Results were reported for induction (weeks 0–8), maintenance (weeks 9–52), and one-year (weeks 0–52) periods. Infusion intervals included mean time (days) between infusions during the first year of treatment. RESULTS: A total of 425 naïve (mean age = 53 years; 74% female) and 467 experienced (mean age = 49 years; 78% female) patients were evaluated. The mean IFX dose per infusion for naïve patients was 436 mg during the induction vs. maintenance period (397 mg vs. 455 mg). The mean IFX dose per infusion for one year was 437 mg. Nearly all naïve patients (98.5%) received no more than 8 infusions in the first year. The mean times between IFX infusions for naïve patients were 19, 29, 56, 57, 55, 52, and 53 days. The mean IFX dose per infusion for experienced patients was lower during the induction vs. maintenance period (428 mg vs. 527 mg). The mean times between IFX infusions for experienced patients were 18, 28, 52, 50, 49, 48, and 41 days. CONCLUSIONS: This observa- tion confirms the study reveals IFX utilization differences between anti-TNF naïve and experienced patients. Both naïve and experienced patients had infusions intervals within the recommended labeling.

Abstracts

PM566
REAL-WORLD TRENDS IN THE DIAGNOSIS AND ASSESSMENT OF RHEUMATOID ARTHRITIS (RA) AMONG RHEUMATOLOGISTS IN THE UNITED STATES

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OBJECTIVES: Diagnosis and management of rheumatoid arthritis (RA) have changed dramatically during the last several years, with the emergence of new guidelines, treatment options, and diagnostic tests. These involve varying degrees of complexity, and place demands on time and resources in routine clinical practice. The aim of this study was to assess current trends in RA diagnosis and assessment practices among US rheumatologists.

METHODS: A sample of rheumatologists (N = 86) was surveyed onlines of a newly-launched managed Internet panel. Physicians were asked which diagnostic and disease severity measures they were aware of, and how often they used those measures—for both diagnosis and disease severity assessment. RESULTS: Physicians were mostly male (n = 62, 72.1%) and practiced in suburban areas (n = 44, 51.2%). The mean number of years in practice (post-residency) was 16.3, and the mean number of RA patients seen per month was 136.5. Physicians treated more RA patients with disease-modifying antirheumatic drugs (DMARDs) and biologics than with non-steroidal anti-inflammatory drugs (NSAIDs), COX-2 inhibitors, and corticosteroids. The most common diagnostic measure was anti-cyclic citrullinated peptide (anti-CCP) assays (97.7%). The most common disease assessments were swollen joint count (88.4%), tender joint count (87.2%), erythrocyte sedimentation rate (81.4%), C-reactive protein (77.9%), patient’s assessment of physical function (75.6%), and patient’s assessment of pain (74.4%). 54 physicians (62.7%) reported employing HRQOL questionnaires to assess patients’ well-being, the Health Assessment Questionnaire (HAQ) being the most common (43.4%). CONCLUSIONS: Though rela- tively new, anti-CCP assays were employed by almost all physicians for RA diagnoses. While other serum markers were often used for diagnosis, they were less likely to be used for disease severity assessment versus physicians’ and patients’ assessments of symptoms and physical function. Although a majority of physicians used HRQOL measures, the opportunity exists for further adoption and standardization of such measures to facilitate better management of RA.

PM567
TWO YEAR MAINTENANCE INFILXIMAB DOSING AND ADMINISTRATION PATTERNS IN PATIENTS WITH RHEUMATOID ARTHRITIS

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OBJECTIVES: Food and Drug Administration (FDA)-approved prescribing information recommends infliximab (IFX) administration at 0, 2, 6 and every 8 weeks with potential dose increase based on patient response for patients with RA. Minimal real world dosing data are available in this population. This study evaluated IFX dosing patterns in patients with rheumatoid arthritis (RA) treated in the outpatient hospital setting.

METHODS: A retrospective longitudinal analysis using the Premier Perspec- tive™ Database, a United States-based hospital database, was conducted. Inclusion criteria were an outpatient hospital discharge RA diagnosis (ICD-9 code: 714.xx) between July 1, 2001 and December 31, 2008, IFX-naïve, and ≥23 IFX doses within ≤56 days of the index infusion. Exclusion criteria included patients with other selected inflammatory diseases. Treatment duration was defined as the time between the index and last IFX dose. The 4th through 15th IFX doses were analyzed representing the first year of maintenance treatment. RESULTS: A total of 2185 patients with RA receiving IFX were identified. Mean (SD) age was 60.3 (14.0) years; 79.0% were female. Mean (SD) treatment duration was 465 (459) days. Patients received a mean (SD) of 9.8 (8.8) IFX administrations. Mean (SD) index IFX dose was 338.2 (156.8) mg. Mean (SD) maintenance IFX dose was 387.7 (169.5) mg. During the initial two years of IFX administration, mean doses remained between 351 and 402 mg. During the initial two years of maintenance IFX administration, the highest observed mean dose represented a 15% increase compared to the first dose in the maintenance period and a 19% increase compared to index dose. Median time between administrations was 55 days for all maintenance infusions. CONCLUSIONS: The observed adminis- tration schedule was consistent with FDA-approved prescribing information. These data suggest IFX dose in patients with RA remained relatively stable and provide stakeholders with an understanding of real world utilization.

PM568
DOSES AND INFUSION INTERVALS FOR INFILXIMAB IN ANTI-TNF NAIVE AND ANTI-TNF EXPERIENCED MANAGED CARE PATIENTS’ WITH RHEUMATOID ARTHRITIS

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OBJECTIVES: To describe infliximab (IFX) doses and infusion intervals in patients with RA who are anti-TNF naïve or anti-TNF experienced.

METHODS: Medical and pharmacy claims for patients ≥18 years with ≥2 RA diagnosis codes received January 2000-December 2006 were included from a database of commercial health plans. Patients were excluded for selected inflammatory conditions. Anti-TNF naïve patients had no biologic use for 6 months prior to IFX. Anti-TNF experienced patients had adalimumab/etanercept prior to IFX. Infused doses were calculated by dividing the plan’s allowed amount for each IFX claim by the acquisition cost for a 100 mg vial. Results were reported for induction (weeks 0–8), maintenance (weeks 9–52), and one-year (weeks 0–52) periods. Infusion intervals included mean time (days) between infusions during the first year of treatment. RESULTS: A total of 425 naïve (mean age = 53 years; 74% female) and 467 experienced (mean age = 49 years; 78% female) patients were evaluated. The mean IFX dose per infusion for naïve patients was 436 mg during the induction vs. maintenance period (397 mg vs. 455 mg). The mean IFX dose per infusion for one year was 437 mg. Nearly all naïve patients (98.5%) received no more than 8 infusions in the first year. The mean times between IFX infusions for naïve patients were 19, 29, 56, 57, 55, 52, and 53 days. The mean IFX dose per infusion for experienced patients was lower during the induction vs. maintenance period (428 mg vs. 527 mg). The mean times between IFX infusions for experienced patients were 18, 28, 52, 50, 49, 48, and 41 days. CONCLUSIONS: This observa- tion confirms the study reveals IFX utilization differences between anti-TNF naïve and experienced patients. Both naïve and experienced patients had infusions intervals within the recommended labeling.