AiTC | ADULT IMMUNIZATION & TRAVEL CLINIC

Shingles Vaccine Eligibility Form

12/5/07

ZOSTAVAX is Merck's live virus vaccine indicated for prevention of herpes zoster (shingles) in older adults. It contains the Oka/Merck strain of live, attenuated varicella-zoster virus (VZV) – the same live, attenuated virus strain found in Merck's VARIVAX varicella vaccine – but at 14 times greater dose.

The risk of developing shingles appears to be related to a decline in VZV-specific immunity. ZOSTAVAX has been shown to boost VZV-specific immunity, which is thought to be the mechanism by which it protects against zoster and its complications.

In the Shingles Prevention Study, ZOSTAVAX prevented about half (51%) of the cases of shingles that would have otherwise occurred. It worked better in those age 60-69 (64% effective) compared with those age 70-79 (41% effective) and age 80+ (18% effective).

ZOSTAVAX is contraindicated in immunosuppressed individuals. From the package insert:

> **Do not administer ZOSTAVAX to individuals with a history of primary or acquired immunodeficiency states including leukemia; lymphomas of any type, or other malignant neoplasms affecting the bone marrow or lymphatic system; or AIDS or other clinical manifestations of infection with human immunodeficiency viruses. ZOSTAVAX is a live attenuated varicella-zoster vaccine and administration may result in disseminated disease in individuals who are immunosuppressed. Do not administer ZOSTAVAX to individuals on immunosuppressive therapy.***
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> * Merck & Co., Inc. July 2007

Patient's Name: _____ Date of Birth: ____/____/____ M / F

This patient is interested in receiving ZOSTAVAX. Please help us determine whether this patient is eligible for ZOSTAVAX by indicating whether this patient has any primary or acquired immunodeficiency.

- ☐ Yes, this patient has a primary or acquired immunodeficiency (please describe below)
- ☐ No, this patient does not have a primary or acquired immunodeficiency.
- ☐ Unknown or unsure (please explain below)

Description / Explanation:

Provider Signature: _____

Provider Name: _____ Provider Phone: _____

Please have the patient bring this form to AITC, or you may return this form directly to us:

(Fax) 415.554.2619
(Mail) 101 Grove Street, Room 102, San Francisco, CA 94102

Questions? Please call the AITC Nurse Manager, Pam Axelson NP, at 415.554.2860