**PSY2**

**OBJECTIVES:** Assess the timing of biologic initiation and associated healthcare utility and costs among psoriatic (PsO) patients. METHODS: Adults (18-64 years) with ≥2 PsO diagnoses (ICD-9-CM=696.1) after 4/30/2004, ≥1 non-biologic pharmacologic systemic treatment ("non-biologic") after the first observed diagnosis, and ≤12-months before (baseline) and 24-months following (study period) the index date. Patients were categorized into two cohorts based on days from the first non-biologic to index date: "≥180-days" and "≤180-days." Study period utilization and costs were compared between cohorts using unadjusted and multivariable adjusted analyses. RESULTS: There were 759 "≥180-days" and 881 "≤180-days" patients identified. Discrete patient-level costs were compared to the "≥180-days" cohort (38.3% vs 31.1%). "≤180-days" patients incurred more inpatients visits, higher medical, inpatient, and outpatient costs; and lower pharmacy costs compared to "≥180-days" patients during baseline. During the study period, the "≥180-days" cohort had higher unadjusted number of emergency department visits (0.52 vs 0.45) and outpatient visits (36.03 vs 31.89) as well as higher total ($20,971 vs $18,031.49) and cumulative costs ($24,502.05 vs $20,971) than the "≤180-days" cohort. In the unadjusted analysis, the numeric difference was as high as 3.38% for patients with a baseline diagnosis of psoriasis. Lower biologic adherence in the "≥180-days" cohort resulted in higher downstream costs associated with acute care, thereby reducing the financial burden of psoriasis from a payer's perspective.

**PSY27**

**OBJECTIVES:** To compare all-cause and thalassemia-related healthcare resource utilization and costs in Medicaid patients with thalassemia. METHODS: A retrospective analysis was performed using the Medicaid 2008 data from October 1, 2007 through December 31, 2008. All patients with a diagnosis of thalassemia from a payer’s perspective. Adherent and non-adherent patients were compared using adjusted incidence rate ratios (aIRR) for RU and adjusted cost differences (aCD). RESULTS: Of the 218 eligible thalassemia patients, 153(67.8%) were adherent. Baseline demographic and clinical characteristics were similar between adherent and non-adherent patients, although adherent patients were younger (20.9 vs. 25.8 years old, p<0.011). The adjusted rate of drug-related outpatient visits (FFPM) was higher in adherent patients (aIRR=1.11, p<0.004). However, adherent patients incurred fewer thalassemia-related hospitalizations (0.80, p=0.002) and ER visits (0.64, p<0.001). FFPM thalassemia-related medical costs followed a similar trend with slightly higher outpatient costs (aCD=$11.5, p=0.025) and lower RU costs (aCD=$2.50, p=0.052). Similar results were observed for all-cause RU and medical costs. While all-cause pharmacy costs were higher in adherent patients (aCD=$1.50, p=0.000), non-ICT pharmacy costs was slightly lower (aCD=$234, p=0.000). CONCLUSIONS: This study shows that thalassemia patients adherent to ICT incurred more outpatient visits, which may be related to better disease monitoring and management, potentially resulting in the lower rates of acute care visits and the lower index date in this cohort. Enhanced adherence to ICT may reduce downstream costs associated with acute care, thereby reducing the financial burden of thalassemia from a payer's perspective.

**PSY28**

**OBJECTIVES:** To investigate the demographic distribution and health care burden of patients diagnosed with ankylosing spondylitis (AS) using Medicare fee-for-service (FFS) data. METHODS: A retrospective analysis was performed using the 2009 Medicare Fee-for-Services data from October 1, 2008 through December 31, 2012. Patients diagnosed with AS were identified using International Classification of Diseases, 9th Revision, Clinical Modification diagnosis code 720.0, and the first diagnosis date was designated as the index date. All patients were required to have continuous medical and pharmacy benefits 1-year pre- (baseline period) and post-index date (follow-up period). Health care resource utilization and costs during the baseline and follow-up periods were calculated. RESULTS: A total of 8,990 AS patients were included in the study. The average age at diagnosis was 75 years. Nearly 88.7% of patients were white, 62.97% were women and many resided in the South U.S. region (40.3%). The most common baseline comorbidities were chronic obstructive pulmonary disease (33.20%), diabetes (30.50%), cerebrovascular disease (22.65%) and congestive heart failure (18.85%). During the follow-up period, 73.04% of patients had inpatient admissions, 52.31% had emergency room visits, 41.43% had outpatient office visits, 91.43% had outpatient visits and 57.67% had pharmacy visits, resulting in average costs of $37,077, $298, $5,397, $5,665, and $6,668, respectively. The total overall costs were $49,440 during the follow-up period. The four most frequently prescribed medications for AS were prednisone hydrochloride (9.37%), methylprednisolone acetate (5.72%), methotrexate (2.79%), and levotiroxine sodium (2.42%). CONCLUSIONS: AS patient demographic and clinical characteristics in the Medicare population were assessed. Study patients were often diagnosed with comorbid conditions, and had high health care utilization and costs.