Sheet (VIS) or EUA Fact Sheet on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised that the patient should remain near the vaccination location for observation for approximately 15 minutes after administration. On behalf of the patient, the patient's heirs and personal representatives, I hereby release and hold harmless each applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above.

I acknowledge that: (a) I understand the purposes/benefits of my state's vaccination registry ("State Registry") and my state's health information exchange ("State HIE"); and (b) the applicable Provider may disclose my vaccination information to the State Registry, to the State HIE, or through the State HIE to the State Registry, or to any state or federal governmental agencies or authorities ("Government Agencies"), such as state, county, or local Departments of Health or the federal Department of Health and Human Services, the Center for Disease Control and Prevention, or their respective designees as may be required by law, for purposes of public health reporting, or to my healthcare providers enrolled in the State Registry and/or State HIE for purposes of care coordination. I acknowledge that, depending upon my state's law, I may prevent, by using a state-approved opt-out form or, as permitted by my state law, an opt-out form ("Opt-Out Form") furnished by the applicable Provider: (a) the disclosure of my vaccination information by the applicable Provider to the State HIE and/or State Registry; or (b) the State HIE and/or State Registry from sharing my vaccination information with any of my other healthcare providers enrolled in the State Registry and/or State HIE. The applicable Provider will, if my state permits, provide me with an Opt-Out Form. I understand that, depending on my state's law, I may need to specifically consent, and, to the extent required by my state's law, by signing below, I hereby do consent to the applicable Provider reporting my vaccination information to the Government Agencies, State HIE, or through the State HIE and/or State Registry to the entities and for the purposes described in this Informed Consent form. Unless I provide the applicable Provider with a signed Opt-Out Form, I understand that my consent will remain in effect until I withdraw my permission and that I may withdraw my consent by providing a completed Opt-Out Form to the applicable Provider and/or my State HIE, as applicable.

I understand that even if I do not consent or if I withdraw my consent, my state's laws or federal law may permit certain disclosures of my vaccination information to or through the State HIE or to Government Agencies as required or permitted by law. I further authorize the applicable Provider to: (a) release my medical or other information, including any communicable disease (including HIV), and mental health information, to, or through, the State HIE or Government Agencies to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment; (b) submit a claim to my insurer for the above requested items and services; and (c) request payment of authorized benefits be made on my behalf to the applicable Provider with respect to the above requested items and services. I further agree to be fully financially responsible for any cost-sharing amounts, including copays, coinsurance and deductibles, for the requested items and services, as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service or, if the applicable Provider invoices me after the time of service, upon receipt of such invoice. PharMerica Corporation may disclose your vaccination information from this visit for public health purposes and will send this information to the Medical Director or Administrator of the LTCF identified above. If you are an employee of the LTCF, PharMerica Corporation will send your vaccination information to your employer as required. I hereby acknowledge that I have received PharMerica's Notice of Privacy Practices.

Print Name: ______ **Patient/Authorized Person signature:** ______ **Date:** ______

SECTION B-1 **SCREENING QUESTIONS.** The following questions will help us determine your eligibility to be vaccinated today.

1. Have you received a previous dose of COVID-19 vaccine? ☐Yes ☐No ☐Don't know
2. Have you had any vaccines in the past 14 days? ☐Yes ☐No ☐Don't know
3. Do you feel sick today? ☐Yes ☐No ☐Don't know
4. In the last 10 days, have you had a COVID-19 test, been exposed to an individual with COVID-19, or traveled? ☐Yes ☐No ☐Don't know
5. Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days? ☐Yes ☐No ☐Don't know
6. Do you have allergies to latex, medications, food, vaccines or any component of vaccines (examples: Polyethylene glycol (PEG) or polysorbate). If yes, please list: ______ ☐Yes ☐No ☐Don't know
7. Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy? ☐Yes ☐No ☐Don't know
8. Do you have a bleeding disorder or are you on a blood thinner? ☐Yes ☐No ☐Don't know
9. **For women of childbearing age**: Are you pregnant or considering becoming pregnant in the next month? ☐Yes ☐No ☐Don't know

Recipient Name: ______

SECTION B-2 I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient or representative of; or (c) a representative of the LTCF and, based upon clinical observation, have sufficient knowledge of the patient's condition to answer the Screening Questions. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.

Patient/LTCF Representative: ______ **Date:** ______

Responsible Party: ______ **Date:** ______

SECTION B-3 Check any known conditions the patient has:

☐ **Blood Disorder** ☐ **Cancer** ☐ **Chronic Lung Disease (e.g. COPD, asthma, etc)** ☐ **Diabetes** ☐ **Heart Disease** ☐ **High Blood Pressure**

☐ **Immunocompromised*** ☐ **Kidney Disease** ☐ **Liver Disease** ☐ **Overweight (BMI ≥25 kg/m^2)/Obesity (BMI ≥30 kg/m^2)** ☐ **Pregnancy**

*I attest that I am immunocompromised as defined by the CDC and am eligible for an additional COVID mRNA dose ______
Signature

SECTION B-4 COVID-19 Vaccine Tracking History

Dose 1 ______/______ Date/Manufacturer Dose 2 ______/______ Date/Manufacturer

SECTION C **INSURANCE – PATIENT TO COMPLETE IF APPLICABLE**

Please ensure to record BOTH pharmacy AND medical insurance information since there are multiple ways immunizations can be billed.

Non-Medicare:	Pharmacy Card	Medical Card
Plan Name:		
Insurance Plan/Plan ID:		
Member/Recipient ID #:		
RX BIN:		
RX PCN:		
Group Number:		
Plan Phone Number:		

Medicare:	Medicare Part B
Medicare Number*:	

*Medicare Claim Number for cards distributed earlier than 2018.

Please provide a photocopy of both sides of your insurance cards and identification.

For residents - Please provide a Face Sheet with relevant demographics and insurance information.

☐ **Uninsured**

Is the patient the cardholder? ☐ Yes ☐ No
If no, please provide cardholders name, date of birth (MM/DD/YYY) and relationship: ______

SECTION D
Complete AFTER vaccine administration

COVID-19 Vaccine Manufacturer	Expiration	Lot Number	Dosage	Site of administration	EUA Fact Sheet/VIS date
				☐ L Deltoid ☐ R Deltoid ☐ Other:	

☐ Dose 1 ☐ Dose 2 ☐ Dose 3 - Immunocompromised ☐ Dose 3 - Booster

Clinician's name (print): ______ **Clinician's signature:** ______ **Title:** ______
If applicable, intern/tech name (print): ______ **Administration date:** ______ **Date EUA Fact Sheet/VIS given to patient:** ______

Influenza Vaccine Manufacturer	Expiration	Lot Number	Dosage	Site of administration	VIS published date
				☐L Deltoid ☐R Deltoid ☐ Other:	

Clinician's name (print): ______ **Clinician's signature:** ______ **Title:** ______
If applicable, intern/tech name (print): ______ **Administration date:** ______ **Date VIS given to patient:** ______

Other Vaccine:	Expiration	Lot Number	Dosage	Site of administration	VIS published date
Manufacturer:				☐L Deltoid ☐R Deltoid ☐ Other:	

Clinician's name (print): ______ **Clinician's signature:** ______ **Title:** ______
If applicable, intern/tech name (print): ______ **Administration date:** ______ **Date VIS given to patient:** ______

1. Update the patient's record with any new allergy, health condition or primary care provider information.
2. Enter vaccine lot #, expiration date and site of administration, then scan the VAR form into the patient's record.

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Vaccine Administration Record (VAR) Updates

- Streamlined to facilitate multi-immunization clinics and capture consent on single form
  - i.e. The form can now be used by a facility to get consent for <u>both</u> a flu shot and a COVID-19 vaccination
  - CDC's Interim Clinical Guidance states that the COVID-19 vaccines may be administered without regard to timing of other vaccines
    - It is no longer required to wait 14 days before/after other vaccines
    - Multiple vaccines can be administered at the same clinic and it is recommended injection sites are at least 1 inch apart, if not in different limbs entirely.

- Updates to the VAR primarily focus on **COVID primary series and 3rd doses for immunocompromised/booster doses**

- For clinics where PMC has provided an immunizer, PMC will <u>**not**</u> be administering other immunizations outside of the COVID-19 vaccines

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Vaccine Administration Record (VAR) Updates – Prior to

The following sections should be completed in preparation of the vaccine delivery/clinic:

- Section A-1
  - Demographics and selection of immunizations
    - VAR instruction form has CDC-acceptable values for Race/Ethnicity fields

SECTION A-1 Please print clearly. ☐ Resident ☐ Staff ☐ Other

First name: ____ **Last name:** ____

Date of birth: ____ **Age:** ____ **Gender:** ☐ Female ☐ Male ☐ Unk/Undftd **Phone:** ____

Race: ____ ☐ Unknown **Ethnicity:** ____ ☐ Unknown

LTCF Name: ____ **Address:** ____

City: ____ **State:** ____ **ZIP code:** ____ **Patient Email address:** ____

I want to receive the following vaccination(s): ☐ **COVID-19 Vaccination** ☐ **Influenza Vaccination** ☐ **Other Vaccination:** ____

- Section A-2
  - Informed Consent to administer vaccine

Vaccine Administration Record (VAR) Updates – Prior to

- Section B-3
  - New section to help identify eligible 3rd/booster dose recipients

SECTION B-3 Check any known conditions the patient has:

☐ Blood Disorder ☐ Cancer ☐ Chronic Lung Disease (e.g. COPD, asthma, etc) ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure

☐ Immunocompromised ☐ Kidney Disease ☐ Liver Disease ☐ Overweight (BMI ≥25 kg/m^2)/Obesity (BMI ≥30 kg/m^2) ☐ Pregnancy ☐ Other*

*I attest that I am at high risk of severe COVID-19 disease as defined by the CDC and am eligible for an additional COVID dose ____________________
Signature

- Section B-4 – Informational only (not required)
  - COVID-19 Vaccine History tracker to ensure appropriate administration schedule and/or manufacturer for additional doses

SECTION B-4 COVID-19 Vaccine Tracking History

Dose 1 ______________/______________
Date/Manufacturer

Dose 2 ______________/______________
Date/Manufacturer

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Vaccine Administration Record (VAR) Updates – Prior to

- Section C
  - Insurance Information - Pharmacy AND Medical

SECTION C **INSURANCE – PATIENT TO COMPLETE IF APPLICABLE**

Please ensure to record BOTH pharmacy AND medical insurance information since there are multiple ways immunizations can be billed.

Non-Medicare:	Pharmacy Card	Medical Card
Plan Name:		
Insurance Plan/Plan ID:		
Member/Recipient ID #:		
RX BIN:		
RX PCN:		
Group Number:		
Plan Phone Number:		

Medicare:	Medicare Part B
Medicare Number*:	

*Medicare Claim Number for cards distributed earlier than 2018.

Please provide a photocopy of both sides of your insurance cards and identification.

For residents - Please provide a Face Sheet with relevant demographics and insurance information.

☐ **Uninsured**

Is the patient the cardholder? ☐ Yes ☐ No

If no, please provide cardholders name, date of birth (MM/DD/YYY) and relationship: ____

- Best Practice
  - Get copies of face sheets for residents
  - Get photocopies of insurance cards/ID for non-residents

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Vaccine Administration Record (VAR) Updates –Time of

At the time of the immunization, the following sections should be completed:

- Section B-1
  - Screening Questions

SECTION B-1 **SCREENING QUESTIONS.** The following questions will help us determine your eligibility to be vaccinated today.

Question			
1. Have you received a previous dose of COVID-19 vaccine?	☐ Yes	☐ No	☐ Don't know
2. Have you had any vaccines in the past 14 days?	☐ Yes	☐ No	☐ Don't know
3. Do you feel sick today?	☐ Yes	☐ No	☐ Don't know
4. In the last 10 days, have you had a COVID-19 test, been exposed to an individual with COVID-19, or traveled?	☐ Yes	☐ No	☐ Don't know
5. Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days?	☐ Yes	☐ No	☐ Don't know
6. Do you have allergies to latex, medications, food, vaccines or any component of vaccines (examples: Polyethylene glycol (PEG) or polysorbate). If yes, please list:	☐ Yes	☐ No	☐ Don't know
7. Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy?	☐ Yes	☐ No	☐ Don't know
8. Do you have a bleeding disorder or are you on a blood thinner?	☐ Yes	☐ No	☐ Don't know
9. **For women of childbearing age**: Are you pregnant or considering becoming pregnant in the next month?	☐ Yes	☐ No	☐ Don't know

- Section B-2
  - Certification that pre-administration screening (B-1) was completed

SECTION B-2 I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient or representative of; or (c) a representative of the LTCF and, based upon clinical observation, have sufficient knowledge of the patient's condition to answer the Screening Questions. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.

Patient/LTCF Representative: ______ **Date:** ______

Responsible Party: ______ **Date:** ______

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Vaccine Administration Record (VAR) Updates – Time of

- Section D
  - First section is for COVID-19 vaccine administration
    - Select correct dose that is being administered
  - Second section is for Influenza vaccine administration
  - Third section can be for any other vaccine

SECTION D

Complete AFTER vaccine administration

COVID-19 Vaccine Manufacturer	Expiration	Lot Number	Dosage	Site of administration	EUA Fact Sheet/VIS date
				☐ L Deltoid ☐ R Deltoid ☐ Other:	

☐ Dose 1 | ☐ Dose 2 | ☐ Dose 3 - Immunocompromised | ☐ Dose 3 - Booster

Clinician's name (print):__________ **Clinician's signature:**__________ **Title:**__________

If applicable, intern/tech name (print):__________ **Administration date:** __________ **Date EUA Fact Sheet/VIS given to patient:** ______

Influenza Vaccine Manufacturer	Expiration	Lot Number	Dosage	Site of administration	VIS published date
				☐ L Deltoid ☐ R Deltoid ☐ Other:	

Clinician's name (print):__________ **Clinician's signature:**__________ **Title:** __________

If applicable, intern/tech name (print):__________ **Administration date:** __________ **Date VIS given to patient:** __________

Other Vaccine:	Expiration	Lot Number	Dosage	Site of administration	VIS published date
Manufacturer:				☐ L Deltoid ☐ R Deltoid ☐ Other:	

Clinician's name (print):__________ **Clinician's signature:**__________ **Title:** __________

If applicable, intern/tech name (print):__________ **Administration date:** __________ **Date VIS given to patient:** __________

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Other Process Updates (Facility Clinic Log)

The Facility COVID-19 Vaccine Clinic Log is recommended to be used by facilities to assist with collection of all tasks/data elements needed for vaccine process

- Dose Number
  - Updated to reflect 3rd dose options of "Immunocompromised" or "Pfizer Booster"

Facility COVID-19 Vaccine Clinic Log v.092321 PharMerica

Facility Name					Clinic Date	Vaccine Clinic Final Counts				Residents # Staff # Other # Wasted #				
Roster			Recipient Type			Dose Number				Document to Collect			Clinic Day - VAR	
								3rd Dose						
Count	Recipient Name	Date of Birth	Staff (x)	Resident (x)	Other (x)	1st Dose (X)	2nd Dose (X)	Immuno-compromised (X)	Pfizer Booster (X)	Consent	PHI Release (Staff only)	Face Sheet/ Insurance Card	VAR Completed	Faxed to Pharmacy (ASAP)
1														
2														
3														
4														
5														

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