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## Standing Orders for Administering Influenza Vaccine to Adults

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**Purpose:** To reduce morbidity and mortality from influenza by vaccinating all adults who meet the criteria established by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices.

**Policy:** Under these standing orders, a licensed pharmacist with a certificate of administration issued by the New York State (NYS) Department of Education, where allowed under state law, may vaccinate patients who meet any of the criteria below. Pharmacists must follow all pertinent NYS laws and regulations. Regulations specific to pharmacist administration of vaccines can be found at [www.op.nysed.gov/part63.htm](http://www.op.nysed.gov/part63.htm).

### Procedure:

1. *Identify adults in need of influenza vaccination based on meeting any of the following criteria:*
  - a. Want to reduce the likelihood of becoming ill with influenza or of transmitting it to others
  - b. Age 50 years or older
  - c. Having any of the following conditions:
    - Chronic disorder of the pulmonary or cardiovascular system, including asthma
    - Chronic metabolic disease (e.g., diabetes), renal dysfunction, hemoglobinopathy, or immunosuppression (e.g., caused by medications, HIV)
    - Any condition that compromises respiratory function or the handling of respiratory secretions or that can increase the risk of aspiration (e.g., cognitive dysfunction, spinal cord injury, seizure disorder or other neuromuscular disorder)
  - d. Being pregnant during the influenza season
  - e. Residence in a nursing home or other chronic-care facility that houses persons of any age who have chronic medical conditions
  - f. In an occupation or living situation that puts one in proximity to persons at high risk, including
    - A healthcare worker, caregiver, or household member in contact with person(s) at high risk of developing complications from influenza
    - A household contact or out-of-home caretaker of a child age 0-59 months or of an adult age 50 years or older
2. *Screen all patients for contraindications and precautions to influenza vaccine:*
  - a. **Contraindications:** serious reaction (e.g., anaphylaxis) after ingesting eggs or after receiving a previous dose of influenza vaccine or an influenza vaccine component. For a list of vaccine components, go to [www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf](http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf).
    - Do not give live attenuated influenza vaccine (LAIV) to an adult who is pregnant or who has any of the conditions described in 1.b. or 1.c. above.
    - Use of inactivated influenza vaccine is preferred over LAIV for close contacts of severely immunosuppressed persons during periods when the immunocompromised person requires a protective environment.
  - b. **Precautions:** moderate or severe acute illness with or without fever; history of Guillain Barré syndrome within 6 weeks of a previous influenza vaccination.
3. *Provide all patients with a copy of the most current federal Vaccine Information Statement (VIS) before administering the immunization:* You must document in the patient's medication profile, the publication date of the VIS and the date it was given to the patient. Provide non-English speaking patients with a copy of the VIS in their native language, if available; these can be found at [www.immunize.org/vis](http://www.immunize.org/vis).
4. *Obtain consent for immunization:* You must inform each recipient of potential side effects and adverse reactions, orally and in writing, prior to immunization. You shall not administer the immunization unless the recipient is adequately informed and consents to the immunization. For recipients incapable of consenting to the administration of an immunization, before an immunization may be administered, either a person legally responsible for the recipient shall have given prior written consent to the immunization after having been informed in writing of potential side effects and adverse reactions, or a person legally responsible for the recipient is in attendance during the immunization and consents to the immunization after having been informed of potential side effects and adverse reactions.
5. *Advise on Adverse Events:* You must provide each patient with written instructions to call their primary care physician or seek care at the local emergency department if they have an adverse reaction to the vaccine.

6. **Administer Vaccine:** Inject 0.5 mL of trivalent inactivated influenza vaccine (TIV) IM (22-25g, 1-1.5" need) in the deltoid muscle. Alternatively, healthy adults younger than age 50 years without contraindications may be given 0.3mL of intranasal LAIV; 0.1 mL is sprayed into each nostril while the patient is in an upright position.
7. **Recommendations for Future Vaccines:** Notify the patient that the influenza vaccine must be taken annually. If patient is in one of the recommended groups for pneumococcal vaccine, suggest that they receive it. The recommended groups can be found at [www.cdc.gov/vaccines/pubs/acip-list.htm](http://www.cdc.gov/vaccines/pubs/acip-list.htm).
8. **Document each patient's vaccine administration information and follow up in the following places:**
  - a. **Patient medication profile:** Record the recipient's name, date, address of administration, administering pharmacist, immunization agent, manufacturer and lot number. If vaccine was not given, record the reason(s) for non-receipt of the vaccine (e.g., medical contraindication, patient refusal).
  - b. **Certificate of Immunization:** You must provide a signed certificate of immunization with this information.
  - c. **Patient's primary care physician:** With the consent of the recipient or a person legally responsible when the recipient is incapable of consenting, communicate this information to the recipient's primary health care practitioner, if one exists, within one month of the administration of such immunization. Such communication may be transmitted in electronic format.
  - d. **New York State Department of Health (NYSDOH):**
    - You must report the administration, absent any individually identifiable information in aggregate to the NYSDOH annually.
    - Identifying information must be submitted to NYS Immunization Information System (NYSIIS) or New York City Immunization Registry (CIR) if the patient is 18 years old. More information about NYSIIS is available at [www.nyhealth.gov/prevention/immunization/information\\_system](http://www.nyhealth.gov/prevention/immunization/information_system) and CIR at [www.nycwebsite.gov](http://www.nycwebsite.gov).
  - b. **Vaccine Adverse Event Reporting System (VAERS):** Report all adverse reactions to influenza vaccine to VAERS. Contact VAERS through [www.Vaers.hhs.gov](http://www.Vaers.hhs.gov) or (800) 822-7967. VAERS report forms are available at [www.vaers.hhs.gov](http://www.vaers.hhs.gov).
9. **Primary Care Provider:** Provide information to recipients on the importance of having a primary health care practitioner. Provide materials from the NYSDOH website.
10. **Be prepared for management of a medical emergency related to the administration of vaccine:** Have a written emergency medical protocol available, as well as equipment and medications, including emergency anaphylaxis treatment agents, related syringes and needles available at the location at which immunizations will be administered.

*If the pharmacist(s) are not identified but are identified as employed under contract with an entity that it legally authorized to employ or contract with pharmacists to provide pharmaceutical services:*

The certified pharmacist(s) are limited to administering immunizations only in the course of such employment or pursuant to such contract with \_\_\_\_\_.  
[name of entity(s)]

This policy and procedure shall remain in effect for all the patients of \_\_\_\_\_ from the effective date stated below until rescinded or until \_\_\_\_\_.  
[end date] [name of entity(s)]

*If the pharmacist(s) are identified:*

This policy and procedure shall remain in effect for all the patients of the pharmacist(s) listed here from the effective date stated below until rescinded or until \_\_\_\_\_.  
[end date]

[Pharmacist name and license number]
[Pharmacist name and license number]
[Pharmacist name and license number]

Name of Issuing Physician or Certified Nurse Practitioner: \_\_\_\_\_  
License Number: \_\_\_\_\_  
Signature: \_\_\_\_\_ Effective date: \_\_\_\_\_