

overall SAS score ($P < 0.001$). Baseline to week 4 differences in overall SAS demonstrate significantly greater improvement for nefazodone mono-therapy compared to CBASP mono-therapy ($P = 0.032$). Conservative estimates of mean direct treatment costs per patient irrespective of response are \$770 (nefazodone), \$1800 (CBASP) and \$2500 (combination). Estimated mean direct treatment costs per acute responder are \$1700 (nefazodone), \$4000 (CBASP), and \$3400 (combination). Multivariate results are presented that highlight the interrelationships of treatment modality, disease severity (HAM-D), functional status (SAS, SF-36, and L.I.F.E.) and costs of treatment. **CONCLUSIONS:** Combination treatment is most efficacious. Direct treatment cost per acute responder is lowest for treatments using nefazodone. Further cost-effectiveness results incorporating variation in time-to-response, other direct costs, and economic benefits associated with treatment will also be presented.

PMH39**HEALTH CARE BURDEN AND COST OF PARKINSON'S DISEASE**Wilson L¹, Huang J², Doshi D³

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OBJECTIVES: Parkinson's disease is a progressive neurodegenerative disease and important contributor to disability. We demonstrated health care status, utilization of health services and total direct costs of Parkinson's disease. **METHODS:** We used a prevalence approach and aggregate national data sources to determine 1997 US annual direct medical cost and general health status of Parkinson's patients from a societal perspective. A sensitivity analysis varied prevalence and utilization of each cost factor around a base case. **RESULTS:** The prevalence of idiopathic Parkinson's disease is 283/100,000 population, of which 82% are greater than 65 years. Only 3% of the population with Parkinson's disease report that they are in excellent health, 11% very good, 19% good, 29% fair and 38% in poor health. Total direct costs are \$6.6 billion, \$3.4 billion for men. Nursing home costs (\$2.9 billion) account for the largest proportion (44%) of these costs, with medications second (\$1.95 billion, 29%) and hospitalizations third most costly (\$1.1 billion, 17%). This is about \$8,738 per person annually. The elderly carry the greatest cost burden, highest for the 75–84 year olds (\$2.6 billion annually). Sensitivity analysis showed a maximum variation in cost from \$3.3 to \$9.4 billion when varying both utilization and prevalence estimates. **CONCLUSIONS:** The societal cost burden is high considering the low prevalence of the disease. Other chronic diseases generally cost only \$1–2,000 annually per patient. There is a large self-perceived health burden, with the majority of patients reporting “poor” health status. This study demonstrates a high

combined economic and social burden for Parkinson's disease patients.

PMH40**ACCESS TO NEW MEDICATIONS TO TREAT SCHIZOPHRENIA**

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OBJECTIVE: To assess factors that influence whether patients with schizophrenia are prescribed second-generation antipsychotic medications (olanzapine, risperidone) or traditional antipsychotics. **METHODS:** Data were obtained from the Schizophrenia Care and Assessment Program study. Participant information was collected through interviews and medical record abstraction ($n = 294$). Treating physicians were surveyed about their demographic, professional, and practice characteristics ($n = 42$). Patient and physician information was linked. Multivariate logistic regression with patient and physician-level predictors was estimated. **RESULTS:** The following variables were positively associated with second-generation medication use at $P < 0.05$: a higher baseline PANSSNS score (e.g. depressed affect), having a physician who has been in practice less than five years or greater than 20 years, one who has attended more than one professional meeting in the last five years, and one who sees more than 25 patients a week. The following variables were positively associated with second-generation medication use at $P < 0.1$ in some of the models: patient age < 35 , race other than African-American or White, diagnosis of other schizophrenia, being uninsured, and having one or no prior psychotic episodes. Medicare, Medicaid, private insurance, CHAMPUS, and other insurance were not significant predictors. **CONCLUSIONS:** One of the perceived advantages of second-generation antipsychotic medications over traditional antipsychotics is their greater effectiveness at reducing the negative symptoms of schizophrenia. Consistent with this belief, we find that physicians are prescribing second-generation antipsychotics to patients who display more negative symptoms. There is also evidence that physicians may be prescribing second-generation antipsychotics to younger patients and those experiencing a first psychotic episode, thus using second-generation medications as first-line treatments. We also find that physician characteristics are influencing whether patients are being prescribed the second-generation medications. Finally, we do not find evidence that insurance status influences access to medications.

PMH41**PATTERNS OF ANTIDEPRESSANT USE AND CONCOMITANT PSYCHOTHERAPEUTIC AGENTS**Fulop G¹, Bona JR², Brookler R¹, Nemeroff CB²¹Merck-Medco Managed Care, LLC, Franklin Lakes, NJ, USA;²Emory University, School of Medicine, Atlanta, Georgia, USA