

2026-2027 Influenza, RSV, and SARS-CoV-2 Immunization Recommendations for Nonpregnant, Immunocompetent Adults and Health Care Personnel

Margot Savoy, MD, MPH, and Corban Wehr, BGS, on behalf of the American Academy of Family Physicians

This immunization guidance from the American Academy of Family Physicians (AAFP) addresses nonpregnant, immunocompetent adults 19 years and older and health care personnel. For other populations, see guidance from the American Academy of Pediatrics (for individuals 18 years and younger), Infectious Diseases Society of America (for individuals with immunocompromise), and American College of Obstetricians and Gynecologists (for pregnant individuals). Recommendations in this document are guided by the AAFP Adult Immunization Schedule. Where AAFP guidance differs from other organizations, the AAFP recommendation should be followed. AAFP immunization recommendations are reviewed and approved annually.

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SUMMARY OF AAFP CLINICAL RECOMMENDATIONS¹

- All adults 19 years and older should receive an annual influenza vaccine and an updated COVID-19 vaccine.
- Adults 65 years and older should preferentially receive an enhanced influenza vaccine (high dose, adjuvanted, recombinant, or mRNA) when available, but vaccination should not be delayed if one is unavailable.
- Adults 65 years and older should receive two doses of the updated COVID-19 vaccine each season, with the first at month 0 and the second 6 months later.
- Adults 75 years and older and adults 50 to 74 years of age who are at increased risk should receive one dose of the respiratory syncytial virus (RSV) vaccine.
- Health care personnel should receive annual influenza and

updated COVID-19 vaccination due to their repeated occupational exposure and contact with patients at high risk of severe disease.

WHY RESPIRATORY IMMUNIZATION IS RELEVANT THIS SEASON

Fall and winter respiratory season brings sharply elevated risk from three vaccine-preventable viruses: influenza, RSV, and SARS-CoV-2. In a Danish nationwide cohort of adults, RSV and influenza each accounted for substantial hospitalizations, with the risk concentrated in older adults and those with chronic cardiopulmonary disease, confirming that RSV burden in adults is comparable with that of influenza rather than incidental to it.² US surveillance through the Respiratory Virus Hospitalization Surveillance Network (RESP-NET) tracks the three viruses and consistently identifies adults 65 years and older as being at highest risk for hospitalization and death.³

Younger adults with chronic conditions (eg, diabetes, obesity, chronic lung disease, cardiovascular disease) also experience substantial respiratory-related hospitalization; healthy younger adults contribute to community transmission.^{2,4} The recommendations in this document address all adults 19 years and older, not only those at highest risk.

Vaccine uptake remains well below where it should be, including in the highest-risk group. During the 2024-2025 influenza season, only 41.9% of adults 18 years and older and 64% of adults 65 years and older received an influenza vaccine.⁵ As of January 2026, 16.1% of adults had received a 2025-2026 COVID-19 vaccine, and 43.9% had received a 2025-2026 influenza vaccine.⁶ RSV vaccine—uptake rates among eligible older adults were similarly low. As of February 2026, 40.9% of adults 75 years and older and 30.9% of adults 50 to 74 years with high-risk conditions reported ever receiving an RSV vaccine.⁶

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Immunization remains the most effective intervention to reduce severe respiratory illness.⁷ This document provides current AAFP recommendations, product guidance, and practical workflows for delivering vaccines efficiently in primary care.

INFLUENZA VACCINATION IN NONPREGNANT, IMMUNOCOMPETENT ADULTS 19 YEARS AND OLDER

AAFP recommendations¹

- All adults 19 years and older should receive an annual influenza vaccine.
- Health care personnel should receive an annual influenza vaccine.
- For adults 65 years and older, the AAFP supports preferential use of a high-dose, adjuvanted, recombinant, or mRNA vaccine over standard-dose unadjuvanted products.

Groups at High Risk

Older Adults (65 Years and Older). Individuals 65 years and older are at substantially higher risk for influenza-related hospitalization and death.⁸ The AAFP recommends preferential use of a high-dose, adjuvanted, recombinant, or mRNA influenza vaccine, when available, for this group.¹ This recommendation is consistent with long-standing guidance from the Advisory Committee on Immunization Practices (ACIP) and the 2025 American College of Physicians (ACP) practice points, which also favor an enhanced (ie, high-dose) product for adults 65 years and older.^{9,10}

Evidence Context. The preferential recommendation is based on consistent immunogenicity and effectiveness advantages for enhanced products. However, trial evidence on severe outcomes is not uniform, and clinicians should understand the nuances.

- In the GALFLU trial (a pragmatic, registry-based, randomized trial of 103,169 community-dwelling adults 65 to 79 years of age conducted in Galicia, Spain), a high-dose vaccine reduced the composite of influenza or pneumonia hospitalization relative to a standard-dose vaccine (relative vaccine effectiveness = 23.7%; 95% CI, 6.6-37.7), with a consistent effect on influenza hospitalization specifically (relative vaccine effectiveness = 31.8%; 95% CI, 5.0-51.3). Serious adverse events were similar between groups.¹¹
- In the DANFLU-2 trial (a pragmatic, randomized trial of 332,438 Danish adults 65 years and older), the primary end point was neutral. Per the trial's prespecified design, no hypothesis testing was performed for cardiovascular secondary and exploratory end points.¹²

Combined, these data support a preferential, but not exclusive, recommendation. The absolute benefit of an enhanced product is modest, and no eligible patient should remain unvaccinated because a preferred product is unavailable. Vaccinating with any age-appropriate product is substantially better than

KEY POINTS FOR VACCINE IMPLEMENTATION AND ACCEPTANCE

- **Recommend vaccines confidently and early.** Use a presumptive recommendation (eg, "You are due for your flu and updated COVID-19 vaccines today."), followed by brief shared decision-making. A strong clinician recommendation is among the most reliable predictors of adult vaccine acceptance.⁵⁵
- **Offer coadministration.** The influenza, COVID-19, and RSV vaccines (when indicated) can be administered at the same office visit with no minimum interval and may be coadministered with other routine vaccines (eg, tetanus, pneumococcal).^{52,59}
- **Use every encounter as a vaccine opportunity.** Previsit planning, standing orders, and prompts from the electronic health record help prevent vaccination from being deferred.⁵⁵
- **Maintain continuity when vaccines are administered at another location.** Vaccination should be documented promptly in the patient's electronic health record and immunization information system.
- **Access the most up-to-date schedule and vaccine information at AAFP.org.** Recommendations and product details may change during the season. The AAFP provides current recommendations at <https://www.aafp.org/clinical-insights/immunizations-and-vaccines/immunizations-schedules-resources>.

deferring vaccination.¹³

Moderna's mFlusiva (mRNA-1010) was approved by the US Food and Drug Administration (FDA) in August 2026 and is available for the 2026-2027 season.^{14,15} For adults 65 years and older, mRNA-1010 is included among the preferentially recommended enhanced products (alongside high-dose, adjuvanted, and recombinant vaccines). For adults in the younger FDA-approved age group (50 to 64 years of age), it also is an age-appropriate option without preferential status.

Options for adults 65 years and older¹⁴⁻¹⁸:

- Fluzone high-dose (HD-IIV3): contains four times the antigen of a standard dose
- Fluad adjuvanted (aIIV3): contains MF59 adjuvant to strengthen immune response
- Flublok recombinant (RIV3): egg-free; contains higher antigen concentration
- mFlusiva (mRNA): egg-free; first influenza vaccine using mRNA technology, the same technology in the COVID-19 vaccines.

Adults With Chronic Conditions. Chronic disease is an independent risk factor for serious influenza complications, including hospitalization and death.¹⁹ High-risk conditions include asthma and chronic lung disease (eg, chronic obstructive pulmonary disease, cystic fibrosis), neurologic and

neurodevelopmental conditions, blood disorders (eg, sickle cell disease), diabetes, history of heart disease or stroke, kidney or liver disorders, severe obesity (ie, body mass index of 40 kg/m² or greater), and immunocompromising conditions or therapies (eg, cancer, cancer treatment). Clinicians should prioritize annual vaccination, encourage early evaluation when influenza is suspected, and initiate antiviral treatment promptly when indicated.

Health Care Personnel. Unvaccinated health care personnel are at increased risk of acquiring occupational influenza, resulting in symptomatic illness and absenteeism during peak season.²⁰ A systematic review and meta-analysis of influenza vaccination in health care workers found lower rates of laboratory-confirmed influenza and reduced absenteeism among vaccinated personnel.²⁰ Likewise, higher vaccination coverage of health care personnel in long-term care settings has been associated with reduced influenza-like illness and lower all-cause mortality in patients, supporting vaccination in health care personnel as a patient and occupational safety intervention.²¹

Timing

For most adults, vaccination during September to October is optimal, continuing throughout the season while influenza viruses are circulating.²² For adults 65 years and older, vaccination during July or August should be avoided unless later vaccination may not be feasible because of evidence of waning protection during the respiratory season.²² Earlier vaccination may be reasonable when influenza is already circulating at elevated levels in the community. Vaccination should not be delayed while waiting for a preferred product to become available.

Product Selection

For most adults, any age-appropriate licensed influenza vaccine is acceptable. Adults 65 years and older should preferentially receive a high-dose, adjuvanted, recombinant, or mRNA product when available.¹⁶⁻¹⁸ People with egg allergies—regardless of the severity of their previous reactions—can receive any age-appropriate influenza vaccine, including egg-based products, with no additional safety precautions beyond those recommended for any vaccine.¹ Product-specific contraindications and precautions (eg, history of severe allergic reaction to a previous dose or vaccine component) apply as listed in each product's labeling and in the AAFP schedule; clinicians should screen for these before administering the vaccine.

Adults who prefer to avoid injections may opt for the live attenuated influenza vaccine (FluMist), which is approved for nonpregnant individuals 2 to 49 years of age without relevant contraindications.²³ FluMist also is now approved for self-administration for adults 18 to 49 years or caregiver administration for individuals 2 to 17 years and can be administered at home.

Thimerosal. A June 2025 ACIP vote to recommend only thimerosal-free influenza formulations was paused by a federal

court stay in March 2026 and is not, as a formal recommendation, currently in effect.²⁴ Historically, thimerosal appeared only in multidose vials, and large studies have found no evidence of harm from those quantities.²⁵ Do not delay vaccination because of concerns about thimerosal.

All US seasonal influenza vaccines are trivalent (IIV3, ccIIV3, RIV3, LAIV3, mRNA) and have been developed to target the A(H1N1)pdm09, A(H3N2), and B/Victoria-lineage viruses.²⁶ Beginning with the 2024-2025 season, the B/Yamagata lineage was removed because the virus has not been detected in global surveillance since March 2020.²⁷ Product names and -4 designations from prior seasons (IIV4, RIV4) no longer apply. Currently available vaccine products for influenza are listed in Table 1.^{1,14,28,29}

2026-2027 Strain Composition²⁶

The FDA's Vaccines and Related Biological Products Advisory Committee (VRBPAC) met March 12, 2026, and recommended the following compositions.³⁰ A video of the meeting is available at <https://www.fda.gov/advisory-committees/advisory-committee-calendar/vaccines-and-related-biological-products-advisory-committee-march-12-2026-meeting-announcement>.

- **Egg-based vaccines:** A/Missouri/11/2025 (H1N1)pdm09-like virus; A/Darwin/1454/2025 (H3N2)-like virus; B/Tokyo/EIS13-175/2025 (B/Victoria lineage)-like virus
- **Cell- or recombinant-based vaccines:** A/Missouri/11/2025 (H1N1)pdm09-like virus; A/Darwin/1415/2025 (H3N2)-like virus; B/Pennsylvania/14/2025 (B/Victoria lineage)

COVID-19 VACCINATION IN NONPREGNANT, IMMUNOCOMPETENT ADULTS 19 YEARS AND OLDER

AAFP recommendations¹

Health care personnel and adults 19 years and older should receive an updated COVID-19 vaccine, especially the following populations:

- Adults 65 years and older
- Adults at increased risk for severe COVID-19
- Adults who have never received a COVID-19 vaccine

2026-2027 Vaccine Composition

The VRBPAC met May 28, 2026, and recommended that the 2026-2027 COVID-19 vaccine composition include the JN.1-lineage XFG variant as the preferred SARS-CoV-2 variant for an updated monovalent vaccine.^{31,32} The committee voted 8 to 0 in favor, with one abstention. Based on the evidence, the FDA advised manufacturers that beginning in fall 2026, COVID-19 vaccines for use in the United States should be a monovalent JN.1-lineage XFG variant vaccine.

Influenza and SARS-CoV-2 undergo continual antigenic change, and their vaccines are periodically updated to better match circulating strains, which is a key reason for necessary annual or updated vaccination rather than a single lifetime

TABLE 1

Influenza Vaccine Products Available in the United States (2026-2027)

Product (manufacturer)	Vaccine type or platform	FDA-approved indication (age)	Comments
Fluarix (GlaxoSmithKline)	Standard-dose IIV3 (egg-based)	≥ 6 months	IM Age-appropriate for most people
Flulaval (GlaxoSmithKline)	Standard-dose IIV3 (egg-based)	≥ 6 months	IM Age-appropriate for most people
Fluzone (Sanofi Pasteur)	Standard-dose IIV3 (egg-based)	≥ 6 months	IM Age-appropriate for most people
Flucelvax (Seqirus)	Cell culture-based IIV3 (ccIIV3)	≥ 6 months	IM Cell-based manufacturing Age-appropriate for most people
Flublok (Sanofi Pasteur)	Recombinant IIV3 (RIV3)	≥ 9 years	Preferred by AAFP for adults ≥ 65 years when available Age indication was lowered from ≥ 18 years to ≥ 9 years during the 2025-2026 season
Fluad (Seqirus)	Adjuvanted IIV3 (aIIV3)	≥ 65 years	Preferred by AAFP for adults ≥ 65 years when available
Fluzone high-dose (Sanofi)	High-dose IIV3 (HD-IIV3)	≥ 65 years	Preferred by AAFP for adults ≥ 65 years when available
FluMist (AstraZeneca)	Live attenuated (LAIV3; intranasal; egg-based)	2-49 years	Use in nonpregnant people with no contraindications Do not use in adults ≥ 50 years Approved for self-administration (18-49 years of age) or caregiver administration (2-17 years of age)
mFlusiva (Moderna)	mRNA	≥ 50 years	Preferred by AAFP for adults ≥ 65 years when available First influenza vaccine using COVID-19 vaccine's mRNA technology

Note: This table reflects the AAFP Adult Immunization Schedule.

AAFP = American Academy of Family Physicians; FDA = US Food and Drug Administration; IM = intramuscular.

Information from references 1, 14, 28, and 29.

series.³³ XFG remains within the JN.1 lineage targeted by the 2025-2026 formula, which preferentially used the LP.8.1 strain.³⁴ This continuity is relevant when counseling patients. Effectiveness estimates from the 2025-2026 season were derived from a JN.1-lineage vaccine against JN.1-descendant circulation. Therefore, estimates remain informative for the 2026-2027 product rather than superseded by it.

High-Risk Groups

Adults at Increased Risk for Severe COVID-19. Risk for severe COVID-19 increases sharply with advancing age,

particularly for individuals 65 years and older.³⁵ Additional high-risk conditions include individuals with moderate to severe immunocompromised conditions, chronic kidney disease, chronic lung disease (eg, chronic obstructive pulmonary disease, interstitial lung disease), diabetes, obesity, cardiovascular disease, cancer, or neurologic conditions (eg, dementia) or in individuals who smoke or formerly smoked. Risk increases in patients with multiple comorbidities or when patients are not up to date on vaccination (eg, the patient has not received an updated COVID-19 vaccine during the current respiratory season).³⁶

TABLE 2

COVID-19 Vaccine Products Available in the United States (2026-2027)

Product (manufacturer)	Vaccine type or platform	FDA-approved indication (age)	Comments
Spikevax (Moderna)	mRNA	≥ 65 years or 6 months to 64 years with one or more underlying conditions conferring high risk for severe COVID-19	Only FDA-approved product for children 6 months to 4 years Dose volume (0.5 mL) differs from mNexSpike (0.2 mL); they should not be interchanged without checking
Comirnaty (Pfizer-BioNTech)	mRNA	≥ 65 years or 5-64 years with one or more underlying conditions	Not approved for children 6 months to 4 years (the prior emergency use authorization for that age group was withdrawn)
mNexspike (Moderna)	mRNA	≥ 65 years or 12-64 years with one or more underlying conditions	Dose volume (0.2 mL) differs from Spikevax (0.5 mL); they should not be interchanged without checking
Nuvaxovid (Novavax)	Protein subunit (adjuvanted)	≥ 65 years or 12-64 years with one or more underlying conditions	Non-mRNA option per patient preference

Note: This table reflects the AAFP Adult Immunization Schedule. This guidance focuses on adults ≥ 19 years; indications for children are included for context.

FDA = US Food and Drug Administration.

Information from references 1 and 39.

Health Care Personnel. Health care personnel frequently have close contact with patients and encounter repeated occupational exposure to SARS-CoV-2. Although current vaccines provide less protection against mild infection with evolving variants, effectiveness evaluations consistently demonstrate meaningful protection against severe outcomes.^{36,37} Interim estimates for the 2025-2026 JN.1-lineage vaccine demonstrated protection against medically attended COVID-19 in immunocompetent adults, and estimates for the 2024-2025 formulation demonstrated protection against severe COVID-19 requiring hospitalization or critical care.^{34,36} Protection against severe outcomes persisted through long-term follow-up in a target trial emulation of the 2024-2025 KP.2 vaccines, although effectiveness against infection waned.³⁷ Together, these studies support vaccination as a key strategy to reduce morbidity in health care personnel and protect staff at high risk of infection.

Timing

Offer updated COVID-19 vaccination as soon as the updated formulation is available, particularly for adults 65 years and older, individuals with immunocompromise, health care

personnel, and residents of long-term care facilities. SARS-CoV-2 circulates year-round, and protection wanes over time.³⁷ Do not delay COVID-19 vaccination while waiting for a preferred product.

Two Doses for Adults 65 Years and Older. To counter waning protection, adults 65 years and older are recommended to receive two doses of the updated COVID-19 vaccine each season, with the first dose at month 0 and the second dose administered 6 months later.³⁸ This two-dose schedule also applies to many adults with moderate or severe immunocompromise. Confirm current guidance and payer coverage at the time of vaccination.

Product Selection and Special Considerations

A preferential recommendation for licensed COVID-19 products is not available. For patients who prefer a non-mRNA option, Nuvaxovid (Novavax, protein subunit) is available.³⁹ All four licensed products carry a risk-based indication rather than a simple minimum age. Currently available vaccine products for COVID-19 are listed in Table 2.^{1,39}

The AAFP recommendation is broader than the

FDA-approved indication. The AAFP recommends COVID-19 vaccination for all adults 19 years and older.¹ The FDA-approved indication, however, denotes the FDA-approved population (not a clinical recommendation) because the FDA does not issue vaccination recommendations. Since 2025, every licensed COVID-19 product is approved only for adults 65 years and older or for adults younger than 65 years with at least one underlying condition that confers high risk for severe COVID-19.⁴⁰ A healthy adult 19 to 64 years of age with no qualifying conditions is outside the FDA-approved indication, although the AAFP recommends vaccination for this population. Vaccinating patients without an underlying high-risk condition is an off-label use of an FDA-approved product, which is within the practice of medicine and supported by AAFP recommendations. The list of qualifying conditions for vaccination is broad (eg, obesity [body mass index of 30 kg/m² or greater], diabetes, cardiovascular disease, chronic lung disease, currently or formerly smoking, physical inactivity), so most adults who want to be vaccinated will qualify on review. Patients may self-attest to having a risk factor; no documentation or attestation form is required.

Member health plans from the AHIP (formerly America's Health Insurance Plans) have stated that all ACIP-recommended immunizations will continue to be covered with no cost-sharing through the end of 2027, which should limit out-of-pocket cost for most patients.⁴¹ However, confirm local coverage because some plans may track the FDA-approved indication. Pharmacy authority to vaccinate is tied to ACIP recommendations in some states, so pharmacy access for patients outside the labeled indication may vary. Where access is uncertain, vaccination should occur in the office.

RSV VACCINATION IN NONPREGNANT, IMMUNOCOMPETENT ADULTS 19 YEARS AND OLDER

AAFP recommendations¹

- Adults 75 years and older: single dose of any age-appropriate, FDA-licensed RSV vaccine
- Adults 50 to 74 years of age at increased risk of severe RSV: single dose of any age-appropriate, FDA-licensed RSV vaccine
- Health care personnel: RSV vaccination should be based on individual health, age, and risk eligibility, not occupational status alone

High-Risk Groups

Adults at Increased Risk for Severe RSV. Individuals at high risk include adults 75 years and older, adults 50 to 74 years of age with chronic heart or lung disease, adults of any age with weakened immune systems, adults with certain other underlying medical conditions, and adults residing in nursing homes or long-term care facilities.^{1,42}

Benefit. A single dose of RSV vaccine substantially reduces

RSV-associated lower respiratory tract disease and hospitalization in older adults.^{43,44} Effectiveness against RSV-associated outcomes was maintained across two respiratory seasons in a large US cohort with supporting randomized and observational data in adults 60 years and older.^{43,44} RSV vaccination is recommended as a one-time dose; currently, evidence is insufficient for recommending revaccination.¹

Health Care Personnel. Health care personnel may have occupational exposure to RSV in close-contact clinical settings. However, current evidence does not support RSV vaccination based on only occupational status; therefore, occupational status alone is not an indication for RSV vaccination.¹ The RSV vaccine should be offered to health care personnel who meet the age- or risk-based eligibility criteria.

Timing

Although eligible adults may receive the RSV vaccine at any time, late summer to early fall is optimal, before RSV activity in the community typically increases.¹ This aligns RSV, influenza, and COVID-19 vaccination outreach and supports one-stop respiratory-season visits.

Product Selection and Safety Considerations

Available Products. Arexvy (GlaxoSmithKline; AS01E adjuvanted), Abrysvo (Pfizer; adjuvant-free), and mResvia (Moderna; mRNA-based) are approved for adults 60 years and older and for younger adults at increased risk for RSV-associated lower respiratory tract disease. No product is preferentially recommended over another.¹ Currently available vaccine products for RSV are listed in Table 3.^{1,45-49}

Safety Considerations. Postauthorization surveillance of RSV vaccines in older adults identified a potential signal for Guillain-Barré syndrome.^{50,51} Pooled evidence estimates an excess of approximately 18 cases per 1 million doses of the bivalent prefusion F (RSVpreF) product; the absolute risk is small relative to the benefits in groups at high risk.⁵² A separate concern for atrial fibrillation arose primarily from trial and postmarketing data for the AS01E-adjuvanted product, and pooled data remain insufficient to quantify any excess risk.⁴⁷ Therefore, this concern should be described as product-specific and not well quantified.

In a prespecified analysis of the DAN-RSV randomized trial including 131,276 adults 60 years and older, the effect of RSVpreF on cardiovascular hospitalization outcomes was evaluated, providing randomized data relevant to cardiovascular safety and benefit.⁴⁴ Clinicians should discuss Guillain-Barré syndrome briefly during shared decision-making, particularly with patients who have a history of the condition.

Applying Age and Risk Criteria. The FDA-approved age range to receive the RSV vaccine is broader than the AAFP recommendation. In March 2026, the FDA expanded the Arexvy indication to include adults 18 to 49 years of age at increased risk for RSV lower respiratory tract disease.⁴⁸ Abrysvo and mResvia are similarly approved for adults 18 years and older who are at risk. These FDA approvals have not been reviewed by

TABLE 3

RSV Vaccine Products Available in the United States (2026-2027)

Product (manufacturer)	Vaccine type or platform	FDA-approved indication (age)	Comments
Arexvy (GlaxoSmithKline)	Protein subunit (pre-fusion F) plus AS01E adjuvant	≥ 60 years 18-59 years at increased risk*	Single dose (0.5 mL) IM Not for use during pregnancy (product limitation) Guillain-Barré syndrome warning based on postmarketing observational data
Abrysvo (Pfizer)	Protein subunit (bivalent prefusion F) without adjuvant	≥ 60 years 18-59 years at increased risk	Single dose (0.5 mL) IM Indicated for use during pregnancy at 32-36 weeks' gestation (separate, nonadult indication) Guillain-Barré syndrome warning based on postmarketing observational data
mResvia (Moderna)	mRNA (prefusion F) without adjuvant	≥ 60 years 18-59 years at increased risk	Single dose (0.5 mL) IM

Note: This table reflects the AAFP Adult Immunization Schedule.

AAFP = American Academy of Family Physicians; ACIP = Advisory Committee on Immunization Practices; CDC = Centers for Disease Control and Prevention; FDA = US Food and Drug Administration; IM = intramuscularly; RSV = respiratory syncytial virus.

*—The FDA-approved age range to receive the RSV vaccine is broader than the AAFP recommendation. In March 2026, the FDA expanded the Arexvy indication to include adults 18-49 years of age at increased risk for RSV lower respiratory tract disease.⁵¹ Abrysvo and mResvia are similarly approved for adults ≥ 18 years who are at risk. These FDA approvals have not been reviewed by ACIP, and current CDC and ACIP guidance and AAFP recommendations do not extend routine RSV vaccination for adults < 50 years. Clinicians should follow the AAFP age and risk thresholds for routine practice. Approvals for younger adults may be considered individually but are not included in routine recommendation.

Information from references 1 and 45-49.

ACIP. Current Centers for Disease Control and Prevention and ACIP guidance and AAFP recommendations do not extend routine RSV vaccination for adults younger than 50 years. Clinicians should follow the AAFP age and risk thresholds for routine practice. Approvals for younger adults may be considered individually but are not included in routine recommendation.

The AAFP recommendation and FDA-approved indications align more closely than they may first appear because every RSV vaccine is labeled for use in adults at increased risk and for those 60 years and older.^{45-48,53} Adults 50 to 74 years of age with a qualifying high-risk condition are included in the AAFP recommendation to vaccinate (ie, a recommendation rather than a shared decision-making option). For adults 60 to 74 years of age without a high-risk condition, vaccination is within the FDA-approved indication of 60 years and older but below the AAFP's risk-based threshold; shared decision-making is appropriate in these instances. For adults 50 to 59 years of age without a qualifying condition, vaccination is neither recommended by AAFP nor within the FDA-approved indication.

PRACTICE IMPLEMENTATION: GETTING VACCINES TO PATIENTS

The AAFP supports universal immunization regardless of

socioeconomic or insurance status and recommends that patients receive all indicated vaccines from their usual source of primary care.⁵⁴ When vaccines are provided at a different location, all vaccine-related information should be submitted to the patient's electronic health record and immunization information system so that the primary care record remains complete and accurate.⁵⁴

Evidence-Based Strategies

A component network meta-analysis of interventions to increase vaccine uptake found that multicomponent strategies combining patient reminders, clinician prompts, and reduced structural barriers outperform single-component approaches and that education delivered in isolation has limited effect.⁵⁵ A systematic review focused specifically on primary care also found that in-person clinician conversations and recommendations are associated with meaningful increases in adult vaccination uptake and that counseling is most effective when combined with workflow supports.⁵⁶ These strategies for increasing vaccination reflect that evidence.

- **Make every visit a vaccine visit.** Use previsit planning to determine rooming workflows and to identify vaccines that are due before the scheduled appointment (eg, standing prompts

for a medical assistant to check the status, registered nurse to provide pending orders) so that vaccination is assessed at acute care, chronic care, and preventive visits.⁵⁵ Incorporating an any-visit approach to vaccination is the most effective structural change a practice can enact to improve immunization coverage.

- **Standing orders and expanded vaccinators.** Implement standing orders consistent with state scope-of-practice laws to allow permitted, trained staff (eg, nurses, pharmacists) to assess eligibility and administer indicated vaccines without a same-day clinician order.⁵⁵

- **Strong recommendations and motivational counseling.** Using a strong, presumptive clinician recommendation (eg, “You are due for your flu and updated COVID-19 vaccines today.”) is among the strongest predictors of adult vaccine acceptance.⁵⁷ When patients express a lack of confidence in the effectiveness of vaccines, try using motivational interviewing techniques to explore concerns without delaying protection.⁵⁵ Shared clinical decision-making can help adults weigh the benefits and risks based on their own circumstances; clinicians may still offer a clear recommendation informed by clinical judgment.⁵⁸

- **Reminder or recall and measurement.** Use the immunization information system—enabled or electronic health record—enabled reminder or recall (eg, text, phone, mail, patient portal) for patients who are due or overdue for vaccination, and pair outreach with clinician assessment and feedback to identify gaps and sustain improvement over time.⁵⁵

- **Coadministration.** When adults are eligible for multiple respiratory vaccines, offer coadministration (eg, influenza plus COVID-19 vaccination, along with RSV [when indicated]) during the same office visit to reduce return trips.⁵² Respiratory vaccines also may be coadministered with other routine vaccines, such as tetanus, shingles, and pneumococcal vaccines. Evidence synthesis identified 17 studies of COVID-19 and influenza coadministration showing immunogenicity and safety comparable with sequential administration, five randomized trials supporting RSV and influenza coadministration in adults 65 years and older, and acceptable immunogenicity and safety for triple coadministration.⁵² Real-world safety surveillance of influenza, COVID-19, and RSV coadministration in older adults did not identify new safety signals.⁵⁹ Counsel patients that mild, short-lived reactogenicity (ie, fatigue, myalgias) may be similar to or modestly more common than with single-vaccine administration.⁵² When possible, different injection sites should be used.⁵²

- **Immunization systems and documentation.** All administered vaccines should be documented promptly in the patient’s electronic health record and submitted to the immunization information system to maintain consolidated vaccination histories and support automated dose forecasting. Query the immunization information system at the point of care to confirm which vaccines a patient has already received; this is particularly important for adults 65 years and older with a two-dose COVID-19 vaccine schedule and for patients who receive vaccines in multiple settings. If all indicated vaccines cannot

be administered in the clinic, bidirectional referral pathways should be established with pharmacies or occupational health facilities to ensure that doses administered elsewhere are documented in the electronic health record and immunization information system. This process ensures that the primary care record remains complete and accurate.

- **Anticipatory guidance.** Use brief, proactive counseling to normalize vaccination expectations before the visit (eg, scheduling outreach messages, rooming scripts, previsit planning), and arrange same-day vaccination when patients arrive. Education has limited evidence as a stand-alone strategy. It is most effective when combined with workflow supports such as reminders, standing orders, and convenient access.⁵⁵

Protecting patients from respiratory illness this season entails combining timely vaccination for influenza, COVID-19, and RSV (when indicated) with practical workflows that prevent missed opportunities. Offering vaccines at every visit, using reminder and recall systems and standing orders, and maintaining accurate records across care settings are the highest yield actions available to primary care practices.⁵⁵ Strong, clear clinician recommendations paired with appropriate shared decision-making remain the most reliable bridge between vaccine availability and patient protection.⁵⁸

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For full transparency, we are sharing two professional engagements disclosed by Margot Savoy, MD, MPH, that were reviewed under the AAFP conflict of interest policy and determined not to be relevant financial relationships. Dr. Savoy authors a chapter on immunizations for the Merck Manual, which maintains editorial independence from Merck’s commer-

cial interests. Dr. Savoy is not compensated for this work. Additionally, Dr. Savoy received compensation from the National Medical Association for presenting on long COVID at an event sponsored by Sanofi.

Readers can learn more about how AAFP vaccine guidance is created in this blog post: <https://www.aafp.org/about/blog/from-science-to-guidance-how-we-make-family-medicine-vaccine-recommendations>.—Sumi Sexton, MD, Editor-in-Chief

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