mandations reduced 57% the probability of uncontrolled blood pressure. Having uncontrolled blood pressure at the baseline stage increased the probability of lack of control in 166%, and per each unit of increase in body mass index the lack of control increased 7%. CONCLUSIONS: CME intervention improved the medical decision making process, increasing the probability of hypertension patients to have blood pressure under control.

PCV85 TREATMENT HISTORY AND PATTERN AMONG ELDERLY PATIENTS
Anita E. Saban-Matovunović
West Virginia University, Mountaintown, WV, USA

OBJECTIVES: The objective of the study was to examine rates of treatment history and patterns of treatment history by demographic, socioeconomic, access to care, health status, and lifestyle characteristics among women with hypertension.

METHODS: The study design was cross-sectional, using data from the Medical Expenditure Panel Survey (MEPS), large-scaled surveys of families and individuals to provide nationally representative estimates of health care use and expenditures. The study included 1304 women aged 22 and older with hypertension and diabetes, identified from MEPS medical condition files. Antidpressants were identified from prescription drug reports and psychotherapy was identified from outpatient visits files. Depression treatment patterns by demographic, socioeconomic, healthcare access and health status were analyzed using chi-square tests, logistic regression and multivariable logistic regression. All analyses accounted for the complex design of the MEPS using SAS 9.2. RESULTS: In our study sample, 23.9% had no depression treatment, 56.8% had antidepressant use only, and 19.3% had psychotherapy with or without antidepressants. Among women with hypertension and depression, African Americans (AOR = 0.47), Latina (AOR = 0.50) and those insured (AOR = 0.39) were significantly less likely to report any treatment for depression compared to Whites and those with private insurance. Compared to no treatment, psychotherapy with or without antidepressants was less likely among those with less than high school education and more likely among women reporting fair/poor mental health. CONCLUSIONS: Nearly one-quarter of women with hypertension did not have treatment for depression. Disparities in treatment history by race/ethnicity, health insurance, and education status were noted. Further studies need to explore reasons for not receiving depression treatment and whether such lack of treatment for depression is associated with poor health outcomes in these women.

PCV86 PATTERNS OF STATIN PRESCRIPTION AMONG PRIVATELY INSURED COMMERCIAL AND MEDICARE PATIENTS
Zhao Z1, Peng X1, Zhai Z2, Zagar A1, Spooneller CA2, LeNarz LA1
1 Eli Lilly and Company, Indianapolis, IN, USA, 2Kowa Pharmaceuticals America, Inc., Montgomery, AL, USA

OBJECTIVES: To compare dosing patterns among patients in whom atorvastatin (AS), simvastatin (SS), or rosuvastatin (RS) was newly prescribed. In both cohorts, simvastatin accounted for the largest share of statin prescriptions (MC: 44.1%, CC: 44.0%), followed by atorvastatin (MC: 31.6%, CC: 31.1%), rosvastatin (MC: 7.8%, CC: 11.2%), pravastatin (MC: 8.1%, CC: 6.5%), lovastatin (MC: 7.4%, CC: 6.6%) and fluvastatin (MC: 0.9%, CC: 0.6%). The majority of statin prescriptions were for generics (MC: 59.6%, CC: 57.1%). The average annual number of statin prescription per user was 9.3 for the MC and 7.6 for the CC. In the CC, 58.1% of prescriptions were filled by male, while 50.4% of prescriptions were filled by male in the MC. Diabetic patients accounted for 35.2% of prescriptions in the MC, and 26.8% in the CC. Milligram dosing distributions (mean, median, mode) were different in both cohorts. In the MC, 35.9mg/40mg for PS patients. The average/median daily dose for the 1st and 12th prescriptions were 20.8mg/20mg and 21.2mg/20mg for AS patients, 10.0mg/10mg and 10.5mg/10mg for SS patients, 28.4mg/20mg and 28.7mg/20mg for SS patients, and 34.6mg for PS patients. The average/median daily dose for the 1st and 12th prescriptions were $2.9 and $3.2 for AS patients, $2.7 and $3.1 for SS patients, $1.5 and $0.8 for SS patients, and $1.4 and $0.9 for PS patients. CONCLUSIONS: Patients initiating AS, RS, SS, and PS experience little escalation of their statin daily dosing over the 24-month follow-up period.

PCV87 FACTORS ASSOCIATED WITH SELECTIONS OF STATINS AMONG ELDERLY PATIENTS
Zhao Z1, Peng X1, Bae JP2, Spooneller CA2, LeNarz LA1
1 Eli Lilly and Company, Indianapolis, IN, USA, 2Kowa Pharmaceuticals America, Inc., Montgomery, AL, USA

OBJECTIVES: To assess demographic and clinical factors associated with statin selection among elderly patients.

METHODS: A retrospective cohort study was conducted to examine predictors of statin selection among patients aged ≥65 years, who initiated pravastatin (PS) vs. simvastatin (SS), atorvastatin (AS), or rosuvastatin (RS) between 1/1/2007 and 12/31/2007. Index statin use was defined as the first statin claim following at least 90 days of no statin access. Multiple logistic regression models were employed to assess predictive factors of PS initiation versus other statin initiations. RESULTS: Of 96,945 statin users identified, there were 8,165 PS initiators, 38,099 AS initiators, 11,520 RS initiators, and 38,866 SS initiators.

Compared to other statin users, a higher percentage of PS initiators were aged ≥75 (SS: 42.3%, PS: 41.0%, AS: 41.1%, RS: 38.0%, P < 0.01) and more likely to be female (PS: 56.6%, SS: 51.3%, AS: 51.5%, RS: 55.7%, P < 0.01). PS initiators were more likely to have atrial fibrillation (PS: 10.0%, SS: 9.4%, AS: 9.6%, RS: 8.6%, P < 0.01) and take warfarin (PS: 31.3%, SS: 10.4%, AS: 10.4%, RS: 9.9%, P < 0.01) and triazoles (PS: 3.1%, SS: 2.4%, AS: 2.8%, RS: 2.8%, P < 0.01) in the baseline period. A higher percentage of PS initiators took more than 3 unique medications 90-day prior to the index date (PS: 85.4%, SS: 81.8%, AS: 83.0%, RS: 83.9%, P < 0.01). After controlling for demographic and clinical characteristics, use of warfarin was associated with initiating PS compared with SS, AS, and RS. Other predictors of PS initiation included prior history of atrial fibrillation, HIV infection and use of calcium channel blockers, ezezimide, and fenofibrate over the 1-year pre-index period compared with SS and AS. CONCLUSIONS: Patient profiles were different among PS users compared to other statin users. Selection of certain comorbidities and prior use of medications were significant predictors of PS initiation among a cohort of Medicare patients.

PCV88 PATTERNS OF STATIN PRESCRIPTION AMONG PRIVATELY INSURED COMMERCIAL AND MEDICARE PATIENTS
Bae JP1, Peng X1, Zhai Z2, Zagar A1, Spooneller CA2, LeNarz LA1
1 Eli Lilly and Company, Indianapolis, IN, USA, 2Kowa Pharmaceuticals America, Inc., Montgomery, AL, USA

OBJECTIVES: In 2008, there were currently 6 stations available in the U.S. market and more than 193 million statin prescriptions were written. We sought to examine the patterns of statin use among privately insured commercial and Medicare patients (MEPS), large-scaled surveys of families and individuals to provide nationally representative estimates of health care use and expenditures. The study included 1304 women aged 22 and older with hypertension and diabetes, identified from MEPS medical condition files. Antidepressants were identified from prescription drug reports and psychotherapy was identified from outpatient visits files. Depression treatment patterns by demographic, socioeconomic, healthcare access and health status were analyzed using chi-square tests, logistic regression and multivariable logistic regression. All analyses accounted for the complex design of the MEPS using SAS 9.2. RESULTS: In our study sample, 23.9% had no depression treatment, 56.8% had antidepressant use only, and 19.3% had psychotherapy with or without antidepressants. Among women with hypertension and depression, African Americans (AOR = 0.47), Latina (AOR = 0.50) and those insured (AOR = 0.39) were significantly less likely to report any treatment for depression compared to Whites and those with private insurance. Compared to no treatment, psychotherapy with or without antidepressants was less likely among those with less than high school education and more likely among women reporting fair/poor mental health. CONCLUSIONS: Nearly one-quarter of women with hypertension did not have treatment for depression. Disparities in treatment history by race/ethnicity, health insurance, and education status were noted. Further studies need to explore reasons for not receiving depression treatment and whether such lack of treatment for depression is associated with poor health outcomes in these women.

PCV89 TREATMENT HISTORY AND PATTERN AMONG ELDERLY PATIENTS
Zhao Z1, Peng X1, Zhai Z2, Zagar A1, Spooneller CA2, LeNarz LA1
1 Eli Lilly and Company, Indianapolis, IN, USA, 2Kowa Pharmaceuticals America, Inc., Montgomery, AL, USA

OBJECTIVES: To compare dosing patterns among patients in whom atorvastatin (AS), simvastatin (SS), or rosuvastatin (RS) was newly prescribed. In both cohorts, simvastatin accounted for the largest share of statin prescriptions (MC: 44.1%, CC: 44.0%), followed by atorvastatin (MC: 31.6%, CC: 31.1%), rosvastatin (MC: 7.8%, CC: 11.2%), pravastatin (MC: 8.1%, CC: 6.5%), lovastatin (MC: 7.4%, CC: 6.6%) and fluvastatin (MC: 0.9%, CC: 0.6%). The majority of statin prescriptions were for generics (MC: 59.6%, CC: 57.1%). The average annual number of statin prescription per user was 9.3 for the MC and 7.6 for the CC. In the CC, 58.1% of prescriptions were filled by male, while 50.4% of prescriptions were filled by male in the MC. Diabetic patients accounted for 35.2% of prescriptions in the MC, and 26.8% in the CC. Milligram dosing distributions (mean, median, mode) were different in both cohorts. In the MC, 35.9mg/40mg for PS patients. The average/median daily dose for the 1st and 12th prescriptions were 20.8mg/20mg and 21.2mg/20mg for AS patients, 10.0mg/10mg and 10.5mg/10mg for SS patients, 28.4mg/20mg and 28.7mg/20mg for SS patients, and 34.6mg for PS patients. The average/median daily dose for the 1st and 12th prescriptions were $2.9 and $3.2 for AS patients, $2.7 and $3.1 for SS patients, $1.5 and $0.8 for SS patients, and $1.4 and $0.9 for PS patients. CONCLUSIONS: Patients initiating AS, RS, SS, and PS experience little escalation of their statin daily dosing over the 24-month follow-up period.