# Respiratory Syncytial Virus (RSV) Monoclonal Antibody (RSV-mAb) Protocol

passive immunization protocol for children birth through 19 months

**Document reviewed and updated:** **August 28, 2025**

## Condition for protocol

To reduce incidence of morbidity and mortality of lower respiratory tract disease among infants due to Respiratory Syncytial Virus (RSV).

## Policy of protocol

The nurse will implement this protocol for RSV prevention using RSV monoclonal antibody product(s).

## 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 |
| Child is less than 8 months of age, is non-acutely ill, has not previously received RSV monoclonal antibody and is born during or entering their first RSV season (October – March).  | Proceed to immunize. |
| Child is less than 8 months of age and mother did not receive RSV vaccination at least 14 days before delivery and is born during or entering their first RSV season (October – March).  | Proceed to immunize. |
| Child is less than 8 months of age and mother received RSV vaccine during pregnancy and at least 14 days before delivery.  | Do not immunize; infant protected by maternal antibodies. |
| Child is age 8-19 months entering their second RSV season and has one of the following conditions that increase their risk for severe RSV (October – March): * Child with severe lung disease of prematurity who requires medical support during the 6 months before RSV season starts.
* Child who is immunocompromised.
* Child with severe cystic fibrosis.
* Alaska native and American Indian ethnic child.
 | Proceed to immunize using nirsevimab (Beyfortus) only.  Follow prescription for second RSV season dosing.Do not vaccinate if the only product available is clesrovimab (Enflonsia); refer to provider that offers nirsevimab (Beyfortus). |

Contraindications

|  |  |
| --- | --- |
| Criteria | Prescribed action |
| Child had a severe allergic reaction (e.g. anaphylaxis) after a previous dose or to a vaccine component.   | Do not immunize.     |

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 immunize.   |
| Person has a moderate to severe illness with or without fever defined as temperature \_\_\_\_°F/°C or higher with symptoms such as: {to be determined by medical prescriber}   | Defer immunization and refer to HCP for further assessment.   |

## Prescription

### For infants in their first RSV Season (October – March\*)

* Give Nirsevimab (Beyfortus) based on child’s weight:
	+ 50 milligrams, 0.5 mL, intramuscular (IM) for infants weighing less than 5 kg (11 pounds)
	+ 100 milligrams, 1 mL, intramuscular (IM) for infants weighing 5 kg (11 pounds) or more
* Give Clesrovimab (Enflonsia) (same dosage regardless of child’s weight):
	+ 105 milligrams, 0.7ml, intramuscular (IM)

### For high-risk children in their second season\* (October – March\*\*)

* Give Nirsevimab (Beyfortus):
	+ 200 milligrams, 2 mL (give 2 doses of 100 mg in separate sites), intramuscular (IM)

\*Clesrovimab is not recommended for high-risk children in their second season.

\*\*For typical RSV season in Minnesota. Dates may need to be adjusted if RSV community spread is abnormally early or late.

## 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: