cost approach, the estimates were similar when patient demographic and clinical characteristics were controlled for in the incremental cost approach.

PMH30 THE SEQUENTIAL COST OF DEPRESSION: EVIDENCE FROM 10,000 SWEDISH PATIENTS IN PSYCHIATRIC CARE
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OBJECTIVES: Depression is a major health problem. Previous studies on the cost of depression have mainly taken a primary care perspective. Such studies do not include all patients with depression, and should be completed by cost estimates from psychiatric care. The objectives of this study were to estimate this societal cost of depression per patient in psychiatric care in Sweden, and to relate costs to disease severity, depressive episodes, hospitalization, and patient functioning. METHODS: Retrospective resource use data in inpatient and outpa- tient care was collected using ICD-10 diagnoses and Global Assessment of Functioning (GAF), were obtained from Northern Stockholm psychiatric clinic with a catchment area including 47% of the adult inhabitants in Stockholm city. This data set was combined with national register data on prescription pharmaceuticals and sick leave to estimate the societal cost of depression. RESULTS: The study included 10,593 patients (63% women). The average annual societal cost per patient was around USD 21,000 in 2006-2008. The largest cost item was indirect costs due to productivity losses (89%), and the second largest was outpatient care (6%). Patients with mild, moderate or severe depression had an average cost of approximately USD 18,000, USD 21,000, and USD 29,000, respectively. Total costs were significantly higher during depressive episodes, for patients with co-morbid psychosis or anxiety, for hospitalized patients, and for patients with low GAF scores.

CONCLUSIONS: The largest share of societal costs for patients with depression in psychiatric care is indirect costs due to productivity losses, which are higher than previously reported from a primary care setting, and strongly related to hospitalization, episodes of active depression, and global functioning. This suggests that effective treatment and rehabilitation that avoid depressive episodes and hospitalization may not only improve patient health, but also reduce the societal cost of depression.

PMH31 THE COST OF A SCHIZOPHRENIA RELAPSE IN THE BRAZILIAN PRIVATE HEALTH CARE SYSTEM
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METHODS: Out of the 842 patients that used the private health care system in a period of 26 months, 388 returned to the hospital (“return patients”, 46%) and accounted for 85% (R$ 217,000) of all costs associated with schizophrenia. OUTPATIENT: 236 (28%) of all costs associated with schizophrenia were partially offset by significant reductions in medical costs for switching, restart and augmentation episodes. Using atypical antipsychotics reduced acute hospital admission but had mixed effects on psychiatric hospital and nursing home admission rates. CONCLUSIONS: There is evidence that the increased drug costs associated with atypical antipsychotics use are partially offset by decreased costs of other medical services.

PMH33 ECONOMIC EVALUATION OF AGOMELATINE FOR MAJOR DEPRESSIVE DISORDERS IN THE GREEK SETTING
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OBJECTIVES: The aim of the present study was to conduct an economic evaluation using Agomelatine with its most common alternatives in daily clinical practice for treating patients with Major depressive disorder (MDD) in Greece.

METHODS: An existing Markov model evaluating the 2-year cost-effectiveness of Agomelatine was adapted to the Greek setting. The model consists of six states and the main transition was set to one-year. The analysis was conducted from the societal perspective. Input data (i.e. transition probabilities, costs assigned to each health state, utility values and probabilities for adverse events) were obtained from published literature, government sources, and experts’ opinion. Head-to-head clinical trials of Agomelatine with other comparators were used, and indirect comparisons were conducted in the absence of directly comparative trials. Both direct and indirect costs were considered in the model. The results were expressed as incremental cost-effectiveness ratios (ICERs) per quality-adjusted-life-year (QALY) gained. RESULTS: The Markov model estimated the average total cost related to 2-year treatment of MDD with Agomelatine is lower compared to Venlafaxine (€435), Sertraline (€257), Escitalopram (€857) and Fluoxetine (€174) and higher compared to Mirtazapine (€304) and Citalopram (€217). Moreover, the average QALYs for Agomelatine-treated patients was found to be higher compared to all other alternatives. In particular, the increase in QALYs varies between 0.015 and 0.088 against Escitalopram and Mirtazapine, respectively. Therefore, Agomelatine is dominant against all comparators with the exception of Mirtazapine and Citalopram where it is cost-effective (€66,662/QALY and €11,055/QALY gained, respectively). The probabilistic sensitivity analysis revealed that Agomelatine is cost-effective against all comparators with a probability between 48.9% and 97% at a willingness-to-pay threshold of €50,000/QALY gained. CONCLUSIONS: Using conservative assumptions, the present economic evaluation indicates that Agomelatine may be a more efficient therapy compared to its alternatives for the management of patients in Greece.

PMH34 LONG-TERM COST-EFFECTIVENESS OF ATYPICAL ANTI-PSYCHOTICS FOR SCHIZOPHRENIA IN THE UNITED STATES
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OBJECTIVES: To conduct a long-term cost-effectiveness analysis to evaluate the 5-year Markov model. From a US payer perspective, was developed to compare lurasidone, generic-olanzapine, aripiprazole, quetiapine, and risperidone. Health states included in the model were: patients on initial AAP, patients switched to a second AAP, and patients on clozapine after failing a second AAP. Incremental cost-effectiveness rates (ICERs) assessed incremental cost/hospitalization avoided. Effectiveness inputs included discontinuations, hospitalizations, weight change, and cholesterol change from comparative clinical trials for lurasidone and for aripiprazole, and CATIE for other comparators. AAP-specific relative risk of diabetes obtained from a retrospective analysis was used to predict cardiometabolic events per the Framingham BI risk equation. Mental health costs (relapsing versus non-relapsing patients) and medical costs associated with cardiometabolic consequences (cardiovascular events and diabetes management) were obtained from published sources. SAP costs were estimated from Redbook prices at dose(s) reported in the clinical data sources used in the model (e.g., weight-averaged dose of lurasidone and average dose for all other comparators). Costs and outcomes were discounted at 3%, and model robustness was tested using one-way and probabilistic sensitivity analyses.

RESULTS: In a 5-year Markov model for lurasidone, olanzapine, aripiprazole, quetiapine, and risperidone in terms of incremental cost/hospitalization avoided. Compared with generic-olanzapine ($106,407 and 0.424 hospitalizations), lurasidone patients had an ICER of $16,522/hospitalization avoided ($107,219 and 0.374 hospitalizations). Lurasidone had an 89.5% probability of being cost-effective compared with generic-olanzapine at a willingness-to-pay of $50,000/hospitalization avoided. One-way sensitivity analysis showed the model is sensitive to hospitalization rates and AAP costs. CONCLUSIONS: Model results show that among adults with schizophrenia, lurasidone is cheaper and more effective compared with quetiapine, aripiprazole, and would be cost-effective compared with generic-olanzapine, due to differences in hospitalization rates and cardiometabolic profile.