drug-dose combination was calculated in 2006 dollars and was compared to prices available through the November 2006 FSS. A savings/pill was calculated to develop a nationally representative estimate of the societal savings that could be achieved if medications could be obtained for FSS prices instead of current pricing systems. RESULTS: Substitution of the FSS price could result in a median annual per person savings in drug expenditures of $308 (interquartile range, $124 to $637) for the Medicare population, age 65 and above. The potential national savings among these 8 classes over one year is $10.7 billion (95% CI $10.0 billion to $11.4 billion). Among Statin medications alone, the annual savings could be $5.9 billion (95% CI $5.4 billion to $6.4 billion) in this age group. CONCLUSION: Substantial savings in drug expenditures, in the tens of billions of dollars, would result if Federal Supply Schedule prices were used by Medicare in place of these commercially available prices.

MD2
PER-PATIENT-PER-MONTH DRUG COSTS IN MEDICARE PART D PROTECTED CLASSES
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OBJECTIVES: The objective of this study was to estimate per patient per month (PPPM) costs of medications in the six Medicare Part D protected classes based on findings among Medicare and dual eligible beneficiaries with drug coverage prior to enactment of the benefit. METHODS: Data were from the Thomson Medstat Marketscan Medicare and Medicaid claims databases. The study sample was constructed by identifying patients who were enrolled either in Medicare or dually in Medicare and Medicaid in 2004. Costs were aggregated within each class, including patient-paid and plan-paid amounts. These costs provided the numerators for the PPPM calculations. Denominators were defined as the aggregated patient months for only those individuals who filled a drug within a particular class. Drugs covered under Part B were excluded. RESULTS: The classes where generic formulations were available (antidepressants and anticonvulsants) showed lower PPPM costs ($45.31 and $50.97, respectively). The costliest class was the antiretrovirals ($1028.13) for dual eligible patients including those age 64 and under. Among the dual eligibles over 65, immunosuppressants were the costliest ($657.72). In the Medicare group, the cost of immunosuppressants ($814.86) was substantially higher than the other five classes. The PPPM cost over all 6 classes for Medicare was $54.75, for dual eligibles it was $157.99, and $116.35 for all patients. CONCLUSION: PPPM costs were not uniformly high among the protected classes. The claims data in this study allowed a “real world” check of how much the protected classes may impact the finances of Part D. There are differences within the classes between the dual eligible and Medicare patients, and also within the dual eligibles by age. This is an important message to policy makers that a change to the structure of the protected classes in Part D may have differential effects across and also within classes.

MD3
CHANGES IN PRESCRIPTION USE AND OUT-OF-POCKET COSTS AMONG MEDICARE ELIGIBLE ADULTS, 2005–2006
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OBJECTIVES: Few assessments of the Medicare Part D Prescription Drug Benefit have been performed. We examined the impact of the drug benefit on drug utilization and out-of-pocket expenditures. METHODS: We used pharmacy claims data from a large national pharmacy to compare drug utilization and out-of-pocket expenditures of Medicare eligible seniors in 2005 to their outcomes in 2006. We used pharmacy customers aged 60–64 during the same period as a control group to capture non-Medicare related trends in drug utilization and costs occurring during the study period. The sample represented approximately 5.1 million unique Medicare beneficiaries aged 65–90 and 1.8 million unique subjects in the control group who filled and obtained at least one prescription in pre-benefit 2005 period. RESULTS: After adjusting for individual characteristics and socio-economic characteristics of subjects’ zip code of residence, preliminary analyses suggest subjects’ annual drug utilization increased by 5.3% (95% confidence interval [CI] 4.7%–6.2%) and subjects’ annual out-of-pocket expenditures decreased by 10.6% (CI 9.6%–11.9%) in 2006 as compared to 2005, net of non-Part D related effects. Dual eligible subjects had little to no increase in drug utilization. However, they had similar declines in out-of-pocket expenditures as the broader beneficiary population. Sensitivity analyses demonstrated that the measured impact was not due to trend differences among different age groups over the study period. CONCLUSIONS: Modest increases in prescription drug utilization and decreases in out-of-pocket expenditures occurred for these Medicare seniors following the implementation of the Medicare Part D Prescription Benefit. Further work is needed to examine these patterns among other beneficiaries and to evaluate the impact of these changes on health outcomes.

MD4
MEDICAID PREFERRED DRUG LISTS’ COSTS TO PHYSICIANS
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OBJECTIVES: To measure costs from complying with Medicaid preferred drug lists (PDLs) for primary care physicians and cardiologists. To quantify the potential costs of a hypothetical universal PDL for Medicare Part D as of January 2006. METHODS: During December 2005 and January 2006 we surveyed cardiologists and primary care physicians in 9 states about their experiences with Medicaid PDLs that covered outpatient prescriptions for statins and antihypertensives. We calculated the opportunity cost of time spent by physicians and their staff on requesting prior authorizations (PAs), appealing rejected PAs, discussing PDLs with others, tracking changes to PDLs, and receiving PDL-related training, as well as physicians’ altruistic costs from suboptimal prescribing decisions. We used comprehensive prescription data from Wolters Kluwer Health (WKH) to generate each physician’s annual prescription volume for statins and antihypertensives separately by PDL coverage status. We combined the survey data on PDL-related costs per physician with the WKH prescription volume data using a bootstrap simulation to calculate total costs and the average cost per physician. We calculated the potential costs of a hypothetical universal Medicare Part D PDL by approximating the number of new Part D prescriptions affected by PDLs and multiplying by the survey-based average variable cost per prescription. RESULTS: There were 986 survey respondents and 47,843 physicians with WKH data. For statins and hypertensives, PDL cost per prescription averaged $110.92 (95% CI: $7.25–$8.78) for on-PDL prescriptions and $141.41 (95% CI: $13.29–$15.53) for off-PDL prescriptions and $7.59 (95% CI: $5.91–$7.28) for on-PDL—led to average Medicaid PDL costs per physician of $1110 (95% CI: $1061–$1161) annually. Similar restrictions for Medicare Part D across all therapeutic classes could have cost
physicians $3.2 billion (95% CI $2.88–$3.49 billion) in 2006.

**CONCLUSION:** Medicaid PDLs for statins and antihypertensives have generated considerable costs for physicians. Physicians would incur substantial additional costs if Medicare adopted similarly-structured PDLs for Part D.

**PODIUM SESSION I: WOMEN’S HEALTH**

**WH1**

**BREAST CANCER PATIENTS’ PREFERENCES FOR LOCAL AND SYSTEMIC THERAPY**

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**OBJECTIVES:** To determine the predictors of breast cancer patients’ (BCPs) willingness to accept local and systemic therapy. **METHODS:** Cross-sectional survey of BCPs ages 36–80 at the University of Maryland Greenebaum Cancer Center, Baltimore, MD. Since “treatment” is considered a “short-term” health state, the chained procedure for the time trade-off (TTO) was used to assess TTO. Willingness to accept therapy was determined using “minimum cancer-free years to accept therapy” (CFYs) as the dependent variable. The number of CFYs was calculated based upon BCPs TTO responses for mastectomy (MRM), breast-conserving therapy (BCT), chemotherapy (CTX) and tamoxifen (TAM). Demographic and clinical data were abstracted from medical records. Tobit regression models were used for multivariate analyses. **RESULTS:** Mean age was 56.0 years (SD ± 9.43, n = 77); 58.2% were white; 75.6% had early stage cancer. BCPs required more CFYs (median = 4) to accept MRM than to accept BCT, CTX, or TAM (median 1 year for each). For all forms of therapy, the mode = 0, suggesting that BCPs were willing to accept therapy even if it provided no additional CFYs. Late stage patients required more CFYs to accept TAM (β = 6.61, p = 0.0489); similarly late stage patients in good physical health required more CFYs to have MRM (β = 0.50, p = 0.0322). Treatment-experienced BCPs were more willing to accept that type of therapy than those who were treatment-naïve. Younger patients (<65) required fewer CFYs to accept chemotherapy (age group 50–54, β = −4.77, p = 0.0403; 55–59, β = −7.25, p = 0.0019). Being non-white and having less education were associated with requiring fewer CFYs to accept CTX (β = −3.86, p = 0.0087; β = −5.10, p = 0.0193, respectively). **CONCLUSION:** BCPs required relatively few CFYs to accept treatment. Willingness-to-accept fewer CFYs for CTX among those with less education and of younger age is consistent with treatment patterns of younger age is consistent with treatment patterns. The trade-off between a chance of response with an associated risk of toxicity OR no treatment and remaining with 100% certainty at baseline ABC. This allows one to measure how much chance of response a woman needs to be indifferent to the corresponding chance of toxicity. **RESULTS:** Mean age was 55.76, 64% were postmenopausal, 11% had breast cancer while 16% had another type of cancer previously. VAS scores were 51.8 (p < 0.01) for baseline ABC, 82.5 (p < 0.01) for response, 57.5 (p < 0.01) for no response and 38.4 (p < 0.01) for disease progression. SG regression results were 0.64 (p < 0.01) for baseline, 0.76 (p < 0.01) for treatment response, 0.67 (p < 0.01) for no response, and 0.50 (p < 0.01) for disease progression. The trade-off between a chance of response with a corresponding chance of toxicity yielded a value of 0.34 (p < 0.01) or utility score of 0.66 (p < 0.01). **CONCLUSION:** Women need at least a 34% chance of treatment response to be indifferent to treatment-related toxicity. These measured values are more appropriate for Quality-adjusted Time Without Symptoms of disease and Toxicity (Q-TWiST) analysis to value oncology treatment.

**WH2**

**REduced work limitation with improvement in mood, sleep and vasomotor symptoms in postmenopausal women**

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**OBJECTIVES:** To determine whether vasomotor symptom reduction is associated with improved work productivity using pooled data from 2 clinical trials for the relief of menopausal hot flushes with desvenlafaxine succinate (DVS). **METHODS:** A total of 843 postmenopausal women experiencing 50 or more moderate-to-severe hot flushes per week received 100 or 150 mg/day DVS or placebo in 2 randomized, double-blind, placebo-controlled trials. Subjects kept daily hot flush and sleep diaries and completed the Profile of Mood States (POMS) and Work Limitations Questionnaire (WLQ) at baseline and week 12. To control for multiplicity, the data were analyzed using multivariate analysis of covariance (MANCOVA), adjusting for age, race, type of menopause, and baseline values. **RESULTS:** At both 100- and 150-mg doses, DVS reduced the number and severity of hot flushes from baseline to week 12 compared with placebo (all comparisons, P < 0.0001). DVS reduced the number of nighttime awakenings due to hot flushes (P < 0.0001) and improved self-perceived sleep quality (P < 0.05) at both doses compared with placebo. The 100 mg dose also significantly increased the daily number of minutes slept (P < 0.05). POMS total mood disturbance score improved significantly in both DVS dose groups compared with placebo (P < 0.001). Work limitation, measured by WLQ total index score, decreased significantly from baseline to week 12 in subjects treated with 100 mg DVS (adjusted mean [SE] reduction = −3.3 [0.9]; P = 0.0115) compared with placebo (−1.4 [0.9]). The 100-mg dose group had significant improvement on the time management (P = 0.0354), mental-interper-