complete claims 180 days pre and 720 days post index. Biologic claim clean period was 180 days pre-index. SQ biologic users with repeat days supplies that were <7 or >90 days were excluded. Duration of action for infusion products was based on package inserts. Patients were censored after a gap of at least 90 days beyond the next expected re-fill interval. Results describe median time to discontinuation (Kaplan-Meier method) for each disease. Gli-squamous IV and SQ hazard ratios. Results: 1830 IV and 5934 SQ patients were identified. Diagnoses in the IV cohort included 29.9% IBD, 50.4% RA, 3.2% PsA and 15.6% any combination or non-specific diagnoses. For both the IV and SQ populations, the Cox model was adjusted for gender and age. Significance of differences across measures of interest between elderly and disabled groups were generally more likely to live; morbidity, health care utilization, and drug spending measures. Methods: Cross-sectional analysis comparing profiles of disabled (n=90,894) and elderly (n=126,752) fee-for-service beneficiaries with continuous 12-month dual-eligibility, or until alive in the 2007-2009 period. A Cox model was assigned to the intervention condition were analyzed daily for intervention opportunities based on a complex set of rules. The rules identify members who may benefit from one or more of 14 potential therapy adjustments including drug-drug and drug-condition interactions, dose optimization, appropriateness of therapy, high-risk medication in the elderly, and generic interchange. Once identified, Catamaran contacted prescribers via fax to recommend therapy adjustments. Verification of therapy changes were determined through claims reviews and prescriber feedback. Only therapy changes that were strongly recommended by the clinician were approved by the pharmacist for treatment or control. Results show that 28% of the clinical recommendations were adopted resulting in a reduction in pharmacy spend of $72,747 and a reduction in medical spend of $1 million. Conclusions: Catamaran’s medication review programs show significant medical and pharmacy cost savings while improving population health through appropriate management of prescription drugs. These programs are intended to help members avoid inappropriate or potentially dangerous medications, improve care quality, optimize medication therapy, and lower medical costs. Moreover, we demonstrate that a collaborative approach to evaluating a proposed vendor solution resulted in a cost effective RCT that offers maximum benefit to members and the health plan.

**REFERENCES**


**APPENDIX**

**A16 VALUE IN HEALTH 17 (2014) A1-A295**

**Table 1**

<table>
<thead>
<tr>
<th>Dual-eligibles (n=65)</th>
<th>Elderly (n=65)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-64 years</td>
<td>65 years and older</td>
</tr>
<tr>
<td>Female</td>
<td>65 years and older</td>
</tr>
<tr>
<td>Male</td>
<td>65 years and older</td>
</tr>
<tr>
<td>Age</td>
<td>65 years and older</td>
</tr>
<tr>
<td>Income</td>
<td>65 years and older</td>
</tr>
</tbody>
</table>

**Table 2**

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Cost of generic drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>$17.89 (95% CI $16.91-$18.87)</td>
</tr>
<tr>
<td>B</td>
<td>$23.0 billion in 2010 to $18.7 billion in 2012 (14.9% decrease)</td>
</tr>
<tr>
<td>C</td>
<td>$253.95 (95% CI $218.07-$285.73)</td>
</tr>
</tbody>
</table>
| D                     | $24.0 to $4.38±$2.58 for brands. We found no statistically significant differences across measures of interest between elderly and disabled groups.

**RESULTS**

Elderly duals were more likely to be female and suffer from chronic conditions such as diabetes, hypertension, and obesity. There were significant differences in demographic, morbidity, health care utilization, and drug spending measures across the elderly vs. disabled duals. Recognizing the differences between sub-populations of dual eligibles is critically important and a "one size fits all" approach may unintentionally create hardships and be detrimental to beneficiaries.

**REFERENCES**

HP43
PHARMACEUTICALS OF PRESCRIPTION MEDICATION USE NOT CAPTURED BY PRESCRIPTION CLAIMS DATABASES
Electricity B, Carroll NN
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OBJECTIVES: Prescription claims databases are commonly used for identifying patients for disease management programs, studying health outcomes and reporting on quality measures. A shortcoming of claims databases for these purposes is that they include only prescriptions that are adjudicated through insurance claims plans. Growth in the use of cash discount generic programs and the frequent use of drug samples suggests that an increasing number of prescriptions dispensed to insured consumers may not be captured on claims databases. We examined the extent to which prescription claims databases do not provide complete service. The uninsured patients’ prescription drug use. METHODS: We used the 2009 Medical Expenditure Panel Survey (MEPS) database. We included participants who purchased at least one prescription drug (e.g., over-the-counter medications). We calculated the proportion of patients that had prescription drug insurance for the MEPS sample. We estimated the percentage of patients that had prescription drug coverage; we compared the number of prescriptions filled by cash, of which 42.5% used at least one potential discount generic program, with the number of prescriptions filled by insurance. RESULTS: Among the uninsured patients, 11.6% of insured consumers received at least one sample medication, 68.0% paid for at least one of their prescribed medications by cash, of which 42.5% used at least one potential discount generic program. Our results indicate that drug samples do not contribute substantially to the problem of missing prescription data on claims databases. On the other hand, substantial number of prescriptions, paid for by cash only, and/or discount generics. We measured the numbers of prescriptions in each of these categories and the numbers of consumers who had at least one prescription in each category. We report descriptive statistics. RESULTS: A total of 75.1% of the U.S. non-institutionalized civilian population was insured for prescription drugs. Of the total number of prescriptions dispensed to insured consumers, at least 88% were drug samples and discounts. 33.9% were paid for by cash only, and 18.6% were payments for cash discount generics. Additionally, 11.6% of insured consumers received at least one sample medication, 68.0% paid for at least one of their prescribed medications by cash, of which 42.5% used at least one potential discount generic program. Our results indicate that drug samples do not contribute substantially to the problem of missing prescription data on claims databases. On the other hand, substantial number of prescriptions, paid for by cash only, and/or discount generics, may be missing from these databases.

HP44
IMPACT OF DRUG REIMBURSEMENT MODALITIES ON TREATMENT ADHERENCE IN PATIENTS COVERED BY PRIVATE DRUG INSURANCE
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OBJECTIVES: To compare adherence to prescribed medications between patients with and those with immediate reimbursement at the point of service among Quebecers (Canada) with private drug insurance. METHODS: A retrospective cohort was constructed by selecting patients aged 18-64 years with private drug insurance from the reMed database between March 2008 and December 2012. An algorithm was developed to assess the patient’s reimbursement modality, i.e. the drug cost covered by the insurance company is reimbursed immediately at the point of service (immediate reimbursement) or at a later time (differed reimbursement). Adherence was measured with the proportion of days covered (PDC) over one point of service (immediate reimbursement) or at a later time (differed reimbursement). RESULTS: The immediate cohort included 6,494 patients with immediate and 1,950 patients with differed reimbursement. The results of the linear regression analyses estimated a 1 point of service (immediate reimbursement) or at a later time (differed reimbursement) and 85% were past or non-smokers. The mean PDC was 79.9 % for patients with immediate reimbursement in the EU5, the FD and the ITA after EMA approval. The reimbursement decision for non-oncology drugs was quantified the extent to which insured patients used drug samples, drugs paid for by cash only, and/or discount generics. We measured the numbers of prescriptions in each of these categories and the numbers of consumers who had at least one prescription in each category. We report descriptive statistics. RESULTS: A total of 75.1% of the U.S. non-institutionalized civilian population was insured for prescription drugs. Of the total number of prescriptions dispensed to insured consumers, at least 88% were drug samples and discounts. 33.9% were paid for by cash only, and 18.6% were payments for cash discount generics. Additionally, 11.6% of insured consumers received at least one sample medication, 68.0% paid for at least one of their prescribed medications by cash, of which 42.5% used at least one potential discount generic program. Our results indicate that drug samples do not contribute substantially to the problem of missing prescription data on claims databases. On the other hand, substantial number of prescriptions, paid for by cash only, and/or discount generics, may be missing from these databases.

HP45
DIFERENCE BETWEEN UNITED STATES AND EU AUTHORISATION TIMELINES AND TIME TO REIMBURSEMENT IN THE EUS
Sut D, Beckerman R
CPhA, New York, NY, USA
OBJECTIVES: The purpose of this study was to estimate the time difference between the FDA and EMA approvals, as well as time to reimbursement in the UK, GER, FRA, ESP and ITA after EMA approval. METHODS: 32 high-cost drugs that were approved by both the FDA and EMA in 2011-2013 were assessed. The third line of the sample were oncology drugs; the remaining one third included drugs treating other specialty diseases. Out of 32 drugs, 17 have obtained reimbursement from all EUS countries. Time to reimbursement was defined as the date of publication of SIMC guidelines in SCT, NICE Final Appraisal Determination in ENG, CT decision in FRA, G-BA decision in GER, AIFA decision in ITA and AEMPS decision in ESP. RESULTS: The time difference between the FDA and EMA approval intervals was 5.9 months (standard deviation = 5.2 months), similar to the median USA-EU approval interval (6 months). The average time to reimbursement after EMA approval varies from 211 days in SCT (SD 79.5 days) to 336 days in ESP (SD 203 days). On average, the proportion of drugs in different reimbursement intervals was sufficiently long as long as for non-oncology drugs (7.0 vs. 3.8 months), but there was minimal difference in time to reimbursement for oncology versus non-oncology drugs in the EUS, except in ESP where the reimbursement decision for non-oncology drugs was 112 days faster than for oncology drugs. CONCLUSIONS: There is still a long gap (5.9 months) between an innovative product’s FDA and EMA approval. Average time to reimbursement in the EU5 after the EMA approval ranges from 7.0-11.2 months. Pharmaceutical companies need to plan ahead and submit the application dossier as early as possible to achieve faster access, especially for oncology products. Early access programmes, such as ATU in FRA and Cinn in ITA, may also be considered in certain countries.

HP46
SOCIODEMOGRAPHIC AND HEALTH DETERMINANTS ASSOCIATED WITH THE USE OF THE AMBULATORY AND HOSPITAL CARE SERVICES WITHIN THE MEXICAN POPULATION
Mor-González AG, Pérez-Reynaud AG, Coello-Reyes LA, Rodríguez-Díaz Fonce MA
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OBJECTIVES: Health care utilization is likely to be conditioned to socioeconomic factors. The aim of this study is to identify the impact of these determinants, as well as the health perceptions of the people, in the use of ambulatory and hospital care services in the Mexican population. METHODS: Data from the National Health Survey 2012 was used to identify social, economic and health perception variables among users of the ambulatory and hospital care services. Statistical analysis was performed to understand the differences in the use of these services in relation to socio-economic and demographic factors. RESULTS: We identified significant determinants that explain the decision and the frequency of health care utilization in the Mexican population.

HP47
RAJASTHAN’S UNIVERSAL HEALTH CARE PLAN WITH FREE DISTRIBUTION OF QUALITY MEDICINES THROUGH COST MINIMIZATION
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OBJECTIVES: Public expenditure on health on India is around 1% of GDP and 79% expenditure in health of people is through out-of-pocket. Almost 30% of the households slide into poverty due to high treatment costs and medicines. Though, India is considered as pharmacy for developing countries, yet due to poor regulatory control there is huge price variation in off-patent branded generics, even 50 times or more and leaving affordability at the mercy of prescribers/dispensers. The Government of Rajasthan (a federal State in India with population about 47 million) has launched a scheme called Chief Minister’s Free Drug Distribution Scheme (CMFDSS) for providing free essential medicines to all irrespective of their economic status, by establishing an autonomous Rajasthan Medical Services Corporation (RMSC). By well-defined transparent prequalification measures for products and suppliers, RMSC procures quality medicines through cost-mitimization. Educational, managerial and regulatory strategies have been used to ensure complete compliance with the prequalification and post-supply verification measures. RESULTS: Quality essential medicines are procured at unbelievable cost less compared to market retail prices, e.g. procurement cost / market retail prices for strip of 10 tablets of DICLOFENAC 50 mg., ATORVASTATIN 10 mg, GLEPIMIRE 2 mg, and CLIOPROP 75 mg are INR 1.24/31.73, 2.98/103.74, 1.95/125.00 and 8.54/147.44 respectively (1 USD=INR 63) resulting an increase in access and equity with monthly patient inflow increased from 44,000 to 66,000,000 and decreasing the pocket expenditure, as amount spent on medicines in 2 years is around INR 5,070,000,000 whereas market price of these medicines would be INR 30,000,000,000. CONCLUSIONS: Essential medicines are not costly but are being made expensive. By utilizing the pricing information of quality medicines along with transparent pooled procurement and proper distribution system can make free access to medicines, especially under-served population with a strong political commitment coupled with the proper strategies in low resource settings.

HP48
WORLDWIDE CLINICAL EVIDENCE DEVELOPMENT: AN ANALYSIS OF RELEVANT INTERNATIONAL MODELS FOR THE POTENTIAL IMPLEMENTATION OF SUCH A PROGRAM IN QUEBEC
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Université de Montréal, Montreal, QC, Canada, 1Montreal InVivo, Montreal, QC, Canada
OBJECTIVES: There is a growing need for the development of real-world clinical evidences, particularly in the field of health technology assessments. The objective of this study is to identify and describe the key elements for the implementation of a program aiming to develop real-world clinical evidences in Quebec. METHODS: A literature review was conducted to analyze the position, progress and development of strategies focusing risk management and development of real-world clinical evidences and uses of evidences. A review of relevant literature was also performed using electronic databases including PubMed, Medline and Embase. Additional guidelines and government policies were retrieved using Google and Google Scholar. The following keywords were used for search, alone or in combination: risk-sharing and product listing agreements, coverage with evidence development.