



Respiratory syncytial virus: 2026-27 recommendations

AAFP respiratory syncytial virus (RSV) recommendations for targeted populations

The American Academy of Family Physicians (AAFP) recommends the following RSV immunization guidance¹⁻³:

- A single dose of an age-appropriate FDA-licensed RSV vaccine for all adults ≥ 75 years and adults 50 through 74 years who are at increased risk of severe RSV
- A single dose of Pfizer's Abrysvo[®] during pregnancy, when eligible, to protect infants from severe RSV disease
- An infant RSV monoclonal antibody (nirsevimab or clesrovimab) for infants < 8 months who are born during or entering their first RSV season and are not adequately protected by maternal vaccination

Updates for the 2026-27 season²⁻⁶

- Maternal RSV vaccination timing has been extended across most of the continental United States. Eligible patients who are pregnant may receive Abrysvo from September 1 through March 1.
- The American Academy of Pediatrics (AAP) expanded second-season nirsevimab eligibility for children 8 through 19 months at increased risk, including additional groups such as children born before 32 weeks' gestation and those with significant congenital heart, pulmonary, neuromuscular or chromosomal conditions.
- FDA indications for adult RSV vaccines now extend to some at-risk adults < 50 years. However, the AAFP routine recommendation remains vaccination of all adults ≥ 75 years and adults 50 through 74 years at increased risk.

Targeted populations

1. ADULTS: RSV VACCINATION^{2,4,5}

- The AAFP recommends a single dose of an age-appropriate FDA-licensed RSV vaccine for all adults ≥ 75 years and adults 50 through 74 years at increased risk of severe RSV.
- Three RSV vaccines are available for adults: Arexvy[®], Abrysvo and mResvia[®]. FDA-approved indications are broader than the AAFP's routine recommendations and include certain at-risk adults as young as 18 years.
- Adults who meet AAFP age- or risk-based eligibility may receive an RSV vaccine at any time; the optimal period is late summer to early fall (typically August through October) before RSV activity increases.

- RSV vaccination is currently a one-time recommendation. People who have already received an RSV vaccine should not receive another dose at this time. Health care personnel should be vaccinated based on age and individual risk, not occupational status alone.

Selection of vaccines^{1,2}

The AAFP makes no preferential recommendation among age-appropriate licensed RSV vaccines. Available products are:

- [GSK's Arexvy](#)
- [Moderna's mResvia](#)
- [Pfizer's Abrysvo](#)

Do not administer an RSV vaccine to a patient with a history of a severe allergic reaction (e.g., anaphylaxis) to a vaccine component.⁷ Postauthorization surveillance has identified a possible Guillain-Barré syndrome (GBS) signal in older adults after RSV vaccination.⁸ The absolute risk is small relative to the expected benefit in eligible high-risk adults. Consider product-specific safety information and prior GBS history when counseling patients.

Optimal RSV vaccination timing

Eligible adults who have not previously received an RSV vaccine may be vaccinated at any time of year, but vaccination in late summer or early fall is preferred in most of the continental United States.² Do not delay vaccination if a later opportunity is uncertain.

Conditions that increase the risk of severe RSV

The following conditions increase the risk of severe RSV, particularly for adults 50 through 74 years⁹:

- Chronic cardiovascular disease (e.g., heart failure, coronary artery disease or congenital heart disease [excluding isolated hypertension])
- Chronic lung or respiratory disease (e.g., COPD, 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 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/m²)
- 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 professionals 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](#).

2. MATERNAL RSV VACCINATION^{1,5}

- Either maternal RSV vaccination or infant immunization with a long-acting RSV monoclonal antibody is recommended to prevent severe RSV disease in infants; most infants do not need both.
- The AAFP recommends a single dose of Abrysvo at 32 0/7 through 36 6/7 weeks' gestation for eligible pregnant patients. In most of the continental United States, the 2026-27 seasonal window is September 1 through March 1.
- If maternal vaccination is declined, was not received during the current pregnancy or occurred <14 days before birth, the infant should receive nirsevimab or clesrovimab when otherwise eligible.

Selection of vaccines⁵

Abrysvo is the only RSV vaccine approved for use during pregnancy. The American College of Obstetricians and Gynecologists (ACOG) recommends vaccination at 32 0/7 through 36 6/7 weeks' gestation for patients who do not have a planned delivery within two weeks, did not receive maternal RSV vaccine during a previous pregnancy and are not planning for the infant to receive nirsevimab or clesrovimab.

Maternal vaccination generates antibodies that cross the placenta and help protect the infant during the first months of life. When maternal vaccination is not used, or protection is expected to be inadequate, infant monoclonal antibody immunization provides an alternative strategy.

Counsel pregnant patients on maternal vaccination and infant monoclonal antibody immunization as safe and effective alternative strategies. Consider patient preferences, access, timing of administration and local availability when choosing a prevention approach.

Optimal RSV vaccination timing

Administer one dose of Abrysvo at 32 0/7 through 36 6/7 weeks' gestation. Patients beyond 36 6/7 weeks should not receive maternal RSV vaccine because there may not be enough time for antibodies to develop and cross the placenta. Instead, the infant should receive an RSV monoclonal antibody when eligible.

For the 2026-27 season, ACOG recommends maternal RSV vaccination from September 1 through March 1 in most of the continental United States, reflecting the later RSV activity observed during the 2025-26 season.

Seasonal timing may differ in Alaska, tropical climates and other jurisdictions with different RSV epidemiology. Follow state, local or territorial guidance when RSV circulation differs from the continental U.S. pattern.

Revaccination guidance for future pregnancies

Pregnant patients who received maternal RSV vaccine during a previous pregnancy should not receive another maternal dose during a subsequent pregnancy. Their infant should instead receive nirsevimab or clesrovimab when eligible. There is no preferential recommendation between the two first-season monoclonal antibodies.

If the patient did not receive maternal RSV vaccine during a previous pregnancy and otherwise meets eligibility criteria, a single maternal dose may be given during the current pregnancy.

Contraindications and precautions

Do not administer Abrysvo to patients with a history of a severe allergic reaction (e.g., anaphylaxis) to a vaccine component.⁷

Postauthorization evidence has not shown an increased risk of preterm birth with recommended maternal RSV vaccination.⁵ Abrysvo labeling includes a GBS warning based on observational data in older adults. GBS has not been reported after maternal vaccination. Mild acute illness is not a contraindication, but vaccination should generally be deferred during moderate or severe acute illness until the patient improves.

For more information, please visit ACOG's [Maternal respiratory syncytial virus vaccination practice advisory](#).

For more information, please visit the CDC's [RSV vaccine guidance for pregnant women](#).

3. INFANTS AND YOUNG CHILDREN:

RSV IMMUNIZATION^{5,10}

- Maternal RSV vaccination (Abrysvo) or infant monoclonal antibody immunization (nirsevimab or clesrovimab) is recommended to prevent severe RSV disease in infants. Most infants do not need both.
- In most of the continental United States, infant RSV antibody administration is generally timed from October through March. Infants born during the season should receive an antibody within the first week of life, ideally during the birth hospitalization; timing may be extended based on local RSV activity.
- Real-world evidence continues to show high effectiveness of nirsevimab against RSV-associated emergency visits, hospitalization, ICU admission and respiratory failure.
- 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^{4–6,11}

Nirsevimab or clesrovimab is recommended for infants <8 months who are born during or entering their first RSV season when they are not adequately protected by maternal vaccination.

The AAP does not prefer one first-season product over the other, but it does recommend administration of RSV immunization in the infant when⁴:

- the patient who is pregnant did not receive maternal RSV vaccine during the current pregnancy, or
- the RSV vaccination status of the patient who is pregnant is unknown or
- the infant was born <14 days after maternal RSV vaccination.

Use the infant's age on the day the antibody is administered to determine eligibility. For most infants born ≥14 days after maternal Abrysvo vaccination, an RSV antibody is not needed.

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.

For eligible infants with prolonged birth hospitalization, RSV immunization should ideally be administered shortly before or promptly after discharge during RSV season. Administration during the hospitalization may be considered based on local activity and clinical judgment.

Recommendation for some young children⁴

For children 8 through 19 months who remain at increased risk of severe RSV disease and are entering their second RSV season, nirsevimab is recommended. The AAP expanded second-season eligibility for 2026–27 based on newer evidence of risk.



Second-season nirsevimab is recommended for children 8 through 19 months who have the following high-risk conditions or circumstances:

- Birth before 32 weeks, 0 days' gestation, regardless of need for ongoing medication
- Chronic lung disease and/or other significant neonatal conditions requiring medical intervention during the 6 months before the start of the second RSV season
- Hemodynamically significant congenital heart disease, including medically treated congestive heart failure requiring surgery or moderate-to-severe pulmonary hypertension
- Anatomic pulmonary abnormalities or neuromuscular disorders that impair airway clearance
- Severe immunocompromise
- Down syndrome or other chromosomal differences that predispose to severe RSV disease
- Cystic fibrosis with severe or rapidly progressing lung disease or weight-for-length <10th percentile
- American Indian or Alaska Native children

Children ≥8 months who are not in a recommended high-risk group should not receive RSV antibody for a second season.

Nirsevimab is not recommended for anyone ≥20 months.¹² Clesrovimab is approved and recommended only for eligible infants entering their first RSV season.¹³ Nirsevimab is currently the only RSV monoclonal antibody indicated for children entering a second RSV season.¹⁴

Palivizumab (Synagis®) has been discontinued. Nirsevimab replaces the former monthly palivizumab strategy for eligible children who need second-season protection.

Table 1. RSV monoclonal antibody dosing¹⁴

Nirsevimab	
<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 immunization timing¹⁴

In most of the continental United States, administer nirsevimab or clesrovimab from October through March, with adjustments when state or local RSV activity supports a different window.

Infants born during the usual seasonal administration window (October 1 through March 31) should receive RSV antibody within one week of birth, ideally during the birth hospitalization. Eligible infants or young children who remain unimmunized late in the season should receive the recommended dose at the earliest opportunity while RSV is circulating.

For infants born April through September and for high-risk children entering their second RSV season, administer RSV antibody shortly before the season begins (typically October or November).

RSV activity varies geographically and may extend beyond the usual season. During 2025-26, many jurisdictions extended pediatric immunization through April because of later RSV activity. Follow state, local or territorial guidance for 2026-27 timing.

Contraindications and precautions

Nirsevimab and clesrovimab are contraindicated in infants and children with a history of severe allergic reaction (e.g., anaphylaxis) to a product component or excipient.

Children with moderate or severe acute illness should generally wait until recovery before receiving nirsevimab or clesrovimab. RSV antibodies can be coadministered with age-appropriate routine vaccines.

For more information, please visit the AAP's [Recommendations for the prevention of respiratory syncytial virus disease in infants and children: policy statement](#).

For more information, please visit the CDC's [RSV immunization guidance for infants and young children](#).

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