loss and resource were similar in Brazil and the 5EU (all p > 0.01).

Conclusions: The phase 3 TENERE (NCT00883337) study comparing teriflunomide with subcutaneous interferon beta-1a (sc IFN-1a) did not meet its primary endpoint (superiority of teriflunomide vs sc IFN-1a) on time to treatment failure (TTTF). Teriflunomide vs IFN-1a was associated with a reduced rate of teriflunomide 14 mg and sc IFN-1a-1a. The objective of the current analysis was to compare patient treatment satisfaction of teriflunomide with that of sc IFN-1a-1a.

Methods: Randomized patients (n = 324) received once-daily teriflunomide 14 mg or 7 mg sc IFN-1a-1a three times per week. The study was completed 48 weeks after the last patient was randomized. Patient satisfaction with treatment was assessed as a secondary endpoint using the Treatment Satisfaction Questionnaire for Medication (TSQM), version 2.0. The TSQM provides three scores for effectiveness, side-effects, convenience, and global satisfaction. A mixed-effect model with repeated measures was used to analyze TSQM scores at Week 48. Magnitude of effects was assessed using effect size (ES), defined as the difference in treatment effect divided by standard deviation. The ES differences were ranked as follows: < 0.2, negligible; ≥ 0.2–0.5, small; ≥ 0.5–0.8, moderate; ≥ 0.8, high.

Results: At Week 48, TSQM scores showed significantly better patient satisfaction in the teriflunomide 14 mg group compared to the IFN-1a-1a group in three domains (side-effects, P = 0.001, confidence, P = 0.02), with no perceived difference on effectiveness (P = 0.28). High ES values favoring teriflunomide 14 mg vs IFN-1a were seen for side-effects (1.83), confidence (1.35), and global satisfaction (0.39). Conclusions: A significant and meaningful improvement in treatment satisfaction for teriflunomide 14 mg vs IFN-1a-1a was observed with regards to side-effects, confidence, and global satisfaction, which may potentially improve treatment adherence and outcomes in clinical practice.

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ANTIEPILEPTIC DRUG (AED) TREATMENT SEQUENCING IN THE UK IN PATIENTS WITH EPILEPSY: REAL-LIFE PRACTICE DATA USING CPRD

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Objectives: Analyze real-life AED treatment sequencing in the UK using prescription data from the Clinical Practice Research Datalink (CPRD), and compare it to the 2012 National Institute for Health and Care Excellence (NICE) clinical guidelines.

Methods: Patients were included if they had an epilepsy diagnosis and an AED prescription between January, 2009 and January, 2014. Patients who entered the database untreated were followed from first AED prescription following an epilepsy diagnosis, for up to five lines of treatment until being censored at the end of registration, death, or end of data coverage. Follow-up time could differ substantially between patients. AED treatment changes were classified as add, switch, or stop. The first two AEDs patients per treatment period were classified as first-line AED combination and each regimen, grouped as Monotherapy, Polytherapy, and “No AED”.

Results: Overall, 8919 patients went through 2469 unique AED treatment sequences. 53% of patients were started on monotherapy, 38% and 9% of patients on their first Monotherapy until censored. 16.5% of initial Monotherapy patients switched to a second Monotherapy; 27% went to “No AED”, 25.7% progressed to Polytherapy. The first treatment line was consistent with NICE guidelines for 70.4% of patients. The most frequent 14.7% of patients followed NICE guidelines in the first 2 lines.

The main divergence from guidelines involved prescribing Polytherapy or “No AED” rather than a second monotherapy in line 2. Largely consistent with NICE, the most frequent (87.1%) initial monotherapy AEDs were valproic acid (30.1%), lamotrigine (22.8%), carbamazepine (10.3%), levetiracetam (10.5%), and phenytoin...