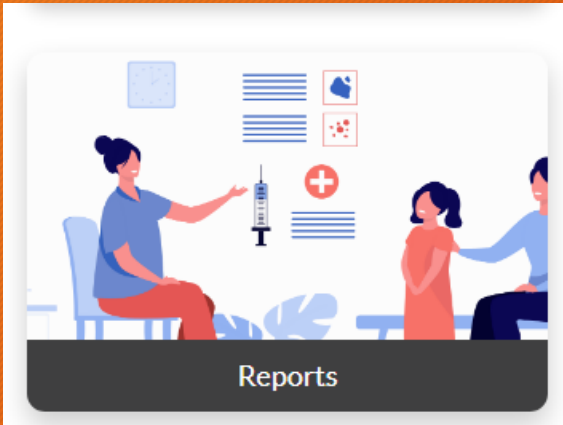


RUNNING DATE - DOSES ABOUT TO EXPIRE REPORT



PIN	Provider	Vaccine Group	NDC	Lot Number	Expiration Date	Vaccine Description	Total
070442	Communitycare - South Austin	MMR (Adult)	00006-4681-00	U019290	06/18/2023	MMR II (MMR), single-dose vial (Adult)	0
070442	Communitycare - South Austin	Hep A (Adult)	58160-0826-52	NZ7GR	06/17/2023	HAVRIX (HEP A), PF syringe (Adult)	13
070442	Communitycare - South Austin	DTaP	58160-0810-52	7KM94	06/10/2023	INFANRIX (DTAP); Pre-Filled Syringe; PED; 10 PACK	0



WHEN DOWNLOAD IS COMPLETED, REPORT WILL BE IN EXCEL FORMAT (EXPAND COLUMNS FOR LEGIBILITY) PRINT UP REPORT AND HIGHLIGHT VACCINES YOU WANT TO TRANSFER OUT OR TYPE UP THE INFORMATION ON THE EMAIL WITH THE DATE ATTACHED.

IF YOU DO NOT HAVE VACCINES TO TRANSFER OUT THIS REPORT STILL MUST BE RUN AND EMAILED TO R.E.

NOTE WE WILL TRANSFER VACCINES IF THERE IS A PROVIDER THAT CAN ADMINISTER THEM PRIOR TO EXPIRATION. WE CANNOT TRANSFER MULTIDOSE VIALS THAT HAVE BEEN PUNCTURED.

PIN	Vaccine Group	NDC	Lot Number	Expiration Date	Vaccine Description	Total Quantity	Transfer
71084	IPV (Polio - Pediatric)	49281-0860-10	T1D481M	20220725	IPOL (IPV); Multi Does Vial; PED; 10 PACK	5	
71084	MMRV (Proquad)	00006-4171-00	U002529	20220724	PROQUAD (MMR/VARICELLA); Single Dose Vial; PED; 10	1	
71084	HIB (Pediatric)	49281-0545-03	UJ522AAA	20220711	ACTHIB (HIB); Single Dose Vial; PED; 5 PACK	5	
71084	Td (Pediatric)	49281-0215-15	U6852AA	20220710	TENIVAC (Td); Pre-Filled Syringe; PED; 1 PACK	1	1
71084	FLU (Pediatric)	19515-0818-52	3A7CG	20220630	Flulaval Quad (2021-2022) Pre-Filled Syringe; 10 Pack (P	0	
71084	FLU (Pediatric)	58160-0887-52	95Z42	20220630	Fluarix Quad (2021-2022) Pre-Filled Syringe; 10 Pack (Pe	0	
71084	FLU (Pediatric)	19515-0818-52	39D2G	20220630	Flulaval Quad (2021-2022) Pre-Filled Syringe; 10 Pack (P	10	
71084	FLU (Pediatric)	19515-0818-52	3A7CG	20220630	Flulaval Quad (2021-2022) Pre-Filled Syringe; 10 Pack (P	0	
71084	Tdap (Pediatric)	58160-0842-11	3E52S	20220621	BOOSTRIX (TDAP) single-dose vial (Ped)	4	
71084	Tdap (Adult)	58160-0842-11	3E52S	20220621	BOOSTRIX (TDAP) single-dose vial (Adult)	0	
71084	HPV (Pediatric)	00006-4121-02	1637648	20220619	GARDASIL (HPV) Pre-Filled Syringe; PED; 10 PACK	4	
71084	Varicella (Pediatric)	00006-4827-00	T020650	20220616	VARIVAX (VARICELLA) single-dose vial (Ped)	4	2
71084	MMR (Adult)	00006-4681-00	T020655	20220616	MMR II (MMR) single-dose vial (Adult)	4	2


REQUESTING VACCINE TRANSFERS

INCLUDE A PRE-FILLED COPY OF THE VTAF – VACCINE TRANSFER AUTHORIZATION FORM WITH YOUR EMAILED DATE REPORT.

YOU WILL ONLY NEED TO FILL IN THE FRONT HIGHLIGHTED AREAS OF THE FORM.

SAVE A PRE-FILLED COPY OF THE VTAF TO YOUR DESKTOP FOR EASIER SUBMISSION. THE ONLY PORTION THAT IS SUBJECT TO CHANGE IS THE DATE SO LEAVE THAT BLANK WHEN SAVING.

THE R.E. WILL FILL IN THE 2ND PAGE WITH THE VACCINES IDENTIFIED FOR TRANSFER FROM THE DATE REPORT AND OR EMAIL.

 **Texas Vaccines for Children (TVFC) and Adult Safety Net (ASN) Program**
Vaccine Transfer Authorization Form

Guidance:
Texas Vaccines for Children and Adult Safety Net (TVFC/ASN) providers are expected to maintain an adequate inventory of vaccine. The routine re-distribution of TVFC/ASN vaccine is not allowed. Vaccine transfers are limited to: short dated vaccine, withdrawal of a provider from the TVFC/ASN Program, or other (i.e., emergency, disaster, or equipment failure). When a vaccine transfer occurs, the proper cold chain must be maintained. When a provider needs to conduct a transfer of vaccine from one clinic to another, permission must be granted from the designated Department of State Health Services (DSHS) Public Health Region (PHR) prior to the vaccine transfer.

Directions for use of this form:
The TVFC/ASN providers must complete the Vaccine Transfer Authorization Form (EC-67) for each vaccine transfer. Each vaccine that is going to be transferred must be listed on a separate row. Transfer requests must be signed by the DSHS PHR and returned to the clinic before a transfer can be conducted. The Vaccine Transfer Authorization Form must be kept on file for a minimum of five (5) years as required by the TVFC/ASN Program and made easily accessible.

Vaccine transfer in emergency situations (i.e., activation of the Emergency Vaccine Storage and Handling Plan):
In the event that a provider must activate their Emergency Vaccine Storage and Handling Plan, providers must transfer vaccines to the alternative storage location identified in the plan. The PIN/Customer ID for the alternative location should not be included on the Vaccine Transfer Authorization Form if the alternative location is not a TVFC/ASN provider. Providers must contact the DSHS PHR by telephone prior to faxing the Vaccine Transfer Authorization Form in the event of an emergency. If the DSHS PHR cannot be contacted, the provider may transfer vaccine to the alternative storage location and must notify the DSHS PHR as soon as possible. A printout of the Tally Sheet from VAOS with the current vaccine counts pre-populated can be attached in lieu of handwriting all vaccine information on page 2.

Vaccine Transferring From:	Vaccine Transferring To:	Reason for Transferring Request: (Check the appropriate reason)
PIN/Customer ID: _____	PIN/Customer ID: _____	<input type="checkbox"/> 1. Short-Dated Vaccine
Facility Name: _____	Facility Name: _____	<input type="checkbox"/> 2. Withdrawal from the TVFC Program
Address: _____	Address: _____	<input type="checkbox"/> 3. Other (please specify): _____
City/State/Zip: _____	City/State/Zip: _____	_____
Phone: _____	Phone: _____	_____
Fax: _____	Fax: _____	_____
Contact: _____	Contact: _____	_____
Email: _____	Email: _____	_____

I hereby certify, subject to penalty under the False Claims Act (31 U.S.C. § 3730) and other applicable Federal and state law, that Vaccines for Children (VFC) and Adult Safety Net (ASN) vaccine dose transfers reported on this form has been accurately reported and conducted in conformance with VFC and ASN provisions for such transfers and further certify that all VFC and ASN transfers will maintain the proper cold chain as outlined in the TVFC/ASN Provider Manual.

Transferring Provider Name: _____ **Transferring Provider Signature:** _____ **Date:** _____

Receiving Provider Name: _____ **Receiving Provider Signature:** _____ **Date:** _____

DSHS PHR Representative Name: _____ **DSHS PHR Signature:** _____ **Date:** _____
¹ Provider or designee with authorization to act on behalf of the organization.

Texas Department of State Health Services
Immunizations

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Stock No. EC-67
Rev. 02/2022