Abstracts

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OBJECTIVE: This study was designed to: 1) identify individuals with and without a claims diagnosis for depression who received new prescriptions for SSRI antidepressants, and 2) describe SSRI usage patterns in those with depression.

METHODS: This was a retrospective database claims analysis. Medical and pharmacy claims records of patients 18–64 years from 13 United Health–affiliated health plans were examined from 1/1/93 to 12/31/97. Patients had a 6-month SSRI-free period before the index SSRI prescription; their claims were examined in the 6 months after their index prescription. They were identified as having an ICD-9 claims diagnosis for depression or not. Results were adjusted using logistic regression.

RESULTS: Of 46,139 patients, 22,693 (49.1%) had a depression diagnosis, 6515 (14.1%) for major depression. A lower proportion of patients with major depression diagnoses (18.5%) achieved stable SSRI therapy (150+ days) than did those with all depression diagnoses (21%). However, a higher proportion of patients with major depression diagnoses had their therapy switched, augmented or titrated (34.8% versus 26.8%). Paroxetine users (OR = 0.53; 95% CI 0.44–0.64) and sertraline users (OR = 0.59; 95% CI 0.48–0.73) were less likely to achieve stable therapy relative to fluoxetine users. They were also less likely to have their SSRI therapy augmented (OR = 0.84; 95% CI 0.73–0.96 and OR = 0.84; 95% CI 0.72–0.99, respectively) but more likely to switch therapy (OR = 1.69; 95% CI 1.49–1.92 and OR = 1.32; 95% CI 1.14–1.52).

CONCLUSIONS: Approximately half the study subjects had no diagnosis for depression. Patients with major depression diagnoses received more alterations in therapy than those with all depression diagnoses. Fluoxetine treatment resulted in greater duration of therapy and less switching.

DEPRESSION IN POOR, YOUNG WOMEN: FLUOXETINE VERSUS SERTRALINE

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OBJECTIVE: To compare continuation rates of fluoxetine and sertraline for treatment of depression in poor, young women, a particularly high-risk subgroup.

METHODS: A cohort was identified using Ohio Medicaid claims data for 7/1/91 to 6/30/96. Patients were continuously enrolled 1 year prior until 1 year following index Rx. Included were females aged 25–44, diagnosis of depression <30 days prior to index Rx. Patients were excluded if they had other mood disorders, were disabled, were prescribed any antidepressant in the last year, or index Rx was prescribed by a mental health specialist. Prescriptions were for ≤30 days, without co-pays. Age, race-adjusted multivariate regression models (ordinary, logistic) were fit, stratified by depression type (single episode, recurrent). Outcome variables were: 1) short-term success, defined as filling three consecutive Rxs for the same drug, with the first two Rxs totaling ≥30 days at usual starting levels (20 mg fluoxetine, 50 mg sertraline), and 2) long-term success, measured as the number of prescriptions filled for the same drug in the following year, among those classified as short-term success.

RESULTS: Sample size was 333: 182 fluoxetine, 151 sertraline. Recurrent depression accounted for 44% of cases. Drug choice was similar for both depression types. Assuming 30-day Rxs, average daily dose was comparable to that found in surveillance studies. Multivariate models produced conflicting results for the two depression types. In single depression, sertraline had fewer short-term successes (OR = 0.496; 95% CI 0.272–0.901), with no statistically significant difference in long-term success. In recurrent depression, although there was no difference in short-term success, sertraline users filled 2.6 additional prescriptions in the coming year (p = 0.02).

CONCLUSION: Fluoxetine had better short-term continuation rates in single-episode depression, sertraline had better long-term continuation in recurrent depression.

PNE9 ANTIDEPRESSANT IMPACT ON SOCIAL FUNCTIONING: REBOXETINE VERSUS FLUOXETINE

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Depression has an impact on social functioning which may lead to a decrease in work productivity by affected individuals. Selective serotonin reuptake inhibitors (SSRIs) such as fluoxetine are commonly used to treat patients with this disorder. However, reboxetine, one of the first in the new class of non-tricyclic selective noradrenaline reuptake inhibitors (NRIs), may lead to improved social functioning due to noradrenaline’s effect on motivation.

OBJECTIVE: The purpose of this analysis was to evaluate the effect of reboxetine relative to fluoxetine in regard to social functioning, as measured by a validated 21-item self rating scale, the Social Adaptation Self Evaluation Scale (SASS).

METHODS: A model using longitudinal patient data from two 8-week clinical trials was developed using a mixed-model analysis of variance approach. Using data from 282 depressed patients, this model depicts the percentage change from baseline SASS score as a function of both time-invariant and time-varying covariates, confounding variables, and covariate interactions. Time-varying covariates include the percentage change from baseline Hamilton Depression scale score (HAM-D), and...
measures from the Clinical Global Impression scale. Additional variables include relevant demographic and disease characteristics.

RESULTS: Depressed patients treated with reboxetine have a greater increase in SASS score from baseline relative to those treated with fluoxetine. We found that this increased effect of reboxetine depends on both the patient’s clinical severity and measurement time. We also found a significant association between the percentage change from baseline HAM-D score and the percentage change from baseline SASS score.

CONCLUSIONS: Our results suggest that, after controlling for patient characteristics and measures of depressive severity, reboxetine is more effective than fluoxetine at increasing overall social functioning as measured by the SASS.

COST-BENEFIT ANALYSIS OF FLUOXETINE INCLUSION IN THE MEDI-CAL FORMULARY
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OBJECTIVE: The purpose of this study was to evaluate, from the perspective of California’s Medicaid program (Medi-Cal), the policy decision to include fluoxetine on its formulary. The analysis includes a review of the formulary adoption process, financial inducement, and data presented to the Medi-Cal program.

METHODS: The time horizon for this analysis extends from 1996 to 2004 (the date of formulary inclusion until patent expiration). Using 1994–1997 values as a baseline, calculation of the incremental Net Present Value involved projecting fluoxetine’s acquisition price, pharmacy dispensing fee, manufacturer’s rebate, treatment authorization costs, CPI for prescription drugs and medical care, number of eligibles enrolled in Medi-Cal fee-for-service, fee-for-service eligibles to be transferred into managed care, population projections, and cost of intention to treat with fluoxetine (which included treatment failures). The net savings in cost-of-care per patient of $3524 (1994 US dollars, p = 0.0024) was provided by previous research. The annual discount rate employed was 5.707%, the FY 1996–1997 rate for the Pooled Money Investment Account (the state’s general funding for Medi-Cal).

RESULTS: The model yielded a Net Present Value for fluoxetine formulary inclusion, which resulted in estimated savings to the State of between $1.025 and $1.760 billion over the 8-year time frame. The sensitivity analysis involved varying the projected number of fee-for-service eligibles to be transferred into contracted managed care.

CONCLUSION: The potential savings to be derived from the appropriate treatment of persons suffering from major depressive disorder are socially and economically significant. More emphasis should be placed on the appropriate pharmacotherapy of major depressive disorder, since the drug acquisition costs are minimal in comparison to the associated healthcare and indirect societal costs.

DIABETES MELLITUS AND OTHER CARDIOVASCULAR RISK FACTORS IN PATIENTS RECEIVING ANTIDEPRESSANT DRUGS
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Diabetes is a common risk factor for cardiovascular disease. Depression is associated with cardiovascular disease and may negatively impact overall management.

OBJECTIVE: The objective of this study was to document the presence of cardiovascular risk factors (diabetes mellitus, hypertension, and hyperlipidemia) and the pharmacotherapeutic management of these conditions in primary care patients receiving antidepressant medications.

METHODS: The electronic medical records (EMR) of primary care patients at an academic medical center were evaluated for the above clinical conditions and medications. Only patients prescribed an antidepressant drug within the previous 6 months were reviewed, in the order in which they were entered into the EMR system.

RESULTS: The electronic records of 115 patients receiving antidepressant drugs were reviewed by two physician researchers. Data for 88 (76.5%) female and 27 (23.5%) male patients were evaluated. The mean age for these patients was 46.5 years. Sixty-one (53.0%) patients were white, 38 (33.0%) were black. Twenty-one (18.3%) patients had diabetes, 56 (48.7%) had hypertension, and 14 (12.2%) had hyperlipidemia. Of special significance was that 20 of 21 (95.2%) patients with diabetes also had hypertension. In addition to cardiovascular risks, 13 (11.2%) had developed coronary artery disease with an additional 3 (2.6%) patients having had myocardial infarction. The mean number of prescriptions for 58 patients without diabetes and hypertension was 2.1 while the mean for 20 patients with diabetes and hypertension was 7.0.

CONCLUSIONS: The link between cardiovascular risk and antidepressant drug use seems to be strong. Clinicians should emphasize the management of cardiovascular risk factors in these patients.

DIRECT MEDICAL COST DIFFERENCES BETWEEN ALZHEIMER’S PATIENTS AND ELDERLY NON-ALZHEIMER’S PATIENTS IN A MANAGED CARE ORGANIZATION
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