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with 48.6% (n = 31,717) and 50.0% (n = 32,614) for the 50-mg and 100-mg doses, respectively. Ninety-four percent of prescriptions were filled with six tablets, and only 2% of prescriptions (n = 1309) exceeded the quantity vs. time limit. Members paid an average copay of $13 per prescription. **CONCLUSIONS:** This estimate of PMPM cost falls within the range previously reported in the literature. In comparison with PMPM costs reported for other drug classes, such as proton pump inhibitors or cyclooxygenase-2 inhibitors, the amount spent on sildenafil citrate is considerably lower and of lesser concern to the pharmacy budget.

PWM10

COST OF ACCESS BY FORMULARY TYPE: A CASE STUDY OF SILDENAFIL CITRATE IN A LARGE MANAGED CARE ORGANIZATION

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OBJECTIVES: Managed care organizations (MCOs) have traditionally used various types of formulary access to control cost, with varied success. In this case study, we determined the actual economic impact of adding sildenafil citrate to the formulary of a large national MCO by types of access status. **METHODS:** Claims data for sildenafil prescriptions were analyzed for the 12-month period from August 2001 through July 2002 for this MCO and for 7 of its regional areas. Per member per month (PMPM) costs of sildenafil coverage were calculated by various formulary status at both the regional and national levels. **RESULTS:** The MCO did not require prior authorization for sildenafil prescriptions but did impose restrictions on the number of sildenafil tablets per monthly prescription cycle. The MCO used open, closed, and incented formularies to control access to sildenafil. Mean number of sildenafil tablets/month varied from 4.9 to 6.7 tablets. PMPM costs of sildenafil coverage for the regional areas were $0.07, $0.11, $0.11, $0.14, $0.15, $0.15, and $0.18. Type of formulary did not fully explain variance in costs between regions. In 5 of the 7 areas in which most patients were covered under an incented formulary, PMPM costs of sildenafil coverage ranged from $0.11 to $0.15. In the 2 regions with the greatest percentage of patients covered under a closed formulary plan, PMPM costs of sildenafil coverage were $0.07 (44% closed) and $0.15 (54% closed). Whereas in the 3 regions with the most patients covered under an open formulary, PMPM costs of sildenafil coverage were $0.11 (27% open), $0.14 (30% open), and $0.15 (30% open). **CONCLUSIONS:** PMPM costs did not vary substantially, regardless of different types of formulary access. Moreover, in line with findings from local and employer-based healthcare plans, addition of sildenafil coverage by this large MCO resulted in lower than expected PMPM costs.

PWM11

COST IMPLICATION OF UNRESTRICTED ACCESS TO SILDENAFIL CITRATE IN FOUR EMPLOYER GROUP PRESCRIPTION PLANS

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OBJECTIVE: The perception persists among employers and benefit managers that the addition of sildenafil citrate adds significant cost to their prescription plans. A Disease Therapy Evaluation is a focused analysis of a drug's performance in a target patient population and provides healthcare managers with information that may lead to better decisions for the individual patient as well as the healthcare organization. The analysis presented here evaluates the per member per month (PMPM) cost of sildenafil without restriction limits on the quantity of tablets dispensed. **METHODS:** This retrospective review covered all sildenafil claims of employees obtained from prescription benefit managers. Prescription claims were obtained for a 6-month interval from December 1999 to May 2000 and imported into an Access database for abstraction of required data. **RESULTS:** Data were combined from 4 prescription plans (3 from the Midwest, 1 from the West Coast) with 361,237 members overall. There were 3477 sildenafil claims in the 6-month period, made by 1493 patients (representing 0.4% of all members). Most of the prescriptions were for the 50-mg (range for 4 plans, 45%–62%) and 100-mg doses (37%–65%) of sildenafil, with 1% to 2.5% for the 25-mg dose. On average, 6 to 11 tablets were dispensed at a time, with a range from 1 to 100 tablets. The average cost per prescription varied from a low end of $50 to a high end of $88; the PMPM cost ranged from $0.03 to $0.24. **CONCLUSIONS:** The actual PMPM cost is markedly lower than the expected projections, despite the fact that no quantity limits were imposed. The costs shown here do not take into account any rebates or other contracting benefits. Thus, employers may wish to consider the addition of sildenafil to their benefit package, as it may increase employee satisfaction without a large impact on the budget.

WOMEN'S & MEN'S HEALTH—Quality of Life/Preference Based Outcomes

PWM12

LONGITUDINAL DIFFERENCES IN PSYCHOLOGICAL ADJUSTMENT FOR MEN WITH ERECTILE DYSFUNCTION: RESULTS FROM EXCEED

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OBJECTIVE: Few studies have assessed the effect of erectile dysfunction (ED) treatment for psychological adjustment. This study assessed the impact of ED therapy on psychological functioning at baseline and 12-month follow-up using a battery of 10 standard psychological measures previously used in ED research. **METHODS:** Using an observational ED disease registry, clinical, sociodemographic psychological, and HRQoL information was collected at baseline prior to treatment and at 3, 6 and 12 months later. Psychological measures included the Beck Depression Inventory, a Life Satisfaction question, Marital Happiness item from the Locke Wallace Marital Adjustment Test, Mental Health Index 5, SF 36 Vitality scale, SOS 10 (a measure of general psychological health), State Trait Anxiety measure, and three MOS subscales (Positive Affect, Belonging/Loneliness, Marital Functioning). Only men who reported undergoing ED treatment were included in this analysis sub-sample. Patients were classified as treatment responders based on improvements in IIEF scores. Group means at baseline and 12-months and change between timepoints were compared using t-tests. **RESULTS:** The cohort consisted of 89 patients. 40 (45%) responded to therapy by the IIEF criteria. At one year, responders reported better psychological functioning on 7 measures, with differences being significant ($p < .05$) on Life Satisfaction, Marital Happiness, Positive Affect, and SOS 10. Responders reported significant improvement ($p < .05$) from baseline on 3 measures (Life Satisfaction, Positive Affect, and SOS 10) and a significant decline on one (SF 36 Vitality). **CONCLUSIONS:** Diagnosing and successfully treating ED has a significant impact on patient psychological functioning. These results should encourage providers to actively diagnose and treat ED. Data from this study show that men who fail primary therapy for ED should be offered secondary treatment, as many men in this study who failed prior therapies still reported improved psychological functioning when they began an effective secondary treatment.

PWM13

PREDICTORS OF RESPONSE TO ERECTILE DYSFUNCTION TREATMENT AT 12 MONTHS: RESULTS FROM THE EXCEED DATABASE

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OBJECTIVE: Response to erectile dysfunction (ED) treatment has typically been reported over a three-month period in a number of pharmaceutical trials. Little is known about the factors associated with response to treatment over a longer period. The current study examines predictors associated with response to treatment at 12 months in a group of men enrolled in an ED disease registry study. **METHODS:** Clinical information was collected at baseline and HRQOL data was collected at baseline, 3, 6, and 12-months. Eighty-nine men reported receiving ED treatment while enrolled in the study and completed the 12-month HRQOL questionnaire. Scores on the IIEF erectile functioning scale at baseline and 12-months were compared. Men who reported a 4-point or greater improvement were considered treatment responders (N = 40). Forty-nine men were classified as non-responders. A multivariate logistic regression model predicting treatment response at 12 months and controlling for age and baseline erectile functioning was specified. **RESULTS:** Men who were treatment responders at the 12-month follow-up were significantly more likely at baseline to have a partner who encourages sex (OR = 4.230, p = .0369), be unmarried (OR = 0.05, p = .0020), report greater rigidity during sex (OR = 4.814, p = .0288), and have more frequent morning erections (OR = 4.360, p = .0432). **CONCLUSIONS:** Long-term response to ED treatment is significantly associated with baseline erectile functioning (as measured by frequency of morning erections and penile rigidity during sex) and the supportiveness of a partner. Practitioners can use this information to guide patient expectations for treatment outcomes and to recommend other treatment if relationship concerns are present.

PWM14

DEVELOPMENT OF A NEW QUALITY OF LIFE INSTRUMENT TO EVALUATE FEMALE SEXUAL DESIRE

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OBJECTIVE: To evaluate the psychometric properties of a new disease specific instrument, the female sexual desire profile (FSDP). **METHODS:** The FSDP is a self-assessment questionnaire containing eight items that address the occurrence of sexual desire and sexual receptivity. The study enrolled a total of 174 patients with hypoactive sexual desire disorder in 5 countries (Canada, UK, Poland, Hungary and The Netherlands) randomized to receive either active treatment or placebo. Patients completed the FSDP on a daily basis during the baseline and treatment periods. Standard psychometric analyses were conducted. **RESULTS:** Confirmatory factor analysis was undertaken to provide evidence of a single construct of desire in the FSDP. All FSDP questions loaded onto the factor in excess of 0.4. Three questions had high loadings in excess of 0.7 (items 2, 4 and 5). The FSDP had good internal consistency, 0.72 for the baseline data and 0.86 for the treatment period. There was no indication of item redundancy. The FSDP scores showed a moderate correlation with desire domain of the Female Sexual Function Index (FSFI) for the baseline period (0.39) and treatment