sources. Direct costs of diabetes complications and drug treatment were projected over patients’ lifetimes from a UK National Health Service perspective. Both costs and QALYs were discounted at 3.5% p.a. Sensitivity analyses were performed.

RESULTS: The model projected that treatment with IAsp would result in an additional 0.08 LYG and 0.09 QALYs per patient. Total lifetime costs/patient were estimated to increase by £419. The cost/LYG was calculated to be £5430 and cost/QALY £4825. CONCLUSION: The model predicted that treatment with insulin aspart would result in long-term improvements in health outcomes and quality of life compared to soluble human insulin in patients with type-1 diabetes. The cost-effectiveness result is well within the range considered to represent good value for money in the UK.

EVALUATION OF THE IMPACT ON THE EQ5D_INDEX (HEALTH-RELATED UTILITY) OF CONVERSION TO INSULIN GLARGINE (LANTUS) FOLLOWING FAILURE ON ORAL AGENTS IN PEOPLE WITH TYPE-2 DIABETES: INTERIM ANALYSIS

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OBJECTIVES: To evaluate the impact of cardiovascular co-morbidity on total and diabetes-related health care costs in patients with type-2 diabetes. METHODS: Retrospective analysis of a state Medicaid claims data was conducted in patients with type-2 diabetes identified using ICD-9 diagnosis codes (250.0x–250.9x, where X = 0 or 2) in the year 2001. Patients 265 years or those with managed care coverage were excluded. Presence of cardiovascular co-morbidity in the year 2001 was identified using appropriate ICD-9 codes. Semi-logarithmic OLS models were used to estimate the impact of cardiovascular co-morbidity on total and diabetes-related health care costs in year 2002, controlling for demographic characteristics (age, gender, race, and urban/rural location), presence of peripheral vascular conditions, cerebrovascular conditions, hypertension, hyperlipidemia, and other co-morbid conditions. Two-part models were used for estimating the impact of cardiovascular co-morbidity on specific costs such as ER/hospitalization, outpatient and prescription. Smearing estimates were used to interpret the results from the semi-logarithmic models. RESULTS: Presence of cardiovascular co-morbidity had a significant impact on all categories of total and diabetes-related health care costs, except diabetes-related prescription drug costs. Type-2 diabetes patients with cardiovascular co-morbidity had significantly higher total health care costs (38.9%, $12,550 vs. $9,031), ER/hospitalization costs (239.8%, $4,845 vs. $1,426), outpatient costs (35.3%, $3,956 vs. $2,925) and prescription drug costs (15.1%, $4,686 vs. $4,071) compared to those without cardiovascular co-morbidity. Similarly, type-2 diabetes patients with cardiovascular co-morbidity had significantly higher diabetes-related total health care costs (59.7%, $4349 vs. $2724), ER/hospitalization costs (346.8%, $1911 vs. $428) and outpatient costs (17.4%, $740 vs. $631) compared to those without cardiovascular co-morbidity. CONCLUSIONS: Presence of cardiovascular co-morbidity in patients with type-2 diabetes significantly increases total and diabetes-related health care costs, with ER/hospitalization costs accounting for the highest percentage increase.

DEPRESSION IN PATIENTS WITH TYPE-2 DIABETES: IMPACT ON UTILIZATION PATTERNS AND ADHERENCE TO ORAL HYPOGLYCEMIC AGENTS

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OBJECTIVE: To examine the impact of pre-existing depression on utilization patterns and adherence to oral hypoglycemic agents (OHAs) in patients newly diagnosed with type-2 diabetes. METHODS: Newly diagnosed type-2 diabetes patients during the three-year period (1998–2000) were identified from a Medicaid claims database. Presence of pre-existing depression was determined on the basis of ICD-9 CM codes for depression. Utilization patterns (switching, augmentation) and adherence to OHAs were computed for a 12-month follow up period from the date of the index OHA prescription. A multivariate framework was used to estimate the impact of depression on utilization patterns and adherence, controlling for confounders such as demographics, co-morbidity, diabetes severity, regimen complexity, and interaction with health care providers. RESULTS: A total of 1326 newly diagnosed type-2 diabetes patients were identified (depressed = 471; non-depressed = 855). A significantly higher number of depressed patients (23.3%) switched or augmented therapy as compared to non-depressed patients (16.2%). Results of a multinomial logit model indicated that controlling for covariates, patients with depression were 1.7 times more likely to switch (p = 0.046) and two times more likely to augment...