resource utilisation compared with SAL/FLU. Although the switches, fewer acute exacerbations, and with similar or lower switch to an alternative ICS

OBJECTIVES: EPR-2 guidelines were developed to improve medication prescription for patients with persistent asthma and to control acute exacerbations of asthma. In addition these guidelines also encourage physician provided asthma education. Little is known about prescribing adherence to EPR-2 guidelines. This study examined physician adherence to EPR-2 asthma medication prescribing guidelines and determine patient and physician factors associated with prescribing of asthma medications.

METHODS: This study was a cross-sectional retrospective analysis of complex NAMCS physician visit survey data from 1998 through 2004. Data were extracted on all patient visits with an ICD-9 code for asthma (493.XX) and reason for visit as 'asthma'. Unit of analysis was individual patient visit. Dependent variables in analyses were specific type of drug class. Independent variables were various patient and physician factors. Logistic regression analysis was used to assess study objectives.

RESULTS: Asthma patients in 2002 were 3.3 times more likely to be prescribed controller medications compared in 1998. Findings in 2004 were not significant. Elderly patients were 54% as likely to receive controller medication compared to the 35–64 year age group. Patients other than whites or African Americans are 40% as likely to receive controller asthma medication compared to whites. Physicians were 6.3 times more likely to prescribe long acting beta agonists compared to 1998. Physicians without ownership stake in their practice were 1.9 times more likely to provide asthma education to their patients compared to those who owned their practice. CONCLUSION: This study using US outpatient setting data provides evidence that physician prescribing of asthma pharmacotherapy in the US does not adequately comply with EPR-2 treatment guidelines.

CONCLUSION: Using claims data and Markov-modeling techniques, we found that budgetary impact can be materially affected by rate of treatment switching/add-on. Detailed, claims-based data are required for this type of analysis, given the real-world nature of treatment patterns and associated medical costs.

OBJECTIVES: Medical care costs for rhinitis are primarily driven by patient care-seeking behavior and physician prescribing patterns, which may evolve over time. Estimating a model of real-world rhinitis treatment from clinical trial data is not feasible due to short trial durations and protocol-driven care. Therefore, we used U.S. health care claims data to model rhinitis treatment patterns and estimate the budgetary impact of a novel rhinitis therapy. METHODS: We developed a three-year budgetary impact model of rhinitis using Markov-modeling techniques. Transitions between treatment regimens (monotherapy, dual-combination therapy, tri-combination therapy), treatment patterns, (therapy switching, add-on rates), and associated medical-care costs, were estimated from a large claims database, by identifying rhinitis patients and tracking changes in therapy over time. Budgetary impact of a novel treatment was assessed for three effectiveness scenarios, where the switching/add-on rates relative to fluticasone propionate, an existing rhinitis therapy, were 50% lower (Scenario 1), 25% lower (Scenario 2) and identical (Scenario 3). The novel treatment was assumed to be priced the same as fluticasone propionate and have a market share of 10%. RESULTS: The claims analysis found annual rates of treatment switching, add-on, and remaining on initial therapy ranging from 6–18%, 20–28%, and 62–72%, respectively, for currently existing rhinitis therapies. Annual rhinitis-related medical costs associated with each treatment pattern were $666, $657, and $538, respectively. In Scenario 1, the model predicted the per-patient-per-month (PPPM) budgetary impact for the novel treatment to be ~$0.06, ~$0.09, and ~$0.11, in years 1–3, respectively. Scenarios 2 and 3 had corresponding PPPM results of $0.00, ~$0.01, and ~$0.01, and ~$0.05, ~$0.06, ~$0.08. CONCLUSION: Using claims data and Markov-modeling techniques, we found that budgetary impact can be materially affected by rates of treatment switching/add-on. Detailed, claims-based data are required for this type of analysis, given the real-world nature of treatment patterns and associated medical costs.

OBJECTIVES: Using claims data to model the budgetary impact of a new treatment for rhinitis

CONCLUSION: This analysis confirms the hypothesis that average MPR may be a misleading indicator of adherence in patients taking combined controller medications and leukotriene modifiers. We suggest an approach