OBJECTIVES: The main purpose was to describe calcium channel blocker (CCB) utilization in hypertensive patients in the Louisiana Medicaid Program. To accomplish this purpose two objectives were formulated: 1) To determine if there were significant demographic differences by type of CCB or prescribing physician specialty, and 2) To determine treatment compliance including the medication possession ratio (MPR), drug switching, dose changes, and discontinuation of therapy. METHODS: A retrospective analysis using paid Louisiana Medicaid claims was performed. The index date was the date of service of the first paid claim with a primary or secondary diagnosis of hypertension between July 1, 2003 and June 30, 2004. Recipient study period was index date plus 365 days preceded by a 6-month washout period. Inclusion criteria were: 18 to 64 years old, at least one CCB during the study period, eligible at least 11 months in study period and during washout. Exclusion criteria were end-stage renal disease and hypertension due to pregnancy. For Objective 1, a chi-square test was performed to determine if there were significant demographic differences by CCB and prescribing physician specialty. For Objective 2, a “compliant” patient was defined as a patient with an MPR > 80%. A switch was defined as a change in prescription medication within CCBs. Dose change was defined as change in strength or quantity for the same CCB. RESULTS: The final dataset contained 2493 patients. The majority (41%) used amldipine, followed by nifedipine (19.74%), diltiazem (15.48%), felodipine (10.31%), verapamil (7.9%), nisoldipine (5.21%), isradipine (0.36%), and nicardipine (0.08%). Cardiologist accounted for 18.41% of the prescribing physician. Average days to discontinuation were 262. Compliance was met by 59% of the patients. Therapy switch occurred 11% of the time; dose changes, 37% of the time. CONCLUSION: CCB utilization results match the literature, although specialist utilization is low.

USE OF RECOMMENDED MEDICATIONS AFTER MYOCARDIAL INFARCTION IN AUSTRIA

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OBJECTIVES: Clinical guidelines recommend long-term use of beta-blockers (BB), statins, and angiotensin converting enzyme-inhibitors or angiotensin receptor blockers (ACEI/ARB) after myocardial infarction (MI). Previous studies have evaluated their use during the MI hospitalization, but data on their use after discharge are scarce. METHODS: From the claims data of 8 sickness funds insuring >50% of the Austrian population, we ascertained all patients discharged with a primary diagnosis of acute MI in 2004. We only included patients who were hospitalized for >4 days and who survived 120 days. We ascertained use of ACEI/ARBs, BBs, and statins from all filled prescriptions between discharge and 120 days post MI. Demographics were noted for each patient and comorbidities were ascertained from use of several indicator drugs during the preceding year. Multivariate logistic regression was used to evaluate the independent determinants of use of each drug class. RESULTS: We evaluated 4105 patients with MI. The mean age was 68.8 (±13.2) years and 59.5% were men. The mean length of stay for their index admission was 10.9 (±5.3) days. Within 120 days of MI, 67% filled a prescription for an ACEI/ARB, 74% for a BB, and 67% for a statin. While 41% received all three drugs and 34% two of these, 25% of patients received only one or none of the study drugs. Older age and presence of mental illness was associated with lower use of all drug classes. Diabetics had greater ACEI/ARB use. BB were more common in patients using other antihypertensives, but less frequent in patients with inhaled steroids or beta-mimetics. Statins use was less in patients using drugs for congestive heart failure (coumadin, diuretics, digitalis; all P < 0.001). CONCLUSION: Recommended medications were underused in Austrian MI survivors. Quality indicators should be established and interventions be implemented to ensure maximum secondary prevention of coronary heart disease in this population.

PREDICTORS OF CLOPIDOGREL THERAPY PERSISTENCE IN ACUTE CORONARY SYNDROME PATIENTS

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OBJECTIVES: Treatment guidelines recommending clopidogrel use in acute coronary syndrome (ACS) have rapidly evolved since 2000. The goal of this study was to examine persistence of clopidogrel in ACS patients in order to establish a baseline for future comparisons. METHODS: Administrative claims data from a large US health plan (from January 1, 2001–June 30, 2003) were used to identify ACS patients by ICD-9 codes for unstable angina or acute myocardial infarction (MI). The first diagnosis claim was the “index event.” Patients were grouped according to receipt of percutaneous coronary intervention (PCI) or not during the index event, and secondly, if they received clopidogrel for >30 days in duration after discharge. Characteristics associated with >30 days clopidogrel use was examined by logistic regression. Patients were observed 1-year before, and followed up to 1-year after, the index event. RESULTS: There were 4385 patients who underwent PCI; 2698 received clopidogrel for >30 days duration (61.5%). There were 935 patients who did not receive PCI; 279 received clopidogrel for >30 days duration (29.8%). In PCI patients, prior use of clopidogrel (OR; 95% CI) (2.023; 1.045–3.916) and cost of index MI (1.407; 1.231–1.608) had the largest positive association with >30 days clopidogrel use. Patients with fibrositis, myalgia and arthralgia were least likely to have >30 days duration of clopidogrel therapy. In non-PCI patients, prior use of clopidogrel (5.599; 2.229–14.063) and hospitalization with the index event (1.949; 1.181–3.218) had the largest positive association with >30 days clopidogrel use. Patients residing in the Northeast US were least likely to have >30 days duration of clopidogrel therapy. CONCLUSION: During this time period, clopidogrel was used more frequently and for longer duration in PCI patients. There were few observable predictors of longer duration of therapy. The single strongest predictor of use for >30 days after an ACS event was clopidogrel use in the baseline period.

EFFECTS OF MEDICAID ACCESS RESTRICTIONS ON STATIN UTILISATION FOR PATIENTS TREATED BY PHYSICIANS PRACTISING IN POOR AND MINORITY NEIGHBORHOODS

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OBJECTIVES: To explore whether Medicaid preferred drug lists (PDL) impact the utilization of restricted statin medications for Medicaid patients equally, or disproportionately impact patients treated by doctors prescribing in poor or minority neighborhoods. METHODS: A retrospective, regression-based analysis, of a pharmacy claims database and census data of the prescriber’s zip-code. Post policy changes in the proportion of statin prescriptions filled for off-PDL medicines were examined in six