ance claims database (TruvenHealth MarketScan® Medicaid) from January 2007 to June 2012. Patients with at least two treatment episodes in the first year after the initial filled prescription were identified. The end of a treatment episode was defined as a period of 60 days with no filled BUP/NAL prescriptions following the theoretical end of the last filled prescription. An ordered logistic regression model was used to assess the impact of health utilization episodes on the number of new episodes in the year following the end of the first episode. Health care resource utilization and related costs during the first year after initiation were compared between the two groups. RESULTS: 2,222 patients were included in the analysis. During the first year, 86% of patients had only one treatment episode, 13% had two and 1% had three. Compared to patients treated continuously over 12 months, the multiple treatment episode group had lower medication costs ($428.87), but higher psychiatric inpatient costs ($+7,870), non-psychiatric inpatient costs ($+2,001) and emergency room costs over 12 months. Total health care costs over 12 months were higher among multiple treatment episode patients ($15,266 vs $13,205). CONCLUSIONS: The costs of total health care costs over 12 months were higher among patients with multiple treatment episodes compared to patients treated continuously.

PMH43 HEALTH CARE COST SAVINGS ASSOCIATED WITH ARIPIPIRAZOLE ONCE-MONTHLY (AOM) TREATMENT AMONG SCHIZOPHRENIA PATIENTS WITH PSYCHIATRIC HOSPITALIZATIONS PRIOR TO AOM TREATMENT INITIATION

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OBJECTIVES: Preliminary data from a multicenter, open-label mirror study of patients who switched to oral-OLZ-LAI demonstrated that switching from oral standard of care (SOC) antipsychotics to aripiprazole once-monthly (AOM) reduced total psychiatric hospitalization rates from 12 months prior to AOM initiation to 12 months of the AOM 12-month prospective period (p<0.0001). A subgroup of patients with at least 1 psychiatric hospitalization per year prior to AOM was analyzed to estimate health care cost savings associated with AOM treatment initiation. An economic model was developed to examine the impact of costs and outcomes of switching to AOM. Cost for hospitalizations, hospita l length of stay, and cost of drug therapy were estimated for a subgroup of 76 patients with schizophrenia who entered the ongoing mirror study (NCT01434446) and had at least 1 psychiatric hospitalization during the retrospective period.

Cost estimates were obtained from HealthCare Costs and Utilization Project, published literature, and US Bureau of Labor Statistics. Adjustments were made to estimates in accordance with patient characteristics summarized in the study (last to follow-up, adverse events, met protocol/investigator withdrawal criteria, protocol deviation, lack of efficacy) and thus did not have complete data on resource use from the trial. RESULTS: Among the 76 patients with hospitalizations during the retrospective period, hospitalizations were reduced to 22.4% (177/766) in the prospective period ($323,313) after switching to AOM was lower than that in the retrospective period ($366,415) in patients treated with SOC for the past year prior to AOM. The costs of hospitalization were reduced from $1,16 to 0.53. Increased cost due to AOM initiation ($6,010) was offset by reduced cost for hospitalizations ($19,112). CONCLUSIONS: Among patients with previous psychiatric hospitalizations, treatment with AOM may reduce total cost of care for health plans.

PMH44 PHARMACOECONOMIC ANALYSIS OF PALIPERIDONE PALMITATE FOR CHRONIC RELAPSING SCHIZOPHRENIA IN FINLAND

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OBJECTIVES: Management of patients with chronic relapsing schizophrenia is difficult and costly. We assessed the cost-effectiveness of paliperidone palmitate long-acting injectable (PP-LAI) versus risperidone depot (RIS-LAI), olanzapine pamoate acting injectable (OLZ-LAI), oral olanzapine (oral-OLZ) and oral clozapine (CLOZ) from the viewpoint of a third party payer in Finland. The primary economic outcome was the incremental cost/QALY. Two MACCE (adverse mortality and coronary events) were obtained from an expert panel study. Drug costs were estimated using mean dose from clinical trials and wholesale acquisition costs. Costs of resources were obtained from a retrospective database study of bipolar depression patients. Model results were tested using one-way and probabilistic sensitivity analyses.

RESULTS: The 3-month time horizon of the model, 52.0% of lurasidone patients achieved remission versus 43.2% of quetiapine XR patients. Mean emergency room visits, inpatient days, and office visits were lower for lurasidone patients (0.48, 2.1, 9.3) than quetiapine XR patients (5.0, 2.2, 9.6), respectively. Total costs were lower for lurasidone patients ($4,447) than quetiapine XR patients ($4,546). Cost-effectiveness results showed that lurasidone was dominant over quetiapine XR. Model testing showed that the results were robust to changes in other parameters. One-way sensitivity analysis showed that the model may be sensitive to the drug cost/month, remission rate, or hospital cost/day. Probabilistic sensitivity analyses showed lurasidone has a 97.4% probability of being cost-effective compared to quetiapine XR. The ICER was found to be -$656/HAMA point which indicates improved effectiveness along with reduction in Hamilton Anxiety Scale (HAMA) scores, and adverse event probabilities were obtained from a head-to-head randomized trial. Resource utilization and associated costs were estimated from standard national sources. Analyses from a third party payer’s perspective focused on the direct medical cost of treatment e.g. drugs, physician visits and dispensing cost. Annual per person for the treatment was calculated and the cost-effectiveness of the treatment options was measured. All costs were reported in 2013 ESU. The ICER was expressed as the incremental cost-effectiveness ratio (ICER). Sensitivity analysis on key input parameters and Monte Carlo simulations was performed to measure the robustness of the model. RESULTS: Lurasidone demonstrated cost-effectiveness in Finland by having lowest total annualized costs, respectively and better outcomes (14 HAMA vs. 13 HAMA point reduction, respectively) and ICER was found to be -$656/HAMA point which indicates improved effectiveness along with reduction in cost by adopting Escitalopram over Paroxetine. Sensitivity analysis demonstrated the robustness of the model. CONCLUSION: Lurasidone appears to be cost-effective compared with Paroxetine in treatment of GAD in the U.S. from a third party payer’s perspective.

PMH47 COST-EFFECTIVENESS ANALYSIS OF ESCITALOPRAM Versus PAROXETINE IN TREATMENT OF GENERALIZED ANXIETY DISORDER (GAD) IN THE UNITED STATES

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OBJECTIVES: Generalized Anxiety Disorder (GAD) affects around 6.8 million U.S. adults. It places a considerable economic burden upon patients and payers alike. Selective serotonin reuptake inhibitors (SSRIs) are among the first-line therapy for treating GAD. Currently, Escitalopram and Paroxetine are the only SSRIs approved by the U.S. FDA for treating GAD. A decision analytic model was developed to compare escitalopram and paroxetine in the treatment of GAD in the U.S. METHODS: A decision analytic model with a 12 month time horizon, adapted to the U.S. setting was constructed. Outcome measured as a reduction in Hamilton Anxiety Scale (HAMA) scores, and adverse event probabilities were obtained from a head-to-head randomized trial. Resource utilization and associated costs were estimated from standard national sources. Analyses from a third party payer’s perspective focused on the direct medical cost of treatment e.g. drugs, physician visits and dispensing cost. Annual per person for the treatment was calculated and the cost-effectiveness of the treatment options was measured. All costs were reported in 2013 ESU. The ICER was expressed as the incremental cost-effectiveness ratio (ICER). Sensitivity analysis on key input parameters and Monte Carlo simulations was performed to measure the robustness of the model. RESULTS: Escitalopram demonstrated cost-effective than paroxetine by having lowest total annualized costs, respectively and better outcomes (14 HAMA vs. 13 HAMA point reduction, respectively) and ICER was found to be -$656/HAMA point which indicates improved effectiveness along with reduction in cost by adopting Escitalopram over Paroxetine. Sensitivity analysis demonstrated the robustness of the model. CONCLUSION: Escitalopram appears to be cost-effective compared with Paroxetine in treatment of GAD in the U.S. from a third party payer’s perspective.