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VP51 Hospitalizations And Costs In Schizophrenia Patients Initiating Long-acting Injectable Antipsychotics

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INTRODUCTION:

Existing evidence on clinical and economic effectiveness of one long-acting injectable antipsychotic (LAI) versus another in successful management of schizophrenia is scarce. The study was conducted to compare all-cause inpatient healthcare utilization and associated costs among Medicaid patients with schizophrenia who initiated LAIs.

METHODS:

This retrospective cohort analysis used the Truven Health Analytics MarketScan® Medicaid claims database. Schizophrenia patients $\geq$18 years with at least one claim for one of the following LAI were identified between 1 January 2013 and 30 June 2014 (identification period): aripiprazole, fluphenazine, haloperidol, paliperidone palmitate, and risperidone. The first day of initiating an LAI was considered the index date. Patients were followed for 1 year from index date. Logistic and general linear regression models were used to estimate risk of inpatient hospitalization and associated costs during follow up.

RESULTS:

Of the identified Medicaid patients with schizophrenia, 1,672 (36.7 percent) initiated an LAI: 44.0 percent received paliperidone, 26.4 percent haloperidol, 13.8 percent risperidone, 9.2 percent aripiprazole, and 6.6 percent fluphenazine. With the aripiprazole cohort as the reference group, the odds of having any inpatient hospitalizations were significantly higher in haloperidol [Odds Ratio, OR (95 percent Confidence Interval, CI): 1.51 (1.05 - 2.16)] and risperidone [OR (95 percent CI): 1.58 (1.07 - 2.33)] cohorts. Fluphenazine and paliperidone palmitate cohorts also had higher risk of having any inpatient hospitalizations compared with aripiprazole, but the differences were not statistically significant ($p>.05$). Among LAI initiators with any inpatient hospitalizations, the adjusted mean inpatient costs were lowest in the aripiprazole cohort (USD25,616), followed by haloperidol (USD30,811), paliperidone (USD30,833), risperidone (USD31,584), and fluphenazine (USD37,338), although differences were not statistically significant.

CONCLUSIONS:

Our study findings highlight the value of aripiprazole in reducing inpatient hospitalizations and associated costs among patients with schizophrenia. However, our study is limited as our results are reflective of a multi-state Medicaid population. Future studies are warranted to confirm the results in non-Medicaid patient populations.

VP53 Cost-Utility Analysis: Adalimumab Verus Etanercept in Rheumatoid Arthritis – Brazil

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INTRODUCTION:

Rheumatoid arthritis (RA) is an inflammatory, autoimmune disease of unknown etiology that usually results in joint lesions and physical incapacitation. RA treatment includes disease-modifying antirheumatic drugs (DMARD), synthetic (sDMARD) and/or biologics (bDMARD). In this study we carried out a cost-utility analysis comparing Adalimumab (ADA) versus Etanercept (ETA), with or without synthetic DMARDs (± sDMARD).

METHODS:

Effectiveness measures used were the Clinical Disease Activity Index (CDAI) and Quality-Adjusted Life Years (QALY) obtained from an open prospective cohort study with Brazilian RA patients. Costs were obtained from a historical cohort composed of every patient who was prescribed medicines to treat RA in the State of Minas Gerais, Brazil. A public sector perspective was adopted. The Markov model included six-month cycles, time horizon of 5 years and 5 percent discount rates. Sensitivity analyses were performed by varying costs and outcome values.

RESULTS:

There was no significant difference in effectiveness between the two bDMARDs. Treatment with ETA (± sDMARD) was more expensive after 5 years of follow-up: incremental cost of USD28,210.87. Overall, treatment with ADA (± sDMARD) was more cost-effective: incremental cost-effectiveness ratio for ETA (± sDMARD) was USD79,148.34/ QALY. Sensitivity analysis showed that this was sensitive to changes in the cost of ETA (± sDMARD).

CONCLUSIONS:

Currently two Anti-tumour Necrosis Factor Alpha (anti-TNF alpha) medicines – ADA and ETA are available within the Brazilian public health system in addition to infliximab. Treatment with ADA (±sDMARD) was more cost-effective with an incremental cost effectiveness ratio for ETA (±sDMARD) at USD79,148.34 per QALY. Sensitivity analysis showed that outcomes are sensitive to changes in the cost of ETA (± sDMARD) treatment. Overall, both therapeutic alternatives are valuable from the public sector perspective especially when the Clinical Protocol and Therapeutic Guidelines are properly applied in patients no longer responding to treatment. Alternatives are needed as some patients will respond differently to different anti-TNF alpha medicines.

VP54 Costs And Benefits Of Intensive Inpatient Rehabilitation After Stroke

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INTRODUCTION:

This study estimated, from the societal perspective, the costs and benefits of the intensive inpatient rehabilitation treatments (IIRT) on patients after stroke using the interim results of a large ongoing registry in Korea, the Korean Stroke Cohort for Functioning and Rehabilitation (KOSCO) (1).

METHODS:

Among others, the benefits were measured by two major cost savings: (i) decrease in government disability subsidy and (ii) caregiver savings. One of the KOSCO study results showed the functional status of the post-stroke patients, measured by the Korean Modified Barthel Index (K-MBI), improved significantly and the disability grades, which the government is using to classify the subsidy amount, reduced as well. Caregiver cost savings were calculated by K-MBI improvements, the average daily compensation of caregivers (USD58.33) and the average period of caregiving. To measure the cost of IIRT on post-stroke patients, the average costs reported by a National Evidence-based Healthcare Collaboration Agency (NECA) Health Technology Assessment report was used (2).

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