taking ratios of predicted prevalence rates for obese versus non-obese individuals. Bootstrapped 95% confidence intervals were generated for prevalence ratios. RESULTS: Among obese adults the unadjusted prevalence of hypertension was (34.40%), followed by dyslipidemia (21.87%), diabetes (16.34%) and asthma (6.92%). Adjusted prevalence of chronic diseases were higher among obese as compared to non-obese and the entire population. The overall prevalence for diabetes was 3.06 (95% CI 2.82-3.30) at the age of 20 and was 2.20 (95% CI 2.09-2.31) at 70 years. At any age, obesity increases the likelihood of these conditions by at least 50% and is increased in both genders. CONCLUSIONS: Prevalence ratios indicate that obesity has highest impact on prevalence of diabetes, followed by hypertension, osteoarthritis, dyslipidemia. Study findings suggest that obesity is not only a disease, but may also be a cause for other chronic disorders. There is a need to develop effective obesity prevention and combat obesity and thus minimize its impact on other diseases in the United States.

PSY60

ECONOMIC CONSEQUENCES OF UNDER-UTILIZATION WITH TUMOR NECROSIS FACTOR INHIBITORS IN RHEUMATOID ARTHRITIS PATIENTS

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OBJECTIVES: Adherence to Food and Drug Administration recommended administration with adalimumab, etanercept, or infliximab may be variable. Suboptimal adherence patterns may contribute to health care cost increases. This study estimated incremental health care costs of tumor necrosis factor inhibitor (anti-TNF) under-utilization from a managed care perspective. METHODS: Medical/Pharmacy claims from the LifeLink™ Health Plan database were used. Inclusion criteria included: switching biologies post-index and selected inflammatory conditions. Under-utilization were defined as prescriptions/infusions with less than recommended dosing for adalimumab (40 mg every other week/weekly with/without methotrexate), etanercept (50 mg weekly), or infliximab (3 mg/kg dose and maintenance infusion interval > 56 days). Incremental increases in health care costs for patients with under-utilization, compared to receiving recommended dosing, were estimated using cost regression models controlling for refill/infusion intervals. Models were estimated for a 12-month time horizon and until index drug discontinuation or loss of enrollment. RESULTS: A total of 4,586 RA patients receiving adalimumab (N = 1,255, 27,540 prescriptions), etanercept (N = 2,422, 48,517 prescriptions), and infliximab (N = 1,089, 19,656 infusions) were included. Median infusion intervals (days) patients received adalimumab (856), etanercept (881), and infliximab (903) were comparable. Proportion of under-utilization events were 16%, 39%, and 2% for adalimumab, etanercept, and infliximab, respectively. Adalimumab or etanercept under-utilization was significantly associated with incremental increased health care costs ($2,352 and $879; p < 0.01) for 12 months and through end of data ($4,677 and $3,806; p < 0.05). Under-utilization in infliximab was infrequent and not associated with increased health care costs. CONCLUSIONS: In this analysis, adalimumab or etanercept under-utilization was associated with incrementally increased health care costs; however, infliximab under-utilization did not have a similar result. Additional research assessing clinical consequences of under-utilization is warranted.

PSY61

CHARACTERISTICS OF GOLIMUMAB UTILIZATION AND COSTS IN A SPECIALTY PHARMACY PROVEN SETTING

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OBJECTIVES: Golimumab is a 50 milligram (mg), once monthly, injected anti-tumor necrosis factor alpha therapy for treatment of rheumatoid arthritis, ankylosing spondylitis and psoriatic arthritis. This study calculated expected costs of annual golimumab therapy based upon observed dosing patterns within a SFP population during the first 16 months of golimumab availability. METHODS: Pharmacy and corresponding ENAVIGATOR™ patient care management data were collected by Diplomat Specialty Pharmacy, Flint, MI for adults with a golimumab prescription between 4/24/2009 and 8/24/2010. Data were analyzed statistically and are reported as mean ± standard deviation (SD) and median. Costs were modeled in US dollars using the wholesale acquisition cost (WAC, effective 6/9/2010) of $1,731.48 per 50 mg. RESULTS: The study included 89 patients. The majority were female (65%); age >45 years (69%); and reported prior biologic use (56%). A 50 mg golimumab dose was dispensed in 100% of patients and 100% of all doses. The mean (±SD) interval between golimumab doses was 32.0 ± 14.3 days and the median was 28 days. The mean golimumab dosing interval in patients reporting bio- logic use prior to golimumab initiation was 32.9 ± 15.9 days (mean ±SD) and was similar to the mean dosing interval observed in patients reporting no biologic use prior to golimumab initiation (mean ±SD: 31.1 ± 11.2 days; p = 0.15; NS). Based upon modeling of these early observations, the average golimumab patient will utilize approximately 11.4 doses of golimumab annually at a cost of $19,739 (WAC). CONCLUSIONS: In this SFP population, all patients received 50 mg of golimumab. The mean and median times between distribution of golimumab doses were 32 days and 28 days, respectively. Based upon the dosing and distribution patterns observed, the estimated average annual per patient cost of golimumab would be $19,739. Golimumab utilization may be similar for patients regardless of prior use of biologic therapies.

PSY62

PERCEIVED BENEFITS AND DISADVANTAGES OF INTRAVENOUS (IV) BIOLOGIC THERAPY AMONG PATIENTS WITH IMMUNOLOGIC CONDITIONS

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OBJECTIVES: To identify perceived benefits and disadvantages of intravenous (IV) biologic therapy among patients with immunologic conditions currently treated with IV biologic medication. METHODS: Semi-structured telephone interviews were conducted with patients self-reporting a diagnosis of ankylosing spondylitis, Crohn’s disease, psoriasis, psoriatic arthritis, rheumatoid arthritis, or ulcerative colitis and currently receiving IV biologic therapy. Study protocol and questionnaire were approved by an independent institutional review board. Participants received IV biologic medication at a hospital infusion room where NPS = not at all satisfied and 7 = very satisfied. Patients also discussed benefits and disadvantages of IV biologic therapy and reasons for IV preference. RESULTS: 405 interviews were conducted. Mean satisfaction was 6.1, 77% rated satisfaction as 6 or 7. The most frequently described benefits of IV therapy related to healthcare professional monitoring and oversight at time of infusion. More than half of patients also experience a social benefit of IV administration, including talking to other patients about experiences (56%) and tying into other activities with infusion facility visits (55%). The most commonly described disadvantages of infusion were duration of infusion (41%) and scheduling issues (23%). Of current IV users, most (82%, n = 332) prefer an IV medication to a subcutaneous injection. The most common reasons for IV preference were: not wanting to self-inject (43%), less frequent dosing (34%), and preference for healthcare professional administration (24%). Satisfaction with medication and perceived benefits varied somewhat by demographic, immunologic condition, and factors related to treatment. CONCLUSIONS: Current IV biologic users are highly satisfied with their medications. Patients perceive the additional opportunities for access to healthcare provider interaction at infusion facilities as a benefit of this mode of administration. These results support the need for continued patient access to IV therapeutic options and shared decision-making between patients and physicians when selecting biologic treatment.

PSY63

LONGITUDINAL ANALYSIS OF INFILXIMAB DOSING AND INFUSION INTERVALS ACROSS 30 INFUSIONS

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OBJECTIVES: Infliximab (IFX) is an infusible anti-tumor necrosis factor (anti-TNF) drug used in the treatment of rheumatoid arthritis (RA), with Food and Drug Administration (FDA) recommended administrations of 3 mg/kg at weeks 0, 2, 6, and 14, followed by every 8 weeks thereafter. Dosing was defined as infusions within 10% less than recommended dosing for infliximab (30 mg every other week/weekly with/without methotrexate), etanercept (50 mg weekly), or infliximab (3 mg/kg dose and maintenance infusion interval > 56 days). Incremental increases in health care costs for patients with under-utilization, compared to receiving recommended dosing, were estimated using cost regression models controlling for refill/infusion intervals. Results: A total of 153 [118 (RA); 20 (PsA); 15 (AS)] patients receiving golimumab were identified as meeting all the inclusion criteria. The mean age was 49 years and 75% were female; 101 (66%)