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PAVING A PATH 4WARD

Vaccine Guidelines

General Vaccination Recommendations:

- **Optimize Timing:**
 - When possible, schedule vaccinations during periods of **lower immunosuppression** to help ensure a stronger immune response
- **B-cell Depleting Therapy:**
 - Plan vaccinations **before** scheduled B-cell depletion therapy. Avoid vaccinating immediately after receiving therapy. (B cells are important to achieving normal responses to vaccines. The response to the vaccine may be muted if you have just been treated with a B-cell depleting medication).
 - If receiving intermittent immunosuppression (for example, B cell depletion every once in a while), aim to be vaccinated **2 to 4 weeks before the first infusion**
- **Partial Protection is Better than None:**
 - If unvaccinated or if you are due for a booster, it is still advisable to receive most vaccines (all vaccines except

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live vaccines) even during immunosuppression, knowing another booster may be necessary later

- **Booster Doses:**

- Consider **booster doses** (also known as **revaccination**) as needed.
- Example: COVID-19 vaccines are sometimes recommended every 6 months rather than yearly for people who are continually immunocompromised because of ongoing treatment

- **Multiple Vaccines in One Visit:**

- It is safe to receive more than one vaccine on the same day. Mild side effects such as fatigue or arm pain can occur – but these can happen, of course, even if you only get one vaccine on a single day.
- **To manage vaccine site soreness:** Use acetaminophen (Tylenol) or ibuprofen (Motrin/Advil) – *if this is approved by your clinical team.*
An ice pack at the vaccination site can also help.

Guidelines to the major vaccines:

- **Influenza (Flu) Vaccine:**

- Inactivated (IIV) or Recombinant (RIV) only
- **Timing:**

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- At least **4 weeks before** starting B-cell depleting therapy for optimal response
 - If already on B cell depletion therapy, vaccinate **5-6 months after the last infusion** and **at least 4 weeks before the next infusion**, if possible
 - **Avoid:** Live nasal spray vaccine (LAIV) because this version, as its name implies, is a live vaccine.
- **COVID-19 Vaccine:**
 - **Timing:**
 - If already on B-cell depletion therapy, administer **2-4 weeks before the next scheduled infusion**
 - **Revaccination** may be needed **6 months after therapy completion** if vaccinated while immunosuppressed
 - **Boosters:**
 - May be needed **6 months** instead of annually—discuss with your healthcare team
 - **Prednisone Considerations:**
 - If on long-term prednisone, vaccination is ideal at 5-10mg daily (or less). If higher doses are required, vaccination is still recommended with a discussion with your healthcare team about booster strategies

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- **Respiratory Syncytial Virus (RSV) Vaccine:**
 - **Recommended for:**
 - **All adults aged 75+**
 - **Adults aged 60-74** with increased RSV risk (including moderate/severe immune compromise)
 - **Not yet recommended** for those under 60 years old

- **Pneumococcal Vaccine (the pneumonia vaccine, designed to protect against Strep pneumococcus)**
 - **Recommended for:**
 - Adults **≥19 years** with immunosuppression
 - **Timing:**
 - Preferably **before therapy**; if given during therapy, immune response may be lower

- **Shingles (Herpes zoster) Vaccine**
 - **Why?** Immunocompromised individuals are 51% more likely to develop shingles compared with those who are not

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- **Recommended for:**
 - **All immunocompromised adults ≥18 years old** (CDC-approved, even if under 50—pharmacists may require CDC documentation)
- **Timing:**
 - 2 doses 2-6 months apart (can be longer if needed to avoid intense immunosuppression periods)
- **Additional Considerations**
 - **Consult your healthcare team** to discuss individual vaccine timing based on your disease activity and treatment schedule
 - **Vaccination** has been shown to **reduce risk** of severe disease and complications even if the immune response is lower
 - **Revaccination** should be considered for individuals who received vaccines while on B-cell depleting therapy

MEASLES (Measles/Mumps/Rubella - MMR) VACCINE

MMR is a **live-attenuated** vaccine. **Live vaccines** can cause infection in people whose immune systems are suppressed—a common situation for many IgG4-RD patients.

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WHO SHOULD NOT GET MMR NOW:

- Taking **prednisone** (any dose)
- Using **DMARDs** such as methotrexate, azathioprine, or mycophenolate
- Received **B-cell–depleting therapy** (rituximab, ocrelizumab, obinutuzumab, inebilizumab) and **B-cells have not yet returned to normal**
- Currently on **B-cell–suppressing agents** such as obexelimab or rilzabrutinib

BOOSTER & TESTING GUIDANCE

• **If you had measles as a child** (likely in the 1940s and 1950s, before vaccinations became available in 1957), then you are probably still immune. If there is any doubt, you may be tested for measles IgG, to determine your level of immunity.

- **If you were vaccinated after the late 1979:** You are probably still immune to the measles. No further action needed.
- **If you were vaccinated before 1979 and are NOT immunocompromised:** A one-time MMR booster may be reasonable (most pharmacies; call ahead). It is also reasonable to have a blood test to measure measles IgG as a way to assess your immunity.
- **Vaccinated before 1979 and immunocompromised:** Request a **measles IgG blood test** as a way to assess your immunity. If your blood test for measles IgG is low, correlating with low immunity and high

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infection risk if exposed, at treatment called intravenous immune globulin (IVIg) can reduce risk if exposed.

WHY TEST MEASLES IgG?

- **Positive result:** You are probably protected even if exposed.
- **Negative result:** If exposed, prompt treatment with **IVIg** can prevent illness.

**Always confirm your plan with your healthcare provider.*

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