Table 1H-1. *Streptococcus* spp. β-Hemolytic Group

Tier 1: Antimicrobial agents that are appropriate for routine, primary testing and reporting	Tier 2: Antimicrobial agents that are appropriate for routine, primary testing but may be reported following cascade reporting rules established at each institution	Tier 3: Antimicrobial agents that are appropriate for routine, primary testing in institutions that serve patients at high risk for MDROs but should only be reported following cascade reporting rules established at each institution	Tier 4: Antimicrobial agents that may warrant testing and reporting by clinician request if antimicrobial agents in other tiers are not optimal because of various factors
Clindamycin[a,b]			
Erythromycin[a,b,c]			
Penicillin[d] or ampicillin[d]		Cefotaxime or ceftriaxone	Cefepime
			Ceftaroline
	Tetracycline		
		Vancomycin	
			Linezolid
			Tedizolid[e]
			Daptomycin[f,g]
			Levofloxacin
			Dalbavancin[g,h]
			Oritavancin[g]
			Telavancin[g]
			Trimethoprim-sulfamethoxazole[i]

Abbreviations: FDA, US Food and Drug Administration; ICR, inducible clindamycin resistance; MDRO, multidrug-resistant organism; MIC, minimal inhibitory concentration.

Table 1H-1. *Streptococcus* spp. β-Hemolytic Group (Continued)

Footnotes

a. Not routinely reported for organisms isolated from urinary tract.

b. ***Rx:*** Recommendations for intrapartum prophylaxis for group B streptococci are penicillin or ampicillin. Although cefazolin is recommended for penicillin-allergic women at low risk for anaphylaxis, those at high risk for anaphylaxis may receive clindamycin or vancomycin (if the isolate is not susceptible to clindamycin).[1] Group B streptococci are susceptible to ampicillin, penicillin, and cefazolin but may be resistant to erythromycin and clindamycin. When clindamycin is being considered for intrapartum prophylaxis (eg, pregnant woman with severe penicillin allergy), erythromycin and clindamycin (including ICR) should be tested, but only clindamycin should be reported. See Table 3J.

c. Susceptibility and resistance to azithromycin and clarithromycin can be predicted by testing erythromycin.

d. Penicillin and ampicillin are drugs of choice for treating β-hemolytic streptococcal infections. Susceptibility testing of penicillins and other β-lactams approved by the FDA for treatment of β-hemolytic streptococcal infections does not need to be performed routinely because nonsusceptible isolates (ie, penicillin MICs > 0.12 and ampicillin MICs > 0.25 µg/mL) are extremely rare in any β-hemolytic streptococci and have not been reported for *S. pyogenes*. If testing is performed, any β-hemolytic streptococcal isolate found to be nonsusceptible should be re-identified, retested, and if confirmed, submitted to a public health laboratory (see Appendix A for additional instructions).

e. Report only on *S. pyogenes* and *S. agalactiae*.

f. Not routinely reported on organisms isolated from the lower respiratory tract.

g. MIC testing only; disk diffusion test is unreliable.

h. Report only on *S. pyogenes, S. agalactiae,* and *S. dysgalactiae*.

i. Testing and reporting should be limited to isolates recovered from skin and skin structure infections; it is not indicated for isolates from other sources (eg, pharyngeal).

NOTE: Information in boldface type is new or modified since the previous edition.

Reference for Table 1H-1

[1] American College of Obstetricians and Gynecologists. Prevention of group B streptococcal early-onset disease in newborns: ACOG Committee Opinion, Number 797. *Obstet Gynecol.* 2020;135(2):e51-e72. doi:10.1097/AOG.0000000000003668