### SUMMARY OF RECOMMENDED VACCINES FOR ADULTS WITH HIV

<table>
<thead>
<tr>
<th>Vaccine Trade Name</th>
<th>Indications</th>
<th>Administration and Revaccination</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td><strong>Haemophilus Influenza Type B Conjugate (Hib)</strong>&lt;br&gt;· Hiberix; ActHIB</td>
<td>Patients at risk of Hib infection; see CDC guidelines for all adults</td>
<td>· Administer according to CDC guidelines for all adults at risk&lt;br&gt;· Revaccination: None</td>
<td>Not routinely recommended for people with HIV in the absence of other risk factors</td>
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<td><strong>Hepatitis A (HAV)</strong>&lt;br&gt;· HAV: Havrix; Vaqta&lt;br&gt;· HAV inactivated + HBV: Twinrix</td>
<td>All patients aged ≥1 year with HIV</td>
<td>· Administer according to CDC guidelines&lt;br&gt;· Obtain HAV IgG at least 1 month after final dose of vaccination series to identify nonresponders&lt;br&gt;· If immune reconstitution appears likely, then consider deferring until patient’s CD4 count &gt;200 cells/mm³&lt;br&gt;· Revaccination: Nonresponders to primary HAV vaccination series should be revaccinated and counseled to avoid exposure</td>
<td>· Covered by the Vaccine Injury Compensation Program*&lt;br&gt;· See NYSDOH AI guideline HBV–HIV Coinfection</td>
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<td><strong>Hepatitis B (HBV)</strong>&lt;br&gt;· HBV 2-dose series: HEPLISAV-B&lt;br&gt;· HBV 3-dose series: Engerix-B, Recombivax HB&lt;br&gt;· HAV inactivated + HBV: Twinrix</td>
<td>Patients who are negative for anti-HBs and do not have chronic HBV infection; see NYSDOH AI guideline HBV–HIV Coinfection, Figure 3</td>
<td>· Administer according to CDC guidelines for all adults&lt;br&gt;· Alternative administration strategies, such as a 3- or 4-injection double-dose vaccination series or an accelerated schedule of 0, 1, and 3 weeks, may be considered&lt;br&gt;· Test for anti–HBs 1 to 2 months after administration of the last dose of the vaccination series&lt;br&gt;· Revaccination: Nonresponders to primary HBV vaccination series (anti–HBs &lt;10 IU/L) should receive a double-dose revaccination series; a 4-dose schedule should be considered</td>
<td>· In patients at risk for HBV infection, initial vaccination should not be deferred if CD4 cell count is &lt;200 cells/mm³&lt;br&gt;· If an accelerated schedule is used, a 4th dose booster should be administered at least 6 months after initiation of the series; the accelerated schedule is not recommended for patients with CD4 counts &lt;500 cells/mm³&lt;br&gt;· The HAV/HBV combined vaccine is not recommended for the double-dose or 4-injection HBV vaccination strategy&lt;br&gt;· A 2-dose (1 month apart) recombinant HBV surface antigen vaccine with a novel adjuvant (HEPLISAV-B) is available. There are no data available on use among people with HIV. There were no autoimmune adverse events among people with HIV exposed to the adjuvant&lt;br&gt;· See NYSDOH AI guideline HBV–HIV Coinfection&lt;br&gt;· Covered by the Vaccine Injury Compensation Program*</td>
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<td><strong>Human Papillomavirus (HPV)</strong>&lt;br&gt;· Gardasil 9</td>
<td>All patients aged 9 to 26 years who were not previously vaccinated or did not receive a complete 3-dose series</td>
<td>· Administer through age 26 years as a 3-dose series according to CDC guidelines for adults with immuno-compromising conditions&lt;br&gt;· Revaccination: None</td>
<td>· A 2-dose schedule is not recommended&lt;br&gt;· Because of the broader coverage offered by the 9-valent HPV vaccine, it is the only HPV vaccine currently available in the United States (see CDC HPV Home &gt; Information for Healthcare Professionals for more information)&lt;br&gt;· Although the 9-valent vaccine has not been specifically studied in people with HIV, it is expected that the response will be the same in this population as with the 4-valent vaccine&lt;br&gt;· Follow recommendations for cervical and anal cancer screening in women with HIV and men who have received the HPV vaccine&lt;br&gt;· Covered by the Vaccine Injury Compensation Program*</td>
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<td><strong>Influenza</strong>&lt;br&gt;· For brand names, see CDC flu vaccines table</td>
<td>For all patients, as determined by CDC guidelines for all adults</td>
<td>· Administer annually during flu season (October through May) according to CDC guidelines for all adults&lt;br&gt;· Revaccination: None</td>
<td>· Covered by the Vaccine Injury Compensation Program*</td>
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<td><strong>Measles, Mumps, and Rubella (MMR)</strong>&lt;br&gt;· M–M–R II&lt;br&gt;· MMR + varicella: ProQuad</td>
<td>For patients with CD4 cell counts ≥200 cells/mm³ who do not have evidence of MMR immunity, as determined by CDC guidelines for all adults</td>
<td>· Two doses at least 28 days apart&lt;br&gt;· Revaccination: Recommended only in the setting of an outbreak</td>
<td>· Contraindicated for patients with CD4 counts &lt;200 cells/mm³&lt;br&gt;· MMRV should not be substituted for MMR&lt;br&gt;· Those who previously received 2 doses of a mumps–containing vaccine and are at increased risk for mumps in the setting of an outbreak should receive a third dose to improve protection against mumps disease and related complications&lt;br&gt;· Covered by the Vaccine Injury Compensation Program*</td>
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*New York State Department of Health AIDS Institute: [www.hivguidelines.org](http://www.hivguidelines.org)*
### Table 20 Continued: (see Tables 7-19 for source and reference information for individual vaccines)

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| **Meningococcal Serotype Non-B (MenACWY)**  
MenACWY: Menactra  
MCV4: Menveo | • All patients with HIV  
• See NYSDOH Health Advisories on Meningococcal Disease | • Administer 2 doses of MenACWY at least 8 weeks apart in those not previously vaccinated  
• For those previously vaccinated with 1 dose of MenACWY, administer the 2nd dose at the earliest opportunity at least 8 weeks after the previous dose  
• **Revaccination:** Administer 1 booster dose of MenACWY every 5 years | • MenACWY is preferred over MPSV4 in adults with HIV >55 years of age  
• Covered by the Vaccine Injury Compensation Program* |
| **Meningococcal Serotype B (MenB)**  
Bexsero, Trumenba | • Patients at risk of MenB infection, as determined by CDC guidelines | • Administer according to CDC guidelines for revaccination  
• **Revaccination:** None | • Not routinely recommended for people with HIV in the absence of other risk factors  
• Covered by the Vaccine Injury Compensation Program* |
| **Pneumococcal**  
- 13-valent: Prevnar 13 (PCV130)  
- 23-valent: Pneumovax 23 (PPSV23) | • All patients with HIV | • The complete series of vaccinations is 1 dose of PCV13 and 2 doses of PPSV23 before age 65 years, followed by 1 additional dose of PPSV23 after age 65 years  
• See Table 16 for detailed administration guidelines based on age and previous vaccination history | • The PCV13 vaccine should not be deferred for patients with CD4 count <200 cells mm⁻³ and/or detectable viral load; however, the follow-up secondary administration of PPSV23 vaccine may be deferred until the patient’s CD4 count is >200 cells mm⁻³ and/or viral load is undetectable |
| **Tetanus, Diphtheria, and Pertussis (Tdap) and Tetanus-Diphtheria (Td)**  
- Tdap: Adacel; Boostrix  
- Td: Tenivac; Decavac (generic 9Td) | • For all patients, as determined by CDC guidelines for all adults | • Administer according to CDC guidelines for revaccination  
• **Revaccination:** Td is usually given as a booster dose every 10 years, but it can also be given earlier after a severe and dirty wound or burn | • Covered by the Vaccine Injury Compensation Program* |
| **Varicella**  
- Varicella: Varivax  
- MMR + varicella: ProQuad | • For patients with CD4 cell counts ≥200 cells/mm³ who do not have evidence of immunity to varicella, as determined by CDC guidelines for all adults  
• HIV–infected children ≥12 months old with CD4+ T-lymphocyte percentages ≥15% | • Administer according to CDC guidelines for all adults  
• **Revaccination:** None | • Contraindicated for patients with CD4 counts <200 cells mm⁻³  
• Anti-varicella IgG screening should be performed in patients with no known history of chickenpox or shingles  
• MMRV should not be used  
• Antiviral agents should be avoided at least 24 hours before and 14 days after administration  
• An interval of at least 3 months is recommended between administration of post-exposure varicella IgG (VarizIG) and varicella vaccination  
• Clinical disease due to varicella after vaccination, a very rare event, should be treated with acyclovir  
• Covered by the Vaccine Injury Compensation Program* |
| **Zoster**  
- RZV: Shingrix—PREFERRED  
- For information on ZVL (brand name Zostavax), see Table 16 | • **MCCC recommendation:** Patients aged ≥50 years with HIV (A2) | • Two IM doses, spaced 2 to 6 months apart, regardless of past receipt of ZVL  
• See CDC information on administering Shingrix  
• Perform anti-varicella IgG screening in patients with no known history of chickenpox or shingles  
• **Revaccination:** None | • RZV is preferred over ZVL (A2)  
• RZV provides strong protection against shingles and post-herpetic neuralgia. Currently, there are no data on efficacy specific to people with HIV; however, superior efficacy and longer duration of protection have been demonstrated among the elderly, and a recombinant vaccine is preferred people with HIV  
• In addition, immunogenicity and safety following a 3-dose schedule has been demonstrated among people with HIV infection.  
*Note: RZV is administered IM in distinction to ZVL which is delivered by SQ injection.* |

**CDC:** Centers for Disease Control and Prevention; **MMR:** measles, mumps, and rubella; **NYSDOH AI:** New York State Department of Health AIDS Institute; **RZV:** recombinant zoster vaccine; **ZVL:** zoster vaccine live.

*Vaccine injury compensation program: Tel: 1-800-338-2382; U.S. Court of Federal Claims, 717 Madison Place, NW, Washington DC 20005

Available at: hivguidelines.org/hiv-care/primary-care-approach/#tab_5_13

New York State Department of Health AIDS Institute: www.hivguidelines.org