Ontario Renal Network

Immunization Recommendations

Dear Dr. _____ , **Date:** _____
(physician name)

It is recommended that _____ _____
(patient name) (date of birth)

receive the following immunizations due to potential immunosuppressant therapy:

☐ **Pneumococcal conjugate 13 (Prevnar® 13)** 0.5 mL IM, followed by **pneumococcal polysaccharide 23 (Pneumovax® 23)** 0.5 mL IM administered at least 8 weeks later.
Patients who require immunosuppressant therapy qualify for Public Health supply of Pneumovax® 23. Patients age 50 or greater who require immunosuppressant therapy qualify for Public Health supply of Prevnar® 13.

☐ **Pneumococcal conjugate 13 (Prevnar® 13)** 0.5 mL IM x 1 dose.
Patients age 50 or greater who require immunosuppressant therapy qualify for Public Health supply of Prevnar®13.

☐ **Pneumococcal polysaccharide 23 (Pneumovax® 23)** 0.5 mL IM x 1 dose.
Patients who require immunosuppressant therapy qualify for Public Health supply of Pneumovax® 23.

☐ **Recombinant zoster vaccine (Shingrix®)*** 0.5 mL IM administered at month 0 and between 2-6 months after first injection.

☐ **Recombinant monovalent hepatitis B*:**
- **Engerix®-B** 40 mcg administered IM at months 0, 1, 2 and 6 **OR**
- **Recombivax-HB®** 40 mcg administered IM at months 0, 1 and 6.

For patients age 19 yrs or younger requiring Recombivax-HB®, the recommended dose is 10 mcg IM.

☐ **Human Papillomavirus 9-valent recombinant vaccine (GARDASIL®-9)*** 0.5 mL IM at month 0, 2 and 6

*Engerix® -B, Recombivax-HB®, Shingrix® and Gardasil®-9 are not covered by Public Health. The patient is aware that he/she will need to inquire about coverage through private insurance or pay out of pocket.

The patient has been asked to contact your office to arrange an appointment to receive these immunizations. As each vaccine is administered, please notify the GN Clinic

_____.
(clinic fax number)

Sincerely,

_____.
(signature)

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Ontario