OLIVE VIEW - UCLA MEDICAL CENTER

Antibiotic	Dose	Route	Frequency	Indication – if NOT a pre-approved indication, MUST have ID approval
☐ Serum Vancomycin trough 30 minutes before 4th dose				
Pt Allergies:		Pt. Weight (Kg):		

A. The following restricted antibiotics can be administered ***without*** **ID approval** for the pre-approved indications.
Write the order above and place a check mark in the appropriate box. All other uses require ID Fellow approval (see C below).
(Note: Suggested doses are based on a 70 kg patient with normal renal function; adjust dose based on pt weight and renal function.)

NOTE: Restricted antibiotics will be automatically stopped after 7 days; continued administration requires written renewal.

Amikacin (15 mg/kg IV every 24 hr)

- ☐ Serious gram negative infection with suspected multi-drug resistance (ie.nursing home, hospital-acquired infection)

Ampicillin/sulbactam (3 gm IV every 6 hr)

- ☐ Animal/human bite infection

Cefepime (2 gm IV every 8 hr for neutropenic fever; lower dose for other indications)

- ☐ Neutropenic fever
- ☐ Nosocomial pneumonia

Fluconazole (400 mg IV every 24 hr)

- ☐ Documented fungal sepsis (e.g. + blood culture for *Candida* sp.) who cannot take/tolerate oral fluconazole
- ☐ Suspected fungal sepsis (e.g. Sepsis + *Candida* species colonization) who cannot take/tolerate oral fluconazole

Levofloxacin (750 mg IV every 24 hr)

- ☐ Community-acquired pneumonia with history of *severe* ß-lactam and cephalosporin allergy (avoid in pts with AIDS or with suspected TB)

Piperacillin/tazobactam Extended Infusion—Dosing*
Normal renal function: 3.375 g IV q8h over 4 h,

- ☐ CrCl <20ml/min: 3.375 g IV q12h over 4 h
- ☐ **Healthcare-associated pneumonia** (Nosocomial infection, recent hospitalization or nursing home)
- ☐ **Complicated UTI** – (Recent ceftriaxone, hospital-acquired, suspected *Pseudomonas*, nephrostomy tube related infection)
- ☐ **Complicated intra-abdominal infection** – (Recent aminoglycoside, ceftriaxone, or sepsis)
- ☐ **Diabetic foot ulcer infection *(ICU or Step-down only)*** Pt *seriously ill* with sepsis or "wet" gangrene. (Ceftriaxone + metronidazole recommended for all others)

* For all pre-approved indications, including HAP.

Vancomycin (1 gm IV every 12 hr)

- ☐ Hospital acquired, ventilator associated, and health-care associated pneumonia (i.e. nursing home)
- ☐ Serious infection due to ß-lactam resistant gram + cocci (culture-confirmed MRSA/MRSE)
- ☐ Empiric therapy of endocarditis
- ☐ Empiric therapy of cellulitis with abscess or purulent drainage
- ☐ Empiric therapy of septic arthritis
- ☐ Empiric therapy for Line/Catheter related infection
- ☐ Empiric therapy of suspected gram + infection in febrile neutropenia (indwelling catheter, evidence of soft-tissue infection)
- ☐ Bacterial meningitis with suspected PCN-resistant *Streptococcus pneumoniae* (500-750 mg every 6 hr)

B. These antibiotics are <u>fully restricted</u> and always require ID fellow approval:

Aztreonam, Amphotericin B, Amphotericin liposomal, Cidofovir, Daptomycin, Doripenem, Ertapenem, Foscarnet, Ganciclovir, HIV anti-retroviral medications, Linezolid, Meropenem, Micafungin, Posaconazole, Synercid, Tigecycline, Vancomycin PO, Voriconazole, Zanamivir

C. ID approval needed for antibiotics in Section A that do not meet pre-approved indications, and all antibiotics in Section B:

_____ **ID Fellow/Attending Name (print)**

_____ **Date/Time approval given**

☐ **Verbally** ☐ **Documented in chart**

(Please be accurate - form is part of medical record and subject to audit)

DATE	TIME	PHYSICIAN'S SIGNATURE M.D.
PHYSICIAN'S I.D. #		PHYSICIAN'S NAME (PRINT)
DATE	TIME	R.N.'S SIGNATURE R.N.
DATE	TIME	CLERK'S SIGNATURE

PATIENT DATA - Imprint or Print Legibly

Name:

MRUN:

Date of Birth:

Ward or Clinic:

Req. Loc. Code:

T-OV2199

RESTRICTED ANTIBIOTIC ORDER FORM