FluMist Home: An Innovative Approach to Expanding Access to Influenza Vaccination – Allyn Bandell, PharmD, US Medical Lead–Influenza, AstraZeneca

Allyn Bandell, PharmD, described the data from the first year of FluMist Home, an integrated, comprehensive system supporting home vaccination with FLUMIST®.

VIEW SLIDES

AstraZeneca's intranasal vaccine, FLUMIST, is as effective as traditional vaccines and might be more acceptable to some children and adults. FluMist Home was piloted in the 2025–26 influenza season to assess whether a home-based strategy could increase vaccine uptake. Participants completed a online medical questionnaire (mirroring the Immune.org screening form) to determine their eligibility for FluMist Home, , and provided their insurance information for verification; the whole process takes about 5–7 minutes. Requests are reviewed by a health care professional—most of whom are U.S. pharmacists. Vaccine packages included internal temperature monitors and were delivered using validated cold chain methods with 2 day delivery. Upon user confirmation vaccination online, the data were reported to an immunization registry. About 90% of users gave contact information for their primary care provider so that their medical records could be kept up to date. This year, FluMist Home expands to all 48 contiguous U.S. states and the District of Columbia.

In its first year, nearly equal percentages of children and their parents or caregivers took FLUMIST through FluMist Home. In contrast, in health clinics, pediatricians' offices, and retail pharmacies, about 97% of FLUMIST doses go to children. In 46% of cases in which a child got FLUMIST, a parent or caregiver in the household also got a dose. Only 10% of children in the FluMist Home program were ages 2–4 years old, because most young children are vaccinated by a primary care provider. The other 90% of children (ages 5–17 years) are typically harder to reach. A total of 25% of pediatric participants were teenagers, a

group that has the lowest pediatric vaccination rates. Patient satisfaction with the ordering experience, delivery, and perceived ease of administration were all very high, according to customer surveys.

Commercial insurance covered 86% of orders through real-time insurance verification. In all, 95% of deliveries were on time (within 2 days). In 98% of cases, the temperature tag verified that the cold chain was maintained. Only about 2% of patient calls about FLUMIST involved clinical questions for a pharmacist. A CDC-funded study modeling the impact of home-administered FluMist predicts that using this method to increase vaccination uptake by as little as 5% could result in less influenza among children and adults.. AstraZeneca is increasing awareness about FluMist Home by expanding patient and provider education, including social media.

mFLUSIVA (Influenza Vaccine, mRNA): Summary of the U.S. Prescribing Information – Wendy Sohn, Executive Director, Moderna

Wendy Sohn summarized the clinical research findings supporting Moderna's new mRNA influenza vaccine, mFLUSIVA.

The effectiveness of influenza vaccination in any given year is affected by antigenic drift and egg-adapted mutations. The Food and Drug Administration recently approved Moderna's mRNA influenza vaccine for people ages 50 years and older, with accelerated approval for people over 65 years, for the 2026–27 influenza season. It contains three antigen strains, no egg products, and no preservatives.

In a randomized controlled trial of about 3,000 people ages 65 years and older, mFLUSIVA resulted in a higher immune response than high-dose quadrivalent influenza vaccine. A large, phase III randomized, controlled trial of 40,000 adults ages 50 years and older compared mFLUSIVA with standard-dose influenza vaccine in the United States and 10 other countries during the 2024–25 influenza season. It found that mFLUSIVA had higher relative vaccine efficacy (rVE) than the standard-dose influenza vaccine and in fact met the criteria for higher superiority. Moreover, in participants ages 65 years and older, rVE was even higher. There were no significant differences related to participant's influenza vaccine status in the prior season. In addition, mFLUSIVA performed well in terms of safety and reactogenicity.

Exploratory analysis of vaccine effectiveness in relation to cases of influenza-like illness that required a health care encounter (i.e., more severe cases) similarly found that mFLUSIVA was superior to standard-dose vaccine. Analysis of a subset of 6,000 patients from the phase III trial showed that people who received mFLUSIVA reported more local and systemic adverse reactions within 7 days of injection than those who had standard-dose vaccines. The most frequent reactions were consistent with expectations (pain, swelling, fatigue, headache, myalgia, etc.) and were grade 1 or 2 in severity. Notably, local and systemic adverse events were lower among older study participants. In terms of overall safety, Moderna found no difference between mFLUSIVA and the control group across any of the studies.

Health Care Provider & Caregiver Perspectives on the 2026 CDC Pediatric Influenza Vaccination Schedule Update – Andrew Rennekamp, PhD, Senior Manager, U.S. Customer Marketing, CSL Seqirus

Andrew Rennekamp, PhD, highlighted the results of a survey about CDC's shift to recommending shared decision-making about the influenza vaccine instead of a universal recommendation.

The flu vaccine manufacturer CSL Seqirus commissioned HawkPartners to conduct two separate 10-minute online surveys in February 2026: one with health care providers and one with caregivers. Eligible providers were board-certified or board-eligible physicians who spent at least 60% of their time in clinical practice and administered influenza vaccine to at least 50 pediatric patients ages 6 months to 17 years. Caregivers had to have a child between the ages of 6 months and 17 years who had received at least one influenza vaccine in the past 3 years; caregivers whose children had been vaccinated after the January 2026 CDC update and consistent non-vaccinators were excluded.

Pediatricians in particular (84%) and primary care providers (PCPs, 47%) had negative reactions to the CDC change. About 6% of pediatricians and more than a quarter of other PCPs had a positive reaction. Respondents said, for example, that the change represented a symbolic downgrade not tied to evidence. They worried that it could fuel vaccine hesitancy, signal that the flu vaccine is less important, reduce uptake, and lead to worse outcomes. As a result of the change, 79% of pediatricians and 59% of the other PCPs planned to rely more heavily on medical associations' guidance. Most physicians said they either would not change their own recommendations or might even increase the strength of their recommendations. About 40% said they planned to increase their deference to parents, while 24% expected to defer less to parents—countering the goal of shared clinical decision-making.

Few caregivers were familiar with the change, but once it was described to them, the majority (51%) reacted positively. In all, 93% said the change would either have no impact on their intention to vaccinate their children or would make them more likely to do so. Among caregivers whose children had been vaccinated at least once in the past 3 years but not consistently for all 3 years, 56% said they were more likely to vaccinate following the CDC change. A total of 63% said their health care provider is already their main resource for decision-making about vaccination, and 72% said they would rely on or defer to their provider even more in the future. More than half of caregivers still expect their child's health care provider to make a definitive recommendation. Although the largest single response in both provider groups was no change in ordering, 52% of pediatricians and 39% of other PCPs expected to decrease orders for the upcoming season—largely based on perceptions of consumer intent that did not align with caregivers' stated responses.

QUESTIONS & ANSWERS

Q: How does the reimbursement cost work if someone gets FLUMIST for a child at the pharmacy? The assumption is that there is zero cost, but do they need a prescription, or some other documentation about who the vaccine is for?

Allyn Bandell (AstraZeneca): At a retail setting, in many states, pharmacists would do the evaluation and write the prescription, or use a protocol to generate the prescription, and administer it at the site. They then document it in the state IIS [immunization information system], generally through STC Health or another consolidator of that medical record, and it's covered by their insurance.

Q: Can you share the efficacy of last year's vaccine formulation? Were there any studies comparing the efficacy of at-home versus in-office FLUMIST administration?

Allyn Bandell (AstraZeneca): For the 2025–26 season, there really isn't enough product in the marketplace to do that comparison—you'd need volumes in the millions of doses, and we're not there yet with the home-administered product, though it's obviously expanding. I do know that California captured some home-administered doses in their vaccine effectiveness study; they have different CVX codes, so you can differentiate whether a dose was health–care- or home-administered. We're looking forward to seeing more of that data.

Q: How does FluMist Home ensure that a VIS [vaccine information statement] is provided?

Allyn Bandell (AstraZeneca): There are two ways the VIS is provided—this is a federally regulated requirement. It's provided via a link, but recipients also receive a hard copy in the mail. We're working on changing that; everything else in this process is electronic, and these are digitally savvy customers. There may be a way for us [AstraZeneca] to require them to click a specific link to view the VIS rather than sending it in the mail with the product, but currently they're exposed to it multiple ways.

Q: What's the cost comparison and reimbursement for mFLUSIVA versus other influenza vaccines?

Wendy Sohn (Moderna): That's a great question, and a complicated one, because we're the first vaccine that will be licensed and made available outside of a formal ACIP [Advisory Committee on Immunization Practices] process, which would normally have addressed all these questions. This is a Part B influenza vaccine, so it will be reimbursed for the 65-and-above population through Medicare, and we're also working with payers for the 50–64 year-old population to get the vaccine reimbursed—we're making good progress there.

On pharmacy scope of practice: you mentioned the VIS. It was updated a few years ago, we haven't seen an update since, and we don't know if there will be a new one—and this is a new vaccine arriving in the middle of all that. However, we're very confident reimbursement

will proceed, even without an ACIP/CDC recommendation, and the vaccine will still be made available through all channels (e.g., retail, nursing homes, integrated delivery networks).

On pricing, I'm not the right person to address that. We have done a lot of work on cost-effectiveness. There are papers coming out, and we'll soon be publishing a public health impact paper. It will reflect a value-derived price, positioned within the more enhanced category for the 65-and-above population, because that's where we feel the vaccine benefits people most.

Q: Are you planning a second-generation mRNA vaccine that includes NA (neuraminidase)?

Wendy Sohn (Moderna): Short answer: it's in discussion with our R&D [research and development] teams. It's not an immediate deliverable, but we are looking at a future next-generation mRNA influenza vaccine that brings in the NA component. It would be nice to see whether there's improvement [in efficacy] beyond the current HA [hemagglutinin]-only mRNA vaccine. It's feasible with our technology and platform, so we're working on it.

Q: We've seen data on cross-coverage of antigenically drifted viruses with some influenza vaccines. Does Moderna have data on that kind of improvement for your vaccine, mFLUSIVA?

Wendy Sohn (Moderna): The 26.6% rVE figure versus standard dose includes all influenza type A and type B strains, not only well-matched ones. Breaking it down: we saw about 29% for H1N1, around 22% for H3N2, and around 29% for the B strain—and those numbers include strains that were not matched to the vaccine formulation. We've also looked at efficacy for only the fully matched strains, and it's a bit higher.

I'd note that in the season we studied, 2024–25, there was significant drift in H3N2; about 45% of circulating strains didn't match the vaccine formulation, and we still showed an rVE of 222% for H3N2 regardless of match over standard dose. With A/H3N2 Antigenic Match the point estimate increased from 22.2% to 30.5%, suggesting that a better match may improve efficacy. We did presented [these findings] to the Vaccine and Related Biological Products Advisory Committee (VRBPAC,

Q: Are you going to disseminate these data [from the CSL Seqirus surveys] more widely, through publication or other forms?

Andrew Rennekamp (CSL Seqirus): This was market research we did internally with an external partner. We don't have a plan to disseminate it more broadly beyond sharing with our partners, as we've done with you all today. If there are specific people you think would be interested, I'm happy to connect and share it directly, but we don't have plans for broader publication. That's generally not something we do with these internal market research projects.

L.J. Tan (NAIIS): The dichotomy you pointed out is obviously interesting for messaging purposes. If you need that data, please contact NAIIS or Dr. Rennekamp directly to make the connection. There was one final question submitted, and we don't have an answer to it: how are ACIP recommendations being determined this year? That's a big question. We don't know if ACIP is even meeting, and if they are, we don't know how they'll be handling recommendations. Stay tuned; we'll hopefully have an answer at some point.

Announcements

- The meeting schedule for this summer is as follows:
    - September 3: CDC Respiratory Virus and Epidemiology Surveillance Updates
- NAIIS Workgroups have resumed regular meetings. Email info@izsummitpartners.org to be added to meeting invites and email threads.
    - Billing and Coding: Meets on the third Monday of the month at 1 pm ET
    - Operationalizing Adult Immunization: Meets on the second Wednesday of the month at 1 pm ET
    - Sustaining Community-Based Organizations: Meets on the first Wednesday of the month at 1 pm ET
    - A survey went out recently to determine the meeting schedule for the new Workplace Workgroup.
- Summit partners are invited to submit events and information for a public resource, the Summit Resource Calendar (via email to info@izsummitpartners.org). Examples include time-bound information such as back-to-school events, fall vaccine news, and seasonal activities.