Depot antipsychotic agents and LARI need to be studied in high-quality effectiveness research in patients with schizophrenia, who have problems with treatment adherence, in order to develop evidence-based treatment/rehabilitation alliance for patients, family members, psychiatrists, and nurses.

**PMH26**

**REVIEW ON HEALTH OUTCOMES ASSOCIATED WITH DEPOT ANTIPSYCHOTIC AGENTS AND LONG-ACTING RISPERIDONE INJECTABLE (LARI) FOR TREATMENT OF SCHIZOPHRENIA**

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**OBJECTIVES:** Long-acting risperidone injectable (LARI) is available for patients with schizophrenia, as advance to depot antipsychotic agents. This work aims to review the literature articles of health outcomes between 1995 and 2005 relating to depot antipsychotic agents and LARI. **METHODS:** Two databases Ovid Medline and EMBase were used in December 2005 to extract the articles with a focus on health outcomes including effectiveness on compliance/adherence, efficacy and effectiveness on improving psychiatric symptoms and quality of life, health care utilization and cost, cost-effectiveness, dosing information, and treatment patterns of depot antipsychotic agents and LARI. Key words “depot antipsychotics”, “delayed-action preparations”, “long-acting” and “schizophrenia” were used in the search to extract a total of 219 full text articles including previous review articles during the period. **RESULTS:** While depot antipsychotic agents were shown to be efficacious in improving symptoms and quality of life, and to be well tolerated, the information is limited to show its effectiveness on improving adherence and reducing health care utilization and costs. The treatment and dosing patterns of depot antipsychotic agents were confounded by socio-demographic factors and treatment settings. Generally favourable views on depot antipsychotic agents existed for patients, psychiatrists and nurses. Between 1995 and 2005, there were 5 published cost-effectiveness models in the United States (2), UK (1), France (1), and Taiwan (1) showing treatment cost saving associated with depot antipsychotics and LARI. Additionally, only 4 depot treatment guidelines including one specifically for dosing and switching and another one for the use of depot in elderly existed in the literature. **CONCLUSION:**

**PMH27**

**THE IMPACT OF PRESCRIBING OFF-LABEL MOOD STABILIZERS FOR PATIENTS WITH SCHIZOPHREНИA**

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**OBJECTIVES:** The study assessed the impact of using off-label mood stabilizers on total health expenditures, inpatient hospitalizations, long term care stays and emergency room (ER) visits for patients with schizophrenia. **METHODS:** Georgia Medicaid claims from 1999–2001 were analyzed for schizophrenic patients ≥16 years who initiated antipsychotic or mood stabilizer treatment between April 1999 and December 2000. A mood stabilizer was considered off-label if none of the ICD-9-CM codes could be matched with the labeled indications. The treatment group was formed of subjects who received an off-label mood stabilizer within 14 days after the treatment initiation, while the comparison group consisted of subjects who did not have any exposure to off-label mood stabilizers during the study period. Differences in annual outcomes were estimated between propensity score matched off-label and on-label users. **RESULTS:** A total of 830 pairs off-label and on-label users were successfully matched. During the one year observation period, both groups shared a similar antipsychotic utilization pattern and the off-label group filled an average 170.32 ± 117.69 days supply of mood stabilizers. The off-label group experienced significantly higher total health costs (net difference: $2060.52; P < 0.0001) than the on-label group. The difference was mainly driven by the higher drug cost (net difference: $907.09; P < 0.0001) and long term care cost (net difference: $572.50; P = 0.0645) associated with the off-label users. Excess utilization of general and mental health related hospital, long term care and ER services were also observed in the off-label group; however, none of these differences was statistically significant. **CONCLUSIONS:** Use of off-label mood stabilizer may increase total health cost without reducing the utilization of hospital, long term care stays and ER services. Despite the widespread off-label use of mood stabilizer, the result of this study does not support the long term utilization of off-label mood stabilizers among schizophrenic patients.
prior to treatment initiation. Multinomial logistic regression models were used to estimate the probability of treatment with olanzapine, quetiapine, or risperidone (reference group) monotherapy based on patients’ demographic, clinical characteristics and health care resource utilization during the three months prior to treatment initiation. RESULTS: A total of 838 patients [mean age 38.9 [SD: 11.4] years] met inclusion criteria. Patients were initiated on monotherapy with either olanzapine (n = 393), risperidone (n = 262), or quetiapine (n = 183). Compared to risperidone, patients aged 25–34, and 55–64 years were more likely than other age groups to receive olanzapine. African-American patients were less likely to initiate olanzapine or quetiapine. Women were more likely than men to receive quetiapine, compared with risperidone. Patients whose first bipolar episode was depressive or who had used second generation antidepressants during the three-month baseline period were less likely to initiate olanzapine. Patients who used second generation antidepressants were more likely to receive quetiapine than risperidone. Patients in the two counties with the largest population of patients diagnosed with bipolar disorder were less likely to initiate quetiapine. CONCLUSIONS: Several variables, including gender, race, type of first bipolar episode, and county of residence were associated with the choice of atypical antipsychotic monotherapy used to treat bipolar disorder.

**ATTENTION DEFICIT HYPERACTIVITY DISORDER MEDICATION CLINICAL PRIOR AUTHORIZATION PROGRAM’S IMPACT ON PRESCRIPTION DRUG UTILIZATION AND COSTS**

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**OBJECTIVES:** This study aims to evaluate the impact of Attention Deficit Hyperactivity Disorder (ADHD) Narcolepsy Clinical Prior Authorization program on prescription drug utilization and costs. METHODS: Using pre-post with control group study approach, prescription records from April 2003 to June 2005 were obtained from pharmacy claims database in a pharmacy benefit management organization. The study group comprised of patients enrolled in ADHD Narcolepsy treatment for BPD were categorized into those using: atypical antipsychotics only (ATYP); conventional antipsychotics, mood stabilizers (including lithium, divalproex, lamotrigine, and carbamazepine), and specific anticonvulsants only (OTHER); medications from both categories (BOTH); and no study-specific psychotropic medications (NONE). The index “prescription” date for the NONE group was defined as six months after the initial diagnosis. Both voluntary and involuntary terminations of employment were included. Regression models controlled for possible confounding factors (age, gender, race, county), and was an effective strategy in controlling prescription drug utilization and costs.

**PMH130**

**EVALUATION OF SELECTIVE SEROTONIN REUPTAKE INHIBITOR STEP CARE PROGRAM ON MEDICATION COSTS AND UTILIZATION**

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**OBJECTIVES:** This study evaluated the impact of Selective Serotonin Reuptake Inhibitor (SSRI) Step Care program on prescription drug utilization and expenditures. METHODS: Using pre-post with control group study approach, prescription records from October 2003 to April 2005 were obtained from pharmacy claims database in a pharmacy benefit management organization. The study group comprised of patients enrolled in SSRI Step Care, while the control group comprised of those not enrolled in this program. Number of prescriptions dispensed and total costs per member per month (PMPM) for both targeted brand drugs and shift-to-generic drugs were compared between the study and control groups. RESULTS: The study group included 62,451 eligible lives, and the control group included 341,971 lives. From the pre to post period, in the study group, the average number of prescriptions per month per thousand eligible lives decreased by 37.5% (from 26 to 16.26) and 31.3% (from $2.25 to $1.54) for the target drugs, and increased by 48% (from 11.7 to 17.3) and 15.4% (from $0.79 to $0.91) for the shift-to-drugs respectively. In the control group, however, the average number of prescriptions and the average PMPM costs increased by 18.3% (from 21.18 to 17.31) and 13.4% (from $1.95 to $1.69) for the target drugs, decreased by 8.6% (from 10.4 to 9.5) and 25% (from $0.82 to $0.62) for the shift-to-drugs. SSRI Step Care was estimated to result in $0.41 PMPM cost savings in the target drugs but $0.31 PMPM cost increase in the shift-to-drugs, and a net PMPM total cost savings of $0.10. CONCLUSIONS: SSRI Step Care was found to shift prescription drug utilization from expensive brand names to low cost generics. A medication management program such as SSRI Step Care has been shown to lower prescription drug expenditures.