Among 3,240,046 Florida Medicaid-enrolled children, 196,687 (6%) were prescribed omalizumab. The incremental cost of omalizumab-treated patients is estimated to be $12,416 per year per patient, 0.22% from total budget, and the cost of treatment was $8,619,778 and on MI were $626,247,288. It was 33.66% from total direct costs $212,243,357 assigned to these diseases and 2.1% of total Slovakia health care budget. The cost of treating a smoker on diseases associated with smoking was $1,114. Decreasing the number of smokers by 10% will reduce health care costs by $7,114. The cost of treatment for smoking using varenicline was $919 per patient. CONCLUSIONS: The direct costs associated with smoking comprise an important part of total health care budget in Slovakia. They signalize the need to establish effective strategies for smoking cessation. 44% clinical effectiveness of varenicline shows to be a cost-effective way in reducing smoking and decreasing health care expenditures.

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Managed-care budget impact of omalizumab for moderate to severe persistent asthma

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OBJECTIVES: Omalizumab (Xolair) is a FDA-approved immunomodulator for the treatment of steroid refractory, uncontrolled (symptomatic), moderate-severe persistant asthma in patients ≥12 years of age with a positive skin test to a perennial aeroallergen extract. The objective was to estimate the budget impact of omalizumab availability on a hypothetical health plan (US payer perspective). METHODS: The budget impact was estimated as the difference in two scenarios where omalizumab is used by moderate-severe uncontrolled asthmatics with a confirmed allergic component over similar controlled asthma patients on standard of care. Publicly available, real-world utilization data were used to develop percentage estimates for omalizumab-eligible patients hierarchically as follows: treated asthmatics in the approved age-groups who exhibited poor symptom control (55% of patients) and were moderate-severe asthmatics (40%) with ≥6 exacerbations per year (60%) and whose levels were increased from the reference level per the omalizumab package insert (61%) were included in the model. Of the data based on real world utilization data, 3.2% would receive omalizumab therapy. Omalizumab-related costs in the model consisted of eligibility screening, drug, and office administration. Health service costs impacted by omalizumab consisted of unscheduled asthma exacerbation office visits, emergency room visits, and hospitalizations. The impact of key model parameters on the budget was assessed in sensitivity analyses (SA). RESULTS: The incremental cost of omalizumab-treated patients was estimated at $1285 per omalizumab user per month ($0.11 per member per month (PMPM) given the additive costs of omalizumab screening, drug and administration. When parameters were varied ± 10% in a one-way sensitivity analysis, the PMPM varied within $0.10 to $0.125. Results were most sensitive to the estimated percentage of patients on omalizumab. CONCLUSIONS: The model demonstrated that omalizumab availability resulted in an incremental cost of $0.11 PMPM. Sensitivity analyses of the model parameters by ± 10% in the SA resulted in a PMPM range of $0.10 to $0.125.

Allergy immunotherapy confers significant health care cost savings within 3 months of initiation: A matched retrospective cohort study of medicaid-enrolled children newly diagnosed with allergic rhinitis


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OBJECTIVES: To compare the health care costs of children with newly-diagnosed allergic rhinitis (AR) who subsequently received allergy immunotherapy (IT) to a matched group of children with newly-diagnosed AR who did not receive IT. METHODS: We examined 10 years (1997–2007) of Florida Medicaid paid claims to identify children (<18 years) newly diagnosed with AR who received IT and had at least 18 months of data following IT initiation (IT Group). Patients were matched (by age at AR diagnosis, sex, race, and presence of asthma, atopic dermatitis, or conjunctivitis) over the same period to newly AR-diagnosed children who did not subsequently receive IT (Control Group). Wilcoxon signed-rank tests were performed for median, and per-patient total health care costs (pharmacy costs + inpatient costs + outpatient costs + IT costs if any) at 3, 6, 12, and 18 months. RESULTS: Among 3,240,046 Florida Medicaid-enrolled children, 196,687 (6%) were newly diagnosed with AR, and 3,931 (2%) subsequently received IT. A subset (N = 2,291) had at least 18 months of follow-up data and were matched to one or more of 71,970 controls. Within three months of IT initiation, the IT Group incurred significant lower total health care costs ($1,066 vs. $1,365, p < 0.0001) than the matched Control Group. Significant cost savings were maintained across 6 months ($1,910 vs. $2,474, p < 0.0001), 12 months ($3,242 vs. $4,519, p < 0.0001), and 18 months ($4,324 vs. $6,136, p < 0.0001), growing from $359 at 3 months to $1,801 at 18 months. In contrast, the time to achieve IT was $250, $360, $488, and $565, respectively. CONCLUSIONS: This is the first U.S.-based study to report significant health care cost savings for IT AR-diagnosed children. Findings suggest that these savings may occur within a few months of treatment initiation, appear to increase over time, and may more than offset the cost of IT.