



Email Edition

Inside This Issue

Page 2

Vaccine Spotlight: Pediarix®
Questions of the Week

Page 3

Improve Your Immunization Rates
Email Reminder/Recall
Upcoming Events

Page 4

Watch the IAIC Webinar online!
VFC Administration Fee
Indiana Influenza Surveillance
Do Not Return Unexpired
Influenza Vaccine
Varivax Packing Slip
New Immunization Program Staff

Page 5

Examples of Series Using
Pentacel® & Pediarix®
Vaccine Available for Transfer
Provider Spotlight

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Increase in Hib Cases

Providers Urged to Make Sure Infants and Children Under Five Are Vaccinated

Minnesota has seen an increase in *Haemophilus influenzae* type b (Hib) cases in children younger than 3 years of age. In 2008, there were 5 confirmed cases of Hib, including one death. This serious disease has been uncommon since routine use of Hib vaccine began over 15 years ago. The last case in Minnesota prior to 2008 was in 1991. Before widespread use of the vaccine, Hib disease struck over 20,000 children per year in the U.S. Although Hib bacteria normally circulates in the community, the current Hib vaccine shortage is jeopardizing the cushion of protection high immunization coverage provides, making infants even more vulnerable.

The entire country has been in a Hib vaccine shortage since December, 2007. This shortage is expected to last into mid-2009; however there are adequate vaccine supplies to provide protective Hib primary series vaccination levels for all of the children who need them. This will require many providers to use Pentacel® for some or all of the Hib doses, even if some of the vaccine components are not needed. Remember, as long as there isn't a contraindication to another component of the vaccine, it is acceptable to use Pentacel as needed to complete the primary series of Hib.

When the Minnesota Department of Health looked at immunization rates in their vaccine registry, they found an 18% difference between eligible children who had received the third dose of DTaP and PCV7 and those who had received the third dose of Hib vaccine. Data from Indiana shows a similar trend. Almost 15% fewer eligible Hoosier children have received the third dose of Hib than either DTaP #3 or PCV7 #3. In 2008, Indiana had two reported cases of Hib in children who were unvaccinated due to parental refusal.

Current recommendations are that infants should receive three doses of available sanofi pastuer Hib vaccine: one each at 2, 4, and 6 months of age. Due to the Hib vaccine shortage, the booster dose normally received at age 12-15 months can be safely deferred, *except* for children at high risk, such as those children with sickle-cell disease, leukemia, HIV and other immune system problems, no spleen, or American Indian/Alaska Native children. Older children who did not receive the Hib vaccine during infancy can be protected with fewer doses.

CDC has initiated enhanced surveillance to look for Hib disease in children across the country. To date, CDC has not identified any additional clusters of Hib disease outside of Minnesota, but it continues to work with the states to follow up on any suspected cases and urges providers to report cases to their health departments.

Parents can look at immunization schedules or find out more information by visiting: <http://www.cdc.gov/vaccines>, or calling 1-800-CDC-INFO.

This document can be found on the CDC website at: <http://www.cdc.gov/vaccines/vpd-vac/hib/downloads/increase-hib-cases-508.doc>

Hib Availability (As of February 13, 2009)

Vaccine Presentation	February Doses Allocated	Doses Available to Order
ActHIB®	6,330	0
PedvaxHIB®	200	200
Pentacel®	4,405*	1,040

*Includes Doses Unused in Previous Month Allocation

Vaccine Spotlight: Pediarix®

Pediarix® is a combination vaccine that contains DTaP, IPV and Hep B vaccines. Pediarix® (GlaxoSmithKline) was approved in December 2002 and was the first pentavalent (5 component) combination vaccine licensed in the United States. Pediarix® contains DTaP (Infanrix®), Hepatitis B (Engerix-B®), and inactivated polio vaccines. No other brand of DTaP and Hep B vaccine may be used to produce this combination.

Recommended Schedule The minimum age for the first dose of Pediarix is 6 weeks, so it cannot be used for the birth dose of the hepatitis B series.

Pediarix is approved only for the first three doses of the DTaP and inactivated polio vaccine (IPV) series, which are usually given at 2, 4, and 6 months of age; it is not approved for fourth or fifth (booster) doses of the DTaP or IPV series. Minimum intervals are determined by the hepatitis B component and must be closely followed to ensure the final dose of hepatitis B (third dose of Pediarix) is not administered before 24 weeks of age.

A dose of Pediarix inadvertently administered as the fourth or fifth dose of the DTaP or IPV series does not need to be repeated. It can be given at 2, 4, and 6 months to infants who received a birth dose of hepatitis B vaccine (total of four doses of hepatitis B vaccine). Although not labeled for this indication by FDA, Pediarix may be used in infants whose mothers are HBsAg positive or whose HBsAg status is not known.

Minimum age Dose 1: 6 weeks; Dose 2: 10 week; Dose 3: 24 weeks

Do not use as birth dose of HepB; **Do not use** as Dose 4 or 5 of the DTaP/IPV series; **Maximum age** 7 years of age or older

Pediarix Dose 1 = HepB: Dose 2	DTaP/IPV: Dose 1
Pediarix Dose 2 = HepB: Dose invalid	DTaP/IPV: Dose 2
Pediarix Dose 3 = HepB: Dose 3	DTaP/IPV: Dose 3

Minimum Intervals Dose 1 to Dose 2: 4 weeks; Dose 2 to Dose 3: 4 weeks

Administration

- Intramuscular (IM) injection
- Given in anterolateral thigh or deltoid of the arm
- Choose the injection site and needle length appropriate to the person's age and body mass
- Can be given at the same visit as other vaccines, separate injection sites by 1-2 inches
- Do not mix in same syringe with other vaccines

Storage & Handling

- Pediarix® is supplied as single-dose (0.5mL) vials (package of 10) and disposable prefilled TIP-LOK® syringes (package of 5, without needles).
- Shake vigorously to obtain a homogeneous, turbid, white suspension
- Do not use if a gel-like substance is present or if resuspension does not occur with vigorous shaking
- Must be kept at refrigerator temperature (35°-46°F; 2°-8°C) at all times
- Pediarix® must never be frozen. Vaccine exposed to freezing temperature must not be used
- Pediarix® contains no preservatives

CHIRP Users Enter as DTaP-HepB-IPV

CHIRP will identify the 2nd dose of Pediarix® as an invalid HepB dose, but after the 3rd dose of Pediarix® will report the HepB series as valid.

Tally Sheet Users Record on Tally sheet at DTaP-HepB-IPV

Questions of the Week

If a child has a commercial insurance as primary and Indiana Medicaid as secondary insurance, do they qualify for VFC vaccines?

Yes. If the child has Indiana Medicaid, even as a secondary insurance, they are VFC qualified. You should use VFC vaccine and bill the administration fee through Medicaid.

What is the maximum number of IM (Intramuscular) or SC (Subcutaneous) doses of vaccines that a child can receive at a single visit? Is it okay for a child to receive 3 live vaccines at one visit (e.g., MMR, Varicella and LAIV)?

All vaccines can be administered at the same visit. There is no limit to the number of IM or SC injections that can be given at a single visit. So, an age-appropriate child can get MMR, Varicella, and LAIV vaccines during a single visit. If they are not administered during the same visit, they should be separated by 4 weeks or more.

For details, consult CDC's "General Recommendations on Immunization" at www.cdc.gov/mmwr/PDF/rr/rr5515.pdf (From Immunization Action Coalition, Ask the Experts)

I have several middle-school students coming in for varicella vaccination. They have never had chicken pox, or some have reported having the disease as young infants. How many doses should they get?

The ACIP recommends two doses of varicella vaccine for any person who has no history of varicella disease (chicken pox.) For children younger than 13 years, two doses of the vaccine should be given with the doses separated by 3 months. For persons 13 years and older, give two doses separated by 28 days.

If the individual reports a history of chicken pox, vaccination for varicella is not necessary.

Indiana school requirements at this time do list only one dose of varicella vaccine as the requirement to attend public school. However, the ACIP recommendation is two doses.

Please continue to call with your vaccine-related questions or email us at [immunize@isdh.in.gov!](mailto:immunize@isdh.in.gov)

Upcoming Events

February 23, 2009

9:30am - 11:30am (EST)

CHIRP User Group Meeting

St. Vincent Hospital
Shafer Room D & E Lower Level
2001 West 86th Street
Indianapolis, IN 46260

February 23, 2009

1:30pm - 3:00pm (EST)

Introduction to CHIRP Training

St. Vincent Hospital
Shafer Room D & E Lower Level
2001 West 86th Street
Indianapolis, IN 46260
Registration required.
Call (888) 227-4439 to register.

March 5, 2009

8:30am - 1:00pm (EST)

Immunizations from A to Z PLUS

Methodist Hospital, South Pavilion
Auditorium, 600 Grant St, Gary, IN
For more information, contact Jodi Morgan (317) 650-5051 or jmorgan@isdh.in.gov
[Click here for registration form.](#)

March 11, 2009

8:30am - 3:30pm (EST)

Immunizations from A to Z PLUS

Greenfield Fire Station #2, 210 W.
New Road, Greenfield, IN 46140
For more information, contact Jill King at (317) 501-7461 or jjking@isdh.in.gov
[Click here for registration form.](#)

March 19, 2009

12:00pm - 3:00pm (EST)

IIC Meeting

Rice Auditorium
Indiana State Department of Health

April 14, 2009

12:00pm - 3:00pm (EST)

IAIC Meeting

Rice Auditorium
Indiana State Department of Health

Improve Your Immunization Rates

Healthy People 2010 (HP 2010) is a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats. Immunization is one of the 10 Leading Health Indicators of HP 2010. In order to reach the HP 2010 goals, we must increase the rates of immunization throughout the state.

Here are some suggestions to improve your immunization rates:

- Use Indiana's Children and Hoosiers Immunization Registry Program (CHIRP) – the registry provides web-based access to reliable immunization histories for any child, even if that child has received immunizations from another provider.
- Use reminder/recall systems for both providers and patients - reminder/recall can inform vaccine providers when patients are due or over due for an immunization. It can also be utilized to notify patients of upcoming appointments.
- Expand access to immunizations for patients – allow patients to walk in during office hours for a “nurse only” visit to receive vaccinations. Also, provide vaccination services during some evening and/or weekend hours.
- Use the ‘Catch-up Immunization Schedule’ for children who have fallen behind in their immunizations and institute a policy of simultaneous administration of vaccines so that all immunization staff are trained to administer multiple vaccinations on the same clinic visit.
- Use a forecasting program or immunization scheduler to determine when the next immunization(s) should occur and make sure that the appointment is scheduled prior to the child leaving the office.

The Immunization Action Coalition lists additional suggestions on their webpage at <http://www.immunize.org/catg.d/p2045.pdf>. You can access this website and other listed websites to assist you in improving your immunization rates at <https://chirp.in.gov/> and <http://www.cdc.gov/vaccines/>.

Email Reminder/Recall Available in CHIRP

This feature is a great way to contact your patients letting them know they are due for a vaccine follow up by their provider. The Email feature is completely **free and time efficient!** Just think! No more return mail due to bad addresses! No more time spent making phone calls to disconnected numbers!

Email is also a great communication tool for many minority groups. Most migrant workers will have an email address, as this is a means of communicating with friends and family members afar. Also, many individuals experiencing difficult times will still have access to their email via friends, family, and library computer use.

The email address is located in the demographic section of CHIRP. The email address can be collected on the Vaccine Signature Form provided by CHIRP (located in the REPORTS/state reports/blank signature form pg1). Also, offices may post a sign at the reception desk asking for an email address. Individuals are usually receptive to providing this information. You may find most Electronic Medical Records also include a section for an email address.

Steps for Using Email Reminder/Recall

1. Begin reminder/recall as usual.
2. At the bottom of the screen under “email reminders” complete the Facility Name, Address, City, Phone and click “SELECT” (to the left).
3. You will see a list of names due and past due for vaccines, and beside the names you will see the email address.
4. Scroll to the bottom of the list and click “SEND EMAILS”.
5. A standardized Reminder/Recall email will go out to all persons with an email address.

If you would like additional information or training for CHIRP, please contact CHIRP support at 888-227-4439.

VFC Administration Fee

The Indiana Health Coverage Programs (IHCP) allows separate reimbursement when the administration of the drug is the only service billed by the practitioner. In addition, if the provider gives more than one injection on the same date of service and bills no E/M (evaluation/management) code, providers may bill a separate administration fee for each injection using the appropriate administration code (90772-90775 or 90779).

When billing for privately purchased vaccine, bill an administration code in addition to the CPT code to obtain reimbursement for both vaccine and its administration.

Do not bill an administration CPT code when billing for VFC vaccine. Providers must bill VFC vaccines with the CPT code for the vaccine and the provider's charge (not to exceed \$8) for VFC vaccine administration.

The VFC administration fee cannot be billed to the member since the vaccine and administration fee are reimbursed by Medicaid.

Additional information can be found at www.indianamedicaid.com/ihcp/publications/maxfee/fee_schedule.asp.

Be aware of the member's primary medical provider assignment, managed care delivery system assignment and third party liability resource(s).

Indiana Influenza Surveillance

The Indiana State Department of Health's Surveillance and Investigation Division participates in a national program by the Centers for Disease Control and Prevention that monitors influenza like activity on a year- round basis. Currently, the CDC is reporting that:

- Influenza A (H1N1) viruses from 30 states have been tested for antiviral resistance to oseltamivir. 97.4% of all Influenza A (H1N1) viruses tested at the CDC are resistant to oseltamivir. Indiana has sent Influenza A (H1's) to the CDC for antiviral resistance studies and currently waiting for the antiviral resistance results.
- All influenza A (H3N2) viruses tested are resistant to the adamantanes and all oseltamivir-resistant influenza A (H1N1) viruses tested are sensitive to the adamantanes.
- Influenza activity in the United States, although increasing, remains relatively low with influenza A (H1N1) viruses predominating overall.
- The level of activity and the relative proportion of circulating virus type or subtype has varied by region and may vary over the course of the season.

This presents challenges for the selection of antiviral medications for the treatment and chemoprophylaxis of influenza and highlights the importance of testing patients for influenza and consulting local surveillance data when evaluating patients with acute respiratory infections during this the influenza season.

- CDC issued interim recommendations for the use of influenza antiviral medications in the setting of oseltamivir resistance among circulating influenza A (H1N1) viruses on December 19, 2008. These interim recommendations are available at <http://www2a.cdc.gov/HAN/ArchiveSys/ViewMsgV.asp?AlertNum=00279>.
- Please be reminded that all Indiana influenza deaths (all ages) are to be reported to the health department within 72 hours of knowledge of death.

All CDC confirmed influenza A (H1) viruses are related to the influenza A (H1N1) component of the 2008-09 influenza vaccine (A/Brisbane/59/2007). All influenza A (H3N2) viruses are related to the A (H3N2) vaccine component (A/Brisbane/10/2007).

Influenza B viruses currently circulating can be divided into two distinct lineages represented by the B/Yamagata/16/88 and B/Victoria/02/87 viruses. Twenty-three influenza B viruses tested belong to the B/Yamagata lineage and are related to the vaccine strain (B/Florida/04/2006). The remaining 55 viruses belong to the B/Victoria lineage and are not related to the vaccine strain.

Annual influenza vaccination is expected to provide the best protection against those virus strains that are related to the vaccine strains, but limited to no protection may be expected when the vaccine and circulating virus strains are so different as to be from different lineages, as is seen with the two lineages of influenza B viruses.

Watch the IAIC Webinar online!

On December 18, 2008 the Indiana Adult Immunization Coalition hosted a Webinar on "Immunizing Healthcare Workers" presented by Dr. Eric Benning.

Watch the webinar online at <http://immunizeinadults.org/>.

Do Not Return Unexpired Influenza Vaccine

Please do not return influenza vaccine prior to the vaccine expiration date. Immunizations against influenza should still be given to those not currently vaccinated. Although your peak period to administer the influenza vaccine may have passed, you should provide the vaccine until the expiration date or the end of the flu season in late Spring.

After the expiration date, expired vaccine can then be returned to McKesson.

Varivax Packing Slip

When receiving a shipment of Varivax vaccine from Merck, the Order Type on the Purchase Order (PO) will be listed as CD for CDC orders and MS for Private stock. Also, the PO Number will start with 408 or 409 on all CDC orders.

New Immunization Program Staff

We are please to announce that we have 2 new staff members in the Immunization program: Chloe Ellis and Angela Blackwell.

Chloe will be handling material orders and assisting in answering phones. Chloe can be reached at (317) 233-7704.

Angela will be assisting in vaccine ordering and vaccine management. Angela can be reached at (317) 233-7503.

2009-2010 Update School Immunization Requirements

Read the School Requirements letter at

https://chirp.in.gov/chirp_files/docs/School%20Immunization%20Requirements.pdf

Vaccine Available for Transfer

HPV 29 Doses Exp:
06/01/09 Decatur County

IPV 20 Doses Exp:
06/01/09 Decatur County

IPV 50 Doses Exp: 6/7/09
Jackson County

IPV 25 Doses 06/09/09
Marion County

IPV 50 Doses Exp:
10/26/09 Johnson County

IPV 100 Doses Exp:
12/12/09 Johnson County

Comvax 20 Doses Exp:
02/13/10 Allen County

Pediarix 230 Doses Exp:
11/19/10 Elkhart County

If you have vaccine that you believe you will not be able to use by the expiration date, please contact your AFIX Field Representative at least 8 weeks prior to the expiration date to arrange a vaccine transfer.

If you would like to request a transfer of any of the above vaccine to your facility, please contact us 800-701-0704 or immunize@isdh.in.gov.

Provider Spotlight

The Kosciusko County Health Department hosted a mass immunization clinic at a local high school in response to a case of reported meningococcal disease.

They were able to vaccinate 488 students in 65 minutes. There were 9 nurses providing immunizations at the clinic.

Great job KCHD!

Examples of Series Using Pentacel® & Pediarix®

The following tables provide examples of how to introduce Pentacel® into your practice.

- Pentacel® contains DTaP, IPV and Hib.
- Pediarix® contains DTaP, IPV, and HepB.

Option 1	Birth	2 months	4 months	6 months	15-18 months	4-6 years
Pentacel® only (3 doses series)	HepB-1 Single Antigen	HepB-2 Single Antigen		HepB-3 Single Antigen		
		DTaP-1 IPV-1 Hib-1 Pentacel® Dose 1	DTaP-2 IPV-2 Hib-2 Pentacel® Dose 2	DTaP-3 IPV-3 Hib-3 Pentacel® Dose 3	DTaP-4 Single Antigen	DTaP-5 IPV-4 Single Antigen

Option 2	Birth	2 months	4 months	6 months	15-18 months	4-6 years
Pentacel® (Dose 1) Pediarix® (Dose 2 & Dose 3)	HepB-1 Single Antigen	HepB-2 Single Antigen				
		DTaP-1 IPV-1 Hib-1 Pentacel® Dose 1	DTaP-2 IPV-2 HepB-Not Valid Pediarix® Dose 2	DTaP-3 IPV-3 HepB-3 Pediarix® Dose 3	DTaP-4 Single Antigen	DTaP-5 IPV-4 Single Antigen
			Hib-2 Single Antigen	Hib-3 Single Antigen		

Option 3	Birth	2 months	4 months	6 months	15-18 months	4-6 years
Pediarix® only (3 doses series)	HepB-1 Single Antigen	DTaP-1 IPV-1 HepB-2 Pediarix® Dose 1	DTaP-2 IPV-2 HepB-Not Valid Pediarix® Dose 2	DTaP-3 IPV-3 HepB-3 Pediarix® Dose 3	DTaP-4 Single Antigen	DTaP-5 IPV-4 Single Antigen
		Hib-1 Single Antigen	Hib-2 Single Antigen	Hib-3 Single Antigen		

	Birth	2 months	4 months	6 months	15-18 months	4-6 years
Without Pentacel® or Pediarix®	HepB-1	HepB-2		HepB-3		
		DTaP-1 IPV-1	DTaP-2 IPV-2	DTaP-3 IPV-3	DTaP-4	DTaP-5 IPV-4
		Hib-1	Hib-2	Hib-3		