PMH51

LAW ENFORCEMENT OFFICERS' READINESS TO PROVIDE NALOXONE IN AN EMERGENCY SITUATION IN THE COMMUNITIES OF WEST VIRGINIA

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OBJECTIVES: Communities in West Virginia (WV) have been disproportionately impacted by the opioid epidemic with 35.5 drug-overdose deaths per 100,000 persons in 2015. Law enforcement officers (LEOs) have the legal authority to stock, carry, and use naloxone, but the real-world use and availability through LEOs in WV is unknown. The objective of our study was to assess the readiness of LEOs in WV to provide emergency naloxone in the communities they serve. **METHODS:** A prospective cross-sectional study was conducted using a self-administered questionnaire between September and December 2016. The questionnaire consists of demographic information, current experiences with naloxone, prior experience with opioid overdose situations, perceived barriers to carrying and administering naloxone, the level of knowledge of opioid overdose management, and attitudes towards managing an opioid overdose. **RESULTS:** The survey was completed by 149 active, non-retired WV officers who had an average age of 45.6(±11.4) years and 13.8(±10.0) years of experience at their department. The results indicated that the use of naloxone was rare, only 12.7% of respondents said that naloxone was available for use, 72.7% of LEOs reported being at the scene of an opioid overdose in the past 12 months, and the majority (58.6%) reported being at the scene before EMS. Half of the respondents were not interested in receiving training to administer naloxone, and of those individuals, 53.5% were serving counties with elevated prescription drug death rates (≥20 per 100,000). Knowledge scores were higher for officers who had completed training on naloxone than those who did not or were not interested (t=2.27,p=0.02). Barriers to naloxone use identified by the LEOs included lack of training, time, safety, cost, storage, and liability. **CONCLUSIONS:** We conclude that willing officers should continue to be trained, but for officers in counties where death rates are the highest, new strategies to increase buy-in are still needed.

PMH52

EFFICACY, SAFETY AND COST-EFFECTIVENESS OF ARIPIPRAZOLE COMPARED TO OLANZAPINE FOR SCHIZOPHRENIA: SYSTEMATIC REVIEW AND META-ANALYSIS

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OBJECTIVES: Aripiprazol is a dopamine-serotonine system stabilizer not included in the standard treatment of schizophrenia in Brazil's universal health system. It has been the reason of many court orders demanding its supply. This study proposes a systematic review with meta-analysis of the efficacy, safety and cost-effectiveness of aripiprazole compared to olanzapine, a standard drug for schizophrenia in Brazil, to evaluate the rationality of its use for the treatment of schizophrenia. **METHODS:** A systematic review was conducted in accordance to the Cochrane Handbook guidelines, including RCTs and complete economic evaluations. A eletronic search in the databases of Medline, The Cochrane Library and Lilacs and a complementary search in theses and dissertations databases, scientific journals, and abstracts of international meetings were conducted. Results of independent studies were combined via meta-analysis. **RESULTS:** Six RCTs and ten economic evaluations were included. None of the studies showed efficacy results that significantly favored aripiprazole and two studies significantly favored olanzapine. Most studies did not show difference between olanzapine and aripiprazole regarding neurological adverse effects. One paper reported a better neurological adverse effects profile for olanzapine. All six studies found worse metabolic profile for olanzapine. The meta-analysis of aripiprazole in comparison with olanzapine showed that patients in use of aripiprazole are more likely to discontinue treatment (RR[IC95%]=1.15[1.06-1.24]; I2=0%; p-value<0.0009) and less likely to have weight gain >7% (RR[IC95%]=0.44[0.25-0.55]; I2=0%; p-value<0.00001). Olanzapine was found dominant in seven economic evaluation studies and aripiprazole was dominant in two. In one study, aripiprazole was less expensive and less effective than olanzapine (RCEI of 3,951.72 €/remission). **CONCLUSIONS:** Aripiprazole was not found to be a better therapeutic alternative than olanzapine. But, despite of being less efficacious and show worse cost-effectiveness profile, aripiprazole might be useful for patients that were considered irresponsive or intolerant to olanzapine.

PMH53

IMPACT OF USING AFFILIATE IDS ON PQA'S OPIOID MULTIPLE PROVIDER MEASURE AMONG MEDICAID BENEFICIARIES

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OBJECTIVES: Computing the Pharmacy Quality Alliance (PQA) measure for obtaining opioids from multiple prescribers and pharmacies relies on the use of provider identifiers to distinguish different providers. However, prescriptions from different providers in the same facility are not reflective of "doctor shopping" and filling prescriptions from chain pharmacies in the same community are not reflective of "pharmacy shopping". This study examined the effect of using affiliate practice IDs compared to individual provider IDs when computing PQA's provider shopping measure. **METHODS:** Mississippi Medicaid claims for 2015-16 were used to identify beneficiaries ≥18 years of age, continuously enrolled, without a cancer diagnosis and ≥2 prescription claims for opioids. The proportion of beneficiaries receiving opioids from 4 or more prescribers AND 4 or more pharmacies were classified as provider shopping. The provider shopping measure was computed using the individual provider and pharmacy identifiers reported on the claims and using affiliate identifiers that grouped prescribers in the same facility and chain pharmacies in the same zip code. **RESULTS:** A total number of 30,494 beneficiaries were included. They were mostly female(72.79%), African American(50.63%), aged 18-44 years(50.22%) and enrolled in Medicaid managed care plans(90.79%). When using affiliate IDs, the number of beneficiaries identified as using 4+ prescribers dropped from 7,276 to 5,674 (22.02% reduction, p<0.0001) and the number identified as using 4+ pharmacies dropped from 2,446 to 2,079 (15.13% reduction, p<0.0001). The percentage of beneficiaries classified as "provider shopping" dropped from 5.21% to 4.01% (p<0.0001). **CONCLUSIONS:** The significant reduction in PQA's measure shows that failing to account for affiliates within the same practice may lead to an overestimation in the number of opioid misusers. Opioid misuse is a sensitive public health issue and affiliate IDs should be used, if possible, when identifying beneficiaries as potential misuse cases.

PMH54

MEDICATION ADHERENCE AND DISCONTINUATION IN PATIENTS WITH BIPOLAR DISORDERS WHO INITIATED A LONG ACTING INJECTABLE ANTIPSYCHOTIC VERSUS THOSE WHO CHANGED ORAL ANTIPSYCHOTICS

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OBJECTIVES: To examine medication adherence and discontinuation in patients with bipolar disorder (BP) initiating a long acting injectable antipsychotic (LAI) versus those who changed to a different oral antipsychotic. **METHODS:** This retrospective cohort analysis used Truven Health Analytics MarketScan® Commercial and Medicaid claims databases. Of the adult patients (≥18 years) diagnosed with BP, two mutually exclusive cohorts were created: LAI cohort, defined as initiating an LAI (no prior LAI therapy) between 01/01/2013 and 06/30/2014; and oral cohort, defined as patients who changed to a different oral antipsychotic (mono-therapy) during the same period. The first day of initiating an LAI or changing oral antipsychotic was the index date. Linear and Cox regression models were conducted to estimate medication adherence (proportion of days covered (PDC)) and time to medication discontinuation (continuous medication gap ≥ 60 days), respectively. Models adjusted for patient demographic and clinical characteristics, baseline medication use, and baseline ED or hospitalizations. **RESULTS:** The final sample consisted of 1,672 (14.7%) LAI initiators and 9,672 (85.3%) oral antipsychotic users. Compared with the oral cohort, LAI initiators had better medication adherence (PDC≥0.8: 30.9% vs. 21.5%, p<0.001; unadjusted mean: 0.51 vs.0.45; p<0.001). Controlling for covariates, the adjusted mean of PDC remained higher in the LAI initiators than in the oral cohort (0.50 vs. 0.45; p<0.001). Additionally, LAI initiators had a lower discontinuation rate (76.5% vs. 82.4%; p<0.001) and a significantly longer time to medication discontinuation than the oral cohort. The median time to discontinue index LAI was 149 days, compared with 99 days for oral monotherapy (p<0.001). The oral cohort had a higher hazard than the LAI cohort for discontinuing their index treatments (hazard ratio: 1.19; p<0.001). **CONCLUSIONS:** This real-world study suggests that patients with BP initiating LAIs had better medication adherence and lower discontinuation risk than those who changed to different oral antipsychotic monotherapy.

PMH55

ADHERENCE AND TREATMENT PATTERNS OF EARLY ADOPTERS OF BREXPIPRAZOLE THERAPY WITH SCHIZOPHRENIA – RESULTS FROM A RETROSPECTIVE ANALYSIS OF LONGITUDINAL PRESCRIPTION DATA

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OBJECTIVES: Brexpiprazole, a serotonin-dopamine activity modulator, was approved in the United States for the treatment of schizophrenia on 10-Jul-2015. This is the first opportunity to examine the characteristics, treatment patterns and adherence in schizophrenia patients treated with brexpiprazole, compared to other atypical antipsychotics (AAPs). **METHODS:** The study utilized longitudinal pharmacy prescription and outpatient medical claims databases. Patients were ≥18 years old, diagnosed with schizophrenia, and newly initiated on brexpiprazole or other AAPs (olanzapine, quetiapine, ziprasidone, risperidone, aripiprazole, or lurasidone) between 10-Jul-2015 and 31-Mar-2016. Patient characteristics and treatment history were measured in the 12 months before therapy initiation. Treatment adherence was measured as a variable medication possession ratio (MPRv) among patients with ≥2 fills. **RESULTS:** 225 patients on brexpiprazole and 30,808 patients on other AAPs (6,112 olanzapine; 7,419 quetiapine; 2,085 ziprasidone; 7,841 risperidone; 3,956 aripiprazole; 1,671 lurasidone) were identified. Brexpiprazole patients were younger (41±15.4 years) than those on other AAPs (p<.0001 for all; 50±15.9 for olanzapine, 50±14.8 for quetiapine, 48±14.0 for ziprasidone, 51±15.2 for risperidone, 48±14.9 for aripiprazole, 46±14.3 for lurasidone). 95% of brexpiprazole patients and 37-63% of other AAP patients had used ≥1 antipsychotic before initiating treatment. Psychiatrists/psychologists more frequently prescribed brexpiprazole (77%) compared to other AAPs (51-68%). Mean MPRv was 92% in brexpiprazole, 90% in olanzapine, 88% in quetiapine and risperidone, 91% in ziprasidone, 87% in aripiprazole, and 88% in lurasidone. Fewer patients treated with brexpiprazole (64%) used ≥1 concomitant psychotropic medication compared to other APPs (67-75%). **CONCLUSIONS:** This is the first study to describe brexpiprazole utilization in schizophrenia patients in the real-world setting. Patients treated with brexpiprazole were different from those treated with AAPs in terms of age, treatment history, prescribing physician specialty, and concomitant medication use. Patients treated with brexpiprazole and other AAPs had comparable therapy adherence. Brexpiprazole was prescribed more often by specialists than other AAPs.