comorbidity burden than age- and gender-matched controls, and incur much higher levels of inpatient service use and overall health care costs.

**PMH16**

**HEALTH CARE COSTS AND UTILIZATION PATTERNS OF INDIVIDUALS WITH GENERALIZED ANXIETY DISORDER (GAD) IN THE UNITED STATES**

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**OBJECTIVES:** GAD is a chronic psychiatric disorder with an estimated lifetime prevalence of 5.7% in the U.S. population. This study evaluated the health care costs and utilization patterns for individuals with GAD in the U.S. **METHODS:** A large, geographically-representative aggregated medical and pharmacy claims database from the UnitedHealth Group was used to construct the study database. The database included approximately 1.4 million covered lives, from May 2000 through July 2005. Individuals were extracted who had at least one ICD-9 code of 300.02 for GAD. The date of first GAD claim was defined as the index date. Individuals were excluded if not enrolled for at least six months prior to and 12 months after the index date. Costs were reported in both nominal and constant dollars (in 2005 dollars). **RESULTS:** After applying the exclusion/exclusion criteria, the study sample included 101,367 eligible individuals with GAD; 65% were female and average age was 39.7 years. On average, annual total non-drug medical costs for an individual with GAD were $6,585 ($8,864 in constant dollars) prior to the index date and increased to $9,562 ($10,904), or 45%, in the post-index date period. Annual total costs for all prescriptions increased from $1212 ($1314) in the pre-index date period to $1959 ($2018), or 62%, in the post-index date period. On average, 19 and 24 prescriptions were filled per year in the pre- and post-index periods, respectively. Most prescribed mental disorder drugs were antidepressants, followed by anxiolytics and anticonvulsants. **CONCLUSIONS:** Individuals with GAD consume enormously high health care services before and after GAD diagnosis, and health care expenditures increase significantly after GAD is diagnosed. Further research is warranted to investigate how cost and utilization patterns relate to factors such as demographic and clinical characteristics to better understand costs and implications of GAD to both patients and society.

**PMH17**

**RESOURCE-USE AND COSTS ASSOCIATED WITH PATIENTS TREATED FOR DEPRESSION IN PRIMARY CARE**

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Despite the clinical and economic importance of depression, resource utilization and cost in clinical practice is not well documented. **OBJECTIVES:** The aim of this study was to investigate medical resource consumption, productivity loss and costs associated with patients treated with antidepressants for depression in primary care. **METHODS:** A total of 447 patients were enrolled at 56 Swedish primary care centres to this naturalistic longitudinal observational study. Patients over 18 years with depressive symptoms, and who initiated a new antidepressant therapy were included in the study. Data on patients’ socio-demographics, daily activity and quality-of-life (EQ-5D) were collected using questionnaires completed during outpatient GP visit for a follow-up period of approximately 6 months. **RESULTS:** Based on a complete sample of 398 patients, the total annual cost per patient was estimated at $13,400 (SEK 12,300–$15,100) in 2005 prices. Direct costs were estimated at $4800 ($4300–$5400), constituting 35% of the total annual cost per patient. Among direct costs, the cost for medical visits was the largest single cost item, representing about 18%. The costs for antidepressants represented only 4% of the total costs. The indirect costs, i.e. productivity loss due to lost working time, were estimated at $9000 per patient ($7600–$10,200), or 65% of the total annual costs per patient. No demographic variables were significantly associated with cost of depression. Direct and indirect costs were however correlated positively with achievement of clinical remission. The presence of sick-leave during follow-up was moreover associated with 1.8 times higher costs. **CONCLUSIONS:** The burden of depression to society is high, both in terms of direct treatments costs and indirect costs for sickness absence and early retirement. Because of the high indirect cost per patient, there seems to be a particular need for therapies that have the potential to reduce absenteeism.

**PMH18**

**ANALYZING PATTERNS OF ANTIDEPRESSANT USE AND THE COST CONSEQUENCES OF PRODUCT SWITCHING**

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**OBJECTIVES:** The study examines patterns of antidepressant use including drug switching and related resource utilization. **METHODS:** Using retrospective claims of managed care enrollees from a national database (PharMetrics), this study followed newly diagnosed depression patients (age 18+) with newly prescribed antidepressants. Patients switching from commonly prescribed selective serotonin reuptake inhibitors (SSRIs; fluoxetine, citalopram, sertraline, and paroxetine) to serotonin-norepinephrine reuptake inhibitors (SNRIs; venlafaxine), and vice versa were identified and quantified. The healthcare costs for a 1-year period following diagnosis for various switcher groups were then aggregated. Multivariate regression analyses were used to determine the predictors of switching and the factors influencing overall and depression-related costs while controlling for confounding factors. **RESULTS:** Of the 48,950 patients included in the study population, 89% were treated with SSRIs and 11% with SNRIs. Twelve percent to 15% of patients switched antidepressants. Of the SSRI switchers, 29% switched to an SNRI. Increased likelihood of switching was associated with female gender, Medicaid coverage, prior anxiolytic use, treatment by a psychiatrist or psychologist, and paroxetine as the index medication. Compared with SSRI non-switchers, costs for SSRI switchers were 36% higher for all causes and 58% higher for depression-related causes. In contrast, compared with SNRI non-switchers, costs for SNRI switchers were 27% higher for all causes and 5% higher for depression-related causes. Thus, patients switching from SSRI to SNRI are accruing relatively greater costs than vice versa. In addition, among SSRI patients switching to SNRL costs increased with the number of switches. Multivariate analyses confirmed that switching was associated with higher overall and depression-related costs. **CONCLUSIONS:** Switching among antidepressants is quite frequent among depression patients. Switchers incur significantly higher overall and depression-related costs, and in general, switching antidepressants is more costly for SSRI patients than for SNRI patients.