Criteria for CAP warranting hospitalization:
- Clinical syndrome consistent with CAP, AND
- Infiltrate on CXR*, AND
- 2 or more CURB-65 criteria, sustained hypoxemia, OR hospitalization warranted for other reason

Diagnostic studies:
- Obtain blood cultures prior to antibiotic therapy
- Sputum culture if concern for S. aureus or resistant gram-negative OR ICU admission
- Initial CT scan not recommended unless concern for complication or co-existing illness

Recommended empiric therapy:
Ceftriaxone 1gm IV daily plus
Azithromycin 500mg IV daily (initial dose IV, transition to oral if tolerating PO medications)

Mild-moderate penicillin allergy:
No change, as above

Severe penicillin allergy (Type 1 hypersensitivity):
Levofloxacin 750mg IV or PO daily**

**Avoid use of fluoroquinolones if risk factors for M. tuberculosis present (born outside United States), as may lead to delay in TB diagnosis

Assess criteria for clinical instability daily:
- Temperature >/= 38.0C
- Heart rate >100/min
- Respiratory rate >24/min
- Systolic blood pressure <90mmHg
- Oxygen saturation <90%
- Not tolerating oral intake
- Abnormal mental status

For clinical worsening or failure to respond, consider:
- Wrong diagnosis or concomitant noninfectious disease
- Parapneumonic effusion, empyema, or lung abscess
- Resistant microorganism (obtain sputum culture)
- Nosocomial superinfection
- Exacerbation of comorbid illness
- Drug fever

Discharge therapy if infecting pathogen not known:
Azithromycin 500mg PO daily

Severe penicillin allergy and treated with levofloxacin:
Levofloxacin 750mg PO daily

Use narrow-spectrum therapy when infecting pathogen known (eg, amoxicillin for susceptible S. pneumoniae)

Disclaimer: This is intended only as a guide for evidence-based decision-making; it is not intended to replace clinical judgment. Assess for antibiotic allergies and use alternative agents as appropriate. Suggested antibiotic doses are for normal renal function; adjust for renal impairment when necessary.

*CXR may be negative early in the course of pneumonia; consider a repeat CXR in 24 hours if suspicion for CAP remains high