

Understanding Maternal Respiratory Syncytial Virus Vaccination: Recommendations and Guidance

Introduction

Pregnancy increases health risks for women and all birthing persons, with the respiratory season posing specific threats to vulnerable populations. Fortunately, now we have a new preventive tool to assist us in keeping our patients who are pregnant safe — the maternal respiratory syncytial virus (RSV) vaccine RSVpreF (Abrysvo™).¹ It is the **ONLY** RSV vaccine approved for use during pregnancy to protect infants through 6 months from RSV-associated lower respiratory tract infection (LRTI).

Recommendation

The Centers for Disease Control and Prevention (CDC) and the American Academy of Family Physicians (AAFP) recommend a single dose of the Abrysvo maternal RSV vaccine for patients who are pregnant during 32 through 36 weeks of gestation, using seasonal administration to prevent RSV-associated LRTI in infants for up to 6 months after birth. The vaccine should be administered from September through January for optimal protection in most states since RSV increases during this time. Hospitalizations due to RSV also increase during this period. In the 2023-24 season, children 0-4 years were disproportionately affected. Their hospitalizations occurred nearly nine times higher than persons 5-64 years.² Therefore, protecting babies is imperative as we prepare for this fall's looming RSV season.

Timing

The RSV season can vary in some parts of the United States. In areas where the RSV circulation is higher, such as Alaska, southern Florida, Guam, Hawaii, Puerto Rico, U.S. Virgin Islands, and the U.S.-affiliated Pacific Islands, physicians and other clinicians should follow their state, local, or territorial guidance on the timing of Abrysvo vaccination.³ Since maternal vaccination should start 1-2 months before the anticipated RSV season and continue through 2-3 months before the expected end of the season, it is not necessary to change the vaccination timing based on seasonal RSV circulation variations.¹

Administration

A single dose (0.5 mL) of Abrysvo should be administered to patients who are pregnant during weeks 32 through 36 of gestation.³ An intramuscular dose should be administered, preferably to the upper region of the arm (i.e., deltoid). Currently, sufficient evidence does not exist to determine if additional doses are needed.

The CDC notes that current data is unavailable on the effectiveness of the first-lifetime dose during subsequent pregnancies or on the safety of additional doses given in subsequent pregnancies. More data will be needed to determine whether additional doses should be administered in subsequent pregnancies. The CDC will continue evaluating the data and may update recommendations prior to the 2024-2025 RSV season.

Contraindication and Precaution

The Abrysvo vaccine should not be administered to a person with a history of severe allergic reaction to any vaccine component (e.g., anaphylaxis). The manufacturer's insert contains additional information about Abrysvo, or you can visit the CDC's Administering RSVpreF Vaccine (<https://www.cdc.gov/vaccines/vpd/rsv/hcp/pregnant-people.html>) section of this webpage.

Physician-Patient Dialogue

In the post-COVID-19 pandemic era, vaccines play a more central role in preventive medicine, and the Abrysvo vaccine is one of the best preventive health tools we have to protect against RSV-associated LRTI in infants.¹ It is crucial that your practice has a plan for conversations about the maternal RSV vaccine with your patients who are pregnant. It should start during the first trimester for patients with a delivery date during the RSV season. Research shows that a physician's recommendation is the single most important factor in a patient's decision to get vaccinated.⁴ Therefore, your plan should involve addressing patients' questions or concerns and providing relevant, evidence-based resources to help guide and inform patients so they can make

the best health care decisions for themselves and their newborns. Recommending the Abrysvo vaccine should be part of that plan.

Initiate the conversation by making the patient aware that their due date falls within the respiratory season and highlight the significance of this timing. Then, follow these steps to ensure an informed discussion:

- Acknowledge the importance of the vaccine for the patient during pregnancy.
- Reassure the patient that the vaccine is safe by providing education and information.
- Prepare the patient about the timing and administration of the vaccine (i.e., a single dose).
- Act at the appropriate time — by week 32 of gestation, the decision should be made, and you should have a plan with the patient to administer the vaccine.

Co-administration with Other Vaccines

It is acceptable to co-administer other recommended vaccines with Abrysvo to patients who are pregnant. These include tetanus, diphtheria, and pertussis (Tdap), influenza, and COVID-19 vaccines, regardless of timing.³ The co-administration of vaccines can occur during the same clinic day or at any interval between vaccine product administration. When determining the co-administration of other vaccines with Abrysvo, please consider the following¹:

- Whether the patient is current with recommended vaccines
- The likelihood that the patient will return for additional vaccines
- The risk of acquiring a vaccine-preventable disease
- Vaccine reactogenicity profiles
- Patient preferences

Co-administration is an essential consideration, specifically for our most vulnerable populations, as well as underserved, uninsured, and marginalized populations. Historically, racial and ethnic minority groups have been less likely to receive vaccines.⁵ This can be attributed to multiple factors, including the social determinants of health (SDOH), so it is essential that options like co-administration are utilized to reduce this disparity.

CDC data from the 2023-24 respiratory season show that for persons 18-49 years who are pregnant, the uptake of Abrysvo was low overall, with the highest uptake among Asian, non-Hispanic populations (25% coverage estimate) and the lowest among Black, non-Hispanic populations (10% coverage estimate).⁶ As the coverage is low for all populations, it is essential to plan for the 2024-25 RSV season by confidently communicating to appropriate patients the importance of vaccination against this dangerous virus for babies.

References

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