location, salary, race, marital status, full-time/part-time status, prior comorbidity index, prior medical costs related to BPD, prior other medical costs, index date, and medical services related to BPD). Treatment groups were compared over a follow-up period ranging from 12 to 24 months after the index prescription date. RESULTS: Six hundred ninety-nine patients with BPD were classified into the ATYP (n = 25), BOTH (n = 190), NONE (n = 170), and OTHER (n = 314) treatment groups. The ATYP group demonstrated the lowest rate of employment termination (1.5%; 95% CI –3.3%, 6.3%) followed by the BOTH (5.8%; 95% CI 2.5%, 9.1%), NONE (8.9; 95% CI 4.7%, 13.2%), and OTHER (9.3%; 95% CI 6.1%, 12.5%) groups. Differences between treatment groups were not significant. The numerical difference between ATYP and OTHER did not reach significance (p = 0.058). CONCLUSIONS: The ATYP group demonstrated the lowest employment termination rate in the follow-up period of 12 to 24 months after the index prescription date. Further research is warranted to examine the influence of specific patient variables and treatment regimens on employment termination in patients with BPD.

PMH32

ANTIPSYCHOTIC THERAPY IN PATIENTS WITH BIPOLAR DISORDER: EFFECTS ON TOTAL AND MENTAL HEALTH CARE COSTS

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OBJECTIVES: Compare total and mental health-related costs among patients with bipolar disorder (BPD) initiated on quetiapine versus other antipsychotics in a state Medicaid system. Economic evaluations comparing quetiapine with other antipsychotics are lacking in the published literature. METHODS: Retrospective study using “de-identified” Medicaid claims data of patients with BPD. Patients assigned to quetiapine (QTP), olanzapine (OLZ), risperidone (RIS), or typical antipsychotic groups based on first prescription filled between January 1, 1999 and December 31, 2001. Total and mental health-related costs (including study drug charges) from 12 months before until 12 months after treatment initiation were analyzed, controlling for various confounders including patient demographics, comorbidities, and prior health care utilization. Total health care costs included costs associated with medical and mental conditions. Mental health-related costs were identified by claims associated with a mental health disorder (ICD-9-CM codes 290.XX–316.XX) or CPT codes for psychiatric services (90801–90899) and psychiatric medications. RESULTS: A total of 825 patients with BPD were classified into OLZ (n = 283, 34.30%), RIS (n = 231, 28.00%), QTP (n = 106, 12.85%), and typical antipsychotic (n = 205, 24.85%) cohorts. Mean (±SD) total health care costs over the 12-month follow-up period were US$15,866 ± US$23,216 (OLZ), US$17,539 ± US$17,570 (RIS), US$13,227 ± US$18,862 (QTP), and US$17,570 ± US$23,842 (typical antipsychotics). Mean mental health-related costs over the 12-month follow-up period were US$10,203 ± US$12,203 (OLZ), US$9,475 ± US$14,202 (RIS), US$8,064 ± US$7,368 (QTP), and US$7,368 ± US$11,239 (typical antipsychotics). Adjustment for confounders using multivariate analysis revealed no significant differences in total and mental health-related costs between the QTP group and the other atypical antipsychotic groups (OLZ, RIS). For the typical antipsychotic group, there was greater total (28.4%) and mental health-related (8.7%) costs compared with the QTP group. CONCLUSIONS: There were no significant differences in total and mental health-related costs between atypical antipsychotic groups. However, patients with BPD treated with QTP incurred lower total and mental health-related costs compared with those receiving typical antipsychotics.

PMH33

DEMOGRAPHIC AND CLINICAL CHARACTERISTICS OF PATIENTS PRESCRIBED ANTIPSYCHOTIC (AP) MONOTHERAPY IN TEXAS MEDICAID

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OBJECTIVE: To describe the demographic and clinical characteristics of Texas Medicaid enrollees prescribed AP therapy. METHODS: This was a retrospective database analysis using electronic medical records from 1997 to 2001 for adults receiving AP monotherapy who were continuously enrolled in Texas Medicaid for at least 18 months. Patients were stratified according to a hierarchy of mutually exclusive primary mental health (PMH) categories for which AP therapy was presumed to be prescribed. RESULTS: Data were available for 19,430 patients. The population was mainly female (65.7%), white (55.1%) and older (mean age 60.3 years; SD: 21.9), with 47.6% ≥65 years. PMH diagnoses were: schizophrenia 16.5%; bipolar disorder 15.5%; dementia 14.3%; psychosis 8.1%; non-psychotic disorder 14.5%; no mental health diagnosis 31.1%; with 32.1% of patients having more than one mental health diagnosis. The percentages of index AP therapy were: first-generation agent 29.3%; clozapine 0.5%; olanzapine 21.6%; quetiapine 6.3%; risperidone 42.2%. This differed when stratified by age (χ2 = 416,748, df = 16, p < 0.001), gender (χ2 = 76,901, df = 4, p < 0.001), race/ethnicity (χ2 = 160,710, df = 12, p < 0.001) and PMH diagnosis (χ2 = 845,046, df = 20, p < 0.001). Risperidone use was more common in those ≥65 years (48.3%), females (43.5%), Hispanics (46.7%), and for dementia patients (50.1%). Olanzapine was primarily used in patients aged 45–54 years (33.6%); males (31.6%); blacks (35.4%), and for schizophrenia (36.5%). The mean daily dose of the second-generation antipsychotics (SGAs) differed by age (p < 0.001) and treatment indication (p < 0.001). Regardless of the SGA, patients aged ≥65 years received doses 43.4–51.2% lower than patients aged <65 years. Regardless of age, doses for schizophrenia were 26–46% higher than for bipolar disorder and 60–70% higher than for dementia patients. CONCLUSIONS: AP agents are prescribed for a diverse range of indications with significant differences in AP dose according to treatment indication and patient age.

PMH34

DETERMINANTS IN ANTIDEPRESSANT TREATMENT SELECTION FOLLOWING THE INTRODUCTION OF DULOXETINE

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OBJECTIVE: We compared factors associated with antidepressant treatment selection for patients initiating on duloxetine versus venlafaxine XR, bupropion, and SSRIs. We tested differences in subgroups with and without depression diagnoses. METHODS: Claims from five US managed care health plans were obtained for adult patients initiating on new prescriptions for select antidepressants between August 31, 2004 to December 31, 2004. Diagnostic and treatment history were established through prior claims (12 months before index medication date).