simulations were performed to propagate the uncertainty of parameters. RESULTS: The estimated cost (and its credibility intervals of 95%) of the prevalent population with AH, DM and dyslipidemia using prices from public health system was in Chilean pesos (CLP) CLP$12,463.3MM (CLP$11,394.4MM – CLP$13,622.2MM), CLP$36,453MM (CLP$25,630.3MM – CLP$49,624.4MM) and CLP$20,658.5MM (CLP$11,000.0MM – CLP$38,460.0MM). While, the estimated cost of public private system was CLP$700,613.9MM (CLP$561,764.4MM – CLP$885,354.5MM), CLP$3,333,921.1MM (CLP$2,523,963.3MM – CLP$4,346,879.7MM) and CLP$680,919.1MM (CLP$537,916.4MM – CLP$835,763.6MM). CONCLUSIONS: The expected cost needed for the treatment of the three conditions studied represent 1.3% and 2.9% in the worst case scenario (33% considering private system prices) of the 2014 health budget, and the effort to improve the diagnostic of these conditions would determine a budget impact of at least 0.86%, only with pharmaceutical treatment.

PCV48 COST-EFFECTIVENESS ANALYSIS AND BUDGET IMPACT OF CONCOR® AM VERSUS BISOPROLOL PLUS AMLODIPINE IN SYSTEMIC ARTERIAL HYPERTENSION TREATMENT, FROM THE PERSPECTIVE OF THE BRAZILIAN PUBLIC HEALTH SYSTEM Fushl K.R.,1 Restrepo M.,2 Fernandes R.A.,1 Haas L.1, Pepe C.,1 Junqueira M.1
1Merce Seron, São Paulo, Brazil, 2Merce Seron, Bogota, Colombia.1 Grupo Resulta, São Paulo, Brazil, 2NeusBD/Medinsight - Grupo Resulta, São Paulo, Brazil. OBJECTIVES: Systemic arterial hypertension (SAH) is a chronic condition, and despite the large number of available antihypertensive drugs, patients with SAH who are drug-treated frequently do not obtain goal Blood Pressure (BP) levels. A combination of drugs is recommended for those cases, however, compliance is improving for long-term treatments as prescribed as fixed combinations rather than separate rate pills. A combination of bisoprol and amlopidine once a day showed a rapid reduction of BP after 4 weeks. The aim of this paper is to perform cost-effectiveness (CE) and budget impact (BI) analyses of Concor® AM compared to bisoprol plus amlopidine as separate TABLES. A Daily-cycle markov model was built considering the outcomes: days on treatment; number of events (stroke, myocardial infarction, hospitalization, death, angina, number with full-time patients on drug interruption -non-compliance); number of full-lifetime-patients with normal blood pressure and days of life. Efficacy data were obtained from literature review and unit costs were obtained from official price lists. The time horizon of the CE and BI model was 30 and 10 years, respectively. A 5% annual discount rate was applied in costs and benefits in the CE model. RESULTS: Concor® AM increased overall survival in 43 days and assured more 2,090 days on treatment, per patient, during lifetime period. Also, reduced 183 events, and allowed more 187 patients with controlled blood pressure, per 1,000 patients. Concor® AM was dominant vs. Concor + Amlodipine, resulting in financial resource saving of approximately 8.1% (BRL 5,720.73 per patient). Additionally, the use of Concor® AM in patients with SAH HAB was associated in a saving of BRL 1,606.8 (US$35.0) per patient, or BRL 10,273.82 (US$205.0) in the period from 2014 to 2025. CONCLUSIONS: Fixed-dose combinations such as Concor-AM do represent an opportunity to increase compliance and consequently health outcomes and its costs.

PCV49 ESTIMATED SAVINGS IN MEDICAL COSTS WHEN NEW ORAL ANTICOAGULANTS ARE USED FOR THE TREATMENT OF PATIENTS WITH NONVALVULAR ATRIAL FIBRILLATION AND VENOUS THROMBOEMBOLISM VS. WARFARIN IN THE U.S. Amin A.1, Bruno A.1, Tzicci J.1, Lin P.1, Lingohr-Smith M.1
1Astrazeneca, CA, USA, 2Astrazeneca, Sankt Aukeb, Plainsboro, NJ, USA, 3 Pfizer, New York, NY, US, 4Novoys Health, Green Brook, NJ, USA. OBJECTIVES: The objective of this study was to estimate the overall differences in medical costs, with apixaban being associated with the greatest savings in medical costs. The direct application of the results to the real-world setting will require further assurance.

PCV50 A RETROSPECTIVE ANALYSIS OF HEALTH CARE RESOURCE UTILIZATION AND THE ECONOMIC BURDEN AMONG U.S. LONG-TERM CARE FACILITY PATIENTS DIAGNOSED WITH STROKE Huang A1, Shrestha S1, Baser O2, Yace H1, Wang L1
1STATinMD Research, Plano, TX, USA, 2STATinMD Research, The University of Michigan, MEF University, Ann Arbor, MI, USA, 3City University of New York & STATinMD Research, New York, NY, USA OBJECTIVES: To assess the economic burden and health care resource utilization of patients with ischemic strokes admitted to long-term care facilities who were diagnosed with stroke. METHODS: Patients diagnosed with stroke (International Classification of Diseases, 9th Revision, Clinical Modification diagnosis codes 433, 434 and 436) were identified using the Long Term Care Minimum Data Set (MDS) linked to 5% Medicare data from 2007-2008. The initial diagnosis date was designated as the index date. Patients without a stroke diagnosis (control cohort) were matched to stroke patients, and 1:1 propensity score matching (PSM) was used to control for age, region, gender and baseline Charlson Comorbidity scores. The index date for the control cohort was randomly chosen to reduce selection bias. Patients in both cohorts were required to be age ≥65 years, have at least two consecutive quarterly assessments documented in MDS data 6 months prior to the index date and have at least one previous medical and pharmacy benefit 1 year before and after the index date. RESULTS: Once PSM was applied, 1,014 patients were included in each cohort, and baseline characteristics were balanced. A higher percentage of stroke patients had ≥2 admissions (46.6% vs. 23.5%, p<0.001), outpatient visits (82.3% vs. 89.5%, p=0.0253), skilled nursing facility (SNF; 37.6% vs. 28.2, p<0.001) and durable medical equipment (DME) claims (30.47% vs. 22.99%, p<0.001) than those in the control cohort. Stroke patients also incurred considerably higher inpatient (US$7,068 vs. US$3,418, p<0.001) and outpatient costs (US$17,126 vs. US$11,492, p<0.001) than those without a stroke diagnosis. CONCLUSIONS: Patients diagnosed with stroke had considerably higher health care resource utilization and costs than those in the control cohort.

PCV51 MEDICATION COST IMPLICATION FOR THE MANAGEMENT OF HYPERTENSION AND DIABETES IN NIGERIA BELTER: TERTIARY HOSPITAL BASED STUDY IN BAYELSA STATE, NIGERIA Gandra S.R.1, Lanksh W.C.2, Shrestha S.3, Henk H.3, Li M.4, Huang A.5, Henk H.5
1University of Benin, Benin City, Nigeria. OBJECTIVES: To assess the economic burden of the management of hypertension and diabetes in two tertiary health facilities in Bayelsa State, Nigeria, South-south Nigeria. METHODS: It is a retrospective review of randomly selected case notes of 531 hypertensive and diabetic patients. The demographics and cost of medications prescribed were obtained from the hospital prices. Patients were randomly selected from those who attended the endocrinology and cardiology clinics of the health facilities in 2011 and 2012. RESULTS: Mean patients’ age was 55.70±12.29 years. Most (42.6%) of the patients were living below the poverty level in the Niger Delta region of Nigeria, the medication cost burden of managing hypertension and diabetes is high and unaffordable by most of the patients.

PCV52 ESTIMATING THE COST OF ILLNESS OF GIANT CELL ARTERITIS Sabineju B.1, Li M.1, Roudouet D.M.1, Best J.H.1, Garrison L.P.1
1University of Washington, Seattle, WA, USA, 2Genentech, Inc, South San Francisco, CA, USA OBJECTIVES: Giant cell arteritis (GCA), a chronic vasculitis commonly presenting with headache, affects approximately 230,000 individuals in the US. However, limited data exist on the health care resource utilization and costs that are attributable to GCA. The objective of this study was to estimate the cost of illness in patients with GCA in the US. METHODS: A retrospective cohort of patients with a new diagnosis of GCA and five matched controls was identified from a large US claims database between January 1st 2008 and December 31st 2011. Newly diagnosed GCA patients were defined by a diagnosis of GCA (ICD-9 446.5) during the study period and no GCA diagnosis in the 15 months prior. Costs were estimated using a GCA diagnosis. GCA patients and controls were matched on age, gender, region, index year of diagnosis, and index month of diagnosis. One-year healthcare costs were compared among cases and controls, adjusting for age, gender, Charlson Comorbidity Index (CCI), chronic disease count, U.S. region, health plan type (HMO vs. other), and year using generalized linear models. RESULTS: A cohort of 11,245 GCA patients and 56,230 controls was identified. The mean age of the cohort was 70 years and 71% were females. Mean CCI was 1.6 for GCA patients and 0.8 for controls. Mean one-year cost for GCA patients was $26,400 (SD: $48,500) and mean one-year cost for controls was $11,500 (SD: $29,200). After multivariate adjustment, the difference in mean cost between GCA patients and controls was $14,900 (p=0.001). CONCLUSIONS: Patients with GCA experience increased healthcare costs compared to patients without GCA after adjusting for covariates related to health care resource utilization and costs. Our results are the first to inform researchers, clinicians, and policymakers on the cost burden of GCA, estimated to be approximately $1 billion annually in the US.

PCV53 ACUTE, SHORT-TERM AND LONG-TERM COSTS OF CARDIOVASCULAR EVENTS AMONG HYPERLIPIDEMIA PATIENTS Fujii R.K.1, Gandra S.R.2, Shrestha S.3, Haas L.4
1University of Washington, Seattle, WA, USA, 2Genentech, Inc, Thousand Oaks, CA, USA, 3Optum, Eden Prairie, MN, USA OBJECTIVES: To assess the economic burden of cardiovascular (CV) outcomes among patients with hyperlipidemia. METHODS: A retrospective cohort study was conducted to examine the economic burden associated with CV events among hyperlipidemia patients.