Mpox in the United States – Frequently Asked Questions

September 2024

This resource was developed in response to health care provider questions regarding clade I and clade II mpox. The information is compiled from resources available from the Centers for Diseases Control and Prevention, the National Institutes of Health and the Health Resources and Servies Administration. Also see CDC's Aug. 7, 2024, Health Alert Network *update and IDSA's resource page (Mpox: What You Need to Know*).

EPIDEMIOLOGY

Why did the World Health Organize Declare a public health emergency of international concern?

Due to a significant increase in clade I mpox cases that had started to spread to multiple African countries, WHO declared a public health emergency of international concern in August 2024.

Clade I mpox is generally thought to cause more serious illness and death and historically has caused more severe illness and death in Central Africa, where previous outbreaks have occurred. According to a May 16, 2024, CDC *MMWR* article, the clade I mpox fatality rate in the current outbreak in the Democratic Republic of Congo ranges from 1.4% to >10% compared with a clade II fatality rate of 0.1% to 3.6%. While it is challenging to compare across populations, in a recent study in the DRC, clade I — when managed with optimal supportive care — had a 1.67% mortality rate.

Clades I and II are both transmitted through close personal contact.

What is the status of mpox in the United States?

While mpox cases in the U.S. have declined significantly since the 2022 to 2023 outbreak, approximately 200 cases of clade II still occur each month, including some resulting in serious illness.

For people with HIV, what are the risks of clade I versus clade II mpox?

People with HIV who are not virally suppressed are at an increased likelihood for serious illness and death from both clade I and clade II mpox. It is recommended that people with untreated HIV who are diagnosed with mpox initiate HIV treatment as soon as possible.

VACCINATION

Is the JYNNEOS vaccine effective against clade I mpox?

The JYNNEOS vaccine is likely to be effective against clade I mpox. According to CDC, only one in four of the approximately 2 million people recommended to receive the vaccine in the U.S. have received the recommended two doses of the JYNNEOS vaccine. Patients at increased likelihood for mpox should be encouraged to get fully vaccinated for the highest protection against acquiring mpox and experiencing serious illness from mpox. See CDC's website: *Risk of Clade 1 Mpox Outbreaks Among Gay, Bisexual and Other Men Who Have Sex With Men in the United States* (July 4, 2024).

Who should be vaccinated for mpox?

The Advisory Committee on Immunization Practices and CDC recommend that people at increased likelihood of mpox exposure get vaccinated. JYNNEOS is the primary vaccine used in the U.S. Vaccination is not recommended for people who have recovered from clade I or II mpox.

Individuals at increased likelihood of exposure include those who:

- Have had a known or suspected exposure to someone with mpox;
- Have had a sex partner in the past 2 weeks who was diagnosed with mpox;
- Are a gay, bisexual, or other man who has had sex with men or a transgender, nonbinary or gender diverse person who in the past 6 months have been diagnosed with one or more sexually transmitted infections or had more than one sex partner;
- In the past 6 months have had sex at a commercial sex venue or sex related to a large commercial event or geographic area where mpox transmission is occurring;
- Anticipate experiencing any of the above.

Should patients who have completed the two-dose JYNNEOS vaccine series receive a booster dose?

A booster dose is not recommended for people who have been fully vaccinated.

Individuals who are at increased likelihood of mpox who have only received one dose should be counseled and encouraged to receive a second vaccine dose to have the highest level of protection against mpox clades I and II. Individuals who have already received one dose of JYNNEOS only need to receive one additional dose. They **do not** need to restart the vaccine series.

Should health care providers get vaccinated?

CDC does **not** recommend mpox vaccination for general health care workers.

CDC recommends the following health care personnel at increased likelihood of occupational exposure get vaccinated: research laboratory personnel working with orthopoxviruses, clinical laboratory personnel performing diagnostic testing for orthopoxviruses, and orthopoxvirus and health care worker response teams designated by appropriate public health and antiterror authorities.

Now that JYNNEOS is sold commercially, how do clinics and providers access it?

Mpox vaccination should be covered by state Medicaid programs and Medicare and by most private health insurers for individuals who are risk of acquiring mpox.

Ryan White HIV/AIDS Program and Community Health Center funds may be used to purchase mpox vaccines and to cover administration fees. For uninsured patients, also check with your state and local health departments to see if they still have mpox vaccines available. Please email HIVMA if you have trouble purchasing the vaccine or your patients have trouble accessing it.

TESTING

Who should be tested for mpox?

Mpox should be suspected in a person with a new characteristic rash (deep-seated vesicular or pustular lesions that are well circumscribed and umbilicated) and one of the following exposures within the past 21 days:

- Contact with someone with a similar appearing rash OR a diagnosis of confirmed or probable mpox;
- Close contact with people in a social network experiencing mpox activity (e.g., men who have sex with men who meet partners through online websites, apps or social events);
- Travel outside the U.S. to a country with confirmed cases of mpox or where mpox virus is endemic;
- Contact with a dead or live wild animal or exotic pet that is an African endemic species or used a product (e.g., game meat, creams) derived from such animals.

CDC recommends that clinicians consider mpox and test patients who have lesions consistent with mpox even if another etiology may be considered, such as herpes simplex virus or syphilis. See CDC's website (Mpox Information for Healthcare Professionals).

How do I access mpox tests?

PCR tests for diagnosing mpox are available through local, state, territorial or tribal health departments and many large commercial labs. Results are typically available within 2 to 4 days. See CDC – mpox testing. Clinicians should collect two swabs from each lesion (two to three lesions total) in case additional clade-specific testing is needed.

Will the PCR tests pick up clade I?

Clade-specific testing is available in some but not all laboratories. The non-variola orthopox (NVO) PCR test that is widely used is expected to be positive for both cla,de I or II. CDC recommends that clinicians notify their state health department and pursue clade-specific testing if they have a patient with mpox-like symptoms who has traveled to Africa, Europe or another country where cases have been reported within the past 21 days or have a test that is NVO positive and clade II negative. See CDC's website (Clinical Testing).

TREATMENT

What treatments are available?

According to CDC, for people with mpox who are not immunocompromised and do not have a skin disease, supportive care and pain control will help them recover without medical treatment.

For people who are immunocompromised and have serious skin conditions such as eczema, mpox can be life-threatening. See CDC's interim guidance for treatment considerations and the mpox sections of the Guidelines for Prevention and Treatment of Opportunistic Infections in Adults and Adolescents With HIV and for Children With and Exposed to HIV.

TPOXX (tecovirimat) is an antiviral available for treatment of patients with mpox primarily through the National Institutes of Health's Study of Tecovirimat for Mpox (STOMP) study. For patients with severe

disease who meet the eligibility criteria, TPOXX may be available through CDC's expanded access EA-IND protocol.

Is TPOXX still recommended for patients with severe disease or at risk for severe disease?

TPOXX is still being evaluated for treating clade II mpox and is primarily available through the STOMP study. Patients **do not** have to have severe disease or be at high risk for severe disease to enroll in STOMP. See CDC's website (Tecovirimat [TPOXX] for Treatment of Mpox) for more information.

A trial conducted in DRC found that tecovirimat was safe but did not reduce the duration of mpox lesions among children and adults with clade I mpox, based on an initial analysis of data from a randomized, placebo-controlled trial. **However, that study mainly enrolled children with the type of mpox virus (clade I) that differs from the type of mpox virus common in the U.S. and Europe (clade II). It remains an open question whether tecovirimat is beneficial in adults with clade II mpox, which is why the STOMP trial addressing this question is continuing.**

How can I access TPOXX for patients in the United States?

Patients or providers can contact the STOMP trial by calling 855-876-9997.

For patients ineligible for STOMP who meet treatment eligibility, TPOXX may be available through CDC's EA-IND protocol.

Providers can contact their state health departments to request a clinical consultation with CDC regarding management of hospitalized patients with mpox.

ACKNOWLEDGEMENTS

Thank you to the following IDSA and HIVMA members for their assistance with this FAQ: Jason Zucker, MD, Columbia University; Joseph Cherabie, MD, MSc, Washington University in St. Louis; Sarah Lim, MBBCh, Minnesota Department of Public Health; Josh Barocas, MD, University of Colorado; Rajesh Gandhi, MD, FIDSA, Massachusetts General Hospital; Julie Vaishampayan, MD, MPH, FIDSA, Stanislaus Health Service Agency; Allison Agwu, MD, ScM, Johns Hopkins University, FIDSA; and Anna Person, MD, FIDSA, Vanderbilt University.