| | | **Recommended Dosing Regimens in Adult Patients**<br>*These dosing recommendations are based on published literature and established clinical practices. They should not replace clinical judgement, are intended to provide initial guidance, and may be modified depending on the individual patient. Please call ID pharmacy (pager 9407) for additional questions.* | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | ***Creatinine Clearance (mL/min)*[3]** | | | | | | | **Comments** |
| **Antimicrobials ($/Day)[1]** | **R/U/24H/NF[2]** | **Specific Indications** | **Greater than 50** | **30-50** | **10-29** | **Less than 10** | **HD[4]** | **CRRT (CVVH[5])** | **Dosing weight[3,6,7]** | |
| Acyclovir IV ($5) | U | Mucocutaneous herpes simplex infections | 5 mg/kg q8h | 5 mg/kg q12h | 5 mg/kg q24h | 2.5 mg/kg q24h[4] | | 5 mg/kg q24h | IBW[7] | **Hydration should be co-administered with IV acyclovir.** The standard recommended amount is 1 mL of fluid per 1 mg of acyclovir to reduce the risk of renal tubular damage. |
| | | Herpes simplex encephalitis<br>Herpes zoster encephalitis<br>Varicella zoster | 10 mg/kg q8h | 10 mg/kg q12h | 10 mg/kg q24h | 5 mg/kg q24h[4] | | 10 mg/kg q24h | AdjBW[7] | |
| Amoxicillin PO ($0.15) | U | | 250-500 mg q8h | 250-500 mg q12h | | 250-500 mg q24h | 500 mg q24h[4] | 250- 500 mg q12h | | |
| Amoxicillin/clavulanate PO ($0.80) | U | | 875 mg q12h | | 250-500 mg q12h | 250-500 mg q24h | No data | No data | | |
| Liposomal amphotericin B (Ambisome®) ($493) | 24H | Aspergillosis, Candidiasis, other molds | 3 – 5 mg/kg q24h | | | | | | Non-obese: TBW[7] | **Consider 500 mL of normal saline over 2 hours before and after dose to minimize nephrotoxicity;** monitor Mg, K, SCr |
| | | Cryptococcosis | 3 – 4 mg/kg q24h | | | | | | | +/- with flucytosine |
| | | Febrile neutropenia | 3 mg/kg q24h | | | | | | Obese[6]: AdjBW[7] | |
| Ampicillin IV ($14) | U | UTI, SSTI | 1 g q6h | 1 g q8h | | 1 g q12h | 1 g q 12h | 1 g q8h | | |
| | | Bacteremia, Intraabdominal | 2 g q4-6h | 2 g q6-8h | | 1 g Q8-12h | 2 g q12-24h[4] | 2 g q8h | | |
| | | Meningitis/endocarditis | 2 g q4h | 2 g q6h | 2g q8h | 1 g q8h | 2 g q12h[4] | 2 g q8h | | |
| Ampicillin/sulbactam($10) | R | | 1.5 – 3 g q6h | 1.5 – 3 g q8h | 1.5 – 3 g q12h | 1.5 – 3 g q24h | 1.5 – 3 g q24h[4] | 3 g q8-12h | | **Pre-approved** for liver transplant surgery prophylaxis (48h), surgical oncology hepatobiliary procedures (48h), ENT, NICU for NEC, OB/GYN, animal bites in ED, and organ donation protocol |
| Azithromycin PO ($3)<br>Azithromycin IV ($12) | U | | 250 – 500 mg q24h | | | | | | | |
| Aztreonam ($150) | R | Usual dose | 1 – 2 g q8h | | 1 – 2 g q12h | 1 g q24h | 1 g q24h[4] | 1 - 2 g q12h | | **Pre-approved** for surgical prophylaxis for patients with severe beta-lactam allergy up to 1-2g x2 doses<br>1st dose in sepsis – Use STOP Sepsis order set<br>*Pseudomonas* MIC >8 consider 2 g q6h |
| | | Meningitis, *Pseudomonas*, neutropenic fever | 2g q8h | | 2 g q12h | 2 g q24h | 2 g q24h[4] | 2 g q12h | | |
| Caspofungin ($44) | 24H | | 70 mg x 1 dose, then 24 hours after start 50 mg q24h | | | | | | | May need dose adjustment for hepatic impairment |
| Cefazolin ($2) | U | Usual dose | 1 g q8h | | 1 g q12h | 1 g q24h | 1 g q24h[4] | 1 – 2 g q12h | | Alternative dosing for HD: Cefazolin 2 g post HD for 48 hour interdialytic interval, 3 g post HD for 72 hour interdialytic interval<br>(example: 2 g post HD Mon and Wed, 3 g post HD Friday)<br><br>**Obese (>120 kg) with MSSA bacteremia** consider Cefazolin 2 g q6h |
| | | MSSA bacteremia, endocarditis, osteomyelitis | 2 g q8h | | 1-2 g q12h | 1 g q24h | 1 g q24h[4] | 2 g q12h | | |
| Cefepime ($17) | R | Cystitis | 1 g q12h (CrCl >60) | 1 g q24h (CrCl 30-60) | 500 mg – 1 g q24h | 500 mg – 1g q24h | 500 mg – 1g q24h[4] | 1 g q12h | | **Pre-approved** for neutropenic patients (2g Q8H)<br>1st dose in sepsis – Use STOP Sepsis order set<br>Alternative dosing for HD: Cefepime 2 g three times weekly post HD |
| | | Usual Dose | 1 g q8h (CrCl >60) | 1 g q12h (CrCl 30-60) | 1 g q24h | 1 g q24h | 1g q24h[4] | 2 g q12h | | |
| | | CNS, concern for pseudomonas, febrile neutropenia | 2 g q8h (CrCl>60) | 2 g q12h (CrCl 30-60) | 2 g q24h | 1 g q24h | 1g q24h[4] | 2 g q12h | | |
| Cefpodoxime PO ($11) | U | | 200 mg q12h | | 200 mg q24h | | 200 mg 3x weekly after HD | No data | | |
| Ceftaroline ($482) | 24H | SSTI, CAP | 600 mg q12h | 400 mg q12h | 300 mg q12h (CrCl 15-29) | 200 mg q12h (CrCl <15) | 200 mg q12h | 400 mg q12h | | |
| | | MRSA (bacteremia, endocarditis, osteomyelitis) | 600 mg q8h | 400 mg q8h | 300 mg q8h (CrCl 15-29) | 400 mg q12h (CrCl <15) | 400 mg q12h | 400 mg q8h | | |
| Ceftazidime ($72) | R | *Pseudomonas, Stenotrophomonas, Burkholderia* | 2 g q8h | 1 g q8h | 1 g q12h | 500 mg -1 g q24h | 1 g q24h[4] | 1-2 g q12h | | Alternative dosing for HD: Ceftazidime 2 g three times weekly post HD |
| Ceftazidime/avibactam ($912) (Avycaz®) | NF | Carbapenemase-producing Enterobacteriaceae, susceptibility variable | 2.5 g q8h | 1.25 g q8h | 1.25 g q12h | 1.25 g q24h | 1.25 g q24h[4] | 1.25 g q8h | | Provides broad Gram-negative coverage against carbapenem-resistant Enterobacteriaceae. It generally does not have additional activity for ceftazidime-resistant *Pseudomonas aeruginosa* or *Acinetobacter baumannii.*<br><br>**Request susceptibility upon or prior to initiation. Anaerobic activity is limited, consider addition of metronidazole.** |

| Antimicrobials ($/Day)[1] | R/U/24H/NF[2] | Specific Indications | Greater than 50 | 30-50 | 10-29 | Less than 10 | HD[4] | CRRT (CVVH[5]) | Dosing weight[3,6,7] | |
|---|---|---|---|---|---|---|---|---|---|---|
| Ceftriaxone ($4) | U | CAP, UTI, intra-abdominal infections | 1 - 2 g q24h | | | | | | | **Pre-approved** for adult meningitis (2 g q12h)<br>Doses > 2g q24h for other indications requires ID approval |
| | | Osteomyelitis, endocarditis, SBP, Lyme disease | 2 g q24h | | | | | | | |
| | | Meningitis, enterococcal endocarditis synergy | 2 g q12h | | | | | | | |
| Ceftolozane/tazobactam ($633) (Zerbaxa®) | NF | MDR *Pseudomonas* - susceptibility variable | 3 g q8h | 1.5 q8h | 750 mg q8h (CrCl 15-29) | Load with 1.5g then 8 hours later start 375 mg q8h (CrCl <15) | Load with 2.25 g, then 8 hours later start 450 mg q8h[4] | 1.5 q8h | | Does not provide coverage against carbapenem-resistant Enterobacteriaceae<br>Does not provide reliable coverage against *Staphylococcus* spp.<br><br>**Request susceptibility upon or prior to initiation. Anaerobic activity is limited, consider addition of metronidazole.**<br><br>Dosing for CrCl <15 mL/min is extrapolated |
| Cefuroxime IV ($6) | U | | 750 mg – 1.5 g q8h | | 750 mg-1.5g q12h | 750 mg-1.5g q24h | 750 mg q24h[4] | 1 g q12h | | Doses > 750mg Q8H require ID approval<br>Neurosurgical procedures may use 1.5 g Q6H |
| Cefuroxime axetil PO ($5) | U | | 250-500 mg BID | | 250-500 mg q24h | 250-500mg q48h | 500 mg q24h[4] | No data | | |
| Cephalexin ($0.48) | U | | 500 mg q6h | | 250 mg q8h-500 mg q12h | 250 mg q12 | 250 mg q12h-500 mg q24h[4] | No data | | |
| Ciprofloxacin IV ($6) | U | Usual dose | 400 mg q12h | | 400 mg q24h[4] | | | 400 mg q12h | | |
| | | *Pseudomonas* | 400 mg q8h | | 400 mg q12h | | | 400 mg q8h | | |
| Ciprofloxacin PO ($0.20) | U | Cystitis | 250 mg q12h | | 250 mg q24h[4] | | | 250 mg q12h | | Mg, Ca, Al – containing antacids, Fe, Zn, sucralfate →separate administration by ≥ 2h |
| | | Usual dose | 500 mg q12h | | 500 mg q24h[4] | | | 500 mg q12h | | |
| | | *Pseudomonas* | 750 mg q12h | | 750 mg q24h[4] | | | 500 mg q12h | | |
| Clindamycin IV ($9) | U | | 600 – 900 mg q8h | | | | | | | **900 mg for necrotizing soft tissue infections and for obese patients >120 kg** |
| Clindamycin PO ($1) | U | | 300 – 450 mg q6h | | | | | | | |
| Colistin ($18) | 24H | | See separate colistin dosing recommendations | | | | | | | **Preferred polymyxin for treatment of UTI** |
| Daptomycin ($177) | 24H | <u>MRSA , MSSA</u><br>Bacteremia<br>Endocarditis<br>Osteomyelitis (8 – 10 mg/kg) | 8 mg/kg q24h | | 8 mg/kg q48h | | 8 mg/kg post HD x 2 sessions; then, 12 mg/kg post HD for 3rd session | 8 mg/kg q48h | Non-obese: TBW[7]<br><br>Obese[6]: AdjBW[7] | Contraindicated for pneumonia;<br>Monitor baseline and weekly CPK levels<br><br>**For *Enterococcus spp*:**<br>**MIC ≤ 1 mcg/mL: 6-8 mg/kg**<br>**MIC = 2 mcg/mL: 10-12 mg/kg**<br>**MIC > 2: Consider <u>at least</u> 12 mg/kg, an alternate agent or combination therapy as MIC testing may be variable** |
| | | <u>Enterococcus/VRE</u><br>Bacteremia<br>Osteomyelitis | 8 – 12 mg/kg q24h (See MIC comment) | | 8 – 12 mg/kg q48h (See MIC comment) | | 8 mg/kg post HD x 2 sessions; then, 12 mg/kg post HD for 3rd session | 8 mg/kg q48h | | |
| | | Enterococcus/VRE Endocarditis | 10 – 12 mg/kg q24h (See MIC comment) | | 10 – 12 mg/kg q48h (See MIC comment) | | 10 mg/kg post HD x 2 sessions; then, 12 mg/kg post HD for 3rd session | 10 mg/kg q48h | | |
| | | SSTI | 4 mg/kg q24h | | 4 mg/kg q48h | | 4 mg/kg post HD x 2 sessions; then, 6 mg/kg post HD for 3rd session | 4 mg/kg q48h | | |
| | | Enterococcus UTI | 6 mg/kg q24h (See MIC comment) | | 6 mg/kg q48h (See MIC comment) | | 6 mg/kg post HD x 2 sessions; then, 9 mg/kg post HD for 3rd session | 6 mg/kg q48h | | |
| Ertapenem ($107) | R | | 1g q24h | | 0.5 g q24h | | | 1 g q24h | | |
| Fluconazole IV/PO ($4/ $0.40) | IV: R<br>PO: U | Invasive candidiasis/candidemia | Loading dose x 1 then 24 hours later start 400 – 800 mg q24h | Loading dose x 1 then 24 hours later start 200 – 400 mg q24h | | Loading dose x 1 then 24 hours later start 100 – 200 mg q24h[4] | | Loading dose x 1 then 24 hours later start 200 – 400 mg q24h | | **Pre-approved** for Kidney-Pancreas, Small Intestine, and Liver Transplant patients (while in SICU or up to 7 days), BMT patients, HIV patients, and surgical prophylaxis for VAD placement (48 hours up to 400mg Q24H)<br><br>**Loading dose (~12mg/kg or 800mg) for severe infections**<br><br>For ***Candida glabrata***:<br>MIC ≤ 4 mcg/mL 800 mg IV/PO x 1 dose then 400 mg q24h<br>MIC = 8 mcg/mL 800 mg IV/PO q24h<br>MIC > 8 consider an alternate antifungal |
| | | Oral candidiasis | 100– 200 mg q24h | 50 – 100 mg q24h | | 50 mg q24h[4] | | 100 – 200 mg q24h | | |
| | | Esophageal candidiasis | 200 – 400 mg q24h | 100 – 200 mg q24h | | 50 – 100 mg q24h[4] | | 200 – 400 mg q24h | | |
| | | Prophylaxis | 200 – 400 mg q24h | 100 – 200 mg q24h | | 50 – 100 mg q24h[4] | | 200 – 400 mg q24h | | |
| Foscarnet ($824) | 24H | | See separate foscarnet dosing recommendations | | | | | | | |

| Antimicrobials ($/Day)[1] | R/U/24H/NF[2] | Specific Indications | Greater than 50 | 30-50 | 10-29 | Less than 10 | HD[4] | CRRT (CVVH[5]) | Dosing weight[3,6,7] | |
|---|---|---|---|---|---|---|---|---|---|---|
| Fosfomycin | R | Uncomplicated cystitis | 3g PO x1 | | | | | | | Not for systemic infections, including pyelonephritis<br>Complicated – male, indwelling catheter, immunosuppression, GU instrumentation |
| | | Complicated cystitis (i.e., male) | 3g PO q48h x 3 doses | 3 g PO q72h x 2 doses (20 – 50 mL/min) | | Not recommended due to low urine concentration | Not recommended due to limited data | | | |
| Ganciclovir IV ($39) | R | | CrCl ≥ 70 | CrCl 50-69 | CrCl 25-49 | CrCl 10-24 | CrCl <10, HD | CRRT | Non-obese: TBW[7]<br><br>Obese[6]: AdjBW[7] | **Pre-approved** for solid organ transplant patients according to protocol |
| | | CMV Induction/Treatment | 5 mg/kg q12h | 2.5 mg/kg q12h | 2.5 mg/kg q24h | 1.25 mg/kg q24h | 1.25 mg /kg 3 times/week | 2.5 mg/kg q24h | | |
| | | CMV Maintenance/ Prophylaxis | 5 mg/kg q24h | 2.5 mg/kg q24h | 1.25 mg/kg q24h | 0.625 mg/kg q24h | 0.625 mg /kg 3 times/week | 1.25 mg/kg q24h | | |
| Imipenem-cilastatin ($40) | R | | 500 mg q6h | 500 mg q8h | 500 mg q12h | 250 mg q12h | 500 mg q12h | 500 mg q8h | | MSHS approved dosing regimen |
| Isavuconazole IV/PO ($249/$146) | 24H | | 372 mg q8h x 6 doses, then 12 hours later start 372 mg q24h | | | | | | | |
| Levofloxacin IV/PO ($5/$0.32) | IV: R<br>PO: U | | 500 – 750 mg q24h | 500 - 750 mg q48h (CrCl 20 – 49) | 750 mg x1, then 48 hours later start 500 mg q48h (CrCl < 20) | 750 mg x1, then 48 hours later start 250 - 500 mg q48h[4] | | 750 mg x1, then 24 hours later start 250 mg q24h | | IV: **Pre-approved** for Adult ED, prophylaxis in BMT patients (if not tolerating PO), SBP protocol if severe beta-lactam allergy, surgical prophylaxis for VAD placement for 48 hours (up to 500 mg q24h)<br>PO: Mg, Ca, Al – containing antacids, Fe, Zn, sucralfate → separate administration ≥ 2 h |
| Linezolid IV/PO ($54/$8) | 24H | | 600 mg q12h | | | | | | | Only first dose pre-approved for BMT patients with history of VRE |
| | | | | | | | | | | |
| Meropenem ($18) | R | Usual dose<br>Febrile neutropenia | 1 g q8h | 1 g q12h | 500 mg q12h | 500 mg q24h[4] | | 1 g q12h | | 1st dose in sepsis – Use STOP Sepsis order set |
| | | Meningitis | 2g q8h | 2g q12h | 1 g q12h | 1 g q24h[4] | | 1g q12h | | |
| Metronidazole IV/PO ($5/$1) | U | | 500 mg q8h | | | | | | | Doses > 500mg Q8H require ID approval<br>1st dose in sepsis – Use STOP Sepsis order set |
| Nafcillin ($68) | U | | 2 g q4h | | | | | | | |
| Nitrofurantoin (Macrobid®) ($5) | U | | 100 mg PO q12h (CrCl ≥ 30) | | Not recommended | | | | | Not for systemic infections, including pyelonephritis |
| Oseltamivir (Tamiflu) ($5) | U | | CrCl ≥ 60 | CrCl 30-60 | CrCl 10-30 | CrCl <10 | HD | PD / CRRT | | |
| | | Influenza A and B Treatment | 75 mg q12h x 5 days | 30 mg q12h x 5 days | 30 mg q24h x 5 days | 30 mg every other day x 5 days | 30 mg x 1 dose, then 30 mg after every hemodialysis cycle for a total of 5 days | PD: 30 mg x 1 dose<br>CRRT: 75 mg q12h x 5 days | | HD dosing example: Patient receives HD on MWF. Patient starts therapy on Tuesday. Give 30 mg on Tuesday, Wednesday and Friday. |
| | | Influenza A and B Prophylaxis | 75 mg q24h x 7 days | 30 mg q24h x 7 days | 30 mg every other day x 7 days | No Data | 30 mg x 1 dose, then 30 mg after every other hemodialysis cycle for a total of 7 days | PD: 30 mg x 1 dose<br>CRRT: 75 mg q24h x 7 days | | HD dosing example: Patient received HD on MWF. Patient starts therapy on Tuesday. Give 30 mg on Tuesday, Wednesday and Monday. |
| Penicillin G potassium/sodium IV ($57) | U | | 2-4 mill unit q4h | 75% q4h | 20-50% q4h | 25-50% q4-6h | 75% q4h | | | **Sodium formulation reserved for renal failure**<br>Dosing highly dependent on indication |
| Piperacillin/tazobactam ($30) | R | Usual dose | 3.375 g q6h (CrCl>40) | 2.25 g q6h (CrCl 20-40) | 2.25 g q8h (CrCl<20) | | 2.25 g q8h | 3.375 g q6h | | **Pre-approved** for surgical oncology hepatobiliary procedures up to 48 hours, organ donation protocol |
| | | Severe nosocomial infection, *Pseudomonas*, Weight >120kg | 4.5 g q6h (CrCl>40) | 3.375 g q6h (CrCl 20-40) | 2.25 g q6h (CrCl<20) | | 2.25 g q8h | 3.375 g q6h | | |
| Polymyxin B ($131) | 24H | | 20,000 Units/kg x 1 dose, then 12 hours later start 12,500 Units/kg q12h | | | | | | Non-obese: TBW[7]<br>Obese[6]: AdjBW | **Preferred polymyxin for treatment of systemic infections other than UTI** |
| Posaconazole PO suspension ($176) | 24H | | Prophylaxis: 200 mg q8h<br>Treatment: 200 mg q6h or 400 mg q12h | | | | | | | **Pre-approved** for prophylaxis in BMT and AML patients<br>Formulations not interchangeable; many drug interactions |
| Posaconazole PO tablets ($182) | 24H | | Prophylaxis & Treatment:<br>300 mg q12h x 2 doses, then 12 hours later start 300 mg q24h | | | | | | | Suspension: Only use suspension if cannot tolerate tablets; requires high fat meal and acidic environment for absorption |
| Sulfamethoxazole/Trimethoprim IV/PO ($56/$0.32) | U | UTI | 1 DS tab q12h | | 1 SS tab q12h | | 1 SS tab q24h[4] | No Data | Non-obese: TBW[7]<br><br>Obese[6]: AdjBW | **Dosing based on trimethoprim (TMP) component**<br>Dosing highly dependent on indication<br><br>Listeria meningitis with beta-lactam allergy: 5 mg/kg IV q6-8h<br><br>Single strength (SS): 80 mg TMP<br>Double strength (DS): 160 mg TMP |
| | | SSTI, MRSA suspected | 5 mg/kg q12h OR 1-2 DS tabs q12h | | 2.5 mg/ kg q12h | 2 - 2.5 mg/kg q12 - 24h[4] | | 2.5 mg/kg q12h | | |
| | | PCP treatment, invasive *Nocardia*, *Stenotrophomonas* | 5 mg/kg q6-8h | | 5 mg/kg q12h | 5 mg/kg q12 - 24h[4] | | 5 mg/kg q12h | | |
| | | PCP + Toxo Prophylaxis | 160 mg IV q24h or 1 DS po q24h | | 80 mg IV q24h[4] or 1 SS PO q24h[4] | | | 80 mg IV q24h or 1 SS PO q24h | | |
| | | PCP Prophylaxis | 80 mg IV q24h or 1 SS po q24h or 1 DS TIW | | 80 mg IV q24h[4] or 1 SS po q24h[4] or 1 DS TIW[8] | | | 80 mg IV q24h or 1 SS PO q24h | | |
| Tigecycline ($144) | 24H | | 100 mg x 1 dose, then 12 hours later start 50 mg q12h | | | | | | | May need dose adjustment for hepatic impairment |
| Valacyclovir ($11) | U | Herpes zoster (shingles) treatment | 1g q8h | 1g q12h | 1g q24h | 500 mg q24h | | No data | | |

| | | **Recommended Dosing Regimens in Adult Patients**<br>*These dosing recommendations are based on published literature and established clinical practices. They should not replace clinical judgement, are intended to provide initial guidance, and may be modified depending on the individual patient. Please call ID pharmacy (pager 9407) for additional questions.* | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | ***Creatinine Clearance (mL/min)***[3] | | | | | | | **Comments** |
| **Antimicrobials ($/Day)**[1] | **R/U/24H/NF**[2] | **Specific Indications** | **Greater than 50** | **30-50** | **10-29** | **Less than 10** | **HD**[4] | **CRRT (CVVH[5])** | **Dosing weight**[3,6,7] | |
| Tigecycline ($144) | 24H | | 100 mg x 1 dose, then 12 hours later start 50 mg q12h | | | | | | | May need dose adjustment for hepatic impairment |
| Valacyclovir ($11) | U | Herpes zoster (shingles) treatment | 1g q8h | 1g q12h | 1g q24h | 500 mg q24h | | No data | | |
| Valganciclovir ($51) | U | | CrCl ≥ 60 | CrCl 40-59 | CrCl 25-39 | CrCl 10-24 | CrCl <10, HD | CRRT | | Prophylaxis dosing may vary depending on CMV risk category |
| | | CMV Induction/Treatment | 900 mg q12h | 450 mg q12h | 450 mg q24h | 450 mg q48h | 200 mg three times per week or 450 mg q48h[4] | No data | | |
| | | CMV Maintenance/ Prophylaxis | 900 mg q24h | 450 mg q24h | 450 mg q48h | 450 mg twice weekly | 100 mg three times per week or 450 mg twice weekly[4] | 450 mg q48h | | |
| Vancomycin PO ($6) | Y | Non severe – Severe *C. difficile* | 125 mg q6h | | | | | | | Pre-approved for *C. difficile* positive patients – vancomycin 125 mg PO q6h x 10 days |
| | | Fulminant *C. difficile* | 500 mg q6h (plus metronidazole 500 mg IV q8h) | | | | | | | Refer to MSHS *C. difficile* guidelines for full details |
| Vancomycin IV ($11) | U | | 15 mg/kg q8-12h | 15 mg/kg q12-24h | 15mg/kg q24-48h | Dose by level | Dose by level | 1 g q24h | | 1st dose in sepsis – Use STOP Sepsis order set |
| Voriconazole PO ($21) | 24H | Aspergillosis Prophylaxis/Treatment | 3 – 4 mg/kg q12h | | | | | | Non-obese: TBW[7] Obese[6]: AdjBW | **Pre-approved** for prophylaxis in BMT patients – IV only when not tolerating PO<br>Round PO to nearest 50 mg |
| Voriconazole IV ($70) | | Aspergillosis Treatment | 6 mg/kg q12h x 2 doses, then 12 hours later start 4 mg/kg q12h | | | | | | | Consider therapeutic drug monitoring if for treatment after 5-7 days of therapy<br>Many drug interactions; may need dose adjustment for hepatic impairment |

[1]Hospital costs/day based on 70 kg patient
[2]R=Restricted (9am-5pm); U=Unrestricted; 24H=ID approval at all times; NF = Non formulary
[3] If total body weight is >30% over ideal body weight (IBW), then use adjusted body weight (AdjBW) to calculate renal function
[4]For HD dosing, use recommended interval and on dialysis days, give dose after dialysis
[5]CRRT: Based on 2 L/hr dialysate flow rate
[6]Obese = Body Mass Index greater than 30

[7] TBW = total body weight
IBW = ideal body weight =
- Male: [(Height (in.)- 60 in.) x 2.3] + 50 kg
- Female: [(Height (in.)-60 in.) x 2.3] + 45.5 kg

AdjBW = adjusted body weight = [(Total – IBW) x 0.4] + IBW
- Use if >30% over ideal body weight (IBW)

CAP: Community acquired pneumonia
GNR: Gram-negative rod
GPC: Gram-positive cocci
MSSA: Methicillin susceptible *S. aureus*
MRSA: Methicillin resistant *S. aureus*
PCP: *Pneumocystis jirovecii* pneumonia
SBP: Spontaneous bacterial peritonitis
SSTI: Skin and soft tissue infection
UTI: Urinary tract infection
VRE: Vancomycin resistant Enterococci
CRRT: Continuous Renal Replacement Therapy
HD: Hemodialysis