A. baumannii			
	Susceptible	Resistant	Doses and relevant notes
Ceftazidime	≤ 32	≥ 64	2g every 8 hours
Ceftazidime- pneumonia	≤ 8	≥ 16	
Cefiderocol	IE		Currently available data do not support the usage of cefiderocol for *A. baumannii* infections
Ciprofloxacin	≤ 1	≥ 2	400 mg IV q8h
Minocycline	≤ 0.5/ ≤ 1	≥ 1/ ≥ 2	Susceptible breakpoints of ≤0.5 and ≤1 correspond to standard and high dose regimens of 100 mg q12h and 200 mg q12h, respectively.
Amikacin	≤ 8	≥ 16	20 mg/kg IV q24 hours
Colistin (No breakpoints for respiratory tract infections)	≤ 2	≥ 4	Polymyxin MIC determinations should be performed with broth microdilution. Colistin susceptibility can be used to infer polymyxin B susceptibility and vice versa. Colistin dosing based on EMA package insert or algorithm by Nation and colleagues. Polymyxin B dosing 2.5 mg/kg/day Polymyxins should be combined with a second active agent whenever possible
Polymyxin B (No breakpoints for respiratory tract infections or lower urinary tract infections)	≤ 2	≥ 4	

P. aeruginosa				
	Susceptible	Intermediate	Resistant	Doses and relevant notes
Cefepime	≤ 8	16	≥ 32	1 g q8h or 2g q12h
Ceftazidime	≤ 8	16	≥ 32	1 g q6h or 2g q8h
Cefiderocol	≤ 4		≥ 8	2g q8h (3-hour infusion)
Cefiderocol-pneumonia	≤ 2		≥ 4	
Piperacillin-Tazobactam	≤ 16/4		≥ 32/4	4.5g q6h (3-hour infusion) or 4.5g q8h (4-hour infusion)
Aztreonam	≤ 8	16	≥ 32	1 g q6h or 2g q8h
Ciprofloxacin	≤ 0.5		≥ 1	400 mg IV q8h
Levofloxacin	≤ 1		≥ 2	750 mg q24h
Colistin (No breakpoints for respiratory tract infections)	≤ 2		≥ 4	Polymyxin MIC determinations should be performed with broth microdilution. Colistin susceptibility can be used to infer polymyxin B susceptibility and vice versa. Colistin dosing based on EMA package insert or algorithm by Nation and colleagues. Polymyxin B dosing 2.5 mg/kg/day Polymyxins should be combined with a second active agent whenever possible
Polymyxin B (No breakpoints for respiratory tract infections or lower urinary tract infections)	≤ 2		≥ 4	
	Susceptible	Susceptible-TDM[2]	Resistant	
Gentamicin[1]	≤ 0.5	1	≥ 2	[1]STIC are based on the use of the extended interval aminoglycoside dosing (i.e., Tobramycin/Gentamicin 7 mg/kg q24h and Amikacin 20 mg/kg q24h). Trough monitoring is recommended for safety in all patients receiving aminoglycosides. [2]The recommended doses are too low to reliably achieve PK/PD targets for efficacy (AUC/MIC ratio of approximately 80) for isolates with an MIC value in the S-TDM category. Therapeutic drug monitoring with dose adjustment as necessary to achieve both AUC/MIC and trough targets is required in this category, otherwise isolates with these MIC values should be considered resistant.
Tobramycin[1]	≤ 0.5	1	≥ 2	
Amikacin[1]	≤ 2	4	≥ 8	

Enterobacterales				
	Susceptible	Intermediate	Resistant	Doses and relevant notes
Cephalexin	No breakpoint recommended			The available evidence does not support the use of either cephalexin or oral cefuroxime for any systemic infection due to Enterobacterales.
Cefuroxime (oral)	No breakpoint recommended			
Cefpodoxime	≤ 1		≥ 2	These STIC are based on high dose cefpodoxime (400 mg every 12 hours) and a net bacterial stasis endpoint. Therefore, they should only be applied to non-severe, uncomplicated infections
Ceftriaxone	≤ 1	2	≥ 4	1g q24h
Cefotaxime	≤ 1	2	≥ 4	1g q8h
Ceftazidime	≤ 4	8	≥ 16	1 g q8h
Cefiderocol	≤ 4		≥ 8	2g q8h (3-hour infusion)
Cefiderocol- pneumonia	≤ 2		≥ 4	
Piperacillin-Tazobactam				
AmpC Enterobacterales	No breakpoint recommended			This category consists of *E. cloacae*, *K. aerogenes*, and *C. freundii*
3GC-R Enterobacterales	No breakpoint recommended			3GC stands for Third generation cephalosporin
3GC-S Enterobacterales	≤ 16/4		≥ 32/4	4.5g q6h (3-hour infusion) or 4.5g q8h (4-hour infusion)
Aztreonam	≤ 4	8	≥ 16	1 g q8h
Ciprofloxacin	≤ 0.25	0.5	≥ 1	400 mg IV q8h
Levofloxacin	≤ 0.5	1	≥ 2	750 mg q24h
Moxifloxacin	≤ 0.25		≥ 0.5	400 mg q24h
Trimethoprim - Sulfamethoxazole	≤ 4/76		≥ 8/152	STIC are for uncomplicated urinary tract infection only and based on a dose of 1 double strength tablet (160/800) q12h
Colistin (No breakpoints for respiratory tract infections)	≤ 2		≥ 4	Polymyxin MIC determinations should be performed with broth microdilution. Colistin susceptibility can be used to infer polymyxin B susceptibility and vice versa.
Polymyxin B (No breakpoints for respiratory tract infections	≤ 2		≥ 4	

or lower urinary tract infections)				Colistin dosing based on EMA package insert or algorithm by Nation and colleagues. Polymyxin B dosing 2.5 mg/kg/day Polymyxins should be combined with a second active agent whenever possible
	Susceptible	Susceptible-TDM[2]	Resistant	
Gentamicin[1]	≤ 0.5	1	≥ 2	[1]STIC are based on the use of the extended interval aminoglycoside dosing (i.e., Tobramycin/ Gentamicin 7 mg/kg q24h and Amikacin 20 mg/kg q24h). Trough monitoring is recommended for safety in all patients receiving aminoglycosides. [2]The recommended doses are too low to reliably achieve PK/PD targets for efficacy (AUC/MIC ratio of approximately 80) for isolates with an MIC value in the S-TDM category. Therapeutic drug monitoring with dose adjustment as necessary to achieve both AUC/MIC and trough targets is required in this category, otherwise isolates with these MIC values should be considered resistant.
Tobramycin[1]	≤ 0.5	1	≥ 2	
Amikacin[1]	≤ 2	4	≥ 8	

S. aureus				
	Susceptible	Intermediate	Resistant	Doses and relevant notes
Cephalexin	≤ 8		≥ 16	These STIC are based on high dose cephalexin (1000 mg every 6 hours) and a net bacterial stasis endpoint. Therefore, they should only be applied to non-severe, uncomplicated infections
Cefuroxime (oral)	No breakpoint recommended			The available evidence does not support the use of either oral cefuroxime or cefpodoxime for any systemic infection due to S. aureus
Cefpodoxime	No breakpoint recommended			

N. gonorrhoeae				
	Susceptible	Intermediate	Resistant	Doses and relevant notes
Ceftriaxone	≤ 0.25			500 mg IM x 1
Azithromycin	≤ 0.25		≥ 0.5	2000 mg oral x 1