Recommended Dosing Regimens in Adult Patients

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.

Updated: June 2023

Antimicrobials ($/Day)[1]	R/U/24H/NF[2]	Specific Indications	*Creatinine Clearance (mL/min)*[3] Greater than 50	30-50	10-29	Less than 10	HD[4]	CRRT (CVVH[5])	Dosing weight[3,6,7]	Comments
Acyclovir IV ($26)	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	AdjBW[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 Herpes zoster encephalitis Varicella zoster	10 mg/kg q8h	10 mg/kg q12h	10 mg/kg q24h	5 mg/kg q24h[4]		10 mg/kg q24h		
Amoxicillin PO ($0.72)	U		500 mg – 1000 mg q8h	500 - 1000 mg q12h		500 - 1000 mg q24h	500 - 1000 mg q24h[4]	500 - 1000 mg q12h		*Streptococcus pneumoniae*: Can infer **amoxicillin** and **amoxicillin/clavulanate** susceptibility *only* when penicillin (PO) non-meningitis is susceptible
Amoxicillin/clavulanate PO ($0.14)	U		875 mg q12h		250-500 mg q12h	250-500 mg q24h	500 mg q24h[4]	No data		
Liposomal amphotericin B (Ambisome®) ($637)	24H	Aspergillosis-invasive, Endophthalmitis, CNS, endocarditis, other molds	5 mg/kg q24h						Non-obese: TBW[7] Obese[8]: AdjBW[7]	**Consider 500 mL of normal saline over 2 hours before and after dose to minimize nephrotoxicity;** monitor Mg, K, SCr Higher doses may be indicated in invasive mold infections.
		Candidemia, Histoplasmosis Febrile neutropenia	3 mg/kg q24h							
		Cryptococcosis	3 – 4 mg/kg q24h							+/- with flucytosine
Ampicillin IV ($17)	U	UTI, SSTI	1 g q6h	1 g q8h		1 g q12h	1 g q 12h	1 g q8h		
		Streptococcus bacteremia	2 g q6h	2 g q8h		1 g q8h	2 g q12h[4]	2 g q8h		
		Enterococcus bacteremia, CNS infection, endocarditis, Gram-negative bacteremia	2 g q4h	2 g q6h	2g q8h	1 g q8h	2 g q12h[4]	2 g q8h		
Ampicillin/sulbactam($23)	R	Usual dose	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, cystectomy procedure (48h) and organ donation protocol
		Acinetobacter	3 g q4h	3 g q6h	3 g q8h	3 g q12h		3 g q8h		
Azithromycin PO ($3) Azithromycin IV ($3)	U		250 – 500 mg q24h							
Aztreonam ($160)	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 1st dose in sepsis – Use STOP Sepsis order set *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 ($40)	R		70 mg x 1 dose, then 24 hours after start 50 mg q24h							May need dose adjustment for hepatic impairment (Child-Pugh Class B). Poor CNS penetration. Does not concentrate in urine.
Cefazolin ($6)	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 (example: 2 g post HD Mon and Wed, 3 g post HD Friday) **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 ($24)	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) 1st dose in sepsis – Use STOP Sepsis order set 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)	1 g q12h	1 g q24h	1g q24h[4]	2 g q12h		
Cefiderocol ($1465)	NF	MDR *Pseudomonas*, *Acinetobacter*, *Stenotrophomonas*, *Burkholderia cepacia*, and NDM Enterobacterales	2 g q6h (CrCl ≥120) 2 g q8h (CrCl 60-119)	1.5 g q8h (CrCl 30-59)	1 g q8h CrCl 15-29)	750 mg q12h (CrCl <15)	750 mg q12h	1.5 g q12h		**Request susceptibility upon or prior to initiation.** **No anaerobic or Gram-positive activity.**
Cefpodoxime PO ($16)	U		200 mg q12h		200 mg q24h		200 mg 3x weekly after HD	No data		
Ceftaroline ($613)	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		Dosing regimen based on PK/PD data, references: https://doi.org/10.1093/jac/dks006 https://doi.org/10.1093/ofid/ofu046
Ceftazidime ($18)	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 ($990) (Avycaz®)	24H	Carbapenemase-producing Enterobacterales, 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 Enterobacterales (CRE). It generally does not have additional activity for ceftazidime-resistant *Pseudomonas aeruginosa* or *Acinetobacter baumannii*. **Request susceptibility upon or prior to initiation. Anaerobic activity is limited, consider addition of metronidazole.** **Criteria for approval by ID without ASP/ID NF approver:** ePlex result warrants Avycaz (ex: KPC) OR Patient with history of documented resistance warranting Avycaz. Intra-Op Dosing: 2.5 grams IV q 3 hours

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 ($7)	U	CAP, UTI, intra-abdominal infections	1 - 2 g q24h							**Pre-approved** for adult meningitis treatment (2 g q12h) 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 ($729) (Zerbaxa®)	24H	MDR *Pseudomonas* - susceptibility variable	3 g q8h	1.5 g 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 Enterobacterales. Does not provide reliable coverage against *Staphylococcus* spp. **Request susceptibility upon or prior to initiation. Anaerobic activity is limited, consider addition of metronidazole.** **Criteria for approval by ID without ASP/ID NF approver:** ePlex result warrants Zerbaxa for difficult to treat *Pseudomonas* OR Patient with history of documented resistance warranting Zerbaxa Dosing for CrCl <15 mL/min is extrapolated Intra-Op Dosing: 3 grams IV q 6 hours
Cefuroxime IV ($11)	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 Neurosurgical procedures may use 1.5 g Q6H
Cefuroxime axetil PO ($0.65)	U		250-500 mg BID		250-500 mg q24h	250-500mg q48h	500 mg q24h[4]	No data		
Cephalexin ($1)	U		500 mg q6h		250 mg q8h-500 mg q12h	250 mg q12	250 mg q12h-500 mg q24h[4]	No data		
Ciprofloxacin IV ($8)	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 ($0.25)	U	Cystitis	250 mg q12h		250 mg q24h[4]			250 mg q12h		Mg, Ca, Al – containing antacids, Fe, Zn, sucralfate →separate administration by 2 hours prior or 4 hours after
		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 ($8)	U		600 – 900 mg q8h							**900 mg for necrotizing soft tissue infections and for obese patients >120 kg**
Clindamycin PO ($3)	U		300 – 450 mg q8h							
Colistin ($30)	24H		See separate colistin dosing recommendations on ASP website							**Preferred polymyxin for treatment of UTI**
Daptomycin ($36)	R	MRSA , MSSA Bacteremia, Endocarditis, Osteomyelitis (8 – 10 mg/kg)	8 mg/kg q24h		8 mg/kg q48h				Non-obese: TBW[f] Obese[6]: AdjBW[f]	Contraindicated for pneumonia; Monitor baseline and weekly CPK levels **For *Enterococcus spp*:** **MIC ≤ 1 mcg/mL: 6-8 mg/kg** **MIC = 2 mcg/mL: 10-12 mg/kg** **MIC > 2: Consider at least 12 mg/kg, an alternate agent or combination therapy as MIC testing may be variable** Alternate *Outpatient* HD Dosing Based on Indication: 4 mg/kg post HD x 2 sessions; then, 6 mg/kg post HD for 3rd session 6 mg/kg post HD x 2 sessions; then, 9 mg/kg post HD for 3rd session 8 mg/kg post HD x 2 sessions; then, 12 mg/kg post HD for 3rd session 10 mg/kg post HD x 2 sessions; then, 12 mg/kg post HD for 3rd session 12 mg/kg post HD sessions
		Enterococcus/VRE Bacteremia Osteomyelitis	8 – 12 mg/kg q24h (See MIC comment)		8 – 12 mg/kg q48h (See MIC comment)					
		Enterococcus/VRE Endocarditis	10 – 12 mg/kg q24h (See MIC comment)		10 – 12 mg/kg q48h (See MIC comment)					
		SSTI	4 mg/kg q24h		4 mg/kg q48h					
		Enterococcus UTI	6 mg/kg q24h (See MIC comment)		6 mg/kg q48h (See MIC comment)					
Ertapenem ($37)	R		1g q24h		0.5 g q24h			1 g q24h		**Pre-approved** for ESBL E. Coli bacteremia (culture confirmed) Alternate *Outpatient* HD Dose: 1 gram three times weekly post HD
Fluconazole IV/PO ($17/ $4)	IV: R PO: U	Invasive candidiasis Candidemia *Candida glabrata* infections*	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[4]			Loading dose x 1 then 24 hours later start 400 – 800 mg q24h	See comments Obese: AdjBW[f]	**Pre-approved** for Kidney-Pancreas, Small Intestine, and Liver Transplant patients (while in SICU or up to 7 days), BMT patients, HIV patients, cystectomy procedure and surgical prophylaxis for VAD placement (48 hours up to 400mg Q24H) **Loading dose (~12mg/kg or 800mg) for severe infections** *For ***Candida glabrata***: 800 mg IV/PO q24h (empiric) MIC ≤ 4 mcg/mL 800 mg IV/PO x 1 dose then 400 mg q24h MIC = 8 mcg/mL 800 mg IV/PO q24h MIC > 8 consider an alternate antifungal Patient weight >100 kg with unknown/MIC <4: Use mg/kg dosing** Patient weight >80 kg with MIC ≥ 4: use mg/kg dosing** ** If recommended dose is 400 mg, use 6 mg/kg; If recommended dose is 800 mg use 12 mg/kg (round to nearest 100 mg)
		Oral candidiasis	100 – 200 mg q24h		100 mg q24h[4]			100 – 200 mg q24h		
		Esophageal candidiasis	200 – 400 mg q24h		100 – 200 mg q24h[4]			200 – 400 mg q24h		
		Prophylaxis	200 – 400 mg q24h		100 – 200 mg q24h[4]			200 – 400 mg q24h		
Foscarnet ($867)	24H		See separate foscarnet dosing recommendations on ASP website							

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 ($217)	R	Uncomplicated cystitis	3 gram PO x1							Not for systemic infections, including pyelonephritis 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 ($120)	R	CMV Induction/Treatment	CrCl ≥ 70	CrCl 50-69	CrCl 25-49	CrCl 10-24	CrCl <10, HD	CRRT	Non-obese: TBW[f] Obese[g]: AdjBW[f]	**Pre-approved** for solid organ transplant patients according to protocol
			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 ($101)	R		500 mg q6h	500 mg q8h	500 mg q12h	250 mg q12h	500 mg q12h	500 mg q8h		MSHS approved dosing regimen
Imipenem-cilastatin-relebactam ($2,270) (Recarbrio®)	NF	Usual dose	1.25 g q6h (CrCl ≥ 90)	1 g q6h (CrCl 60-89)	750 mg q6h (CrCl 30-59)	500 mg q6h (CrCl 15-29)	500 mg q6h	No data		Provides coverage against Enterobacterales (ESBL, KPC, AmpC). **Request susceptibility upon or prior to initiation.** **No activity against Enterobacterales that produce metallo-β-lactamases (ex: NDM, VIM, IMP). The addition of relebactam does not improve activity against *Acinetobacter*.**
		Only indicated for: MDR *Pseudomonas* (MIC ≥ 2), Cystic fibrosis patients regardless of MIC	2.5 g q6h (CrCl ≥ 90)	2 g q6h (CrCl 60-89)	1.25 g q6h (CrCl 30-59)	1 g q6h (CrCl 15-29)	500 mg q6h	No data		
Isavuconazole IV/PO ($316/$186)	24H		372 mg q8h x 6 doses, then 12 hours later start 372 mg q24h							
Levofloxacin IV/PO ($3/$0.40)	IV: R 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) PO: Mg, Ca, Al – containing antacids, Fe, Zn, sucralfate → separate administration by 2 hours
Linezolid IV/PO ($24/$4)	R		600 mg q12h							Only first dose **pre-approved** for BMT patients with history of VRE Do not renal dose adjust for therapy >72 hrs and CrCl <30
Meropenem ($15)	R	Usual dose Febrile neutropenia	1 g q8h	1 g q12h	500 mg - 1 g q12h	500 mg q24h[4]		1 g q12h		1st dose in sepsis – Use STOP Sepsis order set Dose for CrCl 10-29 in Critically Ill patients: 1 g IV q12h
		CNS infection	2g q8h	2g q12h	1 g q12h	1 g q24h[4]		1g q12h		
Metronidazole IV/PO ($3/$1)	U		500 mg q8h							Doses > 500mg Q8H require ID approval 1st dose in sepsis – Use STOP Sepsis order set
Minocycline IV/PO ($200/$2)	NF	*Acinetobacter* *Stenotrophomonas*	200 mg q12h							Mg, Ca, Al – containing antacids, Fe, Zn, sucralfate → separate oral administration by 2 hours prior or 4 hours after. Monitor Mg & K in HD and renal impairment.
Nafcillin ($42)	U		2 g q4h							
Nitrofurantoin (Macrobid®) ($5)	U		100 mg PO q12h (CrCl ≥ 30)		Not recommended					Not for systemic infections, including pyelonephritis
Oseltamivir (Tamiflu) ($4)	U	Influenza A and B Treatment	CrCl ≥ 60	CrCl 30-60	CrCl 10-30	CrCl <10	HD	PD	CRRT	HD dosing example: Patient receives HD on MWF. Patient starts therapy on Tuesday. Give 30 mg on Tuesday, Wednesday and Friday.
			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	30 mg x 1 dose	75 mg q12h x 5 days	
		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	30 mg x 1 dose	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 ($18)	U		2-4 mill unit q4h	75% q4h	20-50% q4h	25-50% q4-6h	75% q4h			**Sodium formulation reserved for renal failure** Dosing highly dependent on indication
Piperacillin/tazobactam ($16)	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 hepatobiliary procedures (including ERCP) & surgical oncology hepatobiliary procedures **up to 48 hours**, organ donation protocol, hepatobiliary infection (including cholecystitis & cholangitis) and intra-abdominal perforation **up to 7 days**
		Severe nosocomial infection, *Pseudomonas*, Weight >120kg	4.5 g q6h (CrCl>40)	3.375 g q6h (CrCl 20-40)	2.25 g q8h (CrCl<20)		2.25 g q8h	3.375 g q6h		
Polymyxin B ($13)	24H		25,000 Units/kg x 1 dose, then 12 hours later start 12,500 Units/kg q12h						Non-obese: TBW[f] Obese[g]: AdjBW	**The preferred polymyxin for treatment of systemic infections other than UTI.** For pneumonia consider: 25,000 Units/kg x 1 dose, then 12 hours later start 15,000 Units/kg q12h
Posaconazole PO suspension ($266)	24H		Prophylaxis: 200 mg q8h Treatment: 200 mg q6h or 400 mg q12h							**Pre-approved** for prophylaxis in BMT and AML patients Formulations not interchangeable; many drug interactions Suspension: Only use suspension if cannot tolerate tablets; requires high fat meal and acidic environment for absorption
Posaconazole PO tablets ($34)	24H		Prophylaxis & Treatment: 300 mg q12h x 2 doses, then 12 hours later start 300 mg q24h							

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]	
Sulfamethoxazole/Trimethoprim IV/PO ($56/$0.61)	U	UTI	1 DS tab q12h		1 SS tab q12h		1 SS tab q24h[4]	No Data	Non-obese: TBW[7] Obese[6]: AdjBW	**Dosing based on trimethoprim (TMP) component** Dosing highly dependent on indication Single strength (SS): 80 mg TMP Double strength (DS): 160 mg TMP
		SSTI, MRSA suspected, Septic Arthritis	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, *Listeria* meningitis, Invasive *Nocardia*, *Achromobacter*	5 mg/kg q6-8h		5 mg/kg q12h	5 mg/kg q12 - 24h[4]		5 mg/kg q12h		
		Stenotrophomonas	5 mg/kg q8-12h		5 mg/kg q 12h	5 mg/kg q12 - 24h[4]		5 mg/kg q12h		
		CNS Toxoplasmosis Treatment	5 mg/kg q12h		5 mg/kg q24h			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[4]			80 mg IV q24h or 1 SS PO q24h		
Tigecycline ($97)	24H	Usual Dose	100 mg x 1 dose, then 12 hours later start 50 mg q12h							May need dose adjustment for hepatic impairment
		MDR Gram-negatives	200 mg x 1 dose, then 24 hours later 100 mg q12h							
Valacyclovir ($4)	U	Herpes zoster (shingles) treatment	1g q8h	1g q12h	1g q24h	500 mg q24h		No data		
Valganciclovir ($15)	U	CMV Induction / Treatment	CrCl ≥ 60: 900 mg q12h	CrCl 40-59: 450 mg q12h	CrCl 25-39: 450 mg q24h	CrCl 10-24: 450 mg q48h	CrCl <10, HD: 200 mg three times per week or 450 mg q48h[4]	CRRT: No data		Prophylaxis dosing may vary depending on CMV risk category
		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 ($22)	U	Non severe – Severe *C. difficile*	125 mg q6h							Pre-approved for *C. difficile* positive patients – vancomycin 125 mg PO q6h x 10 days Refer to MSHS *C. difficile* guidelines for full details
		Fulminant *C. difficile*	500 mg q6h (plus metronidazole 500 mg IV q8h)							
Vancomycin IV ($5)	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 ($9) Voriconazole IV ($50)	24H	Aspergillosis Prophylaxis and Treatment	6 mg/kg q12h x 2 doses, then 12 hours later start 4 mg/kg q12h						Non-obese: TBW[7] Obese[6]: AdjBW	**Pre-approved** for prophylaxis in BMT, AML & LUNG transplant patients – IV only when not tolerating PO **Round PO to nearest 50 mg. Round IV to nearest 100 mg.** **Obtain trough level after 5-7 days of therapy** 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