Table 2. Dalbavancin Use Characteristics

| Dosing Regimens Utilized | n (%) |
|-------------------------|-------|
| 1500 mg x 1             | 29 (55) |
| 1500 mg x 2             | 13 (25) |
| 1500 mg x 1, followed by 1000 mg q1 | 1 (2) |
| 1000 mg q1              | 4 (8) |
| 1000 mg q2              | 1 (2) |
| 1000 mg q3, followed by 500 mg weekly | 3 (6) |
| 1000 mg q1, followed by 375 mg weekly | 1 (2) |
| 750 mg x 1, followed by 875 mg q1 | 1 (2) |

Reason for Selection: Dalbavancin was selected for one or more of the below reasons, all reasons given in medical record were noted so the denominator is > 52

- History of IV drug use
- Lack of safe home environment in which to receive daily IV antibiotics
- Prior non-adherence to outpatient antibiotics
- Clinical contreindications to alternative antibiotics
- Adverse reaction to initial outpatient antibiotic
- Lack of alternative outpatient options due to funding or insurance issues
- Substance use, not IV drug use
- Inability of patient to physically manage PICC
- Patient refused PICC or daily outpatient IV antibiotics
- Prior history of contaminated/manipulated PICC
- Discharging to a setting that could not accommodate daily IV antibiotics
- Prior treatment failure
- Unclear

Table 3. Clinical Endpoints

| Treatment Setting | Number of doses infused | n (%) |
|------------------|-------------------------|-------|
| Inpatient        |                         | 51    |
| Outpatient Infusion Center |               | 30    |
| Home Infusion    |                         | 16    |
| Emergency Department |                    | 2     |

Footnote: N = intravenous / PICC = peripherally inserted central catheter

Table 3. Dalbavancin Use Characteristics

| Number of isolates | FDA | CLSI | EUCAST |
|--------------------|-----|------|--------|
| S-2 (S-2) | R (S-4) | R (S-4) | R (S-4) | R (S-4) |
| Enterobacteriaceae | 15,119 | 98.3 | 1.5 | 1.5 |
| K pneumoniae       | 660  | 82.5 | 17.5 |
| Acinetobacter baumannii | 225  | 86.6 | 11.1 |
| NDM producer       | 311  | 51.1 | 48.9 |
| OSA-IB producer    | 181  | 80.7 | 19.3 |
| VM producer        | 75   | 88.3 | 11.7 |

Conclusion. Differences in BPs between FDA, CLSI and EUCAST could impact on the reporting of susceptibility or resistance to CFDC, particularly for MEM-NS isolates. PK/PD model simulations support 100% GI > MIC up to an MIC of 4 mg/L, and in Phase 3 trials median trough concentration of unbound ceftiraxone was > 4 mg/L. The potential impact of these differences on clinical decision making are important as the greatest clinical utility for CFDC is expected to be in patients with carbapenem-resistant GN infections due to limited treatment options.

Disclosures. Yoshihori Yamano, PhD, Shionogi & Co., Ltd. (Employee) Miki Takemura, MSc, Shionogi & Co., Ltd. (Employee) Christopher Longshaw, PhD, Shionogi B.V. (Employee) Roger Echols, MD, Shionogi Inc. (Consultant)

1270. Early Real-world Evidence in the Use of Eravacycline for the Management of Draconian Infections

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Background. Eravacycline (ERV) is a next-generation tetracycline approved for complicated intra-abdominal infections (cIAI) with in-vitro activity to multidrug-resistant organisms such as carbapenem resistant Enterobacteriaceae, extended spectrum beta-lactamase, and carbapenem-resistant Acinetobacter baumannii (CRAB). The purpose of this study was to identify the utility of ERV in clinical practice.

Methods. Retrospective case series was conducted on patients at AdventHealth that received at least two doses of ERV. Primary endpoint for the study was clinical success while on ERV, meeting none of the following criteria: changing therapy, mortality, or lack of improvement from sign/symptoms.

Results. Of 23 patients, 74% were males with a mean age of 55 ±18 years and mean body weight of 79 ±27 kg. Mean APACHE II and Charleson scores were 20 (±11) and 6 (±4), respectively. 91% received ERV for an off-label indication or organism. Infection types were respiratory (44%), cIAI (35%), skin (9%), and other (11%). All agents had positive cultures, while 61% were treated as a polymicrobial infection and 17% had bacteremia. Microorganisms included A. xylosoxidans, S. maltophilia, CRAB, and K pneumoniae. 48% had ERV susceptibilities from 0.06-4 mcg/mL, including two MIC ≥32mcg/mL for S. maltophilia. 70% were given another antibiotic prior to ERV with a median duration of 5 (1-35) days. Median duration of ERV was 8 (3-30) days. 83% percent received ERV in combination with another antibiotic.

Conclusion. Differences in BPs between FDA, CLSI and EUCAST could impact on the reporting of susceptibility or resistance to CFDC, particularly for MEM-NS isolates. PK/PD model simulations support 100% GI > MIC up to an MIC of 4 mg/L, and in Phase 3 trials median trough concentration of unbound ceftiraxone was > 4 mg/L. The potential impact of these differences on clinical decision making are important as the greatest clinical utility for CFDC is expected to be in patients with carbapenem-resistant GN infections due to limited treatment options.

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