statistical hypothesis was equivalence of clinical efficacy at the test of cure visit (Days 17–21) in the per-protocol populations. Study investigators who were blinded to the treatment group at the time of admission assessed AECB-related hospitalization events. RESULTS: Clinical cure rates for the per-protocol populations of TEL- and AMC-treated patients were similar and statistically equivalent (TEL, 86.1% [n = 115]; AMC, 82.1% [n = 112]). The number of AECB-related hospitalizations was 4 (2.5%) for TEL vs 7 (4.4%) for AMC patients, with a shorter total LOS for TEL vs AMC (28 vs 67 days, respectively).

The rate of hospital days per 100 patients was 17.5 for TEL vs 41.9 for AMC-treated patients. CONCLUSIONS: In this randomized, double-blind clinical trial, treatment with TEL and AMC provided similar rates of clinical efficacy. However, fewer hospital admissions and a reduced total LOS were observed for TEL-treated patients. This shorter LOS may equate to cost savings in the outpatient management of AECB.

**PIN3**

**EFFECTIVENESS OF HAART IN REDUCING VIRAL LOAD (VL) AMONG A LARGE COHORT OF HIV-INFECTED PATIENTS—A SIGNIFICANT UNMET NEED**

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OBJECTIVE: Highly Active Anti-Retroviral Therapy (HAART) has significantly reduced HIV-related morbidity and mortality. Bartlett J et al. recently reviewed its efficacy in a clinical trial setting. The overall percentage of patients with HIV RNA ≤400 copies/ml was 64% at 24 weeks, those with ≤50 copies/ml, 54%. However, real-world effectiveness data on viral control is lacking. Whether efficacious therapy can be translated into effective viral control in communities needs be evaluated. Our objective was to address this issue by examining viral control prevalence in a large HIV+ cohort. METHODS: The study population was derived from Cerner HIV Insight, a large national longitudinal database on US HIV+ subjects. Adult HAART (PI-HAART, NNRTI-HAART, NRTI-only-HAART) recipients during 1996–9/2002 were included. Subjects were followed until week 24 of HAART or switch. Baseline VL was measured ≤30 days prior to HAART initiation. Study outcomes were defined as percentages of patients reaching (a) VL ≤400 copies/ml, (b) VL ≤50 copies/ml, (c) CD4 ≥350/mm3, (d) a and c, and (e) b and c. Multivariate logistic regression models including demographics, regimen and baseline VL and CD4 count were constructed to identify significant predictors of these study outcomes. RESULTS: Analyses included 2776 subjects. Baseline characteristics were summarized (mean age 40, 88% male, 62% caucasian, 92% treatment naive, mean baseline VL 131,877, mean CD4 304). At week 24/switch, overall viral control was poor. For PI-HAART, the percentages of patients reaching outcomes (a)–(e) were 34, 30, 37, 18 and 16, respectively. For NNRTI-HAART: 33, 24, 53, 24 and 17, respectively. For NRTI-HAART: 20, 14, 42, 14 and 11, respectively. Multivariate analyses identified age, regimen, and baseline VL and CD4 count as significant predictors. CONCLUSIONS: Compared to clinical trial efficacy, real-world viral control rates are sub-optimal. More effective HIV therapy options appear to be needed to manage this unmet need and improve patient outcomes.

**PIN4**

**THE INFLUENCE OF PRESCRIPTION DRUG COVERAGE ON ANTIBIOTIC UTILIZATION IN ACUTE RESPIRATORY TRACT INFECTIONS: FINDINGS FROM THE MEDICAL EXPENDITURE PANEL SURVEY (MEPS)**

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OBJECTIVE: Recognizing the effect of prescription drug coverage on the patient’s ability to obtain prescription drugs is crucial and may play an important role in the health care decision making process due to the associated cost and the potential for misutilization. It is the objective of this study to provide specific information on the influence of prescription drug coverage on antibiotic utilization in acute respiratory tract infections (RTIs).

METHODS: A retrospective study of (N = 3181) prescriptions associated with acute upper and lower RTIs have been identified from the Household Component (HC) of the 1996 Medical Expenditure Panel Survey (MEPS). Cases selected included acute nasopharyngitis (common cold), acute sinusitis, acute pharyngitis, acute tonsillitis, acute laryngitis and tracheitis, acute upper RTIs of multiple or unspecified sites, and acute bronchitis and bronchiolitis. Antibiotic use and associated costs were determined by selecting oral antibiotics and the sum of payment associated with each prescription. Logistic regression was used to evaluate prescription drug coverage effect on prescribing an antibiotic and on the type of antibiotic prescribed. RESULTS: Antibiotics accounted for 45.93% of the prescription events for acute RTIs, of which 25.46% were for high cost antibiotics. When compared to patients with prescription drug coverage, patients with no drug coverage were less likely to receive a high cost antibiotic (OR: 0.499; 95% CI: 0.407–0.612), and they were also less likely to receive a high cost antibiotic (OR: 0.096; 95% CI: 0.059–0.157). CONCLUSIONS: The results of the study indicate that, in acute RTIs, the likelihood of being prescribed an antibiotic, that may be unnecessary, is greater when the patient has prescription drug coverage. Providers of such coverage should closely monitor prescribing patterns for acute RTIs to avoid unnecessary cost and consequently, resistance from such antibiotics.