followed by a maintenance every 8 weeks and metotrexate 15 mg/week. This analysis was used to describe treatment patterns of third-party payer. Only direct costs was used in the model: sourced drug acquisition and administration costs. RESULTS: Inclusion of tocilizumab does not imply additional costs to the Colombian health system and may even save resources by 17 million dollars until 2017. In the probabilistic sensitivity analysis, tocilizumab was a intimately higher than the 3 scenarios in terms of the expected net health benefit. Furthermore, that the inclusion of tocilizumab saves costs for the Colombian health system (with increases of the inclusion, more saves) versus capitalization payment unit ($PCP). CONCLUSIONS: The inclusion of tocilizumab to mandatory health plan Colombia, would have an important, thirly indicating that the health budget would not increase with inclusion.

PMS17 COST OF TUMOR NECROSIS FACTOR INHIBITORS AND TREATMENT PATTERNS AMONG MEDICAID BENEFICIARIES WITH RHEUMATOID ARTHRITIS
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OBJECTIVES: To estimate annual cost-per-treated patient and treatment patterns for etanercept, adalimumab, or infliximab among Medicaid beneficiaries with Rheumatoid Arthritis (RA). METHODS: The MarketScan Medicaid Multistate Database was used to identify adult RA patients indexing on etanercept, adalimumab, or infliximab from 2007-2011. The index date was the first index agent claim preceded by 180 days and followed by 360 days of continuous enrollment. Patients with conditions other than RA were excluded. “Continuing” patients had ≥ 1 claim in the 180 days pre-index for their index biologic; “new” patients did not. Cost per treated patient was calculated as the 360 days cost per index agent divided by the total index drug and administration costs to the payer and the costs of switched-to agents; divided by the number of patients who received the index agent. Costs were based on the pharmacy component of all copay, deductibles, and coinsurance. Results from Osteoarthritis Index were similar across treatment groups (mean age 47.4 years, 83% female). The annual cost per treated patient was lowest for etanercept ($18,466), followed by adalimumab ($20,983) and infliximab ($26,516). For all agents, annual costs were lower for new patients ($18,992 for etanercept, $24,438 for adalimumab, and $28,127 for infliximab). Rates of index drug discontinuation (including switching) were 43%, 66.2%, and 50% for etanercept, adalimumab, and infliximab; switching rates were 17.5%, 20.2%, and 31.0%, respectively. CONCLUSIONS: Etanercept had a lower cost per treated patient compared with adalimumab or infliximab in both new and continuing patients among Medicaid enrollees with RA.

PMS18 COMPARISON OF HEALTH CARE COSTS BETWEEN RHEUMATOID ARTHRITIS PATIENTS INITIATING FIRST OR SECOND-LINE SUBCUTANEOUS ABATACEPT, ADAJLUMAB, OR ETANERCEPT: A DIFFERENCE-IN-DIFFERENCE ANALYSIS
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OBJECTIVES: There are no published data on health care costs among rheumatoid arthritis patients initiating with subcutaneous abatacept, adalimumab, or etanercept. METHODS: A retrospective cohort study using a large U.S. administrative claims database. Patients included for study had initiated subcutaneous abatacept or one of the two most commonly-used subcutaneous anti-tumor necrosis factor-a agents, adalimumab and etanercept. METHODS: A retrospective cohort study using a large U.S. administrative claims database. Patients included for study had initiated subcutaneous abatacept, adalimumab, or etanercept between 1/1/2009-1/1/2012 (index); were aged ≥ 18 years at index, and had ≥ 1 baseline medical claim with an ICD-9-CM diagnosis code for RA (714.0a). First-line initiators used no biologic pre-index; second-line initiators used only one biologic pre index. A follow-up period extended from index until the first occurrence of switch to another biologic, disenrollment from health insurance, or 12/31/2012. Total health care costs (medical + pharmacy) were measured during baseline and follow-up on a per-patient-per-month basis. Health care costs were compared using a difference-in-difference (DID) analysis (baselineänder, post若您 subtract the amount of drug used (mg) multiplied by the September 2013 Wholesale Acquisition Cost. Treatment patterns were also described. RESULTS: A total of 1,085 patients met the study criteria: 48% received etanercept (n = 505); 41% received adalimumab (n = 445); 10% received infliximab. Expenditures for treatment and administration costs were similar across treatment groups (mean age 47.4 years, 83% female). The annual cost per treated patient was lowest for etanercept ($18,466), followed by adalimumab ($20,983) and infliximab ($26,516). For all agents, annual costs were lower for new patients ($18,992 for etanercept, $24,438 for adalimumab, and $28,127 for infliximab). Rates of index drug discontinuation (including switching) were 43%, 66.2%, and 50% for etanercept, adalimumab, and infliximab; switching rates were 17.5%, 20.2%, and 31.0%, respectively. CONCLUSIONS: Etanercept had a lower cost per treated patient compared with adalimumab or infliximab in both new and continuing patients among Medicaid enrollees with RA.

PMS20 ONE-YEAR DISEASE-RELATED HEALTH CARE COSTS OF INCIDENT OUTSECTORAL VERTEBRAL FRACTURES IN GERMANY
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OBJECTIVES: We aimed to estimate the mean direct medical costs and the cost-effectiveness of two treatment modalities among the most common fractures related to osteoporosis. They have been shown to be associated with excess mortality, and meaningful health care costs. Costs calculations have illustrated the significant financial burden to society and national security (Coss et al. 2012) on disease-related costs of vertebral fracture. A method of cost associated with fracture care exceeds $21 billion. Yet, not all fractures heal, leading to even further expenses. There is an economic and societal burden to surgical treatment. The purpose of this study is to compare the costs associated with surgical treatment versus non-invasive methods in managing non-unions (fractures that have not healed). METHODS: A retrospective cohort direct match study was performed using administrative claims (integrated medical and pharmacy data) from the IMS LifeLink® Health Plan Claims Database. All patients with at least one claim for EXOGEN® Ultrasound Bone Healing System (non-invasive) or non-union surgery were identified between April 1, 2007 and March 31, 2010, data through March 31, 2011 were used. RESULTS: A total of 6,490 patients were identified and date of initiation was defined as the index date. Mean difference in medical costs in the 4 quarters following the index date between OVCF and OVCF-free patients was $8,200 (p < 0.001). Of the difference, almost two-thirds was attributable to inpatient services and one-quarter to prescription drug costs. The GLM estimated and revealed that OVCF-free patients had $6,490 higher follow-up costs. Compared with baseline, the costs associated with fracture healing were significantly higher ($6,490, p < 0.001). All costs that add up to 6,490 (p < 0.001; CI: 5,809 ± 6,731). CONCLUSIONS: Despite limitations of this study, including sensitivity and specificity of claims-based diagnoses, and generalizability issues, our results are consistent with other research and demonstrate that OVCF’s are associated with significant costs. In light of the high and increasing incidence and prevalence of these fractures, the results emphasize the importance of research in this field.

PMS21 NON-INVASIVE EXOGEN ULTRASONIC TREATMENT OF NON-HEALING FRACTURES LEADS TO DECREASED COSTS COMPARED TO SURGERY
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OBJECTIVES: The cost associated with fracture care exceeds $21 billion. Yet, not all fractures heal, leading to even further expenses. There is an economic and societal burden to surgical treatment. The purpose of this study is to compare the costs associated with surgical treatment versus non-invasive methods in managing non-unions (fractures that have not healed). METHODS: A retrospective cohort direct match study was performed using administrative claims (integrated medical and pharmacy data) from the IMS LifeLink® Health Plan Claims Database. All patients with at least one claim for EXOGEN® Ultrasound Bone Healing System (non-invasive) or non-union surgery were identified between April 1, 2007 and March 31, 2010, data through March 31, 2011 were used. RESULTS: A total of 6,490 patients were identified and date of initiation was defined as the index date. Mean difference in medical costs in the 4 quarters following the index date between OVCF and OVCF-free patients was $8,200 (p < 0.001). Of the difference, almost two-thirds was attributable to inpatient services and one-quarter to prescription drug costs. The GLM estimated and revealed that OVCF-free patients had $6,490 higher follow-up costs. Compared with baseline, the costs associated with fracture healing were significantly higher ($6,490, p < 0.001). All costs that add up to 6,490 (p < 0.001; CI: 5,809 ± 6,731). CONCLUSIONS: Despite limitations of this study, including sensitivity and specificity of claims-based diagnoses, and generalizability issues, our results are consistent with other research and demonstrate that OVCF’s are associated with significant costs. In light of the high and increasing incidence and prevalence of these fractures, the results emphasize the importance of research in this field.