utilization and costs in individuals with probable DMD. METHODS: We identified male children with ≥ 5 out of 11 host genetics and ≥ 2 of the following drug-refractory dystrophy between 11/01/2011 and 10/31/2013 (date of first claim = index) from a US administrative claims database. Patients were required to be continuously enrolled with pharmacy benefits for 12 months after index date. Cardiac drugs, gastrointestinal, antibiotics, and adrenal drugs (including steroids) were evaluated in the 12 months after index. Number of inpatient and ER admissions, number of non-ER outpatient claims and prescriptions, as well as healthcare costs (overall and DMD-specific) were measured 12 months after index date. Costs of patients with probable DMD were identified (mean age 14.5). We observed 368 (31%) patients on adrenals, 356 (30%) on cardiac drugs, and 124 (10%) with gastrointestinal drug use during follow-up. In the year after index, 16% had at least one inpatient admission (13% DMD-specific admissions), and 29% had at least one ER admission (15% DMD-specific). The average number of outpatient claims was 79.8 (33.3 DMD-specific), and average number of prescriptions was 17.8. Mean annual costs were $34,381 ($17,581 DMD-specific) in DMD patients vs $10,784 ($7,381 DMD-specific) in non-DMD patients. The mean cost per DMD patient over 1 year was $40,201 ($23,401 DMD-specific). The annual number of outpatient claims was 79.8 (33.3 DMD-specific), and average number of prescriptions was 17.8. Mean annual costs were $34,381 ($17,581 DMD-specific) in DMD patients. The mean cost per DMD patient over 1 year was $40,201 ($23,401 DMD-specific). The annual number of outpatient claims was 79.8 (33.3 DMD-specific), and average number of prescriptions was 17.8. Mean annual costs were $34,381 ($17,581 DMD-specific) in DMD patients vs $10,784 ($7,381 DMD-specific) in non-DMD patients. The mean cost per DMD patient over 1 year was $40,201 ($23,401 DMD-specific). The annual number of outpatient claims was 79.8 (33.3 DMD-specific), and average number of prescriptions was 17.8. Mean annual costs were $34,381 ($17,581 DMD-specific) in DMD patients vs $10,784 ($7,381 DMD-specific) in non-DMD patients.

OBJECTIVE: The aim of this research is to assess the humanistic and economic burden associated with focal drug-refractory epilepsy in Europe. METHODS: A PubMed literature review was performed to identify publications from January 2004 to December 2014 on prevalence and incidence, impact on quality of life and associated costs of epilepsy. RESULTS: In Europe around 6 million people have epilepsy, with 30-45% of patients being drug-refractory and 70% of those having focal drug-refractory epilepsy. The prevalence and incidence rate of epilepsy is 457 and 43.8 per 100,000 persons, respectively. Epilepsy is associated with psychiatric comorbidities, chronic somatic conditions, significant costs to the healthcare system, and higher all-cause mortality than the general population. In 2004 health care expenditures for the treatment of epilepsy accounted for 0.2% of the total European national income and the annual cost per patient varied from £2,000 to £11,500. In 2010, the yearly cost drivers of epilepsy treatment are hospitalizations, antiepileptic drugs, and lost work productivity due to high unemployment rate, 46% compared with 19% for the matched control population. Standard therapy for drug-refractory focal epilepsy is open surgery which is highly effective but also highly invasive and requires strict screening criteria. Minimally invasive surgical techniques are alternative to open surgery and have shown promising clinical benefits with lower neurological impairment and less hospital stays compared with open surgery. CONCLUSIONS: This data highlights the high humanistic and economic burden of focal drug-refractory epilepsy in Europe, and the need for new procedures to improve health outcomes and reduce health care resource utilization.

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HEALTH CARE COSTS ASSOCIATED WITH GERIATRIC PATIENTS DIAGNOSED WITH MULTIPLE SCLEROSIS TAKING DISEASE MODIFYING AGENTS IN THE UNITED STATES

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OBJECTIVES: Understanding the health care costs associated with Multiple sclerosis (MS) in the geriatric population is not well studied. The objective of this study is to assess the health care costs associated with geriatric patients with MS and taking disease modifying therapies (DMTs) in the US. METHODS: A large US administrative retrospective claims database was used to identify patients diagnosed with MS. The data was restricted to patients prescribed DMTs between January 2016 to December 2012 were included in the study. All patients were ≥ 65 years of age and continuum- ously enrolled in the same health plan for at least a year. Descriptive statistics and chi-square tests were performed on the data and statistical significance level was set at <0.05. RESULTS: There were 86,931 patients that met the study inclusion criteria. Majority (66.9%) of the patients were taking subcutaneous injections (SC), 31.2% were taking IV/IM (IVM)and 1.9% was taking oral (OR) DMTs in the year 2016. Patients on average were charged $4,227.9± 2,354.2 with a significant difference (p<0.001) between the three drug groups (OR $5,087 vs SC $4,225 vs IVM $4,188). However, the mean allowed amount by the health plan was $3,692.5 ± 1,915.5 and the actual paid amount was $3,587 ± 1,921 with a significant difference between the groups (<0.001). With insurance coverage, patient's mean total co-payment was $83.3 ± 304.3 with a difference between the groups (p<0.001). For patients whose prescription was on their health plans formulary were charged lower ($4217 vs $2354.2) with a significant difference (p<0.001) than who were not. There was a significant variation in the cost of the treatments in different regions in the US (p<0.001). CONCLUSIONS: The overall costs for oral DMTs were higher than SC and IVM DMTs.

PND95

DEVELOPMENT OF MS BUDGET MANAGER: A PRACTICAL TOOL TO ASSIST ALTERNATIVE SUGGESTIONS AT MULTIPLE DECISION LEVELS IN THE FORECAST AND FINANCIAL MANAGEMENT FOR MULTIPLE SCLEROSIS (MS)

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OBJECTIVES: There are currently several pharmaceutical options for multiple sclerosis (MS). Some introduced recently and some more coming in the future. They are evolving methodologies used by NICE to assess cost-effectiveness. Greater under- standing of clinical and cost-effectiveness of glatiramer acetate (GA) using 6-year data from the UK Multiple Sclerosis Risk Sharing Scheme (RSS). RESULTS: The primary objective of this analysis was to model the clinical and cost-effectiveness of glatiramer acetate (GA) using 6-year data from the UK Multiple Sclerosis Risk Sharing Scheme (RSS). METHODS: A continuous Markov model was developed to assess mean Expanded Disability Status Scale (EDSS) and utility at year-6 and to determine whether this was consistent with a cost-effective target of £36,000 per quality-adjusted life year (QALY) projected over 20 years. In populating the model, we used data from patients fulfilling the Association of British Neurologists (ABN) and National MS Society (NMS)+ protocols. The overall cost effectiveness of GA compared to the comparator patients until the difference between the theoretical and actual cost effectiveness was £36,000 per QALY was achieved. CONCLUSIONS: The model suggested that all drugs provided no proven clinical benefit, except fingolimod (minor benefit in limited subset of patients with rapidly-evolving severe relapsing-remitting MS), that all drugs provided no proven clinical benefit, except fingolimod (minor benefit in limited subset of patients with rapidly-evolving severe relapsing-remitting MS), and appropriate use of mixed treatment comparisons. In some cases, modelling assumptions accepted in previous appraisals were criticised by NICE in subsequent submissions. By contrast, IQWIG and the Federal Joint Committee (G-BA) concluded that glatiramer provided no proven clinical benefit, except fingolimod (minor benefit in limited subset of patients with rapidly-evolving severe relapsing-remitting MS), due to limited clinical data versus IQWIG-specified comparators.

PND98

A LONG TERM ANALYSIS OF THE CLINICAL AND COST EFFECTIVENESS OF GLATIRAMER ACETATE FROM THE UK MULTIPLE SCLEROSIS RISK SHARING SCHEME

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OBJECTIVE: The primary objective of this analysis was to model the clinical and cost-effectiveness of glatiramer acetate (GA) using 6-year data from the UK Multiple Sclerosis Risk Sharing Scheme (RSS). METHODS: A continuous Markov model was developed to assess mean Expanded Disability Status Scale (EDSS) and utility at year-6 and to determine whether this was consistent with a cost-effective target of £36,000 per quality-adjusted life year (QALY) projected over 20 years. In populating the model, we used data from patients fulfilling the Association of British Neurologists (ABN) and National MS Society (NMS)+ protocols. The overall cost effectiveness of GA compared to the comparator patients until the difference between the theoretical and actual cost effectiveness was £36,000 per QALY was achieved. CONCLUSIONS: The model suggested that all drugs provided no proven clinical benefit, except fingolimod (minor benefit in limited subset of patients with rapidly-evolving severe relapsing-remitting MS), due to limited clinical data versus IQWIG-specified comparators.