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Pharmacist's Letter
Hospital

Expect a Limited Role for Ceftobiprole

You'll get **questions about ceftobiprole medocaril (Zevtera)**...a new IV antibiotic that targets methicillin-resistant *Staph*.

It's a fifth-generation cephalosporin similar to ceftaroline that's been used in Europe for over a decade...and is used for infections from *S. aureus* (including MRSA) and some gram-negatives (*Klebsiella*, etc).

For example, it's FDA-approved for *S. aureus* bacteremia, acute bacterial skin infections, and community-acquired pneumonia (CAP).

But don't expect it to be added to your formulary right away.

Know that it's noninferior to other antibiotics in trials. But some study designs had to compare it to empiric combos we don't usually see in practice (vancomycin plus aztreonam for skin infections, etc).

Point out that observational studies looking at ceftobiprole versus ceftaroline also show similar mortality and adverse effect outcomes.

Compare its costs and workload to ceftaroline. For example, it's typically Q8H at $700/day for CAP...but ceftaroline is Q12H at $500/day.

Continue to generally recommend less expensive, tried-and-true empiric options for *S. aureus* (vancomycin, daptomycin, linezolid, etc) and gram-negatives, such as ceftriaxone, cefepime, etc.

Consult your ID colleagues about possibly using ceftobiprole in rare cases where patients need IV gram-negative plus MRSA coverage...but can't use typical antibiotics due to resistance or intolerable side effects.

Keep ceftobiprole's spectrum gaps in mind.

For instance, don't rely on it for anaerobes (*Bacteroides*, etc)...AmpC or extended spectrum beta-lactamase resistance...or multidrug-resistant *Pseudomonas*. And generally lean away from it for enterococci.

Similarly, caution against using it for ventilator-associated pneumonia (VAP). It's more likely to involve resistant bacteria...and most trials excluded VAP cases. Plus limited VAP data we do have suggest possibly higher mortality with ceftobiprole.

If using ceftobiprole in adults, typically advise 667 mg Q8H for pneumonia and skin infections. But for bacteremia, start with 667 mg Q6H to get higher exposure up front...then space out to Q8H on day 9.

Be aware that regimens need adjustment for low AND high creatinine clearance. For example, adults with a clearance over 150 mL/min need intervals shortened from Q8H to Q6H regardless of the indication.

Keep in mind that each infusion must run over 2 hours...and compatibility data are limited. Ideally adjust med timing...or recommend adding more IV sites...to allow ceftobiprole to run alone.

Reassure that ceftobiprole is usually well-tolerated...but some patients may have nausea, vomiting, anemia, or liver injury.

Check out and share our ceftobiprole quick skim graphic for a snapshot view of dosing, administration, side effects, and more.

Key References:

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