follow-up in subsequent years following a cardiovascular event. First-year costs of the cardiovascular events considered were myocardial infarction (US$5,026), an- giography (US$28,422), continuous ambulatory peritoneal dialysis (US$901), and hemodialysis (US$3,744). Annual exchange rate (1 US$=H11005 72.868 AD). First-year haemodialysis and renal transplantation costs were the highest costs observed overall at US$14,855 and US$14,051, respectively. The highest first-year costs of treating cardiovascular events were stroke (US$892), congestive heart fail- ure (US$2,444), and angina (US$395). The cost of an amputation procedure was US$533, excluding the cost of prosthesis (US$618), with a follow-up cost of US$22. The cost of a laser eye procedure was US$48, while the cost of a cataract operation was US$123. Cost effectiveness analysis (CEA) analysis in a US setting. This current study sets out to assess the long-term CE outcomes of liraglutide vs. sitagliptin based on treatment effects data from the 52-week trial. METHODS: The IMS CORE Diabetes Model, a non-product-specific, validated computer simulation model that projects the long-term outcomes related to interventions for type 2 diabetes, is used for simulation over 35 years. Patients were simulated on one of the three treatment options: liraglutide 1.2 mg daily, 1.8 mg daily, or sitagliptin 100 mg daily, each used as add-on therapy to metformin. Incremental cost-effectiveness ratios (ICER) were generated for liraglutide versus sitagliptin and liraglutide 1.8 mg versus sitagliptin. Transition probabilities, health state utility values and complication costs were obtained from published sources. All outcomes were discounted at 3% per annum, and the analysis was conducted from the perspective of a third-party payer in the US. Sensitivity analyses were performed to test robustness of the base case scenario. RESULTS: For liraglutide 1.8 mg versus sitagliptin, the ICER was US$37,234 per QALY gained, while for liraglutide 1.2 mg versus sitagliptin, the ICER was US$25,742 per QALY gained. In all sensitivity analyses including setting the HbA1c reduction to its 95% lower limit, the ICERs remained below US$50,000/QALY, a commonly accepted threshold in the United States, except for the shortest time horizon of 10 years. Conclusions: The availability of liraglutide 1.2 mg and 1.8 mg with improved efficacy profiles over sitagliptin could improve patient care, while being cost-effective treatment options in addition to metformin.

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MEDICATION ADHERENCE AND MEDICAL COSTS ASSOCIATED WITH EXENATIDE BID VERSUS LIRAGLUTIDE: A RETROSPECTIVE DATABASE ANALYSIS
Pelletier EM1, Pawaskar M2, Chapman R3
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OBJECTIVES: Although, safety and efficacy of exenatide (exenatide) and liraglutide for treating type 2 diabetes (T2D) has been demonstrated in trials, their comparative economic benefits are unknown. This study examined cost offsets ready gathered groups such as at religious functions: such an approach may result in the renal complications group; renal transplantation (US$28,422), continuous ambulatory peritoneal dialysis (US$901) and hemodialysis (US$3,744). Annual exchange rate (1 US$=H11005 72.868 AD). First-year haemodialysis and renal transplantation costs were the highest costs observed overall at US$14,855 and US$14,051, respectively. The highest first-year costs of treating cardiovascular events were stroke (US$892), congestive heart fail- ure (US$2,444), and angina (US$395). The cost of an amputation procedure was US$533, excluding the cost of prosthesis (US$618), with a follow-up cost of US$22. The cost of a laser eye procedure was US$48, while the cost of a cataract operation was US$123. Cost effectiveness analysis (CEA) analysis in a US setting. This current study sets out to assess the long-term CE outcomes of liraglutide vs. sitagliptin based on treatment effects data from the 52-week trial. METHODS: The IMS CORE Diabetes Model, a non-product-specific, validated computer simulation model that projects the long-term outcomes related to interventions for type 2 diabetes, is used for simulation over 35 years. Patients were simulated on one of the three treatment options: liraglutide 1.2 mg daily, 1.8 mg daily, or sitagliptin 100 mg daily, each used as add-on therapy to metformin. Incremental cost-effectiveness ratios (ICER) were generated for liraglutide versus sitagliptin and liraglutide 1.8 mg versus sitagliptin. Transition probabilities, health state utility values and complication costs were obtained from published sources. All outcomes were discounted at 3% per annum, and the analysis was conducted from the perspective of a third-party payer in the US. Sensitivity analyses were performed to test robustness of the base case scenario. RESULTS: For liraglutide 1.8 mg versus sitagliptin, the ICER was US$37,234 per QALY gained, while for liraglutide 1.2 mg versus sitagliptin, the ICER was US$25,742 per QALY gained. In all sensitivity analyses including setting the HbA1c reduction to its 95% lower limit, the ICERs remained below US$50,000/QALY, a commonly accepted threshold in the United States, except for the shortest time horizon of 10 years. Conclusions: The availability of liraglutide 1.2 mg and 1.8 mg with improved efficacy profiles over sitagliptin could improve patient care, while being cost-effective treatment options in addition to metformin.

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