(CI) have a fundamental task of achieving adequate use of these drugs. It is important to establish a suitable circuit for the control of their prescriptions. Knowing how this circuit operates is essential to establish if it is necessary to make any modifications.

**Aim and objectives** To analyse the operation of the prescription/revision circuit for new antibiotics included in the pharmacotherapeutic guide, and to show the adequacy of the prescriptions of antibiotics recently included in the hospital’s pharmacotherapeutic guide.

**Material and methods** Inclusion criteria: prescriptions (January 2018 to September 2019) of ceftaroline, dalbavancin, ceftolozano/tazobactam, ceftazidime/avibactam, tedizolid and isavuconazole. Exclusion criteria: prescriptions in the intensive care unit (which has a different prescription circuit).

The CI and AST decided the indications for the new antibiotics and their prescription circuit. A non-restrictive attitude was decided. Prescription of these antibiotics could be carried out by any specialist, with or without prior advice from the AST. Prescriptions made without AST supervision were reviewed by the AST in 24–48 hours.

The information for review was obtained from medical and electronic prescription records.

**Results** A total of 28 prescriptions were reviewed: 39.3% (n=11) ceftaroline/avibactam, 28.6% (n=8) dalbavancin, 14.3% (n=4) ceftaroline, 7.2% (n=2) ceftolozano/tazobactam, 7.2% (n=2) isavuconazole and 3.4% (n=1) tedizolid. A total of 50% (n=14) of prescriptions were made by the AST and 50% (n=14) were performed by doctors who did not belong to the AST, of which 36% (n=5) had prior consultation with the AST and 64% (n=9) did not consult the AST.

Of the prescriptions that did not receive prior advice from the AST, 55.55% (n=5) were reviewed by the AST. All of the prescriptions (100%, n=14) made by the AST or under their supervision were within the indications established by the CI.

Five of 28 prescriptions were not adequate (2 isavuconazo1, 2 ceftaroline, 1 tedizolid). These were prescriptions made without the advice or revision of the AST. Three of the incorrect prescriptions were in August 2018 and one in August 2019.

**Conclusion and relevance** In general, our circuit worked correctly. Some of the prescriptions out of indication were during the holiday period and not all AST members were working. Therefore, this team should operate at full capacity all year round. The adequacy of antibiotics is greater when there is AST prescription or intervention.

**REFERENCES AND/OR ACKNOWLEDGEMENTS**

No conflict of interest.
patients, such as increased volume of distribution and increased clearance. For instance, subtherapeutic plasma concentrations are a concern.

**Aim and objectives** The objective of this work was to determine if the current dosage of meropenem and piperacillin strategies in clinical practice are enough to achieve pharmacokinetic/pharmacodynamic targets (minimum 100% fT once above MIC, optimal 4–6 times above MIC).

**Material and methods** A prospective study was conducted from February to June 2019 of serum levels of meropenem and piperacillin in an intensive care unit in the south of Spain. In all patients, the initial dose was chosen by the prescribing intensivist (extended infusions, high doses and adjustments for renal impairment were also included). A predose sample (100% fT >MIC) of the target antibiotics within the first 24 hours was included. As the majority of treatments were empirical, the CMI target was defined by EUCAST PK/PD break points (MIC >16 μg/mL for suspected Pseudomonas aeruginosa in the case of piperacillin and >2 μg/mL in the case of meropenem).

**Results** Twenty-eight patients were included. Median age was 64 years (IQR 48–78 years), median APACHE II score was 15 (IQR 14–24) and 18/28 were patients. Of the 28 patients treated, 10 did not reach 100% fT >MIC, mostly in the piperacillin group (6/9) and 4/9 in the meropenem group; 100% fT > 4–6×MIC was not achieved in 8/9 patients in the piperacillin group and in 12/19 in the meropenem group.

**Conclusion and relevance** Over 5 months, thanks to the active surveillance of patients who were candidates for beta-lactam therapeutic drug monitoring and the request for determination of plasma levels by the hospital pharmacist, more than 30% of patients, such as increased volume of distribution and increased clearance. For instance, subtherapeutic plasma concentrations are a concern.

**REFERENCES AND/OR ACKNOWLEDGEMENTS**

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No conflict of interest.