

F24 The Economic Burden Associated with Suicidal Ideation Among Patients with Depression

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BACKGROUND: While there is an established association between major depressive disorder (MDD) and suicidal ideation (SI), few studies have assessed the economic burden associated with MDD with risk for suicide.

OBJECTIVE: This study used patient-reported outcomes to examine work productivity loss, health care resource use (HRU), and indirect and direct costs associated with SI.

METHODS: The 2013 U.S. National Health and Wellness Survey, a nationally representative, self-administered, internet-based survey of adults, was used. To approximate the MDD population, patients who self-reported a diagnosis of depression and scored 15 on the Patient Health Questionnaire-9 (PHQ-9) were included. Patients with a positive screen on the mood disorder questionnaire or a reported diagnosis of bipolar disorder or schizophrenia were excluded. Patient scores on PHQ-9 item 9 (Over the past 2 weeks, how often have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way?) were used to create SI interval groups. Patients who scored 0 (not at all), 1 (several days), 2 (more than half the days), or 3 (nearly every day) were categorized as “no SI,” “low SI,” “moderate SI,” and “high SI,” respectively. Work productivity impairment was assessed with the Work Productivity and Activity Impairment Questionnaire: General Health (WPAI-GH). HRU included the number of traditional health care provider visits, emergency room visits, and hospitalizations in the last 6 months. Monthly per patient indirect and direct costs were monetized, respectively, using Bureau of Labor Statistics data and Medical Expenditure Panel Survey data. One-way analysis of variance with follow-up comparisons examined whether outcomes differed by SI interval group.

RESULTS: Among the 2,196 patients who met the sample inclusion criteria, 22% (n=490) were categorized as high SI (mean age, 44 years; 51.8% male); among patients with no SI, mean age was 46 years and 30.6% were male. Compared with no SI patients, high SI patients had significantly higher work productivity loss (45% vs. 39%; $P=0.039$), incurred greater monthly indirect costs (\$1,472 vs. \$1,078; $P<0.001$), had twice as many hospitalizations in the prior 6 months ($P=0.002$), and incurred greater monthly direct costs (\$1,227 vs. \$801; $P=0.002$).

CONCLUSIONS: Among patients with MDD, those with high SI reported greater work productivity loss, HRU, and monthly indirect and direct costs compared with patients with no SI. More severe SI appears to be associated with greater economic burden.

SPONSORSHIP: Janssen Scientific Affairs.

F25 The Impact of Delaying Adjunctive Treatment with Atypical Antipsychotic Medication for Major Depressive Disorder on Changes in Healthcare Resource Use and Medical Costs

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BACKGROUND: Over half of patients with major depressive disorder (MDD) do not adequately respond to initial treatment with an antidepressant therapy (ADT). Atypical antipsychotics (AAPs) can be effectively added to ADT to improve treatment efficacy.

OBJECTIVE: To measure the impact of delaying adjunctive AAP use on changes in annualized healthcare resource use and medical costs before and after initiating an ADT for MDD.

METHODS: ADT-naïve patients with MDD 18 years of age who were initiated on an ADT (index date) between 7/10/2014 and 9/30/2015 were identified in IQVIAs PharMetrics Plus Adjudicated Claims Database. Patients were required to have 1 post-index pharmacy claim for adjunctive AAP: brexpiprazole, quetiapine, or aripiprazole, have 12 months of continuous medical and drug coverage prior to and after ADT initiation, and 30 days of coverage after the first AAP add-on date. Differences in the annualized healthcare resource use and medical costs, before and after ADT initiation, were compared between patients who initiated an AAP within the first 6 months (early add-on) and after 6 months (delayed add-on) of index date.

RESULTS: 734 early add-on and 333 delayed add-on patients were identified. Mean \pm SD age was 38 ± 14 years. On average, early add-on patients started an AAP within 1.9 months of starting ADT, and had used 1.4 ADTs before AAP add-on; delayed add-on patients started an AAP within 8.9 months and had previously used 1.8 ADTs. Compared to baseline, adding an adjunctive AAP early decreased the proportion of patients hospitalized from 22.6% to 19.8%; however, delayed initiation of adjunctive APP increased hospitalizations from 13.8% to 17.4%. The number of hospitalizations per patient remained the same for early add-on, but increased 1.8 times for delayed add-on. Hospitalization cost per patient decreased by $\$206 \pm \$22,980$ for early add-on, but increased by $\$1,011 \pm \$13,830$ for delayed add-on. Mean number of office visits per patient were twice as high during follow up, compared to baseline in both early and delayed add-on cohorts. During the same period, mean number of MDD-related office visits per patient increased 4.5 times for early add-on; and 7.2 times for delayed add-on. Total annualized medical costs increased by $\$3,061 \pm \$27,975$ for early add-on, and by $\$3,415 \pm 19,009$ for delayed add-on.

CONCLUSIONS: Compared to delayed add-on, early use of adjunct AAP was associated with a numerical decrease in hospital costs and a smaller numerical increase in MDD-related office visits and overall medical costs after starting adjuvant AAP.

SPONSORSHIP: Otsuka Pharmaceutical Development & Commercialization and Lundbeck.

F26 Healthcare Resource Utilization, Work Productivity Impairment, and Economic Burden in Patients with Treatment-Resistant Depression

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BACKGROUND: Treatment-resistant depression (TRD) represents an important subpopulation of patients with major depressive disorder (MDD) with limited effective treatment options and potentially disproportionately greater economic burden.

OBJECTIVE: This study characterized healthcare resource utilization (HRU), work productivity impairment, and economic burden among TRD patients compared with other MDD patients.

METHODS: This study used data from the 2013 U.S. National Health and Wellness Survey, a nationally representative, self-administered, internet-based survey of adults. Patients with MDD were included, defined as those reporting clinician-diagnosed depression and a PHQ-9 score 10 or PHQ-9 score 0-9 and on a medication for depression. Among MDD patients, those with TRD were defined by a PHQ-9 score 15 and on 2 concomitant antidepressants. Patients with bipolar disorder or schizophrenia were excluded. HRU, including