STATE OF NEVADA
H E A L T H D I V I S I O N

Immunization Program ▪ 4150 Technology Way ▪ Suite 210 ▪ Carson City ▪ Nevada ▪ 89706

Vaccines for Children (VFC) Program
2012 Pharmacy Agreement to Participate

_____ _____
Facility Name (Assigned PIN Number)

Physical/Shipping Address: _____
Street Address (No PO Box) Suite City State Zip

Mailing Address: _____
(May be the same as the shipping) Suite City State Zip

Fax Number: (____) _____ Business Phone: (____) _____

Office Vaccine Manager:_____ Phone Number/Ext: _____

Office Vaccine Manager E-mail																																				

Supervisor:_____ Phone Number/Ext: _____

Supervisor E-mail																																					

IMPORTANT – Days and times the clinic is open to accept delivery of vaccines:

DAY OF THE WEEK	TIME OFFICE OPENS	LUNCH TIME (FROM – TO)	TIME OFFICE CLOSES
MONDAY:			
TUESDAY:			
WEDNESDAY:			
THURSDAY:			
FRIDAY:			
Notify the Nevada State Immunization Program (in writing) of any changes, i.e. clinic closures or changes in hours of operation			

What is the minimum age that will be vaccinated in this facility? _____ years

To participate in the VFC Program and receive state supplied vaccine provided to my facility at no cost, I agree to the following conditions, on behalf of myself and all the practitioners, and others associated with the medical office, group practice, managed care organization, community/migrant/rural clinic, health department, pharmacy, or health delivery facility of which I am the Medical Director or equivalent:

Medical Director or equivalent to initial all:

_____1. I will screen (and document) patients at all immunization encounters for VFC and state eligibility and administer *state supplied* vaccine only to children who are18 years of age or younger who meet one or more of the following categories:
- Are VFC vaccine eligible
  - Are Medicaid enrolled or Medicaid eligible
  - Are an American Indian or Alaska Native
  - Have no health insurance
  - Are underinsured: Children who have commercial (private) health insurance but the coverage does not include vaccines, children whose insurance covers only selected vaccines (VFC-eligible for non-covered vaccines only), or children whose insurance caps vaccine coverage at a certain amount (once that coverage amount is reached, these children are categorized as underinsured). Underinsured children are eligible to receive VFC vaccine only through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).
- Are enrolled in Nevada Check Up.

_____2. I will adhere to the appropriate immunization schedule, dosage, and contraindications as established by the Advisory Committee on Immunization Practices (ACIP) unless: a) in my medical judgment, and in accordance with accepted medical practice, I deem such adherence to be medically inappropriate; or b) the particular requirement contradicts religious and medical exemptions (per NRS 432A, 392, 394).

_____3. I agree to never dispense vaccine to a patient; only to administer vaccine on site.

_____4. I will maintain all records related to the Nevada State Immunization Program for a minimum of 3 years, and make these records available to public health officials, including the Nevada Department of Health and Human Services and/or Federal Department of Health and Human Services, upon request. These records include (but are not limited to) "Vaccine Request and Inventory and Accountability Report," "Eligibility Report of Doses Administered," "Nevada State Immunization Program Temperature Log," "Vaccine Incident Report," "UPS Pickup Request for Expired/Spoiled Vaccine," "VFC Vaccine Borrowing and Replacement Report," "Packing List" included with the vaccine shipment, and patient/parent/guardian responses on the Patient Eligibility Screening Record form.

_____5. I will maintain clients' immunization records for a period specified by **NRS 629.051 "**Health care records: Retention; disclosure to patients concerning destruction of records; exceptions; regulations. #1: …*Each provider of health care shall retain the health care records of his or her patients as part of his or her regularly maintained records for 5 years after their receipt or production. Health care records may be retained in written form, or by microfilm or any other recognized form of size reduction, including, without limitation, microfiche, computer disc, magnetic tape, and optical disc… Health care records may be created, authenticated and stored in a computer system which limits access to those records.* #7: *A provider of health care shall not destroy the health care records of a person who is less than 23 years of age on the date of the proposed destruction of the records. The health care records of a person who has attained the age of 23 years may be destroyed in accordance with this section for those records which have been retained for at least 5 years or for any longer period provided by federal law."* If requested, I will make such records available to the Nevada Department of Health and Human Services and/or the Federal Department of Health and Human Services. I will make such records available to the health authority and/or designee, if requested (per NAC 441A.750). This includes the collection of data for quality improvement assessments.

_____6. I will ensure that parent(s), guardian(s), or patient(s) will receive the most current and appropriate Vaccine Information Statement(s) (VIS) prior to the administration of any vaccine and immunization records will be maintained in accordance with the National Childhood Vaccine Injury Act. Vaccine adverse events will be reported to the Nevada State Immunization Program and/or VAERS (www.vaers.hhs.gov), along with any supporting documentation, in accordance with the National Childhood Vaccine Injury Compensation Act (NCVICA) which includes reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System.

_____7. I will not impose a charge for the cost of any state supplied vaccine which is provided to me at no charge.

_____8. I will not charge a vaccine administration fee to non-Medicaid VFC-eligible children that exceeds the administration fee cap of $16.13 per vaccine dose. For Medicaid VFC-eligible children age 0 through 18 years, I will accept the reimbursement for immunization administration set by the state Medicaid agency or the contracted Medicaid health plans.

_____9. I will not deny administration of a state supplied vaccine to a VFC eligible child because of the child's parent/guardian/individual of record's inability to pay the administration fee (per the Federal Register Vol. 59 No. 190/Monday October 3, 1994).

_____10. I will comply with the requirements for vaccine requests, vaccine accountability, and vaccine management per the "Nevada State Immunization Program, Vaccines for Children Program (VFC) Protocol January 2012."

_____11. I will participate in site visits and immunization improvement activities in collaboration with program representatives as requested.

_____12. I agree to operate within the Nevada State Immunization Program in a manner intended to avoid fraud and abuse. Fraud & Abuse is defined in the "Nevada State Immunization Program, Vaccines for Children (VFC) Protocol January 2012."

_____13. I will maintain proper storage and handling standards for vaccines as outlined in CDCs Vaccine Storage & Handling toolkit located at: www.cdc.gov/vaccines/recs/storage/default.htm and in addition as outlined in the following attachments:
- "Acceptable Vaccine Storage Units" technical bulletin located at http://health.nv.gov/Vaccine_VFCProgram.htm
- "Vaccine Storage Unit… Things to Consider" located at http://health.nv.gov/Vaccine_VFCProgram.htm
- "Nevada State Immunization Program, Vaccines for Children (VFC) Protocol January 2012."

_____14. I will not move state supplied vaccines unless I have prior approval from the Nevada State Immunization Program.

_____15. I (the facility) will be financially responsible for the replacement cost of any state-supplied vaccines that are wasted through my failure or the failure of my staff to properly store, handle, account for, or rotate the vaccine. Recapture of Wasted Vaccine is outlined in the "Nevada State Immunization Program, Vaccines for Children (VFC) Protocol January 2012."

_____16. I understand that the Nevada State Immunization Program may terminate this agreement if it determines that the cost of the unused vaccines due to waste or expiration is in excess of 5% of the total doses of vaccines received in the past year. Providers may also be financially responsible for excess above 5%. Recapture of wasted vaccine is outlined in the "Nevada State Immunization Program, Vaccines for Children (VFC) Protocol January 2012."

_____17. I will not borrow VFC vaccine to administer to non-VFC eligible patient(s) unless a rare unplanned situation exists and only with prior approval from the Nevada State Immunization Program. In the event an unplanned situation occurs that requires borrowing of VFC vaccine to administer to a non-VFC eligible patient, I will be required to complete the "VFC Vaccine Borrowing Report" to document borrowed and replaced doses.

_____18. I will record **all** vaccines that our office administers to children and adults into Nevada's immunization registry (Nevada WebIZ) unless the patient has chosen to not participate in the registry. This requirement is in reference to Nevada Revised Statutes (NRS) 439.265 and corresponding Nevada Administrative Code (NAC) R094-09A. Providers with an undue hardship (i.e. no internet access) can comply by completing a WebIZ paper reporting form and mailing to the WebIZ Program. Please contact the WebIZ Help Desk for this form. View these laws at:
- NRS: www.leg.state.nv.us/NRS/NRS-439.html#NRS439Sec265
- NAC: www.leg.state.nv.us/Register/2009Register/R094-09A.pdf
- WebIZ: http://health.nv.gov/Immunization_WebIZ_Policies_Forms.htm

_____19. I understand that either party may cease participation in this agreement at any time, with written notification. If agreement is terminated, I agree to properly return any unused state supplied vaccine to the Nevada State Immunization Program within 30 days as outlined in the "Nevada State Immunization Program, Vaccines for Children (VFC) Protocol January 2012."

_____20. I agree to provide a Certificate of Achievement for each pharmacist that will be administering vaccine at this location as proof that they have completed a Pharmacy-Based Immunization Delivery program provided by the American Pharmacists' Association.

_____21. I agree to provide the Nevada State Immunization Program with a copy of the protocol agreement between this facility and a board-licensed prescribing physician.

_____22. I understand that the Centers for Disease Control (CDC) will be instituting a new Web-based Vaccine Tracking System (VTrckS) which will allow online provider ordering. This will require all new users to register with CDC's Secure Access Management Services (SAMS) system. Providers will be notified when VTrckS goes into effect for Nevada.

Therefore I agree to the following:
- Should my staff, representative, or I access VTrckS, I agree to be bound by CDC's terms of use for interacting with the online ordering system. I further agree to be bound by any applicable federal laws, regulations or guidelines related to accessing a CDC system and ordering publically funded vaccines.

- In advance of any VTrckS access by my staff, representative or myself, I will identify each member of my staff or representative who is authorized to order vaccines on my behalf. In addition, I will maintain a record of each staff member who is authorized to order vaccines on my behalf. If changes occur, I will inform CDC within 24 hours of any change in status of current staff members or representatives who are no longer authorized to order vaccines, or the addition of any new staff authorized to order on my behalf. I certify that my identification is represented correctly on this provider enrollment form.

I certify that I have read and agree to the requirements listed above pertaining to participation in the Nevada State Immunization Program, which includes the Vaccines for Children Program.

Printed Name: Licensed Prescribing Physician	**State of Licensure**	**Medical License #**

Signature: Licensed Prescribing Physician	**Date**

Printed Name: Managing Pharmacist	**License #**

Signature: Managing Pharmacist	**Date**

LIST EACH REGISTERED PHARMACIST ADMINISTERING VACCINE IN THIS FACILITY.

- **Print** the names, title and licensing information in table below

FIRST NAME	LAST NAME	MIDDLE INITIAL	TITLE (i.e. MD, DO, etc.)	MEDICAL LICENSE NUMBER	EXPIRATION DATE

(Attach another sheet if additional space is needed)