IV to PO Step-Down Criteria

Many clinical trials support switching to PO antibiotics after **two to three days** of IV therapy.

When switching is APPROPRIATE

- Absence of suppurative infection or positive blood cultures
- Ability to maintain oral intake or access to functional NG tube
- Temperature less than or equal to 38 °C for at least 24h
- Patient is stable (baseline respiratory rate, WBC less than 11 x 10^9/L)
- For the **following conditions**:
  - Hospital-acquired infections
  - Intra-abdominal infections
  - Pneumonia
  - Skin and soft tissue infections
  - Urinary tract infections

When switching is NOT APPROPRIATE

- Infection requiring very high plasma concentrations or extended IV therapy (e.g. meningitis, endocarditis, bone/joint infections, deep-seated abscess/empyema)
- Patient is immunocompromised (e.g. neutropenia or HIV)
- Patient is NPO or has GI dysfunction
- Patient has condition or drug interaction that can affect bioavailability of oral agent
- Patient is in the ICU

IV to PO Step-Down Chart

Usual IV Dose	Usual PO Dose	PO Bioavailability	ORAL Renal Dose Adjustments
acyclovir 5 to 10 mg/kg Q8H	valACYclovir 1 gram Q8H	~55% once converted to acyclovir	CrCl greater than 30 mL/min: no dosage adjustment CrCl 15 to 30 mL/min: 1 gram Q12H CrCl less than 15 mL/min : 1 gram Q24H
ampicillin 1 to 2 grams Q6H	amoxicillin 250 to 500 mg Q8H	100%	CrCl 10-30 mL/min: 250-500 mg Q12H CrCl less than10 mL/min: 250-500 mg Q24H
azithromycin 500 mg Q24H	azithromycin 250-500 mg Q24H	38%	None
ceFAZolin 1 to 2 grams Q8H	cephalexin 250 to 500 mg Q6H	90%	CrCl 10-50 mL/min : 500 mg Q8-12H CrCl less than 10 mL/min : 250 to 500 mg Q12-24H
cloxacillin 1 to 2 grams Q4-6H	cloxacillin 250 to 500 mg Q6H	90%	None
cefTRIAXone 1 to 2 grams Q24H	amoxicillin/clavulanate 250/125 to 500/125 mg Q8H	100%	CrCl 10 to 30 mL/min: 250 to 500 mg Q12H CrCl less than 10 mL/min: 250 to 500 mg Q24H
cefOXitin 1 to 2 grams Q6-8H	cephalexin 500 mg Q6H & metroNIDAZOLE 500 mg Q8H		CrCl 10-50 mL/min : 500 mg Q8-12H CrCl less than 10 mL/min : 250 to 500 mg Q12-24H
ceftazidime 1 to 2 grams Q8H	ciprofloxacin 250 to 750 mg Q12H	~70%	CrCl 30 to 50 mL/min : 250 to 500 mg Q12H CrCl 5 to 30 mL/min : 250 to 500 mg Q24H
cefuroxime 0.75 to 1.5 grams Q8H	cefuroxime axetil 500 mg Q12H		CrCl 10 to 30 mL/min : 500 mg Q24H CrCl less than 10 mL/min : 500 mg Q48H
ciprofloxacin 200 to 400 mg Q12H	ciprofloxacin 250-750 mg Q12H	~70%	CrCl 30 to 50 mL/min : 250 to 500 mg Q12H CrCl 5 to 30 mL/min : 250 to 500 mg Q24H
clindamycin 600 mg Q8H	clindamycin 300 mg Q6H	90%	None
co-trimoxazole 10 to 20 mg/kg/day TMP divided Q6-8H	co-trimoxazole DS (double strength) Q12H		CrCl 15 to 30 mL/min : SS (single strength) Q12H CrCl less than 15 mL/min : not recommended
fluconazole 100 to 400 mg Q24H	fluconazole 100 to 400 mg Q24H	>90%	CrCl less than 50 mL/min: 50% of dose Q24H
levofloxacin 500-750 mg Q24H	levofloxacin 500-750 mg Q24H	99%	**(for 750 mg Q24H dose)** CrCl 20-49 mL/min: 750 mg Q48H CrCl 10-19 mL/min: 750 mg once, then 500 mg Q48H
linezolid 600 mg Q12H	linezolid 400-600 mg Q12H	100%	None
metroNIDAZOLE 500 mg Q8H	metroNIDAZOLE 500 mg Q8H	100%	None
penicillin G 1 to 2 million units Q4-6H	penicillin V 300 mg QID		None
piperacillin-tazobactam 3.375 grams Q6H	amoxicillin-clavulanate 250/125 to 500/125 mg Q8H		CrCl 10 to 30 mL/min: 250 to 500 mg Q12H CrCl less than 10 mL/min: 250 to 500 mg Q24H

*Once sensitivity is known, selection of oral agent should be based on resistance/sensitivity data