comparison to evaluate the efficacy and safety, with the study of Jiao and cols., an hypothesis was placed in accordance with this efficacy and the Hoehn and Yahr states, an analysis of incremental cost-effectiveness ratio (ICER) was performed. We used a markov model to estimate the CE and performed sensitivity analyses and varying disease progression parameters and costs. The outcome of effectiveness analysis was measured response. RESULTS: For patients with PBA in mild therapy, treatment with levodopa had lower costs and more effectiveness than pramipexole, rasagiline and selegiline treatments. With a time horizon of 5 years, levodopa was 5.04 life years gained and cost $23,765.50, the cost of selegiline was $247,094.21 with 4.1 life years gained, pramipexol had a cost of $247,420.46 with 4.1 life years gained and finally rasagiline $254,006.56 with 3.17 life years gained, all values of ICER were less than one GDP per capital. This results showed that levodopa was the dominant alternative. The sensitivity analysis confirms the results. CONCLUSIONS: Findings of this study indicate that levodopa provides the major effectiveness and the lower cost compared to pramipexole, rasagiline and selegiline treatment option in patients with early Parkinson disease (measured by UDPSR) in monotherapy.

PND36
THE COST-EFFECTIVENESS OF LIDEXAMETAMINE DIMESYLATE FOR THE TREATMENT OF BINGE EATING DISORDER
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OBJECTIVES: Pseudobulbar affect (PBA) is an underdiagnosed condition characterized by sudden, involuntary episodes of crying and/or laughing in patients with traumatic brain injury or certain neurologic diseases, including multiple sclerosis, amyotrophic lateral sclerosis, stroke, Alzheimer’s disease, and others. Studies suggest that PBA symptoms are associated with added healthcare utilization and costs.
METHODS: Retrospective analysis using anonymized patient administrative claims data for a large national health insurer. Claims data (both commercial and Medicare) were assessed for each eligible patient, for an observation period including the 12 months before (baseline) and 12 months after (follow-up) the Index Date, defined as the first date for dextromethorphan/quinidine. Eligibility requirements were an Index Date between January 1, 2007 through August 31, 2013, and continuous insurance eligibility for the entire 24 month observation period.
RESULTS: A cohort of 1245 patients treated with dextromethorphan/quinidine was identified, of whom 488 met eligibility requirements. Healthcare costs, primarily driven by utilization, were reduced in the 12 months following dextromethorphan/quinidine use compared with the 12 month pre-treatment, including decreases in acute care (stroke-related postcare (73%) and ancillary costs (2%). Pre-index costs were not reflective of costs related to acute stroke treatment in stroke patients, as no patient had a stroke during the 12-month pre-index (baseline) period. Despite the added prescription costs, there was a net overall positive mean cost reduction was 5%.
CONCLUSIONS: Patients treated with dextromethorphan/quinidine (NUDEXTA) showed a decrease in healthcare utilization and costs compared to the pre-index period.

PND39
HEALTH CARE RESOURCE UTILIZATION BEFORE AND AFTER NATAZILUMAB INITIATION AMONG MULTIPLE SCLEROSIS PATIENTS IN GERMANY
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OBJECTIVES: To evaluate multiple sclerosis (MS)-related health care resource utilization costs and prior to and after initiating natalizumab in Germany. Methods: A retrospective claims database analysis was performed using the Health Risk Institute research database to identify MS patients initiating natalizumab (index date) between 1/1/2009 and 12/31/2012. Patients had 24 months of continuous enrollment (12 months before and 12 months after the index date) and at least one natalizumab prescription in the 4th quarter after the index date. Furthermore, patients with and without other disease-modifying treatment (DMT) during the pre-period were examined. Primary characteristics, MS-related inpatient stays, and corticosteroid use were compared in both periods using paired statistical tests, where appropriate. Results: The study included 193 patients, mean age 37.1 years (standard deviation 10.2), 64.8% female. The majority (75.1%) used a DMT during the pre-period. After initiating natalizumab, the mean number of MS-related inpatient stays (49.7% versus 14.0%, P<0.001), MS-related inpatient costs (mean $3,759 versus $815, P<0.001), and length of stay (mean 7.0 days versus 2.7 days, P<0.001) were decreased compared to the pre-period. In patients without pre-period DMTs, there was a significant reduction in the percentage of patients with MS-related inpatient stays (~77% versus 0.001) and costs (~3052.0; P<0.001) and patients with DMTs in the pre-period had a similar significant reduction (~75% versus 0.001, respectively, P<0.001 for both).
CONCLUSIONS: The pre-period, there were significant reductions in corticosteroid use for all natalizumab initiators (~62% versus 0.001), which corresponded to the mean corticosteroid cost-per-patient reduction in the average length of stay and costs among natalizumab users with and without DMTs in the prior year.

PND40
SKULL MUSCLE ACTIVITY AND RESOURCE TOOL FOR SPORADIC INCLUSION BODY MYOSIS (SUDBM): CHARACTERIZATION OF RESOURCE UTILIZATION AND FINANCIAL BURDEN EXPERIENCED BY SUDBM PATIENTS
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OBJECTIVES: SUDBM is a progressive idiopathic inflammatory myopathy characterized by atrophy and weakness of proximal and distal muscle groups, knee extensions and wrist/finger flexors and dysphagia processes are frequently involved. Progressive weakening results in loss of independence and need for assistive devices and supportive care. The progressive nature of SUDBM leads to increasing medical expenses, many of which are not covered by third-party payers, making quantification difficult using existing databases. SMART-SUBM, a self-report tool, was developed to better characterize out-of-pocket expenses and non-reimbursable items not captured by health care systems. METHODS: SMART-SUBM was developed based on in-depth interview data from 20 SUDBM patients, review of existing resource-use measures, and input from clinical experts (n=9). SMART-SUBM captures resource utilization and financial data over a 6-month period, including out-of-pocket costs and third-party payer expenses. A cross-sectional study (n=102 SUDBM patients) was conducted in the US to gather preliminary resource utilization and patient-reported data. Draft SMART-SUBM was reviewed with 102 SUDBM patients independently, and were refined before use in the cross-sectional study.
RESULTS: The patients had a mean age of 66 years, disease duration of 1-8 years, and varied physically. All patients reported need for frequent health care visits, and 80% indicated that housekeeping assistance was needed to accommodate SUDBM-related disabilities. Nearly one-third of patients required paid help with household tasks, while more than one-half relied on help from unpaid caregivers (e.g., spouse, friend). Nearly half (45%) reported changes in job status because of SUDBM-related functional limitations.
CONCLUSIONS: Results of


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