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starting 253 days post-stroke (median), with 68.0% remaining on treatment after 12 months. Among patients with PSS, mean all-cause healthcare costs were $62,875 vs $44,472 for patients without PSS (P<0.001), representing 39.6% higher adjusted all-cause healthcare costs among patients with spasticity compared to patients without (P<0.001).

CONCLUSIONS: PSS identified via this claims analysis had a lower rate and later timing than in previous epidemiological studies, possibly due to underreporting and/or delayed reporting in clinical practice. Patients with PSS utilized numerous treatment modalities and experienced higher mean all-cause healthcare costs than did those with stroke but without spasticity. Earlier identification to optimize treatment of PSS may represent an opportunity for cost savings within managed healthcare systems.

SPONSORSHIP: Ipsen

M12 Cost-effectiveness of sequential treatment with abaloparatide followed by alendronate in US men at imminent risk of fracture

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BACKGROUND: Though osteoporosis is predominantly a disease of women, it also affects one in five men and often with more severe consequences, particularly following fractures. Recently, the ATOM study demonstrated that abaloparatide (ABL) resulted in significant increases in bone mineral density (BMD) at the lumbar spine and hip. A cost-effectiveness analysis is needed to inform prescribers about the economic value of ABL in men at imminent risk of fracture.

OBJECTIVE: To estimate the cost-effectiveness of sequential treatment with ABL followed by alendronate (ALN) compared to alternative treatments in US men at imminent risk aged 50-80 years.

METHODS: A validated Markov microsimulation model was adapted to estimate the cost-effectiveness of sequential ABL/ALN in men from a lifetime US payer perspective. Comparators were no treatment, sequential treatment with generic teriparatide (TPTD) followed by ALN and generic ALN monotherapy. Patients were assumed to receive 18 months ABL or generic TPTD followed by 5 years ALN, or 5 years ALN monotherapy. The model accounted for time-specific risk of subsequent fracture in patients with a recent fracture, incorporated incremental costs following fractures up to 5 years and used US men-specific data when available. The effects of ABL/ALN on fracture risk were derived from the ACTIVExtend trial. Evaluation was done for men 50-80 years old with a BMD T-score ≤-2.5 (defined using BMD reference value for US White men) and with a recent fracture.

RESULTS: Over the full age range, sequential ABL/ALN was shown to be dominant (lower costs for more QALYs) compared with sequential generic TPTD/ALN. Sequential ABL/ALN was also cost-effective compared with no treatment, with cost per QALY gained falling under $100,000 from the age of 50 years, and below $50,000 in men aged 70 years and over. Compared with generic ALN monotherapy, the cost per QALY gained was lower than $200,000 in men aged 55-65 years, and below $150,000 in men aged 70 years and older.

CONCLUSIONS: In US men aged 50 years and older at imminent risk of fractures, sequential ABL/ALN is a cost-effective alternative compared to generic TPTD/ALN and no treatment. Note the wholesale acquisition cost for US generic TPTD for 2022 is approximately 35% lower than branded TPTD suggesting that the cost savings from ABL/ALN are even more favorable compared to branded TPTD/ALN. Sequential ABL/ALN could also be considered as cost-effective compared to generic ALN monotherapy in men aged 70 years and older (at a threshold of $150,000).

SPONSORSHIP: Radius Health, Inc

N00-N99 Diseases of the Genitourinary System

(eg, chronic kidney disease)

N3 Real-world outcomes associated with codispensing CYP2D6 substrates metoprolol or carvedilol with CYP2D6 inhibitor mirabegron

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BACKGROUND: Mirabegron, a β3-adrenergic receptor agonist approved for the treatment of overactive bladder (OAB), is a moderate CYP2D6 inhibitor. Codispensing of mirabegron with CYP2D6 substrates may occur when patients have OAB and a comorbid condition requiring treatment, such as