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 PHARMACY POLICY & PROCEDURE MANUAL	Policy: Parenteral to Enteral Medication Conversion Guidelines	
	Original Date Implemented: October 1997	Policy #: 70700-046
	Effective Date: January 2005	Supersedes Policy Dated: October 1997
Written/Revised By : Clinical Pharmacy Staff	Distribution: All Clinical Areas	
Approved By: P & T Committee	Date: January 2005	

POLICY STATEMENT:

In accordance with P&T guidelines, the Department of Pharmacy Services shall facilitate an intravenous to oral switch program with the goal of providing high-quality, cost-effective care.

PROCEDURE:

A. Criteria for the conversion from the intravenous to oral/enteral route includes the following:

Antimicrobial Therapy

Patients with the following characteristics **may** be considered for conversion to oral therapy:

1. Patient has a functioning GI tract as indicated by the ability to take oral fluids and medications or tolerance of enteral feedings via tube.
3. Patient has demonstrated clinical improvement indicated by return of WBC towards normal, improving chest x-ray findings, and lack of fever for 24-48 hours.
4. Organism identified is fully sensitive to antibiotic in question.

Patients with any of the following conditions **should not** be considered for conversion to oral therapy:

1. Presence of any of the following: hypotension, dehydration, acute changes in mentation, hypoxia, continued signs of severe sepsis, or worsening chest x-ray findings.
2. Presence of an infection with a high risk of treatment failure, such as meningitis, ventriculitis, endocarditis, pneumonia caused by *Pseudomonas aeruginosa*, lung or other abscess, empyema, necrotizing soft tissue infections or post-obstructive pneumonia.
3. Immunocompromised patients (i.e., patients with neutropenia, post-transplant, HIV infection, sickle-cell anemia, anatomic or functional asplenia). In these populations, oral conversion may still be suitable for urinary tract infections and other moderately severe infections.

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- An appropriate oral alternative does not exist.

Other Pharmacologic Agents

Oral formulations **should** be considered appropriate unless one of the following criteria are met:

- NPO order (including medications) is documented in the chart.
 - Presence of severe nausea, vomiting, diarrhea, GI obstruction, motility disorder, or malabsorption syndrome.
 - Response to oral medications may be unreliable.
 - Emergency situations (rapid onset of drug action needed), e.g., active upper gastrointestinal bleeding, patient actively seizing, etc.
 - Patient is at risk for aspiration.
 - Patient refuses oral medication (documented on the chart).
- B. The pharmacy department will routinely generate screening lists for targeted agents to be utilized by the clinical pharmacist in their evaluation of appropriate candidates for IV-to-PO switch.
- C. The clinical pharmacist is responsible for evaluating the patient's chart and interacting with other healthcare professionals to determine the appropriateness of IV-to-PO switch. Designated medications reviewed for conversion to oral therapy include:

Azithromycin	Linezolid
Ciprofloxacin	Metronidazole
Clindamycin	Moxifloxacin
Famotidine	Pantoprazole
Fluconazole	

- D. Once the patient is deemed appropriate for IV-to-PO switch, the clinical pharmacist will automatically convert the parenteral product to the appropriate corresponding oral dosing regimen by writing an order in the patient's medical record (the order will indicate the route of administration has been changed per P&T policy).
- E. At any time, a physician may reconvert the patient to the original prescribed route by rewriting the order and indicating "Dispense as written" or "Do not substitute".
- F. Acceptance/disregard of IV-to-PO recommendations will be tracked and reported back to the P&T Committee along with estimated cost implications.