information included date of purchase, quantity of units purchased, unit price, response to each therapy, reasons for change, measures taken to maintain adherence, and justification for purchase (regular use or health litigation). Unit prices were deflated to December 2013 by the IPCA (Brazilian Pricing Index) to allow comparability and evaluation of trends. RESULTS: More than 47 million units of medicines for MS were purchased between January and June 2013. The largest buyer of medicines not included in the guidelines. Over the entire period, a reduction of corrected weighted average prices of PCDT and non-PCDT medicines was observed. CONCLUSIONS: We noted a significant increase in the amount of medicines over time. Changes in medicines financing and procurement, and the enactment of the Productive Development Partnerships may have contributed with the scale-up of AD treatment availability. The reduction of lawsuits demanding medicines suggests normalization of medicine procurement mechanisms for these drugs. The resources consumed with non-PCDT medicines increased in the period.

PDN1: A SYSTEMATIC LITERATURE REVIEW OF GLOBAL ECONOMIC EVALUATIONS OF RASAGILINE FOR PARKINSON’S DISEASE
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OBJECTIVES: This systematic review is conducted to investigate the impact of rasagiline on economics of care for patients with PD. METHODS: A literature search was conducted through a review of Index Medicus abstracts, technology assessments of rasagiline using search terms; title: rasagiline and Parkinson3 AND economic OR budget OR cost; language: English, publication dates: 1/01/1997-6/30/2014 was conducted and reviewed for relevancy of technology assessments. RESULTS: A total of 15 studies (7 cost models, 8 economic evaluations) were identified for inclusion. Four of the studies assessed the cost-effectiveness of rasagiline among patients with PD who had a diagnosis of PD. Three studies assessed the cost-effectiveness of rasagiline relative to generic ropinirole (US $62.50 per QALY), and a US cost-utility analysis showed advantageous use of rasagiline with levodopa and carbidopa/levodopa/entacapone were both dominant strategies over levodopa monotherapy. In a Mexico-based model using a 5-year time horizon the cost per QALY for rasagline was $33,400 (Mexico pesos). Medication and adverse event costs were also evaluated in a Russian model. Observational study results of rasagline were based on US, UK and Croatian data. US studies results comparing rasagline to selegiline show fewer hospitalizations (1.19 vs 2.13, p=0.013) shorter length of stay (2.762 vs 5.556, p=0.014) and lower likelihood of emergency department visits (OR=0.791, 95% CI 0.677 vs 0.926) with rasagline. CONCLUSIONS: Ralasgiline was found cost effective across multiple countries compared with commonly used PD medications. The beneficial impact of rasagline on resource utilization in the observational studies highlights the real world potential of rasagline to result in economic benefits to healthcare systems.

NEUROLOGICAL DISORDERS – Patient-Reported Outcomes & Patient Preference Studies

PND10 ADOPTION AND PERSISTENCE AMONG PATIENTS TREATED WITH FIRST-LINE THERAPIES FOR RELAPSING-REMITTING MULTIPLE SCLEROSIS IN BRAZIL
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OBJECTIVES: To estimate the levels of adherence and persistence of patients with Relapsing-Remitting Multiple Sclerosis (RRMS) and treated with platform therapies in Brazil. METHODS: DATASUS, a nation-wide, anonymized, health-care claims database was used as primary data source. Naïve patients starting on one of the platform therapies for RRMS, between January and June 2013 were followed for at least 13 months (up to 18), until September 2014 after the first entry in DATASUS (considered for this analysis as treatment initiation). Therapies included intramuscular (IM) interferon beta-1a (IFN-β1a), subcutaneous (SC) IFNβ1a, IFNβ1b, and glatiramer acetate (GA). Adherence was measured as medication possession ratio (MPR), calculated as the proportion of months patients possessed their therapies independently of drug change until the end of the analyzed period, where MPR<0.80 was considered adverse. Persistence was time in months from initiation date until a 30-day gap in therapy or the last claim during follow-up. Chi-square assessed the association between treatments and time on therapy. Median difference between MPR was assessed through Kruskal-Wallis Method. Analyses were performed using R, version 3.1. RESULTS: Total number of patients was 3,052 (IM-IFN-β1a: N=351, 33.6%; IFN-β1b: N=145, 13.8%; GA: N=264, 25.1%; and SC-IFN-β1a: N=292, 27.8%). MPR<0.80 was significantly higher (p<0.001) in the IM-IFN-β1a group (71.8%) versus IFN-β1b (58.6%), GA (65.5%), and SC-IFN-β1a (63.7%). There were no consistent differences in persistence between the groups. CONCLUSIONS: While there are limitations in measuring adherence even in controlled trials, MPR seems to be appropriate in real life scenario. Patients initiating treatment with IM-IFN-β1a showed better adherence than those initiating treatment with SC-IFN-β1a, GA and IFN-β1b. Further research reports simil-ular efficacy and safety profile among platform therapies, however, they differ in terms of administration route and dose scheduling. Better adherence results for IM-IFN-β1a may be associated with dosing regimen and convenient administration from an auto-injector device.