none of the drugs supporting psychotherapy in treatment of alcoholism is reimbursed, and new, in which naltrexone is reimbursed within the catalogue of guaranteed health services in the treatment of alcohol-dependent patients. The analysis presents the costs incurred by public payer and by patient associated only with drugs and services used in the treatment of the target population. The costs were not discounted. Consumption of resources was estimated on the basis of epidemiological data and recommended duration of pharmacotherapies. The effect of changes of key parameters and assumptions of primary analysis on the results obtained from the perspective of the public payer was examined in the one-way sensitivity analysis. RESULTS: If the reimbursement of naltrexone is introduced, the annual expenses from the budget of National Health Fund would increase by PLN 11.7 million in the first year, and PLN 11.8 million in the second year of reimbursement. On the other hand, from the patient perspective reimbursement of naltrexone will bring significant cost savings which will annually amount to PLN 28.8 million in the first and second year of the refund. CONCLUSIONS: Reimbursement of naltrexone in the treatment of alcohol-dependent patients in Poland will bring additional costs incurred by public payer (National Health Fund) and patient’s significant cost savings.

PMH20

PSYCHOTROPIC MEDICATION USE AMONG CHILDREN WITH AUTISM SPECTRUM DISORDER: A COMPARISON BETWEEN MEDICAID AND COMMERCIAL INSURANCE

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OBJECTIVES: To compare patterns of psychotropic medication use and the associated costs among children with autism spectrum disorder (ASD) between public and private insurance to bridge a knowledge gap in the literature. METHODS: Retrospective analyses were done using year 2003 claims data from Medicaid and the MarketScan databases, a national sample of privately insured individuals. Two-sample z-tests were used to compare the two different populations. T-tests were used to compare the means given the large sample size. RESULTS: A total of 18,166 children with ASD were identified in Medicaid and 2,716 in MarketScan. Psychotropic medication was used by 86% of ASD children in Medicaid and 78% in MarketScan. The psychotropic medication costs per ASD patient were nearly twice higher in Medicaid ($346 vs $796; P < 0.001). The twelve most costly psychotropic drugs accounted for 82% of all psychotropic drug costs, with Medicaid spending more on all drugs. Risperidone, the most costly drug in both systems, cost $391 per ASD patient in Medicaid and $218 in MarketScan. The higher Medicaid cost was due to more users (27% vs 18%) and higher average cost per prescription ($346 vs $218; P < 0.001). Though the unit costs were similar, the average length of therapy was longer in Medicaid (241 vs 210 days). Similar patterns existed for other drugs such as olanzapine, the second most costly psychotropic medication in Medicaid. Medicaid had more olanzapine users (7.4% vs 4.5%), higher costs per olanzapine user ($2276 vs $1302) due to more days supplied (211 vs 156 days), with the unit cost similar. CONCLUSIONS: Children with ASD in Medicaid had much higher psychotropic drug costs than those in commercial insurance. Similar drugs were used, but the same drug cost much more in Medicaid, due to a higher percentage of children on the medication and a greater duration of use.

PMH21

DIFFERENCES IN DAILY AVERAGE CONSUMPTION AND DAILY COSTS OF DESVENLAFAXINE, VENLAFAXINE XR, DULOXETINE, AND ESCITALOPRAM AMONG COMMERCIALLY INSURED PATIENTS

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BACKGROUND: Differences in daily utilization of antidepressant therapies may have clinical and economic implications, particularly pharmacy expenditures for health plans. OBJECTIVES: To examine antidepressant daily average consumption (DACON) and drug cost per day for patients with major depressive disorder (MDD) newly initiating serotonin-norepinephrine reuptake inhibitors (SNRIs) or escitalopram. METHODS: A retrospective cohort analysis was conducted using a large U.S. health plan database from 1/1/2003 and 12/31/2007 who began treatment with a benzodiazepine within 30 days of their index date were excluded from the study sample (“pre-index” and “post-index”). We identified all persons with evidence of GAD (ICD-9-CM diagnosis code 300.02) using a large U.S. health insurance database. Results obtained from the perspective of the public payer was examined in the one-way sensitivity analysis. RESULTS: We identified a total of 86 patients who initiated benzodiazepine therapy for GAD and who met all other entry criteria; 75% began monotherapy with benzodiazepines, and 25% continued therapy on an add-on basis. Mean total healthcare costs over the 6-month post-index period increased by $2334 relative to pre-index (from $4637 [SD = $9840] to $7087 [SD = $8890]; P < 0.001). This finding increased the unit cost of long-term use of benzodiazepines (i.e., accident-related, other possibly related) was $1099 ($7157 / $7856 vs. $285 ($8437; P < 0.001). CONCLUSIONS: Healthcare costs increase in patients with GAD who receive >90 days of benzodiazepine therapy; the substantial proportion of healthcare costs is associated with accidents and other known sequela of long-term benzodiazepine use.

PMH22

COMPARISON OF HEALTH CARE COSTS AND UTILIZATIONS BETWEEN PATIENTS WHO WERE TREATED WITH AND WITHOUT MEDICATION FOR OPIOID DEPENDENCY

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OBJECTIVES: To compare the differences in healthcare costs and utilizations between opioid-dependent patients who were treated with and without medication. METHODS: We conducted a retrospective database analysis using commercial enrollees from a large U.S. health plan database from 2005 to 2009. Continuously eligible patients with at least one claim of opioid dependence during the identification period and an opioid use disorder diagnosis during the baseline period were included. Propensity score matching was applied to compare the risk-adjusted outcomes between the Any Medication Group and the No Medication Group. Baseline differences in age, gender, region, comorbid scores, baseline healthcare utilization and costs were controlled. RESULTS: Descriptive analysis showed that patients in the Any Medication Group (n = 10,523) were sicker, had more distinct psychiatric diagnoses and medication, and were more likely to have an Eliazhiner index score of more than 3 when compared to patients from the No Medication Group (n = 8,630). After risk adjustment, 6,658 patients from each group were matched. Patients in the Any Medication Group stayed significantly longer in detoxification facilities, and had a higher number of detoxification and/or rehabilitation admission which translated to a higher cost burden. Also, patients in the No Medication Group had more opioid-related and substance abuse psychosocial provider services and higher total healthcare costs during a 6-month post-index period compared to patients in the Any Medication Group.

PMH23

COMPARISON OF HEALTH CARE COSTS AND UTILIZATIONS BETWEEN PATIENTS WHO WERE TREATED WITH PHARMACOLOGICAL AND NON-PHARMACOLOGICAL SUBSTANCE MEDICATIONS FOR ALCOHOL DEPENDENCY

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OBJECTIVES: To compare the differences in healthcare costs and utilizations between alcohol-dependent patients treated with pharmacological and non-pharmacological substance medications for alcohol dependence. METHODS: We conducted a retrospective database analysis using commercial enrollees from a large U.S. health plan database from 2005 to 2009. Continuously eligible patients with at least one claim of alcohol dependence during the identification period and an alcohol use disorder diagnosis during the baseline period were included. Propensity score matching was applied to compare the risk-adjusted outcomes between the No Medication Group and the Any Medication Group. Baseline differences in age, gender, region, comorbid scores, baseline healthcare utilization and costs were controlled. RESULTS: Descriptive analysis shows that patients in the Any Medication Group (n = 10,523) were sicker, had more distinct psychiatric diagnoses and medication, and were more likely to have an Eliazhiner index score of more than 3 when compared to patients from the No Medication Group (n = 8,630). After risk adjustment, 6,658 patients from each group were matched. Patients in the Any Medication Group stayed significantly longer in detoxification facilities, and had a higher number of detoxification and/or rehabilitation admission which translated to a higher cost burden. Also, patients in the No Medication Group had more opioid-related and substance abuse psychosocial provider services and higher total healthcare costs during a 6-month post-index period compared to patients in the Any Medication Group.