Immunizations in Adults

This is a PDF version of the following document:
Module 2: Basic HIV Primary Care
Lesson 4: Immunizations in Adults

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Background

Providing appropriate immunizations is an important component of comprehensive HIV clinical care, but immunizing persons with HIV poses several challenges and concerns related to safety and efficacy. There are numerous vaccines that are used for people with HIV and understanding and distinguishing different vaccines pose unique challenges since vaccines, unlike medications, do not have unique generic names. Therefore, the summary table below provides the abbreviations and trade names for the most commonly used vaccines in adults with HIV.

Table 1. Vaccines Routinely Administered to Adults with HIV

Vaccines	Abbreviations	Trade Names
COVID-19 vaccine	1vCoVmRNA	*Comirnaty* *Spikevax* *mNexspike*
	1vCoVaPS	*Novavax*
Hepatitis A vaccine	HepA	*Havrix* *Vaqta*
Hepatitis A and hepatitis B vaccine	HepA-HepB	*Twinrix*
Hepatitis B vaccine	HepB	*Engerix-B* *Heplisav-B* *Recombivax H*
Human papillomavirus vaccine	HPV	*Gardasil* 9
Influenza vaccine (inactivated, egg-based)	IIV3	Multiple optior
	aIIV3	*Fluad*
	HD-IIV3	*Fluzone* High-D
Influenza vaccine (inactivated, cell culture)	ccIIV3	*Flucelvax*
Influenza vaccine (recombinant)	RIV3	*Flublok*
Measles, mumps, and rubella vaccine	MMR	M-M-R II *Priorix*
Meningococcal serogroups A, C, W, Y vaccine	MenACWY-CRM	*Menveo*
	MenACWY-TT	*MenQuadfi*
Meningococcal serogroup B vaccine	MenB-4C	*Bexsero*
	MenB-FHbp	*Trumenba*
Meningococcal serogroups A, B, C, W, Y vaccine	MenACWY-TT/Men B-FHbp	*Penbraya*

Vaccines	Abbreviations	Trade Names
	MenACWY-CRM/Men B-4C	*Penmenvy*
Mpox vaccine	Mpox	*JYNNEOS*
Pneumococcal conjugate vaccine	PCV15	*Vaxneuvance*
	PCV20	*Prevnar* 20
	PCV21	*Capvaxive*
Pneumococcal polysaccharide vaccine	PPSV23	*Pneumovax* 23
Respiratory syncytial virus vaccine	RSV	*Abrysvo* *Arexvy* *mResvia*
Tetanus and diphtheria toxoid vaccine	Td	*Tenivac*
Tetanus and diphtheria toxoids and acellular pertussis vaccine	Tdap	*Adacel* *Boostrix*
Varicella vaccine	VAR	*Varivax*
Zoster vaccine, recombinant vaccine	RZV	*Shingrix*

Summary Recommendations for Vaccines in Adults with HIV

This topic review will focus on the most important immunizations that are recommended for adults with HIV. Some live vaccines are contradicted in all adults with HIV, whereas others are contradicted only in those with advanced immunosuppression (CD4 count less than 200 cells/mm^3). In addition, people with HIV and advanced immunosuppression often have suboptimal responses to standard recommended vaccine doses; for several vaccines, the response appears to depend on current and nadir CD4 cell counts.[1,3,4] In general, responses to immunization are better when the vaccine is given to persons with higher CD4 cell counts, including after immune reconstitution that has resulted from antiretroviral therapy. Nevertheless, in most circumstances, vaccine administration does not need to be delayed until the CD4 count increases to greater than 200 cells/mm^3. The most important vaccines for adults with HIV will be discussed in detail in this lesson, but the following table provides a brief summary overview of recommendations for immunizations in adults with HIV based on the Adult and Adolescent OI Guidelines.[5]

Table 2. Recommended Immunizations for Adults with HIV

Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV		
Recommended Immunizations for Adults with HIV	Vaccines	Abbreviations	CD4 count <200 cells/mm^3
	COVID-19	1vCOV-mRNA 1vCOV-aps	**Recommended** Number of doses depends on v and prior COVID immunization Consider an additional dose 6 m after the last dose
	Hepatitis A	HepA	**R** 2 doses, with timing (0, 6-1 va
	Hepatitis B	HepB	**R** 2 or 3 doses dep
	Human papillomavirus	9vHPV	**R** 3 doses through ag
			Consider (wit 3 doses for ages 2
	Influenza	IIV3	**R**

Vaccines	Abbreviations	CD4 count <200 cells/mm^3		CD4 count ≥200 cells/mm^3
		inactivated, Recombinant Influenza	RIV3 HD-IIV3	1 Age ≥65 years: use h
		Influenza live, attenuated	LAIV3	**C**
		Measles-mumps-rubella	MMR	**Contraindicated**
		Meningococcal serogroups A, C, W, Y	MenACWY-CRM MenACWY-TT	**R** 2 doses (at least 8 weeks
		Meningococcal serogroup B	MenB-4C MenB-FHbp	**Conside** Shar 3 dose
		Mpox		**Recommer** 2 do
		Pneumococcal	PCV15 PCV20 PCV21 PPSV23	*No Prior Pneumococcal Vaccin* **R** 1 do 1 dose PCV15 follo
		Respiratory Syncytial Virus	RSV	**R** Aged 50-74 years w
		Tetanus-diphtheria-acellular pertussis Tetanus-diphtheria	Tdap Td	**R** 1 dose Tdap then T
		Varicella	VAR	**Contraindicated**
		Zoster, recombinant	RZV	**R** 2 doses (2–6 m

Source:

- Panel on Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the prevention and treatment of opportunistic infections in adults and adolescents with HIV. National Institutes of Health, HIV Medicine Association, and Infectious Diseases Society of America. Immunizations for Preventable Diseases in Adults and Adolescents with HIV. Last updated: May 27, 2026. [HIV.gov]

COVID-19 Vaccination

People with HIV are at elevated risk for significant morbidity and mortality from COVID-19 infection, particularly individuals who have untreated or advanced HIV (as evidenced by a low CD4 T-cell count or detectable HIV RNA) or other medical comorbidities.[6,7,8,9] Limited data exist on the specific safety and efficacy of COVID-19 vaccination for people with HIV, but, based on available data and clinical experience, it is generally accepted that the benefits for reducing COVID-related morbidity and mortality far outweigh any vaccine-related risks.[10,11]

COVID-19 Vaccines

mRNA Vaccines

COVID-19 mRNA vaccines employ novel mRNA technology—the mRNA is delivered in a lipid nanoparticle to express a full-length viral spike protein (Figure 1).[12] These mRNA vaccines stimulate vigorous SARS-CoV-2 B-cell mediated neutralizing antibody responses and T-cell augmentation and memory immune responses against SARS-CoV-2.[12] The most recent 2025-2026 mRNA vaccines are monovalent and target the Omicron variant sublineage LP.8.1 strain.[13,14]

- 2025–2026 Moderna COVID-19 Vaccine (*Spikevax*): approved for use in anyone 6 months of age and older
- 2025–2026 Moderna COVID-19 Vaccine (*mNexspike*): approved for use in anyone 12 years of age and older
- 2025–2026 Pfizer-BioNTech COVID-19 Vaccine (*Comirnaty*): approved for use in anyone 12 years of age and older

Protein Subunit Vaccines

The Novavax COVID-19 vaccine is a protein subunit vaccine contains recombinant SARS-CoV-2 spike protein in combination with an immune-boosting Matrix-M adjuvant.[13] The most recent 2025-2026 Novavax COVID-19 vaccine targets the Omicron variant JN.1, which is a closely-related predecessor of the Omicron JN.1 strain.[13,14]

- 2025–2026 Novavax COVID-19 Vaccine (*Nuvaxovid*): approved for use in anyone 12 years of age and older

Recommendations for COVID-19 Vaccines in Persons with HIV

The Adult and Adolescent OI Guidelines recommend that all adolescents and adults with HIV should receive a dose of the current season COVID-19 vaccine, regardless of their CD4 count, HIV RNA level, pregnancy status, or breastfeeding status.[5] The Centers for Disease Control and Prevention (CDC) recommends that all adults with HIV receive COVID-19 vaccination based on shared decision-making.[13] The number of recommended vaccine doses depends on a person's prior COVID-19 vaccination history and their immune status. Typically an additional dose is recommended 6 months after the last dose for persons 65 years of age and older, untreated HIV, or advanced HIV.[5,13] For COVID-19 vaccine indication purposes, advanced HIV is defined as CD4 cell counts less than 200 cells/mm^3, a history of an AIDS-defining illness without immune reconstitution, or clinical manifestations of symptomatic HIV.[5]

Recommendations for COVID-19 Vaccine Dosing in Adults with HIV

Because COVID vaccine recommendations frequently change and may be complex for moderately or severely immunocompromised persons, we recommend always referring to updated recommendations on the CDC website—Use of COVID-19 Vaccines in the United States: Interim Clinical Considerations.[13]

Hepatitis A Virus (HAV) Vaccination

Hepatitis A virus (HAV) is transmitted through food, water, or objects contaminated with fecal matter.[15] Infection with HAV is usually an acute, self-limiting condition that does not require treatment, though it can rarely cause fulminant liver failure.[15] Following the widespread use of the hepatitis A vaccine beginning in 1995, the number of HAV infections in the United States declined for nearly 2 decades, rose from 2015-2019, but then declined again during 2020–2023 (Figure 2).[16,17] For persons with HIV, the hepatitis A vaccines are safe and usually effective, though seroconversion rates may be diminished for individuals with lower CD4 cell counts.

Hepatitis A Vaccines

Hepatitis A vaccine is an inactivated vaccine that can be given as one of the single-antigen preparations (*Havrix* or *Vaqta*) or as a combination vaccine (*Twinrix*). The two single-antigen brands of hepatitis A vaccine are potentially interchangeable, but ideally, all doses in a vaccine series should be from the same manufacturer (Table 3).[18]

Vaccine Efficacy in People with HIV

One randomized controlled study found seroconversion rates of 94% in persons with HIV compared to 100% in persons without HIV, though rates were only 87% in patients with CD4 counts less than 300 cells/mm^3.[19] In another randomized controlled trial, after two doses of hepatitis A vaccine, seroconversion rates were observed in 68% of persons with HIV who had a CD4 count greater than or equal to 200 cells/mm^3 compared to only 9% of those with CD4 counts less than 200 cells/mm^3.[1]

Recommendations

The following summarizes the Adult and Adolescent OI Guidelines recommendations for administering the hepatitis A vaccine to persons with HIV who are not immune to HAV.[5,18]

- **Recommended Dosing Schedule**: Hepatitis A vaccine should be administered in two doses at 0 and 6–12 months (*Havrix*) or 0 and 6-18 months (*Vaqta*); the minimum interval between the first and second dose of these vaccines is 6 months.[5,18] The combined hepatitis A-hepatitis B vaccine (*Twinrix*) can also be administered as a 3-dose series (0, 1, and 6 months); for this combined vaccine, the minimum intervals are 4 weeks between the first and second doses and 5 months between the second and third doses.[5,18] For nonimmunized persons traveling to countries with endemic HAV, an accelerated dosing schedule with the combined hepatitis A-hepatitis B vaccine can be administered on days 0, 7, 21 to 30 days, with a booster dose given at 12 months.[5,18]
- **General Approach and Timing of Administration**: The Hepatitis A vaccine series should be administered to all adolescents and adults with HIV if they are not immune to HAV, with the timing of administering the vaccine based on the CD4 count (Figure 3).[5]
    - If the CD4 count is greater than 200 cells/mm^3, the hepatitis A vaccine should be given without delay.
    - If the CD4 count is less than 200 cells/mm^3 and there is an ongoing risk of acquiring HAV infection, the HAV vaccine series should be administered without delay. If the individual has a CD4 count of less than 200 cells/mm^3 and no active risk of acquiring HAV, two options exist: (1) administer without delay or (2) wait to give the vaccine series until the CD4 count is greater than 200 cells/mm^3.
    - Some experts recommend separating the hepatitis A vaccine from the conjugate pneumococcal vaccine by at least 1 month based on a study that showed lower serologic responses to the hepatitis A vaccine when these two vaccines were given on the same day.[20]
- **Postvaccination Serologic Testing and Revaccination**: Since persons with HIV may have an

attenuated response to the hepatitis A vaccine, postvaccination serologic testing should be performed in these individuals at least 1–2 months after completing the HAV vaccination series.[5,18] Evidence of postvaccination immunity against HAV is based on an antibody titer of at least 10 mIU/mL.

- If there is no evidence of postvaccination immunity and the CD4 count is greater than or equal to 200 cells/mm^3, then administer a third dose of hepatitis A vaccine.[5]
- If there is no evidence of postvaccination immunity and the CD4 count is less than 200 cells/mm^3 then repeat the entire hepatitis A vaccine series.[5]
- Serology testing should be done again at least 1–2 months after completing either of the above (the third dose or repeat vaccine series). If there is still no evidence of an adequate immune response, further vaccination is not recommended, but the individual should receive counseling on the need for immune globulin after an exposure to HAV.[18]

Hepatitis B Virus (HBV) Vaccination

Hepatitis B virus (HBV) is transmitted through percutaneous and mucosal exposure to infected blood or body fluids. Chronic HBV infection can cause cirrhosis, liver failure, hepatocellular cancer, and death. Individuals with HIV have an increased risk of acquiring HBV through injection drug use and/or condomless sex. When compared to persons with HBV monoinfection, those with HIV and HBV coinfection have an increased likelihood of establishing chronic HBV after initial infection, accelerated progression of liver disease, and significantly higher rates of liver-related mortality compared with individuals without HIV.[21,22] Thus, vaccination against HBV is very important for persons with HIV.

Hepatitis B Vaccines

For adults, there are three U.S. Food and Drug Administration (FDA)-approved recombinant hepatitis B surface antigen (HBsAg) single-antigen recombinant hepatitis vaccines: *Recombivax HB*, *Engerix-B*, and *Heplisav-B*. All hepatitis B vaccines are administered intramuscularly.

- *Heplisav-B*: This vaccine consists of recombinant HBsAg conjugated to the cytosine-phosphate-guanine (CpG 1018) adjuvant, and is available in doses that each contain 20 µg of HBsAg and 3,000 µg of the 1018 adjuvant.[23]
- *Recombivax HB*: This vaccine is a recombinant, single-antigen vaccine that is available as an adult standard formulation (10 µg HBsAg per dose) and a high-dose dialysis formulation (40 µg per dose). The double-dose *Recombivax-HB* is 20 µg.
- *Engerix-B*: This vaccine is a single-antigen, recombinant vaccine, available as a standard 20 µg HBsAg per dose. The double-dose *Engerix*-B is 40 µg.
- *Twinrix*: This combined hepatitis A-hepatitis B vaccine contains 720 EL.U of hepatitis A (antigen component from *Havrix*) and 20 µg per dose of HBsAg (antigen component from *Engerix-B*). It is important to note that administering the *Twinrix* vaccine provides standard-dose, not double-dose strength hepatitis B antigen.

Vaccine Efficacy in People with HIV

Using standard doses of older single antigen hepatitis B vaccines in adults with HIV generated significantly lower seroprotective response rates than in adults without HIV.[24,25] Lower HBV vaccine responses in persons with HIV have been associated with a recent or nadir CD4 count of less than 200 cells/mm^3, detectable HIV RNA levels, coinfection with hepatitis C virus, occult HBV, and overall health of the vaccine recipient.[4,24,26] Past attempts to improve hepatitis B vaccine response rates have included giving a double dose, an increased number of doses, and the use of intradermal vaccines.[27,28] The BEe-HIVe clinical trial compared three doses (0, 1, and 6 months) of the *Heplisav-B* vaccine to placebo in persons with HIV who were hepatitis B vaccine naïve and found 100% of those who received the vaccine had protective hepatitis B surface antibody (anti-HBs) levels greater than 10 mIU/mL at 28 weeks; in addition, at week 8 (4 weeks after the second dose), 87% had protective antibody titers and this number increased to 98.5% at week 24, which was prior to receipt of the third vaccine dose (Figure 4).[29]

Recommendations

The recommendations for hepatitis B immunization in persons with HIV are outlined as follows and are based on recommendations from the Adult and Adolescent OI Guidelines.[5,22]

- **General Approach and Timing of Administration**: All persons with HIV who do not have active HBV or evidence of immunity to HBV should receive the hepatitis B vaccine series if they have ongoing risks of acquiring HBV.[5,22] Individuals non-immune to HBV with a CD4 count less than 350 cells/mm^3 may have decreased response to HBV vaccination. Nonetheless, deferring vaccination until the CD4 count rises to greater than 350 cells/mm^3 is not recommended, as most individuals with a

CD4 count less than 350 cells/mm^3 will mount an adequate antibody response to the HBV vaccine series.[5,22] For hepatitis B vaccine nonresponder who have a CD4 count of less than 200 cells/mm^3, some experts would delay revaccination until after a CD4 count of 200 cells/mm^3 or greater is achieved and sustained on antiretroviral therapy.[5,22]

- **Prevaccine Screening**: Prevaccine screening should include HBsAg, anti-HBs, and hepatitis B core antibody (anti-HBc). A positive HBsAg indicates active infection, and no vaccine is indicated. If the individual has a positive test for both anti-HBs and anti-HBc, no hepatitis B immunization is needed. In addition, if the anti-HBs alone is positive (with a titer greater than 10 mIU/mL), the person is considered immune and has no need for hepatitis B immunization.[22] The approach to patients with isolated anti-HBc is addressed below.

- **Dosing and Schedule for Hepatitis B Immunization**: The following options are recommended for hepatitis B immunization in persons with HIV (Figure 5):[5,22]
    - Preferred
        - *Heplisav-B* given as a 2-dose series at 0 and 4 weeks
    - Alternative (if *Heplisav-B* unavailable)
        - *Engerix-B* 40 mcg (two simultaneous injections of 20 mcg each) at 0, 1, and 6 months (these doses are considered a “double-dose,” three-dose series), *or*
        - *Recombivax HB* 20 mcg (two injections of 10 mcg each) at 0, 1, and 6 months (these doses are considered a “double-dose” three-dose series), *or*
        - *Twinrix* combined HepA and HepB vaccine (1 mL IM) as a three-dose series (at 0, 1, and 6 months). Note that administering the *Twinrix* vaccine provides standard-dose, not double-dose strength of the hepatitis B antigen.
- **Post-vaccine Antibody Testing**: Given the decreased response rate to hepatitis B vaccine among persons with HIV, post-vaccine testing for antibody to hepatitis B surface antigen (anti-HBs) should be performed 4 weeks after completing the final dose of the vaccine series, with a titer of at least 10 mIU/mL considered protective. Individuals with a post-vaccine anti-HB level less than 10 mIU/mL are considered vaccine nonresponders.[22,30] Due to concerns of waning immunity, some experts recommend checking anti-HBs annually and giving a booster dose of hepatitis B vaccine if anti-HBs levels fall below 10 mIU/L, especially for individuals with ongoing risk of acquiring HBV who are not taking tenofovir DF or tenofovir alafenamide as part of their combination antiretroviral regimen.[22]
- **Vaccine Nonresponders**: In one of the arms of the BEe-HIVe trial, people with HIV who were previous hepatitis B vaccine nonresponders were randomized to a 2-dose series of *Heplisav-B*, a 3-dose series of *Heplisav-B* vaccine, and a conventional 3-dose hepatitis B vaccine (*Engerix-B*).[31] Results showed superior protection in the *Heplisav*-B vaccine arms (93.1% seroprotection rate with the 2-dose series and 99.4% with the 3-dose series) compared with the 3-dose *Engerix-B* vaccine regimen (seroprotective rate of 80.6%).[31] If a post-vaccine anti-HBs concentration of at least 10 mIU/mL is not attained, the following are considered as options for hepatitis B vaccine nonresponders:
    - If vaccine nonresponse occurs after receipt of either the *Engerix-B* or *Recombivax HB* series, administer *Heplisav-B* at 0 and 4 weeks with consideration for a third dose of *Heplisav-B* at 24 weeks.
    - If vaccine nonresponse occurs after receipt of a 2-dose *Heplisav-B* series, there are no data, but clinicians can consider a third dose of *Heplisav-B*, given 24 weeks after the first dose.
- **Isolated Hepatitis B Core Antibody**: The optimal approach for persons with HIV who have isolated anti-HBc (positive anti-HBc, negative anti-HBs, and negative HBsAg) is unclear, since this pattern may signify a false-positive result, an exposure in the distant past with waning anti-HBs, or occult HBV infection. Note, with this approach for persons with isolated core antibody, the cutoff representing immunity after the 1 vaccine dose (100 mIU/mL) is 10-fold higher than the standard 10 mIU/mL used to represent immunity following receipt of the HBV immunization series in persons who do not have isolated hepatitis B core antibody.[32] The recommended approach for persons with HIV is outlined below (Figure 6).[5,22]

Human Papillomavirus (HPV) Vaccination

Individuals with HIV have a high burden of human papillomavirus (HPV)-associated disease compared to persons who do not have HIV.[33,34,35] In addition, among people with HIV, genital warts are more common in women and men, abnormal cervical cytology is nearly 11 times more common in women, and anal cancer is approximately 30-fold higher among men.[33,34,35]

HPV Vaccines

Human papillomavirus vaccines are prepared from recombinant noninfectious virus-like particles and are considered safe for immunocompromised individuals since they do not pose a risk of transmission.[36] In the United States, the 9-valent human papillomavirus vaccine (9vHPV) is the only HPV vaccine currently manufactured; this vaccine provides protection against 7 cancer-causing HPV serotypes (16, 18, 31, 33, 45, 52, and 58) and the 2 HPV serotypes 6 and 11, that cause genital warts (Figure 7).[37] The HPV serotypes 16 and 18 account for approximately 66% of cases of cervical cancer; the HPV serotypes 31, 33, 45, 52, and 58 combined account for approximately 15% of cervical cancers and 10% of invasive HPV-associated cancers.[37] The HPV serotypes 6 and 11 account for approximately 90% of genital warts.[37] The 9vHPV vaccine is FDA-approved for use for ages 9 through 45 years.[38]

Vaccine Efficacy in People with HIV

There are limited data for the 9vHPV vaccine in adults with HIV. Available data with the previously used quadrivalent HPV vaccine (4vHPV) suggest HPV vaccine is safe and immunogenic in people with HIV, with seroconversion rates of 95% in men 18 years of age and older and 92.3 to 100% among women with HIV aged 16 to 23 years of age.[39,40] One randomized, double-blind clinical trial compared 4vHPV with placebo in people with HIV who were older than 27 years of age and the trial did not show efficacy for preventing new anal HPV infections.[40]

Recommendations

The following summarizes the Adult and Adolescent OI Guidelines recommendation for administering the HPV vaccine for people with HIV.[5,41]

- **General Approach**: The 9vHPV vaccine series should be given to all people with HIV who are 9 through 26 years of age if they have not previously received the 9vHPV vaccine series. The 9vHPV vaccine is not routinely recommended for persons with HIV who are older than 26 years of age, but it can be considered in this age group using a shared decision-making process.
- **Dosing Recommendation**: For persons with HIV, the HPV vaccination should be given in a 3-dose series (given at 0, 1–2, and 6 months). The 2-dose schedule should not be used in persons with HIV.
- **HPV Vaccine in Pregnancy**: The HPV vaccine is not recommended for pregnant women, but pregnancy testing is not needed prior to vaccination. If a woman is found to be pregnant after receiving a dose of the HPV vaccine while she is pregnant, no intervention is needed. In addition, if a woman has started the vaccine series and becomes pregnant, the remainder of the 3-dose series should be delayed until completion of pregnancy.
- **Use as Therapeutic Vaccine**: The HPV vaccine is not recommended for therapeutic purposes for persons with HPV-related abnormal cervical or anal cytology.

Influenza Vaccination

Influenza viruses typically circulate widely in the United States annually from late autumn through early spring. Influenza A and influenza B are the types of viruses that cause human epidemic disease. New variants emerge due to frequent antigenic change (i.e., antigenic drift) resulting from point mutations and recombination events during viral replication; antigenic drift is the virologic basis for seasonal epidemics and necessitates adjustment of the vaccine components each year.[42] Larger antigenic change, termed antigenic shift, has the potential to cause a worldwide pandemic because there is no preexisting immunity among humans to the novel virus in this situation. Annual influenza vaccination is the primary means of preventing influenza and its complications. Persons with HIV have a higher risk of influenza-associated morbidity and mortality compared to persons without HIV.[43] Studies in individuals with HIV suggest a single dose of inactivated vaccine generates a good humoral immune response, except in some individuals with a low CD4 cell count.[44]

Influenza Vaccines

The recommended inactivated and recombinant influenza vaccines are quadrivalent vaccines (containing two strains of both influenza A and B).[5] All influenza vaccines expected for availability in the United States for the 2025–2026 season are trivalent hemagglutinin-derived vaccines and the different types of vaccines include:

- Inactivated Influenza vaccine (IIV3) (standard-dose, egg-based vaccine)
- ccIIV3 (standard dose, cell culture-based vaccine)
- HD-IIV3 (high-dose, egg-based vaccine)
- aIIV3 (standard-dose, egg-based vaccine with MF59 adjuvant)
- RIV3 (recombinant hemagglutinin [HA] vaccine)

Recommendations

The following summarizes the Adult and Adolescent OI Guidelines recommendation for administering the influenza vaccine in the 2025-2026 season for adults with HIV.[5]

- **General Approach**: All people with HIV should receive a single annual dose of a trivalent influenza vaccine. In general, administering influenza vaccines during July and August should be avoided, unless there is a concern that the person will not receive an influenza vaccine dose later in the season. The live attenuated influenza vaccine (LAIV3), also known as the nasal spray flu vaccine, is not recommended for people with HIV.
- **Pregnant Women**: Pregnant women with HIV can receive an inactivated influenza vaccine or recombinant influenza vaccine at any time during pregnancy.
- **Recommended Vaccines for Persons 65 Years of Age and Older**: People with HIV who are 65 years of age and older should ideally receive a high-dose inactivated influenza vaccine (HD-IIV3) or adjuvanted inactivated influenza vaccine (aIIV3).
- **Persons with Egg Allergy**: The updated recommendations from now state that for persons with a history of egg allergy, any influenza vaccine (egg-based or non-egg-based) can be used, as long as the vaccine is otherwise appropriate for the recipient’s age and health status.

Measles-Mumps-Rubella (MMR) Vaccination

Measles, mumps, and rubella are highly contagious viruses that can cause a wide range of clinical manifestations, including congenital syndromes. In the United States, due to a recent decline in population use of the measles-mumps-rubella (MMR) vaccine, there has been a dramatic surge in measles cases in 2025 and 2026, which reflects the largest number of annual cases since 1992 (Figure 8).[45] Measles can cause significant morbidity and mortality in healthy individuals, and the impact is even greater in immunosuppressed persons, with one case report citing 40% mortality in patients with HIV.[46]

Measles Vaccines

In the United States, the combined MMR vaccine first became available in 1971, and the combined MMR vaccine remains the preferred vaccine for immunization against measles, mumps, and/or rubella. There is also an FDA-approved quadrivalent measles-mumps-rubella-varicella (MMRV) vaccine, but it is rarely used in adults. All currently used measles vaccines contain live attenuated measles virus and thus pose a significant risk of measles infection to severely immunocompromised individuals, including persons with HIV who have low CD4 cell counts.

Vaccine Efficacy in People with HIV

Limited available data suggest that immunologic responses to the MMR vaccine among individuals with HIV are modest at best, and vaccine efficacy in persons with HIV is not well established. There are some data that suggest persons with HIV have an attenuated antibody response to the MMR vaccine.[47,48,49] In addition, there have been case reports of fatal pneumonitis in persons with HIV and advanced immunosuppression who received the MMR vaccine.[50,51]

Recommendations

The following summarizes the Adult and Adolescent OI Guidelines recommendations for administering the MMR vaccine to persons with HIV.[5]

- **General Approach**: The MMR vaccine should only be administered to adults with HIV if (1) they lack immunity to measles, mumps, and rubella and (2) they have a CD4 count of at least 200 cells/mm^3. Persons are considered to have immunity to measles if any of the following are met: (1) they were born before 1957, (2) they have documentation of receipt of two doses of the MMR vaccine, or (3) they have laboratory evidence of immunity (positive measles antibody titer).
- **Recommended Dosing Schedule**: For nonimmune persons with a CD4 count of at least 200 cells/mm^3, give the two-dose MMR vaccine series, with the doses administered at least 4 weeks apart.
- **Quadrivalent Measles-Mumps-Rubella-Varicella (MMRV) Vaccine**: The quadrivalent MMRV vaccine has not been adequately studied in people with HIV and is not recommended, regardless of CD4 cell count.
- **Persons with Advanced Immunodeficiency**: For adults with HIV, the MMR and MMRV vaccines are contraindicated if the CD4 count is less than 200 cells/mm^3.
- **MMR in Pregnancy**: The MMR vaccine is not recommended during pregnancy, and pregnancy should be avoided for 4 weeks after vaccination to minimize the theoretical risk of congenital rubella syndrome. Pregnant women without evidence of rubella immunity who have a CD4 count of at least 200 cells/mm^3 (and receiving antiretroviral therapy) should receive the MMR vaccine series upon completion of pregnancy.
- **Persons who Received Measles Vaccine During 1963-1967**: Receipt of an inactivated measles vaccine, which was an option during 1963-1967 but was ineffective, does not count as a dose of measles vaccine.[52] In addition, if the type of measles vaccine received during 1963-1967 is unknown, then it does not count as a dose.[52]
- **Vaccine Nonresponders**: Currently, there is no guidance on whether to obtain post-MMR vaccine

serologic titers to document vaccine response. If post-MMR vaccine titers are checked and demonstrate a lack of immunity, the recommendation is to consider repeating the 2-dose MMR series, especially if the person did not have suppressed HIV RNA levels at the time of MMR vaccination.

Meningococcal Vaccination

Meningococcal meningitis, which is caused by *Neisseria meningitidis*, can cause severe complications, including hearing loss, brain damage, and death. Available data from population studies suggest that persons with HIV have a 5- to 24-fold higher risk of developing meningococcal disease than persons without HIV. The highest risk is in persons with HIV occurs in those with low CD4 cell counts and high HIV RNA levels.[5,53,54] In addition, several local outbreaks of meningococcal meningitis have been reported in the United States involving gay and bisexual men.[55,56,57] In 2023, the CDC reported an increase in meningococcal disease in persons with HIV, noting 29 cases in 2022 alone, with most of these cases involving persons who had not received meningococcal vaccination (Figure 9).[58] As with other vaccines given to individuals with HIV, a low CD4 count at the time of meningococcal immunization has been associated with decreased vaccine response rates.[59,60]

Vaccines

Multiple meningococcal vaccines are now available, including the quadrivalent meningococcal conjugate vaccines (MenACWY) and the recombinant meningococcal group B vaccine.

- **Quadrivalent Meningococcal Vaccines**: There are two vaccines covering groups A, C, W-135, and Y that are licensed and available for use in the United States: MenACWY-CRM (*Menveo*) and MenACWY-TT (*MenQuadfi*) (Figure 10).[54] The MenACWY vaccine is approved for use in persons 2 months through 55 years of age, and MenACWY-TT is approved for persons at least 2 years of age.[54,61]
- **Recombinant Meningococcal Group B Vaccine**: Two recombinant serogroup B meningococcal vaccines (MenB) are now available: MenB-4C (*Bexsero*), given in a 2-dose series and MenB-FHbp (*Trumenba*) given in a 3-dose series. If both the Men-ACWY and Men-B vaccines are indicated for an individual with HIV, the vaccines can be administered simultaneously, but, if feasible, they should be administered at 2 different anatomic sites.
- **Pentavalent Meningococcal Vaccines**: There are two pentavalent meningococcal vaccines (*Penbraya* and *Penmenvy)* that provide protection against the five meningococcal serogroups A, B, C, W, and Y.

Recommendations

The following summarizes recommendations from the Adult and Adolescent OI Guidelines for administering meningococcal vaccines to adolescents and adults with HIV.[5]

Meningococcal Conjugate Vaccine (A, C, W, Y)

- **General Approach**: Routine administration of either of the quadrivalent meningococcal conjugate vaccines (MenACWY-CRM and MenACWY-TT) is recommended for persons with HIV who are 18 years of age and older. If possible, the same meningococcal vaccine product should be used for all doses.
- **Recommendations for Primary Vaccine Series and Booster Doses**: For adults with HIV, the primary meningococcal vaccine series should consist of 2 doses given at least 8 weeks apart. For individuals with HIV who have previously received the primary conjugate meningococcal vaccine series and are at least 7 years of age, a booster dose of the conjugate meningococcal vaccine should occur every 5 years (and not given within 5 years of the last dose of the primary meningococcal vaccine series) (Figure 11).
- **Use in Pregnancy**: There are no restrictions on the use of the quadrivalent meningococcal conjugate vaccines in pregnancy.

Meningococcal B Vaccine

- **General Approach**: Administration of meningococcal B (MenB) vaccine is not routinely

recommended for adults with HIV. The MenB vaccine may be administered to individuals with HIV if they have an indication for receiving a meningococcal B vaccine, such as functional or anatomic asplenia, persistent complement component deficiency, or receipt of a complement inhibitor (e.g., eculizumab, ravulizumab). In addition, for those individuals 16–23 years of age with HIV, Men B vaccination may be given (using shared clinical decision-making) for short-term protection against most strains of serogroup B meningococcal disease and/or for patients at increased risk, such as those living in dormitories or barracks, and during meningococcal B outbreaks.

- **Dosing Recommendations**: Three doses should be given at 0, 1–2, and 6 months. If the second dose was administered more than 6 months after the first dose in the series, then a third dose is not required. In addition, if the third dose of the vaccine is administered within 4 months after the second dose, the dose should be repeated at least 4 months after the last dose. The MenB-4C and the MenB-FHbp should not be used interchangeably. Persons with an ongoing risk of meningococcal B infection should receive a booster dose of the MenB vaccine 1 year after completing the initial vaccine series, followed by booster doses every 2 to 3 years.
- **Use in Pregnancy**: The MenB vaccine should be avoided during pregnancy, unless the woman is at increased risk of meningococcal infection.

Adults who Need to Receive Both MenACWY and MenB

For adults who need to receive both MenACWY and MenB vaccines, the Adult and Adolescent OI Guidelines provides the option of administering the pentavalent Men-ABCWY (*Penbraya* or *Penmenvy*) vaccine instead of giving separate Men-ACWY and Men-B vaccines. If this strategy is used, the 2 doses of the pentavalent vaccine should be given 2 months apart and a third separate dose of MenB vaccine would be required at month 6, with the same type of MenB that was used in the pentavalent vaccine. There are, however, no published data on the use of pentavalent meningococcal vaccines in people with HIV. In addition, the pentavalent meningococcal vaccines should not be used as a substitute for the quadrivalent vaccine for the every-5 year-booster doses of the quadrivalent meningococcal vaccine.

Mpox Vaccination

Mpox clinical infection is caused by monkeypox virus, a double-stranded DNA virus closely related to smallpox virus.[62] In the 2022-2023 mpox outbreak in the United States, persons with HIV were disproportionately impacted, with roughly 40% of cases involving persons with HIV.[63,64] In addition, persons with HIV with mpox were more likely to require hospitalization, especially those with a CD4 count of less than 350 cells/mm^3 or who were not engaged in care.[64,65] Most cases of mpox reported in the United States have been clade II, but as of February 2026, there have been 15 cases of clade I mpox.[62]

Mpox Vaccines

Currently, two vaccines are available in the United States for the prevention of orthopoxvirus infection. The Modified Vaccinia Ankara (MVA) vaccine, *JYNNEOS*, consists of live, attenuated, non-replicating vaccinia virus.[66,67] It is the preferred vaccine for mpox protection.[66] The *JYNNEOS* vaccine is safe to use in people with HIV. The mpox vaccine can be administered as a subcutaneous injection or intradermal injection.[5] The intradermal injection is not recommended for persons younger than 18 years of age. The second approved vaccine—ACAM2000—is a replication-competent smallpox vaccine that is contraindicated in persons with HIV and, therefore, will not be discussed further.[66]

Recommendations

For persons with HIV who have an indication for the mpox vaccine, vaccination is recommended. The *JYNNEOS* vaccine, which is the only mpox vaccine recommended for persons with HIV, may be administered at the same time as any other vaccines, though ideally in different limbs. Some experts recommend waiting 4 weeks after vaccination against COVID-19 because of the rare side effects of myocarditis or pericarditis associated with both of those vaccines. The following summarizes recommendations from the Adult and Adolescent OI Guidelines for administering the *JYNNEOS* mpox vaccines to adolescents and adults with HIV, including use of the mpox vaccine series before and after an mpox exposure (Figure 13).[5,62]

Vaccination Before Mpox Exposure

- **Indications**: Mpox vaccination should be offered for persons with HIV, regardless of CD4 count, who have the potential for mpox exposure or anticipate potential exposure to mpox. The mpox vaccine is not recommended for people who have had prior mpox infection. A prior history of receiving smallpox vaccines does not alter indications for the mpox vaccine. The mpox vaccine should be given to any person with HIV who requests mpox vaccination, unless they have already received mpox vaccination or had mpox infection.
- **Dosing**: Administer two doses of the *JYNNEOS* MVA vaccine, 0.1 mL intradermal or 0.5 mL subcutaneously, 28 days apart. The intradermal dosing is not recommended for individuals younger than 18 years of age.
- **Booster Doses**: Booster doses are not recommended for persons with prior receipt of the mpox *JYNNEOS* vaccine series.

Vaccination Following Mpox Exposure (Postexposure Prophylaxis)

- **Indications**: For unvaccinated people with HIV who experience a known or presumed exposure, postexposure prophylaxis with mpox vaccination is recommended as soon as possible, ideally within 4 days after exposure. Less preferably, the vaccine can be administered 4 to 14 days after exposure, as it may still provide some protection against mpox if administered during this time frame (Figure).
- **Dosing**: Administer two doses of the *JYNNEOS* MVA vaccine, 0.1 mL intradermal or 0.5 mL subcutaneously at least 28 days apart.

Pneumococcal Vaccination

In the general population, *Streptococcus pneumoniae* causes significant disease, including bacteremia, meningitis, and pneumonia, and is responsible for approximately 4,000 deaths each year in the United States. In the early years of the HIV epidemic, the risk of invasive pneumococcal disease in persons with HIV was approximately 20 times higher than in adults without high-risk conditions.[68] Subsequently, the incidence of invasive pneumococcal disease has decreased in persons with HIV, likely due to (1) the widespread use of potent antiretroviral therapy that resulted in improved immune function and improved humoral responses to pneumococcal antigens during clinical infections and (2) population herd protection against invasive strains of *S. pneumoniae* following the widespread use of conjugate pneumococcal vaccines in children since 2000.[69,70,71] A study that examined the risk of invasive pneumococcal disease in persons with HIV from 1996 through 2011 at a large integrated healthcare system in the United States reported a sevenfold increased risk of invasive pneumococcal disease in adults with HIV compared with adults without HIV.[72]

Vaccines

Four pneumococcal vaccines are currently available for use in the United States: PCV15 (*Vaxneuvance*), PCV20 (*Prevnar*), and PCV21 (*Capvaxive*), and PPSV23 (*Pneumovax*).[5,73] The PCV15, PCV20, and PCV21 are conjugate vaccines that provide more robust and longer lasting immune responses than the PPSV23 polysaccharide vaccine.[73] The PCV20 and PCV21 require one dose only; there are no additional doses needed.[73,74] The PCV20 vaccine includes the same 15 serotypes as in the PCV15 plus 5 additional serotypes; the PCV21 vaccine contains 8 serotypes not included in PCV15, PCV20, or PPSV23, but PCV21 does not contain pneumococcal serotype 4 (Figure 14).[74] Note that pneumococcal serotype 4 is prominent in certain populations and regions in the western United States, especially in Alaska, Colorado, the Navajo Nation, New Mexico, and Oregon.[74]

Vaccine Efficacy in People with HIV

There are limited data that have addressed the efficacy of pneumococcal vaccination in persons with HIV. There are no published major trials on pneumococcal conjugate vaccine in adults with HIV in the United States. The safety and immunogenicity of PCV15 compared to PCV13 was evaluated in approximately 300 adults with HIV in a phase 3, randomized, controlled clinical trial conducted at multiple sites internationally.[75] This study demonstrated the PCV15 vaccine was well tolerated and induced adequate antibody responses to all 15 pneumococcal serotypes included in the vaccine.[73,75] The PCV20 has also been shown to be safe and immunogenic in clinical trials involving adults with some medical conditions, but HIV and other immunocompromising conditions were excluded from the study.[73]

Recommendations

The following summarizes recommendations from Adult and Adolescent OI Guidelines for pneumococcal immunization in persons with HIV, with the exact schedule based on age and whether the individual has previously received any doses of pneumococcal vaccine.[5]

General Approach

Initial pneumococcal immunization for persons with HIV should now utilize the newer conjugate vaccines—PCV15, PCV20, or PCV21. Note that PCV21 is not recommended in regions of the United States where the prevalence of pneumococcal serotype 4 is greater than 30% among pneumococcal isolates.

No Prior Pneumococcal Immunization

Adults with HIV who have never received a pneumococcal vaccine (or their pneumococcal immunization status is unknown) should receive either a single dose of PCV20, a single dose of PCV 21, or a dose of PCV15

followed by a dose of PPSV23 at least 8 weeks later (Figure 15). Regardless of which of these two approaches is used, no further doses of pneumococcal vaccine are needed.

Prior Pneumococcal Immunization

In persons who have received at least one dose of a prior pneumococcal vaccine, the approach, options, and timing for completing the pneumococcal vaccine schedule depend on what prior vaccine was administered (Figure 16).

- **Prior Receipt of PCV13 Only**: Give 1 dose of PCV20 or PCV21; give the dose at least 1 year after the PCV13 dose.
- **Prior Receipt of PCV13 and One or More Doses of PPSV23**: For people with HIV who have received PCV13 and at least 1 dose of PPSV23, but have not completed the vaccine series, two options exist:
    - Received last dose of PPSV23 at age

Respiratory Syncytial Virus (RSV)

Respiratory syncytial virus (RSV) is a common cause of respiratory tract infection across the lifespan, though it is classically associated with significant morbidity in infants, young children, and severely immunocompromised individuals.[76] In adults, RSV typically manifests as an upper respiratory tract infection, but it can progress to severe lower respiratory tract disease, resulting in substantial morbidity and mortality.[76] The highest risk of severe disease is observed among individuals 75 years of age and older, residents of long-term care facilities, and those with chronic medical comorbidities.[77] In the United States, RSV has a seasonal circulation similar to influenza, occurring primarily between October and March, and typically peaking in December.[78] Transmission occurs via respiratory droplets and contact with contaminated surfaces.[76] There are no major studies evaluating RSV infection in people with HIV.[5]

Vaccines

There are three licensed RSV vaccines FDA-approved for use in the United States:

- *Arexvy*: Adjuvanted recombinant RSV prefusion F protein-based vaccine.[79]
- *Abrysvo*: Recombinant RSV prefusion F protein-based vaccine.[80,81]
- *mRESVIA*: An mRNA-based RSV vaccine.[82]

Vaccine Efficacy in People with HIV

Data on RSV vaccination in people with HIV are limited. Individuals with HIV were largely excluded from key registrational vaccine trials. Studies of *Abrysvo* and *mRESVIA* permitted enrollment of persons with well-controlled HIV, though the number enrolled was not reported in either study.[81,82] Large randomized controlled trials, conducted primarily in immunocompetent older adults, demonstrated good efficacy and tolerability.[79,81,82] Serious adverse events were uncommon, though very rare neurologic complications have been reported.[79,81,82] The RSV vaccine *Abrysvo* has also been studied in pregnancy and is recommended to prevent RSV-associated lower respiratory tract disease in infants via transplacental antibody transfer.[80] The RSV vaccine should be administered at weeks 32 to 36 gestation during the months September through January.[5]

Recommendations

Due to limited data on RSV immunization in people with HIV, RSV vaccination recommendations in persons with HIV are extrapolated from recommendations for the general population. The following table summarizes recommendations from the Adult and Adolescent OI Guidelines for use of RSV vaccines in people with HIV (Table 4).[5] At present, one-time vaccination is considered sufficient, and revaccination, including during subsequent pregnancies, is not recommended.

Tetanus, Diphtheria, and Pertussis (Tdap) Vaccination

Tetanus, diphtheria, and pertussis are vaccine-preventable bacterial diseases that can lead to serious complications. Tetanus (lockjaw) can potentially cause muscle paralysis and carries a 20% mortality rate. Diphtheria causes a thick coating to form in the posterior pharynx that can lead to breathing difficulty, and, in some instances, death. Pertussis (whooping cough) causes severe coughing spells that can lead to pneumonia, hypoxia, sleeping problems, and rarely death. Widespread childhood vaccination has markedly reduced the number of serious complications related to tetanus, diphtheria, and pertussis in the United States among all age groups. Although the pertussis vaccine has reduced the incidence of pertussis compared with the prevaccine era, the number of reported cases of pertussis has increased since the 1980s, primarily due to the lack of long-term immunity with the pertussis vaccine.[83] Most individuals with HIV mount adequate antibody responses to tetanus and diphtheria toxins, but responses are often lower among those with a CD4 count of less than 300 cells/mm^3.[84]

Tdap and Td Vaccines

Several tetanus and diphtheria toxoid vaccines (Td) are currently licensed by the FDA.[83] In addition, two tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (Tdap) vaccines are approved by the FDA: *Boostrix* (for persons aged 10 and older) and *Adacel* (for persons aged 11 to 64 years). Both the Tdap and Td vaccines contain inactivated bacteria and thus are unlikely to pose any risk to individuals with HIV. When the Tdap vaccine was initially licensed, concern existed regarding the safety of administering the Tdap vaccine within 5 years of the Td vaccine. Subsequently, studies reported that administering Tdap to an individual who had recently received Td (21 days to 2 years) was safe, other than a mild local reaction.[83,85]

Recommendations

The following summarizes recommendations from the Adult and Adolescent OI Guidelines for administering Tdap and Td for adults with HIV.[5]

- **General Approach**: Adults and adolescents with HIV should receive immunization with Tdap and Td per the same schedule as nonpregnant adults without HIV. The timing and dosing of the Tdap and Td vaccination in persons with HIV is not altered based on CD4 cell count.
- **No Prior Tdap**: For adults and adolescents with HIV who have not received the primary vaccination series for tetanus, diphtheria, or pertussis, give an initial three-dose series consisting of one dose of Tdap, followed by one dose of Td or Tdap at least 4 weeks after Tdap, another dose of Td or Tdap 6 months to 12 months after the last Td or Tdap, then Td or Tdap booster every 10 years.
- **No Tdap After Age 11 Years**: For adults and adolescents with HIV who received the primary vaccine series for tetanus, diphtheria, or pertussis, but have not received a dose of Tdap after age 11 years, give a dose of Tdap, followed by a Td or Tdap booster every 10 years. Adults and adolescents who previously received Td but have not had a Tdap dose should receive the Tdap vaccine regardless of the interval since Td was last administered.
- **Tdap During Pregnancy**: Give Tdap during every pregnancy (in persons with or without HIV) to prevent pertussis morbidity and mortality in infants. The dose of Tdap should be given preferably during gestational weeks 27 to 36, and it should be administered regardless of the pregnant woman’s prior history of receiving Tdap.

Varicella Vaccination

Varicella-zoster virus (VZV), or the chickenpox virus, is a highly contagious virus that causes rash, fever, and potentially severe, disseminated disease in persons with weakened immune systems. Prior to the introduction of the varicella vaccine and the incorporation of this vaccine into the routine childhood immunization schedule, chickenpox was common in the United States general population, causing infection in more than 4 million persons each year. Primary varicella-zoster virus infection is uncommon in adults with HIV since most have acquired immunity through childhood infection or varicella immunization.[86]

Vaccines

The varicella vaccine is a live attenuated vaccine that poses a significant risk to persons with HIV who have advanced immunosuppression.[5,86] The duration of protection from varicella vaccine is not known. In addition to providing protection against primary varicella infection, the varicella vaccine has also been shown in studies to reduce the risk of herpes zoster (when compared with wild-type infection).[87,88]

Recommendations

The following summarizes recommendations from the Adult and Adolescent OI Guidelines for administering varicella vaccine to adults with HIV.[5,86]

- **General Approach**: Adults with HIV should receive varicella vaccine if (1) they do not have immunity to VZV, and (2) they have a CD4 count of at least 200 cells/mm^3.
- **Varicella Serologic Screening**: To identify persons with HIV who lack immunity to VZV, some experts would obtain varicella antibody titers (quantitative IgG) if the individual does not have any of the following: prior varicella immunization, prior clinical varicella (or zoster) infection, or a documented protective varicella IgG titer. The varicella titer lacks optimal sensitivity, especially in persons who have previously received varicella vaccine.
- **Dosing Recommendation**: If varicella vaccine is indicated, administer two doses 4–8 weeks apart.
- **Varicella Vaccine in Pregnancy**: The varicella vaccine is contraindicated during pregnancy, regardless of HIV status. Pregnant women without evidence of varicella immunity and a CD4 count of at least 200 cells/mm^3 should receive (or complete) the varicella vaccine series immediately after delivery.
- **Contraindications**: Varicella vaccine is contraindicated in persons with HIV who have a CD4 count of less than 200 cells/mm^3 and in pregnant women. Further, the quadrivalent measles-mumps-rubella-varicella vaccine is not recommended for individuals with HIV. The zoster vaccine should not be used interchangeably with the varicella vaccine.

Zoster Vaccination

Although primary varicella-zoster virus infection is unusual in persons with HIV, the incidence of zoster among adults with HIV who are not receiving antiretroviral therapy is at least 15-fold higher than among age-matched immunocompetent adults, and the risk is highest in persons with a CD4 count less than 200 cells/mm^3.[86,89,90] Individuals with HIV have an additional increased risk in the first 4 months after starting effective antiretroviral therapy, likely as a result of immune reconstitution.[91] Following the widespread use of potent antiretroviral therapy, the incidence rate of zoster has markedly decreased compared with the early years of the HIV epidemic.[92] Zoster is typically limited to a painful, dermatomal vesicular rash but can result in severe and complicated disease in adults with HIV, especially those with a low CD4 count.[93] The goal of using the zoster vaccine in persons with HIV is twofold: (1) to prevent zoster and (2) to reduce the severity of zoster if it does occur.

Zoster Vaccine

There is only one zoster vaccine currently available in the United States: the recombinant zoster vaccine (RZV, *Shingrix*). The RZV vaccine contains varicella-zoster glycoprotein E combined with a novel adjuvant ($AS01_B$)(Figure 17).[94,95] As of June 30, 2020, the zoster vaccine live (ZVL, *Zostavax*) vaccine was no longer manufactured and sold in the United States. Therefore, the following discussion will address only the RZV vaccine. The RZV is licensed as a 2-dose vaccine series, given 2 to 6 months apart (minimum interval allowed 4 weeks).[61,95] In July 2021, the FDA expanded the indicated use of RZV to include individuals aged 18 years and older who are or will be at increased risk of developing herpes zoster because of immunodeficiency or immunosuppression.[96] The RZV does not contain live varicella-zoster virus and, therefore, poses no risk of causing varicella-zoster infection.

Vaccine Efficacy in People with HIV

The RZV has shown efficacy of greater than 95% in preventing herpes zoster in phase 3 trials that enrolled immunocompetent older adults.[97,98,99] A phase 1/2a trial evaluated RZV in persons with HIV and found it was safe and immunogenic, but this trial did not evaluate the impact of RZV in preventing zoster.[100]

Recommendations

The following summarizes recommendations in the Adult and Adolescent OI Guidelines for the use of RZV in persons with HIV.[5]

- **General Approach**: The RZV is recommended for adults with HIV who are 18 years of age or older, regardless of previous zoster history or previous receipt of ZVL. This vaccine is considered safe regardless of the CD4 cell count.
- **Vaccine Schedule**: The RZV vaccine should be administered as a 2-dose series given 2 to 6 months apart (Figure 18) (**AIII**). If more than 6 months have elapsed by the second dose, the RZV series does not need to be restarted. If, however, the second dose is administered sooner than 4 weeks after the first dose, then another (third) RZV dose should be administered (more than 4 weeks after the dose that was given too early).[96]
- **Timing of Vaccine Administration**: In general, the RZV vaccine is recommended regardless of CD4 count. To maximize immunologic response to the vaccine, some experts recommend delaying vaccination until the individual has started antiretroviral therapy and (1) achieved virologic suppression and/or (2) obtained immune reconstitution, with a CD4 count recovery of at least 200 cells/mm^3 (**CIII**).
- **Prior History of Zoster**: The RZV vaccine is recommended regardless of whether the person with HIV has a history of zoster, but the RZV vaccine should not be given during an episode of acute herpes zoster (**AIII**).
- **Prior Receipt of ZVL**: If an individual with HIV has previously received ZVL, they should undergo

revaccination and receive the standard two-dose series of RZV.

- **Contraindications**: The RZV vaccine should be deferred in women who are pregnant, women who are breastfeeding, or anyone who has a current episode of herpes zoster.[96]

Travel Vaccines

An estimated 8% of travelers to resource-limited regions of the world require treatment during travel, and major disease risks include vaccine-preventable illnesses.[101] Vaccines related to travel are generally not part of the initial evaluation process of persons with HIV. Many persons with HIV may, at some point, travel to regions of the world that require multiple preventive vaccinations, such as typhoid fever, cholera, yellow fever virus, Japanese encephalitis virus, and rabies virus. Recommendations for appropriate travel-related vaccines can be complex and depend on numerous factors, including the immune status of the person with HIV, the specific region of travel, and the types of exposure likely to occur in that region.[102]

Recommendations

All persons with HIV who are planning international travel should undergo an evaluation by a medical provider with expertise in travel-related issues, and this travel evaluation should occur well in advance of the travel date to allow time for all appropriate immunizations to be given. The CDC provides an online resource for general information regarding HIV and travel.[102,103] The Adult and Adolescent OI Guidelines provide information for vaccines to prevent cholera, typhoid, yellow fever, and polio.[5]

Contraindicated Vaccines

The following summarizes vaccines that are available in the United States that are contraindicated in some or all adolescents and adults with HIV.[5] In general, caution should be exerted when considering the use of a live vaccine in any person with HIV.

Live vaccines contraindicated in all people with HIV regardless of CD4 cell count:

- Live intranasal influenza vaccine (LAIV) (*FluMist*)
- Live attenuated oral Typhoid vaccine Ty21a (*Vivotif*)
- Live smallpox/mpox vaccine (ACAM2000)
- Quadrivalent measles-mumps-rubella-varicella vaccine (*ProQuad*)

Live vaccines contraindicated in adults with HIV and CD4 count less than 200 cells/mm^3:

- Live attenuated measles, mumps, and rubella (MMR) vaccine (*M-M-R* II; *Priorix*)
- Live attenuated varicella vaccine (*Varivax*)
- Live attenuated yellow fever vaccine (*YF-VAX*)

Live vaccine with inadequate safety and efficacy data in adults with HIV:

- Live cholera vaccine (lyophilized CVD 103-HgR) (*Vaxchora*)

Live vaccine considered safe in adults with HIV:

- Live smallpox/mpox vaccine (*JYNNEOS*): this vaccine contains nonreplicating virus and is considered safe to give to adults with HIV, regardless of CD4 cell count.

Summary Points

- Hepatitis A vaccine is recommended for all persons with HIV who are not immune to HAV. Postvaccination antibody testing should be performed 1 to 2 months after completion of the primary hepatitis A vaccine series.
- When giving the hepatitis B vaccine to adults with HIV, the preferred initial option is to use 2 doses of *Heplisav-B*. Postvaccination antibody titers should be checked 1 to 2 months after completion of the primary hepatitis B vaccine series.
- Three doses of 9vHPV should be administered to all persons with HIV who are 9 through 26 years of age. For persons with HIV who are 27 through 45 years of age, shared decision-making should be used to determine whether to administer this vaccine.
- All adults with HIV should receive two doses of conjugate meningococcal vaccine and booster doses every 5 years thereafter.
- Mpox vaccination should be offered for persons with HIV who are at risk for mpox exposure.
- Pneumococcal vaccine-naïve persons should receive a single dose of either PCV20, PCV21, or PCV15. If they receive PCV15, a follow-up dose of PPSV23 should be given at least 8 weeks later.
- Two doses of RZV are recommended for persons with HIV who are 18 years of age and older, regardless of CD4 cell count and prior history of zoster.
- Some live virus vaccines are contraindicated in all persons with HIV, and other live vaccines are contraindicated in persons with HIV who have a CD4 count of less than 200 cells/mm^3. The MMR and varicella vaccines are live vaccines that can be administered to people with HIV who have a CD4 count of at least 200 cells/mm^3 if they lack immunity to these vaccine-preventable viruses.

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Figures

Figure 1 (Image Series) - COVID-19 mRNA Vaccines (Image Series) - Figure 1 (Image Series) - COVID-19 mRNA Vaccines
Image 1A: COVID-19 mRNA Vaccine

COVID-19 mRNA vaccines consist of mRNA surrounded by a lipid nanoparticle (LNP). The LNP protects the mRNA from degradation and facilitates cellular uptake of the mRNA. The coding region (orange) is a genetically engineered sequence of nucleoside-modified mRNA that encodes for the prefusion-stabilized SARS-CoV-2 spike protein. The Cap 5′ and 3′ UTR elements enhance the stability and translation of the mRNA.

Illustration: Cognition Studio, Inc.

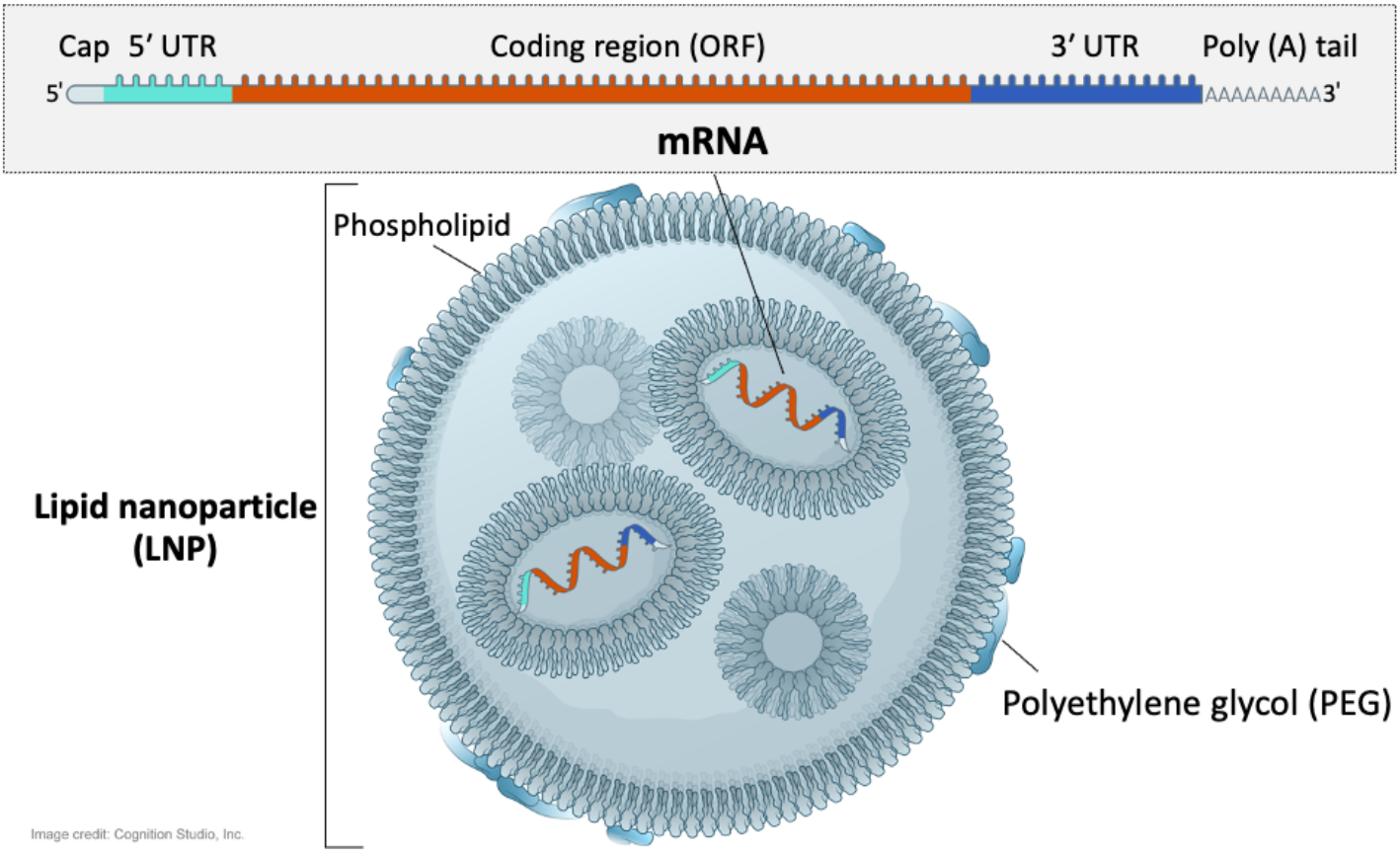

Figure 1 (Image Series) - COVID-19 mRNA Vaccines
Image 1B: COVID-19 mRNA Vaccines and Intracellular Mechanism of Action

The mRNA-1273 enters the cell cytoplasm and does not enter the nucleus. The mRNA is translated by the ribosomes to form prefusion-stabilized SARS-CoV-2 spike proteins. The spike proteins are shuttled to the surface of the cell and are presented to the immune system. The spike proteins are also processed into small peptides that also are presented to the immune system. With this process, the mRNA is non-replicating and is present transiently within the cell.

Illustration: Cognition Studio, Inc.

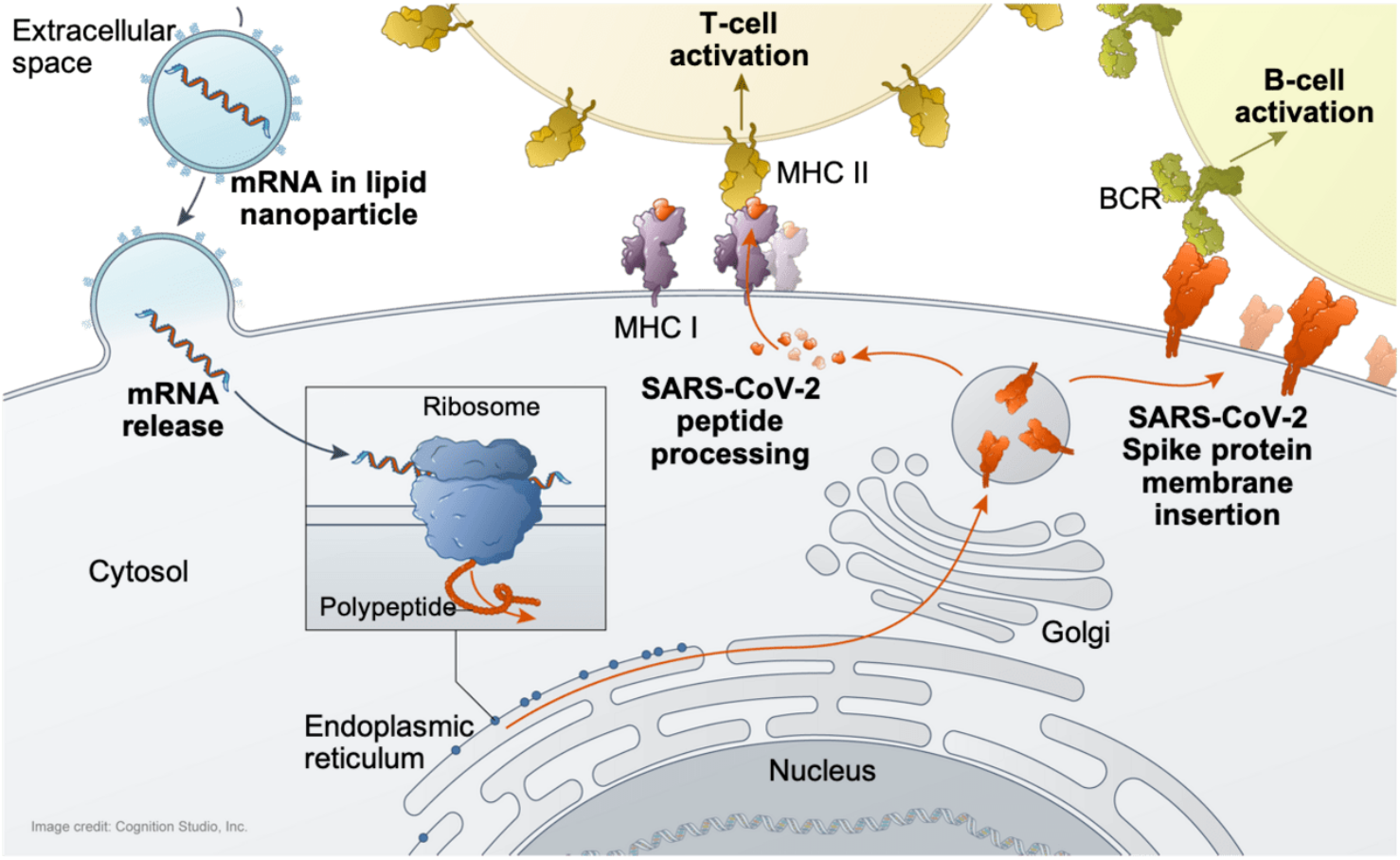

Figure 1 (Image Series) - COVID-19 mRNA Vaccines
Image 1C: COVID-19 mRNA Vaccines and Immune Responses

The immune system responds to the antigens on the surface of the cell produced by the COVID-19 mRNA vaccines. These vaccines generate cellular immune responses (T-cells) and humoral responses (B-cells). The immune response includes: activation of B cells to produce antibodies against SARS-CoV-2; activation of cytotoxic CD8 T-cells that can destroy cells infected with SARS-CoV-2; activation of CD4 T-cells that augment both CD8 T-cell and B-cell responses; generation of memory T- and B-cells that can quickly respond to future SARS-CoV-2 infection.

Illustration: Cognition Studio, Inc.

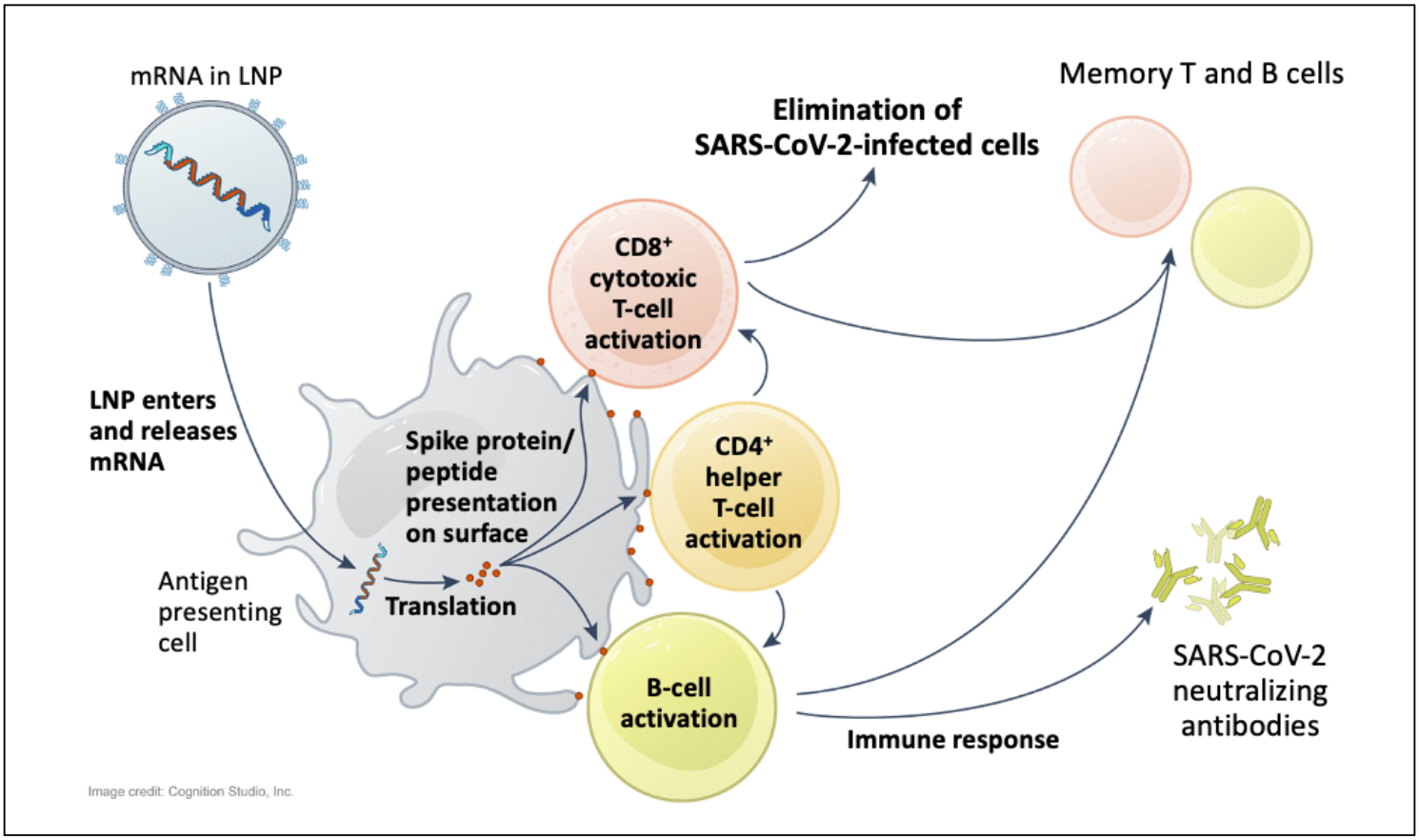

Figure 2 Number of Reported Cases of Hepatitis A Virus (HAV) Infections, United States, 2015-2023

Source: Centers for Disease Control and Prevention (CDC). 2023 Viral Hepatitis Surveillance Report—Hepatitis A. Published April 15, 2025.

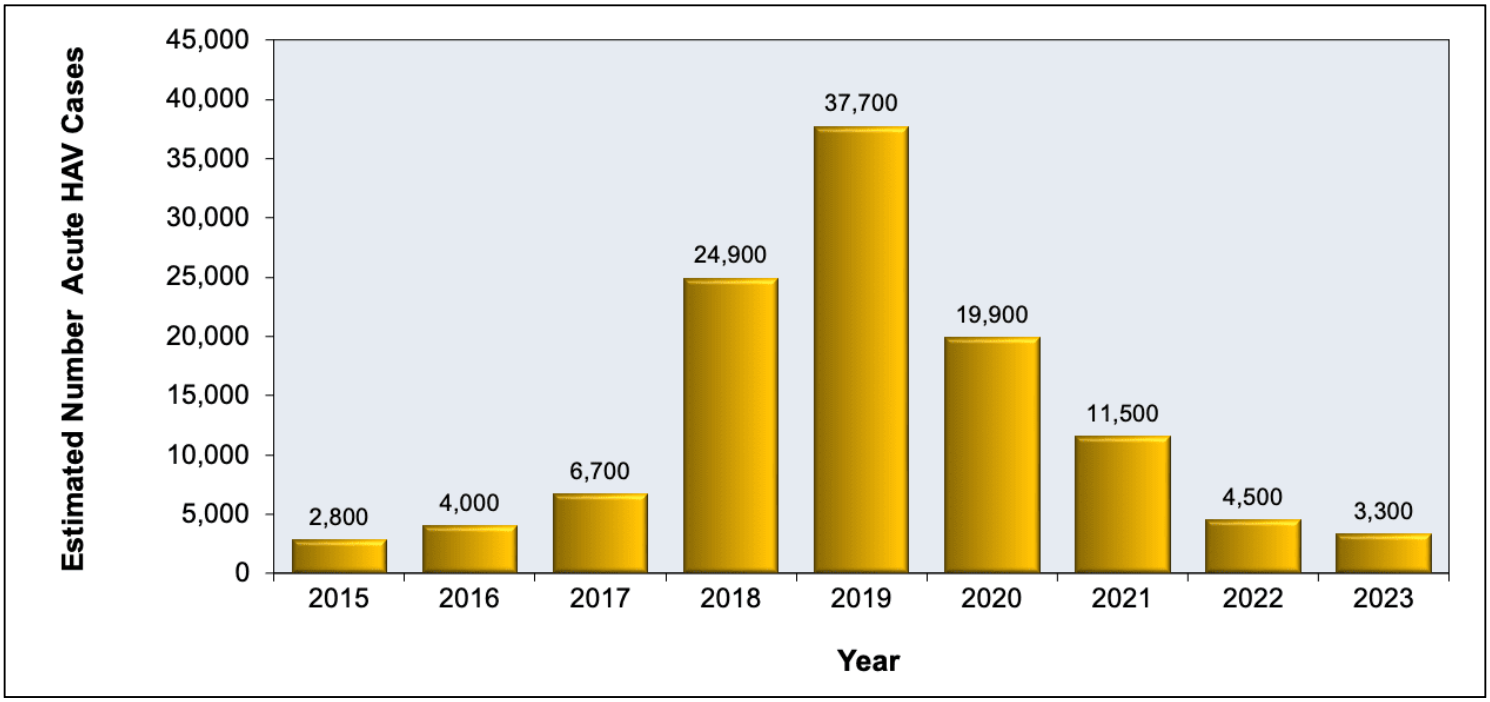

Figure 3 Hepatitis A Vaccine in People with HIV*

These recommendations are based on the CD4 cell count and risk of acquiring hepatitis A virus

Source: Panel on Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the prevention and treatment of opportunistic infections in adults and adolescents with HIV: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Immunizations for Preventable Diseases in Adults and Adolescents Living with HIV. Last updated: February 25, 2026.

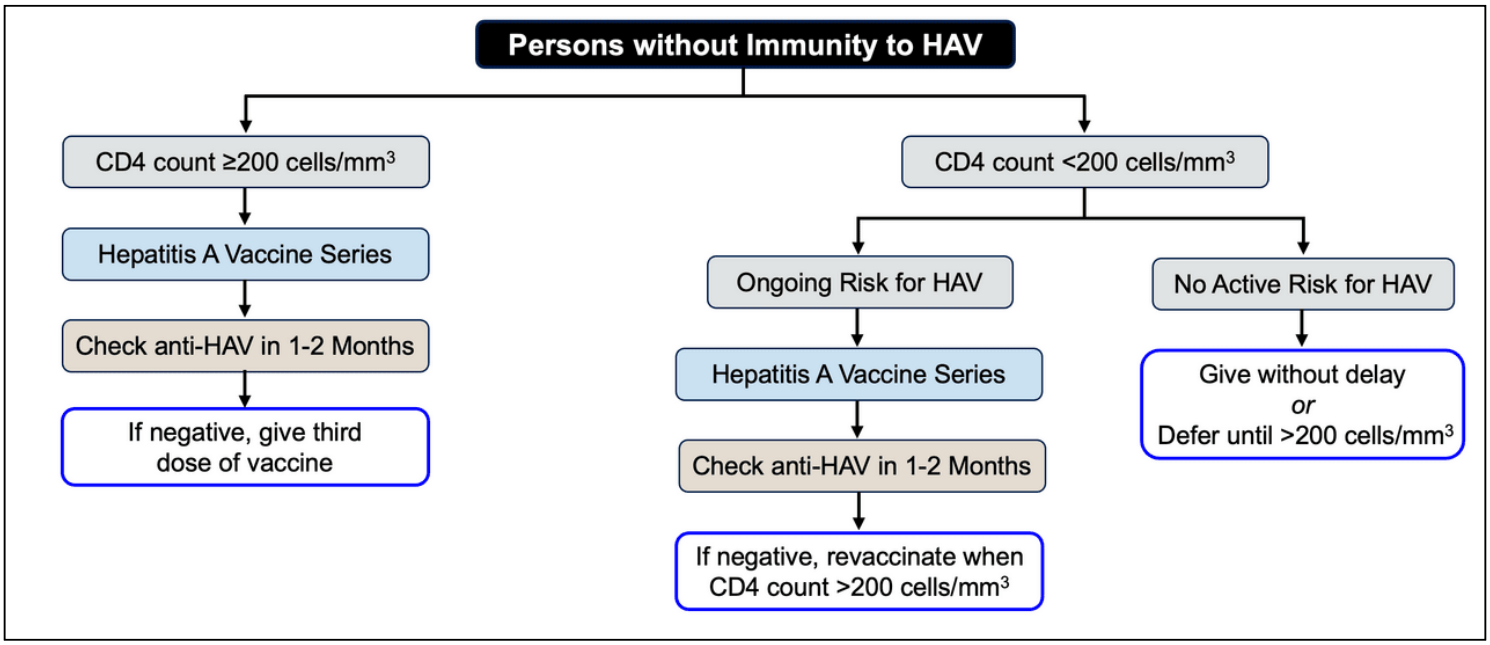

Figure 4 Heplisav-B Vaccine in HBV Vaccine-Naïve People With HIV

This bar graph shows the seroprotective response rates to three doses of Heplisav-B vaccine given at 0, 4, and 24 weeks.

Source: Marks KM, Kang M, Umbleja T, et al. Immunogenicity and Safety of Hepatitis B vaccine with a Toll-like Receptor 9 Agonist Adjuvant (HEPLISAV-B) in HBV Vaccine-naive People with HIV. Clin Infect Dis. 2023;77:414-8.

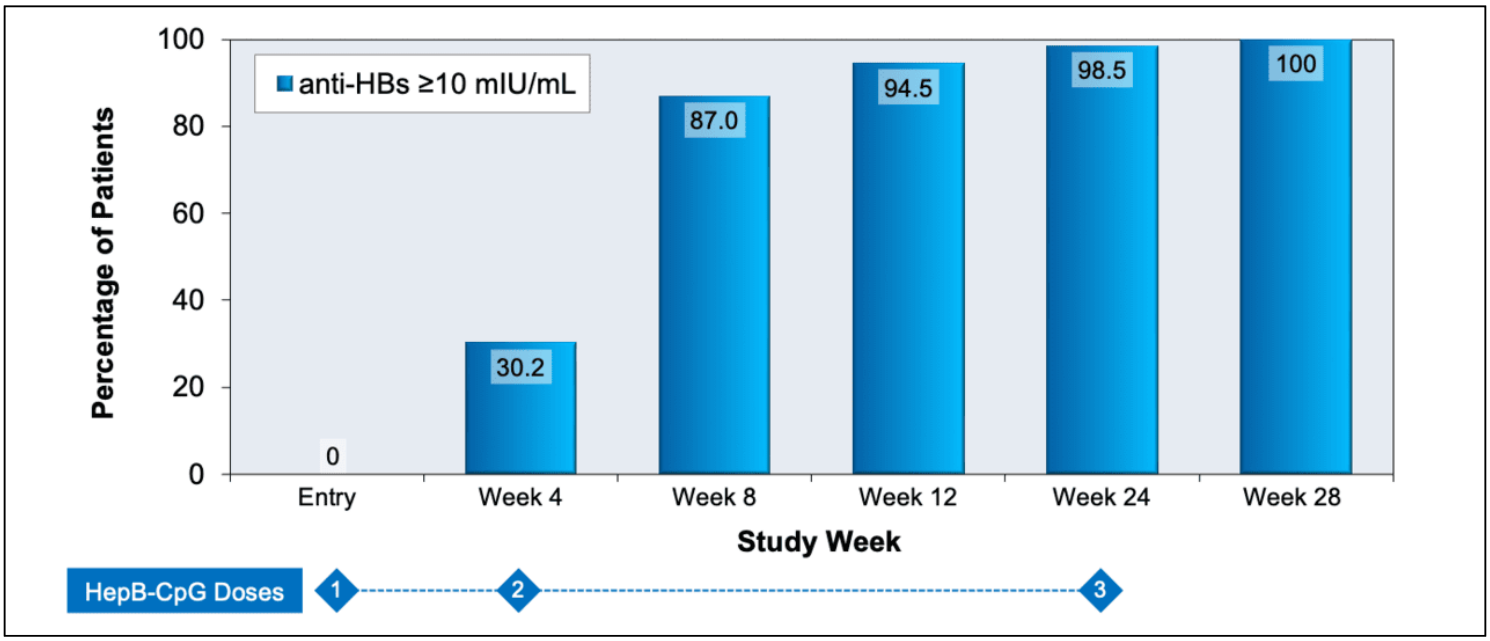

Figure 5 HBV Vaccine Schedule Options in Persons with HIV

Note: A 1.0 mL dose of *Twinrix* contains 720 ELISA units of inactivated hepatitis A virus (antigen component from Havrix) and 20 µg HBsAg (antigen component from Engerix-B). *Twinrix* can be given on an accelerated schedule, but it requires a total of 4 doses (days 0, 7, and 21 to 30) followed by a booster dose at 12 months.

Source: Panel on Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the prevention and treatment of opportunistic infections in adults and adolescents with HIV: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Immunizations for Preventable Diseases in Adults and Adolescents Living with HIV. Last updated: February 25, 2026.

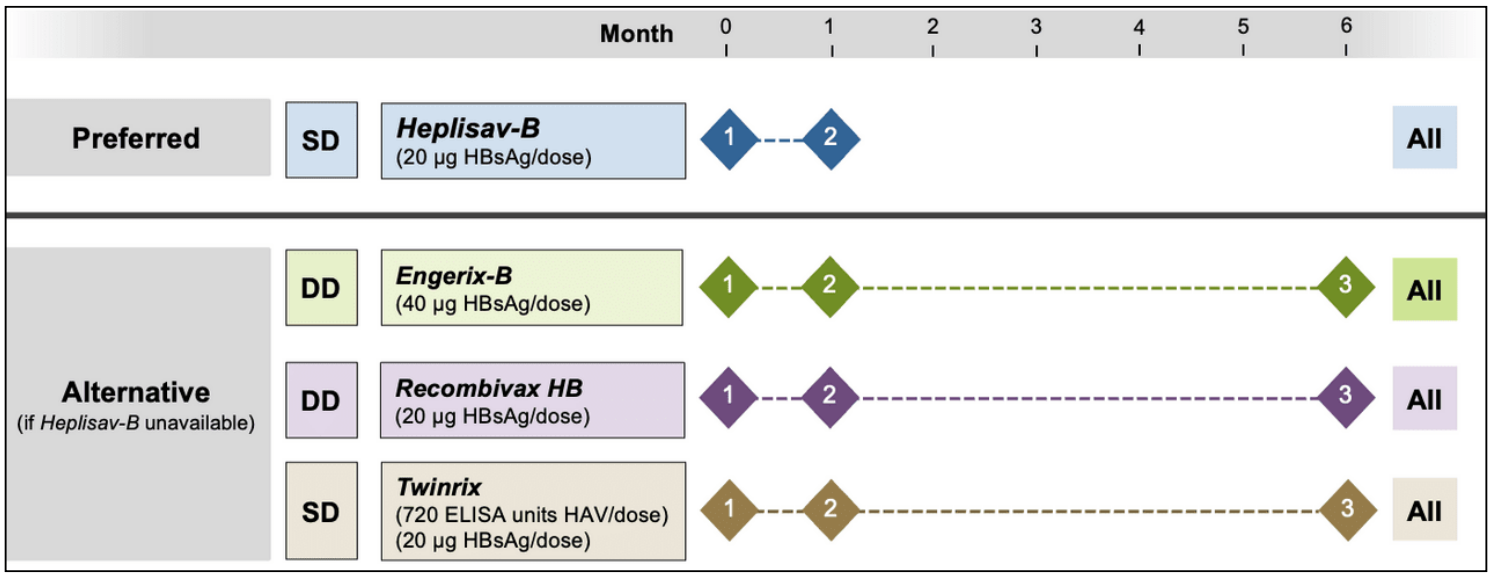

Figure 6 Approach to Isolated Anti-HBc in Persons with HIV

*The full vaccine series options include the 2-dose series using standard-dose *Heplisav-B* or the 3-dose series with double-dose vaccine using *Engerix-B* or *Recombivax HB*.

Source: Panel on Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the prevention and treatment of opportunistic infections in adults and adolescents with HIV: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Hepatitis B virus infection. Last Updated: Last updated: February 25, 2026.

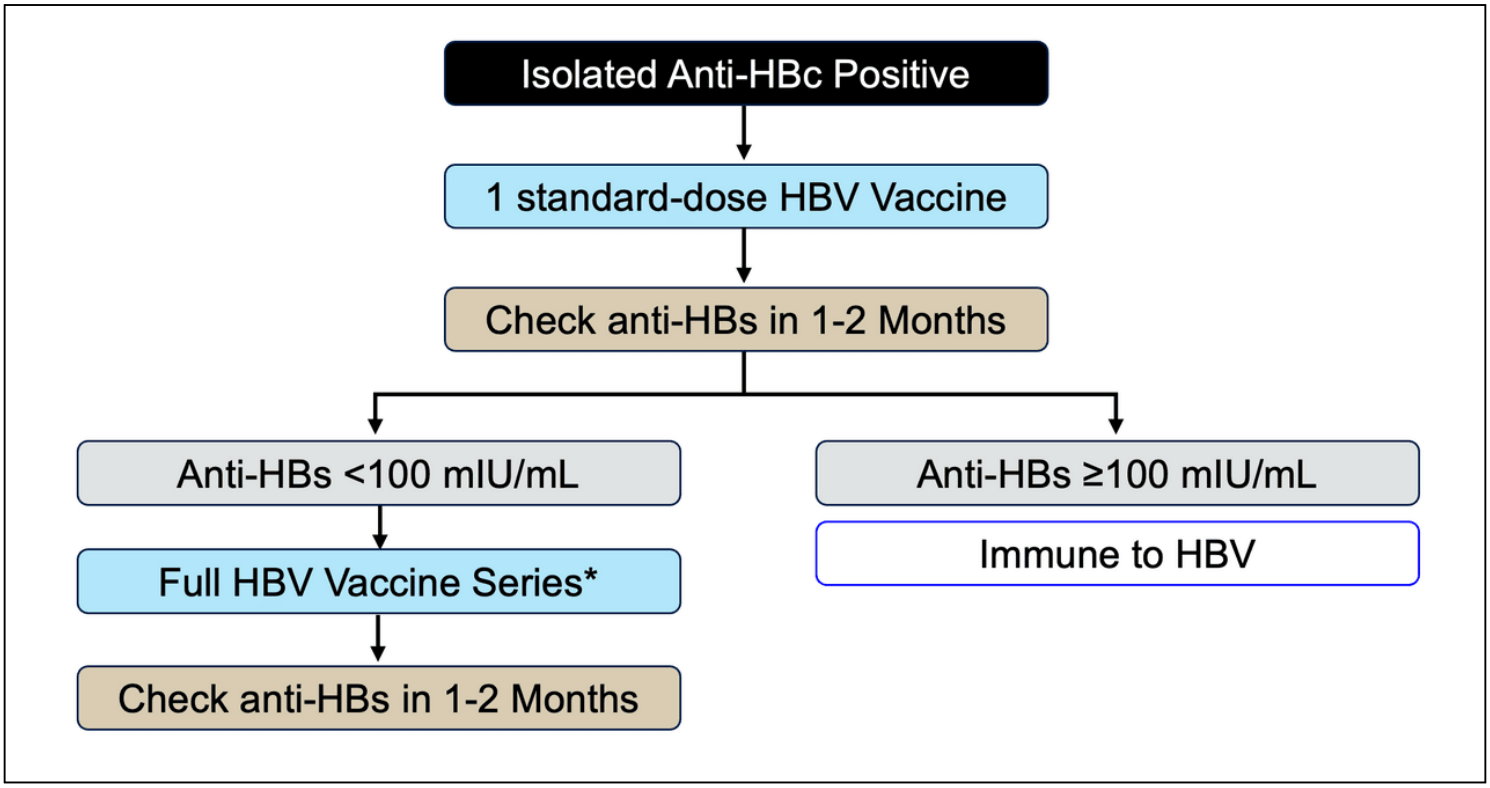

Figure 7 9-valent Human Papillomavirus Vaccine

Illustration: David H. Spach, MD

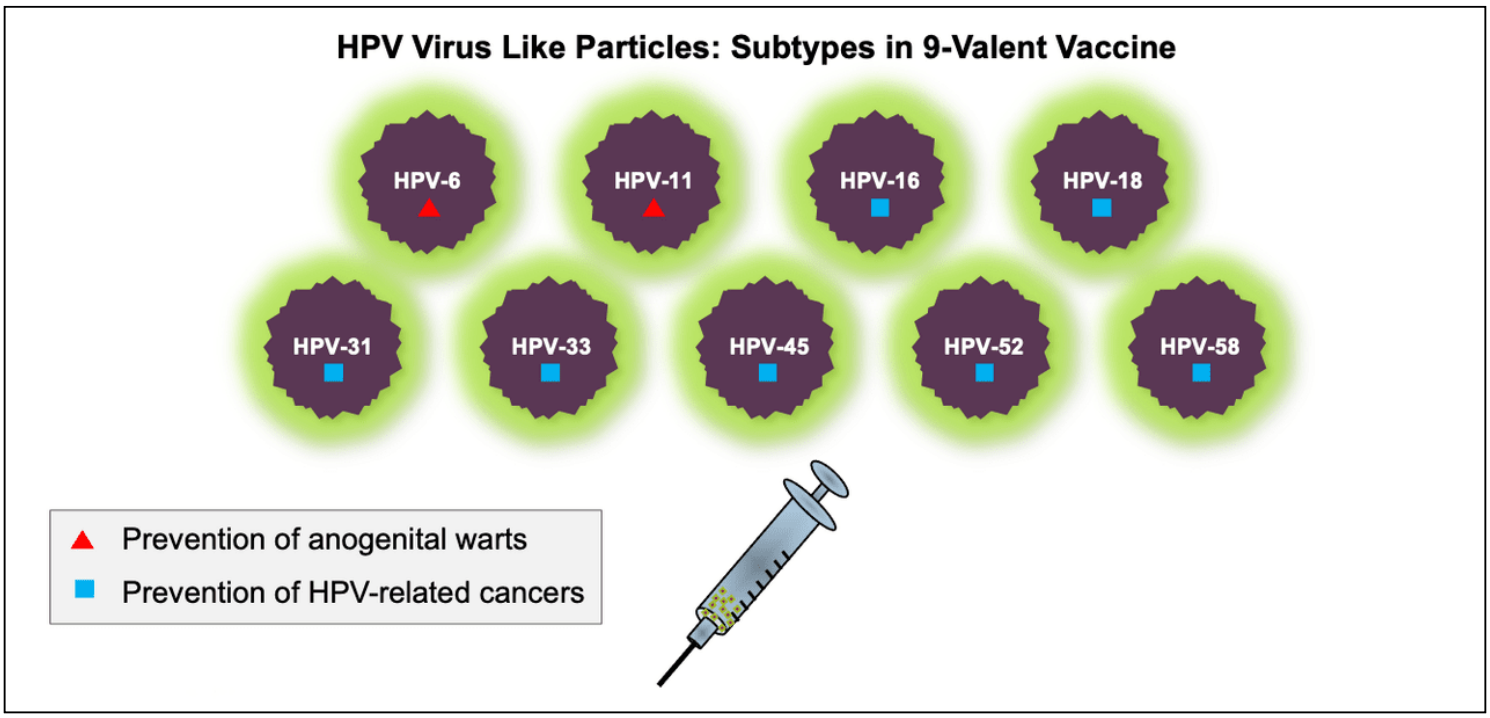

Figure 8 Number of Measles Cases in the United States General Population, Reported by Year, 2010-2026*

*Cases in 2026 indicate cases reported through April 6.

Source: Centers for Disease Control and Prevention

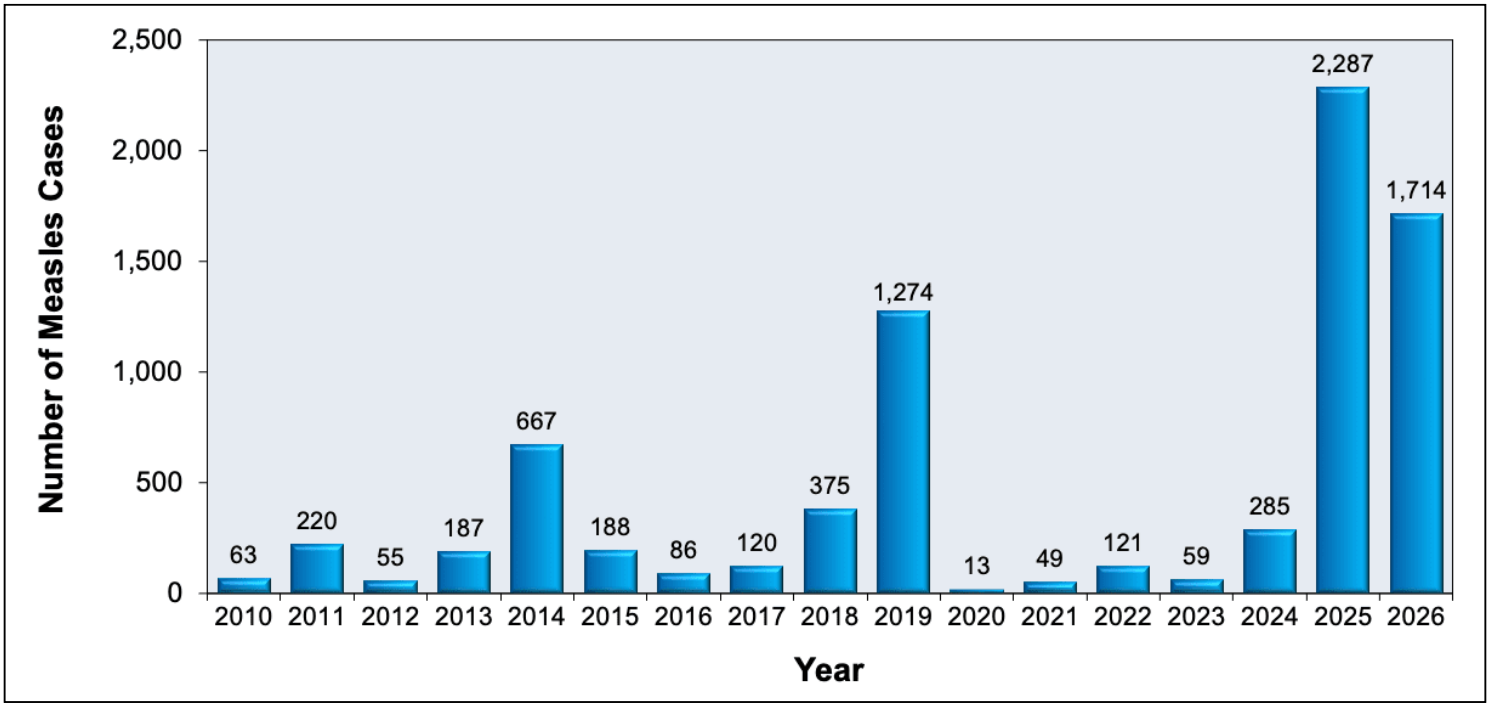

Figure 9 Meningococcal Disease Among People with HIV, United States, 2017-2022

Source: Rubis AB, Howie RL, Marasini D, Sharma S, Marjuki H, McNamara LA. Notes from the Field: Increase in Meningococcal Disease Among Persons with HIV - United States, 2022. MMWR Morb Mortal Wkly Rep. 2023;72:663-4.

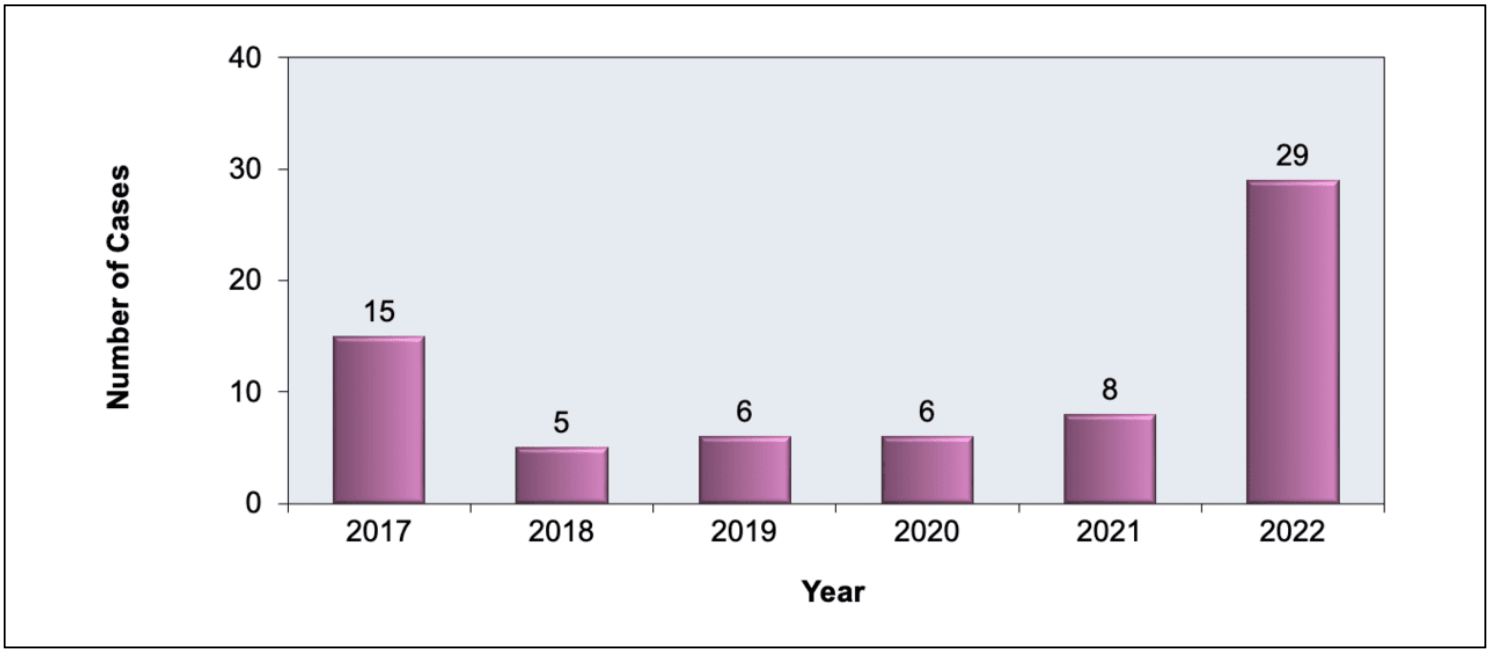

Figure 10 Serotype Composition of Quadrivalent Meningococcal Conjugate Vaccines

Illustration: David H. Spach, MD

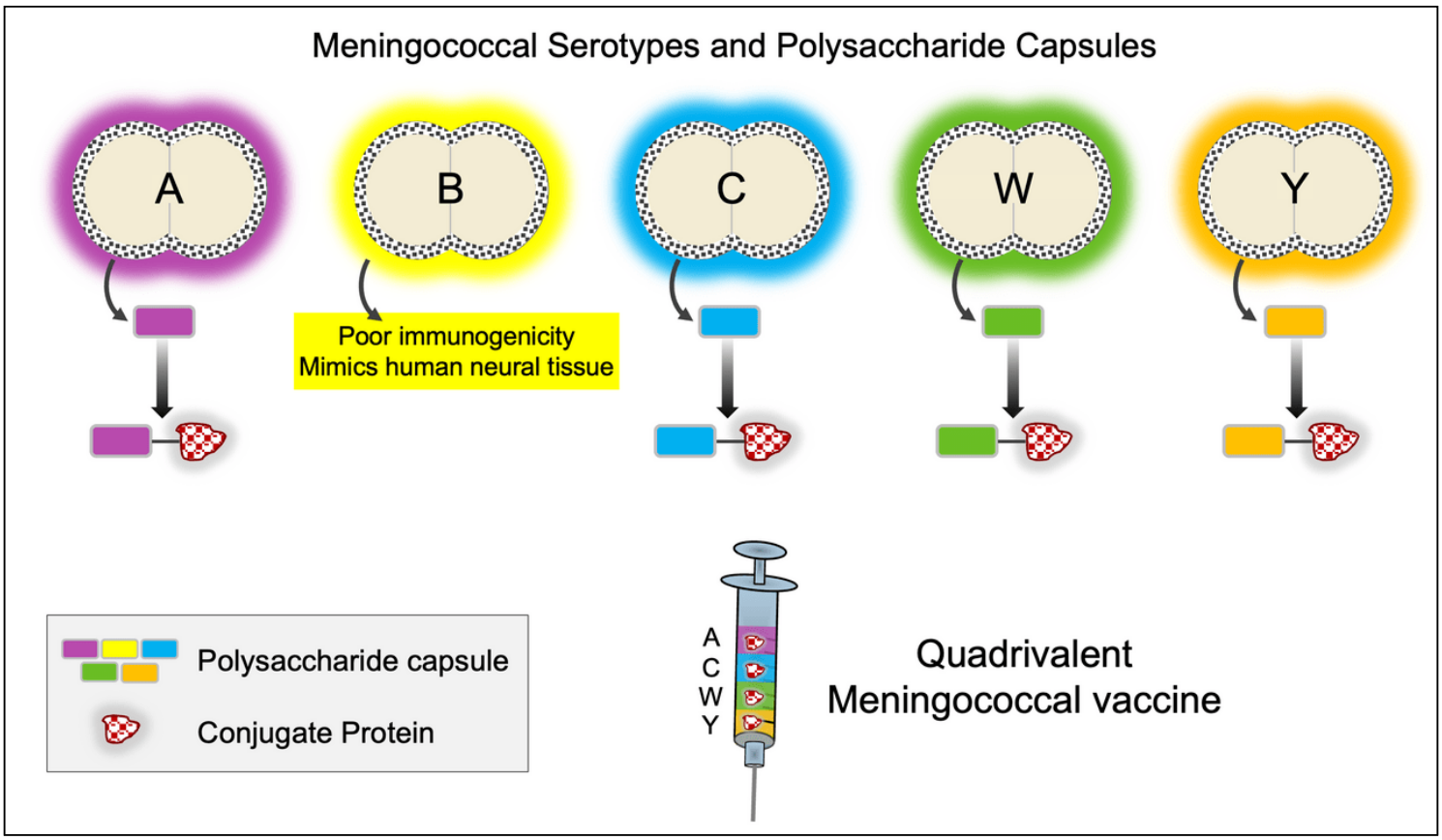

Figure 11 Conjugate Quadrivalent Meningococcal Vaccine in People with HIV

Source: Panel on Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the prevention and treatment of opportunistic infections in adults and adolescents with HIV: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Immunizations for Preventable Diseases in Adults and Adolescents Living with HIV. Last Updated: February 25, 2026.

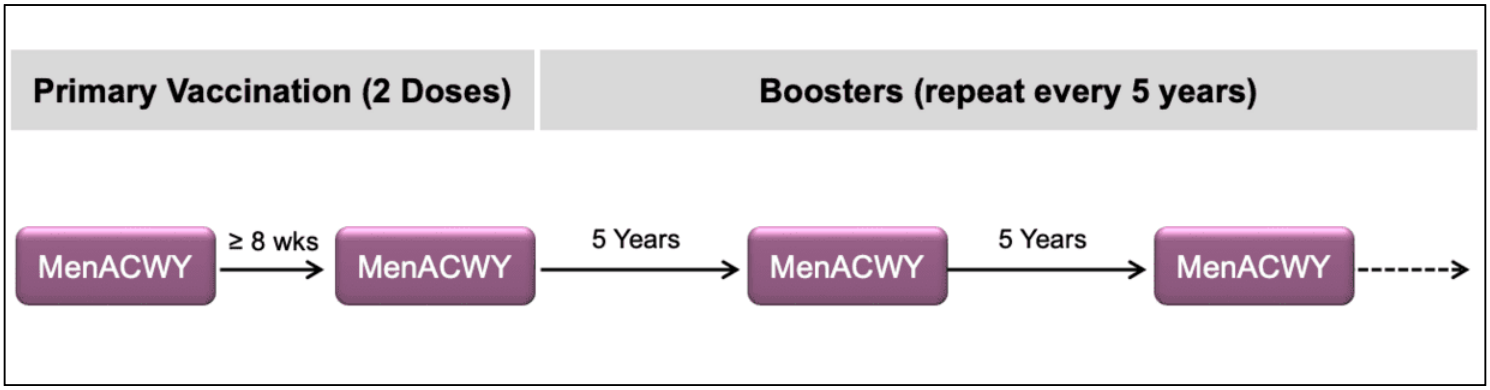

Figure 12 Administration of Mpox Vaccine: Subcutaneous and Intradermal Routes

Illustration: Cognition Studio, Inc. and David H. Spach, MD

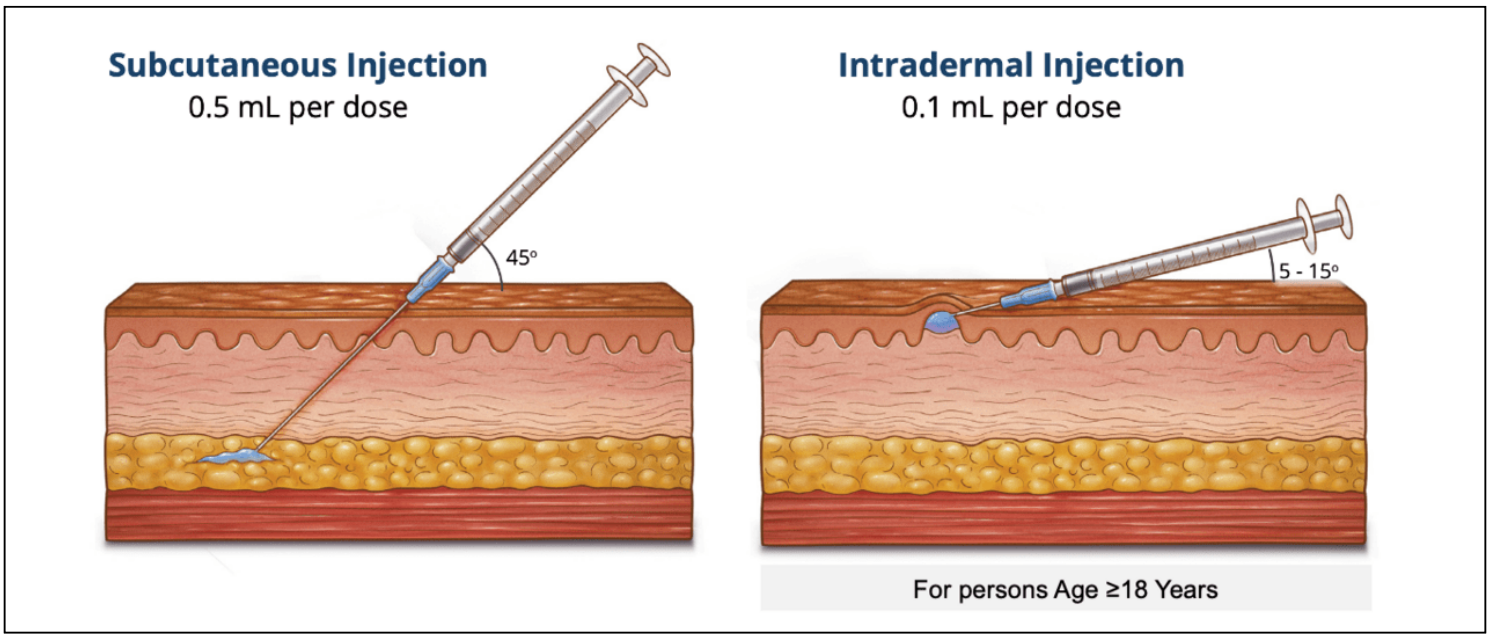

Figure 13 (Image Series) - Mpox Prevention Vaccination in People with HIV (Image Series) -
Figure 13 (Image Series) - Mpox Prevention Vaccination in People with HIV
Image 13A: Mpox Postexposure Prophylaxis in People with HIV

Source: Panel on Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the prevention and treatment of opportunistic infections in adults and adolescents with HIV: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Immunizations for Preventable Diseases in Adults and Adolescents Living with HIV. Last Updated: February 25, 2026.

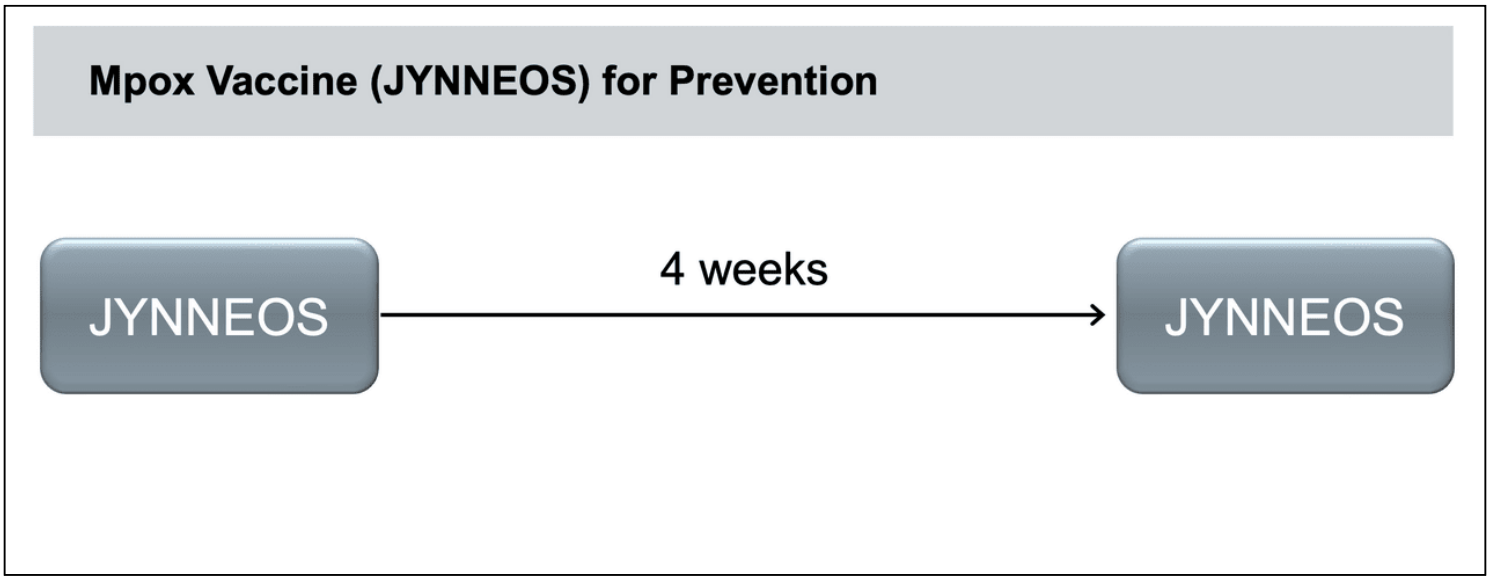

Figure 13 (Image Series) - Mpox Prevention Vaccination in People with HIV
Image 13B: Recommendation for Mpox Postexposure Prophylaxis in People with HIV

Source: Panel on Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the prevention and treatment of opportunistic infections in adults and adolescents with HIV: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Immunizations for Preventable Diseases in Adults and Adolescents Living with HIV. Last Updated: February 25, 2026.

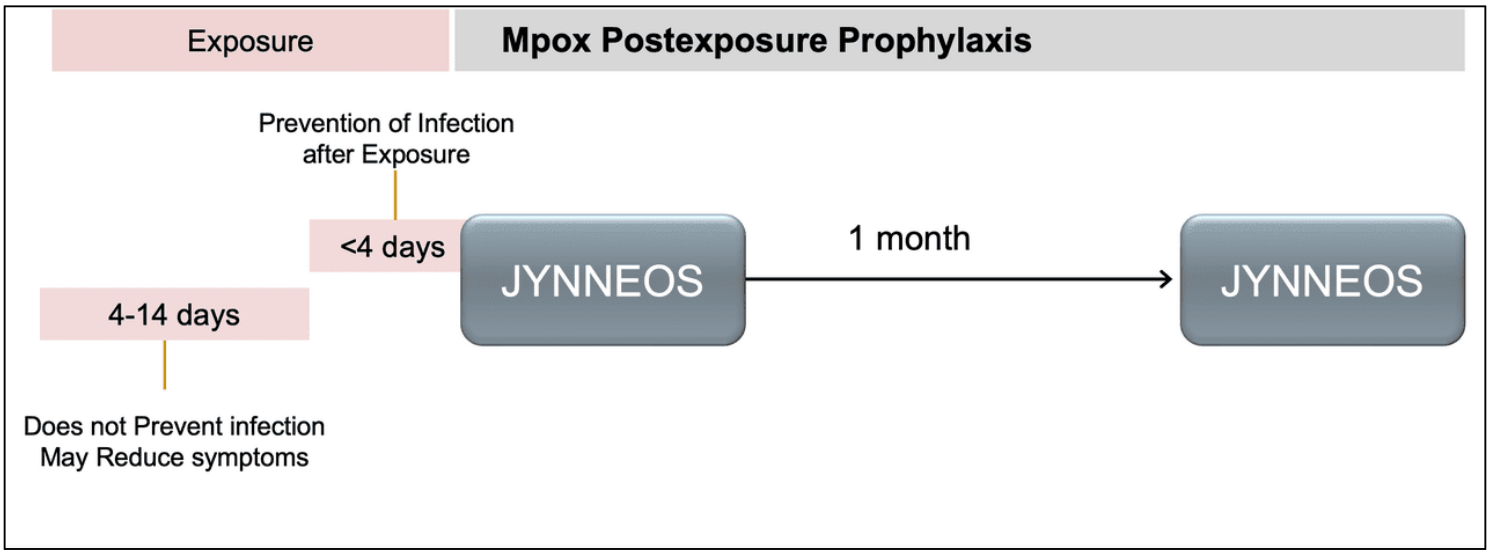

Figure 14 Serotypes in Conjugate Pneumococcal Comjugate Vaccines (PCVs)

Source: Kobayashi M, Leidner AJ, Gierke R, et al. Use of 21-Valent Pneumococcal Conjugate Vaccine Among U.S. Adults: Recommendations of the Advisory Committee on Immunization Practices - United States, 2024. MMWR Morb Mortal Wkly Rep. 2024;73:793-8.

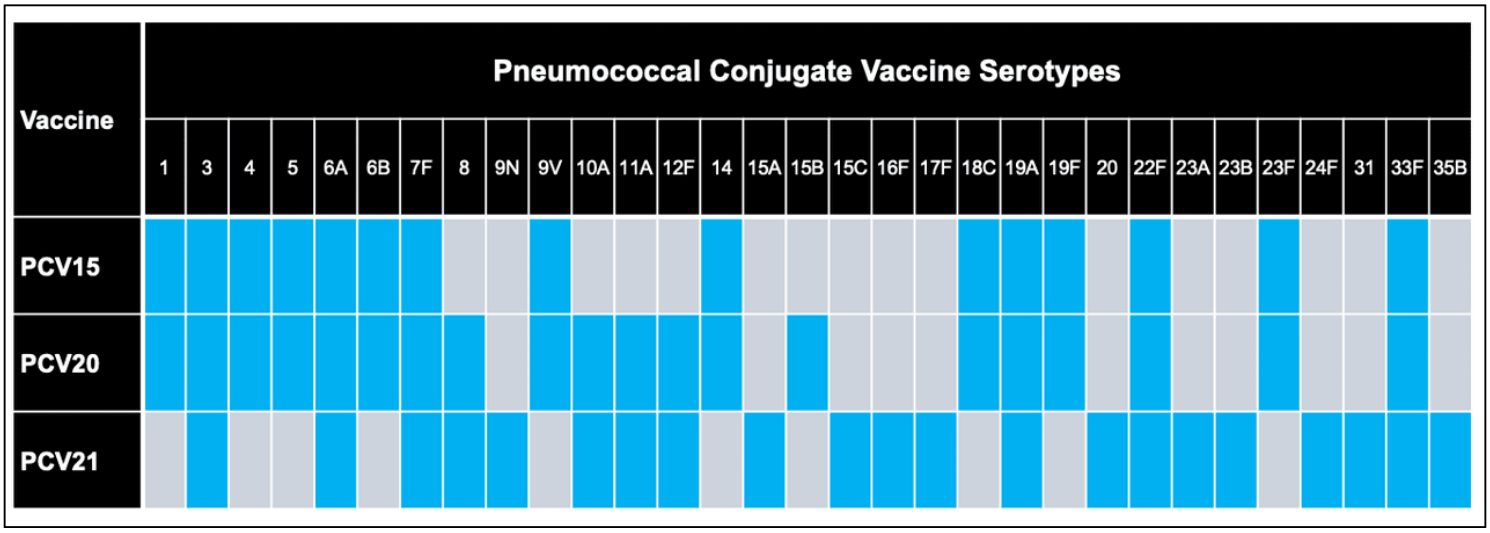

Figure 15 Recommendations for Pneumococcal Immunization in Adults with HIV and No Prior Pneumococcal Immunization

Note: PCV21 is not recommended if the prevalence of pneumococcal serotype 4 is >30% in the region.

Source: Panel on Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the prevention and treatment of opportunistic infections in adults and adolescents with HIV: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Immunizations for Preventable Diseases in Adults and Adolescents Living with HIV. Last Updated: February 25, 2026.

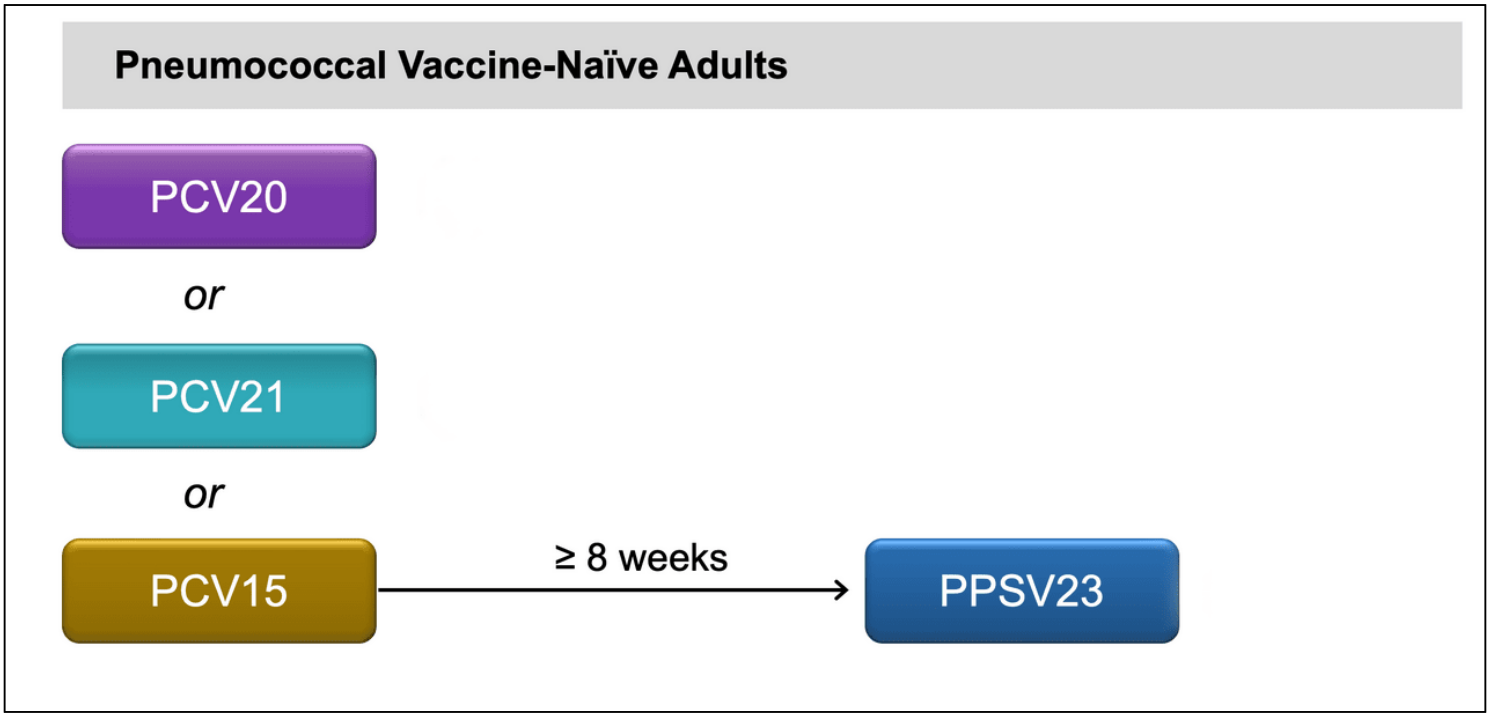

Figure 16 (Image Series) - Prior Receipt of Pneumococcal Vaccine (Image Series) - Figure 16 (Image Series) - Prior Receipt of Pneumococcal Vaccine
Image 16A: Prior Receipt of PCV13 Only

Note: PCV21 is not recommended if the prevalence of pneumococcal serotype 4 is >30% in the region.

Source: Panel on Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the prevention and treatment of opportunistic infections in adults and adolescents with HIV: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Immunizations for Preventable Diseases in Adults and Adolescents Living with HIV. Last Updated: February 25, 2026.

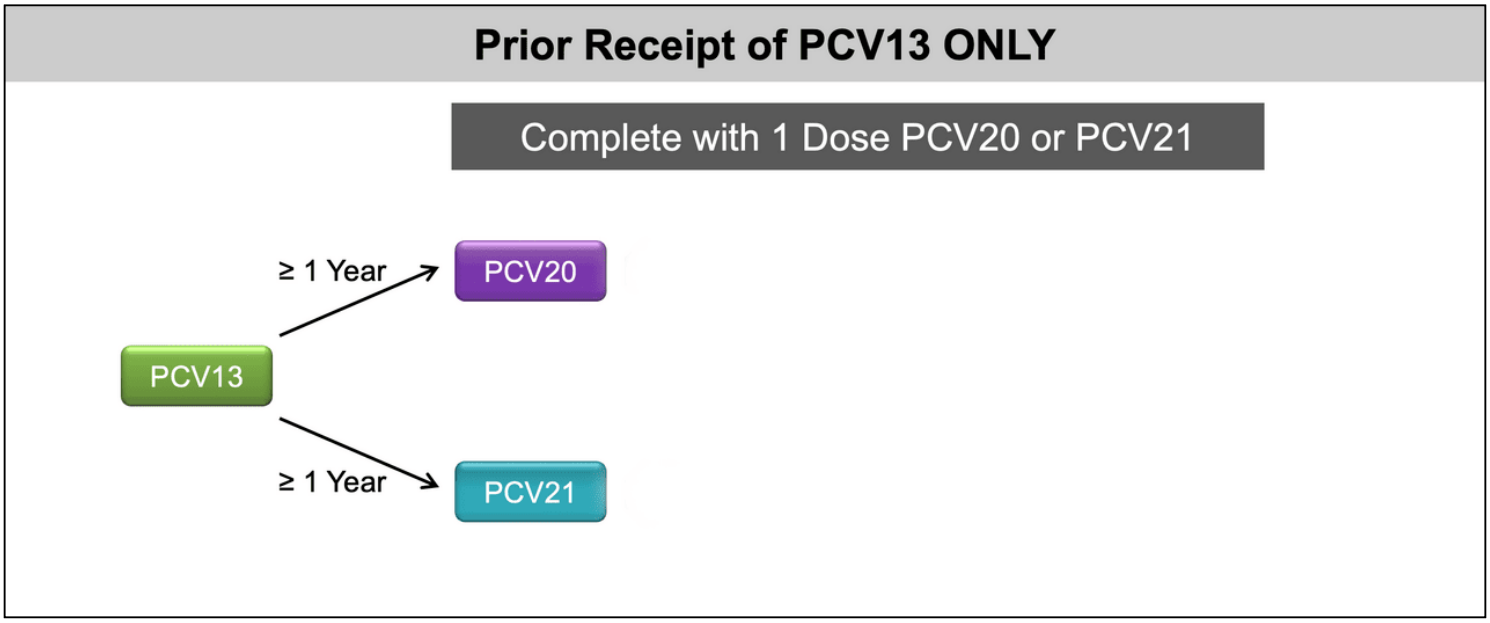

Figure 16 (Image Series) - Prior Receipt of Pneumococcal Vaccine
Image 16B: Prior Receipt of PCV13 and ≥1 Dose PPSV23 (all Prior to Age 65 Years)

Note: PCV21 is not recommended if the prevalence of pneumococcal serotype 4 is >30% in the region.

Source: Panel on Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the prevention and treatment of opportunistic infections in adults and adolescents with HIV: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Immunizations for Preventable Diseases in Adults and Adolescents Living with HIV. Last Updated: February 25, 2026.

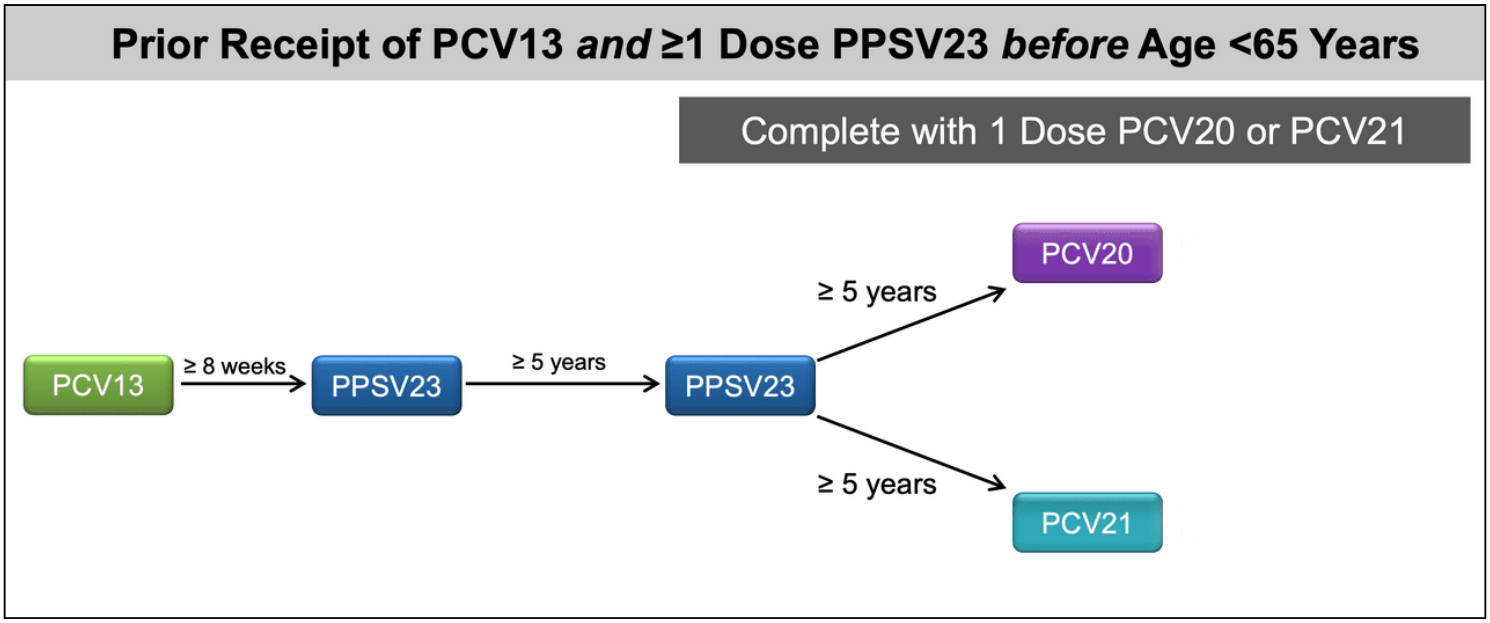

Figure 16 (Image Series) - Prior Receipt of Pneumococcal Vaccine
Image 16C: Prior Receipt of PCV13 and ≥1 Dose PPSV23 (Last Dose ≥Age 65 Years)

Note: PCV21 is not recommended if the prevalence of pneumococcal serotype 4 is >30% in the region.

Source: Panel on Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the prevention and treatment of opportunistic infections in adults and adolescents with HIV: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Immunizations for Preventable Diseases in Adults and Adolescents Living with HIV. Last Updated: February 25, 2026.

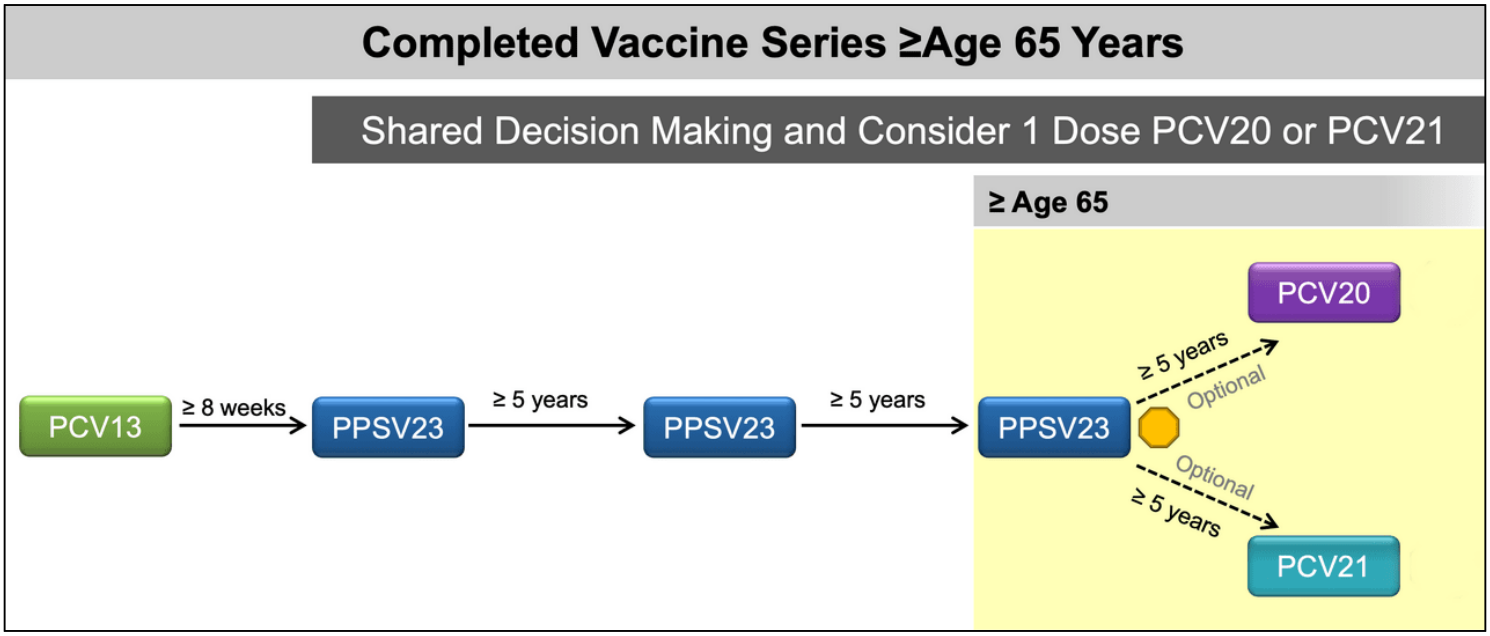

Figure 16 (Image Series) - Prior Receipt of Pneumococcal Vaccine
Image 16D: Prior Receipt of PPSV23 Only

Note: PCV21 is not recommended if the prevalence of pneumococcal serotype 4 is >30% in the region.

Source: Panel on Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the prevention and treatment of opportunistic infections in adults and adolescents with HIV: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Immunizations for Preventable Diseases in Adults and Adolescents Living with HIV. Last Updated: February 25, 2026.

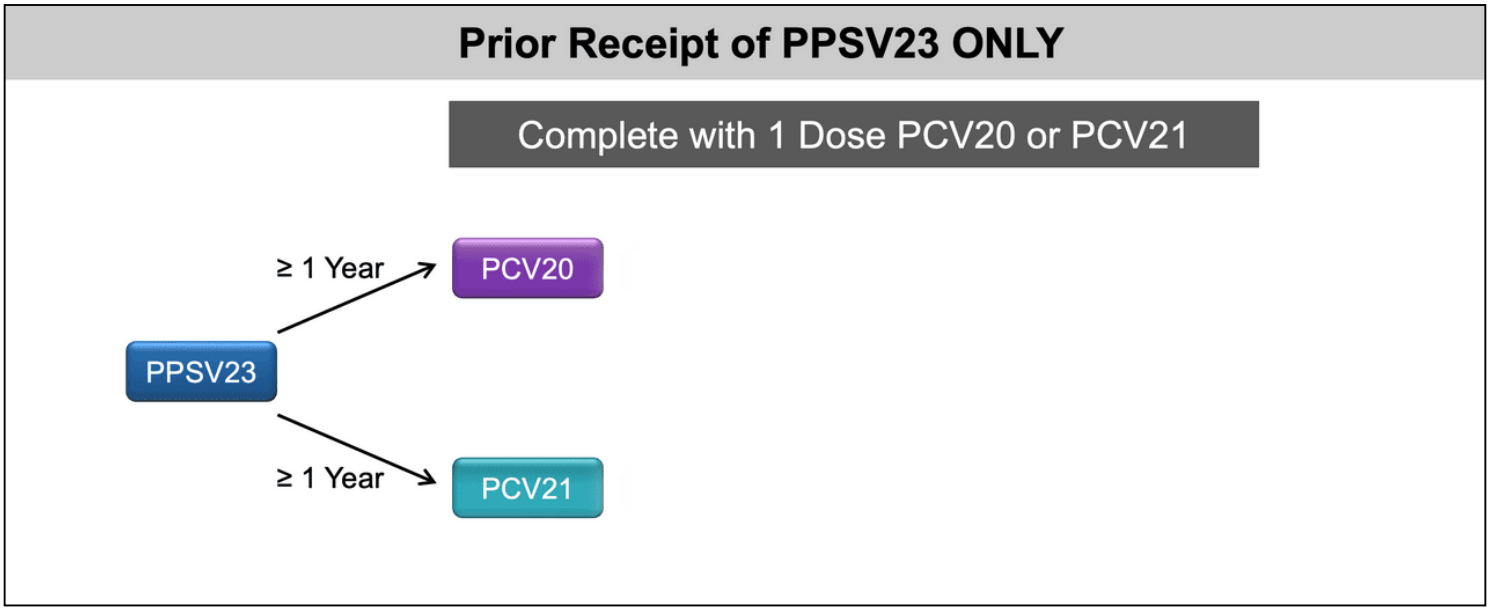

Figure 17 Recombinant Zoster Vaccine

Illustration: David H. Spach, MD

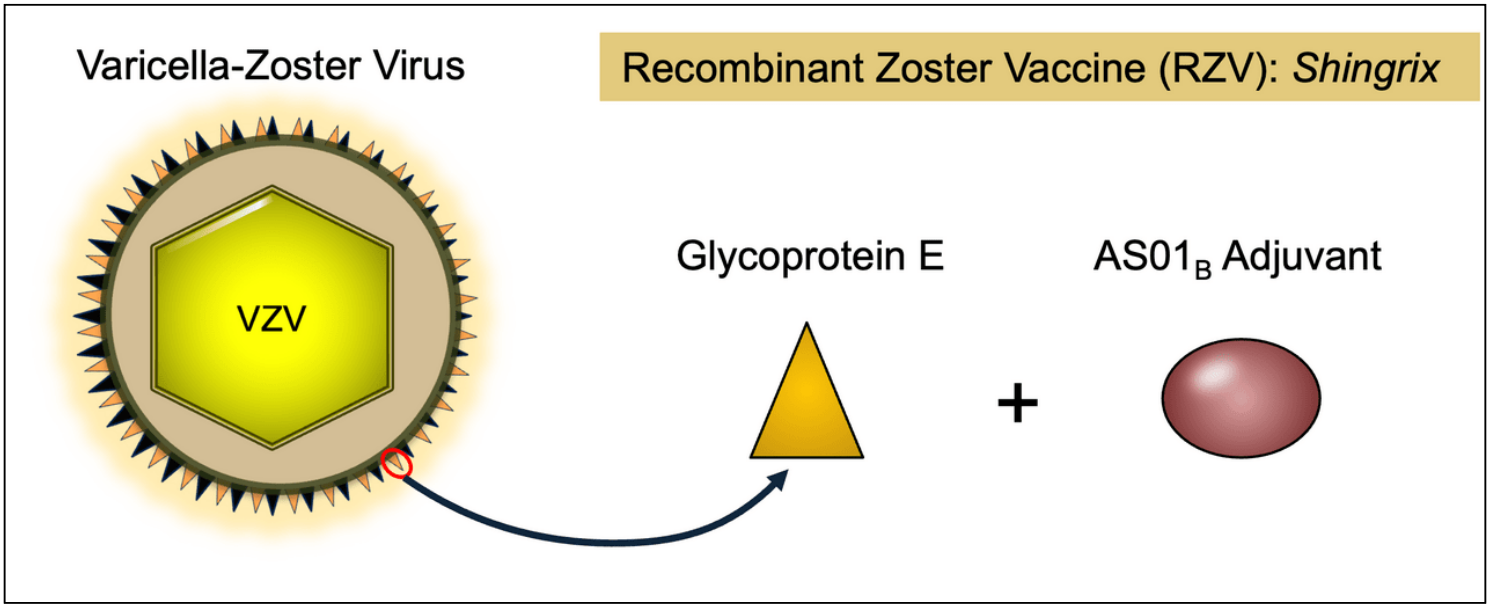

Figure 18 Recommendation for Zoster Vaccine in Persons with HIV

Source: Panel on Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the prevention and treatment of opportunistic infections in adults and adolescents with HIV: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Immunizations for Preventable Diseases in Adults and Adolescents Living with HIV. Last Updated: February 25, 2026.

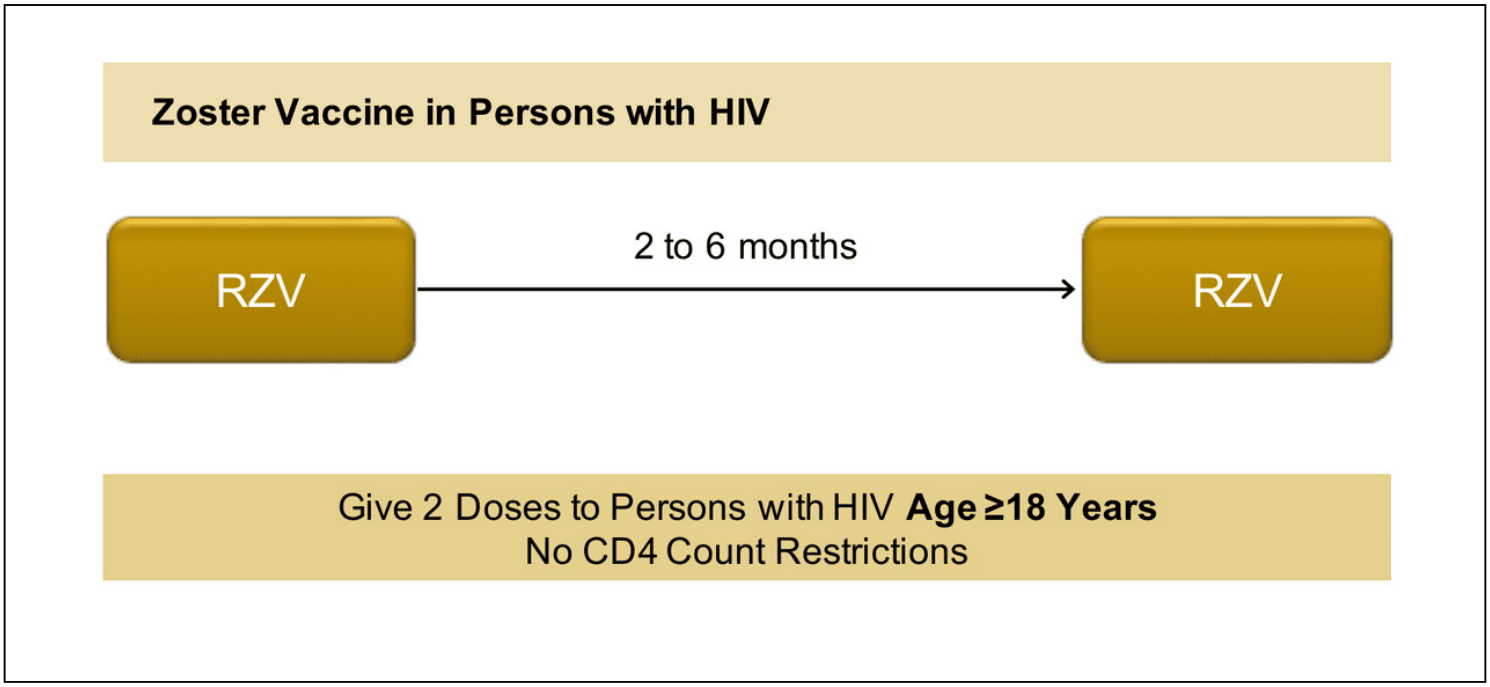

Table 1. Vaccines Routinely Administered to Adults with HIV

Vaccines	Abbreviations	Trade Names
COVID-19 vaccine	1vCoVmRNA	*Comirnaty* *Spikevax* *mNexspike*
	1vCoVaPS	*Novavax*
Hepatitis A vaccine	HepA	*Havrix* *Vaqta*
Hepatitis A and hepatitis B vaccine	HepA-HepB	*Twinrix*
Hepatitis B vaccine	HepB	*Engerix-B* *Heplisav-B* *Recombivax H*
Human papillomavirus vaccine	HPV	*Gardasil* 9
Influenza vaccine (inactivated, egg-based)	IIV3	Multiple optior
	aIIV3	*Fluad*
	HD-IIV3	*Fluzone* High-D
Influenza vaccine (inactivated, cell culture)	ccIIV3	*Flucelvax*
Influenza vaccine (recombinant)	RIV3	*Flublok*
Measles, mumps, and rubella vaccine	MMR	M-M-R II *Priorix*
Meningococcal serogroups A, C, W, Y vaccine	MenACWY-CRM	*Menveo*
	MenACWY-TT	*MenQuadfi*
Meningococcal serogroup B vaccine	MenB-4C	*Bexsero*
	MenB-FHbp	*Trumenba*
Meningococcal serogroups A, B, C, W, Y vaccine	MenACWY-TT/Men B-FHbp	*Penbraya*
	MenACWY-CRM/Men B-4C	*Penmenvy*
Mpox vaccine	Mpox	*JYNNEOS*
Pneumococcal conjugate vaccine	PCV15	*Vaxneuvance*
	PCV20	*Prevnar* 20
	PCV21	*Capvaxive*
Pneumococcal polysaccharide vaccine	PPSV23	*Pneumovax* 23
Respiratory syncytial virus vaccine	RSV	*Abrysvo* *Arexvy* *mResvia*
Tetanus and diphtheria toxoid vaccine	Td	*Tenivac*
Tetanus and diphtheria toxoids and acellular pertussis vaccine	Tdap	*Adacel* *Boostrix*
Varicella vaccine	VAR	*Varivax*
Zoster vaccine, recombinant vaccine	RZV	*Shingrix*

Table 2. Recommended Immunizations for Adults with HIV

Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV Recommended Immunizations for Adults with HIV		
Vaccines	Abbreviations	CD4 count <200 cells/mm^3
COVID-19	1vCOV-mRNA 1vCOV-aps	**Recommended** Number of doses depends on v and prior COVID immunization Consider an additional dose 6 m after the last dose
Hepatitis A	HepA	**R** 2 doses, with timing (0, 6-1 va
Hepatitis B	HepB	**R** 2 or 3 doses dep
Human papillomavirus	9vHPV	**R** 3 doses through ag
		Consider (wit 3 doses for ages 2
Influenza inactivated, Recombinant Influenza	IIV3 RIV3 HD-IIV3	**R** Age ≥65 years: use h
Influenza live, attenuated	LAIV3	**C**
Measles-mumps-rubella	MMR	**Contraindicated**
Meningococcal serogroups A, C, W, Y	MenACWY-CRM MenACWY-TT	**R** 2 doses (at least 8 weeks
Meningococcal serogroup B	MenB-4C MenB-FHbp	**Conside** Shar 3 dose
Mpox		**Recommer** 2 do
Pneumococcal	PCV15 PCV20 PCV21 PPSV23	*No Prior Pneumococcal Vaccin* **R** 1 do 1 dose PCV15 follo
Respiratory Syncytial Virus	RSV	**R** Aged 50-74 years w
Tetanus-diphtheria-acellular pertussis	Tdap Td	**R** 1 dose Tdap then T

Vaccines	Abbreviations	CD4 count <200 cells/mm^3	CD4 count ≥200 cells/mm^3	
		Tetanus-diphtheria		
		Varicella	VAR	**Contraindicated**
		Zoster, recombinant	RZV	**R** 2 doses (2–6 m

Source:

- Panel on Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the prevention and treatment of opportunistic infections in adults and adolescents with HIV. National Institutes of Health, HIV Medicine Association, and Infectious Diseases Society of America. Immunizations for Preventable Diseases in Adults and Adolescents with HIV. Last updated: May 27, 2026. [HIV.gov]

Table 3. Recommended Hepatitis A Vaccines in Adults with HIV

Vaccine	Dosage	Dosing and Route
Hepatitis A Vaccines		
Havrix	1440 EL.U	2-Dose Schedule: 1 mL given IM at 0 and 6-12 months
Vaqta	50 U	2-Dose Schedule: 1 mL given IM at 0 and 6-18 months
Combined Hepatitis A and B Vaccine		
Twinrix	HAV: 720 EL.U *plus* HBsAg: 20 mcg	Standard 3-dose series: 1 mL given IM at 0, 1, and 6 months Accelerated 4-dose series (for travel): 1 mL given IM on days 0, 7, ar followed by a booster dose at month 12
Abbreviations: HAV = hepatitis A virus; HBsAg = hepatitis B surface antigen; IM = intramuscular		

Table 4. RSV Vaccines in People with HIV

Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV

Recommendations for RSV Vaccines in People with HIV

Patient Populations	Recommendation	Timing of Vaccine
Aged ≥75 years	Single dose of one of the following: • *Arexvy* • *Abrysvo* • *mRSEVIA*	Ideally prior to the fall and winter RSV season
Age 50-74 years with: • CD4 count <200 cells/mm^3, *or* • Comorbid conditions associated with increased risk for severe RSV disease*	Single dose of one of the following: • *Arexvy* • *Abrysvo* • *mRSEVIA*	Ideally prior to the fall and winter RSV season
Pregnant women	Single dose of: • *Abrysvo*	Give during weeks 32–36 of pregnancy (if during the months of September to January)

Abbreviations: RSV = Respiratory syncytial virus
*Comorbid conditions that increase risk for severe RSV: chronic cardiovascular disease, chronic lung or respiratory disease, end-stage renal disease or dependence on hemodialysis or other renal replacement therapy, diabetes mellitus with complication or requiring treatment with insulin or sodium-glucose cotransporter-2 (SGLT2) inhibitor, neurologic or neuromuscular conditions causing impaired airway clearance or respiratory muscle weakness, chronic liver disease, chronic hematologic conditions, severe obesity (body mass index ≥40 kg/m^2), moderate or severe immune compromise, residence in a nursing home, other chronic medical conditions or risk factors that a health care provider determines would increase the risk for severe disease due to viral respiratory infection.

Source:

- Panel on Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the prevention and treatment of opportunistic infections in adults and adolescents with HIV. National Institutes of Health, HIV Medicine Association, and Infectious Diseases Society of America. Immunizations for Preventable Diseases in Adults and Adolescents with HIV. Last updated: May 27, 2026. [HIV.gov]