**PMS71**

**EXPLORING THE DIFFERENCES OF DISEASE, HEALTH STATUSES AND HEALTH UTILIZATION BETWEEN ELDERLY WITH AND WITHOUT BONE DISORDERS IN TAIWAN**

Chen YL1, Chang CK2, Chang WT1, Huang SS3, Lin HW1

1China Medical University, Taichung, Taiwan, 2China Medical University Hospital, Taichung, Taiwan

**OBJECTIVES:** Given the evidence that showed bone disorders were one of the top three prevalent chronic conditions among the elderly in Taiwan, the aim of this study was to explore the different characteristic, health status, health care utilization between those who suffered from bone disorders or not among the elderly in Taiwan. **METHODS:** The data used for this study was obtained from the 2005 National Health Interview Survey (NHIS) data of Taiwan. The volunteers who reported to have “osteoarthritis” or “ostearthritis” were grouped into bone disorders group. Otherwise were non-bone disorder group. The appropriate descriptive statistics with sampling weights and inferential analysis approaches were applied on those responses for basic demographics, perceived health status, and self-report health care utilization. **RESULTS:** Of 7277 elderly interviewees in 2005 NHIS, 35.2% reported to have bone disorders and their demographic characteristics were not statistically significant different from the other group, except the proportion of female. (65.0% vs 43%). While bone disorder group tended to have more chronic conditions than non-bone disorder group, they were also more likely to report fall experiences and worse health status. Further, they tended to consume more utilization of health services and hospital stay. **CONCLUSION:** Elderly with and without bone disorders in Taiwan were different not only in the demographic characteristics but also in their health status and health care utilization, including TCM service. Further comprehensive analyses would be needed to explore the extent of contributing factors on the health care utilization among elderly patients suffered from bone disorders.

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**ECONOMY WITH THE NEW BIOLOGICAL AGENTS TO TREAT RHEUMATOID ARTHRITIS IN BRAZIL: THE MINISTRY OF HEALTH PERSPECTIVE**

Xavier LC, Santos ACQ, Bastos EA, Alexandre RF, Nascimento Junior JM, Gadelha CAG

Brazilian Ministry of Health, Brasilia, Brazil

**OBJECTIVES:** Until 2013, only the biological agents adalimumab, etanercept and infliximab were available in the Brazilian public health system (SUS) to treat Rheumatoid Arthritis (RA). Since July 2013, abatacept, certolizumab, golimumab, rituximab and tocilizumab were also made available, according to the treatment algorithm (only certolizumab, etanercept and infliximab were included in the SUS). The main aim of this work is to determine the budget impact of these new technologies, by the MoH perspective. **METHODS:** The number of patients with RA treated with the new biologicals in the SUS was estimated by the ratio between the amount dispensed in 2013 and its recommended dosage. The data about the older biological agents were extracted from the SUS database (Datassus). The drug acquisition costs were used to calculate the relative treatment cost among the different therapeutic alternatives (current values; exchanged by the official exchange rate: US$ 1 = R$ 2.36). The budget impact was calculated by comparing the new biological treatment costs (abatacept, certolizumab, golimumab, rituximab and tocilizumab) and a potential costs in a hypothetical scenario without new agents available (only certolizumab, etanercept and infliximab). **RESULTS:** From July to December 2013, 3,959 patients with RA were treated with new biologicals, implying a total spent of US$ 18,905,770.06. An average of 3.57 million (0.33%) visits was covered self-injectables. This study examines the association between cost sharing and the utilization of new biologicals (Part D biologics) and concurrent drug. **METHODS:** Fee-for-service beneficiaries with continuous Part D coverage and RA (ICD-9-CM 714.xx) in the 2010 Medicare 5% Files (N=12,923) were examined. **RESULTS:** Dependent variables included initiation of any biologic among all RA patients and the number of new biologics start before a specialty tier cost-sharing (from that of the donut hole) were further identified whether a Part D biologic was first initiated in the initial coverage limit (ICL) phase or not. The key independent variable was the beneficiary’s low income subsidy (LIS) status i.e. non-LIS vs. full-LIS as a proxy for higher (initially 25% to 35% in 2014) coverage followed by donut hole) vs. lower cost-sharing ($3-$5 copay, respectively. Multivariable logistic regressions with robust clustered standard errors at the level were estimated. **RESULTS:** Overall RA biologic use was 17% in the sample (10% Part B and 7% Part D biologics). Compared to full-LIS patients, non-LIS patients had lower odds of initiating any RA biologic in the year (OR 0.84, 95% CI 0.75-0.94). Among older biologic users, non-LIS patients were less likely to use a Part D biologic in the entire year (OR 0.19, 95% CI 0.15-0.24) and in the ICL-phase (OR 0.22, 95% CI 0.17-0.28). **CONCLUSIONS:** High cost sharing due to specialty tiers and the coverage gap under Part D may be associated with non-LIS patients foregoing the use of any RA biologic or substituting with insubstantial biologics under Part B.

**PMS75**

**REAL-WORLD TREATMENT BEHAVIOR AMONG PATIENTS WITH DUPUYTREN’S CONTRACTURE: A HEALTH INSURANCE CLAIMS-BASED ANALYSIS**

Dong P1, DeKoven J2, Kaplan FT3, Tursi P4, Lee WC5

1IMS Health, Plymouth Meeting, PA, USA, 2IMS Health, Alexandria, VA, USA, 3Indiana Hand to Shoulder Center, Indianapolis, IN, USA, 4Astute Pharmaceuticals, Inc., Chesterbrook, PA, USA, 5IMS Health, San Francisco, CA, USA

**OBJECTIVES:** Real-world treatment behavior data among patients with Dupuytren’s contracture (DC) has been sparsely reported with limited description of the extent of change. The aim of this study was to assess real-world treatment behavior following Xiaflex® (collagenase clostridium histolyticum) or fasciectomy among adult DC patients. **METHODS:** A retrospective cohort analysis was conducted using the IMS LifeLink™ Health Plan Claims Database. Patients ≥18 years between 2/1/2010–12/31/2011, with a treated finger/joint with Xiaflex or fasciectomy (index event), who were continuously enrolled both in the 12-month pre- and post-index periods, and had ≥1 DC diagnosis code in the 6-month pre-index period were included. A second treatment was defined as having occurred following a gap of ≥30 days from the index event. Descriptive statistics were reported and logistic regression and Cox Proportional Hazards models were used to adjust for baseline characteristics. **RESULTS:** Among 390 Xiaflex/1,264 fasciectomy patients, 86% of the DC patients had a second treatment. The Xiaflex patients had a greater proportion of patients with a second treatment than Xiaflex cohort (54% vs. 14%; p < 0.05). Nearly all patients received Xiaflex as their second treatment (99.12% vs.100% respectively). Demographic and clinical characteristics of patients receiving a second treatment among both cohorts were similar to those who did not receive a second treatment. After adjusting for baseline confounders, fasciectomy patients were 8.3-times more likely to have a second treatment compared to Xiaflex patients (OR: 8.28, 95% CI: 5.79-11.85; p < 0.0001). Older patients, patients with hypothyroidism, higher Charlson Comorbidity Index scores, and higher pre-index health care costs had a greater hazard of having a second treatment (all comparisons p < 0.05). **CONCLUSIONS:** Xiaflex was used as a second treatment among nearly all DC patients. As such, fasciectomy patients may be candidates to be replaced by Xiaflex to reduce the risk and costs of a second treatment.

**PMS76**

**DRUG UTILIZATION PATTERNS FOR RHEUMATOID ARTHRITIS**

Atejra N, Gunjal SS, Bili V, Aparasu RR

1University of Houston, Houston, TX, USA

**OBJECTIVES:** Various medications are commonly used to manage Rheumatoid Arthritis (RA). This study examined drug utilization patterns and factors associated with the use of medications by RA patients. **METHODS:** Data from the 2006-2010 National Ambulatory Medical Care Survey (NAMCS) and the outpatient department component of the National Hospital Ambulatory Medical Care Survey (NHAMCS) were used to examine the RA related ambulatory visits. RA medications were classified into NSAIDs and analogics, corticosteroids, disease modifying Antirheumatic drugs (DMARDs). Bivariate chi-square analysis and multiple logistic regression analysis were performed to evaluate the factors associated with prescribing of RA medications. SAS survey procedures that adjust for the complex sampling design were used in the analysis. **RESULTS:** A total of 14,305 visits were included in this analysis. The most frequently prescribed drugs were NSAIDs and corticosteroids. The prevalence of patients using DMARDs was 10%. **CONCLUSIONS:** There is a need for further research to understand the factors influencing the use of DMARDs in RA patients.
OBJECTIVES: To assess the relationship between duration of rheumatology practice experience and likelihood of use and perception towards biosimilars in a small group of patients before prescribing it in larger scale was (by be/not sure-44%/36%/38%; less/not likely-16%/10%/18%. Perceived duration of use of biosimilars to manage RA patients in the European Union (EU), Brazil, Japan and China was:

- EU: >20yrs: 1-2yrs:53%/56%/43%, 2-10yrs:59%/66%/56%, 10yrs:66%/69%/59%
- Brazil: >20yrs: 1-2yrs:53%/56%/43%, 2-10yrs:43%/48%/40%, 10yrs:53%/56%/43%
- Japan: >20yrs:1-2yrs:43%/48%/40%, 2-10yrs:53%/56%/43%, 10yrs:53%/56%/43%

Key factors noted by rheumatologists that would prevent them from using biosimilars were (by rheumatology-practice-experience): >20yrs: Doubt in similarity to original molecule, 1-2yrs:53%/56%/43%, 2-10yrs:59%/66%/56%, 10yrs:66%/69%/59%

Patients were classified as using biosimilars in a group of patients not using them and those who were previously using them (but not in the selected country). Besides initial HK, RA was the most used drug in arthritis patients. The mean age of patients was: >20yrs:270. Overall, the final model accounted for 9% of the total variance. CONCLUSIONS: Hospital characteristics, such as the region and type, as well as changes to average length of stay between 2008 and 2011 were strong predictors of percent change in average charge for MJR. While several other factors were also statistically significantly related to change in charges for MJR, small effect sizes were not practically meaningful. The percent variance of data was used to conclude that there are other factors not captured by Medicare data that are additionally responsible for growth in health care costs.