regression analyses were performed to identify the contributing factors to absenteeism. **RESULTS:** A sample of 503 patients agreed to participate, of which 488 were evaluable. 364 patients (74.6%) were in employment, 31 (6.4%) were unemployed and 93 (19.1%) were out of the labor market. Among the 364 patients currently in employment, 102 (28.0%), 138 (37.9%) and 124 (34.1%) were in ACR functional class of I, II and III, respectively. **Conclusion:** Regression analyses suggested that ACR functional class and frequencies and duration of flares were the major factors contributing to absenteeism, far ahead of any other socio-economic characteristics. **Conclusions:** Loss of productivity due to RA could be further reduced through better control of disease activity.

MUSCULAR-SKELETAL DISORDERS – Health Care Use & Policy Studies

**PMS90**  A REVIEW OF COST-EFFECTIVENESS EVALUATIONS AS PART OF NATIONAL HTA ASSESSMENTS OF BIOLOGICAL DMARDS IN THE TREATMENT OF RHEUMATOID ARTHRITIS

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**Objectives:** Rheumatoid arthritis is an autoimmune chronic disease which is associated with an increasing disability of patients and high socioeconomic burden. Given the large number of economic evaluations considered by national HTAs, this manuscript attempts to identify whether biologic DMARDS cost-effectiveness and -utility results form the basis for official recommendation by national HTA agencies. **Methods:** Both older biologic anti-TNFα drugs (etanercept, infliximab and adalimumab) and newer biologic DMARDs (abatacept, rituximab and tocilizumab) were considered. All main HTA agencies were searched for published economic evaluations up to 2012. Documents were selected if they included cost-effectiveness or cost-utility as outcome, if they referred to at least one of the above anti-TNFα drugs, if they were published in English and not superseded by other analysis. PICO statements were used to define exclusion criteria. **Results:** Of the 65 documents initially identified through the search strategy, 20 documents were selected. The associated HTA agencies were PBAC (Australia), CADTH (Canada), SMC (Scotland) and NICE (England). In relation to older anti-TNFα drugs, documents published by NICE were found to be the only explicitly recommending the drugs on the basis of obtained cost-utility results. Economic evaluations of novel biologic DMARDs were commonly selected by SMC and NICE. **Conclusions:** No cost-utility analysis or excerpt could not be identified abstact to and list all other drugs conditional on price facilitation and following failure of rituximab. By contrast, cost-utility analysis published by PBAC and CADTH did not appear to influence official recommendations on novel biologic DMARDs. **Conclusions:** Cost-effectiveness and cost-utility evidence was not equally perceived by decision makers and did not have equal weight in defining the official listing of biologic DMARDs for the treatment of RA. Further research should be done to develop better methods for a robust economic analysis and final decisions taken by National HTA agencies.

**PMS91**  COST-EFFECTIVENESS ANALYSIS OF ALENDRONATE THERAPY FOR SECONDARY PREVENTION OF OSTEOPOROTIC FRACTURES

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**Objectives:** Although osteoporotic fractures impose a heavy financial burden on healthcare systems, there are a paucity of data on the cost-effectiveness of antiresorptive therapy for osteoporosis. The purpose of this study was to estimate the cost-effectiveness of alendronate therapy for secondary prevention of osteoporotic fractures in Japan. **Methods:** A patient-level simulation model with nine health states was developed to predict lifetime costs and quality-adjusted life years (QALYs) of five years of alendronate therapy versus no preventive treatment for Japanese women with osteoporosis, who have a history of hip fracture. Fracture risk associated with age and bone mineral density (BMD) was derived from epidemiologic studies in Japan. We ran the model with different combinations of age (50, 60, and 70), BMD (T-score 1.0, 1.5, and 2.0) and BMD-independent fracture risk factors. **Results:** For patients with T-score of -2.0 having no additional risk factors, the incremental cost-effectiveness ratio (ICER) of alendronate was $3,023 and $7,389 per QALY gained for those aged 60 and 70 years, respectively. In all other situations, alendronate was dominant over no preventive treatment, with lifetime cost savings ranging from $30,849 to $1,498,961. These results were fairly robust to variations in model parameters. **Conclusions:** Alendronate therapy for secondary fracture prevention in Japanese women with osteoporosis provided good value for money.

**PMS92**  COMPARISON OF CLINICAL CHARACTERISTICS OF PATIENTS WITH RHEUMATOID ARTHRITIS RECEIVING THEIR FIRST BIOLOGIC AND BIOLOGIC-NAÏVE PATIENTS CONSIDERED BIOLOGIC-SUITABLE IN THE UNITED STATES

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**Objectives:** To assess clinical characteristics of RA patients considered suitable for biologic therapy (by their physicians) in comparison to those currently treated with 1 line biologics in the US. **Methods:** A chart review of study of RA patients was conducted among physicians (primarily rheumatologists) in hospitals/private practices to collect de-identified data on patients who were recently treated with a biologic as part of usual care. Physicians were screened for practice-duration and patient-volume and recruited from a large panel to be geographically representative in each country. Eligible PsA patient charts (5EU:606, US:184); 674 (85%) (5EU:527, US:147) patients were on their first biologic (mean age: 5EU:47.4yrs, US:47.6yrs, female: 5EU:48.6%, US:49.4%). Time-to-first biologic from diagnosis (5EU:41 months, US:27months) and current biologic duration (5EU:16 months, US:36.7 months) differed between regions. Top-2 biologic treatments observed were adalimumab (5EU:47.4%, US:32.1%) and etanercept (36%, US:32%). Among the top-4 reasons for biologic treatment initiation were ‘improve joint function’ and ‘patient experience’ and ‘prevention of structural damage’ were observed in both the 5EU and US. **Key measures documented were: ESR (5EU:20.6mm/h, US:23.7mm/h), CRP (5EU:9.4mg/dl, US:2.8mg/dl), current disease severity per physician-judgment and US. Key lab measures documented were: ESR (5EU:20.6mm/h, US:23.7mm/h), CRP (5EU:9.4mg/dl, US:2.8mg/dl).** **Results:** Patients in 5EU and US. Key lab measures documented were: ESR (5EU:20.6mm/h, US:23.7mm/h), CRP (5EU:9.4mg/dl, US:2.8mg/dl). Among patients with data available, current data, HTA (5EU:1.3, US:0.6), VAS provider score (5EU:3.1, US:2.6), VAS patient score (5EU:3.4, US:2.7) and Swollen Joint Count (5EU:2.5, US:2.0) differed significantly between countries. Among PsA patients receiving their first biologic, disease severity and outcomes differed between 5EU and US, with patients in 5EU with lab measures, results differed between those in remission vs. those who were not: mean ESR(mm/h): 17.0vs.32.1, mean CRP(mg/dl): 7.0vs.15.6, mean MMP3(ng/ml): 2.8vs.4.7. Rheumatoid Factor (positive): 93%, 86% and Anti-CCP (% positive): 75%-vs-79%. Among those with data, recent (mean) disease severity scores were geographically representative in each country. Eligible PsA patient charts (5EU:606, US:184); 674 (85%) (5EU:527, US:147) patients were on their first biologic and RA/PsA naïve but suitable patients (per physician judgment) had relatively higher disease burden. Reasons for non-initiation of biologic treatment among biologic-suitable patients warrant further investigation to alleviate disease burden.

**PMS93**  COMPARISON OF DISEASE STATUS, TREATMENTS AND OUTCOMES OF PATIENTS WITH PSORIASIS ARTHRITIS RECEIVING THEIR FIRST BIOLOGIC IN THE EUROPEAN UNION AND THE UNITED STATES

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**Objectives:** To compare the disease status and outcomes of patients with PsA receiving their first biologic in UK, Germany, France, Italy and Spain (5EU) and the US. **Methods:** A multi-country multi-center medical chart-review study of PsA patients was conducted among physicians (majority: rheumatologists) in hospitals/private practices to collect de-identified data on patients who were recently treated with a biologic as part of usual care. Physicians were screened for practice-duration and patient-volume and recruited from a large panel to be geographically representative in each country. Eligible PsA patient charts (3,503 across regions. **Conclusions:** Compared to the patients currently treated with 1 line biologic, RA/biologic naïve but suitable patients (per physician judgment) had relatively higher disease burden. Reasons for non-initiation of biologic treatment among biologic-suitable patients warrant further investigation to alleviate disease burden.