ZAVICEFTA®
ceftazidime and avibactam

Pfizer

REASSURED outcomes against Gram-negative infections in the real-world setting*,†1–4

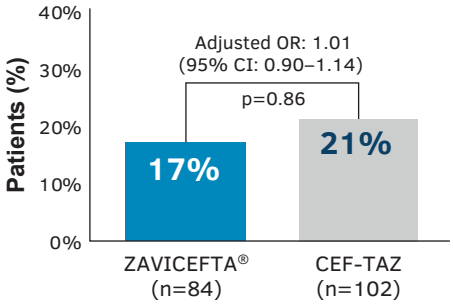
ZAVICEFTA® achieved similar mortality & a lower risk of resistance vs CEF-TAZ in DTR‡ *P. aeruginosa*[2]

Results from 186 patients treated with ZAVICEFTA® (n=84) or CEF-TAZ (n=102) for ≥72 hours in a prospective observational study performed in three US hospitals between 2018–2023.[2]

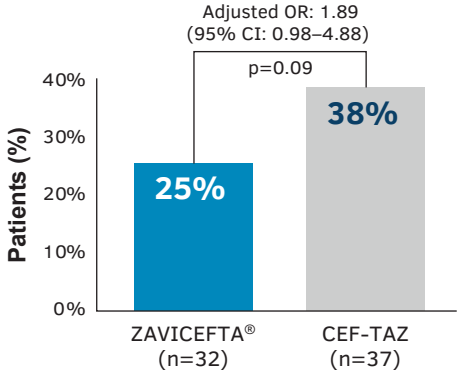
33.9%§ severely immuno-compromised‖ | **43.5%§** on vasopressors | **54.8%§** mechanical ventilation | **58.0%§** in ICU

KEY OUTCOMES

- 30-day all-cause mortality
- Emergence of resistance in a subsequent *P. aeruginosa* isolate within 90 days



30-day mortality



Emergence of resistance

*The results from non-randomised real-world data analyses are limited by potential selection bias and unknown confounding factors.[5] †Clinical efficacy and/or clinical or microbial cure rates, mortality, and/or development of treatment resistance compared with alternative anti-infectives.[2-4] ‡DTR was defined as non-susceptibility to all traditional β-lactam agents (i.e., piperacillin–tazobactam, ceftazidime, cefepime, aztreonam, meropenem and imipenem) and fluoroquinolone agents (i.e., ciprofloxacin and levofloxacin).[2] §Percentages are derived by compiling the number of patients from both treatment arms. ‖Including recent transplantation, receipt of chemotherapy, active graft-vs-host disease, AIDS, autoimmune conditions or low ANC.[2]

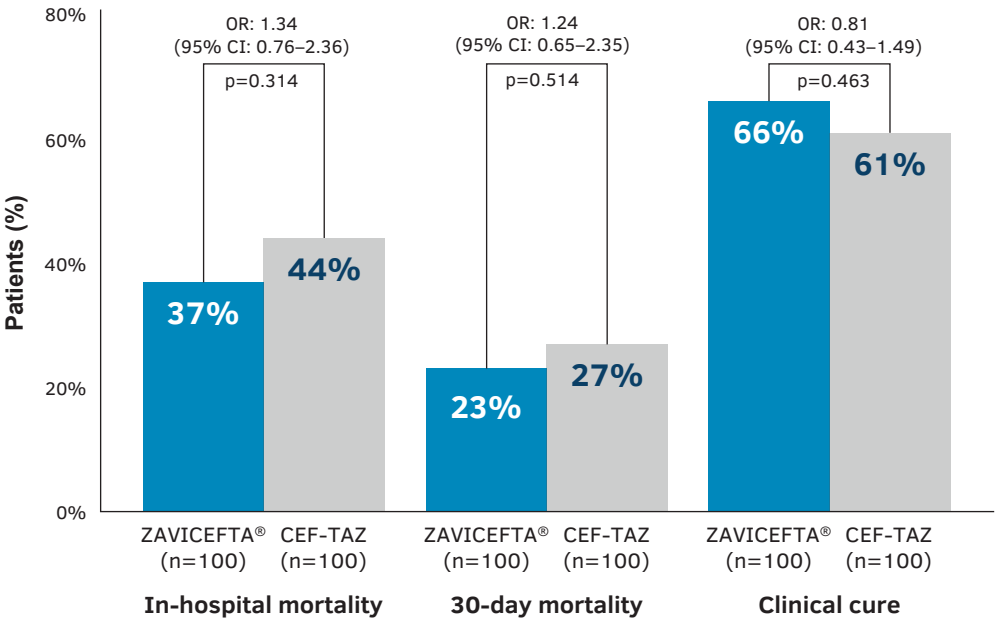
ZAVICEFTA® achieved comparable clinical efficacy to CEF-TAZ in patients with MDR *P. aeruginosa**[3]

Results from 200 patients treated with ZAVICEFTA® (n=100) or CEF-TAZ (n=100) in a prospective observational study performed in six Saudi Arabian hospitals between 2017–2022.[3]

28.0%† HAP | **21.0%†** VAP | **10.5%†** UTI

OUTCOMES

- In-hospital mortality
- 30-day mortality
- Clinical cure



- Microbiological eradication rates and efficacy in acute kidney or liver injury did not statistically differ between treatment arms.
- Length of hospital stay, ICU stay, and duration of mechanical ventilation (where applicable) were also similar.

*MDR *P. aeruginosa* was defined as non-susceptibility to at least one agent in at least three antimicrobial categories.[3] †Percentages are derived by compiling the number of patients from both treatment arms.

Systematic review and meta-analysis evaluating ZAVICEFTA® in treating patients with nosocomial CRE bacteraemia or pneumonia*,†[4]

24 studies, **1,754** patients

269 HAP

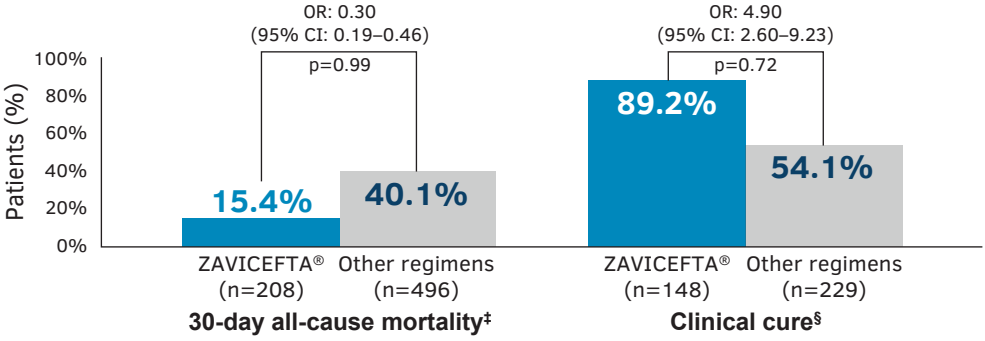
1,485 bacteraemia

1,114 patients receiving ZAVICEFTA®

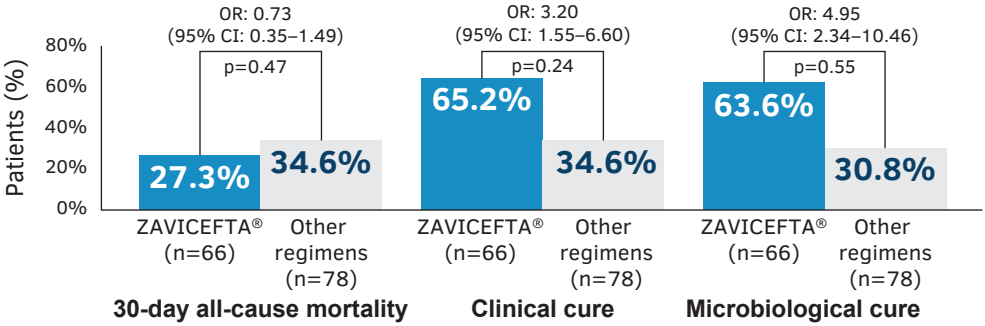
KEY OUTCOMES

- 30-day all-cause mortality
- Clinical cure
- Microbiological cure

Bacteraemia meta-analysis‡,§



HAP meta-analysis‖



***Studies:** The 24 studies included 12 retrospective cohort studies, 10 retrospective case-control studies and 2 prospective registry studies. †**Comparators:** amikacin, azithromycin, colistin, carbapenem, polymyxin B and tigecycline. Unidentified comparators were described as "oral antibiotics", "best available therapy" and "other". ‡Data from 8 studies. Comparator treatment cohort of colistin, "best available therapy", "other antibiotics", "oral antibiotic administration", polymyxin B with carbapenem and amikacin, carbapenem plus aminoglycoside, and carbapenem plus colistin. §Data from 5 studies. Comparator treatment cohort of "best available therapy", "oral antibiotic administration", carbapenem plus aminoglycoside, and carbapenem plus colistin. ‖Data from 2 studies. Comparator treatment cohort of tigecycline and "best available therapy". **Limitations:** Most included studies were retrospective with inherent limitations, reported outcomes were heterogenous, analysis was conducted at the group not patient level.

Consistent dosing across indications

Dosing for adults with estimated CrCl >50 mL/min*[1]

	Type of infection:		
	cIAI[†‡]	cUTI, including pyelonephritis[‡]	HAP, including VAP[‡]
Dose of ZAVICEFTA®	2 g/0.5 g		
Frequency	Every 8 hours		
Infusion time	2 hours		
Duration of treatment	5–14 days	5–10 days[§]	7–14 days

Dosing in special populations[1]

Population		Dose regimen[‖,¶]	Frequency	Infusion time
Estimated CrCl (mL/min)*	31–50	1 g/0.25 g	Every 8 hours	2 hours
	16–30	0.75 g/0.1875 g	Every 12 hours	
	6–15		Every 24 hours	
ESRD including on haemodialysis**			Every 48 hours	
Hepatic impairment		No dosage adjustment		
Elderly				

*The dose of ZAVICEFTA® in patients with estimated CrCl ≤50mL/min should be adjusted according to recommended doses. CrCl is estimated using the Cockcroft-Gault formula. †To be used in combination with metronidazole when anaerobic pathogens are known or suspected to be contributing to the infectious process. ‡To be used in combination with an antibacterial agent active against Gram-positive pathogens when these are known or suspected to be contributing to the infectious process. §The total duration shown may include IV ZAVICEFTA®, followed by appropriate oral therapy. ‖Dose recommendations are based on PK modelling. ¶Ceftazidime/avibactam is a combination product in a fixed 4:1 ratio, and dosage recommendations are based on the ceftazidime component only. **Ceftazidime and avibactam are removed by haemodialysis. Dosing of ZAVICEFTA® on haemodialysis days should occur after completion of haemodialysis.

Abbreviations: AIDS, acquired immunodeficiency syndrome; **ANC**, absolute neutrophil count; **CEF-TAZ**, ceftolozane-tazobactam; **CI**, confidence interval; **cIAI**, complicated intra-abdominal infection; **CrCl**, creatinine clearance; **CRE**, carbapenem-resistant Enterobacterales; **cUTI**, complicated urinary tract infection; **DTR**, difficult-to-treat; **ESRD**, end-stage renal disease; **HAP**, hospital-acquired pneumonia; **IV**, intravenous; **MBL**, metallo-β-lactamase; **MDR**, multidrug-resistant; **OR**, odds ratio; **UTI**, urinary tract infection; **VAP**, ventilator associated pneumonia

References: 1. Zavicefta® (ceftazidime-avibactam) Prescribing Information. Pfizer Corporation Hong Kong Limited: Version May 2024. **2.** Hareza DA, et al. *Antimicrob Agents Chemother* 2024;68:e0090724. **3.** Almangour TA, et al. *Antimicrob Agents Chemother* 2023;67:e0040523. **4.** Shields RK, et al. *Infect Dis Ther* 2024;13:1639–1664. **5.** Alemayehu D, et al. *J Manag Care Pharm* 2011;17(suppl A):S22–26.

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