# Combination Measles, Mumps, Rubella, and Varicella (MMRV) Routine and Catch-up Vaccine Protocol

vaccine protocol for Persons Age one through 12 years

**Document reviewed and updated:** **June 6, 2023**

## Condition for protocol

To reduce incidence of morbidity and mortality of measles, mumps, rubella, and varicella disease.

## Policy of protocol

The nurse will implement this protocol for MMR vaccination using MMRV vaccine.

## Condition-specific criteria and prescribed actions

**Delete this entire paragraph before printing/signing protocol.**

[Instructions for persons adopting these protocols: The table below lists indication, contraindication, and precaution criteria and suggested prescribed actions that are necessary to implement the vaccine protocol. The prescribed actions include examples shown in brackets but may not suit your institution’s clinical situation and may not include all possible actions. A licensed prescriber must review the criteria and actions and determine the appropriate prescribing action.]

Indications

|  |  |
| --- | --- |
| Criteria | Prescribed action |
| Currently healthy child. | Proceed to vaccinate if meets remaining criteria. |
| Child is between ages 12 months and 4 years and is due for first dose MMR and varicella vaccines and parent is requesting the MMRV as a combination injection. | [Give MMR and varicella as separate injections using the respective MMR and varicella protocols. Explain to parent that institution policy is to give MMR and varicella as separate injections for the first dose in this age range. Refer elsewhere if parent insists on combination vaccine.][Review risks for febrile seizures and if parent consents to vaccination knowing risks proceed to vaccinate with MMRV.][Refer to primary care provider for discussion of risks and benefits to giving MMRV for the first dose at age 12 months to 4 years.] |
| Child is 15 months of age or older and is due for second dose of MMR and second dose of varicella. | Proceed to vaccinate with MMRV if meets remaining criteria. |
| Child is between ages 4 years through 12 years and is due for either dose 1 or dose 2 of MMR and varicella. | Proceed to vaccinate with MMRV if meets remaining criteria. |
| Child is less than age 1 year old. | Do not vaccinate. If child is traveling and MMR is indicated, follow MMR protocol.  |
| Child is 13 years or older. | Do not give MMRV; product is not licensed for persons 13 years or older. Give MMR and varicella separately using respective protocols. |
| Child had a prior infection of measles, or mumps, or rubella. | Not a contraindication for MMRV, proceed to vaccinate. [Document date of diagnosis of specific disease.] |
| Child had a prior infection of varicella | [Combination product is not necessary, give MMR.][Not a contraindication for MMRV, may give if MMR is not available] |

Contraindications

|  |  |
| --- | --- |
| Criteria | Prescribed action |
| Child had a severe allergic reaction to a previous dose of MMRV, MMR or varicella vaccine. | Do not vaccinate; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Child had a severe allergic reaction to a component of MMRV, MMR or varicella vaccine, including neomycin. | Do not vaccinate; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Family history of altered immunocompetence, unless verified clinically or by laboratory testing as immunocompetent | Do not vaccinate, refer to primary care provider. |
| Child has any of the following altered immune conditions: blood dyscrasias, leukemia, lym­phomas of any type, or other malignant neoplasms affect­ing the bone marrow or lymphatic system; primary or acquired immunodeficiency including HIV/AIDS, cellular immune deficiencies, hypogam­maglobulinemia, dysgammaglobulinemia; systemic immunosuppressive therapy including oral steroids ≥2 mg/kg or ≥20 mg/day of prednisone or equivalent for persons who weigh >10 kg, when administered for ≥2 weeks; chemotherapy – any kind, or radiation therapy. | Do not vaccinate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; [refer to primary care provider for further evaluation.] |

Precautions

|  |  |
| --- | --- |
| Criteria | Prescribed action |
| Child is currently on antibiotic therapy. | Proceed to vaccinate. |
| Child has a mild illness defined as temperature less than \_\_\_\_°F/°C with symptoms such as: [to be determined by medical prescriber] | Proceed to vaccinate. |
| Child has a moderate to severe illness defined as temperature \_\_\_\_°F/°C or higher with symptoms such as: [to be determined by medical prescriber] | Defer vaccination and [to be determined by medical prescriber] |
| Receipt of antibody-containing blood product within past 11 months. | Obtain date that person last received product and using the attached [CDC: Suggested Intervals Between Administration of Antibody-Containing Products and Measles-Containing or Varicella-Containing Vaccine (www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/a/recommended-intervals-between-administration.pdf)](https://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/a/recommended-intervals-between-administration.pdf) table, determine:* Whether there should be a delay time and
* What the delay time is.
* If delay is indicated, defer until interval is completed.
* If deferral time is expired, vaccinate.
 |
| Child has history or family history of seizures, including febrile seizures.  | Do not give combination MMRV; give MMR and varicella as separate vaccines. |
| Person received a live virus vaccine, such as FluMist, within the past 4 weeks. | Defer vaccination until at least 4 weeks have passed since the dose of live virus vaccine. |
| History of thrombocytopenia or thrombocytopenic purpura | Do not vaccinate; [refer to primary care physician] |

## Prescription

### Routine vaccination

Give MMRV, 0.5 ml, subcutaneously (SC) or intramuscularly (IM) at age 1 year and age 4-6 years.

### Catch-up schedule

Minimum interval:

* Dose 1 to dose 2: 3 months (maximum age is 12 years).

## Medical emergency or anaphylaxis

Follow pre-established agency protocol for anaphylaxis.

## Question or concerns

**Insert overseeing medical consultant’s information below and delete this sentence before printing/signing.**

In the event of questions or concerns call (insert name) at (insert phone number).

**This protocol shall remain in effect until rescinded.**

Name of prescriber (please print):

Prescriber signature:

Date: