claims data evaluates the health care resource utilization of diagnosed premature ejaculation (PE) patients compared to controls (C). METHODS: Diagnosed PE patients (n = 1419) and random controls (n = 1372) from a 2003 Pharmetrics® Database were compared. PE patients and C were >17 years old. Number of physician encounters, concomitant medical diagnoses and drug therapies were evaluated. RESULTS: Mean age of PE patients was 40 (±11) years vs. 41 (±12) years in C. PE patients had 8 office visits in the diagnosis year vs. 3 visits in C. In 2003 total costs for a PE patient was $1,159 vs. $394 for C, including drug costs of $598 and $149 respectively. The differences between groups remained constant in the year following diagnosis. Prior to their PE diagnosis, patients had more and more frequent comorbidities reported than C. Major comorbidities reported were hypercholesterolemia (PE:14.2% vs. C:3.8%), hypertension (11.8% vs. 4.7%), respiratory problems (11.2% vs. 3.5%), prostate hyperplasia (5.4% vs. 0.8%), diabetes (3.9% vs. 0.7%), penis problems, and (10.3% vs. 6.8%) urinary tract problems (5.4% vs. 0.5%) and sexual disorders (4.7% vs. 0%). Only 9% had an erectile dysfunction diagnosis prior to PE. After PE diagnosis, Zoloft (25.9%), Paxil/CR/paroxetine (20.4%) Viagra (10.8%), were the most prescribed drugs compared to 2.5%, 1.7% and 3.2% in C. CONCLUSION: Health care seeking PE patients consume more medical resources due to greater physician visits and drug consumption. Comorbidity findings may reflect reporting bias or indicate real etiological factors, both of which warrant further research.

**INDIVIDUAL’S HEALTH—Health Care Use & Policy**

**PIH7**

**APPROPRIATE MEDICATION PRESCRIBING FOR THE ELDERLY: PHYSICIAN CONFIDENCE AND KNOWLEDGE**

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OBJECTIVE: To examine physician confidence in and knowledge of appropriate medication prescribing for the elderly.

METHODS: Practicing physicians (total n = 64 [attendings n = 36; residents n = 27; fellow = 1]) of a general family medicine practice in a large metropolitan academic medical center were asked to complete a 25-item, web-based survey. Physicians’ characteristics—including age, current level of practice, and number of years in practice—were captured. Confidence in prescribing for the elderly was assessed using a 5-point Likert scale dichotomized into “more confident” (“strongly agree” and “agree”) and “less confident” (“neutral,” “disagree,” and “strongly disagree”). Knowledge was measured using 6 multiple choice clinical vignettes based on medications that should be avoided in the elderly population according to the 2003 Beers Criteria. Information on perceived barriers to appropriate prescribing was collected. Descriptive, Fisher’s exact test, and t-test analyses were conducted as appropriate. RESULTS: Thirty-nine physicians (21 attendings, 17 residents, 1 unknown) completed the survey, yielding a response rate of 61%. Attendings had a mean age of 45 (SD ± 8.9) and had 14 years (SD ± 9.9) of practice. Residents had a mean age of 28 (SD ± 1.6). Ninety-five percent of attendings and 56% of residents were “more confident” in their ability to prescribe appropriately for the elderly (Fisher’s exact test, p < 0.05). The mean individual clinical vignette score was 4.1 (min = 0, max = 6) (SD ± 1.05). Attendings (mean = 4.5, SD ± 0.68) scored better on the clinical vignettes when compared to residents (mean = 3.7, SD ± 1.03) (t-test, p < 0.01). Cost to patient, limited formulary options, and polypharmacy were noted as the most common barriers to appropriate prescribing. CONCLUSION: Overall, results indicate that although the majority of physicians feel confident, there may be room for improvement in knowledge regarding appropriate prescribing. Additionally, educational activities are warranted to enhance resident prescribing confidence. Future research will serve to validate these results and further investigate potential individual and institutional barriers to appropriate prescribing.

**PIH8**

**WITHDRAWN**

**PIH9**

**TEXAS COMMUNITY PHARMACISTS’ WILLINGNESS TO ACCEPT PHARMACIST INITIATED EMERGENCY CONTRACEPTION**

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OBJECTIVES: The objectives were to determine Texas community pharmacists’ knowledge and awareness of emergency contraception (EC), their dispensing of EC, their perceptions about EC, as well as their willingness to participate in pharmacist initiated emergency contraception (PIEC). METHODS: A mail questionnaire was sent to a random sample of 300 Texas community pharmacists. The questionnaire consisted of 40 questions divided into three sections: experience with EC, PIEC (where pharmacists can dispense EC without a prescription), and