data covering the period between January 2000 and December 2005. The outcome variables captured cost of readmissions for a CVD-related condition following an index CVD-related admission. The covariate of interest was an indicator variable for a discharge AMA in the index hospitalization. The difference in the cost of readmissions (at 7-, 31-, 180-, and 365-day intervals) following formal discharges on charge was examined using Heckman sample selection models and log-linear models. The Heckman sample selection model was found to provide a better representation of the data generation process. RESULTS: The sample included 443,049 patients, of which 24,823 (5.6%) were readmitted to the same hospital. Approximately 1% of the patients who were readmitted to the hospital during the study period left AMA on the index admission while 0.87% of those who were not readmitted left AMA (< 0.001%). The cost of the first readmission within 180 days was 9% (p = 0.00) higher for patients discharged AMA on index admission compared to those who were discharged formally. The cost of all readmissions within 180 days and 365 days were 10% (p = 0.02) and 9% (p = 0.02) higher for patients discharged AMA on index admission compared to those who were discharged formally. CONCLUSIONS: A self-discharge AMA among patients admitted for CV events is associated with higher readmissions costs when readmissions occur within 6 months or 1 year.

PCV67 EXPLORATORY COST-CONSEQUENCE AND IMPACT: ANALYSIS OF SIROLIMUS-ELUTING STENT VS. ZOTAROLIMUS-ELUTING STENT FOCUSED ON THE RESTENOSIS AFTER DRUG-ELUTING STENT PLACEMENT UNDER THE PERSPECTIVE OF A BRAZILIAN PRIVATE PAYER
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OBJECTIVES: To identify the differences in the number of restenosis after the placement of sirolimus-eluting stent vs. zotarolimus-eluting stent and measure their related costs. METHODS: A literature review was conducted to identify meta-analyses of randomized clinical trials (RCT) that compared sirolimus-eluting (SES) and zotarolimus-eluting (ZES) stents. The clinical outcome of interest was angiographic restenosis after stent placement given that this is a surrogate endpoint that may predict late mortality. The results of the SORT OUT III trial with 2,333 patients were used which demonstrated that SES offered a lower rate of restenosis vs ZES (0.25% vs 1.25%) [HR: 4.62; 95 CI, 1.33-16.1, p = 0.02] (Lasen, 2009). The perspective is from a private payer in Brazil. Local guidelines for economic evaluation of health care technologies were followed (Vianna, 2007). A decision model was built in Excel. Resource usage was raise in a panel with hospitals and valued by micro-costing based on public sources (CBHPM 5th edition, PROAHS, Brasìndice and SIMPRO). Only direct costs and readmissions costs when readmissions occur within 6 months or 1 year. CONCLUSIONS: Based on our model SES patients had fewer cases of restenosis vs ZES (12 vs 38); Total cost for the SES group was 1.87% below the one found in the ZES group ($29,008 vs $28,559); CONCLUSIONS: Results suggest SES patients had a risk reduction of restenosis compared with ZES patients. Besides SES offer a 1.87% potential reduction in costs.

PCV68 COST-EFFECTIVENESS OF GENOTYPE-DRIVEN ANTIPLATELET THERAPY FOR SECONDARY PREVENTION AFTER ACUTE CORONARY SYNDROME
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OBJECTIVES: To assess cost-effectiveness of rosuvastatin 20 mg treatment in secondary prevention of major cardiovascular disease (CVD) events and mortality for patients with a previous CVD event. METHODS: A probabilistic Monte Carlo simulation model estimated long-term cost-effectiveness of rosuvastatin therapy (20 mg daily) for prevention of CVD mortality and morbidity in patients with a previous CVD event (60% men, age 61 years, mean Framingham score 25%). The relative risk reduction observed with rosuvastatin 20 mg in the JUPITER (Justification for the Use of Statins in Primary Prevention: an Intervention Trial Evaluating Rosuvastatin) trial was used in this secondary-prevention setting based on available literature indicating similar efficacy of statins in primary- and secondary-prevention settings. The quarterly event probabilities were used to construct survival curves for patients in both the treatment and placebo groups. The relative risk of rosuvastatin was estimated and extrapolated beyond the trial duration. The event rates were age adjusted beyond the trial duration. The difference in baseline risk between the JUPITER trial population and population of interest was adjusted using Framingham equation. Cost-effectiveness was assessed from a payer perspective using direct medical costs and a lifetime horizon. Life tables and CVD-attributable mortality risk estimates were derived from Mexican national statistics data. Results are presented as US dollars (exchange rate 1.00 US $ = 12.59 Colombian dollars). RESULTS: The model was run for a hypothetical cohort of 100,000 patients with pre-existing CVD and age 67 years, mean Framingham risk 15%). Estimated quality adjusted life years (QALYs) gained with rosuvastatin therapy compared with no treatment was 51,723 over lifetime and 1,957 over a 20-year horizon. Estimated lifetime, 11,680 events were avoided: 6,076 non-fatal MIs, 2,596 non-fatal strokes, and 3,729 CVD deaths. The estimated incremental cost-effectiveness ratio (ICER) for cost per QALY was $8,931 for a lifetime horizon. For a hypothetical cohort similar to the overall JUPITER population, the ICER was $11,764/QALY over lifetime. For a 20-year horizon, similar ICERs were estimated for the higher-risk ($11,327/QALY) and JUPITER patient populations ($16,279/QALY). CONCLUSIONS: In a higher-risk Mexican population with the mean Framingham risk of 15%, treatment with rosuvastatin 20 mg daily is a cost-effective treatment alternative if the willingness to pay per QALY is higher than $8291.

PCV69 COST-EFFECTIVENESS ANALYSIS OF THE USE OF ROSUVASTATIN IN SECONDARY PREVENTION PATIENTS IN THE UNITED STATES
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OBJECTIVES: To assess cost-effectiveness of rosuvastatin 20 mg treatment in secondary prevention of major cardiovascular disease (CVD) events and mortality for patients with a previous CVD event. METHODS: A probabilistic Monte Carlo simulation model estimated long-term cost-effectiveness of rosuvastatin therapy (20 mg daily) for prevention of CVD mortality and morbidity in patients with a previous CVD event (60% men, age 61 years, mean Framingham score 25%). The relative risk reduction observed with rosuvastatin 20 mg in the JUPITER (Justification for the Use of Statins in Primary Prevention: an Intervention Trial Evaluating Rosuvastatin) trial was used in this secondary-prevention setting based on available literature indicating similar efficacy of statins in primary- and secondary-prevention settings. The quarterly event probabilities were used to construct survival curves for patients in both the treatment and placebo groups. The relative risk of rosuvastatin was estimated and extrapolated beyond the trial duration. The event rates were age adjusted beyond the trial duration. The difference in baseline risk between the JUPITER trial population and population of interest was adjusted using Framingham score. A payer perspective was assessed with direct medical costs and up to a lifetime horizon. RESULTS: For a hypothetical cohort of 100,000 patients with a previous history of CVD and 25% Framingham risk score, estimated quality-adjusted life-years (QALYs) gained with rosuvastatin therapy compared with placebo was 54,319 over lifetime, and 39,252 and 15,341 over 20-year and 10-year horizons, respectively. Rosuvastatin 20 mg was associated with 14,737 events over lifetime, 3,627 non-fatal MIs, 3,367 non-fatal strokes, and 4,429 CVD deaths avoided. Rosuvastatin 20 mg dominated (more effective and less costly) over lifetime and 20-year time horizon. The incremental cost-effectiveness ratio for cost per QALY over 10 years was $18,649. CONCLUSIONS: Results indicate rosvastatin therapy to be cost-effective in secondary-prevention treatment of patients with a history of CVD events.

PCV70 COST-EFFECTIVENESS OF 123I-MIBG (ADREVIEW) IMAGING FOR PATIENT TREATMENT SELECTION IN THE PREVENTION OF SUDDEN CARDIAC DEATH
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OBJECTIVES: To evaluate the costs, benefits, and incremental cost-effectiveness of non-invasive imaging of cardiac sympathetic innervation using AdreView in patients...