hypertension than either US data source (CPRD, 54%; HIRD, 70%; Medicare, 90%).

Conclusions: Characteristics of patients with T2DM initiating dapagliflozin vary based on the source population and data source, potentially due to differences in age, data coding and record structures, and practice patterns. The Medicare cohort had higher levels of most comorbidities, as expected due to age. The patterns of dapagliflozin initiation in the CPRD differed from the US samples, which could be due in part to differing diabetes treatment approaches in the two countries. Using patient information from a variety of populations and practice settings is helpful in evaluating the safety of dapagliflozin.

4154 | Development of antipsychotic doses among persons with newly diagnosed schizophrenia - Ten years of follow-up

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Background: Knowledge on antipsychotic dose trends in treatment of schizophrenia is scarce.

Objectives: The aim of this study was to investigate the development of antipsychotic dose in patients with incident schizophrenia over up to ten years of follow-up.

Methods: The study cohort included all persons newly diagnosed with schizophrenia during 1996-2014 in Finland, without antipsychotic use during the preceding year (N=8,342, median age 36, IQR 26-53; 56.3% men). The study cohort was identified based on first schizophrenia diagnosis recorded in inpatient care, and register-based data linkage covered years 1972-2017. Antipsychotic dispensings were modelled into drug use periods with PRE2DUP method, and local dose estimate was calculated at 6 month intervals up to 10 years after first schizophrenia diagnosis. Dose was calculated by sliding average of defined daily doses (DDDs), summed up from all antipsychotic drugs and using up to three purchases before the time point. Similarly, the number of concurrent antipsychotics (no use, monotherapy and polytherapy, referring to concurrent use of more than one antipsychotic) was measured at every time point.

Results: Six months after diagnosis, 74.7% of persons used at least one antipsychotic and the prevalence of polytherapy was 14.1%. At this point, mean antipsychotic dose was 1.27 (SD 0.91) DDDs per day and 17.5% were categorized to have a high dose (>1.5 DDDs per day). After ten years of follow-up, 80.1% used antipsychotics, 22.5% were defined as having antipsychotic polytherapy, mean dose was 1.43 (SD 1.10) DDDs per day and 26.5% had a high antipsychotic dose.

Conclusions: Antipsychotic dose, prevalence of polytherapy and high dose use increased during ten years of follow-up among persons with initially newly diagnosed schizophrenia.

4157 | Do early prescribers of new drugs have different risk management practices?

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Background: Uptake of new technology occurs first in "early adopters." We hypothesized that early prescribers of new medicines could likewise be identified, possibly influencing interpretation of early post-market assessments.

Objectives: Conduct a statewide prescriber survey to evaluate if self-described early prescribers have differences in risk management practices compared to later prescribers.

Methods: Planned hypothesis generating analysis of a larger survey on opioid prescribing, fielded by state licensing authority in Nov 2019. **Setting**: All DEA-registered Kentucky (US) physicians. **Exposure**: Self-reported affirmation of any of 3 statements: I prescribe new medications before others; I enjoy the variety of prescribing new medicines; I like to share with colleagues about new medicines I've prescribed. (Other options: I feel more comfortable using familiar medications, etc.). **Outcome**: Physician characteristics, opioid prescribing. **Analysis**: Descriptive univariable/bivariable stats

Results: Emails were delivered to 7631 physicians, with 651 respondents (8.5% - similar to other unincentivized physician surveys). After limiting to controlled substance prescribers and removing incommpletes, the analysis sample was n=349, with 83 (24%) early prescribers. Early adopters were disproportionately in early or late career (less than 15 or 35+ practice-years). The male:female ratio was 2:1 among respondents, but proportionately more females (26%) than males (19%) were early adopters. There were no differences in patient load, practice setting, or medical specialty except emergency medicine and general surgery were less likely; and oncology and OB/GYN were more likely to be early adopters. Early prescribers were more likely to use opioid risk stratification tools (OR 1.5; 0.85, 2.7). Abuse deterrent formulation (ADF) opioid prescribing was similar (OR 1.1; 0.65, 1.8). However, early adopters were more likely (OR 1.4; 0.73, 2.6) to prescribe newer non-OxyContin ADFs, with 93% endorsing "innovative nature of abuse-deterrence mechanisms" as a consideration. They supported legislation mandating insurance coverage for ADFs (OR 3.5; 1.6, 8.9), and more strongly endorsed technical solutions like electronic prescription monitoring programs and urine drug screens, while opposing prescribing limits.

Conclusions: In addition to prescribing newer medications, early adopters may differ in other healthcare delivery aspects that may impact care. The survey is being replicated in other states. Quantitative assessments will follow. Studies with historical controls may want to consider impacts of early adopters.