select attributes in order to construct the final list of attributes. This study aims to test the feasibility of using the nominal group technique (NGT) to select attributes for DMARD-IR. Four group discussions were conducted in Belgium and the Netherlands to prioritize a list of twelve potentially important attributes for osteoporosis drug therapy that were retrieved from literature review and expert discussions. The NGT consisted of three steps: 1) an individual ranking of the twelve attributes by importance from 1 to 12; 2) group discussion on each of the attributes including a group review of the aggregate score of the initial rankings; and 3) a second ranking task of the same attributes. The selection of attributes for the DCE was based on groups’ ranking and NGT discussions followed by experts’ discussion. RESULTS: In total, 26 osteoporotic patients participated in five nominal group discussions. Most (80%) patients changed their ranking after the group discussion. However, the average initial and final ranking did not markedly differ, with two exceptions. In the final rank, the most important medication attributes were effectiveness, side-effects, frequency and mode of administration. It was also observed that half (55%) patients did not correctly rank from 1 to 12, and the order of attributes did play a role in the ranking. CONCLUSIONS: The nominal group technique is feasible and useful for selecting attributes for DCE, although the ranking task may be cognitively difficult and attributes order should vary over different NGT sessions.

PM563 ASSESSMENT OF THE OSTEOPOROSIS SELF-EFFICACY SCALE IN RELATION TO OSTEOPROTECTIVE BEHAVIORS AMONG TYPE 2 DIABETICS PATIENTS IN NORTH MALAYSIA

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OBJECTIVES: To assess the factors that most predicts diabetic patients’ self-efficacy toward osteoporosis with respect to dietary calcium and physical exercise activities. METHODS: A cross sectional study was undertaken in 250 diabetic type 2 outpatients (T2DM) over a 3-month period in 2011. A pre-validated questionnaire was administered to assess osteoporosis knowledge tool (OCT-M, two subscale: exercise and calcium), osteoporosis health behaviour scale (OHB-BS, seven subscales: perceived susceptibility, perceived seriousness, barriers to calcium intake, barriers to physical exercise, benefits of calcium intake, benefits of exercise, and health motivation), osteoporosis risk factor and other demographic questionnaires prior to the Malaysian osteoporosis self-efficacy scale (OSES-M, two subscale: calcium and exercise). Then differences, correlations and multiple regressions were examined in 211 type 2 diabetic patients (OCT-M and OHBS-BS). RESULTS: There were significant differences in the independent variables: education and income in relation to OSES-M total scores. Correlations were performed to determine the relationship between the two dependent variables (OSES-M calcium and exercise subscale) and the OCT-M and OHBS-M. The OCT-M calcium and exercise subscale, health motivation and perceived benefits for exercise were positively correlated with both OSES-M exercise and calcium intake. While perceived benefits for calcium intake was positively correlated with self-efficacy for exercise and calcium intake. Perceived barrier for calcium intake was negatively correlated with self-efficacy for exercise and calcium intake. Perceived barrier for exercise intake was negatively correlated with self-efficacy for calcium and exercise intake. With a 6-point cut-off, the sensitivity was 90% and the specificity was 67% for fibromyalgia and non-fibromyalgia patient detection. CONCLUSIONS: This is a screening tool that detects potential fibromyalgia patients among patients with chronic widespread pain. It can be used as a surrogate for ACR classification criteria in primary care settings, and improve referral to appropriate specialists.

PM566 THE MYOTONIC DYSTROPHY TYPE-1 HEALTH INDEX (MDHI): AN ANALYSIS OF ITS ABILITY TO DIFFERENTIATE BETWEEN CLINICALLY DISTINCT POPULATIONS

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OBJECTIVES: Myotonic dystrophy type-1 (DM1) is a dominantly inherited disorder caused by an unstable CTG repeat expansion on chromosome 19. Clinically the disease is associated with a wide variety of symptoms. The Myotonic Dystrophy Health Index (MDHI) is a disease-specific quality of life instrument validated between ACR+ and ACR- patients with an area under the ROC curve of 0.74. A majority of ACR+ patients (77%) and less than half of ACR- (39%) had a score >7, suggesting that patients with such score are likely to be ACR+, and should thus be referred to a fibromyalgia specialist. A total of 8% of ACR+ patients and 79% of ACR- patients had a score <3, suggesting that patients with such score were unlikely to be ACR+, and should thus be not be referred to a fibromyalgia specialist. Patients with a FibroDetect score of 4 or 5 would require further investigation. The predictive accuracy of the tool increased to 0.86 for fibromyalgia and non-fibromyalgia patient detection. With a 6-point cut-off, the sensitivity was 90% and the specificity was 67% for fibromyalgia and non-fibromyalgia patient detection. CONCLUSIONS: The FibroDetect is a screening tool that detects potential fibromyalgia patients among patients with chronic widespread pain. It can be used as a surrogate for ACR classification criteria in primary care settings, and improve referral to appropriate specialists.

PM677 DETECTING POTENTIAL FIBROMYALGIA PATIENTS IN PRIMARY CARE SETTINGS: VALIDATION OF THE FIBRODETECT SCREENING TOOL

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OBJECTIVES: To validate and determine the discriminative power of the FibroDetect screening tool in helping primary care physicians detect patients with fibromyalgia in routine practice. METHODS: The FibroDetect included 14 questions assessing patients’ pain and fatigue, personal history and attitudes, symptoms and impact on lives. To discriminate between American College of Rheumatology positive (ACR+) patients and ACR negative (ACR-) patients (n=270), a scoring method was developed using an iterative process based on statistical and clinical considerations. The discriminant model was then validated with fibromyalgia and non-fibromyalgia patients (n=312). A score threshold for individual ACR classification was defined. RESULTS: Of the 14 original FibroDetect questions, six questions were retained in the final scoring model and the discriminant score between ACR+ and ACR- patients with an area under the ROC curve of 0.74. A majority of ACR+ patients (77%) and less than half of ACR- (39%) had a score >7, suggesting that patients with such score are likely to be ACR+, and should thus be referred to a fibromyalgia specialist. A total of 8% of ACR+ patients and 79% of ACR- patients had a score <3, suggesting that patients with such score were unlikely to be ACR+, and should thus be not be referred to a fibromyalgia specialist. Patients with a FibroDetect score of 4 or 5 would require further investigation. The predictive accuracy of the tool increased to 0.86 for fibromyalgia and non-fibromyalgia patient detection. With a 6-point cut-off, the sensitivity was 90% and the specificity was 67% for fibromyalgia and non-fibromyalgia patient detection. CONCLUSIONS: The FibroDetect is a screening tool that detects potential fibromyalgia patients among patients with chronic widespread pain. It can be used as a surrogate for ACR classification criteria in primary care settings, and improve referral to appropriate specialists.
OBJECTIVES: The current analysis evaluates the long-term impacts on household productivity and social participation of CZP 400mg QW combination therapy over 5 years. METHODS: In this open-label extension (OLE) (NCT01606993) patients (pts) originally enrolled in FAST4WARD (NCT00544594) or study 014 (NCT00544154) received CZP 400 mg QW for 24 wks. Pts who completed or withdrew after WL2 in either study were eligible and were permitted to take DMARDs in OLE. Mean productivity and social participation were assessed through the RA-specific Work Productivity Survey (WPS-RA); results are reported up to WL268 (5.2yrs). The analyzed population consisted of (1) Wk 24 CZP completers from FAST4WARD (N=75) or OLE (N=56) who entered the OLE (all pts group) and (2) FAST4WARD CZP completers who entered OLE and did not receive MTX/DMA Ds (N=48) (monotherapy subgroup). RESULTS: In both populations analyzed, a rapid reduction in the number of days of household work days missed per month was seen from feeder study baseline (BL, 7.4 and 4.1 mean days respectively) over 24wks, the feeder studies to OLE entry (3.5 and 4.1 mean days respectively) and continued to decline over time, up to Week 268 (1.2 and 1.4 mean days respectively). Increased participation in family/social/leisure activities was reported in both populations, with a decrease in the number of days missed per month from feeder study baseline (4.1 and 6.2 mean days, respectively), to entry to OLE, at a mean of 1.3 and 1.1 days respectively for monotherapy pts; improvements continued over the 5 years to 0.4 and 0.2 days on average in the 2 populations respectively.

CONCLUSIONS: CZP treatment, in combination with MTX/DMA Ds or as monotherapy, rapidly decreased the number of household work or family/social/leisure days missed per month. These improvements were maintained up to 5 years with open-label CZP following 24 wks double-blind CZP therapy.

MUSCULAR-SKELETAL DISORDERS - Health Care Use & Policy Studies

PMS68 THE USE OF MONITORING SYSTEMS TO BETTER REGULATE DRUG CONSUMPTION IN HOSPITALARY HOSPITALS
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OBJECTIVES: Due to the global economic crisis, most of the actions of the Hungarian government are focused on cost reductions, including in the health care sector. Accordingly, the hospital system’s changes (i.e., the state becoming the owner), the most important thing is to create a well-monitored and centralized hospital system. In addition to these changes, the government seeks to centralize the procurement of pharmaceuticals and medical equipment at state-owned hospitals. The second criterion is that high-level hospital and political leaders to find how can we strengthen the regulation of drug consumption at hospitals, which is at this time without strict controls.

RESULTS: Due to the specific objectives of the HunDRG system, which are focused more on monitoring the number of DRG cases than tracking resources, there are no incentives for hospitals to maintain strict inventories of their drugs. Except for biological drugs, which use an itemized financing system, there is no pressure by the government to monitor the medical costs at the unit level; as such, only hospital data exists. Based on IMS data in 2011, the total hospital sector was valued at approximately 100 billion HUF. Most of the hospitals do not have adequate computer systems to monitor the patient-level data. CONCLUSIONS: In conclusion, the so-called unit-dose system could be a good solution to measure the drug consumption at the patient level instead of a unit-based drug security (trial system). To sum up, it is very important to gain more data regarding the Hungarian hospital system to be able to create a sustainable, transparent, highly-regulated, and centralized public health care system.

PMS69 KEY DRIVERS FOR PRICING AND REIMBURSEMENT FOR BIOLOGIC DRUGS IN FRANCE
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OBJECTIVES: In France, the reimbursement decisions and price negotiations for new drugs are highly influenced by the National Authority of Health (HAS) recommendations communicated in the formal health technology assessment (HTA). This study aimed to analyse past criteria and consider future possible require-ments into HTA making future decisions. METHODS: A convenient internet review was conducted to identify categories for value drivers in the evaluation of the incremental medical benefit (ASMR) for a new product. An analysis of five biological products reviewed 2006-2012 for rheumatology disorders was conducted using these criteria. Based on the findings, exploratory interviews with two experts were recommended a high-level II- ASMR. Only 2 of 14 phase III studies used an active comparator in Phase III superiority studies. Open label extension studies were commonly used to provide post-launch data. Findings of the interviews suggested that in the future superiority versus current standard of care in France for a clear target population would be the expectation for an ASMR ≤ IV from the HAS.

CONCLUSIONS: These findings emphasise the need to integrate payer evidence requirements into the clinical development strategy early on. Effort should be directed towards the identification of a clear target population demonstrating superior efficacy to standard of care.

PMS70 UTILIZATION OF PAIN MEDICATIONS AMONG OSTEARTHRITIS PATIENTS WHO INITIATED DULOXETINE AND STANDARD OF CARE FOR PAIN MANAGEMENT
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OBJECTIVES: To compare utilization of pain medications between osteoarthritis (OA) patients who initiated duloxetine and standard of care (SOC) after duloxetine’s approval for OA. METHODS: Pharmacy and medical claims from SDI Health were analyzed for adult osteoarthritis patients (ICD-9-CM: 715.xx) initiating duloxetine or SOC (celexobut, gabapentin, pregabalin, or venlafaxine) between 11/2010 and 4/2011. Duloxetine initiation was defined as the first dispense date. Studied outcomes included total opioid use, days present on opioids after index date (49% vs. 56%, p = 0.004) than SOC cohort. After adjusting for baseline characteristics, duloxetine cohort initiated opioids later than SOC cohort (Hazard ratio: 0.85, 95% confidence interval: 0.77-0.95) and had fewer days on opioids (beta: -4.0, p = 0.011). CONCLUSIONS: Patients with OA initiating duloxetine were associated with better compliance to initiated medication and less likely to use opioids than those initiating SOC.

PMS71 UTILIZATION OF DULOXETINE AND CELECOXIB AMONG OSTEARTHRITIS PATIENTS
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OBJECTIVES: To describe utilization patterns of duloxetine and celecoxib and subsequent opioid use among patients with osteoarthritis (OA) after duloxetine’s approval for OA. METHODS: Pharmacy and medical claims from SDI Health were analyzed for adult osteoarthritis patients (ICD-9-CM: 715.xx) who initiated duloxetine or celecoxib between 11/2010 and 4/2011. Duloxetine was defined as no pill coverage or 60 days prior patients had constant opioid use in 6 months before and after the initiation and did not use opioids in 90 days before the initiation. Propensity score matching was used to select patients with similar demographic and clinical characteristics for duloxetine and celecoxib cohorts. Utilization of index medication with prior medication possession ratio (MPR), proportion of days covered (PDC) and proportion discontinued (a 60 + day gap in medication access) for 6 months after index date. Opioids used after index date was assessed and regression models were estimated to compare opioid use between cohorts. RESULTS: A total of 1102 patients initiated duloxetine and 959 patients initiated celecoxib. Duloxetine cohort had fewer days on opioids after index date (49% vs. 56%, p = 0.004) than SOC cohort. After adjusting for baseline characteristics, duloxetine cohort initiated opioids later than SOC cohort (Hazard ratio: 0.85, 95% confidence interval: 0.77-0.95). Duloxetine (mean age: 63 years, female: 79%) and SOC (mean age: 64 years, female: 77%) cohorts, respectively. Duloxetine cohort had significantly higher MPR (0.80 vs. 0.74) and PDC (0.52 vs. 0.43), and were less likely to discontinue initiated medication (Hazard ratio: 6.7, 95% confidence interval: 2.7-16.4). Duloxetine cohort had fewer days on opioids after index date (49% vs. 56%, p = 0.004) and had fewer days on opioids (beta: -4.0, p = 0.011). CONCLUSIONS: Patients with OA initiating duloxetine were associated with better compliance to initiated medication and less likely to use opioids than those initiating SOC.

PMS72 ADHERENCE AND CHANGE OF OPIOID USE AFTER INITIATING DULOXETINE OR CELECOXIB AMONG PATIENTS WITH OSTEOARTHRITIS
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OBJECTIVES: Opioids are commonly used to manage chronic pain, including osteoarthritis (OA). Duloxetine is approved for OA therapy, but no study has assessed changes in utilization of opioid therapy following its approval. This study assessed adherence and the influence of opioid use between patients who initiated duloxetine versus celecoxib. METHODS: Employing administrative claims data, OA pa- tients aged 18 + years who initiated duloxetine or celecoxib between November 2010 and April 2011, and used opioids in 6 months before the initiation, were identified. Initiation was defined as no access to the same medication over the prior 90 days, and the first dispense date of index medication was denoted as the "index date". Patients with >80% days covered by index medication during follow-up were