pared all-cause utilization and costs associated with once-monthly paliperidone palmitate (PP) atypical antipsychotics (OAT) and concurrent schizophrenia medication use. **METHODS:** Adults with schizophrenia or bipolar disorder and concurrently insured schizophrenia or bipolar disorder medications were identified in the Truven Health MarketScan® Commercial Claims and Encounters and Medicare Supplemental and Coordination of Benefits Database. The “index date” was defined as the date of first receipt of an SGA. Patients with enrollment gaps during the 12-month period before the index date (pre-index period) or during the index period (follow-up period) were excluded. Healthcare utilization and costs were examined over the pre-index and follow-up periods. Healthcare encounters with diagnoses of MDD (ICD-9-CM 296.2, 296.3), and SGA and antidepressant prescriptions were designated “MDD-related”.

**RESULTS:** A total of 17,697 patients met study criteria. The most frequently prescribed SGA was aripiprazole (56.3%), followed by quetiapine (34.3%), risperidone (13.4%), and olanzapine (7.8%). During the pre-index and follow-up periods, 23.5% and 75.5% of patients, respectively, were hospitalized for MDD (ICD-9-CM 296.3). 37.3% and 31% had ≥1 emergency department (ED) visits (p < 0.001). Median MDD-related total health care costs during the pre-index period were $5,472 (95% CI: $3,627 to $7,317, p < 0.001). The average cost of SGA prescriptions during the 12-month period was $2,630 (95% CI: $2,105 to $3,155, p < 0.001). **CONCLUSIONS:** Initiation of adjunctive therapy with SGAs in MDD patients is associated with a lower incidence of hospitalization (MDD-related and all-cause) and ED visits.

**PMH26 COMPARING HEALTHCARE RESOURCE UTILIZATION AND COSTS AMONG SCHIZOPHRENIC PATIENTS WHO INITIATED TYPICAL VS. ATYPICAL LONG-ACTING INJECTABLES IN THE U.S. VETERAN POPULATION**

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**OBJECTIVES:** To evaluate healthcare resource utilization and costs among patients with schizophrenia who initiated typical and atypical long-acting injectables (LAI) in the U.S. veteran population. **METHODS:** Using the Veterans Health Administration (VHA) Medical SAS datasets, patients with ≥1 pharmacy claim for LAs were identified from 01OCT2005 through 30SEP2010. The first LAI date was designated as the index date. Patients were required to be age ≥18 years, have continuous health care enrollment for 12 months pre-index date and a schizophrenia diagnosis (International Classification of Diseases, 9th Revision, Clinical Modification [ICD-9-CM] code 295.xx) during the study period. Patient data was collected until the earlier of 12 months from the study end, and patients were considered to be part of the atypical LAI (olanzapine, paliperidone, risperidone) antipsychotic cohorts. All-cause (follow-up) and psychiatric (MDD and bipolar) health care resource utilization and all-cause economic burden were assessed. Follow-up health care costs were adjusted to per-patient-per-month. The generalized linear model (GLM) was used to assess cost and utilization differences between cohorts. A total of 4,796 patients were identified (Typical LAI cohort: n = 3,851; Atypical LAI cohort: n = 945), with a mean age of 52.6 years (61.6% male, 38.4% female). The atypical LAI cohort was older (age 53.81 vs. 50.94 years, p < 0.001) and more likely to be black (34.47% vs. 28.27%, p < 0.001) than atypical LAI patients. After adjusting for baseline differences using GLM, more patients prescribed typical LAs had all-cause emergency room (ER) visits (61.66% vs. 58.11%, p = 0.024) and inpatient stays (63.11% vs. 59.00%, p = 0.008) and psychiatric disorder-related ER visits (33.83% vs. 30.05%, p = 0.011) than those prescribed atypical LAs. However, typical LAI patients incurred lower all-cause pharmacy cost ($197 vs. $433, p < 0.001), total cost ($2,850 vs. $3,073, p = 0.048) and psychiatric disorder-related total costs ($1,615 vs. $1,624, p = 0.908) than atypical LAI patients. **CONCLUSIONS:** Although patients who initiated typical LAs had high health care costs, their economic burden was lower compared to those who initiated atypical LAs.
of commercially insured patients aged <65 years and one of Medicare enrollees—we identified across groups. **RESULTS:** A total of 565 asenapine patients were propensity-matched to a total of 565 aripiprazole patients. Compared to aripiprazole patients, asenapine patients had significantly lower pharmacy costs (mean $886 vs. $1,518, p < 0.001) and non-medication costs (mean $922 vs. $1,707, p = 0.005). Pharmacy costs decreased more among asenapine patients ($769 vs. 5.58, p = 0.65) than among aripiprazole patients ($-2 vs. a $10 increase for aripiprazole patients, p < 0.001). Similarly, total healthcare costs decreased more among asenapine patients ($-863 vs. $1,336, SD = $1,220). Amphetamine salts prescriptions were associated with the highest overall cost ($83.67 billion). Overall drug expenditure did not differ by gender or race. We found a higher proportion of males were diagnosed with ADHD than females (7.97% vs. 3.48%, p < 0.001). Diagnosis with ADHD was less frequent among white children as compared with African-American children (5.79% vs. 7.79%, p = 0.012). **CONCLUSIONS:** We found that 5.70% of U.S. pediatric visits had a mention of ADHD diagnosis. We estimated that in 2010 U.S. expenditure for ADHD medications was $6.62 billion. Diagnosis of ADHD was more frequent among males and African-American children and less frequent among females and whites.

**PMH32**

**PRESCRIPTION MEDICATION COSTS ASSOCIATED WITH CHILDHOOD ATTENTION DEFICIT HYPERACTIVITY DISORDER IN AMBULATORY CARE VISITS IN 2010**

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**OBJECTIVES:** To estimate the national costs of prescription medications for childhood attention deficit hyperactivity disorder (ADHD) in the United States (U.S.) in 2010 and to identify differences in diagnoses and costs by gender and racial/ethnic background.

**METHODS:** To determine childhood ADHD diagnosis and prescription medication use, we used ICD-9- and drug ID codes recorded from pediatric visits in the 2010 National Ambulatory Medical Care Survey (NAMCS). Our analysis included all visits from January 1 to December 31, 2010. We estimated total costs using Medicare unit costs and stratified by gender, race, and ethnicity.

**RESULTS:** In 2010, we identified 5,750 (p = 0.001) were associated with a diagnosis of ADHD and, of those diagnosed, 67.29% (n = 4,846,163) had a mention of a prescribed ADHD medication. The nationally weighted sum of ADHD medication cost was $6.62 billion (mean $1,336, SD $1,220). Amphetamine salts prescriptions were associated with the highest overall cost ($83.67 billion). Overall drug expenditure did not differ by gender or race. We found a higher proportion of males were diagnosed with ADHD than females (7.97% vs. 3.48%, p < 0.001). Diagnosis with ADHD was less frequent among white children as compared with African-American children (5.79% vs. 7.79%, p = 0.012). **CONCLUSIONS:** We found that 5.70% of U.S. pediatric visits had a mention of ADHD diagnosis. We estimated that in 2010 U.S. expenditure for ADHD medications was $6.62 billion. Diagnosis of ADHD was more frequent among males and African-American children and less frequent among females and whites.

**PMH33**

**THE BURDEN OF TREATMENT SWITCH IN PATIENTS WITH MAJOR DEPRESSION:**

A U.S. RETROSPECTIVE ADMINISTRATIVE CLAIMS ANALYSIS

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**OBJECTIVES:** The rate of remission with treatment in major depressive disorder (MDD) is low; thus, switching medications is common. This study describes MDD patients in the US who switched to selected antidepressants, determines the rates of switching, discontinuation, and adherence, and quantifies the healthcare costs following treatment switch. **METHODS:** Adults with >2 MDD-related claims (ICD-9 codes: 296.2x, 296.3x, 296.4x, 296.5x, 296.6x, 296.7x, 296.8x, 296.9x) who switched from an antidepressant to bupropion, citalopram, desvenlafaxine, duloxetine, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline, venlafaxine, or vilazodone (index AS), were identified. The index date was the date of first treatment switch occurring on or after January 1, 2012. Continuous enrollment for ≥12 months prior to and ≥6 months following the index date was required. Patient and treatment characteristics during the 12-month baseline (i.e., pre-index) period are reported. Index and follow-up costs were included. Costs were adapted using Medicare cost-to-charge ratios. Costs associated with switching medications were included. **RESULTS:** Among 9,912 patients were included. On average, patients were 45.9 years old, and 72.7% were female. A mean of 1.9 antidepressants were switched during the baseline period. Patients switched to an index AS for 230.6 days, on average, at baseline. During the 6-month follow-up, 16.8% of patients switched treatment and 28.0% discontinued the index antidepressant. The proportion of adherent patients was 52.2%. Patients incurred an average total healthcare cost of $89,613 (2013 USD) during follow-up. **CONCLUSIONS:** Switching is prevalent, and a notable financial burden is observed among switchers in the US. Discontinuation rates are high, and adherence is suboptimal. Future research is warranted to determine which switching strategies are associated with optimal treatment and costs.