

Birth Dose Hepatitis B Enrollment

Hospital Name: _____

Contact Person: _____
First Last Title

Vaccine Delivery Address: _____
Street Only (No P.O. Boxes)

_____ City State Zip

Mailing Address: _____
Street or PO Box

_____ City State Zip

Email Address: _____

Telephone: () _____ Extension _____ **Fax:** () _____

Days and Times Vaccine May be Delivered: Mon. _____ AM to _____ PM Tues. _____ AM to _____ PM

Wed. _____ AM to _____ PM Thurs. _____ AM to _____ PM Fri. _____ AM to _____ PM

Special Instructions: (i.e. lunch hour, etc) _____

PART I: Provider Agreement

To participate in the program and receive publicly funded (CFDA 93.268, DHHS/CDC Grant 5H231P822520-05) vaccine at my facility for no cost, I agree to the following conditions, on behalf of myself and all the practitioners associated with this facility:

1. I will not impose a charge for the cost of the vaccine or for immune globulin.
2. I will not impose a charge for the administration of the vaccine or immune globulin that exceeds the maximum fee of \$14.52 per dose as established by the Center for Medicare and Medicaid Services (CMS). I will accept the vaccine administration reimbursement fee set by Utah Medicaid and contracted Medicaid health plans.
3. I will not deny administration of a publicly funded vaccine to a child because the child's parent/guardian of record is unable to pay the administration fee.
4. I will make all records available to the Utah Department of Health (UDOH) and/or the Department of Health and Human Services (DHHS) staff during routine site visits and upon request.
5. I will distribute the most current Vaccine Information Statements (VIS) each time a vaccine is administered and maintain records 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 (VAERS).
6. I will comply with Utah Immunization Program requirements for vaccine ordering, submission of vaccine inventories, and submission of temperature logs as requested.
7. I will comply with Utah Immunization Program requirements for submission of the Quarterly Doses Administered Report. I will operate in a manner intended to avoid fraud and abuse.
8. I will appropriately store and handle vaccines according to the Centers for Disease Control and Prevention (CDC), the Utah Immunization Program, and vaccine manufacturer guidelines, which include: appropriate refrigeration equipment, temperature monitoring, immediately storing vaccine shipments, and rotating vaccine stock.

9. I will not pre-fill vaccine syringes prior to use and will only fill syringes at the time of administration.
10. I will develop a written policy on the routine storage, handling, and transport of vaccines, and review with staff annually. I will designate primary and back-up vaccine coordinators responsible for vaccine management.
11. I will develop a written policy on the emergency handling of vaccine (a plan of action should a storage problem occur) and post notices to prevent power from being disconnected from refrigeration units.
12. I will maintain appropriate levels of vaccine inventory, avoid vaccine stockpiling, and clearly distinguish between public and private vaccine stocks.
13. I will notify the Utah Immunization Program of any vaccine loss and I agree to reimburse for any vaccine loss in excess of \$1,000.00 due to inappropriate vaccine storage and handling, if requested.
14. I will be responsible for returning all non-viable publicly funded vaccines directly to McKesson Specialty Distribution and notify the Utah Immunization Program in accordance with policy and instructions.
15. I will notify the Utah Immunization Program if my facility closes or we no longer wish to participate in the birth dose Hepatitis B program. I will submit a final Quarterly Doses Administered Report, and agree to properly transport any remaining vaccines to another facility.
16. The Utah Immunization Program may terminate this agreement at any time for failure to comply with these requirements or I may terminate this agreement at any time for personal reasons.

Signature of Pharmacy Director

Print Name

Date

PART II: Facility Profile

- A. For the 2009 calendar year, project the facility's annual birth cohort by category.

Enrolled in Medicaid		Under-insured	
Am. Indian/Alaskan Nat.		Private Insurance	
No health insurance		Total Birth Cohort	

Type of data used to determine projections:

- A. Benchmarking Data B. Registry Data (USIIS) C. Medicaid Claims Data
D. Doses Administered Data E. Provider Encounter Data F. Other _____

This record is to be submitted to and kept on file with the Utah Department of Health Immunization Program, and must be updated yearly. The original form must be mailed, no faxed copies will be accepted.

Please Mail Form to:
Utah Department of Health Immunization Program
PO Box 142001 Salt Lake City, UT 84114-2001
Phone: (801) 538-9450

UTAH IMMUNIZATION PROGRAM USE ONLY

Date Received: _____ Date Approved: _____ Approved By: _____
VACMAN Entry Date: _____ VACMAN Entry By: _____