DEPARTMENT OF THE AIR FORCE
AIR FORCE RESERVE COMMAND

17 AUG 2012

MEMORANDUM FOR ALL NAF AND WING/CC
604 RSG/CC
610 RSG/CC
622 RSG/CC
951 RSPTS/CC

FROM: AFRC/CV
155 Richard Ray Boulevard
Robins AFB GA 31098-1635

SUBJECT: 2012-2013 Influenza Season

1. AFRC closed out the 2011-2012 influenza season with a hallmark high influenza immunization rate of 95.7%. Within the next few months units will receive robust supplies of 2012-2013 influenza vaccine. Early immunization is key as influenza activity usually peaks in the US between late December and early March. Wings with novel solutions to achieve high immunization rates early will help maintain their Individual Medical Readiness (IMR) compliance on 1 January when influenza immunizations become overdue and count against IMR.

2. As you socialize your wing influenza immunization campaign make sure your Reservists are educated on early recognition of influenza symptoms (Fever >100.5F, cough and sore throat) as well as benefits of frequent hand washing/sanitizing and cough etiquette (cough into elbow or tissue). In heavily populated areas with limited access to hand washing facilities ensure hand sanitizers and tissues are available and easily accessible. These basic disease preventatives can dramatically limit the transmission of disease and loss of work days. The Centers for Disease Control and Prevention offer a variety of free resources at http://www.cdc.gov/flu/about/disease.

3. Documentation is key to a successful influenza immunization campaign. All Reservists that receive influenza vaccination through non-military facilities must provide vaccination records to their military immunization clinic by the next UTA for documentation in the military immunization tracking system IAW AFJI 48-110. This will ensure completed vaccinations are captured in the unit's IMR compliance rate.

4. The enclosed HQ USAF/SG3 guidance memorandum, *Air Force 2012-2013 Influenza Immunization Program Guidance* (Atchs 1 & 2) outlines the implementation plan for this year's seasonal influenza vaccination campaign. Flu vaccination provides proven protection from illness, and DoD policy requires all military members to receive an annual vaccination to maximize force health protection. In accordance with the HQ USAF/SG3 policy memo, the AFRC goal is >90% immunization by 17 December 2012. My POC for this issue is Lt Col James Cowan, HQ AFRC/SGPH, DSN 497-2398.

CRAIG N. GOURLEY, Maj Gen, USAF
Vice Commander

2 Attachments:
1. HQ USAF/SG3, Air Force 2012-2013 Influenza Immunization Program Guidance Memorandum
2. HQ USAF/SG3, 2012-2013 Influenza Immunization Program Guidance

DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE
WASHINGTON DC

AUG 0 9 2012

MEMORANDUM FOR ALMAJCOM/SG

FROM: HQ USAF/SG3
1780 Air Force Pentagon
Washington, DC 20330-1780

SUBJECT: Air Force 2012-2013 Influenza Immunization Program Guidance

This memo and attached guidance provide implementation instructions for the 2012-13 Influenza Immunization Program, supplementing AFJI 48-110, Immunizations and Chemoprophylaxis.

Air Force medical staff will administer influenza vaccines to all military members in accordance with AFJI 48-110 and offer vaccines to eligible beneficiaries as appropriate. The success of this year's influenza program will require earliest possible administration of seasonal influenza vaccine as supplies become available. Begin vaccinating as soon as vaccine is received. Do not hold vaccine with the intent to vaccinate only during a mass vaccination clinic. MTF staff must ensure vaccination of all mission critical military personnel and high-risk beneficiaries. Civilian health care personnel are required to receive the influenza immunization annually, (per ASD(HA) memo, 4 Apr 08).

Immunization personnel and healthcare providers should review the most recent Advisory Committee on Immunization Practices (ACIP) recommendations for updates and changes. MTF leadership should work to improve vaccination coverage and remove barriers to influenza vaccination. While maintaining the high level of influenza vaccine coverage previously achieved for military members, medical staff and commanders should develop programs to target beneficiaries who are at increased risk for influenza-related complications.

My POC for this memorandum is Col Carol A. Fisher, AFMSA/SG3PM, 7700 Arlington Blvd, Falls Church, VA 22042, (703) 681-7102, DSN 761-7102, or e-mail: carol.fisher@pentagon.af.mil.

Charles E. Potter

CHARLES E. POTTER
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DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE
WASHINGTON DC

Air Force 2012-2013 Influenza Immunization Program Guidance

1. Purpose

This message provides Air Force guidance for the influenza vaccination program. Request dissemination of this message to all military treatment facility (MTF) commanders, immunization clinics, other clinics that administer immunizations, public health offices, pharmacy services, medical logistics/supply sections, and primary care managers.

2. Influenza

a. Seasonal influenza epidemics occur annually in the United States, are unpredictable and can be severe. Estimates of influenza-related events include 95 million infections, 30 million patient visits and over 200,000 hospitalizations. Between 1976 and 2006, estimates of flu-associated deaths in the U.S. ranged from a low of about 3,000 to a high of about 49,000.
b. Influenza also contributes to cardiac events, premature births, and low birth weight infants.
c. Immunization is the key to seasonal influenza prevention. Influenza vaccine can reduce the risk of cardiac events in persons with cardiac risk factors, as well as the incidence of premature or low birth weight infants.
d. The Advisory Committee on Immunizations Practices (ACIP) has issued a **universal recommendation for influenza vaccination of all adults and children older than 6 months of age.** High risk groups should be targeted for immunization, but immunizing healthy persons is also recommended.

3. Current Seasonal Influenza Virus Vaccines and Their Availability

a. **<u>Do not</u> use last year's influenza vaccine for this year's program.** All influenza vaccine from the 2011-2012 influenza season should have been removed from inventory and destroyed by 1 July 2012.
b. Both the inactivated and live, attenuated vaccines prepared for the 2012-2013 season include an A/California/7/2009 (H1N1)–like virus, an A/Victoria/361/2011 (H3N2)–like virus, and a B/Wisconsin/1/2010-like virus.
c. Influenza viruses for both Trivalent Inactivated Vaccine (TIV) and Live Attenuated Influenza Vaccine (LAIV) are grown in embryonated chicken eggs and might contain limited amounts of residual egg protein. Persons with a history of severe hypersensitivity to eggs, such as anaphylaxis, should not receive influenza vaccine. Mild allergic reactions are not a contraindication, and may be mitigated by premedicating with allergy medications.

d. Anticipated timelines for TIV and LAIV from Defense Logistics Agency – Troop Support (DLA-TS) are:

Date (2012)	% Complete TIV (vials and 0.5ml prefilled)	% Complete LAIV (FluMist®)	% Complete Peds TIV
31 Aug	70	50	70
30 Sept	30	30	30
31 Oct	--	20	--

e. A high-dose formulation of the seasonal influenza vaccine exists (FluZone High Dose) and can be used for adults over 65 years of age, but is not recommended over other available vaccine formulations. **FluZone High Dose is unavailable through DLA influenza vaccine purchase contracts.** However, if a provider recommends this vaccine for a patient, it is covered by the TRICARE network benefit (Section 4) or through direct vendor delivery (i.e., Impact Card purchase).

f. As there are various influenza vaccine products available this season, it is imperative that utmost care and attention is devoted to providing correct immunizations based on age and medical conditions. Accurate recording of immunizations administered is also critical.

g. Live, attenuated FluMist® should be used whenever not otherwise contraindicated in the healthy, non-pregnant 2-49 year old population.

h. Air Force Medical Logistics (AFMLO) is responsible for ordering and distributing influenza vaccine for AFMS activities. AFMLO will notify units of the quantities ordered and the document numbers being used. Additional quantities required must be coordinated with AFMOA/SG3SLC, DSN: 343-4170, commercial (301) 619-4170. AFMLO website is: https://medlog.detrick.af.mil/index.cfm.

4. TRICARE Influenza Vaccine Benefit

a. **Active Duty Air Force and Air Reserve Component personnel on full-time military status located on an installation with an MTF will receive their vaccines through the MTF.**

b. Air Force service members who are not located on an installation with an MTF (and are considered to be geographically separated based on local determination) or those members in part-time military status (ARC members) should follow local or MAJCOM policy for receiving their vaccination.

c. **Influenza vaccine received outside an MTF.** Commanders must ensure Airmen provide a record of vaccination to an MTF Immunization Clinic (preferably an Air Force immunization clinic) within 24 hours for documentation in an approved immunization tracking system. This will ensure completed vaccinations are properly recorded in ASIMS Web and reflected in the member's Individual Medical Readiness status.

d. All beneficiaries are encouraged to receive their influenza immunization from their local MTF. However, to enhance vaccination coverage, the TRICARE Management Activity has issued the final rule authorizing TRICARE Retail Network Pharmacies to administer seasonal influenza at no cost to authorized beneficiaries. This policy remains in effect for the 2012 – 2013 influenza season. This benefit may reduce the numbers of beneficiaries who utilize an MTF for influenza vaccine and should be taken into account for future seasonal influenza planning purposes.

e. Additional information on the TRICARE benefit is available at: http://www.tricare.mil/mybenefit/jsp/Medical/IsItCovered.do?kw=Flu+Vaccine

5. **Timing of Annual Influenza Immunization**

a. Antibodies sufficient to achieve protection against influenza infection usually develop within two weeks of vaccination and last six to nine months.

b. **Influenza vaccinations should begin as early in the season as is possible. Begin immunizing as soon as vaccine becomes available. Although mass immunization programs can be efficient, withholding immunizations until such time as there is sufficient vaccine for such a campaign leads to delays in immunization and contributes to patient dissatisfaction and confusion.**

c. Influenza activity usually peaks in the United States between late December and early March. Vaccination of susceptible individuals (especially new accessions) into the summer months with "unexpired" vaccine may be beneficial as influenza infections occur throughout the year.

d. National supply and epidemic levels may restrict vaccine availability. However, no prioritization is necessary when production and projected distribution schedules allow for sufficient supply of influenza vaccine.

e. Vaccination of all military members should be completed within one month of receipt of sufficient vaccine supplies. The goal for vaccination coverage is >90% of all service members immunized by Dec 17, 2012.

f. Injectable vaccine is the preferred immunization for new accessions, but both injectable vaccine and FluMist may be administered to military members.

g. Flying/Special Duty populations: In a study comparing Duties Not Involving Flying (DNIF) rates among rated AF aircrew who had received either LAIV or TIV, those who received LAIV (FluMist®) were found to have DNIF rates (in the week post-immunization) equivalent to those who received injectable vaccine (relative risk of 0.88 [95% CI 0.73 – 1.06]) (Lowry & Bonnema, personal communication). Given the results of this study, LAIV is an acceptable form and often preferred by patients, even among aircrew or special duty populations. In order to reduce the operational impact, clinics should consider vaccinating half of an operational unit one week and the other half the next week. Additionally, immunizing on Friday allows for recovery over the weekend and should also help reduce any potential operational impact.

h. Other beneficiaries: Healthy persons 2 to 49 years of age without medical contraindications may be offered FluMist®. Vaccination of these individuals with injectable vaccine should be deferred until the target populations who require TIV have had ample opportunity to receive the vaccine. Pediatric dosage prefilled injectable vaccine should be reserved for the appropriate pediatric populations (6 months to 36 months) that require injectable vaccines.

i. Other Prioritization Plans:

(1) "It is DoD policy that the recommendations for immunization of the Centers for Disease Control and Prevention (CDC) and its Advisory Committee for Immunization Practices (ACIP) shall generally be followed, consistent with requirements and guidance of the Food and Drug Administration (FDA) and consideration for the unique needs of military settings and exposure risks." DoDD 6205.02E

(2) In the event of a severe influenza epidemic, extreme vaccine shortage, or unforeseen distribution delays, target populations will be prioritized in accordance with Assistant

Secretary of Defense, Health Affairs policy guidance. If necessary, more specific priority alterations will be given at the direction of AFMSA/SG3PM.

(3) Immunization clinics should make every attempt to comply with state law related to vaccines preserved with Thimerosal. If Thimerosal-free vaccines are not available in local communities that require them, do not withhold immunizations, but obtain consent for immunization. Provide patients with information regarding the local statute, scientific evidence that vaccines containing Thimerosal are safe, and the potential risk of not receiving the vaccine.

j. The CDC's National Center for Immunization and Respiratory Diseases (NCIRD) strongly recommends that providers draw vaccine only at the time of administration to ensure cold chain is maintained and vaccine is not inappropriately exposed to light.

k. **Pre-drawing vaccine is strongly discouraged**; however, a limited amount of vaccine may be pre-drawn for a mass immunization clinic if the following procedures are followed:

(1) Only one (1) vaccine type may be administered at the clinic unless separate vaccine administration stations are set up for each vaccine type to prevent medication errors.

(2) The type of vaccine, lot number, and date of filling must be carefully labeled on **each syringe**, and vaccine should be administered promptly (preferably within the same hour as drawn), and must be kept within the manufacturer's specifications for temperature handling prior to administration.

(3) Vaccine will not be drawn up in advance of arriving at the clinic site.

(4) Unused pre-drawn vaccine drawn up during a mass immunization clinic **must be discarded by the end of the duty day.**

6. **Special Instructions for Influenza Immunization**

a. The ACIP now has a **universal recommendation for influenza immunization of all adults and all children older than 6 months.**

b. Follow AFJI 48-110 and the most recent ACIP recommendations for high-risk and target populations.

c. Influenza vaccination should proceed in parallel for military members, medically high-risk individuals, and other target populations.

d. Pediatric-specific vaccinations should begin as soon as appropriate vaccine is received; do not await acquisition of adult/Service member supplies to begin providing pediatric vaccinations.

e. **Influenza Vaccination Requirements and Recommendations**

(1) AD and ARC members: Mandatory IAW AFJI 48-110.

(2) Civilian healthcare personnel (HCP): Required for all who "provide direct patient care" in DoD MTFs as a condition of employment, unless there is a documented medical or religious reason not to be immunized IAW ASD(HA) Policies. **Healthcare workers who provide direct patient care can reasonably be interpreted to include any worker whose daily activities include contact with patients or involve work in common areas or clinic/hospital rooms where patients are likely to be present (e.g., clerical staff who interact with patients, food service personnel, and cleaning or janitorial staff).**

(3) Beneficiaries aged ≥ 65 years: Achieve Healthy People 2020 Target of 90%.

(4) Healthy persons aged 18 to 64 years: Achieve Healthy People 2020 Target of 80%.
(5) High-risk adults with underlying chronic medical conditions aged 18 to 64 years: Achieve Healthy People 2020 Target of 90%.
(6) Children aged 6 months to 18 years: Achieve Healthy People 2020 Target of 80%.
(7) Hospitalized patients: Hospitalized patients are often in high risk groups, including beneficiaries aged ≥ 65 years & aged 2-64 years with underlying chronic medical conditions.

7. ACIP Recommendations for the Prevention and Control of Influenza

a. Target Groups for Vaccination

Influenza vaccine should be provided to all persons who want to reduce the risk of becoming ill with influenza or of transmitting it to others. However, emphasis on providing routine vaccination annually to certain groups at higher risk for influenza infection or complications is advised, including all children aged 6 months - 18 years, all persons aged ≥50 years, and other adults at risk for medical complications from influenza or more likely to require medical care. In addition, all persons who live with or care for persons at high risk for influenza-related complications, including contacts of children aged <6 months, should receive influenza vaccine annually. Approximately 83% of the United States population is included in one or more of these target groups; however, preliminary estimates suggest 46% of the U.S. population received an influenza vaccination during the 2011-2012 season which is a 4% increase when compared to the previous two seasons.

(1) **Children Aged 6 Months--18 Years**
Annual vaccination for all children aged 6 months-18 years is recommended. Healthy children aged 2-18 years can receive either LAIV or TIV. Children aged 6-23 months and those aged 2-4 years who have evidence of possible reactive airway disease or who have medical conditions that put them at higher risk for influenza complications should receive TIV. **All children aged 6 months--8 years are recommended to receive 2 doses of vaccine 4 or more weeks apart unless they have received at least 2 doses of seasonal influenza vaccine since July 2010.** Children and adolescents at high risk for influenza complications should continue to be a focus of vaccination efforts as providers and programs transition to routine vaccination of all children.

(2) **Persons at Risk for Medical Complications**
Vaccination to prevent influenza is particularly important for the following individuals who are at increased risk for severe complications from influenza (or at higher risk for influenza-associated clinic, emergency department, or hospital visits). When vaccine supply is limited, vaccination efforts should focus on delivering vaccination to these persons:
(a) All children aged 6 months-4 years (59 months);
(b) All persons aged ≥50 years;

(c) Children and adolescents (aged 6 months-18 years) who are receiving long-term aspirin therapy and who might be at risk for experiencing Reye's syndrome after influenza virus infection;
(d) Women who will be pregnant during the influenza season;
(e) Adults and children who have chronic pulmonary (including asthma), cardiovascular (except hypertension), renal, hepatic, hematological, or metabolic disorders (including diabetes mellitus);
(f) Adults and children who have immunosuppression (including immunosuppression caused by medications or by HIV);
(g) Adults and children who have any condition (e.g., cognitive dysfunction, spinal cord injuries, seizure disorders, or other neuromuscular disorders) that can compromise respiratory function or the handling of respiratory secretions or that can increase the risk for aspiration; and
(h) Residents of nursing homes and other chronic-care facilities.

(3) **Persons Who Live With or Care for Persons at High Risk for Influenza-Related Complications**
To prevent transmission to persons identified above, vaccination with TIV or LAIV (unless contraindicated) also is recommended for the following persons. When vaccine supply is limited, vaccination efforts should focus on delivering vaccination to these persons:
(a) HCPs;
(b) Healthy household contacts (including children) and caregivers of children aged ≤59 months (i.e., aged <5 years) and adults aged ≥50 years; and
(c) Healthy household contacts (including children) and caregivers of persons with medical conditions that put them at higher risk for severe complications from influenza.

(4) For additional information about vaccination of specific populations, visit the CDC at: http://www.cdc.gov/flu/professionals/acip/specificpopulations.htm.

b. **Annual vaccination against influenza is recommended for**

(1) **All persons ≥ 6 months (including healthy children and adults);**
(2) Children and adolescents (aged 6 months-18 years) receiving long-term aspirin therapy who therefore might be at risk for experiencing Reye's syndrome after influenza virus infection;
(3) Women who are pregnant or will likely be pregnant during the influenza season (**See Note**);
(4) Adults and children who have chronic pulmonary (including asthma), cardiovascular, renal, hepatic, hematological or metabolic disorders (including diabetes mellitus);
(5) Adults and children who are immunosuppressed (including immunosuppression caused by medications or by human immunodeficiency virus);
(6) Adults and children who have any condition (e.g., cognitive dysfunction, spinal cord injuries, seizure disorders, or other neuromuscular disorders) that can compromise respiratory function or the handling of respiratory secretions or can increase the risk for aspiration;
(7) Residents of nursing homes and other chronic-care facilities;

(8) All HCPs;
(9) Healthy household contacts (including children) and caregivers of children aged <5 years and adults aged ≥50 years, with particular emphasis on vaccinating contacts of children <6 months;
(10) Healthy household contacts (including children) and caregivers of persons with medical conditions that put them at higher risk for severe complications from influenza; and
(11) All persons who want to reduce the risk of becoming ill with influenza or of transmitting influenza to others.

Note: Inactivated injectable vaccine has a category C indication by the FDA, indicating that the manufacturers have chosen not to submit evidence for safety and efficacy in pregnant women. However, there are numerous studies demonstrating that the inactivated vaccine is safe and effective in pregnant women, and that pregnant women are especially vulnerable to influenza and its secondary complications. **Newer research also shows that receiving the vaccine reduced the incidence of both prematurity and infants born who were small for their gestational age by as much as 56% during influenza season (and 40% overall).** (See Reference g.). Given that the FDA-approved package inserts do not fully reflect ACIP recommendations, immunization clinics and providers should advise pregnant women about the risks and benefits of vaccination before recommending influenza vaccine. **FluMist® should not be used in pregnancy.**

c. Rationale for Immunization of Specific Groups

(1) Persons Infected with HIV: Influenza can result in serious illness. As vaccination with inactivated influenza vaccine can result in the production of protective antibody titers, vaccination will benefit HIV-infected persons, including HIV-infected pregnant women. FluMist® is contraindicated, however, in persons with severely reduced immune competency.
(2) Persons who can transmit influenza to those at high risk:
  (a) Health-care workers;
  (b) Employees of assisted living and other residences for persons in groups at high risk;
  (c) Persons who provide home care to persons in groups at high risk;
  (d) Household contacts (especially school-age children) of persons in groups at high risk;
  (e) Household contacts (anyone who spends a significant amount of time in the home) and out-of-home caregivers of children aged 0-59 months; and
  (f) Healthy persons aged 2-49 years who are close contacts of severely immune-suppressed persons should receive inactivated influenza vaccine (injectable) rather than FluMist®.
(3) Persons Aged 50-64 Years: This group has an increased prevalence of undiagnosed high-risk conditions.

(4) Persons with or at Risk for Cardiovascular Disease: Recent studies demonstrate a 50 to 75% reduction in the risk for both primary and secondary cardiac events in persons who receive the influenza immunization compared with those who do not.
(5) Healthy Young Children (6 months through age 18): School-age populations and children who attend daycare are the group most likely to transmit influenza to each other and their family members. Immunizing healthy children helps protect family members who may not be able to be immunized because of immune system problems.
(6) Children Aged 6-59 Months: This group has a substantially increased risk for influenza-related hospitalizations.
(7) General Population:
  (a) Vaccinate any person who wishes to reduce the likelihood of becoming ill with influenza or transmitting influenza to others should they become infected.
  (b) Vaccinate persons who provide essential community services to minimize disruption of essential activities during influenza outbreaks.
  (c) Encourage students or other persons in institutional settings (e.g., those who reside in dormitories) to receive vaccine to minimize the disruption of routine activities during epidemics.

8. Implementation Strategies to Improve Vaccination Rates

a. Utilize reminder and recall systems to target beneficiaries at increased risk for complications from influenza.
b. Implement standing orders or standard operating procedures. Examples include:
  (1) Develop pre-written vaccine orders for adults or other high-risk beneficiaries.
  (2) Administer influenza vaccine to hospitalized patients prior to discharge, unless there is a contraindication. Consider pneumococcal vaccine administration concurrently.
  (3) Administer inactivated influenza vaccine to pregnant women during routine prenatal care.
c. Assess vaccination coverage rates. MTFs should regularly assess their vaccine coverage rates throughout the influenza season and attempt to improve coverage for military members, enrolled infants and children 6 months to 18 years of age, enrolled beneficiaries aged ≥ 50 years and other medically high-risk individuals. Information on vaccine completion rates for certain groups is updated regularly and available at the Air Force Corporate Health Information Processing Service (AFCHIPS) website.
d. Use self-identification questionnaires and clinic posters. Post informational materials in patient care areas, waiting rooms, prenatal and immunization clinics, and other areas likely to target high-risk groups. Appropriate materials are available at: http://www.cdc.gov/flu/
e. Employ other patient-oriented and community-based approaches to reach target populations.
f. Use the opportunity to evaluate service member and beneficiary shot records to update other immunizations wherever possible.
g. Persons with certain underlying medical conditions will also benefit from pneumococcal vaccination, if not previously vaccinated. MTFs should identify eligible individuals and use the opportunity during influenza campaign to ensure these individuals are up-to-date on pneumococcal vaccination IAW ACIP recommendations or

http://www.cdc.gov/mmwr/preview/mmwrhtml/00047135.htm. The Healthy People 2010 target for one-time pneumococcal vaccination for adults aged ≥ 65 years is 90%.

h. Influenza vaccination for federal civilian employees, foreign nationals or other non-DoD individuals. Contractors must have influenza vaccine requirements specified in their contracts. See AFJI 48-110 for additional guidance.

i. MTFs should ensure communication of plan and local strategies to all involved parties. Public affairs resources are available through CDC at: http://www.cdc.gov/flu. A Seasonal Influenza Communication Plan 2012-13 through MILVAX at: https://www.vaccines.mil/Planning_Documents/Influenza_-_Seasonal.

j. August is National Immunization Awareness month and can be used to communicate and promote the importance of immunizations.

9. Documentation

All vaccinations will be documented in ASIMS Web. For new immunization providers use the following link for access: https://asims.afms.mil/webapp/newaccount.aspx.

a. Mass immunization and workplace vaccination campaign planning must consider this requirement for AD, Reserve Component, and DoD beneficiaries (e.g., automated methods on-site or manual lists at vaccination site compiled and used to update ASIMS Web). The Air Force Corporate Health Information Processing System (AFCHIPS) website provides base-level influenza vaccination completion data throughout influenza season and is available at https://imr.afms.mil/main/main.aspx.

b. Accurate documentation of Flu vaccines given during Flu vaccine programs continues to be a challenge. All influenza immunizations administered will be entered into ASIMS Web. MTFs are strongly encouraged to utilize ASIMS Web when giving immunizations outside the MTF. Paper "sign-in rosters" are highly discouraged. **If paper rosters must be utilized, data must be entered into** ASIMS Web **within 24 hours.**

c. Provide all data being requested in ASIMS (i.e., mfg, lot etc). **Code 088 should only be used when you have no written specification on a vaccine such as mfg, lot number.**

10. DoD Contracted Vaccines (See tables at Attachment 1)

11. Vaccine Information Statement (VIS) and Vaccine Adverse Event Reporting System (VAERS)

a. **VIS and Patient Information.** IAW U.S. Code 42, the VIS on influenza vaccine, published by the CDC, **shall be provided** to any individual receiving a vaccine or, in the case of children, to the child's legal representative (i.e., parents or guardians). **Additionally, reasonable effort to ensure the patient or legal representative understands the materials presented are expected.** The VIS for influenza is available at: http://www.cdc.gov/vaccines/pubs/vis/default.htm.

b. **VAERS Reporting.** All vaccine-related adverse events must be reported through the Vaccine Adverse Event Reporting System. Additionally, health-care professionals should promptly report all clinically significant adverse events after vaccination of children, even if the health-care professional is not certain the vaccine caused the event. The Institute of Medicine has specifically recommended reporting of potential neurological complications

(e.g., demyelinating disorders such as Guillain-Barré Syndrome), although no evidence exists of a causal relationship between influenza vaccine and neurological disorders in children. The VAERS form is available in ASIMS Web or at: https://vaers.hhs.gov/esub/index. The form must be submitted to the Food and Drug Administration (FDA); it may be transmitted electronically through the FDA website.

12. ANG and AFRES Activities

a. Air National Guard (ANG) Activities: For the 2012-2013 influenza season, ANG units should requisition influenza vaccine thru their Active Duty hosts. ANG Wing requirements are based on data in AFCITA. Each ANG Wing and its GSUs vaccine requisition will have a unique document number linked to the local ANG MDG FY DODAAC. Delivery will be made to the ANG MDG. Flu vaccine funds for FY12 have been distributed to the Wing FMs via checkbook. Proof of receipt should include: document number, stock number, and quantity, as well as a copy of any shipping paperwork or Bill of Lading. This is necessary for your host to close the requisition and complete EOY financial reconciliation. This is a mandatory part of the process. Direct questions to Ms. Melissa Pedigo, DSN 612-8556, melissa.pedigo.ctr@ang.af.mil.

b. Air Force Reserve Command (AFRC) Activities: AFRC activities should contact the host base Financial Management account for their requirements. Contact HQ AFRC/SGPH at DSN 497-2398 or commercial at 478-327-2398 if further instruction is necessary. Individual Mobilization Augmentees will be immunized by their supporting AD MTF and should be included in requirements for the MTF.

13. Contact information

a. Influenza vaccine supply, delivery, shortage and availability issues: Contact AFMOA/SGALC, Fort Detrick, MD 21702. DSN 343-4170 or (301) 619-4170, fax: DSN 343-2557 or (301) 619-2557, e-mail: afmoa.sgalc@detrick.af.mil.

b. Policy and prioritization: Contact AFMSA/SG3PM, 7700 Arlington Blvd, Falls Church, VA 22042, DSN 761-7102 or (703) 681-7102, e-mail: carol.fisher@pentagon.af.mil.

c. VAERS: Submit VAERS E-Report to the FDA/CDC through the FDA website at: https://vaers.hhs.gov/esub/index.

d. Influenza surveillance information: Contact USAFSAM Epidemiology Services at USAFSAM/PHR, Facility 20840, 2510 Fifth St, WPAFB, OH 45433-7913. Phone: DSN 798-3214 / 3207 or (937) 938-3214 / 3207. Email: usafsamphr.flu@wpafb.af.mil.

14. References

a. AFJI 48-110, Immunizations and Chemoprophylaxis, 29 Sep 2006

b. ASD (HA) Policy 08-005, Policy for Mandatory Seasonal Influenza Immunization for Civilian Health Care Personnel Who Provide Direct Patient Care in Department of Defense Military Treatment Facilities, 4 April 2008. Available at: http://www.vaccines.mil/documents/1169HCPFluIAPolicy_08_005.pdf

c. Prevention and Control of Influenza, Recommendations of the Advisory Committee on Immunization Practices (ACIP). Available at: http://www.cdc.gov/flu/professionals/acip/index.htm

d. Centers for Disease Control and Prevention (CDC) influenza home page contains provider's information, supply concerns and updates, public affairs and media materials, and patient education materials. Available at: http://www.cdc.gov/flu/professionals/
e. Recommended Immunization Schedules. Available at: http://www.cdc.gov/vaccines/schedules/index.html
f. DoDD 6205.02E, 19 Sep 2006. Policy and Program for Immunizations to Protect the Health of Service Members and Military Beneficiaries. Available at: http://www.vaccines.mil/documents/973Policy620502p.pdf
g. Omer SB, Goodman D, Steinhoff MC, Rochat R, Klugman KP, Stoll BJ, Ramakrishnan U, "Maternal influenza immunization and reduced likelihood of prematurity and small for gestational age births: a retrospective cohort study." 2011 May; 8(5): e1000441. Epub 2011 May 31. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3104979/?tool=pubmed

Attachment 1
Influenza Vaccine Reference Tables

Age Category	Name / Manufacturer	Formulation	NSN	Comments
6 months through 35 months	FluZone (Sanofi-Pasteur)	0.25ml pre-filled syringe	6505-01-604-6926	Thimerosal free
≥ 6 months	FluZone (Sanofi-Pasteur)	5.0 ml multi-dose vial 0.25 ml for 6 mos to 35 mos 0.5 ml for ≥ 36 mos	6505-01-603-5103	Contains Thimerosal alternate to above formulation
≥ 36 months	FluZone (Sanofi-Pasteur)	0.5ml pre-filled syringe	6505-01-604-7721	Contains Thimerosal
≥5 years	Afluria (Merck / CSL Labs)	0.5ml pre-filled syringe	6505-01-605-7630	Thimerosal free
≥5 years	Afluria (Merck / CSL Labs)	5.0 ml multi-dose vial 0.25 ml for 6 mos to 35 mos 0.5 ml for ≥ 36 mos	6505-01-604-6080	Contains Thimerosal alternate to above formulation
2 years through 49 years	FluMist (MedImmune)	Nasal spray, pre-filled sprayer	6505-01-603-9018	Available for military and healthy beneficiaries

FluMist®—live, attenuated influenza vaccine (LAIV): For Healthy children age 2 years and older without contraindications

Age Group	Dosage	Number of Doses
Children age 2 years through 8 years	0.2 ml	See Note
Children and adults age 9 through 49 years	0.2 ml	1 dose

FluZone® — inactivated influenza vaccine

Age Group	Dosage	Number of Doses
6 months to 35 months	0.25 ml	See Note
≥3 years	0.5 ml	See Note

For adults and older children, the recommended site of vaccination is the deltoid muscle. The preferred site for infants and young children is the anterolateral aspect of the thigh.

NOTE: For children aged 6 months through 8 years who received at least 2 or more total doses of seasonal influenza vaccine since July 2010, administer 1 dose for the 2012-13 season. For children in this age group who did not receive 2 or more total doses of seasonal influenza vaccine since July 2010, or for whom it is not certain whether they have received 2 doses since July 2010, administer 2 doses of the 2012-13 seasonal vaccine at least 4 weeks apart. Dosing guidelines for this age group may change in the upcoming 2012 ACIP influenza vaccination recommendations.

Although either FluZone® or FluMist® may be used for the purpose of initial year immunization; they are not interchangeable. The child should receive the same type of vaccine for each immunization.

Afluria®— inactivated influenza vaccine, 5.0 ml multidose vials (10 to 20 doses) (Contains thimerosal)[§]

Age Group	Dosage	Number of Doses
≥ 9 years	0.50 ml	1

[§] ACIP recommends Afluria® not be used in children younger than 9 years because of increased reports of febrile reactions.