Table 1. Healthcare resource utilisation of patients with systemic lupus erythematosus between in Western Australia between 2000-2019.

	Outpatient	ED Visits	Admissions
Patients, n (%)	179 (100)	143 (79.9)	125 (69.8)
Total events, n	13,320	794	678
Visit rate per 100 patient years (95%CI)	738.9 (726.3, 751.4)	44.0 (41.0, 47.2)	37.6 (34.8, 40.5)
Patients with ≥ 2 visit per annum, n (%)	153 (85.5)	110 ()	94 ()
Patients with ≥ 4 visits per annum, n (%)	112 (62.6)		
Patients with >10 visits per annum, n (%)	37 (20.7)	17 ()	13 ()
Discharged from ED, n (%)	-	684	-
Admitted from the ED, n (%)	-	110	110
Average length of stay, median (IQR)	-	3.0(2.1, 4.0) hrs	3.2 (1.5, 5.85) days
Patients with an overnight admission, n (%)	-	-	122 (98)
Overnight admissions, median (IQR)	-	-	3 (1, 5)
Patients with admissions >7 days	-	-	53 (42.4)
Costs AUD (FY2018/19)	\$6,273,720	\$869,430	\$10,997,485

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AB1185

BUDGET IMPACT ANALYSIS OF INTRODUCING SUBCUTANEOUS INFLIXIMAB CT-P13 SC FROM THE UK PAYER PERSPECTIVE

M. Perry¹, M. Jang². ¹Royal Alexandra Hospital, Paisley, United Kingdom; ²Celltrion Healthcare Co., Ltd, Incheon, Korea, Rep. of (South Korea)

Background: CT-P13 subcutaneous (SC) is the first and only SC version of infliximab developed by Celltrion Healthcare and currently approved by the European Medicines Agency (EMA) for the treatment of rheumatoid arthritis (RA). Infliximab has been only available in intravenous (IV) formulation and thus this new mode of administration will allow patients to self-inject at homes. Self-injection will reduce number of outpatient visits and expected to decrease IV administration cost significantly. This research describes the economic impact of introducing infliximab SC from the UK payer perspective.

Objectives: The budget impact analysis (BIA) was conducted to assess the financial impact of the adoption of infliximab SC. The BIA calculates the costs of treatment (drug acquisition cost and administration) for patients with RA as first-line treatments, and compares the cost in a scenario without infliximab SC vs a scenario with infliximab SC to estimate the budget impact over the 5 year period.

Methods: A prevalence-based BIM was developed incorporating epidemiological data, administration cost data from the literature and market share data from IQVIA. The analysis compared a market scenario where a proportion of patients were treated with infliximab SC ('World With' infliximab SC) to an alternative market scenario where infliximab SC were not available and all patients were treated with IV ('World Without' infliximab SC). The model assumed that the clinical outcomes are same between infliximab SC and infliximab IV, and patients entering the model were all naïve and remained in the treatment for 5 years. In the 'World With' scenario, patients receiving infliximab IV switched to SC administration at 30% in Year 1, 45% in Year 2, and remained 60% from Year 3 to 5. The drug cost of infliximab SC is assumed to be the same as that of comparator treatments. Administration cost per infliximab IV infusion was estimated to be £382 and £3.32 per SC administration.

Results: Compared to the "World Without" infliximab SC, the introduction of subcutaneous infliximab resulted in cost savings of £39.6 million in UK over a 5-year period, equating to 4,466 additional patients to be treated with infliximab SC in base case scenario.

Sensitivity analysis includes dose-escalation up to 5mg/kg to reflect the real-world setting. In that scenario, the saving increases to £279.6 million over a 5-year period, equating to 30,839 additional patients to be treated with infliximab SC.

Conclusion: Utilization of subcutaneous infliximab may lead to substantial cost savings for UK payers. Self-injection will significantly reduce the burden on healthcare delivery allowing resource to be spent elsewhere. Sensitivity analysis concluded that treatment with increased IV dose will result in higher savings from switching patients to subcutaneous infliximab.

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AB1186

THE NHS SCOTLAND THERAPEUTIC DRUG MONITORING SERVICE FOR BIOLOGIC MEDICINES: PRELIMINARY ANALYSIS OF UTILISATION AND CLINICAL RESULTS AT YEAR 1

J. Macdonald¹, M. Perry², P. Galloway¹, J. P. Seenan¹, A. Dunlop¹. ¹Queen Elizabeth University Hospital, Glasgow, United Kingdom; ²Royal Alexandra Hospital, Paisley, United Kingdom

Background: Anti-tumour necrosis factor α (anti-TNFα) drugs infliximab (IFX) and adalimumab (ADL) are effective treatments for several rheumatic diseases. Therapeutic drug level and anti-drug antibody monitoring (TDM) has emerged as a useful tool for optimising drug effectiveness, by identifying individuals who may benefit from dose or treatment frequency adjustment, or have secondary drug failure due to immunogenicity.

Objectives: Ensuring safe and effective use of biologic medicines has been identified as a key priority for NHS Scotland. Inequity and inconsistency of access to TDM across the nation was recognised as a barrier to delivering best practice and so a nationally commissioned TDM service was proposed in January 2018 to support clinical practice, providing universal access to TDM for services treating inflammatory diseases across Scotland. Data collection and analysis of results regarding usage and clinical impact of the service were identified as key outcome measures to assess service success and sustainability.

Methods: A service webpage was developed to provide guidance on testing strategies and interpretation of TDM results (1). An automated search of clinical data and test results recorded within the clinical biochemistry electronic results management system was conducted to identify all TDM tests performed between 01/01/2018 and 31/12/2018. Descriptive analysis outcomes included the number of samples received, processed, overall testing population, service utilisation by Health Board, number and results of TDM tests performed per patient. TDM results were interpreted according to published guidance on the service webpage and comparison was made with previously published data (2).

Results: 3609 specimens were received for testing, from 13 of the 14 Scottish Health Boards. 3561 drug level (DL) tests were performed; 1786 IFX, 1775 ADL. 2717 total antidrug anti-body (TABT) tests and 681 free antidrug anti-body tests (FABT) were performed according to service protocol. 2791 individuals had one or more TDM tests during the 12-month period, of whom 541 were tested twice or more (range 2-5).

Table 1. IFX & ADL DL, TABT and FABT results by category as defined in service guidance (AU/ml = Arbitrary Units/ml)]

		INFLIXIMAB	ADALIMUMAB	
Drug level by category	Supratherapeutic DL > 8mcg/ml	546 (30.6%)	708 (39.9%)	Supratherapeutic DL > 10 mcg/ml
	Therapeutic DL ≥3<8.1mcg/ml	738 (41.3%)	636 (35.8%)	Therapeutic DL ≥5<10.1 mcg/ml
	Sub-therapeutic DL < 3mcg/ml	502 (28.1%)	431 (24.3%)	Sub-therapeutic DL < 5 mcg/ml
				Negative (<10 AU/ml)
TABT by category	Negative (<10 AU/ml)	791 (54.2%)	905 (71.9%)	

Table 1. IFX & ADL DL, TABT and FABT results by category as defined in service guidance (AU/ml = Arbitrary Units/ml)]

		INFLIXIMAB	ADALIMUMAB	
FABT by category	Positive (>10 AU/ml)	668 (45.8%)	353 (28.1%)	Positive (>10 AU/ml)
	Negative (< 5AU/ml)	376 (82.8%)	176 (77.6%)	Negative (<10 AU/ml)
	Positive (> 5 AU/ml)	78 (17.2%)	51 (22.4%)	Positive (>10 AU/ml)

Conclusion: TDM has been enthusiastically embraced. It is estimated that > 50% of individuals treated with IFX or ADL have been tested at least once in the first year. DL results were found to be similar to previously published data, as were rates of antibody positivity. The large volume of data generated by the service may provide additional evidence regarding the utility of TDM in predicting clinical response. Next steps are to conduct a comparative effectiveness analysis where proactive vs reactive TDM testing strategies will be compared, with the primary outcome measure being the proportions of patients with secondary loss of response.

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AB1187 TREATMENT ADHERENCE: WHAT ABOUT THE RHEUMATOLOGIST?

R. Pineda-Sic¹, M. M. Castañeda-Martínez¹, I. D. J. Hernandez-Galarza¹, E. I. Guevara Elizondo¹, D. E. Flores Alvarado¹, G. Serna-Peña¹, I. J. Colunga-Pedraza¹, D. Á. Galarza-Delgado¹. ¹Universidad Autónoma de Nuevo León, Monterrey, Nuevo León, Mexico

Background: Adherence to medications among patients with rheumatic diseases is often suboptimal.¹ Adherence to treatment has been described to be affected by several factors.² The rheumatologist plays a crucial role in influencing adherence behavior by addressing perceptions about medication, providing information, and establishing trust in the treatment plan.³ There is no record of attitudes and thoughts of Mexico's rheumatologists about adherence to medication. **Objectives:** To know the rheumatologist's attitudes regarding treatment adherence in follow up consultation.

Methods: Descriptive, cross sectional study. Rheumatologists from across the country were invited to respond an electronic survey created with Google Forms, link was sent by Whatsapp @ message, responses were anonymous. The survey was constructed taking into account the main barriers of adherence related to the doctor. Seven questions were created, from one to six were multiple selections and the seven were open question 1. Where do you practice medicine? 2. Do you ask all your patients about adherence medication? 3. If your answer was positive, do you ask individually for each drug? 4. How long do you spend on explaining: side effects, benefits, and mechanisms of action of drugs? 5. Do you discuss available treatment options with your patients to decide one? 6. What's the definition of adherence? 7. Which activities can the doctor do to improve adherence to their patients?

Results: Data were collected from 158 rheumatologists who completed the survey. Regarding the question where they practice medicine, 19.5% answered they work in public medical institutions, 31.8% do private practice and 48.7% work in both of them, 88.3% answered correctly adherence definition, 93% of rheumatologists ask for adherence to medication in the follow up consultation and only 86.1% do it individually for each medication, 97.4% discuss therapeutic options with their patients. The time used to explain treatment is presented in Figure 1. The interventions considered by rheumatologists to increase adherence are reported in Table 1.

Table 1 Interventions considered by rheumatologists to increase adherence

Patient education (in follow up consultation, conferences, pamphlets)
Develop rapport with patient. ("be accessible", "answer questions" "make the patient part of" don't be paternalistic or authoritarian")
Adherence measure (Use the available method, questionnaires, self-report, drug levels, electronic pillbox, pill count, etc. "Don't matter which one, measure it!")
Interventions for no adherence reasons (phone calls, text messages, telephone alarms) fixed schedules for each medication, cognitive-behavioral therapy, access to medications)
 Family support network
 Presented in order to frequencies and grouped by topic

Figure 1 Time used by rheumatologists to explain treatment in follow up consultation

Conclusion: Rheumatologists ask for adherence medication but more than half use a limited amount of time to explain about medication, nevertheless, they think that patient education is the best intervention to increase adherence.

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AB1188 INFLUENZA VACCINATION TREND IN THE LAST DECADE AND FACTORS INFLUENCING THE RATE OF INFLUENZA VACCINATION IN CHRONIC INFLAMMATORY ARTHRITIS IN THE ITALIAN REGION OF FRIULI VENEZIA GIULIA (2006-2018)

L. Quartuccio¹, A. Zabotti², G. De Marchi², T. Gallo³, S. De Vita¹, F. Valent⁴.

¹Clinic of Rheumatology, Department of Medicine, Academic Hospital "Santa Maria della Misericordia", ASUI, Udine, Italy, Udine, Italy; ²Clinic of Rheumatology, Academic Hospital "Santa Maria della Misericordia", ASUI, Udine, Italy, Udine, Italy; ³Department of Prevention, ASUFC, Udine, Italy, Udine, Italy; ⁴Institute of Epidemiology, Academic Hospital "Santa Maria della Misericordia", ASUI, Udine, Italy, Udine, Italy

Background: vaccination is one of the most important medical intervention to prevent infectious complications in population at risk. EULAR recommendations for vaccination of patients suffering from autoimmune inflammatory rheumatic diseases (AIIRD) have been recently updated (1).

Objectives: to verify the level of coverage of the influenza vaccination in a local population of patients suffering from rheumatoid arthritis (RA), psoriatic arthritis (PsA) or ankylosing spondylitis (AS).

Methods: integration of the information coming from many administrative databases were used to this end. The Regional Health Information System of Friuli Venezia Giulia was used as the source of information for this retrospective cohort study. Patients were residents in Friuli Venezia Giulia and they had to carry the exemption code for RA, or PsA, or AS and at least one prescription of a