

This information leaflet is for use in conjunction with the recent advice issued by the Joint Committee for Vaccination and Immunisation (JCVI) about the identification of patients who are severely immunosuppressed, and as such, may benefit from a third primary vaccine dose to mount an adequate immune response to COVID infection. [**N.B.** A third primary dose is an extra 'top-up' dose for those who may not have generated a full immune response to the first 2 doses. In contrast, a booster dose is a later dose to extend the duration of protection from the primary course of vaccinations.]

It should be read in conjunction with guidance issued by the RCP and the letter circulated to primary and secondary care providers which contains Annexes A, B, C. [**N.B.** see the BAD website for the links]

The JCVI has issued a [statement based on their independent report](#).

What does this mean for our dermatology patients?

As dermatologists we will be asked to identify those patients who are considered at risk of mounting a sub-optimal immune response to COVID vaccines after two primary doses, and as such, would benefit from a third dose. These patients can be identified using the JCVI guidance.

Any decision on the third primary dose, however, will be at the discretion of the clinician. Importantly though, patients should not self-select.

Which patients are eligible for a third primary dose in dermatology?

At this stage, pending further data about the impact of specific disease, patients who might benefit from a third vaccine include any patient aged 12 years and above:

1. with an underlying diagnosis or predisposition as specified on the JCVI list (letter to Trusts; Annex A).
2. on systemic immunosuppression agents, either conventional systemic or biological therapies at the time or within 2 weeks of their primary vaccination
3. deemed severely immunosuppressed at the discretion of their clinician.

How will these patients be identified?

Most of these patients will be part of the [vulnerable or clinically extremely vulnerable groups](#) identified last year and your Trusts may have these patients on databases. [**N.B.** Although the immunosuppressants' grid refers to patients requiring shielding during the pandemic, it is important to note that this is not the case in the context of the third primary vaccination dose]

Additional patients will need identifying if these databases have not been kept up to date.

Next steps

It is likely that your Trust will contact you, if not already, to identify these patients as soon as possible.

When a patient has been identified the Trust will contact their GP advising them that their consultant has identified these patients as eligible for a third primary dose (letter to Trusts; Annex C); the template asks for the justification for this decision.

Their GP will then contact the patient (letter to Trusts; Annex B).

Timing and type of vaccine

The timelines for completion of the identification of patients are not explicit but are indicated as 'as soon as possible' and 'by the end of September'.

The time period during which a patient should be offered the third primary dose is awaited. The third primary dose is advised at least 8 weeks after the second dose.

Ideally, the third primary dose should be given during periods of minimal immunosuppression. Some immune-modulation strategies lend themselves to planned vaccination (e.g. rituximab or infliximab, where vaccination is best timed at 2-3 weeks before the next infusion cycle). For many patients on long-term and stable immunosuppression, the timing of vaccination is less important. In instances where interruption of immunosuppression is both feasible and without risk of destabilising the underlying disease, the JCVI suggests that the ideal timing is 2 weeks after the period of immunosuppression, in addition to the time period for clearance of the therapeutic agent.

In general, patients are to be offered one of the mRNA vaccines for their third primary dose with the option of the Oxford/AstraZeneca vaccine for those who have received this previously.

In summary, by the end of September we need to:

1. Identify and come to a decision on which patients aged 12 and upwards who should be offered the third primary vaccination dose and inform the COVID lead at the Trust.
2. Remember patient selection is at the discretion of the clinician making the decision and patients must not self-select.
3. Some of these patients will have previously been identified as clinically vulnerable so use the table in the BAD's immunosuppressant therapies grid to guide your decision.