mendations reduced 57% the probability of uncontrolled blood pressure. Having uncontrolled blood pressure at the baseline stage increased the probability of lack of control in 166%, and per each unit of increase in body mass index the lack of control increased 7%. **CONCLUSIONS:** CME intervention improved the medical decision-making process to manage hypertension, thus increasing the probability of hypertensive patients to have blood pressure under control.

PCV85

TREATMENT FOR DEPRESSION IN WOMEN WITH HYPERTENSION

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OBJECTIVES: The objective of the study was to examine rates of depression treatment and variations in depression treatment by demographic, socioeconomic, access to care, health status, and life-style characteristics among women with hypertension. **METHODS:** The study design was cross-sectional, using data on from 2006 and 2007 Medical Expenditure Panel Survey (MEPS), large-scale surveys of families and individuals to provide nationally representative estimates of health care use and expenditures. The study included 1304 women aged 22 and older with hypertension and depression, identified from MEPS medical condition files. Antidepressants were identified from prescription drug reports and psychotherapy was identified from outpatient visits files. Depression treatment patterns by demographic, socioeconomic, healthcare access and health status were analyzed using chi-square tests, logistic regression and multinomial logistic regressions. All analysis accounted for the complex design of the MEPS using SAS 9.2. **RESULTS:** In our study sample, 23.9% had no depression treatment, 56.8% had antidepressant use only, and 19.3% had psychotherapy with or without antidepressants. Among women with hypertension and depression, African Americans (AOR = 0.47), Latina (AOR = 0.46), and uninsured (AOR = 0.39) were significantly less likely to report any treatment for depression compared to Whites and those with private insurance. Compared to no treatment, psychotherapy with or without antidepressants was less likely among those with less than high school education and more likely among women reporting fair/poor mental health. **CONCLUSIONS:** Nearly one-quarter of women with hypertension did not have treatment for depression. Disparities in depression treatment by race/ethnicity, health insurance, and education status were noted. Further studies need to explore reasons for not receiving depression treatment and whether such lack of treatment for depression is associated with poor health outcomes in these women.

PCV86

INSURANCE STATUS AND THE USE OF ANGIOTENSIN II RECEPTOR BLOCKERS (ARBS) AND ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS AMONG POST-MYOCARDIAL INFARCTION (MI) PATIENTS

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OBJECTIVES: To evaluate the effect of insurance status on the use of ARBs and ACE inhibitors among post-Myocardial Infarction (MI) patients. **METHODS:** The 2007 full-year consolidated data from the Medical Expenditure Panel Survey (MEPS), nationally representative survey, was used and linked with the prescribed medicine data. A cross-sectional survey data analysis was performed to evaluate the use of ARBs and ACE inhibitors in patients diagnosed with Myocardial Infarction (MI) and its relationship with patients' insurance status. The outcome measures included the binary variables of ACE inhibitor and ARB usage. A total of 464 post-MI patients were included in the analyses by conducting multivariate logistic regression, controlling for socio-economic and demographic variables. **RESULTS:** Out of 464 patients with MI, 67 (14.44%) used only ARBs, 244 (52.59%) used only ACE inhibitors, 15 (3.23%) used both drugs, and 138 (29.74%) used neither ARBs nor ACE inhibitors. Patients with Medicare coverage only and patients without insurance were less likely to use ARBs, compared to patients with private insurance (adjusted OR 0.26, p=0.018; adjusted OR 0.03, p=0.064, respectively). There was no significant difference between health insurance status and use of ACE inhibitors. Furthermore, health insurance status was not significantly different among patients who used neither ARBs nor ACE inhibitors. Among MI patients who used both ARBs and ACE inhibitors, patients with Medicare coverage only were less likely to use both drugs (adjusted OR 0.02, p=0.001), relative to patients with private insurance. Additionally, patients with educational attainment of higher than college degrees were more likely to use both drugs than those who did not finish college degrees (adjusted OR 19.61, p=0.042). **CONCLUSIONS:** Health insurance significantly affected the usage of more expensive ARBs but not less expensive ACE inhibitors. Policy makers need to be aware of the moral hazard arising from the insurance coverage in drug use.

PCV87

FACTORS ASSOCIATED WITH SELECTIONS OF STATINS AMONG ELDERLY PATIENTS

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OBJECTIVES: To assess demographic and clinical factors associated with statin selection among elderly patients. **METHODS:** A retrospective cohort study was conducted to examine predictors of statin selection among patients aged ³65 years, who initiated pravastatin (PS) vs. simvastatin (SS), atorvastatin (AS), or rosuvastatin (RS) between 1/1/2007 and 12/31/2007. Index statin use was defined as the first statin claim following at least 90 days of no statin access. Multiple logistic regression models were employed to assess predictive factors of PS initiation versus other statin initiations. **RESULTS:** Of 96,450 statin users identified, there were 8,165 PS initiators, 38,099 AS initiators, 11,320 RS initiators, and 38,866 SS initiators. Compared to other statin users, a higher percentage of PS initiators were aged75-85 (PS: 42.3%, SS: 41.0%, AS: 41.1%, RS: 38.0%, P<0.01) and more likely to be female (PS: 56.6%, SS: 51.3%, AS: 51.5%, RS: 55.7%, P<0.01). PS initiators were more likely to have atrial fibrillation (PS: 10.0%, SS: 9.4%, AS: 9.6%, RS: 8.6%, P<0.01) and take warfarin (PS: 11.7%, SS: 9.8%, AS: 10.4%, RS: 9.9%, P<0.01) and triazoles (PS: 3.1%, SS: 2.4%, AS: 2.6%, RS: 2.8%, P<0.01) in the baseline period. A higher percentage of PS initiators took more than 3 unique medications 90-day prior to the index date (PS: 85.4%, SS: 81.8%, AS: 83.0%, RS: 83.9%, P<0.01). After controlling for demographic and clinical characteristics, use of warfarin was associated with initiating PS compared with SS, AS, and RS. Other predictors of PS initiation included prior history of atrial fibrillation, HIV infection and use of calcium channel blockers, ezetimibe, and fenofibrates over the 1-year pre-index period compared with AS and SS. **CONCLUSIONS:** Patient profiles were different among PS users compared to other statin users. Selected comorbidities and prior use of certain medications were significant predictors of PS initiation among a cohort of Medicare patients.

PCV88

PATTERNS OF STATIN PRESCRIPTION AMONG PRIVATELY INSURED COMMERCIAL AND MEDICARE PATIENTS

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OBJECTIVES: In 2008, there were currently 6 statins available in the U.S. market and more than 193 million statin prescriptions were written. We sought to examine the patterns of statin use among privately insured commercial and Medicare patients in the U.S. **METHODS:** A retrospective analysis was performed using MarketScan Commercial and Medicare data from Jan. 2008 to Dec. 2008. Two cohorts were created: 1) the commercial cohort (CC) and 2) the Medicare cohort (MC). Statin scripts of minimum 30 day supply were extracted from the pharmacy claims data and individual demographic and clinical information were linked from their medical and administrative records. Prescription patterns were examined and analyses by age and gender were performed. **RESULTS:** There were 18 million and 9.8 million statin prescriptions filled by the CC and MC, respectively. In both cohorts, simvastatin accounted for the largest share of statin prescriptions (MC: 44.1%; CC: 44.0%), followed by atorvastatin (MC: 31.6%; CC: 31.1%), rosuvastatin (MC: 7.8%; CC: 11.2%), pravastatin (MC: 8.1%; CC: 6.5%), lovastatin (MC: 7.4%; CC: 6.6%) and fluvastatin (MC: 0.9%; CC: 0.6%). The majority of statin prescriptions were for generics (MC: 59.6%; CC: 57.1%).The average annual number of statin prescription per user was 9.3 for the MC and 7.6 for the CC. In the CC, 58.1% of prescriptions were filled by male, while 50.4% of prescriptions were filled by male in the MC. Diabetic patients accounted for 35.2% of prescriptions in the MC, and 26.8% in the CC. Milligram dosing distributions (mean; median; mode) were for simvastatin (MC:32.1; 20;20 CC:32.9;20;40); atorvastatin (MC:24.3;20;10 CC:24.7;20;10); rosuvastatin (MC: 12.7; 10;10 CC:13.1;10;10); and pravastatin (MC:37.6;40;40 CC:38.2;40;40). **CONCLUSIONS:** This analysis suggests different statin use patterns by age, gender, and insurance. Most frequently dispensed doses were 20 mg for simvastatin, 10 mg for atorvastatin and rosuvastatin, and 40 mg for pravastatin.

PCV89

COMPARISON OF DOSING PATTERNS AMONG PATIENTS INITIATING STATIN THERAPY IN A MANAGED CARE POPULATION

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OBJECTIVES: To compare dosing patterns among patients in whom atorvastatin (AS), simvastatin (SS), rosuvastatin (RS), or pravastatin (PS) was newly prescribed. **METHODS:** Using a large US managed care database, study patients aged ≥18 who were newly prescribed AS, SS, RS, or PS between 10/01/2006-09/30/2007 were identified with a minimum 12 months pre- and 24 months post-index health plan eligibility. A 6-month washout period free of use of any statin was applied to identify patients in whom statin therapy was newly prescribed. The index date was defined as the date of the first prescription fill for statins and 4 cohorts were created based on index statins: AS, SS, RS, or PS. Patients were followed up to 24 months after the index date, and the average daily dose for 12 prescriptions per person, average/median daily dose in each of the first 12 prescriptions, and the average daily statin costs were compared among 4 cohorts. **RESULTS:** A total of 142,692 patients were identified, comprised of 47,972 AS patients, 21,475 RS patients, 62,954 SS patients, and 10,291 PS patients. The average daily doses of all prescriptions were 21.3mg for AS patients, 10.2mg for RS patients, 29.2mg for SS patients, and 34.6mg for PS patients. The average/median daily dose for the 1st and 12th prescriptions were 20.8mg/20mg and 21.2mg/20mg for AS patients, 10.0mg/10mg and 10.5mg/10mg for RS patients, 28.4mg/20mg and 28.7mg/20mg for SS patients, and 32.8mg/40mg and 35.9mg/40mg for PS patients. The average daily statin costs for the 1st and 12th prescriptions were $2.9 and $3.2 for AS patients, $2.7 and $3.1 for RS patients, $1.5 and $0.8 for SS patients, and $1.4 and $0.9 for PS patients. **CONCLUSIONS:** Patients initiating AS, RS, SS, and PS experienced little escalation of their statin daily dosing over the 24-month follow-up period.

PCV90

FACTORS ASSOCIATED WITH SELECTIONS OF STATINS AMONG PATIENTS IN A LARGE EMPLOYER-BASED CLAIMS DATABASE

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