OBJECTIVES: This study aims to explore physician care-providing behavior in treating children with Attention-deficit/hyperactivity disorder (ADHD). METHODS: The study was conducted using the GE electronic medical records (GE-EMR) 1995-2010. The cohort consisted of all children and adolescents (age<18 years), who were prescribed either stimulants or atomoxetine hydrochloride and had at least one office visit. Incident ADHD cases, defined as those who had not been diagnosed with ADHD or received ADHD prescription in the last 6 months, were followed for a period of 12 months to observe their physician care-providing behavior. RESULTS: A total of 255 children with ADHD diagnosed for the first time were included in the cohort. 4.6% of them were not prescribed any concurrent medications. The most commonly prescribed concurrent non-ADHD medications immediately after the ADHD cases were identified: 4 groups discontinued buprenorphine (24.9% discontinued for 1-3 months, 12.5% for 3 months, 2.1% for 6-12 months, 0.5% for more than 12 months), 19.9% had a switch, 11.6% had an augmentation and 61.8% stopped treatment. The median duration of first-line treatment was 3 months. Most frequently prescribed therapies in second-line were atomoxetine (17.1%), olanzapine (22.5%), quetiapine (13.7%) and risperidine (9.1%), and 6.3% were antipsychotic combinations. CONCLUSIONS: SGA monotherapy was frequently prescribed as first-line treatment, consistently with clinical guidelines of first-line therapy is short and the high proportion of patients without treatment may be intolerable for concern.

PMH78 USE OF MULTIPLE CONCURRENT ANTIPSYCHOTICS IN CHILDREN ENROLLED IN THE MISSISSIPPI CHILDREN PROGRAM Shah B1, Nunnia S1, Bahanaa M1, Hardwick S1, Clark J21, University of Mississippi, University, MS, USA; 2Mississippi Division of Medicaid, Jackson, MS, USA

OBJECTIVES: Little evidence exists to support the increasing concurrent use of multiple antipsychotics (APs) among children. Case reports suggest that use of multiple APs could lead to an increased risk of delirium, serious behavioral changes, cardiac arrhythmia, and death. In 2013, the National Collaborative Program for Clinical Guidelines and Measurement (NCINQ) proposed a quality measure of concurrent use of multiple (2+) APs among children for use in Medicaid and CHIP programs. The Pharmacy Quality Alliance (PQA) has been working on a similar measure using 3+ APs. The objectives were to analyze the performance in the Mississippi Medicaid program on both the 2+ and 3+ proposed quality measures. METHODS: A retrospective analysis was conducted using Mississippi Medicaid data for July 2015 through June 2016. For both methods the denominator contained beneficiaries ages 0 to 21 at 1st July 2015 who were continuously enrolled 3+ months and were on any AP at for at least 90 days. The numerator contained those beneficiaries who were concurrently on 2+ APs or 3+ APs for a period of at least 90 days during the measurement year. RESULTS: The denominator included 4,435 children who were on at least 1 AP. About 464 (10.5%) and 159 (3.6%) beneficiaries were concurrently on 2+ or 3+ APs respectively. The performance rates on the two measures did not significantly differ for the fee-for-service and managed care pharmacy plans. However, there is no clinical support for concurrent use of 3+ APs. Although the percentage of children concurrently taking 3+ APs is small, possible drug utilization management actions are needed to further reduce this occurrence.

PMH79 TRAJECTORIES OF BUPRENORPHINE TREATMENT AND ASSOCIATED EMERGENCY DEPARTMENT AND INPATIENT USE IN A LARGE MEDICAID PROGRAM Lo-Ciganic W1, Gellad WF2, Girardin AP3, Cochran G2, Donohue JM41; 1University of Arizona, Tucson, AZ, USA; 2University of Pittsburgh, Pittsburgh, PA, USA

OBJECTIVES: Buprenorphine is an effective treatment for opioid use disorders. However, uncertainty about optimal duration of buprenorphine treatment may lead to substantial variation in provider decision-making, and patient outcomes. In response to the high cost of treatment, some payers have placed limits on treatment duration. Although little is known about the impact of these limits. We used group-based trajectory models to identify distinct trajectories of buprenorphine use based on prescription refills, and examined emergency department (ED) and inpatient use. METHODS: We analyzed data from a retrospective cohort study of 10,945 adults (18-64 years) Pennsylvania Medicaid enrollees initiating a new episode of buprenorphine treatment between 2007-2011. We used group-based trajectory models to identify trajectories in the 12 months following buprenorphine initiation. Multivariate Cox proportional hazard models were used to examine the association between trajectory membership and ED and inpatient use in the 12 months following initiation. RESULTS: Six trajectories of buprenorphine treatment were identified: 4 groups discontinued buprenorphine (24.9% discontinued within 3 months, 19.9% within 3-5 months, 13.4% within 5-9 months, 9.5% refilled intermittently, and 21.2% refilled persistently for 12 months). Factors associated with treatment discontinuation were minority race, having history of frequent ED visits and hospitalizations, and comorbid psychoses. After adjusting for sociodemographics, health status, and provider level covariates, patients who refilled persistently had a 20% lower risk of all-cause hospitalizations (hazard ratio [HR]=0.80, 95% CI, 0.68-0.94) and 15% lower risk of an ED visit (HR=0.85, 95% CI, 0.77-0.94) in the subsequent year, compared to those discontinuing between 3-5 months. CONCLUSIONS: Buprenorphine treatment trajectories were highly vari-