Pack-size data were sourced from the NHSBSA December 2014 Drug Tariff and BNF 68. A ‘comparable’ drug had the same active ingredient, concentration and admin- istration method as the prescribed drug. Cost-savings, had the cheapest compa- rable drugs been prescribed, were calculated as: [total NIC in 2014] – [total mg of prescribed drugs] x (US$/mg of cheapest comparable drug). 

RESULTS: Actual total NIC for antiepileptics in 2014 was €58,988,547 (if cheapest branded drug prescribed) and €58,315,621 (if most expensive branded drug prescribed). The greatest increase would have been in MHRA category 2 (342,267,393 to €54,191,174). CONCLUSIONS: It was estimated that greater branded prescribing of antiepileptics would have increased NIC from 115.5M to 200.1M, with 91.23% of increase DMT expenditure.

2014 second line DMT participation reaches 86% of new regimens causing the annual cost per patient in second line represents a 35.63% of DMT expenditure. Annual cost per patient in second line of treating multiple sclerosis (MS) patients treated with subcutaneous interferon β-1a (scIFN-β1a), relapse timing relative to discontinuation, and medical costs in patients with multiple sclerosis (MS). METHODS: Patients (aged 18-63 years) with secondary progressive or relapsing-remitting disease and who were treated with IFN-β1a (n=360) and in the IFN-β1a claim (index) months of continuous eligibility before and 24 months after index were identified in the IMS PharMetrics Plus™ database. Discontinuation was defined as a ≥90 day gap in drug usage. Relapse was defined as the first post-first gap inpatient, emergency room (ER) visit or MS outpatient visit with a corticosteroid claim ≥7 days. Relapse was categorized as before or after scIFN-β1a discontinuation. Medical costs [excluding disease-modifying drug (DMD) costs] per day (US$) pre or post discontinuation of scIFN-β1a are presented. Costs were evaluated with general- ized linear regression models using gap, time of first relapse and the interaction as predictors. Prior costs, age, gender and time until relapse were evaluated as covariates. RESULTS: 1450 MS patients met the study criteria; 29.2% had a relapse, and 50% (n=770) discontinued scIFN-β1a during the follow-up period. Patients discontinuing scIFN-β1a averaged 250 (SD=182) days of treatment and 33.1% relapsed, while those who did not discontinue averaged 726 (SD=15) days of treatment and 25.2% relapsed (p<0.001). Non-DMD medical costs per day were lowest for patients with no gap and no relapse ($247.71/day). Patients who discontinued scIFN-β1a and had their first relapse after discontinuation, had non-DMD medical costs of $39.04/day prior to discontinuation, and $52.28/day after discontinuation. Patients with no gap and a relapse while scIFN-β1a was available had lower non-DMD medical costs ($38.88/day), than patients with a gap in scIFN-β1a that experienced a relapse while on treatment ($72.37/day). Models suggest that costs differ depending on gap status and timing of the discontinuation event. CONCLUSIONS: These results suggest the value of maintaining scIFN-β1a treatment.