RESTRICTED ANTIMICROBIAL APPROVAL PROCESS

For physicians :

1. Restricted antimicrobials require Infectious Disease (ID) approval and/or ID consult before they can be dispensed by the pharmacy.
2. ID physician, ID pharmacist or another member of the Antimicrobial stewardship committee will assume responsibility for approving the use of restricted agents:

   Monday through Friday from 8am to 4pm: contact Annette Patterson (ID pharmacist) at 652-6745 or tiger text at pharmacy.infectiousdiseases@ventura.org.

   Saturday, Sunday from 8am to 8pm and any weekday from 4pm to 8pm: contact Dr Nessa Meshkaty (ID physician) on tiger text or cell 619-865-5618.

   During off hours (8pm to 8am): Restricted agents may be ordered without approval from the ID physician or pharmacist. However,

   -Only 1 or 2 doses can be ordered overnight.

   -Criteria for use must be indicated on the order and must follow the indications of use (Refer to Antimicrobial Restriction Form).

   -The ordering physician and/or day physician must contact the ID physician or pharmacist the following morning to obtain formal approval.

For pharmacists:

1. Between 8am to 8pm, upon receiving an order for a restricted agent, the pharmacist should verify that approval by the ID physician or pharmacist has been provided. A clinical intervention must be logged in Cerner to document that the approval has been verified.
2. Between 8pm to 8am, upon receiving an order for a restricted agent and if no approval has been provided, the pharmacist must verify that the criteria for use has been met. The following day, pharmacy must ensure formal approval prior to continuing the medication. A clinical intervention must be logged in Cerner to document that the criteria for use has been reviewed.

Restricted Antimicrobials: Criteria for Use
Ventura County Medical Center-Santa Paula Hospital

	RESTRICTED DRUG	CRITERIA FOR USE	REQUIREMENT
1	**AMIKACIN** (AMIKIN®)	Culture documented infection due to MDR-GNR.	**ID APPROVAL**
2	**AMPHOTERICIN B** (FUNGIZONE®)	Empiric or culture documented treatment of a fungal infection when amphotericin B is the only drug therapy indicated.	**ID CONSULT**
3	**AMPHOTERICIN B LIPOSOMAL** (AMBISOME®)	Empiric or culture documented treatment of a fungal infection when amphotericin B is the only drug therapy indicated.	**ID CONSULT**
4	**AZTREONAM** (AZACTAM®)	Empiric or culture documented gram-negative infection in a patient with a true beta-lactam allergy without other therapeutic options.	**ID APPROVAL**
5	**CEFOTAXIME** (CLAFORAN®)	Restricted to neonatal population (age <1 month).	**None**
6	**CEFTAROLINE** (TEFLARO®)	Culture documented infection due to Penicillin resistant S. *pneumonia* or MRSA without other therapeutic options.	**ID CONSULT**
7	**CEFTAZIDIME-AVIBACTAM** (AVYCAZ®)	Culture documented infection due to Klebsiella *Pneumonia* Carbapenemase (KPC) producing GNR or other MDR-GNR.	**ID CONSULT**
8	**COLISTIMETHATE IV** (COLISTIN®)	Culture documented infection due to MDR -GNR.	**ID CONSULT**
9	**COLISTIMETHATE INH** (COLISTIN®)	1) Culture documented pulmonary infection due to MDR-GNR. 2) Cystic fibrosis patient.	**ID CONSULT**
10	**DAPTOMYCIN** (CUBICIN®)	1) Culture documented VRE bacteremia 2) Culture documented MRSA bacteremia and vancomycin intolerance. 3) Culture documented MRSA bacteremia refractory to vancomycin.	**ID APPROVAL**
11	**ERTAPENEM** (INVANZ®)	Culture documented infection due to ESBL producing GNR resistant to fluoroquinolones and trimethoprim/sulfamethoxazole.	**ID APPROVAL**

12	**FOSFOMYCIN** (MONUROL®)	Culture documented UTI due to VRE or MDR -GNR.	**ID APPROVAL**
13	**IMIPENEM-CILASTATIN** (PRIMAXIN®)	Culture documented infections due to GNR sensitive to imipenem-cilastatin and resistant to meropenem or other beta-lactam agent.	**ID CONSULT**
14	**LINEZOLID IV / PO** (ZYVOX®)	1) Culture documented infection due to VRE. 2) Empiric or culture documented treatment of infection due to MRSA and vancomycin intolerance.	**ID CONSULT**
15	**MEROPENEM** (MERREM®)	1) Empiric treatment of septic shock in patient with a beta-lactam allergy (1st dose available without approval). 2) Empiric treatment of health-care associated infection in patient with prior infection or colonization by a resistant GNR 3) Empiric or culture documented treatment of meningitis in a patient allergic to penicillins or cephalosporins (1st dose available without approval). 4) Empiric or culture documented therapy in febrile neutropenic patients allergic to penicillins and cephalosporins. 5) Culture documented treatment of infections due to GNR and limited antimicrobial options.	**ID APPROVAL**
16	**MICAFUNGIN** (MYCAMINE®)	1) Empiric treatment of suspected fungemia. 2) Empiric or culture documented treatment of azole-resistant Candida infections.	**ID CONSULT**
17	**QUINUPRISTIN/DALFOPRISTIN** (SYNERCID®)	Culture documented infection due to VRE when no other therapeutic option available.	**ID CONSULT**
18	**TIGECYCLINE** (TYGACIL®)	Culture documented infection due to VRE or MDR-GNR (excluding bacteremia and UTI) when no other therapeutic option available.	**ID CONSULT**
19	**VORICONAZOLE** (VFEND®)	1) Empiric or culture documented invasive Aspergillus infection. 2) Continuation of outpatient prophylaxis (only ID approval required).	**ID CONSULT**

Abbreviations:
MDR-GNR: Multiple Drug Resistant Gram Negative rods.

Approvals: Antimicrobial Stewardship Committee 10/2016, Pharmacy & Therapeutics Committee 11/2016