Frequently asked questions (FAQ’s)

Please find below some commonly asked questions regarding general immunisation enquiries including information on catch up immunisations.

1. Q. My patient had 2 doses of Gardasil (HPV) but missed the scheduled dose 3. Do I need to start the course again?

A: No, you should build on the previous documented doses. In almost every circumstance, it is advisable not to start the schedule again, regardless of the interval since the last dose. The recommended 3-dose schedule for the 4vHPV vaccine is at 0, 2 and 6 month intervals.

It is important to complete the full course of three doses for the best protection. The missed dose should be given as soon as is practicable. The minimum interval between dose 2 and 3 is 12 weeks.

2. Q: My patient had 2 doses of Hepatitis B as a child at 2 months and 4 months of age. They are now 14 years old. Do I restart the course? Which Hepatitis formulation do I use?

A: No, you do not need to restart the course. A third dose now will complete the course for your patient. Your patient received the first 2 doses as paediatric formulation, complete the course with the paediatric formulation of Hepatitis B vaccine.

For older children and young adults aged <20 years (who have not received hepatitis B vaccination earlier in life) a 3-dose schedule of the paediatric formulation (0.5 mL) of monovalent hepatitis B vaccine can be used (at 0, 1 and 6 month intervals).

Of note, several studies have demonstrated that adolescents 11–15 years of age who receive 2 doses of adult formulation monovalent hepatitis B vaccine, 4 to 6 months apart, develop similar protective antibody levels to those vaccinated using paediatric formulations in the standard 3-dose schedule.

3. Q: I am completing a catch up schedule for a 2 year old who has never been immunised before. Do I still need to give the scheduled 18months booster dose of DTPa even though the child is past this age timepoint?

A: Yes. a total of 5 doses of DTPa-containing vaccine are recommended for children <10 years of age if born on or after 1 October 2014 as per the current NIP; 3 doses as part of the primary schedule for infants (recommended at 2, 4 and 6 months of age) and 2 booster doses (recommended at 18 months and 4 years of age).

Because the 18-month booster dose was not routinely recommended between 2003 and 2015, there will be children who have only had 3 primary doses of DTPa-containing vaccine prior to a booster dose at 4 years of age. In these circumstances, providing the child’s 4th dose of DTPa-containing vaccine was administered after 3.5 years of age, they do not require any further doses until the single booster dose recommended during adolescence (refer to 4.12 Pertussis). However, any child aged ≥18 months to ≤3.5 years who has not previously received a booster dose of DTPa-containing vaccine at 18 months of age should receive their 1st booster dose (dose 4) now, followed by a 2nd booster dose at 4 years of age (with a minimum interval of 6 months between these doses). These children should
then receive their next booster dose during adolescence as routinely recommended (refer to 4.12 *Pertussis*).

4. Q: I have a patient who will be travelling overseas when they are 11 months of age. Can I give them their 12 month vaccines early and will the doses still be considered valid by ACIR?

A: Overseas travel may warrant early attendance to a provider for opportunistic vaccination. It is recommended that patient’s travelling overseas be seen by an immunisation travel specialist to discuss vaccine requirements. It would be advisable to have vaccines administered at the travel specialist, taking into account dose interval precautions such as with live vaccines which must be administered on the same day or separated by an interval of at least 4 weeks.

In special circumstances such as overseas travel, the AIR will record MMR vaccine given at ≥11 months of age as a valid dose, for purposes of calculating immunisation status.

MenCCV is recommended for use in infants at 12 months of age (as either MenCCV or the combination vaccine Hib-MenCCV). If any MenCCV doses are given before 12 months of age, then a booster dose of MenCCV is recommended at 12 months of age or 8 weeks after the last dose, whichever is later. While best practice is to administer from 12 months of age, the AIR will record MenCCV (or Hib-MenCCV) given at ≥11 months of age as a valid dose for the purposes of calculating immunisation status. It is expected that a single dose of MenCCV provided at ≥11 months (but before 12 months) of age is likely to be immunogenic. *Table 2.1.5* in *The Australian Immunisation Handbook* lists the minimum acceptable ages for the 1st dose of scheduled vaccines in infants. *The Australian Immunisation Handbook 2.1.5 Catch Up*

5. Q: I have a patient who had no immunisation records. What do I do next?

A: The most important requirement for assessment of vaccination status is to have written documentation of vaccination. The approach of immunisation service providers to the problem of inadequate records should be based on the age of the person to be vaccinated, whether previous vaccines have been given in Australia or overseas, and the vaccines being considered for catch-up.

In the absence of immunisation records, it is best practice to assume that the vaccine(s) required have not been given previously and commence a catch up course.

In most circumstances, and for most vaccines, it is more practical to offer vaccination, rather than serological testing. In some instances, serological testing for immunity from prior vaccination and/or infection may be useful to guide the need for catch-up vaccination, such as for measles, mumps, rubella, varicella and hepatitis B. If you are a GP and would like to notify a child’s vaccination exemption due to natural immunity, you can complete an Immunisation Medical Exemption Form. It is important to note that serological testing is not reliable for vaccine-induced immunity in all instances and is specifically *not* recommended to be used to guide the need for catch-up vaccination for certain diseases/vaccines (e.g. pertussis, pneumococcal disease and meningococcal disease). Refer also to recommendations regarding serological testing before and after vaccination in various disease chapters from *The Australian Immunisation Handbook 10th Edition*