patients compared to non-NDRI patients indicate that NDRI results in statistically significant increases in both direct and indirect costs to the employer.

**PRK5**

**ANALYSIS OF COMORBIDITY, HOSPITAL UTILIZATION AND COST OF OVERACTIVE BLADDER IN A CALIFORNIA MEDICAID PROGRAM—A CASE-CONTROL STUDY**

Yu YE, Yu AP, Ahn J, Nichol MB

University of Southern California, Los Angeles, CA, USA

**OBJECTIVES:** To explore the possible comorbidities associated with Overactive Bladder (OAB), and to estimate the resource utilization pattern and cost of OAB in a Medicaid population. **METHODS:** A retrospective case-control matching study was performed. Five thousand five hundred seven continuously enrolled Medi-Cal patients who were diagnosed with OAB and received OAB prescriptions from 1999 to 2001 were 1:2 matched based on age, gender, race, and residence county. Annual hospital utilization and cost were calculated for both OAB and matched control cohorts, and prevalence ratios (PR, OAB over control) for 34 ICD-9 based comorbidity measures from AHRQ were examined. **RESULTS:** Out of 34 comorbidities, 13 occurred in OAB patients at least twice as much as in general Medicaid population: paralysis (PR = 10.46), urinary tract infection (UTI, PR = 3.74), other neurological (PR = 2.79), peripheral vascular disorder (PR = 2.42), valvular disease (PR = 2.32), arrhythmias (PR = 2.31), atopic dermatitis (PR = 2.19), blood loss anemia (PR = 2.14), depression (PR = 2.10), pulmonary circulation disorder (PR = 2.10), hypothyroidism (PR = 2.08), peptic ulcer disease including bleeding (PR = 2.08), and deficiency anemias (PR = 2.05). Among these diagnoses, obesity, UTI, dermatitis and depression are known comorbidities related to OAB. OAB patients had much higher annual resource utilization than the matched control group: physician office encounters (27.39 vs. 2.70, P < 0.0001), and an emergency room visits (0.26 vs. 0.04, P < 0.0001). OAB patients had approximately two-fold higher costs than the control cohort for pharmacy and medical services: $3319.85 vs. $1560.06 (P < 0.0001), $4754.86 vs. $2592.68 (P < 0.0001). **CONCLUSIONS:** OAB patients who received drug treatment incurred a heavy economic and resource burden to the California Medicaid program. Comorbid conditions were much more prevalent in the OAB cohort than in the general Medicaid population.

**PRK6**

**A RETROSPECTIVE CLAIMS ANALYSIS OF THE DIRECT COSTS OF STRESS URINARY INCONTINENCE**

Long S1, Kinchen K2, Orsini LS1, Crown W1, Swindle R1

1The Medstat Group, Inc, Cambridge, MA, USA; 2Eli Lilly and Company, Indianapolis, IN, USA

**OBJECTIVE:** To evaluate direct expenditures associated with urinary incontinence and overall medical expenditures incurred by women diagnosed with stress urinary incontinence (SUI). **METHODS:** This is a Retrospective analysis of administrative claims data. We identified women with a diagnosis of SUI in 1996–1999 and no stress, urge or mixed urinary incontinence diagnoses in the prior year. We compared total expenditures as well as urinary-incontinence-related expenditures for the year before and after the initial SUI diagnosis. We also compared expenditures for SUI patients receiving surgical treatment to those who did not. **RESULTS:** Patients who met eligibility criteria totaled 8126. Mean annual total expenditures and UI-related expenditures for all SUI patients in the year following initial SUI diagnosis were $9147 (SD $12,434) and $1,382 (SD $2,758) respectively (15% of total expenditures). The predicted annual total expenditures and UI-related expenditures for surgical patients were $13,081 (SD $5,015) and $3,905 (SD $1134) (30% of total expenditures). Among women with no comorbid urinary diagnoses, approximately 10% ($733; SD $1,992) of total mean regression-adjusted annual expenditures ($7,075; SD $12,594) were attributable to UI. Predicted total expenditures for surgery patients without comorbid urinary diagnoses were $13,018 (SD $6,234), 31% of which ($4,056; SD $1,519) were for UI-related costs. **CONCLUSIONS:** After diagnosis, annual expenditures for patients were roughly twice that in the year prior to diagnosis. Multivariate analysis suggests that in the year after SUI diagnosis, UI treatment costs represented approximately 10–15% of total expenditures for all SUI patients, and 30–31% of total expenditures for the subset of surgically-treated patients.

**PRK7**

**COMPARISON OF TACROLIMUS WITH CYCLOSPORIN IN KIDNEY TRANSPLANTATION: COST-MINIMISATION AND COST-EFFECTIVENESS ANALYSES**

Klein WH1, McKechnie T2, Schindler TM3

1PharmaExperience, Neubiberg, Germany; 2The Lewin Group Quintiles UK Ltd, Bracknell, United Kingdom; 3Fujisawa GmbH, Munich, Germany

**OBJECTIVES:** The costs associated with kidney transplantation are substantial, not only because of transplantation surgery but also due to the life-long need for immunosuppressive medication to prevent graft rejection. We analyzed the economic consequences of the use of the two baseline immunosuppressants, tacrolimus (Tac) and cyclosporin (CyA), currently administered in clinical practice. **METHODS:** A retrospective economic analysis was performed from a hospital perspective in Italy, Spain, and Germany. The analysis was conducted on the ITT-population comprising 357 patients from 7 European countries. Thus, the clinical and medical resource information for the pharmacoeconomic analysis was pooled multi-country data, the cost data was country specific.
Costs were calculated on the actual resources used by each patient and assigned to the treatment group to which the patient was randomized. Direct medical resource use data was costed over six months post transplantation. A local health economist collected cost information from published sources and personal interviews with clinicians. Costs were collected on study drug, concomitant medication, hospitalization, dialysis, and rejection episodes. To explore the impact of any variability of costs, a one-way sensitivity analysis was conducted. RESULTS: Six months after transplantation, patient survival was 99.3% (Tac) and 98.5% (CyA), p = 0.366; graft survival was 94.6% (Tac) and 91.9% (CyA), p = 0.139. The incidence of acute graft rejection was 32.5% (Tac) and 51.3% (CyA), p < 0.0001. Cost-minimization analysis revealed savings for tacrolimus (per patient) of Euro 583–1874 for surviving patients, and Euro 781–2305 for patients with functioning grafts. Tacrolimus was cost-effective for patients with rejection-free grafts; savings per patient were Euro 4627–9919. The tacrolimus group consistently had lower total costs than the cyclosporin group. The cost advantages for tacrolimus were a result of lower overall hospitalization costs and lower incidences of dialysis and graft rejection. CONCLUSION: A sensitivity analysis regarding the main cost drivers (hospitalization, study drug, and concomitant medication) generally confirmed the robustness of this finding across all three countries.

**PRK8**

COSTS AND CLINICAL CONSEQUENCES OF ALFUZOSIN AND DOXAZOSIN IN BENIGN PROSTATIC HYPERPLASIA IN UKRAINE

Zaliska O, Zhuratnach A
Lviv Medical University, Lviv, Ukraine

OBJECTIVE: Randomized controlled clinical trials have demonstrated, that alfuzosin (dalfaz R) is comparable to doxazosin (cardura) in benign prostatic hyperplasia. We compare the costs and clinical consequences of alfuzosin vs doxazosin from the perspective of public health care in Ukraine. Both drugs provide long-lasting relief of symptoms. METHODS: We compared the rates of PSA assay, of prostate volume, of while urinary flow (Qmax). Patients filled in both the generic IPSS. To calculate the drug-acquisition costs. RESULTS: A total of 106 patients (54 alfuzosin, 52 doxazosin) were treated in 6 months. The mean age of patients was 63.7 years. Relief was seen as early as one week after the initiation of therapy. We compared the rates at 1, 3, and 6 months; the prostate volume decreased by 18% and 19% in the doxazosin and alfuzosin groups, respectively, while urinary flow (Qmax) increased by 28 to 29%. The mean percent change in IPSS was 39.8% (p < 0.05). Overall symptoms improved in two groups. The direct costs of alfuzosin were 910.0 UAH vs doxazosin 714.1 (1USD = 5.3 UAH) per one patient. The total cost of 100 patients treated with doxazosin were decrease by 27.4% vs alfuzosin. CONCLUSIONS: There was no difference in the clinical consequences of doxazosin vs alfuzosin treatment. Our study showed that the treatment with doxazosin may offer economic advantages over alfuzosin, the results may provide a basis for creation of formulary system in Ukraine.

**PRK9**

COST-EFFECTIVENESS OF TAMUSLOSIN, DOXAZOSIN AND TERAZOSIN IN THE TREATMENT OF BENIGN PROSTATIC HYPERPLASIA

Ohsfeldt RL1, Kreder KJ1, Klein R2, Chrischilles EC1
1University of Iowa, Iowa City, IA, USA; 2Medical Decision Modeling, Inc, Indianapolis, IN, USA

OBJECTIVE: To evaluate the cost-effectiveness of tamsulosin, doxazosin or terazosin as initial treatments for moderate benign prostatic hyperplasia (BPH). METHODS: A decision analytic model is used to project the costs and effectiveness of treatment at 6-month intervals over three years following initiation of therapy with tamsulosin, doxazosin or terazosin. Patients initially treated with doxazosin or terazosin who discontinue due to hypotensive events are switched to tamsulosin. Finasteride is added in the event of treatment failure not related to adverse events. Medical treatment failures transition to transurethral resection of the prostate (TURP) and, if needed, a second TURP. Values for treatment failure rates and clinical event cost parameters are derived from the literature. Only direct medical costs are included and are discounted by 3% per year. Effectiveness is measured as successful medical treatment (without TURP) over three years. RESULTS: In the reference case, discounted BPH-related total direct medical costs over 3 years are $3715, $3756, and $3992 for generic terazosin, generic doxazosin, and tamsulosin, respectively. Estimated medical treatment success rates at 3 years are 72.41% for tamsulosin, 69.62% for terazosin and 69.28% for doxazosin. The incremental cost for tamsulosin vs terazosin is $278, which yields an incremental cost-effectiveness ratio of $9964 per success. Decision model results are sensitive to parameter values for treatment efficacy, drug costs, discontinuation rates, and dosing frequency. CONCLUSION: As an initial medical therapy for moderate BPH, tamsulosin is more effective than generic terazosin or doxazosin, with an incremental cost of about $93 per year or about $7.75 per month. From a payer’s perspective, with differential generic/brand patient co-pays of $8/month or more, tamsulosin is cost saving.

**PRK10**

COST-MINIMISATION ANALYSIS AND ACCEPTANCE OF SELF-INJECTING SUBCUTANEOUSLY R-HUEPO WITH RECO-PEN® FOR MANAGEMENT OF ANAEMIA IN A POPULATION OF FRENCH ADULT PATIENTS ON DIALYSIS

Fagnani F1, Emery C2, Saidani N3, Perez-Niddam K3
1CEMKA, Bourg la Reine, France; 2CEMKA EVAL, Bourg la Reine, France; 3Roche, Neuilly sur Seine, France