Long-term political and economic changes may well create a true European market in which cost-effectiveness at the European level will have meaning and relevance. Meanwhile, individual country health care systems seem more concerned with short-term budget impact when making new drugs available. The pharmaceutical industry should not anticipate a reduction in the overall demand for locally targeted economic information.

**PHP22**

**PATIENT ADHERENCE TO DRUG THERAPY IN A THREE-TIER COPayment STRUCTURE**

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**BACKGROUND:** The three-tier copayment plan is designed to reduce the cost of pharmacy benefits to the insuror or payer while maintaining patient choice. Because the patient pays a larger portion of the cost of middle- and high-tier drugs, some have argued that this plan design may adversely impact patient drug utilization for chronic medications. **OBJECTIVE:** To determine whether a three-tier copayment structure adversely affects patient drug utilization for middle- and upper-tier drugs for diabetes and depression. **METHODS:** We conducted a longitudinal, retrospective claims database study using claims data from a national pharmaceutical benefits management company. Claims for two chronic conditions, depression and oral diabetes, were examined for patients on three-tier copayment plans and for patients on an open formulary plan with the same copayment for every drug. Average rates of patient adherence, number of prescriptions filled, and days of therapy were calculated. **RESULTS:** There were statistically significant differences in rates of patient adherence, number of prescriptions filled, days of therapy, amount of copay, and payer costs among patients using drugs in the lower, middle, or upper tier of the three-tier structure. In addition, average patient adherence, number of prescriptions filled, and days of therapy did differ significantly for patients on an open formulary compared to patients on a three-tier copayment structure. These differences were largely a function of sample size, and may be of little practical utility. **CONCLUSIONS:** The larger patient copayment for medications in the middle and upper tiers of a three-tier copayment structure have only a minimal impact on drug utilization in the antidepressant and oral diabetes drug categories. Further research is needed to determine whether these findings would be replicated when applied to other therapeutic classes.
All patients are entitled to equal access to health care resources. The Department of Pharmaco economics at University of Texas MD Anderson Cancer Center (UTM DACC) administers a Patient Assistance Program (PAP) that provides assistance to indigent patients with free pharmaceuticals for their therapy. Drug cost is recovered through a drug reimbursement program offered by pharmaceutical companies. **OBJECTIVE:** The objective of this report is to examine trends in drug cost savings to indigent patients at UTM-DACC using the PAP model. **METHODS:** A retrospective study using data from September 1996 to August 2000 was conducted to determine the value of the program. Patients were enrolled in this program if they qualified based on the Financial Classification Scale. Uninsured patients as well as under-insured patients were considered in this study. Data was analyzed to evaluate the trend in cost savings for the three fiscal years. **RESULTS:** Over $334 million was spent on drug cost over the period. There was an average increase of 22% per year in drug cost. The indigent patients accounted for 9% of the total patient population at UTM-DACC. An estimated $33 million was spent on drugs for indigent patients during that period. The PAP system recovered a total of $16.8 million; $4.1M (1997), $4.3M (1998), $3.5M (1999), and $4.9M (2000). This accounts for 51% in drug cost recovery through this program. The fluctuation in cost saving was attributed to changes in the number of programs, number of patients enrolled, and product mix. **CONCLUSION:** The PAP system has provided free drugs to patients without financial resources and reduced the economic burden of this population on the health care institution. The program has created goodwill between the pharmaceutical companies, the health care institution, the patients and the community.

NO SPECIFIC OR MULTIPLE DISEASES-QUALITY OF LIFE & PREFERENCE-BASED MEASURES

LESSONS LEARNED FROM DEVELOPING A PSYCHOMETRICALLY BASED SEDATION QUESTIONNAIRE IN PHARMACOLOGICALLY PARALYZED CRITICALLY ILL PATIENTS

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**OBJECTIVE:** To share lessons learned from developing a reliable and valid questionnaire for adequacy of sedation in pharmacologically paralyzed critically ill patients. **METHODS:** In phase 1, seven experts listed 21 characteristics describing anxiety in pharmacologically paralyzed patients. In phase 2, two scenarios were created illustrating the experience of paralysis: one with and one without receiving a sedative. A convenience sample of 30 people evaluated scenarios to determine the importance of characteristics obtained from phase 1 using a five-point scale. Items were reduced to the 10 most important characteristics (mean ≥3). Based on these results, the final instrument consisted of 12 questions: 2 categorical addressing memory of the experience and 10 referred to characteristics of anxiety. In phase 3, two groups of critically ill patients were administered the questionnaire: 1) sedated only and 2) sedated and pharmacologically paralyzed. The questionnaire was administered twice for reliability. Questionnaire results were compared to subjective and objective sedation monitoring tools for validity. Calculated sample size was 20 for each group. **RESULTS:** During six months, 21 patients consented to participate. Twelve patients died and nine patients (6 sedated, 3 sedated/paralyzed) were administered questionnaires. Five patients (3 sedated, 2 sedated/paralyzed) did not remember the intensive care unit experience. Two of three patients in the sedated group who answered the questionnaire found it difficult to remember over time. One sedated/paralyzed patient who answered the questionnaire received a sedative without amnesic properties and felt anxious during therapy. The distressful feeling of this patient was comparable to findings of the objective sedation tool. **CONCLUSIONS:** Mortality in this critically ill patient population was high. Due to amnestic properties of sedatives most patients did not remember the experience. Of patients who remembered, their memory deteriorated over time. Based on lessons learned, it may require 2–3 years to achieve the necessary sample size.