EOHU BSEO
Eastern Ontario Health Unit
Bureau de santé de l'est de l'Ontario

Vaccine Order Form for Healthcare Providers

EASTERN ONTARIO HEALTH UNIT
1000 Pitt Street
Cornwall, Ontario K6J 5T1
Telephone: 613-933-1375 ext. 1283

EOHU Use Only – Order Number: _____

When completed, fax or email this form to:
Fax: 613-936-0700
Email: store@eohu.ca

- **Submit a copy of the LAST 4 WEEKS of temperatures with your order.**
- Maintain no more than a one-month supply in your vaccine fridge at any time.
- Refer to the current ***Publicly Funded Immunization Schedules for Ontario*** for eligibility criteria. Call for questions on recommended immunizations.
- **Complete ALL fields to avoid a delay in processing your vaccine order.**

Healthcare Provider/Clinic/Long Term Care Home Name _____

Order Date (Year/Month/Date) _____

Healthcare Provider Contact

Last Name _____ First Name _____ Title _____

Telephone Number _____ Fax Number _____ Email Address _____

Address

Unit Number _____ Street Number _____ Street Name _____ Post Office Box _____ STN/ RPO/ RR _____

City/Town _____ Province _____ Postal Code _____

DESCRIPTION	DOSES ON HAND	SUPPLIED AS DOSES PER PACKAGE	DOSES REQUIRED
VACCINES			
Haemophilus influenzae type b Vaccine **(Hib)** Act-HIB®/HIBERIX		5	
Measles, Mumps and Rubella Vaccine **(MMR)** MMR®II/PRIORIX		10	
Measles, Mumps, Rubella and Varicella Vaccine **(MMRV)** PRIORIX-TETRA / ProQuad®		10	
Meningococcal quadivalent **(Men-C-ACYW135)** NIMENRIX® / MENVEO / MenQuadfi® (Routine vaccination at 12 months)		10	
Pertussis, Diphtheria, Tetanus, Polio and *Haemophilus influenzae* type b Vaccine **(DTaP-IPV-Hib)** PEDIACEL® / PENTACEL® / INFANRIX-IPV/Hib		10	
Pneumococcal 15-valent conjugate **(Pneu-C-15)** Vaxneuvance (Routine schedule for children 6 weeks to 4 years of age)		10	
Polio Vaccine **(IPV)** IMOVAX® Polio		1	
Rotavirus Vaccine **(Rot-1)** ROTARIX		10	
Tetanus and Diphtheria Vaccine **(Td)** Td ADSORBED		10	
Tetanus, Diphtheria and Pertussis Vaccine **(Tdap)** ADACEL®/BOOSTRIX		10	
Tetanus, Diphtheria, Pertussis and Polio Vaccine **(Tdap-IPV)** ADACEL®-POLIO / BOOSTRIX-POLIO)		10	
Varicella Vaccine **(Var)** Varivax®III / VARILRIX		10	
VACCINES – DESIGNATED POPULATIONS			
Pneumococcal 20-valent conjugate **(Pneu-C-20)** Prevnar 20™ (High risk individuals 6 weeks to 64 years of age who meet eligibility criteria)		10	

DESCRIPTION	DOSES ON HAND	SUPPLIED AS DOSES PER PACKAGE	DOSES REQUIRED
Pneumococcal 21-valent conjugate **(Pneu-C-21)** CAPVAXIVE® (Individuals 65 years of age and older only)		10 or 1	
Shingles Herpes Zoster **(HZ)** SHINGRIX (Adults 65-70 yrs of age only)		1	
Tuberculin Purified Protein Derivative (5 TU) – TB testing solution TUBERSOL®		10	
HIGH RISK - WITH INDIVIDUALIZED PRESCRIPTION, INCLUDING ELIGIBILITY CRITERIA			
Hepatitis A Vaccine, Inactivated Pediatric, 0.5 ml **(HA-ped)** HAVRIX / VAQTA® / AVAXIM®		1	
Hepatitis A Vaccine, Inactivated Adult ,1.0 ml **(HA)** HAVRIX / VAQTA® / AVAXIM®		1	
Hepatitis B (Paediatric) Vaccine, 0.5 ml Vial 1 / Box **(HB-ped)** Engerix-B® / RECOMBIVAX HB		1	
Hepatitis B (Adult) Vaccine, 1.0 ml Vial 1 / Box **(HB)** Engerix-B® / RECOMBIVAX HB		1	
Human Papilloma Virus **(HPV-9)** GARDASIL®9 (≤ 26 yrs Men who have sex with men)		1	
Meningococcal Conjugate Vaccine **(Men-C-ACYW135)** NIMENRIX® / MENVEO / MenQuadfi® (Individuals ≥9 months who are eligible)		1	
RESPIRATORY SYNCYTIAL VIRUS (RSV) (SEASONAL VACCINE)			
Eligible adults aged 60 years and older who meet the high risk criteria **(RSV)** AREXVY		1 or 10	
Eligible adults aged 60 years and older who meet the high risk criteria and/or pregnant individuals (28 to 36 weeks gestation) **(RSV)** ABRYSVO®		1 or 10	
RSV MONOCLONAL ANTIBODY **(RSV-Ab)** **Beyfortus® 50mg** for eligible infants (<5kg)		1 or 5	
RSV MONOCLONAL ANTIBODY **(RSV-Ab)** **Beyfortus® 100mg** for eligible infants (≥ 5kg)		1 or 5	
VACCINE RELATED PRODUCTS			
Immunization Cards – Available in English		1	
Immunization Cards – Available in French		1	
Vaccine Temperature Log Book – English		1	
Vaccine Temperature Log Book – French		1	

By submitting this order and signing below, I verify on behalf of the practice the following:

- Refrigerators have maintained temperatures between +2°C to +8°C and temperatures are documented twice daily.
- All temperature excursions outside of +2°C to +8°C (if applicable) have been reported to the EOHU and recommendations regarding usage of the effected vaccines have been implemented by the practice.
- A contingency plan is in place should a power outage and/or cold chain incident occur, including vaccine coolers and extra temperature monitoring devices.

NOTE: *If you are unable to verify any of the above, call EOHU Materials Management at 613-933-1375 ext. 1283.*

To expedite vaccine pick-up, please ensure that you arrive at the Health Unit with your cooler prepped. Cooler must have a min/max digital thermometer and temperatures must be maintained between +2°C to +8°C. In addition, you must have icepacks/ice blankets as well as bubble wrap. Vaccines will not be released until all cold chain requirements are adhered to. Should you require additional materials, please contact the Health Unit.

Customer - Authorized Official (Please print)

Last Name _____ First Name _____ Title _____

Signature _____ Date (Year/Month/Date) _____

If you require this information in an alternate format, please call 1-800-267-7120 and press 0.