increased COT, with an MRSA SSTI incurring at least 2–3 more days for LOS and total COT > $23,000. CONCLUSION: Vancomycin’s clinical and economic efficiency may be reduced for patients with complicated MRSA SSTIs. The level of antibiotic resistance should be factored into comparative economic analyses of vancomycin and new treatments for gram+ infections.

**PIN6**

**INITIATION OF ANTIViral THERAPY AMONG CHRONIC HEPATITIS C PATIENTS ENROLLED IN MEDICAID**

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**OBJECTIVES:** To identify factors contributing to the initiation of antiviral therapy in patients with chronic Hepatitis C virus (HCV) infection in a Medicaid population. **METHODS:** Florida Medicaid claims from January 2000 to December 2004 were analyzed for persons with a diagnosis of HCV infection (ICD 9 codes: 70.50, 70.54). Eligibility was defined as continuous enrollment for 12 months before and after the first HCV claim (index date). Treatment initiation was defined as at least one claim with an NDC code for ribavirin, interferon, peg-interferon or interferon alfa-2b + ribavirin after the index date. Antiviral treated cases and non-treated controls were matched 1:2 on diagnosis year, age at diagnosis, and gender. Predictors of antiviral treatment initiation, including patient characteristics, Charlson comorbidity score, other chronic diseases, and medical services utilization in the 12 months before the index date were examined using logistic regression. **RESULTS:** Of 10,016 HCV patients, 2563 met eligibility criteria. Of these, 550 had more than 1 antiviral medication claim and 2013 had no antiviral claims. Exclusion of 155 with medications prior to HCV index date, 395 patients received treatment initiation. The rate of treatment for newly diagnosed patients was 16.4% (395/2563−395) to 21.5% (550/2563). Liver biopsy was associated with a 4-fold increase in the likelihood of treatment initiation (OR = 3.9, p < 0.0001). Factors associated with a lower likelihood of treatment initiation included history of alcoholism (OR = 0.32, p < 0.001), Charlson comorbidity score of 3 and 4 (OR = 0.65, p = 0.027), and a history of hospitalization in the year before index diagnosis (OR = 0.51, p < 0.001). CONCLUSION: Chronic hepatitis C patients enrolled in Medicaid appear to be treated at a lower rate than observed in other insured populations, with hepatitis C patients enrolled in Medicaid appearing to be treated at a lower rate than observed in other insured populations, with hepatitis C patients enrolled in Medicaid appearing to be treated at a lower rate than observed in other insured populations. This is not surprising, insofar as all patients in our sample have a diagnosis of HIV/AIDS and US payers generally require only one diagnosis code to effect claim payment. These findings underscore the importance of considering use of pharmacologic treatment in estimating prevalence of comorbid conditions in persons with chronic diseases.

**INFECTION—Cost Studies**

**PIN7**

**PREVALENCE OF CACHEXIA (WASTING SYNDROME) DIAGNOSIS AND TREATMENT AMONG PATIENTS WITH HIV/AIDS: A MEDICAL CLAIMS DATABASE ANALYSIS**

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**OBJECTIVES:** To estimate the prevalence of cachexia diagnosis and treatment among patients with HIV/AIDS. **METHODS:** Using a large US managed care claims database (approximately 51 million covered lives; 75 plans), we identified all persons who had ≥1 paid claim listing a primary or secondary diagnosis of HIV/AIDS (ICD-9-CM 042) during calendar years 2004–2005. A concomitant diagnosis of cachexia was assumed if the patient also had ≥1 paid claim during this timeframe listing a primary or secondary diagnosis of malnutrition (ICD-9-CM 263.xx), cachexia (ICD-9-CM 799.4), or other related codes (i.e., ICD-9-CM 783.0, 783.2x, or 783.3). Pharmacologic treatment of cachexia in these patients was assumed if ≥1 pharmacy claim for megestrol acetate, oxandrolone, somatropin, or dronabinol was paid during the same timeframe. **RESULTS:** A total of 23,929 persons had ≥1 claim listing a diagnosis of HIV/AIDS during 2004–2005. Of these, 134 also had a cachexia diagnosis but no treatment, 572 had cachexia treatment but no diagnosis code, and 1028 had a diagnosis code and were treated. Overall prevalence of cachexia was therefore estimated at 1734 persons, or 72.5 per 1000 persons with HIV/AIDS. Higher cachexia prevalence was observed among persons aged 45+ years and men, respectively. **CONCLUSION:** In this database, 7–8% of all persons with HIV/AIDS were cachectic, based on diagnostic and treatment evidence. Approximately 8% of prevalent cachexia cases did not receive an indicated pharmacologic treatment. As many as one-third of prevalent cases (i.e., 572 of 1734) cannot be ascertained through the use of ICD-9-CM diagnosis codes alone. This is not surprising, insofar as all patients in our sample have a diagnosis of HIV/AIDS and US payers generally require only one diagnosis code to effect claim payment. These findings underscore the importance of considering use of pharmacologic treatment in estimating prevalence of comorbid conditions in persons with chronic diseases.

**PIN8**

**BURDEN OF HERPES ZOSTER AND HEALTH AND BUDGET IMPACT OF A VACCINATION PROGRAM**

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**OBJECTIVES:** To estimate the disease burden of herpes zoster (HZ) in people age 60+ and health and budget impact (HBI) of a vaccine to prevent HZ from the payer’s perspective. **METHODS:** The number of annual HZ cases and the associated costs for the 60+ population were estimated from published incidence, the base case U.S. population in 2006, and the age-specific one year average incremental cost of HZ derived from a U.S. claims database. A model was constructed to track individuals through three states (living not vaccinated, living and vaccinated, deceased) from year 2006−2014. Vaccine usage rates were assumed to be between 1–3% in 2006, 4–10% in 2007, and 6–18% in years 2008–2014. Age specific efficacy from the Shingles Prevention Study was used to estimate HZ cases and costs averted, as well as the net cost of a vaccination program at a vaccine price of $150/dose. **RESULTS:** The annual incident number of HZ cases was estimated at 428,000 (60+ population). Annual direct medical costs were estimated at $494 million. Approximately 30% to 60% of the 60+ population were vaccinated by year 2014. Through 2014, vaccination was projected to avert between 210,000 and 540,000 incident cases of HZ, resulting in cost avoidance between $190 and $460 million, and a net cost of the vaccination program between 1.8 and 4.2 billion. The estimated lower and upper bounds of the average per-member-per-month cost for years 2006−2014, for vaccinating a 60+ population with an age distribution (total population) that is equivalent to that of the U.S. population were 6 and 13 cents respectively. **CONCLUSION:** HZ imposes a significant health and economic burden on the 60+ population. An HZ vaccination program is estimated to have a minimal budget impact and may potentially reduce the disease burden of HZ.