systematic differences, and conformity to malaria treatment policy, in terms of the prescribing, diagnostic, cost, and outcomes, hospital length of stay (LOS), MRSA-targeted IV and oral antibiotic use and early discharge (ED) for patients hospitalized in the United Arab Emirates (UAE) with methicillin-resistant Staphylococcus aureus (MRSA) complicated skin and soft-tissue infections (cSSTIs). METHODS: This retrospective observational medical record review study enrolled physicians from four UAE sites to collect data for 24 total patients with documented MRSA cSSTI, hospitalized between July 2010-June 2011, and discharged alive by July 2011. Data include clinical characteristics and outcomes, hospital length of stay (LOS), MRSA-targeted IV and oral antibiotic use and ES and ED eligibility using literature-based and expert-validated criteria. RESULTS: For all patients, the actual length of MRSA-active treatment was 10.8±7 days, with 9.6±6.5 days of IV therapy, and mean LOS 13.9±9.3 days. The most frequent routes of therapy use were oral (87.5%), then IV (7.8%), and ES (3.7%). ES use increased with IV antibiotics (6.0% vs 16.7%, and clindamycin (16.7%). Five patients (20.8%) were switched from IV to oral antibiotics while inpatient. Eight patients were discharged with MRSA-active antibiotics, with linezolid prescribed most frequently (n=3, 37.5%). Fifteen patients (62.5%) met ES criteria and potentially could have discontinued IV therapy 8.3±6.0 days sooner. Eight patients (33.3%) met ED criteria and potentially could have been discharged 10.9±8.5 days earlier: Assuming an average cost of 2,691 dirhams ($720.30), the total savings would be 29,332 dirhams ($7,920) in bed-day cost savings realized per ED-eligible patient. CONCLUSIONS: While one fifth of patients were switched from IV to oral antibiotics in the UAE, there were clear opportunities for further optimization of health care resources. Over half of UAE patients hospitalized for MRSA cSSTI could be eligible for ES and one-third eligible for ED opportunities, resulting in the potential for a substantial reduction in IV days and bed days.

PIN109 COST-EFFECTIVENESS ANALYSIS OF PROTEASE INHIBITOR MONOTHERAPY VERSUS ONGOING TRIPLE- THERAPY IN THE LONG-TERM MANAGEMENT OF HIV PATIENTS Oddershede J1, Walker S2, Paton N3, Stöhr W1, Dunn D1, Schupf M1

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OBJECTIVES: To estimate the cost-effectiveness of a strategy of switching the antiretroviral therapy (ART) to protease inhibitor monotherapy (PIM) with prompt return to combination therapy in the event of viral load rebound to continue the ongoing triple therapy (OTT) in the long-term management of HIV-1 infected patients. METHODS: Within trial cost-effectiveness analysis and modelling of life-time cost-effectiveness based on a randomised controlled trial of Protease Inhibitor monotherapy Versus Ongoing Triple-therapy (PIVOT). The setting was HIV outpatient care in the UK National Health Service and the trial involved 587 patients, aged 18 years or more, who achieved sustained virological suppression and had a CD4+ cell count >100 cells/mm³. Outcomes were NRS costs ($2012 UK Pounds Sterling) and quality-adjusted life-years (QALY) with comparative results for the cost-effectiveness of PIM compared to OTT. RESULTS: Overall, PIM was non-inferior to OTT (2% CI 97.9% to 102.4% with 2-sided 5% significance level) and QALYs were statistically superior to OTT. Sensitivity analysis showed that the incremental costs were £0.007 (95% confidence interval: £-4.77 to £17.21) and the incremental QALY was 0.082. CONCLUSIONS: The results suggest that PIM is a cost-effective treatment option compared to OTT for HIV-1 infected patients who have achieved sustained virological suppression.

PIN111 COST OF ADVERSE DRUG REACTIONS (ADR) WITH PROTEASE INHIBITORS IN THE TREATMENT OF HEPATITIS C IN THE HEALTH SYSTEM OF EXTREMADURA (SE) Gemio Zumalave P1, Carmona Torres C1, Dominguez Rodriguez JC1, Sánchez Chorro JJ1, Hidalgo A2, Vigueres Cruzes JM1

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OBJECTIVES: Evaluate the cost associated with the ADRs from the use of boceprevir (BOC) or telaprevir (TPL) in patients treated with protease inhibitors (PI) in the SES. METHODS: Retrospective observational study of clinical ITT extracting the necessary data from the information systems of SES, from September 2012 to December 2013, for patients treated with TLP or BOC who were treated. Those co-infected patients (HIV) and those who have previous history of drug use and who have had ADRs were excluded. ADRs were assessed afebrile, alopecia, retinitis, itching, weight loss, rash, thrombosis, neutropenia, hemorrhoids, stomach pain, amenorrhea, arthralgia, and the anxiety of infected blood received by patients. To assess the proportion of other public health costs SSPE prices, the NHS and records of units were taken also. RESULTS: Withdrawals caused by ADRs were higher for TLP (12.2% vs 8.1%, p=0.09), frequency of pruriginous erythema (44.4% vs 4%, p<0.001) and anemia (69.4% vs 52%, p=0.142). For BOC, there were higher percentages of dysgeusia (16% vs. 0%, p=0.011), and neutropenia (52% vs 24%, p=0.018). The results showed a significant difference between the treatment cost per patient associated with ADRs caused by BOC (2,617€/patient) vs TLP (5,466€/patient), for 34.7 weeks (BOC) and 26.9 weeks (TLP). CONCLUSIONS: In view of the results obtained, it shows that a lower costs for the health system by the treatment of ADRs due to the use of PI in patients with hepatitis C patients receiving BOC versus TLP. Postmarketing observational studies are needed to determine the actual efficacy and safety of new drugs.

PIN112 PRIMARY CARE PHYSICIANS IN AN INTERFERON-FREE WORLD: COULD SAVER, MORE EFFECTIVE ORAL HEPATITIS C THERAPIES LEAD TO IMPROVED OUTCOMES THROUGH EDUCATION AND PCP-PRESCRIBED TREATMENT? Levine, Cummings SR1, Holman D2, Davies HE3 Decision Resources Group, Burlington, MA, USA

OBJECTIVES: Hepatitis C virus (HCV) treatments have been improved by the availability of highly effective and well-tolerated interferon-free therapies. This study probes the impact of such therapies on the role of primary care physicians (PCPs) in diagnosis, referral, and treatment of HCV patients who have historically been treated by gastroenterologists and hepatologists. METHODS: In the U.S., 100 general internists, 25 primary care specialists, 46 gastroenterologists, and 7 hepatologists in a multi-center observational study conducted by Care Organization (MCO) pharmacy directors/medical directors (PDs/Mds) were surveyed to assess PCP knowledge of and involvement in HCV diagnosis and screening, referral patterns, and treatment options. RESULTS: Survey results identify referral to specialists as a notable barrier to accessing care. Some 77% of PCPs who follow-up with patients they refer to HCV specialists estimate that 24% are lost to follow-up. Similarly, 73% of specialists report having PCP-referral patients who missed their exam, and these specialists estimate that 15% of all PCP referred patients “drop off.” In anticipation of multiple new HCV therapies reaching the major markets, several professional societies have collaborated to develop recommended guidance highlighting underrecognized barriers to more rapid referral and testing for diagnosing and treating HCV patients (www.hcvguidelines.org). Among surveyed PCPs, 74% were unaware of these guidelines; however, once informed, 63% of all PCP respondents indicated greater comfort with presenting treatments recommended by these guidelines. Furthermore, 63% of MCO PDs/Mds and 98% of HCV specialists surveyed reported feeling more comfortable with PCPs prescribing these recommended treatments. CONCLUSIONS: The substantial decline in the cascade of care from PCP referrals to specialists who test that educating PCPs on new interferon-therapies presents an opportunity to maximize retention in care and accelerate efforts to identify undiagnosed cases. Survey responses from PCPs, as well as specialists, and MCO PDs/Mds suggest that practical, regularly updated clinical guidelines prepared by international experts could provide a common framework for educational outreach efforts to PCPs.

PIN113 COVERAGE OR EFFICACY: WHICH FACTOR IS THE MOST INFLUENTIAL FOR REDUCING VARICELLA WITH ROUTINE CHILLOOD VACCINATION IN ITALY? Saudino C1, Holli C2, Amodio F3, Konenti G4, Gabrielli C1, Vitali C1, GlassSmithKline Vaccines, Waour, Belgium, 1University of Palermo, Palermo, Italy, 2University of Florence, Florence, Italy, 3University of Ferrara, Ferrara, Italy

OBJECTIVES: Policymakers may have a concern that a long time interval between two doses, partial efficacy and potential waning after the first dose of varicella vaccine would reduce the impact of a universal childhood varicella immunization program. The objective of this study is to determine the potential impact and policy implication of the combined coverage of the first dose of varicella vaccine (VE-D1) in the context of the long term interval between two doses on varicella epidemiology in Italy. METHODS: An age-structured deterministic model transmission model with an imperfect vaccine was calibrated to observed varicella incidence in Italy in absence of vaccination. Vaccination is introduced with 1 and 2-dose VE, with long time interval between 2 doses (given at 13 months and 6 years of age). Several scenarios were tested including 2 levels of VE-D1 (65%/75%) and 3 coverage levels (75%, 85%, 90%) respectively. Efficacy post-dose 2 is fixed at 95%. RESULTS: For a vaccine coverage of 95%/80%, the reduction in number of varicella cases compared with the absence of vaccination for 75% and 65% VE-D1 was respectively 89%/2%75% 5% by year 30, and 78%/94%/6% by year 80 after vaccination program initiation. For a Vaccine coverage of 85%/70%, the reduction in number of