sonal interviews with physicians. RESULTS: Prescriptions for 276 patients (66% women), average age 56 years (18–88), were collected from 20 specialists. A total of 249 patients had RA (90%), 15 OA (5%) and 12 both (4%). Fifty-three percent were celecoxib prescriptions, 47% rofecoxib. Eighty-four percent of 176 rofecoxib prescriptions to RA patients were of 25 mg strength. Of these, 95% were dosed 1 x 1 and the average daily number of tablets was 1.05. Ninety-four percent of 132 celecoxib prescriptions to RA patients were of 200 mg strength. Of these, 68% were dosed 1 x 2, and the average daily number of tablets was 1.86. The average weighted cost per day for celecoxib was NOK 16.75, and 11.78 for rofecoxib (pharmacy selling prices). CONCLUSION: This study by itself does not allow for an assessment of the drugs’ relative cost-effectiveness. However, the prescription pattern observed among specialists for reimbursed cox-2 inhibitors for RA patients indicates a higher daily drug cost for celecoxib than for rofecoxib.

PAR9

PATTERNS OF USE, DOSING AND ECONOMIC IMPACT OF BIOLOGIC AGENTS IN PATIENTS WITH RHEUMATOID ARTHRITIS

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OBJECTIVE: Variability in dosing of biologic agents among patients with rheumatoid arthritis (RA), and associated economic impact, is of great interest to payers and providers. We examined dosing patterns for patients with RA who were newly treated with infliximab or etanercept as well as corresponding 1-year costs of care.

METHODS: Integrated pharmacy and medical claims data were obtained from 61 U.S. health plans. Patients with a diagnosis of RA who were newly treated with infliximab or etanercept from July 1999 to June 2002 were selected. Among infliximab patients, a maintenance number of vials was determined after the “loading period” (2–3 infusions); those with ≥2 occurrences of an increase in vials or an interval between infusions of ≥70 days were considered to have had escalated. For etanercept patients, a maintenance dose was measured on the second prescription based on the average daily dose dispensed (in mg); those with ≥2 instances of increased average doses were considered to have escalated their dose. RA-related costs at one year post-initiation were examined; statistical comparisons were made using generalized linear models with a gamma distribution.

RESULTS: A total of 1548 patients were identified (n = 598 and 950 for infliximab and etanercept, respectively). Infliximab recipients were somewhat older (50.5 vs. 46.6 years for etanercept). Nearly 60% of infliximab patients experienced an increase in dose at one year, compared to 18% of patients new to etanercept. Infliximab patients who experienced a dose increase had significantly higher annual RA-related costs than those with no increase ($20,915 vs. $16,713; p < 0.0001). Costs among etanercept patients did not substantially differ based on dose escalation ($14,482 vs. $13,866 respectively). CONCLUSIONS: Patients new to infliximab had much higher rates of dose escalation relative to etanercept recipients. These dose increases resulted in significantly higher medical costs at one year.

ARTHRITIS—Quality of Life Studies

PAR10

CROSS-CULTURAL ADAPTATION AND VALIDATION OF KOREAN VERSION OF EQ-5D IN PATIENTS WITH RHEUMATIC DISEASES

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OBJECTIVE: This study aims at translating and adapting the EQ-5D cross-culturally into Korean (KEQ-5D), and evaluating its reliability and validity among patients with various rheumatic diseases. METHODS: The EQ-5D was translated into Korean by 2 translators and back into English by another 2 translators. Then lay assessment was done according to the EuroQol Group’s translation guidelines. Based on the repeated measure data of 65 patients with rheumatoid arthritis (RA), we examined test-retest reliability by intra-class correlation (ICC), and responsiveness by effect size and t-statistic. To evaluate validity, we recruited 100 patients with RA, 103 with osteoarthritis (OA), 111 with systemic lupus erythematosus (SLE), 104 with fibromyalgia syndrome (FMS), and 90 with ankylosing spondylitis (AS). For concurrent validity, we explored correlation between the KEQ-5D and KEQ-VAS (visual analog scale), KSF-36 global, utility measures such as time-trade off (TTO) and standard gamble (SGM), and disease-specific measures, including KHAQ and for RA, KFWOMAC for OA, SLEDAI and SLICC for SLE, KFIQ for FMS, and KBASFI for AS. RESULTS: Test-retest reliability measured by ICC was 0.635. The effect size was 0.683. Correlations with KEQ-VAS and SF-36 global were significant, however those with TTO and SGM were not. Correlations with disease-specific measures were all significant except for SLEAI and SLICC in SLE, ranging from ~0.477 to ~0.603. Correlations between physical domains of KEQ-5D and KSF-36P were higher those with KSF-36M, on the contrary, correlation between anxiety/depression and KSF-36M was higher than that with KSF-36P in both overall and disease-specific analysis. CONCLUSION: These findings indicated that KEQ-5D had stability and responsiveness, and moreover, criterion and construct validity were satisfactory. We concluded that KEQ-5D could be applied to Korean patients with various rheumatic diseases.