Pharmacy Protocol Review
Automatic IV to PO Conversions

- MEDICATIONS CONVERTED TO ORAL EQUIVALENT
  - Famotidine
  - Pantoprazole (converted to lansoprazole ODT if pt inappropriate for solid dosage form)
  - Metoclopramide
  - Metronidazole
  - Levofloxacin
  - Ciprofloxacin
  - Azithromycin
  - Clindamycin
  - Fluconazole
  - Linezolid
  - Doxycycline
  - Levothyroxine

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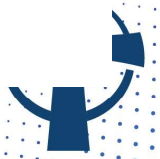
- MEDICATIONS CONVERTED TO ORAL THERAPEUTIC EQUIVALENT
  - Ampicillin/sulbactam (Unasyn) → amoxicillin/clavulanic acid (Augmentin)
  - Ceftriaxone (Rocephin) → cefdinir (Omnicef)
  - Cefazolin (Ancef) → cephalexin (Keflex)
- ANTICONVULSANTS ARE NOT TO BE CHANGED AUTOMATICALLY
  - Fosphenytoin
  - Valproic acid
  - Lacosamide
  - levetiracetam



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- GUIDELINES FOR ALL MEDICATIONS
  - Patient must be concomitantly receiving scheduled (not prn) oral medications.
  - Patient is receiving a solid diet or tolerating tube feedings. (If the patient is receiving tube feedings, a change will be made to a formulation that may give via this route)
  - No anti-nausea medications will have been given within the prior 24 hours.
  - Use sound clinical judgment
  - Phenytoin suspension should be avoided. Bioavailability is greatly reduced with this product

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- ADDITIONAL GUIDELINES FOR ANTI-INFECTIVES
  - 3 day waiting period from start date before conversion.
  - Patients must be afebrile within the past 24 hours.
  - WBC count must be 4000 -- 11,000/mm3
  - On a differential count, the band neutrophil count shall not exceed 5% (“left shift”)
  - If ordered by the physician, erythrocyte sedimentation rate (sed rate) shall not exceed 30 mm/h
  - Exclusions shall be made for the following disease states: endocarditis, osteomyelitis, CNS infections (meningitis, brain abscess), brain tumor, sepsis/SIRS, gangrene, intra-abdominal infections, and current ICU/burn center stay (OK to change once transferred out of the ICU/burn center).
  - Quinolones should not be administered via J-tube. Quinolones are absorbed in the duodenum. J-tubes bypass the duodenum and terminate in the jejunum.
  - Continuous tube feedings might reduce the bioavailability of quinolones. If possible, tube feedings should be held 2 hours before and after quinolone administration.