tatin treatment results in a reduction of cardiovascular (CV) events during the first year of treatment. This study was conducted to estimate the early clinical and economic consequences of initiating statin therapy with atorvastatin vs. simvastatin from a Canadian societal perspective. METHODS: A cost-consequence model was developed to estimate CV events and costs over the first 2 years of treatment associated with initiating atorvastatin or simvastatin in a hypothetical cohort of 100,000 patients. Four groups of new users were considered, including patients with: 1) diabetes; 2) multiple CV risk factors; 3) coronary heart disease; and 4) acute coronary syndrome. RCT data were used to estimate the CV event rate for each statin. CV events included myocardial infarction, stroke, and revascularization procedures. Corresponding direct costs (i.e., health care utilization, drug) were obtained from the Ontario Drug Benefit and Ontario Case Costing Initiative. Estimates of indirect costs (loss of productivity) were obtained from Statistics Canada. All costs were expressed in 2007 Canadian dollars. Multivariate (Monte Carlo simulation) and univariate sensitivity analyses were conducted on model assumptions. RESULTS: Within two years of treatment initiation, the use of atorvastatin is predicted to prevent 1648 CV events (95% CI: 1343–1956) per 100,000 new patients compared with simvastatin. Similarly, the cost of CV events was reduced by $50.8 million (95% CI: $41.9–$59.8). The incremental cost associated with atorvastatin treatment was $31.3 million. This resulted in a net saving of $19.5 million (95% CI: $10.7–$28.7). Savings were also observed across all four groups considered. Results were sensitive to assumptions regarding simvastatin efficacy and levels of persistence. CONCLUSION: Based on this model, atorvastatin use is predicted to result in cost savings to the Canadian society over simvastatin use within 2 years of therapy initiation.

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**Abstracts**

**DH1**

**FOLLOW-UP VISITS FOR PATIENTS WITH MAJOR DEPRESSIVE DISORDER DURING INITIATION OF ANTIDEPRESSANT TREATMENT**

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OBJECTIVE: Clinical guidelines recommend frequent follow-up visits for patients initiating antidepressant treatment in order to provide patient support, adjust dosage, and monitor side effects and clinical response. We examined the frequency of follow-up visits and factors associated with having guideline concordant care during the acute phase of antidepressant treatment.

METHODS: Medical and prescription claims from a large national health plan affiliated with i3 Innovus were analyzed with a retrospective cohort design. Adults newly diagnosed with major depressive disorder (n = 4447) from July 2000 to December 2002 who started a course of antidepressant treatment were included. Follow-up visits during the first three months after the index prescription were counted, and patients were classified as receiving guideline-concordant care if they had at least three visits. Logistic regression was used to explore the predictors for having the minimum number of recommended follow-up visits.

RESULTS: The mean number of follow-up visits during acute phase treatment was 2.68. Only 43.4% of patients received guideline-recommended level of follow-up care. In regression analysis, an initial prescription from a psychiatrist was the strongest predictor (OR = 2.66, 95% CI = 2.30–3.07). Receiving psychotherapy, having comorbid anxiety, and having a lower copayment was also positively associated with the probability of guideline-recommended follow-up care (P < 0.05). CONCLUSION: Routine care for antidepressant management falls short of guideline recommendations, especially in primary care. Modifiable factors such as provider of care and copayments appear to influence the likelihood of receiving guideline-concordant care.

**DH2**

**IMPACT OF ADHERING TO LIPID MANAGEMENT NATIONAL GUIDELINE RECOMMENDATIONS ON CARDIOVASCULAR EVENTS AND COSTS IN A MANAGED CARE POPULATION**

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OBJECTIVE: Estimate the impact of adhering to lipid treatment guidelines [National Cholesterol Education Program’s Third Report on Detection, Evaluation, and Treatment of High Blood Cholesterol and Adult Treatment Panel’s (NCEP-ATP III)] on cardiovascular disease (CVD) events and associated costs in a managed care population. METHODS: A retrospective analysis was conducted using the HealthCore Integrated Research Database on patients with laboratory values on low-density lipoprotein-cholesterol (LDL-C), high-density lipoprotein-cholesterol (HDL-C), & triglycerides (TG) between January 1, 2003-December 31, 2005 [index date], no lipid therapy 6-months pre-index date, and minimum 12 months health plan eligibility pre- and post-index date. Baseline lipid levels and the first post-index follow-up lipid panel (goal attainment), and risk stratification per NCEP-ATP III guidelines were used to categorize patients as appropriately (AM) or inappropriately managed (IAM). End points included counts of CVD events (ischemic heart disease, peripheral vascular disease, stroke and related occurrences and interventions) through Poisson regression and associated annual total CVD-attributable costs ($CV) during follow-up (multivariate generalized linear model regression) between groups after controlling for baseline clinical and demographic differences. RESULTS: A total of 8176 patients (3493 AM; 4683 IAM) were identified. AM patients were significantly older [mean (SD) ages of 51.4 (9.1) vs. 50.0 (9.6); p < 0.01] and comprised of fewer males (43.2% vs. 56.2%; p < 0.01). Baseline Deyo-Charlson comorbidity scores were significantly lower among AM patients (0.20 ± 0.44 vs. 0.32 ± 0.56; p < 0.01). During follow-up, AM patients had a 10% reduction in the annual rate of CV events [Annual Event Rate (AER) = 0.90; 95% CI, 0.86–0.93] as compared to IAM patients. A 12% reduction in annual total SCV [Estimate: 0.88 (95% CI, 0.80–0.98) $696 vs. $788; p = 0.02] was observed among AM patients versus IAM patients. CONCLUSION: Comprehensive dyslipidemia management reflecting clinical guideline treatment recommendations was associated with reductions in CVD events and $CV in this managed care population.

**DH3**

**THE IMPACT OF DRUG VINTAGE ON PATIENT SURVIVAL: A PATIENT-LEVEL APPROACH USING QUEBEC’S PROVINCIAL HEALTH PLAN DATA**

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OBJECTIVE: There is much controversy about the value of new medications and the substantial spending on R&D associated with new treatments. The current study aimed at evaluating the impact of drug innovation on longevity in three important disease areas using patient-level data. METHODS: An analysis of health claims from Quebec’s provincial health plan data