Sixteen percent (n = 3,025) of the caregivers had a child with an ASD diagnosis. As compared to caregivers of children with MHC only, caregivers of children with ASD were more likely to report issues with availability (OR = 1.966; 95% CI = 1.16-2.82), information (OR = 1.89, 95% CI = 1.46-2.45), eligibility (OR = 1.80, 95% CI = 1.38-2.37), cost (OR = 1.67, 95% CI = 1.31-2.14), and appointments (OR = 1.35, 95% CI = 1.09-1.68). When compared to the DD & MHC group, the ASD group was found to be significantly more likely to report issues with availability, obtaining information, and cost of services.

CONCLUSIONS: ASD caregivers reported greater difficulty with all five service difficulty measures as compared to caregivers of children with MHC only. However, ASD group reported greater problems only in availability, obtaining information, and cost of services, when compared to DD & MHC group.

PMH69 GEOGRAPHIC VARIATION IN DIAGNOSIS, MEDICATION USE AND ASSOCIATED COSTS OF ATTENTION DEFICIT DISORDER (ADD) Tian Y, Frasez SG, Henderson RR, Iyengar R Express Scripts, Inc., St. Louis, MO, USA

OBJECTIVES: To use administrative claims to examine geographic variation trends in ADD diagnostic prevalence, medication use and associated medical and pharmacy costs. METHODS: A retrospective design and descriptive analysis of continuously enrolled (medical and pharmacy benefits) commercial members aged four to 40 between January 1, 2008 and December 31, 2010 from MarketScan® Commercial Claims and Encounters dataset. Key metrics included percent of continuously enrolled patients with ADD diagnosis, patients with ADD medication use and associated pharmacy and medical costs per enrollee. ADD diagnosis was defined as having a medical diagnosis (ICD-9-CM 314) at any time during a given year. Medication use was defined as having at least one claim for amphetamines, attention-deficit/hyperactivity-disorder agents or stimulants (NDC codes). Population datasets comprised of 7, 8, 12 and 13 enrollees in 2008, 2009 and 2010, respectively. Results indicate that although the diagnostic prevalence, medication use and associated medical and pharmacy costs were the highest in the South throughout the study period, Northeast region had the highest growing rate. Increasing by 34.1% from 1.9% to 2.5% for patients diagnosed and by 43.0% from 2.4% to 3.5% for patients treated with ADD medications. Growing at rate of 59.0% from $34.21 in 2008 to $54.39 in 2010, Northeast outpaced the other regions by more than 24.1% on ADD related medical and pharmacy spend per enrollee. CONCLUSIONS: Northeast is the fastest growing region for ADD diagnosis, medication use and related spend. Further research is warranted to examine the factors underlying this trend. The findings suggest consideration of utilization management programs and cost containment strategies to ensure appropriate access, patient safety and cost-effective use of ADD medications.

PMH70 HOSPITALIZATIONS AMONG BIPOLAR DISORDER PATIENTS BEFORE AND AFTER INITIATING LURASIDONE IN A COMMERCIALLY INSURED POPULATION Hasnaa S, Wadhwa SW, Meyer NM, Pickett A, Loebel A, Rajapalpan K1

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OBJECTIVES: Bipolar disorder is a chronic and serious mental illness with high rates of hospitalizations compared to several other behavioral disorders. This study aims to compare all-cause and mental health-related hospitalizations among adult patients with bipolar disorder 6-months before and after initiating lurasidone, an atypical antipsychotic. METHODS: Analysis of insurance claims filed with the Health Insurance Review & Assessment Service, prospective depressed patients cohort study (CRESCEND: the Clinical Research Center for Depression Study) from January 2006 to August 2008 and the health insurance claims filed with the Health Insurance Review & Assessment Service, in patients who received HAMD-17 scores ≤ 14 at a screen visit and more than one time claim for reimbursement of antidepressants at HIRA after their cohort enrollment were subject to this analysis on their use of health care institutions, in-patient and out-patient, as well as their medical costs. RESULTS: The hospitalization rate by out-patient diagnosis with a primary diagnosis of bipolar disorder decreased from 27.8% to 17.1% between the pre- and post-index periods were 0.6 and 0.3 for all-cause (p=0.0175) and 0.5 and 0.2 for mental health-related conditions (p=0.0310). CONCLUSION: significant smaller proportions of patients were hospitalized for all-cause and mental health-related diagnoses in the 6 months after initiating lurasidone compared to the 6 months before initiation. The mean numbers of hospitalizations were also significantly lower in the 6-months after initiation on lurasidone.

PMH71 THE MEDICAL COSTS AND HEALTH CARE UTILIZATION FOR DEPRESSION TREATMENT BY KOREAN HEALTH INSURANCE REVIEW & ASSESSMENT SERVICE DATA Kim CM, Lee YJ, Eun YH, Heo S, Choi WS2

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OBJECTIVES: To investigate the use of health care utilizations and direct medical costs for patients with depression. METHODS: This study combined major clinical information of 1183 depressed patients who registered for the prospective depressed patients cohort study (CRESCEND: the Clinical Research Center for Depression Study) from January 2006 to August 2008 and the health insurance claims filed with the Health Insurance Review & Assessment Service, in patients who received HAMD-17 scores ≤ 14 at a screen visit and more than one time claim for reimbursement of antidepressants at HIRA after their cohort enrollment were subject to this analysis on their use of health care institutions, in-patient and out-patient, as well as their medical costs. RESULTS: The hospitalization rate by out-patient diagnosis with a primary diagnosis of bipolar disorder decreased from 27.8% to 17.1% between the pre- and post-index periods were 0.6 and 0.3 for all-cause (p=0.0175) and 0.5 and 0.2 for mental health-related conditions (p=0.0310). CONCLUSIONS: significant smaller proportions of patients were hospitalized for all-cause and mental health-related diagnoses in the 6 months after initiating lurasidone compared to the 6 months before initiation. The mean numbers of hospitalizations were also significantly lower in the 6-months after initiation on lurasidone.

PMH72 IMPACT OF TREATMENT PERSISTENCE ON HEALTH CARE CHARGES AMONG OPIOID-DEPENDENT PATIENTS TREATED WITH BUPRENORPHINE/NALOXONE: 2006-2012 INSURANCE CLAIMS RETROSPECTIVE ANALYSIS IN THE UNITED STATES Clay E1, Khemri A1, Ruby J1, Zah V1, Abella S2

Creative-Ceutical, Paris, France, 1Creative-Ceutical, Tunis, Tunisia, 2Reckitt Benckiser Pharmaceuticals, Inc., JNA, Richmond, VA, USA, 3Zia Outcomes Research Inc., Mississauga, ON, Canada

OBJECTIVES: Buprenorphine/naloxone combination (BUP/NAL) is recommended in the treatment of opioid dependence. Clinical guidelines do not specify the minimum duration of treatment required to achieve long-term remission. This study evaluated the impact of treatment persistence on health care charges. METHODS: Study was conducted on a US insurance claims database. It included patients initiating treatment with BUP/NAL claim between November 2006 and December 2011, not previously treated with buprenorphine, with at least one repeat claim after 30 days. Discontinuation was defined as absence of BUP/NAL claim for 90 days. Health care charges over 12 months were compared between persistent and non-persistent patients, adjusting on baseline characteristics (demographics, comorbidities, treatment, and resource utilization before index date). RESULTS: Of 19,008 patients with an incident claim of BUP/NAL, 35.7% appeared to be short-term users and were excluded. Among the remaining 12,231 patients, the average duration of follow-up was 12.9 months, and 2846 were followed for at least two years. The probability of continuing treatment over 24 months was 40.9%. Patients under 25 years old, with a diagnosis of hepatitis or soft tissue infection were more likely to discontinue. Patients treated for at least 12 months had lower mean total charges compared to non-persistent patients (p=0.032 vs. $317, 461). Adjusted on age and gender, the difference was significant. Among non-persistent patients, total charges per quarter reached a maximum during the first trimester following discontinuation (+91% compared to period from 6 to 4 months before discontinuation, p=0.0001), and were also significantly higher in the second trimester after discontinuation (+52%, p=0.0003), compared with before discontinuation. Main drivers of excess charges were hospitalization and outpatient visits. Majority of long-term users of BUP/NAL discontinued treatment before 24 months. CONCLUSIONS: Non-persistence was associated with higher charges and evidence was consistent with a causal relationship between discontinuation and increased charges. Treatment persistence improvement may lead to cost savings.

PMH73 ASSESSING THE IMPACT OF A MEDICAID PRIOR AUTHORIZATION (PA) POLICY FOR DULOXETINE ON ANTIPSYCHOTIC USE AMONG PATIENTS WITH DEPRESSION Birnbaum HC1, Ivanova JF, Waldman T1, Swindle E, Cummings AK2, Clark T1, Peng X1

Analysis Group, Inc., Boston, MA, USA, 1Analysis Group, Inc., New York, NY, USA, 2El Lilly and Company, Indianapolis, IN, USA

OBJECTIVES: To evaluate if the Iowa Medicaid duloxetine depression Prior Authorization (PA) policy, implemented on May 24, 2011, would have had an impact on antipsychotic use in depressed patients. We compare initiating duloxetine and other relevant medications for depression in Iowa before and after PA implementation and in Missouri, which had no duloxetine PA. METHODS: Using de-identified Medicaid claims data (1999-2010), two cohorts were selected from each state: 2010 policy change cohort (index date: 5/24/2010) and 2009 control cohort (index date: 5/24/2009). Patients had to have ≥1 inpatient or ≥2 other outpatient claims with a depression diagnosis pre-index; ≥1 antidepressant or antipsychotic claim during the