100,000-member health care plan. METHODS: Patient characteristics and AED ef- ficiency (decrease from baseline in frequency of drop seizures) were modeled with clinical trial data. Medication costs were derived from administrative claim data from a large US managed health care plan affiliated with OptumInsight, with the as- sumption that 2.3% of drop seizures required medical care. Budget impact was measured over 2 years. Results were expressed as overall difference in costs (seizure- or disease-related to a health plan, and cost per member per month (PMPM) after the addition of clozabam. Alternative scenario analyses were performed. RESULTS: With the assumption that 0.04 % of the plan population had LGS, addition of clozabam to the formulation resulted in cost savings of $78,660 in Year 1 and $104,000 in Year 2, corresponding to savings of $0.07 and $0.59 PMPM, respectively. Alternative analyses with lower seizure rates upon discontinuation or greater long-term effi- cacy for lamotrigine and topiramate did not substantially alter the conclusion. Assumption that fewer drop seizures require medical care resulted in a modest cost increase with clozabam, suggesting that medically attended drop seizures are a primary driver of costs for LGS patients. Post-assessment therapies also included lidocaine patch and opioids. Clinical and epidemiological data sources consisted of clinical trial data, US census data, and published literature. The US payer perspective model includes direct medical costs (in 2010 US dollars) including pharmacy, physician visits, and treatment of adverse events. Discounting was excluded due to the short timeframe. Drugs were priced at wholesale average cost (WAC). Other pricing fac- tors were assumed to be fully reflected in published prices. Cross-sectional utilization/costs were measured over the follow-up time of each patient with total costs/patient/stage annualized using a patient-year cost approach. RESULTS: A total of 1272 HD patients (752/520 C/M) were included for this study. The mean age was similar between the two populations (C: 48.5 years (SD 13.8); M: 49.3 years (SD 17.2)) with slightly higher female representation in the M population (60.8% vs. 54.1%). A fairly even C patient distribution by stage was noted (30.5%/35.5%/34.0%; early/middle/late). However, most (74.0%) M HD patients were classified as late stage. The mean total annualized cost per patient varied in both populations (early: C: $22,582 (SD $26,049), M: $23,722; middle: C - $37,495 (SD $27,111), M: $42,330 (SD $16,986); late: C - $52,582 (SD $39,028), M - $37,495 (SD $27,111)). Outpa- tient costs were the primary health care cost component, except for M early stage outpatient early: C - 45.8%; middle: C – 48.2%, M – 66.4%; late: C - 41.5%, M – 78.9%; inpatient costs were highest in M: 37.7%). Inpatient early costs contributed to 54.6% of total late stage costs. CONCLUSIONS: HD direct health care costs in- creased with disease progression. Late stage M patients had higher costs than their C counterparts, due to nursing home costs.

PND10 COST OF RELAPSE RESULTS IN HOSPITAL AND EMERGENCY ROOM VISITS AMONG PATIENTS WITH MULTIPLE SCLEROSIS

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OBJECTIVES: To describe diagnosis codes, frequency and cost of multiple sclerosis (MS)-related hospital and emergency room (ER) utilization. METHODS: Two cohorts of MS-diagnosed patients aged 18-64 years were selected from a national managed care database: 1) longitudinal cohort: patients with 12 months pre/post eligibility around first MS diagnosis occurring January 1, 2002 to July 30, 2010, and 2) cross- sectional cohort: patients with an MS diagnosis in 2010. MS-related [multiple sclerosis (ICD-9-CM–340.XX), other demyelinating CNS disease (ICD-9-CM–341.XX), and a group of symptom-related codes] hospitalizations and ER visits were evalu- ated. Rehabilitation (ICD-9-CM–900-909) and certain lifestyle interventions (ICD-9-CM–906-908) were included in the qualitative review of care. Mean number and cost per patient, adjusted to $25/26 were described. RESULTS: There were 31,905 patients in the longitudinal cohort and 32,845 patients in the cross-sectional cohort. In the longitudinal cohort, 18.5% had a post-index hospitalization (any cause) with 5.2% being MS-related (340.XX: 3.2%; 341.XX: 0.4%; rehabilitation: 0.8%, and ondansetron: 1.1%). Mean number and cost (SD) of an MS-related hospitalization were 1.19 (0.55) and $14,358 ($3,256), respectively. In addition, 31.4% of patients experienced a post-index ER visit with 6.9% being MS- related (340.XX: 2.9%; 341.XX: 0.2%, symptom-related: 4.7%). Mean number and cost (SD) of an MS-related ER visit were 1.23 (0.78) and $573 ($815), respectively. In the cross-sectional cohort, 12.5% had a hospitalization (any cause) with 3.7% being MS-related (340.XX: 2.1%; 341.XX: 0.2%; rehabilitation: 1.1%; and symptom-related: 4.5%). Mean number and cost (SD) of an MS-related hospitalization were 1.32 (0.78) and $56,213 ($25,394), respectively. In addition, 27.3% of patients experienced an ER visit with 6.4% being MS-related (340.XX: 2.6%; 341.XX: 0.1%; and symptom-related: 4.5%). Mean number and cost (SD) of an MS-related ER visit were 1.73 (0.89) and $682 ($825), respectively. CONCLUSIONS: Costs for hospitalization and ER visits among MS patients were substantial. Inclusion of rehabilitation and symptom-related codes can account for an under-recognized proportion of expenditures. NID11 COST OF CERVICAL DYSTONIA IN THE UNITED STATES

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OBJECTIVES: Cervical dystonia (CD), or spasmodic torticollis (333.83), is the most common adult-onset focal dystonia and is associated with significant pain and disability. The quality of life burden of CD has been well documented; however, very limited information exists regarding the economic burden of CD. This study aims to quantify the average per-patient cost of CD health care resource use using baseline data from the CD Patient Registry for the Observation of Onabotulinum- toxinA Efficacy (CD PROBE), a large ongoing registry. METHODS: At baseline, partic- ipants reported use of specific health care resources over the preceding 6 months, including visits to a primary care provider, neurologist, pharmacist, physi- cal or occupational therapist, neurosurgeon, alternative care provider, chiroprac-