performed to assess the association between CKD stages and HRu/Costs. RESULTS: The study identified 23,492 T2DM patients (mean age 60.7 years; no CKD: 54.9%; stage 1: 7.1%; stage 2: 12.7%; stage 3A: 15.9%; stage 3B: 7.5%; stage 4: 1.8%). Patients with more advanced CKD stages were associated with greater odds of hospitalization compared to those without CKD (odds ratio [95% confidence interval] [stage 1: 1.0; CI 0.95-1.01; stage 2: 1.57 [1.43-1.72]; stage 3A: 1.63 [1.47-1.81]; stage 3B: 2.00 [1.81-2.22]; stage 4: 4.66 [2.16-3.28]) and ER visits (stage 3A: 1.25 [1.15-1.37]; stage 3B: 1.34 [1.19-1.51]; stage 4: 1.55 [1.25-1.92]). Patients with CKD stage 1, 2, 3A, 4 and had total costs of $1,18, 1.14 [1.00-1.30]; stage 3A: 1.57 [1.43-1.72]; stage 3B: 1.84 [1.63-2.07]; stage 4: $259.784.74 to $375,696.03) increased from 2010 to 2011. Patients with diabetes were older (61 vs. 47) and a greater percentage had public insurance (65% vs. 49%). Average SSTI costs per 6-month period in 2010 and 2011 were: $135.84 (standard deviation [sd] = 259.72) and $873.59 (sd=2275.98) for prescribed medications, $8990.54 (sd=9506.02) and $5850.86 (sd=8685.70) for inpatient and emergency room, $486.55 (sd=1247.08) and $1175.86 (sd=2481.09) for outpatient and office. The mean total SSTI cost difference per patient in 2010 and 2011 was: $434.91 (standard deviation [sd] = 461.68) and $467.71 (sd=78.07) for prescribed medications, $832.92 (sd=1482.56) and $2431.65 (sd=7758.02) for inpatient and emergency care, $1486.58 (sd=1287.81) and $566.92 (sd=1479.08) for outpatient and office. The total mean cost difference between patients with and without diabetes was $1672.93 ($2481.09-$853.16, p-value < 0.05). Patients initiating saxagliptin treatment reported lower costs and hospitalization rates (overall and diabetes-related) compared with patients initiating sitagliptin.

PDB45
CONTINUOUS GLUCOSE MONITORING SYSTEMS: TRENDS IN UPTAKE, PATIENT COSTS, AND RESOURCE UTILIZATION
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OBJECTIVES: Wearable health monitoring devices have become increasingly available and allow for real-time tracking of clinical values. This research aims to assess the trend in the uptake of continuous glucose monitoring systems (CGM) over time and in costs and resource utilization following their initial use. METHODS: Adults aged 18-64 with a diagnosis for diabetes (ICD-9-CM 250.xx) and continuous enrollment in commercial insurance were identified from the Truen Health MarketScan database. A CGM purchase code for CGM (CPT 92250) at least one year after the initial diagnosis and the lack of a previous claim for CGM identified eligible subjects within each year from 2009-2011; the date of the qualifying CGM claim served as the index date. Costs and utilization for pharmacy, inpatient, emergency department, specialty, laboratory, and primary care services were compared between each annual cohort and between the year prior to and following the index date. RESULTS: From 2009 to 2011, the number of initial patients using CGM declined from 1,001 to 770 (p-value < 0.001). The total average costs to treat these patients increased between 2009 and 2010 before declining in 2011, mostly due to dramatic changes in costs related to outpatient pharmacy and inpatient services. Compared to before the CGM was placed, mean costs of primary care visits and laboratory services tended to decrease while the average number of primary care visits consistently and significantly declined (all p < 0.05). However, noticeably higher mean costs related to outpatient pharmacy services were accrued following CGM in both 2009 and 2010. CONCLUSIONS: Devices such as CGM may benefit ongoing patient care by providing more regular insight to treatment progression and, in some cases, lead to more efficient care.

PDB46
LIRAGLUITIDE: A PHARMACOECONOMIC REVIEW OF ITS USE IN TYPE II DIABETES
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OBJECTIVES: As novel treatments for type II diabetes enter the market, there is a need to assess their long-term clinical and economic outcomes compared to current treatments. These comparisons can assist decision-makers in determining the appropriate place in therapy. Our objective was to review the existing pharmacoeconomic literature evaluating the cost-effectiveness and overall costs of treatment associated with liraglutide in type II diabetes. METHODS: We identified English-language cost-effectiveness, cost-utility or cost analyses that compared liraglutide to one or more anti-diabetic agents via MEDLINE and EMBASE through March 1, 2013. Full text articles meeting the inclusion criteria were retrieved and information on the study design and results were abstracted. Costs were converted to 2012 US dollars in order to facilitate comparisons across studies. RESULTS: A total of 3 cost comparison studies and 6 cost-utility studies were identified for inclusion. Across cost comparison studies, liraglutide treatment resulted in cost savings ranging from $1,075 to $1,298 (1.2 mg) and $1,62 to $2,147 (1.8 mg) over a 10 year time horizon. Cost-utility analysis results reported base case ICERs ranging from $15,747 to $40,128/QALY for liraglutide 1.2 mg and $8,497 to $66,031/QALY for liraglutide 1.8 mg. Estimates were most sensitive to variations in time horizon and cardiovascular complication rates. Based on often cited cost-utility thresholds, liraglutide appears to be determined to be cost-effective at an incremental cost of $58,558 (liraglutide 1.8 mg vs. sitagliptin 100 mg) and 93% (liraglutide 1.2 mg vs. glimepiride 4 mg). CONCLUSIONS: Liraglutide appears to be a cost-effective adjunct treatment for type II diabetes and may also be associated with a reduction in diabetes-related complication costs; however, ICER values are largely dependent on the duration of liraglutide treatment benefit and the time horizon of the analysis.

PDB47
LIFE YEARS LOST AND LIFETIME HEALTH CARE EXPENDITURES ASSOCIATED WITH DIABETES IN THE UNITED STATES
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OBJECTIVES: To compare charges and resource use during the 6 months following treatment initiation with saxagliptin or sitagliptin. METHODS: A retrospective cohort study using a US insurance claims dataset was conducted to meet the study objectives. Adult patients with type 2 diabetes mellitus (T2DM) newly initiating saxagliptin or sitagliptin between January 1, 2010, and December 31, 2011, with either saxagliptin or sitagliptin were identified. A 1:1 propensity-matched sample of saxagliptin and sitagliptin patients was created to reduce any potential confounding. Propensity scores were generated based on demographic characteristics, comorbidities, disease severity, and patient treatment patterns prior to the index date. Patients were required to have >6 months of continuous eligibility before (baseline period) and after (follow-up period) treatment initiation. All outcomes were assessed based on an intent-to-treat analysis of the period in the 6 months following treatment initiation. Both overall and diabetes-specific charges were computed; breakdowns of medical and overall (medical plus phar- macy) charges were compared. Appropriate univariate statistical tests were applied to the propensity-matched sample to examine differences in resource utilization outcomes. RESULTS: A total of 8,484 and 23,155 patients initiated treatment with saxagliptin and sitagliptin, respectively. After matching, each cohort consisted of 7,700 patients. Compared with sitagliptin, during the follow-up period; saxagliptin was associated with sig- nificantly lower (all p < 0.01) overall charges ($11,203 vs. $28,391 vs. $14,258 vs. $35,586); diabetes-related overall charges ($5,106 vs $12,129 vs. $5,402 vs $14,201); overall medical charges ($8,454 vs $27,616 vs. $10,502 vs $34,903); and diabetes-related medical charges ($3,389 vs $12,080 vs. $3,689 vs $14,161). Accordingly, the mean total SSTI cost was $1065.60 ($2604.75-$873.59 for outpatient and office in 2010 and $1006.60 ($2604.75-$8590.86 for 2011. The mean total SSTI cost difference per patient in 2010 and 2011 was: $434.91 (standard deviation [sd] = 461.68) and $467.71 (sd=78.07) for prescribed medications, $832.92 (sd=1482.56) and $2431.65 (sd=7758.02) for inpatient and emergency care, $1486.58 (sd=1287.81) and $566.92 (sd=1479.08) for outpatient and office. The total mean cost difference between patients with and without diabetes was $1672.93 ($2481.09-$853.16, p-value < 0.05). Patients initiating saxagliptin treatment reported lower costs and hospitalization rates (overall and diabetes-related) compared with patients initiating sitagliptin.