UK Health Security Agency

NHS

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Measles, mumps and rubella vaccine Patient Group Direction (PGD)

This PGD is for the administration of measles, mumps and rubella (MMR) vaccine to individuals ineligible for the measles, mumps, rubella and varicella (MMRV) vaccine who require vaccination with MMR to complete their routine immunisations, in line with vaccination of individuals with uncertain or incomplete immunisation status or from 6 months of age if early protection is required, in accordance with the national immunisation programme and the national measles guidelines.

This PGD is for use by registered healthcare practitioners identified in section 3, subject to any limitations to authorisation detailed in section 2.

Reference no:	MMR vaccine PGD
Version no:	v7.0
Valid from:	1 January 2026
Review date:	31 May 2028
Expiry date:	30 November 2028

The UK Health Security Agency (UKHSA) has developed this PGD to facilitate the delivery of publicly funded immunisation in England in line with national recommendations.

Those using this PGD must ensure that it is organisationally authorised and signed in section 2 by an appropriate authorising person, relating to the class of person by whom the product is to be supplied, in accordance with Human Medicines Regulations 2012 (HMR2012)[1]. **The PGD is not legal or valid without signed authorisation in accordance with HMR2012 Schedule 16 Part 2.**

Authorising organisations must not alter, amend or add to the clinical content of this document (sections 4, 5 and 6); such action will invalidate the clinical sign-off with which it is provided. In addition, authorising organisations must not alter section 3 (characteristics of staff). **Sections 2 and 7 can be edited within the designated editable fields provided**, **but only for the purposes for which these sections are provided, namely the responsibilities and governance arrangements of the NHS organisation using the PGD. The fields in section 2 and 7 cannot be used to alter, amend or add to the clinical content. Such action will invalidate the UKHSA clinical content authorisation which is provided in accordance with the regulations. The legal validity of this PGD is contingent on those authorising sections 2 and 7 complying with the above.**

Operation of this PGD is the responsibility of commissioners and service providers. The final authorised copy of this PGD should be kept by the authorising organisation completing section 2 for 8 years after the PGD expires if the PGD relates to adults only and for 25 years after the PGD expires if the PGD relates to children only, or adults and children. Provider organisations adopting authorised versions of this PGD should also retain copies for the periods specified above.

Individual practitioners must be authorised by name, under the current version of this PGD before working according to it.

Practitioners and organisations must check that they are using the current version of the PGD. Amendments may become necessary prior to the published expiry date. Current versions of

[1] This includes any relevant amendments to legislation

UKHSA PGD templates for authorisation can be found from: Immunisation patient group direction (PGD) templates.

Any concerns regarding the content of this PGD should be addressed to: immunisation@ukhsa.gov.uk.

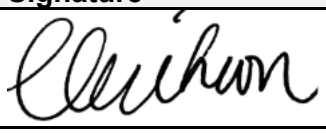
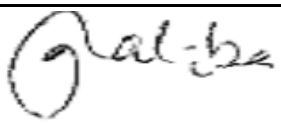
Enquiries relating to the availability of organisationally authorised PGDs and subsequent versions of this PGD should be directed to: Contacts listed on page 5&6 of this PGD

Change history

Version	Change details	Date
v1.0 and v2.0	See previous version of this PGD for details of amendments	3 March 2016 to 17 December 2019
v3.0	PHE MMR PGD amended to: • remove live vaccine intervals table and refer to the Green Book Chapter 11 • revise recommendations relating to MMR second dose before 18 months of age • add sentence to neurological conditions paragraph in cautions section • include minor rewording, layout and formatting changes for clarity and consistency with other PHE PGDs	18 December 2019
v4.0	PHE MMR PGD amended to: • update organisation from PHE to UKHSA • include minor rewording, layout and formatting changes for clarity and consistency with other UKHSA PGDs	16 February 2022
v5.0	UKHSA MMR PGD amended to: • include minor rewording of standard text, layout and formatting changes for clarity and consistency with organisation change, gateway requirements and other UKHSA PGDs • amend NHS England and NHS Improvement (NHSEI) to NHSE following completion of merger on 1 July 2022 • replace Public Health England and PHE with UKHSA, including updated contact details • include updated references, including the National measles guideline 2023 • include detail of phenylalanine content in the vaccine and National Society for Phenylketonuria (NSPKU) advice • clarify dose schedule for individuals vaccinated before the age of one • include updated adverse effect profile and expected physical appearance upon reconstitution for Priorix® and MMRVAXPRO® • update information on co-administration of MMR with varicella and varicella zoster vaccines	25 January 2024
v6.0	UKHSA MMR PGD amended to: • remove the recommendation for a routine dose at one year of age and 3 years 4 months of age, following changes to the MMR childhood immunisation programme, commencing 1 January 2026 • include updated resources, following the launch of the Find Public Health website • include minor rewording of standard text, layout and formatting changes for clarity and consistency with organisation change, gateway requirements and other UKHSA PGDs • addition of dieticians, occupational therapists, pharmacy technicians and podiatrists to section 3 (characteristics of staff)	18 November 2025
v7.0	UKHSA MMR PGD amended to: • remove the recommendation to offer MMR to children in the selective catch up cohort who have immunity against chickenpox and require MMR protection; children born on or after 1 January 2020 should be offered the MMRV vaccine instead • clarify Varilrix® and Varivax® as the monovalent varicella vaccines in the appendix • reclarify in special considerations and additional information, which MMR containing vaccine should be offered based on date of birth	19 December 2025

1. PGD development

This PGD has been developed by the following health professionals on behalf of the UKHSA:

Developed by:	Name	Signature	Date
Pharmacist (Lead Author)	Christina Wilson Lead Pharmacist - Immunisation Programmes, UKHSA		18 December 2025
Doctor	Dr Vanessa Saliba Consultant Medical Epidemiologist, Immunisation and Vaccine Preventable Diseases Division, UKHSA		18 December 2025
Registered Nurse (Chair of Expert Panel)	David Green Nurse Consultant for Immunisations, Immunisation Programmes, UKHSA		18 December 2025

This PGD has been peer reviewed by the UKHSA Immunisations PGD Expert Panel in accordance with the UKHSA PGD and Protocol Policy. It has been ratified by the UKHSA Medicines Governance Committee.

Expert Panel (continued overleaf)

Name	Designation
Dr Nicholas Aigbogun	Consultant in Communicable Disease Control, Yorkshire and Humber Health Protection Team, UKHSA
Jess Baldasera	Health Protection Practitioner, North East Health Protection Team, Regions Directorate, UKHSA
Helen Beynon	Clinical Advisor, Immunisation Clinical Advice Response Service (CARS), NHS England – London
Alison Campbell	Screening and Immunisation Coordinator, Clinical, NHS England – Midlands
Laura Craig	Lead Immunisation Nurse Specialist, Immunisation Programmes – UKHSA
Jane Freeguard	Deputy Director of Vaccination – Medicines and Pharmacy, NHS England
Rosie Furner	Advanced Specialist Pharmacist - Medicines Governance (Patient Group Directions and Medicines Mechanisms), NHS Specialist Pharmacist Services (SPS)
Ed Gardner	Advanced Paramedic Practitioner/Emergency Care Practitioner, Primary Care Based, Southborne Surgery
Shilan Ghafoor	Lead Medicines Governance Pharmacist, Medicines Governance, UKHSA
Michelle Jones	Principal Medicines Optimisation Pharmacist, NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board
Elizabeth Luckett	Senior Screening and Immunisation Manager, Screening and Immunisation Team – Kent and Medway, NHS England – South East
Dr Vanessa MacGregor	Consultant in Communicable Disease Control, East Midlands Health Protection Team, UKHSA
Lesley McFarlane	Lead Immunisation Nurse Specialist, Immunisation Programmes – UKHSA
Briony Mason	Vaccination Manager and Professional Midwifery Advocate, Vaccination and Screening, NHS England –West Midlands
Tushar Shah	Lead Pharmacy Adviser, NHS England – London

2. Organisational authorisation

The PGD is not legally valid until it has had the relevant organisational authorisation.

The fields in this section cannot be used to alter, amend or add to the clinical or other PGD content (sections 3 to 6 inclusive). Such action will invalidate the UKHSA clinical content authorisation which is provided in accordance with the regulations. See page 1 for full details.

It is the responsibility of the organisation that has legal authority to authorise the PGD, to ensure that all legal and governance requirements are met. The authorising body accepts governance responsibility for the appropriate use of the PGD.

NHSE, Integrated Care Board or other authorised commissioner authorises this PGD for use by the services or providers listed below:

Authorised for use by the following organisations and/or services
Immunisation services or NHS Trust providing immunisation services commissioned by NHS England (NHSE), Integrated Care Boards (ICB) or other authorised commissioners of vaccination services and/or programmes
Limitations to authorisation
Authorisation is limited to those registered practitioners listed in Section 3 who are employed by organisations / providers commissioned by NHS England (NHSE), Integrated Care Boards (ICB) or any other authorised commissioners of services to deliver immunisation programmes within the whole of the designated region or defined area

Organisational approval (legal requirement)			
Role	**Name**	**Sign**	**Date**
Deputy Medical Director: System Improvement and Professional Standards NHS England - North East and Yorkshire	**Dr James Gossow**		**7th January 2026**

Additional signatories according to locally agreed policy			
Role	**Name**	**Sign**	**Date**
NHSE NEY screening and immunisation place lead	**Laura Brown**		**6th January 2026**
Medicines Optimisation Pharmacist Lead, NHS NECS	**Kurt Ramsden**		**29th December 2025**

Local enquiries regarding the use of this PGD may be directed to your local screening and immunisation teams. See area-specific contacts below:

For North East and North Cumbria Area (i.e. Northumberland, Tyne & Wear, Durham Darlington and Tees and North Cumbria) use the following:

NHS England Screening and Immunisation Team:

email england.cane.screeningimms@nhs.net

or NECS Medicine Optimisation Pharmacists: Kurt Ramsden: kurtramsden@nhs.net

or Sue White: sue.white14@nhs.net

Please note - All North East and North Cumbria PGDs can be found at:

https://medicines.necsu.nhs.uk/resources/patient-group-directions/

For Yorkshire and Humber Area use the following:

West Yorkshire - england.wysit@nhs.net

South Yorkshire and Bassetlaw - england.sybsit@nhs.net

North Yorkshire and Humber ENGLAND.NYAHSIT@nhs.net

or the Health Protection Team Acute Response Centre (ARC): Contact Number: 0113 3860 300.

Please note - All Yorkshire and Humber PGDs can be found at: https://www.england.nhs.uk/north-east-yorkshire/our-work/information-for-professionals/pgds /

Section 7 provides a practitioner authorisation sheet. Individual practitioners must be authorised by name to work to this PGD. Alternative practitioner authorisation sheets may be used where appropriate in accordance with local policy but this should be an individual agreement or a multiple practitioner authorisation sheet as included at the end of this PGD.

3. Characteristics of staff

Qualifications and professional registration	**All practitioners should only administer vaccination where it is within their clinical scope of practice to do so. Practitioners must also fulfil the additional requirements and continued training requirements to ensure their competency is up to date, as outlined in the section below**. Practitioners working to this PGD must also be one of the following currently registered professionals who can legally supply and administer under a PGD: • nurses and midwives currently registered with the Nursing and Midwifery Council (NMC) • pharmacists and pharmacy technicians currently registered with the General Pharmaceutical Council (GPhC) (Note: this PGD is not relevant to privately provided community pharmacy services) • dieticians, occupational therapists, paramedics, physiotherapists and podiatrists currently registered with the Health and Care Professions Council (HCPC) Check section 2 (Limitations to authorisation) to confirm whether all practitioners listed above have organisational authorisation to work under this PGD.
Additional requirements	Additionally, practitioners: • must be authorised by name as an approved practitioner under the current terms of this PGD before working to it • must have undertaken appropriate training for working under PGDs for supply and administration of medicines • must be competent in the use of PGDs (see NICE Competency framework for health professionals using PGDs) • must be familiar with the vaccine product and alert to changes in the Summary of Product Characteristics (SPC), Immunisation Against Infectious Disease (the Green Book) and national and local immunisation programmes • must have undertaken training appropriate to this PGD as required by local policy and in line with the National Minimum Standards and Core Curriculum for Immunisation Training • must be competent to undertake immunisation and to discuss issues related to immunisation • must be competent in the handling and storage of vaccines and management of the cold chain • must be competent in the appropriate administration method for the vaccines listed in this PGD • must be competent in the recognition and management of anaphylaxis • must have access to the PGD and associated online resources • should fulfil any additional requirements defined by local policy **The individual practitioner must be authorised by name, under the current version of this PGD before working according to it.**
Continued training requirements	Practitioners must ensure they are up to date with relevant issues and clinical skills relating to immunisation and management of anaphylaxis, with evidence of appropriate Continued Professional Development (CPD). Practitioners should be constantly alert to any subsequent recommendations from the UKHSA, NHS England and other sources of medicines information. Note: the most current national recommendations should be followed but a Patient Specific Direction (PSD) may be required to administer the vaccine in line with updated recommendations that are outside the criteria specified in this PGD.

4. Clinical condition or situation to which this PGD applies

Clinical condition or situation to which this PGD applies	Indicated for the active immunisation of individuals for the prevention of measles, mumps or rubella (or a combination) who are ineligible for the MMRV vaccine, in line with the national measles guidelines, vaccination of individuals with uncertain or incomplete immunisation guidance and recommendations given in the measles, mumps and rubella chapters of Immunisation Against Infectious Disease: the Green Book. **Note**: the appendix provides an overview of the scope of this and the MMRV PGD.
Criteria for inclusion	1. Individuals who are unvaccinated, incompletely vaccinated or have an unknown MMR vaccination status with a date of birth (DOB) on or before 31 December 2019 2. where protection is indicated as part of a measles outbreak response, for measles post-exposure prophylaxis in accordance with national recommendations or for travel to a measles endemic area and the individual is not currently eligible for the MMRV vaccine. This includes individuals aged between 6 to 12 months of age at the time of presentation. See special considerations and additional information section for further detail on patient groups at particular risk from measles, mumps or rubella infection and opportunities to check immunisation status and vaccinate as appropriate.
Criteria for exclusion[2] (continued over page)	Individuals for whom no valid consent has been received (or for whom a best-interests decision in accordance with the Mental Capacity Act 2005, has not been obtained). For further information on consent, see chapter 2 of the Green Book). Several resources are available to inform consent (see written information to be given to individual, parent or carer section). Individuals who: • have had a confirmed anaphylactic reaction to a previous dose of any measles, mumps or rubella containing vaccine or to any components of the vaccine. These may include neomycin or gelatine (refer to relevant SPC) • are known to be pregnant • have a primary or acquired immunodeficiency state (see the Green Book chapter 6 for more detail) • are on current or recent high dose immunosuppressive or biological therapy (see the Green Book chapter 6 for more detail) • have received a live varicella-containing or yellow fever vaccine in the preceding 4 weeks, unless protection against measles is rapidly required (see drug interactions) • have received blood products, such as immunoglobulins, in the preceding 3 months, unless protection against measles is rapidly required (see drug interactions) • are awaiting reading of a tuberculin (Mantoux) skin test, unless protection against measles is rapidly required (see drug interactions) • are suffering from acute severe febrile illness (the presence of a minor infection is not a contraindication for immunisation)

[2] Exclusion under the PGD does not necessarily mean the medication is contraindicated, but it would be outside its remit and another form of authorisation will be required

Criteria for exclusion[2] (continued)	• are eligible for vaccination against varicella as part of the routine vaccination programme for MMR and varicella (MMRV), even if the identified reason for vaccination is for non-routine indications, such as travel to a measles endemic area or for measles outbreak purposes - see the MMRV PGD • have received 2 doses of MMR-containing vaccine (including MMRV) at an appropriate age to be considered effective (see also dose and frequency of administration – early vaccination due to travel, outbreak or contact with a probable or confirmed case of measles)
Cautions including any relevant action to be taken	Facilities for management of anaphylaxis should be available at all vaccination sites (see chapter 8 of the Green Book and advice issued by the Resuscitation Council UK). Individuals who are immunosuppressed or who are living with HIV, who are not contraindicated to receive this live vaccine (see the Green Book chapter 6) may not make a full antibody response and revaccination upon cessation of treatment or clinical recovery may be required. This should be discussed with the appropriate specialist and the repeat dose administered under a PSD. If idiopathic thrombocytopenic purpura (ITP) has occurred within 6 weeks of the first dose of MMR, then blood should be taken and tested for measles antibodies before a second dose is given. Serum should be sent to the UKHSA Virus Reference Department, which offers free, specialised serological testing for such children. If the results suggest a lack of immunity against measles, then a second dose of MMR is recommended. The presence of a neurological condition is not a contraindication to immunisation but if there is evidence of current neurological deterioration, deferral of vaccination may be considered, to avoid incorrect attribution of any change in the underlying condition. The risk of such deferral should be balanced against the risk of the preventable infection, and vaccination should be promptly given once the diagnosis or the expected course of the condition (or both) become clear.There will be very few occasions when deferral of immunisation is required. Deferral leaves the child unprotected and so the period of deferral should be minimised, with immunisation commencing as soon as possible. If a specialist recommends deferral, this should be clearly communicated to the individual's primary care provider, who must be informed as soon as the child is fit for immunisation.Children with a personal or close family history of seizures should still be given the MMR vaccine. Priorix® contains 334 micrograms of phenylalanine per 0.5ml dose. MMRVAXPRO® also contains a source of phenylalanine. Though phenylalanine may be harmful to individuals with phenylketonuria (PKU), such individuals (or their parent or carer) will be well versed as to the amounts of phenylalanine tolerable in their diet. The National Society for Phenylketonuria (NSPKU) advise the amount of phenylalanine contained in vaccines is negligible and therefore strongly advise individuals with PKU to take up the offer of immunisation. Syncope (fainting) can occur following, or even before any vaccination especially in adolescents as a psychogenic response to the needle injection. This can be accompanied by several neurological signs such as transient visual disturbance, paraesthesia and tonic-clonic limb movements during recovery. It is important that procedures are in place to avoid injury from faints.
Action to be taken if the individual is excluded (continued over page)	Individuals who have had a confirmed anaphylactic reaction to a previous dose of MMR vaccine or any components of the vaccine should be referred to a clinician for specialist advice and appropriate management.

Action to be taken if the individual is excluded (continued)	Individuals who are pregnant should be advised to avoid contact with known or suspected cases of measles, mumps and rubella infection and report any rash illness or contact with rash illness to their GP or midwife (or both). Women who are lacking 2 documented doses of MMR should be immunised after their pregnancy, at the earliest opportunity and before any further pregnancies. Note: MMR can be given to breastfeeding mothers without any risk to their baby. Individuals who have a primary or acquired immunodeficiency state or who are currently, or were recently on high dose immunosuppressive or biological therapy (see chapter 6) should consult the appropriate specialist regarding the individual's immune status and suitability for receiving live MMR vaccine. Where administration of MMR is advised, a PSD will be required. Further information to guide suitability of the MMR vaccine for individuals living with HIV is available in Table 21.2, chapter 21 of the Green Book. Individuals who have been immunised against varicella (live vaccine),or yellow fever within the last 4 weeks, or received blood products in the preceding 3 months, and do not require rapid protection against measles, mumps or rubella should defer immunisation until the appropriate minimum interval has been observed (see drug interactions section). Individuals who are awaiting reading of a tuberculin (Mantoux) test should delay MMR vaccination until the skin test has been read, unless protection against measles is urgently required. In case of postponement due to acute severe febrile illness, advise when the individual can be vaccinated and ensure another appointment is arranged at the earliest opportunity. Children aged under 6 years on 31 December 2025 (with a date of birth on or after 1 January 2020) without a known history of chickenpox or prior immunisation with a varicella (live) vaccine remain potentially eligible for the MMRV programme – see the MMRV PGD and immunise accordingly. Though numbers are anticipated to be very small, if the individual is identified as requiring concurrent vaccination with both MMR and monovalent varicella vaccines in the same appointment, then MMRV vaccine should be offered instead. See the MMRV PGD. Seek appropriate advice from the local Screening and Immunisation Team, local Health Protection Team or the individual's clinician as appropriate. The risk to the individual of not being immunised must be taken into account. Document the reason for exclusion and any action taken in the individual's clinical records. Inform or refer to the GP or a prescriber as appropriate.
Action to be taken if the individual, parent or carer declines treatment	Advise the individual, parent or carer about the protective effects of the vaccine, the risks of infection and the potential complications of disease. Document the advice given and the decision reached. Inform or refer to the GP or a prescriber as appropriate.
Arrangements for referral for medical advice	As per local policy

5. Description of treatment

Name, strength and formulation of drug	Measles, mumps and rubella vaccine (live): • Priorix®, powder and solvent for solution for injection in a pre-filled syringe • MMRVAXPRO®, powder and solvent for suspension for injection in a pre-filled syringe
Legal category	Prescription only medicine (POM)
Black triangle▼	No
Off-label use	Administration to infants between 6 months and 9 months of age is off-label but is in accordance with the national measles guidelines and recommendations given in the measles, mumps and rubella chapters of Immunisation Against Infectious Disease: the Green Book. The vaccine should be stored according to the conditions detailed in the storage section below. However, in the event of inadvertent or unavoidable deviations of these conditions, refer to Vaccine Incident Guidance. Where vaccines are assessed in accordance with these guidelines as appropriate for continued use, this would constitute off-label administration under this PGD. Where a vaccine is recommended off-label consider, as part of the consent process, informing the individual, parent or carer that the vaccine is being offered in accordance with national guidance but outside of product licence.
Route and method of administration (continued over page)	The vaccine must be reconstituted in accordance with the manufacturer's instructions prior to administration. Administer by intramuscular injection, preferably into the anterolateral aspect of the thigh in infants under one year of age. The deltoid muscle of the upper arm may be used in individuals over one year of age. When administering at the same time as other vaccines, care should be taken to ensure that the appropriate route of injection is used for all vaccinations. The vaccines should be given at separate sites, preferably in different limbs. If given in the same limb, they should be given at least 2.5cm apart. The site at which each vaccine was given should be noted in the individual's records. Individuals with bleeding disorders may be vaccinated intramuscularly if, in the opinion of a clinician familiar with the individual's bleeding risk, vaccines or similar small volume intramuscular injections can be administered with reasonable safety by this route. If the individual receives medication or other treatment to reduce bleeding, for example treatment for haemophilia, intramuscular vaccination can be scheduled shortly after such medication or treatment is administered. Individuals on stable anticoagulation therapy, including individuals on warfarin who are up to date with their scheduled INR testing and whose latest INR was below the upper threshold of their therapeutic range, can receive intramuscular vaccination. A fine needle (equal to 23 gauge or finer calibre such as 25 gauge) should be used for the vaccination, followed by firm pressure applied to the site (without rubbing) for at least 2 minutes. The individual or carer should be informed about the risk of haematoma from the injection. Both Priorix® and MMRVAXPRO® are licensed to be given by either the intramuscular or subcutaneous route. A healthcare professional may determine the subcutaneous route is the preferred route of administration for an individual with a bleeding disorder. Note fewer injection site reactions

Route and method of administration (continued)	were reported with the intramuscular route compared with the subcutaneous route following administration of MMRVAXPRO®. The vaccine should be visually inspected for foreign particulate matter and other variation of expected appearance prior to preparation and administration. Should either occur, do not administer the dose and discard the vaccine in accordance with local procedures. Upon reconstitution, Priorix® is a clear peach to fuchsia pink solution. MMRVAXPRO® forms a clear yellow liquid. The vaccine SPC provides further guidance on preparation and administration.
Dose and frequency of administration	Single 0.5ml dose per administration. **Incomplete immunisation history** Eligible individuals who have not had a dose from one year of age should receive a dose of MMR and be brought up to date at the earliest opportunity. Doses given before the first birthday should be discounted (see section below). An individual who has already received one dose of MMR should receive a second dose at least one month after the first dose to ensure they are protected. See the vaccination of individuals with uncertain or incomplete immunisation status flow chart. **Early vaccination due to travel, outbreak or contact with a probable or confirmed case of measles** The MMR vaccine can be given from 6 months of age when early protection is required. The response to MMR in infants is sub-optimal where the vaccine has been given before one year of age, due to interference from maternal antibody. Therefore, if a dose of MMR is given before the first birthday, the dose should not be counted as part of the recommended 2 dose schedule. Give 2 further doses of MMR (as MMRV if applicable to the individual's date of birth) at the recommended ages in accordance with the routine schedule. For other individuals aged 12 months and over, the second dose should be given at least one month after the first. Where the next dose is given before the age of 15 months, a further routine dose should be given from 18 months of age (as MMRV), in order to ensure full protection. In cases of post-exposure vaccination, the dose should ideally be given within 3 days of exposure to maximise vaccine efficacy.
Duration of treatment	Up to 2 doses of 0.5ml at the recommended interval (see dose and frequency of administration above). Doses that are administered before the age of 12 months, given within 4 weeks of previous yellow fever, live varicella-containing vaccine or within 3 months of receiving blood products may need to be repeated (see drug interactions and dose and frequency of administration sections). Co-administration of MMR with live varicella-containing vaccines on the same day should not affect the immune response and therefore repeating the dose is not advised.
Quantity to be supplied and administered	Single 0.5ml dose per administration.

Supplies	Centrally purchased vaccines for the national immunisation programme for the NHS can only be ordered via ImmForm. Vaccines for use for the national immunisation programme are provided free of charge. National stock may also be used for catch-up vaccination of individuals of any age. Protocols for the ordering, storage and handling of vaccines should be followed to prevent vaccine wastage (see the Green Book chapter 3).
Storage	Store between +2°C to +8°C. Store in original packaging in order to protect from light. Do not freeze. After reconstitution, the vaccine should be administered promptly or stored between +2°C to +8°C and used within 8 hours of reconstitution. If not used after this time, the vaccine must be discarded. In the event of an inadvertent or unavoidable deviation of these conditions, vaccines that have been stored outside the conditions stated above should be quarantined and risk assessed for suitability of continued off-label use or appropriate disposal. Refer to Vaccine Incident Guidance. Contact the vaccine manufacturer where more specific advice is required about managing a temperature excursion.
Disposal	Follow local clinical waste policy and standard operating procedures to ensure safe and secure waste disposal. Equipment used for immunisation, including used vials, ampoules, or discharged vaccines in a syringe or applicator, should be disposed of safely in a UN-approved puncture-resistant sharps box, according to local waste disposal arrangements and NHS England guidance (HTM 07-01): safe and sustainable management of healthcare waste.
Drug interactions (continued over page)	The immunological response may be diminished in those receiving immunosuppressive treatment. Vaccination is recommended even if the antibody response may be limited (see criteria for exclusion). MMR vaccine may be given at the same time as inactivated vaccines or at any interval before or after. MMR may attenuate the response to other live vaccines (see Table 11.4: Recommended time intervals when giving more than one live attenuated vaccine, in chapter 11 of the Green Book). Where protection against measles is required rapidly, other live vaccines and MMR should be given at any interval. The response may be suboptimal if yellow fever and MMR vaccines are co-administered or given within a 4 week interval; an additional dose of MMR should be considered. If live varicella-containing vaccines are not co-administered at the same time as MMR, a 4 week minimum interval should be observed or consideration be given to administering an additional dose of MMR. If protection against measles is urgently required, then the benefit of protection from the vaccine outweighs the potential interference with a tuberculin (Mantoux) test. In this circumstance, the individual interpreting the negative tuberculin test should be made aware of the recent MMR vaccination when considering how to manage that individual. When MMR is given within 3 months of receiving blood products, such as immunoglobulin, the response to the measles component may be reduced. This is because such blood products may contain significant levels of measles-specific antibody, which could then prevent vaccine virus replication. Where possible, MMR should be given at least one month before or deferred until 3 months after receipt of such products. If immediate measles protection is required in someone who has recently received a

Drug interactions (continued)	blood product, MMR vaccine should still be given. To confer longer-term protection, MMR should be repeated after 3 months. A detailed list of drug interactions associated with the MMR vaccine is available from the product's SPC.
Identification and management of adverse reactions	Adverse reactions are attributed to effective replication of the vaccine viruses, with subsequent mild illness. Events due to the measles component occur 6 to 11 days after vaccination. Events due to the mumps and rubella components usually occur 2 to 3 weeks after vaccination but may occur up to 6 weeks after vaccination. Individuals with vaccine-associated symptoms are not infectious to others. The most common adverse reactions are fever and injection site reactions including pain, swelling and erythema. Rash is also commonly reported. Malaise, fever or a rash (or a combination of these) most commonly occur about a week after immunisation, lasting around 2 to 3 days. Upper respiratory tract infection was commonly reported in clinical trial data for Priorix®. Adverse reactions are less common after a second dose of MMRVAXPRO® vaccine than after the first dose; incidence and severity of adverse reactions following a second dose with Priorix® are broadly similar. Hypersensitivity reactions and anaphylaxis can occur but are very rare **Rare and more serious events** Febrile seizures, generally considered benign and short lived are the most commonly reported neurological event following measles immunisation. The rate of febrile seizures following MMR vaccination is lower than that following infection with measles disease and the absolute risk of febrile seizures remains low. Arthropathy (arthralgia or arthritis) has also been reported to occur rarely after MMR immunisation, probably due to the rubella component. If it is caused by the vaccine, it should occur between 14 and 21 days after immunisation. Where it occurs at other times, it is highly unlikely to have been caused by vaccination. The incidence rate is higher and the reaction more marked in adult females, though such reactions are generally well tolerated. ITP has occurred rarely following MMR vaccination, usually within 6 weeks of the first dose and resolves spontaneously. The risk of developing ITP after MMR vaccine is much less than the risk of developing it after infection with wild measles or rubella virus (see cautions). Further details on adverse reactions following MMR vaccine can be found in the Green Book chapters on measles, mumps and rubella. A detailed list of adverse reactions is available from the product's SPC.
Reporting procedure of adverse reactions	Healthcare professionals and individuals, parents or carers are encouraged to report suspected adverse reactions to the Medicines and Healthcare products Regulatory Agency (MHRA) using the Yellow Card reporting scheme or by searching for MHRA Yellow Card in the Google Play or Apple App Store. Any adverse reaction to a vaccine should be documented in the individual's record and the individual's GP should be informed

Written information to be given to individual, parent or carer	Offer the marketing authorisation holder's patient information leaflet (PIL) provided with the vaccine. For resources in accessible formats and alternative languages, please visit Find Public Health resources. Where applicable, inform the individual, parent or carer that large print, Braille or audio CD PILs may be available from emc accessibility by providing the medicine name and product code number, as listed on the product's SPC. Immunisation promotional material may be provided as appropriate: • MMR for all • have you had your MMR vaccines? • measles- protect yourself, protect others • think measles - it's not just a kids problem • measles: information for schools and healthcare centres • measles outbreak resources
Advice and follow up treatment	Inform the individual, parent or carer of possible side effects and their management. Advise about likely timing of and subsequent management of a fever. Advise where relevant that pregnancy should be avoided for one month post vaccination. The individual, parent or carer should be advised to seek medical advice in the event of an adverse reaction and report this via the Yellow Card reporting scheme. When administration is postponed, advise the individual, parent or carer when to return for vaccination. Where applicable, advise the individual, parent or carer when the subsequent dose is due.
Special considerations and additional information (continued over page)	Ensure there is immediate access to adrenaline (epinephrine) 1 in 1000 injection and access to a telephone at the time of vaccination. Data suggests that anaphylactic reactions to MMR vaccine are not associated with hypersensitivity to egg antigens. All children with egg allergy should receive the MMR vaccination as a routine procedure in primary care. MMRVAXPRO® (Sanofi Pasteur MSD) contains porcine gelatine. Priorix® (GSK) does not contain porcine gelatine and can be offered as an alternative to MMRVAXPRO®. Health professionals should be aware of the need to order Priorix® when running clinics for relevant communities (see vaccines and porcine gelatine leaflet). MMR vaccine is recommended when protection against measles, mumps or rubella (or a combination of the 3) is required. MMR vaccine can be given irrespective of a history of measles, mumps or rubella infection or vaccination. There are no ill effects from vaccinating those who are already immune. If there is doubt about an individual's MMR immune status, MMR vaccine should still be given. Children with chronic conditions such as cystic fibrosis, congenital heart or kidney disease, failure to thrive or Down's syndrome are at particular risk from measles infection and should be immunised with MMR vaccine without delay. MMR vaccine can be provided to children and adults of any age over 6 months using this PGD. If a dose of MMR is given before the first birthday, either because of travel to an endemic country, or because of a local outbreak, then this dose should be discounted and 2 further doses should be given at the recommended times (as MMR or MMRV as applicable to

Special considerations and additional information (continued)	date of birth). Maternal antibodies may reduce the response to the first dose of vaccination up to the age of 18 months. To provide additional protection to those who fail to respond to the first dose, therefore, the second MMRV dose should not routinely be given below 18 months of age. The decision on when to vaccinate adults needs to take into consideration the past vaccination history, the likelihood of an individual remaining susceptible and the future risk of exposure and disease (see the Green Book measles, mumps and rubella chapters). Entry into college, university or other higher education institutions, prison or military service provides an opportunity to check an individual's immunisation history. Those who have not received 2 doses of MMR should be offered appropriate MMR immunisation. Pre-conceptual care, antenatal and post-natal checks provide an opportunity to assess MMR status. Individuals who have not received 2 doses of MMR at an appropriate interval should be offered pre-or post-natal MMR immunisation. Pregnancy should be avoided for at least one month following vaccination. Postpartum women who received a blood transfusion around the time of delivery and require rubella protection may experience an inhibited antibody response, due to interference from passively acquired rubella antibodies. A repeat dose of MMR is advised at a minimum interval of 3 months post transfusion. As per the duration of treatment section, this PGD may be used to repeat the dose. Children and adults coming from abroad may not have been immunised against measles, mumps and rubella. Unless there is a reliable history of appropriate immunisation, individuals should be assumed to be unimmunised. See chapter 11 for more information. Individuals aged 18 months and over who have not received MMR or MMRV, or who received a dose of measles-containing vaccine before the age of one should receive 2 doses at least one month apart. An individual who has already received one dose of MMR since their first birthday should receive a second dose of MMR or MMRV as appropriate to their date of birth to ensure that they are protected. **Post exposure** Antibody responses to the rubella and mumps components of MMR vaccine do not develop soon enough to provide effective prophylaxis after exposure to these infections. However, as vaccine-induced measles antibody develops more rapidly than that following natural infection, MMR vaccine should be used to protect susceptible contacts from suspected measles. To be effective against this exposure, vaccine must be administered very promptly and ideally within 3 days. Even where it is too late to provide effective post-exposure prophylaxis with MMR, the vaccine can provide protection against future exposure to all 3 infections. Therefore, contact with suspected measles, mumps or rubella provides a good opportunity to offer MMR vaccine to previously unvaccinated individuals. If the individual is already incubating measles, mumps or rubella, MMR vaccination will not exacerbate the symptoms. In these circumstances, individuals should be advised that a measles, mumps or rubella-like illness occurring shortly after vaccination is likely to be due to natural infection. Immunoglobulin may be indicated for contacts of measles who are infants, immunosuppressed or pregnant. Provision of immunoglobulin is not covered by this PGD (see national measles guidelines for eligibility).

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Special considerations and additional information (continued)	**Implications of the changes to the MMR immunisation programme from 1 January 2026** There will be some children who received MMR vaccine prior to 1 January 2026, who are eligible to be vaccinated with one or 2 doses of MMRV after 1 January 2026. For example, a child with a DOB between 1 January 2020 and 31 August 2022, who is eligible for the delayed selective catch up programme is eligible for a single dose of MMRV if they have not had chickenpox or 2 doses of varicella-containing vaccine. Such children may have had 2 doses of MMR under the old schedule, at 12 months and 3 years 4 months. There are no concerns in giving a third dose of MMR-containing vaccine – the priority is to ensure the child is protected against chickenpox. Where 2 doses of MMR have not been given, an MMR-containing vaccine should be offered in line with vaccination of individuals with uncertain or incomplete immunisation. • children with a DOB on or before 31 December 2019, who require catch up with their routine MMR vaccines are eligible under this PGD. • children with a DOB on or after 1 January 2020 who are missing MMR doses should be caught up using MMRV, not MMR, in line with the system letter. When an individual is identified as requiring both MMR and monovalent varicella vaccine at the same appointment, it is considered more pragmatic under the circumstances to offer vaccination with the combination MMRV vaccination instead. See the MMRV PGD for more information. There may be situations when the MMR vaccine is not readily available, particularly as the use of MMRV becomes commonplace. In line with the inclusion criteria in the MMRV PGD, an individual may be offered the MMRV vaccine where protection is urgently required, such as in managing a measles outbreak or where an opportunistic dose of MMR is required for an unimmunised or partially immunised individual.
Records (continued over page)	The practitioner must ensure the following is recorded: • that valid informed consent was given or a decision to vaccinate was made in the individual's best interests in accordance with the Mental Capacity Act 2005 • name of individual, address, date of birth and GP with whom the individual is registered (or record where an individual is not registered with a GP) • name of immuniser • name and brand of vaccine • date of administration • dose, form and route of administration of vaccine • quantity administered • batch number and expiry date • anatomical site of vaccination • advice given, including advice given if the individual is excluded or declines immunisation • details of any adverse drug reactions and actions taken • supplied via PGD Records should be signed and dated (or password-controlled on e-records). All records should be clear, legible and contemporaneous.

Records (continued)	This information should be recorded in the individual's GP record. Where vaccine is administered outside the GP setting, appropriate health records should be kept and the individual's GP informed. When vaccine is administered to individuals under 19 years of age, notify the local Child Health Information Systems (CHIS) team using the appropriate documentation or pathway as required by any local or contractual arrangement. A record of all individuals receiving treatment under this PGD should also be kept for audit purposes in accordance with local policy.

6. Key references

Key references	**MMR vaccine** • Immunisation Against Infectious Disease: the Green Book chapters on measles, mumps and rubella, Chapter 6 and Chapter 11 • Introduction of a routine varicella (MMRV) vaccination programme (NHS system letter), published 31 October 2025 https://www.gov.uk/government/publications/introduction-of-a-routine-varicella-mmrv-vaccination-programme • Summary of Product Characteristics for Priorix®, GlaxoSmithKline, last updated 15 August 2025 www.medicines.org.uk/emc/medicine/2054 • Summary of Product Characteristics for MMRVAXPRO®, MSD Ltd, last updated 2 September 2025 www.medicines.org.uk/emc/medicine/20968 • MSD Medical Information, Personal communication (via email), 13 December 2023 • UKHSA National measles guidelines, last updated 25 July 2024 https://www.gov.uk/government/publications/national-measles-guidelines • Vaccination of individuals with uncertain or incomplete immunisation status, UKHSA www.gov.uk/government/publications/vaccination-of-individuals-with-uncertain-or-incomplete-immunisation-status • The National Society for Phenylketonuria (NSPKU) Medical Advisory Panel: Vaccines and PKU, issued 2 October 2024 https://nspku.org/download/vaccines-and-pku/ **General** • NHSE Health Technical Memorandum 07-01: safe and sustainable management of healthcare waste, updated 7 March 2023 www.england.nhs.uk/publication/management-and-disposal-of-healthcare-waste-htm-07-01/ • National Minimum Standards and Core Curriculum for Immunisation Training www.gov.uk/government/publications/national-minimum-standards-and-core-curriculum-for-immunisation-training-for-registered-healthcare-practitioners • NICE Medicines Practice Guideline 2 (MPG2): Patient Group Directions, last updated March 2017 www.nice.org.uk/guidance/mpg2 • NICE MPG2 Patient group directions: competency framework for health professionals using patient group directions, updated January 2018

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Key references (continued)	www.nice.org.uk/guidance/mpg2/resources • UKHSA Immunisation Collection www.gov.uk/government/collections/immunisation • Vaccine Incident Guidance, last updated July 2022 www.gov.uk/government/publications/vaccine-incident-guidance-responding-to-vaccine-errors

7. Practitioner authorisation sheet

MMR vaccine PGD v7.0 Valid from: 1 January 2026 Expiry: 30 November 2028

Before signing this PGD, check that the document has had the necessary authorisations in section 2. Without these, this PGD is not lawfully valid.

Practitioner

By signing this PGD, you are indicating that you agree to its contents and that you will work within it. PGDs do not remove inherent professional obligations or accountability.

It is the responsibility of each professional to practice only within the bounds of their own competence and professional code of conduct.

I confirm that I have read and understood the content of this PGD and that I am willing and competent to work to it within my professional code of conduct.			
Name	Designation	Signature	Date

Authorising manager

I confirm that the practitioners named above have declared themselves suitably trained and competent to work under this PGD. I give authorisation on behalf of **insert name of organisation** for the above named healthcare professionals who have signed the PGD to work under it.			
Name	Designation	Signature	Date

Note to authorising manager

Score through unused rows in the list of practitioners to prevent practitioner additions post managerial authorisation.

This authorisation sheet should be retained to serve as a record of those practitioners authorised to work under this PGD.

Appendix: PGD indications for use for MMR, MMRV and monovalent varicella vaccine, in accordance with the individual's age.

	6 to 9 months of age	9 months to less than 12 months of age	12 months of age and over
Monovalent varicella vaccine (V) PGD	Not recommended	Recommended vaccine for pre and post exposure to varicella	Recommended vaccine for pre and post exposure to varicella, where the individual is not eligible for the MMRV programme
MMR PGD	Indications for PGD unchanged: • early vaccination for travel to a measles endemic area • post exposure prophylaxis for measles • measles outbreaks	Indications for PGD unchanged: • early vaccination for travel to a measles endemic area • post exposure prophylaxis for measles • measles outbreaks	The individual is ineligible for the MMRV programme **and either** MMR protection is required in line with vaccination of individuals with uncertain or incomplete immunisation status **or** for travel, post exposure or outbreak
MMRV PGD	Not recommended	Alternative option for varicella pre and post-exposure, where Varivax® or Varilrix® is not available **and** protection is urgently required	**Routine vaccination** at 12 and 18 months for children born on or after 1 January 2025 Individuals ineligible for MMRV, when MMR or monovalent varicella vaccine is not available* and who require urgent protection against MMR or V, such as in managing post-exposure varicella or measles outbreaks or administering an opportunistic catch-up dose of MMR vaccine. Where an individual requires both varicella vaccine and MMR vaccine at the same time, even if they are not eligible for MMRV in the routine programme.

*MMR vaccine will be available for administration outside of the routine childhood programme (for example, for catching up older individuals, where date of birth is on or before 31 December 2019, who have not received 2 doses of MMR and are not eligible for MMRV). Therefore, after 1 January 2026, providers are expected to maintain stock of MMR vaccine for those ineligible for MMRV.