patients were biologic-experienced, and 52 (34%) were biologic-naive before initi- ing golimumab. A higher percentage of female patients were in the bio-experi- enced category (70% vs. 55%). Osteoarthritis (27%), hypertension (24%), dyslipid- emia (17%), and depressive disorders (14%) were the most common comorbidities prior to initiating golimumab therapy. A higher rate of depressive disorder was observed in the biologic-experienced group. Baseline mean C-reactive protein test values were also higher in the biologic-experienced group (3.6 vs. 0.97). Biologic-experi- enced patients on golimumab were switched mostly from adalimumab (n=42) and etanercept (n=25). CONCLUSIONS: In this longitudinal EMR, patients receiving golimumab were more likely to have prior biologic experience. Biologic-experi- enced patients appeared to have higher C-reactive protein test values and greater rates of depressive disorders than their biologic-naive counterparts.

CHARACTERISTICS OF GOLIMUMAB UTILIZATION IN A LARGE NATIONAL PAYER DATABASE
Tandon N1, Saulnier A2, Gunnarsson C2
1Centorc Ortho Biotech Services, LLC, Horsham, PA, USA, 2S2 Statistical Solutions, Inc., Cincinnati, OH, USA
OBJECTIVES: Golimumab (GLM) is a monthly self-injected anti-tumor necrosis fac- tor alpha therapy providing once-monthly dosing for patients with rheumatoid arthritis (RA), ankylosing spondylitis (AS), and psoriatic arthritis (PsA). This study assessed the baseline characteristics and utilization patterns of patients who received GLM. METHODS: We performed a retrospective database analysis of The MarketScan® Research Database from Thomson Reuters. This database contains individual-level, de-identified, healthcare claims information from employers, health plans, hospitals, Medicare, and Medicaid. A total of 29,774 patients in this database had a diagnosis of either RA, PsA or AS and at least one biologic on record and met the following inclusion criteria: ≥18 years of age at the time of the first diagnosis. From this sample, a total of 174 patients had at least one prescription record for GLM. RESULTS: A total of 174 patients receiving GLM were identified as meeting inclusion criteria; with 129 (RA), 30 (PSA), and 16 (AS) patients. The mean age was 48 years and 75% of the sample was female. A total of 155 (89%) patients were biologic-experienced and 19 (11%) were biologic-naive before initiating golimumab. A total of 111 patients received at least two GLM doses. Of the patients with two or more GLM doses, the median and mean ±SD dosing interval was 29.5 days and 33.65 ± 15.56 days. When looking at biologic naive patients the median and mean ±SD dosing interval was 30 days and 35.37 ± 17.63 days versus biologic experienced patients with a dosing interval of 29 days and 33.15 ± 15.00 days. CONCLUSIONS: In the MarketScan® database, the majority of patients with a prescription for GLM was female and had prior biologic experience. GLM median and mean doses were 29.5 and 33.37 days respectively. Previous biologic experience did not significantly change the GLM dosing patterns.

PSY65
BIOLGIC EXPERIENCE AND DOSING OF GOLIMUMAB PATIENTS IN MANAGED CARE
Carter C1, Tandon N2, Smith D2
1Centorc Ortho Biotech Services, LLC, Horsham, PA, USA, 2S2 Health Incorporated, Warrington, PA, USA
OBJECTIVES: Golimumab, a new anti-tumor necrosis factor agent used in patients with rheumatoid arthritis, psoriatic arthritis, and ankylosing spondylitis, has recom- mended dosing of 50 mg once monthly. The objective of this study was to describe the biologic experience and dosing for patients using golimumab in the managed care setting. METHODS: The IMS LifeLink® Health Plan database (~100 managed care plans) was utilized to identify patients aged ≥18 years at index and having an index golimumab pharmacy claim started between 4/24/2009 (product approval) and 10/31/ 2009. Patients were required to have 24 months pre- and ≥2 months post-index continuous enrollment with ≥1 RA, PsA, or AS ICD-9 diagnosis code. Biologic experi- ence was assessed for the pre-index period. Dosing was assessed through end of data or loss of enrollment. RESULTS: A total of 282 patients receiving golimumab were identified; 72% were female; mean age was 52 years. The majority (73%) of patients had pre-index biologic experience. Among the biologic-experienced, 94% received 1 unique biologic, 33% received 2 unique biologics, and 7% received 3+ unique biologics before golimumab. Golimumab patients had experience with various combinations of abatacept, adalimumab, certolizumab, etanercept, and infliximab. Adalimumab alone and etanercept were the biologics most frequently used prior to golimumab. The mean dose at each of the first six prescription fills was 50 mg for over 97% of patients. The mean (median) days between fills spanned 29-33 (29-30) days. CONCLUSIONS: The majority of patients receiving golimumab were biologic-experienced. Observed dosing was consistent with prescribing recommendations. Consistency in dosing was ob- served over the first six prescription fills. The history of biologics used prior to golimumab did not have an apparent increased dose requirement upon initiation. Further research is necessary to confirm these findings in a larger sample size over a longer duration of follow-up.

PSY66
REASONS FOR INITIATING INTRAVENTRIS BIOLGIC THERAPY AMONG PATIENTS WITH IMMUNOLOGIC CONDITIONS: SUBSET ANALYSIS OF PRIOR SUBCUTANEOUS INJECTION (SQ) USERS AND IMPLICATIONS FOR SHARED DECISION MAKING
Centorc Ortho Biotech Services, LLC, Horsham, PA, USA
OBJECTIVES: To understand the reasons for initiating an intravenous (IV) biologic therapy among prior subcutaneous injection (SQ) users, and patient satisfaction before and after switching. METHODS: Semi-structured telephone interviews were conducted with 405 immunology patients currently receiving IV biologic therapy. Patients rated their level of satisfaction with current or prior medication on a 7-point Likert scale (7=Very satisfied; 1=not at all satisfied) and reported reasons for switching from SQ therapy. RESULTS: More than a third (37%) of surveyed IV biologic-treated patients received infliximab (IFX) and adalimumab (ADA) administration. Overall mean satisfaction with SQ was 3.8, with 32% rating the SQ experience as a 1 or 2. Current IV satisfaction ratings among prior SQ users was 6.2 (vs. 6.1 for all patients surveyed). Of prior SQ users, 26% did not self-administer their injections, most frequently due to: dislike of needles; lack of confidence in own ability to administer the injection correctly, and/or physical inability to handle the syringe. Of those who did not self-administer SQ, 39% went to a physician’s office for administration. Primary reasons for switching from SQ to IV administration included lack of effi- cacy (81%), side effects (21%), cost (10%) and dislike of self injections (9%). CONCLUSIONS: In this analysis, current IV biologic users appear highly satisfied with this medication. Dissatisfied SQ users that did not self-administer may offset potential “convenience” advantages of a SQ. They also switched to IV mostly for burdens and appear to be satisfied with an IV. Given the potential for patient preference differences, there appears a need for expanded treatment choices. In- volving the patient in shared decision making and providing access to both IV and SQ modes of administration may be important to optimizing patient satisfaction.

DEFINITIONS OF ANTI-TNF DISCONTINUATION MAY IMPACT UNDERSTANDING OF REAL-WORLD UTILIZATION PATTERNS
Schmoel-Chrulier C1, Buysen E1, Bolge S1, Ingham M1, McKenzie RS1
1Centorc Ortho Biotech Services, LLC, Horsham, PA, USA, 2S2 Innoven, Eden Prairie, MN, USA
OBJECTIVES: To evaluate treatment patterns when different definitions of discontinu- ation are used for assessing biologic therapy providing once-monthly dosing for patients with rheumatoid arthritis, ankylosing spondylitis and psoriatic arthritis (PsA). This study aimed to evaluate the impact of discontinuation rates are observed when different definitions of discontinuation are used. METHODS: Analysis was conducted with 405 immunology patients currently receiving IV biologic therapy. Discontinuation rates are observed when different definitions of discontinuation are employed. This may impact the understanding of real-world prescribing patterns. The data also suggests that patients treated with ADA and ETA experience lengthy gaps in therapy.

MODELING THE IMPACT OF REFILL OR ADMINISTRATION GAPS ON PATIENT VALUE IN HEALTH 14 (2011) A1–A214
M. Carter C1, Bolge S1, Comisar C2
1Centorc Ortho Biotech Services, LLC, Horsham, PA, USA, 2S2 Innoven, Eden Prairie, MN, USA
OBJECTIVES: After a refill or administration gap of one week, mean etanercept levels were at 13% and 73% of SSTL respectively. At two weeks, SSTL were 4% and 55% respectively. Etanercept levels were expressed as a percent of steady state trough levels (SSTL) in

RESULTS: After a refill or administration gap of one week, mean etanercept levels were at 13% and 73% of SSTL respectively. At two weeks, SSTL were 4% and 55% respectively. Etanercept levels were expressed as a percent of steady state trough levels (SSTL) in

CONCLUSIONS: In this longitudinal EMR, patients receiving golimumab were more likely to have prior biologic experience. Biologic-experi- enced patients appeared to have higher C-reactive protein test values and greater rates of depressive disorders than their biologic-naive counterparts.
OBJECTIVES: Provider continuity is defined as seeing the same health care provider over time. Previous studies indicated that high provider continuity improves health care outcomes and the efficiency of health care delivery. The impact of provider continuity in sickle cell disease (SCD) care, however, is unknown. This study compared indicators of health and functional status among sickle cell disease patients with and without provider continuity.

METHODS: The AVIDA® registry is a longitudinal observational study of patients with MDS and is the largest U.S. registry of MDS patients treated with Vidaza® (decitabine). Health outcomes of all registry participants were measured via the validated EORTC-QLQ-C30. Mean (Standard Deviation) scores were calculated for each symptom and co-morbidity and compared between provider continuity groups. Results are corrected using age, sex, body mass index (BMI), race, and ECOG performance status.

RESULTS: Nearly half of the 2674 MDS patients included in the 2004-2007 study group had at least one provider visit in the prior year. Participants with provider continuity had significantly better scores for all health-related quality of life (HRQOL) measures compared to those without provider continuity. Participants with provider continuity had significantly better scores on 4 of 9 symptom/other scores: financial difficulties (34.8 (4.5), 33.4 (4.0), p = 0.0001); insomnia (39.7 (4.0), 37.3 (3.7), p = 0.0141); appetite loss (29.9 (3.8), 27.5 (2.5), 27.3 (2.2), p = 0.0263); and fatigue (53.9 (3.1), 44.3 (2.3), 48.5 (1.8), p = 0.0452). Conclusions: AVIDA registry findings indicate baseline HRQOL among MDS patients in real world settings differs by age in certain domains. These differences suggest HRQOL is similar or better in elderly MDS patients than younger patients. These differences in emotional and cognitive functioning, fatigue, insomnia, appetite loss, and financial difficulties require consideration in clinical trials examining HRQOL among elderly MDS patients.

PSY73 PAIN MEDICATION USE AND DETERMINANTS OF OPIOIDS PRESCRIBING IN THE UNITED STATES OUTPATIENT SETTINGS
Basu R, Cunningham L, Sohraby R, Knell M
University of Missouri-Kansas City, Kansas City, MO, USA

OBJECTIVES: Chronic pain is a major public health concern in the US. Established guidelines are available for management of non-malignant chronic pain, including opioid use. However, discrepancies in opioid prescribing patterns due to physician misconceptions remain concerning. Therefore, this study evaluated pain medication use and investigated determinants of opioid analgesic prescribing in the US outpatient settings for common non-malignant chronic pain indications.

METHODS: This cross-sectional study analyzed the National Ambulatory Medical Care Survey (NAMCS) data from 2002-2007 on patients 18 years and older with non-malignant chronic pain diagnosis based on ICD-9-CM codes identified as reason for visits. Pain medications prescribed were searched using NAMCS drug codes.

Multivariate logistic models examined determinants of opioids prescribing among chronic pain patients.

RESULTS: Approximately 69 million weighted outpatient visits were reported for non-malignant chronic pain between 2000-2007 in the US. The odds of receiving more than five medications were 2.80 times more likely to receive opioids (OR:2.80, CI:2.28-3.44) than those with less than five medications. Patients with PCPs, more than five prescriptions, established patients, and physician visits per year were some of the determinants of opioid prescribing. Increased awareness of opioid prescription guidelines for pain management may eliminate prescription discrepancies and improve patient care.

PSY74 TREATMENT CHOICE FOR PAIN MANAGEMENT IN NURSING HOME HOME/PALLIATIVE CARE RESIDENTS IN THE UNITED STATES
Aravja L, Mhore SK, Sassgry RP
University of Houston, Houston, TX, USA

OBJECTIVES: This study determined factors associated with treatment choice for pain management in US nursing home/palliative care residents.

METHODS: Data were collected from the 2004 National Nursing Home Survey (NHNHS). Residents assigned to a bed in a hospice specialty unit or receiving services from a special program for hospice/palliative care in a nursing home in 2004 were included. Multivariate logistic regression was conducted using SAS version 9.2. The outcome variable was the use of opioids. Independent variables included: age, gender, race, ethnicity, pain location, and pain intensity.

RESULTS: Opioids were the most frequently prescribed medications among hospice/palliative care residents (30.4%). The odds of receiving opioids were significantly higher for residents age 65 or older (OR:1.80, CI:1.20-2.67) and residents who were African American (OR:0.60, CI:0.40-0.89). The odds of receiving opioids were significantly lower for residents with a pain intensity of 5 or higher (OR:0.75, CI:0.59-0.96). The odds of receiving opioids were significantly higher for residents with no other medications (OR:1.91, CI:1.33-2.72) and residents with more than 6 medications (OR:2.02, CI:1.50-2.70). The odds of receiving opioids were significantly higher for residents with a pain location of the abdomen (OR:1.97, CI:1.39-2.77) and residents with a pain location of the back (OR:1.84, CI:1.30-2.61).

CONCLUSIONS: The results of this study suggest that opioid analgesics are an important part of pain management for elderly residents of US nursing homes.