2004–October 2005) were obtained, and a dose interchange table identifying the statin switches providing an LDL-C lowering effect within 10% of the entry drug was developed. The study assumed all patients requiring a higher level of LDL reduction would switch from other equivalent statin doses to simvastatin 20 mg daily. Two different assumptions with four cost scenarios for future generic simvastatin prices were tested: 20% rebate for branded statins, a 50% discount rate, and $5 generic and $15 brand co-payments (assumption 1) and 20% rebate for branded statins, a 60% discount rate, and $10 generic and $30 brand co-payments (assumption 2). RESULTS: With the baseline assumptions in the study, total costs to TPPs for branded statins were $5.57B (assumption 1) and $4.62B (assumption 2). Switching patients to generic simvastatin lowered total costs to $4.34B and $3.25B, respectively, providing potential cost savings for TPPs of $1.03B to $1.37B. One-way sensitivity analyses varying the purchasing discount rate for generic simvastatin from 40%–75% in assumption 1, found the range of cost savings to be $0.06B–$3.46B; varying the discount rate from 50%–75% in assumption 2 found a range of cost savings of $0.4B–$2.83B. CONCLUSION: The switch to generic simvastatin 20 mg for patients requiring cholesterol reduction yielded potential annual cost savings for TPPs over one year. Other long-term studies focusing on the economic impacts on TPPs are encouraged to evaluate potential cost savings following the availability of other generic statin drugs.

PCV69
RETROSPECTIVE STUDY OF CLOPIDOGREL USE AMONG PATIENTS WITH ACUTE CORONARY SYNDROME (ACS) UNDERGOING CORONARY ARTERY BYPASS GRAFT
Hauch Q1, Doyle J1, Stern L1, Berenson K1, Hendlish S2
1AstraZeneca, Wilmington, DE, USA, 2Analytica International, New York, NY, USA
OBJECTIVES: To compare claims data on bleeding complications in ACS patients treated with clopidogrel vs. aspirin/heparin undergoing catheterization prior to coronary artery bypass grafting (CABG). METHODS: Patients >18 years of age with an ACS diagnosis between 2000 and 2004 were identified using ICD-9 codes. Treatment patterns and outcomes were compared across two cohorts: patients on clopidogrel +/- aspirin, heparin, or IIb/IIIa antagonists, and those on aspirin or heparin only. Claims for CABG and catheterization prior to CABG were evaluated. Among CABG patients who received clopidogrel, distribution of days clopidogrel was discontinued pre-surgery was examined. Claims related to bleeding complications among patients with catheterization prior to CABG were evaluated using logistic regression controlling for age, race, time to CABG, IIb/IIIa exposure, and hospital size. RESULTS: We identified 25,289 clopidogrel patients and 21,688 aspirin/heparin patients. The clopidogrel cohort was significantly younger (65.6 versus 69.7, p < 0.0001) with a higher proportion of male patients (62.8% versus 54.7%, p < 0.0001). A total of 2535 clopidogrel patients (10%) and 4358 aspirin/heparin patients (20.1%) underwent CABG; of those, 1633 clopidogrel (64.4%) and 2053 aspirin/heparin (47.1%) patients underwent catheterization prior to surgery during the index admission. Among these clopidogrel patients, 1791 (70.6%) discontinued clopidogrel prior to CABG; a majority discontinued either the day of (41%) or the day before (20.5%) surgery. Among patients undergoing catheterization prior to CABG, claims related to bleeding complications were significantly more likely in the clopidogrel cohort compared to the aspirin/heparin cohort after adjusting for covariates (OR 1.84, 95%CI 1.08–3.13). CONCLUSION: A majority of ACS patients treated with clopidogrel and undergoing catheterization and CABG discontinue clopidogrel closer to CABG than the recommended five days pre-surgery (US Package Insert). Additionally, such patients may be at higher risk for bleeding than patients treated with aspirin/heparin only.