ing an erythropoiesis-stimulating therapy (EST). Patients were included in this analysis if they were >65 years old and received therapy between October 2005 and October 2006. Patient demographics, comorbid conditions, baseline hemoglobin, CKD status, EST dose, and frequency of administration were collected. Drug cost was based on average weekly dose and September 2006 wholesale acquisition cost (EPO $12.17/1000 Units; DARB $4.446/mcg). RESULTS: 862 patient charts were reviewed; 556 patients met eligibility criteria (EPO: 351; DARB: 205). Patient demographics, comorbid conditions, baseline hemoglobin, and CKD status were similar between groups. Weekly and extended (>= every two weeks [= Q2W]) dosing patterns were seen in both groups (EPO: QW, 39%; >= Q2W, 61%; DARB: QW, 8%; >= Q2W, 92%). The average weekly dose over the course of the study (EPO: 10,719 units; DARB: 48 mcg) corresponded to a dose ratio of 223:1 (Units EPO: mcg DARB) and weekly costs of $130 for EPO and $213 for DARB. CONCLUSION: The doses and 39% lower drug cost in the EPO group observed in this study were similar to those published from earlier time periods. The results reported here should be of assistance to clinicians and formulary decision makers in identifying current real-world dosing and subsequent cost of treatment of these erythropoietic agents.

OBJECTIVES: To study treatment outcomes (total cost, hospitalization, hospital stays and physician office visits) associated with thiazolidinedione (TZD) use among Medicare patients with type II diabetes. METHODS: Medicare Current Beneficiary Survey Cost and Use files 2000 and 2001 were used. Patient-year approach was utilized. After applying inclusion and exclusion criteria, patients’ sociodemographic and clinical characteristics were characterized and compared across different treatment groups. Instrumental variable (IV) methodology was applied with TZD geographic area use rate as instrument and IV assumptions were validated. The results of IV method were compared to that of standard ordinary least square (OLS) approach. RESULTS: A total of 417 patients were included in the final analysis. More patients with actual TZD treatment had comorbidities =0 >69.8% vs. 56.4%, p <0.05) and less were non-white/black race (1% vs 7%, p <0.05) than those without. The TZD use rates were 17% and 29% for lower (<20%) and higher TZD area use rate groups respectively (p <0.01). Unadjusted OLS models showed that actual TZD use was associated with increased total annual cost (co-efficient = 0.38, p <0.01) and risk of having more physician office visits by 81%. Adjusted OLS models showed that actual TZD use was still associated with increased total annual cost (co-efficient =0.23, p <0.05) and risk of having more physician office visits by 64% (p <0.05). IV approach demonstrated that higher TZD area use rate was not associated with total annual cost, hospitalization and hospital stays (p >0.1). IV assumption for physician office visits was violated as indicated by a significant Wu-Hausman test. CONCLUSION: Increasing average TZD area treatment rate from 17% to 29% would not lead to increased total annual cost, hospitalization and hospital stays among marginal patients in the cohort of senior diabetic patients in this study. Future research utilizing data with large sample size is suggested.