PATIENTS: Analysis of 190 GP’s and 60 specialists. RESULTS: Escitalopram has a 30% (GP: 113 vs. 144 €/successful treated patient) more favourable cost-effectiveness ratio compared with Venlafaxin XR. Depending on the setting (GP/ Specialist) the incremental cost-effectiveness ratio is considered to be 6800–7400€. The lower costs in the GP’s model are due to referrals to specialists, since from the GP’s perspective no further costs occur. CONCLUSIONS: Escitalopram is a cost-effective alternative to Venlafaxin XR for the treatment of MDD in the German setting.

**PMH28**

**A COST-EFFECTIVENESS ANALYSIS OF ESCITALOPRAM AND SERTRALINE IN THE TREATMENT OF MAJOR DEPRESSIVE DISORDER**

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**OBJECTIVE:** To compare the cost-effectiveness of escitalopram and sertraline for the treatment of depression based upon a head-to-head clinical study and published literature. **METHODS:** A decision analytical model was created based upon data obtained from an eight-week clinical study evaluating escitalopram and sertraline for the treatment of major depressive disorder. The primary outcome of the clinical study was improvement in depressive symptoms as measured by the Montgomery-Asberg Depression Rating Scale. The model was constructed from a payer’s perspective with a six-month time horizon. The clinical trial allowed dose titration for sertraline in 50mg increments. The primary outcome for the model was cost per quality-adjusted life year (QALY). The decision analysis took into account the rate of adverse drug reactions by drug and dose. QALY estimates were assigned to various health states and included depression, adverse events, and treatment failure. Medication costs were obtained from an Internet pharmacy. Costs of adverse events and treatment failure were obtained from published studies. Estimated physician costs were obtained from US Medicare fee schedules. **RESULTS:** The estimated six-month cost was $952 for escitalopram and $1372 for sertraline. The estimated QALYS were 0.403 for escitalopram and 0.393 for sertraline. The cost/QALY for the two agents was $2362 and $3494, respectively. Threshold analyses were conducted to determine variables that influenced the results. The most important variable in the model was the cost of treatment failures. In the primary analysis, the cost of treatment failures was $8141. When this cost was reduced to $5000, the cost/QALY was $1993 and $2808 for escitalopram and sertraline, respectively. **CONCLUSIONS:** The results suggest that escitalopram had a lower cost and resulted in more QALYS. This difference was due mainly to a lower ADR rates for escitalopram and fewer titrations with escitalopram.

**PMH29**

**THE EFFECT OF Raising Three Tier Copayments ON SSRI COMPLIANCE RATES**

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**OBJECTIVES:** 1) To characterize design of drug benefits of SSRI antidepressants in health plans offered by employers in the United States; and 2) To determine the effect of raising copayments on compliance rates of SSRI antidepressants. **METHODS:** Data comprised benefit information and claims from Medstat’s MarketScan database for 2000–2003. Benefit information were compiled from approximately 135 different plans. Any patient who filled a prescription SSRI antidepressants in 2000 and was continuously enrolled through 2001 was identified. A difference in difference approach was used to examine the change in the days supplied and number of claims filled for an employer that raised their three tiered co-payments as compared to an employer that kept constant one tier copayment rates. **RESULTS:** Three tier copayment structures were increasingly common among employers. Most SSRIs fall in tier two although some of the newer SSRIs are commonly found in tier three. The average copayment for tier 1 increased from $5.40 to $7.40. The average copayment for tier 2 increased from $13.60 to $16.80. The average copayment for tier 3 increased from $25.40 to $31.20. When the study employer raised their co-payments by 50%, they experienced a 25% decline in the number of prescriptions per person filled (from 5.2 to 3.9 prescriptions) from 2000 to 2001, while the control employer demonstrated a 20% decline (from 6.0 to 4.8) in the number of prescriptions filled. Days supplied fell by 41.3 days or 24% in the employer that raised copayments and by 36.3 days or 17% in the control employer. **CONCLUSIONS:** Benefit structure and co-pays have trended towards 3-tier plans with increasing copayments. As such, increasing copayments may have a negative effect on compliance and possibly outcomes.