

tion costs, region, health conditions, and treatment patterns) that may influence schizophrenia-related costs and total costs. Estimation was conducted via a two-stage instrumental variable model. **RESULTS:** The mean unadjusted total schizophrenia-related cost per patient per year was \$4,973, and the total unadjusted health care cost per patient per year was \$7,335. Although the daily drug costs associated with olanzapine were higher than risperidone, and patients taking olanzapine on average stayed on therapy longer than those taking risperidone, when looking at total schizophrenia-related costs (services plus prescription utilization), there was no significant difference between drug groups (olanzapine \$81 lower,  $p = 0.7534$ ). Additionally, when total health care costs were analyzed, there was no significant difference in drug groups (olanzapine \$530 lower,  $p = 0.1050$ ). Sensitivity analyses found similar results. **CONCLUSION:** This naturalistic study used data from a Texas Medicaid population to examine the schizophrenia-related costs (and total costs) for patients who received olanzapine versus risperidone. No differences in direct costs were found for patients receiving olanzapine versus risperidone.

**PMH34**

#### **SWITCHING AND AUGMENTATION OF ANTIDEPRESSANTS IN OLDER DEPRESSED PATIENTS**

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Newer antidepressants are often prescribed to geriatric patients with depression because older agents often have side effects that may be problematic in the elderly. Less well-understood are the prescribing patterns of clinicians when such first-line agents are switched or augmented. **OBJECTIVE:** To examine switching and augmentation patterns used during the inpatient and post-discharge period in geriatric patients with major depression (ICD-9-CM codes 296.20-296.36) treated initially with fluoxetine, mirtazapine, sertraline, or venlafaxine. **METHOD:** Data were obtained from the CQI+SM Outcomes Measurement System, an ORYX (JCAHO) accepted performance improvement system, which tracked patients admitted to geropsychiatric inpatient programs in 111 general hospitals across 33 states between 1997–1999. A Medication Usage Questionnaire was used to track medications prescribed just prior to admission, at time of discharge, and at three-month post-discharge follow-up. **RESULTS:** From admission to discharge, over one-third to one-half (37.4–52.1%) of patients switched or augmented specific antidepressant agent. Switching and augmenting rates decreased somewhat from discharge to follow-up (10.5–29.6%) and from admission to follow-up (30.5–38.9%). Remarkably, over twenty distinct antidepressant agents were used when switching occurred, and

fifteen distinct antidepressant agents were used to augment the initial antidepressant agent. **CONCLUSIONS:** A significant number of patients do not appear to improve adequately on their agent of first choice. The great variety of treatment combinations suggests there is no clearly preferred treatment strategy for partial and non-responders. Practice guidelines for treatment strategies to augment and switch in older patients with depression would be beneficial for both clinicians and patients.

**PMH35**

#### **PATTERNS OF ANTIDEPRESSANT AND ANTIPSYCHOTIC MEDICATION USE IN MEDICAID, 1995–1999**

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**OBJECTIVES:** This study sought to: 1) analyze trends in utilization of antidepressant and antipsychotic medications in Medicaid between 1995 and 1999; 2) gauge the utilization and diffusion of new generation, branded antidepressants and antipsychotics during this period. **METHODS:** The study was based on a time-series analysis of quarterly, state-level, Medicaid pharmaceutical claims, as administered by HCFA. Data from 45 states were suitable for analysis. **RESULTS:** In 1998, antidepressants and antipsychotics accounted for 9% of Medicaid prescriptions, but 19% of expenditures. From 1995 to 1998, Medicaid prescriptions for antidepressant and antipsychotic medications grew by 40% and 20%, respectively; corresponding expenditures grew by 96% and 160%. The growth rate in both prescriptions and expenditures for antidepressants and antipsychotics outpaces that observed in Medicaid pharmacy benefits as a whole by more than two-fold. In 1995, new generation antidepressants and antipsychotics accounted for 44% and 17.5% of all prescriptions for Medicaid antidepressants and antipsychotics, respectively. By 1998, these new generation drugs had accounted for 62% and 51% of all Medicaid prescriptions for antidepressants and antipsychotics. **CONCLUSIONS:** Antidepressants and antipsychotics account for a large proportion of Medicaid pharmaceutical prescriptions and reimbursements. The total Medicaid market for antidepressants and antipsychotics grew dramatically over this four-year period. The impact of newer antidepressants and antipsychotics on expenditures is disproportionate to the number of prescriptions for these agents. New generation antidepressants and antipsychotics have been accepted into common use within Medicaid programs. Increased Medicaid expenditures for antidepressants have been driven both by the uptake of new generation agents and by increased overall prescription volume. Increased Medicaid expenditures for antipsychotics have been driven by increased utilization of atypical antipsychotics. Utilization of new-generation antidepressants and antipsychotics varies among the states; not all states have adopted new generation agents as quickly as others.