increasing inpatient utilization, the latter especially true for Hispanics. **CONCLUSION:** Although all veterans dramatically adjusted pharmacy use following the copayment change, ethnic minorities appeared particularly sensitive to drug costs. Similarly, while white veterans appeared to reduce psychotropic use with minimal consequences, minorities experienced substantially elevated admission risks associated with lower cost-related adherence. Benefit changes for veterans with chronic conditions should be implemented cautiously and carefully evaluated. Reconciling budgetary concerns with quality care provision requires sensitive attention to unique patient groups to ensure equity while minimizing economic and health disparities.

PMH67

CLINICAL CHARACTERISTICS AMONG ANTIDEPRESSANT INITIATORS

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OBJECTIVE: To compare clinical characteristics of patients initiating treatment on duloxetine vs. those initiating on venlafaxine XR, escitalopram, and fluoxetine over a two year period. **METHODS:** Retrospective claims analysis of Pharmetrics managed care health plan patients initiating on select antidepressants between September 1, 2004 and August 31, 2006. A total of 798,259 patients were assigned to cohorts based on their most recent antidepressant prescription. Cochran-Mantel-Haenszel test was used to test the proportional differences among the four cohorts. **RESULTS:** Overall, 72.1% of study patients were female with a mean age of 44.3 years. Demographic differences between cohorts were modest. Based on comparison of medical claims within +/–30 days of initiation on venlafaxine XR, escitalopram, and fluoxetine, respectively, duloxetine initiators were more likely to have visited a mental health specialist (24.2% vs. 18.2%, 18.6%, and 16.5%) and been diagnosed with depression (29.2% vs. 24.1%, 25.4%, 24.9%). Among the depressed, duloxetine patients were more frequently diagnosed with major depressive disorder (MDD) (52.8% vs. 44.3%, 40.5%, and 36.4%) and, among those diagnosed with MDD, were more frequently diagnosed with recurrent MDD (78.2% vs. 73.8%, 66.2%, and 64.1%). Duloxetine initiators were more frequently diagnosed with a pain condition (44.8% vs. 27.7%, 27.3%, and 24.9%) , particularly for back (15.5% vs. 7.5%, 7.0%, and 6.3%) or musculoskeletal pain (28.2% vs. 15.5%, 14.4%. and 13.1%), and were more likely to have been treated previously with a narcotic analgesic (24.2% vs. 11.1%, 9.8%, and 9.2%) ($p < 0.05$ for all reported differences). **CONCLUSION:** Duloxetine patients are more likely to present with more severe depression diagnoses and pain than patients on other antidepressants. Case mix adjustments should be made when comparing outcomes and costs associated with treatment with different antidepressants. These findings are broadly consistent with earlier analyses of data from the first four months following introduction of duloxetine in the U.S.

PMH68

CHANGES OVER TIME IN PATIENT CHARACTERISTICS FOLLOWING THE INTRODUCTION OF DULOXETINE: A 24 MONTHS STUDY

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OBJECTIVE: To assess month-by-month changes in clinical characteristics of patients initiating on duloxetine, a new antidepressant, during the first two years following its initial availability in the United States. **METHODS:** Retrospective claims analysis of Pharmetrics managed care health plan patients initiating on duloxetine between September 1, 2004 and August 31, 2006. A total of 102,567 duloxetine initiators were identified for inclusion in this study. Monthly data series for demographic and clinical characteristics were created on the basis of Cymbalta initiation date. Claims within +/–30 days of initiation were used to identify clinical characteristics. **RESULTS:** Demographic patterns of patients initiating on duloxetine remained stable over the two year period (average monthly percent female 73.0%; average monthly age 47.4 years), as did proportions of patients with any anxiety (20.7%) or a GAD diagnosis (5.6%). The average monthly % of patients treated by mental health specialists trended downward over the first 16 months of the study period (from 32.3% to 23.7%), while the % with a depression diagnosis trended downward (51.0% to 45.4%) for the first 12 months, before stabilizing thereafter. The % of patients with a pain diagnosis increased over the first three months (62.4% to 66.6%) and remained stable thereafter. Of those with a depression diagnosis, the % with an MDD diagnosis trended downward (55.8% to 45.8%) for 15 months before stabilizing, while the % of those with MDD diagnosed with Recurrent MDD remained stable over the entire study period (77.8%). **CONCLUSION:** Demographic characteristics of patients initiating on duloxetine in the two years following initial availability in the United States have remained relatively stable. Clinical characteristics have shown some variation, particularly over the first 12 to 16 months following initial availability. These trends in utilization have implications for the selection of appropriate methodologies for developing cohorts for comparing utilization and costs between new and established antidepressant medications.

WITHDRAWN **PMH69**

PMH70

AN INVESTIGATION OF EVIDENCE-BASED USE OF ATYPICAL ANTIPSYCHOTICS IN ARKANSAS MEDICAID PEDIATRIC

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OBJECTIVE: There has been a rapid increase in the use of atypical antipsychotics in pediatric populations over the past few years. Most of these drugs are unapproved in pediatric populations. Study objectives were: 1) To identify the trend of new users of atypical antipsychotics in the Arkansas Medicaid population under the age of 18 for years 2001 through 2005; 2) to classify the use of each atypical antipsychotic as evidence-based or not depending on the diagnoses for which it was prescribed; and 3) to determine which pediatric patients are more likely to receive an evidence-based atypical antipsychotic prescription. **METHODS:** Study was a retrospective database analysis of Arkansas Medicaid for the period from January 2000 to December 2006. Participants were the subjects under 18 years of age, with their first atypical antipsychotic prescription claim between 2001 and 2005, with no prior antipsychotic use and having a continuous two-year Medicaid enrollment. Main outcome measure was the proportion of study cohort with at least one evidence-based atypical antipsychotic prescription claim, which was defined as any use of atypical antipsychotic supported by a clinical study in the literature. **RESULTS:** The final study cohort was 11,700. The trend of new pediatric users of atypical antipsychotic therapy increased from 1482 to 3110 new atypical users from 2001 to 2005. After identifying 86 clinical studies from the literature and defining the evidence-based use for each atypical antipsychotic, it was found that 41.32% of the new pediatric users did not have