OBJECTIVES: To determine healthcare costs among immediate release (IR) hydroco- done patients with opioid abuse concomitant to those without concomitant diagno- sis in the United States (US). METHODS: Retrospective analysis using claims from the Truven MarketScan® commercial, Medicare supplemental, and Medicaid data- bases was performed. Patients prescribed IR hydrocodone during the 6-month base- line period (July 1, 2013 - December 31, 2013) and with concomitant enrollment during the 12-month follow-up period (2014), were selected. IR hydrocodone patients with an ICD-9-CM diagnosis for opioid abuse or dependence (abuse) were identified in the follow-up period. Descriptive and clinical analyses were employed to compare demographic and clinical characteristics between diagnosed opioid abusers and non-abusers. Total healthcare costs (standardized to 2013 US dollars) for abusers vs. non-abusers during the follow-up were estimated by plan type. Propensity score matching was used to calculate incremental costs in the follow-up. RESULTS: A total of 1,743,933 commercial, 277,096 Medicare, and 157,992 Medicaid IR hydrocodone patients were selected. Prevalence of diagnosed opioid abuse for these samples in follow-up was 0.9%, 0.4%, and 0.3%, respectively. Medicaid, Medicare, and commercial patients among commercial patients, unmatched data at baseline showed that abusers had on aver- age higher co-morbidity burden (0.96 vs. 0.67), and higher pill count (60.8 vs. 20.5 pills/month) and days’ supply (67.4 vs. 24.1 days) for IR hydrocodone, compared to Cost per additional responder for PASI and IFX ($18,101 - $19,493) followed by UST 45mg ($23,903 - $24,516), ETN ($37,825 respectively) as compared with non-abusers. CONCLUSIONS: IR hydroco- done patients with diagnosed opioid abuse have higher healthcare costs when com- pared to matched non-abusers, suggesting significant negative economic impact of opioid abuse in the US. Similar trends were observed regardless of plan type.

PSY32

EFFECT OF WEIGHT LOSS (WL) ON CONCOMITANT MEDICATION COSTS IN OBSESE OBESTRICT (OB) INDIVIDUALS WITH METABOLIC SYNDROME (MS). RECEIVING PHENTERMINE/TOPRIMARX EXTENDED-RELEASE (PHEN/TPM ER) Kahan E,1 Karnawat S 1George Washington University School of Public Health and Health Services, Washington, DC, USA, 2VIVUS, Inc, Mountain View, CA, USA

OBJECTIVES: Higher healthcare costs are incurred by patients with MetS. WL may decrease the risk of MetS and its component comorbidities, thereby reducing medi- cation use. PHEN/TPM ER treatment, combined with lifestyle interventions, can induce WL, and reduce incidence of MetS. This post-hoc analysis of a PHEN/TPM ER study evaluated annual cost-offsets associated with changes in concomitant medic- ation use among patients with MetS. METHODS: CONQUER randomized obese overweight patients (BMI ≥27 – <45kg/m²) with ≥2 weight-related comorbidities to placebo (n=994), PHEN 7.5mg/TPM ER 46mg (7.5/46, n=498), or PHEN 15mg/TPM ER 92mg (15/92, n=995). WL was defined as presence of ≥3 of the following risk factors: waist circumference ≥102cm (men), ≥80cm (women); triglycerides ≥150mg/dL; HDL cholesterol <40mg/dL (men), <50mg/dL (women); systolic blood pressure ≥130mmHg or diastolic BP ≥85mmHg; and fasting glucose ≥100mg/dL. This analysis included patients randomized to PHEN/TPM ER, rescue laxatives and placebo treatment (EOT) for hypertension, dyslipidemia, or type 2 diabetes. Cost-offsets (aS) in antihypertensive, lipid-lowering, and antidiabetic medication use were calculated by subtracting costs associated with each treatment. All costs were discounted at 3% per year to baseline to Week 56/EOT. PHEN/TPM ER cost was not included. RESULTS: In total, 349 patients receiving placebo, 184 receiving 7.5/46, and 359 receiving 15/92, had MetS at baseline and received ≥1 concomitant medication. At baseline, mean weight (kg) was 111.8±18.0 among all patients. Baseline annual concomitant medication costs were $1222±1450, $1306±1401, and $1303±1348 for placebo, 7.5/46, and 15/92, respec- tively. At EOT, mean percent WL was -1.9%, -8.6%, and -10.5%, respectively (P<.001 vs placebo). At EOT, cost, mean annual concomitant medication costs increased with placebo and decreased with PHEN/TPM ER. $36±33 (-3%), $83±466 (-6%), and $103±33 (-8%) respectively vs. placebo. CONCLUSIONS: These findings suggest that PHEN/ TPM ER-enhanced WL is associated with a reduction in annual medication costs vs placebo in patients with MetS.

PSY33

PHARMACOTHERAPEUTIC AND ECONOMIC INDICATORS OF THE USE OF IMMUNOLOGICALS DRUGS: ANALYSIS OF A RHEUMATIC PATIENT COHORT Kim HP,1 Magalhaes Dd,1 Albuquerque IMd,1 Vieira Jd,1 Sartori Dd,1 Candido D,1 Alcantara RC,1 Rebouças SVd,1 Filho NGc,1 Rodrigues E2

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OBJECTIVES: Immunobiologics (IMB) should only be used as a second line treatment of rheumatic diseases because of their potential risks and high cost. This study aimed to evaluate the use of IMB, to analyze the pharmaco-economic and phar- maco-economic indicators derived from a cohort of rheumatic patients. METHODS: This was a prospective observational exploratory study that analyzed data from the follow-up chart of 240 patients in treatment with IMB, previously authorized by rheu- matologists and then monitored by a Pharmaceutical Auditing Clinical Management Program of a Health Insurance Provider in Fortaleza, Brazil, from March-2012 to September-2014. For the pharmacotherapeutic and economic analysis, the follow- ing indicators were used: “most used IMB” “treatment of the IMB therapy” “route of administration” and “direct cost”. For calculation of the costs, the electronic source Brasinduse was used. RESULTS: The most common indications for IMB use were rheumatoid arthritis 66.57 % (85/124) and ankylosing spondylitis 41.67 % (85/204). The intravenous route (IV) was more frequent, 63 % (158/251), when compared to the subcutaneous (SC), 37 % (93/251). The main IV IMB was infliximab, 37.27 % (81/215). The most used SC IMB and higher proportional increase prescriptive was adalimuma 15.45 % (38/248). The IMB with higher direct cost was infliximab, US $1,147.82 per ca. The cumulative global cost the immunobiological therapy during the period of study was US $6,366,673.33 as adjusted by weight. CONCLUSIONS: Monitoring of patients using IMB through a multidisciplinary team is an important clinical manage- ment tool, enabling the development of strategies for the rationalization of future interventions and reduction of its high cost.

PSY34

PROJECTING BENEFITS FROM WEIGHT LOSS IN OBESE POPULATIONS: A MICROSIMULATION APPROACH Chen J1, Jacobsen WC2, Wu W2, Dalit T1

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OBJECTIVES: To quantify the clinical and economic benefits of weight loss among obese adult populations, and the benefits vary across subgroups of the obese adult population. METHODS: A validated, Markov-based microsimulation model was used to simulate 10-year health and economic outcomes for different subgroups of the obese adult population, with sample populations drawn from the 2005-2012 National Health and Nutrition Examination Survey. The study outcomes include changes in weight, quality adjustments in weight and healthcare costs. As of November 2014. Administration costs were not included. Cost per additional responder was calculated as the NNT multiplied by 12 week drug costs. RESULTS: Cost per additional responder for PASI 75 was lowest for ADA ($18,065 - $18,647) and NNT across various levels of efficacy may be valuable for decision makers when evaluating multiple medications.

PSY35

DEMONSTRATING THE EFFECT COSTIVENESS OF MOVANTIK FOR THE TREATMENT OF OPIOID INDUCED CONSTITUTION IN PATIENTS WITH INADEQUATE RESPONSE TO LAXATIVES: A UK PERPECTIVE Lawson B,1 Voix H1, Mudunkotuwde S1, King P1, Goh J1, Marsh K1

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OBJECTIVES: Opioid induced constipation (OIC) is the most common, persistent and debilitating side effect reported in patients receiving opioids to manage pain. Laxatives are commonly prescribed to treat OIC but in some patients they provide inadequate response. Movantik is a peripherally acting mu-opioid receptor antago- nist used to treat patients with inadequate response to laxatives (LIR). A Cost effectiv- eness model was constructed from the UK payer perspective to compare Movantik (Movantik® 4mg tablet and Movantik® 8mg tablet) vs. LIR and laxatives and Movantik for the treatment of opioid induced constipation in patients with inadequate response to laxatives. METHODS: Two Phase III 12-week placebo-controlled RCTs, KODIAC 1 and 2, provided data on response rates, transition probabilities and EQ-5D inputs for the model for Movantik, placebo and rescue laxatives. The primary outcome was time to first response. Phase I of both these studies and KODIAC 3, a 52-week safety study. The model comprises a decision tree for the first 4 weeks of treatment, followed by a Markov model with a 4-week cycle length and the following states: non-OIC on treatment, OIC, non-OIC not on treatment, non-OIC not on treatment. A Markov model provides data on OIC status for Relistor and Targin. Resource utility data used in the model were gathered from a UK-based burden of illness study and physician surveys. RESULTS: Movantik has an IER of 20.849 vs. placebo, of 12.639 vs. placebo & rescue laxatives and is dominant vs Relistor over a 5 year horizon in LIR patients. The probabilistic