considered when an increase of 1.2 from baseline in DAS28 or an increase of 1.1 in ASDAS occurred. A cost analysis was done based on the purchasing prices of the 2 drugs at our centre.

Results: In a 12 months period switch to CT-P13 was performed in 60 patients for non-medical reasons. Disease activity (DA) was stable over the observation period and similar to the values observed with IFXor. Median follow-up time was 261 days during which disease worsening occurred in 3 (5%) patients. 1 patient had a minor adverse event (oedema of the lip). These 4 (6.7%) patients stopped the BS. One returned to IFXor and the other 3 switched to another drug. The switch to CT-P13 represented a 26.4% reduction of costs in the use of IFX Tx in these patients.

Abstract AB1231 – Table 1. Numbers are medians unless otherwise stated.

	Total (n=60)	SpA (n=36; 60%)	RA (n=16; 27%)	PA (n=8; 13%)
Age (years)	53 (48–64)	50 (41–59)	59 (52–70)	56 (48–64)
Gender (n,% male)	39 (65%)	30 (83%)	2 (13%)	7 (88%)
Disease duration (years)	17 (10–23)	16 (10–22)	18 (13–24)	16 (10–22)
Patients on methotrexate	41 (68%)	20 (33%)	15 (25%)	6 (10%)
Patients with previous biologic therapy	4 (6.7%)	1 (2.8%)	3 (18.8%)	0 (0%)
Time on IFX originator before switch (years)	7.9 (6.5–11.9)	7.7 (6.4–12.3)	8.4 (6.7–12.4)	7.6 (6.7–9.6)
Time on CT-P13 since switch (months)	9 (7–11)	9 (7–11)	10 (9–10)	9 (4–10)

Abstract AB1231 – Table 2. Variables median from baseline to 9 months after switch to CT-P13. ESR – Erythrocyte Sedimentation Rate; CRP – C-Reactive Protein; PtGA – Patient global assessment of DA; PhGA – Physician global assessment of DA.

	Baseline	3 Months after switch	6 Months after switch	9 Months after switch	Variation from baseline to 9 Months after switch
ESR (mm/h)	15 (10–21)	17 (9–29)	15 (9–24)	15 (9–24)	0
CRP (mg/dL)	0.18 (0.80–0.57)	0.17 (0.06–0.50)	0.19 (0.10–0.46)	0.25 (0.10–0.72)	0.07
PtGA (0–100)	30 (20–50)	20 (30–50)	30 (3–50)	30 (15–50)	0
PhGA (0–100)	20 (10–30)	20 (10–30)	20 (0–30)	20 (10–30)	0

Abstract AB1231 – Figure 1

Conclusions: The switch in routine care of a group of RA, SpA and PsA patients from IFXor to CT-P13 did not affect efficacy and safety and reduced costs in 26.4%.

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AB1232

ESTIMATING THE ECONOMIC VALUE OF A PATIENT SUPPORT PROGRAM IN RHEUMATOID ARTHRITIS IN THE UNITED KINGDOM

A. Ostor¹, V. Garg², M. Yang³, C. Chamberlain⁴, M. Skup². ¹Cabrini Medical Centre, Melbourne, Australia; ²AbbVie, Chicago; ³Analysis Group, Inc.; ⁴Analysis Group, Inc., Boston, USA

Background: A Patient Support Program (PSP) offered by AbbVie to adalimumab-treated patients assists them with issues pertaining to medication costs, nurse support, injection training, pen disposal, and medication reminders. A number of studies have reported the benefit of enrollment in this PSP from different perspectives, including clinical, patient-reported, and adherence outcomes.^{1–2} There is limited information available on the economic value of the PSP.

Objectives: To estimate the incremental economic value associated with enrollment in the PSP for adalimumab-treated patients with rheumatoid arthritis (RA) from a UK societal perspective.

Methods: An Excel-based economic model was developed to describe adalimumab-treated PSP enrollees over non-enrollees in terms of a) improvement in clinical status as measured by the Health Assessment Questionnaire Disability Index (HAQ-DI), which resulted in reduced healthcare resource utilisation (HRU), and b) improvement in work productivity as measured by the Work Productivity and Activity Impairment Questionnaire (WPAI). The associated incremental direct and indirect cost savings were estimated over a 12 month period. Scores on HAQ-DI, work productivity impairment, and employment rate were obtained from a prospective, observational Phase IV study assessing patient satisfaction and outcomes in the context of the PSP (AbbVie Care) among RA patients (NCT01383421, PASSION)¹. Inputs from literature and UK-specific publicly available sources were used to model the association between HAQ-DI score categories (0 –<0.6, 0.6 –<1.1, 1.1 –<1.6, 1.6 –<2.1, 2.1–3) and HRU among RA patients, and to obtain unit costs of HRU (i.e., hospitalizations, specialist visits, imaging assessments) and weekly work compensation.

Results: In PASSION, a greater proportion of PSP enrollees were in the lower HAQ-DI categories (i.e., better outcomes) and enrollees had greater reduction in total work impairment than non-enrollees after treatment with adalimumab. Assuming a population of 10 000 adalimumab-treated RA patients in the UK, this was associated with an incremental annual cost saving of £2,320,809 should all these patients enrol in the PSP. The largest proportion of incremental cost saving resulted from the reduction in RA-related hospitalizations (£1,550,637; 66.8%). Cost saving due to improved work productivity accounted for the second largest proportion (£686,963, 29.6%). Specialist visits and imaging assessments accounted for 1.9% (£44,564) and 1.7% (£38,645) of the total incremental cost saving, respectively.

Conclusions: Enrollment in AbbVie's PSP was shown to be associated with incremental cost saving among adalimumab-treated RA patients due to reduced resource utilisation and improved work productivity.

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AB1233

DOES TIME MATTER? A SYSTEMATIC REVIEW TO ASSESS THE RELATIONSHIP BETWEEN DELAY IN DIAGNOSIS AND COSTS IN DMARD-NAÏVE RA PATIENTS

I. Sahbudin^{1,2}, R. Singh^{1,2}, J. Trickey², A. Tracy³, K. Raza^{2,3}, A. Filer^{1,2}, A. Boonen⁴. ¹Department of Rheumatology, University Hospitals Birmingham NHS Foundation Trust, Queen Elizabeth Hospital Birmingham; ²Rheumatology Research Group, Institute of Inflammation and Ageing, University Hospitals of Birmingham; ³Department of Rheumatology, Sandwell and West Birmingham Hospitals NHS Trust, Birmingham, UK; ⁴Maastricht University Medical Center and Capri Research Institute, Maastricht University, Maastricht, Netherlands

Background: Early diagnosis is crucial to enable timely DMARDs initiation in RA patients. Although, early treatment improves clinical outcomes, it is unclear whether this has a similar impact on health economic outcomes. Early DMARDs

intervention may avert the requirement of expensive biological therapy as second-line treatment, which leads to improved overall cost-effectiveness. As a first step to address this issue, we performed a systematic literature review to appraise existing evidence relating to delay in diagnosis and cost-of-illness in DMARD-naïve newly-diagnosed RA patients.

Objectives: To identify whether disease duration before initiation of first DMARD therapy is a determinant of subsequent direct and indirect costs in DMARD-naïve RA patients.

Methods: We systematically searched Pubmed, EMBASE, CINAHL and Medline databases for published literature relating to rheumatoid arthritis, and direct and/or indirect costs. We included studies with DMARD-naïve patients who fulfilled the 1987 ACR or 2010 ACR/EULAR classification criteria for RA. We excluded: ¹ studies on non-rheumatoid arthritis patients; ² conference abstracts, systematic reviews or review articles; ³ studies with no documented symptom duration prior to diagnosis; ⁴ studies which did not report direct and/or direct costs and/or health utilisation. All studies were required to report their methods and sources of respective cost measurements. We extracted the following data from each study; ¹ study design; ² potential determinants of RA cost; ³ health economic outcomes and ⁴ source of unit cost for the health-resources.

Results: A total of 173 records were identified in the systematic search, five of which included in the analysis. Two were cost-of-illness studies within the context of observational studies and the remaining were cost-of-illness studies alongside clinical trials. The health outcomes reported were heterogeneous: 1) Direct medical costs were reported in three studies; 2) Indirect non-medical costs were reported in one study and 3) Health-care utilisation was reported in one study. Only one study reported indirect costs from the societal perspective e.g. work disability. The definition of symptom duration was not specified in any studies. Three studies reported disease duration of one year or less and two studies reported symptom duration of six months and <two years. The timing and duration of the reported health economic outcomes varied widely (figure 1). The direct medical costs for three papers were adjusted for purchasing power parities and consumer price index for 2017 US Dollars.

Abstract AB1233 – Figure 1

Conclusions: Data on the relationship between symptom duration and costs in DMARD-naïve RA patients is limited. Comparability between studies is hampered due to heterogeneity of the definition for symptom/disease duration and the health economic outcomes reported. An inception cohort of suspected/early RA should include data in resource utilisation and costs studies to identify the relationship between symptom duration and health economic outcomes.

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AB1234

WHAT HAPPENS IF IT ISN'T EARLY INFLAMMATORY ARTHRITIS? A RETROSPECTIVE CASE NOTE REVIEW OF PATIENTS REFERRED TO OUR EIA SERVICE WHO DID NOT HAVE EIA

A.G. Pulikal¹, T. Ahmed², S. Levy². ¹Medical Student, St George's University of London; ²Rheumatology, Croydon University Hospital, London, UK

Background: Early inflammatory arthritis (EIA) has been a flagship subject for Rheumatology in the last few years. There has been a lot of interest in the patients diagnosed with EIA but less is known about those who enter the EIA pathway and are subsequently found not to have EIA.

Objectives: This study looks at the diagnoses and management of those discharged from the EIA pathway and what impact this has on resources, management and time. Croydon University Hospital Rheumatology Department has been running an Early Inflammatory Arthritis service incorporating ultrasound since 2014. In this study we are looking at patients that were referred to the EIA Pathway from August 2014 to August 2015.

Methods: To collect the data we looked at the patient records from our clinical system, Cerner Millennium. We recorded the clinical impression on first appointment, final diagnosis, additional investigations, referrals to therapies and other specialists and those that were discharged within the 6 weeks of referral. The data was analysed using Microsoft Excel 2010

Results: Of the 368 patients who were referred to the EIA pathway 140 (38%) were not diagnosed with EIA. The final diagnosis of these patients was osteoarthritis 29 (26%), no rheumatological diagnosis 16 (14%), soft tissue abnormality 11 (9.8%), gout 7 (6.3%), fibromyalgia/hypermobility 7 (6.3%), SLE 5 (4.5%) and polymyalgia rheumatica 4 (3.6%). The remainder, 29 (26%), had miscellaneous rheumatological diagnoses. Of the 140 patients, 28 were thought to have possible EIA on the first consultation. The final diagnosis in this group was osteoarthritis 7 (25%), no rheumatological diagnosis 7 (25%), soft tissue/musculoskeletal injury 3 (11%) and fibromyalgia 2 (7%). The remainder had miscellaneous diagnosis 9 (32%). All patients had routine bloods and x-rays. In addition, musculoskeletal ultrasound was carried out in 22, MRI in 12, CT in 3, EMG in 4 and 3 patients underwent bone density scanning. 13 were referred on to physiotherapy (8 were to hand therapy). 5 were referred to other medical specialities. 30 patients were discharged within 6 weeks.

Conclusions: This is the first study looking at those who did not have EIA. The Best Practice Tariff for EIA states that those without EIA should be discharged back to the GP within 6 weeks. We have shown that these patients have a variety of rheumatological diagnoses that require investigation, referral and treatment with the majority (79%) remaining under our care at 6 weeks. This study highlights the resources needed to manage the patients attending rheumatology via the EIA pathway who do not have EIA and this should be taken into account when such a service is developed.

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AB1235

WORK PRODUCTIVITY AMONG WORKERS WITH AXIAL SPONDYLOARTHRITIS

C.A. Lopes^{1,2}, F.M. Pimentel-Santos^{1,2}, M. Mateus¹, J.C. Branco^{1,2}.

¹Rheumatology, HOSPITAL EGAS MONIZ – CHLO; ²CEDOC, NOVA Medical School, NOVA University of Lisbon, Lisbon, Portugal

Background: Axial Spondyloarthritis (axSpA) usually starts in early adulthood and the lifetime impact of the disease can be considerable. Pain, stiffness, sleep disturbances contribute to health-related quality of life reduction with significant impact in work productivity. Absenteeism and presenteeism are still responsible for high costs associated with the disease.

Objectives: Assess absenteeism, presenteeism, work and daily-activities impairment and their related associated factors in patients with axSpA.

Methods: Cross-sectional postal, unicenter, non-interventional study. Patients fulfilling the Assessment of SpA International Society Classification criteria for axSpA under working age were included. Two groups were defined: A) patients under current anti-TNF; B) patients under conventional therapy. Quantitative and qualitative surveys were performed: Work Productivity and Activity Impairment Questionnaire in SpA (WPAI); participants' experiences of working and their perceptions of how their condition had affected their work capacity and workplace relationships were recorded. The questionnaires were applied through a telephone call, after consent of the participant and respecting anonymity.

Results: 60 patients were included (table 1). No significant differences were found between the two groups. They worked on average 42±14.7 hours per week (h/w) and missed 2.3±4.1 h/w due to axSpA. Mean absenteeism, presenteeism, work and activities impairment due to axSpA were 6.8%, 32%, 35% and 41%, respectively. The univariable analysis showed correlations between absenteeism and Visual Analogue Scale physician (pVAS) (p=0.027); presenteeism and Anquilosing Spondylitis disease activity score – C reactive protein (ASDAS-CRP) (p=0.002), Bath AS Disease Activity Index (BASDAI) (p=0.03), Bath AS Functional Index (BASFI) (p=0.02), VAS patient (pVAS) and pVAS (p=0.01, p=0.006), erythrocyte sedimentation rate (ESR) (p=0.03), CRP (p=0.024); percent overall work impairment and ASDAS-CRP (p=0.002), BASDAI (p=0.019), BASFI (p=0.026), pVAS and pVAS (p=0.016, p=0.01), ESR (p=0.03) and CRP (p=0.03); percent activity impairment and BASDAI (p=0.006), BASFI (p=0.004), pVAS (p=0.0004) and pVAS (p=0.007). No correlation was found between work productivity and anti-TNF medication, education or marital status. Regression analysis revealed that BASDAI, BASFI, pVAS, pVAS and CRP accounted for 63% of the variance of presenteeism, with 10 points increase in pVAS resulted in an increase of 17% in presenteeism (p=0.046). Over time, 95% had already gone to work sick: economic reasons (60%), not liking staying at home even sick (43%) and importance of work (35%) were the major reasons to presenteeism. Overall, 63% considered that the disease can limit their projects or career progression; 56% had already cancelled or postponed work; 20% had already changed jobs and 15% stated that had already felt discriminated.