Concurrent, p-ffypgqhdypdppdhld RA reaching catastrophic coverage (OR cancer osteoporosis (N 331,337), or rheumatoid arthritis (RA; N 5,712) medications. A comparison group with other chronic conditions (N 368,784) was matched to the study population by age, gender, geography, chronic disease score, and low-income subsidy (LIS) eligibility. Explanatory variables included plan type, coverage gap exposure, disease type, and demographic characteristics. RESULTS: Compared to patients with other chronic conditions (55%), patients with cancer (79%), RA (92%), or osteoporosis (58%) had higher odds of reaching the doughnut hole compared to patients with other chronic conditions (Odds Ratios (OR) = 19.3, 32.1, and 2.1, respectively, p < 0.01 for all). A similar pattern of increased odds was observed for reaching catastrophic coverage (OR cancer = 5.2, RA = 34.5, osteoporosis = 1.4, p = 0.01). Compared with standard prescription drug plan (PDP) enrollees, enhanced PDP enrollees were more (OR = 1.1, p < 0.01), Medicare Advantage enrolles were less (OR = 0.8, p = 0.01), and Retiree Drug Subsidy (RDS) beneficiaries were as well (OR = 0.99, p = 0.88) to reach the doughnut hole. Relative to enrollees without a coverage gap, beneficiaries with one were less likely to reach $4000 in spending (OR = 0.87, p = 0.01); but were more likely to reach catastrophic coverage (OR = 3.6, p < 0.01). CONCLUSIONS: Use of a drug plan, the variable of interest in this study with cancer and RA, and most beneficiaries with osteoporosis faced large out of pocket drug costs. For beneficiaries with these conditions, available prescription coverage may not provide adequate protection from severe financial strain.

RHEUMATOLOGIST INVOLVEMENT IN CARE OF PATIENTS WITH RHEUMATOID ARTHRITIS

Troed D1, Krielic C, Rosseblatt LC1
Bristol-Myers Squibb, Plainsboro, NJ, USA
OBJECTIVES: To determine physician specialties involved in rheumatoid arthritis (RA) diagnosis and follow-up care. METHODS: A retrospective analysis was performed using PharmsMétrix’s claims database. Patients newly diagnosed with RA (no RA diagnosis claim in prior 12 months) were identified from April 1, 2005, to June 30, 2006, and were followed for 1 year. Patients were required to have at least one additional RA diagnostic claim during the follow-up period and had to be continuously eligible 12 months before and after initial diagnosis date. Outcomes of interest were a) specialty of diagnosing physician b) percentage of patients receiving follow-up care by a rheumatologist versus other specialties. RESULTS: Of newly diagnosed RA patients (N = 136,633), 34% were diagnosed by a rheumatologist, 13% by general family medicine (GFP), 13% by internal medicine (IM), and 30% by other specialties (11% were unknown). Of those diagnosed by a rheumatologist, 94% continued receiving rheumatologist care. Of those diagnosed by a GP, 57% continued to receive care from GP and 13% received care from other specialty; of those diagnosed by IM, 65% continued to receive care from IM and 8% received care from other specialties. Approximately 26% of those diagnosed by GP or IM received follow-up care from a rheumatologist. Irrespective of diagnosing physician specialty, the majority of patients (52%) were not followed up by a rheumatologist. CONCLUSIONS: This study demonstrates that the majority of RA patients are not diagnosed or followed by a rheumatologist. Future studies need to assess whether confirmation of RA diagnosis and follow-up by a rheumatologist, who has extensive training and experience in autoimmune disease, has an impact on patient outcomes.

PHARMACY REFILL PATTERNS FOR SUBCUTANEOUS ANTI-TUMOR NECROSIS FACTOR AGENTS USED IN THE TREATMENT OF RHEUMATOID ARTHRITIS IN A MANAGED CARE SETTING

Carter C1, Jones J1, Changlikar A1, McKenzie RS1, Peich CT1
1Centocor Ortho Biotech Services, LLC, Hanover, PA, USA; 2SGOL, PharmaTech Solutions, LLC, Philadelphia, PA, USA
OBJECTIVES: To examine pharmacy refill patterns of etanercept (ETA) and adalimumab (ADA) in the treatment of rheumatoid arthritis (RA) in a managed care population. METHODS: Medical and pharmacy claims (January 1, 2010-December 31, 2006) from a large managed care database were evaluated. Claims for all patients aged 18 years and older with the following criteria were included: new diagnosis codes for RA, no pharmacy or medical history of any biologic use for 6 months prior to anti-TNF agent index date, anti-TNF agent index date occurring on or after the first RA diagnosis date, and ≥65 persistency days. Patients were excluded if they had a diagnosis of indolent lymphoproliths, psoriatic arthritis, psoriasis, Crohn’s disease, or ulcerative colitis at anytime. Refill patterns were examined by calculating the mean time (days) between each pharmacy refill using NDC codes (actual refill days) compared to the mean days supplied on the claims (recommended refill days). Results were reported for the first year following anti-TNF agent initiation. RESULTS: A total of 1239 RA patients newly starting an anti-TNF agent were included (ETA = 902, ADA = 337). ETA patients were slightly younger than ADA patients (ETA = 48.8 years, ADA = 49.2 years, p = 0.0001). There was no significant gender difference between the two groups (ETA = 77% female, ADA = 73% female, p = 0.29). Mean recommended days supplied were 32.2 days for ETA and 33 days for ADA. Mean days between initial ETA pharmacy refills were longer than recommended for 30% of the refill periods. Mean days between actual ADA pharmacy refills were longer than recommended for 28% of the refill periods. CONCLUSIONS: Approximately one-third of the actual pharmacy fills and ETA and ADA had a longer refill compared to the recommended days supply, which may indicate noncompliance.

FIBROMYALGIA: RUSSIAN RHEUMATOLOGISTS’ DISEASE MANAGEMENT

Kasimov E1, Le Lay K2, Soldatov D3, Taib C3
Rheumatology Institute-Russian Federation, Moscow, Russia; 2Pierre Fabre, Bologna, France; 3Pierre Fabre Laboratories, Moscow, Russia
OBJECTIVES: Fibromyalgia syndrome (FMS) is an under-diagnosed disorder, of unknown etiology, which affects over 5% of patients in general medical practice; to describe Russian rheumatologists’ disease management of fibromyalgia patients. METHODS: The questionnaire was sent to a random sample of Russian practitioners, who were answering the same questionnaire as that used by French practitioners in 2003. RESULTS: Seventy-seven of the practitioners claimed that they prescribed a medical treatment to their patients suffering from fibromyalgia: 40% prescribed antalgics, 40% prescribed tricyclic antidepressants, 29% serotoninergic anti-depressants, 30% hypnhetics/sedatives, 8% homeopathic treatments and a little over 1% morphine derivatives. 67% claimed that they prescribed extra treatments for their patients suffering from fibromyalgia: 23% prescribed antalgics, 20% prescribed tricyclic antidepressants, 17% serotoninergic antidepressants, 24% hypnhetics/sedatives, 9% homeopathic treatments and less than 1% morphine derivatives. 82.6% recommended or prescribed other treatments to their fibromyalgia patients, namely: 36% acupunctures, 56% physiotherapy, 14% hypnotherapy, 36% spa treatment, 3% osteopathy and 38% relaxation techniques. 91.8% of the doctors advised regular physical exercise such as swimming and walking (71.9% and 65.6% respectively), with cycling being the activity least often advised, by 12.9% of the doctors. CONCLUSIONS: Treatment for fibromyalgia must be multidisciplinary and multifactorial, its main objective being relieving the patient of their symptoms and allowing them to return to their professional and leisure activities – to which treatment of the condition by Russian practitioners is a testimony.