PCV34
DEVELOPING HOSPICE DRUG FORMULARY USING MULTI-ATTRIBUTE UTILITY THEORY (MAUT) METHODOLOGY
Khandelwal NG1, Krueger KP2, Berger BA1, Carpenter M3, Butz B4
1Auburn University, Auburn, AL, USA, 2Hospice of East Alabama Medical Center, Auburn, AL, USA
OBJECTIVE: With the increasing costs of providing pharmaceutical care, hospices in the U.S. are burdened with the high costs of providing optimum healthcare. There is a need to implement cost-containment strategies such as drug formulary at hospices that will aid in curbing pharmacy-related costs. While most hospices do not have a formulary, there are some that have a preferred drug list of most commonly used drugs, however, they lack appropriate methodology for the purpose of including particular drug(s) on the list. To develop rational hospice drug formulary based on scientific methodology. METHODS: The study was conducted at a hospice center located in the rural township of Alabama State. Multi-Attribute Utility Theory (MAUT) methodology was employed to develop a rational hospice drug formulary. MAUT is a systematic identification and analysis method that facilitates the P&T committee in selecting appropriate drugs on the basis of assessing important drug attributes such as efficacy, safety, cost, and dosage-form related parameters. For each therapeutic drug class, members of the P&T committee at the center ranked and weighted their preferences for different drug attributes that were considered most important for final drug selection process. The preference values were combined in a mathematical formula with the literature values that were obtained through comprehensive and systematic literature review process to yield total utility score values for individual drugs. Within each therapeutic class, final decisions to include particular drug on the formulary were made on the basis of total utility scores i.e. those drugs with highest total utility scores were selected for the formulary. RESULTS: The P&T committee at the hospice center successfully developed their drug formulary using MAUT methodology. CONCLUSIONS: The methods described and employed in this study can be used by P&T committees at other hospices for developing drug formularies at their respective centers.

PCV35
SINGLE SOURCE COST ESTIMATES FOR EVENTS ACROSS VARIOUS CONDITIONS REQUIRING THROMBOEMBOLIC PROPHYLAXIS AND TREATMENT
Patel NM1, Happe L2, Farrell E3, Sarnes M4
1GSK, Collegeville, PA, USA, 2Applied Health Outcomes, Palm Harbor, FL, USA, 3Applied Health Outcomes, Havertown, PA, USA
OBJECTIVES: Many studies have provided cost estimates for thromboembolic events and bleeding episodes in several of the populations for which thromboembolic prophylaxis is recommended. However, these studies have focused on single indications and used various methodologies to generate the cost estimates. This analysis assessed the relative costs of each event type across several thromboembolic prophylaxis or treatment indications from a single data source. METHODS: This was a retrospective analysis of inpatient data from >500 US hospitals. Patients hospitalized for occurrence of a deep vein thrombosis (DVT) or pulmonary embolism (PE), orthopedic surgery (hip fracture, knee or hip replacement), abdominal surgery, or acute coronary syndrome (ACS) between January 2003 and March 2005 were eligible for study inclusion. Patients <18yrs of age were excluded. Eligible patients were divided into eight outcomes groups based on the presence of the secondary diagnosis ICD-9 codes upon hospital discharge: uncomplicated, DVT, PE, both DVT and PE (DVT/PE), thrombocytopenia (TCP), major bleed (MB), minor bleed (mB), and multiple events (multi). Billing files were used to determine the average total cost per hospitalization for each cohort. RESULTS: Sample sizes: orthopedic = 154,321; abdominal = 237,836; TxDVT/PE = 23,698; ACS = 343,703. The cost of an uncomplicated visit served as the baseline cost for that cohort: orthopedic = $13,609; abdominal = $15,989; TxDVT/PE = $5681; ACS = $13,133. Incremental costs for events were highest in the abdominal cohort (mB = $7907 to multi = $48,401), followed by ACS (PE = $4051 to multi = $27,409), orthopedic (mB = $3480 to multi = $17,471), and TxDVT/PE (PE = $2267 to MB = $13,969). Multi and MB were the highest cost events in all cohorts except orthopedic surgery where multi and DVT/PE were the most costly. CONCLUSIONS: Point estimates for average costs for events associated with VTE prophylaxis and treatment differ across conditions. The most costly events are typically multi and MB. Events in the abdominal surgery population lead to the higher cost increases compared to other cohorts.

PCV36
RATE OF LOW-DENSITY LIPOPROTEIN (LDL) GOAL ATTAINMENT WITH LIPID LOWERING THERAPIES AT A LIPID CLINIC IN A PUBLIC HOSPITAL OF HONG KONG—POSSIBLE ROLE OF A CLINICAL PHARMACY SERVICE
Lee VVY, Chung JS, Ng SL, Tomlinson B, Lee KK
The Chinese University of Hong Kong, Shatin, Hong Kong, China
OBJECTIVES: Coronary heart disease (CHD) is the second most important disease leading to mortalities in Hong Kong. In persons with established CHD, evidence has demonstrated that low-density lipoprotein (LDL) lowering therapy has resulted in reduced mortality and cardiovascular events. We evaluated the rate of LDL goal attainment of hyperlipidaemic patients at a public hospital in Hong Kong. METHODS: This is a prospective observational trial conducted at the Lipid Clinic of the Prince of Wales Hospital in Hong Kong. METHODS: This is a prospective observational trial conducted at the Lipid Clinic of the Prince of Wales Hospital in Hong Kong. Chinese patients aged 18 years or above with history of hyperlipidaemia and CHD are included. Statin therapy must be prescribed for at least 3 months after initial hospitalization. Treatment patterns were determined by studying the dosages, titration, switch or discontinuation of statin therapy. A LDL level of 2.6mmol/L was considered satisfactory. RESULTS: Thirty-nine patients were recruited. The mean age of patients was 61 ± 13 years old. Nearly 80% of patients had CHD risk factors and 40% of patients have CHD and CHD risk equivalents. In patients with comorbidities of hypertension and diabetes, nearly 50% and 60% of patients had unsatisfactory blood pressure control and unsatisfactory haemoglobin A1C levels respectively. The mean baseline LDL was 2.97 ± 0.99mmol/L. Only 41% of patients were at LDL goal. Lipid lowering drugs used included rosuvastatin (21.4%), simvastatin (26.2%), atorvastatin (19.0%), fluvastatin (2.4%), ezetimibe (7.1%), cholestyramine (7.1%), gemfibrozil (2.4%) and acipimox (2.4%). Over 45% patients did not understand the purpose of their medications and possible side effects. CONCLUSION: The LDL goal attainment rate was relatively low in the present group of patients and there was room for improvement. The results of the current project paves way for the implementation of a clinical pharmacy service to assist in hyperlipidaemic management by providing drug education to patients and suggestions to physician in lipid lowering drug therapies.