ordinary least squares. Percentage change in per-prescription acquisition cost is regressed on change in the producer price index for finished goods, change in the number of generic and brand-name antiulcer drugs, change in the number of brand name drugs in the submarket (PPIs or H2 antagonist or Carafate), and percentage change in the number of generic manufacturers. RESULTS: The acquisition cost for generic prescriptions decreases over time. With the exception of Pefcitd, the acquisition costs for H2 drugs rise fairly steadily throughout the study period. All of the PPIs have rising per-prescription acquisition costs. For generic drugs, the rise of number of generic companies has a significant negative impact on generic drug acquisition costs (p = 0.0004). Neither the change in the producer price index nor any change in the number of drugs in the drug’s smaller or wider market has a significant impact on acquisition-cost change (p > 0.10). CONCLUSIONS: The cost benefit to Medicaid from a rise in competition is being passed on in terms of lower acquisition costs for generic drugs. Branded medications continue to show a rise in cost per script.

**ECONOMIC ASSESSMENT OF DRUGS AND GI HOSPITALIZATIONS ASSOCIATED WITH APPLYING VA CRITERIA FOR PRESCRIBING NONSTEROIDAL ANTI-INFLAMMATORY AGENTS**

**OBJECTIVE:** The purpose of this study was to assess the cost impact of applying VA Criteria for use of non-steroidal anti-inflammatory drugs (NSAIDs). **METHODS:** These criteria utilize a self-administered Gastrointestinal (GI) Risk Assessment Tool (GI Score). The GI Score is a composite scale used to predict the 1-year risk level for an NSAID-associated GI event (no risk to substantial risk). The risk levels for patients at three facilities were calculated from VA databases regarding demographic, prescription, hospitalizations, and active problem lists. Cost analysis was limited to 2002 VA drug costs and estimated GI-event hospitalization. The perspective was the VA Healthcare System. We assumed no difference in hospitalized GI event rates between NSAID with a PPI or COX-2 inhibitor. **RESULTS:** There were 19,123 NSAID users at three VA Medical Centers. The following GI Score risk factors were found in these patients: 212 GI hospitalization, 212 concurrent warfarin therapy, 725 corticosteroid therapy, and 583 rheumatoid arthritis. There were 36% over the age of 65. Thirty-two percent of the patients (n = 6126) were at high risk for a GI event; 8% substantial and 24% significant. The actual annual drug costs for high risk and low risk patients were $471,898 ($77.02/patient) and $291,960 ($22.46/patient), respectively. Switching to criteria-based therapy is estimated to save 14.7 hospitalizations among the high risk patients. For high risk patients, the base case of adding a PPI to current therapy with decreased GI-associated hospitalizations resulted in a cost of $278,809 ($45.51/patient/year). We applied alternative therapies for sensitivity analysis, switching all high risk patients to a low-cost NSAID with a PPI ($73,433 or $11.99/patient/year) or a COX-2 inhibitor ($1,389,686 or $226.85/patient/year). **CONCLUSIONS:** Our results suggest the criteria-based therapy (base case) could result in a cost savings to the VA.

**GASTROINTESTINAL DISEASES/DISORDERS—Economic Outcomes**

**THE COST-EFFECTIVENESS OF ALTERNATIVE STRATEGIES IN THE MANAGEMENT OF PATIENTS WITH UNINVESTIGATED DYSEPSIA (UD): COMPARING THE CANDYS APPROACH TO EMPIRICAL ANTISECRETORY THERAPY AND PROMPT ENDOSCOPY**

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**OBJECTIVES:** Examine optimal cost-effective management of adult patients with uninvestigated dyspepsia (UD). **METHODS:** We compared the CanDys approach (acid suppression for patients with heartburn predominant symptoms, and a test-and-treat strategy for others, treating H. pylori negative (HP-) patients with acid suppression and HP+ patients with eradication) to empirical antisecrectory therapy (EAS) and prompt endoscopy (PE). All patients presented with UD. EAS was 4 weeks of omeprazole 20 mg od or ranitidine 150 mg bid. The unit of effectiveness was the proportion of patients symptom-free (SF) at four weeks. Probability assumptions were obtained from literature or expert opinion. Direct costs (in 1999 CAN$) for diagnostic tests, physician visits, and medications were derived from provincially set fees. The analysis was conducted using a Monte Carlo simulation in Data 4.0 that incorporated distributions for all variables with elasticities greater than 0.3 (for efficacy or cost). Sensitivity analyses were carried out across clinically relevant ranges of important probability and cost variables. **RESULTS:** Of the non-dominated strategies,