Pharmacist's Letter
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Expand IV-to-PO Switches

Hospitals will refocus on IV-to-po protocols...due to recent data suggesting many eligible patients aren't switched to po.

IV-to-po conversions have been on our radar for years...to improve patient care, decrease workload, reduce cost, etc.

Meds with 1:1 conversions (quinolones, PPIs, etc) are frequent targets for pharmacy protocol switches. But be ready to tackle IV-to-po switches that aren't as straightforward.

Antimicrobials. Work with ID colleagues to create protocols when there's not an exact IV-to-po conversion...or culture results aren't available. Incorporate local resistance patterns.

For example, consider changing ceftriaxone for community-acquired pneumonia to an agent such as amoxicillin/clavulanate, cefdinir, or cefuroxime...once patients are hemodynamically stable and afebrile.

Use similar criteria to switch a patient with uncomplicated gram-negative bacteremia to po...if you also have susceptibility results and an identified source.

For instance, consider TMP/SMX 2 DS tabs bid for susceptible *E. coli* bacteremia from a urinary source...to complete a 7-day course.

But don't jump to po for all infections. For example, work with ID for patients with gram-positive bacteremia, especially *Staph aureus*.

Electrolytes. Adjust your prn replacement protocol for potassium to default to oral instead of IV...unless patients are symptomatic, have levels less than 2.5 mEq/L, are NPO, etc.

Also use po magnesium or phosphorus for asymptomatic patients with mildly low levels...especially during shortages of IV formulations.

But rely on IV magnesium and phosphorus for larger doses due to increased side effects with oral products. For example, giving 800 mg or more of magnesium oxide may increase diarrhea risk.

Plus absorption of oral phosphorus supplements may be unreliable.

Opioids. Create a protocol for post-op or other acute pain patients. Consider changing prn IV opioids to oral after several doses if patients meet po criteria. For example, try oxycodone 5 mg po for morphine 2 to 4 mg IV.

When identifying candidates for any IV-to-po conversion, work with your IT team to create EHR alerts or reports. And add po options to order sets with instructions for nurses to try before IV.

Don't decide that a patient is taking po based strictly on profiled meds. Look at med administration records...or check the EHR for IV lines or enteral tubes. Discuss with the nurse if needed.

Go to our resource, *Considerations for IV-to-PO Conversions*, for guidance on amiodarone, steroids, anticonvulsants, and more.

Key References:

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