than 15 days in medication coverage. Three statistical models corresponding to the three measures of medication refill persistence were performed: Tobit model, logistic regression, and survival analysis. Control variables included demographic and social economic information, health status, medication conditions, health service utilization, and drug benefit characteristics.

RESULTS: The study included 1549 members, 42.0% female, mean age 55.7 years, with member cost-sharing of about $12 per 30 days supply. For every $1 increase in 30 day average cost-sharing, total gap increased by 2.7% (transferred Tobit coefficient = 0.027, 95% CI = [0.011, 0.043], p = 0.001); the odds of non-persistence (PDC < 80%) increased by 2.5% (OR = 1.025, 95% CI = [1.007, 1.042], p = 0.005); and the risk to have a gap of more than 15 days increased by 1.7% (HR = 1.017, 95% CI = [1.007, 1.027], p = 0.001). CONCLUSION: Prescription cost-sharing was associated with a significant and negative impact on medication refill persistence after controlling for other confounders. It is important for health plans and self insured employers to consider the implications of member contribution on medication refill persistence when making pharmacy benefit design decisions.

LONG-TERM HEALTH OUTCOMES FOR PATIENTS HOSPITALIZED WITH UNSTABLE ANGINA AND NSTEMI IN THE CALIFORNIA MEDICAID POPULATION: ASSESSMENT OF CLOPIDOGREL THERAPY IN ACS

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OBJECTIVES: To evaluate the long-term health outcomes of ACS patients taking clopidogrel and aspirin, either alone or in combination, within the California Medicaid population.

METHODS: A retrospective claims study was conducted for the 10-year period from 1995-2004. Patients were ≥18 years of age, with ≥26 months of continuous eligibility prior to index date, and ≥1 month of continuous eligibility after index date. Patients hospitalized with UA or NSTEMI were identified using ICD-9 codes and divided into 3 subgroups: clopidogrel-only (CO), aspirin-only (AO), and clopidogrel/aspirin (CA). Cox proportional-hazard models were used to estimate hazard ratios (HR) for time to death, major bleeding events (MBE; ICD-9 codes 531.x1–535.x1), re-hospitalization, and revascularization with covariate adjustment. The unadjusted time-to-event curves were estimated using Kaplan-Meier (KM) techniques. RESULTS: The UA/NSTEMI study population included 6448 patients. KM curves showed no difference in time to MBE among the 3 groups. With AO (n = 3738) serving as the baseline, HR for CA (n = 2071) was 1.05 (P = 0.63); HR for CO (n = 639) was 0.985 (P = 0.93). The KM curves for CO and AO showed no difference in time to death. However, HR for CA was 0.706 (P = 0.003), indicating that patients taking both drugs had a roughly 30% lower risk of death compared with patients taking AO. In contrast, CA had a 50% higher risk of re-hospitalization (HR = 1.50, P < 0.0001) and revascularization (HR = 1.51, P < 0.0001) than AO. No statistically significant differences in risk were found between CO and AO for re-hospitalization (HR = 0.80, P = 0.18) or revascularization (HR = 1.18, P = 0.18). CONCLUSION: The results suggest patients taking clopidogrel or aspirin, either alone or in combination, have similar long-term bleeding risk. The combination of clopidogrel and aspirin may reduce the risk of death compared with either drug alone. However, combination therapy did not lead to a decrease in re-hospitalization or revascularization compared with either drug alone.