# Recombinant Zoster Vaccine (RZV) Routine and At-risk Vaccine Protocol

vaccine protocol for Persons Age 19 years and older

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

## Condition for protocol

To prevent considerable herpes zoster incidence and related complications in persons 50 years or older who are immunocompetent and for persons 19 years and older who are or will be immunodeficient or immunosuppressed because of disease or therapy.

## Policy of protocol

The nurse will implement this protocol for recombinant zoster vaccine (RZV) vaccination.

## 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 immunocompetent person age 50 years or older. | Proceed to vaccinate if meets remaining criteria. |
| Person is 19 years and older and is immunodeficient orimmunosuppressed because of disease or therapy. | [Refer to primary care for optimal timing of vaccination.] [Proceed to vaccinate if meets remaining criteria.] |
| Person previously received the zoster vaccine live (ZVL). | If it has been 5 years since previous dose proceed to vaccinate if meets remaining criteria. [If it has been less than 5 years and more than 2 months since ZVL proceed to vaccinate if meets remaining criteria.] [If it has been less than 5 years since previous dose, and person will be older than age 70 years before the 5 year interval, proceed to vaccinate if it has been at least 2 months since receipt of zoster vaccine live.] |
| Person has never had or does not know history of varicella disease. | Proceed to vaccinate if meets remaining criteria. |
| Person was tested and found to be VZV negative. | Give varicella vaccine using the Varicella Vaccine Protocol. |
| Person had a prior infection of herpes zoster (shingles). | Proceed to vaccinate if meets remaining criteria. |
| Person has received varicella vaccination. | Proceed to vaccinate if meets remaining criteria. |

Contraindications

|  |  |
| --- | --- |
| Criteria | Prescribed action |
| Person had a severe allergy to a previous dose of RZV. | Do not vaccinate; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Person has a severe allergy to a component of zoster vaccine. | Do not vaccinate; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Precautions

|  |  |
| --- | --- |
| Criteria | Prescribed action |
| Person has a mild illness defined as temperature less than \_\_\_\_°F/°C with symptoms such as: [to be determined by medical prescriber]. | Proceed to vaccinate. |
| Person 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]. |
| Person is pregnant or lactating. | Refer to primary care to determine risk of disease and need for vaccination. |
| Person has a current episode of herpes zoster. | Defer vaccination until the acute stage of the illness is over and symptoms abate [Defer vaccination and to be determined by medical prescriber]. |

## Prescription

* Give recombinant zoster vaccine (RZV): 0.5 ml, IM. Give two doses 2 to 6 months apart.
* Minimum interval 4 weeks; repeat dose if given too soon.

## 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: