OREGON HEALTH AUTHORITY
IMMUNIZATION PROTOCOL FOR PHARMACISTS
MENINGOCOCCAL VACCINES: A, C, Y, W
UPDATED 07/17/2017

Reviewed July 17, 2017:
• Updated maps for 2017
• Updated VAERS information
• Updated all references

This Protocol does NOT cover meningococcal B vaccines. At this time, pharmacists can vaccinate with meningococcal B vaccines only by prescription.

Revisions from the ACIP as of October 2016: ¹, ²

• HIV-infected persons aged ≥7 years should routinely receive meningococcal conjugate vaccine (serogroups A, C, W, Y).

• Persons aged ≥7 years with HIV infection who have not been previously vaccinated should receive a 2-dose primary series of Men ACWY conjugate vaccine.

• Persons aged ≥7 years with HIV infection who have been previously vaccinated with one dose of meningococcal conjugate vaccine should receive a booster dose at the earliest opportunity, provided at least 8 weeks have elapsed since the previous dose, and then continue to receive boosters at the appropriate interval throughout life.

• Either MenACWY-CRM (Menveo®) or MenACWY-D (Menactra®) maybe used in HIV-infected persons.

• MenACWY is recommended for HIV-infected persons aged ≥56 years because of the need for revaccination (i.e. booster doses).

See order next page:
I. OREGON IMMUNIZATION PHARMACY PROTOCOL:

1. Check the ALERT Immunization Information System (IIS) to determine whether the patient needs this vaccine and any other vaccines.
2. Screen clients ≥7 years of age for contraindications.
3. Provide a current Vaccine Information Statement (VIS) and answer any questions.
4. Record all required data elements in the client’s permanent health record.
5. Give a single 0.5mL dose of meningococcal vaccine according to ACIP recommendations, age-appropriate schedules and high-risk conditions.
6. Ask client to remain seated on the premises for 15 minutes after vaccination to decrease the risk of injury should they faint.
7. These vaccines may be given with most* ACIP–recommended vaccinations.

*See page 4, section II. A. footnotes ◊◊, §§.

Immunizing Pharmacist Signature

Date

For multiple signatures see: 1.usa.gov/PharmacyImmunizationProtocols

This order expires July 31, 2018

Revised: 11-2016

This order expires July 31, 2018
## II. A. LICENSED QUADRIVALENT* MENINGOCOCCAL VACCINES

<table>
<thead>
<tr>
<th>Product Name and Route of Administration</th>
<th>Vaccine Components</th>
<th>Recommended Age Range Acceptable Age Range</th>
<th>Thimerosal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Menveo®</strong> (MCV4-CRM) (MenACWY-CRM) IM</td>
<td>Quadrivalent meningococcal conjugate vaccine containing capsular polysaccharide from serogroups A, C, Y and W-135 conjugated to 32.7 to 64.1 µg CRM&lt;sub&gt;197&lt;/sub&gt; protein (diphtheria)</td>
<td>11–12 years of age‡, ≥2 months of age</td>
<td>No (single-dose vials)</td>
</tr>
<tr>
<td><strong>Menactra®</strong> (MCV4-D) (MenACWY-D) IM</td>
<td>Quadrivalent meningococcal conjugate vaccine containing capsular polysaccharide from serogroups A, C, Y and W-135 conjugated to 48 µg of diphtheria toxoid</td>
<td>11–12 years of age‡, ≥9 months of age</td>
<td>No (single-dose vials)</td>
</tr>
<tr>
<td><strong>Menomune®</strong> (MPSV-4) SQ</td>
<td>Quadrivalent meningococcal polysaccharide vaccine containing 50 µg of each of 4 purified bacterial capsular polysaccharides, A, C, Y, and W-135.</td>
<td>≥7 years (unavailable)</td>
<td>No (single-dose vials)</td>
</tr>
</tbody>
</table>

Footnotes next page:
II. A. LICENSED QUADRIVALENT MENINGOCOCCAL VACCINES Cont.

* Quadrivalent meningococcal vaccination in the 3 years before the date of travel is required by the government of Saudi Arabia for all travelers to Mecca during the annual Hajj.14

◊ traveling to or residing in areas with hyperendemic or epidemic meningococcal disease.5, 10

‡See Section III. A for Recommendations for Use.

** Per OIP Medical Director until MPSV–4 is available.

◊◊

§§

*Does not include serogroup A, W–135 or B.13

◊ Immunization with MenHibrix® does not substitute for routine tetanus immunization.13

§ Urine antigen detection may not have a diagnostic value in suspected disease due to H. influenzae type b within 1 to 2 weeks after receipt of a H. Influenzae type b-containing vaccine, including MenHibrix®.13

‡Infants with persistent complement component pathway deficiencies, functional or
III. A. RECOMMENDATIONS FOR USE: QUADRIVALENT MENINGOCOCCAL VACCINES

Children 7 years through 10 years of age who are at increased risk for meningococcal disease attributable to serogroups A, C, W, and Y including:

- Children who have persistent complement component deficiencies (including inherited or chronic deficiencies in C3, C5–9, properdin, factor H, or factor D or taking eculizumab [Soliris®])
- Children who have anatomic or functional asplenia, including sickle cell disease
- Children infected with Human Immunodeficiency Virus (HIV)
- Children traveling to or residing in countries in which meningococcal disease is hyperendemic or epidemic, particularly if contact with local population will be prolonged (MenACWY vaccines only)
- Children identified to be at increased risk because of a meningococcal disease outbreak attributable to serogroups A, C, W, or Y.²

Routine vaccination is recommended for:

- Adolescents 11–18 years of age*
- Adolescents with HIV disease◊
- These high-risk persons 7 years–55 years of age: §, †, **, ‡, ‡‡
  1. First year college students up through age 21 living in residential housing◊◊;
  2. Persons with persistent complement component deficiencies;
  3. Persons with anatomic or functional asplenia;
  4. Persons with HIV;
  5. Lab personnel who are routinely exposed to isolates of *N. meningitides*;
  6. Military recruits;⁶
  7. Travelers to or residents of sub-Saharan Africa’s “Meningitis Belt,” during December to June;
  8. Visitors to Mecca in Saudi Arabia during annual Hajj; and
  9. Countries in which *N. meningitidis* is hyper-endemic or epidemic. §§

- To control outbreaks of meningococcal disease. ‡‡
- MenACWY is recommended for HIV-infected persons aged ≥56 years because of the need for revaccination (i.e. booster doses).¹

*Administer MenACWY at age 11–12 years followed by a booster dose at age 16 years.⁶
For adolescents with HIV, see table IV. A on page 9.

Menactra® (MCV4–D) is preferred among persons ≥9 months of age, and Menveo® (MCV4–CRM) is preferred for persons ≥2 months of age. Persons ≥56 years old for whom meningoococcal vaccination is recommended should receive Menactra® (MCV4–D) or Menveo® (MCV4-CRM) until Menomune® (MPSV–4) is available. 1, 5, 6

Persons at prolonged increased risk for meningococcal disease should be revaccinated with Menactra® (MCV4–D) or Menveo® (MCV4-CRM) because of the need for revaccination (i.e. booster doses). 1, 6

May also be given to college students not living in dorms or to any adolescent upon request. 6

Contact a local travel clinic, health department, or the Centers for Disease Control and Prevention’s (CDC) travel line (877-394-8747) travel web site for the list of high-risk countries. 14

An outbreak is defined as the occurrence of three or more confirmed or probable cases of meningococcal disease during a period of ≤3 months, with a resulting primary attack rate of ≥10 cases per 100,000 population. 6

III. B. RECOMMENDATIONS FOR MPSV4 (Menomune®)*

- Travelers
- Persons at risk as a result of a community outbreak
- High-risk individuals ≥56 years who anticipate requiring a single dose

*If MPSV4 (Menomune®) is unavailable, either quadrivalent conjugate vaccines (Menactra® or Menveo®) may be used. Per OIP Medical Director.
For persons now ≥56 years of age who were vaccinated previously with one of the quadrivalent conjugate vaccines (Menactra® or Menveo®) and who are recommended for revaccination or for whom multiple doses are anticipated (e.g., persons with HIV, asplenia or microbiologists), one of the conjugate vaccines is preferred.1, 6

IV. A. RECOMMENDATIONS FOR HIV-INFECTED PERSONS: 1, 2

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Age of primary vaccination</th>
<th>Recommended schedule and intervals</th>
<th>Booster</th>
</tr>
</thead>
<tbody>
<tr>
<td>MenACWY-CRM (Menveo®)</td>
<td>≥7 years of age</td>
<td>2 doses: 8-12 weeks apart</td>
<td>≥7 years at previous dose: Additional boosters every 5 years.</td>
</tr>
<tr>
<td>MenACWY-D* (Menactra®)</td>
<td>≥7 years of age</td>
<td>2 doses: 8-12 weeks apart</td>
<td></td>
</tr>
<tr>
<td>≥7 years of age with 1 previous dose of either Menveo® or Menactra®</td>
<td>1 dose ASAP as long as at least 8 weeks have elapsed since the previous dose.</td>
<td>≥7 years at previous dose: Additional boosters every 5 years.</td>
<td></td>
</tr>
</tbody>
</table>

*Give Menactra at least 4 weeks after completion of all pneumococcal conjugate vaccine doses to prevent immune response interference.1
### IV.C. QUADRIVALENT (A, C, Y, W-135 only) VACCINE SCHEDULE FOR AGES 2–55 YEARS*

<table>
<thead>
<tr>
<th>Risk group</th>
<th>Primary series</th>
<th>Booster dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons aged 11–18 years</td>
<td>1 dose Menactra* or Menveo*, preferably at age 11 or 12 years</td>
<td>At age 16 years if primary dose given at age 11 or 12 years; 3 years after primary dose, if primary dose given at age 13 through 15 years◊; No booster needed if primary dose on or after age 16 years.</td>
</tr>
<tr>
<td>Persons aged 11–18 years with HIV</td>
<td>2 doses Menactra* or Menveo*, 8–12 weeks apart</td>
<td>At age 16 years if primary series completed at age 11 or 12 years, then every 5 years after; 3 years after primary series, if primary series given at age 13 through 15 years, then every 5 years after◊; Additional boosters every 5 years if primary series on or after age 16 years.</td>
</tr>
<tr>
<td>1st year college students ≤ 21 years old that are living in residential housing</td>
<td>1 dose Menactra* or Menveo*</td>
<td>None</td>
</tr>
<tr>
<td>College students ≤21 years of age living in residential housing who had received a single primary dose &lt;16 years of age and ≥3 years earlier</td>
<td>N/A</td>
<td>1 dose</td>
</tr>
<tr>
<td>Persons aged 7–55 years with persistent complement component deficiency§ or functional or anatomical asplenia‡</td>
<td>2 doses, 8 weeks apart Menveo*, Menactra*</td>
<td>Every 5 years◊◊</td>
</tr>
<tr>
<td>Persons aged 7–55 years with prolonged increased risk for exposure**</td>
<td>1 dose Menveo* or Menactra*</td>
<td>Persons aged 2–6 years: 3 years after 1st dose; then every 5 years if remains at risk◊◊; Persons aged ≥7 years: 5 years after 1st dose; then every 5 years if remains at risk◊◊</td>
</tr>
</tbody>
</table>
IV.C. VACCINE SCHEDULE FOR AGES 7–55 YEARS Cont.

*While MCV4 vaccine is the preferred vaccine for all risk groups, MPSV4 is acceptable when available.6

◊Per Oregon Immunization Program medical director.

§Such as C5–C9, properdin, or factor D16

‡Either conjugate vaccine is recommended 2 weeks before or ≥ 2 weeks after splenectomy. Persons aged ≥ 56 years old undergoing an elective splenectomy should receive MPSV4 if available, otherwise use either of the MenACWY vaccines.16

**Microbiologists routinely working with Neisseria meningitidis and travelers to or residents of countries where meningococcal disease is hyperendemic or epidemic (e.g., “meningitis belt” of sub-Saharan Africa). Travelers to Mecca during the Hajj also should be vaccinated.6, 14

◊◊The every 5-year booster dose schedule for persons with high-risk conditions takes precedent over the routine second dose schedule.3
### IV.D. QUADRIVALENT MENINGOCOCCAL VACCINE RECOMMENDATIONS FOR ≥56 YEARS OF AGE

<table>
<thead>
<tr>
<th>Risk Group</th>
<th>Primary Series</th>
<th>Booster Doses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previously unvaccinated persons who are not anticipated to remain at high risk because of a community outbreak or travelers to countries where meningococcal disease is hyperendemic or epidemic</td>
<td>1 dose of MPSV (Menomune®) if available OR 1 dose of MenACWY (Menveo® or Menactra®)</td>
<td>None</td>
</tr>
<tr>
<td>Previously unvaccinated persons with asplenia, persistent complement component deficiencies, or HIV</td>
<td>2 doses of MenACWY 8 weeks apart (Menveo® or Menactra®)</td>
<td>MenACWY (Menveo® or Menactra®) every 5 years</td>
</tr>
<tr>
<td>Other previously unvaccinated persons at high risk who are anticipated to receive additional doses in the future (e.g., microbiologists routinely working with <em>Neisseria meningitidis</em>)</td>
<td>1 dose of MenACWY (Menveo® or Menactra®)</td>
<td>MenACWY (Menveo® or Menactra®) every 5 years</td>
</tr>
<tr>
<td>Previously vaccinated persons at continued high risk</td>
<td></td>
<td>MenACWY (Menveo® or Menactra®) every 5 years</td>
</tr>
</tbody>
</table>
V. CONTRAINDICATIONS 10, 11, 12, 13

1. A severe allergic (anaphylactic) reaction to thimerosal (Menomune® multi-dose vial) or any other vaccine component, including diphtheria toxoid (for Menactra® and Menveo®) or tetanus toxoid (for MenHibrix®) or to dry natural rubber latex (for Menactra®).6

2. A severe allergic reaction following a prior dose of meningococcal vaccine.17

VI. PRECAUTIONS 10, 11, 12, 13

1. Immunization should be deferred during the course of moderate or severe acute illness.19

2. Apnea following intramuscular vaccination has been observed in some infants born prematurely. Decisions about when to administer an intramuscular vaccine, including MenHibrix® and Menveo®, to infants born prematurely should be based on consideration of the individual infant’s medical status, and the potential benefits and possible risks of vaccination.
VII. A. SIDE EFFECTS AND ADVERSE REACTIONS\textsuperscript{10, 11, 12, 13}

<table>
<thead>
<tr>
<th>Injection site pain</th>
<th>2 years–10 years old</th>
<th>11–18 yrs</th>
<th>18–55 yrs</th>
<th>11–18 years</th>
<th>18–55 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>31%</td>
<td>Not</td>
<td>45%</td>
<td>59%</td>
<td>26%</td>
</tr>
<tr>
<td>Erythema</td>
<td>23%</td>
<td>recommended</td>
<td>22%</td>
<td>11%</td>
<td>8%</td>
</tr>
<tr>
<td>Irritability</td>
<td>18%</td>
<td></td>
<td>12%</td>
<td>16%</td>
<td>4%</td>
</tr>
<tr>
<td>induration</td>
<td>16%</td>
<td></td>
<td>19%</td>
<td>16%</td>
<td>12%</td>
</tr>
<tr>
<td>Sleepiness</td>
<td>14%</td>
<td></td>
<td>11%</td>
<td>30%</td>
<td>11%</td>
</tr>
<tr>
<td>Malaise</td>
<td>12%</td>
<td></td>
<td></td>
<td>22%</td>
<td></td>
</tr>
<tr>
<td>Headache</td>
<td>11%</td>
<td></td>
<td></td>
<td>36%</td>
<td></td>
</tr>
<tr>
<td>Anorexia</td>
<td></td>
<td></td>
<td>8%</td>
<td>11%</td>
<td>9%</td>
</tr>
<tr>
<td>Diarrhea</td>
<td></td>
<td></td>
<td>11%</td>
<td>12%</td>
<td>12%</td>
</tr>
</tbody>
</table>

Adolescent and adult

<table>
<thead>
<tr>
<th>Pain at the injection site</th>
<th>41%</th>
<th>Not recommended</th>
<th>18–55 years</th>
<th>11–18 years</th>
<th>18–55 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache</td>
<td>30%</td>
<td></td>
<td>41%</td>
<td>29%</td>
<td>42%</td>
</tr>
<tr>
<td>Myalgia</td>
<td>18%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malaise</td>
<td>16%</td>
<td></td>
<td>24%</td>
<td>17%</td>
<td>22%</td>
</tr>
<tr>
<td>Nausea</td>
<td>10%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arthralgia</td>
<td></td>
<td></td>
<td>10%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
<td></td>
<td></td>
<td>35%</td>
<td>25%</td>
<td>32%</td>
</tr>
<tr>
<td>Diarrhea</td>
<td></td>
<td></td>
<td>16%</td>
<td>10%</td>
<td>14%</td>
</tr>
</tbody>
</table>

\* All data from Menveo\textsuperscript{®} package insert, text box from page 1.\textsuperscript{10}

\◊ All data from MenHibirx\textsuperscript{®} package insert, text box from page 1.\textsuperscript{13}

\§ Menactra\textsuperscript{®} package insert: Table 2, page 11 for 2 years–10 years of age. Table 3 page 13 for 11–18 years of age. Table 4 page 15 for 18–55 years of age.\textsuperscript{11}

\‡ Menomune\textsuperscript{®} package insert: Table 1, page 10 for 2–10 years of age. Table 2 page 12 for 11–55 years of age.\textsuperscript{12}

Revised: 11-2016 This order expires July 31, 2018
VIII. STORAGE AND HANDLING

All clinics and pharmacies enrolled with the Vaccines for Children (VFC) Program must immediately report any storage and handling deviations to their health educator by calling 971-673-4VFC (4832).

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Temp</th>
<th>Storage Issues</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Menactra®</td>
<td>Store at 2°–8°C</td>
<td>Do not use if vaccine has been frozen. Report to health educator.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>36°–46°F</td>
<td>Do not use after expiration date.</td>
<td></td>
</tr>
<tr>
<td>Menveo®</td>
<td>Store at 2°–8°C</td>
<td>Reconstitute only with the MenCYW-135 liquid conjugate component. It should be</td>
<td>Protect from light</td>
</tr>
<tr>
<td></td>
<td>36°–46°F</td>
<td>administered promptly after reconstituted or stored ≤77°F (25°C) and administered within 8 hours of reconstitution. Do not use if vaccine has been frozen. Report to health educator. Do not use after expiration date.</td>
<td></td>
</tr>
<tr>
<td>Menomune®</td>
<td>Store at 2°–8°C</td>
<td>Vaccine should be administered within 30 minutes after reconstitution.</td>
<td>Use immediately after reconstitution</td>
</tr>
<tr>
<td></td>
<td>36°–46°F</td>
<td>Do not use if vaccine has been frozen. Report to health educator.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Do not use after expiration date.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discard multidose vial 35 days after reconstitution.</td>
<td></td>
</tr>
<tr>
<td>MenHibrix®</td>
<td>Store at 2°–8°C</td>
<td>A single-dose vial should be used immediately after reconstitution. Do not use if vaccine has been frozen. Report to health educator. Do not use after expiration date.</td>
<td>Do not use diluent that has been frozen</td>
</tr>
<tr>
<td></td>
<td>36°–46°F</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diluent</td>
<td>2–25°C</td>
<td>Do not use if vaccine has been frozen. Report to health educator.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>36°–46°F</td>
<td>Do not use after expiration date.</td>
<td></td>
</tr>
</tbody>
</table>
IX. OTHER CONSIDERATIONS

1. **Adverse Events**: epinephrine hydrochloride solution (1:1,000) and other appropriate agents and equipment must be available for immediate use in case of anaphylactic or acute hypersensitivity reaction. 10, 11, 12, 13

2. **Immunocompromised**: individuals with altered immunocompetence may have reduced immune responses. 10, 11, 12, 13 In persons with HIV or persons receiving immunosuppressive therapy for dose schedule. See Recommendations for Use, Section III. A–IVB, pages 6–10. 10, 11, 12, 13

3. **Pregnancy: Safety and effectiveness have not been established in pregnant women.**
   - Menveo® pregnancy registry: 1–877–311–8972.10
   - Menomune®: Use only if clearly needed.12
   - Menactra® pregnancy registry: 1–800–822–2463.11

4. **Lactation**: It is not known whether meningococcal vaccines are excreted in human milk. Use with caution in nursing mothers.10, 11, 12

5. MCV4-CRM, MCV4-D and MPSV4 meningococcal vaccines will stimulate protection only against infections caused by organisms from serogroups A, C, Y and W-135 meningococci. They are not protective against serogroup B meningococci.5

6. **MenHibrix®** vaccine stimulates protection only against infections caused by serogroups C and Y and is not protective against A, B, and W-135.13

7. **Menactra® or Menveo®** are recommended 2 weeks before or ≥ 2 weeks after splenectomy surgery for persons ≥2 years.16

8. Any of the six meningococcal vaccines can be used for outbreak control of a specific serogroup; however, MCV4 is the preferred vaccine if the population targeted includes ages & serogroups for which they are licensed. Persons ≥56 years are recommended for MPSV4 (if available) for specific outbreak control unless they have received MCV4 previously.6

9. **Antimicrobial chemoprophylaxis**: Antimicrobial post-exposure chemoprophylaxis of close contacts of sporadic cases of meningococcal disease is the primary means for prevention of meningococcal disease in the United States.18 Close contacts include:
   - household members
   - daycare-center contacts
   - anyone directly exposed to the patient’s oral s
Contacts of cases should be referred to their primary healthcare provider and local health department for treatment and follow-up. See Investigative Guideline for meningococcal disease for more details.\(^{19}\)

10. Protective levels of antibodies are usually achieved 7–10 days after vaccination.\(^ {17}\)

11. Immunization with MenHibrix\(^ {\circledR}\) does not substitute for routine tetanus immunization.\(^ {13}\)

12. Do not give MenHibrix\(^ {\circledR}\) simultaneously with any other Hib-containing vaccine.\(^ {13}\)

### X. ADVERSE EVENTS REPORTING

Adverse events following immunization must be reported to the Vaccine Adverse Events Reporting System (VAERS). The VAERS online report form is available at [https://vaers.hhs.gov/reportevent.html](https://vaers.hhs.gov/reportevent.html)

A pharmacist who administers any vaccine must report the following elements to the OHA ALERT Immunization Information System in a manner prescribed by OHA within 15 days of administration. This replaces the former requirement to notify the primary health care provider. A pharmacist is not required to notify the primary health care provider. Oregon Administrative Rule 855-019-0290-(2)(3).\(^ {20}\)

**VAERS Reporting Table** *

[https://vaers.hhs.gov/docs/VAERS_Table_of_Reportable_Events_Following_Vaccination.pdf](https://vaers.hhs.gov/docs/VAERS_Table_of_Reportable_Events_Following_Vaccination.pdf)

<table>
<thead>
<tr>
<th>Event and interval from vaccination</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Anaphylaxis or anaphylactic shock (7 days)</td>
</tr>
<tr>
<td>B. Shoulder Injury Related to Vaccine Administration. (7 days)</td>
</tr>
<tr>
<td>C. Vasovagal syncope (7 days)</td>
</tr>
<tr>
<td>D. Any acute complication or sequelae (including death) of above events</td>
</tr>
<tr>
<td>(interval - not applicable)</td>
</tr>
<tr>
<td>E. Events described in manufacturer’s package insert as contraindications to additional doses of vaccine (interval - see package insert)</td>
</tr>
</tbody>
</table>
Effective date: March 21, 2017. The Reportable Events Table (RET) reflects what is reportable by law (42 USC 300aa-25) to the Vaccine Adverse Event Reporting System (VAERS) including conditions found in the manufacturer package insert. In addition, healthcare professionals are encouraged to report any clinically significant or unexpected events (even if not certain the vaccine caused the event) for any vaccine, whether or not it is listed on the RET.

To request this material in an alternative format (e.g., Braille) or to clarify any part of the above order, contact the Oregon Health Authority Immunization Program at 971.673.0300 and 711 for TTY. For other questions, consult with the vaccine recipient’s primary health care provider or a consulting physician.

Electronic copy of this protocol available at:
http://1.usa.gov/PharmacyImmunizationProtocols
REFERENCES


10. Menveo® package insert (August 2013). Available at: 

11. Menactra® package insert (August 2014). Available at: 

12. Menomune® package insert (April 2013) Available at: 

13. MenHibrix® package insert (2012). Available at: 


18. CDC. Appendix A. MMWR 2013;62(RR02);23–24. Available at: 

19. State of Oregon \ Meningococcal disease (vaccine-preventable). Available at: 

APPENDIX A:

Meningococcal Prevention Mandates for Elementary and Secondary Schools
February 2016

Type of Requirements
- Single dose required
- Two doses required
- School must provide education

Current as of 17 July 2017


Revised: 11-2016

This order expires July 31, 2018
APPENDIX B:

Meningococcal ACWY Prevention Mandates for Colleges and Universities
February 2017

Current 17 July 2017


Revised: 11-2016
This order expires July 31, 2018