EVALUATING TRENDS IN CHRONIC PAIN PREVALENCE IN THE UNITED STATES

VETERANS HEALTH ADMINISTRATION POPULATION

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OBJECTIVES: The current study examined chronic pain prevalence in the U.S. Veterans Health Administration (VHA) population. METHODS: The study sample was based on the VHA Medical SAS Datasets from fiscal year 2008 through 2012. All veterans diagnosed with chronic pain throughout the study period were identified using International Classification of Diseases, 9th Revision, Clinical Modification diagnosis codes 338.2 and 338.4. The variation in the prevalence of chronic pain was assessed and categorized according to the pain scale. Pain score was determined using a scale ranging from 0 to 10 as reported by patients using the following categories: 1 to 4: mild, 5 to 6: moderate and ≥ 7: severe pain. To identify prior prevalence, the variation in the prevalence of chronic pain was estimated continuously throughout that fiscal period and at least 2 years prior. RESULTS: In 2008, patients aged 45-64 had the highest percentage of patients with mild (65.4 %), moderate (60.7 %) and severe (65.4 %) pain. This trend was found for all study years. In 2008, white patients had the highest prevalence of chronic pain (62.0 %) and severe (65.0 %) pain. Similarly, in 2008, patients who resided in the South U.S. region had the highest prevalence of mild (32.8 %), moderate (33.6 %) and severe (36.3 %) pain compared to other regions. This trend continued throughout all study years. Utah had the highest prevalence of chronic pain in 2008 (4.9 %) and 2012 (24.0 %). CONCLUSIONS: Among VHA beneficiaries with chronic pain, patients who were age 45-64 years had the highest prevalence of chronic pain. Also, white patients and those who resided in the South U.S. region had the highest prevalence of chronic pain.

USE OF HYDROCODONE/ACETAMINOPHEN: PREVALENCE AND ESTIMATING EMERGENCY DEPARTMENT VISITS

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OBJECTIVES: An estimated 100 million adult Americans suffer from chronic pain. Prescribing opioids remains a primary treatment option for physicians. Hydrocodone/acetaminophen (HC/APAP) is the most commonly prescribed opioid in the US. However, the FDA recently rescheduled HC/APAP from Schedule II to III due to negative outcomes, including its association with emergency department (ED) visits. The objective of this study was to estimate the impact of HC/APAP use in Texas on ED visits, based on the prevalence of HC/APAP prescriptions within the state. METHODS: A retrospective cohort design used data from the Drug Abuse Warning Network (DAWN) on ED visits associated with HC/APAP. Additionally, data from the Texas PDMP 2013 were used and longitudinally matched with the prescription claims from Schedule II to V opioid drugs dispensed within the state for a 12 month period in 2013. Data from the Texas PDMP contained 39,904,964 distinct prescriptions for all Schedule II to V opioid drugs dispensed within the state for a 12 month period in 2013. CONCLUSIONS: The use of HC/APAP requires more active monitoring in order to reduce the number of ED visits associated with its use. Future studies should investigate whether rescheduling HC/APAP leads to reduction of related ED visits.

MORTALITY RISK IN PATIENTS WITH PSORIASIS

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OBJECTIVES: This study examined mortality risk among patients with psoriasis in the United States. METHODS: MarketScan databases were linked to the Social Security Administration death file to select adults with ≥1 inpatient or ≥2 outpatient diagnoses of psoriasis (ICD-9-CM 696.1x) during the study period (7/1/2006 to 6/30/2014). The first psoriasis diagnosis was the index date. Patients had 6 months of pre index continuous enrollment and were followed until the earliest of death or end of the study period. Comorbidities during the pre-index period were examined. Mortality incidence was calculated for psoriasis patients by comorbidities and age group. A Cox proportional hazards model was used to predict identifiers of mortality risk. RESULTS: The sample comprised 102,573 psoriasis patients with mean age of 52.7 years (SD 14.8 years). Patients were followed for an average of 4.9 years and 3.4 % died during the study period. The mean age at death was 75.5 years. The mortality rate was 7.0 per 1,000 person-years (PY) and increased with age (0.8 per 1,000 PY in patients aged 18-24 years versus 45.5 per 1,000 PY in patients ≥ 75 years). The mortality rate was significantly higher for psoriasis patients with hypertension (12.6 vs. 4.8), coronary heart disease (24.9 vs. 5.4), cerebrovascular disease (31.9 vs. 6.2), and peripheral vascular disease (36.8 vs. 6.1) (p ≤ 0.05). Multivariate analytic suggested that older female gender (HR 1.4), Comorbid Index (CCI) score, and presence of comorbidities (diabetes, coronary heart disease, cerebrovascular disease, peripheral vascular disease, and malignancy) were associated with increased risk of mortality amongst psoriasis patients (HR ≥2). CONCLUSIONS: Among patients with psoriasis, the rate of mortality was 7.0 per 1,000 person-years. Diabetes, cardiovascular diseases, malignancy, female gender, older age, and increased CCI scores were associated with an elevated risk of mortality in this cohort of psoriasis patients.

SYSTEMIC DISORDERS/CONDITIONS – Cost Studies

BUDGET IMPACT ANALYSIS OF FACTOR REPLACEMENT THERAPY WITH TURTOCOG ALFA IN THE TREATMENT OF HEMOPHILIA A

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OBJECTIVES: This study aimed to determine the budget impact of adding turoctocog alfa (VIII:C Fc fusion protein [rFVIIIFc]) to a managed care organization (MCO) formulary for the treatment of hemophilia A. METHODS: A budget model was developed to evaluate factor replacement therapy costs, for patients with hemophilia A (without inhibitors), from the perspective of a US managed care plan. Key model inputs included benefit plan characteristics (e.g. number of pediatric and adult patients; mean weight), treatment characteristics (e.g. prophylaxis, on-demand, or perioperative treatment), and disease outcomes (e.g. bleed avoided, related hospitalizations, and related ED visits). The model compared treatment with turoctocog alfa versus marketed recombinant and plasma-derived FVIII alternatives. For children and adults, base case weight-based dosage and frequency for prophylaxis was assumed to follow respective product package insert. Market share was indexed at Year 1. All costs were based on estimated WAC drug costs (US dollars), and product information current as of January 15, 2015. RESULTS: For a hypothetical managed care plan with 1,000,000 members, the estimated number of hemophilia A patients was 39, based on US prevalence data. Assuming proportional adoption of turoctocog alfa from all branded rFVIII and plasma-derived FVIII, total annual treatment costs were $10,118,070 with turoctocog alfa, resulting in a budget impact of $5,076 or 0.00042 per member per month (PMPM). RESULTS: A model was developed in Microsoft® Excel® to evaluate the budget impact of including rFVIIIFc on formulary status. RESULTS: The model estimated that 1.4% of members would be treated on-demand, based on one-way sensitivity analyses. CONCLUSIONS: Inclusion of turoctocog alfa on a formulary provides a budget neutral treatment option, having a negligible budget impact on the annual pharmacy budget.