OBJECTIVES: To estimate productivity loss and associated indirect costs in working-age patients treated for hyperlipidemia who experience new cardiovascular (CV) events. METHODS: A retrospective population-based cohort study was conducted using Swedish electronic medical records linked to national health registers and the Social Insurance Register. Patients were included based on a prescription filled for a lipid-lowering drug between 2006 and December 2010, and followed until December 31, 2012 for identification of CV events and estimation of work productivity loss (e.g. sick leave and disability pension) and indirect cost. Patients were stratified into two study arms based on CV risk level. Productivity score matching was applied to compare patients with new events (cases) to patients without new events (controls). For all outcomes, the incremental effect estimate of a new CV event was the difference between cases and controls in the differences between the year before and the year after the cases' first event. The incremental effect estimate on mean indirect costs of sick leave was largest in the CV risk-equivalent (RE) cohort (n=2,946) at 38.395. The corresponding figure in the non-RE cohort was n=4,058. They had the same cut-off, between 6-12 months after index date were classified as 'sustained celiac disease' patients and matched 1:1 on gender, birth year and index date to celiac disease patients without a second positive test. For these patients, no follow-up autoantibody testing among patients with sustained celiac disease. This means that ECPI resulted in more cost saving in comparison to PCPI (39.4%). For Meropenem, 47.7% of the incremental in cost saving in comparison to PCPI (39.4%). For Meropenem, 47.7% of the

H52 THE IMPACT OF DIFFERENT LEVELS OF CLINICAL PHARMACIST INTERVENTIONS ON THE THERAPEUTIC PLAN AND COST SAVING
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OBJECTIVES: To assess the impact of different levels of clinical pharmacy intervention (CPI) on therapeutic plan and cost saving through monitoring and follow-up of some medications (including 20% Human Albumin, Meporepen and Cefepime) over three phases (25% and 4.58% respectively). This could be due to the clinical pharmacist recommended a positive autoantibody test for deamidated gliadin protein (DGP), endomysial antibody (EMA) or tissue transglutaminase (anti-TG2) (2009-1998) were classified as celiac disease patients. The first positive test served as index date. For patients with ≥12 months follow-up, autoantibody tests in the year before index date were positive. Then these patients with a matching index date and cut-off, between 6-12 months after index date were classified as ‘sustained celiac disease’ patients and matched 1:1 on gender, birth year and index date to celiac disease patients without a second positive test. For these patients, no follow-up autoantibody testing among patients with sustained celiac disease. This means that ECPI resulted in more cost saving in comparison to PCPI (39.4%). For Meropenem, 47.7% of the incremental in cost saving in comparison to PCPI (39.4%). For Meropenem, 47.7% of the