# Vaccine Special Order Request Form

INSTRUCTIONS: Please select indication for use of vaccine and number of doses requested. Upon approval, doses will be shipped directly to your facility. Fax form to: 317-233-3719. **A minimum of 1 dose can be ordered for each vaccine at any time during the month, regardless of a previous order.**

Facility Name: _________________________________________ Facility PIN: ___________________

Name Person Requesting: ______________________________ Date: _________________________

Telephone Number: ___________________________________ Email: _________________________

## Diphtheria-Tetanus (DT – Generic)

| | |
|---|---|
| | ☐ Encephalopathy within seven days of previous dose of DTaP or DTP<br>☐ Allergy to pertussis component of vaccine<br>☐ Temp > 105° F, Persistent inconsolable crying lasting 3 or more hours, or collapse within 48 hours of previous dose of DTaP<br>☐ Seizure within 3 days of receipt previous dose of DTaP vaccine*<br>☐ Progressive or unstable neurologic disorder, uncontrolled seizures or progressive encephalopathy (only until treatment initiated and condition is stabilized)<br>*A family history of seizures or adverse event following vaccination with DTaP is not a contraindication to vaccination with DTaP. |
| | **Number of doses requested _______** |
| **Notes:** | |

## Pneumococcal Polysaccharide Vaccine (PPSV23) - Pneumovax

| Chronic Condition | Asplenia | Immunodeficiency |
|---|---|---|
| ☐ Chronic heart disease<br>☐ Chronic lung disease*<br>☐ Chronic renal disease<br>☐ Diabetes mellitus<br>☐ Cerebrospinal fluid leak<br>☐ Cochlear implant<br>☐ Other ________________<br><br>*Children with asthma only if using long-term oral corticosteroid therapy (does not include inhalers) | ☐ Sickle cell disease<br>☐ Asplenia | ☐ Congenital or acquired immunodeficiency<br>☐ HIV<br>☐ Nephrotic syndrome<br>☐ Cancer / Leukemia<br>☐ Treatment with immunosuppressive drugs<br>☐ Solid organ transplant<br>☐ Other _________________ |
| **Number of doses requested _______** | | |
| **Notes:** | | |

Children with immunocompromising conditions or functional/anatomic asplenia should receive a second dose of PPSV23 5 years following the first dose. For more information on the current ACIP recommendations for the use of PPSV23 in children, please visit: http://www.cdc.gov/vaccines/pubs/ACIP-list.htm

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In addition to these three vaccines listed, Td vaccine should be ordered in limited quantities, **preferably in a minimum of 1-2 doses.** Providers can order this through the Vaccine Order catalog in VTrckS. A Vaccine Special Order Request Form does not need to be completed for this vaccine unless a previous order has already been submitted for the month.

## Td (Tetanus and Diphtheria toxoids) – Tenivac

| A single dose of Tdap should be given to children 7 through 18 years of age who: | A 3-dose series of Tdap and Td* should be given to children 7 through 18 years of age who: |
|---|---|
| 1. Have received tetanus and diphtheria containing vaccines (DT or Td) instead of DTP/DTaP for some or all doses of the childhood series;<br>2. Have received fewer than 5 doses of DTP/DTaP or 4 doses if the fourth dose was administered at age 4 years or older; or | 1. Have never been vaccinated against tetanus, diphtheria, or pertussis (no doses of pediatric DTP/DTaP/DT or Td).<br><br>* The preferred catch-up vaccination schedule is a single Tdap dose, followed by Td for any remaining doses. If not administered as the first dose, Tdap can be substituted for any of the other Td doses in the series. Tdap is preferred over Td for the first dose in the catch-up series.<br><br>Routine Td Schedule for Unvaccinated Persons 7 Years of Age or Older<br><br>Primary 1 Dose (Tdap)<br>Primary 2 Dose (Td) – minimum 4 week interval<br>Primary 3 Dose (Td) – minimum 6 month interval |
| **Number of doses requested _______** | |
| **Notes:** | |

More information about the catch-up is available in Appendix D at:
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5503a1.htm?s_cid=rr5503a1_e

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Name Person Requesting: ______________________________ Date: _________________________

Telephone Number: ___________________________________ Email: _________________________

| **Meningococcal Group B – Trumenba** | **Meningococcal Group B – Bexsero** |
|---|---|
| ☐ Sickle cell disease<br>☐ Asplenia<br>☐ Complement deficiency<br>☐ Microbiologist*<br>☐ High-risk Outbreak Exposure<br><br>*Routinely exposed to isolates of Neisseria meningitidis | ☐ Sickle cell disease<br>☐ Asplenia<br>☐ Complement deficiency<br>☐ Microbiologist*<br>☐ High-risk Outbreak Exposure<br><br>*Routinely exposed to isolates of Neisseria meningitidis |
| **Number of doses requested ______** | **Number of doses requested _______** |
| **Notes:** | |