No differences in improvements in HRQoL were observed with epratuzumab during EMBLEM™, potentially due to short-term treatment, small sample sizes, and active SOC therapy. Sustained improvements were observed in the EMBLEM™ OLE, consistent with those in the ALLEViate RCTs.

PSY3

COMORBIDITIES, HEALTH-RELATED QUALITY OF LIFE AND PRODUCTIVITY LOSS ASSOCIATED WITH OBESITY

Gupta S1, Wang Z2, Pomerantz D1, Crow L1, Tan Y1, Cavanaugh TM1, Heaton P1, Diwan T2, Succop P1, Eckman MH3, Irish W4, Volek P1, Boone J1

OBJECTIVES: Obesity is associated with many health-related risk factors and is a significant economic burden on society. The objectives of this study were to examine the prevalence of patient-reported comorbidities, productivity loss and health-related quality of life (HRQoL) across different BMI ranges. METHODS: Overweight (BMI 25 – 29.9) or obese (BMI 30 or higher) patients from the 2012 U.S. National Health and Wellness Survey, a nationally representative survey of 17,617 respondents were characterized and analyzed by their BMI: overweight (BMI 25 – 29.9 kg/m²), obese class I (BMI 30 – 34.9 kg/m²), obese class II (BMI 35 – 39.9 kg/m²), and obese class III (BMI ≥ 40 kg/m²). Patients provided information on HRQoL. SF-36v2 mental health and vitality and productivity loss (Work Productivity and Activity Impairment questionnaire) and comorbidities (sleep difficulties, insomnia, pain, anxiety and depression) they experienced in the past 12 months. RESULTS: Among 45,641 overweight/obese patients, 49.8% were overweight, 27.9% were obese class I, 12.5% were obese class II, and 9.8% were obese class III. The proportions of patients experiencing sleep difficulties (overweight: 20.3%, obese class I 24.6%, obese class II 28.6%, obese class III 35.3%), pain (overweight: 16.6%, obese class I 38.1%, obese class II 42.5%, obese class III 48.5%), anxiety, depression and sleep problems increased with BMI increase (all p < 0.001). MCS (overweight: 50.0, obese class I 48.9, obese class II 47.8, obese class III 46.1). PCS (objective of 50.0, obese class I 48.8, obese class II 46.5, obese class III 43.0) and health utility scores declined with an increase in BMI (all p < 0.001). Among employed patients, overall work impairment as increased (p < 0.001). CONCLUSIONS: Changes was significantly more likely to be prescribed biologics compared to female patients and those without comorbid PsA, respectively. However, older patients (≥ 65 years) were significantly less likely (OR = 0.8) to be prescribed biologic regimens than patients aged 18–44 years. Differences in prescribing patterns by race, BMI, comorbid RA, and provider specialty were statistically insignificant. CONCLUSIONS: Male gender and uninsured status were associated with likelihood of initiation of a biologic treatment for newly diagnosed PsO patients. Older age (≥ 65 years) was associated with a decreased likelihood of initial treatment with a biologic-containing regimen.

SYSTEMIC DISORDERS/CONDITIONS – Health Care Use & Policy Studies

PSY5

IMPACT OF BMI ON CHARGES AND REIMBURSEMENT IN KIDNEY TRANSPLANT HOSPITALISATION COSTS, PATIENTS’ PREVIOUS USE OF TREATMENT AND LIVING DONOR RECIPIENTS

Crow S1, Tan Y1, Cavanaugh TM1, Heaton P1, Diwan T2, Succop P1, Eckman MH3, Irish W4, Volek P1, Boone J1

OBJECTIVES: Our objective was to determine costs of kidney transplant hospitalization in the United States billed by Medicare based on BMI ranges and based on low risk characteristics. METHODS: Retrospective analysis of USRDS and Medicare Claims from 2004-2009 for primary Medicare beneficiaries of primary kidney transplant of deceased (DD) and living donors (LD) recipients. Subsets were excluded for multiple transplants, donor < 5 yo, and transplantation payment < 15,000 U.S. dollars. BMI was categorized according to WHO classifications. Total direct medical costs were assessed for all patients at time of charges and payments. Costs were standardized to 2012 U.S. dollars. Univariate analyses of covariates were assessed for association with log-transformed charges and payments and significant variables were included in multivariate regression analysis. Base charges and payments include coverage of Medicare mean values and analyzed on low risk characteristics. RESULTS: In multivariate analysis, DB base charges at transplant were $155,906 (adjusted R2 0.314). BMI > 40 and BMI 35 – 39.9 was associated with an additional $13,3662 (p < 0.0001) and $9,823 (p = 0.005) at transplant. BMI 30 – 35.9 was associated with an additional $3,675 (p = 0.018) at transplant. Base reimbursements at transplant were $36,315 (adjusted R2 0.229). Elevated BMI was not attributed at any additional reimbursements, however BMI 18.5 – 24.9 had additional reimbursements of $660 (p < 0.001). For LD, base charges were $112,929 (adjusted R2 0.312) and BMI 30 – 35.9 was associated with an additional $3,675 (p = 0.018) at transplant. Base reimbursements were $38,363 (adjusted R2 0.239). Elevated BMI was not a significant independent predictor of additional reimbursements. CONCLUSIONS: Increased BMI was a significant factor in the amount of health resources utilized for kidney transplantation. While elevated BMI results in significant greater costs to hospitals, no additional reimbursement from Medicare was observed. These findings may play a factor in negative selection against candidates with higher BMI at the time of transplantation.

PSY56

PSY56

DMSA DATABASE CONSULTATION/EVALUATION OF HOSPITAL STAY LENGTH FOR INFANTILE HAEMANGIOMA IN FRANCE PREVIOUS TO AND SUBSEQUENT TO PROPRANOLOL USE

Azzouz L, Paris, France

OBJECTIVES: Infantile haemangioma (IH) appears in the first few days of life, and develops over time. Certain types of IH cause significant functional impairment and treatment is necessary in order to improve quality of life and reduce the risk of complications. In France, since 2006, IH has been covered by public health insurance and treatment can be initiated as soon as the diagnosis is made. However, there are conflicting results on the best treatment options for IH. One of the main controversies is whether propranolol should be used as a first line treatment or if other treatments should be tried first. METHODS: Analysis of the PMSI database covering ambulatory and hospitalization for propranolol use in infants from 2006 to 2012. RESULTS: Between 2006 and 2012, 6,172 children were admitted to hospital for IH. No significant change in length of hospital stays was observed. However, a decrease in the proportion of IH admitted as inpatient from 67% in 2006 to 56% in 2012 was observed. CONCLUSIONS: The use of propranolol as a first line treatment is a reasonable approach in today’s world. However, further studies are needed to confirm these findings.

PSY57

INITIATION OF PRESCRIPTION OF BIOLOGICS FOR PATIENTS WITH PSORIASIS: PREFERENCES OF PATIENTS AND PRESCRIBING PROVIDERS

LeY2, Liao M1, Arcona S1

1Novartis Pharmaceuticals Corporation, East Hanover, NJ, USA, 2KMC Consulting, Inc., Florham Park, NJ

OBJECTIVES: Psoriasis (PsO) is a chronic, recurrent, immune-mediated disease often treated with biologic therapies. However, understanding of prescription initiation of biologics for psoriasis is limited. The current study evaluates patient and provider characteristics in treatment-naive PsO patients prescribed either exclusively oral or biologic-containing regimens. METHODS: A retrospective database analysis was performed using Humedica electronic medical record data for adult patients with at least one diagnosis of PsO and no prior history of PsO or PsO-related therapy within 12 months prior to index date. Eligible patients were classified based on initial prescription as (1) oral only (2) biologics (including oral and biologics as combination treatment). Patients’ demographic characteristics, comorbidities, disease status, prescriber specialty and prescriber preference of biologics were compared across both groups. Willcoxon rank-sum and chi-squared tests were applied to variables of ordinal and nominal measure, respectively. Logistic regression was conducted to determine the variables associated with likelihood of initiation of a biologic treatment. RESULTS: A total of 2,373 patients met inclusion criteria. Of these patients, 1,166 (49%) were classified as males, 856 (36%) were diagnosed with psoriatic arthritis (PsA) and 261 (11%) were diagnosed with rheumatoid arthritis (RA). Male patients (OR = 1.47) and patients with comorbidity PsA (OR = 1.51) were significantly more likely to be prescribed biologics compared to female patients and those without comorbid PsA, respectively. However, older patients (≥ 65 years) were significantly less likely (OR = 0.8) to be prescribed biologic regimens than patients aged 18–44 years. Differences in prescribing patterns by race, BMI, comorbid RA, and provider specialty were statistically insignificant. CONCLUSIONS: Male gender and uninsured status were associated with likelihood of initiation of a biologic treatment for newly diagnosed PsO patients. Older age (≥ 65 years) was associated with a decreased likelihood of initial treatment with a biologic-containing regimen.

PSY58

OPHARM DRUG POLICIES: LOOKING BACKWARD, THINKING FORWARD

Tewaile F1, Korchagina D2, Belgaied W3, Toumi M1

1Cretio-Cretio, London, UK, 2Cretio-Cretio, Paris, France, 3Cretio-Cretio, Tunis, Tunisia

OBJECTIVES: The University Claude Bernard Lyon 1, Lyon, France