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## **Policy Statement Modified Recommendations for Use of Palivizumab for Prevention of Respiratory Syncytial Virus Infections**

COMMITTEE ON INFECTIOUS DISEASES

*Pediatrics* published online Sep 7, 2009;

DOI: 10.1542/peds.2009-2345

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# Policy Statement—Modified Recommendations for Use of Palivizumab for Prevention of Respiratory Syncytial Virus Infections

COMMITTEE ON INFECTIOUS DISEASES

## KEY WORDS

RSV bronchiolitis, palivizumab, immunoprophylaxis

## ABBREVIATIONS

CDC—Centers for Disease Control and Prevention

RSV—respiratory syncytial virus

CHD—congenital heart disease

CLD—chronic lung disease of prematurity

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[www.pediatrics.org/cgi/doi/10.1542/peds.2009-2345](http://www.pediatrics.org/cgi/doi/10.1542/peds.2009-2345)

doi:10.1542/peds.2009-2345

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PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

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## abstract

Palivizumab was licensed in June 1998 by the US Food and Drug Administration for prevention of serious lower respiratory tract disease caused by respiratory syncytial virus (RSV) in pediatric patients who are at increased risk of severe disease. Safety and efficacy have been established for infants born at or before 35 weeks' gestation with or without chronic lung disease of prematurity and for infants and children with hemodynamically significant heart disease. The American Academy of Pediatrics (AAP) published a policy statement on the use of palivizumab in November 1998 (American Academy of Pediatrics, Committee on Infectious Diseases and Committee on Fetus and Newborn. *Pediatrics*. 1998;102[5]:1211–1216) and revised it in December 2003 (American Academy of Pediatrics, Committee on Infectious Diseases and Committee on Fetus and Newborn. *Pediatrics*. 2003;112[6 pt 1]:1442–1446), and an AAP technical report on palivizumab was published in 2003 (Meissner HC, Long SS; American Academy of Pediatrics, Committee on Infectious Diseases and Committee on Fetus and Newborn. *Pediatrics*. 2003;112[6 pt 1]:1447–1452). On the basis of the availability of additional data regarding seasonality of RSV disease as well as the limitations in available data on risk factors for identifying children who are at increased risk of serious RSV lower respiratory tract disease, AAP recommendations for immunoprophylaxis have been updated in an effort to ensure optimal balance of benefit and cost from this expensive intervention. This statement updates and replaces the 2003 AAP statement and the 2006 *Red Book* and is consistent with the 2009 *Red Book* recommendations. *Pediatrics* 2009;124:000

## SUMMARY

1. Recommendations for initiation and termination of prophylaxis are modified to reflect current descriptions from the Centers for Disease Control and Prevention (CDC) of respiratory syncytial virus (RSV) seasonality in different geographic locations within the United States.
2. The recommendations remain unchanged for infants with congenital heart disease (CHD), chronic lung disease of prematurity (CLD [formerly called bronchopulmonary dysplasia]), and birth before 32 weeks' 0 days' gestation.
3. Regardless of the month in which the first dose is administered, the recommendation for a maximal number of 5 doses for all geo-

graphic locations is emphasized for infants with hemodynamically significant CHD, CLD, or birth before 32 weeks' 0 days' gestation. A maximal number of 3 doses is recommended for infants with a gestational age of 32 weeks 0 days to 34 weeks 6 days without hemodynamically significant CHD or CLD who qualify for prophylaxis.

4. Because of inconsistencies among studies that attempted to define risk factors identifying children at greatest risk of serious RSV lower respiratory tract disease, the new recommendations were designed to target children at the highest risk of severe disease with risk factors that are most consistent and predictive. Risk factors for severe disease among infants born between 32 weeks' 0 days' and 34 weeks' 6 days' gestation have been modified to include only:
  - a. infant attends child care; or
  - b. 1 or more siblings or other children younger than 5 years live permanently in the child's household.
5. Infants with a gestational age of 32 weeks 0 days through 34 weeks 6 days born within 3 months before the start of RSV season or at any time throughout the RSV season will qualify for prophylaxis under the new recommendations if they have at least 1 of these 2 risk factors. Previous recommendations required 2 of 5 risk factors.
6. Infants born from 32 weeks' 0 days' through 34 weeks' 6 days' gestation who qualify for prophylaxis under the new recommendations should receive prophylaxis only until they reach 90 days of age or a maximum of 3 doses (whichever comes first). This is a change from the previous recommendation for 5 months of prophylaxis.

7. The American Academy of Pediatrics definition of gestational age is used throughout this document. For example, 32 to 35 weeks' gestation is defined as 32 weeks 0 days through 34 weeks 6 days. The previous definition was 32 weeks 1 day through 35 weeks 0 days.

## BACKGROUND

RSV is an enveloped, nonsegmented, negative-strand RNA virus of the family *Paramyxoviridae*. The virus uses attachment (G) and fusion (F) surface glycoproteins that lack neuraminidase and hemagglutinin activities to infect cells. RSV causes acute upper respiratory tract infection in patients of all ages and is one of the most common diseases of childhood. Most infants are infected during their first year of life, with virtually all children having been infected at least once by their second birthday. A minority of patients experience lower respiratory tract disease, which occurs most commonly during the first infection. Characteristics that increase the risk of severe RSV lower respiratory tract illness are preterm birth; cyanotic or complicated CHD, especially conditions that cause pulmonary hypertension; and CLD. RSV bronchiolitis may be associated with short-term or long-term complications that include recurrent wheezing, reactive airway disease, and abnormalities in pulmonary function. Reinfection with RSV throughout life is common. RSV infection in older children and adults usually manifests as upper respiratory tract illness. More serious disease involving the lower respiratory tract may develop in older children and adults, especially immunocompromised patients and the elderly, particularly those with cardiopulmonary disease. RSV causes the hospitalization of approximately 57 500 children younger than 5 years annually and is estimated to account for 1 of every 334 hospitalizations in this age group each year.<sup>1</sup>

## Prevention of RSV Infections

Palivizumab is the only licensed product available for prevention of RSV lower respiratory tract disease in infants and children with CLD, with a history of preterm birth ( $\leq 35$  weeks' gestation), or with hemodynamically significant CHD. Palivizumab is a humanized murine monoclonal anti-F glycoprotein immunoglobulin with neutralizing and fusion inhibitory activity against RSV.<sup>2</sup> Palivizumab is administered intramuscularly at a dose of 15 mg/kg once every 30 days. An attempt should be made to maintain compliance with monthly administration. In some reports, palivizumab administration in a home-based program was shown to improve compliance and reduce children's risk of exposure to microbial pathogens compared with administration in office- or clinic-based settings.<sup>3</sup> Additional doses of palivizumab should not be given to any patient with a history of a severe allergic reaction after a previous dose. Palivizumab is not effective in the treatment of RSV disease and is not approved or recommended for this indication.

RSV immunoglobulin intravenous (RSV-IgIV), a hyperimmune, polyclonal globulin prepared from donors selected for high serum titers of RSV-neutralizing antibody, is no longer available.

## Clinical Studies of Efficacy of Palivizumab

The efficacy of palivizumab has been evaluated in 2 multicenter, placebo-controlled, randomized clinical trials, both of which used a primary end point of reduction in hospitalization attributable to RSV infection. The RSV-IMPact trial evaluated children 24 months of age or younger with CLD who required continuing medical therapy (supplemental oxygen, bronchodilator, or diuretic or corticosteroid therapy within the previous 6 months) and children

born at 35 weeks' gestation or less who were 6 months of age or younger at the start of the RSV season.<sup>4</sup> Prophylaxis resulted in a 55% overall decrease in the rate of RSV-related hospitalization (10.6% and 4.8% in recipients of placebo versus palivizumab, respectively [ $P < .001$ ]). A second study of infants and children with hemodynamically significant CHD demonstrated a 45% decrease in the rate of RSV-related hospitalization (9.7% and 5.3% in recipients of placebo versus palivizumab, respectively [ $P = .003$ ]).<sup>5</sup> Among different groups of infants at high risk, hospitalization rates attributable to RSV were reduced by 39% to 82%, relative to control groups.<sup>4,5</sup>

### Cost Considerations

Immunoprophylaxis with palivizumab is an effective, although costly, intervention. Optimal cost benefit from immunoprophylaxis is achieved during the peak outbreak months, in which most RSV hospitalizations occur. If prophylaxis is initiated after widespread RSV circulation has begun, infants at high risk may not receive the full benefit of protection. Conversely, early initiation or continuation of monthly immunoprophylaxis during months in which RSV is not circulating widely is not cost-effective and provides little benefit to the recipients.<sup>6</sup>

The primary benefit of immunoprophylaxis is a decrease in the rate of RSV-associated hospitalization. No prospective, randomized clinical trial has demonstrated a significant decrease in the rate of mortality attributable to RSV or in the rate of recurrent wheezing after RSV infection among infants who receive prophylaxis.<sup>7</sup> Economic analyses have failed to demonstrate overall savings in health care dollars because of the high cost if all infants who are at risk receive prophylaxis.<sup>8-14</sup>

### Initiation and Termination of Immunoprophylaxis

In the temperate climates of North America, peak RSV activity typically occurs between November and March, whereas in equatorial countries, RSV seasonality patterns vary and may occur throughout the year. The inevitability of the RSV season is predictable, but the severity of the season, the time of onset, the peak of activity, and end of the season cannot be predicted precisely. Substantial variation in the timing of community outbreaks of RSV disease from year to year exists within and between communities in the same year, even in the same region. These variations occur within the overall pattern of RSV outbreaks, usually beginning in November or December, peaking in January or February, and ending by the end of March or sometime in April. Communities in the southern United States, particularly some communities in the state of Florida, tend to experience the earliest onset of RSV activity. In recent years, the national median duration of the RSV season has been 17 weeks or less.<sup>15,16</sup> Results from clinical trials indicate that palivizumab trough serum concentrations greater than 30 days after the fifth dose will be well above the protective concentration for most infants, thus providing more than 20 weeks of protective serum antibody concentration. In the continental United States, a total of 5 monthly doses for infants and young children with CHD, CLD, or preterm birth before 32 weeks' gestation (31 weeks 6 days) will provide an optimal balance of benefit and cost, even with variation in the season's onset and end (AI; see Appendix).

For infants who qualify for 5 doses, initiation of immunoprophylaxis in November and continuation for a total of 5 monthly doses will provide protection into April and is recommended for most areas of the United States. If pro-

phylaxis is initiated in October, the fifth and final dose should be administered in February (BI).

Data from the CDC have identified variations in the onset and offset of the RSV season in the state of Florida that should affect the timing of palivizumab administration (CDC, unpublished data, 2008; and refs 16 and 17). Northwest Florida has an onset in mid-November, which is consistent with other areas of the United States. In north central and southwest Florida, the onset of RSV season typically is late September to early October. The RSV season in southeast Florida (Miami-Dade County) typically has its onset in July. Despite varied onsets, the RSV season is of equal duration in the different regions of Florida. Children who qualify for palivizumab prophylaxis for the entire RSV season (infants and children with CLD, CHD, or preterm birth born before 32 weeks' gestation) should receive palivizumab administration only during the 5 months after the onset of RSV season in their region (maximum of 5 doses), which should provide coverage during the peak of the season, when prophylaxis is most effective (Table 1) (BIII).

Specific groups of American Indian/Alaska Native children in certain geographic regions may experience more severe RSV disease and a longer RSV season. RSV hospitalizations for Navajo and White Mountain Apache infants and young children may be 2 to 3 times those of similarly aged children in the general US population.<sup>18</sup> How-

**TABLE 1** Palivizumab Prophylaxis for Infants and Young Children With CLD or CHD

Geographic Location	Earliest Date for Initiation of 5 Monthly Doses
Southeast Florida	Jul 1
North-central and southwest Florida	Sep 15
Most other areas of United States	Nov 1

**TABLE 2** Maximum Number of Monthly Doses of Palivizumab for RSV Prophylaxis

Infants Eligible for a Maximum of 5 Doses	Infants Eligible for a Maximum of 3 Doses
Infants with CLD, <24 mo of age, and require medical therapy	Premature infants with a gestational age of 32 wk 0 d to 34 wk 6 d with at least 1 risk factor and born 3 mo before or during RSV season
Infants with CHD, <24 mo of age, and require medical therapy	
Premature infants born at $\leq 31$ wk 6 d	
Certain infants with neuromuscular disease or congenital abnormalities of the airways	

ever, the timing and duration of the RSV season is similar to those in the remainder of the United States (November through March), so standard recommendations for infants and children with CHD, CLD, or preterm birth (before 32 weeks' gestation) still are appropriate. Alaska Native infants in southwestern Alaska experience not only higher RSV hospitalization rates but also a longer RSV season. Pediatricians in this area of Alaska may wish to use CDC-generated RSV hospitalization data to assist in determining the onset and offset of the RSV season for the appropriate timing of palivizumab administration<sup>19</sup> (BII).

Infants and children with CHD, CLD, or birth before 32 weeks' 0 days' gestation who initiate palivizumab prophylaxis after start of the RSV season will not require all 5 doses (Table 2) (AI).

### Eligibility Criteria for Prophylaxis of Infants and Young Children at High Risk

- Infants with CLD: Palivizumab prophylaxis may be considered for infants and children younger than 24 months with CLD who receive medical therapy (supplemental oxygen, bronchodilator, diuretic or chronic corticosteroid therapy) for CLD within 6 months before the start of the RSV season. These infants and young children should receive a maximum of 5 doses. Patients with the most severe CLD who continue to require medical therapy may benefit from prophylaxis during a second RSV season. Data are limited

regarding the effectiveness of palivizumab during the second year of life. Individual patients may benefit from decisions made in consultation with neonatologists, pediatric intensivists, pulmonologists, or infectious disease specialists (AI).

- Infants born before 32 weeks' gestation ( $\leq 31$  weeks 6 days): Infants in this category may benefit from RSV prophylaxis even if they do not have CLD. For these infants, major risk factors to consider include gestational age and chronologic age at the start of the RSV season. Infants born at 28 weeks' gestation or earlier may benefit from prophylaxis during the RSV season whenever that occurs during the first 12 months of life. Infants born at 29 to 32 weeks' gestation ( $\leq 31$  weeks 6 days) may benefit most from prophylaxis up to 6 months of age. However, once an infant qualifies for initiation of prophylaxis at the start of the RSV season, administration should continue throughout the season and not stop when the infant reaches either 6 or 12 months of age. A maximum of 5 monthly doses are recommended for infants in this category (AI).
- Infants born at 32 to less than 35 weeks' gestation (defined as 32 weeks 0 days through 34 weeks 6 days): Numerous factors have been proposed as increasing the risk of acquiring RSV infection among infants in this gestational-age group. Other factors have been associated with an increased risk of severe dis-

ease and hospitalization. Certain factors (CHD, prematurity, CLD) are well-established risk factors for hospitalization, because they consistently are present in various studies. In contrast, other reported risk factors either are found inconsistently, even in studies by the same authors, or increase the risk of hospitalization by a relatively small factor (less than twofold to threefold). A risk-scoring tool developed from a Canadian prospective study of infants born at 33 through 35 weeks' gestation revealed that multiple risk factors needed to be present before a significant increase in hospitalization risk was seen.<sup>20</sup> In addition, available data do not enable definition of a subgroup of infants who are at risk of prolonged hospitalization and admission to the ICU. Therefore, although current recommendations were designed to be consistent with the US Food and Drug Administration approval for marketing of palivizumab for the prevention of serious RSV lower respiratory track disease, they specifically target infants in this group with consistently identified risk factors for RSV hospitalization during the period of greatest risk, which is the first 3 months of life.<sup>21–28</sup> Palivizumab prophylaxis should be limited to infants in this group at greatest risk of hospitalization attributable to RSV, namely infants younger than 3 months of age at the start of the RSV season and infants born during the RSV season who are likely to have an increased risk of exposure to RSV. Epidemiologic data suggest that RSV infection is more likely to occur and more likely to lead to hospitalization for infants in this gestational-age group when at least 1 of the following 2 risk factors is present:

**TABLE 3** Maximum Number of Palivizumab Doses for RSV Prophylaxis of Preterm Infants Without CLD, Based on Birth Date, Gestational Age, and Presence of Risk Factors (Shown for Areas Beginning Prophylaxis on November 1st)

Month of Birth	Maximum No. of Doses for Season Beginning Nov 1		
	≤28 wk 6 d Gestation and <12 mo of Age at Start of Season	29 wk 0 d Through 31 wk 6 d Gestation and <6 mo of Age at Start of Season	32 wk 0 d Through 34 wk 6 d and With Risk Factor <sup>a</sup>
Nov 1–Mar 31 of previous RSV season	5 <sup>b</sup>	0 <sup>c</sup>	0 <sup>d</sup>
Apr	5	0 <sup>c</sup>	0 <sup>d</sup>
May	5	5	0 <sup>d</sup>
Jun	5	5	0 <sup>d</sup>
Jul	5	5	0 <sup>d</sup>
Aug	5	5	1 <sup>e</sup>
Sep	5	5	2 <sup>e</sup>
Oct	5	5	3 <sup>e</sup>
Nov	5	5	3 <sup>e</sup>
Dec	4	4	3 <sup>e</sup>
Jan	3	3	3 <sup>e</sup>
Feb	2	2	2 <sup>e</sup>
Mar	1	1	1 <sup>e</sup>

If the infant is discharged from the hospital during RSV season, fewer doses may be required.

<sup>a</sup> Risk factors: infant attends child care or has sibling younger than 5 years.

<sup>b</sup> Some of these infants may have received 1 or more doses of palivizumab in the previous RSV season if discharged from the hospital during that season; if so, they still qualify for up to 5 doses during their second RSV season.

<sup>c</sup> Zero doses because infant will be older than 6 months at the start of RSV season.

<sup>d</sup> Zero doses because infant will be older than 90 days of age at start of RSV season.

<sup>e</sup> On the basis of the age of patients at the time of discharge from the hospital, fewer doses may be required, because these infants will receive 1 dose every 30 days until the infant is 90 days of age.

- the infant attends child care, defined as a home or facility in which care is provided for any number of infants or toddlers in the child care facility; or
- 1 or more siblings or other children younger than 5 years live permanently in the same household.

Prophylaxis may be considered for infants from 32 through less than 35 weeks' gestation (defined as 32 weeks 0 days through 34 weeks 6 days) who are born less than 3 months before the onset or during the RSV season and for whom at least 1 of the 2 risk factors is present. Infants in this gestational-age category should receive prophylaxis only until they reach 3 months of age and should receive a maximum of 3 monthly doses; many will receive only 1 or 2 doses before they reach 3 months of age. Once an infant has passed 90 days of age, the risk of hospitalization attributable

to RSV lower respiratory tract disease is reduced. Administration of palivizumab is not recommended after 90 days of age (Tables 2 and 3) (BIII).

Infants, especially those at high risk, never should be exposed to tobacco smoke. Tobacco smoke is a known risk factor for many adverse health-related outcomes.<sup>29</sup> However, in published studies, passive household exposure to tobacco smoke has not been associated with an increased risk of RSV hospitalization on a consistent basis. Exposure to tobacco smoke must be controlled by families with infants, especially with infants who are at increased risk of RSV disease. Such preventive measures will be far less costly than palivizumab prophylaxis.

In contrast to the well-documented beneficial effect of breastfeeding against many viral illnesses, existing data are conflicting regarding the

specific protective effect of breastfeeding against RSV infection. Breastfeeding should be encouraged for all infants in accordance with recommendations of the American Academy of Pediatrics.<sup>30</sup> Infants at high risk should be kept away from crowds and from situations in which exposure to infected people cannot be controlled. Participation in group child care should be restricted during the RSV season for infants at high risk whenever feasible. Parents should be instructed on the importance of careful hand hygiene. In addition, all infants (beginning at 6 months of age) and their contacts (beginning when the child is born) should receive influenza vaccine as well as other recommended age-appropriate immunizations.

- Infants with congenital abnormalities of the airway or neuromuscular disease: Immunoprophylaxis may be considered for infants who have either significant congenital abnormalities of the airway or a neuromuscular condition that compromises handling of respiratory tract secretions. Infants and young children in this category should receive a maximum of 5 doses of palivizumab during the first year of life (CIII).
- Infants and children with CHD: Children who are 24 months of age or younger with hemodynamically significant cyanotic or acyanotic CHD may benefit from palivizumab prophylaxis.<sup>5</sup> Decisions regarding prophylaxis with palivizumab in children with CHD should be made on the basis of the degree of physiologic cardiovascular compromise. Children younger than 24 months of age with CHD who are most likely to benefit from immunoprophylaxis include:
  - infants who are receiving medication to control congestive heart failure;

- infants with moderate-to-severe pulmonary hypertension; and
- infants with cyanotic heart disease.

Because a mean decrease in palivizumab serum concentration of 58% was observed after surgical procedures that use cardiopulmonary bypass, for children who continue to require prophylaxis, a postoperative dose of palivizumab (15 mg/kg) should be administered as soon as the patient is medically stable (AI).

The following groups of infants with CHD are not at increased risk of RSV and generally should not receive immunoprophylaxis:

- Infants and children with hemodynamically insignificant heart disease (eg, secundum atrial septal defect, small ventricular septal defect, pulmonary stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus);
- Infants with lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure; and
- Infants with mild cardiomyopathy who are not receiving medical therapy for the condition.

Dates for initiation and termination of prophylaxis should be based on the same considerations as those for high-risk infants with CLD.

- Immunocompromised children: Palivizumab prophylaxis has not been evaluated in randomized trials in immunocompromised children. Although specific recommendations for immunocompromised children cannot be made, infants and young children with severe immunodeficiency (eg, severe combined immunodeficiency or advanced AIDS) may benefit from prophylaxis (CIII).
- Patients with cystic fibrosis: Limited studies suggest that some patients

with cystic fibrosis may be at increased risk of RSV infection. Whether RSV infection exacerbates the chronic lung disease of cystic fibrosis is not known. In addition, insufficient data exist to determine the effectiveness of palivizumab use in this patient population.<sup>31</sup> Therefore, a recommendation for routine prophylaxis in patients with cystic fibrosis cannot be made (CIII).

#### • Special situations

- If an infant or child who is receiving palivizumab immunoprophylaxis experiences a breakthrough RSV infection, monthly prophylaxis should continue until a maximum number of 3 doses have been administered to infants in the 32 weeks' 0 days' through 34 weeks' 6 days' gestational-age group or until a maximum of 5 doses have been administered to infants with CHD, CLD, or preterm birth before 32 weeks' gestation. This recommendation is based on the observation that infants at high risk may be hospitalized more than once in the same season with RSV lower respiratory tract disease and the fact that more than 1 RSV strain often cocirculates in a community (CIII).
- Hospitalized infants who qualify for prophylaxis during the RSV season should receive the first dose of palivizumab 48 to 72 hours before discharge or promptly after discharge (CIII).
- Infants who have begun palivizumab prophylaxis earlier in the season and are hospitalized on the date when the next monthly dose is due should receive that dose as scheduled while they remain in the hospital (AI).
- RSV is known to be transmitted in the hospital setting and to cause

serious disease in infants at high risk. Among hospitalized infants, the major means of reducing RSV transmission is strict observance of infection-control practices, including prompt initiation of precautions for RSV-infected infants.<sup>32</sup> If an RSV outbreak occurs in a high-risk unit (eg, PICU or NICU or stem cell transplantation unit), primary emphasis should be placed on proper infection-control practices, especially hand hygiene. No data exist to support palivizumab use in controlling outbreaks of health care–associated disease, and palivizumab use is not recommended for this purpose (CIII).

- Palivizumab does not interfere with response to vaccines.

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**APPENDIX** Infectious Diseases Society of America—US Public Health Service Grading System for Ranking Recommendations in Clinical Guidelines

Category, Grade	Definition
Strength of recommendation	
A	Good evidence to support a recommendation for use
B	Moderate evidence to support a recommendation for use
C	Poor evidence to support a recommendation
Quality of evidence	
I	Evidence from $\geq 1$ properly randomized, controlled trial
II	Evidence from $\geq 1$ well-designed clinical trial, without randomization; from cohort or case-controlled analytical studies (preferably from $>1$ center); from multiple time series; or from dramatic results from uncontrolled experiments
III	Evidence from opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees

Adapted from Canadian Task Force on the Periodic Health Examination. *Can Med Assoc J.* 1979;121(9):1193–1254.

**Policy Statement Modified Recommendations for Use of Palivizumab for  
Prevention of Respiratory Syncytial Virus Infections**  
COMMITTEE ON INFECTIOUS DISEASES  
*Pediatrics* published online Sep 7, 2009;  
DOI: 10.1542/peds.2009-2345

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