therapy, prior authorization, not in formulary) between January 1, 2005 to December 31, 2006 but who subsequently filled an SGA or conventional antipsychotic within six months of the rejected claim, formed the case group (n = 328). Newly initiated anti-psychotic users who were in health plans with an open formulary and thus did not experience prior authorization on SGA claim formed the control group (n = 1097). All patients were followed up for 13 months. Cox regression models were used to estimate the effect of having rejected claims on all-cause discontinuation of the index drug, defined as discontinuation, add-on or switch. The model controlled for age, sex, co-morbidities, geographic location, index drug, prescription co-payment. RESULTS: Reasons for rejected claims were distributed as follows: 1) drug not on formulary (72.9%); 2) required prior authorization (19.5%); and 3) required step therapy (7.6%). Median time to discontinuation was 120 days for the case group and 127 days for the control group. The adjusted hazard for discontinuation of the index drug (HR = 1.29, 95% CI: 1.08–1.53) was significantly higher for patients with rejected initial SGA claims compared to controls. Co-payments ranging from $20 to $39 were associated with lower discontinuation compared with copayment ranging from $0 to $4 (HR = 0.75, 95% CI: 0.60–0.93). CONCLUSIONS: New antipsychotic users with rejected initial SGA claims due to formulary restrictions were more likely to discontinue their antipsychotic drugs compared to users who did not face such restrictions.

**PMH45**

THE ASSOCIATION OF COPAY BURDEN AND MEDICATION ADHERENCE AMONG PATIENTS WITH SCHIZOPHRENIA

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OBJECTIVES: To assess the association between self-perceived copay burden and medication adherence among patients with schizophrenia. METHODS: Data were collected from December 2007 to February 2008 from a web-based consumer panel. Adults (age 18+) self-reporting a diagnosis of schizophrenia were invited to participate in the study during a mandatory visit to a website and through 41 in-person interview facilities across the USA. Inclusion criteria for analysis were: current use of an SGA, and no exposure to clozapine or a depot formulation antipsychotic. Adherence was assessed using the MMAS, with general adherence defined as MMAS < 2, and complete adherence defined as MMAS < 1. Logistic regression models were developed to assess the effects of self-perceived copay burden on adherence while adjusting for demographics, substance use, comitant psychotropic medications, comorbidities, and health insurance. RESULTS: Of the 351 study respondents who met criteria for analysis, 39% (n = 137) reported experiencing burden from medication copays. Adjusting for covariates, the effect of copay burden on general adherence approached but did not reach significance (p = 0.060). However, patients who experienced a copay burden were less than half as likely to have complete adherence [OR = 0.427; 95% CI: (0.257, 0.711); p = 0.001]. Effects of copay burden on the individual components of the MMAS varied. Patients with copay burden were more likely to forget to take medication [OR = 2.058; 95% CI: (1.270, 3.335); p = 0.003] and to discontinue medication when feeling worse [OR = 2.000; 95% CI: (1.140, 3.507); p = 0.016]. Being careless about taking medication and discontinuing medication when feeling better were not significantly affected by copay burden. CONCLUSIONS: Among patients with schizophrenia using SGAs, copay burden is associated with forgetting to take medication, discontinuing medication when feeling worse, and less likelihood of complete adherence. Less restrictive formulations that reduce copay burden for SGAs may have a positive effect on medication adherence among patients with schizophrenia.

**PMH46**

PREDICTORS OF DULOXETINE TREATMENT PERSISTENCE FOR PATIENTS WITH MAJOR DEPRESSIVE DISORDER

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OBJECTIVES: Treatment of depression is often accompanied by discontinuation and switching of antidepressant medications. Information on factors predicting persistence (and avoidance of switching) would thus be of value to medical decision makers. We assess the impact of demographics, initial dose, prior medications, and comorbidities on duloxetine treatment persistence for patients with major depressive disorder (MDD) using retrospective claims data. MEHTODS: Using the PharMetrics Database, we studied individuals aged 18-64 who initiated duloxetine treatment between April 2005 and March 2006, had ≥1 prior MDD diagnoses, and had continuous insurance coverage 6 months before and 12 months after initiation. Persistence was defined as ≥3 months’ continuous duloxetine treatment. Stepwise logistic regression and tree analyses of demographics, initial dose, prior medications, and comorbidities assessed predictors of persistence. Sensitivity analysis was done by analyzing factors associated with switching to venlafaxine XR or a selective serotonin reuptake inhibitor (SSRI) with no history of duloxetine. RESULTS: Among 9,148 patients (74.1% female; mean age = 45.6, SD = 11.1) who initiated duloxetine treatment, 63.5% had persistence of duloxetine treatment for ≥3 months. Regression results showed the most significant factors for persistence to be initial dose of ≥240 mg QD (OR = 1.38), age group <65 vs. age ≥65 (OR = 1.33), age 18-21 yrs vs. age 18-25 yrs (OR = 1.63), and venlafaxine XR initiated in the prior 3 months (OR = 1.64) (all p-values < 0.001). Sensitivity analysis showed initial dose of <60 mg QD was associated with switching from duloxetine (OR = 1.22), although other factors showed differences from the persistence analysis. CONCLUSIONS: The results suggest that for MDD patients, initial dose, age group, and recent venlafaxine XR/SSRI use predict persistence on duloxetine treatment. Sensitivity analysis on switching showed a consistent effect of initial dose.