prior to treatment initiation. Multinomial logistic regression models were used to estimate the probability of treatment with olanzapine, quetiapine, or risperidone (reference group) monotherapy based on patients’ demographic, clinical characteristics and health care resource utilization during the three months prior to treatment initiation. RESULTS: A total of 838 patients [mean age 38.9 [SD: 11.4] years] met inclusion criteria. Patients were initiated on monotherapy with either olanzapine (n = 393), risperidone (n = 262), or quetiapine (n = 183). Compared to risperidone, patients aged 25–34, and 55–64 years were more likely than other age groups to receive olanzapine. African-American patients were less likely to initiate olanzapine or quetiapine. Women were more likely than men to receive quetiapine, compared with risperidone. Patients whose first bipolar episode was depressive or who had used second generation antidepressants during the three-month baseline period were less likely to initiate olanzapine. Patients who used second generation antidepressants were more likely to receive quetiapine than risperidone. Patients in the two counties with the largest population of patients diagnosed with bipolar disorder were less likely to initiate quetiapine. CONCLUSIONS: Several variables, including gender, race, type of first bipolar episode, and county of residence were associated with the choice of atypical antipsychotic monotherapy used to treat bipolar disorder.

PMH29
ATTENTION DEFICIT HYPERACTIVITY DISORDER MEDICATION CLINICAL PRIOR AUTHORIZATION PROGRAM'S IMPACT ON PRESCRIPTION DRUG UTILIZATION AND COSTS
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OBJECTIVES: This study aims to evaluate the impact of Attention Deficit Hyperactivity Disorder (ADHD) Narcolepsy Clinical Prior Authorization program on prescription drug utilization and costs. METHODS: Using pre-post with control group approach, prescription records from April 2003 to June 2005 were obtained from pharmacy claims database in a pharmacy benefit management organization. The study group comprised of eight clients enrolled in ADHD Narcolepsy program, while the control group comprised of all other clients not enrolled in this program. Number of prescriptions dispensed and total costs per member per month (PMPM) for both targeted brand drugs and shift-to-generic drugs were compared between the study and control groups. RESULTS: The study group included 62,451 eligible lives, and the control group included 341,971 lives. From the pre to post period, in the study group, the average number of prescriptions per month per thousand eligible lives and the average PMPM total costs decreased by 37.5% (from 26 to 16.26) and 31.3% (from $2.25 to $1.54) for the target drugs, and increased by 48% (from 11.7 to 17.3) and 15.4% (from $0.79 to $0.91) for the shift-to-drugs respectively. In the control group, however, the average number of prescriptions and the average PMPM costs increased by 18.3% (from 21.18 to 17.31) and 13.4% (from $1.95 to $1.69) for the target drugs, decreased by 8.6% (from 10.4 to 9.5) and 25% (from $0.82 to $0.62) for the shift-to-drugs. SSRI Step Care was estimated to result in $0.41 PMPM cost savings in the target drugs but $0.31 PMPM cost increase in the shift-to-drugs, and a net PMPM total cost savings of $0.10. CONCLUSIONS: SSRI Step Care was found to shift prescription drug utilization from expensive brand names to low cost generics. A medication management program such as SSRI Step Care has been shown to lower prescription drug expenditures.

PMH30
EVALUATION OF SELECTIVE SEROTONIN REUPTAKE INHIBITOR STEP CARE PROGRAM ON MEDICATION COSTS AND UTILIZATION
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OBJECTIVES: This study evaluated the impact of Selective Serotonin Reuptake Inhibitor (SSRI) Step Care program on prescription drug utilization and expenditures. METHODS: Using pre-post with control group study approach, prescription records from October 2003 to April 2005 were obtained from pharmacy claims database in a pharmacy benefit management organization. The study group comprised of patients enrolled in SSRI Step Care, while the control group comprised of those not enrolled in this program. Number of prescriptions dispensed and total costs per member per month (PMPM) for both targeted brand drugs and shift-to-generic drugs were compared between the study and control groups. RESULTS: The study group included 62,451 eligible lives, and the control group included 341,971 lives. From the pre to post period, in the study group, the average number of prescriptions per month per thousand eligible lives and the average PMPM total costs decreased by 37.5% (from 26 to 16.26) and 31.3% (from $2.25 to $1.54) for the target drugs, and increased by 48% (from 11.7 to 17.3) and 15.4% (from $0.79 to $0.91) for the shift-to-drugs respectively. In the control group, however, the average number of prescriptions and the average PMPM costs increased by 18.3% (from 21.18 to 17.31) and 13.4% (from $1.95 to $1.69) for the target drugs, decreased by 8.6% (from 10.4 to 9.5) and 25% (from $0.82 to $0.62) for the shift-to-drugs. SSRI Step Care was estimated to result in $0.41 PMPM cost savings in the target drugs but $0.31 PMPM cost increase in the shift-to-drugs, and a net PMPM total cost savings of $0.10. CONCLUSIONS: SSRI Step Care was found to shift prescription drug utilization from expensive brand names to low cost generics. A medication management program such as SSRI Step Care has been shown to lower prescription drug expenditures.

PMH31
LIKELIHOOD OF EMPLOYMENT TERMINATION AMONG EMPLOYEES WITH BIPOLAR DISORDER TREATED WITH DIFFERENT PSYCHOTROPIC MEDICATIONS
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OBJECTIVES: To evaluate the likelihood of employment termination among patients with bipolar disorder (BPD) treated with different classes of psychotropic medications. METHODS: Patients with BPD (classified according to ICD-9-CM codes) were identified from the Human Capital Management Services Research Reference Database. Patients with continuous eligibility six months before and 12 months after their initial prescription treatment for BPD were categorized into those using: atypical antipsychotics only (ATYP); conventional antipsychotics, mood stabilizers (including lithium, divalproex, lamotrigine, and carbamazepine), and specific anticonvulsants only (OTHER); medications from both categories (BOTH); and no study-specific psychotropic medications (NONE). The index “prescription” date for the NONE group was defined as six months after the initial diagnosis. Both voluntary and involuntary terminations of employment were included. Regression models controlled for possible confounding factors (age, gender,
location, salary, race, marital status, full-time/part-time status, prior comorbidity index, prior medical costs related to BPD, prior other medical costs, index date, and medical services related to BPD). Treatment groups were compared over a follow-up period ranging from 12 to 24 months after the index prescription date. RESULTS: Six hundred ninety-nine patients with BPD were classified into the ATYP (n = 25), BOTH (n = 190), NONE (n = 170), and OTHER (n = 314) treatment groups. The ATYP group demonstrated the lowest rate of employment termination (1.5%; 95% CI 3.3%, 6.3%) followed by the BOTH (5.8%; 95% CI 2.5%, 9.1%), NONE (8.9; 95% CI 4.7%, 13.2%), and OTHER (9.3%; 95% CI 6.1%, 12.5%) groups. Differences between treatment groups were not significant. The numerical difference between ATYP and OTHER did not reach significance (p = 0.058). CONCLUSIONS: The ATYP group demonstrated the lowest employment termination rate in the follow-up period of 12 to 24 months after the index prescription date. Further research is warranted to examine the influence of specific patient variables and treatment regimens on employment termination in patients with BPD.

PMH32

ANTIPSYCHOTIC THERAPY IN PATIENTS WITH BIPOLAR DISORDER: EFFECTS ON TOTAL AND MENTAL HEALTH CARE COSTS

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OBJECTIVES: Compare total and mental health-related costs among patients with bipolar disorder (BPD) initiated on quetiapine versus other antipsychotics in a state Medicaid system. Economic evaluations comparing quetiapine with other antipsychotics are lacking in the published literature. METHODS: Retrospective study using “de-identified” Medicaid claims data of patients with BPD. Patients assigned to quetiapine (QTP), olanzapine (OLZ), risperidone (RIS), or typical antipsychotic groups based on first prescription filled between January 1, 1999 and December 31, 2001. Total and mental health-related costs (including study drug charges) from 12 months before until 12 months after treatment initiation were analyzed, controlling for various confounders including patient demographics, comorbidities, and prior health care utilization. Total health care costs included costs associated with medical and mental conditions. Mental health-related costs were identified by claims associated with a mental health disorder (ICD-9-CM codes 290.XX–316.XX) or CPT codes for psychiatric services (90801–90899) and psychiatric medications. RESULTS: A total of 825 patients with BPD were classified into OLZ (n = 283, 34.30%), RIS (n = 231, 28.00%), QTP (n = 106, 12.85%), and typical antipsychotic (n = 205, 24.85%) cohorts. Mean (±SD) total health care costs over the 12-month follow-up period were US$17,866 ± US$23,164 (OLZ), US$17,539 ± US$17,570 (RIS), US$13,227 ± US$18,862 (QTP), and US$17,570 ± US$23,842 (typical antipsychotics). Mean mental health-related costs over the 12-month follow-up period were US$10,203 ± US$12,703 (OLZ), US$9,475 ± US$14,202 (RIS), US$8,064 ± US$7,368 (QTP), and US$7,368 ± US$11,239 (typical antipsychotics). Adjustment for confounders using multivariate analysis revealed no significant differences in total and mental health-related costs between the QTP group and the other atypical antipsychotic groups (OLZ, RIS). For the typical antipsychotic group, there was greater total (28.4%) and mental health-related (8.7%) costs compared with the QTP group. CONCLUSIONS: There were no significant differences in total and mental health-related costs between atypical antipsychotic groups. However, patients with BPD treated with QTP incurred lower total and mental health-related costs compared with those receiving typical antipsychotics.

PMH33

DEMOGRAPHIC AND CLINICAL CHARACTERISTICS OF PATIENTS PRESCRIBED ANTIPSYCHOTIC (AP) MONOTHERAPY IN TEXAS MEDICAID

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OBJECTIVE: To describe the demographic and clinical characteristics of Texas Medicaid enrollees prescribed AP therapy. METHODS: This was a retrospective database analysis using electronic medical records from 1997 to 2001 for adults receiving AP monotherapy who were continuously enrolled in Texas Medicaid for at least 18 months. Patients were stratified according to a hierarchy of mutually exclusive primary mental health (PMH) categories for which AP therapy was presumed to be prescribed. RESULTS: Data were available for 19,430 patients. The population was mainly female (65.7%), white (55.1%) and older (mean age 60.3 years (SD: 21.9), with 47.6% ≥ 65 years). PMH diagnoses were: schizophrenia 16.5%; bipolar disorder 15.5%; dementia 14.3%; psychosis 8.1%; non-psychotic disorder 14.5%; no mental health diagnosis 31.1%; with 32.1% of patients having more than one mental health diagnosis. The percentages of index AP therapy were: first-generation agent 29.3%; clozapine 0.5%; olanzapine 21.6%; quetiapine 6.3%; risperidone 42.2%. This differed when stratified by age (χ2 = 416.748, df = 16, p < 0.001), gender (χ2 = 76.901, df = 4, p < 0.001), race/ethnicity (χ2 = 160.710, df = 12, p < 0.001) and PMH diagnosis (χ2 = 845.046, df = 20, p < 0.001). Risperidone was more common in those ≥65 years (48.3%), females (43.5%), Hispanics (46.7%), and for dementia patients (50.1%). Olanzapine was primarily used in patients aged 45–54 years (35.6%); males (31.6%); blacks (35.4%), and for schizophrenia (36.5%). The mean daily dose of the second-generation antipsychotics (SGAs) differed by age (p < 0.001) and treatment indication (p < 0.001). Regardless of the SGA, patients aged ≥65 years received doses 43.4–51.2% lower than patients aged < 65 years. Regardless of age, doses for schizophrenia were 26–46% higher than for bipolar disorder and 60–70% higher than for dementia patients. CONCLUSIONS: AP agents are prescribed for a diverse range of indications with significant differences in AP dose according to treatment indication and patient age.