of commercially insured patients aged <65 years and one of Medicare enrollees—
we identified 52,485 patients (p < 18 years: 48.7%, African-American: 20.2%, 230.6 days, on average, at baseline. During the 6-month follow-up, 16.8% of patients were prescribed during the baseline period. Patients had been on antidepressants for

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 diagnosis 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 and at least one of the following medications: amphetamine salts, atomoxetine, dextroamphetamine, dexmethylphenidate, and methylphenidate. To calculate the costs of medication use, we multiplied the 2010 average wholesale price (AWP) by a prescriber-specific unit number and weighed by national estimates. We compared differences in overall medication cost by gender and race using the student’s t-test and evaluated differences in the proportion of patients diagnosed with ADHD using the chi-square test. RESULTS: Among pediatric visits in the US in 2010, we found that 5.70% (n = 7,201,548) 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 = $1,316, SD = $1,220). Amphetamine salts prescriptions were associated with the highest overall cost ($3.67 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 African-American children (0.79% vs. 7.29%, 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 US 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, 296.8x, 296.9x) who switched from an antidepressant to bupropion, citalopram, desvenlafaxine, duloxetine, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline, venlafaxine, or vilazodone (index AS), were included. 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 AS discontinuation and completed treatment (defined as a treatment gap of ≥24 consecutive days), adherence (defined as ≥80% of days covered with the index antidepressant), and switch rates (from the index antidepressant to another antidepressant) over the 6-month follow-up are reported. Healthcare costs in the index period and 6-month follow-up are also reported. RESULTS: 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 prescribed during the baseline period (SD = 2.3). Patients had an average of 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 $8,837 (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.

PMH34

COST EFFECTIVENESS ANALYSIS OF DIFFERENT TREATMENT ALTERNATIVES IN CHILDREN WITH ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)
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OBJECTIVES: To determine the cost effectiveness of three treatment alternatives (medication, behavioral, and combined treatment of Atomoxetine and behavioral therapy) for attention deficit hyperactivity disorder in children from payer perspectives with time horizon: 12 weeks. METHODS: A prospective trial based economic evaluation was conducted on children in psychiatric outpatients clinic at Abaseya Mental Hospital (AMH), Cairo, Egypt who are 6 to 12 years of age (boys or girls), and had a clinical diagnoses of ADHD as defined in the Diagnostic and statistical manual of mental disorders, 4th edition. Patients were randomized to receive medication only (group I), behavioral therapy only (group II), and combined medication and behavioral therapy (group III). The primary outcome was the cost of treatment and the secondary outcome associated with it. Cost effectiveness ratio comparing the average total cost per child per unit of outcome three-months Quality Adjusted Life Years (“QALY”) in each of the three groups. RESULTS: The combined therapy was associated with the lowest mean cost and the lowest mean QALY (268.16). The combined therapy and medication alone were associated with the highest cost of $1908.05 and highest mean QALY of 2.09. The C/E Ratio for the medication alone was $938.927 LE per QALY, While C/E Ratio of behavioral therapy was 3337.339 LE per QALY. According to base-case analysis, combined therapy resulted in greatest health benefits but at the same time it was the most expensive treatment option. Behavioral therapy was the least effective and cheapest option. The sensitivity anal-

A120