WASHINGTON VACCINE ASSOCIATION

Vaccine Committee Meeting Minutes

May 14, 2014, 10:30 - 11:30 AM Location: Ellis Li McKinstry

I. **Attendance**

The following individuals participated in the meeting:

Committee:
Michele Roberts (T)
Jeffrey Gombosky
Jay Fathi
Jan Hicks-Thomson (T)
Dr. Ed Marcuse
Mary Kay O'Neill
Fred Potter (T)

Consultants & Others:
Margaret Lane, WVA
Dr. John Dunn, consultant
Dr. Rachel Wood, consultant

Absent:
Norm Seabrooks

I. Actions Taken at Meeting

1. Agree to revise Vaccine Committee Charge
2. Request for presentation on 317 funding
3. Request for VAC handouts to be sent to WVA Vaccine members

II. Minutes

At 10:30 AM, a quorum having been established, Dr. Ed Marcuse, Chairman of the Vaccine Committee, opened the meeting.

Welcome, Introductions and Changes in Committee Membership

Dr. Marcuse welcomed committee members and recognized new committee member Dr. Jay Fathi, who represents Coordinated Care.

Ed reported that one purpose of the meeting was to discuss a revised committee charge.

Proposal for Revised Committee Charge

Dr. Marcuse noted that the committee and committee composition are defined by the vaccine statute, which states that committee members are from the WVA board, together with one committee member representing vaccine manufacturers.

However, as the committee was being formed, Dr. Marcuse and others realized that they needed representation from perspectives not present on the board, including the state department of health (DOH) and local health as well large organizations like Group Health that address the clinical and business aspects of vaccines. So these areas are now represented on the committee and as consultants to the committee.

Dr. Marcuse noted that at WVA's formation vaccine selection was controversial. Today, even though this function is running smoothly, holding two committee meetings a year is important. In this way the Vaccine Committee role is maintained so that if issues arise, the committee has a working relationship and is ready to address any issues.

Review of Committee Charge

The Vaccine committee chair and Vice Chair propose to carry out the committee charge through an oversight role. Ms. Lane noted that many components in the charge would not change. The change is from an active role to an oversight role with intervention as needed. Ed reviewed that the WVA Vaccine Committee has responsibility for providing guidance to the Washington State Department of Health (DOH) on selecting vaccines for purchase by the DOH. He noted that the factors listed in the statute are the criteria the committee should use in guiding the DOH on which vaccines to purchase.

Margaret reviewed the key activities of the Vaccine Committee. Ed noted that the Vaccine Committee acts as a secondary review body rather than a primary one. The Committee uses a variety of inputs, including ACIP, other federal advisory bodies and other groups as appropriate. Jan noted that the Vaccine Committee no longer needs to approve default order sets because providers select an order set when they enroll in the Program, and have two opportunities each year to adjust the brands included in their order set. The Committee does not need to address combination vaccine recommendations because all combination vaccines are available to all providers.

The State Vaccine Advisory Committee, on rare occasions, may make recommendations for Washington that vary from the ACIP. Examples of past variations included targeting implementation for hepatitis B vaccination among children in areas at high risk or with high rates of disease and a difference in the timeline of Washington's implementation of varicella vaccination. If any board members have questions about which vaccines are being funded, this committee should respond.

Every six months providers have the opportunity to change vaccine brands (April and October) through an online selection process in the Washington Immunization Information System. Every provider enrolled in the Program has a vaccine order set in place and has the option to change it if desired. DOH has a vaccine choice template with a descriptor and a form so providers new to the Program can choose what they want on their order set and this becomes their new order set. The materials describing the vaccine brands and providing additional reference materials for decision making are posted to the DOH website.

Dr. Marcuse explained that the state Vaccine Advisory Committee is an advisory committee to the DOH. He noted that the WVA board is reviewing its mission and the duties of board members. Ed would like the Committee to consider supporting improved health outcomes from vaccinations. In the last decade vaccinations have become controversial. This support would improve individual and public health without using WVA resources.

The primary Committee role is oversight and being available to problem solve as needed. The committee role is also to provide information to the board about clinical and public health issues.

April 1, 2014 CDC Price Changes

Jan reviewed results of the recently released vaccine price changes from the Centers for Disease Control (CDC). Every April 1 the CDC has a new pricing for every vaccine. The DOH has a process for creating 5 year average price changes for projection purposes. DOH incorporates the April CDC price changes into their formula to calculate the 5-year average increase for each vaccine. DOH provides that information to WVA staff to incorporate into their development process. DOH's projections are very close to what the CDC changes are.

Most of the April 1 changes were not significant; only a few vaccines increased more than 5%. The vaccines with significant increases were expensive vaccines over $100 / dose like HPV and PCV-13. DOH has built these increases into their model so the price increases should only minimally impact the WVA.

Fred Potter noted that the WVA is reviewing these projections very closely due to WVA's close monitoring of its cash balances. Last summer the CDC changed its requirements for vaccine funding from a reimbursement model paid after vaccines were ordered to a pay-in-advance model. In WA this change was equivalent to a $13 million cash call which had not been budgeted and which WVA had 30 days to meet. WVA at that time was in the process of re-funding money through below replenishment rate assessments. WVA had to immediately implement a new assessment rate and come up with the cash. Key Bank provided a line of credit allowing the WVA to make the cash payment in advance for vaccines ordered, and preserve enough operating balances to avoid any impact on state supply. We are now in the process of repaying that indebtedness and re-building a cash reserve.

Dr. Wood raised a question about 317 funding and why CDC had this new demand. Michele Roberts explained the background on the CDC's change in position; CDC was under heightened pressure from Congress around its budget. The second reason was related to VFC; with advance purchasing there was a chance that WA could have been purchasing vaccine with VFC dollars that were not going to a VFC kid. Michele Roberts noted that there was tremendous pushback from the medical and public health communities when this was instituted.

Jan added that the decrease in 317 funding added another level of pressure because CDC could no longer assure they had sufficient 317 to cover state and local purchases on the front end. And since states were replenishing after the fact, in the absence of sufficient 317 funds, there was a risk that VFC funding might at a minimum be perceived as fronting the purchase of state and local vaccines. . Today we have to make sure we are covering the state responsibility for non-VFC vaccine on the front end with state funding.

Dr. Wood noted that the issue of 317 funding continues to come up. Dr. Marcuse suggested it would be helpful to have more information on 317. The Committee agreed that it would be helpful for the committee to have a telephone briefing on 317 funding.

Update on Vaccine Selection

Jan Hicks-Thomson reported that DOH just completed the first cycle of its 2014 Vaccine Selection at the end of April, giving providers the option to decide to continue or change their brand of vaccine for those vaccines with multiple brands. There are two opportunities a year for providers to make changes in the vaccines ordered by their office, in April and October.

Each cycle the DOH has seen fewer changes requested by providers who want to make a change in a brand. Providers don't need to go through the process unless they want to make a change. Only 42 providers chose to make a change, which is less than 4% of providers in the program. The changes were mostly related to the meningococcal vaccine with providers changing to Menveo which has a lower age indication. The brands Menveo (Novartis product) and Menactra (Sanofi Pasteur) have different licensure ages, Menveo is licensed to 2 months and Menactra to 9 months. The other products had less than a 2% brand product change. The next vaccine selection period will be October, 2014.

Other DOH Updates

Childhood Vaccine Supply Update

Jan also addressed vaccine supply and the vaccine pre-book for the 2014 – 2015 flu season. All of the vaccine childhood flu vaccines will in a quadrivalent presentation, which is easier for providers to manage than having some trivalent and some quadrivalent. The pricing differential is fairly significant.

DOH reviewed its vaccine returns after the 2012-2013 flu season, a significant number of doses were returned. The DOH used this information in combination with provider surveys to pre-book for this year. DOH is pre-booking about 1% more vaccines than were ordered last year (about 16% more than ultimately used). DOH will continue to move vaccine from areas not using vaccines to areas that need them, to ensure a sufficient supply. DOH has partnerships with vaccine programs across the country to trade out vaccine products. They need to do a careful job of managing fund sources to ensure that they are still aligned with CDC fund management requirements.

WVA contributed $4 million in revenue for state of WA for the next flu season. Last season 85,612 unused doses of vaccine were returned, which is about 10% of the entire supply. Ed noted that you need to have some flexibility because all it takes is one death to cause the flu vaccine uptake to rise significantly.

Jan reviewed other vaccines presentations that had changed and noted that nasal spray flu mist is a higher percentage of the flu vaccine ordered for children 2 – 18 years of age for this coming season.

Vaccine Advisory Committee

Jan reviewed the latest work of the VAC. At its most recent meeting the VAC addressed clinical guidance for infant meningococcal vaccine. Menhibrix is a new vaccine that covers two strains of meningococcus. There is a tight allocation from the CDC and WA only received 310 doses for the year. In the handout that Jan provided the Department addressed how it would handle ordering for this limited availability vaccine.

Jan noted that the CDC has identified the failure of adolescents to complete their HPV series as one of the top 5 current health risks. The rates for HPV series completion haven't increased; in 2013, according to the National Immunization Survey for Teens, 64.5% of females complete their first series and 43.5% complete the 3-dose series. Efficacy is based on series completion.

The next Vaccine Committee meeting will be in November so it can follow the next cycle of Vaccine Selection.

There being no further business for the Committee, the meeting was adjourned at 11:35 PM.

What: WVA Vaccine Committee Meeting
Date and Time: May 14, 2014, / 10:30 – 11:30 AM
Place of Meeting: Law office of Ellis, Li & McKinstry, PLLC, Market Place Tower, PH-A, 2025 First Avenue, Seattle
Call in Numbers: (local) 206.925.3583; (long distance/toll-free) 877.826.6967; Part code: 1981457183#

AGENDA for Vaccine Committee Meeting (in person attendance if possible)

Approximate Time	Topic/Anticipated Action	Presented by
10:30 – 10:35	1. Welcome a. Introductions b. Purpose of Meeting	E. Marcuse
10:35 – 10:50	2. Review Proposal for Revised Committee Charge	
	a. Vaccine Committee Charge i. Original charge ii. Proposal for revised charge iii. Difference between original and revised charge	E. Marcuse
10:50 – 10:55	3. April 1, 2014 CDC changes a. Vaccine price changes b. Impacts on WVA	J. Hicks-Thomson
10:55 – 11:05	4. Vaccine Selection a. Update on April, 2014 Vaccine Selection b. Vaccine Selection cycle for 2014-2015	J. Hicks-Thomson
11:05 – 11:15	5. Updates:	
	a. Childhood Vaccine Supply Update* b. Vaccine Advisory Committee*	J. Hicks-Thomson
11:15 – 11:20	6. Other items from Committee Members	All
11:20 – 11:25	7. Public comment	
11:25 – 11:30	8. Closing section a. Report at WVA Board June 17, 2014 meeting b. Meeting Schedule 2014-2015 (2 meetings/year, one in fall and one spring)	E. Marcuse

WVA Vaccine Committee – As updated through May 13, 2014

- **= Item has accompanying material**

Washington Vaccine Association
Vaccine Committee
COMMITTEE CHARGE

Purpose:

The WVA Vaccine Committee (VC) is responsible for making recommendations to the WVA Board on specific vaccines to be purchased in each upcoming year by the Department of Health. Factors the Vaccine Committee will consider when making recommendations to the WVA Board on selecting vaccines include:

- Patient safety and clinical efficacy
- Public health and purchaser value
- Patient and provider choice
- Stability of vaccine supply
- Compliance with RCW 70.95M.115

Key Activities:

The Vaccine Committee will fulfill its responsibilities through the following activities:

- Evaluate the use of vaccines from a clinical, pharmacoeconomic and ethical perspective
- Promote safety, effectiveness and improved health outcomes from vaccination
- Be informed by the deliberations and recommendations of the WA State Department of Health Vaccine Advisory Committee

Meeting Frequency and Notice:

The Vaccine Committee will meet at least two times per year with notice provided in the manner set forth in the WVA bylaws for director meetings. Committee members are required to attend meetings in person or by conference telephone.

Reporting Frequency:

- The Vaccine Committee will report to the WVA Board at least two times per year.

Membership:

The Vaccine Committee shall consist of five voting members defined by statute (SHHB 2551 Section 5), one non-voting member and two non –voting ex officio members (see following). Other participants and/or consultants may be invited from time to time to assist the committee. The Chair or Vice-chair will be a physician and WVA board member.

Washington Vaccine Association
Vaccine Committee
COMMITTEE CHARGE

Description of Committee Positions:

Position/Title	Qualifications
Vaccine Committee Voting Members	
1. Physician (Chair)	Member of WVA Board
2. Health Carrier/TPA Member	Member of WVA Board
3. Health Carrier/TPA Member	Member of WVA Board
4. Health Carrier/TPA Member	Member of WVA Board
5. DOH Secretary Designee	Member of WVA Board

Non-voting Member	
1 Representative of Manufacturers	Designated by the Secretary, WA State DOH

Ex Officio Members (Without Vote)	
1. Executive Director of the WVA	
2. Director WA State Immunization Program/ Child Profile	

Member Responsibilities:

Members will comply with the conflict of interest policies of WVA and complete and sign a statement declaring potential conflicts of interest annually and are responsible for informing the Vaccine Committee of any pertinent changes during the year.

Motions may be made and seconded only by voting members. Majority vote of voting members carries a motion.

Members are responsible for rendering decisions regarding the recommendations as required, based upon best available vaccine clinical evidence and on outcomes modeling current best practice standards.

Members shall not have responsibility for making business decisions involving WVA processes for vaccine assessment amounts.

Quorum:

A quorum consists of at least three voting members of the Committee.

Consultants and/or **Other Participants**

To ensure that the Committee’s deliberations are informed by the perspectives of primary care clinicians (pediatricians, or family practice physicians including physicians engaged in office based practice (versus institutional), local heath officers, pharmacists and WA State DOH staff with expertise in vaccine supply and, from time to time others with needed special expertise, the Committee may request that consultants participate in its meetings.

Washington Vaccine Association
Vaccine Committee
COMMITTEE CHARGE

Approval:

This charge will be reviewed by the Vaccine Committee and any recommended revisions approved by the WVA Board.

Charge Author:	WVA Vaccine Committee
Approving Body:	WVA Board and Executive Director

Reviewed By: Vaccine Committee	**Date:**
Approved By: WVA Board	**Date:**

Draft Proposal to Vaccine Committee for Modified Committee Charge

Summary statement

The WVA Vaccine Committee has responsibility for providing guidance to the Washington State Department of Health (DOH) on selecting vaccines for purchase by the DOH. The environment in which the WVA's Vaccine Committee operates has evolved from an at times volatile situation to a state of stability and cohesion. Given this shift, the Vaccine Committee Chair and Vice-Chair propose to carry out the Committee Charge through an oversight role rather than one of active engagement.

Background:

The WVA was launched with multiple challenges before it. Diverse stakeholders including providers, payers, public health, and vaccine manufacturers, had different expectations regarding its outcome and the dosage based assessment system was an un-tested model.

At the outset of the WVA, vaccine selection was a highly controversial issue. Prior to the WVA formation, the Washington State Department of Health chose the vaccine brands that providers in the State Childhood Vaccine Program could order, using a range of clinical and non-clinical criteria. Vaccine manufacturers, on the other hand, strongly favored a system of full provider choice of vaccines.

The Vaccine Committee formed a Vaccine Selection workgroup which developed principles to guide its formation of a vaccine selection recommendation. Working under these principles and learning from presentations from the DOH and vaccine manufacturers, the Vaccine Committee recommended that DOH create and implement a provider survey on vaccine selection. That survey led to a proposal to have full vaccine selection offered twice a year. The twice a year choice has proved to be highly satisfactory to providers in WA state, given the extremely low percentage of providers (less than 1%) who made changes in the vaccine brands they ordered.

Due to the leadership and open process in which the Vaccine Committee did its work, the relationships between the DOH, WVA, and vaccine manufacturers are all positive today.

Assessment:

Since the current environment in which the Vaccine Committee operates is stable, the committee should adopt a different working model to fulfill its statutory responsibilities. The role of the WVA Vaccine Committee moving forward should be through oversight, with readiness to intervene if appropriate.

Meeting Plan Structure for 2014 and beyond:

- Two meetings each year, one in spring and one in the fall
- Ideally one in-person meeting to coincide with a Board meeting and one teleconference

Proposed Modified Role for WVA Vaccine Committee

	Statute	Charge	Revised Approach
Committee Composition	. . . at least five voting board members, including at least three health carrier or third-party administrator members, one physician, and the secretary or the secretary's designee. The committee must also include a representative of vaccine manufacturers, who is a nonvoting member of the committee.	Five voting members defined by statute RCW 70.290.050 (1), one non-voting member and two non – voting ex officio members.* Other participants and/or consultants may be invited from time to time to assist the committee. The Chair or Vice-chair will be a physician and WVA board member. *WVA Executive Director and Director, WA State Immunization and Child Profile	No change
Role of Vaccine Committee	To develop recommendations to the board regarding selection of vaccines to be purchased in each upcoming year by the department.	Evaluate the use of vaccines from a clinical, pharmacoeconomic and ethical perspective. Activities include: • Promote safety, effectiveness and improved health outcomes from vaccination • Be informed by the deliberations and recommendations of the WA State Department of Health Vaccine Advisory Committee • Approve vaccine default order	No change but Committee's role is shifted to oversight with intervention if needed

	Statute	Charge	Revised Approach
		set proposal • Review and approve combination vaccine recommendation • Review survey response data	
Meeting Frequency		The Vaccine Committee will meet at least two times per year and report to the WVA Board at least two times per year.	Meet by phone each spring for an update and an in person meeting each fall to coincide with a Board meeting

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Childhood Vaccine Supply Update

WVA Vaccine Committee

May 14, 2014

Infant Meningococcal Vaccination

- The Vaccine Advisory Committee created Clinical Guidance document finalized (see packet)
- Dissemination:
  - Web posting: DOH web site under VAC Recommendations
  - Update Guidelines for the Use of State Supplied Vaccine
  - E-mail:
    - Local health departments for dissemination to providers
    - Provider professional organizations (AAP, AFP, Practice Managers)
  - Blast fax to providers

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Vaccine Supply Update: Pentacel

- Pentacel Continues to be in short supply
  - Allocation increasing over the next few months
  - Continue distribution to 10 highest volume practices
  - Allocation to all providers at 50% of their pre-shortage order quantities.
    - Accounts for slow build of monthly allocation
    - Allows existing single antigen and alternate combination vaccines to be used up
    - Allows starting and finishing new patients with Pentacel.
    - Allows catch-up for children needing all three components (DTaP; IPV; and Hib)

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Vaccine Supply Update: Other

- GSK Pertussis Containing Products
  - Will experience rolling delays over the summer
- WA will monitor the situation closely
  - Change presentations or brands as needed
  - Assure Pertussis containing vaccine available
- Reminder: providers can now order single dose quantities of DT, PPSV23, and MenCY-tt

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WA Flu Vaccine Supply, Current Season

Vaccine Type	2013 – 2014	Available	2013 – 2014 Ordered
sanofi-pasteur 0.25 mL PF (6-35 Month)	208,000	**16,870**	**191,130 (92%)**
sanofi-pasteur 5.0 mL Multi Dose (3 & up)	302,000	**44,310**	**257,690 (85%)**
GSK .5mL Single Dose Syringe (≥ 3 yrs.)	24,510 QIV	**12,200**	**12,310 (50%)**
MedImmune FluMist	220,000 QIV	**17,500**	**202,500 (92%)**
sanofi-pasteur .5mL Single Dose latex free Syringe (≥ 3 yrs.)	**1,000**	**1,000**	**0**
Totals as of 4/08/13 Grand Totals	**755,510 (100%)**	**91,880 (12.2%)**	**663,630 (87.8%)**

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WA Flu Vaccine Supply 2014 -2015 Season (100% Quadrivalent)

Vaccine Type	2013 – 2014 Ordered	Returned (2012-2013)	2014 – 2015 Pre-book
0.25 mL PF (6-35 Month)	191,130 (92%)	(25,676)	208,400
5.0 mL Multi Dose (3 & up)	257,690 (85%)	(29,244)	202,000
.5mL Single Dose Syringe (≥ 3 yrs.)	12,310 (50%)	(3,900)	9,000
MedImmune FluMist	202,500 (92%)	(26,775)	250,600
Grand Totals	663,630	85,612	670,000

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WA Flu Vaccine Supply 2014 -2015 Season Funding

Vaccine Type	Federal Doses	Federal Dollars	WVA Doses	WVA Dollars	CHIP Doses	CHIP Dollars
0.25 mL PF (6-35 Month)	143,520	$2,502,845	64,480	$1,124,467	400	$6,976
5.0 mL Multi Dose (3 & up)	122,000	$1,561,600	78,000	$998,400	2,000	$25,600
.5mL Single Dose Syringe (≥ 3 yrs.)	5,400	$73,710	3,600	$49,140		
MedImmune FluMist	154,510	$2,795,086	95,490	$1,727,414	600	$10,854
Grand Totals	425,430	$6,933,241	241,570	$3,899,421	3,000	$43,430

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Vaccine Choice Update:

- Conducted April 15 through May 2
- 42 providers change products:
  - There was a 6.6% shift in meningococcal conjugate vaccine market share from Menactra to Menveo
    - Lower age indication for Menveo
  - There was a 2.5% shift in Tdap vaccine market share from Boostrix to Adacel
  - No other product has more than a ½ % market share change
- Next vaccine choice period Oct. 2014

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Remember, cover your cough, wash your hands, and get vaccinated!

Office of Immunization and Child Profile
VACCINE ADVISORY COMMITTEE
Clinical Guidance on Hib-MenCY-TT
February 2014

The State Vaccine Advisory Committee is providing this guidance for use by providers who may see young children with certain rare health conditions that put them at increased risk for meningococcal disease and its complications. The Advisory Committee on Immunization Practices (ACIP) does not recommend routine meningococcal vaccination for infants who are not at increased risk for meningococcal disease. Nothing in this guidance supersedes the recommendations from the ACIP. Providers should review the complete CDC recommendations for use of meningococcal vaccines for additional details regarding available vaccine products and indications, including use of vaccines in allergic patients and other updated guidance.

In the United States, about 5,000 infants each year have a condition that places them at increased risk for meningococcal disease and it's complications. In Washington, the expected number of children less than 2 years of age with these conditions is approximately 220.* The predominant serogroup causing invasive disease varies by age. See the tables on page three for details about the number of cases of invasive meningococcal disease reported in Washington from 2005 to the present by age group and the proportion of cases by serogroup for each age category.

There are three vaccines licensed for the prevention of meningococcal disease. The Novartis quadrivalent meningococcal vaccine (Menveo) and the GlaxoSmithKline bivalent meningococcal Haemophilus influenza b (Hib) vaccine (MenHibrix) are licensed for children as young as 2 months of age. The Sanofi-Pasteur quadrivalent meningococcal vaccine (Menactra) is licensed for 9 months through 55 years of age.

Vaccine Manufacturer and Brand	Age Indication	Indications for Children Less than 2 Years
Sanofi-Pasteur – Menactra (MenACWY-D)	9 months – 55 years	• persistent complement deficiencies • travel to or are residents of countries where disease is endemic • are at risk during a community outbreak attributable to a vaccine serogroup**
Novartis – Menveo (MenACWY-CRM)	2 months – 55 years	• persistent complement deficiencies • functional or anatomic asplenia • HIV, if another indication for vaccination exists • travel to or are residents of countries where disease is endemic • are at risk during a community outbreak attributable to a vaccine serogroup**
***GSK – MenHibrix – (Hib-MenCY-TT)	2 months through 18 months (may be given as early as 6 weeks)	• persistent complement deficiencies • functional or anatomic asplenia • are at risk during a community outbreak attributable to a vaccine serogroup**

* WA represents approximately 2.2% of the US population. The expected number of children under 2 years old with these conditions in WA is approximately 220..
**In accordance with guidance from public health authorities for use of meningococcal vaccine during outbreaks
***Hib-MenCY-TT is not indicated for prevention of disease caused by meningococcal serogroups W135 or A, which are represented in quadrivalent meningococcal vaccines.

Meningococcal Vaccine Use for Children with Increased Risk for Meningococcal Disease:

1. If a provider knows in advance they will be seeing a child with an indication for meningococcal vaccination (see above) and wishes to use MenHibrix for the full vaccination series, the provider should contact the State Office of Immunization and Child Profile and order MenHibrix to vaccinate the child.

2. When a child with an indication for meningococcal vaccination presents for vaccination and the provider did not know in advance, the providers should initiate the meningococcal vaccine series for these children with the meningococcal vaccine they have on hand.
   - Providers who use Menveo for the first dose in the meningococcal series for young children may complete the series with Menveo.
   - After using Menveo for the first dose, providers who then want to complete the series with MenHibrix (Hib-MenCY-TT) for children 2 months through 18 months of age may order the vaccine from the State Department of Health.
   - Providers who have only Menactra on hand should use their clinical judgment when determining whether to use the vaccine for the first dose in the meningococcal series for a child less than 9 months of age since the vaccine is not licensed for this age group.

Ordering from the State Department of Health

MenHibrix is not available for routine ordering due to limited supply and the very small number of children with indications for this product. Providers can order MenHibrix directly from the state as needed:

- Providers may order single doses of this vaccine to complete the series for a child. The vaccine will be shipped from the distributor in a zip locked baggie with a photocopy of the prescribing information.
- Contact information for state staff to assist with order placement:
  - Phone: Office of Immunization and Child Profile: 360-236-3595 (ask to speak to a member of the vaccine management team about ordering vaccine).
  - E-mail: WAChildhoodVaccine@doh.wa.gov

For more information:

Infant Meningococcal Vaccination:
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6203a3.htm

Meningococcal Vaccination:
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6030a3.htm

Interchangeability of Meningococcal Vaccines:
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6202a1.htm#Box1

Number of reported meningococcal cases by serogroup and age group, Washington State, 2005-2013 and 2014 YTD (as of 2/13)

Serogroup		Cases by age group (years)				
		<2 n (%)	2-10 n (%)	11-24 n (%)	25+ n (%)	All ages
Vaccine serogroup	**Total**	**21 (33.5%)**	**14 (37.8%)**	**29 (48.3%)**	**62 (59.0%)**	**126**
	C	7	9	13	17	46
	Y	14	4	15	40	73
	W135	0	1	1	5	7
Non-vaccine serogroup	**Total**	**40 (63.5%)**	**23 (62.2%)**	**29 (48.3%)**	**37 (35.2%)**	**129**
	B	40	23	26	34	123
	Z	0	0	2	1	3
	Not Groupable	0	0	1	2	3
Not tested		**2 (3.2%)**	**0 (0.0%)**	**2 (3.3%)**	**6 (5.7%)**	**10**
Total		**63**	**37**	**60**	**105**	**265**