ASSOCIATIONS BETWEEN BASELINE LOW DENSITY LIPOPROTEIN CHOLESTEROL (LDL-C) LEVELS AND TREATMENT INITIATION OF SELECTED STATINS IN A MANAGED CARE POPULATION

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OBJECTIVES: Individuals who are not at ATP III (Adult Treatment Panel III) LDL-C goal are recommended to take statins along with lifestyle modifications. Different lipid lowering therapies (LLT) vary in their average LDL-C efficacy. The goal of this retrospective, observational study is to examine the association between initiation of selected statins and LDL-C levels before the prescribing in a cohort of CHD/CHD risk equivalents.

METHODS: Using a large managed care administrative claims database, we identified individuals with at least one prescription for simvastatin plus ezetimibe fixed dose combination (simvastatin/ezetimibe), simvastatin, atorvastatin, or rosuvastatin between January 01, 2005 and December 31, 2006. Patients were excluded if they met any of the following criteria: use of any LLT during the 6 months prior (baseline) to the index (first prescription) date; prescription fills for more than one LLT on the index date; no lab value; or at LDL-C goal (<100 mg/dL) at baseline based on ATP III cholesterol guidelines. Three logistic regression models adjusting for age and gender were developed to examine the association between being ≥250% away from the LDL-C goal at baseline and simvastatin/ezetimibe initiation (N = 22,661) relative to simvastatin (N = 2,615), atorvastatin (N = 5,703), and rosuvastatin (N = 1,446) monotherapy.

RESULTS: A total of 13,651 eligible patients were treatment naive and not at LDL-C goal at baseline. Compared to individuals who were <50% away from the LDL III goal, patients who were 50% or more away from goal were 1.8 (95% CI = 1.6–2.1), 1.4 (1.2–1.5), and 1.1 (0.9–1.2) times more likely to be prescribed simvastatin/ezetimibe rather than simvastatin, atorvastatin, and rosuvastatin monotherapy, respectively.

CONCLUSIONS: The positive association between being ≥250% away from LDL-C goal and initiation of simvastatin/ezetimibe vs. simvastatin or atorvastatin suggests that physicians were choosing simvastatin/ezetimibe because of the anticipated higher efficacy with this combination than the statin monotherapy studied.

A LONGITUDINAL ANALYSIS OF ANGIOTENSIN RECEPTOR BLOCKER (ARB) PRESCRIBING PATTERNS UNDER A PRIOR-AUTHORIZATION REQUIREMENT

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OBJECTIVES: Since the introduction of ARBs into the Israeli market in 2001, the Leumit Health Fund has enforced a prior authorization (PA) requirement for these relatively expensive drugs. We hypothesized that the trends in requests by physicians for these drugs would reflect the variance in the intensity of marketing campaigns for the different products over time. The objective of this study was to evaluate the trends in the patterns of requests for the ARBs available in Israel between 2001 and 2008, and to correlate the findings with available information describing the marketing campaigns that were concomitantly launched. METHODS: Data on all requests for PA approval for ARBs was retrieved for the relevant study period. The proportion of requests for individual drugs during each quarter of the eight years studied was calculated. The longitudinal trends in physician patterns for requests were analyzed to identify trends surrounding launch dates of new products, introduction of generic equivalents, and expiration of international marketing licenses.

RESULTS: Initially, four different products were introduced into the market with 49% of requests for losartan, 19% for both valsartan and candesartan, and 13% for irbesartan. During the 3 month period in 2007 prior to the introduction of generic losartan when the drug was no longer being detailed, the proportion of requests for all drugs was: valsartan 58%, losartan 24%, candesartan 17%, and olmesartan 1%. Similar trends were identified for other drugs. CONCLUSIONS: Analysis of variance in the proportion of PA requests for drugs within a pharmacological category is a feasible method for monitoring physician prescribing behavior which may be strongly influenced by aggressive marketing. Under a PA constraint this method is preferable since dispensing data poorly reflects MD preferences due to the barrier created by PA.

PATTERN OF CLOPIDOGREL USE IN PERCUTANEOUS CORONARY INTERVENTION PATIENTS

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OBJECTIVES: Clopidogrel is a thiol-containing drug for coronary artery disease (CAD) patients who undergo percutaneous coronary intervention (PCI). Studies suggest clopidogrel generates more benefit if it is given early. Giving a loading dose of 600 mg has been suggested to achieve a more rapid inhibition of antiplatelet aggregation. This study examined real world clopidogrel use pattern among patients who undergo PCI. METHODS: HealthFactors® (Cerner Corp) is electronic medical record data with time-stamped information. Study cohort was 62,533 patients who received a minimum 300 mg loading dose of clopidogrel between 24 hours before and up to 6 hours after PCI either with or without ACS diagnoses from 40 interventional cardiology centers between January 2006 and March 2008 (Elective PCI n = 3,922, ACS-PCI n = 2,331, of which 972 had UNISTEMI). High dose was defined as 600 mg. Early treatment was reported at 300 mg and 600 mg for 600 mg prior to PCI. RESULTS: Slightly over half(56.9%) the patients received 600 mg or higher loading dose, and 32.0% received 300 mg. The remaining 11.1% received a dose in between. Loading was given as bolus in 74.5%, two doses in 21.5%, and ≤3 in 3.1%. Among UNI/STEMI subgroup, 25.8% initiated first dose at >6 hours, and additional 9.6% started their high dose 21 hour prior to PCI. A majority (68.3%) of PCI, and 56.4% in UNI/STEMI), however, received clopidogrel during or after PCI. CONCLUSIONS: There exist some uncertainties about optimal dosing of clopidogrel in patients who undergo PCI. While 600 mg was frequently chosen, early treatment with clopidogrel was relatively rare in this sample. Further observation will be required to monitor guideline adherence and outcomes.