CONVENTIONAL ANTI PSYCHOTICS CAN BE COST EFFECTIVE FOR BROADLY DEFINED TREATMENT RESISTANT OR INTOLERANT SCHIZOPHRENIA

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OBJECTIVES: To estimate the cost acceptability of conventional antipsychotic (CA) compared to atypical antipsychotic (AA) treatment for people with broadly defined treatment-resistant or treatment intolerant schizophrenia in the UK (poor clinical response or side-effects to one or more antipsychotics, but not considered for cocaine). METHODS: A total of 227 adults with broadly defined treatment resistant or intolerant schizophrenia were enrolled into a pragmatic controlled trial of CA and AA and randomised to a class of drug (CA or AA). The treating physician and patient determined the choice of drug within the class. A societal perspective was used; scheduled follow up was 12 months. The primary outcome was quality adjusted life years (Daly’s) measured by the Aerosol and population utility tariffs. Direct costs were measured as resource use multiplied by published national unit costs. Censored data were predicted (Cox regression) and missing observations imputed. Incremental cost utility ratios (ICER), net benefit statistic and cost acceptability curves for the intent to treat cohort were calculated. Methods related assumptions (link between costs and QALYS (stepwise regression), association between Aerosol and clinical measures (Spearman’s Rho), imputation method, source of unit costs) were tested. RESULTS: Utility values were associated with clinical measures (p < 0.00). QALY’s predicted costs (a = −0.21; p < 0.00). Primary and sensitivity analyses indicated a trend towards QALY gain (0.04–0.08) and cost savings (£1100–£1200) for CA, giving a net benefit statistic of £5500 ($2650–$13,000). Complete case analysis indicated a cost of £20,000/QALY gained. CONCLUSIONS: This study shows that, in the treatment of schizophrenia and bipolar disorder, higher doses of quetiapine may lower levels of mental health resource use, suggesting enhanced efficacy.

COST-EFFECTIVENESS EVALUATION OF LONG-ACTING RISPERIDONE INJECTION

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OBJECTIVE: To assess the cost-effectiveness of long-acting risperidone, oral risperidone (RIS), olanzapine (OLA) and haloperidol decanoate (HAL-DEC) in patients with schizophrenia over a 1-year time period. METHODS: Published medical literature, a consumer health database, and a clinical expert panel were utilized to populate a decision tree model. The model captured rates of compliance, relapse, frequency of relapse, duration of relapse, adverse events, resource utilization and unit cost of health care resources. Outcomes are expressed in terms of percentage, number and duration of relapses per patient per year and total cost per patient per treatment arm. RESULTS: The proportion of patients predicted by the model to experience a relapse requiring hospitalization in 1 year were 66% HAL-DEC, 41% RIS and OLA, 26% long-acting risperidone, while the proportion of patients with an exacerbation not requiring hospitalization were 60% HAL-DEC, 37% RIS and OLA, and 24% long-acting risperidone. The mean number of days of relapse requiring hospitalization per patient per year were predicted to be 28 HAL-DEC, 18 RIS and OLA, 11 long-acting risperidone, while the mean number of days of exacerbation not requiring hospitalization were 8 HAL-DEC, 5 RIS and OLA, and 3 long-acting risperidone. This translates into cost savings with long-acting risperidone compared to oral risperidone, olanzapine, and haloperidol decanoate of $397, $1742, and $8328, respectively. CONCLUSIONS: Predictive modeling suggests that long-acting risperidone can potentially lead to lower rates and fewer days of symptom exacerbation and hospitalization compared to alternative treatments. These lower rates translate into cost savings with the use of long-acting risperidone.