day), abacavir (500 mg without delayed release tablets), and dolutegravir (50mg every 2 weeks), etravirine (400mg every 2 weeks), enfuvirtide (1000mg every 2 weeks), indinavir (400mg every 2 weeks), or ritonavir (200mg every 2 weeks). Treatment data were collected for the first 6 months of treatment. The main comorbidities observed during the baseline period were chronic obstructive pulmonary disease (23.36%), systolic hypertension (20.01%), and diabetes (19.36%). The average age of the patients was 62.9 years, and the median age was 62.9 years. The patients were predominantly male (71.3%). The most commonly prescribed medications were atorvastatin (3.40%), simvastatin (3.40%), and propranolol (3.40%). The average total costs incurred by HIV patients were $22,013. The five most commonly prescribed medications prescribed to treat HIV were stavudine (3.40%), lamivudine (3.40%), didanosine (3.40%), zidovudine (3.40%), and nevirapine (3.40%).

OBJECTIVES: To determine the demographic distribution and health care burden of patients diagnosed with rheumatoid arthritis (RA) using Medicare fee-for-service (FFS) data. METHODS: A retrospective analysis was performed using the 100% Medicare FFS datasets from October 1, 2008 through December 31, 2012. Patients diagnosed with RA were identified using International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes of 714.xx (RA). All patients with a first diagnosis date were designated as the index date. All patients were required to have continuous medical and pharmacy benefits 1 year pre- (baseline period) and post-index date. Baseline and follow-up periods were calculated. RESULTS: Using Medicare FFS data, 112,550 RA patients were identified. The average age at diagnosis was 62.9 years, and 72.5% of patients were women. The most common baseline comorbidities were obesity (33.3%), diabetes (33.3%), and cardiovascular disease (33.3%). The average total costs incurred by RA patients were $37,219. The five most commonly prescribed medications prescribed to treat RA were prednisone (3.40%), ibuprofen (2.13%), omeprazole (2.13%), and furosemide (2.13%). Conclusions: RA patient demographic distributions and RA-related health care cost information was obtained and the most commonly prescribed medications to treat RA were identified.

CONCLUSIONS: The incremental cost of requiring a transfusion is significant, including decreasing over recent years, is still a burden in select patient populations and sickest patients (Charlson ≥ 3). The incremental cost of hospitalization, fracture diagnoses, and oncologic diagnosis were excluded. Logistic regressions – controlling for age, sex, region, hospital size, academic status, payor, procedure year, obesity diagnosis, and Charlson Score – were used to determine the risk of autologous and allogeneic blood transfusion. Generalized linear models (GLM) – controlling for the same factors – predicted the incremental total hospitalization cost associated with transfusion. RESULTS: $51,558 primary (mean age, 66, 37% male), $33,977 bilateral (mean age, 63, 45% male), and $32,489 (mean age 65, 41% male) were the costs for the transfusion. The overall percentage transfused was 14.1%, 36.3%, and 20.0%, respectively. Regressions indicated the following factors were significantly associated with higher transfusion risk: age > 65, females, residing in the Northeast, large hospitals, and higher Charlson Score. Though risk of transfusion decreased over the study period, the highest comorbidity (Charlson ≥ 3) patients were at 2.27 (primary), 1.88 (bilateral), and 2.44 (revised) greater odds of transfusion vs healthy controls. Unadjusted total hospitalization costs were $17,867, $24,960, and $67,972 for each procedure, respectively. The results showed an incremental total hospitalization cost among those with transfusion vs. without of $2,840, $4,985, and $9,267, respectively. CONCLUSIONS: Transfusion risk, while decreasing over recent years, is still a burden in select patient populations. The incremental cost of requiring a transfusion is significant, including not only direct costs of blood administration but staff time and increased hospital resource use. Strategies to decrease transfusion risk among select patient populations were warranted.

PM35

OBJECTIVES: To determine the demographic distribution and health care burden of patients diagnosed with rheumatoid arthritis (RA) using Medicare fee-for-service (FFS) data. METHODS: A retrospective analysis was performed using the 100% Medicare FFS datasets from October 1, 2008 through December 31, 2012. Patients diagnosed with RA were identified using International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes of 714.xx (RA). All patients with a first diagnosis date were designated as the index date. All patients were required to have continuous medical and pharmacy benefits 1 year pre- (baseline period) and post-index date. Baseline and follow-up periods were calculated. RESULTS: Using Medicare FFS data, 112,550 RA patients were identified. The average age at diagnosis was 62.9 years, and 72.5% of patients were women. The most common baseline comorbidities were obesity (33.3%), diabetes (33.3%), and cardiovascular disease (33.3%). The average total costs incurred by RA patients were $37,219. The five most commonly prescribed medications prescribed to treat RA were prednisone (3.40%), ibuprofen (2.13%), omeprazole (2.13%), and furosemide (2.13%). Conclusions: RA patient demographic distributions and RA-related health care cost information was obtained and the most commonly prescribed medications to treat RA were identified.

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PM34

OBJECTIVES: To determine the demographic distribution and health care burden of patients diagnosed with rheumatoid arthritis (RA) using Medicare fee-for-service (FFS) data. METHODS: A retrospective analysis was performed using the 100% Medicare FFS datasets from October 1, 2008 through December 31, 2012. Patients diagnosed with RA were identified using International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes of 714.xx (RA). All patients with a first diagnosis date were designated as the index date. All patients were required to have continuous medical and pharmacy benefits 1 year pre- (baseline period) and post-index date. Baseline and follow-up periods were calculated. RESULTS: Using Medicare FFS data, 112,550 RA patients were identified. The average age at diagnosis was 62.9 years, and 72.5% of patients were women. The most common baseline comorbidities were obesity (33.3%), diabetes (33.3%), and cardiovascular disease (33.3%). The average total costs incurred by RA patients were $37,219. The five most commonly prescribed medications prescribed to treat RA were prednisone (3.40%), ibuprofen (2.13%), omeprazole (2.13%), and furosemide (2.13%). Conclusions: RA patient demographic distributions and RA-related health care cost information was obtained and the most commonly prescribed medications to treat RA were identified.
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OBJECTIVES: Guidelines for primary management of LBP in primary care recommend an initial period of watchful waiting before referral to a specialist, although some evidence suggests early PT may reduce future health care costs for LBP. This study compared LBP-related costs over a 1-year period in patients with acute LBP randomly assigned to usual care versus early PT. METHODS: Adults (age 18-60) visiting primary care with acute, non-specific LBP were recruited. All participants received advice and education about LBP and were randomized to 4 PT sessions or watchful waiting for 4 weeks. Clinical outcomes and LBP-related costs were collected monthly for 1 year after randomization. Notably, costs were based on preoperative hemoglobin levels, but do not differentiate between total hip arthroplasty (THA) and total knee arthroplasty (TKA). This literature review aims at analyzing the cost-effectiveness of preoperative erythropoietin as blood sparing therapy. Its safety and efficacy has been shown in various randomized clinical trials. Questions regarding the cost-effectiveness of this treatment, however, have yet to be answered. Notably, currently, costs are based on preoperative hemoglobin levels, but do not differentiate between total hip arthroplasty (THA) and total knee arthroplasty (TKA). METHODS: Systematic literature review. RESULTS: A MEDLINE database search and subsequent exclusion of irrelevant or inapplicable papers resulted in the inclusion of 8 research articles that at least partially performed a cost-effectiveness or cost-benefit analysis of 1 point of blood reduction in orthopaedic surgery. Four of the studies concluded erythropoietin is not cost-effective, three studies were not able to draw a conclusion based on their data, and one study found erythropoietin cost-effective. CONCLUSIONS: We found that studies were difficult to compare, with inclusion criteria and comparators varying among studies. Notably, most economic evaluations were substantially lacking depth and did not comply with common guidelines for pharmacoeconomic research. Among some articles, erythropoietin generally not cost-effective, their data suggest otherwise within certain patient subgroups. Patients with lower preoperative hemoglobin levels, primary surgery and THA benefitted the most from erythropoietin. Additionally, most studies seemed to overestimate treatment costs, using outdated prices or neglecting cost-variant factors, such as blood transfusions. Therefore, a more differentiated approach is required to elucidate the cost-effectiveness of erythropoietin in orthopedic surgery, discriminating between total hip and knee arthroplasty.

PMS45
RESULTS OF THE INCLUSION OF NEW MEDICATIONS IN THE OBLIGATORY HEALTh SYSTEM PLAN IN COLOMBIA, 2012-2013
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OBJECTIVES: The Colombian Health Care System has had a plan with limited benefits since 2012, 57 drugs have been added to this plan. This research describes the trends of utilization and costs of medications covered by the Agreement 029/2011 and compare them with those that were contained in the benefits plan. METHODS: A descriptive study involving a group of 3.8 million people affiliated with the Colombian Health Care System, in 110 cities from July 2011 until June 2013. The variables were: new medications that were included, comparing them with those that were contained in the benefits plan and those that were not. There are no differences between the study and the control group (9,182/patient), which was mainly attributed to differences in the cost of adjusted room and board ($1,449 vs $1,721, p < 0.05).

PMS46
THE ECONOMIC VALUE OF TOFACITINIB 5 MG BD IN THE TREATMENT OF MODERATE TO SEVERE RHEUMATOID ARTHRITIS: A CANADIAN ANALYSIS
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1Pfizer Canada Inc, Kirkland, QC, Canada, 2PATHY Research Institute, St. Joseph’s Health Care Hamilton/McMaster University, Hamilton, ON, Canada, 3York Health Economics Consortium, University of York, York, UK, 4Pfizer Inc, Groton, CT, USA, 5McMaster University, Hamilton, ON, Canada, 6Pfizer Inc, Collegeville, PA, USA

OBJECTIVES: To estimate incremental cost per quality-adjusted life year (QALY) gained for tofacitinib (PMS44) in the treatment of moderate to severe rheumatoid arthritis (RA), economic evaluations of medications provide critical information for assessing cost-effectiveness. The objective of this study was to estimate incremental cost per quality-adjusted life year (QALY) gained for tofacitinib (PMS44) in the treatment of moderate to severe RA inadequate response to methotrexate, compared to available/recommended treatment strategies as of 2014 using the Canadian 3rd-party-payer perspective and lifetime time horizon. METHODS: The cost utility model is an individual-based model of patient simulation using the Markov-like model. The model compares treatment strategies reflecting 2012 Canadian Rheumatology Association recommendations for the pharmacological management of RA. Tofacitinib was included in the treatment algorithm similar to the anti-TNFs. Efficacy was measured using the continuous variable of Health Assessment Questionnaire Disability Index (HAQ-DI)