(QALYs) gained. Model probabilities were obtained from a systematic review involving international published trials. Comparators used in the assessment were lorazepam (6 mg/day); alprazolam (1.5 mg/day); venlafaxine (75 mg/day) and pregabalin (150-600 mg/day). Resource use and costs were obtained by a panel of Mexican experts through the Delphi technique and official institutional databases. Costs included patient and inpatient services, drug, procedures, etc. The model was validated according to international guidelines. One-way and probabilistic sensitivity analyses were performed and acceptability curves were constructed. RESULTS: Pregabalin had the highest percentage of patients with over 50% reduction on the HAM-A scale (64.7%) followed by venlafaxine (54.1%), lorazepam (40.8%) and alprazolam (38.2%). Regarding QALYs the highest results corresponded to pregabalin (0.1838QALYs); followed by venlafaxine (0.1787QALYs), alprazolam (0.1776QALYs) and lorazepam (0.1755QALYs). The 12-week expected mean costs per patient were US$1,061.52±531.1; US$1,532.6±548.3; US$1,582.2±573.0 and US$1,635.6±604.6 respectively following the last order above. The ICER for pregabalin vs. venlafaxine (baseline) was US$465.7 for HAM-A and US$26,075.7 for QALYs. Pregabalin dominated lorazepam and alprazolam (p = 0.05). First-order Monte Carlo sensitivity analyses showed results robustness and that pregabalin was the most cost-effective therapy using international thresholds. CONCLUSIONS: Pregabalin showed to be a cost-effective and cost-saving therapy in the management of Mexican patients with GAD.

COST-EFFECTIVENESS OF ESCITOLAPRAM VERSUS VENLAFAXINE IN SECOND-LINE TREATMENT OF MAJOR DEPRESSIVE DISORDER (MDD) IN SWEDEN

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OBJECTIVES: The present cost-effectiveness analyses compare escitalopram versus duloxetine in second-line treatment of major depressive disorder (MDD) in Sweden. Making on efficient second-line therapy choice. METHODS: A decision model was based on second-line MDD treatment patterns (6-month timeframe). Effectiveness outcomes were sustained remission (the Montgomery-Asberg Depression Rating Scale (MADRS) N27). Costs for antidepressant therapy, including medical, pharmaceutical and non-pharmaceutical costs, were obtained from Swedish Health and Medical Care Register (SHMCR). Utility estimates were based on deadheads and US panel survey. Unit costs were from standard sources. Due to unavailability of generic venlafaxine unit cost, it was assumed equal to that of escitalopram in Scenario 1 and 5% of the brand venlafaxine cost. RESULTS: Over 6 months, sustained remission rates were 36% for escitalopram and 38% for SNRs (18 difference, 95% Credibility Interval (CrI) 0.8% to 32.9%). The incremental QALY for escitalopram versus both comparators was 0.024 (95% CrI 0.006 to 0.042). For patient savings with escitalopram versus venlafaxine were $670 USD (95% CrI 6689 to 4841) in Scenario 1 and $563 USD (95% CrI 6588 to 4583) in Scenario 2. Versus duloxetine, savings were $615.95 USD ($670 to 4545). With willingness to pay 42,500 USD (equivalent to $350,000 SEK) per QALY, escitalopram was cost effective versus venlafaxine with probabilities 86% and 61.7% in Scenarios 1 and 2, respectively, and with 85.4% probability versus duloxetine. CONCLUSIONS: Escitalopram is cost-effective versus venlafaxine and duloxetine in second-line treatment of MDD in Sweden. The higher sustained remission rate and QALYs are associated with cost savings and support use of escitalopram following failure of first-line treatment.

THE COST BURDEN OF TREATMENT RESISTANCE IN PATIENTS WITH DEPRESSION

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OBJECTIVES: Many patients on antidepressants are not responsive to first-line therapy (‘treatment-resistant’ depression (TRD)) and can undergo switches and optimizations to discover a beneficial therapeutic regimen. While patients with more complex forms of TRD have higher costs than non-TRD patients, little is known about the cost effects for patients among a gradient of TRD classifications (from moderate to complex). METHODS: Patients aged 18-64 years in employer-sponsored plans with at least one continuous and official medical and prescription coverage and at least one antidepressant prescription were found in the 2000-2006 MarketScan Database (n = 78,476). An MGH TRD scale value (range from 0 to 165) was calculated for each patient and a value exceeding 3.5 indicated TRD. Twelve-month direct medical and prescription drug expenditures for patients with TRD (n = 22,593) was compared to expenditures among an equal number of propensity-score matched patients with non-TRD depression. Propensity scores were estimated via demographic characteristics and case-mix. Generalized linear models (gamma family and log link) controlled for demographics and case-mix factors. RESULTS: Average 12-month direct medical care and prescription drug expenditures were almost 40% higher for TRD ($9470 compared to matched non-TRD patients ($6813) (p < 0.01). A one-unit increase in TRD score was associated with a $772 increase in annual costs (p < 0.01). Compared with a matched group of non-TRD patients, annual costs for patients were higher in each MGH score category: 3.5-4.6%, 4.5-5.5%, 5.5-6.6%, 6.5% and 6.1% (p < 0.01). CONCLUSIONS: TRD is a costly disorder and merits consideration as interventions are developed to manage the burden of disease and improve productivity. Even patients with less complex forms of TRD have costs far in excess of those without TRD. Dichotomous definitions of TRD may not be adequate; a gradient from moderate to complex TRD may be more useful for providers and insurers.

INPATIENT COST OF SCHIZOPHRENIA TREATMENT IN TURKEY

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OBJECTIVES: Schizophrenia, influencing approximately 1% of the population, is a chronic psychiatric disease with a substantial health and economical burden for patients, care givers, and society. Despite this, however, its economic burden is often overlooked and/or not widely known in many countries. This study aims at estimation of cost of schizophrenia treatment in an inpatient facility in Turkey. METHODS: The study has been conducted in Manisa Mental Diseases Training and Research Hospital, one of the largest of its type in Turkey. Electronic hospital records of 4177 schizophrenia patients between June 2006 and June 2007 were retrospectively analyzed to calculate the total schizophrenia treatment cost per hospitalization where only direct costs were included. Cost items included in the analyses were antipsychotic and concomitant medication costs, adverse event treatment costs, bed and laboratory/ radiological examination costs. Average length of stay per hospitalization was calculated. The results were presented as daily and total costs. RESULTS: Costs for antipsychotic and concomitant medication costs, adverse event treatment, bed, and laboratory/radiological examinations were 31%, 2%, 1%, 40%, and 26% respectively. CONCLUSIONS: The share of drug costs may be relatively higher than they are in other countries due to relatively lower costs for non-drug cost items in Turkey. This may also stem from the case-mix in this hospital that may care more for severe cases needing tertiary care. This study may stimulate further studies which would help to generate a fuller picture of economic burden of schizophrenia in Turkey.

DIRECT COSTS OF PATIENTS WITH TREATMENT RESISTANT AND NON-TREATMENT RESISTANT MAJOR DEPRESSIVE DISORDER

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OBJECTIVES: Compare direct (medical and drug) costs between privately insured U.S. employees with major depressive disorder (MDD) who had treatment-resistant depression (TRD) and matched antidepressant-treated MDD controls without TRD. METHODS: Employees with >1 inpatient or >2 outpatient/other MDD diagnoses (ICD-9-CM: 296.2, 296.3) during 2004-2006, ages 18-64 years, were selected from a claims database. Employees who initiated a third antidepressant following 2 antidepressant treatments of adequate dose and duration were classified as TRD-likely (n = 2,534). The index date was the date of first antidepressant. Control group was an age and gender matched cohort of randomly chosen antidepressant-treated employees with MDD without TRD. All were required to have continuous health coverage during the 6-month pre-index (baseline) and 12-month post-index (study period). McNemar tests were used to compare baseline comorbidities. Wilcoxon signed-rank tests were used to compare annual patient direct costs from third party payer perspective during the study period. Mental health (MH) related costs were identified with claims with MH disorder diagnoses (ICD-9-CM: 290-319) or MH-related drug costs. RESULTS: TRD-likely employees with MDD were on average 49.2 years old and 60.7% were women. Compared with controls, TRD-likely employees had significantly higher rates of MH disorders, chronic pain, fibromyalgia, but few differences in comorbidities included in the Charlson Comorbidity Index. Average direct annual costs were significantly higher for TRD-likely employees ($10,136) compared with controls ($7,793), $2,339 difference, p < 0.0001. Average MH-related costs were higher among TRD-likely employees ($2,714) compared with controls ($1,256), < 0.0001; the MH-related cost difference of $1,458 accounted for 62% of the direct cost difference. MH-related cost differences were attributable to differences in drug 52.9% outpatient (929.3), inpatient (12.9%), costs. CONCLUSIONS: TRD-likely employees with MDD had higher all-cause and MH-related direct costs compared with matched MDD controls. Excess costs of TRD-likely patients are underestimated when looking only at MH-related costs.

DIRECT COSTS IN OLDER PATIENTS WITH DEPRESSION TREATED AND UNTREATED WITH ANTIDEPRESSANT THERAPY

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OBJECTIVES: Compare comorbidities profile and direct costs in older patients with depression treated or untreated with antidepressants and matched controls without depression. METHODS: Administrative claims from a multi-specialty medical group.