STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

TO: **All Users of State Supplied Adult Vaccines**

FROM: **Vincent Sacco, MS**
Immunization Program Manager

DATE: **November 21, 2011**

SUBJECT: **Provision of state-supplied adult vaccines**

Beginning January 2012, the Immunization Program has created separate forms for providers who administer vaccines only to adults age 19 years and older that are available through several special immunization projects targeting high risk individuals. Please fill out the enclosed *Adult Provider Profile* and *Adult Provider Agreement* forms as completely and accurately as possible paying special attention to the section asking for shipping information including the days and hours your office is open. **Be sure to include any times the office is closed including lunch periods.**

Please continue to screen patients for vaccine eligibility according to the specific adult vaccine program criteria in which you participate, as follows.

1. For the Hepatitis A/B vaccine program, for those individuals with no health insurance or Medicaid AND any one of the following:
    - Injection drug use–current or past history of use
    - Men who have sex with men (MSM)
    - Current or past history of sexually transmitted disease (STD)
    - Household member of a hepatitis B carrier
    - HIV positive without one of the above concurrent issues
    - Hepatitis C positive with no known hepatitis A/B
    - Individuals who identify multiple sex partners
2. For the HPV vaccine program, males and females aged 19-26 yrs with no health insurance
3. For the Tdap Cocoon Program:
    - Pregnant and post-partum women and fathers, mothers and fathers of NICU babies, and adoptive families of infants aged less than 12 months
    - Household contacts and caregivers of infants aged less than 12 months

As a reminder, the maximum administration fee **that can be charged (i.e. collected) to uninsured and underinsured patients** is $21 per dose. The $21 fee is to keep out of pocket costs for uninsured or underinsured patients to a minimum. The administration fee for Medicaid patients continues to be the fee established by the Department of Social Services. The administration fee for private insurance patients can be up to the maximum allowed per the insurance company's policy. The provider agreement language allows providers to bill one fee regardless of the patients' insurance status, but to collect from uninsured and underinsured patients a maximum of $21 per dose administered. Any remaining balance would have to be written off as you would with your Medicaid and private insurance patients.

The completed Adult Provider Profile and Agreement forms must be signed, dated and returned to the Immunization Program by December 31, 2011 in order to continue receiving vaccines on an uninterrupted basis. The forms can either be mailed or faxed. Our fax number is (860) 509-8371. Please remember to fill in your four digit Provider Identification Number (PIN) on the top right hand corner of the Provider Agreement form.

As always, please feel free to contact the Immunization program at (860) 509-7929 with any questions. Thank you for your continued participation.

Connecticut Department of Public Health PIN: _____
Adult Provider Profile

All public and private health care providers who receive state-supplied vaccines for adults age 19 and older must complete this form. This document provides shipping information and helps to determine the amount of vaccine to be supplied. The form is also used to compare estimated vaccine needs with actual vaccine supply. The Immunization Program will keep this record on file with the SIGNED **"*Adult Provider Agreement*"**. The Provider Profile form must be updated annually or if: (1) the number of patients requiring vaccines change, or (2) the address of the facility changes. Complete one form for each office/site/satellite.

Federal Employer Tax ID: _____ Group Medicaid Billing Number: _____

1. Please provide the following information for all personnel who administer vaccines:

Physician _____ CT License # _____ Medicaid Billing # _____

Physician _____ CT License # _____ Medicaid Billing # _____

Physician _____ CT License # _____ Medicaid Billing # _____

RN, APRN _____ CT License # _____ Medicaid Billing # _____

Other _____ Other License # _____ Medicaid Billing # _____

2. Shipping Address:

Facility/Provider Name: _____

Contact Person: _____

Street Address (no P.O. Boxes): _____

City, State, Zip: _____

[+]Phone # _____ Fax # _____

[+]If possible, we would like this number to be a direct line to the person who orders the vaccines.

We are now using both fax and e-mail for communications; please provide us with an e-mail address for your facility (up to two): _____

3. Office Days and Hours:

_____

4. Indicate the Type of Facility (please check one only):

_____ 10 Public Health Department
_____ 12 Public Hospital
_____ 16 Other Public (please specify: _____
_____ 15 Federally Qualified Health Center (FQHC) or federally funded Rural Health Clinic
_____ 20 Private Practice (Individual or Group)
_____ 22 Private Hospital
_____ 24 Other Private (Please specify _____

5. Patient Estimates (complete only for the appropriate adult vaccine program in which the site is participating):

Tdap Cocoon Program Participants

Estimate the total number of pregnant/post-partum women seen at your hospital/clinic last year _____

Estimate the total number of adult (age 19 and up) infant contacts seen at your clinic/practice last year _____

Adult HepA/B and HPV Vaccine Programs

Estimate the total number of high risk individuals seen at your clinic/practice last year for hepatitis vaccine _____

Estimate the total number of individuals seen at your clinic/practice last year for HPV vaccine _____

Return to: State of Connecticut, Department of Public Health; 410 Capitol Avenue, M.S. # 11MUN Hartford, CT 06134-0308
Program Phone: 860-509-7929 Fax: 860-509-8371
created 11/9/11

Connecticut Department of Public Health

Adults Vaccines --Program Provider Agreement PIN: _____

_____ agrees to participate in the Connecticut Adult Vaccines Program through which _____ will
Provider Name Facility Name
receive publicly purchased vaccines and agrees it:

1. shall not impose a charge for the cost of the vaccine received through this program; however may collect a reasonable administration fee per dose given. The administration fee collected for the uninsured or underinsured cannot exceed $21 per dose; the administration fee for all Medicaid recipients shall be the fee schedule established by the Department of Social Services, the administration fee for private insurance patients can be up to the maximum allowed per the insurance company's policy;
2. shall not deny administration of a state-supplied vaccine to an eligible person due to the inability of the individual to pay an administration fee;
3. shall not bill a third party (e.g. insurance company or Medicaid) for vaccines already purchased with public funds. For the purpose of this agreement, multiple antigens such as Tdap or HepA/HepB are considered to be one vaccine;
4. shall provide the Connecticut Immunization Program with the numbers of persons expected to need immunizations at this facility/practice for the 12-month period beginning on January 1, 2012. This information shall be submitted to the Department of Public Health (DPH) on the form entitled ADULT PROVIDER PROFILE as part of the annual procedure to enroll in the state-supplied vaccines program to receive publicly purchased vaccines;
5. shall screen patients for vaccine eligibility using a program-specific screening guidelines and administer state-supplied vaccine only to those eligible individuals;
6. shall comply with the appropriate immunization schedule, dosage, and contraindications, approved by the Advisory Committee on Immunization Practices (ACIP), unless (a) in the exercise of medical judgment, and in accordance with accepted medical practice, deem such compliance to be medically inappropriate;
7. shall provide Vaccine Information Statements (VIS) and maintain records in accordance with the National Childhood Vaccine Injury Act (NCVIA), which includes reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS);
8. shall maintain all vaccine-related records for a period of three (3) years and if requested, shall make such records available to DPH or the U.S. Department of Health and Human Services (DHHS);
9. shall comply with the Immunization Program requirements for ordering vaccines and with other reporting requirements on a monthly basis as detailed on the Vaccine Order Form (VOF) provided by the Immunization Program;
10. shall maintain good vaccine handling and storage practices and shall report to the Immunization Program any vaccine wastage/loss. Providers shall not permanently store vaccines in a dorm style refrigeration unit. Providers agree that they are financially liable for all doses of vaccines ordered through the state-supplied vaccines program and will make every attempt to administer or transfer to another provider every dose ordered from the program;
11. shall report adverse reactions (reactions requiring medical attention) associated with vaccination to DPH within 2 weeks of the event occurring by phone/fax;
12. agrees that only licensed personnel shall administer vaccines to patients;
13. agrees that DPH shall be granted access to the practice/clinic to conduct program and patient record reviews;
14. agrees that should my staff, representative, or I access VTrckS, I am bound by the Centers for Disease Control and Prevention's (CDC) 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 system and ordering publically funded vaccines;
15. 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/agreement form;
16. understands that either party may terminate this agreement at any time for any reason. The provider shall give 30 days written notice before terminating this agreement. DPH may terminate this agreement for failure of the provider to comply with all the requirements;
17. shall properly return any unused state-supplied vaccines upon termination of this agreement;
18. the effective date of this Agreement is January 1, 2012. This Agreement shall thereafter be in effect for a period of 12 months, ending December 31, 2012 unless terminated by either party prior to the stated ending date. This agreement supersedes any previously signed agreement.

THE UNDERSIGNED, BEING THE PROVIDER OR HAVING THE SPECIFIC AUTHORITY TO BIND THE PROVIDER TO THE TERMS OF THIS AGREEMENT HEREBY AGREE TO ABIDE BY AND COMPLY WITH ALL OF THE STIPULATIONS, CONDITIONS, AND TERMS SET FORTH HEREIN.

_____
Provider Name

_____
Name of Authorized Representative (Must be an Authorized Officer, Owner, or Partner) (**Please Print)**

_____ _____
Signature of Authorized Representative Date

This record is to be submitted to and kept on file at the Connecticut Immunization Program and must be updated at least once annually. A copy of this form shall be retained at the provider's office. It shall be shared with all relevant persons at the facility/practice including persons administering vaccines, staff responsible for billing procedures and any others determined at the provider site that need to know the information herein.