drugs (70.75%). The most commonly prescribed anti-rheumatic drugs were NSAIDs and Analgesics (75.60%), DMARDs (20.40%) and Corticosteroids (4.00%). Multiple logistic regression analysis showed that females (OR: 0.55, 95% CI: 0.32-0.95), individuals aged 18 to 64 years (OR: 0.48, 95% CI: 0.29-0.78) were less likely to receive anti-rheumatic drugs, whereas those seeking care from rheumatologists (OR: 4.18) and those with a previous visit in the previous year (OR: 1.26-1.62) were more likely to receive anti-rheumatic drugs. CONCLUSIONS: Most (7 out of 10) visits for the RA involved use of anti-rheumatic drugs. Drug use patterns varied across age, gender, physician specialty, and previous use of health care. Further research is needed to evaluate the variation across drug classes for RA.

PMS77
RELATIONSHIP BETWEEN THE DURATION OF RHEUMATOLOGY PRACTICE EXPERIENCE AND LIKELIHOOD OF USE AND PERCEPTIONS TO BIOMIMETICS IN RHUMATOID ARTHRITIS (RA) ARENA Narayan S. Ipsos Healthcare, Columbia, MD, USA
OBJECTIVES: To assess the relationship between duration of rheumatology practice experience and likelihood of use and perceptions to biomimetics among physicians (mainly rheumatologists) in hospitals and private practices to collect de-identified data on patients who were recently treated with a biologic as part of their routine care. Further research is needed to evaluate the variation across drug classes for RA.

PMS78
OBJECTIVES: To assess the clinical characteristics of patients with RA who received a biologic monotherapy (Mono) and biologic combination therapy (Combo: Biologic-DMARDes) in the US. METHODS: A multi-country multi-center medical chart-review study of RA patients was conducted between Nov 2012-Jan 2013 among physicians (mainly rheumatologists) in hospitals and private practices to collect de-identified data on patients who were recently treated with a biologic as part of their routine care. Physicians were screened for duration of practice (3-30 years) and patient volume (incl. >2RA biologic patients/week) and recruited from a large panel to be geographically representative of the US. Eligible patient charts (=5) were randomly selected from a sample of prospective patients visiting each center/practice during the screening period. Physicians abstracted patient diagnosis, treatment patterns/dynamics and patient symptomatology/disease status. This analysis focused on patients currently on Mono and Combo biologics. RESULTS: 919 eligible patients were included in the analysis, Mono patients: 353 (38%), Combo patients: 566 (62%). Patient characteristics included (Mono/Combo): mean age 47/45.78, female:50%/41%, mean weight(Kg): 75.77/80, top-3 comorbidities: obesity (17%/20%), dyslipidemia (14%/22%), depression/anxiety (9%/16%). Time between RA diagnosis and recent office visit (Mono/Combo): 77/178 months; number of biologic-lines of therapy received (Mono/Combo): 1st-line 80%/70%, 2nd-line 15%/20%, >3rd-line 15%/30%. Methotrexate was used across the two patient groups: adalimumab/etanercept/infliximab/abatacept. Among patients with data-availability, current lab & disease-severity measures were (Mono/Combo): ESR(mm/h)-23.7/25.0, CRFMg/ (mg/dl)-2.0/2.5, Hgb (g/dl)-11.7/12.3, Ht%), the mean vascularity index (VO2) was (Mono/Combo):0.41/0.45, mean ECOG overall disease stage on physician judgement: mild-67%/62%, moderate-29%/23%, severe 4%/5%, mean-HAQ 0.7/0.9, mean-DAS28 2.3/3.0, mean tender joint count: 2.3/3.4, mean swollen joint count:1.4/2.5. CONCLUSIONS: In this cohort of RA patients, 38% were Mono, 62% were Combo. 44% of Mono and 45% of Combo patients had disease per physician judgment and a majority of them were on 1st line treatment; lab measures and joint counts indicated only slightly higher disease burden among Combo patients. Impact of specific biologic treatments on observed patterns and the need for therapeutic sequencing may warrant scrutiny.

PMS79
WE HAVE FACTORS ARE ASSOCIATED WITH INCREASING CHARGES FOR MAJOR JOIN REPLACEMENTS BETWEEN 2008 AND 2017 Chiue GR, Dong X, Wang Z, Mckeeley LM, Miyasato G Truist Furners, LLC, Waltham, MA, USA
OBJECTIVES: To evaluate health care costs and medication use patterns (persistence, discontinuation and switching) in patients with rheumatoid arthritis (RA) on etanercept (ETN), infliximab (IFX) or adalimumab (ADA) in Texas Medicaid. METHODS: Prescription and medical claims data for Texas Medicaid beneficiaries (18-63 years) with RA (ICD-9: 714.0x) for 2008-2011 were obtained from Medicaid Administrative Services Database of Texas Medicaid and Medicare Services (TMMS) for the 6-months pre-index (July 1, 2003 to December 31, 2010) were analyzed over an 18-month study period between July 1, 2003 and August 31, 2011 (6-month pre- and 12-month post-index) based on their index biologic (ADA, ETN, or IFX) use. The primary outcomes were 1-year persistence, discontinuation, switching and health care costs (RA-related and TNF inhibitor costs) to Texas Medicaid post-index, adjusted to 2011 US dollars using the medical consumer price index. Cohorts were constructed using propensity score (PS) matching for baseline differences in demographics and clinical characteristics. RESULTS: After PS matching, 822 patients (n=274/biologic group) comprised the final sample. The mean age (±SD) was 51.9±8.3 years, and 62% were female (53.7%) and female (88.0%). Post-index mean (±SD) total health care costs were $16,477 (±$9,228), RA-related costs were $13,713 (±$8,309) and TNF inhibitor costs were $2,764 (±$1,920). Each cost variable (total health care, RA-related and TNF inhibitor costs), costs incurred by patients on ETN were significantly lower (p<0.01) than those incurred by ADA patients but significantly higher (p<0.01) than those incurred by IFX patients. Persistence to index TNF inhibitor therapy and likelihood to switch or discontinue were comparable among groups. Duration of medication use (i.e. persistence) prior to switching or discontinuation of index therapy was also comparable among groups. CONCLUSIONS: The data suggest comparable medication use patterns but significantly different health care utilization costs among Texas Medicaid RA patients on ETN, IFX or ADA.

PMS80
UTILIZING NORDIC REGISTRIES TO SUPPORT HEALTH ECONOMICS RESEARCH IN RHEUMATIC DISEASES Miller H Karolinska Institutet, Stockholm, Sweden
OBJECTIVES: Rheumatic diseases are often characterized by pain and disability. Many pharmaceuticals are available for their treatment and a considerable number of health economic studies have been published. Nordic countries maintain long-term comprehensive disease and drug registries. HE analyses, particularly those which are based on registry data, can provide important information for health care decision makers. The primary objective of this study is to systematically review the uses of these registries and patients’ claims databases, and to provide a descriptive and critical analysis of this strategy. METHODS: Published literature was identified by searching the following databases: MEDLINE, EMBASE, Scopus, PsycINFO, Cochrane Library and Health Economic Evaluations Database; and PubMed. Search strategies were developed with input from the co-authors. This search strategy is available online. RESULTS: A total of 22 articles were included in the review. Of these, 21 were from Nordic countries (20 from Sweden and 1 from Denmark). The included studies were divided into 4 categories: disease registries, HE registries, patient registries and a combination of registries. Outcome measures of interest were primary clinical outcomes or health economic measurements. The primary conclusion of the review was that the use of registry data allowed for novel studies on rheumatic diseases and HE. One reviewer screened and subsequently extracted data from studies which fulfilled inclusion/exclusion criteria. References and citation search was done on included studies. STUDY TYPES: Studies were categorized into 5 types: registry, observational, economic model, registry plus model or registry plus observational. CONCLUSIONS: Further studies on registries in rheumatic diseases research are needed.