CONCLUSIONS: Schizophrenic outpatients report better subjective feelings about medication use after switching to ziprasidone. These findings have implications for greater patient compliance with ziprasidone and, possibly, for decreased relapse rates and health-care resource use.

**PMH4**

**DRUG SELECTION, DOSING, AND UTILIZATION PATTERNS AMONG DEPRESSED PATIENTS TREATED WITH SSRI'S AND VENLAFAXINE IN US MANAGED CARE PLANS**  
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OBJECTIVE: The purpose of this analysis was to describe and compare patterns of drug selection, dosing, and utilization among depressed patients treated with SSRIs (citalopram, fluoxetine, paroxetine, and sertraline) and venlafaxine in US managed care.

METHODS: Symmetry Health Data Systems’ Episode Treatment Group methodology was applied to PharMetrics’ Integrated Outcomes Database to identify adult subjects (>18 years) diagnosed with depressive disorder and treated with one of the study medications between January 1, 1998 and June 30, 1999. Prescription claims records were used to identify patterns of drug selection, dosing, and utilization (medication persistence, augmentation, switching, and time to change) for each medication cohort. Descriptive statistics were used to characterize drug selection and dosing patterns, and parametric and nonparametric methods (ANOVA and chi-square) were used to compare utilization indicators across study groups.

RESULTS: Twelve thousand twenty six patients met inclusion criteria. The study cohorts were demographically similar. Index antidepressant drug prescriptions were for citalopram (6.2%), fluoxetine (24.6%), paroxetine (29.5%), sertraline (33.4%), and venlafaxine (6.2%). Citalopram patients more often started (86.7%) and ended (78.4%) on the lowest available dose. Each cohort showed similar patterns of dosage titration/adjustment. The mean number of prescriptions was similar across cohorts; citalopram-treated patients had a significantly higher rate of persistence (mean = 118.3 days) than those treated with paroxetine (106.5), sertraline (108.8), and venlafaxine (108.2) cohorts (p < .001). Augmentation and switching rates were similar across cohorts; citalopram patients whose therapy changed had a significantly longer time to change (mean = 80.9 days) than fluoxetine (76.8 days, p = 0.02), paroxetine (72.1 days, p < .001), sertraline (69.6 days, p < .001), or venlafaxine (66.8 days, p < .001) patients.

CONCLUSIONS: Of the antidepressants evaluated, citalopram was most frequently prescribed at the lowest available dose. Persistence rates were also highest with citalopram. Clinicians and payers should consider differences in dosing and persistence to provide optimal care and benefits for depressed patients.

**PMH5**

**THE COST-EFFECTIVENESS OF QUETIAPINE IN THE TREATMENT OF SCHIZOPHRENIC PATIENTS PARTIALLY RESPONSIVE TO PREVIOUS ANTIPSYCHOTICS—AN ECONOMIC ANALYSIS OF THE PRIZE STUDY**  
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OBJECTIVE: Psychiatrists often see patients who show only a partial response to conventional antipsychotics. This study assessed the cost-effectiveness and economic impact of quetiapine treatment in this clinically important patient population.

METHODS: A decision-analytic model with Markov processes was constructed to assess the costs and health benefits of quetiapine and haloperidol treatment over a five-year period in a UK National Health Service (NHS) setting. Response to medication and incidence of extra pyramidal symptoms (EPS), were derived from a prospective, double blind, randomized clinical trial, the PRIZE study. Transition probabilities used in the model were derived from a thorough review of the literature and expert opinion. Resource use unit costs were taken from the literature. Discount rates of 6% were applied to costs and 1.5% to outcomes as recommended in the UK by the National Institute of Clinical Excellence.

RESULTS: This model found the overall cost of quetiapine treatment per patient to be comparable with the cost of treatment with haloperidol over a five-year period (£37,379 quetiapine versus £37,596 haloperidol). Hospitalization and institutionalization costs were £1,911 less with quetiapine. Outpatient cost savings was estimated at £642 with quetiapine per five years. Over the five-year course of the model, the short-term clinical benefits shown in the PRIZE study lead to quetiapine-treated patients experiencing fewer relapses and responding to treatment for a longer time compared to haloperidol-treated patients. Sensitivity analyses showed the results to be robust to testing of key assumptions.

CONCLUSIONS: With better outcomes and similar treatment costs to haloperidol, quetiapine represents a cost-effective treatment for schizophrenia in patients who show only a partial response to conventional antipsychotics.

**PMH6**

**PATTERNS OF COMORBIDITIES AND COPRESCRIBING AMONG DEPRESSED PATIENTS TREATED WITH SSRI’S AND VENLAFAXINE IN US MANAGED CARE PLANS**  
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OBJECTIVE: The purpose of this analysis was to describe and compare patterns of comorbidities and coprescribing among depressed patients treated with SSRIs
(citalopram, fluoxetine, paroxetine, and sertraline) and venlafaxine in US managed care plans.

**METHODS:** Symmetry Health Data Systems’ Episode Treatment Group methodology was applied to the PharMetrics Integrated Outcomes Database to identify adult subjects (>18 years) diagnosed with depressive disorder and treated with one of the study medications between January 1, 1998 and June 30, 1999. Diagnosis codes and prescription claims records were used to identify the existence of comorbidities and coprescribed therapies. Descriptive statistics were used to characterize rates of comorbidities and coprescribing, and parametric and non-parametric methods (ANOVA and chi-square, with corrections for multiple comparisons) were used to compare rates across medication cohorts.

**RESULTS:** Twelve thousand twenty-six patients met the inclusion criteria. The study cohorts were similar in terms of demographics. Most subjects (79%) had no other mental health diagnoses. Among those who did, anxiety (14%) and substance abuse (6%) were most common; paroxetine and sertraline patients had the highest rates of these comorbidities. Hypertension (17%) and hyperlipidemia (12%) were the most prevalent non-mental health comorbidities. Citalopram- and paroxetine-treated patients had the highest rates of these conditions. Coronary artery disease was more prevalent in the paroxetine and sertraline cohorts (p < .001) compared to other study cohorts. Citalopram-treated patients had the highest rate of prior psychotherapy (30%). Most subjects (90%) had no prior use of antidepressant medications, although citalopram- (11%) and venlafaxine-treated (15%) patients had higher rates prior to index diagnosis. The most commonly coprescribed agents for study patients were anxiolytics (15%) and codeine (15%).

**CONCLUSIONS:** Depressed patients treated with newer antidepressant drugs may be complex in their clinical presentation and management. Clinicians and payers should be aware of comorbidity and coprescribing rates to provide optimal care for these unique populations.

**PMH7**

**CHANGES IN SCHIZOPHRENIA-RELATED TOTAL DIRECT MEDICAL COSTS FOLLOWING INITIATION OF OLanzAPINE OR RISPERIDONE IN A PRIVATELY INSURED POPULATION IN THE UNITED STATES**

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**OBJECTIVE:** To determine the change in schizophrenia-related total direct medical costs following initiation of olanzapine or risperidone therapy.

**METHODS:** The MEDSTAT Group’s MarketScan database was used to obtain data on inpatient, outpatient, and prescription drug claims. This database represents the health care experiences of individuals employed in large organizations in the US, as well as the dependants of those individuals. Data between 1996 and 1999 were analyzed. Patients with a diagnosis of schizophrenia, and initiating either olanzapine or risperidone pharmacotherapy were included in the study data set. Inpatient, outpatient, and medication costs were assessed for one year prior to, and one year following the initiation of olanzapine or risperidone.

**RESULTS:** A total of 162 patients on olanzapine and 119 patients on risperidone were identified. There were no significant differences between the two groups in either patient demographics, or resource use in the year prior to initiation of the medications. However, patients initiating on olanzapine incurred higher total schizophrenia-related direct medical costs in the year prior to initiation. The mean initial dose of olanzapine was 11.5 mg, while the mean initial dose of risperidone was 4.5 mg. For patients initiating on olanzapine, there was no significant difference in the change in schizophrenia-related total direct medical costs ($4,337.37 to $5,216.17; p = 0.45) compared to the costs in the year prior to initiation. This is because the higher medication costs in the treatment period were partially offset by lower inpatient costs associated with olanzapine. For patients initiating on risperidone, there was a statistically significant increase in schizophrenia-related total direct medical costs ($2,751.25 to $4,995.01; p = 0.04) compared to the costs in the year prior to initiation.

**CONCLUSION:** The results of this study demonstrate that while initiation of treatment for schizophrenia with olanzapine is not associated with higher total schizophrenia-related direct medical costs, initiation with risperidone is associated with significantly higher total schizophrenia-related direct medical costs over one year.

**PMH8**

**SCHIZOPHRENIA OUTCOMES RESEARCH STUDY IN SPAIN: TOLERABILITY AND ECONOMIC RESULTS WITH ATYPICAL ANTIPSYCHOTICS**

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**OBJECTIVE:** To assess the frequency and management of extrapyramidal symptoms (EPS), sexual dysfunction related adverse events (SD-RAEs) and weight changes which may impede optimal outcomes in schizophrenic patients under antipsychotic treatment and to perform an economic evaluation.

**METHODS:** A cross-sectional study was carried out by 61 Spanish psychiatrists (the EIRE Study Group). Outpatients meeting DSM-IV criteria for schizophrenia and taking a single atypical antipsychotic (olanzapine, quetiapine or risperidone) for at least four weeks were evaluated. EPS, SD-RAEs and weight changes were assessed using a modified-UKU scale, which included a question for assessing management of adverse events. Cost of antipsychotic and