pared all-cause utilization and costs associated with once-monthly paliperidone palmitate (PP) versus oral typical or atypical antipsychotics (OAT). However, typical LAI patients incurred lower all-cause pharmacy ($197 vs. $433, p < 0.001), total ($2,850 vs. $3,073, p = 0.048) and psychiatric disorder-related total costs ($1,615 vs. $1,624, p = 0.908) than atypical LAI patients. CONCLUSIONS: Although patients who initiated typical LAIs had high health-related costs and claims, their economic burden was lower compared to those who initiated atypical LAIs.

PMH21 HEALTH RESOURCE USE AND COST ANALYSIS OF SCHIZOPHRENIA PATIENTS PARTICIPATING IN A RANDOMIZED, MULTICENTER, DOUBLE-BLIND, RELAPSE PREVENTION STUDY OF PALIPERIDONE PALMITATE 3-MONTH FORMULATION (PP3M) versus Placebo (PBO)

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OBJECTIVES: To assess the impact of anxiety and depression-anxiety comorbidity status on health resource utilization and costs among patients with schizophrenia during the PP3M study. METHODS: Survey-eligible adults with ≥2 medical claims for depression from 6/1/2009-5/31/2010 in the HealthCore Integrated Research Database were invited to complete longitudinal prospective assessments based on responses to the PHQ-9 and GAD-7. Respondents completed index and 6-month surveys assessing health measures. Significant anxiety was classified into 4 categories (persistently anxiety free, persistent anxiety, reduced anxiety and emerging anxiety). Anxiety disorder (GAD-7) scores at both survey rounds generated a new model. Respondents’ survey data were linked to 24-months of claims data (+12 months from index survey date). Mean annual post-index costs were compared using non-parametric bootstrapping adjusting for initial differences in demographics and health status using propensity score stratification. Similar models were created adding the interaction of remission status. RESULTS: Of 910 respondents with both surveys, 79.3% were female and mean (SD) age was 47.6 (11.4) years. Most respondents were persistently anxiety free (52.9%), followed by persistent anxiety (23.4%), resolving anxiety (15.1%), and emerging anxiety (8.7%). Higher post-index all-cause healthcare costs were observed in respondents with persistent anxiety compared to others (combined group of resolving, emerging, or persistently anxiety-free) ($15,027 [$1,838] vs. $11,311 [$680], p < 0.001). Persistent anxiety respondents had significantly higher mental health-related costs than persistently anxiety-free respondents ($4,226 [$551] vs. $3,044 [$332], p < 0.001). Respondents with anxiety and non-remitting depression had significantly higher all-cause and mental-health related costs vs. respondents without anxiety and non-remitting depression, with mean differences of $2,480 (95% CI: $337 to $4,643, p < 0.001) and $789 (95% CI: $146 to $1,428, p < 0.001). CONCLUSIONS: Respondents’ survey data linked to 24-months of claims data (+12 months from index survey date). Mean annual post-index costs were compared using non-parametric bootstrapping adjusting for initial differences in demographics and health status using propensity score stratification.