Children's of Alabama®

Children's of Alabama, Antimicrobial Stewardship Program

RESTRICTED ANTIMICROBIAL LIST (2020)

Drug	Criteria for Use	Restriction
Ceftazidime/Avibactam (Avycaz®)	1. Alternative therapy for ESBL-positive E. coli or Klebsiella UTI 2. Treatment of carbapenem-resistant (meropenem R) gram negative pneumonia	**ID consult or ASP approval prior to ordering**
Ceftolozane/Tazobactam (Zerbaxa®)	1. Alternative therapy for ESBL-positive E. coli or Klebsiella UTI or intra-abdominal infection 2. Treatment of Pseudomonas aeruginosa infections resistant to ceftazidime AND meropenem	**ID consult or ASP approval prior to ordering**
Daptomycin	1. VRE bacteremia or history of VRE bacteremia 2. Persistant VRE meningitis (in combination with Linezolid) 3. Persistant MRSA bacteremia in patient with documented/true Vancomycin allergy or intolerance 4. Treatment failure with other standard of care therapy options for persistent MRSA bacteremia or CNS infection (tried and failed 2 other agents)	**ID consult or ASP approval prior to ordering**
Ertapenem	Discharge dose for COA patients on meropenem as inpatient for approved indications, excludes any patient with Pseudomonas infection	**Non-formulary carbapenem that needs Infectious Disease consults or ASP approval for use**
Linezolid	ASP/ID approval: 1. Culture positive Vancomycin-resistant enterococcus (VRE) or history of VRE 2. Persistent VRE meningitis (in combination with daptomycin) 3. Persistant MRSA bacteremia in a patient with documented/true vancomycin allergy or intolerance 4. Treatment failure with other standard of care therapy options for persistent MRSA bacteremia, CNS infection or pneumonia (tried and failed 2 other agents)	**ID consult or ASP approval prior to ordering**
Omadacycline	Treatment of non-tuberculosis mycobacterial infections (see order set)	**ID consult or ASP approval prior to ordering**
Peramivir	Treatment of H1N1 influenza in a patient with absolute contraindication to enteral oseltamivir (i.e. bowel perforation on no other enteral medications)	**ID consult or ASP approval prior to ordering**
Posaconazole	1. History of or confirmed infection with mucormycosis 2. Treatment of invasive cadidiasis or	**ID consult or ASP approval prior to ordering**

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	aspergillosis infection in patients who failed voriconazole therapy 3. Severe adverse drug reaction with voriconazole therapy where mold coverage is still required	
Quinopristin/Dalfopristin (Synercid®)	ASP/ID approval: 1. VRE (Enterococcus faecium ONLY) bacteremia or history of VRE (faecium) 2. Persistent VRE (faecium ONLY) meningitis (in combination with linezolid) 3. Persistant MRSA bacteremia in a patient with documented/true vancomycin allergy or intolerance 4. Treatment failure with other standard of care therapy options for persistent MRSA bacteremia or CNS infection (tried and failed 2 other agents)	**ID consult or ASP approval prior to ordering**
Ribavirin	1. Patients who are positive for RSV documented by PCR testing **AND** be either a BMT patient less than 180 days post-transplant during RSV season (October-March) 2. RSV positive by PCR **AND** BMT patient with GVHD grade II or higher receiving chronic steroids or immunomodulators for GVHD control	**ID consult or ASP approval prior to ordering**
Tigecycline	1. Patients with history or current cultures with mycobacteria chelonae/abscesses (NTM) 2. Adjunct therapy for stenotrophomonas therapy	**Non-formulary antimicrobial that needs Infectious Disease consult or ASP approval for use** 1. CF patients with documented mycobacterial infection (no ID/ASP consult needed) – Please order through the **NTM order set** 2. ID consult or ASP approval needed for non-CF patients
All non-formulary antimicrobials require ID/ASP approval. Please page on call ID fellow. Any antimicrobial prescribed for a ROUTE, that is not routinely given at COA, or orderable in the EMR, requires approval.		

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