Table 1: Clinician Demographics

ID Fellowship	
Currently in ID fellowship	7 (10%)
Completed ID fellowship	50 (75%)

Post Graduate Year	
PGY1-5	10 (15%)
PGY 6-10	16 (24%)
PGY ≥ 11	36 (54%)

Number of patients living with HIV seen per month	
0	2 (3%)
1-10	16 (24%)
11-20	12 (18%)
>20	37 (55%)

Practice Type	
Academic	49 (73%)
Private Practice	6 (9%)
Federally Qualified Health Center	6 (9%)
Other	8 (12%)

Practice Location	
California	23 (34%)
New York	6 (9%)
Maryland	4 (6%)
Other	34 (51%)

Table 2: HBV Vaccination Practices of Physicians Caring for People Living with HIV

Preferred timing of HBV vaccination in a patient newly diagnosed with HIV starting ART	
Vaccinate immediately	53 (79%)
Postpone vaccination until HIV VL is suppressed	12 (18%)
Defer vaccination since the patient is on ART	1 (1%)
Other	1 (1%)

Preferred initial HBV vaccination series for susceptible individuals living with HIV	
Energix-B or Recombivax HB	18 (27%)
Heplisav-B	29 (44%)
Any of the above	19 (29%)

Preferred dose & schedule if using Engerix-B or Recombivax HB for initial vaccine series	
Standard dose at 0, 1, and 6 months	56 (90%)
Double dose at 0, 1, and 6 months	6 (10%)
Standard or double dose at 0, 1, 2, and 6 months	0 (0%)

Preferred intervention if patient does not seroconvert after first vaccination series	
No further intervention	3 (5%)
Repeat with Engerix-B or Recombivax-HB at standard dose at 0, 1, and 6 months	14 (23%)
Repeat with Engerix-B or Recombivax-HB at double dose at 0, 1, and 6 months	15 (24%)
Repeat with Engerix-B or Recombivax-HB at standard dose at 0, 1, 2, and 6 months	2 (3%)
Repeat with Engerix-B or Recombivax-HB at double dose at 0, 1, 2, and 6 months	0 (0%)
Repeat with Heplisav-B	28 (45%)

Preferred hepatitis B immunity monitoring after successful vaccination with seroconversion	
No further monitoring	52 (84%)
Check HBsAb yearly, and repeat series if titer drops below 10mIU/mL	10 (16%)

Preferred management of isolated positive hepatitis B core antibody	
No further intervention	16 (24%)
Initiate hepatitis B vaccination series	17 (25%)
Give a single dose of Engerix-B or Recombivax HB with HBsAb titer check 1 month later	6 (9%)
Check HBV DNA level	28 (42%)

Conclusion: This study provides insight into current HBV vaccination and monitoring practices of physicians who care for patients with HIV. The results revealed varied practice preferences and opportunities for improvement through standardization. Additional research is needed to elucidate the impact these various practices have on patient outcomes and healthcare expenditure.

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28. Immunogenicity of rVSVΔG-ZEBOV-GP Ebola Vaccine (ERVEBO™) in Participants by Age, Sex, and Baseline GP-ELISA Titer: A Post Hoc Analysis of Three Phase 2/3 Trials

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Session: P-2. Adult Vaccines

Background: The recent Ebola virus disease (EVD) outbreak in the Democratic Republic of the Congo highlights the sustained threat of EVD morbidity and mortality where healthcare and vaccine delivery are challenging. ERVEBO®, a live recombinant vesicular stomatitis virus (VSV) vaccine containing the *Zaire ebolavirus* glycoprotein (GP) in place of the VSV GP (rVSVΔG-ZEBOV-GP), was developed by Merck & Co., Inc., Kenilworth, NJ, USA in collaboration with multiple partners to prevent EVD and has been approved for human use in several countries.

Methods: We pooled data from three Phase 2/3 clinical trials conducted in Guinea (FLW), Sierra Leone (STRIVE), and Liberia (PREVAIL) during the 2013–2016 West African outbreak to assess immune responses using a validated assay in each of the three studies and performed a *post hoc* analysis by sex, age (18–50 yrs & >50 yrs) and baseline (BL) GP-enzyme-linked immunosorbent assay (ELISA) titer (< 200 & ≥200 EU/ml). The full analysis set (FAS) population included the primary immunogenicity populations (all vaccinated participants with serology data collected within an acceptable day range) from all three trials. The endpoints were total IgG antibody response (EU/mL) measured by the GP-ELISA and neutralizing antibody response measured by the plaque reduction neutralization test (PRNT) to rVSVΔG-ZEBOV-GP at Days 14, 28, 180, and 365 postvaccination.

Results: In the overall population and in all subgroups, GP-ELISA and PRNT geometric mean titers increased from BL, with most peaking at Day 28 and persisting through Day 365. There were differences between males and females and between participants with BL GP-ELISA < 200 & ≥200 EU/ml. There did not appear to be a difference between age groups.

Conclusion: These data demonstrate that rVSVΔG-ZEBOV-GP elicits a robust and durable immune response up to 12 months in participants regardless of age, sex, or BL GP-ELISA titer. The higher immune responses observed in females and participants with preexisting immunity are consistent with those described in published literature for other vaccines.

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29. Impact of Enhanced Influenza Vaccines on Direct Healthcare Costs for the U.S. Elderly: A Comprehensive Real-World Evaluation of Adjuvanted Trivalent Influenza Vaccine Compared to Trivalent High-Dose Influenza Vaccine for the 2018–19 Influenza Season

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Session: P-2. Adult Vaccines

Background: Influenza generates a substantial economic burden ($3.2B in the U.S. annually) due to direct medical costs such as physician office visits or hospitalizations, especially among the elderly. Recent published literature for the 2018–19 influenza season has demonstrated similar clinical effectiveness between adjuvanted trivalent influenza vaccine (aTIV) and trivalent high dose influenza vaccine (TIV-HD). This research aimed to assess the annualized mean all-cause and influenza-related healthcare costs among subjects 65+ years vaccinated with aTIV or TIV-HD during the 2018–19 influenza season.

Methods: A retrospective cohort analysis was conducted using professional fee, prescription claims and hospital charge master data in the U.S. Baseline characteristics included age, gender, payer type, region, Charlson Comorbidity Index, comorbidities, indicators of frail health status, and pre-index hospitalization rates. Treatment selection bias was adjusted through 1:1 propensity score matching (PSM). Economic outcomes included annualized mean all-cause costs and influenza-related costs, which comprised influenza-related hospitalizations, emergency room (ER) visits, and physician office visits costs. Mean costs were compared using paired t-test. Adjusted analyses were conducted using generalized estimating equation (GEE) models, with two-part models for influenza-related costs. With the GEEs, adjustment for outliers