

PIN (required): _____ **Facility Name:** _____ **Date:** ____/____/____

Delivery Address (if new): _____

Contact Name: _____ **Phone #:** _____ **Fax #:** _____

Email: _____ **Special Delivery Instructions:** _____

VACCINE	TOTAL # OF VFC DOSES ON HAND	VACCINE	TOTAL # OF VFC DOSES ON HAND
DTaP		Polio	
DTaP/HepB/IPV (Pediatrix)		Varicella	
DTaP/Hib/IPV (Pentacel)		PCV13 (Pneumococcal Conjugate)	
DTaP/IPV (Kinrix)		MCV4 (Meningococcal Conjugate)	
Tdap		Hepatitis A	
Hib		Rotavirus	
Hepatitis B		HPV (Human Papillomavirus)	
MMR			

Select the Vaccine Brands You Want to Receive

VACCINE	BRAND NAME (Manufacturer)	VACCINE	BRAND NAME (Manufacturer)
DTAP (Select One Brand Only)	<input type="checkbox"/> Daptacel (Sanofi) <input type="checkbox"/> Infanrix (GSK)	HPV (Select One Brand Only)	<input type="checkbox"/> Cervarix (GSK) <input type="checkbox"/> Gardasil (Merck)
DTaP/IPV	<input type="checkbox"/> Kinrix (GSK) (only for children 4 – 6 yrs of age)	Rotavirus (Select One Brand Only)	<input type="checkbox"/> Rotarix (GSK) <input type="checkbox"/> Rotateq (Merck)
Tdap (Select One Brand Only)	<input type="checkbox"/> Adacel (Sanofi) <input type="checkbox"/> Boostrix (GSK)	Hepatitis A (Select One Brand Only)	<input type="checkbox"/> Havrix (GSK) <input type="checkbox"/> Vaqta (Merck)
MCV4 (Select One Brand Only)	<input type="checkbox"/> Menactra (Sanofi) <input type="checkbox"/> Menveo (Novartis)	Hepatitis B (Select One Brand Only)	<input type="checkbox"/> Engerix (GSK) <input type="checkbox"/> Recombivax (Merck)
Hib (Select One Only)	<input type="checkbox"/> ActHib (Sanofi) and Pediatrix (GSK) <input type="checkbox"/> Pedvax Hib (Merck) and Pediatrix (GSK) <input type="checkbox"/> Pentacel (Sanofi)	Check to receive a supply of single antigen Hib vaccine for catch-up. VFC will determine amount to send <input type="checkbox"/>	

INSTRUCTIONS:

1. Your VFC provider identification number (PIN) is required with every inventory submission.
2. Indicate your vaccine delivery address if it has changed since the last inventory submission.
3. If applicable describe any special delivery instructions (i.e., no delivery on Wednesday).
4. Write in the TOTAL number of doses of each VFC vaccine type (regardless of brand name) you currently have.
For example: 10 doses of Daptacel and 40 doses of Infanrix = 50 total doses on hand of DTaP.
5. Select the vaccine brand you want shipped to you. Select only one brand per vaccine type.
Vaccine substitutions of brand preference may be necessary to expedite your order.

Hib vaccine is routinely shipped as part of a combination package. The Advisory Committee on Immunization Practices (ACIP) recommends the use of combination vaccines whenever possible.

Providers who select Pentacel will NOT routinely receive single antigen Hib vaccine. Pentacel and Pediarix users may check the “box” to request a supply of single antigen Hib vaccine for catch-up usage. The VFC Program will determine the amount of catch-up Hib vaccine to send.

DT pediatric, Hiberix (Hib dose for kids 15 months through 4 yrs of age), PPV23 and Td vaccines are only available upon request. Call the VFC Contact Center, 410-404-4128 or 410-299-5647 to request vaccine.

6. Fax this form to the Maryland Vaccines for Children Program at 410-333-5893.
7. Vaccine delivery can be expected approximately 2 weeks after faxing.
8. This form is available on the internet. Go to www.edcp.org
(click Immunization, click Maryland Vaccines for Children Program).