Clinical Policy: Immunization Coverage

Reference Number: CP.PHAR.28
Effective Date: 10.01.08
Last Review Date: 05.26
Line of Business: Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Immunizations typically confer active immunity. Exposure to a killed or weakened form of the disease organism stimulates antibody production, allowing the body to more effectively resist or overcome infections caused by said organism. Immunization not only protects the person who receives the immunization, but also those who are not immunized with whom they are in contact.

FDA Approved Indication(s)

Immunizations are used to prevent a variety of infectious diseases. They should be started early and continued through the recommended schedule.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that childhood and adult immunizations are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Request for Childhood or Adult Immunization (must meet all)**:**

1. There exists no product-specific clinical policy or custom coverage criteria;
2. Requested immunization will be given in accordance with the recommendations made by the Advisory Committee on Immunization Practices (ACIP) (including the 2025 recommendations made prior to September 2025 that continue to be endorsed by national professional societies such as the American Academy of Pediatrics; *see Appendix D*)*;
   **Eligible immunizations covered under the Vaccines for Children (VFC) program should be provided by the VFC program (see Appendix D for examples)*
3. If request is for a single antigen which is recommended to be given in a combination vaccine (e.g., mumps, measles, rubella, diphtheria, tetanus, and pertussis), documentation supports medical necessity for administration of the single antigen.

Approval duration: Vaccine duration in accordance with ACIP recommendations

II. Continued Therapy: Not applicable

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Unless listed on the preferred drug list (PDL)*, immunizations recommended for travelers or military personnel are not covered, including but not limited to: adenovirus, anthrax, Japanese encephalitis, smallpox (vaccinia), typhoid, and yellow fever.

**Coverage for travel immunizations listed on state specific PDL are authorized*

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ACIP: Advisory Committee on Immunization Practices
FDA: Food and Drug Administration
PDL: preferred drug list
VFC: Vaccines for Children

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

Refer to each product's prescribing information.

Appendix D: General Information

- Current ACIP recommendations can be found at: https://www.cdc.gov/acip-recs/hcp/vaccine-specific/.
- A summary of the current recommended immunization schedules can be found at: https://www.cdc.gov/vaccines/hcp/imz-schedules/.
- The American Academy of Pediatrics recommended immunization schedule can be found at: http://aap.org/ImmunizationSchedule.
- The VFC program provides immunizations **at no cost** for members between the ages of 0-18 years. Additional information about the VFC program can be found at: http://www.cdc.gov/vaccines/programs/vfc/index.html.
  - Vaccine coverage through VFC program include, but are not limited to, the following:

Disease	Single-antigen or combination trade name
Chickenpox (varicella)	Varivax®, ProQuad®
COVID-19	Spikevax™, Comirnaty®
Dengue	Dengvaxia®
Diphtheria, pertussis, and tetanus	Daptacel®, Infanrix®, Quadracel®, Kinrix®, Pediarix®, Pentacel®, Vaxelis™
Haemophilus influenzae type b (Hib)	Pentacel®, Vaxelis™
Hepatitis A	Vaqta®, Havrix®, Twinrix®
Hepatitis B	Pediarix®, Twinrix®, Engerix B®, Recombivax HB®
Human papilloma virus (HPV)	Garvasil®9
Influenza	Fluzone®, Fluarix®, Flucelvax®, Afluria®, FluMist®
Meningococcal	Trumenba®, Bexsero®, MenQuadfi®, Menveo®
Measles, mumps, and rubella	M-M-R®, Priorix, ProQuad®
Mpox	Jynneos®
Polio	IPOL®, Quadracel™, Kinrix®, Pediarix®, Vaxelis™
Pneumococcal	Prevnar 13®, Vaxneuvance™, Prevnar 20®, Pneumovax®23

Disease	Single-antigen or combination trade name
Rotavirus	RotaTeq®, Rotarix®
Respiratory syncytial virus (RSV)	Beyfortus™(nirsevimab-alip)

V. Dosage and Administration

Not applicable

VI. Product Availability

Not applicable

VII. References

1. Advisory Committee on Immunization Practices (ACIP) vaccine recommendations. Centers for Disease Control and Prevention website. Available at: https://www.cdc.gov/acip-recs/hcp/vaccine-specific/. Accessed February 24, 2026.
2. Vaccine immunization schedules. Centers for Disease Control and Prevention website. Page last reviewed October 7, 2025. Available at: https://www.cdc.gov/vaccines/hcp/imz-schedules/. Accessed February 24, 2026.
3. Vaccines for Children (VFC) program. Centers for Disease Control and Prevention website. Page last reviewed September 30, 2025. Available at: http://www.cdc.gov/vaccines/programs/vfc/index.html. Accessed February 24, 2026.
4. Immunity types. Centers for Disease Control and Prevention website. Page last reviewed: July 30, 2024. Available at: https://www.cdc.gov/vaccines/basics/immunity-types.html. Accessed February 24, 2026.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
3Q 2022 annual review: no significant changes; references reviewed and updated.	05.11.22	08.22
3Q 2023 annual review: added to initial criteria that there exists no product-specific clinical policy or custom coverage criteria; references reviewed and updated.	05.30.23	08.23
Clarified initial criteria with asterisk to verify if vaccine is covered by VFC program; clarified approval duration for all vaccines is based on ACIP recommendations; in Section III, clarified vaccines listed in state PDL are authorized; references reviewed and updated.	10.26.23	
3Q 2024 annual review: no significant changes; references reviewed and updated.	06.20.24	08.24
3Q 2025 annual review: no significant changes; references reviewed and updated.	05.30.25	08.25
2Q 2026 annual review: clarified that the requested immunization may be given in accordance with recommendations made by ACIP in 2025 prior to September 2025; references reviewed and updated.	02.24.26	05.26

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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