# Meningococcal B Vaccine Protocol

vaccine protocol for Persons Age 10 years and older

**Document reviewed and updated:** **June 6, 2023**

## Condition for protocol

To reduce incidence of morbidity and mortality of Neisseria meningitidis.

## Policy of protocol

The nurse will implement this protocol for Meningococcal B vaccination.

## Condition-specific criteria and prescribed actions

**Delete this entire paragraph before printing/signing protocol.**

[Instructions for persons adopting these protocols: The table below lists indication, contraindication, and precaution criteria and suggested prescribed actions that are necessary to implement the vaccine protocol. The prescribed actions include examples shown in brackets but may not suit your institution’s clinical situation and may not include all possible actions. A licensed prescriber must review the criteria and actions and determine the appropriate prescribing action.]

Indications

|  |  |
| --- | --- |
| Criteria | Prescribed action |
| Currently non-acutely ill person age 10 years and older with one of the following risk indications:* Complement component deficiency (e.g., C5–C9, properdin, factor H, or factor D).
* Using a complement inhibitor, including eculizumab and ravulizumab.
* Anatomic or functional asplenia, including sickle cell disease.
* Lab personnel routinely exposed to N. meningitidis.
* Person identified to be at risk due to an outbreak of serogroup B meningitis.
 | Give meningococcal B vaccine if meets remaining criteria. [Give meningococcal B vaccine to persons age 10 through age 25 years, refer to \_\_\_\_\_\_\_\_ for off-label vaccination of persons over 25 years of age.] |
| Currently non-acutely ill person age 10 through 25 years who wishes to reduce their risk of meningococcal type B invasive disease. | Proceed to vaccinate if meets remaining criteria. [Defer vaccination until person is at least age 16 years due to short term nature of protection and highest risk occurs in older adolescents.] |
| Person becomes or remains at increased risk for meningococcal disease after completion MenB primary series. | Give meningococcal B vaccine if meets remaining criteria and follow Booster dose schedule. [Refer to \_\_\_\_\_\_\_\_ for off-label vaccination of persons who are recommended to receive booster dose(s).] |
| Person has previous history of meningococcal disease. | Proceed to vaccinate if meets remaining criteria. |
| Person previously received MCV4 or MPSV4. | Proceed to vaccinate if meets remaining criteria. |
| Person is scheduled to receive MCV4 at same visit. | Proceed to vaccinate, give vaccines at separate injection sites. |

Contraindications

|  |  |
| --- | --- |
| Criteria | Prescribed action |
| Person had a severe allergic reaction (anaphylaxis) to a previous dose of MenB vaccine. | Do not vaccinate if previous dose was the product, you currently have available, or the allergy is a component of current vaccine available; refer to provider that has the other product \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Person has a severe allergy to a component of MenB vaccine. | Do not vaccinate; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Precautions

|  |  |
| --- | --- |
| Criteria | Prescribed action |
| Person has a mild illness defined as temperature less than \_\_\_\_°F/°C with symptoms such as: {to be determined by medical prescriber} | Proceed to vaccinate. |
| Person has a moderate to severe illness defined as temperature \_\_\_\_°F/°C or higher with symptoms such as: {to be determined by medical prescriber} | [Refer to health care provider for evaluation of symptoms and determination of whether to vaccinate.] |
| Person started with MenB vaccine product not supplied by this clinic. | [May vaccinate but must receive full series of current vaccine product.][Refer to health care facility that provides the vaccine product patient started.] |
| Person is pregnant. | Refer to primary care to determine risk of disease and need for vaccination. |

## Prescription

### People age 16-23 years not at increased risk

* Give either:
	+ Bexsero® (MenB-4C) 0.5 ml, IM. Give two doses at least 4 weeks apart, or
	+ Trumenba**®** (MenB-FHbp) 0.5 ml, IM. Give two doses at least 6 months apart.
		- If dose 2 is administered earlier than 6 months, administer a 3rd dose at least 4 months after dose 2.

Note: MenB vaccines are not interchangeable, and the same vaccine product must be used for all doses.

* + If one MenB dose was received but the vaccine product is unknown, the series must be restarted with either product to ensure completion of a 2-dose series using the same product.
	+ If 2 doses were administered using different MenB products, one product should be selected for administration of an additional dose at an appropriate interval to ensure valid completion of a MenB series; the dose from the product not selected for series completion should be considered invalid.
	+ For situations in which a MenB dose or doses must be repeated, a minimum interval of 4 weeks should be used between any 2 doses.

### People age 10 years and older at increased risk

* Give either:
	+ Bexsero® (MenB-4C) 0.5 ml, IM. Give two doses at least 4 weeks apart, or
	+ Trumenba**®** (MenB-FHbp) 0.5 ml, IM. Give three doses at 0-, 1-2-, and 6- months.
		- If dose 2 was administered at least 6 months after dose 1, dose 3 is not needed.
		- If dose 3 is administered earlier than 4 months after dose 2, a fourth dose should be administered at least 4 months after dose 3.

#### People age 10 years and older who remain at risk after primary series (booster)

* Give either:
	+ Bexsero® (MenB-4C) 0.5 ml, IM. Give one dose 1 year after completion of primary series and every 2-3 years thereafter if risk remains, or
	+ Trumenba**®** (MenB-FHbp) 0.5 ml, IM. Give one dose 1 year after completion of primary series and every 2-3 years thereafter if risk remains.

## Medical emergency or anaphylaxis

Follow pre-established agency protocol for anaphylaxis.

## Question or concerns

**Insert overseeing medical consultant’s information below and delete this sentence before printing/signing.**

In the event of questions or concerns call (insert name) at (insert phone number).

**This protocol shall remain in effect until rescinded.**

Name of prescriber (please print):

Prescriber signature:

Date: