SAVRR Council Updated Interim Implementation Guidance on 2026-2027 Fall Respiratory Season Vaccination Recommendations

SAVRR Council Interim Implementation Guidance

The SAVRR Council emphasizes that vaccination saves lives, reduces morbidity, and lowers healthcare costs. Thus, the SAVRR Council urges all immunization stakeholders to ensure that: (1) all patients be able to receive vaccines without cost-sharing regardless of insurance type, and (2) any barriers to accessing recommended vaccines be removed so people can receive them at the location of their choice (e.g., doctor's office or pharmacy).

The SAVRR Council recommends that healthcare professionals follow existing 2025-26 influenza, COVID-19, and RSV immunization recommendations from relevant professional medical associations for administering 2026-27 vaccines, once they become available, until updated recommendations for 2026-27 respiratory season vaccines are released.

For adult patients, the American Academy of Family Physicians (AAFP) has published a 2026 adult immunization schedule for all adult vaccines and plans on updating their evidence-based guidance on influenza, COVID-19, and RSV immunizations as well for the 2026-27 respiratory viral season. Additionally, the American College of Obstetrics and Gynecologists (ACOG) anticipates releasing practice guidelines for influenza, COVID-19, and RSV immunizations for the 2026-27 season. The American College of Physicians (ACP) does not anticipate releasing separate guidance for influenza, COVID-19, and RSV immunizations for the 2026-27 season, but has indicated that its immunization committee will review guidance published by other professional societies (ACP, personal communication). ACP has informed the SAVRR Council that their immunization committee has already reviewed the existing vaccine schedules from AAP, AAFP, and ACOG and is moving forward with published statements of support for all three (ACP, personal communication).

For pediatric patients, the American Academy of Pediatrics (AAP) has published a 2026 pediatric immunizations schedule for children and adolescents and plans on updating their evidence-based guidance on influenza, COVID-19, and RSV immunizations as well for the 2026-27 season.

For immunocompromised patients, healthcare professionals should additionally follow the Infectious Diseases Society of America (IDSA) 2025 Guidelines on the Use of Vaccines for the Prevention of Seasonal COVID-19, Influenza, and RSV Infections in Immunocompromised Patients, which provide evidence-based recommendations for this population. These guidelines apply to adults and children with hematologic malignancy, primary immunodeficiency, autoimmune disease on immunosuppressants or biologics, HIV with severe immunosuppression (CD4 15% or 200/mm), solid organ transplant (SOT), hematopoietic cell transplant (HCT), chimeric antigen receptor T-cell therapy (CAR-T), or solid-tumor chemotherapy. Patients with chronic organ dysfunction alone (e.g., dialysis-dependent ESRD, cirrhosis, end-stage heart disease) are not covered by these immunocompromised-specific guidelines and should follow general population recommendations.

Influenza

- Healthcare professionals should follow existing recommendations from the AAP, Advisory Committee on Immunization Practices (ACIP), ACOG, AAFP, and IDSA until updated recommendations are released by professional medical associations. ACIP has not yet met for the upcoming season; its current recommendation remains the recommendation from the 2025-2026 influenza season.

- Influenza vaccination is recommended for all persons 6 months of age and older [recommended by the ACIP (2025-26 recommendations dated August 28, 2025), AAP, AAFP, and ACOG].
  - Current AAP and ACIP recommendations state that children ages 6 months through 8 years of age receiving influenza vaccination for the first time will need two doses, minimally 4 weeks apart.
- Adults 65 years of age and older should receive an enhanced influenza vaccine when available, including recombinant, adjuvanted, or high-dose influenza vaccine. If an enhanced vaccine is not available, they should receive an age-appropriate standard-dose influenza vaccine rather than defer vaccination [AAFP, ACIP (2025-26 recommendations)].
- Pregnant persons are at increased risk for complications from influenza and should receive an age-appropriate influenza vaccine [AAFP, ACOG].
- Immunocompromised persons: IDSA strongly recommends that all immunocompromised individuals aged ≥6 months receive an age-appropriate influenza vaccine annually. Key considerations include:
  - High-dose or adjuvanted influenza vaccines may provide a more robust immune response and may be of particular importance in immunocompromised patients.
  - Live-attenuated influenza vaccine (LAIV) is contraindicated for immunocompromised patients and their household contacts.
  - Vaccination timing should be individualized based on underlying condition, immunosuppressive therapy schedule, and community influenza activity. Optimal timing includes ≥2 weeks before initiating new immunosuppression when feasible, or ≥1 month post-SOT, ≥3 months post-HCT/CAR-T, and ≥3–6 months after B-cell-depleting therapy.
  - Household members and close contacts of immunocompromised patients should be up to date with influenza vaccination.
- To optimize protection during the respiratory virus season, vaccination should be administered in September or October for most populations. Vaccination during July and August is generally not recommended unless there is a risk that vaccination later in the season may not occur. An exception may be considered for individuals in the third trimester of pregnancy, for whom vaccination during July and August may be appropriate to provide protection to the infant after birth, and for children who are recommended to receive 2 doses of influenza vaccine.

COVID-19

- Healthcare professionals should follow existing professional medical society recommendations for the use of 2025-26 COVID-19 vaccines among adults, including during pregnancy (AAFP, ACOG, IDSA), and AAP recommendations for children, until updated 2026-27 vaccine recommendations are released. Current ACIP recommendations are from 2025 (dated December 12, 2024), and no ACIP meetings are yet scheduled for 2026 to address influenza, COVID, or RSV.
- For patients with an indication for COVID-19 vaccination before the updated 2026-27 vaccines are available, the 2025-26 vaccine may be administered. CDC recommends a minimum interval of 2 months for Pfizer and Novavax COVID-19 vaccines, and 3 months for the Moderna COVID-19 vaccine[1].
- Because unexpired 2025-26 COVID-19 vaccines and 2026-27 COVID-19 vaccines might be available at the same time, providers should ensure that patients are receiving the most up-to-date vaccines and removing unused 2025-26 vaccines so that inadvertent administration of this vaccine does not occur when the updated vaccine for 2026-27 is available. Existing guidance on immunization general best practices and vaccine storage and handling are available.
- COVID-19 vaccination is recommended by AAFP and ACOG for all adults 19 years of age and older, including during pregnancy.

[1] CDC Interim Clinical Considerations for Use of COVID-19 Vaccines in the United States: https://www.cdc.gov/covid/downloads/hcp/interim-clinical-considerations.pdf

    - Adults 19-64 who are not immunocompromised are recommended to receive a single dose of the updated COVID-19 vaccine.
    - Adults 65 years and older who are not immunocompromised are recommended to receive two doses of COVID-19 vaccine 6 months apart.
- IDSA strongly recommends that all immunocompromised individuals aged ≥6 months receive age-appropriate COVID-19 vaccination. Key considerations include:
    - An updated COVID-19 vaccine dose should be given as soon as it becomes available.
    - A second dose of COVID-19 vaccine is likely to extend protection in immunocompromised patients. Additional doses may be administered based on shared clinical decision-making, at a minimum interval of 2 months.
    - For never-vaccinated or incompletely vaccinated immunocompromised patients, refer to published ACIP guidelines for initial series completion.
    - Vaccination timing should be tailored to immunosuppressive therapy, clinical stability, and community transmission levels:
        - SOT: ≥2 weeks pre-transplant or ≥3 months post-transplant; defer during acute rejection treatment.
        - HCT/CAR-T: ≥3 months post-transplant/infusion, or ≥3–6 months after B-cell-depleting therapy.
        - Hematologic malignancy: Align with treatment cycles; ideally ≥2 weeks before new immunosuppression.
        - HIV: Vaccinate regardless of CD4 count or viral load when clinically stable.
    - Vaccine effectiveness is lower than in immunocompetent populations, supporting the need for adjunct strategies including vaccination of household contacts, rapid access to antivirals (e.g., nirmatrelvir/ritonavir), and nonpharmaceutical interventions.
    - Patients may self-attest to immunocompromised status for vaccine eligibility.

RSV

- Healthcare professionals should follow existing recommendations from AAFP, ACOG, IDSA, and ACIP until updated recommendations are released by professional medical associations. ACIP has not yet met regarding recommendations for influenza, COVID, and RSV for 2026-27; its current recommendation remains the recommendation on the July 2025 ACIP adult schedule.
- RSV vaccination is recommended for all persons 75 years of age and older.
- RSV vaccination is recommended for persons 50 through 74 years of age who are at increased risk for severe RSV disease. Although there are three Food and Drug Association (FDA)-approved RSV vaccines for adults [RSVPreF3 (Arexvy), RSVPreF (Abrysvo), and mRNA-1345 (mResvia)], only RSVPreF (Abrysvo®) is approved for use in pregnant people.
- RSV vaccination during pregnancy is recommended with Abrysvo® at 32 through 36 weeks' gestation, September through January in most jurisdictions, as a one-time dose. If RSV vaccine was given in a prior pregnancy, no additional maternal RSV vaccines are recommended, but infants whose birth parent was not vaccinated during the pregnancy are recommended to receive RSV monoclonal antibody.
- Immunocompromised persons: IDSA strongly recommends age-appropriate RSV vaccination for all immunocompromised adults and adolescents. Key considerations include:
    - All immunocompromised individuals aged ≥18 years should receive an RSV vaccine. For immunocompromised patients <18 years, administration should be guided by shared decision-making.
    - Solid organ transplant candidates, especially lung transplant candidates, should ideally be vaccinated pre-transplant.
    - Vaccination timing should be individualized:

    - SOT: ≥2 weeks pre-transplant; post-transplant, consider as early as 1 month during RSV season or delay up to 6 months outside RSV season for better immunogenicity.
    - HCT/CAR-T: ≥3 months post-transplant/infusion, or ≥6 months after B-cell-depleting therapy.
    - If vaccine is given earlier than optimal timing, consider re-dosing.
- Household members and close contacts of immunocompromised patients should be up to date with RSV vaccination, if eligible.
- Currently, only a single lifetime dose is currently recommended for immunocompromised and non-immunocompromised people with an indication for vaccination.

Cross-Cutting Guidance for Immunocompromised Patients (All Respiratory Vaccines)

The following principles from the IDSA 2025 Guidelines apply across COVID-19, influenza, and RSV vaccination in immunocompromised patients:

- Co-administration of COVID-19, influenza, and RSV vaccines at the same visit is appropriate.
- Vaccination should not be deferred solely because of immunocompromised status; the benefits of vaccination outweigh the risks of attenuated response.
- Vaccination should be deferred during febrile neutropenia, acute transplant rejection treatment, severe autoimmune flare, or severe/acute illness.
- Shared clinical decision-making is essential, allowing flexibility in timing and dosing to accommodate immunosuppressive therapy schedules, travel, and individual risk factors.
- Household members and close contacts should be up to date with all recommended respiratory virus vaccines to provide indirect protection.
- Adjunct protective strategies remain important for immunocompromised patients, including early antiviral access and nonpharmaceutical interventions (e.g., well-fitting masks), especially for those with poor vaccine responses or contraindications.
- For complete subgroup-specific timing guidance by immunocompromised condition, healthcare professionals should refer to the full IDSA 2025 Guidelines.

Potential Considerations for Influenza, COVID-19, or RSV Vaccination Beginning this Fall

- FDA delays in 2026-27 influenza and COVID-19 vaccine approvals, and in lot releases of these vaccines, could delay vaccine availability.
- The Vaccines and Related Biological Products Advisory Committee (VRBPAC) approved the 2026-27 influenza vaccine strain selection in March 2026. VRBPAC approved the 2026-27 COVID-19 strain composition at its May 28, 2026, meeting.
- The legal challenge to the ACIP committee that was seated after April 2025 remains active. ACIP recommendations made during or after the June 2025 meeting have been stayed by court order; therefore, current ACIP recommendations that are in effect by court order are ACIP recommendations made before June 2025. Additional legal developments affecting ACIP may occur.
- VIP is committed to reviewing and updating the evidence base for influenza, COVID-19, and RSV immunization recommendations.
- Professional medical organizations are committed to issuing updated influenza, COVID-19, and RSV immunization recommendations based on the latest available evidence, including the VIP evidence review. These recommendations should serve as best-practice guidance for adult and respiratory viral vaccination.
- America's Health Insurance Plans (AHIP) member payors, including Blue Cross Blue Shield, have committed to covering vaccinations through 2027[2].

[2] https://www.ahip.org/news/press-releases/ahip-statement-on-vaccine-coverage

Background

The Summit Adult Vaccine Recommendations Review (SAVRR) Council is a multi-organizational body of voting and observer members currently focused on the practical implementation of immunization recommendations for adults and influenza immunization recommendations across the lifespan. Designed to operate free from commercial influence, the Council does not accept funding from vaccine manufacturers, requires voting members to disclose financial interests, and excludes vaccine manufacturers and trade representatives from membership entirely. The Council serves two primary objectives: providing stakeholder feedback to organizations that develop vaccination recommendations and supporting the effective clinical implementation of evidence-based guidance. To advance these goals, the SAVRR Council works to identify and address gaps and inconsistencies among existing recommendations, surface opportunities for improved alignment, and identify and recommend the development of potential interventions in collaboration with Summit working groups and partners. It also plays a communications role, disseminating clear and practical guidance through National Adult and Influenza Immunization Summit (NAIIS) channels to help ensure that science-driven vaccination recommendations are translated effectively into clinical practice.

While immunization to prevent fall and winter respiratory pathogens (influenza, COVID-19, and RSV) typically begins in earnest in September each year, many steps are needed prior to vaccine doses becoming available for vaccination to begin. In recent seasons, the influenza vaccine typically becomes available to vaccine providers in July. The optimal time for influenza vaccination is in September or October.

The Vaccine Integrity Project (VIP) is an initiative dedicated to providing trusted, science-based information to support informed vaccine decision-making. The project operates across three core areas of focus. First, it monitors the information landscape in real time, rapidly identifying and responding to misleading or inaccurate claims related to vaccines and public health. Second, it conducts comprehensive reviews of scientific evidence to develop and disseminate a strong evidence base for immunization recommendations and clinical considerations, engaging healthcare providers, public health professionals, and medical societies in this process. Third, recognizing the scale and complexity of challenges facing the vaccine ecosystem, the initiative regularly convenes stakeholders to foster collaboration, support alignment, and help prioritize and address emerging issues as they arise.

The VIP has indicated that its updated evidence reviews of influenza, COVID-19, and RSV vaccines' safety and effectiveness are underway. The review will assess whether any new published data suggests that changes may be needed for influenza, COVID-19, and RSV vaccination recommendations for the 2026-2027 season.

Utilizing the VIP evidence reviews and additional internal processes for assessing the evidence of these vaccines' safety, effectiveness, and impact on burden of disease, professional medical associations are expected to issue recommendations. Current expectations are that updated influenza, COVID-19, and RSV immunization recommendations from professional medical associations- along with the Vaccine Integrity Project's evidence reviews- will be released together in early September.

Because vaccines may become available and vaccinations started before professional guidance is published, healthcare professionals need clear interim guidance for vaccination decisions during the period between vaccine(s) arrival and publication of updated professional medical association recommendations.