# Hepatitis A and Hepatitis B as TWINRIX Vaccine Protocol

VACCINE PROTOCOL FOR persons age 18 and older

**Document reviewed and updated:** **June 6, 2023**

## Condition for protocol

To reduce incidence of morbidity and mortality of hepatitis A and hepatitis B disease.

## Policy of protocol

The nurse will implement this protocol for TWINRIX vaccination.

## Condition-specific criteria and prescribed actions

**Delete this entire paragraph before printing/signing protocol.**

[Instructions for persons adopting these protocols: The table below lists indication, contraindication, and precaution criteria and suggested prescribed actions that are necessary to implement the vaccine protocol. The prescribed actions include examples shown in brackets but may not suit your institution’s clinical situation and may not include all possible actions. A licensed prescriber must review the criteria and actions and determine the appropriate prescribing action.]

Indications

|  |  |
| --- | --- |
| Criteria | Prescribed action |
| Currently healthy person age 18 years or older. | Proceed to vaccinate if meets remaining criteria. |
| Person is younger than age 18 years. | Do not give TWINRIX. Follow protocols for monovalent hepatitis A and hepatitis B vaccines. |
| Person has previously received an incomplete series of either hepatitis A (only 1 dose) or hepatitis B (only 1 or 2 doses). | Proceed to give the full three-dose series of TWINRIX. |
| Person has previously completed either the hepatitis A vaccination series or the hepatitis B vaccination series. | Do not give TWINRIX; follow the appropriate protocols for the monovalent vaccine needed. |
| Person is more than 1 month behind routine schedule. | Follow minimal intervals for TWINRIX catch-up. |
| Person is traveling and will leave before completing the routine Twinrix schedule. | Follow the 4-dose accelerated schedule, remind patient to return for the final dose at 12 months. |

Contraindications

|  |  |
| --- | --- |
| Criteria | Prescribed action |
| Person had a severe allergic reaction (anaphylaxis) to a previous dose of TWINRIX vaccine. | Do not vaccinate; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Person has a severe allergy to a component of TWINRIX vaccine, including neomycin and yeast. | Do not vaccinate; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Precautions

|  |  |
| --- | --- |
| Criteria | Prescribed action |
| Person is currently on antibiotic therapy. | Proceed to vaccinate. |
| Person has a mild illness defined astemperature less than \_\_\_\_\_\_ °F/°C withsymptoms such as: \_\_\_\_\_ [to bedetermined by medical prescriber] | Proceed to vaccinate. |
| Person has a moderate to severe illnessdefined as temperature less than \_\_\_\_\_°F/°C with symptoms such as: \_\_\_\_ [to bedetermined by medical prescriber] | Defer vaccination and [to be determined by medical prescriber] |
| Person is pregnant. | [Defer vaccination until pregnancy is ended.] [If benefit of preventing hepatitis A disease outweighs theoretical risk of vaccination, proceed to vaccinate.] [Refer to primary care provider for determination of risk and benefit for hepatitis A vaccination.] |

## Prescription

Give TWINRIX (Havrix 720 ELISA units & Engerix-B 20 µg) 1.0 ml, IM, for either schedule:

### 3-dose series (routine and catch-up schedule)

* Follow a schedule of 0, 1, and 6 months.
* Follow these minimum intervals for TWINRIX vaccination if catch-up is necessary:
	+ Give second dose at least four weeks after dose one.
	+ Give third dose at least five months after second dose AND no sooner than 6 months after first dose.

### 4-dose series (accelerated schedule)\*:

* Follow a schedule of 0, 7, and 21-30 days, followed by a booster dose at 12 months after dose one.

\*The 4-day grace period does not apply to the first 3 doses of the accelerated schedule.

## Medical emergency or anaphylaxis

Follow pre-established agency protocol for anaphylaxis.

## Question or concerns

**Insert overseeing medical consultant’s information below and delete this sentence before printing/signing.**

In the event of questions or concerns call (insert name) at (insert phone number).

**This protocol shall remain in effect until rescinded.**

Name of prescriber (please print):

Prescriber signature:

Date: