

Antibiotic

*P

Appropriate Use (Partial)

Notes

Phone Approval 📞

Ceftazidime	Y	Active against PsA	Cefepime is preferred anti-pseudomonal cephalosporin
Ertapenem	Y	ESBL	Does not cover PsA, Acineto, Enterococcus
GCV/ValGCV	Y	Disseminated CMV	Not restricted for transplant patients
Meropenem	Y	ESBL, febrile neutropenia	Equivalent to P/T for PsA in DUH inpatients

MISC (see CustomID for details): cidofovir, foscarnet, fosfomycin, HCV medications (only if already followed in ID clinic, GI may also approve), moxifloxacin (peds only), remdesivir (peds only), EUA COVID-19 treatment monoclonal antibodies (inpatient), oral COVID therapy (inpatient)

Bedside Consult Required ✍️

AmBisome	N	Specific invasive fungal dz; Mold	Preferred over ABLC, amphotericin B deoxycholate
Ceftaroline	N	Salvage for MRSA infections	Very little use, if invasive MRSA use q8h dosing
Daptomycin	Y	MRSA bacteremia, VRE	No use in pneumonia; Check Qweek CPK; Dose by indication
Ceftaz-avibactam	N	Resistant GNR; <u>not</u> anaerobes	Renal adjustment. For PsA prefer ceftolozane/tazobactam. For confirmed KPC prefer meropenem/vaborbactam.
Linezolid/Tedizolid	Y	Proven MRSA or VRE	IV and PO; Caution with SSRIs; Avoid tedizolid in neutropenia
Imipenem	N	Nocardia, mycobacteria	Mero preferred for PsA
Micafungin	Y	Invasive candidal disease, febrile neutropenia	Candidemia dose=100mg/day; No Caspo
Posaconazole	Y	Intolerant to vori (skin, LFT); zygomycosis	Take PO formulations with food.
Voriconazole	Y	Aspergillosis, Fusarium	IV and PO. Limit IV is CrCL<50. PO on empty stomach
Isavuconazole	N	All to Posa/Vori (QTc, LFT); zygomycosis	IV and PO. No renal/hepatic adjustment. Unique dosing.

MISC: tigecycline, polymyxin/colistin IV, ceftolozane-tazobactam, meropenem-vaborbactam, cefiderocol, fidaxomicin (P), Anti-retrovirals (continuation and new starts), maribavir, letermovir (P), peramivir, inhaled ribavirin, baloxavir (P), dalbavancin, bezlotoxumab, baricitinib for COVID-19 (P); Non-formulary (NOT stocked): oritavancin, plazomicin, eravacycline, omadacycline, imipenem-relebactam

*P = Per protocol Exceptions for Approval (See Reverse Side)

www.customid.org ASET PharmD 970-6666

DRUG- AND SERVICE-SPECIFIC PROTOCOLS (i.e. exceptions)

DRUGS

Baricitinib for COVID – not transplant, OS6 severity, no high complexity features (pregnancy, active VTE, new stroke/MI, active non-COVID infxn)

Ceftazidime – pediatric patients < 2 months ☺

Dalbavancin – Requires ID consult and ASET approval (pager 970-6666)

Daptomycin – Febrile neutropenia protocol (history of VRE or VRE + swab) ☺ for 3d, then full consult

Ertapenem

- PID in OB/GYN patients ☺
- Use in colorectal surgery prophylaxis (single pre-op dose) ☺

Fidaxomicin – FMT protocol (per GI) ☺

GCV/ValGCV – Transplant patients ☺

Letermovir – Primary CMV prophy in alloHSCT by protocol ☺

Linezolid

- Adult ICUs – MRSA pneumonia after 2-3 d Vanco ☎
- ED – Suspected CA-MRSA admitted to ICU ☺ for dose in ED, consult required once in ICU

Meropenem or Miconazole – Overnights review in AM; Febrile neutropenia protocols ☺

Voriconazole, Posaconazole

- Febrile neutropenia protocols (no prior history of azole exposures) ☺
- Fungal prophylaxis protocols (lung transplant/BMT) ☺
- Per High Risk Pediatric Hematology Oncology Prophylaxis Guidelines ☺

SERVICES

ICU (ANY)

Linezolid (Suspected MRSA pneumonia after 2-3 d of vanco) ☎

Heme Malignancy/BMT (Febrile Neutropenia protocol)

Meropenem, Miconazole, Voriconazole, Daptomycin (if prior h/o VRE) for first 72 hours. If prolonged use >3d or unstable patient, need ID consult

Voriconazole, Posaconazole – fungal prophylaxis
Letermovir – primary CMV prophylaxis in allo-HSCT

ED

Linezolid for suspected CA-MRSA necrotizing pneumonia.
Baloxavir for non-admit influenza.
Non-admitted HIV PEP.
Non-admitted EUA COVID-19 monoclonal antibodies for treatment, EUA COVID-19 oral agents

Transplant – Heart and Lung

Inhaled ABLC, Vori, Posa, anti-CMV therapy. *Overall antibiotic plans per Txp ID outpatient notes.*

All Pediatric Units

Ceftazidime – patients < 2 months of age

Recent ID Evaluation Exception for Bedside Consult:

Criteria: 1) Continuation of prior therapy, 2) Seen at bedside (inpt or outpt) by Duke ID within last **12 weeks**, 3) Indication unchanged, 4) Reason for admission unrelated and no clinical change to warrant re-evaluation by ID.

Process: 1) Talk with primary team 2) Note .IDRESTRICTEDDRUGCONTINUATION



Telephone approval required



Unrestricted