selective or non-selective and weak opioids (codeine, tramadol, dextropropoxyphene) was extracted and analysed. RESULTS: A total of 23,456 prescriptions were analysed, 18,187 prescribed to adults [18-64 years] and 5,269 to elderly [65-101 years]. The proportion of NSAID prescriptions for non-selective plus selective COX-2 inhibitors, There were 83, did not change during the 5-year period, 91.1, 91.3, 91.4 and 91.5% of patients were prescribed an NSAID. The proportion of prescriptions for traditional non-selective NSAIDs increased from 83.9% to 90.3% from year 2004 to 2008 among adult patients and from 69.7% to 78.7% among elderly. The proportion of prescriptions for COXibs decreased between 2004 and 2008 and were prescribed to 3.6% of patients in this study in 2008. Co-prescription of gastroprotective therapy was made in 12-20% of prescriptions with no differences between NSAIDs, COXibs and non-NSAID. CONCLUSIONS: In this review of NSAID prescription utilisation among patients with a diagnosis of musculoskeletal pain shows an extensive use of anti-inflammatory agents without co-prescription of gastro-protective medication. The impact of this high utilisation of NSAIDs without co-prescription of gastroprotective agents on the risk for upper gastrointestinal complications warrants further evaluation.

**RESULTS:** Among 6,857 ACS discharges across 688 hospitals, 4,154 and 2,703 were

**OBJECTIVES:** To assess induction and maintenance infusion patterns of infliximab (IFX) treatment in ulcerative colitis (UC) patients receiving 1, 2, or 3 induction doses. METHODS: A retrospective analysis of medical claims from an administrative database was conducted for UC patients newly starting IFX. Patients were required to have age >18 yrs, 2 diagnosis codes for UC, IFX index date between September 1, 2005 and January 31, 2008, and ≥26 months of continuous enrollment (minimum 12 months before and 14 months after the index date). Patients with select pre-index inflammatory disorders were excluded. The analysis evaluated induction (IFX doses during first 56 days post-index) and maintenance (doses >56 days and <12 months post-index). Infusion duration was defined by a medication possession ratio (MPR) of >80%. Results were stratified by the number of induction doses (1, 2, or 3). RESULTS: A total of 354 UC patients were included in the analyses: mean (SD) age of 44 (16) yrs; 48.3% female; 62.4% received IFX in the outpatient office setting. There were 27, 83, and 244 patients in the 1, 2, and 3 induction dose groups, respectively. Overall, the mean (SD) number of days during the induction period was 35 (14), and days increased with the number of induction doses. During the maintenance period, patients received an overall mean (median) of 5 (6) infusions. The median infusion frequency was 0.5 (0.7) infusions per month, with an MPR >80%. Infusion patterns for the first year post-induction were consistent with recommended prescribing information, with a median of 56 days between infusions. CONCLUSIONS: The majority of IFX patients received 3 induction doses. Infusion patterns were consistent with recommended dosage infusion patterns, especially for those patients receiving 3 induction doses. These data support administering 3 IFX doses during induction to ensure appropriate dosing and optimal medication adherence during maintenance.

**RESULTS:** After adjustment for patient and hospital characteristics, hospital volume was no costs ($11,358 vs. $12,013, p = 0.004), mortality (0.9% vs. 1.7%, p = 0.004), LOS (gamma distribution, log link) between volume groups while controlling for gender, age, payer, number of comorbidities, and hospital characteristics, including rural vs. urban location, teaching status, bed size, ownership type, and hospital region. METHODS: Using the 2006-2007 Nationwide Inpatient Sample (NIS), we identified ACS patients based on ICD-9-CM codes 517.3 (ACS) or 486 (pneumonia) among discharges with SCD (Clinical Classification Code 61). SCD volume represented the average number of SCD discharges from a hospital per year over the 2-year study period. Given that majority of patients were treated in a relatively small number of hospitals, the top decile was selected to represent high volume hospitals. We used generalized estimating equations to evaluate whether the relatively small number of hospitals, the top decile was selected to represent high volume hospitals. We used generalized estimating equations to evaluate whether the probability of achieving specified clinical endpoints. From this model, cost-effectiveness estimations can be made for patients receiving primary prophylaxis versus on-demand treatment with recombinant factor VIII among children with severe hemophilia A. METHODS: Prophylactic infusions of fVIII-FS have been shown to reduce the frequency of bleeding episodes and the risk of joint damage in children with hemophilia A with no pre-existing joint damage. Clinical studies have shown significant improvements in outcomes with the use of prophylactic treatment, as well as apparent gains in health-related quality of life. However, recombinant clotting factors are also associated with relatively high cost. Using a lifetime Markov model, the cost-effectiveness of primary prophylaxis treatment was compared to on-demand treatment. This model is among the few that model long-term and effectiveness and is unique in that it takes into account the probability of inhibitor development, use of central venous access device (CVAD), and total bleeding risk including CNS and joint bleeds. Prophylactic treatment is assumed to be from birth until 16 years of age. Built in the model were also 5 health states: being alive, surgery, inhibitor development, disability and deceased. SUMMARY: From this model, cost-effectiveness estimations can be made for patients receiving on-demand treatment versus primary prophylaxis. Cost-effectiveness can vary by the frequencies of events between treatment arms, age where prophylaxis begins and ends, dose/frequency of factor VIII, cost of medications and key hospital-related events, and the probability of achieving specified clinical endpoints. CONCLUSIONS: The strengths and distinguishing characteristics of this model versus previously published hemophilia prophylaxis models include long-term effectiveness, probability of inhibitor development, use of CVAD, and CNS bleeds. There are a few study limitations related to the lack of data for model assumptions. Obtaining stronger evidence for these parameters may substantiate or potentially improve the model results.

**RESULTS:** Using patient focus groups to inform economic modeling: experience from a hemophilia patient focus group. Lalla A*, Boor K*, Pacozzi F, Scan B

Centocor Ortho Biotech Services, LLC, Horsham, PA, USA, *Institute of Hematology, University of Pennsylvania, Philadelphia, PA, USA

BACKGROUND: Decision modeling is commonly used to assess the cost-utility of drugs or technologies. For a real-world application, models should include aspects of the disease relevant to the patient. In recent years, patient focus groups have been used to help define health utility values. METHODS: Hemophilia patients attending the National Hemophilia Foundation’s 61st Annual Meeting were invited to participate in a focus group to inform the development of a decision model, evaluating prophylaxis.