tatin and simvastatin in early 2006, respectively, created a unique opportunity to examine patients with pre-existing differences for brand-name and generic drugs, impact therapeutic substitution and medication adherence with statins. METHODS: Using the 2006 5% Medicare files we identified continuous fee-for-service Part D covered patients with hyperlipidemia (ICD-9-CM 272.0-272.4) using the brand-name (30-day supply/patient) or generic (30-day gap) of statins was also examined. Difference-in-difference regressions were used to examine impact on use of brand-name statins, generic statins, and overall adherence to statins, overall, and overall use of statins in the 30 day supply and 30 day gap of statins was also examined. RESULTS: Compared to Lis patients, non-Lis patients had a larger decline in brand-name statin use (-0.24 30-day-supply/month, p<0.001). Correspondingly, a decrease in adherence on any statin was observed in non-Lis patients relative to Lis patients. CONCLUSIONS: A substantial brand/generic cost-sharing differential was associated with therapeutic substitution of brand-name statins with generic statins; however, it also resulted in declines in adherence and increases in discontinuation of statins.

PCV107 DIRECT MEDICAL COST COMPARISON BETWEEN PATIENTS RECEIVING CANGRELOR AND CLIDOGREG DURING INTERVENTION: CHAMPION PHOENIX ECONOMIC SUB-STUDY RESULTS
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OBJECTIVES: To estimate annual hospitalization rate and associated direct costs for Medicare patients with heart failure (HF). METHODS: A national sample of Medicare beneficiaries was used to identify individuals with first observed primary inpatient claim for HF (ICD-9: 428.xx) between 07/01/2005 and 12/31/2011. Patients hospitalized ≥2 times in the 6 months prior to their first observed inpatient claim were excluded. Patient demographics, use of HF medications and medical devices were reported. Annual hospitalization rate and associated total costs (the Centers for Medicare and Medicaid Services payment, as well as patient out-of-pocket costs) were calculated. RESULTS: A total of 63,678 patients met the study criteria. Mean age was 82 years and 61% of patients were women. Among patients with part D coverage (n=35,788), 64.6% of patients used ß blockers. On average, patients were hospitalized 2.19 times for HF-related hospitalization and 1.30 times for CV-related hospitalization. The costs associated with first observed all-cause hospitalization were $15,270 and for CV-related hospitalization were approximately $16,000. CONCLUSIONS: Patients with HF who have been hospitalized had frequent subse-quent hospitalizations. Ongoing hospitalizations, especially for HF-related hospitalizations per year, one of them being due to worsening of HF. These hospitalizations were costly, with costs ranging from $14,000 to $17,300 per episode.

PCV110 BASELINE DEMOGRAPHICS AND CLINICAL CHARACTERISTICS ASSOCIATED WITH HEALTHCARE COSTS AMONG PATIENTS WITH Atherosclerotic Cardiometabolic disease (ASCVD).
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OBJECTIVES: To identify baseline demographics and clinical characteristics associated with healthcare costs among patients with atherosclerotic cardiometabolic disease (ASCVD). METHODS: This retrospective cohort study identified newly diagnosed ASCVD patients aged ≥18 years using claims data from the HealthCore Integrated Research Database (HIRD) between 1/1/2007 and 12/31/2010 (index date). Claims with ASCVD diagnosis had been ≥12 months pre- and post-index insurance enrollment, valid baseline lipid panel values, and no baseline lipid lowering medication use. Costs were adjusted to 2013 U.S. dollar values. Bivariate analysis was used to identify baseline factors which were associated with health care costs. RESULTS: In the regression model for all-cause and ASCVD-related costs, being of older age, plan region including South and West (vs. Midwest), higher Quan-Charlson Comorbidity Index, index acute coronary syndrome (ACS), ischemic stroke or transient ischemic attack, baseline depression, pain, obesity, and chronic kidney disease, baseline use of antihypergent agents, antihypertensive medications, and digoxin, and higher baseline triglycerides were positively associated with follow-up all-cause healthcare costs (p<0.05). In addi- tion, female, Northeast plan (vs. Midwest), Health Maintenance Organization (vs. Preferred Provider Organization), Medicare Advantage plans, index coronary heart disease (except for ACS) or peripheral artery disease, baseline dyslipidemia, and baseline goal attainment of low-density lipoprotein cholesterol (<100 mg/dL), high-density lipoprotein cholesterol (≥40/50 mg/dL for males and females respectively), triglycerides (<150 mg/dL), and total cholesterol level (<200 mg/dL) were negatively associated with follow-up all-cause healthcare costs (p<0.05). Similar findings were reported for ASCVD-related healthcare costs (N=26,376). CONCLUSIONS: As expected, age, gender, baseline comorbid conditions, baseline use of specific medications, baseline lipid profiles, and more severe index ASCVD were significantly associated with all-cause and ASCVD-related healthcare costs. Geographic location and health insurance type also played a significant role in healthcare costs among ASCVD patients.

PCV112 ANNUAL HOSPITALIZATION FREQUENCY FOR PATIENTS WITH HEART FAILURE: A COMPARISON BETWEEN COMMERCIAL AND MEDICARE ADVANTAGE POPULATION
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OBJECTIVES: To estimate the cumulative annual hospitalization rate for patients with heart failure (HF). METHODS: A retrospective analysis was undertaken using a large claims database. For the CHAMPION PHOENIX trial, the MICE imputation method was used to calculate a cumulative rate of hospitalization to account for varying lengths of follow-up. Patients ≥18 years, with a first observed inpatient heart failure claim (ICD-9: 428.xx) in primary position between 01/01/08 and 06/30/13 were included. Patients having an inpatient claim for HF in the 2 months prior to the first
obtained the following categories of insurance, specifically, commercial and Medicare advantage. **RESULTS:** A total of 85,938 patients met the study criteria of which 68.3% (n = 72,702) had Medicare advantage coverage and 31.7% (n = 13,236) had commercial insurance. The mean age was 63 years for patients with commercial insurance and 77 for those with Medicare advantage. For the total population (commercial + Medicare advantage), the cumulative hospitalization rate, inclusive of the first hospitalization, was 1.07 per patient-year for HF-related hospitalized patients, 1.16 for CV-related hospitalized patients (inclusive of HF) and 1.76 for all-cause hospitalizations. Cumulative hospitalization rates for patients with commercial insurance were 0.93, 1.00 and 1.52 for HF-related, CV, and all-cause hospitalizations, respectively. For patients with Medicare advantage coverage, the cumulative hospitalization rates were 1.14, 1.24 and 1.88 for HF-related, CV, and all-cause hospitalizations, respectively. **CONCLUSIONS:** Patients with heart failure who have been hospitalized have frequent subsequent hospitalizations. On average, these individuals were hospitalized at least once a year for worsening heart failure, irrespective of their coverage.

**PCV113**

**ASSESSING THE HEALTH CARE RESOURCE UTILIZATION AND ECONOMIC BURDEN AMONG U.S. CARDIOVASCULAR DISEASE PATIENTS IN THE VETERANS HEALTH ADMINISTRATION POPULATION**

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**OBJECTIVES:** To assess health care resource utilization and costs among U.S. patients diagnosed with cardiovascular disease (CVD) using the Veterans Health Administration (VHA) inpatient and outpatient registry database. **METHODS:** Patients diagnosed with CVD or who underwent CVD-related procedures were identified (International Classification of Disease, 9th Revision, Clinical Modification [ICD-9-CM] diagnosis codes 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 419.9, 419.81, 419.82, 419.9, 419.83, 419.9, 419.84, 419.9, 419.85, and 419.9) using the VHA data set from 01/07/2008 through 30/07/2012. The initial diagnosis date was designated as the index date. Patients without a CVD diagnosis, who were of the same age, race and gender as study CVD patients, were identified for comparison. An index date was selected at random to minimize bias. Patients in both groups were required to be age ≥ 18 years with continuous medical and pharmacy benefits 1 year prior to and 1 year after the index date. One-to-one propensity score matching (PSM) was used to compare health care resource utilization and costs between the CVD and comparison groups during the follow-up period, adjusting for baseline demographic and clinical characteristics. **RESULTS:** After risk-adjusted analysis using the PSM, 536,125 patients in each group were matched. More CVD patients had inpatient admissions (14.40% vs. 1.43%, p < 0.0001) and emergency room (14.89% vs. 3.66%, p < 0.0001), outpatient office (60.90% vs. 47.19%, p < 0.0001), outpatient (61.35% vs. 47.96%, p < 0.0001) and pharmacy visits (64.43% vs. 54.89%, p < 0.0001) compared to those without CVD. CVD patients also incurred higher costs. Costs were significantly higher for CVD patients than for those without CVD ($8,248 vs. $1,638, p < 0.0001). **CONCLUSIONS:** CVD patients in the VHA population more frequently used medical care resources and incurred higher costs than those without CVD.

**PCV114**

**STUDY ON THE INPATIENT HOSPITAL COSTS OF HEMORRHAGIC STROKE PATIENTS IN CHINA**

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**OBJECTIVES:** By estimating the direct medical cost of hemorrhagic stroke inpatients with urban basic health insurance scheme/exclude new rural cooperative medical care system from 2010 to 2012 in China, we try to provide evidence for the government to manage the illness more effectively. **METHODS:** The inpatients with discharge diagnosis code identified with ICD-10 (I60, I61, I62) were extracted from the China Health Insurance Research Association claim database which includes a nationwide, cross-sectional sampling of inpatients from 2010 to 2012 in this paper. In the descriptive statistic analysis was used. **RESULTS:** The analysis included 6715 patients(male:63.49%), patients with older than 50 years accounted for 82.87%(n=5565). From 2010 to 2012, the average hospitalization expenses of each visits were 24656.025131 4 and 24959.08 yuan(the average hospitalization expenses in the whole country:84948,8852 and 9372 yuan).Third-level hospitals, second-level hospitals and under second-level hospitals accounted for 57.85%, 34.22% and 9.41%, respectively, total hospitalization expenses accounted for 71.55%, 22.69% and 5.85%, the average hospitalization expenses were 30303.49, 16446.19 and 18624.96 yuan.78.78% of inpatient hospital expenses were accounted for 57.85%,34.22% and 9.41%, respectively; total hospitalization expenses in large hospitals, middle hospitals and small hospitals were significantly higher for CVD patients than for those without CVD ($8,248 vs. $1,638, p < 0.0001), respectively. **CONCLUSIONS:** CVD patients in the VHA population more frequently used medical care resources and incurred higher costs than those without CVD.

**PCV115**

**EVIDENCE REQUIREMENTS FOR FUTURE ANTIARRHYTHMIC TREATMENTS FOR ATRIAL FIBRILLATION (AF)**

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**OBJECTIVE:** To understand why dronedarone failed to unseat amiodarone as the first-line therapy choice for prevention of AF, this paper reviewing the clinical outcome requirements for a future AF therapy to achieve optimal market access. **METHODS:** Review published HTA reports and clinical trial outcomes for dronedarone to assess market access outcomes and associated payer rationale for decision making and managed care. We also followed key opinion leaders (KOLs) in US and thirteen (13) ex-Payers and AF KOLs in Europe (mix of stakeholders encompassing France, Germany, Italy, Spain, and UK) for validation and gap filling. **RESULTS:** Dronedarone has significantly lower efficacy than amiodarone, and fewer than 1 deaths as part of the clinical evidence package. Lower rates of bradycardia, liver toxicity, and no proarrhythmia will drive a favorable regulatory safety evaluation compared to amiodarone. **CONCLUSIONS:** The sub-optimal bioavailability and relatively low utilization of dronedarone resulted primarily from a failure to demonstrate an improvement in recurrence as compared to amiodarone, as well as a significant number of deaths during pivotal trials. Manufacturers considering development of novel antiarrhythmics should strive for equivalent efficacy but superior safety to amiodarone if a 40% reduction in recurrence is not clinically feasible.