in the Azi group (12%, 26 of 224) compared to the Clari group (6%, 14 of 221). The total drug costs for additional antibiotics were $853 and $690 for the Azi and Clari groups, respectively. The major reason for additional antibiotics was due to bacteriological and clinical failures. CONCLUSIONS: Clari is superior to Azi in the eradication of S. pyogenes and in the resolution of symptoms of pharyngitis/tonsillitis. In addition, more subjects in the Azi group had additional antibiotics prescribed for pharyngitis/tonsillitis during the follow-up period. The lower rate of additional antibiotic usage would be expected to result in cost savings in the overall management of pharyngitis/tonsillitis.

DISEASE (HEALTH) MANAGEMENT RESEARCH

ID4

A COST ANALYSIS OF LEVOFLOXACIN VERSUS CEFTRIAXONE IN ADULT INPATIENTS WITH COMMUNITY-ACQUIRED PNEUMONIA

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OBJECTIVE: To supplement previous efficacy analyses from pivotal Phase III trials with a comparison of the community-acquired pneumonia (CAP)-related costs of inpatient treatment using either IV levoflaxacin or IV ceftriaxone as initial primary therapy.

METHODS: Patients with a primary diagnosis of CAP were enrolled in a prospective, randomized, open-label, active-controlled Phase III clinical trial. They were assigned to one of two treatment groups: levoflaxacin (IV or PO) and ceftriaxone (IV) and/or cefuroxime axetil (PO) in inpatient and outpatient settings. Resource utilization data were collected alongside clinical trial data. To make legitimate and meaningful cost comparisons between similar types of patients (inpatients) getting similar (IV) drugs, this economic analysis examined only the resource utilization of inpatient trial enrollees who received IV formulations as initial treatment. Medicare resource cost estimates were multiplied by resource units used by patients to generate cost estimates. Sample size had been determined based on efficacy endpoints in the Phase III trial protocol.

RESULTS: The results showed a statistically significant total cost difference per patient that favored levoflaxacin over ceftriaxone ($6012 versus $7482; a difference of $1410; p = 0.048). Levoflaxacin was also associated with a statistically significant reduction in mean study medication cost per patient ($195 versus $388; a difference of $193; p = 0.0001).

CONCLUSIONS: As initial primary inpatient treatment of adults with community-acquired pneumonia, IV levoflaxacin is less costly than IV ceftriaxone, the most prescribed inpatient CAP treatment.

DM1

RANDOMIZED EVALUATION OF A DISEASE MANAGEMENT PROGRAM FOR DYSPEPSIA IN A MANAGED CARE SETTING

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OBJECTIVES: The study purpose was to determine whether a disease management program (DSM) using dyspepsia guidelines would improve provider compliance with “best practices” and result in improved health and/or economic outcomes.

METHODS: We randomized eight clinics in a capitated managed care medical group to “usual care” versus a dyspepsia DSM for non-NSAID and NSAID-related dyspepsia. This analysis includes only patients with non-NSAID-related dyspepsia. The program included the use of evidence-based practice guidelines, “on-site” HP testing, academic detailing of physicians, and patient education. Symptom severity, and quality of life were measured at baseline, 3 and 6 months, and compliance with guidelines and utilization was assessed at 6 months.

RESULTS: One hundred sixty-seven intervention and 180 control patients entered the final analysis. There were no significant differences in baseline characteristics in the two groups. HP testing was performed in 61% of intervention and 11% of control patients (P = 0.001). Appropriate anti-HP therapy was given to 100% of HP-positive intervention patients and 0% of HP-positive control patients (P = 0.001). Drug costs were reduced by $4.70 PMPM in the intervention group compared to the control group (P = 0.001). Other than a reduction in costs attributable to barium radiography in the intervention group (P = 0.05), there were no significant differences between groups in the costs attributable to non-drug resource utilization. Symptom severity and quality of life scores were similar between groups at 3 and 6 months.

CONCLUSIONS: This preliminary analysis suggests that a DSM using evidence-based guidelines and academic detailing improved the process of care for patients with dyspepsia not taking NSAIDs. Implementation of this DSM resulted in significant reductions in PMPM pharmacy costs, without compromising symptom severity or health-related quality of life.

DM2

MEASURING THE EFFECTIVENESS OF A DIABETES DISEASE MANAGEMENT PROGRAM

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