# Pneumococcal Conjugate Vaccine, 21-Valent (PCV21) Vaccine Protocol

vaccine protocol for Persons Age 19 Years or older

**Document reviewed: November 5, 2024**

## Condition for protocol

To reduce incidence of morbidity and mortality of *Streptococcal* *Pneumoniae* invasive disease.

## Policy of protocol

The nurse will implement this protocol for PCV21 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 |
| Person is age 50 years or older, is non-acutely ill and has one of the following: * Not previously received PCV.
* Received only PCV7 at any age.
* Received only PCV13 at any age at least 12 months ago.
* Received only PPSV23 at any age at least 12 months ago.
* Received PCV13 at any age and PPSV23 at age <65 years at least 5 years ago.
* Received PCV13 at any age and PPSV23 at age >65 years at least 5 years ago and decision to vaccinate is based on a shared clinical decision.
* Vaccination history is unknown.
 | Proceed to vaccinate. |
| Person is age 19 through 49 years, is non-acutely ill, is immunocompromised\*, has a CSF leak, or cochlear implant and has one of the following: * Not previously received PCV.
* Received only PCV7 at any age.
* Received only PCV13 at least 12 months ago.
* Received only PPSV23 at least 12 months ago.
* Received PCV13 and 1 or more doses of PPSV23 at least 5 years ago.
* Vaccination history is unknown.

*\*Chronic renal failure, nephrotic syndrome, immunodeficiency, iatrogenic immunosuppression, generalized malignancy, HIV infection, Hodgkin disease, leukemia, lymphoma, multiple myeloma, solid organ transplant, congenital or acquired asplenia, or sickle cell disease or other hemoglobinopathies.* | Proceed to vaccinate. |
| Person is age 19 through 49 years, is non-acutely ill, with chronic medical conditions\* and has one of the following: * Not previously received PCV.
* Received only PCV7 at any age.
* Received only PCV13 at least 12 months ago.
* Received only PPSV23 at least 12 months ago.
* Vaccination history is unknown.

 *\*Alcoholism; chronic heart disease, including congestive heart failure and cardiomyopathies; chronic liver disease; chronic lung disease, including chronic obstructive pulmonary disease, emphysema, and asthma; cigarette smoking; or diabetes mellitus.* | Proceed to vaccinate. |

Contraindications

|  |  |
| --- | --- |
| Criteria | Prescribed action |
| Person had a systemic allergic reaction (e.g., anaphylaxis) to a previous dose of pneumococcal conjugate vaccine (PCV), or to any vaccine containing diphtheria toxoid. | Do not vaccinate; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Person has a systemic allergy to a component of pneumococcal conjugate vaccine (PCV), or to any vaccine containing diphtheria toxoid. | 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} |

## Prescription

Give pneumococcal conjugate vaccine (PCV), 21-valent (CAPVAXIVE), 0.5 mL, intramuscular  (IM).

## 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: