



Nirsevimab Implementation Guide

This resource is not meant to be comprehensive. It is to serve as a guide for practices who have used the Practice Readiness Checklist and are ready to implement administration of nirsevimab in their practice or organization. See other Academy [resources](#) for additional guidance.

Product Ordering and Inventory Management

Group Purchasing: Take advantage of purchasing through group purchasing organizations/vaccine purchasing groups to maximize discounts where available.

Immunization Management: Although this is an immunization that is not a vaccine, inventory management and storage and handling should follow similar protocols to your organization's vaccine management. There are several places to look for vaccine management resources, such as:

- [Immunize.org](https://immunize.org),
- [The AAP](#) (includes resources from CDC, IAC, EZIZ).

Stocking: Nirsevimab is packaged in pre-filled syringes. Have the following formulations in stock:

- 50mg (0.5mL) with **purple plunger rod** (for infants weighing <5 kg)
- 100 mg (1mL) with **light blue plunger rod** (weighing ≥5kg)

VFC vs Private Stock: it is possible that your clinic may receive nirsevimab with the same lot numbers for both private and VFC stock. It is imperative that you **make physical distinctions** in your refrigerator to reduce errors.

Tracking: Track your rate of acceptance/refusal of nirsevimab and use data to inform ongoing ordering practices. Make every effort to have adequate stock to optimize the ability to administer nirsevimab at every opportunity. (see "documentation" for additional details)

Identifying Eligible Patients

- Infants born shortly before or during RSV season (*October through March*)
 - Consider if any of these infants have a parent who was eligible to receive the maternal RSV vaccine. Make sure to flag these for parental follow up in your EHR.
- Infants born earlier that year who will be <8 months at the start of RSV season (typically from February/March through September)
 - *Tip: To determine who to reach out to, choose a start date in which it will be realistic to schedule those first appointments. This will ensure patients will be < 8 months of age at time of administration.*
- High risk children, who will be 8-19 months of age *at the onset of the RSV season (October)*
 - Include any high-risk patient who received one or more doses of Palivizumab this season (but < 5 doses) who will be eligible to receive nirsevimab 30 days after their last palivizumab dose.

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- [High risk children](#) include:
 - Children who were born prematurely and have chronic lung disease (*required medical support such as chronic corticosteroid therapy, diuretic therapy or supplemental oxygen any time during the 6-month period before the start of the second RSV season*).
 - Children who are severely immunocompromised.
 - Children with cystic fibrosis who have severe disease (*such as previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest imaging that persist when stable or have weight-for-length that is <10th percentile*).
 - American Indian and Alaska Native children (*note that this is a new group for whom second-season prophylaxis is recommended in contrast to the current palivizumab recommendations*).
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Prioritizing Timely Administration

See the AAP [Nirsevimab Administration Visual Guide](#)

- Identify and prioritize those patients who are born in February/March and will turn 8 months old at the beginning of the RSV season (*there is a narrow window for immunizing these children before they turn 8 months*).
 - Identify and prioritize those patients who are high risk and eligible and will turn 20 months of age at the beginning of the RSV season (*narrow window*).
 - Implement your outreach plan to contact these patients and make sure they are appropriately scheduled.
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Offering Nirsevimab at the Point of Care

Shortly Before or During RSV Season (typically October-March, but may vary in specific geographies)

- Once eligible patients have been identified, develop a way to flag them in the EHR for easy recognition (*Include the last date of eligibility in the flag if possible*). This will help alert schedulers at the time of scheduling.
- Indicate to the family that they will be offered nirsevimab during their office visit (per your readiness workflow).
- Use the practice huddle to identify and flag patients who are eligible 1-2 days in advance and again on the date of their appointment.
- Newborn Scheduling:
 - Review your practice scheduling to ensure newborns are seen within the first week of life.
 - Implement your practice workflow for obtaining information on whether or not the patient received nirsevimab prior to newborn hospital discharge.
 - Document the status in the EHR in a consistent manner so that all team members can easily find it.
- Well-Visit Protocols:

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- Add routine orders to well visit templates in the EHR for infants from birth to 6 months of age so that it can be routinely offered during preventive care visits if not already administered.
- Update office well-visit protocols to include nirsevimab at the appropriate visits (birth - 6 months of age).

Outside of RSV season

- At well-visits outside of RSV season, discuss with eligible families (ie child will still be <8 months of age or high risk 8 - 19 months) that they should be prepared to return on/after October 1st to receive nirsevimab.
- Consider scheduling a “nirsevimab only” future visit for infants who will not be due for a well visit at the beginning of RSV season.

Population Health Proactive Recalls:

After you have identified your eligible population, implement a practice recall plan to reach out to all eligible patients and encourage them to schedule in a timely manner. Consider dedicated time slots in your practice schedule and/or allow for self-scheduling with clear communication of eligibility constraints (age and/or risk group). Due to the critical nature of this immunization and timing, make sure staff clearly understands the need for multiple outreach methods (portal messages, calls, texts, etc.) and continuous follow-up.

Utilize [additional resources](#) from the AAP to explore recall and reminder resources.

Consider continuing to offer nirsevimab to eligible patients during the RSV season even if families have been hesitant or previously declined. Discuss whether your recall efforts will include families who have previously declined. If so, agree upon a practice protocol on how all team members will discuss this with families.

Documentation

Implement your practice plan to document both consent and refusal for nirsevimab administration on all eligible patients.

- Consent should be consistent with state or territorial regulations (*can use the same process already used for immunization consent*).
- If verbal consent is given, appropriate wording should be documented in the EHR in a consistent manner across all staff (*quick phrases or defaults can simplify this process*).
- Documentation of administration should be similar to what is required for vaccines (*some/all of which may be integrated within the functionality of your EHR*):
 - Manufacturer
 - Lot number
 - Date of administration

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- Name and business address of healthcare professional administering the immunization
- Date the [Immunization Information Sheet](#) is provided
- Site of administration
- Route of administration
- Expiration date of immunization
- Use the [Vaccine Refusal/Declination form](#) from the AAP to document declination from any patient who is eligible (*use the "other" category until this can be added*).
- Make sure the clinical team documents both acceptance and refusal consistently in the EHR and consider how that information might be pulled out of the EHR to manage purchasing and inventory.

Community Outreach and Family Education

Community connections and collaborative efforts can assist in maximizing safe and equitable implementation of a nirsevimab program. Some things to consider:

- Provide information in multiple languages for eligible patients immediately prior to and during the RSV season to reinforce family education.
- Work with OB/GYNs in your community to distribute information to pregnant families so they know the options available to them (*the maternal RSV vaccine vs. nirsevimab*).
- Discuss during prenatal visits within the pediatric office.
- Work with birthing hospitals to distribute information before and after delivery (*such as including information about the maternal RSV vaccine and nirsevimab in childbirth classes, and making sure families know to communicate vaccine status at delivery and with their pediatrician*).
- Use of practice social media accounts.

Make sure you implement your communication plan that you outlined during your practice readiness assessment.

Coding and Payment

Use [AAP resources](#) to follow updated coding guidelines.

Product CPTs:

- **90380:** Respiratory syncytial virus, monoclonal antibody, seasonal dose; **0.5 mL** dosage, for intramuscular use
- **90381:** Respiratory syncytial virus, monoclonal antibody, seasonal dose; **1 mL** dosage, for intramuscular use

**Note, if you use 2 vials (2 mL) in an older child, there should be two units of 90381*

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Administration CPTs:

- **96380** Administration of respiratory syncytial virus, monoclonal antibody, seasonal dose by intramuscular injection, with counseling by physician or other qualified health care professional (Per CPT, this is only to be used with CPT's 90380 and 90381)
- **96381** Administration of respiratory syncytial virus, monoclonal antibody, seasonal dose by intramuscular injection (Per CPT, this is only to be used with CPT's 90380 and 90381)
- Qualified Healthcare Professional (QHP) is defined as an individual that is able to report services such as E/M's under their own NPI number. Counseling provided by clinical staff is not reported with CPT **96380**.

During the transition to the new codes, payer policies may require reporting 96372 therapeutic, prophylactic, or diagnostic injection instead of 96380 and 96381. The AAP is working with payers to update their payment systems and payment policies.

Preventive counseling CPT:

- **99401** Preventive medicine counseling provided to an individual; approximately 15 minutes (This code is only reportable if you provide counseling, but the parent or caregiver refuses nirsevimab. You must spend at least 8 minutes counseling to use this code, and it cannot be reported in the context of a well visit)

Diagnosis Code

- **Z29.11** Encounter for prophylactic immunotherapy for respiratory syncytial virus (RSV) (Do not use **Z23** encounter for immunizations. This code only applies to vaccines/toxoid products)

Monitoring payment

- Monitor claims payments for every payer and respond promptly to denials.
- Monitor claims payments and compare the cost of product as referenced on the [CDC private sector price list](#).
- Work with Pediatric Councils to address inadequate payment.

Advanced Administration Efforts

To maximize infants who are born outside of the RSV season and/or those who are high risk, consider running a “nirsevimab only” immunization clinic to maximize coverage at the beginning of the season. You may want to adapt [flu clinic resources](#) depending on the size of your eligible patient population.