Statistical analyses were performed using SAS v9.3 software.

CONCLUSIONS: To validate a Chinese version of NUCOG METHODS: Accepted translation procedures were followed to develop a Chinese version of NUCOG. Patients from two hospitals were recruited between July and October, 2012. Statistical analysis was performed using SPSS 20.0. Subgroup analysis according to diagnosis was performed. Receiver Operating Characteristic (ROC) curves were utilized to test criterion validity. Convergent validity was assessed via correlations between NUCOG and MMSE and internal consistency was measured to test the reliability. RESULTS: 529 subjects comprised of patients with epilepsy (n=194), neurological diseases (n=81), dementia (n=84), control group (n=269) completed NUCOG and MMSE. Overall, both NUCOG and MMSE scores differed significantly across four groups with dementia-epilepsy-neurology-controls (p<0.0001). Analysis of NUCOG indicated different cognitive patterns for four groups, with patients group scoring lowest in memory and executive domains. All the four groups achieved higher scores in the language domain than in other domains. The NUCOG, but not the MMSE, discrimination between patients with dementia and control group was significant.

BACKGROUND: A large national retail pharmacy chain developed a patient-centric program providing enhanced levels of monitoring and care for patients taking MS Specialty Drugs as dispensed in a retail setting. MS biologics covered in the ConnectedCare for Multiple Sclerosis (CCMS) program during this analysis period included: Glatiramer acetate (Copaxone, Teva), fingolimod (Gilenya, Novartis), and Rebif (Orencia, Biogen Idec).

To compare adherence rates for MS biologics between managed and non-managed patients new to retail pharmacy or the CCMS program. The effect of health conditions and comorbidity on adherence rates was also explored.

METHODS: This was a retrospective analysis of MS patients new to therapy (or pharmacy chain) during the initial six months of CCMS. Patients were followed for one year. Adherence was measured using proportion of days covered (PDC). For the primary objective, propensity scores based on patients’ gender, age, presence of chronic comorbidities, and pre-study adherence to chronic medications were used to match the CCMS intervention group to a comparisons group. Sub-group analysis on health complications (chronic medication comorbidity, or assessment screenings for depression and fatigue) used Analysis of Covariance to adjust for the propensity variables when examining PDC in the presence of health complications across managed cohorts.

RESULTS: Mean PDC was nearly 10% higher for the managed CCMS patients than for non-managed patients. Patients not managed with at least one chronic comorbidity had an about 11% lower PDC than non-managed patients without a comorbid condition, whereas, managed patients indicated little difference in relation to the presence of a comorbidity. Adherence levels were also reduced for non-managed patients reporting fatigue and depression, yet self-reports of fatigue and depression did not significantly affect adherence levels among managed patients. CONCLUSIONS: Adherence levels for non-managed patients significantly increases adherence to MS biologic medications. Among non-managed patients, adherence is even further reduced among patients with fatigue and depression.
OBJECTIVES: To report the effect of BG-12 (dimethyl fumarate) in reducing the number of relapses requiring intravenous (IV) steroids and multiple sclerosis (MS)-related hospitalizations from a pre-specified integrated analysis of DEFINE and CONFIRM. The analysis was designed to estimate the precise effect of BG-12 versus placebo.

METHODS: Eligible patients were aged 18-55 years with relapsing-remitting MS (McDonald criteria) and an Expanded Disability Status Scale score of 0-5.0. Patients who received oral BG-12 240 mg twice (BID) or three (TID) times daily (TID) or placebo were included in the integrated analysis. The integrated analysis was to be conducted only if baseline characteristics and treatment effects were similar between the studies. Numbers of relapses requiring IV steroids and MS-related hospitalizations in DEFINE and CONFIRM were assessed.

RESULTS: The integrated analysis included 769, 761, and 771 patients who received BG-12 BID, TID, and placebo, respectively. Baseline characteristics and treatment effects were generally similar across the DEFINE and CONFIRM. There were significantly fewer relapses requiring steroids and MS-related hospitalizations in both BG-12 groups compared with placebo. BG-12 reduced the annualized rate of relapses requiring IV steroids by 48% (BID; rate ratio 0.52 [0.40–0.68]) and 50% (TID; 0.50 [0.41–0.61]) versus placebo (both p<0.001) and reduced the annualized rate of MS-related hospitalizations by 34% (BID; 0.66 [0.47–0.92]; p<0.0146) and 47% (TID; 0.53 [0.37–0.75]; p<0.0004) at 2 years. CONCLUSIONS: BG-12 significantly reduced the number of relapses requiring IV steroids and MS-related hospitalizations, which suggests benefits with regard to patient burden and health economic savings due to decreased resource utilization. These findings further support the efficacy results of DEFINE and CONFIRM.