of the intervention under evaluation were found both in the percentage of patients maintaining total abstinence as well as in the percentage of relapsed patients. Statistically significant in favor of naltrexone treatment when assessing too such endpoint as alcohol craving intensity assessment for the NAL/PSY vs ACA/PSY analysis, in a long treatment period and for the NAL/PSY vs FL/PSY analysis in a short term. Long-term results (52 weeks) of the analysis quoted indicate on a comparable clinical efficacy (no statistical significance of results obtained) of the use of naltrexone and placebo in the group of alcohol-dependent patients undergoing psychotherapy. The events related to the treatment are usually mild and transient. The most frequent ones are: headaches, sleep disorders, anxiety, nervousness, gastrointestinal disorders such as abdominal pain, nausea, vomiting. CONCLUSIONS: Summing up, the results of the analysis carried univocally prove that naltrexone administered in a 50mg dose a day is an effective and safe drug in the treatment of alcohol dependent patients who additionally undergo a psychotherapy.

PMH15 IMPACT OF ADHERENCE TO FIRST THERAPY ON THE RISK OF ANTIDEPRESSANT SWITCHING
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OBJECTIVES: To assess the impact of adherence to first antidepressant (AD) therapy on risk of AD switching, using nationwide claims database. METHODS: Using the Korean Health Insurance Review & Assessment Service (HIRA) claims database (2006-2008), newly diagnosed depression patients who aged 18-84, without medical visit due to depression (ICD=10-F06, F31.3, F31.4, F33, F33.4, F38.1, F41.2) within 6 months before the first observed prescription of ADs between Jul 2006 to Jun 2017 (8 months index period), and with at least 3 psychiatric visits within 3 months from index date were identified. ADs were categorized as tricyclic antidepressants, selective serotonin reuptake inhibitors (SSRIs), and other antidepressants (NADES). For each AD category, adherence by 90 days post-index period. Medication possession ratio (MPR) was estimated. Switching was defined prescription of different class of AD therapy from last AD regimen. Time to first switching was assessed. The presence of hazards model was used to investigate the relationship between adherence to AD and time to switch. RESULTS: A total of 88,070 patients satisfied the selection criteria, among which mean age of 45.2 years and 67.3% of women. When assessed AD therapy within 90 days from index date, 31.3% of the patients prescribed SSRIs monotherapy, 36.4% prescribed TCAs monotherapy, and 15.2% prescribed SSRIs+NADs polytherapy. Overall rate of switching was 38.1%. When adjusted for age, gender, and AD regimen, patients with higher adherence (MPR>75%) showed lower rate of switching (adjusted OR=0.995; 95% CI=0.91-0.95). CONCLUSIONS: Switching AD therapy can be inferred as indicator of insufficient effective efficacy or drug reaction. Improving adherence to AD therapy in newly diagnosed depression patients is important to prevent the switching AD therapy afterwards.

PMH16 CHARACTERISTICS OF PATIENTS IN COMMUNITY BEHAVIORAL HEALTH ORGANIZATIONS RECEIVING TWO INJECTABLE FORMS OF ATYPICAL ANTIPSYCHOTICS AS COMPARED WITH OTHER ANTIPSYCHOTICS
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OBJECTIVES: To describe characteristics of patients with schizophrenia receiving treatment with atypical injectable antipsychotics paliperidone palmitate and risperidone long-acting as compared to other antipsychotics therapy at community behavioral health organizations (CBHOs) in the United States. METHODS: A longitudinal, noninterventional observational registry, Research and Evaluation of Antipsychotic Treatment in Community Behavioral Health Organizations OUTcomes (REACH OUT) is collecting information on use of paliperidone palmitate, risperidone long-acting therapy (LAT), and other antipsychotics by patients with schizophrenia or bipolar type 1 disorder receiving treatment at CBHOs. Patients are followed for 1 year, with assessments at baseline, 6, and 12 months. Sites use a Web-based data-collection tool to enter patient self-reports, interviewer assessments, and medical record abstractions. RESULTS: At time of analysis, baseline patient and site report data from 134 patients with schizophrenia were collected at 10 sites in the following cohorts: 44% paliperidone palmitate injections, 33% risperidone injections, and 23% other antipsychotics. Patients in the paliperidone palmitate or risperidone LAT cohorts were older, on average, than those receiving other antipsychotics (p<0.001). CONCLUSIONS: Improvement in antipsychotic therapy in newly diagnosed depression patients is important to prevent the switching AD therapy afterwards.

PMH17 PREVALENCE OF ANTICHOLINERGIC DRUG PRESCRIBING IN ELDERLY OUTPATIENTS WITH DEMENTIA
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OBJECTIVES: Anticholinergic medications, though frequently used in the elderly population, are associated with cognitive impairment and use of these agents is a concern in dementia patients. This study examined the prevalence and predictors of anticholinergic events prescribed to elderly outpatients with dementia. METHODS: Data from 2006-2007 National Ambulatory Medical Care Survey (NAMCS) and the outpatient National Hospital Ambulatory Medical Care Survey (NHAMCS) were combined to analyze elderly (65 years or older) patient visits for dementia (ICD-9-CM codes 290-299.X, 291.2, 294.X, 331.XX, 066.1 and 046.5). Anticholinergic drugs were identified using a previously published classification of anticholinergic drugs (Csirovich et al, 2004), which classified anticholinergic drugs into four levels in increasing order of their anticholinergic activity. Descriptive analysis was used to evaluate prevalence patterns and multiple logistic regression was conducted to examine the factors associated with prescribing of medications with marked anticholinergic activity (Level 2 or Level 3). RESULTS: According to the 2006-2007 NAMCS and NHAMCS data, there were a total of 6.9 million (95% Confidence Interval (CI) 5.27-8.44 million, 0.32%) ambulatory care visits for dementia. Nearly 43% (95% CI 35.24%-50.48%) of all elderly dementia patient visits involved prescribing of at least one anticholinergic drug; 36.76% of the above visits involved Level 1 medications, 10.85% of visits involved Level 2 or Level 3 medications. While age (75-84 years; Odds Ratio (OR) 0.26, 95% CI 0.08-0.85) and acetylcholine esterase inhibitor use (OR 0.21, 95% CI 0.07-0.63) increased the likelihood of prescribing medications with marked anticholinergic activity, total number of medications prescribed also (OR 1.41, 95% CI 1.81-1.67) increased the likelihood of these prescriptions. CONCLUSIONS: Over 10% of elderly dementia visits involved prescribing of medications with marked anticholinergic activity. Given the severe cognitive adverse events, there is strong need to optimize anticholinergic drug prescribing in elderly outpatients with dementia.

PMH18 IMPACT OF COGNITIVE IMPAIRMENT ON FUNCTIONING, MEDICAL RESOURCE UTILIZATION, ADHERENCE AND HEALTH-RELATED QUALITY OF LIFE IN PATIENTS WITH SCHIZOPHRENIA
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OBJECTIVES: To examine the influence of cognitive impairment on functioning, medical resource utilization, adherence, and health-related quality of life (HRQoL) in patients with schizophrenia. METHODS: Data analyzed were from a cross-sectional study of patients with schizophrenia and their physicians (2005 Adelphi US Psychoses XI Disease Specific Programme). Outpatient schizophrenia patients aged ≥18 years with ≥4 physician encounters in the past 12 months were identified. Physicians evaluated patients’ cognitive impairment, positive and negative symptoms, treatment (empathic) adherence, and treatment satisfaction (relationship). Cognitive impairment was measured by the patient perspective. The target population consisting of the alcohol-dependent patients, who are treated in the dependent treatment centres and are eligible for naloxone treatment was estimated on the basis of epidemiological data and clinical expert’s opinion. In the analysis two scenarios were compared: present, in which...
none of the drugs supporting psychotherapy in treatment of alcoholism is reimbursed, and new, in which naltrexone is reimbursed within the catalogue of guaranteed health services in the treatment of alcohol-dependent patients. The analysis presents the costs incurred by public payer and by patient associated only with drugs used to treat alcohol dependence in the target population. These costs were not discounted. Consumption of resources was estimated on the basis of epidemiological data and recommended duration of pharmacotherapies. The effect of changes of key parameters and assumptions of primary analysis on the results obtained from the perspective of the public payer was examined in the one-way sensitivity analysis. RESULTS: If the reimbursement of naltrexone is introduced, the annual expenses from the budget of National Health Fund would increase by PLN 11.7 million in the first year, and PLN 11.8 million in the second year of reimbursement. On the other hand, from the patient perspective reimbursement of naltrexone would bring significant cost savings which will annually amount to PLN 28.8 million in the first and second year of the refund. CONCLUSIONS: Reimbursement of naltrexone in the treatment of alcohol-dependent patients in Poland will bring additional costs incurred by public payer (National Health Fund) and patient’s significant cost savings.

PMH20

PSYCHOTROPIC MEDICATION USE AMONG CHILDREN WITH AUTISM SPECTRUM DISORDER: A COMPARISON BETWEEN MEDICAID AND COMMERCIAL INSURANCE

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OBJECTIVES: To compare patterns of psychotropic medication use and the associated costs among children with autism spectrum disorder (ASD) between public and private insurance to identify potential barriers to access to treatment.

METHODS: Retrospective analyses were done using year 2003 claims data from Medicaid and the MarketScan databases, a national sample of privately insured individuals. Two sample t-tests were conducted for continuous comparisons. T-tests were used to compare the means given the large sample size. RESULTS: A total of 18,166 children with ASD were identified in Medicaid and 2,716 in MarketScan. Psychotropic medication use was defined as length of therapy without exceeding a 30-day gap in drug coverage, and drug cost per day was defined as length of therapy without exceeding a 30-day gap in drug coverage. Differences in daily utilization of antidepressant therapies may affect follow-up healthcare resource utilization and costs. Patients treated with antidepressants had more distinct psychiatric diagnoses and medication, and were more likely to have an Elixauser index score of more than 3 when compared to patients from the Any Medication Group (n = 10,523) were sicker, had more distinct psychiatric diagnoses and medication, and were more likely to have an Elixauser index score of more than 3 when compared to patients from the No Medication Group (n = 8,630). After risk adjustments, 6,658 patients from each group were matched. Patients in the Any Medication Group stayed significantly longer in detoxification facilities, and had a higher number of detoxification and/or rehabilitation admission which translated to a higher cost burden. Also, patients in the Any Medication Group had more opioid-related and substance abuse psychosocial provider services and higher total healthcare costs during a 6-month post-index period.

CONCLUSIONS: After controlling for confounders such as demographic factors, comorbidity conditions and baseline healthcare utilization, we showed that medication treatment affects follow-up healthcare resource utilization and costs. Patients treated with medication incurred higher healthcare costs and utilizations than patients who were treated with medication.

PMH21

DIFFERENCES IN DAILY AVERAGE CONSUMPTION AND DAILY COSTS OF DESVENLAFAXINE, VENLAFAXINE XR, DULOXETINE, AND ESCITALOPRAM AMONG COMMERCIALLY INSURED PATIENTS

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BACKGROUND: Differences in daily utilization of antidepressant therapies may affect follow-up healthcare resource utilization and costs. To compare the differences in healthcare costs and utilizations between opioid-dependent patients who were treated with and without medication. METHODS: We conducted a retrospective database analysis using commercial enrollees from a large U.S. health plan database from 2005 to 2009. Continuously eligible patients with at least one claim of opioid dependence during the identification period and an opioid use disorder diagnosis during the baseline period were included. Propensity score matching was applied to compare the risk-adjusted outcomes between the Any Medication Group and the No Medication Group. Baseline differences in age, gender, region, comorbid scores, socio-economic status, and baseline healthcare utilization and costs were controlled. RESULTS: Descriptive analysis showed that patients in the Any Medication Group (n = 10,523) were sicker, had more distinct psychiatric diagnoses and medication, and were more likely to have an Elixauser index score of more than 3 when compared to patients from the No Medication Group (n = 8,630). After risk adjustments, 6,658 patients from each group were matched. Patients in the Any Medication Group stayed significantly longer in detoxification facilities, and had a higher number of detoxification and/or rehabilitation admission which translated to a higher cost burden. Also, patients in the Any Medication Group had more opioid-related and substance abuse psychosocial provider services and higher total healthcare costs during a 6-month post-index period.

CONCLUSIONS: After controlling for confounders such as demographic factors, comorbidity conditions and baseline healthcare utilization, we showed that medication treatment affects follow-up healthcare resource utilization and costs. Patients treated with medication incurred higher healthcare costs and utilizations than patients who were treated with medication.

PMH22

CLINICAL AND ECONOMIC CONSEQUENCES OF LONG-TERM USE OF BENZODIAZEPINES IN PATIENTS WITH GENERALIZED ANXIETY DISORDER

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OBJECTIVES: To compare patterns of healthcare utilization and cost in the 6-month periods immediately before and after the initiation of benzodiazepine therapy among patients with generalized anxiety disorder (GAD) deemed long-term users of such therapy. METHODS: Using a large U.S. health insurance database, we identified all persons with evidence of GAD (ICD-9-CM diagnosis code 300.2) between 1/1/2003 and 12/31/2007 who began treatment with a benzodiazepine anxiolytic. The date of the first benzodiazepine claim was designated the “index date,” and we limited attention to patients with evidence of use of benzodiazepines for ≥90 days. Patients with <6 months of complete data preceding and following their index date were excluded from the study sample (“pre-index” and “post-index”, respectively). We then compared healthcare utilization and costs between the 6-month pre-index and post-index periods. All healthcare utilization—and corresponding costs—was characterized as possibly attributable to long-term use of benzodiazepines (such as “accident-related” [e.g., fractures] or “other possibly related” [e.g., mental confusion/disorientation, cognitive impairment, disorientation]) or not, based on relevant ICD–9–CM diagnosis codes. RESULTS: We identified a total of 866 patients who initiated benzodiazepine therapy for GAD and who met all other entry criteria; 75% began monotherapy with benzodiazepines, and 25% initiated such therapy on an add-on basis. Mean total healthcare costs over the 6-month post-index period increased by $2334 relative to pre-index ($4637; 95% CI: $2197, $6210), p < 0.001, the substantial proportion of which is attributed to long-term use of benzodiazepines (i.e., accident-related, other possibly related) was $1099 ($7157; $7656) vs. $285 ($4136; p < 0.001). CONCLUSIONS: Healthcare costs increase in patients with GAD who receive ≥90 days of benzodiazepine therapy. The substantial proportion of which is attributed to long-term use of benzodiazepines is associated with accidents and other known sequelae of long-term benzodiazepine use.