MONTANA
Department of Public Health & Human Services

Immunization Program

Vaccine Order Form

Return form to: Home IV Pharmacy
2601 ½ Continental Drive
Butte MT 59701
FAX 406-723-4059

If faxing, please also send a copy in the mail.

Please check your assigned ordering frequency:

☐Quarterly ☐Bimonthly ☐Monthly ☐As Needed

Date Submitted:

VFC ID #:

Facility Name:

Physical Address (No PO Boxes):

Contact Person:

Contact's Direct Phone:

Contact's E-mail:

VACCINE	MINIMUM DOSE ORDER	DOSES ORDERED	DOSES ON HAND (Must complete inventory if not submitted with monthly report)
DTaP	10		
DTaP/IPV (Kinrix®)	10		
DTaP/IPV/HIB (Pentacel®)	5		
DTaP/IPV/Hep B (Pediarix®)	10		
IPV	10		
Hib (Must check one) ☐ **ActHIB**	5		
☐ **PedvaxHIB**	10		
☐ **Hiberix**	10		
PCV13	10		
Pneumococcal Polysaccharide (for high-risk 2–18 yr olds)	10		
Rotavirus (Must check one) ☐ **2 dose**	10		
☐ **3 dose**	10		
MMR	10		
Varicella	10		
Tdap (for 10 or 11–18 yr olds)	10		
Td (for 7–18 yr olds)	10		
MCV	5		
HPV	10		
Hep A (0–18 yrs)	10		
Hep B (0–18 yrs)	10		
Other:			

Current forms can be found at www.immunization.mt.gov.