IAC’s Honor Roll for Mandatory Influenza Vaccination of Healthcare Personnel climbs to nearly 600 enrollees.
Major professional societies support mandatory vaccination.

In October 2009, the Immunization Action Coalition (IAC) launched the “Honor Roll for Mandatory Influenza Vaccination of Healthcare Personnel” at www.immunize.org/honor-roll/influenza-mandates. This was one of the earliest efforts to promote mandatory influenza vaccination of healthcare staff. Since that time, many national healthcare organizations have established position statements supporting mandatory influenza vaccination of healthcare personnel. These organizations include:

- American Academy of Family Physicians
- American Academy of Pediatrics
- American College of Physicians
- American Hospital Association
- American Medical Directors Association
- American Pharmacists Association
- American Public Health Association
- Association for Professionals in Infection Control and Epidemiology
- Infectious Diseases Society of America
- National Association of County and City Health Officials
- National Business Group on Health
- National Patient Safety Foundation
- Pediatric Infectious Diseases Society of America
- Society for Healthcare Epidemiology

Details about the position statements of these organizations can be found in the summary article titled “FirstDoNoHarm: Mandatory Influenza Vaccination Policies for Healthcare Personnel Help Protect Patients,” which is featured on page 9 of this issue of VACCINATE ADULTS. The position statements are also available on IAC’s website at www.immunize.org/honor-roll/influenza-mandates.

IAC would like to recognize some of the earliest members of the honor roll, along with the Infectious Diseases Society of America (IDSA), which was the first professional society to issue such a policy statement. Hospitals and healthcare systems that were honored at the launch include Barnes Jewish Corporation (BJC) Healthcare, Missouri; Children’s Hospital of Philadelphia; Creighton University; Hospital of the University of Pennsylvania; Loyola University Health System, Illinois; MedStar Health, Maryland and Washington, DC; TriHealth, Good Samaritan and Bethesda North Hospitals, Cincinnati, Ohio; University of Iowa Hospitals; and Virginia Mason Medical Center, Seattle.

At this time, nearly 600 healthcare systems, hospitals, and medical practices have met all of the requirements to be honored. A complete list of members of the honor roll is available online at www.immunize.org/honor-roll/influenza-mandates/honorees.asp.

Please Apply for the Honor Roll
If your organization requires influenza vaccination for its healthcare personnel but is not yet on the honor roll, please apply. To be added, your healthcare system must (1) require influenza vaccination for all staff and (2) include strong measures (e.g., a mask requirement, reassignment to non-patient care, or dismissal) to prevent transmission of influenza to patients from staff who do not get vaccinated.

The honor roll application form is available online at www.immunize.org/honor-roll/influenza-mandates/apply.aspx.

Find out more about IAC’s Honor Roll for Mandatory Influenza Vaccination of Healthcare Personnel at www.immunize.org/honor-roll/influenza-mandates.
Ask the Experts—continued from page 1

Is it acceptable to administer a dose of the quadrivalent influenza vaccine to a patient who has already received the trivalent vaccine?

No. CDC’s Advisory Committee on Immunization Practices (ACIP) does not recommend more than 1 dose of influenza vaccine in a season (except for certain children age 6 months through 8 years for whom 2 doses are recommended).

How late in the season can I vaccinate my patients with influenza vaccine?

Peak influenza activity generally occurs in January or February. Providers should continue vaccinating patients throughout the influenza season, including into the spring months (for example, through May), as long as they have unexpired vaccine in stock and unvaccinated patients in their office.

Because influenza occurs in many areas of the world during April through September, vaccine should be given to travelers who missed vaccination in the preceding fall and winter. Vaccine can be given through the month of June since most injectable influenza vaccine has a June 30 expiration date.

If an unvaccinated patient who has just recovered from a diagnosed case of influenza comes into our office, should we vaccinate this patient?

Yes. Influenza vaccine contains three or four influenza virus strains; two A viruses and one or two B viruses, which are prepared based on circulating viruses from the previous influenza season. Infection from one virus type does not confer immunity to other types and a person could be exposed to more than one type during a typical influenza season, so a person who has recently had influenza will benefit from receipt of a vaccine that contains additional influenza virus strains.

A study published in 2014 found that the injectable vaccine Fluzone High-Dose (Sanofi) protects people 65 years and older better than standard-dose Fluzone. Does ACIP preferentially recommend use of Fluzone High-Dose for all people age 65 years and older?

No. ACIP recommends that adults age 65 years and older and is not recommended for younger people.

Sometimes patients age 65 years and older who have received the standard-dose influenza vaccine hear about Fluzone High-Dose and want to receive that, too. Is this okay to administer?

No. ACIP does not recommend that anyone receive more than 1 dose of influenza vaccine in a season (except for certain children age 6 months through 8 years for whom 2 doses are recommended).

Would giving an older patient 2 doses of standard-dose influenza vaccine be the same as administering the high-dose product?

No, and this is not recommended.

Is the nasal spray influenza vaccine, FluMist, contraindicated for adults with asthma?

Asthma is a precaution for the live attenuated influenza vaccine. However, despite published evidence of better protection from Fluzone High-Dose when compared to standard-dose Fluzone (N Engl J Med 2014; 371:635–45), ACIP has not stated a preference for this vaccine for people age 65 years and older.

May I give Fluzone High-Dose to patients younger than age 65 years?

No. Fluzone High-Dose is licensed only for people age 65 years and older and is not recommended for younger people.

Ask the Experts—continued on page 3

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IAC’s “Ask the Experts” team from the Centers for Disease Control and Prevention

Andrew T. Kroger, MD, MPH
Donna L. Weaver, RN, MN

Debra A. Strodthoff, MD
Immunization Action Coalition

DISCLAIMER: Vaccinate Adults! is available to all readers free of charge. Some of the information in this issue is supplied to us by the Centers for Disease Control and Prevention in Atlanta, Georgia, and some information is supplied by third-party sources. The Immunization Action Coalition (IAC) has used its best efforts to accurately publish all of this information, but IAC cannot guarantee that the original information as supplied by others is correct or complete, or that it has been accurately published. Some of the information in this issue is created or compiled by IAC. All of the information in this issue is of a time-critical nature, and we cannot guarantee that some of the information is not now outdated, inaccurate, or incomplete. IAC cannot guarantee that reliance on the information in this issue will cause no injury. Before you rely on the information in this issue, you should first independently verify its current accuracy and completeness. IAC is not licensed to practice medicine or pharmacology, and the providing of the information in this issue does not constitute such practice. Any claim against IAC must be submitted to binding arbitration under the auspices of the American Arbitration Association in St. Paul, Minnesota.
Ask the Experts…continued from page 2

What is the preferred anatomic site for administration of inactivated influenza vaccine (IIV)?
With the exception of intradermal vaccine (Fluzone Intradermal, Sanofi), IIV should be administered in the deltoid muscle of an older child, adolescent, or adult. The anterolateral thigh muscle can also be used if necessary. It is critical that intramuscular influenza vaccine be injected into a muscle. Influenza vaccination season is an opportune time to review proper intramuscular injection techniques with your staff. IAC has prepared a handout on how to administer intramuscular vaccine injections (available at www.immunize.org/catg.d/p2020.pdf) that can be used as a staff training tool.

We offer healthcare professionals live attenuated influenza vaccine (LAIV) but question whether newborn intensive care unit (NICU) staff can receive this vaccine without compromising neonates. Neonates in an NICU are not considered severely immunocompromised. NICU personnel may receive LAIV if otherwise eligible (younger than 50 years, healthy, and not pregnant).

Should staff at drive-through influenza vaccination clinics encourage drivers to park and wait for 15 minutes after vaccination to make sure they don’t have a vaccination reaction or syncopal (fainting) episode? Yes. Syncope has been reported following vaccination. It is prudent for all persons to be observed for syncope for at least 15 minutes after vaccination.

Some of our patients believe that they have had reactions to influenza vaccine in the past, and request the dose to be split into 2 doses administered on different days. Is this an acceptable practice? This is definitely not an acceptable practice. Doses of influenza vaccine (or any other vaccine) should never be split into “half doses.” If a “half dose” is given, it should not be accepted as a valid dose and should be repeated as soon as possible with a full age-appropriate dose.

The pneumococcal conjugate vaccine (PCV13, Prevnar, Pfizer) package insert says that in adults, antibody responses to PCV13 were diminished when given with inactivated influenza vaccine. Does this mean we should not give PCV13 and influenza vaccine at the same visit? The available data have been interpreted that any changes in antibody response to either of the vaccines’ components were clinically insignificant. If PCV13 and influenza vaccine are both indicated and recommended they should be administered at the same visit. See the PCV13 ACIP recommendations at www.cdc.gov/mmwr/pdf/wk/mm6337.pdf, page 824.

Do statin medications (taken to lower blood lipid levels) affect the efficacy of influenza vaccine? Two recent studies raise the possibility that statin medications may blunt the effectiveness of influenza vaccines in seniors. Experts caution that more research is needed to better understand the issue. Because of their benefit, seniors should not stop taking their statin without consultation with their health care provider. Influenza vaccine remains the best protection we have against influenza, and provides at least some protection in people who take statins, so patients should still receive an influenza vaccine to be protected. There is no change to the ACIP recommendation for influenza vaccine.

Pneumococcal vaccines

Do patients who were vaccinated with 1 or 2 doses of PPSV23 before age 65 need an additional dose of PPSV23 at age 65? Yes. Patients who received 1 or 2 doses of PPSV23 for any indication at age 64 years or younger should receive an additional dose of PPSV23 vaccine at age 65 years or older if at least 5 years have elapsed since their previous PPSV23 dose. Patients age 65 years and older who have not already received a dose of pneumococcal conjugate vaccine (PCV13) will need this as well. PCV13 is routinely recommended at age 65 and PPSV23 is administered one year later.

Should a healthy 75-year-old patient who was given PPSV23 at age 65 years be revaccinated? No. Adults who were first vaccinated at age 65 years or older do not require revaccination. Make sure they have also received a dose of PCV13, which is routinely recommended at age 65 years.

Can we administer PCV13 and PPSV23 to a person 65 years of age or older at the same visit? If not, what is the recommended interval between doses? PCV13 and PPSV23 should not be given at the same visit. Healthy people 65 years of age and older should receive PCV13 first, followed by a dose of PPSV23 one year later. If the patient has a high-risk medical condition (such as immunocompromised or asplenia) the first PPSV23 dose can follow the PCV13 dose by 8 weeks.

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Ask the Experts…continued from page 4

Rather than giving PCV13 first and waiting 8 weeks to give PPSV23 as recommended for an immunocompromised adult patient, we inadvertently gave both vaccines at the same visit. We are looking for guidance.

Although PCV13 and PPSV23 should not be administered at the same visit, CDC does not recommend repeating either vaccine dose should this occur. You should inform the patient of the error and let them know that they will not need to repeat either dose.

What is the recommended interval between doses for adult patients who have already received 1 dose of PPSV23 and now need PCV13?

For patients who have already had one or more doses of PPSV23, it is recommended to wait at least a year after PPSV23 before administering PCV13. If the patient is recommended to receive a second dose of PPSV23, delay that second PPSV23 dose at least 8 weeks following PCV13 and 5 years or more following the first dose of PPSV23.

If patients who are in a recommended risk group for PPSV23 or PCV13 aren’t sure if they have previously received these vaccines, should health care providers vaccinate them?

If patients do not have a documented vaccination history for these two vaccines and their records are not readily obtainable, you should administer the recommended doses. Extra doses will not cause harm to the patient.

If influenza vaccine is recommended for healthcare workers to protect high-risk patients from getting influenza, why aren’t pneumococcal vaccines also recommended?

Influenza virus is easily spread from healthcare workers to their patients, and infection usually leads to clinical illness. Pneumococcus is probably not spread from healthcare workers to their patients as easily as is influenza, and infection with pneumococcus does not necessarily lead to clinical illness. Host factors (such as age and underlying illness) are more important in the development of invasive pneumococcal disease than nasopharyngeal colonization with the organism. When you’re giving influenza vaccine to your patients in the fall, don’t forget to assess their need for pneumococcal vaccines as well as all other vaccines, including Tdap and zoster.

Vaccinate Adults correction policy

If you find an error, please notify us immediately by sending an email message to admin@immunize.org. We publish notification of significant errors in our email announcement service, IAC Express. Be sure you’re signed up for this service. To subscribe, visit www.immunize.org/subscribe.
## Influenza Vaccine Products for the 2015–2016 Influenza Season

<table>
<thead>
<tr>
<th>Manufacturer</th>
<th>Trade Name (vaccine abbreviation)</th>
<th>How Supplied</th>
<th>Mercury Content (μg Hg/0.5mL)</th>
<th>Age Group</th>
<th>Vaccine Product Billing Code2</th>
<th>CPT</th>
<th>Medicare3</th>
</tr>
</thead>
<tbody>
<tr>
<td>bioCSL, Inc.</td>
<td>Afluria (IIV3)</td>
<td>0.5 mL (single-dose syringe)</td>
<td>0</td>
<td>9 years &amp; older4,5</td>
<td>90656</td>
<td>90656</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5.0 mL (multi-dose vial)</td>
<td>24.5</td>
<td></td>
<td>90658</td>
<td>Q2035</td>
<td></td>
</tr>
<tr>
<td>GlaxoSmithKline</td>
<td>Fluarix (IIV4)</td>
<td>0.5 mL (single-dose syringe)</td>
<td>0</td>
<td>3 years &amp; older</td>
<td>90686</td>
<td>90686</td>
<td></td>
</tr>
<tr>
<td>ID Biomedical Corp. of Quebec, a subsidiary of GlaxoSmithKline</td>
<td>FluLaval (IIV4)</td>
<td>0.5 mL (single-dose syringe)</td>
<td>0</td>
<td>3 years &amp; older</td>
<td>90686</td>
<td>90686</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5.0 mL (multi-dose vial)</td>
<td>&lt;25</td>
<td></td>
<td>90688</td>
<td>90688</td>
<td></td>
</tr>
<tr>
<td>MedImmune</td>
<td>FluMist (LAIV4)</td>
<td>0.2 mL (single-use nasal spray)</td>
<td>0</td>
<td>2 through 49 years</td>
<td>90672</td>
<td>90672</td>
<td></td>
</tr>
<tr>
<td>NVS Influenza Vaccines (formerly Novartis)</td>
<td>Fluvirin (IIV3)</td>
<td>0.5 mL (single-dose syringe)</td>
<td>≤1</td>
<td>4 years &amp; older</td>
<td>90656</td>
<td>90656</td>
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<tr>
<td></td>
<td></td>
<td>5.0 mL (multi-dose vial)</td>
<td>25</td>
<td></td>
<td>90658</td>
<td>Q2037</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Flucelvax (ccIIV3)</td>
<td>0.5 mL (single-dose syringe)</td>
<td>0</td>
<td>18 years &amp; older</td>
<td>90661</td>
<td>90661</td>
<td></td>
</tr>
<tr>
<td>Protein Sciences Corp.</td>
<td>Flublok (RIV3)</td>
<td>0.5 mL (single-dose vial)</td>
<td>0</td>
<td>18 years &amp; older</td>
<td>90673</td>
<td>90673</td>
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</tr>
<tr>
<td>Sanofi Pasteur, Inc.</td>
<td>Fluzone (IIV3)</td>
<td>5.0 mL (multi-dose vial)</td>
<td>25</td>
<td>6 through 35 months</td>
<td>90657</td>
<td>90657</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5.0 mL (multi-dose vial)</td>
<td>25</td>
<td>3 years &amp; older</td>
<td>90658</td>
<td>Q2038</td>
<td></td>
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<tr>
<td></td>
<td>Fluzone (IIV4)</td>
<td>0.25 mL (single-dose syringe)</td>
<td>0</td>
<td>6 through 35 months</td>
<td>90685</td>
<td>90685</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>0.5 mL (single-dose syringe)</td>
<td>0</td>
<td>3 years &amp; older</td>
<td>90686</td>
<td>90686</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>0.5 mL (single-dose vial)</td>
<td>0</td>
<td>3 years &amp; older</td>
<td>90686</td>
<td>90686</td>
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<tr>
<td></td>
<td></td>
<td>5.0 mL (multi-dose vial)</td>
<td>25</td>
<td>6 through 35 months</td>
<td>90687</td>
<td>90687</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>5.0 mL (multi-dose vial)</td>
<td>25</td>
<td>3 years &amp; older</td>
<td>90688</td>
<td>90688</td>
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<tr>
<td></td>
<td>Fluzone High-Dose (IIV3)</td>
<td>0.5 mL (single-dose syringe)</td>
<td>0</td>
<td>65 years &amp; older</td>
<td>90662</td>
<td>90662</td>
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<tr>
<td></td>
<td>Fluzone Intradermal (IIV4)</td>
<td>0.1 mL (single-dose microinjection system)</td>
<td>0</td>
<td>18 through 64 years</td>
<td>90630</td>
<td>90630</td>
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</tr>
</tbody>
</table>

### Footnotes
1. IIV3 = egg-based and cell culture-based trivalent inactivated influenza vaccine (injectable); where necessary to refer to cell culture-based vaccine, the prefix “cc” is used (e.g., ccIIV3). IIV4 = egg-based quadrivalent inactivated influenza vaccine (injectable); LAIV4 = egg-based quadrivalent live attenuated influenza vaccine (nasal spray); RIV3 = trivalent recombinant hemagglutinin influenza vaccine (injectable).
2. Effective for claims with dates of service on or after 1/1/2011, CPT (Current Procedural Terminology) code 90658 is no longer payable for Medicare; rather, HCPCS (Healthcare Common Procedure Coding System) Q codes, as indicated above, should be submitted for payment purposes.
3. An administration code should always be reported in addition to the vaccine product code. Note: Third party payers may have specific policies and guidelines that might require providing additional information on their claim forms.
4. In 2010, ACIP recommended that Afluria not be used in children younger than age 9 years. If no other age-appropriate IIV is available, Afluria may be considered for a child age 5 through 8 years at high risk for influenza complications, after risks and benefits have been discussed with the parent or guardian. Afluria should not be used in children younger than age 5 years. This recommendation continues for the 2015–2016 influenza season.
5. Afluria is approved by the Food and Drug Administration for intramuscular administration with the Pharmajet Stratis Needle-Free Injection System for persons age 18 through 64 years.
Screening Checklists for Contraindications to Inactivated Injectable Influenza Vaccines

For patients (both children and adults) to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer “yes” to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

1. Is the person to be vaccinated sick today? □ □ □
2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine? □ □ □
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? □ □ □
4. Has the person to be vaccinated ever had Guillain-Barré syndrome? □ □ □

For use with people age 2 through 49 years: The following questions will help us determine if there is any reason we should not give you or your child live attenuated intranasal influenza vaccine (Fluidmist) today. If you answer “yes” to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

1. Is the person to be vaccinated sick today? □ □ □
2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine? □ □ □
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? □ □ □
4. Is the person to be vaccinated younger than 2 years of age or older than 49 years? □ □ □
5. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease (including asthma), kidney disease, neurologic disease, liver disease, metabolic disease (e.g., diabetes), or any other blood disorder? □ □ □
6. Has the person to be vaccinated ever had Guillain-Barré syndrome? □ □ □
7. Has the person to be vaccinated ever had a serious reaction to a previous influenza vaccine? □ □ □
8. Has the person to be vaccinated ever had an anaphylactic reaction to any vaccine component? □ □ □
9. Has the person to be vaccinated ever had an anaphylactic reaction to an influenza vaccine? □ □ □
10. Has the person to be vaccinated ever had a severe reaction to a prior dose of a pneumococcal vaccine? □ □ □
11. Has the person to be vaccinated ever had a severe reaction to a prior dose of a meningococcal vaccine? □ □ □
12. Has the person to be vaccinated ever had a severe reaction to a prior dose of a Haemophilus influenzae type b (Hib) vaccine? □ □ □

Information for Healthcare Professionals about the Screening Checklists for Contraindications to Inactivated Injectable Influenza Vaccination (IIV or RIV):

Are you interested in learning why we included a certain question on the screening checklist? If so, read the information below. If you want to find out more, consult the sources listed at the bottom of this page.

1. Is the person to be vaccinated sick today? There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events. People with an acute illness (fever or cough lasting more than 1 week) or active lung disease should not be vaccinated. There is no evidence that active illness or active lung disease has led to adverse reactions or deaths following injection of influenza vaccine. There is no evidence that active illness or active lung disease has led to adverse reactions or deaths following injection of inactivated influenza vaccine. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine? Although current influenza vaccines contain various vaccine components, there is no evidence of a link between vaccine components and anaphylaxis or severe allergic conditions. People with a moderate or severe allergy to eggs, although they are unlikely to have an egg allergy. However, there is evidence of high-cross-reactivity between egg protein and viral envelope glycoprotein. Although people who had eggs, gelatin, or any insulin must be examined. As a rule, people should not be vaccinated if the health care provider tells you the child had wheezing or asthma? □ □ □

3. Has the person to be vaccinated ever had a serious reaction to a previous influenza vaccine? □ □ □
4. Has the person to be vaccinated ever had a serious reaction to a previous pneumococcal vaccine? □ □ □
5. Has the person to be vaccinated ever had a serious reaction to a previous meningococcal vaccine? □ □ □
6. Has the person to be vaccinated ever had a serious reaction to a previous Haemophilus influenzae type b (Hib) vaccine? □ □ □

For a ready-to-copy 8½ x 11” version of the 2-page injectable influenza checklist, visit www.immunize.org/catg/d/p4066.pdf

For a ready-to-copy 8½ x 11” version of the 2-page nasal spray checklist, visit www.immunize.org/catg/d/p4067.pdf
Use This Standing Orders Template to Streamline Flu Vaccination in Your Healthcare Setting

Download this standing orders template and use “as is” or modify it to suit your work setting.

STANDING ORDERS FOR Administering Influenza Vaccine to Adults

Purpose

To reduce morbidity and mortality from influenza by vaccinating all adults who meet the criteria established by the Centers for Disease Control and Prevention’s Advisory Committee on Immunization Practices.

Policy

Where allowed by state law, standing orders enable eligible nurses and other health care professionals (e.g., pharmacists) to assess the need for vaccination and to vaccinate adults who meet any of the criteria below.

Procedure

1. Assess Adults for Need of Vaccination against influenza
   - All adults are recommended to receive influenza vaccination each year.
   - People who do not recall whether they received influenza vaccine this year should be vaccinated.

2. Screen for Contraindications and Precautions

Contraindications for use of all influenza vaccines

- Do not give influenza vaccine to a person who has experienced a serious systemic or anaphylactic reaction to a prior dose of the vaccine or to any of its components.

Precautions for use of all influenza vaccines

- Do not give live attenuated influenza vaccine (LAIV; FluMist, nasal spray) to a person who:
  - Has a history of either an anaphylactic or non-anaphylactic allergic reaction to eggs
  - Is pregnant
  - Has immunosuppression (including that caused by medications or HIV)
  - Is age 50 years or older
  - Has received influenza antivirals (e.g., amantadine, rimantadine, zanamivir, or oseltamivir) within the previous 48 hours or will possibly receive them within 14 days after vaccination

- Provides care for a severely immunocompromised person who requires a protective environment

3. Prepare to Administer Vaccine

- Assess Adults for Need of Vaccination against influenza
- Prepare to Administer Vaccine
  - Assess Adults for Need of Vaccination against influenza
  - Prepare to Administer Vaccine

4. Prepare to Administer Vaccine

- Assess Adults for Need of Vaccination against influenza
- Prepare to Administer Vaccine
  - Assess Adults for Need of Vaccination against influenza
  - Prepare to Administer Vaccine

5. Administer Influenza Vaccine according to the criteria and guidance in the table below.

<table>
<thead>
<tr>
<th>Type of Vaccine</th>
<th>Age Group</th>
<th>Dose</th>
<th>Route</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inactivated influenza vaccine (IIV)</td>
<td>65 years and older</td>
<td>0.5 mL</td>
<td>Intramuscular (IM)</td>
<td>Administer vaccine in deltoid muscle</td>
</tr>
<tr>
<td>Intranasal influenza vaccine (IIV)</td>
<td>6 months through 4 years</td>
<td>0.03 mL, i.e., infant dose</td>
<td>Intranasal (IN)</td>
<td>Insert needle of the microneedle system at a 90 degree angle in the nares area</td>
</tr>
<tr>
<td>Intradermal influenza vaccine (IIV)</td>
<td>50 years and older</td>
<td>0.02 mL</td>
<td>Intradermal (ID)</td>
<td>Administer vaccine intradermally</td>
</tr>
</tbody>
</table>

6. Document Vaccination

- Document each patient’s vaccine administration information and follow up in the following places:
  - Medical record: Document the date the vaccine was administered, the manufacturer and lot number, the vaccination site and route, and the name and title of the person administering the vaccine. You must also document, in the patient’s medical record or office log, the publication date of the VIS and the date it was given to the patient. If vaccine was not administered, record the reason(s) for non-receipt of the vaccine (e.g., medical contraindication, patient refusal).
  - Personal immunization record card: Record the date of vaccination and the name/location of the administering clinic.
  - Immunization Information System (IIS) or registry: Report the vaccination to the appropriate state/local IIS, if available.

For the standing orders template, visit www.immunize.org/catg.d/p3074.pdf

Additional standing orders templates for all routinely recommended vaccines are available at www.immunize.org/standing-orders
How to Administer Intramuscular, Intradermal, and Intranasal Influenza Vaccines

**Intramuscular injection (IM)**
Inactivated Influenza Vaccines (IIV), including recombinant hemagglutinin influenza vaccine (RIV3)

1. Use a needle long enough to reach deep into the muscle. Infants age 6 through 11 mos: 1"; 1 through 2 yrs: 1–1¼"; children and adults 3 yrs and older: 1–1½".
2. With your left hand*, bunch up the muscle.
3. With your right hand*, insert the needle at a 90° angle to the skin with a quick thrust.
4. Push down on the plunger and inject the entire contents of the syringe. There is no need to aspirate.
5. Remove the needle and simultaneously apply pressure to the injection site with a dry cotton ball or gauze. Hold in place for several seconds.
6. If there is any bleeding, cover the injection site with a bandage.
7. Put the used syringe in a sharps container.

* Use the opposite hand if you are left-handed.

**Intradermal administration (ID)**
Inactivated Influenza Vaccine (IIV)

1. Gently shake the microinjection system before administering the vaccine.
2. Hold the system by placing the thumb and middle finger on the finger pads; the index finger should remain free.
3. Insert the needle perpendicular to the skin, in the region of the deltoid, in a short, quick movement.
4. Once the needle has been inserted, maintain light pressure on the surface of the skin and inject using the index finger to push on the plunger. Do not aspirate.
5. Remove the needle from the skin. With the needle directed away from you and others, push very firmly with the thumb on the plunger to activate the needle shield. You will hear a click when the shield extends to cover the needle.
6. Dispose of the applicator in a sharps container.

**Intranasal administration (NAS)**
Live Attenuated Influenza Vaccine (LAIV)

1. FluMist (LAIV) is for intranasal administration only. Do not inject FluMist.
2. Remove rubber tip protector. Do not remove dose-divider clip at the other end of the sprayer.
3. With the patient in an upright position, place the tip just inside the nostril to ensure LAIV is delivered into the nose. The patient should breathe normally.
4. With a single motion, depress plunger as rapidly as possible until the dose-divider clip prevents you from going further.
5. Pinch and remove the dose-divider clip from the plunger.
6. Place the tip just inside the other nostril, and with a single motion, depress plunger as rapidly as possible to deliver the remaining vaccine.
7. Dispose of the applicator in a sharps container.
First Do No Harm: Mandatory Influenza Vaccination Policies for Healthcare Personnel Help Protect Patients

American Academy of Family Physicians (AAFP)  
AAFP Mandatory Influenza Vaccination of Health Care Personnel (6/11)  
"The AAFP supports annual mandatory influenza immunization for health care personnel (HCPs) except for religious or medical reasons (not personal preferences). If HCPs are not vaccinated, policies to adjust practice activities during flu season are appropriate (e.g., wear masks, refrain from direct patient care)."

American Academy of Pediatrics (AAP)  
Influenza Immunization for All Health Care Personnel: Keep It Mandatory, a reaffirmation of AAP’s policy on mandatory influenza immunization of health care personnel (Oct. 2015)  
http://pediatrics.aappublications.org/content/136/4/809
"Mandating influenza vaccine for all HCP nationwide is ethical, just, and necessary. For the prevention and control of influenza, we must continue to put the health and safety of the patient first."

American College of Physicians (ACP)  
ACP calls for immunization for all health care providers (1/14/2013)  
http://www.acponline.org/newsroom/hcp_vaccinations.htm
"Proper immunization safely and effectively prevents a significant number of infections, hospitalizations, and deaths among patients as well as preventing workplace disruption and medical errors by absent workers due to illness."

American Public Health Association (APHA)  
Annual Influenza Vaccination Requirements for Health Workers (11/9/10)  
www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/11/14/36/annual-influenza-vaccination-requirements-for-health-workers
"Encourages institutional, employer, and public health policy to require influenza vaccination of all health workers as a precondition of employment and thereafter on an annual basis, unless a medical contraindication recognized in national guidelines is documented in the worker’s health record."

Association for Professionals in Infection Control and Epidemiology (APIC)  
Mandatory Immunization of Health Care Personnel Against Influenza and Other Infectious Diseases (rev. 12/10/13)  
"As a profession that relies on evidence to guide our decisions and actions, we can no longer afford to ignore the compelling evidence that supports requiring influenza vaccine for HCP. This is not only a patient safety imperative, but is a moral and ethical obligation to those who place their trust in our care."

Infectious Diseases Society of America (IDSA)  
Mandatory Immunization of Health Care Personnel Against Influenza and Other Infectious Diseases (rev. 12/10/13)  
http://www.idsociety.org/HCW_Policy
"Preventing healthcare-associated transmission of influenza and other infectious diseases can protect patients, HCP, and local communities. For this reason, IDSA supports mandatory immunization of HCP according to recommendations of the Advisory Committee for Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC)."

National Business Group on Health (NBGH)  
Hospitals Should Require Flu Vaccination for all Personnel to Protect Patients’ Health and Their Own Health (10/18/11)  
www.businessgrouphealth.org/pub/f314b0a7-2354-d714-511f-57f12807ba2c
"Hospitals should require flu vaccination for all personnel to protect patients’ health and their own health."

National Patient Safety Foundation (NPSF)  
NPSF Supports Mandatory Flu Vaccinations for Healthcare Workers (11/11/15)  
www.npsf.org/news/259784/National-Patient-Safety-Foundation-Supports-Mandatory-Flu-Vaccine-For-Health-Care-Workers.htm
"NPSF recognizes vaccine-preventable diseases as a matter of patient safety and supports mandatory influenza vaccination of health care workers to protect the health of patients, health care workers, and the community."

Society for Healthcare Epidemiology of America (SHEA)  
Influenza Vaccination of Healthcare Personnel (rev. 8/31/10)  
www.journals.uchicago.edu/doi/full/10.1086/656558
"SHEA views influenza vaccination of HCP as a core patient and HCP safety practice with which noncompliance should not be tolerated."

Immunization Action Coalition  
Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

Access policy statements from leading medical societies and additional professional groups about implementing a mandatory influenza vaccination program in your healthcare setting.

First Do No Harm: Mandatory Influenza Vaccination Policies for Healthcare Personnel Help Protect Patients

Refer to the position statements of the leading medical organizations listed below to help you develop and implement a mandatory influenza vaccination policy at your healthcare institution or medical setting. Policy titles, publication dates, links, and excerpts follow.

VIEW THE COMPLETE LIST:
www.immunize.org/honor-roll/influenza-mandates

American Academy of Family Physicians (AAFP)  
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"The AAFP supports annual mandatory influenza immunization for health care personnel (HCPs) except for religious or medical reasons (not personal preferences). If HCPs are not vaccinated, policies to adjust practice activities during flu season are appropriate (e.g., wear masks, refrain from direct patient care)."

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These influenza educational materials will help protect your patients as well as staff

1. Influenza: Questions and Answers

2. Don’t take chances with your family’s health – make sure you all get vaccinated against influenza every year!

3. Seek emergency medical care if you or a family member shows the signs below – a life could be at risk!

4. Protect yourself from influenza…

5. Destination of influenza Vaccination

6. Influenza Vaccination of People with a History of Egg Allergy

For 8 1/2 x 11” copies of the pieces above, visit IAC’s website: www.immunize.org/handouts/influenza-vaccines.asp

1. Influenza: Questions and Answers  
   www.immunize.org/catg.d/p4208.pdf

2. Don’t take chances with your family’s health – make sure you all get vaccinated against influenza every year!
   www.immunize.org/catg.d/p4069.pdf

3. Seek emergency medical care if you or a family member shows the signs below – a life could be at risk!
   www.immunize.org/catg.d/p4073.pdf

4. Protect yourself from influenza…
   Get vaccinated!
   www.immunize.org/catg.d/p4073.pdf

5. Declination of Influenza Vaccination

6. Influenza Vaccination of People with a History of Egg Allergy
   www.immunize.org/catg.d/p3094.pdf
Pneumococcal Vaccination Recommendations for Children and Adults by Age and/or Risk Factor

Routine Recommendations for Pneumococcal Conjugate Vaccine (PCV13) and Pneumococcal Polysaccharide Vaccine (PPSV23)

### For children age 2 months and older
Administer PCV13 series to all children beginning at age 2 months, followed by doses at 4 months, 6 months, and 12–15 months (booster dose).

### For adults age 65 years and older
Administer 1-time dose to PCV13-naïve adults at age 65 years, followed by a dose of PPSV23 12 months later.

---

### Risk-based Recommendations
People with Underlying Medical Conditions or Other Risk Factors

<table>
<thead>
<tr>
<th>Risk Group</th>
<th>Underlying medical condition or other risk factor</th>
<th>PCV13</th>
<th>PPSV23</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immuno-competent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic heart disease</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Chronic lung disease</td>
<td>X</td>
<td></td>
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</tr>
<tr>
<td>Diabetes mellitus</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Cerebrospinal fluid leak</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Cochlear implant</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic liver disease, cirrhosis</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cigarette smoking (≥19 yrs)</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Functional or anatomic asplenia</td>
<td>Sickle cell disease/other hemoglobinopathy</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Congenital or acquired asplenia</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Immuno-compromised</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Congenital or acquired immunodeficiency</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>HIV</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Chronic renal failure</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Nephrotic syndrome</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Leukemia</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Lymphoma</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Hodgkin disease</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Generalized malignancy</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Iatrogenic immunosuppression</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Solid organ transplant</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Multiple myeloma</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

2. Particularly cyanotic congenital heart disease and cardiac failure in children; including congestive heart failure and cardiomyopathy in all ages; excluding hypertension in adults.
3. Including asthma in children if treated with high-dose oral corticosteroid therapy, as well as chronic obstructive pulmonary disease (COPD), emphysema, and asthma in adults.
4. Includes B- (humoral) or T-lymphocyte deficiency, complement deficiencies (particularly C1, C2, C3, and C4 deficiencies), and phagocytic disorders (excluding chronic granulomatous disease).
5. Diseases requiring treatment with immunosuppressive drugs, including long-term systemic corticosteroids and radiation therapy.

Technical content reviewed by the Centers for Disease Control and Prevention

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Standing Orders for Administering Pneumococcal Vaccine to Adults

**Procedure**

1. **Assess Adults for Need of Vaccination**

   - Routine pneumococcal vaccination:Administers adults age 65 years or older for need of pneumococcal vaccination. Pneumococcal conjugate vaccine (PCV13) should be administered routinely to all previously unvaccinated adults age 65 years and older. For con-
   - Risk-based pneumococcal vaccination for adults ages 19–64 years
   - Risk-based pneumococcal vaccination for adults ages 65 years and older

2. **Screen for Contraindications and Precautions**

   - *Excluding hypertension*
   - *Including asthma*

   - Assess Adults for Need of Vaccination

3. **Provide Vaccine Information Statements**

   - Provide all patients with a copy of the most current federal Vaccine Information Statement (VIS). Provide non-
   - English-speaking patients with a copy of the VIS in their native language, if one is available and desired; these can be obtained at www.immunize.org/vis. (For information about how to document that the VIS was given, see section 6 titled “Document Vaccination.”)

4. **Prepare to Administer Vaccine**

   - PCV13 must be given intramuscularly (IM). PPSV23 may be administered either IM or subcutaneously (Subcut).

5. **Administer PCV13 or PPSV23, 0.5 mL, according**

   - PCV13 must be administered by the IM route.
   - All patients must receive 2 doses of PPSV23 at least 8 weeks apart

6. **Document Vaccination**

   - Document each patient’s vaccine administration information and follow up in the following places:
   - Medical record: Document the date the vaccine was administered, the manufacturer and lot number, the vaccination site and route, and the name and title of the person administering the vaccine. You must also document, in the patient’s medical record or office log, the publication date of the VIS and the date it was given to the patient. If vaccine was not administered, record the reason(s) for non-receipt of the vaccine (e.g., medical contraindication, patient refusal).

**Risk-based vaccination for adults ages 19–64 years**

- Administer PCV13 at least 1 year after PPSV23.
- Administer another PPSV23 at least 5 years after previous dose of PPSV23.
- Administer PCV13 at least 8 weeks after PCV13.
- Administer PCV13 at least 1 year after PCV13.
- Administer PCV13 at least 1 year after PPSV23 #1.
- Administer PCV13 followed by PPSV23 #1 then administer PCV13 at least 8 weeks after PCV13.
- Administer PCV13 at least 1 year after previous dose of PPSV23.
- Administer PCV13 followed by PPSV23 #1 then administer PCV13 at least 8 weeks after PCV13.
- Administer PCV13 at least 1 year after PPSV23.
- Administer another PPSV23 at least 5 years after previous dose of PPSV23.
- Administer PCV13 at least 8 weeks after PPSV23.

**Risk-based vaccination for adults ages 65 years and older**

- Administer PCV13 at least 1 year after PPSV23 #1.
- Administer another PPSV23 at least 5 years after previous dose of PPSV23.
- Administer PCV13 at least 8 weeks after PPSV23.
- Administer PCV13 at least 1 year after PPSV23.

**Immunization Action Coalition**

- Saint Paul, Minnesota - 651-647-9099

Download and use this standing orders template “as is,” or modify to suit your work setting.


---

*Note: This standing orders template may be adapted for a particular setting without obtaining permission from IAC. As a courtesy, please acknowledge IAC as its source.*
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February 17, 2016

Houston, Tex.  
February 19, 2016

Seattle, Wash.  
March 15, 2016

Phoenix, Ariz.  
March 17, 2016

Tucson, Ariz.  
March 18, 2016

Orlando / Daytona Beach, Fla.  
April 12, 2016

Fort Lauderdale, Fla.  
April 13, 2016

Atlanta, Ga.  
April 15, 2016

Boston, Mass.  
June 6, 2016

New York, N.Y.  
June 8, 2016

June 9, 2016

Baltimore, Md.  
June 11, 2016

**Who should attend**

Clinicians, nurses, and clinic managers

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✔ This workshop is a one-stop shop to help you easily implement standing orders in your practice.

✔ Using standing orders for adult immunizations can help your practice be a leader in quality adult care.

✔ Our support for your practice does not end with the workshop. You receive full access to direct phone and email support for one year after attending.

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Use Standing Orders to Vaccinate Adults

www.StandingOrders.org

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**L.J Tan**, MS, PhD, Chief Strategy Officer, Immunization Action Coalition

**Deborah L. Wexler**, MD, Executive Director, Immunization Action Coalition

**William Atkinson**, MD, MPH, Associate Director for Immunization Education, Immunization Action Coalition

**Alexandra Stewart**, JD, Associate Professor, George Washington University

This free workshop is provided by the Immunization Action Coalition (IAC), with sponsorship from Pfizer, Inc.

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**Register online now** at www.StandingOrders.org/registration. Don’t delay! Space is limited.
It’s Federal Law! You must use Vaccine Information Statements when vaccinating adults

Federal law requires that VISs must be given to adult patients when administering vaccines (influenza, pneumococcal conjugate, and others) that are also given to children.

For facts on how to use VISs, visit www.immunize.org/catg.d/p2027.pdf.

It’s Federal Law! You must give your patients current Vaccine Information Statements (VISs)

Federal law requires that VISs must be used for patients of ALL ages when administering these vaccines:
- DTaP (includes DT)
- Td and Tdap
- Hib
- hepatitis A
- hepatitis B
- HPV
- influenza (inactivated and live, intranasal vaccines)

Using VISs is legally required!

Federal law (under the National Childhood Vaccine Injury Act) requires a health care provider to give a copy of the current VIS to an adult patient or to a child’s parent/legal representative before vaccinating an adult or child with a dose of the following vaccines: diphtheria, tetanus, pertussis, measles, mumps, rubella, polio, hepatitis A, hepatitis B, Haemophilus influenzae type b (Hib), influenza, pneumococcal conjugate, meningococcal, rotavirus, human papillomavirus (HPV), and varicella (chickenpox only).

Where to get VISs

All available VISs can be downloaded from the websites of the Immunization Action Coalition at www.immunize.org/vis or CDC at www.cdc.gov/vaccines/hcp/vis/index.html. Ready-to-copy versions may also be available from your state or local health department.

Top 10 Facts About VISs

FACT 1
It’s federal law! You must give current VISs to all your patients before vaccinating them.

Federal law requires that VISs must be used for patients of ALL ages when administering these vaccines:
- DTaP (includes DT)
- Td and Tdap
- Hib
- hepatitis A
- hepatitis B
- HPV
- influenza (inactivated and live, intranasal vaccines)

For the vaccines not covered under the National Childhood Vaccine Injury Act (i.e., adenovirus, anthrax, Japanese encephalitis, pneumococcal polysaccharide, rabies, shingles, typhoid, and yellow fever), providers are not required by federal law to use VISs unless they have been purchased under CDC contract. However, CDC recommends that VISs be used whenever these vaccines are given.

FACT 2
VISs can be given to patients in a variety of ways.

In most medical settings, VISs are provided to patients (or their parents/legal representatives) in paper form. However, VISs also may be provided using electronic media. Regardless of the format used, the goal is to provide a current VIS just prior to vaccination.

Vaccines covered under the National Childhood Vaccine Injury Act (i.e., all vaccines listed above except varicella) are required to have VISs in paper form. VISs for vaccines covered under the National Childhood Vaccine Injury Act and not covered under the Vaccine Injury Act (i.e., adenovirus, anthrax, Japanese encephalitis, pneumococcal polysaccharide, rabies, shingles, typhoid, and yellow fever) are not required to have VISs in paper form.

Most current versions of VISs (table)

As of November 12, 2015, the most recent versions of the VISs are as follows:

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Date of last revision</th>
<th>Date of publication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adenovirus</td>
<td>6/11/14</td>
<td></td>
</tr>
<tr>
<td>Anthrax</td>
<td>3/10/10</td>
<td></td>
</tr>
<tr>
<td>Chickenpox</td>
<td>2/13/08</td>
<td></td>
</tr>
<tr>
<td>DTaP</td>
<td>5/17/07</td>
<td></td>
</tr>
<tr>
<td>Hib</td>
<td>4/2/15</td>
<td></td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>10/25/11</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>2/2/12</td>
<td></td>
</tr>
<tr>
<td>HPV-Cervarix</td>
<td>3/5/11</td>
<td></td>
</tr>
<tr>
<td>HPV-Gardasil</td>
<td>8/15/15</td>
<td></td>
</tr>
<tr>
<td>Japanese enceph.</td>
<td>1/24/14</td>
<td></td>
</tr>
<tr>
<td>MCV4/MPSV4</td>
<td>10/14/11</td>
<td></td>
</tr>
<tr>
<td>MenB</td>
<td>8/14/15</td>
<td></td>
</tr>
</tbody>
</table>

A handy list of current VIS dates is also available at www.immunize.org/catg.d/p2029.pdf.

To access federal Vaccine Information Statements and their translations in more than 35 languages, visit www.immunize.org/vis.
These products are available for purchase from the Immunization Action Coalition

**The Vaccine Handbook: A Practical Guide for Clinicians** ("The Purple Book") by Gary Marshall, MD

*During my more than 20 years in the field of immunization education, I have not seen another book that is so brimming with state-of-the-science information.* – Deborah L. Wexler, MD, Executive Director, IAC

**NEW!** Fifth edition extensively updated for 2015!

Purchase *The Vaccine Handbook* (560 pages) from IAC at www.immunize.org/vaccine-handbook. $29.95 + shipping • Discount pricing available!

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- **DVD:** $17 each
  
  *The California Department of Public Health, Immunization Branch, updated its award-winning training video, “Immunization Techniques: Best Practices with Infants, Children, and Adults.” The 25-minute DVD can be used to train new employees and to refresh the skills of experienced staff on administering injectable, oral, and nasal-spray vaccines to children, teens, and adults.*

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Immunization record cards give health care professionals a way to help patients maintain a permanent record of their vaccinations. Having one’s own vaccination record is handy for patients when they enter daycare, kindergarten, or college; change health care providers; or travel abroad. The Immunization Action Coalition offers three record cards: adults, children and teens, and lifetime. Each is designed for a specific age group and lists all vaccines recommended for people in that age group. Sized to fit in a wallet, each is brightly colored to stand out and is printed on durable rip-, smudge-, and water-proof paper. To order record cards or any of our other essential immunization resources, print out and mail or fax the form below, or place your order online at www.immunize.org/shop.

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