OBJECTIVES: Anti-TNF-α drugs (Biologics) have become a cornerstone in the treatment of Rheumatoid Arthritis (RA). Since initial choice of agents is sometimes driven by expected treatment costs and related cost-effectiveness, we assessed the cost-effectiveness of Etanercept (ETA) and Infliximab (INF) based on published real-world data from the German Biologics Registry.

METHODS: We designed an excel-based cost-effectiveness model and calculated the costs per LUNDEX responder month. The LUNDEX score developed by Kristensen et al. (2006) is combining the proportion of patients fulfilling a selected response criterion (e.g. ACR 20) with the proportion of patients adhering to a therapy. Our model compares the costs per LUNDEX-responder over six months for the treatment with ETA and INF from a payer-perspective and calculates the cost per LUNDEX responder month. ACR 20 response rates (INF = 46%; ETA = 58%), adherence to therapy (INF = 77%, ETA = 82%) and real-world dosing data (INF = 4 mg/kg body weight, ETA = 47.5 mg/week) were derived from published registry data. Drugs cost were calculated based on list prices. Administration and lab costs were derived from official databases. RESULTS: from official databases.

Based on list prices. Administration and lab costs were derived from published registry data. Drug costs were calculated based on published real-world data from the German Biologics Registry.

CONCLUSION: ETA is more cost-effective than INF in a real-world setting in Germany. Our cost-effectiveness analysis supports decision making based on a combined measure of response and therapy adherence. Long-term data on both response and adherence are needed to further assess real-world cost-effectiveness of Biologics.

OBJECTIVES: To evaluate the impact of co-existing IMIDs on health care costs in RA patients. METHODS: A retrospective study utilizing administrative claims data from Blue Cross Blue Shield health plans was conducted. Patients initiating anti-TNF (infliximab, etanercept, or adalimumab) therapy between January 1, 2003 and June 30, 2005, were required to have >6 months of continuous eligibility prior to and >12 months following their index date. Two mutually exclusive groups were developed based on the number of IMIDs (RA, psoriatic arthritis, ankylosing spondylitis, psoriasis, Crohn’s disease, or ulcerative colitis) diagnoses: RA and RA plus >1 other IMID (RA + IMID). The Charlson-Deyo Comorbidity Index (CDCI) was used to control for overall illness burden. IMID-attributable and all-cause health care costs were compared between two groups. RESULTS: Of the 2409 patients, 1654 (68.7%) were diagnosed with RA and 755 (31.3%) with RA + IMID. Over two-thirds of the patients were female (70.5%) and the mean (SD) age was 48 ± 10 years. Although the RA group had a higher pre-period CDECI score (1.12 versus 0.71, p < 0.0001), during the 12-month post period, it had lower IMID-attributable costs ($15,146.83 versus $16,162.44; p = 0.5567), and all-cause health care costs ($21,412.68 versus $22,419.36; p = 0.2769) compared to the RA + IMID group. After adjusting for confounding variables (age, gender, and CDECI score) via multivariate analysis, there were significant differences (p < 0.05) between the IMID-attributable and all-cause costs of the groups. Also, compared to the RA + IMID group, the RA group had lower costs in each health service category: inpatient admissions, outpatient services, doctor visits, emergency room visits, and pharmacy costs. CONCLUSION: This study indicates that co-existing IMIDs increase health care costs in patients with RA. Anti-TNF therapy may be more cost-effective in the treatment of patients with more than one IMID. Additional analyses are needed to examine the effectiveness of anti-TNF therapies in patients with more than one IMID.

OBJECTIVES: The purpose of this study is to quantify the correlates and consequences of scenario rejection in a study of stated preferences for rheumatoid arthritis (RA) treatments. METHODS: An on-line panel of RA patients completed a stated-choice survey, that required respondents to choose among ten pairs of treatment alternatives with different treatment features and a current-treatment alternative. Subjects who refuse to correctly complete the tradeoff tasks in a stated-preference survey may reject the hypothetical-treatment scenarios in 3 ways: refuse to answer any of the trade-off questions, answer all the ques