

**Public Health Unit Use Only – Order Number:**

**Instructions:**

- All information must be filled out for each vaccine ordered to avoid a delay in processing.
- Four weeks of vaccine fridge temperature logs must be included with every vaccine order.
- When completed, fax this form to your local Algoma Public Health (APH) office:

Sault Ste. Marie 294 Willow Ave.	Submit order by Wednesday at 4:00 PM. Pick-up on Friday between 9:00 AM–12:00 PM or 1:00 PM–4:00 PM.	Phone: 705-759-5409 Fax: 705-541-5959
Blind River 9B Lawton St.	Submit order by Tuesday at 4:00 PM. Pick-up on Friday between 9:00 AM–12:00 PM or 1:00 PM–4:00 PM.	Phone: 705-356-2551 Fax: 705-356-2494
Elliot Lake 302-31 Nova Scotia Walk	Orders may be submitted at any time and will be ready for pick-up after two business days.	Phone: 705-848-2314 Fax: 705-848-1911
Wawa 18 Ganley St.	Orders may be submitted at any time and will be ready for pick-up after two business days.	Phone: 705-856-7208 Fax: 705-856-1752

- Eligibility criteria for high risk vaccines can be found in “Table 3: High Risk Vaccine Programs” in the current edition of the Publicly Funded Immunization Schedules for Ontario.

<b>Healthcare Provider / Agency Name:</b>	<b>Date:</b>
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<b>Name of Contact Person:</b>	<b>Phone Number:</b>
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<b>Fax Number:</b>	<b>City/Town:</b>
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HIGH RISK Vaccines/Age/Product ID	HIGH RISK Eligibility Criteria (Please mark all that apply)	Doses Required
<b>DTaP-IPV-Hib – Diphtheria, Tetanus, Acellular Pertussis, Inactivated Poliomyelitis, and Haemophilus Influenzae type b Vaccine (5-6 years)</b> <b>(Pentacel®)</b> <b>[6571-3348-0] – 5 dose/box</b> <b>Age of client(s): _____</b>	<input type="checkbox"/> Asplenia (functional or anatomic) <b>(1 dose)</b> <input type="checkbox"/> Bone marrow or solid organ transplant recipients <b>(1 dose)</b> <input type="checkbox"/> Cochlear implant recipients (pre/post implant) <b>(1 dose)</b> <input type="checkbox"/> Hematopoietic stem cell transplant (HSCT) recipient <b>(3 doses)</b> <input type="checkbox"/> Immunocompromised individuals related to disease or therapy <b>(1 dose)</b> <input type="checkbox"/> Lung transplant recipient <b>(1 dose)</b> <input type="checkbox"/> Primary antibody deficiency <b>(1 dose)</b>	_____
<b>Hib - Haemophilus Influenzae Type b Vaccine (≥ 5 years)</b> <b>(Act-HIB®)</b> <b>[6571-3255-0] – 5 dose/box</b> <b>Age of client(s): _____</b>	<b>Note:</b> High risk children 5 to 6 years of age who require DTaP-IPV and Hib should receive DTaP-IPV-Hib instead of Hib.	_____
<b>IPV – Inactivated Poliomyelitis Vaccine (≥18 years)</b> <b>(Imovax Polio®)</b> <b>[6571-3220-2] – 1 dose/box</b>	<input type="checkbox"/> Travellers who have completed their immunization series against polio and are travelling to areas where poliovirus is known or suspected to be circulating  Refer to the Committee to Advise on Tropical Medicine and Travel (CATMAT) for recommendations  <b>Note:</b> Travellers are eligible to receive a single adult lifetime booster dose of IPV-containing vaccine. The most appropriate vaccine (i.e., IPV or Tdap-IPV) should be selected.	_____
<b>Tdap-IPV – Tetanus, Diphtheria, Acellular Pertussis and Inactivated Poliomyelitis (≥18 years)</b> <b>(Adacel-Polio® / Boostrix-Polio®)</b> <b>[6571-2013-1] – 10 dose/box</b> <b>Age of client(s): _____</b>		_____

HIGH RISK Vaccines/Age/Product ID	High Risk Eligibility Criteria (Please mark all that apply)	Doses Required
<p><b>HA - Hepatitis A Vaccine</b></p> <p>(Avaxim®/ Havrix®/Vaqta®) [6571-3256-0] – 1 dose/box – Paediatric (≥ 1 years)</p> <p>Avaxim®/ Havrix®//Vaqta® [6571-3257-0] – 1 dose/box – Adult (≥ 1 years)</p> <p>Age of client(s): _____</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Persons engaging in intravenous drug use (<b>2 doses</b>)</li> <li><input type="checkbox"/> Chronic liver disease (including Hepatitis B and C) (<b>2 doses</b>)</li> <li><input type="checkbox"/> Men who have sex with men (<b>2 doses</b>)</li> </ul>	<p>_____</p> <p>_____</p>
<p><b>HB - Hepatitis B Vaccine</b></p> <p>(Engerix® -B/ Recombivax HB®) [6571-3251-0] – 1 dose/box – Paediatric (≥0 years)</p> <p>(Engerix® -B/ Recombivax HB®) [6571-3243-0] – 1 dose/box – Adult (≥0 years)</p> <p>(Engerix® -B/ Recombivax HB®) [6571-3324-1] – 1 dose/box – Renal Dialysis (≥0 years)</p> <p>Age of client(s): _____</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Child &lt;7 years old whose families has immigrated from countries of high prevalence for HBV and who may be exposed to HBV carriers through their extended family (<b>3 doses</b>)</li> <li><input type="checkbox"/> Household and sexual contacts of chronic carriers and acute cases (<b>3 doses</b>)</li> <li><input type="checkbox"/> History of a sexually transmitted disease (<b>3 doses</b>)</li> <li><input type="checkbox"/> Infants born to HBV-positive carrier mothers: <ul style="list-style-type: none"> <li>- premature infants weighing &lt;2,000 grams at birth (<b>4 doses</b>)</li> <li>- premature infant weighing ≥2,000 grams at birth and full/post term infants (<b>3 doses</b>)</li> </ul> </li> <li><input type="checkbox"/> Intravenous drug use (<b>3 doses</b>)</li> <li><input type="checkbox"/> Liver disease (chronic), including hepatitis C (<b>3 doses</b>)</li> <li><input type="checkbox"/> Awaiting liver transplants (<b>2nd and 3rd doses only</b>)</li> <li><input type="checkbox"/> Men who have sex with men (<b>3 doses</b>)</li> <li><input type="checkbox"/> Multiple sex partners (<b>3 doses</b>)</li> <li><input type="checkbox"/> Needle stick injury in a non-health care setting (<b>3 doses</b>)</li> <li><input type="checkbox"/> On renal dialysis or those with diseases requiring frequent receipt of blood products (e.g., haemophilia) (<b>2nd and 3rd doses only</b>)</li> </ul>	<p>_____</p> <p>_____</p> <p>_____</p>
<p><b>HPV-9 - Human Papillomavirus 9-Valent Vaccine (Males 9 to 26 years)</b></p> <p>(Gardasil®9) [6571- 3390-0] – 1 dose/box</p> <p>[6571- 3390-1] – 10 dose/box</p> <p>Age of client(s): _____</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Men who have sex with men</li> </ul>	<p>_____</p>
<p><b>4CMenB - Meningococcal B Vaccine (2 months to 17 years)</b></p> <p>(Bexsero®) [6571-3314-0] – 1 dose/box</p> <p>Age of client(s): _____</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Acquired complement deficiencies (e.g., receiving eculizumab)</li> <li><input type="checkbox"/> Asplenia (functional or anatomic)</li> <li><input type="checkbox"/> Cochlear implant recipients (pre/post implant)</li> <li><input type="checkbox"/> Complement, properdin, factor D, or primary antibody deficiencies</li> <li><input type="checkbox"/> HIV</li> </ul>	<p>_____</p>
<p><b>Men-C-ACYW135 - Meningococcal Conjugate Quadrivalent Vaccine (9 months* and older)</b></p> <p>(Menactra®) [6571-3360-0] – 1 dose/box</p> <p>(Nimenrix®) [6571-3370-0] – 1 dose/box</p> <p>(MenQuadfi®) [6571-3340-0] – 10 dose/box <i>*only authorized for individuals over 12 months</i></p> <p>Age of client(s): _____</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Functional or anatomic asplenia</li> <li><input type="checkbox"/> Complement, properdin, factor D, or primary antibody deficiency</li> <li><input type="checkbox"/> Cochlear implant recipient - pre/post implant</li> <li><input type="checkbox"/> Acquired complement deficiency</li> <li><input type="checkbox"/> HIV</li> </ul>	<p>_____</p>

HIGH RISK Vaccines/Age/Product ID	High Risk Eligibility Criteria (Please mark all that apply)	Doses Required
<p><b>Pneu-C-20</b> - Pneumococcal 20-Valent Conjugate Vaccine <b>(6 weeks to 64 years)</b></p> <p><b>(Prenar™ 20)</b> <b>[6571-4020-1]</b> – 10 dose/box</p> <p>Age of client(s): _____</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Asplenia (functional or anatomic), splenic dysfunction</li> <li><input type="checkbox"/> Congenital (primary) immunodeficiencies involving any part of the immune system, including B-lymphocyte (humoral) immunity, T-lymphocyte (cell) mediated immunity, complement system (properdin, or factor D deficiencies), or phagocytic functions</li> <li><input type="checkbox"/> HIV infection</li> <li><input type="checkbox"/> Immunocompromising therapy, including use of long-term systemic corticosteroid, chemotherapy, radiation therapy, post-organ transplant therapy, certain anti-rheumatic drugs and other immunosuppressive therapy</li> <li><input type="checkbox"/> Malignant neoplasms, including leukemia and lymphoma</li> <li><input type="checkbox"/> Sickle-cell disease and other sickle cell hemoglobinopathies</li> <li><input type="checkbox"/> Solid organ islet cell transplant (recipient)</li> <li><input type="checkbox"/> Hepatic cirrhosis due to any cause</li> <li><input type="checkbox"/> Chronic renal disease, including nephrotic syndrome</li> <li><input type="checkbox"/> Chronic cardiac disease</li> <li><input type="checkbox"/> Chronic liver disease, including hepatitis B and C</li> <li><input type="checkbox"/> Chronic respiratory disease, excluding asthma, except those treated with high-dose corticosteroid therapy</li> <li><input type="checkbox"/> Chronic neurologic conditions that may impair clearance of oral secretions</li> <li><input type="checkbox"/> Diabetes mellitus</li> <li><input type="checkbox"/> Cochlear implant recipients (pre/post implant)</li> <li><input type="checkbox"/> Chronic cerebral spinal fluid leak</li> <li><input type="checkbox"/> Residents of nursing homes, homes for the aged and chronic care facilities or wards</li> <li><input type="checkbox"/> Hematopoietic stem cell transplant (HSCT) (recipient)</li> </ul> <p>Note: Age at first dose: 6 weeks to 4 years of age (<b>up to 4 doses</b>) 5 to 64 years of age with certain medical and non-medical conditions (<b>1 lifetime dose</b>) 5 to 64 years of age Post HSCT (<b>4 doses</b>)</p>	
<p><b>RSV</b> - Respiratory Syncytial Virus Vaccine for Adults <b>(use this order form only for individuals 60 to 74 years of age – for individuals over 75 years, or those who are pregnant, use the routine vaccine order form).</b></p> <p><b>(Arexvy®)</b> <b>[6571-2300-0]</b> – 1 dose/box</p> <p><b>(Abrysvo™)</b> <b>[6571-2324-0]</b> – 1 dose/box</p> <p><b>(Abrysvo™)</b> <b>[6571-2324-1]</b> – 10 dose/box</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Residents of long-term care homes, Elder Care Lodges, or retirement homes including similar settings (e.g. co-located facilities)</li> <li><input type="checkbox"/> Individuals in hospital receiving alternate level of care (ALC) including similar settings (e.g., complex continuing care, hospital transitional programs)</li> <li><input type="checkbox"/> Individuals with glomerulonephritis (GN) who are moderately to severely immunocompromised</li> <li><input type="checkbox"/> Individuals receiving hemodialysis or peritoneal dialysis</li> <li><input type="checkbox"/> Recipients of solid organ or hematopoietic stem cell transplants</li> <li><input type="checkbox"/> Individuals experiencing homelessness</li> <li><input type="checkbox"/> Individuals who identify as First Nations, Inuit, or Métis</li> </ul>	

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<p><b>(RSVAb)</b> Respiratory Syncytial Virus Monoclonal Antibody – <b>for infants born on April 1, 2025 or later, and who are less than 8 months of age, use the routine vaccine/supply order form.</b></p> <p><b>(Beyfortus®)</b> [6571-2200-0] – 0.5 ml Prefilled Syringe, 1 dose/box <input type="checkbox"/> Infants &lt;5kg: 50 mg in 0.5 mL (50 mg/mL)</p> <p><b>(Beyfortus®)</b> [6571-2400-0] – 1 ml Prefilled Syringe, 1 dose/box <input type="checkbox"/> Infants ≥ 5kg: 100 mg in 1 mL (100mg/mL)</p> <p><b>(Beyfortus®)</b> [6571-2400-1] – 1ml Prefilled Syringe, 5 dose/box <input type="checkbox"/> Infants ≥ 5kg: 100 mg in 1 mL (100mg/mL)</p>	<p>Children 8 months to less than 24 months of age who have one of the following conditions:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Chronic lung disease (CLD), including bronchopulmonary dysplasia <i>Note: children who were &lt;12 months of age and approved for coverage in the previous RSV season for chronic lung disease and bronchopulmonary dysplasia remain eligible</i></li> <li><input type="checkbox"/> Hemodynamically significant congenital heart disease (CHD) defined as infants requiring corrective surgery or are on cardiac medication for congestive heart failure or diagnosed with moderate to severe pulmonary hypertension</li> <li><input type="checkbox"/> Severe immunodeficiency</li> <li><input type="checkbox"/> Down syndrome/Trisomy 21</li> <li><input type="checkbox"/> Cystic fibrosis with recurrent pulmonary exacerbations requiring hospitalization, deteriorating pulmonary function and/or severe growth delay</li> <li><input type="checkbox"/> Neuromuscular disease impairing clearance of respiratory secretions</li> <li><input type="checkbox"/> Severe congenital airway anomalies impairing the clearing of respiratory secretions</li> </ul>	<p>_____</p> <p>_____</p>
<p><b>Var</b> – Varicella Vaccine <b>(Born in or prior to 1999)</b></p> <p><b>(Varilrix/Varivax III)</b> [6571-3305-0] – 10 dose/box</p> <p><b>Age of client(s):</b> _____</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Susceptible children and adolescents given chronic salicylic acid therapy</li> <li><input type="checkbox"/> Susceptible individuals with cystic fibrosis</li> <li><input type="checkbox"/> Susceptible household contacts of immunocompromised individuals</li> <li><input type="checkbox"/> Susceptible individuals receiving low dose steroid therapy or inhaled/topical steroids</li> <li><input type="checkbox"/> Susceptible immunocompromised individuals, see the Canadian Immunization Guide</li> </ul>	<p>_____</p>

**By submitting this order, I verify on behalf of the practice that:**

- The vaccine fridge has maintained temperatures between +2°C to +8°C.
- Temperatures (minimum, maximum, and current) are documented and cleared twice daily.
- All temperature excursions outside of +2°C to +8°C have been reported to APH, and any recommendations from APH regarding use of the affected vaccines and proper storage have been implemented by the practice.
- A contingency plan is in place should a power outage, fridge failure and/or cold chain incident occur.