Medi-Cal Rx

2026 Immunization Update: COVID-19, Influenza, RSV, and HPV

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Disclaimer: This article was published by the Medi-Cal Drug Use Review (DUR) Program and is not an official Department of Health Care Services (DHCS) policy.

Each year, the California Medi-Cal DUR Program issues an annual summary of updates on immunization guidelines, products, and/or research in collaboration with the California Department of Public Health (CDPH) Immunization Branch. This summary includes any significant updates since the 2025 Immunization Update was published on May 4, 2026.

Learning Objectives

- Discuss populations at high risk for severe outcomes from the three major respiratory viruses that co-circulate each year: SARS-CoV-2, influenza virus, and respiratory syncytial virus (RSV).
- Review the recommendations for COVID-19, influenza, and RSV vaccination.
- Analyze trends regarding recommended vaccinations for adolescents, including the human papillomavirus (HPV) vaccine.

General Recommendations

CDPH and the West Coast Health Alliance (WCHA) continue to recommend vaccination for children and adolescents in alignment with the American Academy of Pediatrics (AAP) as detailed in the Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger and for adults in accordance with immunization guidance from the American Academy of Family Physicians (AAFP) as detailed in the Recommended Adult Immunization Schedule for Ages 19 Years or Older. All vaccines recommended by CDPH continue to be covered by health insurance, including Medi-Cal.

COVID-19 Vaccine

On September 4, 2026, CDPH and WCHA issued the Consensus WCHA 2026-2027 Respiratory Virus Season Immunization Recommendations. These recommendations reflect seasonal vaccination guidance for COVID-19, influenza, and RSV from leading national medical organizations, including the AAP, AAFP, and the American College of Obstetricians and Gynecologists (ACOG). CDPH and WCHA recommend COVID-19 vaccination for individuals at increased risk of severe disease and support access to vaccination for everyone 6 months of age or older who chooses to be vaccinated. Vaccination is particularly recommended for infants and toddlers, adults 65 years of age or older, pregnant individuals, people with underlying risk factors for severe COVID-19, and individuals who are immunocompromised.

Individuals who are in close contact with people at increased risk, including healthcare workers, are also encouraged to receive vaccination. COVID-19 remains a public health concern, causing millions of illnesses, hundreds of thousands of hospitalizations, and tens of thousands of deaths annually in the United States. Vaccination continues to reduce the risk of severe outcomes, including hospitalization, intensive care unit admission, and death.

The COVID-19 vaccines available for the 2026 – 2027 season are monovalent and based on the SARS-CoV-2 JN.1 lineage, targeting the XFG variant, as recommended by the U.S. Food and Drug Administration (FDA) to more closely match circulating SARS-CoV-2 variants. For storage and administration information, refer to the COVID-19 Vaccine Product Guide.

Adults 65 years of age or older are recommended to receive two doses of the 2026 – 2027 COVID-19 vaccine 6 months apart, with a minimum interval of 2 months (3 months for Moderna mNEXSPIKE). Individuals who are moderately or severely immunocompromised may require multiple doses based on age and prior vaccination history, and additional doses may be administered under shared clinical decision-making. The COVID-19 Risk Factors List provides examples of conditions associated with increased risk. The COVID-19 Vaccine Timing Chart provides detailed schedules based on age, vaccination history, and immune status.

COVID-19 vaccination during pregnancy remains important for protecting both pregnant individuals and their infants. Infants younger than 6 months of age are not eligible for COVID-19 vaccination and are at increased risk of severe disease. CDC surveillance data have shown that COVID-19-associated hospitalization rates among infants younger than 6 months of age are higher than those of most other age groups, except adults 75 years of age or older. Among hospitalized infants, approximately 1 in 5 required intensive care. On June 10, 2026, ACOG released an updated Maternal Immunization Schedule and Maternal Immunizations Committee Statement recommending COVID-19 vaccination during pregnancy. Pregnancy is associated with an increased risk of severe illness from COVID-19, and vaccination reduces the risk of severe disease and hospitalization. Vaccination during pregnancy also generates maternal antibodies that cross the placenta and can protect infants during the first months of life when they are not yet eligible for COVID-19 vaccination.

Additional resources and information about COVID-19 vaccines, including a communications toolkit for providers, are available on the COVID-19 Vaccine page of the CDPH website. The Public Health for All Californians Together (PHACT) Coalition also developed the following messaging guide to help providers during the respiratory virus season: California Respiratory Virus Season Vaccine Messaging for Community Partners and Public Health Messengers.

Influenza Vaccine

Routine annual influenza vaccination is recommended for all individuals 6 months of age or older without contraindications. Seasonal influenza vaccines remain trivalent, containing two influenza A viruses (H1N1 and H3N2) and one influenza B virus (Victoria lineage).

For the 2026 – 2027 season, available influenza vaccines include inactivated influenza vaccine (IIV3), recombinant influenza vaccine (RIV3), live attenuated influenza vaccine (LAIV3), and, for the first time, an mRNA influenza vaccine for adults 50 years of age or older.

U.S. egg-based IIV3 and LAIV3 vaccines contain hemagglutinin (HA) derived from the following strains:

- A/Missouri/11/2025 (H1N1) pdm09-like virus (different strain from last season)
- A/Darwin/1454/2025 (H3N2)-like virus (different strain from last season)
- B/Tokyo/EIS13-175/2025 (Victoria lineage)-like virus (different strain from last season)

U.S. cell culture-based inactivated (ccIIV3) and RIV3 vaccines contain HA derived from:

- A/Missouri/11/2025 (H1N1) pdm09-like virus (different strain from last season)
- A/Darwin/1415/2025 (H3N2)-like virus (different strain from last season)
- B/Pennsylvania/14/2025 (Victoria lineage)-like virus (different strain from last season)

The FDA approved mFLUSIVA (mRNA-1010; Moderna) on August 5, 2026, as the first mRNA-based seasonal influenza vaccine licensed in the United States. Currently, mFLUSIVA is indicated for adults 50 years of age or older. mFLUSIVA is produced using mRNA technology and does not contain egg protein, antibiotics, or preservatives. It contains three mRNAs encoding the HA glycoproteins of:

- A/Missouri/11/2025 (H1N1) pdm09-like virus
- A/Michigan/105/2025, an A/Darwin/1415/2025 (H3N2)-like virus
- B/Pennsylvania/19/2025, a B/Pennsylvania/14/2025 (Victoria lineage)-like virus

Adults 65 years of age or older should preferentially receive high-dose inactivated (HD-IIV3), recombinant (RIV3), adjuvanted inactivated (aIIV3), or mRNA influenza vaccine. If none of these vaccines are available at the time of vaccination, any other age-appropriate influenza vaccine may be administered. Solid organ transplant recipients 18 through 64 years of age receiving immunosuppressive therapy may receive HD-IIV3 or aIIV3 as acceptable options, without preference over other age-appropriate IIV3 or RIV3 products.

Influenza vaccination is also recommended during any trimester of pregnancy. Vaccination during pregnancy protects both the pregnant individual and the newborn through transplacental antibody transfer, providing protection during the first months of life before infants are eligible for influenza vaccination. The ACOG Maternal Immunization Schedule and Maternal Immunizations Committee Statement recommends that individuals who are or will be pregnant during influenza season receive an age-appropriate inactivated or recombinant influenza vaccine during any trimester. Influenza vaccination should ideally be administered before the start of the influenza season, although vaccination at any time during the influenza season is encouraged. ACOG's Influenza in Pregnancy: Prevention and Treatment Practice Advisory provides additional information regarding the safety and efficacy of influenza vaccination during pregnancy and the benefits of passive protection for newborns.

The AAP also continues to recommend annual influenza vaccination for all children 6 months of age or older who have no contraindications. Children 6 months through 8 years of age who are receiving the influenza vaccine for the first time, who have received only one previous dose before July 1, 2026, or whose vaccination history is unknown, should receive two doses of influenza vaccine administered at least 4 weeks apart, ideally completing both doses by the end of October. Children in this age group who have previously received at least two doses of

influenza vaccine at least 4 weeks apart before July 1, 2026, require only one dose for the 2026 – 2027 season. For additional guidance, including recommendations for children at high risk for influenza complications, providers may refer to the Recommendations for Prevention and Control of Influenza in Children, 2026–2027: Policy Statement, published by AAP on August 10, 2026.

To improve influenza vaccination rates among children and adolescents, providers may refer to resources from the CDPH Immunization Branch, including Tips for Speaking with Parents about Flu Vaccine and additional influenza resources available through the California Vaccines for Children (VFC) Program.

RSV Vaccine

RSV is a significant cause of respiratory illness and hospitalization, particularly among infants, older adults, and individuals with certain underlying medical conditions. RSV activity typically increases during the fall and winter months in the United States. RSV immunization strategies include vaccination of eligible adults, maternal vaccination during pregnancy, and administration of long-acting monoclonal antibodies to eligible infants and young children.

For the 2026 – 2027 respiratory virus season, CDPH and WCHA recommend RSV vaccination for all adults 75 years of age or older and for adults 50 through 74 years of age who are at increased risk of severe RSV disease. Conditions and other factors that increase the risk of severe RSV illness include:

- Chronic heart or lung disease
- Immunocompromising conditions
- Certain other underlying medical conditions
- Frailty
- Residence in a nursing home or other long-term care facility

For a complete list of medical conditions that increase the risk of severe RSV, providers may refer to the Clinical Overview of RSV on the CDC website.

Three RSV vaccines are available for adults: GSK's Arexvy, Pfizer's Abrysvo, and Moderna's mRESVIA. There is no preferential recommendation among the available products. RSV vaccination may be administered at any time of year but is ideally given in late summer or early fall, before the onset of the RSV season. RSV vaccination is currently recommended as a single dose rather than annually, and individuals who have already received an RSV vaccine are not recommended to receive an additional dose at this time.

To protect infants from severe RSV disease, CDPH and WCHA recommend either maternal RSV vaccination with Abrysvo during weeks 32 through 36 of pregnancy, from September 1 to March 1 (the season is now extended compared to 2025 – 2026), or administration of a long-acting RSV monoclonal antibody to the infant from October 1 to March 31. RSV monoclonal antibody options for infants younger than 8 months of age include nirsevimab or clesrovimab. Nirsevimab is also recommended for certain children 8 through 19 months of age who are at increased risk of severe RSV disease as they enter their second RSV season. Most infants do not need both maternal

vaccination and an RSV monoclonal antibody; however, many birthing facilities do not consistently provide monoclonal antibodies to newborns, so maternal vaccination may be key for RSV protection at birth.

On September 2, 2026, the AAP published its Recommendations for the Prevention of Respiratory Syncytial Virus Disease in Infants and Children: Policy Statement, which reviews evidence and expands eligibility for nirsevimab among children 8 through 19 months of age who are at increased risk of severe RSV disease as they enter their second RSV season. Groups eligible for nirsevimab in their second RSV season now include children:

- Who are American Indian or Alaska Native;
- Who are born preterm (<32 weeks);
- With Down syndrome or other chromosomal differences that place them at higher risk of severe disease;
- Who are severely immunocompromised;
- With anatomic pulmonary abnormalities or neuromuscular disorders;
- With hemodynamically significant congenital heart disease;
- With cystic fibrosis and either manifestations of severe lung diseases or weight-for-length <10th percentile; or
- With chronic lung disease due to prematurity or other neonatal conditions who required medical support during the 6 months prior to RSV season.

For more information about the timing and administration of clesrovimab and nirsevimab, providers can refer to the RSV Immunization Guide for Infants and Toddlers, developed by CDPH. Additional resources and information about RSV, including a communications toolkit for providers, are available on the RSV (Respiratory Syncytial Virus) page on the CDPH website.

HPV Vaccine

HPV is a common viral infection associated with multiple cancers, including cervical, anal, oropharyngeal, and other anogenital cancers, as well as genital warts. Vaccination is a highly effective strategy for preventing HPV-related cancers and diseases, and CDPH, WCHA, and AAP continue to recommend routine HPV vaccination for adolescents 11 or 12 years of age. However, vaccination can begin as early as 9 years of age. HPV vaccination is also recommended for all individuals 26 years of age or younger who have not previously been vaccinated. For adults 27 to 45 years of age who are not adequately vaccinated, HPV vaccination may be considered through shared clinical decision-making.

For individuals initiating vaccination before 15 years of age, a 2-dose series is recommended, with the second dose administered 6 to 12 months after the first. For those initiating vaccination at 15 years of age or older, or for immunocompromised individuals 9 through 26 years of age, a three-dose series is recommended, with the second dose administered 1 to 2 months after the first and the third 6 months after the first. Completion of the full vaccine series is necessary to achieve optimal protection.

Newly published national data show gaps in HPV vaccination rates and underscore the need for continued efforts to improve HPV vaccination rates among adolescents. In 2025, among adolescents 13 to 17 years of age, 77.7% had received at least one dose of the HPV vaccine, but only 63.4% were up to date with the recommended HPV vaccination series. HPV vaccination coverage has not increased for four consecutive years and continues to lag behind coverage for other routinely recommended adolescent vaccines, including tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine (Tdap; 88.8%) and quadrivalent meningococcal conjugate vaccine (MenACWY; 89.0%).

Coverage was particularly low among younger adolescents, with fewer than half of 13-year-olds up to date with HPV vaccination. Substantial geographic disparities also persist, with adolescents in rural areas having lower rates of HPV vaccine initiation and series completion than those in urban areas. Notably, rural–urban disparities in HPV vaccination were observed across poverty levels, whereas similar disparities in MenACWY vaccination were limited to adolescents living below the poverty level. This difference suggests that barriers to HPV vaccination extend beyond geographic access and socioeconomic factors alone. HPV vaccination coverage also varied considerably across U.S. regions, states, selected local areas, and territories. In comparison, geographic variation was substantially lower for Tdap and MenACWY vaccination, highlighting persistent disparities specific to HPV vaccine uptake.

Similar findings were observed in a report on HPV vaccination data in California in 2023. In 2023, 13-year-olds in rural California counties had lower HPV vaccine initiation (60%) and series completion rates (36%) than 13-year-olds in urban counties (65% and 44%, respectively). The report also found that California adolescents who initiated the HPV vaccine at 9 years of age had higher series completion rates (91%) than those who initiated at older ages (ranging from 89% to 63%).

These findings highlight an important opportunity for providers to improve HPV vaccination coverage. Because adolescents routinely present for other recommended vaccines, including Tdap and MenACWY, every vaccination visit should be used to assess HPV vaccination status and administer the HPV vaccine when due. A strong, routine recommendation from a healthcare provider, with HPV vaccination presented alongside other recommended adolescent vaccines, remains an important strategy for increasing vaccine uptake and preventing HPV-associated cancers.

For current HPV vaccine recommendations and provider resources, refer to the Human Papillomavirus (HPV) page on the CDPH website. Additional national data on adolescent vaccine uptake and disparities are available in the CDC's *Morbidity and Mortality Weekly Report (MMWR)*, Vaccination Coverage Among Adolescents Aged 13–17 Years — National Immunization Survey-Teen, United States, 2025.