
H1N1 Clinicians Questions and Answers

October 2, 2009, 3:30 PM ET

Who is recommended to receive the 2009 H1N1 flu vaccine?

When vaccine is first available, the CDC Advisory Committee on Immunization Practices (ACIP) has recommended the 2009 H1N1 vaccine for the following 5 **target** groups (approximately 159 million persons nationally):

- Pregnant women
- Household and caregiver contacts of children younger than 6 months of age (e.g. parents, siblings, and daycare providers)
- Health care and emergency medical services personnel
- Persons from 6 months through 24 years of age
- Persons aged 25 through 64 years who have medical conditions associated with a higher risk of influenza complications

Once providers meet the demand for vaccine among persons in these initial target groups, vaccination is recommended for all persons 25 through 64 years of age. Current studies indicate that the risk for infection among persons age 65 or older is less than the risk for younger age groups. However, once vaccine demand among younger age groups has been met, programs and providers should offer vaccination to people 65 or older.

How should providers prioritize among the initial target groups recommended by ACIP?

The recommendations are broad and allow for flexibility to accommodate local variability in vaccine needs and demands. Providers should be aware of and follow any additional guidance provided by their state or local health departments. If no additional guidance is provided at the state or local level, providers should vaccinate among the initial target group populations on a first come, first served basis.

How likely is it that recommendations for target groups may change during the immunization period?

Although it is unlikely the ACIP recommendations will change, predicting the behavior of 2009 H1N1 influenza virus is difficult. CDC will continue to monitor the epidemiology of the evolving pandemic very closely. The Advisory Committee on Immunization Practices will be updated frequently on the status of the pandemic, including groups at highest risk of complications, and recommendations will be modified as necessary.

How will the 2009 H1N1 vaccine flow from manufacturers to providers?

The Federal Government will allocate vaccine to states based on population size. States are responsible for identifying providers who will participate in administration of 2009 H1N1 vaccine. Vaccine will be shipped to participating providers through a centralized distribution process. Through this process, placing of orders is facilitated by the state/local health department, and this information sent to CDC to be transferred to the distributor for processing. Because of limitations related to the number of sites to which the distributor can directly ship vaccine, some project areas (includes all states, territories, Chicago, DC, NYC, and LA county) may develop additional means of distributing vaccine to providers which will be communicated to providers on a local level.

How can providers obtain vaccine?

State/Local public health departments will be responsible for directing the flow of vaccine to providers within every state. They will determine which providers will receive vaccine, and will allocate vaccine among providers as it becomes available to them. Public health departments are in the process of ascertaining which providers are interested in administering vaccine. For more information go to your state's public health department website or to the [CDC 2009 H1N1](#) website for information on how to become a 2009 H1N1 vaccine provider. Participating providers will sign a Provider Agreement assuring they intend to meet state requirements

Will vaccine be distributed equitably across providers?

Public health departments will strive to ensure equitable distribution, taking into account which target groups are seen by different types of providers as well as their internal resources for possible re-distribution of vaccine.

What supplies will be included with the 2009 H1N1 vaccine shipments?

The Federal Government will purchase vaccine and supplies (syringes, alcohol swabs, sharps containers, and vaccine record cards) and distribute these at no cost to healthcare providers who make agreements with state and local public health authorities to provide the 2009 H1N1 vaccine. Supplies will be shipped separately from vaccine and are expected to arrive before or on the same day as vaccine.

How can providers determine what percentage of their patients plan on getting the 2009 H1N1 vaccine in a physician's office?

It is difficult to predict where individuals will go to receive the 2009 H1N1 vaccine. However, based on unpublished data from the Adult National Immunization Survey, during the 2006-2007 influenza season, among 19-49 year olds who were vaccinated, approximately 38% of persons at increased risk of complications from influenza reported receiving influenza vaccine in a physician's office. Approximately 26% of persons with household contact with a high risk person and 25% of persons with no specific indications for influenza vaccine were vaccinated in a physician's office.

What are some possible approaches a practice might take to administer the 2009 H1N1 vaccine?

Options include holding special clinics, integrating the 2009 H1N1 vaccination into usual care, providing walk-in immunizations, or coordinating with local public health clinics if unable to administer 2009 H1N1 vaccine themselves. In determining the best option, each practice should consider several factors, including availability of vaccine, practice resources and patient demand.

If my patients are vaccinated outside of my practice, how will that information be available for inclusion in the patient's permanent medical record?

Recipients of the 2009 H1N1 vaccine will be provided with a hand-held card to serve as a record of vaccination and a source of information should a report to the Vaccine Adverse Event Reporting System (VAERS) be needed. Vaccine recipients will be encouraged to bring the hand-held card at their next visit to their primary care provider so that vaccination information can be transcribed into the patient's permanent medical record.

What CDC information will be available for use in practices to help explain the need for both seasonal and 2009 H1N1 vaccine?

A variety of materials are available on the CDC 2009 H1N1 website at <http://www.cdc.gov/h1n1flu/vaccination/>. In addition, a 2009 H1N1-specific Vaccine Information Statement (VIS) will be available that will help explain the vaccine to recipients.

Can patients who are allergic to eggs receive the 2009 H1N1 flu vaccine?

Asking persons if they can eat eggs without adverse effects is a reasonable way to determine who might be at risk for allergic reactions from receiving influenza vaccines. Persons who have had symptoms such as hives or swelling of the lips or tongue, or who have experienced acute respiratory distress after eating eggs, should consult a physician for appropriate evaluation to help determine if influenza vaccine should be administered. Persons who have documented (IgE)-mediated hypersensitivity to eggs, including those who have had occupational asthma related to egg exposure or other allergic responses to egg protein, also might be at increased risk for allergic reactions to influenza vaccine, and consultation with a physician before vaccination should be considered. A regimen has been developed for administering influenza vaccine to asthmatic children with severe disease and egg hypersensitivity (*J Pediatr* 1985;106:931-3.).

Will private health insurance plans reimburse private providers for administration of 2009 H1N1 vaccine?

According to America's Health Insurance Plans, a national association representing nearly 1,300 companies that provide health insurance to over 200 million Americans, "Every year health plans contribute to the seasonal flu vaccination campaign in several ways:

- a) Health plans communicate directly with plan sponsors and members on the current ACIP recommendations and encourage immunization; they also provide information on where to get vaccinations, and who to contact with any questions.
- b) Just as health plans have provided extensive coverage for the administration of seasonal flu vaccines in the past, public health planners can make the assumption that health plans will provide reimbursement for the administration of 2009 H1N1 vaccine to their members by private sector providers in both traditional settings e.g., doctor's office,

ambulatory clinics, health care facilities, and in non-traditional settings, where contracts with insurers have been established.”

Can seasonal influenza vaccine and 2009 H1N1 vaccine be given at the same visit?

Both seasonal and 2009 H1N1 vaccines are available as inactivated and live attenuated (LAIV) formulations. The simultaneous and sequential administration of seasonal and 2009 H1N1 inactivated vaccines is currently being studied. However, existing recommendations are that two inactivated vaccines can be administered at any time before, after, or at the same visit as each other (General Recommendations on Immunization, MMWR 2006;55[RR-15]). Existing recommendations also state that an inactivated and live vaccine may be administered at any time before, after or at the same visit as each other. Consequently, providers can administer seasonal and 2009 H1N1 inactivated vaccines, seasonal inactivated vaccine and 2009 H1N1 LAIV, or seasonal LAIV and inactivated 2009 H1N1 at the same visit, or at any time before or after each other. Live attenuated seasonal and live 2009 H1N1 vaccines should NOT be administered at the same visit until further studies are done. If a person is eligible and prefers the LAIV formulation of seasonal and 2009 H1N1 vaccine, these vaccines should be separated by a minimum of four weeks.

Can 2009 H1N1 vaccine be administered at the same visit as other vaccines?

Inactivated 2009 H1N1 vaccine can be administered at the same visit as any other vaccine, including pneumococcal polysaccharide vaccine. Live 2009 H1N1 vaccine can be administered at the same visit as any other live or inactivated vaccine EXCEPT seasonal live attenuated influenza vaccine.

Will the 2009 H1N1 vaccine be recommended for patients who had influenza-like illness since spring 2009?

All people in a recommended vaccination target group who did not have 2009 H1N1 virus infection confirmed by real-time reverse transcriptase-polymerase chain reaction (rRT-PCR) test should be vaccinated with the 2009 H1N1 vaccine. **People who had an illness confirmed by rRT-PCR to be 2009 H1N1 virus earlier in 2009 can be considered to be immune and do not need to be vaccinated this year.** However, most people with respiratory illnesses since this spring have not had testing with the rRT-PCR test, which is the only test that can confirm infection specifically with the 2009 H1N1 virus. Tests such as rapid antigen detection assays and diagnoses based on symptoms alone without rRT-PCR testing, cannot specifically determine if a person has 2009 H1N1 influenza. Although people who were not tested, but who became ill within 1-4 days after close contact with a person with lab confirmed 2009 H1N1 influenza might have been infected with 2009 H1N1, they cannot be certain since many pathogens can cause respiratory illness. These people should get the 2009 H1N1 vaccine as recommended for their age and risk group.

People who were infected with the 2009 H1N1 virus and who are not severely immune compromised will likely have immunity to subsequent infection with 2009 H1N1 virus. However, vaccination of a person with some existing immunity to the 2009 H1N1 virus will not be harmful, and patients who are uncertain about how they were diagnosed should get the 2009 H1N1 vaccine. In addition, people recommended for seasonal vaccine should get a seasonal vaccine because infection with the 2009 H1N1 virus does not provide protection against seasonal influenza viruses.

The age for two doses is different for seasonal (6 months through 8 years) and 2009 H1N1 monovalent vaccine (6 months through 9 years) in the package inserts. Does CDC recommend that clinicians follow the recommendation in the package inserts?

CDC recommends that clinicians follow the guidance in the manufacturer package inserts. For 2009 H1N1 monovalent vaccines, that means that clinicians should administer two doses of 2009 H1N1 monovalent vaccine to children 6 months through 9 years of age. Persons 10 years and older should receive one dose.

The interval between 2009 H1N1 monovalent vaccine doses, for children 6 months through 9 years, is stated as "approximately 1 month" in the package inserts. What does "approximately 1 month" mean?

CDC recommends that the two doses of 2009 H1N1 monovalent vaccine be separated by 4 weeks. However, if the second dose is separated from the first dose by at least 21 days the second dose can be considered to be valid. If the interval separating the doses is less than 21 days the second dose should be repeated four weeks after the first dose was given.

If seasonal live attenuated influenza vaccine (LAIV) and 2009 H1N1 LAIV are given during the same visit, do either or both doses need to be repeated, and if so, when?

There are no data on the administration of seasonal and 2009 H1N1 LAIV during the same visit. CDC's Advisory

Committee on Immunization Practices (ACIP) recommends that seasonal and 2009 H1N1 LAIV not be administered during the same visit. However, if both types of LAIV are inadvertently administered during the same visit, neither vaccine needs to be repeated.

If seasonal and 2009 H1N1 LAIV are not administered during the same visit, but are separated by less than 4 weeks, do either or both doses need to be repeated, and if so, when?

Seasonal LAIV and 2009 H1N1 LAIV should not be administered during the same visit, and should be separated by at least 4 weeks. However, if the interval between administration of LAIV and seasonal 2009 H1N1 vaccine is less than 4 weeks, neither vaccine needs to be repeated.

Can a person who has received LAIV test positive on a rapid influenza diagnostic test?

The live attenuated influenza vaccine viruses in LAIV (seasonal vaccine and 2009 H1N1 monovalent vaccine) can cause a positive result on a rapid influenza diagnostic test. The tests are designed to detect influenza viruses and cannot differentiate between live attenuated and wild-type influenza viruses. A positive test in a person who recently (in the previous 7 days) received LAIV and who also has an influenza-like illness could be caused by either LAIV or wild-type influenza virus.

- Links to non-federal organizations are provided solely as a service to our users. These links do not constitute an endorsement of these organizations or their programs by CDC or the federal government, and none should be inferred. CDC is not responsible for the content of the individual organization Web pages found at these links.