# 2015-2016 Preventive Care Guidelines

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Introduction

Blue Cross and Blue Shield of Illinois, Blue Cross and Blue Shield of Montana, Blue Cross and Blue Shield of New Mexico, Blue Cross and Blue Shield of Oklahoma, and Blue Cross and Blue Shield of Texas ("the Plans") publish and disseminate evidence-derived Preventive Care Guidelines ("Guidelines") based upon the recommendations of recognized sources such as professional medical associations, specialty societies, professional consensus panels, national task forces, and governmental entities. The Guidelines are designed to improve physician/practitioner awareness of (and compliance with) effective clinical preventive care, to improve patient education and to increase the percentage of members who receive recommended clinical preventive care services.

The Guidelines do not cover all possible circumstances, but should be considered a summary of basic preventive services for these populations:
1. Children from birth to 17 years
2. Adults 18 years and older
3. Adults 65 years and older
4. Women needing perinatal care

The Guidelines are focused upon primary prevention; that is, strategies that have been shown to reduce the likelihood of future adverse outcomes in individuals prior to the onset of symptomatic disease. Services such as immunizations, education and counseling, and screening tests are primary preventive services. The Guidelines apply to average risk, asymptomatic and otherwise healthy individuals. Preventive care interventions appropriate for those with other levels of risk (increased or decreased) will vary by individual circumstance, and physicians/practitioners are encouraged to tailor the approach to these patients as necessary. For certain increased risk groups, additional guidelines have been included to assist physicians/practitioners.

Expert groups may disagree on certain preventive interventions, and as a consequence, recommendations regarding preventive services are not always identical. Despite this disparity, there are numerous areas where consensus exists, allowing for the formulation of this set of guidelines. Whenever possible, the Guidelines follow the recommendations of the United States Preventive Services Task Force (USPSTF) that are considered “recommended” ("A" and "B" level recommendations). When USPSTF recommendations do not provide sufficient guidance, the Plans, with input from network providers, have adopted the recommendations of other professional organizations that evaluate the value of clinical preventive services.

The Guidelines represent a minimal set of recommended preventive health services. Additional interventions may be indicated, except where there is a specific recommendation against routine screening. Individual considerations for a given patient should dictate clinical decisions. In addition, physicians/practitioners are encouraged to review the USPSTF statements regarding services that are should not be routinely used (level “D”). These are available at: http://www.uspreventiveservicestaskforce.org/BrowseRec/Index.

Important Considerations

The following points should be emphasized when using the guidelines:

- Unless specified, guidelines are meant to apply to average risk, asymptomatic and otherwise healthy individuals. Preventive care interventions appropriate for those with other levels of risk (increased or decreased) will vary by individual circumstance, and physicians are encouraged to tailor the approach to these patients as necessary.
The interventions listed are *minimal guidelines*. Additional interventions may be useful.

The Guidelines are designed to assist clinicians by providing a guide to clinical preventive care that is usually appropriate, and are not intended to replace a clinician's judgment, establish a protocol for all patients, or define standards of practice. The final decision regarding medical treatment, including preventive care services, is made by the physician and the patient.

The Guidelines document is *not a statement of coverage*. Coverage is based upon member eligibility, the member’s specific benefit plan design, and state or federal law. There is substantial variation in coverage between benefit programs, and *inclusion of a service in the Guidelines does not imply that the service is necessarily a covered benefit and does not guarantee payment*.

Because the Guidelines summarize a large amount of information, all details cannot be provided. The practitioner is, therefore, encouraged to review the original sources for more complete discussion of indications and contraindications for specified preventive care services, and to verify the accuracy of the summary.

Sources are cited for each guideline. Where possible, the exact recommendation of the source is used. In some cases, the recommendation, or its periodicity, has been modified to resolve conflicting recommendations by various sources, or to facilitate practical usage of the guideline in clinical practice settings.

This material is provided for informational purposes only and is not intended to be a substitute for the sound independent medical judgment of health care practitioners. Health care providers are instructed to exercise their independent medical judgment based on the patient’s individual medical circumstances including, but not limited to symptoms, history, family history and other factors. The final decision about whether a particular service or treatment should be rendered is between the health care provider and the member (patient). The fact that a particular medical service is listed in this document is not a guarantee that benefits are available for such service. The member is instructed to refer to their health benefits document or certificate of coverage to determine what benefits are available for the particular medical service.

### Key to Major Professional Organizations Referenced in the Guidelines

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>AAP</td>
<td>American Academy of Pediatrics</td>
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<td>ACIP</td>
<td>Advisory Committee on Immunization Practices of the CDC</td>
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<td>ACS</td>
<td>American Cancer Society</td>
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<td>ACOG</td>
<td>American Congress of Obstetricians and Gynecologists</td>
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<td>AAFP</td>
<td>American Academy of Family Practice</td>
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<td>AHA</td>
<td>American Heart Association</td>
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<td>ADA</td>
<td>American Diabetes Association</td>
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<td>AMA</td>
<td>American Medical Association</td>
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<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<td>HHS</td>
<td>U.S. Department of Health and Human Services</td>
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<tr>
<td>IDPH</td>
<td>Illinois Department of Public Health</td>
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<tr>
<td>MDPHHS</td>
<td>Montana Department of Public Health and Human Services</td>
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<tr>
<td>NCI</td>
<td>National Cancer Institute</td>
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<td>NMDOH</td>
<td>New Mexico Department of Health</td>
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<td>NMHSD</td>
<td>New Mexico Human Services Department</td>
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<td>OSDH</td>
<td>Oklahoma State Department of Health</td>
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<td>TDSHS</td>
<td>Texas Department of State Health Services</td>
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<tr>
<td>USPSTF</td>
<td>U.S. Preventive Services Task Force</td>
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Preventive Health Guidelines for Children Age Birth To 17

Part I: Neonates (Birth to 1 Month)

1. History and Physical Examination (Reference: 1-AAP)
   Perform newborn examination and at 3-5 days:
   a) History
   b) Physical exam
   c) Length and weight, weight for length
   d) Head circumference
   e) Development surveillance

2. Screening Tests (References: 2, 3 – AAP; 4, 5, 6 – USPSTF; 7, 8, 9, 10, 11 – States of Illinois, Montana, New Mexico, Oklahoma and Texas)
   Perform screening tests prior to discharge or transfer from the nursery, but no later than 7 days of age.
   USPSTF recommends screening for phenylketonuria, congenital hypothyroidism and sickle-cell disease as a minimum. However, state regulations define required screening. The state-specific lists of required newborn screening can be found at these sites:
   IL  http://www.idph.state.il.us/HealthWellness/newborn_screening/index.htm
   MT  http://www.dphhs.mt.gov/publichealth/newborn/screening.shtml
   NM  http://archive.nmhealth.org/phd/nbs/
   TX  http://www.dshs.state.tx.us/newborn/screened_disorders.shtm

3. Ocular Chemoprophylaxis (Reference: 12 – USPSTF)
   Administer ocular antibiotic prophylaxis at birth.

4. Immunizations (References: 13, 19 – CDC)
   Administer immunizations in accordance with the ACIP Recommended Immunization Schedules for Persons Aged 0 through 18 Years. Copies of the Schedules are attached at the end of the document.

5. Counseling/Anticipatory Guidance (Reference: 1 – AAP)
   Relevant topics include injury prevention, nutrition, and sleep positioning.

Part II: Children Age 1 month to 17 years – Average Risk Pediatric Population

1. General Recommendations – see table below. Provide preventive services for children in accordance with the recommendation summarized in the following table. (References: 1, AAP; 14, 16, 17, 18, 21, 22, 56, 66 - USPSTF)
2. **Immunizations** (References: 13 - CDC, 19 – ACIP; 20 – NMDOH)

Administer immunizations in accordance with ACIP Recommended Immunization Schedules for Persons Aged 0 through 18 years, or in accordance with state law or mandates if such exist. Copies of the ACIP immunization schedules are attached at the end of this document. NOTE: New Mexico physicians/practitioners are encouraged to follow the optimized “Done By One” immunization schedule. A copy of the “Done By One” schedule is attached and the most current version is available online at http://nmhealth.org/publication/view/general/450.
3. **Prevention of Dental Caries in Children from Birth through Age 5 Years** (Reference: 67 - USPSTF)
   The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride. It is also recommended that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.

**Part III: Recommendations for Select Populations at Risk**

1. **Iron Supplementation** (Reference: 15 – USPSTF)
   Routine iron supplementation is recommended for asymptomatic children age 6-12 months who are at increased risk for iron deficiency anemia. Premature and low birth weight infants are at increased risk for iron deficiency. In the U.S. race, income, education, and other socioeconomic factors are also associated with iron deficiency.

2. **Hepatitis B Screening** (Reference: 68 – USPSTF)
   Screen for Hepatitis B in adolescents at high risk for infection. Risk factors include country of origin, HIV-positive persons, injection drug users, household contacts or sexual partners of persons with HBV infection, and men who have sex with men. Screening is also recommended for persons receiving hemodialysis or cytotoxic or immunosuppressive therapy.

3. **Behavioral Counseling to Prevent Skin Cancer** (Reference: 62 – USPSTF)
   Children and adolescents age 10 to 17 that have fair skin should be counseled about minimizing ultraviolet radiation to reduce risk for skin cancer.

4. **Sexually Transmitted Infections:** (Reference: 16, 17, 18 – USPSTF)
   a) Gonorrhea - Screen for Gonorrhea in sexually active adolescent females.
   b) Chlamydia - Screen for Chlamydia in sexually active adolescent females.
   c) Behavioral Counseling - Intensive behavioral counseling is recommended for all sexually active adolescents

**Preventive Health Guidelines for Adults 18 years and Older**

**Part I: Adults at Average Risk**

1. **History and Physical Examination** (Reference: 28 - ACS)
   a) Height and Weight Measurement: Every 1-3 years age 18 and older (References: 29 – AHA; 30 - USPSTF)
   b) Calculation of Body Mass Index: Every 1-3 years age 18 and older (References: 30 – USPSTF; 29 - AHA)
   c) Blood Pressure Measurement: Every 1 to 2 years age 18 and older (References: 31 - USPSTF)
   d) Female clinical breast exam (Reference: 32 – ACS; also see reference 33 - USPSTF)
      o Age 20 to 39 every 3 years
      o Age ≥40: annually

2. **Counseling**
   Provide health counseling regarding the following topics (Reference: 18, 30, 34, 35, 36, 37, 62 – USPSTF, 38 - ACS)
a) Avoidance of tobacco and/or tobacco cessation
b) Weight loss for obese adults
c) Promotion of healthy diet
d) Benefits of physical activity
e) Alcohol use
f) Sexually transmitted infection prevention
g) Risks and symptoms of endometrial cancer to women of average risk at the time of menopause. Strongly encourage women to report any unexpected bleeding or spotting to their physicians.
h) Minimizing exposure to ultraviolet radiation to reduce risk for skin cancer (for adults through age 24 who have fair skin).

3. Screening Tests

a) Cholesterol

Note: Recommendations from different national entities vary. We encourage review of the detailed and nuanced language in the following references (References: 39 – USPSTF; 40 - ADA; 70 - AHA)

- Screen men age 35 and older for lipid disorders.
- Screen women age 45 and older for lipid disorders if they are at increased risk for coronary heart disease.
- Men age 20 to 35 and women age 20 to 45 that are at increased risk for coronary heart disease should be screened for lipid disorder.
- Reasonable options for screening interval include: every 5 years; screening at &lt;5 year intervals for people who have lipid levels close to those warranting therapy; and screening at intervals &gt;5 years for low-risk people who have had low or repeatedly normal lipid levels.
- For adult diabetics, perform a lipid profile at least annually. If lipid values are low-risk, the lipid profile may be performed every two years.

b) Breast cancer screening (female only)

Note: Recommendations from different national entities vary. We encourage review of the detailed and nuanced language in the following references. (References: 33, 41 – USPSTF; 32 – ACS)

- Screen women aged 50 to 74 years for breast cancer with biennial mammography. Some entities recommend annual mammography in this age group.
- The decision to start regular, biennial screening mammography before the age of 50 years should be an individual one and take patient context into account, including the patient’s values regarding specific benefit and harm. Some entities recommend annual mammography in the 40 to 49 age group.
- Primary care providers should screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.

c) Cervical Cancer Screening (Pap) (female only) (References: 25 – USPSTF; 26 – ACS; also see Reference 27 – ACOG)

- Screen for cervical cancer with cytology (Pap smear) every three years in women age 21 to 65. An option for women ages 30 to 65 who want to lengthen the screening interval is screening with a combination of cytology and HPV testing every 5 years.
- Screening is not recommended for women younger than age 21.
For women older than age 65 who have had adequate prior screening and are not otherwise at high risk for cervical cancer, screening is not recommended.

- For women who have had a hysterectomy with removal of the cervix and do not have a history of high grade precancerous lesions, screening is not recommended.

- Screening with HPV testing is not recommended for women younger than age 30 years.

d) Prostate Cancer Screening (male only) (Reference: 42 – ACS; also see references 43 – USPSTF and 44 – AUA)

Prostate cancer screening recommendations vary, and review of the detailed language in the references is recommended. While the USPSTF recommends against PSA-based screening for prostate cancer, the American Cancer Society (ACS) and the American Urological Association (AUA) recommend an informed decision making process for men age 50 and older (ACS) or men age 55-69 (AUA) who have at least a ten year life expectancy. Among the potential considerations for informed decision making are the risks, benefits and uncertainties of screening, as well as individual values and preferences. ACS states that prostate cancer screening should not occur without an informed decision making process.

e) Colorectal Cancer Screening (Reference: 46 – USPSTF; also see References 45 – ACS and 47 - ACOG)

Screen men and women age 50-75 for colorectal cancer using:

- Fecal occult blood test annually; or
- Flexible sigmoidoscopy every 5 years; or
- Colonoscopy every 10 years

Individuals at increased risk or high risk of colorectal cancer should be screened beginning at an earlier age and according to a different schedule.

Note: Single–panel gFOBT performed in the medical office using a stool sample collected during a digital rectal examination is not a recommended option for CRC screening due to its very low sensitivity for advanced adenomas and cancer.

f) Screening for Alcohol Misuse (Reference: 35– USPSTF)

- Screen adults 18 and over for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief counseling interventions to reduce alcohol misuse.

g) Screening for Depression (Reference: 48 – USPSFT)

- Screen adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.

h) Screening for Tobacco Use (Reference: 34 - USPSTF)

- Ask all adults, including pregnant women, about tobacco use.

i) Screening for Obesity (Reference: 30 - USPSTF)

- Screen all adults for obesity. Clinicians should offer or refer patients with a body mass index (BMI) of 30 kg/m2 or higher to intensive, multicomponent behavioral interventions.
j) **HIV Serology** (Reference: 56 – USPSTF)
   - Screen for HIV infection in adults age 18 to 65 years. Older adults who are at increased risk should also be screened. Screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown. The evidence is insufficient to determine optimum time intervals for HIV screening.

k) **Screening for Intimate Partner Violence** (Reference: 59 – USPSTF)
   - Screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services.

l) **Screening for Hepatitis C** (Reference: 64 – USPSTF)
   - Screen for Hepatitis C (HCV) infection in persons at high risk for infection and offer one-time screening for HCV infection to adults born between 1945 and 1965.

m) **Screening for Lung Cancer** (Reference: 69 - USPSTF)
   - Screen annually for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.

4. **Immunizations** (References: 49, 50, 19 – ACIP)
   - Administer immunizations in accordance with the ACIP Recommended Adult Immunization Schedule or in accordance with state law or regulations. See the ACIP Recommended Adult Immunization Schedule at the end of this document.

5. **Preventive Treatment**
   a) **Aspirin** (Reference: 51 – USPSTF)
      - Men age 45-79 should use aspirin when the potential benefit of reducing the risk of myocardial infarction outweighs the potential harm of gastrointestinal bleeding. Women age 55-79 should use aspirin when the potential benefit of reducing the risk of ischemic stroke outweighs the potential harm of gastrointestinal bleeding.
   
   b) **Folic acid** (Reference: 52 – USPSTF)
      - All women planning or capable of pregnancy should take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.
   
   c) **Chemoprevention of breast cancer** (Reference: 53 – USPSTF)
      - Engage in shared, informed decision making with women who are at increased risk for breast cancer about medications to reduce their risk. For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications.
Part II: Recommendations for Select Adult Populations at Increased Risk

1. Screening for Diabetes (References: 54 – USPSTF; 55 – ADA)
Screen adults with sustained blood pressure greater than 135/80 mmHg for diabetes. The decision to screen individual patients who do not have blood pressure greater than 135/80 mmHg is a matter of clinical judgment. Consider screening at 3-year intervals beginning at age 45. Consider screening at a younger age in individuals who are overweight or obese (BMI >25kg/m2) and have additional risk factors:
- Are physically inactive
- Have a first-degree relative with diabetes
- Are members of a high-risk race/ethnicity (African American, Latino, Native American, Asian-American, or Pacific Islander)
- Have delivered a baby weighing >9 pounds or have been diagnosed with gestational diabetes mellitus
- Have HDL cholesterol<35 mg/dL and/or triglyceride level >250 mg/dL
- Had A1c >5.7%, impaired glucose tolerance or impaired fasting glucose on previous testing
- Have polycystic ovary syndrome
- Have other conditions associated with insulin resistance
- Have a history of cardiovascular disease (CVD)

2. Tuberculosis Test (References: 23, 24 – CDC)
- Conduct targeted tuberculin testing programs only among groups at high risk for developing tuberculosis and discourage routine testing in those at low risk. Persons with increased risk for developing TB include the following:
  - Persons who may have recent infection, including: close contacts of persons with infectious pulmonary TB; persons who have recently immigrated from areas of the world with high rates of TB; or groups of people with high rates of TB transmission (homeless persons, those with HIV infections, injection drug use, persons who reside or work in institutional settings).
  - Persons with clinical conditions that are associated with progression to active TB, including: HIV infection, injections drug use, pulmonary fibrotic lesions on CXR, underweight, silicosis, chronic renal failure on hemodialysis, diabetes, gastrectomy, jejunoileal bypass, renal and cardiac transplantation, head and neck cancer, other neoplasms, prolonged corticosteroid or immunosuppressive therapy.

3. Syphilis Serology (References: 57, 58 – USPSTF)
- Perform for all pregnant women.
- Perform for those at increased risk, including: persons who exchange sex for money or drugs; men who have sex with men and engage in high risk sexual behavior; persons in adult correctional facilities; or persons with other sexually transmitted disease who may be more likely than others to engage in high risk behavior, putting them at risk for syphilis.

4. Gonorrhea Screening (References: 17 – USPSTF)
- Screen for gonorrhea in sexually active women age 24 years and younger and in older women who are at increased risk for infection.

5. Chlamydia Screening (References: 16 – USPSTF)
o Screen for chlamydia in sexually active women age 24 years and younger and in older women who are at increased risk for infection.

6. **Counseling and Interventions to Address Tobacco Use** (Reference: 34 – USPSTF)
   o Ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. Provide augmented, pregnancy-tailored counseling for pregnant women who smoke.

7. **Healthful Diet and Physical Activity for Cardiovascular Disease Prevention in Adults With Cardiovascular Risk Factors: Behavioral Counseling** (Reference: 37 - USPSTF)
   o Offer or refer adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.

8. **Screening for Hepatitis B Virus Infection** (Reference: 68 - USPSTF)
   o Screen for Hepatitis B in adults at high risk for infection.
   o Risk factors include country of origin, HIV positive persons, Injection drug users, household contacts or sexual partners with HBV infection, and men who have sex with men.
   o Screening is also recommended for persons receiving hemodialysis or cytotoxic or immunosuppressive therapy.

9. **Sexually Transmitted Infections: Behavioral Counseling** (Reference: 18- USPSTF)
   o The USPSTF recommends intensive behavioral counseling for adults who are at increased risk for sexually transmitted infections (STIs).

**Part III: Additional Recommendations for Adults Age 65 and Older**

In addition to the services recommended in the guidelines for adults age 18 and older, the following services are recommended for individuals age 65 and older:

1. **Immunizations** (Reference: 49 – ACIP)
   o Administer immunizations in accordance with the ACIP Recommended Adult Immunization Schedule. A copy is attached.

2. **Osteoporosis Screening** (Reference: 60 – USPSTF)
   o Screen women age 65 and older routinely for osteoporosis, with screening to begin at age 60 for women at increased risk for osteoporotic fractures.

3. **Screening for Abdominal Aortic Aneurysm** (Reference: 61 - USPSTF)
   o Men ages 65 to 75 who have ever smoked should be screened one time for abdominal aortic aneurysm, using ultrasonography.

4. **Prevention of Falls In Community Dwelling Older Adults** (Reference: 63 - USPSTF)
   o Exercise or physical therapy and vitamin D Supplementation to prevent falls is recommended for community-dwelling adults aged 65 years or older who are at increased risk for falls.
Part IV: Women Receiving Perinatal Care (References: 49 - CDC; 65 - ACOG; 71 - USPSTF)

The following summary addresses key aspects of the American College of Obstetricians and Gynecologists Guidelines for Preconception Care, Prenatal Care and Postpartum Care, as they apply in uncomplicated situations. However, it does not attempt to cover all details, and readers are encouraged to refer to the original source document for the comprehensive guidelines.

I. Preconception Care

Preconception care aims to optimize a woman’s health, health behaviors, and knowledge prior to conception. Recommended care includes:

- History
  - Gynecologic, obstetrical, medical, surgical and psychiatric histories
  - Family history and genetic history
  - Assessment of socioeconomic, educational and cultural context
  - Immunization status
  - Medications (prescription and nonprescription)

- Physical Exam
- Preconception counseling and interventions, including:
  - Substance use (tobacco, alcohol, and drugs)
  - Family planning
  - Sexually transmitted diseases including HIV
  - Nutritional counseling and folic acid use
  - Safety and social supports
  - Immunizations, as indicated
  - Evaluation of medications
  - Consideration of preconception genetic screening

- Management of medical conditions, including diabetes, hypertension, epilepsy, thyroid conditions, maternal phenylketonuria, asthma, history of bariatric surgery, hemoglobinopathies, inherited thrombophilias, obesity, and other chronic diseases

II. Prenatal Care

Prenatal care involves an ongoing process of risk identification, assessment and management. Prenatal care visits should begin in the first trimester. A typical visit schedule is every 4 weeks for the first 28 weeks of gestation, every 2 weeks until 36 weeks of gestation, and weekly thereafter. The visit schedule may be altered for women requiring close surveillance, such as those with medical or obstetric problems or at the extremes of reproductive age.
**First Prenatal Visit**

- **History**
  - Obstetrical and medical histories
  - Family history and genetic history
  - History of substance use and abuse, including tobacco, alcohol, drugs
  - Assessment of socioeconomic, educational and cultural context
  - Immunization status
  - Medications (prescription and nonprescription) and allergies
- Physical exam including pelvic exam
- Education about the expected course of pregnancy, nausea and vomiting, signs and symptoms to report to the physician, laboratory tests to be done, costs, physician/midwife coverage for labor and delivery
- Education and counseling about safety practices (lap and shoulder belt use, infection prevention), counseling about substance use and abuse, psychosocial issues, nutrition, exercise, air travel
- Documentation of Last Menstrual Period (LMP) and assignment of Estimated Date of Delivery (EDD) / Estimated Date of Confinement (EDC)
- Recommend prenatal vitamins with folic acid and iron

**Each Subsequent Prenatal Visit**

- Blood pressure
- Weight
- Uterine size for progressive growth and consistency with EDD
- Presence of fetal heart activity at appropriate gestational ages
- Ask about fetal movement (at appropriate gestational ages), leakage of fluid, vaginal bleeding
- Urine dipstick, as clinically indicated

**Initial Testing**

- Blood type, D(Rh) type, Antibody screen
- Complete blood count
- Urinalysis
- Hepatitis B (HBsAg)
- Syphilis (VDRL/RDR)
- Rubella titer
- HIV
- Chlamydia
- For women at higher risk:
  - Gonorrhea
  - Tuberculin skin test
- Ultrasound, as indicated to address specific clinical questions

### Antepartum Genetic Screening and Diagnosis
- Family history and ethnic background are key considerations in the need for genetic testing. There are a variety of ways to screen for fetal birth defects or genetic abnormalities. Obstetric providers should provide recommended screening or establish referral sources for screening. Patients should be educated about available options.
- Screening for aneuploidy should be offered to all women who seek prenatal care before 20 weeks gestation, regardless of maternal age, along with counseling to assist in informed decision-making.

### Recommended Subsequent Testing

#### Testing recommended for all pregnant women
- Hematocrit or hemoglobin – early in third trimester
- Diabetes screening – usually at 24-28 weeks with a plasma glucose one hour after a 50 g oral glucose challenge. A 3 hour oral glucose tolerance test should be performed for those with an abnormal screening test.
- Screening for Group B streptococcal disease at 35-37 weeks
  - Women with group B streptococcal bacteriuria during the current pregnancy and those who have previously given birth to a neonate with early-onset group B streptococcal disease do not need to be screened, but should be treated with intrapartum prophylactic antibiotics.

#### Testing recommended when indicated
- Ultrasound
  - The timing and type of ultrasound should be based on the clinical question being asked. The optimal timing for a single ultrasound examination in the absence of specific indications for a first trimester exam is 18-20 weeks of gestation.
- Antepartum tests of fetal well-being are indicated when there is increased risk of fetal demise.
  - The type of test, when to start testing, and frequency of testing are dependent upon the clinical situation.

#### Testing recommended only for women at increased risk
- Antibody tests in unsensitized D-negative patients at 28-29 weeks
- Third trimester HIV, chlamydia, syphilis, gonorrhea
- Testing at time of hospital admission: Hepatitis B

### Education and Counseling (After Initial Prenatal Visit)
- Working
- Childbirth education classes
- Newborn care provider
- Anticipating labor
- Preterm labor
- Trial of labor after Cesarean delivery
- Elective deliveries are not recommended prior to 39 weeks of gestation without medical indication and documentation of term gestation
- Breastfeeding
- Postpartum contraception/sterilization/tubal ligation
- Psychosocial issues, including substance use or abuse, depression, intimate partner violence

### Treatment
- Anti-D immune globulin for unsensitized D-negative patients at 28-29 weeks and at the time of ectopic gestation, abortion, procedures associated with possible fetal-to-maternal bleeding, conditions associated with fetal-maternal hemorrhage, unexplained vaginal bleeding, delivery of a newborn who is D-positive.
- Immunizations:
  - Influenza vaccine for women who will be pregnant during the influenza season, using inactivated influenza vaccine.
  - Tdap – Administer one dose of Tdap during each pregnancy, preferably between 27 and 36 weeks gestation, regardless of the interval since prior Td or Tdap vaccination.
  - Other vaccines when specifically indicated: Hepatitis A, Hepatitis B, pneumococcal, meningococcal
- Use low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.

### III. Postpartum Care

For women with a Cesarean section or complicated pregnancy, a visit 7-14 days after delivery may be recommended. A postpartum visit is recommended for all women approximately 4-6 weeks after delivery. Services at that visit should include:

#### Postpartum Visit

**Interval History**

**Physical Exam**
- Weight, blood pressure, breasts, abdomen, pelvic exam (including examination of episiotomy repair and evaluation of uterine involution)
- Pap test if needed

**Testing**
- Women with gestational diabetes should be screened for diabetes 6-12 weeks postpartum

**Counseling**
- Breastfeeding
- Screen for postpartum depression, postpartum blues
<table>
<thead>
<tr>
<th>Discuss contraception and plans for future pregnancies</th>
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<tbody>
<tr>
<td>Discuss implication of any pregnancy complications on future pregnancies</td>
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<tr>
<td>Review immunizations and administer Tdap, rubella and/or varicella vaccines if indicated</td>
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<tr>
<td>Counseling regarding behaviors, such as tobacco, alcohol, and other substance use, with referrals for follow up care if appropriate</td>
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</tbody>
</table>
# Immunization Schedules 2015

## Childhood: 0-18 Years

**Figure 1.** Recommended immunization schedule for persons aged 0 through 18 years – United States, 2015.  
*(FOR THOSE WHO FALL BEHIND OR START LATE, SEE THE CATCH-UP SCHEDULE (FIGURE 2)).*  
These recommendations must be read with the footnotes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars in Figure 1.  
To determine minimum intervals between doses, see the catch-up schedule (Figure 2). School entry and adolescent vaccine age groups are shaded.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Birth</th>
<th>1 mo</th>
<th>2 mos</th>
<th>4 mos</th>
<th>6 mos</th>
<th>8 mos</th>
<th>10 mos</th>
<th>12 mos</th>
<th>15 mos</th>
<th>18 mos</th>
<th>19-23 mos</th>
<th>2-3 yrs</th>
<th>4-6 yrs</th>
<th>7-10 yrs</th>
<th>11-12 yrs</th>
<th>13-15 yrs</th>
<th>16-18 yrs</th>
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<tbody>
<tr>
<td>Hepatitis B (HepB)</td>
<td>1st</td>
<td>2nd</td>
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<tr>
<td>Diphtheria, tetanus, &amp; acellular pertussis†</td>
<td>1st</td>
<td>2nd</td>
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<td>Haemophilus influenza type b (Hib)</td>
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<td>Pneumococcal conjugate® (PCV13)</td>
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<td>Measles, mumps, rubella® (MMR)</td>
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<td>Varicella® (VAR)</td>
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<td>Annual vaccination (HepA) or 1 or 2 doses</td>
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<td>Human papillomavirus® (HPV2: females only; HPV1: males and females)</td>
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<tr>
<td>Meningococcal C2 (B- mening/2:5 series)</td>
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<td>Annual vaccination (Meningococcal C2) or 1 or 2 doses</td>
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<tr>
<td></td>
<td><strong>Range of recommended ages for catch-up vaccination</strong></td>
<td><strong>Range of recommended ages for certain high-risk groups</strong></td>
<td><strong>Range of recommended ages for certain high-risk groups</strong></td>
<td><strong>Not routinely recommended</strong></td>
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This schedule includes recommendations in effect as of January 1, 2015. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The HPV1 recombinant vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at [http://www.cdc.gov/vaccines/hcp/acip-recs/index.html](http://www.cdc.gov/vaccines/hcp/acip-recs/index.html). Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online ([http://www.vaers.hhs.gov](http://www.vaers.hhs.gov)) or by telephone (800-822-7967). Suspected cases of vaccine-preventable diseases should be reported to the state or local health department. Additional information, including precautions and contraindications for vaccination, is available from CDC online ([http://www.cdc.gov/vaccines/recs/vac-admin/contraindication.html](http://www.cdc.gov/vaccines/recs/vac-admin/contraindication.html)) or by telephone (800-CDC-INFO (800-232-4636)).

This schedule is approved by the Advisory Committee on Immunization Practices ([http://www.cdc.gov/vaccines/acip](http://www.cdc.gov/vaccines/acip)), the American Academy of Pediatrics ([http://www.aap.org](http://www.aap.org)), the American Academy of Family Physicians ([http://www.aafp.org](http://www.aafp.org)), and the American College of Obstetricians and Gynecologists ([http://www.acog.org](http://www.acog.org)).

**NOTE:** The above recommendations must be read along with the footnotes of this schedule.
**Catch-up Schedule: 4 Months to 18 Years**

Catch-up immunization schedule for persons aged 4 months through 18 years who start late or who are more than 1 month behind — United States, 2015.

The figure below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child’s age. Always use this table in conjunction with Figure 1 and the footnotes that follow.

![Catch-up Immunization Schedule](image)

**NOTE:** The above recommendations must be read along with the footnotes of this schedule.
Footnotes — Recommended immunization schedule for persons aged 0 through 18 years—United States, 2015

For further guidance on the use of the vaccines mentioned below, see: http://www.cdc.gov/vaccines/hcp/acip-recs/index.html. For vaccine recommendations for persons 19 years of age and older, see the Adult Immunization Schedule.

Additional information:
- For contraindications and precautions to use of a vaccine and for additional information regarding that vaccine, vaccination providers should consult the relevant ACIP statement available online at http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.
- For purposes of calculating intervals between doses, 4 weeks = 28 days. Intervals of 4 months or greater are determined by calendar months.
- Vaccine doses administered 4 days or less before the minimum interval are considered valid. Doses of any vaccine administered ≥5 days earlier than the minimum interval or minimum age should not be counted as valid doses and should be repeated as age-appropriate. The repeat dose should be spaced after the invalid dose by the recommended minimum interval. For further details, see MMWR, General Recommendations on Immunization and Reporting/Vol. 60/No. 2 Table 1. Recommended and minimum ages and intervals between vaccine doses available online at http://www.cdc.gov/mmwr/pdf/rr/rr6002.pdf.
- Information on travel vaccine requirements and recommendations is available at http://wwwnc.cdc.gov/travel/destinations/list.

1. Hepatitis B (HepB) vaccine. (Minimum age: birth)

- Routine vaccination:
  - Birth:
    - Administer monovalent HepB vaccine to all newborns before hospital discharge.
    - For infants born to hepatitis B surface antigen (HBsAg) positive mothers, administer HepB vaccine and 0.5 mL of hepatitis B immune globulin (HBIG) within 1 hour of birth. These infants should be tested for HBsAg and antibody to HBsAg (anti-HBs) 1 to 2 months after completion of the HepB series at age 9 through 18 months (preferably at the next well-child visit).
    - If mother’s HBsAg status is unknown, within 12 hours of birth administer HepB vaccine regardless of birth weight.
  - For infants weighing less than 2,500 grams, administer HBIG in addition to HepB vaccine within 12 hours of birth. Determine mother’s HBsAg status as soon as possible and, if mother is HBsAg-positive, also administer HepB at 1 to 2 months, 1 to 2 months after the first dose (minimum interval of 4 weeks). The third dose should be administered at ≥2 months and at least 6 months after the first dose. If the third dose is given at ≥2 months and ≤6 months after the first dose, it is considered part of the series. If the third dose is given >6 months after the first dose, it is considered a catch-up dose and is considered part of the series.
  - Administration of a total of 4 doses of HepB vaccine is recommended when a combination vaccine containing HepB is administered after the birth dose.

- Catch-up vaccination:
  - Unvaccinated persons should receive 3 doses of HepB vaccine.
  - 2-dose series (doses separated by at least 4 months) of adult formulation Recombivax HB is licensed for use in children aged 11 through 18 years.

2. Rotavirus (RV) vaccines. (Minimum age: 6 weeks for both RV1 [Rotarix] and RV5 [Rotaela])

- Routine vaccination:
  - Administer a series of RV vaccines to all infants as follows:
    - 1. If Rotarix is used, administer a 2-dose series at 2 and 4 months of age.
    - 2. If Rotaela is used, administer a 3-dose series at 2, 4, and 6 months of age.
  - 1 dose of any Rotavirus vaccine given to children ≥2 years of age.

- Catch-up vaccination:
  - For infants born ≤14 day’s failure to receive a dose of Rotavirus vaccine in the first 2 weeks of life, give 1 dose of Rotarix or Rotaela.
  - For infants born ≥15 days to 1 month of age, give 1 dose of Rotarix or Rotaela.
  - For infants born ≥1 month to 11 months of age, give 3 doses of Rotarix or Rotaela.
  - For infants born ≥11 months of age, give 1 dose of Rotarix or Rotaela.

3. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine (cont’d)

- Catch-up vaccination:
  - The fifth dose of DTaP vaccine is not necessary if the fourth dose was administered at age 4 years or older.
  - For other catch-up guidance, see Table 2.

4. Tetanus and diphtheria toxoids and acellular pertussis (TDaP) vaccine. (Minimum age: 10 years for both Boostrix and Adacel)

- Routine vaccination:
  - Administer 1 dose of DTaP vaccine to all adolescents aged 11 through 12 years.
  - Teenagers aged 13 through 18 years who have not received DTaP vaccine should receive a dose followed by tetanus and diphtheria toxoids (Td) every 10 years thereafter.

- Catch-up vaccination:
  - Adults who are not fully immunized with Td vaccine should receive Td vaccine at one of the following: (1) at least 6 months after the last dose of DTaP vaccine; (2) at least 6 months after the last dose of tetanus toxoid containing product; (3) at least 6 months after the last dose of tetanus toxoid, diphtheria toxoid (Td); or (4) at least 6 months after the last dose of tetanus toxoid, diphtheria toxoid, and pertussis (Tdap) vaccine.

- For other catch-up guidance, see Table 2.

5. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks for PRP-1 [ActHIB], DTaP-IPV/Hib; Pentacel); and Hib-MenCY (MenHibrix), PRP-OMP [PedvaxHib or COMVAX], 12 months for PRP-T (Hiberix)

- Routine vaccination:
  - Administer a 0- or 2-3 dose schedule of Hib vaccine primary series and a booster dose (3 or 4 depending on vaccine used in primary series) at age 12 through 15 months to complete a full Hib vaccine series.
  - For the primary series with ActHIB, MenHibrix, or PerServ consists of doses and should be administered at 2, 4, and 6 months of age. The primary series with PedvaxHib or COMVAX consists of 2 doses and should be administered at 2 and 4 months of age at age 6 months of age is not indicated.
  - One booster dose (dose 3 or 4 depending on vaccine used in primary series) of any Hib vaccine should be administered at age 12 through 15 months. An exception is Hibercen vaccine. Hibercen should only be used for the primary and booster dose in children aged 12 months through 4 years who have received at least 1 prior dose of Hib-containing vaccine.

For further guidance on the use of the vaccines mentioned below, see: http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.

5. Pneumococcal vaccine (cont’d)

Catch-up vaccination:
- All children aged 2 to 18 months and 2 to 15 months and 2 to 15 months of age living in households with children aged 2 to 18 months who have received at least 2 doses of PCV13 or PCV02.

Catch-up vaccination with PCV13:
- All children who have received at least 2 doses of PCV13 who have not been vaccinated with PCV23.

Catch-up vaccination with PCV23:
- All children who have received at least 2 doses of PCV23 who have not been vaccinated with PCV13.

6. Pneumococcal vaccines. (Minimum age: 6 weeks for PCV13, 2 years for PCV23)

Routine vaccination with PCV13:
- All children who have not received the series of PCV13 at ages 2, 4, and 6 months and 2 to 15 months of age living in households with children aged 2 to 18 months who have received at least 2 doses of PCV13.

Catch-up vaccination with PCV13:
- All children who have received at least 2 doses of PCV23 who have not been vaccinated with PCV13.

Catch-up vaccination with PCV23:
- All children who have received at least 2 doses of PCV13 who have not been vaccinated with PCV23.

Vaccination of persons with high-risk conditions with PCV13 and PCV23:
- All children who have received at least 2 doses of PCV13 and PCV23.

For children 2 to 4 months of age with any of the following conditions: chronic heart disease, chronic lung disease, immune system disorders, or other immunocompromised states, including those with HIV infection; chronic renal failure; nephrotic syndrome; diseases associated with treatment with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, and adrenal glands; and congenital immunodeficiency.

1. Administer 1 dose of PCV13 if any incomplete schedule of 3 doses of PCV13 or PCV23 were received previously.
2. Administer 2 doses of PCV13 at least 8 weeks apart if unvaccinated or any incomplete schedule of fewer than 3 doses of PCV13 or PCV23 were received previously.
3. Administer 1 supplemental dose of PCV13 if 4 doses of PCV13 or other vaccine were received previously.

7. Influenza vaccines. (Minimum age: 6 months for inactivated influenza vaccine [IIV], 2 years for live, attenuated influenza vaccine [LAIV], and 3 years for subunit influenza vaccine [SIV])

For children aged 6 months through 8 years:
- Administer LAIV to any children aged 2 to 18 months and 2 to 15 months who have not been vaccinated with LAIV in the past 4 years or at least 6 months after the previous dose.

For children aged 9 years and older:
- Administer IIV to any children aged 9 years and older who have not been vaccinated with IIV in the past 4 years or at least 6 months after the previous dose.

For persons aged 8 years and older:
- Administer IIV to any children aged 8 years and older who have not been vaccinated with IIV in the past 4 years or at least 6 months after the previous dose.

For persons aged 8 years and older:
- Administer IIV to any children aged 8 years and older who have not been vaccinated with IIV in the past 4 years or at least 6 months after the previous dose.
For further guidance on the use of the vaccines mentioned below, see: http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.

9. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months for routine vaccination)
   Routine vaccination:
   - Administer a 2-dose series of MMR vaccine at ages 12 through 15 months and 4 through 6 years.
   - The second dose may be administered before age 4 years, provided at least 4 weeks have elapsed since the first dose.
   - Administer 1 dose of MMR vaccine to infants aged 6 through 11 months before departure from the United States for international travel. These children should be revaccinated with 2 doses of MMR vaccine, the first at age 12 through 15 months (12 months in a high-risk area) and the second dose at least 4 weeks later.
   - For children 12 through 15 months old or older, the second dose should be administered before departure from the United States for international travel. The first dose should be administered on or after age 12 months and the second dose at least 4 weeks later.

   Catch-up vaccination:
   - Ensure that all school-aged children and adolescents have had 2 doses of MMR vaccine; the minimum interval between the 2 doses is 4 weeks.

10. Varicella (VAR) vaccine. (Minimum age: 12 months)
    Routine vaccination:
    - Administer a 2-dose series of VAR vaccine at ages 12 through 15 months and 4 through 6 years. The second dose may be administered before age 4 years, provided at least 4 weeks have elapsed since the first dose. If the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.

    Catch-up vaccination:
    - Ensure that all children aged 7 through 18 years without evidence of immunity (see MMWR 2007/56 [No. 5]) at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5605a1.htm) have 2 doses of varicella vaccine. For children aged 7 through 12 years, the recommended minimum interval between doses is 3 months; if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid; for children aged 13 years and older, the minimum interval between doses is 4 weeks.

11. Hepatitis A (HepA) vaccine. (Minimum age: 12 months)
    Routine vaccination:
    - Administer HepA vaccine series at 12 through 23 months separately, the 2 doses by 6 to 18 months.
    - Children who have received 1 dose of HepA vaccine before age 24 months should receive a second dose 6 to 18 months after the first dose.
    - Children who have not already received the HepA vaccine series and 2 doses of HepA vaccine separated by 6 to 18 months may be administered if immunity against Hepatitis A virus infection is desired.

    Catch-up vaccination:
    - The minimum interval between the two doses is 6 months.

    Special populations:
    - Children born to hepatitis B virus (HBV) infected mothers or to hepatitis C virus (HCV) infected mothers, or who are at increased risk for infection.
    - Children who are adopted from countries that have high or intermediate endemicity for infection.
    - Children born to HBV-infected primates or with HIV in a research laboratory.
    - Children with clotting factor disorders, persons with chronic liver disease, and persons who participate in close personal contact (e.g., household or regular babysitting) with an international adoption.
    - Children who are travelers to or reside in countries that have hepatitis A infection!

12. Human papillomavirus (HPV) vaccines. (Minimum age: 9 years for HPV2 [Cervarix] and HPV4 [Gardasil])
    Routine vaccination:
    - Administer a 2-dose series of HPV vaccine on a schedule of 0, 1-2, and 6 months to all adolescents aged 9 through 12 years.
    - Either HPV2 or HPV4 may be used for females, but only HPV4 may be used for males.
    - The vaccine series may be started at any age.
    - Administer the second dose 2 months after the first dose (minimum interval of 4 weeks).
    - Administer the second dose 24 weeks after the first dose and 15 weeks after the second dose (minimum interval of 12 weeks).

    Catch-up vaccination:
    - Administer the vaccine series to females (either HPV2 or HPV4) and males (HPV4) at age 13 through 18 years if not previously vaccinated.
    - Use recommended routine dosing intervals (see Routine vaccination above) for vaccine series catch-up.

13. Meningococcal conjugate vaccines. (Minimum age: 6 weeks for Hib-MenCY [MenHibrix], 9 months for MenACYW-D [Menactra], 2 months for MenACYW-CRM [Menveo])
    Routine vaccination:
    - Administer a single dose of Menactra or Menveo vaccine at age 11 through 12 years, with a dose booster at age 16 years.
    - Adolescents aged 11 through 18 years with human immunodeficiency virus (HIV) infection should receive 2-dose primary series of Menactra or Menveo with at least 6 weeks between doses.
    - For children aged 2 months through 18 years with high-risk conditions, see below.

    Catch-up vaccination:
    - Administer Menactra or Menveo vaccine at age 13 through 18 years if not previously vaccinated.
    - If the first dose is administered at age 12 through 15 years, a booster dose should be administered at age 16 years.
    - If the first dose is administered at age 16 years or earlier, a booster dose is not needed.

    For other catch-up guidance, see Figure 2.

    Vaccination of persons with high-risk conditions and other persons at increased risk of disease:

    a. Children with anatomic or functional asplenia (including sickle cell disease):
       - Menactra
         - Children who initiate vaccination at 4 weeks through 6 months: Administer doses at 4, 6, and 12 months of age.
         - Unvaccinated children 7 through 23 months: Administer 2 doses, with the second dose at least 12 weeks after the first dose and 1 month after the first birthday.
         - Children 24 months and older who have not received a complete series: Administer 2 primary doses at least 6 weeks apart.

    b. Meningococcal disease
       - Children 6 weeks through 18 months: Administer doses at 2, 4, 6, and 18 through 15 months of age.
       - If the first dose of Menactra is given at or after 12 months of age, a total of 2 doses should be given at least 8 weeks apart to ensure protection against serogroups B and C meningococcal disease.
    - Menactra
       - Children 6 weeks through 18 months: Administer 2 primary doses at least 6 weeks apart.
    - Menveo
       - If the first dose is administered to a child with asplenia (including sickle cell disease), complete the series with 2 additional doses until 2 years of age and 4 weeks after the completion of all vaccination dose.

    c. Children with persistent complement components deficiency:
       - Menactra
         - Children who initiate vaccination at 4 through 8 months: Administer doses at 4, 6, and 12 months of age.
         - Unvaccinated children 7 through 23 months: Administer 2 doses, with the second dose at least 12 weeks after the first dose and 1 month after the first birthday.
         - Children 24 months and older who have not received a complete series: Administer 2 primary doses at least 6 weeks apart.

    d. For children who travel or reside in countries in which meningococcal disease is hyperendemic or epidemic, including countries in the African meningitis belt or the Haj: Administer an age-appropriate formulation and series of Menactra or Menveo for protection against serogroups A and W meningococcal disease. Prior receipt of Menactra is not sufficient for children traveling to the meningitis belt or the Haj because it does not contain serogroups A or W.

    e. For children at risk during a community outbreak attributable to a vaccine serogroup, administer or complete an age-appropriate formulation and series of MenHibrix, Menactra, or Menveo.

    For further catch-up recommendations for these persons, and complete information on use of meningococcal vaccines, including guidance related to vaccination of persons at increased risk of infection, see MMWR March 22, 2013 /6209R031-22. Available at http://www.cdc.gov/mmwr/pdf/rr/rr6203.pdf
**Childhood: Optimized “Done By One” Schedule (NM)**

The New Mexico Optimized “Done BY One” Schedule takes advantage of the fact that childhood immunizations can be completed by the first birthday. Research has shown that this increases the likelihood children will get their full set of immunizations. The 2014 schedule is the most current version available at the time of publication. More Information is at: [http://nmhealth.org/publication/view/general/450](http://nmhealth.org/publication/view/general/450)

![“Done By One” Childhood Immunization Schedule](image)

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Age of child in months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Birth</td>
</tr>
<tr>
<td>DTaP¹ (Diphtheria, Tetanus, Pertussis)</td>
<td></td>
</tr>
<tr>
<td>Hepatitis A²</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B³</td>
<td></td>
</tr>
<tr>
<td>HIB⁴ (Haemophilus influenzae type b)</td>
<td></td>
</tr>
<tr>
<td>Influenza⁸</td>
<td></td>
</tr>
<tr>
<td>MMR⁸ (Measles, Mumps, Rubella)</td>
<td></td>
</tr>
<tr>
<td>Meningococcal⁷</td>
<td></td>
</tr>
<tr>
<td>Pneumococcal⁸</td>
<td></td>
</tr>
<tr>
<td>Polio</td>
<td></td>
</tr>
<tr>
<td>Rotavirus⁹</td>
<td></td>
</tr>
<tr>
<td>Varicella¹⁰</td>
<td></td>
</tr>
</tbody>
</table>

¹ ‘DBC’ indicates the earliest ages for routine administration of currently licensed childhood vaccines, as of July 22, 2014 for children aged 0 through 6 years. Additional information is available at [www.cdc.gov/vaccines/recs/schedules](http://www.cdc.gov/vaccines/recs/schedules).

² Any dose not administered at the recommended age should be administered at any subsequent visit, when indicated and feasible. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines are recommended whenever any components of the combination are indicated and other components of the vaccine are not contraindicated if approved by the Food and Drug Administration for that dose of the series. Providers should consult the respective Advisory Committee on Immunization Practices statement for detailed recommendations, including for high risk conditions: [http://www.cdc.gov/vaccines/pubs/ACIP-list.htm](http://www.cdc.gov/vaccines/pubs/ACIP-list.htm). Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete VAERS form is available at [vaers.hhs.gov](http://vaers.hhs.gov) or by telephone, 800-822-7967.

**New Mexico 2014**

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Divisions of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association
New Mexico Optimized “Done by One” Schedule Footnotes

1. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). (Minimum age: 6 weeks)
   - The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose.
   - Administer the final dose in the series at age 4-6 years.

2. Hepatitis A vaccine (HepA). (Minimum age: 12 months)
   - HepA is recommended for all children aged 1 yr (i.e., aged 12-23 months). The 2 doses in the series should be administered at least 6 months apart.
   - Children not fully vaccinated by age 2 years can be vaccinated at subsequent visits.

3. Hepatitis B vaccine (HepB). (Minimum age: birth)
   - Administer monovalent HepB vaccine to all newborns weighing more than 2 kg (4 lbs) 6.5 oz) prior to hospital discharge. Delaying HepB vaccine until smaller infants reach 2 kg except that all infants with Hepatitis B surface antigen (HBsAg) positive mothers must be given HepB vaccine and 0.5 ml of hepatitis B immune globulin (HBIG) within 12 hours of birth.
   - If mother’s HBsAg status is unknown, administer HepB within 12 hours of birth. Determine the HBsAg status as soon as possible and if HBsAg-positive, administer HBIG (no later than age 1 week).
   - If mother is HBsAg negative, the birth dose can be delayed, in rare cases, with a provider’s order and a copy of the mother’s negative HBsAg laboratory report in the infant’s medical record.
   - After the birth dose:
     - The HepB series should be completed with either monovalent HepB or a combination vaccine containing HepB. The second dose should be administered at age 1-2 months. The final dose should be administered no earlier than age 24 weeks. Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg after completion of at least 3 doses of a licensed HepB series, at age 18-24 months (generally at the next well-child visit).

4. Haemophilus influenzae type b conjugate vaccine (Hib). (Minimum age: 6 weeks)
   - Pedvax-Hib or Comvax are recommended for Native American patients.
   - If PRP-OMP (PedvaxHib® or Comvax® [Merck]) is administered at both 2 and 4 months, a dose at age 6 months is not indicated.
   - Tri-HIB (DTaP/Hib) should not be used for doses at ages 2, 4, or 6 months but can be used as the final dose in children 12 months or older.

5. Influenza vaccine. (Minimum age: 6 months for inactivated influenza vaccine [IIV]; 2 years for live, attenuated influenza vaccine [LAIV])
   - Administer annually to all over 6 months of age.
   - For healthy nonpregnant persons (i.e., those who do not have underlying medical conditions) that predispose them to influenza complications aged 2 through 49 years, either LAIV or IIV may be used.
   - Children receiving IIV should receive 0.25 ml if aged 6 through 35 months or 0.5 ml if aged 3 years or older.
   - Administer 2 doses (separated by at least 4 weeks) to children aged younger than 9 years who are receiving influenza vaccine for the first time. Most children younger than 9 years who have not received at least 2 doses in the past 2 years may also need 2 doses. Check current flu season immunization information at www.fl.gov for algorithm to see who needs a second dose.

6. Measles, mumps, and rubella vaccine (MMR). (Minimum age: 12 months)
   - Administer the second dose of MMR at age 4-6 years. MMR may be administered before age 4-6 years, provided 4 weeks or more have elapsed since the first dose.
   - Where children may be exposed to measles during travel, the first dose may be given as early as 8 months, but any dose delivered before 12 months does not count toward the 2 doses needed at the regularly scheduled ages.

7. Meningococcal vaccine. (Minimum age: 9 months for meningococcal conjugate vaccine (MCV) and 2 years for meningococcal polysaccharide vaccine (MPSV))
   - MCV is recommended for children aged 9 months to 10 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high-risk groups. Use of MPSV is also acceptable.
   - Persons who received MPSV 3 or more years prior and remain at increased risk for meningococcal disease should be vaccinated with MCV.

8. Pneumococcal vaccine. (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV], 2 years for pneumococcal polysaccharide vaccine [PPSV])
   - Administer one dose of PCV 13 to all healthy children aged 24-59 months who are not completely vaccinated for their age.
   - Administer PPSV to children aged 2 years and older with underlying medical conditions. The definition of qualifying medical conditions causing a need for a PPSV dose is contained in the ACIP statement available at http://www.cdc.gov/mmwr/preview/mmwrhtml/m9002a1.htm.

8. Rotavirus vaccine (RV). (Minimum age: 6 weeks)
   - Administer the first dose at age 8 through 14 weeks (maximum age: 14 weeks 6 days). Vaccination should not be initiated for infants aged 15 weeks or older (i.e., 15 weeks 0 days or older).
   - Administer the final dose in the series by age 8 months 0 days.
   - Only two doses of Rotavirus are needed, the first no later than 14 weeks 6 days, and the second no later than 8 months.

8. Varicella vaccine. (Minimum age: 12 months)
   - Administer second dose at age 4-6 years; may be administered 3 months or more after first dose.
   - Don’t repeat second dose if administered 28 days or more after first dose.

The NM “Done by One” Childhood Immunization Schedule is consistent with the schedule approved by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/recs/acip), the American Academy of Pediatrics (http://www.aap.org), and the American Academy of Family Physicians (http://www.aafp.org).

New Mexico Department of Health & New Mexico Medical Society, IPAC (Immunization Practices Advisory Council), July 2014
**Recommended Adult Immunization Schedule—United States - 2015**

*Note: These recommendations must be read with the footnotes that follow containing number of doses, intervals between doses, and other important information.*

### Figure 1. Recommended adult immunization schedule, by vaccine and age group

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>AGE GROUP</th>
<th>19-21 yrs</th>
<th>22-24 yrs</th>
<th>25-49 yrs</th>
<th>50-64 yrs</th>
<th>≥ 65 yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza*</td>
<td>1 dose annually</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetanus, diphtheria, pertussis (Tdap)*</td>
<td>Substitute 1-time dose of Tdap for Td booster; then boost with Td every 10 yrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella*</td>
<td>2 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human papillomavirus (HPV) Females*</td>
<td>3 doses</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Human papillomavirus (HPV) Males*</td>
<td>3 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, mumps, rubella (MMR)*</td>
<td>1 or 2 doses</td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Pneumococcal 13-valent conjugate (PCV13)*</td>
<td>1 dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal polysaccharide (PPSV23)*</td>
<td>1 or 2 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Meningococcal*</td>
<td>1 dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A*</td>
<td>2 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B*</td>
<td>2 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haemophilus influenzae type b (Hib)*</td>
<td>1 dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Covered by the Vaccine Injury Compensation Program

**For all persons in this category who meet the age requirements and who lack evidence of previous infection; otherwise, vaccine recommended regardless of prior episode of aseptic meningitis.**

Report all clinically significant post-vaccination reactions to the Vaccine Adverse Event Reporting System (VAERS). Reporting forms and instructions on filing a VAERS report are available at www.vaers.hhs.gov or by telephone: 800-822-7967.

VAERS is a program run by the Centers for Disease Control and Prevention and the Food and Drug Administration. More information is available at www.vaers.hhs.gov or by telephone: 800-822-7967. To file a report online, please visit www.vaers.hhs.gov. Additional information about the vaccine, its schedule, extent of available data, and contraindications for vaccination are also available at

Additional information about the vaccine can be found in the Vaccine Safety Databank or from the CDC-INFO Contact Center at 800-232-4636 in English and Spanish, 8:00 a.m. – 8:00 p.m., Eastern Time, Monday –Friday, excluding holidays.

*Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

The recommendations in this schedule were approved by the Centers for Disease Control and Prevention’s (CDC) Advisory Committee on Immunization Practices and the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), American College of Obstetricians and Gynecologists (ACOG), and other medical organizations.

### Figure 2. Vaccines that might be indicated for adults based on medical and other indications

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>INDICATION</th>
<th>IMMUNE-COMPROMISING (INCLUDING HIV/AIDS)</th>
<th>HIV INFECTION</th>
<th>RENAL DISEASE</th>
<th>HEART DISEASE</th>
<th>ASPLENIA</th>
<th>CHRONIC DISEASE</th>
<th>DIABETES</th>
<th>HEALTHCARE PERSONAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza*</td>
<td>Pregnancy</td>
<td>1 dose annually</td>
<td>1 dose annually</td>
<td>1 dose IV annually</td>
<td>1 dose IV annually</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetanus, diphtheria, pertussis (Tdap)*</td>
<td>Pregnancy</td>
<td>Substitute 1-time dose of Tdap for Td booster; then boost with Td every 10 yrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella*</td>
<td>Contraindicated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human papillomavirus (HPV) Females*</td>
<td>3 doses through age 26 yrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human papillomavirus (HPV) Males*</td>
<td>3 doses through age 26 yrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, mumps, rubella (MMR)*</td>
<td>Contraindicated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal 13-valent conjugate (PCV13)*</td>
<td>1 dose</td>
<td>1 dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal polysaccharide (PPSV23)*</td>
<td>1 or 2 doses</td>
<td>1 or 2 doses</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Meningococcal*</td>
<td>1 dose</td>
<td>1 dose</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Hepatitis A*</td>
<td>2 doses</td>
<td>2 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B*</td>
<td>2 doses</td>
<td>2 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haemophilus influenzae type b (Hib)*</td>
<td>1 or 2 doses</td>
<td>1 or 2 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

*Covered by the Vaccine Injury Compensation Program

**For all persons in this category who meet the age requirements and who lack evidence of previous infection; otherwise, vaccine recommended regardless of prior episode of aseptic meningitis.**

U.S. Department of Health and Human Services

Centers for Disease Control and Prevention

CDC

Divisions of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association
Footnotes—Recommended Immunization Schedule for Adults Aged 19 Years or Older: United States, 2015

1. Additional information
   - Additional guidance for the use of the vaccines described in this supplement is available at http://www.cdc.gov/vaccines.
   - Information on vaccination recommendations when vaccination status is unknown or uncertain is available in the General Recommendations on Immunization at www.cdc.gov/vaccines/pubs/om/gencovrec.htm.
   - Information on vaccine requirements and recommendations (e.g., for travel to specific countries or regions) is available at the Traveler’s Health website www.cdc.gov/travel.
   - The Advisory Committee on Immunization Practices (ACIP) recommends that all women of childbearing age be counseled about the benefits and risks of the rubella vaccine.
   - For information on vaccines for adolescents and adults aged 13 through 26 years, see the Adolescent and Young Adult Immunization Recommendations, 2015, issued by the ACIP.
   - The ACIP recommends that all women of childbearing age be counseled about the benefits and risks of the rubella vaccine.

2. Influenza vaccination
   - Annual influenza vaccination is recommended for all persons aged 6 months and older.
   - Persons aged 6 months or older, including pregnant women and persons with chronic medical conditions, should receive the influenza vaccine if they are at high risk for serious influenza-related complications.
   - Pregnant women should receive the influenza vaccine if they are at high risk for serious influenza-related complications.

3. Tetanus, diphtheria, and acellular pertussis (Td/Tdap) vaccination
   - Administer 1 dose of Tdap vaccine to pregnant women during each pregnancy (preferably during the 27th to 36th week of gestation) regardless of prior Td or Tdap vaccination.
   - Pregnant women aged 12 years or older who have not received Tdap vaccine or for whom vaccination status is unknown should receive a dose of Tdap vaccine before delivery.
   - Adults with an unknown or incomplete history of completing a 3-dose primary vaccine series and/or containing vaccine should receive a primary vaccine series including Tdap vaccine.

4. Varicella vaccination
   - All adults without evidence of immunity to varicella (as defined below) should receive 2 doses of single-antigen varicella vaccine or a second dose if they have received Tdap vaccination.
   - Vaccination should be administered to persons at high risk for severe disease (e.g., health care personnel and family contacts of persons with immunocompromising conditions) or at high risk for exposure to persons with varicella (e.g., students in any educational institution, teachers, or residents and staff members of institutional settings, including correctional institutions and long-term care facilities, who help care for pediatric or adult residents who have varicella.
   - Pregnancy women should be assessed for evidence of immunity to varicella vaccination.

5. Human papillomavirus (HPV) vaccination
   - Two vaccines are licensed for use in females: bivalent HPV vaccine (HPV2) and quadrivalent HPV vaccine (HPV4), and one HPV vaccine (HPV16/18). For females, either HPV4 or HPV2 is recommended in a 3-dose series for routine vaccination in 2 doses at 0, 4, and 12 months or for those aged 13 through 26 years, if not previously vaccinated.

6. Zoster vaccination
   - A single dose of zoster vaccine is recommended for adults aged 60 years and older, including those who have had varicella vaccine and staphylococcal disease.
   - Persons aged 60 years or older should receive the zoster vaccine, regardless of previous vaccination.
   - Persons with history of zoster who have had varicella vaccine should receive the zoster vaccine.

7. Measles, mumps, rubella (MMR) vaccination
   - Adults born before 1957 are generally considered immune to measles and mumps, and adults born before 1957 who do not have documentation of 1 or more doses of MMR vaccine should have a medical contraindication to the vaccine or laboratory evidence of immunity to both of the three diseases.

8. Pneumococcal (13-valent pneumococcal conjugate vaccine [PCV13] and 23-valent pneumococcal polysaccharide vaccine [PPSV23]) vaccination
   - General information
   - Administration of only one single dose of PCV13 is recommended for adults.
   - No additional doses of PPSV23 are recommended for adults vaccinated with PCV13.

Alternate Text: The figure above shows the recommended vaccinations indicated for adults based on medical and other indications.
8. Pneumococcal vaccination (continued)
   — Have received PCV13 but have received 1 or more doses of PPSV23.
   — Have received PCV13 but have not received PCV13 or PPSV23.
   — Have received PCV13 but have received PCV13 or PPSV23.
   — Have received PCV13 but have not received PCV13 or PPSV23.
   — Have received PCV13 but have received PCV13 or PPSV23.
   — Have received PCV13 but have received PCV13 or PPSV23.
   — Have received PCV13 but have received PCV13 or PPSV23.
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References and Links to Websites


8. Texas Department of State Health Services. All Texas newborns are screened for these disorders. Available at: http://www.dshs.state.tx.us/newborn/screened_disorders.shtm. Accessed April 23, 2015. A list of the disorders for which Texas newborns are screened is provided.

9. Oklahoma State Department of Health. Newborn Screening. Accessed 05/18/2015. Available at: http://www.ok.gov/health/Child_and_Family_Health/Screening, and Special Services/Newborn Screening Program/Disorders screenedindex.html. Every baby born in Oklahoma is required to have a blood test in the first week of life; a link is provided to the list of disorders included in the testing.


15. U.S. Preventive Services Task Force. Screening and supplementation for iron deficiency anemia May 2006. Available at: http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/iron-deficiency-anemia-screening. Accessed April 23, 2015. *USPSTF concludes that evidence is insufficient to recommend for or against routine screening for iron deficiency anemia in asymptomatic children aged 6 to 12 months, but recommends routine iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia. USPSTF concluded that evidence is insufficient to recommend for or against routine iron supplementation for asymptomatic children aged 6 to 12 months who are at average risk for iron deficiency anemia.*


25. U.S. Preventive Services Task Force. Screening for cervical cancer March 2012. Available at: http://www.uspreventiveservicestaskforce.org/uspsft11/cervcancer/cervcancererrs.htm. Accessed April 27, 2015. *The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screen with a combination of cytology and human papillomavirus (HPV) testing every 5 years. The USPSTF recommends against screening for cervical cancer in women younger than age 21 years. The USPSTF recommends against routinely screening women older than 65 for cervical cancer and recommends against routine Pap smear screening in women who have had a hysterectomy with removal of the cervix and who do not have a history of a high-grade precancerous lesion or cervical cancer. The USPSTF recommends against screening for cervical cancer with HPV testing, alone or in combination with cytology, in women younger than age 30 years.*

26. Saslo D. Soloman D, Lawson, HW et al. American Cancer Society, American Society for Colposcopy and Cervical Pathology, and American Society for Clinical Pathology. Screening guidelines for the prevention and early detection of cervical cancer. CA cancer J Clin 2012; 62:147-172. Available at: http://onlinelibrary.wiley.com/doi/10.3322/caac.21139/pdf. Accessed April 27, 2015. *ACS and its partners recommend no screening for cervical cancer before 21 years of age. For women aged 21-29 years, cervical cytology alone is recommended every 3 years with HPV testing not recommended for screening in this age group. For women age 30-65 years, options include HPV and cytology “cotesting” every 5 years (preferred) or cytology alone every 3 years (acceptable). Screening by HPV testing alone is not recommended for most clinical settings. For women age >65 years, no screening is recommended following adequate
negative prior screening and are not otherwise at high risk for cervical cancer. Women who have received HPV vaccine should be screened in the same manner as women who have not been vaccinated.


- Cervical cancer screening should begin at age 21 years. Women younger than age 21 years should not be screened regardless of the age of sexual initiation or the presence of other behavior-related risk factors.
- Women aged 21-29 years should be tested with cervical cytology alone, and screening should be performed every 3 years. Co-testing with cytology and human papillomavirus (HPV) should not be performed in women younger than 30 years.
- For women aged 30-65 years, co-testing with cytology and human papillomavirus (HPV) testing every 5 years is preferred.
- In women aged 30-65 years, screening with cytology alone every 3 years is acceptable. Annual screening should not be performed.
- Women who have a history of cervical cancer, have human immunodeficiency virus (HIV) infection, are immunocompromised or were exposed to diethylstilbestrol in utero should not follow routine screening guidelines.
- In women who have had a hysterectomy with removal of the cervix (total hysterectomy and have never had cervical intraepithelial neoplasia (CIN) 2 or higher), routine cytology screening and HPV testing should be discontinued.
- Screening by any modality should be discontinued after age 65 years in women with evidence of adequate negative prior screening results and no history of CIN 2 or higher.


30. U.S. Preventive Services Task Force. Screening for and management of obesity of adults, June 2012. Available at: http://www.uspreventiveservicestaskforce.org/uspstf/uspsobes.htm. Accessed April 27, 2015. The USPSTF recommends screening all adults for obesity. Body mass index is calculated from the measured weight and height of an individual. No evidence was found about appropriate intervals for screening. Clinicians should offer or refer patients with a body mass index (BMI) of 30 kg/m² or higher to intensive, multicomponent behavioral interventions.
31. U.S. Preventive Services Task Force. Screening for high blood pressure December 2007. Available at: http://www.uspreventiveservicestaskforce.org/uspstf/uspshype.htm. Accessed April 27, 2015. The USPSTF recommends that adults age 18 and older be screened for high blood pressure and notes that evidence is lacking to recommend an optimal interval for screening adults for hypertension. The seventh report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7) recommends screening every 2 years in persons with blood pressure less than 120/80 mm Hg and every year with systolic blood pressure of 120 to 139 mm Hg or diastolic blood pressure of 80 to 89 mm Hg.


33. U.S. Preventive Services Task force. Screening for breast cancer December 2009. Available at: http://www.uspreventiveservicestaskforce.org/uspstf/uspsbrca.htm. Accessed April 09, 2014. The USPSTF recommends biennial screening mammography for women aged 50 to 74 years. The decision to start regular, biennial screening mammography before the age of 50 years should be an individual one and take patient context into account, including the patient’s values regarding specific benefits and harms. The USPSTF concluded that the current evidence is insufficient to assess the additional benefits and harms of screening mammography in women 75 years or older. The USPSTF recommends against teaching breast self-examination (BSE) and concludes that the current evidence is insufficient to assess the additional benefits and harms of clinical breast examination (CBE) beyond screening mammography in women 40 years or older.


35. U.S. Preventive Services Task Force. Screening and behavioral counseling interventions in primary care to reduce alcohol misuse. May 2013. Available at: http://www.uspreventiveservicestaskforce.org/uspstf/uspsdrin.htm. Accessed April 09, 2014. The USPSTF recommends that clinicians screen adults aged 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce misuse. The USPSTF concluded that the current evidence is insufficient to assess the balance of benefits and harms of screening and behavioral counseling interventions in primary care settings to reduce alcohol misuse in adolescents.

healthful diet and physical activity is small. Clinicians may choose to selectively counsel patients rather than incorporate counseling into the care of all adults in the general population.


39. U.S. Preventive Service Task Force. Screening for lipid disorders in adults June 2008. Available at: http://www.uspreventiveservicestaskforce.org/uspstf/uspschol.htm. Accessed April 27, 2015. The USPSTF strongly recommends screening men age 35 and older for lipid disorders. The USPSTF strongly recommends screening women age 45 and older for lipid disorders if they are at increased risk for coronary heart disease. The USPSTF recommends screening men age 20-35 and women age 20-45 if they are at increased risk for coronary heart disease. The optimal interval for screening is uncertain. Reasonable options include every 5 years, shorter intervals for people who have lipid levels close to those warranting therapy, and longer intervals for those not at increased risk who have had repeatedly normal lipid levels.


41. U.S. Preventive Services Task Force. Risk assessment, genetic counseling, and genetic testing for BRCA-related cancer in women December 2013. Available at: http://www.uspreventiveservicestaskforce.org/uspstf/uspbsbrgen.htm. Accessed April 28, 2015: The USPSTF recommends that primary care providers screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.

cancer, after receiving information about the benefits, risks, and uncertainties associated with prostate cancer. Prostate cancer screening should not occur without an informed decision-making process.


44. American Urological Association. Early detection of prostate cancer. Available at: http://www.auanet.org/common/pdf/education/clinical-guidance/Prostate-Cancer-Detection.pdf. Accessed June 01, 2015. The AUA recommends against screening for prostate cancer in men under age 40 years, does not recommend routine screening in men age 40-54 years at average risk, and recommends shared decision making for men age 55-69 years that are considering PSA screening, and proceeding based on a man’s values and preferences. A routine screening interval of two years or more may be preferred over annual screening in those who have decided on screening. Routine PSA screening is not recommended in men over 70 years of age or in any man with less than a 10-15 year life expectancy.

45. Smith, R. A., Manassaram-Baptiste, D., Brooks, D., Doroshenk, M., Fedewa, S., Saslow, D., Brawley, O. W. and Wender, R. (2015), Cancer screening in the United States, 2015: A review of current American Cancer Society guidelines and current issues in cancer screening. CA: A Cancer Journal for Clinicians, 65: 30–54. doi: 10.3322/caac. Available at: http://onlinelibrary.wiley.com/doi/10.3322/caac.21261/full Accessed June 01, 2015. The American Cancer Society recommends that beginning at age 50, men and women should have colorectal cancer screening by means of one of the following screening options: annual FOBT with at least 50% test sensitivity for cancer or FIT with at least 50% test sensitivity for cancer , flexible sigmoidoscopy every 5 years, gFOBT or FIT annually plus flexible sigmoidoscopy every 5 years, double contrast barium enema every 5 years, colonoscopy every 10 years, computed tomography colonography every 5 years, or stool DNA test , for which the screening interval is uncertain.

46. U.S. Preventive Services Task Force. Screening for colorectal cancer October 2008. Available at: http://www.uspreventiveservicestaskforce.org/uspstf/uspscolo.htm. Accessed June 01, 2015. The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults age 50-75. The USPSTF recommends against routine screening for colorectal cancer in adults age 76-85, although there may be considerations that support screening in an individual patient. The USPSTF recommends against screening in adults older than 85 years. The USPSTF concludes that evidence is insufficient to assess the benefits and harms of computed tomographic colonography and fecal DNA testing as screening modalities for colorectal cancer. Modeling suggests equal effectiveness of three regimens: annual high sensitivity FOBT, sigmoidoscopy every five years plus high sensitivity FOBT every three years, and colonoscopy every ten years.

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50. Centers for Disease Control and Prevention. Prevention and control of influenza with vaccines. Recommendations of the Advisory Committee on Immunizations Practice 2014-2015. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6332a3.htm. Accessed June 01, 2015. Routine annual influenza vaccination of all persons aged ≥6 months continues to be recommended. No preferential recommendation is made for one influenza vaccine product over another for persons for whom more than one product is otherwise appropriate.

51. U. S. Preventive Services Task Force. Aspirin for the primary prevention of cardiovascular disease March 2009. Available at: http://www.uspreventiveservicestaskforce.org/uspstf/uspsasmi.htm. Accessed June 01, 2015. The USPSTF recommends the use of aspirin for men age 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in GI hemorrhage. The USPSTF recommends the use of aspirin for women age 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm due to an increase in GI hemorrhage. The USPSTF concludes that evidence is insufficient to assess the balance of benefits and harms of aspirin for cardiovascular disease prevention in men and woman age 80 or older. The USPSTF recommends against the use of aspirin for stroke prevention in women younger than 55 years and for myocardial infarction prevention in men younger than 45 years.

52. U.S. Preventive Services Task Force. Folic acid to prevent neural tube defects May 2009. Available at: http://www.uspreventiveservicestaskforce.org/uspstf/uspsnrfol.htm. Accessed June 01, 2015. The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 (400 to 800 µg) of folic acid.

53. U.S. Preventive Services Task Force. Medications for risk reduction of primary breast cancer in women September 2013. Available at: http://www.uspreventiveservicestaskforce.org/uspstf/uspsbrpv.htm. Accessed June 01, 2015. The USPSTF recommends that clinicians engage in shared, informed decision making with women who are at increased risk for breast cancer about medications to reduce their risk. For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications.


Divisions of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association 34
- Physical inactivity
- First-degree relative with diabetes
- High-risk race/ethnicity (e.g., African American, Latino, Native American, Asian American, Pacific Islander)
- Women who deliver a baby weighing >9lb or were diagnosed with GDM
- Hypertension (≥140/90 mmHg or on therapy for hypertension)
- HDL cholesterol level <35mg/dL (0.90 mmol/L) and/or a triglyceride level >250 mg/dL (2.82 mmol/L)
- Women with polycystic ovary syndrome
- A1c ≥5.7IGT or IFG on previous testing
- Other clinical conditions associated with insulin resistance (e.g., severe obesity, acanthosis nigricans)
- History of CVD

In the absence of the above criteria, testing for diabetes should begin at age 45 years. If results are normal, testing should be repeated at least at 3 year intervals, with consideration of more frequent testing depending on initial results (e.g. those with prediabetes should be tested yearly) and risk status.

56. U.S. Preventive Services Task Force. Screening for human immunodeficiency virus infection. April 2013. Available at: http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm. Accessed April 29, 2015. The USPSTF recommends that clinicians screen for HIV infections in adolescents and adults aged 15 to 65 years. Younger adolescents and older adults who are at risk should also be screened. The USPSTF recommends that clinicians screen all pregnant women for HIV. The evidence is insufficient to determine optimum time intervals for HIV screening.


59. U.S. Preventive Services Task Force. Screening for intimate partner violence and abuse of elderly and vulnerable adults. January 2013. Available at: http://www.uspreventiveservicestaskforce.org/uspstf/uspsipv.htm. Accessed June 01, 2015. The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening all elderly or vulnerable adults (physically or mentally dysfunctional) for abuse and neglect.

60. U.S. Preventive Services Task Force. Screening for osteoporosis January 2011. Available at: http://www.uspreventiveservicestaskforce.org/uspstf10/osteoporosis/osteurs.htm. Accessed June 01, 2015. The USPSTF recommends screening for osteoporosis in women aged 65 years or older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors. The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for osteoporosis in men.


and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.

70. American Heart Association. American College of Cardiology/American Heart Association Task Force on Practice 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk: A report of The American College of Cardiology/American Heart Association task force on practice guidelines. Available at: \Rchcls1hcmdata\hcmdata\QIP\Wellness Guidelines\Wellness Guidelines 2015 - 2016\Resources 2015\S49.full.pdf Accessed June 24, 2015. The AHA recommends it is reasonable to assess traditional ASCVD risk factors every 4 to 6 years in adults 20 to 79 year of age who are free from ASCVD and estimate 10-year ASCVD risk every 4 to 6 years in adults 40 to 79 years of age who are free from ASCVD. The race- and sex-specific Pooled Cohort Equations to predict 10-year risk for a first hard ASCVD* event should be used in nonHispanic African Americans and nonHispanic Whites, 40 to 79 years of age.