This is a corrected version of the Practice Guideline that appeared in ePub ahead of print.

ACIP Releases 2016 Adult Immunization Recommendations

Key Points for Practice

- Nonavalent HPV vaccine can be used for routine vaccination in adolescents and adults.
- Human immunodeficiency virus infection is not an indication for routine vaccination with MenACWY-D or meningococcal B vaccine.
- The interval of at least one year between administering PCV13 and PPSV23 in adults 65 years and older aligns with the ACIP recommendation and Centers for Medicare and Medicaid Services coverage policy.

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Each year, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention reviews and updates the adult immunization schedule to incorporate any published updates or corrections from the previous year. The 2016 adult immunization schedule is available at http://www.aafp.org/patient-care/immunizations/schedules.html.

Human Papillomavirus Vaccine

In February 2015, the ACIP recommended nonavalent human papillomavirus (HPV) vaccine (Gardasil 9) as one of three formulations that can be used for routine vaccination in adolescents and adults. The nonavalent HPV vaccine is a noninfectious, virus-like particle vaccine that protects against HPV 6, 11, 16, 18, 31, 33, 45, 52, and 58. Although routine HPV vaccination is recommended at 11 or 12 years of age, it is also recommended in women through 26 years of age and men through 21 years of age. Men at high risk (e.g., men who have sex with men; immunocompromised men, including those infected with human immunodeficiency virus) from 21 to 26 years of age may also be vaccinated. There is no recommendation for revaccination for those who previously completed a full series.[1] The nonavalent vaccine is administered in a three-dose schedule at zero, one to two months, and six months.

Meningococcal Vaccine

It is recommended that those at increased risk of meningococcal disease be routinely vaccinated with a quadrivalent meningococcal conjugate vaccine (MenACWY-D [Menactra]), which protects against serogroups A, C, W, and Y. The ACIP recommends use of a series of either of the meningococcal B vaccines (MenB-4c [Bexsero], MenB-FHbp [Trumenba]) among certain groups of persons 10 years and older who are at increased risk of serogroup B meningococcal disease. Adults with asplenia or complement deficiencies or who work in outbreak settings are considered at increased risk. Human immunodeficiency virus infection is not an indication for routine vaccination with MenACWY-D or meningococcal B vaccine. In addition, young adults 16 to 23 years of age may be vaccinated to provide short-term protection against most strains of meningococcal B disease. There is no recommendation for revaccination or for travelers.[2] There is no contraindication to giving quadrivalent meningococcal conjugate vaccine and meningococcal B vaccine on the same day as long as different injection sites are used.

Pneumococcal Vaccine

Two pneumococcal vaccines are licensed for use in the United States: the 13-valent pneumococcal conjugate vaccine (PCV13 [Prevnar 13]) and the 23-valent pneumococcal polysaccharide vaccine (PPSV23 [Pneumovax 23]). The ACIP recommends that a dose of PCV13 be followed by a dose of PPSV23 in all adults 65 years and older who have not previously received pneumococcal vaccine, and in persons two years and older who are at high risk of pneumococcal disease because of underlying medical conditions. In June 2015, ACIP changed the recommended interval between PCV13 and PPSV23 from

six to 12 months to at least one year for immunocompetent adults 65 years and older. This aligns with the Centers for Medicare and Medicaid Services coverage policy. Recommended intervals for all other age and risk groups were not changed.[3]

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REFERENCES

1. Petrosky E, Bocchini JA Jr, Hariri S, et al.; Centers for Disease Control and Prevention. Use of 9-valent human papillomavirus (HPV) vaccine: updated HPV vaccination recommendations of the Advisory Committee on Immunization Practices. *MMWR Morb Mortal Wkly Rep*. 2015;64(11):300-304. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6411a3.htm. Accessed October 22, 2015.
2. Folaranmi T, Rubin L, Martin SW, Patel M, MacNeil JR; Centers for Disease Control and Prevention. Use of serogroup B meningococcal vaccines in persons aged ≥ 10 years at increased risk for serogroup B meningococcal disease: recommendations of the Advisory Committee on Immunization Practices, 2015 [published correction appears in *MMWR Morb Mortal Wkly Rep*. 2015;64(29):806]. *MMWR Morb Mortal Wkly Rep*. 2015;64(22):608-612. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6422a3.htm. Accessed October 22, 2015.
3. Kobayashi M, Bennett NM, Gierke R, et al. Intervals between PCV13 and PPSV23 vaccines: recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR Morb Mortal Wkly Rep*. 2015;64(34):944-947. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6434a4.htm. Accessed October 22, 2015. ■