Australian Government

COVID-19 VACCINATION

Immunocompromised FACT SHEET

Version 2 – October 2023

This Factsheet provides advice on eligibility requirements for an additional COVID-19 Booster dose for people with immunocompromising conditions and therapies.

	Additional 2023 COVID-19 booster dose (September 2023 guidance)
Age	**At risk#**
<5 years	Not recommended
5-17 years	Not recommended
18-64 years	Consider **if severe immunocompromise^**
65-74 years	Consider
≥ 75 years	**Recommended**

N.B. The following list is not exhaustive. Clinicians may use their judgement for conditions or medications that are not listed, and which are associated with severe immunocompromise.

- Active haematological malignancy.
- Non-haematological malignancy with current active treatment (e.g. chemotherapy, whole body irradiation).
- Solid organ transplant with immunosuppressive therapy.
- Haematopoietic stem cell transplant (HSCT) recipients or chimeric antigen receptor T-cell (CAR-T) therapy within 2 years of transplantation.
  - These patients require revaccination with 3 additional doses of COVID-19 vaccine, irrespective of doses given prior to transplantation, commencing generally ≥3-6 months after their transplant after discussion with their treating specialist.
  - Those beyond 2 years from transplant should discuss with their treating specialist about the need for a 3rd dose.
- Immunosuppressive therapies including:
  - High dose corticosteroid treatment equivalent to:

    - For people 16 and older, >20mg/day of prednisone for ≥14 days in a month, or pulse corticosteroid therapy.
    - For people under 16 years of age, >1mg/kg of prednisone (or >20mg/day) for > 30 days.
  - Multiple immunosuppressants where the cumulative effect is considered to be severely immunosuppressive.
  - Selected conventional synthetic disease-modifying anti-rheumatic drugs (csDMARDS):
    - including mycophenolate, methotrexate (≥10 mg/week), leflunomide, azathioprine (≥ 1mg/kg day), 6-mercaptopurine (≥ 0.5mg/kg/day), alkylating agents (e.g. cyclophosphamide, chlorambucil), and systemic calcineurin inhibitors (e.g. cyclosporin, tacrolimus).
    - excluding hydroxychloroquine or sulfasalazine when used as monotherapy.
  - Biologic and targeted therapies anticipated to reduce the immune response to COVID-19 vaccine. **Refer to the table below** for examples. However, clinicians may use their judgement for medications which are not listed.
- Primary immunodeficiency including combined immunodeficiency and syndromes, major antibody deficiency (e.g. common variable immune deficiency (CVID) or agammaglobulinemia), defects of innate immunity (including phagocytic cells), defects of immune regulation, complement deficiencies and phenocopies of primary immunodeficiencies.
- Advanced or untreated HIV with CD4 counts <250/μL or those with a higher CD4 count unable to be established on effective anti-retroviral therapy.
  - a 3rd primary dose is not required for people living with HIV, receiving ART with CD4 counts ≥250/μL.
- Long term haemodialysis or peritoneal dialysis.

An additional COVID-19 dose should be considered for people taking the following biologics:

Class	Examples
Anti-CD20 antibodies	rituximab, obinutuzumab, ocrelizumab, ofatumumab
BTK inhibitors	ibrutinib, acalabrutinib, zanubrutinib
JAK inhibitors	tofacitinib, baricitinib, ruxolitinib, upadacitinib
Sphingosine 1-phosphate receptor modulators	fingolimod, siponimod
Anti-CD52 antibodies	alemtuzumab
Anti-complement antibodies	eculizumab
Anti-thymocyte globulin	anti-thymocyte globulin

ATAGI will continue to monitor the evidence around duration of protection in immunocompromised populations to address waning of protection or risk from variants.

For more information on booster doses refer to **ATAGI Update on the COVID-19 Vaccination Program**