criteria and completed the test per protocol. Administration of the test utilized a stewardship pharmacist-driven, nursing administered, protocol that has three phases: puncture, intradermal, and oral challenge (optional phase). The primary outcome assessed was change made to antimicrobial regimen directly related to PST. A secondary outcome assessed was cost savings associated with PST.

Results. Over 13 months, 116 patients were consulted for PST with 100 patients completing PST per protocol. Self-reported allergies consisted of IGE-mediated and unknown in 52% and 30% of patients respectively. Seventy-one of 98 patients who tested negative (73%) had changes directly made to their antimicrobial regimens related to PST after consultation from the stewardship pharmacist. Thirty-four patients who had received carbapenems were changed directly to a penicillin or cephalosporin. A previous evaluation at our institution showed an average total antimicrobial acquisition cost savings per patient to be $314.75, which would result in $2,347.25 in direct savings for the institution over the course of 13 months exceeded $20,000. Our study confirmed the overall utility of PST as a cost effective antimicrobial stewardship tool, especially as a carbapenem-sparing strategy.

Conclusion. PST led to immediate antimicrobial de-escalation in the majority of patients who tested negative. Most of these patients were transitioned to optimal therapy or de-escalated from carbapenem therapy. A total direct cost savings for the institution over the course of 13 months exceeded $20,000. Our study confirmed the overall utility of PST as a cost effective antimicrobial stewardship tool, especially as a carbapenem-sparing strategy.

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1572. Elimination of Aerosol Ribavirin Use in Immunocompromised Patients with Metapneumovirus and Parainfluenza Virus Infections

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Background. Administration of ribavirin by aerosol (AR) is often used in attempted treatment of respiratory virus infections in severely immunocompromised patients and was the standard of care at Stanford Health Care (SHC) in the management of metapneumovirus (MPV), parainfluenza virus (PIV), as well as respiratory syncytial virus infections, in hematopoietic stem cell (HCT) and lung transplant (LT) recipients.

Methods. A literature review by the transplant ID team in November 2014 failed to provide evidence of benefit of AR for treatment of MPV and PIV infections and also, taking into account its extraordinary cost, it was decided by the transplant ID group that AR should not be used for these infections. An SOP with HCT and LT MDs, however, failed to achieve their concurrence, all evidence was posted online for easy access. An independent expert panel of HCT and pulmonary MDs was asked to review the evidence and they concurred with the conclusion of ID. A meeting was held with all stakeholders together with the P&T committee at which all opinions were heard. All were invited to a subsequent P&T meeting at which it was decided to ban the use of AR for MPV and PIV infections, although oral ribavirin was allowed. The decision was confirmed by the SHC Medical Executive Committee and implemented Dec 2015 after removal of the option from the EHR orders and creation of an escalation pathway for appropriate use.

Results. AR DOT for MPV and PIV infections decreased from 119 (23 patients) in the previous 12 months to 2 (2 patients) in the subsequent 12 months. The drug acquisition cost was reduced from $2,777,222 to $46,676 – a recurring annual saving of $2,730,546. Additional savings accrued from reduced hospital days, freeing of air borne isolation rooms, reduced housekeeping costs, and reduced exposure of women of childbearing age to the potential teratogenic effects of ribavirin. There were no adverse adverse effects from the restriction of AR use.

Conclusion. Careful examination of clinical practice together with relentless efforts in changing prescriber behavior can result in elimination of ineffective therapy with large associated cost savings and without adverse clinical effects.

Disclosures. All authors: No reported disclosures.
empiric treatment of NF in patients meeting specific criteria. After 48 hours, the guide-
lines recommend discontinuing vancomycin if resistant Gram-positive organisms are
not identified. An analysis of vancomycin use for NF at our institution revealed 35% of
patients had vancomycin discontinued appropriately at 48 hours. Based on these results,
a vancomycin stewardship team defined criteria for continuation of vancomycin past 48
hours: an increase in surveillance of vancomycin use through ANT oversight. The
objective of this study is to assess the incidence of vancomycin discontinuation at 48
hours with the new criteria of use and the addition of pharmacist led stewardship.

Methods. This study included NF patients who were treated with an antipseuo-
domonal β-lactam and vancomycin from January to August 2017. Criteria for van-
comycin continuation beyond 48 hours included culture-documented Gram-positive
infection, positive Methicillin Resistant Staphylococcus aureus (MRSA) nasal swab with evidence of
pneumonia, or hemodynamic instability due to septic shock. Patients who received
antistaphylococcal, or a single dose of vancomycin were excluded through ANT oversight.

Results. Sixty-nine patients with 73 admissions were initiated on vancomycin
for NF during the study period. Vancomycin was appropriately discontinued in 63% (46/73)
compared with 35% (19/54) previously. An additional 8% (6/73) was dis-
continued between 48 and 72 hours, and 20% (15/73) was continued past 72 hours
inappropriately. The most common reasons for continuation was lack of neutrophil
recovery (5) and cellulitis (4). AST recommended discontinuation on 5 patients, all of
which were accepted.

Conclusion. Establishing criteria for vancomycin use along with pharmacist led
antibiotic surveillance, AST, and provider education improved the use of vancomycin
with the discontinuation rate increasing from 35% to 63% (P = 0.002)

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