HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use INFASURF® and INFASURF DS™ safely and effectively. See full prescribing information for INFASURF and INFASURF DS™.

INFASURF® (calfactant) intratracheal suspension
Initial U.S. Approval: 1998
INFASURF DS™ (calfactant) intratracheal suspension
Initial U.S. Approval: 202X

RECENT MAJOR CHANGES

Dosage and Administration (2)	XX/2026
Dosage forms and Strengths (3)	XX/2026

INDICATIONS AND USAGE

INFASURF® and INFASURF DS™ are surfactants indicated:

- to reduce the risk of respiratory distress syndrome (RDS) in preterm neonates < 29 weeks gestational age at risk for RDS. (1)
- for the rescue treatment of preterm neonates ≤72 hours of age with RDS who require endotracheal intubation. (1)

INFASURF DS™ is a higher strength pharmaceutical alternative to INFASURF®. **Unless otherwise noted, INFASURF information refers to both products.**

DOSAGE AND ADMINISTRATION

- For intratracheal administration only (2)
- The recommended dose of INFASURF is 3 mL/kg body weight at birth. The recommended dose for INFASURF DS is 1.5 mL/kg body weight at birth. (2.2)
- Up to 3 doses of INFASURF can be administered. (2.2)
- Doses should not be given more frequently than every 12 hours. (2.2)
- Administration instructions: (2.3)
  - *Side-port adapter into the endotracheal tube:* two equal aliquots while ventilation is continued over 20 to 30 breaths for each aliquot.
  - *5-French feeding catheter inserted into the endotracheal tube*: four equal aliquots with the catheter removed between each of the instillations and mechanical ventilation resumed for 0.5 to 2 minutes.
  - Single aliquot (INFASURF DS only).

DOSAGE FORMS AND STRENGTHS

Intratracheal Suspension:

- 126 mg/1.8 mL (70 mg/mL) single-dose vial (3)
- 105 mg/3 mL (35 mg/mL) single-dose vial (3)
- 210 mg/6 mL (35 mg/mL) single-dose vial (3)

CONTRAINDICATIONS

None. (4)

WARNINGS AND PRECAUTIONS

- Acute Changes in Oxygenation and Lung Compliance: INFASURF administration can rapidly affect oxygenation and lung compliance. Frequently monitor neonates after administration of INFASURF to adjust oxygen therapy and ventilator pressures appropriately. (5.1)
- Administration-Related Adverse Reactions: Adverse reactions associated with INFASURF include cyanosis, bradycardia, airway obstruction, and reflux of INFASURF into the endotracheal tube. In the event of these adverse reactions, stop INFASURF administration, and take appropriate measures to alleviate the adverse reactions and resume INFASURF with appropriate monitoring. (5.2)
- Intraventricular Hemorrhage and Periventricular Leukomalacia: Some INFASURF-treated neonates developed intraventricular hemorrhage and periventricular leukomalacia in randomized clinical trials. (5.3)

ADVERSE REACTIONS

Most common adverse reactions associated with the use of INFASURF are cyanosis (65%), airway obstruction (39%), bradycardia (34%), reflux of surfactant into the endotracheal tube (21%), requirement for manual ventilation (16%), and reintubation (3%). (6)

To report SUSPECTED ADVERSE REACTIONS, contact ONY Biotech Inc. at 1-877-663-4179 or FDA at 1-800-FDA-1088 or *www.fda.gov/medwatch*.

See 17 for PATIENT COUNSELING INFORMATION

Revised: XX/202X

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FULL PRESCRIBING INFORMATION

1 INDICATIONS AND USAGE

INFASURF and INFASURF DS™ are indicated:

- to reduce the risk of respiratory distress syndrome (RDS) in preterm neonates <29 weeks of gestational age at risk for RDS.
- for the rescue treatment of RDS in preterm neonates ≤72 hours of age with RDS who require endotracheal intubation.

2 DOSAGE AND ADMINISTRATION

2.1 Recommended Dosage

The recommended dose of INFASURF is 3 mL/kg and that of INFASURF DS is 1.5 mL/kg body weight at birth administered intratracheally through an endotracheal tube. INFASURF can be administered every 12 hours for a total of up to three doses.

To reduce the risk of RDS in preterm neonates <29 weeks of gestational age at risk for RDS, administer INFASURF or INFASURF DS within 30 minutes after birth.

2.2 Preparation Instructions

- INFASURF does not require reconstitution. Do not dilute or sonicate.
- INFASURF does not need to reach room temperature before administration.
- Gently swirl or agitate the INFASURF intratracheal suspension vial for redispersion. Do not shake.
- Visually inspect the INFASURF intratracheal suspension for discoloration prior to administration. The color of the INFASURF intratracheal suspension should be off-white. Discard the INFASURF vial if the intratracheal suspension is discolored. Visible flecks in the intratracheal suspension and foaming at the surface are normal.
- Using a 20-gauge or larger needle and syringe to avoid excessive foaming, withdraw INFASURF from the vial.
- Discard unopened INFASURF vials stored at room temperature for more than 24 hours.
- Discard unused INFASURF after the initial vial entry.

2.3 Administration Instructions

INFASURF should be administered by healthcare providers who are experienced in the acute care of neonates with RDS who require intubation. Two attendants should be present to facilitate dosing; one to instill the INFASURF, the other to monitor the neonate.

Administer INFASURF intratracheally through an endotracheal tube using the prepared syringe *[see Dosage and Administration (2.2)]* using either of the following two methods. Instill the INFASURF dose through a:

- Side-port adapter into the endotracheal tube as two equal aliquots of 1.5 mL/kg each. During and after each aliquot that is instilled, position the neonate with either the right or the left side dependent and maintain ventilation over 20 to 30 breaths for each aliquot, with small bursts timed only during the inspiratory cycles. Between aliquot administration evaluate the respiratory status and reposition to the other side.

- 5-French feeding catheter inserted into the endotracheal tube as four equal aliquots of 0.75 mL/kg each. During and after each aliquot is instilled, position the neonate in four different positions (i.e., prone, supine, right, and left lateral) to facilitate even distribution of INFASURF. Remove the catheter between each of the instillations and resume mechanical ventilation for 0.5 to 2 minutes.

INFASURF DS may be given by either method described above. However, due to its low volume, multiple aliquots are not necessary.

After INFASURF administration, frequently monitor neonate oxygenation and ventilatory status *[see Warnings and Precautions (5.1)]*.

3 DOSAGE FORMS AND STRENGTHS

Intratracheal Suspension: INFASURF (calfactant) is an off-white suspension available as:

- 126 mg/1.8 mL (70 mg/mL) single-dose vial
- 105 mg/3 mL (35 mg/mL) single-dose vial
- 210 mg/6 mL (35 mg/mL) single-dose vial

4 CONTRAINDICATIONS

None.

5 WARNINGS AND PRECAUTIONS

5.1 Acute Changes in Oxygenation and Lung Compliance

The administration of exogenous surfactants, including INFASURF, can rapidly affect oxygenation and lung compliance. Frequently monitor neonates who receive INFASURF so that oxygen and ventilatory support can be modified in response to changes in respiratory status. INFASURF should only be administered by those trained and experienced in the care, resuscitation, and stabilization of preterm neonates with RDS who require intubation.

5.2 Administration-Related Adverse Reactions

Administration-related adverse reactions associated with INFASURF use included cyanosis, bradycardia, airway obstruction, and reflux of INFASURF into the endotracheal tube. These adverse reactions occurred more frequently in neonates who received repeat doses of INFASURF at 12-hour intervals than neonates that received colfosceril palmitate, the comparator, in randomized controlled trials (Trials 1 and 3) *[see Clinical Studies (14)]*. If these adverse reactions occur during INFASURF administration, stop INFASURF and institute appropriate measures to alleviate these adverse reactions and resume INFASURF with appropriate monitoring.

5.3 Intraventricular Hemorrhage and Periventricular Leukomalacia

An increased proportion of INFASURF-treated neonates compared to colfosceril palmitate-treated neonates in randomized clinical trials (Trials 1 and 3) *[see Clinical Studies (14)]* developed intraventricular hemorrhage and periventricular leukomalacia. These adverse reactions were not associated with increased mortality in those studies. In contrast, the same proportion of INFASURF-treated neonates compared to beractant-treated neonates in randomized clinical trials (Trials 2) developed intraventricular hemorrhage and periventricular leukomalacia *[see Adverse Reactions (6.2)]*. While there is no specific treatment for these complications, affected infants may be at increased risk for neurologic complications, including seizures and neurodevelopmental impairment, and should be monitored as per local guidelines.

6 ADVERSE REACTIONS

The following clinically significant adverse reactions are described elsewhere in the labeling:

- Acute Changes in Oxygenation and Lung Compliance *[see Warnings and Precautions (5.1)]*

- Administration-Related Adverse Reactions *[see Warnings and Precautions (5.2)]*
- Intraventricular Hemorrhage and Periventricular Leukomalacia *[see Warnings and Precautions (5.3)]*

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

The safety of INFASURF is based on the pooled safety population from three, randomized, active-controlled clinical trials that evaluated INFASURF to reduce the risk of respiratory distress syndrome (RDS) and rescue treatment of RDS *[see Clinical Studies (14)]*, which included 1,554 preterm neonates who received at least one dose of INFASURF.

The most common INFASURF administration-related adverse reactions were cyanosis (65%), airway obstruction (39%), bradycardia (34%), reflux of surfactant into the endotracheal tube (21%), requirement for manual ventilation (16%), and reintubation (3%).

6.2 Complications of RDS and Neurodevelopmental Outcomes

Incidence of Common Complications of Prematurity

The controlled trials of INFASURF included the incidence of common complications of prematurity and RDS as safety endpoints. Tables 1 and 2 display the results in the INFASURF vs. colfosceril palmitate trials and the INFASURF and beractant trials, respectively. Trials 1, 2, and 3 were not designed to evaluate meaningful comparisons of the incidence of adverse reactions in the INFASURF and the colfosceril palmitate and beractant treatment groups.

Table 1 Common Complications of Prematurity and RDS in Controlled Trials of INFASURF vs colfosceril palmitate

Complication	INFASURF (N=1,001) %	colfosceril palmitate (N=978) %
Apnea	61	61
Patent ductus arteriosus	47	48
Intracranial hemorrhage	29	31
Severe intracranial hemorrhage*	12	10
IVH and PVL†	7	3
Sepsis	20	22
Pulmonary air leaks	12	22
Pulmonary interstitial emphysema	7	17
Pulmonary hemorrhage	7	7
Necrotizing enterocolitis	5	5

* Grade III and IV by the method of Papile.
† Patients with both intraventricular hemorrhage and periventricular leukomalacia.

Table 2 Common Complications of Prematurity and RDS Controlled Trials of INFASURF vs beractant

Complication	INFASURF (N=553) %	beractant (N=566) %
Apnea	76	76
Patent ductus arteriosus	45	48

Intracranial hemorrhage	36	36
Severe intracranial hemorrhage*	9	7
IVH and PVL†	5	5
Sepsis	28	27
Pulmonary air leaks	15	15
Pulmonary interstitial emphysema	10	10
Pulmonary hemorrhage	7	6
Necrotizing enterocolitis	17	18

* Grade III and IV by the method of Papile.
† Patients with both intraventricular hemorrhage and periventricular leukomalacia.

Neurodevelopmental Outcomes

Two-year follow-up data of neurodevelopmental outcomes in 415 neonates who enrolled in the INFASURF vs. colfosceril palmitate controlled-trials demonstrated significant developmental delays in both the INFASURF and colfosceril palmitate groups; however, there was no significant differences between the groups.

8 USE IN SPECIFIC POPULATIONS

8.4 Pediatric Use

The safety and effectiveness of INFASURF have been established to reduce the risk of RDS in preterm neonates < 29 weeks of gestational age at risk for RDS and for the rescue treatment of RDS in preterm neonates ≤72 hours of age with RDS who require endotracheal intubation, and the information on these uses is discussed throughout the labeling. The safety and effectiveness of INFASURF have not been established in older pediatric patients.

10 OVERDOSAGE

If respiration, ventilation, or oxygenation is clearly affected after an accidental overdose, aspirate as much of the intratracheal suspension as possible and provide the neonate with supportive treatment.

11 DESCRIPTION

Calfactant is an extract of natural bovine lung (pulmonary) surfactant consisting of 85% phospholipids, 8% neutral lipids, and 7% hydrophobic surfactant-associated proteins B and C (SP-B and SP-C). The molecular weight of SP-B is 8.7 kDa and the molecular weight of SP-C is 3.7 kDa.

INFASURF (calfactant) intratracheal suspension is a sterile, off-white suspension for intratracheal use. INFASURF contains calfactant at a concentration of 35 mg/mL in either a 105 mg/3 mL or 210 mg/6 mL single-dose vial. Each milliliter of INFASURF contains 35 mg of phospholipids and 0.7 mg of surface-associated proteins of which 0.26 mg is SP-B, a 79-amino acid protein, and 0.44 mg is SP-C, a 35-amino acid peptide. Each milliliter of INFASURF DS contains 70 mg of phospholipids and 1.4 mg of surface-associated proteins of which 0.52 mg is SP-B, a 79-amino acid protein, and 0.88 mg is SP-C, a 35-amino acid peptide. The amount of phospholipids is calculated from the content of phosphorous and contains 26 mg of phosphatidylcholine of which 16 mg is disaturated phosphatidylcholine. It is suspended in 0.9% Sodium Chloride Irrigation, USP. The pH is approximately 5.0 - 6.2 (target pH 5.7).

INFASURF contains no preservatives.

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

Endogenous lung surfactant is essential for effective ventilation because it modifies alveolar surface tension thereby stabilizing the alveoli. Lung surfactant deficiency is the cause of Respiratory Distress Syndrome (RDS) in preterm neonates. INFASURF is a lung surfactant that restores lung surface activity in preterm neonates with RDS by adsorbing to the surface of the air:liquid interface and modifying surface tension similarly to natural lung surfactant.

12.2 Pharmacodynamics

Calfactant dose-response relationships and the time course of pharmacodynamic response are unknown. *In vitro,* INFASURF lowered minimum surface tension to ≤ 3 mN/m as measured on a pulsating bubble surfactometer. *Ex vivo,* INFASURF restored the pressure volume mechanics and compliance of surfactant-deficient rat lungs. *In vivo*, INFASURF improved lung compliance, respiratory gas exchange, and survival in preterm lambs with profound surfactant deficiency.

12.3 Pharmacokinetics

The absorption, distribution, metabolism, and excretion of calfactant in humans following intratracheal administration of INFASURF is unknown.

12.6 Immunogenicity

The immunogenicity of INFASURF is unknown. No INFASURF DS clinical trials have been conducted.

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

Studies to assess potential carcinogenic effects of calfactant have not been conducted.

Calfactant was not mutagenic in a single bacterial reverse mutation assay (Ames test).

No studies to assess reproductive effects of calfactant have been performed.

14 CLINICAL STUDIES

14.1 Overview of Clinical Trials

The efficacy of INFASURF to reduce the risk of respiratory distress syndrome (RDS) in preterm neonates <29 weeks of gestational age at risk for RDS and for the rescue treatment of RDS in preterm neonates ≤72 hours of age with RDS who required endotracheal intubation was based on three randomized, active-controlled clinical trials that enrolled 3,098 neonates:

- INFASURF vs colfosceril palmitate to reduce the risk of RDS in preterm neonates (Trial 1)
- INFASURF vs beractant to reduce the risk of RDS and treatment of RDS in preterm neonates (Trial 2)
- INFASURF vs colfosceril palmitate for treatment of RDS in preterm neonates (Trial 3)

INFASURF vs beractant trial (Trial 2) was one trial that included two cohorts that assessed the efficacy of INFASURF to reduce the risk of RDS (cohort #1) and for the rescue treatment of RDS (cohort #2).

While efficacy cannot be established from uncontrolled trials, there were four uncontrolled trials that included 15,500 preterm neonates who were treated with INFASURF. However, efficacy results are presented only for the three controlled trials described below.

14.2 Reduction of Risk for Neonatal Respiratory Distress Syndrome

INFASURF vs Colfosceril Palmitate Trial to Reduce the Risk of Respiratory Distress Syndrome

A total of 853 neonates <29 weeks gestation were enrolled in a randomized, double-blind, active-controlled, parallel group trial (Trial 1) that compared INFASURF (3 mL/kg) to colfosceril palmitate (5 mL/kg). The initial dose was administered within 30 minutes of birth. If the patient remained intubated, repeat doses were administered every 12 hours (for up to a total of 3 doses). Each dose was divided in 2 equal aliquots and administered intratracheally in small bursts over 20 to 30 inspiratory cycles through a side port adapter into the proximal end of the endotracheal tube. After each aliquot was instilled, the neonate was positioned with either the right or the left side dependent.

The primary efficacy endpoints for this trial were incidence of RDS, incidence of bronchopulmonary dysplasia (BPD) at day 28, and death due to RDS evaluated at 14 days for all treated patients. Select secondary endpoints included death at 28 days or prior to discharge, incidence of air leaks due to RDS, and the cross over to other surfactant treatment. Table 3 displays the efficacy results in this trial.

Table 3 Efficacy Results in Preterm Neonates (< 29 weeks of gestational age) (Trial 1)

	INFASURF (N=431) %	**colfosceril palmitate (N=422) %**	**p-Value**
Primary Endpoints			
Incidence of RDS	15	47	≤0.001
Bronchopulmonary dysplasia*	16	17	0.60
Death due to RDS	2	5	≤0.01
Secondary Endpoints			
Any death to 28 days	12	16	0.10
Any death before discharge	18	19	0.56
Incidence of air leaks†	10	15	0.01
Crossover to other surfactant‡	0.2	3	<0.001

* Bronchopulmonary dysplasia, diagnosed by positive X-ray and oxygen dependence at 28 days.
† Pneumothorax and/or pulmonary interstitial emphysema.
‡ If the neonate failed to respond to the three doses of the initial randomized surfactant, was <72 hours of age, and had an a/A PO_2 ratio <0.1, the neonate was permitted to receive the comparator surfactant.

INFASURF vs. Beractant Trial to Reduce the Risk of Respiratory Distress Syndrome

A total of 1,119 neonates were enrolled in the INFASURF vs beractant trial (Trial 2) which included two cohorts that evaluated INFASURF to reduce the risk of RDS (cohort #1) and for the rescue treatment of RDS (cohort #2) *[see Clinical Studies (14.3)]*. Cohort #1 was a randomized, double-blind, active-controlled, trial in 457 neonates ≤ 30 weeks gestation and ≤ 1,250 grams birth weight that compared the 4 mL/kg (100 mg phospholipids/kg) dose of INFASURF to the 4 mL/kg dose of beractant. Note that the INFASURF formulation and dose used in this trial were different from the marketed INFASURF formulation and the recommended dose of 3 mL/kg (105 mg phospholipid/kg). The initial dose was administered intratracheally within 15 minutes of birth and if the patient required ≥30% oxygen repeat doses were administered intratracheally at ≥6 hours following the previous INFASURF dose (for a total of 3 repeat doses before 96 hours of age (a total of 4 doses including the initial dose and the repeat doses)); the recommended frequency of INFASURF repeat dosing is every 12 hours and the maximum number of doses including the initial and repeat doses is three *[see Dosage and Administration (2.1)]*. The surfactant treatments were administered through a 5-French feeding catheter inserted into the endotracheal tube. Each dose was instilled in four equal aliquots (between each of the instillations, the catheter was removed and mechanical ventilation resumed for 0.5 to 2 minutes). Each of the aliquots was administered with the patient in one of four different positions (prone, supine, right, and left lateral).

There was increased mortality from any cause at 28 days (p=0.03) and in death due to respiratory causes (p=0.005) in INFASURF-treated neonates compared to beractant-treated neonates. For evaluable patients (patients who met the protocol-defined entry criteria), mortality from any cause and mortality due to respiratory causes were also higher in the INFASURF group (p = 0.07 and 0.03, respectively). However, these observations have not been replicated in other adequate and well-controlled trials and their relevance to the intended population is unknown. There was no significant difference in the incidence of RDS, air leaks, BPD, and treatment failure between INFASURF and beractant groups.

14.3 Rescue Treatment of Neonatal Respiratory Distress Syndrome

INFASURF vs Colfosceril Palmitate Trial for the Rescue Treatment of Respiratory Distress Syndrome

A total of 1,126 neonates ≤72 hours of age with RDS who required endotracheal intubation and had an arterial/Alveolar oxygen ratio (a/A) $PO_2 < 0.22$ were enrolled into a randomized, double-blind, active-control, parallel group trial (Trial 3) that compared INFASURF (3 mL/kg) and colfosceril palmitate (5 mL/kg). Patients received an initial dose, and if intubation was still required, patients received one repeat dose 12 hours later (total of 2 doses). Each dose was instilled intratracheally in small bursts over 20 to 30 inspiratory cycles in two aliquots through a side-port adapter into the proximal end of the endotracheal tube. After each aliquot was instilled, the neonate was positioned with either the right or the left side dependent.

The primary efficacy endpoints for this trial were the incidence of RDS-related air leaks, incidence of BPD at 28 days, and mortality secondary to RDS. Select secondary endpoints included any death at day 28 or prior to hospital discharge and crossover to other surfactant. Table 4 describes the efficacy results of this trial.

Table 4 Efficacy Results in Neonates ≤72 Hours of Age (Trial 3)

	INFASURF (N=570) %	colfosceril palmitate (N=556) %	p-Value
Primary Endpoints			
Air leaks [*]	11	22	≤0.001
BPD [†]	5	6	0.41
Death due to RDS	4	4	0.95
Secondary Endpoints			
Any death to 28 days	8	10	0.21
Any death before discharge	9	12	0.07
Crossover to other surfactant [‡]	4	4	1

[a] Pneumothorax and/or pulmonary interstitial emphysema.
[†] BPD is bronchopulmonary dysplasia, diagnosed by positive X-ray and oxygen dependence at 28 days.
[‡] If the neonate failed to respond to the two doses of the initial randomized surfactant, was <96 hours of age, and had an a/A PO_2 ratio <0.1, the neonate was permitted to receive the comparator surfactant.

INFASURF versus Beractant Trial for the Rescue Treatment of Respiratory Distress Syndrome

A total of 1,119 neonates were enrolled in the INFASURF vs. beractant trial (Trial 2) which included two cohorts that evaluated INFASURF to reduce risk of RDS (cohort #1) *[see Clinical Studies (14.2)]* and for rescue treatment of RDS (cohort #2). Cohort #2 was a randomized, double-blind, active-controlled trial in 662 neonates with RDS who required endotracheal intubation and had an a/A PO_2 <0.22 that compared the 4 mL/kg (100 mg phospholipids/kg) dose of INFASURF to the 4 mL/kg dose of beractant. Note that the INFASURF formulation and dose used in this trial were different from the marketed INFASURF formulation and the recommended dose of 3 mL/kg (105 mg phospholipids/kg). If the neonate required ≥30% oxygen, repeat doses were administered at ≥6 hours following the previous treatment (for a total of four doses before 96 hours of age). Note that the recommended frequency of INFASURF repeat dosing is every 12

hours and the maximum number of doses including the initial and repeat doses is three *[see Dosage and Administration (2.1)]*. The surfactant was administered intratracheally through a 5-French feeding catheter inserted into the endotracheal tube. Each dose was instilled in four equal aliquots (the catheter was removed between each of the instillations and mechanical ventilation resumed for 0.5 to 2 minutes). Each of the aliquots was administered with the patient in one of four different positions (prone, supine, right, and left lateral) to facilitate even distribution of the surfactant.

The primary efficacy endpoints were the incidence of air leaks, death due to respiratory causes or to any cause, BPD, or treatment failure evaluated at 28 days or to discharge. There was no significant difference between the INFASURF and beractant groups in these efficacy endpoints.

16 HOW SUPPLIED/STORAGE AND HANDLING

INFASURF and INFASURF DS (calfactant) intratracheal suspension are an off-white suspension available in a sterile, rubber-stoppered glass single-dose vial packaged as one vial per carton:

- 126 mg/1.8 mL (70 mg/mL) (NDC 61938-XXX-01)
- 105 mg/3 mL (35 mg/mL) (NDC 61938-456-03)
- 210 mg/6 mL (35 mg/mL) (NDC 61938-456-06)

Refrigerate INFASURF and INFASURF DS (calfactant) intratracheal suspension at 2°C to 8°C (36°F to 46°F) and protect from light. Must store the 105 mg/3 mL (35 mg/mL) vial upright. Do not remove INFASURF from the refrigerator for more than 24 hours.
Unopened, unused INFASURF vials that have reached room temperature within 24 hours can be refrigerated for future use; however, do not re-refrigerate INFASURF more than once. Record the date and time on the carton when INFASURF is removed from the refrigerator.

17 PATIENT COUNSELING INFORMATION

Inform caregivers of the following risks of INFASURF:

- Advise patient's caregivers of acute changes in oxygenation and/or lung function typically occur when a surfactant-deficient neonate with respiratory distress is given a surfactant, including INFASURF *[see Warnings and Precautions, (5.1)]*.

- Advise patient's caregivers of temporary adverse reactions, including skin turning blue, heart rate slowing, airway blockage, or reflux of INFASURF into the infant's breathing tube may occur when INFASURF is administered *[see Warnings and Precautions (5.2)]*. If any of these adverse reactions occurs, the healthcare provider will interrupt INFASURF administration and take appropriate measures to alleviate the adverse reactions.

- Advise patient's caregivers that infants treated with INFASURF may have evidence of bleeding into the brain and/or loss of brain tissue *[see Warning and Precautions (5.3)]*. Bleeding into the brain and loss of brain tissue are sometimes seen in preterm infants, including those who do not receive surfactant treatment, since the main risk factor is being born at or before 32 weeks' gestation. There is no treatment for these complications but affected infants may be at risk for later neurologic complications, including seizures and/or developmental delay, and may require additional evaluation after discharge from the hospital.

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