INFECTION PREVENTION: MPOX (MONKEYPOX) GUIDELINE

Target audience

All staff at Alfred Health and Monash Health Women's @ Sandringham Hospital.

Purpose

- To provide guidance to healthcare workers (HCWs) in the identification and management of patients with suspected or confirmed Mpox (monkeypox) virus infection, and to prevent transmission of the virus to others.
- To provide guidance for the management of patients and staff who have received Mpox (monkeypox) vaccination.

For the purposes of this guideline, Mpox and monkeypox are synonymous. Hereafter, this guideline will refer to **Mpox** in accordance with World Health Organisation recommendations.

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Summary

Clinical features
- Prodromal symptoms: Flu-like symptoms, lymphadenopathy
- Rash (maculopapular, vesicular, pustular - may be present in various stages of development); may affect entire body and/or be concentrated on genital or anal region.
- Other common presentations include severe oral or anorectal pain

Infectious period
- From first symptom onset until all scabs have dried and fallen off, and fresh skin has formed underneath.
- Typically 2-4 weeks.

Transmiss-ion
- Droplet and contact (direct and indirect including fomites)
- Low risk of airborne transmission during aerosol generating procedures and activities

PPE
- **Modified airborne & contact precautions recommended**
- N95 mask, protective eyewear, gown, gloves

Placement
- Barrier airflow room recommended for suspected/confirmed mpox and for high & medium risk contacts.
- Single room with dedicated bathroom is appropriate if barrier airflow room not available.
- Must have dedicated bathroom/commode

Specimen
- For inpatients, order 'Monkeypox PCR' in EMR; for outpatients, complete paper-based pathology request
- Dry swabs of rash (preferred) +/- biopsy or scabs in specimen container +/- nasopharyngeal, throat or anorectal swabs based on symptoms and exposure history
- DO NOT send specimens via pneumatic chute

Linen
- Must not be shaken or excessively handled
- Must go into a yellow biohazard plastic bag prior to being placed in a linen skip

Waste
- All waste from the patient's room to be discarded as clinical waste.
- Bins handles, lid to be wiped over with Clinell wipes prior to transport

Exposures
- High risk and medium risk contacts of mpox to be isolated in single room/dedicated bathroom up to 21 days.
- Low risk contacts to be monitored only (isolation not required, but avoid placement on 5E/7E).

GUIDELINE

1. Clinical features and background

Background (epidemiology)	Mpox is endemic to Central and West Africa, and until recently cases were rarely reported outside of these regions. A global outbreak of clade IIb began in 2022 and continues to this day, including in some African countries. There are also growing outbreaks of clades Ia and Ib affecting the Democratic Republic of the Congo and other countries in Africa. As of August 2024, clade Ib has also been detected beyond Africa. These outbreaks have disproportionately affected men who have sex with men, however anyone who has had prolonged contact with a person who has Mpox infection may be at risk.
Causative agent	Mpox virus, previously referred to as monkeypox virus (MPXV). There are two distinct clades of the virus: clade I (with subclades Ia and Ib) and clade II (with subclades IIa and IIb).
Incubation period	The time from exposure to Mpox, to the development of first symptoms, is typically 7-14 days (but may range 5-21 days). The incubation period tends to be shorter following invasive exposure (e.g. via broken skin or mucous membranes).[1]
Clinical presentation	Mpox is usually a self-limiting disease with symptoms resolving within 2-4 weeks, though severe illness may occur. Clinical presentation may commence with a prodromal phase which includes flu-like symptoms (fever, chills, headache, backache, myalgia, lethargy, sore throat) and/or lymphadenopathy (present in around half of cases). Not all cases experience prodromal symptoms. A maculopapular rash typically develops 1-5 days after fever onset, and may be generalised, localised, discrete or confluent. Classic cases present with a centrifugal rash that is concentrated on the face and extremities; however in the current outbreak, many cases experience a mild localised rash with 5 lesions or less, with the rash often concentrated in the genital or perianal area. The rash tends to present as flat lesions before becoming raised, vesicular (filled with clear fluid) then pustular (filled with yellow fluid). The lesions typically crust over or scab around 14-21 days later. [1] Other symptoms may include pain on urination (urethritis), or rectal pain – which may be severe, bloody stools and/or diarrhoea (proctitis). Atypical presentations may occur in people fully or partially vaccinated against Mpox, and may be less severe. These presentations are increasing. Children and immunosuppressed individuals are at higher risk of severe disease or complications such as secondary infections, pneumonia, sepsis, encephalitis, corneal infections and visual loss. Severity of infection may also be influenced by the route of exposure and the strain (clade), with Clade I (formerly referred to as the Congo Basin strain) associated with more severe disease than Clade II (the West African strain). [1]
Infectious period	From onset of first symptom, until all lesions have crusted, scabs have fallen off and a fresh layer of skin has formed underneath.[2]
Transmission	Direct contact with someone who has Mpox is the key route of transmission, and includes:

	• Transmission via broken skin or mucous membranes; • Contact with skin lesions of the infected person; • Direct prolonged contact, especially sexual/intimate contact. Droplet transmission may also occur during prolonged face to face contact, or during aerosol-generating procedures. Other potential routes of transmission include fomites (surfaces contaminated with the virus), transmission via exposure to blood/semen/vaginal fluids (limited evidence), and vertical transmission during birth.[1,3,4]
Diagnosis	Diagnosis is via PCR - see testing and specimen handling below.
Notification requirements	Mpox is an urgent notifiable condition.[2] **Patients suspected to have Mpox who require testing by PCR swab should be notified by the treating clinician to:** • **the Victorian Department of Health on 1300 651 160** (the clinician will be asked for the patient's residential postcode and automatically connected to the relevant local public health unit (LPHU) to assist with management and follow up) • **the ID registrar or consultant on call.** The ID Consultant will notify Infection Prevention & Operations during business hours.
Treatment	Supportive therapy may include intravenous fluids, symptom management and antibiotics for secondary infections. See the Monkeypox Treatment Guideline for more information. Antiviral treatments may be considered in severe or high-risk cases, in discussion with ID. Information about these treatments can be found in the Australian Human Monkeypox Treatment Guidelines and the Tecovirimat Guideline. Access Tecovirimat via National Medical Stockpile (NMS).
Decision to admit	Please refer to the Monkeypox Treatment Guideline regarding the clinical indications for admission.
Patient information	Information sheets which have undergone consumer review are available on the Alfred Health Patient Information portal, and on the Victorian Department of Health's Better Health Channel.[5]

2. Case definitions

Confirmed Mpox	Laboratory-confirmed diagnosis of Mpox virus.
Suspected Mpox[6]	Patient with vesicular or pustular rash on any part of the body (may include the genital/perianal region and features of proctitis) *or* generalised rash concentrated on face/extremities, *with or without* compatible symptoms such as lymphadenopathy, fever (>38ºC), headache, myalgia, arthralgia, back pain or fatigue) **AND** Epidemiological risk for Mpox (any of the following): • Sexual or physically intimate contact with a man who has had sex with men in the past 21 days; • Known or likely exposure to a person with confirmed or probable Mpox in the past 21 days; • International travel in past 21 days;

	• Intimate contact with individuals at social events associated with Mpox activity in the past 21 days before symptom onset.
Close contact of Mpox[1]	The risk from exposure to Mpox will depend on the nature of contact, length of time, and whether clothing or PPE was worn. The period of risk is up to 21 days from the last exposure. **High risk contacts** are those who have had prolonged or direct exposure to infectious body fluids or particles from someone with Mpox. This includes all household contacts, and people who have had direct contact (or exposure to highly contaminated materials such as bed linen) via broken skin or mucous membranes. Examples include: • Living with, sleeping in same bed with, or sexual/intimate contact (including kissing on the mouth) with someone who has Mpox; • Providing care to someone with Mpox, or receiving care from someone who has Mpox, where the exposed person has broken skin or mucous membrane exposure. • Splash to mucus membrane (e.g. eyes) or needlestick injury with body fluids from a patient with Mpox. **Medium risk contacts** have had direct or indirect contact with a Mpox case or their linen/clothing, but the exposure is intermittent, distanced, and/or involves intact skin. Examples include: • Healthcare workers not wearing appropriate PPE during routine care of a patient with Mpox or management of their bed linens; • Healthcare workers not wearing appropriate PPE and other patients in the shared room during aerosol generating procedures on a patient with Mpox; **Low risk contacts** are those who have had indirect contact with a Mpox case in a crowded or enclosed setting. Brief non-physical contact with a person who has Mpox, or healthcare workers wearing the required PPE when caring for a patient with Mpox, are **not** considered contacts of Mpox. Further information can be found in the Exposure Management table below.

3. Testing and specimen handling for suspected cases

Authorisation for testing	Approval is not required for samples requiring Mpox PCR testing, but if ordered, must be notified to the Department of Health in accordance with the Notifiable Infectious Diseases, Medical Conditions and Micro-Organisms Guideline. Testing is performed at VIDRL on a daily basis (Mon-Fri). Testing is not routinely performed on weekends. Test results are typically available the next weekday. If **urgent** testing of a patient with suspected Mpox is required, the Microbiology registrar or consultant **must** be contacted to discuss the case and facilitate out-of-hours courier, and testing at VIDRL. Cases may require additional approval from VIDRL and/or Victorian Department of Health. **MSHC** should contact VIDRL directly to discuss specimen requirements and transport.

Ordering specimens	For inpatients, order **Monkeypox Virus PCR** in the electronic medical record. Where multiple specimens will be requested, select **Monkeypox Virus PCR (multiple)**. For outpatients, a paper request form must be completed with details of the location of swabs collected and any other comments. MSHC should follow locally established protocols. Collector certification must be completed in the request form and specimens. Other investigations must be ordered (and collected) **separately**.
Recommended specimens for diagnosis	Collect samples of the rash • Sampling of several lesions (with different appearances from several body locations) is recommended. • Visible material should be seen on the swab. Vesicles or pustules may need to be de-roofed with the tip of a needle to sample the fluid inside; if no fluid is present, vigorously swab the base of the ulcer. • **Dry swabs are preferred.** If not available, VTM or UTM swabs may be used. **DO NOT use e-swabs.** • Lesion tissue (e.g. biopsies) or scabs from lesions are also acceptable and should be placed into a specimen/urine container (do not add formalin). Testing of Nasopharyngeal Swabs, serum or EDTA whole blood is not routinely required, however a throat swab should be collected if oral symptoms are present. Note: Collect **separate swabs** for other investigations e.g. Herpes PCR
Collection of samples	Samples should be collected by staff wearing modified airborne and contact PPE.
Specimen handling and transport	Diagnostic samples for Mpox must be placed into a specimen bag, sealed, and wiped over with Clinell Universal wipes. Ensure tube caps are secured to prevent leakage of any sample. Walk the specimen to the lab immediately **(do not use pneumatic chute)** and verbally handover sample to a laboratory staff member. Samples being sent from an external site, e.g. Sandringham, must be placed into a further specimen bag before being placed into an esky. Samples with approval for urgent testing should be sent to Alfred Pathology urgently by separate courier, ensuring the Microbiology laboratory is notified of the courier details including the job number. **MSHC** should follow direct advice from VIDRL about specimen handling/transport. The above samples from patients with suspected Mpox are designated Category A infectious substance, categorised under UN2814 “infectious substance affecting humans,” and shipped by the laboratory with appropriate packing and labelling during sample transportation. All other routine specimens (e.g. urine, blood): Wipe outside of specimen bag with Clinell Universal wipes, then can be handled with standard precautions including use of chute.
Results	Testing is performed Monday to Friday. Results are available on the **following weekday**. If urgent testing is required, please refer to “Approval for Testing” section above.

	Confirmed Mpox results must be notified by the lab to Infection Prevention and the Infectious Diseases Registrar or Consultant on call. Results will be uploaded to PowerChart. It is the responsibility of the treating medical team to notify the patient of their result.

4. Infection Prevention recommendations – suspected or confirmed Mpox

Isolation precautions required	**Modified Airborne and Contact Precautions, with door closed.** Appropriate signage must be displayed on the outside of the room. An isolation order must be made in the electronic medical record.
Patient placement	**Inpatients, and patients presenting to Alfred E&TC or Sandringham Emergency, with highly suspected or confirmed Mpox:** • A single barrier airflow room is recommended; Refer to the Use of Negative Pressure and Barrier Airflow Rooms Guideline for more information about barrier airflow rooms and decision support regarding patient placement. • If a barrier airflow room is not available, or where clinical suspicion is low, a single room with closed door and ensuite/dedicated commode is suitable (noting that airborne transmission risk is relatively low for Mpox). • Do not delay care of patients whilst awaiting the preferred type of room/bed. • For **inpatients**, placement is always recommended in a low-risk ward (i.e. patients not to be admitted to, or remain on, high risk wards such as 7E and 5E). • Patients with suspected or confirmed Mpox at Sandringham or Caulfield should be transferred to The Alfred at the earliest opportunity. • Cohorting of inpatients with confirmed or suspected Mpox is not recommended; discuss with Infection Prevention. Do not place patients with suspected or confirmed Mpox in positive pressure rooms. **Outpatients:** Telehealth, deferral, or home visits should be considered for a patient with suspected or confirmed Mpox. Where the patient needs to attend in person, the patient must wear a mask (N95 preferred, otherwise surgical) and be taken directly to a single room with closed door and managed in modified airborne and contact precautions (remove linen from room prior to patient attending, if possible). Ensure the patient does not spend time in waiting areas and coordinate the visit to minimise movement to different areas of the hospital (e.g. for prescriptions, other appointments). Ensure isolation clean completed once the patient leaves.
Personal Protective Equipment (PPE)	N95 mask; protective eyewear; gowns, gloves. Staff must be wearing an N95 mask for which they passed a fit test, and ensure a fit check is carried out with each application.
Aerosol generating procedures and activities	**Aerosol generating procedures (AGPs)** include tracheal intubation/extubation, non-invasive ventilation, advanced airway management during CPR, manual ventilation before intubation, disconnection of the ventilator circuit, bronchoscopy, high flow nasal oxygen, open airway suctioning, sputum induction, nebulisation, and specific respiratory and upper digestive procedures

	utilising high speed devices (e.g. drills) and endoscopy of the respiratory or upper digestive tract. Modified airborne and contact precautions must be utilised during AGPs and for 30 minutes post (including where the patient has left the room). AGPs should only be carried out when essential (defer or find alternative methods where clinically appropriate to do so). Additional **aerosol generating activities** from skin lesions or the resuspension of dried exudates from a patient with Mpox include shaking/fanning of soiled linen, showering patients, or conducting oropharyngeal procedures. These should be avoided or minimised where possible (and where required, modified airborne and contact PPE must be utilised).
Patient transport	The receiving area *must* be notified in advance of the precautions required for this patient. All staff caring for or transporting the patient must be in modified airborne and contact PPE. The patient should wear a mask if able to do so (N95 mask preferred, alternatively surgical mask).
Hand hygiene	Hand hygiene must be practised as per the 5 moments for hand hygiene, including prior to donning gloves and on removal of gloves. Use alcohol-based hand rub if hands are visibly clean. Wash hands with soap and water if hands are visibly soiled. Refer to the Hand Hygiene Guideline.
Staffing	Minimise number of staff/repeated entries into isolation room but ensure all essential clinical care and cleaning continues. Students, pregnant and immunosuppressed staff *not* to enter patient's room or provide care / transport of patients with suspected or confirmed Mpox.
Visitors	Visitors should not be permitted entry into the room. Discuss special considerations with Infectious Diseases (e.g. end of life).
Equipment cleaning	Dedicate equipment to the patient's room or use single-use equipment where possible. All other clinical items/equipment must be cleaned with Clinell Universal wipes allowing 60 seconds contact time. BMWs and other electronic medical equipment are permitted into isolation rooms if essential to clinical care and patient safety (e.g. medication administration), and must be thoroughly disinfected on exit with Clinell Universal wipes. Sensitive mobile electronic devices, such as tablets, should be cleaned with alcohol wipes. Staff must be wearing modified airborne and contact PPE during the cleaning process.
Environmental cleaning	Cleaning staff must wear modified airborne and contact PPE in the patient's room/bathroom (including where the patient is not in the room). Daily isolation clean by Spotless/Non Clinical Support Services using sodium hypochlorite 1000ppm (ActiChlor Plus) and must include all high touch points and clinical equipment in the patient's room, and the bathroom. Following discharge, a terminal isolation clean (incorporating any remaining clinical equipment in the room) using bleach 1000ppm (ActiChlor Plus) must be completed. Antimicrobial curtains must be discarded in clinical waste on patient discharge. **Outpatient/clinic settings:** Non-Clinical Support Services/Spotless must complete a terminal isolation clean for patients discharged from these areas.

Meal trays	Meal monitors must not enter the room of patients with suspected or confirmed Mpox. Meal requests should be collected by calling the patient's bedside phone, or asking nursing staff to collect the patient meal preferences. Finished meal trays, dishes, cups, and utensils should be removed from the isolation room by nursing staff and placed directly onto the dirty meal tray trolley, after which PPE may be removed and hand hygiene performed.
Linen	Prevent use of linen where possible (e.g. clinic settings). Minimise handling of linen in inpatient settings, and do not shake (risk of dispersing aerosols). Linen from suspected or confirmed Mpox patients should be put into a yellow biohazard plastic bag, and then placed into the linen skip.
Waste management	All waste from the patient's room including used PPE must be discarded into the clinical waste (yellow) stream. Ensure that the waste bin is positioned at least one metre from the clean PPE trolley. More frequent emptying of the waste bins may be required. The bins should be wiped down with Clinell Universal wipes, prior to removal.
Discharge considerations	The relevant local public health unit (based on the patient's residential postcode) is responsible for following up and providing advice to cases isolating in the community. For patients within their infectious period but medically cleared for discharge, ideally the treating clinician should notify the relevant local public health unit (based on the patient's postcode) to reduce any delays in follow up. .
Patients in the community	Staff visiting patients (e.g. in their private residence or facility) must undertake modified airborne and contact precautions for the duration of the visit. PPE must be donned prior to entering the patient's residence, and only removed on leaving the patient's residence (e.g. outside of the closed front door). Used PPE must be disposed of as clinical waste (tie off bag and wipe over with Clinell Universal wipes before transport/disposal). Ensure only disposable or cleanable items, limited to what is necessary, are taken into the patient's residence. Inside the residence, items should be placed on a hard surface that has been wiped down by the staff member with Clinell Universal wipes. On completion of the visit, items should be cleaned with Clinell Universal wipes. Further recommendations regarding patients isolating at home can be found in the CDNA Monkeypox Case and Contact Management guidance and Better Health Channel information sheets (available for cases, and different types of contacts).
Cessation of isolation	**For confirmed or probable cases of Mpox**: Modified airborne and contact precautions must remain in place until all lesions have scabbed over, fallen off and a fresh layer of skin has formed underneath. The decision to cease isolation should be made by **the treating medical team**. The medical team should update the local public health unit by emailing *SEPHU.Trace@monash.org*, who will provide a clearance letter to patients with confirmed Mpox. The patient may come out of isolation whilst awaiting the clearance letter. The isolation order in the EMR must be cancelled by medical or nursing staff.
Clearance of staff with Mpox	Staff with confirmed Mpox cannot attend the workplace in person until they have received clearance from the local public health unit (relevant to their residential postcode).

5. Exposure management

Staff exposure	Staff who have had contact with Mpox while not wearing appropriate PPE should report this to the ID consultant or Infection Prevention for assessment. Staff with potential workplace exposure will be risk assessed according to the definitions below, while also prioritising direct contact as the highest risk exposure, and considering the very infrequent nature of healthcare acquisition. Staff assessed to be high or medium risk contacts of Mpox may be furloughed from work in clinical areas for up to 21 days, and will be encouraged to work from home where possible. Staff with low risk exposure are able to continue working but should avoid contact with highly immunocompromised patients (i.e. 5E/7E/ICU), and should undertake self-monitoring; if a rash, flu-like symptoms or lymph node swelling develops, they must not attend work in person and should notify Infection Prevention). The advice for staff contacts may differ on a case by case basis and should be assessed by Infection Prevention or ID. Factors for consideration will include including length of exposure, exposure type, PPE worn, duration of illness.
Management of close contacts (patients)	Patients who are high or medium risk contacts of Mpox should be managed in **modified airborne and contact precautions in a single room with a closed door** for up to 21 days from their last exposure. The treating medical team is responsible for the decision to cease isolation, and may seek advice from ID or Infection Prevention regarding ceasing isolation sooner than 21 days (e.g. after 14 days in some instances). Patients must be monitored daily for flu-like symptoms, lymph node swelling or development of rash. Testing should take place if compatible symptoms are identified. Low risk contacts do not require isolation unless compatible signs or symptoms develop. Preferably, avoid placing low risk contacts in 5E and 7E. In the absence of a rash, used linen from all Mpox contacts may be placed directly into a linen skip. For close contacts in the community, including those who are for discharge, please notify the local public health unit (relevant to the patient's residential postcode). The local public health unit is responsible for management of non-hospitalised Mpox cases and contacts.
Contact tracing	Infection Prevention is responsible for contact tracing Mpox exposures that occur at Alfred Health. The relevant local public health unit is responsible for following up exposures that occur in the general community/ outside of Alfred Health, and for providing ongoing follow up to contacts who are outpatients or discharged from Alfred Health.
Vaccination	Vaccines to prevent Mpox infection are available and include: • Modified vaccinia Ankara (third generation vaccines), given subcutaneously at 0 and 28 days. This is available at Alfred Health (JYNNEOS® vaccine). • ACAM2000, a live attenuated smallpox vaccine, is not routinely used in Australia, but may have been received by a patient overseas or in special

	circumstances. ACAM2000 is available through the National Medicines Stockpile only. This requires approval from the Chief Medical Officer or delegate. Please see application form on MedsNet.
Post Exposure Prophylaxis Vaccination (PEPV)	As per the Australian Technical Advisory Group on Immunisation (ATAGI): "PEPV should be considered as soon as possible after first exposure to a confirmed Mpox case. Vaccination within 4 days of first exposure to an infectious case will provide the highest likelihood of prevention of disease. Vaccination between 4 to 14 days is anticipated to attenuate disease."[7(p.8)] **Post exposure prophylaxis for close contacts directed to present to ED by the LPHU:** The ID Consultant on Call (or LPHU consultant on call) must approve Mpox PEP. If approved, the vaccine may be accessed. JYNNEOS® is the preferred vaccine for PEPV. See Appendix 1 for availability and access. • If the patient presents after 9pm, they should be encouraged to return the next morning for a dose
Management of patients who have had vaccinia virus vaccination	Patients who have had modified vaccinia Ankara (third generation) vaccination (e.g. Bavarian Nordic, Jynneos) can be managed in **standard precautions**. Staff who have had this vaccination are able to continue working. Patients or staff who have received ACAM2000 vaccination will develop pox at the vaccination site, which may spread to other parts of the body. Any patient who has received the ACAM2000 vaccination must be managed in **contact precautions** until the vaccination scab (and any other lesions) have fallen off, typically 2-3 weeks. The vaccination site should be kept covered with dry gauze. Staff who have received ACAM2000 vaccination must not attend work in person until the vaccination scab (and any other lesions) have fallen off.

Appendix

Appendix 1: Mpox Vaccine Access

Key relevant documents

Key aligned policy

- Alfred Health Preventing and Controlling Healthcare Associated Infections Policy

Key legislation, acts & standards:

- Charter of Human Rights and Responsibilities Act 2006 (Vic)[1]

Other relevant documents:

- Hand Hygiene Guideline
- Personal Protective Equipment (PPE) for Reducing Transmission of Health Care Associated Infections Guideline
- Transmission Based Precautions for Infection Prevention Guideline
- Standard Precautions for Infection Prevention Guideline
- Tecovirimat Guideline

[1] REMINDER: Charter of Human Rights and Responsibilities Act 2006 – All those involved in decisions based on this guideline have an obligation to ensure that all decisions and actions are compatible with relevant human rights.

- Use of Negative Pressure and Barrier Airflow Rooms Guideline
- Waste Management Guideline
- Notifiable Infectious Diseases, Medical Conditions and Micro-Organisms Guideline
- Monkeypox Treatment Guideline

PowerPlans/IPOCS/QRGs

- Nil

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Disclaimer: This guideline has been developed within the context of Alfred Health service delivery. Alfred Health shall not be responsible for the use of any information contained in this document by another organisation outside of Alfred Health.		

Appendix 1 - Mpox Vaccine Access

In Victoria, the Mpox vaccine (JYNNEOS® vaccine) is available to eligible individuals as per the Victorian Mpox Treatment Guidelines.

Access of Mpox vaccine for Post-exposure Preventative Vaccination (PEPV) is available during **business hours**:

- Alfred Health ID outpatient clinic (Mon-Fri – 0800-1700)
- Melbourne Sexual Health Centre (Mon-Fri – 0830-1700)
- Alfred ED (whilst Pharmacist on site 0700-2100 pager #4025). This can be accessed from Inpatient Pharmacy.

Out of hours, patients are advised to return to a clinic/health service during business hours to access the vaccine.

For more information see the **Victorian Mpox Treatment guidelines**.