All requests must be sent to OEMS@delaware.gov

SHOC Resource Form for Monkeypox Vaccine, Antiviral, and Testing Supplies	Requesting Agency Contact Information	
Date:	Time:	Event: 2022 MPX
Requestor's Name:		Title:
Requestor's Organization:		
Phone #:	Mobile #:	Fax #:
Email Address:		

Antiviral Request Information	
TPOXX (Tecovirimat): ☐ Yes ☐ No	**Number of Courses Requested:** (1 course = 2 dose series)
Patient Risk Level/Exposure	
Patient Risk Level: High ☐ Intermediate ☐ Low ☐	DE OIDE (Office of Infectious Disease Epidemiology) Notified: ☐ Yes ☐ No
Additional Information for Consideration:	Patient Confirmed Positive: ☐ Yes ☐ No Case Number (if applicable):
Vaccine Request Information	
****Provider Injection Method** - Provider must indicate whether they plan to use IM or ID injection.**	
Intramuscular **(IM)** injection: **1 vial = 1 dose:** ☐ Yes ☐ No	
Intradermal **(ID)** injection: **1 vial = 2 to 5 doses:** ☐ Yes ☐ No	
******FDA EUA announcement of ID injections increases vaccine availability. *******	
JYNNEOS Vaccine Dose 1: ☐ Yes ☐ No	JYNNEOS Vaccine Dose 2: ☐ Yes ☐ No
Vaccination to occur within 8 weeks of receiving: ☐ Yes ☐ No	
Indication: ☐ Monkeypox ☐ Smallpox ☐ PrEP ☐ PEP ☐ PEP++	Patient 18 years or older: ☐ Yes ☐ No
Number of Vials Requested:	**Number of Vials Requested:**
MPX Testing Supplies Request	
MPX Testing Supplies Needed: ☐ Yes ☐ No	Normal resource chain exhausted ☐ Yes ☐ No
Number of Testing supplies needed:	
****NOTE**** If additional PPE is needed, provide must fill out SHOC Resource Request Form (separate form).	

Delivery Site Information (one delivery site per form)		
Delivery Address *(include facility name, street, city, state and zip)*:		
Delivery Site POC (Point of Contact):		Email:
POC 24-hour Phone #:	POC Mobile #:	POC Fax #:
Additional Information or Comments:		

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POD Type/Method				
For any doses that will be given outside your clinic/office walls and/or for which you are working with a partner (e.g., bringing a church group into your clinic or partnering with a community based organization or partner to deliver the vaccine in an off-site location), please complete the following:				
POD Type/Method: ☐ Open	☐ Closed	☐ Drive-thru	☐ Walk-up	☐ Other
Target population list all that apply:				

Date of event:	Partner name:
Number of doses:	Dose type: ☐ 1st dose ☐ 2nd dose
Remainder of Document Internal Processing	
Verification	
JYNNEOS Dose 1: ☐ Yes ☐ No	JYNNEOS Dose 2: ☐ Yes ☐ No
TPOXX Dose 1 ☐ Yes ☐ No	TPOXX Dose 2: ☐ Yes ☐ No
Specimen Collection Kits Needed: ☐ Yes ☐ No	

Ability to fill request/Allocation Group				
☐ In entirety	☐ Partially	☐ Pending	☐ Redirected	☐ Other
Comments (*why partial pending, redirected or other*)				
Send to DelVAX or SHOC Logistics for action				
Received by:				

Vaccine Unit Director Recommendation:	Date and Time:
Vaccine Unit Director Signature:	