### Stanford Health Care Antimicrobial Dosing Reference Guide

This document is also located on the SHC Intranet (http://portal.stanfordmed.org/depts/Antimicrobials/StewardshipProgram) and

http://bugsanddrugs.stanford.edu  •  ABX Subcommittee Approved: March 2017

**Formulas for dosing weights:** Ideal body weight IBW (male) = 50kg + (2.3 x height in inches > 60 inches)  
Ideal body weight IBW (female) = 45kg + (2.3 x height in inches > 60 inches)  
Adjusted Body Weight ABW (kg) = IBW + 0.4 (TBW – IBW)

<table>
<thead>
<tr>
<th>Drug</th>
<th>CrCl &gt; 50 mL/min</th>
<th>CrCl 10 – 50 mL/min</th>
<th>CrCl &lt; 10 mL/min</th>
<th>Intermittent Hemodialysis (IHD)</th>
<th>CRRT</th>
</tr>
</thead>
</table>
| Acyclovir (IV) | HSV: 5 mg/kg q8h  
HSV encephalitis/zoster:  
10 mg/kg q8h | Same dose  
CrCl 25 – 50: q12h  
CrCl 10 – 25: q24h | HSV: 2.5 mg q24h  
HSV encephalitis/zoster:  
5 mg/kg q24h | **CVVH:** 5 – 10 mg/kg q24h  
CVVHD: 5 – 10 mg/kg q12h | **CVS:** 5 – 10 mg/kg q12h |
| Acyclovir (PO) | HSV mucocutaneous  
All: 200 mg 5x daily | 400 mg q8h  
VZV | See CrCl < 10 mL/min  
No data | | |
| Amikacin | CrCl > 60  
CrCl 40 – 60 | CrCl 20 – 40 | CrCl < 20 | | |
| | 5 – 7.5 mg/kg q8h  
5 – 7.5 mg/kg q12h | 5 – 7.5 mg/kg q12h | 5 – 7.5 mg/kg load, then by level | | |
| | High-dose extended-interval dosing  
15 mg/kg q36h | 15 mg/kg q24h  
15 mg/kg q48h  
CrCl > 30:  
CrCl < 30:  
No recommended  
all: 7.5 mg/kg q48-72h | | |
| | **Timing of levels:** Draw trough 30 min prior to 4th dose. Draw peak 30 min after infusion ends  
**Once daily dosing:** goal peak 35 – 60 mcg/mL; goal trough < 4 mcg/mL  
**Conventional dosing:** goal peak 25 – 35 mcg/mL for serious infections; 15 – 20 mcg/mL for UUT; goal trough < 4 – 8 mcg/mL | | |
| Amoxicillin (PO) | Usual dose: 250 – 500 mg q8h  
875 mg q12h  
H pylori: 1,000 mg q12h  
Procedural pps: 2,000 mg x 1 | CrCl 10 – 30:  
250 – 500 mg q12h | CrCl > 500 mg q24h; administer additional dose at the end of dialysis | No data | |
| | Amoxicillin/clavulanate (PO) | Usual dose: 250 – 500 mg q8h  
875 mg q12h | CrCl < 30:  
Do not use  
785 mg tablet or ER tab  
CrCl 10 – 30:  
250 – 500 mg q12h | CrCl > 500 mg q24h; administer additional dose at the end of dialysis | No data |
| | | | | | |
| Amphotericin B Liposomal | 3 – 6 mg/kg/day  
Dose daily, but after HD on HD  
Optional: 70 mg x 1, then 50 mg q24h | No change  
No change | No change  
No change | No change  
No change | |
| Ampicillin (IV) | Mild/uncomplicated:  
1 – 2 g q8h  
Meningitis/endovascular/PJI:  
2 g q4h | Mild/uncomplicated:  
1 g q6-h  
Meningitis/endovascular  
P/I: 2 g q24-h  
P/J: 2 g q12-24h, or 1 g q8h | Mild/uncomplicated:  
1 g q12h  
Meningitis/endovascular  
P/I: 2 g q12-24h  
P/J: 2 g q4h | **CVVH:** 2 g q8-12h  
CVVHD: 2 g q6-8h | **Meningitis/endovascular**  
P/I: 2 g q8-12h |
| | Severe/Meningitis:  
2 g q6-h | | | | |
| | Mild/uncomplicated:  
1.5 – 3 g q8h | | | | |
| | Mild/uncomplicated:  
1.5 – 3 g q12h | | | | |
| | | | | | |
| Azithromycin (IV/PO) | 500 mg q24h | No change | No change | No change | |
| | | | | | |
| Aztreonam | 1 – 2 g q8h  
Severe/Meningitis:  
2 g q6-h | CrCl < 30:  
1 g q8h | CrCl < 15:  
1.5 – 3 g q24h | 1.5 – 3 g q12-24h | 3 g q6-8h |
| | Severe/Meningitis:  
1 g q8-h | | | | |
| | | | | | |
| Cefazolin | 70 mg x 1, then 50 mg q24h | No change | No change | No change | |
| | Mild/moderate: 1 g q8h  
Severe: 2 g q8h | | | | |
| | Mild/moderate: 0.5 g q12h  
Severe: 1 g q12h | | | | |
| Cefepime | **Extended Infusion** (4-hour infusion) | | | | |
| | CrCl > 60  
CrCl 30 – 60  
CrCl < 30 | General  
0.5 – 1 g q24h | 0.5 – 1 g q24h | 0.5 – 1 g q24h | |
| | General  
1 g q8h or 2 g q12h  
1 g q12h or 2 g q24h | | | | |
| | CNS/FN  
2 g q8h  
2 g q12h  
1 g q12h | | | | |
| | | | | | |
| Cefditoren | CrCl > 50  
CrCl 30 – 50  
CrCl 15 – 30  
CrCl < 15 | 200 mg q8-12h | | | |
| | General  
600 mg q12h  
400 mg q12h  
300 mg q12h  
200 mg q12h | | | | |
| | Endocarditis/  
S. aureus bacteremia  
600 mg q8-12h  
400 mg q8-12h  
300 mg q8-12h  
200 mg q8-12h | | | | |
| | | | | | |
| Cefditoren (SHC Restriction) | | | | | |
| | | | | | |
| Cefotaxime | Usual dose: 1 – 2 g q8h  
Severe: 2 g q8h | CrCl < 5:  
0.5 g q24h | 0.5 – 1 g q24h | 0.5 – 1 g q24h | |
| | | | | | |
| | | | | | |
| Cefepime | **SHC Restriction** | | | | |
| | | | | | |
| Ceftriaxone | 2.5 g q8h | CrCl 31 – 50:  
1.25 g q8h  
CrCl 16 – 30:  
0.94 g q24h | | | |
| | | CrCl 8 – 15:  
0.94 g q48h | | | |

### References

2. ABX Subcommittee Approved: March 2017  
3. See appendix for complete guidelines  
4. The dosing information is provided as a reference for healthcare providers.  
5. It is essential to consult with a pharmacist or a healthcare provider for specific dosing recommendations based on patient factors and medical history.  
6. Adjustments may be necessary based on individual patient needs, drug interactions, and adverse effects.
<table>
<thead>
<tr>
<th>Drug</th>
<th>CrCl &gt; 50 mL/min</th>
<th>CrCl 10 – 50 mL/min</th>
<th>CrCl &lt; 10 mL/min</th>
<th>Intermittent Hemodialysis (IHD)</th>
<th>CRRT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ceftriaxone (IV)**</td>
<td>1 – 2 g q24h</td>
<td>No change</td>
<td>No change</td>
<td>No change</td>
<td>No change</td>
</tr>
<tr>
<td>Cephalaxin (PO)**</td>
<td>100 mg q12h</td>
<td>Uncomplicated cystitis: 500 mg q12h</td>
<td>CrCl &lt; 30: same dose q24h</td>
<td>Same dose, post-HD only</td>
<td>No data</td>
</tr>
<tr>
<td>Ciprofloxacin (IV/PO)*</td>
<td>400 mg IV q12h</td>
<td>CrCl &lt; 50</td>
<td>200 – 400 mg IV q24h</td>
<td>400 mg IV q12–24h</td>
<td>500 mg PO q12–24h</td>
</tr>
<tr>
<td>Clindamycin**</td>
<td>600 – 900 mg IV q8h</td>
<td>No change</td>
<td>No change</td>
<td>No change</td>
<td>No change</td>
</tr>
<tr>
<td>Colistin (IV)**</td>
<td>80</td>
<td>CrCl &gt; 80</td>
<td>Loading Dose: 4 x IBW (kg)</td>
<td>Loading Dose: 4 x IBW (kg)</td>
<td>Maintenance Dose: 65 mg q12h</td>
</tr>
<tr>
<td>Cefazolin/azulactam** (SCM Restriction)</td>
<td>General/ CF exacerbation: 1.5 g q8h</td>
<td>15 – 25 mg/kg/day</td>
<td>Same</td>
<td>Loading Dose: 4 x IBW (kg) (max dose: 300 mg)</td>
<td>Maintenance Dose: 220 mg q12h</td>
</tr>
<tr>
<td>Ceftriaxone (IV)**</td>
<td>100 mg q12h</td>
<td>Uncomplicated cystitis: 500 mg q12h</td>
<td>2.5 mg/kg q24h</td>
<td>Loading Dose: 6 – 10 mg/kg q48h</td>
<td>withholding of Dose: 4 – 8 mg/kg q24h</td>
</tr>
<tr>
<td>Cefradin (IV/PO)**</td>
<td>1 g q24h</td>
<td>CrCl &lt; 30: 500 mg q24h</td>
<td>Same</td>
<td>Same dose q48h</td>
<td>Same dose q48h</td>
</tr>
<tr>
<td>Cefepine (IV/PO) **</td>
<td>200 mg q12h x 10 days</td>
<td>No change</td>
<td>No change</td>
<td>No change</td>
<td>No change</td>
</tr>
<tr>
<td>Ceftriaxone (IV)</td>
<td>1 – 2 g q24h</td>
<td>No change</td>
<td>No change</td>
<td>No change</td>
<td>No change</td>
</tr>
<tr>
<td>Ceftriaxone (IV)**</td>
<td>100 mg q12h</td>
<td>Uncomplicated cystitis: 500 mg q12h</td>
<td>Same</td>
<td>Same dose q48h</td>
<td>Same dose q48h</td>
</tr>
<tr>
<td>Cefepine (IV/PO)**</td>
<td>200 mg q12h x 10 days</td>
<td>No change</td>
<td>No change</td>
<td>No change</td>
<td>No change</td>
</tr>
</tbody>
</table>

* Dosage expressed in terms of colistin base activity (CBA). Use ideal BW in obese.
** (SCM Restriction) (Use adjusted BW in obese)
<table>
<thead>
<tr>
<th>Drug</th>
<th>CrCl &gt; 50 mL/min</th>
<th>CrCl 10 – 50 mL/min</th>
<th>CrCl &lt; 10 mL/min</th>
<th>Intermittent Hemodialysis (IHD)</th>
<th>CRRT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foscarnet</td>
<td>CMV Induction</td>
<td>CMV maintenance</td>
<td>CMV</td>
<td>CMV</td>
<td></td>
</tr>
<tr>
<td>(IV)</td>
<td>CrCl (mL/min/kg)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Consider adjusted BW in obese)</td>
<td>1.4 or 2.0 or 3.0</td>
<td>1.1 or 2.0 or 3.0</td>
<td>1.1 or 2.0 or 3.0</td>
<td>1.1 or 2.0 or 3.0</td>
<td></td>
</tr>
<tr>
<td>Nafcillin</td>
<td>5 mg/kg q12h</td>
<td>2.5 mg/kg q24h</td>
<td>1.25 mg/kg q24h</td>
<td>1.25 mg/kg q24h</td>
<td></td>
</tr>
<tr>
<td>Linezolid</td>
<td>0.8 mg/kg q24h</td>
<td>0.5 mg/kg q24h</td>
<td>0.25 mg/kg q24h</td>
<td>0.25 mg/kg q24h</td>
<td></td>
</tr>
<tr>
<td>Levofloxacin</td>
<td>0.8 mg/kg q24h</td>
<td>0.5 mg/kg q24h</td>
<td>0.25 mg/kg q24h</td>
<td>0.25 mg/kg q24h</td>
<td></td>
</tr>
<tr>
<td>Meropenem</td>
<td>0.8 mg/kg q24h</td>
<td>0.5 mg/kg q24h</td>
<td>0.25 mg/kg q24h</td>
<td>0.25 mg/kg q24h</td>
<td></td>
</tr>
<tr>
<td>Metronidazole</td>
<td>0.8 mg/kg q24h</td>
<td>0.5 mg/kg q24h</td>
<td>0.25 mg/kg q24h</td>
<td>0.25 mg/kg q24h</td>
<td></td>
</tr>
<tr>
<td>Moxifloxacin</td>
<td>0.8 mg/kg q24h</td>
<td>0.5 mg/kg q24h</td>
<td>0.25 mg/kg q24h</td>
<td>0.25 mg/kg q24h</td>
<td></td>
</tr>
<tr>
<td>Nafcillin</td>
<td>5 mg/kg q12h</td>
<td>2.5 mg/kg q24h</td>
<td>1.25 mg/kg q24h</td>
<td>1.25 mg/kg q24h</td>
<td></td>
</tr>
<tr>
<td>Penicillin G</td>
<td>0.8 mg/kg q24h</td>
<td>0.5 mg/kg q24h</td>
<td>0.25 mg/kg q24h</td>
<td>0.25 mg/kg q24h</td>
<td></td>
</tr>
</tbody>
</table>

**CMV**

**Induction (I)**

CrCl > 70:

5 mg/kg q12h

2.5 mg/kg q24h

1.25 mg/kg q24h

CMV Induction dosage

**Maintenance (M)**

2.5 mg/kg q24h

1.25 mg/kg q24h

0.625 mg/kg q24h

CMV Maintenance dosage

**Goal levels**

CMV: Goal peak for traditional dosing 4 – 8 mcg/mL; goal trough < 1 – 2 mcg/mL

**Timing of levels:**

Draw peak 30 minutes after completion of 3rd dose. Draw trough 30 minutes prior to 4th dose (For CrCl < 20 mL/min, may check levels sooner than 3rd/4th dose)

For 7 mg/kg once-daily dosing, draw a single random level 8 – 12 hours after dose administration. Adjust based on Hartford nomogram

For HD, draw pre-treatment level 4h post-HD; and peak 30 minutes after end of each infusion

**Staphylococci**

1,2,3,5

**Gram-negative infections**

Goal peak 3 – 4 mcg/mL; goal trough < 1 mcg/mL

**Gram-positive synergy**

Goal peak 3 – 4 mcg/mL; goal trough < 1 mcg/mL

**Adj**

1,2,3,6

Drugs:

- Fosfomycin
- Levofloxacin
- Linezolid
- Meropenem
- Metronidazole
- Moxifloxacin
- Nafcillin
- Oseltamivir (PO)
- Penicillin G

See appendix for complete guidelines

*Manufacturer’s CrCl cutoff. Please refer to BMT protocols if applicable*
**Valganciclovir (PO) [1,2,45]**

<table>
<thead>
<tr>
<th>Valganciclovir (PO)</th>
<th>Usual Dose (max. 500 mg daily)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral suspension</td>
<td>500 mg daily</td>
</tr>
</tbody>
</table>

**Tobramycin**

Refer to Gentamicin for dosing. See appendix for complete guidelines.

**Trimethoprim (TMP)/Sulfamethoxazole (IV/PO) [2,4,6]**

(Dose by adjusted BW in obese)

- **PO/IV**: 80 mg TMP + 10 mg po sulfa
- **DS = 160 mg TMP = 20 mL po soln
- **SS = 80 mg TMP = 10 mL po soln

**Valacyclovir (PO)**

Please refer to transplant protocols if applicable

**Valganciclovir (PO)**

Please refer to transplant protocols if applicable

**Vancomycin (IV)**

(Use actual body weight; refer to Vancomycin Guide Appendix C for obesity dosing)

**Vancomycin (PO)**

Poor systemic absorption - used for the treatment of *Clostridium difficile*-associated diarrhea

- **Mild/moderate/severe**: 125 mg PO q8h
- **Severe**: 625 mg PO q6h

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**Drug**

**CrCl > 50 mL/min**

**CrCl 10 – 50 mL/min**

**CrCl < 10 mL/min**

Interruption Hemodialysis (IHD)

CRRT

<table>
<thead>
<tr>
<th>Drug</th>
<th>CrCl &gt; 50 mL/min</th>
<th>CrCl 10 – 50 mL/min</th>
<th>CrCl &lt; 10 mL/min</th>
<th>Intermittent Hemodialysis (IHD)</th>
<th>CRRT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CrCl &gt; 40</td>
<td>CrCl 20 – 40</td>
<td>CrCl &lt; 20</td>
<td>CrCl &lt; 15</td>
<td>CrCl &lt; 15</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Use is not recommended, but if needed for PCP/Stenotrophomonas: 5 - 10 mg/kg TMP post-HD only</td>
<td>CrCl &lt; 15</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2.5 – 5 mg/kg TMP q24h</td>
<td>CrCl &lt; 15</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PCP/Stenotrophomonas: 5 – 10 mg/kg TMP divided q24h</td>
<td>CrCl &lt; 15</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Dose daily, but after HD on HD days</td>
<td>CrCl &lt; 15</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>all: 5 – 20 mg/kg TMP post-HD only</td>
<td>CrCl &lt; 15</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5 – 10 mg/kg/day TMP divided q24h</td>
<td>CrCl &lt; 15</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2.25 g q12h (maximum: 25,000 units/kg/day)</td>
<td>CrCl &lt; 15</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3.75 g q12h over 4-hr</td>
<td>CrCl &lt; 15</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3.75 g q12h over 4-hr</td>
<td>CrCl &lt; 15</td>
</tr>
</tbody>
</table>

**Vancomycin PO**

Poor systemic absorption - used for the treatment of *Clostridium difficile*-associated diarrhea

- **Mild/moderate/severe**: 125 mg PO q8h
- **Severe**: 625 mg PO q6h

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**Polymerase Inhibitors**

- **Valganciclovir (PO):**
  - **Usual Dose:** Oral Suspension
  - **Usual Dose (max. 500 mg daily):** 500 mg daily
  - **Dosage:** Dose daily, but after HD on HD days
  - **Intermittent Hemodialysis (IHD):** No data
  - **CRRT:** No data

**Trimethoprim (TMP)/Sulfamethoxazole (IV/PO):**

- **Usual Dose:** PO: T = 2 DS tabs q12-24h
  - IV: 8 – 20 mg/kg/day TMP divided q8-12h
- **UTI:** 1 DS lab PO BID
- **SSTI:** 1 – 2 DS lab PO BID
- **PCP/Stenotrophomonas:** T = 20 mg/kg/day TMP divided q8-6h (approximately 2 DS lab q8h)
- **PCP/Stenotrophomonas:** 7.5 – 10 mg/kg/day TMP divided q8-12h
- **PCP/Stenotrophomonas:** Dose daily, but after HD on HD days
- **PCP/Stenotrophomonas:** 5 – 10 mg/kg TMP divided q24h
- **PCP/Stenotrophomonas:** 5 – 10 mg/kg/day TMP divided q24h

**Valacyclovir (PO):**

Please refer to transplant protocols if applicable

**Valganciclovir (PO):**

Please refer to transplant protocols if applicable

**Vancomycin (IV):**

(Use actual body weight; refer to Vancomycin Guide Appendix C for obesity dosing)

**Vancomycin (PO):**

Poor systemic absorption - used for the treatment of *Clostridium difficile*-associated diarrhea

- **Mild/moderate/severe:** 125 mg PO q8h
- **Severe:** 625 mg PO q6h

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**Piperacillin/tazobactam:**

- **IV/PO:** 4.5 g q6h

**Valacyclovir (PO):**

Please refer to transplant protocols if applicable

**Valganciclovir (PO):**

Please refer to transplant protocols if applicable

**Vancomycin (IV):**

(Use actual body weight; refer to Vancomycin Guide Appendix C for obesity dosing)

**Vancomycin (PO):**

Poor systemic absorption - used for the treatment of *Clostridium difficile*-associated diarrhea

- **Mild/moderate/severe:** 125 mg PO q8h
- **Severe:** 625 mg PO q6h

---

**Polymerase Inhibitors**

- **Valganciclovir (PO):**
  - **Usual Dose:** Oral Suspension
  - **Usual Dose (max. 500 mg daily):** 500 mg daily
  - **Dosage:** Dose daily, but after HD on HD days
  - **Intermittent Hemodialysis (IHD):** No data
  - **CRRT:** No data

**Trimethoprim (TMP)/Sulfamethoxazole (IV/PO):**

- **Usual Dose:** PO: T = 2 DS tabs q12-24h
  - IV: 8 – 20 mg/kg/day TMP divided q8-12h
- **UTI:** 1 DS lab PO BID
- **SSTI:** 1 – 2 DS lab PO BID
- **PCP/Stenotrophomonas:** T = 20 mg/kg/day TMP divided q8-6h (approximately 2 DS lab q8h)
- **PCP/Stenotrophomonas:** 7.5 – 10 mg/kg/day TMP divided q8-12h
- **PCP/Stenotrophomonas:** Dose daily, but after HD on HD days
- **PCP/Stenotrophomonas:** 5 – 10 mg/kg TMP divided q24h
- **PCP/Stenotrophomonas:** 5 – 10 mg/kg/day TMP divided q24h

**Valacyclovir (PO):**

Please refer to transplant protocols if applicable

**Valganciclovir (PO):**

Please refer to transplant protocols if applicable

**Vancomycin (IV):**

(Use actual body weight; refer to Vancomycin Guide Appendix C for obesity dosing)

**Vancomycin (PO):**

Poor systemic absorption - used for the treatment of *Clostridium difficile*-associated diarrhea

- **Mild/moderate/severe:** 125 mg PO q8h
- **Severe:** 625 mg PO q6h
Voriconazole (IV/PO) 25-30 mg/kg

<table>
<thead>
<tr>
<th>Drug</th>
<th>CrCl &gt; 50 mL/min</th>
<th>CrCl 10 – 50 mL/min</th>
<th>CrCl &lt; 10 mL/min</th>
<th>Intermittent Hemodialysis (IH)</th>
<th>CRRT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voriconazole (IV/PO) 25-30 mg/kg</td>
<td>6 mg/kg IV q12h x 2, then 4 mg/kg q12h</td>
<td>PO: 400 mg PO q12h x 2, then 200 mg PO q12h</td>
<td>IV→PO conversion 1:1 (round to nearest tablet size available in 200 mg and 50 mg tablets)</td>
<td>Caution with IV: accumulation of IV vehicle cyclodextran occurs. Consider PO if CrCl &lt; 50 mL/min unless benefits justify risks of IV use.</td>
<td>Levels shown to have great degree of interpatient variability. Consider drawing a trough 4 – 7 days after new dose.</td>
</tr>
</tbody>
</table>

Abbreviations: SCR = serum creatinine; LD = loading dose; MU = million units; PNA = pneumonia; HD = hemodialysis; CAP = community-acquired pneumonia; CRRT = continuous renal replacement therapy; TMP = trimethoprim; PCP: pneumocystis jiroveci pneumonia; TB = tuberculosis; UF = ultrafiltration

CRRT dosing: doses are listed as CVVHDF and CVVHHD modalities, which are the most common modes at SHC. Note that these are generally higher than doses used in CVVH.

LBW (men) = (1.10 x Weight(kg)) - 128 x (Weight(kg) x Height(m)²/10000)

LBW (women) = (1.07 x Weight(kg)) - 148 x (Weight(kg) x Height(m)²/10000)

Reference:


