IREDELL HEALTH SYSTEM

IV to PO Conversion	
Approved by: Laura Rollings, PharmD, BCPS, BCGP	Last Revised/Reviewed Date: 12/2022
Department of Medicine Critical Care Committee P&T Committee	Date: 07/2022 08/2022 12/2022

Purpose:
Conversion of intravenous (IV) to oral (PO) therapy represents a cost-effective strategy that minimizes IV therapy complications, facilitates earlier hospital discharge, and enhances patient convenience while providing equivalent clinical outcomes.

Policy:
Pharmacists will convert appropriate medications from the IV to PO form in patients who meet defined criteria for conversion. For pediatric patients meeting criteria, the pharmacist will contact the prescribing provider. The medications selected should have documented pharmacokinetic data to support efficacious oral bio-availability. The conversion will apply only to those patients capable of absorbing these agents orally.

Patient Selection Criteria

I. Inclusion criteria. Patients must meet all of the following:

A. have received IV therapy for at least 48 hours;
B. have an intact and functioning GI tract;
C. are tolerating other medications by mouth, NG tube, or GT; Note: if no PO medications are ordered, patient must be tolerating diet;
D. are tolerating liquid diet or more advanced diet or tube feedings for at least 24 hours;
E. are clinically stable with no deterioration expected

For antibiotic conversion, patients must meet all of these additional criteria:

A. have been afebrile (temperature < 100.4 F) for 24 hours
B. white blood cell (WBC) count is within normal limits

II. Exclusion criteria. Patients will be excluded from conversion if any of the following are present:

A. NPO status
B. Diagnosis of severe illness: meningitis, brain abscess, endocarditis, Gram-positive bacteremia, and/or neutropenic fever in hematology/oncology patients

Medications:
The following medications or classes of medications shall be considered for parenteral to oral conversion, when appropriate, on a milligram to milligram basis:

- Fluoroquinolones (levofloxacin)
- H-2 antagonists (famotidine)
- Fluconazole
- Metronidazole
- Doxycycline
- Linezolid

- Azithromycin
- Proton pump inhibitors
- Rifampin
- Thiamine
- Folic Acid

Other conversions:

Medication Ordered	PO Conversion
Ciprofloxacin 400 mg IV	Ciprofloxacin 500 mg – 750 mg PO (See Appendix A)
Ciprofloxacin 200 mg IV	Ciprofloxacin 250 mg PO
Levothyroxine IV	Levothyroxine PO at twice the IV dose
Clindamycin 600 mg IV q8 hours	Clindamycin 300 mg PO q6 hours or 450 mg PO q8 hours (See Appendix A)
Rally Pack (MVI 10 mL, thiamine 100 mg, NS 0.9% 1000 mL) IV daily	Multivitamin PO daily + thiamine 100 mg PO daily
Voriconazole IV – weight based dosing (3-4 mg/kg q12h)	200 mg PO q12h
Voriconazole IV – fixed (non-weight based) dosing	Mg to mg conversion

See Appendices A and B for conversions.

INITIAL EFFECTIVE DATE: 03/2006
DATES REVISIONS EFFECTIVE: 02/2013, 10/2015, 12/2017, 06/2019, 08/2022, 12/2022
DATES REVIEWED (no changes):

Appendix A: Adult Medication Route Conversion Table

Medication	Intravenous Dose	Oral Dose	Notes
azithromycin	250 mg IV q24h 500 mg IV q24h	250 mg PO q24h 500 mg PO q24h	Although azithromycin has low bioavailability, it is well-distributed to tissues.
ciprofloxacin	200 mg IV q12h 200 mg IV q24h 400 mg IV q8h 400 mg IV q12h 400 mg IV q24h	250 mg PO q12h 250 mg PO q24h 750 mg PO q12h 500 mg PO q12h 500 mg PO q24h	Avoid concurrent divalent and trivalent cation administration 2 hours before or 6 hours after. Avoid administration with tube feeds.
clindamycin	600 mg IV q8h	300 mg PO q6h 450 mg PO q8h	
doxycycline	100 mg IV q12h	100 mg PO q12h	Avoid concurrent divalent and trivalent cation administration 1 hours before or 4 hours after. Avoid administration with tube feeds.
fluconazole	100 mg IV q24h 200 mg IV q24h 400 mg IV q24h	100 mg PO q24h 200 mg PO q24h 400 mg PO q24h	
levofloxacin	500 mg IV q24h 750 mg IV q24h	500 mg PO q24h 750 mg PO q24h	Avoid concurrent divalent and trivalent cation administration 2 hours before or 6 hours after. Avoid administration with tube feeds.
linezolid	600 mg IV q12h	600 mg PO q12h	
metronidazole	500 mg IV q8h	500 mg PO q8h	
Thiamine	IV (dose equivalent)	Thiamine PO (dose equivalent)	
Folic Acid	IV (dose equivalent)	Folic Acid PO (dose equivalent)	

Appendix B: *Pediatric* Medication Route Conversion Table

Medication	Intravenous Dose	Oral Dose	Notes
azithromycin	5-10 mg/kg q24h	5-10 mg/kg q24h *(max: 500 mg/day)*	Although azithromycin has low bioavailability, it is well-distributed to tissues.
ciprofloxacin	10-15 mg/kg q8-12h *(max: 400 mg/dose or 40 mg/kg/day)*	10-15 mg/kg q8-12h *(max: 750 mg/dose or 40 mg/kg/day)*	Avoid concurrent divalent and trivalent cation administration 2h before or 6h after. Avoid with tube feeds.
clindamycin	10 mg/kg q6-8h *(max: 1800 mg/day)*	10-13.5 mg/kg q8h *(max: 2700 mg/day)*	
doxycycline	2.2 mg/kg q12h *(max: 100 mg/dose)*	2.2 mg/kg q12h *(max: 100 mg/dose)*	Avoid concurrent divalent and trivalent cation administration 1h before or 4h after. Avoid administering with tube feeds.
fluconazole	3-12 mg/kg q24h *(max: 800 mg/dose)*	3-12 mg/kg q24h *(max: 800 mg/dose)*	
levofloxacin	< 5 y/o: 10 mg/kg q12h ≥ 5 y/o: 10 mg/kg q24h *(max: 750 mg/day)*	< 5 y/o: 10 mg/kg q12h ≥ 5 y/o: 10 mg/kg q24h *(max: 750 mg/day)*	Avoid concurrent divalent and trivalent cation administration 2h before or 6h after. Avoid administering with tube feeds.
linezolid	< 12 y/o: 10 mg/kg q8h ≥ 12 y/o: 10 mg/kg q12h *(max: 600 mg/dose)*	< 12 y/o: 10 mg/kg q8h ≥ 12 y/o: 10 mg/kg q12h *(max: 600 mg/dose)*	
metronidazole	10 mg/kg q6-8h *(max: 500 mg/dose or 40 mg/kg/day)* ***OR*** 30 mg/kg q24h *(max: 1.5g/dose)*	10 mg/kg q6-8h *(max: 500 mg/dose or 50 mg/kg/day)*	