COVID-19 Vaccine, mRNA (Pfizer-BioNTech) (Systemic)

Nucleoside-modified mRNA (modRNA) vaccine used to stimulate active immunity to severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

Class: 80:12 • Vaccines (AHFS primary)

Brands:

*also available generically

Special Alerts:

On August 23, 2021, COVID-19 Vaccine (Pfizer-BioNTech) received full FDA approval for active immunization to prevent coronavirus disease 2019 (COVID-19) caused by SARS-CoV-2 in individuals 16 years of age or older. FDA approved the biologics license application (BLA) for use of the Pfizer-BioNTech COVID-19 vaccine in this age group after reviewing efficacy and safety data accrued through March 13, 2021, for approximately 44,000 individuals 16 years of age or older enrolled in the ongoing randomized, placebo-controlled clinical trial of the vaccine. At the time of the efficacy analysis for the BLA, 25,245 trial participants 16 years of age or older (12,796 received the Pfizer-BioNTech COVID-19 vaccine and 12,449 received placebo) had been followed for at least 4 months after the second dose. Vaccine efficacy in participants with or without evidence of prior SARS-CoV-2 infection was 90.3% (SARS-CoV-2 infection occurring at least 7 days after the second dose was confirmed in 81 individuals in the vaccine group and 854 individuals in the placebo group). Vaccine efficacy against severe COVID-19 (as defined in the study protocol) in those with or without evidence of prior SARS-CoV-2 infection was 95.3% (severe SARS-CoV-2 infection occurring at least 7 days after the second dose was confirmed in 1 individual in the vaccine group and 21 individuals in the placebo group). An emergency use authorization (EUA) for the Pfizer-BioNTech COVID-19 vaccine is still in effect and authorizes use of the vaccine in adolescents 12 through 15 years of age and administration of a third dose of the vaccine in certain immunocompromised individuals 12 years of age or older.

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Uses

Prevention of Coronavirus Disease 2019 (COVID-19)

- Being investigated and used for prevention of COVID-19 caused by SARS-CoV-2.
- Used for active immunization to prevent COVID-19 in individuals ≥16 years of age. Although efficacy and safety not definitively established in adolescents 12 through 15 years of age, COVID-19 vaccine (Pfizer-BioNTech) is available under an FDA emergency use authorization (EUA) for active immunization to prevent COVID-19 in this age group.
- On December 11, 2020, FDA issued an EUA that permitted use of the Pfizer-BioNTech COVID-19 vaccine in individuals ≥16 years of age. FDA reissued the EUA for the Pfizer-BioNTech COVID-19 vaccine on May 10, 2021 to permit use of the vaccine in individuals ≥12 years of age. On August 12, 2021, FDA reissued the EUA to authorize administration of a third dose of the vaccine in individuals ≥12 years of age who are solid organ transplant recipients or diagnosed with conditions considered to have an equivalent level of immunocompromise.
- The EUA requires that the vaccine be administered by vaccination providers as described in the EUA (see Dosage under Dosage and Administration) and that vaccination providers participate and comply with terms and training required by CDC’s COVID-19 vaccination program, including monitoring and complying with CDC and/or emergency response stakeholder vaccine management requirements concerning obtaining, tracking, and handling the vaccine and reporting vaccine administration data to CDC and state/local jurisdiction’s Immunization Information System (IIS) or other designated systems.
- FDA issued the EUA for the Pfizer-BioNTech COVID-19 vaccine after concluding that emergency use of the vaccine for prevention of COVID-19 met the criteria for issuance of an EUA for the following reasons: SARS-CoV-2 can cause a serious or life-threatening disease or condition, including severe respiratory illness; based on the totality of scientific evidence available to FDA, it is reasonable to believe that the vaccine may be effective in preventing COVID-19 and, when used under the conditions described in the authorization, known and potential benefits outweigh known and potential risks; and there are no adequate, approved, and available alternatives to emergency use of the vaccine to prevent COVID-19.
- The EUA for the Pfizer-BioNTech COVID-19 vaccine authorizes that distribution of the vaccine will be controlled by the US government for use consistent with the terms and conditions of the EUA. (See Restricted Distribution under Preparations.)
- To mitigate risks of this unapproved vaccine, the EUA includes certain mandatory requirements (e.g., providing the recipient or caregiver with information consistent with the EUA fact sheet for recipients and caregivers, ensuring that all vaccination administration errors and all serious adverse events potentially attributable to the vaccine are reported as specified in the EUA fact sheet for healthcare providers). (See EUA Requirements for Postvaccination Monitoring and Mandatory Vaccine Adverse Event Reporting under Cautions.)
- CDC’s Advisory Committee on Immunization Practices (ACIP) issued interim recommendations for use of the Pfizer-BioNTech COVID-19 vaccine for prevention of COVID-19 in individuals ≥16 years of age and adolescents 12 through 15 years of age. ACIP also issued interim recommendations for use of mRNA COVID-19 vaccines, including the Pfizer-BioNTech COVID-19 vaccine, in individuals who have moderate or severe immunocompromise.
- There currently are 3 different COVID-19 vaccines available for use in the US, including 2 mRNA vaccines (Pfizer-BioNTech COVID-19 vaccine and Moderna COVID-19 vaccine) and a viral-vector vaccine (Janssen COVID-19 vaccine). ACIP does not state a preference for any specific COVID-19 vaccine when the vaccines are used within the scope of their respective BLA or EUA and states that individuals should be encouraged to receive the earliest vaccine available to them. However, currently available COVID-19 vaccines are not interchangeable with each other. (See Dosage under Dosage and Administration.)

Dosage and Administration

General

- Must have appropriate medications and supplies immediately available to manage immediate allergic reactions in the event that an acute anaphylactic reaction occurs following administration of a COVID-19 vaccine, including COVID-19 vaccine (Pfizer-BioNTech). Healthcare personnel trained and qualified to recognize signs and symptoms of anaphylaxis and administer IM epinephrine should be available at vaccination locations at all times. Vaccination locations that anticipate vaccinating large numbers of people (e.g., mass vaccination clinics) should plan adequate staffing and supplies (including epinephrine) for assessment and management of anaphylaxis. (See Hypersensitivity Reactions under Cautions.)
- Prior to administration of each dose of the Pfizer-BioNTech COVID-19 vaccine, screen all individuals for contraindications and precautions to vaccination. Do not give the vaccine to those with a contraindication. (See Contraindications and see Warnings/Precautions under Cautions.)
- Monitor all vaccine recipients for immediate adverse reactions according to CDC (ACIP) guidelines. When administered to individuals with no contraindications to vaccination with an mRNA COVID-19 vaccine, ACIP states observe those who have a history of an immediate allergic reaction of any severity to any other vaccine or injectable therapy and those who have a history of anaphylaxis due to any cause not considered a contraindication for 30 minutes, and observe all other individuals for 15 minutes. A longer period of observation may be indicated in some individuals based on clinical concern (e.g., pruritus and swelling confined to the injection site develops during observation period). Instruct vaccine recipients to seek immediate medical care if they develop signs or symptoms of an allergic reaction after their observation period ends and they have left the vaccination site. (See Hypersensitivity Reactions under Cautions.)
- Syncope (vasovagal or vasodepressor reaction; fainting) may occur following administration of parenteral vaccines; such reactions usually occur within 15 minutes following vaccine
Thawed Pfizer-BioNTech COVID-19 suspension concentrate should appear as a white to off-white suspension and may contain white to off-white amorphous particles; do not use if it is discolored or contains other particles.

Thawed vaccine must not be refrozen.

**Dilution**

Thawed Pfizer-BioNTech COVID-19 vaccine suspension concentrate must equilibrate to room temperature prior to dilution and must be diluted within 2 hours after reaching room temperature.

Prior to dilution, invert vial(s) containing thawed vaccine suspension concentrate 10 times; do not shake.

Using aseptic technique, withdraw 1.8 mL of 0.9% sodium chloride injection into a 3- or 5-mL transfer syringe (21-gauge needle or narrower) and inject into vial of thawed vaccine suspension concentrate; do not add more than 1.8 mL of diluent to the vial. To equalize vial pressure, withdraw 1.8 mL of air into empty diluent syringe before removing the needle from the vial. Do not use any other diluents (e.g., bacteriostatic 0.9% sodium chloride injection).

After adding 0.9% sodium chloride diluent, gently invert vial 10 times to mix; do not shake.

Following dilution, the Pfizer-BioNTech COVID-19 vaccine should appear as an off-white suspension; do not use if it is discolored or contains particulates.

Must record date and time of dilution on the vaccine vial.

May store vials containing diluted Pfizer-BioNTech COVID-19 vaccine between 2–25°C, but must use diluted vaccine within 6 hours after dilution (regardless of storage temperature). Discard any unused diluted vaccine remaining in vials if not used within 6 hours after dilution.

**Dosage**

Administer the Pfizer-BioNTech COVID-19 vaccine in a series of two 0.3-mL doses given 3 weeks (21 days) apart in adults and adolescents ≥12 years of age. Immunocompromised individuals (i.e., solid organ transplant recipients or those diagnosed with conditions considered to have an equivalent level of immunocompromise) may receive a third 0.3-mL dose of the Pfizer-BioNTech COVID-19 vaccine administered at least 28 days after the second dose. Each 0.3-mL dose contains 30 mcg of mRNA.

The 2-dose regimen of the Pfizer-BioNTech COVID-19 vaccine is considered a complete, valid vaccination series. Individuals should not receive more than one complete vaccination series for active immunization against COVID-19 (i.e., 2-dose regimen of an mRNA vaccine [Pfizer-BioNTech COVID-19 vaccine or Moderna COVID-19 vaccine] or single dose of Janssen COVID-19 vaccine).

Individuals are considered fully vaccinated against COVID-19 if ≥2 weeks have elapsed since they completed a 2-dose vaccination series of an mRNA vaccine (Pfizer-BioNTech COVID-19 vaccine or Moderna COVID-19 vaccine) or received a single dose of the Janssen COVID-19 vaccine. Those who have a contraindication to vaccination or who otherwise cannot complete a vaccination series are not considered fully vaccinated.

Ensure that individuals who receive the first dose of the Pfizer-BioNTech COVID-19 vaccine receive a second dose of the same vaccine at the recommended interval to complete the vaccination series.

FDA EUA that permits use of the Pfizer-BioNTech COVID-19 vaccine specifies an interval of 3 weeks (21 days) between the first and second vaccine doses. ACIP states schedule individuals to receive the second vaccine dose as close to the recommended day as possible, but not earlier than 3 weeks after the first dose; however, a second dose of the vaccine administered up to 4 days before or at any time after the recommended interval is still considered valid.

The Pfizer-BioNTech COVID-19 vaccine is not interchangeable with the Moderna COVID-19 vaccine or any other COVID-19 vaccine.

Safety and efficacy of a mixed vaccination series of mRNA COVID-19 vaccines not evaluated; individuals who receive a dose of the Pfizer-BioNTech COVID-19 vaccine should complete the series using the same vaccine. Make every effort to determine which mRNA COVID-19 vaccine was used for first dose to ensure completion of the vaccination series using the same vaccine. ACIP states that in exceptional situations when the mRNA COVID-19 vaccine used for first dose cannot be determined or is no longer available, may administer any available FDA-authorized mRNA COVID-19 vaccine using a minimum interval of 28 days between doses to complete the mRNA COVID-19 vaccination series. In situations where the same mRNA vaccine is temporarily unavailable, ACIP states it is preferable to delay the second dose (up to 6 weeks) to allow completion of the vaccination series using the same mRNA COVID-19 vaccine rather than administering a mixed vaccination series composed of 2 different mRNA COVID-19 vaccines. If 2 doses of different mRNA COVID-19 vaccines are administered in such situations (or inadvertently), ACIP states that no additional doses of either vaccine are recommended at this time.

Safety and efficacy regarding use of the viral vectored vaccine (Janssen COVID-19 vaccine) after a dose of an mRNA COVID-19 vaccine not established. However, ACIP states that, in limited, exceptional situations when an individual received the first dose of an mRNA COVID-19 vaccine but is unable to complete the vaccination series with either the same or different mRNA COVID-19 vaccine (e.g., due to a contraindication), may consider giving a single dose of the
Janssen COVID-19 vaccine at least 28 days after the dose of mRNA COVID-19 vaccine. (See Hypersensitivity Reactions under Cautions.) In such exceptional circumstances, consider the individual to have received valid, single-dose vaccination with Janssen COVID-19 vaccine, not a mixed vaccination series.

Report all vaccine administration errors and deviations from currently recommended dosage and vaccination schedule to the vaccinee and the Vaccine Adverse Event Reporting System (VAERS). (See EUA Requirements for Postvaccination Monitoring and Mandatory Vaccine Adverse Event Reporting under Cautions.) Information on preventing and reporting COVID-19 vaccine administration errors and recommendations for specific actions to take if an administration error or deviation from recommended vaccination schedule occurs are available at CDC website at https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html.

**Pediatric Patients**

**Prevention of COVID-19**

> Adolescents 12 through 15 Years of Age

**IM:** FDA EAU that permits use for prevention of COVID-19[†‡] (see Prevention of Coronavirus Disease 2019 [COVID-19] under Uses) states that adolescents 12 through 15 years of age should receive two 0.3-mL doses of the vaccine administered 3 weeks (21 days) apart.

> Immunocompromised Adolescents ≥12 Years of Age

**IM:** FDA EAU permits administration of a third 0.3-mL dose at least 28 days after the second dose in solid organ transplant recipients or those diagnosed with conditions considered to have an equivalent level of immunocompromise. (See Individuals with Alterned Immunocompetence under Cautions.)

**Adults**

**Prevention of COVID-19**

**IM:** Individuals ≥16 years of age should receive two 0.3-mL doses of the vaccine administered 3 weeks (21 days) apart.

> Immunocompromised Adults

**IM:** FDA EAU permits administration of a third 0.3-mL dose at least 28 days after the second dose in solid organ transplant recipients or those diagnosed with conditions considered to have an equivalent level of immunocompromise. (See Individuals with Alterned Immunocompetence under Cautions.)

### Cautions

#### Contraindications

- Known history of severe allergic reaction (e.g., anaphylaxis) to any component of the vaccine. (See Actions.)
- ACIP considers the following to be contraindications to vaccination with both mRNA COVID-19 vaccines (Pfizer BioNTech COVID-19 vaccine and Moderna COVID-19 vaccine):
  - Severe allergic reaction (e.g., anaphylaxis) after a previous dose of an mRNA COVID-19 vaccine or severe allergic reaction to a component of the vaccine (e.g., polyethylene glycol [PEG]).
  - Immediate allergic reaction of any severity after a previous dose of an mRNA COVID-19 vaccine or known (diagnosed) allergy to a component of the vaccine (e.g., PEG).

#### Warnings/Precautions

**Sensitivity Reactions**

**Hypersensitivity Reactions**

Although immediate allergic reactions not reported to date in clinical trials evaluating the Pfizer-BioNTech COVID-19 vaccine, severe allergic reactions, including anaphylaxis, reported rarely following administration of mRNA COVID-19 vaccines outside of clinical trials.

Following issuance of the FDA EAU for the Pfizer-BioNTech COVID-19 vaccine, safety monitoring data identified 21 cases of anaphylaxis occurring between December 14–23, 2020 among 1,893,360 individuals in the US who received the first dose of the vaccine (11.1 cases per million vaccine doses administered); this included 17 cases in individuals with documented history of allergies or allergic reactions to drugs or medical products, foods, or insect stings (7 of these had a history of anaphylaxis, including one after receipt of a dose of rabies vaccine and another after receipt of influenza vaccine). Median interval from receipt of vaccine to onset of anaphylaxis symptoms was 13 minutes (range: 2–150 minutes); 71% had onset of symptoms within 15 minutes after the dose and 95% were treated with epinephrine. No fatalities from anaphylaxis were reported; 17 individuals were treated in an emergency department and the other 4 were hospitalized (including 3 in an intensive care unit).

Following issuance of the FDA EAU for the Moderna COVID-19 vaccine, safety monitoring data identified 10 cases of anaphylaxis among 4,041,396 individuals in the US who received the first dose of the vaccine (2.5 cases per million vaccine doses administered); this included 9 cases in individuals with documented history of allergies or allergic reactions to drugs, contrast media, or food (5 of these had a history of anaphylaxis). Median interval from receipt of vaccine to onset of anaphylaxis symptoms was 7.5 minutes (range: 1–45 minutes); 9 of the 10 individuals had onset within 15 minutes and one had onset after 30 minutes; all 10 were treated with epinephrine. No fatalities from anaphylaxis were reported; 4 individuals were treated in an emergency department and the other 6 were hospitalized (including 5 in an intensive care unit).

Between December 14–23, 2020, VAERs identified 83 cases of nonanaphylactic allergic reactions after administration of the first dose of the Pfizer-BioNTech COVID-19 vaccine; 87% of these cases were classified as nonserious and 67% had a documented history of allergies or allergic reactions. Median interval from receipt of the vaccine dose to onset of such symptoms was 12 minutes (range: less than 1 minute to 20 hours); 85% had onset of symptoms within 30 minutes. Hypersensitivity reactions reported with the vaccine have included rash, pruritus, urticaria, itch/scratchy sensations in the throat, angioedema, and mild respiratory symptoms.

Delayed-onset local reactions (e.g., erythema, induration, pruritus, tenderness) around the injection site area reported in some vaccine recipients, including some clinical trial participants, after first dose of an mRNA COVID-19 vaccine. These local reactions may begin a few days through the second week after the first dose and may be quite large. In some reported cases, such delayed-onset local reactions after first vaccine dose resolved in a median of 6 days (range: 2–11 days), and some individuals had similar (but less severe) local reactions after the second vaccine dose. ACIP states that delayed-onset local reaction after the first dose of an mRNA COVID-19 vaccine is not a contraindication or precaution to administration of the second vaccine dose. Therefore, individuals with such injection site reactions after the first dose of an mRNA COVID-19 vaccine should receive the second dose of the same vaccine at the recommended interval, preferably in the opposite arm.

If a hypersensitivity reaction, including anaphylaxis, occurs following COVID-19 vaccination, report the case to VAERS. (See EUA Requirements for Postvaccination Monitoring and Mandatory Vaccine Adverse Event Reporting under Cautions.)

Because anaphylactic reactions reported rarely following administration of COVID-19 vaccines, ACIP issued interim guidance with contraindications and precautions for use of COVID-19 vaccines pending further investigation. For purposes of this interim guidance, ACIP states that an immediate allergic reaction to a vaccine or medication is defined as any hypersensitivity-related signs or symptoms such as urticaria, angioedema, respiratory distress (e.g., wheezing, stridor), or anaphylaxis occurring within 4 hours following administration. If reactions occur following vaccination with an mRNA COVID-19 vaccine, the vaccinator should attempt to determine whether the reactions are consistent with immediate allergic reactions that would contraindicate additional doses of mRNA COVID-19 vaccines or are reactions commonly observed following vaccination (e.g., vasovagal reactions, postvaccination adverse effects) not considered contraindications to the second dose of the 2-dose vaccination series.

History of severe allergic reaction (e.g., anaphylaxis) after a previous dose of an mRNA COVID-19 vaccine or any of its components (e.g., PEG): ACIP considers this a contraindication to vaccination with both the Pfizer-BioNTech and the Moderna COVID-19 vaccines. ACIP states may consider using an alternative COVID-19 vaccine (Janssen COVID-19 vaccine) in such individuals. However, because of potential cross-reactive hypersensitivity between ingredients in mRNA COVID-19 vaccines and the Janssen COVID-19 vaccine (including PEG and polysorbate 80, respectively), consider consultation with an allergist-immunologist to help determine if the individual can safely receive the Janssen COVID-19 vaccine. US healthcare providers and health departments can also request a clinical consultation from the Clinical Immunization Safety Assessment COVIDVax project (https://www.cdc.gov/vaccinesafety/ensuring-safety/monitoring/cisa/index.html) when making such decisions. Although safety and efficacy of administering the Janssen COVID-19 vaccine after an mRNA COVID-19 vaccine not established, ACIP states that, in those exceptional situations when an individual received the first dose of an mRNA COVID-19 vaccine but is unable to complete the series with either the same or different mRNA COVID-19 vaccine (e.g., due to a contraindication), may consider giving a single dose of the Janssen COVID-19 vaccine at a minimum interval of 28 days after the mRNA COVID-19 vaccine dose. (See Dosage under Dosage and Administration.)

History of immediate allergic reaction of any severity to a previous dose of an mRNA COVID-19 vaccine or known (diagnosed) allergy to a component of the vaccine (e.g., PEG): ACIP considers this a contraindication to vaccination with both the Pfizer-BioNTech and the Moderna COVID-19 vaccines. ACIP states may consider using an alternative COVID-19 vaccine (Janssen COVID-19 vaccine) in such individuals. However, because of potential cross-reactive hypersensitivity between ingredients in mRNA COVID-19 vaccines and the Janssen COVID-19 vaccine (including PEG and polysorbate 80, respectively), consider consultation with an allergist-immunologist to help determine if the individual can safely receive the Janssen COVID-19 vaccine. US healthcare providers and health departments can also request a clinical consultation from the Clinical Immunization Safety Assessment COVIDVax project (https://www.cdc.gov/vaccinesafety/ensuring-safety/monitoring/cisa/index.html) when making such decisions. Although safety and efficacy of administering the Janssen COVID-19 vaccine after an mRNA COVID-19 vaccine not established, ACIP states that, in those exceptional situations when an individual received the first dose of an mRNA COVID-19 vaccine but is unable to complete the series with either the same or different mRNA COVID-19 vaccine (e.g., due to a contraindication), may consider giving a single dose of the Janssen COVID-19 vaccine at a minimum interval of 28 days after the mRNA COVID-19 vaccine dose. (See Dosage under Dosage and Administration.)

History of polysorbate allergy: ACIP considers this a precaution to vaccination with both the Pfizer-BioNTech COVID-19 vaccine and the Moderna COVID-19 vaccine. ACIP states polysorbate allergy is a contraindication to vaccination with the Janssen COVID-19 vaccine; may consider using an mRNA COVID-19 vaccine (Pfizer-BioNTech COVID-19 vaccine or Moderna COVID-19 vaccine) in such individuals.
Modern COVID-19 vaccine) in such individuals. However, polyosorbates are structurally related to PEG and there is potential for cross-reactive hypersensitivity. Consider consultation with an allergist-immunologist to help determine if the individual with polyosorbate allergy can safely receive an mRNA COVID-19 vaccine. US healthcare providers and health departments can also request a clinical consultation from the Clinical Immunization Safety Assessment COVIDVax project (https://www.cdc.gov/vaccinesafety/ensuring-safety/monitoring/cis/ index.html) when making such decisions. If a decision is made to administer an mRNA COVID-19 vaccine to an individual with a contraindication to the Janssen COVID-19 vaccine (e.g., polyosorbate allergy), administer the vaccine only in an appropriate setting under supervision of a healthcare provider experienced in management of severe allergic reactions.

History of any immediate allergic reaction to any other vaccine or injectable therapy (i.e., IM, IV, or sub-Q vaccines or therapies): ACIP considers this a precaution, but not a contraindication, to COVID-19 vaccination. ACIP states that history of allergic reaction to sub-Q immunotherapy for allergies (i.e., allergy shots) is not a contraindication or precaution to COVID-19 vaccination.

History of immediate allergic reaction to a vaccine or injectable therapy that contains multiple components (one or more of which is a component of a COVID-19 vaccine), but it is not known which component elicited the reaction: ACIP considers this a precaution, but not a contraindication, to the COVID-19 vaccine.

History of allergic reactions (including severe allergic reactions) not related to COVID-19 vaccines, other vaccines, or injectable therapies: ACIP states that food, pet, insect, venom, or environmental allergies and allergic reactions to oral medications (including the oral equivalents of injectable medications) are not a contraindication or precaution to COVID-19 vaccination. Late allergy is not a contraindication or precaution since vial stoppers of COVID-19 vaccines are not made with natural rubber latex. Allergies to eggs or gelatin are not a contraindication or precaution since COVID-19 vaccines do not contain eggs or gelatin. In addition, a family history of allergies is not a contraindication or precaution to COVID-19 vaccination.

History of delayed-onset local reactions (e.g., erythema, induration, pruritus) around the injection site area after first dose of an mRNA COVID-19 vaccine: ACIP states that these local reactions are not a contraindication or precaution for administration of second dose of mRNA COVID-19 vaccine. Such individuals should receive second dose using the same mRNA COVID-19 vaccine used for first dose at the recommended interval, preferably in the opposite arm.

If a precaution for COVID-19 vaccination is identified, ACIP recommends performing a risk assessment to help decide whether the individual should be vaccinated. The risk assessment should consider risk of exposure to SARS-CoV-2 (e.g., because of residence in a congregate setting such as a long-term care facility, occupation), risk of severe disease or death due to COVID-19 (e.g., because of age or underlying medical conditions), unknown risk of anaphylaxis (including fatal anaphylaxis) following COVID-19 vaccination in individuals with a history of immediate allergic reactions to other vaccines or injectable therapies, and ability to be vaccinated in a setting where appropriate medical care is immediately available to treat anaphylaxis if it occurs.

When a COVID-19 vaccine, including the Pfizer-BioNTech COVID-19 vaccine, is administered to individuals without a contraindication to such vaccines, ACIP states observe those with a history of an immediate allergic reaction of any severity to any other vaccine or injectable therapy and those with a history of anaphylaxis due to any cause not considered a contraindication for 30 minutes after the vaccine dose and observe all other individuals for 15 minutes. Instruct vaccine recipients to seek immediate medical care if they develop signs or symptoms of an allergic reaction after their observation period ends and they have left the vaccination site.

Appropriate medications and supplies to assess and manage immediate allergic reactions (e.g., sufficient quantities of epinephrine in prefilled syringes or autoinjectors) must be immediately available in the event that an acute anaphylactic reaction occurs following administration of a COVID-19 vaccine. Early recognition of clinical signs and symptoms of anaphylaxis is important since such reactions require immediate treatment. Immediately treat individuals with suspected anaphylaxis with IM epinephrine.

ACIP interim guidance regarding early recognition of clinical signs and symptoms of anaphylaxis and guidance regarding preparation for and management of anaphylaxis at COVID-19 vaccination sites, including recommendations for medications and supplies to have immediately available and specific recommendations regarding therapeutic management of anaphylaxis, are available at the CDC website at https://www.cdc.gov/vaccines/covid-19/clinical-considerations/managing-anaphylaxis.html and https://www.cdc.gov/vaccines/covid-19/infoby-product/clinical-considerations.html.

When confronted with a complex COVID-19 vaccine safety question concerning an individual patients that is not readily addressed by ACIP guidance, US healthcare personnel or health departments can request a clinical consultation from the Clinical Immunization Safety Assessment COVIDVax project (https://www.cdc.gov/vaccinesafety/ensuring-safety/monitoring/cis/index.html).

**Lymphadenopathy**

Lymphadenopathy reported in clinical trials evaluating COVID-19 vaccine (Pfizer-BioNTech). Data from the ongoing phase 2/3 trial evaluating the Pfizer-BioNTech COVID-19 vaccine indicate lymphadenopathy reported in 0.3% of vaccine recipients. Lymphadenopathy lasted an average of 10 days, occurred more frequently in vaccine group than placebo group, and was temporally associated with the vaccine.

Unilateral axillary adenopathy, including palpable axillary mass, identified through self-detection or incidentally on breast imaging in individuals who received an mRNA COVID-19 vaccine outside of clinical trials. In some reported cases, axillary adenopathy on same side as the vaccination site was seen on breast ultrasound performed 5–13 days after receipt of an mRNA COVID-19 vaccine. Consider vaccine-induced hyperplastic axillary adenopathy in differential diagnosis if unilateral axillary adenopathy identified on breast imaging in individuals who recently received an mRNA COVID-19 vaccine. Some experts suggest scheduling routine screening mammography or ultrasound prior to first dose of an mRNA COVID-19 vaccine or 4–6 weeks following second dose of the vaccine, if possible, and if this would not unduly delay appropriate care.

Consider that increased axillary lymph node or deltoid uptake has been detected on positron emission tomography (PET) or other imaging performed in individuals who recently received an mRNA vaccine; some experts suggest obtaining detailed history regarding COVID-19 vaccination (date of vaccination, arm used for vaccine injection) to guide optimal follow-up and avoid unnecessary biopsies in patients undergoing such imaging.

**Myocarditis and Pericarditis**

Rare post-authorization reports of acute myocarditis or pericarditis in recipients of mRNA COVID-19 vaccines (Pfizer-BioNTech COVID-19 vaccine or Moderna COVID-19 vaccine) that suggest an increased risk of myocarditis and pericarditis following vaccination, particularly following the second dose. Symptoms onset typically within 2–7 days (range: 0–40 days) after receipt of a dose of an mRNA COVID-19 vaccine. Reported more frequently after the second vaccine dose than the first dose. Data to date indicate myocarditis and pericarditis following vaccination with an mRNA COVID-19 vaccine occurred predominantly in male adolescents and young adults (range: 12–29 years of age). In most reported cases, patients were hospitalized and responded to medications and rest with rapid improvement or resolution of symptoms. Additional data needed regarding potential for long-term sequelae.

Consider the possibility of myocarditis and pericarditis in the differential diagnosis for adolescents or young adults with acute chest pain, shortness of breath, or palpitations. During initial evaluation of suspected cases, query the patient about prior COVID-19 vaccination in addition to usual pertinent medical history. Consider expert consultation regarding diagnosis, management, and follow-up.

Individuals who developed myocarditis or pericarditis after a first dose of an mRNA COVID-19 vaccine: Because is it unclear whether such individuals are at increased risk of further adverse cardiac effects following a second dose of the vaccine, experts recommend deferring the second dose until additional safety data are available. ACIP states there may be some circumstances when administration of the second dose can be considered, taking into account the individual's personal risk of severe COVID-19 (e.g., age, underlying conditions), level of COVID-19 in the community and personal risk of infection, availability of additional data on risk of myocarditis or pericarditis in such situations, and availability of additional data on long-term outcomes. Those who choose to receive a second dose should wait until their episode of myocarditis or pericarditis has completely resolved, including resolution of symptoms attributed to myocarditis or pericarditis with no evidence of ongoing heart inflammation or sequelae as determined by the individual's clinical team, which may include a cardiologist, and special testing to assess cardiac recovery.

Individuals with a history of myocarditis or pericarditis unrelated to mRNA COVID-19 vaccination (e.g., prior to COVID-19 vaccination): Data are limited regarding the safety and efficacy of COVID-19 vaccines in such individuals. FDA states that a decision to administer the Pfizer-BioNTech COVID-19 vaccine to an individual with a history of myocarditis or pericarditis should take into account the individual's clinical circumstances. ACIP states that any FDA-authorized COVID-19 vaccine can be administered after the episode of myocarditis or pericarditis unrelated to COVID-19 vaccination has completely resolved, including resolution of symptoms attributed to myocarditis or pericarditis with no evidence of ongoing heart inflammation or sequelae as determined by the individual's clinical team, which may include a cardiologist, and special testing to assess cardiac recovery.

If myocarditis or pericarditis occurs after receipt of a COVID-19 vaccine, report the case to VAERS. (See EUA Requirements for Postvaccination Monitoring and Mandatory Vaccine Adverse Event Reporting under Cautions.)

**Thrombocytopenia**

Very rare reports of thrombocytopenia, including immune thrombocytopenia (ITP), in recipients of mRNA COVID-19 vaccines (Pfizer-BioNTech COVID-19 vaccine or Moderna COVID-19 vaccine) during post-authorization surveillance. As of February 4, 2021, >18 million doses of the Pfizer-BioNTech COVID-19 vaccine and >16 million doses of the Moderna COVID-19 vaccine had been administered in the US, and FDA has identified 15 cases of thrombocytopenia in recipients of the Pfizer-BioNTech COVID-19 vaccine and 13 cases in recipients of the Moderna COVID-19 vaccine (reporting rates of 0.8 per million doses for both mRNA vaccines). FDA stated that this number of post-vaccination cases of thrombocytopenia does not suggest a safety concern attributable to mRNA COVID-19 vaccines.

As of April 24, 2021, data from the Vaccine Safety Datalink (VSD) regarding reports of cerebral venous sinus thrombosis (CVST) in recipients of mRNA COVID-19 vaccines identified
11 CVST cases (3 in recipients of the Pfizer-BioNTech vaccine and 8 in recipients of the Moderna vaccine). However, only 6 were considered to be potential incident cases of CVST since 5 of the cases were ruled out based on patient history (e.g., history of head injury, history of cavernous sinus syndrome); thrombocytopenia was not reported in any of these patients. At the time of this analysis, 6.3 million doses of mRNA COVID-19 vaccines had been administered at the healthcare organizations included in the VSD network, and there were no confirmed cases of CVST with thrombocytopenia in recipients of the Pfizer-BioNTech COVID-19 vaccine or Moderna COVID-19 vaccine.

**Concomitant Illness**

Base decision to administer or delay vaccination in an individual with a current or recent febrile illness on the severity of symptoms and etiology of the illness.

ACIP states that a moderate or severe acute illness is a precaution for administration of vaccines and recommends that a risk assessment be performed with potential deferral of vaccination. Deferring vaccination until an individual has recovered avoids superimposing vaccine adverse effects on the underlying illness or mistakenly concluding that a manifestation of the underlying illness resulted from vaccine administration.

**Individuals with Current SARS-CoV-2 Infection**

ACIP recommends deferring COVID-19 vaccination in individuals with known current SARS-CoV-2 infection until they have recovered from the acute illness (if symptomatic) and until criteria for discontinuance of isolation have been met. This recommendation applies to individuals who experience SARS-CoV-2 infection before receiving any doses of COVID-19 vaccine and those who experience SARS-CoV-2 infection after receiving the first dose of an mRNA COVID-19 vaccine but before receiving the second dose of the vaccine. There is no recommended minimum interval between SARS-CoV-2 infection and COVID-19 vaccination, but evidence to date suggests that risk of reinfection is low in the months after initial infection, but may increase with time due to waning immunity.

ACIP states that viral testing to assess for acute SARS-CoV-2 infection or serologic testing to assess for infection solely for the purpose of COVID-19 vaccination decision-making is not recommended. (See Interpretation of SARS-CoV-2 Testing in Vaccinated Individuals under Cautions.)

**Individuals with Recent Exposure to SARS-CoV-2 Infection**

ACIP states that COVID-19 vaccines not currently recommended for outbreak management or for postexposure prophylaxis in individuals with a specific known exposure to SARS-CoV-2; postexposure vaccination is unlikely to be effective in preventing disease following such exposures. (See Limitations of Vaccine Effectiveness under Cautions.)

**Individuals in the community or outpatient setting with a known COVID-19 exposure:**

ACIP states that such individuals should not seek COVID-19 vaccination until their quarantine period has ended to avoid potentially exposing healthcare personnel and other individuals to SARS-CoV-2 during the vaccination visit. This recommendation also applies to individuals with a known COVID-19 exposure after receiving the first dose of an mRNA COVID-19 vaccine but before receiving the second dose of the vaccine.

**Individuals residing in congregate healthcare settings (e.g., long-term care facilities) or congregate non-healthcare settings (e.g., correctional and detention facilities, homeless shelters) with a known COVID-19 exposure:**

ACIP states that such individuals may receive COVID-19 vaccination since exposure and transmission of SARS-CoV-2 can occur repeatedly for long periods of time in these settings and healthcare personnel and other staff are already in close contact with residents in these settings. Individuals providing vaccination services should employ appropriate infection prevention and control procedures.

**Residents in congregate settings (healthcare and non-healthcare) with a known COVID-19 exposure waiting for results of SARS-CoV-2 testing:**

ACIP states that such individuals may receive COVID-19 vaccination if they do not have symptoms consistent with COVID-19. Individuals providing vaccination services should employ appropriate infection prevention and control procedures. Viral testing to assess for acute SARS-CoV-2 infection solely for the purpose of COVID-19 vaccination decision-making is not recommended. (See Interpretation of SARS-CoV-2 Testing in Vaccinated Individuals under Cautions.)

**Individuals with Prior SARS-CoV-2 Infection**

Available data suggest that COVID-19 vaccines can be given safely to individuals with evidence of prior SARS-CoV-2 infection. ACIP states COVID-19 vaccination should be offered to individuals regardless of history of prior symptomatic or asymptomatic SARS-CoV-2 infection, including those with prolonged post-COVID-19 symptoms.

Data not available to date regarding safety and efficacy of administering COVID-19 vaccines to individuals who have received passive antibody therapy with investigational SARS-CoV-2-specific monoclonal antibodies or investigational COVID-19 convalescent plasma as part of treatment of COVID-19. (See Specific Drugs under Drug Interactions.)

**Individuals with a History of Multisystem Inflammatory Syndrome**

Data not available to date regarding safety and efficacy of COVID-19 vaccines in adults or children with a history of multisystem inflammatory syndrome (MIS-A or MIS-C, respectively). Mechanisms of MIS-A and MIS-C are not well understood, but include a dysregulated immune response to SARS-CoV-2 infection. It is unclear whether those with a history of MIS-A or MIS-C are at risk for recurrence of the same dysregulated immune response following reinfection with SARS-CoV-2 or in response to COVID-19 vaccination. ACIP recommends weighing these theoretical concerns against the known risks of COVID-19 following reinfection and the benefits of protection following COVID-19 vaccination. Although children with MIS-C have high antibody titers to SARS-CoV-2, it is unclear whether this correlates with protection against reinfection and the duration of protective antibody levels in such children is not known.

ACIP states that individuals with a history of MIS-A or MIS-C may choose to be vaccinated. Although a conversation between the patient, their guardian(s), and their clinical team or a specialist may assist with decisions regarding COVID-19 vaccination in such individuals, a conversation with a healthcare provider is not required before vaccination. When making decisions regarding COVID-19 vaccination in those with a history of MIS-A or MIS-C, considerations include clinical recovery from MIS-C or MIS-A (including return to normal cardiac function), personal risk of severe acute COVID-19 (e.g., age, underlying conditions), levels of COVID-19 transmission in the community and personal risk of reinfection, lack of safety data regarding administration of COVID-19 vaccines following MIS-A or MIS-C, and timing of any immunomodulatory therapies.

Current evidence suggests that the risk of reinfection with SARS-CoV-2 is low in the months after initial infection, but may increase with time due to waning immunity. ACIP states that individuals with a history of MIS-A or MIS-C should consider deferring COVID-19 vaccination until they have recovered from their illness and for 90 days after the date MIS-A or MIS-C was diagnosed, recognizing that the risk of reinfection and, therefore, the benefit from vaccination might increase with time following the initial infection.

If MIS-A or MIS-C associated with a confirmed SARS-CoV-2 infection develops after receipt of a COVID-19 vaccine, consider referral to a specialist in infectious diseases, rheumatology, or cardiology. US healthcare providers and health departments can also request a clinical consultation from the Clinical Immunization Safety Assessment COVIDvax project (https://www.cdc.gov/vaccinesafety/ensuring safety/monitoring/cisa/index.html).

If MIS-A or MIS-C occurs following COVID-19 vaccination, report the case to VAERS. (See EUA Requirements for Postvaccination Monitoring and Mandatory Vaccine Adverse Event Reporting under Cautions.)

**Individuals with Underlying Medical Conditions**

ACIP states that individuals with altered immunocompetence or certain underlying medical conditions may receive any FDA-authorized COVID-19 vaccine, unless they have a contraindication to the vaccine. ACIP does not state a preference for any specific COVID-19 vaccine in such individuals. Clinical trials of COVID-19 vaccines demonstrated that safety and efficacy profiles in individuals with some underlying medical conditions, including those that place them at increased risk for severe COVID-19, are similar to safety and efficacy profiles in those without comorbidities.

US healthcare providers and health departments can request a clinical consultation from the Clinical Immunization Safety Assessment COVIDvax project (https://www.cdc.gov/vaccinesafety/ensuring safety/monitoring/cisa/index.html) if they have concerns about vaccinating individuals with certain underlying medical conditions.

**Individuals with Altered Immunocompetence**

FDA-authorized mRNA COVID-19 vaccines (Pfizer-BioNTech COVID-19 vaccine and Moderna COVID-19 vaccine) are not live vaccines and, therefore, can be safely administered to immunocompromised individuals.

Individuals with altered immunocompetence, including those receiving immunosuppressive therapy (see Specific Drugs under Interactions), may have diminished immune responses to vaccines.

Clinical trial data indicate immunocompromised individuals (e.g., solid organ transplant recipients, those with lymphoid malignancies) may have reduced immune responses following a 2-dose vaccination series of an mRNA COVID-19 vaccine compared with those who are not immunocompromised. There also is evidence that vaccinated immunocompromised individuals may have a higher rate of breakthrough SARS-CoV-2 infections than vaccinated individuals in the general population.

Data from small studies demonstrated that administration of an additional dose of mRNA COVID-19 vaccine after the initial 2-dose vaccination series may enhance immune responses to the vaccine in some immunocompromised individuals. Results of a study evaluating safety and effectiveness of a third dose of the Pfizer-BioNTech COVID-19 vaccine in solid organ transplant recipients indicate the third dose is only moderately effective in increasing potentially protective antibody titers in such patients.

FDA EUA for the Pfizer-BioNTech COVID-19 vaccine permits administration of a third dose of the vaccine at least 28 days after completion of the initial 2-dose vaccination series in individuals ≥12 years of age who are solid organ transplant recipients or diagnosed with conditions considered to have an equivalent level of immunocompromise.

ACIP states that, although clinical benefit of an additional (third) dose of an mRNA COVID-19 vaccine after an initial 2-dose vaccination series in immunocompromised individuals not precisely known, the potential for increased immune response and the acceptable safety profile of mRNA COVID-19 vaccines support the recommendation for a third dose in individuals with moderate to severe immunocompromise resulting from a medical condition or receipt of immunosuppressive medications or treatments.
ACIP recommends that a third dose of the Pfizer-BioNTech COVID-19 vaccine be considered for individuals with moderate to severe immunocompromise including, but not limited to, the following:

- Active treatment for solid tumor and hematologic malignancies
- Receipt of solid organ transplant and taking immunosuppressive therapy
- Receipt of chimeric antigen receptor (CAR) T-cell therapy or hematopoietic stem cell transplant (within 2 years of transplantation or taking immunosuppression therapy)
- Moderate or severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome)
- Advanced or untreated HIV infection
- Active treatment with high-dose corticosteroids (e.g., prednisone dosage at least 20 mg daily or equivalent), alkylation agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, tumor necrosis factor (TNF) blocking agents, and other biologic agents that are immunosuppressive or immunomodulatory

ACIP states that factors to consider when assessing the general level of immune competence include disease severity, duration, clinical stability, complications, comorbidities, and any potentially immunosuppressive treatment.

Counsel immunocompromised individuals, including those who receive a third dose of the Pfizer-BioNTech COVID-19 vaccine, about the unknown safety profile and effectiveness of COVID-19 vaccines in immunocompromised populations and the potential for reduced immune responses. Advise them of the need to continue following all current guidelines (e.g., wearing a mask, physically distancing) to protect themselves from COVID-19. Encourage close contacts of immunocompromised individuals to be vaccinated against COVID-19.

Antibody testing to assess for immunity to COVID-19 following COVID-19 vaccination in individuals with altered immunocompetence not recommended. (See Interpretation of SARS-CoV-2 Testing in Vaccinated Individuals under Cautions.)

Individuals with Autoimmune Conditions
ACIP states that individuals with autoimmune conditions may receive any FDA-authorized COVID-19 vaccine, unless they have a contraindication to the vaccine. Individuals with autoimmune conditions were included in clinical trials evaluating mRNA COVID-19 vaccines and safety and efficacy of the vaccines in this population were similar to that in the general population.

Recommendations for individuals with altered immunocompetence apply to individuals with autoimmune conditions who are immunocompromised because of drug therapy (e.g., high-dose corticosteroids, biologic agents). (See Individuals with Altered Immunocompetence under Cautions.)

Individuals with Liver Disease
American Association for the Study of Liver Diseases (AASLD) released a consensus statement regarding use of COVID-19 vaccines in individuals with chronic liver disease or a liver transplant.

Although safety and efficacy data regarding use of COVID-19 vaccines in individuals with chronic liver disease are limited and additional studies are needed, safety and efficacy of the vaccines in such individuals expected to be similar to the general population. AASLD states that individuals with chronic liver disease receiving antiviral treatment for HBV or HCV infection and those receiving medical therapy for primary biliary cholangitis or autoimmune hepatitis should not discontinue such therapy when receiving COVID-19 vaccination. In addition, consider COVID-19 vaccination for patients with hepatocellular carcinoma undergoing locoregional or systemic therapy without interruption of treatment.

AASLD states that liver transplant candidates should receive COVID-19 vaccination prior to transplantation, whenever possible, to help ensure an adequate immune response. The best time for COVID-19 vaccination in previously unvaccinated liver transplant recipients is likely to be ≥3 months after transplant; however, vaccination may be given as early as 6 weeks after transplant if indicated based on ongoing community spread of SARS-CoV-2, especially in those at highest risk with other comorbid factors associated with severe COVID-19.

Reducing immunosuppressive therapy in liver transplant recipients solely as an effort to elicit an immune response to COVID-19 vaccination not recommended because of the risk of acute cellular rejection (ACR) with lower immunosuppression. AASLD recommends that COVID-19 vaccination be avoided in liver transplant recipients with active ACR, those being treated for cellular rejection (ACR) with lower immunosuppression. AASLD recommends that COVID-19 vaccination not recommended because of the risk of acute cellular rejection (ACR) with lower immunosuppression.

ACIP states that individuals with a history of GBS may receive COVID-19 vaccination, unless they have a contraindication to the vaccine. A history of GBS is not usually considered a contraindication or precaution to vaccination with most vaccines.

If GBS occurs following COVID-19 vaccination, report the case to VAERS. (See EUA Requirements for Postvaccination Monitoring and Mandatory Vaccine Adverse Event Reporting under Cautions.)

Individuals with a History of Bell's Palsy
Although a causal relationship not established, several cases of Bell’s palsy reported in clinical trials in individuals who received the Pfizer-BioNTech or the Moderna COVID-19 vaccines.

Data from the ongoing phase 2/3 trial evaluating the Pfizer-BioNTech COVID-19 vaccine identified 4 cases of Bell’s palsy (facial paralysis) in vaccine recipients. Onset of facial paralysis in one individual occurred on day 37 after first vaccine dose (participant did not receive second dose) and onset occurred on days 3, 5, or 48 after second dose in the other individuals; no cases of Bell’s palsy reported in the placebo group. FDA stated that these 4 cases in the vaccine group do not represent a frequency greater than that expected in the general population.

ACIP states, in the absence of a causal relationship between COVID-19 vaccines and Bell’s palsy, individuals with a history of Bell’s palsy may receive COVID-19 vaccination, unless they have a contraindication to the vaccine.

If Bell’s palsy occurs following COVID-19 vaccination, report the case to VAERS. (See EUA Requirements for Postvaccination Monitoring and Mandatory Vaccine Adverse Event Reporting under Cautions.)

Individuals with Increased Bleeding Risk
Advise individuals who have bleeding disorders or are receiving anticoagulant therapy and/or their caregiver about the risk of hematoma from IM injections.

ACIP states that IM vaccines may be given to individuals who have bleeding disorders if a clinician familiar with the patient’s bleeding risk determines that the preparation can be administered with reasonable safety. In these cases, use a fine needle (23 gauge or smaller) to administer the vaccine and apply firm pressure to the injection site (without rubbing) for ≥30 minutes. In individuals receiving therapy for hemophilia, schedule IM vaccines for administration shortly after a dose of such therapy.

Individuals receiving anticoagulation therapy presumably have the same bleeding risk as those with clotting factor disorders and should follow the same guidelines for IM administration. If possible, schedule IM vaccines prior to use of an anticoagulant so that patient’s risk of bleeding is not increased by the drug’s therapeutic action.

History of Dermal Filler Use
Administration of an mRNA COVID-19 vaccine to individuals who have received injectable dermal fillers (e.g., hyaluronic acid dermal fillers) has infrequently resulted in swelling at or near site of dermal filler injection (usually face or lips) starting 1–2 days after vaccination. This effect reported when the vaccine was given 2 weeks to 6 months or longer after last dermal filler injection; appears to be temporary and resolves with medical treatment, including corticosteroid therapy.

ACIP states that individuals who have received injectable dermal fillers may receive COVID-19 vaccination, unless they have a contraindication to the vaccine. However, advise such individuals to contact their healthcare provider for evaluation if they develop swelling at or near site of dermal filler injection following vaccination.

Individuals Vaccinated Outside the US
Some individuals in the US may have previously received vaccination against COVID-19 in another country using a vaccine not authorized by FDA and/or not listed for emergency use by WHO. For the purposes of public health guidance, ACIP states that only individuals who have received all recommended doses of a COVID-19 vaccine authorized by FDA or listed by WHO for emergency use are considered fully vaccinated.

Data not available regarding safety and efficacy of administering an FDA-authorized COVID-19 vaccine to individuals who previously received a COVID-19 vaccine not authorized in the US. However, ACIP states that such individuals may be offered revaccination with an FDA-authorized COVID-19 vaccine in certain circumstances. If an FDA-authorized COVID-19 vaccine is administered to an individual who previously received a vaccine not authorized by FDA, the minimum interval between last dose of a non-FDA-authorized COVID-19 vaccine and dose of an FDA-authorized COVID-19 vaccine is 28 days.

Fully or Partially Vaccinated with an FDA-authorized COVID-19 Vaccine
Individuals vaccinated outside the US with an FDA-authorized COVID-19 vaccine do not need any additional doses in the US if they previously received all the recommended doses of the vaccine.

If an individual in the US received the first dose of an FDA-authorized COVID-19 vaccine outside the US and a 2-dose regimen is required, ACIP states the vaccination series does not need to be restarted; administer the second dose of the vaccine as close to the recommended interval as possible.

Previously Received a COVID-19 Vaccine not Authorized by FDA but Listed for Emergency Use by WHO
ACIP states that individuals who completed a COVID-19 vaccination series with a vaccine listed for emergency use by WHO do not need any additional doses using an FDA-authorized COVID-19 vaccine.
may offer a complete vaccination series using an FDA-authorized COVID-19 vaccine to individuals who partially completed a COVID-19 vaccination series outside the US with a vaccine listed for emergency use by WHO.

Previously Received a COVID-19 Vaccine not Authorized by FDA or Listed for Emergency Use by WHO

May offer a complete vaccination series using an FDA-authorized COVID-19 vaccine to individuals who completed or partially completed a COVID-19 vaccination series outside the US with a vaccine not authorized by FDA or listed for emergency use by WHO.

Limitations of Vaccine Effectiveness

May not protect all vaccine recipients against COVID-19.

The Pfizer-BioNTech COVID-19 vaccine is administered as a series of 2 doses given 3 weeks (21 days) apart (see Dosage under Dosage and Administration). Data from the ongoing phase 2/3 trial indicate that estimated vaccine efficacy is 52% following the first dose and 95% following the second dose. Counsel vaccine recipients on the importance of completing the 2-dose vaccination series to optimize protection against COVID-19.

Use of COVID-19 vaccines for outbreak management or for postexposure prophylaxis to prevent SARS-CoV-2 infection in individuals with a specific known exposure to the virus is unlikely to be effective, and not currently recommended. ACIP states that, because median incubation period of SARS-CoV-2 infection is 4–5 days, it is unlikely that a dose of COVID-19 vaccine would provide an adequate immune response within the incubation period for effective postexposure prophylaxis.

FDA states that data are too limited to assess the effect of the Pfizer-BioNTech COVID-19 vaccine for prevention of asymptomatic SARS-CoV-2 infection (as measured by detection of the virus and/or detection of antibodies against non-vaccine antigens that would indicate infection rather than an immune response induced by the vaccine); additional evaluations needed, including data from clinical trials and from use of the vaccine after issuance of the EUA.

FDA states that data are too limited to assess the effect of the Pfizer-BioNTech vaccine against transmission of SARS-CoV-2 from individuals who become infected despite vaccination. Demonstrated high efficacy against symptomatic COVID-19 may translate to overall prevention of transmission in populations with high enough vaccine uptake; however, it is possible that if efficacy against asymptomatic infection were lower than efficacy against symptomatic infection, asymptomatic cases in combination with reduced mask-wearing and social distancing could result in significant continued transmission of the virus. Additional evaluations needed, including data from clinical trials and from use of the vaccine after issuance of the EUA, to assess effect of the vaccine in preventing virus shedding and transmission, particularly in individuals with asymptomatic infection.

Based on the unknown duration of vaccine-induced protection and unknown extent of protection against emerging SARS-CoV-2 variants, counsel individuals who receive COVID-19 vaccination and are considered fully vaccinated (see Dosage under Dosage and Administration) to continue to follow current guidance for fully vaccinated individuals to protect themselves and others. This may include wearing a mask and physically distancing in certain settings and venues if required by federal, state, local, tribal, or territorial laws, rules, and regulations and following CDC travel guidance and any applicable local business or workplace guidance. CDC issued interim public health recommendations for individuals who are fully vaccinated against COVID-19 (defined as at least 2 weeks after completion of a 2-dose vaccination series of the Pfizer-BioNTech COVID-19 vaccine or the Moderna COVID-19 vaccine or at least 2 weeks after a single dose of the Janssen COVID-19 vaccine). Consult these recommendations (available at the CDC website at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html) for information on precautionary measures that fully vaccinated individuals should take in various social situations and/or following exposure to someone with suspected or confirmed COVID-19.

Data limited to date regarding vaccine protection in some immunocompromised individuals, including those receiving immunosuppressive drugs (e.g., drugs such as mycophenolate and rituximab used to suppress rejection of transplanted organs or to treat rheumatologic conditions); such individuals should discuss the need for personal protective measures after COVID-19 vaccination with their healthcare provider.

Withholding COVID-19 vaccination due to concerns about efficacy against current or future SARS-CoV-2 viral variants not recommended. If COVID-19 vaccine breakthrough infection occurs in an individual who is fully vaccinated against COVID-19 (i.e., RNA or antigen detected in a respiratory specimen collected ≥14 days after an individual completed all recommended doses of an FDA-authorized COVID-19 vaccine), healthcare providers, local health departments, and clinical laboratories are encouraged to request that the respiratory specimen be held for further testing and the case reported to the state health department for further investigation and reporting to the national system. If COVID-19 vaccine breakthrough infection results in hospitalization or death, report the case to VAERS. (See EUA Requirements for Postvaccination Monitoring and Mandatory Vaccine Adverse Event Reporting under Cautions.)

Duration of Immunity

Duration of protection against SARS-CoV-2 infection following vaccination with a 2-dose regimen of the Pfizer-BioNTech COVID-19 vaccine not fully evaluated.

Improper Storage and Handling

Improper storage or handling of vaccines may reduce or destroy vaccine potency resulting in inadequate or no immune response in vaccinees. Inspect all vaccines on delivery and monitor during storage to ensure that recommended storage temperatures are maintained.

The Pfizer-BioNTech COVID-19 vaccine must be shipped, stored, and handled under specific conditions at all times, including maintaining cold chain conditions and chain of custody, according to specifications in the EUA fact sheet for healthcare providers and guidance from the manufacturer and CDC. (See Storage under Stability.)

Contact the manufacturer at 800-666-7245 or 877-829-2619 for guidance if there are concerns about mishandling, including inadvertent temporary temperature excursions.

EUA Requirements for Postvaccination Monitoring and Mandatory Vaccine Adverse Event Reporting

Safety and efficacy not established. FDA issued an EUA that permits use of the Pfizer-BioNTech COVID-19 vaccine for prevention of COVID-19 in individuals ≥12 years of age when administered according to the 2-dose vaccination series specified in the EUA. (See Prevention of Coronavirus Disease 2019 [COVID-19] under Uses.)

Some data are available regarding adverse effects associated with use of the vaccine. (See Common Adverse Effects under Cautions.) Additional adverse effects, some of which may be serious, may become apparent with more widespread use.

Monitor all vaccine recipients for immediate adverse reactions according to CDC (ACIP) guidelines. (See General under Dosage and Administration.)

Provide vaccine recipients or their caregivers with information on, and encourage participation in, CDC’s voluntary smartphone-based tool (v-safe) that uses text messaging and web surveys to check in with individuals who have received a COVID-19 vaccine to identify potential adverse effects. Reports to v-safe that indicate a medically important health impact are followed up by the CDC v-safe call center to collect additional information to complete a VAERS report. Information on v-safe is available at https://www.cdc.gov/vsafe.

It is mandatory that vaccination providers administering the Pfizer-BioNTech COVID-19 vaccine report all vaccine administration errors (even if not associated with an adverse event) and serious adverse events (irrespective of attribution to vaccination) that occur following vaccination and also report all cases of multisystem inflammatory syndrome (MIS) and COVID-19 that result in hospitalization or death in vaccine recipients to VAERS. Consult FDA fact sheet for healthcare providers for the Pfizer-BioNTech COVID-19 vaccine available at FDA website and at https://www.cvdvaccine.com for requirements and instructions regarding reporting of adverse reactions and vaccination errors.

Interpretation of SARS-CoV-2 Testing in Vaccinated Individuals

Results of SARS-CoV-2 viral tests (nucleic acid amplification or antigen tests) not affected by prior COVID-19 vaccination.

Currently available antibody tests for SARS-CoV-2 assess IgM and/or IgG to one of two viral proteins (spike or nucleocapsid). Because COVID-19 vaccines, including the Pfizer-BioNTech COVID-19 vaccine, encode the spike protein of the virus, a positive test for spike protein IgM/ IgG could indicate either prior infection or vaccination. Use a test that specifically evaluates IgM/ IgG to the nucleocapsid protein to assess for evidence of prior infection in an individual who received COVID-19 vaccination.

Antibody testing not currently recommended to assess for immunity to SARS-CoV-2 following COVID-19 vaccination. Antibody tests currently authorized for use under EUAs have variable sensitivity and specificity, as well as positive and negative predictive values, and are not authorized for assessment of immune response in individuals who have received COVID-19 vaccination. In addition, serologic correlates of protection against SARS-CoV-2 not established, and antibody testing does not evaluate cellular immune response, which may also play a role in vaccine-mediated protection. If antibody testing is performed following COVID-19 vaccination, do not administer additional doses of the same or different COVID-19 vaccine beyond those recommended based on results of antibody testing.

Interpretation of Tuberculosis Tests in Vaccinated Individuals

ACIP states do not delay COVID-19 vaccination in situations when an immune-based method of tuberculosis testing (e.g., in tuberculin skin test [TST] or serum interferon gamma release assay [IGRA]) is required or indicated. If TST or IGRA required according to administrative policies (e.g., healthcare employment, admission to long-term care facilities), perform such testing before or during same visit that COVID-19 vaccine is administered. If such testing cannot be done prior to or at the same time as COVID-19 vaccination, ACIP recommends delaying testing until ≥4 weeks after vaccination. If a tuberculosis testing requirement or policy cannot be modified to accept a delay in TST or IGRA testing during the COVID-19 pandemic, it should be understood that a false-negative TST or IGRA cannot be excluded; in such situations, consider repeating a negative TST or IGRA test ≥4 weeks after completion of COVID-19 vaccination. In addition, if TST was performed as the
initial test, consider the possibility that boosting could be a factor if results of a repeat TST are positive. ACIP states COVID-19 vaccines can be given to individuals who have active tuberculosis disease or an illness being evaluated as active tuberculosis disease; however, consider that a moderate or severe acute illness usually is a precaution for vaccination (see Concomitant Illness under Cautions). If TST or IGRA is being considered for medical diagnosis of latent tuberculosis infection (e.g., during contact investigation after exposure to contagious tuberculosis disease), a decision to delay such testing until ≥4 weeks after completion of COVID-19 vaccination is at the discretion of the responsible medical provider and local tuberculosis program overseeing the contact investigation. If a decision is made to not delay TST or IGRA testing (e.g., in individuals at high risk for progression to tuberculosis disease) and test results are negative, ACIP states consider retesting ≥4 weeks after completion of COVID-19 vaccination.

Specific Populations

Pregnancy

Data insufficient to date regarding use of the Pfizer-BioNTech COVID-19 vaccine to inform vaccine-associated risks during pregnancy. A reproductive and developmental toxicity study in female rats using a vaccine formulation containing the same quantity of mRNA and other ingredients as the Pfizer-BioNTech COVID-19 vaccine did not reveal evidence of vaccine-related adverse effects on female fertility, fetal development, or postnatal development. Available data suggest that, while the absolute risk is low, pregnant and recently pregnant women with COVID-19 are at increased risk of severe illness, including illness resulting in hospitalization, admission to an intensive care unit (ICU), mechanical ventilation, extracorporeal membrane oxygenation (ECMO), or death compared with women who are not pregnant. Pregnant and recently pregnant women with comorbidities such as obesity and diabetes mellitus may be at even higher risk of severe COVID-19. Additionally, pregnant women with COVID-19 are at an increased risk of preterm birth and may be at an increased risk of adverse pregnancy complications or outcomes, such as preeclampsia, coagulopathy, and stillbirth. Postauthorization surveillance safety data are accumulating regarding COVID-19 vaccination during pregnancy and clinical trials evaluating safety and efficacy of COVID-19 vaccines in pregnant women are underway or planned. There is some evidence that pregnant women who receive an mRNA vaccine (Pfizer-BioNTech COVID-19 vaccine or Moderna COVID-19 vaccine) during pregnancy have immune responses comparable to those observed in nonpregnant individuals and may develop anti-SARS-CoV-2 antibody titers greater than those observed in women diagnosed with SARS-CoV-2 infection during pregnancy. The Pfizer-BioNTech COVID-19 vaccine cannot cause SARS-CoV-2 infection in the pregnant woman or her fetus. FDA states pregnancy is not a contraindication to use of the Pfizer-BioNTech COVID-19 vaccine; pregnant women should discuss potential benefits and risks of vaccination with their healthcare providers.

ACIP states vaccination against COVID-19 is recommended for pregnant women. These experts state that evidence regarding safety and efficacy of COVID-19 vaccines available from both animal and human studies indicates that benefits of vaccination against COVID-19 during pregnancy outweigh any known or potential risks. ACOG recommends that pregnant women be vaccinated against COVID-19. When recommending the COVID-19 vaccine to pregnant women, ACOG suggests that clinicians review available data on risks and benefits of vaccination, including risks of not getting vaccinated, in the context of the individual patient’s current health status and risk of exposure (e.g., possibility for exposure at work or home) and possibility for exposing high-risk household members. In addition, take into account the individual patient’s values and perceived risk of various outcomes; autonomous decision-making should be respected and supported.

ACIP and ACOG state that a conversation between the pregnant woman and her clinical team may assist with decisions regarding use of COVID-19 vaccines; however, such a conversation is not required and written permission is not needed prior to vaccination. ACIP and ACOG recommend that women who become pregnant after receiving the first dose of an mRNA COVID-19 vaccination series should receive the second dose according to the usual schedule, unless contraindicated.

ACOG states do not withhold Rho(D) immune globulin when indicated in an individual who is planning to receive or recently received a COVID-19 vaccine. (See Specific Drugs under Interactions.)

Adverse effects similar to those reported in non-pregnant individuals can occur following COVID-19 vaccination in pregnant women. Advise pregnant women who experience fever following vaccination to take acetaminophen; may also offer acetaminophen as an option for pregnant women experiencing other postvaccination symptoms.

Encourage women who receive a COVID-19 vaccine during pregnancy and those who become pregnant within 30 days after receiving a COVID-19 vaccine to participate in CDC’s v-safe program. (See EUA Requirements for Postvaccination Monitoring and Mandatory Vaccine Adverse Event Reporting under Cautions.)

Females and Males of Reproductive Capacity

Routine pregnancy testing not recommended before receiving a COVID-19 vaccine. ACIP states vaccination against COVID-19 recommended for women currently trying to become pregnant and those who might become pregnant in the future. Women trying to become pregnant do not need to avoid pregnancy after COVID-19 vaccination.

ACOG recommends vaccination for all eligible individuals, including those who may consider future pregnancy.

There is no evidence that any FDA-authorized COVID-19 vaccines affect current or future fertility. FDA states there is no scientific evidence to suggest that Pfizer-BioNTech COVID-19 vaccine could cause infertility in women. In addition, infertility not known to occur as a result of natural COVID-19 disease, further demonstrating that immune responses to the virus, whether induced by infection or a vaccine, are not a cause of infertility.

Lactation

Not known whether Pfizer-BioNTech COVID-19 vaccine administered to a woman who is breast-feeding has any effects on breast-fed infant or milk production.

FDA states that breast-feeding is not a contraindication to use of the Pfizer-BioNTech COVID-19 vaccine; breast-feeding women should discuss benefits and risks of vaccination with their healthcare providers.

ACIP states that vaccination against COVID-19 recommended for lactating women. FDA-authorized COVID-19 vaccines administered to breast-feeding women cannot cause SARS-CoV-2 infection in women or their infants; therefore, breast-feeding women can receive COVID-19 vaccination.

ACOG recommends that lactating women be vaccinated against COVID-19. ACOG also states that theoretical concerns regarding safety of vaccinating lactating women do not outweigh potential benefits of the vaccine; there is no need for individuals who receive a COVID-19 vaccine to avoid initiating breast-feeding or to discontinue breast-feeding.

Although there is some evidence that antibodies that develop following vaccination with mRNA COVID-19 vaccines are present in breast milk, additional data needed to determine if these antibodies convey protection against SARS-CoV-2 infection in breast-fed infants.

Pediatric Use

FDA EUA permits use of the Pfizer-BioNTech COVID-19 vaccine for prevention of COVID-19† in adolescents ≥12 years of age based on safety and efficacy in this age group and in adults.

The Pfizer-BioNTech COVID-19 vaccine is not authorized for use in children <12 years of age.

Geriatic Use

At the time of FDA’s safety and efficacy analyses of data from the ongoing phase 2/3 trial, 21.4% of vaccine recipients were ≥65 years of age and 4.3% were ≥75 years of age.

Common Adverse Effects

Local adverse effects in adults and adolescents ≥16 years of age in clinical trials: Injection site pain (84.1%), swelling (10.5%), erythema (9.5%). Most local reactions have been mild to moderate in severity; severe pain reported in <1% of vaccine recipients across all age groups. After second dose of the 2-dose vaccination series, median duration of adverse local effects is 2.3–2.6 days (range: 1–36 days).

Systemic adverse effects in adults and adolescents ≥16 years of age in clinical trials: Fatigue (62.9%), headache (55.1%), muscle pain (38.3%), chills (31.9%), joint pain (23.6%), fever (14.1%), nausea (11.1%), malaise (0.5%), lymphadenopathy (0.3%). Systemic adverse effects reported more frequently after second dose of the 2-dose vaccination series and reported more frequently in those 16–55 years of age than in those ≥56 years of age. Generally observed within 1–2 days after vaccination and resolved within a few days. Use of antipyretic or pain medication within 7 days after receiving the first or second vaccine dose reported in 27.8 or 45%, respectively, of those 18–55 years of age and in 19.8 or 37.7%, respectively; of those ≥56 years of age. In study participants 19–55 years of age, serious adverse events reported in 0.4% of vaccine recipients and 0.3% of placebo recipients; in those ≥56 years of age, serious adverse events reported in 0.8 or 0.6% of vaccine or placebo recipients, respectively.

Local adverse effects in adolescents 12 through 15 years of age in a clinical trial: Injection site pain (90.5%), swelling (9.2%), erythema (8.6%). Mean duration of pain at injection site was 2.4 days (range: 1–10 days) after first dose of the 2-dose vaccination series.

Systemic adverse effects in adolescents 12 through 15 years of age in a clinical trial: Fatigue (77.5%), headache (75.5%), chills (49.2%), muscle pain (42.2%), fever (24.3%), joint pain (20.2%), lymphadenopathy (0.8%), nausea (0.4%). Use of antipyretic or pain medication within 7 days after receiving the first or second vaccine dose reported in 36.8 or 50.8%, respectively. Serious adverse events reported in 0.4% of vaccine recipients and 0.1% of placebo recipients.

Solid organ transplant recipients: Data indicate adverse event profile following a third dose of the Pfizer-BioNTech COVID-19 vaccine in transplant (heart, kidney, liver, lung, pancreas) recipients similar to that following the second dose; no grade 3 or 4 adverse events reported during 1 month of follow-up after third dose.

Serious allergic reactions (including anaphylaxis) and other hypersensitivity reactions (e.g., rash, pruritus, urticaria, angioedema) reported rarely when the vaccine was administered outside of clinical trials. (See Hypersensitivity Reactions under Cautions.)

Other adverse effects reported during post-authorization surveillance include GI effects (diarrhea, vomiting) and extremity pain (arm).
Data not available to date to assess concomitant administration of COVID-19 vaccine (Pfizer-BioNTech) with other vaccines.

Although ACIP previously recommended giving COVID-19 vaccines alone, with a minimum interval of 14 days before or after administration of any other vaccines, these experts currently state that COVID-19 vaccines and other vaccines may be administered without regard to timing, including on the same day or within 14 days of each other.

Extensive experience with non-COVID-19 vaccines demonstrated that immunogenicity and adverse event profiles are generally similar whether vaccines are administered concomitantly or alone. However, it is not known whether reactogenicity of COVID-19 vaccines is increased when administered concomitantly with other vaccines, including those known to be more reactogenic (e.g., adjuvanted vaccines, live vaccines). Base decisions to administer a COVID-19 vaccine concomitantly with other vaccine(s) on whether routine immunizations with the other vaccines have been delayed or missed, the individual's risk of vaccine-preventable disease (e.g., during an outbreak or occupational exposures), and reactogenicity profiles of the vaccines.

If a COVID-19 vaccine is administered concomitantly with other vaccines, give each parenteral vaccine at a different injection site and, if possible, separate injection sites by ≥1 inch. ACIP states that, although >1 vaccine can be given IM into the deltoid muscle in adolescents and adults, give COVID-19 vaccines and vaccines likely to cause a local reaction (e.g., tetanus toxoid-containing vaccines, adjuvanted vaccines) in different limbs, if possible.

### Specific Drugs

<table>
<thead>
<tr>
<th>Drug</th>
<th>Interaction</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antiviral agents</strong></td>
<td>Antiviral agents given at any interval before or after COVID-19 vaccination unlikely to impair development of vaccine-induced protective antibody responses</td>
<td>To avoid potential interference with vaccine immune response, ACIP recommends deferring COVID-19 vaccination for ≥90 days after such antibody therapy based on estimated half-life of SARS-CoV-2 antibody therapies and evidence suggesting reinfection uncommon in first 90 days after initial infection; however, COVID-19 vaccination not contraindicated in those who received passive antibody therapy within the past 90 days and COVID-19 vaccine doses received &lt;90 days after receipt of passive antibody therapy do not need to be repeated if COVID-19 subsequently develops in a vaccinated individual, ACIP states prior receipt of COVID-19 vaccine should not affect treatment decisions, including use of SARS-CoV-2 antibody therapies, or timing of such treatment.</td>
</tr>
<tr>
<td><strong>COVID-19 convalescent plasma</strong></td>
<td>Data not available; not known whether prior receipt of such antibody therapy interferes with immune response to the vaccine</td>
<td></td>
</tr>
<tr>
<td><strong>SARS-CoV-2-specific monoclonal antibodies</strong> (bamlanivimab and etesevimab, casirivimab and imdevimab, sotrovimab)</td>
<td>May give COVID-19 vaccine concurrently with or at any interval before or after immune globulin or antibody therapies <strong>not</strong> specific for SARS-CoV-2</td>
<td>To avoid potential interference with vaccine immune response, ACIP recommends deferring COVID-19 vaccination for ≥90 days after such therapy to complete COVID-19 vaccination.</td>
</tr>
<tr>
<td><strong>Rh[D] immune globulin</strong></td>
<td>Possible decreased or suboptimal antibody responses to vaccines, including the Pfizer-BioNTech COVID-19 vaccine</td>
<td>Data insufficient to date to inform optimal timing of COVID-19 vaccination for individuals planning to receive immunosuppressive therapies</td>
</tr>
</tbody>
</table>

ACIP states that individuals receiving immunosuppressive therapy may receive COVID-19 vaccination if they have no contraindications to the vaccine. Based on general best practices for vaccination of immunocompromised individuals, ACIP states COVID-19 vaccination should ideally be completed ≥2 weeks before initiation or resumption of immunosuppressive therapies whenever possible; consider individual's risks related to their underlying condition and response to the vaccine if making decisions to delay immunosuppressive therapy to complete COVID-19 vaccination. Revaccination after immune competence regained not recommended in individuals who received COVID-19 vaccine during chemotherapy or treatment with other immunosuppressive agents. Corticosteroids given topically or by local injection (e.g., intra-articular, intrabursal, or tendon injection): COVID-19 vaccines may be administered without regard to timing of corticosteroid administration. If COVID-19 subsequently develops in a vaccinated individual, ACIP states prior receipt of COVID-19 vaccine should not affect treatment decisions, including use of corticosteroids, or timing of such treatment.
antibody therapy based on estimated half-life of SARS-CoV-2 antibody therapies and evidence suggesting reinfection uncommon in first 90 days after initial infection; however, COVID-19 vaccination not contraindicated in those who received passive antibody therapy within the past 90 days and COVID-19 vaccine doses received <90 days after receipt of passive antibody therapy do not need to be repeated.

If COVID-19 subsequently develops in a vaccinated individual, ACIP states prior receipt of COVID-19 vaccine should not affect treatment decisions, including use of SARS-CoV-2 antibody therapies, or timing of such treatment.

Stability

Storage

Parenteral Suspension Concentrate, for IM Use

Supplied as a frozen suspension concentrate in multiple-dose vials that must be shipped at ultra-low temperatures (between -80 to -60°C) and stored frozen at specific temperatures. Provided in cartons or vial trays that are shipped in specialized thermal shipping containers with dry ice and a temperature-monitoring device to ensure that the vials are maintained at required ultra-low temperatures during transport.

After thermal shipping containers containing the frozen multiple-dose vials of suspension concentrate are received, immediately remove the vial trays from the thermal container and preferably store in an ultra-low-temperature freezer (between -80 to -60°C); alternately, may store frozen multiple-dose vials at -25 to -15°C for up to 2 weeks. Vials stored at -25 to -15°C for up to 2 weeks may be returned one time to recommended storage condition of -80 to -60°C; however, track total time vials are stored at -25 to -15°C and do not exceed 2 weeks at this temperature. If ultra-low-temperature freezer not available, may use the thermal shipping container as temporary storage if consistently replenished with dry ice per instructions provided with the thermal container to ensure that temperature between -90 to -60°C is maintained. Keep multiple-dose vials upright and store in the vial trays protected from light; must be kept frozen until ready to thaw to prepare doses for administration.

If local redistribution of frozen Pfizer-BioNTech COVID-19 vaccine needed and transport of full cartons containing vials at preferred temperature of -90 to -60°C not possible, may transport frozen multiple-dose vials at -25 to -15°C; however, must include any hours used for transport at -25 to -15°C in the 2-week limit for storage at this temperature. May return frozen vials transported at -25 to -15°C one time to recommended storage temperature of -90 to -60°C.

Consult EUA fact sheet for healthcare providers and information provided by CDC and the manufacturer for information on storage, handling, and stability of the vaccine. Various documents and videos describing shipping, storage, and handling requirements and procedures, including specifics about temperature requirements and temperature monitoring, thermal shipping containers, ultra-low-temperature freezers, and safe handling of dry ice, are available at the manufacturer's website at https://www.cvdvaccine.com.

Immediately contact manufacturer at 800-666-7248 or 877-829-2619 if there are concerns about mishandling.

Multiple-dose vials of frozen suspension concentrate that have been thawed in a refrigerator (2–8°C) per manufacturer's directions. May store for up to 1 month in the refrigerator prior to dilution with 0.9% sodium chloride per manufacturer's directions.

Multiple-dose vials of frozen suspension concentrate that have been thawed at room temperature (up to 25°C) per manufacturer's directions. Dilute with 0.9% sodium chloride injection immediately after reaching room temperature per manufacturer's directions; alternatively, may be stored for up to 2 hours at room temperature (including thawing time) prior to dilution. If not used within 2 hours, place thawed vials in a refrigerator.

If transport of one or more vials of thawed Pfizer-BioNTech COVID-19 vaccine needed, available data support transport of such vials at 2–8°C for up to 12 hours.

Following dilution with 0.9% sodium chloride: May be stored between 2–25°C, but must be used within 6 hours after dilution. Discard any unused diluted vaccine 6 hours after dilution.

Once thawed, do not re-freeze.

During storage, minimize exposure to room light and avoid exposure to direct sunlight and ultraviolet light. May handle thawed vaccine vials in room light conditions.

Because it is possible that expiration dates may be extended as more stability data become available, contact the manufacturer prior to discarding vaccine to determine if the expiration date has been extended.

Compatibility

Parenteral Solution Compatibility

Compatible

Sodium chloride 0.9%

Incompatible

Bacteriostatic sodium chloride 0.9%

Actions

● Nucleoside-modified mRNA (modRNA) vaccine formulated in lipid nanoparticles (LNPs).

● The modRNA contained in the Pfizer-BioNTech COVID-19 vaccine encodes a membrane-anchored, full-length spike (S) glycoprotein receptor-binding domain (RBD) antigen of SARS-CoV-2 with 2 proline modifications that lock the S protein in an antigenically preferred prefusion conformation. Following IM injection, the LNPs in the vaccine enable delivery of the modRNA into host cells where it is released and translated to the encoded S antigen of SARS-CoV-2. The S antigen is then incorporated into cellular membranes and elicits an immune response to provide protection against SARS-CoV-2.

● Data from clinical trials in adults indicate that a 2-dose vaccination series of the Pfizer-BioNTech COVID-19 vaccine induces SARS-CoV-2 neutralizing titers and S1-binding IgG levels. Antibody responses are evident after first vaccine dose and substantially boosted after second vaccine dose, supporting need for a 2-dose vaccination series. Some evidence from animal studies that the vaccine can elicit strong CD4+ and CD8+ T-cell responses.

● Data from clinical trial in adolescents 12 through 15 years of age indicate immune responses 1 month after the second vaccine dose are noninferior (within 1.5-fold) compared with immune responses in those 16 through 25 years of age.

● COVID-19 vaccine (Pfizer-BioNTech) available for use for the FDA EUA is provided as a frozen suspension concentrate in multiple-dose vials. Following thawing and dilution with 0.9% sodium chloride as directed by the manufacturer, each 0.3-mL dose of the Pfizer-BioNTech COVID-19 vaccine contains 30 mcg of modRNA encoding the S glycoprotein of SARS-CoV-2. Each dose also contains LNPs composed of 4 different lipids in a defined ratio (4-hydroxybutylyl)azanediyldibis(hexane-6,1-diyl)bis[2-hexyldecanoate], 2[(PEG)-2000]-N,N-ditetradecyl acetamide, 1,2-distearyloxy-3-glycerol-3-phosphocholine, and cholesterol) and potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate, and sucrose.

● Does not contain preservatives; vial stoppers are not made with natural rubber latex.

Advice to Patients

● Prior to administration of COVID-19 vaccine (Pfizer-BioNTech), must provide vaccine recipient or their caregiver with information consistent with the Fact Sheet for Recipients and Caregivers: Emergency Use Authorization (EUA) of the Pfizer-BioNTech COVID-19 Vaccine to Prevent Coronavirus Disease 2019 (COVID-19) in Individuals 12 Years of Age or Older and either give them a copy of the fact sheet or direct them to the manufacturer’s website at https://www.cvdvaccine.com to obtain the fact sheet.

● At the time that the first dose of the Pfizer-BioNTech COVID-19 vaccine is administered, inform vaccine recipient or their caregiver that the vaccine is administered in a series of 2 doses given 3 weeks (21 days) apart and advise them of the importance of receiving the second dose of the 2-dose vaccination series to optimize protection against COVID-19. Give vaccine recipient or their caregiver a vaccination card that provides the date when recipient needs to return for second vaccine dose and inform them of the importance of bringing the card when they return for the second dose.

● Inform individuals who are immunocompromised that they may receive a third dose of the Pfizer-BioNTech COVID-19 vaccine at least 1 month (28 days) after the second dose. Advise such individuals that the third dose may still not provide full immunity to COVID-19 and they should continue to follow preventative measures (e.g., wearing a mask, physically distancing) to help prevent COVID-19. In addition, inform immunocompromised individuals that their close contacts should be vaccinated as appropriate.
● Provide vaccine recipient or their caregiver with information on, and encourage participation in, CDC's voluntary smartphone-based tool (v-safe) that uses text messaging and web surveys to check in with individuals who have received a COVID-19 vaccine to identify potential adverse effects; live telephone follow-up is provided if a medically important health impact is reported. Information on v-safe is available at https://www.cdc.gov/vsafe.

● Inform vaccine recipients or their caregivers that FDA authorized emergency use of the Pfizer-BioNTech COVID-19 vaccine, which is an investigational vaccine that has not received FDA approval, for use in individuals ≥12 years of age. Advise them that clinical trials have shown that a 2-dose series of the vaccine can prevent COVID-19; however, duration of protection following vaccination is unknown and the vaccine may not protect everyone who receives it.

● Inform vaccine recipients or their caregivers that the vaccination provider cannot charge them for the vaccine dose, any out-of-pocket vaccine administration fees, or any other fees for COVID-19 vaccination. However, vaccination providers may seek appropriate reimbursement from a program or plan that covers COVID-19 vaccine administration fees for the vaccine recipient (e.g., private insurance, Medicare, Medicaid, US Health Resources & Services Administration [HRSA] COVID-19 assistance program for non-insured recipients). Individuals who become aware of any potential violations of these requirements are encouraged to report them to the Office of the Inspector General, US Department of Health and Human Services by phone (800-HHS-TIPS) or online (https://tips.oig.hhs.gov).

● Inform vaccine recipients or their caregivers that they have the option to accept or refuse the vaccine.

● Provide vaccine recipients or their caregivers with information on available alternative vaccines and the risks and benefits of those alternatives.

● Inform vaccine recipients or their caregivers about the significant known and potential risks and benefits of the vaccine, and the extent to which such risks and benefits are unknown. Inform them that local adverse effects (injection site pain, swelling, redness) and systemic adverse effects (tiredness, headache, muscle pain, chills, joint pain, fever, nausea, feeling unwell, swollen lymph nodes [lymphadenopathy], nonsevere allergic reactions [rash, pruritus, hives, facial swelling]) have been reported in recipients of the vaccine.

● Inform vaccine recipients or their caregivers that myocarditis (inflammation of the heart muscle) and pericarditis (inflammation of the lining outside the heart) reported rarely in some recipients of the Pfizer-BioNTech COVID-19 vaccine with symptom onset usually within a few days after the second vaccine dose. Importance of immediately seeking medical attention if chest pain, shortness of breath, or fast-beating, fluttering, or pounding heart occurs.

● Importance of vaccine recipient informing vaccination provider of any allergies or fever. Advise vaccine recipients or their caregivers that there is a remote chance that the vaccine could cause a severe allergic reaction and such reactions would usually occur within a few minutes to 1 hour after receiving a dose and may include difficulty breathing, swelling of the face and throat, fast heartbeat, bad rash all over the body, and dizziness and weakness.

● Importance of vaccine recipient informing the vaccination provider if they have had a severe allergic reaction to any ingredient in the vaccine (e.g., PEG) or if they had a severe allergic reaction after receiving first dose of the 2-dose vaccination series; importance of such individuals not receiving the vaccine.

● Importance of vaccine recipient informing the vaccination provider if they previously received any other COVID-19 vaccine, have any medical conditions (e.g., bleeding disorders, myocarditis or pericarditis, immunocompromising diseases), or are receiving anticoagulants or immunosuppressive therapy.

● Importance of women informing clinicians if they are or plan to become pregnant or plan to breast-feed.

Preparations

Excipients in commercially available drug preparations may have clinically important effects in some individuals; consult specific product labeling for details.

COVID-19 vaccine (Pfizer-BioNTech) is not commercially available. FDA issued an emergency use authorization (EUA) for the Pfizer-BioNTech COVID-19 vaccine that permits use of the vaccine for the prevention of COVID-19† in individuals ≥12 years of age. Allocation of the vaccine for use under the EUA is being directed by the US government. The vaccine will be supplied directly from the manufacturer or authorized US distributor(s) and distributed to emergency response stakeholders as directed by the US government, including the CDC and/or other designee.

COVID-19 Vaccine, mRNA (Pfizer-BioNTech)

Parenteral
Suspension concentrate, for IM use

30 mcg (of modRNA) per 0.3-mL dose

Pfizer-BioNTech
COVID-19 Vaccine,
Pfizer