

Suggested intervals between administration of immune globulin preparations and measles- or varicella-containing vaccine

Product / Indication	Dose, including mg immunoglobulin G (IgG)/kg body weight	Recommended interval before measles or varicella-containing vaccine administration ¹
RSV monoclonal antibody (Synagis™) ²	15 mg/kg intramuscularly (IM)	None
Tetanus IG (TIG)	250 units (10 mg IgG/kg) IM	3 months
Hepatitis A IG		
Contact prophylaxis	0.02 mL/kg (3.3 mg IgG/kg) IM	3 months
International travel	0.06 mL/kg (10 mg IgG/kg) IM	3 months
Hepatitis B IG (HBIG)	0.06 mL/kg (10 mg IgG/kg) IM	3 months
Rabies IG (RIG)	20 IU/kg (22 mg IgG/kg) IM	4 months
Measles prophylaxis IG		
Standard (i.e., nonimmunocompromised) contact	0.25 mL/kg (40 mg IgG/kg) IM	5 months
Immunocompromised contact	0.50 mL/kg (80 mg IgG/kg) IM	6 months
Blood transfusion		
Red blood cells (RBCs), washed	10 mL/kg negligible IgG/kg intravenously (IV)	None
RBCs, adenine-saline added	10 mL/kg (10 mg IgG/kg) IV	3 months
Packed RBCs (Hct 65%) ³	10 mL/kg (60 mg IgG/kg) IV	6 months
Whole blood (Hct 35%-50%) ³	10 mL/kg (80-100 mg IgG/kg) IV	6 months
Plasma/platelet products	10 mL/kg (160 mg IgG/kg) IV	7 months
Cytomegalovirus intravenous immune globulin (IGIV)	150 mg/kg maximum	6 months
IGIV		
Replacement therapy for immune deficiencies ⁴	300-400 mg/kg IV ³	8 months
Immune thrombocytopenic purpura	400 mg/kg IV	8 months
Immune thrombocytopenic purpura	1000 mg/kg IV	10 months
Postexposure varicella prophylaxis ⁵	400 mg/kg IV	8 months
Kawasaki disease	2 g/kg IV	11 months

This table is not intended for determining the correct indications and dosages for using antibody-containing products. Unvaccinated persons might not be fully protected against measles during the entire recommended interval, and additional doses of immune globulin or measles vaccine might be indicated after measles exposure. Concentrations of measles antibody in an immune globulin preparation can vary by manufacturer's lot. Rates of antibody clearance after receipt of an immune globulin preparation also might vary. Recommended intervals are extrapolated from an estimated half-life of 30 days for passively acquired antibody and an observed interference with the immune response to measles vaccine for 5 months after a dose of 80 mg IgG/kg.

1 "Varicella-containing vaccine," as used here, does not include zoster vaccine. Zoster vaccine may be given with antibody-containing blood products.

2 Contains antibody only to respiratory syncytial virus.

3 Assumes a serum IgG concentration of 16 mg/mL.

4 Measles and varicella vaccinations are recommended for children with asymptomatic or mildly symptomatic human immunodeficiency virus (HIV) infection but are contraindicated for persons with severe immunosuppression from HIV or any other immunosuppressive disorder.

5 The investigational product VariZIG, similar to licensed VZIG, is a purified human immune globulin preparation made from plasma containing high levels of anti-varicella antibodies (immunoglobulin class G [IgG]). When indicated, health-care providers should make every effort to obtain and administer VariZIG. In situations in which administration of VariZIG does not appear possible within 96 hours of exposure, administration of immune globulin intravenous (IGIV) should be considered as an alternative. IGIV also should be administered within 96 hours of exposure. Although licensed IGIV preparations are known to contain anti-varicella antibody titers, the titer of any specific lot of IGIV that might be available is uncertain because IGIV is not routinely tested for antiviral antibodies. The recommended IGIV dose for postexposure prophylaxis of varicella is 400 mg/kg, administered once. For a pregnant woman who cannot receive VariZIG within 96 hours of exposure, clinicians can choose either to administer IGIV or closely monitor the woman for signs and symptoms of varicella and institute treatment with acyclovir if illness occurs. (CDC. A new product for postexposure prophylaxis available under an investigational new drug application expanded access protocol. *MMWR* 2006;55:209-10.)