Department of Pharmacy/Antimicrobial Stewardship Program (August 2026)
Antimicrobial Renal Dosing Guideline

Antibiotic	Usual Dose (Normal Renal Function)	CrCl (ml/min)	Dosage Adjustment
Acyclovir IV 500 mg/vial	5 (10*) mg/kg IV q8h <u>Treatment of Severe HSV/VZV Infections</u> *Use 10 mg/kg for CNS infection or herpes zoster Dose based on **ideal body wt** (not actual body wt), use **adjusted body wt** for BMI>30 **^Ensure adequate hydration to prevent AKI**	25-50	5 (10*) mg/kg IV q12h
		10-24	5 (10*) mg/kg IV q24h
		<10 or HD	2.5 (5*) mg/kg IV q24h (give after HD on dialysis days, e.g. 10PM)
		CRRT	5 (10*) mg/kg IV q12-24h
	250 mg IV q12h • HSV/VZV Prophylaxis in Immunocompromised Patients	<30	250 mg IV q24h
		HD	250 mg IV q24h (dosed after HD)
		CRRT	250 mg IV q12h

Aminoglycosides IV (Gentamicin, Tobramycin, Amikacin) Please see <u>Aminoglycoside Dosing Guidelines</u> for full recommendations (e.g. conventional dosing in special populations, dosage adjustments for renal replacement therapy, peak and trough monitoring, etc.) on Sanford Guide via intranet.	• Dosed based on **ideal body wt** • Use **adjusted body wt** if total body wt > 1.2 * ideal body wt	**Gentamicin/Tobramycin**	**Amikacin**
	CrCl (ml/min)	***For all infections except UTI or synergy in staphylococcal/enterococcal infection***	
	>60	5-7 mg/kg IV q24h	15-20 mg/kg IV q24h
	>30-59	5-7 mg/kg IV q48h	15-20 mg/kg IV q48h
	<u>≤</u>30	1.5-2 mg/kg IV q24h	5 mg/kg IV q24h
	HD	1.5-2 mg/kg IV after HD	5-7.5 mg/kg IV after HD
		For UTI	
	>30	3 mg/kg IV q24h	10 mg/kg IV q24h
	<u>≤</u>30	1.5 mg/kg IV q24h	5 mg/kg IV q24h
	HD	1-1.5 mg/kg IV after HD	5-7.5 mg/kg IV after HD
		For synergy in staphylococcal or enterococcal infections (gentamicin only)	
	>60	1 mg/kg IV q8h	N/A
	>30-59	1 mg/kg IV q12h	
	20-30	1mg/kg IV q24h	
	<20	1 mg/kg IV (Dose by level)	
	HD	1 mg/kg IV after HD	

Amoxicillin/Clavulanate Tablet: 500 mg/125 mg, 875 mg/125 mg	875mg PO q12h	10-30	500 mg q12h
		<10 or HD	500 mg q24h (give after HD on dialysis days, e.g. 10PM)
Ampicillin IV 1 gm, 2 gm	1-2 gm IV q6h	10-30	Normal dose IV q8h
		<10 or HD	Normal dose IV q12h
		CRRT	Normal dose IV q8-6h
	*2 gm IV q4h for Listeria meningitis, Enterococcal endocarditis	30-<50	2 gm IV q6h
		10-<30	2 gm IV q8h
		<10 or HD	2 gm IV q12h
		CRRT	2 gm IV q4-6h

<table>
<tr><td rowspan="12">Ampicillin/Sulbactam IV
1.5 gm, 3 gm</td><td rowspan="3">3 gm IV q6h</td><td>15-29</td><td>3 gm IV q12h</td></tr>
<tr><td><15 or HD</td><td>3 gm IV q24h (give after HD on dialysis days, e.g. 10PM)</td></tr>
<tr><td>CRRT</td><td>3 gm IV q8h</td></tr>
<tr><td rowspan="3">3 gm IV q4h
Carbapenem-resistant
Acinetobacter baumannii infections (intermittent infusion dosing)</td><td>15-29</td><td>3 gm IV q8h</td></tr>
<tr><td><15 or HD</td><td>3 gm IV q12h</td></tr>
<tr><td>CRRT</td><td>3 gm IV q6h</td></tr>
<tr><td rowspan="5">9 gm IV q8h infused over 4 hours
Carbapenem-resistant
Acinetobacter baumannii infections (extended infusion dosing)</td><td>60-89</td><td>6 gm IV q8h infused over 4 hours</td></tr>
<tr><td>30-59</td><td>3 gm IV q6h infused over 4 hours</td></tr>
<tr><td>15-29</td><td>3 gm IV q8h infused over 4 hours</td></tr>
<tr><td><15 or HD</td><td>3 gm IV q12h infused over 4 hours</td></tr>
<tr><td>CRRT</td><td>3 gm IV q6h infused over 4 hours</td></tr>
<tr><td rowspan="2">Amphotericin B Liposomal (Ambisome), 50 mg/vial, $74/vial</td><td colspan="2">All doses based on actual body wt, use adjusted body wt for BMI >30

<u>3 mg/kg IV daily</u>
• Non-CNS invasive candidiasis or mold infection
• Cryptococcal meningitis
<u>5 mg/kg IV daily</u>
• CNS invasive candidiasis or mold infection
• Non-CNS invasive mucormycosis
<u>10 mg/kg IV daily</u>
• CNS mucormycosis
• Cryptococcal meningitis as a single dose x1</td></tr>
<tr><td><10</td><td>Normal dose IV q48h</td></tr>
<tr><td>HD</td><td>No dose adjustment</td></tr>
<tr><td>Artemether/Lumefantrine (Coartem)
Tablet: Artemether 20 mg/ Lumefantrine 120 mg</td><td colspan="2">4 tablets (total artemether 80 mg/lumefantrine 480 mg ORALLY), 4 tablets again after 8 hours, then 4 tablets q12h for the next 4 days (total course is 10 doses=40 tablets)</td><td>No renal adjustment necessary</td></tr>
<tr><td>Artesunate IV</td><td colspan="3">Please contact ID pharmacist ASAP if you are requesting Artesunate IV. Please see Malaria Treatment Guidelines for indication, dosing, and monitoring.</td></tr>
<tr><td rowspan="3">Aztreonam IV
1 gm, 2 gm</td><td rowspan="3">1-2 gm IV q8h</td><td>10-30</td><td>Normal dose IV q12h</td></tr>
<tr><td><10 or HD</td><td>Normal dose IV q24h (give after HD on dialysis days, e.g. 10PM)</td></tr>
<tr><td>CRRT</td><td>Normal dose IV q12h</td></tr>
<tr><td rowspan="3">Aztreonam/Avibactam (Emblaveo)

2 gm, $317/vial</td><td rowspan="3">2g IV q6h</td><td>30-50</td><td>2g IV x1 → 1g IV q6h</td></tr>
<tr><td>15-29</td><td>1.8g IV x1 → 0.9g IV q8h</td></tr>
<tr><td>≤15 or HD</td><td>1.33g IV x1 → 0.9g IV q12h</td></tr>
<tr><td rowspan="4">Cefazolin IV
1 gm, 2 gm</td><td rowspan="4">2 gm IV q8h</td><td>10-35</td><td>2 gm IV q12h</td></tr>
<tr><td><10</td><td>1 gm IV q24h</td></tr>
<tr><td>HD</td><td>1 gm IV q24h (give after HD on dialysis days, e.g. 10PM)
or
2 gm/2 gm/3 gm IV after HD (M/W/F or T/Th/Sat)</td></tr>
<tr><td>CRRT</td><td>2 gm IV q12h</td></tr>
</table>

	2 gm IV q6h *CNS infections, augmented renal clearance (CrCl ≥ 130), obesity	31-50	2 gm IV q8h
		10-30	2 gm IV q12h
		<10	1 gm IV q24h
		HD	1 gm IV q24h (give after HD on dialysis days, e.g. 10PM) or 2 gm/2 gm/3 gm IV after HD (M/W/F or T/Th/Sat)
		CRRT	2 gm IV q12h
Cefdinir PO Capsule: 300 mg Suspension: 50 mg/ml	****NOT RECOMMENDED for the treatment of UTI or intra-abdominal infections (use cefuroxime PO as an alternative)** 300 mg PO q12h	<30 or HD	300 mg PO q24h (give after HD on dialysis days, e.g. 10PM)
Cefepime IV IV: 1 gm, 2 gm	2 gm IV q8h (Neutropenic Fever, Pseudomonas, HECK-Yes*, CNS Infection) *Severe infections caused by *E. cloacae, C. freundii or K. aerogenes*	30-60	2 gm IV q12h
		10-29	1 gm IV q12h or 2 gm IV q24h
		<10 or HD	1 gm IV q24h (give after HD on dialysis days, e.g. 10PM) Or 2 gm/2 gm/2 gm IV after HD (M/W/F or T/Th/Sat)
		CRRT	2 gm IV q12h
	2 gm IV q12h (non-severe infections, including cystitis)	30-60	2 gm IV q24h
		10-29	1 gm IV q24h
		<10 or HD	1 gm IV q24h (give after HD on dialysis days, e.g. 10PM) Or 2 gm/2 gm/2 gm IV after HD (M/W/F or T/Th/Sat)
		CRRT	2 gm IV q12h
Cefiderocol IV 1 gm, $228/vial	2 gm IV q8h	>120	2 gm IV q6h
		30-60	1.5 gm IV q8h
		15-30	1 gm IV q8h
		<15	750 mg IV q12h
		HD	750 mg IV q12h
		CRRT	2 gm IV q12h
Cefoxitin IV 1 gm, 2 gm	1-2 gm IV q8h	10-29	1-2 gm IV q12h-q24h
		<10	1 gm IV q24h
		HD	1 gm after HD (give after HD on dialysis days, e.g. 10PM)
Ceftaroline IV 400 mg, 600 mg, $173/vial	600 mg IV q8h	30-49	400 mg IV q8h
		15-29	300 mg IV q8h
		<15 or HD	200 mg IV q8h
		CRRT	400 mg IV q8h

Ceftazidime/Avibactam IV (Avycaz) 2.5 gm, $410/vial	2.5 gm IV q8h	31-50	1.25 gm IV q8h
		<30, HD	0.94 gm IV q12h
		CRRT	1.25-2.5 gm IV q8h
Ceftolozane/Tazobactam IV (Zerbaxa) 1.5 gm, $177/vial	3 gm IV q8h	30-50	1.5 gm IV q8h
		15-29	750 mg IV q8h
		HD	2.25 gm IV x 1, then 450mg IV q8h
		CRRT	1.5 gm IV q8h
Cefuroxime PO (Ceftin) Tablet: 250 mg, 500 mg	500 mg PO q12h	10-30	500 mg PO q24h
		<10	500 mg PO q48h
		HD	500 mg after HD (give after HD on dialysis days, e.g. 10PM)
Cephalexin PO Capsule: 250 mg, 500 mg Suspension: 50 mg/ml	500 mg PO q6h or 1 gm PO q8h	10-29	500 mg PO q8h or 1 gm PO q12h
		<10	500 mg PO q12h
		HD	500 mg PO q24h (give after HD on dialysis days, e.g. 10PM)
Cidofovir IV 375 mg/vial, $441/vial	5 mg/kg IV once weekly x 2 weeks, then 5 mg/kg IV every other week and give with saline hydration and probenecid 2 gm PO 3 hrs before and 1 gm at 2 hrs and 8 hrs after (total 4 gm) **Low dose:** 0.5-1 mg/kg IV weekly (BK virus), probenecid is optional Dose based on **actual body wt**, use **adjusted body wt** for BMI>30	CKD or ESRD	3 mg/kg IV every other week
	Intravesicular instillation: 5mg/kg once a week in 60 ml normal saline instill through a foley catheter over 15 min and clamp for 1 hr.	No renal adjustment needed	
Ciprofloxacin IV, PO Tablet: 250 mg, 500 mg IV: 200 mg, 400mg	400 mg IV q12h (q8h-Pseudomonas)	<30 or HD	400 mg IV q24h
		CRRT	400 mg IV q8-12h
	500 mg PO q12h (750mg-Pseudomonas)	<30 or HD	500 mg PO q24h (give after HD on dialysis days, e.g. 10PM)
		CRRT	500 mg PO q12h
Daptomycin IV IV: 500 mg/vial, $15/vial	8-12 mg/kg IV q24h (serious infections excluding uncomplicated SSTI/UTI) **Enterococcal bacteremia/endocarditis: start 10-12 mg/kg IV q24h* 6 mg/kg IV q24h (SSTI, UTI) Dose based on **actual body wt**, use **adjusted body wt** for BMI>30	<30	Normal dose IV q48h
		HD	Normal dose IV q48h after HD (give after HD on dialysis days, e.g. 10PM)
		CRRT	Normal dose IV q24h

<table>
<tr><td rowspan="3">Ertapenem IV, IM
IV: $10/vial</td><td rowspan="3">1 gm IV/IM q24h</td><td><30</td><td colspan="2">500 mg IV/IM q24h</td></tr>
<tr><td>HD</td><td colspan="2">1 gm IV/IM three times weekly after dialysis OR 500 mg IV/IM q24h (give after HD on dialysis days, e.g. 10PM)</td></tr>
<tr><td>CRRT</td><td colspan="2">1 gm IV/IM q24h</td></tr>
<tr><td rowspan="4">Fluconazole IV, PO
Tablet: 50 mg, 100 mg, 200 mg;
IV: 100 mg, 200 mg, 400 mg</td><td rowspan="4">100-400* mg IV/PO q24h

C. glabrata infections: 800 mg IV/PO q24h

*Consider giving loading dose (2 x normal dose) as first dose if severe infection (max dose 800 mg)</td><td><50</td><td colspan="2">50% of normal dose IV/PO q24h</td></tr>
<tr><td>HD</td><td colspan="2">50% of normal dose IV/PO q24h (give after HD on dialysis days, e.g. 10PM)</td></tr>
<tr><td>CRRT</td><td colspan="2">400 mg IV/PO q24h</td></tr>
<tr><td colspan="3">Note: 150 mg x 1 dose for vaginal candidiasis or 100 mg/day – no renal adjustment necessary</td></tr>
<tr><td rowspan="4">Flucytosine PO
Capsule: 250mg, 500mg</td><td rowspan="4">25 mg/kg PO q6h
Dose based on ideal body wt</td><td>20-40</td><td colspan="2">Normal dose PO q12h</td></tr>
<tr><td>10-20</td><td colspan="2">Normal dose PO q24h</td></tr>
<tr><td><10</td><td colspan="2">Normal dose PO q48h</td></tr>
<tr><td>HD</td><td colspan="2">25-50 mg/kg/dose PO q48h</td></tr>
<tr><td rowspan="8">Foscarnet IV
6 gm/vial, $221/vial</td><td rowspan="8">Induction: 90 mg/kg IV q12h

Maintenance: 90 mg/kg IV q24h

Dose based on actual body wt, use adjusted body wt for BMI>30

^Ensure adequate hydration to prevent AKI</td><td>CrCl (ml/min/kg)</td><td>Induction</td><td>Maintenance</td></tr>
<tr><td>>1-1.4</td><td>70 mg/kg IV q12h</td><td>70 mg/kg IV</td></tr>
<tr><td>>0.8-1</td><td>50 mg/kg IV q12h</td><td>50 mg /kg IV</td></tr>
<tr><td>>0.6-0.8</td><td>80 mg/kg IV q24h</td><td>80 mg/kg IV</td></tr>
<tr><td>>0.5-0.6</td><td>60 mg/kg IV q24h</td><td>60 mg/kg IV</td></tr>
<tr><td>≥0.4-0.5</td><td>50 mg/kg IV q24h</td><td>50 mg/kg IV</td></tr>
<tr><td><0.4</td><td>No data</td><td>No data</td></tr>
<tr><td>HD</td><td colspan="2">45-60 mg/kg/dose after HD days</td></tr>
<tr><td rowspan="7">Ganciclovir IV
500 mg/vial</td><td rowspan="7">Induction: 5 mg/kg IV q12h*

Maintenance or Prophylaxis: 5 mg/kg IV q24h

*High dose induction: 10 mg/kg IV q12h for low level CMV resistant strain with UL97 mutation, EC 50 < 5 x normal

Dose based on actual body wt, use adjusted body wt for BMI>30</td><td></td><td>Induction</td><td>Maintenance or Prophylaxis</td></tr>
<tr><td>50-69</td><td>2.5 mg/kg IV q12h</td><td>2.5 mg/kg IV</td></tr>
<tr><td>25-49</td><td>2.5 mg/kg IV q24h</td><td>1.25 mg/kg IV</td></tr>
<tr><td>10-24</td><td>1.25 mg/kg IV q24h</td><td>0.625 mg/kg IV q24h</td></tr>
<tr><td>HD</td><td>1.25 mg/kg IV after HD</td><td>0.625 mg/kg IV after HD</td></tr>
<tr><td>CVVH</td><td>2.5 mg/kg IV q24h</td><td>1.25 mg/kg IV</td></tr>
<tr><td>CVVHD, CVVHDF</td><td>2.5 mg/kg IV q12h</td><td>2.5 mg/kg IV q24h</td></tr>
<tr><td rowspan="4">Imipenem/Cilastatin/ Relebactam IV
1.25 gm, $301/vial</td><td rowspan="4">1.25 gm IV q6h</td><td>60-89</td><td colspan="2">1 gm IV q6h</td></tr>
<tr><td>30-59</td><td colspan="2">750 mg IV q6h</td></tr>
<tr><td>15-29</td><td colspan="2">500 mg IV q6h</td></tr>
<tr><td><15 on HD</td><td colspan="2">500 mg IV q6h</td></tr>
</table>

IVIG 2.5 g, 5 g, 10 g, 20 g, 40 g $77/g (i.e. $2000-5500/dose for a 70kg patient)	Toxic shock (GAS, MRSA): 1 g/kg IV on day 1, 0.5 g/kg IV on days 2 and 3 Last resort *C. difficile* colitis: 400 mg/kg IV once Measles post-exposure for high-risk patient: 400 mg/kg IV once (Use **ideal body wt** for dosing, use **adjusted body wt** for BMI>30; round the dose to the nearest 5 g)		
Levofloxacin IV, PO Tablet: 500 mg, 750mg IV: 500 mg, 750mg	750 mg IV/PO q24h ** 500mg IV/PO q24h (if CrCl<20, use q48h) for prophylaxis regimens **	20-49	750mg IV/PO q48h
		10-19, HD	750 mg IV/PO x1, then 500mg IV/PO q48h
		CRRT	750mg IV/PO q48h
Meropenem IV 500 mg, 1 gm	500 mg IV q6h	26-49	500 mg IV q8h
		10-25	500 mg IV q12h
		<10 or HD	500 mg IV q24h (give after HD on dialysis days, e.g. 10PM)
		CRRT	1 gm IV q12h
	2 gm IV q8h (Meningitis, intermediate susceptibility to carbapenems)	26-49	1 gm IV q8h
		10-25	1 gm IV q12h
		<10 or HD	1 gm IV q24h (give after HD on dialysis days, e.g. 10PM)
		CRRT	1 gm IV q8h
Meropenem/Vaborbactam 2 gm, $222/vial	4 gm IV q8h ****DOSE USING eGFR INSTEAD OF CrCl****	eGFR 30-49 or CRRT	2 gm IV q8h
		eGFR 15-29	2 gm IV q12h
		eGFR <15 or HD	1 gm IV q12h
Oseltamivir PO Capsule: 75 mg, 30 mg Suspension: 6 mg/ml	**Treatment:** 75 mg PO q12h **Prophylaxis:** 75 mg PO daily		**Treatment** / **Prophylaxis**
		30-60	30 mg PO q12h / 30 mg PO daily
		<30	30 mg PO daily / 30 mg PO q48h
		HD	30 mg PO after HD / 30 mg PO after every other HD session
Penicillin G IV	3-4 million units IV q4h	10-50	Normal dose IV q8h-q6h
		<10 or HD	Normal dose IV q12h
		CRRT	4 million units IV x1, then normal dose IVq4-6h (Maximum dose: 20 million units)
Piperacillin/Tazobactam IV 4.5 gm	**Standard 4-hour Extended Infusion** (Preferred for all indications) 4.5 gm IV q8h	<20 or HD	4.5 gm IV q12h
		CRRT	4.5 gm IV q8h
	Limited IV Access: 30-minute Infusion (*Pseudomonas*, nosocomial pneumonia, or organism MIC 16) 4.5 gm IV q6h	20-40	4.5 gm IV q8h
		<20 or HD	4.5 gm IV q12h
		CRRT	4.5 gm IV q8h
	Limited IV Access: 30-minute Infusion (All other indications) 4.5 gm IV q8h	<20 or HD	4.5 gm IV q12h
		CRRT	4.5 gm IV q8h

Polymyxin B IV 500,000 units/vial	12,500 units/kg IV q12h (Use total body wt if < 100 kg or adjusted body wt if > 100 kg) Single maximum dose: 1.5 million units		No renal adjustment necessary Monitor Cr, urine output
Ribavirin for RSV, PO Capsule: 200 mg	10 mg/kg PO q8h Maximum dose: 1800 mg/day (Monitor Hgb closely)	30-50	200 mg PO q8h
		10-30	200 mg PO daily
Sulbactam/Durlobactam 2 gm $525/dose	2 g IV q6h (1 g sulbactam + 1 g durlobactam) *with meropenem IV for carbapenem-resistant *Acinetobacter baumannii* infections	≥130	2 g IV q4h
		30-44	2 g IV q8h
		15-29	2 g IV q12h
		<15 or HD	2 g IV q12h x3 doses → 2 g IV daily
Sulfamethoxazole/ Trimethoprim IV, PO SS: trimethoprim 80 mg DS: trimethoprim 160 mg	Dose based on trimethoprim component UTI/SSTI: **1DS (160 mg) - 2DS (320mg) PO q12h** PJP: **15 mg/kg/day IV/PO divided in q8-6h** Serious systemic infection/*S. maltophilia* infections outside of urinary tract: **5 mg/kg IV/PO q12h**	10-30 or HD	UTI/SSTI: 1DS (160 mg) PO q24h PJP: 5-7.5 mg/kg/day IV/PO divided in q12-24h Others: 5 mg/kg/day IV/PO q24h
		CRRT	No dosage adjustment required
Valacyclovir (Valtrex) Tablet: 500 mg, 1 g	2 g PO q8h <u>Indication</u>: • CNS infection – VZV	30-50	2 g PO q12h
		10-29	2 g PO q24h
		<10	1 g PO q24h
		HD	2 g PO post-HD
		CRRT	2 g PO q12h
	1 g PO q8h <u>Indications</u>: • CNS infection – HSV • Herpes zoster/Varicella zoster infections	30-50	1 g PO q12h
		10-29	1 g PO q24h
		<10	500 mg PO q24h
		HD	1 g PO post-HD
		CRRT	1 g PO q12h
	1 g PO q12h <u>Indications</u>: • HSV mucocutaneous infections (orolabial, genital)	10-29	1 g PO q24h
		<10	500 mg PO q24h
		HD	1 g PO post-HD
		CRRT	1 g PO q12h
	500 mg PO q12h <u>Indications</u>: • HSV/VZV Prophylaxis in Immunocompromised Patients	<30	500 mg PO q24h
		HD	500 mg PO q24h (dose after HD)
		CRRT	500 mg PO q12h

<table>
<tr><td rowspan="5">Valganciclovir
tablet: 900 mg, 450 mg</td><td rowspan="5">Induction: 900 mg PO q12h

Maintenance: 900 mg PO q24h

Prophylaxis: 450 mg PO q12h or 900 mg PO q24h</td><td></td><td>Induction</td><td>Maintenance or Prophylaxis</td></tr>
<tr><td>40-59</td><td>450 mg PO q12h</td><td>450 mg PO q24h</td></tr>
<tr><td>25-39</td><td>450 mg PO q24h</td><td>450 mg PO q48h</td></tr>
<tr><td>10-24</td><td>450 mg PO q48h</td><td>450 mg PO twice</td></tr>
<tr><td>HD</td><td>450 mg PO after</td><td>450mg PO after HD</td></tr>
</table>

Montefiore Medical Center Department of Pharmacy
Vancomycin Dosing Guidance

<table>
<tr><th colspan="5">Vancomycin Dosing Table</th></tr>
<tr><th colspan="4">Select Initial Dose Based on Patient's Weight</th><th>Goal</th><th>Monitoring</th></tr>
<tr><td><50 kg</td><td colspan="3">500 mg IV</td><td rowspan="11">Trough level: 10-15 ug/ml</td><td rowspan="11">Obtain trough level prior to the 4th dose

Refer to 'Dose Modifications for Standing Regimens' for adjustments</td></tr>
<tr><td>50-64.9 kg</td><td colspan="3">750 mg IV</td></tr>
<tr><td>65-84.9 kg</td><td colspan="3">1000 mg IV</td></tr>
<tr><td>85-99.9 kg</td><td colspan="3">1250 mg IV</td></tr>
<tr><td>100-130 kg</td><td colspan="3">1500 mg IV</td></tr>
<tr><td colspan="4">Select Initial Interval Based on CrCl and Patient Age</td></tr>
<tr><td></td><td>Age ≤ 50</td><td>Age 50 – 80</td><td>Age ≥ 80</td></tr>
<tr><td>≥100 ml/min</td><td>Q8H*-Q12H</td><td>Q12H</td><td>Q12H*-Q24H</td></tr>
<tr><td>60-99 ml/min</td><td>Q12H</td><td>Q12H</td><td>Q24H</td></tr>
<tr><td>30-59 ml/min</td><td colspan="3">Q24H</td></tr>
<tr><td>AKI or <30 ml/min</td><td colspan="3">Dose by random level; Re-dose when level <15</td></tr>
<tr><td colspan="6">* Reserve this empiric dosing frequency in septic shock on pressors or CNS infection, otherwise use lower frequency

Trough levels must be checked for patients on standing vancomycin regimens
• Must be obtained at steady state (within 30 minutes before 4th or 5th dose)
• If already at steady state and dose is adjusted, obtain new trough before 3rd dose of new regimen

Therapeutic Trough Target: 10-15 ug/ml for all infection types
• We no longer endorse targeting trough goals of 15-20 ug/ml
• 10-15 ug/ml correlates to an AUC:MIC goal of 400-600 and is associated with less nephrotoxicity

Random levels are checked for patients:
• On dialysis
• With renal insufficiency (CrCl <30 ml/min) but not on dialysis, or
• With elevated vancomycin trough levels >15 ug/ml</td></tr>
<tr><td rowspan="4">Intermittent Hemodialysis (iHD)</td><td colspan="2">Initial Dose</td><td colspan="2">Maintenance Dose</td><td rowspan="4">Random pre-HD level: <20 ug/mL</td><td rowspan="4">Obtain random level PRIOR to HD</td></tr>
<tr><td colspan="2" rowspan="3">Dose based on weight as above</td><td>Weight (kg)</td><td>Post-HD Dose</td></tr>
<tr><td>< 70</td><td>500 mg IV</td></tr>
<tr><td>70 – 100</td><td>750 mg IV</td></tr>
<tr><td>Continuous Renal Replacement Therapy (CRRT)</td><td colspan="4">10-15 mg/kg Q24H – round to the nearest 250 mg increment

For morbidly obese patients, consider Q12H</td><td>Random pre-HD level: <15 ug/mL</td><td>Obtain random level within 12-24 hours</td></tr>
</table>

Peritoneal Dialysis (PD) (Max dose is 2000 mg)	**Intermittent IP**	30 mg/kg IP every 5-7 days	Random level: 10-15 ug/ml	Obtain random level every 3-5 days
	Continuous IP (all exchanges)	Load: 1000 mg IP		
		Maintenance: 25 mg/L IP		
	Intermittent IV	15 mg/kg IV x1 dose		

Antibiotic that Do NOT Require Renal Dose Adjustment

- Azithromycin
- Ceftriaxone
- Chloramphenicol
- Clindamycin
- Dicloxacillin
- Doxycycline
- Eravacycline
- Linezolid
- Metronidazole
- Micafungin
- Nafcillin
- Omadacycline
- Oxacillin
- Remdesivir
- Posaconazole
- Voriconazole

Prepared by:

Yi Guo, PharmD, BCIDP

HongKai (Jack) Bao, PharmD, BCIDP

Mei H. Chang, PharmD, BCIDP

Andy Lim, PharmD, BCIDP

Ilya Krichavets, PharmD, BCIDP