between treatment groups. Differences reflected the known efficacy and safety profile of BRV. Where reported for other AEDs, changes from baseline and treatment group differences are similarly small, raising questions about the appropriateness of short-term fixed-dose trials as a source of HRQoL data for adjunctive AEDs in refractory patients. Long-term assessments may be more informative. Supported by UCBC.

NEUROLOGICAL DISORDERS – Health Care Use & Policy Studies

PND81 DOES CRGS PROVIDE PROPER GUIDES FOR AN EFFICIENT PHARMACEUTICAL PRESCRIPTION IN ALZHEIMER PATIENTS?
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OBJECTIVES: This paper is to analyze pharmaceutical expenditure in Alzheimer patients from a Europe southeastern region (Valencian Region (Spain)), by using the clustering patients system Clinical Risk Group (CRGs). We focused on obtaining more information about Alzheimer patients, stabilizing a more accurate prediction of their resources consumption and individuating patterns of pharmacoeconomic analysis. METHODS: A cross-sectional study of the inhabitants of a Valencian region with a population of 5,000,000 was carried out, using data extracted from Electronic Health Records for 2013. A sample of 24641 Alzheimer individuals were identified. RESULTS: From our sample 29.4% men and 70.6% women were found. The annual average cost per Alzheimer patient is €1 709.051. By gender, women average cost is 1718.66 € while men average consumption is 1685.97 €. Age is the main variable which most affect pharmaceutical cost, while severity levels are not capable to explain cost variability. CONCLUSIONS: Valuable information about pharmaceutical cost of Alzheimer patients was found. In contradiction to other research, the severity of Alzheimer case, both severity levels do not provide a clear explanation of pharmaceutical cost variability.

PND82 DEVELOPMENT OF A SCREENING TOOL TO SUPPORT IDENTIFICATION OF PATIENTS WITH SECONDARY PROGRESSIVE MULTIPLE SCLEROSIS (SPMS)
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OBJECTIVES: Transition from RRMS to SPMS is difficult to diagnose. Here, we describe methodology for developing a screening tool that can help physicians to diagnose SPMS early. METHODS: Tool will be developed along 3 steps: Quantitative research: A retrospective cross-sectional study to describe differentiating characteristics between SPMS and late RRMS patients using Adelphi Real World database. 2791 MS patient records from 40 countries (including RRMS and SPMS) will be analyzed for key variables will include: age, gender, diseases and MS phenotypes, MS history, treatment history, daily activities, symptoms and clinical characteristics including MRI activity. Patients will be stratified based on EDSS and disease duration into Early RRMS (control group), Late RRMS and Early SPMS: A multivariate regression analysis will identify the significant predictors of patient classification as ‘Late RRMS’ or ‘Early SPMS’ by physician. Qualitative research: (1) Open-ended qualitative interviews of patients (16 each in the US and Germany)–8 RRMS and 8 SPMS patients, 8 MS physicians (4 from EDSS database and 4 from MRIs) to identify and characterize key differentiating features of these two MS phenotypes. (2) Integrating interviews with quantitative research to draft the tool. (3) Use of draft version by physicians treating MS patients in the US and Germany to validate the tool. RESULTS: A total of 11,551 MD patients with 12 months continuous enrollment, and 4,547 individuals with MD and 36 months continuous enrollment were identified, of which 14% -20% filled a subsequent prescription for ACE-inhibitor. There were 94 (2%) patients with 36 months enrollment who had evidence of severe renal dysfunction, of which 50 (53%) filled at least one subsequent prescription for an ACE-inhibitor. CONCLUSIONS: Cardio-protective treatment with ACE-inhibitors among MD patients is significant. Although severe renal dysfunction is not highly prevalent in this unselected population, these findings do not support the administration of ACE-inhibitors, despite a possible contradiction, especially in patients with severe disease. New therapies in development which address underlying disease rather than complications may enable patients to avoid potential contradictions.

PND83 COSTS ASSOCIATED WITH PATIENTS DIAGNOSED WITH RELAPSING-REMITTING MULTIPLE SCLEROSIS TAKING ONCE DAILY FINGOLIMOD CAPSULES IN THE UNITED STATES
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OBJECTIVES: Fingolimod oral tablets were approved in the United States (US) in September 2010 for the treatment of relapsing remitting multiple sclerosis (RRMS). The objective of this study is to assess the costs associated with Fingolimod treatment for patients with MS in the US. Methods: An administrative retrospective claims database was used to identify patients diagnosed with RRMS and were prescribed Fingolimod between January 2010 to December 2012 were included in the study. All patients were 18 years of age and continuously enrolled in the same health plan for a year. Descriptive statistics and chi-square tests were performed on the data. RESULTS: There were a total of 28,477 patients that met the inclusion criteria. The prescription criteria for Fingolimod were charged $5270.93 ± 260.33 for their treatment with Fingolimod during the study period. However, the allowed amount by the health plan was $6242.41 ± 270.65 and the actual paid amount was $4529.98 ± 2074.58. On average, patient’s deductible was $13.64 and 18.80% co-payment was $86.33 ± 316.10. For patients whose prescription was on their health plans formulary paid on average higher costs compared to patients who were not (paid amount $4679 vs $4317). Even though most of the patients were females, but they had overall lower costs compared to males (amount charged $4513 vs $4582, p<0.05; co-payment $79 vs $106, p<0.05). Patients who received treatment in the Midwest region of the USA had a higher costs compared to east, west and south regions (paid amount $4618 vs $4608 vs $4408 vs $4405). CONCLUSIONS: The cost of Fingolimod treatment for RRMS patients is higher and costing the health plan around $5352 for 3 months. The cost of the drug treatment was higher in southern US and males were paying more in general.

PND84 OVER-PRESCRIPTION OF FINGOLIMOD IN GERMANY
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OBJECTIVES: Fingolimod is an orally available immune-modulatory drug for treating relapsing remitting Multiple Sclerosis (RRMS). It was approved by the European Medicines Agency in 2013. Some urgent safety warnings (e.g. progressive multifocal leukoencephalopathy (PML) and cardiovascular events) have been reported in the meantime. Early benefit assessment by the Federal Joint Committee (G-BA) for Fingolimod in 2012 and 2013 showed only additional benefit for a certain group of patients. Therefore the use of Fingolimod has widely been discussed in Germany. We analyzed prescriptions of Fingolimod and the impact of Health Technology Assessment (HTA) and drug safety warnings. METHODS: We used routine data of the German National Health Service and underwrote an additional data set of more than 8.2 million insured, from 2012 to 2014. We looked for prescriptions of disease-modifying therapies (DMT) for patients with Multiple Sclerosis (MS). Diagnosis of MS was identified by G55 according to ICD-10. Considered DMT were Fingolimod, Gilenria (Alemtuzumab), Natalizumab, Interferon beta-1a, Interferon beta-