AAFP Clinical guidance

Respiratory syncytial virus: 2025–26 recommendations

AAFP RSV recommendations for targeted populations

The American Academy of Family Physicians (AAFP) recommends the following vaccination guidance for respiratory syncytial virus (RSV)[1,2]:

- A single dose of any FDA-licensed RSV vaccine for all adults 75 years and older and adults 50-74 years who are at an increased risk of severe RSV.
- A single dose of RSV vaccine (Pfizer's Abrysvo®) for pregnant people to protect infants from severe RSV disease.
- An infant RSV monoclonal antibody (nirsevimab or clesrovimab) for infants younger than 8 months who are born during or are entering their first RSV season (October through March).

Updates for the 2025–26 Season[2,3]

- Adults 50-59 years who are at increased risk of severe RSV should receive a single dose of any FDA-licensed RSV vaccine.
- Infants younger than 8 months who are born during or entering their first RSV season and are not protected by maternal vaccination should receive one dose of clesrovimab. There is no preferential recommendation between nirsevimab and clesrovimab.

Targeted populations

Adults RSV vaccination[1,4]

- The AAFP recommends a single dose of any FDA-licensed RSV for all adults 75 years and older and adults 50-74 years at increased risk of severe RSV.
- There are three FDA-approved RSV vaccines currently available for adults 75 years and older, as well as for adults 50-74 years who are at increased risk of severe RSV.
- Adults eligible for the RSV vaccine may receive it at any time. However, the optimal period for vaccination is typically late summer to early fall—from August through October in most of the continental United States—before the RSV season begins.
- Annual RSV vaccination is not currently recommended. Individuals who have already received one dose, including those vaccinated last year, are considered fully vaccinated and should not receive another dose at this time.

Selection of vaccines[4]

There are three FDA-approved RSV vaccines currently available for all adults 75 years and older and adults 50-74 years at increased risk of severe RSV. The AAFP makes no preferential recommendation for a specific vaccine when multiple licensed and recommended options are available:

- GSK's Arexvy
- Moderna's mResvia®
- Pfizer's Abrysvo®

The three FDA-approved RSV vaccines should not be administered to individuals with a history of severe allergic reactions, such as anaphylaxis, to any component of the vaccine. Family physicians and other primary care clinicians should independently assess the potential risk of adverse events associated with each vaccine.

Optimal RSV vaccination timing

Eligible adults who have not previously received an RSV vaccine may be vaccinated at any time of year. However, the most significant benefit is achieved when vaccination occurs in late summer or early fall—just before the onset of RSV season. For most of the continental United States, this optimal window typically falls between August and October.

Conditions that increase the risk of severe RSV

Listed are the conditions that increase the risk of severe RSV, particularly for adults 50-74 years:

- Chronic cardiovascular disease (e.g., heart failure, coronary artery disease or congenital heart disease [excluding isolated hypertension])
- Chronic lung or respiratory disease (e.g., chronic obstructive pulmonary disease, emphysema, asthma, interstitial lung disease or cystic fibrosis)
- End-stage renal disease or dependence on hemodialysis or other renal replacement therapy
- Diabetes mellitus complicated by chronic kidney disease, neuropathy, retinopathy, or other end-organ damage, or requiring treatment with insulin or sodium-glucose cotransporter-2 (SGLT2) inhibitor
- Neurologic or neuromuscular conditions causing impaired airway clearance or respiratory muscle weakness (e.g., poststroke dysphagia, amyotrophic lateral sclerosis or muscular dystrophy [excluding history of stroke without impaired airway clearance])
- Chronic liver disease (e.g., cirrhosis)
- Chronic hematologic conditions (e.g., sickle cell disease or thalassemia)
- Severe obesity (i.e., body mass index ≥40 kg/m^2)
- Moderate or severe immune compromise
- Residence in a nursing home
- Other chronic medical conditions or risk factors that a health care professional determines would increase the

risk for severe disease due to viral respiratory infection (e.g., frailty, situations in which health care providers have concern for the presence of undiagnosed chronic medical conditions or residence in a remote or rural community where transportation of patients with severe RSV disease for escalation of medical care is challenging)

For more information, please visit the CDC's RSV Vaccine Guidance for Adults.

Maternal RSV vaccination[1,5]

- Either the maternal RSV vaccination or an infant immunization with RSV monoclonal antibody is recommended to prevent severe RSV disease in infants.
- The AAFP recommends that pregnant patients receive a single dose of the Abrysvo maternal RSV vaccine between 32 and 36 weeks of gestation, ideally administered during September to January.
- Most infants do not require both the maternal RSV vaccine and the RSV monoclonal antibody to achieve protection against RSV disease.

Selection of vaccines[5]

A single dose of the FDA-approved maternal RSV vaccine Abrysvo is recommended between 32 and 36 weeks of pregnancy. In most parts of the United States, this vaccine is typically administered from September through January to coincide with the peak RSV season.

Protection through maternal vaccination for the infant decreases over time. Since the maternal RSV vaccine (i.e., Abrysvo) is administered between September and January, the immunity transferred to the baby is expected to provide coverage during their first RSV season.

Pregnant patients should engage in a shared decision-making conversation with their family physician or primary care clinician about maternal RSV vaccination and the use of RSV monoclonal antibodies (i.e., nirsevimab or clesrovimab) to determine the best option for their family.

Optimal RSV vaccination timing

One single dose of Abrysvo is recommended for patients who are pregnant during 32 0/7 weeks' through 36 6/7 weeks' gestation. Patients who are pregnant and beyond 36 weeks and 6 days should not receive the vaccine, as there may not be sufficient time for maternal antibodies to develop, cross the placenta and protect the infant. In such cases, the infant should instead receive an RSV monoclonal antibody (i.e., either nirsevimab or clesrovimab) shortly before or at the onset of RSV season.

In much of the continental United States, pregnant patients should receive the RSV vaccine between September and January. This timing—starting 1-2 months before the anticipated onset of RSV season and ending 2-3 months before its expected conclusion—helps ensure that maternal antibodies develop and transfer to the infant, protecting against severe RSV disease after birth.

Family physicians and other primary care clinicians should not administer the maternal RSV vaccine outside of the seasonal timeframe unless the individual lives in an area where RSV circulation is less predictable and peak activity may vary, including Alaska and tropical climates (including but not limited to southern Florida, Guam, Hawaii, Puerto Rico, U.S.-affiliated Pacific Islands and the U.S. Virgin Islands).

Revaccination guidance for future pregnancies

Currently, a pregnant patient who has already received a maternal RSV vaccine during a previous pregnancy should not receive another dose during subsequent pregnancies. If the pregnant patient was not vaccinated during their current pregnancy, the infant should receive nirsevimab or clesrovimab (there is no preferential recommendation between the RSV monoclonal antibodies) between October and March. October is recommended if the infant is born between April and September, or at birth if born between October and March.

The evaluation of data is ongoing to determine whether there is sufficient benefit to revaccination during subsequent pregnancies.

Contraindications and precautions

Do not administer the Abrysvo vaccine to pregnant patients who have a history of severe allergic reactions (e.g., anaphylaxis) or to those allergic to any component of the vaccine.

Pregnant patients with a minor acute illness (i.e., cold) can receive the maternal RSV vaccine. If the pregnant patient has a moderate or severe acute illness, with or without fever, vaccination should be postponed until the patient's health improves.

For more information, please visit the American College of Obstetricians and Gynecologists' Maternal Respiratory, Syncytial Virus Vaccination, Practice Advisory.

For more information, please visit the CDC's RSV Vaccine Guidance for Pregnant Women.

Infants and young children RSV vaccination[6]

- The maternal RSV vaccination (i.e., Abrysvo) or an infant monoclonal antibody (i.e., nirsevimab or clesrovimab) is recommended to prevent severe RSV disease in infants. Most infants do not need both to achieve effective protection against RSV disease.
- RSV antibody administration is recommended from October through March in most of the United States. Ideally, infants should receive the antibody shortly before the RSV season begins (e.g., October to November), or within the first week of life if born between October and March, preferably during the birth hospitalization.

- Administration of infant RSV antibodies has demonstrated high efficacy in preventing RSV-associated hospitalizations.
- Side effects are usually mild (e.g., pain, redness or swelling at the injection site), with these issues typically resolving quickly. Hypersensitivity reactions are uncommon but have been reported with similar antibody products.

Recommendation for infants

The infant RSV monoclonal antibody (i.e., nirsevimab or clesrovimab) is recommended for infants younger than 8 months who are born during or entering their first RSV season (i.e., typically fall through spring), if they meet the following:

- The pregnant patient did not receive a single dose of Abrysvo (i.e., maternal RSV vaccine) between 32 and 36 weeks of gestation, or
- The pregnant patient's vaccination status is unknown, or
- The infant was born within 14 days of the maternal RSV vaccination.

To determine the child's eligibility for immunization, the child's age on the day the infant RSV antibody is administered should be used. An infant RSV antibody is not needed for most infants born 14 days or more after the pregnant patient has received a single dose of Abrysvo.

Family physicians and other primary care clinicians should discuss with parents and recommend an infant RSV antibody for eligible children. It is preferred that infants born from October through March receive an infant RSV antibody during their birth hospitalization. Administration can occur during any visit, including well-child visits.

If an infant is eligible to receive RSV antibody but experiences a prolonged hospitalization shortly before or during the RSV season, family physicians and other primary care clinicians may consider administering the antibody during the hospital stay to reduce the risk of health care-associated RSV infection. This decision should be carefully weighed against the potential risks and benefits.

Recommendation for some young children

For certain children 8 to 19 months who are at increased risk of severe RSV disease and are entering their second RSV season, nirsevimab is recommended.

Children 8 to 19 months with the following conditions are recommended to receive nirsevimab shortly before or as early as possible during their second RSV season:

- Chronic lung disease of prematurity who required medical support (i.e., chronic corticosteroid therapy, diuretic therapy or supplemental oxygen) at any time during the six months before the start of the second RSV season
- Severe immunocompromised
- Cystic fibrosis with either manifestations of severe lung disease (i.e., previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest imaging that persist when stable), or weight-for-length is <10th percentile
- American Indian or Alaska Native children

Children 8 months and older who are not at increased risk of severe RSV disease should not receive an infant RSV antibody. Nirsevimab is not currently recommended for anyone 20 months or older.

Clesrovimab is not recommended for children over 8 months and does not have FDA approval for children entering their second RSV season.

The American Academy of Pediatrics (AAP) publishes recommendations for palivizumab. They include considerations for the use of palivizumab in conjunction with nirsevimab recommendations. Beginning December 31, 2025, palivizumab will no longer be available.

Table 1. Selection of vaccination

NIRSEVIMAB	
Less than 8 months	• 50 mg for infants weighing <5 kg (<11 lb) • 100 mg for infants weighing ≥5 kg (≥11 lb)
8 months through 19 months	• 200 mg, administered as two 100-mg injections
CLESROVIMAB	
All eligible infants	• 105 mg

Optimal RSV vaccination timing

The infant RSV monoclonal antibody (i.e., nirsevimab or clesrovimab) should be administered from October through the end of March in most of the continental United States.

Infants born during the seasonal administration window (October 1 through March 31) should receive an RSV antibody within one week of birth—ideally during their birth hospitalization. In March, any eligible infant or young child who has not yet received a recommended dose of the RSV antibody should be administered it at the earliest opportunity.

For infants born outside the seasonal administration window (i.e., April through September), and for young children at increased risk for severe RSV disease who are entering their second RSV season, RSV antibody administration is ideally shortly before the season begins (e.g., October or November).

Since RSV activity can vary geographically across regions of the United States, public health authorities may issue updated guidance on the timing of RSV antibody administration based on local epidemiology. This may include starting administration before October, continuing beyond March or adjusting the duration of the administration period.

Public health officials should carefully weigh the benefits and drawbacks of modifying the timing of vaccination. Family physicians and other primary care clinicians, including those in regional medical centers and health systems, should consult with their state or territorial health departments before changing the recommended administration schedule for eligible patients.

Contraindications and precautions

Nirsevimab and clesrovimab are contraindicated in infants and children with a history of severe allergic reactions (e.g., anaphylaxis) to any components or excipients in the product. See nirsevimab FDA package insert and clesrovimab FDA package insert.[3]

Children who have a moderate or severe acute illness should usually wait until they recover before getting an infant RSV antibody (nirsevimab or clesrovimab). See CDC's General Best Practice Guidelines for Immunization.

For more information, please visit the AAP's Recommendations for the Prevention of RSV Disease in Infants and Children: Policy Statement.

For more information, please visit the CDC's RSV Immunization Guidance for Infants and Young Children.

References

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