Walgreens Immunization On-Site Clinics

Preparation Guide

055168 (05-14-2021)

Preparing for your Walgreens immunization clinic

By partnering with Walgreens for COVID-19 vaccination administration, you're taking proactive measures to help ensure your participants and members are protected from vaccine-preventable illnesses.

This guide will help your organization safely prepare for an upcoming immunization clinic.

Here's what we're doing to keep you safe:

Daily screening

We conduct **daily temperature checks** for pharmacists and staff before the start of each shift.

Safety protocols

We follow standard OSHA safety protocols to **prevent infection** including handwashing, changing gloves between patients, and swabbing the injection site with alcohol.

Face masks

Our immunizers wear **surgical face masks**, as well as face shields, to protect both patients and our team members.

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Member of Walgreens Boots Alliance

Walgreens immunization clinic overview

1 | PREPARING FOR THE CLINIC

Coordination

Identify an on-site coordinator to work with your Walgreens contact on clinic site information, staffing, hours, etc.

Clinic setup

Set-up the appointment scheduling tool. Follow clinic set-up requirements to ensure safety, hygiene and social distancing.

Forms & registration

Distribute necessary forms to participants planning to get an immunization.

For select **COVID-19** clinics, you will be required to register your participants through a dedicated COVID-19 Registration Portal that your Walgreens contact will share with you.

2 | DAY OF THE CLINIC

Immunization

Participants must follow health and safety guidelines to receive their immunization*. Walgreens immunizers will administer the immunizations and keep record.

3 | POST-CLINIC

Follow-up

In case of an adverse event in response to the vaccine, report it to VAERS. Participants may receive reminders for subsequent doses if necessary.

**Employers are responsible for ensuring vaccine recipients are the intended clinic participants.*

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Clinic coordination

Assign coordinator

Assign *at least* one person as **clinic coordinator** to work directly with local Walgreens contact to plan each clinic.

Please ensure that the following information about the clinic coordinator is relayed to your Walgreens contact when they reach out via email and/or phone:

- Name
- Phone
- Role
- Email
- Best time to be reached

Confirm clinic site information

Your Walgreens contact will need **addresses of all desired clinic locations and dates for each clinic**, as well as **accurate estimates of number of shots** to be administered. You may be asked to **confirm participant count** at least 72 hours prior to clinic date.

Your Walgreens contact will work with you to determine appropriate staffing, hours, room size, clinic set up and any additional supplies required to serve your participants.

Clinic setup

Clinic location requirements

Room must be:
- Well-ventilated
- Clean
- Spacious enough for social distancing before, during, and 15-30 minutes after immunization

Room must allow for:
- Reception table with garbage bin
- At least one chair for support staff
- Table with two chairs for immunizer and participant
- Additional chairs for participants
- Non-fabric chairs preferred for proper disinfecting procedures
- Displayed social distancing signage

If you are unable to meet these requirements, your clinic may be postponed or rescheduled until they can be met.

Appointment scheduling tool

1. Work with your local pharmacy contact to enable the **appointment scheduling tool** to assist recipients with scheduling an appointment time, allowing for proper social distancing at the clinic
2. Once enabled, provide the appointment scheduling link to clinic participants
3. Participants will receive all necessary preparation information and pre-clinic forms to complete ahead of time

Face masks & coverings

All participants **must** wear a face mask or face covering prior to arriving to the immunization clinic and for the duration of their visit.

Clinic setup

Sample workflow set up

- 2 check-in stations
- 4 immunization stations
- Dedicated waiting area
- Observer / Flex

Roles & responsibilities*

Check-in assistant
- Hand out consent forms
- Verify third-party billing information
- Direct patients to immunization station

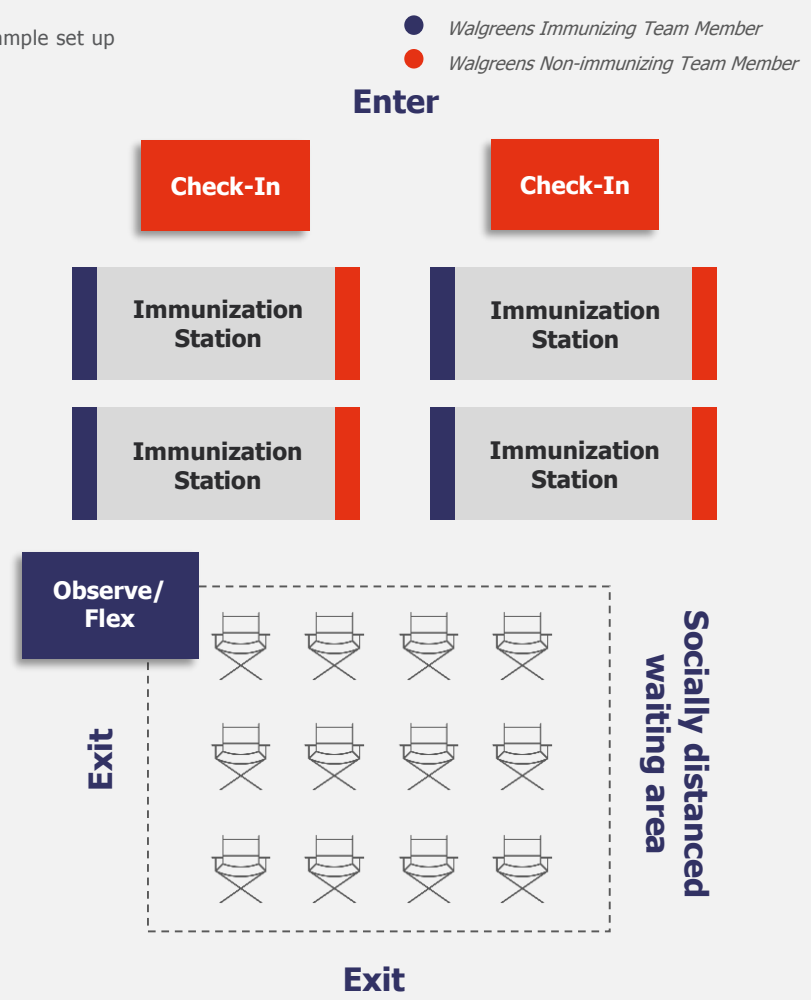
Immunization assistant
- Prepare vaccination supplies
- Take-away documents
- Lot/Exp recorded on consent form
- Duties as requested by immunizer

Immunizer
- Review consent form for contraindications
- Administer immunization
- Sign and complete consent form

Observer / Flex
- Observe patient post-vaccination
- Flex duties based on need

**Walgreens will bring adequate support staff needed to facilitate a clinic. Clinic set up may vary. Your Walgreens contact can help you determine the best option for your site and participants.*

Sample set up



Forms & registration

Pre-immunization clinic paperwork

Make the following form(s) available to all participants who intend on receiving an immunization:

Vaccine Administration Record (VAR)

- Request that all participants complete **Sections A, B, C and D** of this VAR form ahead of the clinic.

Vaccine Fact Sheets and Information Statements*:

- Pfizer-BioNTech COVID-19 Vaccine
- Moderna COVID-19 Vaccine
- Janssen COVID-19 Vaccine
- Flu Vaccine Information Statement (VIS)
- All participants who intend on getting an immunizations should review the appropriate Vaccine Fact Sheet or Information Statement ahead of the clinic so that the pharmacist can address any questions or concerns they may have before the vaccine is provided.

**For clinics that include other immunizations (e.g., pneumonia, shingles), your pharmacy team will provide the appropriate Vaccine Information Statements prior to your clinic(s).*

Forms & registration

Participants who intend on getting an immunization should complete **Sections A, B, C and D (if applicable)** of the **Vaccine Administration Record** (VAR), **ahead of the clinic**. Participants should bring this completed form, along with their ID and insurance card, with them to the clinic.

For Section A:

Complete all information in Section A.

Optional: If participants would like Walgreens to inform their Primary Care Provider about the immunization(s) they received, they must provide the contact details and this information will be shared with their office.

For Section B:

All persons must answer **questions 1 through 10*.** Questions 12 - 19 should only be answered if you are receiving one of the indicated vaccines.

For Section C:

Sign and Date this form as directed.

**For COVID-19 vaccines, please answer question 11.*

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Vaccine Administration Record (VAR)—Informed Consent for Vaccination Walgreens

If the patient is requesting a flu vaccination, indicate the patient's age group:
☐ Under age 65
☐ Age 65 or older

OFF-SITE CLINIC BILLING GROUP:

Store number: _____
Rx number: _____
Store address: _____

SECTION A Please print clearly.

First name: _____ **Last name:** _____

Date of birth: _____ **Age:** _____ **Gender:** ☐ Female ☐ Male **Phone:** _____

☐ **I wish to receive text message alerts regarding my prescriptions.**

Home address: _____ **City:** _____

State: _____ **ZIP code:** _____ **Email address:** _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Other Race _____ ☐ Unknown ☐ Unable to report due to policy/law

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ethnicity ☐ Unable to report due to policy/law

Walgreens will send vaccination information from this visit to your doctor/primary care provider using the contact information provided below.

Doctor/primary care provider name: _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **ZIP code:** _____

I want to receive the following vaccination(s): _____

SECTION B The following questions will help us determine your eligibility to be vaccinated today.

All vaccines

1.	Do you feel sick today?	☐ Yes ☐ No ☐ Don't know
2.	Have you been diagnosed with or tested positive for COVID-19 in the last 14 days?	☐ Yes ☐ No ☐ Don't know
3.	In the past 14 days have you been identified as a dose contact to someone with COVID-19?	☐ Yes ☐ No ☐ Don't know
4.	Do you have a history of allergic reaction or allergies to latex, medications, food or vaccines (examples: polyethylene glycol, polysorbate, eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)? If yes, please list: _____	☐ Yes ☐ No ☐ Don't know
5.	Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy?	☐ Yes ☐ No ☐ Don't know
6.	Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré syndrome (a condition that causes paralysis) or other nervous system problem?	☐ Yes ☐ No ☐ Don't know
7.	Have you received any vaccinations or skin tests in the past eight weeks? If yes, please list: _____	☐ Yes ☐ No ☐ Don't know
8.	Have you ever received the following vaccinations? ☐ Pneumonia: Date received _____ ☐ Shingles: Date received _____ ☐ Whooping cough: Date received _____	
9.	Do you have any chronic health condition such as cancer, chronic kidney disease, immunocompromised, chronic lung disease, obesity, sickle cell disease, diabetes, heart disease? If yes, please list: _____	☐ Yes ☐ No ☐ Don't know
10.	For women: Are you pregnant or considering becoming pregnant in the next month?	☐ Yes ☐ No ☐ Don't know
11.	**For COVID-19 vaccine only**: Have you been treated with antibody therapy specifically for COVID-19 (monoclonal antibodies or convalescent plasma)?	☐ Yes ☐ No ☐ Don't know
	For chickenpox, MMR® II, shingles, Vaxchora®, yellow fever only: Answer the following questions only if you are receiving any vaccinations listed above.	
12.	Do you have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS, transplant)?	☐ Yes ☐ No ☐ Don't know
13.	Are you currently on home infusions, weekly injections such as Humira® (adalimumab), Remicade® (infliximab) or Enbrel® (etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments?	☐ Yes ☐ No ☐ Don't know
14.	Are you currently taking high-dose steroid therapy (prednisone > 20mg/day or equivalent) for longer than 2 weeks?	☐ Yes ☐ No ☐ Don't know
15.	Have you received a transfusion of blood or blood products or been given a medication called immune (gamma) globulin in the past year?	☐ Yes ☐ No ☐ Don't know
16.	Do you have a history of thymus disease (including myasthenia gravis, DiGeorge syndrome or thymoma), or had your thymus removed? (yellow fever only)	☐ Yes ☐ No ☐ Don't know
17.	Do you have a history of thrombocytopenia or thrombocytopenic purpura? (MMR only)	☐ Yes ☐ No ☐ Don't know
18.	Have you consumed any food or drink in the last hour? (Vaxchora® only)	☐ Yes ☐ No ☐ Don't know
19.	Have you taken antibiotics in the last 14 days or antimalarials in the last 10 days? (Vaxchora® only)	☐ Yes ☐ No ☐ Don't know

SECTION C

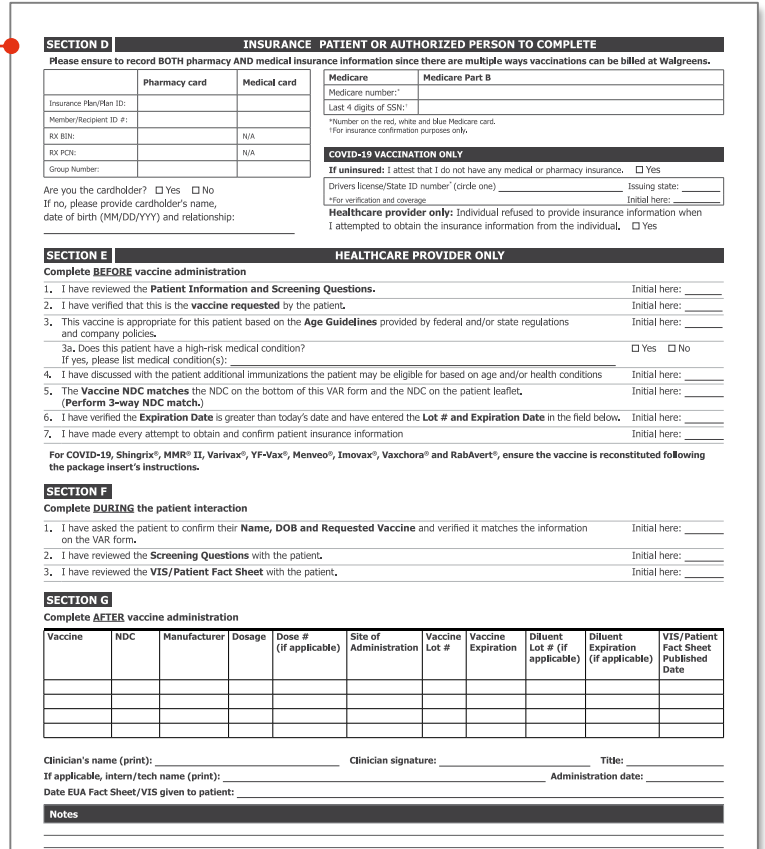
I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient; or (c) a person authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves. Further, I hereby give my consent to Walgreens or Duane Reade 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 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 Centers 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 Forms. 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 from. Unless I provide the applicable Provider with a signed Opt-Out Form, I understand that my consent

Forms & registration

For Section D:

This section is applicable for particular administration site options where Walgreens is billing insurance rather than direct billing. For employer-site clinics with direct bill, this section does not need to be completed.

Review the applicable vaccine information forms, which should be provided to participants ahead of the clinic, so that the pharmacist can address any questions or concerns the participant may have before the vaccine is provided.



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SECTION D INSURANCE PATIENT OR AUTHORIZED PERSON TO COMPLETE

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

	Pharmacy card	Medical card
Insurance Plan/Plan ID:		
Member/Recipient ID #:		
RX BIN:		N/A
RX PCN:		N/A
Group Number:		

Medicare	Medicare Part B
Medicare number:*	
Last 4 digits of SSN:*	

*Number on the red, white and blue Medicare card.
†For insurance confirmation purposes only.

Are you the cardholder? ☐ Yes ☐ No
If no, please provide cardholder's name, date of birth (MM/DD/YYY) and relationship: _____

COVID-19 VACCINATION ONLY

If uninsured: I attest that I do not have any medical or pharmacy insurance. ☐ Yes

Drivers license/State ID number* (circle one) _____ Issuing state: _____
*For verification and coverage Initial here: _____

Healthcare provider only: Individual refused to provide insurance information when I attempted to obtain the insurance information from the individual. ☐ Yes

SECTION E HEALTHCARE PROVIDER ONLY

Complete BEFORE vaccine administration

1. I have reviewed the **Patient Information and Screening Questions.** Initial here: _____
2. I have verified that this is the **vaccine requested** by the patient. Initial here: _____
3. This vaccine is appropriate for this patient based on the **Age Guidelines** provided by federal and/or state regulations and company policies. Initial here: _____
   3a. Does this patient have a high-risk medical condition? ☐ Yes ☐ No
   If yes, please list medical condition(s): _____
4. I have discussed with the patient additional immunizations the patient may be eligible for based on age and/or health conditions Initial here: _____
5. The **Vaccine NDC matches** the NDC on the bottom of this VAR form and the NDC on the patient leaflet. (**Perform 3-way NDC match.**) Initial here: _____
6. I have verified the **Expiration Date** is greater than today's date and have entered the **Lot # and Expiration Date** in the field below. Initial here: _____
7. I have made every attempt to obtain and confirm patient insurance information Initial here: _____

For COVID-19, Shingrix®, MMR® II, Varivax®, YF-Vax®, Menveo®, Imovax®, Vaxchora® and RabAvert®, ensure the vaccine is reconstituted following the package insert's instructions.

SECTION F

Complete DURING the patient interaction

1. I have asked the patient to confirm their **Name, DOB and Requested Vaccine** and verified it matches the information on the VAR form. Initial here: _____
2. I have reviewed the **Screening Questions** with the patient. Initial here: _____
3. I have reviewed the **VIS/Patient Fact Sheet** with the patient. Initial here: _____

SECTION G

Complete AFTER vaccine administration

Vaccine	NDC	Manufacturer	Dosage	Dose # (if applicable)	Site of Administration	Vaccine Lot #	Vaccine Expiration	Diluent Lot # (if applicable)	Diluent Expiration (if applicable)	VIS/Patient Fact Sheet Published Date

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

Notes

Immunization Overview

Participants will NOT be vaccinated, and SHOULD NOT attend the clinic if:

- They are feeling sick, have a fever, or are exhibiting any respiratory symptoms.
- Have been diagnosed with COVID-19 within the last 2 weeks.

Face mask

Participants must wear a face mask or face covering prior to arriving for the immunization clinic and for the duration of their visit.

Efficient immunization

If possible, wear clothing that allows the immunizer to easily access the shoulder area for a more efficient immunization process (i.e. t-shirt and/or easy to remove layers).

Observation: Vaccine recipients will be asked to wait for **~15-30** minutes post-administration

Social distancing

When waiting for their immunization, participants will need to practice appropriate social distancing guidelines, maintaining at least a 6 ft. distance from others.

Temperature check

The pharmacist will take their temperature using the touch-free digital thermometer. Immunization should be deferred if they are sick or have a fever.

Forms & record cards

Bring the **completed** VAR form, along with and **ID** to the clinic.

When applicable, Walgreens clinic team member will fill out an **immunization record card** for each recipient of the vaccine; it is important that each vaccine recipient keep this record and bring it to subsequent clinics, as needed.

Participants should only attend the clinic if they intend on receiving an immunization.

Follow-up

Monitor for adverse events

If there is an adverse event (side effect) in response to the vaccine by any recipient, it is recommended that it is reported to the **Vaccine Adverse Event Reporting System (VAERS)**.

VAERS is co-managed by the CDC and FDA.

Anyone can report an adverse event to VAERS, although Walgreens is happy to assist you, simply call your Walgreens point of contact.

Return for second dose, if necessary

In the case of multiple-dose vaccines, patients will be reminded to follow-up to get subsequent doses administered.

Reporting

When required, Walgreens will report the record of all vaccinations to your State Immunization Registry and the Centers for Disease Control (CDC).

More questions about our employer vaccination program?

Reach out to your sales account manager or Walgreens contact with any questions.

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