

## COVID-19 Vaccines FAQs for Family Physicians

Updated April 29, 2021

Evidence is emerging and the environment is evolving around COVID-19 and the vaccines. To help inform the work of our members, the OCFP has compiled this list of frequently asked questions and answers about vaccines.

### Q. What do I need to know about the AstraZeneca vaccine now?

**UPDATED:** All COVID-19 vaccines approved in Canada, including AstraZeneca, are highly effective at preventing severe illness, hospitalization, and death from COVID-19. The benefit-risk analysis for the use of the AZ vaccine includes many factors, such as the prevalence of COVID-19 in the area and vaccine supply. Family doctors are encouraged to address patient questions. Here is the latest on the AZ vaccine:

- [Updated guidance from NACI](#) (April 23, 2021) notes that the AZ vaccine may be used in **people age 30 and older**. That recommendation updates earlier NACI guidance that limited the AZ vaccine to people 65 and older, which was itself a change to earlier guidance that set the eligibility at 55+.
- **Ontario** continues to offer the AZ vaccine to people 40 and older, citing vaccine supply challenges for not aligning with the NACI threshold of age 30.
- Changing guidance is related to emerging evidence, including the rare condition vaccine-induced immune thrombotic thrombocytopenia (VITT or VIPIT), which has been observed following AZ COVID-19 vaccination.
  - RESOURCES: [Thrombosis Canada](#) has information on the AZ vaccine, including identification and treatment of VITT, patient FAQs and more; Ontario's Science Advisory Table has [Interim Guidance of Healthcare Professionals in the Outpatient Setting](#); this [post on the topic from Unambiguous Science](#) is a digestible summary that may also be suitable to share with patients.

### Q. **NEW:** What is the treatment for VITT?

Vaccine-induced immune thrombotic thrombocytopenia (VITT or VIPIT) is an uncommon complication of the AstraZeneca vaccine that mimics severe heparin-induced thrombocytopenia (HIT) without exposure to heparin. From [CMAJ \(April 26, 2021\)](#): “Clinical features of VITT include thrombocytopenia and unusual thrombi, including cerebral venous sinus thrombosis and splanchnic vein thrombosis. A 4Ts score, substituting “vaccine” for “heparin,” can be used. **“Treatment for VITT is like the treatment for HIT but emphasizes high-dose intravenous immunoglobulin.”** See also the Ontario's Science Advisory Table's [Interim Guidance of Healthcare Professionals in the Outpatient Setting](#).

**Q. NEW: What's the latest on vaccines for pregnant women? | Is the AstraZeneca vaccine safe in pregnancy?**

The [Society of Obstetricians and Gynaecologists](#) (SOGC) cites data that approximately 1 in 10 pregnant individuals will require hospital admission, and 1 in 100 will require intensive care following infection with COVID-19. SOGC “**supports the use of all available COVID-19 vaccines** approved in Canada in any trimester of pregnancy and during breastfeeding”.

While there are risks of “rare adverse events”, i.e., VITT, following vaccination with viral vector vaccines, including AZ, such risk should be discussed in context of the disease. **Preventing COVID-19 disease among pregnant individuals must be considered a priority and vaccination is a central tool to protect individuals from severe COVID-19 infection.** This [decision-making tool](#) from the Provincial Council for Maternal and Child Health can help in patient conversations.

Given emerging evidence of higher risk of serious illness from COVID-19, pregnancy is now a “highest priority” health condition in the Ministry of Health’s [Phase 2 Guidance for Prioritization](#).

**Q. Why are family doctors not more involved in Ontario's vaccination efforts, including not being allocated vaccines to administer to our patients?**

**UPDATED:** The primary care vaccine pilots across six PHUs that rolled out in March/April met the Ministry of Health’s vaccination targets. On April 1, the Ministry announced [expansion of vaccination efforts to include primary care locations in all 34 Public Health Units](#). The OCFP continues to advocate strongly for widespread access to the vaccine for all interested family practices able to support the vaccination effort. We know our patients best and know how to reach those who are most vulnerable. With vaccine supply increasing, family doctors must play a central role and help ensure an efficient and equitable rollout. You can reach out to your local [Public Health Unit](#) for more information about current rollout plans and to signal your interest to participate.

**Q. Is the use of the COVaxON system mandatory?**

Yes, use of the COVaxON provincial system is mandatory for all vaccines administered. You must register through your Public Health Unit to access COVaxON and will receive access information in an email from the Salesforce platform. Training is available through [OntarioMD](#) – sign up for upcoming sessions, see recordings of past sessions and more.

**Q. What is the evidence to support extension of the interval between vaccine doses to 16 weeks?**

Given limited real-world data, in recommending the extended interval [NACI says it looked at evidence](#) from studies on efficacy and effectiveness of the vaccines in preventing outcomes such as infection, symptomatic disease, hospitalizations and death from COVID-19 and that “short-term sustained protection is consistent with immunological principles and vaccine science”. The objective in giving up a short-interval second dose is to allow additional people to be vaccinated and potentially save a life or avoid hospitalization.

The [Vaccine Clinical Advisory Group](#) (VCAG) has recommended two exceptions to the extended dose interval: transplant recipients (including solid organ transplants and hematopoietic stem cell transplants) and those with malignant hematologic disorders and non-hematologic malignant solid tumors receiving active treatment (chemotherapy, targeted therapies, immunotherapy).

Based on research around timing of immunization and immune response, these individuals are recommended to follow the dosing intervals in the product monographs. The VCAG has said it will continue to evaluate the recommended 16-week interval for the elderly and pregnant women.

**Q. Is the dosing interval for vaccination for family doctors and/or other healthcare workers the same as for the general public, ie, up to 16 weeks or four months?**

Yes, there is currently no difference in [immunization schedule](#) for healthcare workers and others – the second dose may be given **up to 16 weeks** after the first for two-dose mRNA vaccines.

**Q. Where can I find a comparison of the authorized vaccines for efficacy?**

See [this table](#) from the Centre for Effective Practice for a summary of vaccines efficacy and more.

**Q. How effective are the vaccines against the variants?**

**NEW:** Studies of the effectiveness of the current vaccines were done largely before variants emerged, so evidence is limited. For now, all three vaccines appear to provide at least some effectiveness against the B.117 variant (the most common of the variants) but less so against the other variants.

From this [JAMA article](#) on **Determining How Much Immunity is Enough**: “It appears that the vaccines elicit lower levels of neutralizing antibodies against the variants than against older, more common isolates. However, that might still be sufficient to protect against COVID-19 and at least severe COVID-19.”

Here is [factsheet](#) from Public Health Ontario comparing the variants of concern.

**Q. How long should a patient wait after and before another vaccine before getting the COVID-19 vaccine?**

A waiting period after or before getting another type of vaccine is recommended so that any side effects from one vaccine are not confused with side effects of another. The recommendation is to wait 14 days after receiving another vaccine, and 28 days before giving another vaccine.

**Q. What is the best timing for the COVID-19 vaccine around routine allergy shots or immunization of allergen immunotherapy?**

Allergy shots are not vaccines. There is no definitive guideline but most allergists advise to avoid the shots on the same day, and the [American Academy of Allergy, Asthma and Immunology](#) recommends a 48-hour interval between shots, so that immediate or delayed reactions to either injection can be monitored.



**Q. How long after having had COVID-19 can one get the vaccine?**

Patients who are acutely ill should not get the vaccine. The [current recommendation](#) is that “people with current infection should wait until they have recovered from the acute illness and are eligible to discontinue isolation.”

**Q. Should a patient who had COVID-19 previously still receive the full course of the two-dose vaccine (versus a single only)?**

For now, those who have previously had COVID should get a full course of the vaccine. It is still [uncertain how long antibodies last](#).

**Q. Is it okay to give Prolia closely before or following the vaccine?**

Patients on medications for osteoporosis can receive the COVID vaccine. Recent recommendations (March 26, 2021) from [Osteoporosis Canada](#): Since intravenous zoledronate (Aclasta) or injected denosumab (Prolia) or romosozumab (Evenity) medications may also result in a flu-like reaction or local injection site reaction, it is advisable that these medications not be administered at the same time as the COVID-19 vaccine although there is no safety risk if they are given at the same time. Osteoporosis Canada recommends an interval of one week between infusion of the intravenous bisphosphonate zoledronate (Aclasta) and 4 to 7 days between an injection of denosumab (Prolia) or romosozumab (Evenity) and the COVID-19 vaccination.

**Q. Does the vaccine stop transmission of the virus? | Can vaccinated people get together with others who are vaccinated?**

Although the vaccine will protect you, at this time it hasn't been proven that getting vaccinated will stop you from carrying the virus and possibly infecting others. In addition, [recent research](#) on one population – organ transplant recipients – shows significantly blunted immune response to the first dose of mRNA vaccine, so they may remain at higher early risk for COVID-19 despite being vaccinated. Given the current evidence, after vaccination one should continue to follow all public health measures, including physical distancing, wearing a mask and hand hygiene. Socializing with people in other households is still discouraged for now.

**Q. How long does the protection conferred by the vaccine(s) last?**

Because the vaccines are relatively new, we don't know for sure how long the vaccines are protective and whether/when a booster may be needed. Information is being collected now in real time and research is ongoing to determine how long immunogenicity lasts.

**Q. Can a patient who received the AstraZeneca vaccine now receive the Pfizer-BioNTech or Moderna as the second dose?**

The safety and efficacy of interchanging vaccines are not currently known. [NACI](#) recommends that “the vaccine series be completed with the same vaccine product.” If the previously received dose is not known or not available, a similar type of vaccine could complete the series. It is not recommended that vaccines of different types (e.g., mRNA vaccine and viral vector vaccine) be used in the same series.

**Q. What is the latest on vaccines for kids?**

Children under the age of 18 (Moderna and AstraZeneca) and under the age of 16 (Pfizer-BioNTech) were not part of the original clinical trials. The Pfizer-BioNTech vaccine may be offered to individuals 12 to 15 years of age who are at very high risk of severe outcomes of COVID-19 (e.g., due to a pre-existing medical condition known to be associated with increased risk of hospitalization or mortality) AND/OR are at increased risk of exposure (e.g., due to living in a congregate care facility). Currently, Moderna is conducting trials in children age six months to 11 years, and Pfizer in children 12 to 15 years old; Johnson & Johnson has said it also plans to test in children.

**Q. How do I handle patient requests for letters proving high-risk conditions that are listed for priority vaccination?**

Currently, [proof of pre-existing illness is NOT required](#) at time of vaccination. There is no need for a ‘doctor’s note’ to confirm a condition.

**Q. Our practice is receiving calls asking for clearance of vaccine for patients who are receiving or booked for vaccine at pharmacies. Who is responsible for clearance?**

Consent or written documentation from a doctor or health care provider is not required in the great majority of cases. Some patients must verbally attest that they have talked with a provider (such as when receiving CAR T-cell therapy), and those with severe allergy to a previous dose or component of the vaccine must have [documentation of counselling](#) from an allergist and a vaccination plan. See the OCFP’s information on [Vaccination for Special Populations](#).

**Q. Does an individual require a valid health card to receive the vaccine?**

Not having OHIP coverage or a health card should not be a barrier to receiving the vaccine. See this [INFOBulletin](#), which includes temporary billing codes, issued early in the pandemic and states: “... if an individual does not have a valid health card **please do not turn them away.**” Online booking systems may ask for a health card number, but an appointment may be booked by phone without one.