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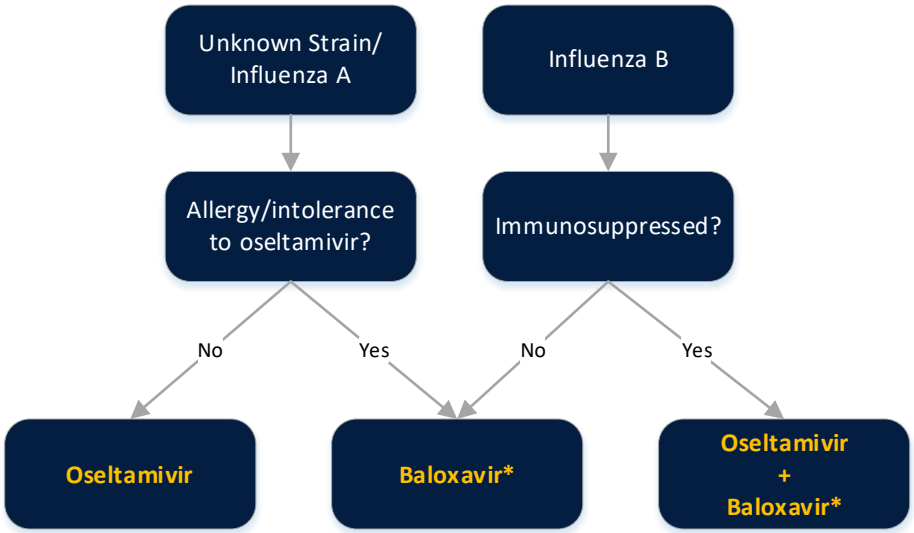
TREATMENT AND PROPHYLAXIS OF INFLUENZA IN ADULT PATIENTS

General Approach to Influenza positive treatment



** Can consider inpatient administration of baloxavir in select patients after consultation with Infectious Diseases*
** If immunosuppressed patient started on oseltamivir and later found to have influenza B, recommend adding on baloxavir*

Additional considerations and treatment details are in the corresponding treatment tables.

Consult with Infection Prevention or the Health Department for institutional/hospital outbreaks.
Consult with Occupational Health or Infection Prevention for occupational exposures

Inpatient Treatment	Outpatient Treatment	Exposure Chemoprophylaxis

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Inpatient Treatment of Influenza

Patient population	Definitive Therapy	Duration of Therapy	Comments & References
Inpatient Hospitalized patients with suspected or confirmed influenza regardless of time from symptom onset	Preferred: **Oseltamivir*** 75 mg PO (or via tube) BID Alternative **Baloxavir** 40 - 79 kg: 40 mg x1 ≥80 kg: 80 mg x1 **ID consult** is *required* for the use of **baloxavir** (see comments) Restricted alternative for patients with documented influenza in which drug delivery by a route other than IV is not feasible: **Peramivir*** 600 mg IV once daily	**Oseltamivir:** 5 days In most ICU patients or those with mild to moderate immunosuppression, 5 days is recommended **Baloxavir:** 1 day **Peramivir:** Should not exceed 5 days in hospitalized patients. Patients with uncomplicated influenza in the ED or outpatient setting (in which drug delivery by a route other than IV is not feasible) should receive a one-time dose	• High-risk patients are more likely to develop pneumonia/ARDS from influenza infection. Close follow-up is recommended • Combination treatment should be considered in patients with influenza B and immunocompromised patients **Oseltamivir** • May rarely cause neuropsychiatric effects • Well absorbed in the setting of vasopressor therapy and enteral feeding **Baloxavir** • ID approval is required as this is a Tier 1 agent. • The use of baloxavir should be considered in patients with influenza B. • Should be administered at least 2 hours prior or 4 hours after administration of polyvalent cations due to the formation of a chelate which can significantly decrease baloxavir exposure. • No safety data in pregnant / nursing patients **Peramivir** • May rarely cause neuropsychiatric effects • Oseltamivir resistant influenza is often resistant to peramivir. At this time, peramivir is not recommended in suspected or confirmed oseltamivir-resistant influenza. ID consultation is recommended in such cases.

*Adjust dose based on renal function. Refer to institutional guidelines here.

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Outpatient Treatment of Influenza

Patient population	Definitive Therapy	Duration of Therapy	Comments & References
Outpatient / ED Discharge Outpatients with suspected or confirmed influenza who are at high risk for influenza complications per CDC guidelines (click link)	Preferred: **Oseltamivir** 75 mg PO BID Alternative (Preferred in Influenza B) **Baloxavir** 40 - 79 kg: 40 mg x1 ≥80 kg: 80 mg x1	**Oseltamivir:** 5 days **Baloxavir:** 1 day	• Can consider for outpatients with suspected or confirmed influenza who lack risk factors for complications, if treatment can start within 48 hours of symptom onset • One study showed that baloxavir was superior to oseltamavir in influenza B • Addition of baloxavir should be considered in immunocompromised patients that are later confirmed to have influenza B **Oseltamivir** • May rarely cause neuropsychiatric effects **Baloxavir** • **Should not be used routinely due to its low barrier to resistance. Adults studies have shown a resistance rate up to 9.7%.** • Should be administered at least 2 hours prior or 4 hours after administration of polyvalent cations due to the formation of a chelate which can significantly decrease baloxavir exposure. • No safety data in pregnant / nursing patients

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Chemoprophylaxis of Influenza

Patient Population	Definitive Therapy	Comments & References

• *Consider for select patients (below) with documented ongoing influenza exposure OR in whom prophylaxis can be started within 48 hours of a single exposure:*
  ○ Patients at high risk for complications (click link) who have not received an influenza vaccine or were vaccinated within the last 2 weeks
  ○ Family members who are unimmunized and are likely to have ongoing, close exposure to:
  ▪ unimmunized children at high risk
  ▪ unimmunized infants and toddlers who are younger than 24 months
• In seasons where the vaccine is a poor match for circulating influenza strains, prophylaxis of high-risk patients may be considered regardless of immunization status.
• Vaccinated individuals at high risk for complications (see above) and at high risk for a poor response to the vaccine (e.g., transplant, rituximab treatment)
	Preferred:
	Oseltamivir* 75 mg PO (or via tube) once daily for 7 days
	
	Alternative for patients with a documented intolerance to oseltamivir or an influenza strain resistant to oseltamivir:
	Baloxavir single dose (see above for dosing)
	OR
	Zanamivir 2 inhalations (10 mg) once daily for 10 days
		• Oseltamivir may rarely cause neuropsychiatric effects
		• CDC does not recommend seasonal or pre-exposure antiviral chemoprophylaxis
		• Amantadine and rimantadine are no longer recommended due to increasing rates of resistance
		• Baloxavir has been associated with infection with resistance strains (2.7%) that may require neuraminidase inhibitor
		• Baloxavir has no safety data in pregnant / nursing patients

*Adjust dose based on renal function. Refer to institutional guidelines here.

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References:

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Antimicrobial Subcommittee Approval:	09/2017; 12/2020; 02/2021	Originated:	10/2017
P&T Approval:	10/2017; 03/2021	Last Revised:	03/2021

Revision History:
12/20: Revised baloxavir criteria, added baloxavir therapy guidance
02/21: Revised baloxavir criteria and therapy guidance