Massachusetts Department of Public Health
Massachusetts Vaccine Purchasing Advisory Council (MVPAC) Meeting

Date: Thursday, July 18, 2013
Time: 4-6 PM
Location: Massachusetts Medical Society, 860 Winter Street, Waltham, MA 02451
Commonwealth Conference Room

MVPAC Council Members

Ronald Adler, MD
Michael Chin, MD
Kevin Cranston, MDiv
Marie DeSisto, RN, MSN
Tony Dodek, MD
Benjamin Kruskal, MD, PhD
Thomas Hines, MD
Susan Lett, MD, MPH
Cody Meissner, MD
Richard Moriarty, MD
David Norton, MD
Sean Palfrey, MD
Ronald Samuels, MD, MPH
Kate Wallis, RN, BSN

Additional Attendees

Beth English, MPH, MDPH
Larry Madoff, MD, MDPH
Bob Morrison, MDPH
Pejman Talebian, MA, MPH, MDPH
Cynthia McReynolds, MBA, MCAAP
Leonard Friedland, GlaxoSmithKline Vaccines
Deborah Gonyar, GlaxoSmithKline Vaccines
Misha Honaker, GlaxoSmithKline Vaccine
Reno Soucy, GlaxoSmithKline Vaccines
Andrew Trofa, GlaxoSmithKline Vaccines
Anthony Urciuoli, GlaxoSmithKline Vaccines
Elizabeth Blowers-Nyman, Merck Vaccines
Judy Butler, Merck Vaccines
Michael Goldstein, Merck Vaccines
Barbara Homeier, MD, Merck Vaccines
Joe Costello, Novartis Vaccines
Clem Lewin, Novartis Vaccines
Patricia Novy, Novartis Vaccines
Debora Elliott, Sanofi Pasteur
Sherry Schilb, Sanofi Pasteur
Steven Smith, Sanofi Pasteur

Welcome

Dr. Madoff convened the meeting for Mr. Cranston. Dr. Madoff noted that the DPH budget and legislative updates would be tabled until Mr. Cranston arrived.

Meeting attendees introduced themselves.

Review of Hepatitis Containing Vaccines

- Overview of products to be considered
- Manufacturer presentations
- Deliberation and voting

Overview of products to be considered

Dr. Lett directed attendees to the MDPH Hepatitis A- and Hepatitis-B Containing Vaccine Group handouts. Binders with the packaging inserts and a document listing the packaging insert links also were available if needed for Council deliberations.

Dr. Lett reviewed the recommended schedule, available vaccines, cost per dose and whether MDPH provided the Hepatitis A-containing vaccines, Havrix and VAQTA. She noted that information was not provided for Pediarix because that was discussed at the April meeting. In addition, the combination Hepatitis A-Hepatitis B vaccine, Twinrix, was not scheduled to be on the agenda because of its age indication (Note: later in the meeting representatives from GlaxoSmithKline clarified that this vaccine is approved for use in those 18 years of age and older, not 20 years of age and older as indicated in the table).

A question was raised about whether catch-up could be initiated for children who have only had one dose. Mr. Talebian noted that at this time, DPH only has catch-up funding for children enrolled in the Vaccines for Children Program. The DPH budget is in process and this issue may re-visited in the fall.

Dr. Lett also reviewed the Hepatitis B-Containing Vaccine Group handout.

The combination Hib-HepB vaccine, Comvax, cannot be administered earlier than six weeks of age because of potential suppression of the immune response to the Hib component. It also cannot be used for booster doses. ACIP has approved an off-label use for children whose mother is HBsAg positive or whose HBsAg status is unknown.

Dr. Lett noted that Engerix is approved for some alternative dosages and 4-dose schedules in specific populations, e.g., infants born to HbsAg positive mothers, recent exposure to virus and travelers to high-risk areas.

Recombivax HB (adult formulation) also is licensed for use in children 11-15 years of age as a 2-dose alternative schedule, given at least 16 weeks apart and completed by 16 years of age.

No difference in immunogenicity has been observed when 1 or 2 doses of Hepatitis B vaccine produced by one manufacturer are followed with doses from another.

Manufacturer Presentations

Mr. Talebian noted that DPH legal counsel confirmed that any handouts or presentations utilized during an open meeting are of public record, and therefore must be shared. Therefore, presenters may be speaking during this meeting without presentations.

Merck Vaccines (VAQTA, Recombivax)

Dr. Barbara Homeier, Regional Medical Director, Merck Vaccines, presented information about the Merck Hepatitis A and Hepatitis B vaccines, VAQTA and Recombivax. Dr. Homeier confirmed that Merck supports provider choice.

While national and global vaccination efforts against Hepatitis A and Hepatitis B have been good, the disease is still circulating. 35,000 cases of Hepatitis B per year are diagnosed in the US. CDC also

estimates that only 10% of actual numbers of Hepatitis A disease numbers are actually reported. There was a recent Hepatitis A outbreak in the US, from pomegranates originating from Turkey.

Recombivax, Merck's single-antigen hepatitis B vaccine for children, comes in a 5 µg 0.5 mL dose vial and pre-filled syringe, and is recommended for a three-dose regimen at 0, 1 and 6 months. Recombivax HB is recommended for all pediatric age groups.

Dr. Homeier confirmed the dose, volume and schedule, detailed the immunogenicity and efficacy studies in infants, children and adolescents, and reviewed the contraindications and side effects for Recombivax HB.

She noted that immunogenicity and efficacy studies in infants, children and adolescents who received three 5 µg doses of the vaccine showed protective levels of 100%, 99% and 99% respectively. Efficacy studies with regards to mothers who were surface antigen positive after 1 dose, plus 3 prescribed doses, showed 95% prevention of chronic Hepatitis B.

Recombivax is contraindicated for anyone who has had an allergic reaction to the vaccine or its components.

Recombivax has a nice safety profile. Side effects include diarrhea, fatigue fever and irritability.

The duration of protection has not been defined. There is data out to 30 years, and international studies up to 26 years.

Comvax, the combination Hib-HepB vaccine, is recommended at 2 and 4 months of age, with a booster at 12-15 months of age. The vaccine has a similar safety profile to Recombivax.

Dr. Homeier also reviewed VAQTA, Merck's Hepatitis A vaccine.

One dose is recommended at 12 months of age, with a second dose administered 6 to 12 months later.

The dosage for children is 25 U/0.5 mL dose.

In an efficacy study of 1,000 children in a New York community, where ½ of those included in the study received the vaccine and ½ received a placebo, 50 days after receiving the vaccine, there was 100% efficacy of those who received the vaccine.

Booster dose efficacy has been shown out to 9 years; at 10 years, the booster dose is still showing protective levels.

The vaccine has effectiveness that has been modeled out to 25 years.

VAQTA is contraindicated in one who has had an allergic reaction to the vaccine or its components

VAQTA has a nice safety profile. Side effects include pain, tenderness, erythema and fever.

<u>Discussion</u>

Dr. Meissner commented that while 24,000 babies are born to surface antigen positive mothers, only 70% of newborns receive the Hepatitis B vaccine.

Dr. Lett added that DPH would like improve Hepatitis B vaccination rates in Massachusetts. Vaccination rate for the birth dose of hepatitis B vaccine have dropped from 90% to 70%. While rates are not great for the birth dose, 90% have completed the 3-dose series on time and 98% of adolescents have gotten three doses of Hepatitis B. She added that there is a large national initiative to improve vaccination rates by communicating the message that giving the first dose in the hospital is best.

There was discussion as to why the birth dose was not given in the hospital – whether it was because of process or parental choice. Many providers don't want the first dose given in the hospital, because it is difficult to confirm that the dose was administered. Dr. Lett mentioned that continued roll-out of the MIIS will help to address that concern. Some providers report that many parents and providers want the first dose to be administered in the provider's office.

GlaxoSmithKline Vaccines (GSK) - HAVRIX, ENGERIX-B

Misha Honaker, Marketing/Commercial Strategy, GSK, presented information about GSK's hepatitis A- and hepatitis B-containing vaccines.

GSK's hepatitis products have been on the market for a number of years, are well-established.

Ms. Honaker noted that GSK's adequate supply of the Hepatitis vaccines is expected to continue, but added that there have been supply challenges historically for these vaccines. GSK supports provider choice as the best choice for the Commonwealth.

The package inserts and prescribing information was distributed to attendees.

Ms. Honaker showed slides detailing the indications, safety information and efficacy data for HAVRIX, GSK's Hepatitis A-containing vaccine.

HAVRIX is indicated for active immunization against disease caused by hepatitis A virus (HAV). HAVRIX is approved for use in persons 12 months of age and older. Primary immunization should be administered at least 2 weeks prior to expected exposure to HAV.

HAVRIX is available in vials and two types of pre-filled syringes.

In clinical trials with HAVRIX, the most common solicited adverse reactions were injection-site soreness and headache.

An immunogenicity trial of 1,074 children, 11 to 25 months of age, demonstrated a 99-100% immune response. This study supported a change in indication down to 12 months, which supported the ACIP recommendation as well.

The recommended dose and schedule aligns with ACIP recommendations and the pediatric routine immunization schedule.

Ms. Honaker noted that the combination vaccine, TWINRIX, recommended for 18 years of age and older, and is available for 18 year olds through the VFC Program.

The PI also details other co-administration studies. Children who received MMR, varicella and HAVRIX together had more frequently reported adverse events.

Ms. Honaker also reviewed ENGERIX-B, GSK's Hepatitis B-containing vaccine.

ENGERIX-B is available in vials and two types of pre-filled syringes.

ENGERIX-B is contraindicated in those who have had an allergic reaction to a Hepatitis-B containing vaccine.

Slides detailing safety data and immunogenicity were reviewed.

In clinical trials with ENGERIX-B, the most frequently reported adverse reactions were injection-site soreness and fatigue.

Questions/Comments

Andrew Trofa, GSK, noted that on page 9, Section 14.1 of the PI, a small study of 58 children born to high-risk mothers, demonstrated a high protective efficacy for ENGERIX-B alternative 4-dose schedule. The seroprotection rates are comparable.

Deliberation and Voting

Council members deliberated on the following:

1. For the Hepatitis A-containing vaccines, does the Council recommend:
   - Maintain current DPH policy of exclusively supplying VAQTA (Merck vaccine);
   - Change DPH policy to exclusively supply HAVRIX (GSK vaccine);
   - Change DPH policy to allow for provider choice on Hepatitis A vaccines?

2. For the Hepatitis B-containing vaccines, does the Council recommend:
   - Maintain current DPH policy of exclusively supplying Recombivax (Merck vaccine);
   - Change DPH policy to exclusively supplying ENGERIX-B (GSK vaccine);
   - Change DPH policy to allow for provider choice on Hepatitis B vaccines?

3. Comvax, Merck's combination Hib-Hepatitis B vaccine is currently not supplied by DPH. Should DPH maintain this policy or should it consider supplying it?

Hepatitis A Vaccine Discussion

Mr. Talebian clarified that the pediatric decision is independent of what the DPH would do for adults. Because of a limited budget and supply, DPH only provides adult vaccine for those people who are uninsured and vaccinated in the public sector. However; this is less than 2% of the adult population in Massachusetts.

He also noted that the vaccine price differential is inconsequential based on the overall DPH budget. Vaccines prices may come down over time, as prices are lowered to meet other vaccine prices. There is a price premium for combination vaccines.

A comment was made regarding provider choice that many providers feel that if two vaccines are equal in efficacy and similar in price it is good to offer provider choice, but many providers want that choice to be made at a higher level, not by vaccine representatives visiting provider offices and providers choosing individually.

If the products are comparable and interchangeable and choice is offered, somewhere in the product marketing, advertising to providers can become harassing. This can be a problem for primary care providers, especially if they are given misinformation. Choice is important, but what it means for the practitioner should be considered.

DPH clarified that the Council can make recommendations about how vaccine purchasing decisions are made and to what degree the decision should be at the individual provider level.

A comment was made that simplicity is one of the Council's Guiding Principles.

DPH currently provides guidance to providers regarding changing formulations: providers are asked to switch only once a year, and need to use up their current formulations before making a change. DPH clarified they could not attempt to ensure market share through regional formulation allocations and assigning providers to a particular formulation. While the vaccines being discussed are interchangeable, the ACIP prefers finishing the series with the vaccine that you start with for a patient.

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It was noted that at its April meeting, the Council recommended moving towards provider choice for the pertussis-containing vaccine formulations. The Commissioner accepted this recommendation and DPH will be sending out an advisory regarding choice for Tdap vaccine formulations next week.

Ms. English noted that online vaccine ordering began on July 1st and has been a significant undertaking by the DPH, with intensive provider coaching by registry and vaccine management staff. Adding the burden of allocating formulations at the practice level would be very challenging at this time.

Mr. Morrison noted that it isn't difficult to manage choice by providers. Providers can limit their interaction with vaccine representatives. Providers can change only one time per year.

Dr. Lett also noted that many states that allow provider choice don't allow providers to switch within a year.

Any changes in available vaccine formulations will be included on the DPH vaccine order form.

A request was made for DPH to communicate to providers in the ordering process that all vaccines have been reviewed and approved by MVPAC and DPH.

Should the decision towards choice go stepwise and slowly? Should the Council see what happens with DTaP to see how the system is evolving? DTaP might not be a good marker, because the DTaP vaccines are so similar.

A comment was made that the biggest concern with multiple vaccines is the issues of confusion and mistakes.

The Council can make a conditional proposal – noting that a decision will be revisited after a certain time period.

DPH would prefer operationally that choices and changes are made at the provider level, not assigned arbitrarily by the vaccine management staff. It would take a significant amount of time to monitor provider ordering patterns to appropriately allocate vaccines if DPH were to make the decision for them.

Council members can include provider feedback as an agenda item at a Council future meeting. A request was made to add this item to the Council's next meeting agenda.

If choice were introduced for these vaccines, it was suggested that at least a year would be needed to gather information before the process should be reviewed.

After discussion, the Council recommended that DPH introduce a one-year pilot to permit provider choice across the two manufacturers for Hepatitis A vaccine with Council intent to review the ordering process and provider feedback on the process after one year.

Hepatitis B Vaccine Discussion

A comment was made that with the Hepatitis B vaccine, there is a problem with administering the birth dose at the hospital versus in the provider's office. Could there be a problem with different vaccines being administered through hospitals and provider offices. Optimally, the first dose would be given at the birth hospital and the second dose would be given in the office. It was suggested that different vaccines aren't the problem; documentation of vaccination is a problem.

There is an opportunity for education as the change to provider choice would be implemented – communicate choice, that the vaccine used makes no difference, but please make every effort to re-increase birth dose to 100%.

After discussion, the Council recommended that DPH introduce a one-year pilot to permit provider choice across the two manufacturers for Hepatitis B vaccine with Council intent to review the ordering process and provider feedback on the process after one year.

Comvax Combination Hepatitis B Vaccine Discussion

There is a premium cost to this vaccine, which is not included in the current DPH budget.

There is more potential that use of the vaccine might cause trouble with the birth dose. The combination vaccine does not fit well with the usual schedules in current use and could lead to confusion with other vaccines.

After discussion, the Council recommended that DPH not purchase Comvax.

DPH Budget and Legislative Updates

Mr. Cranston noted Cheryl Bartlett has been named as the Commissioner of Public Health. Ms. Bartlett is a nurse and a long-time community health leader.

He also noted Mr. Talebian has been named Director, MDPH Immunization Program, and Ms. English has been named Associate Director, MDPH Immunization Program. He also noted that Dr. Lett will continue in her role as Medical Director, MDPH Immunization Program.

Mr. Cranston reported that DPH did not fare badly in the state budget process; however, because the Vaccine Trust Fund legislation did not pass, there still is not adequate funding for MIIS maintenance costs and no ability yet to return to full universal status for pediatric vaccine supply policy. DPH may propose supplementary budget language to help cover the MIIS maintenance costs in this state fiscal year.

Mr. Cranston thanked MCAAP for its advocacy on behalf of the bill.

The meeting was adjourned.