Abstracts

Chemical classification and Defined Daily Dose (DDD) measurement unit. Data of wholesalers, who are legally obliged provide this information to the Slovak Institute for Drug Control, was used for the analysis. The results were expressed in the numbers of the packages, finance units (€) and defined daily doses per 1000 inhabitants per day (DID). RESULTS: The collected data showed a slight increases in consumption of drugs for treatment of neurological disorder from 1997 to 2006 in term of DID (in 1997 (111.00), in 2001 (111.30) and in 2006 (130.34). A significant increase in consumption of psychoanaleptics (in 1997 (13.07), in 2001 (24.69) and in 2006 (39.73) and slight decrease in consumption of psycholeptics (in 1997 (41.49), in 2001 (40.19) and in 2006 (38.29) in term of DID can be seen from this analysis. We can see a slight increase in consumption of drugs in term of DID within the group of antiepileptics (in 1997(4.35), in 2001 (4.82) and 2006 (6.19) and anti-parkinson drugs (in 1997(2.78), in 2001 (3.42) and in 2006 (3.60). Financial expenditures for psychoanaleptics (in 1997 (11,211,000 €), in 2001 (26,817,000 €) and in 2006 (24,671,000 €), for psycholeptics (in 1997 (9,149,000 €), in 2001 (14,747,000 €) and in 2006 (28,839,000 €) can be seen in this study. CONCLUSION: Inseparable components of the Slovak drug policy must be viewed realistically with regard to the consumption of drugs for neurological disorder.

USE OF HEALTH CARE RESOURCES AND CORRESPONDING COSTS IN NEUROLOGICAL DISORDERS IN THE PRIMARY CARE SETTING

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OBJECTIVES: To characterize the use of health care services and the corresponding costs of patients with Neurological Disorders (ND) managed at Primary Care Settings (PCS) under usual medical practice. METHODS: A retrospective, multicenter study was carried out. All patients seen by 5 PCS during year 2006 were included in the analysis. The control group was formed with the rest of patients without NDs. Outcomes measures included sociodemographics, comorbidities, Charlson index (severity), use of health care resources and ambulatory costs (drugs, diagnostic/therapeutic procedures, referrals and visits). Statistical analysis included descriptive, logistic regression model and ANCOVA models. RESULTS: A total of 80,775 patients were included, of which 19,423 had any ND (24.0%; 95%CI: 23.7-24.3%). Patients requiring health care for their ND were older (46.2 ± 22.1 vs. 38.9 ± 22.9, p < 0.001), with increased severity (0.3 ± 0.6 vs. 0.2 ± 0.5, p < 0.001), predominantly female (63.6 vs. 49.8%, p < 0.001), larger number of health problems (6.1 ± 4.0 vs. 4.3 ± 3.2, p < 0.001) and increased per patient per year medical visits (9.9 ± 9.4 vs. 7.2 ± 7.7, p < 0.001) and days of work absenteeism due to disability (73.3 ± 124.4 vs. 56.8 ± 107.6, p < 0.001). Main symptoms demanding care were: vertigo/dizziness (25.6%) and headache (17.7%). Neurological treatment was associated with women (OR = 1.8), depressive syndrome (OR = 1.5) and cardiovascular events (OR = 1.2), p < 0.0001 in all cases. Crude and adjusted (age, gender and comorbidities) mean annual cost were significantly higher in patients with NDs than in controls; €708.25 ± 900.94 vs. €443.10 ± 678.44, p < 0.001, and €932.85 ± €712.38, p < 0.001. All per patient per year components of costs (fixed/semi-fixed, tests, referrals) were significantly higher in the ND group, particularly pharmaceutical expenditures; €621.26 vs. €479.25, p < 0.001. CONCLUSION: Patients requiring care for NDs in the primary care setting showed a large number of comorbidities, increased use of health resources and higher per patient per year cost.

COST-EFFECTIVENESS OF GLATIRAMER ACETATE AND NATALIZUMAB IN RELAPSING-REMITTING MULTIPLE SCLEROSIS IN THE PRESENCE OF LONG-TERM CLINICAL EVIDENCE

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OBJECTIVES: To assess lifetime cost-effectiveness of glatiramer acetate (GA) compared to natalizumab (NZ) in patients diagnosed with relapsing-remitting multiple sclerosis (RRMS) in the presence of long-term clinical evidence. METHODS: A literature-based Markov model was developed with patients transitioning through health-states based on Kurtzke expanded disability status scale (EDSS). Patients in the model are ≥ 21 years of age with RRMS and start in any of the health-states at diagnosis. Patients with an EDSS score below 6.0 receive treatment. Treatment effects for relapse and disease progression were obtained from clinical trials and long-term clinical evidence where available. Transition rates were estimated by applying a percent reduction of treatment effects to natural history rates of relapse and disease progression. Rates were adjusted for treatment discontinuation and persistent NZ antibodies. Patients incurred drug, other medical and lost worker productivity costs. Patients on NZ incurred additional costs for monitoring, diagnosis, and treatment of progressive multifocal leukoencephalopathy (PML), a possible serious adverse event for patients on NZ. Utility weights for each health-state were taken from published utility assessments for people with RRMS. The primary outcomes of the model were lifetime costs and quality-adjusted life years (QALYs). Costs (2005$US) and outcomes were discounted at 3% annually. RESULTS: The lifetime costs per patient for GA were $352,762 and for NZ were $422,210. QALYs during the lifetime of a patient on GA were 9.303 and 9.300 for a patient on NZ. The incremental cost per QALY for patients on GA and NZ compared to symptomatic treatment alone was $258,464 and $580,119 respectively. GA is cost-saving when compared to NZ. PML had very little impact on results. CONCLUSION: While incorporating all the long-term clinical evidence, model results indicated that GA was both less costly and more effective over a patient’s lifetime than NZ in treating RRMS.

AN ANALYTICAL MODEL TO PREDICT THE COST-EFFECTIVENESS OF LONG-TERM ESZOPICLONE FOR THE TREATMENT OF PRIMARY INSOMNIA

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OBJECTIVES: To assess the cost effectiveness of long-term treatment with eszopiclone for chronic primary insomnia in adults. METHODS: We used patient level data from a 6-month, double-