ECONOMIC BURDEN OF OSTEOPOROSIS, BREAST CANCER, AND CARDIOVASCULAR DISEASE AMONG WOMEN
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OBJECTIVES: To investigate the financial burden of osteoporosis, breast cancer, and cardiovascular disease among women age 50 to 64 years in terms of the direct health care and indirect work-loss costs to an employer.

METHODS: Administrative medical and disability claims data from seven large employers (n = 600,000) were analyzed between 1998 and 2000. Patients were identified as female beneficiaries, age 50 to 64 years, who were enrolled in a managed indemnity health plan. Treatment samples were defined using ICD-9 codes to identify principal diagnoses for each of the three study conditions and then compared to a random sample of women, age 50 to 64 years. RESULTS: For the year 2000, osteoporosis patients had direct medical care costs that were $2277 greater than those for the random sample ($4543 versus $2266, P < 0.05). For breast cancer, the difference was $12,379 (P < 0.05), with hospital outpatient costs accounting for the largest share of total costs (43%). For cardiovascular disease the difference was $12,814 (P < 0.05), with hospital inpatient costs accounting for the largest share of total costs (48%). The average number of medical claims per patient was 18.6 for the random sample, compared to 38.4 for osteoporosis patients, 76.0 for breast cancer patients, and 67.0 for cardiovascular patients (P < 0.05). Ongoing research will control for demographic characteristics using multivariate regression and also explore differences in medically related work absence costs. CONCLUSIONS: These findings are the first estimates of the lifetime medical cost burden of three chronic conditions suffered by women. The levels of these costs suggest the need for further research and methodological refinements to increase awareness of the lifetime burden of chronic conditions.

THE LIFETIME MEDICAL COSTS OF WOMEN: CARDIOVASCULAR DISEASE, DIABETES, AND STRESS URINARY INCONTINENCE
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OBJECTIVE: The purpose of this study was to generate the first estimates of the lifetime medical costs of treating women with either cardiovascular disease (“CVD”), diabetes, or stress urinary incontinence (“SUI”).

METHODS: Women under age 65 years, who have been treated for CVD, diabetes, or SUI, were identified using administrative medical claims data from a large employer (n > 100,000). A case-control methodology was used to estimate the annual medical costs of these women. Annual estimates were then calculated for women 65 years and older based on a set of assumptions and published government statistics. An incidence-based methodology with steady-state assumptions was used to project these annual costs to the lifetime medical costs of treating women with CVD, diabetes, or SUI. Costs are incremental and are estimated as the additional costs incurred by patients, as compared to demographically similar controls without the condition. The methodology used does not account for cost inflation, technological change, or the time value of money. RESULTS: The lifetime costs associated with CVD, diabetes, and SUI are substantial. CVD is the most expensive condition on a lifetime basis, followed by diabetes, and then SUI. The incremental lifetime medical cost of treating a woman with CVD (in 2002 dollars) is $423,000. The lifetime cost of treating a woman with diabetes is $233,000 and with SUI is $58,000. CONCLUSIONS: These findings are the first estimates of the lifetime medical cost burden of three chronic conditions suffered by women. The levels of these costs suggest the need for further research and methodological refinements to increase awareness of the lifetime burden of chronic conditions.
with 48.6% (n = 31,717) and 50.0% (n = 32,614) for the 50-mg and 100-mg doses, respectively. Ninety-four percent of prescriptions were filled with six tablets, and only 2% of prescriptions (n = 1309) exceeded the quantity vs. time limit. Members paid an average copay of $13 per prescription.

CONCLUSIONS: This estimate of PMPM cost falls within the range previously reported in the literature. In comparison with PMPM costs reported for other drug classes, such as proton pump inhibitors or cyclooxygenase-2 inhibitors, the amount spent on sildenafil is considerably lower and of lesser concern to the pharmacy budget.

COST OF ACCESS BY FORMULARY TYPE: A CASE STUDY OF SILDENAFIL CITRATE IN A LARGE MANAGED CARE ORGANIZATION

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OBJECTIVES: Managed care organizations (MCOs) have traditionally used various types of formulary access to control cost, with varied success. In this case study, we determined the actual economic impact of adding sildenafil citrate to the formulary of a large national MCO by types of access status. METHODS: Claims data for sildenafil prescriptions were analyzed for the 12-month period from August 2001 through July 2002 for this MCO and for 7 of its regional areas. Per member per month (PMPM) costs of sildenafil coverage were calculated by various formulary status at both the regional and national levels. RESULTS: The MCO did not require prior authorization for sildenafil prescriptions but did impose restrictions on the number of sildenafil tablets per monthly prescription cycle. The MCO used open, closed, and incented formularies to control access to sildenafil. Mean number of sildenafil tablets/month varied from 4.9 to 6.7 tablets. PMPM costs of sildenafil coverage for the regional areas were $0.07, $0.11, $0.11, $0.14, $0.15, $0.15, and $0.18. Type of formulary did not fully explain variance in costs between regions. In 5 of the 7 areas in which most patients were covered under an incented formulary, PMPM costs of sildenafil coverage ranged from $0.11 to $0.15. In the 2 regions with the greatest percentage of patients covered under a closed formulary plan, PMPM costs of sildenafil coverage were $0.07 (44% closed) and $0.15 (54% closed). Whereas in the 3 regions with the most patients covered under an open formulary, PMPM costs of sildenafil coverage were $0.11 (27% open), $0.14 (30% open), and $0.15 (30% open). CONCLUSIONS: PMPM costs did not vary substantially, regardless of different types of formulary access. Moreover, in line with findings from local and employer-based healthcare plans, addition of sildenafil coverage by this large MCO resulted in lower than expected PMPM costs.

COST IMPLICATION OF UNRESTRICTED ACCESS TO SILDENAFIL CITRATE IN FOUR EMPLOYER GROUP PRESCRIPTION PLANS

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OBJECTIVE: The perception persists among employers and benefit managers that the addition of sildenafil citrate adds significant cost to their prescription plans. A Disease Therapy Evaluation is a focused analysis of a drug’s performance in a target patient population and provides healthcare managers with information that may lead to better decisions for the individual patient as well as the healthcare organization. The analysis presented here evaluates the per member per month (PMPM) cost of sildenafil without restriction limits on the quantity of tablets dispensed. METHODS: This retrospective review covered all sildenafil claims of employees obtained from prescription benefit managers. Prescription claims were obtained for a 6-month interval from December 1999 to May 2000 and imported into an Access database for abstraction of required data. RESULTS: Data were combined from 4 prescription plans (3 from the Midwest, 1 from the West Coast) with 361,237 members overall. There were 3477 sildenafil claims in the 6-month period, made by 1493 patients (representing 0.4% of all members). Most of the prescriptions were for the 50-mg (range for 4 plans, 45%-62%) and 100-mg doses (37%-65%) of sildenafil, with 1% to 2.5% for the 25-mg dose. On average, 6 to 11 tablets were dispensed at a time, with a range from 1 to 10 tablets. The average cost per prescription varied from a low end of $50 to a high end of $88; the PMPM cost ranged from $0.03 to $0.24. CONCLUSIONS: The actual PMPM cost is markedly lower than the expected projections, despite the fact that no quantity limits were imposed. The costs shown here do not take into account any rebates or other contracting benefits. Thus, employers may wish to consider the addition of sildenafil to their benefit package, as it may increase employee satisfaction without a large impact on the budget.

LONGITUDINAL DIFFERENCES IN PSYCHOLOGICAL ADJUSTMENT FOR MEN WITH ERECTILE DYSFUNCTION: RESULTS FROM EXCEED

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