with pharmacist-managed ESA clinics (n = 314) and at six sites with usual care only (n = 167), outpatient were followed for 6 months in 2009. We took a VA perspective with projections over a five-year time horizon; costs and effectiveness values were discounted at 3%/yr. Strategy-specific likelihoods of target range hemoglobin values (10-12 g/dL) were based on study results. Utilities for ND-CKD and ESA-related adverse events and their likelihoods were obtained from the literature. ESA costs were based on an assumed monthly epoetin and darbepoetin doses per patient during the study and VA ESA cost data. RESULTS: In the base case analysis, cost and effectiveness were $12,500 and 2.096 quality-adjusted life-years (QALYs) in the pharmacists-managed ESA clinics and $15,500 and 2.093 QALYs in usual care, ESA clinics dominated ND-CKD. In one-way sensitivity analysis, ESA clinics no longer dominated ND-CKD if patients’ probability of being in the target range fell to 0.54 (base case 0.71) or if the mean cost/month of epoetin or darbepoetin in ESA clinics increased to approximately $360 (base case $211) or $460 (base case $250), respectively. When all parameters were varied in a probabilistic sensitivity analysis, ESA clinics were favored in 80% of the time regardless of willingness-to-pay threshold. CONCLUSIONS: Pharmacists-managed ESA clinics were less costly and more effective than usual care in patients receiving ESAs for anemia and ND-CKD. Results were robust to variation and support the use of pharmacist-managed ESA clinics.

PUK20

COST-UTILITY ASSESSMENT OF SIROLIMUS VERSUS TACROLIMUS FOR PRIMARY PREVENTION OF GRAFT REJECTION IN RENAL TRANSPLANT RECIPIENTS IN MEXICO
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OBJECTIVES: Immunosuppressive agents have affected the incidence of acute rejection and early graft survival. The purpose of this study was to evaluate the cost-utility of sirolimus versus tacrolimus for primary prevention of graft rejection in renal transplant recipients using the Mexican Institute of Social Security (IMSS) perspective.

METHODS: A Markov model was developed to estimate the cost-effectiveness of sirolimus versus tacrolimus to prevent graft rejection in adult patients with end-stage renal disease (ESRD). The model estimated total costs and QALYs per patient in each prophylaxis group. To extrapolate trial results to lifetime horizon, the model was extended through one-year Markov cycles. The probabilities of experiencing a graft loss, dialysis, and death were estimated from trial published data; long-term mortality, acquisition costs, and direct treatment costs were retrieved using IMSS published sources. Cost utility assessment was expressed in terms of incremental cost-utility ratios. Probabilistic sensitivity analyses were carried out to test the robustness of the results.

RESULTS: In comparison to tacrolimus, sirolimus improved life expectancy, number of QALYs gained, and reduced incidence of complications. The lifetime overall costs of pretransplant graft rejection in adult patients with ESRD resulted in $5846. Over the lifetime period, sirolimus was estimated to gain 8.18 QALYs per patient compared to 7.33 QALYs for tacrolimus. A cost per QALY gained of $5846. The base case analysis showed that the use of sirolimus was cost-effective compared to tacrolimus with a cost per QALY gained of $5846. The mean incremental cost of this strategy was estimated at $17,104 ($211) or $460 (base case $250), respectively. When all parameters were varied in a probabilistic sensitivity analysis, sirolimus was favored in 80% of the time regardless of willingness-to-pay threshold. CONCLUSIONS: This is true as well for Symptom/ problem list, Effects of kidney disease, and burden of Kidney Disease scores. For SF-12, all of physical and mental domains were not significantly different as well as all of disease specific scores were not significantly associated with hemodialysis times in weekly intervals (all, p < 0.05).

CONCLUSIONS: These findings implied that thrice-weekly could not reflect the better quality of life than twice-weekly hemodialysis. There was no significant difference in quality of life from the Symptom/ problem list, Effects of kidney disease, and burden of Kidney Disease between twice and thrice-weekly hemodialysis as well as the utility scores from SF-6D, EQ-5D and VAS. Further large cohort study of utility scores or cost effectiveness analysis between the difference of dialysis frequency at weekly intervals, however, should be conducted.

PUK23

UNDERSTANDING THE EFFECTS ON HR-QOL OF TREATMENT FOR OVERACTIVE BLADDER: A DETAILED ANALYSIS OF EQ-5D CLINICAL TRIAL DATA FOR MIRABEGRON
OBJECTIVES: Analysis of EQ-5D data often focuses on changes in utility, ignoring valuable information from other parts of the instrument. Our objective was to explore how the utility index, EQ-5D profile, and EQ-VAS captured change in clinical trials of Mirabegron, a new treatment for overactive bladder (OAB).

METHODS: Data were pooled from three phase III clinical trials that investigated the efficacy and safety of Mirabegron versus placebo. Tolterodine was used as a positive control. EQ-5D data were collected at baseline, week 4, 8, and 12. Analyses were performed on full protocol data sets and protocol data sets using UK utilities. Analysis controlled for relevant patient characteristics. Analysis of Covariance identified changes from baseline at each time point in utilities and EQ-VAS, while Areas Under the Curve (AUC) were estimated to summarise intertemporal differences in effect. RESULTS: In per protocol analyses, mirabegron 50mg was superior to tolterodine 4mg in changes from baseline utilities after 12 weeks (p < 0.05); similarly, A1C results showed mirabegron 50mg to be superior to tolterodine (p < 0.05) and to placebo (p < 0.05). In both cases, the benefit is already apparent at 4 weeks (p < 0.05). EQ-VAS more consistently indicated superior outcomes: all three mirabegron doses showed statistically significant greater effectiveness compared to tolterodine at 12 weeks. Individual EQ-5D dimensions and the overall profile showed no significant differences between study arms. CONCLUSIONS: Despite slight contrasts in results between the EQ-5D derived utilities and EQ-VAS, mirabegron showed quicker and superior improvement in HR-Qol compared to tolterodine 4mg ER. Research is required to address future utility measurements, especially in relation to EQ-5D dimensions in OAB patients.

PUK24

EXAMINING THE ROLE OF CAREGIVER TOWARDS BLOOD TRANSFUSION DECISIONS AMONG INDIVIDUALS WITH CHRONIC KIDNEY DISEASE
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OBJECTIVES: To compare the utility scores and quality of life scores between patients who have twice and three-weekly hemodialysis. METHODO: This was a cross-sectional analytical study in 5 hemodialysis sites of Nephrology Unit at Siriraj Hospital (the largest university hospital in Thailand). Face-to-face interview using EuroQol questionnaire (EQ-5D), VAS, and KDQOL-36 (consists of 3 kidney disease subscales and SF-12) was conducted between April 2011 and June 2011, one hundred and thirty-three hemodialysis patients were recruited from the chronic hemodialysis clinic unit. This study compared the difference of hemodialysis times in weekly to utility scores and quality of life scores of patients by using Independent Student's t-test. RESULTS: SF-6D (derived from SF12), EQ-5D (UK and Thai preference weight), and VAS between the patients who received twice and three-weekly hemodialysis were not significantly different (p > 0.05). This is true as well for Symptom/ problem list, Effects of kidney disease, and burden of Kidney Disease scores. For SF-12, all of physical and mental domains were not significantly different as well as all of disease specific scores were not significantly associated with hemodialysis times in weekly intervals (all, p < 0.05).

CONCLUSIONS: These findings implied that thrice-weekly could not reflect the better quality of life than twice-weekly hemodialysis. There was no significant difference in quality of life from the Symptom/ problem list, Effects of kidney disease, and burden of Kidney Disease between twice and thrice-weekly hemodialysis as well as the utility scores from SF-6D, EQ-5D and VAS. Further large cohort study of utility scores or cost effectiveness analysis between the difference of dialysis frequency at weekly intervals, however, should be conducted.
Providers should consider adopting shared-decision making with their patients about benefits, risks, and costs of blood transfusions. A significant number feel that primary sources of information about blood transfusions. Gaps in knowledge exist ining techniques and quality of blood, and risks of infections. Among previously costs. Over 60% said that it is extremely important to know right blood type, screen- sons for and benefits of getting a blood transfusion. Less than two-thirds received too much information. More than 80% of transfused indicated they knew the rea- (80.5%). Among those previously transfused, 62% received right amount of infor- transfusions. Top two sources of information were doctor (93.8%) and Internet /H11005 179) had received blood transfusion, whereas, 57% (n/150) stage 3 CKD. 54% (n/181) stage of kidney disease (CKD) may impair work ability, job performance and in- crease absenteeism. We sought to evaluate the association of post-transplant CKD with work ability and labor supply. METHODS: We contacted all patients at 2 Mid- western KTAs clinics. All consenting patients answered a questionnaire about socio- demographic characters, working conditions, quality of life and work ability (Work Ability Index, WA). A second survey about labor supply was sent after 6 months. We abstracted biochemistry results, treatments and comorbidities data from clin- ical records. We excluded patients with multiple or multi-organ transplant, and laboratory evidence of an acute cardiac ischemic episode in the month prior to assessment. At least one creatinine assessment in the 3 months screening period and age between 18-65 years was required for inclusion. We assessed differences in WA, Work Ability and Glances OA (for the employment to population ratio, we used the median per-session dose in the 30 days pre-hospitalization. The employment-to-population ratio was 63%. Mean WAI score was 38.8±5.9. CKD severity was associated with WAI (p<0.04, p<0.01). GFI was associated with WAI after adjusting for possible confounders (p<0.06, p<0.01). Ninety-three percent of patients responded to the follow up survey. Of those employed at baseline 20% lost their job and 25% of previously jobless had found one. Patients with severe CKD worked 4.69 weeks less than subject with mild or moderate CKD (p<0.03). GFI was associated with the labor supply (p<0.01) after the 6-months follow up after adjusting for possible confounders (p=0.07, p=0.03) CONCLUSIONS: Severe CKD was associated with a mild reduction in self-reported work ability and a strong reduction in labor supply after kidney transplant.