OBJECTIVES: Regulatory policies, including economic incentivization through patent extension, were implemented to facilitate contraceptive research, however, disparity exists for the neonatal subpopulation. This analysis was conducted to identify the availability of neonate-specific data for frequently used medications in Neonatal Intensive Care Units (NICUs) and to determine the extent to which pediatric exclusivity has increased information for neonates. A search was conducted utilizing the FDALabels database to identify all FDA-approved NDA, BLA and ANDAs from 01/01/1980 to 08/01/2013 searching for the terms “neonate,” “newborn” and “infant” present in any of the following: Indications, Indication and Usage, Dosage and Administration and Pediatric Use.

The results were cross-referenced with a recently published list of 100 frequently prescribed drugs in NICUs and drugs granted pediatric exclusivity by the FDA as of August, 2013. RESULTS: A total of 737 unique labels for 110 distinct drugs were identified (including 18 combination products and 15 modified versions of previously marketed drugs). “Newborn” was identified in 450 labels; “infant” in 414 labels and “neonate” in 379 labels. More than one-drug used in NICUs in 294 date. Only 19% of drugs frequently used in NICUs mentioned neonates, newborns or infants on their labels. Mention of neonates, newborns or infants occurred in 4.5% (n=9) of the drugs with pediatric exclusivity, while 8.7% (n=17) of drugs granted pediatric exclusivity did not. CONCLUSIONS: Only two drugs frequently used in NICUs mentioned neonate, newborn or infant on their label and had pediatric exclusivity.

OBJECTIVES: To evaluate fracture-related expenses and health care resource utilization among post-menopausal women in the U.S. Medicare POPULATION: Women with fractures diagnosed with International Classification of Disease, 10th Revision, Classification [ICD-10-CM] codes: J72.1, J72.2, J72.3, J72.4, J72.5, J72.6, J72.7, J72.8, J72.9, J73.1, J73.2, J73.3, J73.4, J73.5, J73.6, J73.7, J73.8, J73.9, S02.0, S02.1, S02.2, S02.8, 733.12-.16, 805.0, 805.2, 805.4, 805.6, 805.8, 808.0, 808.4, 808.8, 810.0, 810.1, 812.2, 812.4, 813.0, 813.2, 813.2, 813.4, 813.8, 814.0, 820.0, 820.2, 820.8, 821.0, 821.2, 823.2, 823.4, 823.8, 828.3 were identified using U.S. Medicaid data from January 2002 through December 2008. The initial date of diagnosis was designated as the index date. A control cohort that included patients without fractures of the same age, race, region and Charlson Comorbidity Index score was created. The index date for the control cohort was randomly assigned to minimize selection bias. Patients in both cohorts were required to be age ≥50 years, with continuous medical and pharmacy benefits for 1-year pre- and post-index date. Propensity score matching (PSM) was used to compare health care costs and utilizations during the follow-up period. RESULTS: Before matching (n=60,510), fracture patients were more likely to be white (71.2% vs. 46.2%), reside in the South U.S. region (39.2% vs. 34.1%) and have chronic obstructive pulmonary disease (26.7% vs. 21.3%). After 1:1 PSM, a total of 22,089 patients with proportionate baseline characteristics were identified in each cohort. Patients in the fracture cohort had higher proportions of inpatient stays (31.0% vs. 8.1%, p<0.0001), emergency-room and physician office (73.6% vs. 47.3%, p<0.0001). Higher health care resource utilizations translated to higher costs for post-menopausal fracture patients than for controls, including long-term care ($9,191 vs. $7,212, p<0.0001), physician office visit ($428 vs. $293, p<0.0001) and total costs ($17,696 vs. $13,032, p<0.0001). CONCLUSIONS: Post-menopausal women with fractures had significant health care resource utilization and expenses compared to those without fractures.

PIH59

EXPOSURE AND DETERMINANTS OF USE OF POTENTIALLY INAPPROPRIATE MEDICATIONS IN ELDERLY INPATIENTS: STOP AND START CRITERIA

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Objectives: The incidence of refillable contraceptive use increased minimally: from 3.45% in the pre-PPACA-period 1 (January 1, 2011 to June 30, 2011) compared to 0.50% in the pre-PPACA-period 2 (July 1, 2011 to June 30, 2012). The incidence of refillable contraceptive use increased minimally: from 3.45% in the pre-PPACA-period 1 (January 1, 2011 to June 30, 2011) compared to 0.50% in the pre-PPACA-period 2 (July 1, 2011 to June 30, 2012). The incidence of refillable contraceptive use increased minimally: from 3.45% in the pre-PPACA-period 1 (January 1, 2011 to June 30, 2011) compared to 0.50% in the pre-PPACA-period 2 (July 1, 2011 to June 30, 2012). The incidence of refillable contraceptive use increased minimally: from 3.45% in the pre-PPACA-period 1 (January 1, 2011 to June 30, 2011) compared to 0.50% in the pre-PPACA-period 2 (July 1, 2011 to June 30, 2012). The incidence of refillable contraceptive use increased minimally: from 3.45% in the pre-PPACA-period 1 (January 1, 2011 to June 30, 2011) compared to 0.50% in the pre-PPACA-period 2 (July 1, 2011 to June 30, 2012). The incidence of refillable contraceptive use increased minimally: from 3.45% in the pre-PPACA-period 1 (January 1, 2011 to June 30, 2011) compared to 0.50% in the pre-PPACA-period 2 (July 1, 2011 to June 30, 2011).