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## Non-Patient Specific Order for Pharmacists Administering Influenza Vaccine to Adults

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**Purpose:** To reduce morbidity and mortality from influenza by vaccinating all adults, 18 years of age and older, 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 [http://www.health.ny.gov/prevention/immunization/providers/pharmacists\\_as\\_immunizers.htm](http://www.health.ny.gov/prevention/immunization/providers/pharmacists_as_immunizers.htm).

### Procedure:

1. *Identify adults with no history of influenza vaccination during the current influenza season.*
2. *Screen all patients for contraindications and precautions to influenza vaccine:*
  - a) **Contraindications:** a serious systemic or anaphylactic reaction after ingesting eggs, after receiving a previous dose of influenza vaccine, or to 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; nasal spray) to an adult with a history of hypersensitivity to eggs, either anaphylactic or non-anaphylactic; who is pregnant, is age 50 years or older, or who has chronic pulmonary (including asthma), cardiovascular (excluding hypertension), renal, hepatic, neurologic/neuromuscular, hematologic, or metabolic (including diabetes) disorders; immunosuppression, including that caused by medications or HIV.
  - b) **Precautions:** moderate or severe acute illness with or without fever; history of Guillain Barré syndrome within 6 weeks of a previous influenza vaccination; for TIV only, allergic reaction to eggs consisting of hives only (observe patient for at least 30 minutes following vaccination); for LAIV only, close contact with an immunosuppressed person when the person requires protective isolation, receipt of influenza antivirals (e.g., amantadine, rimantadine, zanamivir, or oseltamivir) within the previous 48 hours or possibility of use within 14 days after 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 <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. *Administer vaccine:*
  - a) **Trivalent inactivated vaccine (TIV) intramuscular (IM):** For adults of all ages, give 0.5 mL of injectable TIV-IM intramuscularly (22–25g, 1–1½" needle) in the deltoid muscle; or
  - b) **High-dose TIV-IM:** For adults ages 65 years and older, give 0.5 mL of high-dose TIV-IM intramuscularly (22–25g, 1–1½" needle) in the deltoid muscle.
  - b) **Live attenuated influenza vaccine (LAIV):** For healthy adults younger than age 50 years, give 0.2 mL of intranasal LAIV; 0.1 mL is sprayed into each nostril while the patient is in an upright position; or
  - d) **Trivalent inactivated vaccine (TIV) intradermal (ID):** For adults ages 18 through 64 years, give 0.1 ml TIV-ID intradermally by inserting the needle of the microinjection system at a 90 degree angle in the area of the deltoid muscle.

6. **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. You should also be prepared for management of a medical emergency related to the administration of vaccine. You must 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. Report all adverse reactions to influenza vaccine to Vaccine Adverse Event Reporting System (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).
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 the 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 [http://www.health.ny.gov/prevention/immunization/information\\_system/](http://www.health.ny.gov/prevention/immunization/information_system/) and CIR at <http://www.nyc.gov/html/doh/html/cir/cir-home.shtml>.
9. **Advise patient on importance of having a primary care provider:** More information can be found on the NYSDOH website, [http://www.health.ny.gov/prevention/immunization/having\\_a\\_medical\\_home.htm](http://www.health.ny.gov/prevention/immunization/having_a_medical_home.htm).

*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(s) and License Number(s)


Name of Issuing Physician or Certified Nurse Practitioner: \_\_\_\_\_

License Number: \_\_\_\_\_

Signature: \_\_\_\_\_ Effective date: \_\_\_\_\_