Nirsevimab Administration Visual Guide

American Academy of Pediatrics
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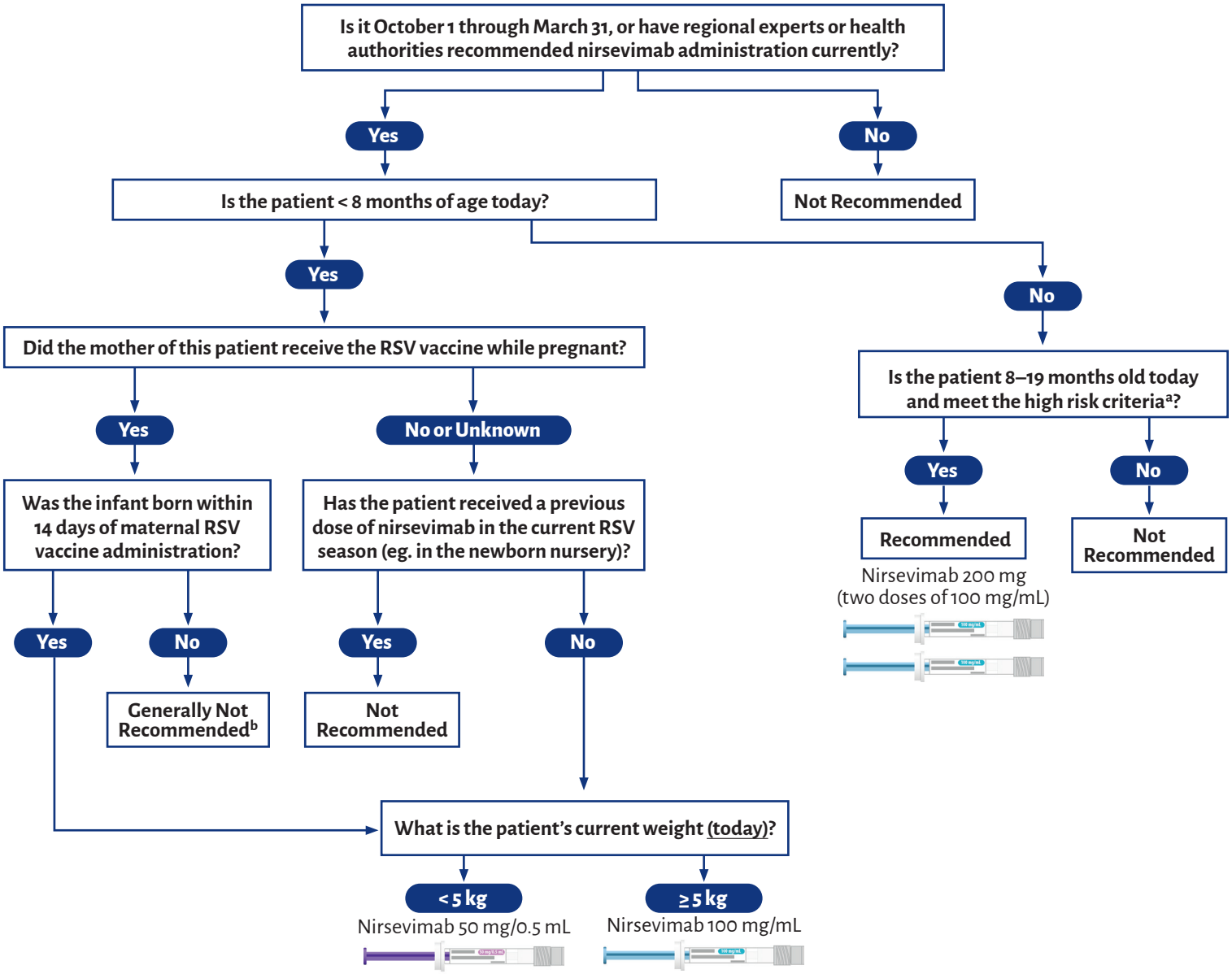

a. Children 8 through 19 months of age who are recommended to receive nirsevimab when entering their second RSV season because of increased risk of severe disease.
- Children with chronic lung disease of prematurity who required medical support (chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) any time during the 6-month period before the start of the second RSV season.
- Children who are severely immunocompromised.
- Children with cystic fibrosis who have manifestations of severe lung disease (previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest imaging that persist when stable) or have weight-for-length that is <10th percentile.
- American Indian and Alaska Native children (note that this is a new group for whom second-season prophylaxis is recommended in contrast to the current palivizumab recommendations).

b. Nirsevimab can be considered when, per the clinical judgement of the healthcare provider, the potential incremental benefit of administration is warranted, including but not limited to the following rare circumstances:
- Infants born to pregnant people who may not mount an adequate immune response to vaccination or have conditions associated with reduced transplacental antibody transfer.
- Infants who have undergone cardiopulmonary bypass or extracorporeal membrane oxygenation leading to loss of maternal antibodies.
- Infants with substantial increased risk for severe RSV disease (eg, hemodynamically significant congenital heart disease, intensive care admission and requiring oxygen at discharge).

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These interim recommendations apply to healthcare settings with limited nirsevimab availability during the 2023–2024 RSV season.

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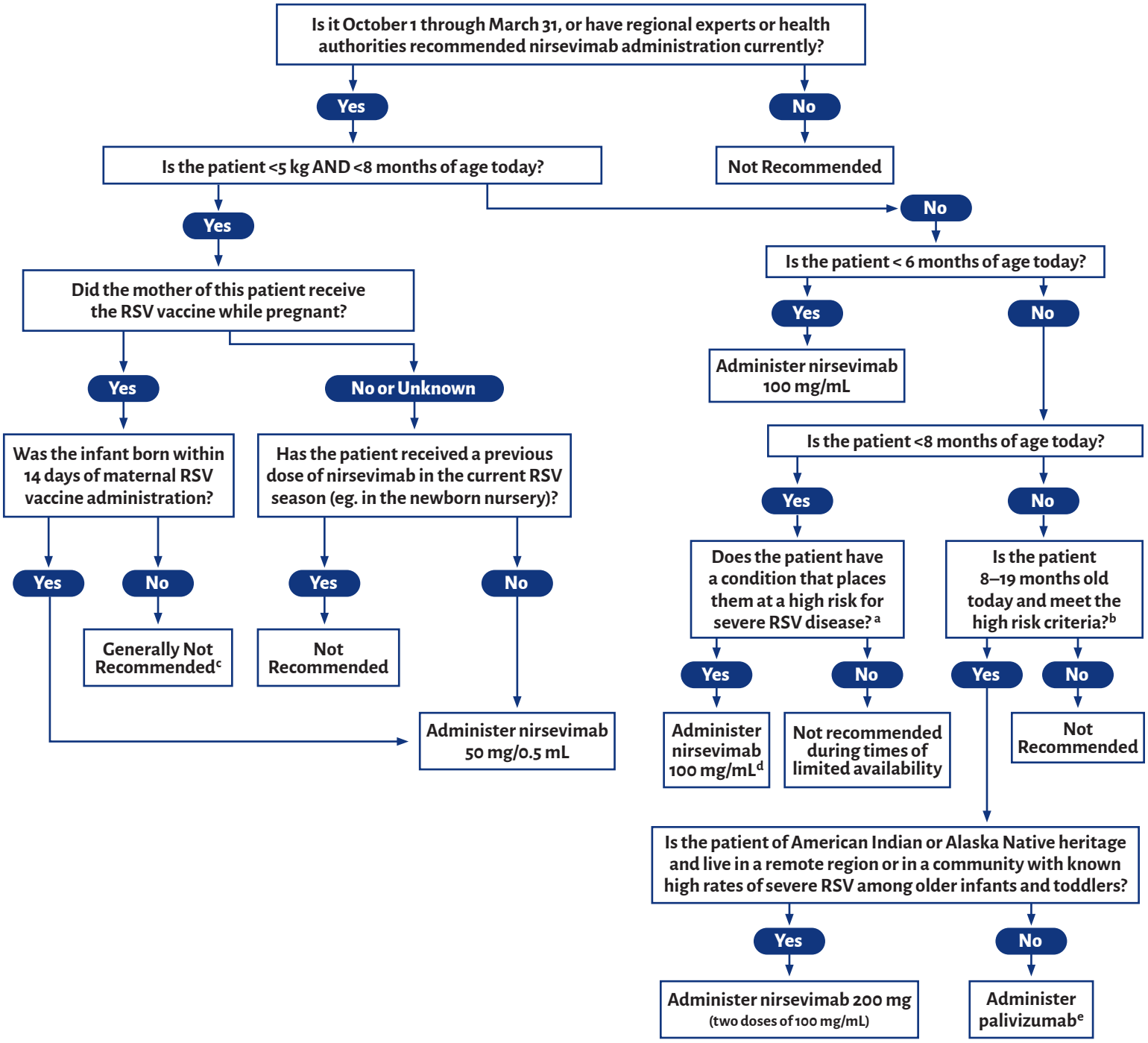

a. American Indian/Alaska Native, premature birth at <29 weeks' gestation, chronic lung disease of prematurity, hemodynamically significant congenital heart disease, severe immunocompromise, severe cystic fibrosis (either manifestations of severe lung disease or weight-for-length less than 10th percentile), neuromuscular disease or congenital pulmonary abnormalities that impair the ability to clear secretions.

b. Children 8 through 19 months of age who are recommended to receive nirsevimab when entering their second RSV season because of increased risk of severe disease.
- Children with chronic lung disease of prematurity who required medical support (chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) any time during the 6-month period before the start of the second RSV season.
- Children who are severely immunocompromised.
- Children with cystic fibrosis who have manifestations of severe lung disease (previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest imaging that persist when stable) or have weight-for-length that is <10th percentile.
- American Indian and Alaska Native children (note that this is a new group for whom second-season prophylaxis is recommended in contrast to the current palivizumab recommendations).

c. Nirsevimab can be considered when, per the clinical judgement of the healthcare provider, the potential incremental benefit of administration is warranted, including but not limited to the following rare circumstances:
- Infants born to pregnant people who may not mount an adequate immune response to vaccination or have conditions associated with reduced transplacental antibody transfer.
- Infants who have undergone cardiopulmonary bypass or extracorporeal membrane oxygenation leading to loss of maternal antibodies.
- Infants with substantial increased risk for severe RSV disease (eg, hemodynamically significant congenital heart disease, intensive care admission and requiring oxygen at discharge).

d. If nirsevimab is not available, administer palivizumab to eligible infants.

e. For palivizumab dosing information, please reference Palivizumab Prophylaxis in Infants and Young Children at Increased Risk of Hospitalization for Respiratory Syncytial Virus Infection.

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Immunization Administration Tips

At the time of administration, affirm the 7 rights to reduce errors:

1. Right patient
2. Right time (age, in RSV season)
3. Right immunization (correct medication)
4. The right dosage (based on weight)
5. The right route, needle length, and technique

Intramuscular (IM) injection
Use a 22–25 gauge needle. Choose the injection site and needle length that is appropriate to the person's age and body mass.

Age	Needle length	Injection site
Newborns (1st 28 days)	⅝"[a]	Anterolateral thigh muscle
Infants (1–12 months)	1"	Anterolateral thigh muscle
Toddlers (1–2 years)	1–1¼"	Anterolateral thigh muscle[c]
	⅝[b]–1"	Deltoid muscle of arm

6. Right site
7. The right documentation

Co-administration and Suggested Injection Volumes

In accordance with the CDC's General Best Practice Guidelines for Immunization, simultaneous administration of nirsevimab with age-appropriate vaccines is recommended. CDC does not address the issue of maximum volumes that can be injected into each muscle group in different age groups. CDC is in the process of creating a job aid for healthcare providers to help address the issue and offers the suggested volumes as follows:

- **Deltoid muscle of arm:** Average 0.5 mL (range 0.5–2 mL)
- **Anterolateral thigh muscle (Vastus Lateralis):** Average 1–4 mL (range 1–5 mL)

Infants and toddlers would fall at the lower end of the range, whereas adolescents and adults would generally fall on the higher end of the range. Strategies healthcare providers can use to decrease the number/injection volume include:

- Healthcare providers should always use professional judgement when administering injections. Muscle size can vary greatly from one patient to another.
- Include an age-appropriate combination vaccine in the facility's inventory (Pentacel, Pediarix, Vaxelis).
- Use an alternate route (other than IM) if possible. IPV (single component, NOT a combination vaccine), MMR (toddlers and infant travelers only), Varicella-containing vaccines (toddlers only), and PPSV23 (high-risk toddlers only) can be administered subcutaneously.
- Take advantage of recommended age ranges some of the routinely recommended vaccines have. For example, the 3rd dose of HepB can be given as late as 18 months of age.

a. If skin is stretched tightly and subcutaneous tissues are not bunched.

b. Alternate needle lengths may be used if the skin is stretched tightly and subcutaneous tissues are not bunched, as follows: a) a ⅝" needle in toddlers, children, and patients weighing less than 130 lbs (less than 60 kg) for IM injection in the deltoid muscle only, or b) a 1" needle for administration in the thigh muscle for adults of any weight.

c. Preferred site

NOTE: Always refer to the package insert included with each biologic for complete vaccine administration information. CDC's Advisory Committee on Immunization Practices (ACIP) recommendations for the particular vaccine should be reviewed as well. Access the ACIP recommendations at www.immunize.org/acip.