performed to assess the association between CKD stages and HRU/costs. **RESULTS:** The study identified 23,492 T2DM patients (mean age: 60.7 years; no CKD: 54.9%; stage 1: 17.1%; stage 2: 12.7%; stage 3A: 15.9%; stage 3B: 7.5%; stage 4: 1.8%). Patients with more advanced CKD stages were associated with greater odds of hospitalization compared to those without CKD (odds ratio [95% confidence interval] [stage 1: 1.53 [1.13−2.07]; stage 2: 1.63 [1.63−2.07]; stage 3: 2.66 [2.16−3.28]) and ER visits (stage 3A: 1.25 [1.15−1.37]; stage 3B: 1.34 [1.19−1.51]; stage 4: 1.55 [1.25−1.92]). Patients with CKD stage 1, 2, 3A, 3B, and 4 had total costs of $1,18, 1,41, 1,54, 1,81, and $2,07, respectively. Of those who had more advanced stages of CKD in T2DM patients was associated with higher HRU and costs compared to those without CKD. Additionally, HRU and costs increased with more advanced stages of CKD. Prevention of CKD progression may help contain the economic burden.

**PD842**

**IMPACT OF DIABETES ON EXPENDITURES ASSOCIATED WITH SOFT SKIN AND TISSUE INFECTIONS**

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**OBJECTIVES:** To assess the impact of diabetes on direct medical expenditures for visits and prescribed medications related to skin and soft tissue infections (SSIs). **METHODS:** Hospital inpatient, outpatient, office, and emergency room visits and prescribed medications related to SSIs were identified from the 2010 and 2011 Medical Expenditure Panel Survey. Total SSSI costs per patient were calculated by summing overall costs of all SSSI medical events. Differences in mean and median SSSI costs between patients with and without diabetes were assessed with the Wisconsin-Mann-Whitney and median two-sample tests. **RESULTS:** We identified 1684 patients, 9% (154 patients, including 9% (128 patients) of patients with diabetes. Patients and their expenditures were identified 1684 SSTI events from 438 patients, including 93 (21%) having diabetes. Treatment groups 2010 and 2011 edition of Truven MarketScan Commercial. Patients were identified retrospectively using administrative health care insurance claims from the not related to diabetes. For patients in the same treatment cohort of the prior year using CSII. For both groups, the majority of the total treatment expenditures were (SSTIs).

**PDB45**

**CONTINUOUS GLUCOSE MONITORING SYSTEMS: TRENDS IN UPTAKE, PATIENT COSTS, AND RESOURCE UTILIZATION**

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**OBJECTIVES:** Wearable health monitoring devices have become increasingly available and allow for real-time tracking of clinical values. This research aims to assess the growth and trends related to CGM uptake in the past decade. **METHODS:** Total costs and resource utilization following their initial use. **RESULTS:** Adults aged 18-64 with a diagnosis for diabetes (ICD-9-CM 250.xx) and continuous enrollment in commercial insurance were identified from the Truven Health MarketScan Database. During the covered period (2008-2012). An initial procedure code for CGM (CPT 95250) at least one year after the initial diagnosis and the lack of a previous claim for CGM identified eligible subjects within each year from 2009-2011; the date of the qualifying CGM claim served as the index date. Costs and utilization for pharmacy, inpatient, emergency department, specialty, laboratory, and primary care services were compared between each annual cohort and between the year prior to and following the index date. **RESULTS:** From 2009 to 2011, the number of initial patients using CGM declined as patients aged 1,001 to 770 (p = 0.001) for 2009-2011. The total average costs to treat these patients increased between 2009 and 2010 before declining in 2011, mostly due to dramatic changes in costs related to outpatient pharmacy and inpatient services. Compared to those before the CGM was placed, mean costs of primary care visits and laboratory services tended to decrease while the average number of primary care visits consistently and significantly declined (all p < 0.05). However, noticeably higher mean costs related to outpatient pharmacy services were accrued following CGM use in both 2009 and 2010. **CONCLUSIONS:** Devices such as CGM may benefit ongoing patient care by providing more regular insight to treatment progression and, in some cases, lead to more efficient care.

**PD846**

**LIRAGLUTIDE: A PHARMACOECONOMIC REVIEW OF ITS USE IN TYPE II DIABETES**

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**OBJECTIVES:** As novel treatments for type ii diabetes enter the market, there is a need to assess their long-term clinical and economic outcomes compared to current treatments. These comparisons can assist decision-makers in determining the appropriate place in therapy. Our objective was to review the existing pharmacoeconomic literature evaluating the cost-effectiveness and overall costs of treatment associated with liraglutide in type ii diabetes. **METHODS:** We identified English-language cost-effectiveness, cost-utility or cost analyses that compared liraglutide to one or more anti-diabetic agents via MEDLINE and EMBASE through March 1, 2013. Full text articles meeting the inclusion criteria were retrieved and information on the study design and results were abstracted. Costs were converted to 2012 US dollars in order to facilitate comparisons across studies. **RESULTS:** A total of 3 cost comparison studies and 6 cost-utility studies were identified for inclusion. Across cost comparison studies, liraglutide treatment resulted in cost savings ranging from $1,075 to $1,298 (1.2 mg) and $1,62 to $2,147 (1.8 mg) over a 10 year time horizon. Cost-utility analysis results reported base case ICERs ranging from $55,740 to $76,832/QALY for liraglutide 1.2 mg and $68,132 to $86,970/QALY for liraglutide 1.8 mg. Estimates were most sensitive to variations in time horizon and cardiovascular complication rates. Based on often cited cost-utility thresholds, liraglutide treatment was determined to be cost-effective at 10 year time horizon. Stage 3B 58% (liraglutide 1.8 mg vs. sitagliptin 100 mg) and 93% (liraglutide 1.2 mg vs. glimepiride 4 mg). **CONCLUSIONS:** Liraglutide appears to be a cost-effective adjunct treatment for type ii diabetes and may also be associated with a reduction in diabetes-related complication costs; however, ICER values are largely dependent on the duration of liraglutide treatment benefit and the time horizon of the analysis.