PERSISTENCE AND COMPLIANCE OF DEFEROXAMINE VERSUS DEFERASIROX IN MEDICAID PATIENTS WITH SICKLE-CELL DISEASE (SCD)

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OBJECTIVES: This study compares the frequency of hospitalizations, persistence, and compliance of SCD patients treated with deferoxamine (DFO) versus deferasirox (Exjade®), two iron chelating therapies (ICTs). METHODS: Health care claims from Medicaid Florida (1998–2007), Missouri (1993–2008), and New Jersey (1996–2008) were analyzed. Patients with continuous enrollment for 26 months prior to ICT initiation and ≥2 SCD diagnosis were included. Patients were divided into four cohorts: treated with DFO (any DFO cohort), treated with deferasirox (any deferasirox group), initiated on DFO and then switched to deferasirox (deferasirox switchers), and treated with deferasirox (deferasirox only group). Frequency of hospitalization for SCD-related conditions was assessed. ICT initiation and ≥2 SCD diagnosis were included. Persistence was defined as time to drug discontinuation with ≥1 Rx gap. Compliance was estimated using the medication possession ratio (MPR) based on the drug exposure. RESULTS: 217, 275, 105, and 166 patients were included in the any DFO, any deferasirox, deferasirox switchers, and deferasirox only groups, respectively. After ICT initiation, the any deferasirox and deferasirox only groups experienced a significant reduction in the per patient per month frequency of hospitalizations relative to pre-treatment (any deferasirox: from 0.09 to 0.06, P = 0.010; deferasirox only: from 0.11 to 0.07, P = 0.018). The Kaplan-Meier rates of medication persistence after one year of ICT were significantly greater for all three deferasirox cohorts compared to the DFO cohort (any DFO: 0.21, any deferasirox: 0.29, deferasirox switchers: 0.37, deferasirox only: 0.24). Deferasirox treated patients were also significantly more compliant than DFO cohort (MPR: any DFO: 0.64, any deferasirox: 0.78, deferasirox switchers: 0.75, deferasirox only: 0.80). CONCLUSIONS: Deferasirox patients were more compliant and persistent to their treatment than those treated with DFO. Frequency of hospitalizations for SCD-related conditions was significantly reduced in the observation period for the any deferasirox and deferasirox only groups.

CORRELATES OF ADHERENCE TO IMMUNOSUPPRESSANT MEDICATIONS IN COMMUNITY DWELLING SOLID ORGAN TRANSPLANT RECIPIENTS

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OBJECTIVES: To address limited data in Midwest solid organ transplant recipient (SOTR) populations we determined the patient’s demographic and medical characteristics associated with self-reported immunosuppressant (IST) adherence on a 4-item measure (ITAS). More than half (420/557; 75.6%) of the SOTRs were on different IST regimens (Tacrolimus based combination IST, cyclosporine based combination IST, antibody based IST, monthly rituximab, monoclonal antibody based IST). Median income was $55,000 annual income (57.3%), metro-resident (59%), Medicare-insurance (47.8%), $70,000 annual income (20.4%), and Asian race/ethnicity (14.5%). The SOTRs were on different IST regimens (Tacrolimus based combination IST, cyclosporine based combination IST, antibody based IST, monthly rituximab, monoclonal antibody based IST). Median income was $55,000 annual income (57.3%), metro-resident (59%), Medicare-insurance (47.8%), $70,000 annual income (20.4%), and Asian race/ethnicity (14.5%). The SOTRs were on different IST regimens (Tacrolimus based combination IST, cyclosporine based combination IST, antibody based IST, monthly rituximab, monoclonal antibody based IST). Median income was $55,000 annual income (57.3%), metro-resident (59%), Medicare-insurance (47.8%), $70,000 annual income (20.4%), and Asian race/ethnicity (14.5%). The SOTRs were on different IST regimens (Tacrolimus based combination IST, cyclosporine based combination IST, antibody based IST, monthly rituximab, monoclonal antibody based IST). Median income was $55,000 annual income (57.3%), metro-resident (59%), Medicare-insurance (47.8%), $70,000 annual income (20.4%), and Asian race/ethnicity (14.5%). The SOTRs were on different IST regimens (Tacrolimus based combination IST, cyclosporine based combination IST, antibody based IST, monthly rituximab, monoclonal antibody based IST). Median income was $55,000 annual income (57.3%), metro-resident (59%), Medicare-insurance (47.8%), $70,000 annual income (20.4%), and Asian race/ethnicity (14.5%).

METHODS: Cross-sectional survey-data (patient: residence zip code, education, marital status, annual income, health-status, insurance coverage; condition: comorbidities; therapy: total number of medications other than IST; and ITAS) was collected from 3 longitudinal surveys of adults with SCD index diagnosis were included. Patients were divided into four cohorts: treated with DFO (any DFO cohort), treated with deferasirox (any deferasirox group), initiated on DFO and then switched to deferasirox (deferasirox switchers), and treated with deferasirox (deferasirox only group). Frequency of hospitalization for SCD-related conditions was assessed. ICT initiation and ≥2 SCD diagnosis were included. Persistence was defined as time to drug discontinuation with ≥1 Rx gap. Compliance was estimated using the medication possession ratio (MPR) based on the drug exposure. RESULTS: 217, 275, 105, and 166 patients were included in the any DFO, any deferasirox, deferasirox switchers, and deferasirox only groups, respectively. After ICT initiation, the any deferasirox and deferasirox only groups experienced a significant reduction in the per patient per month frequency of hospitalizations relative to pre-treatment (any deferasirox: from 0.09 to 0.06, P = 0.010; deferasirox only: from 0.11 to 0.07, P = 0.018). The Kaplan-Meier rates of medication persistence after one year of ICT were significantly greater for all three deferasirox cohorts compared to the DFO cohort (any DFO: 0.21, any deferasirox: 0.29, deferasirox switchers: 0.37, deferasirox only: 0.24). Deferasirox treated patients were also significantly more compliant than DFO cohort (MPR: any DFO: 0.64, any deferasirox: 0.78, deferasirox switchers: 0.75, deferasirox only: 0.80). CONCLUSIONS: Deferasirox patients were more compliant and persistent to their treatment than those treated with DFO. Frequency of hospitalizations for SCD-related conditions was significantly reduced in the observation period for the any deferasirox and deferasirox only groups.
metric tests (frequency, factor analysis, reliability tests) were used to verify the relevance and determinacy of the attributes. Repertory grid analysis was used to identify the constructs used by patients to characterize overweight and obesity therapy. Respondents were presented with cards outlining the preference dimensions and asked to rank all relevant dimensions in order of relevance. RESULTS: The relevance of attributes and endpoints resulted in categories that emerged as relevant spanning from therapy attributes as technical care, access, empowerment and interpersonal care. The factor analysis of the attributes resulted in 8 factors with a KMO of 74.4; chronbach alpha between 0.78 and 0.552 and a total mean square of 55.416. The repertory grid and ranking resulted in five patient-relevant endpoints (e.g. functional status, side effects, outcome and risk factors). CONCLUSIONS: The novelty of this analysis is the combination of qualitative and quantitative methods to build a conceptual map of patient preferences to be used to plan comprehensive assessment of patient preferences in overweight and obesity therapy. The map concludes important attributes and endpoints and makes it possible to sort them in categories and subcategories. Theoretical issues concerning the nature of attributes and their interrelationships are raised and the implications for the measurement of patient preferences are discussed.

EXTENDED-RELEASE OXYMORPHONE IS ASSOCIATED WITH LOWER SUBJECTIVE MONETARY VALUE THAN CONTROLLED-RELEASE OXYCODONE IN NONDEPENDENT RECREATIONAL OPIOID USERS

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OBJECTIVES: This study assessed the subjective drug valuations of two opioids. This valuation may contribute to a better understanding of beneficiary preferences unrelated to drug effectiveness. METHODS: This exploratory, randomized, double-blind, placebo-controlled, 5-way crossover study compared the subjective and objective effects of equal mean doses of extended-release oxymorphone (15 mg ± 10 mg) and controlled-release oxycodone (30 mg ± 60 mg) plus placebos in healthy nondependent recreational opioid users. Subjects received single, double-blind, over-encapsulated, intact doses of each opioid or placebo treatment with ≥ 28 day washout period between treatments. Assessments included subjective drug value, 2 series of theoretical choices that forced subjects to select between receiving another dose of the same drug to take home or a specified amount of money in Canadian dollars ($) The Subjective Drug Value was administered at the 4, 8 and 24 hour time points of each treatment period with a minimum value of $0.25 and a maximum value of $48.00. RESULTS: Thirty five out of forty subjects completed the study. Extended-release oxymorphone was associated with statistically lower mean (SE) subjective drug values than equianalgesic doses of controlled-release oxycodone: extended-release oxymorphone 30 mg ± 16.8 (2.78) vs. controlled-release oxycodone 60 mg ± 25.32 (2.78), p = 0.013; extended-release oxymorphone 5 mg ± 19.85 (2.77) vs. controlled-release oxycodone 30 mg ± 25.00 (2.80), p < 0.001. CONCLUSIONS: Oral intact extended-release oxymorphone had lower subjective drug values than equianalgesic doses of controlled-release oxycodone in this exploratory study. The impact of subjective valuation on drug utilization patterns in recreational drug users and patients merits further investigation.

PATIENT AND CAREGIVER-REPORTED SYMPTOMS AND REASONS FOR STARTING/STOPPING RECOMBINANT FACTOR VIIa (RFVIIa): HOME TREATMENT OF ACUTE BLEEDS IN THE DOSING OBSERVATIONAL STUDY IN HEMOPHILIA (DOSE)

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OBJECTIVES: This study assessed the subjective drug valuations of two opioids. This valuation may contribute to a better understanding of beneficiary preferences unrelated to drug effectiveness. METHODS: This exploratory, randomized, double-blind, placebo-controlled, 5-way crossover study compared the subjective and objective effects of equal mean doses of extended-release oxymorphone (15 mg ± 10 mg) and controlled-release oxycodone (30 mg ± 60 mg) plus placebos in healthy nondependent recreational opioid users. Subjects received single, double-blind, over-encapsulated, intact doses of each opioid or placebo treatment with ≥ 28 day washout period between treatments. Assessments included subjective drug value, 2 series of theoretical choices that forced subjects to select between receiving another dose of the same drug to take home or a specified amount of money in Canadian dollars ($) The Subjective Drug Value was administered at the 4, 8 and 24 hour time points of each treatment period with a minimum value of $0.25 and a maximum value of $48.00. RESULTS: Thirty five out of forty subjects completed the study. Extended-release oxymorphone was associated with statistically lower mean (SE) subjective drug values than equianalgesic doses of controlled-release oxycodone: extended-release oxymorphone 30 mg ± 16.8 (2.78) vs. controlled-release oxycodone 60 mg ± 25.32 (2.78), p = 0.013; extended-release oxymorphone 5 mg ± 19.85 (2.77) vs. controlled-release oxycodone 30 mg ± 25.00 (2.80), p < 0.001. CONCLUSIONS: Oral intact extended-release oxymorphone had lower subjective drug values than equianalgesic doses of controlled-release oxycodone in this exploratory study. The impact of subjective valuation on drug utilization patterns in recreational drug users and patients merits further investigation.

A COMPARISON OF PHYSICIAN-PRESCRIBED AND PATIENT/CAREGIVER REPORTED DOSING OF RECOMBINANT FACTOR VIIa (RFVIIa): HOME TREATMENT OF ACUTE BLEEDS IN THE DOSING OBSERVATIONAL STUDY IN HEMOPHILIA (DOSE)

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OBJECTIVES: This study assessed the subjective drug valuations of two opioids. This valuation may contribute to a better understanding of beneficiary preferences unrelated to drug effectiveness. METHODS: This exploratory, randomized, double-blind, placebo-controlled, 5-way crossover study compared the subjective and objective effects of equal mean doses of extended-release oxymorphone (15 mg ± 10 mg) and controlled-release oxycodone (30 mg ± 60 mg) plus placebos in healthy nondependent recreational opioid users. Subjects received single, double-blind, over-encapsulated, intact doses of each opioid or placebo treatment with ≥ 28 day washout period between treatments. Assessments included subjective drug value, 2 series of theoretical choices that forced subjects to select between receiving another dose of the same drug to take home or a specified amount of money in Canadian dollars ($) The Subjective Drug Value was administered at the 4, 8 and 24 hour time points of each treatment period with a minimum value of $0.25 and a maximum value of $48.00. RESULTS: Thirty five out of forty subjects completed the study. Extended-release oxymorphone was associated with statistically lower mean (SE) subjective drug values than equianalgesic doses of controlled-release oxycodone: extended-release oxymorphone 30 mg ± 16.8 (2.78) vs. controlled-release oxycodone 60 mg ± 25.32 (2.78), p = 0.013; extended-release oxymorphone 5 mg ± 19.85 (2.77) vs. controlled-release oxycodone 30 mg ± 25.00 (2.80), p < 0.001. CONCLUSIONS: Oral intact extended-release oxymorphone had lower subjective drug values than equianalgesic doses of controlled-release oxycodone in this exploratory study. The impact of subjective valuation on drug utilization patterns in recreational drug users and patients merits further investigation.

ASSOCIATION BETWEEN SELF-REPORTED NEUROPATHIC PAIN SEVERITY AND THE EQ-5D IN PATIENTS WITH PAINFUL DIABETIC PERIPHERAL NEUROPATHY (PDPN) OR POST-HERPETIC NEURALGIA (PHN)

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OBJECTIVES: To assess the association between self-reported neuropathic pain severity and the EQ-5D. METHODS: This study used data from baseline responses from 2791 participants to 3 longitudinal internet surveys who 1) reported ≥ 3 months of PDPN/PHN; 2) were receiving a prescription/OTC medication to treat PDPN/PHN; and 3) had completed at least EQ-5D. Ordered logistic regression models were used to assess the association between EQ-5D items and pain severity, adjusting for age, gender and years since PDPN/PHN diagnosis. Pain severity was assessed using the 11-point pain-intensity numerical rating scale (0 = no pain to 10 = pain as bad as you can imagine). The likelihood-ratio test was used to test the proportionality of odds assumption. RESULTS: Respondents were 56% female, mean age 55.48 (±10.65) years, had PDPN/PHN duration for 5.1 (±4.7) years, and had (mean) pain severity of 5.7 (±0.6). The proportionality of odds assumption was not rejected (P = 0.05). Compared with reference pain severity = 0, participants with greater pain severity were more likely to report greater health deficits on the EQ-5D items. All covariates were significantly (P ≤ 0.05) associated with the EQ-5D items except for age on “Mobility” and lower pain severity (1 or 2) on “Mobility” and “Self-care”. As expected, items “Pain/discomfort” demonstrated greater association with PDPN/PHN pain severity. For instance, relative to responders with pain severity = 0, responders with pain severity = 1 and = 10 were 2.52 (p = 0.026) and 1954.33 (p ≤ 0.0001) times more likely to report more severe “pain/discomfort”, respectively. In comparison, responders with pain severity = 10 were 13.05, 13.83, 24.50, and 38.83 times more likely to report more difficulties on “Self-care”, “Anxiety/depression” “Mobility”, and “Usual activities” (p ≤ 0.0001), respectively, relative to responders with pain severity = 0. CONCLUSIONS: A strong association exists between self-reported neuropathic pain severity and the EQ-5D. The EQ-5D is sensitive in detecting health disparities among moderate to severe chronic PDPN/PHN patients.