required a discount greater than 61% and 71%, respectively, from the branded WAC to achieve cost per unit of LDL-C reduction lower than generic lovastatin. **CONCLUSION:** To facilitate effective and efficient management of patients with dyslipidemia, a tiered formulary could include generic simvastatin or pravastatin as the cost-effective generic statin in the first tier (depending upon level of discount to current WAC) and rosuvastatin as the cost-effective branded statin in the second tier.

**PCV31**

**COST-EFFECTIVENESS OF ACHIEVING ADDITIONAL LIPID TARGETS WHEN SUBSTITUTE FENOFOBATE 145 MG FOR STANDARD FENOFOBATE THERAPY**

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**OBJECTIVES:** Clinical evidence suggests that achieving recommended HDL-C levels reduces the likelihood of CHD events and mortality. The benefits of standard fenofibrate formulation on HDL-C and triglyceride levels (TG) are well established; however, full benefits have typically required administration with food. Furthermore, evidence suggests that as many as 30% of people do not comply with food requirements. A new formulation of fenofibrate (fenofibrate 145) that does not require administration with food has been developed. A cost-effectiveness model was developed to determine the incremental cost of meeting additional recommended lipid levels when fenofibrate 145 is substituted for a standard fenofibrate formulation that requires food administration in a diabetic population.

**METHODS:** A simulation model using a managed care perspective was designed to predict changes in lipid levels [HDLC, LDL-C, TG, and total cholesterol (TC)] and associated drug costs based on Wholesale Acquisition Costs over the course of 1 year. Lipid targets were based on NCEP-ATP III. A hypothetical cohort of 1000 was modeled for a diabetic population with abnormal lipid levels based on NHANES data. Lipid changes were based on the study of fenofibrate by Arhyros, et al. 2002. A reduction in efficacy for each lipid parameter, based on previously reported work, was applied against patients on standard fenofibrate therapy (requiring food co-administration).

**RESULTS:** In a cohort of 1000 patients, substituting fenofibrate 145 for standard fenofibrate therapy resulted in 9.4% more diabetic patients reaching TG targets. Seventy-two more patients (11% increase) on fenofibrate 145 achieved at least 2 targets and 27 more patients (18% increase) achieved at least 3 targets. The incremental 1-year cost per additional patient reaching TG targets was $0.78. **CONCLUSION:** Substituting a non-food requiring fenofibrate for a standard fenofibrate increases the number of patients achieving TG and multiple target goals at 1 year at a low cost.

**PCV32**

**IMPACT OF DEPRESSION ON HEALTH STATUS AND HEALTH CARE UTILIZATION IN PATIENTS WITH HYPERTENSION: RESULTS FROM THE MEDICAL EXPENDITURE PANEL SURVEY (MEPS 2002–2003)**

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**OBJECTIVES:** Previous studies have examined the association between depression and hypertension. This study aims to examine whether health status and health care costs differ between hypertensive patients with and without depression.

**METHODS:** The study sample was all adult survey respondents with a self-reported diagnosis of hypertension from the MEPS (2002–2003). These respondents were also asked about the presence of conditions related to depression. Health status measures include SF-12 physical component summary (PCS) and SF-12 mental component summary (MCS) score, and EQ-5D utility score. Health care utilization was explored in the following categories: outpatient, inpatient, dental, and pharmacy. The impact of depression on health status or health care utilization was explored using multivariate linear regression models with depression as an independent dummy variable, after controlling for age, gender, ethnicity, marital status, income, and health insurance.

All analyses were weight to the US population by the personal level weights reported in the MEPS data set. **RESULTS:** Among a total of 5052 MEPS respondents having hypertension, 1962 reported having (38.84%) depression problems. These two groups (with and without depression) were comparable in age and ethnicity. Female hypertensive patients with lower income level or with Medicare or Medicaid coverage had a higher proportion of depression. In regression models, hypertensive patients with depression had worse health status: SF-12 PCS score (−5.6, p < 0.0001), SF-12 MCS score (−13.5, p < 0.0001), and EQ-5D utility score (−0.20, p < 0.0001). Hypertensive patients with depression had higher utilization of outpatient ($415, p < 0.0001) and pharmacy ($10, p < 0.0001) services, but both groups had comparable expenditures in inpatient care ($0.09, p < 0.0001) and dental service (−$23, p > 0.05). **CONCLUSION:** In the U.S. population, hypertensive patients with depression had poorer health status and higher health care expenditure in outpatient services and prescription drug compared with those without depression. The difference in inpatient cost between these groups was very small.

**PCV33**

**ANALYSIS OF CLOPIDOGREL USE IN OUTPATIENT SETTINGS**

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**OBJECTIVES:** Using recent US national claims data, this study examined characteristics of managed care patients taking clopidogrel in outpatient settings and analyzed patterns of use.

**METHODS:** This retrospective study identified patients with oral antplatelet claims in a large, national, managed care claims database (Pharmetrics) between 1/2003–6/2006 (n = 47,364). All medical and pharmacy claims were analyzed during this period. Analysis focused on outpatient use patterns of clopidogrel and patient characteristics, e.g., demographics, comorbidities, inpatient history, and other cardiovascular medication use. Aspirin therapy was not available in the prescription claims data.

**RESULTS:** Clopidogrel was the most widely prescribed antplatelet, representing 93% of all prescriptions. Men represented 65% of the patients taking clopidogrel. The mean age was 56.9 years, with 69% of individuals aged 50 to 65 years. The most common outpatient diagnoses were essential hypertension (61%), unspecified hyperlipidemia (57%), hypercholesterolemia (44%), and unspecified chest pain (43%). On average, users of clopidogrel had 3.41 prescriptions per month in 2006 at a health plan cost of $376.50/month. Average length of therapy for clopidogrel was 292 days. By patient type, it varied from 283 days for PCI patients to 336 days for percutaneous coronary intervention (PCI), and 344 days for stroke. However, 10.4% of PCI patients took clopidogrel for ≤30 days. Patients refilled their clopidogrel prescriptions for 93% of the daily regimen needed during therapy. Frequent concomitant cardiac medications included statins (63.9%), beta-blockers (55.0%), ACE-inhibitors (48.7%), and diuretics (14.2%). Data show that 40–50% of patients discontinued another concomitant cardiac