



<b>Refrigerator/Freezer Temperature Recording- past 3 months (REQUIRED FOR ORDER)</b>				Provider's Name		Contact Name		VFC Provider Number			
				Refrigerator HIGH		Freezer HIGH		Provider's Address		Telephone Number ( )	
Refrigerator LOW		Freezer LOW		City		Zip		Date Ordered / /		Clinic NPI Number	
Degrees C / F		Degrees C / F									

**All sections on this order form must be completed for VFC to process your vaccine order**

Vaccine Inventory*		Date of previous inventory: / /		Date of current inventory: / /				Vaccine Order*		(orders should reflect three-month projection)		
	Lot # /Expiration Date	Previous Inventory	Vaccine Received From ODH at Last Order	Total Vaccine Administered	Vaccine Transferred To (-) or From (+) Another Provider	Expired or Wasted Vaccine	Current Vaccine Inventory	Vaccine Choice	Presentation	Min Dose Order	Doses Requested	
DTaP								<input type="checkbox"/> Daptacel ®	1 dose vial	10		
								<input type="checkbox"/> Infanrix ®	<input type="checkbox"/> 1 dose vial <input type="checkbox"/> 1 dose syringe	10		
DTaP, IPV, Hib (Pentacel)								<input type="checkbox"/> Pentacel ®	1 dose vial	5		
DTaP, IPV, HBV (Pediarix)								<input type="checkbox"/> Pediarix ®	1 dose syringe	10		
DTaP - IPV (Kinrix)								<input type="checkbox"/> Kinrix ®	<input type="checkbox"/> 1 dose vial	10		
									<input type="checkbox"/> 1 dose syringe	10		
Td								<input type="checkbox"/> Tenivac ®	1 dose vial	10		
Tdap								<input type="checkbox"/> Boostrix ®	<input type="checkbox"/> 1 dose vial <input type="checkbox"/> 1 dose syringe	10		
									<input type="checkbox"/> Adacel ®	<input type="checkbox"/> 1 dose vial <input type="checkbox"/> 1 dose syringe		10 5
Polio								<input type="checkbox"/> IPOL ®	10 dose vial	10		
Hib								<input type="checkbox"/> ActHIB ®	1 dose vial	5		
								<input type="checkbox"/> PedvaxHIB ®	1 dose vial	10		
Hep B								<input type="checkbox"/> Engerix B ®	<input type="checkbox"/> 1 dose vial <input type="checkbox"/> 1 dose syringe	10		
									<input type="checkbox"/> Recombivax HB ®	1 dose vial		10
Pneumococcal Conjugate - PCV13								<input type="checkbox"/> Prevnar 13 ®	1 dose syringe	10		



	Lot # /Expiration Date	Previous Inventory	Vaccine Received in From ODH at Last Order	Total Vaccine Administered	Vaccine Transferred To (-) or From (+) Another Provider	Expired or Wasted Vaccine	Current Vaccine Inventory	Provider's Name		VFC provider number	
								Vaccine Choice	Presentation	Min Dose Order	Doses Requested
MMR								<input type="checkbox"/> MMRII ®	1 dose vial	10	
Varicella (chickenpox)								<input type="checkbox"/> Varivax ®	1 dose vial	10	
MMR-V (ProQuad)								<input type="checkbox"/> ProQuad ®	1 dose vial	10	
HPV								<input type="checkbox"/> Gardasil 9 ® (HPV9)	1 dose vial	10	
								<input type="checkbox"/> Cervarix ® (HPV2)	1 dose syringe	10	
Rotavirus								<input type="checkbox"/> RotaTeq ® (RV5)	<input type="checkbox"/> 1 dose tube	10	
									<input type="checkbox"/> 1 dose tube	25	
								<input type="checkbox"/> Rotarix ® (RV1)	1 dose vial	10	
Hep A								<input type="checkbox"/> Havrix ®	<input type="checkbox"/> 1 dose vial	10	
									<input type="checkbox"/> 1 dose syringe	10	
								<input type="checkbox"/> Vaqta ®	<input type="checkbox"/> 1 dose vial	10	
									<input type="checkbox"/> 1 dose syringe	10	
Meningococcal (MCV4)								<input type="checkbox"/> Menactra ®	1 dose vial	5	
								<input type="checkbox"/> Menveo ®	1 dose vial	5	
Meningococcal B								<input type="checkbox"/> Bexsero ®	1 dose syringe	10	
								<input type="checkbox"/> Trumenba ®	1 dose syringe	10	
<b>Items below available on a case-by-case basis with written request - Please specify why the vaccine is medically necessary</b>											
Pediatric DT								<input type="checkbox"/> Ped-DT	1 dose vial	10	
Pneumococcal Polysaccharide								<input type="checkbox"/> Pneumovax ®	1 dose vial	10	
Vaccine Order Phone (614) 752-1352    Immunization Program Phone (800) 282-0546											

**1. All sections of the VFC Order Form must be completed for an order to be processed.**

- A.** Comments and special Instructions should be included on the fax cover page and should include any restricted shipping hours, reasons why additional doses of vaccine are being ordered or why special vaccines, such as DT, Pneumococcal Polysaccharide, or Td are being ordered. VFC clinics should be providing Tdap to their adolescent population rather than Td.
- B.** All sites must submit the highest and lowest temperatures they have recorded over the last three months on both the refrigerator and freezer where VFC vaccine is stored.

**2. Complete the Vaccine Inventory Section**

- A. Lot #/Expiration Date** - Include lot # information and expiration date for for all vaccine transactions within the last order period.
- B. Previous Inventory** – The doses of VFC vaccine you had in stock prior to your last order.
- C. Vaccines Received from ODH at Last Order** – The VFC doses you last received from ODH.
- D. Total Vaccine Administered** – The doses administered to VFC eligible patients.
- E. Vaccine Transferred To or From Another Provider** – List the number of doses that were taken from your VFC stock and transferred to another site (this number should read as a negative). List the number of VFC doses that were brought in from another site's VFC stock and added to your supply (this number should read as a positive). The ODH Vaccine Transfer Form must be completed to document these transfers.
- F. Expired or Wasted VFC Vaccine** – The number of VFC doses that were lost due to expiration or wastage. Note: Your VFC Consultant should be notified and these vaccines must be sent back to McKesson accompanied by the VFC Transfer Form.
- G. Current Vaccine Inventory** – The current supply of VFC vaccine on hand at the time of this order.

**Note: Vaccine Inventory must be completed on all VFC vaccines regardless of the numbers or types of vaccines that are ordered.**