with depot and oral antipsychotics, respectively. 25 patients were not treated with any antipsychotic medication, so were excluded from the analyses. Compared with oral users, depot patients were more likely to: have had more previous episodes of schizophrenia; have spent more days in hospital, be male; be less educated; be unemployed; be violent; and have experienced non-violent crimes. Approximately 50% of all depot users were treated with an oral antipsychotic supplement as co-therapy. A higher proportion of depot users were admitted and re-admitted to hospital throughout the study, with significant differences in year 2 and 3 (p < 0.01, respectively). The ALoS was consistently higher in depot users compared with oral users over the three years.

CONCLUSION: Patients treated with typical depot antipsychotics appear to be distinctly different from those treated with oral antipsychotics. Depot users were found to consume considerably more health care resources. This study indicates that there may be a subset of the schizophrenia population whose clinical needs are not currently well met by existing treatment options.

NICE’S COST-EFFECTIVENESS APPRAISAL OF CHOLINESTERASE INHIBITORS: ASKING THE RIGHT QUESTION

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OBJECTIVE: The National Institute for Clinical Excellence’s (NICE) initial evaluation of cholinesterase inhibitors for Alzheimer’s disease failed to account for current guidance in the UK, which states that only patients who respond to treatment should continue with therapy. This study re-values cost-effectiveness estimates using the same model in accordance with current guidance. METHODS: The Assessment of Health Economics in Alzheimer’s Disease (AHEAD) model, published in 2001, was adapted by the NICE appraisal group for their evaluation. The original AHEAD model was used to estimate the cost-effectiveness of continuing therapy only in responders. Where possible, model inputs were based on values used by NICE. Only patients who experienced no decline in cognition after six months of treatment with galantamine continued treatment, for the subsequent five years. A health care payer perspective was adopted. Sensitivity analyses on costs, utilities, discount rates, treatment effects and time horizon were conducted.

RESULTS: NICE reported the cost-effectiveness of galantamine as £46,000 per discounted QALY gained in its augmented base case results. Shadowing NICE inputs, and assuming all patients continue with treatment regardless of response, the original AHEAD model results in a ratio £32,000, so some differences between the two analyses remain even when using similar inputs. Using AHEAD, if only responders continue with treatment, the ratio falls to £11,000, a 67% drop. If a responder analysis in the NICE study would also result in a 67% reduction in their estimate, one would expect a new NICE ratio of roughly £15,000. Treatment costs and time horizon were influential. If projections are extended to 6 years, the ratio falls to £7000. Varying the daily cost of galantamine by £0.50 changes cost per QALY estimates by about £5000. CONCLUSIONS: NICE’s initial cost-effectiveness assessment was not in agreement with current guidance and results in inappropriately high estimates of cost-effectiveness.

MEDICAL COSTS AND HOSPITALIZATION OF ADULTS DIAGNOSED WITH ATTENTION-DEFICIT/HYPERACTIVITY DISORDER WHO RECEIVED ALTERNATIVE THERAPIES

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OBJECTIVES: To compare 6-month medical costs and hospitalization risk of adults diagnosed with attention-deficit/hyperactivity disorder (ADHD) receiving extended-release methylphenidate (OROS-MPH, CONCERTA®) to those receiving mixed amphetamine salts extended release (MAS-XR, Adderall XR®) or atomoxetine (Strattera®) from employer perspective. METHODS: We examined data from a U.S. employer claims database of 5 million beneficiaries (1999–2004). Analysis was restricted to adults aged 18–64 with at least one diagnosis of ADHD (ICD-9: 314.x) and at least one prescription of OROS-MPH, MAS-XR, or atomoxetine. Adults were required to have continuous eligibility 6 months before and after their latest therapy initiation and have no ADHD therapy in the prior 6 months. Descriptive measures of medical costs (including outpatient and inpatient costs) and hospitalization risk were computed over 6 months following therapy initiation. Generalized estimating equations (GEE) models were used to compare costs of adults receiving alternative therapies adjusting for baseline demographic characteristics, substance abuse, depression, and the Charlson comorbidity index. Costs were adjusted to 2004 dollars using medical CPI. RESULTS: Of the research sample (n = 4569), 31.8% received OROS-MPH, 34.0% MAS-XR, and 34.2% atomoxetine. In the 6-month follow-up period, medical costs were $1251 for OROS-MPH, $1422 for MAS-XR, and $1581 for atomoxetine-treated adults. The GEE model adjusting for patient characteristics found that 6-month medical costs for OROS-MPH-treated adults were $141 less than for the MAS-XR-treated (p = 0.02) and $312 less than for the atomoxetine-treated (p = 0.03). The risk of having at least one hospitalization was 42% higher for adults treated with MAS-XR (OR = 1.42, 95% CI: 0.99–2.05) and 51% higher for adults treated with atomoxetine (OR = 1.51, 95% CI: 1.05–2.17) compared to adults treated with OROS-MPH. CONCLUSIONS: Over the 6-month period after therapy initiation, adults treated with OROS-MPH had lower medical costs than those treated with MAS-XR and lower medical costs and risk of hospitalization than adults treated with atomoxetine.

UROLOGICAL/RENAL

THE ECONOMIC IMPACT OF EPOETIN ALFA (EPO) THERAPY ON DELAYING TIME TO DIALYSIS IN ELDERLY PATIENTS WITH CHRONIC KIDNEY DISEASE (CKD)

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OBJECTIVE: This analysis evaluated the medical cost savings of delaying time to dialysis in elderly CKD patients receiving EPO. METHODS: Using health claims and laboratory data from >35 health plans between January 1999 and April 2004, dialysis patients (265 years) who had ≥1 hemoglobin (Hb) value and ≥1 glomerular filtration rate (GFR) value <60 mL/min prior to dialysis were identified. Patients were excluded if they had an organ transplant, had received blood transfusions or darbepeotin alfa, or had received dialysis for non-CKD reasons. Each CKD patient...