

C), and triglyceride (TG) goal attainment, annual cardiovascular disease (CVD)-related health care utilization and costs among patients initiating combination statin and extended-release niacin (NER) therapy (S + NER + S). **METHODS:** A retrospective cohort study of patients initiating S + ERN between January 1, 2000 and June 30, 2006 was conducted utilizing medical, pharmacy and laboratory result data from the HealthCore Integrated Research Database. Patients were primary or secondary risk, aged ≥ 18 years, had ≥ 1 lipid laboratory result 12 months prior to index date, and ≥ 12 months pre- and post-index eligibility. Clinical and economic outcomes were evaluated during the 12 months prior to and after initiation of S + ERN. Lipid goal attainment was determined based on US national lipid guidelines. CVD-related resource utilization and costs were annualized post-index. Change in lipid goal attainment, annual resource utilization and costs were tested using Generalized Estimating Equations (GEE). Model covariates for lipid goal attainment included age, gender, time to NER addition, and co-morbidity index. **RESULTS:** A total of 845 (51% secondary risk) patients initiating NER + S were identified. Patients were predominantly male (77%), mean age 52.6 (± 9.05) years and time to addition of NER was 225 (± 306) days. Mean change in lipid values (mg/dL) for LDL-C, HDL-C, and TG was (-10.81 ± 30.67 , 2.73 ± 7.24 for HDL-C, and (-22.67 ± 106.79 respectively. Multivariate analysis demonstrated increased likelihood of goal attainment for LDL-C (OR: 1.56; $p = 0.0016$), HDL-C (OR: 1.58; $p = 0.0004$), and TG (OR: 1.39; $p = 0.0078$) after initiation of NER + S therapy. GEE results demonstrated significant improvement from pre-index in annual CVD attributable inpatient visits (17 ± 49 vs 9 ± 31 per 100 patients; $p < 0.0001$) and total medical cost ($\$3214 \pm 10,282$ vs. $\$2039 \pm 7117$; $p < 0.0001$). **CONCLUSIONS:** Comprehensive treatment approach of combination NER + S therapy was associated with improved change in lipid values, target lipid value attainment, and reduced CVD-related inpatient visits and total medical cost.

PCV83

AN EVALUATION OF THE INCREMENTAL CHANGE IN THE INCIDENCE OF CARDIOVASCULAR EVENTS AND RELATED COSTS WITH THE ADDITION OF FIXED-DOSE NIACIN EXTENDED-RELEASE AND SIMVASTATIN THERAPY TO THE MANAGED CARE FORMULARY

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OBJECTIVES: To model the impact of the addition of fixed-dose niacin extended-release and simvastatin (NER/S) therapy to a health plan formulary in terms of cardiovascular (CV) events and corresponding attributable costs. **METHODS:** Two hypothetical formularies with all major branded and generic lipid drugs were modeled over a three year time horizon: a formulary not including NER/S (current formulary) and a formulary which did (revised formulary). Primary and secondary risk patients with ≥ 1 sub-optimal lipid parameter were sampled from the HealthCore Integrated Research Database between 1/1/2000 and 2/28/2005. Package insert efficacy of antihyperlipidemic medications in each formulary was applied to the sample population. Changes in clinical outcomes (combined lipid value attainment of low density lipoprotein cholesterol, high density lipoprotein cholesterol, and triglycerides, and CV events) between formularies were evaluated relative to incremental change in pharmacy and CV disease-related medical costs. Market penetration of NER/S was assumed to be 1.5% and payer discounts of 17% and 50% were applied to brand and generic wholesale acquisition costs. **RESULTS:** For every 1% increase in NER/S market share there

was a corresponding 0.38% increase in the incremental rate of combined OLV achievement and 0.06% decrease in the incremental incidence of CV events between current and revised formularies. Total health system drug expenditure increased by 15% while CV event costs decreased by 10%. The incremental cost per CV event avoided was \$46,593 and \$12,957 per CV event related hospital day avoided. **CONCLUSIONS:** The addition of NER/S to the health plan formulary increases combined optimal lipid value achievement and correspondingly reduces the three year incidence of CV events and CV event related costs in this hypothetical patient population.

PCV84

HEALTH CARE RESOURCES AND QUALITY OF LIFE IN ACUTE CORONARY SYNDROME PATIENTS IN 2007: FRENCH BASELINE RESULTS FROM THE ANTIPLATELET TREATMENT OBSERVATIONAL STUDY (APTOR)

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OBJECTIVES: This analysis aims to explore management of acute coronary syndromes (ACS) from acute event to hospital discharge in France. **METHODS:** This 12-month prospective, observational study recruited ACS patients undergoing percutaneous coronary intervention (PCI), January-August 2007, capturing practice patterns, resource use and quality of life. In France, all interventional cardiologists were invited to participate. **RESULTS:** 497 ACS-PCI patients (483 analyzed), enrolled by 59 interventional cardiologists from public university hospitals-36%, public non-university hospitals-45%, and private hospitals-19%, were: mean age 60.9 \pm 12.8, mean weight 79.7 kg \pm 14.8, 18% female, 16% diabetics and 12% prior myocardial infarction (MI). Index diagnosis was: unstable angina or non-ST-elevation MI (UA/NSTEMI)-53% and ST-elevation MI (STEMI)-47%. Almost all patients (96%) were implanted stents: 67% bare metal stents (BMS), 23% drug eluting stents (DES) and 11% both. Antiplatelet loading oral medications used were aspirin-91% and clopidogrel-95% (no use of ticlopidine). Antithrombotic agents were infused too: abiximab-16%, tirofiban-18%, eptifibatide-3%, and bivalirudin-3%. Clopidogrel loading dose (LD) was given in intensive care unit-32%, emergency room-24%, ambulance-21%, previous hospital-12%, catheter lab-6% and other ward-4%, and close to PCI (previous 6 hours, during or after) in 46% of cases. Total clopidogrel loading dose was over 300 mg in 34% of cases, and in-hospital maintenance dose (MD) was 150 mg in 26%, and 75 mg in 74% of cases. At time of hospital discharge, 96% of patients were receiving clopidogrel (discharge dose 150 mg in 23%) and EQ-5D QoL score was a median 0.85 (IQR 0.73-1.00). **CONCLUSIONS:** These data reflect contemporary real-life management of ACS patients in France. DES are implanted 3 times less than BMS. Variation in oral antiplatelet agent dosing pattern (LD and MD) and timing of administration is frequent.

PCV85

STROKE PATIENT RESOURCE USE AND CAREGIVER BURDEN OUTCOMES BY SEVERITY (RECOVERY) STUDY: METHODS AND RESULTS FROM THE ATHENS STROKE REGISTRY

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OBJECTIVES: To collect location of care, resource utilization, utilities and quality of life data in relation to post-stroke physical