Canadian Society of Transplantation
Société canadienne de transplantation
LEADERSHIP IN CANADIAN TRANSPLANTATION | LEADERSHIP EN TRANSPLANTATION AU CANADA

National Transplant Consensus Guidance on COVID-19 Vaccine

Introduction

The following document provides expert consensus guidance that can be used by provincial organ donation organizations and regional transplant and donation programs to guide the management of COVID-19 vaccination in transplant recipients.

It is understood that each organization, program, and jurisdiction will develop their own policies. Since the situation is evolving, regular teleconferences will be held with national experts to discuss and update this consensus guidance. These discussions, and the consensus itself, will continue to be informed by recommendations from the Canadian Society for Transplantation, Canadian Blood Services' advisory committees, Health Canada, Public Health Agency of Canada, WHO, provincial agencies, and international partners (including UK and Spain).

This document was last updated on **June 1st, 2021** and will continue to be updated as new evidence and information becomes available.

What do we know about COVID-19 and transplant recipients?

COVID-19 is a disease caused by the SARS-CoV-2 virus that is predominantly a respiratory virus but can cause multi-system disease. Several organ transplant recipients have contracted COVID-19 and symptoms have ranged from mild disease to the need for ICU care and death. COVID-19 appears to have a greater severity in transplant recipients but the role of immunosuppression is unclear. Many transplant patients are older and have comorbid conditions such as chronic kidney disease, diabetes, and heart/lung disease that increases the risk of severe COVID-19 disease. Lung transplant patients also seem to be at particularly high risk of severe disease.

What is the status of COVID-19 vaccines in Canada?

There are several formulations of the COVID-19 vaccine that have been approved or are in various stages of development.

<u>mRNA Vaccines:</u>

Two mRNA vaccines (Pfizer/BioNTech and Moderna) have been authorized by Health Canada for use. Both vaccines are composed of mRNA in a lipid nanoparticle and have specific storage conditions. Approximately 70,000 persons have participated in placebo-controlled phase 3 trials with these vaccines. The Pfizer vaccine has an efficacy of 95% in immunocompetent persons and is for use in persons 12 years of age and older. The Moderna vaccine has a 94.1% efficacy and is used in persons 18 years of age and older. Both vaccines are given as a two dose series.

<u>Adenovirus Vector Vaccines:</u>

Two vaccines (University of Oxford/AstraZeneca and Johnson & Johnson) have been authorized for use by Health Canada. Both vaccines are adenovirus vector vaccines that can be stored at 2 to 8 °C, similar to standard vaccines. The Oxford/AZ vaccine uses a chimpanzee adenovirus vector to encode spike protein and has 62 to 90% efficacy in a phase 3 trial. It is given as a 2-dose series, 4 to 12 weeks apart. Due to a lack of data in older populations, the National Advisory Committee on Immunization has recommended this vaccine for persons less than or equal to 65 years of age. The J&J vaccine uses the Ad26 vector to encode spike protein and has 66% overall efficacy with its one dose preparation although has 86% efficacy in preventing severe disease. It is given as a single dose.

Vaccines may have reduced efficacy for circulating variants and therefore efforts are being made to study booster doses of vaccine that could be effective against SARS-CoV-2 variants.

What are the side effects of COVID-19 vaccine?

Local and systemic side effects can occur after any of the four vaccines. These include tenderness, swelling, and redness at the injection site. Relatively common systemic symptoms include fever, myalgias, and headache. In the Pfizer vaccine trial, systemic symptoms were more common in younger age groups and after the second vaccine dose. Similarly, in the Moderna vaccine trial, there were more systemic events after the second dose. Adenovirus vector vaccines appear to have a similar side effect profile to mRNA vaccines.

For the Oxford/AZ vaccine, several cases of thrombosis and thrombocytopenia have been reported worldwide during post-licensure use. The mechanism of action appears to be similar to spontaneous heparin-induced thrombocytopenia (called Vaccine-Induced Immune Thrombotic Thrombocytopenia or VITT). The estimate in Canada as of April 28, 2021 is 1 in 100,000. There have been few reported cases of VITT with the J&J vaccine.

Systemic symptoms from vaccination are similar to COVID-19 disease so patients receiving vaccine should be counseled on the possibility of these symptoms occurring in the first few days after each dose.

What data are available about the COVID-19 vaccine in transplant recipients?

Although transplant recipients were not enrolled in phase 3 studies of COVID-19 vaccines, multiple recent studies have assessed the safety and the response of mRNA-based vaccines in solid organ transplant (SOT) recipients. These studies did not show any unexpected short term local and systemic side effects of vaccine. However, overall, the studies have shown a lower antibody response to vaccine among SOT recipients when compared to the general population. Emerging studies have shown a detectable SARS-CoV-2 specific T-cells response in some patients, despite a lack of antibody response; therefore, SOT recipients might derive clinical benefit from the vaccine despite an absent antibody response. Studies to assess vaccine effectiveness,

particularly for protection against severe COVID-19 as a clinical end-point in SOT, are still lacking.

Can transplant patients receive the COVID-19 vaccine?

Although further data are needed, the opinion of experts is that transplant patients may receive any of the authorized COVID-19 vaccines. Experts believe that based on the mechanism of action of mRNA vaccines, there is no reason to suspect that adverse events will be any different than in the general population. Similarly, the adenovirus used in vector vaccines is non-replicative and therefore, such vaccines can be given to transplant recipients. Therefore, transplant recipients can receive any of the currently authorized vaccines available to them, assuming age requirements are met.

In summary, based on expert opinion, the potential benefits of vaccine likely outweigh the theoretical risks. All vaccines lead to a vaccine-specific immune response and the generation of alloimmunity or rejection following vaccination is unlikely based on the mechanisms of the vaccines, and the broad experience with other vaccines in the transplant population.

Should transplant patients receive a 3rd dose of vaccine?

Currently, there are no efficacy, immunogenicity, or safety data available to support vaccinating patients beyond the second dose. Trials are ongoing.

Can transplant patients receive a different type of vaccine for their second dose?

Persons who received a first dose of Oxford/AZ vaccine may receive either Oxford/AZ vaccine or an mRNA vaccine for their second dose.

For optimum vaccine efficacy, it is suggested that:

- When possible, vaccine should be administered in the pre-transplant setting, with the final dose at least 1 to 2 weeks prior to transplant
- It is not necessary to put a patient on hold for transplant while waiting for vaccination
- In post-transplant patients, wait at least 1 month after transplant to provide the vaccine, regardless of induction therapy.
- Ideally, the full 2-dose series (Pfizer, Moderna, Oxford/AZ) should be given at the recommended interval. If the patient undergoes transplantation between the first and second doses, provide the second dose at > 1 month after transplant. Additional doses are not recommended.
- Prolonging dosing interval beyond that studied in phase 3 trials is not recommended for transplant recipients since immunogenicity may be lower and wane more quickly.
- In patients undergoing active treatment for acute rejection, vaccination can be deferred for a 1-month period.
- Avoid giving vaccine for at least 3 months after rituximab for improved efficacy.

- If a patient has had COVID-19 before, it is prudent to wait until symptom resolution and the individual is no longer considered infectious, prior to giving COVID-19 vaccine.
- COVID-19 vaccines and other vaccines can be given on the same day, as well as co-administered within 14 days.
- Vaccine should not be given to patients that have had an anaphylactic reaction to a known component of the vaccine (i.e., polyethylene glycol in mRNA vaccines).
- Antibody testing is not recommended after vaccination. The levels of protective antibody and association with vaccine effectiveness are not known.
- Since efficacy is expected to be lower than the general population, it is strongly recommended that patients continue to practice infection control measures. In addition, household contacts of the transplant recipient should also be vaccinated when possible.

When will the vaccine be available for transplant patients?

In Canada, all adult SOT recipients have been eligible to receive COVID-19 vaccination since April 2021. The vaccine given may differ depending on the age of the transplant recipient. Some provinces are also extending the interval between doses to up to 4 months. One dose of a two-dose regimen is likely to have lower efficacy in transplant recipients compared to the general population. The durability of response to one dose of vaccine is also unclear. Therefore, where possible, transplant recipients should receive vaccine at the intervals that were studied in clinical trials rather than extended intervals.

What about pediatric transplant patients?

On May 5, 2021, Health Canada authorized the Pfizer-BioNTech COVID-19 vaccine for use in children 12 to 15 years of age. This vaccine has not yet been studied in children with transplants. Although further data are needed, the opinion of experts is that SOT children 12 to 15 years of age may receive the Pfizer vaccine. Data are lacking for children under 12 years of age including those with transplants; but once approved, we expect similar recommendations to apply to pediatric transplant recipients.

What are the national and international recommendations?

The CDC Advisory Committee on Immunization Practices (ACIP;U.S.) and the Joint Committee on Vaccination and Immunisation (JCVI; U.K.) has stated that vaccine can be given to the immunocompromised population when it becomes available. The JCVI has listed patients with a transplant as being a prioritized vulnerable population. The AST (American Society of Transplantation) and ISHLT (International Society for Heart and Lung Transplantation) have also recommended COVID-19 vaccine to be given to transplant patients when available. Health Canada and FDA have not contraindicated the vaccine for immunocompromised, although they've stated that there are no data on efficacy and adverse events in this population.

The National Advisory Committee on Immunization in Canada has updated its recommendations and stated that complete two-dose vaccine series with an mRNA

COVID-19 vaccine should be offered to individuals in authorized age groups, including those who are immunosuppressed. Efficacy may be lower in the immunosuppressed state so immunocompromised patients should continue to practice infection control measures against COVID-19 until further notice.

Summary

Given that: (a) COVID-19 can cause serious illness in a transplant recipient, (b) transplant recipients often have comorbidities, (c) the mechanism of action of vaccine is specific, and (d) transplantation is not a contraindication to COVID-19 vaccine according to Health Canada, we recommend that vaccine may be given to the pre- and post-transplant patient population when it is available to them. Based on expert opinion, we recommend that the potential benefits of vaccine outweigh any theoretical risks or concerns about immunogenicity. Due to the severity of COVID-19 in this population, we also recommend that transplant patients be prioritized for vaccination. Transplant patients should be made aware that they may not have adequate protection from vaccine alone and advised to continue infection control measures. In addition, household contacts of the transplant recipient should be vaccinated when possible.

Disclaimer

The guidance provided is not meant to replace clinical judgement. The field is also rapidly evolving and as such the guidance will likely change over time. Any clinical decisions should be made in consideration of the latest available information.

Endorsement

These guidelines were written by Dr. Deepali Kumar and Dr. Atul Humar, updated by the Canadian Society of Transplantation's Transplant Infectious Diseases Group, and endorsed by the Canadian Society of Transplantation.

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